STAR 2000™

Preface

The *STAR Financials Patient Accounting Reference Guide* is a multivolume document written for all users of the system. This volume contains a detailed explanation of the Account Inquiry and Account Revision 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).

STAR Financials Patient Accounting Reference Guide - Account Inquiry and Revision Volume
October 2012   *Release 18.0*   *iii*
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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 Account Inquiry and Account Revision functions in the base Patient Accounting system. This manual contains the following chapters:

Chapter 1: Account Inquiry

This chapter discusses the Account Inquiry function, which enables you to view a patient's admission, medical, and financial information.

Chapter 2: Account Revision

This chapter discusses the Account Revision function, which enables you to view and edit a patient's admission, medical, and financial information.

Chapter 1 - ACCOUNT INQUIRY

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ACCOUNT INQUIRY

The Account Inquiry function enables you to view a patient's admission, medical, and financial information. With the exception of the Account Notes option, you cannot edit any of the screens displayed through Account Inquiry.

In **Admission Information**, you can view account such information as:

- Patient demographics

- Patient employer demographics

- Guarantor data

- Guarantor employer

- Patient relatives

- Patient insurance

- UB data

- Medical data

The STAR Patient Care system provides this information to the STAR Financials Patient Accounting system.

In **Medical Information**, you can view such account information as:

- General medical data

- DRG information

- HCPCS procedures

- Diagnosis information

- Procedure information

- Location information

- Medical Records Diagnosis information

- Admissions Diagnosis information

The STAR Patient Care system provides this information to the STAR Financials Patient Accounting system.

In **Financial Information**, you can view such financial data as:

- Billing information

- Claim information

- Transaction history

- Insurance follow-up

- Account follow-up

- Account balance summary

The **Account Notes** option enables you to post freeform or standard notes to patient accounts. These notes are used to keep track of items normally noted on patient folders manually. You can add a new note or view and edit existing notes. Standard notes are brief hospital-defined notes which can be selected from a list and consist of messages such as *Called Guarantor* or *Claim returned - wrong address.* Freeform notes are used to enter up to 13 lines of text. For example, you can add additional information to a standard note or document a telephone conversation.

After you select the Account Inquiry function, the system displays the following prompt:

Patient (P) or guarantor (G) lookup? [P]--

To look up information about an account by patient, enter **P** or press ENTER to accept the default. To look up information about an account by guarantor, enter **G**.

If this is a multifacility installation and you are allowed to display information for multiple facilities, if you enter **P** or press ENTER to look up information about an account by patient, the system prompts you to select a facility. Select the facility from the list displayed on the screen. If you enter **G** to look up information about an account by guarantor, the system displays information about only the guarantor in the facility or facilities you are allowed to view.

The system then displays the following prompt:

Enter account, 'C'orporate, 'S'ocial security/health card or 'U'nit number, name or '-'name for soundex--

Select the account you want to display using the techniques described for the FPI Lookup procedure in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide.*

The system then displays the following screen:

```
              General Hospital Account Inquiry Processor
                                          Fri Mar 10, 2007 12:36 pm
 Account      Name                  FC Typ Admit    Disch       Balance  Loc
 A0514000007  CREED,MARK            S  O/P 05/20/05 05/20/05      0.00    PA/FCRV
  1 Total Charges    2 Total Adj      3 Total Payments   4 Ref? Exp? Pat Class
           $0.00            $0.00             $0.00        No   No
  5 Ins Liability    6 Ins Adj        7 Ins Payments     8 Agency
           $0.00            $0.00             $0.00
  9 Pt Liability    10 Patient Adj   11 Pt Payments     12 Last Pt Payment
           $0.00            $0.00             $0.00
 13 Wkfl    14 Sch  15 Schd Typ   16 Phone 17 Inv Gu Addr 18 Lst FU Dt Ty Sq Hld
            3           Separate      Y/N/Y   No                            No
 19 BD Pre-Listed   20 BD Date    21 Agency            22 BD Transfer Amount

 23 SSN #        24 Birth Date 25 BillHld 26 DPW/CMS 27 Nts 28 PRE/Adm 29 Accts
    345-35-4354    05/12/1968     No        No/No     No      /MLK       Yes
 30 COB Ins Carrier       #Clm LCS SubmitDt   Est Amt Due   Amt Pd Dsp Date

 $   1  BLUE CROSS OF GA  1   1            $538.40     $100.00  P  06/20/08
     2  BLUE CROSS 1500
     3  PRIMARY PLAN      1   3              $0.00
     4  TESTING           1   4              $9.60




 Press NL for Menu, enter code, or '-' for list--
```

This screen provides a quick reference for key financial information about the patient's account. From this screen, press ENTER and the Account Inquiry menu is displayed. You can enter a function code or enter a hyphen (**-**) for a table lookup of valid function codes.

Field Explanations

1.   TOTAL CHARGES (DISPLAY ONLY)
This field contains the dollar value of all charges for the patient.

2.   TOTAL ADJ (DISPLAY ONLY)
This field contains the dollar value for all adjustments (both patient and insurance) made on the account.

3.   TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total payments posted to this account.

4.   REF? EXP? PAT CLASS (DISPLAY ONLY)
This field displays the refund indicator, the expiration indicator, and the patient's classification.

Ref contains either a **Y** for yes to indicate that a refund has been posted for this account or an **N** for no to indicate that no refund has been posted for this account. The indicator reflects the account having a guarantor and/or carrier refund. A carrier or guarantor

refund with a status of Hold or Exclude does not reflect as a Yes. Only refunds processed or with a status of Approved are reflected with Yes.

Exp contains either a **Y** for yes to indicate that the patient is expired or a **N** for no to indicate that the patient is not expired.

Under Pat Class, the system displays the Patient Classification for the account. If the Financial Patient Classification Table had the Alert on PA? field was set to Y when the classification was determined for the account, then the patient classification is displayed with leading and trailing asterisks, for example, **VIP**. If Alert on PA? was set to N when the classification was determined for the account, then the patient classification is displayed without leading and trailing asterisks, for example, EMP.

The final position indicates whether follow-up for the account is being suppressed. If the Financial Patient Classification Table had the Suppress F/Up on PA? field was set to N when the classification was determined for the account, then **a** is displayed, indicating that follow-up continues to be produced. If the Suppress F/Up on PA? field was set to Y when the classification was determined for the account, and the suppression indicator in Account Status has not been changed to Clear, then **s** is displayed, indicating follow-up is suppressed. If the Suppress F/Up on PA? field was set to Y when the classification was determined for the account, and a user has cleared the suppression indicator in Account Status, then **c** is displayed, indicating follow-up is not suppressed due to a user overriding the value set by the Financial Patient Classification Table.

5. INS LIABILITY (DISPLAY ONLY)
This field contains the current balance due from all insurance plans.

6. INS ADJ (DISPLAY ONLY)
This field contains the dollar value of all insurance adjustments made on the account.

7. INS PAYMENTS (DISPLAY ONLY)
This field contains the dollar value of all insurance payments made on the account.

8. EXTERNAL AGENCY (DISPLAY ONLY)
This field contains the collection agency code, status code, status, and status date.

9. PT LIABILITY (DISPLAY ONLY)
This field contains the current balance due from the patient on the account.

10. PATIENT ADJ (DISPLAY ONLY)
This field contains the total of all patient adjustments posted to the account.

11. PT PAYMENTS (DISPLAY ONLY)
This field contains the dollar value of all patient payments made on the account.

12. LAST PT PAYMENT (DISPLAY ONLY)
This field contains the last patient payment date and the payment amount.

13. WKFL (DISPLAY ONLY)
This field contains any workfile entries that exist for the account. Multiple workfile codes are separated by a comma. Workfile codes include:

- A - Active

- B - Business Office

- D - Delinquent

- I - Insurance

- P - Partial Payment

- R - Promise to Pay

- S - Standard

- E - Pending/Candidate

- W - Internal/Bad Debt

- C - Agency

- FI - Focus Insurance

- FP - Focus Patient

- FC - Focus Claim

14. SCHD (DISPLAY ONLY)
This field contains the follow-up schedule code assigned to the account.

15. SCHD TYPE (DISPLAY ONLY)
This field contains the follow-up schedule type assigned to the account.

16. PH (DISPLAY ONLY)
This field indicates whether it is acceptable to leave a phone message for the patient and whether the phone number is a confidential number.

- The first position of this field displays a Y for Yes to indicate it is acceptable to leave a message for the patient or it displays an N for No to indicate it is not acceptable to leave a message for the patient. The phone message field contained on the Patient Page or Alternate Address page for the patient is used for the first position of the field.

    - If the phone number is not a confidential phone number, the system uses the value in the Phone Message field on the Patient Page in Patient Processing.

- If the phone number is a confidential phone number, the system uses the value in the Phone Message field on the Alternate Address screen for the patient.

- The second position of this field displays a Y for Yes to indicate the phone number is a confidential phone number or it displays an N for No to indicate it is not a confidential phone number. The phone number contained in the Phone Number field on the Alternate Address page is considered the confidential phone number when the Confidential Add-Ph field on the Alternate Address screen is set to Yes.

   - If there is a phone number on the Alternate Address page and the Confidential Add-Ph field is set to Yes, the second portion of the field displays a Y for Yes, there is a confidential phone number.

   - If there is not a phone number contained in the Phone Number field on the Alternate Address page or the Confidential Add-Ph field on the Alternate Address screen is not set to Yes, there is not a confidential phone number defined.

- The third position of this field reflects whether the confidential/alternate address is being used at the visit level. The parameter contains Y for Yes if the confidential/ alternate address is being used; it contains N for No if the confidential/alternate address is not being used.

17. INV GU ADDR (DISPLAY ONLY)
This field indicates whether the guarantor address is invalid or missing on the guarantor page or alternate guarantor page depending on which address is being used. A **Y** reflects the address is invalid or missing. An **N** reflects a valid and existing guarantor address.

18. LST FU DT TY SQ HLD (DISPLAY ONLY)
This field contains the last follow-up date, type, and sequence number processed for the account. The HLD (Hold) field indicates whether the account has been placed on follow-up hold, the account is assigned to a guarantor's schedule, or the guarantor has been placed on follow-up hold.

19. BD PRE-LISTED (DISPLAY ONLY)
This field indicates the Bad Debt prelist status of the account.

20. BD DATE (DISPLAY ONLY)
This field indicates the Bad Debt prelist date, or if the account is already in Bad Debt, the transfer to Bad Debt date.

21. AGENCY (DISPLAY ONLY)
This field contains the assigned collection agency for the account if the account has been prelisted or transferred to Bad Debt.

22. BD TRANSFER AMOUNT (DISPLAY ONLY)
This field contains the balance for the account that was transferred to Bad Debt.

(US) 23.SOCIAL SEC # (DISPLAY ONLY)
(CN) 23.HEALTH CARD # (DISPLAY ONLY)
This field contains the account's Social Security/Health Card Number. The Social
Security Number is displayed in a filtered or unfiltered format based on parameters set
on the STAR Patient Processing Employee Demographic screen. Those parameters
define whether you can view all, part, or none of the Social Security Number for the
patient, guarantor, or relative.

24. BIRTH DATE (DISPLAY ONLY)
This field contains the patient's date of birth.

25. BILL HLD (DISPLAY ONLY)
This field indicates (either Yes, No, or DPW) whether the account has been placed on
billing hold for the account. If the account in on billing hold because of the DRG
payment window (DPW), the system displays DPW.

26. DPW/CMS (DISPLAY ONLY)
This field indicates Yes or No for the DPW Indicator, followed by a slash (/), and then
Yes, No, or blank for the CMS Compliant Indicator. The DPW indicates Yes when an
account is flagged on the DRG Payment Window (DPW). This field indicates Yes for
the CMS Compliant Indicator if the CMS Compliant field within the Insurance Plan
Table is Yes for any one of the insurance plans on the account. This determination is
made for the account at the point each insurance is assigned to the account.

27. NOTES? (DISPLAY ONLY)
This field indicates (either Yes or No) whether there are existing notes for the account.

28. PRE/ADM (DISPLAY ONLY)
This field contains the initials of the person who admitted the patient.

29. ACCTS (DISPLAY ONLY)
This field indicates if the patient has had other visits to the facility.

**30. COB, INS CARRIER, # CLM, LCS, SUBMIT DT, CLAIM AMT, AMT PD, DSP, DATE
(DISPLAY ONLY)**
Up to five different insurance carriers can be displayed in this field. The insurance
carriers will be displayed in the Coordination of Benefits order. The COB number and
insurance description display in the COB column. An **r** to the left of the column
indicates that this COB has a replaced claim. A dollar sign (**$**) to the left of the column
indicates that either Payments or Adjustment has been applied to any claim for this
carrier/plan. The number of claims for this carrier is displayed in the # Clm column. The
last claim sequence number for the carrier is displayed in the LCS column. The
submission date of the last claim is displayed in the Submit Dt column. The Estimated
Amount Due for the claim is displayed in the Claim Amount column if the claim has
been submitted. The amount paid for the last claim sequence is displayed in the Amt
Pd column. Dispositions can be **F**-Final, **P**-Partial, **D**-Denied, **A**-Adjusted to zero, **T**-
Transfer, or **C**-Clear disposition. The disposition of the last claim sequence is displayed
in the DSP column. The date of the last claim sequence is displayed in the Date
column.

When you finish reviewing this screen, you can enter a hyphen (**-**), a valid code, or press ENTER. If you enter a hyphen, the following screen is displayed:

```
                  General Hospital Account Inquiry Processor
                                               Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ  Admit    Disch       Balance  Loc
A98-23900001 RANIER,WANDA        M  I/P 08/27/98           31160.00 PA/FCRV
 1 Total Charges    2 Total Adj       3 Total Payments  4 Ref? Exp? Pat Class
      $31,160.00          $0.00             $0.00       No   No
 5 Ins Liability    6 Ins Adj         7 Ins Payments    8 Agency
      $59,516.00          $0.00             $0.00
 9 Pt Liability    10 Patient Adj    11 Pt Payments    12 Last Pt Payment
      $28,356.00-         $0.00             $0.00
13 Wkfl    14 Schd 15 Schd Typ 16 PH  17 Lst FU Dt Ty Sq 18 FU Hold 19 DPW/CMS
    S          220      Standard   Y/Y   02/28/04  W 5                   No/Yes
20 BD Pre-Listed   21 BD Date     22 Agency              23 BD Transfer Amount

24 Social Sec #    25 Birth Date   26 Bill Hld 27 Notes? 28 PRE/Adm 29 Oth Acct
                      03/03/1933       No          No     /P M      No
30 COB Ins Carrier      #Clm LCS SubmitDt    Est Amt Due   Amt Pd Dsp Date
$r  1  TEST PLAN FOR PAT   47  50            $3,430.00

Mon Mar 07, 2011 12:00 pm
Account       Name                   FC Typ  Admit    Disch       Balance  Loc
A1106600001  ADAMS,ANNIE          S  SN3 03/07/11                0.00 PA /ND
 1 Total Charges    2 Total Adj       3 Total Payments  4 Ref? Exp? Pat Class
       $0.00             $0.00             $0.00       No   No
 5 Ins Liability    6 Ins Adj         7 Ins Payments    8 Agency
Page:01                     Additional Information
( 1) B-Billing Information          (14) IPC-Insurance Agency Collectio
( 2) C-Claim Information            (15) J-Bill Request
( 3) CE-View Edit PA Charge Log     (16) K-Balance Summary
( 4) CV-Elec Claim Sys Claim Viewer (17) L-Contact Information
( 5) DB-Demand Bill                 (18) M-Adm Medical Information
( 6) DC-Reprint Claim               (19) N-Notes
( 7) DR-DRG Information              (20) PC-Int/Ext Agency Collections
( 8) DX-MR Diagnosis Information     (21) PTC-Patient Compass Status
( 9) DA-Adm Diagnosis Information    (22) PX-Procedure Information
(10) F-Financial Information         (23) RP-Totals by Responsible Party
(11) H-Transaction History           (24) V-Guarantor's Accounts
(12) HC-HCPCS Information             (25) Y-Refund Information
(13) I-Insurance COB Information      (26) Z-Guarantor Payment History


 Enter choice--
                    next pg(/ or PG DN)  Search(TAB)
```

The additional options displayed at the bottom of your screen provide a means to go to a specific function. The following functions are displayed on your screen:

- B - Billing Information

- C - Claim Information

- CV - EC 2000 CA Claim Viewer

- CE - View Edit PA Charge Log

- DB - Demand Bill

- DC - Reprint Claim

- DR - DRG Information

- DX - MR (Medical Records) Diagnosis Information

- DA - Adm (Admissions) Diagnosis Information

- F - Financial Information

- H - Transaction History

- HC - HCPCS Information

- I - Insurance COB Information

- IPC - Insurance Agency Collection

NOTE: For security purposes, the IPC and PC options have limited access when the Receivables Workstation is active. If Receivables Workstation is active, the system looks to the Collector Access module to determine whether permission is granted to access these options. For those customers not using Receivables Workstation, permission is always granted.

- J - Bill Request

- K - Balance Summary

- L - Contact Information

- M - Medical Information

- N - Notes

- PC - Int/Ext Agency Collections

NOTE: For security purposes, the IPC and PC options have limited access when the Receivables Workstation is active. If Receivables Workstation is active, the system looks to the Collector Access module to determine whether permission is granted to access these options. If you do not use Receivables Workstation, permission is always granted for these options.

- PX - Procedure Information

- RP - Totals by Responsible Party

- V - Guarantor's Accounts

- Y - Refund Information

- Z - Guarantor Payment History

To display one of these functions, enter the number associated with the function. Each function that can be accessed from Account Inquiry Flash Card screen is described below.

NOTE: Completing each of the previously listed functions returns you to the Flash Card screen.

Billing Information

Billing Information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to "Billing Information" on page 1-138.

Claim Information

Claim Information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

View Edit PA Charge Log

Information changed on a charge for the HCPCS, HCPCS modifiers, diagnosis, ABN/ ABN Reason, PA Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/Compre/ Comp HCPCS can be viewed. The list of fields changed in the STAR Patient Accounting charge can be viewed, as well as the current charge information. For detailed information about this function, see "View Edit PA Charge Log" on page 1-222.

EC2000 Claim Viewer

Claims located on Claims Administrator can be accessed from the Account Inquiry and the Account Revision Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Demand Bill

Demand Bill information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

DRG Information

DRG information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to *"DRG Information" on page 1-111*.

MR Diagnosis Information

Medical Records Diagnosis information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to *"Medical Records Diagnosis Information" on page 1-129*.

Admissions Diagnosis Information

Admissions Diagnosis information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to *"ADM Medical Information" on page 1-111*.

Financial Information

Financial information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to *"FINANCIAL INFORMATION" on page 1-138*.

HCPCS Information

HCPCS information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, see "Display Charges by Service Date/ HCPCS" on page 1-221.

Reprint Claim

Reprint Claim information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*. Canadian clients should refer to the *Canadian Claims Processing Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Insurance COB Information

Insurance COB Information can be accessed from the Account Inquiry Flash Card screen. When you access this function, the system displays the following screen:

```
                 General Hospital Account Inquiry Processor
                                              Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch       Balance Loc
A9905700007  SHORE,DAD            M  LOR 02/26/99 02/26/99     85.22   BD/FCRV


COB Ins Carrier       #Clm LCS SubmitDt  Est Amt Due    Amt Pd  Dsp Date
        Plan               Last Clm Chg      COB Adj    COB Pd  Prv Dsp Date
 1  100 MEDICARE        5   33              $3,114.95      $5.25  F  03/31/99
    100 TEST INSURANCE      $4,379.44        $25.00- $4,597.80  R  03/30/99-26
 2  100 MEDICARE       13   36              $1,012.49
    200 MEDICARE PROFES      $724.83         $0.00      $0.00
 3  500 COMMERCIAL      5   37               $252.00
    100 COMMERCIAL BASI      $4,379.44       $0.00    $400.00
 4  500 COMMERCIAL     13   40                 $0.00
    200 1500 BASIC PLAN      $724.83         $0.00      $0.00
 5  901 KRIS' OTHER INS 5   41                 $0.00
    901 KRIS' OTHER INS      $4,379.44       $0.00    $100.00




                 F1Prev Page F2Next Page F7  Exit
```

Field Explanations

COB, INS CARRIER, # CLM, LCS, SUBMIT DT, CLAIM AMT, AMT PD, DSP, DATE (DISPLAY ONLY)
Up to nine different insurance carriers can be displayed on this screen. The screen information is the same as that in the COB Ins(urance) Carrier field of the Flash Card Screen.

The Amt Pd column shows the payment amount for the last claim. This only reflects the last payment and is not the total amount of payments for this COB.

PLAN (DISPLAY ONLY)
This field displays the full carrier plan name and number on two lines of information.

LAST CLM CHG (DISPLAY ONLY)
This field displays the total amount of charges that loaded on the last claim for this carrier plan.

NOTE: If the last claim loaded was a late claim, the total amount of charges loaded only reflects the late charges for the claim.

COB ADJ (DISPLAY ONLY)
This field displays the total amount of adjustments posted for the carrier plan. It is not claim specific.

COB PD (DISPLAY ONLY)
This field displays the total amount of money paid for the carrier plan. It is not claim specific.

PREV DSP DT (DISPLAY ONLY)
If the current claim replaced a prior claim that dispositioned, this field displays the most recent previous claim's disposition, date, and corresponding claim number.

When you are finished viewing this screen, press ENTER to return to the Flash Card screen.

Each of the options shown on this screen is described under separate headings below.

Transaction History

Transaction History information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to of this volume.

Bill Request

Bill Request information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Balance Summary

This function enables you to review the insurance coverage, the payment, adjustment, refund, and balance transfers for the insurances and patient and the balances for the insurances, patient, and account. For more information about this function, refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Contact Information

Contact Information can be accessed from the Account Inquiry Flash Card screen. When you access this function, the system displays the following screen:

```
                    General Hospital Account Inquiry Processor
                                              Fri Mar 10, 2006 12:36 pm
Account      Name                FC Typ Admit    Disch     Balance Loc
A0131000001  KASS, JOHN           S   ER  11/06/01 11/06/01   1000.00  BD/FCRV

Desc  Rel Name                Telephone/Ext       Contact Name     Verify Dt
Telephone/Ext - * Confidential number, No phone message
          Approval Number    Policy Number
Pt        KASS,JOHN          (770)445-6423
          11112                 A500999809876
PtEmp     A1 HARDWARE        (404)393-6000

Guar  B  KASS, BOB          (404)647-2555

GuEmp    A1 HARDWARE         (404)344-8897

Rel1  A  KASS, FRED

COB1  9  PATRICE'S COMMERCI

AdmDr    BABB,GARY H         (404)899-7666




                   F1Prev Page F2Next Page F7  Exit

```

This screen provides you with a list of contacts for the account. Some of the information displayed on this screen is Patient Care information. If your network is down when you access this screen, the system displays *Information Not Available* in the date line.

Field Explanations

DESC (DISPLAY ONLY)
This field contains the description of the contact. The contacts are Patient, Patient Employer, Guarantor, Guarantor Employer, Relative 1, Relative 1 Employer, Relative 2, Relative 2 Employer, COB 1-9, and Admitting Doctor. The name has a strike-through formatting if the address is considered invalid.

REL (DISPLAY ONLY)
This field contains the relation of the patient to the contact. For the Guarantor, Relative 1 or Relative 2 is shown in this field. For COB 1-9, this is the Relation to the Insured field.

NAME (DISPLAY ONLY)
This field displays the name of the contact.

TELEPHONE/EXT (DISPLAY ONLY)
This field displays the telephone number of the contact and phone extension, if available. The phone number has a strike-through formatting if it is considered invalid.

An asterisk (*) preceding the phone number indicates that it is not acceptable to leave a message for the patient and to use the alternate phone number instead. If the phone number is bolded, it indicates that it is not acceptable to leave a message for the patient.

CONTACT NAME (DISPLAY ONLY)
This field contains the contact's name. This field displays only where there is a contact name. For example, the contact name for COB1 is Ann Smith.

VERIFY DT (DISPLAY ONLY)
This field displays the insurance verification date for COB information.

NOTE: This field controls the setting of sub location of COB 1. If this field is blank (default), or if you update the patient record and the verified date field is blank based on the update, the sub location of the patient record for COB 1 is INSR (Insurance Verification Not Completed). The sub location of the patient record for COB 1 is ND (Not Discharged) if the patient record is updated and this field contains information.

APPROVAL # (DISPLAY ONLY)
This field contains the insurance approval number for the COB information.

POLICY NUMBER (DISPLAY ONLY)
This field displays the policy number for the patient account's insurance plans.

Medical Information

Medical information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to "MEDICAL RECORDS MEDICAL INFORMATION" on page 1-111 of this volume.

Notes

Notes information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to "ACCOUNT NOTES" on page 1-230 of this volume.

Agency Collection

Agency collection status information can be accessed from the Account Inquiry Flash Card screen. There are two variations of agency collection information: one is applicable to internal/external agency collections (PC menu option), and the other is applicable to insurance agency collections (IPC menu option). For more detailed information about this function, refer to the *Follow-Up Functions Volume* of the STAR Financials Patient Accounting Reference Guide.

Procedure Information

Procedure information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to "Procedure Information" on page 1-132 of this volume.

Guarantor Accounts

Guarantor Accounts information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Refund Information

Refund Information can be accessed from the Account Inquiry Flash Card screen.

When you access this function, the system displays the following screen:

```
                    General Hospital Account Inquiry Processor
                                              Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch      Balance  Loc
A9423100001  SMITH,ANN S           C  I/P 08/19/94            11559.75 PA/FCRV

   Refund Activity

Status     Date     Type  Code/Desc                                   Amount
Excluded   09/14/94 Guar  C00000509 SMITH,ANN S                       $10.00
Approved   09/13/94 Carr  988450    Commercial                        $90.00










                  F1Prev Page F2Next Page F7  Exit
```

This screen lists all active refund information for the account. The refund information is displayed in reverse chronological order. Refunds with a status of hold, approved, and excluded are displayed on this screen.

Field Explanations

STATUS (DISPLAY ONLY)
This field indicates the current status of the refund record.

DATE (DISPLAY ONLY)
This field indicates the date that the refund status was assigned.

TYPE (DISPLAY ONLY)
This field indicates the type of refund. The types of refunds include Carr for carrier and Guar for Guarantor.

CODE/DESC (DISPLAY ONLY)
This field displays the refund code and description. For carrier refunds, this is the carrier/plan number. For guarantor refunds, this is the guarantor corporate number.

DATE PRINTED (DISPLAY ONLY)
This field indicates the date the refund was printed.

AMOUNT (DISPLAY)
This field indicates the amount of the refund.

Guarantor Payment History

Guarantor Payment History information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Follow-Up Functions Volume* of the STAR Financials Patient Accounting Reference Guide.

If you press ENTER on the Account Inquiry snapshot screen, the following menu screen is displayed:

```
              General Hospital Account Inquiry Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name              FC Typ Admit    Disch     Balance  Loc
A98-33600004 CARNACK,AUDREY      M  I/P 12/02/98 12/02/98  10853.55 AR/FCRV
             Option No.  Option
             ---------------------------------------
                1        Admission Information
                2        Medical Information
                3        Financial Information
                4        Account Notes
                5        Insurance Eligibility Response Inquiry




 Enter option number--
```

The system displays patient demographic data (account number, patient name, financial class, patient type, dates of admission and discharge and current account balance) at the top of the screen. This information is displayed on all screens in the Account Inquiry function.

ADMISSION INFORMATION

The Admission Information function enables you to view patient admission data. This data comes from the STAR Patient Care admission process and includes

- Patient Demographics

- Patient Employer Demographics

- Guarantor Data

- Guarantor Employer

- Patient Relatives

- Patient Insurance

- UB Data

- Medical Data

- Miscellaneous Data

- User Defined Fields

After you select this option, the system displays the following menu screen:

```
          General Hospital Admission Information Processor
                                            Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit   Disch    Balance   Loc
A98239-00001 RANIER,WANDA          M  I/P 08/27/98 08/30/99  174345.00 AR/FCRV
          Option No.  Option
          --------------------------------------
              1       Patient Information
              2       Patient Employer Page
              3       Guarantor Information
              4       Guarantor Employer Page
              5       Relative One Page
              6       Relative One Employer Page
              7       Relative Two Page
              8       Insurance Process
              9       UB Condition Codes
             10       UB Value Codes
             11       UB Occurrence Codes
             12       Medical Information
             13       Miscellaneous Page
             14       Miscellaneous Two Page
             15       User Defined Fields

Enter option number--
```

Patient Information

Select the Patient Information option to view patient demographic information such as the patient's address, telephone number, marital status, etc. This information comes from STAR Patient Care admission data.

After you select this option, the system displays the following screen.

```
              General Hospital Patient Information Processor
                                              Tue Feb 14, 2012 01:41 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
C12031-00001 CRANE,BOB             M  I/P 01/31/12 01/31/12      750.00 PA /DNFB
             Option No.  Option
             ---------------------------------------
                 1       Patient Page
                 2       Patient Alternate Address
                 3       Patient Additional Information




 Enter option number--
```

PATIENT PAGE

Select the Patient Page option to view patient demographic information such as the patient's address, telephone number, marital status, etc. This information comes from STAR Patient Care admission data.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
                    General Hospital Patient Page Processor
              Patient                            Fri Mar 10, 2006 12:36 pm
Account        Name                  FC Typ Admit    Disch     Balance  Loc
 A03138-00009 TATE, JANET            S  I/P 03/18/03           14399.16 PA/FCRV
 1 Name                                       2 Entitle    3 Sex
   TATE, JANET                                                  FEMALE
 4 Birthdate   Age    5 Birthplace            6 Race
   05/05/1955  50Y     BARTN                    1 CAUCASIAN
 7 Marital Status    8 Address Line 1          9 Address Line 2
   M MARRIED          PATIENT ADDRESS 1          PATIENT ADDRESS 2
10 City              11 St 12 ZIP Code  13 County        14 Country
   ROSWELL              GA    30076       1 FULTON         US UNITED STATE
15 Phone        16 Ext 17 Phone Message  18 Geo.Cd/Census Tract
   (404)338-2851   111    Yes              N NORTH ATLANTA
19 Residence Type     20 Since     21 Addl/Alt&Confidential Add-Ph
   fh FAMILY HOME                    Yes      No
23 Invalid Address/Phone
   Z Inquiry address is mail receiving service. Thoro
24 Soc Sec Number              25 Nationality        26 Language
   440-13-3412                   1 AMERICAN US           E ENGLISH


Press NL--
```

Field Explanations

1.   NAME (DISPLAY ONLY)
This field contains the patient's name in the format of LAST,FIRST MIDDLE

2.   ENTITLE (DISPLAY ONLY)
This field contains any title for the patient (e.g., JR., SR., III, PHD., MD.).

3.   SEX (DISPLAY ONLY)
This field contains the patient's sex.

4.   BIRTHDATE AGE (DISPLAY ONLY)
This field contains the patient's date of birth in the selected format (for example, MM/DD/YY) and the patient's age (system-calculated from the date of birth).

5.   BIRTHPLACE (DISPLAY ONLY)
This field contains the patient's place of birth.

(US) 6.RACE (DISPLAY ONLY)
(CN) 6.ETHNIC ORIGIN (DISPLAY ONLY)
This field contains the patient's race/ethnic origin.

7.   MARITAL STATUS (DISPLAY ONLY)
This field contains patient's marital status.

8.   ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the patient's mailing or street address.

9. ADDRESS LINE 2 (DISPLAY ONLY)
This field contains the second line of the patient's mailing or street address.

10. CITY (DISPLAY ONLY)
This field contains the city portion of the patient's address.

(US) 11.ST (DISPLAY ONLY)
(CN) 11.PR (DISPLAY ONLY)
This field contains the state/province portion of the patient's address.

(US) 12.ZIP CODE (DISPLAY ONLY)
(CN) 12.POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the patient's address. It displays the ZIP code in either five or nine digits. The alphanumeric Canadian postcode displays in an X9X9X9 format.

13. COUNTY (DISPLAY ONLY)
This field contains the county portion of the patient's address.

14. COUNTRY (DISPLAY ONLY)
This field contains the country portion of the patient's address.

15. PHONE (DISPLAY ONLY)
This field contains the telephone number at which the patient can be reached.

16. EXT. (DISPLAY ONLY)
This field contains the patient's extension number, if one exists.

17. PHONE MESSAGE (DISPLAY ONLY)
This field indicates whether a phone message can be left at the phone number on this page. Values are:

Yes= Yes, it is okay to leave a message at the phone number on this page.

No = No, do not leave a message at the phone number on this page.

(US) 18GEO. CODE/CENSUS TRACT (DISPLAY ONLY)
(CN) 18.RESIDENCE CODE (DISPLAY ONLY)
This field contains the hospital-defined geographic/residence code associated with the patient's address. In the U.S., this field may display a census tracking code instead of a geographic code.

19. RESIDENCE TYPE (DISPLAY ONLY)
This field contains the code for the patient's residence type:

20. SINCE (DISPLAY ONLY)
This field contains the date on which the patient began living at the address specified in the address fields.

21. ALT/CONFIDENTIAL ADDRESS (DISPLAY ONLY)
This field is a two-part field:

- Under **Alt**, it displays Yes if alternate address information has been entered for this patient. The field is blank if alternate address information has not been entered.

- Under **Confidential Add-Ph**, it displays what is entered (Yes, No, or blank) in the Confidential Add-Ph field on the Alternate Address subscreen. If Yes is displayed here, the alternate address and phone number should be used to contact the patient.

23. INVALID ADDRESS/PHONE (DISPLAY ONLY)
This field contains the code for the invalid address/phone. The description associated with the code is displayed also.

(US) 24SOC SEC NUMBER (DISPLAY ONLY)
(CN) 24.PROV HC #/VERSION/EXP DATE (DISPLAY ONLY)
This field contains the patient's Social Security/Health Card number. The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

25. NATIONALITY (DISPLAY ONLY)
This field contains the patient's nationality.

26. LANGUAGE (DISPLAY ONLY)
This field contains the patient's primary language.

PATIENT ALTERNATE ADDRESS

Select the Patient Alternate Address option on the Patient Information Processor to view alternate address information for the patient. For this option to be available, Yes must be selected in the Alt/Confidential field on the Patient Page Processor.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
             General Hospital Patient Alternate Address Processor
                                              Fri Mar 10, 2007 12:36 pm
Account      Name                 FC Typ Admit   Disch      Balance  Loc
A02190-00003 SAKS, ELAINE         V  O/P 07/09/02 07/09/02   0.00    AR/FCRV
Alternate  1 Address Line 1          2 Address Line 2

           3 City                4 St  5 ZIP Code    6 County

           7 Country             8 Residence Type    9 Phone

10 Invalid Address/Phone

11 Phone Message  12 Mail To Address?  13 Confidential Add-Ph

14 Alt Phone

Additional      15 Mother's Name              16 Father's Name




Press NL--
```

Field Explanations

1. (ALTERNATE) ADDRESS LINE 1 (DISPLAY ONLY)
This is the patient's alternate address.

2. (ALTERNATE) ADDRESS LINE 2 (DISPLAY ONLY)
This field displays additional alternate address information, if necessary.

3. (ALTERNATE) CITY (DISPLAY ONLY)
This is the patient's alternate city.

(US) 4.(ALTERNATE) STATE (DISPLAY ONLY)
(CN) 4.(ALTERNATE) PROVINCE (DISPLAY ONLY)
This is the patient's alternate state/province.

(US) 5.(ALTERNATE) ZIP CODE (DISPLAY ONLY)
(CN) 5.(ALTERNATE) POSTCODE (DISPLAY ONLY)
This is the patient's alternate ZIP code/postcode.

6. (ALTERNATE) COUNTY (DISPLAY ONLY)
This is the patient's alternate county.

7. (ALTERNATE) COUNTRY (DISPLAY ONLY)
This is the patient's alternate country.

8) RESIDENCE TYPE
This is the patient's alternate residence type code, such as a vacation or college address.

9. (ALTERNATE) PHONE (DISPLAY ONLY)
This field contains the patient's alternate phone number.

10. INVALID ADDRESS/PHONE (DISPLAY ONLY)
This field contains the code for the invalid address/phone.

11 PHONE MESSAGE (DISPLAY ONLY)
This field indicates whether a phone message can be left at the alternate phone number on this page. Values are:

Yes= Yes, it is okay to leave a message at the phone number on this page.

No = No, do not leave a message at the phone number on this page.

12. (ALTERNATE) MAIL TO ADDRESS? (DISPLAY ONLY)
This field indicates whether mail can be sent to the alternate address on this page. Values are:

Yes= Yes, it is okay to send mail to this address.

No (or blank) = No, do not send mail this address.

13. CONFIDENTIAL ADD-PH (DISPLAY ONLY)
This field indicates whether the alternate address and/or phone number should be used for communications from your facility. Values are:

Yes= Yes, it is okay to use the alternate address/phone for communications.

No (or blank) = No, do not use the alternate address/phone for communications. Use the primary address/phone for communications.

14. ALT PHONE (DISPLAY ONLY)
This field contains the alternate phone number for the patient.

15. MOTHER'S NAME (DISPLAY ONLY)
This field contains the name of the patient's mother.

16. FATHER'S NAME (DISPLAY ONLY)
This field contains the name of the patient's father.

Patient Additional Information

This screen displays additional information for the patient.

```
            General Hospital Patient Additional Information Processor
                                              Tue Feb 14, 2012 01:44 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
C12031-00001 NEW, BOB            M  I/P 01/31/12 01/31/12     750.00 PA /DNFB
 1 Mother's Name                   2 Father's Name

 3 Cell Phone                      4 E-Mail Address



```

Field Explanations

1. MOTHER'S NAME (DISPLAY ONLY)

This field contains the name of the patient's mother. This name is used with other information in patient lookups to verify that you have selected the correct patient.

2. FATHER'S NAME (DISPLAY ONLY)

This field contains the name of the patient's father.

3. CELL PHONE (DISPLAY ONLY)

This field contains the patient's area code and cell phone number.

4. E-MAIL ADDRESS (DISPLAY ONLY)

This field contains the patient's e-mail address.

Patient Employer Page

Select the Patient Employer Page option to view information about the patient's employer, such as the employer's name, telephone number, address, etc.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
                General Hospital Patient Employer Page Processor
                                                   Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch      Balance  Loc
A92209-00007 HALL,JERRY               C  SER 07/27/92 09/30/92   2556.80  AR/FCRV
 1 Employment Status         2 Retirement Date
   2 PART TIME
 3 Employer/School           4 Work Phone       5 Ext.
   SB SOUTHERN BELL
 6 Employer Address Line 1   7 Employer Address Line 2
   505 PEACHTREE ST
 8 City                      9 State          10 ZIP Code
   ATLANTA                     GA                30303
11 County                   12 Country
   1 FULTON                    US United State
13 Occupation               14 Employed Since  15 Employee ID
   39 OTHER                    08/31/93




Press NL--
```

Field Explanations

1. EMPLOYMENT STATUS (DISPLAY ONLY)
This field contains the code that describes the current status of the patient's employment (for example, Part Time, Full Time, etc.).

2. RETIREMENT DATE (DISPLAY ONLY)
This field contains the retirement date of the patient.

3. EMPLOYER /SCHOOL (DISPLAY ONLY)
This field contains the code that describes the patient's employer or school.

4. WORK PHONE (DISPLAY ONLY)
This field contains the patient's work phone number.

5. EXT. (DISPLAY)
This field contains the patient's work phone extension number.

6. EMPLOYER ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the employer's primary address.

7. EMPLOYER ADDRESS LINE 2 (DISPLAY ONLY)
This field contains the employer's secondary address, if applicable (for example, a suite number).

8. CITY (DISPLAY ONLY)
This field contains the employer's city.

(US) 9.STATE (DISPLAY ONLY)
(CN) 9.PROV. (DISPLAY ONLY)
This field contains the state/province in which the employer is located. The state/province is displayed in the standard two-character state/province abbreviation format.

(US) 10.ZIP CODE (DISPLAY ONLY)
(CN) 10.POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the employer's address. It displays the ZIP code in either five or nine digits. The alphanumeric Canadian postcode displays in an X9X9X9 format.

11. COUNTY (DISPLAY ONLY)
This field contains the county portion of the patient's address.

12. COUNTRY (DISPLAY ONLY)
This field contains the country portion of the patient's address.

13. OCCUPATION (DISPLAY ONLY)
This field contains the patient's occupation.

14. EMPLOYED SINCE (DISPLAY ONLY)
This field contains the date the patient began employment with the above employer.

15. EMPLOYEE ID (DISPLAY ONLY)
This field contains the patient's employee identification number.

Guarantor Information

Select the Guarantor Information option to view guarantor demographic information such as the guarantor's relationship to the patient, address, telephone number, marital status, etc. This information comes from STAR Patient Care admission data.

After you select this option, the system displays the following screen.

```
                General Hospital Guarantor Information Processor
                                                Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch       Balance Loc
A9425900002  SMITH, MARY K           M  I/P 09/14/94 03/08/95   36903.44 PA/FCRV
            Option No.  Option
            ---------------------------------------
                1       Guarantor Page
                2       Guarantor Alternate Address




  




  Enter option number--
```

GUARANTOR PAGE

Select the Guarantor Page option to view information about the patient's guarantor, such as the guarantor's name, address, telephone number, and relationship to the patient. After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
                  General Hospital Guarantor Page Processor
                                                Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch       Balance Loc
A0121200004  KELLY, MIKE             M  I/P 07/31/01 08/01/01    3292.00 PA/FCRV
 1 Relation to Patient   2 MPI Search   3 Name
   S SELF                  00002612       KELLY, MIKE
 4 Entitle  5 Sex        6 Birthdate   Age       7 DOD          8 Race
   JR        MALE          04/04/1944   59Y                     1 CAUCASIAN
 9 Marital Status  10 Address Line 1          11 Address Line 2
   M MARRIED          12345 MAIN STREET
12 City             13 St   14 ZIP Code       15 County
   ATLANTA            NJ       30346           1 FULTON
16 Phone            17 Phone Message           18 Geo.Cd/Census Tract
   (404)338-2851                               N NORTH
19 Addtl/Alt     20 Guarantor Class          21 Soc Sec Number
22 Invalid Address/Phone
   Z Inquiry address is mail receiving service. Thoro
Address &    23 Score-Date/Time          24 Permission      25 Request
Credit Check




  Press NL--
```

Field Explanations

1.   RELATION TO PATIENT (DISPLAY ONLY)
This field contains the code that describes the guarantor's relationship to the patient.
The code and the description are displayed.

2.   MPI SEARCH (DISPLAY ONLY)
This field contains the guarantor's corporate number which is a number that is
permanently assigned to the patient when the patient is first admitted to any facility
belonging to the hospital group. N/A is displayed in this field if the guarantor has never
been a patient in the STAR Patient Care system.

3.   NAME (DISPLAY ONLY)
This field contains the guarantor's name in the format of LAST,FIRST MIDDLE.

4.   ENTITLE (DISPLAY ONLY)
This field contains a title such as JR., SR., III, PHD., MD., etc.

5.   SEX (DISPLAY ONLY)
This field contains the guarantor's sex.

6.   BIRTHDATE AGE (DISPLAY ONLY)
This field contains the guarantor's date of birth and age.

7.   DOD (DISPLAY ONLY)
If the patient has expired, the system displays the date of death in this field.

(US) 8.RACE (DISPLAY ONLY)
(CN) 8.ETHNIC ORIGIN (DISPLAY ONLY)
This field contains the guarantor's race/ethnic origin.

9.   MARITAL STATUS (DISPLAY ONLY)
This field contains the code that describes the guarantor's marital status.

10. ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the guarantor's mailing address.

11. ADDRESS LINE 2 (DISPLAY ONLY)
This field contains the guarantor's secondary address, if applicable (for example,
apartment number).

12. CITY (DISPLAY ONLY)
This field contains the guarantor's city.

(US) 13.STATE (DISPLAY ONLY)
(CN) 13.PROV. (DISPLAY ONLY)
This field contains the state/province in which the employer is located. The state/
province is displayed in the standard two-character state/province abbreviation format.

(US) 14.ZIP CODE (DISPLAY ONLY)
(CN) 14. POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the employer's address. It displays the ZIP code in either five or nine digits. The alphanumeric Canadian postcode is displayed in an X9X9X9 format.

15. COUNTY (DISPLAY ONLY)
This field contains the code of the county in which the guarantor lives. The code and the description are displayed.

16. PHONE (DISPLAY ONLY)
This field contains the guarantor's area code and home phone number.

17. PHONE MESSAGE (DISPLAY ONLY)
This field indicates if it is okay to leave a message for the guarantor at this phone number. If it is okay, this field contains a Y. If it is not okay, this field contains an N.

(US) 18.GEO. CODE/CENSUS TRACT (DISPLAY ONLY)
(CN) 18.RESIDENCE CODE (DISPLAY ONLY)
This field contains the hospital-defined geographic/residence code associated with the guarantor's address. In the U.S., this field may display a census tracking code instead of a geographic code.

19. ADDTL (DISPLAY ONLY)
This field indicates whether there is additional information (which can include alternate address) for the guarantor. If Yes is displayed in this field, there is additional information. To display additional information, select the Guarantor Alternate Address option on the Guarantor Information Processor screen.

20. GUARANTOR CLASS (DISPLAY ONLY)
This field contains the code that describes the guarantor's classification. Examples of guarantor class include: VIP-Very Important Person, DIA-Diabetic, BDM-Board Member.

(US) 21.SOC SEC NUMBER (DISPLAY ONLY)
(CN) 21.HC/PROV/VERSION/EXP DATE (DISPLAY ONLY)
This field contains the patient's Social Security/Health Card number. The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

22. INVALID ADDRESS/PHONE (DISPLAY ONLY)
This field contains the invalid address/phone flag code. The description is also displayed.

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Address & Credit Check

23. SCORE - DATE/TIME (DISPLAY ONLY)
This field contains the most recently received healthcare score, and the date and time it was received. If the user logged on does not have a security level that allows him to view a patient's healthcare score (designated on the System Wide Parameters screen in STAR Patient Processing), an asterisk (*) is displayed in this field.

24. PERMISSION (DISPLAY ONLY)
This field indicates whether the guarantor has given permission for an address and/or credit check to be performed.

A is displayed if permission to perform an address check has been given.

C is displayed if permission to perform a credit check has been given.

B is displayed if permission to perform both checks has been given.

25. REQUEST (DISPLAY ONLY)
Through STAR Patient Processing, this field allows the user to submit a request for an address/credit check.

GUARANTOR ALTERNATE ADDRESS (ADDITIONAL INFORMATION)

Select the Guarantor Alternate Address option on the Guarantor Information Processor to view additional information (which can include alternate address information) for the guarantor. For this option to be available, Yes must be selected in the Addtl field on the Guarantor Page Processor. After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Guarantor Alternate Address Processor
                                                      Fri Mar 10, 2006 12:36 pm
Account      Name                    FC Typ Admit    Disch      Balance  Loc
A05181-00003 KASS, BOB               M  I/P 06/30/05            15707.91 PA/FCRV
Additional    1 Ext   2 Country         3 Residence Type        4 Since
Information    111    US UNITED STATE    fh FAMILY HOME
 5 Mother's Name                 6 Father's Name


 7 Birthplace               8 Nationality           9 Language
   BARTN                     1 AMERICAN US            E ENGLISH
Alternate    10 Address Line 1                 11 Address Line 2
Address
12 City                  13 State   14 ZIP Code     15 County

16 Country               17 Residence Type

18 Invalid Address/Phone

19 Phone                 20 Phone Message       21 Mail To Address?

22 Alt Phone



Press NL--
```

Field Explanations

Additional Information

1. EXT. (DISPLAY ONLY)
This field contains the guarantor's extension number.

2. COUNTRY (DISPLAY ONLY)
This field contains the country in which the guarantor lives.

3. RESIDENCE TYPE (DISPLAY ONLY)
This field contains the code for the guarantor's residence type.

4. [RESIDENT] SINCE (DISPLAY ONLY)
This field contains the date the guarantor began living at the above address.

5. MOTHER'S NAME (DISPLAY ONLY)
This field contains the guarantor's mother's name. This name is later used for verification that this is the correct patient.

6. FATHER'S NAME (DISPLAY ONLY)
This field contains the guarantor's father's name.

7. BIRTHPLACE (DISPLAY ONLY)
This field contains the guarantor's place of birth.

8. NATIONALITY (DISPLAY ONLY)
This field contains the code that describes the guarantor's nationality.

9. LANGUAGE (DISPLAY ONLY)
This field specifies the type of language spoken by the guarantor.

Alternate Address

10. ADDRESS LINE 1 (DISPLAY ONLY)
This is the guarantor's alternate address.

11. ADDRESS LINE 2 (DISPLAY ONLY)
This is the second line of the alternate address, if used.

12. CITY   (DISPLAY ONLY)
This is the guarantor's alternate city.

(US) 13.STATE (DISPLAY ONLY)
(CN) 13.PROVINCE (DISPLAY ONLY)
This is the guarantor's alternate state/province.

(US) 14. ZIP CODE (DISPLAY ONLY)
(CN) 14.POSTCODE (DISPLAY ONLY)
This is the guarantor's alternate ZIP code/postcode.

15. COUNTY (DISPLAY ONLY)
This is the guarantor's alternate county.

16. COUNTRY (DISPLAY ONLY)
This is the guarantor's alternate country.

17. RESIDENCE TYPE (DISPLAY ONLY)
This field contains the residence type for the guarantor's alternate address.

18. INVALID ADDRESS/PHONE (DISPLAY ONLY)
This field contains the code for the invalid address flag and a description.

19. PHONE (DISPLAY ONLY)
This field contains the guarantor's alternate phone number.

20. PHONE MESSAGE (DISPLAY ONLY)
This field indicates if it is okay to leave a message for the guarantor at the alternate address phone number. If it is okay, this field contains a Y. If it is not okay, this field contains an N.

21. MAIL TO ADDRESS? (DISPLAY ONLY))
This field indicates whether all correspondence from your facility should be directed to this alternate address. If the alternate address is to be used, this field contains a Y. If the alternate address is not to be used, this field contains an N.

22. ALT PHONE (DISPLAY ONLY)
This field contains the alternate phone number.

Guarantor Employer Page

Select the Guarantor Employer Page option to view information about the guarantor's employer, such as the employer's name, address, telephone number, etc. After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Guarantor Employer Page Processor
                                                  Fri Mar 10, 2006 12:36 pm
 Account       Name                  FC Typ Admit    Disch       Balance  Loc
 A93146-00011  STEPHENS,CHARLES A    C  ECU 01/15/93              1760.00  PA/FCRV
   1 Employment Status        2 Retirement Date
     1 FULL TIME
   3 Employer/School          4 Work Phone       5 Ext.
     SB SOUTHERN BELL           (404)475-3498      257
   6 Address Line 1           7 Address Line 2
     505 PEACHTREE ST
   8 City                     9 State           10 ZIP Code
     ATLANTA                    GA                 30303
  11 County                  12 Country
     1 FULTON                   US United State
  13 Occupation              14 Employed Since  15 Employee ID
     8 MANAGER                  03/24/71           304678




 Press NL--
```

Field Explanations

1. EMPLOYMENT STATUS (DISPLAY ONLY)
This field contains the code that describes the current status of the guarantor's employment (for example, Part Time, Full Time, etc.).

2. RETIREMENT DATE (DISPLAY ONLY)
This field contains the retirement date of the guarantor.

3. EMPLOYER/SCHOOL (DISPLAY ONLY)
This field contains the code that describes the guarantor's employer or school.

4. WORK PHONE (DISPLAY ONLY)
This field contains the guarantor's work phone number.

5. EXT. (DISPLAY ONLY)
This field displays the guarantor's work extension number.

6.   ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the address of the guarantor's employer.

7.   ADDRESS LINE 2 (DISPLAY ONLY)
This field contains the employer's secondary address, if applicable (for example, suite number).

8.   CITY (DISPLAY ONLY)
This field contains the city in which the employer is located.

(US) 9.STATE (DISPLAY ONLY)
(CN) 9.PROV. (DISPLAY ONLY)
This field contains the state/province in which the employer is located. The state/province is displayed in the standard two-character state/province abbreviation format.

(US) 10.ZIP CODE (DISPLAY ONLY)
(CN) 10.POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the employer's address. The ZIP code is displayed in either five or nine digits. The alphanumeric Canadian postcode is displayed in an X9X9X9 format.

11. COUNTY (DISPLAY ONLY)
This field contains the county where the guarantor's employer is located.

12. COUNTRY (DISPLAY ONLY)
This field contains the country where the guarantor's employer is located.

13. OCCUPATION (DISPLAY ONLY)
This field contains the guarantor's occupation.

14. EMPLOYED SINCE (DISPLAY ONLY)
This field contains the date that the guarantor began employment with the above employer.

15. EMPLOYEE ID (DISPLAY ONLY)
This field contains the guarantor's employee identification number.

Relative One Page

Select the Relative One Page option to view information about the patient's nearest relative, such as the relative's name, relationship to the patient, telephone number, address, etc. After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
                General Hospital Relative One Page Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit      Disch       Balance  Loc
A88146-00011 STEPHENS,CHARLES A       C  ECU 04/05/90               1760.00  PA/FCRV
 1 Relation             2 Name
   M MOTHER               SMITH,RAMONA B
 3 Sex                  4 Soc Sec Number        5 Birthdate   Age
   FEMALE                 254-32-1495             07/23/49    44Y
 6 Mailing Address Line 1                       7 Mailing Address Line 2
   2925 ROSEMONT PKWY
 8 City                 9 State      10 ZIP Code     11 County
   ROSWELL                GA            30076            1 FULTON
12 Country             13 Resident Since        14 Phone        15 Ext.
   US United State        01/01/76              (404)664-4754
16 Work Phone          17 Ext.
   (404)123-4567          123




Press NL--
```

Field Explanations

1. RELATION (DISPLAY ONLY)
This field contains the code that describes the relative's relationship to the patient.

2. NAME (DISPLAY ONLY)
This field contains the relative's name in the format of LAST,FIRST MIDDLE.

3. SEX (DISPLAY ONLY)
This field contains the relative's sex.

(US) 4.SOC SEC NUMBER (DISPLAY ONLY)
(CN) 4.HC# (DISPLAY ONLY)
This field contains the relative's Social Security/Health Card number. The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

5. BIRTHDATE AGE (DISPLAY ONLY)
This field contains the relative's birthdate and age.

6. MAILING ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the relative's mailing address.

7. MAILING ADDRESS LINE 2 (DISPLAY ONLY)
If the relative has a secondary address (for example, an apartment number), it is displayed in this field.

8. CITY (DISPLAY ONLY)
This field contains the city in which the relative lives.

(US) 9.STATE (DISPLAY ONLY)
(CN) 9.PROV. (DISPLAY ONLY)
This field contains the state/province in which the relative lives. The state/province is displayed in the standard two-character state/province abbreviation format.

(US) 10.ZIP CODE (DISPLAY ONLY)
(CN) 10.POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the relative's address. The ZIP code is displayed in either five or nine digits. The alphanumeric Canadian postcode is displayed in an X9X9X9 format.

11. COUNTY (DISPLAY ONLY)
This field contains the code of the county in which the relative lives. The code and the description are displayed.

12. COUNTRY (DISPLAY ONLY)
This field contains the code of the country in which the relative lives.

13. RESIDENT SINCE (DISPLAY ONLY)
This field contains the date that the relative began living at the above address.

14. PHONE (DISPLAY ONLY)
This field contains the relative's area code and home phone number.

15. EXT (DISPLAY ONLY)
This field contains the relative's extension number.

16. WORK PHONE (DISPLAY ONLY)
This field contains the work phone number of the relative, if known.

17. EXT. (DISPLAY ONLY)
This field contains the work extension number, if applicable.

Relative One Employer Page

Select the Relative One Employer Page option to view information about the employer of the patient's nearest relative, such as the employer's name, address, telephone number, etc.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
                  General Hospital Relative One Employer Page Processor
                                                     Fri Mar 10, 2006 12:36 pm
 Account        Name                    FC Typ Admit    Disch        Balance  Loc
 A92188-00233 STEPHENS,CHARLES A    C  ECU 07/03/92 07/07/92        109.00   AR/FCRV
  1 Employment Status          2 Retirement Date
    7 SELF EMPLOYED              09/20/99
  3 Employer/School            4 Employer Address Line 1
                                1203 ROSEMONT PARKWAY
  5 Employer Address Line 2    6 City                 7 State   8 ZIP Code
                                ROSWELL                 GA        30346
  9 County                    10 Country             11 Work Phone    12 Ext.
    1 FULTON                     US United State         (404)664-3400    123
 13 Occupation                 14 Employed Since      15 Employee ID
    23 CONSULTANT




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

Field Explanations

1. EMPLOYMENT STATUS (DISPLAY ONLY)

This field contains the code that describes the current status of the relative's employment (for example, Part Time, Full Time, etc.).

2. RETIREMENT DATE (DISPLAY ONLY)

This field contains the retirement date of the relative.

3. EMPLOYER /SCHOOL (DISPLAY ONLY)

This field contains the code that describes the relative's employer or school.

4. EMPLOYER ADDRESS LINE 1 (DISPLAY ONLY)

This field contains the address of the relative's employer.

5. EMPLOYER ADDRESS LINE 2 (DISPLAY ONLY)

This field contains the employer's secondary address, if applicable (for example, suite number).

6. CITY (DISPLAY ONLY)

This field contains the city in which the employer is located.

(US) 7.STATE (DISPLAY ONLY)
(CN) 7.PROV. (DISPLAY ONLY)

This field contains the state/province in which the employer is located. The state/ province is displayed in the standard two-character state/province abbreviation format.

(US) 8.ZIP CODE (DISPLAY ONLY)
(CN) 8.POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the employer's address. The ZIP code is displayed in either five or nine digits. The alphanumeric Canadian postcode is displayed in an X9X9X9 format.

9.   COUNTY (DISPLAY ONLY)
This field contains the county where the relative's employer is located.

10. COUNTRY (DISPLAY ONLY)
This field contains the country where the relative's employer is located.

11. WORK PHONE (DISPLAY ONLY)
This field contains the relative's work phone number.

12. EXT. (DISPLAY ONLY)
This field contains the relative's employer telephone extension.

13. OCCUPATION (DISPLAY ONLY)
This field contains the relative's occupation.

14. EMPLOYED SINCE (DISPLAY ONLY)
This field contains the date that the relative began employment with the above employer.

15. EMPLOYEE ID (DISPLAY ONLY)
This field contains the relative's employee identification number.

Relative Two Page

Select the Relative Two Page option to view information about the patient's second relative, such as the relative's name, relationship to patient, telephone number, address, etc.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Relative Two Page Processor
                                           Fri Mar 10, 2006 12:36 pm
Account        Name                   FC Typ Admit    Disch      Balance  Loc
A88146-00011 STEPHENS,CHARLES A   C  ECU 04/05/90              1760.00  PA/FCRV
 1 Relation            2 Name
   G GRANDPARENT          MOSSINGHAM,VERNON
 3 Sex                 4 Soc Sec Number         5 Birthdate   Age
   MALE                   134-54-8736            08/31/24    69Y
 6 Mailing Address Line 1                       7 Mailing Address Line 2
   6355 AIRPORT BLVD
 8 City                9 State   10 ZIP Code   11 County
   MOBILE               AL          34567
12 Country            13 Resident Since        14 Phone        15 Ext.
   US United State                                (205)434-6954
16 Work Phone         17 Ext.




Press NL--
```

Field Explanations

1. RELATION (DISPLAY ONLY)
This field contains the code that describes the relative's relationship to the patient.

2. NAME (DISPLAY ONLY)
This field contains the relative's name in the format of LAST,FIRST MIDDLE.

3. SEX (DISPLAY ONLY)
This field contains the relative's sex.

(US) 4.SOC SEC NUMBER (DISPLAY ONLY)
(CN) 4.HC# (DISPLAY ONLY)
This field contains the relative's Social Security/Health Card number. The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

5. BIRTHDATE AGE (DISPLAY ONLY)
This field contains the relative's date of birth and age.

6. MAILING ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the relative's mailing address.

7. MAILING ADDRESS LINE 2 (DISPLAY ONLY)
If the relative has a secondary address (for example, apartment number), it is displayed in this field.

8. CITY (DISPLAY ONLY)
This field contains the city in which the relative lives.

(US) 9.STATE (DISPLAY ONLY)
(CN) 9.PROV. (DISPLAY ONLY)
This field contains the state/province in which the relative lives. The state/province is displayed in the standard two-character state/province abbreviation format.

(US) 10.ZIP CODE (DISPLAY ONLY)
(CN) 10.POSTCODE (DISPLAY ONLY)
This field contains the ZIP code/postcode of the relative's address. It displays the ZIP code in either five or nine digits. The alphanumeric Canadian postcode is displayed in an X9X9X9 format.

11. COUNTY (DISPLAY ONLY)
This field contains the code of the county in which the relative lives. The code and the description are displayed.

12. COUNTRY (DISPLAY ONLY)
This field contains the code of the country in which the relative lives.

13. RESIDENT SINCE (DISPLAY ONLY)
This field contains the date that the relative began living at the above address.

14. PHONE (DISPLAY ONLY)
This field contains the relative's area code and home phone number.

15. EXT (DISPLAY ONLY)
This field contains the relative's extension number.

16. WORK PHONE (DISPLAY ONLY)
This field contains the work phone number of the relative, if known.

17. EXT. (DISPLAY ONLY)
This field contains the work extension number, if applicable.

Insurance Process

This series of screens provides patient insurance information.

After you select this option, the system lists the carrier/plans associated with this patient on a screen similar to the following:

```
               General Hospital Insurance Process Processor
                                           Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit   Disch      Balance  Loc
A10003-00006 SMITH, MARY A.        DD OB  02/02/90 02/05/90  1956.75  AR/FCRV

COB   Code Insurance Name                    Policy Number    Ver PreCert FC

#1 500023 LINCOLN NATIONAL                   12345654         No  No      DD
#2 220000 AMERICAN SECURITY                  22450000         No  No




Select a plan--
            MSP(Q), next screen(/) or previous screen(/P) [/]
```

The information displayed includes the COB sequence, the carrier/plan code, the plan name, the policy number, whether verification and precertification are required, and the financial class associated with the visit.

To view information for a specific insurance plan, enter the COB number of the plan you want to review and press ENTER. The system displays the following menu screen. If you enter a **Q** for a Medicare Secondary Payor plan, refer to the *Patient Processing* module in the *STAR Patient Care Reference Guide* for a description of the Medicare Secondary Payor screens.

```
               General Hospital Insurance Process Processor
                                           Fri Mar 10, 2010 12:36 pm
Account       Name                 FC Typ Admit   Disch      Balance  Loc
10003-00006  SMITH, MARY A         DD OB  02/02/90 02/05/90  1956.75  AR/FCRV
             Option No.  Option
             ---------------------------------------
                1        Plan Demographics
                2        Basic Coverage
                3        Room Coverage
                4        Ancillary Coverage
                5        Major Medical Coverage
                6        Daily/Blood Deductibles
                7        Flat Rate Coverage
                8        Plan Attachments
                9        Plan Comments
               10        Billing/Collection Options
               11        Claim/Proration Control
               12        Exceptions/Reimbursement/Logs


Enter option number--
```

Each option is explained in the order listed on the screen.

PLAN DEMOGRAPHICS

There are several screens involved in Plan Demographics. Whether the screen below is displayed depends on how the Insurance Plan master table is completed (for the carrier/plan selected). If the hospital sets up an admission comment for the insurance plan, this screen will always display. It will also display if the insurance requires verification and certification but the process has not been completed.

```
            General Hospital Plan Demographics Processor
                                             Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch      Balance  Loc
88146-00011 STEPHENS,CHARLES A       C  ECU 04/05/90             990.00  PA/FCRV



               Verification is required!

               Prenotification is required!



   |Please include group number on all correspondence.        |
   |Hospital must call FOCUS prior to admission!               |
   |                                                           |
   |                                                           |

Press NL--
```

Press ENTER, and the first screen of carrier demographic information is displayed. This screen provides information relating to the patient's guarantor, the insured party, and the carrier plan.

The next two screens differ depending on the insurance type. The following screen shows the Commercial Insurance type.

```
            General Hospital Insurance Process Processor
                                             Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch      Balance  Loc
A99-15500002 TEST,AARON              O  LTC 06/04/99            25216.95 PA/FCRV
Plan: 500100 COMMERCIAL BASIC PLAN               Provider: 5555
 1 Carrier-Plan                           2 Same As
   COMMERCIAL BASIC PLAN
 3 Insured Name              4 Sex of Insured  5 Relation to Insured
   TEST,MOTHER                 FEMALE             18 PARENT
 6 Insured's Birthdate    7 Soc Sec #           8 Policy Number

 9 Group Name                 10 Group Number     11 Group Phone
   GROUP NAME                    123456              (770)555-6666
12 Ext.       13 Mail To           14 Contact's Name / "Mail to" Person
               Employer               QONTACT QNAME
15 Contact's Company Name                16 Address Line 1
   NEW KONTACT KOMPANY KNAME              123 ICE AVENUE
17 Address Line 2           18 City           19 St  20 ZIP Code    21 Cn
                             WINTER WONDERLAND    AL    99999           US
22 Comment

Press NL--
```

Field Explanations

1. CARRIER-PLAN (DISPLAY ONLY)
The insurance plan name is displayed based on the selection made previously.

2. SAME AS (DISPLAY ONLY)
This field displays P if the insured person is the patient, G for guarantor, or R for relative.

3. INSURED NAME (DISPLAY ONLY)
This field displays the insured's name, exactly as it appears on the insurance card, in the format of LAST,FIRST MIDDLE.

4. SEX OF INSURED (DISPLAY ONLY)
This field displays the sex of the insured as M or F, which is displayed as MALE or FEMALE.

5. RELATION TO INSURED (DISPLAY ONLY)
This field displays the code that describes the patient's relationship to the insured. The code and description are displayed.

6. INSURED'S BIRTHDATE (DISPLAY ONLY)
This field displays the insured's birthdate.

7. SOC SEC # (DISPLAY ONLY)
This field displays the insured's social security number without hyphens (-). The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

8. POLICY NUMBER (DISPLAY ONLY)
This field displays the insured's policy number exactly as it appears on the insurance card.

9. GROUP NAME (DISPLAY ONLY)
This field displays the group name for this policy exactly as it appears on the insurance card. For plans that have associated 1500 plans, the group name is automatically brought to the associated fields on the 1500 plan screen.

10. GROUP NUMBER (DISPLAY ONLY)
This field displays the group number for this policy exactly as it appears on the insurance card. For plans that have associated 1500 plans, the group number is automatically brought to the associated fields on the 1500 plan screen.

11. GROUP PHONE (DISPLAY ONLY)
This field displays the group area code and phone number for this policy.

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12. EXT. (DISPLAY ONLY)
This field displays the group phone number extension.

13. MAIL TO (DISPLAY ONLY)
This field displays E (employer), C (carrier), G (group), or P (plan) to indicate where the claim information is to be mailed.

14. CONTACT'S NAME / "MAIL TO" PERSON (DISPLAY ONLY)
This field displays the name of the person that is to receive the claim.

15. CONTACT'S COMPANY NAME (DISPLAY ONLY)
If the company for the contact person is different than that for the insurance plan, the company is displayed in this field.

16. ADDRESS LINE 1 (DISPLAY ONLY)
This field displays the address to which the claim is to be mailed.

17. ADDRESS LINE 2 (DISPLAY ONLY)
If there is a secondary address (for example, suite number) where the claim is to be mailed, it is displayed in this field.

18. CITY (DISPLAY ONLY)
This field displays the city to which the claim is to be mailed.

19. STATE (DISPLAY ONLY)
This field displays the state to which the claim is to be mailed in the standard state abbreviation format.

20. ZIP CODE (DISPLAY ONLY)
This field displays the ZIP code to which the claim is to be mailed.

21. CN (DISPLAY ONLY)
This field displays the country to which the claim is to be mailed.

22. COMMENT (DISPLAY ONLY)
This field displays any additional information or comments concerning this insurance coverage or carrier.

After you complete your review of this screen, press ENTER to view the next screen in this sequence, which provides employment information.

```
              General Hospital Insurance Process Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch     Balance Loc
A99-15500002 TEST,AARON             O  LTC 06/04/99           25216.95 PA/FCRV
Plan: 500100 COMMERCIAL BASIC PLAN              Provider: 5555
 1 Claim/Case #     2 Notified Date   3 Verify Phone     4 Ext
                                      (707)333-4567         222
 5 Verify Fax                 6 Verified Date     7 Verified Name
   (860)889-7473
 8 Verified By                9 2nd Opinion      10 2nd Opinion Status

11 Approval Name            12 Approval #        13 Appr Date   14 Appr LOS

15 Appr Phone    16 Ext     17 Appr Fax          18 Appr Visits 19 Appr Until
   (518)472-0130      22       (555)121-2345
20 Review Agency            21 Contact Name         22 Reference Number
   UM REVIEW AGENCY TBL....X    JOHN T. CONTACT         REF#77777
23 Review Phone  24 Ext     25 Review Fax        26 Reviewed by
                   (770)        (777)777-7777
27 EMG Code                           28  SVC Auth Exception Code

Press NL--
```

Field Explanations

1. EMPLOYMENT STATUS (DISPLAY ONLY)
This field indicates the current status of the patient's employment (for example, Part Time, Full Time, etc.). This information is used on the UB.

2. EMPLOYMENT INFO. (DISPLAY ONLY)
This field contains the code that describes the person for whom the employment information is provided (for example, the patient). This information is used on the UB.

3. EMPLOYER (DISPLAY ONLY)
This field contains the code that describes the insured's employer.

4. ADDRESS LINE 1 (DISPLAY ONLY)
This field contains the employer's primary address.

5. ADDRESS LINE 2 (DISPLAY ONLY)
If the employer has a secondary address (for example, a suite number), it will be displayed in this field.

6. CITY (DISPLAY ONLY)
This field contains the employer's city.

7. STATE (DISPLAY ONLY)
This field contains the state in which the employer is located. The state is displayed in the standard two-character state abbreviation format.

8. ZIP CODE (DISPLAY ONLY)
This field contains the employer's ZIP code.

9. WORK PHONE (DISPLAY ONLY)
This field contains the area code and phone number of the insured's work telephone number.

10. EMPLOYEE ID (DISPLAY ONLY)
This field contains the patient's employee identification number. This information is used on the UB.

11. CLAIM/CASE # (DISPLAY ONLY)
For insurance carriers that assign a unique number to each case, this field is used to store that number.

12. NOTIFIED DATE (DISPLAY ONLY)
This field contains the date the hospital notified the insurance company that the patient was hospitalized. If a date is present in this field, it indicates the hospital is waiting for information from the carrier for precertification or approval.

13. VERIFIED NAME (DISPLAY ONLY)
This field contains the name of the person who verified the insurance information. The name is displayed in the LAST,FIRST MIDDLE format.

14. VERIFIED DATE (DISPLAY ONLY)
This field contains the date this insurance was verified.

NOTE: This field controls the setting of sub location of COB 1. If this field is blank (default), or if you update the patient record and the verified date field is blank based on the update, the sub location of the patient record for COB 1 is INSR (Insurance Verification Not Completed). If the patient record is updated and this field contains information, the sub location of the patient record for COB 1 is ND (Not Discharged).

15. 2ND OPINION (DISPLAY ONLY)
This field indicates whether a second opinion is required.

NOTE: Fields 16-19 are used for storing information for insurance carriers that require approval for hospitalization.

16. APPROVAL NAME (DISPLAY ONLY)
This field contains the name of the person approving this hospital stay for the patient. The name appears in the LAST,FIRST MIDDLE format.

17. APPROVAL # (DISPLAY ONLY)
This field contains the approval number. This number can be used for the treatment authorization number in locator 63 of the UB.

18. APPR DATE (DISPLAY ONLY)
This field contains the date this insurance was approved.

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19. APPR LOS (DISPLAY ONLY)
This field contains the number of days that have been approved for this patient based on the insurance carrier.

20. REVIEW AGENCY (DISPLAY ONLY)
This field displays the review agency for this insurance plan.

21. CONTACT NAME (DISPLAY ONLY)
This field displays the contact name at the review agency.

22. REFERENCE NUMBER (DISPLAY ONLY)
This field displays the reference number for the review agency.

23. REVIEW PHONE (DISPLAY ONLY)
This field displays the telephone number of the review agency.

24. EXT (DISPLAY ONLY)
This field displays the telephone extension for the contact at the review agency.

25. REVIEW FAX (DISPLAY ONLY)
This field displays the fax number for the review agency.

26. REVIEWED BY (DISPLAY ONLY)
This field displays the name of the hospital employee that contacted the review agency and performed the review.

27. EMG CODE (DISPLAY ONLY)
This field displays the EMG code for this insurance plan, if applicable. The code and description display. EMG codes are used for state-specific Medicaid billing.

28. SVC AUTH EXCEPTION CODE (DISPLAY ONLY)
This field indicates the reason a service was performed without obtaining authorization.

BASIC COVERAGE

Select the Basic Coverage option to view information related to this insurance plan's basic coverage.

NOTE: The insurance coverage pages are copied to the patient's record from the Insurance Plan Coverage Table at the time of admission. The Account Revision function can be used to change the fields to be specific for the patient. The following screens display patient specific information.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Basic Coverage Processor
                Basic Coverage                    Fri Mar 10, 2006 12:36 pm
Account       Name                    FC Typ Admit     Disch       Balance  Loc
A88146-00011 STEPHENS,CHARLES A        C  ECU 04/05/98              990.00  PA/FCRV
 1 Benefits Assigned                  2 Baby Covered
   Yes                                  Yes
 3 Days Before Coverage Begins        4 Days Coverage is Active
   0                                    Unlimited
 5 Professional Fee Coverage          6 Coordinate Benefits
   Include                              Yes, Duplicating
 7 Source of Last Update




 Press NL--
```

Field Explanations

1. BENEFITS ASSIGNED (DISPLAY ONLY)

This field indicates whether the plan's benefits are assigned to the hospital rather than the patient. This field can be used to update the UB claim form. Refer to the UB Claim Load and Edit Parameters in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide for more information.

2. BABY COVERED (DISPLAY ONLY)

This field indicates whether newborn babies are covered under this plan. This field is not implemented at this time.

3. DAYS BEFORE COVERAGE BEGINS (DISPLAY ONLY)

This field contains the number of days from admission or registration before coverage begins. Any charges that occur before this day will be considered non-covered.

4. DAYS COVERAGE IS ACTIVE (DISPLAY ONLY)

This field contains the number of days from admission or registration that this plan's coverage is active.

5. PROFESSIONAL FEE COVERAGE (DISPLAY ONLY)

This field indicates whether professional fees are I (included in this plan), E (excluded from this plan), or O (the only charges covered by this plan).

6. COORDINATE BENEFITS (DISPLAY ONLY)
This field indicates whether the benefits should be coordinated with the patient's other insurance plans. If the plan coordinates benefits, the field also indicates if the coverage is duplicating or non duplicating.

If the plan coordinates benefits:

- The liability is calculated, and any remaining liability is passed on to another coordinating plan for consideration.

- The liability accepted by another carrier is not covered by this plan.

The order in which the coverages display for the patient determines which insurance is primary, secondary, and so forth.

If the plan does not coordinate benefits:

- The plan prorates its liability and does not pass on any remaining liability to another carrier.

- The plan would cover what another carrier also covers.

If the amount that a non-coordinating plan covers exceeds the patient's account balance, a credit balance is shown for the patient's liability when the account is prorated. For a majority of cases, individual policies are the only non-coordinating plans.

7. SOURCE OF LAST UPDATE (DISPLAY ONLY)
This field indicates whether the information was entered by a user or updated by the system for an account's insurance plan from the Insurance Coverage table when the patient type changes for the account. The values that may be displayed in this field are: Insurance Coverage Table Inpatient (Ins Cov Table-I/P), Insurance Coverage Table Outpatient (Ins Cov Table-O/P), Insurance Coverage Table Patient Type (Ins Cov Table PType-xxx (xxx represents the patient type used to access the table), or User Change.

ROOM COVERAGE

Select the Room Coverage option to view information related to this insurance plan's room coverage. This information is copied to the patient's record from the Insurance Plan Coverage Master.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Room Coverage Processor
              Room Coverage      Page  1 of  2  Fri Mar 10, 2006 12:36 pm
Account      Name               FC Typ Admit    Disch        Balance  Loc
A88146-00011 STEPHENS,CHARLES A   C  ECU 04/05/98              990.00  PA/FCRV
  1 Ward Room Allowance     2 Percent Cvd   3 Difference To  4 Transfer Limit
    Not Covered               0%              Patient          Unlimited
  5 SP Room Allowance       6 Percent Cvd   7 Difference To  8 Transfer Limit
    Semiprivate             100%             Patient          Unlimited
  9 Private Room Allowance 10 Percent Cvd  11 Difference To 12 Transfer Limit
    Semiprivate             100%             Patient          Unlimited
 13 ICU Room Allowance     14 Percent Cvd  15 Difference To 16 Transfer Limit
    Unlimited               100%             Patient          Unlimited
 17 Maximum Room/Bed Days Covered          18 Maximum ICU Days Covered
    Unlimited                                 Unlimited
 19 Maximum Ancillary Days Covered         20 Source of Last Update




 Press NL--
```

Field Explanations

1. WARD ROOM ALLOWANCE (DISPLAY ONLY)
This field contains the amount this plan covers for a ward room. Options are 0 to $9,999.99, **W** (the hospital's standard ward rate), **S** (the hospital's standard semiprivate rate), **U** (unlimited), or **N** (not covered).

2. PERCENT CVD (DISPLAY ONLY)
This field contains the percentage of ward room coverage provided by this plan. The range is 0 to 100 percent.

3. DIFFERENCE TO (DISPLAY ONLY)
This field indicates whether the portion of the ward room rate that is not covered should be assigned to major medical coverage or to the patient if there is a difference between the room rate and the amount covered. Options are M (major medical) or P (patient); the default is P.

For example, if the Ward Room Allowance field contains $50 and the hospital's ward room rate is $75, this field indicates how the $25 difference is covered.

4. TRANSFER LIMIT (DISPLAY ONLY)
This field contains the maximum amount of the not covered portion of the ward room rate that can be transferred to major medical. The range is 0 to $9,999.99, W (ward), S (semiprivate), or U (unlimited). If the Difference To field contains M, then a dollar amount, W, S, or U can be displayed here. If the Difference To field contains P, the system automatically completes this field with U.

If a W is displayed in this field, major medical will be responsible for the difference only up to the ward rate, as defined for each nurse station through the STAR Patient Care Location Table. If S is displayed in this field, major medical will be responsible for the difference only up to the semiprivate rate, as defined for each nurse station in the STAR Patient Care Location Table.

If a dollar amount is specified (for example, the $25 difference between the Ward Room Allowance of $50 and the hospital's ward rate of $75), the dollar amount will be covered by the coverage indicated in major medical. If there is a difference between the amount specified as the limit and the amount calculated as the difference, the remaining amount becomes the responsibility of the patient.

If this field contains U, the entire difference is covered under major medical.

5. SP ROOM ALLOWANCE (DISPLAY ONLY)
This field contains the amount this plan covers for a semiprivate room. Options are 0 to $9,999.99, S (the hospital's standard semiprivate rate), U (unlimited), or N (not covered).

6. PERCENT CVD (DISPLAY ONLY)
This field contains the percentage that the insurance plan uses to calculate the semiprivate room allowance. The range is 0 to 100%.

7. DIFFERENCE TO (DISPLAY ONLY)
This field indicates whether the portion of the semiprivate room rate that is not covered should be assigned to major medical coverage or to the patient if there is a difference between the room rate and the amount covered. Options are M (major medical) or P (patient); the default is P.

For example, if the SP Room Allowance field contains $100 and the hospital's semiprivate room rate is $250, this field indicates how the $150 difference is covered.

8. TRANSFER LIMIT (DISPLAY ONLY)
This field contains the maximum amount of the not covered portion of the semiprivate room rate that can be transferred to major medical.

The range is 0 to $9,999.99, S (semiprivate), or U (unlimited). If the Difference To field contains M, then a dollar amount, S, or U can be displayed here. If the Difference To field contains P, the system automatically completes this field with U.

If an S is displayed in this field, major medical will be responsible for the difference only up to the semiprivate rate, as defined for each nurse station through the STAR Patient Care Location Table.

If a dollar amount is specified, the dollar amount indicated will be covered by major medical.

9. PRIVATE ROOM ALLOWANCE (DISPLAY ONLY)
This field contains the amount this plan covers for a private room. The range is 0 to $9,999.99, W (the hospital's standard ward rate), S (the hospital's semiprivate room rate), U (unlimited), or N (not covered).

10. PERCENT CVD (DISPLAY ONLY)
This field contains the percentage that the insurance plan uses to calculate the private room allowance. The range is 0 to 100%.

11. DIFFERENCE TO (DISPLAY ONLY)
This field indicates whether the portion of the private room rate that is not covered should be assigned to the patient's major medical or to the patient. Options are M (major medical) or P (patient); the default is P.

12. TRANSFER LIMIT (DISPLAY ONLY)
This field contains the maximum amount of the not covered portion of the private room rate that can be transferred to major medical. The range is 0 to $9,999.99, S (semiprivate), or U (unlimited). If the Difference To field contains M, then a dollar amount, S (semiprivate), or U (unlimited) can be displayed here. If the Difference To field contains P, the system automatically completes this field with U.

If an S is displayed in this field, major medical is responsible for the difference only up to the semiprivate rate, as defined for each nurse station through the STAR Patient Care Location Table. If this field contains a U, major medical covers the entire difference. If the Difference To field contains P and the system fills this field with U, the patient is responsible for any difference. The patient is also responsible for any difference when the Difference To field contains M and the dollars exceed the amount entered in the Transfer Limit field.

13. ICU ROOM ALLOWANCE (DISPLAY ONLY)
This field contains the amount this plan covers for a room in intensive care. The range is 0 to $9,999.99, W (ward), S (semiprivate), U (unlimited), or N (not covered).

14. PERCENT CVD (DISPLAY ONLY)
This field contains the percentage this insurance plan uses to calculate the ICU room allowance. The range is 0 to 100 percent.

15. DIFFERENCE TO (DISPLAY ONLY)
This field indicates whether the portion of the ICU rate that is not covered should be assigned to major medical or to the patient. Options are M (major medical) or P (patient); the default is P.

16. TRANSFER LIMIT (DISPLAY ONLY)
This field contains the maximum amount of the not covered portion of the ICU room that can be transferred to major medical. The range is 0 to $9,999.99, S (semiprivate), or U (unlimited). If the Difference To field contains M, then a dollar amount, S (semiprivate), or U (unlimited) can be displayed here. If the Difference To field contains P, the system automatically completes this field with U.

17. MAXIMUM ROOM/BED DAYS COVERED (DISPLAY ONLY)
This field contains the total number of days of room/bed charges covered by this plan. The range is 1 to 999 days or U (unlimited). If the number of stay days exceeds the day limit, charges become non-covered.

18. MAXIMUM ICU DAYS COVERED (DISPLAY ONLY)
This field contains the maximum number of ICU days covered by this plan. The range is 1 to 999 or U (unlimited). If the ICU days limit is reached, additional ICU days are prorated in the same manner as a semiprivate day.

19. MAXIMUM ANCILLARY DAYS COVERED (DISPLAY ONLY)
This field indicates (either Yes or No) whether ancillary limits are based on days entered in the Maximum Room/Bed Days Covered field.

20. SOURCE OF LAST UPDATE (DISPLAY ONLY)
This field indicates whether the information was entered by a user or updated for an account's insurance plan from the Insurance Coverage table when the patient type changes for the account. The values that may be displayed in this field are: Insurance Coverage Table Inpatient (Ins Cov Table-I/P), Insurance Coverage Table Outpatient (Ins Cov Table-O/P), Insurance Coverage Table Patient Type (Ins Cov Table PType-xxx (xxx represents the patient type used to access the table), or User Change.

When you finish reviewing the first Room Coverage screen, press ENTER. The Accommodation Exceptions screen is displayed.

```
         General Hospital Room Coverage Processor
              Room Coverage Except    Page  2 of  2    Fri Mar 10, 2006 12:36 pm
Account        Name                 FC Typ Admit    Disch        Balance  Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/98                990.00  PA/FCRV
Page:01                     Accommodation Exceptions
( 1) NURSERY A
( 2) CORONARY CARE
( 3) INTENSIVE CARE
( 4) MEDICALLY JUSTIFIED
( 5) WARD









 Enter option to edit or `A` to add--
```

This screen displays accommodation codes that have exceptions to the basic room coverage. To display any of these exceptions, select the option to view, and press ENTER. The system displays the following screen:

```
             General Hospital Room Coverage Processor
               Room Coverage Except   Page  2 of  2   Fri Mar 10, 2006 12:36 pm
Account       Name               FC Typ Admit    Disch      Balance  Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/98            2200.00 PA/FCRV
 1 Accommodation                             2 Same as Room Type
   C-CORONARY CARE                             Semiprivate
 3 Room Allowance         4 Percent Cvd   5 Difference To  6 Transfer Limit










 Press NL--
```

Field Explanations

1. ACCOMMODATION (DISPLAY ONLY)
This field contains the STAR Patient Care Accommodation code and description.

2. SAME AS ROOM TYPE (DISPLAY ONLY)
This field indicates whether the Accommodation code should operate like the semiprivate, private, or ICU room coverage, as defined on screen 1. Options are S (semiprivate), P (private), or I (ICU).

3. ROOM ALLOWANCE (DISPLAY ONLY)
This field contains the amount this plan covers for a room used by a patient with this accommodation code. The range is 0 to $9,999.99, W (ward), S (semiprivate), U (unlimited), or N (not covered).

4. PERCENT CVD (DISPLAY ONLY)
This field contains the percentage of room cost paid by this plan for this accommodation code exception. The range is 0 to 100.

5. DIFFERENCE TO (DISPLAY ONLY)
This field indicates whether the portion of this room rate that is not covered should be assigned to major medical or to the patient. Options are M (major medical) or P (patient); the default is P.

6. TRANSFER LIMIT (DISPLAY ONLY)
This field contains the maximum amount of the not covered portion of the room that can be transferred to major medical. The range is 0 to $9,999.99, W (ward), S

(semiprivate), or U (unlimited). If the Difference To field contains M, then a dollar amount, S (semiprivate), or U (unlimited) can be displayed here. If the Difference To field contains P, the system automatically completes this field with U.

