McKESSON
Empowering Healthcare

STAR 2000™

STAR FINANCIALS PATIENT ACCOUNTING REFERENCE GUIDE
Canadian Claims Processing

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Reader comments

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

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Preface

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

Documentation Conventions

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

Revisions

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

Canadian Documentation

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

Key Names

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

Key Chords

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

ENTER

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

Data Entries

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

Selecting an Entry

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

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

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

Prompts

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

Enter patient name--

Field Characteristics

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

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

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

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

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Introduction

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

Chapter 1: Parameters

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

Chapter 2: Claim Types

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

Chapter 3: Billing & Claim Processing Hints

This chapter provides hints on processing Ontario OHIP (MOH), British Columbia Medical Services Plan (BC MSP), and British Columbia Worker's Compensation Electronic (BC Workers Comp Elec) claims.

Chapter 4: Provincial Claims Reports (Ontario Only)

This chapter provides information on the Provincial Claims reports for Ontario.

Chapter 5: Automatic Repricing by Financial Class

This chapter provides information on automatic repricing by financial class.

Chapter 1 - PARAMETERS

INTRODUCTION

Claim Types

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

- K-UNV – Universal claim, used to submit to commercial carriers in Ontario. This form is also available to send to commercial carriers requiring this format in other provinces. The Universal Claim form is not currently used in British Columbia.
- Y-CPBC – Canadian Patient Bill Claim, used to submit to payors that accept the charges in a patient bill format. This may include commercial carriers. This claim type may also be used in a suppressed printing mode to attach to payors that require an invoice-style report in order for cash payments to be received.

BRITISH COLUMBIA ONLY

- P- BC MSP, British Columbia Ministry of Health, referred to as MSP claims
- Q-BC WORKER'S COMP ELEC, British Columbia Worker's Compensation Board electronic claims
- V-BC Out of Prov., used to submit electronic claims for out of province reimbursement

ONTARIO ONLY

- H-MOH – Ontario Ministry of Health, referred to as OHIP claims
- W-WCB – Ontario Worker's Compensation Board
- 10-ON OOP ICD10 - Ontario Out of Province ICD10 Inpatient claims
- 12-ON OOP ICD10 - Ontario Out of Province ICD10 Outpatient claims

NOVA SCOTIA ONLY

- 2-WCB NS, Nova Scotia Worker's Compensation Board
- 3-Comm NS, Nova Scotia Inpatient Commercial
- 4-OP Comm NS, Nova Scotia Outpatient Commercial
- 5-OutPrv NS, Nova Scotia, Outpatient Out of Province
- 6-InPrv NS, Nova Scotia, Inpatient Out of Province

Information regarding the province of Nova Scotia's claims is provided in the *Nova Scotia Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Demographic Information

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

Assignment of Charges

Charge Control Parameters are not used in Canada. Charges are assigned as either insurance or patient responsibility based on the coverage and proration summary code exceptions established on each insurance plan. During the billing and claims process, the charges are assigned to the appropriate insurance carrier, or to the patient if the charge is not covered by any insurance. This segregation of charges is often referred to as *charge piles*. Each non-zero charge is evaluated and assigned to only one charge pile. Therefore, a charge will appear on only one claim. The charges are assigned in COB order, in other words, beginning with the primary insurance. For more information on Charge Piles, please refer to "PATIENT BILLING" on page 3-3.

CLAIM GENERATION PARAMETERS

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

```
          General Hospital Claim Generation Parameters Processor
                                                Tue Jun 13, 2006 10:46 am
Claim Generation Parameters
 1 Code           2 Description                          3 Status
   BC               BLUE CROSS                           Active
 4 Edit by                                               5 Edit date
   Smith,Mary A                                          05/27/06 04:56pm
 6 Suspense Days
   0
 7 Cycle Claim Transaction Code          8 Final Claim Transaction Code
   Z0001-CYCLE CLAIM                       Z0001-CYCLE CLAIM
 9 Adjustment Claim Transaction Code    10 Reprint Claim Transaction Code
   Z0004-REPRINT CLAIM                     Z0004-REPRINT CLAIM
11 Late Claim Transaction Code          12 Cycle Adjustment Claim Transc Code
   Z0003-UB82 LATE CHARGES CLAIM           Z0004-UB82 ADJUSTMENT CLAIM




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

Field Explanations

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

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

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

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

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

6. SUSPENSE DAYS (2-N-R)
This field enables you to define the number of days to hold before printing. Enter a number from 0 to 99 or U for Unlimited. The suspense days for claims sent to the Ministry should always be unlimited.

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

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

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

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

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

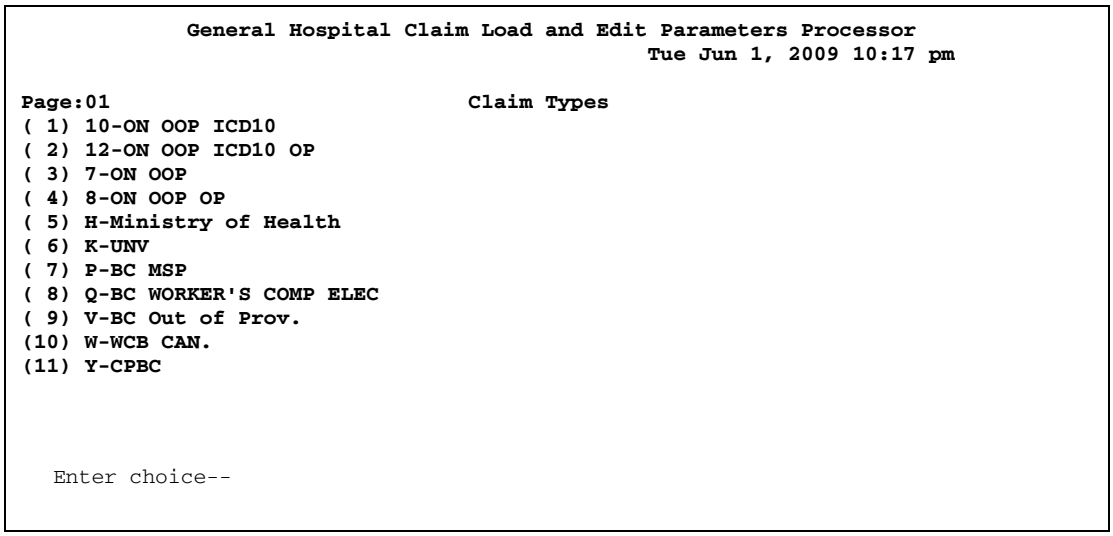
12. CYCLE ADJUSTMENT CLAIM TRANSAC CODE (4-N-R)
This field contains the transaction code that is used when a cycle adjustment claim is generated and for transactions associated with a cycle adjustment claim. The transaction type Z (claims processing) is always associated with this transaction code. You can enter the code or a hyphen (-) to display a list of valid codes.

CLAIM LOAD AND EDIT PARAMETERS

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

This parameter is not split by facility.

After this parameter is selected, the system prompts you to select a claim type. Claim types are defined by McKesson. The current choices for Canadian customers are outlined in “INTRODUCTION” on page 1-3 and include Ontario Ministry of Health (MOH), British Columbia Medical Services Plan (BC MSP), and Workers Compensation (WCB or BC Worker’s Comp Elec).



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

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

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

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

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

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

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

```
            General Hospital Claim Load and Edit Parameters Processor
                                                Thur Jun 10, 2009, 2:06 pm


 1 Code      2 Claim Form   3 1500 Format      4 Description
   H           H MOH                           MINISTRY OHIP CLAIM
 5 Begin Date           6 End Date             7 Claim Media
   2002/01/01             2002/01/01             D Diskette
 8 Electronic Types     9 Start Detail   10 Stop Detail    11 Load $0.00 Claim
                          53                 58
12 Generation Pending? 13 Last Generated      14 Out of Province Hospital Code
                          2002/01/01
15 Code for Maiden Name      16 Load Part 2 for MSP Claim  17 On OPC Code Not Req

18 Edit Date                 19 Edit By

   2005/08/08 10:53             New, Nancy,



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

Field Explanations

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

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

This will be one of the valid Canadian claim types, such as H-MOH, W-WBC, Y-CPBC, and P-BC MSP.

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

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

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

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

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

Ministry claims such as OHIP, MSP, and British Columbia Workman's Compensation should be set to D for Diskette.

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

8. ELECTRONIC TYPES (TABLE LOOKUP)
This field contains the claim types that can be spooled to the electronic spool file if the Insurance Plan Master specifies that electronic claims should be generated. The options are Adjustment Claims, Cycle Claims, Final Claims, Late Claims, Reprint Claims, and Tracer Claims. This field is not required. You can access this field only if the claim type is K (Universal), W (Ontario's WCB CAN), or Nova Scotia claim types 2 through 6.

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

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

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

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

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

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

NOTE: OHIP Claims must have the start detail and end detail = 79.

11. LOAD $0.00 CLAIM (TABLE LOOKUP-O)
This field indicates whether a claim should load even if there are no charges for the insurance. This field is valid only for claim type K (Universal). When this field is accessed, a table of claim types is displayed. Highlight the claim types (Adjustment, Cycle, Final, Late, Reprint, Tracer) that should load a $0.00 claim if there are no charges for the insurance. If no claim types are selected, the field defaults to No, Do not load a $0.00 claim.

For Universal (claim type K) plans, when the Load $0.00 Claim field is set to load a $0.00 claim for a claim type (Adjustment, Cycle, etc.), the system only loads this $0.00 claim if there is also a higher priority Universal (claim type K) or WCB (claim type W) plan. For example, if you had the following:

COB 1 = OHIP claim, $500.00

COB 2 = Universal claim, 75.00

COB 3 = Universal claim, 0.00

The COB 3 plan would load the $0.00 claim. However, if you had the following:

COB 1 = OHIP claim, $500.00

COB 2 = Universal claim, 0.00

COB 3 = Universal claim, 0.00

The COB 2 plan would not load the $0.00 claim, since there is no higher priority Universal plan. The COB 3 plan would still load the $0.00 claim, and you will have to review the Universal/WCB Activity Report (FARCUAx) to determine if this claimshould be deleted. For details on that report, see the Reports Volume of the STAR Financials Patient Accounting Reference Guide.

When loading a $0.00 claim, the claim loads with all of the Demographic information, but no Charge information.This allows you to update the Claim Charge Data amount, and the system sets the Expected Number of Payments for the insurance to be greater than 0 (thereby allowing the system to do an automatic balance transfer to the insurance).

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

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

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

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

15. CODE FOR MAIDEN NAME (3-AN-R)
This field contains the code for the patient's maiden name. You can enter a code or select one by entering a hyphen (-) at the following prompt:

Enter name type or `-` to list--

If you enter a hyphen (-), a list of name types is displayed.

16. LOAD PART 2 FOR MSP CLAIM (1-A-R)
This field can only be accessed if the claim type is P, MSP for British Columbia. The value in this field determines whether Part 2 of the MSP claim should be completed or space filled. Part 2 information is required for Fee for Service Claims for patients from provinces with an Other Insurer agreement with British Columbia. When this field is accessed, the following prompt is displayed:

Do you want to load Part 2 for this MSP Claim? (Y/N)

You can enter **Y** (Yes) to load Part 2 or **N** (No) if you do not want to load Part 2.

17. ON OPC CODE NOT REQ(Y/N-C)
This field can be accessed only if the claim type is 12 (On OOP ICD10 OP). This parameter is used to indicate that the absence of an OPC code should not prevent a charge from being analyzed for inclusion on claim type 12. This means that a charge without an OPC code can load to the claim, if it is associated with an outpatient patient type. Unless the parameter is set to Yes, charges without OPC codes are not included in the analysis for inclusion on claim type 12. The prompt for this field is as follows:

Should an OPC code NOT be required when analyzing charges for claim type 12 (ON OOP ICD10 OP)? (Y/N)--

- If a response of Y is keyed, ancillary charges without OPC codes are included in the analysis for claim type 12. This means that all charges are analyzed for the high dollar charge, and a charge without an OPC code can load to the claim.

- If the response is N or ENTER is pressed to indicate no response, or the field is not updated, and is therefore blank, ancillary charges without OPC codes are not included in the analysis for claim type 12. Only charges with OPC codes are analyzed to determine the high dollar charge.

Analysis occurs during Midnight Processing to determine qualifying charges for outpatient claims. For outpatients, the value for the Claim Load/Edit Parameter recorded for the account is used. If outpatient charges are being analyzed for an inpatient claim, the value for the outpatient Claim Load/Edit Parameter for the account's insurance is used. The current value for On OPC Code Not Req for the Claim Load/Edit Parameter for the insurance is determined from the Insurance Plan Coverage table.

If one of the charges for an outpatient claim is missing an OPC code, the claim is not released automatically. The missing OPC code must be supplied using Claim Charge Data or the claim must be released manually.

The display for Claim Charge Data for claim type 12 includes this field. This field appears before the list of charges on the right side of the screen. If claim service lines exist without OPC codes, the number of claim service lines appears after the field label "No OPC Indicated:". Whenever a change is made to Claim Charge Data and the changes are recorded, the claim charges are re-evaluated to determine if claim service lines exist missing OPC codes. If the only error preventing the automatic release of the claim was missing OPC codes and they are supplied using Claim Charge Data, then the claim is released from Claim Charge Data.

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

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

After you complete this screen, press ENTER and the system prompts:

Delete? (N)-

If you do not want to delete this parameter, enter ENTER again to accept the default of N for No. The system displays the following prompt:

Enter form locator or '-' to list--

Editing Claim Form Fields

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

After a form locator is entered or selected, the system gives you the option to change the form locator description. The claim form locator and description appear on the top part of the screen along with the claim parameter code and description. If you change the locator description, the description you currently see is changed. If you enter N, the description remains unchanged and a list of field definitions relevant to the selected claim form locator appears. Claim form locators can contain single or multiple field definitions, which are used to update the boxes on the claim forms or data within the downloaded files. For example, twelve fields are identified for the claim form locator Header Record 1 for the Ontario Ministry of Health claim, while a single field is identified for the claim form locator Patient Name for the Canadian Patient Bill claim.

When you select one of the field definitions, the following screen is displayed.

