McKESSON
Empowering Healthcare

STAR 2000™

STAR FINANCIALS PATIENT ACCOUNTING REFERENCE GUIDE
Tables, Masters, and Parameters Volume

Release 18.0
October 2012

F18000021

Publication date

October 2012

Produced in Cork, Ireland

Product and version

STAR 2000 Release 18.0

Publication number

F18000021

Reader comments

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

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Preface

The *STAR Financials Patient Accounting Reference Guide* is a multivolume document written for all users of the system. This volume provides detailed information about each table, master file, and parameter in the base Patient Accounting System.

The *General Information Volume* is prerequisite reading for all other volumes of the *STAR Financials Patient Accounting Reference Guide*. Successful use of the *Tables, Masters, and Parameters Volume* depends on your knowledge of the concepts covered in the *General Information Volume*.

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

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

Enter patient name--

Field Characteristics

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

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

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

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

Table of Contents

Chapter 5 - STATISTICS MAINTENANCE

Chapter 6 - MCKESSON-MAINTAINED INFORMATION

Introduction

This document contains a detailed explanation of the purpose and impact of the tables included in the Patient Accounting module of STAR Financials. It is divided in this manner:

Chapter 1: Financial Table Maintenance

Financial Table Maintenance includes most of the Patient Accounting tables and discusses the table's purpose, how it is completed, and its impact on the system.

Chapter 2: PA/AR Master File Maintenance

PA/AR Master File Maintenance deals with the HCPCS Summarization, Provider, Insurance Plan Coverage, and Reimbursement masters.

Chapter 3: PA/AR Parameter File Maintenance

PA/AR Parameter Maintenance explains the Billing, Billing Requirements, Claim Generation, Claim Load and Edit, UB Charge Control, 1500 Charge Control, and 1500 Department/Supplier Override parameters.

Chapter 4: GL Mapping Maintenance

GL Mapping Maintenance covers the definition and maintenance of the parameters and keys used to map accounting events from patient accounting to the general ledger.

Chapter 5: Statistics Maintenance

Statistics Maintenance deals with the definition and accumulation of statistics in patient accounting.

Chapter 6: McKesson-Maintained Information

McKesson-Maintained Information includes descriptions about some of the tables and parameters used in STAR that can only be defined or edited by McKesson personnel. The information about the tables and parameters in this chapter is limited to a specific purpose or definition (for example, claim formats such as X=UB or B=1500).

Chapter 1 - FINANCIAL TABLE MAINTENANCE

INTRODUCTION

This chapter contains a listing and explanation of the tables used by the STAR Financials Patient Accounting System. Each table is presented with its purpose and use, the screen or screens used in completing it, and a detailed explanation of the screen fields involved.

At the end of the detailed explanation of each table, two columns are provided. The first column, which is marked Dependent On, lists the tables that must be completed prior to completing the table currently accessed. The second column, which is marked Reference, lists tables where reference is made to the table currently accessed. The tables in this second column should be completed after the table currently accessed is completed.

All tables described in this chapter can be accessed by selecting Tables from the STAR Financials main menu and then selecting Financial Table Maintenance from the subsequent menu. When accessing individual tables, you are prompted to enter a particular code. At this point, you have these options:

- Enter valid code for this table, if you know one. The system then displays the code and its description along with other pertinent information that can be edited.

- Enter a new code. The system prompts you to confirm your desire to add this code and then displays the screen(s) required to do so.

- Enter a hyphen (-) to display a list of codes already entered for this table. You can then select a code. This is called the Table Lookup feature. For more information on using this feature, refer to the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide.*

NOTE: These tables are available in a view-only version. The view-only version allows you to access tables without making changes. All tables described in this chapter can be viewed by selecting Tables from the STAR Financials main menu and then selecting Financial Table Maintenance - View from the subsequent menu.

If you want to print a list of codes included in a table:

1. Access the table.

2. When the system prompts you to enter a code, press the ENTER key, and enter **Yes** to the subsequent prompt.

The system prints the list at the printer assigned to the CRT from where the request originated. The system also spools the request to Report Definition FINX where *X* is the facility code of the hospital. For information on printer assignments and viewing/ printing spooled reports, refer to the *MultiSTAR Software Environment for UNIX Operations Guide*.

NOTE: This chapter contains screens, field explanations, and other documentation for Canadian usage of this product. Generally, the documentation reflects the base (US) product. Documentation for the Canadian version appears in the online version with blue highlighting. Canadian documentation is further identified by (CN) and (CN Only).

AGENCY FOLLOW-UP SCHEDULES

The Agency Follow-up Schedule contains information regarding the timing and type of follow-up used for accounts in a bad debt status. Accounts on Agency Follow-up Schedules defined as Internal can receive follow-up types of T for Telephone, D for Detail Statement, L for Letter, and W for Wait. Bad Debt accounts can only have account level schedules. Accounts on Internal Schedules can only be set up on Account Level payment plans, custom schedules, and separate schedules. Accounts on Agency Follow-up Schedules defined as external can only receive the follow-up type of W for Wait. Agency Follow-up Schedules that are defined as Internal can be set to automatically transfer accounts to an External Bad Debt Agency. This table also determines if bad debt accounts should become eligible for automatic Bad Debt Archive Deletion.

```
             General Hospital Financial Table Maintenance Processor
                                                 Wed Jan 11, 2006 09:07 am
Agency Follow-up Schedules
 1 Schedule #        2 Description                          3 Internal?
   927                 60 schedule                          Yes
 4 Wait Days         5 Day of Month    6 Day of Week        7 Week of Month
   30
 8 Due Days          9 Grace Days     10 Restart %          11 Restart Amount
   10                  10
12 Max Paper Bal    13 Min Balance    14 Max Delete Bal     15 Auto Delete?
   Unlimited           $5.00             $20.00               Yes
16 Xfer External    17 Ext Agency     18 Min External Bal   19 Max External Bal
   Yes              ->
20 Delinquent F/U Type        21 Delinquent F/U Message
   Detail Statement              1  DETAIL STATE 1ST STATEMENT

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

Field Explanations - Screen 1 of 2

1. SCHEDULE # (3-N-R)
This field displays the code used to identify the agency follow-up schedule.

2. DESCRIPTION (30-AN-R)
This field contains the description associated with the agency follow-up schedule code.

3. INTERNAL? (1-A-R)
This field indicates whether this Follow-up Schedule is an Internal or External Agency Follow-up Schedule. This field is completed at initial setup of the schedule and cannot be changed. Entry options are **Y** for Yes or **N** for No. If the parameter is set to Yes, then this schedule is an Internal Agency Schedule. If the parameter is set to No, then this schedule is an External Agency Schedule.

4. WAIT DAYS (2-N-R)
This field determines the number of days the system should wait, from today's date, before beginning follow-up. The entry range for this field is 0 to 99; 0 is the default.

Defining Follow-up Frequency

The frequency of account follow-up is defined in one of three ways: completing the Day Of Month or Day Of Week/Week of Month fields or completing Intervals. If you select Day of Month, leave the Day of Week and Week of Month fields for each sequence blank. If you select Day of Week, complete the Week of Month field and leave the Day of Month field for each sequence blank.

5. DAY OF MONTH (2-AN-O)
This field identifies the day of the month on which follow-up should be performed for guarantors are assigned to this schedule. Entry options are 1 through 28 or **L** for the last day of the month. If you complete this field, guarantors assigned to this schedule receive follow-up every month on the day you enter to this field. If this field is left blank, you must complete the Day of Week or Week of Month field or interval option (on the second screen of this function).

This field is not required for external agencies.

6. DAY OF WEEK (1-N-O)
This field identifies the day of the week on which follow-up should be performed for guarantors assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, ... Saturday = 7. If you complete this field, guarantors assigned to this schedule might receive follow-up every month on the day you enter to this field. If this field is left blank, you must complete the Day of the Month field or interval option (on the second screen of this function).

This field is not required for external agencies.

7. WEEK OF MONTH (1-N-O)
This field identifies the week of the month on which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete this field, guarantors assigned to this schedule receive follow-up every month during the week you enter to this field. This field is not required if the Day of Month field is completed.

This field is not required for external agencies.

8. DUE DAYS (2-N-R)
This field contains the number of days used in calculating the due date for payment plans. The entry range is 0 to 99 days; the default is 0.

This field is not required for external agencies.

9. GRACE DAYS (2-N-R)
This field contains the number of days after the due date before an account is delinquent. The entry range is 0 to 99 days; the default is 0. The statement print date plus the due days plus the grace days equals the delinquent date for payment plans.

This field is not required for external agencies.

10. RESTART % (2-N-O)
This field contains the percent of the balance due that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence) until this percent is paid. The entry range is 0 to 99.99%.

This field is not required for external agencies.

11. RESTART AMOUNT (8-N-O)
This field contains the minimum amount that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point).

This field is not required for external agencies.

12. MAX PAPER BAL (9-AN-R)
This field contains the maximum balance required for paper follow-up. The entry range is 0 to $999,999.99 or U for unlimited; the default is U. If the account balance is greater than the maximum paper balance, the account is selected for telephone follow-up only.

An overpayment causes the system to produce paper follow-up if this is less than the value in the Max Paper Balance field. For example, if the Max Paper Balance field is set to 1000 and the overpayment amount is -100, the system takes the absolute value of the overpayment which would be 100 in this scenario and if this is less than the value in the Max Paper Balance field, the system produces paper follow-up. If overpayment amount is greater than the value in the Max Paper Balance field, telephone follow-up is initiated. Overpayment follow-up is only initiated if an account qualifies for appeal follow-up. The insurance follow-up schedule needs to have the Appeal field set to Yes. Please see the Denial Tracking Payor table and the Claim Disposition Rules for more information on overpayment denial tracking.

This field is not required for external agencies.

13. MIN BALANCE (9-N-R)
This field identifies the minimum balance required to not perform follow-up. This field contains the amount for hospital debit small balance write-off. If the account balance is less than or equal to the minimum balance, the account does not receive follow-up but instead is selected for small balance write-off.

14. MAX DELETE BAL (9-N-R)
This field displays the maximum balance that an account can have and still be eligible for automatic bad debt deletion. If Auto Delete field, is set to N then the account never qualifies for automatic bad debt archiving. The entry range is 0 to $999,999.99; the default is $0.

15. AUTO DELETE? (1-A-R)
This field indicates whether the account should be automatically deleted after the last scheduled follow-up. Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter **N**, the system remove the account from follow-up and does not prelist the

account for archiving after the last scheduled follow-up. A response of **Y** removes the account from follow-up and automatically prelists the account for archiving after the last scheduled follow-up.

16. XFER EXTERNAL? (1-A-R)
This field indicates if an internal bad debt agency should transfer to an external bad debt collection agency. This field is only accessed if the Internal field is set to Yes. If XFER External field is completed with a Yes, you can access the Ext Agency field, the Min External Bal field, and the Max External Bal field.

This field is not required for external agencies.

17. EXT AGENCY (TABLE LOOKUP)
This field contains the external agency that accounts transfer to if the Xfer External field is completed with a Yes. This field is only accessed if the Xfer External field is set to Yes. This field is not required for external agencies.

18. MIN EXTERNAL BAL (9-N-R)
This field contains the minimum account balance for transfer to an external agency. This field is not required for external agencies.

19. MAX EXTERNAL BAL (9-N-R)
This field contains the maximum account balance for transfer to an external agency. This field is not required for external agencies.

20. DELINQUENT F/U TYPE
This field indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Entry options are **D** (detail statements), **L** (letter), or **T** (telephone).

21. DELINQUENT F/U MESSAGE
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

When you complete the fields on this screen, the system prompts you to accept, edit, or delete the information entered. Accepting this screen completes this part of the transaction. The system then displays the second screen of the transaction:

```
            General Hospital Financial Table Maintenance Processor
                                                  Mon Mar 17, 1997 03:42 pm
Agency Follow-up Schedules
 1 Schedule #               2 Description
   926                        BAD DEBT INTERNAL
 3 Edit date                4 Edit by
   03/17/97 03:43pm           West,Cary

 5 Seq #  F/U Type             F/U Msg   Phone Code   Restart Seq   Interval
->
   1       D  Detail Statement    1          9                          30
   2       L  Follow-up Letter    1          11             1           30
   3       T  Telephone                      10             1           30
   4       T  Telephone                      14             1           30









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

Field Explanations - Screen 2 of 2

1. SCHEDULE # (DISPLAY ONLY)
This field contains the follow-up schedule entered on the first screen of the transaction.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule entered on the first screen of the transaction.

3. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the system user who last edited this table entry.

5. SEQ # (DISPLAY ONLY)
This field displays the system-supplied number identifying a combination of follow-up procedures. The sequence number and the follow-up type and code control the order in which follow-up is performed by the agency on this account.

F/U TYPE (1-A-R)
This field contains the type of follow-up that is performed for this sequence number. Entry options are **L** (collection letter), **D** (detail statement), **T** (telephone), or **W** (wait). Select W (wait) if no follow-up is to be done during this sequence. This field can only be completed with a W if the Agency Follow-up schedule has been set to No for the Internal field. The default for Internal bad debt is wait (W).

F/U MSG (TABLE LOOKUP)
This field contains the code identifying the paper message used when generating a collection letter or detail statement. This field can only be completed if the Agency Follow-up schedule has been set to Yes for the Internal field.

This field is not required for external agencies.

PHONE CODE (4-N-O)
This field identifies the code representing the telephone message inserted into the collector's telephone follow-up. It is generated if the F/U Type field is equal to a T or if the maximum paper balance for this account is reached. These messages are entered and maintained in the Telephone Messages table. This field can only be completed if the Agency Follow-up schedule has been set to Yes for the Internal field.

This field is not required for external agencies.

RESTART SEQ (3-N-O)
This field is not required for external agencies.

INTERVAL (3-N-O)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed *only* if the Day of Month, Day of Week/Week of Month fields are not completed in the first screen of this transaction. The system schedules the first follow-up from the AR to Bad Debt transfer date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number.

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

Dependent On	Reference
Detail Statement Messages	Collection Agency
Follow-up Letters	
Telephone Messages	

ALTERNATE SUMMARY CODES 1, 2, AND 3

The Alternate Summary Code table enables you to set up summary categories for groups of like charges that can be used on third-party claim forms that do not use UB Summary Codes. While the system normally uses UB Codes for claims processing in the US, the Alternate Summary codes can be used in lieu of these.

In Canada, the Alternate Summary Code table is used to set up summary categories for the WCB claim form. Alternate Summary Codes 2 and 3 are used as follows:

Alternate Summary Code 2
: Any entry here is used to summarize charges by Diff Code. These are used by the WCB Inpatient and WCB Community Clinic claim forms.

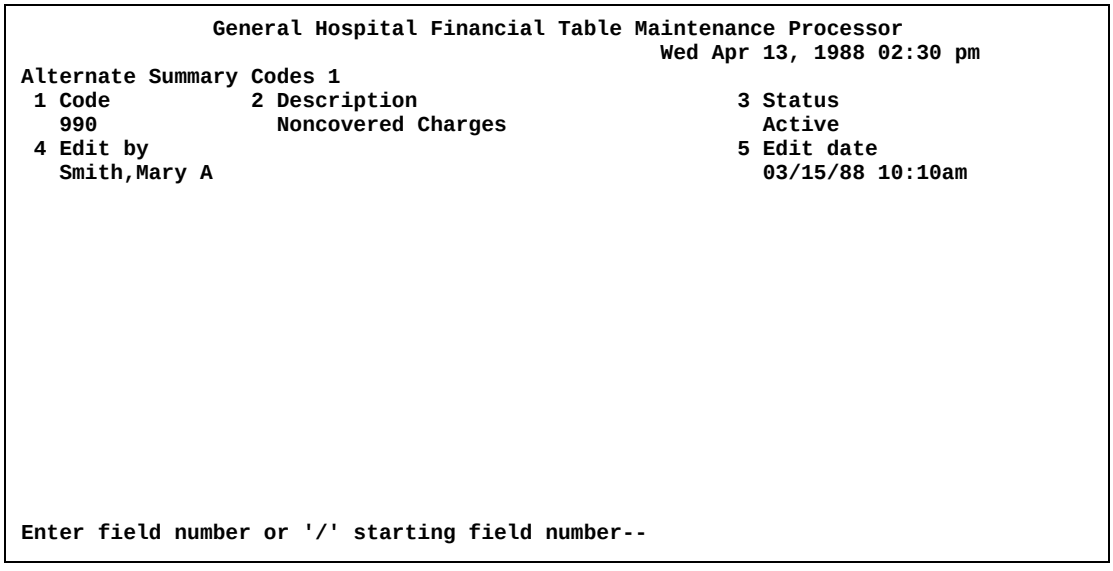
Alternate Summary Code 3
: Any entry here is used to summarize charges for inclusion into the various types of WCB claim forms (L - Lab, O - Outpatient, C - Community Clinic, T - Therapy, R - Radiology, I - Inpatient, or E-Evaluation).

The codes entered here can also be used for final and cycle bills. As a summary category, these codes are linked with individual items in the STAR Patient Care Financial Item Master. There are three Alternate Summary Code tables available and each one is set up in the same manner. These tables can be split by facility.

Use of the alternate summary codes on claims and bills must be discussed and approved by McKesson prior to their use.

After this table is selected, the system prompts you to enter an Alternate Summary Code or a hyphen (-) to display a list of valid codes.

After a code is entered or selected, this screen is displayed.



Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the alternate summary code identifying this group of charges.

2. DESCRIPTION (30-C-R)
This field contains the description of this alternate summary code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when the code is created.

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

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

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

Dependent On	Reference
	Financial Item Master

BILLERS

The Billers table contains codes representing the hospital's billers and their supervisors and managers. Billers are automatically assigned to an account at admission or O/P registration. Billers are also assigned to an account's claims.

All billers and billing supervisors and managers must be entered in the Hospital Employee File before they can be entered in this table. Billing supervisors must be entered in this table before billers.

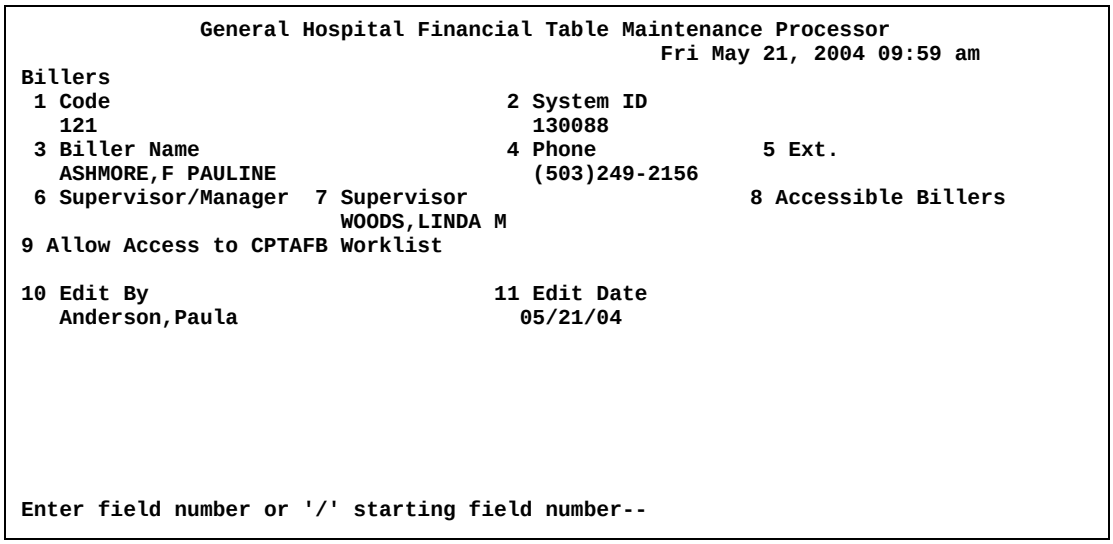
This table is not split by facility.

You can generate a printout of the Billers Table by entering **Y** at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FIN.

After this table is selected, the system prompts you to select the desired facility and then enter the Biller code or a hyphen (-) to display a list of biller names and codes. After you enter or select the name, the system displays the following screen:



Field Explanations

1. BILLER CODE (DISPLAY ONLY)
This field contains the code identifying the biller.

2. SYSTEM ID (12-N-R)
This field contains the system security code assigned to this biller (as a hospital employee) in the security system. You can enter the employee's system ID number,

the employee number, the last name of the biller, or a hyphen (-) to display a list of billers.

3. BILLER NAME (DISPLAY ONLY)
This field displays the name of the biller name based on value entered in the System ID field.

4. PHONE (10-N-O)
This field contains the biller's phone number. You enter the number in the format 4045551212 and the system displays it as (404) 555-1212.

5. EXT. (4-N-O)
This field contains the biller's phone number extension.

6. SUPERVISOR/MANAGER FLAG (1-A-R)
This field indicates whether the biller is a supervisor, manager, or neither. Entry options are **M** (manager), **S** (supervisor), and **N** (neither); the default is N.

7. SUPERVISOR (3-N-C)
This field contains the name of the biller's supervisor and is required if the Supervisor/ Manager Flag field contains N. The system automatically displays a list of billers who have been designated as supervisors. You select a value from the table display.

8. ACCESSIBLE BILLERS (TABLE LOOKUP)
This field allows you to choose the billers whose workfiles are accessible to the manager. This field, which is optional, can be accessed only if the Supervisor/Manager Flag field contains M. The system automatically displays a list of billers. You can select a value from the table display, select an unlimited number of billers, or enter **A** to select all billers. Multiple managers can have access to the same billers.

NOTE: Biller 99 must be McKesson.

9. ALLOW ACCESS TO CPTAFB WORKLIST (1-A-R)
This field indicates whether the biller can have access to the CPTAFB worklist. When this field is accessed, the following prompt is displayed:

Allow biller access to the CPTAFB Worklist? (Y/N) [N]--

You can enter **Y** for Yes to allow access or **N** for No to deny access. If a biller has access to the CPTAFB worklist, the biller can view work associated with only his/her biller code or All biller codes. The biller code that is associated with your sign on is the one that the system checks to determine if you have access to the CPTAFB worklist.

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

11. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

If you are a supervisor, you have access to your own workfiles as well as the workfiles of all billers who report to you. If you are a manager, you have access to the workfiles of the billers entered in the Accessible Billers field.

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

Dependent On	Reference
Hospital Employee File	Billing Groups

CLAIM ATTACHMENTS

This table contains codes that can be associated with a specific insurance plan, indicating an attachment is needed for the claim. These codes can also be linked with an individual item in the STAR Patient Care Financial Item Master. For UB claims, an attachment that is service-item related, department-related, or proration summary-related looks to the charges on the claim itself when detemining if a claim should fail for the attachment.

- If the claim attachment is service-item related, the UB claim fails only if this service item is on the claim.
- If the claim attachment is department-related, the UB claim fails only if this FIM department is reflected in the charges on the claim.
- If the claim attachment is proration summary-related, the UB claim fails only if this proration summary code is reflected in the charges on the claim.

If the UB Claim Load Edit Parameter has the Claim Split field set to A for New York ALC claims, and there is at least one ALC code on the account, the system looks to the charges on the bill that in turn loads the claims for claim attachments. However, if the UB Claim Load Edit Parameter has the Claim Split field set to A for New York ALC claims, but there are no ALC codes on the account, the system looks to the charges on each claim to determine claim attachments.

This table is not split by facility. After the table is selected, the system prompts you to enter the Claim Attachment code or select from a list of existing codes. After the code is entered or selected, the following screen is displayed.

```
          General Hospital Financial Table Maintenance Processor
                                                 Tue Apr 21, 1998 11:15 am
Claim Attachments
 1 Code      2 Description                    3 Primary/Secondary/All
   CF          Consent Form                     All
 4 Service Item Related
   No
 5 Department Related
   CAR
 6 Pro Summary Code Related

 7 Status    8 Edit by                                9 Edit date
   Active      Osborne,Julie M                          03/06/98 10:03am









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the claim attachment.

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

3. PRIMARY/SECONDARY/ALL (1-N-R)
This field specifies if an attachment is required when the insurance is primary (COB 1), secondary (COB 2 through 9), or All. The default is All.

4. SERVICE ITEM RELATED (1-A-R)
This field indicates whether or not the claim attachment is related to a STAR Patient Care service item. Entry options are **Y** for Yes and **N** for No.

If you enter **Y**, the item must be linked with the proper SIM item in the STAR Patient Care Financial Item Master and on the Insurance Plan. After this is done, when the item is charged or credited, the required attachment appears in claim edit for the account. The claim is not produced until the attachment requirement is satisfied.

5. DEPARTMENT RELATED (TABLE LOOKUP)
This field displays all of the departments in the SIM Departments table and allows you to highlight all departments that require the attachment. You can access this field only if the Service Item Related field is set to No.

6. PRO SUMMARY CODE RELATED (TABLE LOOKUP)
This field displays all of the Proration Summary Codes in the Proration Summary Code table and allows you to highlight all proration summary codes that require the attachment. You can access this field only if the Service Item Related field is set to No.

> **NOTE 1**: If you enter both the Department Related and the Pro Summary Code Related fields, both conditions must be met in order for the claim to fail for the attachment. For example, if Pro Summary Codes of 480 and 340 are set up with a Department Related of Emergency Room, then one charge must have either a department of Emergency Room and a proration summary code of 480 or a charge with a department of Emergency Room and a proration summary code of 340 to fail for the claim attachment.
>
> **NOTE 2**: When using a Claim Attachment that is Department and/or Proration Summary Code related, the attachment has to exist on the insurance when the charges are *placed* in order to fail for the attachment. If the attachment is added *after* the charges are placed, even if the charges have the specified Department and or Proration Summary Code, the added claim does not fail for the attachment.

7. STATUS (DISPLAY ONLY)
This field indicates whether this claim attachment code is active or inactive in the system. A code that is *filed as deleted* by the user becomes inactive and can be

reactivated at any time. The system defaults this field to active when you create the code.

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

9. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

BILLING GROUPS

The Billing Groups table contains codes grouping like billers together (for example, commercial, self-pay, Medicare, workmen's compensation, etc.). It is used to assign specific billers to an account for patient bill and claim production. Billing Group codes are used in the Insurance Coverage Master and the Financial Classes table. This table also defines the Billing Group's default biller, provides a list of all billers in the group, and the range of patient last names and types they are responsible for billing.

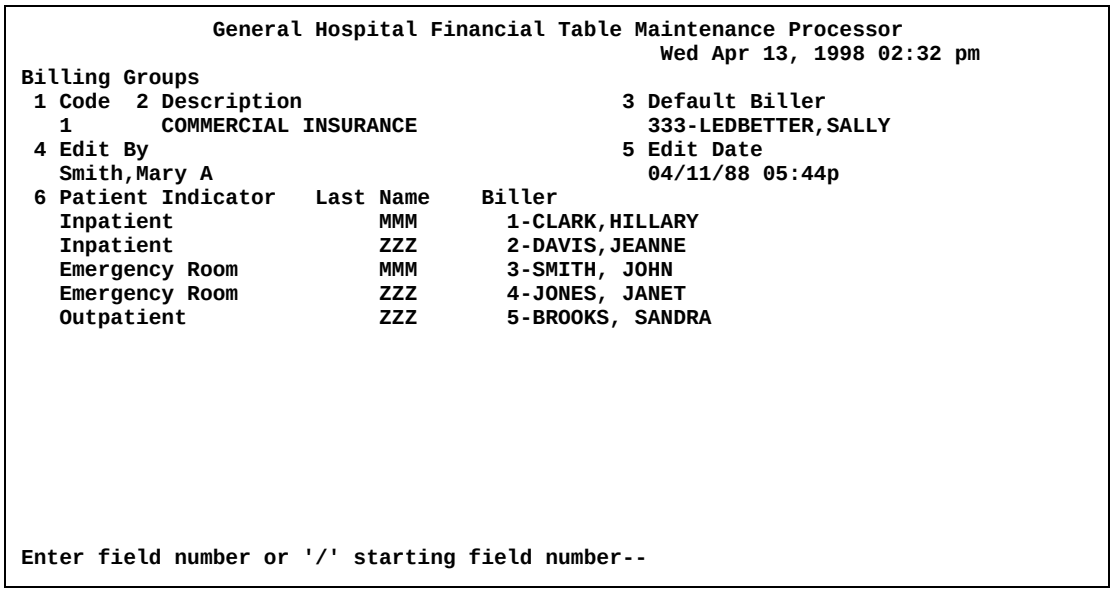
Patients are assigned to a billing group based on their primary insurance coverage. If a patient does not have insurance, then the assignment is based on the patient's financial class. If a patient has multiple insurance plans and these plans require separate claims, each claim has its own biller assigned from the Insurance Coverage master. Should separate claims not be required, the biller assigned to the primary insurance is responsible for the final bill and all claims for the account. In either case, the biller responsible for the primary insurance is responsible for the patient bill. Claims are loaded to the claim file when a bill is produced. A biller is assigned to a claim when the claim is loaded.

This table is not split by facility.

After this table is selected, the system prompts you to enter a Billing Group code or select from a list of Billing Group codes established in the system.

NOTE: Biller Code 99 is reserved for “McKesson Employee” and cannot be used for a hospital biller.

After a code is entered or selected, this screen is displayed.



Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the billing group code.

NOTE: Biller code 99 is reserved for “McKesson Employee” and cannot be used for a hospital biller.

2. DESCRIPTION (30-C-R)
This field contains the description of the billing group code.

3. DEFAULT BILLER (3-N-R)
This field contains the code identifying the biller who handles all billing duties not covered by assignments made in the Patient Indicator/Last Name/Biller field on this screen. If the default biller is handling all billing duties for the group, you do not need to complete the Patient Indicator/Last Name/Biller field.

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

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

Assigning Billing Responsibility

The next three fields assign patient billing responsibility among billers according to patient indicator and patient last name. All billing assignments are user-defined.

6. PATIENT INDICATOR (1-A-O)
This field specifies the type of patient to be billed. Entry options are **E** (emergency room), **I** (inpatient), or **O** (outpatient).

LAST NAME (3-A-C)
This field contains up to three letters of the patients' last name. This field is used to separate billers responsibility by the patient's last name.

For example, Biller 1 is responsible for all inpatients whose last names begin with letters included in the range A through M while Biller 2 is responsible for all inpatients whose last names begin with M through Z. The entry for Biller 1 would be MZZ while the entry for Biller 2 would be ZZZ.

This field is required if the Patient Indicator field is completed.

BILLER (3-N-C)
This field contains the code identifying the biller responsible for this patient indicator and last name range. You can enter a hyphen (-) to display a list of names and codes from the Biller Table. This field is required if the Patient Indicator field is completed.

When these fields are completed, you have the option to accept or edit the information on the screen. Accepting the screen completes the transaction.

Dependent On	Reference
Billers	Financial Class
	Insurance Coverage

BUSINESS OFFICES

This table identifies a logical business office. The business office is assigned to the facility for which it bills and collects in the PAAR Control section of Facility Maintenance. This table defines the criteria that must be met in order for the system to initiate business office follow-up. This table is not used if the Receivables Workstation module is activated.

After you select this table, the system prompts you to enter a business office code. You can enter a code or a hyphen (-) to display a list of codes. After the business office code is entered or selected, this screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                  Tue Jun 23, 1997 04:25 pm
Business Offices
 1 Code         2 Description                              3 Status
   AB             CONVERTED BUS OFF                          Active
 4 Edit by               5 Edit date           6 Telephone F/U Last Pmt Days
   Smith,Mary A            06/22/92 1128am       2
 7 Telephone Follow-Up Transaction Code  8 Promise To Pay Transaction Code
   T0008-Telephone Follow Up               T9300-Telephone Follow Up
 9 Facilities Served
   GHA,GHB
10 Seq#         Balance      Patient/Acct Balance
   2          $1,500.00       Account
   3            $250.00       Patient









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the business office.

2. DESCRIPTION (33-C-R)
This field contains the description of the business office.

3. STATUS (DISPLAY ONLY)
This field indicates if this business office is active or inactive in the system. A code that is *filed as deleted* becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

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

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

6. TELEPHONE F/U LAST PMT DAYS (3-N-R)
This field contains the minimum number of days since the last payment that causes the system to initiate telephone follow-up for the business office collector.

7. TELEPHONE FOLLOW-UP TRANSACTION CODE (4-N-R)
This field contains the transaction code that appears on the account transaction history once business office follow-up has occurred. You can enter the code or a hyphen to display a list of valid codes under transaction type T (telephone).

8. PROMISE TO PAY TRANSACTION CODE (4-N-R)
This field contains the transaction code that appears in the account's transaction history when the business office collector processes the promise to pay follow-up. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type T (telephone).

9. FACILITIES SERVED (DISPLAY ONLY)
This field contains the facilities that are served by this business office. The business office is tied to the facility on the Maintain Facility Information - PAAR Control screen.

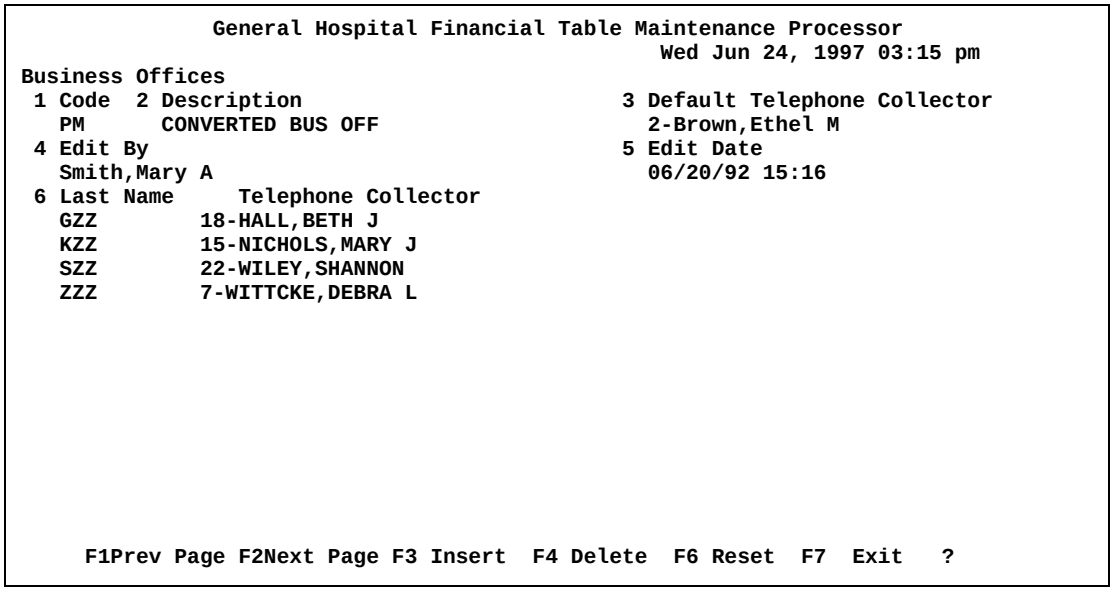
10. SEQ# (2-N-R)
This field displays the minimum follow-up schedule step in order to be selected for business office follow-up.

BALANCE (9-N-R)
This field displays the minimum balance this account must have in order to be selected for this sequence of follow-up.

PATIENT/ACCT BALANCE (1-A-R)
This field determines whether the system should use the Patient or the Account balance in selecting this account for follow-up. Enter **P** to use the patient balance. Enter **A** to use the account balance.

When these fields are completed, you have the option of accepting or editing the information on the screen.

If you accept the screen, the system displays the second business office screen:



Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code of the business office.

2. DESCRIPTION (33-C-O)
This field contains the description of the business office.

3. DEFAULT TELEPHONE COLLECTOR (2-N-R)
This field contains the name of the collector who serves as the default in the event that you do not define collectors who would be responsible for accounts, based on an alphabetic breakdown, in the Last Name/Telephone Collector field on this screen. This collector would also be assigned to an account if the patient's last name does not fall into the categories defined in the Last Name/Telephone Collector field.

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

5. EDIT DATE (DISPLAY ONLY)
This field contains the date and time on which this table entry was last edited.

NOTE: Use the function keys at the bottom of the screen to enter data in the following fields. When you have finished defining collectors, press **F7** to exit this scrolling screen.

6. LAST NAME (3-A-O)
This field allows you to define alphabetic categories, based on the patient last name, for business office telephone follow-up. You can define as many categories as you

want. For example, if you enter GZZ as the first category, collector Beth Hall would be responsible for the telephone follow-up for all patients whose last names begin with AAA and end with GZZ. Following this example, collector Mary Nichols would be responsible for the telephone follow-up for the patients whose last names begin with HAA and end with KZZ.

6. TELEPHONE COLLECTOR (2-N-O)
This field contains the collector who is responsible for the telephone follow-up for the patients whose last names fall within the defined range. You can enter the collector code or a hyphen (-) to display a list of valid codes.

When these fields are completed, you have the option of accepting or editing the information on the screen. After you accept the screen, the system allows you to add and/or revise financial class exceptions for this business office.

Adding/Revising Financial Class Exceptions

If financial class exceptions exist for this business office, you can revise those exceptions and/or add new exceptions. If no financial class exceptions exist for this business office, you can add new exceptions.

REVISING FINANCIAL CLASS EXCEPTIONS

If financial class exceptions exist for this business office, you can revise them and/or add new exceptions. The system displays the following prompt:

Do you wish to revise financial class exceptions? (Y/N) [N] --

If you do not wish to revise financial class exceptions, enter **N** or press ENTER. The system then gives you the option to add new financial class exceptions.

If you do wish to revise financial class exceptions, enter **Y**. The system displays a screen listing the existing financial class exceptions set up for this business office. Select the option number(s) of the financial class exceptions you wish to revise and press ENTER. The system highlights your selections. After you have selected all desired financial class exceptions, press only ENTER to the prompt. The system then displays a screen containing the information regarding the first financial class exception you selected. If you selected multiple financial class exceptions to revise, when you exit this screen the system displays the next financial class exception.

When you finish revising all selected financial class exceptions, the system displays the following prompt:

Do you wish to add financial class exceptions? (Y/N) [N] --

To exit from this function without adding financial class exceptions, enter **N** or press ENTER. To add new financial class exceptions for this business office, enter **Y**. The procedure for adding financial class exceptions is explained below.

ADDING FINANCIAL CLASS EXCEPTIONS

To add financial class exceptions, enter **Y** when the system displays the following prompt:

Do you wish to add financial class exceptions? (Y/N) [N] --

The system displays this prompt if no financial class exceptions exist for this business office or if you have either completed revising or declined the opportunity to revise existing business office financial class exceptions. If you do not wish to add financial class exceptions, enter **N** or press ENTER to this prompt.

After you enter **Y** to the add prompt, the system displays a screen listing the financial classes. Select the option number(s) of the financial classes for which you want to create financial class exceptions and press ENTER. The system highlights your selections. After you have selected all desired financial classes, press only ENTER to the prompt. The system displays a screen you use to define exceptions for the first financial class you selected, as in the screen below. If you selected multiple financial classes, when you exit this screen the system displays the screen for the next financial class.

```
              General Hospital Financial Table Maintenance Processor
                                                    Tue Jun 23, 1992 04:46 pm
Business Offices
 1 F/C  2 Description                        3 Default Telephone Collector
   C      COMMERCIAL                           1-Anderson,Amy
 4 Edit By                                   5 Edit Date
   Smith,Mary                                  06/22/92 1056am
 6 Last Name     Telephone Collector
   AAA         3-Collier,David A.
   GZZ         11-Ellis,Janice









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

Field Explanations

1. F/C (DISPLAY ONLY)
This field displays the code of the financial class for which an exception is being revised or added.

2. DESCRIPTION (33-C-O)
This field contains the description of the financial class.

3. DEFAULT TELEPHONE COLLECTOR (2-N-R)
This field contains the name of the collector who serves as the default collector for this financial class. The system sends work to this collector if accounts do not meet the criteria defined in the Last Name/Telephone Collector fields on this screen. This collector would also be assigned to an account if you do not establish collectors in the Last Name/Telephone Collector fields.

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

5. EDIT DATE (DISPLAY ONLY)
This field contains the date and time on which this table entry was last edited.

NOTE: Use the function keys at the bottom of the screen to enter data in the following fields. When you have finished defining collectors, press **F7** to exit this scrolling screen.

6. LAST NAME (3-A-O)
This field allows you to define alphabetic categories, based on the patient last name, for financial class exceptions for this business office telephone follow-up. You can define as many categories as you want. For example, if you enter GZZ as the first category, collector David Collier would be responsible for the telephone follow-up for all patients whose last names begin with AAA and end with GZZ. Following this example, collector Janice Ellis would be responsible for the telephone follow-up for the patients whose last names begin with HAA and end with KZZ.

TELEPHONE COLLECTOR (2-N-O)
This field contains the collector who is responsible for the telephone follow-up for the patients whose last names fall within the defined range and who have the financial class displayed in the F/C field. You can enter the collector code or a hyphen (-) to display a list of valid codes.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction. The system then displays:

Exception Filed

When all financial class exceptions have been added or revised, the system displays:

Filed

CLAIM DISPOSITION RULES

The Claim Disposition Rules table is used to define Claim Disposition Rule Codes, which provide the ability to assign a claim disposition based on a rule or group of rules. The Claim Disposition Rules table allows a payment tracking indicator to be defined so that payments can be identified as underpayments and overpayments.

Each Claim Disposition Rule Code can have one or more rules associated with it. Multiple rules can be defined under one 'umbrella' code. In the screen example shown under “Claim Disposition Rules Screen” on page 1-30, the umbrella code used is *JA1* with three user defined rules. What displays in the Code field is what was initially keyed in upon entering the Claim Disposition Rules table. To define or change rules, key a back slash/6 (/6) to enter the field. The system processes claims against the rules according to the priority that is associated with each rule.

There are three screens associated with the Claim Disposition Rules table, each of which is explained below:

1. Claim Disposition Rules

2. Claim Disposition Rules-Priorities

3. Claim Disposition Rules-Detail

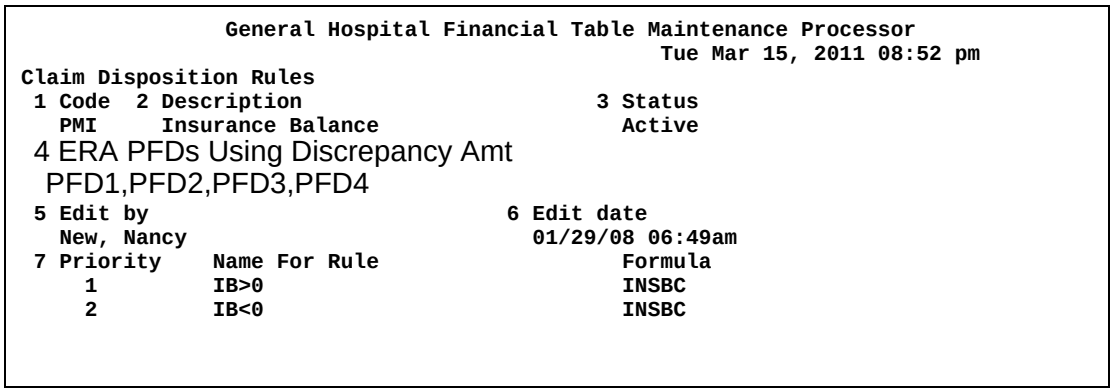
Claim Disposition Rules Screen

During processing, to be considered for a rule, the system must satisfy all criteria that are defined under the Selection Criteria section of the screen. If all of the criteria for the rule are not met, the system moves to the review the next rule, if one is defined. If there is an error during processing (the formula is missing a key piece of data in order for it to process), the system does not move to the next rule. If no fields are defined, the system automatically meets the selection criteria, but might not satisfy the formula if it needs a piece of data in order to calculate the formula.

When an account meets an error condition, the system won't update the account with the disposition or payment tracking indicator. The disposition that was assigned to the claim either through a default parameter through ERA, a CAS reason code, or through a manually-assigned disposition in a cash batch remains associated with the claim.

To reach the Claim Disposition Rules Code table, select Tables from the Financial system main menu, followed by Financial Table Maintenance. The system prompts

you to enter the claim disposition rule code. Enter the code or enter a hyphen (-) to select from a list of claim disposition rule codes.



Field Explanations

1. CODE (4-AN- R)
This field displays the claim disposition rules code that was defined by the hospital. A claim disposition rule code contains a rule or group of rules that is used to determine the claim disposition for claims in a cash batch.

2. DESCRIPTION (30-AN- R)
This field displays the user-defined description associated with the claim disposition rules code. After you enter a new code and description, the system goes directly to the Claim Disposition Details screen so that you can enter in the detail associated with the rule.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to Active when the code is created.

4. ERA PFD'S USING DISCREPANCY AMT (TABLE LOOKUP-O)
This field is used to link the ERA CAS Reason codes (which are defined in the ERA PFD table) that are used for determining a discrepancy amount. Adding an ERA PFD code to this list activates the functionality for payments processed using that ERA PFD. The discrepancy amount is then used in new formulas to determine if the contractual adjustment amount should be suppressed and if the payment should be dispositioned as final, denial or partial. Dispositioning as partial would allow an updated claim to be submitted.

When this field is accessed, the system displays the list of defined ERA PFD codes. You can select one or more ERA PFD codes from the list. Note that if you select an ERA PFD code in the Claim Disposition Rules table, the ERA CAS Codes for Discrepancy Amount on the ERA Payment File Definition table must be defined; otherwise, an ERA PFD is not displayed in the list. Once an ERA PFD code is added

into the ERA PFD's Using Discrepancy Amount field, the functionality for suppressing the contractual amount is activated.

After selecting ERA PFD code(s) in this field, the Claim Disposition Rules screen is redisplayed. From this point you would create a new rule to define a formula and selection criteria to evaluate for suppressing the contractual adjustment amount. Refer to the "Claim Disposition Rules-Detail Screen" on page 1-33 to define a rule and formula.

5. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last updated the table.

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

7. PRIORITY (DISPLAY ONLY)
This field displays the priority number associated with the rule. When this field is accessed, the Claim Disposition Rules-Priorities screen is displayed:

Claim Disposition Rules-Priorities

The Claim Disposition Rules-Priorities screen is used to update the priority order of the rules associated with a claim disposition group code. The name for the rule(s) can also be directly updated on this screen.

The screen sample below shows there are three rules defined under the JA1 code. To view or change a defined rule, use the arrow key to highlight the priority sequence and press the F5 key.

```
               General Hospital Financial Table Maintenance
                                          Tue Nov 04, 2008 04:29 pm
Claim Disposition Rules-Priorities
 Priority      Name for Rule                 Formula
     1         CLM AMT FINAL <10             CLMPA
     2         CLM AMT PARTIAL >10           CLMPA
     3         A1 CLAIM AMOUNT               CLMPA
     4         OVERPMT                       CLMPA




 F1Prev Page F2Next Page F3 Insert  F4 Delete  F5Edit F6 Reset  F7  Exit   ?
```

Field Explanations

PRIORITY (2-N-O)
This column contains the priority associated with the rule. This field can be updated by entering in a new priority number. When the screen is saved, the system displays the priorities in numeric order. The rules are processed in priority order with one (1) being

the highest priority. When this field is accessed, the Claim Disposition Rules-Detail screen is displayed.

NAME FOR RULE (30-AN-R)
This field displays the name for the rule. When this field is accessed, the following prompt is displayed:

Enter Name for Rule

FORMULA (TABLE LOOKUP-R)
This field contains the name of the formula associated with the rule. The formulas that can be selected are pre-defined by McKesson. The formulas available are related to account balance, insurance balance, claim amount, reimbursement, percentages, and suppressing contractual adjustment amounts. When this field is accessed, the Claim Disposition Rules-Detail screen is displayed.

Claim Disposition Rules-Detail Screen

The screen below is the Claim Disposition Rules - Detail screen. This screen is where the details of the rule are created and maintained. The screen sample below shows a simple rule using the Claim Amount formula and when this is applied to a cash batch, if the result of the formula is between $0 and $10, the claim is marked with a Final Pmt Disposition.

Once the screen is exited, the Priority screen is displayed. You can arrow down to the next rule and press the F5 key for the Details screen.

```
                    General Hospital Financial Table Maintenance
                                          Tue Mar 15, 2011 12:26 pm
Claim Disposition Rules-Detail
 1 Priority  2 Name for Rule                  3 Formula
   1           RULE TWO                         select a discrepancy amt formula
                           Selection Criteria
 4 Reimbursement                        5 Calc Reim Method

 6 COB            7 Insurance Plans

 8 Claim Type     9 Type of Claim Form

10 Operator                11 Value
   Greater Than or Equal      10

                             Rule Disp Results
12 Payment Tracking Ind   13 Disposition   14 Suppress C/A 15 Rpt on FAR126
                             Yes             Yes

          Rule Disp Results when Tracking Denial through Denial Mgmt
16 Payment Tracking Ind    17 Disposition               18 Report on FAR126
                                                          No



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

Field Explanations

1. PRIORITY (DISPLAY ONLY)
This field displays the priority associated with the rule. For a new rule, the priority is assigned automatically.

2. NAME FOR RULE (30-AN-R)
This field contains the user-defined name associated with the rule. The name for the rule can be updated on this screen and on the Priorities screen.

3. FORMULA (TABLE LOOK-UP-R)
This field contains the code and description of the formula. You can enter a valid formula code or a hyphen (-) to select a formula code from the list of formulas that are pre-defined by McKesson. The list of formulas is sorted by formula code. To get more details regarding the formulas, the Claim Disposition Formula report (FTFACF) can be printed.

The following list shows the pre-defined McKesson formulas:

- ACTBD-Acct Bal - (Pmt-CAdj-OAdj-RSA+CoPy+PtRsp+Coin+Ded)

  CAdj represents contractual adjustment.

  OAdj represents other adjustment used in processing ERA files,

RSA represents reverse system adjustment used in processing ERA files.

- ACTBA-Act Bal - (Pmt - Adj)
- ACTBC-Per Cent (Pmt - Adj)/Account Balance
- CLMPA-ClmAmt-(Pmt-CAdj-OAdj+CoPy+PtRsp+Coi+Ded)
- CLMPC-Per Cent Money in Pymt/Claim Amount
- INSBA-Ins Bal - (Pmt - Adj)
- INSBC-Per Cent (Pmt - Adj)/Insurance Balance
- INSMA (Ins Bal - (Pmt-Adj+CoPy+PtRsp+Coi+Ded). This formula can be used for a payment for a final, adjustment, or late claim and it must be the last payment in the batch for that account and insurance.

  (Pmt-Adj+CoPy+PtRsp+Coi+Ded) is calculated for each payment in the batch for the account and insurance. That sum is subtracted from the current insurance balance. The meanings of the abbreviations are as follows:

  - Pmt Payment
  - Adj Sum of all adjustments for payment which can include the contractual adjustment, other adjustment, and/or reverse system adjustment.
  - CoPy Co-Pay for the payment
  - PtRsp Pat Resp for the payment
  - Coi Coinsurance for the payment
  - Ded Deductible for the payment

  For ERA payments, Adj, CoPy, PtRsp, Coi, and Ded are determined per the CAS codes and users can edit these fields in the cash batch. For non-ERA payments, these fields can be keyed.

- OPPSA-Est Reim (OPPS) - Payment
- OPPSC-Per Cent Payment/Est Reim (OPPS)
- PCNBA-Est Reim (PCNB) - Payment
- PCNBC-Per Cent Payment/Est Reim (PCNB)
- PCNIA-Est Reim (PCNI) - Payment

- PCNIC-Per Cent Payment/Est Reim (PCNI)
- PCNJA-Est Reim (PCNJ) - Payment
- PCNJC-Per Cent Payment/Est Reim (PCNJ)
- PCNJG-Est Reim (PCNJ)-(Pmt-OAdj+CoPy+PtRsp+Coi+Ded)
- PCNJJ-Est Reim (PCNJ)-(Pmt+CoPy+Coi+Ded)
- STARA-Est Reim (STAR) - Payment
- STARC-Per Cent Payment/Est Reim (STAR)
- The following formulas are used to determine the discrepancy amount. Note that DA=Discrepancy amount:
  - DA amt - add up qualifying CAS dollar amt
  - DA/Exp Reim x 100
  - DA amt/Claim Amt X 100
  - DA amt/Ins Bal X 100

4. REIMBURSEMENT (TABLE LOOKUP- CONDITIONALLY REQUIRED)
This field contains the reimbursement codes associated with the rule. The system limits the matching of the rule to the selected codes. After selecting the Reimbursement codes by selecting the number or numbers that corresponds to the reimbursement type code(s), the system displays the selected reimbursement type codes in the field.

The reimbursement codes displayed are the valid ones contained in the system and maintained internally by McKesson. For reimbursement -related rules, a reimbursement type and COB must be defined. If a rule is related to reimbursement, for example an OPPS rule. you would need to select H for OPPS and Primary COB. If you don't select a reimbursement code, and it is required by the formula, an error message displays as follows:

Error: Reimbursement is required due to Formula!

5. CALC REIMB METHOD (TABLE LOOK-UP OPTIONAL)
This field is used only if the Reimbursement field is set to a J (PCON by Claim). If a J is selected with other reimbursement types, this field can't be accessed. Valid values for this field are Claim Amount, DRG and New York.

6. COB (TABLE LOOK-UP-CONDITIONALLY REQUIRED)
The field can be completed with one, selected values, all valid values, or no selected values. If a rule is related to a specific payor such as a secondary payor, the COB field should be defined. For reimbursement-related rules a COB is required. If a COB is required and not entered, the following error message is displayed:

Error: COB is required due to Formula!

When this field is accessed, a list of COB Types is displayed. You can select one, all, or none of the choices.

The following values are displayed in the field depending on your selections:

P is displayed if If Primary COB is selected.

F is displayed if Primary 1500 COB is selected.

S is displayed if If Secondary COB is selected.

5 is displayed if If PCON 1500 COB is selected.

7. INSURANCE PLANS(TABLE LOOKUP- 60AN-O)
This field contains the insurance plans that are associated with the rule.

8.) CLAIM TYPE (TABLE- OPTIONAL)
This field contains the selected claim types associated with the rule. Claim types are final, adjustment, late, cycle, and cycle adjustment. Cycle claims should not be selected for either Insurance or Account Balance related formulas. For example, if you select an insurance balance formula and select cycle claims in your criteria, if your account had a cycle claim, you would meet the criteria, but the formula isn't valid for cycles, so an error is generated, and you wouldn't be considered for any other rule because you already were evaluated for a rule. If cycle claims are selected, a claim based formula would be best, such as claim amount or any claim based reimbursement type such as J, or H.

9. TYPE OF CLAIM FORM (TABLE- OPTIONAL)
This field contains the claim form type associated with the rule. Valid claim form types are determined by what claim form types are contained internally on the McKesson system. The selected claim form type code and description are displayed in the field.

10. OPERATOR (TABLE LOOKUP-R)
This field contains comparison operators for the rule. Comparison operators are:

1 - BE-Between or Equal l

2 - Between

3- EQ-Equal l

4 -GE-Greater Than or Equal

5- GT-Greater Than

6- LE-Less Than or Equal

7- LT-Less Than

8-NBE-Not Between or Equal

9-NBT-Not Beween

10-NE-Not Equal

If the operator field contains a *between* value, the Value field is required.

11. VALUE (4-N-CONDITIONAL)
The entry in this field is determined by the entry in the Operator field. Any value in the Operator field that is not a *between* value requires only one value. For any *between* operator, a Value 1 and Value 2 must be entered, delineated with a comma. An example of this is: 1,100. Valid values are numeric including zero and negative values are denoted with a preceding dash. An example of this is: -30. When this field is accessed, the following prompt is displayed:

Enter value 1, value 2 for Between Comparison--

12. PAYMENT TRACKING IND (1-A-R)
This field determines if a claim payment should be marked as an underpayment or overpayment if it meets the criteria for the rule. Claims are reviewed when a cash batch is analyzed. If a claim is associated with a payment tracking indicator, the claim can be monitored through Receivables Workstation.

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

Assign Payment Tracking Ind for (U)nderpayments, (O)verpayments, or (B)oth-- |

You can assign a payment tracking indicator of **U** for underpayments, **O** for overpayments, or **B** for both.

If this field is left blank, the system does not mark the claim with a payment tracking indicator. If the result of a rule is a negative value, it can be considered for an Overpayment indicator if it meets the criteria in the Value field. For example,if the Payment Tracking Indicator is set to Both, and the Value field is defined as -30,30 the claim would be assigned an Overpayment indicator if the result of the rule was a -20. Note that when the payment tracking indicator is updated to be an under/overpayment, the associated under/overpayment amount can be used as the appeal minimum on the Payment Tracking Parameters on the Denial Tracking Payor Parameters.

13. DISPOSITION (1-A-R)
This field contains the disposition that a claim is updated to if it meets the criteria for the rule. When this field is accessed, the following prompt is displayed:

Update claim disposition to be (F)inal, (P)artial, or (D)enied-- |

You can indicate whether the claim disposition should be Final, Partial, or Denied.

14. SUPPRESS C/A (1-A-O)
This field defines whether the contractual adjustment is suppressed if the claim satisfies the discrepancy amount rule. When this field is accessed, the following prompt is displayed:

Suppress the cont adj if the claim satisfies the DA rule (Y/N)?

- If you answer Yes, the entire contractual adjustment amount is suppressed.
- If you answer No, the cont adj amount is posted per the ERA CAS Reason codes.

15. REPORT ON FAR126 (1-A-O)
The Claim Disposition Analysis report (FAR126) is generated automatically when a cash batch is analyzed and data is being updated. This field is used to indicate whether the report is to print with or without dispositioning the data. The field can be accessed only if the Payment Tracking Indicator and Disposition fields are blank. When the Payment Tracking Indicator or Disposition fields are completed with a value, the system automatically updates selected accounts and produces the FAR126 report.

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

Report payment on FAR126? (Y/N)-- |

If you enter Yes, the system prints the report and dispositioning data is not applied. This allows hospitals to view which claims would be selected for updating. A value of No or blank prints the report when the rule is applied to the cash batch and the disposition data is applied.

If you are not applying any updates but would like to see what accounts are selected by the rule, you can enter **Y** (Yes) to indicate the report should be printed.

16. PAYMENT TRACKING IND (1-A-R)
If a claim meets the criteria of a rule, the system can assign the corresponding payment tracking indicator as specified in this field. A payment tracking indicator of Overpayment can be assigned when the result of a rule is a negative balance. When this field is accessed, the following prompt is displayed:

Assign Payment Tracking Ind for (U)nderpayments, (O)verpayments, or (B)oth--

Note that when the payment tracking indicator is updated to be an under/overpayment, the associated under/overpayment amount can be used as the appeal minimum on the Payment Tracking Parameters on the Denial Tracking Payor Parameters.

17. DISPOSITION (1-A-O)
This field contains the disposition that a claim is updated to if it meets the criteria for the rule. A claim must have met the criteria to be tracked for Denials through the Denial Tracking Interface for the claim to get the disposition in this field. The system reviews both ERA and Manual Cash batch entries when the Claim Disposition Rule is applied to determine if the claim is eligible for denial tracking. If the claim isn't eligible for denial tracking, the disposition for the claim is displayed in field 13 in the Rule Disposition Results section. For example, if a manual cash entry had denial codes, when the claim disposition rule code was applied it would determine if it was eligible for denial tracking. If the claim was eligible for denial tracking it would get the disposition associated in field 15 under the Rule Disposition Results when Tracking Through Denial Management. If the claim wasn't eligible for denial tracking, it would get the disposition associated in field 13 under the Rule Disposition Results section. Note, even though the claim was reviewed for denial tracking when the Claim Disposition Rule was applied, the system doesn't clear out the associated denial codes in the Claim Denial Info field. For example in the scenario above for the manual cash batch entry, the system would indicate the claim wasn't tracking for denials when the batch posted, although it would do the denial evaluation to get the correct disposition when the claim disposition rule was applied.

NOTE: If a discrepancy amount formula is selected in the Formula field, the Disposition field cannot be used. If a claim doesn't qualify for denial tracking it is reviewed for the discrepancy amount rule. If the claim could be considered for Denial Tracking (ex: the Den Trk tilde is set, check the carrier/plan, is this a PCON claim or rmb type = J) the claim/payment does not qualify to be reviewed for the discrepancy amount formula and rules. These types of claims/payments move on for selection via another rule/formula.

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

Update claim disposition to be (F)inal, (P)artial, or (D)enied-- |

You can indicate whether the claim disposition should be Final, Partial, or Denied.

18. REPORT ON FAR126 (1-A-O)
The Claim Disposition Analysis report (FAR126) is generated automatically when a cash batch is analyzed and data is being updated. This field is used to indicate whether the report is to print with or without dispositioning the data. The field can be accessed only if the Payment Tracking Indicator and Disposition fields are blank. When the Payment Tracking Indicator or Disposition fields are completed with a value, the system automatically updates selected accounts and produces the FAR126 report.

NOTE: If a discrepancy amount formula is selected in the Formula field, the Report on FAR126 field cannot be used. If a claim doesn't qualify for denial tracking

it is reviewed for the discrepancy amount rule. If the claim could be considered for Denial Tracking (ex: the Den Trk tilde is set, check the carrier/plan, is this a PCON claim or rmb type = J) the claim/payment does not qualify to be reviewed for the discrepancy amount formula and rules. These types of claims/payments move on for selection via another rule/formula.

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

Report payment on FAR126? (Y/N)-- |

If you enter Yes, the system prints the report and dispositioning data is not applied. This allows hospitals to view which claims would be selected for updating. A value of No or blank prints the report when the rule is applied to the cash batch and the disposition data is applied.

If you are not applying any updates but would like to see what accounts are selected by the rule, you can enter **Y** (Yes) to indicate the report should be printed.

COLLECTION AGENCY CODE

The Collection Agency Code table contains demographic data for the collection agencies used by the facility. The Collection Agency Code table is used by AR and Bad Debt agencies. It also contains information about the manner in which the agency is notified of accounts being placed with them.

The fields within this table that contain BD are for Bad Debt agencies. The Follow-up Schedules field is used by both Bad Debt and Pre-Collection agencies. The Follow-up Schedule field is dependent on the Agency Type field.

This table is not split by facility.

To reach the Collection Agency Code table, select Tables from the financial system main menu, followed by Financial Table Maintenance. The system prompts you to enter the collection agency code. Enter the code or enter a hyphen (-) to select from a list of collection agency codes.

NOTE: Collector Code 99 is reserved for McKesson Employee and should not be used for a hospital collector.

After the code is selected, the following screen is displayed:

```
            General Hospital Financial Table Maintenance Processor
                                                 Sat Jun 03, 2007 08:40 am
Collection Agency Code
1 Agency  2 Description                      3 Status         4 Agency Type
   COL       MODEL HOSPITAL AGENCY                             External BD
 5 Address Line 1                             6 Address Line 2
   101 COLLECTION DRIVE
 7 City                  8 St  9 Zip code   10 Data File Location
   ATLANTA                 GA    30346-4435    hbo/tmp/mikein/
11 Contact                              12 Phone Number      13 Extension
   MARTIN, KAREN                          (404)338-3481
14 BD Fees Trans Code/Desc              15 BD Cash Trans Code/Desc
   V0231-KARINA'S AGENCY FEES              E0231-KARINA'S AGENCY CASH
16 BD Collector Group Code/Desc         17 Follow Up Schedule
   51-apc test group                       10-FOLLOW-UP BEFORE ARCHIVE
18 Collection Group                     19 Insurance Follow Up Schedule

20 BD Notification Format               21 BD Pass Adm Diag  22 BD Tape Format
   New Format Agency Tape                  Yes                  EBCDIC
23 BD COB Format  24 Edit Date          25 Edited By
   4                 02/04/03 8:46         Carey, Bob
```

Field Explanations

1. AGENCY (DISPLAY ONLY)
This field contains the code identifying this collection agency.

NOTE: Collector Code 99 is reserved for McKesson Employee and cannot be used for a hospital collector.

2. DESCRIPTION (30-C-R)
This field contains the description of the collection agency.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to Active when the code is created.

4. AGENCY TYPE (TABLE LOOKUP-R)
This field indicates the type of collection agency. When this field is accessed, the Collection Agency Types table is displayed. You can select one of the following agency types from the table:

- Internal Agency
- External Agency
- Computer Credit Inc. Collection (CCI)
- Internal Bad Debt
- External Bad Debt

5. ADDRESS LINE 1 (25-C-R)
This field contains the first line of this collection agency's address.

6. ADDRESS LINE 2 (25-C-O)
This field contains the second line of this collection agency's address (for example, P.O. Box number).

7. CITY (20-C-O)
This field contains the name of the city where this collection agency is located.

(US) 8.STATE (2-C-O)
(CN) 8.PROVINCE (2-C-O)
This field contains the two-character abbreviation of the state/province in which this collection agency is located.

(US) 9.ZIP CODE (9-AN-O)
(CN) 9.POST CODE (9-AN-O)
This field contains the ZIP code/post code portion of the collection agency's address. The five- or nine-digit ZIP code or the six-character Canadian post code is accepted.

10. DATA FILE LOCATION (32-AN-O)
This field contains the file path location to which agency outbound files (guarantor and claim), Notes upload, and payment file data files are copied when they are uploaded/ downloaded to/from STAR.

NOTE: This is a user-defined parameter. Your IS department must create the UNIX path and control read/write permissions to it. You are also responsible for determining the appropriate naming convention for the various agencies to use. A problem may occur if the same name is assigned to data files and the previously received file was not processed on STAR Patient Accounting.

11. CONTACT (30-C-O)
This field contains the name of the contact person at this collection agency.

12. PHONE NUMBER (10-N-O)
This field contains the agency's area code and phone number entered in the format 4045551212. The system displays the area code and phone number in the format (404)555-1212.

13. EXTENSION (4-N-O)
This field contains the agency contact person's phone extension.

14. BD FEES TRANS CODE/DEC (4-N-R)
This field contains the transaction code (up to four digits) used to automatically record the fees withheld by the collection agency in the general ledger. You can enter the transaction code or a hyphen (-) to display and select from a list of valid transaction codes under transaction type V (agency fees).

15. BD CASH TRANS CODE/DEC (4-N-R)
This field contains the transaction code used to record cash received by the hospital from the collection agency. This information is recorded in the account's transaction history and is used to update general ledger via the mapping table. You can enter the code or a hyphen (-) to display a list of valid transaction codes under transaction type E (agency cash collected).

16. BD COLLECTOR GROUP CODE/DEC (2-N-R)
This field contains the code identifying the collector group assigned to the guarantor associated with this account. The collector is assigned when the account is transferred to an agency. You can enter the code, or enter a hyphen (-) to select from a list of valid collector group codes.

17. FOLLOW-UP SCHEDULE (3-N-R)
This field contains the code of the Agency Follow-up schedule that is assigned to accounts with this agency. The code entered here must be one already established in the system. Enter a hyphen (-) to display a list of valid codes. This field is dependent on the Agency Type field.

If the agency type is External Bad Debt or Internal Bad Debt, only Agency Follow-up Schedules are displayed. If the agency type is CCI, Internal, or External, only External Agency Follow-up Schedules are displayed.

If this field is not completed, and a claim is assigned to this agency, the system generates a rejection for Pre-collect Info Not Defined.

18. COLLECTION GROUP (TABLE LOOKUP-O)
This field contains the code of the collector group that is assigned to accounts that are being evaluated for Candidate/Pending and for accounts that transfer to agency collection. This field should only be completed if the Agency Type field is set to CCI, Internal Agency, or External Agency. The code entered must be one that is already established in the system. Enter a hyphen (-) to display a list of valid codes.

19. INSURANCE FOLLOW-UP SCHEDULE (TABLE LOOKUP-O)
This field defines the external follow-up schedule to be assigned when a claim is transferred to a collection agency. If this field is not completed, and a claim is assigned to this agency, the system generates a rejection for Pre-collect Info Not Defined.

20. BD NOTIFICATION FORMAT (1-A-R)
This field contains the code identifying the manner in which the hospital sends information to the collection agency. This format must already be established in the system. You can select either New Format Agency Tape or Old Format Agency Tape. The new format enables the interface to handle dollar amounts up to ten million dollars.

If a data file is not sent to the collection agency, press ENTER to leave the field blank. If this field is left blank, only a report is produced.

21. BD PASS ADM DIAG? (1-A-O)
This field indicates whether the admitting diagnosis is included on the Collection Agency data file sent to the collection agency. Entry options are **Y** for Yes and **N** for N. The system defaults to Yes.

22. BD TAPE FORMAT (1-A-R)
This field contains the format that the collection agency tape is created. Enter **A** if the collection agency tape is to be created in ASCII format. Enter **E** if the collection agency tape is to be created in EBCDIC format. This parameter does not apply if the datafile is generated to a PC file or UNIX file.

23. BD COB FORMAT (1-N-R)
This field contains either the 4 or 9 COB format. This field indicates whether the bad debt collection agency file contains either 4 or up to 9 insurance carriers. This field is used when generating a bad debt collection agency file under the Collection Agency Functions Processor.

The system displays the following prompt:

Enter the (4) COB or (9) COB format [4] --

Enter the number **4** or **9**. The default is 4. If you enter 9 the alternate Collection Agency tape format is used.

24. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

25. EDITED BY (DISPLAY ONLY)
This field contains the name of the user who last edited this table entry.

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

You can generate a printout of the Collection Agency Code Table by entering Y for Yes at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FTFAA, and it is spooled to FIN.

COLLECTION AGENCY GROUP

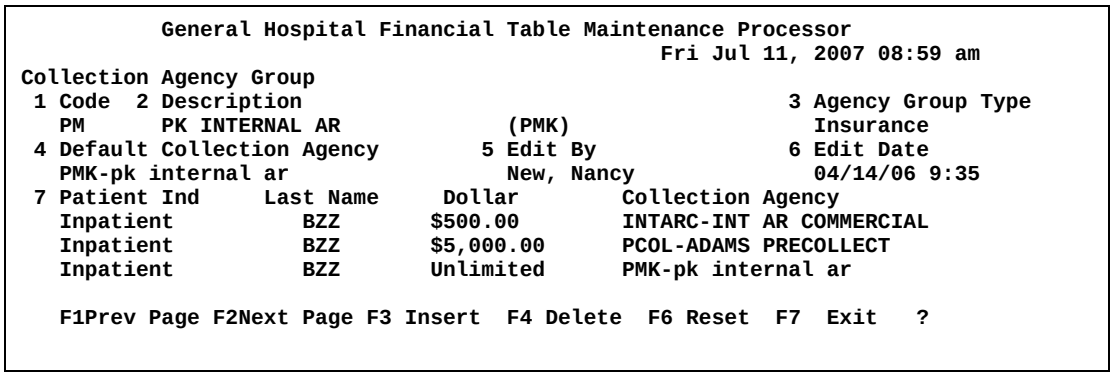
The Collection Agency Group table is used to identify collection agencies to be assigned to patient accounts for use in guarantor and insurance collections. The information stored in this table is used in assigning accounts/claims to an AR agency. This table is not split by facility.

The table is defined by agency types of Bad Debt, CCI, Agency, and Insurance. The collection agency assigned to an account and insurance claim is based on the following collection agency group assignment parameters:

- Patient Indicators (inpatient, outpatient, emergency)
- Guarantor Last Name (accounts) and Patient Last Name (claims)
- Collection Agency Code
- Dollar Limit

Financial class and/or patient type exceptions are defined on a facility-specific basis, using the Collection Agency Group - Exceptions screen.

The system prompts you to enter a collection agency group code. You can enter a code or a hyphen (-) to display a list of valid codes. When the code is entered, a screen is displayed that allows you to define a collection agency group.