ANCILLARY COVERAGE

Select the Ancillary Coverage option to view information related to the ancillary coverage for this account. Ancillary Coverage information is copied from the Insurance Plan Coverage Master.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Ancillary Coverage Processor
                 Ancillary Coverage                  Fri Mar 10, 2006 12:36 pm
Account      Name                    FC Typ Admit    Disch       Balance  Loc
A88146-00011 STEPHENS,CHARLES A       C  ECU 04/05/98             990.00   PA/FCRV
 1 Include Room Charges in Ancillary Coverage                2 Limits are
   Yes                                                         Covered charges

                            First Ancillary Coverage
 3 Deductible Amount    4 Co-Pay       5 Percent Covered    6 Dollar Limit
    $0.00                                100                   Unlimited

                           Second Ancillary Coverage
 7 Deductible Amount               8 Percent Covered    9 Dollar Limit


10 Source of Last Update
   Ins Cov Table-I/O




 Press NL--
```

Field Explanations

1. INCLUDE ROOM CHARGES IN ANCILLARY COVERAGE (DISPLAY ONLY)
This field indicates whether room charges should be included in ancillary coverage. If this field contains N for No, the room coverage percentages entered on the Room Coverage screens (not the ancillary charges) are used to calculate amounts. Room charges are not used to satisfy deductibles, and dollar limits are for ancillary charges only.

If this field contains Y, room charges use the ancillary percentage and limit dollars. Room charges are used to satisfy deductibles. The allowance or amount per day is still derived from the Room Coverage function.

2. LIMITS ARE (DISPLAY ONLY)
This field indicates whether the dollar limits in fields 5 and 8 are C (covered charges) or B (benefits).

For example, if an insurance carrier's coverage is 80% to $1000.00 and the carrier's liability is $800.00, this field would contain C (covered charges - $1000 x .80 = $800). If an insurance carrier's coverage is 80% to $1000.00 and the carrier's liability will be $1000.00, this field would contain B (benefits).

First Ancillary Coverage

3. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the first coverage period's deductible.

4. CO-PAY (DISPLAY ONLY)
This field contains the amount of the first coverage period's co-pay.

5. PERCENT COVERED (DISPLAY ONLY)
This field contains the percentage of covered charges handled during the first coverage period.

6. DOLLAR LIMIT (DISPLAY ONLY)
This field contains the maximum dollar amount of accumulated charges handled during the first coverage period. The range is 0 to $99,999,999.99 or U (unlimited). When this limit is reached (providing a dollar amount is entered), the plan's second ancillary coverage goes into effect. If this field contains U, the secondary ancillary coverage is not valid.

Second Ancillary Coverage

7. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the second coverage period's deductible.

8. PERCENT COVERED (DISPLAY ONLY)
This field contains the percentage of covered charges handled during the second coverage period.

9. DOLLAR LIMIT (DISPLAY ONLY)
This field contains the maximum dollar amount of accumulated charges handled by the second ancillary coverage. Any overage is assigned to major medical.

NOTE: When ancillary limits are reached, remaining liability transfers to major medical coverage.

10. SOURCE OF LAST UPDATE (DISPLAY ONLY)
This field indicates whether the updated information was entered by a user or updated for an account's insurance plan from the Insurance Coverage table when the patient type changes for the account. The values that may be displayed in this field are: Insurance Coverage Table Inpatient (Ins Cov Table-I/P), Insurance Coverage Table Outpatient (Ins Cov Table-O/P), Insurance Coverage Table Patient Type (Ins Cov Table PType-xxx (xxx represents the patient type used to access the table), or User Change.

MAJOR MEDICAL COVERAGE

Select the Major Medical Coverage option to view information related to the major medical coverage for this account. Major medical coverage information is drawn from the Insurance Plan Coverage Master.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
               General Hospital Major Medical Coverage Processor
                 Major Med Coverage                 Fri Mar 10, 2006 12:36 pm
Account      Name                   FC Typ Admit    Disch       Balance  Loc
A10003-00006 SMITH,MARY A.          DD OB  02/02/98 02/05/98    1956.75  AR/FCRV
 1 Room Charges Included?  2 Room Chgs in Limits?        3 Limits Are
   Yes                       Yes                           Covered charges
 4 Ancillary Charges Included?
   Yes


                            First Major Medical
 5 Deductible Amount       6 Percent Coverage             7 Dollar Limit
    $0.00                    100                             $10,000.00


                           Second Major Medical
 8 Deductible Amount       9 Percent Coverage             10 Dollar Limit
    $100.00                  80                              $50,000.00


                            Third Major Medical
11 Deductible Amount      12 Percent Coverage             13 Dollar Limit



Press NL--
```

Field Explanations

1. ROOM CHARGES INCLUDED? (DISPLAY ONLY)
This field indicates whether the room and bed charge differences are used to satisfy the deductible. Options are Y for Yes and N for No; the default is Y.

2. ROOM CHGS IN LIMITS? (DISPLAY ONLY)
This field determines whether the room and bed differences should be included in calculating the limits. This field is required only if the Room Charges Included field is set to No. Options are Y for Yes or N for No; the default is Y. If this field contains a Y, the room charges are included.

3. LIMITS ARE (DISPLAY ONLY)
This field indicates whether the coverage limits entered here pertain to hospital charges or patient benefits. The options are C (covered charges) or B (benefits); the default is C.

For example, if a carrier covers 80% to $1000.00 and the carrier's liability is $800.00, this field contains C (covered charges - $1000 x .80 = $800).

If a carrier covers 80% to $1000.00 and the carrier's liability is $1000.00, this field contains B (benefits). The system determines the dollar amount applied to the 80% before referring to the next level of coverage, in this case, $1250--$1250 x .80 = $1000.

4. ANCILLARY CHARGES INCLUDED? (DISPLAY ONLY)
This field determines whether ancillary charges are included in satisfying major medical deductibles and limits.

First Major Medical

5. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the first major medical coverage period's deductible. The range is 0.00 to $9,999.99.

6. PERCENT COVERED (DISPLAY ONLY)
This field contains the percentage of patient charges handled by the first major medical coverage period's deductible. The range is 0 to 100%.

7. DOLLAR LIMIT (DISPLAY ONLY)
This field contains the maximum dollar amount of accumulated charges handled by the first major medical coverage period. Any overage is assigned to another patient insurance (if available), directly to the patient, or to the second major medical. The range is 0 to $99,999,99.99 or U (unlimited).

Second Major Medical

The second major medical information goes into effect when the first major medical dollar limit has been reached. The range is 0 to $9,999.99.

8. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the percentage of patient charges handled by the second major medical coverage period. The range is 0 to 100%.

9. PERCENT COVERED (DISPLAY ONLY)
This field contains the percentage of patient charges handled by the second major medical coverage period. The range is 0 to 100%.

10. DOLLAR LIMIT (DISPLAY ONLY)
This field contains the maximum dollar amount of accumulated charges handled by the second major medical coverage period. Any overage is assigned to another patient insurance (if available), directly to the patient, or to the third major medical. The range is 0 to $99,999,999.99 or U (unlimited).

Third Major Medical

The third major medical information will go into effect when the second major medical dollar limit has been reached.

11. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the third major medical coverage period's deductible. The range is
0 to $9,999.99.

12. PERCENT COVERED (DISPLAY ONLY)
This field contains the percentage of patient charges handled by the third major
medical coverage period. The range is 0 to 100%.

13. DOLLAR LIMIT (DISPLAY ONLY)
This field contains the maximum dollar amount of accumulated charges handled by the
third major medical coverage period. Any overage is assigned to another patient
insurance (if available) or directly to the patient. The range is 0 to $99,999,999.99 or U
(unlimited).

NOTE: When major medical coverage is exhausted, payment responsibility is
transferred to another patient insurance (if available) or directly to the patient.

DAILY/BLOOD DEDUCTIBLES

Select the Daily/Blood Deductibles option to view information about the daily
deductibles and blood deductibles for this account. This information is copied from the
Insurance Plan Coverage Master.

After you select this option, the system displays the following screen. When you
complete your review, press ENTER to exit the transaction.

```
            General Hospital Daily/Blood Deductibles Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name               FC Typ Admit     Disch      Balance  Loc
A88146-00011 STEPHENS,CHARLES A   C  ECU 04/05/98             990.00  PA/FCRV
First Daily Deductible
 1 Start After Days     2 Days Active          3 Deductible Amount
   60                     30                      $250.00
Second Daily Deductible
 4 Start After Days     5 Days Active          6 Deductible Amount
   90                     60                      $125.00
Third Daily Deductible
 7 Start After Days     8 Days Active          9 Deductible Amount

Blood Deductible
10 Deductible Pints    11 Furnished in Replaced?  12 Blood Summary Code
   2                      Yes                         391
13 Source of Last Update




 Press NL--
```

Field Explanations

First Daily Deductible

1. START AFTER DAYS (DISPLAY ONLY)
This field contains the number of days from admission or registration before starting this deductible. The range is 0 to 999 days.

2. DAYS ACTIVE (DISPLAY ONLY)
This field contains the number of days this deductible is active. The range is 1 to 999 days or U (unlimited).

3. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the daily deductible amount. The range is 0 to $9,999.99.

Second Daily Deductible

This information can be completed only after the first daily deductible information is defined.

4. START AFTER DAYS (DISPLAY ONLY)
This field contains the number of days from admission to wait before starting this deductible. The range is 0 to 999 days.

5. DAYS ACTIVE (DISPLAY ONLY)
This field contains the number of days this deductible is active. The range is 1 to 999 days or U (unlimited).

6. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the daily deductible amount. The range is 0 to $9,999.99.

Third Daily Deductible

This information can be completed only if the second daily deductible information has been defined. The Third Daily Deductible can be used at the beginning of a new year for Medicare patients when the co-insurance or life time reserve rate changes.

7. START AFTER DAYS (DISPLAY ONLY)
This field contains the number of days from admission to wait before starting this deductible. The range is 0 to 999 days.

8. DAYS ACTIVE (DISPLAY ONLY)
This field contains the number of days this deductible is active. The range is 1 to 999 days or U (unlimited).

9. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the daily deductible amount. The range is 0 to $9,999.99.

10. DEDUCTIBLE PINTS (DISPLAY ONLY)

This field contains the number of pints of blood that this plan will not cover. This field is used for Value code 38 on the UB. If the patient receives blood, the system accumulates the amount of blood based on charges associated with the UB revenue code that is entered in the Blood Summary Code field. This field is not used in proration.

11. FURNISHED IN REPLACED? (DISPLAY ONLY)

This field indicates whether units of blood furnished under this plan should be included in the units replaced, value code 39 on the UB claim form. Options are Y for Yes or N for No.

12. BLOOD SUMMARY CODE (DISPLAY ONLY)

This field contains the appropriate UB revenue code. This code is used in concert with fields 10 and 11. If charges exist for the UB revenue code entered in this field and the Furnished in Replaced field contains Y, the number of units of blood is loaded as Value Code 37, Blood Furnished, and Value Code 39, Blood Replaced, on the UB. If the Furnished in Replaced field contains N, the number of units furnished is loaded only.

13. SOURCE OF LAST UPDATE (DISPLAY ONLY)

This field indicates whether the information was entered by a user or updated for an account's insurance plan from the Insurance Coverage table when the patient type changes for the account. The values that may be displayed in this field are: Insurance Coverage Table Inpatient (Ins Cov Table-I/P), Insurance Coverage Table Outpatient (Ins Cov Table-O/P), Insurance Coverage Table Patient Type (Ins Cov Table PType-xxx (xxx represents the patient type used to access the table), or User Change.

FLAT RATE COVERAGE

Select the Flat Rate Coverage option to view information about this insurance plan's flat rate coverage. This information is copied to the patient's record from the Insurance Plan Coverage Master. Flat rate coverage takes priority over any other ancillary benefits that exist for the insurance plan.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Flat Rate Coverage Processor
              Inpatient/Outpatient              Tues May 25, 2004 12:16 pm
Carrier:BLUE CROSS                              Facility :All
Plan   :BLUE CROSS 1500                         Effective:Current
Patient type: Inpatients/Outpatients
 Inpatient
 1 Flat Rate per    2 Maximum Days   3 Flat Rate Amount  4 Deductible Amount
   Day                    30                $20.00                 $100.00
 5 Source of Last Update




Press NL--
```

Field Explanations

1. FLAT RATE PER (DISPLAY ONLY)
This field indicates the type of flat rate for inpatients. Entry options are per day (D) or entire stay (S).

- A **per day** flat rate enables one rate to be applied for each day the patient stays in the hospital.

- A **per bill** flat rate enables a flat rate to be applied for each interim or cycle bill and for the final bill.

- A **per stay** flat rate enables one rate to be applied for each occurrence.

2. MAXIMUM DAYS (DISPLAY ONLY)
This field contains the maximum number of days this flat rate is effective from the admission date.

3. FLAT RATE AMOUNT (DISPLAY ONLY)
This field contains the flat rate amount this plan pays per day, per bill, or for the entire stay, depending on the entry in the Flat Rate Per field.

4. DEDUCTIBLE AMOUNT (DISPLAY ONLY)
This field contains the flat rate deductible amount for an inpatient stay.

5.   SOURCE OF LAST UPDATE (DISPLAY ONLY)
This field indicates whether the information was entered by a user or updated for an account's insurance plan from the Insurance Coverage table when the patient type changes for the account. The values that may be displayed in this field are: Insurance Coverage Table Inpatient (Ins Cov Table-I/P), Insurance Coverage Table Outpatient (Ins Cov Table-O/P), Insurance Coverage Table Patient Type (Ins Cov Table PType-xxx (xxx represents the patient type used to access the table), or User Change.

PLAN ATTACHMENTS

This screen displays the attachment table. Codes which are applicable to the patient are highlighted on this table.

The Plan Attachments function is used to identify attachments that must accompany a claim against this coverage plan. These attachments (for example, an Admission Summary, EKG Certification, Discharge Summary, etc.) can be required by specific carriers and plans when a claim is submitted. The codes are maintained in the user-defined Billing Attachment table. After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
           General Hospital Plan Attachments Processor
                                        Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit   Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A     C  ECU 04/05/90             990.00  PA/FCRV
Page:01                        Billing Attachments        ##=Current Choices
( 1) AA-AA CERTIFICATION
( 2) AS-ADMISSION SUMMARY
( 3) CP-CPT-4 CODES
( 4) CC-CRIPPLED CHILDREN CERT.
( 5) DS-DISCHARGE SUMMARY
( 6) EK-EKG CERTIFICATION
( 7) PT-PHYSICAL THERAPY CERTIFICATION
( 8) TL-TUBAL LIG. CERTIFICATION




 Press NL--
```

PLAN COMMENTS

Select the Plan Comments option to view any comments that have been entered about this insurance plan. An example of a plan comment could be information alerting insurance billers and verifiers about particular plan requirements. The comments displayed on this screen are copied to the patient's record from the Insurance Coverage Master at admission and registration. You can enter specific comments related to this patient through the Account Revision function. The comments are

displayed in a list similar to plan attachments and can be referenced during insurance verification. When you select this option, the system displays the following screen:

```
              General Hospital Plan Comments Processor
              Comments                          Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch        Balance  Loc
A90000-00009 JONES,JOHN             B  I/P 01/16/90 01/31/90    1050.00  AR/FCRV
Page:01                                Comments
( 1) XYZ-A COPY OF ALL DETAIL CHARGES




 Enter choice
```

This screen displays a list of the comments associated with this plan, along with the comment code and the first 29 characters of the message.

Enter the number of the comment you want to display, and press ENTER. A screen similar to the following is displayed.

```
              General Hospital Plan Comments Processor
              Comments                          Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch        Balance  Loc
A90000-00009 JONES,JOHN             B  I/P 01/16/90 01/31/90    1050.00  AR/FCRV
Comment:XYZ
             1         2         3         4         5         6
   12345678901234567890123456789012345678901234567890123456789012
01|A COPY OF ALL DETAIL CHARGES IS REQUIRED IF THE BILL         |
02|EXCEEDS $10,000.00                                           |
03|                                                             |
04|                                                             |




 Press NL--

   F1           F2           F3      F4     F5           F6           F7    F10
   Delete Line  Insert Line  Center  Exit   Store Line   Restore Line Pack  Help
```

BILLING/COLLECTION OPTIONS

Select the Billing/Collection Options function to view billing and collection information related to this insurance plan. This information is originally obtained from the Insurance Plan Coverage Master but can be changed through the Account Revision function.

After you select this option, the system displays the following screen. When you complete your review, press ENTER to exit the transaction.

```
                General Hospital Billing/Collection Options Processor
                                            Fri Mar 10, 2006 12:36 pm
 Account      Name                  FC Typ Admit    Disch      Balance Loc
 A00125-87    SMITH, MARY           C  O/P 10/01/00 11/01/00     50.00  BD/FCRV
  1 Payment Transaction Code              2 Cont. Adj. Trans Code at Payment
    I0010-AUGNET PAYMENT                    A0010-AUGUST/AUGNET CONT ADJ
  3 Insurance Refund Transaction Code
    D0010-AUGNET REFUND
  4 Primary F/U Sch Dollar Definition    5 Secondary F/U Sch Dollar Definition
    883-COMMERCIAL INS FOLLOW-UP SCHED      883-COMMERCIAL INS FOLLOW-UP SCHED
  6 Billing Group                        7 Collector Group
    13-MEDICARE HOSPICE                    2-COMMERCIAL
  8 Final Bill Parameter                 9 Cycle Billing Parameter
    1-COMMERCIAL-FINAL SUMM-DX
 10 Perform Pre-bill Edits              11 Final Bill if Pre-bill Edits Exist
     Yes                                   Yes




 Press NL--
```

Field Explanations

1. PAYMENT TRANSACTION CODE (DISPLAY ONLY)
This field contains the one-letter transaction type and the user-defined, four-digit transaction code used to record a payment received from insurance.

2. CONTRACTUAL ADJUSTMENT TRANSACTION CODE AT PAYMENT (DISPLAY ONLY)
This field contains the one-letter transaction type and the user-defined, four-digit transaction code used to record a contractual adjustment for this insurance carrier. If contractual adjustments are not valid for this carrier, the field is blank.

3. INSURANCE REFUND TRANSACTION CODE (DISPLAY ONLY)
This field contains the one-letter transaction type and the user-defined, four-digit transaction code used to record (in this account's transaction history) any refunds made to this carrier.

4. PRIMARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition assigned to this carrier plan. You can enter another code or display and

select from a list of insurance follow-up schedule dollar definitions. This code is used for follow up if this carrier is the primary carrier for outpatient accounts under this plan.

5.   SECONDARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition assigned to this carrier plan. You can enter another code or display and select from a list of insurance follow-up schedule dollar definitions. This code is used for follow up if this carrier is the secondary carrier for outpatient accounts under this plan.

6.   BILLING GROUP (DISPLAY ONLY)
This field contains the user-defined code and description identifying the billing group responsible for generating and submitting claims for this carrier/plan. This field is used in assigning a biller to a claim. If this is the primary carrier, the billing group is also used to assign a biller to the account.

7.   COLLECTOR GROUP (DISPLAY ONLY)
This field contains the user-defined code and description identifying the collection group responsible for collecting the balance due from this carrier/plan. This field is used in assigning a collector for insurance follow-up.

8.   FINAL BILL PARAMETER (DISPLAY ONLY)
This field contains the code and description identifying the final bill parameter assigned to this carrier/plan. This parameter defines when billing will occur once the patient is discharged. Billing is based on the parameter of the primary insurance.

9.   CYCLE BILLING PARAMETER (DISPLAY ONLY)
This field contains the code and description identifying the cycle bill parameter assigned to this carrier/plan. This parameter defines when and if billing will occur prior to discharge. Billing is based on the parameter of the primary carrier.

10. PERFORM PRE-BILL EDITS? (DISPLAY ONLY)
This field indicates whether pre-bill edits are to be performed for this account. A value of Yes in the field indicates pre-bill edits can be performed.

11. FINAL BILL IF PRE-BILL (DISPLAY ONLY)
This field indicates whether this account should be final billed if pre-bill edits exist for the account. A value of Yes in the field indicates final bill should occur even though pre-bill edits exist.

CLAIM/PRORATION CONTROL

Select the Claim/Proration Control option to view claim and proration control information related to this insurance plan. This information is originally obtained from the Insurance Coverage Plan Master but can be changed through the Account Revision function.

After you select this option, the system displays the Claim/Proration Control Options screen (shown below). When you complete your edit, press ENTER to return to the previous menu.

```
                General Hospital Claim/Proration Control Processor
                 Proration/Claim Ctrl            Fri Mar 10, 2008 12:36 pm
Account       Name                    FC Type Admit    Disch       Balance Loc
C0715600001  HANSEN,OLAF              O   O/P 06/05/07 06/05/07   $1970.33 AR
 1 Claim Form Type     2 Produce Claim? 3 Print on UB?       4 Prorate?
   UB                    Yes              Yes                   Yes
 5 Claim Load/Edit Parameter            6 Claim Charge Control Parameter
   99-TEST COMMERCIAL                     01-COMMERCIAL CHARGES
 7 Claim Generation Parameter         8 Load Separate Claim?  9 Hold for Pmt?
   UB-UB82 Claim generation             Yes                   Yes
10 ASB/Crossover Hold Exceptions
   100100,999100,500100,300200,601601,888444,007011
11 Print Paper Claim Label?              12 Suppress?  13 EOB Indicator
   No                                      No             No
14 Provider Number                     15 Provider Master
   OP20202                                2-COMMERCIAL MODEL HOSP
                         Electronic Claims
16 Electronic Media     17 Prt Elec Clm Label 18 Delay Reason Code
   Electronic Media A      No
19 Payor ID,Sub ID   20 Primary Payor   21 Source of Payment
   12345,9876




Press NL--
```

Field Explanations

1. CLAIM FORM TYPE (DISPLAY ONLY)
This field indicates the type of claim form to be produced for this carrier plan. The options available include the UB and the 1500 (OHIP, WCB, and Universal) claim forms.

2. PRODUCE CLAIM? (DISPLAY ONLY)
This field indicates whether a claim should be produced for this insurance. The system displays Y if either an electronic or paper claim is to be produced when the claim is released. The system displays N if no claim is to be produced when the claim is released. Copies of claims can always be generated by using the Reprint Claim option. Suppressed claims are listed on the Claim Prints Suppressed Report.

3. PRINT ON UB? (DISPLAY ONLY)
This field indicates whether the insurance plan information should print on the UB claim form in Locators 50 through 66. The system displays Yes if the insurance plan information is to print in form locators 50 through 66 on the UB. The system displays No if the insurance plan information is not to print on the UB. This field is used by the following Setup Routines (linked to Internal Elements) in the Claim Load and Edit Parameters to identify insurance plan information to print on claims:

•   UB Carrier 1

- UB Carrier 2

- UB Carrier 3

NOTE: This field does not determine what claim form loads for the insurance. It determines, for those insurances on the account that load a UB, what information is printed in the above-mentioned locators.

4. PRORATE? (DISPLAY ONLY)
This field indicates whether or not claims should be prorated according to the coverage and limits of this plan.

This field controls how the patient's charges will be handled for proration purposes. If the value is set to Y for Yes, all patient plans are prorated according to the benefit information entered for the plan. If the value is N for No, all patient plans are prorated at 100%, and the excess amount is stored in a Third Party Excess field.

For example, a patient has two insurance coverages coordinating benefits and this field is set to Y with covered charges of $1000.00. As a result:

- Plan 1 pays 80%

- Plan 2 pays 90%

- Plan 1 is prorated for a plan liability of $800.00

- Plan 2 is prorated for a plan liability of $200.00

If you set this field to N, using the same information in the above example results in this situation:

- Plan 1 is prorated at $1000.00

- Plan 2 is prorated at $1000.00

- A Third Party Excess field is updated for $1000.00

5. CLAIM LOAD/EDIT PARAMETER (DISPLAY ONLY)
This field contains the user-defined code and description of the parameter defining how the claim demographic information is loaded and edited for this carrier.

6. CLAIM CHARGE CONTROL PARAMETER (DISPLAY ONLY)
This field contains the user-defined code and description of the parameter defining how charges are printed on the claim form. This field is not used for Canadian claims processing.

7.   CLAIM GENERATION PARAMETER (DISPLAY ONLY)

This field contains the user-defined code and description of the parameter defining the number of days the claim for this carrier should be held in a failed state before automatically releasing.

8.   LOAD SEPARATE CLAIM? (DISPLAY ONLY)

This field indicates whether or not a separate claim for this carrier/plan should be generated if this plan is not providing primary coverage. This information is used for the UB only.

9.   HOLD CLAIM FOR PMT? (DISPLAY ONLY)

This field indicates whether or not a claim for this plan should be held until the claims for prior plans with overlapping coverage are dispositioned as final payment, adjusted to zero, or denied.

10. ASB/CROSSOVER CLAIMS EXCEPTIONS (DISPLAY ONLY)

This field contains carrier/plan exceptions for ASB/Crossover claims. The field displays as many carrier/plan exceptions as will fit on the line. If there are more entries than will fit, the line has a plus sign (+) at the end.

11. PRINT PAPER CLAIM LABEL? (DISPLAY ONLY)

This field indicates whether or not a mailing label for paper claims on this carrier/plan should be printed when the claim is printed. This field is not used for Canadian OHIP or WCB claims.

12. SUPPRESS? (DISPLAY ONLY)

This field indicates if unreleased claims should be suppressed or not suppressed when a payment, adjustment or balance transfer is posted which leaves the carrier or account with a zero balance. An entry of Yes indicates that claims that have an account balance of zero or a carrier balance of zero are automatically suppressed. An entry of No indicates that claims that have an account balance of zero or a carrier balance of zero will not be suppressed. For additional information on this field, refer to the PA/AR Master File Maintenance chapter in the *Tables, Masters and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide.

13. EOB INDICATOR (DISPLAY ONLY)

This field indicates whether a paper explanation of benefit was requested for the carrier. An entry of Yes indicates a paper EOB was requested. An entry of No indicates a paper EOB was not requested.

14. PROVIDER NUMBER (DISPLAY ONLY)

This field contains the provider number assigned to this insurance at the account level.

15. PROVIDER MASTER (DISPLAY ONLY)

This field contains the Provider Master associated with this account. The appropriate master is linked to the Patient Type table or the COB1 plan. If there are unique provider numbers not associated with a particular patient type but related to a particular carrier/plan, you can add this master to the plan and the plan assignment on the COB1 plan overrides the patient type assignment.

The system assigns this provider master to the account at admission or registration based on patient type. The providers numbers for Medicare, Medicaid, and Blue Cross are defined within the master. While the account is in PA, the provider number changes automatically if the patient type changes or the primary insurance changes (if the provider number is related to an insurance carrier.)

Electronic Claims

16. ELECTRONIC MEDIA (DISPLAY ONLY)
This field indicates what type of electronic media should be used to communicate a claim against this plan to the carrier. This field is not used for Canadian OHIP or WCB claims. The 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 will spool the claim to the paper spool file.

17. PRINT ELECTRONIC CLAIM LABEL (DISPLAY ONLY)
This field indicates whether a claim mailing label should be printed for this insurance plan when the electronic claims are spooled in the system.

18. DELAY REASON CODE (DISPLAY ONLY)
This field contains the discharge delay reason code.

19. PAYOR ID, SUB ID (DISPLAY ONLY)
This field is used for McKesson state regulations.

20. PRIMARY PAYOR (DISPLAY ONLY)
This field is used for McKesson state regulations.

21. SOURCE OF PAYMENT (DISPLAY ONLY)
This field is used for McKesson state regulations.

EXCEPTIONS/REIMBURSEMENT/LOGS

Select the Exceptions/Reimbursement/Logs option to view information about exceptions to the coverages associated with this insurance plan.

After you select this option, the system displays the following screen. When you complete your review, press **ENTER** to exit the transaction.

```
            General Hospital Summary Code Exceptions Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch       Balance  Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90              990.00   PA/FCRV
            Option No. Option
            ----------------------------------------
                1         Summary Code Exceptions
                2         Reimbursement
                3         Third Party Logs




 Enter option number--
```

Each of these options is discussed under its own heading below.

Summary Code Exceptions

Select the Summary Code Exceptions option to view information about this insurance plan's proration summary code exceptions. The proration summary code exceptions contain deductibles specified at different percentages than the main policy or for items indicated as Not Covered.

For Canadian users, the summary code exceptions are used to assign charges to insurance and patient responsibility.

After you select this option, the system displays the Summary Code Exceptions screen (shown below). When you complete your review, press **ENTER** to return to the previous menu.

```
            General Hospital Summary Code Exceptions Processor
                Summary Code Except.            Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch       Balance  Loc
A97-29700001 STEPHENS,CHARLES A    C  ECU 04/05/98              990.00   PA/FCRV
Page:01                              Proration Summary Code
( 1) LABORATORY
( 2) ANESTHESIA
( 3) CARDIO VASCULAR LAB
( 4) BILL SUMMARY CODE



 Enter choice--
```

Enter the number of the summary code exception you want to view and press **ENTER**. The next page of summary code exception information is displayed.

```
              General Hospital Summary Code Exceptions Processor
                 Summary Code Except.               Fri Mar 10, 2006 12:36 pm
 Account      Name                   FC Typ Admit    Disch       Balance  Loc
 A97-29700002 STEPHENS,CHARLES A     C  ECU 04/05/98              990.00  PA/FCRV
  1 Summary Code/Description
    540-ANESTHESIA
                              Exception Information
  2 Summary Code Covered             3 Covered Percentage
    Yes
  4 Deductible Per    5 Deductible %    6 Deductible Amount    7 Greater/Lesser
    Charge              100%              $250.00                Greater




 Press NL--
```

Field Explanations

1. SUMMARY CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the three-digit Proration Summary code and its up to 30-character description.

The following fields apply to charges relating to service items grouped under this Proration Summary code.

Exception Information

2. SUMMARY CODE COVERED (DISPLAY ONLY)
This field indicates whether or not this Proration Summary code should be covered by this plan. The options are Y for Yes and N for No. If N is displayed here, the Covered Percentage, Deductible Per, Deductible Percentage, Deductible Amount, and Greater/Lesser fields are not completed.

3. COVERED PERCENTAGE (DISPLAY ONLY)
This field contains the percentage of coverage for this Proration Summary code.

4. DEDUCTIBLE PER (DISPLAY ONLY)
This field indicates whether a deductible is applied per charge or per Proration Summary category total, if the Proration Summary code has a deductible. The options are C (per charge or per service item) or T (per category total or per Proration Summary code).

5. DEDUCTIBLE% (DISPLAY ONLY)
This field contains this plan's deductible, represented as a percentage, for the Proration Summary code.

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6.   DEDUCTIBLE AMOUNT (DISPLAY ONLY)

This field contains this plan's deductible, represented as a dollar and cents amount, for the Proration Summary code.

7.   GREATER/LESSER (DISPLAY ONLY)

This field indicates whether the greater or lesser amount between the deductible amount and the deductible percentage (if both have been entered) should be used in prorating charges under this plan. The options are G (greater) or L (lesser).

Reimbursement

Select the Reimbursement option to view reimbursement information associated with this insurance plan. This information is originally copied from the Insurance Coverage Master but can be modified for the patient through the Account Revision function.

After you select this option, the system displays the following screen. When you complete your review, press **ENTER** to exit the transaction.

```
                General Hospital Reimbursement Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch      Balance Loc
A10003-00006 SMITH,MARY A.         C  OB  02/02/98 02/05/98   1956.75 AR/FCRV

 1 Post Cont. Adj. at Final Bill        2 Reimbursement Master Payor
   Yes                                    LN-LINCOLN NATIONAL
 3 Reimbursement Type                   4 Contractual Adj. Transaction Code
   M-Medical Service                      A0001-ADJUSTMENT
 5 Reimbursement Type                   6 Contractual Adj. Transaction Code
   P-ICD-9 Procedure Code                 A0001-ADJUSTMENT
 7 Reimbursement Type                   8 Contractual Adj. Transaction Code
   O-Overall Plan                         A0001-ADJUSTMENT
 9 Reimbursement Type                  10 Contractual Adj. Transaction Code

11 OPPS Cont. Adj.  12 Pass-through      13 Star Calculated Reimbursement Method

14 PCON 1500




 Press NL--
```

Field Explanations

1.   POST CONT. ADJ. AT FINAL BILL (DISPLAY ONLY)

This field indicates whether any contractual adjustments on this account balance should be calculated and applied when the final bill is produced. The options are Yes or No.

2.   REIMBURSEMENT MASTER PAYOR (DISPLAY ONLY)

This field contains a user-defined code representing the reimbursement payor for this carrier plan.

Because carriers may reimburse at different rates, the system can store up to four different reimbursement types per patient per carrier to determine reimbursement. Reimbursement types are established in the system and include:

- A - ASC Payment Group
- D - ICD Diagnosis code
- P - ICD Procedure code
- G - DRG Code
- M - Medical Service
- O - Overall Plan
- I - Pathways Contract Management
- H - Medicare Outpatient Prospective Payment System (OPPS)
- J - PCON/Cycle

To use these reimbursement types, the reimbursement payor must have this type defined in the Reimbursement Payor Definition table. The information is originally copied from the Insurance Coverage Master but can be modified for the patient through the Account Revision function.

3. REIMBURSEMENT TYPE (DISPLAY ONLY)
This field indicates the first type on which this plan reimburses the hospital. The type is displayed in hierarchical order and must be a valid type for the reimbursement payor. Refer to the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide for more information.

4. CONTRACTUAL ADJ. TRANSACTION CODE (DISPLAY ONLY)
This field contains the transaction code associated with the reimbursement type entered in the Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made.

5. REIMBURSEMENT TYPE (DISPLAY ONLY)
This field indicates the second type on which this plan reimburses the hospital. The type is displayed in hierarchical order and must be a valid type for the reimbursement payor.

6. CONTRACTUAL ADJ. TRANSACTION CODE (DISPLAY ONLY)
This field contains the transaction code associated with the reimbursement type entered in the second Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made on the account.

7. REIMBURSEMENT TYPE (DISPLAY ONLY)
This field indicates the third type on which this plan reimburses the hospital. The type is displayed in hierarchical order and must be a valid type for the reimbursement payor.

8. CONTRACTUAL ADJ. TRANSACTION CODE (DISPLAY ONLY)
This field contains the transaction code associated with the reimbursement type entered in the third Reimbursement Type field. This code is used to update the

account's transaction history and the General Ledger when an adjustment is made on the account.

9. REIMBURSEMENT TYPE (DISPLAY ONLY)

This field indicates the fourth type on which this plan reimburses the hospital. The type is displayed in hierarchical order and must be a valid type for the reimbursement payor.

10. CONTRACTUAL ADJ. TRANSACTION CODE (DISPLAY ONLY)

This field contains the transaction code associated with the reimbursement type entered in the fourth Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made on the account.

Third Party Logs

Select the Third Party Logs option to view information related to any third party logs associated with this account. Third Party Logs is not available for Canadian users.

After you select this option, a screen similar to the following will be displayed:

```
              General Hospital Third Party Logs Processor
                                           Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A88146-00011 STEPHENSON,ROGER A    C  ECU 04/05/98             990.00  PA/FCRV
Page:01                            Log Identifiers
( 1) COMMERCIAL  O/P
( 2) COMMERCIAL SECONDARY




 Enter option to edit or `A` to add--
```

This screen displays the third party logs that are valid for the patient. If you enter an A, the log table is displayed. The logs which are applicable to the patient are highlighted on the screen.

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To view more information for a specific log, enter the number of the log you want to see and press ENTER. The following screen is displayed:

```
                  General Hospital Third Party Logs Processor
                   3rd Party Logs                    Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch         Balance  Loc
A92146-00011 STEPHENS,CHARLES A    C  ECU 12/15/97                990.00   PA/FCRV
 1 Log Identifier                        2 Carrier Status
   COMMERCIAL O/P                           Any
 3 In/Out/ER/All patients
   ALL




 Press NL--
```

Field Explanations

1. LOG IDENTIFIER (DISPLAY ONLY)
This field contains the code and description of the log identifier selected.

2. CARRIER STATUS (DISPLAY ONLY)
This field contains the status this carrier must have for patients using this plan to be included in the log. The options are A (any), P (primary carrier only), or S (secondary carrier only). The default is A. If this field is set to P and the carrier plan is not the patient's primary plan, the logs will not be updated. This field is blank for logs not applicable to the patient.

3. IN/OUT/ER/ALL PATIENTS (DISPLAY ONLY)
This field indicates which patients using this plan should be included in this log. The options are I (inpatients only), O (outpatients only), E (emergency room patients only), or A (all patients). The default is All. This field is blank for logs not applicable to the patient.

Notice of Admission Information

This screen displays United Healthcare Insurance fields of admission acceptance for an account. This information is sent from STAR Patient Processing.

```
                  General Hospital Insurance Process Processor
                                          Fri Dec 04, 2010 01:26 pm
         Account        Name      FC Typ Admit    Disch     Balance  Loc
         C0933800001  TEST,NOA   O  I/P 12/04/09            2660.80  PA /INSR



          1 Administrative Reference Number
            REF123456

          2 Notification Receipt Number
            RECEIPT121212

          3 Review Identification Number
            REVIEW131313

          4 Date Received
            12/04/2009

          5 Time Received (Eastern Standard Time)
            13:26

         Press NL--
```

Field Explanations

1. ADMINISTRATIVE REFERENCE NUMBER (DISPLAY ONLY)
This field contains the administrative reference number from United Healthcare.

2. NOTIFICATION RECEIPT NUMBER (DISPLAY ONLY)
This field contains the notification receipt number from United Healthcare.

3. REVIEW IDENTIFICATION NUMBER (DISPLAY ONLY)
This field contains the review identification number from United Healthcare.

4. DATE RECEIVED (DISPLAY ONLY)
This field contains the date the United Healthcare Notice of Admission was received by STAR Patient Processing.

5. TIME RECEIVED (DISPLAY ONLY)
This field contains the time the United Healthcare Notice of Admission was received by STAR Patient Processing.

UB Condition Codes (US Only)

The UB Condition Codes page displays UB information pertinent to this visit. This information is available to print on the patient's admission form and/or to print on the patient's UB claim form.

Several codes can be automatically generated from the system. For more information, refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*. If a code is automatically

generated from the Provider Master, the code is loaded to the UB claim form, and does not need to be entered on this screen.

The UB Condition Codes page is displayed as follows. This screen is visit-specific, and none of the information is brought forward from a previous visit.

```
            General Hospital UB Condition Codes Processor
                                           Mon Jun 22, 2009 04:24 pm
Account       Name            FC Typ Admit    Disch       Balance Loc
C0916900001  TEST,PEGSTER M  O/P 06/18/09 06/18/09      0.00 PA /INSR
 1 Condition Code 1         2 Condition Indicator 1    3 Condition Code 2
   01 MILITARY SRV RELATE                                A5 DISABILITY
 4 Condition Indicator 2    5 Condition Code 3         6 Condition Indicator 3

 7 Condition Code 4         8 Condition Indicator 4    9 Condition Code 5

10 Condition Indicator 5   11 Condition Code 6        12 Condition Indicator 6

13 Condition Code 7        14 Condition Indicator 7   15 Condition Code 8

16 Condition Indicator 8   17 Condition Code 9        18 Condition Indicator 9

19 Condition Code 10       20 Condition Indicator 10  21 Condition Code 11

22 Condition Indicator 11

23 Treatment Authorization 24 Special Program

Press NL--
```

Field Explanations

1. CONDITION CODE 1 (DISPLAY ONLY)
This field contains the code that specifies the first UB condition code related to this visit, for example, 02 - Condition Employment Related. Both the code and the description are displayed.

2. CONDITION INDICATOR 1 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the first condition code. Both the code and the description are displayed.

3. CONDITION CODE 2 (DISPLAY ONLY)
This field contains the code that specifies the second UB condition code related to this visit. Both the code and the description are displayed.

4. CONDITION INDICATOR 2 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the second condition code. Both the code and the description are displayed.

5. CONDITION CODE 3 (DISPLAY ONLY)
This field contains the code that specifies the third UB condition code related to this visit. Both the code and the description are displayed.

6. CONDITION INDICATOR 3 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the third condition code.
Both the code and the description are displayed.

7. CONDITION CODE 4 (DISPLAY ONLY)
This field contains the code that specifies the fourth UB condition code related to this
visit. Both the code and the description are displayed.

8. CONDITION INDICATOR 4 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the fourth condition
code. Both the code and the description are displayed.

9. CONDITION CODE 5 (DISPLAY ONLY)
This field contains the code that specifies the fifth UB condition code related to this
visit. Both the code and the description are displayed.

10. CONDITION INDICATOR 5 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the fifth condition code.
Both the code and the description are displayed.

11. CONDITION CODE 6 (DISPLAY ONLY)
This field contains the code that specifies the sixth UB condition code related to this
visit. Both the code and the description are displayed.

12. CONDITION INDICATOR 6 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the sixth condition code.
Both the code and the description are displayed.

13. CONDITION CODE 7 (DISPLAY ONLY)
This field contains the code that specifies the seventh UB condition code related to this
visit. Both the code and the description are displayed.

14. CONDITION INDICATOR 7 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the seventh condition
code. Both the code and the description are displayed.

15. CONDITION CODE 8 (DISPLAY ONLY)
This field contains the code that specifies the eighth UB condition code related to this
visit. Both the code and the description are displayed.

16. CONDITION INDICATOR 8 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the eighth condition
code. Both the code and the description are displayed.

17. CONDITION CODE 9 (DISPLAY ONLY)
This field contains the code that specifies the ninth UB condition code related to this
visit. Both the code and the description are displayed.

18. CONDITION INDICATOR 9 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the ninth condition code. Both the code and the description are displayed.

19. CONDITION CODE 10 (DISPLAY ONLY)
This field contains the code that specifies the tenth UB condition code related to this visit. Both the code and the description are displayed.

20. CONDITION INDICATOR 10 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the tenth condition code. Both the code and the description are displayed.

21. CONDITION CODE 11 (DISPLAY ONLY)
This field contains the code that specifies the eleventh UB condition code related to this visit. Both the code and the description are displayed.

22. CONDITION INDICATOR 11 (DISPLAY ONLY)
This field contains the condition indicator that was entered for the eleventh condition code. Both the code and the description are displayed.

23. TREATMENT AUTHORIZATION (DISPLAY ONLY)
This field contains the treatment authorization number assigned as a result of the insurance verification process.

24.SPECIAL PROGRAM (DISPLAY ONLY)
With the UB, special program codes should be entered as alphanumeric condition codes, for example, A3 - Special Federal Funding. Both the code and the description are displayed.

UB Value Codes (US Only)

The UB Value Codes page displays additional UB information pertinent to this visit. This information is available to print on the patient's admission form and/or to print in the patient's UB claim form.

Several codes can be automatically generated from the system. For more information, refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide. If a code is automatically generated from the Provider Master, the code is loaded to the UB claim form, and does not need to be entered on this screen. The UB Value Codes page is displayed as

follows. This screen is visit-specific, and none of the information is brought forward from a previous visit.

```
                  General Hospital UB Value Codes Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch        Balance Loc
A9316900001  SMITH,MARY             C  O/P 06/18/93             0.00    PA/FCRV
 1 Value Code 1          2 Amount 1      3 Value Code 2       4 Amount 2
   14-AUTO NO FAULT OR    $450.00        43-DISABLED UNDER 65   $200.00
 5 Value Code 3          6 Amount 3      7 Value Code 4       8 Amount 4

 9 Value Code 5         10 Amount 5     11 Value Code 6      12 Amount 6

13 Value Code 7         14 Amount 7     15 Value Code 8      16 Amount 8

17 Value Code 9         18 Amount 9     19 Value Code 10     20 Amount 10

21 Value Code 11        22 Amount 11    23 Value Code 12     24 Amount 12




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

Field Explanations

1. VALUE CODE 1 (DISPLAY ONLY)
This field contains the code that specifies the first UB value code related to this visit, for example, 37 - Pints of Blood Furnished. Both the code and the description are displayed.

2. AMOUNT 1 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 1. This field is required if the preceding value code was entered.

3. VALUE CODE 2 (DISPLAY ONLY)
This field contains the code that specifies the second UB value code related to this visit. Both the code and the description are displayed.

4. AMOUNT 2 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 2. This field is required if the preceding value code was entered.

5. VALUE CODE 3 (DISPLAY ONLY)
This field contains the code that specifies the third UB value code related to this visit. Both the code and the description are displayed.

6. AMOUNT 3 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 3. This field is required if the preceding value code was entered.

7. VALUE CODE 4 (DISPLAY ONLY)
This field contains the code that specifies the fourth UB value code related to this visit. Both the code and the description are displayed.

8. AMOUNT 4 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 4. This field is required if the preceding value code was entered.

9. VALUE CODE 5 (DISPLAY ONLY)
This field contains the code that specifies the fifth UB value code related to this visit. Both the code and the description are displayed.

10. AMOUNT 5 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 5. This field is required if the preceding value code was entered.

11. VALUE CODE 6 (DISPLAY ONLY)
This field contains the code that specifies the sixth UB value code related to this visit. Both the code and the description are displayed.

12. AMOUNT 6 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 6. This field is required if the preceding value code was entered.

13. VALUE CODE 7 (DISPLAY ONLY)
This field contains the code that specifies the seventh UB value code related to this visit. Both the code and the description are displayed.

14. AMOUNT 7 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 7. This field is required if the preceding value code was entered.

15. VALUE CODE 8 (DISPLAY ONLY)
This field contains the code that specifies the eighth UB value code related to this visit. Both the code and the description are displayed.

16. AMOUNT 8 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 8. This field is required if the preceding value code was entered.

17. VALUE CODE 9 (DISPLAY ONLY)
This field contains the code that specifies the ninth UB value code related to this visit. Both the code and the description are displayed.

18. AMOUNT 9 (DISPLAY ONLY)
This field contains the amount (such as dollar, pints, days) of value code 9. This field is required if the preceding value code was entered.

19. VALUE CODE 10 (DISPLAY ONLY)

This field contains the code that specifies the tenth UB value code related to this visit. Both the code and the description are displayed.

20. AMOUNT 10 (DISPLAY ONLY)

This field contains the amount (such as dollar, pints, days) of value code 10. This field is required if the preceding value code was entered.

21. VALUE CODE 11 (DISPLAY ONLY)

This field contains the code that specifies the eleventh UB value code related to this visit. Both the code and the description are displayed.

22. AMOUNT 11 (DISPLAY ONLY)

This field contains the amount (such as dollar, pints, days) of value code 11. This field is required if the preceding value code was entered.

23. VALUE CODE 12 (DISPLAY ONLY)

This field contains the code that specifies the twelfth UB value code related to this visit. Both the code and the description are displayed.

24. AMOUNT 12 (DISPLAY ONLY)

This field contains the amount (such as dollar, pints, days) of value code 12. This field is required if the preceding value code was entered.

UB Occurrence Code (US Only)

The UB Occurrence Codes page displays additional UB information pertinent to this visit. This information is available to print on the patient's admission form and/or to print in the patient's UB claim form.

Several codes can be automatically generated from the system. For more information, refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide. If a code is automatically generated from the Provider Master, the code is loaded to the UB claim form, and does not need to be entered on this screen. The UB Occurrence Code is displayed as follows. This screen is visit-specific, and none of the information is brought forward from a previous visit.

```
                General Hospital UB Occurrence Codes Processor
                          Mon Jun 22, 2009 04:53 pm
Account       Name                  FC Typ Admit     Disch        Balance Loc
C0916900001  MOORE, BOB             M  O/P 06/18/09 06/18/09         0.00 PA /INSR
 1 Occurrence Code 1       2 Date        3 Occurrence Code 2     4 Date
   05 OTHER ACCIDENT          06/18/09
 5 Occurrence Code 3       6 Date        7 Occurrence Code 4     8 Date


 9 Occurrence Code 5      10 Date       11 Occurrence Code 6    12 Date


13 Occurrence Code 7      14 Date       15 Occurrence Code 8    16 Date


17 Occurrence Span A       18 From Date A   19 Thru Date A
   70 QUAL'ING STAY DATES     01/01/09         12/31/09
20 Occurrence Span B       21 From Date B   22 Thru Date B
   72 FIRST/LAST VISIT        05/03/00         05/06/00
23 Occurrence Span C       24 From Date C   25 Thru Date C


26 Occurrence Span D       27 From Date D   28 Thru Date D
```

Field Explanations

1. OCCURRENCE CODE 1 (DISPLAY ONLY)
This field contains the code that specifies the first UB occurrence related to this visit, for example, 01 - Auto Accident. Both the code and the description are displayed.

2. DATE (DISPLAY ONLY)
This field contains the date related to the first occurrence code.

3. OCCURRENCE CODE 2 (DISPLAY ONLY)
This field contains the code that specifies the second UB occurrence related to this visit. Both the code and the description are displayed.

4. DATE (DISPLAY ONLY)
This field contains the date related to the second occurrence code.

5. OCCURRENCE CODE 3 (DISPLAY ONLY)
This field contains the code that specifies the third UB occurrence related to this visit. Both the code and the description are displayed.

6. DATE (DISPLAY ONLY)
This field contains the date related to the third occurrence code.

7. OCCURRENCE CODE 4 (DISPLAY ONLY)
This field contains the code that specifies the fourth UB occurrence related to this visit. Both the code and the description are displayed.

8. DATE (DISPLAY ONLY)
This field contains the date related to the fourth occurrence code.

9. OCCURRENCE CODE 5 (DISPLAY ONLY)
This field contains the code that specifies the fifth UB occurrence related to this visit. Both the code and the description are displayed.

10. DATE (DISPLAY ONLY)
This field contains the date related to the fifth occurrence code.

11. OCCURRENCE CODE 6 (DISPLAY ONLY)
This field contains the code that specifies the sixth UB occurrence related to this visit. Both the code and the description are displayed.

12. DATE (DISPLAY ONLY)
This field contains the date related to the sixth occurrence code.

13. OCCURRENCE CODE 7 (DISPLAY ONLY)
This field contains the code that specifies the seventh UB occurrence related to this visit. Both the code and the description are displayed.

14. DATE (DISPLAY ONLY)
This field contains the date related to the seventh occurrence code.

15. OCCURRENCE CODE 8 (DISPLAY ONLY)
This field contains the code that specifies the eighth UB occurrence related to this visit. Both the code and the description are displayed.

16. DATE (DISPLAY ONLY)
This field contains the date related to the eighth occurrence code.

17. OCCURRENCE SPAN A (DISPLAY ONLY)
This field contains the code that specifies the first UB occurrence span code related to this visit, for example, - 71 Prior Stay Dates. Both the code and the description are displayed.

18. FROM DATE A (DISPLAY ONLY)
This field contains the date that the first occurrence span began. This field is required if the Occurrence Span field is entered.

19. THROUGH DATE A (DISPLAY ONLY)
This field contains the date that the first occurrence span ended. This field is required if the Occurrence Span field is entered.

20. OCCURRENCE SPAN B (DISPLAY ONLY)
This field contains the code that specifies the second UB occurrence span code related to this visit. Both the code and the description are displayed.

21. FROM DATE B (DISPLAY ONLY)
This field contains the date that the second occurrence span began. This field is required if the Occurrence Span field is entered.

22. THROUGH DATE B (DISPLAY ONLY)
This field contains the date that the second occurrence span ended. This field is required if the Occurrence Span field is entered.

23. OCCURRENCE SPAN C (DISPLAY ONLY)
This field contains the code that specifies the third UB occurrence span code related to this visit. Both the code and the description are displayed.

24. FROM DATE C (DISPLAY ONLY)
This field contains the date that the third occurrence span began. This field is required if the Occurrence Span field is entered.

25. THROUGH DATE C (DISPLAY ONLY)
This field contains the date that the third occurrence span ended. This field is required if the Occurrence Span field is entered.

26. OCCURRENCE SPAN D (DISPLAY ONLY)
This field contains the code that specifies the fourth UB occurrence span code related to this visit. Both the code and the description are displayed.

27. FROM DATE D (DISPLAY ONLY)
This field contains the date that the fourth occurrence span began. This field is required if the Occurrence Span field is entered.

28. THROUGH DATE D (DISPLAY ONLY)
This field contains the date that the fourth occurrence span ended. This field is required if the Occurrence Span field is entered.

Admissions Medical Information

This option enables you to view the patient's medical information. The system obtains this data from the STAR Patient Care admitting sequence, the master patient records, and changes made in the STAR Patient Care Medical Records screen.

The screen and menu displays for diagnoses and procedures are based on the existence of data, as follows:

- If both ICD-10 and ICD-9 data exist, the system starts with ICD-10 data with the ability to toggle to ICD-9.

- If only ICD-9 data exists, the system displays ICD-9 only.

- If only ICD-10 data exists, the system displays ICD-10 only.

- If no information exists, the system displays the ICD-10 screen only if indicated by the admission date of the patient and the USA Effective Date for ICD-10 on the Hospital Facility Options screen in STAR Patient Processing. Otherwise, the system displays the ICD-9 screen only.

After you select this option, the system displays the Medical Information Processor.

```
         General Hospital Medical Information Processor
                                   Fri Mar 10, 2009 12:36 pm
Account      Name                   FC Typ Admit   Disch       Balance  Loc
A9425900002 SMITH,MARY M             M  I/P 09/14/94 03/08/95    36903.44 PA/FCRV
            Option No.  Option
            ---------------------------------------
                1        Medical Page
                2        Medical Comment
                3        Physicians Page
                4        Accident Information
                5        Admitting/Principal Diagnosis
                6        ICD-10 Secondary Diagnosis
                7        ICD-9 Secondary Diagnosis
                8        Reason for Visit Diagnoses







 Enter option number--
```

NOTE: The Menu that displays depends on the account information. If there are both ICD-10 admissions Secondary Diagnoses and ICD-9 admissions Secondary Diagnoses, the above menu displays both the ICD-9 and ICD-10 options. If there are only ICD-10 admissions Secondary Diagnoses, only the ICD-10 Secondary Diagnosis option is displayed. If there are only ICD-9 admissions Secondary Diagnoses, only the ICD-9 Secondary Diagnosis option is displayed.

MEDICAL PAGE

After you select this option from the Medical Information Processor, the system displays the Medical Page screen. When you complete your review, press ENTER to exit the transaction.

```
                   General Hospital Medical Page Processor
                                            Fri Mar 10, 2006 12:36 pm
Account      Name                FC Typ Admit    Disch     Balance  Loc
A9425900002  SMITH, MARY M        M  I/P 09/14/94 03/08/95   36903.44 PA/FCRV
 1 Locations    2 Admission Type    3 Admission Source    4 Arrival Mode
                1 EMERGENCY         2 CLINIC REF/PREMA
 5 Arrival Date  6 Time    7 Allergies                       8 Smoker

 9 Service
   MED MEDICAL
10 Admitting Diagnosis          11 Additional Diagnoses     12 Acc?
   401.9-HYPERTENSION NOS
13 Surgery Scheduled                        14 Date    15 Tumor Reg #

16 Opt Out  17 Opt Out Date   18 Publicity      19 Case Category

20 ELOS-Dis Date  21 Plan Dis Time  22 Organ  23 ADs 24 ADs Ver Dt  25 Comment




   Press NL--
```

Field Explanations

1. LOCATIONS (DISPLAY ONLY)
This field displays the locations where the patient was seen.

2. ADMISSION TYPE (DISPLAY ONLY)
This field contains the type of admission. For example, 1 - Emergency. Both the code and description display.

3. ADMISSION SOURCE (DISPLAY ONLY)
This field contains the source suggesting admission for the patient. For example, 1 - physician referral. Both the code and the description display.

4. ARRIVAL MODE (DISPLAY ONLY)
This field indicates how the patient arrived at the facility.

5. ARRIVAL DATE (DISPLAY ONLY)
This field contains the date that the patient was brought to this facility.

6. TIME (DISPLAY ONLY)
This field contains the time that the patient was brought to this facility.

7. ALLERGIES (DISPLAY ONLY)
This field contains any allergies previously noted for the patient. This field allows you to keep nursing allergies distinct from pharmacy allergies.

8. SMOKER (DISPLAY ONLY)
This field indicates whether the patient is a smoker. A Yes will display if the patient is a smoker.

9. SERVICE (DISPLAY ONLY)
This field contains the code which indicates the type of hospital service for this patient (for example, MSE - Medical Surgery Emergency). Both the code and description display.

10. ADMITTING DIAGNOSIS (DISPLAY ONLY)
This field contains the code which indicates the patient's admitting diagnosis. Both the code and the description display.

11. ADDITIONAL DIAGNOSES (DISPLAY ONLY)
This field displays **Entries Defined** if there are additional diagnoses (from admitting or medical records) entered for the patient. The field is blank if no additional diagnoses were entered. If there are additional diagnoses from Medical Records, after you press ENTER, the following screen is displayed:

```
              General Hospital Account Inquiry Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name              FC Typ Admit   Disch       Balance Loc
A03062-00001 ANDERSON,ROBERT      S  OPS 03/03/03             52779.15 PA/FCRV


                     Additional Diagnoses/Medical Records
                 Code  Description           DRG Dx  Tumor Ind.  Type
 Admitting       820.00  FX FEMUR INTRCAPS NOS-CL
 Principal       820.22 SUBTROCHANTERIC FX-CLOSE
 Secondary ( 1) 827.0  FX LOWER LIMB NEC-CLOSED
          ( 2) 830.0  DISLOCATION JAW-CLOSED
          ( 3) E800.0 RR COLLISION NOS-EMPLOY
          ( 4) 825.20 FX FOOT BONE NOS-CLOSED

Press NL to exit or 'A' for Additional Diagnoses from Admitting --
```

Additional diagnoses are Admitting, Working, Principal, and one or more Secondary Diagnoses. Press ENTER to view additional diagnoses from Admitting.

12. SURGERY SCHEDULED (DISPLAY ONLY)
This field lists the procedure code that describes the surgery or procedure to be performed on the patient.

13. DATE (DISPLAY ONLY)
This field contains the scheduled date for the surgery defined in the Surgery Scheduled field.

14. TUMOR REG # (DISPLAY ONLY)
This field contains the patient's tumor registration number.

15. OPT OUT (DISPLAY ONLY)
This field indicates whether the patient wants his name to appear on a directory listing. Values are:

Yes = The patient will not appear on the directory listing (Name Inquiry) and related patient search functions accessed from defined CRTs.

No or blank = The patient will appear on all directory listings.

16. OPT OUT DATE (DISPLAY ONLY)
This field contains the date the Opt Out decision was made.

17. PUBLICITY (DISPLAY ONLY)
This field contains the hospital-defined code indicating the publicity or visitation rights allowed the patient (for example, no phone calls, publicity blackout, family visitation only, etc.).

18. CASE CATEGORY (DISPLAY ONLY)
This field indicates the category of the patient's illness or injury.

19. ACC? (DISPLAY ONLY)
This field indicates whether the admission was the result of an accident. If Yes is displayed in this field, there is additional information about the accident. To display the additional accident information, select Accident Information from the Medical Information Processor.

20. ELOS-DIS DATE (DISPLAY ONLY)
This is the patient's estimated length of stay (ELOS) in days, followed by the date of discharge.

21. ORGAN (DISPLAY ONLY)
This field indicates whether this patient is an organ donor.

22. ADs (DISPLAY ONLY)
This field displays whether this patient has any advanced directives.

23. ADS VER DT (DISPLAY ONLY)
This field indicates the verification date for the patient's advanced directives.

24. COMMENT (DISPLAY ONLY)
If Yes is displayed in this field, there is a comment about this patient's medical condition. To display the comment, select Medical Comment from the Medical Information Processor.

MEDICAL COMMENT

After you select this option from the Medical Information Processor, the system displays the Medical Comment screen. For this option to be available, Yes must be

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displayed in the Comment field on the Medical Page processor. When you complete your review, press ENTER to exit the transaction.

```
              General Hospital Medical Comment Processor
                                              Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch     Balance  Loc
A9425900002  SMITH,MARY M            M  I/P 09/14/94 03/08/95  36903.44 PA/FCRV
 1 Comment
   PATIENT HAS COMPLAINED OF HEADACHES FOR OVER TWO WEEKS.

 Press NL--
```

Field Explanations

1.   COMMENT (DISPLAY ONLY)
This field contains any comments associated with this visit.

PHYSICIANS PAGE

After you select this option from the Medical Information Processor, the system displays the Physicians Page screen. When you complete your review, press ENTER to exit the transaction.

```
                General Hospital Physicians Page Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch      Balance  Loc
A9425900002 SMITH,MARY M            M  I/P 09/14/94 03/08/95  36903.44 PA/FCRV
 1 Admitting Physician                2 Attending Physician
   256 HAUSMANN, HELEN                  256 HAUSMANN,HELEN
 3 Primary Care Physician             4 Referring Physician
   256 HAUSMANN, HELEN                  256 HAUSMANN, HELEN
 5 ER Physician                       6 Shared Care Physician




 Press NL--
```

Field Explanations

1. ADMITTING PHYSICIAN (DISPLAY ONLY)
This field contains the name (and hospital-defined code) of the physician who admitted this patient.

2. ATTENDING PHYSICIAN (DISPLAY ONLY)
This field contains the name (and hospital-defined code, if applicable) of the patient's physician-of-record.

3. PRIMARY CARE PHYSICIAN (DISPLAY ONLY)
This field contains the name of the patient's primary care physician.

4. REFERRING PHYSICIAN (DISPLAY ONLY)
This field contains the name (and hospital-defined code, if applicable) of the physician who referred this patient.

5. ER PHYSICIAN (DISPLAY ONLY)
If this patient was admitted through the emergency room, this field contains the name (and hospital-defined code, if applicable) of the patient's emergency room physician.

6. SHARED CARE PHYSICIAN (DISPLAY ONLY)
This field contains the name (and hospital-defined code, if applicable) of the physician who is sharing in the primary care for the patient.

ACCIDENT INFORMATION

After you select this option from the Medical Information Processor, the system displays the Accident Information screen. To be available, Yes must be displayed in the Accident field on the Medical Page Processor. When you complete your review, press ENTER to exit the transaction.

```
                   General Hospital Medical Page Processor
                                              Tue Jan 22, 2002 09:03 am
   No           Name              Sex   BD    Room    Physician    SVC    Status
 9819700001    RAND,PAUL           M  09/04/46        AKER,TOM     PST    MED
 1 Accident Type           2 Accident Date   3 Accident Time   4 Case #

 5 Place of Accident/County   6 Nature of Accident      7 Nature of Injury

 8 Acc Country     9 SB?  10 Treated? 11 Prv Land 12 Police Auth Concerned

 13 Driver               14 Veh Reg #        15 Driver's Address

 16 Address              17 City             18 State     19 ZIP Code

 20 Insurance Company                        21 Policy Number

 22 Insurance Co. Address                     23 Address}|

 24 City                 25 State            26 ZIP Code




 Press NL--|
```

Field Explanations

1. ACCIDENT TYPE (DISPLAY ONLY)
This field indicates the type of accident that caused this admission (for example, Work Related or Auto).

2. ACCIDENT DATE (DISPLAY ONLY)
This is the date the accident occurred.

3. ACCIDENT TIME (DISPLAY ONLY)
This is the time of day the accident occurred.

4. CASE # (DISPLAY ONLY)
This is the case number associated with this accident.

5. PLACE OF ACCIDENT/COUNTY (DISPLAY ONLY)
This is the location and/or county where the accident occurred.

6. NATURE OF ACCIDENT (DISPLAY ONLY)
This field indicates the type of accident, or a reason for the accident.

7.   NATURE OF INJURY (DISPLAY ONLY)
This field indicates the nature of injury associated with this accident.

8.   ACC COUNTRY
This field indicates the country in which the accident occurred if it occurred outside the U.S. This field is required for the UB and 1500 claims if the accident occurred outside the U.S.

9.   SB? (DISPLAY ONLY)
This field indicates whether a seat belt was being used at the time of the accident.

10. TREAT AT SCENE (DISPLAY ONLY)
This field indicates whether the patient was treated at the scene of the accident.

11. PRIVATE LAND (DISPLAY ONLY)
This field indicates whether the accident occurred on private land.

12. POLICE AUTH CONCERNED (DISPLAY ONLY)
This field indicates the police authority handling the accident, if applicable.

13. DRIVER (DISPLAY ONLY)
This is the name of the driver, if known.

14. VEH REG # (DISPLAY ONLY)
This is the vehicle registration number or license tag number, if known.

15. DRIVER'S ADDRESS (DISPLAY ONLY)
This is the driver's home address, if known.

16. ADDRESS (DISPLAY ONLY)
This is the second line of the driver's address, if known.

17. CITY (DISPLAY ONLY)
This is the city associated with the driver's address.

(US) 18.STATE (DISPLAY ONLY)
(CN) 18.PROV. (DISPLAY ONLY)
This is the state/province associated with the driver's address.

(US) 19.ZIP CODE (DISPLAY ONLY)
(CN) 19.POSTCODE (DISPLAY ONLY)
This is the ZIP code/postcode associated with the driver's address.

20. INSURANCE COMPANY (DISPLAY ONLY)
This is the name of the driver's insurance company, if applicable.

21. POLICY NUMBER (DISPLAY ONLY)
This is the driver's insurance policy number, if known.

22. INSURANCE CO. ADDRESS (DISPLAY ONLY)
This is the mailing address of the driver's insurance company.

23. ADDRESS (DISPLAY ONLY)
This is the secondary address for the insurance company (for example, a suite number).

24. CITY (DISPLAY ONLY)
This is the city for the insurance company's mailing address.

(US) 25.STATE (DISPLAY ONLY)
(CN) 25.PROV. (DISPLAY ONLY)
This is the state/province where the insurance company is located.

(US) 26.ZIP CODE (DISPLAY ONLY)
(CN) 26.POSTCODE (DISPLAY ONLY)
This is the ZIP code/postcode associated with the insurance company's address.

ADMITTING/PRINCIPAL DIAGNOSIS

This option enables you to view the patient's admitting and principal diagnosis codes from admissions. The system obtains this data from the STAR Patient Processing admitting sequence.

The following prompts are displayed on the screen:

- When there are both ICD-10 and ICD-9 admissions Admitting and Principal Diagnosis Codes on the account, the system displays the ICD-10 admissions Admitting and Principal Diagnosis Codes with the ability to toggle to the ICD-9 admissions. The following prompt is displayed:

  View ICD-9 (I) Admission Diagnoses or Press NL--

  You can enter **I** to view the ICD-9 admissions Admitting and Principal Diagnosis Codes on the account. When viewing the ICD-9 admissions Admitting and Principal Diagnosis Codes when there are also ICD-10 admissions Admitting and Principal Diagnosis Codes, the ICD-9 Admitting/Principal Diagnosis screen allows you to go back to the ICD-10 Admitting/Principal Diagnosis screen. The following prompt is displayed:

  View ICD-10 (T) Admission Diagnoses or Press NL--

- When there are only ICD-10 admissions Admitting and Principal Diagnosis Codes on the account, the system displays the ICD-10 admissions Admitting and Principal Diagnosis Codes. The following prompt is displayed:

  Press NL--

- When there are only ICD-9 admissions Admitting and Principal Diagnosis Codes on the account, the system displays the ICD-9 admissions Admitting and Principal Diagnosis Codes. The following prompt is displayed:

   Press NL--

After you select this option, the system displays the Medical Information Processor.

```
          General Hospital Admitting/Principal Diagnosis Processor
                                             Mon Jun 22, 2009 05:16 pm
 Account        Name                  FC Typ Admit    Disch         Balance Loc
 C0916800003  ALDEN, BOB             M  O/P 06/17/09 06/17/09        623.94 PA /INSR

  1 ICD
    ICD-10-CM
  2 Admitting Diagnosis
    M00.011-Staphylococcal arthritis, right shoulder
  3 Principal Diagnosis
    M00.071-Staphylococcal arthritis, right ankle and foot

  4 Secondary Diagnoses
    M00.062   Staphylococcal arthritis, left knee
    M00.10    Pneumococcal arthritis, unspecified joint




 View ICD-9 (I) Admission Diagnoses or Press NL--  |
```

Field Explanations

1. ICD (DISPLAY ONLY)
This field contains either ICD-10-CM or ICD-9-CM, depending on if you are viewing the ICD-10 admission Admitting and Principal Diagnosis Codes or the ICD-9 admission Admitting and Principal Diagnosis Codes. The ICD version displays only once, although it applies to all admission diagnosis codes on the screen. In other words, each screen displays either the ICD-10 admission Admitting and Principal Diagnosis Codes, or the ICD-9 admission Admitting and Principal Diagnosis Codes, and not a mixture of the two.

2. ADMITTING DIAGNOSIS (DISPLAY ONLY)
This field contains the admitting ICD diagnosis code and description.

3. PRINCIPAL DIAGNOSIS (DISPLAY ONLY)
This field contains the principal ICD diagnosis code and description.

4. SECONDARY DIAGNOSIS (DISPLAY ONLY)
This field contains the secondary ICD diagnosis code and description.

SECONDARY DIAGNOSES

The screen displays either the ICD-10 Secondary Diagnosis codes or the ICD-9 Secondary Diagnosis codes, depending on which menu option was selected.

```
          General Hospital ICD-10 Secondary Diagnosis Processor
                                          Fri Mar 20, 2009 04:56 pm
Account      Name                FC Typ Admit    Disch       Balance Loc
 C0916800003  ALDEN, BB           M  O/P 06/17/09 06/17/09     623.94 PA /INSR
Secondary Diagnoses

  M00.062    Staphylococcal arthritis, left knee
  M00.10     Pneumococcal arthritis, unspecified joint




                     F1Prev Page F2Next Page F7  Exit
```

Field Explanations

1. SECONDARY DIAGNOSIS (DISPLAY ONLY)
This screen contains either the ICD-10-CM or the ICD-9-CM secondary diagnoses, depending on which menu option you selected and the existence of data on the account.

MISCELLANEOUS PAGE

Select the Miscellaneous Page option to view miscellaneous patient data obtained from the STAR Patient Care admission process. This screen contains information such as previous visit data, arrival mode, patient's church and denomination, whether the patient had valuables upon arrival, etc.

After you select this option, the system displays the Miscellaneous Page screen. When you complete your review, press ENTER to exit the transaction.

```
                  General Hospital Miscellaneous Page Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name              FC Typ Admit    Disch       Balance Loc
A97-14700006 BAILEY,PATRICK      B  ADV 05/27/99 05/28/99     0.00    AR/FCRV
 1 Previous  2 Prev Visit Date 3 Prev Facility/Visit Info   4 Other Names
   Yes         04/25/99                                        Entries Defined
 5 Church                           6 Denomination              7 Clergy Notify

 8 Clergy Request         9 Req Date               10 Courtesy Discharge

11 Pref. Accom.          12 Val                    13 Valuables Disposition

14 Phone                 15 Power of Atty          16 Veteran
                                                      No
                         17 Patient Class          18 Staff Alert
                            VIP VIP
19 Alien Number          20 Referring Facility     21 Referral Reason

22 Transferred From                 23 Comment



Press NL--
```

Field Explanations

1. PREVIOUS (DISPLAY ONLY)
This field indicates whether the patient was previously admitted at this facility.

2. PREV VISIT DATE (DISPLAY ONLY)
This field contains the date of the patient's most recent admission (if applicable).

3. PREV FACILITY/VISIT INFO (DISPLAY ONLY)
This field contains any information related to prior visits or previous facilities for the patient.

4. OTHER NAMES (DISPLAY ONLY)
If the patient has any other names in the MPI, Entries Defined is displayed in this field.

NOTE: The system uses this field to track patients who may have been previously admitted under a maiden name or who have otherwise changed their name.

5. CHURCH (DISPLAY ONLY)
This field contains the name of the patient's church.

6. DENOMINATION (DISPLAY ONLY)
This field contains the patient's denomination.

7. CLERGY NOTIFY (DISPLAY ONLY)
This field displays Y for Yes if the clergy should be notified of the patient's hospital stay. It displays N for No if the clergy should not be notified.

NOTE: If the field contains Y, the patient is included on the Church and Denomination Censuses. If the field contains N, the patient is not included on these censuses.

8. CLERGY REQUEST (DISPLAY ONLY)
This field displays the patient's clergy request, such as Communion or Last Rites.

9. REQ DATE (DISPLAY ONLY)
This field displays the date the patient would like the clergy to visit.

10. COURTESY DIS? (DISPLAY ONLY)
This field indicates whether the patient has courtesy discharge privileges. Options are Y (the patient may leave the hospital without seeing the cashier) or N (the patient must see the cashier before leaving the facility).

11. PREF. ACCOM. (DISPLAY ONLY)
This field indicates the code and description of the patient's bed preference for admission (for example, private or semi-private).

12. VAL (DISPLAY ONLY)
This field indicates whether the patient was admitted with personal valuables.

13. VALUABLES DISPOSITION (DISPLAY ONLY)
This field indicates the current disposition of the patient's valuables if the patient was admitted with valuables.

14. PHONE (DISPLAY ONLY)
This field indicates whether or not the patient requested a telephone.

15. POWER OF ATTORNEY (DISPLAY ONLY)
This field indicates that the patient has a signed power of attorney on file.

16. VETERAN (DISPLAY ONLY)
This field indicates if the patient is a veteran.

17. PATIENT CLASS (DISPLAY ONLY)
This field displays the code and description of the patient's class (for example, BRD Board Member).

18. STAFF ALERT (DISPLAY ONLY)
This field displays the code and description of the staff alert(s) that the hospital staff should be aware of during the patient's stay.

19. ALIEN NUMBER (DISPLAY ONLY)
If the patient is not a citizen of the country where your facility resides, the patient's legal alien number is displayed in this field.

20. REFERRING FACILITY (DISPLAY ONLY)
This field contains the name, if applicable, of the facility that referred the patient.

21. REFERRAL REASON (DISPLAY ONLY)
This field indicates the reason the patient was referred to the hospital for admission.
The code and description are displayed in the field.

22. TRANSFERRED FROM (DISPLAY ONLY)
This field indicates the institution or place where the patient resided before admission.
The system displays the code and description.

23. COMMENT (DISPLAY ONLY)
This field contains any additional comments or information pertaining to this patient or
admission.

MISCELLANEOUS TWO PAGE

Select the Miscellaneous Two Page option to view miscellaneous patient data
obtained from the STAR Patient Care admission process. This screen contains
information such as case team, case team manager, affiliated community agency,
substance taken, etc.

After you select this option, the system displays the Miscellaneous Page screen. When
you complete your review, press ENTER to exit the transaction.

```
          General Hospital Miscellaneous Two Page Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch       Balance Loc
A0210000011  ADAMS,RHEA             S2 O/P 04/10/02 04/10/02     100.00  AR/FCRV
 1 Case Team                   2 Case Team Manager   3 Community Agency

 4 Day Care Function           5 Substance Taken      6 Education Level

 7 Privileges        8 First Day/Night Admit  9 Medical Record#  10 Radiology #

11 Charge To/From                        12 Mom/Baby Comb  13 No of Charge Froms


   Please enter if required by patient's Insurance
14 Pregnant?     15 LMP          16 Cycle     17 Estimated Delivery Date

Press NL--
```

Field Explanations

1. CASE TEAM (DISPLAY ONLY)
When you access this field, you have two choices:

• Enter the code for the patient's case team, if you know it.

• Enter a hyphen (-) to display the table for selection.

2. CASE TEAM MANAGER (DISPLAY ONLY)
If you make an entry in the Case Team field, the system displays that case team's
manager in this field (if one is set up with the case team in the Case Team table).

3. COMMUNITY AGENCY (DISPLAY ONLY)
A community agency or agencies involved in the patient's case.

4. DAY CARE FUNCTION (DISPLAY ONLY)
The code for the patient's day care function.

5. SUBSTANCE TAKEN (DISPLAY ONLY)
This field is used to indicate if a patient is using or abusing some kind of substance. If Y is entered in this field, the system displays a subscreen with a table:

The following screen is an example:

```
                        General Hospital Admission Processor
                  Miscellaneous Page 2                 Wed Mar 06, 2002 09:45 am
   No.            Name           Sex   BD     Room     Physician      SVC    Status
 9404-500-001  TURNER,JOY M       F  01/25/76 NSY-14  BABB,GARY H     ERS    I/P 2
 NO.    SUBSTANCES TAKEN                    CLASSIFICATION       INJECTED?    INIT
  1     1 BEER                           2 ALCOHOL               No          N C
  2     2 HEROIN                         1 ILLICIT DRUGS         Yes         N C
  3




                    Enter substance taken code or '-' to list--
        F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

6. EDUCATION LEVEL (DISPLAY ONLY)
This field contains the level of education for the patient.

7. PRIVILEGES (DISPLAY ONLY)
This field is used to indicate what types of privileges the patient may have during the visit.

8. FIRST DAY/NIGHT ADMIT (DISPLAY ONLY)
This field indicates whether or not this is the patient's first regular day/night admission.

9. MEDICAL RECORD # (DISPLAY ONLY)
This field contains the patient's medical record number. This field is provided for hospitals that converted from a previous medical record numbering system to the STAR Patient Care System's unit number process. This field is only used as a reference to the previous number.

10. RADIOLOGY NUMBER (DISPLAY ONLY)
This field contains the patient's radiology film number. This is the unique patient number defined by the Radiology department. This field is only used if the film number is different from the unit number.

11. CHARGE TO/FROM (DISPLAY ONLY)

This field displays the account number to which all charges are transferred using the Combine Bills function. If you select to view the Miscellaneous Page of the charge from account, this field is named Charge To Number and displays the account number and name of the charge to account. If you select to view the Miscellaneous Page of the charge to account, this field is named Charge From Number and displays the account number and name of the charge from account.

When a combined bill is generated, the charges for the charge from account are billed on the charge to account. For more information about the Combine Bills function, refer to the Patient Billing section in the Billing and Claims Volume of the STAR Financials Patient Accounting Reference Guide.

12. MOM/BABY COMB (DISPLAY ONLY)

This field identifies whether this account is being combined to place charges for a mother and baby into the same account. A display of Y indicates that charges for these accounts are being combined into a mother/baby account. Your facility's print bill program should mark the charges appropriately. When you generate bills, the system marks the from charges as the baby charges on the bill. If this account is not being combined to place charges for a mother and baby into the same account, the field displays N. For more information about the Combine Bills function, refer to the Patient Billing section in the Billing and Claims Volume of the STAR Financials Patient Accounting Reference Guide.

13. NO. OF CHARGE FROMS (DISPLAY ONLY)

This field displays the number of accounts from which charges have been transferred.

14. PREGNANT? (DISPLAY ONLY)

This field indicates whether the patient is pregnant (Yes), not pregnant (No) or if it is unknown (Unknown).

15. LMP (DISPLAY ONLY)

The date of the patient's last menstrual period (LMP).

16. CYCLE (DISPLAY ONLY)

The number of days in the patient's last menstrual cycle. This field is used with the LMP field to calculate the entry in the EDD (Estimated Delivery Date) field.

17. ESTIMATED DELIVERY DATE (DISPLAY ONLY)

This field contains the date entered by the user or calculated by the system for the baby's delivery, based on LMP and Cycle. The following formula is used:

LMP + 7 + 280 Days + (Cycle -28)=Estimated Delivery Date

REASON FOR VISIT DIAGNOSES

When selecting this option, the screen displays the Admitting Diagnosis code and description from Admissions, the Working Diagnosis code and description from Admissions, the Principal Diagnosis code and description from Admissions, and the

three Reason for Visit diagnoses codes and descriptions. This screen is display only. When accessing the Reason for Visit Diagnoses via Account Inquiry, Admission Information, Adm Medical Information, Reason for Visit Diagnoses, the Admitting Diagnosis, the Working Diagnosis, and the Principal Diagnosis continue to be the diagnoses entered via the admissions process. There are only three Reason for Visit Diagnoses, that are shared between Admissions and Medical Records. If Reason for Visit Diagnosis Codes are entered via the Dispositioning screen, if Medical Records later updates the Reason for Visit Diagnosis Codes, the Medical Record updates overlay the Admissions Reason for Visit Diagnosis Codes.

The screen displays either the ICD-10 Reason for Visit diagnosis codes, or the ICD-9 Reason for Visit diagnosis codes, and not a mixture of the two.

- When there are both ICD-10 and ICD-9 Reason for Visit diagnosis codes on the account, the system displays the ICD-10 Reason for Visit diagnosis codes and allows the user to toggle to the ICD-9 Reason for Visit diagnosis codes. The following prompt is displayed:

  View ICD-9 (I) Reason for Visit Diagnoses or Press NL--

  You can enter I to view the ICD-9 Reason for Visit diagnosis codes. When viewing the ICD-9 Reason for Visit diagnosis codes when there are also ICD-10 Reason for Visit diagnosis codes, the ICD-9 Reason for Visit Diagnosis screen allows you to go back to the ICD-10 Reason for Visit screen. The following prompt is displayed:

  View ICD-10 (T) Reason for Visit Diagnoses or Press NL--

- When there are only ICD-10 Reason for Visit diagnosis codes on the account, the system displays the ICD-10 Reason for Visit diagnoses. The following prompt is displayed:

  Press NL--

- When there are only ICD-9 Reason for Visit diagnosis codes on the account, the system displays the ICD-9 Reason for Visit diagnoses. The following prompt is displayed:

  Press NL--

When this option is selected, the following screen is displayed:

```
                    General Hospital Reason for Visit Diagnoses Processor
                                            Thu Jan 17, 2008 11:56 am
Account        Name                FC Typ Admit    Disch       Balance Loc
C08017-00001 HANSEN,JAN            C  O/P 01/17/08 01/17/08      350.75 PA /INSR

ICD
 10

Admitting Diagnosis
M79.661A-TEST DIAGNOSIS CODE

Working Diagnosis
B34.567D-ANOTHER TEST CODE

Principal Diagnosis
M48.50xA-NEW DIAGNOSIS CODE

Reason for Visit Diagnosis
(1)Reason for Visit: M79.661A-TEST DIAGNOSIS CODE
(2)Reason for Visit:
(3)Reason for Visit:



View ICD-9 (I) Reason for Visit Diagnoses or Press NL--


```

Field Explanations

ICD (DISPLAY ONLY)
This field contains either 10 or 9, depending on if you are viewing the ICD-10 Reason for Visit diagnosis codes or the ICD-9 Reason for Visit diagnosis codes.

ADMITTING DIAGNOSIS (DISPLAY ONLY)
This field displays the admitting diagnosis from Admissions.

WORKING DIAGNOSIS (DISPLAY ONLY)
This field displays the working diagnosis from Admissions.

PRINCIPAL DIAGNOSIS (DISPLAY ONLY)
This field displays the principal diagnosis from Admissions.

REASON FOR VISIT DIAGNOSIS (DISPLAY ONLY)
This field displays the coded Reason for Visit diagnoses codes.

User-defined Fields

The User-Defined Fields page contains up to 40 fields. Up to 20 of the fields are retained in the MPI and are brought forward with each subsequent visit. The remaining 20 fields are visit-specific. The MPI level fields are displayed first, followed by the Visit level fields. Each field can be defined by your hospital as yes/no, freeform, table-driven, or date format.

Based on parameters set by your facility in Table Maintenance (see the Tables appendix in the *STAR Patient Care Reference Guide*, *Patient Processing Module* for details), you are able to define the fields that display on this screen in the admission sequence including the label, question, code and description length, and whether or not the field is required. You maintain tables for the table-driven fields in the regular Table Maintenance function.

If your entries in Table Maintenance are accepted, the screen you set up is displayed in the admission sequence on the User-defined Fields page. The field labels on this screen are a result of the entries made on the Table processor. The same screen that is displayed in the admission sequence also is displayed in the abstracting function. These fields can be edited via the abstracting functions.