NOTE: This is a sample of the screen that displays when the third field of MOH claim form locator number 1 is selected.

```
            General Hospital Claim Load and Edit Parameters Processor
                                                 Wed Jan 30, 2002 11:06 am
Claim Parameters: H MINISTRY
Claim Locator   : 1 Header Record 1
 1 Field #      2 Description                        3 Required?     4 Print?
   3              Version Code                         No              Yes
 5 Form Row     6 Form Column            7 Form Length        8 Field Type
   1              14                       2                    X Alphanumeric
 9 Valid Entries                        10 Default Value

11 Internal Element                     12 Set Up Routine
   PATIENT HEALTH CARD VERSION #
13 Print Routine                        14 Online Edit Routine
   STANDARD PRINT (NO FORMATTING)
15 Display Routine                      16 Batch Edit Routine

17 Insurance UDF Code




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

Field Explanations

1. FIELD # (DISPLAY ONLY)
This field displays the number of this field definition in the claim locator. For example, the claim locator Header Record 1 contains twelve fields included in the header record for Ontario MOH claims. The field Version Code is the third field definition in this locator group and is assigned #3 by the system. This field is set up by McKesson and cannot be edited.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13. PRINT ROUTINE (TABLE LOOKUP)
This field indicates the format that is used when the data is printed on the claim form. For example, field definitions that have dollar field types provide you with multiple

choices regarding how the dollars should print. You can enter a hyphen (-) to display a list of choices.

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

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

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

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

MINISTRY OF HEALTH CLAIM MASTER

The following table contains the records sent to the Ontario Ministry of Health for OHIP claims (Claim Type H). The system creates one provincial claim record per account for each bill sequence. The hospital can set up as many claim load and edit parameters as required.

There are three separate Form Locators corresponding to the three records passed to the Ministry. These are Header Record 1, Header Record 2, and Address Record. Each Form Locator contains the fields specified by the Ministry of Health.

Ministry of Health Claim Master Records

Box	Description	Req	Prt	Start	End	Lgth	Type	Valid	Def	Internal Element
Header Record 1										
1	Trans ID	Yes	Yes	1	3	3	A		HEH	N/A
2	Health No	Yes	Yes	4	13	10	N			Patient Health
										Card Number
3	Version No	No	Yes	14	15	2	A			Pt HCN Version Code
4	Patient Bday	Yes	Yes	16	21	6	N			Patient Birthdate
5	Acct No	Yes	Yes	22	29	8	N			Account Number
6	Pymt Pgm	Yes	Yes	30	32	3	A		HCP	N/A
7	Payee	Yes	Yes	33	33	1	A		P	N/A
8	Ref Prov No	No	Yes	34	39	6	N			Physician Code
9	Facility	Yes	Yes	40	43	4	N			Institution Number
10	Pt Admit Date	Yes	Yes	44	49	6	N		For Outpatients: 8 spaces	For inpatients: Admission Date For Outpatients: Remove Admission Date internal element
11	Ref Lab No	No	Yes	50	53	4	AN			N/A
12	Man Review Indicator	No	Yes	54	54	1	A			N/A
Header Record 2										
1	Trans ID	Yes	Yes	1	3	3	A		HER	N/A
2	OHIP Reg No	No	Yes	4	15	12	AN			N/A
3	Pt Last Name	No	Yes	16	24	9	AN			Patient Name
4	Pt First Name	No	Yes	25	29	5	AN			Patient Name
5	Pt Sex	No	Yes	30	30	1	N			Patient Sex
12	Province Cd	No	Yes	31	32	2	A			Patient Province
Address Record										
1	Trans ID	Yes	Yes	1	3	3	A		HEA	N/A
2	Address Line 1	No	Yes	4	28	25	AN			Street Address

Box	Description	Req	Prt	Start	End	Lgth	Type	Valid	Def	Internal Element
3	Address Line 2	No	Yes	29	53	25	AN			Street Address
4	Province	No	Yes	54	55	2	A			Province
5	City	No	No	54	71	26	AN			City/Town
6	Postcode	No	Yes	72	79	6	AN			Zip Code

Field Explanations for Header Record 1

1. TRANS ID
This field defaults to HEH per Ministry specifications.

2. HEALTH NUMBER
This field contains the Patient Health Insurance Number.

3. VERSION NUMBER
The Patient Health Insurance Number Version Number prints in this field if a version code was entered on the patient record.

4. PATIENT BIRTHDAY
This field contains the date on which the patient was born.

5. ACCOUNT NUMBER
This field contains the patient's account number.

6. PAYMENT PROGRAM
This field defaults to HCP per Ministry specifications.

7. PAYEE
This field defaults to P per Ministry specifications.

8. REFERRING PROVIDER NUMBER
This field defaults to a blank value. This value is blank in the header record. It is filled in when the charges are processed and will contain the referring physician OHIP number.

9. FACILITY
This is the Provincial Institution field from the Financial Provider Table. The provider for the account is assigned based on the patient type or primary insurance.

10. PATIENT ADMIT DATE
This field contains the date on which the patient was admitted.

11. REFERRING LAB NUMBER
This field defaults to a blank value.

12. MANUAL REVIEW INDICATOR
This field defaults to a blank value.

Field Explanations for Header Record 2

1. TRANS ID
This field is HER per Ministry specifications.

2. OHIP REG NUMBER
This field defaults to a blank value.

3. PATIENT LAST NAME
This field contains the last name of the patient.

4. PATIENT FIRST NAME
This field contains the first name of the patient.

5. PATIENT SEX
This field contains the sex of the patient.

6. PROVINCE CODE
This field contains the province code for the patient.

Field Explanations for Address Record

1. TRANS ID
This field is HEA per Ministry specifications.

2. ADDRESS LINE 1
This field contains the first line of the patient's address.

3. ADDRESS LINE 2
This field contains the second line of the patient's address.

4. PROVINCE
This field contains the description of the patient province.

5. CITY
This field contains the patient's city.

6. POSTCODE
This field contains the patient's postcode.

ONTARIO OUT OF PROVINCE ICD 10

The following table contains the records sent for Out of Province Claims, Claim Type 10 (Inpatient) and Claim Type 12 (Outpatient).

Ontario Out of Province, Claim Type 10, Inpatient Claim Master Records

Fld #	Description	Rqd	Print	Length	Type	Default Value	Internal Element
1	Institution Number	Y	Y	5	A		OOP INSTITUTION CODE - PROVIDER
2	Health Care Number	Y	Y	12	A		OOP HEALTH CARD NUMBER
3	Postal code	Y	Y	6	A		OOP POSTAL CODE; Print and Display:ZIP CODE-UNIVERSAL
4	Gender	Y	Y	1	A		OOP PATIENT SEX
5	Province	Y	Y	2	A		OOP PATIENT PROV FOR HC#
6	Birth Date	Y	Y	8	Date		PATIENT BIRTHDATE
7	Admission Date	Y	Y	8	Date		OOP ADMISSION DATE
8	Discharge Date	Y	Y	8	Date		OOP DISCHARGE DATE

Fld #	Description	Rqd	Print	Length	Type	Default Value	Internal Element
9	Discharge Disposition (per ministry discharge disposition may be blank if cycle bill)	N	Y	2	N		OOP DISCHARGE STATUS
10	Most Responsible Diagnosis	Y	Y	7	A		OOP Most Responsible Diagnosis
11	Principal Intervention Date	N	Y	8	Date		OOP Principal Intervention Date
12	Principal Intervention code	N	Y	10	A		OOP Principal Intervention Code
13	Coding Classification Indicator	Y	Y	1	A	0	NONE
14	Adjustment Indicator	Y	Y	1	A	N	NONE
15	Health Care Number Expiry Date	N	Y	8	Date		OOP HC# Expiry Date
16	Patient Information						
16-1	Last Name	Y	Y	20	A		PATIENT LAST NAME
16-2	First Name	Y	Y	20	A		PATIENT FIRST NAME
16-3	Patient Address Line 1	Y	Y	35	A		Patient Address 1
16-4	Patient Address Line 2	N	Y	35	A		Patient Address 2
16-5	Patient City	Y	Y	35	A		Patient City

Fld #	Description	Rqd	Print	Length	Type	Default Value	Internal Element
16-6	Patient Address Province	Y	Y	2	A		Patient State
17	Death Indicator	Y	Y	1	Y/N		OOP DEATH INDICATOR
18	Long Stay Indicator	Y	Y	1	Y/N		OOP Long Stay Indicator
19	Accident Indicator	Y	Y	1	Y/N		OOP Accident Indicator
20	Accident Code	N	Y	7			OOP Accident Code
21	Hospital Claim Number	Y	Y	15	A		ACCOUNT NUMBER
22	Claim Type	Y	Y	1	A	I	NONE
23	Record Type	Y	Y	1	A	D	NONE
24	High Cost Charge	Y	N	1	Y/N		HIGH COST CHARGE
25	Med Rec Date	Y	N	8	A		MED REC DATE
26	Hospital Code	Y	N	3	n		OOP Inpatient Hospital Code

1. INSTITUTION NUMBER

This field contains Medical Records data if available, else it contains the Institution code associated with patient's provider master appended to the value 5. Completes field 0101.

2. HEALTH CARE NUMBER

This field contains Med Rec data if available, else it contains the value from the Out of Province Patient Info Processor screen or patient data. Completes field 0301.

3. POSTAL CODE

This field contains Med Rec data or the value from the Out of Province Patient Info Processor screen or patient data. Completes field 0302.

4. GENDER

This field contains Med Rec Data or the value from the STAR Sex field. Completes field 0304.

5. PROVINCE
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen or patient data. Completes field 0305.

6. BIRTH DATE
This field contains the birth date in YYYYMMDD format. Completes field 0308.

7. ADMISSION DATE
If this is the first cycle bill, the system uses the admission date, if not, it uses the bill thru date of the previous bill; if patient has no cycle bills, it uses the patient admission date in YYYYMMDD format. Completes field 0401.

8. DISCHARGE DATE
For cycle bills, the system uses bill thru date plus 1; for final bill, it uses the discharge date in YYYYMMDD format. Completes field 0501.

9. DISCHARGE DISPOSITION
This field contains the value from Med Rec data or Ontario Reciprocal Billing Mapping Table for patient's Discharge Status/Disposition. Completes field 0505.

NOTE: Per Ministry, the discharge disposition may be blank for a cycle bill.

10. MOST RESPONSIBLE DIAGNOSIS
This field contains the value from Med Rec data or Out of Province Patient Info Processor. Completes field 1002-01.

11. PRINCIPAL INTERVENTION DATE
This field contains the value from Med Rec data or Out of Province Patient Info Processor; completes field 1101-01.

12. PRINCIPAL INTERVENTION CODE
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen; completes field 1102-01.

13. CODING CLASSIFICATION INDICATOR
This field loads the default value N to the claim. It completes field I-MOH01.

14. ADJUSTMENT INDICATOR
This field loads the default value 0 to the field. Completes field I-MOH02.

15. HEALTH CARE NUMBER EXPIRY DATE
This field contains the value from the Out of Province Patient Info Processor, Expiry Date field.or patient demographic data.

YYYYMMDD format. Completes field I-MOH03.

16. PATIENT INFORMATION
See fields 16-1 through 16-6.

16-1.LAST NAME
This field contains the last name of the patient from patient demographic data. This field completes field I-MOH04.

16-2.FIRST NAME
This field contains the first name of the patient from patient demographic data. This field completes field I-MOH05.

16-3.PATIENT ADDRESS LINE 1
This field contains the first line of the patient's address from patient demographic data. This field completes field I-MOH06.

16-4.PATIENT ADDRESS LINE 2
This field contains the second line of the patient address from patient demographic data. This field completes field I-MOH07.

16-5.PATIENT CITY
This field contains the patient's city from patient demographic data. Completes field I-MOH08.

16-6.PATIENT ADDRESS PROVINCE
This field contains the patient's province from patient demographic data. Completes field I-MOH09.

17. DEATH INDICATOR
If discharge Disposition is defined as Expiration type in STAR Discharge Status/ Disposition table, and this is a final, adjustment or late bill, this field contains Yes, otherwise, it contains No. Completes field I-MOH19.

18. LONG STAY INDICATOR
If this is a final, adjustment or late bill, and the difference between the discharge date and admission date is not less than 30 days. this field contains Y. For cycle or cycle adjustment bills, it is Y if the difference between the bill thru date+ 1 and the admission date is not less than 30 days otherwise it contains N; Completes field I-MOH-20.

19. ACCIDENT INDICATOR
This field contains the value from Out of Province Patient Info Processor screen. If blank, send N. Completes field I-MOH21.

20. ACCIDENT CODE
This field contains the value from Out of Province Patient Info Processor screen. Completes field I-MOH22.

21. HOSPITAL CLAIM NUMBER
This field contains the patients' external account number. Completes field I-MOH23.

22. CLAIM TYPE
This field contains the default value of I. Completes field I-MOH24.

23. RECORD TYPE
This field contains the default value of D. Completes field I-MOH25.

24. HIGH COST CHARGE
This information does not load to the claim. It is used for claim edits only. If the patient has a high cost procedure and associated charge, or vice versa, this field contains a Y (and pass edits). If the patient has neither a high cost procedure nor associated charge, it contains a N, (and pass edits). If the patient has one, but not both, a high cost procedure, or an H-type (high cost) charge, the field is blank and the claim fails.

25. MED REC DATE
This information does not load to the claim. It is used only to create a claim edit. This field loads N/A if patient type is not in Patient types for OOP Data Entry table or result of cycle bill; else loads date Med Rec data was processed.

26. HOSPITAL CODE
This field contains the OOP inpatient hospital code, assigned based on the patient type associated with the first charge appearing in the claim charge data. It is used to identify the download data file in which to include the patient.

Ontario Out of Province, Claim Type 12, Outpatient Claim Master Records

Fld #	Description	Rqd	Print	Length	Type	Default Value	Internal Element
1	Reporting Facility Amb Care Number	Y	Y	5	A		OOP INSTITUTION NUMBER - PROVIDER
2	Health Care Number	Y	Y	12	A		OOP Health CARD NUMBER
3	Providence	Y	Y	2	A		OOP Patient Prov for HC #
4	Postal Code	Y	Y	6	A		OOP ZIP (POSTAL) CODE ; Print and Display:ZIP CODE-UNIVERSAL
5	Gender	Y	Y	1	A		OOP PATIENT SEX
6	Birth Date	Y	Y	8	D		PATIENT BIRTHDATE YYYYMMDD
7	Main Problem	N	Y	7	A		OOP MOST RESPONSIBLE DIAGNOSIS
8	Main Intervention	N	Y	10	A		OOP PRINCIPAL INTERVENTION CODE

Fld #	Description	Rqd	Print	Length	Type	Default Value	Internal Element
9	Main Intervention Date	N	Y	8	D		OOP PRINCIPAL INTERVENTION DATE
10	Coding Classification Indicator	Y	Y	1	N	0	NONE
11	Adjustment Indicator	Y	Y	1	A	N	NONE
12	Health Care Number Expiry Date	N	Y	8	N		OOP HC# EXPIRY DATE
13	Patient Information						
13-1	Last Name	Y	Y	20	A		PATIENT LAST NAME
13-2	First Name	Y	Y	20	A		PATIENT FIRST NAME
14	Hospital Claim Number	Y	Y	15	A		ACCOUNT NUMBER
15	Claim Type	Y	Y	1	A	O	NONE
16	Record Type	Y	Y	1	A	D	NONE
17	Med Rec Date	Y	N	8	A		MED REC DATE
18	Hospital Code	Y	N	3	N		OOP Outpatient Hospital Code

Field Explanations

1. REPORTING FACILITY AMB CARE NUMBER
This field contains the value from institution field from provider master associated with the patient appended to the value 5. Completes field 00B.

2. HEALTH CARE NUMBER
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen or patient data. Completes field 2.

3. PROVIDENCE
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen or patient data. Completes field 3.

4. POSTAL CODE
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen or patient data. Completes field 5.

5. GENDER
This field contains the value from Med Rec Data or STAR patient sex; Completes field 7.

6. BIRTH DATE
This field contains the patient's date of birth from Med Rec data or patient data. This completes field 8.

7. MAIN PROBLEM
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen; Completes field 44.

8. MAIN INTERVENTION
This field contains the value from Med Rec data or Out of Province Patient Info Processor; Completes field 46.

9. MAIN INTERVENTION DATE
This field contains the value from Med Rec data or Out of Province Patient Info Processor screen; completes field 109.

10. CODING CLASSIFICATION INDICATOR
This field contains the default value from the claim load & edit parameter, which should be zero. This field completes field O-MOH01.

11. ADJUSTMENT INDICATOR
This field contains the default value of N. This field completes field O-MOH02.

12. HEALTH CARE NUMBER EXPIRY DATE
This field completes the value from Out of Province Patient Info Processor screen or patient data; Completes field O-MOH03.

13. PATIENT INFORMATION
See fields 13-1 through 13-2.

13-1.LAST NAME
This field contains the patient's last name from patient demographic data. This field completes field O-MOH04.

13-2.FIRST NAME
This field contains the patient's first name from patient demographic data. This field completes field O-MOH05.

14 .HOSPITAL CLAIM NUMBER
This field contains the patient's external account number. This field completes field O-MOH08

15. CLAIM TYPE
This field contains the default value of O. This field completes field O-MOH09

16. RECORD TYPE
This field contains the default value of D.This field completes field O-MOH10

17. MED REC DATE
This field loads N/A if patient type is not in Patient types for OOP Data Entry table or result of cycle bill; else loads date Med Rec data was processed. This field does not output in the Out of Province submission data. It is used for claim edits only.

18. HOSPITAL CODE
This field contains the OOP outpatient hospital code, based on the patient type for the claim. If that patient type appears in the Hospital Codes for Patient Types with a Hospital Code, the Hospital Code is used. Otherwise, the Hospital Code from Download Parameters found under Ontario Electronic Reciprocal Billing Parameters is used. When the download occurs, a separate file is created for each of the Hospital Codes with claim data.

WCB CLAIM MASTER

The following table contains the records sent to the Ontario Worker's Compensation Board (Claim Type W).

You specify which charges should be included on the various WCB claims by entering the WCB claim type code in the field Alternate Summary Code 3 on the FIM.When the claim is loaded, the system looks to this field to determine if the charge should be included on a WCB claim and if so, which specific claim. Charges cannot appear on more than one WCB claim.

The process is as follows:

When the claim is loaded, all charges associated with any of the six WCB claims are loaded with separate claim sequence numbers. The information for each charge includes the data required for each claim. When the claim is released and printed, it is formatted according to the specifications of the specific claim.

The following explain the six WCB claim forms in more detail.

WCB claims consist of six different forms. These are Laboratory, Out Patient, Community Clinic, Occupational Therapy and Physical Therapy (which share one form), Radiology, and In Patient.

The charge detail information for the individual claim includes all datarequired for each claim. The following describes each claim form:

1. Claim L, Laboratory

The charge detail on this claim is sorted by service date. Each individual charge prints on a separate line and the charges do not summarize. These claims print relative value units rather than quantity. The laboratory claim form prints LMS units. If the LMS units on a laboratory claim total more than 99, the charges are split onto multiple claim forms when they print. If the dollar amount of a charge line nets to zero, it is suppressed from printing.

2. Claim O, Out Patient

The charge detail prints by service date. Each individual charge prints on a separate line and the charges do not summarize. If thedollar amount of a charge line nets zero, it is suppressed from printing.

3. Claim C, Community Clinic

This claim summarizes by diff code. The diff code is located in the Alternate Summary Code 2 field on the FIM. Diff codes 92 and 93 cannot exist without diff code 91. If a claim is loaded with this condition, it fails the edit, and the error message *Missing Diff Code 91* is displayed. Only charges with diffcodes 91, 92, or 93 and flagged with claim code C, Community Clinic, print on this claim form. If the dollar amount of a charge line nets to zero, it is suppressed from printing.

4. Claim T, Occupational Therapy, and Claim P, Physical Therapy
A mark must be made on the claim form to distinguish between Occupational Therapy and Physical Therapy. Occupational Therapy prints an X, and Physical Therapy prints XX in order to aid you with identification and form alignment. In addition to alternate summary code = T, O for occupational therapy or P for physical therapy must be entered in the Type of Service field on the FIM.

If charges for a therapy claim cross multiple months, then the system loads and print multiple therapy claims.

The therapy claim prints quantity rather than number of days.

If the dollar amount of a charge line nets to zero, it is suppressed from printing.

5. Claim R, Radiology
Charge detail on this claim is sorted by service date. Each individual charge prints on a separate line and the charges do not summarize. If the dollar amount of a charge line nets to zero, it is suppressed from printing.

6. Claim I, In Patient
Only room and bed charges are displayed on this form. Print a separate line for each different diff code. Only charges flagged as Room/Bed charges are included on this claim form. A charge can be flagged as a WCB In Patient charge, but if it is not a Room/Bed charge, it is not included on the claim. If the dollar amount of a charge line nets to zero, it is suppressed from printing.

7. Claim E, Airec (acute injury rehab evaluation centre) Daily Evaluation
Only charge detail which has an alternate summary code 3 value of E will print to this claim. This claim summarizes by assessment date.

WCB Claim Master Records

The same procedure is used for the WCB as with the OHIP when you are setting the Claim Load and Edit Parameters. The following table contains the records that are sent to the Ministry.

Box	Description	Req	Prt	Row	Colm	Lgth	Type	Valid	Def	Internal Element
1	Agency Reg No	Y	Y	2	8	14	A			This field is preprinted by the Ministry and is blank.
2	Pt Name	Y	Y	2	30	25	A			Patient Name
3	Claim No	Y	Y	2	68	22	N			WCB Claim Number from the Insurance Plan

Box	Description	Req	Prt	Row	Colm	Lgth	Type	Valid	Def	Internal Element
4a	Provider Name	Y	Y	4	3	25	A			This field is preprinted and is blank.
4b	Provider Address 1	Y	Y	5	3	25	A			This field is preprinted and is blank.
4c	Provider Address 2	Y	Y	6	3	25	A			This field is preprinted and is blank.
5a	Patient Address 1	Y	Y	4	30	25	A			Patient Address 1
5b	Patient Address 2	Y	Y	5	30	25	A			Patient Address 2
5c	Patient Province	Y	Y	6	30	18	A			Patient State
5d	Patient Postcode	Y	Y	6	50	2	A			Patient Zip
6	Treatment Agency Ref Number	Y	Y	9	3	25				Patient Account Number
7	Birthdate	Y	Y	9	30	9				Patient Birthdate
8	Social Insurance Number	Y	Y	9	40	15	N			Patient SS No
9	Accident Date	N	Y	9	57	10	N			Acc/Occ Date
10	Nature of Disability	Y	Y	11	3	30	A			Admitting Diagnosis Desc
11a	Insured's Employer Information	N	Y	11	35	18				Insured's Employer Information
11b	Insured's Employer Postal Code	N	Y	11	55	18				Insured's Employer Zip Code
12	Referral Date	N	Y	8	67	10	D			Admission Date

NOTE: The Treating Agency Signature is not a field since it does not exist on all claim forms.

The following provides a brief explanation of the fields in the WCB Claim Master Records.

1. AGENCY REFERENCE NUMBER
This field is preprinted by the Ministry and is not printed by STAR Financials.

2. PATIENT NAME
This field contains the patient's name in the format LAST, FIRST.

3. CLAIM NUMBER
This is the WCB claim number from the patient insurance plan. The claim number is generally an eight-digit number.

4a. PROVIDER NAME
The provider name and address is preprinted on the claim form.

4b. PROVIDER ADDRESS 1
Refer to the provider name field explanation.

4c. PROVIDER ADDRESS 2
Refer to the provider name field explanation.

5a. PATIENT ADDRESS 1
This field contains the first line of the patient's address.

5b. PATIENT ADDRESS 2
This field contains the second line of the patient's address.

5c. PATIENT PROVINCE
This field contains the province in which the patient lives.

5d. PATIENT POSTAL CODE
This field contains the postcode of the patient. The postcode format is A1A1A1.

6. TREATING AGENCY REFERENCE NUMBER
This field contains the patient's account number.

7. BIRTHDATE
This field contains the patient's birthdate.

8. SOCIAL INSURANCE NUMBER
This field contains the Health Insurance Number of the patient.

9. ACCIDENT DATE
The accident date prints in this field if it exists for the patient. Internal elements first look at medical information, then check WCB Insurance Demographics Incident Date.

10. NATURE OF DISABILITY
This field contains the Principal Diagnosis Description.

11a. EMPLOYER NAME
This field contains the name of the patient's employer.

11b. EMPLOYER ADDRESS
This field contains the address of the patient's employer. This field prints the employer's street address, province, and postcode and truncates as necessary.

12. REFERRAL DATE
This locator prints only for AIREC (E type) claims)

UNIVERSAL CLAIM MASTER

The following table contains the record sent to other insurers and may be used to submit to payors accepting the Universal claim form (claim Type K.).

Universal Claim Master Records

The following table contains the record of the Claim Load and Edit Parameters for a Universal claim.

Box	Description	Req	Prt	Row	Colm	Lgth	Type	Valid	Def	Internal Element
1	Carrier Name	Yes	Yes	4	11	66	X			Ins Car/Pln Name
2	Carrier Address 1	Yes	Yes	7	11	66	X			Ins Car/Pln Address 1,2, City, Province, Post Code
3	Insured Name	Yes	Yes	11	11	42	X			Insured's Name
4	Insured Birthday	Yes	Yes	11	61	17	D			Insured's Birthdate
5	Insured Address	Yes	Yes	13	11	66	X			Insured's Address, City, Province, Post Code
6	Relation	Yes	Yes	15	6,19,32,45	1	X the box			1500 Patient Relation to Insured
7	Policy No	Yes	Yes	17	13	14 9				Cert/SSN/ HIC Number
8	Section No	Yes	Yes	17	38	15	9 OR X			Insurance group number
9	ID Number	No	No	17	62	16	9 OR X			Certificate Number - Canada
10	Insured's Employer	Yes	Yes	20	11	66	X			Ins's Employer Name
11	Patient Name	Yes	Yes	24	11	42	X			Patient Name
12	Patient Bday	Yes	Yes	24	61	22	D			Patient Birthdate

Box	Description	Req	Prt	Row	Colm	Lgth	Type	Valid	Def	Internal Element
13	Patient Address	Yes	Yes	26	11	66	X			Patient Address, City, Province and Post Code
14	Benefits	Yes	Yes	28	6=N, 14=Y	1	X the box			Canadian Hospital Benefits
15	Other Policy Number	No	Yes	30	9	18	9 OR X			If Benefits = Y, print other insurance policy number. (Cert/SSN/ HIC ID Number)
16	Other Carrier	No	Yes	30	29	24	X			If Benefits = Y, print other insurance name. (Insurance Carrier/Plan Name)
17	Insured's Birthday	No	Yes	30	55	22	D			If Benefits = Y, print insured's birthdate. (Insured's Birthdate)
18	Assignment Date	Yes	Yes	35	14	13	D			Admission Date
19	Insured Signature	Yes	Yes	35	48	30	X		Signa-ture on file	none
20	ROI Date	Yes	Yes	39	16	13	X			Admission Date
21	Patient Signature	Yes	Yes	39	48	30	X		Signa-ture on file	none
22	Hospital Name	No	Yes	44	11	66	X			
23	Hospital Address	No	Yes	46	11	66	X			
24	Account Number	Yes	Yes	48	11	17	X			Account Number
25	Patient Name	Yes	Yes	48	37	41	X			Patient Name

Box	Description	Req	Prt	Row	Colm	Lgth	Type	Valid	Def	Internal Element
26	Admit Date	Yes	Yes	50	19	9	D			Bill From Date
27	Discharge Date	Yes	Yes	50	43	11	D			Bill Thru Date
28	Daily Differential	Yes	Yes	50	68	10	M			Most common semi-private rate from PAAR control
29	Type of Care	Yes	Yes	52	4	1	X the box			
30	Work Related Indicator	No	Yes	52	62=Y 70=N	1	X the box		X	Canadian Universal Work Related ACC
31	Claim Date	No	No	66	14	14	D			Claim Gen Date
32	Biller Signature	No	No	66	42	36	X			Biller Name-Insurance

The following provides a brief explanation of the fields in the Universal Claim Load and Edit parameters.

1. CARRIER NAME
This field contains the carrier name.

2. CARRIER ADDRESS
This field contains the carrier address.

3. INSURED NAME
This field contains the insured's name.

4. INSURED BIRTHDAY
This field contains the insured's birthday.

5. INSURED ADDRESS
This field contains the insured's address.

6. RELATION
This field contains the patient's relationship to the insured.

7. POLICY NUMBER
This field contains the insured's policy number.

8. SECTION NUMBER
This field contains the insurance section number.

9. ID NUMBER
This field contains the insurance identification number.

10. INSURED'S EMPLOYER
This field contains the insured's employer name.

11. PATIENT NAME
This field contains the patient's name in the format of LAST, FIRST.

12. PATIENT BIRTHDAY
This field contains the patient's birthday.

13. PATIENT ADDRESS
This field contains the patient's address.

14. BENEFITS
This field contains a **Yes** or **No** and indicates whether the patient has hospital benefits covered under any other plan. The Benefits flag is set to Yes if there are two commercial insurances or if there is WCB and a commercial insurance.

15. OTHER POLICY NUMBER
This field contains the policy number of the patient's other hospital benefit plan if the Benefits flag is set to Yes.

16. OTHER CARRIER
This field contains the carrier name of the patient's other hospital benefit plan if the Benefits flag is set to Yes.

17. INSURED'S BIRTHDAY
This field contains the insured's birthday.

18. ASSIGNMENT DATE
This field contains the assignment date.

19. INSURED SIGNATURE
This field contains the insured signature.

20. ROI DATE
This field contains the ROI date.

21. PATIENT SIGNATURE
This field contains the patient's signature and defaults with Signature on File.

22. HOSPITAL NAME
This field contains the hospital name.

23. HOSPITAL ADDRESS
This field contains the hospital address.

24. ACCOUNT NUMBER
This field contains the patient's account number.

25. PATIENT NAME
This field contains the patient's name.

26. ADMIT DATE
This field contains the patient's admission date.

27. DISCHARGE DATE
This field contains the patient's discharge date.

28. DAILY DIFFERENTIAL
This field contains the normal semi-private room rate.

29. TYPE OF CARE
This field contains the type of care indicator.

30. WORK RELATED INDICATOR
This field contains a **Yes** or **No** and indicates whether confinement is due to work related accident or sickness. If yes, then position 64 on the claim is marked with an X; otherwise position 70 on the form is marked.

31. CLAIM DATE
This field contains the date the claim was generated.

32. BILLER SIGNATURE
This field contains the biller signature and defaults with Signature on File.

PATIENT BILL CLAIM MASTER

The following table contains the record sent to insurers that do not require a specific claim form. Claim Type Y produces a claim that lists charges and header information in the format of the Canadian Patient Bill.

Patient Bill Claim Master Records

The following table contains the record of the Claim Load and Edit Parameters for a Patient Bill claim that are sent to the Ministry.

Box	Description	Req	Prt	Row	Colm	Lgth	Type	Valid	Def	Internal Element
1	Bill Date	Y	Y	5	69	10	D			Bill Date
2	Patient Name	Y	Y	8	1	25	A			Patient Name
3	Patient Account Number	Y	Y	8	29	11	X			Account Number
4	Guarantor Corporate Number	Y	Y	8	43	8	X			Corporate Number
5	Admit Date	Y	Y	8	58	10	D			Admission Date
6	Discharge Date	N	Y	8	69	10	D			Discharge Date
7a	Insurance Name	Y	Y	11	15	25	X			Insurance Carrier/Plan Name
7b	Insurance Address	Y	Y	12	15	25	X			Insurance Address Line 1
7c	Insurance City	Y	Y	13	15	18	X			Insurance City
7d	Insurance State	Y	Y	13	34	2	X			Insurance State
7e	Insurance Country	Y	Y	14	15	19	X			Insurance Country
7f	Insurance ZIP Code	Y	Y	14	35	10	X			Insurance ZIP Code

The following provides a brief explanation of the fields in the Patient Bill Claim Load and Edit parameters.

1. BILL DATE
This field contains the bill date.

2. PATIENT NAME
This field contains the patient's name.

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

4. GUARANTOR CORPORATE NUMBER
This field contains the guarantor's corporate number.

5. ADMIT DATE
This field contains the patient's admission date.

6. DISCHARGE DATE
This field contains the patient's discharge date.

Mail To Information

The insurance fields listed below extract the insurance information from the insurance carrier/plan associated with the claim.

7a. INSURANCE NAME
This field contains the name of the patient's insurance carrier.

7b. INSURANCE ADDRESS
This field contains the first line of the insurance carrier's address.

7c. INSURANCE CITY
This field contains the insurance carrier's city.

7d. INSURANCE STATE
This field contains the insurance carrier's province.

7e. INSURANCE COUNTRY
This field contains the insurance carrier's country.

7f. INSURANCE ZIP CODE
This field contains the insurance carrier's postal code.

BC MSP CLAIM MASTER

The following table contains the form locators used to compile the demographic information sent to the British Columbia Ministry of Health for MSP claims (Claim Type P). The system creates one MSP General Information record per account for each bill sequence. The hospital can set up as many claim load and edit parameters as required.

BC MSP Claim Master Records

Box	Description	Req	Prt	Start	End	Lgth	Type	Valid	Def	Internal Element
MSP General Information										
1	MSP Rec Code Ident	Yes	Yes	1	N/A	3	AN		C01	N/A
2	MSP Data Centre #	Yes	Yes	4	N/A	5	AN			N/A
3	MSP Reg #	Yes	Yes	9	N/A	10	AN			Health Card Number
4	MSP Patient Name Verif	Yes	Yes	19	N/A	4	AN			Patient Name Verification (FMLL)
5	MSP Dependent #	Yes	Yes	23	N/A	2	AN			Patient Health Card Version #
6	MSP Service To Day	Yes	Yes	25	N/A	2	AN			MSP Service To Date
7	MSP Office Folio #	No	Yes	27	N/A	2	AN		00	N/A
8	MSP Correspondence Code	No	Yes	31	N/A	1	AN	0,B,C,N	0	N/A
9	MSP Patient Birth Date	Yes	Yes	32	N/A	4	D			Patient Birthdate
10	MSP Motor Vehicle Acc	No	Yes	36	N/A	1	AN	N,Y		Motor Vehicle Accident
11	MSP ICBC Claim Number	No	Yes	37	N/A	8	AN			Case Number
MSP Part 2 for Reciprocal Billing										
1	MSP2 Insurer Code	Yes	Yes	46	47	2	AN			MSP2 Patient Prov for HC#.
2	MSP2 Registration Number	Yes	Yes	48	59	12	AN			MSP2 Patient Health Card Number.

Box	Description	Req	Prt	Start	End	Lgth	Type	Valid	Def	Internal Element
3	MSP2 Patient Date of Birth	Yes	Yes	60	67	8	Date			MSP2 Patient Date of Birth.
4	MSP2 Patient First Name	Yes	Yes	65	76	12	AN			MSP2 Patient First Name.
5	MSP2 Patient Middle Initial	Yes	Yes	77	77	1	AN			MSP2 Patient Middle Initial.
6	MSP2 Patient Last Name	Yes	Yes	78	98	18	AN			MSP2 Patient Last Name.
7	MSP2 Patient Gender	Yes	Yes	96	96	1	AN			MSP2 Patient Gender.
8	MSP2 Patient Address 1	Yes	Yes	97	121	25	AN			MSP2 Patient Address 1.
9	MSP2 Patient Address 2	Yes	Yes	122	146	25	AN			MSP2 Patient Address 2.
10	MSP2 Patient City	Yes	Yes	147	172	25	AN			MSP2 Patient City.
11	MSP2 Patient Province	Yes	Yes	173	197	25	AN			MSP2 Patient Province.
12	MSP2 Patient Postal Code	Yes	Yes	198	203	6	AN			MSP2 Patient Postal Code.

Field Explanations - MSP General Information

1. MSP RECORD CODE IDENTIFIER
This field defaults to C01 in the master claim load and edit parameter, but is not used for actually creating the claim to send to the Ministry. It is included in the download file as a C02 per British Columbia Ministry specifications.

2. MSP DATA CENTRE NUMBER
This field contains the data center number that has been assigned by the Ministry. The hospital should enter their assigned number in the default value.

3. MSP REGISTRATION NUMBER
This field contains the patient's British Columbia Health Card Number.

4. MSP PATIENT NAME VERIFICATION
This field contains the first initial of the first name, followed by first initial of middle name or blank, followed by the first 2 characters of the patient's last name.

5. MSP DEPENDENT NUMBER
This field contains the patient's British Columbia Health Card Version Number.

6. MSP SERVICE TO DAY
This field contains the 2-digit day of an inpatient's discharge date. It contains zeroes if the patient has not been discharged. This field contains zeroes for outpatients.

7. MSP OFFICE FOLIO NUMBER
This field defaults to 00.

8. MSP CORRESPONDENCE CODE
This field defaults to 0.

9. MSP PATIENT BIRTH DATE
This field contains the patient's birthdate in YYMM format. It is included in the download file in CCYYMMDD format.

10. MSP MOTOR VEHICLE ACCIDENT
This field indicates whether the patient was involved in a motor vehicle accident. It contains a Y or N depending on the road traffic accident indicator in the accident type. If the visit was not as a result of an accident, the field will be set to "N".

11. MSP ICBC CLAIM NUMBER
This field contains the Case Number as entered on the Accident Information screen.

Field Explanations - MSP Part 2 for Reciprocal Billing

1. MSP2 INSURER
This field contains the HC Prov. maintained in the Pers Hlth #/Unit Code/Exp Date field of the Patient Page.

2. MSP2 REGISTRATION NUMBER
This field contains the Pers Health # maintained in the Pers Hlth #/Unit Code/Exp Date field of the Patient Page.

3. MSP2 PATIENT DATE OF BIRTH
This field contains the Birthdate from the Birthdate field on the Patient Page.

4. MSP2 PATIENT FIRST NAME
This field contains the patient first name from the Name field on the Patient Page.

5. MSP2 PATIENT MIDDLE INITIAL
This field contains the patient middle initial from the Name field on the Patient Page. It is the middle initial or the first character of the middle name.

6. MSP2 PATIENT LAST NAME
This field contains the patient last name from the Name field of the Patient Page.

7. MSP2 PATIENT GENDER
This field contains the patient gender from the Sex field on the Patient Page.

8. MSP2 PATIENT ADDRESS 1
This field contains the patient address 1 from the Address Line 1 field of the Patient Page.

9. MSP2 PATIENT ADDRESS 2
This field contains the patient address 2 from the Address Line 2 field of the Patient Page.

10. MSP2 PATIENT CITY
This field contains the patient city from the City field on the Patient Page.

11. MSP2 PATIENT PROVINCE
This field contains the patient province from the Pr field of the Patient Page.

12. MSP2 PATIENT POSTAL CODE
This field contains the patient postal code from the Postcode field on the Patient Page.

BC WORKER'S COMP ELEC

The following table contains the records sent to the British Columbia Worker's Compensation Board for outpatient Worker's Compensation claims. Claim type "Q" looks exactly like the MSP claim type. However, when the records are downloaded some information filled out for MSP is sent as zeros because the information appears in more detail at the end of the record.

BC Worker's Comp Elec Claim Master Records

Box	Description	Req	Prt	Start	End	Lgth	Type	Valid	Def	Internal Element
1	MSP Rec Code Ident	Yes	Yes	1	N/A	3	AN		C01	N/A
2	MSP Data Centre #	Yes	Yes	4	N/A	5	AN			N/A
3	MSP Reg #	Yes	Yes	9	N/A	10	AN			Health Card Number
4	MSP Patient Name Verif	Yes	Yes	19	N/A	37	AN			Patient Name
5	MSP Dependent #	Yes	Yes	23	N/A	2	AN			Patient Health Card Version #
6	MSP Service To Day	Yes	Yes	25	N/A	2	AN			MSP Service To Date
7	MSP Office Folio #	No	Yes	27	N/A	2	AN		00	N/A
8	MSP Correspondence Code	No	Yes	31	N/A	1	AN	0,B,C, N	0	N/A
9	MSP Patient Birth Date	Yes	Yes	32	N/A	4	D			Patient Birthdate
10	MSP Motor Vehicle Acc	No	Yes	36	N/A	1	AN		N	N/A
11	MSP ICBC Claim Number	No	Yes	37	N/A	8	AN			Case Number

Field Explanations

1. MSP RECORD CODE IDENTIFIER
This field defaults to C01 in the master claim load and edit parameter, but is not used for actually creating the claim to send to the Ministry. It is included in the download file as a C02 per British Columbia Ministry specifications.

2. MSP DATA CENTRE NUMBER
This field contains the data center number that has been assigned by the Ministry. The hospital should enter their assigned number in the default value.

3. MSP REGISTRATION NUMBER
This field contains the patient's British Columbia Health Card Number. It is included in the download file as zeroes per British Columbia Ministry specifications. The registration number is included in the reciprocal record when sent to the Ministry.

4. MSP PATIENT NAME VERIFICATION
This field contains the patient's name in last name, first name, and middle name format. It is included in the download file as blanks per British Columbia Ministry specifications, and the patient's name is included in the reciprocal record broken out by patient first name, patient middle name initial or blank, and patient's last name.

5. MSP DEPENDENT NUMBER
This field contains the patient's British Columbia Health Card Version Number. It is included in the download file as zeroes per British Columbia Ministry specifications.

6. MSP SERVICE TO DAY
This field contains the 2-digit day of an inpatient's discharge date. It contains zeroes if the patient has not been discharged. This field contains zeroes for outpatients.

7. MSP OFFICE FOLIO NUMBER
This field defaults to 00.

8. MSP CORRESPONDENCE CODE
This field defaults to 0.

9. MSP PATIENT BIRTH DATE
This field contains the patient's birthdate in YYMM format. It is included in the download file in CCYYMMDD format.

10. MSP MOTOR VEHICLE ACCIDENT
This field defaults to "N" for Worker's Compensation claims.

11. MSP ICBC CLAIM NUMBER
This field contains the Case Number as entered on the Accident Information screen. For Worker's Compensation Claims this number should be zeroes.

BC OUT OF PROVINCE CLAIM MASTER

The following table contains the records sent for Out of Province Claims, Claim Type V. The hospital can set up as many claim load and edit parameters as required.

BC Out of Province Claim Master Records

Box	Description	Req	Prt	Start	End	Lgth	Type	Valid	Def	Internal Element
1	Patient Account #	Yes	Yes	1	N/A	9	AN			Account Number
2a	Patient Last Name	Yes	Yes	9	N/A	18	AN			Patient Last Name
2b	Patient First Name	Yes	Yes	27	N/A	12	AN			Patient First Name
3a	Patient's Address 1	Yes	Yes	39	N/A	25	AN			Patient Address 1
3b	Patient's Address 2	No	Yes	64	N/A	25	AN			Patient Address 2
3c	Patient's City	Yes	Yes	89	N/A	25	AN			Patient City
3d	Patient's Province Code	Yes	Yes	114	N/A	2	AN			Patient State
3e	Patient's Postal Code	Yes	Yes	116	N/A	6	AN			Patient Zip Code
4	Patient's Insurance Number	Yes	Yes	122	N/A	12	AN			Cert/SSN/ HIC ID Number
5	Patient's Birthdate	Yes	Yes	134	N/A	10	D			Patient Birthdate
6	Patient Sex	Yes	Yes	142	N/A	1	AN			Patient Sex
7	Patient's Admit Date	Yes	Yes	158	N/A	10	D			Admission Date
8	Patient's Discharge Date	Yes	Yes	166	N/A	10	D			Discharge Date
9	Deceased Flag	Yes	Yes	184	N/A	1	Y	N,Y		Deceased Flag
10	Reason in British Columbia	Yes	Yes	186	N/A	1	AN			Residence Type
11	Accident Code	No	Yes	152	N/A	6	AN			ECODE Diagnosis Code

Field Explanations

1. PATIENT ACCOUNT NUMBER
This field contains the Patient Account Number.

2a. PATIENT LAST NAME
This field contains the patient's last name.

2b. PATIENT FIRST NAME
This field contains the patient's first name.

3a. PATIENT'S ADDRESS 1
This field contains Address Line 1 of the patient's address.

3b. PATIENT'S ADDRESS 2
This field contains Address Line 2 of the patient's address.

3c. PATIENT'S CITY
This field contains the patient's city.

3d. PATIENT'S PROVINCE CODE
This field contains the patient's province.

3e. PATIENT'S POSTAL CODE
This field contains the patient's postal code.

4. PATIENT'S INSURANCE NUMBER
This field contains the patient's health card number. It is entered in the policy # field on the out of province insurance screen.

5. PATIENT'S BIRTH DATE
This field contains the patient's birthdate in YYYYMMDD format.

6. PATIENT'S SEX
This field contains the sex of the patient.

7. PATIENT'S ADMIT DATE
This field contains the patient's admission date in YYYYMMDD format.

8. PATIENT'S DISCHARGE DATE
This field contains the patient's discharge date in YYYYMMDD format.

9. DECEASED FLAG
This field contains a Y if the patient is deceased; otherwise, it contains N.

10. REASON IN BRITISH COLUMBIA
This field contains the one character code indicating the reason the patient is in British Columbia. This is entered in the Out of Province Reason field on the Out of Province

insurance screen. The Out of Province Reason field table should be completed with valid entries for electronic claim submission.

11. ACCIDENT CODE

This field contains the first E-diagnosis code encountered in the secondary diagnosis string for the patient when the facility is using ICD-9 diagnosis codes. Once the conversion is made to ICD-10 diagnosis codes, the accident code reported will be the first secondary diagnosis meeting one of the following criteria: the first character of the diagnosis begins with a “V” and the first 2 digits of the diagnosis code are greater than zero; the first character of the diagnosis begins with a “W” or an “X”; or the first character of the diagnosis code begins with a “Y” and the first 2 digits of the diagnosis code are less than ninety-nine (99).

Chapter 2 - CLAIM TYPES

INTRODUCTION

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

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

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

THE CLAIMS PROCESS

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

Claim Load and Edit

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

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

- Claim Load and Edit Parameters

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

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

- Claim Generation Parameters

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

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

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

spoolfile. Claims submitted by diskette, such as the OHIP claims in Canada, do not create pages or spooled files, and therefore these can not be printed.

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

Claim Review and Release

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

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

Claim Status

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

PRODUCTION STATUS CODES

Production status codes indicate whether the claim has been:

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

WORK STATUS CODES

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

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

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

- **Delete (D)**

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

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

- **Edit (E)**

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

- **Fail (F)**

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

  Claims also fail if attachments are required. On the OHIP claims, charges can cause claims to fail edits for the following:

  - Performing Dr ID error, if an invalid performing doctor exists on a charge line.

  - SoB Error, if an invalid SoB code exists on a charge line, or if two claim charge detail lines have the same service date and SoB code but different billing physicians.

  - Diagnosis Code Errors, if the SoB code requires a diagnosis but one does not exist for the claim charge detail line.

  - Invalid Qty Errors, if the quantity is zero or a credit.

- Referring Dr ID Errors, if the referring doctor ID is not present.

- **Hold (H)**

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

- **Manually Released (M)**

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

- **System Released (R)**

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

- **System Released Forced (S)**

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

- **Suppressed (P)**

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

- **Claim Disposition**

  Refer to the Claim Disposition field for additional information.

CLAIMS PROCESSING

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

- Maintain Claims by Account
- Maintain Claims by Biller
- Add Claim to Insurance
- Balance Transfer and Claim Disposition
- Archive Claims
- Purge Archived Claims
- Print Pending Claims Report
- Ministry Claim Data
- Recreate Download Diskette

Accessing Claims By Account

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

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

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

```
              General Hospital Account Inquiry Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                          FC Typ Admit    Disch      Balance Loc
C01000001    TESTBERRY,OUTPATIENTONE       OH XRC 02/01/22 02/01/22   30.44   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     02/02/22 02/02/22 BC MS NP   F           111111,BRITISH COLUMBIA



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

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

Field Explanations

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

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

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

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

CLM TYPE (DISPLAY ONLY)
This field contains the type of claim form for this claim. The above example includes a BC MSP claim type.

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

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

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

OPPS STS (DISPLAY ONLY)
This field indicates the status of an OPPS claim and is not applicable for Canada.

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

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

You may select a claim by entering the number of the claim you want to view, or you may choose to limit the claims that are displayed by entering I, C, or O. If you select I, only incomplete claims are displayed. If you enter C, only completed claims are displayed. If you select L, all claims are displayed, and it is included in this prompt to allow you to see all claims after limiting the claims that are displayed.

If you select O, the following prompt is displayed:

Limit claims by 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 can select one or more claim types to be displayed for the account. The display is limited to claims valid for the facility. Valid claim types for Canada include:

```
              General Hospital Account Inquiry Processor
                                                 Fri Jul 03, 2009 08:00 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
J5-0260771   MOON, BOB            OP O/P 09/06/10 09/06/10      855.00 AR /ACCF

Page:01                            Claim Types                ##=Current Choices
( 1) 1-IL 1443
( 2) 10-ON OOP ICD10
( 3) 12-ON OOP ICD10 OP
( 4) 7-ON OOP
( 5) 8-ON OOP OP
( 6) H-Ministry of Health
( 7) K-UNV
( 8) P-BC MSP
( 9) Q-BC WORKER'S COMP ELEC
(10) V-BC Out of Prov.
(11) W-WCB CAN.
(12) Y-CPBC









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
                                                 Tue Mar 14, 2006 10:33 am
Account      Name                       FC Typ Admit    Disch      Balance Loc
C01000001    TESTBERRY,OUTPATIENT ONE   OH XRC 02/01/22 02/01/22   30.44   AR/FCRV

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




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

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

If you select **B**, the system displays the following prompt:

Enter earliest bill thru date [Earliest] –

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

Enter latest bill thru date [Latest] –

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

If you select S, the system displays the following prompt:

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

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

Enter latest submission date [Latest] –

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

Selecting a claim that has a production status of Produced or Suppressed for detail review presents you with these options shown on the following screen:

```
          General Hospital Maintain Claims by Account Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                          FC Typ Admit    Disch      Balance Loc
C01000001    TESTBERRY,OUTPATIENT ONE      OH XRC 02/01/22 02/01/22   30.44   AR/FCRV

     Clm Adj   Bill     Bill   Clm   Prd Wk  OPPS Clm
     Seq Clm   From     Thru   Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
       1     01/22/02 01/22/02 BC MS P    M           111111,BRITISH COLUMBI

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


Enter option number--
```

NOTE: The above screen is for a claim that has already been produced or manually released. If this claim had not been produced or manually released, the Reload Claim Demographic/Visit Errors option would display as option 9, rather than the Re-Print Claim option. The Reload Claim Demographic/Visit Errors option is only available until the claim is produced or manually released. Following one of these events, the Re-Print Claim option becomes available.

If you select archived or purged claims, the system presents the first two menu options only.

Accessing Claims by Biller

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

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

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

```
                General Hospital Claims by Biller Processor
                                                Tue Jun 20, 1994 10:24 pm
Biller:ASHLAND,MARY
Page:01                          Claim Types                ##=Current Choices
( 1) Claims that Failed Edits
( 2) Claims that Passed Edits
( 3) Generated Claims Not Yet Submitted
( 4) Claims Already Submitted
( 5) Claims Replaced by Adjustment Claims
( 6) Completed Claims









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

- **Claims that Failed Edits**

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

- **Claims that Passed Edits**

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

- **Generated Claims not Yet Submitted**

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

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

- Biller statistics are updated when claims are submitted.

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

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

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

- **Claims Already Submitted**

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

- **Claim Replaced by Adjustment Claims**

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

- **Completed Claims**

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

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

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

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

If you access Claims by Biller and then request Claims that Failed Edits, Claims that Passed Edits, Generated Claims Not Yet Submitted, Claims Already Submitted,

Claims Replaced by Adjustment Claims, or Completed Claims, if the claim data does not match the biller data for the claim, this claim does not appear and is marked to be fixed during midnight processing.