```
          General Hospital Financial Table Maintenance Processor
                                                Fri Jul 11, 2007 08:59 am
Collection Agency Group
 1 Code  2 Description                                    3 Agency Group Type
   PM      PK INTERNAL AR             (PMK)                 Insurance
 4 Default Collection Agency        5 Edit By               6 Edit Date
   PMK-pk internal ar                 New, Nancy              04/14/06 9:35
 7 Patient Ind     Last Name     Dollar        Collection Agency
   Inpatient          BZZ       $500.00       INTARC-INT AR COMMERCIAL
   Inpatient          BZZ       $5,000.00     PCOL-ADAMS PRECOLLECT
   Inpatient          BZZ       Unlimited     PMK-pk internal ar

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

Field Explanations

1. CODE (6-AN-R)
This field contains the code identifying this collection agency group.

2. DESCRIPTION (30-C-R)
This field contains a description of this collection agency group.

3. AGENCY GROUP TYPE (TABLE LOOKUP-R)
This field defines whether the group is related to one of the four types (Agency, CCI, Bad Debt, and Insurance). Internal and external Bad Debt agencies are grouped together for the purpose of this table definition. When this field is accessed, the Collection Agency Group Types table is displayed:

```
Page: 01              Collection Agency Group Types
(1) 1-Bad Debt
(2) 2-CCI
(3) 3-Agency
(4) 4-Insurance

Enter choice--
```

You can select the collection agency group type from the table.

4. DEFAULT COLLECTION AGENCY (TABLE LOOKUP-R)
This field contains the default collection agency code and name for this group. This agency is responsible for all accounts not assigned to another agency from within the Pat Ind field on this screen. You can enter a collection agency code or a hyphen (-) to select an agency from the Collection Agencies table.

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

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

7. PAT IND (TABLE LOOKUP-O)
This field is used to define the patient indicator, such as emergency, inpatient, or outpatient. Enter a hyphen (-) to select a patient indicator from the list of patient indicators. If this field is not completed, the system uses the agency in the Default Collection Agency field to assign to accounts.

LAST NAME (3-C-O)
This field defines a name parameter for assignment to the collection agency. The Name entry refers to the first three characters of the last guarantor name for which this agency is responsible. For example, if the first entry is GZZ, the agency involved collects from all eligible guarantors whose last name begins with a letter from A to G. If RZZ is entered for the next range, the assigned agency collects from all accounts whose guarantor's last name begins with a letter from H to R.

DOLLAR (1-AN-R)
This field contains the dollar amount for which the agency is responsible. You can enter **U** (Unlimited) for the agency to be assigned to any dollar amount account or enter a number from **1.00** to **999,999.99**.

COLLECTION AGENCY (6-C-C)
This field contains the collection agency responsible for the range of guarantors defined in the Name field. You can enter an agency code or a hyphen (-) to display a list of valid codes. This field is required if a name parameter is identified in the Last Name field.

After accepting this screen, you can add financial class/patient type exceptions by facility. The following prompt is displayed:

Enter Financial Class/Patient Type exceptions by Facility? (Y/N) [N]--

If you enter **N** (No), the listing of Financial tables is displayed. If you enter **Y** (Yes), a list of facilities is displayed, and you can select a facility. After you enter the facility, a list of financial class exceptions is displayed. You can select one of them, then press ENTER to display a list of Patient Type Exceptions. If you do not select a financial class, you can still select a patient type in order to define Patient Type exceptions only (in comparison to financial class/ patient type definitions). Active patient types are not displayed which are specific to the facility. Contract and pre-admit patient types are not displayed in the list. After you select a patient type exception from the list, press ENTER. The following prompt is displayed:

Do you wish to copy from Master? (Y/N) [N]-- |

If you enter **Y** (Yes), the Collection Agency Group - Exceptions Table is displayed with all fields populated from the generic, non-patient exceptions screen. This information is used as a starting point and can be edited.

If you enter **N** (No), the Collection Agency Group - Exceptions Screen is displayed with the Code, Description, Agency Group Type, Facility, Financial Class, and Patient Type fields populated.

```
               General Hospital Financial Table Maintenance Processor
                                                 Wed May 10, 2007   10:32 am
Collection Agency Group - Exceptions
 1 Code         2 Description                              3 Agency Group Type
   233            GROUP EXCEPTION                            Agency
 4 Facility     5 Financial Class    6 Patient Type
   A              DW                   ADV
 7 Default Collection Agency         8 Edit By               9 Edit Date

10 Patient Ind     Last Name     Dollar        Collection Agency




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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying this collection agency group.

2. DESCRIPTION (DISPLAY ONLY)
This field contains a description of this collection agency group.

3. AGENCY GROUP TYPE (DISPLAY ONLY)
This field defines whether the group is related to one of the four types (Agency, CCI, Bad Debt, and Insurance). Internal and external Bad Debt agencies are grouped together for the purpose of this table definition.

4. FACILITY (DISPLAY ONLY)
This field indicates the facility for the exceptions.

5. FINANCIAL CLASS (DISPLAY ONLY)
This field represents financial class exceptions.

6. PATIENT TYPE (DISPLAY ONLY)
This field represents patient type exceptions.

7. DEFAULT COLLECTION AGENCY (TABLE LOOKUP-R)
This field contains the default collection agency code and name for this group. This agency is responsible for all accounts not assigned to another agency from within the Pat Ind field on this screen. You can enter a hyphen (-) to select a default agency from the Collection Agencies table.

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

9. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

10. PAT IND (TABLE LOOKUP-O)
This field is used to define the patient indicator, such as emergency, inpatient, or outpatient. You can enter a hyphen (-) to select a patient indicator from the list of patient indicators. If this field is not completed, the system uses the agency in the Default Collection Agency field to assign to accounts.

LAST NAME (3-C-O)
This field defines a name parameter for assignment to the collection agency. The Name entry refers to the first three characters of the last guarantor name for which this agency is responsible. For example, if the first entry is GZZ, the agency involved collects from all eligible guarantors whose last name begins with a letter from A to G. If RZZ is entered for the next range, the assigned agency collects from all accounts whose guarantor's last name begins with a letter from H to R.

DOLLAR (1-AN-R)
This field contains the dollar amount for which the agency is responsible. You can enter **U** (Unlimited) for the agency to be assigned to any dollar amount account or enter a number from **1.00** to **999,999.99**.

COLLECTION AGENCY (6-C-C)
This field contains the collection agency responsible for the range of guarantors defined in the Name field. You can enter an agency code or a hyphen (-) to display a list of valid codes. This field is required if a name range is identified in the Last Name field.

Accepting the screen completes the transaction.

Dependent On	Reference
Collection Agency Table	Financial Classes

COLLECTION GROUP

The Collection Group table contains codes grouping like collectors together. It is used to assign specific collectors to guarantors or to accounts for collection of insurance portions of patient accounts. It includes the group's default collector and names the collectors in the group. This table also specifies the collector responsible for guarantor follow-up (indicated by the letters of the guarantor's last name), pre-collection follow-up, and bad debt follow-up. The system assigns a collector to a guarantor at admission or O/P admission and assigns an insurance collector when the resulting claim is submitted to the carrier. Insurance collectors are assigned to accounts according to the first characters of the patient's last name.

The system assigns a collector for follow-up when the account is flagged for pre-collection consideration. The collector is assigned according to the collector group that is defined in the Collection Group field of the Collection Agency Code table.

The system assigns the collector for bad debt when the account transfers to bad debt. The collector is assigned according to the collector group that is defined in the Bad Debt Collector Group Code field of the Collection Agency Code table.

Collectors are assigned only to new guarantors. If a patient is assigned to an existing guarantor during the admission or registration process, a new collector assignment is not made. For example, if an emergency patient is registered, and the guarantor is not in the MPI, a collector is assigned to the patient based on the collector group in the Financial Class table that matches the patient's financial class. If the patient returns for another visit, or another family member is admitted or registered, and the same guarantor is responsible for the bill, no assignment of a collector is made.

The Collector Group table determines which collector is assigned to the guarantor based on the patient's inpatient, outpatient, or emergency Indicator, and the guarantor's last name.

For insurance portions of a patient account, a collector assignment is made on each individual account by insurance carrier and claim. The collector group code is in the Insurance Coverage table. A collector is assigned to a carrier and claim at the time of claim submission (mail date). Carriers that share a claim have only one collector assigned, and that is the primary carrier's collector. Those carriers that require or have a separate claim have their own collector assigned.

This table is not split by facility.

NOTE: The Collector Table must be completed before this table.

After this table is selected, the system prompts you to enter a collection group code. You can enter a code or a hyphen (-) to display a list of valid codes.

After the collection group code is entered or selected, the following screen is displayed.

```
         General Hospital Financial Table Maintenance Processor
                                                 Fri Apr 14, 2000 10:51 am
Collection Group
 1 Code  2 Description                        3 Default Collector
   1       COLLECTION GROUP                     111-BREWER,STACEY R
 4 Edit By                                    5 Edit Date
   Bass, Bob                                    04/15/99 04:05p
 6 Patient Ind     Last Name     Dollar       Collector
   Emergency          BZZ       Unlimited      11-BLEAU,TRISH
   Emergency          JZZ       Unlimited      30-COLLECTOR,HECTOR C
   Emergency          MZZ       Unlimited      3-COLE, MIKE
   Emergency          TZZ       Unlimited      4-WHITE,BOB
   Emergency          ZZZ       Unlimited      35-PORTER, LANCE
   Inpatient          CZZ       Unlimited      3-SMITH, DIANE


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

Field Explanations

1. CODE (4-N-R)
This field contains the code identifying this collection group.

2. DESCRIPTION (30-C-R)
This field contains a description for this collection group.

3. DEFAULT COLLECTOR (3-N-R)
This field contains the code identifying the collector who handles all collecting duties not covered by assignments made in the Patient Indicator, Last Name, Dollar, and Collector fields on this screen. If the default collector is to handle all collections for the group, the Patient Indicator, Last Name, Dollar, and Collector fields are not completed. You can enter the code or a hyphen (-) to display a list of valid codes. The default collector is not responsible for the coverage of accounts assigned to other collectors; they are the responsibility of the collection supervisor.

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

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

Assigning Collection Responsibility

The next three fields assign patient collection responsibility among collectors in the group according to the patient indicator and either guarantor last name (for guarantor collections) or patient last name (for insurance collections).

NOTE: If one person is to be responsible for all accounts in a group, complete the Default Collector field only. The rest of the table does not need to be completed.

6. PATIENT INDICATOR (1-A-O)
This field indicates the type of patient account to be followed up. You can enter the patient indicator of **E** (emergency room), **I** (inpatient), or **O** (outpatient).

LAST NAME (3-A-C)
This field defines the letters of patient last names for whom this collector is responsible. For example, collector 1 collects from all inpatients whose last names begin with letters in the range A through M, while collector 2 collects from all inpatients whose last names begin with letters in the range M through Z. The entry for collector 1 would be M while the entry for collector 2 would be ZZZ. This field is required if the Patient Indicator field is completed.

DOLLAR (8-AN-R)
The dollar field contains the dollar amount that is used to assign accounts to collectors. When this field is accessed, the following prompt is displayed:

Enter maximum balance for collector assignment [U]nlimited]--

This field is dependent on the Collector Assignment Balance field in PAAR Control Maintenance for the assignment of PA, AR, Pre-collection, and Internal Bad Debt collectors. The system uses either the account or patient balance to assign PA, AR, Pre-collection and Internal Bad Debt collectors. The system uses the claim amount to assign insurance collectors.

To prevent the collector assignment from using the default collector, the dollar column must be defined through an unlimited value for a specific Last Name range. The following is an example for an emergency patient indicator for names from A through BZZ: If one definition reflects a dollar value of $5,000, any value over $5,000 goes to the default collector. If assignments from $5,000.01 to unlimited go a collector other than the default collector, a second definition for BZZ would need to be defined.

COLLECTOR (3-N-C)
This field contains a code representing the collector responsible for this patient indicator and the value in the Last Name field. You can enter the code or a hyphen (-) to display a list of collectors previously entered in the system. This field is required if the Patient Indicator and Last Name fields have values.

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

Dependent On	Reference
Collectors	Collection Agency Table
	Financial Class Table
	Insurance Coverage Master
	PAAR Control Maintenance

COLLECTORS

The Collectors table is user-defined and contains codes representing the hospital's collectors and their supervisors and managers. Collectors are automatically assigned to new guarantors at the time of final bill. Insurance collectors are assigned to accounts at the time of claim submission. Collectors are assigned when the accounts transfer to an AR agency and when accounts are pending for agency collection. The collector is assigned according to the collector group defined in the Collector Group field in the Collection Agency Code table for the AR agency. Internal Bad Debt Collectors are assigned when the account transfers to an Internal Bad Debt agency. The Internal Bad Debt collector is assigned according to the collector group defined in the BD Collector Group Code/Desc field on the Collection Agency Code table for the Internal Bad Debt agency. This table is not split by facility.

NOTE: All collectors, collection supervisors and managers must be entered in the Hospital Employee File before they can be entered in this table. Collection supervisors and managers must be entered in this table before collectors.

The Collectors table is used to grant or restrict a collector’s rights to approve refunds. The table defines the maximum dollar limit for refund approvals by type of refund. When a refund approval screen is accessed, the maximum dollar amount analysis is made by the system. If the dollar value defined on this table is not met, the person cannot access the screen to approve the refund. The maximum dollar value is not facility-specific.

After this table is selected, the system prompts you to enter the Collector code or to select one from a list of codes already established. After the code is entered or selected, this screen is displayed.

```
                General Hospital Financial Table Maintenance Processor
                                                Th May 19, 2006 08:28 am
Collectors
 1 Code                        2 System ID
   6                             33016
 3 Collector Name              4 Phone                         5 Ext.
   Base, Marge                  (123)456-7890                   1234
 6 Supervisor/Manager          7 Supervisor                    8 Maximum Accounts
   Manager
 9 Accessible Collectors                     10 Refund Collectors
   30,6
11 Guarantor Refund           12 Carrier Refund               13 Unapplied Refund
   $5,000.00                     $4,000.00                       $1,000.00
14 Edit by                                                    15 Edit date
   Base, Marge                                                   04/24/06 01:14pm



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

Field Explanations

1. CODE (5-N-R)
This field contains the code identifying the collector.

2. SYSTEM ID (12-N-R)
This field contains the collector's system identification code as entered in the STAR hospital employee file. All collectors entered in this table must be valid hospital employees who have been set up in the hospital employee file. System ID codes may vary in length by hospital.

You have several entry options for this field:

- Collector's system ID number
- Employee Number
- Employee Last Name

3. COLLECTOR NAME (DISPLAY ONLY)
This field contains the name of the collector.

4. PHONE (10-N-O)
This field contains the collector's phone number. It is entered in the format 4045551212 and displayed in the format (404) 555-1212.

5. EXT. (5-N-O)
This field contains the collector's phone extension.

6. SUPERVISOR/MANAGER (1-A-O)
This field identifies the collector as a supervisor, manager, or neither. Entry options are **M** (manager), **S** (supervisor), and ENTER (neither). The default is blank for neither a manager or supervisor.

7. SUPERVISOR (TABLE LOOKUP)
This field contains the name of the supervisor. This field is required if the Supervisor/ Manager Flag field contains N. The system automatically displays a list of collector supervisors. You select a value from the table display.

8. MAXIMUM ACCOUNTS (3-N-O)
This field contains the maximum number of accounts requiring telephone follow-up (both guarantor and insurance) that can be present in this collector workfile at one time. The range is 1 to 999,999 accounts. If this number is exceeded, the surplus accounts are referred to the collector's supervisor.

9. ACCESSIBLE COLLECTORS (TABLE LOOKUP)
This field allows you to choose the collectors whose workfiles are accessible to the manager. This field, which is optional, can be accessed only if the Supervisor/ Manager field contains M. The system automatically displays a list of collectors from which to select. Multiple managers can have access to the same collectors. Make your selection(s) from the list, or enter **A** for all.

10. REFUND COLLECTORS (TABLE LOOKUP-R)
This field allows you to define the collectors who can request refunds. When this field is accessed, the system displays a list of the collectors who entered a refund or were the last to edit a refund entry and can have the refund approved. This field applies only

to the refund approval process, not the refund request/revise options. Anybody who has access to the refund request menu option can request/edit a refund.

11. GUARANTOR REFUND (8-N-R)
This field defines the maximum guarantor refund dollar value which can be approved by the collector. When the field is accessed, the following prompt is displayed:

Enter the maximum guarantor refund dollar amount to be approved (0 - 999,999.99) [0] -

You can enter a dollar amount from **0.00** to **999,999.99**.

12. CARRIER REFUND (8-N-R)
This field defines the maximum carrier refund dollar value which can be approved by the collector. When the field is accessed the following prompt is displayed:

Enter the maximum carrier refund dollar amount to be approved (0 - 999,999.99) [0] -

You can enter a dollar amount from **0.00** to **999,999.99**.

13. UNAPPLIED REFUND (8-N-R)
This field defines the maximum unapplied cash refund dollar value which can be approved by the collector. When the field is accessed, the following prompt is displayed:

Enter the maximum unapplied cash refund dollar amount to be approved (0 - 999,999.99) [0] -

You can enter a dollar amount from **0.00** to **999,999.99**.

14. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited this table entry.

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

If you are a supervisor, you have access to your own workfiles as well as the workfiles of all collectors who report to you. If you are a manager, you have access to the workfiles of the collectors entered in the Accessible Collectors field.

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

NOTE: You cannot delete a collector from the file or file a collector as deleted if there is existing work in the collector's workfile.

Dependent On	Reference
Hospital Employee File	Collection Group Table

CONTRACT FINANCIAL INFORMATION

This table is used for defining a contract as to how it functions on the Patient Accounting system. The top part of the screen displays information from the Contract Names table maintained by Patient Care. The bottom part of the screen identifies information applicable to the financial aspect of the contract such as: first, assignment of the collector; second, assignment of the collection schedule; third, designation of number of contract bills to place on a detail statement and telephone workfile entry; fourth, transaction code for telephone and detail statement to be placed in transaction history; fifth, assignment of the detail statement format; sixth, assignment of a transaction code for the automatic contractual write-off which is displayed in transaction history and controls the G/L account to post the contractual write-off amount; seventh, assignment of the automatic contractual write-offs as an overall default amount, write-off percentage based on a specific SIM department and/or the dollar amount to be charged based on a specific charge within a SIM department (also see description below); and finally, the designation whether zero value bills should be printed.

This table needs to be completed every time a new contract is entered on Patient Care. This screen is not automatically displayed when the new contract is entered and forced to be completed. The main reason is the Contract Names table is controlled by Patient Care and Contract Financial Information table is controlled by Patient Accounting. A manual procedure is mandatory to have this table completed after entering a new contract. If this table is not completed, bills are not produced. If you try to create a contract bill on demand without first completing this table, you receive the following error message:

Contract financial information missing - bill request not allowed

The contractual write-off percentage/dollar amount is a three tier process. The three tiers are an overall percentage write-off amount, a more specific write-off percentage write-off amount associated with a specific SIM department, and specifying a dollar amount to charge for a specific charge within a SIM department. This information is specific for a contract code for each facility (if applicable). The percentages identified can be a markdown (+10%) or a markup (-10%). Another way of specifying an amount to charge is through FIM pricing levels. If this method is used, the Contract Financial Table W/O Percent would be set to 0 with no SIM level or charge specific exceptions.

After the table is selected, the system prompts to select a contract code. You may enter the code or a hyphen (-) to display a list of valid codes. After the contract code is entered, the screen used in this transaction is displayed as follows:

```
              General Hospital Financial Table Maintenance Processor
                                                  Thu Jan 11, 1996 05:50 pm
Contract Financial Information
 1 Code   2 Description                  3 F/U Contact Name
   ANDE     ANDERSON CONSULTING
 4 F/U Address 1                        5 F/U Address 2
   44 HILLCOAST RD
 6 F/U City            7 F/U State      8 F/U Zip Code
   COAL VALLEY           IL               98798
 9 F/U Collector                       10 F/U Sched #     11 Multiple?
   5-COLLECTORFIVE,MANAGER                 124                Yes
12 Statement Format Code               13 Statement Transaction Code
   HBO Contract Statement Format           T0033-TELEPHONE FOLLOW UP
14 Workfile Memo Transaction Code      15 Telephone Transaction Code
   M0013-Workfile    Telephone Entry       T0031-COLLECTION LETTER
16 Auto Adjust Transaction Code        17 W/O Percent  18 Suppress 0 Bills?
   G0001-CONTRACT ADJUSTMENTS              5.00%           Yes



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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the contract code as created through the Patient Care Contract Names table process. It is beneficial for multi-facility hospitals if the code structure can be easily distinguished by facility. An example would be to have the first character be the facility code (A1234, B1234).

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description associated to the specific contract code. The field is maintained by the Patient Care Contract Names table processor.

3. F/U CONTACT NAME (DISPLAY ONLY)
This field contains the contact person at the specific contract. The information is maintained through the Patient Care Contract Names table. It is used in the billing process as the mail to information. The follow-up processes uses this in the mail to information for the detail statements as well as the telephone workfile process contact person.

4. F/U ADDRESS 1 (DISPLAY ONLY)
This field contains the address of the contract as maintained by the Patient Care Contract Names table. This address identifies where to send contract bills and contract detail statements.

5. F/U ADDRESS 2 (DISPLAY ONLY)
This field contains the address of the contract as maintained by the Patient Care Contract Names table. This address identifies where to send contract bills and contract detail statements.

6. F/U CITY (DISPLAY ONLY)
This field contains the city of the contract as maintained by the Patient Care Contract Names table. This address identifies where to send contract bills and contract detail statements.

(US)7.F/U STATE (DISPLAY ONLY)
(CN)7.F/U PROVINCE (DISPLAY ONLY)
This field contains the state/province of the contract as maintained by the Patient Care Contract Names table. This address identifies where to send contract bills and contract detail statements.

(US)8.F/U ZIP CODE (DISPLAY ONLY)
(CN)8.F/U POSTCODE (DISPLAY ONLY)
This field contains the zip code/postcode of the contract as maintained by the Patient Care Contract Names table. This address identifies where to send contract bills and contract detail statements.

9. F/U COLLECTOR (3-N-R)
This field controls who is responsible for collecting on outstanding balances for the specific contract. This information is pulled from the Collector Table within the Financial Table Maintenance menu option. This table contains collectors associated with contracts and the non contract patient accounting collection process. This collector information is later used when an Aged Trial Balance (ATB) report is generated. It is preferred to have this field completed.

10. F/U SCHED # (3-N-R)
This field identifies the follow-up schedule to use in regards to the specific contract. The valid entries are taken from the Contract Follow-up table processor. This table is located on the Patient Accounting system within the Tables menu option and the Maintain Financial Tables menu option. Because the information is pulled from this table, it must be built first. The schedule cannot be customized for a specific contract as is the case with the noncontract portion of the Patient Accounting process.

11. MULTIPLE? (1-A-R)
This fields controls how many bills are grouped together for the collection process. If the prompt is completed as Yes, the system groups non-zero bills with a positive balance on details statements and on telephone workfile entries. In other words, only one telephone workfile or detail statement is generated at any point in time when more than one contract bill having a positive balance at the time follow-up is processed for the contract. If the prompt is completed as No, the system generates one telephone or detail statement for each contract bill having a positive balance at the time follow-up is processed for the contract bill. If the parameter is changed, the system converts the prior information to conform to the new parameter setting. An example is having ten contract bills with a balance and the Multiple parameter originally set to No and then changed to Yes. The next follow-up date is determined using the wait days on the follow-up schedule attached to the contract. The system deletes the follow-up request for the ten separate bills and combines them to be linked to the contract. Vice versa, the system automatically creates a follow-up request for each bill if the Multiple parameter is changed from Yes to No. The next follow-up date is the next date

associated with the contract level follow-up. The next follow-up step assigned to the individual bills is the step associated with the contract level follow-up.

12. STATEMENT FORMAT CODE (TABLE DISPLAY)
This field contains the statement format code. This table identifies the format of the detail statement to be used in the collection process. The Format Code table is part of the McKesson Table option. Only one statement format is defined at this time.

13. STATEMENT TRANSACTION CODE (TABLE DISPLAY)
This field contains the statement transaction code. The entries to select from are defined within the Patient Accounting Table processor, within the Financial Table Maintenance menu option and within the Transaction Codes table for the T transaction types. The entries in the T Transaction Codes table must be predefined by you. This transaction code is placed in transaction history whenever a Contract statement is produced.

14. WORKFILE MEMO TRANSACTION CODE (TABLE DISPLAY)
This field contains the workfile memo transaction code. The entries to select from are defined within the Patient Accounting Table processor, within the Financial Table Maintenance menu option and within the Transaction Codes table for the M transaction types. The entries in the M Transaction Codes table must be predefined by you. This transaction code is placed in transaction history whenever a Telephone Workfile Entry is produced.

15. TELEPHONE TRANSACTION CODE (TABLE DISPLAY)
This field identifies the transaction code that is displayed in transaction history when a telephone entry is worked. The entries are selected from predefined options within the T Transaction Codes table within the Financial Table Maintenance menu option.

16. AUTO ADJUST TRANSACTION CODE (TABLE DISPLAY)
This field identifies the transaction code that is displayed in transaction history when a contractual write-off is processed as part of the billing process. The entries are selected from the predefined options within the G Transaction Code table within the Financial Table Maintenance table menu option. It also directs the system as to which General Ledger account to post the Debit side of the Contractual Adjustment journal entry. The mapping is made through the General Ledger mapping functions option.

17. W/O PERCENT (3-N-R)
This field identifies the percentage write-off if no SIM level or charge level exceptions are specified to be used in the calculation of the Automatic Contractual Write-Off Process. A positive value results in a write-off while a negative value results in a mark up on charges. This field would be set to 0 if the pricing structure is controlled through the FIM price or pricing levels.

18. SUPPRESS 0 BILLS? (1-A-R)
This field controls whether a zero balance bill should be produced. If the prompt is completed with a No, a bill is generated if no charges exist for the bill. If the prompt is completed with a Yes, the system does not generate a bill if charges net to zero or no

charges were placed on the contract or a contract patient since the last bill was produced. If a bill is not generated, a transaction history entry is not generated.

If charges net to zero because a charge has a corresponding credit or if no charges exist that are unbilled, do not generate a contract cycle bill. A transaction history entry is not generated if a bill is not produced. If a debit/credit charge scenario exists, do not mark them as billed until a subsequent bill is produced. Zero balance final bills are generated as well as the corresponding transaction history entry.

Any unbilled charges and offsetting credits are linked to the final bill if not previously billed. Charges and credits are considered to be off-setting if the charges are for the same item and the same amount and have the same service date and SIM description. If off-setting charges and credits have different SIM descriptions, they print on the bill.

Completing a demand bill does not suppress the bill even if no charges exist.

After the screen is completed the following prompt is displayed:

Delete? (N)--

Enter **Y** for Yes to delete the information entered for the screen. Enter **N** for No to display information that pertains to the SIM level exceptions or the Charge level exceptions.

For SIM level exceptions the following prompt is displayed:

Enter SIM department (D), Charge (C) exceptions, or Table (T) copy options --

Enter **S** for SIM department to indicate that SIM level exceptions are to be added, deleted, or revised. After you enter S, the following prompt is displayed:

Enter SIM department exception, (A) to add or '-' for exception list --

Enter **A** for All to show a table lookup of the SIM departments not set up as an exception. Enter a hyphen (-) for a table lookup of the SIM departments previously defined with an exception. A SIM level exception does not need to be created if the percentage is equal to the amount entered in the W/O Percent field.

If you enter A for All, a screen similar to the following screen is displayed.

```
             General Hospital Financial Table Maintenance Processor
                                                Thu Jan 11, 1996 05:53 pm

 Code    Contract Name
 ANDE    ANDERSON CONSULTING

 Page:01                          SIM Departments
 ( 1) DTY-DIETARY                 (15) OT-OCCUPATIONAL THE
 ( 2) DTA-DIETARY (A)             (16) PED-PEDIATRICS
 ( 3) EDP-EMER DPT PHYSIC         (17) PT-PHYSICAL THERAPY
 ( 4) ED-EMERGENCY DEPART         (18) PSY-PSYCHIATRIC
 ( 5) ICU-INTENSIVE CARE          (19) RRD-Rad Department
 ( 6) LD-LABOR & DELIVERY         (20) RR-RECOVERY ROOM
 ( 7) LAB-Laboratory              (21) RT-RESPIRATORY THER
 ( 8) LB2-LABORATORY 2            (22) RMB-ROOM AND BED
 ( 9) LB3-LABORATORY 3            (23) ST-SPEECH THERAPY
 (10) MED-MEDICAL/SURGICA         (24) SGY-SURGERY
 (11) MSC-MISCELLANEOUS
 (12) NSH-Nourishments
 (13) NSY-NURSERY
 (14) OB-OBSTETRICS/GYNOC


Enter choice--
```

At the enter choice prompt enter the sequence number of the SIM department that you want to add as a SIM level exception.

If you enter a hyphen (-), a screen similar to the screen below is displayed.

```
             General Hospital Financial Table Maintenance Processor
                                                Thu Jan 11, 1996 05:52 pm
Code    Contract Name
ANDE    ANDERSON CONSULTING

Page:01    SIM Dept/Description                 Percent
( 1)       ANS ANESTHESIA                       100.00 %
( 2)       CAR CARDIOLOGY                        15.00 %
( 3)       CCU CORONARY CARE UNIT                55.55 %
( 4)       CLN CLINICAL NUTRITION                50.00 %
( 5)       CNS Department Consults                9.99 %
( 6)       CSR CENTRAL SERVICES                  90.00 %
( 7)       EEG EEG                               15.00 %
( 8)       RAD (A) Radiology                     16.00 %
( 9)       RT  RESPIRATORY THERAPY              Charges Only
(10)       ST  SPEECH THERAPY                   Charges Only




Enter choice--
```

All of the SIM departments previously set up with a SIM level exception is displayed. Under the Percent column, the percentage amount or Charge Only is displayed for each SIM department. If a percentage amount is displayed, this states that a SIM level exception was previously created. Any charge level exceptions are not reflected in the Percent column.

You can select any entry to change the percentage write-off amount or delete the entry. When you select an entry, a screen similar to the following is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                 Thu Jan 11, 1996 05:52 pm
Code    Contract Name
ANDE    ANDERSON CONSULTING

Page:01    SIM Dept/Description                    Percent
 ( 1)      ANS ANESTHESIA                          100.00 %









Enter SIM department write off percentage--
```

The Code and Description fields are display only fields. To change the Write-off Percentage, enter the new or changed percentage. The value for this percentage is 100% to -100%.

For charge level exceptions, the following prompt is displayed:

Enter SIM department (D), Charge (C) exceptions, or Table (T) copy options --

Enter **C** for charge exceptions to indicate the Sim Department of the charge exception. After you enter C, the following prompt is displayed:

Enter SIM department or "-" for a lookup--

Enter the SIM department or a hyphen (-).for a table lookup of the SIM departments previously defined with a charge level exception.

A screen similar to the following screen is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                    Thu Jan 11, 1996 05:53 pm
Code    Contract Name
ANDE    ANDERSON CONSULTING
Page:01                            SIM Departments
( 1) DTY-DIETARY           (15) OT-OCCUPATIONAL THE
( 2) DTA-DIETARY (A)       (16) PED-PEDIATRICS
( 3) EDP-EMER DPT PHYSIC   (17) PT-PHYSICAL THERAPY
( 4) ED-EMERGENCY DEPART   (18) PSY-PSYCHIATRIC
( 5) ICU-INTENSIVE CARE    (19) RRD-Rad Department
( 6) LD-LABOR & DELIVERY   (20) RR-RECOVERY ROOM
( 7) LAB-Laboratory        (21) RT-RESPIRATORY THER
( 8) LB2-LABORATORY 2      (22) RMB-ROOM AND BED
( 9) LB3-LABORATORY 3      (23) ST-SPEECH THERAPY
(10) MED-MEDICAL/SURGICA   (24) SGY-SURGERY
(11) MSC-MISCELLANEOUS     (12) NSH-Nourishments
(13) NSY-NURSERY           (14) OB-OBSTETRICS/GYNOC


Enter choice--
```

At the enter choice enter the sequence number of the SIM department that you want to add as a SIM level exception. The following prompt is displayed:

Enter charge exception, (A) to add or '-' for exception list --

Enter **A** for All to show a table lookup to select a charge to set up the charge level exception. Enter a hyphen (-) for a table lookup of the SIM departments previously defined with a charge level exception.

If you enter a hyphen (-), a screen similar to the screen below is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                    Thu Jan 11, 1996 05:52 pm
Code    Contract Name
ANDE    ANDERSON CONSULTING

Code    Contract Name               SIM Dept/Description
ANDE    ANDERSON CONSULTING         RAD (A) Radiology
Page:01    SIM     Description                          Dollar Amount
( 1)       7422    XR ABD SERIES W/PA CHEST  74022          99,999.99









Enter choice--
```

You can select any entry to change the dollar amount. When you select an entry, a screen similar to the following is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                    Thu Jan 11, 1996 05:52 pm
Code    Contract Name
ANDE    ANDERSON CONSULTING

Code    Contract Name                SIM Dept/Description
 ANDE    ANDERSON CONSULTING          RAD (A) Radiology
1 SIM            2 Description                    3 Dollar Amount
  7420             XR ABD SUPINE & UPRIGHT        ->









Enter SIM charge amount --            |
```

The Code and Description fields are display only fields. To change the Dollar Amount, enter the new or changed dollar amount.

For table copy options, the following prompt is displayed:

Enter SIM department (D), Charge (C) exceptions, or Table (T) copy options --

Enter **T** for table copy options. The entry of T is used for accessing the copy function of part(s) of the Contract Financial Information table to another contract within the same facility. The process is intended to make the process of creating SIM department or Charge level exceptions or copying the initial screen information to other contracts an easier process. This is helpful when new contracts are established or SIM department or Charge exceptions are updated with new values which apply to multiple contracts. The contract code to be copied from is the one to access via the Contract Financial Information table. The contract code to copy to is prompted for in the following screen.

After you enter T, a screen similar to the screen below is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                  Wed Mar 06, 1996 08:57 am
Code    Contract Name
MDK     MDK INDUSTRIES
 1 Copy Financial Information         2 Copy Department Exceptions

 3 Copy Charge Exceptions             4 Copy To









Create New(N) tables only or press ENTER to not copy --  |
```

Field Explanations

1. COPY FINANCIAL INFORMATION (1-R-A)
This field determines if the process should copy the initial screen for the Contract Financial Information. If ENTER is pressed, the initial screen information is not copied to other contract codes. If you enter N, the system only copies the initial screen information if the copy to contracts do not have any information. The process never overlays existing information. If information exists for the copy to, you need to manually change the information. Below are the fields of the Contract Financial Information table which is copied.

F/U Collector
F/U Sched #
Multiple?
Statement Format Code
Statement Transaction Code
Workfile Memo Transaction Code
Telephone Transaction Code
Auto Adjust Transaction Code
W/O Percent
Suppress 0 Bills?

2. COPY DEPARTMENT EXCEPTIONS (1-R-A)
This field determines if the SIM department exceptions should be copied to other contracts. After you enter this option the following prompt is displayed:

Add New(N) items only, Replace(R) old items, or replace All(A)? -- |

Enter **N** to only copy SIM department exceptions which do not exists for the copy to contract but do for the copy from contract. Enter **R** to copy the SIM Department exceptions information to the copy to contract if it previously existed. This option is intended to be used for updating percentage information resulting from revised contractual agreements. Enter **A** to copy all SIM department exceptions to the copy to contract from the copy from contract. If the copy to contract contains SIM department exceptions not part of the copy from contract, the exceptions are not updated or deleted. These exceptions need to be updated manually if appropriate. Completing the prompt with ENTER does not copy any SIM department exception information.

3. COPY CHARGE EXCEPTIONS (1-R-A)
This field determines if the copy charge exceptions are to be copied. After you enter this option, the following prompt is displayed:

Add New(N) items only, Replace(R) old items, or replace All(A)? -- |

Enter **N** to only copy Charge level exceptions which do not exists for the copy to contract but do for the copy from contract. Enter **R** to copy the Charge level exceptions information to the copy to contract if it previously existed. This option is intended to be used for updating dollar information resulting from revised contractual agreements. Enter **A** to copy all Charge level exceptions to the copy to contract from the copy from contract. If the copy to contract contains Charge level exceptions not part of the copy from contract, the exceptions are not updated or deleted. These exceptions need to be updated manually if appropriate. Completing the prompt with a ENTER does not copy any information.

4. COPY TO (1-R-A)
This field determines which contracts are to be revised. After you enter this option, the following prompt is displayed:

Do you want to copy to all contracts? (Y/N) [N] --

Enter **Y** for Yes to copy information from the contract code accessed to all other contracts. Enter **N** for No to be able to select which contracts to copy information to by selecting them off of a table.

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

CONTRACT FOLLOW-UP SCHEDULES

This table contains the information regarding the timing and type of follow-up used for contracts. One of these schedules are assigned to a contract through the Contract Financial Information table. A specific contract can only be assigned to one follow-up schedule. The schedule can be changed at any time but is not retrospective. The change takes effect the next time follow-up is scheduled for the specific contract.

This table is not split by facility. The schedule determines the frequency and type based on the individual step being processed.

After the table is selected, the system prompts you to select a contract follow-up schedule code. You may enter the code or a hyphen (-) to display a list of valid codes. After the Contract Follow-up Schedule code is entered, the screen used in this transaction is displayed as follows:

```
            General Hospital Financial Table Maintenance Processor
                                                 Mon Jan 15, 1996 02:09 pm
Contract Follow Up Schedules
  1 Schedule #        2 Description          3 Wait Days
    123                 SCHEDULE ONE           99
 4 Day of Month        5 Day of Week         6 Week of Month

 7 Max Paper Bal     8 Min Balance
   Unlimited           $100.00
 9 Seq #   Paper Code    Phone Code                              Interval
    1      88            12                                      3
    2      77            12                                      3









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

Field Explanations

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (30-C-R)
This field contains the description of the contract follow-up schedule code.

3. WAIT DAYS (2-N-R)
This field contains the number of days to wait after a bill with a positive balance before follow-up is initially started. The entry range is 0 to 99 days. The value is also used to determine the Follow-up date when the Multiple? field in the Contract Financial Information table is changed from Yes to No.

Defining Follow-up Frequency

There are three ways to define the frequency of account follow-up: Completing the Day of Month, Day of Week/Week of Month, or Interval Days fields. These options, one of which must be selected are defined below. The interval option is entered in the Schedule Steps field.

4. DAY OF MONTH (2-N-O)
This field contains the day of the month on which the hospital wants follow-up performed on the contract. Entry options are 1 through 28 or **L** for the last day of the month. For example, you would enter 15 if you wanted follow-up performed as part of the 15th's batch process (Actually produced the morning of the 16th).

5. DAY OF WEEK (1-N-O)
This field contains the day of the week on which the hospital wants follow-up performed on the contract. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3....Saturday = 7. If this field is selected, Week of Month field must also be completed and is a required field.

6. WEEK OF MONTH (1-N-C)
This field contains the week of the month during which follow-up is performed on the contract and is only used if the Day of Week field is completed. Entry options are 1 through 4. If this field and the Day of Week field are selected, contracts receive follow-up once a month, during the week entered here and on the day entered in the Day of Week field.

7. MAX PAPER BALANCE (8-N-R)
This field contains the maximum dollar balance that appears on a detail statement. If the dollar amount is larger than what is specified here, the system automatically creates a telephone workfile. If the Collector Workstation module is not purchased, the field should be set to Unlimited. The only way to access a contract telephone workfile is through the Collector Workstation. If the Contract Financial Information table parameter Multiple? is set to No, the system compares the bill balance to this dollar amount. If the Multiple? parameter is set to Yes, this system compares the contract balance to this field.

8. MIN BALANCE (8-N-R)
This field specifies at what balance contract statements should not be created and sent. This field does not come into play if a telephone entry is requested. If the dollar amount is set to $500 and the Collector Workstation is not used, the Contracts do not receive any notice of amount owed by use of the system for a balance. The next step and date is incremented even though no type of follow-up was generated. If the Contract Financial Information table parameter Multiple? is set to No, the system compares the bill balance to this dollar amount. If the Multiple? parameter is set to Yes, this system compares the contract balance to this field.

9. SCHEDULE STEPS

This section of the schedule identifies what type of follow-up occurs and how to recalculate the next follow-up date. Each line contains four parts which may be completed.

SEQ # - This can be considered the step number.

Paper Code - The list of possible values is determined by entries created via the Contract Statement Messages table. If this field is left blank, the system generates a telephone workfile entry (assuming the Collector Workfile module is used).

Phone Code - This field can only be accessed if the Collector Workstation is used. If it is not, the system displays an error message, this field can not be accessed. If the field can be accessed, the system only accepts entries which were previously defined in the Contract Telephone Messages table. This telephone follow-up occurs if the paper code field is blank or if the Max Paper Bal field has been exceeded.

Interval Days - This field is only accessible if the user does not specify a Day of Month or Day of Week / Week of Month options noted earlier. The entry range is 1 to 999 days. The number of days between follow-up can vary by sequence number.

Upon leaving the Contact Follow-up Table, the system prompts you to print a report listing the entries. The sort option is by message code or alphabetic by description. Entries which are inactive can be include or ignored based on your preference. The report is spooled to FIN.

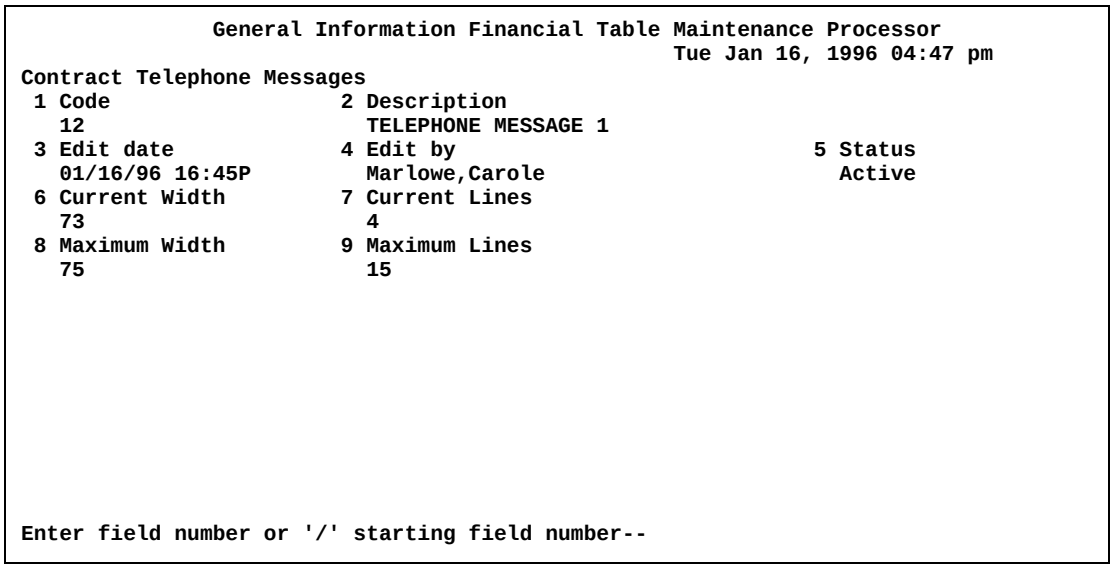
When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting this screen completes the transaction.

CONTRACT STATEMENT MESSAGES

This table defines the messages printed on the contract detail statements. These messages are used in the Contract Follow-up schedules. No internal elements are defined specifically for use in the Contract Statement Messages.

This table is not split by facility.

After this table is selected, the system prompts you to enter a contract statement message code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the system displays the first of two Contract Statement Messages screens. The first screen is used to define the message format and the second screen is used to enter or edit the message text.



```
              General Information Financial Table Maintenance Processor
                                                  Tue Jan 16, 1996 04:47 pm
Contract Telephone Messages
 1 Code                  2 Description
   12                      TELEPHONE MESSAGE 1
 3 Edit date             4 Edit by                          5 Status
   01/16/96 16:45P         Marlowe,Carole                     Active
 6 Current Width         7 Current Lines
   73                      4
 8 Maximum Width         9 Maximum Lines
   75                      15









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the contract telephone message.

2. DESCRIPTION (30-C-R)
This field contains the description of the contract telephone message code. This field be edited at any point.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is filed as deleted by the user becomes inactive and be reactivated at any time. The system defaults this field to active when you create the code.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the established message you are editing. This field is blank if you are creating a new message.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the established message you are editing. This field is blank if you are creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum number of columns which can be used of this message. The entry range is 10-75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum number of lines the message can contain. The entry range is 1 to 18 lines; the default is 18.

When you complete and accept the first screen, the system displays the second Contract Statement Message screen.

```
             General Hospital Financial Table Maintenance Processor
                                                  Mon Jan 15, 1996 11:41 am
Contract Statement Messages 12 - TELEPHONE MESSAGE
   1       2       3       4       5       6       7
12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345
| 01|GENERAL REMINDER PAYMENT HAS NOT BEEN RECEIVED.
| 02|
| 03|
| 04|
| 05|
| 06|
| 07|
| 08|
| 09|
| 10|
| 11|
| 12|
| 13|
| 14|
| 15|

F2     F3      F4    F5         F6           F7   F8      F9       F10
Delete Insert Center Exit  Store Line Restore Line Pack Preview DataBase Help
```

Field Explanations - Screen 2 of 2

Enter the message text on this screen using the format you defined on the first Contract Statement Message processor screen. Pressing the **F4** key saves the message and exits the screen, completing the transaction. The contract statement message prints on the Contract Detail Statement.

Upon leaving the Contact Statement Table, the system prompts you to print a report listing the entries. The sort option is by message code or alphabetic by description. Entries which are inactive can be include or ignored based on your preference. The report is spooled to FIN.

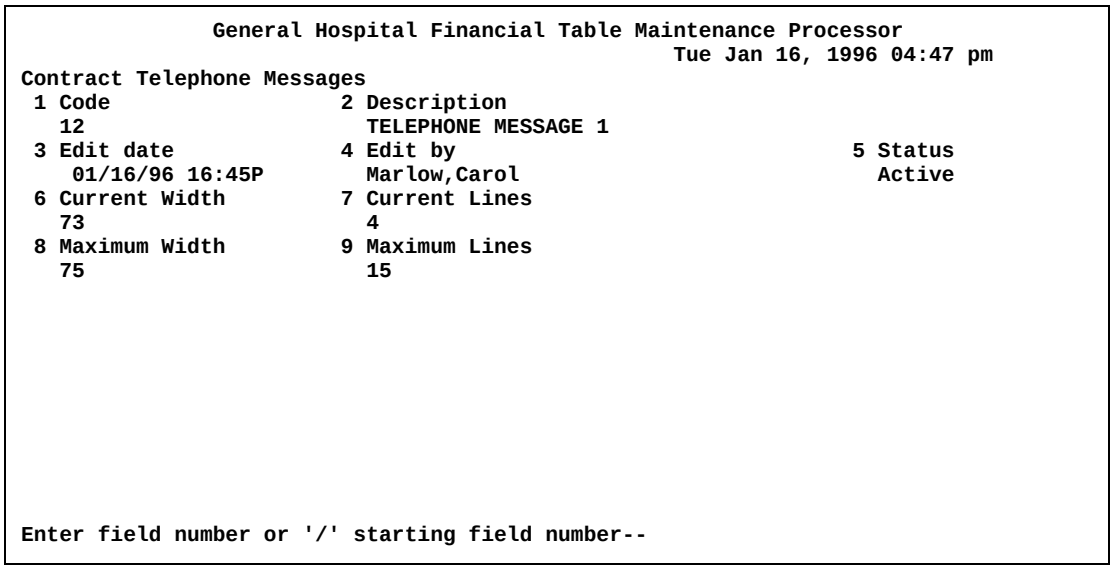
When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting this screen completes the transaction.

CONTRACT TELEPHONE MESSAGES

This table contains the messages used in the collector workfile for contract telephone follow-up. The codes representing these messages are used in the Contract Follow-up Schedules. No internal elements are defined specifically for use in the Contract Telephone messages.

This table is not split by facility.

After this table is selected, the system prompts you to enter a contract telephone message code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the system displays the first of two Contract Telephone Messages screens. The first screen is used to define the message format and the second to enter or edit the message text.



Field Explanation

1. CODE (DISPLAY ONLY)
This field contains the code identifying the contract telephone message.

2. DESCRIPTION (30-C-R)
This field contains the description of the contract telephone message code. This field may be edited at any point.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is filed as deleted by you becomes inactive and be reactivated at any time. The system defaults this field to active when you create the code. Inactive messages are not displayed in any dash (-) lookup.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the established message you are editing. This field is blank if you are creating a new message.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the established message you are editing. This field is blank if you are creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum number of columns which can be used of this message. The entry range is 10-75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum number of lines the message can contain. The entry range is 1 to 18 lines; the default is 18.

When you complete and accept the first screen, the system displays the second Contract Telephone Messages screen.

```
               General Hospital Financial Table Maintenance Processor
                                                    Mon Jan 15, 1996 11:41 am
Contract Telephone Messages 12 - TELEPHONE MESSAGE
   1       2       3       4       5       6       7
12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345
| 01|GENERAL REMINDER PAYMENT HAS NOT BEEN RECEIVED.
| 02|
| 03|ATTEMPT TO GET A PAY DATE TO RECEIVE A CHECK.
| 04|
| 05|
| 06|
| 07|
| 08|
| 09|
| 10|
| 11|
| 12|
| 13|
| 14|
| 15|

F2     F3      F4    F5         F6           F7   F8      F9       F10
Delete Insert Center   Exit     Store Line    Restore Line Pack Preview DataBase Help
```

Field Explanations - Screen 2 of 2

Enter the message text on this screen using the format you defined on the first Contract Telephone Message processor screen. Pressing the **F4** key saves the message and exits the screen, completing the transaction. The contract telephone message is displayed in the collector workfile to assist the collector in making a collection call.

Upon leaving the Telephone Message Table processor, the system prompts you to print a report listing the entries. The sort option is by message code or alphabetic by description. Entries which are inactive can be include or ignored based on your preference. The report is spooled to FIN.

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

DATA CONTROL CODES

Data Control Codes are used in final bill preparation to identify the department responsible for supplying information used in preparing the bill. For example, the final diagnosis is required to produce a bill and Medical Records is responsible for supplying that information. The Failed Billing Requirements report includes the data control code and the absent data element causing the bill to fail edits. Data control codes are assigned to data elements that are set up as part of the Billing Requirements parameter. This table is not split by facility.

After this table is selected, the system prompts you to enter a data control code, (which can be up to three letters) or a hyphen (-) to display a list of valid codes.

NOTE: Data Control codes should correspond to STAR Patient Care department abbreviations to make identification of the responsible department easier on reports and screen displays.

You can enter the code or a hyphen (-) to display a list of valid codes. After the data control code is entered or selected, this screen is displayed.

```
       General Hospital Financial Table Maintenance Processor
                                                 Thu Apr 16, 1998 03:21 pm
Data Control Codes
 1 Code           2 Description                        3 Status
   ADM              ADMISSIONS                           Active
 4 Print on Failed Bill Require Rpt
   Yes
 5 Print on Failed Bill Req by Ctrl Cd Rpt    6 Include Accnts with $0 charges
   Yes                                          No
 7 Sort Seq on Failed Bill Req by Ctrl Cd Rpt
   Attending Physician, Biller Code Bill
 8 Edit by                                    9 Edit date
   Moore,Eugenia                                03/11/98 06:17pm









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the data control code.

2. DESCRIPTION (30-C-R)
This field contains the description of the data control code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

4. PRINT ON FAILED BILL REQUIRE RPT (1-A-R)
This field indicates whether billing errors associated with this data control code should print on the Failed Billing Requirements Report (FBR210). Entry options are Y for Yes and N for No. The default is N. If the items are excluded from the Failed Billing Requirements Report, they still appear as errors in the Biller Workfile and on the Failed Billing Requirements by Control Code Report (FBR220).

5. PRINT ON FAILED BILL REQ BY CTRL CODE RPT (1-A-R)
This field indicates whether billing errors associated with this data control code should print on the Failed Billing Requirements by Control Code Report (FBR220). Entry options are **Y** for Yes and **N** for No. The default is **Y**. If the items are excluded from the Failed Billing Requirements Report, they may still appear as errors in the Biller Workfile and on the Failed Billing Requirements Report (FBR210).

6. INCLUDE ACCTS WITH $0 CHARGES (1-A-R)
This field indicates whether to include accounts with $0.00 charges on the Failed Billing Requirements by Control Code Report (FBR220). Access to this field is valid only if the response in the Print on Failed Bill Req by Ctrl Cd Rpt is Y. When you access this field, the system displays the following prompt:

Include accts with $0.00 chgs on the Failed Bill Req by Ctrl Cd Rpt (FBR220)? Y/N -- [Yes]

The default is Yes. If you enter **Y** or press ENTER, accounts with zero charges within this data control code are included in the report. If you enter **N**, accounts within this data control code with zero charges are suppressed from printing.

7. SORT SEQUENCE ON FAILED BILLING REQ BY CTRL CD RPT (TABLE LOOKUP)
The sort sequence determines the order in which the information is printed on the Failed Billing Requirements by Control Code Report (FBR220). The report always lists all inpatients before outpatients, then is sorted by data control code. You can select up to three additional sub-sorts within each data control code. If no additional sorts are defined, the information for the data control code is sub-sorted by patient name. The following sub-sorts are available:

Attending Physician - The patient's attending physician
Biller Code Bill - The patient's primary biller
Carrier/Plan Code - The patient's primary insurance carrier/plan
Descending Acct Balance - The patient's account balance
Discharge Date - The patient's discharge date
Financial Class - The patient's financial class
Medical Records Number - The patient's medical record number
Medical Service - The patient's medical service
Patient Type - The patient's patient type
Registration Initials - The initials of the person who registered the account

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

9. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

Dependent On	Reference
	Billing Requirement Parameters

DENIAL/APPEAL PARAMETERS

This table provides the ability to set and/or display parameters relating to Denial and Appeal tracking at the facility level.

When this option is selected, the following screen is displayed:

```
          General Hospital Denial/Appeal Parameters Processor
                                                Mon Jun 23, 2003 02:22 pm


Denial Tracking
 1 Denial Method                        2 PCON Release
   Live with PCON                         8.0 with denial tracking


Appeal Tracking
 3 Appeal Tracking Status               4 Receivables Workstation Status
   Live                                   Installed

 5 Default Appeal Dollar Definition     6 Default Appeal Collector Group
   64 TEST 64                             1-COLLECTION GROUP









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

Field Explanations

1. DENIAL METHOD? (1-A-R))
This field displays the Denial Capture Method used for STAR Patient Accounting. Entry options for the field are **(D**) Do not capture denials, **(L)** Live with PCON or **(LW)** Live without PCON.

Initially, the field displays Do not capture denials. This setting allows users to build the denial tracking tables without turning on the denial capturing process in cash posting, adjustment posting, and balance transfer.

This field is dependent on the UB Active and the UB PCON Release fields. This field cannot be set to Live with PCON unless the UB Active field is set to Yes for the facility on the Pathways Contract Management Processor on the Reimbursement Processor and the UB PCON Release field on the Pathways Parameters Processor is set to release 8.0 or higher with the effective date matching or preceding the current date. A McKesson employee must update the field to Live with PCON.

After the tables are built, the setting of this field must be changed to either Live with PCON or Live without PCON in order for the denial capturing process to begin.

Only a McKesson employee can set this field to Live with PCON if the Pathways Contract Management Release is 8.0 or higher with the effective date of the release matching or preceding the current date. Once this field is set to Live with PCON, it cannot be changed to any other value.

A user can change the field from Do not capture denials to Live without PCON without McKesson intervention. Once this field is set to Live without PCON, it cannot be changed back to Do not capture denials. It can, however, be changed by a McKesson employee from Live without PCON to Live with PCON. This allows for the possibility of migrating from the Denial Management configuration without Pathways Contract Management to the configuration with Pathways Contract Management.

When Pathways Contract Management UB Is Not Active Or Is Active for Pathways Contract Management Release Less Than 8.0

If the Pathways Contract Management UB module is not active for this facility, a user accessing the Denial Method field for the first time receives the following prompt:

Do you want to begin capturing denials? Y/N [N]?

NOTE: The Reimbursement Master, Pathways Contract Management option contains the UB Active indicator for each facility. If UB Active is blank or set to No then the above prompt displays, and the PCON Release field displays "Not installed".

Entry options are **Y** for Yes and **N** for No. No is the default. No does not change the setting of this field. If you enter Yes, the following prompt displays:

Are you sure you want to begin capturing denials without PCON Y/N?

Entry options are **Y** for Yes and **N** for No. There is no default. Pressing the ENTER key or entering No leaves the field as Do not capture denials. Entering Yes changes the setting of this field to Live without PCON and the PCON Release field continues to display Not installed.

If the Pathways Contract Management UB module is active for this facility but Pathways Contract Management release 8.0 or greater is not being used, a user accessing the Denial Method field for the first time receives the following prompt:

Do you want to begin capturing denials? Y/N [N]?

NOTE: The Release field on the Pathways Parameters Interface screen contains the current release of Pathways Contract Management being used for UBs. The field also contains the effective date for Pathways Contract Management 8.0.

Entry options are **Y** for Yes and **N** for No. No is the default. No does not change the setting of this field. If you enter Yes, then the following prompt is displayed:

Are you sure you want to begin capturing denials without PCON Y/N?

Entry options are Y for Yes and N for No. There is no default. If you press ENTER or enter No, the field contains Do not capture denials. An entry of Yes changes the setting of this field to Live without PCON and the PCON Release field displays the current release of Pathways Contract Management along with the reminder "without denial tracking".

When Pathways Contract Management UB Is Active for Pathways Contract Management Release 8.0 or higher

A user accessing this field when the PCON UB Active indicator is set to Yes receives the following prompt:

Do you want to begin capturing denials with PCON Y/N [N]?

Entry options are **Y** for Yes and **N** for No. No is the default. No causes the following prompt to be displayed:

Do you want to begin capturing denials WITHOUT PCON Y/N [N]?

An entry of No does not change the setting of this field. An entry of Yes double-dares the user, and the following prompt is displayed:

You have PCON installed for this facility. Are you sure you want to capture denials without PCON? Only say Yes if you did not purchase PCON Denial Tracking! Y/N

Entry options are **Y** for Yes and **N** for No. There is no default. Pressing the ENTER key or entering No leaves the field as Do not capture denials. An entry of Yes changes the setting of this field to Live without PCON and the PCON Release field displays the current Pathways Contract Management release and the phrase "without denial tracking." For example: 8.0 without denial tracking.

A user accessing the Denial Capture Method field with the PCON UB module Active can respond Yes instead of No to the following prompt:

Do you want to begin capturing denials with PCON Y/N [N]?

If the entry is Yes, the following message is displayed:

Please contact your McKesson Representative to Go Live with Denial Capturing with PCON. You must be live with the 8.0 release of PCON and your facility must have purchased PCON Denial Tracking. Press Enter.

If you press ENTER, the setting of this field is unchanged.

If the person accessing this screen is a McKesson employee instead of a hospital employee, the following prompt is displayed:

McKesson employee, are you sure you want to "Go Live" with denial capturing with PCON? The customer must have purchased denial tracking with PCON. Your name will be recorded as the person who started this process so please set it correctly. Kindly respond Y/N.

Entry options are **Y** for Yes and **N** for No. There is no default. If you press ENTER or enter No, the field contains Do not capture denials. An entry of Yes changes the setting of this field to Live with PCON and the PCON Release field displays the release number with the phrase "with denial tracking." For example: 8.0 with denial tracking. Once this field is set to Live with PCON, it cannot be changed to any other setting.

2. PCON RELEASE (DISPLAY ONLY)

This field displays the Pathways Contract Management Release as displayed on the Pathways Parameter Interface screen in the UB PCON Release field. If denial tracking is not turned on, but a release of Pathways Contract Management is installed, the display shows, for example, “8.0 without denial tracking". If Pathways Contract Management is installed and denial tracking is turned on, the field displays "8.0 with denial tracking."

3. APPEAL TRACKING STATUS (1-A-O)

This field allows the user the ability to choose whether or not to track appeals, build tracking tables prior to going Live, or to go Live with Appeal tracking.

The following prompt is displayed:

Enter None(N), Build (B), or Live(L)

Entry options are **N** (None), **B** (Build), or **L** (Live). Entry of the None option suppresses the display of the appeal tracking fields in the Denial tracking payor table. The appeal tracking fields in the Insurance Follow-up and in the Insurance Follow-up Schedule Dollar Definition table cannot be updated for appeal tracking if this field is set to None.

The field displays the words None, Build, or Live, depending on the value entered. A value of L for Live is only accepted if the Denial Method field is set to Live with PCON or Live without PCON and the Receivables Workstation is installed.

A double-dare prompt is displayed when you set the value to Live.

Are you sure you want to Go Live with Appeal Tracking on the Receivables Workstation? Y/N

A user cannot change from Live to Build or Live to None. If this is attempted, the following prompt is displayed:

Please call McKesson if you wish to turn Appeal tracking to Off.

The reason for this is that the McKesson support analyst needs to evaluate if any accounts are in appeal follow-up or have been set to an appeal status of Pre-appeal and determine how to clean up those accounts prior to turning the system off.

The user cannot change from None to Live. When this is attempted, the following prompt is displayed:

Must be in Build Status prior to going Live!

The user can change from Build to None. Any information set up on the Payor table related to appeal tracking is not seen once the parameter has been turned off. On appeal insurance follow-up schedules or the Insurance Follow-up Schedule Dollar Definition table, the appeal fields still are set for appeal tracking if these have been built by the user but are not assigned to any accounts.

4. RECEIVABLES WORKSTATION STATUS (DISPLAY ONLY)
This field indicates if the Receivables Workstation is installed. The field displays either Installed or Not Installed.

5. DEFAULT APPEAL DOLLAR DEFINITION (3-AN-R)
This field contains the default insurance follow-up dollar definition code and description. The insurance follow-up schedule dollar definition defines which appeal follow-up schedule is assigned to claims that have been manually appealed and the appeal dollar definition cannot be determined from the payor table. This field must be populated before going live with Appeal Tracking.

The following prompt is displayed:

Enter Insurance F/U Schedule Appeal Dollar Definition or `-` for list

6. DEFAULT APPEAL COLLECTION GROUP (3-AN-R)
This field displays the pre-defined collection group that has been set up in the collection group table for accounts that are appealed. This collection group is automatically assigned to any account that is manually appealed, and the appeal collection group cannot be determined from the payor table. This field must be populated prior to going Live with Appeal Tracking.

The following prompt is displayed when the field is accessed:

Enter Appeal Collector Group or `-` for list--

DENIAL TRACKING - INSURANCE/CARRIER PLAN

This function is used to associate a denial tracking payor group with the insurance carrier/plan.

After this option is selected, the system prompts you to select the facility for which the fields are defined or updated. The following screen is displayed:

```
                General Hospital Denial Tracking Processor
              Insurance Plan                    Tues Jun 24, 2003 11:35 am
Carrier:AARP TYPE INSURANCE                     Facility :Model Hospital A
Plan   :GET A PLAN PLAN (AARP)                  Effective:Current

 1 Denial Tracking Payor Code          2 Denial Tracking Reason Group
->
 3 Edit by                             4 Edit date
   Rogers, Amy                           06/24/03 11:09
```

Field Explanations

1. DENIAL TRACKING PAYOR CODE (4-AN-R)
This field is used to establish the link between the insurance plan and denial management. If this field is not defined, denials are not captured for this insurance carrier/plan. When the field is accessed, the Denial Tracking Payor Table is displayed. Select the Denial Tracking Payor Code for the insurance plan.

2. DENIAL TRACKING REASON GROUP (DISPLAY ONLY)
This field displays the name of the reason code group that is used for this insurance carrier/plan. The denial tracking reason group that is displayed is the one associated with the Denial Tracking Payor Code defined in the Denial Tracking Payor Code field. The reason group contains the denial code set associated with this insurance/carrier plan.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this code was last edited.

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

DENIAL TRACKING NORMALIZED REASON CODE TABLE

The Denial Tracking Normalized Code Table allows you to establish an overall list of normalized codes that cross all payors. These codes are used to identify the highest priority denial reasons for tracking.

After this table is selected, the system prompts you to enter a denial tracking normalized reason code or a hyphen (-) to display a list of valid codes.

After the code is entered or selected, the following screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                  Fri Apr 25, 2003 02:09 pm
Denial Tracking Normalized Reason Code
 1 Code           2 Description                        3 Status
   HCPC             HCPCS CODE MISSING                   Active
 4 PCON Normalized Code
   HCPCS00001
 5 Edit by                                             6 Edit date
   New, Nancy                                          03/17/03 11:12am









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

Field Explanations

1. CODE (4-AN-R)
Enter the code for the table.

2. DESCRIPTION (40-A-R)
Enter the description of the normalized reason code.

3. STATUS (DISPLAY ONLY)
This field describes the status of the entry, either active, or filed as deleted.

4. PCON NORMALIZED CODE (10-A/N-R)
This field contains a code that is used on Pathways Contract Management to summarize denials into normalized groups. The PCON Normalized code in this field should match the PCON Normalized code contained in the PCON Normalized Denial Reason Code Maintenance table on Pathways Contract Management. For example, if STAR normalized code is 600 and the corresponding normalized code on Pathways Contract Management is 600MEDNEC, the value in this field should be 600MEDNEC.

5. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

6. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

DENIAL TRACKING ROOT CAUSE CODE TABLE

The Denial Tracking Root Cause Code table allows users to define a code and a description for the root cause of a claim denial. The denial root cause is intended to be a specific reason why a claim was denied. This table is shared with the Pathways Contract Management Denial and Appeal Analysis Module.

This table is not split by facility. After this table is selected, the system prompts you to enter a denial tracking root cause code, (which can be up to four alphanumeric characters) or a hyphen (-) to display a list of valid codes.

After the code is entered or selected, the following screen is displayed.

```
          General Hospital Financial Table Maintenance Processor
                                                 Fri Apr 25, 2003 10:28 am

Denial Tracking Root Cause
 1 Code          2 Description                          3 Status
   NCOV            NON COVERED SERVICE                    Active
 4 Edit by                                              5 Edit date
   New, Nancy                                             04/25/03 10:27am









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

Field Explanations

1. CODE (4-AN-R)
Enter the denial root cause code.

2. DESCRIPTION (36-AN-R)
This field contains a description of the denial root cause. When this field is accessed, the system displays the following prompt:

Enter description --

The description is intended to be a very specific reason why the claim was denied.

3. STATUS (DISPLAY ONLY)
This field describes the status of the entry, either active, or filed as deleted.

4. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

5. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

After accepting the screen, the entry is filed, and you can request a printed listing.

DENIAL TRACKING REASON GROUPS TABLE

The Denial Tracking Reason Groups table allows you to define payor reason groups and to define within each group a payor-specific set of denial reason codes for denial tracking. A normalized reason, a root cause, denial type, and a priority are to be defined for each payor-specific reason code. If the Type of Reason Codes for Group field is set to CAS, then you must define the additional field called Electronic RA Claim Adj groups.