The following screen is an example of a User-defined Fields page that was set up during the admission sequence..

```
            General Hospital User Defined Fields Processor
                                        Tue Apr 06, 1999 05:20 pm
  No           Name            Sex  BD    Room   Physician    SVC   Status
1-0001498     BARCLAY,BARBARA L F  06/06/57 M226-01 REED,WILLIAM  ALC   I/P 29


User Defined Field Label         Response

BLOOD TYPE
MOTHER'S BLOOD TYPE
FATHER'S BLOOD TYPE
HIGH BLOOD PRESSURE
NUMBER OF CHILDREN              ONE
NUMBER OF SIBLINGS             TWO
CANCER IN FAMILY?              YES
WHO?                          SISTER
DATE DIAGNOSED                06/06/97
VISION PROBLEMS?
LAST CHEST XRAY               01/01/99
LAST PHYSICAL                 01/02/99
ADDITIONAL INFORMAT           DOES NOT DRIVE
FAVORITE FRUIT                MANGO
COUNTRIES VISITED
AMBULANCE SERVICE
Enter the patient's blood type, or - lookup--
             F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

This is a scrolling screen. For information on using scrolling screens, refer to the Information Entry Techniques section of the *STAR Patient Care Reference Guide*, *General Information Volume*.

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MEDICAL RECORDS MEDICAL INFORMATION

This function enables you to view various medical data related to a patient's visit. This information is provided by the STAR Medical Records system.

NOTE: Refer to STAR Medical Records documentation for more information.

When you select the Medical Information option, the following menu screen is displayed:

```
              General Hospital Medical Information Processor
                                            Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch       Balance Loc
A90000-00001 SMITH, JOHN A.        C  E/R 02/07/90 02/07/90    1411.00 AR/FCRV
             Option No.  Option
             ----------------------------------------
             1           Adm Medical Information
             2           DRG Information
             3           HCPCS Procedures
             4           MR Diagnosis Information
             5           Procedure Information
             6           Location Information
             7           UM UB Data




 Enter option number--
```

Each of these options is discussed under its own heading below.

ADM Medical Information

After you select this option from the Medical Information Processor, the system displays the Admissions Medical Page menu. For explanations of the options on this menu refer to Admissions Medical Page refer to "Medical Page" on page 1-93.

MEDICAL COMMENT

After you select this option from the Medical Information Processor, the system displays the Medical Comment screen. For this option to be available, Yes must be displayed in the Comment field on the Medical Page processor. For explanations of the fields on this screen refer to "Medical Comment" on page 1-95.

DRG Information

This option provides Primary DRG and APR-DRG non-reimbursed data from the 3M DRG Grouper and the 3M APR-DRG Grouper, and reimbursed Primary APR-DRG from the 3M APR-DRG grouper (and to QuadraMed using the Generic Encoder). STAR Patient Accounting uses the estimated reimbursement from 3M APR-DRG

grouper and from QuadraMed Generic Encoder in order to take a contractual adjustment.

Three types of DRGs are calculated. If the admitting diagnosis in the admission sequence is linked to the Admission Diagnosis Pointer table or when an admitting diagnosis is entered on the diagnosis screen, the admitting DRG is displayed in the Admit DRG field. After other diagnosis information is entered, a provisional DRG is calculated and displayed in the DRG and Provisional DRG fields. When a patient is discharged, the DRG is changed to Final, and the system enables you to accept this DRG for billing and claims purposes.

After a DRG is accepted as final, the necessary DRG calculation information for the patient is passed to the billing system. The patient bill can then be printed and submitted for reimbursement. Any adjustments are done at billing prior to claim load.

When accessing the DRG Information option, the system displays a list of the DRGs that exist for the account and allows you to select the DRG to view. The possible DRGs are: the Primary ICD-10 DRG (based on COB 1), the Primary ICD-9 DRG (based on COB 1), the Secondary ICD-10 DRG (not yet available), the Secondary ICD-9 DRG, and the Non Reimbursed APR ICD-9 DRG. The Non Reimbursed APR ICD-10 DRG is not yet available.

The screen displays the bill type (Cycle, Final, Adjustment) and ICD Indicator for the most recent bill. The ICD Indicator is based on the COB 1 insurance at time of billing. The ICD is based on any ICD-10 Effective Dates in the Insurance Plan, Insurance Carrier, or Financial Class tables if there is no ICD-10 Effective Date for the Final Billing Parameter. If the account has not received a bill, this line of information does not display for the account. Self pay accounts will display the ICD indicator based on the (self pay) Final Billing Parameter, or based on Financial Class if there is no ICD-10 Effective Date for the Final Billing Parameter.

If there are no Medical Records diagnoses codes, and/or there is no DRG information available on the account, the DRG screens cannot be accessed. If the account does not have any Medical Records diagnoses and/or procedures, and if there is no DRG information on the account, the system gives the following message at the bottom of the screen. The user must press the Enter key to exit this screen display.

    No DRGs assigned for this account. Press ENTER to exit.

The following screen shows the basic information on the DRG Inquiry screen on Patient Accounting for when there is no coding done on the account:

EXAMPLE WITH NO DRG INFORMATION

```
                    General Hospital Account Inquiry Processor
                                        Mon Aug 13, 2012 12:42 am
Account       Name                 FC Typ Admit    Disch       Balance Loc
C1221900001  JONES, BOB            M  I/P 08/01/12 08/06/12    9999.20 AR /ACCF
 1 Disch Disposition                  2 LOS
   5 *HOME OR SELF CARE                 5 Days
 3 Unit Number                        4 Corporate Number
   C0000000122                          00006897
 5 Bill Type/ICD Indicator for Most Recent Bill
   Final/10




No DRGs assigned for this account. Press ENTER to exit.
```

EXAMPLE WITH DRG INFORMATION

```
                    General Hospital Account Inquiry Processor
                                        Mon Aug 13, 2012 12:42 am
Account       Name                 FC Typ Admit    Disch       Balance Loc
C1221900001  JONES,BOB             M  I/P 08/01/12 08/06/12    9999.20 AR /ACCF
 1 Disch Disposition                  2 LOS
   5 *HOME OR SELF CARE                 5 Days
 3 Unit Number                        4 Corporate Number
   C0000000122                          00006897
 5 Bill Type/ICD Indicator for Most Recent Bill
   Final/10



Page:01                     Existing DRG's for Account
( 1) Primary ICD10 DRG
( 2) Primary ICD9 DRG






Enter choice--
```

Fields

1. DISCH DISPOSITION (DISPLAY ONLY)
This field contains the discharge disposition code from STAR Patient Processing. If the account is not yet discharged, the Disch Disposition field will be blank.

2. LOS (DISPLAY ONLY)
This field contains the length of stay.

3. UNIT NUMBER (DISPLAY ONLY)
This field contains the patient's unit number.

4. CORPORATE NUMBER (DISPLAY ONLY)

This field contains the corporate number for the patient.

5. BILL TYPE/ICD INDICATOR FOR MOST RECENT BILL (DISPLAY ONLY)

This field contains the bill type followed by the ICD indicator for the most recent bill. An example is Final/10. The ICD Indicator is based on the COB 1 insurance at time of billing. The ICD is based on any ICD-10 Effective Dates in the Insurance Plan, Insurance Carrier, or Financial Class tables if there is no ICD-10 Effective Date for the Final Billing Parameter. If the account has not received a bill, this line of information does not display for the account. Self pay accounts will display the ICD indicator based on the (self pay) Final Billing Parameter, or based on Financial Class if there is no ICD-10 Effective Date for the Final Billing Parameter.

Existing DRG's for Account

- Non Reimbursed APR ICD-9 DRG

  - An APR-DRG was determined in Medical Records not using the functionality to obtain estimated reimbursement information (Payor Code has a value of 12 when using the 3M Interface). This displays as the Non Reimbursed APR ICD-9 DRG. Once a Non Reimbursed APR ICD-10 DRG can be calculated, the DRG information could display under Non Reimbursed APR ICD-9 DRG and/ or Non Reimbursed APR ICD-10 DRG.

- Primary ICD-9 DRG

  - The reimbursed DRG can be a CMS DRG or can be the reimbursed Medicaid APR-DRG. The Other Payor Code for the APR Reimbursed DRG is 142 for the 3M Interface. The Other Payor Code for the APR Reimbursed DRG is 142 (Medicaid), 143 (Medicaid Managed Care), 144 (Worker's Comp), or 145 (No Fault) for the Generic Encoder Interface when using QuadraMed for New York depending upon the type of APR-DRGs being determined. Other Medicaid APR-DRGs can be calculated via the 3M Interface. Please refer to the 3M documentation.

- Primary ICD-10 DRG

  - The reimbursed DRG can be a CMS DRG (and will display under the Primary ICD-9 DRG and/or the Primary ICD-10 DRG screen option), or can be the reimbursed Medicaid APR-DRG (and will display under the Primary ICD-9 DRG screen option only until Medicaid can group using ICD-10. At that time, the reimbursed APR-DRG will display under the Primary ICD-9 DRG and/or the Primary ICD-10 DRG screen option). Currently, the only ICD-10 DRG available is the CMS DRG.

- Secondary ICD-9 DRG

- • The Secondary ICD-9 DRG is from using the Multiple Grouper. The secondary ICD-9 DRG does not affect reimbursement or take a write-off.

- • Secondary ICD-10 DRG (not yet available)

    - • The Secondary ICD-10 DRG is from using the Multiple Grouper. The secondary ICD-10 DRG does not affect reimbursement or take a write-off.

Users enter the choice (for example, number 1, 2, 3 or 4) in order to view the appropriate DRG. Note that the DRGs that exist for patients will differ.

The below screens are examples only of the DRG Inquiry screens. These screens can differ and display different information based on the DRG Payor.

Non-reimbursed APR-DRG

```
                    General Hospital Account Inquiry Processor
                                          Fri Mar 10, 2010 12:36 pm
Account       Name                FC Typ Admit    Disch      Balance Loc
A0510200004  INPT,CARE             M  I/P 04/12/05 04/12/05    600.00    PA/FCRV
 1 Other Payor       2 Age          3 Sex          4 Dischg Disposition
   12                92Y             FEMALE          INTERMEDIATE CARE FA
 5 Major Diagnostic Category                       6 FINAL ACCEPT DATE
   008 DISEASES AND DISORDERS OF THE MUSCULOSKELETAL
 7 APRDRG                                          8 Weight
   342 FRACTURES &  DISLOCATIONS EXCEPT FEMUR,       0.4098
 9 Outlier Status                     10 LOS       11 Charges
   1 LOS Inlier                        1                  600.00
12 Short Trim Point                   13 High Trim Point
   1                                   8
14 Severity of Illness                15 Risk of Mortality
   Minor                                 Minor


View Primary DRG information (P) or New Line to exit--

```

Field Explanations

1. OTHER PAYOR (DISPLAY ONLY)
This field contains the DRG payor linked to the patient's primary insurance and financial classification.

2. AGE (DISPLAY ONLY)
This field contains the patient's age (system-calculated from the date of birth).

3. SEX (DISPLAY ONLY)
This field contains the patient's sex.

4. DISCHG DISPOSITION (DISPLAY ONLY)
This field contains the discharge disposition.

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

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

7.   APRDRG (DISPLAY ONLY)
This field contains the APRDRG code and description assigned by the 3M Coding and Reimbursement system.

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

9.   OUTLIER STATUS (DISPLAY ONLY)
If the DRG surpasses the LOS Threshold, *High Stay* displays in this field. If the DRG surpasses Charge Threshold, *Cost* is displayed in this field. If both the LOS and the Charge Thresholds are surpassed, the one that pays the most reimbursement is displayed in this field.

10. LOS (DISPLAY ONLY)
This field contains the length of stay entered on the first screen of the simulation processor. If a length of stay was not entered, this field is blank.

11. CHARGES (DISPLAY ONLY)
This field contains the dollar amount of all charges ordered for this patient and is updated concurrently.

12. SHORT TRIM POINT (DISPLAY ONLY)
This field contains the low length of stay (number of days) trim point for low length of stay outlier status.

13. HIGH TRIM POINT (DISPLAY ONLY)
This field contains the high length of stay (number of days) trim point for high length of stay outlier status.

14. SEVERITY OF ILLNESS (DISPLAY ONLY)
This field contains the claim level severity of illness. Values are:

- 0 Refinement not possible

- 1 Minor patient severity of illness

- 2 Moderate patient severity of illness

- 3 Major patient severity of illness

- 4 Extreme patient risk of illness

15. RISK OF MORTALITY (DISPLAY ONLY)

This field contains the claim level of the risk of mortality. Values are:

- 0 Refinement not possible

- 1 Minor patient severity of illness

- 2 Moderate patient severity of illness

- 3 Major patient severity of illness

- 4 Extreme patient risk of illness

Secondary DRG

```
                    General Hospital DRG Information Processor
                                        Thu Mar 15, 2012 04:23 pm
Account      Name               FC Typ Admit    Disch      Balance Loc
A1205200001  CRAME, BOB          M  I/P 02/21/12 02/26/12    2881.64 AR /ACCF
 1 DRG Type            2 Other Payor/Type          3 Age    4 Sex
   CHAMPUS                      03                   72Y        FEMALE
 5 Major Diagnostic Category                      6 Dischg Disposition
   005  DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM   *HOME OR SELF CARE
 7 DRG                           8 ICD  9 Charges   10 FINAL ACCEPT DATE
   305 v27.0 HYPERTENSION W/O MCC       9      4171.44   02/26/12
11 DRG Wght      12 Geom LOS   13 Tech. Add-on   14 Day Thresh  15 Cost Thresh
   0.7033           1.90                                         76365.13
16 DRG Base Amt  17 Reimb Amt  18 Total DSH      19 Tot IME     20 Tot Outlier
                    6607.86                         611.62         0.00
21 Tot Reimb Amt                 22 Variance                 23 Outlier Indication
   6607.86                          2436.42                     1 Standard paym




   Press NL--

```

Primary DRG

The screen is the same for the ICD-9 and ICD-10 Primary DRG. The "ICD" field displays if this is the ICD-9 (9) or ICD-10 (10) DRG. Note that fields may differ based on the payor code used for the DRG.

```
                DRG Information Processor General Hospital
                                Thu Mar 15, 2012 04:23 pm
Account        Name               FC Typ Admit    Disch       Balance Loc
A1205200001   CRANE, BOB           M  I/P 02/21/12 02/26/12     2881.64 AR /ACCF
 1 DRG Payor          2 Other Payor  3 Age   4 Sex     5 Dischg Disposition
   M MEDICARE              00          72Y     FEMALE    *HOME OR SELF CARE
 6 Major Diagnostic Category                         7 Final Accept Date
   005   DISEASES & DISORDERS OF THE CIRCULATORY SYSTEM     02/26/12
 8 DRG                          9 Version 10 ICD  11 LOS   12 Charges
   307   HYPERTENSION W/O MCC             28.0        10    5          4171.44
13 DRG Wght    14 Geom LOS 15 Short Stay Trim   16 Day Thresh 17 Cost Thresh
   0.6789         2.20                                           28335.39
18 Tot Cap Reimb  19 Reimb Amt  20 Total DSH    21 Total IME  22 Tot Outlier
                   3449.71        295.90            64.04         0.00
23 Tot Reimb Amt                 24 Variance            25 Outlier Indication
   5678.90                          1507.46               1 Not an Outlie
26 Initial Reimb  27 HAC Proc Required       28 HAC Status

29 Initial DRG    30 DRG Return Code



Press NL--
```

Field Explanations

1. DRG PAYOR (DISPLAY ONLY)
This field contains the DRG payor linked to the patient's primary insurance and financial classification.

2. OTHER PAYOR (DISPLAY ONLY)
This field contains the DRG payor's rate table number linked to the patient's primary insurance and financial classification.

3. AGE (DISPLAY ONLY)
This field contains the patient's age (system-calculated from the date of birth).

4. SEX (DISPLAY ONLY)
This field contains the patient's sex.

5. DISCHG DISPOSITION (DISPLAY ONLY)
This field contains the discharge disposition.

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

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

8. DRG (DISPLAY ONLY)
This field contains the DRG code and description assigned by the 3M Coding and Reimbursement system.

9. VERSION (DISPLAY ONLY)
This field displays the grouper version used in determining the DRG (for example, 25.0, 26.0) when that information is available in STAR Medical Records information.

10. ICD (DISPLAY ONLY)
This field displays the ICD that was used for the DRG: 9 or 10.

11. LOS (DISPLAY ONLY)
This field contains the length of stay.

12. CHARGES (DISPLAY ONLY)
This field contains the dollar amount of all charges ordered for this patient and is updated concurrently.

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

14. GEOM LOS (DISPLAY ONLY
This field contains the length of stay entered on the first screen of the simulation processor. If a length of stay was not entered, this field is blank.

15. SHORT STAY TRIM (DISPLAY ONLY)
This field contains the low length of stay (number of days) trim point for low length of stay outlier status.

16. DAY THRESH (DISPLAY ONLY
This field contains the day threshold for the DRG.

17. COST THRESHOLD (DISPLAY ONLY)
This field contains the cost threshold for the DRG.

18. TOT CAP REIMB (DISPLAY ONLY)
This field contains the total reimbursement for the DRG.

19. REIMB AMT (DISPLAY ONLY)
This field contains the total reimbursement amount for the DRG.

20. TOTAL DSH (DISPLAY ONLY)
This field displays the reimbursement amount for disproportionate share hospital (DSH) for the calculated DRG (displayed in the DRG field). This information is obtained from the 3M Coding and Reimbursement System and stored with the patient.

21. TOTAL IME (DISPLAY ONLY)
This field contains the educational adjustment percentage.

22. TOT OUTLIER (DISPLAY ONLY)
This is the total outlier amount. This is the total for the outlier indicated in the field "Outlier Indication".

23. TOT REIMB AMT DISPLAY ONLY)
This field contains the total amount reimbursed.

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

25. OUTLIER INDICATION (DISPLAY ONLY)
This field displays, if applicable, the code and description for the outlier status of the patient. The outlier status is determined by the 3M Coding and Reimbursement System and uploaded into STAR. If the patient is not an outlier, this field is blank. If the patient is a high cost outlier, this field displays HIGH COST. If the patient is a high stay outlier, this field displays HIGH STAY. If the patient is transferred, this field displays TRANSFER. If this patient is a short stay outlier (i.e., the LOS is below the short stay trim), this field displays SHORT STAY. The outlier status is uploaded from the 3M Coding and Reimbursement System and stored with the patient's data in STAR.

26. INITIAL REIMB (DISPLAY ONLY)
This field displays the reimbursement prior to HAC Processing.

27. HAC PROCESSING REQUIRED (DISPLAY ONLY)
This field displays a value of Yes or No to indicate whether processing was required for the DRG, meaning secondary diagnoses were evaluated to determine whether they were hospital acquired conditions.

28. HAC STATUS (DISPLAY ONLY)
This field contains one of the following indicators if hospital acquired conditions processing occurred.

If the DRG version is 26.0, then the HAC values are as follows:

    0   HACs Not Evaluated

    1   No HACs

    2   HACs But No Demotion

    3   Demotions But No DRG Change

    4   Demotions and Different DRG

If the DRG version is 27.0 or higher, then the HAC values are as follows:

    0   N/A

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    1   No DRG Change

    2   DRG Change

    3   DRG Changed to Ungroupable

29. INITIAL DRG (DISPLAY ONLY)
This field displays the DRG that would have been assigned if no HAC Processing occurred. This can match the DRG assigned to the account.

30. DRG RETURN CODE (DISPLAY ONLY)
This field can contain all of the following DRG return codes since STAR can receive DRG data from other sources. Note however that 3M is not sending back these DRG Return Codes. They are only seen when grouping the account on 3M, to tell you that there is an issue with the account that needs to be corrected. Therefore STAR Patient Accounting does not display these codes when grouping in 3M. The codes generated if an account is grouped in STAR are 0, 2, 6, 7, 9, 12, and 14.

0 Grouped

1 Diagnosis cannot be used as principal dx

2 No qualifying DRG in MDC for prin dx

3 Invalid age

4 Invalid sex

5 Invalid discharge status

6 Illogical principal diagnosis

7 Invalid principal diagnosis

8 (8 is not currently used)

9 POA Ind nonexempt - HAC-POA(s) invalid or missing

10 POA Ind invalid/missing - HAC-POA(s) are N,U

11 POA Ind invalid/missing - HAC-POA(s) invalid/missing

12 POA Ind nonexempt - HAC-POA(s) are 1

13 POA Ind invalid/missing - HAC-POA(s) are 1

14 POA Ind nonexempt - multi distinct HAC-POA not Y,W,N,U

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15 POA Ind invld/missing - multi distinct HAC-POAs not Y,W

Reimbursed APR-DRG Information (Displays As Primary DRG)

```
              General Hospital DRG Information Processor
                                        Wed Apr 19, 2010 09:48 am
   Account        Name        FC Typ Admit    Disch     Balance    Loc
   A0932100002  TEST,APRDRG   K  I/P 11/10/09 11/17/09  1039337.68 AR /ACCF
    1 DRG Payor                 2 Other Payor/Type  3 Age     4 Sex
      OTHER PAYERS                142/Medicaid       44Y        MALE
    5 Major Diagnostic Category                     6 FINAL ACCEPT DATE
      019 MENTAL DISEASES & DISORDERS
    7 DRG/Version                      8 LOS   9 Dischg Disposition
      756 V26.1 ACUTE ANXIETY & DELIRIUM    7      *HOME OR SELF CARE
   10 DRG Wght              11 Average LOS        12 Acute Days
      0.4625                   2                     5
   13 ALS                   14 Charges            15 Base Pay
      2                        8871687.51            513.19
   16 Cost Thresh           17 Cost Outlier Payment 18 Surcharge Payment
      212179.73                23764.13              68314.62
   19 Pool Admin Fee        20 Tot IME             21 ALC Pay
      0.00                     6.94                   50.00
   22 Transfer Pay          23 Status Code/Description  24 Tot Reimb Amt
      0.00                     3-High Cost Outlier         1038692.68
   25 Severity of Illness   26 Risk of Mortality
      Minor                    Minor
   Press NL--

 View Primary DRG information (P) or New Line to exit--
```

Field Explanations

1. DRG PAYOR (DISPLAY ONLY)
This field contains the DRG payor linked to the patient's primary insurance and financial classification.

2. OTHER PAYOR TYPE (DISPLAY ONLY)
This field contains the payor code and type for the returned codes as follows:

 1 Medicaid

 2 Medicaid Managed Care

 3 Worker's Comp

 4 No Fault

3. AGE (DISPLAY ONLY)
This field contains the patient's age (system-calculated from the date of birth).

4. SEX (DISPLAY ONLY)
This field contains the patient's sex.

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

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

7. DRG/VERSION (DISPLAY ONLY)
This field contains the DRG code, version, and description.

8. LOS (DISPLAY ONLY)
This field contains the length of stay entered on the first screen of the simulation processor. If a length of stay was not entered, this field is blank.

9. DISCHG DISPOSITION (DISPLAY ONLY)
This field contains the discharge disposition.

10. DRG WEIGHT (DISPLAY ONLY)
This is the weight of the APR-DRG. This weight is a value used as a multiplier in calculating a hospital's reimbursement for a particular DRG.

11. AVERAGE LOS (DISPLAY ONLY)
This is the average length of stay for the APR-DRG. This field is only populated if using the 3M interface, and only if there is data returned.

12. ACUTE DAYS (DISPLAY ONLY)
This is the acute days for the APR-DRG. This field is only populated if using the 3M interface, and only if there is data returned.

13. ALS (DISPLAY ONLY)
This is the number of days the patient was in an Alternate Level of Stay bed. Situations include patients staying in the Acute Care facility only until a SNF or Hospice bed is available. This field is only populated if using the 3M interface, and only if there is data returned.

14. CHARGES (DISPLAY ONLY)
This field contains the dollar amount of all charges ordered for this patient and is updated concurrently.

15. BASE PAY (DISPLAY ONLY)
This field contains the base payment for the APR-DRG.

16. COST THRESHOLD (DISPLAY ONLY)
This field contains the cost threshold for the APR-DRG.

17. COST OUTLIER PAYMENT (DISPLAY ONLY)
This field contains the cost outlier payment for the APR-DRG.

18. SURCHARGE PAYMENT (DISPLAY ONLY)
This field contains the surcharge payment for the APR-DRG.

19. POOL ADMIN FEE (DISPLAY ONLY)
This field contains the pool administration fee for the APR-DRG.

20. TOT IME (DISPLAY ONLY)
This field contains the total IME payment for the APR-DRG.

21. ALC PAY (DISPLAY ONLY)
This field contains the alternate level of care payment for the APR-DRG.

22. TRANSFER PAY (DISPLAY ONLY)
This field contains the transfer payment for the APR-DRG.

23. STATUS CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the status code and description for the APR-DRG.

24. TOT REIMB AMT (DISPLAY ONLY)
This field contains the total reimbursement amount for the APR-DRG.

25. SEVERITY OF ILLNESS (DISPLAY ONLY)
This field contains the account level severity of illness. Values are:

0   No class spec

1   Minor

2   Moderate

3   Major

4   Extreme

26. RISK OF MORTALITY (DISPLAY ONLY)
This field contains the account level risk of mortality. Values are:

0   No class spec

1   Minor

2   Moderate

3   Major

4   Extreme

When you complete your review, press ENTER to exit the transaction.

HCPCS Procedures

This screen displays information regarding HCPCS codes describing procedures performed on the patient. The HCPCS procedure code can be printed on the UB.

The following is an example of the screen that is displayed when you select the HCPCS Procedures option. You can use this function to review detail information for HCPCS procedures.

```
                    General Hospital HCPCS Procedures Processor
                                      Fri Aug 17, 2012 01:07 pm

    Account        Name              FC Typ Admit    Disch        Balance Loc
    C04239-00002 JONES,NANCY          O  I/P 08/26/04 01/19/07   399659.40 AR /ACCF

      Code   Description             Grp UB Rev Code          Amount
  (1) 10061 DRAINAGE OF SKIN ABSCESS  0  360-OR Services          $2.50
  (2) 00215 ANESTH, SKULL FRACTURE    1  270-Medical/Surgical  $314.00
                                         Total  --             $316.50




NEWLINE, or selection to view [NL]--
```

The screen lists each HCPCS procedure for the account number, indicating the HCPCS code, the description, the ASC group number, the UB Revenue Code, and the estimated reimbursement amount. The total estimated reimbursement amount for all procedures for the account is also included.

Press ENTER to exit the screen, or enter the number to the left of the HCPCS procedure code for which you want to review detail.

If you select to view detail, the system displays the detail screen.

```
              General Hospital HCPCS Procedures Processor
                                    Fri Aug 17, 2012 01:07 pm

  Account      Name              FC Typ Admit   Disch      Balance Loc
  C04239-00002 JONES,NANCY        O  I/P 08/26/04 01/19/07  399659.40 AR /ACCF


 1 Epis Date & Time    2 Procedure Code                3 Modifier
   02/17/99 06:57        10061-DRAINAGE OF SKIN ABSCESS   Entries Defined
 4 UB Revenue Code    5 ASC Group    6 Amount          7 Tissue Code
   360-OR Services        0             $5.00            DEGENERATION &
 8 Surgeon                          9 Specialty
   ADAIR,FRANK C                      NEP NEPHROLOGY
10 Anesth Code       11 Anesth Start Time 12 Anesth End Time 13 Anesth Dura
   HALOTHANE            05:00              06:00               60 minutes
14 ASA-PS Class       15 Other Institution
   P1 NORMAL HEALTHY PT   11 REGIONAL HOSPITAL
16 Epis Location      17 Epis End Date/Time           18 Episode Duration

19 Rec Location       20 Rec Start Date/Time          21 Rec End Date/Time

22 Procedure Team Information



Enter view modifiers(M), team information(T) or enter to continue--
```

Field Explanations

1. EPIS DATE & TIME (DISPLAY ONLY)
This field displays the episode date and time associated with the procedure.

2. PROCEDURE CODE (DISPLAY ONLY)
This field displays the procedure code and description.

3. MODIFIER (DISPLAY ONLY))
This field accesses a subscreen that contains up to 5 modifier codes and descriptions. If modifiers exist for this HCPCS code, the field displays Entries Defined. If no modifiers have been associated with this HCPCS code, this field is blank. To view this information, enter M at the prompt.

4. UB REVENUE CODE (DISPLAY ONLY)
This field displays the UB revenue code.

5. ASC GROUP (DISPLAY ONLY)
This field displays the ASC group code associated with the selected HCPCS code.

6. AMOUNT (DISPLAY ONLY)
This field displays the expected reimbursement amount for this procedure based on the associated ASC group code and HCPCS payor code.

7. TISSUE CODE (DISPLAY ONLY)
This field identifies the pathological status of the tissue (if any) removed during this procedure.

8. SURGEON (DISPLAY ONLY)
This field contains the primary surgeon for this procedure.

9. SPECIALTY (DISPLAY ONLY)
This field identifies the specialty associated with the surgeon.

10. ANESTH CODE (DISPLAY ONLY)
This field identifies the type of anesthesia used for this procedure.

11. ANESTH START TIME (DISPLAY ONLY)
This field contains the time the administration of the anesthesia began.

12. ANESTH END TIME (DISPLAY ONLY))
This field contains the time the administration of the anesthesia ended.

13. DURATION (DISPLAY ONLY)
This field displays the total duration time (in minutes) of the anesthesia.

14. ASA-PS CLASS (DISPLAY ONLY)
This field contains the ASA-PS Class associated with the Anesthesia code.

15. OTHER INSTITUTION (DISPLAY ONLY)
This field indicates if this procedure was performed at another institution during the patient's stay at your facility.

16. EPIS LOCATION (DISPLAY ONLY)
This field identifies the room/location where the procedure(s) was performed.

17. EPIS END DATE/TIME (DISPLAY ONLY)
This field identifies the date and time this episode ended.

18. EPIS DURATION (DISPLAY ONLY)
This field contains the number of minutes of this episode based on the difference between the Epis Date & Time and Epis End Date/Time fields.

19. REC LOCATION (DISPLAY ONLY)
This field identifies the room/location where the patient recovered from the procedure episode.

20. REC START DATE/TIME (DISPLAY ONLY)
This field identifies the date and time the recovery began.

21. REC END DATE/TIME (DISPLAY ONLY)
This field identifies the date and time the recovery ended.

22. PROCEDURE TEAM INFORMATION (DISPLAY ONLY)

This field accesses a scrolling screen that contains members of the procedure team. If team information exists for this procedure, this field displays Entries Defined. If no team information has been associated with this procedure, this field is blank. To view this information, enter **T** at the prompt.

To view HCPCS modifiers, enter **M**. To view team information, enter **T**. To return to the summary screen, press ENTER.

If you enter M, the system displays a screen with up to five modifiers:

```
                      General Hospital HCPCS Procedures Processor
                                        Fri Aug 17, 2012 01:07 pm

    Account       Name                 FC Typ Admit    Disch      Balance Loc
    C04239-00002 JONES,NANCY            O  I/P 08/26/04 01/19/07  399659.40 AR /ACCF

 1 HCPCS Modifier # 1                 2 HCPCS Modifier # 2
   32 MANDATED SERVICES                 20 MICROSURGERY
 3 HCPCS Modifier # 3                 4 HCPCS Modifier # 4
   21 PROLONGED EVAL/MGMT SERV           23 UNUSUAL ANESTHESIA
 5 HCPCS Modifier # 5
   24 UNRELATED EVAL/MGMT SERV




 Press NL--
```

Press ENTER to return to the detail screen.

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If you enter T, the system displays a screen that shows the team information:

```
                    General Hospital HCPCS Procedures Processor
                                         Fri Aug 17, 2012 01:07 pm

      Account       Name              FC Typ Admit    Disch       Balance Loc
      C04239-00002 JONES,NANCY         O  I/P 08/26/04 01/19/07   399659.40 AR /ACCF


   1 Epis Date & Time     2 Procedure Code                     3 Suffix
      02/17/99 06:57          45.13-SM BOWEL ENDOSCOPY NEC
   No      Procedure Team Member          Specialty           Type
   1       ALEXANDER, RALPH               Surgical            CONSULTANT
   2       FREEMAN,ROBERTA                Surgery Division     SURGICAL A












           Enter Doctor code or '-' for table, or name- for partial table--
                      F1Prev Page F2Next Page F7  Exit
```

You cannot edit while in this function.

To move to a previous page, press **F1**. To move to the next page, press **F2**. To return to the detail screen, press **F7**.

Medical Records Diagnosis Information

Select this option to view a patient's diagnosis data extracted in Medical Records.The principal and secondary diagnoses are displayed on this screen, along with the ICD code and description. Subsequent screens allow you to view the Reason for Visit diagnosis codes and Nosocomial Infection codes.

NOTE: If your hospital is collecting ICD-10 information for accounts, when accessing the MR Diagnosis Information screen, if there are no coded diagnoses in Medical Records, the bottom of the screen gives the message:

   NO ICD-10-CM DIAGNOSES

If your hospital is NOT collecting ICD-10 information for accounts, and is only collecting ICD-9 information for accounts, when accessing the MR Diagnosis Information screen, if there are no coded diagnoses in Medical Records, the bottom of the screen gives the message:

   NO ICD-9 DIAGNOSES

The screen displays ICD diagnosis codes as follows:

- When there are only ICD-10 Diagnosis Codes on the account, the system displays the ICD-10 Diagnosis Codes. When entering an **R** for Reason for Visit or N for Nosocomial while on the ICD-10 Diagnosis Code screen, only the ICD-10 Reason for Visit and Nosocomial information displays. The following prompt is displayed:

     View (R)eason for Visit, (N)osocomial, or Press NL-

- When there are only ICD-9 Diagnosis Codes on the account, the system displays the ICD-9 Diagnosis Codes. When entering an **R** for Reason for Visit or N for Nosocomial while on the ICD-9 Diagnosis Code screen, only the ICD-9 Reason for Visit and Nosocomial information displays.The following prompt is displayed:

     View (R)eason for Visit, (N)osocomial, or Press NL-

- When there are both ICD-10 and ICD-9 Diagnosis Codes on the account, the system displays the ICD-10 Diagnosis Codes, and allows the user to toggle to the ICD-9 diagnosis information. The following prompt is displayed:

     View ICD-9 (I) Diagnoses, (R)eason for Visit, (N)osocomial, or Press NL-

     You can enter **I** to view the ICD-9 Diagnosis Codes. When viewing the ICD-9 Diagnosis Codes, if there are also ICD-10 Diagnosis Codes on the account, the ICD-9 MR Diagnosis Information screen allows you to return to the ICD-10 MR Diagnosis Information screen. The following prompt is displayed:

     View ICD-10 (T) Diagnoses, (R)eason for Visit, (N)osocomial, or Press NL-

```
                    General Hospital MR Diagnosis Information Processor
                                          Fri Mar 10, 2009 12:36 pm
 Account        Name                   FC Typ Admit    Disch        Balance Loc
 C0916800003  TEST,ICDTEN              M  O/P 06/17/09 06/17/09       623.94 PA /INSR
     ICD-10 Code        Description                  DRG Dx Tumor    Type POA/HAC
 Admitting  B26.82      MUMPS MYOCARDITIS                                      Y
 Principal  B06.82      RUBELLA ARTHRITIS                                      Y
 2ndary( 1) B00.52      HERPESVIRAL KERATITIS                                  Y
       ( 2) B05.81      MEASLES KERATITIS AND KERATOCO                         Y




 View ICD-9(I) Diagnoses, (R)eason for Visit, (N)osocomial, or Press NL--  |
```

Field Explanations

ICD ADMITTING CODE (DISPLAY ONLY)
This field contains the admitting ICD diagnosis code.

ICD ADMITTING DESCRIPTION (DISPLAY ONLY)
This field contains the description from the admitting ICD diagnosis code.

ICD PRINCIPAL CODE (DISPLAY ONLY)
This field contains the principal ICD diagnosis code.

PRINCIPAL DESCRIPTION (DISPLAY ONLY)
This field contains the description of the principal ICD diagnosis code.

2NDARY (X) SECONDARY CODE (DISPLAY ONLY)
This field contains the secondary (as many as exist, with a counter in parenthesis such as (2)) ICD diagnosis code.

2NDARY SECONDARY DESCRIPTION (DISPLAY ONLY)
This field contains the description of the secondary ICD diagnosis code.

DRG DX (DISPLAY ONLY)
This field contains **C/C** if the diagnosis is a complication or comorbidity that affected the DRG calculation.

TUMOR IND (DISPLAY ONLY)
This field identifies whether a diagnosis could be related to a tumor.

TYPE (DISPLAY ONLY
This field contains a type (or modifier) to the diagnosis code.

POA (DISPLAY ONLY)
This field contains the Present on Admission indicator for the diagnosis code

HAC (DISPLAY ONLY)
This field contains the Hospital Acquired Condition indicator for the diagnosis code

Nosocomial Codes

This screen displays the ICD-10 nosocomial information if you were on the MR Diagnosis Information Screen for ICD-10 diagnoses. The system displays the ICD-9

nosocomial information if you were on the MR Diagnosis Information Screen for ICD-9 diagnoses.

```
                    General Hospital MR Diagnosis Information Processor
                                          Fri Jan 18, 2008 10:42 am
Account       Name                  FC Typ Admit    Disch        Balance Loc
A0731900001   WAN,OBI                S  I/P 11/15/07 12/11/07      196.63 AR /ACCF
                    ICD-10  ICD-10                       NHSN
Seq   NNIS   MDRO   Proc    Description               Op Cat  Loc
1     24     M      0KE52P3 ICD10 TEST PROCEDURE         AMP     P
2     03     O      FQ27GCZ RESP AND CIRCULATION VENTILATION CV  C
3     23     V      009730Z Drainage of Cerebral Hemisphere NS   P
```

Field Explanations

NNIS
This field contains the Nosocomial Infection code.

MDRO
This field contains the Multidrug-resistant Organisms (MDRO) code related to the Nosocomial Infection code.

ICD
This field contains the ICD coding system for the procedure code: ICD-9 or ICD-10.

ICD PROC
This field contains the ICD procedure code.

ICD DESCRIPTION
This field contains a description of the ICD procedure code.

NHSN
This field contains the NHSN operative category code, which identifies the eligible surgical site infection.

This field contains the NHSN operative category code, which identifies the eligible surgical site infection

Procedure Information

Select this option to view procedural data and charges for the selected account.

• When there are both ICD-10 and ICD-9 Procedure Codes on the account, the system displays the ICD-10 Procedure Codes and allows the user to toggle to the ICD-9 Procedure Codes. The following prompt is displayed:

View Charges(C), ICD-9(I), or select procedure to view--

You can enter **C** to view charges or **I** to view the ICD-9 Procedure Codes. When viewing the ICD-9 Procedure Codes when there are also ICD-10 Procedure Codes, the ICD-9 Procedure Information screen allows you to go back to the ICD-10 Procedure Information screen. The following prompt is displayed:

View Charges(C), ICD-10(T), or select procedure to view--

- When there are only ICD-10 Procedure Codes on the account, the system displays the ICD-10 Procedure Codes. The following prompt is displayed:

  View Charges(C) or select procedure to view--

- When there are only ICD-9 Procedure Codes on the account, the system displays the ICD-9 Procedure Codes. The following prompt is displayed:

  View Charges(C) or select procedure to view---

After you select this option, the system displays the following screen. Pressing ENTER exits the transaction.

```
                General Hospital Procedure Information Processor
                                            Thu Aug 16, 2012 02:25 pm
Account      Name                  FC Typ Admit    Disch       Balance Loc
A11243-00001 JONES,NAN             C  O/P 08/31/11 08/31/11      138.67-AR /ACCF

      ICD-10-PCS Code  Description              Date/Time       Surgeon      AC
P  (1) 5A02210 Assistance with Cardiac Output u 06/17/09 7:00    SCOTT,EDWARD




View Charges(C), ICD-9(I), or select procedure to view-
```

Field Explanations

The system displays the ICD code and description, the date of the procedure, and the surgeon's name for the procedure. For a complete discussion of medical procedures, refer to the *Patient Processing Volume* of the *STAR Patient Care Reference Guide*.

Location Information

Select this option to view patient location data such as when a patient was admitted, whether the patient preadmitted, the room and bed number assigned to the patient, when the patient was discharged, patient type, etc. This function tracks all rooms the patient has occupied and indicates whether the patient was admitted through ER. Also, cancellations of the admission or discharge will be displayed on this screen.

After you select this option, the system displays the following screen. Pressing ENTER exits the transaction.

```
                General Hospital Location Information Processor
                                             Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A92303-00003 STEPHENS,CHARLES A    C  I/P 10/29/92 11/20/92     8234.25 AR/FCRV
   Departments                  Unit #      Corp #      SS#       Adm Date
                                0000-105686  00004021  777-88-8999  10/29/92
   System Date/Time   Type  Action              Int  Room/Bed or Departments

1  11/20/92 02:04pm   I/P   Discharge 11/20     DJK
2  10/29/92 10:30am   I/P   Admission           DJK  1E 2113-1
3  10/29/92 10:29am   I/P   Admission           LTR
4  10/29/92 10:21am   I/P   Preadmission        LTR




   Press NL--
```

Field Explanations

The system displays the date and time each location change was entered to the system, the patient type, the action, the initials of the user entering the change, and the room/bed or department to which the patient was relocated. For a complete description of the patient admission procedure, refer to the *Patient Processing Volume* of the *STAR Patient Care Reference Guide*.

UM UB Data

Select the UM UB Data option to view billing information associated with a patient's account. When this option is selected, the following screen is displayed:

```
                    General Hospital UM UB Data Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch       Balance Loc
A9316600001  CRAFT,DORENE            B  O/P 06/15/93 06/15/93    2221.44 AR/FCRV
 1 Approval Ind                          2 App From      3 App To      4 Tot Non-Cov
   APPROVED AS BILLED                                                    0 Days
 5 ICF Days          6 SNF Days          7 Denied Days   8 Grace Days  9 LOA Days

10 Tot Avoid Days  11 Tot Acute Days  12 ALOC Days      13 RES Days
                        1
14 Notice Date     15 Reinst. Date    16 Steri/Hyster  17 Co-Pay Exception
                                          Ind               Code




Press NL--
```

Field Explanations

1.   APPROVAL IND (DISPLAY ONLY)
This field indicates the status of the patient's review activity.

2.   APP FROM (DISPLAY ONLY)
This field is used to indicate the beginning date of approval. The system automatically completes this field with the admission date of the patient, or you can edit the date.

3.   APP TO (DATE)
This field is used to indicate the ending date of approval. The system automatically completes this field with the discharge date of the patient, or you can edit the date. If the patient has not been discharged, this field is blank.

4.   TOT NON-COV (DISPLAY ONLY)
This field indicates the total number of non-covered days for this patient's stay. The number in this field reflects the number of days associated with a Non-Covered Days Code that is tied to the UB buckets. The system automatically calculates this number based on the information entered in the Avoidable/Non-Covered Days Screen of the Add/Edit Review function. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

5.   ICF DAYS (DISPLAY ONLY)
This field contains the number of Intermediate Care Facility Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the

Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

6. SNF DAYS (DISPLAY ONLY)
This field contains the number of Skilled Nursing Facility Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field in the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

7. DENIED DAYS (DISPLAY ONLY)
This field contains the number of Denied Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the information in the Avoidable/Non-Covered Days screen.

8. GRACE DAYS (DISPLAY ONLY)
This field contains the number of Grace Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the non-covered days information in the UM Avoidable/Non-Covered Days screen.

9. LOA DAYS (DISPLAY ONLY)
This field contains the number of Leave of Absence Days as defined by CMS and/or the facility's fiscal intermediary. This field is automatically completed by the system based on the number of days in the Non-Covered Day Type field of the Avoidable/Non-Covered Days screen with a link to this UB bucket type. This field can only be edited by updating the non-covered days information in the UM Avoidable/Non-Covered Days screen.

10. TOT AVOID DAYS (DISPLAY ONLY)
This field contains the total number of avoidable days. This field is automatically completed by the system based on the number of days associated with an Avoidable Days Code in the Avoidable/Non-Covered Days screen of the Add/Edit Review function. This field can only be edited by updating the Avoidable Day Type field in this screen.

11. TOT ACUTE DAYS (DISPLAY ONLY)
This field contains the total number of acute care days administered to the patient during this stay. This field is automatically completed by the system based on the total length of stay minus the total non-covered days. This field can only be edited by updating the Non-Covered Day Type field in the UM Avoidable/Non-Covered Days screen.

12. ALOC DAYS (DISPLAY ONLY)
Enter the specified number of Alternate Level of Care days for the patient. ALOC Days information is required by the 3M Encoding product and the NJ Multiple Grouper programs.

13. RES DAYS (DISPLAY ONLY)
Enter the number of Residential Level of Care Days for this patient. RES days maybe added to the UB Non-Covered Summary screen. Users will manually enter the Avoidable Days total in this field.

14. NOTICE DATE (DISPLAY ONLY)
This field contains the date on which the patient received notice regarding termination of benefits. This field is automatically completed by the system based on the information in the UM Contact to Advisor detail screen of the Add/Edit Review function. This field can only be edited by updating the information in the UM Contact to Advisor screen.

15. REINST DATE (DISPLAY ONLY)
This field contains the date on which the patient's benefits were reinstated. This field is automatically completed by the system based on the information in the UM Contact to Advisor screen of the Add/Edit Review function. This field can only be edited by updating the information in the UM Contact to Advisor screen.

16. STERI/HYSTER IND (DISPLAY ONLY)
This field indicates if the Sterilization Hysterectomy consent form has been signed. Valid entries are Y for Yes, N for No or blank.

17. CO-PAY EXCEPTION (DISPLAY ONLY)
The two digit numeric code that indicates the reason the patient is exempt from co-payment.

Valid entries are: 01 = Pregnancy

02 = Resident of an OMH/OMRDD Certified Community Residence.

NOTE: This information is networked to Patient Accounting.

When you update this screen, the following prompt is displayed:

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

Select one of the following options:

- Enter **N** for No to not accept the screen and the following prompt is displayed:

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

- Enter **Y** for Yes to accept the screen

FINANCIAL INFORMATION

The Financial Information option enables you to view financial data for a patient.

After this function is selected, the system displays the following screen:

```
          General Hospital Financial Information Processor
                                        Thu May 5, 2011 03:44 pm
Account      Name              FC Typ Admit    Disch       Balance Loc
A00004-01436 SHORE,ONE          S  OPE 07/20/07 07/20/07      0.00 PA /DNFB
           Option No.  Option
           ---------------------------------------
              1        Billing Information
              2        Claim Information
              3        Transaction History
              4        Insurance Status
              5        Insurance Follow-Up
              6        Account Follow-Up
              7        Balance Summary
              8        Display Charges by Service Date/HCPCS
              9        View Edit PA Charge Log
             10        Series Account Tracking Information
             11        PCON 1500 Reimbursement Information
             12        Service Time Tracking History
             13        Totals by Responsible Party




 Enter option number--
```

Each of the options shown on this screen is described below.

Billing Information

This screen enables you to view patient billing data.

After this option is selected, the system displays the first Billing Information screen, shown below.

After you review this data, you can select additional screens to review billing detail, proration summaries, billing recap totals, billing totals, or unbilled charges and credits.

```
                General Hospital Billing Information Processor
                                          Fri Mar 10, 2009 12:36 pm
 Account       Name                FC Typ Admit    Disch      Balance Loc
 A90035-00001 BROWN,DAVID A         C  E/R 02/03/98 02/04/98    6.80   AR/FCRV
  1 Provider           2 ICD  3 State ICD   4 Biller            5 CycA
    01 ACUTE CARE        10       DIAG-B     3 BILLERTHREE,BILL
  6 Final Bill Parameter          7 Cycle Bill Parameter        8 Old Chgs
    3 MEDICARE OUT, FINAL          7 GENERAL EOM, CYCLE
  9 Billed Amt        10 Final Bill Amt   11 Unbilled Amt   12 Unprorated
    $252.57             $252.57            $0.00            $0.00
 13 #Cycles 14 Last Cyc  15 Last Cyc Bill Thru 16 Final Bill  17 CPTAFB DT
                                               01/30/08
 18 Last Rebill          19 Last Bill No.  20 Bill Status and Date
                            1-F
 21 Contract             22 Pre-bill Edit Status      23 PBE Status Date




 Proceed to detail(D), pro summaries(S), unbilled chgs(U) or billing recap(B)--
```

Field Explanations

1. PROVIDER (DISPLAY ONLY)
This field contains the code name of the provider for the patient. Through the provider, claim-specific addresses, the federal tax ID, and numbers needed for the claims are resident. Refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide.

2. ICD (DISPLAY ONLY)
This field contains the account level ICD flag, as determined by the Hospital Facility Options, USA ICD-10 Eff Date field, on STAR Patient Processing, and any exceptions for the Insurance Plan, Insurance Carrier, or Financial Class on the account. Possible values are:

- 9 and blank field: ICD-9 Diagnoses and Procedures are collected on the account.

- 10: ICD-10 Diagnoses and Procedures are collected on the account.

- B: Both ICD-10 and ICD-9 Diagnoses and Procedures are collected on the account.

3. STATE ICD (DISPLAY ONLY)
This field contains State ICD-10 Exceptions for the current patient type, as determined by the State ICD-10 Patient Type Exceptions table on STAR Patient Processing. Possible values are:

- DIAG-B: The State reporting requires ICD-9 Diagnosis Codes, therefore, both ICD-9 and ICD-10 Diagnosis Codes are collected on the account in STAR Medical

Records. Only ICD-10 Procedure Codes are collected on the account. STAR Patient Processing, STAR Order Management, STAR Lab, STAR Radiology, and STAR Pharmacy do not look to the STATE ICD flag. This flag is only used by STAR Medical Records when coding.

- PROC-B: The State reporting requires ICD-9 Procedure Codes, therefore, both ICD-9 and ICD-10 Procedure Codes are collected on the account in STAR Medical Records. Only ICD-10 Diagnosis Codes are collected on the account. STAR Patient Processing, STAR Order Management, STAR Lab, STAR Radiology, and STAR Pharmacy do not look to the STATE ICD flag. This flag is only used by STAR Medical Records when coding.

- B: The State reporting requires ICD-9 Diagnosis and Procedure Codes. Therefore, both ICD-9 and ICD-10 Diagnosis and Procedure Codes are collected on the account in STAR Medical Records. STAR Patient Processing, STAR Order Management, STAR Lab, STAR Radiology, and STAR Pharmacy do not look to the STATE ICD flag. This flag is only used by STAR Medical Records when coding.

4. BILLER (DISPLAY ONLY)
This field contains the name and number of the biller assigned to this account.

5. CYCA (DISPLAY ONLY)
This field indicates whether cycle adjustment billing is allowed for the account, according to the setting in the Cycle Adj Bill Ind field on the Patient Bill Format level for an overall facility level setting or for a specific payor in the Cycle Billing parameters. The setting in the Cycle Adj Bill Ind field is copied to the account and becomes the cycle adjustment bill indicator for the account. This field contains the value of Yes if cycle adjustment billing is allowed for the account or the value of No if cycle adjustment billing is not allowed for the account.

6. FINAL BILL PARAMETER (DISPLAY ONLY)
This field contains the final billing parameter code and description assigned to this account.

7. CYCLE BILL PARAMETER (DISPLAY ONLY)
This field contains the cycle bill parameter code and description assigned to this account.

8. OLD CHGS (DISPLAY ONLY)
This field displays the value of Yes if the account has charges in the Unbilled Charge Worklist.

9. BILLED AMOUNT (DISPLAY ONLY)
This field contains the amount of charges that have been billed.

10. FINAL BILL AMT (DISPLAY ONLY)
This field contains the amount of charges that were billed on the final bill.

11. UNBILLED AMT (DISPLAY ONLY)
This field contains the amount of charges that have not been billed.

12. UNPRORATED AMOUNT (DISPLAY ONLY)
This field contains charges not yet prorated. Charges are prorated through demand billing, an on-line proration request, and nightly by the system.

13. # OF CYCLES (DISPLAY ONLY)
This field contains the number of cycle bills generated for this account. This does not include cycle adjustment bills.

14 LAST CYC (DISPLAY ONLY)
This field contains the date of the last cycle bill. This does not include cycle adjustment bills.

15. LAST CYC BILL THRU (DISPLAY ONLY)
This field contains the last date for which cycle billing occurred.

16. FINAL BILL (DISPLAY ONLY)
This field contains the final billing date.

17. CPTAFB DT (DISPLAY ONLY)
This field contains the last date that a patient type was changed after final billing. If there has not been a change in the patient type after final bill, the field is blank.

18. LAST REBILL (DISPLAY ONLY)
This field contains the last rebill date, including cycle adjustments. The field displays the first and last cycle adjustment bill date concatenated with the bill type. An example of this is: 01/01/06-Z; 01/20/06-A.

19. LAST BILL NO. (DISPLAY ONLY)
This field contains the last bill sequence number followed by the bill type. An example of this is: 6-Z; 10-A.

20. BILL STATUS AND DATE (DISPLAY ONLY)
This field contains the billing status and the date the billing status was established or last changed. Valid statuses are blank, hold, bill requested, cycle adjustment bill requested, or errors. Bills are not produced for accounts with a status of hold, CPTAFB billing hold, or DPW billing hold. A status of *Bill requested* indicates the hospital has requested a bill for the account to be produced during Midnight Processing. A status of *Errors* indicates the final bill cannot be produced until errors are cleared.

21. CONTRACT (DISPLAY ONLY)
This field contains the contract registration number.

22. PRE-BILL EDIT STATUS (DISPLAY ONLY)
This field contains the pre-bill edit status, if the account qualifies for pre-bill edits. Pre-bill statuses are:

1 = Pre-bill account (Selected for Pre-bill)—This status indicates that the pre-bill edit process was initiated in STAR Patient Accounting for the account, the primary insurance carrier changed, or the patient type changed.

2 = Flagged for Pre-bill batch process (In progress)—This status indicates the creation of a pre-bill is pending. This could occur when the account is initiated into the pre-bill process or a trigger event occurs.

3 = Manually queued for pre-bill (Manually queued)—This status indicates that a pre-bill was requested by the GUI worklist (Pre-bill Edit Worklist).

4 = Processed - no edits (Processed/no edits)—This status indicates the current pre-bill processed without edits. This does not indicate that the account is ready to final bill because the Medical Records edits might not have been employed yet or the account does not qualify for a final bill as yet. A trigger event can cause the process to be repeated.

5 = Processed - with edits (Processed/edits)—This status indicates that the current pre-bill account processed with edits.

6 = Queued for another pre-bill (Edits existed or re-queued for pre-bill)—This status indicates that all edits were removed from the worklist by the user, another pre-bill request was triggered automatically, and the pre-bill edit status is changed to 6.

7 = Pre-bill edit process completed (Complete)—This status indicates that the latest pre-bill was created with no edits and Medical Records edits have been performed if appropriate. The account is marked with this status when the pre-bill batch process occurs. These types of accounts are ready to final bill and should not have any bill/claim edits on the actual bill.

8 = Pre-bill edits bypassed - suspense day (Bypassed/suspense days)—This status indicates that billing suspense days for the account have expired. The pre-bill edit status is changed to 8 when the request for the final bill is created.

9 = Pre-bill edits bypassed - manual bill request (Bypassed/single bill request—This status indicates that a single bill request was made on an account that cannot have pre-bill edits (Perform Edits field is set to No), and the pre-bill edit process for the account is incomplete.

10 = Pre-bill edits bypassed - final bill (Bypassed/final bill)- This status indicates that the user has elected for billing to occur if PBE edits exist but there are no bill edits. It can also occur if the dollar amount limit is not exceeded.

11 - No Errors/No Bill Req - This status indicates that no request for a final bill is being placed by Pre Bill Edit logic per the values for Request Final Bill If No Pre-Bill Edits in the Pre-bill Edit Parameters. Accounts will receive the No Errors/No Bill Req when the patient type is listed as an exception to Request Final Bill If No Pre-Bill Edits on the Pre-bill Edit Parameters.

12 - No Errors/Bill Req—This status indicates that a request for a final bill was placed by Pre Bill Edit logic per the values for Request Final Bill If No Pre-Bill Edits in the Pre-bill Edit Parameters. The following criteria were met when the most recent PBE bill was processed.

*   No PBE edits were found for any of the PBE Active Sources employed by the facility and appropriate for the account.

*   Charges exist for the account

*   Patient Processing historization has occurred

*   Patient Accounting billing suspense days have not passed

*   No PBE trigger events for the account indicate another PBE bill should be produced due to data updates

13 - Final Bill Req Canc -This status indicates that the previous status was No Errors/Bill Req, a subsequent Pre-bill Edit trigger event selected for the facility occurred, meaning data was updated, and the request for the final bill was removed

23. PBE STATUS DATE (DISPLAY ONLY)
This field contains the date the pre-bill status was changed.

The screen displays the following prompt:

Proceed to detail (D), pro summaries (S),billing recap (B), billing totals (T), or unbilled amt (U)--

NOTE: The option to view billing totals (T) is shown on the prompt only if there are unbilled charges or credits for a previous billing period. The option to view unbilled amounts (U) is displayed on the prompt only if there are outstanding unbilled amounts for any bill associated with an account.

You have the following entry options:

*   Enter **D** to view charge detail information. For details, see "Detail Billing Information" on page 1-144,

*   Enter **S** to view proration summaries. For details, see "Summary Billing Information" on page 1-152.

*   Enter **U** to view unbilled charges and credits. For details, see "Unbilled Charges Information" on page 1-156.

• Enter **B** to view billing recap information. For details, see "Billing Recap Information" on page 1-153.

• Enter **T** to view billing totals. For details, see "Billing Totals" on page 1-159.

DETAIL BILLING INFORMATION

To view charge detail, enter **D**. The following message is displayed:

Select date to begin--

A list of Charge Service Dates is displayed on the screen. Select a Charge Service Date and press ENTER. A list of the charges is displayed in charge number order by date on a screen similar to the following. All charges starting with the date selected and subsequent dates display. Press slash (/) ENTER to display additional charges. The charge number, department, description, service date, quantity, and price display on each charge.

```
              General Hospital Billing Information Processor
                                          Fri Mar 10, 2009 12:36 pm
Account       Name                  FC Typ Admit    Disch       Balance Loc
A90035-00001 BROWN,DAVID A           C  E/R 02/03/98 02/04/98     6.80    AR/FCRV
 1 Provider              2 ICD  3 State ICD   4 Biller              5 CycA
   01 ACUTE CARE            10       DIAG-B     3 BILLERTHREE,BILL
 6 Final Bill Parameter            7 Cycle Bill Parameter          8 Old Chgs
   3 MEDICARE OUT, FINAL           7 GENERAL EOM, CYCLE
 9 Billed Amt        10 Final Bill Amt  11 Unbilled Amt  12 Unprorated
   $252.57            $252.57            $0.00            $0.00
13 #Cycles 14 Last Cyc  15 Last Cyc Bill Thru 16 Final Bill  17 CPTAFB DT
                                                 01/30/08
18 Last Rebill             19 Last Bill No.  20 Bill Status and Date
                              1-F
21 Contract             22 Pre-bill Edit Status      23 PBE Status Date
Page:01                       Charge Summary              ##=Current Choices
     Chg# Dpt Description                  Srv Date Time  Qty    Price CO
( 1)    1 CSR MATTRESS, ROHO              07/23/07 0342P   1   $75.90
( 2)    2 CSR HYPERBARIC OXYGEN CHAMBER 8" 07/23/07 0230P  1   $100.57
( 3)    3 CSR PORTABLE SUCTION MACHINE    07/24/07 0614P   1   $11.51

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
             end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

CO (DISPLAY ONLY)
This is the Charge Origin indicator. This field is used to document the source of a system generated charge or credit on an account. The indicator consists of two positions and displays the following codes:

Position 1:

    *   Created by the charge from/to link.

blankCreated by combine billing in midnight processing (Second position must be C, O, or B).

\# For Canadian clients, the system repriced a charge due to a financial class change on the account.

? Source is either from the charge from/to link or combined billing but the charge occurred prior to the conversion.

Position 2:

C Credit placed on the charge from account to cancel the charge.

B Baby charge placed on the charge to account.

O Non-baby charge (other) placed on the charge to account.

U Charge is uncombined. A credit is placed on the charge TO account to cancel the charge. The charge is placed on the charge FROM account.

Enter the number of the charge you want to see and press ENTER. The following screen is displayed.

```
                General Hospital Billing Information Processor
                                        Thu Aug 23, 2009 11:25 am
Account      Name               FC Typ Admit    Disch       Balance Loc
C04239-00002 CRANE, BB           O  I/P 08/26/04 01/19/07   399659.40 AR /ACCF
SIM: 77-10000 INCISION DRAINAGE 1 LESION               Serv: 01/22/08
Qty: 1                             Amt: $72.74       Post:   01/22/08 O/P

 1 Type of Unit                 2 Reference Facility          3 PA Edit

 4 Room/Bed  5 R&B Min   6 Accommodation        7 Charge Type 8 IDE
                                                              Ancillary
 9 Late Chg 10 Baby Chg 11 Fim Code  12 Statistics 13 Order#    14 Rev Dept
                      62516070     Yes          1            6251
15 UB Code                         16 HCPCS/Modifier          17 NDC
   270-Medical/Surgical Supplies
18 ICD-9 DX   19 ICD-10 DX  20 Charging Physician  21 Performing Physician
   001.0        123.45xA      501 TEST,ABC            2042 SILVA,MD ONE
22 ICD ABN/ABN      23 ABN Reason              24 Frequency Limit
   10/No     NOS-Patient Refused Signature
25 Conflicting HCPCS ~ Override                26 Take Home   27 Old Chg


28 From CRT 29 Initials 30 Reference
   DP         KEC
                 next screen(/) or prev. screen(/P) [/]
```

Field Explanations

SIM (DISPLAY ONLY)
This field contains the Service Item Master number and description.

SERV (DISPLAY ONLY)
This field contains the date and time the service was delivered.

QTY (DISPLAY ONLY)
This field contains the quantity of the item ordered and charged to the patient. If there is a pharmacy unit and the pharmacy department is RXf, where f is the facility, the billing quantity is displayed first, then a slash (/), and then the pharmacy quantity.The pharmacy National Drug Code information, if present, then follows in the following format:

Charge Billing Quantity (then a slash)

Pharmacy Quantity Used for Medicare Claims (then another slash)

Pharmacy NDC Quantity Used for Claims (then a space)

Pharmacy NDC Unit Qualifier for Pharmacy Quantity Used for Claims

For example: Qty: 1/6/123.456 UN

AMT (DISPLAY ONLY)
This field contains the amount of the credit or charge.

POST (DISPLAY ONLY)
This field contains the date on which the charge was posted to the patient account followed by the patient type that is stored in the charge. This patient type may be different from the one displayed in the account header because of patient type changes. The patient type displayed here is used to split the charge out on split claims that are split by patient type.

1.   TYPE OF UNIT (DISPLAY ONLY)
This field contains the type of unit on which the patient is located (if the patient was occupying a bed when the item was charged).

2.   REFERENCE FACILITY (DISPLAY ONLY)
The code and description for the reference facility are displayed from the Reference Facility Table in STAR Patient Processing.

3.   PA EDIT (DISPLAY ONLY)
Yes is displayed in this field If changes were made to HCPCS, HCPCS Modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/Compre/Comp HCPCS in the STAR Financials Patient Accounting charge data.

4.   ROOM/BED (DISPLAY ONLY)
This field contains the patient's room number and bed number.

5.   R&B MINUTES (DISPLAY ONLY)
This field displays the room and board minutes for timed (not daily) room and bed charges only.

6. ACCOMMODATION (DISPLAY ONLY)
This field contains the patient's room type.

7. CHARGE TYPE (DISPLAY ONLY)
This field contains the charge type. Valid charge types are room and bed, ancillary, or professional fee.

8. IDE (DISPLAY ONLY)
This field displays the Investigational Device Exemption code for the charge from the Financial Item Master.

9. LATE CHARGE (DISPLAY ONLY)
This field contains Yes if the charge is a late charge. A late charge is one entered on an account after the final bill has been generated.

10. BABY CHARGE (DISPLAY ONLY)
This field will contain Yes if this charge is for a newborn.

11. FIM CODE (DISPLAY ONLY)
This field contains the Financial Item Master number from the charge.

12. STATISTICS (DISPLAY ONLY)
This field indicates (either Yes or No) whether the charge updates statistics.

13. ORDER # (DISPLAY ONLY)
This field contains the order number for this item charged to the patient.

14. REV DEPT (DISPLAY ONLY)
The revenue department code for the charge is displayed in this field if changes were made to HCPCS, HCPCS Modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/Compre/Comp HCPCS in the STAR Patient Accounting charge data,

15. UB CODE (DISPLAY ONLY)
This field contains the UB code associated with the item charged to the patient.

16. HCPCS/ MODIFIER (DISPLAY ONLY)
This field contains the HCPCS procedure code along with any modifiers from the charge.

17. NDC (DISPLAY ONLY)
This field displays the National Drug Code (NDC) without the dashes. This code comes from STAR Pharmacy or STAR Order Management.

18. ICD-9 DX (DISPLAY ONLY)
This field displays any ICD-9 Ordering Diagnosis for the charge.

19. ICD-10 DX (DISPLAY ONLY)
This field displays any ICD-10 Ordering Diagnosis for the charge.

20. CHARGING PHYSICIAN (DISPLAY ONLY)
This field contains the name and number of the physician who charged this item.

21. PERFORMING PHYSICIAN (DISPLAY ONLY)
This field contains the name and number of the performing physician on the professional fee charge record.

22. ICD/ABN/ABN (DISPLAY ONLY)
This field displays data entered in STAR Patient Care. It indicates whether an Advanced Beneficiary Notification (ABN) form is necessary, based upon the patient type, plan, patient's diagnosis, and procedure code. The field displays either 9 for ICD-9 or 10 for ICD-10, and indicates which version of the Diagnosis was used for ABN processing. Note that if the account collects both ICD-9 and ICD-10 diagnosis codes, the ICD-10 diagnosis codes are always used for ABN processing.This field may be blank. The field displays one of the following where FQ is Frequency and SP is Self Pay:

Blank, 9/App, 10/App, 9/Yes, 10/Yes, 9/No, 10/No, 9/FQ/Y, 10/FQ/Y, 9/FQ/N, 10/FQ/N, 9/SP/Y, 10/SP/Y, 9/SP/N, 10/SP/N, 9/SP/FQ/Y, 10/SP/FQ/Y, 9/SP/FQ/N, 10/SP/FQ/N

The following are descriptions of possible values in addition to the ICD version:

Yes	An ABN is required and has been printed and signed by the patient for this charge.
No	An ABN is required and has *not* been printed and signed by the patient for this charge; an override reason has been entered instead of a signed ABN form.
App	An ABN is not required—The SIM item ordered has an approved diagnosis or approved diagnoses have not been defined for this procedure in the STAR Medical Records HCPCS Table.
FQ/Y	The charge has a frequency limit and an ABN was signed.
FQ/N	The charge has a frequency limit and an ABN was not signed.
SP/Y	The charge is self pay and an ABN was signed.
SP/N	The charge is self pay and an ABN was not signed
SP/FQ/Y	The charge is self pay, has a frequency limit, and an ABN was signed.
SP/FQ/N	The charge is self pay, has a frequency limit, and an ABN was not signed.

In the event of a Late Charge and the account is for an outpatient with a CMS Compliant plan, this field defaults to No.

Charges with ABN flags can be defined in the UB Charge Control Parameters to print in the non-covered column of the UB claim form. If a HCPCS modifier or modifiers have been defined in the STAR Patient Care SIM Department Table in Table Maintenance, this modifier is appended to the HCPCS procedure code in STAR Patient Care and printed on the appropriate claim form.

23. ABN REASON (DISPLAY ONLY)
This field displays the ABN Reason from the ABN Modifier and Reason Table in STAR Patient Processing if the ABN field contains any of the following:

- Yes (ABN Signed)

- No (ABN Not Signed)

- FQ/Y (Frequency limit and ABN signed)

- FQ/N (Frequency limit and ABN not signed)

- SP/Y (Self Pay ABN Signed)

- SP/N (Self Pay ABN Not Signed)

- SP/FQ/Y (Self Pay Frequency Limit and ABN Signed)

- SP/FQ/N (Self Pay Frequency Limit and ABN Not Signed)

The ABN Reason indicates one of the following:

1.) Why the ABN was not signed if the test was not determined to be medically necessary based on the ICD diagnostic codes defined in the STAR Medical Records HCPCS Table (ABN=No, or ABN=SP/N) or there is a frequency limit for the service and the ABN was not signed (ABN=FQ/N or ABN=SP/FQ/N).

2.) Why the ABN was needed and signed if the test was not determined to be medically necessary based on the ICD diagnostic codes defined in the STAR Medical Records HCPCS Table (ABN=Yes, or ABN=SP/Y) or there is a frequency limit for the service and the ABN was signed (ABN=FQ/Y or ABN=SP/FQ/Y).

In the event of a Late Charge, this field automatically defaults to the freeform text override reason Late Charge - Patient not avail.

If the ABN field or the Ordering Diagnosis field is edited while the charge is still active on STAR Patient Care, the system updates the STAR Patient Accounting charge record.

24. FREQUENCY LIMIT (DISPLAY ONLY)
This field displays the frequency limit associated with the HCPCS procedure. The field is displayed from the Medical Records HCPCS table in STAR Patient Care.

25. CONFLICTING HCPCS ~ OVERRIDE (DISPLAY ONLY)
This field displays four pieces of information.

The first piece of data displays the type of conflict if one exists for this charge. Valid options are Dup, Excl, Compt (Component), or Comph (Comprehensive). If the type of conflict is Dup, the third piece of information does not appear, as it is redundant.

The second piece of information displays **Yes** if a conflict exists for this charge and the conflict was determined to be medically necessary. A *No* displays if a conflict exists for this charge and the conflict was determined to not be medically necessary. A null displays if no conflict was found for this charge.

The third piece of information included in the display is the conflicting HCPCS code if one has been entered.

After the last piece of data has been displayed the screen displays a tilde (~) followed by the HCPCS Override reason if one exists.

26. TAKE HOME? (DISPLAY ONLY)
This field displays data entered in STAR Pharmacy. It indicates whether an item was designated as a take home medication at the time the charge was entered.

If a charge is received that has the take home indicator set to Yes, then the UB Revenue Code is changed on the charge to the user-defined revenue code specific to take home medications. This revenue code may be defined as non-covered in the insurance plan, thus causing it to appear in the non-covered column of the UB claim form.

27. OLD CHGS (DISPLAY ONLY)
This field can contain one of the following values relating to a charge on the Unbilled Charge Worklist:

- Y Unbilled Chg

- U User requested reversal

- P User requested reversal via master charge

- R Reversal of unbilled charge

- G Reversal of unbilled charge with changed GL keys

- M User requested removal of charge from worklist

- X User requested removal via master charge

28. FROM CRT (DISPLAY ONLY)
This field contains the code for the CRT on which the charge was entered.

29. INITIALS (DISPLAY ONLY)
This field contains the initials of the person who entered the charge.

30. REFERENCE (DISPLAY ONLY)
This field contains the charge reference account number and patient name if the charge was used for combined billing. For charges generated at the time the accounts are combined for billing, this field displays the following on the "to" account:

Comb From: A9999999999

For the off-setting credit placed on the "from" account, this field displays:

Comb To: A9999999999

For charges generated by the charge from/to link, this field displays:

Chg From: A9999999999 Patient Name

For charges that are uncombined as a result of unlinking, this field displays the following:

Uncomb From: A9999999999

For DRG Payment Window (DPW) charges, this field displays DPW followed by the DPW status of the charge and the account number for the DPW pair. For example,

DPW Transfer: A9999999999

DPW charge statuses are Pending, Not Adm Related, Report, Not Transferred, Excluded, Return from IP, Transfer from OP, Transfer, Reversal, and Return.

This field remains blank on all other charges.

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SUMMARY BILLING INFORMATION

To view summary billing information, enter **S** on the Billing Information screen. The following screen is displayed:

```
            General Hospital Billing Information Processor
                                        Wed May 03, 2009 08:03 pm
1 Bill Seq   2 Bill Date   3 Bill Type   4 From Bill Date  5 To Bill Date
   2           01/28/09      Adjustment     01/23/09         01/23/09
 6 Selection           7 Payments        8 Adjustments    9 Amount Billed
   Instant Adj Bill       $0.00           $0.00             $893.27
10 Charge/CR Amount 11 Adj By 12 Adj Bill 13 Biller
   $893.27              1                  520-Dudley,Doright
14 Insurances Loading Claims
   300100 300200 100200 500300
15 Biller Group       16 Final DRG      17 Stay Outl 18 Cost Outl 19 Bill ICD
   1-BILLING GROUP       756/A/26.1                                ICD-9


Page:01                        Bill Summary
    UB Description              UOS Qty        Amount  ProSum AC      Rate
( 1) 740   EEG                   2   2       $589.36   740
( 2) 750   Gastro-Intestinal Services  1   1  $269.33  740
( 3) 986   Professional Fees EEG   1   1       $34.58  980

Enter choice--
```

For each Summary Category, the following information is displayed: the UB Code, Description, Units of Service, Amount, Proration Summary Code, Accommodation Code (for room charges), and Rate per room (for room charges). If a summary category is selected, the detail charges are displayed.

Once a Bill is selected, the Bill ICD field displays that bill's ICD indicator, either ICD-9 or ICD-10, at the time the bill loaded. This is determined by the Billing Parameter's ICD-10 Effective Date setting, and if blank, on the Hospital USA ICD-10 Effective Date, any Insurance Plan, Insurance Carrier, or Financial Class Exceptions, and on the patient's admission date.

NOTE: Charges for the Final Bill or a previous Adjustment Bill are still displayed after an Adjustment Bill has been produced.

BILLING RECAP INFORMATION

To view billing recap information, enter B on the Billing Information screen. The system displays the first of two screens:

```
         General Hospital Billing Information Processor
                                     Fri Mar 10, 2006 12:36 pm
Account       Name              FC Typ Admit    Disch       Balance Loc
A9623500042   JONES,MARY        M  LIC 09/05/96 09/06/96    3137.60 AR/FCRV
                      X/117-007  B/117-009   X/117-005  X/117-005 **
              Bill/    X/500-700
BS     BT    Unbill    Payment
Fr/Dt To/Dt  Amount     Adjust                                   Rem Bal
1      C      5.00       0.00                                        6.00
03/17 03/17   6.63-      0.00
2      C     20.00       0.00                                       22.00
03/18 03/21              0.00
4/2    Z     20.00       0.00                                        0.00
03/18 03/21              0.00
6/2    Z     36.63       0.00                                        0.00
03/18 03/21              0.00
8/2    Z     36.63       0.00                                        0.00
03/18 03/21              0.00
10/2   Z     36.63       0.00                                        0.00
03/18 03/21              0.00
12/2   Z     36.63       0.00                                        0.00
03/18 03/21              0.00




         F1Prev Page F2Next Page F5View Totals F7  Exit
```

For each bill sequence, the system displays the net insurance payment and insurance adjustment per COB. Zero dollar bill sequences are not displayed on the billing recap screen. Carrier totals and patient payments, adjustments, and refunds (which are not bill-specific) display on the second screen. If there are no insurances on the account, the system proceeds directly to the second screen.

Payment and adjustments per claim sequence are maintained in the Claim Audit Carrier Specific Record. The bill sequence is contained in the Claim Audit Generic Information record. Some carrier payment and adjustment totals by bill sequence will be the sum of multiple claim sequences. For example, if 1500's are split by physician multiple 1500's may be produced for the same bill sequence/COB combination.

Field Explanations

COB/INSURANCE PLAN # (DISPLAY ONLY)
This field displays the current insurance plans assigned to the account, in COB order. Plans that have been deleted do not display. The claim type (such as B-1500) is displayed preceding the carrier/plan number.

NOTE: Only the first four insurances are displayed.

BS (DISPLAY ONLY)
This field displays the bill sequence number.

FR/DT (DISPLAY ONLY)
The field displays the service from date for this bill sequence number.

BT (DISPLAY ONLY)
This field displays the bill type: C (Cycle), F (Final), A (Adjustment), L (Late), or Z
(Cycle Adjustment Bill).

TO/DT (DISPLAY ONLY)
This field displays the service through date for this bill sequence number.

BILL/UNBILL AMOUNT (DISPLAY ONLY)
This field displays the total billed and unbilled charges for the specified bill sequence;
the value displayed is not cumulative. For example, if the first bill sequence had a $35
x-ray charge, this field displays $35. If the second bill sequence had a $20 lab charge,
this field displays $20. This field would not display the sum of the charges ($55). If a
final bill was replaced by an adjustment bill which included late charges, the billed
charges for the adjustment bill would equal the final bill charges plus any late charges.
This figure coincides with the actual charges included on the bill.

PAYMENT (DISPLAY ONLY)
This field contains the insurance payment received from this carrier for the specified
bill sequence. The system assumes payments are credits and displays a minus sign
next to the payment only in the event of a debit payment.

ADJUST (DISPLAY ONLY)
This field contains the insurance adjustment received from this carrier for the specified
bill sequence. For credit adjustments, the system displays a minus sign following the
amount.

REM BAL (DISPLAY ONLY)
This field contains the amount remaining for the bill sequence number. This field
includes information from COB'S five through nine even though they are not displayed
on this screen.

At the bottom of the screen, the system displays the following function keys for you to
use while viewing this screen:

F1 Prev Page
This function key pages backwards through bill sequences.

F2 Next Page
This function key pages forward through bill sequences.

F5 View Totals
This function key displays the second screen of the function.

If the account has more than four insurances when the F5 View Totals function key is
selected, the system displays the following prompt:

Select Bill Seq to display or press NL to view Totals --

Enter any valid bill seq number for the account or press ENTER to view payment and adjustment information for all nine insurances.

F7 Exit
This function key returns you to the Billing Summary screen.

When you finish viewing the contents of this screen, press F5. If you press ENTER, the Totals screen is displayed. The system displays the second screen of this function:

```
                 General Hospital Billing Information Processor
                                              Fri Mar 10, 2006 12:36 pm
 Account        Name                  FC Typ Admit    Disch       Balance Loc
 A9623500042  JONES,MARY              M  LIC 09/05/96 09/06/96    3572.60 AR/FCRV
                          X/117-007  B/117-009  X/117-005  X/117-005 **
 Ins totals:
  Payments                  0.00         0.00       0.00      10.00
  Adjust                    0.00         0.00       0.00    1563.35
  Refund                  400.00         0.00       0.00       0.00
  Bal Trf                 600.46-        0.00       0.00    1466.51
  Balance                  93.62-        0.00     106.84    3126.70


 Patient totals:
  Payments                  0.00
  Adjust                    0.00
  Refund                   35.00
  Bal Trf/TPX             866.05-         0.00
  Balance                  35.00

 Unbilled Amt               0.00




 Press NL
```

Field Explanations

Insurance Totals

This portion of the screen displays totals for the insurance carrier/plan. This information is stored in the Balances/Totals for Insurance record.

PAYMENTS (DISPLAY ONLY)
This field displays the total payment received from the insurance carrier for this account. The system assumes payments are credits and displays a minus sign next to the payment only in the event of a debit payment.

ADJUST (DISPLAY ONLY)
This field displays the total adjustment amount posted for the insurance carrier for this account.

REFUND (DISPLAY ONLY)
This field displays the amount of the insurance refund credited.

BAL TRF (DISPLAY ONLY)
This field displays the total of any amounts transferred to or from this insurance.
Balance transfers can be posted to or from another carrier/plan or patient.

BALANCE (DISPLAY ONLY)
This field displays the current balance for each insurance.

Patient Totals

This portion of the screen displays totals for the patient. This data is stored in the
Balances/Totals for Account and Patient record.

PAYMENTS (DISPLAY ONLY)
This field displays the total payment received from the patient for this account.

ADJUST (DISPLAY ONLY)
This field displays the total adjustment posted for the patient for this account.

REFUND (DISPLAY ONLY)
This field displays the amount of any patient refund credited.

BAL TRF/TPX (DISPLAY ONLY)
This field displays the total of any amounts transferred to or from the patient. Balance
transfers can be posted to or from insurances. If applicable, the third party excess
amount is displayed in the next column. Third party excess occurs when insurances
are not prorated. For example, if a patient has two insurance plans which are not
prorated, the liability for both insurance plans will display the total charges due. The
offset is displayed as Third Party Excess.

BALANCE (DISPLAY ONLY)
This field displays the current balance for the patient.

UNBILLED AMOUNT (DISPLAY ONLY)
This field displays the amount of unbilled charges.

UNBILLED CHARGES INFORMATION

To view unbilled charges, enter **U** on the Billing Information screen. Charges and
credits are displayed by the associated bill period and bill sequence number. The
option to access this screen is only available if there are outstanding unbilled amounts
for any bill associated with an account. This screen can be used to assist you in

identifying detail charges/credits that need to be rebilled. Only unbilled charges and credits are displayed on the following screen:

```
                    General Hospital Billing Information Processor
                                            Mon Apr 10, 2006 01:44 pm
Account      Name                    FC Type Admit    Disch       Balance Loc
A06097-00001 TATE, JOE              PK  SER 04/01/06 04/07/06   $330.59-PA
Bill Period-Sequence for Unbilled Amount
Srv Date  Qty  UB Dpt  SIM Code and Description             ABN     Amount
      HCPCS Description                 HCPCS/Mod     HCPCS Conflict
04/01/06-04/01/06 BS 6/1
   04/01   1   270 CSR   6070 CONNECTOR, "Y"------------------         $5.00

04/02/06-04/02/06 BS 7/2
   04/02  -1   730 CAR     98 HOLTER MONITOR/WMC                    $125.00-
          CARDIOVASCULAR STRESS TEST         93015

04/05/06-04/07/06 BS 10/5
   04/07  -1   730 CAR   1100 ECG 12 LEAD---------------------      $109.50-
          CARDIOVASCULAR STRESS TEST         93015
   04/07  -1   985 CAR   1104 ECG PROFESSIONAL FEE                   $16.09-
          ELECTROCARDIOGRAM REPORT           93010



Press NL--
```

Field Explanations

ACCOUNT (DISPLAY ONLY)
This field displays the account number for the patient.

NAME (DISPLAY ONLY)
The field displays the name of the patient.

FC (DISPLAY ONLY)
This field displays the financial class associated with the patient.

TYPE (DISPLAY ONLY)
This field displays the patient type associated with the patient.

ADMIT (DISPLAY ONLY)
This field displays the admission date for the patient.

DISCH (DISPLAY ONLY)
This field displays the discharge date for the patient.

BALANCE (DISPLAY ONLY)
This field displays the account balance for the patient.

LOC (DISPLAY ONLY)
This field displays the account location for the patient.

BILL PERIOD-SEQUENCE FOR UNBILLED AMOUNT (DISPLAY ONLY)
This field displays the bill from and through period for the unbilled amount in MM/DD/YY format and the bill sequence associated with the unbilled amount. The bill sequence displays the most recent bill sequence number followed by the original bill sequence number delimited by a forward slash. For example, BS 3/1 would display if three was the most recent bill sequence for the bill and one was the original bill sequence.

SRV (SERVICE) DATE (DISPLAY ONLY)
This field displays the date the service was delivered.

QTY (DISPLAY ONLY)
This field displays the quantity of the item ordered for which the patient is charged.

UB (DISPLAY ONLY)
This field displays the UB code related to this visit.

DPT (DISPLAY ONLY)
This field displays the department where the service was rendered.

SIM CODE AND DESCRIPTION (DISPLAY ONLY)
This field displays the Service Item Master number and description.

ABN (DISPLAY ONLY)
This field displays data entered in STAR Patient Care. It indicates whether an Advanced Beneficiary Notification (ABN) form is necessary, based upon the patient type, plan, patient's diagnosis, and procedure code. This field may be blank or contain one of the following:

- Yes - An ABN is required and has been printed and signed by the patient for this charge.

- No - An ABN is required and has not been printed and signed by the patient for this charge; an override reason has been entered instead of a signed ABN form.

- App - An ABN is not required. The SIM item ordered has an approved diagnosis or approved diagnoses have not been defined for this procedure in the STAR Medical Records HCPCS Table.

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

HCPCS DESCRIPTION (DISPLAY ONLY)
This field contains the HCPCS description.

HCPCS/MOD (DISPLAY ONLY)
This field contains the HCPCS modifier (if present) associated with the charge.

HCPCS CONFLICT (DISPLAY ONLY)
If a HCPCS conflict has been identified, this field displays the type of conflict, the CCE
Modifier Indicator of Yes or No, and the HCPCS code that is identified as the conflict.
Valid types of conflicts are:

- Dup (Duplicate)—Duplicate HCPCS charge

- Excl (Exclusive)—Mutually exclusive with a previous charge

- Comph (Comprehensive)—Comprehensive of a previous charge

- Compt (Component)—Component of a previous charge

BILLING TOTALS

This function enables you to review totals for bills. It includes both insurance and self
pay accounts. The Billing Totals option is similar to the billing recap option, but this
option displays only the most recent bill and associated totals for payments and
adjustments for all bills for the billing period. On the Billing Recap screen, all of the bills
and the totals are included for each bill, whereas the Billing Totals screen summarizes
the payments, adjustments and other information across all bills for the associated
billing period. For example, if you had a cycle bill and then did a rebill on it, only the
most recent bill would display with the associated totals from both bills.

When this option is selected, the system displays the following screen:

```
                General Hospital Billing Information Processor
                                          Thu Jun 01, 2006 11:36 am
Account      Name                FC Typ Admit    Disch      Balance  Loc
A0611800002  BALES, AARON        O  SER 04/25/06 04/28/06     95.46  AR
             Bill/   X/918-100   B/500-200
BS     BT    Unbill     Payment     Payment
Fr/Dt To/Dt  Amount     Adjust      Adjust                            Rem Bal
11/1   Z     105.57       0.00        0.00                             83.46
04/25 04/25    0.00      22.11-       0.00
12/2   A      15.00       0.00        0.00                             12.00
04/26 04/28    0.00       3.00-       0.00
```

Field Explanations

ACCOUNT (DISPLAY ONLY)
This field displays the account number for the patient.

NAME (DISPLAY ONLY)
The field displays the name of the patient.

FC (DISPLAY ONLY)
This field displays the financial class associated with the patient.

TYPE (DISPLAY ONLY)
This field displays the patient type associated with the patient.

ADMIT (DISPLAY ONLY)
This field displays the admission date for the patient.

DISCH (DISPLAY ONLY)
This field displays the discharge date for the patient.

BALANCE (DISPLAY ONLY)
This field displays the account balance for the patient.

LOC (DISPLAY ONLY)
This field displays the account location for the patient.

BS (DISPLAY ONLY)
This field displays the most recent bill sequence number and the original bill's sequence number.

BT (DISPLAY ONLY)
This field displays the bill type associated with the bill. The bill types are:

- C for Cycle.

- Z for Cycle Adjustment

- F for Final.

- A for Adjustment.

- L for Late.

BILL/UNBILL AMOUNT (DISPLAY ONLY)
This field displays the billed amount and any unbilled charges associated with the bill. For example, if cycle bill 1 was billed with total charges of $1000.00 and then another charge was entered for cycle bill one for $200.00, the billed charges would display $1000.00, and $200.00 of unbilled charges would display underneath the billed charges. An unbilled charge is associated with a bill sequence according to the bill from/through date.

FR/DT (DISPLAY ONLY)
The field displays the Service From date for this bill sequence number.

TO/DT (DISPLAY ONLY)
This field displays the Service To date for this bill sequence number.

PAYMENT ADJUST (DISPLAY ONLY)
This column displays the total payments and adjustments for the bill period for the associated insurance. All payments and adjustments for all associated bills for a billing period are included in the total. For example, bill sequence 1 had a $100.00 payment made to the associated claim. Next, a cycle adjustment bill was done that replaced bill sequence 1 with bill sequence 2. A $20.00 payment was applied to the claim associated with bill sequence 2. The amount that would display in the Payment field is $120.00, reflecting the payments associated with both bill sequence 1 and 2.

REM BAL
This column displays the total remaining balance for the associated bill. This field is calculated by taking the billed amount and subtracting all of the payments and adjustments.

Claim Information

This function enables you to view claim information such as claim status, claim carrier status, claim demographic/visit data, claim attachments, and claim charge data. Each transaction is available for viewing but screen information cannot be changed.

Canadian users should refer to the *Canadian Claims Processing Volume* of the STAR Financials Patient Accounting Reference Guide for detailed information about Canadian claim screens.

When this option is selected, the system displays the following screen:

```
                General Hospital Account Inquiry Processor
                                             Fri Mar 10, 2006 12:36 pm
Account       Name                FC Typ Admit    Disch       Balance   Loc
A98239-00001 RANIER,WANDA          M  I/P 06/12/01 06/12/01    174710.00 AR/FCRV


    Clm Adj   Bill     Bill    Clm   Prd Wk  OPPS Clm
    Seq Clm   From     Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
Page:01                              All Claims
( 1)  1     06/12/01 06/12/01 UB  NP   S   E    C  500700,MEDICARE


Enter choice or (I)ncomplete, (C)omplete, (L)ist All, or (O)ther --
                  next pg(/ or PG DN)  Search(TAB)
```

This screen displays the claims associated with the selected account. Information includes:

• Claim sequence number

• Whether this is an adjusted claim

• Bill from and through date

• Claim type (UB, 1500, or other)

• Production status (produced or not produced)

- Work status (forced, hold, fail, produced, manually released, etc.)

- OPPS Status—Q (Queued to 3M), A (3M Processed), E (3M Errors/No reim calc),
  B (Processed but 3M Errors), C (Not Queued due to errors), or L (Check 3M Log)

- Claim disposition

- Carrier/plan associated with the claim

- Whether or not the claim is shared with another carrier. An asterisk (*) indicates the
  claim is shared.

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 Claim (T)ype, (D)isp, (B)ill Dt, (S)ubm Dt, or (C)OB [D]--

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

```
                General Hospital Account Inquiry Processor
                                       Fri Mar 10, 2006 12:36 pm
Account        Name                FC Typ Admit    Disch       Balance   Loc
A98239-00001 RANIER,WANDA          M  I/P 08/27/98 08/30/99    174710.00 AR/FCRV


Page:01                            Claim Types           ##=Current Choices
( 1) A-MA 310                          (16) P-BC MSP
( 2) B-1500                            (17) Q-BC WORKER'S COMP ELEC
( 3) C-MA 319 PI                       (18) R-MEDI-CAL UB
( 4) D-MA 319 MS                       (19) S-BC WORKER'S COMP PAPER
( 5) E-MI1645                          (20) T-TI19
( 6) F-MI1649                          (21) U-UB
( 7) G-MI1500                          (22) V-BC Out of Prov.
( 8) H-MOH                             (23) W-WCB
( 9) I-MCLI                            (24) X-UB
(10) J-CA25-1                          (25) Y-CPBC
(11) K-UNV                             (26) Z-NON PRO FEE 1500
(12) L-2360
(13) M-MA 319 DENTAL FORM
(14) N-NJ MC19
(15) O-MCLO


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

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

```
                   General Hospital Account Inquiry Processor
                                            Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch      Balance   Loc
A98239-00001 RANIER,WANDA         M  I/P 08/27/98 08/30/99   174710.00 AR/FCRV

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




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

You 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 will be included in the list of claims on the account if the bill through date on the claim falls within the range of bill through dates specified.

If you select S, 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 will be 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.

If you enter the number of the claim you want to view and press ENTER, the system displays the following menu screen:

```
          General Hospital Claim Information Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch      Balance Loc
A92063-00003 HALL,THEODORE          M  I/P 06/12/01             78.50   PA/FCRV


    Clm Adj   Bill     Bill    Clm   Prd Wk  OPPS Clm
    Seq Clm   From     Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
     1        06/12/01 06/12/01 UB    NP   S   E    C  500700,MEDICARE

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



 Enter option number--
```

Each function is explained in the order shown on the screen.