SORT OPTIONS

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

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

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

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

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

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

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

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

```
                General Hospital Claims by Biller Processor
                                              Tue Dec 05, 1993 10:27 am
Biller:ASHLAND,MARY
                                                                  Page:01
     Clm Adj Bill Date  Account   Type Status Carrier/Plan(*Shared) Name
( 1)   6     93/10/22 89234-00007 Gen    Rel   ADJUSTCO/W.C.       SCHALLIP,
( 2)   1     93/11/01 89299-00003 Comp   Rel   EBI/W.C.            ROHDE,C L
( 3)   6     93/11/02 89268-00001 Fail  Wait   ADJUSTCO/W.C.       LOWENSTEI
( 4)   9     93/11/02 89234-00007 Gen    Rel   ADJUSTCO/W.C.       SCHALLIP,
( 5)   1     93/11/05 89305-00001 Gen    Rel   ALEXSIS RISK MGMT/W ROHDE,J A
( 6)  11     93/11/13 89270-00003 Fail  Wait   ADJUSTCO/W.C.       CURRAN,BT
( 7)   3     93/11/28 89332-00007 Fail  Wait   EBI/W.C.            HALL,F B
( 8)   6     93/11/29 89332-00007 Fail  Wait   EBI/W.C.            HALL,F B
( 9)  12     93/12/03 89234-00007 Fail  Wait   ADJUSTCO/W.C.       SCHALLIP,




Enter choice--
```

Field Explanations

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

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

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

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

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

- Claims that Failed Edits - Fail
- Claims that Passed Edits - Pass
- Claims that have been Generated - Gen
- Claims that have been Submitted - Sub
- Claims Replaced by Adjustment Claim - Repl
- Completed Claims - Comp

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

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

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

CLAIM FUNCTIONS

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

```
              General Hospital Maintain Claims by Account Processor
                                                 Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000001    TESTBERRY,OUTPATIENT ONE    OH XRC 02/01/22 02/01/22   30.44   AR/FCRV

     Clm Adj   Bill     Bill    Clm   Prd Wk  OPPS Clm
     Seq Clm   From     Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
       1     01/22/02 01/22/02 BC MS P    M           111111,BRITISH COLUMBI

            Option No.  Option
            ------------------------------------
                1       Claim Status Information
                2       Carrier Status Information
                3       Claim Demographic/Visit Data - Errors Only
                4       Claim Demographic/Visit Data - All Screens
                5       Claim Demographic/Visit Data - Select Screens
                6       Claim Attachments
                7       Claim Charge Data
                8       Claim Disposition
                9       Re-Print Claim
               10       Account Inquiry
               11       Account Revision
Enter option number--
```

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

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

Claim Status Information

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

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

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

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

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

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

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

NOTE: Claims marked for resubmission are also deleted if present from the temporary download files used to create diskettes to send to the Ministry or to download/upload to other systems for transmission. These include Ontario OHIP Claims (Claim Type H), British Columbia MSP and Worker's Compensation Claims (Claim Type P and Q), and British Columbia Out of Province Claims (Claim Type V).

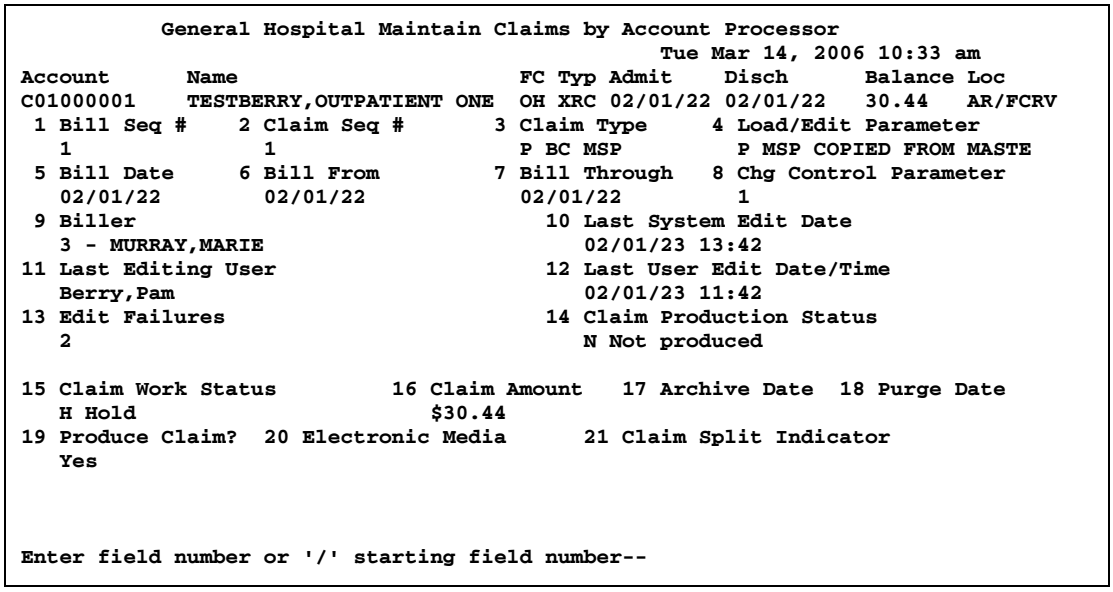
If the claim was manually released with errors originally, and then the claim is later marked for resubmission, the Reload Claim Demographic/Visit Errors function cannot be used to reload fields in error. The system generates the following message:

Reload function not valid for claims marked for resubmission

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

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

If a claim is edited for resubmission, the system writes to Transaction History "xxxx Claim Edited Resubmission" where xxxx is the claim type, for example MOH or BC MSP.



Field Explanations

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

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

3. CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type code and description. Some examples of claim types are H (MOH), P (BC MSP), W (WCB), and Y(CPBC).

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

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

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

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

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

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

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

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

- The biller enters a new date on the claim.
- A payment is made on a carrier and secondary carriers are waiting for payment.
- The reload option is used.

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

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

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

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

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

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

- Claims that have a work status of Awaiting Payment can be changed to M (manually released). If you change the status from Awaiting Payment to Manually Released, you cannot change the status back to Awaiting Payment.

- If you try to change the work status from Awaiting Payment to any work status other than Manually Released, the system displays the following error:

  Error: Status can only be changed to Manually Released

  Claims that have a work status of Awaiting Payment can be deleted in a two-step process. First, change the status to **M** (manually released). This updates the primary claim so it no longer attempts to release this claim when payment is received. After the status has changed to manually released, you can change the status to **D** (delete).

- Claims that have a work status of Edit can be changed to **M** (manually released), **H** (hold), or **D** (delete).

- Claims that have a work status of Failed can be changed to **H** (hold), **D** (delete), or **E** (edit). Some failed claims may also be changed to **M** (manually released). Ontario OHIP Claims (Claim Type H) and British Columbia MSP Claims (Claim Type P) may **not** be changed to Manually Released if there are errors. Inpatient British Columbia Out of Province Claims may **not** be manually released if there are missing diagnosis codes on the charge line or if the charge line has an invalid charge amount. Outpatient British Columbia Out of Province Claims may **not** be manually released if there are erroneous Out of Province Service Codes on the charge line or if the charge line has an invalid charge amount.

- Claims that have a work status of Hold that are in a failed or passed status can be changed to **M** (manually release), **D** (delete), or **E** (edit). Claims that have a work status of Hold because they were edited for resubmission can only be changed to **M** (manually release).

- Claims that have a work status of Manually Release can be changed to **D** (delete), **E** (edit), or **H** (hold), except for Ontario OHIP Claims (MOH) which can only be changed to a work status of hold or delete once manually released.

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

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

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

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

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

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

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

The system creates a separate spool file for each type of claim communication. For a list of claim spoolfiles, refer to the Billing and Claims Reports chapter in the *Reports Volume* 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, or Reprint) that are to be sent electronically.

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

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

NOTE: Claims that are sent either by diskette or where diskettes are created for download/upload into other software for transmission to the carrier do not use the electronic media indicators. The claim media in the claim load and edit parameters for these claims are set to D for diskette, and the claims are marked as submitted when the diskettes are created. These include Ontario OHIP Claims (Claim Type H), British Columbia MSP and Workers Compensation Claims (Claim Type P and Q), and British Columbia Out of Province Claims (Claim Type V). Electronic media is only appropriate for Claim Type K- Universal and Claim Type Y- CPBC Patient Bill Format claims.

21. CLAIM SPLIT INDICATOR (DISPLAY ONLY)
For British Columbia Out of Province Claims, this field indicates whether an inpatient or outpatient claim format has been created.

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

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

Delete Claim (Y/N)—

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

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

Also note that claims that have already been submitted to the Ministry such as Ontario OHIP claims and British Columbia MSP and Worker's Compensation claims should not be deleted.

Carrier Status Information

This function enables you to review basic claim information relating to the carrier(s) associated with this claim. If this is a shared claim, the system prompts you to select a carrier to review. If thisis not a shared claim, the following screen is bypassed, and you are taken directly to the next screen. After you select this option, the system displays the following screen:

```
                  General Hospital Claims by Biller Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                       FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT               10 I/P 95/10/25 95/10/31   7165.00 AR/FCRV

    COB        Carriers                                                 Page:01
( 1) 1  099001 CANADIAN PROVINCIAL INSURANCE









Enter choice--
```

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

```
                General Hospital Maintain Claims by Account Processor
                                                 Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000001    TESTBERRY,OUTPATIENT ONE    OH XRC 02/01/22 02/01/22   30.44   AR/FCRV

        COB: 1  Carrier/Plan: 111111 BRITISH COLUMBIA MINISTRY OF HLTH
   Attn: ADAM CRAFT                              Phone:
Mail To: BRITISH COLUMBIA MINISTRY OF HLTH
         125 ARDEN WALK
         VANCOUVER BC X9X9X-9


 1 Claim Type       2 Claim Loaded     3 Claim Generated  4 Est Amount Due
   P BC MSP           02/01/22                            $30.44
 5 Payment Amount   6 First Payment    7 Last Payment     8 Adjustment Amt

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

12 Claim Submitted 13 Paid In Full?   14 Disp Date       15 Claim Disposition
   02/01/23

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

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

Field Explanations

1. CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type code and description. Some examples are W (WCB), H (MOH), and Y (CPBC).

2. CLAIM LOADED (DISPLAY ONLY)
This field contains the date on which this claim was loaded in the system.

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

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

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

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

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

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

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

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

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

12. CLAIM SUBMITTED (6-N-O)
This field contains the date on which the claim was submitted to the carrier. Enter the date in the format of YYMMDD or YY/MM/DD. Leave this field blank if the claim has not been submitted. The claim submission date must be equal to or greater than the claim load date. You can enter a claim submission date at any time. However, once you enter the date, you can change it but you cannot leave the field blank. If you change the date, the assigned follow-up schedule information is not altered. If the claim has not been produced and you enter a claim submission date, the system issues a warning but you can still submit the claim. The submission of the claim updates the account's transaction history and initiates insurance follow-up for this carrier if the account is in AR. The system automatically generates submission dates for electronically submitted claims on the day the claim form is generated. For British Columbia MSP and Worker's Compensation Board Claims and for British Columbia Out of Province claims, the submission date is entered when the diskette is created. For OHIP claims, the submission date is entered when the Ministry diskette is created.

NOTE: If you try to submit a claim that has a future date, the following message displays *Cannot be future date!*. If you enter a claim submission date that is less than the date the claimwas loaded, the following message displays *Must be same or after claim load date!*.

If an OHIP claim has charges which have been submitted and/or re-submitted with multiple dates, an asterisk (*) follows the submit date and the date displayed is the first submission date.

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

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

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

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

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

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

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

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

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

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

Claim Demographic/Visit Data

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

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

The screens that follow are examples of the Ontario Ministry of Health OHIP (H-MOH), Ontario Workers Compensation Board (W-WCB), Universal (K-UNV), Patient Bill (Y-CPBC), British Columbia MSP (P-BC MSP), British Columbia Worker's Compensation Electronic (Q-BC WORKER'S COMP ELEC), British Columbia Worker's Compensation Electronic (Q-BC WORKER'S COMP ELEC), British Columbia electronic Out of Province (V-BC OUT OF PROV.), and Ontario OOP ICD10 (10-ON OOP ICD10 and 12-ON OOP ICD10 OP) claim forms.

To create a form on the system, copy the Claim Load and Edit Parameter from the McKesson masters. For more information, refer to the discussion of Claim Load and Edit Parameters in the *Tables, Masters, and Parameters Volume* of the *STAR*

Financials Patient Accounting Reference Guide and Chapter 1 of this manual. This function enables you to review and edit the information associated with the selected claim.

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

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

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

```
                      General Hospital Claims by Biller Processor
                                              Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT            10 I/P 95/10/25 95/10/31   7165.00 AR/FCRV

Page:01                                                ##=Current Choices
     From Field                        Thru Field                 Errors
( 1) 1-Trans ID                        1-Manual Review Ind
( 2) 2-Trans ID                        3-Postal Code









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

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

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

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

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

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

OHIP CLAIM FORM - SCREEN 1 OF 3

When you select the first option from the Claim Demographic-Select Screens, the system displays the following screen:

```
                    General Hospital Claims by Biller Processor
                                Page  1 of 3       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT              10 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Trans ID             2 Health Ins Number     3 Version Code
   HEH                    123-45-678              A
 4 Patient Birthdate    5 Account Number        6 Payment Program
   251010                 A00200001               HCP
 7 Payee    8 Referring Provider #               9 Facility Number
   P                                             1234
10 Patient Admit Date  11 Referring Lab #      12 Manual Review Ind
   950801
13 Error Messages









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

Field Explanations

1. TRANS ID (1-A-R)
This field contains the transaction ID, which defaults to HEH per Ministry specifications.

2. HEALTH INS NUMBER (9-N-R)
This field contains the patient health insurance number.

3. VERSION CODE (2-A-O)
This field contains the patient health insurance number version code.

4. PATIENT BIRTHDATE (6-N-O)
This field contains the patient's date of birth.

5. ACCOUNT NUMBER (4-AN-R)
This field contains the patient's account number, which is the visit-specific account number assigned to this patient.

6. PAYMENT PROGRAM (3-AN-R)
This field contains the payment program, which defaults to HCP per Ministry specifications.

7. PAYEE (1-A-R)
This field contains the party to be paid. P indicates a provider.

8. REFERRING PROVIDER # (6-AN-O)
This field is always blank and is determined by the detail charges.

9. FACILITY NUMBER (4-AN-R)
This field contains the facility number as defined in the provider table. The provider for the account is assigned based on the patient type or primary insurance.

10. PATIENT ADMIT DATE (6-N-0)
This field contains the date the patient was admitted or registered to the provider for care.

11. REFERRING LAB # (4-AN-O)
This field contains the referring laboratory number.

12. MANUAL REVIEW IND (26-AN-O)
This field contains the manual review indicator.

13. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays the error messages pertainingto the information displayed on this screen. For example, if the Patient Birthdate field is required but was not completed, the error message *Patient Birthdate is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the two screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

OHIP CLAIM FORM - SCREEN 2 OF 3

```
              General Hospital Claims by Biller Processor
                                Page  2 of 3       Tue Mar 14, 2006 10:33 am
Account      Name                       FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT               10 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Location Code        2 Reserved for OOC      3 Trans ID
   H                                             HER
 4 Registration No      5 Patient Last Name     6 Patient First Name
                          PINCEL                  OHIP
 7 Patient Sex          8 Province Code
   F                      ON
 9 Trans ID            10 Address Line 1
   HEA                    123 FIFIFIF
11 Address Line 2                 12 City
                                     HAMILTON
13 Error Messages




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

Field Explanations

1. LOCATION CODE (4-AN-R)
This field contains the service location indicator.

2. RESERVED FOR OOC (DISPLAY ONLY)
This field contains the name of the OOC.

3. TRANS ID (3-AN-R)
This field contains the transaction ID, which defaults to HER per Ministry specifications.

4. REGISTRATION NO (12-AN-O)
This field contains the registration number.

5. PATIENT LAST NAME (9-A-O)
This field contains the last name of the patient.

6. PATIENT FIRST NAME (5-A-O)
This field contains the first name of the patient.

7. PATIENT SEX (1-A-O)
This field enables you to enter the sex of the patient at the time the claim is loaded. The patient's sex is recorded on the date of admission, outpatient service or the start of care. Enter **M** for Male or **F** for Female.

8. PROVINCE CODE (2-A-O)
This field contains the province code.

9. TRANS ID (3-AN-R)
This field contains the transaction ID, which defaults to HEA per Ministry specifications.

10. ADDRESS LINE 1 (25-AN-O)
This field contains the first line of the patient's street address, which is loaded from the patient's demographic file.

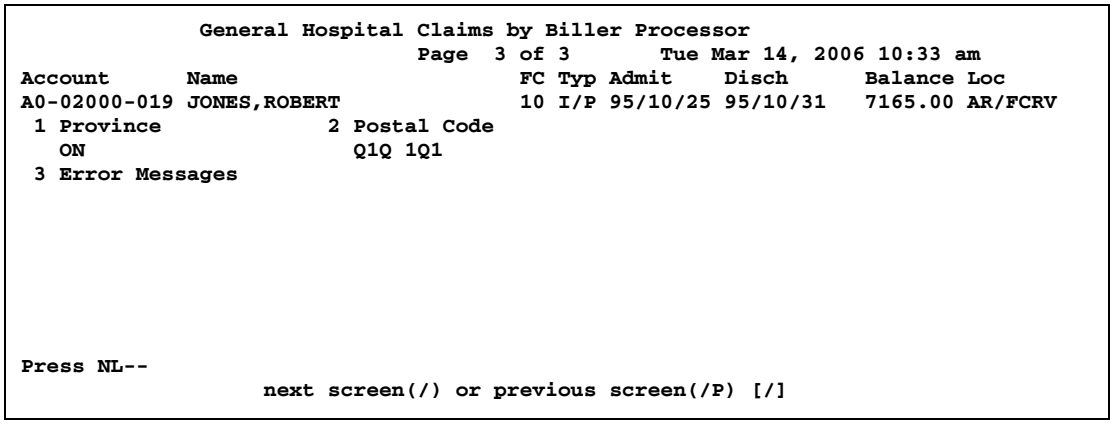
11. ADDRESS LINE 2 (25-AN-O)
This field contains the second line of the patient's street address, which is loaded from the patient's demographic file.

12. CITY (25-A-O)
This field contains the patient's city, which is loaded from the patient demographic file.

13. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Province Code field was required but not completed, the error message *Province Code is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the three screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

OHIP CLAIM FORM - SCREEN 3 OF 3



Field Explanations

1. PROVINCE (2-A-O)
This field contains the patient's province, which is loaded from the patient demographic file.

2. POSTAL CODE (8-AN-O)
This field contains the patient's alphanumeric postcode, which is loaded from the patient's demographic file.

3. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

Ontario Out of Province Inpatient Claim Form (Claim Type 7) - 1 of 3

```
                  General Hospital Maintain Claims by Account Processor
                                Page  1 of 3       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C10000804    SHOOPIP,EIGHT             OP LIC 04/11/30 04/12/03   1200.00 AR/FCRV
 1 Hospital Name and Location                                2 Facility No.
   COMMUNITY HEALTH CTR HAMILTON, ON
 3 Province of Residence                          4 Code
   ALBERTA                                        1234
 5 Plan Registration No.              6 Expiry Date
   321654871                          2009/12/31
 7 Patient Surname                    8 Patient First Name
   SHOOPIP                            EIGHT
 9 Patient Address 1   10 Patient Address 2
   1 NOT QUEBEC
11 Error Messages
   Facility No. is Required


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

Field Explanations

1. HOSPITAL NAME AND LOCATION (48-AN-R)
This field contains the hospital name and location.

2. FACILITY NO. (2-AN-R)
This field contains the MOH Facility ID – Claim value that is defined on the Institution Codes table.

3. PROVINCE OF RESIDENCE (35-AN-R)
This field contains the description associated with the Province code for the patient.

4. CODE (12-AN-R)
This field contains the Province code defined on the Province Abbreviations table.

5. PLAN REGISTRATION NO. (12-AN-R)
This field contains the health card number for the patient.

6. EXPIRY DATE (9-N-R)
This field contains the heath card expiry date.

7. PATIENT SURNAME (20-AN-R)
This field contains the patient's surname.

8. PATIENT FIRST NAME (20-AN-R)
This field contains the patient's first name.

9. PATIENT ADDRESS 1 (25-AN-R)
This field contains the first line of the patient's address.

10. PATIENT ADDRESS 2 (25-AN-O)
This field contains the second line of the patient's address.

11. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

Ontario Out of Province Inpatient Claim Form - Screen 2 of 3

```
            General Hospital Maintain Claims by Account Processor
                                Page  2 of 3       Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C10000804    SHOOPIP,EIGHT               OP LIC 04/11/30 04/12/03   1200.00 AR/FCRV
 1 Patient City,Prov,Postal Code    2 Date of Birth         3 Patient Sex
   CITY AB A1A1A1                     1952/03/21              F
 4 ICD-9 Diagnostic Code 1          5 ICD-9 Diagnostic Code 2

 6 ICD-9 Diagnostic Code 3          7 ICD-9 Diagnostic Code 4

 8 ICD-9 Diagnostic Code 5          9 CCSP Procedure Code 1

10 CCSP Procedure Code 2           11 CCSP Procedure Code 3

12 Error Messages

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

Field Explanations

1. PATIENT CITY, PROV, POSTAL CODE (22-AN-R)
This field contains the patient's city, province, and postal code.

2. DATE OF BIRTH (8-N-R)
This field contains the patient's birthdate in the format of YYMMDD or YY/MM/DD.

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

4. ICD-9 DIAGNOSTIC CODE 1 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

5. ICD-9 DIAGNOSTIC CODE 2 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

6. ICD-9 DIAGNOSTIC CODE 3 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

7. ICD-9 DIAGNOSTIC CODE 4 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

8. ICD-9 DIAGNOSTIC CODE 5 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

9. CCSP PROCEDURE CODE 1 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

10. CCSP PROCEDURE CODE 2 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

11. CCSP PROCEDURE CODE 3 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

12. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

ONTARIO OUT OF PROVINCE INPATIENT CLAIM FORM - SCREEN 3 OF 3

```
             General Hospital Maintain Claims by Account Processor
                                Page  3 of 3       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C10000804    SHOOPIP,EIGHT             OP LIC 04/11/30 04/12/03   1200.00 AR/FCRV
 1 CCSP Procedure Code 4            2 CCSP Procedure Code 5

 3 Death Indicator      4 Long-stay             5 Accident E Code 1
   N
 6 Accident E Code 2    7 Accident E Code 3     8 Accident E Code 4

 9 Accident E Code 5

10 Error Messages



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

Field Explanations

1. CCSP PROCEDURE CODE 4 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

2. CCSP PROCEDURE CODE 5 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

3. DEATH INDICATOR (1-A-R)
This field indicates whether the patient was discharged with a disposition of Death. Values are Yes or No.

4. LONG-STAY (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

5. ACCIDENT E CODE 1 (8-AN-R)
If your facility captures this information and stores it in STAR Patient Accounting, you can edit this field to pull the information using the internal elements E-CODE1, E-CODE2, E-CODE3, E-CODE4, and E-CODE5.

6. ACCIDENT E CODE 2 (8-AN-R)
If your facility captures this information and stores it in STAR Patient Accounting, you can edit this field to pull the information using the internal elements E-CODE1, E-CODE2, E-CODE3, E-CODE4, and E-CODE5.

7. ACCIDENT E CODE 3 (8-AN-R)
If your facility captures this information and stores it in STAR Patient Accounting, you can edit this field to pull the information using the internal elements E-CODE1, E-CODE2, E-CODE3, E-CODE4, and E-CODE5.

8. ACCIDENT E CODE 4 (8-AN-R)
If your facility captures this information and stores it in STAR Patient Accounting, you can edit this field to pull the information using the internal elements E-CODE1, E-CODE2, E-CODE3, E-CODE4, and E-CODE5.

9. ACCIDENT E CODE 5 (8-AN-R)
If your facility captures this information and stores it in STAR Patient Accounting, you can edit this field to pull the information using the internal elements E-CODE1, E-CODE2, E-CODE3, E-CODE4, and E-CODE5.

10. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

Ontario Out of Province Outpatient Claim Form - Screen 1 of 2

```
            General Hospital Maintain Claims by Account Processor
                          Page  1 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                 FC Typ Admit    Disch      Balance   Loc
C50073086    SHOOPOP,TWO          OP LOC 04/12/01 04/12/01   50255.00  AR/FCRV
 1 Hospital Name and Location                  2 Facility No.
   COMMUNITY HEALTH CTR HAMILTON, ON
 3 Province of Origin                          4 Code
   QUEBEC                                        8521
 5 Plan Registration No.           6 Expiry Date
   32146598715                       2009/12/21
 7 Patient Surname                 8 Patient Given Name
   MAIDEN                            TWO
 9 Patient Middle Initial         10 Date of Birth        11 Patient Sex
                                     1955/03/21              F
12 Error Messages
   Facility No. is Required




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

Field Explanations

1. HOSPITAL NAME AND LOCATION (48-AN-R)
This field contains the hospital name and location.

2. FACILITY NO. (2-AN-R)
This field contains the MOH Facility ID – Claim value that is defined on the Institution Codes table.

3. PROVINCE OF ORIGIN (35-AN-R)
This field contains the description associated with the Province code for the patient.

4. CODE (12-AN-R)
This field contains the Province code defined on the Province Abbreviations table.

5. PLAN REGISTRATION NO. (12-AN-R)
This field contains the health card number for the patient.

6. EXPIRY DATE (8-N-R)
This field contains the heath card expiry date.

7. PATIENT SURNAME (20-AN-R)
This field contains the patient's surname.

8. PATIENT GIVEN NAME (20-AN-R)
This field contains the patient's first name.

9. PATIENT MIDDLE INITIAL (2-AN-R)
This field contains the patient's middle initial.

10. DATE OF BIRTH (8-N-R)
This field contains the patient's birthdate in the format of YYMMDD or YY/MM/DD.

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

12. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

Ontario Out of Province Outpatient Claim Form - Screen 2 of 2

```
        General Hospital Maintain Claims by Account Processor
                                Page  2 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance   Loc
C50073086    SHOOPOP,TWO             OP LOC 04/12/01 04/12/01   50255.00  AR/FCRV
 1 ICD-9 Diagnosis Code 1            2 CCSP Procedure Code 1
   0
 3 Error Messages









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

Field Explanations

1. ICD-9 DIAGNOSIS CODE 1 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

2. CCSP PROCEDURE CODE 1 (8-AN-R)
If your facility captures this information and stores it in STAR, you can edit the field to pull information using one of the existing internal elements.

3. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

ONTARIO OUT OF PROVINCE ICD10, INPATIENT CLAIM FORM, SCREEN 1 OF 3

```
                General Hospital Maintain Claims by Account Processor
                                Page  1 of 3       Fri Jul 03, 2009 07:37 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
J1-0000609   MERRITT,HICOST CHARG OP I/P 09/05/28 09/05/29      592.00 AR /ACCF
 1 Institution Number   2 Health Care Number    3 Postal Code
   51234                  9994657787             E3R 4T5
 4 Gender   5 Province              6 Birth Date            7 Admission Date
   F          BC                     440512                  090528
 8 Discharge Date       9 Discharge Disposition
   090529                 DS
10 Most Responsible Diagnosis      11 Principal Intervention Date

12 Error Messages
   Most Responsible Diagnosis is Required









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

1. INSTITUTION NUMBER (5-N-R)
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.

This field contains the value 5 followed by the institution code associated with patient's provider master, or the value from medical records. This field completes field 0101 of the Ontario Reciprocal claims download data.

2. HEALTH CARE NUMBER (12-N-R)
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. POSTAL CODE (8-AN-O)
This field contains the patient's alphanumeric postcode, which is loaded from the patient's demographic file. 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. GENDER (1-A-R)
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.

This field contains the gender of the patient from Med Rec data if available, else it contains patient data. Completes field 0304 of the Ontario Reciprocal claims.

5. PROVINCE (2-A-O)
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.

This field contains the patient's province from Med Rec data if available, else it contains the value from the Out of Province Patient Info Processor screen or patient data. Completes field 0305 of the Ontario Reciprocal claims download data.

6. BIRTH DATE (DATE-R)
This field contains the patient's birthdate in YYMMDD format from Med Rec data if available, else from patient data. Completes field 0308 of the Ontario Reciprocal claims download data.

7. ADMISSION DATE (DATE-R)
If bill following cycle bill, this field contains one date after bill thru date of previous cycle bill. Otherwise, the field contains the admission date. Completes field 0401 of the Ontario Reciprocal claims download data.

8. DISCHARGE DATE (DATE-R)
This field contains the account discharge date for final, adjustment, or late bills. Otherwise, 1 is added to the STAR bill thru date. Completes field 0501 of the Ontario Reciprocal claims download data.

9. DISCHARGE DISPOSITION (2-N-R)
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.

This field is blank unless the bill is final, adjustment, or late bill. If completed, the field contains the value from Medical Records or the value from the Out of Province Discharge Status table.. Completes field 0505 of the Ontario Reciprocal claims download data.

10. MOST RESPONSIBLE DIAGNOSIS (7-AN-R)
This field contains Med Rec data if available, else it contains the value from the Out of Province Patient Info Processor screen. There is no ICD-10 table 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. Completes field 1002-01 of the Ontario Reciprocal claims download data.

11. PRINCIPAL INTERVENTION DATE (DATE-R)
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.

This field contains Med Rec data if available, else it contains the value from the Out of Province Patient Info Processor screen. Completes field 1101-01 of the Ontario Reciprocal claims download data.

12. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen.

ONTARIO OUT OF PROVINCE ICD10, INPATIENT CLAIM FORM, SCREEN 2 OF 3

```
                General Hospital Maintain Claims by Account Processor
                                Page  2 of 3       Fri Jul 03, 2009 07:41 am
Account      Name                  FC Typ Admit    Disch        Balance Loc
J1-0000609   SMITH, BOB            OP I/P 09/05/28 09/05/29      592.00 AR /ACCF
 1 Principal Intervention Code      2 Coding Classification Ind
                                      0
 3 Adjustment Indicator             4 Health Care Number Expiry Date
   N
 5 Patient Last Name                6 Patient First Name
   SMITH                             HICOST
 7 Patient Address Line 1
   888 ANOTHER PLACE
 8 Patient Address Line 2

 9 Patient City
   HAMILTON
10 Error Messages









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

                    next screen(/) or previous screen(/P) [/]
```

Field Explanations

1. PRINCIPAL INTERVENTION CODE (10-AN-R)
This field contains the value from Med Rec data if available or Out of Province Patient Info Processor, Prin Intrvntn Code field. Completes field 1102-01 of the Ontario Reciprocal claims download data.

2. CODING CLASSIFICATION IND (1-N-R)
The default value of 0 loads to this field. Completes field I-MOH01 of the Ontario Reciprocal claims download data.

3. ADJUSTMENT INDICATOR (1-A-R)
The default value of N loads to this field. Completes field I-MOH02 of the Ontario Reciprocal claims download data.

4. HEALTH CARE NUMBER EXPIRY DATE (DATE-C)
Not all provinces have an expiry date. The claim load & edit parameter should be set to either require this field or not, depending on the province. This field contains the value from the Out of Province Patient Info Processor screen or patient data. Completes field I-MOH03 of the Ontario Reciprocal claims download data.

5. PATIENT LAST NAME (20-A-R)
This field contains the last name of the patient from patient data. Completes field I-MOH04 of the Ontario Reciprocal claims download data.

6. PATIENT FIRST NAME (20-A-R)
This field contains the first name of the patient from patient data. Completes field I-MOH05 of the Ontario Reciprocal claims download data.

7. ADDRESS LINE 1 (35-AN-R)
This field contains the first line of the patient's street address, from patient data. Completes field I-MOH06 of the Ontario Reciprocal claims download data.

8. ADDRESS LINE 2 (35-AN-R)
This field contains the second line of the patient's street address from patient data. Completes field I-MOH07 of the Ontario Reciprocal claims download data.

9. PATiENT CITY (35-AN-R)
This field contains the patient's city from patient data. Completes field I-MOH08 of the Ontario Reciprocal claims download data.

10. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen.

Ontario Out of Province ICD10, Inpatient Claim Form, Screen 3 of 3

```
                    General Hospital Maintain Claims by Account Processor

                                   Page  3 of 3       Fri Jul 03, 2009 07:41 am

Account      Name                  FC Typ Admit    Disch        Balance Loc
J1-0000609   MERRITT,HICOST CHARG OP I/P 09/05/28 09/05/29      592.00 AR /ACCF
 1 Patient Address Province          2 Death Indicator
   BC                                  N
 3 Long Stay Indicator               4 Accident Indicator    5 Accident Code
   N                                   N
 6 Hospital Claim Number             7 Claim Type            8 Record Type
   1-0000609                           I                       D
 9 High Cost Charge    10 Med Rec Date                      11 Hospital Code
   N                      N/A                                  123
12 Error Messages




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

FIELD EXPLANATIONS

1. PATIENT ADDRESS PROVINCE (2-A-R)
This field contains the code for the province for the patient. Completes field I-MOH09 of the Ontario Reciprocal claims download data.

2. DEATH INDICATOR (1-A-R)
If the claim is associated with a final, adjustment, or late bill, the value is determined from the STAR disposition. Otherwise, the value of N loads. Completes field I-MOH19 of the Ontario Reciprocal claims download data.

3. LONG STAY INDICATOR (1-A-R)
If the claim is associated with a final, adjustment, or late bill the field contains Y, if the difference between the discharge date and admission date is not less then 30 days. For cycle or cycle adjustment bill this is Y, if the difference between the bill thru date + 1 and admission date is not less than 30 days. Otherwise, the value is N. Completes field I-MOH20 of the Ontario Reciprocal claims download data.

4. ACCIDENT INDICATOR (1-A-R)
This field contains the value from Out of Province Patient Info Processor screen. If that value is blank, the value is N (No). Completes field I-MOH21 of the Ontario Reciprocal claims download data.

5. ACCIDENT CODE (7-AN-C)
This field contains the value from Out of Province Patient Info Processor screen. If that value is blank, the value is N (No). Completes field I-MOH22 of the Ontario Reciprocal claims download data.

6. HOSPITAL CLAIM NUMBER (15-N-R)
The patient's STAR External account number loads to this field. This completes field I-MOH23.

7. CLAIM TYPE (1-A-R)
The default value of I loads to the claim. Completes field I-MOH24 of the Ontario Reciprocal claims download data.

8. RECORD TYPE (1-A-R)
The default value of D (for detail) loads to the claim. Completes field I-MOH25 of the Ontario Reciprocal claims download data.

9. HIGH COST CHARGE (1-A-R)
This field does not output in the Out of Province submission data. It is used for claim edits. This field is set to Yes if a high cost charge exists in a claim service line and in Medical Records or in Out of Province Patient Information.

10/ MED REC DATE (1-A-R)
This field does not output in the Out of Province submission data. It is used for claim edits only. The field contains N if patient type is not abstracted and N if the bill type is cycle or cycle adjustment bill. The field contains the date of import for Medical Records data used for claim. The second piece for this field is the reference date for the Medical Records date used. The third piece for this field is an asterisk if the Medical Records data changed in a subsequent upload.

11. HOSPITAL CODE (3-N-R)
For the first charge appearing in Claim Charge Data after the claim loads, the patient type is determined. If that patient type appears in the Hospital Codes for Patient Types with a Hospital Code, the Hospital Code is used. Otherwise, the Hospital Code from Download Parameters found under Ontario Electronic Reciprocal Billing Parameters is used to load to the claim. When the download occurs, a separate file is created for each of the Hospital Codes with claim data.

12. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen This field is available to edit for all inpatients

Ontario Out of Province ICD10, Outpatient Claim Form, Screen 1 of 2

```
            General Hospital Maintain Claims by Account Processor
                                Page  1 of 1       Fri Jul 03, 2009 07:52 am
Account      Name                  FC Typ Admit    Disch        Balance Loc
J5-0260771   MERRITT,B             OP O/P 09/06/10 09/06/10      855.00 AR /ACCF
 1 Reporting Fac Amb Care Number    2 Health Care Number    3 Providence
   51234                              9154545454              BC
 4 Postal Code          5 Patient Gender        6 Birth Date
   Q1Q 1Q1                F                       650912
 7 Main Problem         8 Main Intervention     9 Main Intervention Date

10 Coding Classification Ind       11 Adjustment Indicator
   0                                  N
12 Error Messages









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

Field Explanations

1. REPORTING FACILITY AMBULATORY CARE NUMBER (5-N-R)
This field contains the value 5 followed by the institution number from the patient's provider master or from medical record information. Completes field 00B of the Ontario Reciprocal claims download data.