After this table is selected, the following prompt is displayed:

Enter Denial Tracking Reason Group code or `-` for a list --

Enter a code, and the following prompt is displayed:

Add Denial Tracking Reason Group Code XX? (Y/N)--

Enter Yes, and the Denial Tracking Reason Group table is displayed with the Reason Group Code you entered:

```
          General Hospital Financial Table Maintenance Processor
                                              Thu Sep 15, 2005 09:30 am

 1 Reason Group Code    2 Reason Group Description           3 Status
   26                     NEW CODE                             Active
 4 Type of Reason Codes for Group      5 ERA Payment File Definition Override
   CAS Codes
 6 Edit by                                                 7 Edit date
   New, Nany                                                 05/22/03 03:54pm
 8 Current Reason Codes/Description         Denial Type    Priority  Active


       1 Deductible Amount                          C            49       Yes
     123 PAYER REFUND DUE TO OVERPAYMNT             C             3       Yes
      45 CHARGES EXCEED FEE ARRANGEMENT             O             1       Yes
      55 SVC DENIED/EXPERIMENTAL PROC               A             3       Yes
      93 No Claim Level Adjustments                               1       Yes
      A2 CONTRACTUAL ADJUSTMENT                     O             1       Yes

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

Field Explanations

1. REASON GROUP CODE (4-AN-R)
Enter the reason group code that was selected or entered.

2. REASON GROUP DESCRIPTION (29-AN-R)
This field contains a description of the reason group code. When this field is accessed, the system displays the following prompt:

Enter description --

3. STATUS (DISPLAY ONLY)
This field describes the status of the entry, either active, or filed as deleted.

4. TYPE OF REASON CODES FOR GROUP (1-A-R)
This field contains the type of reason code for the group, either CAS or Non-CAS. When this field is accessed, the following prompt is displayed;

Are these CAS Reason Codes (Y/N)--

Entry options are **Y** for Yes or **N** for No. If you answer Yes, the system displays **CAS Codes** in the field. If you answer No, the system displays **Non-CAS Codes** in the field.

5. ERA PAYMENT FILE DEFINITION OVERRIDE (4-AN-O)
If an ERA Payment File Definition code is indicated in this field, the PFD Reason Codes provide the basis for the Denial Tracking Reason Groups Reason Codes rather than the ERA CAS Reason Codes. When this field is accessed, the following prompt is displayed:

Enter ERA PFD code or `-` for table lookup if you want to use a PFD Reason Code Tbl rather than the ERA CAS Reason Code Tbl for the Den Tracking Rsn Grp--

You can enter the code or a hyphen (-) to look up the table. If an ERA PFD code is keyed or selected, and an ERA CAS Reason Codes Table has not been indicated on screen two of the ERA Payment File, the following error message is displayed:

PFD Reason Codes Table does not exist for ERA PFD code xx!

The denial reason codes available for use are determined from the Denial Tracking Payor and associated Denial Tracking Reason Group. The Denial Tracking Payor is determined from the insurance plan.

If CAS codes are used for denial reason codes and a PFD Reason Codes table serves as the basis for the denial reason codes, the PFD Clm Adj Grp table is used to select and verify Claim Adj Groups.

6. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

7. EDIT DATE (DISPLAY ONLY)
This field displays the date the table was last changed.

8. CURRENT REASON CODES/DESCRIPTION (1-A-R)
Enter the reason code and description.

After entering the required fields, the system displays the following prompt:

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

- If you enter Yes at the prompt, the system displays a message that the screen has been filed, which indicates the code was saved. Next, enter the reason codes and their associated codes. The system displays the following prompt:

  Add reason codes for XXXX? (Y/N) [Y]

  XXXX represents the 4-character, alphanumeric Reason Group Code.

  - Enter Yes to define reason codes.

    - For Non-CAS denial reason codes, the prompt displays:

      Enter Denial Reason Code or `-` for a list-

      Enter a payor specific reason code or enter a hyphen (-) to display a list. If the denial reason group selected has never had any reason codes associated to it, there are no codes to be displayed in the list. Codes for Non-CAS denial reason groups are manually added; there is not a pre-defined table to select from like the CAS reason codes.

    - For CAS denial reason codes, the following prompt is displayed:

      Enter CAS Reason Code or `-` for a list--

      Enter a payor specific reason code or enter a dash to display a list. The list that displays are the codes included in the ERA CAS Reason Code table. To add a code that does not exist in the ERA CAS Reason Code table, enter the code and the system displays a prompt to add the code to the group.

  After you enter a code to be added as a payor-specific denial reason code, the system displays the following prompt:

  - For Non-CAS:

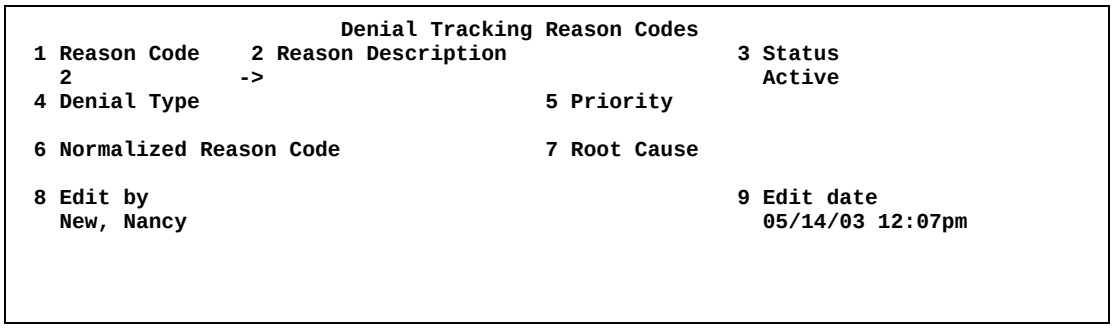
    Add Denial Tracking Reason Code XXXX? (Y/N)--

  - For CAS:

    Add Denial Tracking CAS Reason Code XXXX? (Y/N)--

  Enter **Y** to add the code. The Denial Tracking Reason Code screen displays on the bottom half of the screen with the associated Denial Tracking Reason Group Code

on the top half of the screen. For an ERA CAS reason code, the screen is different, as shown under "ERA CAS Reason Codes" on page 1-95.



Field Explanations

1. REASON CODE (TABLE LOOKUP-R)
This field contains the denial reason code.

2. REASON DESCRIPTION (29-AN-R)
This field contains the description of the reason group code.

3. STATUS (DISPLAY ONLY)
This field describes the status of the entry, either active, or filed as deleted.

4. DENIAL TYPE (1-A-R)
When this field is accessed, the following prompt is displayed:

Enter (C)linical, (A)dministrative, or (O)ther denial type--

5. PRIORITY (2-N-R)
This field contains the denial tracking reason priority.

6. NORMALIZED REASON CODE (TABLE LOOKUP-R)
This field contains the normalized reason code that is used in the Pathways Contract Management Denial and Appeals Analysis to summarize denials into normalized groups.

7. ROOT CAUSE (TABLE LOOKUP-R)
This field contains the denial root cause, which is a specific reason why a claim was denied.

8. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

9. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

ERA CAS Reason Codes

For ERA CAS Reason Codes, the following screen is displayed:

```
                    Denial Tracking CAS Reason Codes
 1 ERA CAS Reason Code                2 ERA CAS Reason Description
   1                                    Deductible Amount
 3 Status                             4 Electronic RA Claim Adj Groups
   Active                            ->
 5 Denial Type                        6 Priority

 7 Normalized Reason Code             8 Root Cause

 9 Edit by                                          10 Edit date
   New, Nancy                                          05/13/03 10:52am
Enter Electronic RA Claim Adj Group or `-` to select one or more from list
```

Field Explanations

1. ERA CAS REASON CODE (3-N-R)
Enter the ERA CAS Reason Code.

2. ERA CAS REASON CODE DESCRIPTION (29-AN-R)
Enter the description of the reason code.

3. STATUS (DISPLAY ONLY)
This field describes the status of the entry, either active, or filed as deleted.

4. ELECTRONIC RA CLAIM ADJ GROUPS (3-N-R)
Enter the Electronic RA Claim Adjustment Groups associated with this ERA CAS Reason Code. When this field is accessed, the following prompt is displayed:

Enter Electronic RA Claim Adj Group or '-' to select one or more from the list.

5. DENIAL TYPE (1-A-R)
When this field is accessed, the following prompt is displayed:

Enter (C)linical, (A)dministrative, or (O)ther denial type--

Entry options are C (Clinical), A (Administrative) or O (Other).

6. PRIORITY (2-N-R)
Enter the denial tracking reason priority.

7. NORMALIZED REASON CODE (3-N-R)
Enter the normalized reason code that is used on Pathways Contract Management Denial and Appeals Analysis to summarize denials into normalized groups.

8. ROOT CAUSE (3-N-R)
Enter the denial root cause, which is a specific reason why a claim was denied.

9. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

10. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

When the required fields are completed on the screen, the system displays the following prompt:

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

- To accept the screen and enter another Denial Tracking Reason Code, enter **Y** for Yes.
- To accept the screen and exit from the function, press ENTER until the following prompt is displayed:

  Do you want a printed list sorted by (C)ode, (D)escription, (P)riority,

  (N)ormalized Code, or (R)oot Cause?--

A table listing report is generated and sorted according to the selected option.

DENIAL TRACKING PAYOR TABLE

The Denial Tracking Payor Table allows users to:

- Establish default denial tracking minimum values to be used for the automatic denial and appeal tracking process and to define which denial reason codes (835 ERA or a payor-specific code set) are to be used for the payor.

- Add criteria for tracking underpayments and overpayments through the Denial Tracking Interface. For example, if a claim was included in an ERA file and it didn't have any associated denial reason codes that qualified it for denial tracking in Denials Management but it qualifies as an underpayment or overpayment, the system allows you to direct the claim to Denials Management by associating a payment tracking reason code for underpayments or overpayments. The system uses the payment tracking reason code that is associated with the claim and if the payment tracking reason code is a valid code in the associated denial tracking reason group table, it tracks the claim as an underpayment or overpayment through Denials Management. The system uses the underpayment or overpayment amount as the denial amount to determine if the claim qualifies for an appeal.

  The Payment Tracking parameters are used when a claim is marked as an underpayment or overpayment through the Claim Disposition Rules table. If the Payment Tracking parameters are defined the hospital can have underpayments and overpayments tracked on the Receivables Workstation and sent to Pathways Contract Management. In addition, payment variances can be routed to a particular collector/collector group on the Receivables Workstation.

Two separate screens are available for the Denial Tracking Payor Table:

- One set is used when Receivables Workstation is not used for Appeal Tracking

- One set is used when Receivables Workstation is used for Appeal Tracking; therefore Appeal Tracking cannot be live on STAR Patient Accounting.

The screen set that displays is controlled by whether or not the Receivables Workstation is installed for the customer and also by the setting of the Appeal Tracking Status field on the Denial/Appeal Parameters screen.

The first screen described in each of the following sections is displayed when the Receivables Workstation is installed and the Appeal Tracking Status field is set to either Build or Live.

The second screen described in each of the following sections is displayed when the Receivables Workstation is not installed, or when the Receivables Workstation is installed and the Appeal Tracking Status field is set to None.

After this table is selected, the system prompts you to enter a denial tracking code. You can enter the two-character code or a hyphen (-) to display a list of existing denial tracking codes. When a code is entered, one of two screens may be displayed. The first screen is displayed if Receivables Workstation with Appeal Tracking is being used. used. The second screen is displayed if Receivables Workstation with Appeal Tracking is not being used.

The initial screen with Receivables Workstation Appeal Tracking is as follows:

```
          General Hospital Financial Table Maintenance Processor
                                                 Mon Apr 28, 2003 10:21 am
Denial Tracking Payors
 1 Code           2 Description                        3 Status
   1234             ERA PAYOR                            Active
 4 Capture Denials                                5 Denial Tracking Reason Group
   Yes                                               1-NON-ERA
                          Denial Default Values
 6 Reason Code                               7 Electronic RA Claim Adj Group Code
   99 Beginning Code

                       Appeal Tracking Assignment Values

 8 Appeal Definition                          9 Appeal Collector Group
   3 MEDICAID SCHEDULE (IFDD)                   33-TEST GROUP
10 Inpatient auto-appeal minimum             11 Outpatient auto-appeal minimum
   101.00                                       250.00
12 Inpatient pre-appeal minimum              13 Outpatient pre-appeal minimum
   5,300.00                                     400.00

14 Edit by                                   15 Edit date
   New, Nancy                                   04/28/03 10:00am
```

The initial screen without Receivables Workstation Appeal Tracking is as follows:

```
          General Hospital Financial Table Maintenance Processor
                                                 Mon Apr 28, 2003 10:21 am
Denial Tracking Payors
 1 Code           2 Description                        3 Status
   1234             ERA PAYOR                            Active
 4 Capture Denials                                5 Denial Tracking Reason Group
   Yes                                               1-NON-ERA

                               Default Values
 6 Reason Code                               7 Electronic RA Claim Adj Group Code
   99 Beginning Code
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the Denial Tracking Payor Code entered or selected on the previous screen.

2. DESCRIPTION (30-A-R)
Enter a description of the Denial Tracking Payor.

3. STATUS (DISPLAY ONLY)
This field describes the status of the entry, either active, or filed as deleted.

4. CAPTURE DENIALS (1-A-R)
This field allows you to define whether or not to capture denials for this Denial Tracking Payor. When this field is accessed, the following prompt is displayed:

Do you want to capture denials for this payor? (Y/N)--

If you enter **Y** for Yes, the STAR Patient Accounting cash and adjustment posting processes capture and retain denial information. If you enter **N** for No, STAR Patient Accounting cash and adjustment posting processes do not capture and retain denial information for this payor, but you may still establish a reason code or patient type exception.

If you enter Yes, all of the remaining fields on the screen are required. If you enter No, access is not allowed to any of the remaining fields except for the Denial Tracking Reason Group field, which is required. You can enter exceptions by Reason Code, Patient Type, or by Reason Code within Patient Type.

5. DENIAL TRACKING REASON GROUP (4-AN-R)
This field defines the payor-specific denial tracking reason group, which includes the payor-specific set of denial tracking reason codes that are used in cash posting to record the reason a payment is denied. The Denial Tracking Reason Group, which is defined in a separate table, is either an Electronic Remittance Advice type or a Non-Electronic Remittance type. An Electronic Remittance Advice type of Denial Tracking Reason Group uses the standard Electronic Remittance Advice CAS Reason Codes as the basis for the denial tracking reason codes used in insurance cash posting. A Non-Electronic Remittance Advice type of Denial Tracking Reason Group uses a payor-specific set of reason codes as the denial tracking reason code set.

This field can only be updated at the time the payor is defined.

Denial Default Values—The following fields are conditionally required. If the Capture Denials field is set to Yes, all of the default value fields are required. If the Capture Denials field is set to No, none of the default value fields are required.

6. REASON CODE (4-AN-R)
This field is the default denial tracking reason used for a denial if a denial tracking reason is not assigned for any reason. When the field is accessed, the following prompt is displayed:

Enter Default Reason Code from Reason Group XXXXXXX (9999) or '-' for a list.

7. ELECTRONIC RA CLAIM ADJ GROUP CODE (DISPLAY ONLY)
This field is the default denial tracking claim adjustment reason group used for ERA-based denials if a denial tracking claim adjustment reason group is not assigned for any reason. This field is accessible only if the Denial Tracking Reason Group for this Denial Tracking Payor is an ERA type of Reason Group. The user can select the claim adjustment group from a table of valid values. If the type of denial tracking reason group is non-ERA based, the field remains blank and cannot be accessed.

NOTE: The Claim Adjustment Group Code field in the denial record of the Pathways Contract Management activity file interface is populated with the value 'NE' for non-ERA reason groups instead of leaving the field blank.

8. APPEAL DOLLAR DEFINITION (4-AN-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the Insurance Follow-up Schedule Dollar Definition to be used for this payor. The user can select the Insurance Follow-up Schedule Dollar Definition from a table of valid values.

9. APPEAL COLLECTOR GROUP (2-N -C)
If using Receivables Workstation with Appeal Tracking, this field allows the entry of the collector group controlling the collector assignment of appeals and pre-appeals in Receivables Workstation. The following prompt is displayed:

Enter table code-- |

You can select the Appeal Collector Group from a table of valid values.

10. INPATIENT AUTO-APPEAL MINIMUM (9-N-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes a denied insurance payment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation.

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal—

The inpatient auto-appeal minimum must be greater than the inpatient pre-appeal minimum. This value may be set to No even if a dollar amount is specified already in the inpatient pre-appeal minimum.

11. OUTPATIENT AUTO-APPEAL MINIMUM (9-N–C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes a denied insurance payment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation. The following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

The outpatient auto-appeal minimum must be greater than the outpatient pre-appeal minimum. This value may be set to No even if a dollar amount is already specified in the Outpatient Pre-appeal Minimum field.

12. INPATIENT PRE-APPEAL MINIMUM (9-N-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes a denied insurance payment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Pre-appeals

are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal—

The inpatient pre-appeal minimum must be less than the inpatient auto-appeal minimum. This value may also be set to No, regardless of the setting of the dollar amount in the Inpatient Auto-appeal Minimum field.

13. OUTPATIENT PRE-APPEAL MINIMUM (9-N–C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes a denied insurance payment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal—

The outpatient pre-appeal minimum must be less than the outpatient auto-appeal minimum. This field can also be set to No, regardless of the setting of the dollar amount in the Outpatient Auto-appeal Minimum field.

14. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

15. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

After you accept the screen, the Payment Tracking screen is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                  Wed Jul 09, 2008 09:42 am
Payor UD1 Payment Tracking
Underpayment      1 Payment Tracking Reason Code         2 Elec RA Clm Adj Grp
                    45 CHARGES EXCEED FEE ARRANGEMENT
 3 Appeal Dollar Definition             4 Appeal Collector Group
   65 FAC B DEFAULT DOLLAR DEFINITION     61-COLLECTOR 6 ONLY (FOCUS INS)
 5 Inpatient auto-appeal minimum        6 Outpatient auto-appeal minimum
   500.00                                 250.00
 7 Inpatient pre-appeal minimum         8 Outpatient pre-appeal minimum
   215.00                                 65.00
Overpayment                             9 Copy from Underpayment
                                          No
10 Payment Tracking Reason Code        11 Elec RA Clm Adj Grp
   45 CHARGES EXCEED FEE ARRANGEMENT
12 Appeal Dollar Definition            13 Appeal Collector Group
   ABC JULIE'S APPEAL DOLLAR DEF          98-PMK APPEAL COLLECTOR GROUP
14 Inpatient auto-appeal minimum       15 Outpatient auto-appeal minimum
   500.00                                 250.00
16 Inpatient pre-appeal minimum        17 Outpatient pre-appeal minimum
   215.00                                 65.00

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

Field Explanations

1. PAYMENT TRACKING REASON CODE (4-AN-R)

This field contains the payment tracking reason code used to track a claim through the Denial Tracking Interface if the claim qualifies as an underpayment. A claim qualifies as an underpayment according to the criteria on the Claim Disposition Rules table. If a claim qualifies as an underpayment, but a payment tracking reason code is not defined, the system does not track the underpayment through the denial tracking interface. If a claim qualifies as an underpayment and has both a payment tracking code and denial tracking reason codes associated with it the system will use the denial tracking reason code(s) to track the denial and underpayment. If the denial tracking codes associated with a claim are not valid for denial tracking then the system will use the payment tracking reason code if it is defined to track the underpayment. When the field is accessed, the following prompt is displayed:

Enter Default Reason Code from Reason Group XXXXXXX (9999) or '-' for a list.

2. ELECTRONIC RA CLAIM ADJ GROUP CODE (DISPLAY ONLY)

This field contains the denial tracking claim adjustment reason group used for ERA based Denials. The system prompts for this field automatically after the Payment Tracking Reason Code field is updated. The system displays a list of adjustment groups payment tracking reason codes, and you can select one from the list. Valid values for this field are dependent on the claim adjustment group code values in the denial tracking reason group table for the reason code selected in field the Payment Tracking Reason code field. This field is accessible only if the Denial Tracking Reason Group for this Denial Tracking Payor is an ERA type of Reason Group. If the type of

denial tracking reason group is non-ERA based, the field remains blank and cannot be accessed.

3. APPEAL DOLLAR DEFINITION (4-AN-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the Insurance Follow-up Schedule Dollar Definition to be used for this payor for tracking underpayments. You can select the Insurance Follow-up Schedule Dollar Definition from a table of valid values. This field controls which Appeal Follow-Up schedule is assigned according to the Appeal Dollar Definition selected.

When the field is accessed the following prompt is displayed:

Enter Insurance F/U Schedule Appeal Dollar Definition or `-` for list--

4. APPEAL COLLECTOR GROUP (2-N -C)
If using Receivables Workstation with Appeal Tracking, this field allows the entry of the collector group controlling the collector assignment of appeals and pre-appeals in Receivables Workstation for underpayments. The following prompt is displayed:

Enter table code-- |

You can select the Appeal Collector Group from a table of valid values.

5. INPATIENT AUTO-APPEAL MINIMUM (9-N-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an underpayment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation.

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal—

The inpatient auto-appeal minimum must be greater than the inpatient pre-appeal minimum. This value may be set to No even if a dollar amount is specified already in the inpatient pre-appeal minimum.

6. OUTPATIENT AUTO-APPEAL MINIMUM (9-N–C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an underpayment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation. The following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

The outpatient auto-appeal minimum must be greater than the outpatient pre-appeal minimum. This value may be set to No even if a dollar amount is already specified in the Outpatient Pre-appeal Minimum field.

7. INPATIENT PRE-APPEAL MINIMUM (9-N-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an underpayment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Claims with a pre-appeal status can be selected by using the focus claim process on the RWS and placed in a focus claim worklist. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal—

The inpatient pre-appeal minimum must be less than the inpatient auto-appeal minimum. This value may also be set to No, regardless of the setting of the dollar amount in the Inpatient Auto-appeal Minimum field.

8. OUTPATIENT PRE-APPEAL MINIMUM (9-N–C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an underpayment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal—

The outpatient pre-appeal minimum must be less than the outpatient auto-appeal minimum. This field can also be set to No, regardless of the setting of the dollar amount in the Outpatient Auto-appeal Minimum field.

9. COPY FROM UNDERPAYMENT (1-A-O)
This field allows you to copy all of the parameters defined for Underpayments to Overpayments. The copy functions copies the fields to the lower part of the screen, and you can edit as needed. After the copy is completed, the two portions of the screen continue to be maintained separately. When this field is accessed, the following prompt is displayed:

Do you want to copy Overpayment Information from the current Underpayment Information? (Y/N)-- |

10. PAYMENT TRACKING REASON CODE (4-AN-R)
If you use Receivables Workstation with Appeal Tracking, this field contains the payment tracking reason code used to track a claim through the Denial Tracking Interface if the claim qualifies as an overrpayment. A claim qualifies as an overpayment according to the criteria on the Claim Disposition Rules table. If a claim qualifies as an underpayment, but a payment tracking reason code is not defined, the system does not track the underpayment through the denial tracking interface. If a claim qualifies as an underpayment and has both a payment tracking code and denial tracking reason codes associated with it the system will use the denial tracking reason

code(s) to track the denial and overpayment. If the denial tracking codes associated with a claim are not valid for denial tracking then the system will use the payment tracking reason code if it is defined to track the underpayment. When the field is accessed, the following prompt is displayed:

Enter Default Reason Code from Reason Group XXXXXXX (9999) or '-' for a list.

11. ELECTRONIC RA CLAIM ADJ GROUP CODE (DISPLAY ONLY)
If you use Receivables Workstation with Appeal Tracking, this field contains the denial tracking claim adjustment reason group used for ERA based Denials. The system prompts for this field automatically after the Payment Tracking Reason Code field is updated. The system displays a list of adjustment groups payment tracking reason codes, and you can select one from the list. Valid values for this field are dependent on the claim adjustment group code values in the denial tracking reason group table for the reason code selected in field the Payment Tracking Reason code field. This field is accessible only if the Denial Tracking Reason Group for this Denial Tracking Payor is an ERA type of Reason Group. If the type of denial tracking reason group is non-ERA based, the field remains blank and cannot be accessed.

12. APPEAL DOLLAR DEFINITION (4-AN-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the Insurance Follow-up Schedule Dollar Definition to be used for this payor for tracking overpayments. You can select the Insurance Follow-up Schedule Dollar Definition from a table of valid values. This field controls which Appeal Follow-Up schedule is assigned according to the Appeal Dollar Definition selected.

When the field is accessed the following prompt is displayed:

Enter Insurance F/U Schedule Appeal Dollar Definition or `-` for list--

13. APPEAL COLLECTOR GROUP (2-N -C)
If using Receivables Workstation with Appeal Tracking, this field allows the entry of the collector group controlling the collector assignment of appeals and pre-appeals in Receivables Workstation for overpayments. The following prompt is displayed:

Enter table code-- |

You can select the Appeal Collector Group from a table of valid values.

14. INPATIENT AUTO-APPEAL MINIMUM (9-N-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an overpayment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation.

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal—

The inpatient auto-appeal minimum must be greater than the inpatient pre-appeal minimum. This value may be set to No even if a dollar amount is specified already in the inpatient pre-appeal minimum.

15. OUTPATIENT AUTO-APPEAL MINIMUM (9-N–C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an overpayment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation. The following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

The outpatient auto-appeal minimum must be greater than the outpatient pre-appeal minimum. This value may be set to No even if a dollar amount is already specified in the Outpatient Pre-appeal Minimum field.

16. INPATIENT PRE-APPEAL MINIMUM (9-N-C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an overpayment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Claims with a pre-appeal status can be selected by using the focus claim process on the RWS and placed in a focus claim worklist. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal—

The inpatient pre-appeal minimum must be less than the inpatient auto-appeal minimum. This value may also be set to No, regardless of the setting of the dollar amount in the Inpatient Auto-appeal Minimum field.

17. OUTPATIENT PRE-APPEAL MINIMUM (9-N–C)
If you use Receivables Workstation with Appeal Tracking, this field allows the entry of the minimum dollar amount that causes an overpayment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal—

The outpatient pre-appeal minimum must be less than the outpatient auto-appeal minimum. This field can also be set to No, regardless of the setting of the dollar amount in the Outpatient Auto-appeal Minimum field.

After you accept the screen, you can enter reason code exceptions. The system displays the following prompt:

Do you want to enter Reason Code exceptions for payor XXXX? (Y/N) [N]--

If Yes is entered, you are prompted to select a facility and enter one reason code. After either adding a reason code exception or choosing one from the table, one of two screens is displayed. The first screen is displayed if Receivables Workstation with Appeal Tracking is used. The second screen is displayed if Receivables Workstation with Appeal Tracking is not used:

The following screen is the reason code exceptions with Receivables Workstation Appeal Tracking.

```
              General Hospital Financial Table Maintenance Processor
                                                  Wed Jul 02, 2008 12:08 pm

Payor 9999 Facility A Reason Code Exception COA2
 1 Capture Denials                       2 Denial Tracking Reason Group
   Yes                                     PMK2-PMK TEST FOR ERA

                           Denial Default Values
 3 Reason Code                           4 Electronic RA Claim Adj Group Code
   A2 Contractual Adjustment               CO

                       Appeal Tracking Assignment Values
 5 Appeal Dollar Definition              6 Appeal Collector Group
->
 7 Inpatient auto-appeal minimum         8 Outpatient auto-appeal minimum

 9 Inpatient pre-appeal minimum         10 Outpatient pre-appeal minimum


11 Status   12 Edit by                                    13 Edit date
               New, Nancy                                   07/02/08 12:08pm

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

The following screen is the reason code exceptions without the Receivables Workstation Appeal Tracking:

```
          General Hospital Financial Table Maintenance Processor
                                                  Wed Apr 30, 2003 09:49 am
Payor 1234 Facility A Reason Code Exception 99
 1 Capture Denials                        2 Denial Tracking Reason Group
   No                                       1-NON-ERA

                               Default Values
 3 Reason Code                          4 Electronic RA Claim Adj Group Code
   99 TEST CODE 99
 5 Status   6 Edit by                                    7 Edit date
              More, Tom                                    01/23/03 05:30pm
```

Field Explanations

1. CAPTURE DENIALS (1-A-R)
This field allows you to define whether or not to track denials for this exception. When this field is accessed, the following prompt is displayed:

Do you want to capture denials for this exception? (Y/N)--

2. DENIAL TRACKING REASON GROUP (4-AN-R)
This field defines the payor-specific denial tracking reason group, which includes the payor-specific set of denial tracking reason codes that are used in cash posting to record the reason a payment is denied. The Denial Tracking Reason Group, which is defined in a separate table, is either an Electronic Remittance Advice type or a Non-Electronic Remittance type. An Electronic Remittance Advice type of Denial Tracking Reason Group uses the standard Electronic Remittance Advice CAS Reason Codes as the basis for the denial tracking reason codes used in insurance cash posting. A Non-Electronic Remittance Advice type of Denial Tracking Reason Group uses a payor-specific set of reason codes as the denial tracking reason code set.

3. REASON CODE (4-AN-R)
This field is the default denial tracking reason used for a denial if a denial tracking reason is not assigned for any reason. When the field is accessed, the following prompt is displayed:

Pick Default Reason Code from Reason Group XXXXXXX (9999)

4. ELECTRONIC RA CLAIM ADJ GROUP CODE (4-AN-R)
This field is the default denial tracking claim adjustment reason group used for a denial if a denial tracking claim adjustment reason group is not assigned for any reason. This field is accessible only if the Denial Tracking Reason Group for this Denial Tracking Payor is an Electronic Remittance Advice-type of Reason Group. The user can select the claim adjustment group from a table of valid values.

5. DOLLAR DEFINITION (3-AN-R)
This field contains the Insurance Follow-up Schedule Dollar Definition to be used for this payor. You can select the Insurance Follow-up Schedule Dollar Definition from a table of valid values.

6. APPEAL COLLECTOR GROUP
This field contains the collector group controlling the collector assignment of appeals and pre-appeals in Receivables Workstation. You can select the Appeal Collector Group from a table of valid values.

7. INPATIENT AUTO-APPEAL MINIMUM (7-AN-R)
This field contains the minimum dollar amount that causes a denied insurance payment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes, and are placed in an appeal worklist on Receivables Workstation. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

The value in this field must be greater than the value in the Inpatient Pre-Appeal Minimum field.

8. OUTPATIENT AUTO-APPEAL MINIMUM (7-AN-R)
This field contains the minimum dollar amount that causes a denied insurance payment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes, and are placed in an appeal worklist on Receivables Workstation. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

Enter a value in this field that is greater than the value in the Outpatient Pre-Appeal Minimum field.

9. INPATIENT PRE-APPEAL MINIMUM (7-AN-O)
This field contains the minimum dollar amount that causes a denied insurance payment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal-

The value in this field must be less than the value in the Inpatient Pre-Appeal Minimum field.

10. OUTPATIENT PRE-APPEAL MINIMUM (7-AN-O)
This field contains the minimum dollar amount that causes a denied insurance payment to be automatically placed in a pre-appeal worklist on STAR Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment.

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal-

The value in this field must be less than the value in the Outpatient Pre-Appeal Minimum field.

11. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when the code is created.

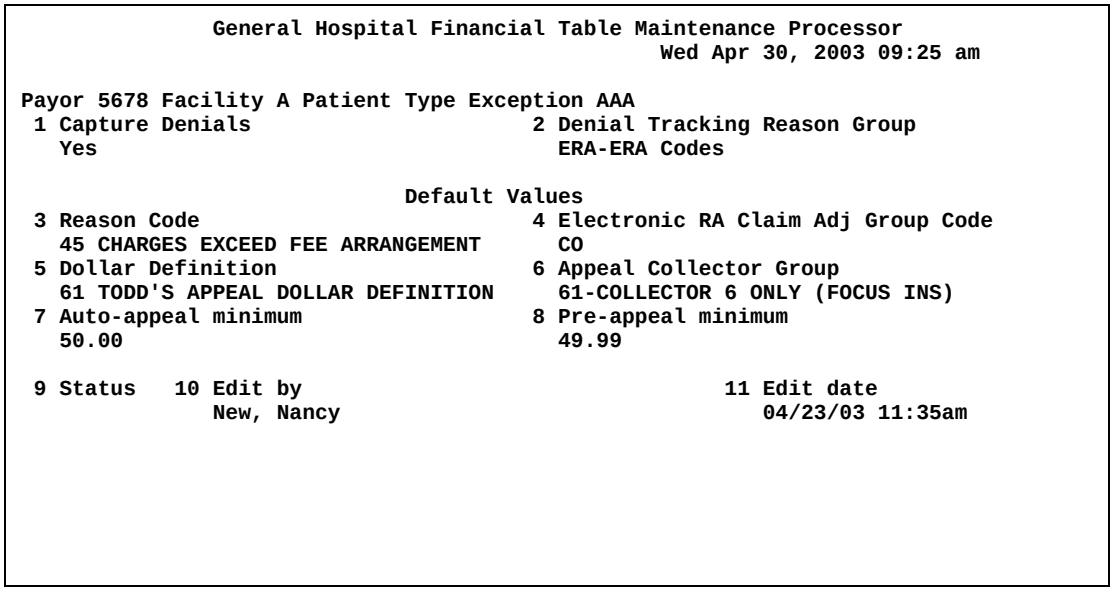
12. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

12. EDIT DATE (DISPLAY ONLY)
This field displays the date this table was last edited.

After the screen is accepted, you can enter patient type exceptions for the insurance plan. The following prompt is displayed:

Do you want to enter Patient Type Exceptions? (Y/N) [N]-- Y

If you enter Yes, the Patient Type Table is displayed. After you select a patient type from the table, the following screen is displayed:



Field Explanations

1. TRACK DENIALS/APPEALS (1-A-R)
This field is used to define whether or not to track denials and appeals for this exception. When this field is accessed, the following prompt is displayed:

Do you want to capture denials for this exception? (Y/N)--

2. DENIAL TRACKING REASON GROUP (4-AN-R)
This field defines the payor-specific denial tracking reason group, which includes the payor-specific set of denial tracking reason codes that are used in cash posting to record the reason a payment is denied. The Denial Tracking Reason Group, which is defined in a separate table, is either an Electronic Remittance Advice type or a Non-Electronic Remittance type. An Electronic Remittance Advice type of Denial Tracking Reason Group uses the standard Electronic Remittance Advice CAS Reason Codes as the basis for the denial tracking reason codes used in insurance cash posting. A Non-Electronic Remittance Advice type of Denial Tracking Reason Group uses a payor-specific set of reason codes as the denial tracking reason code set.

3. REASON CODE (4-AN-R)
This field is the default denial tracking reason used for a denial if a denial tracking reason is not assigned for any reason. When the field is accessed, the following prompt is displayed:

Pick Default Reason Code from Reason Group XXXXXXX (9999)

4. ELECTRONIC RA CLAIM ADJ GROUP CODE (4-AN-R)
This field is the default denial tracking claim adjustment reason group used for a denial if a denial tracking claim adjustment reason group is not assigned for any reason. This field is accessible only if the Denial Tracking Reason Group for this Denial Tracking Payor is an Electronic Remittance Advice-type of Reason Group. The user can select the claim adjustment group from a table of valid values.

5. DOLLAR DEFINITION (4-AN-R)
This field contains the Insurance Follow-up Schedule Dollar Definition to be used for this payor. You can select the Insurance Follow-up Schedule Dollar Definition from a table of valid values.

6. APPEAL COLLECTOR GROUP (4-AN-R)
This field contains the collector group controlling the collector assignment of appeals and pre-appeals in Receivables Workstation. You can select the Appeal Collector Group from a table of valid values.

7. AUTO-APPEAL MINIMUM (10-AN-R)
This field contains the minimum dollar amount that causes a denied insurance payment to be automatically appealed. Appealed denials are sent to Pathways Contract Management for denial tracking with an appeal disposition of Yes and are placed in an appeal worklist on Receivables Workstation. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing an auto-appeal or `N` for no auto-appeal--

8. PRE-APPEAL MINIMUM (10-AN-O)
This field contains the minimum dollar amount that causes a denied insurance payment to be automatically placed in a pre-appeal worklist on Receivables Workstation. Pre-appeals are not automatically sent to Pathways Contract Management. Users can review the entries in the pre-appeal worklist to determine whether or not to appeal the denied insurance payment. When this field is accessed, the following prompt is displayed:

Enter the minimum amount causing a pre-appeal or `N` for no pre-appeal-

9. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when the code is created.

10. EDIT BY (DISPLAY ONLY)
This field displays the name of the person who last edited this table entry.

11. EDIT DATE (DISPLAY ONLY)
This field displays the date and time this table entry was last edited.

After accepting the screen, you can enter reason code exceptions for the patient type exceptions. The following prompt is displayed.

Do you want to enter Reason Code exceptions for payor 5678 for patient type AAA for facility A? (Y/N) [N]--

If you answer **Y** for Yes, the Patient Type Table screen is displayed. For field explanations, see “Field Explanations” on page 1-111.

DETAIL STATEMENT MESSAGES

This table defines the messages printed on Guarantor, Internal Pre-Collection and Internal Bad Debt detail statements. These messages are used in the follow-up and insurance follow-up schedules. This table is not split by facility.

After this table is selected, the system prompts you to enter a detail statement message code. You can enter the code or display and select from a list of codes established in the system. There are two screens involved in this transaction. The first is used to define the message's format and the second to enter/edit the message text.

After the detail statement message code is entered or selected, this first screen is displayed.

```
            General Hospital Financial Table Maintenance Processor
                                                 Fri Dec 30, 1988 10:10 am
Detail Statement Messages
 1 Code                  2 Description
   1                       Detail Statement Message 1
 3 Edit date             4 Edit by                                  5 Status
   12/30/88 10:10am        Smith,Mary A                               Active
 6 Current Width         7 Current Lines
   42                      1
 8 Maximum Width         9 Maximum Lines
   75                      10









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the detail statement message.

2. DESCRIPTION (30-C-R)
This field contains the description of the detail statement message.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when the code is created.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the established message that you are editing. This field is blank if you are creating a new message. Once the message has been created, the width is displayed in this field.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the established message that you are editing. This field is blank if you are creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum number of columns that can be used for this message. The entry range is 10 to 75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum number of lines that the message can contains. The entry range is 1 to 10 lines; the default is 10.

NOTE: Any change to the entry in the maximum width or maximum lines fields affects not only the detail statement message you are editing but **all** detail statement messages. If you change this field, the system checks all existing messages to ensure they do not exceed the new maximums. If one or more existing messages exceeds the new maximum, the system displays the following error message:

Warning - message exceeds width and/or length defaults!

Dependent On	Reference
Internal Elements	Follow-up Schedules
Format Types	Insurance Follow-up Schedules
	Pre-Collection Follow-up Schedules
	Agency Follow-up Schedules

When you complete and accept this screen, the system displays the second Detail Statement Message screen.

```
              General Hospital Financial Table Maintenance Processor
                                                  Fri Dec 30, 1988 10:10 am
Detail Statement Messages 1 - Detail Statement Message 1
          1         2         3         4         5         6
   12345678901234567890123456789012345678901234567890123456789012345
01|Your balance is due upon receipt of this statement.  If you have |
02|any questions regarding this bill, please call me Monday through |
03|Friday 8:30am-5:00pm.                                           |
04|                                                                 |
05|Jane Jones                                                       |
06|404-555-1212                                                     |
07|Ext. 2323                                                        |
08|                                                                 |
09|                                                                 |
10|                                                                 |




 F1     F2     F3      F4    F5         F6           F7   F8      F9   F10
 Delete Insert Center  Exit  Store Line Restore Line Pack Preview Database Help
```

NOTE: Jane Jones, the phone number, and phone extension are internal elements.

Field Explanations - Screen 2 of 2

You can enter or edit the message using the function keys at the bottom of the screen.

Inserting Data Elements In The Message Text

Data elements are defined and maintained by McKesson. You can insert these data elements into a detail statement message:

Data Base Element	Suggested Print Routine
ACC/OCC Date	User Preference
Account Restart Amount	Money (with $ sign)
Actual Amount From Promise to Pay	Money (with $ sign)
Actual Date of Promise to Pay	Money (with $ sign)
Amount of Payments Made - Account	Money (with $ sign)
Amount of Payments Made - Patient	Money (with $ sign)
Average Operating Cost	Money (with $ sign)
Bad Debt Transfer Date	Use default
Biller Name - Primary	Name (First MI Last)
Biller Phone Extension	Use default
Bill Phone Number	(999)999-9999
Collection Agency Name	Use Default
Collection Agency Transfer Date	Use default

Data Base Element	Suggested Print Routine
Collector Name	Name (First MI Last)
Collector Phone Number	Use default
Collector's Extension	Use default
Guarantor Restart Amount	Use default
Hospital Area Code	Use default
Hospital Telephone Number	Use default
Insurance Collector Name*	Use default
Length of Stay	Standard Print (no formatting)
Per Diem Rate	Money (with $ sign)
Promise to Pay Amount	Money (with $ sign)
Promise to Pay Date	User Preference
Provider Phone Number	(999)999-9999
UB/92 Provider Claim Name	Use default
*Use these elements only for guarantor insurance time out notification.	

These elements print the specific data relevant for the patient. For example, if you want the collector's name and phone number in the message, set up the message to include the Collector Name and Collector Phone Number elements. When patients receive a detail statement with that message, the system individually selects the proper collector name and phone number depending on the specific patient.

In order to insert data elements into a detail statement message:

1. Position the cursor in the text where you want the data element inserted.

2. Press the **F9** key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display a list of available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted.

   The highlighted area represents the maximum length of the selected element. The format displayed represents the default print routine for the element. For example, most date elements have a default print routine of MM/DD/YY. After accepting the element, the system displays a list of alternate print routines, if applicable. For example, dates can be printed as YYMMDD, MM/DD, MM/YY, etc. If you want the element to print in one of the alternate formats, select the desired format. Otherwise, press ENTER to accept the default print routine. When you accept the element, the process is complete.

5. Press the **F4** key to save the message and exit the screen.

NOTE: Since you are entering text for a letter, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

Dependent On	Reference
Internal Elements	Follow-up Schedules
Format Types	Insurance Follow-up Schedules
	Pre-Collection Follow-up Schedules
	Agency Follow-up Schedules

FINANCIAL CLASSES

This table defines the financial class codes used by a facility. The financial class groups patients according to their primary payor. Examples of financial class codes are Blue Cross, CHAMPUS, Medicare, Medicaid, Self-pay, Workers' Compensation, etc.

A default financial class is assigned to each insurance plan. This default financial class is assigned to the patient when a primary insurance is associated with the patient at the time of admission or registration. The financial class is re-assigned whenever the primary insurance plan for the patient is revised.

Additional financial class codes can be assigned to insurance plans. For example, if the hospital wants to have a financial class that indicates Medicare for disabled patients, the hospital can assign the normal Medicare financial class to the insurance plan as the default or as the main financial class for the plan, and the Disability Medicare financial class as one that can also be used for this insurance plan. The user can only change a patient's financial class through insurance processing and the new financial class assigned must be valid for that insurance plan. The system does not allow you to make changes to the financial class if it is invalid for the insurance plan.

Financial class codes can be used in mapping Patient Accounting transactions to the general ledger. If you want a breakdown of revenue in your general ledger by financial class, setting this code can be very important.

Financial class codes are also used when aging the hospital's receivables. The Aged Trial Balance report provides totals by hospital-defined categories and financial class.

Many of the statistics that are captured by the system can be kept by financial class. For patients without insurance, the financial class determines when a patient account is billed and who the biller is.

A collector and follow-up schedule is assigned to a new guarantor based on the guarantor's financial class.

Codes used for refund processing and payment posting are also held in the Financial Class table.

This table appears to be split by facility since the facility indicator is displayed for selection. However, this table is not split by facility. If Financial Class Code B (Blue Cross) is added in facility A, facility B must also use Financial Class Code B for Blue Cross. Facility B cannot change the definition of Financial Class Code B. If facility B decides not to use Financial Class Code B, the information for this class would not be added to facility Be’s financial class table. Thus, Financial Class Code B for Blue Cross would be valid for facility A but not for facility B.

This table is, therefore, defined as a non-split table with facility-specific information.

After this table is selected, the system prompts you to enter a financial class code. You can enter the two-character code or a hyphen (-) to display a list of valid financial class codes. When a code is entered, this first screen is displayed.

```
         General Hospital Financial Table Maintenance Processor
                                                Fri Apr 14, 2009 11:07 am
Financial Classes
 1 Code      2 Description
   B           BLUE CROSS
 3 Restricted to                          4 Allow Insurance Time Out?
                                            Yes
 5 Payment Transaction                    6 Edit Date
   P0001-PERSONAL PAYMENT-CHECK             04/12/00 08:54am
 7 Refund Transaction                     8 Edit By
   R0001-GUARANTOR REFUND                   Sakowski,Bob
 9 PA Collector Group                    10 PA Collector Group Exceptions
   1-COLLECTION GROUP                       No
11 AR COLLECTOR GROUP                    12 AR Collector Group Exceptions
   1-COLLECTION GROUP                       No
13 Collection Agency Group               14 Biller Group
   20-COLLECTION AGENCY GROUP               BILLING GROUP
15 DRG Payor                             16 HCPCS Payor
   O-OTHER PAYERS                           Z-TEST
17 Statistical Group              18 Sales Commission     19 ICD-10 Eff Date
   BLUE CROSS                        Yes


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

Once fields 1 and 2 are completed, the information does not vary for multiple facilities. All other fields are facility-specific.

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying this financial class.

2. DESCRIPTION (30-C-R)
This field contains the description of the financial class code.

3. RESTRICTED TO (1-A-R)
This field indicates whether the financial class is restricted to self-pay (S) accounts or the default of (N) No Restriction. The system edits this field to ensure that accounts without insurance are assigned to those financial classes designated as self-pay, and accounts with insurance are not assigned a self-pay financial class.

4. ALLOW INSURANCE TIME OUT? (1-A-R)
This field indicates whether patients who have this financial class are responsible for the insurance liability after all follow-up efforts have been exhausted. Entry options are **Y** for yes or **N** for no; the default is Y. If you enter N, the guarantor is not considered responsible for the insurance liability when the insurance reaches the end of the follow-up schedule. If you enter Y, the guarantor is considered responsible for the insurance liability. For example, a hospital may want to enter N for Medicaid to prevent patients

who have Medicaid from being responsible for the insurance portion of the bill if Medicaid is delinquent in paying its share.

5. PAYMENT TRANSACTION (4-N-O)
This field contains the transaction code used in recording the posting of patient cash. This is the default transaction code used for posting patient cash. You can enter the code or a hyphen (-) to display a list of valid codes. After a code is entered or selected, the transaction type, transaction code, and code description display in this field. When posting patient cash for accounts with this financial class, the system automatically loads the transaction code entered here.

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

7. REFUND TRANSACTION (4-N-R)
This field contains the transaction code used as the refund approval code when a guarantor is approved for a refund and the patient account has this financial class.

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

9. PA COLLECTOR GROUP (2-N-R)
This field contains the code identifying the collector group assigned to a guarantor's accounts in a PA location. A collector is assigned to a new account when the account is admitted for facilities using PA follow-up.

10. PA COLLECTOR GROUP EXCEPTIONS (1-A-O)
This field provides the option of defining PA collector group exceptions by patient type. To add exceptions, enter **Y** for Yes to the following prompt, and a screen is displayed which allows the user to define patient type exceptions. When a patient type is entered, you can define a different PA Collector Group for each patient type exception.

Add/Revise PA Collector Group Patient Type Exceptions?

11. AR COLLECTOR GROUP (2-N-R)
This field contains the code identifying the collector group assigned to accounts in AR follow-up. A collector is assigned to a new guarantor when the account is final billed. If the guarantor has active accounts in the system, the patient is assigned to the collector of the guarantor.

12. AR COLLECTOR GROUP EXCEPTIONS (1-A-O)
This field provides the option of defining AR collector group exceptions by patient type. To add exceptions, enter **Y** for Yes at the following prompt, and a screen is displayed that allows you to define patient type exceptions. When a patient type is entered, you can define a different AR Collector Group for each patient type exception.

Add/Revise AR Collector Group Patient Type Exceptions? (Y/N) [N]-

13. COLLECTION AGENCY GROUP (2-N-R)
This field contains the code identifying the collection agency group to which accounts with this financial class are sent. You can enter the code or a hyphen (-) to display a list of valid codes.

14. BILLER GROUP (2-N-R)
This field contains the code identifying the billing group assigned to this financial class. This group is used for self-pay accounts only. Accounts with insurance are assigned to the biller group associated with the primary insurance plan. The billing group is used to assign a biller to the patient account. A biller is assigned to the account at the time of admission or registration. You can enter the desired billing group code or a hyphen (-) to display a list of valid codes.

15. DRG PAYOR (DISPLAY ONLY)
This field contains the code and name of the DRG payor associated with this financial class. The DRG Payor table is maintained in STAR Patient Care Medical Records. This field cannot be edited.

(US)16.HCPCS PAYOR (DISPLAY ONLY)
(CN)16.SoB PAYOR (DISPLAY ONLY)
This field contains the HCPCS payor/SoB Payor code and description associated with this financial class. The HCPCS Payor/SoB Payor table is maintained in STAR Patient Care Medical Records. This field cannot be edited. This field cannot be used in Canada.

17. STATISTICAL GROUP (1-N-R)
This field contains the financial class statistics group used to identify the financial classes for statistical reporting. You can enter the code or a hyphen (-) to display a list of valid groups.

18. SALES COMMISSION (DISPLAY ONLY)
This field indicates if the financial class is eligible for capturing sales commission data. If Yes is displayed in this field, the financial class is eligible for capturing sales commission data. This applies only to outpatient patient types. STAR Laboratory does not capture sales commission data for inpatient class types. If No is displayed in this field, the financial class selected is not eligible for capturing sales commission data. Refer to the Tables section of the *Maintenance Functions Volume* of the *STAR Laboratory Reference Guide* for more information about this field.

19. ICD-10 EFF DATE (DATE FORMAT-O))
Exceptions to ICD-10 processing can be entered for particular Financial Classes. Enter the date that this financial class should begin using ICD-10 coding if it differs from the date in the US ICD-10 Effective Date field in the STAR Admissions and General Parameters.

NOTE: The date should be after the date in the US ICD-10 Effective Date field in Admission and General Parameters. The system ignores the date if it is earlier than the date on the parameter screen.

The system prompts for ICD-10 Diagnosis and Procedure codes only for any account with an admission date on or after the date listed in the USA ICD-10 Eff Date field found on the Hospital Facility Options, unless exceptions are listed in the Insurance Plans table, the Insurance Carriers table, and/or the Financial Class table. If there is an Exception for the patient, you have the option to also code ICD-9 Diagnosis and Procedure codes on the account (in addition to the ICD-10 Diagnosis and Procedure codes).

The system has a hierarchy for ICD-10 Exceptions.

- The system first looks to the ICD-10 Eff Date (ICD-10 Effective Date) field at the Insurance Plan Table when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes.

- The system next looks to the ICD-10 Eff Date in the Insurance Carriers Table when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes.

- The system lastly looks to the ICD-10 Eff Date in the Financial Class table when admitting a patient, and when adding, deleting, or resequencing insurance, when the permanent account number is assigned in the admission/registration flow, and with admission date changes.

When these fields are completed, you have the option of accepting or editing the displayed information or of deleting this financial class. If you enter **D** to delete the financial class, the system displays:

Enter delete(D) from file or file(F) as deleted [F]--

To delete the financial class, enter **D**. To file the financial class as deleted, but retain the information in the system so that you may later restore it, enter **F** or press ENTER.

You may want to review the Insurance Plan Coverage Table, page 1 of the Billing/ Claims Parameter option, to remove the deleted financial class from the Valid Financial Classes and/or Default Financial Class fields. Removing the information from the table prevents users from modifying financial classes via insurance process to an inactive/ deleted financial class.

When you accept the screen, the system displays the second screen of the function. This screen is used for additional information relating to cycle bills, final bills, and payment transaction information .

```
              General Hospital Financial Table Maintenance Processor
                                                  Sun May 31, 2009 10:01 pm
Financial Classes
 1 Code      2 Description
   B           BLUE CROSS

Inpatient    1 Cycle Bill Parm                  3 Final Bill Parm
               COMMERCIAL INSURANCE, CYCLE        COMMERCIAL INSURANCE, FINAL
             2 PA Follow-up Schedule            4 AR Follow-up Schedule
               3-TEST 3                           220-PATRICE'S BILL PATIENT
Outpatient   5 Cycle Bill Parm                  6 Final Bill Parm
                                                  COMMERCIAL INSURANCE, FINAL
             7 PA Follow-up Schedule            8 AR Follow-up Schedule
               3-TEST 3                           220-PATRICE'S BILL PATIENT









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

Field Explanations - Screen 2 of 2

1. CODE (DISPLAY ONLY)
This field contains the financial class code.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the financial class code.

Inpatient

1. CYCLE BILL PARM (3-C-O)
This field contains the code identifying the cycle billing schedule for an inpatient account assigned this financial class. This cycle bill parameter is used if there is no insurance associated with an account. Refer to the Billing Parameters section for more information.

2. PA FOLLOW-UP SCHEDULE (3-C-R)
This field contains the code identifying the PA follow-up schedule that is assigned to an account. This assignment is made upon admission or registration to the hospital. This field is required for financial classes not set up as exceptions to PA follow-up. The exception schedule defined in PAAR controls cannot be used here.

3. FINAL BILL PARM (3-C-R)
This field contains the code identifying the final billing schedule for an inpatient account assigned this financial class. This final bill parameter is used if there is no insurance

associated with an account. Refer to the Billing Parameters section for more information.

4. AR FOLLOW-UP SCHEDULE (3-C-R)
This field contains the code identifying the AR follow-up schedule that is assigned to a guarantor. This assignment is made when a final bill is issued to a new guarantor. If this guarantor has active accounts in the system, new accounts for an existing guarantor use the follow-up schedule already assigned to the guarantor.

Outpatient

5. CYCLE BILL PARM (3-C-O)
This field contains the code identifying the cycle billing schedule for an outpatient account assigned this financial class. This cycle bill parameter is used if there is no insurance associated with an account. Refer to the Billing Parameters section for more information.

6. FINAL BILL PARM (3-C-R)
This field contains the code identifying the final billing procedure for an outpatient account assigned this financial class. This final bill parameter is used if there is no insurance associated with an account. Refer to the Billing Parameters section for more information.

7. PA FOLLOW-UP SCHEDULE (3-N-C)
This field contains the code identifying the PA follow-up schedule that is assigned to an account. This assignment is made upon admission or registration to the hospital. This field is required for financial classes not set up as exceptions to PA follow-up. The exception schedule defined in PAAR controls cannot be used here.

8. AR FOLLOW-UP SCHEDULE (3-C-R)
This field contains the code identifying the AR follow-up schedule that is assigned to a guarantor. This assignment is made when a final bill is issued to a new guarantor. If this guarantor has active accounts in the system, new accounts for an existing guarantor use the follow-up schedule already assigned to the guarantor.

When these fields are completed, you have the option of accepting or editing the entered information. Accepting the screen prompts the system to display the following prompt:

Add/revise Patient Type exceptions for AR Follow-Up? (Y/N) [N]--

Press ENTER if you do not want to add or revise patient type exceptions to this financial class definition. Enter **Y** if you want to add or edit patient type exceptions. Patient type exceptions within the financial class are defined when you want the account to be placed on a follow-up schedule that is separate from the guarantor's follow-up schedule. A second reason for defining patient type exceptions is for changing follow-up information due to financial class changes. The 'To' financial class and patient type combination would need to be defined. The system displays the following screen:

```
              General Hospital Financial Table Maintenance Processor
                                                    Thu Oct 18, 1990 11:10 am
Financial Classes
 1 Code      2 Description
   50          AUGNET

Page:01                      Patient Type Exceptions          ##=Current Choices
( 1) ADM INPATIENT - NO BED ASSIGNMENT
( 2) ADV INPATIENT ADVANCE ADMISSION
( 3) E/R EMERGENCY ROOM
( 4) I/P INPATIENT
( 5) E/R EMERGENCY ROOM
( 6) I/P INPATIENT
( 7) O/P OUTPATIENT









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

Any patient types that were chosen previously are highlighted by the system. Follow the prompt at the bottom of the screen to choose or remove the types.

Dependent On	Reference
Billing Groups	Report Aging Code
Billing Parameters	Facility Information
	Demographic/Defaults
Collection Groups	Facility Information Data Retention
Patient Type Transaction Code	Insurance Coverage
	Facility Information Insurance Time Out
	Facility Information Balance Designation

FINANCIAL CLASS STATISTICAL GROUP

This table is used to group financial classes for statistical group type reporting. This table is used by the Revenue Statistics by FC Group report (FSR350).

NOTE: In order to properly create the Revenue Statistics by FC Group report, you must define the statistical mapping keys as follows:

FC	Financial Class	PI	Patient Indicator
SD	SIM Department	SI	SIM Item

When you select this table, the system displays the following prompt:

Enter statistical group code--

Enter the group code or use a hyphen (-) to display and select from a list of existing group codes. Codes must be single numerals (for example, from 1-9). If you enter a code for which a financial class statistical group does not exist, the system displays the following prompt, where # is the code you entered:

Add this code '#'? (Y/N) [Y]--

To create a new statistic group using this code, enter **Y** or press ENTER to accept the default. To return to the preceding prompt, enter **N**.

When you identify the code, the system displays the following screen:

```
             General Hospital Financial Table Maintenance Processor
                                                 Thu Aug 29, 1991 04:31 pm
Financial Class Statistical Groups
 1 Code           2 Description                                  3 Status
   6                MEDICATE
 4 Edit by                                              4 Edit date
   Smith,Mary A                                           01/29/91 1128am









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

Field Explanations

1. CODE (1-N-R)
This field contains the code identifying the financial class statistical group.

2. DESCRIPTION (30-C-R)
This field contains the description of the financial class statistical group.

3. STATUS (DISPLAY ONLY)
This field indicates the activity status of the code. If the code is active, this field is blank. If the code has been filed as deleted, this field displays inactive.

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

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

FINANCIAL PATIENT CLASSIFICATIONS

This table is used to designate which classifications alert patient accounting users and suppresses follow-up to the account's guarantor for the account.

After this table is selected, you are prompted to select a facility and then enter a classification. You may enter a hyphen (-) to display the Patient Care Classification Table entries or key the three character Classification code. (The entry into this table is similar to the Financial Class table, where Patient Care controls the definition of the code and description, and Patient Accounting has additional criteria to define.) After a code is entered the following screen is displayed:

```
            General Hospital Financial Table Maintenance Processor
                                                  Thu Feb 04, 1999 08:32 am
Financial Patient Classifications
 1 Code    2 Description
   PHY       PHYSICIAN
 3 Alert on PA?                      4 Suppress Follow-up on PA?
   Yes                                 Yes
 5 Edit Date                         6 Edit By
   02/04/99 8:32                       Walsh,Meggie









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the three-character code for the classification.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the 24-character description of the classification.

3. ALERT ON PA?
This field enables an alert indicator (**) displayed beside this classification when the classification is assigned as the Patient Classification for an account. The system displays the following prompt:

Alert Patient Accounting users of Pt Class? (Y/N) - - [N]

Valid responses are **Y** and **N**. The default is **N**. Blank is also **N**. If **Y**, the Patient Classification on selected Patient Accounting screens and reports displays the Patient Classification with leading and trailing asterisks, for example, "**BRD**." Patient

Classifications that do not have the alert status are displayed without the asterisks, for example, " EMP ".

4. SUPPRESS F/UP ON PA? (1-A-O)
This field enables you to suppress follow-up on the account if the Alert on PA field is set to **Y**. The system displays the following prompt:

Suppress F/Up for accounts with this patient classification? (Y/N) - - [N]

Valid responses are **Y** and **N**. The default is **N.** Blank is also **N**. If **N**, PA and AR follow-up continue to be generated, according to the associated follow-up schedule. If **Y**, follow-up in PA and AR is suppressed until the user changes the suppression indicator to "Clear" in the Account Status screen within Account Revision. The account is also not selected for Bad Debt prelisting, but it is listed on the Bad Debt Prelist Exception Report (FFR385).

NOTE: Insurance follow-up is not suppressed. Insurance Time Out follow-up which is directed to the guarantor of the account is suppressed. Follow-up generated from a payment plan in PA and AR is not suppressed.

Upon exiting the table, the user is given the option to start a conversion adding classification to accounts based on the patient's classification and determining the indicator based on the classification table. The prompt appears until the conversion is started one time. The conversion is executed for all facilities at the same time because the Financial Patient Classification Table is a shared table as is the Classification Table in Patient Care. The system displays the following prompt:

Start classification conversion? (Y/N(C)ancel) - - [N]

If the response is Yes, verify that the user wants to run the conversion by displaying the following prompt:

This conversion can be run once. Are you sure you have completed all necessary Financial Patient Classification Table updates? (Y/N) - - [N]

If **Y**, the conversion executes in the background and pauses when the system is unavailable. If the response is (C)ancel, then the following prompt displays:

If you cancel the conversion prompt, you will not be able to run the conversion in the future. Are you sure you want to cancel the conversion? (Y/N) - - [N]

If the response is **Y**, then the start classification conversion prompt no longer is displayed and the user is no longer prompted to run the conversion. Access to the Financial Patient Classification is not allowed after the conversion starts until its completion. If the conversion is processing, the following prompt is displayed:

Financial Patient Classification conversion is processing. Please try later. Press NL.

If the conversion is not processing but has not completed, the following prompt is displayed:

Financial Patient Classification conversion did not complete. Please contact HBOC during normal business hours. Press NL.

Upon exiting the table, the user is given the option to print a report of table entries.

FOLLOW-UP LETTER MESSAGES

This table is used to define paragraphs that are combined into follow-up letters. These follow-up letters can be used for guarantor, Pre-Collection, and Internal Bad Debt Follow-up. These paragraphs or messages are free-form and can include internal data elements such as the amount of payments made, collector name, etc. The format of each follow-up letter includes information such as the account name, number, and salutation. Therefore this data should not be included in a follow-up letter message.

This table includes a message code called MCK for MCK Free Form Message. The MCK message code is used when building follow-up letters. The MCK message code allows hospitals to create letters that can contain a free form message. This allows collectors to utilize the Edit Collection Letter functionality and type in a free form message through the PA, AR or BD Demand Follow-Up forms on the Receivables Workstation.

This table is not split by facility.

After this table is selected, you are prompted to select a facility and enter a follow-up letter message code.

NOTE: To view the MCK message code, you must perform a dash lookup to view the table. You cannot enter the code of MCK. The MCK message code has an associated description of MCK Free Form Message. This code cannot be updated or viewed. When selecting this code from the list, the following message displays: *Message controlled by McKessonHBOC, press NL.*

You can enter the code or a hyphen (-) to display a list of valid codes. There are two screens used in entering a message into the system. The first defines the name, length

and width of the message while the second is used to enter the message itself. After a code is entered, this screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                 Thu Oct 06, 1988 04:31 pm
Follow-up Letter Messages
 1 Code                  2 Description
   3                       AGENCY ACTION
 3 Edit date             4 Edit by                                  5 Status
   10/06/88 04:30          Smith,Mary A                               Active
 6 Current Width         7 Current Lines
   75                      3
 8 Maximum Width         9 Maximum Lines
   75                      18









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the follow-up letter message.

2. DESCRIPTION (30-C-R)
This field contains the description of the follow-up letter message.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults to active when the code is created.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the existing message. If you are creating a new message, this field is blank.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the existing message. If you are creating a new message, this field is blank.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum width of the message in terms of number of columns. The entry range is 10 to 75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum length of the message in terms of number of lines. The entry range is 1 to 18 lines; the default is 18.

NOTE: The MCK message code does not have limit of 18 lines. You can free form an entire letter into one MCK message code when you are utilizing the Edit Collection Letter functionality available through demand follow-up in the Receivables Workstation.

The following information is automatically included on the letter by the system:

Guarantor Name,
Address, City, State, ZIP code
Date of Letter
Greeting
Patient Name
Account Number (from each account)
Admission Date
Discharge Date
Account Balance
Amount Due
Estimated Insurance Due
Total Amount Due

After these fields are completed, the system prompts you to accept the screen. You have the option of accepting or editing the information entered.

When the screen is accepted, this second screen of the transaction is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                 Wed Apr 13, 1988 02:34 pm
Follow-up Letter Messages 1 - Closing
           1         2         3         4         5         6         7
   12345678901234567890123456789012345678901234567890123456789012345678901234567
01|Your account balance of $500.00 is now past due.  Please contact Mary A    | 02|Smith
in our business office at 555-1212.                                          |
03|                                                                                |
04|                                                                                |
05|                                                                                |
06|                                                                                |
07|                                                                                |
08|                                                                                |
09|                                                                                |
10|                                                                                |
11|                                                                                |
12|                                                                                |
13|                                                                                |
14|                                                                                |
15|                                                                                |
16|                                                                                |
17|                                                                                |
18|                                                                                |

F1Delete F2Insert F3Center F4Exit F5Store F6Restore F7Pack F8View F9Data F10Help
```

Field Explanations - Screen 2 of 2

Enter or edit the message using the function keys at the bottom of the screen.

Inserting Data Elements In The Message Text

Internal data elements are defined and maintained by McKesson. You can insert the following data elements into a follow-up letter message:

Data Base Element	Suggested Print Routine
Account Restart Amount	Money (with $ sign)
Amount of Payments Made - Account	Money (with $ sign)
Amount of Payments Made - Patient	Money (with $ sign)
Bad Debt Transfer Date	Use Default
Claim Submission Date*	Use default
Collection Agency Name	Use default
Collection Agency Transfer Date	Use default
Collector Name	Name (First MI Last)
Collector Phone Number	Use default
Collector's Extension	Use default
Guarantor Restart Amount	Money (with $ sign)
Insurance Name*	Use default
Patient Name	First MI Last
*Use these elements only for guarantor insurance time out notification.	

In order to do so:

1. Position the cursor in the text where you want the data element inserted.

2. Press the **F9** key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display a list of available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted.

   The highlighted area represents the maximum length of the selected element. The format displayed 86.

   represents the default print routine for the element. For example, most date elements have a default print routine of MM/DD/YY. After accepting the element, the system displays a list of alternate print routines, if applicable. For example, dates can be printed as YYMMDD, MM/DD, MM/YY, etc. If you want the element to print in one of the alternate formats, select the desired format. Otherwise, press ENTER to accept the default print routine. When you accept the element, the process is complete.

5. Pressing the **F4** key saves the message and completes the function.

NOTE: Since you are entering text for a letter, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

Dependent On	Reference
Format Types	Follow-up Letters
Internal Elements	

FOLLOW-UP LETTERS

This table is used to combine follow-up letter messages into follow-up letters. The follow-up letter codes entered here represent a combination of previously defined follow-up letter messages. The Follow-up Letters are used in the PA Follow-up Schedules, Follow-up Schedules, Pre-Collect Follow-up Schedules, Agency Follow-up Schedules, and Insurance Follow-up Schedules to indicate when a letter should be sent to a guarantor. The letters are also used when requesting demand follow-up for a guarantor. Receivables Workstation uses this table for the Edit Collection Letter function. You can attach the MCK message code to any letter to which you want to be able to add free form text. The description of the MCK message code is MCK Free Form Message. Note, if you attach the MCK message code to a letter multiple times, then the same free form message prints multiple times. McKesson advises that you only associate one MCK message code to your letter.

This table is not split by facility.