CLAIM STATUS INFORMATION

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

When you select this option, the following screen is displayed. After you complete your review, press ENTER to return to the previous screen.

```
                 General Hospital Claims Processor
                                         Tue Jun 23, 2009 04:21 pm
Account       Name                FC Typ Admit    Disch       Balance Loc
C0915900001   TEST,ICDTEN          O  O/P 06/08/09 06/08/09      661.77 AR /ACCF
 1 Bill Sq    2 Clm Sq  3 Claim Type  4 Claim Format  5 Load/Edit Parameter
   1            1        X UB          UB04            99 COMMERCIAL ICD10 OUT
 6 Bill Date  7 Bill From   8 Bill Through 9 ICD    10 Chg Control Parameter
   06/08/09     06/08/09      06/08/09       ICD-10   99 COMMERCIAL ICD10 OUT
11 Biller                        12 Last System Edit Date
   520 - Dudley,Doright              06/08/09 16:16
13 Last Editing User             14 Last User Edit Date/Time

15 Edit Failures 16 Claim Production Status   17 ASB/Crossover Link
               P Produced

18 Claim Work Status      19 Claim Amount   20 Archive Date  21 Purge Date
   R Released                 $661.77
22 Prod/Supp Claim?  23 Electronic Media   24 Claim Split Indicator
   Yes/No                                   Primary
25 Alternate Provider Master              26 Payor Claim ID 27 CA UB



Press NL--
```

Field Explanations

1.   BILL SEQ # (DISPLAY ONLY)
This field contains the system-assigned number identifying the bill associated with this claim. For example, if this patient has three cycle bills, their sequence numbers would be bill #1, bill #2, and bill #3 (with 1 being the first cycle, 2 being the second cycle, etc.).

2.   CLAIM SEQ # (DISPLAY ONLY)
This field contains the system-assigned number identifying this claim. For example, if an account has three claims associated with it, their sequence numbers, would be claim #1, claim #2, and claim #3 (with 1 being the first cycle, 2 being the second cycle, etc.).

3.   CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type code and description. Some examples of claim types are B (1500) and X (UB).

4.   CLAIM FORMAT (DISPLAY ONLY)
This field contains the claim's format: UB92 or UB04.

5. LOAD/EDIT PARAMETER (DISPLAY ONLY)
This field contains the claim load and edit parameter code and description used for this claim. The claim load and edit parameters indicate how the claim data will print and edit.

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

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

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

9. ICD (DISPLAY ONLY)
This field displays either a *ICD-9* if ICD-9 diagnosis and procedure codes were loaded to the claim, or a *ICD-10* if ICD-10 diagnosis and procedure codes were loaded to the claim. Which code sets load is determined by the ICD-10 Effective Date field on the Claim Load Edit Parameter, and the Admission Date or Discharge Date of the patient. If the ICD-10 Effective Date field on the Claim Load Edit Parameter is blank, the system determines which code set loads to the claim based on the USA ICD-10 Effective Date field on STAR Patient Processing, and on any Insurance Plan, Insurance Carrier, or Financial Class exceptions. The ICD flag is set for the claim at time of Claim Load, and does not change for the life of the claim. Therefore, if the ICD-10 Effective Date field is updated on the Claim Load Edit Parameter, this does not update the ICD flag of previously loaded claims.

10. CHG CONTROL PARAMETER (DISPLAY ONLY)
This field contains the charge control parameter code and description used for the claim. The charge control parameters are assigned through the Insurance Plan Coverage Master file.

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

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

- The biller enters a new date on the claim.

- A payment is made on a primary carrier and secondary carriers are waiting for payment.

- The reload option is used.

Failed claims are edited during midnight processing based on the optional batch job Claim Reload.

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

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

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

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

17. ASB/ CROSSOVER LINK (DISPLAY ONLY)
This field displays the COB, the Claim Sequence (CS), and the Claim Split Indicator, if splits are defined, for any ASB (Accelerated Secondary Billing) link set on the secondary (COB 2-9) insurance in the Insurance Coverage Table. The ASB/Crossover Link points forward from the COB 1 claim to the Next Highest UB linked claim, and it also points backward from this Next Highest UB claim to the linked COB 1 claim. For example, if the Next Highest UB plan was COB 3, and this loaded a Primary and a Mammography claim, if the Primary claim for COB 3 was claim sequence 4, this may point back to COB 1 CS 1 Primary. The same field, when looking at claim sequence 1 would point forward to COB 3 CS 4 Primary.

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

19. CLAIM AMOUNT (DISPLAY ONLY)
This field contains the amount of this claim. This figure represents the amount of charges included on the claim.

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

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

22. PROD/SUPP CLAIM (DISPLAY ONLY)

This field indicates whether a claim should be produced, either electronically or as a printed paper claim. Entry options are Y for Yes or N for No; the default is Y. If this field contains Y, the claim will be spooled to the appropriate spoolfile (paper or electronic) when it is released. If this field contains N, the claim will not be spooled when the claim is released. Copies of suppressed claims can always be generated using the Reprint Claims function.

23. ELECTRONIC MEDIA (DISPLAY ONLY)

This field indicates how the claim is transmitted to the carrier. 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), or T (electronic media T, formerly magnetic tape). An entry in this field will cause the system to put the claim in a separate file for electronic submission when it is released. The Claim Load and Edit parameter for the claim must also be set up to send claims electronically in the Claim Media and Electronic Types field.

24. CLAIM SPLIT INDICATOR (DISPLAY ONLY)

This field displays the physician or the department the claim is for with a CMS 1500 claim, and the physician the claim is for with a Pennsylvania MA319 Physician Invoice claim. This field displays the department the claim is for with a Non Professional Fee 1500 claim or a New York Title XIX claim when split by department. If not split by department, this field is blank. The field displays either the type of service or physician number and name if this is an Illinois 2360 claim. If not split by Type of Service or Physician, this field is blank. This field displays either an O# or S#, where # represents a number and represents speech, and O represents occupational therapy, if this is an Illinois 1443 claim type.

For UB claims, this field displays either the Split Claim name from the UB Split Claims Criteria Table or the word Primary, for the primary claim, or is blank when not spitting UB claims. If the split claim criteria include splitting by date, the service date follows the Split Claim Name. If the claim was added with the Add Claim to Insurance function, the sequence number follows the Split Claim name.

The following are examples:

- Split claim, not split by service date: VACCINE

- Split claim, not split by service date, added with the Add Claim to Insurance function: VACCINE2

- Primary claim: PRIMARY

- Primary claim added with the Add Claim to Insurance function: PRIMARY1

- Split claim, split by service date, where CAH is the Split Name: CAH 05/03/05

•   Split claim, split by service date, where CAH is the Split Name, added with the Add Claim to Insurance function: CAH7 05/03/05

25. ALTERNATE PROVIDER MASTER (DISPLAY ONLY)

This field contains the alternate Provider Master that is used for this split claim.

26. PAYOR CLAIM ID (DISPLAY ONLY)

This field displays the Payor Claim ID for the claim, which is the Facility Indicator + Account Number + Original Claim Sequence Number. UB claims must be set to use the Internal Element *Payor Claim ID* (FACILITY + ACCT + ORIG CLM#) in Locator 3 of the Claim Load Edit Parameter for Patient Control Number. 1500 claims must be set to use Internal Element *Payor Claim ID* (FACILITY + ACCT + ORIG CLM#) in Locator 26 of the Claim Load Edit Parameter for Patient Account Number.

27. CA UB (DISPLAY ONLY)

This field represents California (Medicaid) UB. If the CA UB field in the UB Charge Control Parameter used to load the claim is set to Yes, then Yes is displayed in this field. If the CA Modifier Table is set in the UB Charge Control Parameter used to load the claim, the field displays YES, a dash, and the table number for the California Modifier Table.

CARRIER STATUS INFORMATION

This function enables you to review basic claim information relating to the carrier(s) associated with this claim. If this is a shared claim, the system prompts you to select a carrier to review. If this is not a shared claim, the following screen is bypassed and you are taken directly to the next screen. After you select this option, the system displays the following screen:

```
              General Hospital Claims Processor
                                          Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit   Disch        Balance Loc
A89305-00001 SMITH,JERRY A        WC O/P 04/05/90 04/05/90     4239.50 AR/FCRV

   COB      Carriers                                           Page:01
( 1) 1  152998 ABC RISK MGMT/W.C.
( 2) 2  150998 BLUE CROSS









     Enter choice--
```

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

```
                General Hospital Claims Processor
                                                Fri Mar 10, 2006 12:36 pm
Account      Name                    FC Typ Admit    Disch       Balance Loc
A89305-00001 SMITH,JERRY A           WC O/P 04/05/94 04/05/94    4239.50 AR/FCRV

             COB: 6  Carrier/Plan: 152998 ABC RISK MGMT/W.C.
   Attn: Claims Department                       Phone: (987) 123-4567
Mail To: ABC RISK MGMT/W.C.
         1500 MAIN ST, STE 900
         ATLANTA, GA 30001

  1 Claim Type      2 Claim Loaded     3 Claim Generated  4 Est Amount Due
    X UB            04/10/94                              $4,239.50
  5 Payment Amount  6 First Payment    7 Last Payment     8 Adjustment Amt

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

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



 Press NL--
```

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

Field Explanations

1. CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type code and description. Some examples of claim
types are B (1500) and X (UB).

2. CLAIM LOADED (DISPLAY ONLY)
This field contains the date on which this claim was loaded in the claim system.

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

4. EST AMOUNT DUE (DISPLAY ONLY)
This field contains the estimated amount due from the carrier for this claim. This
amount is the result of the proration process.

5. PAYMENT AMOUNT (DISPLAY ONLY)
This field contains the amount of payments received for this claim from the carrier. If
no carrier payments have been received for this claim, this field is blank.

6. FIRST PAYMENT (DISPLAY ONLY)
This field contains the date of the first payment received from the carrier for this claim. If no payment has been received, this field is blank.

7. LAST PAYMENT (DISPLAY ONLY)
This field contains the date of the most recent payment received from the carrier for this claim. If no payment has been received, this field is blank.

8. ADJUSTMENT AMT (DISPLAY ONLY)
This field contains the amount of any adjustments to this claim. If there are no adjustments, this field is blank.

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

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

11. EXT CLAIM # (DISPLAY ONLY)
This field contains a number assigned by the carrier which identifies this claim. If this information was entered on the patient's insurance demographic screen, it will be displayed here. This field can be used to store a number issued to this claim by the carrier.

12. CLAIM SUBMITTED (DISPLAY ONLY)
This field contains the date on which the claim was submitted to the carrier, entered in the format MMDDYY or MM/DD/YY. If the claim has not been submitted, this field is blank. Electronic claims are automatically marked as submitted when they spool to the electronic spool file.

13. PAID IN FULL (DISPLAY ONLY)
This field indicates whether this claim has been paid in full. Entry options are Y for Yes or N for No. If the claim is final dispositioned (final payment, adjusted to zero, or denied), this field contains Y. If a partial or no payment has been posted, this field is blank. Claims that have been final dispositioned are not included in insurance follow-up.

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

15. CLAIM DISPOSITION (DISPLAY ONLY)
This field 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.

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

CLAIM DEMOGRAPHIC/VISIT DATA

This function enables you to view the completed claim form for each claim generated for this account. The claim forms available include the UB, 1500, and/or state-related forms used by your hospital.

The form is presented in a series of screens whose length and content is determined by how your hospital has adjusted the associated claim form for its use. For more information, refer to Claim Load and Edit Parameters in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide.

You can choose to view only those screens containing errors made in completing the form or all screens making up the form. If you select to view the error screens only, they display in form-locator order and are numbered based on the total number of screens containing errors for this form. For example, if the claim selected was submitted on a UB claim form and contained errors on the third and fifth screen of the UB form as your hospital defines it, viewing error screens only would result in these two screens being numbered screen one and screen two for this transaction.

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

```
              General Hospital Claims by Account Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name               FC Typ Admit    Disch       Balance  Loc
89242-00002  CURNANE,JOHN M      C  I/P 04/30/92 05/01/92    6507.00- AR/FCRV

Page:01                                               ##=Current Choices
    From Field                      Thru Field                     Errors
( 1) 1-Provider Name                4-Type of Bill - Third Digit
( 2) 5-BC/BS Provider Name          11-Patient's Street 2
( 3) 12-Patient's Birthdate         22-Statement From Date
( 4) 22-Statement Through Date      30-Occurrence Code 3
( 5) 30-Occurrence Date 3           34-Guarantor Address        Yes
( 6) 34-Guarantor City              40-Blood Not Replaced
( 7) 40-Blood Deductible            47-Value Code 6
( 8) 47-Value Code 6 Amount         57-Insurance COB 1
( 9) 57-Insurance COB 2             60-Deductible - COB 2
(10) 60-Deductible - COB 3          63-Prior Payments - COB 1
(11) 63-Prior Payments - COB 2      65-Insured's Name - COB 2   Yes
(12) 65-Insured's Name - COB 3      68-CERT/SSN/HIC/ID No. - COB 2
(13) 68-CERT/SSN/HIC/ID No. - COB 3 74-EID - COB 2
(14) 72-Employments Status Code - COB 1 76-Principal Diagnosis Desc

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

This screen displays the names of the fields of information and their form locator for each screen of claim information. Note that there may be multiple fields for the same form locator. For example, in the screen the Statement From Date and the Statement Through Date fields are both part of Form Locator 22 — Statement Covers Period. For information on form locators as defined in the Claim Load and Edit Parameters, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

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

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

Screens containing errors display the error(s) in the final field labeled Error Messages. For example, *Final diagnosis is required*, or *Admitting physician is required.*

You can move backward and forward among the screens by using the / and /P commands displayed by the prompt.

For information on each screen and field for the UB and CMS 1500/Non Professional Fee 1500 claim forms, refer to the Claim Functions, Claim Demographic/Visit Data section in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide.*

CLAIM ATTACHMENTS

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

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

```
                      General Hospital Edit Claims Processor
                                               Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch      Balance Loc
A92188-00003 CLARKSON,RONALD       C  IP1 07/03/92 07/07/92    109.00  AR/FCRV

Page:01                          Completed Attachments
( 1) AS-Admission Summary
( 2) HP-H&P Discharge Summary



Press NL --
```

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

CLAIM CHARGE DATA

This function enables you to view claim charge information used on the claim form. Selecting this option displays the charge screen for the account and claim selected. For details on this function, refer to Chapter 3: Claims in the Billing and Claims Volume of the STAR Patient Accounting Reference Guide.

Transaction History

This function enables you to view the transaction history for the account selected. The transaction history includes all accounting events such as payments, adjustments, refunds, notes and memos, final bills, claims, and account transfers. These events are identified by a transaction type and code. There are three screens involved in this function. The first displays a listing of all transactions associated with the account selected, the second can be used to view detailed information about a selected transaction, and the third screen displays the service line detail associated with the insurance payment for the patient account.

When you select the Transaction History option, the following message is displayed:

Search by post dt (P) or trans type (T), balance (B), or display all (A) [A]--

If you want to display transactions by posting date, the system prompts you to enter a start and finish date for the search. Displaying account transaction history by transaction type results in the system displaying a list of the Summary Transaction types established.

NOTE: If the PAAR Control Parameter for Transaction History View is set to Prompt, and you select to display account transaction history by Balance Transactions or All, the following prompt is displayed:

> *Display (B)alance Forward or Transaction (D)ate format? (B/D) [D]--*

> (For more information about setting this parameter, see the *General Information Volume* of the STAR Financials Patient Accounting Reference Guide.)

The system then displays a list of payment, adjustment, and refund transaction history entries sorted according to the format you chose.

```
              General Hospital Transaction History Inquiry Processor
                                          Fri Mar 10, 2007 12:36 pm
Account       Name                  FC Typ Admit    Disch        Balance Loc
A90064-00006 JONES,ROGER            C  SER 02/26/90 03/07/90       190.00  AR/FCRV

Trans Comment: Detail Statement - Memo III

Seq    Tran  Description             Tran     Post       Tran  Loc Tran  Bat
Nbr    Code                          Date     Date       Amount     Type  Nbr
1      I4370 BLUE CROSS OTHER PAYMENT 04/06/90 04/06/90   400.00- AR Cash  93
2      T9000 DETAIL STATEMENT         03/26/90 03/26/90     0.00  AR Note
3      Z4371 UB Claim Submitted       03/10/90 03/10/90   590.00  AR Bill
4      Z4371 UB Claim Printed         03/09/90 03/08/90   590.00  AR Bill
5      Z2011 UB Claim Loaded          03/09/90 03/08/90   590.00  AR Bill
6      S9999 Account Transfer PA to AR 03/09/90 03/08/90  590.00  PA STrn
7      Y0001 FINAL BILL               03/09/90 03/09/90   590.00  PA Bill
8      S9999 Transfer Financial Class 03/08/90 03/08/90   590.00  PA STrn
9      M0045 COB 3 (437999) reseq to 1 03/08/90 03/08/90          PA Memo
10     M0045 COB 2 (201003) reseq to 3 03/08/90 03/08/90          PA Memo
11     M0045 COB 1 (201001) reseq to 2 03/08/90 03/08/90          PA Memo
12     M0045 Added COB 3 (437999)      03/08/90 03/08/90          PA Memo
13     T0004 Address/Credit Check      06/27/03                   PA Note
14     S0004 DENIAL ROOT CAUSE SET UP  06/01/07 06/01/07   10.00  AR STrn
15     S0004 Denial To Be Tracked      06/01/07 06/01/07          AR STrn




       F1Prev Page F2Next Page F5View Detail Trans F6 Reset  F7  Exit   ?
```

NOTE: If the follow-up generated for the account is a memo message, the Transaction Comment field will indicate Memo Detail Statement or Memo Letter, followed by the statement or letter number. If the same number is used for both detail and memo detail statements, the description will reflect the detail statement message. McKesson recommends that you do not use the same number for both messages and memo messages.

The system displays a sequence number identifying this transaction to the patient account. The most recent transaction will have a code of one. The transaction code,

description, transaction and posting dates, the transaction amount, accounting location, transaction type, and batch number for each transaction are displayed.

The following function keys are displayed at the bottom of the screen:

- **F1** -Press F1 to return to the previous page.

- **F2** -Press F2 to go to the next page.

- **F5** -Press F5 to view detail of a transaction. A highlight indicates the transaction that can be viewed.

- **F6** -Press F6 to reset the screen.

- **F7** -Press F7 to exit the transaction.

The cursor is displayed on the sequence number of the first transaction and can be moved from transaction to transaction using the Arrow keys. To view transaction detail, place the cursor on the desired sequence number and press the F5 key.

The following screen is displayed:

```
              General Hospital Transaction History Inquiry Processor
                                             Fri Mar 31, 2006 12:36 pm
Account       Name                   FC Typ Admit   Disch      Balance Loc
A0418100001  KERNS, BOB             M  ER  06/29/04 06/29/04    284.39  AR/FCRV
 1 Trans Code/Description              2 Origin        3 Trans Date/Time
   M0013-Workfile Telephone Entry        System          09/06/05 02:03am
 4 User ID                        5 Terminal Location  6 BS/CS     7 PCI
   SYSTEM - ^SYSTEM                   STAR FINANCIALS
 8 Prior Location  9 Prior Balance  10 New Balance      11 Bill Seq Printed On
   AR/FCRV          $284.39             $284.39
12 Posting Date   13 Trans Amount   14 From Carrier/Plan        15 Days Pd
   09/05/05         $284.39
16 Cash Post Type 17 Batch Num/Seq   18 To Carrier/Plan          19 DRG Pd

20 Receipt Number 21 Remit Date 22 Remit Advice Number     23 Outlier Type

24 Coin/Ded/Co-Pay/Pat Resp                            25 Claim Disposition

26 Status Type    27 Old/New Status     28 Note Type/No 29 ERA Clm Status
                    AR/ *AR/FCRV
30 Ref Trans?   31 Comment
                  Standard f/u - Existing entry for collector 6

Press ENTER to return, L for list of changes, or C for Charge Detail --
```

Field Explanations

1. TRANS CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the one-letter transaction type, four-digit transaction code number, and accompanying description associated with the transaction selected.

2. ORIGIN (DISPLAY ONLY)
This field indicates where the transaction originated, either System or User.

3. TRANS DATE/TIME (DISPLAY ONLY)
This field contains the date and time this transaction was entered or system-generated.

4. USER ID (DISPLAY ONLY)
This field contains the ID number of the person responsible for entering this transaction or System if it is system-generated.

5. TERMINAL LOCATION (DISPLAY ONLY)
This field contains the location of the terminal used to enter this transaction.

6. BS/CS (DISPLAY ONLY)
This field contains the bill or claim sequence number if the transaction is used for a bill or a claim. If both the bill and claim sequence numbers are displayed, they are displayed in the format of 99/99.

7. PCI (DISPLAY ONLY)
If the payment was created from an ERA file and a Payor Claim ID was used to identify the claim for the payment, this field contains the claim sequence number of the Payor Claim ID. The Payor Claim ID contains the facility code, account number, and claim sequence number where the claim sequence number is carried forward for adjustment claims.

8. PRIOR LOCATION (DISPLAY ONLY)
This field indicates the account location and sub location of the account prior to entering the transaction. The account location of a patient determines which sub locations are available. For more information about sub locations and their corresponding locations, see the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

9. PRIOR BALANCE (DISPLAY ONLY)
This field contains this account's balance prior to entering the transaction.

10. NEW BALANCE (DISPLAY ONLY)
This field contains this account's balance after the transaction was entered.

11. BILL SEQ PRINTED ON (DISPLAY ONLY)
This field contains the number of the bill sequence on which the transaction was printed.

12. POSTING DATE (DISPLAY ONLY)
This field contains the date the transaction was posted to the account's transaction history.

13. TRANS AMOUNT (DISPLAY ONLY)
This field contains the dollar amount, if any, associated with this transaction.

14. FROM CARRIER/PLAN (DISPLAY ONLY)
If this transaction involves a balance transfer, this field contains the carrier/plan from which liability is being transferred.

15. DAYS PD (DISPLAY ONLY)
This field contains the number of stay days for which the payment was made. This field is applicable for insurance cash.

16. CASH POST TYPE (DISPLAY ONLY)
This field indicates the type of payment posted, if any (for example, patient, guarantor, insurance, etc.).

17. BATCH NUM/SEQ (DISPLAY ONLY)
This field contains the batch number and sequence number for this transaction. This field is applicable for cash and adjustments.

18. TO CARRIER/PLAN (DISPLAY ONLY)
If this transaction involves a balance transfer, this field contains the carrier/plan to which liability is being transferred.

19. DRG PAID (DISPLAY ONLY)
This field contains the DRG number for which payment was made on this account and the DRG indicator, in the following format: Paid DRG number, a forward slash, and a DRG indicator, if it is associated with the DRG. An example is: 001/M. DRG indicators are used to edit a DRG entry.

 The valid DRG indicators are:

- M for Medicare MS DRG

- C for Medicare Classic DRG (CMS Version 24)

- T for Tricare/Champus DRG

- O for Other DRG

- A for Reimbursed APR DRG

This field is applicable for insurance cash.

20. RECEIPT NUMBER (DISPLAY ONLY)
This field contains the receipt number for this transaction. This field is applicable for cash.

21. REMIT DATE (DISPLAY ONLY)
This field contains the remittance date for this transaction. This field is applicable for insurance cash.

22. REMIT ADVICE NUMBER (DISPLAY ONLY)
This field contains the remittance advice number for this transaction. This field is applicable for insurance cash.

23. OUTLIER TYPE (DISPLAY ONLY)
This field contains the outlier type. This field is applicable for insurance cash.

24. COIN/DED/CO-PAY/PAT RESP (DISPLAY ONLY)
This field contains the Coinsurance, Deductible, Co-Payment, and Patient Responsibility for the insurance cash payment. Each number is separated by a slash (/). If the number does not exist, the field is blank. For example, if a payment was posted with a coinsurance of $10.00 and a co-payment of $5.00, the field would display the following: $10.00//$5.00.

25. CLAIM DISPOSITION (DISPLAY ONLY)
This field displays the claim disposition at the time of the insurance payment or balance transfer. Valid dispositions are Final Payment, Adjusted to Zero, Denied, Partial Payment, Transfer, and Clear Disposition.

26. STATUS TYPE (DISPLAY ONLY)
If a status changes, this field records the type of change. For example, when an account is final billed, this field will display Account Loc indicating a change from Patient Accounting to Accounts Receivable. If you change a key field such as Medical Service, Financial Class, or Admitting and Attending Physician, the acronym for the name is displayed in this field.

27. OLD /NEW STATUS (DISPLAY ONLY)
This field contains the Old Status and New Status of the key field. For example, the old status field would display the name of the old admitting physician and the new status field would display the name of the new admitting physician. Another example would be if an account changed location from PA to AR or from AR to BD.

If billing status changed, and there was a value in the field previously, the field displays one of the following statuses:

H   On Hold

E   Errors

D   DPW Hold

B   CPTAFB HOLD

F   Final bill Req

C   Cycle Bill Req

L   Late Bill Req

A   Adj Bill Req

R   Reprint Bill Req

The Comment field contains the new value and comment, such as: Changed to D-DPW bill hold.

If the field contains *Edit PA Chg,* charge information was changed in the STAR Patient Accounting data. The Old/New Status field contains both the previous HCPCS code and the new HCPCS code. The previous HCPCS can be the HCPCS from Order Management or it can be the STAR Patient Accounting HCPCS code previously edited. The HCPCS codes can be the same if other fields were edited in the STAR Patient Accounting charge.

The Comment field contains the SIM department and SIM code followed by the list of fields changed. If the transaction was created due to a charge revision, *-OM Rev* is displayed at the end of the Comment field.

28. NOTE TYPE/NO (DISPLAY ONLY)
This field displays Guar Acct, indicating a note was added either on the guarantor or the account. The sequence number assigned with the note is also displayed.

29. ERA CLM STATUS (DISPLAY ONLY)
This field displays 17 characters of the description for the ERA Claim Status if the payment transaction was created from ERA processing. If a Payment File Definition Claim Status Table was used, it is the source of the description. Otherwise, the ERA Claim Status Table is used. If no description exists for the code, only the code is displayed. If an ERA Payment File Definition code is present with the Claim Status code, it follows the claim status code, and the two are separated by a slash (/).

30. REF TRANS? (DISPLAY ONLY)
This field indicates whether this transaction screen will reference another transaction screen. For instance, when insurance cash is posted, was there a contractual adjustment made simultaneously? If there was, this field would display Yes.

NOTE: If two transactions reference each other, a prompt appears at the bottom of the screen asking if you want to see the referenced transaction.

31. COMMENT (DISPLAY ONLY)
This field contains any comments associated with this transaction and displays the ICD version of the Diagnosis or the Procedure that was revised. An example is: ICD-9 Changed from 8252 to 8374.

Some examples of comments are as follows:

•   If a billing status changed, and it had a value previously, the comment field indicates the old value and description along with the new value and description. For example, a comment could be as follows: Changed from A-ADJ BILL REQ to

B-CPTAFB HOLD. The code and description appear in the Status fields when the transaction history message is displayed in detail. If a billing status changed, and it was blank previously, the comment indicates the new value and description. For example, a comment could be as follows: Changed to D-DPW Bill Hold. The code and description appear in the New Status fields when the transaction history message is displayed in detail.

- If the transaction history comment is for XXXX Claim Loaded, the field indicates whether the claim was loaded from a bill in Midnight Processing or online with Instant Adjustment Bill, or was loaded with the Add Claim to Insurance function. If the claim was loaded from a billing event, the Comment field displays *BILL*. If the claim was loaded from Add Claim to Insurance, the Comment field displays *ADD*. The Claim Split Indicator (if one exists for the claim) also displays after the word *BILL* or *ADD*.

- If service time processing is active, the Comment field contains the effective date and time for key data changes. For example, *KEY DATA CHANGED Effective Date 07/31/07 0600*.

When you view detailed information for a selected transaction, the system may display a prompt that provides you with certain viewing options.

- If you are viewing a claim that was processed through ERA, the system displays the following prompt:

  Press NL to return, (R)emittance Data, (V)iew Remit Summary, Service Line (D)etail--

- If you are viewing a contractual adjustment transaction, the system may display the following prompt:

  Press NL to return or 'R' for Reimbursement or 'C' to view comments

  The system displays reimbursement information and any comments that were entered when the transaction was entered. If no comments were entered, the system would not display the option to view comments.

- The following prompt is displayed if the charge diagnosis or HCPCS code was edited in the STAR Patient Accounting Edit PA Charges function:

  Press ENTER to return, L for list of changes, or C for Charge Detail

  If you enter **L** for List of Changes, the system displays a list of changed items. When entering **L** to List Changes, the screen displays a header of what was changed (for example, HCPCS, DX, ABN, Freq ABN), and an Old and New value for the data. Changes to the ordering diagnosis are prefaced with either an ICD-9 or ICD-10 to identify which ordering diagnosis was revised. For details on this

screen, see the Account Inquiry screen shown under .

If you enter C for Charge Detail, the current charge information for the edited charge noted in transaction history is displayed on the Billing Information screen. For details on this screen, see the Billing Information Screen on Page   .

- If you are viewing a claim for which denials are being tracked (the transaction code is S0004-Denial To Be Tracked), the following prompt is displayed:

  Press NL to continue or `D` to view Denial Reason Codes--

  If you enter **D**, the following screen is displayed:

```
                    General Hospital Account Inquiry Processor
                                            Thu Jul 19, 2007 10:41 am

Account        Name                  FC Typ Admit    Disch        Balance Loc

A0715100004   KANE, BOB             S2 O/P 05/31/07 05/31/07      286.77 AR /PCA1

Seq Code Grp  Denial Amount  HCPCS               Charge Amt   Pymt Amount

1   18   CO           5.00  22222GA                100.00       -10.06

2   18   PR           5.00  22222GA                100.00       -10.06

```

Field Explanations

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

CODE (DISPLAY ONLY)
This column contains the payor's denial reason code(s).

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.

DENIAL AMOUNT (DISPLAY ONLY)
This field contains the denial amount for this denial reason code.

HCPCS CODE (DISPLAY ONLY)
This field contains the HCPCS procedure code with any attached HCPCS modifiers for the charge. This code is only for ERA claims.

LINE ITEM CHARGE AMT (DISPLAY ONLY)
This field contains the charge amount on the line item. This field is only for ERA claims.

LINE ITEM PTMT AMT (DISPLAY ONLY)
This field contains the payment that is related to the service line on the claim.

- The following prompt is displayed for insurance payments for which the service line detail has been uploaded and posted:

  Press NL to return or 'D' for Service Line Detail - - -

If you press ENTER, you are returned to the Payment Detail screen. If you answer **D** to this prompt, the following screen is displayed:

```
            General Hospital Transaction History Inquiry Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch      Balance Loc
A0204400002   ANDERSON,ALICE       M  O/P 02/13/02 02/13/02    0.00   AR/FCRV

Claim Adj: CO-A2 1234.56, PR-35 250
Claim Rmk: MA01,MA07,MA11

Seq  Svc Date PT Proc  Mods   Rev   APC  UOS Adjustments   Payments Status    V
1    02/13/02 NU              250         3     149.64       56.76 Pd RA
2    02/13/02 NU              270        12     421.66      159.94 Pd RA
3    02/13/02 NU              370        45     156.60       59.40 Pd RA
4    02/13/02 NU              610         9     481.98      182.82 Pd RA
5    02/13/02 NU              710         1     193.14       73.26 Pd RA
6    02/13/02 NU              760         1      11.02        4.18 Pd RA
7    02/13/02 HC 36535 M1 M2  360   789   1                 386.10 Pd RA
8    02/13/02 HC 71010        320   678   1      97.44       36.96 Pd RA
9    02/13/02 HC 75961        320   567   1     800.98      303.82 Pd RA
10   02/13/02 HC 80048        300         1                  10.14 Pd RA
11   02/13/02 HC 82960        300         1                   8.38 Pd RA
12   02/13/02 HC 85025        300         1                  10.74 Pd RA
13   02/13/02 HC 85730        300         1                   8.30 Pd RA

    F1Prev Page F2Next Page F5View Expanded Detail F6 Reset  F7  Exit   ?
```

Field Explanations

CLAIM ADJ (DISPLAY ONLY)
The Adjustment Group and CAS Adjustment Reason Code are displayed if a contractual adjustment or other adjustment was posted to the account at the claim level. (Transaction History Notations do not display.) More than one adjustment may appear in the field. In the following example, adjustments are separated by a comma.

   Claim Adj: CO-97 123.45, CO-123 250

CLAIM RMK (DISPLAY ONLY)
The remarks codes for the claim display.   If there is not enough room to display all codes, (more) is displayed at the end of the line. In the following example, remarks codes are separated by a comma.

Claim Rmk : MA101, MA102, MA103, MA104, MA105

SEQ NBR (DISPLAY ONLY)
This column displays a system-defined number for the service line.

SERVICE DATE (DISPLAY ONLY)
This column displays the date of service.

PT (DISPLAY ONLY)
This column displays the type of procedure. HC indicates a HCPCS code. Blank or NU indicates a UB revenue code.

PROC (DISPLAY ONLY)
This column displays the procedure code for the service, typically the HCPCS code.

MODS (DISPLAY ONLY)
This column displays the first two modifiers associated with the HCPCS code if available.

REV CODE (DISPLAY ONLY)
This column displays the Revenue Code for the service line.

APC (DISPLAY ONLY)
This column displays the APC code for the service line if it is available.

UNITS (DISPLAY ONLY)
This column displays the units of service.

ADJUSTMENTS (DISPLAY ONLY)
This column displays the total dollar amount of the adjustments posted to the account for this service line.

PAYMENTS (DISPLAY ONLY)
This column displays the payment amount for this service line.

STATUS (DISPLAY ONLY)
This column indicates the status of the service line in regard to reconciliation with the claim.

Status	Description
No Payment	This claim service line exists and no corresponding payment was received.
Pd RA	The payment was received, reconciled to a claim service line, and the service line detail was extracted from a remittance advice.

Status	Description
B 99999mmmm * B 99999 Pd B 99999 NoClm	Bundled charge from ERA
U 99999mmmm *	Unbundled charge from ERA
P 99999mmmm *	Partially unbundled charge from ERA

* 99999mmmm where 99999 represents the HCPCS code and mmmm represents the first two modifiers from SVC06, which is the submitted service information if different from the paid service information.

V (DISPLAY ONLY)
This field displays additional information regarding the matching and variance status of the paid service line to the claim.   When the status of the line is **Pd RA**, the following values may display:

X	Payment posted - no matching claim line
blank	Payment posted - matched a claim line
*	Payment posted - matched a claim line - payment variance exists

The following function keys are displayed at the bottom of the screen:

F1Prev Page F2Next Page F5View Expanded Detail F6 Reset F7 Exit

F1 and F2 are used to view additional pages of service line detail. F5 displays an expanded view of the service line detail for the selected service line. If F5 is selected, you can view service line detail reconciled with expected reimbursement and submitted charge information. Detail for payments, adjustments, coinsurance, and

deductibles is displayed, if available. The following screen is displayed after you select F5:

```
         General Hospital Transaction History Inquiry Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name            FC Typ Admit   Disch      Balance Loc
A0204400002  ANDERSON,ALICE   M  O/P 02/13/02 02/13/02   0.00    AR/FCRV

Svc Date:  02/13/02    Sub Chg Amt:      258.00    Non Cov'd:

          RevCd PT  Proc  Mods   Description                  Units   APC
 Actual: 250   NU                                              3
Expected: 250                                                  3

       Chg Amount    Coinsurance     Deductible    Adjustments     Payment
Act:     258.00                        51.60         149.64         56.76
Exp:     258.00                        51.60         149.64         56.76
Var:
Adjustments                                           Remarks: No
CO-45  Charges exceed fee arrangement                 149.64

Select (P)revious Line, (N)ext Line, (R)emarks, (E)xit--
```

Field Explanations

SVC DATE (DISPLAY ONLY)
This field displays the date of service.

SUB CHG AMT (DISPLAY ONLY)
This field displays the submitted charge amount.

NON COV'D (DISPLAY ONLY)
This field displays the expected non-covered charge amount.

For each of the following columns, actual and expected payment information is displayed. Actual information is extracted from the 835 ERA payment advice. Expected information is calculated from a reimbursement system. A variance is calculated and reported on the dollar amount fields. For unmatched service line payments, where a payment is received that cannot be matched to a submitted charge, the actual information is populated, and the expected information is left blank or zero filled. For unmatched service lines, where a payment is not received, the expected information is populated and the actual information is left blank or zero filled.

REVCD (DISPLAY ONLY)
This column displays the Revenue Code for the service line.

PT (DISPLAY ONLY)
This column displays the type of procedure. HC indicates a HCPCS code. NU or blank indicates a NUBC UB code.

PROC (DISPLAY ONLY)
This column displays the procedure code for the service, typically the HCPCS code.

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MODS (DISPLAY ONLY)
This column displays the first two modifiers associated with the HCPCS code if available.

UNITS (DISPLAY ONLY)
This column displays the units of service.

APC (DISPLAY ONLY)
This column displays the APC code for the service line if it is available.

CHARGE AMOUNT (DISPLAY ONLY)
This column displays the covered charge amount. The amount on the actual line is the extracted from the 835 payment advice. A "b" indicates that the value was blank in the 835 file. The amount on the expected line is the submitted covered charge amount.

COINSURANCE (DISPLAY ONLY)
This column displays the coinsurance amount for the service line.

DEDUCTIBLE (DISPLAY ONLY)
This column displays the deductible amount for the service line.

ADJUSTMENTS (DISPLAY ONLY)
This column displays the total dollar amount of the adjustments posted to the account for this service line. Additional adjustment detail is available at the bottom of the screen.

PAYMENTS (DISPLAY ONLY)
This column displays the payment amount for this service line. A **b** indicates that the value was blank in the 835 file.

ADJUSTMENTS (DISPLAY)
This field displays the adjustments that were posted to the account. For each adjustment, this field displays the Adjustment Group Code, the CAS Reason Code, and the CAS Reason Code description. Only entries defined as Adjustment Types **C** (Contractual Adjustment) and **O** (Other Adjustments) display. Entries defined as Transaction History Notes and entries not defined in the CAS Reason Code table do not appear.

The following prompt is displayed at the bottom of the screen:

  Select (P)revious Line, (N)ext Line, (R)emarks, (E)xit--

If you enter P, the system displays the expanded detail screen for the previous service line. This option is not available if you chose the first service line. If you enter E, the system displays the Transaction History Inquiry Processor screen, showing all of the service lines. If you enter N, the system displays the expanded detail screen for the next service line. If you enter R, the system displays the expanded detail screen for the service line with remarks displayed at the bottom of the screen. Up to 4 remarks codes

and associated descriptions can be displayed. Additional remarks (if available) can be viewed by entering Yes to the following prompt at the bottom of the screen:

View more remarks (Y/N) [Y]--

NOTE: You can toggle back and forth between the detail adjustments and the remarks, if any, by selecting R(emarks) or A(dj).

Insurance Status

This function enables you to view the current status for an insurance carrier for an account.

After this function is selected, the system displays the following screen:

```
               General Hospital Insurance Status Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A90059-00006 SMITH,MARY            BC O/P 02/27/90 02/28/90      590.00  AR/FCRV

Page:01    Carrier                               Plan

( 1) 1   437-BLUE CROSS OTHER               999-BLUE CROSS OTHER/COMM I/P
( 2) 2   403-AETNA                          057-AETNA/PACIFIC P & L




Enter choice--
```

This screen displays a list of insurance carriers and plans associated with this account. Select the desired carrier and press ENTER. The system then displays the following screen.

```
               General Hospital Insurance Status Processor
                                          Wed Aug 05, 2009 07:52 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A0904700003  ADAMS,ONE             JA O/P 02/16/09 02/16/09     1182.98-AR /ACCF

               COB 1    750-JULIE'S COMMERCIAL   100-JULIES BLUE

 1 Last Payment Date     2 Payment Amount        3 Payments Expected
   02/17/09                $1,002.61               1
 4 Last Adjustment Date  5 Adjustment Amount
   02/18/08                $925.65-
 6 Pending Refunds       7 Last Refund Date      8 Refund Amount
   0                       08/05/09                $350.00
 9 Transfer In          10 Transfer Out         11 Time Out Status




Press NL--
```

Field Explanations

1. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the date of the last payment made to this insurance plan for this account.

2. PAYMENT AMOUNT (DISPLAY ONLY)
This field contains the total amount of the payments posted to this insurance plan for this account.

3. PAYMENTS EXPECTED (DISPLAY ONLY)
This field contains the number of payments expected for this carrier.

4. LAST ADJUSTMENT DATE (DISPLAY ONLY)
This field contains the date of the last adjustment made to this insurance plan for this account.

5. ADJUSTMENT AMOUNT (DISPLAY ONLY)
This field contains the total amount of the adjustments posted to this insurance plan for this account.

6. PENDING REFUNDS (DISPLAY ONLY)
This field contains the number of refunds pending for this insurance plan for this account. Refunds pending are approved refunds, with checks not yet processed.

7. LAST REFUND DATE (DISPLAY ONLY)
This field contains the date of the most recent refund issued to this insurance plan for this account.

8. REFUND AMOUNT (DISPLAY ONLY)
This field contains the amount of the most recent refund issued to this insurance plan for this account.

9. TRANSFERRED IN (DISPLAY ONLY)
This field contains the amount, if any, transferred to this carrier from the patient or another carrier through the balance transfer function.

10. TRANSFERRED OUT (DISPLAY ONLY)
This field contains the amount, if any, transferred from this carrier's liability to the patient or another carrier through the balance transfer function.

11. TIME OUT STATUS (DISPLAY ONLY)
This field indicates whether the account still has active follow-up pending or whether the insurance for the account is set to time out. If the account is currently receiving active follow-up or if follow-up has not yet been generated, this field is blank. If the account is set to be timed out on a specific day, this field contains a value of Pending. When the account times out and the insurance is no longer responsible, the status indicates Timed Out.

Insurance Follow-up

This function enables you to view information concerning insurance carrier follow-up for a particular account by claim.

NOTE: Insurance follow-up is not initiated when a balance transfer is applied to an archived claim.

After this function is selected, the system displays the following screen:

```
            General Hospital Insurance Follow-Up Processor
                                      Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch      Balance Loc
A90059-00006 SMITH,MARY           BC O/P 02/27/90 02/28/90     590.00  AR/FCRV

Page:01    Carrier                          Plan

( 1) 1   437-BLUE CROSS OTHER              999-BLUE CROSS OTHER/COMM I/P
( 2) 2   403-AETNA                         057-AETNA/PACIFIC P & L








    Enter choice--
```

This screen contains a list of insurance carriers and plans associated with this account. Select the desired carrier and press ENTER. The system then displays the following screen.

```
                General Hospital Insurance Follow-up Processor
                                              Fri Mar 10, 2006 12:36 pm
Account        Name                FC Typ Admit    Disch        Balance Loc
A0034100016   MARTIN, PATRICIA     PK O/P 12/06/00 12/06/00      1730.03 AR/FCRV

          COB 1    917-PATRICE'S  COMERCIAL    001-PATRICE'S COMMERCIAL

      Claim in follow-up;Claim not in follow-up

Page:01    Adj    Bill            Service        Claim      Submit    Clm  P
     CS  CS    From/Thru       From/Thru       Amount     Date      Dsp  d
( 1)   2          12/06 12/06/00 12/06 12/06/00   1730.03
( 2)   1    2     12/06 12/06/00 12/06 12/06/00   3000.00  12/05/01  R






Enter choice--
```

This screen contains a list of claim sequences for this carrier. The claims that are receiving insurance follow-up are highlighted on the screen; the screen heading "Claim in follow-up" is also highlighted.

Field Explanations

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

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

BILL FROM/THRU (DISPLAY ONLY)
This field contains the beginning and ending billing dates covered by this claim.

SERVICE FROM/THRU (DISPLAY ONLY)
This field contains the beginning and ending service dates covered by this claim.

CLAIM AMOUNT (DISPLAY ONLY)
The total amount of the claim.

SUBMIT DATE (DISPLAY ONLY)
The date the claim was submitted and follow-up began.

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

PD (DISPLAY ONLY)
This field indicates whether this claim has been paid in full. Values are **Y** for Yes or **N** for No.

Select the desired claim sequence and press ENTER. The system then displays the following screen.

```
         General Hospital Insurance Follow-Up Processor
                                       Fri Mar 10, 2007 12:36 pm
Account      Name              FC Typ Admit    Disch       Balance Loc
A0111400002  Green, Bob         O  LIC 04/21/01 04/27/01    3280.70 AR/FCRV

COB 1   500-COMMERCIAL    100-GENERIC COMMERCIAL    CS 11
 1 Collector Name                        2 Hold F/U      3 Custom Schedule
   Cross,Nancy
 4 Follow-up Schedule  5 Next Follow-up   6 Next Seq
   882                   05/30/01           2
 7 Last Follow-up      8 Last Type        9 Last Number   10 Last Seq
    05/01/01             Collection Lett    558               1
11 Last Balance       12 Disposition      13 Disp Date
   $242.68
14 External Agency Information
   MIKEIN P-ACT 051506


```

NOTE: This screen is blank until the claim is submitted.

1. COLLECTOR NAME (DISPLAY ONLY)
This field contains the name of the collector assigned to the account for this carrier follow-up.

2. HOLD F/U (DISPLAY ONLY)
This field indicates whether or not a hold was placed on all follow-up activities for this account. This field contains *Yes* if follow-up is on hold.

3. CUSTOM SCHEDULE (DISPLAY ONLY)
This field indicates whether or not the claim for this account was placed on a custom insurance follow-up schedule. This field contains *Yes* if it has been placed on a custom insurance follow-up schedule.

4. INS. FOLLOW-UP SCHD (DISPLAY ONLY)
This field contains the code of the insurance follow-up schedule used for this account.

5. NEXT FOLLOW-UP (DISPLAY ONLY)
This field contains the date of the next follow-up activity.

6. NEXT SEQ. (DISPLAY ONLY)
This field contains the next follow-up sequence used for this account.

7. LAST FOLLOW-UP (DISPLAY ONLY)
This field contains the date of the last scheduled follow-up, according to this insurance follow-up schedule.

8. LAST TYPE (DISPLAY ONLY)
This field contains the last type of scheduled follow-up (letter, detail statement, telephone) performed for this account.

9. LAST NUMBER (DISPLAY ONLY)
This field contains the code identifying a specific example of the entry in the Last Follow-up Type field. For example, if the follow-up is a letter, this field identifies which letter was sent.

10. LAST SEQ (DISPLAY ONLY)
This field contains the last follow-up sequence used on this account.

11. LAST BALANCE (DISPLAY ONLY)
This field contains the amount owed by the carrier on this account when the last follow-up sequence was performed.

12. DISPOSITION (DISPLAY ONLY)
This field displays the disposition of the 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.

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

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.

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

14. EXTERNAL AGENCY INFORMATION (DISPLAY ONLY)
This field displays the following information for an account in agency collection:

- Collection Agency Code

- Status

    - D - Deleted

    - F - Flagged

    - P - Pending

    - T - Transferred

- Date of last status update (mmddyy format)

Account Follow-up

This function enables you to view information concerning the follow-up being performed for this account for the guarantor. After this function is selected, the system displays the following screen for both PA and AR accounts..

```
               General Hospital Account Follow-Up Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch      Balance Loc
A98-27500005 SAS,DR               V  OPC 10/02/98 10/02/98     0.00   AR/FCRV
 1 Last Payment    2 Total Payments   3 Last Adjustment   4 Total Adjustments

 5 Last Refund     6 Total Refunds    7 Refunds Pending   8 # of Transfers

 9 BD Pre-Listed  10 BD Pre-List Date 11 Zero Balance
                                         10/26/98
12 Archive Indication               13 Converted Acct?

14 Financial Class                  15 Medical Service
   V VIP (SELF PAY)                    TPH 1234567890987654321

                  BD Collection Agency Information
16 Agency                           17 Agency Type

18 BD Tran Date   19 BD Tran Amount  20 Agency Tran Date 21 Agency Notify Date



Press NL--
```

Field Explanations

1.   LAST PAYMENT (DISPLAY ONLY)
This field contains the posting date of the most recent payment received for this account.

2.   TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total amount of payments made on this account to date.

3.   LAST ADJUSTMENT (DISPLAY ONLY)
This field contains the posting date of the most recent adjustment, if any, made to this account's balance.

4.   TOTAL ADJUSTMENTS (DISPLAY ONLY)
This field contains the total amount of all adjustments, if any, made to this account's balance to date.

5.   LAST REFUND (DISPLAY ONLY)
This field contains the amount of the most recent refund, if any, issued for this account.

6.   TOTAL REFUND (DISPLAY ONLY)
This field contains the total amount of all refunds, if any, issued for this account to date.

7.   REFUNDS PENDING (DISPLAY ONLY)
This field contains the amount of any refunds pending on this account. These refunds are approved refunds but the checks have not yet been processed.

8.   # OF TRANSFERS (DISPLAY ONLY)
This field contains the number of balance transfers to and from this account through the balance transfer function.

9.   BD PRE-LISTED (DISPLAY ONLY)
This field indicates whether this account has been pre-listed for transfer to bad debt. If the account has been pre-listed, this field will display Yes.

10. BD PRE-LIST DATE (DISPLAY ONLY)
This field contains the date this account was pre-listed for transfer to bad debt.

11. ZERO BALANCE (DISPLAY ONLY)
This field contains the posting date, if any, of the transaction which caused this account to reach a zero balance.

12. ARCHIVE INDICATION (DISPLAY ONLY)
This field indicates whether the account has been placed on archive hold. If the account has been placed on archive hold in account revision, a value of Hold will be displayed. If the account is not placed on hold, this field will be blank.

13. CONVERTED ACCT? (DISPLAY ONLY)
This field indicates whether this account has been converted from another financial system to STAR Financials. Yes will display if the account is converted.

14. FINANCIAL CLASS (DISPLAY ONLY)
This field contains the financial class assigned to this account.

15. MEDICAL SERVICE (DISPLAY ONLY)
This field contains the code number representing the medical service assigned to this account.

Collection Agency Information

If this account has been transferred to a collection agency, these fields are completed by the system.

16. AGENCY (DISPLAY ONLY)
This field contains the collection agency name.

17. INTERNAL AGENCY? (DISPLAY ONLY)
This field indicates (Yes or No) whether the collection agency is internally controlled.

18. BD TRANSFER DATE (DISPLAY ONLY)
This field contains the date on which this account was transferred to a collection agency.

19. BD TRANSFER AMOUNT (DISPLAY ONLY)
This field contains the balance of the account when it was transferred to the collection agency.

20. AGENCY TRAN DATE (DISPLAY ONLY)
This field contains the date the account transferred to the agency with which it is associated.

21. AGENCY NOTIFY DATE (DISPLAY ONLY)
This field contains the date the agency was notified of the account either through a tape or file.

When you are finished reviewing this screen, press ENTER and the second screen of account follow-up information is displayed for AR accounts.

NOTE: The subsequent screens of follow-up information that are displayed for PA accounts are described beginning with "PA Account Follow-Up" on page 1-205.

```
              General Hospital Account Follow-Up Processor
                                          Fri Mar 10, 2006 12:36 pm
Account      Name                FC Typ Admit    Disch       Balance Loc
A91049-00007 BROWN,JOHN          SP OPO 02/18/91 02/19/91     75.00   AR/FCRV
 1 Guarantor Name                      2 Collector Name
   JOHN,BROWN                            Smith,Janet
 3 Collection Schedule                 4 Schedule Type
   1                                      Standard
 5 Total # of Follow-ups    6 Last Follow-up Date     7 Last Follow-up Type
   3                          03/05/91                  Detail Statement
 8 Last F/U Amt       9 Last Follow-up Message           10 Last F/U Seq. #
   $75.00             101-SELF PAY DETAIL STMT MESSAGE        4
11 BD Pre-List Date         12 Next Follow-up Date     13 Next Follow-up Seq.  #
                             03/06/91                     5
14 Hold F/U?      15 Hold Follow Up Date   16 Plan Amount      17 Prepaid Amt

18 Delinquent Date         19 Delinquent Amount      20 Times Delinquent

21 Promise To Pay  22 Promise Amount   23 Prom. Pay Date   24 Prom. Pay Amount

25 Healthcare Score/Desc - Date
   300-Possible Charity, Provide Application 6/13/03
Press NL--
```

Field Explanations

1. GUARANTOR NAME (DISPLAY ONLY)
This field contains the name of the guarantor assigned to the account.

2. COLLECTOR NAME (DISPLAY ONLY)
This field contains the name of the collector assigned to the account.

3. COLLECTION SCHEDULE (DISPLAY ONLY)
This field contains the hospital-defined follow-up schedule code number.

4. SCHEDULE TYPE (DISPLAY ONLY)
This field indicates the type of schedule the account is on (such as Standard, Separate, Payment Plan, Guarantor Payment Plan, Guarantor Custom, and so on.)

5. TOTAL # OF FOLLOW-UPS (DISPLAY ONLY)
This field contains the total number of follow-ups sent on this account.

6. LAST FOLLOW-UP DATE (DISPLAY ONLY)
This field contains the date in which the last follow-up occurred.

7. LAST FOLLOW-UP TYPE (DISPLAY ONLY)
This field contains the last follow-up type code number.

8. LAST F/U AMT (DISPLAY ONLY)
This field contains the last follow-up amount.

9. LAST FOLLOW-UP MESSAGE (DISPLAY ONLY)
This field contains the message number and table description of the message that was printed on the detail statement or follow-up letter or was recorded in the collector workfile as a phone message.

10. LAST F/U SEQ. (DISPLAY ONLY)
This field contains the last follow-up sequence number.

11. BD PRE-LIST DATE (DISPLAY ONLY)
This field contains the date (if any) on which the account was pre-listed for transfer to bad debt.

12. NEXT FOLLOW-UP DATE (DISPLAY ONLY)
This field contains the date when the next follow-up will occur.

13. NEXT FOLLOW UP SEQ # (DISPLAY ONLY)
This field contains the next follow-up sequence number.

14. HOLD F/U? (DISPLAY ONLY)
This field indicates whether or not a hold has been placed on all follow-up activities. This field contains Yes if follow-up is on hold.

15. HOLD FOLLOW-UP DATE (DISPLAY ONLY)
This field contains the date (if any) on which a hold was placed on follow-up activities.

16. PLAN AMOUNT (DISPLAY ONLY)
This field contains the periodic payment amount set up for the payment plan.

17. PREPAID AMOUNT
This field contains the prepayment amount. This field displays an amount only if the Prepaid Amount field on the PAAR Control Table is set to Yes. If the account is on a payment plan and has amounts which are prepaid (prior to billing for the periodic plan amount), an amount is displayed in this field.

18. DELINQUENT DATE (DISPLAY ONLY)
This field contains the date of delinquent payment.

19. DELINQUENT AMOUNT (DISPLAY ONLY)
This field contains the delinquent amount.

20. TIMES DELINQUENT (DISPLAY ONLY)
This field contains the number of times payment was delinquent on the account.

21. PROMISE TO PAY (DISPLAY ONLY)
This field contains the date on which payment is promised from the guarantor.

22. PROMISE AMOUNT (DISPLAY ONLY)
This field contains the dollar amount promised by the guarantor by the promise to pay date.

23. PROM. PAY DATE (DISPLAY ONLY)
This field contains the date on which the promised amount was actually paid.

24. PROM. PAY AMOUNT (DISPLAY ONLY)
This field contains the actual dollar amount that was paid as the promised amount.

If the Schedule Type field contains Yes, the following prompt is displayed at the bottom of the screen:

   Display Custom Schedule (Y/N)

If you enter **N**, the screen is not displayed.

If you enter **Y**, the Custom Schedule is displayed. For more information, see .

25. 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.

Custom Schedule Screen

If the Prom. Pay Amount field described above contains a Y, and you enter a **Y** at the *Display Custom Schedule (Y/N)* prompt, the Custom Schedule screen is displayed:

```
            General Hospital Account Follow-Up Processor
                                    Mon Jul 17, 2006 01:14 pm
Account        Name              FC Typ Admit    Disch      Balance Loc
A0608100002  NORTON, BOB         P M  PAT 03/22/06 03/28/06    74603.74-AR /ACCF
 1 Schedule #       2 Description                      3 Wait Days
   97                 PATRICE'S BILL PATIENT             30
 4 Day of Month     5 Day of Week     6 Week of Month   7 Plan Amount
                                                          $99,000.00
 8 Due Days         9 Grace Days     10 Ins Pending    11 Bill Balance
   1                  1                 Bill               Patient
12 Reseq. Balance  13 Max Paper Bal  14 Min Balance    15 Min Refund Amt
   $10.00             Unlimited         $5.00              $5.00
16 Min Attempts    17 Auto Pre-List  18 Pre-List Max Bal
   0                  Yes               $22.22
19 Small Bal WriteOff Trans Code     20 Prelist Ins?    21 Days After Ins
   A0039-OTHER CHARITY ALLOWANCES       No                 30
22 Bad Debt Transfer Trans Code      23 Delinquent F/U Type
   S0002-AR TO BD TRANSFER              Telephone
24 Delinquent F/U Message            25 Partial Payment F/U Type
   14  Delinquent Telephone            Detail Statement
26 Partial Payment F/U Message       27 Partial Payment F/U %
   8   DETAIL STATEMENT TEST MESSAGE    100.00%
Press NL--
```

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. WAIT DAYS (DISPLAY ONLY)
This field contains the minimum number of days to wait, from final billing, before including the account on a follow-up schedule. The range is 1 to 99 days. For interval schedules, these days will be used to schedule the first event.

DEFINING FOLLOW-UP FREQUENCY

There are three ways to define the frequency of account follow-up: completing the Day of Month, Day of Week, or Interval fields. These options, one of which must be selected, are defined below. The Interval option is entered on the second screen.

4. DAY OF MONTH (DISPLAY ONLY)
This field contains the day of the month on which the hospital wants follow-up performed for guarantors assigned to this schedule. Options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

5. DAY OF WEEK (DISPLAY ONLY)
This field contains the day of the week on which the hospital wants follow-up performed for the account assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, . . . Saturday = 7. If this option is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here.

6. WEEK OF MONTH (DISPLAY ONLY)
This field contains the week of the month during which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete the Day Of Week field, you must also complete this field. This field is not required if the Day Of Month field is completed. If this option is selected, the account assigned to this schedule will receive follow-up once a month, during the week entered here and on the day entered in the Day Of Week field.

7. PLAN AMOUNT (DISPLAY ONLY)
This field contains the total plan amount.

8. DUE DAYS (DISPLAY ONLY)
This field contains the number of days used in calculating the due date for payment plan accounts. The entry range is 0 to 99 days; the default is 0.

9. GRACE DAYS (DISPLAY ONLY)
This field contains the number of grace days allowed after the due days of a payment plan before the guarantor is considered delinquent. The entry range is 0 to 99; the

default is 0. The follow-up date plus the due days plus the grace days equals the delinquent date.

10. INS PENDING (DISPLAY ONLY)
This field determines what type of follow-up occurs on accounts with pending insurance. Options are B (bill), S (suppress), or M (memo); the default value is B.

If B is displayed in this field, the type of follow-up that occurs depends on how the *Bill Balance* field is set.

If S is displayed in this field, the following can occur:

- No follow-up occurs until all insurance liability is gone.

- Accounts appear on the Follow-up Suppression report (FFR440) on the days that follow-up will occur.

- Accounts will not have the next step incremented if all accounts attached to the guarantor follow-up schedule are being suppressed.

NOTE: Suppressed accounts become *new accounts* when the insurance liability is gone and uses the resequence parameters in the follow-up schedule.

If M is displayed in this field, the following can occur:

- A memo message will print for accounts with pending insurance.

- If there is no insurance liability a regular follow-up occurs requesting the entire account balance.

- If one account has insurance liability and the other account does not, memo and regular follow-up will be produced. For detail statements, the system will attempt to put both types on one piece paper. Collection letters will appear on two separate pages.

11. BILL BALANCE (DISPLAY ONLY)
This field contains the dollar amount that is requested from the guarantor during follow-up. Options are P (patient balance) or A (account balance); the default is P.

If P is displayed in this field, the following can occur:

- No memo message is created.

- A request for the patient portion will appear with information noting the insurance liability on the paper follow-up.

- No follow-up will occur if there is no patient liability.

NOTE: The account will not be considered a *new account* until all insurance liabilities are gone. A new account forces the system to resequence based on dollars and the new account sequence number in the follow-up schedule. Under this scenario a guarantor that had accounts past the end of the schedule and was ready to prelist, and the same guarantor has an account that transferred part of the money to the patient, the account would not resequence. This account could then qualify for prelisting prior to receiving follow-up. To keep this from occurring, the Prelist Insurance Flag should be set to no. When the bad debt prelist is run, this account would show as a prelist exception, and will repeat the last step of this schedule. Once the insurance liability is gone, the account will resequence according to the new account resequence parameters.

If A is displayed in this field, the following can occur:

- No memo message is created.

- A request for the account balance will appear on the paper follow-up.

- Follow-up will always occur.

12. RESEQ. BALANCE (DISPLAY ONLY)
This field contains the minimum balance that is required to cause resequencing of the guarantor in the follow-up schedule if a new account is added to the guarantor's schedule. Options are a number up to 999,999.99 (you must enter the decimal point) or U (unlimited); the default is U. The guarantor is resequenced if the account balance of the new account exceeds the amount entered in this field. If you enter U, the addition of new accounts to the guarantor will never cause resequencing of the guarantor follow-up schedule. The patient balance causes follow-up resequencing. This resequence occurs only if there is no insurance liability for the account.

NOTE: When a new account is added to a guarantor who has reached the end of the follow-up schedule, the guarantor will resequence to the New Account Restart Step number if the account:

- Meets the resequencing balance criteria, and

- Has a resequencing step entered in the *New Account Restart Sequence Number* field.

- There is no longer insurance liability for Memo, Suppressed, or Bill/Patient accounts, or it is a newly final billed account whose schedule is bill/account.

The exception to this rule exists when the new account resequence steps are not used in the follow-up schedule and a guarantor is past its steps in the follow-up schedule (ready to prelist). This guarantor will be resequenced back to its last step in order to avoid any accounts prelisting prior to receiving any follow-up. The resequence balance will not be considered under this scenario.

13. MAX PAPER BALANCE (8-AN-R)

This field contains the maximum dollar amount balance required for paper follow-up. The entry range is 0 to 999,999.99 or U for unlimited. The default is U. If the balance is greater than the maximum paper balance, telephone follow-up will occur. If U is entered, paper follow-up will always occur unless there is a step in the schedule for telephone only.

14. MIN BALANCE (DISPLAY ONLY)

This field contains the minimum account balance that is required to continue sending statements. This amount is the hospital small balance write-off for debit balances. Options are 0 to $999,999.99.

15. MIN REFUND AMT (DISPLAY ONLY)

This field contains the minimum credit balance required to produce a patient refund. This amount is the hospital small balance write-off amount for credit balances. The entry range is 0 to $99.99.

16. MIN ATTEMPTS (DISPLAY ONLY)

This field contains the minimum number of follow-up attempts that should be performed before a small balance write-off is processed. This field enables the hospital to bill a guarantor as many times as indicated for the small balance of an individual account. A zero indicates no follow-up will be performed for the small balance. The entry range is 0 to 99; the default is 0. If the balance rises above the minimum for small balance write-off as indicated in the Min Balance field, the minimum attempts counter is reset to zero for the account. If the balance falls below the minimum balance again, the system begins the minimum attempts again.

17. AUTO PRE-LIST (DISPLAY ONLY)

This field indicates whether the account should be selected for bad debt pre-listing after the last event (sequence) in the follow-up schedule. Options are Y for Yes or N for No; the default is N. If you enter N, the follow-up schedule sequence will be repeated, when the schedule reaches the last event (sequence) until the account is manually pre-listed for transfer to bad debt. Accounts are eligible for automatic pre-listing only if they have reached the end of the follow-up schedule, have this field set to Y, and the balance of the account is under the maximum prelist balance.

18. PRE-LIST MAX BAL (DISPLAY ONLY)

This field contains the maximum account balance for automatic pre-listing for possible transfer to bad debt. The entry range is 0 to $999,999.99; the default is 0. If an account balance is greater than the pre-list maximum balance at the end of the follow-up schedule, the last sequence number will remain in effect until the balance is less than the pre-list maximum balance or the guarantor pays the restart amount and percentage and is resequenced. This account will not be automatically pre-listed until the account balance falls below the defined maximum.

This field is set to No if the Bill/Patient option is chosen in the schedule. If the field is not set to No, accounts may be sent to bad debt prior to receiving any follow-up. Refer to the *Bill Patient* field for additional information.

19. SMALL BAL WRITEOFF TRANS CODE/DESC (DISPLAY ONLY)
This field contains the transaction code used to update the patient account transaction history and the general ledger. This code is used when an account is automatically written off because it meets the small balance write-off criteria as defined in this follow-up schedule. You can enter the code or a hyphen (-) to display a list of codes under transaction type A (adjustments).

20. PRELIST INS? (DISPLAY ONLY)
This field indicates whether an account with pending insurance payments should be pre-listed for bad debt. Options are Y for Yes or N for No; the default is N. The account is not prelisted if there is pending insurance balance.

21. DAYS AFTER INS (DISPLAY ONLY)
This field contains the number of days to wait (up to 99) after the final insurance payment before transferring the account to bad debt. The days after insurance are grace days given to the patient to pay any outstanding amount on the account that was not paid by insurance.

22. BAD DEBT TRANSFER TRANS CODE/DESC (DISPLAY ONLY)
This field contains the transaction code indicating the transfer of this account from accounts receivable to bad debt. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type S (status transfer). This code is used to update the account transaction history. The transfer to bad debt is controlled by the hospital and takes place for pre-listed accounts.

23. DELINQUENT F/U TYPE (DISPLAY ONLY)
This field indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Options are D (detail statement), L (letter), or T (telephone).

24. DELINQUENT F/U MESSAGE (DISPLAY ONLY)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

25. PARTIAL PAYMENT F/U TYPE (DISPLAY ONLY)
This field contains the type of follow-up that is generated when less than the expected payment plan amount is received on a payment plan account. Entry options are **D** (detail statement), **L** (letter), or **T** (telephone).

26. PARTIAL PAYMENT F/U MESSAGE (DISPLAY ONLY)
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field.

27. PARTIAL PAYMENT F/U % (DISPLAY ONLY)
This field contains the percentage of the current amount due that is required to prevent partial payment follow-up.

PA ACCOUNT FOLLOW-UP

After reviewing the screen shown in , press ENTER to review the next follow-up screen for PA accounts:

```
                 General Hospital Account Follow-Up Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                    FC Typ Admit    Disch      Balance Loc
A0125700006  KELLY, MIKE              M  I/P 09/14/01 09/17/01    3483.00 PA/FCRV
 1 Guarantor Name                      2 Collector Name
   KASS, BOB                             KESOR, MIKE
 3 Collection Schedule                 4 Schedule Type
   3                                      Separate
 5 # of PA Follow-ups   6 Last Follow-up Date        7 Last Follow-up Type
   7                      07/07/02                      Wait Step
 8 Last F/U Amt         9 Last Follow-up Message      10 Last F/U Seq. #
   $3,483.00                                             5
11 Next F/U Date       12 Next F/U Seq. #    13 Hold F/U?      14 Hold F/U Date
   08/04/02              5
15 Pay Plan Type       16 Advanced Amount    17 Outstanding    18 Plan Amount

19 Prepaid Amt         20 Delinquent Date    21 Delinquent Amt  22 # Delinquent

23 Healthcare Score/Desc - Date


Display Separate Schedule (Y/N) [N]?--
```

Field Explanations

1. GUARANTOR NAME (DISPLAY ONLY)
This field contains the name of the guarantor assigned to the account.

2. COLLECTOR NAME (DISPLAY ONLY)
This field contains the name of the collector assigned to the account.

3. COLLECTION SCHEDULE (DISPLAY ONLY)
This field contains the hospital-defined follow-up schedule code number.

4. SCHEDULE TYPE (DISPLAY ONLY)
This field indicates the type of schedule the account is on (such as Separate and Payment Plan).

5. TOTAL # OF FOLLOW-UPS (DISPLAY ONLY)
This field contains the total number of follow-ups sent on this account.

6. LAST FOLLOW-UP DATE (DISPLAY ONLY)
This field contains the date in which the last follow-up occurred.

7. LAST FOLLOW-UP TYPE (DISPLAY ONLY)
This field contains the last follow-up type code.

8. LAST F/U AMT (DISPLAY ONLY)
This field contains the last follow-up amount.

9.   LAST FOLLOW-UP MESSAGE (DISPLAY ONLY)
This field contains the message number and table description of the message printed on the detail statement, follow-up letter, or telephone workfile.

10. LAST F/U SEQ. # (DISPLAY ONLY)
This field contains the last follow-up sequence number.

11. NEXT F/U DATE (DISPLAY ONLY)
This field contains the date when the next follow-up will occur.

12. NEXT FOLLOW UP SEQ # (DISPLAY ONLY)
This field contains the next follow-up sequence number.

13. HOLD F/U? (DISPLAY ONLY)
This field indicates whether or not a hold has been placed on all follow-up activities. This field contains Yes if follow-up is on hold.

14. HOLD F/U DATE (DISPLAY ONLY)
This field contains the date (if any) on which a hold was placed on follow-up activities.

15. PAY PLAN TYPE (DISPLAY ONLY)
This field contains the payment plan type (Advanced or Balance).

16. ADVANCED AMOUNT (DISPLAY ONLY)
This field contains the dollar amount of payment plan the patient or guarantor made prior to being admitted to the hospital

17. OUTSTANDING (DISPLAY ONLY)
This field contains the outstanding amount of the advanced payment plan.

18. PLAN AMOUNT (DISPLAY ONLY)
This field contains the periodic payment amount set up for the payment plan.

19. PREPAID AMOUNT (DISPLAY ONLY
This field contains the prepayment amount. This field displays an amount only if the Prepaid Amount field on the PAAR Control Table is set to Yes. If the account is on a payment plan and has amounts which are prepaid (prior to billing for the periodic plan amount), an amount is displayed in this field.

20. DELINQUENT DATE (DISPLAY ONLY)
This field contains the date the periodic payment plan is delinquent.

21. DELINQUENT AMOUNT (DISPLAY ONLY)
This field contains the delinquent amount pertaining to the payment plan.

22. # DELINQUENT (DISPLAY ONLY)
This field contains the cumulative number of times payment on the account's payment plan was delinquent.

23. 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.

When you are finished reviewing this screen, enter Yes to display the separate schedule:

```
                   General Hospital Account Follow-Up Processor
                                            Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch       Balance Loc
A0125700006  DEAN, KARL           M  I/P 09/14/01 09/17/01    3483.00 PA/FCRV
 1 Schedule #    2 Description                                3 Wait Days
   3              DOWSUNWOM1                                   2
 4 Day of Month  5 Day of Week   6 Week of Month  7 Due Days   8 Grace Days
                  Sunday                           3           1
 9 Ins Pending  10 Bill Balance 11 Restart %     12 Restart Amt 13 Min Balance
   Bill            Account          10.00%          $12.00        $2.00
14 Transfer Balance Pymt Plan to AR?  15 AR Payment Plan Schedule #
   No
16 Transfer Advanced Pymt Plan to AR? 17 AR Payment Plan Schedule #
   No
18 Transfer Customized Account to AR? 19 AR Custom Schedule #
   No
20 Delinquent F/U Type               21 Delinquent F/U Message
   Detail Statement                      3  DETAIL STATE PAST DUE 60 DAYS
22 Partial Payment F/U Type          23 Partial Payment F/U Message
   Detail Statement                      4  DETAIL STATE PAST DUE 90 DAYS
24 Partial Payment F/U %
    10.00%
```

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the guarantor for this specific patient account.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. WAIT DAYS (DISPLAY ONLY)
This field contains the number of days to wait, from admission date, before initiating follow-up. The range is 1 to 99 days.

DEFINING FOLLOW-UP FREQUENCY

There are three ways to define the frequency of account follow-up: completing the Day Of Month, Day Of Week/Week of Month, or Intervals. These options are defined below. The Interval option is entered on the second screen.

4. DAY OF MONTH (DISPLAY ONLY)
This field contains the day of the month on which the hospital wants follow-up performed. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

5. DAY OF WEEK (DISPLAY ONLY)
This field contains the day of the week on which the hospital wants follow-up performed for the account. Options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, . . . Saturday = 7. If this option is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here. The week of the month is defined in the Week of Month field.

6. WEEK OF MONTH (DISPLAY ONLY)
This field contains the week of the month during which follow-up is performed. This field works in conjunction with the Day of Week field. Entry options are 1 through 4.

7. DUE DAYS (DISPLAY ONLY)
This field contains the number of days used in calculating the delinquent date for payment plan accounts. The range is 0 to 99 days; the default is 0.

8. GRACE DAYS (DISPLAY ONLY)
This field contains the number of grace days allowed after the due days of a payment plan before the guarantor is considered delinquent. The default is 0. The follow-up date plus the due days plus the grace days equals the delinquent date.

9. INS PENDING (DISPLAY ONLY)
This field determines what type of follow-up occurs on accounts with pending insurance. Entry options are B (bill) or M (memo); the default value is B. If B is displayed in this field, the type of follow-up that occurs depends on how the Bill Balance field is set. If the field contains M, the following can occur:

- A memo message prints for the account with pending insurance.

- If there is no insurance liability, a regular follow-up occurs requesting the entire account balance.

10. BILL BALANCE (DISPLAY ONLY)
This field contains the dollar amount that is requested from the guarantor during follow-up. This field is only accessible if the Ins Pending field is set to bill (B). Entry options are P (patient balance) or A (account balance); the default is P.

- If P is entered in this field, the following can occur:

  - No memo message is created.

  - A request for the patient portion appears with information noting the insurance liability on the paper follow-up.

- No follow-up occurs if there is a zero or credit patient liability.

- If this field contains A, the following can occur:

  - No memo message is created.

  - A request for the account balance appears on the paper follow-up.

  - Follow-up always occurs asking for the account balance.

11. RESTART % (DISPLAY ONLY)
This field contains the percent of the balance due that must be paid in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence) until this percent is paid. The percentage is compared to the 'Last Follow-up Amt' noted on the previous screen. The entry range is 0 to 99.99%.

12. RESTART AMOUNT (DISPLAY ONLY)
This field contains the minimum amount which must be paid in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The range is 0 to $99,999.99.

13. MIN BALANCE (DISPLAY ONLY)
This field contains the minimum account balance required to continue sending detail statements or collection letters. The range is 0 to $999,999.99.

14. TRANSFER BALANCE PYMT PLAN TO AR? (DISPLAY ONLY)
This field only applies if the account's follow up type is defined as a (B)alance type payment plan.

15. AR PAYMENT PLAN SCHEDULE # (DISPLAY ONLY)
This field contains the AR Payment Plan Schedule and is transferred from the table information in Tables, Financial Table Maintenance, Follow up Schedules (PA). This field is used if the Transfer Balanced Pymt Plan To AR? field contains a Yes. When account payment plans transfer to AR, they use the schedule defined in this field. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step, and Next Follow-up Date when they transfer to AR.

16. TRANSFER ADVANCED PYMT PLAN TO AR? (DISPLAY ONLY)
This only applies if the account's follow-up type is defined as a (A)dvanced type payment plan.

17. AR PAYMENT PLAN SCHEDULE # (DISPLAY ONLY)
This field contains the AR Payment Plan Schedule and is copied from the Follow up Schedules (PA) information (Tables, Financial Table Maintenance, Follow up Schedules (PA)). This field is used if the Transfer Advanced Pymt Plan To AR? field contains a Yes. When account payment plans transfer to AR, they use the schedule defined in this field. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step and Next Follow-up Date, when they transfer to AR.

18. TRANSFER CUSTOMIZED ACCOUNT TO AR? (DISPLAY ONLY)
This field only applies if the account's follow-up type is defined as a custom type schedule.

19. AR CUSTOM SCHEDULE # (DISPLAY ONLY)
This field contains the AR Custom Schedule and is only used if the account's follow-up schedule is customized. This field is required if the Transfer Customized Account to AR? field contains a Yes. When customized plans transfer to AR, they use the schedule defined in this field.

20. DELINQUENT F/U TYPE (DISPLAY ONLY)
This field indicates the type of follow-up generated when a payment plan account becomes delinquent. Entry options are D (detail statement) or L (letter).

21. DELINQUENT F/U MESSAGE (DISPLAY ONLY)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

22. PARTIAL PAYMENT F/U TYPE (DISPLAY ONLY)
This field indicates the type of follow-up that is generated when a payment plan account receives a payment less than the percentage in the plan amount defined in the Partial Pay F/U % field. Options are D (detail statement) or L (letter).

23. PARTIAL PAYMENT F/U MESSAGE (DISPLAY ONLY)
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field.

24. PARTIAL PAY F/U % (DISPLAY ONLY)
This field contains the percentage of the current amount due that must be received to not produce partial payment follow-up. This field is dependent on the Partial Payment F/U Type and the Partial Payment F/U Message. If the Partial Payment F/U Type and the Partial Payment F/U Message fields are not completed, then this field cannot be completed.

After you accept this screen, the system displays the second Follow-up Schedule (PA) screen.

```
                 General Hospital Account Follow-Up Processor
                                            Fri Mar 10, 2007 12:36 pm
 Account       Name                   FC Typ Admit    Disch       Balance Loc
 A0105000012  KALE,SERIES             SP SER 02/19/01 02/25/01      0.00   AR/FCRV
 1 Schedule #              2 Description
    976                      POST CCI SCHEDULE FOR SELF PAY
  3 Edit date              4 Edit by
    06/13/03 15:07            New, Mike
                           F/U  Memo  Phone  New Accts  Rest             Agency
  5 Seq#  Follow Type      Msg  Msg   Code   Rest Seq#  Seq#   Interval  Group
    1     D Detail Statement 1        9      1          1      10




 Press NL--
```

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. SEQ # (DISPLAY ONLY)
This field contains a sequential number identifying the order of events for this follow-up schedule. You can define as many events as you wish. The sequence number and the follow-up type and code control the order in which follow-up is performed.

FOLLOW TYPE (DISPLAY ONLY
This field contains the type of paper follow-up that is used for this sequence number. Entry options are **L** (follow-up letter), **D** (detail statement), or **T** (telephone).

F/U MSG (DISPLAY ONLY
This field contains the follow-up message that appears on the detail statement or letter. You can enter the code (up to four digits) or a hyphen (-) to display a list of valid codes. This message prints on the follow-up type when the guarantor is selected for that event (sequence). If it is a telephone message, the message displays in the assigned collector's workfile.

MEMO MESSAGE (DISPLAY ONLY)
This field contains the code identifying the memo message that appears on the follow-up letter or detail statement. You can enter the code (up to four numbers) or a hyphen (-) to display a list of valid codes. If the *Insurance Pending* field on the previous screen contains Memo, this message appears on the guarantor detail statement and/or collection letter when insurance is pending on an account.

NEW ACCOUNTS RESTART SEQ # (DISPLAY ONLY
This field indicates the step in the follow-up schedule to which the guarantor is resequenced if a new account is added to the guarantor schedule and the criteria established in the Reseq. Balance field on the previous screen is met. The restart sequence number must be less than or equal to the current sequence number. This field is not valid for accounts on custom schedules or payment plans.

RESTART SEQ # (DISPLAY ONLY)
This field contains the follow-up sequence number that is used if the restart % or amount is met and the account balance is paid by the guarantor prior to the next follow-up date. The restart sequence number must be less than or equal to the current sequence number.

For example, General Hospital A sets up the follow-up sequences below:

Sequence	Paper Follow-up Type/Code	Restart
1	D - Detail Statement	
2	D - Detail Statement	1
3	L - Follow-up Letter	1
4	L - Follow-up Letter	2
5	T - Telephone	2

The follow-up event defined in sequence 1 has been performed on the guarantor and the guarantor has either not made a payment or the payment did not meet the restart percent or amount criteria before sequence 2 is scheduled to occur. The sequence 2 follow-up is performed, and the guarantor now pays the restart amount or percent before sequence 3 is performed. Since sequence 3 is now the follow-up event the guarantor would normally receive, the system checks the restart sequence field assigned to sequence 3 because payment has been received. If the restart sequence is 1, the event defined in sequence 1 is performed the next time the guarantor receives follow-up. If the minimum amount is paid, the guarantor can remain at the beginning of the follow-up schedule. If the guarantor does not pay the minimum amount, the follow-up continues through the sequences.

Only payments trigger the restart.

This field is optional, but it is suggested that you complete it to ensure that guarantors who make payments receive the proper follow-up messages and are not sent to bad debt.

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If the account is on a payment plan, the plan amount and delinquent amount must be paid in order for the follow-up to resequence.

INTERVAL (DISPLAY ONLY)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed *only* if the Day Of Month, Day Of Week, and Week Of Month fields are *not* completed. The first follow-up is scheduled from the claim submission date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number. This field is optional but one interval day should be defined.

AGENCY GROUP (DISPLAY ONLY)
This field contains the code for the collection agency group.

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

Balance Summary

This function enables you to review the insurance coverage, the payment, adjustment, refund, and balance transfers for the insurances and patient, and the balances for the insurances, patient, and account.

After this option is selected, the system displays the first Balance Summary screen, shown below.