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. HEALTH CARE NUMBER (12-N-R)
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.

This field contains the value from Med Rec data or Out of Province Patient Info Processor screen or patient data. Completes field 2 of the Ontario Reciprocal claims download data.

3. PROVINCE (2-A-O)
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.

This field contains the patient's province value from Med Rec data, or Out of Province Patient Info Processor screen or patient data. Completes field 3 of the Ontario Reciprocal claims download data.

4. POSTAL CODE (8-AN-O)
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.

This field contains the value from Med Rec data or Out of Province Patient Info Processor screen or patient data. Completes field 5 of the Ontario Reciprocal claims download data.

5. GENDER (1-A-R)
This field contains the gender of the patient from Med Rec data or patient data. Completes field 7 of the Ontario Reciprocal claims download data.

6. PATIENT BIRTH DATE (DATE-R)
This field contains the patient's birthdate from Med Rec data or patient data in YYMMDD format. Completes field 8 of the Ontario Reciprocal claims download data.

7.MAIN PROBLEM (7-AN-R)
This field contains the ICD-10 diagnosis from Medical Records information or from the out of province Patient Info Processor, Prin Diagnosis field. Completes field 44 of the Ontario Reciprocal claims download data.

8 MAIN INTERVENTION CODE (10-AN-R)
This field contains the ICD-10 procedure from medical records information or from the Out of Province Patient Info Processor, Prin Intrvntn Code field. Completes field 46 of the Ontario Reciprocal claims download data.

9. MAIN INTERVENTION DATE (DATE-R)
This field contains the date associated with the ICD-10 procedure from medical records information or from the Out of Province Patient Info Processor, Prin Intrvntn Date field. Completes field 109 of the Ontario Reciprocal claims download data.

10. CODING CLASSIFICATION IND (1-A-R)
This field contains the default value from the claim load & edit parameter, which should be zero. Completes field O-MOH01 of the Ontario Reciprocal claims download data.

11. ADJUSTMENT INDICATOR (1-A-R)
This field contains the default value of N from the claim load & edit parameter. Completes field O-MOH02 of the Ontario Reciprocal claims download data.

12. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen

Ontario Out of Province ICD10, Outpatient Claim Form, Screen 2 of 2

```
            General Hospital Maintain Claims by Account Processor
                                Page  2 of 2       Fri Jul 03, 2009 07:55 am
Account      Name                  FC Typ Admit    Disch        Balance Loc
J5-0260771   MERRITT,B             OP O/P 09/06/10 09/06/10      855.00 AR /ACCF
 1 Health Care Number Expiry Date   2 Last Name
                                     MERRITT
 3 First Name                       4 Hospital Claim Number
   B                                  5-0260771
 5 Claim Type           6 Record Type           7 Med Rec Date
   O                      D                       N/A
 8 Hospital Code
   123
 9 Error Messages









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

Field Explanations

1. HEALTH CARE EXPIRY DATE (DATE-C)
Not all provinces have an expiry date. The claim load & edit parameter should be set to either require this field or not, depending on the province. Value from Out of Province Patient Info Processor, Expiry Date field or patient demographic data is used. Completes field O-MOH03 of the Ontario Reciprocal claims download data.

2. LAST NAME (20-A-R)
This field contains the last name of the patient from patient demographic data. Completes field O-MOH04 of the Ontario Reciprocal claims download data.

3. FIRST NAME (20-A-R)
This field contains the first name of the patient from patient demographic data. Completes field O-MOH05 of the Ontario Reciprocal claims download data.

4. HOSPITAL CLAIM NUMBER

This field contains the External account number of the patient. Completes field O-MOH08 of the Ontario Reciprocal claims download data.

5. CLAIM TYPE (1-A-R)
The default value of O loads to the claim. Completes field O-MOH09 of the Ontario Reciprocal claims download data.

6. RECORD TYPE (1-A-R)
The default value of D (for detail) loads to the claim Completes field O-MOH10 of the Ontario Reciprocal claims download data.

7. MED REC DATE (1-A-R)
This field does not output in the Out of Province submission data. It is used for claim edits only, and is"N/A" if patient typeis not abstracted. "N/A" if bill type is cycle or cycle adjustment bill. Otherwise, the Date of import for Medical Records data used for claim.displays.

8. HOSPITAL CODE (3-N-R)
The patient type used for the Claim Split Indicator determines the Hospital Code. If that patient type appears in the Hospital Codes for Patient Types with a Hospital Code, the Hospital Code is used. Otherwise, the Hospital Code from Download Parameters found under Ontario Electronic Reciprocal Billing Parameters is used. When the download occurs, a separate file is created for each of the Hospital Codes with claim data.

9. ERROR MESSAGES (DISPLAY ONLY)
The system displays the error messages pertaining to the information displayed on this screen

WCB DEMOGRAPHICS CLAIM FORM - SCREEN 1 OF 2

The following screen is the claim demographic screen for the WCB claim form.

```
              General Hospital Claims by Account Processor
                                Page  1 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT            15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Agency Registration Number       2 Patient Name
                                      ROBERT
 3 Claim Number          4 Provider Name
   123131
 5 Provider Address 1                6 Provider Address 2

 7 Patient Address 1                 8 Patient Address 2
   29 PERIMETER ST                     NEAR THE MALL
 9 Patient City                     10 Patient Province    11 Patient Postal Code
   TORONTO                             ON ONTARIO             A1A1A1
12 Error Messages









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

Field Explanations

1. AGENCY REGISTRATION NUMBER (12-AN-O)
This field is preprinted by the Ministry and is not printed by STAR Financials.

2. PATIENT NAME (25-A-R)
This field contains the patient's name in the format LAST, FIRST.

3. CLAIM NUMBER (20-AN-O)
This field contains the WCB claim number from the patient insurance plan. The claim number is typically an eight-digit number.

4. PROVIDER NAME (25-AN-O)
This field contains the name of the hospital or other healthcare facility which provides the patient's care. The provider name and address is preprinted on the claim form. If at a future date you need to print the provider information on the claim, the Claim Load and Edit parameters can be modified to select the Provider Name.

5. PROVIDER ADDRESS 1 (25-AN-O)
This field contains the first line of the provider's address.

6. PROVIDER ADDRESS 2 (25-AN-O)
This field contains the second line of the provider's address.

7. PATIENT ADDRESS 1 (25-AN-R)
This field contains the first line of the patient's address.

8. PATIENT ADDRESS 2 (25-AN-O)
This field contains the second line of the patient's address.

9. PATIENT CITY (18-AN-O)
This field contains the city in which the patient lives.

10. PATIENT PROVINCE (10-AN-O)
This field contains the province in which the patient lives.

11. PATIENT POSTAL CODE (10-AN-R)
This field contains the patient's postcode.

12. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Provider Name field was required but not complete, the error message *Provider Name is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the two screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains.

WCB DEMOGRAPHICS CLAIM FORM - SCREEN 2 OF 2

```
              General Hospital Claims by Account Processor
                              Page  2 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                     FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT             15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Treating Agency Ref Number       2 Patient's Birthdate
   0-02000-19                        63/02/15
 3 Patient SIN           4 Accident Date        5 Nature of Disability
   654-32-1                06/09/95               ABDOMINAL PAIN
 6 Insured's Employer Information
   ACE Time  29 PERIMETER ST ON ONTARIO
 7 Insured Postal Code
   A1A1A1
 8 Error Messages









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

Field Explanations

1. TREATING AGENCY REF NUMBER (10-AN-R)
This field contains the patient account number.

2. PATIENT'S BIRTHDATE (8-N-R)
This field contains the patient's birthdate in the format of YYMMDD or YY/MM/DD.

3. PATIENT SIN (17-AN-O)
This field contains the patient's Social Insurance Number.

4. ACCIDENT DATE (11-N-O)
If applicable, this field contains the date on which the accident occurred.

5. NATURE OF DISABILITY (25-AN-R)
This field contains the diagnosis of the patient at the time of admission. This field is free-form.

6. INSURED'S EMPLOYER INFO (43-AN-R)
This field contains the name, address, and province of the patient's employer as stored in the insurance plan demographic screen.

7. INSURED'S EMPLOYER POSTAL CODE (7-AN-R)
This field contains the employer's postcode.

8. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Nature of Disability field is required but not completed, the system displays the following error message *Nature of Disability is Required.*

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the two screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. Accepting this screen completes the transaction.

UNIVERSAL DEMOGRAPHICS CLAIM FORM - SCREEN 1 OF 5

The following five screens are the Claim Demographics screens for claim form K UNV (Universal Demographics).

```
             General Hospital Claims by Biller Processor
                             Page  1 of 5       Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT            15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Carrier Name
   BLUE CROSS-GENERAL HOSPITAL
 2 Carrier Address 1               3 Carrier Address 2
   150 FERRAND DRIVE,
 4 Carrier City         5 Carrier Province      6 Carrier Postcode
   DON MILLS              ON                      M3C 1H6
 7 Insured Name                                  8 Insured Birthday
   JONES,ROBERT
 9 Insured Address 1                            10 Insured City

11 Error Messages
   Insured Address 1 is Required
   Insured City is Required




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

Field Explanations

1. CARRIER NAME (66-AN-R)
This field contains the name of the insurance company through which the patient is insured.

2. CARRIER ADDRESS 1 (20-AN-R)
This field contains the first line of the insurance carrier's address.

3. CARRIER ADDRESS 2 (16-AN-O)
This field contains the second line of the carrier's address.

4. CARRIER CITY (18-AN-R)
This field contains the city of the carrier.

5. CARRIER PROVINCE (2-A-R)
This field contains the province of the carrier.

6. CARRIER POSTCODE (10-AN-R)
This field contains the postcode of the carrier.

7. INSURED NAME (42-A-R)
This field contains the name of the person who holds the insurance.

8. INSURED BIRTHDAY (17-N-R)
This field contains the date of birth of the insured person.

9. INSURED ADDRESS 1 (36-AN-R)
This field contains the first line of the insured's address.

10. INSURED CITY (18-AN-R)
This field contains the name of the city in which the insured resides.

11. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Insured Name field is required but not completed, the following error message *Insured Name is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the five screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains.

UNIVERSAL DEMOGRAPHICS CLAIM FORM - SCREEN 2 OF 5

```
              General Hospital Claims by Biller Processor
                              Page  2 of 5       Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT            15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Insured Province     2 Insured Postcode

 3 Insured Relation                                          4 Policy Number
   Self                                                        445627532
 5 Section Number       6 Identification Number

 7 Insured Employer

 8 Patient Name                                    9 Patient Birthday
   BOSWORTH,RICHIE                                   63/02/15
10 Patient Address 1
   29 PERIMETER ST
11 Error Messages
   Insured Province is Required
   Insured Postcode is Required
   Section Number is Required
   Identification Number is Required
   Insured Employer is Required

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

Field Explanations

1. INSURED PROVINCE (2-A-R)
This field contains the province in which the insured patient lives.

2. INSURED POSTCODE (10-AN-R)
This field contains the insured patient's postcode.

3. INSURED RELATION (1-A-R)
This field establishes the relationship between the person whose name the insurance is in and the patient. Enter **S** for Self, **T** for Spouse, **P** for Parent, or **O** for Other.

4. POLICY NUMBER (14-AN-R)
This field contains the policy number.

5. SECTION NUMBER (15-AN-R)
This field contains the section number.

6. IDENTIFICATION NUMBER (16-AN-O)
This field contains the identification number for the insured person.

7. INSURED EMPLOYER (66-AN-R)
This field contains the name of the insured person's employer.

8. PATIENT NAME (42-AC-R)
This field contains the patient's name in the format of LAST, FIRST.

9. PATIENT BIRTHDAY (22-N-R)
This field contains the patient's birthday in the format of YYMMDD or YY/MM/DD.

10. PATIENT ADDRESS 1 (20-AN-R)
This field contains the first line of the patient's address.

11. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Insured Relation field is required butnot completed, the error message *Insured Relation is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the five screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains.

UNIVERSAL DEMOGRAPHICS CLAIM FORM - SCREEN 3 OF 5

```
              General Hospital Claims by Biller Processor
                                Page  3 of 5        Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT              15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Patient Address 2     2 Patient City          3 Patient Province
   NEAR THE HOSPITAL       TORONTO                 ONTARIO
 4 Patient Postcode      5 Benefits              6 Other Policy Number
   L9H 6B2                 No                      445627532
 7 Other Carrier                    8 Insured Birthday

 9 Assignment Date     10 Insured Signature                11 ROI Date
   95/10/25              Signature on file                   95/10/25
12 Error Messages









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

Field Explanations

1. PATIENT ADDRESS 2 (16-AN-O)
This field contains the second line of the patient's address.

2. PATIENT CITY (18-AN-R)
This field contains the city in which the patient lives.

3. PATIENT PROVINCE (2-AN-R)
This field contains the province in which the patient resides.

4. PATIENT POSTCODE (10-AN-R)
This field contains the patient's postcode.

5. BENEFITS (15-A-R)
This field indicates if the patient has benefits or does not have benefit. Enter **Y** for Yes to indicate that the patient has benefits. Enter **N** for No to indicate that the patient does not have benefits. The Benefits flag is set to Yes if there are two commercial insurances or if there is WCB and a commercial insurance.

6. OTHER POLICY NUMBER (18-AN-R)
This field contains the certificate number of the other insurance if the Benefits flag is set to Yes.

7. OTHER CARRIER (24-AN-O)
This field contains the name of the other carrier if the Benefits flag is set to Yes.

8. INSURED BIRTHDAY (22-N-O)
This field contains the birthday of the insured person.

9. ASSIGNMENT DATE (13-N-R)
This field contains the assignment date.

10. INSURED SIGNATURE (30-A-R)
This field contains the insured's signature.

11. ROI DATE (13-N-R)
This field contains the ROI date.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the five screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains.

UNIVERSAL DEMOGRAPHICS CLAIM FORM - SCREEN 4 OF 5

```
             General Hospital Claims by Biller Processor
                              Page  4 of 5       Tue Mar 14, 2006 10:33 am
Account      Name                     FC Typ Admit    Disch      Balance Loc
AO-02000-019 JONES,ROBERT             15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
 1 Patient Signature
   Signature on file
 2 Hospital Name
   GENERAL HOSPITAL
 3 Hospital Address                                4 Hospital City
   1234 MAPLE ST                                     TORONTO
 5 Hospital Province    6 Hospital Postal Code
   ON                     X9X 9X9
 7 Account Number       8 Patient Name
   A0-02000-019           JONES,ROBERT
 9 Admit Date          10 Discharge Date       11 Daily Differential
   95/10/25               95/10/31                $150.00
12 Error Messages




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

Field Explanations

1. PATIENT SIGNATURE (30-A-R)
This field contains the patient's signature.

2. HOSPITAL NAME (DISPLAY ONLY)
This field indicates the name of the hospital where care was provided.

3. HOSPITAL ADDRESS (DISPLAY ONLY)
This field contains the first line of the hospital's address.

4. HOSPITAL CITY (DISPLAY ONLY)
This field contains the city where the hospital is located.

5. HOSPITAL PROVINCE (DISPLAY ONLY)
This field contains the province where the hospital is located.

6. HOSPITAL POSTAL CODE (DISPLAY ONLY)
This field contains the hospital's postcode.

7. ACCOUNT NUMBER (17-AN-R)
This field contains the patient's account number.

8. PATIENT NAME (41-A-R)
This field contains the patient's name in the format of LAST, FIRST.

9. ADMIT DATE (9-N-R)
This field indicates the date that the patient was admitted in the format of YYMMDD or YY/MM/DD.

10. DISCHARGE DATE (11-N-R)
This field indicates the date that the patient was discharged in the format of YYMMDD or YY/MM/DD.

11. DAILY DIFFERENTIAL (10-N-R)
This field contains the most common semi-private room rate.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the five screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains.

UNIVERSAL DEMOGRAPHICS CLAIM FORM - SCREEN 5 OF 5

```
              General Hospital Claims by Biller Processor
                                Page  5 of 5       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT              15 I/P 95/09/08 95/09/11   7165.00 AR/FCRV
 1 Type of Care
   X
 2 Work related indicator
   No
 3 Claim Date           4 Biller Signature
                          BILLER,CINDY
 5 Error Messages









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

Field Explanations

1. TYPE OF CARE (1-A-R)
This field contains the type of care code which is set to print an X as the default in the claim load and edit parameter.

2. WORK RELATED INDICATOR (1-A-R)
This field indicates whether or not confinement is due to a work related accident or illness. Enter **Y** for Yes or **N** for No.

3. CLAIM DATE (14-N-O)
This field contains the date of the claim in the format of YYMMDD or YY/MM/DD.

4. BILLER SIGNATURE (36-A-R)
This field contains the biller's signature.

5. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Type of Care field is required but not completed, the following error message *Type of Care is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the five screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. Accepting this screen completes the transaction.

PATIENT BILL DEMOGRAPHICS CLAIM FORM - SCREEN 1 OF 2

The following two screens are the claim demographic screens for the CPBC claim form.

```
             General Hospital Maintain Claims by Account Processor
                              Page  1 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A97000021    HARRISON, GENEVA R        09 O/P 97/10/21 97/10/21   4236.64 AR/FCRV
 1 BILL DATE            2 PATIENT NAME
   97/10/27               HARRISON,GENEVA R
 3 PATIENT ACCOUNT NUMBER           4 GUARANTOR CORPORATE NUMBER
   A97000021                          00000427
 5 ADMIT DATE           6 DISCHARGE DATE        7 INSURANCE NAME
   97/10/21               97/10/21                MOUNTED POLICE
 8 INSURANCE ADDRESS                9 INSURANCE CITY       10 INSURANCE STATE
   172 CENTRAL PKWY.                  VANCOUVER                 BC
11 INSURANCE COUNTRY
   Canada
12 Error Messages









Press NL--
```

1. BILL DATE (10-N-R)
This field contains the date of the bill in the format of YYMMDD or YY/MM/DD.

2. PATIENT NAME (25-A-R)
This field contains the patient's name.

3. PATIENT ACCOUNT NUMBER (11-AN-R)
This field contains the patient's account number.

4. GUARANTOR CORPORATE NUMBER (8-AN-R)
This field contains the guarantor's corporate number.

5. ADMIT DATE (10-N-R)
This field indicates the date that the patient was admitted in the format of YYMMDD or YY/MM/DD.

6. DISCHARGE DATE (10-N-O)
This field indicates the date that the patient was discharged in the format of YYMMDD or YY/MM/DD.

7. INSURANCE NAME (25-AN-R)
This field contains the name of the patient's insurance carrier.

8. INSURANCE ADDRESS (25-AN-R)
This field contains the first line of the insurance carrier's address.

9. INSURANCE CITY (18-A-R)
This field contains the insurance carrier's city.

10. INSURANCE STATE (2-A-R)
This field contains the insurance carrier's province.

11. INSURANCE COUNTRY (19-A-R)
This field contains the insurance carrier's country.

12. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Admit Date field, which is required, is not completed, the error message *Admit Date is Required* is displayed in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the next screen included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains.

PATIENT BILL DEMOGRAPHICS CLAIM FORM - SCREEN 2 OF 2

```
            General Hospital Maintain Claims by Account Processor
                              Page  2 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
A97000021    HARRISON,GENEVA R       09 O/P 97/10/21 97/10/21   4236.64 AR/FCRV
 1 INSURANCE ZIP CODE
   X1X 2X3
 2 Error Messages









Press NL--
```

Field Explanations

1. INSURANCE ZIP CODE (10-A-R)
This field contains the insurance carrier's postal code.

2. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Insurance Zip Code field, which is required, is not completed, the error message *Insurance Zip Code is Required* is displayed in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. Accepting this screen completes the transaction.

BRITISH COLUMBIA MSP CLAIM FORM - SCREEN 1 OF 3

The following three screens are the claim demographic screens for Claim Type P-British Columbia MSP claim form.

```
          General Hospital Maintain Claims by Account Processor
                              Page  1 of 3      Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C01000001    BERRY,TESS                OH XRC 02/01/22 02/01/22   30.44   AR/FCRV
 1 MSP Record Code Identifier       2 MSP Data Centre Number
   C01                                T1234
 3 MSP Registration Number          4 MSP Patient Name Verification
   9071071987                         OOTE
 5 MSP Dependent Number             6 MSP Service To Day
   00                                 00
 7 MSP Office Folio Number          8 MSP Correspondence Code
   00                                 0
 9 MSP Patient Birth Date          10 MSP Motor Vehicle Accident
   5402                               N
11 Error Messages



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

Field Explanations

1. MSP RECORD CODE IDENTIFIER (3-AN-R)
This field defaults to C01 in the master claim load and edit parameter, but is not used for actually creating the claim to send to the Ministry. It is included in the download file as a C02 per British Columbia Ministry specifications.

2. MSP DATA CENTRE NUMBER (5-AN-R)
This field contains the unique identifier assigned to the site, and defaults to the value set by the facility in the Claim Load and Edit Parameter.

3. MSP REGISTRATION NUMBER (10-N-R)
This field contains the patient's personal health number, which is the health card number assigned to the person by the province.

4. MSP PATIENT NAME VERIFICATION (4-AN-R)
This field contains the initials of the patient's first (F), middle (M), and last name (L). The field is formatted as FMLL.

5. MSP DEPENDENT NUMBER (2-N-R)
This field contains the dependent number assigned to the patient's personal health number. It is stored in the Health Card Version # field.

6. MSP SERVICE TO DAY (2-AN-R)
This field contains the last day of patient's hospital stay each month. This field will contain 00 for outpatients, 00 for inpatients that have not been discharged, and the discharge day for discharged inpatients.

7. MSP OFFICE FOLIO NUMBER (2-AN-O)
This field currently defaults to 00 per Ministry specifications.

8. MSP CORRESPONDENCE CODE (1-AN-O)
This field contains the type of correspondence or electronic note being sent to the Ministry. This field defaults to 0 when the claim is loaded.

9. MSP PATIENT BIRTHDATE (4-AN-R)
This field contains the year and month of the patient's birthdate in YYMM format. It is included in the download file in CCYYMMDD format.

10. MSP MOTOR VEHICLE ACCIDENT (1-AN-0)
This field indicates whether the patient's visit was due to a motor vehicle accident. If the visit is marked as an accident, field 4 in the accident type table is checked to determine if the accident type entered is specified as road traffic = "Yes". If Yes, this field contains a Y.

11. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the MSP Registration Number is required but not completed, the following error message displays in this field:

MSP Registration Number is Required

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the three screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information is contains. Accepting this screen completes the transaction.

BRITISH COLUMBIA MSP CLAIM FORM - SCREEN 2 OF 3

```
             General Hospital Maintain Claims by Account Processor
                              Page 2 of 3       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C01000001    BERRY,TESS                OH XRC 02/01/22 02/01/22   30.44   AR/FCRV
 1 MSP ICBC Claim Number            2 MSP2 Insurer Code
                                      MB
 3 MSP2 Registration Number         4 MSP2 Patient Date of Birth
   655784412                          05/12/55
 5 MSP2 Patient First Name          6 MSP2 Patient Middle Initial
   MSP                                P
 7 MSP2 Patient Last Name           8 MSP2 Patient Gender
   MERRITT                            M
 9 MSP2 Patient Address 1
   ASD   ASDASD
10 Error Messages




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

Field Explanations

1. MSP ICBC CLAIM NUMBER (8-AN-O)
This field contains the Case Number entered on the Accident Information screen.

NOTE: The following fields are accessible only if you have entered Yes on the MSP Claim Load and Edit Parameter header screen.

2. MSP2 INSURER CODE (8-AN-O)
This field contains the insurance carrier's code entered on the Insurance Processor screen.

3. MSP2 REGISTRATION NUMBER (10-N-R)
This field contains the patient's personal health number, which is the health card number assigned to the person by the province.

4. MSP2 PATIENT DATE OF BIRTH (4-AN-R)
This field contains the year and month of the patient's birthdate in YYMM format.

5. MSP2 PATIENT FIRST NAME (12-AN-R)
This field contains the patient's first name.

6. MSP2 PATIENT MIDDLE INITIAL (2-AN-R)
This field contains the patient's middle initial.

7. MSP2 PATIENT LAST NAME (18-AN-R)
This field contains the patient's last name.

8. MSP2 PATIENT GENDER (1-A-R)
This field contains the patient's gender.

9. MSP2 PATIENT ADDRESS 1 (25-AN-R)
This field contains the first line of the patient's address.

10. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the MSP ICBC Claim Number is required but not completed, the following error message *MSP ICBC Claim Number is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the three screens included in this function.

British Columbia MSP Claim Form - Screen 3 of 3

```
          General Hospital Maintain Claims by Account Processor
                                Page  3 of 3       Sun Aug 13, 2006 11:19 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C01000001    BERRY,TESS                OH XRC 02/01/22 02/01/22   30.44   AR/FCRV
 1 MSP2 Patient Address 2           2 MSP2 Patient City
   ASDAD                              HAMILTON
 3 MSP2 Patient Province            4 MSP2 Patient Postal Code
   AB                                 S1Q1Q1
 5 Error Messages
```

Field Explanations

1. MSP2 PATIENT ADDRESS 2 (25-AN-R)
This field contains the second line of the patient's address.

2. MSP2 PATIENT CITY (25-AN-R)
This field contains the patient's city.

3. MSP2 PATIENT PROVINCE (2-AN-R)
This field contains the patient's province code.

4. MSP2 PATIENT POSTAL CODE (25-AN-R)
This field contains the patient's postal code.

5. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the three screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information is contains. Accepting this screen completes the transaction.

BRITISH COLUMBIA WORKER'S COMP CLAIM FORM - SCREEN 1 OF 2

The following two screens are the claim demographic screens for Claim Type Q – BC Worker's Comp Elec.

```
            General Hospital Maintain Claims by Account Processor
                              Page  1 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C01000006    TESTBERRY,EMERGENCY ONE   WC UCC 02/01/24 02/01/24   176.90  AR/FCRV
 1 Record Code Identifier           2 Data Center Number
   C01                                T1234
 3 Registration Number              4 Patient Name Verification
   1874569870                         TESTBERRY,EMERGENCY ONE
 5 Dependent Number     6 Service To Day        7 Office Folio Number
   00                     00                      00
 8 Correspondence Code              9 Patient Birth Date
   0                                  7506
10 Motor Vehicle Accident         11 ICBC Claim Number
   N                                  12345678
12 Error Messages
Enter field number or '/' starting field number--
                    next screen(/) or previous screen(/P) [/]
```

Field Explanations

1. MSP RECORD CODE IDENTIFIER (3-AN-R)
This field defaults to C01 in the master claim load and edit parameter, but is not used for actually creating the claim to send to the Ministry. It is included in the download file as a C02 per British Columbia Ministry specifications.

2. MSP DATA CENTRE NUMBER (5-AN-R)
This field contains the unique identifier assigned to the site, and defaults to the value set by the facility in the Claim Load and Edit Parameter.

3. MSP REGISTRATION NUMBER (10-N-R)
This field contains the patient's British Columbia Health Card Number. It is included in the download file as zeroes per British Columbia Ministry specifications. The registration number is included in the reciprocal record when sent to the Ministry.

4. MSP PATIENT NAME VERIFICATION (37-AN-R)
This field contains the patient's name in last name, first name, and middle name format. It is included in the download file as blanks per British Columbia Ministry specifications, and the patient's name is included in the reciprocal record broken out by patient first name, patient middle initial or blank, and patients last name.

5. MSP DEPENDENT NUMBER (2-N-R)
This field contains the patient's British Columbia Health Card Version Number. It is included in the download file as zeroes per British Columbia Ministry specifications.

6. MSP SERVICE TO DAY (2-AN-R)
This field contains the last day of patient's hospital stay each month. This field will contain 00 for outpatients, 00 for inpatients that have not been discharged, and the discharge day for discharged inpatients.

7. MSP OFFICE FOLIO NUMBER (2-AN-O)
This field currently defaults to 00 per Ministry specifications.

8. MSP CORRESPONDENCE CODE (1-AN-O)
This field contains the type of correspondence or electronic note being sent to the Ministry. This field defaults to 0 when the claim is loaded.

9. MSP PATIENT BIRTHDATE (4-N-R)
This field contains the year and month of the patient's birthdate in YYMM format. It is included in the download file in CCYYMMDD format.

10. MSP MOTOR VEHICLE ACCIDENT (1-AN-0)
This field defaults to "N" as the claim is for worker's compensation.

11. MSP ICBC CLAIM NUMBER (8-AN-R)
This field contains the Case Number entered on the Accident Information screen for MSP ICBC and should not be entered for Worker's Compensation claims.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the two screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information is contains. Accepting this screen completes the transaction.

NOTE: Currently Screen 2 is identical to Screen 1 for Claim Type Q.

BRITISH COLUMBIA OUT OF PROVINCE CLAIM FORM - SCREEN 1 OF 2

The following two screens are the claim demographic screens for Claim Type V – BC Out of Province Claims.

```
              General Hospital Maintain Claims by Account Processor
                                Page  1 of 2       Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000013    TESTBERRY,OTHERPROV O       OP XRC 02/01/25 02/01/25   195.00  AR/FCRV
 1 Patient Account Number           2 Patient Last Name
   01000013                           TESTBERRY
 3 Patient First Name   4 Patient's Address 1
   OTHERPROV              987 EAST TEST AVENUE
 5 Patient's Address 2              6 Patient's City
                                      WALKER
 7 Patient's Province Code          8 Patient's Postal Code
   AB                                 X9X 9X
 9 Patient's Insurance Number      10 Patient's Birthdate
   578123456                          1954/07/10
11 Error Messages


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

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

2. PATIENT LAST NAME (18-AN-R)
This field contains the last name of the patient.

3. PATIENT FIRST NAME (12-AN-R)
This field contains the first name of the patient.

4. PATIENT'S ADDRESS 1 (25-AN-R)
This field contains the patient's first line of address.

5. PATIENT'S ADDRESS 2 (25-AN-O)
This field contains the patient's second line of address, if present.

6. PATIENT'S CITY (25-AN-R)
This field contains the patient's city.

7. PATIENT'S PROVINCE CODE (2-AN-R)
This field contains the patient's 2-character province abbreviation.

8. PATIENT'S POSTAL CODE (6-AN-R)
This field contains the patient's postal code.

9. PATIENT'S INSURANCE NUMBER (12-AN-R)
This field contains the insurance number entered in the Policy Number field on the out of province insurance screen. Typically, this is the patient's health card number from their home province.

10. PATIENT'S BIRTHDATE (10-N-R)
This field contains the patient's birthdate in YYYYMMDD format.

11. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Patient's Birthdate is required but not completed, the following error message *Patient's Birthdate is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the two screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information is contains. Accepting this screen completes the transaction.

BRITISH COLUMBIA OUT OF PROVINCE CLAIM FORM - SCREEN 2 OF 2

```
            General Hospital Maintain Claims by Account Processor
                                Page  2 of 2        Tue Mar 14, 2006 10:33 am
Account      Name                     FC Typ Admit    Disch      Balance Loc
C01000013    TESTBERRY,OTHERPROV O    OP XRC 02/01/25 02/01/25   195.00  AR/FCRV
 1 Patient's Sex        2 Patient's Admit Date
   F                      2002/01/25
 3 Patient's Discharge Date         4 Deceased Flag
   2002/01/25                       N
 5 Reason in British Columbia       6 Accident Code
   1
 7 Error Messages




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

Field Explanations

1. PATIENT'S SEX (1-AN-R)
This field contains the patient's sex.

2. PATIENT'S ADMIT DATE (10-N-R)
This field contains the patient's admit date in YYYYMMDD format.

3. PATIENT'S DISCHARGE DATE (10-N-R)
This field contains the patient's discharge date in YYYYMMDD format.

4. DECEASED FLAG (1-A-R)
This field contains whether the patient is deceased. A "Y" indicates the patient is deceased. Otherwise, it will contain "N".

5. REASON IN BRITISH COLUMBIA (1-AN-R)
This field contains the reason the patient is in British Columbia. It is entered in the Out of Province field on the Out of Province Insurance screen, and should contain a valid code from the out of province reason code table.