After this table is selected, the system prompts you to enter a follow-up letter code. You can enter the code or a hyphen (-) to display a list of valid codes. After the follow-up letter code is entered or selected, this screen is displayed.

```
            General Hospital Financial Table Maintenance Processor
                                                  Thu Oct 12, 2001 12:30 pm
Follow-up Letters
 1 Code                 2 Description                          3 Status
   1                      1st Guarantor F/U Letter               Active
 4 File Type            5 Edit date                            6 Edit by
   Automatic              01/05/00 13:50                         Smith,Mary A

             Follow Up Messages
 7 Seq      Msg  Description                 Blank Lines Disallow page break?
   1.       5551 GUARANTOR F/U INTRO             02              Yes
   2.       5552 1ST Guarantor F/U Body          02              Yes
   3.       5557 Guarantor F/U Conclusion        02              Yes









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the follow-up letter.

2. DESCRIPTION (30-C-R)
This field contains the description of the follow-up letter code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

4. FILE TYPE (1-A-R)
This field indicates the spool file to which the follow-up letter is sent. Entry options are **R** (Review) or **A** (Automatic). Entry of **R** spools the letter to the Review Collection Letter spool files. Entry of **A** (Automatic) spools the letter to the Collection Letter Spool files.

The spool file names for these review collection letters are:

FFR152 - Review F/U Insurance F/U Letter

FFR157 - Review Demand Insurance F/U Letter

FFR153 - Review Insurance F/U Letter to the Guarantor

FFR158 - Review Demand Insurance F/U Letter to the Guarantor

5. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry last edited.

6. EDIT BY
This field contains the name of the user who last edited this table entry.

Organizing Messages Into Letters

You are combining follow-up letter messages into follow-up letters in this part of the table.

7. SEQ (DISPLAY ONLY)
This field contains the sequence number identifying the message. You can enter as many sequences as you like in constructing your letters. The system displays the next number when you access this field for data entry.

MSG (4-N-R)
This field contains the code identifying the follow-up letter message associated with this sequence number. You can enter the code or a hyphen (-) to display a list of valid codes. Select the MCK message code to add a free form message in this letter through the demand PA, AR, or BD Follow-up forms in Receivables Workstation.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up letter message code.

BLANK LINES (2-N-O)
This field contains the number of blank lines between this message and the next. The range is 1 to 99 lines.

DISALLOW PAGE BREAKS (1-A-R)
This field indicates whether the message can be split between multiple pages of the letter. Entry options are Y for Yes and N for No. An entry of Y indicates that the paragraph are not split between multiple pages. If the paragraph does not fit on one page, the entire paragraph is printed on a subsequent page. This field can only be set to No when it is associated with the MCK message code.

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

FOLLOW-UP SCHEDULES (AR)

This table contains information regarding the timing and type of follow-up used for guarantor accounts. If the guarantor is new to the hospital, the system assigns a follow-up schedule to that guarantor at final billing. Established guarantors already have an assigned follow-up schedule. Follow-up schedule assignments can be changed at any time and can be established for specific patients and guarantors.

In the case of new guarantors, the patient's financial class determines the follow-up schedule assignment. There is no assignment for active guarantors since a follow-up schedule for them already exists. An inactive guarantor (one without accounts in AR) receives a new follow-up schedule when a new account is transferred to AR.

A new guarantor is scheduled for follow-up when the first account final bills. The type and frequency of follow-up is determined by events in this schedule. Events are defined with sequence numbers.

The account contains the next follow-up date and sequence number. All further follow-up is scheduled on the day follow-up is initiated. For example, when the guarantor receives the first event, the second event is scheduled. This process is used for all guarantors.

Customized schedules can be created for accounts or guarantors requiring different treatment. Refer to the *Account Inquiry and Revision* and the *Follow-Up Functions* volumes of the *STAR Financials Patient Accounting Reference Guide* for more information.

Accounts with pending insurance can receive memo information only, be suppressed from getting any follow-up, receive follow-up on the entire account balance, receive follow-up of the patient balance, or receive no follow-up when 100% insurance liability exists.

This table is also used to transfer an AR account, linked to an internal collections process, to a collection agency group.

This table is not split by facility.

After this table is selected, the system prompts you to select a follow-up schedule code. You can enter the code or a hyphen (-) to display a list of valid codes.

After the Follow-up Schedule (AR) code is entered, the first of two screens used in this transaction is displayed.

```
          General Hospital Financial Table Maintenance Processor
                                                Mon Apr 17, 2000 10:29 am
Follow-up Schedules (AR)
 1 Schedule #    2 Description                    3 Wait Days
   5               5                                1
 4 Day of Month  5 Day of Week     6 Week of Month  7 Due Days    8 Grace Days
                                                    2             1
 9 Ins Pending  10 Bill Balance   11 Acct Rest %   12 Acct Rest Amt
   Suppress
13 Guar Rest %  14 Guar Rest Amt  15 Reseq Balance 16 Max Paper Bal
                                     $1.00            Unlimited
17 Min Balance  18 Min Refund Amt 19 Small Bal WriteOff Trans Code
   $1.00           $1.00             A0002-O/P M'CARE B HOSPITAL AL
20 Min Attempts 21 Auto Pre-List  22 Pre-List Max Bal    23 Pre-List Ins
   1               No                $1.00                  No
24 Days After Ins  25 Bad Debt Transfer Trans Code       26 Delinq F/U Type
   1                  S0001-PA TO AR TRANSFER               Collection Letter
27 Delinq F/U Message             28 Partial Pay F/U Type
   2  COL LTR INS TIME OUT LETTER    Detail Statement
29 Partial Pay F/U Message        30 Partial Pay F/U %
   1  DETAIL STATE 1ST STATEMENT      100.00%

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

Field Explanations - Screen 1 of 2

1. SCHEDULE # (3-N-R)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (30-C-R)
This field contains the description of the follow-up schedule code.

3. WAIT DAYS (2-N-R)
This field contains the minimum number of days to wait from final billing before the first step of follow-up is scheduled. If a guarantor (guarantor-level) currently has AR accounts with non-zero balances, new accounts are not affected by wait days but receive follow-up on the next day scheduled for the guarantor. The entry range is 0 to 99 days. Accounts using account level follow-up always uses this parameter.

If a value of zero is defined, the next follow-up is processed during the next Saturday run. This occurs because the next follow-up date is calculated as the final billing date plus wait days. Since guarantor follow-up select runs at 8:00 PM, the next time pas follow-up dates are reviewed is during the Saturday night selection process.

Defining Follow-up Frequency

There are three ways to define the frequency of account follow-up: Completing the Day Of Month, Day of Week, or Interval fields. These options, one of which must be selected, are defined below. The Interval option is entered on the second screen.

4. DAY OF MONTH (2-AN-O)
This field contains the day of the month on which the hospital wants follow-up performed for guarantors assigned to this schedule. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

5. DAY OF WEEK (1-N-O)
This field contains the day of the week on which the hospital wants follow-up performed for guarantors assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, ... Saturday = 7. If this field is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here. The Week of Month field works in conjunction with this field.

6. WEEK OF MONTH (1-N-C)
This field contains the week of the month during which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete the Day of Week field, you must also complete this field. This field is not required if the Day of Month field is completed. If this field is selected, guarantors assigned to this schedule receive follow-up once a month, during the week entered here and on the day entered in the Day of Week field.

7. DUE DAYS (2-N-R)
This field contains the number of days used in calculating the due date for payment plans. The entry range is 0 to 99 days; the default is 0.

8. GRACE DAYS (2-N-R)
This field contains the number of days after the due date before an account is delinquent. The entry range is 0 to 99 days; the default is 0. The statement print date plus the due days plus the grace days equals the delinquent date for payment plans.

9. INS PENDING (1-AN-0)
This field determines what type of follow-up occurs on accounts with pending insurance. Entry options are B (bill), S (suppress), or M (memo); the default is B.

If you enter B in this field, the type of follow-up that occurs depends on how the Bill Balance field is set.

If you enter S in this field, the following can occur:

- No follow-up occurs until all insurance liability is gone.
- Accounts appear on the Follow-up Suppression report (FFR440) on the days follow-up occurs.
- Accounts do not have the next step incremented if a single account attached to the guarantor follow-up schedule is being suppressed.

NOTE: Suppressed accounts become *new accounts* when the insurance liability is gone and the resequence parameters in the follow-up schedule are used.

If you enter M in this field, the following can occur:

- A memo message prints for accounts with pending insurance.
- If there is no insurance liability, a regular follow-up occurs requesting the entire account balance.
- If one account has insurance liability and the other account does not, memo and regular follow-up are produced. For detail statements, the system attempts to put both types on one piece paper. Collection letters appear on two separate pages.
- If there is one account for a guarantor with both insurance and patient liability, a memo message is sent showing the entire account balance.

10. BILL BALANCE (1-A-R)
This field contains the dollar amount that is requested from the guarantor during follow-up. Entry options are **P** (patient balance) or **A** (account balance); the default is P. This field is only used when the Insurance Pending (INS PENDING) field is set to B.

If you enter P in this field, the following can occur:

- No memo message is created.
- A request for the patient portion appears with information noting the insurance liability.
- No follow-up occurs if there is no patient liability.

NOTE: The account is not considered a *new account* until all insurance liabilities are gone. A new account forces the system to resequence based on dollars and the new account sequence number in the follow-up schedule. Under this scenario a guarantor that had accounts past the end of the schedule and was ready to prelist, and the same guarantor has an account that transferred part of the money to the patient, the account would not resequence. This account could then qualify for prelisting prior to receiving follow-up. To keep this from occurring, the Prelist Insurance Flag should be set to no. When bad debt prelist is run, this account would show as a prelist exception and repeats the last step of this schedule. Once the insurance liability is gone, the account resequences according to the new account resequence parameters.

If you enter **A** in this field, the following can occur:

- No memo message is created.
- A request for the account balance appears on the paper follow-up.
- Follow-up always occurs.

The Restart % and Restart Amount Fields

These fields determine the minimum payment amount or percentage of the account balance the guarantor must send in order to cause resequencing in the schedule. If the amount or percent of amount due is received before the next follow-up, the system resequences or restarts follow-up based on the defined restart sequence number.

For example, the hospital enters 30% in the Restart % field and $50.00 in the Restart Amount field. The guarantor pays $45.00 towards a $100.00 bill. Despite the fact that the guarantor has not paid $50.00, he has satisfied 30% of the amount due and is, therefore, eligible for resequencing.

You can complete either the Restart % or Restart Amount field, both, or neither. If neither field is completed, any guarantor payment causes resequencing. If the Restart % field is completed, only a percent value is used to resequence. If both fields are completed, only one criterion needs to be met to cause resequencing.

11. ACCT REST % (2-N-O)
This field contains the percent of the last follow-up amount for the account that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence) until this percent is paid. The entry range is 0 to 100.00%. This field is used by accounts on account level follow-up.

12. ACCT REST AMOUNT (8-N-O)
This field contains the minimum amount that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point). This field is used by accounts on account level follow-up.

13. GUAR REST %
This field contains the percent of the last follow-up amount for the guarantor that must be paid by the guarantor in order to resequence follow-up to another event. follow-up continues on to the next event until this percent is paid. The entry range is 0 to 100.00%. This field is used by accounts on guarantor level follow-up.

14. GUAR REST AMT
This field contains the minimum amount that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point). This field is used by accounts on guarantor level follow-up.

15. RESEQ. BALANCE (8-AN-R)
This field contains the minimum balance required to cause resequencing of the guarantor follow-up schedule if a new account is added to the guarantor schedule. You can enter up to 999,999.99 (you must enter the decimal point) or U (unlimited); the default is U. The guarantor is resequenced if the account balance of the new account exceeds the amount entered in this field. If you enter U, the addition of new accounts to the guarantor never causes resequencing of the guarantor follow-up schedule.

Assuming the criteria in this field is met, the carrier balance must be zero in order for resequencing to occur.

NOTE: When a new account is added to a guarantor who has reached the end of the follow-up schedule, the guarantor resequences to the New Account Restart Step number if the account:

- Meets the resequencing balance criteria, and
- Has a resequencing step entered in the *New Account Restart Sequence Number* field.
- There is no longer insurance liability for Memo, Suppressed, or Bill/Patient accounts, or it is a newly final billed account whose schedule is bill/account.

16. MAX PAPER BALANCE (8-AN-R)
This field contains the maximum balance required for paper follow-up. The entry range is 0 to $999,999.99 or U for unlimited; the default is U. If the account balance is greater than the maximum paper balance, the account is selected for telephone follow-up only.

17. MIN BALANCE (8-N-R)
This field contains the minimum account balance required to continue sending statements. This amount is the hospital small balance write-off for debit balances. The entry range is 0 to $999,999.99.

18. MIN REFUND AMT (4-N-R)
This field contains the minimum credit balance required to not produce a patient refund. This field contains the amount for the hospital credit write-off. If the account balance is less than or equal to the minimum balance, the account does not qualify for a refund but is instead selected for small balance write-off.

NOTE: The amount entered in this field should correspond to the MIN AMOUNT in the Refund Parameter screen under Maintain Facility Information.

19. SMALL BAL WRITE-OFF TRANS CODE/DESC (4-AN-R)
This field contains the transaction code used to update the patient account transaction history and the general ledger. This code is used when an account is automatically written off because it meets the small balance write-off criteria as defined in this follow-up schedule. You can enter the code or a hyphen (-) to display a list of codes under transaction type A (adjustments).

20. MIN ATTEMPTS (2-N-R)
This field contains the minimum number of follow-up attempts to be performed before a small balance write-off is processed. This field allows the hospital to bill a guarantor as many times as indicated for the small balance. A zero indicates no follow-up is performed for the small balance. The entry range is 0 to 99; the default is 0. The entry made here is based on the Minimum Balance field.

21. AUTO PRE-LIST (1-A-R)
This field indicates whether the account should be selected for bad debt pre-listing after the last event (sequence) in the follow-up schedule. Entry options are **Y** for Yes or **N** for No; the default is N. If you enter N, the follow-up schedule sequence is repeated, when the schedule reaches the last event (sequence) until the account is manually pre-listed for transfer to bad debt. Accounts are eligible for automatic prelisting only by reaching the end of the follow-up schedule and having this field set to Y.

This field should be set to No if the Bill/Patient option is chosen in the schedule. If the field is not set to No, accounts may be sent to bad debt prior to receiving any follow-up. Refer to the Bill Balance field for additional information.

22. PRE-LIST MAX BAL (8-N-R)
This field contains the maximum account balance for automatic prelisting for possible transfer to bad debt. The entry range is 0 to $999,999.99; the default is 0. If an account balance is greater than the prelist maximum balance at the end of the follow-up schedule, the last sequence number remains in effect until the balance is less than the prelist maximum balance or the guarantor pays the restart amount and percentage and is resequenced. The account is not automatically prelisted until the account balance falls below the defined maximum. The type of balance (patient or account) is determined by the Select Balance field on this screen.

23. PRE-LIST INS? (1-A-R)
This field indicates whether an account with pending insurance should be prelisted for bad debt. Entry options are Y for Yes or N for No; the default is N.

24. DAYS AFTER INS (3-N-R)
This field contains the number of days to wait - up to 99 - after the final insurance payment before transferring the account to bad debt. The days after insurance are grace days given to the patient to pay any outstanding amount on the account not paid by insurance.

25. BAD DEBT TRANSFER TRANS CODE/DESC (4-N-R)
This field contains the transaction code indicating the transfer of this account from accounts receivable to bad debt. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type S (status transfer). This code is displayed in the patient account transaction history. The transfer to bad debt is controlled by the hospital and takes place for prelisted accounts.

26. DELINQ F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Entry options are D (detail statement), L (letter), or T (telephone).

27. DELINQ F/U MESSAGE (4-N-R)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

28. PARTIAL PAYMENT F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account receives a payment that is not equal to full payment. Entry options are **D** (detail statement), **L** (letter), or **T** (telephone).

29. PARTIAL PAYMENT F/U MESSAGE
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field.

30. PARTIAL PAY F/U % (3-N-O)
This field contains the percentage of the current amount due that must be received to not produce partial payment follow-up. This field is dependent on the Partial Payment F/U Type and the Partial Payment F/U Message. If the Partial Payment F/U Type and the Partial Payment F/U Message fields are not completed, then this field cannot be completed.

The system also verifies current amount due remaining on the account after the payment is posted is greater than or equal to the minimum amount for follow-up. The minimum amount to produce follow-up is the value contained in the Min Balance field on the AR Follow-up schedule. If the current amount due for the guarantor is less than the value in the Min Balance field, the system suppresses the partial payment follow-up. The current amount due for a guarantor is a value calculated for payment plan follow-up.

After you complete and accept this screen, the system displays the second Follow-up Schedules (AR) screen.

```
       General Hospital Financial Table Maintenance Processor
                                              Sun Feb 28, 2006 01:06 pm
Follow-up Schedules (AR)
 1 Schedule #               2 Description
   30                         Guarantor Follow-Up
 3 Edit date                4 Edit by
   02/28/97 13:06             Smith,Carol
                           F/U  Memo  Phone  New Accts  Rest            Agency
 5 Seq#  Follow Type       Msg  Msg   Code   Rest Seq#  Seq#  Interval  Group
   1        W Wait                           1          1      49      KBA
```

Field Explanations - Screen 2 of 2

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. SEQ # (DISPLAY ONLY)
This field contains a sequential number identifying the order of events for this follow-up schedule. You can define as many events as you wish. The sequence number and the follow-up type and code control the order in which follow-up is performed on guarantors assigned to this schedule.

FOLLOW TYPE (1-A-R)
This field contains the type of paper follow-up used for this sequence number. Entry options are **L** (follow-up letter), **D** (detail statement), **T** (telephone), or **W** (wait).

F/U MSG (4-N-R)
This field contains the follow-up message that appears on the detail statement or letter. You can enter the code or a hyphen (-) to display a list of valid codes. This message prints as a follow-up type when the guarantor is selected for that event (sequence). If it is a telephone message, the message is displayed in the assigned collector's workfile.

MEMO MESSAGE (4-N-O)
This field contains the code identifying the memo message that appears on the follow-up letter or detail statement. You can enter the code (up to four numbers) or a hyphen (-) to display a list of valid codes. If the *Insurance Pending* field on the previous screen contains Memo, this message appears on the guarantor detail statement and/or collection letter when insurance is pending on an account.

PHONE CODE (4-N-R)
This field contains the code identifying the phone message used in the collector's workfile, if this is a telephone follow-up. Telephone follow-up occurs if the follow-up type of T (telephone) or if the Max Paper Bal field has been exceeded for this account. You can enter the code (up to four numbers) or a hyphen (-) to display a list of valid codes

NEW ACCOUNTS RESTART SEQ # (2-N-O)
This field indicates the step in the follow-up schedule to which the guarantor is resequenced if a new account is added to the guarantor schedule and the criteria

established in the *Reseq Balance* field on the previous screen is met. The restart sequence number must be less than or equal to the current sequence number.

RESTART SEQ # (2-N-O)
This field contains the follow-up sequence number that is used if the restart % or amount is met and the account balance is paid by the guarantor prior to the next follow-up date. The restart sequence number must be less than or equal to the current sequence number.

For example, General Hospital A sets up the following follow-up sequences:

Sequence	Paper Follow-up Type/Code	Restart
1	D - Detail Statement	
2	D - Detail Statement	1
3	L - Follow-up Letter	1
4	L - Follow-up Letter	2
5	T - Telephone	2

The follow-up event defined in sequence 1 has been performed on the guarantor and the guarantor has either not made a payment or the payment did not meet the restart percent or amount criteria before sequence 2 is scheduled to occur. The sequence 2 follow-up is performed and the guarantor now pays the restart amount or percent before sequence 3 is performed. Since sequence 3 is now the follow-up event the guarantor would normally receive, the system checks the restart sequence field assigned to sequence 3 because payment has been received. If the restart sequence is 1, the event defined in sequence 1 is performed the next time the guarantor receives follow-up. If the minimum amount is paid, the guarantor can remain at the beginning of the follow-up schedule. If the guarantor does not pay the minimum amount, the follow-up continues through the sequences.

Only payments trigger the restart. If new accounts are added to the guarantor, resequencing does not occur and these accounts are treated in the same manner as the others.

This field is optional but it is suggested that you complete it to ensure that guarantors who make payments receive the proper collection messages and are not sent to bad debt.

INTERVAL (3-N-C)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed only if the Day of Month or Day of Week/Week of Month fields are not completed. The first follow-up is scheduled from the final bill date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number.

If this field is completed, the interval days should be defined in conjunction with the Agency Process Optional Batch job interval days. If the Agency Processing optional batch job is run daily, the interval days need to be four or greater in order for the account to go through the statuses of flagged, pending, and transfer. Another example is running the optional batch job weekly. In this situation, the interval days need to be 22 or greater (7 Optional batch job interval x 3 statuses x 1).

AGENCY GROUP (6-C-C)
This field contains the Collection Agency Group table code for bad debt, CCI, agency, or insurance collections. You can enter a code or a hyphen (-) to select one from the Collection Agency Group Code Types table. If an agency group code is entered in this field, accounts receive a maintenance code of flagged when this follow-up step is processed.

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

Dependent On	Reference
Collection Agency Group	Financial Class
Detail Statement Messages	
Follow-up Letters	
Telephone Messages	
Transaction Codes	

FOLLOW-UP SCHEDULES (PA)

After the Follow-up Schedule (PA) code is entered, the first of two screens used in this transaction is displayed.

```
          General Hospital Financial Table Maintenance Processor
                                                 Mon Apr 17, 2000 11:23 am
Follow-up Schedules (PA)
 1 Schedule #    2 Description                                    3 Wait Days
   999             INPATIENT SCHEDULE                               10
 4 Day of Month  5 Day of Week   6 Week of Month  7 Due Days      8 Grace Days
                                                   10               10
 9 Ins Pending  10 Bill Balance 11 Restart %     12 Restart Amt  13 Min Balance
   Bill            Account                                          $0.00
14 Transfer Balance Pymt Plan to AR?   15 AR Payment Plan Schedule #
   No
16 Transfer Advanced Pymt Plan to AR?  17 AR Payment Plan Schedule #
   No
18 Transfer Customized Account to AR?  19 AR Custom Schedule #
   No
20 Delinquent F/U Type                 21 Delinquent F/U Message

22 Partial Payment F/U Type            23 Partial Payment F/U Message

24 Partial Payment F/U %


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

Field Explanations - Screen 1 of 2

1. SCHEDULE # (3-N-R)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (30-C-R)
This field contains the description of the follow-up schedule code.

3. WAIT DAYS (2-N-R)
This field contains the number of days to wait from admission date before follow-up is scheduled to begin. The entry range is 0 to 99 days.

Defining Follow-up Frequency

There are three ways to define the frequency of account follow-up: Completing the Day Of Month, Day of Week/Week of Month, or Interval fields. These options, one of which must be selected, are defined below. The Interval option is entered on the second screen.

4. DAY OF MONTH (2-AN-O)
This field contains the day of the month on which the hospital wants follow-up performed for accounts assigned to this schedule. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

5. DAY OF WEEK (1-N-O)
This field contains the day of the week on which the hospital wants follow-up performed for guarantors assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, ... Saturday = 7. If this field is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here. If this field is completed, the *Week of Month* field is required.

6. WEEK OF MONTH (1-N-C)
This field contains the week of the month during which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete the Day of Week field, you must also complete this field. This field is required if the Day of Month field is not completed. If this field is selected, guarantors assigned to this schedule receive follow-up once a month, during the week entered here and on the day entered in the Day of Week field.

7. DUE DAYS (2-N-R)
This field contains the number of days used in calculating the due date. The entry range is 0 to 99 days; the default is 0. This field applies only to payment plans.

8. GRACE DAYS (2-N-R)
This field contains the number of days after the due date before an account is delinquent. The entry range is 0 to 99 days; the default is 0. The statement print date plus the due days plus the grace days equals the delinquent date. This only applies to payment plans.

9. INS PENDING (1-AN-0)
This field determines what type of follow-up occurs on accounts with pending insurance. Entry options are **B** (bill) or **M** (memo); the default is B.

If you enter B in this field, the type of follow-up that occurs depends on how the *Bill Balance* field is set.

If you enter M in this field, the following can occur:

- A memo message prints for accounts with pending insurance.
- If there is no insurance liability, a regular follow-up occurs requesting the entire account balance.

10. BILL BALANCE (1-A-R)
This field contains the dollar amount that is requested from the guarantor during follow-up. Entry options are P (patient balance) or A (account balance); the default is P. This field is only used for regular PA follow-up and payment plans that have a payment plan type of balance.

If you enter P in this field, the following can occur:

- A request for the patient portion appears with information noting the insurance liability.

- No follow-up occurs if there is not a positive patient liability balance.
- A transaction history record is written when follow-up is scheduled but not performed because there is no positive patient liability.

If you enter **A** in this field, the following occurs:

- A request for the account balance appears on the paper follow-up.
- Follow-up always occurs.

The Restart % and Restart Amount Fields

These fields determine either the minimum payment amount or the percentage of the account's last follow-up amount which must be posted to the patient account in order to cause the next follow-up step to be resequenced. If the amount or percent of amount due is received before the next follow-up date, the system resequences or restarts follow-up based on the defined restart sequence number reflected in the step definition on the succeeding page of the schedule. If the field is not completed, resequencing does not occur.

For example, the hospital enters 30% in the Restart % field and $50.00 in the Restart Amount field. The guarantor pays $45.00 towards a $100.00 bill. Despite the fact the guarantor has not paid $50.00, he has satisfied 30% of the amount due on the last follow-up processed and is, therefore, eligible for resequencing of the next follow-up step.

You can complete either the Restart % or Restart Amount field, both, or neither. If neither field is completed, any guarantor payment causes resequencing. If the Restart % field is completed, only a percent value is used to resequence. If both fields are completed, only one of the two criteria needs to be met to cause resequencing.

NOTE: Payments are posted to individual accounts. Guarantors are resequenced based on a single account meeting the resequence criteria. It is suggested that the percent, if used, be set high enough so small payments ($5 or $10) do not cause the next follow-up step to be resequenced.

11. RESTART % (2-N-O)
This field contains the percent of the balance due from the last follow-up event that must be paid in order to resequence the next follow-up step. Follow-up continues on to the next event (sequence) until this percent is paid. The entry range is 0 to 99.99%.

12. RESTART AMOUNT (8-N-O)
This field contains the minimum amount to be paid in order to resequence follow-up to another event sequence. Follow-up continues with the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point).

13. MIN BALANCE (8-N-R)
This field contains the minimum account balance required to continue sending detail statements or collection letters. This field is not used for payment plans set to *Advanced*. The entry range is 0 to $999,999.99.

14. TRANSFER BALANCE PYMT PLAN TO AR?
This field indicates if accounts on balance types of payment plans should remain on payment plans when they transfer to AR. Valid values for this field are **Yes** for *Transfer account payment plan to AR* and **No** for *Do not transfer account payment plan to AR*. If you select Yes, then the system prompts you for an AR Payment Plan Schedule #. When account payment plans transfer to AR, they use the schedule defined in the AR Payment Plan Schedule field. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step, and Next Follow-up Date.

15. AR PAYMENT PLAN SCHEDULE #
This field contains the AR Payment Plan Schedule. This field is required if the Transfer Balanced Pymt Plan To AR? field contains a *Yes*. When account payment plans transfer to AR, they use the schedule defined in this field. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step, and Next Follow-up Date when they transfer to AR.

16. TRANSFER ADVANCED PYMT PLAN TO AR?
This field indicates if accounts on advanced payment plans should remain on payment plans when they transfer to AR. Valid values for this field are **Yes** for *Transfer account payment plan to AR* and **No** for *Do not transfer account payment plan to AR*. If you select Yes, the system prompts for an AR Payment Plan Schedule #. When account payment plans transfer to AR, they use the schedule defined for the AR Payment Plan Schedule. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step, and Next Follow-up Date when they transfer to AR.

NOTE: Only accounts on advanced payment plans that are active in follow-up qualify to transfer to a payment plan in AR. Accounts that have already met their advanced amount do not receive follow-up, so they do not transfer to a payment plan in AR.

17. AR PAYMENT PLAN SCHEDULE #
This field contains the AR Payment Plan Schedule. This field is required if the Transfer Acct Level Advanced Pymt Plan To AR? field contains a *Yes*. When account payment plans transfer to AR, they use the schedule defined in this field. The accounts also retain their Payment Plan Amount, Delinquent Amount, Prepaid Amount, Next Follow-up Step and Next Follow-up Date, when they transfer to AR.

18. TRANSFER CUSTOMIZED ACCOUNT TO AR?
This field indicates if accounts on customized schedules should transfer to AR as customized account level follow-up accounts. Valid values for this field are **Yes** for *Transfer account level custom account to AR* and **No** for *Do not transfer as a customer account level to AR*. If you select Yes, the system prompts you for a Custom AR

Schedule #. When accounts transfer to AR, thy use the schedule defined for the AR Custom Schedule.

19. CUSTOM AR SCHEDULE #
This field contains the AR Custom Schedule. This field is required if the Transfer Customized Account to AR? field contains a *Yes*. When customized plans transfer to AR, they use the schedule defined in this field.

20. DELINQUENT F/U TYPE (1-A-O)
This field indicates the type of follow-up generated when a payment plan account becomes delinquent. Entry options are **D** (detail statement) or **L** (letter).

21. DELINQUENT F/U MESSAGE (4-N-R)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field. This field is required only when the *Delinquent F/U Type* is defined.

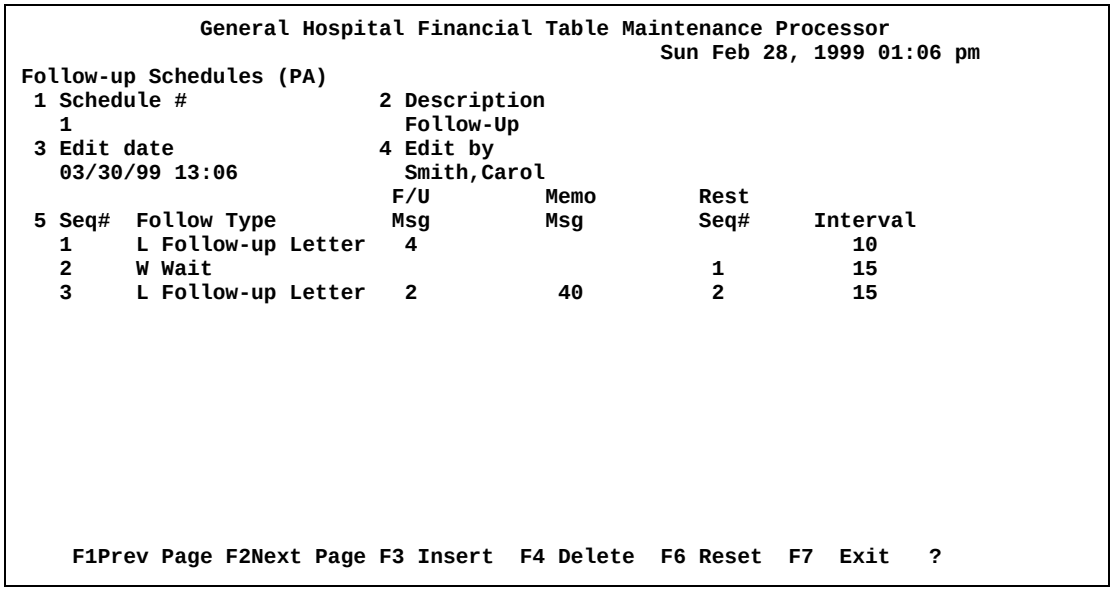
22. PARTIAL PAYMENT F/U TYPE (1-A-O)
This field indicates the type of follow-up generated when a payment plan account receives a payment not equal to or greater than a full payment. Entry options are **D** (detail statement) or **L** (letter).

23. PARTIAL PAYMENT F/U MESSAGE
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field. This field is required only when the *Partial Payment F/U* Type field is defined.

24. PARTIAL PAY F/U % (3-N-O)
This field contains the percentage of the current amount due that must be received to not produce partial payment follow-up. This field is dependent on the Partial Payment F/U Type and the Partial Payment F/U Message. If the Partial Payment F/U Type and the Partial Payment F/U Message fields are not completed, then this field cannot be completed.

The system also verifies the current amount due remaining on the account after the payment is posted is greater than or equal to the minimum amount for follow-up. The minimum amount to produce follow-up is the value contained in the Min Balance field on the PA Follow-up schedule. If the current amount due for the guarantor is less than the value in the Min Balance field, the system suppresses the partial payment follow-up. The current amount due for a patient account is a calculated value for payment plan follow-up only.

After you complete and accept this screen, the system displays the second Follow-up Schedules (PA) screen.



Field Explanations - Screen 2 of 2

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the follow-up schedule code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. SEQ # (DISPLAY ONLY)
This field contains a sequential number identifying the order of events for this follow-up schedule. You can define as many events as you wish. The sequence number, the follow-up type, and code control the order in which follow-up is performed on patient accounts assigned to this schedule.

FOLLOW TYPE (1-A-R)
This field contains the type of paper follow-up that is used for this sequence number. Entry options are **L** (follow-up letter), **D** (detail statement), or **W** (wait).

F/U MSG (4-N-R)
This field contains the follow-up message appearing on a detail statement or collection letter. You can enter the code or a hyphen (-) to display a list of valid codes. This

message prints as a follow-up type when the patient account is selected for that event (sequence).

RESTART SEQ # (2-N-O)
This field contains the follow-up sequence number that is used if the restart % or amount is met (defined on Screen 1 of the PA Follow-Up Schedule Definition.) The restart sequence number must be less than or equal to the current sequence number. Only guarantor/patient payments trigger the restart functionality.

INTERVAL (3-N-C)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed only if the Day of Month or Day of Week/ Week of Month fields are not completed. The first follow-up is scheduled from the admission date plus the wait days. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number.

HIPAA INSURANCE TYPE

For details on this table, please refer to the *Tables Volume* of the *STAR Patient Care Reference Guide*.

HIPAA INSURED RELATION

For details on this table, please refer to the *Tables Volume* of the *STAR Patient Care Reference Guide*.

INSURANCE FOLLOW-UP SCHEDULE DOLLAR DEFINITIONS

This table determines which insurance follow-up schedule is assigned to a claim when it is submitted and is used in the process of targeting high-dollar insurance claims and producing insurance follow-up more frequently for the high-dollar claims. It provides the ability to define a relationship between the insurance follow-up schedules and the claim amounts. You enter a dollar amount and the code for the follow-up schedule on this table. The table values are used when assigning insurance schedules. The system uses the claim amount associated with a claim when assigning an insurance follow-up schedule.

This table also determines which appeal follow-up schedule to assign for appeal tracking. When the Appeal Tracking field is set to yes, this insurance follow-up schedule dollar definition is defined as an appeal dollar definition. Appeal Dollar Definitions are contained in the Denial Tracking Payor Table Definitions Processor and in the Denial Appeal Parameters Processor. If the Appeal Tracking field is set to Yes, only appeal follow-up schedules can be selected in both the Default Ins F/U Schedule and the Schedule fields.

After this table is selected, the system prompts you to enter a code for the follow-up schedule dollar definition. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, the following screen is displayed:

```
       General Hospital Financial Table Maintenance Processor
                                                Mon Jun 23, 2006 10:00 am
Insurance F/U Sch Dollar Definition
 1 Code          2 Description                          3 Appeal?
   2               COMMERCIAL INSURANCE SCHED (IFDD)      No
 4 Default Ins F/U Schedule        5 Edit By             6 Edit Date
   2-COMMERCIAL INSURANCE SCHEDUL    Bass, Mike           06/23/06 02:18p
 7 Dollar          Schedule
   $3.00          6-TODD'S NON APPEAL SCHEDULE



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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the Insurance Follow-up schedule definition.

2. DESCRIPTON (DISPLAY ONLY)
This field contains the code description.

3. APPEAL? (1-A-R)
This field contains Yes, if this is an insurance appeal dollar definition. When the field is accessed, the following prompt is displayed:

Is this an insurance appeal dollar definition (Y/N) [N]?--

4. DEFAULT INS F/U SCHEDULE (TABLE LOOKUP)
This field contains the default schedule code. If the Appeal Tracking field is set to Yes, then only appeal follow-up schedules are displayed and can be selected. If the schedule is set to No, only standard follow-up schedules can be selected (this excludes appeal and external schedule types).

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

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

7. DOLLAR (9-N-R)
This field contains the dollar amount used to assign the schedule. Valid entries are a dollar amount or **U** (Unlimited). The system uses the claim amount associated with a claim when assigning the insurance follow-up schedule.

SCHEDULE (TABLE LOOKUP)
This field contains the code and the description of the insurance follow-up schedule. You can enter a hyphen(-) to display a list of insurance schedules. This field is required if the Dollar amount is entered. If the schedule is set to No, only standard follow-up schedules can be selected (this excludes appeal and external schedule types). If the Appeal Tracking field is set to Yes, only appeal follow-up schedules are displayed and can be selected. This field is required if the Dollar field is entered.

When adding a new Insurance F/U Dollar Definition code for the first time, after completing the information on the screen, press F7. The following prompt is displayed:

Accept this screen Y/N?

If you enter Y for Yes, the system accepts the Insurance F/U Dollar Definition code and returns to the Insurance F/U Dollar Definition code table lookup screen.

When editing an existing Insurance F/U Dollar Definition code, after modifying the fields in the Insurance F/U Dollar Definition entry, press F7 to exit. The following prompt is displayed:

Accept this screen Y,N,D[Y]?

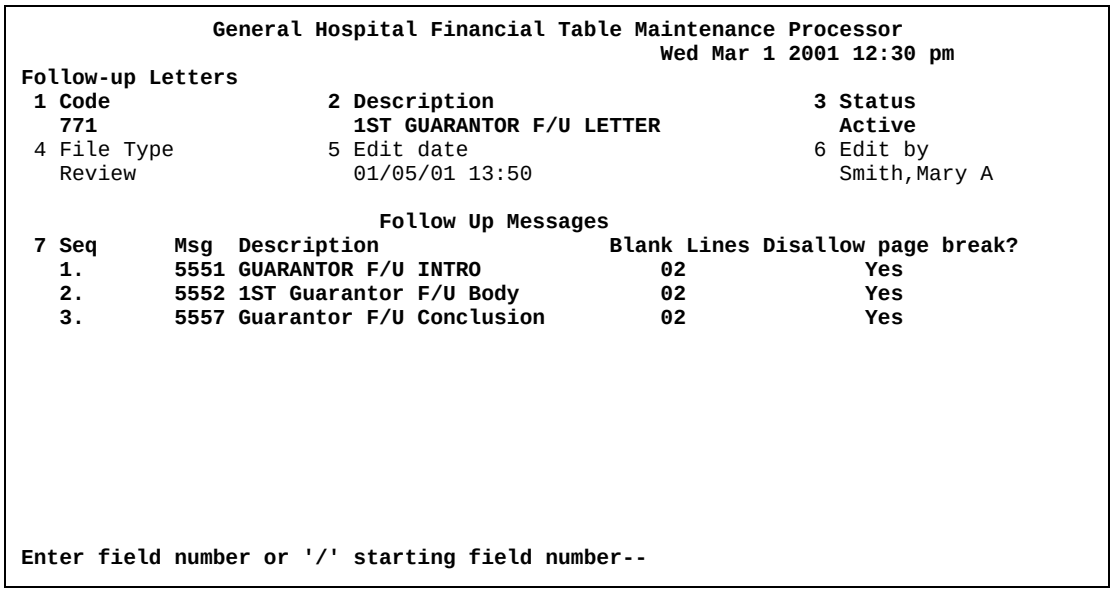
If you answer Y for Yes, the changes are saved and the Insurance F/U Dollar Definition table lookup screen is displayed. If you answer N for No, the system does not accept the changes and returns to the prompt. If you respond D for Delete, the system deletes the Insurance F/U Dollar Definition code.

INSURANCE FOLLOW-UP LETTERS

This table is used to combine insurance follow-up letter messages into insurance follow-up letters. Letters are constructed from the messages defined in the Insurance Message table. The insurance follow-up letters are used in the Insurance Follow-up Schedules to indicate whether a letter should be sent to an insurance company and to determine what messages are contained in the letter.

This table is not split by facility

After this table is selected, the system prompts you to enter an insurance follow-up letter code. You can enter the code or a hyphen (-) to display a list of valid codes. After the insurance follow-up letter code is entered or selected, this screen is displayed.



```
              General Hospital Financial Table Maintenance Processor
                                                  Wed Mar 1 2001 12:30 pm
Follow-up Letters
 1 Code                 2 Description                          3 Status
   771                    1ST GUARANTOR F/U LETTER               Active
 4 File Type            5 Edit date                            6 Edit by
   Review                 01/05/01 13:50                         Smith,Mary A

                            Follow Up Messages
 7 Seq      Msg  Description                  Blank Lines Disallow page break?
   1.       5551 GUARANTOR F/U INTRO              02              Yes
   2.       5552 1ST Guarantor F/U Body           02              Yes
   3.       5557 Guarantor F/U Conclusion         02              Yes









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying this insurance follow-up letter.

2. DESCRIPTION (30-C-R)
This field contains the description of the insurance follow-up letter code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

4). FILE TYPE (1-A-R)
This field indicates the spool file to which the follow-up letter is sent. Entry options are **R** (Review) or **A** (Automatic). Entry of **R** spools the letter to the Review Collection Letter spool files. Entry of **A** (Automatic) spools the letter to the Collection Letter Spool files.

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

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

SEQ (DISPLAY ONLY)
This field contains the sequence number identifying the message. You can enter as many sequences as you wish in constructing your letters. The system displays the next number when you access the field for data entry.

MSG (4-N-R)
This field contains the code identifying the insurance follow-up letter message associated with this sequence number. You can enter the code or a hyphen (-) to display a list of valid codes.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the insurance follow-up letter message code.

BLANK LINES (2-N-O)
This field contains the number of blank lines between this message and the next. The range is 1 to 99 lines.

DISALLOW PAGE BREAKS (1-A-R)
This field indicates whether the message can be split between multiple pages of the letter. Entry options are Y for Yes or N for No. An entry of Y indicates that the paragraph is not split between multiple pages. If the paragraph does not fit on one page, the entire paragraph is printed on a subsequent page.

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

Dependent On	Reference
Insurance Letter Messages	Insurance Follow-up Schedules

INSURANCE FOLLOW-UP SCHEDULES

This table defines the type and frequency of follow-up performed for an insurance carrier after a claim is submitted and also which Collection Agency may be assigned to the claim by use of the Collection Agency Group table linked to a follow-up step. The schedule definition specifies whether the schedule is used for internal collections or for external collections. Insurance follow-up schedule assignment is based on the patient's insurance carrier and plan as assigned in the follow-up parameters of the Insurance Plan Coverage master. A different follow-up schedule can be assigned to each of the possible four/nine insurance plans supported for each patient.

Appeal follow-up and Appeal Insurance follow-up schedules for insurance plans can also be defined on this table. The Appeal follow-up is initiated after a denial occurs on a claim, if the claim meets denial/appeal criteria. The appeal schedules are assigned after the claim becomes an active appeal, and are assigned at the payor level with a defined schedule, allowing for different schedules based on denial reason codes, patient types or patient type and denial reason codes. The Appeal field must be set to Yes to create an insurance appeal schedule.

Follow-up schedules specifically for the Appeal process can be assigned based on either user or system active appeal status. The appeal schedules are assigned after the claim becomes an active appeal and are assigned at the payor level with a default schedule, allowing for different schedules based on denial reason codes, patient types or patient type and denial reason codes.

When a schedule is defined as an external type, the fields that can be updated are restricted. The Schedule Code, Description, Wait Days, and Ext PC? fields can be defined. The Max Paper Bal, Min Balance, Timeout Days, and Resequence fields are defaulted by the system and cannot be edited. The Post Agy Sch field can be updated, and it is user-defined. Any insurance follow-up schedule not defined as an appeal or external pre-collect type can be selected. This schedule is used to allow the claim to time out and, subsequently, to transfer balances to the next carrier/patient. The schedule steps are defined only with wait steps, since the collection process is terminated through STAR Patient Accounting. The interval days and pre-col group can also be edited by the user. When the claim is processed for follow-up, and the step is defined with a Collection Group, the claim may be automatically transferred from one agency to another.

This table is not split by facility.

After this table is selected, the system prompts you to enter an insurance follow-up schedule code. You can enter the code or a hyphen (-) to display a list of valid codes. There are two screens involved in entering or editing Insurance Follow-up Schedules. The first defines follow-up frequency and the second defines the steps in the follow-up

sequence. After the insurance follow-up schedule code is entered or selected, the first screen is displayed.

```
        General Hospial Financial Table Maintenance Processor
                                        Wed Jun 22, 2011 03:32 pm
Insurance Follow-up Schedules
 1 Schedule  2 Description                    3 Appeal  4 Ext Agy  5 Multiple
   528         laura's appeal schedule          Yes       No         No
 6 Wait Day  7 Appeal Due Days   8 Day of Month  9 Day of Week 10 Week of Month
   0           0
11 Max Paper Bal 12 Min Balance  13 Timeout Days 14 Resequence 15 Post Agy Sch
   Unlimited        $0.00           Unlimited       No
16 ISBWO            17 ISBWO Amount      18 ISBWO Claims
   No
19 ISBWO Days from Submit Date           20 ISBWO Trans Code/Desc

21 Insurance Letter To Guarantor Message 22 Auto Update Appeal 23 Auto Transfer
                                           No
24 Days Past Bill 25 Auto Re-Assign Step 26 Ins F/U Dollar Definition

Guar Time Out   27 F/U Type        28 Code                      29 Amt Due Bal

30 Produce F/U for CCI Accts    31 Produce F/U for Agency Accts(int/ext)
```

Field Explanations - Screen 1 of 2

1. SCHEDULE # (3-N-R)
This field contains the code identifying this insurance follow-up schedule.

2. DESCRIPTION (30-C-R)
This field contains the description of the insurance follow-up schedule code.

3. APPEAL? (1-A-R)
This field indicates if this is an appeal follow-up schedule. When this field is accessed, the following prompt is displayed:

Is this an insurance appeal follow-up schedule? (Y/N) N]--

If this field is set to Yes, the follow-up schedule is considered an appeal follow-up schedule and the following fields are set as follows:

Field	Value
Multiple?	No
Timeout Days	Unlimited
Resequence	No
ISBWO?	No

4.) EXT PC? (1-A-R)
This field defines whether this schedule type is used for internal collections or for external pre-collections. This field does not apply to denial and appeal schedules, and

is accessible only if the Appl? (Appeal) field is defined as No. When this field is accessed, the following prompt is displayed:

External Pre-Collect Schedule (Y/N)? [N] -

You can enter **Y** (Yes) if the schedule is used for external pre-collections or **N** (No) if the schedule is used for internal collections. When the schedule is defined as External, the Step Definition screen is updated to allow access only to the Interval Days and the PreCol Group fields. Only wait steps can be defined. An External schedule type triggers the system to create a data file to be sent to the specific collection agency. The only fields that can be completed by the user are Wait Days and Post PC Sch. The Max Paper Bal, Min Balance, Timeout Days, and ISBWO? fields are updated by the system with appropriate defaults and cannot be edited by users.

5. MULTIPLE? (1-A-R)
This field indicates whether multiple accounts should be included on one follow-up letter to the carrier. Multiple accounts print on the same follow-up letter if the accounts are selected for the same follow-up message and are associated with the same carrier and plan. Entry options are Y for Yes or N for No; the default is N.

For appeal follow-up schedules, this field is automatically set to No.

6. WAIT DAYS (2-N-R)
This field contains the minimum number of days to wait, after a claim is submitted, before the first follow-up event occurs. The entry range is **0** to **99**.

7. APPEAL DUE DAYS (3-N-C)
This field contains the number of days to begin appeal follow-up based on the days from the appeal due date. Valid values are 0 to 999. If the appeal due date is 120 days from appeal date, and this field is set to 30, the first follow-up date is 90 days after the date originally set to appeal. If no appeal due date exists at the time the account is worked, the default date is the number of days specified in the wait days. When this field is accessed, the following prompt is displayed:

Enter number of days prior to appeal due date to begin --

If the field is modified, the is displayed as follows:

Enter new number of days prior to appeal due date to begin --

Defining Follow-up Frequency

There are three ways to define the frequency of account follow-up: Completing the Day Of Month, Day Of Week, or Interval fields. These options, one of which must be selected, are defined below. The Interval option is entered on the second screen.

8. DAY OF MONTH (2-AN-O)
This field contains the day of the month on which the hospital wants follow-up performed for carriers assigned to this schedule. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter 15 if you wanted follow-up performed on day 15 of every month.

9. DAY OF WEEK (1-N-O)
This field contains the day of the week on which the hospital wants follow-up performed for carriers assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, ... Saturday = 7. If this field is selected, claims assigned to this schedule receive follow-up once per month, on the day entered here.

10. WEEK OF MONTH (1-N-C)
This field contains the week of the month during which follow-up is performed for carriers assigned to this schedule. Entry options are 1 through 4. If you complete the Day Of Week field, you must also complete this field. This field is not required if the Day Of Month field is completed. If this field is selected, claims assigned to this schedule receive follow-up once a month, during the week entered here and on the day entered in the Day Of Week field.

11. MAX PAPER BAL (8-AN-R)
This field contains the maximum dollar balance required for paper follow-up. The entry range is 0 to $999,999.99 or U for unlimited; the default is U. If the sum of the carrier responsibility is greater than the maximum paper balance, the carrier is selected for telephone follow-up only.

12. MIN BALANCE (8-N-R)
This field contains the minimum claim balance required to continue insurance follow-up. If the claim balance drops below this amount, no paper insurance follow-up is produced. However, the next date and sequence continue to update until the claim is either final dispositioned or time-out occurs. The entry range is 0 to $999,999.99.

13. TIMEOUT DAYS (3-AN-O)
This field contains the number of days, after the last follow-up sequence is completed, for the system to examine the Insurance Time-out parameters to determine if the remaining carrier liability is transferred to the patient or to another carrier. Insurance time-out indicates the liability of the insurance transfers to someone else. Time-out can be disallowed by the Timeout Parameter in the Financial Class table. The Insurance Time-out parameter is used to indicate where the balance is transferred. The entry range is 0 to 999 days or U (unlimited).

Time-out occurs when the claim is at the end of the schedule.

For appeal follow-up schedules, this field is automatically set to Unlimited.

14. RESEQUENCE? (1-A-O)
This field determines if partial insurance payments should resequence insurance follow-up back to step one. A value of Y for Yes indicates that follow-up should

resequence back to step one. A value of N for No indicates follow-up should not resequence back to step one.

For appeal follow-up schedules, this field is automatically set to No.

15. POST AGY SCH (1-A-O)
This field contains the Collection Schedule that AR accounts automatically transfer to when pre-listed for Bad Debt.

For appeal follow-up schedules, this field is automatically set to No.

16. ISBWO? (1-A-O)
This field determines if an insurance should be reviewed for an insurance small balance write-off (ISBWO). Only accounts in an accounts receivable location can be considered for an ISBWO. Entry options are Y for yes or N for no. The default is N. Enter **Y** to indicate an insurance using this follow-up schedule should be considered for an ISBWO. Enter **N** or press ENTER to indicate that an insurance using this follow-up schedule should not be considered for an ISBWO. When you access this field, the system displays the following prompt:

Review insurance for small balance writeoff? (Y/N) [N]

For appeal follow-up schedules, this field is automatically set to No.

If this field is set to Yes, the ISBWO Amount, ISBWO Claims, and the ISBWO Trans Code fields are required.

17. ISBWO AMT (4-A-CONDITIONAL)
This field contains the maximum insurance balance required for an insurance to be considered for an ISBWO. This amount is the upper limit for an ISBWO. The lower limit is defined by the Insurance Refund parameter. When you access this field, the system displays the following prompt:

Enter maximum insurance balance required for an ISBWO --

This field is required if the ISBWO? field is set to Yes.

18. ISBWO CLAIMS (1-A-CONDITIONAL)
This field indicates whether accounts with an insurance, using this follow-up schedule, should be considered for an ISBWO if there are claims for the insurance that have not been submitted and do not have a final disposition. Entry options are Y for yes or N for no. The default is N. Enter **Y** to indicate that accounts with an insurance using this follow-up schedule should be considered for an ISBWO regardless of if the claim has not been submitted or does not have a final disposition. Enter **N** to indicate accounts with an insurance using this follow-up schedule should not be considered for an ISBWO if there are claims for the insurance that have not been submitted and do not have a final disposition. When you access this field, the system displays the following prompt:

Select for ISBWO if there are outstanding claims for insurance? (Y/N) [N]

This field is required if the ISBWO? field is set to Yes.

19. ISBWO DAYS FROM SUBMIT DATE (3-N-R)
This field contains the number of days after the claim submit date the system should wait before performing an Insurance Small Balance Write-off. This field is valid only if the ISBWO Claims field is set to No. This field allows the Insurance Carrier time to pay before the system processes an ISBWO. When you access this field, the system displays the following prompt:

Days to wait after Claim Submit Date for Insurance Small Balance Writeoff --

20. ISBWO TRANS CODE/DESC (TABLE LOOKUP)
This field contains the transaction type and code identifying this insurance small balance write-off. A transaction type and code can be entered directly into the field, or you can select one from the table lookup. For example, if the transaction type is an A, all transaction codes with a type of A are displayed in the table lookup. When you access this field, the system displays the following prompt:

Enter transaction code, or '-' for list --

This field is required if the ISBWO? field is set to Yes.

21. INSURANCE LETTER TO GUARANTOR MESSAGE (2-N-O)
This field determines if an Insurance Letter for the Guarantor is generated when an Insurance Letter is produced for the insurance carrier/plan through the insurance follow-up schedule. This field also controls what message prints on the first page of the Insurance Letter to the Guarantor. If the Multiple Accts field on the Insurance Follow-Up schedule is set to Yes, the Insurance Letter to Guarantor Message field cannot be completed. If the field already was completed, it is blanked out when the Multiple Accts field is set to Yes.

22. AUTO UPDATE APPEAL? (1-A-C
This field indicates whether the system should automatically update the active appeal status and appeal action. When the field is accessed, the following prompt is displayed:

Auto update active appeal status and action (Y/N) [N]?--

If you enter **Y** for Yes, the system updates the status and actions automatically. When letters are generated, the status is updated and the action is updated with an action of LETTR. If a workfile entry is generated and the entry is processed, the system updates the status and the action of CALL is updated on the account. The status is updated incrementally, from Active - 1st attempt, to Active - 2nd attempt, etc.

23.AUTO TRANSFER (1-A-O)
This field indicates whether a claim should automatically transfer to the post agency insurance follow-up schedule when the associated financial class is set not to allow time out.This field can be accessed only if the Ext Agy field is set to Yes.

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

Auto Transfer to Post Agy Sch when FC Time Out is set to No(Y/N)? [N]--

You can enter Y (Yes) Yes to indicate that the system auto transfers to the schedule defined in the Post Agy Sch field.

24.DAYS PAST BILL (4-N-O)
This field contains the number of days past bill date that triggers the re-assignment of the insurance follow-up schedule. If the claim associated with the bill is a cycle claim the system uses the associated cycle bill date. If the claim associated with the bill is a final claim the system uses the associated final bill. If the cycle or final claim has been adjustment billed it will still use the first cycle bill date and the final bill date in the calculation for Days Past Bill. For example, if the field contains a value of 90 and the claim is a final claim then the system will use the final bill date and determine if account is 180 days past the bill date. If the account final billed on 12/01/10 then 90 days past 2/01/10 is 3/1/11. On 3/01/11, the claim will qualify to have the insurance f/u schedule reassigned.

Note, if the Auto Re-Assign Step field is completed then the claim must satisfy both the Days Past Bill and the Auto Re-Assign Step field for the claim to move to the new schedule. The claim starts at step 1 of the new follow-up schedule and the next follow-up date is set according to the wait days in the new follow-up schedule. Also the claim doesn't qualify for re-assignment if it is associated with an appeal or external insurance follow-up schedule. Claims that have time out set to NO and are looping the last step would be evaluated when follow-up processed. If the claim met the criteria for schedule re-assignment then it would change schedules.

25.AUTO RE-ASSIGN STEP (3-N-O)
This field contains the insurance follow-up step that triggers the re-assignment of the insurance follow-up schedule.If this field is completed, the account must satisfy both the Days Past Bill and the Auto Re-Assign Step field for the claim to move to the insurance follow-up schedule. The claim starts at step 1 of the new follow-up schedule and the next follow-up date will be set according to the wait days in the new follow-up schedule.

26.INS F/U DOLLAR DEFINITION (TABLE LOOKUP-O)
This field contains the insurance follow-up dollar definition code used if the claim meets the criteria for reassignment. The system uses the insurance dollar definition code to determine the insurance follow-up schedule. Claims can't be reassigned to insurance follow-up schedules defined as appeal or external insurance follow-up schedules.

GUAR TIME OUT

27. F/U TYPE (1-A-O)
This field indicates the type of follow-up sent to the guarantor when insurance time-out occurs. The guarantor should be notified through a follow-up event that the bill is now his responsibility. Entry options are D (detail statement), L (letter), or T (telephone). If you leave this field blank, the next two fields (Code and Amount Due Balance) are also blank.

If the Amount Due (patient or account, depending on the entry in the Amount Due Balance field) is a credit, zero amount, or below the minimum balance to send guarantor follow-up, the system does not print the follow-up type (detail statement or letter).

25. CODE (2-N-O)
This field contains the code identifying the message used with the follow-up type selected in the F/U Type field. You can enter the code or a hyphen (-) to display a list of valid codes.

26. AMOUNT DUE BALANCE (1-A-R)
This field indicates whether the patient or account balance is used as the balance due amount for guarantor follow-up at time-out. Entry options are P (patient balance) or A (account balance); the default is A.

27. PRODUCE F/U FOR CCI ACCOUNTS (1-A-O)
This field determines if the time out guarantor follow-up, specified in the above follow-up type field, should be produced for CCI Internal Pre-Collection carriers timing out. A value of Y for Yes indicates that time-out follow-up should be produced for accounts with a CCI type of Internal Pre-Collection. A value of N for No indicates time-out follow-up should not be produced for accounts at CCI Internal Pre-Collection.

28. PRODUCE F/U FOR AGENCY ACCOUNTS (INT/EXT) (1-A-O)
This field determines if the time out guarantor follow-up, specified in the above follow-up type field, should be produced for Internal Pre-Collection accounts that time-out. A value of Y for Yes indicates that time-out follow-up should be produced for accounts at Internal Pre-Collection. A value of N for No indicates that time-out follow-up should not be produced for accounts at Internal Collection.

After these fields are completed, you have the option of accepting, editing or deleting the information on the screen. Accepting the screen displays the second Insurance Follow-up Schedules screen.

```
              General Hospital Financial Table Maintenance Processor
                                                        Mon Jul 10, 2007 12:26 pm
Insurance Follow-up Schedules
 1 Schedule #          2 Description                  3 Appeal  4 Ext PC
   7                     TEST7                          No        No
 5 Edit date           6 Edit by
   09/16/05 14:29        New, Nancy
                                                                   Agency
 7 Seq #   Paper Code    Phone Code                        Interval  Group

   1             1             13
   2             2             14
   3             2             99


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

Field Explanations - Screen 2 of 2

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying the selected insurance follow-up schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the insurance follow-up schedule.

3. APPEAL (DISPLAY ONLY)
This field contains the value of Yes if the schedule is an appeal follow-up schedule and the value of No if the schedule is not an appeal follow-up schedule.

4. EXT PC? (DISPLAY ONLY)
This field defines whether the insurance follow-up is used for internal collections or for external collections. An external schedule allows only for intervals and a collection agency group to be defined.

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

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

7. SEQ # (DISPLAY ONLY)
This field contains a number identifying the order of events for this follow-up schedule. You can define as many events as you wish. The sequence number and the follow-up type and code control the order in which follow-up is performed on carriers assigned to this schedule.

PAPER CODE (4-N-O)
This field contains the code representing one of the following:

- Insurance Follow-up Letter sent during this sequence;
- **T** (tracer - copy of the claim with the word Tracer printed on it);
- Blank indicates telephone follow-up should be performed for this sequence.

You can enter a code or a hyphen (-) to display a list of valid codes. Pressing the ENTER key (leaving this field blank) indicates a phone call should be the next step.

PHONE CODE (4-N-R)
This field contains the code identifying the phone message used in the collector's workfile if the event is telephone follow-up. Telephone follow-up occurs if the *Paper Code* field is blank or if the *Max Paper Bal* field has been exceeded for the carrier for this account. You can enter the code or a hyphen (-) to display a list of valid codes.

INTERVAL (3-N-C)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed *only* if the Day of Month, Day of Week, and Week of Month fields are not completed. The first follow-up is scheduled from the final bill date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number. This field is optional but one interval should be defined.

AGENCY GROUP (TABLE LOOKUP-O)
This field contains the Collection Agency Group code. The field is used to define which Collection Agency is assigned to this claim by use of the Collection Agency Group table. You can enter a code or a hyphen (-) to select one from the Collection Agency Group Codes table. If an agency code is entered in this field, accounts receive a maintenance code of flagged when this follow-up step is processed. Follow-up steps that contain an agency code are called collection steps. There can be multiple collection steps defined on the follow-up schedule.

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

Dependent On	Reference
Detail Statement Messages	Insurance Plan Coverage Master
Follow-up Letters	
Insurance Follow-up Letters	
Telephone Messages	

INSURANCE MESSAGES

This table contains sentences or paragraphs that are combined into insurance follow-up letters. Internal data elements can be inserted in the messages to make them account-specific (the insurance last payment date, for example). A list of representative data elements is included. This table is not split by facility.

NOTE: The MCK (MCK Free Form) message code is used for the Edit Insurance Collection Letter function available through the Receivables Workstation. This code is used when building insurance follow-up letters. The MCK Message code allows hospitals to create insurance letters that contain a free-form message. This allows collectors to type in a free-form message through the Insurance Demand Follow-Up form on the Receivables Workstation.

After this table is selected, the system prompts you to enter an insurance message code. You can enter the code or a hyphen (-) to display a list of valid codes. There are two screens involved with entering or editing insurance messages. The first screen associates a code, description, width and length with the message while the second is used to enter or edit the message itself. After the insurance message code is entered or selected, the first insurance message screen is displayed.

```
            General Hospital Financial Table Maintenance Processor
                                                Fri Dec 30, 1988 10:10 am
Insurance Messages
 1 Code                  2 Description
   4442                    1st Insurance F/U Body
 3 Edit date             4 Edit by                                    5 Status
   10/22/90 10:10am        Smith,Mary A                                 Active
 6 Current Width         7 Current Lines
   58                      1
 8 Maximum Width         9 Maximum Lines
   65                      18









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying this insurance message.

2. DESCRIPTION (30-C-R)
This field contains the description of the insurance message code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the existing message you are editing. If you are creating a new message, this field is blank.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the existing message you are editing. This field is blank if you are creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum message width in terms of number of columns. The entry range is 10 to 75; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum message length in lines. The entry range is 1 to 18 lines; the default is 18.

NOTE: Any change to the entry in the maximum width or maximum lines fields affects not only the message you are editing but **all** Insurance messages. If you change this field, the system checks all existing messages to ensure they do not exceed the new maximums. If one or more existing messages exceeds the new maximum, the system displays the following error message:

Warning - message exceeds width and/or length defaults!

The system automatically includes this information in the letter heading:

Mail To	Social Security Number
Name	Cert/SSN/HIC/ID No.
Address	Date(s) of Service
Attn:	Claim Submission Date
Date of Letter	Group Name
Insured Name	Group Number
Patient Name	Account Number
Total Billed Charges	

After you complete and accept this screen, the system displays the second Insurance Messages screen.