```
                 General Hospital Balance Summary Processor
                                           Fri Mar 10, 2006 12:36 pm
Account       Name                FC Typ Admit    Disch      Balance Loc
A97-14800003 JONES,KRISTILE E      O  O/P 05/28/97 05/28/97    1825.50 AR/FCRV
Prorated:     2,281.87 at 05/30/97 3P Last Pay:      Tot chg:    $2281.87
             XI/500-100 XE/300-100 BO/300-200 ZO/100-200    Patient     Account
-Non Cvrd        0.00      72.98    2208.89    2208.89
+Room Cvrd       0.00       0.00       0.00       0.00
+Anc Cvrd     2281.87    2208.89      72.98      72.98
-Lim Exces       0.00       0.00       0.00       0.00
- Deduct         0.00       0.00       0.00       0.00
- Coins          0.00       0.00       0.00       0.00
- COB Adj        0.00    2208.89      72.98      72.98
=Est Liab     2281.87       0.00       0.00       0.00       0.00
-------------------------------------------------------------------------
Act. Liab     2281.87       0.00       0.00       0.00       0.00
-Payment         0.00       0.00       0.00       0.00       0.00       0.00
+Adjust       -456.37       0.00       0.00       0.00       0.00     456.37-
+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      1825.50       0.00       0.00       0.00       0.00    1825.50

Press NL--
```

Field Explanations

PRORATED (DISPLAY ONLY)
This field contains the total of all credits and charges assigned to this account since admission or registration. The displayed date and time represent the last time this account was prorated.

LAST PAY (DISPLAY ONLY)
This field contains the date on which the last payment for the account was made.

TOT CHG (DISPLAY ONLY)
This field contains the total charges for the account.

Column 1

PLAN ORDER/CARRIER CODE-PLAN CODE (DISPLAY ONLY)
This field lists the carriers in COB order and the carrier and plan number for the carriers (up to nine). The first character before the carrier is the claim type (for example, X=UB, B=CMS 1500, Z=Non Pro Fee 1500). The second character before the carrier reflects the Professional Fee Coverage. An I means the plan includes pro fees, E means the plan excludes pro fees, and an O means the plan only covers pro fees. The system then displays the word Patient, which is patient responsibility information, and the word Account, which is account balance information.

-NON CVRD (NON-COVERED CHARGES) (DISPLAY ONLY)
This field contains the charges assigned to this account that are not covered by this insurance plan. Charges that are not covered are items that have 0% coverage.

+ROOM CVRD (COVERED ROOM AND BED CHARGES) (DISPLAY ONLY)
This field contains the total of all room and bed charges covered by this plan.

+ANC CVRD (ANCILLARY CHARGES COVERED) (DISPLAY ONLY)
This field contains the total of all non-room and bed charges covered by this insurance plan. This amount is total covered charges that is added to the covered room and bed charge.

-LIM EXCESS (LIMITED EXCESS) (DISPLAY ONLY)
This field contains the amount of charges exceeding the plan limits set in the Insurance Plan Coverage master. For example, if there is a coverage limit of $10,000, any covered charges over this amount would be limit excess.

-DEDUCT (PLAN DEDUCTIBLE) (DISPLAY ONLY)
This field contains the deductible amount for this plan.

-COINS (COINSURANCE) (DISPLAY ONLY)
This field contains the amount of covered charges for this carrier/plan that are the responsibility of the patient. For example, if coverage is set at 80% of covered charges, the remaining 20% would be coinsurance.

-COB ADJ (COORDINATION OF BENEFITS ADJUSTMENT) (DISPLAY ONLY)
This field contains the amount of charges that have been covered by this plan but are not due because another carrier with a higher COB has already covered this amount. Primary insurance will never have a COB adjustment.

=EST LIABILITY (ESTIMATED LIABILITY) (DISPLAY ONLY)
This field contains the estimated liability of this plan. This field is calculated by subtracting limit excess, deductible, coinsurance, and COB adjustment from covered charges.

ACT. LIABILITY (ACCOUNT LIABILITY) (DISPLAY ONLY)
This field contains the total liability for this carrier/plan. This field equals the estimated liability at the time of final bill and while the account is in account location PA. If the insurance coverage is changed and the account is reprorated once the account is in AR, the estimated liability may change but the account liability will not change. The balances for insurances and patient are updated on AR and BD accounts through proration only when the account is rebilled.

PAYMENT (DISPLAY ONLY)
This field contains the amount of any payments made by this carrier/plan.

ADJUST (DISPLAY ONLY)
This field contains the amount of any adjustments made by this carrier/plan. An example could be a contractual write-off.

REFUND (DISPLAY ONLY)
This field contains the amount of any refunds issued to this carrier/plan.

BAL TRF (DISPLAY ONLY)
This field contains the total of any liability amounts transferred to or from this carrier to another carrier, this carrier to a patient, or a patient to this carrier.

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

Columns 2 Through 4

The liability of other carrier plans associated with this account (up to nine) are displayed in columns two through four. Press ENTER to view insurances five through nine if the account has more than four insurances.

Column 5

The following fields are only updated for the patient liability, estimated liability (which are the patient portion of the account), account liability, payment, adjustment, refund, balance transfer, and balance.

The "T" remains until the account is re-prorated by either online in the Instant Adjustment Bill function or in midnight processing by a Single Bill Request for an adjustment bill.

Column 6

The following fields are updated for the Account Column:

Account Liability - only present if the primary carrier's prorate flag is set to N, there is other insurance, and not all carriers have paid. This will be the Third Party Excess.

Payment, Adjustment, Refund, Balance Transfer - these fields will be the totals for all insurances and the patient.

After you view the proration information and press ENTER, the system displays the following prompt if reimbursement criteria has been defined for the patient through the patient's COB1 insurance screen:

Display Billing reimbursement (B)?--

You can display reimbursement data by entering **B**. If there is no reimbursement data, a message is displayed, and you are returned to the FPI lookup prompt so you can select another account. If reimbursement data does exist, the system displays the following screen:

```
                    General Hospital Proration Processor
                                           Fri Mar 10, 2006 12:36 pm
 Account       Name                    FC Typ Admit    Disch       Balance Loc
 89324-00001  LOWMAN,JAMES S           C  I/P 11/20/01 12/15/02     8171.36 PA/FCRV
  1 Carrier-Plan                        2 Payor
    403999 AETNA/COMM                     AO Aetna
  3 Covered Days 4 Post Date            5 Error Description
      25
  6 Table No.    7 Reimb. Type          8 Calc. Method     9 Stop Loss
    05             DRG

    Covered Charges            8,999.76
    Payments/Adjustments         838.55
    Balance                    8,061.21
    Estimated Contractual      2,230.57
    Expected Reimbursement     5,830.64




 Display Billing reimbursement (B)?--
```

Field Explanations

1. CARRIER-PLAN (DISPLAY ONLY)
This field contains the primary insurance carrier plan code and description.

2. PAYOR (DISPLAY ONLY)
This field contains the reimbursement payor code and description.

3. COVERED DAYS (DISPLAY ONLY)
This field contains the number of days that are a part of this reimbursement.

4. POST DATE (DISPLAY ONLY)
This field contains the date on which the contractual adjustment was posted to the account. Contractual adjustments are posted at the time of final bill, late bill, and rebill.

5. ERROR DESCRIPTION (DISPLAY ONLY)
This field contains the error message regarding the account's reimbursement calculations if an error exists. Possible entries are listed below:

1 = No DRG record

2 = No DRG Payor

3 = No final DRG

4 = No DRG Reimb. Amount

5 = no effective date (admission/discharge in table)

6 = no table found within range of effective date

7 = no principal diagnosis (ICD9 - Diagnosis)

8 = no medical service (Medical Service)

9 = no principal procedure code (ICD9 - Procedure)

An error indicates that reimbursement will not be done at bill time. The error must be corrected in order to generate an automatic contractual adjustment.

The Pathways Contract Management error messages are as follows. These messages describe the reason why the account was not sent to Pathways Contract Management.

No Pathways Contr Mgmt Record

Pathways Contr Mgmt Rec-not returned

Pathways Contr Mgmt Rec-not posted

Rec not sent / Claim Work Sts M—This message includes the claim work status. Valid claim work statuses that may be displayed for the claim waiting to be sent to Pathways Contract Management are as follows:

M   Manually Released

R   System Released

S   Released - Suspense Days

D   Deleted

F   Failed System Edits

H   Hold

E   Perform System Edits

P   Suppressed due to Final disposition or zero balance

Claim work statuses of **M, R, and S** require no additional attention from the user. These accounts are sent to Pathways Contract Management for reimbursement calculation in the next midnight processing run. A status of **D** is not sent to Pathways. A status of **P** is sent to Pathways if the account has a positive balance. A status of **F** or **H** requires user intervention before the claim can be released, which triggers the account to go to Pathways Contract Management.

6.   TABLE NO. (DISPLAY ONLY)
This field contains the table number of the Reimbursement payor that was used to calculate the reimbursement.

7.   REIMB. TYPE (DISPLAY ONLY)
This field contains the type of reimbursement associated with this patient for this account.

- DRG Code

- Overall Plan

- Medical Service

- ASC Payment Group

- ICD-9-CM Diagnostic Code

- ICD-9-CM Procedure Code

- Specific DRG Code

- Major Diagnostic Category

- Pathways Contract Management Interface

8.   CALC. METHOD (DISPLAY ONLY)
This field contains the reimbursement method of calculation for this account. Possible entries are:

•   flat rate

•   charge (amount or percentage)

•   by day (per diem)

9.   STOP LOSS (DISPLAY ONLY)
This field contains the maximum reimbursement amount for this payor. This stop loss calculation can be per diem, flat rate, or charge (amount or percentage). Each payor table can have a separate table for stop loss calculations.

COVERED CHARGES (DISPLAY ONLY)
This field contains the total covered charges for this carrier/plan.

PAYMENTS/ADJUSTMENTS (DISPLAY ONLY)
This field contains the total amount of payments/adjustments posted to this carrier/plan for this account.

BALANCE (DISPLAY ONLY)
This field contains the current liability for this carrier/plan. This is the covered charges minus the payments/adjustments.

ESTIMATED CONTRACTUAL (DISPLAY ONLY)
This field contains the dollar amount of the contractual adjustment to be posted, based on the reimbursement calculation. This field is displayed only if the patient has been discharged and a final DRG has been assigned.

EXPECTED REIMBURSEMENT (DISPLAY ONLY)
This field contains the dollar amount expected from this carrier/plan. It is the difference between the Balance and the Estimated Contractual amounts. This field is displayed only if the patient has been discharged and a final DRG has been assigned.

For more detailed information regarding reimbursement, refer to the documentation on reimbursement.

After you view this screen, the following prompt is displayed:

Press NL to return or press `D` for Detail claim information.

You can press ENTER to return to the FPI lookup prompt so you can select another account. If you enter **D** to display detail claim information, the following screen is displayed:

```
                    General Hospital Balance Summary Processor
                                             Fri Jun 09, 2006 01:45 pm
Account       Name              FC Typ Admit    Disch      Balance  Loc
A0613900004   SMITH, PAM         O  I/P 05/19/06            16798.15 PA/INSR

BS         CS BT   Elg Dt   Cov Chgs  Exp Reimb    Exp CA      Ded      Coins
1           1  C 05/22/06    5417.73              -5417.73
2           4  C 05/26/06
3           7  C 05/30/06
4          10  C 06/03/06
5          13  C 06/07/06

Total                        5417.73              -5417.73



                    F1Prev Page F2Next Page F7  Exit

```

Field Explanations

BS (DISPLAY ONLY)
This field displays the bill sequence number.

BT (DISPLAY ONLY)
This field displays the bill type: C (Cycle), F (Final), A (Adjustment), L (Late), or Z (Cycle Adjustment Bill).

COV CHGS (DISPLAY ONLY)
This field contains the total covered charges for this carrier/plan.

EXP REIMB (DISPLAY ONLY)
This field contains the dollar amount expected from this carrier/plan. It is the difference between the Balance and the Estimated Contractual amounts. This field is displayed only if the patient has been discharged and a final DRG has been assigned.

EXPECTED CA (DISPLAY ONLY)
This field contains the dollar amount of the contractual adjustment to be posted, based on the reimbursement calculation. This field is displayed only if the patient has been discharged and a final DRG has been assigned.

DED (PLAN DEDUCTIBLE) (DISPLAY ONLY)
This field contains the deductible amount for this plan.

COINS (COINSURANCE) (DISPLAY ONLY)
This field contains the amount of covered charges for this carrier/plan that are the responsibility of the patient. For example, if coverage is set at 80% of covered charges, the remaining 20% would be coinsurance.

Display Charges by Service Date/HCPCS

This function enables you to review any HCPCS conflicts for a charge line. For each charge line displayed, if a HCPCS conflict has been identified, the system displays the type of conflict, the CCE Indicator of Yes or No, and the HCPCS code that is identified as the conflict. Valid types of conflicts are:

Dup - Duplicate

Excl - Exclusive

Comph - Comprehensive

Compt - Component

After this option is selected, the system displays the Display Charges by Service Date/ HCPCS Processor screen, shown below.

```
        General Hospital Display Charges by Service Date/HCPCS Processor
                                                  Fri Mar 10, 2006 12:36 pm
Account      Name                   FC Typ Admit    Disch      Balance Loc
A01058-00001 MOORE,SANDY            V  O/P 02/26/01 02/26/01    46.27   PA/FCRV

Srv Date  Qty   UB Dpt   SIM Code and Description                    ABN
          HCPCS Description                  HCPCS/Mod    HCPCS Conflict
          OBSERVATION CARE                     99220
03/29/01   1  250 RXA     362 DEXTROSE 40%,1000 ML
03/29/01   1  740 EEG    3220 EEG WAKE SLEEP
03/29/01   1  740 EEG    3107 POLYSOMNOGRAPH
          POLYSOMNOGRAPHY                      95828
03/30/01   1  120 RMB    1050 SEMI-PRIVATE ROOM CHARGE
          OBSERVATION CARE                     99220
03/30/01  -1  120 RMB    1050 SEMI-PRIVATE ROOM CHARGE
          OBSERVATION CARE                     99220
03/30/01   1  250 RXA     362 DEXTROSE 40%,1000 ML
03/30/01   1  740 EEG    3220 EEG WAKE SLEEP
03/30/01   1  740 EEG    3107 POLYSOMNOGRAPH
          POLYSOMNOGRAPHY                      95828
03/31/01   1  120 RMB    1050 SEMI-PRIVATE ROOM CHARGE

Press NL--
```

Field Explanations

SRV (SERVICE) DATE (DISPLAY ONLY)
This field contains the date the service was delivered.

QTY (DISPLAY ONLY)
This field contains the quantity of the item ordered for which the patient is charged.

UB (DISPLAY ONLY)
The UB code related to this visit.

DPT (DISPLAY ONLY)
The code for the department where the service was rendered.

SIM CODE AND DESCRIPTION (DISPLAY ONLY)
This field contains the Service Item Master number and description.

ABN
This field displays data entered in STAR Patient Care. It indicates whether an
Advanced Beneficiary Notification (ABN) form is necessary, based upon the patient
type, plan, patient's diagnosis, and procedure code. This field may be blank or contain
one of the following:

Yes	An ABN is required and has been printed and signed by the patient for this charge.
No	An ABN is required and has *not* been printed and signed by the patient for this charge; an override reason has been entered instead of a signed ABN form.
App	An ABN is not required—The SIM item ordered has an approved diagnosis or approved diagnoses have not been defined for this procedure in the STAR Medical Records HCPCS Table.

HCPCS DESCRIPTION (DISPLAY ONLY)
This field contains the HCPCS description.

HCPCS/MOD (DISPLAY ONLY)
This field contains the HCPCS modifier (if present) associated with the charge.

HCPCS CONFLICT (DISPLAY ONLY)
If a HCPCS conflict has been identified, the system displays the type of conflict, the
CCE Modifier Indicator of Yes or No, and the HCPCS code that is identified as the
conflict. Types of conflicts are:

Dup (Duplicate)—Duplicate HCPCS charge

Excl (Exclusive)—Mutually exclusive with a previous charge

Comph (Comprehensive)—Comprehensive of a previous charge

Compt (Component)—Component of a previous charge

View Edit PA Charge Log

This function enables you to review changes to HCPCS, HCPCS modifiers, diagnosis,
ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, Mutual Excl/Compre/

Comp HCPCS, or Reference Facility in Patient Accounting charge information. When you select this function, the following screen is displayed:

```
                   General Information View Edit PA Charge Log Processor
                                           Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch       Balance Loc
A05105-00003 MOORE,CAB              A  OPC 04/10/05 04/10/05      146.28  PA/FCRV

Trans Comment: CSR/6010 HC,RF

Seq   Tran  Description                  Tran
Nbr   Code                              Date     Dept/SIM     Srv Dt
1     S0101 Edit PA Chg for Inactive A 01/20/06   CSR/6010     04/10/05




     F1Prev Page F2Next Page F5View Detail Trans F6 Reset  F7  Exit   ?

```

The system displays a sequence number identifying this transaction to the patient account. The most recent transaction will have a code of one. The transaction code, description, transaction and posting dates, the transaction amount, accounting location, transaction type, and batch number for each transaction are displayed.

The following function keys are displayed at the bottom of the screen:

-   **F1** -Press F1 to return to the previous page.

-   **F2** -Press F2 to go to the next page.

-   **F5** -Press F5 to view detail of a transaction. A highlight indicates the transaction that can be viewed.

-   **F6** -Press F6 to reset the screen.

-   **F7** -Press F7 to exit the transaction.

The cursor is displayed on the sequence number of the first transaction and can be moved from transaction to transaction using the Arrow keys. To view transaction detail, place the cursor on the desired sequence number and press the F5 key. The following screen is displayed if a HCPCS code or HCPCS modifiers were edited in the STAR

Patient Accounting charge and a charge revision from STAR Order Management removed information previously entered in STAR Patient Accounting:

```
                    General Hospital Account Inquiry Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch       Balance  Loc
A04303-00001 TESTA,PCONF            KE OPC 10/29/04 10/29/04     1859.60- AR/FCRV
 1 Trans Code/Description              2 Origin          3 Trans Date/Time
   S0004-Edit PA Chg                     User              06/15/05 01:02am
 4 User ID                          5 Terminal Location  6 BS/CS      7 PCI
   Charge,Fixer
 8 Prior Location  9 Prior Balance  10 New Balance      11 Bill Seq Printed On
                                       $2,040.00
12 Posting Date    13 Trans Amount   14 From Carrier/Plan           15 Days Pd
   06/15/05
16 Cash Post Type 17 Batch Number    18 To Carrier/Plan             19 DRG Pd
                                        500/700-TEST PLAN FOR PAT
20 Receipt Number 21 Remit Date 22 Remit Advice Number       23 Outlier Type

24 Coin/Ded/Co-Pay/Pat Resp                         25 Claim Disposition

26 Status Type     27 Old/New Status       28 Note Type/No 29 ERA Clm Status
   Edit PA Chg         ABCDE/LMNOP
30 Ref Trans?    31 Comment
                    RAD/1015  HC-OM Rev
Press ENTER to return, L for list of changes, or C for Charge Detail --
```

This screen can also be reached through the Transaction History function. For details on the screen, see . For the View PA Charge Edit function, the following fields contain information relating to a change made in the Edit PA Charge function:

• The Status Type field contains *Edit PA Chg,* indicating that charge information was changed in the Patient Accounting data.

• The Old/New Status field contains both the previous and new HCPCS code. The previous Patient Accounting HCPCS can be the HCPCS from Order Management or it can be the Patient Accounting HCPCS code previously edited. The HCPCS codes can be the same if other fields were edited in the Patient Accounting charge.

• The Comment field contains the SIM department and SIM code followed by the list of fields changed. If the transaction was created due to a charge revision, *-OM Rev* is displayed at the end of the comment.

When the status field contains Edit PA Chg, the following prompt is displayed:

Press ENTER to return, L for list of changes, or C for Charge Detail --

You have the following entry options:

• Press ENTER to return to the previous screen.

- Enter **C** for Charge Detail, to view the current charge information for the edited charge noted in transaction history. For details on this screen, see the Billing Information Screen on page .

- Enter **L** to review a list of changes in STAR Patient Accounting to the HCPCS code, HCPCS modifiers, the order/charge diagnosis stored for the charge in STAR Patient Accounting, ABN information, NDC information, and Reference Facility. Included in the HCPCS modifier field are the ABN indicators, CPT Level I and CPT Level II Modifiers which may be used in duplicate HCPCS processing and cross-reference code set conflict processing. The following screen shows both the old and the new values for the fields that changed:

```
                   General Hospital Account Inquiry Processor
                                            Fri Mar 10, 2009 12:36 pm
Account       Name                     FC Typ Admit    Disch       Balance  Loc
A04303-00001 LANE, BOB                 KE OPC 10/29/04 10/29/04     1859.60- AR/FCRV
CAR/1100     01/18/08     DUPLICATE ECG 12 LEAD
HCPCS   93015              CARDIOVASCULAR STRESS TEST
DX      M00.252/414.02 Other streptococcal/CRN ATH ATLG VN BPS GRFT
Item                 Old
                     New

DX                   ICD-10: M01.x11 Direct infection of right shoulder in infec
                     ICD-10: M00.252 Other streptococcal arthritis, left hip
DX                   ICD-9: 411.1 INTERMED CORONARY SYND
                     ICD-9: 414.02 CRN ATH ATLG VN BPS GRFT
ABN                  10/Yes-ABNY-PATIENT SIGNED AND WITNESSED
                     10/No-ABNN-ABN NOT OBTAINED/WE FORGOT
NDC Info             60 GR
                     120 GR




Press ENTER to exit--
```

Field Explanations

DX (DISPLAY ONLY)
This field displays the most recent ordering diagnoses and descriptions on the charge. The diagnosis codes display first. The ICD-10 Ordering Diagnosis displays if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this code and the slash, such as *A12.34xD/.* If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as */825.1.* If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows: A12.34xD/825.1. The diagnosis descriptions then display. The ICD-10 Ordering Diagnosis description displays if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis description if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this description and the slash, such as: Collapsed Vertebra NOS, Site Unspecified /. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as: /Vertebra Injury. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows:Collapsed Vertebra NOS, Site Unspecified/ Vertebra Injury.

ITEM (DISPLAY ONLY)
This column contains the name of the field that was changed.

OLD (DISPLAY ONLY)
This column contains the value of field before it was changed.

NEW (DISPLAY ONLY)
This column contains the value of the field after it was changed.

Series Account Tracking Information

This function enables you to review accounts which are part of an auto series discharge and registration chain existing in location PA. The selected account and all linked accounts are displayed along with the occurrence code and value code for physical, occupational, speech, and cardiac rehab therapy recorded for each account.

After this option is selected, the system displays the Series Account Tracking Inform Processor, shown below:

```
            General Hospital Series Account Tracking Inform Processor
                                               Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch         Balance Loc
A0111700001  Vance, Bob             M  SD2 04/27/01 05/26/01        0.00   AR/FCRV


      Account #      Adm Date     Dis Date      Last Active     Init
    PT Date - Vsts   OT Date - Vsts   ST Date - Vsts    CR Date - Vsts
  1   A0107900006    03/20/01      03/20/01                      CJW
     03/20/01     1
  3   A0108000001    03/21/01      03/22/01                      ***
     03/21/01     1    03/21/01     2
  5   A0108200001    03/23/01      04/03/01                      ***
                      03/23/01     3
  7   A0109400001    04/04/01      04/25/01                      ***
     04/24/01     1    04/22/01     1    04/22/01     1    04/21/01     2
  9   A0111600001    04/26/01      04/26/01                      ***
                                        04/26/01     1    04/26/01     1
 10   A0111700001    04/27/01      05/26/01                      ***




Press NL--
```

Field Explanations

ACCOUNT # (DISPLAY ONLY)
This field displays the patient account number. The last entry is the current account number.

ADM DATE (DISPLAY ONLY)
This field displays the date of admission associated with the account number entry.

DIS DATE (DISPLAY ONLY)
This field displays the date of discharge associated with the account number entry.

LAST ACTIVE (DISPLAY ONLY)
This field displays the last date the account had activity. Activity is considered a visit check in date, a last charge date, and a discharge date.

INIT (DISPLAY ONLY)
This field displays the initials of the person who assigned the account number. The only actual entry will be the first one. All subsequent account numbers are assigned automatically by the system for automatic re-admit series patients. The account numbers assigned by the system are indicated by three asterisks (***) in this field.

PT DT - VSTS (DISPLAY ONLY)
This field displays the start date and number of Physical Therapy visits associated with this visit. The values being displayed are the stored values for Occurrence code 35 and Value code 50. This field is calculated by the system based on the charges on the account, and the UB therapy revenue code table. It does not include a user-entered occurrence or value code for therapy (entered on the UB value codes or UB occurrence codes screen in the admission information).

OT DT - VSTS (DISPLAY ONLY)
This field displays the start date and number of Occupational Therapy visits associated with this visit. The values displayed are the stored values for Occurrence code 44 and Value code 51. This field is calculated by the system based on the charges on the account and the UB therapy revenue code table. It does not include a user-entered occurrence or value code for therapy (entered on the UB value codes or UB occurrence codes screen in the admission information).

ST DT - VSTS (DISPLAY ONLY)
This field displays the start date and number of Speech Therapy visits associated with this visit. The values displayed are the stored values for Occurrence code 45 and Value code 52. This field is calculated by the system based on the charges on the account and the UB therapy revenue code table. It does not include a user-entered occurrence or value code for therapy (entered on the UB value codes or UB occurrence codes screen in the admission information).

CR DT - VSTS (DISPLAY ONLY)
This field displays the start date and number of Cardiac Rehab visits associated with this visit. The values displayed are the stored values for Occurrence code 46 and Value code 53. This field is calculated by the system based on the charges on the account and the UB therapy revenue code table. It does not include a user-entered occurrence or value code for therapy (entered on the UB value codes or UB occurrence codes screen in the admission information).

Service Time Tracking History

This function displays all key data events and their associated data for accounts if service time processing is active for the facility and for the account. The screen assists in tracking the status of key data changes for accounts that qualify for service time processing.

After this option is selected, the system displays the following screen:

```
          General Hospital Service Time Tracking History Processor
                                          Thu Aug 23, 2007 05:32 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A0720600003   SHORE,FRED            O  LIC 07/25/07             16564.83 PA /INSR
                    Pat      Med        Adm    Att
Date     Time       Type PI  Serv  FC   Dr     Dr
07/25/07 18:23      LIC  I   ER    O    32     10
07/24/07 06:32      I/P  I/P ER    O    32     10
07/23/07 20:23      ER   E   ER    O    32     10
Initial             ER   E   ER    S    32     10








                  F1Prev Page F2Next Page F7  Exit
```

The header record on this screen displays current patient account information.

Following the header is a display of key data events that can impact revenue reclassification. The information being displayed is the key information as of the effective date and time being logged, in reverse chronological order.

A second header displays below the patient account header information with the following columns:

Date - This column displays the effective date that the transaction contained when it was received on STAR Patient Accounting.

Time - This column displays the effective time that the transaction contained when it was received on STAR Patient Accounting.

Pat Type - This column contains the patient type associated with the visit for the effective date/time logged.

PI - This column contains the patient indicator associated with the visit for the effective date/time logged.

Med Serv - This column contains the medical service associated with the visit for the effective date/time logged.

FC - This column contains the financial class associated with the visit for the effective date/time logged.

Adm Dr - This column contains the admitting doctor associated with the visit for the effective date/time logged.

Att Dr - This column contains the attending doctor associated with the visit for the effective date/time logged.

If a user accesses this function and service time processing is not active for the facility, the system displays the following error message:

Error: Service Time Processing is not active for this facility.

If service time processing is active for the facility, but the account does not qualify for service time processing because processing was not active at the time that this visit was initiated on STAR Patient Accounting, the system displays the following error message:

Error: This account is not active for Service Time Processing.

ACCOUNT NOTES

This function enables you to edit and view notes for specific accounts. These notes can be freeform or standard notes.

Standard notes are system-defined and contain a brief description of a particular account event. An example of a standard note could be Sent claim - claim returned - wrong address. Standard notes are assigned a transaction type of T and are recorded in the account's transaction history. The hospital can define any number of standard notes in the system.

Freeform notes are made up of two parts. The first part is a brief one line description of the contents of the note as summarized by the user. This line description can be used in the future to locate the note. The second part can be up to 13 lines of 75 characters. Here, you can fully describe the account event. Freeform notes are also recorded in the account transaction history using the transaction code specified in PA/AR Control. Access to and editing of freeform notes depends on the parameters established in the Biller/Collector Worklist Control table. For details on these parameters, refer to the *General Information Volume* of the STAR Financials Patient Accounting Reference Guide.

After you select the Account Notes function, the following screen is displayed:

```
            General Hospital Account Notes Processor
                                     Fri Mar 10, 2006 12:36 pm
Account      Name              FC Typ Admit    Disch       Balance Loc
A89334-00001 HALL,RUTH A       C  I/P 11/25/89 11/30/89      60.00  AR/FCRV
Page:01                            Notes                 ##=Current Choices
( 1) BILLER NOTE 1/RFH              11/30/89 [F] Smith,Mary A
( 2) WAITING FOR ATTACHMENTS - MR   11/30/89 [S] Smith,Mary A
( 3) FF BILLER NOTE FOR RAH         12/04/89 [F] Smith,Mary A
( 4) CLAIM RETURNED - WRONG ADDRESS 12/04/89 [S] Smith,Mary A
( 5) CREDIT CHECK REQUESTED         06/17/03 [F] Smith,Mary A
( 6) ADDRESS CHECK REQUESTED        06/17/03 [F] Smith,Mary A
( 7) ADDRESS/CREDIT CHECK REQUESTED 06/17/03 [F] Smith,Mary A




 Enter choice, view all(V), add free form(F) or standard(S) notes--
                        end selection(NL)
```

Information displayed on this screen includes the patient account number, patient name, financial class, patient type, admit and discharge dates, the account balance and accounting location. Note information includes the note and description, the date it was assigned to this account, whether the note is freeform (F) or standard (S), and the name of the system user who assigned this standard note or created this freeform note.

When this screen is displayed, you have several options:

- You can select a note or notes to view or edit (only freeform notes can be edited). Only a freeform note can be edited and only by the original creator of the note. The Edit Notes field in the Biller/Collector Worklist Control table must be set to Yes.

- You can view all account notes by entering **V** (view all). You can also edit the freeform notes. A freeform note can be edited only by its original creator. The Edit Notes field in the Biller/Collector Worklist Control table must be set to Yes.

- You can add a freeform note by entering **F** (freeform).

- You can add a standard note by entering **S** (standard).

NOTE: Once you add a freeform or standard note to an account, you cannot delete the note. When the account is archived, the associated notes are also archived. If note confidentiality has been activated, only users with a security code equal to or greater than the security attached to the freeform note have access to the note text. If you do not have the appropriate security, the note text will display as ****Account Note is Confidential****.

Adding a Standard Note

After you enter S (standard notes), the system prompts you to enter the transaction code used to record this note in the account transaction history. You can enter the code (up to four digits) or a hyphen (-) to display a list of valid codes. If you enter a hyphen (-), the system displays the following screen:

```
              General Hospital Account Notes Processor
                                           Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch        Balance Loc
A89334-00001 HALL,RUTH A            C  I/P 11/25/89 11/30/89      60.00   AR/FCRV
   Transaction                               Valid         Combined to
   Type  Code  Description                   Accts   Combine Type  Code
( 1) T - 0007  SENT DATA MAILER              A/R
( 2) T - 0008  TELEPHONE FOLLOW UP           ANY
( 3) T - 0010  SENT COLLECTION LETTER        A/R
( 4) T - 0011  SENT DETAILED STATEMENT       A/R
( 5) T - 0099  NOTES                         ANY




 Enter choice--
```

Along with basic patient account data, information displayed includes the transaction type, transaction code, a description of the note, the type of accounts for which this

note is valid, whether the note is a combined print, and what (if any) transaction types/ codes this standard note is combined to for printing.

After you enter or select the transaction code, the note associated with the code is added to the account and the transaction is completed.

NOTE: Editing and confidentiality do not apply to standard notes.

Adding a Freeform Note

After you enter **F** (freeform notes), the system displays the following screen:

```
           General Hospital Account Notes Processor
                                     Fri Mar 10, 2006 12:36 pm
 Account       Name               FC Typ Admit    Disch       Balance Loc
 A89334-00001 HALL,RUTH A         C  I/P 11/25/95 11/30/95      60.00   AR/FCRV
  1 Code      2 Description                       3 Last Edit date
    NEW                                             12/06/95 11:52am
  4 Created By                 5 Creation Date    6 Edit text?   7 Security
    Smith,Mary A               12/06/95




 Press NL--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the word NEW in this field. Once the message is completed and accepted, the system assigns a code number. Each freeform note is assigned a code number corresponding to the order of its creation. The first note is 1, the second 2, and so on.

2. DESCRIPTION (30-C-R)
This field contains the description of the purpose of the note. This description is displayed in the account's transaction history and on the first screen of the Account Notes function.

3. LAST EDIT DATE (DISPLAY ONLY)
This field contains the date and time this note was last edited. When a new note is being created, the system displays the current date and time.

4. CREATED BY (DISPLAY ONLY)
This field contains the name of the user creating this note.

5. CREATION DATE (DISPLAY ONLY)

This field contains the date on which the note was created. This date is used as the note creation date in the account's transaction history and is displayed on the list of Account notes. Account notes are displayed in reverse chronological order.

6. EDIT TEXT? (1-A-R)

This field indicates whether the length of a new freeform note exceeds the 30-character description. If the note exceeds the 30-character description, enter **Y**. If the note does not exceed 30-characters, enter **N**. The default is N. If you enter Y, the system displays the following screen:

```
                General Hospital Account Notes Processor
                                           Fri Mar 10, 2006 12:36 pm
 Account       Name                   FC Typ Admit    Disch        Balance Loc
 A89334-00001 HALL,RUTH A             C  I/P 11/25/95 11/30/95       60.00   AR/FCRV
  1 Code       2 Description                    3 Last Edit date
    NEW          Ins. Coverage Terminated          12/06/95 11:52am
  4 Created By                   5 Creation Date  6 Edit text?       7 Security
    Smith,Mary A                   12/06/95         Yes ----------------------------
  -----------------------------------------------
 01| Patient's employer called to advise that insurance coverage is being     |
 02| terminated at end of month.  Patient notified and will make financial     |
 03| arrangements, if necessary, but anticipates being discharged prior to     |
 04| end of month.  Attending physician's office notified.                     |
 05|                                                                           |
 06|                                                                           |
 07|                                                                           |
 08|                                                                           |
 09|                                                                           |
 10|                                                                           |
 11|                                                                           |
 12|                                                                           |
 13|                                                                           |
    F1          F2           F3        F4     F5           F6          F7     F10
    Delete Line  Insert Line  Center   Exit   Store Line   Restore Line Pack  Help
```

The function keys listed at the bottom of this screen are used to help you enter this message. Pressing F4 exits the extended message text. The system then prompts you to accept the screen.

7. SECURITY (2-N-R)

This field contains the two-digit security code assigned to the note. This can be any number from 0 to 80. It defaults to the security level of the user entering the note. Since the security assigned to the note will be changed only on an exception basis, the cursor does not automatically enter this field. You can access the field by entering / and the field number. When you access this field, the prompt to enter the new security level of the note is displayed. Enter any security level from 0 to 80. If note confidentiality has been activated, only users with a security level equal to or greater than the security on the note may view the note text.

Editing a Freeform Note

A freeform note may be modified if the Edit Notes field in the Biller/Collector Worklist Control table is set to Yes. However, you can edit only the notes that you created.

Select the note to be edited and then the Description, Edit Text?, or Security fields. Once all editing is completed, accepting the screen completes the transaction.

Totals By Responsible Party

Totals by Responsible Party can be accessed from the Account Inquiry Flash Card screen. The system displays total dollar amount for the coinsurance, co-pay, deductible and patient responsibility for the account and all carrier/plans when a payment is received. If the information is unknown for a claim/account or no reimbursement is being estimated, *UNK* is displayed in the Exp Rmb Adj field. If the account has not final billed or there is an error description, *TBD* is displayed in the Exp Rmb Adj field.

If the following error message is displayed, you should try to access the account at a later time. This error message means the account is already locked or in use by another user and if the account is already locked the system cannot lock the account and total these amounts.

    Error: Please try later. Cannot lock account to create pt resp totals!

When you access this function, the system displays the following screen:

```
                  General Hospital Totals by Responsible Party
                                         Fri Feb 25, 2011 03:50 pm
Account       Name               FC Typ Admit    Disch      Balance Loc
A09021-00001 MOORE,CGS A          A  OPC 01/21/09 01/21/09   24056.26-AR /ACCF
Last Pat Pay:          0.00 10/28/10  Ins Pay:           0.00 10/18/10 (COB2)
Total Chg:             0.00             Exp Pay: 3
          XI/500-700 BO/500-200 XI/500-700             Patient     Account
Coins         200.00
Co-Pay        100.00
Ded           750.00
Pt Resp
Total Pt Resp 1050.00
#Adj/Pmts
Exp Rmb Adj     UNK
-----------------------------------------------------------------------
Act Liab      8000.00
-Payment      7977.20        0.00       0.00              50.00     7977.20
+Adjust     -16131.26        0.00       0.00               0.00    16131.26-
+Refund          0.00        0.00       0.00               0.00        0.00
+Bal Trf         3.00        0.00       0.00               3.00-       0.00
=======================================================================
=Balance    -24105.46        0.00       0.00              49.20    24056.26-

Press NL to exit--
```

Field Explanations

LAST PAT PAY (DISPLAY ONLY)
This field contains the amount and date of the last patient payment.

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INS PAY (DISPLAY ONLY)
This field contains the amount and date of the last insurance along with the COB number.

TOTAL CHGS (DISPLAY ONLY)
This field contains the total dollar amount of the charges posted to the account.

EXP PAY (DISPLAY ONLY)
This field contains the number of expected payments is displayed.

The amounts in the fields below are all displayed and totaled for each carrier/ plan:

COINS (DISPLAY ONLY)
This field contains the total coinsurance amount as defined by the payor.

COPAY (DISPLAY ONLY)
This field contains the total copay amount as defined by the payor.

DED (DISPLAY ONLY)
This field contains the total deductible amount as defined by the payor.

PT RESP (DISPLAY ONLY)
This field contains the total patient responsibility amount as defined by the payor.

TOTAL PT RESP (DISPLAY ONLY)
This field contains the sum of the patient responsibility, deductible, coinsurance, and copya are totaled for viewing.

 # PMT/ADJ (DISPLAY ONLY)
This field contains the total number of payments and adjustments posted to the account.

EXP RMB ADJ (DISPLAY ONLY)
This field contains the contractual adjustment amount as calculated by reimbursement (i.e. PCON, OPPS, STAR Reimbursement).

ACT LIAB (DISPLAY ONLY)
This field contains the actual liability as calculated for the carrier/plan.

PAYMENT (DISPLAY ONLY)
This field contains the total dollar amount of payments received and posted from the payor.

ADJ (DISPLAY ONLY)
This field contains the total dollar amount of adjustments received and posted from the payor.

REFUND (DISPLAY ONLY)
This field contains the total dollar amount of any refunds that have been processed.

BAL TRF (DISPLAY ONLY)
This field contains the total dollar amount of any balance transfers that have occurred for this plan.

BALANCE (DISPLAY ONLY)
This field contains the current balance for this carrier/plan.

Chapter 2 - ACCOUNT REVISION

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

ACCOUNT REVISION

The Account Revision function enables you to view and edit a patient's admission and financial information, including:

- Patient Financial Class

- Patient Biographics

- Guarantor Information

- Insurance Information

Many of the fields on the account revision screens are parameter- or master file-driven, and/or contain information that is retained as part of the MPI (Master Patient Index). If, for example, you decide to change the name of the patient, you are prompted whether the old name and information should be retained in the MPI. The new patient name entered retains the old patient data and, if you respond Yes to the prompt, you can reference the account by the old name.

After you select the Account Revision function, the system displays the following prompt:

Patient (P) or guarantor (G) lookup? [P]--

To access the account you want to revise according to the patient, enter **P** or press ENTER to accept the default. To access the account you want to revise according to the guarantor, enter **G**.

If this is a multifacility installation and you are allowed to access information for multiple facilities, if you enter P or press ENTER, the system displays a screen displaying the facilities you can access. Select the facility from the list on the screen. If you enter G to access an account by guarantor, the system only displays information about the guarantor in the facility or facilities you are allowed to view.

The system then displays the following prompt:

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

Select the account you want to revise using the techniques described for the FPI Lookup procedure in the *General Information Volume* of the STAR Financials Patient Accounting Reference Guide.

After you select an account, the system displays a list of accounts for the patient or guarantor. Press ENTER, and the following screen is displayed:

```
              General Hospital Account Revision Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name              FC Typ Admit    Disch      Balance Loc
A0507700002  CROWN, MARK        M  CBP 03/18/05 03/19/05     0.00   AR/FCRV
 1 Total Charges    2 Total Adj      3 Total Payments  4 Ref? Exp? Pat Class
         $0.00             $0.00            $0.00        No   No
 5 Ins Liability   6 Ins Adj        7 Ins Payments    8 External Agency
         $0.00             $0.00            $0.00
 9 Pt Liability   10 Patient Adj   11 Pt Payments    12 Last Pt Payment
         $0.00             $0.00            $0.00
13 Wkfl    14 Sch  15 Schd Typ   16 Phone 17 Inv Gu Addr 18 Lst FU Dt Ty Sq Hld
                      Separate     Y/N/Y   No                              No
19 BD Pre-Listed   20 BD Date    21 Agency            22 BD Transfer Amount

23 SSN #      24 Birth Date 25 BillHld 26 DPW/CMS 27 Notes 28 PRE/Adm 29 Accts
   345-35-4354   05/12/1968    No        No/Yes     No       /MLK       Yes
30 COB Ins Carrier      #Clm LCS SubmitDt   Est Amt Due   Amt Pd Dsp Date
    1  MEDICARE A
    2  MEDICARE PROFESSI  1   2               $0.00


Press NL for Menu, enter code, or '-' for list--
```

This screen provides a quick reference for key financial information about the patient's account. From this screen, press ENTER and the Account Revision menu screen is displayed. You can enter a hyphen (-) for a table look-up for valid function codes or the function code.

Field Explanations

1.   TOTAL CHARGES (DISPLAY ONLY)
This field contains the dollar value of all charges for the patient.

2.   TOTAL ADJ (DISPLAY ONLY)
This field contains the dollar value for all adjustments (both patient and insurance) made on the account.

3.   TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total payments posted to this account.

4.   REF? EXP? PAT CLASS (DISPLAY ONLY)
This field displays the refund indicator, the expiration indicator, and the patient's classification.

Ref contains either a Y for yes to indicate that a refund has been posted for this account or an N for no to indicate that no refund has been posted for this account.

Exp contains either a Y for yes to indicate that the patient is expired or a N for no to indicate that the patient is not expired.

Under **Pat Class**, the system displays the Patient Classification for the account. If the Financial Patient Classification Table had the Alert on PA? field set to **Y** when the classification was determined for the account, the system displays the patient classification with leading and trailing asterisks, for example, "**VIP**". If Alert on PA? was set to **N** when the classification was determined for the account, the system displays the patient classification without leading and trailing asterisks, for example, "EMP".

The final position indicates whether follow-up for the account is being suppressed. If the Financial Patient Classification Table had the Suppress F/Up on PA? field set to **N** when the classification was determined for the account, then *a* is displayed, indicating that follow-up continues to be produced. If the Suppress F/Up on PA? field was set to **Y** when the classification was determined for the account, and the suppression indicator in Account Status has not been changed to Clear, then *s* is displayed, indicating follow-up is suppressed. If the Suppress F/Up on PA? field was set to **Y** when the classification was determined for the account, and a user has cleared the suppression indicator in Account Status, then *c* is displayed, indicating follow-up is not suppressed due to a user overriding the value set by the Financial Patient Classification Table.

5. INS LIABILITY (DISPLAY ONLY)
This field contains the current balance due from all insurance plans.

6. INS ADJ (DISPLAY ONLY)
This field contains the dollar value of all insurance adjustments made on the account.

7. INS PAYMENTS (DISPLAY ONLY)
This field contains the dollar value of all insurance payments made on the account.

8. EXTERNAL AGENCY (DISPLAY ONLY)
This field contains the external agency code, collection status code, group word, and group word date.

9. PT LIABILITY (DISPLAY ONLY)
This field contains the current balance due from the patient on the account.

10. PATIENT ADJ (DISPLAY ONLY)
This field contains the total of all patient adjustments posted to the account.

11. PT PAYMENTS (DISPLAY ONLY)
This field contains the dollar value of all patient payments made on the account.

12. LAST PT PAYMENT (DISPLAY ONLY)
This field contains the last patient payment date and the payment amount.

13. WKFL (DISPLAY ONLY)
This field contains any workfile entries that exist for the account. Multiple workfile codes are separated by a comma. Workfile codes include:

- A - Active

- B - Business Office

- D - Delinquent

- I - Insurance

- P - Partial Payment

- R - Promise to Pay

- S - Standard

- E - Pending/Candidate

- W - Internal/Bad Debt

- C - Internal Collection

- FI - Focus Insurance

- FP - Focus Patient

- FC - Focus Claim

14. SCHD (DISPLAY ONLY)
This field contains the follow-up schedule code assigned to the account.

15. SCHD TYPE (DISPLAY ONLY)
This field contains the follow-up schedule type assigned to the account.

16. PHONE (DISPLAY ONLY)
This field indicates whether it is acceptable to leave a phone message for the patient and whether the phone number is a confidential number.

- The first position of this field displays a Y for Yes to indicate it is acceptable to leave a message for the patient or it displays an N for No to indicate it is not acceptable to leave a message for the patient. The phone message field contained on the Patient Page or Alternate Address page for the patient is used for the first position of the field.

  - If the phone number is not a confidential phone number, the system uses the value in the Phone Message field on the Patient Page in Patient Processing.

  - If the phone number is a confidential phone number, the system uses the value in the Phone Message field on the Alternate Address screen for the patient.

- The second position of this field displays a Y for Yes to indicate the phone number is a confidential phone number or it displays an N for No to indicate it is not a confidential phone number. The phone number contained in the Phone Number field on the Alternate Address page is considered the confidential phone number when the Confidential Add-Ph field on the Alternate Address screen is set to Yes.

    - If there is a phone number on the Alternate Address page and the Confidential Add-Ph field is set to Yes, the second portion of the field displays a Y for Yes, there is a confidential phone number.

    - If there is not a phone number contained in the Phone Number field on the Alternate Address page or the Confidential Add-Ph field on the Alternate Address screen is not set to Yes, there is not confidential phone number defined.

- The third position of this field reflects whether the confidential/alternate address is being used at the visit level. The parameter contains Y for Yes if the confidential/ alternate address is being used; it contains N for No if the confidential/alternate address is not being used.

17. INV GU ADDR (DISPLAY ONLY)
This field indicates whether the guarantor address is invalid or missing on the guarantor page or alternate guarantor page depending on which address is being used. A **Y** reflects the address is invalid or missing. An **N** reflects a valid and existing guarantor address.

18. LST FU DT TY SQ HLD (DISPLAY ONLY)
This field contains the last follow-up date, type, and sequence number processed for the account. The HLD (Hold) field indicates whether the account has been placed on follow-up hold, the account is assigned to a guarantor's schedule, or the guarantor has been placed on follow-up hold.

19. BD PRE-LISTED (DISPLAY ONLY)
This field indicates the Bad Debt prelist status of the account.

20. BD DATE (DISPLAY ONLY)
This field indicates the Bad Debt prelist date, or if the account is already in Bad Debt, the transfer to Bad Debt date.

21. AGENCY (DISPLAY ONLY)
This field contains the assigned collection agency for the account if the account has been prelisted or transferred to Bad Debt.

22. BD TRANSFER AMOUNT (DISPLAY ONLY)
This field contains the balance for the account that was transferred to Bad Debt.

(US) 23.SOCIAL SEC # (DISPLAY ONLY)
(CN) 23.HEALTH CARD # (DISPLAY ONLY)
This field contains the account's Social Security/Health Card Number. The Social
Security Number is displayed in a filtered or unfiltered format based on parameters set
on the STAR Patient Processing Employee Demographic screen. Those parameters
define whether you can view all, part, or none of the Social Security Number for the
patient, guarantor, or relative.

24. BIRTH DATE (DISPLAY ONLY)
This field contains the patient's date of birth.

25. BILL HLD (DISPLAY ONLY)
This field indicates (either Yes, No, or DPW) whether the account has been placed on
billing hold for the account. If the account in on billing hold because of the DRG
payment window (DPW), the system displays *DPW*.

26. DPW (DISPLAY ONLY)
This field indicates Yes when an account is flagged for DRG Payment Window (DPW).
This field applies to COB1 only. This field is left blank for accounts that do not meet the
preliminary criteria. The default value is blank.

27. NOTES? (DISPLAY ONLY)
This field indicates (either Yes or No) whether there are existing notes for the account.

28. PRE/ADM BY (DISPLAY ONLY)
This field contains the initials of the person who admitted the patient.

29. ACCTS (DISPLAY ONLY)
This field indicates if the patient has had other visits to the facility.

30. COB, INS CARRIER, # CLM, LCS, SUBMIT DT, EST AMT DUE, AMT PD, DSP, DATE
(DISPLAY ONLY)
Up to five different insurance carriers can be displayed in this field. The insurance
carriers will be displayed in the Coordination of Benefits order. The COB number and
insurance description display in the COB column. The number of claims for this carrier
is displayed in the # Clm column. The last claim sequence number for the carrier is
displayed in the LCS column. The submission date of the last claim is displayed in the
Submit Dt column. The Estimated Amount Due for the claim is displayed in the Claim
Amount column if the claim has been submitted. The amount paid for the last claim
sequence is displayed in the Amt Pd column. Dispositions can be F-Final, P-Partial, D-
Denied, A-Adjusted to zero, T-Transfer, or C-Clear disposition. The disposition of the
last claim sequence is displayed in the DSP column. The date of the last claim
sequence is displayed in the Date column.

When you finish reviewing this screen, you can enter a hyphen (-), a valid code, or press ENTER. If you enter a hyphen, the following screen is displayed:

```
                  General Hospital Account Revision Processor
                                         Fri Mar 10, 2007 12:36 pm
Account      Name                  FC Typ Admit    Disch      Balance   Loc
A98239-00001 RANIER,WANDA          M  I/P 08/27/98 08/30/99  174345.00 AR/FCRV
 1 Total Charges    2 Total Adj      3 Total Payments   4 Ref? Exp? Pat Class
         $0.00             $0.00             $0.00        No   No
 5 Ins Liability   6 Ins Adj       7 Ins Payments    8 External Agency
         $0.00             $0.00             $0.00
 9 Pt Liability   10 Patient Adj   11 Pt Payments    12 Last Pt Payment
         $0.00             $0.00             $0.00
13 Wkfl    14 Sch  15 Schd Typ   16 Phone 17 Inv Gu Addr 18 Lst FU Dt Ty Sq Hld
                   Separate       Y/N/Y    No                           No
19 BD Pre-Listed   20 BD Date    21 Agency                22 BD Transfer Amount

23 SSN #        24 Birth Date 25 BillHld 26 DPW/CMS 27 Notes 28 PRE/Adm 29 Accts
   345-35-4354    05/12/1968    No         No/Yes    No       /MLK       Yes
30 COB Ins Carrier      #Clm LCS SubmitDt    Est Amt Due    Amt Pd Dsp Date
    1  MEDICARE A
    2  MEDICARE PROFESSI  1   2                $0.00
                          03/25/1988    0         No          R L        Yes
Page:01                      Additional Information
( 1) A-Add Claim to Insurance       (14) I-Insurance COB Information
( 2) B-Billing Information          (15) IPC-Insurance Agency Collection
( 3) C-Maintain Claim Information   (16) J-Bill Request
( 4) CE-View Edit PA Charge Log     (17) K-Balance Summary
( 5) CV-EC 2000 CA Claim Viewer     (18) L-Contact Information
( 6) DB-Demand Bill                 (19) M-Adm Medical Information
( 7) DC-Reprint Claim               (20) N-Notes
( 8) DR-DRG Information              (21) PC-Int/Ext Agency Collections
( 9) DX-MR Diagnosis Information     (22) PX-Procedure Information
(10) DA-Adm Diagnosis Information    (23) T-Balance Trans & Claim Disp
(11) F-Financial Information         (24) V-Guarantor's Accounts
(12) H-Transaction History           (25) Y-Refund Information
(13) HC-HCPCS Information            (26) Z-Guarantor Payment History
(13) I-Insurance COB Information

Enter choice--
                    next pg(/ or PG DN)  Search(TAB)
```

The additional options displayed at the bottom of your screen provide a means to go to a specific function. The following functions are displayed on your screen:

• A - Add Claim to Insurance

• B - Billing Information

• C - Maintain Claim Information

• CE - View Edit PA Charge Log

• CV - EC 2000 CA Claim Viewer

• DB - Demand Bill

• DC - Reprint Claim

- DR - DRG Information

- DX - MR Diagnosis Information

- DA - Adm Diagnosis Information

- DX - Diagnosis Information

- F - Financial Information

- HC - HCPCS Information

- H - Transaction History

- I - Insurance COB Information

- J - Bill Request

- K - Balance Summary

- L - Contact Information

- N - Notes

- PC - Int/Ext Agency Collection

- IPC - Insurance Agency Collection

- PX - Procedure Information

- T - Balance Transfer and Claim Disposition

- V - Guarantor Accounts

- Y - Refund Information

- Z - Guarantor Payment History

To display one of these functions, enter the number associated with the function. Each function that can be accessed from Account Revision Flash Card screen is described below.

NOTE: Completing each of the above functions returns you to the Flash Card screen.

Add Claim to Insurance

For information about this function refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Billing Information

Billing information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Maintain Claim Information

Maintain Claim Information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 3: Claims in the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide. Canadian customers should also refer to the *Canadian Claims Processing* volume of the STAR Financials Patient Accounting Reference Guide.

View Edit PA Charge Log

Information changed on a claim for the HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, PA Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/Compre/Comp HCPCS can be viewed. The list of fields changed in the STAR Patient Accounting charge can be viewed, as well as the current charge information. For detailed information about this function, refer to Chapter 1 of this volume.

Demand Bill

Demand Bill information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 2: Patient Billing in the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Reprint Claim

Reprint Claim information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 3: Claims in the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide. Canadian customers should also refer to the *Canadian Claims Processing Volume* of the STAR Financials Patient Accounting Reference Guide.

DRG Information

DRG information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Diagnosis information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Medical Records (MR) Diagnosis Information

Diagnosis information from Medical Records can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Admissions (ADM) Diagnosis Information

Diagnosis information from Admissions can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Financial Information

Financial information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

HCPCS Information

HCPCS information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide.* Canadian clients should refer to the *Canadian Claims Processing Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Transaction History

Transaction History information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to the Transaction History topic as explained later in this chapter.

Insurance COB Information

Insurance COB Information can be accessed from the Account Revision Flash Card screen.

When you access this function, the system displays the following screen:

```
             General Hospital Account Inquiry Processor
                                         Fri Mar 10, 2006 12:36 pm
Account       Name                FC Typ Admit    Disch      Balance  Loc
A98-33600004 CARNACK,AUDREY        M  I/P 12/02/98 12/02/98   10853.55 AR/FCRV

COB Ins Carrier      #Clm LCS SubmitDt  Est Amt Due   Amt Pd  Dsp Date
        Plan              Last Clm Chg     COB Adj    COB Pd  Prv Dsp Date
 1  100 MEDICARE      5   10              $7,252.55
    100 MEDICARE PART A    $10,880.55       $27.00-    $0.00
 2  100 MEDICARE      6   12              $3,041.50
    200 MEDICARE PROFES     $2,774.00       $0.00      $0.00
 3  852 JULIE'S CARRIER 2  13                $11.00
    902 NON-PRO FEE PLA    $10,566.55       $0.00      $0.00




                  F1Prev Page F2Next Page F7  Exit
```

Field Explanations

COB, INS CARRIER, # CLM, LCS, SUBMIT DT, CLAIM AMT, AMT PD, DSP, DATE (DISPLAY ONLY)
Up to nine different insurance carriers can be displayed on this screen. The screen information is the same as that in Field 28 of the Flash Card Screen. When you are done viewing this screen press ENTER to return to the Flash Card screen.

PLAN (DISPLAY ONLY)
This field displays the full carrier plan name and number on two lines of information.

LAST CLM CHG (DISPLAY ONLY)
This field displays the total amount of charges that loaded on the last claim for this carrier plan.

NOTE: If the last claim loaded was a late claim, the total amount of charges loaded only reflects the late charges for the claim.

COB ADJ (DISPLAY ONLY)
This field displays the total amount of adjustments posted for the carrier plan. It is not claim specific.

COB PD (DISPLAY ONLY)
This field displays the total amount of money paid for the carrier plan. It is not claim specific.

PREV DSP DT (DISPLAY ONLY)
If the current claim replaced a prior claim that dispositioned, this field displays the most recent previous claim's disposition, date, and corresponding claim number.

Bill Request

Bill Request information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Balance Summary

This function enables you to review the insurance coverage, the payment, adjustment, refund, and balance transfers for the insurances and patient and the balances for the insurances, patient, and account. For more information about this function, refer to *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Contact Information

Contact Information can be accessed from the Account Revision Flash Card screen. When you access this function, the system displays the following screen:

```
                    General Hospital Account Revision Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch        Balance Loc
A0131000001  KASS, JOHN             S  ER  11/06/01 11/06/01      1000.00 BD/FCRV
Desc  Rel Name               Telephone/Ext      Contact Name      Verify Dt
          Approval Number    Policy Number
Pt        KASS,JOHN          (770)445-6423
          11112                 A500999809876
PtEmp     A1 HARDWARE        (404)393-6000

Guar  B   KASS, BOB          (404)647-2555

GuEmp     A1 HARDWARE        (404)344-8897

Rel1  A   KASS, FRED

COB1  9   PATRICE'S COMMERCI

AdmDr     BABB,GARY H        (404)899-7666




                  F1Prev Page F2Next Page F7  Exit
```

This screen provides you with a list of contacts for the account. Some of the information displayed on this screen is Patient Care information. If your network is down when you access this screen, the date line displays *Information Not Available*.

Field Explanations

DESC (DISPLAY ONLY)
This field displays the description of the contact. The contacts are Patient, Patient Employer, Guarantor, Guarantor Employer, Relative 1, Relative 1 Employer, Relative 2, Relative 2 Employer, COB 1-9, and Admitting Doctor.

REL (DISPLAY ONLY)
This field contains the relation of the patient to the contact. For the Guarantor, Relative 1 or Relative 2 is shown in this field. For COB 1-9, this is the Relation to the Insured field.

NAME (DISPLAY ONLY)
This field displays the name of the contact.

TELEPHONE (DISPLAY ONLY)
This field displays the contact telephone number.

CONTACT NAME (DISPLAY ONLY)
This field contains the contact's name. This field displays only where there is a contact name. For example, the contact name for COB1 is Ann Smith.

VERIFY DT (DISPLAY ONLY)
This field displays the insurance verification date for COB information.

NOTE: This field controls the setting of sub location of COB 1. If this field is blank (default), or if you update the patient record and the verified date field is blank based on the update, the sub location of the patient record for COB 1 is INSR (Insurance Verification Not Completed). If the patient record is updated and this field contains information, the sub location of the patient record for COB 1 is ND (Not Discharged).

APPROVAL # (DISPLAY ONLY)
This field contains the insurance authorization number for the COB information.

POLICY NUMBER (DISPLAY ONLY)
This field displays the policy number for the patient account's insurance plans.

Medical Information

Medical information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Notes Information

Notes information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Account Notes topic as explained later in this chapter.

Agency Collection

Agency collection information can be accessed from the Account Inquiry Flash Card screen. There are two variations of agency collection information: one is applicable to guarantor collections (PC menu option), and the other is applicable to insurance collections (IPC menu option). For more detailed information about this function, refer to the *Follow-Up Functions Volume* of the STAR Financials Patient Accounting Reference Guide.

Procedure Information

Procedure information can be accessed from the Account Inquiry Flash Card screen. For detailed information about this function, refer to Chapter 1 of this volume.

Balance Transfer and 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 Chapter 1: Posting Transactions in the *Account Transactions Volume* of the STAR Financials Patient Accounting Reference Guide.

Guarantor Accounts

Guarantor Accounts information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1: Guarantor Functions in the *Follow-Up Functions Volume* of the STAR Financials Patient Accounting Reference Guide.

Refund Information

Refund Information can be accessed from the Account Revision Flash Card screen.

When you access this function, the system displays the following screen:

```
              General Hospital Account Revision Processor
                                          Fri Mar 10, 2006 12:36 pm
Account      Name                    FC Typ Admit    Disch     Balance  Loc
A9423100001  SMITH,ANN S            C  I/P 08/19/94           11559.75 PA/FCRV

   Refund Activity

Status    Date     Type  Code/Desc                             Amount
Excluded  09/14/94 Guar  C00000509 SMITH,ANN S                 $10.00
Approved  09/13/94 Carr  988450    Commercial                  $90.00




                  F1Prev Page F2Next Page F7  Exit
```

This screen provides you with a list of all active refund information for the account. The refund information is displayed in reverse chronological order. Refunds with a status of hold, approved, and excluded display on this screen.

Field Explanations

STATUS (DISPLAY ONLY)
This field indicates the current status of the refund record.

DATE (DISPLAY ONLY)
This field indicates the date that the refund status was assigned.

TYPE (DISPLAY ONLY)
This field indicates the type of refund. The type of refunds include Carr for carrier and Guar for Guarantor.

CODE/DESC (DISPLAY ONLY)
This field displays the refund code and description. For carrier refunds, this is the carrier/plan number. For guarantor refunds, this is the guarantor corporate number.

DATE PRINTED (DISPLAY ONLY)
This field indicates the date the refund was printed.

AMOUNT (DISPLAY)
This field indicates the amount of the refund.

Guarantor Payment History

Guarantor Payment History information can be accessed from the Account Revision Flash Card screen. For detailed information about this function, refer to Chapter 1: Guarantor Functions in the *Follow-Up Functions Volume* of the STAR Financials Patient Accounting Reference Guide.

When you are finished reviewing this screen, press ENTER and the following menu screen is displayed:

```
             General Hospital Account Revision Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                FC Typ Admit    Disch      Balance Loc
A10000-00006 SMITH,MARY A         M  OB  02/02/90 02/05/90    1956.75 AR/FCRV
             Option No.  Option
             ---------------------------------------
                1        Admission Information
                2        Financial Information












 Enter option number--
```

Admission Information contains patient data (provided by the STAR Patient Care Processing such as patient employer demographics, guarantor data, guarantor employer, patient relatives, patient insurance, and UB data).

Financial Information contains patient financial data, allowing maintenance of account status, insurance follow-up, and account follow-up, and account notes.

Each of these options is explained in the following pages.

ADMISSION INFORMATION

The Admission Information function enables you to view and edit visit-specific patient data drawn from the STAR Patient Care admission process. Available information includes patient demographics, patient employer demographics, guarantor data, guarantor employer information, patient relatives, patient insurance, UB data, medical data, miscellaneous information, and user-defined fields.

After you select the Admission Information option, the following menu screen is displayed:

```
          General Hospital Admission Information Processor
                                       Fri Mar 10, 2006 12:36 pm
Account      Name              FC Typ Admit    Disch     Balance   Loc
A98239-00001 RANIER,WANDA       M  I/P 08/27/98 08/30/99  174345.00 AR/FCRV
          Option No.  Option
          ---------------------------------------
             1        Patient Information
             2        Patient Employer Page
             3        Guarantor Information
             4        Guarantor Employer Page
             5        Relative One Page
             6        Relative One Employer Page
             7        Relative Two Page
             8        Insurance Process
             9        UB Condition Codes
            10        UB Value Codes
            11        UB Occurrence Codes
            12        Medical Information
            13        Miscellaneous Page
            14        Miscellaneous Two Page
            15        User Defined Fields

Enter option number--
```

Each of the options displayed on this menu screen is explained below.

Patient Page

Select the Patient Page option to view and edit patient demographic information such as the patient's name, address, telephone number, religion, marital status, etc. This information comes from STAR Patient Care admission data.

After you select this option, the system displays the following screen.

```
                    General Hospital Patient Page Processor
              Patient                 Page 1 of 16  Fri Mar 10, 2006 12:36 pm
Account       Name               FC Typ Admit    Disch      Balance  Loc
A03138-00009 TATE, JANET          S  I/P 03/18/03            14399.16 PA/FCRV

 1 Name                                        2 Entitle    3 Sex
   TATE,JANET                                                  FEMALE
 4 Birthdate    Age    5 Birthplace            6 Race
   01/01/1865   140Y                             2 BLACK
 7 Marital Status     8 Address Line 1          9 Address Line 2
   S SINGLE           K,KK                        =
10 City              11 St 12 ZIP Code   13 County         14 Country
   CITYFORMODELHOSP.A    NJ    30346        1 FULTON           US UNITED STATE
15 Phone          16 Ext  17 Phone Message  18 Geo.Cd/Census Tract
                                              N NORTH
19 Residence Type       20 Since       21 Addl/Alt&Confidential Add-Ph
                                          No
22 Invalid Address/Phone

23 Soc Sec Number                      24 Nationality        25 Language
   444-11-2222                                                E ENGLISH



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

Field Explanations

1.   NAME (37-C-R)

Enter the patient's name in the format of LAST,FIRST MIDDLE (special characters are allowed). The first name must follow the comma (,) with no spaces. All information entered after the first space is considered the middle name by the system. There are no restrictions regarding entry on this portion of the patient's name.

If you change the name, the following prompt is displayed after you accept the screen:

Retain `NAME,PREVIOUS` in the MPI? (Y/N)-- |
    It will be available when searching the MPI and as an `Other Name`.

Enter **N** for No to simply change the name in the MPI.

Enter **Y** for Yes to retain the previous name in the Other Names section of MPI Inquiry, MPI Revision, and MPI Review. Both names (old and new) are retained for use in searching. The individual whose name changed is displayed under the Changed section of the MPI Activity Report.

If you enter Y, an additional prompt is displayed:

Enter name type or `-` to list-- |

•   Enter the appropriate code for the name type of the patient's previous name.

- Enter a hyphen (**-**). The system displays the Name Type table with the codes and descriptions for selection.

When you select a name type, an additional prompt for verification is displayed:

Retain `NAME,PREVIOUS` in the MPI
with a name type of `PREVIOUS`? (Y/N)-- |

If you enter Y, the name and name type are saved. If you enter N, the original prompt is repeated.

2. ENTITLE (5-AC-O)
This is a free-form field which allows the entry of JR., SR., III, PHD., MD., etc. This field should be entered in a format that can be used at the end of the patient's name (i.e., MD vs. Dr.).

3. SEX (1-A-R)
Enter the patient's sex as **M** or **F**, which is displayed as MALE or FEMALE.

4. BIRTHDATE AGE (15-C-R)
Enter the patient's date of birth. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the General Information volume of the *STAR Patient Care Reference Guide* for details.

The system automatically calculates the age. Enter the century if different from the current one. The system does not accept an invalid or future date. Age is calculated in days up to two months, in months up to two years, and in years for any ages over two.

5. BIRTHPLACE (23-AC-O)
Enter the patient's place of birth. Spaces and special characters are allowed in this field.

(US) 6.RACE (TABLE LOOKUP)
(CN) 7.ETHNIC ORIGIN (TABLE LOOKUP)
You have two choices:

- Enter the appropriate code for the patient's race/ethnic origin if you know it.

- Enter a hyphen (**-**). The system displays the race/ethnic origin table with the codes and descriptions for selection.

7. MARITAL STATUS (TABLE LOOKUP)
You have two choices:

- Enter the patient's marital status.

- Enter a hyphen (**-**). The system displays the table with the abbreviations and descriptions for selection.

8.   ADDRESS LINE 1 (25-C-R)
Enter the patient's mailing address.

9.   ADDRESS LINE 2 (25-C-O)
Enter additional patient mailing address information.

10. CITY (18-C-R)
Enter the patient's city.

If you enter the city's ZIP code/postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/Residence Code, and ZIP Code/ Postcode fields.

(US) You can enter either five or nine characters, but only the first five are compared with the ZIP code table entries.

If you enter a code not in the table, that number moves to the ZIP Code/Postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 11.ST (TABLE LOOKUP)
(CN) 11.PR (TABLE LOOKUP)
You have three choices:

*   Enter the appropriate two-character abbreviation for the patient's state/province if you know it. The system validates the field entry with the user-defined state/ province table.

*   Enter a hyphen (-). The system displays the table with the states/provinces. When you select one, the system automatically uses the two-character abbreviation.

*   Enter an equal sign (=) for the system default (the hospital's state/province).

(US) 12.ZIP CODE (9-N-R or 6-AN-R)
(CN) 12.POSTCODE (6-AN-R or 9-N-R)
Enter the patient's ZIP code/postcode. If you enter an equal sign (=), the system automatically fills the field with the default ZIP code/postcode.

NOTE: **US:**Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes are displayed with a hyphen (**-**) between the ZIP code and the ZIP code extension. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X9X9 format.

NOTE: **CN:**The system displays the postcode in a X9X9X9 format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

13. COUNTY (TABLE LOOKUP)
Enter the patient's county. You have three choices:

- Enter the appropriate code for the patient's county if you know it.

- Enter a hyphen (-). The system displays the county table with the codes and descriptions for selection.

- Enter an equal sign (=) for the system default (the hospital's county).

If a county was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

14. COUNTRY (TABLE LOOKUP)
Enter the code of the country in which the patient lives. You have three choices:

- Enter the appropriate code for the patient's country if you know it.

- Enter a hyphen (**-**). The system displays the country table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's country).

If a country was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

15. PHONE (10-NC-O)
Enter the patient's area code and home phone number. You can enter it in a variety of formats. If you enter it without parentheses or a hyphen, the system automatically inserts them for you. You can also use these formats: (404)393-6000 or 404/393-6000, for example. You can use any special character between the area code and prefix, or between the prefix and suffix. If you enter a local number without the area code, the system automatically enters that for you as well.

16. EXT. (4-N-O)
Enter the patient's extension number, if one exists.

17. PHONE MESSAGE (1-A-R)
This field contains information on whether a phone message can be left at the phone number on this page. Values are:

Yes= Yes, it is okay to leave a message at the phone number on this page.

No = No, do not leave a message at the phone number on this page.

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

Is it okay to leave a message at this phone number? (Y/N)--

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(US) 18. GEO. CODE/CENSUS TRACT (TABLE LOOKUP)
(CN) 18. RESIDENCE CODE (TABLE LOOKUP)
You have three choices:

- Enter the appropriate code for the patient if you know it.

- Enter a hyphen (-). The system displays the Geographic Code/Residence Code table with the codes and descriptions for selection.

- Enter an equal sign (=) for the system default (the hospital's code).

If a Geographic Code/Residence Code was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

NOTE: US: This field can be used in conjunction with a census tracking program.

19. RESIDENCE TYPE (TABLE LOOKUP)
You have two choices:

- Enter the code for the patient's residence type if you know it.

- Enter a hyphen (-). The system displays the table with the codes and descriptions for selection.

20. SINCE (DATE)
Enter the date that the patient began living at the address entered above. You can enter the date in one of these formats: MM/YY or MM/DD/YY. If you choose to enter in the MM/YY format, the system automatically fills in "01" for the first day of the month. For example, if you enter *12/95*, the system displays *12/01/95*.

21. ADDL/ALT&CONFIDENTAL ADD-PH (1-A-O)
When you access this field, the system displays the following prompt:

   Edit the patient's alternate address information? (Y/N) [N]--

Do one of the following:

- Enter **N** or press ENTER for No if you do not want to add or edit this information.

- Enter **Y** for Yes to add or edit an alternate address.

This field is a two-part field:

- Under **Alt**, it displays Yes if alternate address information has been entered for this patient. The field is blank if alternate address information has not been entered.

- Under **Confidential Add-Ph**, it displays what is entered (Yes, No, or blank) in the Confidential Add-Ph field on the Alternate Address subscreen. If Yes is displayed

here, the alternate address and phone number should be used to contact the
patient.

When you enter **Y** to edit alternate address information, the system displays the
Alternate Address subscreen:

```
                    General Hospital Patient Page Processor
                 Patient                    Wed May 25, 2005 01:21 pm
  No.        Name           Sex   BD    Room    Physician    SVC    Status
000003194    TATE,JANET      F  09/06/66
Alternate  1 Address Line 1            2 Address Line 2
         ->
           3 City                 4 St  5 ZIP Code    6 County


           7 Country           8 Residence Type       9 Phone
10 Invalid Address/Phone
   J INQUIRY ADDRESS IS A HOTEL/MOTEL

11 Mother's Name                   12 Father's Name

13 Phone Message  14 Mail To Address?  15 Confidential Add-Ph
                                              No
16 Alt Phone


Enter alternate address line 1--
```

Subfield Explanations

1.   ADDRESS LINE 1 (25-C-O)
Enter the patient's alternate address.

2.   ADDRESS LINE 2 (25-C-O)
Enter additional alternate address information, if necessary.

NOTE: Follow the same procedures for inserting information into the rest of the
alternate address fields (City, State/Province, ZIP Code/Postcode, County,
Country, and Phone) as you did for the main address fields on the Patient
Page.

3.   CITY (18-C-O)
Enter the patient's alternate city.

(US) 4.STATE (TABLE LOOKUP)
(CN) 4.PROVINCE (TABLE LOOKUP)
Enter the patient's alternate state/province.

(US) 5. ZIP CODE (9-N-0 or 6-AN-O)

(CN) 5.POSTCODE (6-AN-O or 9-N-O)
Enter the patient's alternate ZIP code/postcode.

6.   COUNTY (TABLE LOOKUP)
Enter the patient's alternate county.

7. COUNTRY (TABLE LOOKUP)
Enter the patient's alternate country.

8. RESIDENCE TYPE
Enter the residence type for the patient's alternate address (vacation home, college address, business address, etc.). You have two choices:

•   Enter the residence type code if you know it.

•   Enter a hyphen (**-**). The system displays the table with residence type codes and descriptions for selection.

9. PHONE (13-C-O)
Enter the patient's alternate phone number.

10. INVALID ADDRESS/PHONE (1-A-R))
This field contains the invalid address/phone code. When this field is accessed, the following prompt is displayed:

Enter Invalid Address/Phone Code or `-` to list--

You can enter an invalid address/phone code or enter a hyphen (-) to select one from a list of invalid address flag codes.

11. MOTHER'S NAME (13-AN-O))
Enter the name of the patient's mother.

12. FATHER'S NAME (13-AN-O)
Enter the name of the patient's father.

13. PHONE MESSAGE (1-A-O)
When you access this field, the following prompt is displayed:

Is it okay to leave a message at this phone number? (Y/N)-- |

Enter **Y** if it is okay to leave a message at the alternate phone number entered on this page. Enter **N** if not.

14. MAIL TO ADDRESS? (1-A-O)
When you access this field, the following prompt is displayed:

Should mail be sent to this address? (Y/N)--

Enter **Y** to indicate that mail should be sent to the alternate address. Enter **N** or leave the field blank to indicate that mail should be sent to the primary address.

15. CONFIDENTIAL ADD-PH (1-A-O)
When you access this field, the following prompt is displayed:

Use Alternate Address/Phone for communications? (Y/N)--

Enter **Y** to indicate that the alternate address and/or phone number should be used for communications from your facility. Enter **N** to indicate that the primary address/phone number should be used.

16. ALTERNATE PHONE (13-C-O)
Enter the patient's alternate phone number.

When you have finished entering information into these fields, the system displays the following prompt:

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

You have two choices:

- Enter **Y** for Yes to accept the screen and return to the Patient Page. The system displays *Yes* in the **Alt** portion of the Alt/Confidential Add-Ph field.

- Enter **N** for No if you want to make changes to any of the fields.

Field Explanations for Patient Page (Cont'd)

23. INVALID ADDRESS/PHONE (1-A-TABLE LOOKUP)
Enter the code for an invalid address or phone. You can enter an invalid address code or a hyphen (-) to select the code from a list of invalid address flag codes.

(US) 24.SOC SEC NUMBER (9-N-O)
Enter the patient's social security number. If you enter it without hyphens, the system inserts them. If the social security number you enter has already been assigned to another patient, the system displays the following error message:

This SS# is assigned to Last,First MI! Accept anyway? (Y/N) [N]--

(where Last,First MI is the name of another patient)

Verify the social security number entered, and do one of the following:

- Press **N** or ENTER for No to enter another social security number.

- Press **Y** for Yes to override the error and enter the social security for the current patient anyway.

Once this field is accepted, the Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee

Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

(CN) 26.PROV HC#/VERSION/EXP DATE
When you access this field, the system displays the following subscreen at the bottom:

```
 1 HC Prov.        2 Health Card #          3 Version     4 Exp Date
   ON                 9090-909-090          ->
 5 Validation                               6 Val Date/Time



 Enter version #--    |
```

Subfield Explanations

1.   HC PROV (2-C-R)
Enter the two-character province abbreviation where the Health Card was issued. The default is the province associated with the patient's address.

2.   HC # (16-N-O)
Enter the patient's Health Card number. If you enter a Health Card number that has already been assigned to another patient, the system displays the following error message:

This HC# is assigned to Last,First MI! Accept anyway? (Y/N) [N]--

(where Last,First MI is the name of another patient)

Verify the Health Card number entered, and do one of the following:

•   Press **N** or ENTER for No to enter another number.

•   Press **Y** for Yes to override the error and enter the Health Card number for the current patient anyway.

If the Health Card number has been changed or deleted, the system displays the following message:

Changed or deleted HC#! Accept Anyway? (Y/N) [N] --

•   Press **N** or ENTER for No to enter another number.

•   Press **Y** for Yes to override the message and enter the Health Card number for the current patient anyway.

3. VERSION (2-AN-O)
Enter the version number of the Health Card.

4. EXP. DATE (DATE)
Enter the expiration date of the patient's Health Card.

5. VALIDATION (DISPLAY ONLY)
6. VAL DATE/TIME (DISPLAY ONLY)
For information on these fields, refer to Patient Page Updates in Appendix C of the
Patient Processing Module of the *STAR Patient Care Reference Guide.*

Field Explanations for Patient Page (Cont'd)

25. NATIONALITY (TABLE LOOKUP)
You have two choices:

• Enter the code for the patient's nationality if you know it.

• Enter a hyphen (-). The system displays the table with the codes and descriptions for selection.

26. LANGUAGE (TABLE LOOKUP)
You have three choices:

• Press ENTER to enter the system default language (it appears in the prompt).

• Enter the code for the patient's language if you know it.

• Enter a hyphen (-). The system displays the table with the codes and descriptions for selection.

NOTE: If this field contains English or any language besides Spanish, the system prints consultative messages in STAR Pharmacy in English. If this field contains Spanish, the system prints consultative messages in Spanish.

Patient Employer Page

Select the Patient Employer Page option to view and edit information about the patient's employer, such as the employer's name, telephone number, address, etc.

STAR Financials offers the capability of linking employers to their specific insurance plans. You can assign insurance to an account by patient, guarantor, or relative employer. If you change a patient's employer, rather than the employer's address or other demographic data, you should verify the account's insurance as it may have been assigned according to the employer.

After you select this option, the system displays the following screen.

```
            General Hospital Patient Employer Page Processor
                                        Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A92188-00213 STEPHENS,CHARLES A    C  ECU 07/03/92 07/07/92     109.00  AR/FCRV
 1 Employment Status        2 Retirement Date
   2 PART TIME
 3 Employer/School          4 Work Phone       5 Ext.
   SB SOUTHERN BELL        ->
 6 Employer Address Line 1  7 Employer Address Line 2
   505 PEACHTREE ST
 8 City                     9 State           10 ZIP Code
   ATLANTA                    GA                  30303
11 County                  12 Country
   1 FULTON                   US United State
13 Occupation              14 Employed Since  15 Employee ID
   39 OTHER                   08/31/93




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

Field Explanations

1. EMPLOYMENT STATUS (TABLE LOOKUP)

Enter the code that describes the current status of the patient's employment (for example, Part Time, Full Time, etc.). If the employment status has been identified as retired or unemployed, in the Employment Status Table, the system asks *Clear the Employment information? Y/N*. If you select **Y** for Yes, the remaining fields on the screen are automatically deleted. If you select **N** for No, the employment information is accessible for revision.

2. RETIREMENT DATE (DATE)

Enter the date of retirement. This field is only accessible if the employment status entered has been identified in the Employment Status Table as retired. If the patient has been designated as retired in the Employment Status field, this field is required. Dates can be entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/YY format. If you choose to enter in the MM/YY format, the system automatically fills in *01* for the first day of the month. For example, if you enter *12/95*, the system displays 12/01/95. Refer to the Information Entry Techniques section in the General Information volume *o*f the *STAR Patient Care Reference Guide* for further details. You can enter any special characters between the month, day, and year.

3. EMPLOYER/SCHOOL (TABLE LOOKUP)

Enter the code that describes the patient's employer or school. To override the table, enter a hyphen (-) followed by a free-form entry of up to 24 characters. This allows you to enter an employer/school that is not on the table. If the employer/school is selected from the table, the following fields (if defined in the table) are brought forward: work phone, address, city, state/province, county, country and ZIP code/postcode. If no employer is entered, the cursor skips this and all remaining fields on this screen.

Pressing ENTER displays the prompt that enables you to accept the screen and continue with the next screen in the sequence.

4. WORK PHONE (10-NC-O)
Enter the employer's area code and work phone number. You can enter it in a variety of formats. If you enter it without parentheses or a hyphen, the system automatically inserts them for you. You can also use these formats: (404)393-6000 or 404/393-6000, for example. You can use any special character between the area code and prefix, or between the prefix and suffix. If you enter a local number without the area code, the system automatically enters that for you as well.

5. EXT. (4-N-O)
Enter the patient's work telephone extension number.

6. EMPLOYER ADDRESS LINE 1 (25-C-O)
Enter the primary address of the patient's employer.

7. EMPLOYER ADDRESS LINE 2 (25-C-O)
If the patient's employer has a secondary address (for example, a suite number) enter it in this field.

8. CITY (18-C-O)
Enter the city of the patient's employer.

If you enter the city's ZIP code/postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/Residence Code, and ZIP Code/ Postcode fields.

NOTE: US: You can enter either five or nine characters, but only the first five are compared with the ZIP Code table entries.

If you enter a code not in the table, that number moves to the ZIP code/postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 9.STATE (TABLE LOOKUP)
(CN) 9.PROV. (TABLE LOOKUP)
Enter the state/province of the patient's employer in the standard two-character abbreviation. You have three choices:

*   Enter the appropriate two-character abbreviation for the state/province if you know it. The system validates the field entry with the user-defined state/province table.

*   Enter a hyphen (**-**). The system displays the table with the states/provinces. When you select one, the system automatically uses the two-character abbreviation.

*   Enter an equal sign (**=**) for the system default (the hospital's state/province).

(US) 10.ZIP CODE (9-N-R or 6-AN-R)
(CN) 10.POSTCODE (6-AN-R or 9-N-R)
Enter the employer's ZIP code/postcode. If you enter an equal sign (=), the system automatically fills the field with the default ZIP code/postcode.

NOTE: **US:**Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes are displayed with a hyphen (**-**) between the ZIP code and the ZIP code extension. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X9X9 format.

NOTE: **CN:**The system displays the postcode in a X9X9X9 format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

11. COUNTY (TABLE LOOKUP)
Enter the county of the patient's employer. You have three choices:

- Enter the appropriate code for the county if you know it.

- Enter a hyphen (**-**). The system displays the county table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's county).

If a county was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

12. COUNTRY (TABLE LOOKUP)
Enter the country where the patient's employer is located. You have three choices:

- Enter the appropriate code for the country if you know it.

- Enter a hyphen (**-**). The system displays the country table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's country).

If a country was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

13. OCCUPATION (TABLE LOOKUP)
Enter the code that describes the patient's occupation. To override the table, enter a hyphen (-) followed by a free-form entry of up to 25 characters. This allows you to enter an occupation that is not in the table.

14. EMPLOYED SINCE (DATE)
Enter the date that the patient began employment with the above employer. Dates can be entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/YY format. If you choose to enter in the MM/YY format, the system automatically

fills in *01* for the first day of the month. For example, if you enter 12/95, the system displays *12/01/95*. Refer to the Information Entry Techniques section in the General Information volume of the *STAR Patient Care Reference Guide* for further details. You can enter any special characters between the month, day, and year.

15. EMPLOYEE ID (15-C-O)
Enter the patient's employee identification number. This is a free-form field.

Guarantor Page

Select the Guarantor Page option to view and edit information about the patient's guarantor, such as the guarantor's name, address, telephone number, relationship to the patient, etc. The information contained on this screen is part of the MPI and is important to the admission process. Since it also directs mailings and telephone follow-up for guarantor accounts, it is important that demographic data be kept as accurately as possible.