6. ACCIDENT CODE (6-AN-O)
This field contains the first E-diagnosis code encountered in the secondary diagnosis fields for the patient when the facility is using ICD-9 diagnosis codes. Once the conversion is made to ICD-10 diagnosis codes, the accident code reported will be the first secondary diagnosis meeting one of the following criteria: the first character of the diagnosis begins with a "V" and the first 2 digits of the diagnosis code are greater than zero; the first character of the diagnosis begins with a "W" or an "X"; or the first character of the diagnosis code begins with a "Y" and the first 2 digits of the diagnosis code are less than ninety-nine (99).

7. ERROR MESSAGES (DISPLAY ONLY)
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Reason in British Columbia is required but not completed, the following error message *Reason in British Columbia is Required* displays in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the two screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information is contains. Accepting this screen completes the transaction.

Claim Attachments

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

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

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

```
                    General Hospital Edit Claims Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                       FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT               15 I/P 95/10/25 95/10/31   7165.00 AR/FCRV

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









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

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

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

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

Accepting the screen completes the transaction.

Claim Charge Data

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

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

MOH CLAIM CHARGE DETAIL

```
                General Hospital Claims by Biller Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A0-02000-019 JONES,ROBERT              10 I/P 95/10/25 95/10/31   7165.00 AR/FCRV
                                                  Performing Dr ID Errors: None
                                                  SoB Errors:              None
                                                  Diagnosis Code Errors:   None
                                                  Invalid Qty Errors:      None
                                                  Referring Dr ID Errors:  None
Seq  Units  Charges   Svc Date   SoB     Billing Phys   Diag  Refer Dr ST  SubDT
                    PD Payments Adjusted Tech Fee Pro Fee SEQ MOH Bill #
1  *   1     110.00   95/10/25   A002A   842712551150         123456   PND
2  *   1      20.00   95/10/25   A025A   842712331122         123456   PND
3  *   1     110.00   95/10/26   A002A   842713310121         123456   PND
4  *   1      20.00   95/10/26   A025A   842703411111         123456   PND
5      1     110.00   95/10/27   A002A   842702512365         123456   PND
6      1      20.00   95/10/27   A025A   842713593465         123456   PND
7      1     110.00   95/10/28   A002A   842713614512         123456   PND
8      1      20.00   95/10/28   A025A   842714716743         123456   PND
9      1     110.00   95/10/29   A002A   842715189856         123456   PND
10     1      20.00   95/10/29   A025A   842716290189         123456   PND
11     1     110.00   95/10/30   A002A   842717313203         123456   PND
12     1      20.00   95/10/30   A025A   842718524141         123456   PND

                  F1Prev Page F2Next Page F5Select F7  Exit
```

NOTE: The second line only displays if you are in inquiry only or if the claim is already produced.

Field Explanations

1. PERFORMING DR ID ERRORS (DISPLAY ONLY)

This field contains the number of performing doctor ID errors. This code is verified against the Physician Bill Code for OHIP table.

2. SoB ERRORS (DISPLAY ONLY)

This field contains the number of SoB errors. The first four characters must be a valid SoB code and the last character must be an A, B or C. An SoB error is also recorded when two claim charge detail lines have the same service date and SoB code but different billing physicians.

3. DIAGNOSIS CODE ERRORS (DISPLAY ONLY)

This field contains the number of diagnosis code errors.

4. INVALID QTY ERRORS (DISPLAY ONLY)

This field contains the number of invalid quantity errors. The quantity must be positive and non-zero.

5. REFERRING DR ID ERRORS (DISPLAY ONLY)
This field contains the number of referring doctor ID errors. McKesson only checks to verify if this error is numeric and non-zero.

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

7. ORIGINAL CHARGE INDICATOR (DISPLAY ONLY)
An asterisk (*) displays if the charge line was loaded from the original claim load.

8. UNITS (4-N-R)
This field contains the total quantity of the charge line.

9. CHARGES (9-N-R)
This field contains the amount of the charge on this line. When a charge amount is entered, the system prompts you to enter the technical component amount.

10. SVC DATE (8-N-R)
This field contains the date on which the patient received service.

11. SoB (5-AN-R)
This field contains the schedule of benefits (SoB) code of the charge. The field is edited to the SoB table.

12. BILLING PHYS (12-N-R)
This field contains the physician billing id number associated with the charge. This field is edited to the Physician Billing Code for OHIP table. Entering a hyphen (-) displays the Physician Billing Codes available.

13. DIAG (4-N-C)
This field contains the Canadian diagnosis code for the charge. The diagnosis code is required for specific SoB codes as defined in the Schedule of Benefits table on Patient Care.

The Diagnosis for the charge will only be sent if the SoB code (Service Code) indicates that it is required in the Schedule of Benefits Table. If the Schedule of Benefits Table indicates that the code is required, then the following will apply:

- No decimal places will be sent. For example, if the diagnosis code is 825.02, then the HET record will have 825. If the code is 3 digits long, after removing the decimal places, the code will be left justified in the HET record.

- The field length is 4 digits. If the code is greater than 4 digits long after removing the decimal places, the system will truncate the code to 4 digits. For example, code 12345 would become 1234.

- If a freeform diagnosis was entered when the charge was placed, (a diagnosis that has a leading semi-colon globally on STAR Patient Accounting), a diagnosis will not be sent for this SoB code in the HET record.

- If a freeform (such as an L or an X) or non-valid diagnosis code is entered on the Claim Charge Data screen within Claims Management, then this code will be sent in the HET record. Any code manually entered into the claim itself will be sent.

- If a diagnosis code is entered on the Claim Charge Data screen within Claims Management for an SoB code that does not require a diagnosis, this code will be sent in the HET record. Any code manually entered into the claim itself will be sent.

- If the diagnosis code is an X, the diagnosis code will not be loaded/sent. However, if the diagnosis code begins with X, but has values after the X, such as X12.34 the then diagnosis would be loaded/sent as X12.

- If a charge does not have an SoB code (service code), then any diagnosis for this charge will no t load to the claim.

- Diagnosis codes that have leading alphas that are not freeform diagnosis codes (such as with some ICD10 codes) will load to the claim. For example, code B37.81 will be loaded/sent as B37.

- The exception to the formatting of XXX.XX for diagnosis codes (where the OHIP claim will use the positions before the decimal) is with E diagnosis codes. With E diagnosis codes, the format is XXXX.X. The OHIP claim will take the positions before the decimal. For example, E803.9 will load/send E803.

- If the Diagnosis field is either blank or set to No in the Schedule of Benefits Table for the SoB code on the charge, no diagnosis will be loaded/sent for the charge line, even if there is a valid diagnosis for the SoB code.

- When in the Claim Charge Data screen within Claims Management, the screen allows you to enter any alphanumeric Diagnosis value, 1 to 4 digits in length. The screen does not edit the diagnosis code or clear a freeform diagnosis.

14. REFER DR (6-N-R)
This field contains the OHIP number of the referring doctor for the charge. This is a free form field.

15. ST (DISPLAY ONLY)
This field contains the current status of the charge line. Values include PND - Pending, DWN - Download to file, SUB - Submitted to Ministry via diskette, RES - Resubmitted to Ministry, PD - Paid by Ministry, and various exception codes returned from the Ministry.

16. SUBDT (DISPLAY ONLY)
This field contains the date this charge line was submitted via diskette to the Ministry.

17. PD (DISPLAY ONLY)
This field indicates whether the claim charge line has been paid in full. An asterisk will display if the claim charge line has been fully satisfied.

18. PAYMENTS (DISPLAY ONLY)
This field contains the total amount of payments applied to that particular claim charge detail line.

19. ADJUSTED (DISPLAY ONLY)
This field contains the total adjustment amounts applied to that particular claim charge detail line.

20. TECH FEE (DISPLAY ONLY)
This field contains the technical component amount of the claim charge detail line.

21. PRO FEE (DISPLAY ONLY)
This field contains the professional component amount of the claim charge detail line.

22. SEQ (DISPLAY ONLY)
This field contains the internal charge sequence number.

23. MOH BILL # (DISPLAY ONLY)
This field contains the Ministry of Health claim number returned on the remittance.

WCB CLAIM CHARGE DETAIL

NOTE: When charge information for daily evaluation claims (WCB claims with a type of E-Evaluation) is viewed in Claim Charge Data, the title line is *Daily Evaluation Charges.*

```
                  General Hospital Claims by Account Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                       FC Typ Admit    Disch      Balance Loc
A9-00134-95  BRWERRY,CRIS JASON       15 I/P 96/01/29 96/02/02   573.00  AR/FCRV

                               Inpatient Charges
Description --: DBW WARD
Seq  From/Serv Date  To Date   SoB      UOS  Diff       Amount        Error
1    960131          960201                92

                  F1Prev Page F2Next Page F5Select F7  Exit
```

Field Explanations

SEQ
This field contains the sequential number identifying the line number on the screen.

FROM/SERV DATE
This field contains the beginning service date for the charge.

TO DATE
This field contains the ending service date for the charge.

SoB
This field contains the schedule of benefits (SoB) code of the charge. The field is edited to the SoB table. This field is not used for WCB claims with a type of E-Evaluation.

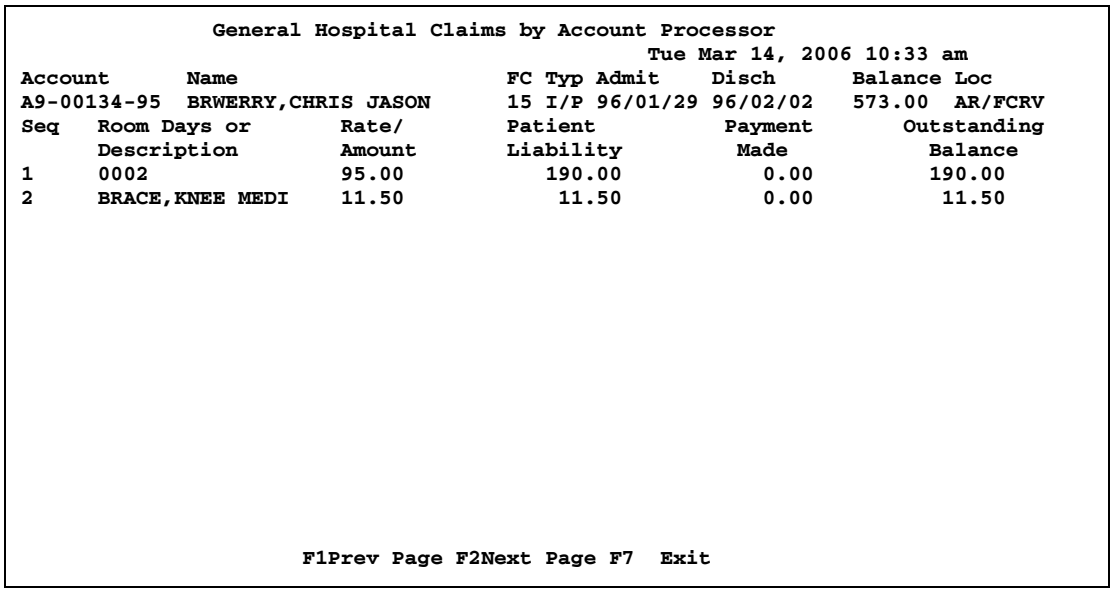
UOS
This field contains the units or service or the LMS units for laboratory.

DIFF
This field contains the diff code.This field is not used for WCB claims with a type of E-Evaluation.

AMOUNT
This field contains the amount of the claim charge line.

ERROR
When applicable, the system displays error messages pertaining to the information on this screen. For example, if the Daily Differential field is required but not completed, the error message *Daily Differential is Required* displays in this field.

UNIVERSAL CLAIM CHARGE DETAIL



Field Explanations

SEQ
This field contains the sequential number identifying the line items on the screen.

ROOM DAYS OR DESCRIPTION
This field contains the number of room days being reported for a semi-private or private differentials or the description of the charge being covered.

RATE/AMOUNT
This field contains the actual rate of the charge.

PATIENT LABILITY
This field contains the total amount of the charges.

PAYMENT MADE
This field contains the default of zero.

OUTSTANDING BALANCE
This field contains the total amount of the charges.

BRITISH COLUMBIA MSP CLAIM CHARGE DETAIL

```
          General Hospital Maintain Claims by Account Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                         FC Typ Admit    Disch      Balance Loc
C01000003    TESTBERRY,OUTPATIENT ONE     OH XRC 02/01/23 02/01/23   58.14   AR/FCRV
                                                 Practitioner Errors:        2
                                                 MSP Errors:              None
                                                 Invalid Qty Errors:      None
                                                 Diagnosis Code Errors:   None
                                                 SvcClarification Errors: None
                                                 Referring Dr ID Errors:     2
Seq  Units  Charges  Svc Date   MSP  Payee  Pract ICD   SCC  SUB  Loc Refer DR1
Refer Dr2  SvcST/Fin   Short Comment        Facility  Sub-Facility  ST  SubDT
1  *    1     29.07  02/01/23  08530 3644   34562        00   0    H    B 45672
0 00000    0000 0000                        00000     00000       PND
2  *    1     29.07  02/01/23  08531 3644   45672        00   0    H    B 34562
0 00000    0000 0000                        00000     00000       PND



F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Add Note F6 Reset  F7  Exit   ?
```

NOTE: An additional line displays if you are in inquiry only or if the claim is already produced.

Field Explanations

1. PRACTIONER ERRORS (DISPLAY ONLY)
This field contains the number of performing doctor ID errors. This code is verified against the Physician Bill Code-Ministry table.

2. MSP ERRORS (DISPLAY ONLY)
This field contains the number of MSP errors. The MSP code must be a valid code in the MSP table.

3. INVALID QTY ERRORS (DISPLAY ONLY)
This field contains the number of invalid quantity errors. The quantity must be positive and non-zero.

4. DIAGNOSIS CODE ERRORS (DISPLAY ONLY)
This field contains the number of diagnosis code errors. It edits for data or not; validity of value is not determined.

5. SVCCLARIFICATION ERRORS (DISPLAY ONLY)
This field contains the number of service clarification errors. If the MSP fee code requires a service clarification code (as defined in the MSP Fee Code Table), this field must be completed.

6. REFERRING DR ID ERRORS (DISPLAY ONLY)
This field contains the number of referring doctor ID errors. Referring Doctor 1 is required, and must be contained in the Physician Bill Code-Ministry table. Although

Referring Doctor 2 is not required, if not equal to zero, it must also be contained in the Physician Bill Code-Ministry table.

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

8. ORIGINAL CHARGE INDICATOR (DISPLAY ONLY)
An asterisk (*) displays if the charge line was loaded from the original claim load.

9. UNITS (3-N-R)
This field contains the total quantity of the charge line.

10. CHARGES (6-N-R)
This field contains the amount of the charge on this line. When a charge amount is entered, the system prompts you to enter the technical component amount.

11. SVC DATE (8-N-R)
This field contains the date on which the patient received service.

12. MSP (5-N-R)
This field contains the MSP Fee for Service Item (MSP) code of the charge. The field is edited to the MSP table.

13. PAYEE (5-N-R)
This field contains the number assigned by MSP to the practitioner/facility who will receive payment for the claim submitted. The payee ID is stored in the Billing Institution # in the Provider Master.

14. PRACT (5-N-R)
This field contains the Provincial License # for the performing doctor on the charge. This license # must exist in the Physician Billing Code-Ministry table, and the billing type for the physician must be either Practitioner or Practitioner/Referring in order to be valid.

Entering a hyphen (-) displays the Physician Billing Codes available.

15. ICD (5-AN-O)
This field contains the ICD9 diagnosis code for the charge. Currently this code is not being edited. A free-form diagnosis entered with a charge will not load to the claim.

16. SCC (2-N-R)
This field contains the service clarification code if needed. This field defaults to 00.

17. SUB (1-AN-R)
This field contains the type of submission for MSP Claims Processing purposes. Regular claim submissions include a 0 in this field. This field can be edited to indicate a resubmission reason, but this code must exist in the MSP Resubmission Codes table in order to be valid.

18. LOC (1-A-R)
This field contains the location of service, which is associated with Service Location field found in the patient type table. The service location is assigned based on the patient's patient type at the time of the charge. If the Service Location field is blank in the patient type table at the time the charge is placed, the following defaults are used:

I If the Patient Indicator is I (Inpatient)

E If the Patient Indicator is E (Emergency)

P If the Patient Indicator is O (Outpatient)

19. REFER DR1 (1-A-R/5-N-R)
This field contains the first referral by or to indicator and the valid practitioner's number for the referring doctor. This field will default to "B", and the referring doctor ID will be the Provincial License # for the Charging Physician on the charge record. The provincial license # must exist in the Physician Billing Code-Ministry table, and the billing type for the physician must be either Referring or Practitioner/Referring in order to be valid.

20. REFER DR2 (1-A-R/5-N-R)
This field contains the second referral by or to indicator (B, T, or zero) and the valid practitioner's number or zeroes. The referring doctor 2 field is not required and is not automatically loaded. Both fields default to zeroes. However, if entered, number must exist in the Physician Billing Code-Ministry table, and the billing type for the physician must be either Referring or Practitioner/Referring in order to be valid.

21. SVCST/FIN (4-N-R/4-N-R)
This field contains the service start and finish times. MSP can require as policy demands. The times are based on a 24-hour clock, formatted as HHMM. The default is zeroes.

22. SHORT COMMENT (20-AN-O)
This field contains an optional twenty character short comment that may be entered during the ordering/charging process. If passed in the charge record, this comment automatically loads to the claim charge line. The default is blanks. The field should not be used in conjunction with a note record. When a note record is added, any short comment that exists is set to blanks.

23. NOTE INDICATOR (DISPLAY ONLY)
An asterisk (*) will display if a long note record exists for the claim charge line.

24. FACILITY (5-AN-R)
This field contains the main facility number assigned by MSP. The facility number is entered into the MSP table, and if present, will load onto the claim. The default is zeroes.

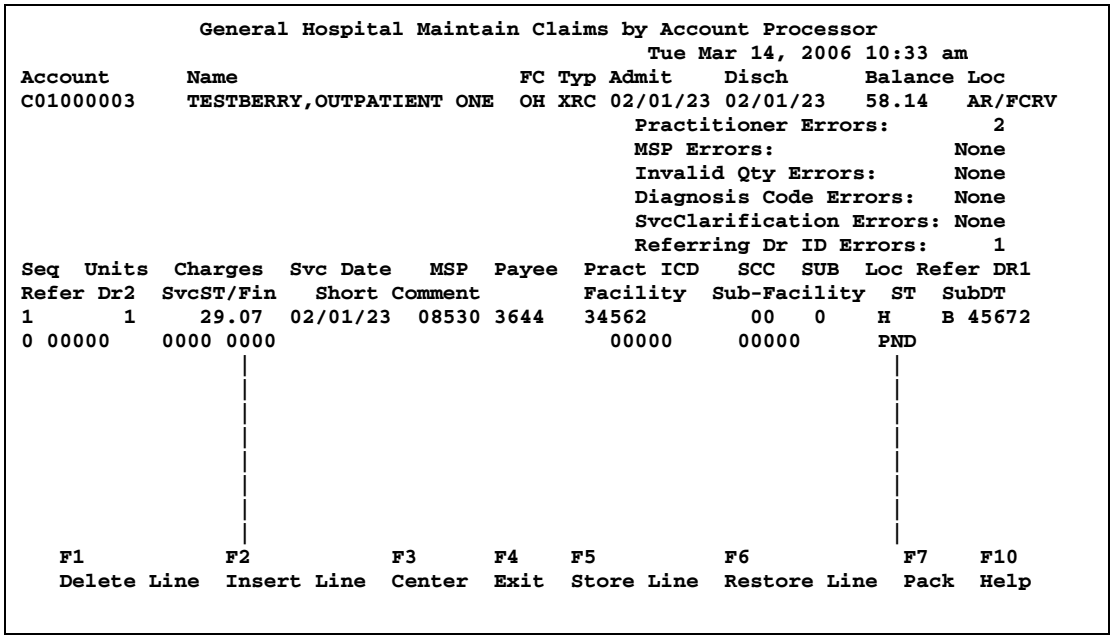
25. SUB-FACILITY (5-AN-R)
This field contains the sub-facility number assigned by MSP. This field currently defaults to zeroes.

26. ST (DISPLAY ONLY)
This field contains the current status of the charge line. Values include PND - Pending, DWN - Download to file, SUB - Submitted to Ministry (i.e, diskette has been created), RES – Resubmitted to Ministry, PD - Paid by Ministry, and various exception codes returned from the Ministry.

27. SUBDT (DISPLAY ONLY)
This field contains the date this charge line was submitted via diskette to the Ministry.

MSP provides the ability to submit an electronic note record for each claim to clarify reason for claim being submitted. Submission of a note can delay payment of a claim depend on adjudication requirements and time required to manually review. The note record should only be submitted where it is a requirement by MSP or an explanation is felt needed to prevent refusal of the claim. An alternative for comments 20 characters or less is to enter the short comments on the claim.

In order to enter a note, the user presses F5 Add Note on the claim charge line for which the note applies. If short comments exist on the claim charge line, these will be automatically deleted when the note is accepted. The following screen appears in order to enter the note:



Up to 400 characters of notes can be entered and sent to the Ministry (8 lines containing 50 characters each). To delete the note,delete each line and then press F4

to exit. Once the note has been entered, any short comments associated with the charge line are removed, and the note indicator on the claim charge line is set to an asterisk (*). Currently, the additional note cannot be viewed when in inquiry only mode.

Once the screen is accepted, the user is returned to the claim charge data entry screen.

In Inquiry Only Mode, the following fields will also display:

28. PD (DISPLAY ONLY)
This field indicates whether the claim charge line has been paid in full. An asterisk will display if the claim charge line has been fully satisfied.

29. PAYMENT (DISPLAY ONLY)
This field contains the total amount of payments applied to that particular claim charge detail line.

30. ADJ AMT (DISPLAY ONLY)
This field contains the total adjustment amounts applied to that particular claim charge detail line.

31. TECH FEE (DISPLAY ONLY)
This field contains the technical component amount of the claim charge detail line.

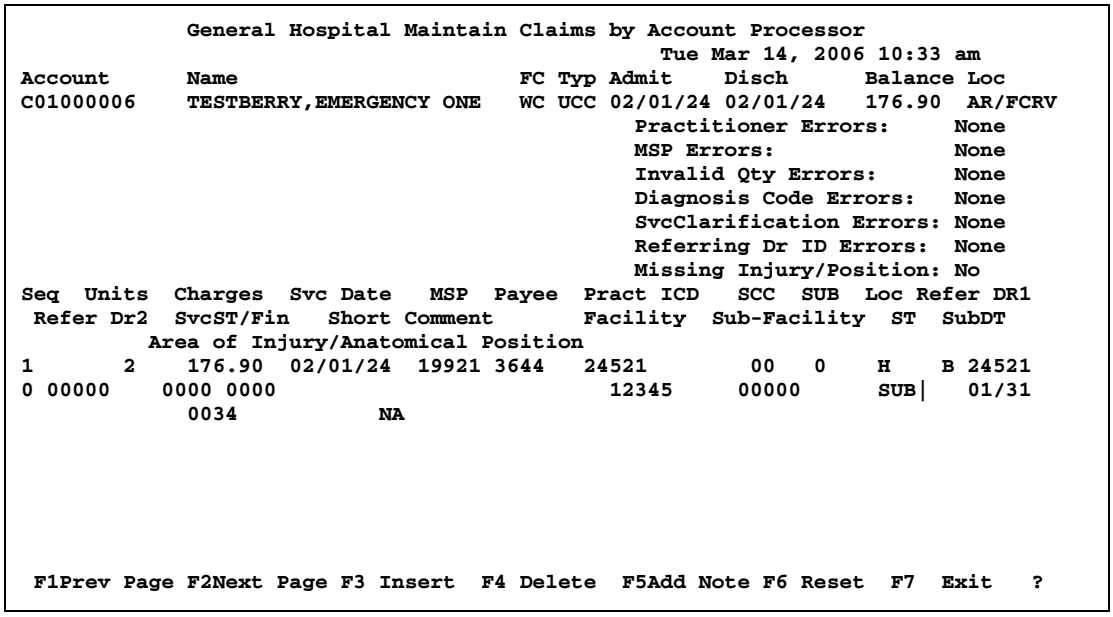
32. PRO FEE (DISPLAY ONLY)
This field contains the professional component amount of the claim charge detail line.

33. DATA SEQ (DISPLAY ONLY)
This field contains the 7-digit unique sequence number assigned when the claim charge line was loaded onto diskette.

34. MIS DT (DISPLAY ONLY)
This field contains the date the Ministry of Health received the original claim.

35. ADJ IND (DISPLAY ONLY)
This field contains the adjustment indicator received on the remittance advice.

BRITISH COLUMBIA WORKER'S COMPENSATION CLAIM CHARGE DETAIL



NOTE: Additional items display on the third line if you are in inquiry only or if the claim is already produced.

Field Explanations

1. PRACTIONER ERRORS (DISPLAY ONLY)
This field contains the number of performing doctor ID errors. This code is verified against the Physician Bill Code-Ministry table.

2. MSP ERRORS (DISPLAY ONLY)
This field contains the number of MSP errors. The MSP code must be a valid code in the MSP table.

3. INVALID QTY ERRORS (DISPLAY ONLY)
This field contains the number of invalid quantity errors. The quantity must be positive and non-zero.

4. DIAGNOSIS CODE ERRORS (DISPLAY ONLY)
This field contains the number of claim service lines which do not contain a diagnosis code. Diagnosis codes are not edited for validity of data.

5. SVCCLARIFICATION ERRORS (DISPLAY ONLY)
This field contains the number of service clarification errors. If the MSP fee code requires a service clarification code (as defined in the MSP Fee Code Table), this field must be completed.

6. REFERRING DR ID ERRORS (DISPLAY ONLY)
This field contains the number of referring doctor ID errors. Referring Doctor 1 is required, and must be contained in the Physician Bill Code-Ministry table. Although Referring Doctor 2 is not required, if not equal to zero, it must also be contained in the Physician Bill Code-Ministry table.

7. MISSING INJURY/POSITION (DISPLAY ONLY)
This field indicates whether any of the claim charge lines are missing the Area of Injury or the Anatomical Position. These are required for British Columbia Worker's Compensation claims.

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

9. ORIGINAL CHARGE INDICATOR (DISPLAY ONLY)
An asterisk (*) displays if the charge line was loaded from the original claim load.

10. UNITS (3-N-R)
This field contains the total quantity of the charge line.

11. CHARGES (6-N-R)
This field contains the amount of the charge on this line. When a charge amount is entered, the system prompts you to enter the technical component amount.

12. SVC DATE (8-N-R)
This field contains the date on which the patient received service.

13. MSP (5-N-R)
This field contains the MSP Fee for Service Item (MSP) code of the charge. The field is edited to the MSP table.

14. PAYEE (5-N-R)
This field contains the number assigned by MSP to the practitioner/facility who will receive payment for the claim submitted. The payee ID is stored in the Billing Institution # in the Provider Master.

15. PRACT (5-N-R)
This field contains the Provincial License # for the performing doctor on the charge. This license # must exist in the Physician Billing Code-Ministry table, and the billing type for the physician must be either Practitioner or Practitioner/Referring in order to be valid.

Entering a hyphen (-) displays the Physician Billing Codes available.

16. ICD (5-AN-O)
This field contains the ICD9 diagnosis code for the charge. A free-form diagnosis entered with a charge does not load to the claim. ICD-10-CM codes do not load to the claim.

17. SCC (2-N-R)
This field contains the service clarification code if needed. This field defaults to 00.

18. SUB (1-AN-R)
This field contains the type of submission for MSP Claims Processing purposes. Regular claim submissions include a 0 in this field. This field can be edited to indicate a resubmission reason, but this code must exist in the MSP Resubmission Codes table in order to be valid.

19. LOC (1-A-R)
This field contains the location of service, which is associated with Service Location field found in the patient type table. The service location is assigned based on the patient's patient type at the time of the charge. If the Service Location field is blank in the patient type table at the time the charge is placed, the following defaults are used:

I If the Patient Indicator is I (Inpatient)

E If the Patient Indicator is E (Emergency)

P If the Patient Indicator is O (Outpatient)

20. REFER DR1 (1-A-R/5-N-R)
This field contains the first referral by or to indicator and the valid practitioner's number for the referring doctor. This field will default to "B", and the referring doctor ID will be the Provincial License # for the Charging Physician on the charge record. The provincial license # must exist in the Physician Billing Code-Ministry table, and the billing type for the physician must be either Referring or Practitioner/Referring in order to be valid.

21. REFER DR2 (1-A-R/5-N-R)
This field contains the second referral by or to indicator (B, T, or zero) and the valid practitioner's number or zeroes. The referring doctor 2 field is not required and is not automatically loaded. Both fields default to zeroes. However, if entered, number must exist in the Physician Billing Code-Ministry table, and the billing type for the physician must be either Referring or Practitioner/Referring in order to be valid.

22. SVCST/FIN (4-N-R/4-N-R)
This field contains the service start and finish times. MSP can require as policy demands. The times are based on a 24-hour clock, formatted as HHMM. The default is zeroes.

23. SHORT COMMENT (20-AN-O)
This field contains an optional twenty character short comment that may be entered during the ordering/charging process. If passed in the charge record, this comment automatically loads to the claim charge line. The default is blanks. The field should not be used in conjunction with a note record. When a note record is added, any short comment that exists is set to blanks.

24. NOTE INDICATOR (DISPLAY ONLY)
An asterisk (*) will display if a long note record exists for the claim charge line. This is not currently working for British Columbia Worker's Compensation claims.

25. FACILITY (5-AN-R)
This field contains the main facility number assigned by MSP. The facility number is entered into the MSP the SIM Department table, and if present for the first charge used to create a charge service line, it loads onto the claim. The default is zeroes.

26. SUB-FACILITY (5-AN-R)
This field contains the sub-facility number assigned by MSP. This field is populated from the BC Sub-Facility code field on the Patient Type table. The default is zeroes.

27. ST (DISPLAY ONLY)
This field contains the current status of the charge line. Values include PND - Pending,

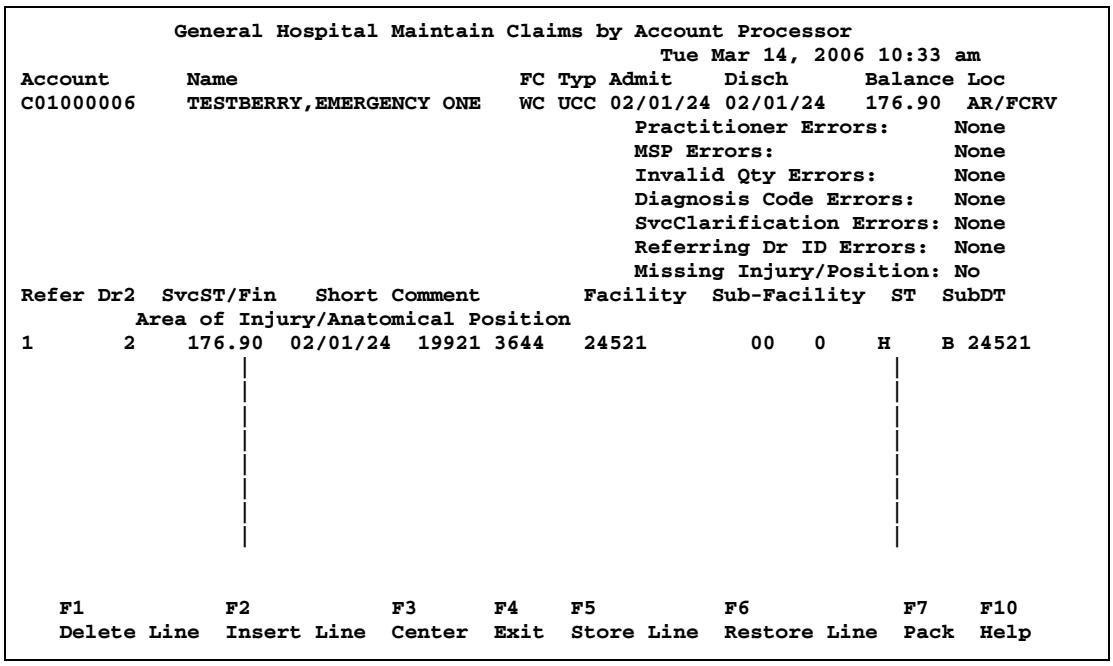
DWN - Download to file, SUB - Submitted to Ministry (i.e, diskette has been created), RES – Resubmitted to Ministry, PD - Paid by Ministry, and various exception codes returned from the Ministry.

28. SUBDT (DISPLAY ONLY)
This field contains the date this charge line was submitted via diskette to the Ministry.

29. AREA OF INJURY/ANATOMICAL POSITION (5-AN-R/2-AN-R)
This field contains the area of injury (body part) and the anatomical position, and both are required for British Columbia Worker's Compensation Claims. These will automatically pull forward to the claim charge detail line if these items are included in the charge record sent from Patient Care. A Table Look-up is provided for each of these items, using the Body Parts and Anatomical Position tables respectively.

MSP provides the ability to submit an electronic note record for each claim to clarify reason for claim being submitted. Submission of a note can delay payment of a claim depend on adjudication requirements and time required to manually review. The note record should only be submitted where it is a requirement by MSP or an explanation is felt needed to prevent refusal of the claim. An alternative for comments 20 characters or less is to enter the short comments on the claim.

In order to enter a note, the press F5 Add Note on the claim charge line for which the note applies. If short comments exist on the claim charge line, these are automatically deleted when the note is accepted. The following screen appears in order to enter the note:



Up to 400 characters of notes can be entered and sent to the Ministry (8 lines containing 50 characters each). To delete the note, delete each line and then press F4 to exit. Once the note has been entered, any short comments associated with the charge line are removed, and the note indicator on the claim charge line is set to an asterisk (*). Currently, the additional note cannot be viewed when in inquiry only mode.

Once the screen is accepted, the user is returned to the claim charge data entry screen.

NOTE: The note function is currently not working for British Columbia Worker's Compensation claims even though pressing F5 will bring up the Add Notes screen.

In Inquiry Only Mode, the following fields will also display:

28. PD (DISPLAY ONLY)
This field indicates whether the claim charge line has been paid in full. An asterisk will display if the claim charge line has been fully satisfied.

29. PAYMENT (DISPLAY ONLY)
This field contains the total amount of payments applied to that particular claim charge detail line.

30. ADJ AMT (DISPLAY ONLY)
This field contains the total adjustment amounts applied to that particular claim charge detail line.

31. TECH FEE (DISPLAY ONLY)
This field contains the technical component amount of the claim charge detail line.

32. PRO FEE (DISPLAY ONLY)
This field contains the professional component amount of the claim charge detail line.

33. DATA SEQ (DISPLAY ONLY)
This field contains the 7-digit unique sequence number assigned when the claim charge line was loaded onto diskette.

34. MIS DT (DISPLAY ONLY)
This field contains the date the Ministry of Health received the original claim.

35. ADJ IND (DISPLAY ONLY)
This field contains the adjustment indicator received on the remittance advice.

BRITISH COLUMBIA OUT OF PROVINCE CLAIM CHARGE DETAIL

The claim charge detail for a British Columbia out of province claim will differ depending on whether the claim is for inpatient or outpatient.

British Columbia Out of Province Inpatient Claim Charge Detail

For an inpatient out of province claim, the following claim charge detail will appear.