```
              General Hospital Financial Table Maintenance Processor
                                                  Fri Dec 30, 1988 10:10 am
 Insurance Messages 1 - Insurance Filed
            1         2         3         4         5         6         7
    12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345
 01|Please contact us with the date and the amount of the payment.                                    |
 02|                                                                                                  |
 03|                                                                                                  |
 04|                                                                                                  |
 05|                                                                                                  |
 06|                                                                                                  |
 07|                                                                                                  |
 08|                                                                                                  |
 09|                                                                                                  |
 10|                                                                                                  |
 11|                                                                                                  |
 12|                                                                                                  |
 13|                                                                                                  |
 14|                                                                                                  |
 15|                                                                                                  |
 16|                                                                                                  |
 17|                                                                                                  |
 18|                                                                                                  |

F1Delete F2Insert F3Center F4Exit F5Store F6Restore F7Pack F8View F9Data F10Help
```

Field Explanations - Screen 2 of 2

You enter the message text on this screen using the format you defined on the first screen.

Inserting Data Elements In The Message Text

Internal data elements are defined and maintained by McKesson. You can insert these data elements into an insurance message:

Database Element	Heading
Acc/Occ Date	User Preference
Claim Submission Date	User Preference
Current Carrier Balance	Money (with $ sign)
Expected Reimb Contr Adj/COB 1	Money (with $ sign)
Expected Reimb Liability/COB 1	Money (with $ sign)
Expected Reimbursement/COB 1	Money (with $ sign)
Hospital Area Code	Use default

Database Element	Heading
Hospital Telephone Number	Use default
Insurance Collector Name	Name (First MI Last)
Insurance Collector Phone Number	Use default
Insurance Collector Extension	Use default
Insurance Last F/U Date	Use default
Insurance Last Payment Date	Use default

These elements print the specific data relevant for the patient but should be used only if you are not combining multiple accounts on insurance follow-up. This is controlled by the insurance follow-up schedule.

In order to select data elements:

1. Position the cursor in the text where you want the data element inserted.

2. Press the **F9** key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display a list of available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted.

   The highlighted area represents the maximum length of the selected element. The format displayed represents the default print routine for the element. For example, most date elements have a default print routine of MM/DD/YY. After accepting the element, the system displays a list of alternate print routines, if applicable. For example, dates can be printed as YYMMDD, MM/DD, MM/YY, etc. If you want the element to print in one of the alternate formats, select the desired format. Otherwise, press ENTER to accept the default print routine. When you accept the element, the process is complete.

5. Pressing the **F4** key saves the message and exits the screen.

NOTE: Since you are entering text for a letter, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

When the message is completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction.

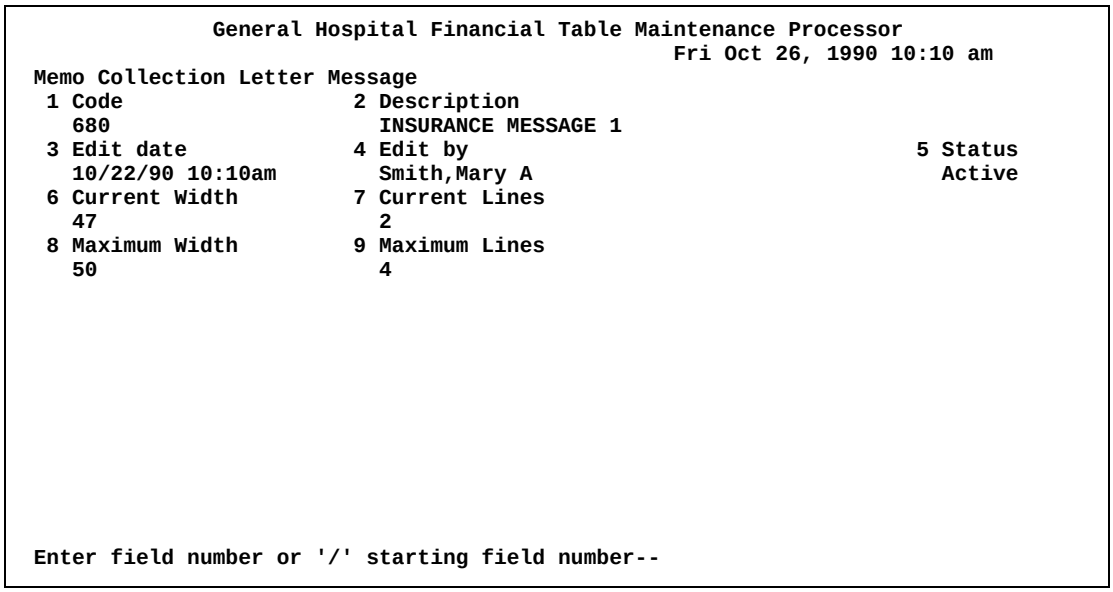
Dependent On	Reference
Format Types	Insurance Follow-up Letters
Internal Elements	

MEMO COLLECTION LETTER MESSAGES

This table, which is not split by facility, contains messages used in building letters that are sent to guarantors who have accounts with pending insurance. The memo collection letters are used in the Follow-up schedules and Agency Follow-up schedules.

NOTE: The MCK (MCK Free Form) message code is used for the Edit Collection Letter function available through the Receivables Workstation. This code is used when building memo follow-up letters. The MCK message code allows hospitals to create letters that contain a free form message. This allows collectors to type in a free form message through the PA or AR Demand Follow up forms on the Receivables Workstation.

After this table is selected, the system prompts you to enter a collection letter memo message code, which can be up to three digits. You can enter the code or a hyphen (-) to display a list of valid codes. There are two screens involved with entering or editing memo collection letter messages. The first screen associates a code, description, width and length with the message while the second is used to enter or edit the message itself. After the collection letter memo message code is entered or selected, the first Memo Collection Letter Message screen is displayed.



Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying this insurance message.

2. DESCRIPTION (30-C-R)
This field contains the description of the memo collection letter message code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the existing message you are editing. If you are creating a new message, this field is blank.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the existing message you are editing. This field is blank if you are creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum message width in terms of number of columns. The entry range is 10 to 75; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum message length in lines. The entry range is 1 to 18 lines; the default is 18.

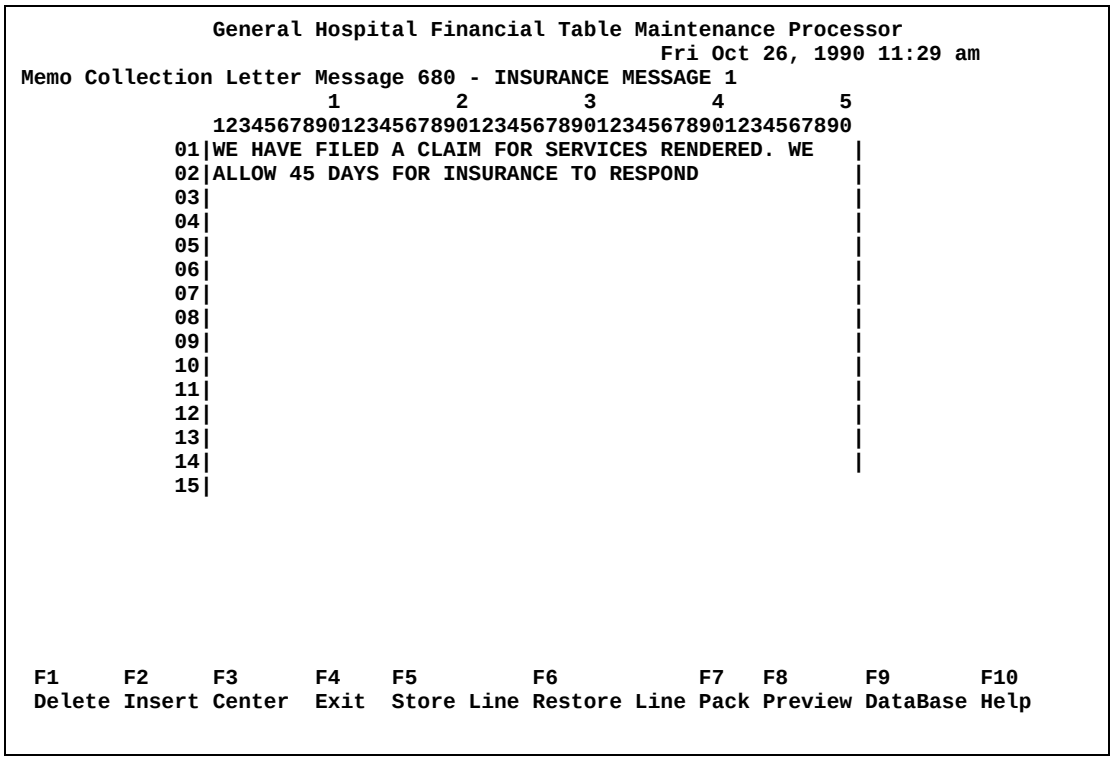
NOTE: Any change to the entry in the maximum width or maximum lines fields affects not only the detail collection letter you are editing but **all** collection letter messages. If you change this field, the system checks all existing messages to ensure they do not exceed the new maximums. If one or more existing messages exceeds the new maximum, the system displays the following error message:

Warning - message exceeds width and/or length defaults!

The system automatically includes this information in the letter heading:

Guarantor Name	Guarantor Address
Guarantor	Guarantor State
Guarantor ZIP	Date of Letter
Admission Date	Account Number
Discharge Date	Account Balance
Estimated Insurance Liability	Greeting
Amount Due	

After you complete and accept this screen, the system displays the second Memo Collection Letter Messages screen.



Field Explanations - Screen 2 of 2

You enter the message text on this screen using the format you defined on the first screen.

Inserting Data Elements In The Message Text

Internal data elements are defined and maintained by McKesson. You can insert these data elements into a memo collection letter message:

Data Base Element	Heading
Acc/Occ Date	User Preference
Account Restart Amount	Money (with $ sign)
Amount of Payments Made - Account	Money (with $ sign)
Amount of Payments Made - Patient	Money (with $ sign)
Biller Name - Primary	Name (First MI Last)
Biller Phone Extension	Use default

Data Base Element	Heading
Biller Phone Number	(999)999-9999
Collector Name	Use default
Collector Phone Number	Use default
Collector's Extension	Use default
Guarantor Restart Amount	Money (with $ sign)
Hospital Area Code	Use default
Hospital Telephone Number	Use default
Provider Phone Number	(999)999-9999
UB82/92 Provider Claim Name	Use default

These elements print the specific data relevant for the patient. For example, if you want the collector's name and phone number in the message, set up the message to include the Collector Name and Collector Phone Number elements. When guarantors receive a letter with that message, the system individually selects the proper collector name and phone number depending on the specific patient.

In order to select data elements:

1. Position the cursor in the text where you want the data element inserted.

2. Press the **F9** key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display a list of available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted.

   The highlighted area represents the maximum length of the selected element. The format displayed represents the default print routine for the element. For example, most date elements have a default print routine of MM/DD/YY. After accepting the element, the system displays a list of alternate print routines, if applicable. For example, dates can be printed as YYMMDD, MM/DD, MM/YY, etc. If you want the element to print in one of the alternate formats, select the desired format. Otherwise, press ENTER to accept the default print routine. When you accept the element, the process is complete.

5. Pressing the **F4** key saves the message and exits the screen.

NOTE: Since you are entering text for a memo collection letter message, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

When the message is completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction.

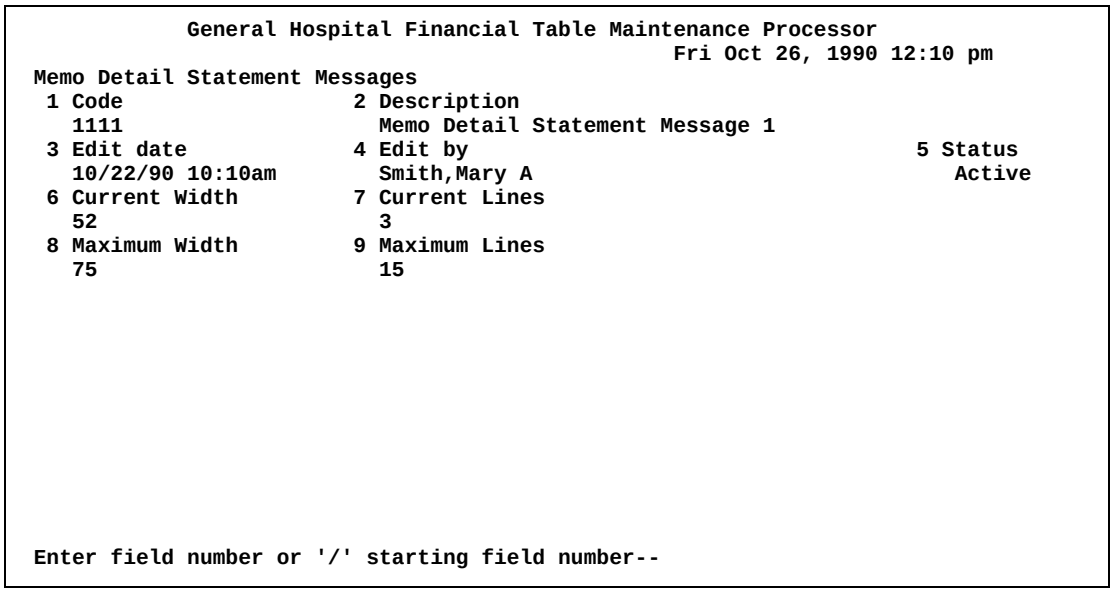
Dependent On	Reference
Format Types	Memo Follow-up Letters
Internal Elements	

MEMO DETAIL STATEMENT MESSAGES

This table defines the messages that are printed on Guarantor and Internal Collection detail statements for accounts with pending insurance. This table is not split by facility.

After this table is selected, the system prompts you to enter a detail statement memo message code, which can be up to four digits. You can enter the code or a hyphen (-) to display a list of codes established in the system. There are two screens involved in this transaction. The first is used to define the message's format and the second to enter/edit the message text.

After the detail statement memo message code is entered or selected, the system displays the first screen:



Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the memo detail statement message.

2. DESCRIPTION (30-C-R)
This field contains the description of the memo detail statement message.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when the code is created.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the established message that you are editing. This field is blank if you are creating a new message.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the established message that you are editing. This field is blank if you are creating a new message.

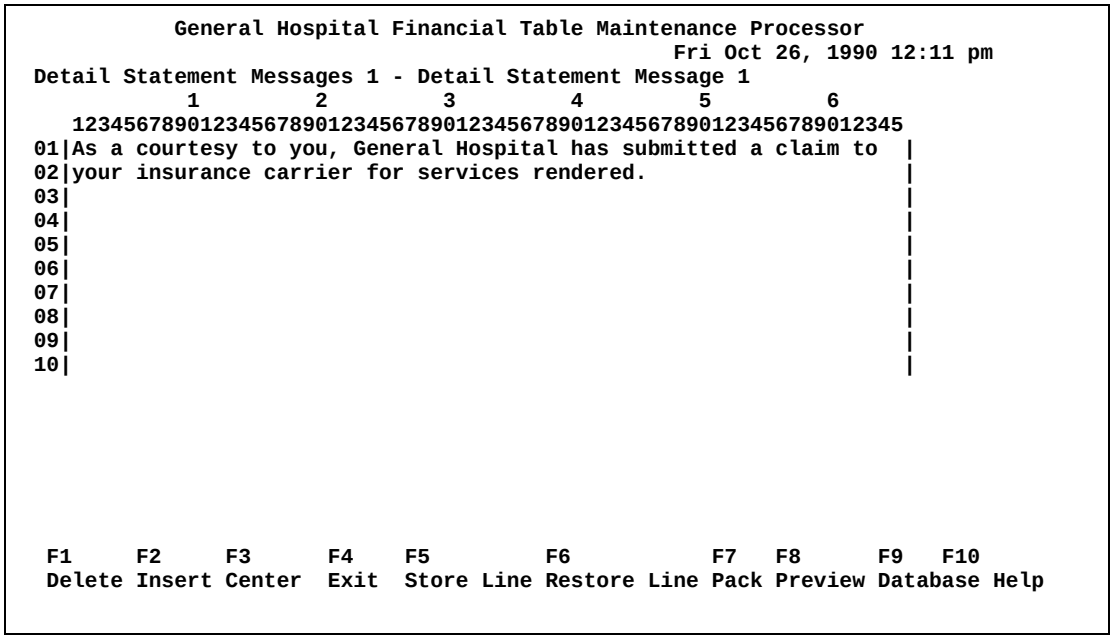
8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum number of columns that can be used for this message. The entry range is 10 to 75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum number of lines that the message can contains. The entry range is 1 to 15 lines; the default is 15.

NOTE: Any change to the entry in the maximum width or maximum lines fields affects not only the detail statement message you are editing but **all** detail statement messages. If you change this field, the system checks all existing messages to ensure they do not exceed the new maximums. If one or more existing messages exceeds the new maximum, the system displays the following error message:

Warning - message exceeds width and/or length defaults!

When you complete and accept this screen, the system displays the second screen.



Field Explanations - Screen 2 of 2

You can enter or edit the message using the function keys at the bottom of the screen.

Dependent On	Reference
Internal Elements	Follow-up Schedules
Format Types	

MEMO FOLLOW-UP LETTERS

This table is used to combine previously defined memo collection letter messages into memo collection letters. These letters are then used in the Follow-up Schedules and in PA and AR Demand Follow-up to indicate when a letter should be sent to a guarantor.

NOTE: The MCK message code is used for the Edit Collection Letter function available through the Receivables Workstation. To use this function, attach the MCK message code to any letter that you want to be able to add free form text. The description of the MCK message code is MCK Free Form Message. If you attach the MCK message code to a letter multiple times then the same free form message prints multiple times. McKesson advises that you only associate one MCK message code to your letter.

This table is not split by facility.

After you select this table, the system prompts you to enter a memo letter code (which can be up to three digits). You can enter the code or a hyphen (-) to display a list of valid codes. The system displays the following screen after the code is entered or selected.

```
             General Hospital Financial Table Maintenance Processor
                                                 Wed. Mar 1, 2001 12:30 pm
Memo Follow up Letters
 1 Code                 2 Description                          3 Status
   101                    1st Guarantor Memo F/U Letter          Active
4 File Type             5 Edit date                            6 Edit by
   Review                 01/05/01 13:50                         Smith,Mary A

                           Follow Up Messages
 7 Seq      Msg  Description                  Blank Lines Disallow page break?
   1.       5551 Guarantor Memo F/U Intro         02              Yes
   2.       5552 1ST Guarantor Memo F/U Body      02              Yes
   3.       5557 Guarantor Memo F/U Conclusion    02              Yes









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the memo follow-up letter.

2. DESCRIPTION (30-C-R)
This field contains the description of the memo follow-up letter code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

4). FILE TYPE (1-A-R)
This field indicates the spool file to which the follow-up letter is sent. Entry options are **R** (Review) or **A** (Automatic). Entry of **R** spools the letter to the Review Collection Letter spool files. Entry of **A** (Automatic) spools the letter to the Collection Letter Spool files.

5. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry last edited.

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

Organizing Messages Into Letters

You are combining memo collection letter messages into memo follow-up letters in this part of the table.

7.) SEQ (DISPLAY ONLY)
This field contains the sequence number identifying the message. You can enter as many sequences as you wish in constructing your letters. The system displays the next number when you access this field for data entry.

MSG (4-N-R)
This field contains the code identifying the memo collection letter message associated with this sequence number. You can enter the code or a hyphen (-) to display a list of valid codes.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the memo collection letter message code.

BLANK LINES (2-N-O)
This field contains the number of blank lines between this message and the next. The range is 1 to 99 lines.

DISALLOW PAGE BREAKS (1-A-R)
This field indicates whether the message can be split between multiple pages of the letter. Entry options are **Y** for Yes and **N** for No. An entry of Y indicates that the paragraph is not split between multiple pages. If the paragraph does not fit on one page, the entire paragraph is printed on a subsequent page. This field can only be set to No when it is associated with the MCK message code.

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

MISCELLANEOUS CASH CODES

This table contains codes and descriptions used to handle the accounting for non-patient revenue items such as cafeteria and parking lot receipts. These codes are used when miscellaneous cash is posted.

This table is split by facility and requires the definition of an entity prior to set-up.

After this table is selected, the system prompts you to enter a miscellaneous cash code. You can enter the code (three-character, alphanumeric) or a hyphen (-) to display a list of valid codes. After the code is entered or selected, this screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                    Fri Dec 30, 1988 10:10 am
Miscellaneous Cash Codes
 1 Code      2 Description
   321         Gift Shop Receipts
 3 Transaction Type/Code                        4 Entity
   F0002-GIFT SHOP RECEIPTS                       1
 5 Department      6 Subaccount
   110               001
 7 Status    8 Edit by                                    9 Edit date
   Active      Smith,Mary A                                 12/30/88 10:10am









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

Field Explanations

1. CODE (3-N-R)
This field contains the code identifying the miscellaneous cash.

2. DESCRIPTION (30-C-R)
This field contains the description of the miscellaneous cash code.

3. TRANSACTION TYPE/CODE (4-N-R)
This field contains the transaction code used to make the debit posting in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid codes used for recording miscellaneous cash under transaction type F (Miscellaneous Cash.)

4. ENTITY (DISPLAY ONLY)
This field contains the code of the GL entity to which this revenue is posted. The GL Entity Master must be completed.

5. DEPARTMENT (4-N-O)
This field contains the code representing the GL department in the general ledger that receives the revenue or credit posting. You can enter the department code or a hyphen (-) to display a list of valid department codes. You do not need to enter leading zeros with the department code. The length of this field is determined by the Dept # Size and Subaccount Size fields on the Fiscal Year Definitions screen in the STAR Financials General Ledger System.

6. SUBACCOUNT (4-N-O)
This field contains the code representing the GL subaccount in the general ledger that receives the revenue or credit posting. You can enter the subaccount code or a hyphen (-) to display a list of valid subaccount codes. You do not need to enter leading zeroes with the subaccount code. The length of this field is determined by the Dept # Size and Subaccount Size fields on the Fiscal Year Definitions screen in the STAR Financials General Ledger System.

7. STATUS (DISPLAY ONLY)
This field indicates whether this code is active or inactive. A code that is *filed as deleted* by the user becomes inactive in the system and can be reactivated at any time. The system defaults this field to active when you create the code.

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

9. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

Dependent On	Reference
Chart of Accounts	
Entity Master	
GL Mapping Parameters	
Transaction Codes	

NJ CHARITY CARE SUBSIDY APPROVAL

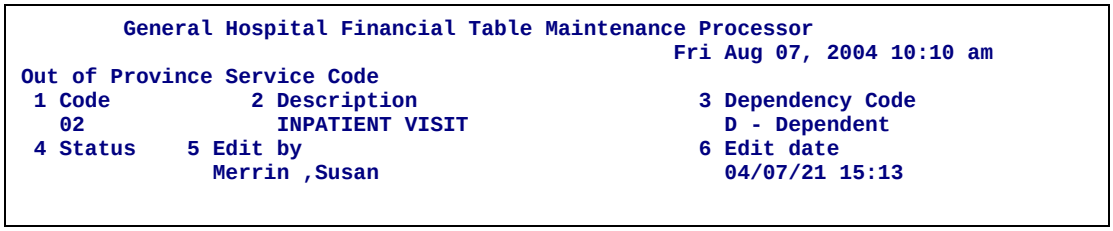
For details on this table, please refer to *STAR 2000 State Regulations - New Jersey* . See your McKesson representative to obtain a copy of this documentation.

NJ CHARITY CARE NOTIFICATION CODE

For details on this table, please refer to *STAR 2000 State Regulations - New Jersey* . See your McKesson representative to obtain a copy of this documentation.

OUT OF PROVINCE SERVICE CODE (BRITISH COLUMBIA, ONLY)

Out of Province Service Codes codes are associated with FIM charges in the OPC field. If there is not an Out of Province Service Code associated with a charge, a separate line is created for the charges within the out of province claim. When this table is accessed, the following screen is displayed:



Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the service code.

2. DESCRIPTION (33-AN-R)
This field contains a description of the out of province service code.

3. DEPENDENCY CODE (1-AN-R)
This field contains the dependency code for the patient. When this field is accessed, the following prompt is displayed:

Enter dependency code (I) Independent or D (Dependent)--

You can enter **I** for Independent or **D** for Dependent. For non-room and bed charges identified as dependent, the out of province claim looks at all dependent charges and determines the high dollar charge. This is the only non-room and board charge placed on the claim. For non-room and bed charges, all independent charges are accumulated and reported on line one (1) of the claim.

4. STATUS (DISPLAY ONLY)
This field cannot be accessed.

5. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this out of province service code.

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this out of province service code was last edited.

PATIENT BILL MESSAGES

This table contains the codes and descriptions of messages that can be printed on patient bills. These messages can be used to notify patients of collection policies, to indicate the bill is for informational purposes, to indicate the biller contact for inquiries, or to send a greeting, such as *Seasons Greetings*.

This table is not split by facility.

After this table is selected, the system prompts you to enter a patient bill message code. You can enter the code or a hyphen (-) to display a list of valid codes. This transaction uses two screens to enter patient bill message information. The first screen defines the format of the message while the second is used to enter the message itself.

After a patient bill message code is entered or selected, this screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                  Fri Dec 30, 1988 10:10 am
Patient Bill Messages
 1 Code                  2 Description
   4                       INSURANCE MESSAGE
 3 Edit date             4 Edit by                    5 Status
   12/30/88 10:10am        Smith,Mary A                 Active
 6 Current Width         7 Current Lines
   60                      4
 8 Maximum Width         9 Maximum Lines
   65                      4









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying this patient bill message.

2. DESCRIPTION (30-C-R)
This field contains the description of the patient bill message code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the existing message that you are editing. This field is blank if you are creating a new message.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the existing message that you are editing. This field is blank if you are creating a new message.

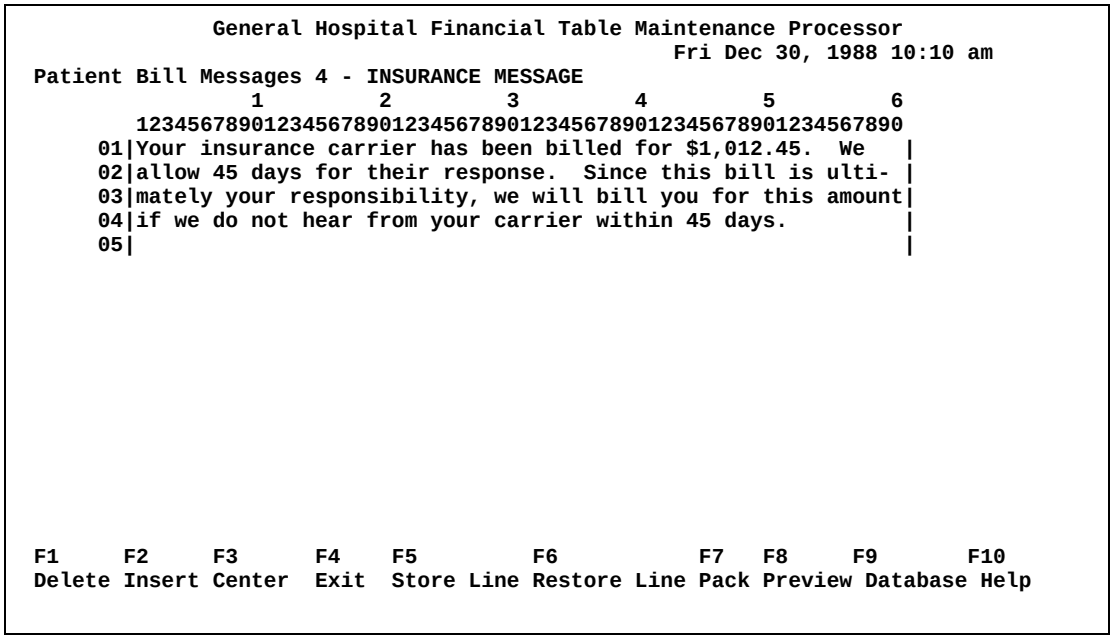
8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum message width in terms of number of columns. The entry range is 10 to 75; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum message length in lines. The entry range is 1 to 5 lines; the default is 5.

NOTE: Any change to the Maximum Width or Maximum Lines field affects not only the patient bill message you are currently editing, but *all* patient bill messages. The system checks your entry to these fields against the size of the existing patient bill messages. If one or more existing patient bill messages are too wide or too long for your entry to this field, the system displays the following message:

Warning - message exceeds width and/or length defaults

After you complete and accept this screen, the system displays the next screen used to define the text of the patient bill message.



Enter the message text on this screen using the format defined on the first screen. Pressing the F4 key saves the message and exits the screen.

Inserting Data Elements In The Message Text

Internal data elements are defined and maintained by McKesson. You can insert these data elements into a patient bill message:

Data Base Element	Suggested Print Routine
Admitting Diagnosis Code	Use default
Admitting Diagnosis Description	Use default
Amount of Payments Made - Account	Money (with $ sign)
Amount of Payments Made - Patient	Money (with $ sign)
Average Operating Cost	Money (with $ sign)
Biller Name — Primary	First MI Last
Biller Phone Extension	Use default (9999)
Biller Phone Number	Use default ((999) 999-9999)
Last Payment Date - Account	Use default (MM/DD/YY)
Last Payment Date - Patient	Use default (MM/DD/YY)
Last Service Date	Use default (MM/DD/YY)
Length of Stay	Standard Print (no formatting)

Data Base Element	Suggested Print Routine
Per Diem Rate	Money (with $ sign)
Provider Phone Number	(999) 999-9999
UB82/92 Provider Claim Name	Use default

These elements print the specific data relevant for the patient. For example, if you want the biller's name and phone number in the message, set up the message to include the Biller Name and Biller Phone Number elements. When patients receive a patient bill with that message, the system individually selects the proper biller name and phone number depending on the primary biller assigned to this patient's account.

In order to insert data elements into a detail statement message:

1. Position the cursor in the text where you want the data element inserted.

2. Press the F9 key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display a list of available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted. Accepting the element completes the process.

   The highlighted area represents the maximum length of the selected element. The format displayed represents the default print routine for the element. For example, most date elements have a default print routine of MM/DD/YY. After you accept the element, the system displays a list of alternative print routines, if applicable. For example, you can choose to print dates as YYMMDD, MM/DD, MM/YY, or others. If you want the element to print using one of the alternative formats, select the desired format. Otherwise, press ENTER to accept the default print routine. Accepting the element completes the process.

5. Pressing the F4 key saves the message and exits the screen.

NOTE: Since you are entering text for a letter, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

If you are using the data element Biller Name, the system uses the entry from the Hospital Employee File to complete this field. You may want to verify that this data element was entered in initial caps (uppercase and lowercase letters.)

Dependent On	Reference
Format Types	Insurance Follow-up Letters
Internal Elements	

PRE-BILL EDIT USERS

The Pre-Bill Edit Users Table is used to identify work queues by person. Most billers are also Pre-bill Edit users. Because of this, this table is used to link a Biller and Pre-bill Edit user. There may be employees who are not billers, but they work Pre-bill edits, such as Medical Record staff, Clinical Department (Lab, Rad, RX), and Order Management staff. The table includes initials which link a worklist queue to a person. An example of this is a registration or pre-registration person. Employees must be defined on this table before they can use the Pre-bill Edit Worklist (GUI module).

NOTE: A Pre-bill Edit user who is defined on the Pre-bill Edit Users table cannot be deleted if the user is defined as a default person/group on the Pre-bill Edit Parameters table.

You can generate a printout of the Pre-bill Edit Users table by entering **Y** at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FTFPBE.

After you select this Financial table, the system prompts you to enter a Pre-bill edit user code or a hyphen (-) to display a list of valid codes. After you enter or select a code, this screen is displayed:

```
             General Hospital Financial Table Maintenance Processor
                                                  Wed Jun 05, 2007 10:01 am
PBE Users
 1 Pre-bill Edit User Code            2 System ID
   7                                    33336
 3 Pre-bill Edit User Name            4 Biller Code
   MOORE, ANNE                         7-MOORE, ANNE
 5 Registration Clerk
   Yes
 6 Edit By                            7 Edit Date
   Employee,HBO                         03/24/04 10:43a









Delete? (N)--
```

Field Explanations

1. PRE-BILL EDIT USER CODE (DISPLAY ONLY)
This field contains the code that defines the person. It may be the same as the person's biller code.

2. SYSTEM ID (5-AN-R)
This field contains the System ID of the person as defined by the Hospital Employee Information table. Only active employees can be added to this table. You can enter the code or a hyphen (-) to display a list of active employees.

3. PRE-BILL EDIT USER NAME (DISPLAY ONLY)
This field contains the person's name as defined in the Hospital Employee File table.

4. BILLER CODE (5-AN-R)
This field contains information for the person as defined in the Biller Table. You can enter the code or a hyphen (-) to display a list of biller codes.

5. REGISTRATION CLERK (1-A-R)
This field defines whether the pre-bill edit user is a registration clerk. If he/she is, the user sign on code is used to link edits to the person. This information is used when you access the Pre-bill edit workfiles. When this field is accessed, the following prompt is displayed:

Are you a registration clerk (Y/N) [N]? --

You can enter **Y** (Yes) if you are a registration clerk or **N** (No) if you are not.

6. EDIT BY (DISPLAY ONLY
This field contains the name of the person who last updated this table.

7. EDIT DATE (DISPLAY ONLY
This field contains the date this table was last updated.

Charge Detail Information

When you enter **I** from the prompt on the PBE Status Information Processor, the following screen is displayed:

```
              General Hospital PBE Status Information Processor
                                                Mon Mar 27, 2007 10:40 am
Account      Name                    FC Typ Admit    Disch        Balance Loc
A04155-00002 NEW, NANCY              M  O/P 06/03/04 06/03/04     516.48  PA/FCRV


PBE Status: Processed/Errors            PBE Status Date: 08/10/04
  Message followed by claim line and accounts charges comprising the claim line

0997           06/03/04 Covered Charges must equal Noncovered Charges (CHG A8 L
  SRC/E 0997                          CCC           06/03/04             11.00   TRS
    A8 LAB/12345 12345 HYDROPROGESTERONE.. 5678      06/03/04 1             5.50
    A8 LAB/12345 12345 HYDROPROGESTERONE.. 5678      06/03/04 1             5.50


               06/03/04 HCPCS required for 1500 Claim (CHG 6 RAD/4545)
  SRC/C 320  RADIOLOGY - DIAGNOSTIC     C             06/03/04 1           265.55
    A6 RAD/4545  JENNIE'S OTHER SIM                   06/03/04 1           265.55









                     F1Prev Page F2Next Page F7  Exit
```

This screen shows the pre-bill edit error message by claim line charges. If TRS is displayed next to the edit, it indicates that an edit was transferred from one user/group to another.

PRE-BILL EDIT USER DEFINED EDIT GROUPS

The PBE User Defined Edit Groups table can be used to supplement the options available for Pre-bill Edit Worklist Assignment in Pre-bill Edit Parameters for a facility. The PBE User Defined Edit Groups provides added choices for Worker Assignment and for Default Group/Person. Also, the table can be used to provide other options for Transfer To User in the Transfer function.

The data control codes in report FBR220 (Failed Bill Req. by Control Code) include Pre-bill Edit User Types, and a description is supplied for these codes. The codes in the PBE User Defined Edit Groups table can appear in FBR220 as data control codes and the description to be is obtained from that table.

When accessing the Pre-Bill Edit Parameters, on the third screen for the Pre-bill Edit Worklist Assignment, these PBE User Defined Edit Groups can be assigned for the edit Category in the Inpatient, Outpatient, Emergency, and Pt Type Except fields.

If the Worker Assignment for the Category is Biller for first COB, Registration Clerk, or Preadmission Clerk, the PBE User Defined Edit Group can then be assigned as the Default Group/Person for when the Biller for the first COB, the Registration Clerk, or the Preadmission Clerk is not set up in the PBE Users table.

In the Pre-bill Edit User Access workstation (GUI), you can associate a user code with an edit group defined on this table. The access is as follows:

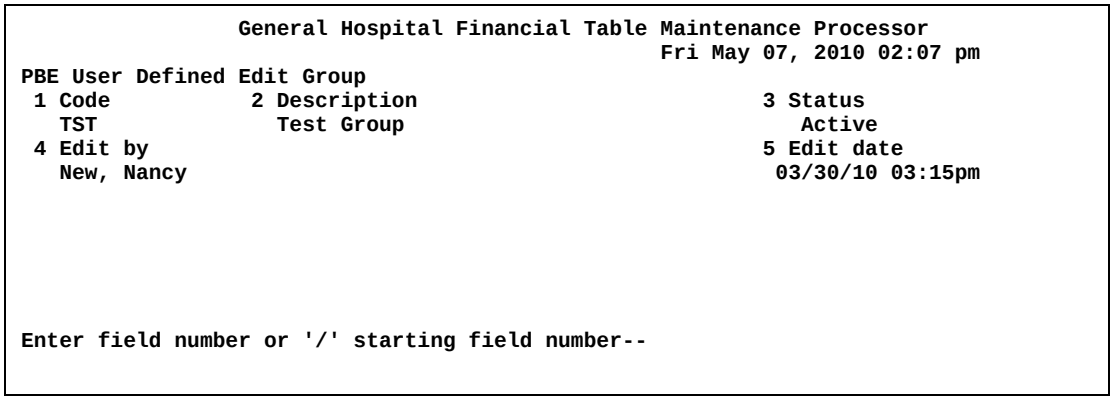
Pre-bill Edit User Access

- select the User Code

- click the middle tab for PBE User Assignments

- in the Access Types drop down box, select User Groups

- highlight the new user defined edit group you added above



Field Explanations

1. CODE (3-AN-R)
This field contains the user-defined edit group.

2. DESCRIPTION (30-AN-R)
This field contains a user-defined description.

3. STATUS (DISPLAY ONLY)
This field indicates whether the edit category is active or filed as deleted (inactive).

5. EDIT BY (DISPLAY ONLY
This field contains the name of the person who last updated this table.

6. EDIT DATE (DISPLAY ONLY
This field contains the date this table was last updated.

When exiting the Pre-bill Edit User Defined Edit Groups table, the system prompts:

Do you want a printed list? (Y/N) [N]--

If you enter Y (Yes), the report spools to FIN and is a printout of the User Defined Edit Groups and descriptions.

PRE-BILL EDIT CATEGORY

This table defines the categories of pre-bill edits. This table is used by the Pre-bill Edit Fields table. Pre-bill edit categories are:

- E = No CA Claims
- D = Demographics
- I = Insurance
- M = Medical Record
- C = Charges.

Situations could exist where an edit is not linked to a category. When this occurs, the system defaults the Demographic category.

NOTE: The table is pre-populated with pre-bill edit categories. You can delete entries from this table even though the category is being used in current worklists and/or statistics files. The person maintaining the table should be familiar with categories being deleted.

After you select this Financial table, the system prompts you to enter a Pre-bill Edit Category code or a hyphen (-) to display a list of valid codes. After you enter or select a code, this screen is displayed:

```
        General Hospital Financial Table Maintenance Processor
                                                Wed Aug 04, 2004 10:06 am
PBE Edit Category
 1 Code           2 Description                      3 Status
   C                Charge                             Active
 4 Edit Type
   Charge
 5 Edit by                                           6 Edit date
   New, Nancy                                          07/29/04 06:34pm




Delete? (N)--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the user-defined category code.

2. DESCRIPTION (DISPLAY ONLY)
This field contains a user-defined description.

3. ACTIVE (DISPLAY ONLY)
This field indicates whether the edit category is active or filed as deleted (inactive).

4. EDIT TYPE (1-A-R)
This field contains the pre-bill edit type. When this field is accessed, the following prompt is displayed:

Enter (R)egistration, (I)nsurance, (C)harge, or (M)edical Records edit type-

You can enter **R** for Registration, **I** for Insurance, **C** for Charge, or **M** for Medical Records.

5. EDIT BY (DISPLAY ONLY
This field contains the name of the person who last updated this table.

6. EDIT DATE (DISPLAY ONLY
This field contains the date this table was last updated.

PRE-BILL EDIT EC2000 EDIT MESSAGES

This table is used to define EC 2000 CA edit codes. This table is populated when an edit is received by STAR from EC 2000 CA. In order to minimize the size of the file, the table is populated only with edits actually used. The table is populated the first time the edit is encountered and is limited to 50 characters in the description. The code is limited to 12 characters which is the maximum length allowed on EC 2000 CA. These descriptions can be edited by users to make them more informative when displayed on the FCRPREANA statistic report.

When you access this table, the following prompt is displayed:

PBE EC 2000 CA edit message or `-` for list--

After you select this Financial table, the system prompts you to enter a Pre-bill Edit EC 2000 CA Edit Message code or a hyphen (-) to display a list of valid codes. After you enter or select a code, this screen is displayed:

```
         General Hospital Financial Table Maintenance Processor
                                                  Wed Aug 04, 2004 10:08 am
PBE EC 2000 CA Edit Messages
 1 Code
   6
 2 Description
   6 Source of admission, locator 20, must be present
 3 Status
   Active
 4 Edit by                                              5 Edit date
   New, Nancy                                             07/28/04 07:16am




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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code for the EC 2000 Claims Administrator edit message.

2. DESCRIPTION (30-AN-O)
This field contains a description of the edit message. This description is defined by EC 2000 CA and can be updated here to make it more descriptive.

3. STATUS (DISPLAY ONLY)
This field indicates whether the parameter code is active or inactive.

4. EDIT BY (DISPLAY ONLY)

When the system automatically generates this table, this field contains Employee, HBO. After a user revises the description, the information is updated with the user's name.

5. EDIT DATE (DISPLAY ONLY)

This field contains the date the table was last updated.

PRE-COLLECTION FOLLOW-UP SCHEDULE

The Pre-Collection Follow-up Schedule table contains information about the timing and type of follow-up used for accounts with an agency process status. Accounts are assigned to a collection agency based on a Collection Agency Group definition.

When a schedule is defined as an external type, the schedule definition has some restrictions:

- The following fields are required to be completed by the user: Schedule, Description, Agency Type, Wait Days, Min Ref Amt, Small Bal Write Off Trans, Auto Prelist, Post Agency Sch, PreList Max Mal, PreList Ins, Days After Ins, and Bad Debt Transfer Trans.

- The following fields are updated by the system when the screen is accepted by the user: Ins Pending, Bill Balance, Rest %, Rest Amt, Reseq Bal, Max Paper Bal, Min Balance, and Min Attempts.

- The step definitions allow only for Wait steps to be defined with interval days and/or an Agency Group.

- The Agency Goup information is used to systematically transfer the account from one agency to another. The agency group types that can be selected are internal, external, or CCI.

After you select this Financial table, the system prompts you to enter a Pre-Collection follow-up Schedule code or a hyphen (-) to display a list of valid codes. After you enter or select a code, this screen is displayed.

```
          General Hospital Financial Table Maintenance Processor
                                              Thu Jun 01, 2007 02:23 pm
Pre-Collect Follow-up Schedules
 1 Schedule #     2 Description                3 Agency Type  4 Wait Days
   8                CCI                          No-External    10
 5 Day of Month   6 Day of Week   7 Week of Month  8 Due Days     9 Grace Days
                                                   1              0
10 Ins Pending   11 Bill Balance 12 Rest %        13 Rest Amt    14 Reseq Bal
   Bill             Account          0.00%          $0.00          Unlimited
15 Max Paper Bal 16 Min Balance  17 Min Ref Amt   18 Small Bal WriteOff Trans
   Unlimited        $5.00           $5.00           A0001-I/P MEDICARE PART A
19 Min Attempts  20 Auto PreList 21 Post Agy Sch  22 PreList Max Bal
   0                No              976             $0.00
23 PreList Ins   24 Days After Ins                25 Bad Debt Transfer Trans
   No               0                               S0002-AR TO BD TRANSFER
26 Delinquent F/U Type           27 Delinquent F/U Message

28 Partial Pay F/U Type          29 Partial Pay F/U Message

30 Partial Pay F/U %


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

Field Explanations Screen 1 of 2

1. SCHEDULE # (3-N-R)
This field contains the code identifying this Pre-Collection Follow-up Schedule.

2. DESCRIPTION (30-C-R)
This field contains the description of the Pre-Collection Follow-up Schedule Code.

Defining Follow-up Frequency

3. AGENCY TYPE (1-A-R)
This field indicates the type of collection agency. When this field is accessed, the Collection Agency Types table is displayed. You can select one of the following agency types from the table:

- Internal Agency
- External Agency
- CCI

4. WAIT DAYS (2-N-R)
This field contains the minimum number of days to wait from transfer to agency processing before follow-up is scheduled. The entry range is 0 to 99 days.

There are three ways to define the frequency of account follow-up: Completing the Day Of Month, Day of Week, or Interval field.

5. DAY OF MONTH (2-AN-O)
This field contains the day of the month on which the hospital wants follow-up performed for guarantors assigned to this schedule. Entry options are 1 through 28 or L for the last day of the month. For example, you would enter **15** if you wanted follow-up performed on day 15 of every month.

6. DAY OF WEEK (1-N-O)
This field contains the day of the week on which the hospital wants follow-up performed for guarantors assigned to this schedule. Entry options are 1 through 7, with Sunday = 1, Monday = 2, Tuesday = 3, ... Saturday = 7. If this field is selected, guarantors assigned to this schedule receive follow-up once per month, on the day entered here.

7. WEEK OF MONTH (1-N-C)
This field contains the week of the month during which follow-up is performed for guarantors assigned to this schedule. Entry options are 1 through 4. If you complete the Day of Week field, you must also complete this field. This field is not required if the Day of Month field is completed. If this field is selected, guarantors assigned to this schedule receive follow-up once a month, during the week entered here and on the day entered in the Day of Week field.

8. DUE DAYS (2-N-R)
This field contains the number of days used in calculating the due date. The entry range is 0 to 99 days; the default is 0. This pertains to payment plans.

9. GRACE DAYS (2-N-R)
This field contains the number of days after the due date before an account is delinquent. The entry range is 0 to 99 days; the default is 0. The statement print date plus the due days plus the grace days equals the payment plan delinquent date.

10. INS PENDING (1-AN-0)
This field determines what type of follow-up occurs on accounts with pending insurance. Entry options are B (bill), S (suppress), or M (memo); the default is B.

If you enter **B** in this field, the type of follow-up that occurs depends on how the Bill Balance field is set.

If you enter **S** in this field, the following can occur:

No follow-up occurs until all insurance liability is gone.

- Accounts appear on the Follow-up Suppression report (FFR440) on the days follow-up occurs.

If you enter **M** in this field, the following occurs:

A memo message prints for accounts with pending insurance.

- If there is no insurance liability, a regular follow-up occurs requesting the entire account balance.

11. BILL BALANCE (1-A-R)
This field contains the dollar amount that is requested from the guarantor during follow-up. Entry options are P (patient balance) or A (account balance); the default is P.

- If you enter **P** in this field, the following occurs:
    - A request for the patient portion appears with information noting the insurance liability. No follow-up occurs if there is no patient liability.
- If you enter **A** in this field, the following occurs:
    - A request for the account balance appears on the paper follow-up.

Follow-up always occurs.

12. REST % (2-N-O)
This field contains the percent of the balance due that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence) until this percent is paid. The entry range is 0 to 99.99%.

13. REST AMOUNT (8-N-O)
This field contains the minimum amount that must be paid by the guarantor in order to resequence follow-up to another event. Follow-up continues on to the next event (sequence number) until this amount is paid. The entry range is 0 to $99,999.99 (you must enter the decimal point).

14. RESEQ BALANCE (8-AN-R)
This field contains the minimum balance that is required to cause resequencing of the Pre-Collection Follow-up Schedule if an account qualifies as a new account. You can enter up to 999,999.99 (you must enter the decimal point) or U (unlimited); the default is U. The account is resequenced if the account balance exceeds the amount entered in this field. If you enter **U**, the account never resequences when it becomes a New Account. An account is considered a new account depending on it's schedule type.

15. MAX PAPER BALANCE (8-AN-R)
This field contains the maximum dollar amount balance required to not produce paper follow-up. The entry range is 0 to 999,999.99 or **U** for unlimited. The default is U. If the balance is "greater than or equal to" the maximum paper balance, telephone follow-up occurs. If U is entered, paper follow-up always occurs unless there is a step in the schedule for telephone only.

16. MIN BALANCE (8-N-R)
This field contains the minimum account balance that is required to continue producing follow-up. This amount is the hospital small balance write-off for debit balances. The entry range is $0.00 to $99.99.

17. MIN REF AMT (4-N-R)
This field contains the minimum credit balance required to produce a patient refund. This amount is the hospital small balance write-off amount for credit balances. The entry range is $0.00 to $99.99.

18. SMALL BAL WRITE-OFF TRANS (4-AN-R)
This field contains the transaction code used to update the patient account transaction history and the general ledger. This code is used when an account is automatically written off because it meets the small balance write-off criteria as defined in this Pre-Collection Follow-up Schedule. Enter the code or a hyphen (-) to display a list of codes under transaction type A (adjustments).

19. MIN ATTEMPTS (2-N-R)
This field contains the minimum number of follow-up attempts that should be performed before a small balance write-off is processed. This field allows the hospital to bill a guarantor as many times as indicated for the small balance. A zero indicates no follow-up is performed for the small balance. The entry range is 0 to 99; the default is 0. The entry made here is based on the Minimum Balance field.

20. AUTO PRE-LIST (1-A-R)
This field indicates whether the account should be selected for bad debt pre-listing after the last event (sequence) in the follow-up schedule. Entry options are Y for Yes or N for No; the default is N. If you enter **N**, the follow-up schedule sequence is

repeated, when the schedule reaches the last event (sequence) until the account is manually pre-listed for possible transfer to bad debt. Accounts are eligible for automatic prelisting only by reaching the end of the Internal Follow-up Schedule and having this field set to Y.

21. POST AGY SCH (3-N-R)
This field contains the Collection Schedule that AR accounts automatically transfer to when pre-listed for Bad Debt.

NOTE: Once accounts are pre-listed for a Bad Debt collection agency, the system deletes the accounts from Agency Processing. It also moves the accounts to the guarantor follow-up schedule defined in the Post Agy Sch field of the Pre-Collection Follow-up schedule. Accounts are put back into follow-up using the schedule in the Post Agy Sch field if the accounts are put on Bad Debt Prelist Hold. For example, accounts that receive a payment after they are prelisted for Bad Debt and before they are transferred to Bad Debt receive a Bad Debt Prelist Hold code of H. These accounts are reflected on the Bad Debt Prelist Report with a Hold status.

22. PRELIST MAX BAL (8-N-R)
This field contains the maximum account balance for automatic prelisting for possible transfer to bad debt. The entry range is $0.00 to $999,999.99; the default is $0.00. If an account balance is greater than the prelist maximum balance and at the end of the follow-up schedule, the last sequence number remains in effect until the balance is less than the prelist maximum balance. The account is not automatically prelisted until the account balance falls below the defined maximum. The account appears on the Bad Debt Pre-List Exception Report and receives the last step in the Follow-up schedule when the Bad Debt Pre-List Selection Optional Batch Job runs.

23. PRELIST INS? (1-A-R)
This field indicates whether an account with pending insurance should be automatically prelisted for bad debt. Entry options are Y for Yes or N for No, the default is N. If this field is set to No and an account has an insurance balance, the account is not automatically prelisted until insurance is no longer pending. The account appears on the Bad Debt Pre-List Exception report

24. DAYS AFTER INS (2-N-R)
This field contains the number of days to wait - up to 99 - after the final insurance payment before transferring the account to bad debt. The days after insurance are grace days given to the patient to pay any outstanding amount on the account that was not paid by insurance.

25. BAD DEBT TRANSFER TRANS (4-N-R)
This field contains the transaction code indicating the transfer of this account from accounts receivable to bad debt. Enter the code or a hyphen (-) to display a list of valid codes under transaction type S (status transfer). This code is displayed in the patient account transaction history. The transfer to bad debt is controlled by the hospital and takes place for prelisted accounts.

26. DELINQUENT F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account becomes delinquent. Entry options are D (detail statement), L (letter), or T (telephone).

27. DELINQUENT F/U MESSAGE (4-N-R)
This field contains the message that appears on the follow-up type entered in the Delinquent F/U Type field.

28. PARTIAL PAYMENT F/U TYPE (1-A-O)
This field indicates the type of follow-up that is generated when a payment plan account receives a payment that is not equal to full payment. Entry options are **D** (detail statement), **L** (letter), or **T** (telephone).

29. PARTIAL PAYMENT F/U MESSAGE
This field contains the message that appears on the follow-up type entered in the Partial Payment F/U Type field.

30. PARTIAL PAY F/U % (3-N-O)
This field contains the percentage of the current amount due that must be received to not produce partial payment follow-up. This field is dependent on the Partial Payment F/U Type and the Partial Payment F/U Message. If the Partial Payment F/U Type and the Partial Payment F/U Message fields are not completed, then this field cannot be completed.

The system also verifies that the current amount due that remains on the account after the payment is posted is greater than or equal to the minimum amount for follow-up. The minimum amount to produce follow-up is the value contained in the Min Balance field on the Pre-Collection Follow-up schedule. If the current amount due for the guarantor is less than the value in the Min Balance field, the system suppresses the partial payment follow-up. The current amount due for a guarantor is a value that is calculated for payment plan follow-up.

After these fields are completed, the system prompts you to accept the screen. When the screen is accepted, the second screen of the transaction is displayed.

```
        General Hospital Financial Table Maintenance Processor
                                                Thu Feb 23, 2007 02:18 pm
Pre-Collect Follow-up Schedules
 1 Schedule #             2 Description                      3 Agency Type
   55                       JULIE A PRECOLL                    No - Internal
 4 Edit date              5 Edit by
   06/13/03 14:18           Kane, Karen
                            F/U  Memo  Phone  New Accts  Rest            Agency
 6 Seq#  Follow Type        Msg  Msg   Code   Rest Seq#  Seq#  Interval  Group









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

Field Explanations - Screen 2 of 2

1. SCHEDULE # (DISPLAY ONLY)
This field contains the code identifying this Pre-Collection Follow-up Schedule.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of this Pre-Collection Follow-up Schedule.

3. AGENCY TYPE (DISPLAY ONLY)
This field defines the type of agency for the follow-up schedule: Agency, CCI, Bad Debt, or Insurance. The steps can be defined only as Wait for an external-type schedule.

4. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

6. SEQ # (DISPLAY ONLY)
This field contains a sequential number identifying the order of events for this follow-up schedule. The sequence number and the follow-up type and code control the order in which follow-up is performed on guarantors assigned to this schedule.

FOLLOW TYPE (1-A-R)
This field contains the type of follow-up that is used for this sequence number. You can enter **L** (follow-up letter), **D** (detail statement), **T** (telephone), or **W** (wait). CCI schedules and external-type schedules only allow for wait step.

F/U MSG (4-N-R)
This field contains the follow-up message that appears on the detail statement or letter. You can enter the code or a hyphen (-) to display a list of valid codes. This message prints as a follow-up type when the guarantor is selected for that event (sequence).

MEMO MESSAGE (4-N-O)
This field contains the code identifying the memo message that appears on the follow-up letter or detail statement. You can enter the code (up to four numbers) or a hyphen (-) to display a list of valid codes. If the Insurance Pending field on the previous screen contains Memo, this message appears on the guarantor detail statement and/or collection letter when insurance is pending on an account.

PHONE CODE (4-N-R)
This field contains the follow-up message that appears in the telephone workfile. You can enter the code or a hyphen (-) to display a list of valid codes.

NEW ACCOUNTS RESTART SEQ # (2-N-O)
This field indicates the step in the follow-up schedule to which the guarantor is resequenced if an account becomes a new account and the criteria established in the Reseq Balance field on the previous screen is met. The restart sequence number must be less than or equal to the current sequence number.

RESTART SEQ # (2-N-O)
This field contains the follow-up sequence number used if the restart % or amount is met and the account balance is paid by the guarantor prior to the next follow-up date. The restart sequence number must be less than or equal to the current sequence number.

INTERVAL (3-N-C)
This field contains the number of days between follow-up events. The entry range is 1 to 999 days. This field is completed only if the Day of Month, Day of Week/Week of Month fields are not completed. The first follow-up is scheduled from the transfer to Pre-Collection date. All subsequent follow-up activity is scheduled from the date of the most recent follow-up. The number of days between follow-up can vary by sequence number.

AGENCY GROUP (TABLE LOOKUP-R)
This field can be used to transfer accounts to an AR agency. You can enter a code or a hyphen (-) to select one from the list of Collection Agency Group codes. If an agency code is entered in this field, accounts receive a maintenance code of flagged when this follow-up step is processed. Follow-up steps that contain an agency code are called collection steps. There can be multiple collection steps defined on the follow-up schedule.

After you have completed these fields, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction.

PRE-COLLECTION INFORMATION

The Pre-Collection Information table enables the facility to define criteria for transferring accounts to AR agency processing. Accounts on a pre-collection step in a follow-up schedule are eligible to become Pending/Candidate or Transfer to Agency Processing, if the criteria defined in the agency's parameters have been met. Each Collection Agency code has its own set of pre-collection Information parameters. Pre-collection information can be defined for both guarantor and insurance collections.

The Pre-Collection Information parameters for an internal, external, CCI, or bad debt collection agency consist of data parameters (for external agencies only), a required Master record of inclusion and exclusion criteria, the optional Patient Indicator Exception records, and the Prioritization record. External agencies have data file parameters which allow you to specify which records are sent to an external pre-collection agency for guarantor and/or insurance collections. The Pre-Collection Information parameters for all agency types have Patient Indicator Exception records to allow the facility to define different criteria for each patient indicator. The Prioritization record allows you to set priorities for rejection reasons for the Pending/Candidate Rejection report and the Agency Rejection report. The Pre-Collection Information parameters are required for accounts to have a Pending/Candidate or Transfer to Agency Processing status.

After you select this table, the system prompts you to select a facility. After you enter the facility, the system prompts you to enter a collection agency code or a hyphen (-) to display the collection agency codes. You can select one from the list, and then press ENTER to display the next screen. The sequence of screens displayed depends on the type of collection agency code you entered or selected:

- If you entered or selected an internal or CCI collection agency code, the next screen displayed is the Inclusion Criteria Screen (see “Master Record - Inclusion Criteria (Guarantor Version)” on page 1-219), followed by the Exclusion Criteria screen (see “Master Record - Exclusion Criteria” on page 1-224). After these screens are completed, the Patient Indicator Exception screen is displayed (see “Patient Indicator Exception Record” on page 1-226). You can define inclusion and exclusion criteria for patient indicator exceptions. The next screens allow you to define rejection reasons which can be assigned a priority sequence number (see “Prioritization Record” on page 1-228***).***

- If you entered or selected an external collection agency code, the following screen is displayed, which allows you to define whether you are setting insurance or guarantor parameters for a data file:

```
        General Hospital Financial Table Maintenance Processor
                                                Mon Jul 10, 2006 11:02 pm
Pre-Collection Information for Model Hospital A
Code      Description
MIKEGA    EXT PRECOLLECT - GUARANTOR ONL

Page:01                          Parameter Types
( 1) G-Guarantor
( 2) I-Insurance




Enter choice--
```

After you select **G** (Guarantor) or **I** (Insurance), the system displays the Data File Parameters Screen (see “Data File Parameters” on page 1-217). The screen title reflects either guarantor or insurance, depending on your selection. After the Data File Parameters are defined, the Inclusion Criteria screen is displayed:

- If you selected G, the guarantor version of the Inclusion Criteria screen is displayed (see “Master Record - Inclusion Criteria (Guarantor Version)” on page 1-219).
- If you selected I, the insurance version of the Inclusion Criteria screen is displayed (see “Master Record - Inclusion Criteria (Insurance Version)” on page 1-221).

Next, the Exclusion Criteria screen is displayed (see “Master Record - Exclusion Criteria” on page 1-224). After these screens are completed, the Patient Indicator Exception screen is displayed (see “Patient Indicator Exception Record” on page 1-226). You can define inclusion and exclusion criteria for patient indicator exceptions. The next screens allow you to define rejection reasons which can be assigned a priority sequence number (see “Prioritization Record” on page 1-228).

Data File Parameters

This screen is used to define which records are sent to an external agency for guarantor and/or insurance collections.

```
               General Hospital Financial Table Maintenance Processor
                                                  Fri Apr 21, 2006 08:37 am
Pre-Collection Information for Model Hospital A
Code      Description
MIKEIN    test agency for insurance

                         Guarantor Data File Parameters
 1 Summary Transaction Types
   A,B,C,M,N,R,T
 2 New Account Assignment
   PATI,GUAR,GEMP,PEMP,REL1,INS,LCHG,FINA,MISC,NOTE,THIS
 3 Excluded Transaction Codes
   Entries defined for transaction types - M
 4 Edited By                                        5 Edit Date
   New, Nancy                                         04/20/06 16:25
```

Field Explanations

1. SUMMARY TRANSACTION TYPES (TABLE LOOKUP)
This field defines the transaction types (defined in the Transaction Code table) to be sent in the record. When this field is accessed, the following screen is displayed:

```
       General Hospital Financial Table Maintenance Processor
                                                 Mon Jul 10, 2006 11:45 pm
Pre-Collection Information for Model Hospital A
Code      Description
MIKEGA    EXT PRECOLLECT - GUARANTOR ONL

                         Guarantor Data File Parameters
 1 Summary Transaction Types
-> A,B,C,M,N,R,T
Page:01                    Summary Transaction Types         ##=Current Choices
( 1) A-Adjustments
( 2) B-Billing/Claims
( 3) C-Cash
( 4) M-Memo
( 5) N-Notes
( 6) R-Refunds
( 7) T-Status Transfers



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

You can select one or all summary transaction types. The highlighted entries are displayed in the field as letters delimited by commas (for example, A,B,C,M).

2. NEW ACCOUNT ASSIGNMENT (TABLE LOOKUP)
This field defines the type of data file to send to the agency. When this field is accessed, the table of data file types is displayed:

```
      Page:01                          Data File Types            ##=Current Choices
( 1) PATI-Patient Data                   (10) NOTE-Notes Data
( 2) GUAR-Guarantor Data                 (11) THIS-Transaction History
( 3) GEMP-Guarantor Employer Data
( 4) PEMP-Patient Employer Data
( 5) REL1-Relative Data
( 6) INS-Insurance Data
( 7) LCHG-Late ChargeData
( 8) FINA-Financial Data
( 9) MISC-Miscellaneous Data

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

At least one record type must be selected in order to accept the page. The items highlighted are reflected in the field as codes only. The option of INS creates an individual record for each insurance linked to the account. If the account has no insurances, none of the INSx records are built. If the account has five insurances, INS1, INS2, INS3, INS4, INS5 records are built.

3. EXCLUDED TRANSACTION CODES (TABLE LOOKUP-O)
This field is used to exclude transaction codes from being transferred to the collection agency. The assumption is that most transactions are transferred. This is also the method to be used in excluding standard notes which were received from the agency through the inbound notes interface. When this field is accessed, the following screen is displayed:

```
Page:01                          Transaction Types
( 1) A-Adjustment                        ( 8) J-Other Refunds
( 2) B-Balance Transfer                  ( 9) M-System Memos
( 3) D-Insurance Refund                  (10) N-Non Patient Cash
( 4) E-Agency Cash Agency Collected      (11) O-Miscellaneous Notes
( 5) F-Miscellaneous Cash                (12) P-Payment
( 6) G-Other Adjustments                 (13) R-Refund
( 7) I-Insurance Payment                 (14) S-Status Transfer

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

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

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

After this screen is accepted, the next screen displayed depends on whether you entered G (Guarantor) or I (Insurance).

- If you entered G (Guarantor), see “Master Record - Inclusion Criteria (Guarantor Version)” on page 1-219.

- If you entered I (Insurance), see "Master Record - Inclusion Criteria (Insurance Version)" on page 1-221.

Master Record - Inclusion Criteria (Guarantor Version)

Accounts that have an AR agency defined and also meet all the criteria defined in the following fields on the Inclusion and Exclusion Criteria screens, are selected for Pending/Candidate or Transfer to agency processing. When the Pre-Collection Information Master record is completed, the Exception and Prioritization records can be defined.

The following screen shows the Pre-Collection Information Inclusion Criteria screen (guarantor version).

```
            General Hospital Financial Table Maintenance Processor
                                                 Thu Mar 27, 2007 02:44 pm
Pre-Collection Information for Model Hospital A
Code      Description
INTSP     INTERNAL PRE-COLL SELF PAY

                              Inclusion Criteria
 1 Min Days Discharge     2 Min Days Final Bill    3 Min Days Patient Payment
   90                       90                       60
 4 Patient Payment Amt    5 Patient Payment %      6 Min Patient Balance
   100.00                                            25.00
 7 Max Patient Balance    8 Min # Paper F/U        9 Min Days Ins Payment
   99,999.00                1                        30
10 Pending Ins Balance   11 Min Acct Balance      12 Max Acct Balance
   No                       99,999.00
13 Reselect Days         14 Agency Trans Code/Desc
                            M0055-COLLECTION UPDATE
15 Primary Sort for Reject Reports
   Guarantor Name
16 Edited By                                      17 Edit Date
   Jones,Mary                                         03/25/97 02:39pm



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

Field Explanations

CODE (DISPLAY ONLY)
This field contains the code identifying this Pre-Collection Information Parameter. It displays the external agency code, the internal agency code, or the CCI Collection Agency Code.

DESCRIPTION (DISPLAY ONLY)
This field contains the AR Agency code description.

1. MIN DAYS DISCHARGE (3-N-R)
This field contains the minimum number of days that must elapse following discharge in order for an account to qualify for AR agency processing.

2. MIN DAYS FINAL BILL (3-N-R)
This field contains the minimum number of days that must elapse following final bill in order for an account to qualify for AR agency processing selection.

3. MIN DAYS PATIENT PAYMENT (3-N-R)
This field contains the minimum number of days that must elapse following receipt of a patient payment in order for an account to qualify for AR agency processing:

4. PATIENT PAYMENT AMOUNT (10-N-R)
This field contains the minimum amount the patient must pay in order for an account not to qualify for AR agency processing.

5. PATIENT PAYMENT % (6-N-R)
This field contains the minimum percentage of the Last Follow-up amount that the patient must pay in order to not to qualify for AR agency processing.

6. MIN PATIENT BALANCE (10-N-R)
This field contains the minimum patient balance in order for an account to qualify for AR agency processing.

7. MAX PATIENT BALANCE (10-N-R)
This field contains the maximum patient balance in order for an account to qualify for AR agency processing.

8. MIN # OF PAPER F/U (2-N-R)
This field contains the minimum number of patient paper follow-ups that must be generated either in the form of detail statements or letters, in order for an account to qualify for AR agency processing.

9. MIN DAYS INS PAYMENT (3-N-R)
This field contains the minimum number of days that must elapse following receipt of an insurance payment in order for an account to qualify for AR agency processing.

10. PEND INS BAL (1-N-R)
This field determines whether accounts with an insurance balance qualify for AR agency processing. Valid values are Y for yes and N for no. If this field contains a Y, the system allows accounts with an insurance balance to qualify for AR agency processing. If this field contains a N, the system does not allow accounts with an insurance balance to transfer to agency processing. The default value is N.

11. MIN ACCT BAL (1-A-R)
This field contains the minimum account balance in order for an account to qualify for AR agency processing.

12. MAX ACCT BAL (1-A-R)
This field contains the maximum account balance in order for an account to qualify for AR agency processing.

13. RESELECT DAYS (3-N-R)
This field contains the number of days that the system waits after the Pre-Collection Delete Date before allowing an account to be reselected for Pre-Collection. The default value is zero. This field is not used for Internal Collection and is only valid for CCI Collection.

14. AGENCY TRANS CODE/DESC (4-N-R)
This field contains the transaction code for agency collection transactions. This transaction code is used to log collection events in the account's transaction history. Enter the code, if known, or enter a hyphen (-) to select it from a table display. Enter the code, or enter a hyphen (-) to display a list of valid transaction codes under transaction type M (System Memos).

15. PRIMARY SORT FOR REJECT REPORTS (1-A-O)
The Primary Sort for Reject Reports field determines if primary sort of the Agency Rejection Report, FFR630, and the Pending/Candidate Rejection Report, FFR640, should be Guarantor Name or Rejection Reason Code.

16. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last updated the pre-collection information.

17. EDIT DATE (DISPLAY ONLY)
This field contains the date the pre-collection information was last updated.

Master Record - Inclusion Criteria (Insurance Version)

The following screen shows the Pre-Collection Information Inclusion Criteria screen (insurance version).

```
          General Hospital Financial Table Maintenance Processor
                                                Fri May 26, 2007 09:53 am
Pre-Collection Information for Model Hospital A
Code      Description
MIKEGA    EXT PRECOLLECT - GUARANTOR ONL

                              Inclusion Criteria
 1 Min Days Discharge     2 Min Days Final Bill    3 Min Days Carrier Payment
   0                        0                        0
 4 Carrier Payment Amt    5 Carrier Payment %      6 Min Carrier Balance
   50.00                     0.00%                    .00
 7 Max Carrier Balance    8 Min Acct Balance       9 Max Acct Balance
   9,999,999.00             .00                      99,999.00
10 Reselect Days         11 Agency Trans Code/Desc
   0                        M0016-PRE-COLLECTION UPDATE
12 Primary Sort for Reject Reports
   Reject Reason Code


13 Edited By                                      14 Edit Date
   New, Nancy                                       05/26/06 9:38

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

Field Explanations

CODE (DISPLAY ONLY)
This field contains the code identifying this Pre-Collection Information Parameter. It displays the external Pre-Collection Agency code.

DESCRIPTION (DISPLAY ONLY)
This field contains the external Pre-Collection Agency code description code description.

1. MIN DAYS DISCHARGE (3-N-R)
This field contains the minimum number of days that must elapse, following discharge, in order for an account to qualify for AR agency processing.

2. MIN DAYS FINAL BILL (3-N-R)
This field contains the minimum number of days that must elapse, following final bill, in order for an account to qualify for AR agency processing.

3. MIN DAYS CARRIER PAYMENT (3-N-R)
This field contains the minimum number of days that must elapse, following receipt of a carrier payment, in order for an account to qualify for AR agency processing.

4. CARRIER PAYMENT AMOUNT (10-N-R)
This field contains the minimum amount the carrier must pay in order for an account not to qualify for AR agency processing.

5. CARRIER PAYMENT % (6-N-R)
This field contains the minimum percentage of the Last Follow-up amount that the carrier must pay in order not to qualify for AR agency processing.

6. MIN CARRIER BALANCE (10-N-R)
This field contains the minimum carrier balance an account must have to qualify for AR agency processing.

7. MAX CARRIER BALANCE (10-N-R)
This field contains the maximum carrier balance an account must have to qualify for AR agency processing.

8. MIN ACCT BAL (1-A-R)
This field contains the minimum account balance an account must have to qualify for AR agency processing.

9. MAX ACCT BAL (1-A-R)
This field contains the maximum account balance an account must have to qualify for AR agency processing.

10. RESELECT DAYS (3-N-R)
This field contains the number of days that the system waits, after the Pre-Collection Delete Date, before allowing an account to be reselected for agency processing. The default value is zero.

11. AGENCY TRANS CODE/DESC (4-N-R)
This field contains the transaction code for collection agency transactions. This transaction code is used to log collection events in the account's transaction history. Enter the code, if known, or enter a hyphen (-) to select from a table display of transaction codes under transaction type M (System Memos).

12. PRIMARY SORT FOR REJECT REPORTS (1-A-R)
This field determines if primary sort of the Agency Rejection Report, FFR630, and the Pending/Candidate Rejection Report, FFR640, should be sorted by patient name or rejection reason code. When this field is accessed, the following prompt is displayed:

Sort by (P)atient Name or (R)ejection Reason [R]

You can enter **P** to sort by patient name or **R** to sort by rejection reason code.

13. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last updated the pre-collection information.

14. EDIT DATE (DISPLAY ONLY)
This field contains the date the pre-collection information was last updated.

Master Record - Exclusion Criteria

After the data for Inclusion Criteria is accepted, the Exclusion Criteria screen is displayed. The following screen shows the Pre-Collection Information Exclusion Criteria screen:

```
         General Hospital Financial Table Maintenance Processor
                                                  Fri May 28, 2006 01:15 pm
Pre-Collection Information for Model Hospital A
Code      Description
INSTP     INTERNAL PRECOLLECT SELF PAY

                               Exclusion Criteria
( 1)Patient Indicators       :
( 2)Patient Types            :
( 3)Financial Classes        :
( 4)Insurance Carriers       :
( 5)Insurance Plans          :
( 6)Occupation Codes         :20
( 7)Zip Codes                :30319
( 8)Church Codes             :4
( 9)Invalid Address
(10)Payment Plan             :Yes



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

Field Explanations for Exclusion Criteria

CODE (DISPLAY ONLY)
This field contains the code identifying this Pre-Collection Information Parameter. It displays the Internal Pre-Collection Agency code or the CCI Pre-Collection Agency code.

DESCRIPTION (DISPLAY ONLY)
This field contains the CCI Collection Agency code description or the Internal Pre-Collection Agency code description.

1. PATIENT INDICATOR (TABLE LOOKUP)
This field contains the patient indicators that are excluded from AR agency processing. This field is not included on the Patient Indicator Exception screen.

2. PATIENT TYPE (TABLE LOOKUP)
This field contains the patient types that are excluded from AR agency processing.If a patient type changes because of a Change Patient Type After Final Bill (CPTAFB) transaction and as a result of the change in patient, the account no longer qualifies for either internal or external precollect, the system deletes the account from agency processing and returns it to either guarantor or account follow-up depending on the value in the Agencyl Del Act field in PAAR Control. If the new patient type isn't defined as exclusion criteria, the CPTAFB transaction wouldn't have any impact on the account in internal or external agency processing. If the account doesn't qualify for precollect, and it was deleted from agency processing, it would no longer be associated with a

precollect follow-up schedule but would now be associated with either a guarantor or account level follow-up schedule.

3. FINANCIAL CLASS (TABLE LOOKUP)
This field contains the financial classes that are excluded from AR agency processing.

4. INSURANCE CARRIER (TABLE LOOKUP)
This field contains the insurance carriers that are excluded from AR agency processing.

5. INSURANCE PLAN (TABLE LOOKUP)
This field contains the insurance plans that are excluded from selection for AR agency processing.

6. OCCUPATION CODE (TABLE LOOKUP
This field contains the occupation codes that are excluded from AR agency processing.

7. ZIP CODE (TABLE LOOKUP)
This field contains the guarantor ZIP codes that are excluded from AR agency processing. If the patient has indicated that communications should go to a confidential address, the system uses the ZIP code from the confidential address for this field.

8. CHURCH CODE (TABLE LOOKUP)
This field contains the church codes that are excluded from AR agency processing.

When the Pre-Collection Information Master record is completed, the Exception and Prioritization records can be defined.

After the Inclusion and Exclusion criteria for the Master Record are entered, the following prompt is displayed:

Enter Patient Indicator (E)xceptions or (P)riority Sequence--

Enter **E** for patient indicator exceptions. Enter **P** for prioritization. Both of these records are discussed below.

9. INVALID ADDRESS (TABLE LOOKUP-R)
This field is used to exclude accounts with a specific Invalid Address Flag from being considered for AR agency processing. When this field is accessed, the STAR Patient Processing Invalid Address/Phone table is displayed. The table displays entries defined as A (Address) or B (Both), since the exclusion applies only to invalid addresses. For codes defined as Both, the system flags the accounts where the reason is for address or phone information. You can select one or multiple codes. Accounts that are excluded, due to having the invalid address flag selected on this screen, are not selected for transfer to an AR agency.

10. PAYMENT PLANS (1-A-O)
This field indicates whether accounts on a guarantor or account level payment plan are prevented from being transferred to an external agency. This field does not affect external insurance pre-collect processes. When this field is accessed, the following prompt is displayed:

Exclude accounts on a payment plan (Y/N)--

If you enter **N** (No), the accounts can be transferred to the external AR agency and removed from the payment plan. If you enter **Y** (Yes), the account is prevented from being transferred to an external guarantor AR agency.

Patient Indicator Exception Record

Once a Patient Indicator Exception record is added to the system, the Patient Indicator is highlighted on the Exception screen. The system also provides a copy function to facilitate completing the Patient Indicator Exception. The prompt that allows you to copy from the master record is *Do you wish to copy from the Master?*. A Patient Indicator Exception can only be added if the indicator is not excluded on the Master record. For example, if the inpatient indicator is set as excluded on the Master record, an exception can not be defined for the inpatient indicator. If a Patient Indicator Exception record is defined for an indicator, the Master record can not be set to exclude the indicator before the Patient Indicator Exception record is deleted. For example, if the Inpatient Indicator is defined as an Exception record, the Inpatient Indicator is not displayed as an option under the Patient Indicator field on the Master record.