After you select this option, the system displays the following screen.

```
                  General Hospital Guarantor Page Processor
                                       Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch        Balance Loc
A0304400001  KELLY, MIKE          B  O/P 02/13/03 02/13/03     4244.24 AR/FCRV
 1 Relation to Patient  2 MPI Search   3 Name
   S SELF              00002228       KELLY, MIKE
 4 Entitle  5 Sex      6 Birthdate    Age      7 DOD         8 Race
   JR        MALE       02/29/1904    99Y                    1 CAUCASIAN
 9 Marital Status  10 Address Line 1          11 Address Line 2
   C COMMON LAW      PAT ADDRES 1              PAT ADDRESS 2
12 City             13 St   14 ZIP Code       15 County
   ROSWELL          GA        30076           1 FULTON
16 Phone            17 Phone Message          18 Geo.Cd/Census Tract
   (404)333-8285       ->
19 Addl/Alt   20 Guarantor Class        21 Soc Sec Number
   Yes                                    440-13-3412
22 Invalid Address/Phone
-> Z Inquiry address is mail receiving service.
Address &      23 Score-Date/Time         24 Permission      25 Request
Credit Check



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

Field Explanations

1. RELATION TO PATIENT (TABLE LOOKUP-R)
Enter the code that describes the guarantor's relation to the patient. The code and the description are displayed. Enter an equal sign (=) if the patient is the guarantor, and the guarantor and guarantor employer screens are completed from the patient information entered previously. If this field currently displays SELF and is adjusted to any other relationship, all fields on this screen are cleared.

2. MPI SEARCH (8-N-R)
This field displays the guarantor's corporate number, which is a number that is permanently assigned when he/she was first admitted to any facility or first became a guarantor for a patient in any facility belonging to the hospital group. This number is subsequently used by all facilities in the multifacility environment. Hence, the patient has only one corporate number that can be accessed from any facility in a multifacility environment.

N/A is displayed in this field if the guarantor has never been a patient in the STAR Patient Care System since a corporate number has never been assigned. When adding a new guarantor, the normal MPI search process is performed while the cursor is in this field. A guarantor's unit number can be entered in this field to bypass the searching process. Once the new guarantor is identified, the corporate number (if applicable) is displayed, and any/all information on file for the Guarantor page is brought forward to expedite the admission.

3. NAME (37-C-R)
Enter the guarantor's name in the format of LAST,FIRST MIDDLE. This field allows special characters. The first name must follow the comma (,) with no spaces. All information entered after the first space is considered the middle name by the system; however, there are no restrictions regarding entry on this portion of the patient's name. If you entered an equal sign (=) in Field 1, Relation to Patient, the patient's name and the remaining fields on the screen are entered automatically by the system. If the guarantor information was pulled forward from the MPI or was entered previously, and the Name field is to be revised, the following additional prompt is displayed:

> *Are you changing the guarantor(G), or is this a name correction(N)?--*

If you enter **G**, the system returns the cursor to the MPI Search field to perform the MPI search again. If you enter **N**, the name is adjusted just as it is on the Patient page. After you enter the name change, the system displays a reminder message as follows:

> *All information for NAME,PREVIOUS will apply to NAME,NEW*
> *   Accept? Y/N [N]--*

Enter **Y** for Yes to accept the name change, or **N** or ENTER for No. If you enter Y, an additional prompt is displayed when you accept the screen:

> *Retain `NAME,PREVIOUS` in the MPI? (Y/N)-- |*
> *   It will be available when searching the MPI and as an `Other Name`.*

Enter **N** for No to simply change the name in the MPI.

Enter **Y** for Yes to retain the previous name in the Other Names section of MPI Inquiry, MPI Revision, and MPI Review. Both names (old and new) are retained for use in searching. The individual whose name changed is displayed under the Changed section of the MPI Activity Report.

If you enter Y, an additional prompt is displayed:

Enter name type or `-` to list-- |

- Enter the appropriate code for the name type of the patient's previous name.

- Enter a hyphen (**-**). The system displays the Name Type table with the codes and descriptions for selection.

When you select a name type, an additional prompt for verification is displayed:

Retain `NAME,PREVIOUS` in the MPI
with a name type of `PREVIOUS`? (Y/N)-- |

If you enter Y, the name and name type are saved. If you enter N, the first prompt regarding saving the previous name in the MPI is repeated.

4. ENTITLE (5-AC-O)
This field allows the entry of JR., SR., III, PHD., MD., etc. This should be entered in a format that can be used at the end of the patient's name (i.e., MD vs. Dr.).

5. SEX (1-A-R)
Enter the guarantor's sex as M or F, which displays as MALE or FEMALE.

6. BIRTHDATE AGE (15-C-R)
Enter the guarantor's date of birth. Dates can be entered in a variety of formats. Refer to the Information Entry Techniques section in the General Information volume of the *STAR Patient Care Reference Guide* for details. The system automatically calculates the age. Enter the century if different from the current one. The system does not accept an invalid or future date. Age is calculated in days up to two months, in months up to two years, and in years for any ages over two.

7. DOD (DISPLAY ONLY)
If the guarantor has expired, the system displays the date of death.

(US) 8.RACE (TABLE LOOKUP)
(CN) 8.ETHNIC ORIGIN (TABLE LOOKUP)
This field contains the patient's race or ethnic origin. You have two choices:

- Enter the appropriate code for the guarantor's race/ethnic origin if you know it.

- Enter a hyphen (**-**). The system displays the race/ethnic origin table with the codes and descriptions for selection.

9. MARITAL STATUS (TABLE LOOKUP-O)
You have two choices:

- Enter the guarantor's marital status.

- Enter a hyphen (**-**). The system displays the table with the abbreviations and descriptions for selection.

10. ADDRESS LINE 1 (25-C-R)
Enter the guarantor's home address. Enter an equal sign (=) if it is the same as the patient's address. The system fills the address fields as well as the following fields with information from the Patient Page: City, State/Province, ZIP Code/Postcode, Phone, County, Geo. Code, Country, and Residence Since fields.

11. ADDRESS LINE 2 (25-C-O)
If the guarantor has a secondary address (for example, apartment number), enter it in this field.

12. CITY (18-C-R)
Enter the guarantor's city.

If you enter the city's ZIP Code/Postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/Residence Code, and ZIP Code/Postcode fields.

US: You can enter either five or nine characters, but only the first five are compared with the ZIP Code table entries.

If you enter a code not in the table, that number moves to the ZIP Code/Postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 13.STATE (TABLE LOOKUP)
(CN) 13.PROVINCE (TABLE LOOKUP)
You have three choices:

- Enter the appropriate two-character abbreviation for the patient's state/province if you know it. The system validates the field entry with the user-defined state/province table.

- Enter a hyphen (**-**). The system displays the table with the states/provinces. When you select one, the system automatically uses the two-character abbreviation.

- Enter an equal sign (**=**) for the system default (the hospital's state/province).

(US) 14.ZIP CODE (9-N-R or 6-AN-R)
(CN) 14.POSTCODE (6-AN-R or 9-N-R)
Enter the guarantor's ZIP code/postcode. If you enter an equal sign (=), the system automatically fills the field with the default ZIP code/postcode.

NOTE: US: Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes are displayed with a hyphen (**-**) between the ZIP code and the ZIP code

extension. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X9X9 format.

NOTE: CN: The system displays the postcode in a X9X9X9 format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

15. COUNTY (TABLE LOOKUP-O)
You have three choices:

*   Enter the appropriate code for the guarantor's county if you know it.

*   Enter a hyphen (**-**). The system displays the county table with the codes and descriptions for selection.

*   Enter an equal sign (**=**) for the system default (the hospital's county).

If a county was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

16. PHONE (10-NC-O)
Enter the guarantor's area code and home phone number. You can enter it in a variety of formats. If you enter it without parentheses or a hyphen, the system automatically inserts them for you. You can also use these formats: (404)393-6000 or 404/393-6000, for example. You can use any special character between the area code and prefix, or between the prefix and suffix. If you enter a local number without the area code, the system automatically enters that for you as well.

17. PHONE MESSAGE (1-A-O)
Enter **Y** if it is okay to leave a message for the guarantor at this phone number. Enter **N** if not.

(US)18.GEO. CD/CENSUS TRACT (TABLE LOOKUP-O
(CN) 18.RESIDENCE CODE (TABLE LOOKUP-O)
You have three choices:

*   Enter the appropriate code for the guarantor if you know it.

*   Enter a hyphen (**-**). The system displays the Geographic Code/Residence Code table with the codes and descriptions for selection.

*   Enter an equal sign (**=**) for the system default (the hospital's code).

If a Geographic Code/Residence Code was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

19. ADDTL/ALT (1-A-O)
When you access this field, the system displays the following prompt:

Edit the Guarantor's Additional/Alt Address information? (Y/N) [N]-- --

You can do one of the following:

- Press **N** or ENTER for No if you do not want to add or edit this information.

- Press **Y** for Yes to add or edit the guarantor's additional information.

When you enter **Y**, the system displays the Guarantor Additional Information subscreen:

```
                          General Hospital Processor
               Guarantor              Page 3 of 16          Wed Jun 25, 2005 10:19 am
  No.         Name            Sex   BD    Room    Physician      SVC    Status
0232900002    ROBINSON,CHRIS   F  01/01/55          DOCTOR,ADMITT MED    ADV
Additional    1 Ext   2 Country          3 Residence Type       4 Since
Information    ->
 5 Mother's Name                  6 Father's Name
    SALLY
 7 Birthplace              8 Nationality            9 Language
                                                      E ENGLISH
Alternate     10 Address Line 1                11 Address Line 2
Address
12 City                  13 St     14 ZIP Code     15 County

16 Country                 17 Residence Type
                              O OTHER
18 Invalid Address/Phone

19 Phone                   20 Phone Message        21 Mail To Address?

22 Alt Phone



Enter phone ext--
```

Subscreen Field Explanations

Additional Information

1. EXT. (4-N-O)
Enter the guarantor's telephone extension, if applicable.

2. COUNTRY (TABLE LOOKUP-O)
You have three choices:

- Enter the appropriate code for the guarantor's country if you know it.

- Enter a hyphen (**-**). The system displays the country table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's country).

If a country was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

3. RESIDENCE TYPE (TABLE LOOKUP-O)
You have two choices:

- Enter the code for the guarantor's residence type if you know it.

- Enter a hyphen (**-**). The system displays the table with the codes and descriptions for selection.

4. [RESIDENT] SINCE (8-NC-O)
Enter the date the guarantor began living at the above address. You can enter the date in one of these formats: MM/YY or MM/DD/YY. If you choose to enter in the MM/YY format, the system automatically fills in "01" for the first day of the month. For example, if you enter *12/92*, the system displays *12/01/92*.

5. MOTHER'S NAME (25-AC-O)
Enter the name of the guarantor's mother. This name is used with other information in patient lookups to verify that you have the correct guarantor. You can enter spaces and special characters in this field. Depending on hospital procedures, you may enter the mother's maiden name or first name.

6. FATHER'S NAME (25-AC-O)
Enter the guarantor's father's name. You can enter spaces and special characters in this field.

7. BIRTHPLACE (25-AC-O)
Enter the guarantor's place of birth. You can enter spaces and special characters in this field.

8. NATIONALITY (TABLE LOOKUP-O)
Enter the code that describes the guarantor's nationality. The code and the description are displayed.

9. LANGUAGE (TABLE LOOKUP-O)
You have the following choices:

- Press ENTER to enter the system default language (it appears in the prompt).

- Enter the code for the patient's language if you know it.

- Enter a hyphen (**-**). The system displays the table with the codes and descriptions for selection.

Alternate Address

10. ADDRESS LINE 1 (25-C-O)
Enter the guarantor's alternate address. If the guarantor's alternate address is the same as the patient's alternate address, enter an equal sign (=) to copy the information.

11. ADDRESS LINE 2 (25-C-O)
Enter additional alternate address information, if necessary.

NOTE: Refer to the discussion of the address fields on the Guarantor Page to follow the same procedures for inserting information into the rest of the alternate address fields (City, State/Province, ZIP Code/Postcode, County, Country, and Phone).

12. CITY (18-C-O)
Enter the guarantor's alternate city.

(US) 13.STATE (TABLE LOOKUP)
(CN) 13.PROVINCE (TABLE LOOKUP)
Enter the guarantor's alternate state/province.

(US) 14. ZIP CODE (9-N-O)
(CN) 14. POSTCODE (6-AN-O)
Enter the guarantor's alternate ZIP code/postcode.

15. COUNTY (TABLE LOOKUP-O)
Enter the guarantor's alternate county.

16. COUNTRY (TABLE LOOKUP-O)
Enter the guarantor's alternate country.

17. RESIDENCE TYPE (TABLE LOOKUP-O)
You have two choices:

- Enter the code for the residence type for the guarantor's alternate address.

- Enter a hyphen (-). The system displays the table with the codes and descriptions for selection.

18. INVALID ADDRESS/PHONE (1-A-TABLE LOOKUP)
Enter the code for an invalid address or phone. You can enter an invalid address code or a hyphen (-) to select the code from a list of invalid address flag codes.

19. PHONE (13-C-O)
Enter the guarantor's alternate phone number.

20. PHONE MESSAGE (1-A-O)
Enter **Y** if it is okay to leave a message for the guarantor at this alternate phone number. Enter **N** if not.

21. MAIL TO ADDRESS? (1-A-O)
Enter **Y** if all correspondence from your facility should be directed to this alternate address. Enter **N** if not.

When you are finished entering information into these fields, the system displays the following prompt:

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

You have two choices:

- Enter **Y** for Yes to accept the screen and return to the Guarantor page. The system displays *Yes* in the Addtl field.

- Enter **N** for No if you want to make changes to any of the fields.

Field Explanations for Guarantor Page cont.

20. GUARANTOR CLASS (TABLE LOOKUP)
Enter the code that describes the person's classification (for example, VIP for Very Important Person, DIA for Diabetic, BDM for Board Member). The system displays the code and description in the field.

(US) 21. SOC SEC NUMBER (9-N-O)
Enter the guarantor's social security number. If you enter it without hyphens, the system inserts them. The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

(CN) 21. HC/PROV/VERSION/EXP DATE
When you access this field, the system displays the following fields at the bottom of the screen:

```
 27 Prov HC#/Version/Exp Date         28 Nationality         29 Language
                                        2 CANADIAN              E ENGLISH

 1 HC Prov.        2 Health Card #         3 Version      4 Exp Date

Enter province code (= for default)--
```

Subscreen Field Explanations

1. HC PROV (2-C-R)

Enter the two-character province abbreviation where the health card was issued. The default is the province associated with the guarantor's address.

2. HEALTH CARD # (16-N-O)

Enter the guarantor's health card number. If the health card number has been changed or deleted, the system displays the following message:

Changed or deleted HC#! Accept Anyway? (Y/N) [N] --

- Press **N** or ENTER for No to enter another number.

- Press **Y** for Yes to override the message and enter the health card number for the current patient anyway.

3. VERSION (2-AN-O)

Enter the version number of the health card.

4. EXP. DATE (DATE)

Enter the expiration date of the guarantor's health card.

Field Explanations for Guarantor Page cont.

Address & Credit Check

22. SCORE - DATE/TIME (DISPLAY ONLY)

This field contains the most recently received healthcare score, and the date and time it was received. If the user logged on does not have a security level that is able to view a patient's healthcare score (designated on the System Wide Parameters screen), an asterisk (*) is displayed in this field.

23. PERMISSION (1-A-O)

This field indicates whether the guarantor has given permission for an address and/or credit check to be performed. When this field is accessed, the following prompt is displayed:

Permission to perform (A)ddr Ck, (C)redit ck, or (B)oth (A/C/B)--
next(/) or previous screen(/P) [/]

The default for the prompt is determined by what requests the facility has decided can be performed. Those options are entered in the Address/Credit Check Paths field of the Address/Credit Check Options parameter.

Enter **A** if permission to perform an address check has been given.

Enter **C** if permission to perform a credit check has been given.

Enter **B** if permission to perform both checks have been given.

24. REQUEST (1-A-O)
This field allows the user to request a check. When this field is accessed, the following prompt is displayed:

[S]end new request, or [N]one? [N]--

Enter **N** to not submit a request. Enter **S** to proceed with submission of a request. If you enter **S** to continue, the Address/Credit Check Request screen is displayed. For more information, see .

Address/Credit Check Request Screen

```
                         General Hospital Processor
                                      Mon May 19, 2003 02:20 pm
   No.          Name           Sex   BD    Room   Physician    SVC    Status
03038-00001   INGMIRE,JOHNSON   F  06/25/80         ADAIR,FRANK M MED    MH
 1 Request Type
   Credit




    INFORMATION TO BE SENT
 2 Name                        3 Entitle
   INGMIRE,JOHNSON
 4 Birthdate                   5 SSN
   01/01/1959
 6 Address 1                   7 Address 2
   A
 8 City              9 State          10 ZIP          11 Telephone
   ALPHARETTA         NJ               30005


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

Field Explanations

1. REQUEST TYPE (1-A-O)
Enter the type of request (Address, Credit or Address and Credit) you wish to submit. When this field is accessed, the following options are displayed:

```
Page:01                          Request Type
( 1) Address
( 2) Address/Credit
( 3) Credit



Enter choice--
```

When you enter a request type:

- If permission has not been given to perform that type of check (address and/or credit) in the Addr/Cr Check Permission field on the Guarantor Page, and the Address Permission Message field (or the Credit Permission Message field) of the Address/Credit Check Options screen is set to display a warning, the following message is displayed:

  Permission not received for this transaction. Do you want to continue?

  If you enter **Y** to continue, the Address Check Days field (or Credit Check Days field) is reviewed. If the last response from a request is within the number of days that your organization considers a response to remain valid, the following message is displayed:

  Current Address Check exists, do you want to continue?

  - or -

  Current Credit Check exists, do you want to continue?

  After you have entered an answer to the prompt, the following prompt is redisplayed:

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

  Press ENTER to continue the submit process. For more information, see .

- If permission has not been given to perform that type of check (address and/or credit) in the Addr/Cr Check Permission field on the Guarantor Page, and the Address Permission Message field (or the Credit Permission Message field) of the Address/Credit Check Options screen is set to display an error, the following message flashes on the screen:

  Permission not received for Address/Credit Check!

  The user is not able to submit a request.

- If permission has been given to perform that type of check, the process to submit a request proceeds. For more information, see .

INFORMATION TO BE SENT

The information displayed in this area is pulled from the guarantor pages. All of these fields are display only and cannot be edited.

NOTE: If a default social security number has been assigned to the guarantor, it is not sent in the transaction to Transaction Solutions Hub™.

NOTE: The social security number field is sent as blank to prevent transaction-related errors.

Submit a request

Once the screen is accepted, the following prompt is displayed:

Submit Request? (Y/N) [Y]--

If you enter **Y** to submit the request, the following messages flash on the screen:

Filed!

Checking for Address/Credit Check Response!

If no response is received within five seconds, the following prompt is displayed:

Address/Credit Check Response not Received! Continue waiting? (Y/N) [N]--

Enter **Y** to have the prompt display every five seconds until a response is received.

Enter **N** to continue processing without waiting for a response and to return to the previous screen.

A proprietary transaction (non-HL7) is sent to Transaction Solutions Hub. A free-form Account Note is generated to document the request. If the request was submitted without permission (the warning was bypassed), that is also indicated in the Account Note.

Once a response is received, the following screen is displayed:

```
                        General Hospital Processor
             Guarantor              Page 3 of 16 Fri Jun 13, 2003 08:59 am
  No.          Name           Sex   BD    Room     Physician     SVC    Status
0300900002    RIGELSKY,BABY 1 G F  01/09/03        DOCTOR,ADMITT NUR    ADV
Seq  Type  Req Dt/Time    Score  Description     Last Act  Fraud VictimPage:01
( 1) AC   06/13/03 859am  300   Possible Charity                No




 




 Enter selection to view--
```

If you enter a selection to view, the following screen is displayed:

```
                         General Hospital Processor
               Guarantor              Page 3 of 16 Fri Jun 13, 2003 08:59 am
  No.          Name             Sex    BD    Room    Physician     SVC    Status
0300900002   RIGELSKY,BABY 1 G F  01/09/03           DOCTOR,ADMITT NUR    ADV
Type       Req Dt/Time    Last Act  Score  Description
Addr/Cred  06/13/03 859am           300    Possible Charity
Fraud Victim                        Safescan Warning
    No                             Your inquiry has gone through the SAFESCA
                          STAR Data                    Equifax Data
    Name              - RIGELSKY,BABY 1 GIRL
    Entitle           -
    Birthday          - 01/08/2003
    Social Security # -
Page:01                                                ##=Current Choices
                          STAR Data                    Equifax Data
( 1) Address 1        - 123 TEST ST
( 2) Address 2        -
( 3) City             - ALPHARETTA                  ALPHARETTA
( 4) State            - GA                          GA
( 5) ZIP              - 30202                       30202
( 6) Telephone        -

No differences found, press NL to continue--
                          end select(NL)
```

The prompt at the bottom of the screen indicates if a difference between the MPI data and the response data exists.

If the Update Data on Compare? field on the Address/Credit Check Options screen is set to:

• N - The information is view-only.

• Y - The user is able to update the data in the MPI with the demographic data returned on the Compare Screen. If the option to update the MPI is selected, the user needs to reevaluate the Geo Code, County and Country fields to verify they are synchronized with the new address information.

For more information about this screen, see "Viewing previous responses" on page 2-46.

Viewing previous responses

If there are previous responses available to view, the following message is displayed:

(V)iew Previous Responses or (S)end New Request? (V/S) [V]--

If you enter **S** to send a new request, the processing flow is described in "Address/ Credit Check Request Screen" on page 2-43.

If you enter **V** to view previous responses, the following screen is displayed. This screen contains summary information about prior requests.

```
                        General Hospital Processor
                Guarantor              Page 3 of 16 Fri Jun 13, 2003 08:59 am
  No.          Name          Sex   BD   Room    Physician       SVC    Status
0300900002    RIGELSKY,BABY 1 G F  01/09/03           DOCTOR,ADMITT NUR    ADV
Seq  Type  Req Dt/Time    Score  Description      Last Act  Fraud VictimPage:01
( 1)  AC   06/13/03 859am  300    Possible Charity                   No




 Enter selection to view--
```

Field Explanations

SEQ (DISPLAY ONLY)
This field contains a number identifier of the request that allows it to be chosen at the prompt.

TYPE (DISPLAY ONLY)
This field contains the type of check requested.

REQ DT/TIME (DISPLAY ONLY)
This field contains the date and time the request was submitted.

LAST ACT (DISPLAY ONLY)
When a request is made for any of the four possible Address/Credit Check Paths, the response returns a Header segment, but the credit file is not always accessed. If the credit file is accessed for the request, this is the date of last activity (in the FULL segment) where a change occurred to any part of the credit file. If the credit file is not accessed for the request, this field is blank.

SCORE (DISPLAY ONLY)
This field contains the healthcare score of the guarantor.

DESCRIPTION (DISPLAY ONLY)
This field contains the facility-defined description of the healthcare score returned.

FRAUD VICTIM (DISPLAY ONLY)
This field contains Yes if this guarantor has been identified as a victim of fraud; it contains No if the guarantor was not identified as a fraud victim.

If you enter a selection to view in detail, the following screen is displayed:

```
                          General Hospital Processor
                 Guarantor              Page 3 of 16 Fri Jun 13, 2003 08:59 am
   No.          Name           Sex   BD    Room    Physician       SVC    Status
 0300900002  RIGELSKY,BABY 1 G F  01/09/03           DOCTOR,ADMITT NUR    ADV
 Type       Req Dt/Time     Last Act  Score  Description
 Addr/Cred  06/13/03 859am            300    Possible Charity
 Fraud Victim                       Safescan Warning
     No                             Your inquiry has gone through the SAFESCA
                            STAR Data              Equifax Data
     Name              - RIGELSKY,BABY 1 GIRL
     Entitle           -
     Birthday          - 01/08/2003
     Social Security # -
 Page:01                                            ##=Current Choices
                            STAR Data              Equifax Data
 ( 1) Address 1         - 123 TEST ST
 ( 2) Address 2         -
 ( 3) City              - ALPHARETTA              ALPHARETTA
 ( 4) State             - GA                      GA
 ( 5) ZIP               - 30202                   30202
 ( 6) Telephone         -

 No differences found, press NL to continue--
                          end select(NL)
```

The prompt at the bottom of the screen indicates whether a difference between the MPI data and the response data exists. If the Update Data on Compare? field on the Address/Credit Check Options screen is set to Y(es), the user is able to update the data in the MPI with the demographic data returned on the Compare Screen. If that field is set to N, the information is view-only.

This screen contains patient information in the header.

Field Explanations

SEQ (DISPLAY ONLY)
This field contains a number identifier of the request that allows it to be chosen at the prompt.

TYPE (DISPLAY ONLY)
This field contains the type of check requested.

REQ DT/TIME (DISPLAY ONLY)
This field contains the date and time the request was submitted.

LAST ACT (DISPLAY ONLY)
When a request is made for any of the four possible Address/Credit Check Paths, the response returns a Header segment, but the credit file is not always accessed. If the credit file is accessed for the request, this is the date of last activity (in the FULL segment) where a change occurred to any part of the credit file. If the credit file is not accessed for the request, this field is blank.

SCORE (DISPLAY ONLY)
This field contains the healthcare score of the guarantor.

DESCRIPTION (DISPLAY ONLY)
This field contains the facility-defined description of the healthcare score returned.

FRAUD VICTIM (DISPLAY ONLY)
This field contains Yes if this guarantor has been identified as a victim of fraud; it contains No if the guarantor was not identified as a fraud victim.

SAFESCAN WARNING (DISPLAY ONLY)
This field contains a warning message, on which the facility needs to follow-up to ensure correct information has been provided by/for the patient. Some examples are:

Social Security No. never issued by the Social Security Administration
Social Security No. reported misused. Thorough verification suggested
Inquiry address is US Post Office Street Address. Verify Thoroughly!
Inquiry address is a campground. Thorough verification suggested.
Inquiry address is a prison /detention facility. Verify thoroughly
Telephone number has been reported misused.

If no warnings are generated for the patient during the Safescan screening, the following message is displayed:

Your inquiry has gone through the SAFESCAN database

The screen displays Guarantor Information on STAR (MPI) versus what currently exists on Equifax including name, entitle, birthdate, social security number, address and phone number.

If there are multiple responses available for viewing and you select to view a response in detail that is older than the most current, the following prompt is displayed:

A more recent Address Check exists, updates not allowed!
                    end select(NL)

This prompt indicates that the information residing on this response cannot be used to update the MPI database.

Guarantor Employer Page

Select the Guarantor Employer Page option to view and edit information about the guarantor's employer, such as the employer's name, address, telephone number, etc. As with the patient employer, the guarantor employer can be used as a means of assigning insurance plans to an account. If you change a guarantor's employer, rather than just the demographic information, you should review the account's insurance

coverage to verify it is still correct. It is possible that one of the plans assigned may still be linked to the employer.

After you select this option, this screen is displayed.

```
              General Hospital Guarantor Employer Page Processor
                                              Fri Mar 10, 2006 12:36 pm
Account       Name               FC Typ Admit    Disch      Balance Loc
A92188-00293 STEPHENS,CHARLES A   C  ECU 07/03/92 07/07/92    109.00 AR/FCRV
 1 Employment Status      2 Retirement Date
   1 FULL TIME
 3 Employer/School        4 Work Phone      5 Ext.
   SB SOUTHERN BELL         (404)475-3498     257
 6 Address Line 1         7 Address Line 2
   505 PEACHTREE ST       ->
 8 City                   9 State          10 ZIP Code
   ATLANTA                  GA                30303
11 County                12 Country
   1 FULTON                 US United State
13 Occupation            14 Employed Since 15 Employee ID
   8 MANAGER                03/24/71           304678




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

Field Explanations

1. EMPLOYMENT STATUS (TABLE LOOKUP)
Enter the code that describes the current status of the guarantor's employment (for example, Part Time, Full Time, etc.). If the employment status has been identified as retired or unemployed, in the Employment Status Table, the system asks *Clear the Employment information? Y/N*. If you select **Y** for Yes, the remaining fields on the screen are automatically deleted. If you select **N** for No, the employment information is accessible for revision.

2. RETIREMENT DATE (DATE)
Enter the date of retirement. This field is only accessible if the employment status entered has been identified in the Employment Status Table as retired. If the guarantor has been designated as retired in the Employment Status field, this field is required. Dates can be entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/YY format. If you choose to enter in the MM/YY format, the system automatically fills in *01* for the first day of the month. For example, if you enter *12/95*, the system displays *12/01/95*. Refer to the Information Entry Techniques section in the *General Information Volume o*f the *STAR Patient Care Reference Guide* for further details. You can enter any special characters between the month, day, and year.

3. EMPLOYER/SCHOOL (TABLE LOOKUP)
Enter the code that describes the guarantor's employer or school. To override the table, enter a hyphen (-) followed by a free-form entry of up to 24 characters. This allows you to enter an employer that is not in the table. If the employer or school is selected from the table, the following fields are brought forward if they are defined in

the employer table: work phone, address, city, state/province, county, country, and ZIP code/postcode. If no employer or school is entered, the cursor skips this and all remaining fields on this screen. Pressing ENTER displays the Accept prompt, and you can continue with the next screen in the sequence.

4.   WORK PHONE (10-NC-O)
Enter the guarantor's employer's area code and work phone number without the parentheses () and hyphen (-). The system automatically enters the parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local number, and the system will automatically enter the area code. You can also enter the number in one of the following formats, if desired: (404)393-6000 or 404/393-6000. You can enter any special characters between the area code and prefix, or between the prefix and suffix.

5.   EXT. (4-N-O)
Enter the guarantor's employer's telephone extension, if applicable.

6.   ADDRESS LINE 1 (25-C-O)
Enter the guarantor's employer's primary address.

7.   ADDRESS LINE 2 (25-C-O)
If the guarantor's employer has a secondary address (for example, suite number) enter it in this field.

8.   CITY (18-C-O)
Enter the city of the guarantor's employer.

If you enter the city's ZIP Code/Postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/Residence Code, and ZIP Code/Postcode fields.

NOTE: US: You can enter either five or nine characters, but only the first five are compared with the ZIP code table entries.

If you enter a code not in the table, that number moves to the ZIP Code/Postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 9.STATE (TABLE LOOKUP)
(CN) 9.PROV (TABLE LOOKUP)
Enter the state/province of the guarantor's employer. You have three choices:

- Enter the appropriate two-character abbreviation for the state/province if you know it. The system validates the field entry with the user-defined state/province table.

- Enter a hyphen (**-**). The system displays the table with the states/provinces. When you select one, the system automatically uses the two-character abbreviation.

- Enter an equal sign (**=**) for the system default (the hospital's state/province).

(US) 10.ZIP CODE (9-N-R or 6-AN-R)
(CN) 10.POSTCODE (6-AN-R or 9-N-R)
Enter the ZIP code/postcode of the guarantor's employer. If you enter an equal sign (=), the system automatically fills the field with the default ZIP code/postcode.

NOTE: **US:**Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes are displayed with a hyphen (**-**) between the ZIP code and the ZIP code extension. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X9X9 format.

NOTE: **CN:**The system displays the postcode in a X9X9X9 format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

11. COUNTY (TABLE LOOKUP)
Enter the county of the guarantor's employer. You have three choices:

- Enter the appropriate code for the county if you know it.

- Enter a hyphen (**-**). The system displays the county table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's county).

If a county was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

12. COUNTRY (TABLE LOOKUP)
Enter the country where the guarantor's employer is located. You have three choices:

- Enter the appropriate code for the country if you know it.

- Enter a hyphen (**-**). The system displays the country table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's country).

If a country was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

13. OCCUPATION (TABLE LOOKUP)
Enter the code that describes the guarantor's occupation. To override the table, enter a hyphen (-) followed by a free-form entry up to 25 characters. This allows you to enter an occupation that is not in the table.

14. EMPLOYED SINCE (8-C-O)

Enter the date that the patient began employment with the above employer. Dates can be entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/YY format. If you choose to enter in the MM/YY format, the system automatically fills in 01 for the first day of the month. For example, if you enter *12/95*, the system displays *12/01/95*. Refer to the Information Entry Techniques section in the General Information volume *o*f the *STAR Patient Care Reference Guide* for further details. You can enter any special characters between the month, day, and year.

Relative One Page

Select the Relative One Page option to view and edit information about the patient's nearest relative, such as the relative's name, relationship to the patient, telephone number, address, etc.

After you select this option, the system displays the following screen.

```
              General Hospital Relative One Page Processor
                                        Fri Mar 10, 2006 12:36 pm
Account        Name               FC Typ Admit    Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90             1760.00 PA/FCRV
1 Relation              2 Name
   M MOTHER                SMITH,RAMONA B
 3 Sex                  4 Soc Sec Number         5 Birthdate   Age
   FEMALE                 254-32-1495              07/23/49    44Y
 6 Mailing Address Line 1                      7 Mailing Address Line 2
   2925 ROSEMONT PKWY
 8 City               9 State         10 ZIP Code      11 County
   ROSWELL              GA                30076           1 FULTON
12 Country            13 Resident Since       14 Phone          15 Ext.
   US United State      01/01/76               (404)664-4754
16 Work Phone         17 Ext.



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

Field Explanations

1. RELATION (TABLE LOOKUP)

Enter the code that describes the relative's relationship to the patient. The code and the description are displayed. Enter an equal sign (=) if the guarantor is the relative, and the relative and relative employer screens are completed from the guarantor information entered previously. (If the guarantor is the patient, the system does not allow the relative to be the patient also.) If the appropriate relationship does not exist on the table, you can enter a hyphen (-) followed by the relation description to override the table, up to 18 characters.

2. NAME (37-C-R)

Enter the relative's name in the format of LAST,FIRST MIDDLE with no special characters in the last name. The first name must follow the comma (,) with no spaces. All information entered after the first space is considered the middle name by the

system; however, there are no restrictions regarding entry on this portion of the patient's name.

3.   SEX (1-A-O)
Enter the relative's sex as M or F, which is displayed as MALE or FEMALE.

(US) 4.SOC SEC NUMBER (9-N-O)
(CN) 4.HC# (16-N-O)
Enter the relative's social security number/health card number without hyphens (-). The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

5.   BIRTHDATE AGE (15-C-O)
Enter the relative's date of birth. Dates can be entered in a variety of formats. Refer to the Information Entry Techniques section in the General Information volume of the *STAR Patient Care Reference Guide* for details. The system automatically calculates the age. Enter the century if different from the current one. The system does not accept an invalid or future date. Age is calculated in days up to two months, in months up to two years, and in years for any ages over two.

6.   MAILING ADDRESS LINE 1 (25-C-O)
Enter the relative's home address. Enter an equal sign (=) if it is the same as the patient's address, and the address, city, state/province, ZIP code/postcode, phone, county, country, and residence since fields are filled using the patient information entered previously.

7.   MAILING ADDRESS LINE 2 (25-C-O)
If the relative has a secondary address (for example, apartment number) enter it in this field.

8.   CITY (18-C-O)
Enter the relative's city. If you enter the city's ZIP code/postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/ Residence Code, and ZIP Code/Postcode fields.

NOTE: US: You can enter either five or nine characters, but only the first five are compared with the ZIP Code table entries.

If you enter a code not in the table, that number moves to the ZIP Code/Postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 9.STATE (TABLE LOOKUP)
(CN) 9.PROV (TABLE LOOKUP)
You have three choices:

- Enter the appropriate two-character abbreviation for the relative's state/province if you know it. The system validates the field entry with the user-defined state/province table.

- Enter a hyphen (**-**). The system displays the table with the states/provinces. When you select one, the system automatically uses the two-character abbreviation.

- Enter an equal sign (**=**) for the system default (the hospital's state/province).

(US) 10.ZIP CODE (9-N-R or 6-AN-R)
(CN) 10.POSTCODE (6-AN-R or 9-N-R)
Enter the relative's ZIP code/postcode. If you enter an equal sign (=), the system automatically fills the field with the default ZIP code/postcode.

NOTE: **US:** Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes are displayed with a hyphen (**-**) between the ZIP code and the ZIP code extension. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X9X9 format.

NOTE: **CN:** The system displays the postcode in a X9X9X9 format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

11. COUNTY (TABLE LOOKUP)
Enter the relative's county. You have three choices:

- Enter the appropriate code for the relative's county if you know it.

- Enter a hyphen (**-**). The system displays the county table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's county).

If a county was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

12. COUNTRY (TABLE LOOKUP)
Enter the code of the country in which the relative lives. The code and the description display. If a country was entered in the ZIP Code table, it is displayed but can be revised if necessary. An equal sign (=) can be entered, and the hospital's country (default country) is displayed from the system default screen.

13. RESIDENT SINCE (5-C-O)
Enter the date that the relative began living at the above address. Dates can be entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/YY format. If you choose to enter in the MM/YY format, the system automatically fills in *01* for the first day of the month. For example, if you enter *12/95*, the system displays *12/01/95*. Refer to the Information Entry Techniques section in the

General Information volume *of* the *STAR Patient Care Reference Guide* for further details. You can enter any special characters between the month, day, and year.

14. PHONE (10-NC-O)
Enter the relative's area code and home phone number without the parentheses () and hyphen (-). The system automatically enters the parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local number, and the system will automatically enter the area code. You can also enter the number in one of the following formats, if desired: (404)393-6000 or 404/393-6000. You can enter any special characters between the area code and prefix, or between the prefix and suffix.

15. EXT. (4-N-O)
Enter the relatives telephone extension, if applicable.

16. WORK PHONE (10-NC-O)
Enter the work phone number of the relative, if known.

17. EXT. (4-N-O)
Enter the work extension number, if applicable.

Relative One Employer Page

Select the Relative One Employer Page option to view and edit information about the employer of the patient's nearest relative, such as the employer's name, address, telephone number, etc.

STAR Financials offers the capability of linking employers to their specific insurance plans. You can assign insurance to an account by patient, guarantor, or relative employer. If you change a relative's employer, rather than the employer's address or other demographic data, you should verify the account's insurance as it may have been assigned according to the employer.

After you select this option, the system displays the following screen.

```
              General Hospital Relative One Employer Page Processor
                                                Fri Mar 10, 2006 12:36 pm
Account        Name                    FC Typ Admit     Disch        Balance Loc
A92188-00233 STEPHENS,CHARLES A    C  ECU 07/03/92 07/07/92     109.00  AR/FCRV
 1 Employment Status            2 Retirement Date
   7 SELF EMPLOYED
 3 Employer/School              4 Employer Address Line 1
                                  1203 ROSEMONT PARKWAY
 5 Employer Address Line 2      6 City               7 State   8 ZIP Code
                                  ROSWELL                GA       30346
 9 County                    10 Country             11 Work Phone    12 Ext.
   1 FULTON                     US United State        (404)664-3400
13 Occupation                14 Employed Since       15 Employee ID
   23 CONSULTANT




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

Field Explanations

1.   EMPLOYMENT STATUS (TABLE LOOKUP)
Enter the code that describes the current status of the relative's employment (for
example, Part Time, Full Time, etc.). If the employment status has been identified as
retired or unemployed, in the Employment Status Table, the system asks *Clear the
Employment information? Y/N*. If you select Y for Yes, the remaining fields on the
screen are automatically deleted. If you select N for No, the employment information is
accessible for revision.

2.   RETIREMENT DATE (DATE)
Enter the date of retirement. This field is only accessible if the employment status
entered has been identified in the Employment Status Table as retired. If the relative
has been designated as "retired" in the Employment Status field, this field is required.
Dates can be entered in a variety of formats. You can enter the date in either a MM/YY
or MM/DD/YY format. If you choose to enter in the MM/YY format, the system
automatically fills in 01 for the first day of the month. For example, if you enter *12/92*,
the system displays *12/01/92*. Refer to the Information Entry Techniques section in the
General Information volume of the *STAR Patient Care Reference Guide* for further
details. You can enter any special characters between the month, day, and year.

3.   EMPLOYER/SCHOOL (TABLE LOOKUP)
Enter the code that describes the relative's employer or school. To override the table,
enter a hyphen (-) followed by a free-form entry up to 20 characters. This allows you to
enter an employer that is not on the table. If the employer or school is selected from
the table, the following fields are brought forward if defined in the employer table: work
phone, address, city, state/province, county, and country, and ZIP code/postcode. If no
employer is entered, the cursor skips this and all remaining fields on this screen.
Pressing ENTER displays the Accept prompt, and you can continue with the next
screen in the sequence.

4.   EMPLOYER ADDRESS LINE 1 (25-C-O)
Enter the relative's employer's primary address.

5.   EMPLOYER ADDRESS LINE 1 (25-C-O)
If the employer has a secondary address (for example, suite number) enter it in this field.

6.   CITY (18-AN-O)
Enter the employer's city.

If you enter the city's ZIP code/postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/Residence Code, and ZIP Code/ Postcode fields.

NOTE: **US:**You can enter either five or nine characters, but only the first five are compared with the ZIP code table entries.

If you enter a code not in the table, that number moves to the ZIP code/postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 7.STATE (TABLE LOOKUP)
(CN) 7.PROV (TABLE LOOKUP)
Enter the state/province of the employer in the standard two-character abbreviation. You have three choices:

•   Enter the appropriate two-character abbreviation for the state/province if you know it. The system validates the field entry with the user-defined state/province table.

•   Enter a hyphen (**-**). The system displays the table with the states/provinces. When you select one, the system automatically uses the two-character abbreviation.

•   Enter an equal sign (**=**) for the system default (the hospital's state/province).

(US) 8.ZIP CODE (9-N-R or 6-AN-R)
(CN) 8.POSTCODE (6-AN-R or 9-N-R)
Enter the ZIP code/postcode of the relative's employer. If you enter an equal sign (=), the system automatically fills the field with the default ZIP code/postcode.

NOTE: **US:**Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes are displayed with a hyphen (**-**) between the ZIP code and the ZIP code extension. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an X9X9X9 format.

NOTE: **CN:**The system displays the postcode in a X9X9X9 format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

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9. COUNTY (TABLE LOOKUP)

Enter the county where the relative's employer is located. You have three choices:

- Enter the appropriate code for the county if you know it.

- Enter a hyphen (**-**). The system displays the county table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's county).

If a county was entered in the ZIP code/Postcode table, the system enters it in the field, but you can revise it if necessary.

10. COUNTRY (TABLE LOOKUP)

Enter the country where the relative's employer is located. You have three choices:

- Enter the appropriate code for the country if you know it.

- Enter a hyphen (**-**). The system displays the country table with the codes and descriptions for selection.

- Enter an equal sign (**=**) for the system default (the hospital's country).

If a country was entered in the ZIP Code/Postcode table, the system enters it in the field, but you can revise it if necessary.

11. WORK PHONE (10-NC-O)

Enter the employer's area code and work phone number without the parentheses () and hyphen (-). The system automatically enters the parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local number, and the system will automatically enter the area code. You can also enter the number in one of the following formats, if desired: (404)393-6000 or 404/393-6000. You can enter any special characters between the area code and prefix, or between the prefix and suffix.

12. EXT. (4-N-O)

Enter the relative's employer's telephone extension, if applicable.

13. OCCUPATION (TABLE LOOKUP)

Enter the code that describes the relative's occupation. To override the table, enter a hyphen (-) followed by a free-form entry up to 25-characters. This allows you to enter an occupation that is not in the table.

14. EMPLOYED SINCE (8-C-O)

Enter the date that the relative began employment with the above employer.

Dates can be entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/YY format. If you choose to enter in the MM/YY format, the system automatically fills in *01* for the first day of the month. For example, if you enter *12/95*,

the system displays *12/01/95*. Refer to the Information Entry Techniques section in the General Information volume *o*f the *STAR Patient Care Reference Guide* for further details. You can enter any special characters between the month, day, and year.

15. EMPLOYEE ID (15-C-O)
Enter the relative's employee identification number.

Relative Two Page

Select the Relative Two Page option to view and edit information about the patient's second relative, such as the relative's name, relationship to patient, telephone number, address, etc.

After you select this option, the system displays the following screen.

```
               General Hospital Relative Two Page Processor
                                         Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/93              1760.00 PA/FCRV
 1 Relation                2 Name
   G GRANDPARENT             MOSSINGHAM,VERNON
 3 Sex                      4 Soc Sec Number        5 Birthdate   Age
   MALE                       134-54-8736             08/31/24    69Y
 6 Mailing Address Line 1                          7 Mailing Address Line 2
   6355 AIRPORT BLVD
 8 City                    9 State   10 ZIP Code   11 County
   MOBILE                    AL          34567
12 Country                13 Resident Since        14 Phone         15 Ext.
   US United State                                    (205)434-6954
16 Work Phone             17 Ext.




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

Field Explanations

1. RELATION (TABLE LOOKUP)
Enter the code that describes the relative's relationship to the patient. The code and the description are displayed. If the appropriate relationship does not exist on the table, you can enter a hyphen (-) followed by the relation description to override the table up to 20 characters.

2. NAME (37-C-R)
Enter the relative's name in the format of LAST,FIRST MIDDLE with no special characters in the last name. The first name must follow the comma (,) with no spaces. All information entered after the first space is considered the middle name by the system; however, there are no restrictions regarding entry on this portion of the patient's name.

3. SEX   (1-A-O)

Enter the relative's sex as M or F, which is displayed as MALE or FEMALE.

(US) 4.SOC SEC NUMBER (9-N-O)
(CN) 4.HC# (16-N-O)

Enter the relative's social security number/health card number without hyphens (-). The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

5. BIRTHDATE AGE (15-C-O)

Enter the relative's date of birth. Dates can be entered in a variety of formats. Refer to the Information Entry Techniques section in the General Information volume of the *STAR Patient Care Reference Guide* for details. The system automatically calculates the age. Enter the century if different from the current one. The system does not accept an invalid or future date. Age is calculated in days up to two months, in months up to two years, and in years for any ages over two.

6. MAILING ADDRESS LINE 1 (25-C-O)

Enter the relative's home address. Enter an equal sign (=) if it is the same as the patient's address, and the address, city, state/province, ZIP code/postcode, phone, county, country, and residence since fields are filled using the patient information entered previously.

7. MAILING ADDRESS LINE 2 (25-C-O)

If the relative has a secondary address (for example, apartment number) enter it in this field.

8. CITY (18-C-O)

Enter the relative's city. If you enter the city's ZIP code/postcode in the City field, the system automatically fills the City, State/Province, County, Country, Geo. Code/ Residence Code, and ZIP Code/Postcode fields.

NOTE: US: You can enter either five or nine characters, but only the first five are compared with the ZIP Code table entries.

If you enter a code not in the table, that number moves to the ZIP Code/Postcode field while the cursor remains in the City field for you to freeform an entry. You can also enter an equal sign (**=**) for the system to fill these fields with the defaults (the hospital's address information).

(US) 9.STATE (TABLE LOOKUP)
(CN) 9.PROV TABLE LOOKUP)

You have three choices:

- Enter the appropriate two-character abbreviation for the relative's state/province if you know it. The system validates the field entry with the user-defined state/ province table.

•   Enter a hyphen (**-**). The system displays the table with the states/provinces. When
    you select one, the system automatically uses the two-character abbreviation.

•   Enter an equal sign (**=**) for the system default (the hospital's state/province).

(US) 10.ZIP CODE (9-N-R or 6-AN-R)
(CN) 10.POSTCODE (6-AN-R or 9-N-R)
Enter the relative's ZIP code/postcode. If you enter an equal sign (=), the system
automatically fills the field with the default ZIP code/postcode.

NOTE: **US:**Enter either five or nine characters for the ZIP code. Nine-digit ZIP codes
            are displayed with a hyphen (**-**) between the ZIP code and the ZIP code
            extension. If you enter a six-digit, alphanumeric Canadian postcode, it is
            displayed in an X9X9X9 format.

NOTE: **CN:**The system displays the postcode in a X9X9X9 format. You can also
            enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the
            system automatically puts a hyphen between the code and the extension.

11. COUNTY (TABLE LOOKUP)
Enter the relative's county. You have three choices:

•   Enter the appropriate code for the relative's county if you know it.

•   Enter a hyphen (**-**). The system displays the county table with the codes and
    descriptions for selection.

•   Enter an equal sign (**=**) for the system default (the hospital's county).

If a county was entered in the ZIP Code/Postcode table, the system enters it in the
field, but you can revise it if necessary.

12. COUNTRY (TABLE LOOKUP)
Enter the code of the country in which the relative lives. The code and the description
display. If a country was entered in the ZIP Code table, it is displayed but can be
revised if necessary. An equal sign (=) can be entered, and the hospital's country
(default country) is displayed from the system default screen.

13. RESIDENT SINCE (5-C-O)
Enter the date that the relative began living at the above address. Dates can be
entered in a variety of formats. You can enter the date in either a MM/YY or MM/DD/
YY format. If you choose to enter in the MM/YY format, the system automatically fills
in *01* for the first day of the month. For example, if you enter *12/95*, the system displays
12/01/95. Refer to the Information Entry Techniques section in the General Information
volume *o*f the *STAR Patient Care Reference Guide* for further details. You can enter
any special characters between the month, day, and year.

14. PHONE (10-NC-O)
Enter the relative's area code and home phone number without the parentheses () and hyphen (-). The system automatically enters the parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local number, and the system will automatically enter the area code. You can also enter the number in one of the following formats, if desired: (404)393-6000 or 404/393-6000. You can enter any special characters between the area code and prefix, or between the prefix and suffix.

15. EXT. (4-N-O)
Enter the relatives telephone extension, if applicable.

16. WORK PHONE (10-NC-O)
Enter the work phone number of the relative, if known.

17. EXT. (4-N-O)
Enter the work extension number, if applicable.

Insurance Process

This series of screens provides patient insurance information and enables verification, certification, and benefit changes to be made. Insurance additions, resequencing, and deletions are also done through this function.

NOTE: Once insurance information is changed through Account Revision, admissions can no longer access the benefits pages of the insurance plans.

```
                General Hospital Insurance Process Processor
                                          Fri Mar 10, 2006 12:36 pm
Account        Name                   FC Typ Admit    Disch       Balance Loc
A10003-00006 SMITH, MARY A.           DD OB  02/02/90 02/05/90    1956.75 AR/FCRV

COB   Code Insurance Name                  Policy Number      Ver PreCert FC

#1 500023 LINCOLN NATIONAL                 12345654           No  No       DD
#2 220000 AMERICAN SECURITY                22450000           No  No







Modify financial class(M), select a plan, delete(D), add(A)--
        MPI Table (T), MSP(Q), next screen(/) or previous screen(/P) [/]
```

The information displayed includes the COB sequence, the carrier/plan code, the plan name, the policy number, whether verification and recertification is required, and the financial class. Up to nine insurance plans can be added to a patient. Accounts in

Accounts Receivable and Bad Debt must be rebilled in order for proration to apply balances to the newly added insurance. To produce a bill, use the Single Bill Request function. If only a claim is needed, use the Add a Claim function.

INSURANCE VERIFICATION AND RECERTIFICATION

On the insurance plan master table, you indicate whether the insurance or hospital procedures require verification or certification. If they are required, the system will display a Yes if the verification or certification has been done. No is displayed if it has not been done. The field will be blank if it is not applicable, or PRE is displayed under the Pre Cert column to indicate certification is pending.

The completion of the verified name and date will satisfy the verification requirements. The completion of the approval date and name will satisfy the certification requirements. The notified date is used to indicate that the insurance has been notified of the hospital admission or registration but approval has not yet been given. The notified date causes the PRE to appear under the Pre Cert column.

When the above screen is displayed, you have the following options:

- Enter M to change the financial class of the patient.

- Enter D to delete an insurance plan.

- Enter A to add an insurance plan.

- Enter R to resequence the COB of the plans associated with this patient.

- Enter T to add or view an insurance plan for the MPI table.

- Enter **Q** to add or view the Medicare Secondary Payor Questionnaire screens. If you enter Q for a Medicare Secondary Payor (MSP) plan, refer to the *Patient Processing* module in the *STAR Patient Care Reference Guide* for a description of the Medicare Secondary Payor screens.

- Enter the number of the plan to revise insurance information (select a plan).

NOTE: Insurance demographic information is maintained on STAR Patient Care and networked to STAR Financials. There may be a delay in STAR Financials' receipt of the information from STAR Patient Care. The following message is displayed if there is a delay in sending the information:

Insurance Integrity problem on the Financial CPU; notify HBOC

If you receive this message, try again later. If you still receive the message, contact McKesson.

Once a financial class has been assigned to a patient, changing the primary insurance plan or modifying the financial class may cause reclassification of statistics and revenue. When you exit the insurance function after performing one of the above processes, if the financial class has changed, the following prompt will appear:

Enter effective date or earliest reclass date possible, (E) [Today]

This prompt enables you to set the effective date of the change. A calendar date can be entered in the MMDDYY format, or you can enter **E** for the earliest date or **T** for today's date. The default is Today. Refer to the Data Entry Conventions in the *General Information Volume* of the STAR Financials Patient Accounting Reference Guide for more information about entering the date. The date cannot be prior to the patient admission or registration date. The date also cannot be prior to the earliest reclassification date.

There is a parameter (located in PAAR Control) that indicates how many periods back you can allow reclassification and whether closed fiscal periods can be effected. This parameter controls the earliest reclassification date. The effective date of the change can never be prior to this date. Enter **E** to display the earliest date. To accept the date, enter **Y** or press ENTER. Enter **N** if this is not the effective date that you wish to use. Enter **T** for today to make the change effective as of today's date.

CHANGING THE FINANCIAL CLASS

After you enter M, the system displays a list of valid financial classes applicable for the primary carrier. Select the desired class. The system then displays the screen with the new financial class added.

DELETING AN INSURANCE PLAN

Before you delete an insurance plan through account revision, you must consider the following:

- Does the insurance plan have related log entries? Before you delete an insurance plan through Account Revision you should delete related log entries. If an insurance plan is deleted before the log entry, you cannot access the log to change or delete the data.

- Do outstanding claims exist for the plan, have financial transactions (payments/ adjustments) been posted to this insurance plan, or does the insurance have a balance? You cannot delete an insurance plan if the above exist for the insurance. If offsetting transactions have been made that cause the transaction totals to equal zero, the plan can be deleted if there are no claims for the insurance and if the balance for the insurance is zero. If the insurance has a balance or has claims loaded, you must use the Insurance Management function to delete the insurance.

To delete an insurance plan, enter **D**. The following prompt is displayed:

Select the insurance plan to be deleted--

Enter the COB number associated with the plan to be deleted.

After the COB number associated with the plan to be deleted is entered, the first page of the insurance detail information is displayed:

```
               General Hospital Insurance Process Processor
                                             Fri Mar 10, 2006 12:36 pm
 Account       Name               FC Typ Admit    Disch       Balance Loc
 A9316600001  JONES,DORENE        C  O/P 06/15/93 06/15/93     1310.72 AR/FCRV
  1 Code                          2 Comment
    20                              HUSBAND TO BRING CARDS
  3 Same As   4 Insured Name             5 Sex      6 Relation to Insured
    Guarantor   JONES,AARON                MALE        2 SPOUSE
  7 Insured's Birthdate  8 Soc Sec #    9 BS? 10 Group Name
    05/04/50  43Y           765-88-7654   Yes    NAT'L DIST
 11 Group Number        12 Group Phone   13 Ext.   14 Subscriber ID Number
    GR58763               (404)111-5555     456       87325
 15 Mail To  16 Contact's Name / "Mail to" Person   17 Address Line 1
    Plan        BELK,JILLIAN                          123 MAPEL STREET
 18 Address Line 2        19 City            20 State  21 ZIP Code
    SUITE 500               ATLANTA            GA        30062-2345



 Are you sure you want to delete? (Y/N) [N]-- Y
          Error: Cannot delete if outstanding claims still exist!!
          Error: Cannot delete unless insurance balance is zero!
```

The following prompt is displayed:

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

NOTE: The information on this screen cannot be edited. You cannot delete a plan if outstanding claims exist for that plan or if the insurance balance is not zero.

If you enter **N**, the summary screen is displayed again, unchanged. If you enter **Y**, the selected insurance plan is deleted from the patient's record. All remaining insurances 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 an error message and 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.

If you entered Y for Yes to the previous prompt and the Insurance Master Delete field in the Hospital Facility Options Table is set to Yes, the system displays an additional prompt:

Delete this plan from the insurance master? (Y/N) [N]--

If you enter **Y** for Yes, the system deletes the plan from the patient's Insurance Master table. In you enter **N** for No, the insurance plan for the Insurance Master Table remains

in the system. For either a Y or N entry, the system deletes the plan for the current active visit.

ADD A PLAN

If you selected A to add an insurance plan, the following prompt is displayed:

Enter a carrier/plan, or use the employer plans from the patient(P), guarantor(G) or relative(R)--

This prompt refers to the patient, guarantor, or relative's employer insurance plans as specified in the Employer table. If insurance plans were specified for the employer, they display with all appropriate information from the selected individual (**P** for patient, **G** for guarantor, **R** for Relative 1) and the plan information entered in the Plan and Carrier tables. If you have not specified insurance plans for the employer, this will be indicated. You can use the normal table lookup process to access the insurances, or you can enter a six-digit plan code for direct access to that plan. If you select a carrier and display its insurance plans, the list includes any alternate names for the plan(s).

After the carrier/plan is selected, the system displays the two screens involved in Plan Demographics. Refer to the Plan Demographic documentation (described in this section) to complete these screens.

RESEQUENCING A PLAN

The letter R is displayed if the patient has more than one insurance plan. If the patient has two insurance plans and R is entered, the system automatically reverses the plan order. If three or four insurance plans are associated with this visit, and R is entered, an additional prompt is displayed, as follows:

Select the COB number that you wish to resequence--

After you select the insurance plan's associated COB number you wish to move, the following prompt is displayed:

Enter COB 'X's new COB number--

where X is the previously selected COB. After you enter the new COB for the originally selected insurance, the system prompts you with the following:

Enter COB 'Y''s new COB number--

where Y is the number you enter for the new COB number for the originally entered insurance.

Throughout this process the system automatically adjusts the financial class to the default financial class associated with the primary insurance (the default is assigned in the plan carrier table). Edits are performed on all insurance plans entered in the

Primary Insurance field (COB 1). If the insurance entered in the Primary Insurance field cannot be used as a primary plan (as indicated in the insurance plan/carrier tables) the following error message is displayed:

Error! INSURANCE CARRIER PLAN NAME cannot be a primary insurance!

The transaction is not allowed. In the error message, the actual name of the insurance carrier plan name is displayed.

When an insurance is resequenced, the Claim Form Type (for example, UB), the Claim Load and Edit Parameter, and the Claim Charge Control Parameter is reassigned for the insurance from the Insurance Plan Coverage Master based on whether the insurance is now primary (COB 1) or secondary (COB 2 through 9). Any modifications made to these fields prior to resequencing are overlaid with the Insurance Plan Coverage values.

SELECTING A PLAN

To view or edit information for a specific insurance plan, enter the COB number of the plan you want to review and press the ENTER key.

The following screen is displayed:

```
          General Hospital Insurance Process Processor
                                     Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch       Balance Loc
A10003-00006 SMITH, MARY A           DD OB  02/02/90 02/05/90     1956.75 AR/FCRV
             Option No.  Option
             -------------------------------------
                1        Plan Demographics
                2        Basic Coverage
                3        Room Coverage
                4        Ancillary Coverage
                5        Major Medical Coverage
                6        Daily/Blood Deductibles
                7        Flat Rate Coverage
                8        Plan Attachments
                9        Plan Comments
               10        Billing/Collection Options
               11        Claim/Proration Control
               12        Exceptions/Reimbursement/Logs
               13        Denial Tracking




 Enter option number--
```

Each option is explained in the order listed on the screen.

Plan Demographics

There are several screens involved in Plan Demographics. Whether or not the first screen, which follows, is displayed depends upon how the Insurance Plan and Coverage master table is completed (for the carrier/plan selected) in the STAR

network. If this screen is assigned to an insurance plan, it is displayed immediately before the actual insurance carrier screen. Its purpose is to inform the admitting department about any verification, recertification, prenotification, or other information required by the plan before the patient can be admitted. This screen is for display purposes only and cannot be edited.

```
              General Hospital Plan Demographics Processor
                                         Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch        Balance Loc
A88146-00011 STEPHENS,CHARLES A     C  ECU 04/05/90               990.00  PA/FCRV



            Verification is required!

            Prenotification is required!



    |Please include group number on all correspondence.         |
    |Hospital must call FOCUS prior to admission!               |
    |                                                           |
    |                                                           |

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

Press ENTER, and the first screen of carrier demographic information is displayed. This screen provides information relating to the policy numbers and insured information.

NOTE: This screen and the second page of insurance demographics differ depending on the insurance type. The following screen shows the Commercial Insurance type.

```
              General Hospital Plan Demographics Processor
                                         Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch        Balance Loc
A9316600001  JONES,DORENE           C  O/P 06/15/93 06/15/93     1310.72 AR/FCRV
 1 Code
   10
 2 Same As   3 Insured Name                 4 Sex      5 Relation to Insured
   Guarantor    JONES,AARON                  MALE        2 SPOUSE
 6 Insured's Birthdate     7 Soc Sec #        8 Group Name
   05/04/50 43Y             765-88-7654        NAT'L DIST
 9 Group Number       10 Group Phone      11 Ext.    12 Policy Number
   28346N             (404)888-4444        345          893467887
13 Mail To  14 Contact's Name / "Mail to" Person   15 Address Line 1
   Plan        JILLIAN BELK                          7165 RIVERDALE RD
16 Address Line 2        17 City               18 State  19 ZIP Code
   SUITE 500              ATLANTA                GA        30346
20 Comment



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

Field Explanations

1. CODE (DISPLAY ONLY)
The two-character numeric-insurance carrier code is displayed. Numeric codes are the only valid entry for this field.

2. SAME AS (1-A-O)
This field contains a code that can be used to update several fields automatically. If the insured is the same person as the patient (P), guarantor (G), or relative one (R), the Insured Name, Sex, Birthdate, and Social Security Number fields (as well as the employer information on the next screen) are completed automatically. Similarly, if this field is changed, the associated fields are deleted/adjusted as necessary.

The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

3. INSURED NAME (28-AC-R)
This field contains the insured's name, in the format of LAST,FIRST MIDDLE. If you entered P (patient), G (guarantor), or R (relative one) in the Same As field, then the insured's name has already been completed.

4. SEX (1-A-R)
This field contains the sex of the insured. Entry options are **M** or **F**, which are displayed as MALE or FEMALE.

5. RELATION TO INSURED (TABLE LOOKUP)
This field contains the code that describes the patient's relationship to the insured. The code and description are displayed. This field is required. If this field is not completed, insurance information is not updated for the patient.

6. INSURED'S BIRTHDATE (15-C-0)
This field contains the insured's birthdate and age in years. If you entered P (patient), G (guarantor), or R (relative one) in the Same As field, the insured's birthdate is automatically filled in from the previous pages but can be revised. You can enter the date as MM/DD/YY or as MM/DD/YYYY.

7. SOC SEC # (9-N-O)
This field contains the insured's Social Security Number. The system displays the number and inserts the hyphens. If you entered P (patient), G (guarantor), or R (relative one) in the Same As field, then the insured's Social Security Number has already been completed.

The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

8. GROUP NAME (30-C-O)
This field contains the group name for this policy. If the plan table contained a group name, it would originally be copied from the plan table.

9. GROUP NUMBER (17-C-O)
This field contains the group number for this policy. If the plan table contained a group number, it would originally be copied from the plan table.

10. GROUP PHONE (10-NC-O)
This field contains the group area code and phone number for this policy. The system automatically enters parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local number, and the system will automatically enter the area code. If the plan table contained a group phone number, it would originally be copied from the plan table.

11. EXT. (4-C-O)
This field contains the group phone number extension. If the plan table contained a group phone number extension, it would originally be copied from the plan table.

12. POLICY NUMBER (20-C-O)
This field contains the insured's policy number.

13. MAIL TO (1-A-O)
This field contains one of the following codes: E (employer), C (carrier), G (group), P (plan) or blank. If this field is blank, it responds as if it is a P for plan. This code indicates where the claim information is to be mailed. This information is used for mailing labels and insurance follow-up letters. This field can be set up on the plan table or changed for a specific patient. An E indicates the claim and follow-up information will be directed to the Employer Name and Employer Address in the patient's insurance demographics. A C indicates the claim and follow-up will be directed to the carrier name and address from the Carrier Table. A G indicates the claim and follow-up will be directed to the group name and Address Line 1, Address Line 2, City, State, and ZIP Code fields in the patient's insurance demographics. A P indicates the claim and follow-up will be directed to the plan in the Insurance field and address information in the Address Line 1, Address Line 2, City, State, and ZIP Code fields in the patient's insurance demographics.

14. CONTACT'S NAME / "MAIL TO" PERSON (36-C-O)
This field contains the name of the person that is to receive the claim.

15. ADDRESS LINE 1 (25-C-O)
This field contains the address to which the claim is to be mailed.

16. ADDRESS LINE 2 (25-C-O)
If the above address contains a secondary address line, (for example, suite number) it is displayed here.

17. CITY (15-A-O)

This field contains the city to which the claim is to be mailed. If the city's ZIP code is in the ZIP code table and you enter it in the City field, the city, state and zip code automatically fill the appropriate fields. The ZIP code you enter can be either five or nine characters (only five characters are edited against the ZIP code table entries). If the ZIP code you enter is not in the table, it moves to the ZIP code field and the cursor remains at the city field for your free-form entry. An equals sign (=) can be entered for the default city, state and ZIP code.

18. STATE (2-A-O)

This field contains the state to which the claim is to be mailed. The state is displayed in the standard two-character state abbreviation format. This entry is validated with the user-defined state table. An equals sign (=) can be entered for the default state.

19. ZIP CODE (9-N-O)

This field contains the ZIP code to which the claim is to be mailed. The ZIP code you enter can be five or nine characters. An equals sign (=) can be entered for the default ZIP code. If you enter a six-digit alphanumeric Canadian ZIP code, the system displays it in a *X9X9X9* format.

20. COMMENT (36-C-O)

This field contains any additional information or comments concerning this insurance coverage or carrier. This comment is for online inquiry purposes.

After you complete your review of this screen, press the ENTER key to view or edit the next screen in this sequence (shown below), which provides employment information. Employment information for the insured will be supplied for either the patient, the patient's relative, or the guarantor, depending upon the information entered in Same As field on the preceding screen.

```
                General Hospital Plan Demographics Processor
                                         T Fri Mar 10, 2006 12:36 pm
Account       Name               FC Typ Admit    Disch       Balance Loc
A92188-00723 STEPHENS,CHARLES A   C  ECU 07/03/92 07/07/92    109.00  AR/FCRV
 1 Employment Status      2 Employment Info.       3 Employer
   1 FULL TIME              P PATIENT DATA           1 HBO & COMPANY
 4 Address Line 1          5 Address Line 2
   301 PERIMETER CENTER       SUITE 500
 6 City                    7 State     8 ZIP Code      9 Work Phone
   ATLANTA                   GA          30346           (404)393-6000
10 Employee ID            11 Claim/Case #            12 Notified Date
   A23115H                   2134                       02/13/93
13 Verified Name          14 Verified Date          15 2nd Opinion
   SMITH,MITCHELL A          02/15/93                   Yes
16 Approval Name          17 Approval #           18 Appr Date   19 Appr LOS
   FENWICK,HARRISON T.       267254162               02/19/93         5
20 Review Agency          21 Phone                22 Contact Name
   SOUTH NEW JERSEY          (404)555-1212            JONES,TED
23 Reference Number       24 EMG Code
   3827491S


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

Field Explanations

1. EMPLOYMENT STATUS (TABLE LOOKUP)
This field indicates the current status of the insured's employment (for example, Part Time, Full Time, etc.). This information is used on the UB.

2. EMPLOYMENT INFO. (TABLE LOOKUP)
This field contains the code that describes the person for whom the employment information is provided (for example, the patient). This information is used on the UB.

3. EMPLOYER (TABLE LOOKUP)
This field contains the code that describes the insured's employer. To enter an employer not listed on the table, enter a hyphen (-) followed by a free-form entry of up to 20 characters. If the employer is selected from the table, the following fields (if defined in the table) are brought forward: Work Phone, Address, City, State And ZIP Code. If no employer is entered, the cursor skips this and all remaining fields on this screen. Pressing ENTER displays the prompt enabling you to accept the screen and continue with the next screen in the sequence.

4. ADDRESS LINE 1 (25-C-O)
This field contains the employer's primary address.

5. ADDRESS LINE 2 (25-C-O)
If the employer has a secondary address (for example, a suite number), it is displayed in this field.

6. CITY (18-C-O)
This field contains the employer's city. If the city's ZIP code is in the ZIP code table and you enter it in the City field, the city, state and ZIP code automatically fill the appropriate fields. The ZIP code you enter can either be five or nine characters (only five characters are edited against the ZIP code table entries). If the ZIP code you enter is not in the table, it moves to the ZIP Code field and the cursor remains at the City field for your free-form entry. An equals sign (=) can be entered for the system's default city, state, and five-digit ZIP code.

7. STATE (2-N-O)
This field contains the state in which the employer is located. The state is displayed in the standard two-character state abbreviation format. The entry is validated with the user-defined state table. An equals sign (=) can be entered for the default state.

8. ZIP CODE (9-N-O)
This field contains the employer's ZIP code. The ZIP code can be either five or nine characters. An equals sign (=) can be entered for the default ZIP code. If you enter a six-digit alphanumeric Canadian ZIP code, the system displays it in a *X9X9X9* format.

9. WORK PHONE (10-NC-O)
This field contains the insured's work phone number and area code. The system automatically enters parentheses around the area code and inserts a hyphen in the phone number. You can enter the phone number without the area code if it is a local

number, and the system automatically enters the area code. The phone can also be entered as (XXX)XXX-XXXX or XXX/XXX-XXXX if desired. In may also be entered with any special character between the area code and prefix, or the prefix and suffix.

10. EMPLOYEE ID (10-AN-O)

This field contains the insured's employee identification number. This is a free-form field. This information is used on the UB.

11. CLAIM/CASE # (15-C-O)

This field contains the claim/case number. This field contains a free-form number, which is usually assigned to the claim by the insurance company.

In Medicare cases, if the Social Security Number of the person defined in the Same As field (this is either the patient's, guarantor's or relative one's Social Security Number) is already defined in the Admission information and you know the suffix, press the equals sign (=) and enter the suffix (for example, =B1). The Social Security Number is displayed as part of the claim number with the suffix attached (for example, 123-45-6789B1).

12. NOTIFIED DATE (10-C-O)

This field contains the date the insurance company was notified. The date entered must be valid and cannot be a future date. If this date is entered, and the approved date has not been entered, it is assumed that certification is in process but not complete.

13. VERIFIED NAME (15-AC-O)

This field contains the name of the person verifying this insurance in this format: LAST,FIRST MIDDLE. No additional spaces or special characters are allowed.

14. VERIFIED DATE (10-C-O)

This field contains the date this insurance was verified. The date entered must be a valid date, and cannot be a future date. If this date is entered, the system assumes the verification is complete.

NOTE: This field controls the setting of sub location of COB 1. If this field is blank (default), or if you update the patient record and the verified date field is blank based on the update, the sub location of the patient record for COB 1 is INSR (Insurance Verification Not Completed). If the patient record is updated and this field contains information, the sub location of the patient record for COB 1 is ND (Not Discharged).

15. 2ND OPINION (1-A-O)

This field indicates whether a second opinion is required. Enter **Y** for Yes if a second opinion is required. Enter **N** for No if a second opinion is not required.

16. APPROVAL NAME (25-AC-O)

This field contains the name of the person approving this hospital stay. The name appears in this format: LAST,FIRST MIDDLE. No extra spaces or special characters

are allowed. This field, along with the approval number and date, satisfies certification requirements.

17. APPROVAL # (15-C-O)
This field contains the approval number. This number can be used for the treatment authorization number in location 63 of the UB.

18. APPR DATE (10-C-O)
This field contains the date this insurance was approved. The date entered must be a valid date and cannot be a future date. If this date is entered, the system assumes that certification is complete.

19. APPR LOS (3-N-O)
This field contains the number of days that have been approved for this patient based on the insurance carrier.

20. REVIEW AGENCY (TABLE LOOKUP)
This field indicates the review agency for this insurance plan.

21. PHONE (13-C-O)
This field indicates the telephone number of the review agency.

22. CONTACT NAME (20-A-O)
This field indicates the contact name at the review agency.

23. REFERENCE NUMBER (10-C-O)
This field indicates the reference number for the review agency.

24. EMG CODE (1-A-O)
This field contains the EMG code that prints for the carrier in locator 24I of the CMS 1500 claim form and the Non Professional Fee 1500 claim form. The Charge Control Parameter must be set to print the EMG code.

Basic Coverage

Select the Basic Coverage option to view and edit information related to this insurance plan's basic coverage.

After you select this option, the system displays the Basic Coverage screen (shown as follows). When you complete your edit, press the ENTER key to return to the previous menu.

```
                    General Hospital Basic Coverage Processor
                    Basic Coverage                     Fri Mar 10, 2006 12:36 pm
Account         Name                 FC Typ Admit    Disch        Balance Loc
A88146-00011 STEPHENS,CHARLES A      C  ECU 04/05/90               990.00  PA/FCRV
 1 Benefits Assigned                   2 Baby Covered
   Yes                                   Yes
 3 Days Before Coverage Begins         4 Days Coverage is Active
   0                                     Unlimited
 5 Professional Fee Coverage           6 Coordinate Benefits
   Include                               Yes




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

Field Explanations

1. BENEFITS ASSIGNED (1-A-R)
This field indicates whether the plan's benefits are assigned to the hospital rather than the patient. Entry options are **Y** for Yes or **N** for No; the default is Y. This field can be used to update the UB claim form. You should refer to the UB Claim Load and Edit Parameters for additional information.

2. BABY COVERED (1-A-R)
This field indicates whether newborn babies are covered under this plan. Entry options are **Y** for Yes or **N** for No; the default is Y.

NOTE: This field is not implemented at this time.

3. DAYS BEFORE COVERAGE BEGINS (3-N-R)
This field contains the number of days from admission or registration before coverage begins. The entry range is 0 to 999 days; the default is 0.

Any charges that occur before this day are considered non-covered.

4. DAYS COVERAGE IS ACTIVE (3-AN-R)
This field contains the number of days from admission or registration that this plan's coverage is active. The entry range is 0 to 999 days or U (unlimited). The default is U. If the benefits are not based on the number of days of coverage, you should enter U.

5. PROFESSIONAL FEE COVERAGE (DISPLAY ONLY)
This field indicates whether professional fees are I (included in this plan), E (excluded from this plan), or O (the only charges covered by this plan). The default is I. This field cannot be edited.

6.   COORDINATE BENEFITS (1-A-R)

This field indicates whether the benefits should be coordinated with the patient's other insurance plans. Entry options are **Y** for Yes or **N** for No. The default is Y. If you enter Y, this plan coordinates with other plans. If you enter N, this plan does not coordinate with other plans.

If you enter Y, the following prompt asks you whether the plan is also a duplicating plan:

Duplicating? (Y/N) [Y]

A duplicating plan covers the same charges as the patient's other insurance plans. A non-duplicating plan covers only charges not covered by the other plans.

Enter **Y** if the plan is a duplicating plan. Enter **N** if the plan is non-duplicating. The default is Y. When you respond, the system proceeds based on whether the plan coordinates benefits.

If the plan coordinates benefits:

•   The liability is calculated, and any remaining liability is passed on to another coordinating plan for consideration.

•   The liability accepted by another carrier is not covered by this plan.

The order in which the coverages display for the patient determines which insurance is primary, secondary, and so forth.

If the plan does not coordinate benefits:

•   The plan prorates its liability and does not pass on any remaining liability to another carrier.

•   The plan would cover what another carrier also covers.

If the amount that a non-coordinating plan covers exceeds the account balance, a credit balance is shown for the patient's liability when an account is prorated.

For a majority of cases, individual policies are the only non-coordinating plans.

Once these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes this transaction and returns you to the list of coverage and exception options.

Room Coverage

Select the Room Coverage option to view and edit information related to this insurance plan's room coverage.

After you select this option, the system displays the Room Coverage screen (shown below). When you complete your edit, press the ENTER key to return to the previous menu.

```
                  General Hospital Room Coverage Processor
                  Room Coverage       Page  1 of  2    Fri Mar 10, 2006 12:36 pm
Account        Name                   FC Typ Admit     Disch        Balance Loc
A88146-00011 STEPHENS,CHARLES A     C  ECU 04/05/90               990.00  PA/FCRV
 1 Ward Room Allowance       2 Percent Cvd    3 Difference To  4 Transfer Limit
   Unlimited                   100%             Patient          Unlimited
 5 SP Room Allowance         6 Percent Cvd    7 Difference To  8 Transfer Limit
   Semiprivate                 0%              Patient          Unlimited
 9 Private Room Allowance   10 Percent Cvd   11 Difference To 12 Transfer Limit
   Not Covered                 0%              Patient          Unlimited
13 ICU Room Allowance       14 Percent Cvd   15 Difference To 16 Transfer Limit
   Not Covered                 0%              Patient          Unlimited
17 Maximum Room/Bed Days Covered            18 Maximum ICU Days Covered
   Unlimited                                   150
19 Maximum Ancillary Days Covered




Press NL--
```

Field Explanations

1. WARD ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a ward room. Entry options are 0 to $9,999.99, **W** (the hospital's standard ward rate), **S** (the hospital's standard semiprivate rate), **U** (unlimited), or **N** (not covered). If you enter S or W, note that the semiprivate and ward room rates are stored for each nurse station.

2. PERCENT CVD (3-N-R)
This field contains the percentage of ward room coverage provided by this plan. The entry range is 0 to 100 percent. You must enter a whole number.

3. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the ward room rate that is not covered should be assigned to major medical coverage or to the patient if there is a difference between the room rate and the amount covered. Entry options are **M** (major medical) or **P** (patient); the default is P.

For example, if the Ward Room Allowance field contains $50 and the hospital's ward room rate is $75, this field indicates how the $25 difference is covered.

4. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the ward room rate that can be transferred to major medical. The entry range is 0 to $9,999.99, W (ward), S (semiprivate), or U (unlimited). If the Difference To field contains M, you can enter a dollar amount, W, S, or U here. If the Difference To field contains P, the system automatically completes this field with U.

If you enter W in this field, major medical is responsible for the difference only up to the ward rate, as defined for each nurse station through the STAR Patient Care Location Table. If you enter S in this field, major medical is responsible for the difference only up to the semiprivate rate, as defined for each nurse station in the STAR Patient Care Location Table.

If a dollar amount is specified (for example, the $25 difference between the Ward Room Allowance of $50 and the hospital's ward rate of $75), the dollar amount is covered by the coverage indicated in major medical. If there is a difference between the amount specified as the limit and the amount calculated as the difference, the remaining amount becomes the responsibility of the patient.

If this field contains U, the entire difference is covered under major medical.

5.   SP ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a semiprivate room. Entry options are 0 to $9,999.99, **W** (the hospital's standard ward rate), **S** (the hospital's standard semiprivate rate), **U** (unlimited), or **N** (not covered). If you enter S, note that the semiprivate room rate is stored for each nurse station.

6.   PERCENT CVD (3-N-R)
This field contains the percentage of semiprivate room coverage provided by this plan. The entry range is 0 to 100 percent. You must enter a whole number.

7. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the semiprivate room rate that is not covered should be assigned to major medical coverage or to the patient if there is a difference between the room rate and the amount covered. Entry options are **M** (major medical) or **P** (patient); the default is P.

For example, if the SP Room Allowance field contains the $100 and the hospital's semiprivate room rate is $250, this field indicates how the $150 difference is covered.

8.   TRANSFER LIMIT (DISPLAY ONLY)
This field contains the maximum amount of the not covered portion of the semiprivate room rate that can be transferred to major medical. The entry range is 0 to $9,999.99, **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, S, or U here. If the Difference To field contains P, the system automatically completes this field with U.

If you enter S in this field, major medical is responsible for the difference only up to the semiprivate rate, as defined for each nurse station through the STAR Patient Care Location Table.

The following is an example of setting a dollar amount as a limit:

• Room Allowance for the semi-private room is set to $100.00

- Semi-Private Room Rate is $250.00

- Difference To is M (major medical)

- $100 is set as the limit and covered under major medical. (The remaining $50.00 becomes the patient's responsibility.) If the limit is set to U unlimited, the entire difference is covered under major medical.

9. PRIVATE ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a private room. The entry range is 0 to $9,999.99, **W** (the hospital's standard ward rate), **S** (the hospital's semiprivate room rate), **U** (unlimited), or **N** (not covered).

10. PERCENT CVD (3-N-R)
This field contains the percentage of private room coverage provided by this plan. The range is 0 to 100 percent. You must enter a whole number.

11. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the private room rate that is not covered should be assigned to the patient's major medical or to the patient. Entry options are **M** (major medical) or **P** (patient); the default is P.

For example, if the Private Room Allowance field contains S and the hospital's semiprivate room rate is $250 and its private room rate is $270, this field indicates how the $20 difference is covered.

12. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the private room rate that can be transferred to major medical. The entry range is 0 to $9,999.99, **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, S (semiprivate), or U (unlimited) here. If the Difference To field contains P, the system automatically completes this field with U.

If you enter S in this field, major medical is responsible for the difference only up to the semiprivate rate, as defined for each nurse station through the STAR Patient Care Location Table. If you enter U, major medical covers the entire difference. If the Difference To field contains P and the system fills this field with U, the patient is responsible for any difference. The patient also is responsible for any difference when the Difference To field contains M and the dollars exceed the amount entered in the Transfer Limit field.

13. ICU ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a room in intensive care. The entry range is 0 to $9,999.99, **W** (ward), **S** (semiprivate), **U** (unlimited), or **N** (not covered).

14. PERCENT CVD (3-N-R)
This field contains the percentage of ICU coverage provided by this plan. The entry range is 0 to 100 percent. You must enter a whole number.

15. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the ICU rate that is not covered should be assigned to major medical or to the patient. Entry options are **M** (major medical) or **P** (patient); the default is P.

For example, if the ICU Room Allowance field contains $100 and the hospital's semiprivate room rate is $250, this field indicates how the $150 difference is covered.

If you enter S in this field, major medical is responsible for the difference only up to the semiprivate rate, as defined for each nurse station through the STAR Patient Care Location Table. If you enter U, major medical covers the entire difference. If the Difference To field contains P and the system fills this field with U, the patient is responsible for any difference. The patient is also responsible for any difference when the Difference To field contains M and the dollars exceed the amount entered in the Transfer Limit field.

16. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the ICU room that can be transferred to major medical. The entry range is 0 to $9,999.99, S (semiprivate), or U (unlimited). If the Difference To field contains M, you can enter a dollar amount, S (semiprivate), or U (unlimited) here. If the Difference To field contains P, the system automatically completes this field with U.

17. MAXIMUM ROOM/BED DAYS COVERED (3-AN-R)
This field contains the total number of days of room/bed charges covered by this plan. The entry range is 1 to 999 days or U (unlimited). If the number of stay days exceeds the day limit, charges become non-covered.

18. MAXIMUM ICU DAYS COVERED (3-AN-R)
This field contains the maximum number of ICU days covered by this plan. The entry range is 1 to 999 or U (unlimited). The number of days entered here cannot exceed the maximum number of room/bed days entered in the previous field. If the ICU days limit is reached, these charges are prorated in the same manner as the semiprivate rate.

19. MAXIMUM ANCILLARY DAYS COVERED (1-A-R)
This field indicates whether ancillary limits are based on days entered in the Maximum Room/Bed Days Covered field. Entry options are **Y** for Yes or **N** for No; the default is N. This field is not yet implemented.

When you finish reviewing the first Room Coverage screen, press ENTER and the Accommodation Exceptions screen is displayed.

```
                  General Hospital Room Coverage Processor
                  Room Coverage Except Page  2 of  2  Fri Mar 10, 2006 12:36 pm
Account       Name                    FC Typ Admit    Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90              990.00  PA/FCRV
Page:01                         Accommodation Exceptions
( 1) NURSERY A
( 2) CORONARY CARE
( 3) INTENSIVE CARE
( 4) MEDICALLY JUSTIFIED
( 5) WARD




            Enter option to edit or `A` to add--
```

This screen displays accommodation exceptions (from STAR Patient Care admission) to the insured's basic room coverage. To display or view for editing any of these exceptions, select the option to edit or view and press ENTER.

A screen similar to the following is displayed.

```
                  General Hospital Room Coverage Processor
                  Room Coverage Except Page  2 of  2  Fri Mar 10, 2006 12:36 pm
Account       Name                    FC Typ Admit    Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90             2200.00 PA/FCRV
 1 Accommodation                            2 Same as Room Type
   C-CORONARY CARE                            Semiprivate
 3 Room Allowance        4 Percent Cvd   5 Difference To  6 Transfer Limit




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

Field Explanations

1. ACCOMMODATION (DISPLAY ONLY)
This field contains the STAR Patient Care accommodation code and description. This field cannot be edited.

2. SAME AS ROOM TYPE (1-A-O)

This field indicates whether the accommodation code should operate like the semiprivate, private, or ICU room coverage, as defined on the first screen. Entry options are **S** (semiprivate), **P** (private), or **I** (ICU). This field can also be left blank if you are defining special coverage. If you complete this field, the remaining fields on this screen are left blank.

3. ROOM ALLOWANCE (7-AN-C)

This field contains the amount this plan pays for a room used by a patient with this accommodation code. The entry range is 0 to $9,999.99, **W** (ward), **S** (semiprivate), **U** (unlimited), or **N** (not covered). This field is required if the Same As Room Type field is blank.

4. PERCENT CVD (3-N-C)

This field contains the percentage of room cost paid by this plan for this accommodation code exception. The entry range is 0 to 100. You must enter a whole number. This field is required if the Same As Room Type field is blank.

5. DIFFERENCE TO (1-A-C)

This field indicates whether the portion of this room rate that is not covered should be assigned to major medical or to the patient. Entry options are **M** (major medical) or **P** (patient); the default is P.

6. TRANSFER LIMIT (7-AN-C)

This field contains the maximum amount of the portion not covered of the room that can be transferred to major medical. The entry range is 0 to $9,999.99, **W** (ward), **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, **S** (semiprivate), or **U** (unlimited) here. If the Difference To field contains P, the system automatically completes this field with U.

Ancillary Coverage

Select the Ancillary Coverage option to view and edit information related to the ancillary coverage for this account.

After you select this option, the system displays the Ancillary Coverage screen (shown below). When you complete your edit, press the ENTER key to return to the previous menu.

```
                General Hospital Ancillary Coverage Processor
                  Ancillary Coverage                 Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit     Disch        Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90                  990.00  PA/FCRV
 1 Include Room Charges in Ancillary Coverage              2 Limits are
   Yes                                                       Covered charges

                         First Ancillary Coverage
 3 Deductible Amount   4 Co-Pay        5 Percent Covered   6 Dollar Limit
    $0.00                 ->               100                Unlimited

                        Second Ancillary Coverage
 7 Deductible Amount                   8 Percent Covered   9 Dollar Limit


10 Source of Last Update
   Ins Cov Table-I/O




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

Field Explanations

1. INCLUDE ROOM CHARGES IN ANCILLARY COVERAGE (1-A-R)

This field indicates whether room charges should be included in ancillary coverage. Entry options are **Y** for Yes or **N** for No.

If you enter N, the room and coverage percentages entered on the Room Coverage screens (not the ancillary charges) are used to calculate amounts, room charges are not used to satisfy deductibles, and dollar limits are for ancillary charges only.

If you enter Y, room charges use the ancillary percentage and limit dollars. Room charges are used to satisfy deductibles. The allowance or amount per day is still derived from the Room Coverage function.

2. LIMITS ARE (1-A-R)

This field indicates whether the coverage limits are C (covered charges) or B (benefits). The default is C.

For example, if an insurance carrier's coverage is 80% to $1000.00 and the carrier's liability is $800.00, this field would contain C (covered charges - $1000 x .80 = $800). If an insurance carrier's coverage is 80% to $1000.00 and the carrier's liability will be $1000.00, this field would contain B (benefits).

First Ancillary Coverage

4. CO-PAY (7-N-O)

This field contains the amount of the first coverage period's co-pay. When this field is accessed, the following prompt is displayed:

Enter first co-pay amount (NNNN.NN) --

The entry range is 0 to $9,999.99.

5. DEDUCTIBLE AMOUNT (7-AN-R)
This field contains the first coverage period's deductible. The entry range is 0 to $9,999.99. If there is no deductible, you must enter 0.00.

WARNING: Pressing ENTER initializes fields 3 through 8.

6. PERCENT COVERED (3-N-C)
This field contains the percentage of covered charges handled during the first coverage period. The entry range is 0 to 100. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

7. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled during the first coverage period. The entry range is 0 to $99,999,999.99 or **U** (unlimited). When this limit is reached (providing a dollar amount is entered), the plan's second ancillary coverage goes into effect. If you enter U, the secondary ancillary coverage is not valid. This field is required if the Deductible Amount field contains a dollar value.

Second Ancillary Coverage

NOTE: The fields in the second ancillary coverage are completed only if the dollar limit has been defined in the first ancillary coverage.

8. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the second coverage period's deductible. The entry range is 0 to $9,999.99. If there is no deductible, you must enter 0.00.

WARNING: Pressing ENTER will initialize the Deductible Amount, Percent Covered, and Dollar Limit fields.

9. PERCENT COVERED (3-N-C)
This field contains the percentage of covered charges handled during the second coverage period. The range is 0 to 100. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

10. DOLLAR LIMIT (11-N-C)
This field contains the maximum dollar amount of accumulated charges handled by the second ancillary coverage. Any overage is assigned to major medical. The entry range is 0 to $99,999,999.99. This field is required if the Deductible Amount field contains a dollar value.

NOTE: When ancillary limits are reached, remaining liability transfers to major medical coverage.

Major Medical Coverage

Select the Major Medical Coverage option to view and edit information related to the major medical coverage for this account. Major medical coverage information is drawn from the Insurance Plan Coverage Master.

After you select this option, the system displays the Major Medical Coverage screen (shown below). When you complete your edit, press the ENTER key to return to the previous menu.

```
              General Hospital Major Medical Coverage Processor
                Major Med Coverage                Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A10003-00006 SMITH,MARY A.          M  OB 04/02/90 04/05/90    1956.75 AR/FCRV
 1 Room Charges Included?  2 Room Chgs in Limits?          3 Limits Are
   Yes                       Yes                             Covered charges
 4 Ancillary Charges Included?
   Yes


                           First Major Medical
 5 Deductible Amount      6 Percent Coverage            7 Dollar Limit
    $0.00                   100                            $10,000.00

                           Second Major Medical
 8 Deductible Amount      9 Percent Coverage            10 Dollar Limit
    $100.00                 80                             $50,000.00

                           Third Major Medical
11 Deductible Amount     12 Percent Coverage            13 Dollar Limit
->

Enter third deductible (NNNNNN.NN)--
```

Field Explanations

1. ROOM CHARGES INCLUDED? (1-A-R)
This field indicates whether the room and bed charge differences are used to satisfy the deductible. Options are **Y** for Yes and **N** for No; the default is Y.

2. ROOM CHGS IN LIMITS? (1-A-R)
This field determines whether the room and bed differences should be included in calculating the limits. This field is required only if the Room Charges Included field is set to No. Options are **Y** for Yes or **N** for No; the default is Y. If this field contains a Y, the room charges are included.

3. LIMITS ARE (1-A-R)
This field indicates whether the coverage limits entered here pertain to hospital charges or patient benefits. The options are **C** (covered charges) or **B** (benefits): the default is C.

For example, if a carrier covers 80% to $1000.00 and the carrier's liability is $800.00, this field would contain C (covered charges - $1000 x .80 = $800). If a carrier covers 80% to $1000.00 and the carrier's liability is $1000.00, this field would contain B

(benefits). The system determines the dollar amount applied to the 80% before referring to the next level of coverage, in this case, $1250--$1250 x .80 = $1000.

4. ANCILLARY CHARGES INCLUDED? (1-A-R)
This field determines whether ancillary charges are included in satisfying major medical deductibles and limits.

First Major Medical

5. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the first major medical coverage period's deductible. The entry range is 0.00 to $9,999.99. If there is no deductible, you must enter 0.00.

WARNING: Pressing ENTER initializes fields 4 through 13.

6. PERCENT COVERED (3-N-C)
This field contains the percentage of patient charges handled by the first major medical coverage period's deductible. The range is 0 to 100%. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

7. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled by the first major medical coverage period. Any overage is assigned to another patient insurance (if available), directly to the patient, or to the second major medical. The entry range is 0 to $99,999,999.99 or **U** (unlimited). If you enter U in this field, the fields in the second and third major medical sections of this screen are *not* completed. This field is required if the Deductible Amount field contains a dollar value.

Second Major Medical

The second major medical information goes into effect when the first major medical dollar limit has been reached.

8. DEDUCTIBLE AMOUNT (6-N-O)
This field contains the second major medical coverage period's deductible. The entry range is 0 to $9,999.99. A zero deductible must be entered as 0.00.

WARNING: Pressing ENTER initializes fields 8 through 13.

9. PERCENT COVERED (3-N-C)
This field contains the percentage of patient charges handled by the second major medical coverage period. The entry range is 0 to 100%. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

10. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled by the second major medical coverage period. Any overage is assigned to another patient insurance (if available), directly to the patient, or to the third major medical. The entry

range is 0 to $99,999,999.99 or **U** (unlimited). This field is required if the Deductible Amount field contains a dollar value.

Third Major Medical

The third major medical information goes into effect when the second major medical dollar limit has been reached.

11. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the third major medical coverage period's deductible. The entry range is 0 to $9,999.99. If there is no deductible, you must enter 0.00.

WARNING: Pressing ENTER initializes fields 11 through 13.

12. PERCENT COVERED (3-N-C)
This field contains the percentage of patient charges handled by the third major medical coverage period. The range is 0 to 100%. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

13. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled by the third major medical coverage period. Any overage is assigned to another patient insurance (if available) or directly to the patient. The entry range is 0 to $99,999,999.99 or **U** (unlimited). This field is required if the Deductible Amount field contains a dollar value.

NOTE: When major medical coverage is exhausted, payment responsibility is transferred to another patient insurance (if available) or directly to the patient.

Daily/Blood Deductibles

Select the Daily/Blood Deductibles option to view and edit information about the daily deductibles and blood deductibles for this account.

This information is drawn from the Insurance Plan Coverage Master.