```
            General Hospital Maintain Claims by Account Processor
                                                  Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
C01000010    TESTBERRY,OTHERPROV I     OP IPC 02/01/23 02/01/24   635.00  AR/FCRV
                                                 Room Units Errors:       None
                                                 Claim Amount Errors:     None
                                                 Diagnosis Code Errors:      1
Seq      Units    Per Diem Rate   Claim Amount    Diagnosis     Procedure
Notes/Comments
1         1          545.00          545.00



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

Field Explanations

1. ROOM UNITS ERRORS (DISPLAY ONLY)
This field indicates if there are room units errors on the claim. If the units of service for the room charges does not equal the length of stay (discharge date – admit date), the resulting error is displayed in this field. The claim fails edits and is not released until the errors are corrected. Units of service must be changed in order for the error to be corrected.

2. CLAIM AMOUNT ERRORS (DISPLAY ONLY)
This field contains the number of claim amount errors on the claim. The claim amount must not be greater than 999999.99; otherwise, a claim amount error occurs. The claim cannot be manually released if a claim amount error exists.

3. DIAGNOSIS CODE ERRORS (DISPLAY ONLY)
This field contains the number of diagnosis errors on the claim. The claim cannot be manually released if there are missing diagnosis codes on the charge line.

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

5. UNITS (3-N-R)
This field contains the total quantity of the charge line.

6. PER DIEM RATE (6-N-R)
This field contains per diem rate for the patient's stay. It is calculated by taking the total amount of the of the room and bed charges divided by the units.

7. CLAIM AMOUNT (8-N-R)
This field contains the amount of the charge on this line.

8. DIAGNOSIS CODE (5-N-R)
This field contains the patient's primary ICD-9 diagnosis code. (without the decimal). When a diagnosis code is entered on this line, it must be a valid ICD-9 diagnosis code.

9. PROCEDURE CODE (4-N-O)
This field contains the patient's primary ICD-9 procedure code (without the decimal). When a diagnosis code is entered on this line, it must be a valid ICD-9 procedure code.

10. NOTES/COMMENTS (30-AN-O)
This field contains any notes or comments that the user wants to send when the claim is submitted.

British Columbia Out of Province Outpatient Claim Charge Detail

For an outpatient out of province claim, the following claim charge detail will appear.

```
          General Hospital Maintain Claims by Account Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000013    TESTBERRY,OTHERPROV O       OP XRC 02/01/25 02/01/25   195.00  AR/FCRV
                                                 Svc Date Errors:           None
                                                 Svc Code Errors:           None
                                                 Claim Amount Errors:       None
Seq  Svc Date     Svc Code/Description   Claim Amt   Error Description
Comments/Notes
1    2002/01/25   04-Computerized Axi     195.00


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

Field Explanations

1. SVC DATE ERRORS (DISPLAY ONLY)
This field indicates the number of service date errors on the claim. A service date error occurs when the service date is not within the past calendar year.

2. SVC CODE ERRORS (DISPLAY ONLY)
This field contains the number of out of province service code errors on the claim. The service code must be a valid service code defined in the Out of Province Service Code table. The claim cannot be manually released if a service code error exists.

3. CLAIM AMOUNT ERRORS (DISPLAY ONLY)
This field contains the number of claim amount errors on the claim. The claim amount must not be greater than 999999.99; otherwise, a claim amount error occurs. The claim cannot be manually released if a claim amount error exists.

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

5. SERVICE DATE (8-N-R)
This field contains the service date of the charge line.

6. SVC CODE/DESCRIPTION (2-N-R)
This field contains the out of province service code for the charge line, followed by up to sixteen characters of the description of the code from the Out of Province Service Code Table. When entered, the service code must be in the Out of Province Service Code table.

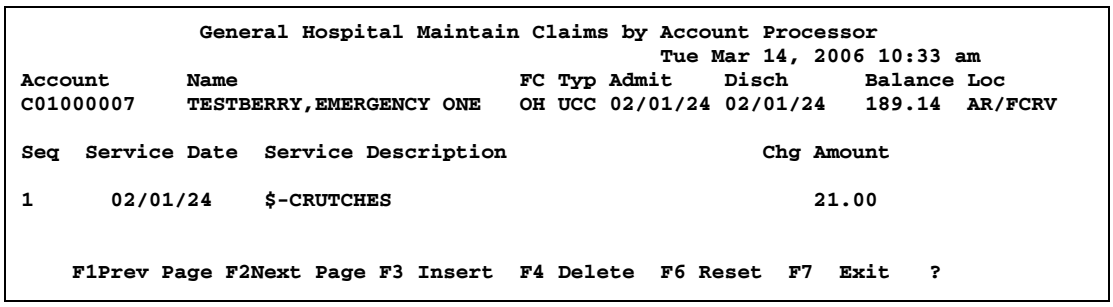
7. CLAIM AMOUNT (6-N-R)
This field contains the claim amount associated with the out of province service code on the charge line. The Out of Province Service Code table has an indicator which defines the service as either an “independent” service or a “dependent” service. When the outpatient claim loads, each charge designated as the responsibility of the out of province insurance plan is evaluated to determine if the out of province service code associated with the charge is dependent or independent. For charges that have a

service code defined as “Dependent”, only one charge line will load. The claim amount for this charge line will be the dependent charge with the highest dollar value. Using the same criteria for determining the claim amount, one charge line is loaded for each service code defined as “Independent”.

8. ERROR DESCRIPTION (DISPLAY ONLY)
This field contains the description of the error(s), if any, associated with the claim charge line.

9. COMMENTS/NOTES (30-AN-O)
This field contains any notes or comments that the user wants to send when the claim is submitted.

Patient Bill Claim Charge Detail



Field Explanations

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

2. SERVICE DATE (6-N-R)
This field contains the service date of the charge line.

3. SERVICE DESCRIPTION (36-AN-O)
This field contains description of the charge, and although not required, should be entered in order to expedite payment.

4. CHG AMOUNT (7-N-R)
This field contains the amount of the charge line. When entered, the amount must be entered with a decimal point.

Function Keys

The function keys at the bottom of the screen are used to help you enter/edit information on this screen.

F1 - Prev Page

If the detail extends beyond one page, you use this key to return to the previous page.

F2 - Next Page

If the detail extends beyond one page, you use this key to move to the next page.

F3 - Insert

If you want to insert a line of information, position your cursor at the point where you want to insert and press the F3 key. All detail lines that follow this line are moved down one line and enable you to add additional detail information.

This function is used in British Columbia's MSP claims (Claim type P) and Ontario's OHIP claims (Claim type H). For complete information regarding this option, refer to the next chapter, Billing & Claim Processing Hints.

F4 - Delete

If you want to delete a detail line, use this key.

F5 – Add Note

This function is only applicable to British Columbia MSP and Worker's Comp Elec claim types (P and Q). If you want to add a note to the claim charge line, use this key.

F6 - Reset

If you want to return to the original data after keying changes, use this key.

F7 - Exit

When you have completed your review and changes, use this key to exit this screen and return to the claims options menu. If you made changes to the detail information, the following prompt is displayed:

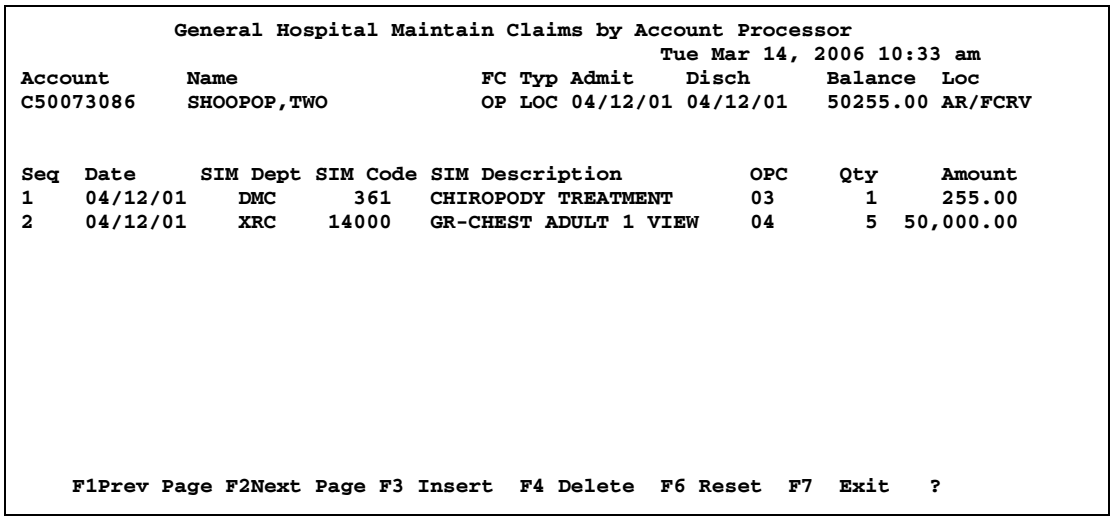
Accept (Y/N)?

Enter **Y** to save the changes or **N** to disregard the changes. The system returns you to the claims options menu.

Any changes, additions, and/or deletions made in this screen are reported on the Claim Charge Data Control Report. An entry is also entered in the patient's transaction history. Both of the above transactions provide an audit trail of the biller who changed charge information on a patient's claim form. Changes made in this screen do not update the account balance. You can make changes until the claim is produced.

Ontario Out of Province Outpatient Claim Charge Detail

For an outpatient out of province claim, the following claim charge detail is displayed.



Field Explanations

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

DATE (DISPLAY ONLY)
This field contains the date of the charges.

SIM DEPT (DISPLAY ONLY)
This field contains the SIM Department, from the Service Item Master table.

SIM CODE (DISPLAY ONLY)
This field contains the SIM Department code, from the Service Item Master table.

SIM DESCRIPTION (DISPLAY ONLY)
This field contains the description of the SIM Department, from the Service Item Master table.

OPC (DISPLAY ONLY)
This field contains the out of province code, from the Out of Province Code table.

QTY (DISPLAY ONLY)
This field contains the quantity of treatments.

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

Ontario Out of Province Inpatient Claim Charge Detail

For an inpatient out of province claim, the following claim charge detail is displayed.

```
                General Hospital Maintain Claims by Account Processor
                                                  Tue Mar 14, 2006 10:33 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
C10000804    SHOOPIP,EIGHT           OP LIC 04/11/30 04/12/03   1200.00 AR/FCRV


Seq From/Serv Date  Thru/Serv Date    Total Days   Std Ward Rate      Amount
1      04/11/30        04/12/02            3            400.00      1,200.00









              F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

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

FROM/SERV DATE (DISPLAY ONLY)
This field contains the beginning service date.

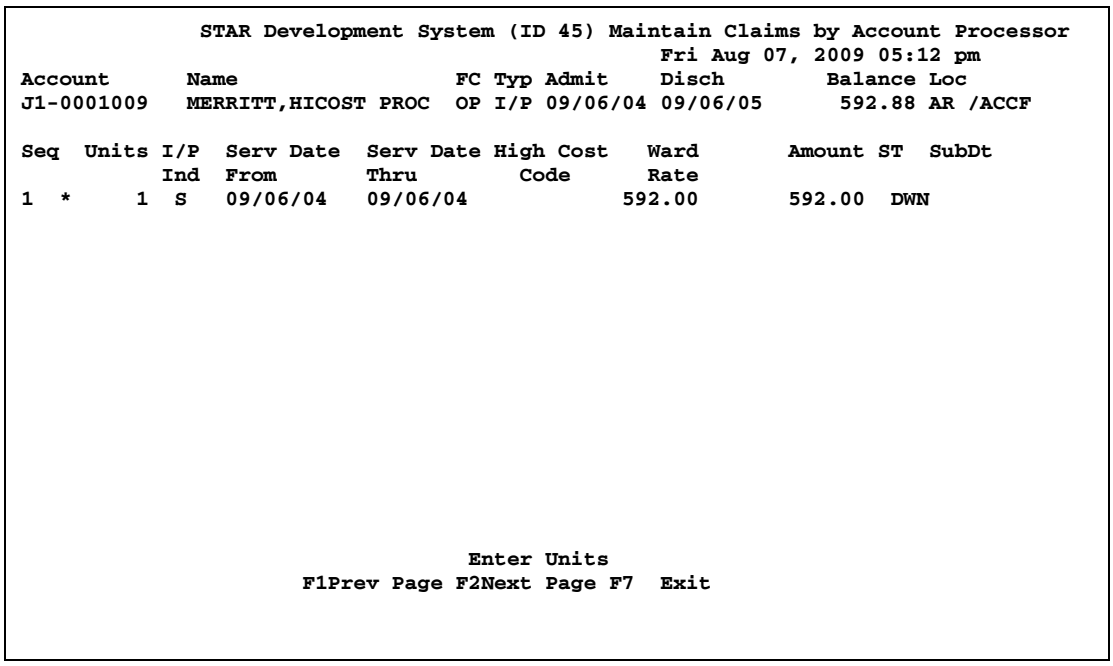
THRU/SERV DATE (DISPLAY ONLY)
This field contains the ending service date.

TOTAL DAYS (DISPLAY ONLY)
This field contains the total days of the patient's hospital stay.

STD WARD RATE (DISPLAY ONLY)
This field contains the standard ward rate.

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

Ontario Out of Province ICD10, Inpatient Claim Charge Detail



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

I/P IND (DISPLAY ONLY)
This field contains S for Standard Ward Rate or H for High Cost.

SERV DATE FROM (6-N-R)
This field contains the beginning service date for an R&B charge, or the date of service for a High cost charge.

SERV DATE THRU (6-N-R)
This field contains the ending service date for an R&B charge. Entry is not allowed for high cost charge units.

HIGH COST CODE
This field contains the value from High Cost Code field on the High Cost Procedure table associated with SIM department and SIM Item for the charge.

WARD RATE
This field contains the dollar amount associated with R&B charges.

AMOUNT
This field contains the amount of the charge. For the standard ward rate (S), the amount is the total for all R&B charges with charge amount. For high cost procedures (H) this is the charge amount.

STATUS
This field contains the status of the claim, as follows

- PND: pending, indicates that this claim was not submitted
- DWN: downloaded to data file
- SUB: claim has been submitted via download
- RES: resubmit, indicates that this claim will be resubmitted
- PPD: partial payment based on calculation (pymt + adj = total charge)
- PD: indicates this claim line was paid from cash posting

NOTE: If all charge lines are marked as PD, the claim is marked as Final Disp.

SUB DATE
This field contains the date the download option was run.

Ontario Out of Province ICD10, Outpatient Claim Charge Detail

```
                General Hospital Maintain Claims by Account Processor
                                        Tue Mar 14, 2009 10:33 am

Account      Name           FC Typ Admit    Disch         Balance Loc
J5-0260736   MARLOWE, BOB   OP O/P 06/01/25 06/01/26      122.00 AR

                                                      No OPC Indicated:

                     SIM  SIM      SIM
Seq  Qty Date        Dept Code   Description     OPC    Amount  ST    SubDT
1    1 06/01/25      DSU   130   ANTRUM LAVAGE   02    100.00  PND
2    1 06/01/26      OT    108   BUTTON HOOK     07      11.00  PND



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

NO OPC INDICATED ERROR:
If claim service lines exist without OPC codes, the number of claim service lines appears after the No OPC Indicated field label. Whenever a change is made to Claim Charge Data and the changes are recorded, the claim charges are re-evaluated to determine if claim service lines exist missing OPC codes. If the only error preventing the automatic release of the claim was missing OPC codes and they are supplied using Claim Charge Data, the claim is released from Claim Charge Data.

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

DATE (DISPLAY ONLY)
This field contains the service dates for the charge.

SIM DEPT (DISPLAY ONLY)
This field contains the SIM Department, from the Service Item Master table.

SIM CODE (DISPLAY ONLY)
This field contains the SIM Department code, from the Service Item Master table.

SIM DESCRIPTION (DISPLAY ONLY)
This field contains the description of the SIM Department, from the Service Item Master table.

OPC
This field contains the OPC value from FIM for the charge.

AMOUNT
:This field contains the amount of the charge on this line.

STATUS
This field contains the status of the claim, as follows

- PND: pending, indicates that this claim was not submitted
- DWN: downloaded to data file
- SUB: claim has been submitted via download
- RES: resubmit, indicates that this claim will be resubmitted
- PPD: partial payment based on calculation (pymt + adj = total charge)
- PD: indicates this claim line was paid from cash posting

NOTE: If all charge lines are marked as PD, the claim is marked as Final Disp.

SUB DATE
This field contains the date the download option was run.

Claim Disposition

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

```
              General Hospital Maintain Claims by Account Processor
                                                  Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A9-00134-95  BRWERRY,CRIS JASON       20 I/P 96/01/29 96/02/02   573.00  AR/FCRV

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

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

Enter option number--
```

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

```
              General Hospital Maintain Claims by Account Processor
                                                  Fri Jul 03, 2009 08:43 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
J5-0260771   NEW, NAN             OP O/P 09/06/10 09/06/10      855.00 AR /ACCF
Den-App Ind: Not Valid
 1 C  2 Carrier/Plan          3 EP     4 Pd    5 Orig Balance   6 New Balance
   1    150100 BRITISH COLU     1                     860.00           860.00
   P                                                    0.00             0.00
                                                 =============    =============
        PC-           Total                          855.00           855.00




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




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

Field Explanations

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

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

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

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

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

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

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

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

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

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

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

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

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

If the claim disposition is changed to D (denied), the claim is removed from insurance follow-up. If the disposition is changed to F (final payment) or A (adjustment to zero), it is also removed from insurance follow-up. If you transfer the balance to another carrier, the claim and carrier record is added to insurance follow-up. Any other claim disposition will not affect insurance follow-up for the claim. However, if you enter a balance transfer with the new disposition and leave the carrier with a zero balance, insurance follow-up will stop for that carrier.

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

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

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

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

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

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

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

COMMENT (1-A-R) and (60-C-C)
This field provides space for comments regarding this balance transfer. You must first respond to a prompt asking if you want to enter a comment concerning this balance transfer. Entry options are Y for Yes or N for No; the default is N. You can enter up to 60 characters of comment. Comments entered display in the account's transaction history under Comment.

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

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

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

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

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

In general, you should not use this function for any claim where remittance posting is by individual claim charge detail line. This includes Ontario OHIP, British Columbia MSP and British Columbia Worker's Compensation claims.

Reprinting a Claim

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

After you select the reprint claim option, the system prompts you to confirm that you want to reprint this claim. Enter **Y** for Yes or **N** for No. The default is N. When you enter **N**, the system returns you to the previous menu. When you enter **Y**, the system displays the following prompt:

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

If you enter **I** for immediately or press ENTER, the selected claim prints right away at the printer requested. When printing immediately, you can point the claim to any of the

printers assigned to the claim form in Reports Maintenance. If you enter **B** for batch, the request is filed to print in midnight processing. The default is I. In either case, the transaction history reflects the claim reprint activity. You repeat this procedure for each claim that you want to reprint.

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

- Claims that are produced by creating diskettes will place the claim in the appropriate temporary download file in preparation for creating the diskette. This includes the following claim types: MOH, BC MSP, BC WORKER'S COMP ELEC, AND BC Out of Prov.
- OHIP claims that have been replaced by an Adjustment Claim cannot be reprinted.
- Reprints of claims that have been replaced by an Adjustment Claim should not be requested for the following claim types: BC MSP, BC WORKER'S COMP ELEC, and BC Out of Prov.
- Claims that have no charge detail lines in a status of PND or DWN will not reprint. This applies to MOH, BC MSP, and BC WORKER'S COMP ELEC claim types.

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

Reload Claim Demographic/Visit Errors

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

After you select this function, which only displays on the claims options menu if the claim has not been produced, the system displays the message: Reloading Claim Demographics. The system accesses the information, loads it, and freezes your terminal for the duration of the process. After the process is complete, the system returns you to the claims options menu.

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

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

Reload function not valid for claims marked for resubmission

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

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

ADD CLAIM TO INSURANCE

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

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

The steps for this procedure are:

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

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

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

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

Error: No Insurance exists for Account!

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

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

```
            General Hospital Add Claim to Insurance Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE     OH UCC 02/01/24 02/01/24   189.14  AR/FCRV









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

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

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

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

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

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

Can only create combined claims for UB92's

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

```
         General Hospital Add Claim to Insurance Processor
                                                 Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE     OH UCC 02/01/24 02/01/24   189.14  AR/FCRV

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




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

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

Field Explanations

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

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

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

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

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

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

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

```
           General Hospital Add Claim to Insurance Processor
                                                 Tue Mar 14, 2006 10:33 am
Account      Name                          FC Typ Admit    Disch      Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE       OH UCC 02/01/24 02/01/24   189.14  AR/FCRV

COB  Carrier/Plan                                Type              Claim
 1   111111 BRITISH COLUMBIA MINISTRY OF HLTH  BC MSP               1
 2   780100 WESTBURY CANADIAN LIFE INSUR. CO   CPBC                2




Create Claim for COB 1 ? (Y/N) [N] --
```

Field Explanations

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

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

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

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

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

Create Claim for COB 1? (Y/N) [N]—

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

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

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

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

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

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

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

xxxx claim loaded. Hold claim for prior payment?

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

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

- the claim is not replaced
- the claim is not completed (is not dispositioned as Final Payment, Adjusted to Zero, or Denied)
- the claim is for the same bill sequence as the added claim

- for combined claims, the system will only display claims for higher priority plan that were loaded from the latest bill sequence that was chosen to load the combined claim

- the claim is for a higher priority insurance plan

- the Pro Fee Coverage Indicator of the Basic Coverage Screen determines which higher priority insurance the added claim can wait on. If the insurance you are adding a claim for “Includes” Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on all prior plans. If the insurance you are adding a claim for “Excludes” Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on prior plans set to Include or Exclude Pro Fees in the Basic Coverage Screen. It does not allow the plan to wait on prior plans set to Only Pro Fees in the Basic Coverage Screen. If the insurance you are adding a claim for “Only” Covers Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on prior plans set to Include or Only Cover Pro Fees in the Basic Coverage Screen. It does not allow the plan to wait on prior plans set to Exclude Pro Fees in the Basic Coverage Screen.

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

```
              General Hospital Add Claim to Insurance Processor
                                                  Tue Mar 14, 2006 10:33 am
Account      Name                          FC Typ Admit    Disch      Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE       OH UCC 02/01/24 02/01/24   189.14  AR/FCRV

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




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

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

Field Explanations

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

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

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

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

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

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

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

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

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

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

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

NOTE: For British Columbia Out of Province claims, if there are no charges to load, the system will add either an Inpatient or an Outpatient claim depending on the patient indicator. Emergency room patients should add an outpatient claim type.

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

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

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

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

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

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

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

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

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

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

If you enter Y, the system displays the message:

TY Claim manually released

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

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

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

The system then displays the following prompt:

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

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

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

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

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

Claim Print Started

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

Claim Print Filed

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

BALANCE TRANSFER & CLAIM DISPOSITION

The Balance Transfer and Claim Disposition function enables you to transfer account balance liability amounts between one or more carriers and the patient balance for an account, disposition claims, and change the financial class of an account in accounts receivable and bad debt. For detailed information regarding this function, refer to the Posting Transaction section in the *Accounts Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

ARCHIVE CLAIMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PURGE ARCHIVED CLAIMS

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

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

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

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

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

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

PENDING CLAIMS REPORT

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

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

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

DOWNLOAD MINISTRY CLAIM DATA

The Download Ministry Claim Data function is used to download claim information from the STAR system to a diskette or file for submission to the Ministry of Health, based on the specifications provided by the Ministry.

In Ontario, this covers OHIP (MOH) claims. In British Columbia, both MSP and Worker's Compensation claims are downloaded with this function. For detailed information, refer to the *Ontario Electronic Claims and Payments Volume* or the *British Columbia Electronic Claims and Payments Volume* of the STAR Financials Patient Accounting Reference Guide.

RECREATE DOWNLOAD DISKETTES

The Recreate Download Diskettes function provides the capability to reproduce a previously created diskette from archived data files. For detailed information refer to the *Ontario Electronic Claims and Payments Volume* or the *British Columbia Electronic Claims and Payments Volume* of the *STAR Financials Patient Accounting Reference Guide*.

ONTARIO OUT OF PROVINCE PATIENT REPORT DEFINITION

This function is used to define selection criteria for the Ontario Out of Province Patient Report. This report identifies patients who have a province other than Ontario assigned at time of admitting. This report reflects all charges and credits that have been placed on the account. Information on this report is a reflection of account information at the time that the report was generated.

Default values have been defined for each field on the report definition. This enables the optional batch job to generate a report even if you do not define selection criteria.

When you access this function, the following screen is displayed:

```
        General Hospital Ontario Out of Province Patient Report Processor
                                                Tue Aug 16, 2005 10:47 am


 1 AR Accounts           2 Patient Indicator          3 Admit Date
   Only                    All                          Earliest
 4 Limit to COB 1        5 Fin Class Page Break
   No                      No
 6 Edit Date             7 Edit by
   04/12/03 10:22          New, Nancy S









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

Field Explanations

1. AR ACCOUNTS (1-A-O)
This field indicates whether the report contains both PA and AR accounts. When this field is accessed, the following prompt is displayed:

Report on AR Accounts - (I)nclude, (E)xclude, or (O)nly [E]--

You can enter **I** (Include) to produce a report that has both PA and AR accounts on it, **E** (Exclude) to produce a report that has only accounts in location PA on it, or **O** (Only) to produce a report that has only accounts in location AR on it.

2. PATIENT INDICATOR (1-A-O)
This field indicates whether the report contains inpatients, outpatient/emergency, or both. When this field is accessed, the following prompt is displayed:

Report on (I)npatient, (O)utpatient/Emergency, or (A)ll [A]

You can enter **I** (Inpatient) to produce a report that has only Inpatients on it. You can enter **O** (Outpatient/Emergency) to produce a report that has only Outpatients and Emergency Patients on it. You can enter **A** (All) to produce a report that has both Inpatients and Outpatients on it.

3. ADMIT DATE (6-AN-O)
This field is used to limit the selection of accounts for the report to a starting admission date. When this field is accessed, the following prompt is displayed:

Enter the starting admit date or (E)arliest [E]--

You can enter a starting admit date or enter **E** (Earliest) to select all accourts that meet the other defined selection criteria on the report.

4. LIMIT TO COB 1 (1-A-O)
This field is used to limit account selection to accounts that have a balance for the primary insurance. When the field is accessed, the following prompt is displayed:

Limit account selection to COB 1 having a balance? (Y/N) [N]--

If you enter **Y** (Yes), only accounts with a balance for the primary insurance are selected for the report. If you enter **N** (No), all accounts that meet the other defined selection criteria are included in the report.

5. FIN CLASS PAGE BREAK (1-A-O)
This field defines whether page breaks on the report are by financial class or by account. When this field is accessed, the following prompt is displayed:

Page break by Financial Class? (Y/N) [N]--

You can enter **Y** (Yes) to have the report break by financial class or **N** (No) to have the report break by account.

6. EDIT DATE (DISPLAY ONLY)
This field contains the date this screen was last edited.

7. EDIT BY (DISPLAY ONLY
This field contains the name of the user who last edited this screen.

When exiting this screen, you can run the report immediately by answering Yes to the following prompt.

Run the report immediately (Y/N) [N]--

If you answer No to the prompt, the report definition is saved, but the report is not generated.

ONTARIO RECIPROCAL CLAIMS

This facility-specific option is used to download the reciprocal billing, out of province claim information from the STAR system to a file for submission to the Ontario Ministry of Health. The claims are available for download after they are released.

This processor is used to download accumulated claim information to a PC directory. When a claim of type 10 or 12 loads, imported Medical Records information is saved for this download. When a claim of type 10 or 12 is printed, the claim information is formatted for the download file. The information is downloaded when the user elects to create the download file. Each claim service line appears in a separate record and its status is updated to DWN when the record is downloaded. When the file is downloaded, report FMRONRCSx is created.

Once the field has been accepted, the temporary download file, created when the claims are released through the claim Print process, is processed. Error message if there are no claims to download.

The following types of claims are included in a new data submission:

- Original Claim
- Resubmitted claim

The download consists of the following data:

- 1 header record
- 1 or more detail records, containing patient data
- 1 trailer record

The file is a standard dos text file, with each line ending with a carriage return/line feed, and the file ends with an end of file character. The filename used in the output is as follows:

"I" or "O" followed by a dash "-" followed by the Hospital Number followed by a dash "-" followed by the billing date in YYYYMMDD format, ending with the extension ".txt"

The file can be downloaded again using Recreate Ont Reciprocal Data found on the Interface Functions menu. A copy of FMRONRCSx is created again.

When this function is accessed, a series of prompts is displayed on the screen.

- *Create (I)npatient or (O)utpatient Out of Province Claim diskette? (I/O)--*

  This prompt is displayed since inpatient and outpatient claims must be submitted in separate files, with different formats. Selecting I specifies that the Inpatient

Layout should be used. Selecting O specifies that the Outpatient Layout should be used.

You can enter **I** to create an inpatient diskette or **O** to create an outpatient diskette.

- *Enter Default MOHLTC Hospital Code [987]--*

  The MOHLTC Hospital Code is used to name the download file. The value from the Download Parameters screen displays. It may be overridden. This value is used to complete the Hospital Number field of the Common Header. It is also used as the 1st 3 positions of the Batch ID field.

- *Enter bill date [T]--*

  The bill date is used to name the download file. You can enter the date in YY/MM/DD format or accept the default of T (Today).

- *Enter Drive to output data (A/B/C) [C]--*

  You can accept **C** as the drive for output data or enter another drive (**A or B**).

- *Enter Directory Path C:\ [\IHA\]--*

  You can accept the default directory path or enter another one in the same format as shown in the prompt.

After the last prompt, the next prompt displayed is:

Press ENTER to begin download to PC for Hospital Code 987--

You can press ENTER to begin the download. The system notifies you when the download is successful.

RECREATE ONTARIO RECIPROCAL DATA

If there is a problem with a data file after transmission and loading to the RHBS (Reciprocal Hospital Billing System), Ministry staff contacts the hospital and requests a new file be transmitted. This might be necessary if the file was corrupted. This function submits data which was previously submitted. The report FMRONRCS is created, and the title reflects it was a re-creation run.

Re-create without Modifying the File

After you select the function, the following prompt is displayed:

Re-create (I)npatient or (O)utpatient Out of Province Claim diskette? (I/O)--

You can enter **I** to re-create an inpatient diskette or **O** to re-create an outpatient diskette. The next prompt is:

(M)odify existing data or (R)e-create without modification (M/R)--

You can enter **R** to recreate the file without modification.

The system displays a list of download files by date and hospital code. You can select the file to download. The system prompts as follows:

Enter Drive to output data (A/B/C) [C]--

You can accept **C** as the drive for output data or enter another drive (**A or B**).

Enter Directory Path C:\ [\IHA\]--

You can accept the default directory path or enter another one in the same format as shown in the prompt.

The system notifies you when the download is complete.

Modify Existing Data and Download

After you select the function, the following prompt is displayed:

Re-create (I)npatient or (O)utpatient Out of Province Claim diskette? (I/O)--

You can enter **I** to re-create an inpatient diskette or **O** to re-create an outpatient diskette. The next prompt is:

(M)odify existing data or (R)e-create without modification (M/R)--

You can enter **M** to modify and download the file**.** If (M) is keyed, the list of files available to be downloaded are listed for selection. After a file is selected, all claims in

the original download are listed in a table lookup where the account number and claim sequence number appear. If a claim was marked to be excluded previously, an asterisk is displayed after the account number and claim sequence number. Selected claims that were not excluded previously, are marked to be excluded from the download. Selected claims that were excluded previously, are marked to be included. This provides the opportunity to correct the incorrect section of a claim for exclusion.

After all choices are made from the list of claims and ENTER is pressed, the following prompt is displayed:

Accept changes and process download? (Y/N)--

If Y is keyed, the following messages appear documenting the updates being made.

Updating the exclusion indicator for selected claims!

Recalculating totals for trailer record!

After you select one or more claims, the next prompt is:

Enter Drive to output data (A/B/C) [C]--

You can accept **C** as the drive for output data or enter another drive (**A or B**).