To enter data for the patient indicator exception record, enter **E** to the *Enter Patient indicator (E)xceptions or (P)riority Sequence* prompt. The following screens display for the Patient Indicator Exceptions record.

```
     General Hospital Financial Table Maintenance Processor
                                                  Fri Feb 28, 1997 09:05 am
Pre-Collection Information for Model Hospital A
Code      Description
INTSP     INTERNAL PRE-COLLECT SELF PAY

Page:01                  Patient Indicator Exceptions
( 1) E-Emergency
( 2) I-Inpatient
( 3) O-Outpatient









Enter choice--
```

After you enter the patient indicator to add as an exception, the following prompt is displayed:

Do you wish to copy from Master? (Y/N) [N]--

You can enter **Y** (Yes) to copy data from the master record or **N** (No) not to copy data from the master record.

The next two patient indicator screens are displayed:

```
          General Hospital Financial Table Maintenance Processor
                                                Fri Feb 28, 2007 01:15 pm
Pre-Collection Information for Model Hospital A
Code      Description                           Patient Indicator
INTSP     INTERNAL PRE-COLLECT SELF PAY         EMERGENCY

                              Inclusion Criteria
 1 Min Days Discharge     2 Min Days Final Bill    3 Min Days Patient Payment
   30                       30                       7
 4 Patient Payment Amt    5 Patient Payment %      6 Min Patient Balance
   50.00                     50.00%                  10.00
 7 Max Patient Balance    8 Min # Paper F/U        9 Min Days Ins Payment
   99,999.99                1                        30
10 Pending Ins Balance   11 Min Acct Balance      12 Max Acct Balance
   No                       10.00                    99,999.99
13 Reselect Days         14 Agency Trans Code/Desc
                            M1234-Internal Pre-Collect Updates
15 Edited By                                     16 Edit Date
   Smith, Carol                                     02/18/97 15:36



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

```
    General Hospital Financial Table Maintenance Processor
                                                Fri Apr 21, 2006 01:15 pm
Pre-Collection Information for Model Hospital A
Code      Description                           Patient Indicator
INTSP     INTERNAL PRE-COLLECT SELF PAY         EMERGENCY

                               Exclusion Criteria
( 1)Patient Types            :
( 2)Financial Classes        :M,B
( 3)Insurance Carriers       :200
( 4)Insurance Plans          :
( 5)Occupation Codes         :
( 6)Zip Codes                :30319
( 7)Church Codes             :
( 8)Invalid Addr Codes
( 9)Payment Plans            :No




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

To add Patient Indicator exceptions:

1. Select the Patient Indicator to add as an exception. The Patient Indicator Exception record contains two screens: Inclusion Criteria and Exclusion Criteria. The screens are similar to the Master Record screens except that Patient Indicator is not included under the Exclusion criteria. Refer to the explanation of the Master Record - Inclusion and Exception Criteria for an explanation of these fields.

2. Complete the fields as appropriate and accept the screen to complete the transaction.

To revise Patient Indicator exceptions:

1. Select the Patient Indicator exception to edit. The system displays the Patient Indicator Exception record. Refer to the explanation of the Master Record - Inclusion and Exception Criteria for an explanation of these fields.

2. Edit the fields as necessary and accept the record to complete the transaction.

To delete Patient Indicator exceptions:

1. Select the Patient Indicator exception to delete. Once the first screen of the exception record is displayed, the following prompt is displayed *Delete? (N)*. Enter **Y** and accept the screen. The exception is deleted. If an exception has been deleted, it is no longer highlighted on the Patient Indicator Exception screen.

Prioritization Record

This record allows the facility to set priorities for rejection reasons. This controls how the rejection reasons display on the Pending/Candidate and Agency Rejection reports. If a priority is not set for a reason, and an account fails for that reason, the account is not reflected on the Pending/Candidate or Agency Rejection reports. Rejection Reasons are also displayed on the Agency Process Status screen. The Agency Process Status screen displays all Rejection Reasons even if there is not a priority assigned. If there is a priority assigned, the screen displays the primary reason, the description, and the subsequent rejection reason codes.

To enter data for the prioritization record, enter **P** to the *Enter Patient indicator (E)xceptions or P(riority) sequence* prompt. The following screens show the Pre-Collection Information Prioritization screens.

```
          General Hospital Financial Table Maintenance Processor
                                                Fri May 28, 2005 09:05 am
Pre-Collection Information for Model Hospital A
Code      Description
INTSP     INTERNAL PRE-COLLECT SELF PAY


 1 Rejection Reason                          Priority Sequence
   64-AR/BD STATUS BLOCK              (*)           1
   78-F/U HOLD BLOCK                  (*)
   33-INSURANCE BALANCE BLOCK         (*)           8
   29-STEP OR SCHEDULE CHANGE BLOCK   (*)           19
   25-ACCOUNT BALANCE TOO HIGH BLOCK
   23-ACCOUNT BALANCE TOO LOW BLOCK                 21
   46-CHURCH CODE BLOCK                             2
   35-DAYS FINAL BILL LOW BLOCK                     3
   34-DAYS FROM DISCHARGE LOW BLOCK                 4
   39-DAYS INS PAYMENT LOW BLOCK                    5
   62-FINANCIAL CLASS BLOCK                         7
   57-INSURANCE CARRIER BLOCK                       9
   58-INSURANCE CARRIER-PLAN BLOCK                  10
   30-MINIMUM RESELECT DAYS BLOCK                   12
   59-OCCUPATION CODE BLOCK                            13
   60-INVALID ADDRESS/PHONE BLOCK                   14

               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

```
    General Hospital Financial Table Maintenance Processor
                                                 Fri Feb 28, 1997 09:26 am
Pre-Collection Information for Model Hospital A
Code      Description
INTSP     INTERNAL PRE-COLLECT SELF PAY


 1 Rejection Reason                          Priority Sequence
   22-PATIENT BALANCE TOO HIGH BLOCK                15
   12-PATIENT BALANCE TOO LOW BLOCK                 16
   40-PATIENT F/U COUNT LOW BLOCK                   17
   88-PATIENT INDICATOR BLOCK                       19
   42-PATIENT PAYMENT BLOCK                         8
   48-PATIENT TYPE BLOCK                            18
   16-WAIT ONE CYCLE                                22
   87-ZIP CODE BLOCK                                20









               F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

Field Explanations for Prioritization Record

CODE (DISPLAY ONLY)
This field contains the code identifying this Pre-Collection Information Parameter. It displays the Internal Agency code or the CCI Collection Agency Code.

DESCRIPTION (DISPLAY ONLY)
This field contains the CCI Colllection Agency code description or the Internal Agency code description.

REJECTION REASON (DISPLAY ONLY)
This field contains the rejection reason codes. Refer to Appendix A - Collection Codes in the Collection Agency book in the STAR Financials Patient Account reference guide for an explanation of the rejection reason codes.

PRIORITY SEQUENCE (2-N-O)
This field contains the priority sequence number.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction and the Pre-Collection Information parameters are filed for the facility.

PHYS BILL CODE-MINISTRY (CN ONLY)

For the province of **Ontario**, the Phy Bill Code-Ministry table enables you to validate all performing physicians on charges which are sent on OHIP claims. When a physician submits the required paperwork to the Ministry and the hospital, his/her billing code is entered here. This allows the hospital to bill the Ministry for services performed by the physician.

For the province of **British Columbia**, this table enables you to validate both referring and/or performing physicians on charges that are sent on the MSP claim form. When a physician submits the required paperwork to the Ministry and the hospital, his/her billing code is entered here. This table allows you to maintain a list of valid physician bill codes for reporting to the ministry when billing for services performed by the physician.

```
            General Hospital Financial Table Maintenance Processor
                                                  Tue Feb 07, 2004 09:34 am
 Phys Bill Code-Ministry
  1 Code      2 Description             3 Billing type
    12345       Aker, John                Practitioner/Referring
  4 Status    5 Edit by                 6 Edit date
    ACTIVE      Smith,Mary A              03/01/24 16.40









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

Field Explanations

1. CODE (12-AN-R)
This field contains the code identifying the clinic (4-digits), performing physician code (6-digits) and physician specialty (2-digits).

NOTE: This field is accessable for new entries only. After a code is entered and saved, it cannot be edited.

2. DESCRIPTION (33-A-R)
This field contains the description of the physician bill code (usually the doctor's name and clinic name).

3. BILLING TYPE (1-A-C)
This field is accessable to British Columbia customers only. Options are R for Referring, P for Practioner, or B for Both. Enter whether this physician bill code

number is valid for the performing physician, referring physician or both. During MSP claim charge creation for a performing physician, if the physician bill number is not in the table or the value in this field is set to Referring only, a practitioner error is generated. If the check is being done for a referring physician, and the physician bill code number is not found in this table, or this field is set to Practitioner only, a referring doctor ID error is generated.

4. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is filed as deleted by you becomes inactive and can be reactivated at any time. The system defaults this field to active when the code is created.

5. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited this table entry.

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

After you have completed these fields, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction.

PLACE OF SERVICE (US ONLY)

This table contains the valid Place of Service codes the system uses in 1500 claim form processing. The system uses this code to update Box 24b of the 1500 claim form. You should review your 1500 manual for appropriate values before you set up this table.

This table is not split by facility.

After this table is selected, the system prompts you to enter a Place of Service code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, this screen is displayed.

```
     General Hospital Financial Table Maintenance Processor
                                                 Fri Dec 30, 1988 10:10 am
Place of Service
 1 Code          2 Description                       3 Status
   3               Physician's Office                  Active
 4 Edit by                                           5 Edit date
   Smith,Mary A                                        12/30/88 10:10am









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the Place of Service. When you add a new code at the prompt, you should use the 1500 codes.

2. DESCRIPTION (30-C-R)
This field contains the description of the Place of Service code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

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

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

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

PRORATION SUMMARY CODE

These codes, which are associated with individual items in the STAR Patient Care Financial Item Master, are used to group similar charges for proration purposes. The Financial Item Master charges that are pointed to a proration summary code must all either be ancillary or professional fee charges. In other words, you can not have both ancillary and professional fee charges going to the same proration summary code. If both the ancillary and professional fee charges point to the same proration summary code, proration is incorrect. Ancillary and professional fee charges can, however point to the same UB Revenue Code.

In Canada, the proration summary code is used to determine whether a charge is eligible for inclusion on a claim or is entirely the responsibility of the patient, based on the Summary Code Exceptions established in the Insurance Plan Coverage Processor. For more information on how these codes are used in Canada, refer to the *Canadian Claims Processing Volume* of the *STAR Financials Patient Accounting Reference Guide.*

After this table is selected, the system prompts you to enter a Proration Summary code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, this screen is displayed.

```
     General Hospital Financial Table Maintenance Processor
                                                  Wed May 22, 1996 10:43 am
Proration Summary Code
 1 Code           2 Description                        3 Status
   960              PROFESSIONAL FEES                    Active
 4 Edit by                                             5 Edit date
   Smith,Mary A                                         03/31/88 04:28pm









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

Field Explanations

1. CODE (6-N-R)
This field displays the up to six-digit proration summary code you selected or entered.

2. DESCRIPTION (30-C-R)
This field contains the description of the proration summary code.

The proration summary code and description print on the Proration Summary Bill and can also be used as a summary method for detail and summary bills if chosen previously.

3. STATUS (DISPLAY ONLY)
This field indicates whether this code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

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

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

NOTE: U.S. customers should set up as many proration summary codes as necessary to prorate like charges. One suggestion is to have your proration summary codes match your UB Revenue Codes. By doing this, you can summarize your patient bills to match the UB claim.

Also note you must have proration summary code that are unique for professional fee charges. If ancillary charges and professional fee charges point to the same proration summary code in the Financial Item Master, proration is incorrect. Ancillary and professional fees can point to the same UB Revenue Code, but you must have either ancillary or professional fees pointed to each proration summary codes, not both.

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

Dependent On	Reference
	Financial Item Master

REFUND CHECK MESSAGES

The Refund Check Messages table is used to create explanatory messages printed on the check remittance statement. You can insert selected internal data elements in the message text. This function contains two screens. The first screen sets the description name and system defaults for the message size. The second screen is used to enter the message.

To complete this table, an insurance message and guarantor message must be set up for the refund parameters through the Facility Information function.

Additional messages can also be set up since messages can contain overrides in the refund approval process. Though elements are provided in the refund message text, these are not needed since all elements defined for refunds are included automatically by the system.

An example of a guarantor refund messages is:

Your insurance company has paid for a bill previously paid by you.

An example of an insurance refund message is:

The primary carrier has paid for these services. Your overpayment is being returned.

After this table is selected, the system prompts you to enter a Refund Check Message code. You can enter the code or a hyphen (-) to display a list of valid codes. After a code is entered, the first screen of this function is displayed.

```
       General Hospital Financial Table Maintenance Processor
                                                Tue Jul 19, 1988 11:52 am
Refund Check Messages
 1 Code                  2 Description
   1                       PATIENT REFUND - COB
 3 Edit date             4 Edit by                                  5 Status
   07/19/88 11:33am        Smith,Mary A                               Active
 6 Current Width         7 Current Lines

 8 Maximum Width         9 Maximum Lines
   75                      6









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the refund check message.

2. DESCRIPTION (30-C-R)
This field contains the description of the refund check message.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

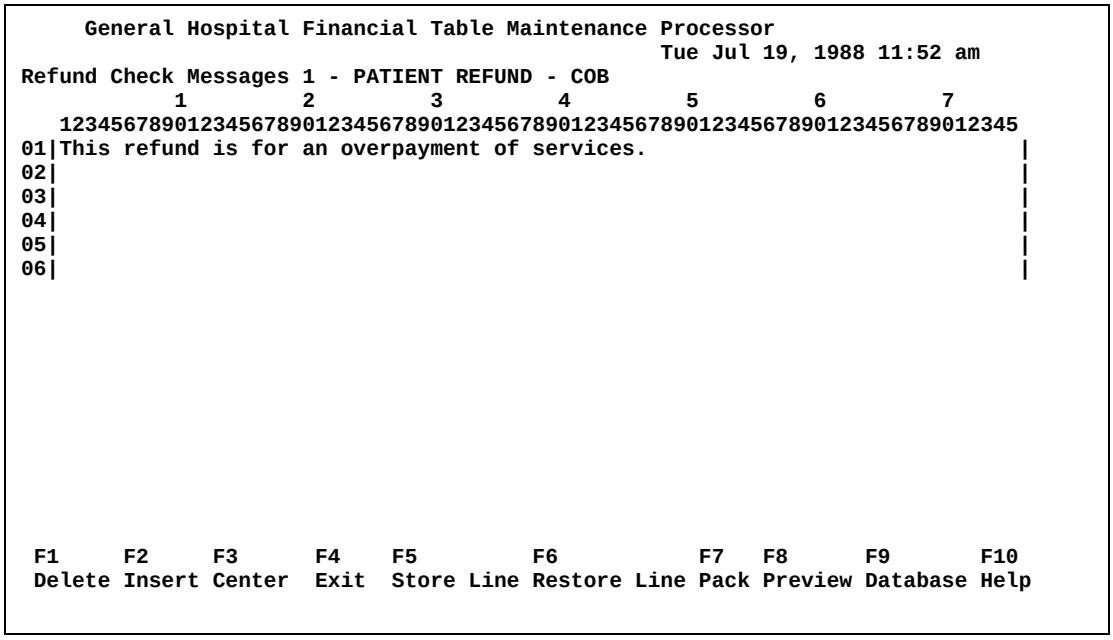
6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the existing message that you are editing. This field is blank if you are creating a new message.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the existing message that you are editing. This field is blank if you creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum number of columns that can be used for this message. The entry range is 10 to 75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum number of lines that the message can contain. The entry range is 1 to 6 lines; the default is 6.

When these fields are completed, the system displays the second screen of this function which is used to enter the message text.



Inserting Data Elements In The Message Text

The only data element you can insert into a refund check message is the account number. To do so:

1. Position the cursor in the text where you want the data element inserted.

2. Press the **F9** key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted. Accepting the element completes the process.

5. Pressing the **F4** key saves the message and exits the screen.

NOTE: Since you are entering text for a letter, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

The following elements are printed on the refund automatically by the system:

Data Base Element	Suggested Print Routine
2nd Address	Use default
Account Number	Account Number (hospital format)
Cert/Social Security Number/HIC Number	Standard print (no formatting)
Contract Number	Use default
Insurance Group Number	Standard Print (no formatting)
Insurance Carrier/Plan Name	Standard Print (no formatting)

Dependent On	Reference
Format Types	Facility Information Refund Parameters
Internal Elements	

REPORT AGING CODE - CROSS FACILITY

This table allows the hospital to specify the end day of the aging categories used when the Cross Facility Account Selection Reports and Cross Facility Aged Trial Balance (ATB) Reports are produced. This table can only be accessed if the Cross Facility module is activated.

Bad Debt Reserve percentages may also be established for use on the Aged Trial Balance Reports. The Financial Class Exception option can be used to establish reserve percentages for bad debt for a given financial class within the standard aging parameter.

This table may be split by facility.

Up to thirteen aging categories may be defined. Multiple report aging codes may be defined. You select the appropriate code to be used when the ATB or Cross Facility Account Selection Report is requested.

After this table is selected, the system prompts you to enter a Report Aging Code or a hyphen (-) to display a list of valid codes. After a code is entered or selected, the following screen is displayed:

```
         General Hospital Financial Table Maintenance Processor
                                                Mon Mar 27, 2006 04:36 pm
Report Aging Code-Cross Facility
 1 Report Aging Code     2 Description
   1                       STANDARD ACCOUNT AGING
 3 Edit Date             4 Edit by
   03/21/06 09:39am        Nelsen,Bobbie F

Aging Category 1         5 Ending Day      6 Inpatient %       7 Outpatient %
                           30 DAYS
Aging Category 2         8 Ending Day      9 Inpatient %      10 Outpatient %
                           60 DAYS
Aging Category 3        11 Ending Day     12 Inpatient %      13 Outpatient %
                           90 DAYS            12.00%              13.00%
Aging Category 4        14 Ending Day     15 Inpatient %      16 Outpatient %
                           120 DAYS           15.00%              16.00%
Aging Category 5        17 Ending Day     18 Inpatient %      19 Outpatient %
                           150 DAYS
Aging Category 6        20 Ending Day     21 Inpatient %      22 Outpatient %
                           180 DAYS


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

You can enter **/P** to access a second screen containing the fields for Aging Categories 7 through 13. The following screen is displayed:

```
          General Hospital Financial Table Maintenance Processor
                                                 Mon Mar 27, 2006 04:36 pm
Report Aging Code-Cross Facility
 1 Report Aging Code     2 Description
   1                       STANDARD ACCOUNT AGING

Aging Category 7         3 Ending Day      4 Inpatient %       5 Outpatient %
                           210 DAYS       ->
Aging Category 8         6 Ending Day      7 Inpatient %       8 Outpatient %
                           240 DAYS
Aging Category 9         9 Ending Day     10 Inpatient %      11 Outpatient %
                           241 DAYS+
Aging Category 10       12 Ending Day     13 Inpatient %      14 Outpatient %

Aging Category 11       15 Ending Day     16 Inpatient %      17 Outpatient %

Aging Category 12       18 Ending Day     19 Inpatient %      20 Outpatient %

Aging Category 13       21 Ending Day     22 Inpatient %      23 Outpatient %



Enter Inpatient reserve percentage--
```

Field Explanations

1. REPORT AGING CODE (2-N-R)
This field contains the code identifying the report aging category.

2. DESCRIPTION (30-C-R)
This field contains the description of the report aging category code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. AGING CATEGORY 1 ENDING DAY (4-N-R)
This field contains the ending day for the first aging category which is measured from the date of the user-defined criteria. The entry range is 0 to 9999 days. A category of 0 to 30 is indicated with an entry of 30 in this field.

6. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the first aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates the hospital expects 5% of this category to become bad debt.

7. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the first aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve

percentage of 5.00 indicates the hospital expects 5% of this category to become bad debt.

NOTE: If you press ENTER in one of the remaining aging category fields, the field value for that aging category is incremented by one. The entry also is displayed with a plus sign (+), signifying this number of days and beyond. For example, if the value of Aging Category 1 field is 30 and you press ENTER in the Aging Category 2 field, 31 DAYS+ is displayed in the Aging Category 2 field.

8. AGING CATEGORY 2 ENDING DAY (4-N-O)
This field contains the ending day for the second aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days. A category of 30 to 60 is indicated with an entry of 60 in this field.

9. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the second aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

10. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the second aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

11. AGING CATEGORY 3 ENDING DAY (4-N-O)
This field contains the ending day for the third aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days. A category of 60 to 90 is indicated with an entry of 90 in this field.

12. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the third aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

13. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the third aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

14. AGING CATEGORY 4 ENDING DAY (4-N-O)
This field contains the ending day for the fourth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

15. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the fourth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

16. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the fourth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

17. AGING CATEGORY 5 ENDING DAY (4-N-O)
This field contains the ending day for the fifth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

18. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the fifth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

19. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the fifth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

20. AGING CATEGORY 6 ENDING DAY (4-N-O)
This field contains the ending day for the sixth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

21. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the sixth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

22. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the sixth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

Report Aging Code - Cross Facility Screen 2

1. REPORT AGING CODE (2-N-R)
This field contains the code identifying the report aging category.

2. DESCRIPTION (30-C-R)
This field contains the description of the report aging category code.

3. AGING CATEGORY 7 ENDING DAY (4-N-O)
This field contains the ending day for the seventh aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

4. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the seventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

5. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the seventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

6. AGING CATEGORY 8 ENDING DAY (4-N-O)
This field contains the ending day for the eighth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

7. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the eighth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

8. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the eighth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

9. AGING CATEGORY 9 ENDING DAY (4-N-O)
This field contains the ending day for the ninth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

10. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the ninth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

11. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the ninth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve

percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

12. AGING CATEGORY 10 ENDING DAY (4-N-O)
This field contains the ending day for the tenth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

13. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the tenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

14. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the tenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

15. AGING CATEGORY 11 ENDING DAY (4-N-O)
This field contains the ending day for the eleventh aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

16. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the eleventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

17. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the eleventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

18. AGING CATEGORY 12 ENDING DAY (4-N-O)
This field contains the ending day for the twelfth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

19. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the twelfth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

20. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the twelfth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve

percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

21. AGING CATEGORY 13 ENDING DAY (DISPLAY ONLY)
This field contains the ending day for the thirteenth aging category. The entry is displayed with a plus sign (+), signifying this number of days and beyond. For example, if the entry in the *Aging Category 12* field is 150 days, and you press ENTER in the *Aging Category 13* field, the number that is displayed in the *Aging Category 13* field is 151 DAYS+.

22. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the thirteenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

23. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the thirteenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

Editing/Adding Financial Class Exceptions

After these fields are completed, you have the option of editing or accepting this screen. When the screen is accepted, the system provides the opportunity to first edit financial class exceptions currently associated with this parameter and then to add them to the list. You can use one, both, or neither of these options.

Should you wish to edit or add financial class exceptions, the system displays a list of those established for this transaction including code, description, and current status.

Following the prompt, you can select or remove a single or range of financial class exceptions. After you have made your selection, the following screen is displayed.

```
        General Hospital Financial Table Maintenance Processor
                                                Mon Mar 27, 2006 04:50 pm
Report Aging Code-Cross Facility
Financial Class: 1-TEST
 1 Report Aging Code     2 Description
   1                       STANDARD ACCOUNT AGING
 3 Edit Date             4 Edit by
   03/27/06 04:50pm        Wyeth,Janis J

Aging Category 1         5 Ending Day      6 Inpatient %       7 Outpatient %
                           30 DAYS
Aging Category 2         8 Ending Day      9 Inpatient %      10 Outpatient %
                           60 DAYS
Aging Category 3        11 Ending Day     12 Inpatient %      13 Outpatient %
                           90 DAYS            12.00%              13.00%
Aging Category 4        14 Ending Day     15 Inpatient %      16 Outpatient %
                           120 DAYS           15.00%              16.00%
Aging Category 5        17 Ending Day     18 Inpatient %      19 Outpatient %
                           150 DAYS
Aging Category 6        20 Ending Day     21 Inpatient %      22 Outpatient %
                           180 DAYS

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

NOTE: Enter **/P** to access a second screen containing the fields for Aging Categories 7 through 13.

A financial class exception only needs to be defined if the financial class reserve percentage needs to be more or less than those previously defined. Only financial classes with exceptions need to be defined.

The Ending Day field contains the same values as those of the parameter initially selected. The Inpatient Reserve Percentage and Outpatient Reserve Percentage fields have been edited to define the exception. Only the reserve percentages can be edited. This screen is displayed for each financial class exception being edited or added.

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

Dependent On	Reference
Cross Facility module being activated	

REPORT AGING CODE

This table allows the hospital to specify the end day of the aging categories used when the Account Selection Reports, Aged Trial Balance (ATB) Reports, Receivables Workstation Focus Work, and the OHIP Reconciliation report (Canada only) are produced.

The Ending Day parameters are measured based on user-defined criteria, for example, final bill, last payment, or discharge for the ATB. Other examples are Admission Date, Last Account Payment, Bill Date, Last Insurance F/U Date, Claim Date, Last Insurance Payment, Discharge Date, Last Patient F/U Date, and Last Patient Payment. Bad Debt Reserve percentages may also be established for use on the Aged Trial Balance Reports. The Financial Class Exception option can be used to establish reserve percentages for bad debt for a given financial class within the standard aging parameter.

This table may be split by facility.

Up to thirteen aging categories may be defined. Multiple report aging codes may be defined. You select the appropriate code to be used when the ATB or Account Selection Report is requested.

After this table is selected, the system prompts you to enter a Report Aging Code or a hyphen (-) to display a list of valid codes. After a code is entered or selected, the following screen is displayed:

```
         General Hospital Financial Table Maintenance Processor
                                                Mon Mar 27, 2006 03:49 pm
Report Aging Code
 1 Report Aging Code     2 Description
   30                      EVERY 30 DAYS
 3 Edit Date             4 Edit by
   03/15/06 02:24pm        Nelsen,Bonnie F

Aging Category 1         5 Ending Day      6 Inpatient %       7 Outpatient %
                           30 DAYS
Aging Category 2         8 Ending Day      9 Inpatient %      10 Outpatient %
                           60 DAYS
Aging Category 3        11 Ending Day     12 Inpatient %      13 Outpatient %
                           90 DAYS
Aging Category 4        14 Ending Day     15 Inpatient %      16 Outpatient %
                           120 DAYS
Aging Category 5        17 Ending Day     18 Inpatient %      19 Outpatient %
                           150 DAYS
Aging Category 6        20 Ending Day     21 Inpatient %      22 Outpatient %
                           180 DAYS


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

You can enter **/P** to access a second screen containing the fields for Aging Categories 7 through 13. The following screen is displayed:

```
            General Hospital Financial Table Maintenance Processor
                                                  Mon Mar 27, 2006 03:49 pm
Report Aging Code
 1 Report Aging Code     2 Description
   30                      EVERY 30 DAYS

Aging Category 7         3 Ending Day      4 Inpatient %       5 Outpatient %
                           210 DAYS
Aging Category 8         6 Ending Day      7 Inpatient %       8 Outpatient %
                           230 DAYS
Aging Category 9         9 Ending Day     10 Inpatient %      11 Outpatient %
                           231 DAYS+
Aging Category 10       12 Ending Day     13 Inpatient %      14 Outpatient %

Aging Category 11       15 Ending Day     16 Inpatient %      17 Outpatient %

Aging Category 12       18 Ending Day     19 Inpatient %      20 Outpatient %

Aging Category 13       21 Ending Day     22 Inpatient %      23 Outpatient %



Do you wish to add financial class exceptions? (Y/N) [N] --
```

Field Explanations

1. REPORT AGING CODE (2-N-R)
This field contains the code identifying the report aging category.

2. DESCRIPTION (30-C-R)
This field contains the description of the report aging category code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. AGING CATEGORY 1 ENDING DAY (4-N-R)
This field contains the ending day for the first aging category which is measured from the date of the user-defined criteria. The entry range is 0 to 9999 days. A category of 0 to 30 is indicated with an entry of 30 in this field. This is a required field.

6. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the first aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates the hospital expects 5% of this category to become bad debt.

7. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the first aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve

percentage of 5.00 indicates the hospital expects 5% of this category to become bad debt.

NOTE: If you press ENTER in one of the remaining aging category fields, the field value for that aging category is incremented by one. The entry also is displayed with a plus sign (+), signifying this number of days and beyond. For example, if the value of Aging Category 1 field is 30 and you press ENTER in the Aging Category 2 field, 31 DAYS+ is displayed in the Aging Category 2 field.

8. AGING CATEGORY 2 ENDING DAY (4-N-O)
This field contains the ending day for the second aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days. A category of 30 to 60 is indicated with an entry of 60 in this field.

9. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the second aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

10. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the second aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

11. AGING CATEGORY 3 ENDING DAY (4-N-O)
This field contains the ending day for the third aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days. A category of 60 to 90 is indicated with an entry of 90 in this field.

12. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the third aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

13. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the third aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

14. AGING CATEGORY 4 ENDING DAY (4-N-O)
This field contains the ending day for the fourth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

15. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the fourth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

16. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the fourth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

17. AGING CATEGORY 5 ENDING DAY (4-N-O)
This field contains the ending day for the fifth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

18. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the fifth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

19. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the fifth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

20. AGING CATEGORY 6 ENDING DAY (4-N-O)
This field contains the ending day for the sixth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

21. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the sixth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

22. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the sixth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

Report Aging Code Screen 2

1. REPORT AGING CODE (2-N-R)
This field contains the code identifying the report aging category.

2. DESCRIPTION (30-C-R)
This field contains the description of the report aging category code.

3. AGING CATEGORY 7 ENDING DAY (4-N-O)
This field contains the ending day for the seventh aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

4. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the seventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

5. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the seventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

6. AGING CATEGORY 8 ENDING DAY (4-N-O)
This field contains the ending day for the eighth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

7. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the eighth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

8. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the eighth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

9. AGING CATEGORY 9 ENDING DAY (4-N-O)
This field contains the ending day for the ninth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

10. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the ninth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

11. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the ninth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve

percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

12. AGING CATEGORY 10 ENDING DAY (4-N-O)
This field contains the ending day for the tenth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

13. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the tenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

14. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the tenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

15. AGING CATEGORY 11 ENDING DAY (4-N-O)
This field contains the ending day for the eleventh aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

16. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the eleventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

17. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the eleventh aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

18. AGING CATEGORY 12 ENDING DAY (4-N-O)
This field contains the ending day for the twelfth aging category which is measured from the date of final bill, last payment, or discharge. The entry range is 0 to 9999 days.

19. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the twelfth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

20. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the twelfth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve

percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

21. AGING CATEGORY 13 ENDING DAY (DISPLAY ONLY)
This field contains the ending day for the thirteenth aging category. The entry is displayed with a plus sign (+), signifying this number of days and beyond. For example, if the entry in the *Aging Category 12* field is 150 days and you press ENTER in the *Aging Category 13* field, the number that is displayed in the *Aging Category 13* field is 151 DAYS+.

22. INPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the inpatient reserve percentage for the thirteenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

23. OUTPATIENT RESERVE PERCENTAGE (5-N-O)
This field contains the outpatient reserve percentage for the thirteenth aging category. The entry range is 0 to 100% with fractional percentages (99.99%) included. A reserve percentage of 5.00 indicates that the hospital expects 5% of this category to become bad debt.

Editing/Adding Financial Class Exceptions

After these fields are completed, you have the option of editing or accepting this screen. When the screen is accepted, the system provides the opportunity to edit financial class exceptions currently associated with this parameter and to add them to the list. You can use one, both, or neither of these options.

If you want to edit or add financial class exceptions, the system displays a list of those established for this transaction including code, description, and current status. You can

select or remove one or a range of financial class exceptions. After you have made your selection, the following screen is displayed.

```
            General Hospital Financial Table Maintenance Processor
                                                 Mon Mar 27, 2006 03:52 pm
Report Aging Code
Financial Class: W-WORKER'S COMPENSATION
 1 Report Aging Code     2 Description
   30                      EVERY 30 DAYS
 3 Edit Date             4 Edit by
   03/27/06 03:50pm        Wyeth,Janis J

Aging Category 1         5 Ending Day      6 Inpatient %       7 Outpatient %
                           30 DAYS
Aging Category 2         8 Ending Day      9 Inpatient %      10 Outpatient %
                           60 DAYS
Aging Category 3        11 Ending Day     12 Inpatient %      13 Outpatient %
                           90 DAYS
Aging Category 4        14 Ending Day     15 Inpatient %      16 Outpatient %
                           120 DAYS
Aging Category 5        17 Ending Day     18 Inpatient %      19 Outpatient %
                           150 DAYS
Aging Category 6        20 Ending Day     21 Inpatient %      22 Outpatient %
                           180 DAYS

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

NOTE: Enter **/P** to access a second screen containing the fields for Aging Categories 7 through 13.

A financial class exception only needs to be defined if the financial class reserve percentage needs to be more or less than those previously defined. Only financial classes with exceptions need to be defined.

The Ending Day field contains the same values as those of the parameter initially selected. The Inpatient Reserve Percentage and Outpatient Reserve Percentage fields have been edited to define the exception. Only the reserve percentages can be edited. This screen is displayed for each financial class exception being edited or added.

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

Dependent On	Reference
Financial Class	

REFERENCE FACILITY ID NUMBERS

The Reference Facility ID Numbers Table enables you to list all ID numbers for a reference facility. The appropriate numbers can then be sent to EC2000 CA/Data Extract for the electronic claims. The Reference Facility codes entered on this table are from the Reference Facility Table on STAR Order Management.

After this table is selected, the system prompts you to enter a Reference Facility Code or a hyphen (-) to display a list of valid codes. After a code is entered or selected, the following screen is displayed:

```
               General Hospital Financial Table Maintenance Processor
                                                 Mon Feb 06, 2006 01:45 pm
Reference Facility ID Numbers
 1 Reference Facility Code     2 Reference Facility Description      3 Status
   QST                           QUE DIAGNOSTICS                     Active
 4 Blue Cross Prov #       5 Blue Shield Prov #         6 Medicare Prov #
   BX1234567890123           BS1234567890123             CARE12345678901
 7 Medicaid Prov #         8 Prov UPIN #                9 CHAMPUS ID #
   CAID12345678901           UPIN12345678901             CHAMPUS12345678
10 Prov Commercial #      11 Prov Plan Network ID #    12 NPI
   COMM12345678901           NET123456789012             1234567890
13 Employer's ID #        14 CLIA #
   EMP123456789012           CLIA123456
15 Edit by                                             16 Edit date
   New, Nancy                                             02/06/06 11:00am



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

Field Explanations

1. REFERENCE FACILITY CODE (DISPLAY ONLY)
This field displays the code entered when accessing the table.

2. REFERENCE FACILITY DESCRIPTION (DISPLAY ONLY)
This field contains a description for the Reference Facility code entered when accessing the table. The description is pulled from the Reference Facility Table on STAR Order Management.

3. STATUS (DISPLAY ONLY)
This field displays the status of the Reference Facilities. The value of *Active* is always displayed, since Reference Facilities marked as Filed as Deleted, or Deleted, are not accessible in the Reference Facility ID Numbers table. To update IDs for a Reference Facility with a status of Filed as Deleted, you can activate the Reference Facility in the STAR Order Management Reference Facility Table, and then re-access the Reference Facility ID Numbers table in STAR Patient Accounting.

4. BLUE CROSS PROV # (15-AN-O)
This field contains the Blue Cross provider number. When this field is accessed, the following prompt is displayed:

Enter the Blue Cross Provider Number--

You can enter the Blue Cross Provider Number.

5. BLUE SHIELD PROV # (15-AN-O)
This field contains the Blue Shield Provider number. When this field is accessed, the following prompt is displayed:

Enter the Blue Shield Provider Number--

You can enter the Blue Shield Provider Number.

6. MEDICARE PROV # (15-AN-O)
This field contains the Medicare provider number. When this field is accessed, the following prompt is displayed:

Enter the Medicare Provider Number--

You can enter the Medicare Provider Number.

7. MEDICAID PROV # (15-AN-O)
This field contains the Medicaid provider number. When this field is accessed, the following prompt is displayed:

Enter the Medicaid Provider Number--

You can enter the Medicaid Provider Number.

8. PROV UPIN # (15-AN-O)
This field contains the Provider UPIN number. When this field is accessed, the following prompt is displayed:

Enter the Provider UPIN Number--

You can enter the Provider UPIN Number.

9. CHAMPUS ID # (15-AN-O)
This field contains the CHAMPUS ID number. When this field is accessed, the following prompt is displayed:

Enter the CHAMPUS Identification Number--

You can enter the CHAMPUS Identification Number.

10. PROV COMMERICAL # (15-AN-O)
This field contains the Provider Commercial ID number. When this field is accessed, the following prompt is displayed:

Enter the Provider Commercial ID Number--

You can enter the Provider Commercial ID Number.

11. PROV PLAN NETWORK ID # (15-AN-O)
This field contains the Provider Plan Network ID number. When this field is accessed, the following prompt is displayed:

Enter the Provider Plan Network Identification Number--

You can enter the Provider Plan Network Identification Number.

12. NPI (10-N-O)
This field contains the National Provider ID. When this field is accessed, the following prompt is displayed:

Enter the National Provider ID--

You can enter the National Provider ID.

13. EMPLOYER'S ID # (15-AN-O)
This field contains the employer's ID (Tax ID). When this field is accessed, the following prompt is displayed:

Enter the Employer's Identification Number--

You can enter the employer’s identification number.

14. CLIA # (DISPLAY ONLY)
This field contains the CLIA # from the Reference Facility table.

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

16. EDIT DATE (DISPLAY ONLY)
This field contains the last edit date of the table.

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

REIMBURSEMENT PAYOR CODES

This table defines the hospital's third party payors with which the hospital has special arrangements.

In addition to your non-DRG based payors, it is necessary to set up a payor for DRG-based payors. All other reimbursement tables for DRG-based payors are not necessary since this information is maintained in STAR Patient Care. This table is not split by facility.

After this table is selected, the system prompts you to enter a Reimbursement Payor code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, the following screen is displayed:

```
     General Hospital Financial Table Maintenance Processor
                                                 Wed Apr 20, 1988 02:28 pm
Reimbursement Payor Code
 1 Code      2 Description
   CO          COMMERCIAL
 3 Status    4 Edit by                                  5 Edit date
   Active      Smith,Mary A                               03/29/88 02:51pm









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the reimbursement payor code.

2. DESCRIPTION (30-C-R)
This field contains the description of the reimbursement payor code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

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

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

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

Dependent On	Reference
	Payor Table Definition
	Insurance Plan Coverage Master

SECONDARY BILLING DIRECTIONS

The Secondary Billing Directions Table must be completed to indicate the insurance plans for which prior payment information is sent to EC 2000 CA. As soon as any entries appear in this table, no prior payment information is sent to EC 2000 CA unless all of the qualifying prior insurance plans for the claim and the insurance plan for the claim are defined in the Secondary Billing Directions Table. The Secondary Billing Directions Table provides options on how to format payment information provided for secondary claims including whether items are included, excluded, or reported only, and whether information is rolled up to the claim level.

The All Plans, Carriers, and Plans fields are used to define pairings between a secondary and preceding insurance, and the pairing determined for two insurance plans must provide a unique Secondary Billing Directions code. The rules for assigning the pairing are as follows:

- If secondary carriers are selected in the Carriers field, and the All Plans field is set to All or None, those secondary carriers cannot be selected as a secondary carrier in another Secondary Billing Directions table. The use of the carrier does not prohibit using an associated plan code in a Secondary Billing Directions table. Secondary Billing Directions for an insurance plan takes precedence over Secondary Billing Directions for an insurance carrier.

- If secondary plans are selected in the Plans field and All Plans field is set to All or None, those secondary plans cannot be selected as a secondary plan in another Secondary Billing Directions table. The use of the plan does not prohibit using the associated carrier code in a Secondary Billing Directions table. Secondary Billing Directions for an insurance plan take precedence over Secondary Billing Directions for an insurance carrier.

- If a secondary carrier and/or plan are selected and a Preceding Plan is selected, then the same pairing cannot be selected in another Secondary Billing Directions table.

```
            General Hospital Financial Table Maintenance Processor
                                                Wed Mar 02, 2011 07:11 pm

                     Select Secondary Insurance Information
 1 Code      2 Description                    3 Carrier(s)     4 Plan(s)
   22          TEST 2 CHAR                      22
                     Select Preceding Insurance Information
            5 All Plans                       6 Carrier(s)     7 Plan(s)
              Yes

 8 Copy Previous Entry               9 Process Option     10 Format Option
                                       Include               Claim Level
11 ERA Payment File Definition Override

12 Exclude CAS Codes/Claim          13 Exclude CAS Codes/Service Line

14 Include Other Info/Claim         15 Include Other Info/Service Line

16 Edit by                                    17 Edit date
   New, Nancy                                     03/12/10 05:10pm


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

Field Explanations

1. CODE (1-AN-R)
This field contains a unique code assigned by the user for the Secondary Billing Directions.

2. DESCRIPTION (12-AN-R)
This field contains a unique description is assigned by the user for the Secondary Billing Directions.

3. CARRIER(S) (TABLE LOOKUP-R)
This field is used to select insurance carriers for which the Secondary Billing Directions can be used when sending claim information for the insurance carrier to EC 2000 CA. A match in the Secondary Billing Directions table must be found for the insurance for the claim being sent to EC 2000 CA and for a preceding insurance for which payment information would be included. Insurance carriers can be entered in this field; insurance plans are entered in the Plans field.

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

Enter carrier code or `-` for a list-

You can enter the code or a hyphen (-) to display a list of carrier codes. You can select one or more carrier codes.

4. PLAN(S) (TABLE LOOKUP-R)
This field is used to select insurance plans for which the Secondary Billing Directions can be used when sending claim information for the insurance carrier to EC 2000 CA. A match in the Secondary Billing Directions table must be found for the insurance for the claim being sent to EC 2000 CA and for a preceding insurance for which payment information would be included. Insurance carriers can be entered in the Carriers field.

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

Enter plan code or `-` for a list-

You can enter the code or a hyphen (-) to display a list of plan codes. You can select one or more plan codes.

5. ALL PLANS (1-A-O)
This field is used to indicate whether all preceding carriers should be selected for the Secondary Billing Directions.

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

Select all preceding insurance plans? (Y/N)--

You can enter Y (Yes) to select all preceding insurance plans. The Secondary Billing Directions defined by this table entry are used for any secondary insurance carriers defined in the Plans field and for any secondary insurance plans defined in this field.

6. CARRIER(S) (TABLE LOOKUP-R)
This field is used to select insurance carriers for which the Secondary Billing Directions can be used when sending prior payment information to EC 2000 CA. A match in the Secondary Billing Directions table must be found for the insurance for the claim sent to EC 2000 CA and for a preceding insurance for which payment information would be included. Insurance carriers can be entered in this field, and insurance plans can be entered in the Plans field.

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

Enter carrier code or `-` for a list--

You can enter the code or a hyphen (-) to display a list of carrier codes. You can select one or more carriers.

7. PLAN(S) (TABLE LOOKUP-R)
This field is used to select insurance plans for which the Secondary Billing Directions can be used when sending prior payment information to EC 2000 CA. A match in the Secondary Billing Directions table must be found for the insurance for the claim being sent to EC 2000 CA and for a preceding insurance for which payment information would be included. Insurance carriers can be entered in the Carriers field, and insurance plans can be entered in this field.

The prompt for this field is as follows:

Enter plan code or `-` for a list-

You can enter the code or a hyphen (-) to display a list of plan codes. You can select one or more plans.

8. COPY PREVIOUS ENTRY (1-A-O)
This field is used to copy information from another entry in the table for the following fields: Process Option, Format Option, ERA Payment File Definition Override, Exclude CAS Codes/Claim, Exclude CAS Codes/Service Line, Include Other Info/Claim, Include Other Info/Claim, Include Other Info/Service Line. When this field is accessed, the following prompt is displayed:

Do you want to copy information from another Secondary Billing Directions code? (Y/N)-

If a response of Y for Yes is keyed, the subsequent prompt is as follows.

Enter Secondary Billing Directions code or `-` for a list--

The Secondary Billing Directions code which should be used for copying information can be indicated by keying the code or performing a table lookup.

9. PROCESS OPTION (1-A-O)
This field identifies how prior payment information is handled for the secondary and preceding insurance defined in the table when information for EC 2000 CA is being formatted.

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

Enter (I)nclude in download, (E)xclude from download, (R)eport only, or key B to include and report information--

- If Include is selected, the payment information is sent in the EC 2000 CA download but not reported.
- If Exclude is selected, no prior payment information is sent in the download for EC 2000 CA and nothing is reported.
- If Report only is selected, the prior payment information is not sent in the download to EC 2000 CA but the information may be reported on any of the Secondary Billing reports.
- If B for Both is selected, the prior payment information is sent in the download to EC 2000 CA and reported on the FCRCASCMx and FCRCASCYx reports.

10. FORMAT OPTION (1-A-O)
This field determines whether information from the CAS, QTY, AMT, and LQ segments are summarized at the claim level or service line detail is sent in addition to any claim level information. The prompt for the field is as follows:

> Provide (S)ervice Line Detail or summarize information to (C)laim Level--

11. ERA PAYMENT FILE DEFINITION OVERRIDE (1-A-O)
The Exclude CAS Codes/Claim field and the Exclude CAS Codes/Service Line field can be used to exclude CAS information from the prior payment information for EC 2000 CA. The ERA CAS Reason Codes table and the ERA Claim Adjustment Groups table assist in defining these exclusions unless an ERA Payment File Definition is indicated in this field. If that occurs, the ERA CAS Reason Codes and the ERA Claim Adjustment Groups table for the selected ERA Payment File Definition are used.

The prompt for the field is as follows:

> Enter ERA PFD code or `-` for table lookup if you want to select CAS exclusions using the CAS tables for the selected ERA PFD code--

A valid code in the ERA Payment File Definition table can be keyed or the ERA Payment File Definition can be selected from a table lookup.

12. EXCLUDE CAS CODES/CLAIM (TABLE LOOKUP-O)
This field is used to select CAS Codes found at the claim level in the ERA file which should not be included in the file created for EC 2000 CA. If the field is selected, a screen is displayed, allowing the selection of Reason Codes and Group Codes. A Reason Code can be selected once for the Secondary Billing Directions code by keying the code or keying a dash (-) so Reason Codes not selected previously appear in a lookup list. A Reason Code can appear only once in this table.

Group Code(s) for the Reason Code can be selected by keying the desired codes separated by commas or keying a dash (-) so codes can be selected from a table lookup of the ERA Claim Adjustment Groups table.

13. EXCLUDE CAS CODES/SERVICE LINE (TABLE LOOKUP-O)
This field is used to select CAS Codes found at the service line level in the ERA file which should not be included in the file created for EC 2000 CA. If the field is selected, a screen is displayed, allowing the selection of Reason Codes and Group Codes. A Reason Code can be selected once for the Secondary Billing Directions code by keying the code or keying a dash (-) so Reason Codes not selected previously appear in a lookup list. A Reason Code can appear only once in this table. Group Code(s) for the Reason Code can be selected by keying the desired codes separated by commas or keying a dash (-) so codes can be selected from a table lookup of the ERA Claim Adjustment Groups table.

14. INCLUDE OTHER INFO/CLAIM (1-A-O)
Information from AMT, QTY, and LQ segments found at the claim level in the ERA file is not included unless the segment is selected in this field. If the field is selected, a screen is displayed, allowing the selection of Segment, Qualifier Code, and Segment Option. An ERA Segment is selected by keying AMT, QTY, or LQ. A corresponding Qualifier Code is keyed and there are no edits on this field. For AMT segments, this is the value appearing in AMT01 (for example AMT*B6). For QTY segments, this is the value appearing in QTY01. For LQ segments, this is the value appearing in LQ02.

The Segment Option defines how the data is formatted for the EC 2000 CA file. For AMT and QTY segments, one of two options can be selected.

- If S for Sum is keyed, the numbers in the second piece for the record are added together.

- If M for Maximum is keyed, the maximum number in the second piece for the record is used.

- For LQ segments, the only possible response is E for Eliminate duplicate. That means one occurrence of the LQ reason code is included in the EC 2000 CA file.

15. INCLUDE OTHER INFO/SERVICE LINE (1-A-O)
Information from AMT, QTY, and LQ segments found at the service line level in the ERA file is not included unless the segment is selected in this field. If the field is selected, a screen is displayed, allowing the selection of Segment, Qualifier Code, and Segment Option. An ERA Segment is selected by keying AMT, QTY, or LQ. A corresponding Qualifier Code is keyed and there are no edits on this field. For AMT segments, this is the value appearing in AMT01 (for example AMT*B6). For QTY segments, this is the value appearing in QTY01. For LQ segments, this is the value appearing in LQ02.

The Segment Option defines how the data is formatted for the EC 2000 CA file. For AMT and QTY segments, one of two options can be selected.

- If S for Sum is keyed, the numbers in the second piece for the record are added together.

- If M for Maximum is keyed, the maximum number in the second piece for the record is used.

- For LQ segments, the only possible response is E for Eliminate duplicate. That means one occurrence of the LQ reason code is included in the EC 2000 CA file.

SERVICE AUTHORIZATION EXCEPTIONS

For details on this table, please refer to the *Tables Volume* of the *STAR Patient Care Reference Guide*.

TELEPHONE MESSAGES

This user-defined table contains the messages used in the Guarantor, AR Agency, and Internal Bad Debt collector workfiles for telephone follow-up. The codes representing these messages are used in the Guarantor, Pre-collection, and Agency Follow-up schedules and Insurance Follow-up schedules. These messages can include internal data elements to identify account-related information.

This table is not split by facility.

After this table is selected, the system prompts you to enter a Telephone Message code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the system displays the first of two Telephone Messages screens. The first screen is used to define the message format and the second to enter the message text.

```
     General Hospital Financial Table Maintenance Processor
                                                Fri Dec 30, 1988 10:10 am
Telephone Messages
 1 Code                  2 Description
   1                       Telephone Message 1
 3 Edit date             4 Edit by                                5 Status
   12/30/88 10:10am        Smith,Mary A                             Active
 6 Current Width         7 Current Lines
   35                      1
 8 Maximum Width         9 Maximum Lines
   75                      15









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the telephone message.

2. DESCRIPTION (30-C-R)
This field contains the description of the telephone message code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

6. CURRENT WIDTH (DISPLAY ONLY)
This field contains the width, in columns, of the established message that you are editing. This field is blank if you are creating a new message.

7. CURRENT LINES (DISPLAY ONLY)
This field contains the length, in lines, of the established message you are editing. This field is blank if you are creating a new message.

8. MAXIMUM WIDTH (2-N-R)
This field contains the maximum number of columns that can be used for this message. The entry range is 10 to 75 columns; the default is 75.

9. MAXIMUM LINES (2-N-R)
This field contains the maximum number of lines that the message can contain. The entry range is 1 to 15 lines; the default is 15.

NOTE: Any change to the entry in the maximum width or maximum lines fields affects not only the detail telephone message you are editing but **all** telephone messages. If you change this field, the system checks all existing messages to ensure they do not exceed the new maximums. If one or more existing messages exceeds the new maximum, the system displays the following error message:

Warning - message exceeds width and/or length defaults!

When you complete and accept the first screen, the system displays the second Telephone Message screen.

```
     General Hospital Financial Table Maintenance Processor
                                                  Fri Dec 30, 1988 10:10 am
Telephone Messages 1 - Telephone Message 1
           1         2         3         4         5         6         7
  12345678901234567890123456789012345678901234567890123456789012345678901234567890123456789012345
01|Need to get commitment for balance.  Do not allow payments to exceed more  |
02|than 3 months.                                                            |
03|                                                                          |
04|                                                                          |
05|                                                                          |
06|                                                                          |
07|                                                                          |
08|                                                                          |
09|                                                                          |
10|                                                                          |
11|                                                                          |
12|                                                                          |
13|                                                                          |
14|                                                                          |
15|                                                                          |

 F1     F2     F3      F4    F5         F6           F7   F8      F9       F10
 Delete Insert Center  Exit  Store Line Restore Line Pack Preview Database Help
```

Field Explanations - Screen 2 of 2

Enter the message text on this screen using the format you defined on the first Telephone Message Processor screen.

Inserting Data Elements In The Message Text

Internal data elements are defined and maintained by McKesson. The system enables you to insert specific data elements that are unchangeable and maintained by McKesson into the message text. These data elements are:

Data Base Element	Heading
Account Restart Amount	Money (with $ sign)
Guarantor Restart Amount	Money (with $ sign)
Insurance Last Payment Date	Use default

To do so:

1. Position the cursor in the text where you want the data element inserted.

2. Press the **F9** key.

3. Respond to the subsequent system prompt asking for a data base description by entering a hyphen (-) to display a list of available elements. Select the desired element.

4. The system automatically inserts the element in the area you designated and prompts you to accept or change the element inserted.

   The highlighted area represents the maximum length of the selected element. The format displayed represents the default print routine for the element. For example, most date elements have a default print routine of MM/DD/YY. After accepting the element, the system displays a list of alternate print routines, if applicable. For example, dates can be printed as YYMMDD, MM/DD, MM/YY, etc. If you want the element to print in one of the alternate formats, select the desired format. Otherwise, press ENTER to accept the default print routine. When you accept the element, the process is complete.

5. Pressing the **F4** key saves the message and exits the screen.

NOTE: Since you are entering text for a message, be sure that the ALPHA LOCK feature on your CRT is turned off. If it is on, all letters are entered in upper case.

Pressing the F4 key saves the message and exits the screen, completing the transaction.

The telephone message can be displayed in the collector workfile. It can be used to assist the collector in making a collection call. The elements display the specific data relevant to the account.

TRANSACTION CODES

This table contains codes representing system transactions. Each transaction code is associated with a transaction type. For example, the transaction type Adjustment could have several transaction codes such as courtesy discounts, employee discounts, and charity write-offs associated with it. Transaction codes are used in cash and adjustment posting, balance and location transfer, and memo notations. They are also used in several system parameters and masters.

These codes are used to update the patient account transaction history when the event occurs. For example, when a claim is produced, the system uses transaction type Y (patient bills) and the applicable transaction code to update the patient account.

This table is not split by facility.

Transaction Types

Every transaction code is associated with a transaction type. Transaction types are used to group similar transaction codes together. For example, the transaction type Adjustment is represented by transaction type A. It can have several adjustment transaction codes representing specific adjustments such as employee discounts, courtesy discounts, small balance write-off, and contractual adjustments associated with it. Transaction types are defined and maintained by McKesson.

A complete understanding of the system is needed before building the transaction code table since it is used in many functions, tables, and parameters. The following are the transaction codes established in the system:

Type Code	Use	Description
A	P	Adjustment *
E	P	Agency Cash Agency Collected *
B	P	Balance Transfer
Z	P	Claims Processing
T	P	Collector Notes
I	P	Insurance Payment *
D	P	Insurance Refund *
F	N	Miscellaneous Cash *
O	V	Miscellaneous Notes (not implemented)
N	V	Nonpatient Cash *
G	V	Other Adjustments *
Y	P	Patient Bills
P	P	Payment *

Type Code	Use	Description
R	P	Refund *
S	P	Status Transfer
M	P	System Memos
U	U	Unapplied Cash*
V	N	Agency Fees*
J	U	Other Refunds*

CODE USE

N - Not patient-specific
P - Patient-specific
U - Unapplied cash-specific
V - Vendor-specific

* - Adding a transaction code of this type requires the GL Mapping table to be set up for this new transaction code.

A detailed explanation of the transaction types is provided below:

Transaction Type	Explanation	Example
A	Used for adjustments to patient accounts for the insurance portion and patient portion of an account.	Medicare Contractual Employee Discount Small Balance
E	Used to apply cash to bad debt accounts collected by the Collection Agency on behalf of the hospital.	Payment by Check Payment by MasterCard Payment by VISA
B	Used to transfer a balance from one insurance to another, from the insurance to patient, or from the patient to insurance within a single account.	Insurance to Insurance Transfer Patient to Insurance Transfer Insurance to Patient Transfer
Z	Used when a claim is loaded, printed, and submitted. The various types of claims should be set up as the transaction description since the message that is loaded, printed, and submitted by the system is done so automatically. Blue Cross Reprint Claim Blue Cross Tracer Claim (only one fourth facility)	Blue Cross Cycle Claim Blue Cross Final Claim Blue Cross Late Charge Claim Blue Cross Adjustment Claim

Transaction Type	Explanation	Example
T	Used to apply a standard or free-form collector note to an account. A free-form note uses the transaction description entered at the time the note was produced to update the patient account. The standard note uses the description set up in the Transaction Code table to update the patient account. The standard note is used to indicate when letters, statements, and phone calls are made. This is also used when a wait step is processed.	Free-form Note Sent Patient Detail Bill Patient Called for Balance Detail Statement Generated
I	Used to apply insurance payment to a patient account.	Medicare Payment Blue Cross Payment Aetna Payment
D	Used to update insurance refunds. One transaction code can be set up for the refund approval process. If an approved refund is deleted, the system overrides the approval description and indicates the refund has been deleted.	Insurance Refund Approved
F	Used to update the cash account in the general ledger for items not related to the patient for which the hospital receives revenue. A single transaction code, miscellaneous cash codes, or multiple transaction codes can be used.	Cafeteria Receipts Newspapers Vending Machines Gift Shop
O	Not implemented.	
N	Non-patient cash.	
G	Other adjustments.	
J	Not implemented.	
Y	Used when a bill is produced. A transaction code for each type of bill should be set up.	Final Bill Produced Cycle Bill Produced Late Bill Produced Reprint Bill Produced
P	Used to update guarantor payments to an account.	Payment by Check Payment by MasterCard Payment by VISA Payment by Cash

Transaction Type	Explanation	Example
R	Used to update guarantor refunds. A single transaction code can be set up for the refund approval process. If an approved refund is deleted, the system overrides the approval description and indicates the refund has been deleted. The hospital may also wish to set up an insurance refund transaction code. This allows the hospital to refund a carrier for a patient for whom the hospital has no prior knowledge.	Guarantor Refund Approved Insurance Refund Approved
S	Used to indicate change of an account from one account location to another. The account locations are PA unbilled, AR billed, and BD accounts turned over to a collection agency. Accounts can move from PA to AR, AR to BD, and BD to AR. A status transfer code is also needed for key information changes on an account. This transaction code is used when the account's financial class, medical service, physician, admit date, or discharge date changes. One transaction code can be set up for these events since the system overrides the description based on the key date that is changed.	PA to AR Transfer AR to BD Transfer BD to AR Transfer Key Data Changed
M	Used to make notations on accounts for certain events, such as holding accounts from being sent to bad debt, adding or deleting an insurance plan, prelisting an account for bad debt, and processing a refund check. These transactions are used in Facility Information PA/AR Control and Refund Parameters.	Insurance Refund Printed User Hold and Archive Guarantor Refund Printed Manual BD Archive User Hold BD Transfer Agency Update

Transaction Type	Explanation	Example
U	Used to apply cash to the unapplied account. The cash that the hospital has collected but does not know where is should be applied is applied to the unapplied account. Blue Cross Payment Medicare Payment Commercial Insurance Payment	Guarantor Payment Check Guarantor Payment Master Card Guarantor Payment VISA
V	Used to apply the agency fee to the general ledger. The hospital receives a check from the collection agency for patients from whom the owed money has been collected. The agency deducts its collection fee from the check. The transaction code is used to record the collection expense in the general ledger. If a separate general ledger expense account exists for each collection agency, a transaction code must be defined for each collection agency. If there is only one general ledger account, only one transaction code needs to be defined.	Ace Collection Expense B&B Collection Expense

After you select this table, the system prompts you to enter a transaction type. You can enter the type or a hyphen (-) to display a list of valid types. The system then prompts you to enter a transaction code or a hyphen (-) to display a list of valid codes for the selected type. If you display the list, the system displays a screen similar to the following.

```
     General Hospital Financial Table Maintenance Processor
                                                Tue May 29, 1990 01:32 pm

   Transaction                                  Valid            Combined to
   Type  Code  Description                      Accts   Combine  Type  Code
( 1) A - 0010  AUGUST/AUGNET CONT ADJ           Any     Combined   P - 0006
( 2) A - 0030  BESTCARE CONT ADJ                Any
( 3) A - 0050  BCBSO PPO CONT ADJ               Any
( 4) A - 0051  BLUE CROSS/BLUE SHIELD MRI ADJ   Any
( 5) A - 0052  BLUE CROSS COMMERCIAL CONT/ADJ   Any
( 6) A - 0090  COLUMBIA HEALTH CONT ADJ         Any
( 7) A - 0099  ADJUSTMENT                       Any     Combined   I - 0030
( 8) A - 0100  TEST COMBINING TRANSACTIONS      Any     Combined   I - 0050
( 9) A - 0110  LINCOLN HLTH/FAM HLTH CONT ADJ   Any
(10) A - 0130  FOUNDATION HEALTH CONT ADJ       Any
(11) A - 0150  GHP CONT ADJ                     Any
(12) A - 0151  GHP PCT W/O                      Any
(13) A - 0152  GHP MEDICARE CONT ADJ            Any
(14) A - 0153  GHP MEDICARE PCT W/O             Any
(15) A - 0154  GHP PHARM DISC COMM              Any
(16) A - 0156  GHP PHARM DISC PMC EMPL          Any

Enter choice--
```

Each transaction code associated with the selected transaction type is displayed. The type, code, description, type of accounts for which this code is valid, and whether the code is combined with another code are displayed. After a code is selected from this screen or entered at the system prompt, the following screen is displayed.

```
     General Hospital Financial Table Maintenance Processor
                                                Thu Apr 21, 1988 10:06 am

 1 Transaction Type          2 Transaction Type Description
   A                           Adjustment
 3 Transaction Code          4 Transaction Description          5 Accum. Stats?
   2001                        CONTRACTUAL ADJ. - MEDICARE        Yes
 6 Valid Accounts            7 Combine
   Any                         Combined
 8 Combined to Transaction Type          9 Combined to Transaction Code
   I-Insurance Payment                     2001-MEDICARE PAYMENT
10 Edited by                            11 Last edited
   Smith,Mary A                            03/16/88 01:31pm









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

Field Explanations

1. TRANSACTION TYPE (1-A-R)

This field contains the code identifying the transaction type.

2. TRANSACTION TYPE DESCRIPTION (30-C-R)
This field contains the description of the transaction type code.

3. TRANSACTION CODE (4-N-R)
This field contains the code representing this transaction. On the system screens, the transaction code always is displayed with its associated type. For example, A-1001 would indicate transaction type A and transaction code 1001.

4. CODE DESCRIPTION (30-C-R)
This field contains the description of the transaction code. This description is used in transaction history and on bills and follow-up statements if the transaction code is printed.

Transaction code descriptions should be as complete as possible. For example, the description *Blue Cross Cycle Claim* is more informative than *Cycle Claim*.

If an account has more than one insurance coverage, detailed descriptions help to eliminate confusion in the transaction history.

5. ACCUM. STATS? (1-A-R)
This field indicates whether the system should maintain statistics for this transaction code. Entry options are Y for Yes or N for No; the default is Y. The statistics include the number and dollar (if applicable) figure of the transaction for daily, fiscal period, and fiscal year accumulations.

6. VALID ACCOUNTS (1-A-R)
This field indicates the accounts that are valid for this transaction code. Entry options are **A** (any - PA, AR, and collection accounts), **C** (bad debt), or **R** (PA and AR). The default is A.

7. COMBINE (1-A-R)
This field indicates whether the transaction code is combined with another transaction code on bills and statements. Entry options are **Y** for Yes or **N** for No; the default is N. Only adjustment type transactions can be combined and they can only be combined with insurance payments (transaction type I) or patient payments (transaction type P).

Only cash, refunds, and adjustments print on bills and statements (transaction types: A - Adjustment, D - Insurance Refund, I - Insurance Payment, P - Patient Payment, and R - Guarantor Refund).

If an adjustment transaction code is combined with a payment code, the system prints the adjustment with the payment transaction code and description if both a payment and adjustment transaction exist on the account. If the adjustment is an insurance adjustment, the payment must be an insurance payment for the same carrier and plan. If the payment and adjustment do not match, the system prints the adjustment transaction code and the payment description.

8. COMBINED TO TRANSACTION TYPE (1-A-C)
This field contains the transaction type with which the transaction code should be combined for bills and follow-up statements. You can enter the code or a hyphen (-) to display a list of valid codes.

This field is required if the *Statement Print Option* field contains C. If the entry in the *Statement Print Option* field is not C, this field cannot be accessed. This field and the *Combined To Transaction Code* field enable carrier payments and adjustments to be summarized as one line on follow-up statements and bills.

9. COMBINED TO TRANSACTION CODE (4-N-C)
This field contains the transaction code (up to four digits) associated with the transaction type entered in the previous field. This field is required if the *Statement Print Option* field contains C. If the entry in the *Statement Print Option* field is not C, this field cannot be accessed. You can enter the code or a hyphen (-) to display a list of valid codes.

Example entries to fields 8 and 9:

You are setting up a Medicaid Adjustment transaction code. Enter an **I** for insurance transaction type in field 8. Enter the transaction code for Medicaid payments in field 9. When statements and bills are printed, the adjustment combines with the Medicaid payment and printed on the statement with the payment code and description.

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

11. LAST EDITED (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

Dependent On	Reference
Transaction Types	Billing Parameters
	Claim Generation Parameters
	Collection Agency Table
	Facility Information - PA/AR
	Facility Information - Balance Designation
	Parameters
	Facility Information - Refund Parameters
	Facility Information - Insurance Time Out

Dependent On	Reference
	Financial Class
	Follow-up Schedules
	Insurance Coverage
	G/L Mapping Table
	Miscellaneous Cash Codes

TYPE OF SERVICE

This table defines the type of service codes for 1500 claim form processing. These codes are used in the STAR Patient Care Financial Item Master for each professional fee. Type of Service codes entered in this table identify valid entries in Box 24C of the 1500 claim form.

NOTE: You should refer to your 1500 billing manual for valid codes.

This table is not split by facility.

In Canada, this table defines the type of service codes for WCB claim form processing. These codes are used in the STAR Patient Care Financial Item Master (FIM) for each item that may be submitted the WCB for Therapy claims.

Valid codes include **O** for occupational therapy and **P** for physiotherapy.

After this table is selected, the system prompts you to enter a Type of Service code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, this screen is displayed.

```
     General Hospital Financial Table Maintenance Processor
                                                 Fri Dec 30, 1988 10:10 am
Type of Service
 1 Code           2 Description                        3 Status
   4                Anesthesia                           Active
 4 Edit by                                             5 Edit date
   Smith,Mary A                                         12/30/88 10:10am









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

Field Explanations

1. CODE (2-AN-R)
This field contains the code identifying the type of service.

2. DESCRIPTION (30-C-R)
This field contains the description of the type of service code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when the code is created.

4. EDIT BY (DISPLAY ONLY)
This field contains the new name of the system user who last edited this table entry.

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

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

Dependent On	Reference
	Financial Item Master

UB CONDITION CODES (SPECIAL STATISTICS CODES)

This table defines the codes the system uses to update the UB condition codes on a patient account.

NOTE: You should refer to your State UB or UB Manual for more information on the values and use of these codes.

This table is not split by facility.

In Canada, this table defines the codes that the hospital uses to enter special statistics, such as poison involvement, during the disposition process. These statistics are used in conjunction with the Monthly Census Summary Report and the ER Log.

After this table is selected, the system prompts you to enter a UB Condition Code/ Special Statistics Code. You can enter a code or a hyphen (-) to display a list of valid codes. After the code is entered, this screen is displayed:

```
     General Hospital Financial Table Maintenance Processor
                                                 Fri Aug 14, 2009 11:29 am
UB Condition Codes
( 1)Code               : 17
( 2)Description        : PATIENT OVER 100 YR
( 3)Indicator Required :

( 4)Edit by            : New, Nancy
( 5)Edit date          : 04/26/09 09:44am









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the UB condition code/special statistics code.

2. DESCRIPTION (30-C-R)
This field contains the description of the UB condition code/special statistics code.

3. INDICATOR REQUIRED (1-A-O)
This field indicates whether a UB Condition Indicator is required for this UB condition code. If you enter Yes, the indicator is required for the condition code.

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

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

NOTE: Refer to the Provider Master for information regarding the automatic generation of condition codes.

UB OCCURRENCE CODES (US ONLY)

This table defines the codes the system uses to update the UB occurrence codes on a patient account.

This table is not split by facility.

NOTE: You should refer to your state UB or UB manual for more information on the values and use of these codes.

After this table is selected, the system prompts you to enter a UB Occurrence Code. You can enter a code or a hyphen (-) to display a list of valid codes. After the code is entered, this screen is displayed:

```
     General Hospital Financial Table Maintenance Processor
                                                 Mon Oct 16, 1989 10:03 am
UB Occurrence Code
( 1)Code         : 01
( 2)Description  : AUTO ACCIDENT

( 3)Edit by      : Smith,Mary A
( 4)Edit date    : 03/11/89 03:40pm









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the UB occurrence code.

2. DESCRIPTION (30-C-R)
This field contains the description of the UB occurrence code.

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

4. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

NOTE: Refer to the Provider Master for information regarding the automatic generation of occurrence codes.

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

UB OCCURRENCE SPAN CODES (US ONLY)

This table defines the codes the system uses to update the UB occurrence span codes on a patient account.