After you select this option, the system displays the Daily/Blood Deductibles screen (shown below). When you complete your edit, press the ENTER key to return to the previous menu.

```
              General Hospital Daily/Blood Deductibles Processor
                 Daily/Blood Deduct.              Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90             990.00  PA/FCRV
First Daily Deductible
 1 Start After Days      2 Days Active            3 Deductible Amount
   60                      30                       $540.00
Second Daily Deductible
 4 Start After Days      5 Days Active            6 Deductible Amount
   90                      60                       $240.00
Third Daily Deductible
 7 Start After Days      8 Days Active            9 Deductible Amount

Blood Deductible
10 Deductible Pints     11 Furnished in Replaced? 12 Blood Summary Code
    2                      No                        391 Blood Administration




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

Field Explanations

First Daily Deductible

1. START AFTER DAYS (3-N-O)
This field contains the number of days from admission or registration before starting this deductible. The entry range is 0 to 999 days.

2. DAYS ACTIVE (3-AN-C)
This field contains the number of days this deductible is active. The range is 1 to 999 days or U (unlimited). This field is required if the Start After Days field contains a value.

3. DEDUCTIBLE AMOUNT (7-N-C)
This field contains the daily deductible amount. The entry range is 0 to $9,999.99. This field is required if the Start After Days field contains a value.

Second Daily Deductible

This information can be completed only after the first daily deductible information is defined.

4. START AFTER DAYS (3-N-O)
This field contains the number of days from admission to wait before starting this deductible. The entry range is 0 to 999 days.

5.   DAYS ACTIVE (3-AN-C)
This field contains the number of days this deductible is active. The entry range is 1 to 999 days or U (unlimited). This field is required if the Start After Days field contains a value.

6.   DEDUCTIBLE AMOUNT (7-N-C)
This field contains the daily deductible amount. The entry range is 0 to $9,999.99. This field is required if the Start After Days field contains a value.

Third Daily Deductible

This information can be completed only if the second daily deductible information has been defined.

7.   START AFTER DAYS (3-N-O)
This field contains the number of days from admission to wait before starting this deductible. The entry range is 0 to 999 days.

8.   DAYS ACTIVE (1-AN-C)
This field contains the number of days this deductible is active. The entry range 1 to 999 days or **U** (unlimited). This field is required if the Start After Days field contains a value.

9.   DEDUCTIBLE AMOUNT (7-N-C)
This field contains the daily deductible amount. The entry range is 0 to $9,999.99. This field is required if the Start After Days field is completed.

10. DEDUCTIBLE PINTS (2-N-O)
This field contains the number of pints of blood that this plan will not cover. This field is used for value code 38 on the UB. If the patient receives blood, the system accumulates the amount of blood based on charges associated with the UB revenue code that is entered in the Blood Summary Code field. This field is not used in proration.

11. FURNISHED IN REPLACED? (1-A-R)
This field indicates whether units of blood furnished under this plan should be included in the units replaced, value code 39 on the UB claim form. Options are **Y** for Yes or **N** for No.

12. BLOOD SUMMARY CODE (3-N-R)
This field contains the appropriate UB revenue code. This code is used in concert with fields 10 and 11. If charges exist for the UB revenue code entered in this field and the Furnished in Replaced field contains Y, the number of units of blood is loaded as value code 37, Blood Furnished, and Value Code 39, Blood Replaced, on the UB. If the Furnished in Replaced field contains N, the number of units furnished is loaded only.

Flat Rate Coverage

Select the Flat Rate Coverage option to view and edit information about this insurance plan's flat rate coverage.

After you select this option, the system displays the Flat Rate Coverage screen (shown below). When you complete your edit, press the ENTER key to return to the previous menu.

```
            General Hospital Flat Rate Coverage Processor
              Flat Rates                        Fri Mar 10, 2006 12:36 pm
 Account       Name                 FC Typ Admit    Disch       Balance Loc
 A92188-00713 STEPHENS,CHARLES A     C  ECU 07/03/92 07/07/92    109.00  AR/FCRV
                             Flat Rate Coverage
  1 Flat Rate per    2 Maximum Days    3 Flat Rate Amount  4 Deductible Amount
    Day                   120               $350.00             $0.00









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

Field Explanations

1. FLAT RATE PER (1-A-R)
This field indicates the type of flat rate for inpatients. Entry options are per day (**D**) or entire stay (**S**). If you enter S, the Maximum Days field cannot be completed.

• A per day flat rate enables one rate to be applied for each day the patient stays in the hospital.

• A per bill flat rate enables a flat rate to be applied for each interim or cycle bill and for the final bill.

• A per stay flat rate enables one rate to be applied for each day the patient stays in the hospital.

2. MAXIMUM DAYS (3-AN-C)
This field contains the maximum number of days this flat rate is effective from the admission date. The entry range is 0 to 999 days or **U** (unlimited). This field is required if the Flat Rate Per field contains D or S.

3. FLAT RATE AMOUNT (9-N-R)

This field contains the flat rate amount this plan pays per day, per bill, or for the entire stay, depending on the entry in the Flat Rate Per field. The entry range is 0 to $999,999.99.

4. DEDUCTIBLE AMOUNT (9-N-R)

This field contains the flat rate deductible amount for an inpatient stay. The entry range is 0 to $9,999,999.00; the default is 0.

Plan Attachments

Select the Plan Attachments option to view and edit information related to any billing attachments associated with this account.

This transaction enables you to identify attachments that must accompany a claim against this coverage plan. These attachments (for example, an Admission Summary, EKG Certification, Discharge Summary, etc.) can be required by specific carriers and plans when a claim is submitted. The codes are maintained in the user-defined Billing Attachment table.

After you select this option, the system displays the Plan Attachments screen (shown below). When you complete your edit, press the ENTER key to return to the previous menu.

```
            General Hospital Plan Attachments Processor
              Attachments                      Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit     Disch       Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90              990.00 PA/FCRV
Page:01                      Billing Attachments          ##=Current Choices
( 1) AA-AA CERTIFICATION
( 2) AS-ADMISSION SUMMARY
( 3) CP-CPT-4 CODES
( 4) CC-CRIPPLED CHILDREN CERT.
( 5) DS-DISCHARGE SUMMARY
( 6) EK-EKG CERTIFICATION
( 7) PT-PHYSICAL THERAPY CERTIFICATION
( 8) AL-TEST FOR SIM RELATED
( 9) TL-TUBAL LIG. CERTIFICATION




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

The Billing Attachments that apply to the patient are highlighted. Select the code number to add a new billing attachment or enter a hyphen (-) and the code number to remove an attachment.

Plan Comments

Select the Plan Comments option to view and edit any comments that have been entered about this insurance plan. An example of a plan comment could be information alerting insurance billers and verifiers about particular plan requirements. The comments entered here are copied to the patient's record and display in a list similar to plan attachments. These comments can be referenced during insurance verification.

Once this option is selected, if there are no comments associated with this plan, the following message is displayed:

Enter comment code to add (XXX) --

Enter the three-character code of the comment you want to add, and press ENTER. A screen similar to the screen below is displayed. If the plan already has comments, when the Plan Comment option is selected a screen similar to the following is displayed:

```
           General Hospital Plan Comments Processor
              Comments                           Fri Mar 10, 2006 12:36 pm
Account       Name                    FC Typ Admit    Disch        Balance Loc
A90000-00009 JONES, JOHN              C  I/P 01/16/90 01/31/90     1050.00 AR/FCRV
Page:01                                 Comments
( 1) XYZ-A COPY OF ALL DETAIL CHARGES








 Enter option to edit, or `A` to add--
```

This screen displays a list of comments entered for this plan, along with the three-character comment code and the first 29-characters of the message. You have the option of editing or adding messages.

After a message has been selected or a new message code entered, the following screen is displayed.

```
               General Hospital Plan Comments Processor
                  Comments                        Fri Mar 10, 2006 12:36 pm
Account       Name                     FC Typ Admit    Disch         Balance Loc
A90000-00009 JONES, JOHN               C  I/P 01/16/90 01/31/90       1050.00 AR/FCRV
Comment:XYZ
            1         2         3         4         5         6
    12345678901234567890123456789012345678901234567890123456789012345678901234567890
01|A COPY OF ALL DETAIL CHARGES IS REQUIRED                    |
02|                                                            |
03|                                                            |
04|                                                            |




    F1           F2            F3       F4     F5          F6          F7     F10
   Delete Line  Insert Line  Center   Exit   Store Line  Restore Line  Pack   Help
```

You can enter four lines of up to 60 characters each, using the functions keys at the bottom of the screen to complete the task. Once the text is entered, you can either accept the screen or continue editing.

Billing/Collection Options

Select the Billing/Collection Options function to view and edit billing and collection information related to this insurance plan.

After you select this option, the system displays the Billing/Collections Options screen (shown below).

When you complete your edit, press the ENTER key to return to the previous menu.

```
              General Hospital Billing/Collection Options Processor
                 Bill/Collect Parms                 Fri Mar 10, 2006 12:36 pm
 Account       Name                    FC Typ Admit    Disch      Balance Loc
 A88146-00011 STEPHENS,CHARLES A        C  ECU 04/05/90            990.00  PA/FCRV
  1 Payment Transaction Code              2 Cont. Adj. Trans Code at Payment
    I2003-BLUE CROSS PAYMENT                A0001-ADJUSTMENT
  3 Insurance Refund Transaction Code
    D9999-BLUE CROSS REFUND
  4 Primary Follow-Up Schedule            5 Secondary Follow-Up Schedule
    1-BLUE CROSS OF GA                      5-BLUE CROSS SECONDARY
  6 Billing Group                         7 Collector Group
    22-BLUE CROSS BILLERS                   2-BLUE CROSS INS COLL
  8 Final Bill Parameter                  9 Cycle Billing Parameter
    T-BLUE CROSS FINAL PARM                 T1-BLUE CROSS CYCLE PARM
 10 Perform Pre-bill Edits               11 Final Bill if Pre-bill Edits Exist




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

Field Explanations

1. PAYMENT TRANSACTION CODE (TABLE LOOKUP)
This field contains the one-letter transaction type and the user-defined, four-digit transaction code used to record a payment from this insurance carrier. This code will be used as a default during cash posting for the insurance carrier shown. You can enter another code or display and select from a list of codes under the transaction type I (insurance payment).

2. CONTRACTUAL ADJUSTMENT TRANSACTION CODE AT PAYMENT (TABLE LOOKUP)
This field contains the one-letter transaction type and the user-defined, four-digit transaction code used to record any contractual adjustments made on a payment from this insurance carrier in this account's transaction history. You can enter another code or display and select from a list of codes under the transaction type A (adjustment). Adjustments cannot be made on accounts at the time a payment is made unless this code is present.

3. INSURANCE REFUND TRANSACTION CODE (TABLE LOOKUP)
This field contains the one-letter transaction type and the user-defined, four-digit transaction code used to record any refunds made to this carrier in this account's transaction history. You can enter another code or display and select from a list of codes under the transaction type D (insurance refund). This code is used as a default if a refund is made to the carrier for this patient.

4.   PRIMARY FOLLOW-UP SCHEDULE (TABLE LOOKUP)

This field contains the user-defined code identifying the primary follow-up schedule assigned to this carrier/plan. This code can be up to three digits long. You can enter another code or display and select from a list of follow-up schedules. This schedule is used for follow-up if this carrier is the primary carrier.

5.   SECONDARY FOLLOW-UP SCHEDULE (TABLE LOOKUP)

This field contains the user-defined code identifying the secondary follow-up schedule assigned to this carrier/plan. This code can be up to three digits long. You can enter another code or display and select from a list of follow-up schedules. If this is the secondary carrier, this schedule is used for follow-up.

6.   BILLING GROUP (DISPLAY ONLY)

This field contains the user-defined code identifying the billing group responsible for generating and submitting claims for this carrier/plan.

7.   COLLECTOR GROUP (TABLE LOOKUP)

This field contains the user-defined code identifying the collection group responsible for collecting the balance due from this carrier/plan. This field can be up to three digits long. You can enter another code or display and select from a list of collection groups in the system.

NOTE: The Final Bill Parameter and Cycle Billing Parameter fields indicate the billing parameters that are assigned to the account if this insurance carrier is the primary carrier. If you want to change the billing parameters, select the Account Status option under the Financial Information section of Account Revision.

8.   FINAL BILL PARAMETER (DISPLAY ONLY)

This field contains the code identifying the final bill parameter assigned to this carrier/plan. This field cannot be edited. This parameter defines the bill parameter type, what type of bill is produced, whether it is prorated and combines professional fees, the transaction codes recording this bill in this account's transaction history and the message (if any) printed on the bill.

9.   CYCLE BILLING PARAMETER (DISPLAY ONLY)

This field contains the code identifying the cycle bill parameter assigned to this carrier/plan. This field cannot be edited. This parameter defines the bill parameter type, what type of bill is produced, whether it is prorated and combines professional fees, the transaction codes recording this bill in this account's transaction history and the message (if any) printed on the bill.

10. PERFORM PRE-BILL EDITS (1-A-O)

This field indicates whether pre-bill edits can be performed on the account. When this field is accessed, the following prompt is displayed:

Perform pre-bill edits on this account? (Y/N)--

You can enter **Y** for Yes, perform pre-bill edits or **N** for No, do not perform pre-bill edits on this account.

11. FINAL BILL IF PRE-BILL EDITS EXIST (1-A-O)
This field indicates whether the account should be final-billed if pre-bill edits exist for the account. This field can be accessed if the Perform Pre-Bill Edits field is set to Yes, perform pre-bill edits. When this field is accessed, the following prompt is displayed:

Do you want to final bill if pre-bill edits exist? (Y/N)--

You can enter **Y** for Yes, final bill if pre-bill edits exist or **N** for No, do not final bill if pre-bill edits exist on the account.

Claim/Proration Control

Select the Claim/Proration Control option to view and edit claim and proration control information related to this insurance plan.

After you select this option, the system displays the Claim/Proration Control Options screen, which follows.

When you complete your edit, press the ENTER key to return to the previous menu.

```
               General Hospital Claim/Proration Control Processor
              Proration/Claim Ctrl                 Fri Mar 10, 2008 12:36 pm
 Account      Name                    FC Type Admit     Disch       Balance Loc
 C0715600001  HANSEN,OLAF              O  O/P 06/05/07 06/05/07     $1970.33 AR
  1 Claim Form Type     2 Produce Claim? 3 Print on UB?        4 Prorate?
    UB                    Yes               Yes                   Yes
  5 Claim Load/Edit Parameter         6 Claim Charge Control Parameter
    99-TEST COMMERCIAL                 01-COMMERCIAL CHARGES
  7 Claim Generation Parameter       8 Load Separate Claim?  9 Hold for Pmt?
    UB-UB82 Claim generation           Yes                    Yes
 10 ASB/Crossover Hold Exceptions
  100100,100300,100400,500100,500300,500999,600100,600300,600999,900100+
 11 Print Paper Claim Label?         12 Suppress?  13 EOB Indicator
    No                                  No           No
 14 Provider Number                 15 Provider Master
    OP20202                            2-COMMERCIAL MODEL HOSP
                         Electronic Claims
 16 Electronic Media     17 Prt Elec Clm Label 18 Delay Reason Code
    Electronic Media A      No
 19 Payor ID,Sub ID   20 Primary Payor    21 Source of Payment
    12345,9876



                  next(/) or previous screen(/P) [/]
```

Field Explanations

1. CLAIM FORM TYPE (TABLE LOOKUP)
This field indicates the type of claim form to be produced for this carrier plan. The options available include the UB and 1500 (OHIP, WCB, and Universal) claim forms. This field is required. If you attempt to modify this field to a non-UB Claim Form Type

and the Reimbursement Type in the Reimbursement Facility Options is set to I-Pathways Contract Management, then the following error message is displayed:

Error: Claim Type must be UB or Medi-Cal UB for Pathways reimbursement.

2. PRODUCE CLAIM? (1-A-C)

This field indicates whether a claim is to be produced (printed or spooled) for this insurance. Entry options are **Y** for Yes, produce an electronic or paper claim when the claim is released, or **N** for No, do not produce a claim when the claim is released. The default is Y. Copies of suppressed claims can always be generated using the Reprint Claims option. Claims will load for the insurance regardless of the setting of this field. Suppressed claims are listed on the Claim Prints Suppressed Report.

3. PRINT ON UB? (1-A-R)

This field indicates whether the insurance plan information should print on the UB claim form in Locators 50 through 66. You can enter **Y** for Yes, print insurance plan information in locators 59 through 66 on the UB or **N** for No, do not print those locators on the UB. This field is used by the following Setup Routines (linked to Internal Elements) in the Claim Load and Edit Parameters to identify insurance plan information to print on claims:

•   UB Carrier 1

•   UB Carrier 2

•   UB Carrier 3

NOTE: This field is not used to determine which claim form loads for the insurance. It determines, for those insurances on the account that load a UB, the information that is printed in the above-mentioned locators.

4. PRORATE? (1-A-O)

This field indicates whether or not claims should be prorated according to the coverage and limits of this plan. The options are **Y** for Yes or **N** for No.

The value (either Y or N) entered in this field controls how the patient's charges are handled for proration purposes. If the value is set to Y, all patient plans are prorated according to the benefit information entered for the plan. If the value is N, all patient plans are prorated at 100% and the excess amount carried in a Third Party Excess field.

For example, a patient has two insurance coverages coordinating benefits and this field is set to Y with covered charges of $1000.00. As a result:

•   Plan 1 pays 80%

•   Plan 2 pays 90%

- Plan 1 is prorated for a plan liability of $800.00

- Plan 2 is prorated for a plan liability of $200.00

If you set this field to Y, using the same information in the above example results in this situation:

- Plan 1 is prorated at $1000.00

- Plan 2 is prorated at $1000.00

- A Third Party Excess field is updated for $1000.00

5. CLAIM LOAD/EDIT PARAMETER (TABLE LOOKUP)
This field contains the user-defined code and description of the parameter defining how claims for this carrier are loaded and edited. You can enter the parameter code or display and select from a list of claim load/edit parameters in the system. The entry in this field indicates what information and edits will be performed on the claim.

6. CLAIM CHARGE CONTROL PARAMETER (TABLE LOOKUP)
This field contains the user-defined code and description of the parameter defining how charges are printed on the claim form. You can enter the parameter code or display and select from a list of claim charge control parameters in the system. This field is not used for Canadian claims processing.

7. CLAIM GENERATION PARAMETER (TABLE LOOKUP)
This field contains the user-defined code and description of the parameter which defines how claims are generated. This parameter determines the maximum number of hold days for claims with errors for this carrier. You can enter the parameter code or display and select from a list of claim generation parameters in the system.

8. LOAD SEPARATE CLAIM? (1-A-R)
This field indicates whether or not a separate claim for this carrier/plan should be generated if this plan is not providing primary coverage.The options are **Y** for Yes or **N** for No. The default is Y. This information is used for the UB claims only.

9. HOLD CLAIM FOR PMT? (1-A-R)
This field indicates whether or not a claim for this plan should be held until the claims for prior plans with overlapping coverage are dispositioned as final payment, adjusted to zero, or denied. The options are **Y** for Yes and **N** for No with a default entry of N. A separate claim must be loaded to set this parameter to Yes.

10. ASB/CROSSOVER HOLD EXCEPTIONS (TABLE LOOKUP)
This field is used to define, for carriers/plans that are COB 1 plans, that the next highest UB plan's claim(s) should not hold for prior payment for the COB 1 claim. This should be the Payer in Line 50B of the UB claim form, if your 1500 and Non Pro Fee 1500 insurances have the Print on UB? field set to *No,* in the Facility Options, Billing and Claims, page 2 of 5, of the Insurance Coverage Table. Crossover and ASB claims are not held for prior payment based on the COB 1 plan. These ASB/Crossover claims are

released later, and the print/spool suppressed, but the claims are marked as Produced. This allows the Crossover and ASB claims to be submitted at a later date.

This field contains carrier/plan exceptions for ASB/Crossover claims. The field displays as many carrier/plan exceptions as will fit on the line. If there are more entries than will fit, the line has a plus sign (+) at the end.

This field is accessible only when the Hold Claim for Prior Payment? field is set to Yes. When accessing the field, the following prompt is displayed:

Key Y to select/view plans or Key N for No Exceptions? [N]--

Key N (No) to remove the ASB/Crossover Hold Exceptions for this insurance and account.

If you enter Y (Yes), the following prompt is displayed if insurance plans had already been established:

Enter insurance plan codes in a list or partial code`-` for list --

The system first displays the insurances already selected. You can remove insurance plans previously selected. To select additional insurance plans, press ENTER, and key the insurance plan codes or a hyphen (-) to select from a list of insurance plans.You can do a partial lookup, or a lookup on all insurance plans with a UB claim type. If you do a lookup on all insurance plans, those plans already selected are highlighted. If you type an insurance plan or plans directly in the prompt, these entered plans overlay the previously-selected insurance plans. For example, if you had previously selected plans 100100, 300100, and 999100, if you directly type in insurance plans 500100 and 600100, these will be the only plans in the ASB/Crossover Hold Exceptions list. Therefore, if you want to add plans, you should do a table lookup at the prompt, your existing insurance plans are highlighted, and you can highlight additional insurance plans. These are added to the existing ASB/Crossover Hold Exceptions.

If the response is Y for Yes and the current display for the field is "See Insurance Plan Coverage Table" or the Hold for Payment ASB/Crossover Exceptions is being established for the account, the subsequent prompt is as follows:

Enter insurance plan codes in a list, key partial code`-` for list, or key `U` to use List from Insurance Coverage Table--

If insurance plans are selected in this field, they are saved with account information and they are the only insurance plans for which the setup is performed for ASB/ Crossover Hold Exceptions. If U is keyed, then the setup is performed if the insurance pairing exists in the Insurance Plan Coverage table when the claim loads due to a billing event (therefore any updates made to the Insurance Plan Coverage table would be taken into account at time of billing). If U is keyed, the field displays:

See Insurance Plan Coverage Table

If insurance plans were selected for the account in the past, the current selections appear in a table lookup which can be used to remove entries. If you want to rely on the Insurance Plan Coverage table to identify the relationship, then remove all entries from this table and key U to the subsequent prompt:

> *Enter insurance plan codes in a list, key partial code`-` for list, or key `U` to use List from Insurance Coverage Table--*

If you want to edit the list so it continues to be specific for the account, then remove insurance plans as desired from the table look-up titled "Insurance Plans Selected for ASB/Crossover Process" and add insurance plans if desired per the following prompt:

> *Enter insurance plan codes in a list, key partial code`-` for list, or key `U` to use List from Insurance Coverage Table--*

If the list of insurance plans for which the crossover claim can be created is being determined from the list maintained for the account and insurance, then that list appears in the display for the field. The display ends with ++ if there are too many insurance plans for the field display.

The ASB/Crossover Hold Exceptions flag is set for an insurance for an account when the insurance coverage information for the insurance is assigned, if any ASB/ Crossover Hold Exceptions have been indicated in the Insurance Plan Coverage Table. When claims are loading due to a billing event, if ASB/Crossover Hold insurance plans have not been indicated for the insurance for the account, and the field ASB/ Crossover Hold Exceptions is set to "See Insurance Plan Coverage Table", then the list for the account in the Insurance Plan Coverage table is used.

NOTE: An insurance at the account level may have the field ASB/Crossover Hold Exceptions set to "See Insurance Plan Coverage Table" that may not necessarily go through the ASB logic. The system, once it identifies an ASB link with the COB 1 plan, stops evaluating lower plans for an ASB link. Only one ASB link per account will be identified. For example, if COB 1 is a UB plan 100100, COB 3 is a UB plan 500100 and lists 100100 as an ASB/Crossover Hold Exception in the Insurance Plan Coverage Table, and COB 5 is a UB plan 300100 that also lists 100100 as an ASB/Crossover Hold Exception in the Insurance Plan Coverage Table, then only the claims for 500100 will be marked for ASB processing. The system will not continue to the lower plan 300100 since a link has already been established.

Also, the system will only evaluate the first UB plan it encounters after the COB 1 plan. So using the above example, where COB 1 is a UB plan 100100, COB 3 is a UB plan 500100, and COB 5 is a UB plan 300100, if COB 3 (which is the next highest UB plan) does not qualify for an ASB link, then the system does not continue to the next UB plan to evaluate that plan. There will be no ASB link for the account.

NOTE: Any updates made to this field for the insurance at the account level only affect claims that load via a billing event (Midnight Processing or Instant Adjustment Bill) after the updates have been made. If claims have already

loaded and the ASB/Crossover Hold Exceptions field is updated, these updates do not affect the current claims.

When updating the ASB/Crossover Hold Exceptions field, or when adding, deleting, or resequencing insurances, and loading an Adjustment Bill and Claims, if the Next Highest UB plan goes from being an ASB/Crossover plan, to a non ASB/Crossover plan, or vice versa (from a non ASB/Crossover plan to an ASB/Crossover plan), if the Next Highest UB claims no longer match on the Claim Split Indicator, the claims show as being replaced by the new Primary claim for the insurance, or the claim with the blank Claim Split Indicator for the insurance.

11. PRINT PAPER CLAIM LABEL? (1-A-C)

This field indicates whether a claim mailing label should be printed for this insurance

12. SUPPRESS? (1-A-R)

This field indicates if unreleased claims should be suppressed or not suppressed when a payment, adjustment or balance transfer is posted which leaves the carrier or account with a zero balance. An entry of **Y** for Yes indicates that claims that have an account balance of zero or a carrier balance of zero are automatically suppressed. An entry of **N** for No indicates that claims that have an account balance of zero or a carrier balance of zero will not be suppressed. The default is N. For additional information on this field, refer to the PA/AR Master File Maintenance section in the *Tables, Masters and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide*.*

13. EOB INDICATOR (1-A-O)

This field indicates whether a paper explanation of benefit was requested for the carrier. When this field is accessed, the following prompt displays:

Are you requesting a paper EOB? (Y/N) [N]-- |

An entry of Yes indicates a paper EOB was requested. An entry of No indicates a paper EOB was not requested. The default is No.

15. PROVIDER NUMBER (22-AN-O)

This field contains the provider number assigned to this insurance at this account level.

16. PROVIDER MASTER (TABLE LOOKUP)

This field contains the Provider Master associated with this account. The appropriate master is linked to the Patient Type table or the COB1 plan. If there are unique provider numbers not associated with a particular patient type but related to a particular carrier/ plan, you can add this master to the plan and the plan assignment on the COB1 plan overrides the patient type assignment.

The system assigns this provider master to the account at admission or registration based on patient type. The providers numbers for Medicare, Medicaid, and Blue Cross are defined within the master. While the account is in PA, the provider number changes automatically if the patient type changes or the primary insurance changes (if the provider number is related to an insurance carrier.)

Electronic Claims

15. ELECTRONIC MEDIA (TABLE LOOKUP)
This field indicates what electronic media should be used to communicate a claim to the carrier. This field is not used for Canadian OHIP or WCB claims. Entry options are:

- **A** for Electronic Media A

- **B** for Electronic Media B

- **C** for Electronic Media C (formerly CPU-to-CPU)

- **D** for Electronic Media D

- **E** for Electronic Media E

- **T** for Electronic Media T (formerly Magnetic Tape)

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

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

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

To send claims electronically, the Claim Media field in the Claim Load and Edit Parameters must be set to B (for Both Paper and Electronic), or E (for Electronic). Also, the Electronic Types field in the Claim Load and Edit Parameters must be set to the claims (Final, Cycle, Adjustment, Late, Reprint, or Tracer) that are to be sent electronically. The system sends claims to the paper spoolfile if they are not marked to send electronically in the Electronic Types field.

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

17. PRINT ELECTRONIC CLAIM LABEL (1-A-O)
This field indicates whether a claim mailing label should be printed for this insurance plan when the electronic claims are spooled in the system. The options are **Y** for Yes or **N** for No; the default is N.

18. PAYOR ID, SUB ID (10-N-O)
This field is used for McKesson state regulations.

NOTE: The Primary Payor and Source of Payment fields are for electronic claims and are not implemented at this time.

19. PRIMARY PAYOR (1-AN-O)
If electronic claims are generated for the hospital, every plan should have this field completed. The Primary Payor code is one character.

20. SOURCE OF PAYMENT (TABLE LOOKUP-O)
This field contains the code identifying the electronic claim submissions for the carrier. A code can be entered or you can select a code from the Source of Payment table. Source of Payment codes are used in electronic claims to inform the insurance carrier which carrier or carriers are valid for the patient for this visit. If the hospital is submitting claims electronically, this field must be completed for every plan.

Exceptions/Reimbursement/Logs

Select the Exceptions/Reimbursement/Logs option to view and edit information about exceptions to the coverages associated with this insurance plan.

After you select this option, the system displays the Exceptions/Reimbursement/Logs Options menu screen:

```
              General Hospital Summary Code Exceptions Processor
                                           Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch        Balance Loc
A92188-00713 STEPHENS,CHARLES A     C  ECU 07/03/92 07/07/92      109.00  AR/FCRV
           Option No.  Option
           ---------------------------------------
               1       Summary Code Exceptions
               2       Reimbursement
               3       Third Party Logs




 Enter option number--
```

Each of these options is discussed under its own heading below.

Summary Code Exceptions

Select the Summary Code Exceptions option to view and edit information about this insurance plan's proration summary code exceptions. The proration summary code exceptions contain deductibles specified at different percentages than the main policy or for items indicated as not covered. Canadian customers use the summary code exceptions to assign charges to insurance and patient responsibility.

After you select this option, the system displays the Summary Code Exceptions screen, which follows.

When you complete your edit, press the ENTER key to return to the previous menu.

```
              General Hospital Summary Code Exceptions Processor
                  Summary Code Except.              Fri Mar 10, 2006 12:36 pm
Account        Name                    FC Typ Admit    Disch        Balance Loc
A88146-00011 STEPHENS,CHARLES A     C   ECU 04/05/90                 990.00  PA/FCRV
Page:01                   Proration Summary Code Exceptions
( 1) LABORATORY
( 2) ANESTHESIA
( 3) CARDIO VASCULAR LAB
( 4) BILL SUMMARY CODE




 Enter option to edit, or `A` to add--
```

You can add a summary code or edit an existing summary code. To add a summary code, enter **A** and select a code from the list of proration summary codes displayed.

To edit an existing summary code, enter the number of the code you want to edit, and press the ENTER key. The following screen is displayed:

```
              General Hospital Summary Code Exceptions Processor
                  Summary Code Except.              Fri Mar 10, 2006 12:36 pm
Account        Name                    FC Typ Admit    Disch        Balance Loc
A88146-00011 STEPHENS,CHARLES A     C   ECU 04/05/90                 990.00  PA/FCRV
 1 Summary Code/Description
   001-LABORATORY
                             Exception Information
 2 Summary Code Covered            3 Covered Percentage
   No                                0%
 4 Deductible Per    5 Deductible %   6 Deductible Amount    7 Greater/Lesser




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

Field Explanations

1.   SUMMARY CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the three-digit proration summary code and its up to 30-character description. This field cannot be edited. The following fields apply to charges relating to service items grouped under this Proration Summary code.

Exception Information

2. SUMMARY CODE COVERED (1-A-R)

This field indicates whether or not this Proration Summary code should be covered by this plan. The options are **Y** for Yes and **N** for No. If N is entered here, the Covered Percentage, Deductible Per, Deductible Percentage, Deductible Amount, and Greater/ Lesser fields are not completed.

3. COVERED PERCENTAGE (3-N-O)

This field contains the percentage of coverage for this Proration Summary code. The entry options are 0 to 100%.

4. DEDUCTIBLE PER (1-A-O)

This field indicates whether a deductible is applied per charge or per Proration Summary category total, if the Proration Summary code has a deductible. The options are **C** (per charge or per service item) or **T** (per category total or per Proration Summary code).

5. DEDUCTIBLE % (3-N-O)

This field contains this plan's deductible, represented as a percentage, for the Proration Summary code. The entry range is 0 to 100% in whole percentages.

6. DEDUCTIBLE AMOUNT (6-N-O)

This field contains this plan's deductible, represented as a dollar and cents amount, for the Proration Summary code. The entry range is 0 to $9,999.99.

7. GREATER/LESSER (1-A-R)

This field can be completed only if both the Deductible Percentage and the Deductible Amount fields are completed.

Should the greater or lesser amount between the deductible amount and the deductible percentage be used in prorating charges under this plan? The options are G (greater) or L (lesser). For example, a plan has a deductible amount of $150 and a deductible percentage of 10%. If an outpatient's charges are $1000, their deductible amount would remain the same ($150) while the percentage amount would be $100. This field determines if the deductible dollar figure in this example would be $100 (L-lesser) or $150 (G-greater).

Once these fields are completed, you have the option of accepting or editing the information on the screen.

Reimbursement

Select the Reimbursement option to view and edit reimbursement information associated with this insurance plan. The information is originally copied from the Insurance Plan Coverage master but can be changed for the patient through this option.

After you select this option, the system displays the following Reimbursement screen:

```
                General Hospital Reimbursement Processor
                   Reimbursement                      Fri Mar 10, 2010 12:36 pm
Account       Name                    FC Typ Admit    Disch        Balance Loc
A10003-00006 SMITH,MARY A.            C  OB  02/02/90 02/05/90     1956.75 AR/FCRV

1. Post. Cont. Adj. at Bill              2. Reimbursement Master Payor
   Yes                                      CM-Pathways Contract Management
 3. Reimbursement Type                   4. Contractual Adj. Transaction Code
    I-PCON by Claim                          A0001-I/P MEDICARE PART A ALLOWANCE
 5. Reimbursement Type                   6. Contractual Adj. Transaction Code

 7. Reimbursement Type                   8. Contractual Adj. Transaction Code

 9. Reimbursement Type                  10. Contractual Adj. Transaction Code

11 OPPS Cont. Adj.                      12.  Pass-through
                                             Yes
13. Edit by                            14.  Effective date
   Marsh, Nancy                              05/16/03 01:24pm




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

Field Explanations

1.   POST CONT. ADJ. AT BILL (1-A-R)
This field indicates whether or not any contractual adjustments on this account should
be calculated and applied when the bill is produced. The options are **Y** for Yes and **N**
for No. If this field contains N, the reimbursement is calculated, but the automatic
contractual adjustment is not done. Calculations can be viewed in Account Inquiry
balance information or (while the patient is in-house) on the Financial Review Report.

For reimbursement types of I (PCON by Bill) or J (PCON By Claim) , if you set this field
to No, the claim is sent to Pathways Contract Management and returned to STAR, and
the contractual adjustment is saved internally in STAR, but not posted. If the response
is No, the following occurs:.

*   The estimated reimbursement is retained in STAR.

*   Posting of the contractual adjustment is bypassed meaning a contractual
    adjustment does not appear in the contractual adjustment batch for the PCON
    upload file.

*   The return of the information from PCON can be documented in transaction history
    depending upon the answers to Stand Transc His and Post C/A=No Transc His
    which are fields on the Pathways Contract Management screen for the UB
    Interface found on the Reimbursement Master menu.

*   The return of the information is noted in the FBR282 report, in the section titled
    Contractual Adjustment is not being Posted. The report summary page has new

summary heading under No C/A Posted for accounts that did not post a contractual adjustment.

- The calculations in STAR relying on a posted contractual adjustment and using the difference between the liability and estimated reimbursement are not used because no contractual adjustment was posted. These calculations include logic in ERA processing when the Contractual Adjustment Method is Variance or Reverse Sys Adj and in reversing previous contractual adjustments for adjustment bills.

2.   REIMBURSEMENT MASTER PAYOR (TABLE LOOKUP)

This field contains a user-defined code representing the reimbursement payor for this carrier plan. You can enter the code or display and select from a list of payors in the Reimbursement Payor table. This table contains third party payors having special reimbursement arrangements with the hospital. This field is required if you entered Y to the Post Cont. Adj. At Final Bill field.

Because carriers may reimburse at different rates, the system enables you to enter up to four different reimbursement types per patient per carrier to determine reimbursement. Reimbursement types are established in the system and include:

- A - ASC Payment Group
- D - ICD-9-CM Diagnosis code
- P - ICD-9-CM Procedure code
- G - DRG Code
- M - Medical Service
- O - Overall Plan
- I - PCON by Bill
- H - Medicare Outpatient Prospective Payment System (OPPS)
- J - PCON by Claim

To use these reimbursement types, the reimbursement payor must have this type defined in the Reimbursement Payor Definition table. The information is originally copied from the Insurance Coverage Master but can be modified for the patient through this option. For more information, refer to the Reimbursement Master section of the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide.

3.   REIMBURSEMENT TYPE (TABLE LOOKUP)

This field indicates the first type on which this plan reimburses the hospital. When this field is accessed, the list of reimbursement types defined for the payor is displayed. One type is selected to complete this field. The type is displayed in hierarchy order and must be valid for the reimbursement payor. If the type is not valid for the reimbursement payer, the system displays the following error message:

  Error: This type not defined for this payer

If you attempt to modify this field to I- Pathways Contract Management and the Claim Form Type field is set to anything other than X - UB or R - Medi-Cal UB, then the following error message is displayed:

Error: Claim Type must be UB or Medi-Cal UB for Pathways reimbursement.

To change the reimbursement type from or to PCON by Bill or PCON by Claim, the claim form attached to the carrier must be either UB or Medi-Cal UB and the account cannot have produced even one cycle bill. The following error messages are displayed when the change does meet those conditions:

- If a claim form type other the UB or Medi-Cal UB is assigned, you cannot select I (PCON by Bill) or J (PCON by Claim), and the system displays the following message:

  Claim Type must be UB or Medi-Cal for PCON/Cycle

- If the account has already produced at least one cycle bill, the system displays the following error message:

  Error: Account has cycle bills. Use reimb type I (PCON by Bill)!

NOTE: If this field is defined as J (PCON by Claim), you cannot enter any other reimbursement types that are attached to the payor that is defined in the Reimbursement Master Payor field. And, if the Reimbursement Master Payor field is defined as any reimbursement type other than PCON by Claim or PCON by Bill, you cannot select PCON by Claim or PCON by Bill as the reimbursement type.

4. CONTRACTUAL ADJ. TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code associated with the reimbursement type entered in the Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made. You can enter the code or display and select from a list of codes under the transaction type A (adjustments).

5. REIMBURSEMENT TYPE (TABLE LOOKUP)
This field indicates the second type on which this plan reimburses the hospital. When this field is accessed, the list of reimbursement types defined for the payor is displayed. One type is selected to complete this field. The type is displayed in hierarchy order and must be valid for the reimbursement payor.

6. CONTRACTUAL ADJ. TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code associated with the reimbursement type entered in the second Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made on the account. You can enter the code or display and select from a list of codes under the transaction type A (adjustments).

7. REIMBURSEMENT TYPE (TABLE LOOKUP)
This field indicates the third type on which this plan reimburses the hospital. When this field is accessed, the list of reimbursement types defined for the payor is displayed.

One type is selected to complete this field. The type is displayed in hierarchy order and must be valid for the reimbursement payor.

8. CONTRACTUAL ADJ. TRANSACTION CODE (TABLE LOOKUP)
This field contains the transaction code associated with the reimbursement type entered in the third Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made on the account. You can enter the code or display and select from a list of codes used for recording insurance refunds set up under the transaction type A (adjustments).

9. REIMBURSEMENT TYPE (TABLE LOOKUP)
This field indicates the fourth type on which this plan reimburses the hospital. When this field is accessed, the list of reimbursement types defined for the payor is displayed. One type is selected to complete this field. The type is displayed in hierarchy order and must be valid for the reimbursement payor.

10. CONTRACTUAL ADJ. TRANSACTION CODE (4-N-O)
This field contains the transaction code associated with the reimbursement type entered in the fourth Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made on the account. You can enter the code or display and select from a list of codes used for recording insurance refunds set up under the transaction type A (adjustments).

12. PASS-THROUGH (DISPLAY ONLY)
This indicates if primary UB claims will be sent to Pathways Contract Management as pass-through claims. Enter **Y** for Yes, to send pass-through claims to Pathways Contract Management and **N** for No, to not send pass-through claims to Pathways Contract Management. The value of this field is dependent on how the Pass-through field is defined on the Payor Table Definitions Processor for the associated Reimbursement Master Payor Code and Reimbursement Type combination at the time the insurance was added to the account. For example, for Reimbursement Master Payor Code equal to MC and Reimbursement Type equal to H-OPPS, if the Pass-through field on the Payor Table Definition Processor is set to Yes when this insurance is added to the account then this field is set to Yes. If the Reimbursement Master Payor code and Reimbursement type are updated on the account's insurance, the Pass-through field displays what the pass-through value is set to on the Payor Table Definition Processor for the associated Reimbursement Master Payor Code and Reimbursement Type combination at the time the insurance was updated. Modifying the pass-through field on the Payor Table Definitions Processor for a Reimbursement Master Payor Code and Reimbursement Type combination after insurance has been added to the account will not result in any accounts being automatically updated with this new value.

When you are finished entering information into these fields, the system displays the following prompt:

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

After you enter Yes to accept the screen or press ENTER, the following can occur, based on the account location, if you have changed the Reimbursement Type from or to J (PCON by Claim):

• The account is in location PA and has not produced a cycle bill, and you change the reimbursement type from or to the PCON by Claim Reimbursement type—The system allows all changes for accounts that have not yet produced a cycle bill. If the reimbursement type is changed to J-PCON by Claim, the account passes to Pathways Contract Management once the first claim loads from a billing process.

• The account is in location PA and has produced at least one cycle bill, and you change the reimbursement type from the PCON by Claim type to another reimbursement type—The system displays the following prompt:

  PCON Update will remove cycle claims from PCON. Continue? (Y/N) [N] --

  Valid options are Y for Yes and N for No; the default value is N for No. If you respond Yes to the prompt, cycle claims are removed from PCON. In the source file that is created for the next night, STAR Patient Accounting sends over one claim delete request for each claim that is marked as having been passed to Pathways Contract Management. Claims are sent in reverse sequential order with the most recent being first.

  If you press ENTER or enter N, the system does not accept the change of the reimbursement type that was entered in the Reimbursement Type field and re-displays the screen with PCON by Claim as the value in that field. The following prompt is displayed:

  No changes made to reimbursement information. Press NL.

  If you press ENTER, the screen is accepted.

• The account is in location AR, and you change the reimbursement type from a non-PCON by Claim type (including a blank type) to the J-PCON by Claim type—The system displays the following prompt:

  PCON cycle cannot be selected for AR accounts. Use Pathways Contract Mgmt (Reimbursement type I) to send account to PCON. Press NL.

  Press ENTER to continue. The system does accept the change of the reimbursement type and re-displays the screen with the most recently accepted value in the field. The following prompt is displayed:

  No changes made to reimbursement information. Press NL

• The account is in location AR, and you change the reimbursement type from a J - PCON by Claim type to another reimbursement type—The system edits the account to determine if the account has had a payment posted by ERA using the

variance method. If this has occurred for any claim, the system displays the following message:

xx claims have an ERA Payment using the variance Contractual Adjustment method. Continue? (Y/N) [N]

Valid options are Y for Yes and N for No; the default is N for No. If you press ENTER or enter No, the system does not accept the change of the reimbursement type that was entered in the reimbursement type field and re-displays the screen with the values that existed prior to any updates that may have just been entered. The following prompt is displayed:

No changes made to reimbursement information. Press NL

If you press ENTER, the system next looks to see if any claims for the account have been archived or purged. If this has occurred for any claims, the system displays the following message:

xx Archived/purged claims exist. Continue? (Y/N) [N]

Valid options are Y for Yes and N for No; the default value is N for No. If you press ENTER or enter N, the system does not accept the change of the reimbursement type that was entered in the reimbursement type field and re-displays the screen with the values that existed prior to any updates that may have just been entered. The following prompt is displayed:

No changes made to reimbursement information. Press NL

If you enter Y for Yes, the system displays the following prompt:

Adjustment bill with claim for primary insurance is needed to delete claims from PCON and to calculate reimbursement. Continue? (Y/N) [N]

Valid options are Y for Yes and N for No, the default value is N for No. If you press ENTER or enter No, the system does not accept the change of the reimbursement type that was entered in the reimbursement type field and re-displays the screen with the values that existed prior to any updates that may have just been entered. The following prompt is displayed:

No changes made to reimbursement information. Press NL

If you press ENTER, the screen is accepted. The system does not automatically generate an adjustment bill request. You are required to place the adjustment bill request. As a result of the adjustment bill request, the cycle claims are deleted from Pathways Contract Management.

Third Party Logs

Select the Third Party Logs option to view and edit information related to any third party logs associated with this account. Third Party Logs is not available for Canadian users.

After you select this option, the system displays the following Third Party Logs screen:

```
          General Hospital Third Party Logs Processor
              3rd Party Logs                   Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch      Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90            990.00  PA/FCRV
Page:01                         Log Identifiers
( 1) COMMERCIAL O/P
( 2) COMMERCIAL SECONDARY




















 Enter option to edit or `A` to add--
```

This screen displays the third party logs that are valid for the patient. To add an additional log for the patient, enter A and the log table is displayed. The system highlights the logs applicable to the patient on the log table screen.

To view more information for a specific log, enter the number of the log you want to see and press ENTER. The following screen is displayed:

```
          General Hospital Third Party Logs Processor
              3rd Party Logs                   Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch      Balance Loc
A88146-00011 STEPHENS,CHARLES A    C  ECU 04/05/90            990.00  PA/FCRV
 1 Log Identifier                  2 Carrier Status
   COMMERCIAL O/P                     PRIMARY

 3 In/Out/ER/All patients
   ALL












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

Field Explanations

1. LOG IDENTIFIER (DISPLAY ONLY)
This field contains the code and description of the log identifier selected. This field cannot be edited.

2. CARRIER STATUS (1-A-O)
This field contains the status this carrier must have for patients using this plan to be included in the log. The options are **A** (any), **P** (primary carrier only), or **S** (secondary carrier only). The default entry is A. If this field is set to P and the carrier plan is not the patient's primary plan, the logs are not updated.

3. IN/OUT/ER/ALL PATIENTS (1-A-O)
This field indicates which patients using this plan should be included in this log. The options are **I** (inpatients only), **O** (outpatients only), **E** (emergency patients only), or **A** (all patients). The default entry is A.

DENIAL TRACKING

This option is used to modify the denial tracking parameters assigned to the patient from the insurance plan.

When selecting this option, the insurance plan must be primary, and the reimbursement type must be J (PCON/Cycle), and claims must be defined to go to Pathways Contract Management for denial tracking.

- If the insurance is not primary, selecting the Denial Tracking option returns the following error message:

  Denial Tracking Information is saved for the primary insurance only. Press NL.

- If the insurance is primary, but is not defined to go to Pathways Contract Management for denial tracking, then the following prompt is displayed:

  Reimbursement type must be J (PCON/Cycle) or claims must be going to PCON via the Pass-through interface. Press NL.

If the above conditions are met, the following screen is displayed:

```
                General Hospital Denial Tracking Processor
                Denial Tracking                    Fri Mar 10, 2006 12:36 pm
Account       Name                    FC Typ Admit    Disch      Balance  Loc
A01155-00002 ANDERSON,LAURA          KE OPS 06/04/02 06/04/02   30869.83- AR/FCRV

 1 Track Denials/Appeals             2 Denial Tracking Payor Code
   Yes                                 1234-NON ERA PAYOR
 3 Denial Tracking Reason Group
   1-NON-ERA

                             Default Values
 4 Reason Code                       5 Electronic RA Claim Adj Group Code
   46 Non covered service
 6 Dollar Definition                 7 Appeal Collector Group
   61 TODD'S APPEAL DOLLAR DEFINITION   1-COLLECTION GROUP
 8 Auto-appeal minimum               9 Pre-appeal minimum
   1,000.00                            500.00



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

Field Explanations

1. TRACK DENIALS/APPEALS (1-A-R)
This field allows you to define whether or not to track denials and appeals for this exception. When this field is accessed, the following prompt is displayed:

Do you want to track denials for this exception? (Y/N)--

2. DENIAL TRACKING PAYOR CODE (TABLE LOOKUP)
This field contains the denial tracking payor code. When the field is accessed, the Payor Table is displayed. Select the payor code for the insurance plan.

3. DENIAL TRACKING REASON GROUP (TABLE LOOKUP)
This field defines the payor-specific denial tracking reason group, which includes the payor-specific set of denial tracking reason codes that are used in cash posting to record the reason a payment is denied. The Denial Tracking Reason Group, which is defined in a separate table, is either an Electronic Remittance Advice type or a Non-Electronic Remittance type. An Electronic Remittance Advice type of Denial Tracking Reason Group uses the standard Electronic Remittance Advice "CAS Reason Codes" as the basis for the denial tracking reason codes used in insurance cash posting. A Non-Electronic Remittance Advice type of Denial Tracking Reason Group uses a payor-specific set of reason codes as the denial tracking reason code set.

4. REASON CODE (TABLE LOOKUP)
This field is the default denial tracking reason used for a denial if a denial tracking reason is not assigned for any reason. When the field is accessed, the following prompt is displayed:

Pick Default Reason Code from Reason Group XXXXXXX (9999)

5. ELECTRONIC RA CLAIM ADJ GROUP CODE (DISPLAY ONLY)

This field is the default denial tracking claim adjustment reason group used for a denial if a denial tracking claim adjustment reason group is not assigned for any reason. This field is accessible only if the Denial Tracking Reason Group for this Denial Tracking Payor is an Electronic Remittance Advice-type of Reason Group. The user can select the claim adjustment group from a table of valid values.

6. DOLLAR DEFINITION (TABLE LOOKUP)

This field contains the Insurance Follow-up Schedule Dollar Definition to be used for this payor. You can select the Insurance Follow-up Schedule Dollar Definition from a table of valid values.

7. APPEAL COLLECTOR GROUP (TABLE LOOKUP)

This field contains the collector group controlling the collector assignment of appeals and pre-appeals in STAR Receivables Workstation. You can select the Appeal Collector Group from a table of valid values.

8. AUTO-APPEAL MINIMUM (10-AN-R)

This field contains the minimum dollar amount that causes a denied insurance payment to be automatically appealed.   Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes, and are placed in an Appeal Worklist on STAR Receivables Workstation. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

9. PRE-APPEAL MINIMUM (10-AN-O)

This field contains the minimum dollar amount that causes a denied insurance payment to be automatically placed in a pre-appeal worklist on STAR Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the Pre-Appeal worklist to determine whether or not to appeal the denied insurance payment. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal-

UB Condition Codes (US Only)

The UB Condition Codes page allows the entry of UB information pertinent to this visit. This information is then available to print on the patient's admission form and/or to print on the patient's UB claim form.

Several codes can be automatically generated from the system. For more information, refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide. If a code is automatically generated from the Provider Master, the code is loaded to the UB claim form and does not need to be entered on this screen.

The UB Condition Codes page is displayed as follows. This screen is visit-specific, and none of the information is brought forward from a previous visit.

```
                    General Hospital UB Condition Codes Processor
                                            Fri Mar 10, 2006 12:36 pm
 Account      Name                 FC Typ Admit      Disch        Balance Loc
 A9316900001  SMITH,MARY            M  O/P 06/18/93                 0.00    PA/FCRV
  1 Condition Code 1      2 Condition Code 2      3 Condition Code 3
    2 EMPLOYMENT RELATED
  4 Condition Code 4      5 Condition Code 5      6 Condition Code 6

  7 Condition Code 7      8 Special Program       9 Treatment Authorization
                          3 SPECIAL FED FUNDING     76555




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

Field Explanations

1. CONDITION CODE 1 (TABLE LOOKUP)
This field contains the code that specifies the first UB condition code related to this visit, for example, 02 - Condition Employment Related. Both the code and the description are displayed.

2. CONDITION CODE 2 (TABLE LOOKUP)
This field contains the code that specifies the second UB condition code related to this visit. Both the code and the description are displayed.

3. CONDITION CODE 3 (TABLE LOOKUP)
This field contains the code that specifies the third UB condition code related to this visit. Both the code and the description are displayed.

4. CONDITION CODE 4 (TABLE LOOKUP)
This field contains the code that specifies the fourth UB condition code related to this visit. Both the code and the description are displayed.

5. CONDITION CODE 5 (TABLE LOOKUP)
This field contains the code that specifies the fifth UB condition code related to this visit. Both the code and the description are displayed.

6. CONDITION CODE 6 (TABLE LOOKUP)
This field contains the code that specifies the sixth UB condition code related to this visit. Both the code and the description are displayed.

7. CONDITION CODE 7 (TABLE LOOKUP)
This field contains the code that specifies the seventh UB condition code related to this visit. Both the code and the description are displayed.

If ENTER is pressed on any of the condition code fields, the cursor advances to the Special Program field.

8. SPECIAL PROGRAM (TABLE LOOKUP)
With the UB, special program codes should be entered as alphanumeric condition codes, for example, A3 - Special Federal Funding. Both the code and the description are displayed.

9. TREATMENT AUTHORIZATION (10-AN-O)
This field contains the treatment authorization number assigned as a result of the insurance verification process.

UB Value Codes (US Only)

The UB Value Codes page allows the entry of additional UB information pertinent to this visit. This information is then available to print on the patient's admission form and/ or to print in the patient's UB claim form.

Several codes can be automatically generated from the system. For more information, refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of the STAR Financials Patient Accounting Reference Guide. If a code is automatically generated from the Provider Master, the code is loaded to the UB claim form, and does not need to be entered on this screen.

The UB Value Codes page is displayed as follows. This screen is visit-specific, and none of the information is brought forward from a previous visit.

```
                    General Hospital UB Value Codes Processor
                                             Fri Mar 10, 2006 12:36 pm
Account        Name                  FC Typ Admit    Disch        Balance Loc
A9316900001  SMITH,MARY               M  O/P 06/18/93               0.00    PA/FCRV
 1 Value Code 1        2 Amount 1       3 Value Code 2        4 Amount 2
   14-AUTO NO FAULT OR    $450.00         43-DISABLED UNDER 65    $200.00
 5 Value Code 3        6 Amount 3       7 Value Code 4        8 Amount 4

 9 Value Code 5       10 Amount 5      11 Value Code 6       12 Amount 6

13 Value Code 7       14 Amount 7      15 Value Code 8       16 Amount 8

17 Value Code 9       18 Amount 9      19 Value Code 10      20 Amount 10

21 Value Code 11      22 Amount 11     23 Value Code 12      24 Amount 12




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

Field Explanations

1. VALUE CODE 1 (TABLE LOOKUP)
This field contains the code that specifies the first UB value code related to this visit, for example, 37 - Pints of Blood Furnished. Both the code and the description are displayed.

2. AMOUNT 1 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 1. This field is required if the preceding value code was entered.

3. VALUE CODE 2 (TABLE LOOKUP)
This field contains the code that specifies the second UB value code related to this visit. Both the code and the description are displayed.

4. AMOUNT 2 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 2. This field is required if the preceding value code was entered.

5. VALUE CODE 3 (TABLE LOOKUP)
This field contains the code that specifies the third UB value code related to this visit. Both the code and the description are displayed.

6. AMOUNT 3 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 3. This field is required if the preceding value code was entered.

7. VALUE CODE 4 (TABLE LOOKUP)
This field contains the code that specifies the fourth UB value code related to this visit. Both the code and the description are displayed.

8. AMOUNT 4 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 4. This field is required if the preceding value code was entered.

9. VALUE CODE 5 (TABLE LOOKUP)
This field contains the code that specifies the fifth UB value code related to this visit. Both the code and the description are displayed.

10. AMOUNT 5 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 5. This field is required if the preceding value code was entered.

11. VALUE CODE 6 (TABLE LOOKUP)
This field contains the code that specifies the sixth UB value code related to this visit. Both the code and the description are displayed.

12. AMOUNT 6 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 6. This field is required if the preceding value code was entered.

13. VALUE CODE 7 (TABLE LOOKUP)
This field contains the code that specifies the seventh UB value code related to this visit. Both the code and the description are displayed.

14. AMOUNT 7 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 7. This field is required if the preceding value code was entered.

15. VALUE CODE 8 (TABLE LOOKUP)
This field contains the code that specifies the eighth UB value code related to this visit. Both the code and the description are displayed.

16. AMOUNT 8 9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 8. This field is required if the preceding value code was entered.

17. VALUE CODE 9 (TABLE LOOKUP)
This field contains the code that specifies the ninth UB value code related to this visit. Both the code and the description are displayed.

18. AMOUNT 9 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 9. This field is required if the preceding value code was entered.

19. VALUE CODE 10 (TABLE LOOKUP)
This field contains the code that specifies the tenth UB value code related to this visit. Both the code and the description are displayed.

20. AMOUNT 10 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 10. This field is required if the preceding value code was entered.

21. VALUE CODE 11 (TABLE LOOKUP)
This field contains the code that specifies the eleventh UB value code related to this visit. Both the code and the description are displayed.

22. AMOUNT 11 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 11. This field is required if the preceding value code was entered.

23. VALUE CODE 12 (TABLE LOOKUP)
This field contains the code that specifies the twelfth UB value code related to this visit. Both the code and the description are displayed.

24. AMOUNT 12 (9-NC-C)
This field contains the amount (such as dollar, pints, days) of value code 12. This field
is required if the preceding value code was entered.

UB Occurrence Codes (US Only)

The UB Occurrence Codes page allows the entry of additional UB information pertinent
to this visit. This information is then available to print on the patient's admission form
and/or to print in the patient's UB claim form.

Several codes can be automatically generated from the system. For more information,
refer to the Provider Master section in the *Tables, Masters, and Parameters Volume* of
the STAR Financials Patient Accounting Reference Guide. If a code is automatically
generated from the Provider Master, the code is loaded to the UB claim form and does
not need to be entered on this screen.

The UB Occurrence Codes page is displayed as follows. This screen is visit- specific,
and none of the information is brought forward from a previous visit.

```
                General Hospital UB Occurrence Codes Processor
                                              Fri Mar 10, 2006 12:36 pm
Account      Name                   FC Typ Admit    Disch      Balance Loc
A9316900001  SMITH,MARY              M  O/P 06/18/93            0.00    PA/FCRV
 1 Occurrence Code 1       2 Date       3 Occurrence Code 2     4 Date
   4 ACCIDENT/EMPLOYMENT    06/18/93      27 HOME HEALTH PLAN     01/01/90
 5 Occurrence Code 3       6 Date       7 Occurrence Code 4     8 Date


 9 Occurrence Code 5      10 Date      11 Occurrence Code 6    12 Date


13 Occurrence Code 7      14 Date      15 Occurrence Code 8    16 Date


17 Occurrence Span A      18 From Date A   19 Through Date A
   72 FIRST/LAST VISIT       12/03/92         12/04/92
20 Occurrence Span B      21 From Date B   22 Through Date B






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

Field Explanations

1. OCCURRENCE CODE 1 (TABLE LOOKUP)
This field contains the code that specifies the first UB occurrence related to this visit,
for example, - 01 Auto Accident. Both the code and the description are displayed.

2. DATE (25-C-O)
This field contains the date related to the first occurrence code. There are several
formats you can use to enter the date. Refer to the Information Entry Techniques

section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

3. OCCURRENCE CODE 2 (TABLE LOOKUP)
Enter the code that specifies the second UB occurrence related to this visit. Both the code and the description are displayed.

4. DATE (25-C-O)
Enter the date related to the second occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

5. OCCURRENCE CODE 3 (TABLE LOOKUP)
This field contains the code that specifies the third UB occurrence related to this visit. Both the code and the description are displayed.

6. DATE (25-C-O)
This field contains the date related to the third occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

7. OCCURRENCE CODE 4 (TABLE LOOKUP)
This field contains the code that specifies the fourth UB occurrence related to this visit. Both the code and the description are displayed.

8. DATE (25-C-O)
This field contains the date related to the fourth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

9. OCCURRENCE CODE 5 TABLE LOOKUP)
This field contains the code that specifies the fifth UB occurrence related to this visit. Both the code and the description are displayed.

10. DATE (25-C-O)
This field contains the date related to the fifth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

11. OCCURRENCE CODE 6 (TABLE LOOKUP)
This field contains the code that specifies the sixth UB occurrence related to this visit. Both the code and the description are displayed.

12. DATE (25-C-O)
This field contains the date related to the sixth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

13. OCCURRENCE CODE 7 (TABLE LOOKUP)
This field contains the code that specifies the seventh UB occurrence related to this visit. Both the code and the description are displayed.

14. DATE (25-C-O)
This field contains the date related to the seventh occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

15. OCCURRENCE CODE 8 (TABLE LOOKUP)
This field contains the code that specifies the eighth UB occurrence related to this visit. Both the code and the description are displayed.

16. DATE (25-C-O)
This field contains the date related to the eighth occurrence code. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details.

If ENTER is pressed at any occurrence code field, the cursor advances to the Occurrence Span field.

17. OCCURRENCE SPAN A (TABLE LOOKUP)
This field contains the code that specifies the first UB occurrence span code related to this visit, for example, 71 - Prior Stay Dates. Both the code and the description are displayed.

18. FROM DATE A (10-C-C)
This field contains the date that the first occurrence span began. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details. This field is required if the Occurrence Span field is entered.

19. THROUGH DATE A (10-C-C)
This field contains the date that the first occurrence span ended. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details. This field is required if the Occurrence Span field is entered.

20. OCCURRENCE SPAN B (TABLE LOOKUP)

This field contains the code that specifies the second UB occurrence span code related to this visit. Both the code and the description are displayed.

21. FROM DATE B (10-C-C)

This field contains the date that the second occurrence span began. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details. This field is required if the Occurrence Span field is entered.

22. THROUGH DATE B (10-C-C)

This field contains the date that the second occurrence span ended. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *General Information* volume of the *STAR Patient Care System Reference Guide* for details. This field is required if the Occurrence Span field is entered.

Miscellaneous Page

Select the Miscellaneous Page option to view or edit miscellaneous patient data obtained from the STAR Patient Care admission process. This screen contains information such as previous visit data, arrival mode, patient's church and denomination, whether the patient had valuables upon arrival, etc.

After you select this option, the system displays the Miscellaneous Page screen.

```
             General Hospital Miscellaneous Page Processor
                                       Fri Mar 10, 2006 12:36 pm
Account        Name              FC Typ Admit    Disch      Balance Loc
A00-14700006 TATE,ANNIE          B  ADV 03/27/00 03/28/00    0.00   AR/FCRV
 1 Previous  2 Prev Visit Date 3 Prev Facility/Visit Info   4 Other Names
   Yes          03/05/00      ->                              Entries Defined
 5 Church                        6 Denomination            7 Clergy Notify
                                   BAP BAPTIST                 No
 8 Clergy Request        9 Req Date              10 Courtesy Discharge

11 Pref. Accom.         12 Val                   13 Valuables Disposition

14 Phone                15 Power of Attorney      17 Veteran
                                                     No
16 Publicity            18 Patient Class          19 Staff Alert
                           PHY PHYSICIAN
20 Alien Number         21 Referring Facility     22 Referral Reason

23 Transferred From               24 Comment



Enter previous facility/visit information--
                  next(/) or previous screen(/P) [/]
```

Field Explanations

1.   PREVIOUS (1-A-R)
If the patient has been admitted in the STAR Patient Care system before this visit, the system displays Yes in this field to indicate a previous visit. If the patient has not been entered in the system but has visited the hospital before, enter **Y**, which is displayed as Yes. If this is the patient's first visit, enter **N**, which is displayed as No. The default response is No.

2.   PREV VISIT DATE (14-C-O)
The system displays the patient's most recent admission date in this field. Or, you can enter the date of the patient's last visit. There are several formats you can use to enter the date. Refer to the Information Entry Techniques section in the *STAR Patient Care Reference Guide, General Information Volum*e for details.

3.   PREV FACILITY/VISIT INFO (25-C-O)
Enter information related to a previous facility or visit for the patient in this freeform field. This is typically used to enter information concerning previous hospital stays within the last 60 days, for example.

4.   OTHER NAMES (SPECIAL FORMAT-O)
When you access this field, the following prompt is displayed:

   Access the patient's other name information? (Y/N) [N]--

If you enter N or press ENTER, the screen process continues. If you enter Y, the Other Names screen is displayed:

```
             General Hospital Miscellaneous Page 1 Processor
                                      Thu Apr 27, 2000 02:08 pm
   No.          Name          Sex    BD    Room   Physician     SVC    Status
0010800001    TATE,ANNIE       F  04/23/60 144-02  COLEMAN,MICHA MED   LAA 4
Page:01                               Other Names
     Other Names                         Name Type      Date     Employee ID
( 1) O'NEAL,ANNIE                        M MAIDEN       04/27/00 #33524    A R
( 2) TATE,ANN                            P PREVIOUS     04/26/00 #33524    A R




                                                        




Enter `A` to add, or select choice--
```

You can view the patient's other names, add additional other names, or adjust the name type of existing other names.

For each other name, the system displays the name, name type, date the name was added, and the ID and initials of the employee who added it.

Enter **A** to add an additional name, or select a name to edit its name type.

If you select a name for which you want to edit the name type or if you enter A to add a name, the following subscreen is displayed:

```
                   General Hospital Miscellaneous Page 1 Processor
                                          Thu Apr 27, 2000 02:20 pm
   No.           Name            Sex   BD    Room    Physician     SVC   Status
 0010800001    TATE,ANNIE         F  04/23/60 144-02  COLEMAN,MICHA MED   LAA 4
  1 Name                                 2 Name Type
    O'NEAL,ANN                             M MAIDEN
  3 Edit Date              4 Edit by
    04/27/00 14:09            Ryan,Amy



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

Subscreen Field Explanations

1. NAME (37-C-R for adding or DISPLAY ONLY for editing)
If you are editing a name type, you cannot access this field. If you are adding a name, enter the name in the format of LAST,FIRST MIDDLE (special characters are allowed). The first name must follow the comma (,) with no spaces. All information entered after the first space is considered the middle name by the system.

2. NAME TYPE (TABLE LOOKUP-R)
Enter the code for the name type if you know it, or enter a hyphen (-) followed by ENTER to select from a table of name types.

3. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this other name was added.

4. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who added this other name.

Field Explanations for Miscellaneous Page 1 cont.

5. CHURCH (TABLE LOOKUP)
Enter the code that specifies the church where the patient is a member or parishioner. The system displays the code, the description of the church, and the associated denomination. To override the table, enter a hyphen (-) followed by a freeform entry up to 25 characters long. This allows you to enter a church that is not on the table. By identifying a patient as a member of a church, the patient's name appears on that church's census. If you override the table, the church name you enter does not appear on a church census.

6. DENOMINATION (TABLE LOOKUP)
If a church is selected from the table, the denomination associated with the patient's church is displayed. If the patient is not a member of a specific church but does belong to a particular denomination, you can enter the code signifying that denomination in this field.

This is a table-driven field. Enter the code that specifies the denomination of the patient. The system displays the code and description. To override the table, enter a hyphen (-) then type in a freeform entry (up to 13 characters).

When you identify a patient's denomination, the patient's name appears on that denomination's census. If you override the table, the denomination name you enter does not appear on a denomination census.

7. CLERGY NOTIFY (1-A-R)
Enter **Y** for Yes if the clergy should be notified of the patient's hospital stay. Enter **N** for No if the clergy should not be notified. The default is Y.

NOTE: If you enter Y, the patient is included on the Church and Denomination Censuses. If you enter N, the patient is not included on these censuses.

8. CLERGY REQUEST (TABLE LOOKUP-O)
Select the patient's request from a table of clergy requests, such as Communion or Last Rites.

9. REQ DATE (10-C-O)
Enter the date the patient would like the clergy to visit. This field is optional.

10. COURTESY DIS (1-A-R)
Enter **Y** for Yes to indicate that the patient is a courtesy discharge. Enter **N** for No to indicate that the patient should see the cashier when discharged.

11. PREF. ACCOM. (TABLE LOOKUP)
Enter the code for the patient's bed preference for admission (for example, private or semi-private), or enter a hyphen (-) to display the table for selection. To override the table, enter a hyphen (-) then type in a freeform entry (up to 6 characters).

12. VAL (1-A-R)
Enter **Y** for Yes or **N** for No to indicate whether or not the patient was admitted with valuables. If you enter **N**, the cursor skips past the Valuables Disposition field.

13. VALUABLES DISPOSITION (25-C-O)
This is a freeform entry field. Enter the location of the valuables received from the patient, for example, "Receipt # 132" or "Valuables in Safe."

14. PHONE (1-A-O)
Enter **Y** for Yes or **N** for No to indicate whether or not the patient has requested a telephone. The default response is Yes.

15. POWER OF ATTORNEY (1-A-O)
Enter **Y** for Yes or **N** for No to indicate whether or not the patient has a signed power of attorney on file.

16. PUBLICITY (TABLE LOOKUP)
This is a hospital-controlled table-driven field. Enter the code corresponding to the type of publicity or visitation allowed (or disallowed) for this patient. The indicator is displayed on the Name Inquiry function next to the patient's name, as well as throughout the system and its reports. Examples include the following codes and descriptions:

Code	Description
@	No Phone Calls Accepted
*	No Publicity
#	Family Visitation Only

17. VETERAN (1-A-O)
Enter **Y** for Yes or **N** for No to indicate whether or not the patient is a veteran.

18. PATIENT CLASS (TABLE LOOKUP)
Enter the code corresponding to the patient's class (for example, BRD Board Member). The system displays the code and description. To display the table for selection, enter a hyphen (-).

19. STAFF ALERT (TABLE LOOKUP)
Enter the code corresponding to the staff alert(s) that the hospital staff should be aware of during the patient's stay. To display the table for selection, enter a hyphen (-).

20. ALIEN NUMBER (9-N-0)
If the patient is not a citizen of the country where your facility resides, enter the patient's legal alien number in this field.

21. REFERRING FACILITY (TABLE LOOKUP)
Enter the code describing the specific facility that referred the patient to your facility for admission. The code and the description display.

22. REFERRAL REASON (TABLE LOOKUP)
Enter the code indicating the reason the patient was referred to the hospital for admission. The code and description are displayed in the field. To display the table for selection, enter a hyphen (-).

23. TRANSFERRED FROM (TABLE LOOKUP)
Enter the code for the institution or place where the patient resided before admission. The system displays the code and description. To display the table for selection, enter a hyphen (-).

24. COMMENT (37-C-O)
Use this freeform field to enter any additional information or comments pertaining to the patient or this admission.

NOTE: If the patient is a newborn, this field contains the mother's unit number and truncated name, prefixed with "MOM." This facilitates a visible link between the baby and mother.

Miscellaneous Two Page

Select the Miscellaneous Two Page option to view or edit miscellaneous patient data obtained from the STAR Patient Care admission process. This screen contains information such as case team, case team manager, affiliated community agency, substance taken, etc.

After you select this option, the system displays the Miscellaneous Two Page screen.

```
             General Hospital Miscellaneous Two Page Processor
                                             Fri Mar 10, 2006 12:36 pm
Account       Name                  FC Typ Admit    Disch      Balance Loc
A0210000011  ADAMS,RHEA             S2 O/P 04/10/02 04/10/02    100.00  AR/FCRV
 1 Case Team                    2 Case Team Manager   3 Community Agency

 4 Day Care Function            5 Substance Taken     6 Education Level

 7 Privileges        8 First Day/Night Admit  9 Medical Record#  10 Radiology #

11 Charge To/From                      12 Mom/Baby Comb  13 No of Charge Froms


    Please enter if required by patient's Insurance
14 Pregnant?    15 LMP          16 Cycle     17 Estimated Delivery Date

Press NL--
```

Field Explanations

1. CASE TEAM (TABLE LOOKUP)
When you access this field, you have two choices:

• Enter the code for the patient's case team, if you know it.

• Enter a hyphen (**-**) to display the table for selection.

2. CASE TEAM MANAGER (DISPLAY ONLY)
If you make an entry in the Case Team field, the system displays that case team's manager in this field (if one is set up with the case team in the Case Team table).

3. COMMUNITY AGENCY (TABLE LOOKUP)
When you access this field, the system displays the following prompt:

Enter Delete (D) or Add (A) a community agency.

Enter **A** to indicate to begin the process of selecting a community agency or agencies involved in the patient's case. The system displays this prompt:

Enter community agency code--

You have two choices.

- Enter the code of the community agency if you know it. The system displays the code with its description on a subscreen, and redisplays the following prompt:

    Enter Delete (D) or Add (A) a community agency.

    Do one of the following:

    - Press ENTER if you want to select only the one agency. "Entries Defined" is now displayed in the field.

    - Enter **A** to continue adding codes. The system displays the Community Agency table to select from. The option number of the code already entered is highlighted. As you enter option numbers, they become highlighted as well. Press ENTER twice when you are finished making your selections. "Entries Defined" is now displayed in the field.

    - Enter **D** to delete your selection. The system prompts you to enter the option number of the community agency code, asks you to confirm the deletion, and then redisplays the original prompt to Delete or Add a community agency.

- Enter a hyphen (**-**). The Community Agency table is displayed at the bottom of the screen for selection.As you enter the option numbers to the left of the codes and descriptions, these numbers are highlighted.When you are done selecting, press ENTER. The system displays a new subscreen listing your selections. You now have three choices:

    - Press ENTER. The subscreen is removed, and "Entries Defined" is now displayed in the field.

    - Enter **A** to return to the table to make more selections.

    - Enter **D** to delete one or more of the selected agencies.

4. DAY CARE FUNCTION (TABLE LOOKUP)
When you access this field, the system displays the following prompt:

Enter day care function code--

You have two choices:

- Enter the code for the patient's special day care program, if you know it.

- Enter a hyphen (**-**) to display the table for selection.

The code and description are displayed in the field.

5. SUBSTANCE TAKEN (TABLE LOOKUP)

This field is used to indicate if a patient is using or abusing some kind of substance. When you access this field, the system displays the following prompt:

Enter Substances Taken? (Y/N) [N]--

Enter **Y** for Yes to begin the process of selecting substances. If you do not want to enter any substances, enter **N** or for No.

If you enter **Y**, the system displays a subscreen with a table, with this prompt at the bottom of the subscreen:

Enter substances taken code or '-' to list--

You have two choices:

- Enter the code of the substance if you know it.

- Enter a hyphen (**-**) to display the Substances Taken table for selection.

As you enter each substance, the system lists it on the subscreen, with its code and description and its classification, and then prompts you to indicate with a **Y** (for Yes) or **N** (for No) response whether the patient injected the substance. The following screen is an example:

```
                      General Hospital Admission Processor
                 Miscellaneous Page 2                Wed Mar 06, 1996 09:45 am
  No.         Name            Sex   BD     Room    Physician    SVC    Status
 9404-500-001 TURNER,JOY M     F  01/25/76 NSY-14 BABB,GARY H   ERS    I/P 2
 NO.    SUBSTANCES TAKEN              CLASSIFICATION      INJECTED?    INIT
  1    1 BEER                        2 ALCOHOL              No         N C
  2    2 HEROIN                      1 ILLICIT DRUGS        Yes        N C
  3




                  Enter substance taken code or '-' to list--
      F1Prev Page F2Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

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Use the function keys at the bottom of the screen to delete a substance from the table (F4), to clear out the table to start over (F6), and to exit when you are done making your selections (F7).

6. EDUCATION LEVEL (TABLE LOOKUP)

To enter the level of education for the patient, do one of the following:

- Enter the code indicating the education level, if you know it.

- Enter a hyphen (**-**) to display the Education Level table for selection.

When you have made your selection, the code and description are displayed in the field.

7. PRIVILEGES (TABLE LOOKUP)

This field is used to indicate what types of privileges the patient may have during the visit. When you access this field, the system displays the following prompt:

Enter Delete (D) or Add (A) Privileges.

The steps for selecting and deleting the patient's privileges are the same as those for community agencies. For a review of these steps, refer back to the discussion on the Community Agency field.

8. FIRST DAY/NIGHT ADMIT (1-A-O)

When you access this field, you see this prompt:

Is this the first regular day/night admission? (Y/N) [N]--

Enter **Y** for Yes or **N** for No to indicate whether or not this is the patient's first regular day/night admission.

9. MEDICAL RECORD # (10-N-O)

Enter the patient's medical record number. This field is provided for hospitals that converted from a previous medical record numbering system to the STAR Patient Care System's unit number process. This field is only used as a reference to the previous number.

10. RADIOLOGY NUMBER (10-N-O)

Enter the patient's radiology film number. This is the unique patient number defined by the Radiology department. This field is only used if the film number is different from the unit number.

11. CHARGE TO/FROM (DISPLAY ONLY)

This field is usually blank during the admission process. However, if the Charge-To/From function is used after admission, this field identifies the link between the two accounts. The corresponding account number and name are displayed.

If you select to view the Miscellaneous Page of the charge to account, this field is labeled Charge From Number and displays the account number and name of the Charge From account. When a combined bill is generated, the charges for the charge from account are billed on the Charge To account.

If you select to view the Miscellaneous Page of the charge from account, this field is labeled Charge To Number and displays the account number and name of the charge to account. When a combined bill is generated, the charge to account bill contains the charges for the charge from account.

This is a billing function and does not impact the way that charges are displayed or maintained on STAR Patient Care.

12. MOM/BABY COMB (DISPLAY ONLY)
This field, usually blank during the admission process, identifies whether this account has been combined in order to place all charges for a mother and baby on the same bill. A display of Y indicates that charges for these accounts are being combined on a mother/baby bill. Your facility's print bill program should mark the charges appropriately. If this account is not being combined to place charges for a mother and baby on to the same bill, the field displays N.

13. NO. OF CHARGE FROMS (DISPLAY ONLY)
This field displays the number of accounts from which charges have been transferred.

14. PREGNANT? (1-A-O)
This field indicates whether the patient is pregnant (Yes), not pregnant (No) or if it is unknown (Unknown). When this field is accessed, the following prompt displays:

   Is the patient pregnant? (Y/N/U) [N]

Enter **Y** for Yes, the patient is pregnant, **N** for No, the patient is not pregnant, or **U** for Unknown. The default is **No**.

15. LMP (DATE FORMAT)
Enter the date of the patient's last menstrual period (LMP). When this field is accessed, the following prompt displays:

   Enter date of last menstrual period

If you answered **Yes** to field 12 (Pregnant?), enter the date of the patient's last menstrual period. This data is used with the Cycle field to calculate the entry in the Estimated Delivery Date field.

16. CYCLE (2-N-O)
Enter the number of days in the patient's typical menstrual cycle. When this field is accessed, the following prompt displays:

   Enter # of days in last menstrual cycle [28]

The default response is 28. This field is used with the LMP field to calculate the entry in the EDD (Estimated Delivery Date) field.

15. ESTIMATED DELIVERY DATE (DATE FORMAT OR CALCULATED)
Enter a date in this field if the LMP and Cycle fields are not completed. When you access this field, the system displays the following prompt:

Estimated delivery date [MM/DD/YY]--

where MM/DD/YY is the default date the system calculated by using this formula:

LMP + 7 + 280 Days + (Cycle -28)=Estimated Delivery Date

User-Defined Fields

The User-Defined Fields Page contains up to 40 fields. Up to 20 of the fields are retained in the MPI and are brought forward with each subsequent visit. The remaining 20 fields are visit-specific. The MPI level fields are displayed first, followed by the Visit level fields. Each field can be defined by your hospital as yes/no, freeform, table-driven, or date format.

Based on parameters set by your facility in Table Maintenance (see the Tables appendix in the *STAR Patient Care Reference Guide, Patient Processing Module* for details), you are able to define the fields that display on this screen in the admission sequence including the label, question, code and description length, and whether or not the field is required. You maintain tables for the table-driven fields in the regular Table Maintenance function.

If your entries in Table Maintenance are accepted, the screen you set up is displayed in the admission sequence on the User Defined Fields Page. The field labels on this screen are a result of the entries made on the Table processor. The same screen that is displayed in the admission sequence also is displayed in the abstracting function. These fields can be edited via the abstracting functions.

The following screen is an example of a User Defined Fields page that was set up during the admission sequence.

```
          General Hospital User Defined Fields Processor
                                              Tue Apr 06, 1999 05:20 pm
   No           Name            Sex  BD     Room   Physician      SVC    Status
 1-0001498     BARCLAY,BARBARA L F  06/06/57 M226-01 REED,WILLIAM   ALC    I/P 29


User Defined Field Label         Response

BLOOD TYPE
MOTHER'S BLOOD TYPE
FATHER'S BLOOD TYPE
HIGH BLOOD PRESSURE
NUMBER OF CHILDREN               ONE
NUMBER OF SIBLINGS               TWO
CANCER IN FAMILY?                YES
WHO?                             SISTER
DATE DIAGNOSED                   06/06/97
VISION PROBLEMS?
LAST CHEST XRAY                  01/01/99
LAST PHYSICAL                    01/02/99
ADDITIONAL INFORMAT              DOES NOT DRIVE
FAVORITE FRUIT                   MANGO
COUNTRIES VISITED
AMBULANCE SERVICE
Enter the patient's blood type, or - lookup--
           F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

This is a scrolling screen. For information on using scrolling screens refer to the Information Entry Techniques section of the *STAR Patient Care Reference Guide, General Information Volume*.

FINANCIAL INFORMATION

These functions enable you to edit an account's financial information.

After this option is selected, the system displays these options with basic information about the account selected.

```
          General Hospital Financial Information Processor
                                        Thu Jun 04, 2009 09:45 pm
Account      Name                FC Typ Admit    Disch       Balance Loc
J1-0005808   NEW, NANCY          OP I/P 09/02/04 09/02/04     766.50 AR /ACCF
             Option No.  Option
             ---------------------------------------
                 1       Account Status
                 2       Account Follow-up
                 3       Insurance Follow-up
                 4       Account Notes
                 5       Balance Transfer & Claim Disposition
                 6       Add Claim to Insurance
                 7       Maintain Claim Information
                 8       Out of Province Patient Information




 Enter option number--
```

Each of the options shown on this screen is described below.

Account Status

This function enables you to review and edit system-assigned values for an account. It deals primarily with billing options and also enables you to suspend the archiving activity and change an account's financial class without reclassifying revenue.

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

```
                    General Hospital Account Status Processor
                                             Wed Mar 29, 2006 12:36 pm
 Account        Name                    FC Typ Admit    Disch     Balance   Loc
 A9807200003  DAVIS,LATHAM              S  I/P 03/13/98           152861.62 PA/FCRV
  1 Final Bill Parameter               2 Cycle Bill Parameter        3 CycA
    927-Patrice Final Bill Outpatient    929-Patrice Outpatient cycle    Yes
  4 Biller                            5 Provider
    3-BILLERTHREE,BILLER                 1-MODEL HOSPITAL A
  6 Billing Status            7 Status Date       8 On Hold By
    CycA Bill Requested         01/30/06
  9 CPTAFB DT                 10 Pre-bill Edit Status     11 PBE Status Date
                                Bypassed/Suspense Days      01/20/06
 12 Financial Class          13 Pat Class        14 Pat Class Suppress F/Up
    O-OTHER COMMERCIAL
 15 Archive Status        16 Archive Date        17 Sub location
                                                    AR/FCRV




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

Field Explanations

1. FINAL BILL PARAMETER (3-N-O)
This field contains the final billing parameter assigned by either the primary insurance
plan (if this account has insurance) or the financial class (if this account is self-pay).
The system assigns this parameter to an account during admitting but you can modify
this parameter if necessary. Enter the code or a hyphen (-) to display a list of valid
codes. A change of patient type or primary insurance re-assigns this parameter if the
account is in location PA.

2. CYCLE BILL PARAMETER (3-N-O)
This field contains the cycle billing parameter assigned by either the primary insurance
plan (if this account has insurance) or the financial class (if this account is self-pay).
The system assigns this parameter to an account during admitting, but you can change
this parameter if necessary. Enter the code or a hyphen to display a list of valid codes.
A change of patient type or primary insurance will re-assign this parameter if the
account is in location PA.

3. CYCA (1-A-O)
This field indicates whether cycle adjustment billing is allowed for the account. This
field can be updated only after the first cycle bill is produced for the account. When this
field is accessed, the following prompt is displayed:

Allow cycle adjustment bills to be created for this account? (Y/N) [N]--

You can enter **Y** (Yes) to allow cycle adjustment processing or **N** (No) to disallow it. If
cycle adjustment processing is valid for the account, this cycle adjustment bill indicator
displays the value of *Yes;* if cycle adjustment processing is not valid, the indicator

displays the value of *No.* The CycA field is set at the time of the first cycle bill and subsequent bills must comply with the setting of the indicator. The cycle adjustment bill indicator is set depending on the parameter setting of the Cycle Adj Bill Ind on the cycle billing parameters or the Patient Bill Format processor. Once the indicator is set for an account, it can be updated to *No*, and it can also be set to *Yes* if the Cycle Adj Bill Ind on the cycle billing parameters or the Patient Bill Format processor is set to *Yes.*

If the Cycle Adj Bill Ind field is updated, a transaction history generates with the message: *CycA Indicator Revision.* The associated transaction comment displays the value that was associated with the account and the value it was changed to. For example, CycA changed from Yes to No.

4.   BILLER (TABLE LOOKUP)
This field contains the biller responsible for sending and reviewing the patient bill and the primary insurance claim for this account. The system assigns a biller to the account during admission. The assignment is based on the Biller Group indicated on the primary insurance plan for this account.

If this account does not have insurance, the Biller Group (and thus the biller) is assigned according to the account's financial class. Changing the biller here directs all future billing activity to this new biller. However, if billing activity is already in the biller workfile, you must transfer this work from the initial biller workfile to the new biller using the Transfer Biller Work transaction. If the primary insurance or patient type is changed while the account is in location PA, the biller will be re-assigned. For more information on this transaction, refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

When changing the biller on the Account Status screen, any claims that were already assigned to this biller for the account are updated to use the new biller. Claims that did not have the biller on the Account Status screen are not updated to the new biller. Only existing claims may be updated. Claims that load after the biller was changed on this screen continue to look to the Biller Group assigned to the insurance to determine the biller on the claim.

5.   PROVIDER (TABLE LOOKUP)
This field contains the Provider Master associated with this account. The appropriate master is linked to the Patient Type table or the COB1 plan. If there are unique provider numbers not associated with a particular patient type but related to a particular carrier/plan, you can add this master to the plan and the plan assignment on the COB1 plan overrides the patient type assignment.

The system assigns this provider master to the account at admission or registration based on patient type. The providers numbers for Medicare, Medicaid, and Blue Cross are defined within the master. While the account is in PA, the provider number changes automatically if the patient type changes or the primary insurance changes (if the provider number is related to an insurance carrier.)

6. BILLING STATUS (1-A-O)

This field indicates whether the system should hold automatic cycle, final, late, adjustment cycle, and adjustment bills for this account. You can place the account on billing hold, DRG Payment Window (DPW) billing hold, or CPTAFB hold.

AR accounts that have a Bill Hold type of O assigned will hold cycle adjustment bills, adjustment bills, and late bills. You cannot place an account on a bill hold type of O. The system places charges automatically on bill hold type of O if there is one charge on the AR account that exceeded the Chg Bill Window value when the charge was received in STAR Patient Accounting. You can remove bill hold type of O from the account, however.

If you set this status flag to hold bills, you must manually change this status before the system can issue bills for this account.

- If the account is not on billing hold, the following prompt is displayed:

  Place account on billing (H)old, (D)PW billing hold, CPTAF(B) billing hold,
  or (N)o Hold [H]-- - |

  To place the account on hold, press ENTER or enter **H**.

- If the account is already on billing hold, the system displays the following prompt:

  Remove account from billing hold (Y/N)?

  Enter **Y** (Yes) to remove the account from hold.

- To place the account on DPW billing hold, enter **D**. If the account is already on DPW billing hold, the system displays the following prompt:

  Remove account from DPW billing hold (Y/N)?

  To remove the account from DPW billing hold, enter **Y**. To remove an account from billing hold, enter **N** for no hold.

- To place an account on CPTAFB hold, enter **B** for CPTAFB billing hold. If an account is currently in the CPTAFB Worklist and you remove the CPTAFB bill hold type, you can assign a bill hold type of O (Old Charge), if the account is in the Unbilled Charge Worklist and qualifies for the hold type of O.

- To remove the billing hold type of O from the account, press ENTER. If an account is already on Bill Hold for a reason type other than O (Old Charge), the system does not override that hold type. A transaction history message is generated to reflect that the hold type of O qualified, but was not assigned.

7.   STATUS DATE (DISPLAY ONLY)
This field contains the date on which the billing status was changed to hold billing. This field is system-maintained.

8.   ON HOLD BY (DISPLAY ONLY)
This field contains the name of the person who placed the account on hold (see the Billing Status field). This field is system-maintained.

9.   CPTAFB DT (DISPLAY ONLY)
This field contains the last date the patient type was changed after final billing. If there has not been a change in the patient type after final billing, the field is blank.

10. PRE-BILL EDIT STATUS (DISPLAY ONLY)
This field contains the pre-bill edit status of the account, if the account qualifies for pre-bill edits. Pre-bill statuses are:

This field contains the pre-bill edit status, if the account qualifies for pre-bill edits. Pre-bill statuses are:

1 = Pre-bill account (Selected for Pre-bill)—This status indicates that the pre-bill edit process was initiated in STAR Patient Accounting for the account, the primary insurance carrier changed, or the patient type changed.

2 = Flagged for Pre-bill batch process (In progress)—This status indicates the creation of a pre-bill is pending. This could occur when the account is initiated into the pre-bill process or a trigger event occurs.

3 = Manually queued for pre-bill (Manually queued)—This status indicates that a pre-bill was requested by the GUI worklist (Pre-bill Edit Worklist).

4 = Processed - no edits (Processed/no edits)—This status indicates the current pre-bill processed without edits. This does not indicate that the account is ready to final bill because the Medical Records edits might not have been employed yet or the account does not qualify for a final bill as yet. A trigger event can cause the process to be repeated.

5 = Processed - with edits (Processed/edits)—This status indicates that the current pre-bill account processed with edits.

6 = Queued for another pre-bill (Edits existed or re-queued for pre-bill)—This status indicates that all edits were removed from the worklist by the user, another pre-bill request was triggered automatically, and the pre-bill edit status is changed to 6.

7 = Pre-bill edit process completed (Complete)—This status indicates that the latest pre-bill was created with no edits and Medical Records edits have been performed if appropriate. The account is marked with this status when the pre-bill batch process occurs. These types of accounts are ready to final bill and should not have any bill/ claim edits on the actual bill.

8 = Pre-bill edits bypassed - suspense day (Bypassed/suspense days)—This status indicates that billing suspense days for the account have expired. The pre-bill edit status is changed to 8 when the request for the final bill is created.

9 = Pre-bill edits bypassed - manual bill request (Bypassed/single bill request—This status indicates that a single bill request was made on an account that cannot have pre-bill edits (Perform Edits field is set to No), and the pre-bill edit process for the account is incomplete.

11. PBE STATUS DATE (DISPLAY ONLY)
This field contains the date the account's pre-bill status was changed.

12. FINANCIAL CLASS (2-N-O)
This field contains the code and description for the financial class of the account. The financial class can be modified only when the account is in location AR or BD. This financial class change does not initiate re-classification of stats and revenue. No parameters are re-assigned based on this change. Changing the financial class causes a memo transaction to be updated in the patient's transaction history, and the financial class entered in this field becomes the patient's new financial class. Enter the code or a hyphen (-) to display a list of valid codes.

13. PAT 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

14. PAT CLASS SUPPRESS F/UP (1-A-O)
This field contains the Patient Classification Follow-up Suppression indicator. Valid display values are Suppress, Clear, and Alert Only. If the field displays Alert Only, the field cannot be edited. Alert Only indicates that when the classification was determined for the account, the Financial Patient Classification Table defined this Patient Class to be an alert only status and to continue to produce follow-up. This status cannot be changed.

If the field displays either Suppress or Clear, the following prompt is displayed:

Suppress follow-up to the guarantor (Y/N)? - - |

There is not a default value for this field. Yes indicates that follow-up directed to the guarantor of the account is suppressed, and the field displays Suppress. No indicates that follow-up is not suppressed, and the field displays Clear. This field may be changed from Suppress to Clear so that follow-up is not suppressed even though the Financial Patient Classification is defined to suppress follow-up to the guarantor of the account. This field may also be changed from Clear to Suppress to resume the suppression of follow-up as allowed by the Financial Patient Classification Table.

This field is updated for all of a patient's accounts in all facilities if the patient classification changes for the patient via an update in Patient Processing. A change to the guarantor classification also changes the patient classification for accounts where the guarantor is the patient. A status of Clear is maintained if it is compatible with the new Patient Classification that is assigned.

Transaction history for the account is updated when Patient Class Suppress F/U indicator is changed from Suppress to Clear or from Clear to Suppress.

If the field is changed from Suppress to Clear, you are given the ability to view the last follow-up information for the account or guarantor and to change the next follow-up date and sequence. The follow-up information is displayed on the lower portion of the Account Status screen, as shown below.