Enter Directory Path C:\ [\IHA\]--

You can accept the default directory path or enter another one in the same format as shown in the prompt.

The system notifies you when the download is complete.

Chapter 3 - BILLING & CLAIM PROCESSING HINTS

PATIENT BILLING

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

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

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

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

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

RESUBMITTING CLAIM CHARGE LINES

Overview

In order to resubmit individual claim charge lines to the Ministry of Health and to facilitate the reconciliation process, a method different from the one used for other claim types is necessary for loading and subsequently processing claims for Ontario OHIP (MOH) and British Columbia Medical Services Plan (BC MSP) and British Columbia Worker's Compensation Electronic (BC WORKERS COMP ELEC) claims. These differences are necessary since each claim charge line is considered a claim.

Each claim charge line has one of the following statuses:

- PND - Pending - The charge line has not yet been released for submission to the Ministry.
- DWN - Downloaded - Once the claim has been released, the claim charge lines are changed to a status of download.
- SUB - Submitted - When the diskette is created, the charge line is marked as submitted. The submitted date in the claim reflects the first date a charge line was submitted. Subsequent resubmissions do not update the submit date at the carrier level nor do they impact insurance follow-up; however, the carrier record is marked, and an asterisk is displayed by the submit date on the Snapshot screen and on the Carrier Status screen.
- RES - Resubmitted - The charge line has been resubmitted to the Ministry.
- Pd - Paid in Full - The charge line has been paid in full. When all of the charge lines are marked paid in full, the claim is marked paid in full and the disposition is set to Final Payment.
- DBT - Debit Request - A debit request has been submitted to the Ministry for British Columbia's MSP claim.
- Any 2 characters - Exception/Rejection Code - The charge line has been returned from the Ministry of Health with an exception or rejection code. The system automatically uses 00 if status becomes spaces.

When an OHIP, MSP, or BC Workers Comp claim is initially loaded, all of the charge lines are marked PND, for pending. Once the claim is released for printing, either through batch or through the reprint process, the status on the charge lines changes to DWN, for downloaded. Claim charge lines in a pending or downloaded status can be edited. Once the claim charge lines have been submitted by creating the download diskette for the Ministry, no further updates are allowed and the status on the charge line becomes SUB, for submitted. In addition, the date the charge line was submitted displays on the individual charge line. As already noted, the original submission date is stored at the carrier level and initiates insurance follow-up.

Once an OHIP, MSP, or BC Workers Comp claim has been released and printed by the system, it is flagged as Produced. For OHIP, MSP, and BC Workers Comp claims, it is sometimes necessary to resubmit some or all of the claim charge detail lines on the claim. When this occurs, the user should access the Claim Status screen and mark the claim for resubmission to the Ministry. This prompt only displays if the claim has already been produced.

```
            General Hospital Maintain Claims by Account Processor
                                                    Tue Mar 14, 2006 10:33 am
Account      Name                        FC Typ Admit    Disch      Balance Loc
C01000007    TESTBERRY,EMERGENCY ONE     OH UCC 02/01/24 02/01/24   189.14  AR/FCRV
 1 Bill Seq #     2 Claim Seq #       3 Claim Type     4 Load/Edit Parameter
   1                1                   P BC MSP         P MSP COPIED FROM MASTE
 5 Bill Date      6 Bill From         7 Bill Through   8 Chg Control Parameter
   02/01/29         02/24/02            02/01/24         1
 9 Biller                               10 Last System Edit Date
   3 - MURRAY,MARIE                        02/02/02 14:21
11 Last Editing User                    12 Last User Edit Date/Time
   Berry,Pam                               02/02/02 14:21
13 Edit Failures                        14 Claim Production Status
   1                                       P Produced

15 Claim Work Status          16 Claim Amount   17 Archive Date  18 Purge Date
   M Manually Released           $168.14
19 Produce Claim?  20 Electronic Media      21 Claim Split Indicator
   Yes



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

In order to access the claim detail information, enter **Y** for Yes. Entering Yes automatically changes the production status from P, Produced, to NP, Not Produced, and sets the claim work status to H, Hold. Insurance follow-up is not impacted by flagging the claim for resubmission. When the claim charge detail screen is accessed and resubmitted lines are entered, the status remains at Hold until the user manually releases the claim to prevent the system from automatically releasing the claim before the user has the opportunity to complete all required modifications to the claim. The Claims on Hold report (FCR320) has been provided to alert the user that there are claims in a Hold status. For Ontario OHIP claims, if edits are done to the claim demographics first or if changes to the claim charge detail are deleted and there are no pending lines, the status of the claim changes back to Produced and Manually Released.

Once the claim has been flagged for resubmission, edits may be performed to the claim demographic information and claim charge detail. Keep in mind that edits to the claim demographic detail overlay the original claim demographic information. The system maintains original charge detail lines that have been submitted to the Ministry even when a claim has been edited for resubmission in order to maintain an accurate log of charge lines released to the Ministry and any response from the Ministry for each of these lines.

Ontario MOH (OHIP) Claim Resubmission

After the OHIP claim has been flagged for resubmission, edits may be performed to the claim demographic information and claim charge detail. If a claim has already been produced but none of the charge lines have been submitted to the Ministry (in other words, the diskette(s) has not yet been created and the status of the charge line is DWN for downloaded), then editing for resubmission deletes the downloaded charge line(s) from the download file and reverts the detail lines back to a Pending status (PND). The charge lines are placed back into the download file once the claim is printed.

To resubmit charge lines to the Ministry, access the Claim Charge Data, and the following screen is displayed:

```
                  General Hospital Claims by Account Processor
                                          Tue Mar 14, 2006 10:33 am
Account      Name                     FC Typ Admit    Disch      Balance Loc
A8-00002-79  EROHIP,ONE               10 ERM 10/06/95 10/06/95   314.35  AR/FCRV

Performing Dr ID Errors:  None
     SoB Errors:              None
     Diagnosis Code Errors:   None
     Invalid Qty Errors:      None
     Referring Dr ID Errors:  None

Seq  Units  Charges Svc Date   SoB      Billing Phys   Diag   Refer Dr    ST  SubDT
1  *    1   50.00   95/10/06   X111A    7777-664661-00        567890      SUB 06/15
2  *    1   88.00   95/10/06   X112A    7777-664661-00        567890      SUB 06/15
3  *    1   50.00   95/10/06   X111A    7777-987654-00        567890      SUB 06/15
4  *    1   88.00   95/10/06   X112A    7777-987654-00        567890      SUB 06/15
5  *    1   38.35   95/10/06   X101A    8821-567890-12        567890      SUB 06/13
```

Note that the original claim charge lines are displayed with an asterisk. Claim charge lines that were converted when the software was installed display a vertical bar (|) after the status.

There are two options for resubmitting a claim charge detail line. If no changes need to be made to the detail line but the charge line needs to be resubmitted to the Ministry, the resubmit function should be used. If, however, the charge line needs to be resubmitted after changes are made to the claim charge detail line, the modify and resubmit function should be used. Again, the difference in the two options is the ability to edit the newly-created claim charge line and the reporting of these fees on the OHIP Bill Summary and OHIP Production Reports.

To resubmit a charge line, press the **F3** key (Insert). At the Units prompt, press **R** to Resubmit or **M** to Modify and Resubmit, and the system prompts you for the line to be resubmitted. Enter the sequence number of the line to be resubmitted, and the system

automatically completes the remainder of the charge line. Perform any necessary edits to the charge lines to be resubmitted if the modify and resubmit option was chosen. Continue this process until all of the charge lines that need to be resubmitted have been entered. When you have completed your resubmission entry, press the **F7** key (Exit), and accept the updates.

If changes to claim demographic information are also required, access Claim Demographics and make the necessary changes. Remember to resubmit the charge lines prior to updating claim demographic data. If you first access claim demographic information and edit the information or if there are edits performed to the claim charge detail screen that are subsequently deleted and there are no pending charge lines remaining, you receive two warning messages:

"No charges to resubmit --- BYPASSING RESUBMISSION!"
"Restoring to Manually Released and Produced!"

At this point, the claim production status is changed back to Produced and the claim work status becomes Manually Released. In order to resubmit any charges, you must again access Claim Status Information and answer **Y** for Yes to the resubmission prompt.

NOTE: When a claim charge line is resubmitted, the status of the original claim line is changed to RES, for resubmitted and no further updates are allowed to the original line. If a partial payment has been made to the resubmitted line, this amount is carried forward to the new line as long as the chargeamount on the resubmission remains the same. If the charge amount is changed on the line to be resubmitted, then the payment and adjustment information is changed to zero, since the system has no way of knowing what values should be carried forward to the new charge line.

Once this process has been completed and you have made all of the necessary edits, change the claim work status to Manually Released, and either reprint the claim or let the system produce the new claim information during batch that night. You may always wish to reprint the claim immediately. Should you forget to manually release the claim, it will appear on the Claims on Hold Report.

New claim charge lines may also be addedto the claim. Again, if the claim has already been produced, you must first edit the claim for resubmission using the instructions above. When you access the claim charge data, you may enter a new charge line by pressing the **F3** (Insert) key, and entering the new charge information or by copying a line and making any required changes. To copy a line, enter **C** in the Units field and the system prompts you for the line number to copy. The charge information is copied to the inserted line and you can make any necessary edits. The copy function should only be used when you are adding charge lines to a claim. If you are resubmitting a charge line, enter **R** for resubmit or **M** for modify and resubmit.

If you enter a charge amount on a new line or edit the charge amount on a copied line, the system prompts you to enter the Technical component. For example, if you have

an $80.00 charge and $25.00 is the technical component, then 80.00 should be entered as the charge quantity, and 25.00 should be entered when you receive the prompt for the technical component. This gives the system the ability to report on technical and professional components even when claim charge detail lines are added or modified. Claim charges automatically loaded to the claim use the charge detail on the patient's account to determine the technical and professional components.

Key points to remember:

1. Only claim charge lines that have been previously submitted to the Ministry can be resubmitted. Therefore, the charge line status must either contain an exception code or be in a submitted status.

2. If the resubmission requires a change in demographic information only, you must still mark the charge detail lines for resubmission in order to preserve the history and reporting capability of the system. Remember to access the claim charge data screen first and to mark the charge lines to resubmit prior to editing the claim demographic information.

3. Resubmission does not update the original submission date at the carrier level nor does it impact insurance follow-up. The claim remains in the Claims Already Submitted workfile with the original submission date. However, the submit date at the carrier level will display with an asterisk on the carrier status screen and the snapshot screen if additional submissions have occurred.

4. Claim prints only print lines that are in a pending (PND) status. Therefore, if you have not updated any charge lines and all are in a status other than PND, no release to the download file occurs. An error message *No Pending Claim Details! - Use Edit to Resubmit* is displayed when a reprint is requested and there are no charge lines in a pending (PND) status. If a claim is manually released, a reprint is not requested, and batch processing determines that there are no pending charge lines, the claim is reported on a report, Claim Prints Suppressed report (FCR320). This lets you know that a claim was edited for resubmission, but there were no charges to resubmit.

5. Add A Claim has the option to Add/Suppress or Add/Produce a claim. Answering Add/Suppress sets the Claim Produce Flag equal to No, which in effect suppresses the printing of a claim. This option should only be used for claims that are being added to the system strictly for cash posting reasons (in other words, you have received a payment from the Ministry and there is no claim on file - in this event, you do not want to submit the charges to the Ministry as payment has already been made). Otherwise, the Add/Produce option should be used, and the claim should be released for download using the normal process. OHIP claims with a Produce Claim Flag = No will also appear on the Claim Prints Suppressed report (FCR320) with a Produce = NO message.

6. Claims that have been submitted to the Ministry should not be deleted.

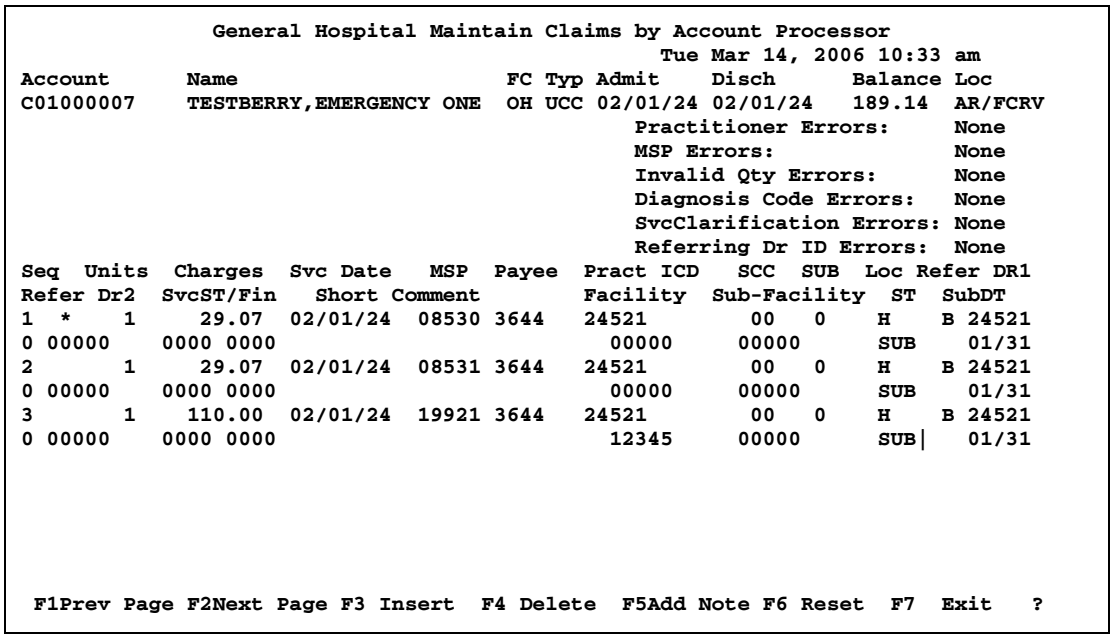
7. If a claim charge line is resubmitted, prior payment and adjustment activity is carried forward to the resubmitted line as long as the charge amount on the new line is equal to the original claim charge line. The payment and adjustment amounts are retained on the original line. If the charge amount is changed on the new line being submitted to the Ministry, the system has no way of knowing the relationship of previous payments and adjustments to the new charge amount. Therefore, the payment and adjustment amounts are set to zero on the new charge line.

Editing British Columbia MSP & Worker's Compensation Claim Submissions

After the BC MSP or Worker's Compensation claim has been flagged for resubmission, edits may be performed to the claim demographic information and claim charge detail.

To resubmit charge lines to the Ministry, access the Claim Charge Data, and the following screen is displayed depending on the type of claim. The process is the same for both claim types.

BRITISH COLUMBIA MSP CLAIM CHARGE DATA



BRITISH COLUMBIA WORKER'S COMP ELEC CLAIM CHARGE DATA

```
            General Hospital Maintain Claims by Account Processor
                                                  Tue Mar 14, 2006 10:33 am
Account      Name                         FC Typ Admit    Disch      Balance Loc
C01000006    TESTBERRY,EMERGENCY ONE      WC UCC 02/01/24 02/01/24   176.90  AR/FCRV
                                                 Practitioner Errors:     None
                                                 MSP Errors:              None
                                                 Invalid Qty Errors:      None
                                                 Diagnosis Code Errors:   None
                                                 SvcClarification Errors: None
                                                 Referring Dr ID Errors:  None
                                                 Missing Injury/Position: No
Seq  Units  Charges  Svc Date   MSP  Payee  Pract ICD   SCC  SUB  Loc Refer DR1
 Refer Dr2  SvcST/Fin   Short Comment       Facility  Sub-Facility  ST  SubDT
          Area of Injury/Anatomical Position
1       2    176.90  02/01/24  19921 3644   24521        00   0    H    B 24521
0 00000    0000 0000                         12345     00000      SUB|   01/31
             0034           NA

F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Add Note F6 Reset  F7  Exit   ?
```

NOTE: Original claim charge lines that have never been edited are displayed with an asterisk.

Resubmit Claim Charge Detail Lines

There are two options for resubmitting a claim charge detail line. If no changes need to be made to the detail line but the charge line needs to be resubmitted to the Ministry, the resubmit function should be used. If, however, the charge line needs to be resubmitted after changes are made to the claim charge detail line, the modify and resubmit function should be used. Again, the difference in the two options is the ability to edit the newly-created claim charge line.

To resubmit a charge line, press the **F3** key (Insert). At the Units prompt, press **R** to resubmit or **M** to Modify and Resubmit, and the system prompts you for the line to be resubmitted. Enter the sequence number of the line to be resubmitted, and the system automatically completes the remainder of the charge line. Perform any necessary edits to the charge lines to be resubmitted if the modify and resubmit option was chosen. Continue this process until all of the charge lines that need to be resubmitted have been entered. When you have completed your resubmission entry, press the **F7** key (Exit), and accept the updates.

If changes to claim demographic information are also required, access Claim Demographics and make the necessary changes.

NOTE: When a claim charge line is resubmitted, the status of the original claim line is changed to RES, for resubmitted and no further updates are allowed to the original line. If a partial payment has been made to the resubmitted line, this amount is carried forward to the new line as long as the chargeamount on the resubmission remains the same. If the charge amount is changed on the line

to be resubmitted, then the payment and adjustment information is changed to zero, since the system has no way of knowing what values should be carried forward to the new charge line.

Once this process has been completed and you have made all of the necessary edits, change the claim work status to Manually Released, and either reprint the claim or let the system produce the new claim information during batch that night. You may always wish to reprint the claim immediately. Once the claim is reprinted, it will change back to a produced status. Should you forget to manually release the claim, it will appear on the Claims on Hold Report.

Add Claim Charge Lines

New claim charge lines may also be added to the claim. Again, if the claim has already been produced, you must first edit the claim for resubmission using the instructions above. When you access the claim charge data, you may enter a new charge line by pressing the **F3** (Insert) key, and entering the new charge information or by copying a line and making any required changes. To copy a line, enter **C** in the Units field and the system prompts you for the line number to copy. The charge information is copied to the inserted line and you can make any necessary edits. The copy function should only be used when you are adding charge lines to a claim. If you are resubmitting a charge line, enter **R** for resubmit or **M** for modify and resubmit.

If you enter a charge amount on a new line or edit the charge amount on a copied line, the system prompts you to enter the Technical component. For example, if you have an $80.00 charge and $25.00 is the technical component, then 80.00 should be entered as the charge quantity, and 25.00 should be entered when you receive the prompt for the technical component. This gives the system the ability to report on technical and professional components even when claim charge detail lines are added or modified. Claim charges automatically loaded to the claim use the charge detail on the patient's account to determine the technical and professional components.

Create Debit Request

Facilities may submit a debit request and return money to the Ministry when a charge has been paid in error. If the claim has already been produced, you must first edit the claim for resubmission using the instructions above. When you access the claim charge data, you can enter a new charge line by pressing **F3**, and entering submission code **E**. The system prompts you for the line. Lines for which debit requests are being issued are marked with a status of DBT.

Similar to a line with a status of RES, a line with a status of DBT is handled as follows:

- The line cannot prevent the disposition of a claim being marked as final payment.
- The line cannot be selected in insurance cash posting.

- The amount for the DBT line is not included in the total claim amount when Claim Charge Data recalculates the claim total.

Key points to remember:

1. Only claim charge lines that have been previously submitted to the Ministry can be resubmitted. Therefore, the charge line status must either contain an exception code or be in a submitted status.

2. If the resubmission requires a change in demographic information only, you must still mark each claim charge detail line for resubmission in order to appropriately submit the claim.

3. Resubmission does not update the original submission date at the carrier level nor does it impact insurance follow-up. The claim remains in the Claims Already Submitted workfile with the original submission date. However, the submit date at the carrier level will display with an asterisk on the carrier status screen and the snapshot screen if additional submissions have occurred. In Release 7.0, an option to update insurance follow-up has been added when the claim status is marked to edit for resubmission.

4. Claim prints only print lines that are in a pending (PND) status. Therefore, if you have not updated any charge lines and all are in a status other than PND, no release to the download file occurs even though you request a reprint or you manually release the claim and reprint the claim during batch. If a claim is manually released, a reprint is not requested, and batch processing determines that there are no pending charge lines, the claim is reported on a report, Claim Prints Suppressed report (FCR320). This lets you know that a claim was edited for resubmission, but there were no charges to resubmit.

5. Add A Claim has the option to Add/Suppress or Add/Produce a claim. Answering Add/Suppress sets the Claim Produce Flag equal to No, which in effect suppresses the printing of a claim. This option should only be used for claims that are being added to the system strictly for cash posting reasons (in other words, you have received a payment from the Ministry and there is no claim on file - in this event, you do not want to submit the charges to the Ministry as payment has already been made). Otherwise, the Add/Produce option should be used, and the claim should be released for download using the normal process. Claims with a Produce Claim Flag = No will also appear on the Claim Prints Suppressed report (FCR320) with a Produce = NO message.

6. Claims that have been submitted to the Ministry should not be deleted.

7. If a claim charge line is resubmitted, prior payment and adjustment activity is carried forward to the resubmitted line as long as the charge amount on the new line is equal to the original claim charge line. The payment and adjustment amounts are retained on the original line. If the charge amount is changed on the new line being submitted to the Ministry, the system has no way of knowing the

relationship of previous payments and adjustments to the new charge amount. Therefore, the payment and adjustment amounts are set to zero on the new charge line.

POSTING CASH TO OHIP CLAIMS

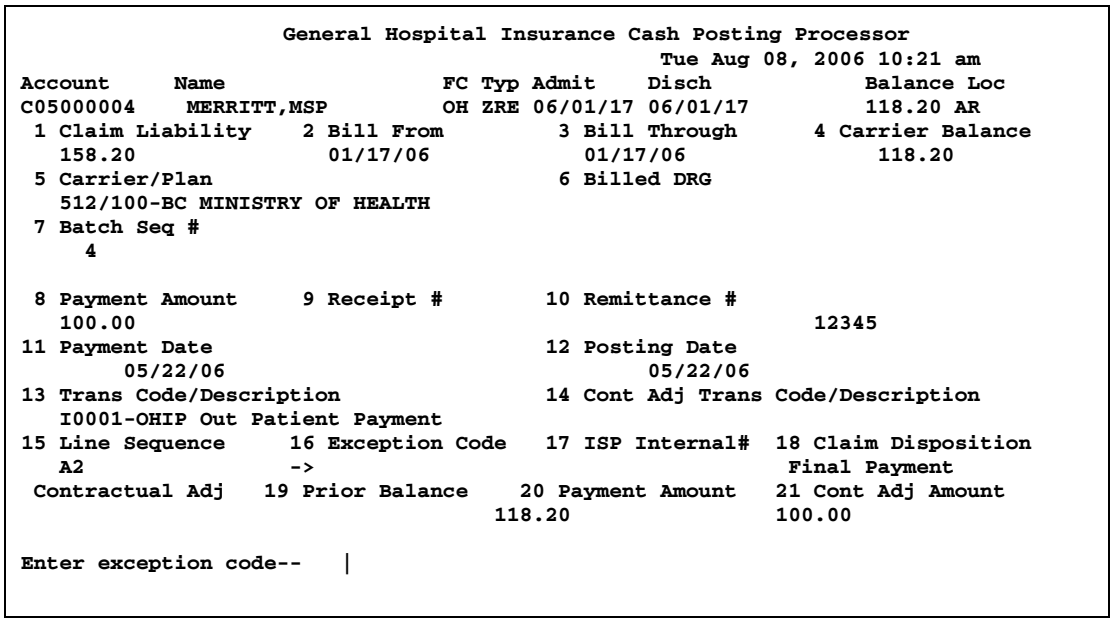
To facilitate the reconciliation process, insurance cash posting to OHIP claims retains payment, adjustment, OHIP claim number, and exception codes at the claim charge line and transaction history level. Payments are sent by the Ontario Ministry of Health at the charge level. Therefore, the Electronic Remittance processor matches individual charge lines within a claim to the payments being returned from the Ministry. In addition, manual insurance cash posting for OHIP claims must be posted to a specific charge sequence number within the claim.

An insurance cash batch is automatically created by the system when the electronic remittance file is processed. This cash batch includes all payments for which the system could find a unique match to a claim charge line. Payments with exception codes defined in the OHIP Exceptions table are automatically rejected from the cash batch. Once reviewed, these rejections can be manually entered into the cash batch.

NOTE: Manual posting of OHIP cash is not allowed through the Line Item Cash Processor. If an account with OHIP insurance is selected, and the OHIP carrier is entered, the system displays *No Claims for this Carrier/Plan*. It displays this error even if claims exist for OHIP.

Detailed information about processing electronic remittance files is included in the *Ontario Electronic Claims and Payments Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Below is the insurance cash posting screen for OHIP claims. This screen is displayed whenever insurance cash is posted either through the Post Insurance Cash function or the Post Insurance Cash from Unapplied Cash to an OHIP claim.



The *Line Sequence, Exception Code, and OHIP Claim Number* fields are retained in the transaction history record when the payment is posted to the claim. The line sequence and exception code are required entries whenever a manual cash posting entry is made. The charge lines within the claim are displayed when the user accesses the Line Sequence number to facilitate posting to the correct claim charge detail line. Payments may be posted to all charge lines that are not in a RES (Resubmitted) status.

When the cash batch is approved, the system posts the information to the claim and updates the individual charge line specified, as well as the overall carrier/claim information. The charge line on the claim is marked as Paid in Full (Pd) when the payment and adjustment amount satisfy the charge amount for the claim. When all of the charge lines within a claim have been marked as paid, the claim is marked Paid in Full and the disposition of the claim is set to Final Payment. Since the system is determining whether a claim is paid in full based on the status of the claim charge detail lines, the claim disposition flag on the insurance cash batch should always be set to P - PARTIAL. As a result, the only valid entry in the claim disposition field for OHIP claims is P - PARTIAL. This is also true for the claim disposition field on the Electronic Remittance Setup Processor screen.

If the charge line is not paid in full, the exception code entered is displayed in the status of the claim charge detail line. These lines are considered unreconciled and appear on the Reconciliation Reports as unreconciled.

If a payment is posted inadvertently to an incorrect charge line, the payment should be reversed by posting a negative payment. Since an exception code is required for all manual cash posting entries, you may want to establish a two-character code that is not used by the Ministry for use in correcting posting errors that are made.

Key points to remember:

1. Since the reconciliation process is dependent upon payments being posted to individual claim charge detail lines, all payment and adjustment activity to OHIP claims should be posted via the insurance cash processor. The Electronic Remittance Software for OHIP claims automatically creates entries into the insurance cash batch for payments that can be matched.

2. The Claim Disposition and Balance Transfer functions do not disposition individual claim charge detail lines. These functions, along with the Adjustment Processor, are claim-based.

3. Multiple payments can be posted to a single claim charge line. The payments and adjustments are accumulated with each posting. When the claim charge amount is satisfied, the claim charge line is marked as Pd-Paid in Full. When all claim charge lines are Paid in Full, the claim disposition is set to Final Payment, the claim is marked paid in full and removed from insurance follow-up, and the claim becomes a completed claim.

POSTING CASH TO BC MSP AND WORKER'S COMPENSATION CLAIMS

To facilitate the reconciliation process, insurance cash posting to BC MSP and Worker's Compensation claims retains payment, adjustment, MSP Internal #, and exception codes at the claim charge line and transaction history level. Payments are sent from the British Columbia Ministry of Health at the claim charge level. Therefore, the Electronic Remittance processor matches individual charge lines within a claim to the payments being returned from the Ministry. In addition, manual insurance cash posting for BC MSP and Worker's Compensation claims must be posted to a specific charge sequence number within the claim.

An insurance cash batch is automatically created by the system when the electronic remittance file is processed. This cash batch includes all payments for which the system could find a unique match to a claim charge line. The unique sequence number assigned to the charge line when the Ministry diskette is created is used to identify the claim charge line. Payments with exception codes defined in the PP Exceptions table are automatically rejected from the cash batch. Once reviewed, these rejections can be manually entered into the cash batch.

NOTE: Manual posting of BC MSP and Worker's Compensation cash should not be done through the Line Item Cash Processor since line item cash does not support claim charge line posting.

Detailed information about processing electronic remittance files is included in the British Columbia Electronic Claims and Payments Volume of the STAR Financials Patient Accounting Reference Guide.

Below is the insurance cash posting screen for BC MSP and Worker's Compensation claims. This screen is displayed whenever insurance cash is posted either through the Post Insurance Cash function or the Post Insurance Cash from Unapplied Cash to an BC MSP or Worker's Compensation claim.

Below is the insurance cash posting screen for BC MSP and Worker's Compensation claims. This screen is displayed whenever insurance cash is posted either through the Post Insurance Cash function or the Post Insurance Cash from Unapplied Cash to an BC MSP or Worker's Compensation claim.

```
          General Hospital Insurance Cash Posting Revision Processor
                                                Tue Aug 08, 2006 11:13 am
Account                    Name                FC  Typ  Admit    Disch          Balance
LocJ5-0260734              MEANS,K C            WC O/P 05/12/13 05/12/13       50.00 AR
Clm Liab:        409.00    Bill Dts: 12/13/05-12/13/05  Ins Bal:        409.00
Ins:  250/400-OUT PATIENT THERAPY            Billed DRG:                  PCI:
 1 Batch Seq #        2 Pt Class
           2
 3 Payment Amount     4 Receipt #           5 Remittance #
            200.00                                              123
 6 Payment Date       7 Posting Date        8 New Account Balance
          05/22/06             05/22/06                  150.00-
 9 Trans Code/Description                  10 Cont Adj Trans Code/Description
   I0001-OHIP Out Patient Payment
11 Expected Reimbursement                  12 Outlier  13 Days Paid  14 DRG Paid
      Not Available                           ->                                  1
15 Coinsurance   16 Deductible             17 Co-Pay          18 Pat Resp

19 Claim Disp 20 Claim Denial Info        21 ERA Other Adjustment
   Final
 Contractual Adj     22 Prior Balance   23 Payment Amount  24 Cont Adj Amount
                                          409.00                   200.00
```

The Line Sequence, Exception Code, and MSP Internal Number fields are retained in the transaction history record when the payment is posted to the claim. The line sequence and exception code are required entries whenever a manual cash posting entry is made. The charge lines within the claim are displayed when the user accesses the Line Sequence number to facilitate posting to the correct claim charge detail line. Payments may be posted to all charge lines that are not in a RES (Resubmitted) status.

When the cash batch is approved, the system posts the information to the claim and updates the individual charge line specified, as well as the overall carrier/claim information. The charge line on the claim is marked as Paid in Full (Pd) when the payment and adjustment amount satisfy the charge amount for the claim. When all of the charge lines within a claim have been marked as paid, the claim is marked Paid in Full and the disposition of the claim is set to Final Payment. Since the system is determining whether a claim is paid in full based on the status of the claim charge detail lines, the claim disposition flag on the insurance cash batch should always be set to P - PARTIAL. As a result, the only valid entry in the claim disposition field for BC MSP and Worker's Compensation claims is P – PARTIAL. This is also true for the claim disposition field on the Electronic Remittance Setup Processor screen. Remember for these claim types to always default the disposition on the insurance batch screen to P for Partial to prevent the claim from being marked as completed and paid in full when there are still outstanding claim charge lines.

If the charge line is not paid in full, the exception code entered is displayed in the status of the claim charge detail line. These lines are considered unreconciled for claim payment purposes.

If a payment is posted inadvertently to an incorrect charge line, the payment should be reversed by posting a negative payment. Since an exception code is required for all

manual cash posting entries, you may want to establish a two-character code that is not used by the Ministry for use in correcting posting errors that are made.

Key points to remember:

1. Since the reconciliation process is dependent upon payments being posted to individual claim charge detail lines, all payment and adjustment activity to BC MSP and Worker's Compensation claims should be posted via the insurance cash processor. (The Electronic Remittance Software for BC MSP and Worker's Compensation claims automatically creates entries into the insurance cash batch for payments that can be matched and that do not have exception codes).

2. The Claim Disposition and Balance Transfer functions do not disposition individual claim charge detail lines. These functions, along with the Adjustment Processor, are claim-based.

3. Multiple payments can be posted to a single claim charge line. The payments and adjustments are accumulated with each posting. When the claim charge amount is satisfied, the claim charge line is marked as Pd-Paid in Full. When all claim charge lines are Paid in Full, the claim disposition is set to Final Payment, the claim is marked paid in full and removed from insurance follow-up, and the claim becomes a completed claim.

Chapter 4 - PROVINCIAL CLAIMS REPORTS (ONTARIO ONLY)

Illustrations

INTRODUCTION

This chapter provides you with information for printing reports. Included within this chapter is an explanation on how to print the Provincial Claims reports. Also provided are sample reports.

OHIP REPORT PRINTING

To print OHIP claim and reconciliation reports perform the following steps:

1. Select Account Management from the Initial Menu Processor screen.

2. Select Account Reports from the Account Management Processor screen.

3. Select Provincial Claims Reports from the Account Reports Processor screen. The following screen is displayed:

```
                  General Hospital Provincial Claims Reports Processor
                                                 Mon Jun 12, 1995 12:30 pm
Provincial Claims Reports Input Options

            Option No.  Option
            ---------------------------------------
Request         1       OHIP Bill Summary Report
                2       OHIP Production Report
                3       OHIP Diskette Submission (Reprint)
                4       OHIP Outstanding A/R Report
                5       OHIP Reconciliation Report









Enter option number--
```

This screen allows you to chose the specific the OHIP report that you want to print. Each option is discussed below.

OHIP Bill Summary Report

After you select the OHIP Bill Summary Report option from the Provincial Claims Report Processor screen and enter the facility code, the following screen is displayed:

```
                    General Hospital OHIP Bill Summary Report Processor
                                                  Wed Jun 14, 1995 08:15 am
 1 Sort
   Physician ID
 2 Physician ID(s)
   429201653524, 429204686247, 429218632033,  872413594733
 3 Clinic(s)

 4 Doctor(s)

 5 Claim Production Dates
   Earliest thru 95/06/14









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

Field Explanations

1. SORT (1-A-R)
This field indicates how the OHIP Bill Summary report is sorted. After you select this option, the following prompt is displayed:

Sort the report by (P)hysician ID, (C)linic or (D)octor [P] --

Enter **P** to sort the report by the twelve-digit physician billing number. Enter **C** to sort the report by clinic. Enter **D** to sort the report by the six-digit physician code. The default is P.