This table is not split by facility.

NOTE: You should refer to your State UB or UB Manual for more information on the values and use of these codes.

After this table is selected, the system prompts you to enter a UB Occurrence Span Code. You can enter a code or a hyphen (-) to display a list of valid codes. After the code is entered, this screen is displayed:

```
     General Hospital Financial Table Maintenance Processor
                                                 Mon Oct 16, 1989 09:57 am
UB Occur Span Codes
( 1)Code         : 70
( 2)Description  : QUALIFYING STAY DTS

( 3)Edit by      :
( 4)Edit date    : 08/29/86 01:04pm









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the UB occurrence span code.

2. DESCRIPTION (30-C-R)
This field contains the description of the UB occurrence span code.

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

4. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

NOTE: Refer to the Provider Master for information regarding the automatic generation of occurrence span codes.

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

UB REVENUE CODES (INSURANCE SUMMARY CODES)

This table contains the UB revenue codes/insurance summary codes used to summarize detailed charges on the UB claim form. These codes can also be used to summarize patient detail and summary bills.

NOTE: You should refer to your State UB or UB Manual for more information on the values and use of these codes.

In Canada, these codes are referred to as insurance summary codes. Although they are attached to individual items in the STAR Patient Care Financial Item Master, they do not control claim processing for Canadian claims. In general, the insurance summary codes entered are the same as the proration summary codes, which do control claim processing in Canada.

After this table is selected, the system prompts you to enter a UB Revenue Code/ Insurance Summary Code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, this screen is displayed.

```
     General Hospital Financial Table Maintenance Processor
                                                 Mon Aug 19, 2002 05:17 pm
UB Revenue Codes
 1 Code           2 Description                       3 Status
   540              AMBULANCE                           Active
 4 Charge Group->
 5 Edit by                                            6 Edit date
   Moore ,Susan                                        10/09/00 15:24
```

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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the UB revenue code/insurance summary code.

2. DESCRIPTION (30-C-R)
This field contains the description of the UB revenue code/insurance summary code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

4. CHARGE GROUP (1-A-O)
When this field is accessed, the following prompt is displayed:

Enter Charge Grouping of (P)ro Fee Only, (A)ncillary Only, or (B)oth -- |

Valid options are **P** for Pro Fee Only, **A** for Ancillary Only, or **B** for both Pro-Fee and Ancillary. There is no default.

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

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this table entry was last edited.

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

Dependent On	Reference
	Insurance Plan Coverage Master
	UB Charge Control Parameters
	Diagnostic Revenue Code Table

UB VALUE CODES (US ONLY)

This table defines the codes the system uses to update the UB value codes on a patient account.

This table is not split by facility.

NOTE: You should refer to your State UB or UB Manual for more information on the values and use of these codes.

After this table is selected, the system prompts you to enter a UB value code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, this screen is displayed.

```
      General Hospital Financial Table Maintenance Processor
                                                  Fri Dec 30, 1988 10:10 am
UB Value Code
 1 Code           2 Description                       3 Status
   05               Professional Fees                   Active
 4 Edit by                                            5 Edit date
   Smith,Mary A                                        12/30/88 10:10am









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the UB value code.

2. DESCRIPTION (30-C-R)
This field contains the description of the UB value code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

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

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

NOTE: Refer to the Provider Master for information regarding the automatic generation of value codes.

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

UM ALC CODE

For details on this table, please refer to the *Tables Volume* of the *STAR Patient Care Reference Guide*.

UM CO-PAY EXCEPTION CODE

For details on this table, please refer to the *Tables Volume* of the *STAR Patient Care Reference Guide*.

INTERNAL ELEMENT DOCUMENTATION

This menu option provides the ability to display and print documentation for internal elements, set-up routines, and print routines. You cannot update or add documentation for internal elements, setup routines, or print routines.

- Internal Elements are used to select database elements within varied applications in STAR Patient Accounting. The applications are as follows:

  Contract Statement Messages

  Patient Bill Messages

  PA Refund Check Messages

  Detail Statement Messages

  TRENDSTAR and Horizon Performance Manager Interfaces

  Insurance Letter Messages

  Collection Letter Messages

  Memo Follow Up Letter Messages

  Billing Requirements

  Sort Elements for Paper Output

  Telephone Messages

  Claims

  1500 Claims

  Detail Statement Memo Messages

- Set-Up Routines are used to refine the selection of an element from the database. For example, if an Internal Element related to insurance is being used, the set-up routine identifies the account's insurance for which the selection is made.

- Print Routines define the format used to print the element.

This option is accessed from the Patient Accounting menu/Tables/Internal Element Information. When the Internal Elements menu item is selected, the following screen is displayed:

```
                    General Hospital Internal Element Information Processor
                                                  Wed Jul 21, 2010 08:16 am
Internal Element Information Input Options

            Option No.  Option
            ---------------------------------------
                1       Display All/Claim Internal Elements
                2       Display Billing Requirements Internal Elements
                3       Display Trendstar/HPM Internal Elements

                4       Display Set-Up Routines for Internal Elements

                5       Display Print Routines for Internal Elements

                6       Print Internal Element Documentation
                7       Print Set-Up Routine Documentation
                8       Print Print Routine Documentation
```

Each of the options on the screen is discussed on the following pages:

- Display internal elements
- Display Billing Requirements Internal Elements
- Display TRENDSTAR/HPM Internal Elements

Display Internal Elements

Three processors are available to display Internal Element documentation:

- Display All/Claim Internal Elements - The lookup list of internal elements includes all elements. Any internal element in the list can be selected for a field in a Claim Load and Edit parameter.
- Display Billing Requirements Internal Elements - The lookup displays documentation for internal elements used for Billing Requirements.
- Display TRENDSTAR/HPM Internal Elements - The lookup displays internal elements used for TRENDSTAR user-defined fields and Horizon Performance Manager user-defined fields and TRENDSTAR user-defined attributes.

When one of the options is used, the following prompt is displayed:

Enter beginning of description for Internal Element--

You can enter either a hyphen (-) to display all internal elements or one or more letters to display internal elements beginning with the letters you entered. The lookup list begins with items with descriptions matching the beginning description keyed and continues with subsequent items in the lookup list. The description for the Internal Element in the lookup list is followed by *** if documentation exists for the item.

NOTE: The list of internal elements displayed varies depending on the option chosen.

A sample of the lookup list is as follows:

```
        General Hospital Display All/Claim Internal Elements Processor
                                                Thu May 27, 2010 07:44 am
   Page:01     All/Claim Internal Elements - *** Marks Documented Items
( 1) ABSTRACT COMPLETE DATE                 ***
( 2) ACC/OCC DATE                           ***
( 3) ACCID/ONSET SYMPTOMS DATE              ***
( 4) ACCID/ONSET SYMPTOMS/LMP DATE          ***
( 5) ACCIDENT DATE/TIME                     ***
( 6) ACCIDENT HOUR                          ***
( 7) ACCIDENT INFORMATION                   ***
( 8) ACCIDENT STATE                         ***
( 9) ACCIDENT TYPE                          ***
(10) ACCOUNT BALANCE                        ***
(11) ACCOUNT LOCATION                       ***
(12) ACCOUNT NUMBER                         ***
(13) ACCOUNT RESTART AMOUNT                 ***
(14) ACTUAL AMOUNT FROM PROMISE TO PAY      ***
(15) ACTUAL DATE OF PROMISE TO PAY          ***
(16) ACTUAL LIABILITY                       ***
   Enter choice--
                        next pg(/ or PG DN)  Search(TAB)
```

If an item is selected with no documentation, the following message is displayed, and the selection list appears again.

Internal Element is not documented yet!

Following is a sample of the display for a selected item and the documentation of the information provided. The documentation for some internal elements may require a second screen of information. You can use the F2 key to view the next screen.

```
                  General Hospital Display All/Claim Internal Elements Processor
                                                Tue Jul 20, 2010 07:32 am


INSURANCE ADDRESS LINE 1
      Mail To Address Line 1 for insurance selected in the Set-Up Routine.


 INSURANCE ADDRESS LINE 1
 Rev: PM  051110
 Mail To Address Line 1 for insurance selected in the Set-Up Routine.

 Database Location                  |A-I2 (2) ADDR
 Field Type                         |Alphanumeric
 Table Used                         |
 Modules                            |Trendstar/HPM Interface
 STIs                               |
 Sample Data                        |
 Set-Up Routines                    |Corresponding PBE Field
 UB CARRIER 1                       |132-Insurance Address Line 1
 UB CARRIER 2                       |132-Insurance Address Line 1
 UB CARRIER 3                       |132-Insurance Address Line 1
 INSURANCE COB 4                    |132-Insurance Address Line 1
 INSURANCE COB 3                    |132-Insurance Address Line 1
 INSURANCE COB 2                    |132-Insurance Address Line 1

                     F1Prev Page F2Next Page F7  Exit
```

```
            General Hospital Display All/Claim Internal Elements Processor
                                                Wed Sep 15, 2010 10:31 pm



 INSURANCE COB 1                    |132-Insurance Address Line 1
 CARRIER OF REQUEST FOR CLAIM       |132-Insurance Address Line 1
 INSURANCE COB FROM CLAIM           |132-Insurance Address Line 1
 INSURANCE PRIMARY TO MEDICARE      |132-Insurance Address Line 1
 INSURANCE COB 5                    |132-Insurance Address Line 1
 INSURANCE COB 6                    |132-Insurance Address Line 1
 INSURANCE COB 7                    |132-Insurance Address Line 1
 INSURANCE COB 8                    |132-Insurance Address Line 1
 INSURANCE COB 9                    |132-Insurance Address Line 1
 Print Routines                     |
 STANDARD PRINT (NO FORMATTING) (D) |BLANK
                             Source Screens
 Financials, Account Management, Account Inquiry, Select Account, Press
 ENTER, Admission Information, Insurance Process, Select Insurance, and Plan
 Demographics.  Press ENTER as needed to proceed to screen containing the
 information.


                     F1Prev Page F2Next Page F7  Exit
```

Field Explanations

NAME FOR INTERNAL ELEMENT
The name for the internal element is displayed at the top of the screen. A description is displayed on the line after the name.

DATABASE LOCATION
This line contains the location of the field in the STAR database. A location exists if the element is tied to a field in the database. The global name is displayed along with the node name, piece number, and description. This information helps STAR Support answer questions about the internal element.

FIELD TYPE
This contains the format of the field. The possible values are as follows:

- Alpha
- Date
- Money
- Numeric
- Time
- Alphanumeric
- Yes/No Flag

TABLE USED
This line contains the name of the STAR table used to collect the item.

MODULES
This line contains the names of the modules selected for the internal element. Multiple responses are possible. If there is more than one response, they can be displayed in either column. The possible descriptions for modules are as follows:

Contract Statement Messages

Patient Bill Messages

PA Refund Check Messages

Detail Statement Messages

Trendstar/HPM Interface

Insurance Letter Messages

Collection Letter Messages

Memo Follow Up Letter Messages

Billing Requirements

Sort Elements for Paper Output

Telephone Messages

Claims

1500 Claims

Detail Statement Memo Messages

Any internal element can be used for a Claim Load and Edit Parameter. *Claims* does not need to appear as a Module.

STIS
This field contains STIs under which the internal element was created or updated.

SAMPLE DATA
This section may contain an example of the data.

SET-UP ROUTINES
This section contains the list of set-up routines for the internal element. The two columns of data for set-up routines are labeled Setup Routines and Corresponding PBE Field. The PBE Field determines how an edit message appears on the PBE Worklist when a data problem is identified by PBE due to a Billing Requirement or a Claim Load and Edit Parameter using that internal element and set-up routine.

When an internal element has set-up routines, the PBE Field is associated with the pairing created by the internal element and set-up routine.

PBE FIELD
If a pre-bill edit field has been selected for the Internal Element in the base system, it is displayed. The PBE Field determines how an edit message appears on the PBE Worklist when a data problem is identified by PBE due to a Billing Requirement or a Claim Load and Edit Parameter for a claim. If an internal element has set-up routines, the PBE Field is associated with the pairing created by the internal element and set-up routine.

PRINT ROUTINES
This section contains the list of available print routines for the internal element. Both columns are used for the list. The list appears unless the Field Type is Date, Money, or Time. The list is not displayed when the field type is Date, Money, or Time because the number of choices can be large.

SOURCE SCREEN
This item in the display provides information on viewing the field in the STAR Database. If the item can be viewed in Patient Accounting, the starting point is labeled Financials. If the item can be viewed in Patient Processing, the starting point is labeled Patient Processing followed by the type of CRT which has access to the data. For example, some items can be viewed using a Nursing CRT, a Medical Records CRT, or a Utilization Management CRT.

F1 (Prev Page) and F2 (Next Page) can be used to navigate through the display of information for an internal element. When F7 is pressed, the display for the internal element stops and the following prompt is displayed:

View (N)ext Item, Return to (C)urrent List, (S)tart New List, or (E)xit--

- If N is keyed, the information for the next internal element in the alphabetic list is displayed.
- If C is keyed, the lookup list started previously is redisplayed.
- If S is keyed, the following prompt appears allowing a different internal element to be selected.

  Enter beginning of description for Internal Element--

- If E is keyed, the main menu is displayed.

Display Set-Up Routines for Internal Elements

Display Set-Up Routines for Internal Elements is used to display documentation for set-up routines for internal elements. When the option is selected, the following prompt appears:

Enter beginning of description for Set-Up Routine--

You can enter either a hyphen (-) to display all set-up routines or one or more letters r to display set-up routines beginning with the letters you entered. The lookup list begins with items with descriptions matching the beginning description keyed and continues with subsequent items in the lookup list. The description for the set-up routine in the lookup list is followed by *** if documentation exists for the item.

The list of internal elements displayed varies depending on the option chosen. A sample of the lookup list is as follows:

```
   General Hospital Display Set-Up Routines for Internal Elements Processor
                                                    Thu Jul 22, 2010 12:02 pm
Page:01              Set-Up Routines for Internal Elements

   ( 1) INSURANCE COB 1                      ***
   ( 2) INSURANCE COB 2                      ***
   ( 3) INSURANCE COB 3                      ***
   ( 4) INSURANCE COB 4                      ***
   ( 5) INSURANCE COB 5                      ***
   ( 6) INSURANCE COB 6                      ***
   ( 7) INSURANCE COB 7                      ***
   ( 8) INSURANCE COB 8                      ***
   ( 9) INSURANCE COB 9                      ***
   (10) INSURANCE COB FROM CLAIM             ***
   (11) INSURANCE PRIMARY TO MEDICARE        ***
   (12) LAST UM REVIEW                       ***
   (13) MA 319C PRO FEE MEDICAID NUM         ***
   (14) MED REC & CHARGE DIAGNOSIS           ***
   (15) MED REC & CHARGE DX (MR/ADM)
   (16) MED REC DIAG ONLY (MR/ADM)

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

If an item is selected with no documentation, the following message is displayed and the selection list is redisplayed:

Set-Up Routine is not documented yet!

Following is a sample of the display for a selected item and documentation of the information provided:

```
     General Hospital Display Set-Up Routines for Internal Elements Processor
                                                    Thu Jul 22, 2010 12:02 pm


Page:01              Set-Up Routines for Internal Elements


Name                               |INSURANCE COB 1
Type                               |Alpha, Date, Money,
                                    Numeric, Time, Alphanumeric,Yes/No Flag

                                       Description
    Selects the first insurance plan for the account.
```

NAME
This line contains the name of the internal element.

TYPE
This line contains a list of valid types of set-up routines. Multiple lines can be used to display the entire list. A Set-Up Routine can be used for an Internal Element if the Field Type for the Internal Element appears in the valid list of Field Types for the Set-Up Routine.

DESCRIPTION
This section of the display provides a description for the set-up routine.

F1 (Prev Page) and F2 (Next Page) can be used to navigate through the display of information for an internal element. When F7 is pressed, the display for the internal element stops and the following prompt is displayed:

View (N)ext Item, Return to (C)urrent List, (S)tart New List, or (E)xit--

- If N is keyed, the information for the next set-up routine in the alphabetic list is displayed.
- If C is keyed, the lookup list started previously is redisplayed.
- If S is keyed, the following prompt appears allowing a different set-up routine to be selected.

  Enter beginning of description for set-up routine--

- If E is keyed, the main menu is displayed.

Display Print Routines for Internal Elements

This option is used to display documentation for print routines for internal elements. When the option is selected, the following prompt is displayed:

Enter beginning of description for Print Routine--

You can enter either a hyphen (-) to display all print routines or one or more letters to display print routines beginning with the letters you entered. The lookup list begins with items with descriptions matching the beginning description keyed and continues with subsequent items in the lookup list. The description for the print routine in the lookup list is followed by *** if documentation exists for the item.

```
      General Hospital Display Print Routines for Internal Elements Processor
                                          Thu May 27, 2010 11:25 am


   Page:01              Print Routines for Internal Elements
   ( 1) DATE & TIME MILITARY(NO PUNCTU      ***
   ( 2) DATE ( DD MM  YY)                   ***
   ( 3) DATE (CCYYMMDD)         ($ZZDK      ***
   ( 4) DATE (DD     MM     YYYY)
   ( 5) DATE (DD  MM YY)                    ***
   ( 6) DATE (DD/MM/YY)                     ***
   ( 7) DATE (FEB   DD   YYYY)              ***
   ( 8) DATE (HOSPITAL FORMAT)              ***
   ( 9) DATE (MM    DD    YY)               ***
   (10) DATE (MM DD YY)                     ***
   (11) DATE (MM DD YYYY)                   ***
   (12) DATE (MM-DD)                        ***
   (13) DATE (MM/DD)                        ***
   (14) DATE (MM/DD/YY DEFAULT TODAY)       ***
   (15) DATE (MM/DD/YY)                     ***
   (16) DATE (MM/YY)                        ***

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

If an item is selected with no documentation, the following message is displayed and the selection list is redisplayed:

Print Routine is not documented yet!

Following is a sample of the information provided for a selected print routine:

```
           General Hospital Display Print Routines for Internal Elements Processor
                                                Thu Jul 22, 2010 03:18 pm



 Name                                |DATE (MM/YY)ACCOUNT # (FAC_LAST 9 DIGITS)
 Type                                |DateAlphanumeric
                                     Description
 If the field is not blank, then month and year print separated by a slash. If the date
is April 1, 2002 then 04/02 prints. The second character of the field is eliminated
from the print. The intent
 of the field is to eliminate the second character when the field contains
 the account number including the facility code.


                       F1Prev Page F2Next Page F7  Exit
```

FIELD EXPLANATIONS

NAME
This contains the name of the print routine.

TYPE
This line contains the data type of the print routine. Multiple lines can be used to display the entire list. A Print Routine can be used for an Internal Element if the Field Type for the Internal Element appears in the valid list of Field Types for the Print Routine.

DESCRIPTION
This section of the display provides a description for the print routine.

F1 (Prev Page) and F2 (Next Page) can be used to navigate through the display of information for an internal element. When F7 is pressed, the display for the internal element stops and the following prompt is displayed:

View (N)ext Item, Return to (C)urrent List, (S)tart New List, or (E)xit--

- If N is keyed, the information for the next print routine in the alphabetic list is displayed.
- If C is keyed, the lookup list started previously is redisplayed.
- If S is keyed, the following prompt appears allowing a different print routine to be selected.

  Enter beginning of description for Internal Element--

- If E is keyed, the main menu is displayed.

Print Internal Element Documentation

Print Internal Element Documentation can be used to produce a report with documentation for internal elements. The report can be filtered by the type of Internal Element and the Date of Last Edit.

When the option is selected, the following prompt is displayed:

Do you want to limit the print by description? (Y/N) [N]--

- If **Y (Yes)** is keyed, the following prompts are displayed. A listing for All/Claim Internal Elements is produced where the beginning of the description appears in the inclusive range defined by Starting and Ending Characters.

  Starting character(s)--

  Ending character(s)--

  The system then prompts:

  Include (A)ll, (D)ocumented, or (N)ot Documented [D]--

You can enter A (All) to print both documented and undocumented internal elements, (D) Documented to print only documented internal elements, or N (Not Documented) to print only undocumented internal elements.

- If N for No is keyed, the next prompt is as follows:

  Print Internal Elements for (A)ll/Claim, (B)illing Requirements, or (T)rendstar/HPM?-

  If A is keyed, all Internal Elements appear in the report because any Internal Element can be selected in the Claim Load and Edit Parameters for claims.

  If B is keyed, Internal Elements which can be selected as Billing Requirements appear in the report .

  If T is keyed, Internal Elements which can be selected as a UDF for TRENDSTAR or a UDA for Horizon Performance Manager appear in the report.

- If no selection is made, the following prompt is displayed:

  Do you want to limit the print by description? (Y/N) [N]--

  The next prompt is as follows:

  Enter A for all entries or key a date to limit report to elements updated on or after keyed date [A]--

  The date of last entry/update for Internal Elements is retained for changes made after STI F10575 for the Internal Element Documentation tool was marked Complete in Release. If a date is keyed in response to the preceding prompt, an Internal Element is printed if a date of last entry/update is recorded and it equals or follows the keyed date.

The report is spooled to FINTELM Internal Element Reports. The information provided for internal elements in the report has the same format as the display of that information.

Print Set-Up Routine Documentation

This option is used to produce a report with documentation for set-up routines. After the option is selected, the following prompt appears:

Enter A for all Set-up Routines or key a date to limit report to items updated on or after keyed date [A]--

If a date is keyed in response to the preceding prompt, an item is printed if a date of last entry/update is recorded and it equals or follows the keyed date. If only a month and date are keyed, the system assumes the current year. If the response is A, a report

is produced for all set-up routines. A set-up routine is listed even if no documentation exists.

The report is spooled to the report titled FINTELM. The information provided for set-up routines in the report has the same format as the display of that information.

Print Print Routine Documentation

This option is used to produce a report with documentation for print routines. After the option is selected, the following prompt appears:

Enter A for all Print Routines or key a date to limit report to items updated on or after keyed date [A]--

If a date is keyed in response to the preceding prompt, an item is printed if a date of last entry/update is recorded and it equals or follows the keyed date. If only a month and date are keyed, the system assumes the current year. If the response is A, a report is produced for all print routines. A print routine is listed even if no documentation exists.

The report is spooled to the report titled FINTELM. The information provided for print routines in the report has the same format as the display of that information.

Chapter 2 - PA/AR MASTER FILE MAINTENANCE

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

INTRODUCTION

This chapter contains a listing and explanation of the master files used by STAR Financials. Each master is presented with its purpose and use, the screen or screens involved in completing it, and a detailed explanation of the screen fields involved.

At the end of the detailed explanation of each master, two columns are listed. The first column, which is labeled Dependent On, lists the tables or masters that must be completed prior to completing the master currently accessed. The second column, which is labeled Reference, lists the tables or masters where reference is made to the master currently accessed. The tables in the second column should be completed after the master currently accessed is completed.

HCPCS SUMMARIZATION MASTER (US ONLY)

This function enables you to group HCPCS Procedures so they can be summarized on the UB claim. This is done by defining a HCPCS Summary Code and assigning a HCPCS procedure to it from the McKesson-maintained HCPCS Table.

The first digit of the summary code entered controls the HCPCS codes that can be selected. For example, if 800 is entered as the code in field 1, only HCPCS codes starting with 8 display and can be entered in the HCPCS Description field. In most cases, this code and the quantity of the charges become the revised HCPCS Procedure Code (see the following documentation).

This function is tied to the UB Charge Control processor. If a UB revenue code has the HCPCS Procedures field set to FIM/Charge in the UB Charge Control Parameter, you are prompted to respond to the question whether the HCPCS Summary master should be checked for this UB revenue code for possible summarization.

This master is not split by facility.

After this master is selected, the system prompts you to enter a HCPCS Summary Code. You have the option of entering the code or a hyphen (-) to display a list of valid codes. After the code is entered, this screen is displayed.

```
              General Hospital HCPCS Summary Code Processor
                                                 Thu May 16, 1996 10:59 am

 1 Code      2 Description                      3 Number Charges   4 Max Count
   800         LAB PROFILE                        1                  19
 5 Status      6 Edit Date           7 Edit By
   Active        05/09/96 05:17pm      Smith,Mary A

 8 Seq HCPCS Description                Seq HCPCS Description
   1   82040 ALBUMIN                    14  84100 PHOSPHORUS
   2   82250 BILIRUBIN, TOTAL OR DIRECT  15  84132 ASSAY SERUM POTASSIUM
   3   82251 BILIRUBIN, TOTAL AND DIRECT 16  84155 ASSAY PROTEIN, TOTAL
   4   82310 CALCIUM                     17  84295 ASSAY SERUM SODIUM
   5   82374 CARBON DIOXIDE CONTENT      18  84460 TRANSFERASE;ALANINE AMINO(SGPT)
   6   82435 CHLORIDES                   19  84450 TRANSFERASE;ASPARTATE AMINO(SGOT)
   7   82465 CHOLESTEROL                 20  84478 TRIGLYCERIDES
   8   82550 CREATINE (CK) (CPK) TOTAL   21  84520 UREA NITROGEN (BUN)
   9   82565 CREATININE                  22  84550 URIC ACID
   10  82947 GLUCOSE (SUGAR)
   11  82977 GLUTAMYL TRANSPETIDASE, GAMMA
   12  83615 LACTIC DEHYDROGENASE (LDH)
   13  84075 PHOSPHATASE, ALKALINE

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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the HCPCS Summary Code. The first digit controls which HCPCS Codes display.

2. DESCRIPTION (30-C-R)
This field contains the description of the HCPCS Summary Code. This description is used on the UB claim form to identify the summarized procedures.

3. NUMBER CHARGES (3-N-R)
This field contains the number of HCPCS procedure charges (in this summary group) necessary to initiate summarization on the claim. The entry range is 1 to 999. This field should be set to 1 for the 800 HCPCS Summarization table.

4. MAX COUNT (2-N-R)
This field contains the maximum number of units of service that the revised HCPCS code can become. The entry range is 1 to 99. This field is not used for the 800 HCPCS Summarization table, but is used for any other HCPCS Summarization table.

For example, assume the MAX Count field contains 19 and the number of charges equals 3. If the hospital's HCPCS Summary Code is 900 and the patient receives three charges matching listed HCPCS procedures, the revised HCPCS Code becomes 90003. If the patient receives 22 charges matching the listed HCPCS procedures, the HCPCS Code becomes 90019 since this is the maximum number of units to which the HCPCS Procedure Code can be revised.

5. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this HCPCS summarization code was last edited.

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

8. SEQ HCPCS DESCRIPTION (3-N-R)
This field records the code and description of the HCPCS procedure codes included in this summarization group. You can enter the new HCPCS code or a hyphen (-) to display a list of valid codes. You can also delete codes that are no longer valid.

For the 800 HCPCS Summarization Master Table, the system processes the HCPCS as follows:

1. For charges with the HCPCS Procedure field set to FIM/Charge, Yes to the HCPCS Summarization Master, and Yes to Date in the UB Charge Control Parameter. For each unique service date:

    - If the account's charges that match the HCPCS Codes in the table have a total quantity of one or two, the revised HCPCS Code is 80002.

    - If the account's charges that match the HCPCS Codes in the table have a total quantity of 13 through 16, the revised HCPCS Code is 80016.

- If the account's charges that match the HCPCS Codes in the table have a total quantity of 17 or 18, the revised HCPCS Code is 80018.

- If the account's charges that match the HCPCS Codes in the table have a total quantity of 19 or more and the service date on these charges is in 1995 or earlier, the revised HCPCS Code is 80019.

  If the account's charges that match the HCPCS Codes in the table have a total quantity of 19 and the service date on these charges is in 1996 or later, the revised HCPCS Code is 80019.

- If the account's charges that match the HCPCS Codes in the table have a total quantity of 20 and the service date on these charges is in 1996 or later, the revised HCPCS Code is G0058.

- If the account's charges that match the HCPCS Codes in the table have a total quantity of 21 and the service date on these charges is in 1996 or later, the revised HCPCS Code is G0059.

- If the account's charges that match the HCPCS Codes in the table have a total quantity of 22 or more and the service date on these charges is in 1996 or later, the revised HCPCS Code is G0060.

  Since Medicare stated that you should not have more than 22 multi-channel tests for the same day on the patient, if there are more than 22 tests, the system prints the HCPCS Code G0060, but the claim has a claim charge error. The error appears in the claim Charge Data screen after the Procedure Code Error and on the Failed Claims Requirement Report (FCR250) as follows:

  HCPCS Summarization Quantity Errors:

  On the Claim Charge Data screen, this error message has either the number of charge lines that have the G0060 HCPCS code with a quantity on the charges greater than 22 or the word NONE if there are no HCPCS Summarization Quantity errors.

- If the account's charges that match the HCPCS Codes in the table do not fall within the quantity ranges above, the revised HCPCS Code is the 800 table number, concatenated with the true quantity of the charges that match the HCPCS Codes in the HCPCS Summarization Table. For example, if there are two charges that match the HCPCS Codes in the HCPCS Summarization Table, each with a quantity of two, the revised HCPCS Code is 80004.

2. For charges with the HCPCS Procedure field set to FIM/Charge, Yes to the HCPCS Summarization Master, and No to Date, the system assumes *all* the charges that match the HCPCS codes in the HCPCS Summarization Master have a service date of 1996 or later. Therefore, the summarization is the same as above except when the quantity of charges is 20 or greater. In other words:

- If the account's charges that match the HCPCS Codes in the table have a total quantity of 19, the revised HCPCS Code is 80019.
- If the account's charges that match the HCPCS Codes in the table have a total quantity of 20, the revised HCPCS Code is G0058.
- If the account's charges that match the HCPCS Codes in the table have a total quantity of 21, the revised HCPCS Code is G0059.
- If the account's charges that match the HCPCS Codes in the table have a total quantity of 22 or more, the revised HCPCS Code is G0060.

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

Dependent On	Reference
HCPCS Codes (supplied by the AMA)	

PROVIDER MASTER (US ONLY)

The Provider Master contains the claim form names, addresses, provider numbers, and UB condition, occurrence, occurrence span, and value codes used in claim form processing. Providers are assigned according to patient type with exceptions entered in the Insurance Plan Coverage master. Exceptions should be entered for Medicare primary insurances in order to automatically generate the correct condition, occurrence, occurrence span, and value codes for the Medicare claims. New Provider Masters should be built for the insurance exceptions and then linked to the insurances in the Insurance Plan Coverage master, Facility Options, Billing/Claim Parameters, page 3. Update the fields I/P Provider Master and O/P Provider Master to use when this plan is primary.

There are seven screens involved in setting up a Provider Master. The first is to enter demographic information and the second to enter provider numbers. The third is used to select which condition, occurrence, occurrence span, or value code table(s) to view or update. The fourth is used to highlight which condition codes should be automatically generated on the UB claim form. The fifth is used to highlight which occurrence codes should be automatically generated on the UB claim form. The sixth is used to highlight which occurrence span codes should be automatically generated on the UB claim form, and the seventh is used to highlight which value codes should be generated automatically on the UB claim form.

After the Provider Master is selected, the system prompts you to enter a Provider code. You can enter the code or a hyphen (-) to display a list of valid codes. After the Provider code is entered or selected, the following screen is displayed:

```
                General Hospital Master Provider Processor
                                          Wed Feb 08, 2007 11:45 am
Provider Master
 1 Prov Code  2 Provider Name          3 Federal Tax ID    4 Federal Tax Sub ID
   1           MODEL HOSPITAL A         FED1234567          SUBI
 5 UB Claim Name                      6 UB Street Address
   MAIN HOSPITAL                        301 PERIMETER CENT
 7 1500 Claim Name                    8 1500 Street Address
   MODEL HOSPITAL A                     301 PERIMETER CENTER
 9 Medicaid Claim Name               10 Medicaid Street Address
   MODEL HOSPITAL A                     301 PERIMETER CENTER NORTH
11 City                    12 State     13 Zip code       14 Country Code
   ATLANTA                    GA           30342-5555        US
15 Phone Number            16 FAX Phone Number     17 Alt Prov Name
   (404) 555-1212             (404) 111-2222          CLINIC NAME
18 Alt Prov Address 1        19 Alt Prov Address 2
   ALTERNATE 123 MAIN STREET    ALTERNATE P.O. BOX 123
20 Alt Prov City             21 Alt State 22 Alt Zip    23 Alt Prov Phone
   DUNWOODY                     GA           30005         (404) 111-2222
24 Status   25 Edited By                                  26 Edit Date
   Active      New, Nanc                                     09/01/2006 07:45am


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

Field Explanations - Screen 1 of 8

1. PROVIDER CODE (DISPLAY ONLY)
This field contains the code identifying the provider. This number, which is user-defined and not used on the claim form, identifies the facilities' need for multiple provider numbers.

2. PROVIDER NAME (20-C-R)
This field contains the name of the provider. The name entered here is not used on the claim form.

3. FEDERAL TAX ID (10-C-R)
This field contains the provider's federal tax ID. This number is used on the UB claim form.

4. FEDERAL TAX SUB ID (4-C-O)
This field contains the providers federal tax sub ID.

5. UB CLAIM NAME (25-C-O)
This field contains the name the provider uses on the UB claim form in Locator 1. If different names or numbers are needed for this provider, multiple Provider Masters must be identified.

6. UB STREET ADDRESS (25-C-O)
This field contains the address the provider uses on the UB claim form in Locator 1.

7. 1500 CLAIM NAME (30-C-O)
This field contains the name the provider uses on the 1500 claim form if the *1500 Provider Claim Name* internal element is used.

8. 1500 STREET ADDRESS (30-C-O)
This field contains the address the provider uses on the 1500 claim form if the *1500 Provider Street* internal element is used.

9. MEDICAID CLAIM NAME (30-C-O)
This field contains the name the provider uses on the Medicaid claim form if the *Provider Medicaid Claim Name* internal element is used.

10. MEDICAID STREET ADDRESS (30-C-O)
This field contains the address the provider uses on the Medicaid claim form if the *Provider Medicaid Street* internal element is used.

11. CITY (18-C-R)
This field contains the provider's city. This information is used for form locator 1 on the UB claim forms, and for the provider city on other claim forms.

12. STATE (2-A-R)
This field contains the provider's state. The U.S. Postal Service abbreviation is used. This information is used for form locator 1 on the UB claim forms, and for the provider state on other claim forms.

13. ZIP CODE (5 or 9-N-R)
This field contains the provider's zip code; either five or nine digits can be entered. This information is used in form locator 1 on the UB claim forms, and for the provider zip on other claim forms.

14. COUNTRY CODE (2-A-O)
This field contains the provider's country code. This information is used for form locator 1 on the UB04 claim forms, and for the country code on other claim forms.

15. PHONE NUMBER (10-N-R)
This field contains the provider's phone number, entered in the format 4045551212 and displayed as (404)555-1212. It is used for form locator 1 on the UB04 claim form, and for the provider's phone on other claim forms.

16. FAX CODE (10-N-O)
This field contains the provider's fax number, entered in the format 4045551212 and displayed as (404)555-1212. It is used for form locator 1 on the UB04 claim form, and for the fax code on other claim forms.

17. ALT PROV NAME (25-AN-O)
This field contains the name of the alternate provider. This information can be pulled to a claim using the Element Alt Provider Name internal element.

18. ALT PROV ADDRESS 1 (25-AN-O)
This field contains line 1 of the address. This information can be pulled to a claim using the Alt Provider Address 1 internal element.

19. ALT PROV ADDRESS 2 (25-AN-O)
This field contains line 2 of the alternate address. This information can be pulled to a claim using the Alt Provider Address 2 internal element.

20. ALT PROV CITY (25-AN-O)
This field contains the alternate provider's city.This information can be pulled to a claim using the Alt Provider City or Alt Prov City ST ZIP internal elements.

21. ALT STATE (2-AN-O)
This field contains the alternate provider's state. This information can be pulled to a claim using the Alt Provider State or Alt Prov City ST ZIP internal elements.

22. ALT ZIP (10-N-O)
This field contains the alternate provider's ZIP code. This information can be pulled to a claim using the Alt Provider ZIP Code or Alt Prov City ST ZIP internal elements.

23. ALT PROV PHONE (10-N-O)
This field contains the alternate provider's phone. This information can be pulled to a claim using the Alt Provider Phone internal element.

24. STATUS (DISPLAY ONLY)
This field indicates whether the provider code is active or inactive. A code that is filed as deleted by the user becomes inactive and can be reactivated at anytime. The system defaults this field to active when you create the code.

25. EDITED BY (DISPLAY ONLY)
This field contains the name of the user who last edited this provider code.

26. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this provider code was last edited.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting this screen prompts the system to display the second Provider master screen.

```
                General Hospital Master Provider Processor
                                                Tue Jul 20, 2007 04:05 pm
Providers
 1 Provider Code                       2 Provider Name
   5                                     GENERAL HOSPITAL
 3 UB Provider Nmbr  4 1500 Provider Nmbr    5 Blue Cross Provider Nmbr
   1234-56789          1234-56789              GA-987654321
 6 Medicaid State 1                    7 Medicaid Provider Number 1
   GA                                    GA12345
 8 Medicaid State 2                    9 Medicaid Provider Number 2
   TN                                    TN98765
10 Medicaid State 3                   11 Medicaid Provider Number 3
   FL                                    FL56565
12 Lab CLIA #            13 Provider NPI #       14 Taxonomy Code
                            1123454446
15 Pt Exceptions









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

Field Explanations - Screen 2 of 8

1. PROVIDER CODE (DISPLAY ONLY)
This field contains the code identifying the provider. This code is displayed from the first screen.

2. PROVIDER NAME (DISPLAY ONLY)
This field contains the name of the provider, which is displayed from the first screen.

3. UB PROVIDER NMBR (10-C-O)
This field contains the Medicare/Champus provider number used on the UB claim form.

4. 1500 PROVIDER NMBR (11-C-O)
This field contains the 1500 provider number pulled with Internal Element *1500 Provider Number*. Refer to the 1500 Claim Load and Edit Parameters for information.

5. BLUE CROSS PROVIDER NMBR (22-C-O)
This field contains the Blue Cross provider number used on the UB claim form.

6. MEDICAID STATE 1 (2-A-O)
This field contains the state in which the facility is located. The U.S. Postal Service abbreviation is used. For insurances with a Medicaid insurance type that are loading a UB claim form, the patient's state is used to determine the correct Medicaid Provider number to load on the claim form. If the patient's state is not one listed in the Provider Master fields 6, 8, or 10, the Medicaid Provider Number 1 is used as the default.

7. MEDICAID PROVIDER NUMBER 1 (18-C-O)
This field contains the provider's Medicaid number for state #1. The Medicaid provider number is used on the UB claim forms and any separate Medicaid claim forms required. It is used for all patients unless the patient's state matches the state entered in either the Medicaid State 2 or Medicaid State 3 fields (if they are completed) of this provider master.

8. MEDICAID STATE 2 (2-A-O)
This field contains the state for those situations where the hospital has a different provider number for Medicaid claims in a bordering state. The U.S. Postal Service abbreviation is used. For insurances with a Medicaid insurance type that are loading a UB claim form, the patient's state is used to determine the correct Medicaid Provider number to load on the claim form. If the patient's state is not one listed in the Provider Master fields 6, 8, or 10, the Medicaid Provider Number 1 is used as the default.

9. MEDICAID PROVIDER NUMBER 2 (18-C-O)
This field contains the provider number that is used in lieu of the provider number for Medicaid State 1 if the patient's state matches the state entered in the Medicaid State 2 field. This number is used on the UB claim forms and on separate Medicaid forms in the field designated for this number.

10. MEDICAID STATE 3 (2-A-O)
This field contains the state for those situations where the hospital has a different provider number for Medicaid claims in a bordering state. The U.S. Postal Service abbreviation is used. For insurances with a Medicaid insurance type that are loading a UB claim form, the patient's state is used to determine the correct Medicaid Provider number to load on the claim form. If the patient's state is not one listed in the Provider Master fields 6, 8, or 10, the Medicaid Provider Number 1 is used as the default.

11. MEDICAID PROVIDER NUMBER 3 (18-C-O)
This field contains the provider number that is used in lieu of the provider number for Medicaid State 1 or Medicaid State 2 if the patient's state matches the state entered in

the Medicaid State 3 field. This number is used on the UB claim forms, and on separate Medicaid forms in the field designated for this number.

12. LAB CLIA # (10-A-O)
This field contains the Lab Clinical Laboratory Improvement Amendment Number. This value can be pulled to a claim by using Internal Element "LAB CLIA."

13. PROVIDER NPI # (10-N-O)
This field contains the National Provider ID (NPI). This number can be pulled to a claim using the Provider NPI internal elements in the Claim Load and Edit Parameter.

14. TAXONOMY CODE (10-AN-O)
This field contains the provider's taxonomy code.

15. PT EXCEPTIONS (1-A-O)
This field contains patient type exceptions for the Provider NPI # and Taxonomy Code fields. When this field is accessed, the following prompt is displayed:

Do you want to enter patient type exceptions for Provider NPI and Taxonomy Code (Y/N) [N]--

If you enter Yes in response to the prompt, the following screen is displayed for you to enter patient type exceptions for the Provider NPI # and the Taxonomy Code:

```
                  General Hospital Master Provider Processor
                                                    Fri Oct 27, 2006 01:41 pm
Provider Master
Pt Type   Description                    Provider NPI #   Taxonomy Code
ER        Emergency Room                 1231231239
OB        Obstetric Admission                             1234567890
SER       Series                         1122334455       9988776655



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

Field Explanations

PT TYPE (2-A-R)
You can enter a patient type in this field or a hyphen (-) to display a list of patient types and select one. Only one patient type at a time can be selected. For this selected patient type, you can enter the exception for the NPI number, the taxonomy number, or both. You can enter as many patient type exceptions as needed.

DESCRIPTION (DISPLAY ONLY)
This field contains a description of the patient type.

PROVIDER NPI # (9-AN-R)
This field contains the Provider NPI # for which you are adding a patient type exception.

TAXONOMY CODE (10-AN-R)
This field contains the taxonomy code for which you are adding a patient type exception.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen prompts the system to display the third Provider Master screen for the provider as follows:

```
            General Hospital Master Provider Processor
                                                  Wed Jul 21, 2007 10:34 am
Providers
Page:01                  Codes to Auto Load for UB      ##=Current Choices
( 1) Condition Codes to Auto Load
( 2) Occurrence Codes to Auto Load
( 3) Occurrence Span Codes to Auto Load
( 4) Value Codes to Auto Load









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

Field Explanations - Screen 3 of 8

Codes To Auto Load For UB (Table List)

This screen allows the user to chose which tables are to be updated for the automatic generation of Condition Codes, Occurrence Codes, Occurrence Span Codes, and Value Codes on the UB. You can chose one or more options to view or update by highlighting the appropriate table numbers.

The system takes the Condition/Occurrence/Occurrence Span/Value codes that are automatically generated from the Provider Master and the codes that are on the UB screens in the Admission flow and Account Revision, and puts the codes in numeric sequence followed by alphanumeric sequence (01 through 99 followed by A0 through Z9). If there are more codes than can fit on the UB claim form, the trailing codes do not load or print on the claim. For example, the UB has locators for 7 condition codes. If there are ten condition codes between the ones entered on the UB screens and the automatically generated codes from the Provider Master, then the last three condition codes after being ordered in sequence do not load or print on the claim form. Also, if the user enters a code in the UB screens that is also automatically generated from the Provider Master, the code and the date or amount from the UB screen that you entered override the Provider Master code and amount on the UB claim form. Duplicate codes are not generated on the UB claim form but may be generated on the UB claim form.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen prompts the system to display the fourth Provider Master screen for the provider as follows:

```
                  General Hospital Master Provider Processor
                                                 Tue Jun 16, 1998 09:25 am
Provider Master
Page:01                  Condition Codes to Auto Load        ##=Current Choices
( 1) 02-Condition Employment Related
( 2) 09-Patient Nor Spouse is Employed
( 3) 10-Pt/spouse employed, no EGHP
( 4) 26-VA eligible, chooses Medicare
( 5) 28-Pt/spouse EGHP second to Medic
( 6) 40-Same Day Transfer
( 7) 60-Day Outlier
( 8) 61-Cost Outlier
( 9) Y5-New York Cost Outlier









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

Field Explanations - Screen 4 of 8

Condition Codes To Auto Load (Table List)

Highlight the condition codes that are to automatically generate on the UB claim form. The system generates the codes as follows:

02 - Condition is Employment Related
If the account has an Accident Type that points to a UB Occurrence code of 04 in the Accident Type table (Acc/Employment Related), then condition code 02 auto generates.

09 - Patient Nor Spouse is Employed
If the patient's marital status is M for Married, if the Patient Employment Status on the Patient Employer Page of the Admissions screens points to an indicator of *R* or *U* for Retired or Unemployed in the Employment Status table, and the Spouse Employed field on the Medicare Secondary Payer screen is set to No, the system generates Condition Code 09.

If the Patient Employment Status points to an indicator of *R* or *U* for Retired or Unemployed in the Employment Status table but the patient is not married, the system still generates Condition Code 09. The system does not look for information on a spouse if the patient's marital status is anything other than an *M* for Married.

10 - Pt/Spouse Employed, No EGHP
If the Medicare questionnaire indicates that the patient/spouse is employed and no group plan is entered, condition code 10 auto generates.

26 - VA Eligible, Chooses Medicare
If, on the Medicare questionnaire, the field "DVA authorized and agreed" is set to Yes, condition code 26 auto generates. If the field is set to Unknown or No, Condition Code 26 does not auto generate.

28 - Pt/Spouse EGHP is Second to Medic
If the Medicare questionnaire indicates that the patient/spouse has employer health coverage that is secondary to Medicare, condition code 28 auto generates.

40 - Same Day Transfer
If the account's admit date is the same as the discharge date, and Transfer To field is loaded, condition code 40 auto generates.

60 - Day Outlier
If a day outlier is calculated from the DRG Assignment screen, then condition code 60 auto generates.

61 - Cost Outlier
If a cost outlier is calculated from the DRG Assignment screen, then condition code 61 auto generates.

Y5 -New York Cost Outlier
If a cost outlier is calculated from the DRG Assignment screen, then condition code Y5 auto generates.

When these fields are completed, you have the option of accepting or editing the information on the screen.

Accepting the screen prompts the system to display the fifth Provider Master screen for the provider as follows:

```
                General Hospital Master Provider Processor
                                              Sat Aug 15, 2012 04:58 pm
Provider Master
Page:01                  Occurrence Codes to Auto Load       ##=Current Choices

( 1) 01-Auto Accident                    (18) 55-Date of Death
( 2) 02-Auto Accident/No Fault Insur     (19) A1-Birthdate of Insured Payer A
( 3) 03-Auto Accident/Tort Liability     (20) B1-Birthdate of Insured Payer B
( 4) 04-Accident/Employment Related      (21) C1-Birthdate of Insured Payer C
( 5) 05-Other Accident
( 6) 06-Crime Victim
( 7) 10-Last menstrual period
( 8) 18-Date of Retirement - Patient
( 9) 19-Date of Retirement - Spouse
(10) 31-Intent to Bill Accommodations
(11) 32-Intent to Bill Notification Dt
(12) 35-Physical Therapy Start Dt
(13) 42-Date of discharge
(14) 44-Occupational Therapy Start Dt
(15) 45-Speech Therapy Start Dt
(16) 46-Cardiac Rehab Start Date
(17) 50-Assessment Date


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

Field Explanations - Screen 5 of 8

Occurrence Codes To Auto Load (Table List)

Highlight the occurrence codes that are to automatically generate on the UB claim form. The system generates the codes as follows:

01 - Auto Accident
If the account has an Accident Type in the Medical/Accident Information Page of the admissions that points to a UB Occurrence code of 01 in the Accident Type table, then occurrence code 01 auto generates. The accident date is pulled from the field *Accident Date* on the Medical/Accident Information Page of the admission.

02 - Accident/No Fault
If the account has an Accident Type in the Medical/Accident Information Page of the admissions that points to a UB Occurrence code of 02 in the Accident Type table, then occurrence code 02 auto generates. The accident date is pulled from the field *Accident Date* on the Medical/Accident Information Page of the admission.

03 - Accident/Tort Liability
If the account has an Accident Type in the Medical/Accident Information Page of the admissions that points to a UB Occurrence code of 03 in the Accident Type table, then occurrence code 03 auto generates. The accident date is pulled from the field *Accident Date* on the Medical/Accident Information Page of the admission.

04 - Accident/Employment Related
If the account has an Accident Type in the Medical/Accident Information Page of the admissions that points to a UB Occurrence code of 04 in the Accident Type table, then occurrence code 04 auto generates. The accident date is pulled from the field *Accident Date* on the Medical/Accident Information Page of the admission.

05 - Other Accident
If the account has an Accident Type in the Medical/Accident Information Page of the admissions that points to a UB Occurrence code of 05 in the Accident Type table, then occurrence code 05 auto generates. The accident date is pulled from the field *Accident Date* on the Medical/Accident Information Page of the admission.

06 - Crime Victim
If the account has an Accident Type in the Medical/Accident Information Page of the admissions that points to a a UB Occurrence code of 06 in the Accident Type table, then occurrence code 06 auto generates. The accident date is pulled from the field *Accident Date* on the Medical/Accident Information Page of the admission.

10 - Last Menstrual Period
Occurence Code 10 loads to the claim as follows:

- If there is an ICD-9-CM Principal Diagnosis Code in Medical Records in the 634 - 639 range for Abortion, but no Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with no date.

- If there is an ICD-9-CM Principal Diagnosis Code in Medical Records in the 634 - 639 range for Abortion, and a Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

- If a Last Menstrual Period date is entered on the account, regardless of the Principal Diagnosis Code entered in Medical Records, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

- If there is an ICD-10-CM Principal Diagnosis Code in Medical Records with leading digits in the O00 - O08 range for Abortion, but no Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with no date.

- If there is an ICD-10-CM Principal Diagnosis Code in Medical Records with leading digits in the O00 - O08 range for Abortion, and a Last Menstrual Period date is entered on the account, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

- If a Last Menstrual Period date is entered on the account, regardless of the Principal Diagnosis Code entered in Medical Records, Occurrence Code 10 loads to the claim with an Occurrence Code Date of the last menstrual period.

18 - Date of Retirement Patient/Beneficiary
If the Patient Employment Status on the Patient Employer Page of the Admissions screens points to an indicator of *R* for Retired in the Employment Status table, then Occurrence Code 18 automatically generates. The retirement date is pulled from the Retirement Date field on the Patient Employer Page of the Admissions screens.

19 - Date of Retirement Spouse
If the Medicare Secondary Payer screen has the field *Retired* answered with a Yes for the spouse, then occurrence code 19 auto generates. The retirement date is pulled from the Mrfield *Date* for the spouse. If a spouse's Retirement Date is entered in the MSP field in a MM/DD/YY format, then the system continues to load Occurrence Code 19 and the date to the claim. If U for Unknown was entered in the MSP field or if the date format was other than MM/DD/YY, the system does the following:

- If a U for Unknown is entered for the spouse’s Retirement Date in the MSP field, then the system loads Occurrence Code 19 with no date. This does not fail the claim on the STAR Patient Accounting side, unless you have set all of the Occurrence Code Date fields to be Required in the UB Claim Load and Edit Parameters, which is not recommended. Since the system sorts the Occurrence Codes, there is no way to know beforehand which locator (32-35) Occurrence Code 19 loads to. Your third party billing system, if one exists, would have to catch the presence of Occurrence Code 19 with no date.

- If a spouse's Retirement Date is entered in the MSP field in a MM/YYYY format, then the system defaults to the first of that month, and the claim loads Occurrence Code 19 with this date. For example, if the user enters 05/1982, then the claim loads Occurrence Code 19 with date 05/01/1982.

- If a spouse's Retirement Date is entered in the MSP field in a YYYY format, then the system loads Occurrence Code 19 with no date. This does not fail the claim on the STAR Patient Accounting side, unless you have set all of the Occurrence Code Date fields to be Required in the UB Claim Load and Edit Parameters, which is not recommended. Since the system sorts the Occurrence Codes, there is no way to know beforehand which locator (32-35) Occurrence Code 19 loads to. Your third party billing system, if one exists, would have to catch the presence of Occurrence Code19 with no date.

31 - Intent to Bill Accommodations
This stands for Date Beneficiary Notified of Intent to Bill Accommodations. If this is an ALC UB claim, the Notify Date for that ALC code reflected on the claim is loaded. You can view the Notify Date for the ALC Code on the Utilization Management Alternate Level of Care screen in Patient Processing.

32 - Intent to Bill Notification Date
This stands for Date Beneficiary Notified of Intent to Bill (Procedures or Treatments). The value contains the date of the notice provided to the beneficiary that requested care (diagnostic procedures or treatments) which may not be reasonable or necessary. Therefore, the system looks to the ABN flags and the modifier of GA to signify that an

ABN was presented for Occurrence Code 32. This code can auto load to the UB04 claim.

When Occurrence Code 32 is highlighted in the Provider Master, the following conditions load the occurrence code:

- If a charge on the claim has an ABN flag of Yes or Frequency Yes for ABN is required and has been printed and signed by the patient for this charge, and the HCPCS for the charge has modifier GA for presented ABN, Occurrence Code 32 loads with the service date for the charge. All HCPCS modifiers are scanned for the HCPCS for cases where there is more than one modifier.

- If a charge on the claim has an ABN flag of No or Frequency No for ABN is required and has not been signed by the patient for this charge (but an ABN was presented), and the HCPCS for the charge has modifier GA for presented ABN, Occurrence Code 32 loads with the service date for the charge. All HCPCS modifiers are scanned for the HCPCS for cases where there is more than one modifier.

- If there is more than one charge on the claim with an ABN indicator of Yes or No and the GA modifier, the system loads Occurrence Code 32 once for each unique service date on the charges with the ABN flags. Therefore, if all charges with ABN flags and the GA modifier have the same service date, Occurrence Code 32 loads only once on the claim with this service date. If the charges with ABN flags and the GA modifier have different service dates, Occurrence Code 32 loads for each unique service date.

- If a charge on the claim has an ABN flag of Approved for ABN is not required, the SIM item ordered either has an approved diagnosis or approved diagnoses have not been defined for this Procedure in the Medical Records HCPCS table, this flag does not auto generate Occurrence Code 32.

The system calculates Occurrence Code 32 at claim load. If the system loads Occurrence Code 32 at claim load, but a user then either deletes modifier GA, or the HCPCS and the modifier GA, it is up to the user to also delete Occurrence Code 32. Also, even if the charge has a HCPCS and modifier GA, if the UB Charge Control Parameters are not set to load the HCPCS/modifiers for this revenue code, the system does not load Occurrence Code 32. The system is looking to the claim charges, and not to the charges at the account level.

The Provider Master does not auto generate any modifiers (including modifier GA or GZ) for the charges on the claim.

35 - Physical Therapy Start Dt

If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Physical Therapy UB Revenue Code, occurrence code 35 auto generates with the earliest service date for charges with the physical therapy revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto

Series Discharge and Re-registration. This code generates only on the UB claims that have the revenue code(s) specified for Physical Therapy.

42 - Date of Discharge
If the patient has been discharged, occurrence code 42 auto generates.

44 - Occupational Therapy Start Dt
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Occupational Therapy UB Revenue Code, occurrence code 44 auto generates with the earliest service date for charges with the occupational therapy revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto Series Discharge and Re-registration. This code generates only on the UB claims that have the revenue code(s) specified for Occupational Therapy.

45 - Speech Therapy Start Dt
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Speech Therapy UB Revenue Code, occurrence code 45 auto generates with the earliest service date for charges with the speech therapy revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto Series Discharge and Re-registration. This code generates only on the UB claims that have the revenue code(s) specified for Speech Therapy.

46 - Cardiac Rehab Start Date
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Cardiac Rehab Therapy UB Revenue Code, occurrence code 46 auto generates with the earliest service date for charges with the cardiac rehab therapy revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto Series Discharge and Re-registration. This code generates only on the UB claims that have the revenue code(s) specified for Cardiac Rehab.

50 - Assesment Date
When this Occurrence Code is highlighted, the system scans the claim's charges that have revenue code 0024/024/24 for Inpatient Rehab. If the system finds one or more charges with revenue code 0024/024/24 on the claim, the earliest service date found on these charges loads with Occurrence Code 50. If no charges are found with revenue code 0024/024/24 on the claim, Occurrence Code 50 does not load to the claim.

The system is looking to the charges on each claim, not at the charges at the account level. What this means is if you have split claims, for example, a Primary claim for the inpatient portion, and a Split claim such as Vaccine, only the claim(s) with revenue code 0024/024/24 load Occurrence Code 50.

The Service Date need not load to the individual charge line with revenue code 0024/024/24 in order to load the Occurrence Code 50 and date.

55 - Date of Death
This occurrence code reports the date of death. The logic to auto load occurrence code 55 is as follows:

- A discharge date and discharge disposition must exist for the account.
- If a date of death exists in Medical Records data, it is used for occurrence code 55.
- If there is no date of death in Medical Records, and if the UB code for the discharge disposition is 20, 40, 41, or 42, the discharge date is used for occurrence code 55.

A1 - Birthdate Insured A
The insured's birthdate from the insurance demographics screen is pulled for UB Carrier 1. The demographics screen copies the birthdate from the patient, guarantor, or relative one screen if the *Same As* field on the Demographics page of the insurance is answered with a P, G, or R. This birthdate can be overridden in the insurance demographics screen.

B1 - Birthdate Insured B
The insured's birthdate from the insurance demographics screen is pulled for UB Carrier 2. The demographics screen copies the birthdate from the patient, guarantor, or relative one screen if the *Same As* field on the Demographics page of the insurance is answered with a P, G, or R. This birthdate can be overridden in the insurance demographics screen.

C1 - Birthdate Insured C
The insured's birthdate from the insurance demographics screen is pulled for UB Carrier 3. The demographics screen copies the birthdate from the patient, guarantor, or relative one screen if the *Same As* field on the Demographics page of the insurance is answered with a P, G, or R. This birthdate can be overridden in the insurance demographics screen.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen prompts the system to display the sixth Provider Master screen for the provider as follows:

```
                  General Hospital Master Provider Processor
                                              Thu Jul 03, 2003 02:28 pm
Provider Master
Page:01                Occurrence Span Codes to Auto Load     ##=Current Choices
( 1) 72-First/last visit for series
( 2) 74-Non-Covered Level of Care/LOA
( 3) 75-SNF Level of Care
( 4) M0-PRO/UR Approved Stay Dates









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

Field Explanations - Screen 6 of 8

Occurrence Span Codes To Auto Load (Table List)

Highlight the occurrence span codes that are to automatically generate on the UB claim form. The system generates the codes as follows:

72 - First/Last Visit for Series
If the patient type is identified as a series type on the Patient Type Master, occurrence span code 72 auto generates.

74-Non-Covered Level of Care/LOA
If this is a UB claim, Occurrence Span Code 74 is created for each Non-Skilled Nursing Facility ALC stay period (up to two occurrences). The system looks to the ALC Type field for each ALC Code entered on the account. If it finds one or more ALC Types that are not equal to 1 for SNF, and not a blank ALC Type, it loads Occurrence Span Code 74 with the From and Thru Dates for the ALC Code. Since only two Occurrence Span Codes can load to the paper UB, if there are more than two ALC Codes with an ALC Type not equal to 1 for SNF or blank, the system loads the first two ALC span codes that qualify. You can view the From and Thru Dates for the ALC code on the Utilization Management Alternate Level of Care screen.

The system then looks to the charges on the claim. If there are any charges with Revenue Code 18x or 018x (with x being a wild card), Occurrence Span Code 74 loads, with the Earliest charge service date for 18x/018x as the FROM date, and the Latest charge service date for 18x/018x for the THROUGH date for the Occurrence Span Code.

- If there are no charges on the claim with revenue code 18x/018x, the system does not auto load Occurrence Span Code 74.

- If there is only 1 charge on the claim with revenue code 18x/018x, the system auto loads Occurrence Span Code 74, using the service date as both the FROM and the THROUGH date.

- If there is more than 1 charge for the claim with revenue code 18x/018x, the system looks for continuous service dates. As soon as the system determines a gap in service dates, it loads occurrence code 74 an additional time on the claim. For example, if the claim had the following charges:

  180 Leave of Absence 7/14/02 $0.00

  180 Leave of Absence 7/15/02 $0.00

  180 Leave of Absence 7/21/02 $0.00

  180 Leave of Absence 7/22/02 $0.00

The system would auto generate Occurrence Span Code 74 twice as follows:

	FROM	THROUGH
74	07/14/02	07/15/02
74	07/21/02	07/22/02

If in the above example, you did not have the charge line with service date 7/22/02 (you only had the charge with 7/14/02, 7/15/02, and 7/21/02), the system would generate the following:

	FROM	THROUGH
74	07/14/02	07/15/02
74	07/21/02	07/21/02

Finally, if in the above example, you only had a charge line with a 7/14/02 date, and another with a 7/21/02 date, the system would generate the following:

	FROM	THROUGH
74	07/14/02	07/14/02
74	07/21/02	07/21/02

Since only two Occurrence Span Codes can load to the paper UB, if there are more than two ALC Codes with an ALC Type not equal to 1 for SNF or blank, and/or more than two 18x revenue codes that qualify for Occurrence Span Code 74, the system first

loads the ALC span codes that qualify and then looks to the revenue code 18x charges that qualify.

75-SNF Level of Care
If this is a UB claim, Occurrence Span Code 75 is created for each Skilled Nursing Facility ALC stay period (up to two occurrences) as this code reflects the days the patient remained in the hospital because of the non-availability of a SNF bed. The system looks to the ALC Type field for each ALC Code entered on the account. If it finds one or more ALC Types that are equal to 1 for SNF, it loads Occurrence Span Code 75 with the From and Thru Dates for the ALC Code. Since only two Occurrence Span Codes can load to the paper UB, if there are more than two ALC Codes with an ALC Type equal to 1 for SNF, the system loads the first two ALC span codes that qualify. You can view the From and Thru Dates for the ALC code on the Utilization Management Alternate Level of Care screen.

M0 - PRO/UR Approved Stay Dates
The span code M0 and the approved from and through dates is pulled from the Utilization Management function (UB Non Covered Days screen) if entered.