```
                 General Hospital Account Status Processor
                                        Fri Mar 10, 2006 12:36 pm
 Account       Name              FC Typ Admit    Disch      Balance Loc
 A99-05500001 MOORE,RFC          C  IPC 02/24/99 03/18/99    6328.66 AR/FCRV
  1 Final Bill Parameter               2 Cycle Bill Parameter
    11-CHAMPUS I/P FINAL                 7-COMMERCIAL INSURANCE, CYCLE
  3 Biller                            4 Provider
    44-MOTHERSHED,JENNIE;M              1-MODEL HOSPITAL A
  5 Billing Status          6 Status Date      7 On Hold By

  8 Financial Class         9 Pat Class       10 Pat Class Suppress F/Up
    C-CHAMPUS                  **PMC**            Clear
  * * * * * * * * * * * *   Last Follow Up Information  * * * * * * * * * *
  1 Last Follow-up          2 Last Seq #         3 Last F/U Type

  4 Last Message


    * * * * * * * * *   Change Next F/U Information   * * * * * * * * * *
  5 Next F/U Date                      6 Next Sequence
    04/03/99                             1

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

Subscreen Field Explanations

1. LAST FOLLOW-UP (DISPLAY ONLY)
This field contains the date of the last follow-up event.

2. LAST SEQ # (DISPLAY ONLY)
This field contains the number of the last follow-up event from the follow-up schedule.

3. LAST F/U TYPE (DISPLAY ONLY)
This field contains the last follow-up type (telephone, letter, detail statement).

4. LAST MESSAGE (DISPLAY ONLY)
This field contains the last message for this account. This message is tied to the last follow-up type.

5. NEXT F/U DATE (6-N-R)
This required field contains the date the next follow-up event is selected for the guarantor or account. The next follow-up date, which is maintained by the system while the follow-up is suppressed due to the patient classification, is displayed. The next follow-up date may be modified to re-schedule the next follow-up event if necessary. The next follow-up date is blank and cannot be updated if the account or the guarantor is on hold for follow-up or if the account has a zero balance and is no longer in follow-up. The following messages are displayed if the next follow-up date cannot be updated:

ACCOUNT on follow-up hold.

GUARANTOR on follow-up hold.

Account not in follow-up due to zero balance.

6. NEXT SEQUENCE (2-N-R)
This required field contains the sequence number of the next follow-up event that you want to assign to this account.

When these fields are completed, you have the option of accepting or editing the information entered. Accepting the screen returns you to the Account Status screen.

Account Status Fields (Continued)

15. ARCHIVE STATUS (1-A-R)
This field indicates whether the system should suspend transferring this account to the history file (archive). This field applies to BD and AR type accounts. If you want to retain an account in the system even if it meets the archive criteria, you can place the account on archive hold. If the account is not on archive hold, the following prompt is displayed:

Suspend this account from archiving? (Y/N)--

Enter **Y** to place the account on archive hold.

If the account is already on archive hold, the following prompt is displayed:

Allow this account to archive (Y/N)

Enter **Y** to remove the account from archive hold.

16. ARCHIVE DATE (DISPLAY ONLY)
This field contains the date on which the archive status was changed to suspend transfers. This field is updated by the system automatically.

17. SUB LOCATION (4-C-O)
This field contains the account location and sub location for the patient. When you access this field, the following prompt is displayed:

Enter new sub location code, "-" look up, or NL to blank out code [NL] --

You cannot edit the account location from this field. However, the account location of a patient determines which sub locations can be entered.

Enter the account sub location. Valid entries for sub location are blank, INSR, FCRV, ND, DNFB, ACCF, PCA#, RFDB, BDP, BDI or BDE. You can also enter a hyphen (-) to display a list of sub locations from which you can select. Press ENTER to blank out the code.

NOTE: If you press ENTER in this field, the sub location is removed. To exit without changing the entry in the field, enter a period (.) and then press ENTER.

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.*

AR Account Follow-Up

Follow-up for an account that is in location AR takes place based on the follow-up schedule assigned to the guarantor. This function enables you to place a specific account on a custom follow-up schedule, payment plan, separate schedule, or guarantor schedule. If you want to place the guarantor on a custom schedule, use Guarantor Functions. This function is used only if the particular patient account should be handled differently from the rest of the accounts the guarantor owes.

After you select this option, the system displays the following screen.

```
               General Hospital Account Follow-up Processor
                                             Fri Mar 10, 2006 12:36 pm
Account        Name                 FC Typ Admit    Disch       Balance Loc
A0204200001  MILLER, TOM            B  PAT 02/11/02 03/26/02    764.89  AR/FCRV
 1 Collector                               2 Hold F/U?   3 Schedule Type
                                                           Payment Plan
 4 Schedule #     5 Last Follow-up     6 Last Seq #   7 Last Type
   50
 8 Last Message                       9 Last Follow-up Amount
                                         $764.89
10 BD Pre-List                        11 BD Pre-List Date

12 Delinquency Date 13 Delinquent Amt  14 Prepaid Amt   15 Current Due Amt
   04/18/02            $0.00              $0.00             $30.00
16 Next F/U Date      17 Next Sequence
   04/25/02             2
18 Healthcare Score/Desc - Date
   300-Possible Charity, Provide Application 6/13/03




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

Field Explanations

1. COLLECTOR (DISPLAY ONLY)
This field contains the name and number of the collector assigned to collect the liability
for this account. Since there are different follow-up schedule types (for example,
custom guarantor, custom account, guarantor payment plan, account payment plan,
account separate, and guarantor standard), there is the possibility that multiple
collectors might be assigned to different accounts for the same guarantor.

2. HOLD F/U? (DISPLAY ONLY) or (1-A-O)
This field enables you to suspend the follow-up schedule for this account. Entry options
are Y for Yes, hold follow-up activities, or N for No, do not hold follow-up. The system
defaults to No. This field can be accessed if the account is assigned to any schedule
but a guarantor schedule.

3. SCHEDULE TYPE (1-A-R)
This field identifies the type of schedule on which the account is placed for follow-up
purposes. Entry options are **G** (guarantor), **C** (custom plan), **P** (payment plan), or **S**
(separate schedule); the default is G.

NOTE: If you chose P (Payment Plan), a Follow-up Processor screen is displayed
which gives you the opportunity to set up the payment plan for the account.
For more information on this screen, see "Setting Up a Payment Plan" on
page 2-156.

4.   SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the guarantor and all other accounts for which the guarantor is responsible. You can edit this field if the guarantor has accounts in AR and you have a security level greater than 30.

5.   LAST FOLLOW-UP (DISPLAY ONLY)
This field contains the date on which the last follow-up activity was performed.

6.   LAST SEQ # (DISPLAY ONLY)
This field contains the sequence number of the last activity performed according the follow-up schedule.

7.   LAST TYPE (DISPLAY ONLY)
This field contains the last type of activity performed according to the follow-up schedule. Valid types include L - letter, T - telephone call, and D - detail statement.

8.   LAST MESSAGE (DISPLAY ONLY)
This field contains the message number associated with the last follow-up event.

9.   LAST FOLLOW-UP BALANCE (DISPLAY ONLY)
This field contains the balance that was billed to or requested from the guarantor in the last follow-up event.

10. BD PRE-LIST (DISPLAY ONLY)
This field indicates whether the account has been pre-listed for transfer to bad debt.

11. BD PRE-LIST DATE (DISPLAY ONLY)
This field contains the date the account was pre-listed for transfer to bad debt status.

NOTE: The next three fields contain information only if the account is on a payment plan.

12. DELINQUENCY DATE (6-N-O)
This field, which applies to payment plan accounts, contains the date on which the account is considered delinquent. The system calculates this field based on the due days and grace days in the follow-up schedule to which this account is assigned. You can, however, override it.

13. DELINQUENT AMOUNT (8-N-O)
This field contains the payment plan amount that is past due. The entry range is 0 to $999,999.99 (you must enter the decimal point).

14. PREPAID AMOUNT (DISPLAY)
This field contains the prepayment amount. This field displays an amount only if the Prepaid Amount field on the PAAR Control Table is set to Yes. If the account is on a payment plan and has amounts which are prepaid (prior to billing for the periodic plan amount), an amount is displayed in this field.

15. CURRENT DUE AMOUNT (8-N-O)

This field contains the payment plan amount that is currently due. The entry range is 0 to $999,999.99 (you must enter the decimal point).

16. NEXT F/U DATE (6-N-C)

This field contains the next follow-up date. You can enter a follow-up date only if the Hold F/U? field is blank or contains N. This field enables you to modify the next follow-up date for an account that is on a custom schedule. For example, if there is a reason to send a follow-up event sooner than the schedule indicates or to suspend sending follow-up for a period of time, the follow-up schedule date can be modified.

17. NEXT SEQUENCE (2-N-O)

This field contains the next activity to be performed according to the follow-up schedule for this account. This field enables you to modify the next follow-up sequence for an account on a custom schedule. For example, if there is a reason to modify the sequence number due to an agreement made with the guarantor, the sequence number can be changed.

NOTE: If the Schedule Type field on the first account follow-up screen contains either Payment Plan or Custom when you access it, the system prompts you to:

> *Revise Payment Plan (Y/N) [N]?--*

> or

> *Revise Collection Schedule (Y/N) [N]?--*

> If you enter **N** to either of the prompts, the screen is not displayed.

> If you enter **Y** at either of the prompts, the Payment Plan/Schedule screen is displayed. For more information, see "Payment Plan/Schedule Screen" on page 2-147.

18. 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.

PAYMENT PLAN/SCHEDULE SCREEN

If the Schedule Type field on the first account follow-up screen contains either Payment Plan or Custom when you access it, and you enter a Y at either the

Revise Payment Plan (Y/N) [N]?-- or the Revise Collection Schedule (Y/N)
[N]?-- prompts, the Payment Plan/Schedule screen is displayed:

```
                    General Hospital Account Follow-up Processor
                                        Mon Jul 17, 2006 12:58 pm
Account       Name                 FC Typ Admit    Disch      Balance Loc
A0608100002  NORTON, PAT       P M  PAT 03/22/06 03/28/06   74603.74-AR /ACCF
 1 Schedule #      2 Description                    3 Wait Days
   97               PAY PLAN 3                         30
 4 Day of Month    5 Day of Week     6 Week of Month  7 Plan Amount
 ->                                                     $10.00
 8 Due Days        9 Grace Days      10 Ins Pending  11 Bill Balance
   1                1                    Bill            Patient
12 Reseq. Balance  13 Max Paper Bal  14 Min Balance   15 Min Refund Amt
   $10.00             Unlimited          $5.00            $5.00
16 Min Attempts    17 Auto Pre-List  18 Pre-List Max Bal
   0                  Yes                $22.22
19 Small Bal WriteOff Trans Code     20 Prelist Ins?  21 Days After Ins
   A0039-OTHER CHARITY ALLOWANCES        No               30
22 Bad Debt Transfer Trans Code      23 Delinquent F/U Type
   S0002-AR TO BD TRANSFER              Telephone
24 Delinquent F/U Message            25 Partial Payment F/U Type
   14  Delinquent Telephone             Detail Statement
26 Partial Payment F/U Message       27 Partial Payment F/U %
   8   DETAIL STATEMENT TEST MESSAGE     100.00%
```

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the guarantor and all
other accounts for which the guarantor is responsible. You can edit this field if the
guarantor has accounts in AR.

2. DESCRIPTION (30-C-R)
This field contains the description of the follow-up schedule code. You can edit the
description if necessary.

3. WAIT DAYS (2-N-R)
This field contains the minimum number of days to wait, from final billing, before
including the guarantor on a follow-up schedule. The entry range is 1 to 99 days. For
interval schedules, these days will be used to schedule the first event.

DEFINING FOLLOW-UP FREQUENCY

There are three ways to define the frequency of account follow-up: completing the Day
Of Month, Day Of Week, or Interval fields. These options, one of which must be
selected, are defined below. The Interval option is entered on the second screen.

4. DAY OF MONTH (2-AN-O)
This field contains the day of the month on which the hospital wants follow-up
performed for guarantors assigned to this schedule. Entry options are 1 through 28 or
L for the last day of the month. For example, you would enter 15 if you wanted follow-
up performed on day 15 of every month.

5.   DAY OF WEEK (1-N-O)

This field contains the day of the week on which the hospital wants follow-up performed for the account assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, . . . Saturday = 7. If this option is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here.

6.   WEEK OF MONTH (DISPLAY ONLY)

This field contains the week of the month during which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete the Day Of Week field, you must also complete this field. This field is not required if the Day Of Month field is completed. If this option is selected, the account assigned to this schedule will receive follow-up once a month, during the week entered here and on the day entered in the Day Of Week field.

7.   PLAN AMOUNT (5-N-O)

This field contains the plan amount, up to $99,000.00.

8.   DUE DAYS (2-N-R)

This field contains the number of days used in calculating the due date for payment plan accounts. The entry range is 0 to 99 days; the default is 0.

9.   GRACE DAYS (2-N-R)

This field contains the number of grace days allowed after the due days of a payment plan before the guarantor is considered delinquent. The entry range is 0 to 99; the default is 0. The follow-up date plus the due days plus the grace days equals the delinquent date.

10. INS PENDING (1-AN-0)

This field determines what type of follow-up occurs on accounts with pending insurance. Entry options are **B** (bill), **S** (suppress), or **M** (memo); the default value is B.

If you enter **B** in this field, the type of follow-up that occurs depends on how the *Bill Balance* field is set.

If you enter **S** in this field, the following can occur:

*   No follow-up occurs until all insurance liability is gone.

*   Accounts appear on the Follow-up Suppression report (FFR440) on the days that follow-up will occur.

*   Accounts do not have the next step incremented if all accounts attached to the guarantor follow-up schedule are being suppressed.

NOTE: Suppressed accounts become *new accounts* when the insurance liability is gone and uses the resequence parameters in the follow-up schedule.

If you enter **M** in this field, the following can occur:

- A memo message prints for accounts with pending insurance.

- If there is no insurance liability, a regular follow-up occurs requesting the entire account balance.

- If one account has insurance liability and the other account does not, memo and regular follow-up are produced. For detail statements, the system will attempt to put both types on one piece paper. Collection letters appear on two separate pages.

- If there is one account for a guarantor with both insurance and patient liability, a memo message is sent showing the entire account balance.

11. BILL BALANCE (1-A-R)
This field contains the dollar amount that is requested from the guarantor during follow-up. Entry options are **P** (patient balance) or **A** (account balance); the default is P.

If you enter P in this field, the following can occur:

- No memo message is created.

- A request for the patient portion appears with information noting the insurance liability on the paper follow-up.

- No follow-up occurs if there is no patient liability.

NOTE: The account is not considered a *new account* until all insurance liabilities are gone. A new account forces the system to resequence based on dollars and the new account sequence number in the follow-up schedule. Under this scenario, if a guarantor that had accounts past the end of the schedule and was ready to prelist also had an account that transferred part of the money to the patient, the account would not resequence. This account could then qualify for prelisting prior to receiving follow-up. To keep this from occurring, the Prelist Insurance Flag should be set to No. When the bad debt prelist is run, this account shows as a prelist exception and repeats the last step of this schedule. Once the insurance liability is gone, the account resequences according to the new account resequence parameters.

If you enter **A** in this field, the following can occur:

- No memo message is created.

- A request for the account balance appears on the paper follow-up.

- Follow-up always occurs.

12. RESEQ BALANCE (8-AN-R)
This field contains the minimum balance that is required to cause resequencing of the guarantor in the follow-up schedule if a new account is added to the guarantor's schedule. You can enter up to 999,999.99 (you must enter the decimal point) or **U** (unlimited); the default is U. The guarantor is resequenced if the account balance of the new account exceeds the amount entered in this field. If you enter U, the addition of new accounts to the guarantor will never cause resequencing of the guarantor follow-up schedule. The patient balance causes follow-up resequencing. This resequence occurs only if there is no insurance liability for the account.

NOTE: When a new account is added to a guarantor who has reached the end of the follow-up schedule, the guarantor resequences to the New Account Restart Step number if the account:

- Meets the resequencing balance criteria, and

- Has a resequencing step entered in the *New Account Restart Sequence Number* field.

- There is no longer insurance liability for Memo, Suppressed, or Bill/Patient accounts, or it is a newly final billed account whose schedule is bill/account.

The exception to this rule exists when the new account resequence steps are not used in the follow-up schedule and a guarantor is past its steps in the follow-up schedule (ready to prelist). This guarantor is resequenced back to its last step in order to avoid any accounts prelisting prior to receiving any follow-up. The resequence balance is not considered under this scenario.

13. MAX PAPER BALANCE (8-AN-R)
This field contains the maximum dollar amount balance required for paper follow-up. The entry range is 0 to 999,999.99 or **U** for unlimited. The default is U. If the balance is greater than the maximum paper balance, telephone follow-up occurs. If U is entered, paper follow-up always occurs unless there is a step in the schedule for telephone only.

14. MIN BALANCE (8-N-R)
This field contains the minimum account balance that is required to continue sending statements. This amount is the hospital small balance write-off for debit balances. The entry range is 0 to $999,999.99.

15. MIN REFUND AMT (4-N-R)
This field contains the minimum credit balance required to produce a patient refund. This amount is the hospital small balance write-off amount for credit balances. The entry range is 0 to $99.99.

16. MIN ATTEMPTS (2-N-R)
This field contains the minimum number of follow-up attempts that should be performed before a small balance write-off is processed. This field enables the hospital to bill a guarantor as many times as indicated for the small balance of an individual

account. A zero indicates no follow-up will be performed for the small balance. The entry range is 0 to 99; the default is 0. If the balance rises above the minimum for small balance write-off as indicated in the Min Balance field, the minimum attempts counter is reset to zero for the account. If the balance falls below the minimum balance again, the system begins the minimum attempts again.

17. AUTO PRE-LIST (1-A-R)
This field indicates whether the account should be selected for bad debt pre-listing after the last event (sequence) in the follow-up schedule. Entry options are **Y** for Yes or **N** for No; the default is N. If you enter N, the follow-up schedule sequence is repeated when the schedule reaches the last event (sequence) until the account is manually pre-listed for transfer to bad debt. Accounts are eligible for automatic pre-listing only if they have reached the end of the follow-up schedule, have this field set to Y, and the balance of the account is under the maximum prelist balance.

18. PRE-LIST MAX BAL (8-N-R)
This field contains the maximum account balance for automatic pre-listing for possible transfer to bad debt. The entry range is 0 to $999,999.99; the default is 0. If an account balance is greater than the pre-list maximum balance at the end of the follow-up schedule, the last sequence number remains in effect until the balance is less than the pre-list maximum balance or the guarantor pays the restart amount and percentage and is resequenced. This account is not automatically pre-listed until the account balance falls below the defined maximum.

This field should be set to No if the Bill/Patient option is chosen in the schedule. If the field is not set to No, accounts may be sent to bad debt prior to receiving any follow-up. Refer to the *Bill Patient* field for additional information.

19. SMALL BAL WRITEOFF TRANS CODE/DESC (4-N-R)
This field contains the transaction code used to update the patient account transaction history and the general ledger. This code is used when an account is automatically written off because it meets the small balance write-off criteria as defined in this follow-up schedule. You can enter the code or a hyphen (-) to display a list of codes under transaction type A (adjustments).

20. PRELIST INS (1-A-R)
This field indicates whether an account with pending insurance payments should be pre-listed for bad debt. Entry options are **Y** for Yes or **N** for No; the default is N. The account is not prelisted if there is pending insurance balance.

21. DAYS AFTER INS (2-N-R)
This field contains the number of days to wait (up to 99) after the final insurance payment before transferring the account to bad debt. The days after insurance are grace days given to the patient to pay any outstanding amount on the account that was not paid by insurance.

22. BAD DEBT TRANSFER TRANS CODE/DESC (4-N-R)
This field contains the transaction code indicating the transfer of this account from accounts receivable to bad debt. You can enter the code or a hyphen (-) to display a

list of valid codes under transaction type S (status transfer). This code is used to update the account transaction history. The transfer to bad debt is controlled by the hospital and takes place for pre-listed accounts.

23. DELINQUENT F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Entry options are **D** (detail statement), **L** (letter), or **T** (telephone).

24. DELINQUENT F/U MESSAGE (4-N-R)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

25. PARTIAL PAYMENT F/U TYPE (1-A-O)
This field contains the type of follow-up that is generated when less than the expected payment plan amount is received on a payment plan account. Entry options are **D** (detail statement), **L** (letter), or **T** (telephone).

26. PARTIAL PAYMENT F/U MESSAGE (4-N-O)
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field.

27. PARTIAL PAYMENT F/U % (4-N-R)
This field contains the percentage of the current amount due that is required to prevent partial payment follow-up.

When you finish editing this screen, accept the changes, and press ENTER. The system displays the third Account Follow-up screen:

```
               General Hospital Account Follow-up Processor
                                         Fri Mar 10, 2007 12:36 pm
 Account      Name                  FC Typ Admit    Disch       Balance Loc
 A92188-00213 WEBSTER,DAVID J        SP I/P 07/03/92 07/07/92     109.00  AR/FCRV
  1 Schedule #              2 Description
    98                        TEST FOR PAYMENT PLANS
  3 Edit date               4 Edit by
    09/11/06 9:16             Kassidy,Mike L
                            F/U      Memo     Rest
  5 Seq#  Follow Type       Msg      Msg      Seq#        Interval
    1     W Wait




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

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. SEQ # (DISPLAY ONLY)
This field contains a sequential number identifying the order of events for this follow-up schedule. You can define as many events as you wish. The sequence number and the follow-up type and code control the order in which follow-up is performed for the account.

FOLLOW TYPE (1-A-R)
This field contains the type of paper follow-up that is used for this sequence number. Entry options are **L** (follow-up letter), **D** (detail statement), or **T** (telephone).

F/U MSG (4-N-R)
This field contains the follow-up message that appears on the detail statement or letter or that is used for telephone follow-up. You can enter the code (up to four digits) or a hyphen (-) to display a list of valid codes. This message prints on the follow-up type when the guarantor is selected for that event (sequence). If it is a telephone message, the message is displayed in the assigned collector's workfile.

MEMO MESSAGE (4-N-O)
This field contains the code identifying the memo message that appears on the follow-up letter or detail statement. You can enter the code (up to four numbers) or a hyphen (-) to display list of valid codes. If the Memo/Separate Statement field on the previous screen contains M, this message appears on the guarantor detail statement; if the field contains S, this message appears on the separate detail statements.

PHONE CODE (4-N-R)
This field contains the code identifying the phone message that is used in the collector's worklist if the event is telephone follow-up. Telephone follow-up occurs if the follow-up type is T for telephone or if the Max Paper Bal field has been exceeded for this carrier for this account. You can enter a code or a hyphen (-) to display a list of valid codes.

NEW ACCTS REST SEQ # (2-N-O)
This field indicates the step in the follow-up schedule to which the guarantor is resequenced if a new account is added to the guarantor schedule and the criteria established in the Reseq. Balance field on the previous screen is met. The restart sequence number must be less than or equal to the current sequence number.

REST SEQ # (2-N-O)
This field contains the follow-up sequence number that is used if the restart % or amount is met and the account balance is paid by the guarantor prior to the next follow-

up date. The restart sequence number must be less than or equal to the current sequence number.

For example, General Hospital A sets up the follow-up sequences as follows:

Sequence	Paper Follow-up Type/Code	Restart
1	D - Detail Statement	
2	D - Detail Statement	1
3	L - Follow-up Letter	1
4	L - Follow-up Letter	2
5	T - Telephone	

The follow-up event defined in sequence 1 has been performed on the guarantor, and the guarantor has either not made a payment or the payment did not meet the restart percent or amount criteria before sequence 2 is scheduled to occur. The sequence 2 follow-up is performed, and the guarantor now pays the restart amount or percent before sequence 3 is performed. Since sequence 3 is now the follow-up event the guarantor would normally receive, the system checks the Restart Seq # field assigned to sequence 3 because payment has been received. If the Restart Seq # is 1, the event defined in sequence 1 is performed the next time the guarantor receives follow-up. If the minimum amount is paid, the guarantor can remain at the beginning of the follow-up schedule. If the guarantor does not pay the minimum amount, the follow-up continues through the sequences.

Only payments trigger the restart. If new accounts are added to the guarantor, resequencing will not occur and these accounts are treated in the same manner as the others. New accounts may cause resequencing to prior steps, depending on the entry in the New Accounts Restart Seq # field.

This field is optional but it is suggested that you complete it to ensure that guarantors who make payments receive the proper collection messages and are not sent to bad debt.

INTERVAL (3-N-C)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed *only* if the Day Of Month, Day Of Week, and Week Of Month fields are not completed. The first follow-up is scheduled from the final bill date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number. This field is optional, but one interval day should be defined.

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

NOTE: If you change the Schedule Type field from any type to Payment Plan type, the system displays another Account Follow-up screen which allows you to set up the payment plan for the account (see "Setting Up a Payment Plan" on page 2-156).

SETTING UP A PAYMENT PLAN

If you change the Schedule Type field from any type to Payment Plan type, the system displays the following Account Follow-up screen:

```
              General Hospital Account Follow-up Processor
                                          Fri Mar 10, 2006 12:36 pm
 Account        Name              FC Typ Admit    Disch       Balance Loc
 P90232-00004 WEBSTER,DAVID J     SP I/P 08/19/90 08/20/90      50.00   AR/FCRV
  1 Collector                       2 Schedule #   3 Schedule Type
    23-CLEMENS,LEONA J.                 991           Payment Plan
                   4 Next F/U Date            5 Next Sequence
                     11/06/90                     1
  6 Plan Amount      7 Current Due Amount  8 Delinquent Amount  9. Delinquency Date
    $100.00            $100.00               $0.00                 12/11/90




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

Field Explanations

1. COLLECTOR (DISPLAY ONLY)
This field contains the name and number of the collector assigned to the guarantor of this and all other accounts for which the guarantor is responsible.

2. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the guarantor of this and all other accounts for which the guarantor is responsible.

3. SCHEDULE TYPE (1-A-R)
This field reflects Payment Plan since this screen only displays if the schedule type is a payment plan.

4. NEXT F/U DATE (6-N-C)
This field contains the next follow-up date. This field enables you to modify the next follow-up date for an account that is any schedule other than the guarantor schedule. For example, if there is a reason to send a follow-up event sooner than the schedule indicates or to suspend sending follow-up for a period of time, the follow-up schedule date can be modified.

5. NEXT SEQUENCE (2-N-R)

This field contains the next activity to be performed according to the follow-up schedule for this account. This field enables you to modify the next follow-up sequence for an account on any schedule other than the guarantor schedule. For example, if there is a reason to modify the sequence number due to an agreement made with the guarantor, the sequence number can be changed.

6. PLAN AMOUNT (8-N-R)

This field contains the periodic payment amount set up for the payment plan.

7. CURRENT DUE AMOUNT (8-N-R)

This field contains the amount of the payment plan that is currently due. The current amount due plus the delinquent amount equals the full amount due from the guarantor. When you are first setting up the payment plan, enter 0 in this field. The system automatically updates the field when follow-up is generated for the guarantor.

8. DELINQUENT AMOUNT (8-N-R)

This field contains the payment plan amount that is past due. When you are first setting up the payment plan, enter 0 in this field. The system automatically calculates the delinquent amount when and if the guarantor does not pay according to the payment plan terms.

9. DELINQUENCY DATE (6-N-C)

This field contains the date on which the account is considered delinquent. The system calculates this field based on the due days and grace days in follow-up schedule to which this account is assigned. You do not need to update this field since it is updated by the system when follow-up is generated for the payment plan.

When these fields are completed, the system displays the second and third account follow-up screens and allows you to customize the follow-up schedule.

PA Account Follow-Up

This function is used to send paper follow-up to accounts in location PA.   The follow-up process is only account level (not guarantor level). Only paper follow-up can be sent through this process which includes detail statements and collection letters. Wait steps are another option available. Telephone follow-up is generated by use of the Active Patient Worklist processor.

Three different types of PA follow-up methodologies are available. The first type is the standard follow-up as is completed on AR accounts. The second type is a Balance payment plan which works similarly to an AP payment plan. The third type involves advanced payment plans. This process allows patients/guarantors to make payments prior to being admitted to the hospital. Examples where this can be used is for maternity stays or procedures resulting in a large patient responsibility balance on elective procedures. The process is activated by users via the PAAR Control Parameter screens. The fields controlling the process are on the second screen of the PA/AR Control Parameter option. The **Perform Auto PA F/U** should be set to Yes to

indicate that the system should perform standard follow-up. The user then specifies specific financial classes which will receive PA follow-up. The Financial Class table identifies the PA Follow-up schedule for the account as well as the Collection Group, which in turn defines the assigned collector. Exceptions can be defined for specific patient types as to the Collection Group used. The PA follow-up schedule determines whether the payment plan, advanced payment plan, or custom schedule will be carried over with the account when it is transferred to AR.

If PA follow-up is not established for PA accounts, users can still set up specific accounts in follow-up. The PA F/U Exception Schedule # parameter on the PA/AR Control screen controls this functionality. If a schedule is defined, users can manually set up PA follow-up on PA advanced payment schedules.   An account number needs to be assigned to the patient. The only schedule which can be assigned is the schedule defined in the PA F/U Exception Schedule # parameter.

After the PA follow-up parameters are set up, the next Midnight Processing establishes PA follow-up to the appropriate PA patient accounts. Changing parameters to unselect PA accounts also becomes effective after the next Midnight Processing run.

To place a PA account on a custom follow-up schedule, select the Account Follow-up Option. The system displays the following screen:

```
             General Hospital Account Follow-up Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit   Disch      Balance  Loc
A0205000003  SMITH, ANNIE          SP I/P 02/19/02           41420.85 PA/FCRV
 1 Collector                              2 Hold F/U?      3 Schedule Type
   55-BROWN, JOE                                              Separate
 4 Schedule #          5 Last Follow-up   6 Last Seq #     7 Last Type
   926                   03/22/02           2                D
 8 Last Follow-up Message               9 Last Follow-up Amount
   2-DETAIL STATEMENT PAST 30 DAY          $24,170.85
10 Payment Plan Type  11 Advanced Amount  12 Outstanding Advanced Amount

13 Delinquency Date   14 Delinquent Amt   15 Prepaid Amt   16 Current Due Amt

17 Next F/U Date      18 Next Sequence
   04/21/02              2
19 Healthcare Score/Desc - Date
   300-Possible Charity, Provide Application 6/13/03




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

Field Explanations

1. COLLECTOR (DISPLAY ONLY)
This field contains the collector code and collector name assigned to the account.

2. HOLD F/U? (DISPLAY ONLY) or (1-A-O)
This field indicates whether or not a hold has been placed on all follow-up activities. This field contains Yes if follow-up is on hold or No or blank if follow up activities are being completed.

3. SCHEDULE TYPE (1-A-R)
This field indicates the type of schedule the account is using. Valid types are Separate (S), Payment Plan (P), or Custom (C).

4. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the account.

5. LAST FOLLOW-UP (DISPLAY ONLY)
This field contains the date on which the last follow-up activity was performed.

6. LAST SEQ # (DISPLAY ONLY)
This field contains the sequence number of the last activity performed.

7. LAST TYPE (DISPLAY ONLY)
This field contains the last type of activity performed according to the follow-up schedule. Valid types include L - letter, and D - detail statement.

8. LAST MESSAGE (DISPLAY ONLY)
This field contains the message number and description associated with the last follow-up event.

9. LAST FOLLOW-UP BALANCE (DISPLAY ONLY)
This field contains the balance which was requested from the last follow-up event.

10. PAYMENT PLAN TYPE (1-A-O)
This field is only applicable when the schedule type is Payment Plan. The following prompt is displayed when this field is accessed:

Advanced (A) or Balance (B) payment plan-- |

The two types of plans are Advanced (A) payments and Balance (B), a payment plan requesting the account/patient balance.

11. ADVANCED AMOUNT (6-N-O)
This field is only applicable when the Payment Plan Type field is set to Advanced. This dollar amount is the total amount to be collected prior to the patient being admitted.

12. OUTSTANDING ADVANCED AMOUNT (6-N-O)
This field is only applicable if the Payment Plan Type field is set to Advanced. It represents the amount remaining to be collected.

13. DELINQUENCY DATE (6-N-O)
This field applies to payment plans. It contains the date on which the account is considered delinquent. The system calculates this field based on the due days and

grace days in the follow-up schedule to which this account is assigned. This field can be manually updated.

14. DELINQUENT AMT (8-N-O)
This field contains the payment plan amount which is past due. The entry range is 0 to $999,999.99 and requires the decimal point to be entered if manually updated.

15. PREPAID AMOUNT (DISPLAY)
This field contains the prepayment amount. This field displays an amount only if the Prepaid Amount field on the PAAR Control Table is set to Yes and the account is on a payment plan. The amount reflects the amount which is prepaid prior to billing for the periodic plan amount or if payments received exceed the agreed upon payment amount.

16. CURRENT DUE AMT (8-N-O)
This field contains the payment plan amount currently due. The entry range is 0 to $999,999.99 and the decimal point must be entered if manually updated.

17. NEXT F/U DATE (6-N-C)
This field contains the next follow-up date. You can enter a follow-up date only if the Hold F/U? field is blank or contains N. For example, if there is a reason to send a follow-up event sooner than the schedule indicates or to suspend sending follow-up for a period of time, the follow-up schedule date can be manually modified.

18. NEXT SEQUENCE (2-N-O)
This field contains the next activity to be performed according to the follow-up schedule for this account. This field enables you to modify the next follow-up sequence for an account. For example, if there is a reason to modify the sequence number due to an agreement made with the guarantor, the sequence number can be changed.

NOTE: When the account's follow-up type is changed to a Payment Plan type, a screen is displayed which allows you to set up a payment plan for the account. For information on this screen, see "Setting Up a Payment Plan" on page 2-168.

NOTE: If the Schedule Type field contains either Payment Plan or Custom when you access it, one of the following prompts is displayed:

Revise Payment Plan (Y/N) [N]?--

For information on the screen that is displayed, see "Revising a Payment Plan" on page 2-167.

Revise Collection Schedule (Y/N) [N]?--

For information on the screen that is displayed, see "Revising a Custom Schedule" on page 2-161.

19. 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.

Revising a Custom Schedule

The following screen is displayed when you answer Yes to the following prompt, which is displayed on the first follow-up screen:

Revise Collection Schedule (Y/N) [N]?--

```
                  General Hospital Account Follow-up Processor
                                            Fri Mar 10, 2006 12:36 pm
Account       Name                   FC Typ Admit    Disch      Balance  Loc
A0205000003  SMITH, MARY             SP I/P 02/19/02            41420.85 PA/FCRV
 1 Schedule #    2 Description                              3 Wait Days
   926             PATRICE'S PA F/U                           1
 4 Day of Month  5 Day of Week   6 Week of Month  7 Due Days      8 Grace Days
 ->                                               1               1
 9 Ins Pending  10 Bill Balance 11 Restart %    12 Restart Amt  13 Min Balance
   Bill            Patient         50.00%          $25.00          $5.00
14 Transfer Balance Pymt Plan to AR?   15 AR Payment Plan Schedule #

16 Transfer Advanced Pymt Plan to AR?  17 AR Payment Plan Schedule #

18 Transfer Customized Account to AR?  19 AR Custom Schedule #
   No
20 Delinquent F/U Type                 21 Delinquent F/U Message

22 Partial Payment F/U Type            23 Partial Payment F/U Message

24 Partial Payment F/U %

Enter day of the month (1-28) or `L` for last day --
```

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number assigned to the guarantor's PA account. You can edit this field if the guarantor has accounts in AR.

2. DESCRIPTION (30-C-R)
This field contains the description of the follow-up schedule code. You can edit the description if necessary.

3. WAIT DAYS (2-N-R)
This field contains the minimum number of days to wait, from admission date, before initiating follow-up. The entry range is 1 to 99 days. These days are used to schedule the first event.

NOTE: There are three ways to define the frequency of account follow-up: completing the Day Of Month or Day Of Week/Week of Month. These options, one of which must be selected, are defined below.

4. DAY OF MONTH (2-AN-O)
This field contains the day of the month on which the hospital wants follow-up performed. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

5. DAY OF WEEK (1-N-O)
This field contains the day of the week on which the hospital wants follow-up performed for the account. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, . . . Saturday = 7. If this option is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here.

6. WEEK OF MONTH (DISPLAY ONLY)
This field contains the week of the month during which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete the Day Of Week field, you must also complete this field. This field is not required if the Day Of Month field is completed. If this option is selected, the account assigned to this schedule will receive follow-up once a month, during the week entered here and on the day entered in the Day Of Week field.

7. DUE DAYS (2-N-R)
This field contains the number of days used in calculating the delinquent date for payment plan accounts. The entry range is 0 to 99 days; the default is 0.

8. GRACE DAYS (2-N-R)
This field contains the number of grace days allowed after the due days of a payment plan before the guarantor is considered delinquent. The entry range is 0 to 99; the default is 0. The follow-up date plus the due days plus the grace days equals the delinquent date.

9. INS PENDING (1-AN-0)
This field determines what type of follow-up occurs on accounts with pending insurance. Entry options are B (bill) or M (memo); the default value is B. If you enter B in this field, the type of follow-up that occurs depends on how the Bill Balance field is set.

If you enter M in this field, the following can occur:

- A memo message prints for the account with pending insurance.

- If there is no insurance liability, a regular follow-up occurs requesting the entire account balance.

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10. BILL BALANCE (1-A-R)
This field contains the dollar amount requested from the guarantor during follow-up. This field is only accessible if the Ins Pending field is set to bill (B).

Entry options are P (patient balance) or A (account balance); the default is P.

If you enter P in this field, the following can occur:

•   No memo message is created.

•   A request for the patient portion appears with information noting the insurance liability on the paper follow-up.

•   No follow-up occurs if there is a zero or credit patient liability.

If you enter A in this field, the following can occur:

•   No memo message is created.

•   A request for the account balance appears on the paper follow-up.

•   Follow-up always occurs asking for the account balance.

11. RESTART % (2-N-O)
This field contains the percent of the balance due that must be paid in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence) until this percent is paid. The percentage is compared to the 'Last Follow-up Amt' noted on the previous screen. The entry range is 0 to 99.99%.

12. RESTART AMOUNT (8-N-O)
This field contains the minimum amount which must be paid in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point).

13. MIN BALANCE (8-N-R)
This field contains the minimum account balance required to continue sending detail statements or collection letters. The entry range is 0 to $999,999.99.

14. TRANSFER BALANCE PYMT PLAN TO AR? (1-A-O)
This field will only accept a Yes/No response.   It also only applies if the accounts Follow up Type is defined as a (B)alance type payment plan.

15. AR PAYMENT PLAN SCHEDULE # (DISPLAY ONLY)
This field contains the AR Payment Plan Schedule and is transferred from the table information in Tables, Financial Table Maintenance, Follow up Schedules (PA). This field is used if the Transfer Balanced Pymt Plan To AR? field contains a Yes. When account payment plans transfer to AR, they use the schedule defined in this field. The

accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step, and Next Follow-up Date when they transfer to AR.

16. TRANSFER ADVANCED PYMT PLAN TO AR? (1-A-O)
This field will only accept a Yes/No response.   It also only applies if the accounts Follow up Type is defined as a (A)dvanced type payment plan.

17. AR PAYMENT PLAN SCHEDULE # (DISPLAY ONLY)
This field contains the AR Payment Plan Schedule and is copied from the Follow up Schedules (PA) information (Tables, Financial Table Maintenance, Follow up Schedules (PA). This field is used if the Transfer Advanced Pymt Plan To AR? field contains a Yes. When account payment plans transfer to AR, they use the schedule defined in this field. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step and Next Follow-up Date, when they transfer to AR.

19. TRANSFER CUSTOMIZED ACCOUNT TO AR? (1-A-O)
This field will only accept a Yes/No response.   It also only applies if the account's Follow-up Type is defined as a custom type schedule.

19. AR CUSTOM SCHEDULE # (1-A-O)
This field contains the AR Custom Schedule and is only used if the account's follow up schedule is customized. This field is required if the Transfer Customized Account to AR? field contains a Yes. When customized plans transfer to AR, they use the schedule defined in this field.

20. DELINQUENT F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Entry options are D (detail statement) or L (letter).

21. DELINQUENT F/U MESSAGE (1-A-O)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

22. PARTIAL PAYMENT F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account receives a payment less than the percentage of the plan amount defined in the Partial Pay F/U % field. Entry options are D (detail statement) or L (letter).

23. PARTIAL PAYMENT F/U MESSAGE (1-A-O)
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field.

24. PARTIAL PAY F/U % (1-A-O)
This field contains the percentage of the current amount due that must be received to not produce partial payment follow-up. This field is dependent on the Partial Payment F/U Type and the Partial Payment F/U Message. If the Partial Payment F/U Type and the Partial Payment F/U Message fields are not completed, this field cannot be completed.

After you complete and accept this screen, the system displays the second Account
Follow-up Processor screen.

```
              General Hospital Account Follow-up Processor
                                          Fri Mar 10, 2006 12:36 pm
Account      Name                 FC Typ Admit    Disch       Balance  Loc
A0205000003  BROWN, MARY            SP I/P 02/19/02            41420.85 BD/FCRV
PA
 1 Schedule #              2 Description
   926                       PATRICE'S PA F/U
 3 Edit date               4 Edit by
   08/02/01 11:34             Kess, Pat M
                           F/U       Memo      Rest
 5 Seq#  Follow Type       Msg       Msg       Seq#       Interval
   1     D Detail Statement 1                             30
   2     D Detail Statement 2                   1         30




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

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. SEQ #
This field contains a sequential number identifying the order of events for this follow-
up schedule. You can define as many events as you wish. The sequence number and
the follow-up type and code control the order in which follow-up is performed.

FOLLOW TYPE (1-A-R)
This field contains the type of paper follow-up that is used for this sequence number.

Entry options are L (follow-up letter), D (detail statement), or W (wait).

F/U MSG (4-N-R)
This field contains the follow-up message that appears on the detail statement or letter.

REST SEQ # (2-N-O)
This field contains the follow-up sequence number that is used if the restart % or amount is met and the account balance is paid prior to the next follow-up date. The restart sequence number must be less than or equal to the current sequence number.

For example, General Hospital A sets up the follow-up sequences as follows:

Sequence	Paper Follow-up Type/Code	Restart
1	D - Detail Statement	
2	D - Detail Statement	1
3	L - Follow-up Letter	1
4	L - Follow-up Letter	2
5	T - Telephone	

The follow-up event defined in sequence 1 has been performed on the guarantor, and the guarantor has either not made a payment or the payment did not meet the restart percent or amount criteria before sequence 2 is scheduled to occur. The sequence 2 follow-up is performed, and the guarantor now pays the restart amount or percent before sequence 3 is performed. Since sequence 3 is now the follow-up event the guarantor would normally receive, the system checks the Restart Seq # field assigned to sequence 3 because payment has been received. If the Restart Seq # is 1, the event defined in sequence 1 is performed the next time the guarantor receives follow-up. If the minimum amount is paid, the guarantor can remain at the beginning of the follow-up schedule. If the guarantor does not pay the minimum amount, the follow-up continues through the sequences.

Only payments trigger the restart. If new accounts are added to the guarantor, resequencing will not occur and these accounts are treated in the same manner as the others. New accounts may cause resequencing to prior steps, depending on the entry in the New Accounts Restart Seq # field.

This field is optional but it is suggested that you complete it to ensure that guarantors who make payments receive the proper collection messages and are not sent to bad debt.

INTERVAL (3-N-C)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed *only* if the Day Of Month, Day Of Week, and Week Of Month fields are not completed. The first follow-up is scheduled from the final bill date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number. This field is optional, but one interval day should be defined.

You can enter the code or a hyphen (-) to display a list of valid codes. This message prints as a follow-up type when the account is selected for that event (sequence).

Revising a Payment Plan

If you change the Schedule Type field (on the screen shown in "PA Account Follow-Up" on page 2-157) from any type to Payment Plan type, the system displays the following Account Follow-up screen:

```
              General Hospital Account Follow-up Processor
                                       Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch      Balance  Loc
A0205200003  CHEN, MIKE           SP I/P 02/21/02            46030.85 PA/FCRV
 1 Schedule #    2 Description                               3 Wait Days
   926             F/U SCHEDULE #5                           1
 4 Day of Month  5 Day of Week   6 Week of Month  7 Plan Amount   8 Due Days
->                                                $2.00           1
 9 Grace Days   10 Ins Pending   11 Bill Balance  12 Min Balance
   1              Bill             Patient          $5.00
13 Transfer Balance Pymt Plan to AR?   14 AR Payment Plan Schedule #

15 Transfer Advanced Pymt Plan to AR?  16 AR Payment Plan Schedule #
   No
17 Transfer Customized Account to AR?  18 AR Custom Schedule #

19 Delinquent F/U Type                 20 Delinquent F/U Message

21 Partial Payment F/U Type            22 Partial Payment F/U Message

23 Partial Payment F/U

Enter day of the month (1-28) or `L` for last day --
```

NOTE: Most of the fields on this screen are explained in "Revising a Custom Schedule" on page 2-161. However, the field numbers are different. The fields that are not explained (because they appear on the screen that is displayed for payment plans only and not the custom schedule screen) are explained below.

Field Explanations

7. PLAN AMOUNT
This field represents the amount which the patient/guarantor agreed to pay during one follow-up cycle.   This field can be edited after the plan is initially created as well as when the payment plan is created.

Setting Up a Payment Plan

When the account's follow-up type is changed to a Payment Plan type, the following screen is displayed.

```
                  General Hospital Account Follow-up Processor
                                          Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A0110800004  SMITH, MARY           JA ALL 04/18/01              1594.93 PA/FCRV
 1 Collector                           2 Schedule #   3 Schedule Type
    55-ADAMS,JULIE                       1               Payment Plan
                   4 Next F/U Date              5 Next Sequence
                     10/26/01                     2
                   6 Payment Plan Type       7 Advanced Amount
                     Balance
    8 Plan Amount    9 Current Due Amount 10 Delinquent Amount 11 Delinquency Date
->                                                             10/29/01


 Enter plan amount--
```

Field Explanations

1. COLLECTOR (DISPLAY ONLY)
This field displays the collector code and name associated with this account.

2. SCHEDULE # (DISPLAY ONLY)
This field displays the PA Follow up Schedule attached to the account.

3. SCHEDULE TYPE (DISPLAY ONLY)
This field reflects Payment Plan since this screen will only display if the schedule type is a payment plan.

4. NEXT F/U DATE (6-N-C)
This field contains the next follow-up date.

5. NEXT SEQUENCE (2-N-R)
This field reflects the next step which will be generated when follow-up is processed for the account.

6. PAYMENT PLAN TYPE (1-A-R)
This field determines whether the payment plan will be considered an Advanced or Balance type payment plan.

7. ADVANCED AMOUNT (8-N-R)
This field will only be completed when the Payment Plan type is defined as Advanced. This dollar value determines the total amount to be collected prior the patient being admitted.

8. PLAN AMOUNT (8-N-R)

This field represents the amount which the patient/guarantor agreed to pay during one follow-up cycle.   This field can be edited after the plan is initially created as well as when the payment plan is created.

9. CURRENT DUE AMOUNT (8-N-R)

This field contains the amount of the payment plan that is currently due. The current amount due plus the delinquent amount equals the full amount due from the guarantor. When you are first setting up the payment plan, enter 0 in this field. The system automatically updates the field when follow-up is generated for the guarantor.

10. DELINQUENT AMOUNT (8-N-R)

This field contains the payment plan amount that is past due. When you are first setting up the payment plan, enter 0 in this field. The system automatically calculates the delinquent amount when and if the guarantor does not pay according to the payment plan terms.

11. DELINQUENCY DATE (6-N-C)

This field contains the date on which the account is considered delinquent. The system calculates this field based on the due days and grace days in follow-up schedule to which this account is assigned. You do not need to update this field since it is updated by the system when follow-up is generated for the payment plan.

When these fields are completed, the system displays follow-up screens that allow you to customize the follow-up schedule. For information on these screens, see "Revising a Custom Schedule" on page 2-161.

Insurance Follow-Up

Insurance follow-up occurs based on the insurance follow-up schedule assigned to the account. This function enables you to review insurance follow-up data for an account or modify the next date or sequence.

The first follow-up event is scheduled when a claim is submitted for the primary carrier or when the primary carrier payment is received and the secondary claim has been submitted for a secondary carrier. You cannot initiate the original follow-up; claim submission causes the first follow-up to occur.

After this function is selected, the following screen is displayed. This screen contains a list of insurance carriers and plans associated with this account.

```
              General Hospital Insurance Follow-up Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit   Disch      Balance Loc
A0034100016  MARTIN, PATRICE       PK O/P 12/06/00 12/06/00   1730.03 AR/FCRV

Page:01
       Carrier                          Plan
( 1) 1  917-PATRICE'S  COMERCIAL        001-PATRICE'S COMMERCIAL




Enter choice--
```

Select a carrier from the list, press ENTER, and the following screen is displayed:

NOTE: You cannot access accounts in this function unless insurance follow-up has begun. If follow-up has not begun, when you select this option the following message is displayed at the bottom of the screen:

> *Warning: No claims submitted*

Insurance follow-up is not initiated if a balance transfer is posted to an archived or purged claim.

```
              General Hospital Insurance Follow-up Processor
                                        Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit   Disch      Balance Loc
A0034100016  MARTIN, PATRICIA      PK O/P 12/06/00 12/06/00   1730.03 AR/FCRV

          COB 1    917-PATRICE'S  COMERCIAL    001-PATRICE'S COMMERCIAL

    Claim in follow-up;Claim not in follow-up

Page:01   Adj    Bill         Service       Claim      Submit    Clm  P
     CS   CS     From/Thru    From/Thru     Amount     Date      Dsp  d
( 1)  2          12/06 12/06/00 12/06 12/06/00   1730.03
( 2)  1    2     12/06 12/06/00 12/06 12/06/00   3000.00  12/05/01  R








Enter choice--
```

This screen contains a list of claim sequences for this carrier. The claims that are receiving insurance follow-up are highlighted on the screen, as is the screen heading "Claim in follow-up."

Field Explanations

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

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

BILL FROM/THRU (DISPLAY ONLY)
This field contains the beginning and ending billing dates covered by this claim.

SERVICE FROM/THRU (DISPLAY ONLY)
This field contains the beginning and ending service dates covered by this claim.

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

SUBMIT DATE (DISPLAY ONLY)
This field contains the date the claim was submitted and follow-up began.

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

PD (DISPLAY ONLY) (DISPLAY ONLY)
This field indicates whether this claim has been paid in full. Values are Y for Yes or N for No.

Select the desired claim sequence and press ENTER. The system displays the following screen.

```
              General Hospital Insurance Follow-up Processor
                                       Fri Mar 10, 2007 12:36 pm
Account        Name              FC Typ Admit    Disch       Balance Loc
A92188-00713 BROWN,JOHN A        BC E/R 07/03/92 07/07/92      109.00  AR/FCRV

COB 1   50-BLUE CROSS    0002-BLUE CROSS GENERAL PLAN    CS 1
 1 Collector                           2 Hold F/U?    3 Custom Schedule?
   13-JONES,CHARLES                        No             Yes

 4 Last Follow-up            5 Last Seq #        6 Last Type

 7 Last Message                         8 Last Follow-up Balance

 9 Next F/U Date     10 Next Sequence   11 Schedule #
                          1                      883
12 External Agency Information
   MIKEIN P-ACT 051506

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

At the top of the screen, the system displays the account number, patient name, financial class, patient type, admission and discharge dates, account balance, and account location/sub location. Below this, the system displays the COB number, carrier code and description, plan number and description, and the claim sequence.

NOTE: Claims which are assigned to an external collection agency do not have the following screen information updated: next follow-up date, next follow-up step, hold, schedule type, and step information.

Field Explanations

1. COLLECTOR (2-N-O)
This field contains the one- or two-digit code number assigned to the account along with the name of the collector.

2. HOLD F/U? (1-A-R)
This field indicates whether insurance follow-up activities for this claim for the account should be put on hold. Entry options are **Y** for Yes which places follow-up on hold, or **N** for No which does not place follow-up activities on hold. The default is N. If you enter Y, the system blanks out the Next F/U Date field and records an entry in the account's transaction history that indicates the account is on insurance follow-up hold.

3. CUSTOM SCHEDULE? (1-A-O)
This field enables you to customize the insurance follow-up schedule for this account for this carrier. Customizing the follow-up schedule enables follow-up events to be specific for this account. Entry options are **N** for No or **Y** for Yes. Once this field is set to Y, it cannot be edited.

NOTE: Changes made to the master tables for the insurance follow-up schedule do not affect accounts on custom schedules.

4. LAST FOLLOW-UP (DISPLAY ONLY)
This field contains the date on which the last follow-up activity was performed.

5. LAST SEQ # (DISPLAY ONLY)
This field contains the sequence number of the last follow-up activity performed for this carrier for this account.

6. LAST TYPE (DISPLAY ONLY)
This field contains the last type of activity performed according to the follow-up schedule (for example, a letter, telephone call, or tracer for this carrier for this account).

7. LAST MESSAGE (DISPLAY ONLY)
This field contains the number of the last follow-up message sent.

8. LAST FOLLOW-UP BALANCE (DISPLAY ONLY)
This field contains the last follow-up balance.

9. NEXT F/U DATE (6-N-R)
This field contains the next follow-up date. If you want to make follow-up occur sooner or later than currently scheduled, you can use this field to change the next follow-up date.

NOTE: The system blanks out this field if you entered Y to the Hold F/U field.

10. SEQUENCE (2-N-O)
This field contains the next activity to be performed according to the follow-up schedule for this account. The sequence can be modified if you want to change the current event.

11. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule number.

12. EXTERNAL AGENCY INFORMATION (DISPLAY ONLY)
This field displays the following information for the account:

- Collection Agency Code

- Status

    - D - Deleted

    - F - Flagged

    - P - Pending

    - T - Transferred

- Date of last status update in mmddyy format

If the Custom Schedule? field contains Yes, the system displays the following message when you finish editing this screen and press ENTER:

Revise Collection Schedule (Y/N)

Enter **Y,** and the system displays the following screen. If the account is not on a custom schedule but you want to set up a custom schedule for the account, access the Custom Schedule? field. The system displays the following prompt:

Customize Collection Schedule (Y/N)?

Enter **Y** for Yes and the system prompts you to revise the collection schedule. Enter **Y** to revise custom schedule and the following screen is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                Mon Jul 10, 2007 12:22 pm
Insurance Follow-up Schedules
 1 Schedule 2 Description                   3 Appeal   4 Ext Agy  5 Multiple
   51          JULIE'S INS FUP                 No         No         No
 6 Wait Day 7 Appeal Due Days   8 Day of Month  9 Day of Week 10 Week of Month
   0                    Last
11 Max Paper Bal    12 Min Balance      13 Timeout Days    14 Resequence?
   $500.00             $0.00               1                   Yes
15 ISBWO ?           16 ISBWO Amount     17 ISBWO Claims ?
   No
18 ISBWO Days from Submit Date           19 ISBWO Trans Code/Desc

20 Insurance Letter To Guarantor Message 21 Auto Update Appeal 22 Post Agy Sch
                                              No


                   Time Out Follow Up For Guarantor
23 F/U Type           24 Code                          25 Amount Due Balance

26 Produce F/U for CCI Accts    27 Produce F/U for Agency Accts(int/ext)


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

Field Explanations

1. SCHEDULE # (3-N-R)
This field contains the code identifying this insurance follow-up schedule.

2. DESCRIPTION (30-C-R)
This field contains the description of the insurance follow-up schedule code.

3. APPEAL? (1-A-R)
This field indicates if this is an appeal follow-up schedule. When this field is accessed, the following prompt is displayed:

Is this an insurance appeal follow-up schedule? (Y/N) N]--

If this field is set to Yes, the follow-up schedule is considered an appeal follow-up schedule and the following fields are set as follows:

Field	Value
Multiple?	No
Timeout Days	Unlimited
Resequence	No
ISBWO?	No

4.   EXT AGY (1-A-R)

This field defines whether this schedule type is used for internal collections or for external collections. This field does not apply to denial and appeal schedules and is accessible only if the Appl? (Appeal) field is defined as No. When this field is accessed, the following prompt is displayed:

External Agency (Y/N)? [N] -

You can enter **Y** (Yes) if the schedule is used for external agency collections or **N** (No) if the schedule is used for internal collections. When the schedule is defined as External, the Step Definition screen is updated to access only the interval days and the Agency Group columns. Only wait steps can be defined. An External type of schedule triggers the system to create a data file to be sent to the specific collection agency. The only fields that can be completed by the user are Wait Day and Post PC Sch. The Max Paper Bal, Min Balance, Timeout Days, and ISBWO? fields are updated by the system with appropriate defaults that cannot be edited by users.

5.   MULTIPLE? (1-A-R)

This field indicates whether multiple accounts should be included on one follow-up letter to the carrier. Multiple accounts print on the same follow-up letter if the accounts are selected for the same follow-up message and are associated with the same carrier and plan. Entry options are Y for Yes or N for No; the default is N.

For appeal follow-up schedules, this field is automatically set to No.

6.   WAIT DAYS (2-N-R)

This field contains the minimum number of days to wait, after a claim is submitted, before the first follow-up event occurs. The entry range is 0 to 99; the default is 0.

7.   APPEAL DUE DAYS (3-N-C)

This field contains the number of days to begin appeal follow-up based on the days from the appeal due date. Valid values are 0 to 999. If the appeal due date is 120 days from appeal date, and this field is set to 30, the first follow-up date is 90 days after the date originally set to appeal. If no appeal due date exists at the time the account is worked, the default date is the number of days specified in the wait days. When this field is accessed, the following prompt is displayed:

Enter number of days prior to appeal due date to begin --

If the field is modified, the is displayed as follows:

Enter new number of days prior to appeal due date to begin --

Defining Follow-up Frequency

There are three ways to define the frequency of account follow-up: Completing the Day Of Month, Day Of Week, or Interval fields. These options, one of which must be selected, are defined below. The Interval option is entered on the second screen.

8. DAY OF MONTH (2-AN-O)

This field contains the day of the month on which the hospital wants follow-up performed for carriers assigned to this schedule. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

9. DAY OF WEEK (1-N-O)

This field contains the day of the week on which the hospital wants follow-up performed for carriers assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, ... Saturday = 7. If this field is selected, claims assigned to this schedule receive follow-up once per month, on the day entered here.

10. WEEK OF MONTH (1-N-C)

This field contains the week of the month during which follow-up is performed for carriers assigned to this schedule. Entry options are 1 through 4. If you complete the Day Of Week field, you must also complete this field. This field is not required if the Day Of Month field is completed. If this field is selected, claims assigned to this schedule receive follow-up once a month, during the week entered here and on the day entered in the Day Of Week field.

11. MAX PAPER BAL (8-AN-R)

This field contains the maximum dollar balance required for paper follow-up. The entry range is 0 to $999,999.99 or U for unlimited; the default is U. If the sum of the carrier responsibility is greater than the maximum paper balance, the carrier is selected for telephone follow-up only.

12. MIN BALANCE (8-N-R)

This field contains the minimum claim balance required to continue insurance follow-up. If the claim balance drops below this amount, no paper insurance follow-up is produced. However, the next date and sequence continue to update until the claim is either final dispositioned or time-out occurs. The entry range is 0 to $999,999.99.

13. TIMEOUT DAYS (3-AN-O)

This field contains the number of days, after the last follow-up sequence is completed, for the system to examine the Insurance Time-out parameters to determine if the remaining carrier liability is transferred to the patient or to another carrier. Insurance time-out indicates the liability of the insurance transfers to someone else. Time-out can be disallowed by the Timeout Parameter in the Financial Class table. The Insurance Time-out parameter is used to indicate where the balance is transferred. The entry range is 0 to 999 days or U (unlimited).

Time-out occurs when the claim is at the end of the schedule.

For appeal follow-up schedules, this field is automatically set to Unlimited.

14. RESEQUENCE? (1-A-O)

This field determines if partial insurance payments should resequence insurance follow-up back to step one. A value of Y for Yes indicates that follow-up should

resequence back to step one. A value of N for No indicates follow-up should not resequence back to step one.

For appeal follow-up schedules, this field is automatically set to No.

15. ISBWO? (1-A-O)

This field determines if an insurance should be reviewed for an insurance small balance write-off (ISBWO). Only accounts in an accounts receivable location can be considered for an ISBWO. Entry options are Y for yes or N for no. The default is N. Enter **Y** to indicate an insurance using this follow-up schedule should be considered for an ISBWO. Enter **N** or press ENTER to indicate that an insurance using this follow-up schedule should not be considered for an ISBWO. When you access this field, the system displays the following prompt:

Review insurance for small balance writeoff? (Y/N) [N]

For appeal follow-up schedules, this field is automatically set to No.

16. ISBWO AMT (4-NC-R)

This field contains the maximum insurance balance required for an insurance to be considered for an ISBWO. This amount is the upper limit for an ISBWO. The lower limit is defined by the Insurance Refund parameter. When you access this field, the system displays the following prompt:

Enter maximum insurance balance required for an ISBWO --

17. ISBWO CLAIMS (1-A-R)

This field indicates whether accounts with an insurance, using this follow-up schedule, should be considered for an ISBWO if there are claims for the insurance that have not been submitted and do not have a final disposition. Entry options are Y for yes or N for no. The default is N. Enter **Y** to indicate that accounts with an insurance using this follow-up schedule should be considered for an ISBWO regardless of if the claim has not been submitted or does not have a final disposition. Enter **N** to indicate accounts with an insurance using this follow-up schedule should not be considered for an ISBWO if there are claims for the insurance that have not been submitted and do not have a final disposition. When you access this field, the system displays the following prompt:

Select for ISBWO if there are outstanding claims for insurance? (Y/N) [N]

18. ISBWO DAYS FROM SUBMIT DATE (3-N-R)

This field contains the number of days after the claim submit date the system should wait before performing an Insurance Small Balance Write-off. This field is valid only if the ISBWO Claims field is set to No. This field allows the Insurance Carrier time to pay before the system processes an ISBWO. When you access this field, the system displays the following prompt:

Days to wait after Claim Submit Date for Insurance Small Balance Writeoff --

19. ISBWO TRANS CODE/DESC (TABLE LOOKUP)
This field contains the transaction type and code identifying this insurance small balance write-off. A transaction type and code can be entered directly into the field, or you can select one from the table lookup. For example, if the transaction type is an A, all transaction codes with a type of A are displayed in the table lookup. When you access this field, the system displays the following prompt:

Enter transaction code, or '-' for list --

20. INSURANCE LETTER TO GUARANTOR MESSAGE (2-N-O)
This field determines if an Insurance Letter for the Guarantor is generated when an Insurance Letter is produced for the insurance carrier/plan through the insurance follow-up schedule. This field also controls what message prints on the first page of the Insurance Letter to the Guarantor. If the Multiple Accts field on the Insurance Follow-Up schedule is set to Yes, the Insurance Letter to Guarantor Message field cannot be completed. If the field already was completed, it is blanked out when the Multiple Accts field is set to Yes.

21. AUTO UPDATE APPEAL? (1-A-C
This field indicates whether the system should automatically update the active appeal status and appeal action. When the field is accessed, the following prompt is displayed:

Auto update active appeal status and action (Y/N) [N]?--

If you enter **Y** for Yes, the system updates the status and actions automatically. When letters are generated, the status is updated and the action is updated with an action of LETTR. If a workfile entry is generated and the entry is processed, the system updates the status and the action of CALL is updated on the account. The status is updated incrementally, from Active - 1st attempt, to Active - 2nd attempt, etc.

22. POST AGY SCH (TABLE LOOKUP-CONDITIONAL)
This field defines the insurance follow-up schedule, which is used when a claim is removed from an external collection agency (due to being at the end of the schedule), and the claim defaults back into STAR collections. This parameter can be accessed only for a schedule type defined as external. The schedule type can only be defined as an internal type schedule. When this field is accessed, the system displays a list of all the active, internal collection schedules. You can select a collection schedule from the list.

Claims that are deleted from agency collection for a reason other than being at the end of the schedule are placed back into insurance follow-up using the follow-up information (collector group and Insurance dollar definition parameters). When the claim completes the cycle for external collections, the claim is added back to the internal collection process using this internal insurance follow-up schedule. This schedule is used to cause the claim to time out and to transfer money to the next carrier/patient.

Time Out Follow Up For Guarantor

23. F/U TYPE (1-A-O)
This field indicates the type of follow-up sent to the guarantor when insurance time-out occurs. The guarantor should be notified through a follow-up event that the bill is now his responsibility. Entry options are D (detail statement), L (letter), or T (telephone). If you leave this field blank, the next two fields (Code and Amount Due Balance) are also blank.

If the Amount Due (patient or account, depending on the entry in the Amount Due Balance field) is a credit, zero amount, or below the minimum balance to send guarantor follow-up, the system does not print the follow-up type (detail statement or letter).

24. CODE (2-N-O)
This field contains the code identifying the message used with the follow-up type selected in the F/U Type field. You can enter the code or a hyphen (-) to display a list of valid codes.

25. AMOUNT DUE BALANCE (1-A-R)
This field indicates whether the patient or account balance is used as the balance due amount for guarantor follow-up at time-out. Entry options are P (patient balance) or A (account balance); the default is A.

26. PRODUCE F/U FOR CCI ACCOUNTS (1-A-O)
This field determines if the time out guarantor follow-up, specified in the above follow-up type field, should be produced for CCI carriers timing out. A value of **Y** for Yes indicates that time-out follow-up should be produced for CCI accounts. A value of **N** for No indicates time-out follow-up should not be produced for CCI accounts.

27. PRODUCE F/U FOR AGENCY ACCOUNTS (INT/EXT) (1-A-O)
This field determines if the time out guarantor follow-up, specified in the above follow-up type field, should be produced for AR agency accounts that time-out. A value of **Y** for Yes indicates that time-out follow-up should be produced for accounts at AR Agency collection. A value of **N** for No indicates that time-out follow-up should not be produced for accounts at AR agency collection.

After these fields are completed, you have the option of accepting, editing or deleting the information on the screen. Accepting the screen displays the second Insurance Follow-up Schedules screen.

```
              General Hospital Financial Table Maintenance Processor
                                                    Mon Jul 10, 2007 12:26 pm
 Insurance Follow-up Schedules
  1 Schedule #          2 Description                3 Appeal   4 Ext PC
    7                     TEST7                         No         No
  5 Edit date           6 Edit by
    09/16/05 14:29         New, Nancy
                                                                    Agency
  7 Seq #    Paper Code     Phone Code                  Interval  Group

    1            1            13
    2            2            14
    3            2            99


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

Field Explanations - Screen 2 of 2

1.   SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying the selected insurance follow-up schedule.

2.   DESCRIPTION (DISPLAY ONLY)
This field contains the description of the insurance follow-up schedule.

3.   APPEAL (DISPLAY ONLY)
This field contains the value of Yes if the schedule is an appeal follow-up schedule and the value of No if the schedule is not an appeal follow-up schedule.

4.   EXT PC? (DISPLAY ONLY)
This field defines if the insurance follow-up is used for internal collections or for external collections. An external schedule allows only for intervals and a collection agency group to be defined.

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

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

7.   SEQ # (DISPLAY ONLY)
This field contains a number identifying the order of events for this follow-up schedule. You can define as many events as you wish. The sequence number and the follow-up type and code control the order in which follow-up is performed on carriers assigned to this schedule.

PAPER CODE (4-N-O)
This field contains the code representing one of the following:

- Insurance Follow-up Letter sent during this sequence;
- **T** (tracer - copy of the claim with the word Tracer printed on it);
- Blank indicates telephone follow-up should be performed for this sequence.

You can enter a code or a hyphen (-) to display a list of valid codes. Pressing the ENTER key (leaving this field blank) indicates a phone call should be the next step.

PHONE CODE (4-N-R)

This field contains the code identifying the phone message used in the collector's workfile if the event is telephone follow-up. Telephone follow-up occurs if the *Paper Code* field is blank or if the *Max Paper Bal* field has been exceeded for the carrier for this account. You can enter the code or a hyphen (-) to display a list of valid codes.

INTERVAL (3-N-C)

This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed *only* if the Day of Month, Day of Week, and Week of Month fields are not completed. The first follow-up is scheduled from the final bill date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number. This field is optional but one interval should be defined.

AGENCY GROUP (TABLE LOOKUP)

This field contains the Collection Agency Group code and is used to define which Collection Agency is assigned to this claim by using the Collection Agency Group table. You can enter a code or a hyphen (-) to select one from the Collection Agency Group table. If an agency code is entered in this field, accounts receive a maintenance code of flagged when this follow-up step is processed. Follow-up steps that contain an agency code are called agency collection steps. There can be multiple collection steps defined on the follow-up schedule.

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

Account Notes

This function enables you to create, edit, and view notes for specific accounts. These notes can be free-form or standard notes.

Standard notes are system-defined and contain a brief description of a particular account event. An example of a standard note could be *Sent claim — claim returned-wrong address.* Standard notes are assigned a transaction type of T and are recorded in the account's transaction history. The hospital can define any number of standard notes in the system.

Free-form notes are made up of two parts. The first part is a brief, one-line description of the contents of the note as summarized by the user. This line description can be used in the future to locate the note. The second part can be up to 13 lines of 75 characters. Here, you can fully describe the account event. Free-form notes are also

recorded in the account transaction history using the transaction code specified in PA/ AR Control. Access to and editing of free-form notes depends on the parameters established in the Biller/Collector Worklist Control table. For details on these parameters, refer to the *General Information Volume* of the STAR Financials Patient Accounting Reference Guide.

After you select the Account Notes function, the following screen is displayed:

```
                General Hospital Account Notes Processor
                                            Fri Mar 10, 2006 12:36 pm
Account      Name                  FC Typ Admit    Disch      Balance Loc
A89334-00001 HALL,RUTH A           C  I/P 04/04/90 04/05/90     60.00   AR/FCRV
Page:01                               Notes                   ##=Current Choices
( 1) BILLER NOTE 1/RFH                11/30/89 [F] Smith,Mary A
( 2) WAITING FOR ATTACHMENTS - MR     11/30/89 [S] Smith,Mary A
( 3) FF BILLER NOTE FOR RAH           12/04/89 [F] Smith,Mary A
( 4) CLAIM RETURNED - WRONG ADDRESS   12/04/89 [S] Smith,Mary A
( 5) CREDIT CHECK REQUESTED           06/17/03 [F] Smith,Mary A
( 6) ADDRESS CHECK REQUESTED          06/17/03 [F] Smith,Mary A
( 7) ADDRESS/CREDIT CHECK REQUESTED   06/17/03 [F] Smith,Mary A




 Enter choice, view all(V), add free form(F) or standard(S) notes--
                        end selection(NL)
```

Information displayed on this screen includes the patient account number, patient name, financial class, patient type, admit and discharge dates, account balance, and account location/sub location. Note information includes the note and description, the date it was assigned to this account, whether the note is free-form [F] or standard [S], and the name of the system user who assigned this standard note or created this free-form note.

When this screen is displayed, you have several options:

- You can select a note or notes to view or edit (only free-form notes can be edited). Only a free-form note can be edited and only by the original creator of the note. The Edit Notes field in the Biller/Collector Worklist Control table must be set to Yes.

- You can view all account notes by entering **V** (view all). You can also edit the free-form notes. A free-form note can be edited only by its original creator. The Edit Notes field in the Biller/Collector Worklist Control table must be set to Yes.

- You can add a free-form note by entering **F** (free-form).

- You can add a standard note by entering **S** (standard).

You can view all or selected choices of notes. As the notes are displayed:

- You can press ENTER to take you to the next note.

- You can enter /P to take you back to the previous note.

- You can enter / to take you to the next note.

- You can press ENTER to exit the Note function.

NOTE: Once you add a free-form or standard note to an account, you cannot delete the note. When the account is archived, the associated notes are also archived. If note confidentiality has been activated, only users with a security code equal to or greater than the security attached to the free-form note have access to the note text. If you do not have the appropriate security, the note text is displayed as ****Account Note is Confidential****.

ADDING A STANDARD NOTE

After you enter **S** (standard notes), the system prompts you to enter the transaction code used to record this note in the account transaction history. You can enter the code (up to four digits) or a hyphen (-) to display a list of valid codes. If you enter a hyphen (-), the system displays the following screen:

```
            General Hospital Account Notes Processor
                                     Fri Mar 10, 2006 12:36 pm
Account       Name                 FC Typ Admit    Disch       Balance Loc
A89334-00001 HALL,RUTH A           C  I/P 04/04/90 04/05/90     60.00   AR/FCRV
   Transaction                                 Valid         Combined to
   Type  Code  Description                     Accts   Combine  Type  Code
( 1) T - 0007  SENT DATA MAILER                A/R
( 2) T - 0008  Telephone Follow Up             Any
( 3) T - 0010  SENT COLLECTION LETTER          A/R
( 4) T - 0011  SENT DETAILED STATEMENT         A/R
( 5) T - 0099  NOTES                           Any




 Enter choice--
```

Along with basic patient account data, information displayed includes the transaction type, transaction code, a description of the note, the type of accounts for which this note is valid, whether the note is a combined print, and what (if any) transaction types/ codes this standard note is combined to for printing.

NOTE: Editing and confidentiality do not apply to standard notes.

After you enter or select the transaction code, if no guarantor changes are taking place, the note associated with the code is added to the account and the transaction is completed.

If an account change is underway when the system tries to save the account note, the following prompt is displayed:

> *Guarantor in use. Retry? (Y/N) [Y] --*

If you enter N at the prompt, the following message displays:

> *No note update made!*

If you enter Y at the prompt, the system attempts to save the account note. If an account change is underway, the following prompt is displayed:

> *Account in use. Retry? (Y/N) [Y] --*

If you enter Y at the prompt, but the guarantor update has not completed when the program tries to save the account note, the following prompt is displayed:

> *PA is awaiting guarantor update.*

> *If problem persists, contact HBOC during normal business hours. Try again? (Y,N) [Y] --*

If the prompt continues to appear after you answer Yes in response to the above prompt, contact McKesson support. An incomplete merge or transfer visit may exist for the account.

ADDING A FREE-FORM NOTE

After you enter F (free-form notes), the system displays the following screen:

```
           General Hospital Account Notes Processor
                                        F Fri Mar 10, 2006 12:36 pm
Account        Name              FC Typ Admit    Disch        Balance Loc
A89334-00001 HALL,RUTH A         C  I/P 04/04/96 04/05/96       60.00   AR/FCRV
 1 Code      2 Description                      3 Last Edit date
   NEW                                            04/05/96 11:52am
 4 Created By                5 Creation Date    6 Edit text?   7 Security
   Smith,Mary A              04/05/96




 Press NL--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the word NEW. Once the message is completed and accepted, the system assigns a code number. Each free-form note is assigned a code number corresponding to the order of its creation. The first note is 1, the second 2, and so on.

2. DESCRIPTION (30-C-R)
This field contains the description of the purpose of the note. This description is displayed in the account's transaction history and on the first screen of the Account Notes function.

3. LAST EDIT DATE (DISPLAY ONLY)
This field contains the date and time this note was last edited. When a new note is being created, the system displays the current date and time.

4. CREATED BY (DISPLAY ONLY)
This field contains the name of the user creating this note.

5. CREATION DATE (DISPLAY ONLY)
This field contains the date on which the note was created. This date is used as the note creation date in the account's transaction history and is displayed on the list of Account notes.

6. EDIT TEXT? (1-A-R)
This field indicates whether the length of a new free-form note exceeds the 30-character description. If it does, enter **Y**; if it does not, enter **N**. The default is N. If you enter Y, the system displays the following screen:

```
              General Hospital NEW NOTES [ALL TYPES] Processor
                                          Fri Mar 10, 2006 12:36 pm
 Account       Name               FC Typ Admit    Disch       Balance Loc
 A89334-00001 HALL,RUTH A          C  I/P 04/04/9604/05/96      60.00  AR/FCRV
  1 Code       2 Description                      3 Last Edit date
    NEW          Ins. Coverage Terminated            04/05/90 11:52am
   4 Created By                    5 Creation Date   6 Edit text?  7 Security
    Smith,Mary A                     04/05/96            Yes
   ----------------------------------------------------------------------------
  01| Patient's employer called to advise that insurance coverage is being     |
  02| terminated at end of month.  Patient notified and will make financial    |
  03| arrangements, if necessary, but anticipates being discharged prior to    |
  04| end of month.  Attending physician's office notified.                    |
  05|                                                                          |
  06|                                                                          |
  07|                                                                          |
  08|                                                                          |
  09|                                                                          |
  10|                                                                          |
  11|                                                                          |
  12|                                                                          |
  13|                                                                          |
     F1          F2           F3     F4    F5          F6           F7    F10
     Delete Line  Insert Line  Center Exit  Store Line  Restore Line  Pack  Help
```

The function keys listed at the bottom of this screen are used to help you enter this message. Pressing F4 exits the extended message text. The system then prompts you to accept the screen.

7. SECURITY (2-N-R)
This field contains the two-digit security code assigned to the note. This can be any number from 0 to 80. It defaults to the security level of the user entering the note. Since the security assigned to the note will be changed only on an exception basis, the cursor does not automatically enter this field. You can access the field by entering / and the field number. When you access this field, the prompt to enter the new security level of the note is displayed. Enter any security level from 0 to 80. If note confidentiality has been activated, only users with a security level equal to or greater than the security on the note may view the note text.

EDITING A FREE-FORM NOTE

A free-form note may be modified if the Edit Notes field in the Biller/Collector Worklist Control table is set to Yes. However, you can edit only the notes that you created. Select the note to be edited and then the Description, Edit Text?, or Security fields. Once all editing is completed, accepting the screen completes the transaction.

Balance Transfer & Claim Disposition

For information about this function refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Add Claim to Insurance

For information about this function refer to the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Maintain Claim Information

This option allows you to update the claims without having to exit Account Revision. For more information about this function, refer to Section 3 of the *Billing and Claims Volume* of the STAR Financials Patient Accounting Reference Guide.

Out of Province Patient Information

This screen allows you to modify patient demographic data, which may be necessary since patients may have been out of province at the time of visit, but have since moved elsewhere, including in-province.

If you are accessing the screen through Account Revision, data entry is allowed as follows:

- If the patient type is defined in the Patient Types for OOP Data Entry table (indicating non-abstracted) this screen allows entry to all fields. The first time the screen is accessed, data from STAR patient demographics loads to the fields.

- If the patient type is inpatient and not in the table (indicating abstracted), and there is no discharge date, or the date precedes the discharge date, the screen allows entry to all fields. This accommodates interim billing for inpatients requiring diagnoses.The first time the screen is accessed, data from STAR patient demographics loads to the field.

- If the patient type is inpatient and not in the table (indicating abstracted), the patient has a discharge date, and the data is for the discharge date, only the Accident Indicator and Accident Code fields can be accessed, because it is assumed that information from the Medical Records vendor is correct. Other fields display information imported from the Medical Records vendor, and cannot be accessed. An error message is displayed if these fields are selected.

- If the patient type is non-series outpatient and not in the table (indicating abstracted), and has a discharge date, none of the fields can be accessed.

- If the patient type is series outpatient and not in the table (indicating abstracted), and has NACRS data for the selected date of service, none of the fields can be accessed.

- If the patient type is series outpatient and not in the table (indicating abstracted), and does not have NACRS data for the selected date of service, the screen allows entry to all fields. The first time the screen is accessed, data from STAR patient demographics loads to the field.

Modification changes only the data to be loaded to the claim. This information is retained so that it can be used for subsequent claims for the patient. For example, if an adjustment or late claim is loaded, the information previously entered in this field is displayed and used to load new claims. It does not update the current patient demographic data.

When the option is selected, the dates for which information exists appear in a table lookup. After the date is selected, the information for the date is displayed.

The reference date for the information is selected from the list of dates with charges for the account or by keying **A** to use the Admission/Registration Date. The reference date is compared with the bill from/thru dates of the claim and the last date of information within the timeframe is used. If Medical Records information exists when the information is keyed initially, some of the fields are defaulted from Medical Records information and that information cannot be updated. If Medical Records information is expected, some of the fields cannot be updated even if they are blank. Note that when the claim loads, the current Medical Records information is used.

Based on the patient types used for the account, one or more of the following prompts is displayed after the account is selected. The information is used to make decisions about soliciting the information for the account.

Select (I)npatient or (O)utpatient data--

Enter Patient Type for this visit information--

```
                    Out of Province Patient Information Processor
                                            Fri Jun 05, 2009 12:31 am
Account       Name                  FC Typ Admit    Disch        Balance Loc
J1-0005808    SMITH, MARK           OP I/P 09/02/04 09/02/04      766.50 AR /ACCF
Patient Type:      I/P
Using Patient Type: I/P
Record Date:       2009/02/04
Med Rec Data Date:

 1 Most Responsible Diagnosis    2 Prin Intrvntn Code    3 Prin Intrvntn Date

 4 Health Care Number    5 Expiry Date    6 Province    7 Postal Code
                           2009/02/04
 8 Accident Indicator                     9 Accident Code
   No
10 Edit By                               11 Edit Date/Time
   New, Nancy                               09/02/04 13:22



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

Field Explanations

The header contains patient information. In addition, if the patient is a series type outpatient, the service date selected is displayed. If medical record data has been imported, that date is displayed.

1. MOST RESPONSIBLE DIAGNOSES (7-A-O)
This field contains the Medical Records or Out of Province Diagnosis Patient Information. No ICD-10 table is available for table lookup or verification.

This field is available only if the patient type is in the Patient Types for OOP Data entry table (non-abstracted) or does not have a Med Rec Data date.

2. PRINCIPAL INTERVENTION CODE (10-A-O)
There is no ICD-10 table available for table lookup or verification for this field.

This field is available only if the patient type is in the Patient Types for OOP Data entry table (non-abstracted) or does not have a Med Rec Data date.

3.   PRINCIPAL INTERVENTION DATE (DATE-O)

This field contains the principal intervention date from Medical Records or Out of Province Diagnosis Patient Information.This field is available only if the patient type is in the Patient Types for OOP Data entry table (non-abstracted) or does not have a Med Rec Data date.

4.   HEALTH CARE NUMBER (12-A-R)

This field contains the patient's heath care number. This field is available only if the patient type is in the Patient Types for OOP Data entry table (non-abstracted) or does not have a Med Rec Data date.

5.   EXPIRY DATE (DATE-O)

This field contains the heath card expiration date.This field is available for all patients. For all patients, the Expiry Date from Patient Demographics is displayed.

6.   PROVINCE/TERRITORY ISSUING HLTH CARE NUMBER (12-A-R)

This field contains the Province code defined on the Province Abbreviations table. This field is available only if the patient type is in the Patient Types for OOP Data entry table (non-abstracted) or does not have a Med Rec Data date.

7.   POSTAL CODE (12-A-R

This field contains the patient's postal code. This field is available only if the patient type is in the Patient Types for OOP Data entry table (non-abstracted) or does not have a Med Rec Data date.

8.   ACCIDENT INDICATOR (Y/N-O)

This field is available to edit for all patients.

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October 2012   *Release 18.0*   *Index-1*
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■ R e a d e r   C o m m e n t   F o r m ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide* for Release 18.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

_____

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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

May we contact you?   Yes or No (circle one)

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