2. PHYSICIAN ID(S)
This field contains the twelve-digit OHIP physician ID that prints on the report. This field references the OHIP Billing Doctor table. When this option is selected a table look-up of physician IDs is displayed. Select the physician IDs to be displayed on the report. If this field is entered, the fields Clinic and Doctor are blank.

3. CLINIC(S) (TABLE LOOK-UP)
This field contains the OHIP clinic codes that print on the OHIP Bill Summary report. This field references the OHIP Billing Doctor table. When this option is selected a table look-up of clinic codes displays. Select the clinic codes to be displayed on the OHIP Bill Summary report.

NOTE: When you specify clinics that are to be included on the OHIP Bill Summary report and you do not include any doctors, the report shows all the physicians

for the clinics that you specify. If you specify doctors and do not include any clinic numbers, the report shows all doctors selected in each clinic. If you specify doctors and clinics, the report shows you all the clinics and doctors that you specified.

4. DOCTOR(S) (TABLE LOOK-UP)

This field contains the six-digit doctor codes that print on the OHIP Bill Summary report. This field references the OHIP Billing Doctor table. When this option is selected a table look-up of doctor codes displays. Select the performing doctor codes to be displayed on the OHIP Bill Summary report.

NOTE: When you specify doctors that are to be included on the OHIP Bill Summary report and you do not include any clinic numbers, the report shows all the clinics for the doctors that you specify. If you specify clinics and do not include any doctors, the report shows all doctors selected in the specified clinics. If you specify doctors and clinics, the report shows you all the clinics and doctors that you specified.

5. CLAIM PRODUCTION DATES (6-N-R)

The field contains the date on which the claim was produced and released into the download file.

After you select this option, the following prompts are displayed:

Enter Claim Production date [Earliest] --
Enter Claim Production date [Latest] --

Enter the beginning and ending claim production dates in the format of YYMMDD or YY/MM/DD. The default is Earliest to Latest.

After you accept this screen the OHIP Bill Summary Report can be viewed or printed.

The OHIP Bill Summary report is automatically produced during midnight processing for claims that have been produced and released to the download file that day. These claims are not yet submitted but will be when the diskettes are created. The daily version of the OHIP Bill Summary Report sorts by Physician IDs and serves as an audit tool for claims released by billing to the Ministry of Health.

In addition the OHIP Bill Summary report may be produced by user-specified time periods, physician IDs, clinic, or doctor. These report formats also show a breakdown of technical and professional components. The report prints on 132-character width paper.

The report header includes the following information:

- Facility
- Report title

- Date/time the report was compiled
- Report name
- Page number
- Claim production date

The report body includes the following information:

- Bill number (bill sequence - claim sequence)
- Patient's account number
- Patient name
- Patient health card number and version code
- Patient birthdate
- Patient sex
- Referring physician OHIP number
- Admit date
- Date of service
- Diagnosis code
- Benefit Code (SoB code)
- Number of services
- Fee - detail component total for patient
- Total fees per performing physician billing code

The report summary includes the following information:

- Total fees
- Technical fees
- Professional fees
- Resubmitted fees

The following is an example of a OHIP Bill Summary Report.

Figure 4.1 FMRPCSA - OHIP Bill Summary Report

```
Date: 15/06/95                                    GENERAL HOSPITAL                                    Page  : 1
Time: 13.20                                   OHIP Bill Summary Report                                Report: FMRPCSA
                                                   Clinic 4321
      Patient      Patient Name     Patient          Birth       Ref   Admit    Service  Diag Benef   #          Bill
Bill# ID           Last    First    Health #         Date    Sex Phys#          Date     Code Code   Ser  Fee     Fee
08/06/95
2-2   A8-00002-49  REOHIP,ER,ONE    587-4569-871     14/01/52 M 991332 08/06/95 08/06/95      X101A   1   38.35*    0.00
09/06/95
3-3   A8-00002-49  REOHIP,ER,ONE    587-4569-871     14/01/52 M 991332 08/06/95 08/06/95      X101A   1   38.35    38.35
   Doctor 4321-567890-12Technical:       38.35 Professional:      0.00 Total:           38.35 Resubmitted:      38.35
                                                                                                              -------
                                                                                          Total Fees:            38.35
                                                                                       Technical Fees            38.35
                                                                                     Professional Fees            0.00
                                                                                      Resubmitted Fees            38.35
_____________________________________________________________________________________________________________________
Date: 15/06/95                                    GENERAL HOSPITAL                                    Page  : 2
Time: 13.20                                   OHIP Bill Summary Report                                Report: FMRPCSA
                                                   Clinic 5678
      Patient      Patient Name     Patient          Birth       Ref   Admit    Service  Diag Benef   #          Bill
Bill# ID           Last    First    Health #         Date    Sex Phys#          Date     Code Code   Ser  Fee     Fee
11/06/95
1-1   A8-00002-84  REOHIP,SERIES,TH 897-4587-888     15/06/78 F 567890 11/06/95 11/06/95      J001C   1   28.00    28.00
13/06/95
2-2   A8-00002-84  REOHIP,SERIES,TH 897-4587-888     15/06/78 F 567890 11/06/95 12/06/95      J001C   1   28.00    28.00
15/06/95
1-1   A8-00002-85  REOHIP,SERIES,FO 897-5632-145     29/01/57 M 567890 11/06/95 12/06/95      J001C   1   28.00
                                                                                 15/06/95      J001C   1   28.00    56.00
   Doctor 5678-567890-12Technical:      112.00 Professional:      0.00 Total:          112.00 Resubmitted:      0.00
11/06/95
1-1   A8-00002-84  REOHIP,SERIES,TH 897-4587-888     15/06/78 F 567890 11/06/95 11/06/95      X111A   1   50.00
                                                                                 11/06/95      X112A   1   88.00   138.00
   Doctor 5678-664661-00Technical:       50.00 Professional:     88.00 Total:          138.00 Resubmitted:      0.00
11/06/95
1-1   A8-00002-82  REOHIP,SERIES,ON 875-4214-558     25/02/53 F 991332 11/06/95 11/06/95      J001C   1   28.00    28.00
1-1   A8-00002-83  REOHIP,SERIES,TW 459875621        30/04/38 M 991332 11/06/95 11/06/95      J001C   1   28.00    28.00
13/06/95
2-2   A8-00002-82  REOHIP,SERIES,ON 875-4214-558     25/02/53 F 991332 11/06/95 12/06/95      J001C   1   28.00    28.00
   Doctor 5678-991332-12Technical:       84.00 Professional:      0.00 Total:           84.00 Resubmitted:      0.00
                                                                                                              -------
                                                                                          Total Fees:           334.00
                                                                                       Technical Fees           246.00
                                                                                     Professional Fees            88.00
                                                                                      Resubmitted Fees             0.00*
         Grand Total                                  372.35          284.35          88.00        38.35
                                                      End of Report
```

OHIP Production Report

After you select the OHIP Production Report option from the Provincial Claims Report Processor screen and enter the facility code, the following screen is displayed:

```
                    General Hospital OHIP Production Report Processor
                                                  Mon Jun 12, 1995 12:49 pm
 1 Sort
   Physician ID
 2 Physician ID(s)

 3 Clinic(s)
   4292,8724,8826,8889,9113
 4 Doctor(s)
   016535,046862,186320
 5 Claim Production Dates
->




Enter Claim Production date [Earliest] --
```

Field Explanations

1. SORT (1-A-R)
This field indicates how the OHIP Production report is sorted. After you select this option, the following prompt is displayed:

Sort the report by (P)hysician ID, (C)linic or (D)octor [P] --

Enter **P** to sort the report by the twelve-digit physician billing number. Enter **C** to sort the report by clinic. Enter **D** to sort the report by the six-digit physician code. The default is P.

2. PHYSICIAN ID(s) (TABLE LOOK-UP)
This field contains the twelve-digit OHIP physician ID that prints on the report. This field references the OHIP Billing Doctor table. When this option is selected, a table look-up of physician IDs is displayed. Select the physician IDs to be displayed on the OHIP Production report. If this field is entered, the fields Clinic and Doctor are blank.

3. CLINICS (S) (TABLE LOOK-UP)
This field contains the OHIP clinic codes which will print on the OHIP Production report. This field references the OHIP Billing Doctor table. When this option is selected a table look-up of clinic codes displays. Select the clinic codes to be displayed on the OHIP Production report.

NOTE: When you specify clinics that are to be included on the OHIP Production report and you do not include any doctors, the report shows all the physicians

for the clinics that you specify. If you specify doctors and do not include any clinic numbers, the report shows all doctors selected in each clinic. If you specify doctors and clinics, the report shows you all the clinics and doctors that you specify.

4. DOCTORS (TABLE LOOK-UP)

This field contains the six-digit doctor codes that print on the OHIP Production report. This field references the OHIP Billing Doctor table. When this option is selected, a table look-up of doctor codes is displayed. Select the doctor codes to be displayed on the OHIP Production report.

NOTE: When you specify doctors that are to be included on the OHIP Production report and you do not include any clinic numbers, the report shows all the clinics for the doctors that you specify. If you specify clinics and do not include any doctors, the report shows all doctors selected in the specified clinics. If you specify doctors and clinics, the report will show you all the clinics and doctors that you specified.

5. CLAIM PRODUCTION DATES (6-N-R)

The field contains the date on which the claim was produced and released into the download file.

After you select this option, the following prompts are displayed:

Enter Claim Production date [Earliest] --
Enter Claim Production date [Latest] --

Enter the beginning and ending claim production dates in the format of YYMMDD or YY/MM/DD. The default is Earliest to Latest.

After you accept this screen the OHIP Production Report can be viewed or printed.

The OHIP Production Report provides a summarization by procedure code of all charge activities for the selected physicians and/or for clinics within the specified claim production dates. The report also shows a breakdown of technical and professional components, along with a total of resubmitted charges for the selected period. The report prints on 80-character width paper.

The report header includes the following information:

- Facility
- Report title
- Date/time the report was compiled
- Report name
- Page number
- Claim production date

The report body includes the following information:

- Procedure code
- Description
- Quantity of service
- Percent of total service
- Charged fee
- Percent of total charges
- Total
- Technical and professional

The report summary includes the following information:

- Physician name
- Physician ID (STAR physician number)
- Physician number (twelve-digit OHIP billing code)
- Technical fees
- Professional fees
- Total fees
- Resubmitted fees

The following is an example of an OHIP Production Report.

Figure 4.2 FMRPCP - OHIP Production Report

```
Date: 15/06/95                  GENERAL HOSPITAL                Page  : 1
Time: 14.09                     Production Report               Report: FMRPCPA

                               Earliest - 15/06/95

                          Detail Report for Doctor 567890


Proc.                                    Qty of        % of    Charged      % of
code                                    Services    Services        Fee   Charges

.....................................................................................
     For Clinic 4321
X101A    GR-ABDOMEN KUB                     1     100.00%      38.35   100.00%
                                          ====               =========
                    TOTALS:                 1                  38.35

                           Technical:                          38.35
                           Professional:                        0.00
                           Resubmitted:                        38.35
.....................................................................................
     For Clinic 5678
J001C    J001                               4     100.00%     112.00   100.00%
                                          ====               =========
                    TOTALS:                 4                 112.00

                           Technical:                         112.00
                           Professional:                        0.00
                           Resubmitted:                         0.00
.....................................................................................
     For Clinic 8821
X101A    GR-ABDOMEN KUB                    21     100.00%     839.00   100.00%
                                          ====               =========
                    TOTALS:                21                 839.00

                           Technical:                         795.00
                           Professional:                       44.00
                           Resubmitted:                       115.05
.....................................................................................
Doctor Totals
                                          ====               =========
                    TOTALS:                26                 989.35

                           Technical:                         945.35
                           Professional:                       44.00
                           Resubmitted:                       153.40
```

OHIP Diskette Submission (Reprint)

After you select OHIP Diskette Submission (Reprint) option from the Provincial Claims Report Processor screen and the facility code is entered, the OHIP Diskette Submission Report can be displayed or printed. Refer to the *Ontario Electronic Claims and Payments Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description and sample of the OHIP Diskette Submission Report.

OHIP Outstanding A/R Report

This function is under development.

OHIP Reconciliation Report

After you select the OHIP Reconciliation Report option from the Provincial Claims Report Processor screen and the facility code is entered, the following screen is displayed:

```
                    General Hospital Provincial Claims Report Processor
                                                Thu Jun 08, 1995 03:07 pm
 1 Report ID               2 Report Format        3 Sort
   Reconciliation            Detail                 Clinic
 4 Pt Indicator            5 Physician ID(s)
   All                       999956789012
 6 Clinic(s)               7 Doctor(s)

 8 Reconciled?             9 Status              10 Report Aging Code
   Include                   All
11 Service Dates          12 Claim Submit Dates
   Earliest thru 95/08/06    Earliest thru 95/08/06









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

Field Explanations

1. REPORT ID (DISPLAY ONLY)
This field contains the type of OHIP Reconciliation report to be produced.

2. REPORT FORMAT (1-A-R)
This field contains the OHIP Reconciliation report format. After you select this option, the following prompt is displayed:

Report on (D)etail, (S)ummary, (B)oth or (A)ged --

Valid responses are **D** for detail, **S** for summary, **B** for both summary and detail, and **A** for aged.

3. SORT (1-A-R)
This field indicates how the OHIP Reconciliation report is sorted. After you select this option, the following prompt is displayed:

Sort the reconciliation report by (P)hysician ID, (C)linic, or (D)octor [P] --

Enter **P** to sort the report by the twelve-digit physician billing number. Enter **C** to sort the report by clinic. Enter **D** to sort the report by the six-digit physician code. The default is P.

4. PT INDICATOR (1-A-R)
This field indicates the type of patient accounts that are to be included in the OHIP Reconciliation report. After you select this option, the following prompt is displayed:

Include (I)npatient, (O)utpatient, (E)mergency, or (A)ll accounts? [A] --

Enter **I** to include inpatients only on the OHIP Reconciliation report. Enter **O** to include outpatients only on the OHIP Reconciliation report. Enter **E** to include emergency patients only on the OHIP Reconciliation report. Enter **A** to include all patients on the OHIP Reconciliation report. The default is A.

5. PHYSICIAN ID(S) (TABLE LOOK-UP)
This field contains the twelve-digit OHIP physician ID that prints on the report. This field references the OHIP Billing Doctor table. When this option is selected, a table look-up of physician IDs is displayed. Select the physician IDs to be displayed on the OHIP Reconciliation report. If this field is entered, the fields Clinic and Doctor are blank.

6. CLINIC(S) (TABLE LOOK-UP)
This field contains the OHIP clinic codes that print on the OHIP Reconciliation report. This field references the OHIP Billing Doctor table. When this option is selected, a table look-up of clinic codes is displayed. Select the clinic codes to be displayed on the OHIP Reconciliation report.

NOTE: When you specify clinics that are to be included on the OHIP Reconciliation report and you do not include any doctors, the report shows all the physicians for the clinics that you specify. If you specify doctors and do not include any clinic numbers, the report shows all doctors selected in each clinic. If you specify performing physicians and clinics, the report shows you all the clinics and physicians that you specified.

7. DOCTOR(S) (TABLE LOOK-UP)
This field contains the six-digit doctor codes that print on the OHIP Reconciliation report. This field references the OHIP Billing Doctor table. When this option is selected, a table look-up of doctor codes is displayed. Select the doctor codes to be displayed on the OHIP Reconciliation report.

NOTE: When you specify doctors that are to be included on the OHIP Reconciliation report and you do not include any clinic numbers, the report shows all the clinics for the doctors that you specify. If you specify clinics and do not include any doctors, the report shows all doctors selected in the specified clinics. If you specify doctors and clinics, the report shows you all the clinics and doctors that you specified.

8. RECONCILED? (1-A-R)

This field allows selection based on whether or not the claim charge detail line has been reconciled. A charge line is considered reconciled if the amount submitted less the amount paid and/or adjusted is equal to zero. After you select this option, the following prompt is displayed:

Enter (I)nclude, (E)xclude, or (O)nly [I] --

Enter **I** to include all charges on the OHIP Reconciliation report. Enter **E** to exclude reconciled charges on the OHIP Reconciliation report. Enter **O** to include only reconciled charges on the OHIP Reconciliation report. The default is I.

9. STATUS (3-A-R)

This field contains the exception/rejection codes that have been returned from the Ministry for specific claim charge detail line. After you select this option, the following prompt is displayed:

Enter exception codes to report or include All [A] --

Enter the status code(s) or **A** for all status codes. The default is A.

10. REPORT AGING CODE (TABLE LOOK-UP)

This field allows you to select the aging categories to be used on the Aged Reconciliation report. This field references the Report Aging Code table. When this option is selected, a table look-up of report aging codes is displayed. Select the report aging codes to be displayed on the report.

11. SERVICE DATES (6-N-R)

This field contains the date of service for the charge of the claim. This field allows you to specify claims with specific service dates to be included on the OHIP Reconciliation report. In order for the claim to be included on the report, the claim must have a charge line with a service date within the requested range.

After you select this option, the following prompts are displayed:

Enter Service date [Earliest] --
Enter Service date [Latest] --

Enter the beginning and ending service dates in the format of YYMMDD or YY/MM/DD. The default is Earliest to Latest.

12. CLAIM SUBMIT DATES (6-N-R)
This field contains the date ofwhen the claim charge line was submitted to the Ministry. This field allows you to specify claims with specific submit dates to be included on the OHIP Reconciliation report. In order forthe claim to be included on the report, the claim must have a submit date within the requested range.

After you select this option, the following prompts are displayed:

Enter Claim Submission date [Earliest] --
Enter Claim Submission date [Latest] --

Enter the beginning and ending claim submit dates in the format of YYMMDD or YY/MM/DD. The default is Earliest to Latest.

After you accept this screen, the OHIP Reconciliation Report can be viewed or displayed. Refer to the *Ontario Electronic Claims and Payments Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description and sample of the OHIP Reconciliation Report.

Chapter 5 - AUTOMATIC REPRICING BY FINANCIAL CLASS

INTRODUCTION

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

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

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

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

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

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

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

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

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

If the patient's account is active in Patient Care, the charge data is obtained from the Patient Care system, and the resulting credits and charges are handled as regular charges and credits. However, if the patient's account is no longer active in Patient Care, then the charge information must be obtained from the Patient Accounting system. These charges are logged as late charges and credits. In either case, a log entry is made to the patient's transaction history stating that the repricing event occurred.

The Change Financial Class report (FAFCRPT), a new midnight processing report, has been added to Patient Accounting. This report lists all changes in financial class that occurred during the day, and lists any charges that were automatically adjusted showing the credit information and the new charge information. Manually-priced and inactive items are highlighted for hospital review. Refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on this report.

To activate the automatic repricing feature, you must set a parameter in Patient Care. To set this parameter, access Patient Care, Tables, Hospital Facility Options, Order Management and Charging Parameters. In a multi-facility environment, the system asks you to select a facility. When you select the facility, the following screen is displayed:

```
      General Hospital Order Management and Charging Parameters Processor
                                                    Tue Apr 30, 1996 11:36 am

 ORDERS/CHARGES
 1 Cont. Chg. Suspense       2 Room and Bed Charging      3 Display Room/Bed Screen
   60                          Yes                          Yes
 4 Professional Fees         5 Late Charge Days           6 Panels
   Yes                         999                          Yes
 7 Order Hist. Chgs          8 R/B Increase?              9 Cart Report
    No                         No                           Summary
10 Default Service Date     11 AdV SIM Dept              12 Reprice if FC Changes
   Charge Date                                             Yes
13 Edit By                                              14 Edit Date
   Smith,Mary M                                            96/04/11 11.31




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

12. REPRICE IF FC CHANGES (1-A-R)

This field determines if charges are automatically evaluated for repricing when a change in a patient's financial class occurs. Valid options are **Y** for Yes and **N** for No. The default is N.

REPRICED CHARGE INQUIRY

This function provides detailed information regarding the charges and repricing that may have occurred on a particular account. In order to use this inquiry, the patient must be active on STAR Patient Care. The patient may be accessed via account number, bed code, or by name. Once the patient is entered, the system sorts the data in internal order number sequence and prompts you to enter the order number to begin the inquiry. The default for this prompt is A for all. If the account entered has had no repricing done, you receive the message *No Repricing Done for this Account!* and are returned to the account number prompt. Once an account has been selected that has been evaluated for repricing, the following screen is displayed:

```
              General Hospital Repriced Charge Inquiry Processor
                                                    Tue Mar 14, 2006 10:33 am
Account      Name                 FC Typ Admit    Disch      Balance Loc
A9607900003  BERRYMORE,JASON      10 ER   96/03/19 96/03/19  53.90   AR/FCRV
RP  Chg#  Dept Description                Pst Date  Srv Date  Qty      Price
                                  Order#: 3
 *     3  CSR  BABY OIL                    96/03/19  96/03/19    1       3.90
                                  Order#: 2
 *     2  RAD  XR KNEE AP & LAT  735643    96/03/19  96/03/19    1     123.25
 *  Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19   -1    -123.25
    Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19    1      35.00
                                  Order#: 1
 *     1  LAB  CBC WITH DIFF              96/03/19  96/03/19    1      21.00
 *  Late  LAB  CBC WITH DIFF              96/03/24  96/03/19   -1     -21.00
    Late  LAB  CBC WITH DIFF              96/03/24  96/03/19    1      15.00




Press NL--
```

Field Explanations

RP (DISPLAY ONLY)
This field displays an asterisk to indicate the beginning of a repricing event.

CHG # (DISPLAY ONLY)
This field contains the charge number. The word *Late* is displayed if the charge was a late charge.

DEPT (DISPLAY ONLY)
This field displays the SIM department of the charge.

DESCRIPTION (DISPLAY ONLY)
This field displays the description of the charge.

PST DATE (DISPLAY ONLY)
This field contains the posting date of the charge.

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

QTY (DISPLAY ONLY)
This field displays the charge quantity.

PRICE (DISPLAY ONLY)
The field displays the total charge amount.

PA REPRICED CHARGE INQUIRY

This function also provides detailed information regarding the charges and repricing that have occurred on a particular account. It displays the same information as the Repriced Charge Inquiry. The only difference is that the PA Repriced Charge Inquiry can be used for both active and inactive patients.

You can access the patient by account number, corporate number, health card number, unit number, or by name. After you select the patient, the system sorts the data in internal order number sequence and prompts you to enter the order number to begin the inquiry. The default for this prompt is A for All. If no repricing has been done for the account, the system displays the message *No Repricing Done for this Account!* and returns to the account number prompt.

If the account has been evaluated for repricing, the following screen is displayed:

```
          General Hospital PA Repriced Charge Inquiry Processor
                                                    Tue Mar 14, 2006 10:33 am
Account      Name                   FC Typ Admit    Disch      Balance Loc
A9607900003  BERRYMORE,JASON        10 ER  96/03/19 96/03/19   53.90   AR/FCRV
RP  Chg#  Dept Description                Pst Date  Srv Date  Qty      Price
                                   Order#: 3
 *     3  CSR  BABY OIL                    96/03/19  96/03/19    1      3.90
                                   Order#: 2
 *     2  RAD  XR KNEE AP & LAT  735643    96/03/19  96/03/19    1    123.25
 *  Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19   -1   -123.25
    Late  RAD  XR KNEE AP & LAT  735643    96/03/24  96/03/19    1     35.00
                                   Order#: 1
 *     1  LAB  CBC WITH DIFF               96/03/19  96/03/19   1     21.00
 *  Late  LAB  CBC WITH DIFF               96/03/24  96/03/19   -1    -21.00
    Late  LAB  CBC WITH DIFF               96/03/24  96/03/19    1     15.00




Press NL--
```

Field Explanations

RP (DISPLAY ONLY)
This field displays an asterisk to indicate the beginning of a repricing event.

CHG # (DISPLAY ONLY)
This field contains the charge number. The word *Late* is displayed if the charge was a late charge.

DEPT (DISPLAY ONLY)
This field displays the SIM department of the charge.

DESCRIPTION (DISPLAY ONLY)
This field displays the description of the charge.

PST DATE (DISPLAY ONLY)
This field contains the posting date of the charge.

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

QTY (DISPLAY ONLY)
This field displays the charge quantity.

PRICE (DISPLAY ONLY)
The field displays the total charge amount.

REPRICING HISTORY

The repricing history function provides an online history of the repricing events that have occurred in an account. You can access the account by account number, corporate number, health card number, unit number, or name. If the account has had no repricing transactions, the system displays the message *No Repricing Events exist!* and returns to the account entry prompt.

When you select the patient, a prompt is displayed requesting the repricing sequence number. Enter the number or a hyphen (-) to display a list of repricing sequence events. The default for this prompt is the last repricing event that has occurred. The list of resequence events is the FC Repricing Log. It provides the start and start time of the resequence event, the initiating CRT and process, the old financial class, and the new financial class.

When you select the repricing sequence, the following screen is displayed:

```
            General Hospital Repricing History Processor
                                                Tue Mar 14, 2006 10:33 am
Account      Name             FC Typ Admit    Disch      Balance Loc
A9607900003  BERRYMORE,JASON  10 ER  96/03/19 96/03/19   53.90   AR/FCRV
  Reprice Seq#:  1  Started: 96/03/24 10:32   Completed:  96/03/24 10:32
Seq  Srv       Post      SIM Dept/Code/Description           Qty    Amount

2    96/03/19  96/03/19  RAD  7356  XR KNEE AP & LAT  73     1       123.25  O
     96/03/19  96/03/24  RAD  7356  XR KNEE AP & LAT  73    -1       123.25- AL
     96/03/19  96/03/24  RAD  7356  XR KNEE AP & LAT  73     1        35.00  NL

1    96/03/19  96/03/19  LAB  2090  CBC WITH DIFF            1        21.00  O
     96/03/19  96/03/24  LAB  2090  CBC WITH DIFF           -1        21.00- AL
     96/03/19  96/03/24  LAB  2090  CBC WITH DIFF            1        15.00  NL

Original:      $144.25        Adjustments:  $144.25-        New:     $50.00
Manual:          $0.00
Inactive:        $0.00


Press NL--
```

Field Explanations

REPRICE SEQ# (DISPLAY ONLY)
This field contains the sequence number of the repricing event.

STARTED (DISPLAY ONLY)
This field contains the date and time the resequencing event began.

COMPLETED (DISPLAY ONLY)
This field contains the date and time the resequencing event completed.

SEQ (DISPLAY ONLY)
This field contains the sequence number associated with the charge.

SRV (DISPLAY ONLY)
This field contains the service date of the charge.

POST (DISPLAY ONLY)
This field contains the date the charge was posted.

SIM DEPT/CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the SIM Department, SIM Code, and SIM Description.

QTY (DISPLAY ONLY)
This field contains the charge quantity.

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

Original charges are marked with an O. Adjustment charges are marked with an A. New charges applied are marked with an N. An L beside the indicator means that the charge is considered a late charge in the system. Manually priced items and inactive items display as identified with an M and an I respectively.

Totals are provided for the original charges, the adjusted charges, the new charges, and manually priced and inactive items.

RESTART REPRICING EVENT

Use this function to complete any repricing event that has not completed normally. You should use it only if an error has logged to the Patient Care console indicating that a restart of the repricing event may be necessary. Remember that the charges and credits reissued must be processed through the charge processor. Depending on the network, there may be a delay between the time the financial class is changed and the time the charges are available in Patient Accounting.

The system logs a transaction to the patient's transaction history when repricing begins and logs another transaction when repricing has completed. The Change Financial Class Report also shows the start and completion times of the repricing event.

When you select this option, the system prompts you for the account. You can access the account by account number, corporate number, health card number, unit number, or name. If the repricing events for the account have been completed, the system displays the message *Repricing Completed for Last Event* and returns to the FPI lookup.

If there is an incomplete repricing event, the following screen is displayed:

```
             General Hospital Restart FC Repricing Processor
                                                    Tue Mar 14, 2006 10:33 am
Account      Name                      FC Typ Admit    Disch      Balance Loc
A1-00001-96  LONG,BABE                 M  NWB 96/04/15 96/04/18   2300.00 AR/FCRV

Using network job starts, Restart FC Repricing continues FC Repricing
for the last Repricing event for the selected account.

If the system has been down or the network is behind,
EXECUTE this later.

Patient Care ABORTS the job if queued network job starts exist.

If Patient Care finds an error or a locked patient, the
process stops and a message appears on the Patient Care console.

If the patient is locked, retry later.
(Repricing may be completing.)

Monitor the Patient Care Console and the Repricing Log
to determine failure or success.
Are you SURE that repricing should restart (YES/N) [N]--
```

Enter **Y** to accept the screen and begin the restart process. The default is N for No. During the restart process, messages appear on the Patient Care console. These messages log under FC Reprice ID XXX, where XX is the ID of the environment being processed. For example, repricing messages for the Live ID, ID 1, would be logged under FC Reprice ID 1.

REPRICE CHARGES

Use this function to reprice individual charge items. It is particularly useful when an item is priced differently based on the patient type of the patient and the patient type has changed. In order to use this function, the patient must be active in Patient Care. It cannot be used once the patient has gone inactive in Patient Care. Therefore, the hospital should carefully review accounts whose patient type has changed.

Select the Reprice Charges function through the Charge/Credit Functions in Billing/ Claims. Select the account through the normal Patient Care lookup (account number, bed code, or name). The system prompts you to enter the date on which to begin the charge review. The default is today.

When you select the date, the following screen is displayed:

```
               General Hospital Reprice Charges Processor
                                                    Tue Apr 30, 1996 01:25 pm
  No        Name              Sex  BD       Room    Physician   SVC     Status
00010195    BERRYMORE,JASON    M  81/01/31 2112-01 ADAIR,FRANK C MED   I/P 36

Charges for  Eligible Departments   During the 24 Hours Ending  96/04/29

No  Chg#  Dept Description                              Srv Date  Qty     Price
 1    38  RMB  DBW SEM/WARD PANEL                       04/29/96    1       .00
 2    37  CSR  CRUTCHES,PR-ADULT                       04/15/96    1     28.60









              All charges have been listed for the date shown!
Enter number, summary(S) or new date [previous date]--
```

Select the Item Number that needs to be repriced. The following screen is displayed:

```
             General Hospital  Reprice Charges Processor
                                                  Tue Apr 30, 1996 02:53 pm
  No      Name               Sex BD       Room    Physician     SVC   Status
00010195  BERRYMORE,JASON    M  81/01/31 2112-01 ADAIR,FRANK C MED   I/P 36

 1 Charge Number       2 From CRT              3 Department          4 Type
   37                    FIN STAR FINANCIAL      CENTRAL SERVICES      Charge
 5 Charge Location              6 Date Charged           7 Charged By
   1E 1 EAST                      96/04/29 12.17           PMB
 8 Code   Bill Code             9 Description
   0472   6251-0472               CRUTCHES,PR-ADULT
10 Quantity 11 Price      12 Date of Service  13 Order Diagnosis
   1          $28.60        04/15/96
14 Charging Physician      15 Performing Physician          16 Fin. Class
   32 ADAIR,FRANK C                                           10 OHIP FINA
17 Revenue Code            18 Accommodation Code    19 SoB    20 Clinic #
   CENTRAL SERVICES                                           0000-000000-00


(E)dit or (R)eprice charge?--
                  next charge(/) or previous charge(/P) [/]
```

Enter **R** at the prompt. The system evaluates the charge and displays the following screen:

```
                 General Hospital Reprice Charges Processor
                                                  Tue Apr 30, 1996 03:09 pm
  No       Name               Sex BD       Room    Physician     SVC   Status
00010195  BERRYMORE,JASON    M  81/01/31 2112-01 ADAIR,FRANK C MED   I/P 36
Chg#      Dept Description                   Qty  Old Price New Price   Status
  37      CSR  CRUTCHES,PR-ADULT              1       28.60     32.00      *









Reprice Charges as Indicated Y/N [N]--
```

If the price for the item remains the same, a message appears at the bottom of the screen saying *Cannot Reprice. No Prices Changed. Press NL to Continue*. Otherwise, to reprice the charges, enter **Y**. The default is N for No. If you enter N, the system displays *No Repricing Done*. Press ENTER and the system returns to the previous screen. If you enter Y, the system cancelsthe charge and reissues the charge with the new price. When the repricing is completed, the system displays *Reprice Complete. Press NL to Continue*. In the above example, the following screen would be displayed:

```
              General Hospital Reprice Charges Processor
                                                  Tue Apr 30, 1996 03:09 pm
  No      Name               Sex BD       Room    Physician     SVC   Status
00010195  BERRYMORE,JASON     M  01/31/81 2112-01 ADAIR,FRANK C MED   I/P 36

Charges for  Eligible Departments   During the 24 Hours Ending  Midnight Tonight

No  Chg#     Dept    Description                       Srv Date  Qty      Price
 1    40     CSR     CRUTCHES,PR-ADULT                 96/04/15    1      32.00
 2    39     CSR     CRUTCHES,PR-ADULT                 96/04/15   -1     -28.60









             All charges have been listed for the date shown!
Enter number, summary(S) or new date [previous date]--
```

Index

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Canadian Claims Processing Volume* of the *STAR Financials Patient Accounting Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

_____

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Other Comments:

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Thanks for your help in improving the documentation.

Your Name and Position _____

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May we contact you? Yes or No (circle one)

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