When these fields are completed, you have the option of accepting or editing the information on the screen. When the screen is accepted, the system displays the seventh Provider Master screen for the provider as follows:

```
            General Hospital Master Provider Processor
                                              Thur Dec 28, 2006 09:12 pm
Provider Master
Page:01                     Value Codes to Auto Load          ##=Current Choices
( 1) 01-Semi Private Rate                (18) 50-Physical Therapy # Visits
( 2) 02-Private Room Rate                (19) 51-Occupational Therapy # Visits
( 3) 05-Professional Fees                (20) 52-Speech Therapy # Visits
( 4) 07-Medicare Cash Deductible         (21) 53-Cardiac Rehab Therapy # Visits
( 5) 08-Medicare Lifetime Reserve Amt    (22) 54-Newborn Weight in Grams
( 6) 09-Medicare Coinsurance Amount      (23) 80-Covered Days
( 7) 12-Working aged beneficiary-EGHP    (24) 81-Non Covered Days
( 8) 14-Nofault inc auto/other           (25) 82-Co Insurance
( 9) 16-PHS or other federal agency      (26) 83-Lifetime Reserve Days
(10) 24-NY Medicaid Rate Code            (27) A1-Deductible Payer A
(11) 24I-Illinois Number of Department   (28) A2-Coinsurance Payer A
(12) 31-Patient Liability Amount         (29) A3-Est. Responsibility Payer A
(13) 37-Pints of Blood Furnished         (30) A8-Patient Weight in Kilograms
(14) 38-Blood Deductible Pints           (31) A9-Patient Height in Centimeters
(15) 39-Pints of Blood Replaced          (32) AA-LA Mandated Service Charge
(16) 45-Accident Hour                    (33) B1-Deductible Payer B
(17) 46-Number of grace days             (34) B2-Coinsurance Payer B


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

Field Explanations - Screen 7 of 8

Value Codes To Auto Load (Table List)

Highlight the value codes that are to automatically generate on the UB claim form. The system generates the codes as follows:

01 - Most Common Semi Private Rate
The rate pulls from the PAAR Control Table based on the claim load date. Depending on the claim load date, the system compares the date to the dates in the Eff. Date fields and pulls either the first or the second rate. The system defaults to the first rate.

02 - Hospital Has No Semi Private Rooms
The value code 02 and amount 0.00 print to indicate that the hospital has no semi private rooms.

05 - Professional Fees Included in Charges
The system adds up the dollar amount for the professional fees on the claim. This code looks at the charges on each claim to determine the professional fee amount. If the UB Claim Load Edit Parameter has the Claim Split field set to A for New York ALC claims, and there is at least one ALC code on the account, the system looks to the bill that in turn loads the claims for Value Code 05. However, if the UB Claim Load Edit Parameter has the Claim Split field set to A for New York ALC claims, but there are no ALC codes on the account, the system looks to the charges on each claim to determine Value Code 05.

07 - Medicare Cash Deductible
The system takes the Bill Total Deductible from proration, subtracts the Daily Deductible Amount #1 (coinsurance amount) if reached, and adds the Daily Deductible Amount #2 (lifetime reserve days deductible) if reached. This code and amount does not print on the UB claim form, only the UB-82 claim form. With the UB claim form, this value code is now reserved for national use.

08 - Medicare Lifetime Reserve Amount in First Calendar Year
The system prints the Deductible Amount for the Second Daily Deductible in the Daily/ Blood Deductibles screen of the Insurance Plan Coverage master if the account has met the days to use the lifetime reserve days. If the account has not been in-house enough days to start into the lifetime reserve days, then 0.00 prints as the amount.

09 - Medicare Co-Insurance Amount in First Calendar Year
The system prints the Deductible Amount for the First Daily Deductible in the Daily/ Blood Deductibles screen of the Insurance Plan Coverage master if the account has met the days to have a daily coinsurance. If the account has not met the days to have a daily coinsurance, then 0.00 prints as the amount.

12 - Working Aged Beneficiary - EGHP
If the Medicare questionnaire indicates that the entitlement is based on Age, and the patient or spouse has employer group health care coverage and that Medicare is

secondary to that coverage, value code 12 auto generates. The system first looks for the insurance plan listed as the patient's Group Health Plan. If blank, the system looks for the insurance plan listed as the spouse's Group Health Plan. The system starts with COB 1 and works down until either the Group Health Plan is identified, or until it encounters a Medicare plan. If the listed Group Health Plan is not found on the account before encountering a Medicare plan, then the system stops and value code 12 is not generated. If the insurance listed as the Group Health Plan is found, the system loads the total payment amount for this insurance as the Value Code Amount. Since the value code is created with Claim Load, if the system does not have payment information for the insurance, the code loads with 000 as the Value Code Amount.

14 - Nofault Inc Auto/Other

If the Medicare questionnaire indicates that the patient was involved in an auto accident/no fault, and the liability carrier is listed in the No Fault Insurance field, and Medicare is secondary to the liability plan, value code 14 auto generates. The system looks for the insurance plan listed in the No Fault Insurance field, starting with COB 1 and working down. If the listed plan is not found on the account, or if a Medicare plan is encountered before identifying the no fault plan (meaning, Medicare is not secondary to this plan), then the system stops and value code 14 is not generated. If the listed No Fault Insurance is found on the account, the system loads the total payment amount for this insurance as the Value Code Amount. Since the value code is created with Claim Load, if the system does not have payment information for the insurance, the code loads with 000 as the Value Code Amount.

16 - PHS or Other Federal Agency

If Medicare is secondary to the patient's public health insurance, determined by having a Yes in the MSP field "Svcs paid by gov't research pgm", value code 16 auto generates. If the COB 1 insurance for the patient is not a Medicare plan, then the system loads the total payment amount for this insurance as the Value Code Amount. If the COB 1 plan is a Medicare plan, then the system stops and value code 16 is not generated. Since the value code is created with Claim Load, if the system does not have payment information for the insurance, the code loads with 000 as the Value Code Amount.

24 - NY Medicaid Rate Code

For New York alternate level of care (ALC) UB claims, as indicated by the Claim Split field being set to an A for ALC on the first screen of the UB Claim Load and Edit Parameter, the system loads Value Code 24 with the ALC Rate from the UM ALC Code Table for the ALC Code that loaded the claim. The system loads a separate UB claim for each unique ALC Code/From and Thru Date entered in the Utilization Management Alternate Level of Care Information screen on the account. The charges on each claim are those charges with Service Dates within the From and Thru Dates for that ALC Code.

For New York Products of Ambulatory Surgery (PAS) UB claims, the system loads Value Code 24 with the PAS Rate from the New York PAS Procedures Table, either Primary or Secondary, depending on whether the ICD-9-CM procedure is Primary or Secondary. If the Claim Split field is set to P for PAS on the first screen of the UB Claim

Load and Edit Parameter, the system loads a separate UB claim for each PAS Value Code 24. The demographics and the charge data for each PAS UB claim loaded for the account are the same.

31 - Patient Liability Amount
This value contains the patient's current balance at the time of claim load.

37 - Pints of Blood Furnished
This value contains the total number of pints of whole blood or packed red cells furnished to the patient. This value code is calculated based on the number of charges that have the revenue code specified in the Blood Summary Code field on the Daily/ Blood Deductibles screen of the Insurance Plan Coverage master. The account must go through proration to calculate this field.

38 - Blood Deductible Pints
This value code contains the number of non-replaced pints of whole blood or packed red cells furnished for which the patient is responsible. This value code is calculated as the sum of the Blood Furnished and the Blood Replaced amounts. If these two fields are blank, then the system defaults to the Deductible Pints field on the Daily/Blood Deductibles screen of the Insurance Plan Coverage master.

39 - Pints of Blood Replaced
This value code contains the number of pints of whole blood or packed red cells furnished to the patient that have not been replaced by or on behalf of the patient. Credits should be entered in the system for blood replaced to offset the pints of blood furnished. This value code can equal the Pints of Blood Furnished amount by entering a Yes in the *Furnished in Replaced* field on the Daily/Blood Deductibles screen of the Insurance Plan Coverage master. Since the Blood Deductible value code is the sum of the Blood Furnished and the Blood Replaced amount, we suggest that you set the field *Furnished in Replaced* to No, and enter credits for the blood replaced. The blood furnished would then reflect the credits, and the blood furnished would equal the blood deductible. For example, if the account had 5 pints furnished, and 3 pints replaced, and we entered credits for the blood replaced, we would get the following:

Furnished in Replaced = Yes
- Blood Furnished = 2
- Blood Replaced = 2
- Blood Deductible = 4

Furnished in Replaced = No
- Blood Furnished = 2
- Blood Replaced = 0
- Blood Deductible = 2

The account must go through proration to calculate this value code and amount. This value code and amount only prints if value code 37 and amount (Blood Furnished) prints. If blood replaced is null or zero, the amount is 0.00.

45 - Accident Hour
This value code is calculated based on the *Accident Time* field on the Medical/Accident Information Page of the admissions screens. This accident hour is converted to the appropriate accident hour code (for example, 2:00 pm is accident hour code 14) based on the NUBC UB specifications. If the field Accident Y/N is answered with a Yes, but the *Accident Time* field is blank, value code 45 prints with an accident hour code of 99 for unknown.

46 - Number of Grace Days
For New York alternate level of care (ALC) UB claims, the Grace Days for the ALC code reflected on the claim is loaded. You can view the Grace Days for the ALC code on the Utilization Management Alternate Level of Care screen. If this is not an ALC claim, the system pulls the number of grace days from the Utilization Management UB Non Covered Days Summary Processor screen. The Grace Days field is automatically completed by the system based on the number of days in the Non-Covered Day Type field on the Avoidable/Non-Covered Days screen with a link to this UB bucket type.

50 Physical Therapy # Visits
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Physical Therapy UB Revenue Code, Value Code 50 auto generates with the number of unique service dates for the revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto Series Discharge and Re-registration.

If the Add Manual Value Code Amount? field in the UB Therapy Revenue Code table is set to yes, and if value code 50 and the amount is manually entered by the user, and the system also attempts to auto generate the same code on the UB, the value code amount entered by the user on the account loading the claim is added only to the system-calculated amount for the same value code. By doing this, past visits for the patient, that were either not in an auto series discharge re-registration link, or that were on another system, can be added to the STAR-calculated number of visits.

If the Add Manual Value Code Amount? field is left blank or set to no, any manually entered value code 50 and amount continue to override the system-calculated value code and amount.

The number of visits is loaded in the dollar portion of the form locator, right justified to the left of the dollar delimiter, with the cents being 00.

This code generates only on the UB claims that have the revenue code(s) specified for Physical Therapy.

51 Occupational Therapy # Visits
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Occupational Therapy UB Revenue Code, Value Code 51 auto generates with the number of unique service dates for the revenue code. The system searches for the revenue code on the account for the claim and all previous accounts

in the registration chain if the account was registered via Auto Series Discharge and Re-registration.

If the Add Manual Value Code Amount? field in the UB Therapy Revenue Code table is set to yes, then if value code 51 and the amount is manually entered by the user, and the system also attempts to auto generate the same code on the UB, the value code amount entered by the user on the account loading the claim is added only to the system calculated amount for the same value code. By doing this, past visits for the patient, that were either not in an auto series discharge re-registration link, or that were on another system, can be added to the STAR-calculated number of visits.

If the Add Manual Value Code Amount? field is left blank or set to no, any manually entered value code 51 and amount continues to override the system calculated value code and amount.

The number of visits is loaded in the dollar portion of the form locator, right justified to the left of the dollar delimiter, with the cents being 00.

This code is generated only on the UB claims that have the revenue code(s) specified for Occupational Therapy.

52 Speech Therapy # Visits
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Speech Therapy UB Revenue Code, Value Code 52 auto generates with the number of unique service dates for the revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto Series Discharge and Re-registration.

If the Add Manual Value Code Amount? field in the UB Therapy Revenue Code table is set to yes, then if value code 52 and the amount is manually entered by the user, and the system also attempts to auto generate the same code on the UB, the value code amount entered by the user on the account loading the claim is added only to the system calculated amount for the same value code. By doing this, past visits for the patient that were either not in an auto series discharge re-registration link or were on another system can be added to the STAR Patient Accounting-calculated number of visits.

If the Add Manual Value Code Amount? field is left blank or set to no, any manually entered value code 52 and amount continues to override the system calculated value code and amount.

The number of visits is loaded in the dollar portion of the form locator, right justified to the left of the dollar delimiter, with the cents being 00.

This code is generated only on the UB claims that have the revenue code(s) specified for Speech Therapy.

53 Cardiac Rehab Therapy # Visits
If the patient has charges with the revenue code specified in the UB Therapy Revenue Code table for Cardiac Rehab Therapy UB Revenue Code, Value Code 53 auto generates with the number of unique service dates for the revenue code. The system searches for the revenue code on the account for the claim and all previous accounts in the registration chain if the account was registered via Auto Series Discharge and Re-registration.

If the Add Manual Value Code Amount? field in the UB Therapy Revenue Code table is set to yes, then if value code 53 and the amount is manually entered by the user, and the system also attempts to auto generate the same code on the UB, the value code amount entered by the user on the account loading the claim is added only to the system calculated amount for the same value code. By doing this, past visits for the patient, that were either not in an auto series discharge re-registration link, or that were on another system, can be added to the STAR-calculated number of visits.

If the Add Manual Value Code Amount? field is left blank or set to no, any manually entered value code 53 and amount continues to override the system calculated value code and amount.

The number of visits is loaded in the dollar portion of the form locator, right justified to the left of the dollar delimiter, with the cents being 00.

This code generates only on the UB claims that have the revenue code(s) specified for Cardiac Rehab.

54 - Newborn Weight in Grams
This value contains the newborn weight in grams and is auto loaded if the Admission Type is 4 (Newborn). Since the newborn weight is stored in kilograms, it is multiplied by 1000 and rounded to no decimals to provide the newborn weight in grams. If the Admission Type is 4, but no newborn weight exists, nothing is auto loaded to this value code.

80 - Covered Days
This value code loads the covered days from proration. This value auto loads only for Inpatient Patient Types. The system looks to the patient type at time of claim load. Therefore, if a patient goes from an outpatient or emergency patient type to an inpatient patient type before claim load, the value code is loaded. The system determines the covered days for the bill that loaded the claim. Therefore, the covered days reflected on previous bills is subtracted out of the total. If proration has not calculated an amount for the Value Code, the Value Code loads with a 0.00 amount.

This value code only loads to UB claims loading in the UB04 format. The value code does not load to UB claims loading in the UB92 format. A blank loads a value code amount of 0.00.

81 - Non Covered Days
This value code loads the noncovered days from proration. This value auto loads only for Inpatient Patient Types. The system looks to the patient type at time of claim load. Therefore, if a patient goes from an outpatient or emergency patient type to an inpatient patient type before claim load, the value code is loaded. The system determines the non covered days for the bill

that loaded the claim. Therefore, the non covered days reflected on previous bills is subtracted out of the total. If proration has not calculated an amount for the Value Code the Value Code loads with a 0.00 amount.

An insurance can have Non Covered Days if, on the Basic Coverage screen of the insurance, there is a value for "Days Before Coverage Begins" and/or "Days Coverage is Active". This in turn affects your Covered Days.

This value code only loads to UB claims loading in the UB04 format. The value code does not load to UB claims loading in the UB92 format. A blank loads a value code amount of 0.00.

82 - Co Insurance Days

This value code loads the CoInsurance days from proration. This value auto loads only for Inpatient Patient Types. The system looks to the patient type at time of claim load. Therefore, if a patient goes from an outpatient or emergency patient type to an inpatient patient type before claim load, the value code is loaded. Co-Insurance Days are considered the inpatient Medicare days occurring after the 60th day and before the 91st day or inpatient SNF/Swing Bed days occurring after the 20th and before the 101st day in a single spell of illness. The system determines the coinsurance days for the bill that loaded the claim. Therefore, the coinsurance days reflected on previous bills is subtracted out of the total. If proration has not calculated an amount for the Value Code the Value Code loads with a 0.00 amount.

The system determines the Coinsurance Days from the First Daily Deductible on the Daily/Blood Deductibles screen for the insurance. The system will use the number of days met/used for Value Code 82.

This value code only loads to UB claims loading in the UB04 format. The value code does not load to UB claims loading in the UB92 format. A blank loads a value code amount of 0.00.

83 - Lifetime Reserve Days

This value code loads the lifetime reserve days from proration. This value auto loads only for Inpatient Patient Types. The system looks to the patient type at time of claim load. Therefore, if a patient goes from an outpatient or emergency patient type to an inpatient patient type before claim load, the value code is loaded. Under Medicare, each beneficiary has a lifetime reserve of 60 additional days of inpatient hospital services after using 90 days of inpatient hospital services during a spell of illness. The system determines the lifetime reserve days for the bill that loaded the claim. Therefore, the lifetime reserve days reflected on previous bills is subtracted out of the total.

The system determines the Lifetime Reserve Days from the Second Daily Deductible on the Daily/Blood Deductibles screen for the insurance. The system will use the number of days met/used for Value Code 83.

This value code only loads to UB claims loading in the UB04 format. The value code does not load to UB claims loading in the UB92 format. A blank loads a value code amount of 0.00.

A1 - Deductible Payer A
This value code contains the amount calculated by the hospital to be the patient's deductible for the primary payer (UB Carrier 1). This amount is calculated by proration.

A2 - Coinsurance Payer A
This value code contains the amount calculated by the hospital to be the patient's coinsurance for the primary payer (UB Carrier 1). This amount is calculated by proration.

A3 - Estimated Responsibility Payer A
This value code contains the amount calculated by the hospital to be paid on this claim by the primary payer (UB Carrier 1). This amount is calculated by proration, and does not include any payments, adjustments, refunds, or balance transfers.

A8 - Patient Weight in Kilograms
This value code contains the weight of the patient in kilograms. When selected, the Patient Weight maintained on the Revise Patient Nursing screen is automatically loaded to the claim. For newborns, use Value Code 54 - Newborn Weight in Grams.

A9 - Patient Height in Centimeters
This value code contains the height of the patient in centimeters. When selected, the Patient Height maintained on the Revise Patient Nursing screen is automatically loaded to the claim.

B1 - Deductible Payer B
This value code contains the amount calculated by the hospital to be the patient's deductible for the secondary payer (UB Carrier 2). This amount is calculated by proration.

B2 - Coinsurance Payer B
This value code contains the amount calculated by the hospital to be the patient's coinsurance for the secondary payer (UB Carrier 2). This amount is calculated by proration.

When these fields are completed, you can enter **/P** to display the eighth Provider Master screen for the provider as follows:

```
                    General Hospital Master Provider Processor
                                              Fri Jun 06, 2008 10:23 am
Provider Master
Page:02                   Value Codes to Auto Load          ##=Current Choices
( 1) B3-Est. Responsibility Payer B
( 2) C1-Deductible Payer C
( 3) C2-Coinsurance Payer C
( 4) C3-Est. Responsibility Payer C
( 5) D3-Est. Responsibility Patient
( 6) FC-Patient Paid Amount
( 7) X1-Indigent Care Assessment Pay A
( 8) X2-Indigent Care Assessment Pay B
( 9) X3-Indigent Care Assessment Pay C
(10) Y1-GME Assessment Payer A
(11) Y2-GME Assessment Payer B
(12) Y3-GME Assessment Payer C




Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
          end select(NL) previous pg(/P or PG UP)
```

Field Explanations - Screen 8 of 8

Value Codes To Auto Load (Table List)

Highlight the value codes that are to automatically generate on the UB claim form. The system generates the codes as follows:

B3 - Estimated Responsibility Payer B
This value code contains the amount calculated by the hospital to be paid on this claim by the secondary payer (UB Carrier 2). This amount is calculated by proration and does not include any payments, adjustments, refunds, or balance transfers.

C1 - Deductible Payer C
This value code contains the amount calculated by the hospital to be the patient's deductible for the tertiary payer (UB Carrier 3). This amount is calculated by proration.

C2 - Coinsurance Payer C
This value code contains the amount calculated by the hospital to be the patient's coinsurance for the tertiary payer (UB Carrier 3). This amount is calculated by proration.

C3 - Estimated Responsibility Payer C
This value code contains the amount calculated by the hospital to be paid on this claim by the tertiary payer (UB Carrier 3). This amount is calculated by proration, and does not include any payments, adjustments, refunds, or balance transfers.

D3 - Estimated Responsibility Patient
This value code contains the amount estimated by the hospital to be paid on the claim by the patient. This amount is calculated by proration and includes any payments, adjustments, refunds, and balance transfers.

FC - Patient Paid Amount

This value code contains the total of the patient payments made on the account. Patient Payments are not applied to either the Bill or the Claim. Therefore, if the patient has received Cycle Bills/Claims, the amount is not specific to that bill/claim. For example, if the patient paid $100.00 after receiving the first Cycle Bill, and paid $200.00 after receiving the second Cycle Bill, the Final Claim, when loading Value Code EC, would have an amount of $300.00. The value code would not reflect what was paid by the patient on that particular claim.

If there have been no patient payments, the Value code FC loads with a 0.00 amount.

NOTE: X1, X2, X3, Y1, Y2, and Y3 are New York Healthcare Reform Act (NYHCRA) specific. For detailed information about these codes, please refer to *STAR State Regulations, New York*.

When these fields are completed, you have the option of accepting or editing the information on the screen.

PROVIDER MASTER (CN Only)

The Provider Master contains the billing institution number (facility number) used in claim form processing. Providers are assigned according to patient type, with exceptions entered in the Insurance Plan Coverage Master.

After the Provider Master is selected, the system prompts you to enter a Provider code. You can enter the code or a hyphen (-) to display a list of valid codes. After the Provider code is entered or selected, the following screen is displayed:

```
                General Hospital Master Provider Processor
                                                  Tue Aug 13, 2004 04:05 pm
Providers
( 1) Code           : 8
( 2) Description    : CFB INPATIENT
( 3) Billing Inst # : 8888
( 4) Location Code  : 8888
( 5) Alt Provider Code 1:  888LAB
( 6) Alt Provider Code 2:  888RAD
( 7) Alt Provider Code 3:  IPCFB8888
( 8) Edit by        : Bean,Pam
( 9) Edit date      : 03/04/28









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

Field Explanations

1. PROVIDER CODE (DISPLAY ONLY)

This field contains the code identifying the provider. This number, which is user-defined and not used on the claim form, identifies the facilities' need for multiple providers.

2. PROVIDER NAME (20-A-R)

This field contains the name of the provider.

3. BILLING INST # (5-AN-R)

This field contains the institution (facility) number that should be used for billing this provider. A length of 5 is used only for British Columbia. If a code of length 5 is entered, and the province is not British Columbia, the code is disallowed and the following error message is displayed:

Length must be 4 or less!

4. LOCATION CODE (4-AN-R)

For province of Ontario, the value from this field is used to populate the Service Location Indicator needed for OHIP claim submission, Claim Locator 1 Header Record, Field Location Code.

5. ALT PROVIDER CODE 1 (13-AN-O)
This field contains the Lab Provider number used for Nova Scotia CFB commercial insurance carrier/plans when the claim contains Lab charges. This field must be completed by Nova Scotia customers.

5. ALT PROVIDER CODE 2 (13-AN-O)
This field contains the Radiology Provider number used for Nova Scotia CFB commercial insurance carrier/plans when the claim contains Rad charges. This field must be completed by Nova Scotia customers.

6. ALT PROVIDER CODE 3 (13-AN-O)
This field contains the Provider number used for Nova Scotia CFB commercial insurance carrier/plans. This field must be completed by Nova Scotia customers.

7. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this provider code.

8. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this provider code was last edited.

When these fields are completed, you have the option of accepting or editing the information on the screen.

INSURANCE PLAN COVERAGE

The Insurance Plan Coverage Master contains information that is necessary for proration, reimbursement, production of claims, updating of logs, collector assignment, insurance follow up, and claim denial and appeal tracking. Each coverage option has a series of screens that enables you to create different information sets based on the patient's status as Inpatient, Outpatient, or Patient Type Exceptions. When the insurance is added to an account, the correct coverage copies down to the account level, based on the patient type. If the patient type changes, the insurance coverage is reassigned. Many of the previously built tables are referenced in the Insurance Plan Coverage Master. This table is not split by facility; therefore, a code that exists for one facility means the same for another facility. For example, if code 060300 is defined as Medicare Part A, it must be Medicare Part A for all facilities.

You can print this table by backing out of the menu option to get the following prompt:

Do you want a printed list? (Y/N) [N]--

If you enter **Y**, the system displays a list of all the insurance carriers and the following prompt:

Enter carrier(s) to print or A for All (A)--

Select the carriers you want to print from this list. Since the size of the spool file can be very large, use a specific carrier rather than all carriers. If you choose all carriers, you are prompted to verify that you intended to print all carriers. Select the carriers you want to print, the following prompt is displayed:

Enter plans to print (e.g. 1, 7, 5-9), All (A)--

Select the plans you want to print. After you select the plans, the system prompts you to choose the areas of the insurance plan coverage table to print. The following screen is displayed:

```
Page:01                          Coverage Options              ##=Current Choices
( 1) 1-Basic Coverage
( 2) 2-Room Coverage
( 3) 3-Ancillary Coverage
( 4) 4-Major Medical Coverage
( 5) 5-Daily/Blood Deductibles
( 6) 6-Flat Rate Coverage
( 7) 7-Summary Code Exceptions
( 8) 8-Plan Comments
( 9) 9-Billing/Claim Parameters
(10) 10-Collection Parameters
(11) 11-LOG ID'S
(12) 12-Reimbursement
(13) 13-Claim Attachments
(14) 14-Denial Tracking









Enter coverage to print (e.g. 1,7,5-9) or A for All [A]--
                                end selection(NL)
```

After you make your selection(s), the following prompt is displayed:

Do you want to print plans that are filed as deleted? (Y/N) [N]--

After you respond to this prompt, the system identifies which facilities you would like to print. This applies only to multifacility environments. The following prompt appears:

Do you want to print all of your valid facilities? (Y/N) [N]--

After you select the facility(s), the system begins to spool out the information to the report named FTINM_facility code.

When a patient is given an insurance plan, either at time of admission/registration or if the insurance is changed through account revision, a copy of the information stored in the Insurance Coverage Master is made for the patient. This information then becomes specific to the patient.

In order for an insurance plan to be valid for a facility, the Billing/Claims and Collection Parameters must be defined.

NOTE: The Insurance Carrier and Insurance Plan tables must be completed before this master.

After this master is selected, the system prompts you to enter a carrier code. You can enter the code or a hyphen (-) to display a list of valid codes. After the Carrier Code is

entered or selected, the system prompts you to enter a Plan Code. You can enter the code or a hyphen (-) to display a list of valid codes.

If there are no pending changes to the selected carrier and plan, the system displays the following prompt:

Enter effective date or current (C) insurance [C]--

You have the option of entering an effective date (in the format MMDDYY and at least one day ahead of the current date) or **C** (to edit the current insurance plan). The default is C. Entering an effective date enables you to set up insurance plans that become effective in the future. It also allows the same carrier plan number to have multiple sets of coverage. For example, for Medicare, the hospital could set up next year's coverage before year end with all patients admitted in the new year receiving the new plan coverage. If you enter a date, the system prompts you to confirm your desire to create a new plan that is effective on that date.

If facility options have not been completed for the Billing/Claim Parameters, the Collection Parameters, and the Reimbursement Parameters, the effective date prompt displays so that plans can be defined for a future date. Those three screens are required; the Log ID and Claim Parameters are not required. Once any one of the three required screens are completed, the effective date does not display until all three required options are completed.

The system then prompts you to determine if you want to copy coverage information from another insurance plan. Refer to the Copy Insurance Plan Function section.

If there are pending changes, the system displays the following prompt:

Edit current (C) insurance, edit pending (P) changes [P]--
delete (D) pending changes or change effective date (E)

If you enter C or P, the system prompts you to determine if you want to copy coverage information from another plan. Refer to the Copy Coverage Information section.

If you enter E, the system prompts you to enter a new effective date. If you enter D, the system displays the following prompt:

Are you sure you want to delete pending changes for 09/04/90? [N]--

Enter **Y** if you want to delete the pending changes. Press ENTER if you want to retain the pending changes.

Copy Coverage Information Function

The system allows you to copy coverage information from one plan to another. If you choose to edit current insurance plans or pending changes, the system displays the following prompt:

Do you wish to copy any coverage information from another plan? (Y/N) [N]--

If you press ENTER, the system displays a screen listing the Coverage and Exception options for the insurance plan. Refer to the Coverage and Exceptions section.

If you enter Y, the system prompts you to enter the codes of the carrier and plan from which you want to copy information. The plan code cannot be the same as the plan to which you want the information copied.

The system then prompts you to:

Enter effective date or current(C) insurance [C]--

You can enter a future date, at which time the information becomes effective, or C to make the changes effective immediately. If you enter a date, the system prompts you to confirm it.

The system then displays a table of the coverage options. Refer to the Coverage and Exceptions section for detailed information regarding each option. You can select the options as desired by following the prompt instructions at the bottom of the screen. After you make your selection(s), the system prompts you to confirm that you want to copy the selected information. If you enter Y, the system updates the destination plan's data.

NOTE: The plan that you want to copy must be defined for the facility to which the information is copied. If the facility information is incomplete, the system issues an error message since it cannot copy any information.

Coverage and Exception Options

If you want to edit pending or current changes to an insurance plan but do not want to use the copy function, the system displays a menu of specific coverages and exceptions for the selected carrier and plan. Each coverage option has a series of screens that enable you to create different information sets based on the patient's type -- Inpatient, Outpatient, or Patient Type Exceptions. To move through the screens to the one you want to edit, press ENTER. The patient type is displayed in the header. When the insurance is added to an account, the correct coverage copies down to the account level, based on the patient type. If the patient type changes, the insurance coverage is reassigned.

```
        General Hospital Insurance Plan Coverage Processor
                                                 Mon Sep 03, 1997 01:54 pm
Carrier:COLUMBIA HEALTH                          Facility :All
Plan   :COLUMBIA HEALTH                          Effective:Current
           Option No.  Option
           ---------------------------------------
               1       Basic Coverage
               2       Room Coverage
               3       Ancillary Coverage
               4       Major Medical Coverage
               5       Daily/Blood Deductibles
               6       Flat Rate Coverage
               7       Summary Code Exceptions
               8       Plan Comments
               9       Facility Options




Enter option number--
```

NOTE: You can enter/edit plan coverages and exceptions in any order.

Basic Coverage

This function records a plan's basic information. After this coverage option is selected, the system displays the following screen.

```
               General Hospital Basic Coverage Processor
              Inpatients                  Sat Oct 28, 1997 02:37 pm
Carrier:COLUMBIA HEALTH                         Facility :All
Plan   :COLUMBIA HEALTH                         Effective:Current
 1 Benefits Assigned                2 Baby Covered
   Yes                                Yes
 3 Days Before Coverage Begins      4 Days Coverage is Active
   0                                  Unlimited
 5 Professional Fee Coverage        6 Coordinate Benefits
   Include                            Yes,Duplicating
 7 Edit by                          8 Effective date









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

Field Explanations

1. BENEFITS ASSIGNED (1-A-R)
This field indicates whether the plan's benefits are assigned to the hospital rather than the patient. Entry options are **Y** for Yes or **N** for No; the default is Y. This field can be used to update the UB-82 or UB claim form. You should refer to the UB Claim Load and Edit Parameters for additional information.

2. BABY COVERED (1-A-R)
This field indicates whether newborn babies are covered under this plan. Entry options are **Y** for Yes or **N** for No; the default is Y.

NOTE: This field is not implemented at this time.

3. DAYS BEFORE COVERAGE BEGINS (3-N-R)
This field contains the number of days from admission or registration before coverage begins. The entry range is 0 to 999 days; the default is 0.

Any charges that occur before this day is considered non-covered.

4. DAYS COVERAGE IS ACTIVE (3-AN-R)
This field contains the number of days from admission or registration that this plan's coverage is active. The entry range is 0 to 999 days or **U** (unlimited). The default is U. If the benefits are not based on the number of days of coverage, you should enter U.

5. PROFESSIONAL FEE COVERAGE (1-A-R)
This field indicates whether professional fees are **I** (included in this plan), **E** (excluded from this plan), or **O** (the only charges covered by this plan). The default is I. This field effects waiting claims and automatic balance transfers. For more information, refer to the Billing/Claim Parameters of the Insurance Plan Coverage Master, page 2 of 4, Hold Claim for Prior Payment field in this manual and the Balance Designation Parameters in the *General Information Volume* in the *STAR Financials Patient Accounting Reference Guide*.

6. COORDINATE BENEFITS (1-A-R)
This field indicates whether the benefits should be coordinated with the patient's other insurance plans. Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter Y, this plan coordinates with other plans. If you enter N, this plan does not coordinate with other plans.

If you enter Y, the following prompt asks you whether the plan is also a duplicating plan:

Duplicating? (Y/N) [Y]

A duplicating plan covers the same charges as the patient's other insurance plans *but only up to the amount the plan would pay if it was COB1.* A non-duplicating plan covers only charges not covered by the other plans.

Enter **Y** if the plan is a duplicating plan. Enter **N** if the plan is non-duplicating. The default is Y. When you respond, the system proceeds based on whether the plan coordinates benefits.

An example of duplicating plans follows:

COB1 is a UB plan, $100 deductible, 80% coverage, and includes pro fees.

COB2 is a UB plan, $0 deductible, 80% coverage, and includes pro fees. The Coordinate Benefits flag on COB2 is set to Yes, Duplicating.

If covered charges are $10,000.00, COB1 would cover:

$10,000.00 Covered Charges
- 100.00 Deductible
$9,900.00

(9,900.00 x .2) = $1,980.00 Co-insurance

COB1 estimated liability = (10,000.00 - 100.00- 1980.00) = $7920.00

If the COB2 plan was COB1, it would cover:

$10,000.00 Covered Charges
- 0.00 Deductible
$10,000.00

(10,000.00 x .2) = $2,000.00 Co-insurance

The plan would have an estimated liability of (10,000.00 - 0.00 - 2,000.00) = $8,000.00 if it was COB1.

The system takes the covered charges for COB2 of $10,000 and subtracts the estimated liability for COB1 of $7920.00, which is $2080.00. Since this is less than what the COB2 plan would have covered had it been COB1 (if COB1, it would have covered $8,000), the COB2 plan covers the whole $2080.00. When the system took the covered charges for COB2 and subtracted the estimated liability for COB1, if the amount was greater than $8000.00, the COB2 plan would only pay $8000.00.

The system would calculate the COB adjustment for COB2 as:

$10,000.00 Covered Charges
- 2,000.00 Coinsurance
$8,000.00

$ 8,000.00
- 2,080.00 Estimated Liability COB2
$5,920.00 COB Adjustment

The resulting figures on the balance summary screen would be:

	COB1	COB2
Covered Charges	**10,000.00**	**10,000.00**
Deductible	**100.00**	**0.00**
Coinsurance	**1,980.00**	**2,000.00**
COB Adjustment	**0.00**	**5,920.00**
Estimated Liability	**7,920.00**	**2,080.00**

If COB2 was a non-duplicating plan, the coverage would be calculated as follows:

If the COB2 plan was COB1, it would have an estimated liability of $8,000.00 as outlined in the previous example.

The COB1 plan has an estimated liability of $7920.00.

The system takes what the COB2 plan's estimated liability would have been if it was COB1, and subtracts the estimated liability for COB1. The difference here from a duplicating plan is that a duplicating plan subtracts the COB1 estimated liability from covered charges for the secondary insurance and a non duplicating plan subtracts the COB1 estimated liability from the estimated liability of the secondary insurance had it been COB1. The estimated liability of this COB2 plan when non duplicating is:

$8,000.00 Estimated liability if COB2 was COB1
- 7,920.00 Estimated liability COB1
$80.00 Estimated liability COB2

The system would calculate the COB adjustment for COB2 as:

$10,000.00 Covered Charges
- 2,000.00 Coinsurance
$8,000.00

$8,000.00
- 80.00 Estimated Liability COB2
$ 7,920.00 COB Adjustment

The resulting figures on the balance summary screen would be:

	COB1	COB2
Covered Charges	**10,000.00**	**10,000.00**
Deductible	**100.00**	**0.00**
Coinsurance	**1,980.00**	**2,000.00**
COB Adjustment	**0.00**	**7,920.00**
Estimated Liability	**7,920.00**	**80.00**

If the plan coordinates benefits:

- The liability is calculated and any remaining liability is passed on to another coordinating plan for consideration.
- The liability accepted by another carrier is not covered by this plan.

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

If the plan does not coordinate benefits:

- The plan prorates its liability and does not pass on any remaining liability to another carrier.
- The plan would cover what another carrier also covers.

If the amount that a coordinating and non-coordinating plan covers exceeds the patient's account balance, a credit balance is shown for the patient's liability when an account is prorated.

For a majority of cases, individual policies are the only non-coordinating plans.

7. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

8. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When this screen is completed, another identical screen is displayed. The purpose of this second screen is to provide you the opportunity to enter basic coverage parameters for outpatients using this plan. A third screen, also identical to the first, is displayed after the second is completed so patient type exceptions to this plan's basic coverage parameters can be entered.

When these screens are completed, you have the option of accepting or editing the information on the screen. Accepting the screens completes this transaction and returns you to the list of coverage and exception options. You can add/edit another coverage or exception for this carrier or select another carrier and plan or return to the PA/AR Master File Maintenance menu.

Room Coverage

This function records a plan's room coverage and exceptions to this coverage based on accommodation codes.

There are two screens involved in Room Coverage. The first defines semiprivate, private, and ICU room coverage while the second handles accommodation code exceptions to this plan's coverage. If the policy is set up as an all inclusive policy (100% of first $10,000, then 80%), room allowances must still be completed on these screens.

After this coverage option is selected, this screen is displayed.

```
                  General Hospital Room Coverage Processor
               IP Room Coverage     Page  1 of  2  Mon April 20, 1998 12:54 pm
Carrier:COLUMBIA HEALTH                          Facility :All
Plan   :COLUMBIA HEALTH                          Effective:Current
 1 Ward Room Allowance     2 Percent Cvd    3 Difference To  4 Transfer Limit
   Unlimited                 100%             Patient          Unlimited
 5 SP Room Allowance       6 Percent Cvd    7 Difference To  8 Transfer Limit
   Unlimited                 100%             Patient          Unlimited
 9 Private Room Allowance 10 Percent Cvd   11 Difference To 12 Transfer Limit
   Unlimited                 100%             Patient          Unlimited
13 ICU Room Allowance     14 Percent Cvd   15 Difference To 16 Transfer Limit
   Unlimited                 100%             Patient          Unlimited
17 Maximum Room/Bed Days Covered           18 Maximum ICU Days Covered
   Unlimited                                  Unlimited
19 Maximum Ancillary Days Covered

20 Edit by                                 21 Effective date
   Harrison,Geneva                            04/20/98 12:07pm




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

Field Explanations - Screen 1 of 2

1. WARD ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a ward room. Entry options are 0 to $9,999.99, **W** (the hospital's standard ward rate), **S** (the hospital's standard semiprivate rate), **U** (unlimited), or **N** (not covered). If you enter S or W, note that the semiprivate and ward room rates are stored for each nurse station.

2. PERCENT CVD (3-N-R)
This field contains the percentage of ward room coverage provided by this plan. The entry range is 0 to 100 percent. You must enter a whole number.

3. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the ward room rate that is not covered should be assigned to major medical coverage or to the patient if there is a difference between the room rate and the amount covered. Entry options are **M** (major medical) or **P** (patient); the default is P.

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

4. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the ward room rate that can be transferred to major medical. The entry range is 0 to $9,999.99, W (ward), S (semiprivate), or U (unlimited). If the Difference To field contains M, you can enter a dollar amount, W, S, or U here. If the Difference To field contains P, the system automatically completes this field with U.

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

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

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

5. SP ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a semiprivate room. Entry options are 0 to $9,999.99, W (the hospital's standard ward rate), S (the hospital's standard semiprivate rate), U (unlimited), or N (not covered). If you enter S or W, note that the semiprivate and ward room rates are stored for each nurse station.

6. PERCENT CVD (3-N-R)
This field contains the percentage of semiprivate room coverage provided by this plan. The entry range is 0 to 100 percent. You must enter a whole number.

7. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the semiprivate room rate that is not covered should be assigned to major medical coverage or to the patient if there is a difference between the room rate and the amount covered. Entry options are M (major medical) or P (patient); the default is P.

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

8. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the semiprivate room rate that can be transferred to major medical. The entry range is 0 to $9,999.99, **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, S, or U here. If the Difference To field contains P, the system automatically completes this field with U.

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

If a dollar amount is specified (for example, the $150.00 difference between the SP Room Allowance of $100 and the hospital's semiprivate rate of $250) and the Difference To field contains M, the dollar amount is covered by the coverage indicated in major medical.

If $100.00 is set as the limit, the remaining $50.00 becomes the responsibility of the patient. If this field contains U, the entire $150.00 difference is covered under major medical.

9. PRIVATE ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a private room. The entry range is 0 to $9,999.99, **W** (the hospital's standard ward rate), **S** (the hospital's standard semiprivate room rate), **U** (unlimited), or **N** (not covered).

10. PERCENT CVD (3-N-R)
This field contains the percentage of private room coverage provided by this plan. The range is 0 to 100 percent. You must enter a whole number.

11. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the private room rate that is not covered should be assigned to the patient's major medical or to the patient. Entry options are **M** (major medical) or **P** (patient); the default is P.

For example, if the Private Room Allowance field contains S and the hospital's semiprivate room rate is $250 and its private room rate is $270, this field indicates how the $20 difference is covered.

12. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the private room rate that can be transferred to major medical. The entry range is 0 to $9,999.99, **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, S (semiprivate), or U (unlimited) here. If the Difference To field contains P, the system automatically completes this field with U.

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

13. ICU ROOM ALLOWANCE (7-AN-R)
This field contains the amount this plan covers for a room in intensive care. The entry range is 0 to $9,999.99, **W** (ward), **S** (semiprivate), **U** (unlimited), or **N** (not covered).

14. PERCENT CVD (3-N-R)
This field contains the percentage of ICU coverage provided by this plan. The entry range is 0 to 100 percent. You must enter a whole number.

15. DIFFERENCE TO (1-A-R)
This field indicates whether the portion of the ICU rate that is not covered should be assigned to major medical or to the patient. Entry options are **M** (major medical) or **P** (patient); the default is P.

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

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

16. TRANSFER LIMIT (7-AN-R)
This field contains the maximum amount of the not covered portion of the ICU room that can be transferred to major medical. The entry range is 0 to $9,999.99, **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, S (semiprivate), or U (unlimited) here. If the Difference To field contains P, the system automatically completes this field with U.

17. MAXIMUM ROOM/BED DAYS COVERED (3-AN-R)
This field contains the total number of days of room/bed charges covered by this plan. The entry range is 1 to 999 days or U (unlimited). If the number of stay days exceeds the day limit, charges become non-covered.

18. MAXIMUM ICU DAYS COVERED (3-AN-R)
This field contains the maximum number of ICU days covered by this plan. The entry range is 1 to 999 or **U** (unlimited). The number of days entered here cannot exceed the maximum number of room/bed days entered in the previous field. If the ICU days limit is reached, these charges are prorated in the same manner as the semiprivate rate.

19. MAXIMUM ANCILLARY DAYS COVERED (1-A-R)
This field indicates whether ancillary limits are based on days entered in the Maximum Room/Bed Days Covered field. Entry options are Y for Yes or N for No; the default is N.

20. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

21. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

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

The system then prompts you to select accommodation code exceptions to the room coverages for this plan. A list of STAR Patient Care accommodation code exceptions is displayed. Once an accommodation code is selected, the following screen is displayed.

NOTE: Room coverages are covered the same as semiprivate unless you define special coverage through this function.

```
                  General Hospital Room Coverage Processor
              OP Room Exceptions    Page  2 of  2  Sat Oct 28, 1997 02:37 pm
Carrier:COLUMBIA HEALTH                           Facility :All
Plan   :COLUMBIA HEALTH                           Effective:Current
 1 Accommodation                                 2 Same as Room Type
   M-CCU
 3 Room Allowance          4 Percent Cvd   5 Difference To  6 Transfer Limit
    $100.00                  80%             Patient          Unlimited
 7 Edit by                                    8 Effective date









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

Field Explanations - Screen 2 of 2

You have the following choices in terms of defining the room exception information:

- You can cover the accommodation code as the semiprivate, private, or ICU room coverage, as defined on screen 1. You complete the Same As Room Type field with S, P, or ICU.

- You can set up special coverage by leaving the Same as Room Type field blank and completing the remaining fields.

1. ACCOMMODATION CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the STAR Patient Care accommodation code and description you selected from the table display. Accommodation codes define the types of rooms a hospital has (for example, private, semiprivate, ward, isolation, coronary care, ICU, nursery, etc.). Exceptions to plan coverage can be based on the type of patient accommodation.

2. SAME AS ROOM TYPE (1-A-O)
This field indicates whether the accommodation code should operate like the semiprivate, private, or ICU room coverage, as defined on screen 1. Entry options are S (semiprivate), P (private) or I (ICU). This field can also be left blank if you are defining special coverage. If you complete this field, the remaining fields on this screen are left blank.

3. ROOM COVERAGE ALLOWANCE (7-AN-C)
The amount this plan pays for a room used by a patient with this accommodation code. The entry range is 0 to $9,999.99, **W** (ward), **S** (semiprivate), **U** (unlimited), or **N** (not covered). This field is required if the Same As Room Type field is blank.

4. PERCENT CVD (3-N-C)
This field contains the percentage of room cost paid by this plan for this accommodation code exception. The entry range is 0 to 100. You must enter a whole number. This field is required if the Same As Room Type field is blank.

5. DIFFERENCE TO (1-A-C)
This field indicates whether the portion of this room rate that is not covered should be assigned to major medical or to the patient. Entry options are **M** (major medical) or **P** (patient); the default is P.

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

6. TRANSFER LIMIT (7-AN-C)
This field contains the maximum amount of the not covered portion of the room that can be transferred to major medical. The entry range is 0 to $9,999.99, **W** (ward), **S** (semiprivate), or **U** (unlimited). If the Difference To field contains M, you can enter a dollar amount, S (semiprivate), or U (unlimited) here. If the Difference To field contains P, the system automatically completes this field with U.

7. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

8. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When these screens are completed, an identical set of screens is displayed. The purpose of this second set of screens is to provide you with the opportunity to enter room coverage parameters for outpatients using this plan. A third set of screens, also identical to the first, is displayed after the second is completed so patient type exceptions to this plan's room coverage parameters can be entered.

When these screens are completed, you have the option of accepting or editing the information on the screen. Accepting the screens completes this transaction and displays the list of accommodation exceptions that are defined for the selected carrier

and plan. You can select/add another code and repeat this process or return to the Insurance Plan list of options.

Ancillary Coverage

This function defines ancillary limits and coverage. Ancillary charges are defined as all charges that are not room charges.

```
              General Hospital Ancillary Coverage Processor
               Inpatient                          Sat Jun 17, 2006 01:06 pm
Carrier:BLUE CROSS                               Facility :All
Plan   :BLUECROSS MEDICAID                       Effective:Current
Patient type: Inpatients
 1 Include Room Charges in Ancillary Coverage             2 Limits are
->

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


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

10 Edit by                                      11 Effective date

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

Field Explanations

1. INCLUDE ROOM CHARGES IN ANCILLARY COVERAGE (1-A-R)
This field indicates whether room charges should be included in ancillary coverage. Entry options are **Y** for Yes or **N** for No.

If you enter N, the room and coverage percentages entered on the Room Coverage screens (not the ancillary charges) are used to calculate amounts, room charges are not used to satisfy deductibles, and dollar limits are for ancillary charges only.

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

2. LIMITS ARE (1-A-R)
This field indicates whether the coverage limits are **C** (covered charges) or **B** (benefits). The default is C.

For example, if total covered charges is $10,000.00, the insurance percentage covered is 80%, the dollar limit is $6,000, and there is a $100.00 deductible, the system calculates:

Covered charges of:

10,000.00 Covered Charges

- 100.00 Deductible
9,000.00 Total bill charges
-6,000.00 Dollar limit
3,900.00 Limit excess

The insurance liability is $6,000.00 x .80 = $4,800.00. The co-insurance is $6,000.00 x .20 = $1200.00. This results in an insurance estimated amount due of $4,800.00, and a patient estimated amount due of $5,200.00 (100.00 deductible + 1200.00 co-insurance + 3900.00 limit excess).

Benefits of:

.80 x ? = $6,000.00 which results in $6,000.00 divided by .80 = $7,500.00.

10,000.00 Covered Charges
- 100.00 Deductible
9,000.00 Total bill charges
-7,500.00 Benefits
2,400.00 Limit excess

The insurance liability is $6,000.00. The coinsurance is $7,500.00 x .20 = $1500.00. This results in an insurance estimated amount due of $6,000.00, and a patient estimated amount due of $4,000.00 (100.00 deductible + 1500.00 co-insurance + 2,400.00 limit excess).

First Ancillary Coverage

3. DEDUCTIBLE AMOUNT (7-AN-R)
This field contains the deductible for the first first coverage period. You can enter an amount from **0** to **9,999.99**. If there is no deductible, you must enter 0.00.

WARNING: Pressing ENTER initializes fields 3 through 8.

4. CO-PAY (7-N-O)
This field contains the first coverage period's co-pay amount. When this field is accessed, the following prompt is displayed:

Enter first co-pay amount (NNNN.NN) --

You can enter an amount from **0** to **9,999.99**.

5. PERCENT COVERED (3-N-C)
This field contains the percentage of covered charges handled during the first coverage period. The entry range is 0 to 100. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

6. DOLLAR LIMIT (11-AN-C))
This field contains the maximum dollar amount of accumulated charges handled during the first coverage period. The entry range is 0 to $99,999,999.99 or **U** (unlimited).

When this limit is reached (providing a dollar amount is entered), the plan's second ancillary coverage goes into effect. If you enter U, the secondary ancillary coverage is not valid. This field is required if the Deductible Amount field contains a dollar value.

Second Ancillary Coverage

NOTE: The fields in the second ancillary coverage are completed only if the dollar limit has been defined in the first ancillary coverage.

7. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the second coverage period's deductible. The entry range is 0 to $9,999.99. If there is no deductible, you must enter 0.00.

WARNING: Pressing ENTER initializes fields 6 through 8.

8. PERCENT COVERED (3-N-C)
This field contains the percentage of covered charges handled during the second coverage period. The range is 0 to 100. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

9. DOLLAR LIMIT (11-N-C)
This field contains the maximum dollar amount of accumulated charges handled by the second ancillary coverage. Any overage is assigned to major medical. The entry range is 0 to $99,999,999.99. This field is required if the *Deductible Amount* field contains a dollar value.

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

10. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

11. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When this screen is completed, an identical screen is displayed. The purpose of this second screen is to provide you the opportunity to enter ancillary coverage parameters for outpatients using this plan. A third screen, also identical to the first, is displayed after the second is completed so patient type exceptions to this plan's ancillary coverage parameters can be entered.

When these screens are completed, you have the option of accepting or editing the information on the screen. Accepting the screens completes this part of the transaction and returns you to the list of coverage and exception options. You can add/edit another coverage or exception for this carrier or select another carrier and plan or return to the PA/AR Master File Maintenance menu.

Major Medical Coverage

This function defines the nature and limits of the major medical coverage. First, second, and third major medical coverages and limits can be defined.

```
              General Hospital Major Medical Coverage Processor
               Inpatient                          Sat Oct 28, 1997 02:39 pm
Carrier:COLUMBIA HEALTH                           Facility :All
Plan   :COLUMBIA HEALTH                           Effective:Current
 1 Room Charges Included?  2 Room Chgs in Limits?          3 Limits Are
   Yes                       Yes                           Covered charges
 4 Ancillary Charges Included?
   No

                             First Major Medical
 5 Deductible Amount       6 Percent Coverage              7 Dollar Limit
    $100.00                  80                               $10,000.00

                             Second Major Medical
 8 Deductible Amount       9 Percent Coverage             10 Dollar Limit
    $50.00                   60                               $5,000.00

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

14 Edit by                                        15 Effective date

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

Field Explanations

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

2. ROOM CHGS IN LIMITS? (1-A-R)
This field determines whether the room and bed differences should be included in calculating the limits. This field is required only if the Room Charges Included field is set to No. Options are **Y** for Yes or **N** for No; the default is Y. If this field contains a Y, the room charges are included.

3. LIMITS ARE (1-A-R)
This field indicates whether the coverage limits entered here pertain to hospital charges or patient benefits. The options are **C** (covered charges) or **B** (benefits): the default is C.

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

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

4. ANCILLARY CHARGES INCLUDED? (1-A-R)
This field determines whether ancillary charges are included in satisfying major medical deductibles and limits.

First Major Medical

WARNING: Pressing ENTER initializes fields 5 through 13.

5. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the first major medical coverage period's deductible. The entry range is 0.00 to $9,999.99. If there is no deductible, you must enter 0.00.

6. PERCENT COVERAGE (3-N-C)
This field contains the percentage of patient charges handled by the first major medical coverage period's deductible. The range is 0 to 100%. You must enter a whole number. This field is required if the Deductible Amount field (#4) contains a dollar value.

7. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled by the first major medical coverage period. Any overage is assigned to another patient insurance (if available), directly to the patient, or to the second major medical. The entry range is 0 to $99,999,999.99 or **U** (unlimited). If you enter U in this field, the fields in the second and third major medical sections of this screen are NOT completed. This field is required if the Deductible Amount field (#4) contains a dollar value.

Second Major Medical

The second major medical information goes into effect when the first major medical dollar limit has been reached.

WARNING: Pressing ENTER initializes fields 8 through 13.

8. DEDUCTIBLE AMOUNT (6-N-O)
This field contains The second major medical coverage period's deductible. The entry range is 0 to $9,999.99. A zero deductible must be entered as 0.00.

9. PERCENT COVERAGE (3-N-C)
This field contains the percentage of patient charges handled by the second major medical coverage period. The entry range is 0 to 100%. You must enter a whole number. This field is required if the Deductible Amount field (#8) contains a dollar value.

10. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled by the second major medical coverage period. Any overage is assigned to another patient insurance (if available), directly to the patient, or to the third major medical. The entry range is 0 to $99,999,999.99 or **U** (unlimited). This field is required if the *Deductible Amount* field (#8) contains a dollar value.

Third Major Medical

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

WARNING: Pressing ENTER initializes fields 11 through 13.

11. DEDUCTIBLE AMOUNT (7-N-O)
This field contains the third major medical coverage period's deductible. The entry range is 0 to $9,999.99. If there is no deductible, you must enter 0.00.

12. PERCENT COVERAGE (3-N-C)
This field contains the percentage of patient charges handled by the third major medical coverage period. The range is 0 to 100%. You must enter a whole number. This field is required if the Deductible Amount field contains a dollar value.

13. DOLLAR LIMIT (11-AN-C)
This field contains the maximum dollar amount of accumulated charges handled by the third major medical coverage period. Any overage is assigned to another patient insurance (if available) or directly to the patient. The entry range is 0 to $99,999,999.99 or **U** (unlimited). This field is required if the Deductible Amount field (#11) contains a dollar value.

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

14. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

15. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When this screen is completed, another identical screen is displayed. The purpose of this second screen is to provide you the opportunity to enter major medical coverage parameters for outpatients using this plan. A third screen, also identical to the first, is displayed after the second is completed so patient type exceptions to this plan's major medical coverage parameters can be entered.

When these screens are completed, you have the option of accepting or editing the information on the screen. Accepting the screens completes this part of the transaction and returns you to the Insurance Plan Coverage options. You can add/edit another coverage or exception for this carrier or select another carrier and plan or return to the PA/AR Master File Maintenance menu.

Daily/Blood Deductibles

This screen defines up to three daily deductibles and the blood deductible for this plan. After you select this option, the system displays the following screen:

```
             General Hospital Daily/Blood Deductibles Processor
               Pat Type Exceptions              Sat Oct 28, 1989 02:40 pm
Carrier:COLUMBIA HEALTH                         Facility :All
Plan   :COLUMBIA HEALTH                         Effective:Current
First Daily Deductible
 1 Start After Days       2 Days Active           3 Deductible Amount
   60                       30                      $540.00
Second Daily Deductible
 4 Start After Days       5 Days Active           6 Deductible Amount
   90                       60                      $240.00
Third Daily Deductible
 7 Start After Days       8 Days Active           9 Deductible Amount

Blood Deductible
10 Deductible Pints      11 Furnished in Replaced?  12 Blood Summary Code
   2                        No                        391 BLOOD/ADMIN.
13 Edit by                                        14 Effective date




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

Field Explanations

First Daily Deductible

1. START AFTER DAYS (3-N-O)
This field contains the number of days from admission or registration before starting this deductible. The entry range is 0 to 999 days.

2. DAYS ACTIVE (3-AN-C)
This field contains the number of days this deductible is active. The range is 1 to 999 days or **U** (unlimited). This field is required if the Start After Days field (#1) contains a value.

3. DEDUCTIBLE AMOUNT (7-N-C)
This field contains the daily deductible amount. The entry range is 0 to $9,999.99. This field is required if the Start After Days field contains a value.

Second Daily Deductible

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

4. START AFTER DAYS (3-N-O)
This field contains the number of days from admission to wait before starting this deductible. The entry range is 0 to 999 days.

5. DAYS ACTIVE (3-AN-C)
This field contains the number of days this deductible is active. The entry range is 1 to 999 days or **U** (unlimited). This field is required if the Start After Days field (#4) contains a value.

6. DEDUCTIBLE AMOUNT (7-N-C)
This field contains daily deductible amount. The entry range is 0 to $9,999.99. This field is required if the Start After Days field (#4) contains a value.

Third Daily Deductible

This information can only be completed if the second daily deductible information has been defined.

7. START AFTER DAYS (3-N-O)
This field contains the number of days from admission to wait before starting this deductible. The entry range is 0 to 999 days.

8. DAYS ACTIVE (1-AN-C)
This field contains the number of days this deductible is active. The entry range 1 to 999 days or **U** (unlimited). This field is required if the Start After Days field contains a value.

9. DEDUCTIBLE AMOUNT (7-N-C)
This field contains the daily deductible amount. The entry range is 0 to $9,999.99. This field is required if the Start After Days field contains a value.

Blood Deductible

10. DEDUCTIBLE PINTS (2-N-O)
This field contains the number of pints of blood that this plan does not cover. This field is used for form locator 43 on the UB-82 and for value code 38 on the UB. If the patient receives blood, the system accumulates the amount of blood based on charges associated with the UB revenue code that is entered in the Blood Summary Code field.

This field is not used in proration. The entry range is 0 to 99 pints.

11. FURNISHED IN REPLACED? (1-A-R)
This field indicates whether units of blood furnished under this plan should be included in the units replaced, form locator 41 on the UB-82 claim form and value code 39 on the UB claim form. Entry options are **Y** for Yes or **N** for No; the default is Y.

12. BLOOD SUMMARY CODE (3-N-R)
This field contains the appropriate UB revenue code. You can enter the code or a hyphen (-) to display a list of valid codes. This code is used in concert with fields 10 and 11. If charges exist for the UB revenue code entered in this field and the Furnished in Replaced field contains Y, the number of units of blood is loaded in form locators 40, Blood Furnished, and 41, Blood Replaced, on the UB-82, or is loaded as value code

37, Blood Furnished, and value code 39, Blood Replaced, on the UB. If the Furnished in Replaced field contains N, the number of units furnished is loaded only.

13. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

14. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When this screen is completed, another identical screen is displayed. The purpose of this second screen is to provide you the opportunity to enter daily/blood deductibles parameters for outpatients using this plan. A third screen, also identical to the first, is displayed after the second is completed so patient type exceptions to this plan's daily/blood deductibles parameters can be entered.

When these screens are completed, you have the option of accepting or editing the information on the screen. Accepting the screens completes this part of the transaction and returns you to the list of coverage and exception options. You can add/edit another coverage or exception for this carrier or select another carrier and plan or return to the PA/AR Master File Maintenance menu.

Flat Rates

This screen contains a plan's flat rate coverage for inpatients and outpatients.

Flat rate coverage takes priority over any other ancillary benefits that exist for the insurance plan. The inpatient and outpatient information is defined independently. After you select the Flat Rate Coverage option, the system displays the following screen:

```
              General Hospital Flat Rate Coverage Processor
                Inpatient/Outpatient              Mon Sep 03, 1990 02:17 pm
Carrier:COLUMBIA HEALTH                           Facility :All
Plan   :COLUMBIA HEALTH                           Effective:Current
 Inpatient
 1 Flat Rate per    2 Maximum Days    3 Flat Rate Amount  4 Deductible Amount
   Day                100                $1,000.00          $100.00



 Outpatient
 5 Flat Rate per                      6 Flat Rate Amount  7 Deductible Amount
                                         $1,000.00          $100.00




 8 Edit by                                          9 Effective date
   Harrison,Geneva                                      04/20/98 12:15pm
Enter field number or '/' starting field number--
```

Field Explanations

Inpatient

1. FLAT RATE PER (1-A-O)
This field indicates the type of flat rate for inpatients. Entry options are per day (**D**) or entire stay (**S**). If you enter S, the Maximum Days field cannot be completed.

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

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

NOTE: If room and bed coverage is included in the flat rate, you must enter Yes in the Include Room Charges in Ancillary Coverage field on the Ancillary Coverage screen; if this field contains No, room and bed coverage is not included in the flat rate coverage.

2. MAXIMUM DAYS (3-AN-C)
This field contains the maximum number of days this flat rate is effective from the admission date. The entry range is 0 to 999 days or **U** (unlimited). This field is required if the Flat Rate Per field (#1) contains D.

3. FLAT RATE AMOUNT (9-N-R)
This field contains the flat rate amount this plan pays per day or for the entire stay, depending on the entry in the Flat Rate Per field (#1). The entry range is 0 to $999,999.99.

4. DEDUCTIBLE AMOUNT (9-N-R)
This field contains flat rate deductible amount for an inpatient stay. This amount is a one-time deductible and is subtracted from covered charges before the flat rate coverage is applied. The entry range is 0 to $9,999,999.00; the default is 0.

Outpatient

5. FLAT RATE PER (1-A-O)
This field indicates the type of flat rate for outpatients, which is per entire stay (**S**). A per stay flat rate enables one rate to be applied for each day the patient stays in the hospital.

6. FLAT RATE AMOUNT (9-N-R)
This field contains the flat rate amount this plan pays per visit, per bill, or for the entire outpatient visit, depending on the entry in the outpatient Flat Rate Per field. The entry range is 0 to $999,999.99; the default is $0.00.

7. DEDUCTIBLE AMOUNT (9-N-R)
This field contains the flat rate deductible amount for an outpatient visit. The entry range is 0 to $9,999,999.00; the default is 0.

8. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

9. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes this part of the transaction and returns you to the list of coverage and exception options.

Summary Code Exceptions

This function allows exceptions to ancillary coverage by Proration Summary codes. A Proration Summary code is user-defined and groups like charges for proration purposes. Each item in the STAR Patient Care Financial Item Master (FIM) is assigned a Proration Summary code.

For Canadian users, summary code exceptions are used to determine assignment of charges for billing and claims purposes. Refer to the *Canadian Claims Processing Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information.

This option enables you to add/edit Proration Summary code exceptions as dictated by this plan. After you select this option, the system displays a screen listing the summary code exceptions assigned to the plan:

```
         General Hospital Summary Code Exceptions Processor
               Summary Codes                      Tue Apr 20, 1998 05:50 pm
Carrier:GENERAL MUNICIPAL                         Facility :All
Plan   :BASIC PLAN                                Effective:Current
Page:01                Proration Summary Code Exceptions     ##=Current Choices
( 1)-020 R&B Semi-Private,Two Bed
( 2)-250 Pharmacy









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

To modify a summary code exception, enter the option number of the summary code exception you wish to modify. The system then displays the screen similar to the one below for the selected code.

To add a new summary code exception, enter A. The system displays all summary code exceptions available, highlighting in reverse video those that have already been established for the plan. At the bottom of the screen, the system prompts you to identify the summary code exceptions you wish to add:

Enter choices (E.g. 1,7,5-9) or '-'choices to remove
end selection(NL) next page(/)

Enter the option number(s) of the summary code exceptions, either individually or as a range of numbers separated by a hyphen (-), that you want to assign to the plan. The system highlights your selections on the list in bright blinking reverse video. You may select new codes to add or existing codes to modify or delete.

When you finish selecting the summary code exceptions you wish to add, modify, or delete, the system displays the following screen for each entered or selected code.

```
         General Hospital Summary Code Exceptions Processor
               Summary Codes                      Tue Apr 20, 1998 05:33 pm
Carrier:BLUE CROSS                                Facility :All
Plan   :BLUE CROSS BASIC PLAN                      Effective:Current
 1 Summary Code/Description
   001-Total Charges
                                 Outpatient
 2 Summary Code Covered               3 Covered Percentage
   No                                   0%
 4 Deductible Per    5 Deductible %    6 Deductible Amount     7 Greater/Lesser

                                 Inpatient
 8 Summary Code Covered               9 Covered Percentage
   No                                   0%
10 Deductible Per   11 Deductible %   12 Deductible Amount    13 Greater/Lesser

14 Edit by                                      15 Effective date




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

Field Explanations

1. SUMMARY CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the proration summary code and its description. The following fields apply to charges relating to service items grouped under this Proration Summary code.

Outpatient

2. SUMMARY CODE COVERED (1-A-R)
This field indicates whether the Proration Summary code is covered for outpatients by this plan. Entry options are **Y** for Yes or **N** for No. If you enter N, the Covered Percentage, Deductible Per, Deductible Percentage, Deductible Amount, and Greater/Lesser fields are not completed. N for No indicates charges with this Proration Summary code for this insurance plan are not covered. Y for Yes indicates the charges are covered. However, they are covered differently than the other ancillary charges.

3. COVERED PERCENTAGE (3-N-O)
This field contains the percentage of outpatient coverage for this Proration Summary code. The entry range is 1 to 100%. You must enter a whole number.

4. DEDUCTIBLE PER (1-A-O)
If the Proration Summary code has a deductible, this field indicates whether the deductible is applied per charge or per Proration Summary category total. Entry options are C (per charge or per service item) or T (per category total or per Proration Summary code).

5. DEDUCTIBLE PERCENTAGE (3-N-O)
This field contains this plan's deductible, represented as a percentage, for the Proration Summary code for outpatients. The entry range is 0 to 100%. You must enter a whole number. If the deductible is a percentage, this field should be completed.

6. DEDUCTIBLE AMOUNT (7-N-O)
This field contains this plan's deductible, represented as a dollar and cents amount, for the Proration Summary code for outpatients. The entry range is 0 to $9,999.99. If the deductible is a flat amount, this field should be completed.

7. GREATER/LESSER (1-A-C)
This field indicates whether the greater or lesser amount between the deductible amount and the deductible percentage should be used. Entry options are **G** (greater) or **L** (lesser). This field is required if both the Deductible Percentage and the Deductible Amount fields are completed.

NOTE: It is not necessary to enter both a deductible percentage and flat dollar amount.

For example, a plan has a deductible amount of $150 and a deductible percentage of 10%. If an outpatient's charges are $1000, the deductible amount would be $150 but the percentage amount would be $100. This field determines if the deductible dollar figure in this example would be $100 (L-lesser) or $150 (G-greater).

Inpatient

8. SUMMARY CODE COVERED (1-A-R)
This field indicates whether the Proration Summary code is covered for inpatients by this plan. Entry options are **Y** for Yes or **N** for No. If you enter N, the Covered Percentage, Deductible Per, Deductible Percentage, Deductible Amount, and Greater/Lesser fields are not completed. N for No indicates charges with this Proration Summary code for this insurance plan are not covered. Y for Yes indicates the charges are covered. However, they are covered differently than the other ancillary charges.

9. COVERED PERCENTAGE (3-N-O)
This field contains the percentage of inpatient coverage for this Proration Summary code. The entry range is 1 to 100%. You must enter a whole number.

10. DEDUCTIBLE PER (1-A-O)
If the Proration Summary code has a deductible, this field indicates whether the deductible is applied per charge or per Proration Summary category total. Entry options are **C** (per charge or per service item) or **T** (per category total or per Proration Summary code).

11. DEDUCTIBLE PERCENTAGE (3-N-O)
This field contains this plan's deductible, represented as a percentage, for the Proration Summary code for inpatients. The entry range is 0 to 100%. You must enter a whole number. If the deductible is a percentage, this field should be completed.

12. DEDUCTIBLE AMOUNT (6-N-O)
This field contains this plan's deductible, represented as a dollar and cents amount, for the Proration Summary code for inpatients. The entry range is 0 to $9,999.99. If the deductible is a flat amount, this field should be completed.

13. GREATER/LESSER (1-A-C)
This field indicates whether the greater or lesser amount between the deductible amount and the deductible percentage should be used. Entry options are **G** (greater) or **L** (lesser). This field is required if both the Deductible Percentage and the Deductible Amount fields are completed.

For example, a plan has a deductible amount of $150 and a deductible percentage of 10%. If an inpatient's charges are $1000, the deductible amount would be $150 but the percentage amount would be $100. This field determines if the deductible dollar figure in this example would be $100 (L-lesser) or $150 (G-greater).

NOTE: It is not necessary to enter both a deductible percentage and flat dollar amount.

14. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

15. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes this part of the transaction and returns you to the list of coverage and exception options. You can add/edit another coverage or exception for this carrier or select another carrier and plan or return to the PA/AR Master File Maintenance menu.

Plan Comments

This transaction enables you to enter free-form information regarding a specific insurance plan. One example is information alerting insurance billers and verifiers

about particular plan requirements. The comments entered here are copied to the patient's record. They can be referenced during insurance verification, insurance billing, or during the follow-up process.

After this option is selected, the system displays a list of comments already entered in the system. Each plan on the list is identified by its three-digit code and the first twenty-nine characters of the message. You have the option of editing or adding messages.

After a message has been selected or a new message code entered, the following screen is displayed:

```
          General Hospital Plan Comments Processor
               Outpatient Comments              Sat Oct 28, 1997 02:44 pm
Carrier:COLUMBIA HEALTH                         Facility :All
Plan   :COLUMBIA HEALTH                         Effective:Current
Comment:A
           1         2         3         4         5         6
   12345678901234567890123456789012345678901234567890123456789012345678901234567890
01|A copy of the detailed charges is required if the bill      |
02|exceeds $10,000.00.                                         |
03|                                                            |
04|                                                            |









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

You should use plan comment codes that are easily recognized by the people using them. For example, a certification requirement could be labeled CER, while a billing requirement could be labeled BIL. Entry of comments is optional.

Facility Options

The facility options are divided into the following categories:

- Billing/Claims Parameters
- Collection Parameters
- Log IDs (not applicable for Canadian users)
- Reimbursement
- Claim Attachments

- Denial Tracking

The Billing/Claims Parameters and Collection Parameters must be completed in order for a plan to be valid for a facility.

BILLING/CLAIMS PARAMETERS

This transaction defines the billing and claims parameters used for the carrier plan. It contains three screens: the first records billing parameters for this plan; the second records claim parameters for this plan; and the third records how claims for this plan should be processed.

Billing parameters and billers are assigned to an account at admission or registration, when the primary insurance changes, and when the patient type changes. Billers are assigned to claims at the time of billing.

The billing/claims and collection parameters for the plan are validated for the facility through their definition. If facility options do not exist for the plan, the plan is not valid for the facility.

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

```
       General Hospital Billing/Claims Parameters Processor
                Billing Parameters Page  1 of  5  Tue Aug. 3, 2004 03:41 pm
Carrier:COLUMBIA HEALTH                           Facility :PROVIDENCE MEDICAL C
Plan   :COLUMBIA HEALTH                           Effective:Current
 1 Billing Group
   6-COMMERCIAL BILLING GROUP
 2 Valid Financial Classes               3 Default Financial Class
   54                                      54-COLUMBIA HEALTH
 4 I/P Final Billing Parameter Code      5 I/P Cycle Billing Parameter Code
   3-CONTRACTS I/P-FINAL SUMM-DXC          103-CONTRACTS I/P-CYCLE SUMM BILL
 6 O/P Final Billing Parameter Code      7 O/P Cycle Billing Parameter Code
   4-CONTRACTS O/P-FIN SUMM-NO DX          104-CONTRACTS O/P-CYCLE SUMM BILL
 8 Patient Type Billing Parameter Exceptions
   Pat    Final Billing Parameter            Cycle Billing Parameter
   Type   Biller Group
   ASU    204-CONTRACTS O/P FIN SUMM-DX      104-CONTRACTS O/P-CYCLE SUMM BILL
          6-COMMERCIAL BILLING GROUP
   E/R    204-CONTRACTS O/P FIN SUMM-DX      104-CONTRACTS O/P-CYCLE SUMM BILL
          6-COMMERCIAL BILLING GROUP
 9 Edit by                                 10 Effective date
   Owens,Julie M                                02/27/98 03:41pm

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

Field Explanations - Screen 1 of 5

1. BILLING GROUP (2-N-R)
This field contains the billing group assigned to this carrier and plan. You can enter the code or a hyphen (-) to display a list of valid billing groups. The billing group is used to assign a biller to an account, primary claim, and secondary claims if the claim is separate.

2. VALID FINANCIAL CLASSES (2-A-R)
This field contains the financial class codes in this facility that are valid for this plan. When this field is initially accessed, the system displays a list of all financial classes used by this facility. You can add to and delete from the list. Only valid financial classes can be entered on this plan. If the insurance is the primary insurance for the patient, the financial class can be changed only to the values listed in this field.

3. DEFAULT FINANCIAL CLASS (TABLE LOOKUP)
This field contains the default financial class for this plan. When this required field is accessed, the system displays a list of financial classes valid for this facility and this carrier/plan. The default financial class is assigned to patients who have this plan as their primary insurance plan unless the financial class is changed to another valid financial class. This financial class is automatically assigned to the patient if this insurance plan is the patient's primary insurance plan.

4. I/P FINAL BILLING PARAMETER CODE (3-C-R)
This field contains the final bill parameter code that is assigned to any inpatient who has this insurance plan as the primary insurance. You can enter the code or a hyphen (-) to display the valid billing parameter codes. Billing parameters are assigned to an account at the time of admission, when the primary insurance plan is revised, or when the patient type changes. Refer to the Billing Parameters in the next section for additional information regarding billing parameters.

5. I/P CYCLE BILLING PARAMETER CODE (3-C-O)
This field contains the interim or cycle billing parameter code that is assigned to any inpatient who has this insurance plan as the primary insurance. If cycle bills are not allowed or are not wanted for this insurance plan, you should leave this field blank. You can enter the code or a hyphen (-) to display a list of valid cycle billing parameters. Billing parameters are assigned to an account at the time of admission, when the primary insurance plan is revised, or when the patient type changes. Refer to the Billing Parameters in the next section for additional information regarding billing parameters.

6. O/P FINAL BILLING PARAMETER CODE (3-C-R)
This field contains the interim or cycle billing parameter code that is assigned to any outpatient who has this insurance plan as the primary insurance. If cycle bills are not allowed or are not wanted for this insurance plan, you should leave this field blank. You can enter the code or a hyphen (-) to display the valid cycle billing parameters. Billing parameters are assigned to an account at the time of registration, when the primary insurance plan is revised, or when the patient type changes. Refer to the Billing Parameters in the next section for additional information regarding billing parameters.

7. O/P CYCLE BILLING PARAMETER CODE (3-C-O)
This field contains the interim or cycle billing parameter code that is assigned to any outpatient who has this insurance plan as the primary insurance. If cycle bills are not allowed or are not wanted for this insurance plan, you should leave this field blank. You can enter the code or a hyphen (-) to display a list of valid cycle billing parameters. Billing parameters are assigned to an account at the time of registration, when the primary insurance plan is revised, or when the patient type changes. Refer to the Billing Parameters in the next section for additional information regarding billing parameters.

NOTE: Cycle bills are produced only for series outpatient patient types. If all series patients are billed based on the same day or dollar criteria, the cycle parameter used can be entered in this field. Cycle bills are not produced for outpatient types that automatically get discharged, even though the patient can have a cycle bill parameter associated with his record.

8. PATIENT TYPE BILLING PARAMETER EXCEPTIONS (TABLE LOOKUP)
This field contains the patient types that require a biller, final billing parameter, or cycle billing parameter other than what has been defined above.

This optional field requires the entry of a patient type and final bill parameter. If the exception is being entered only to specify a different biller, it is still necessary to enter the final bill parameter even if it is the same as the one entered in the I/P Final Billing Parameter Code or O/P Final Billing Parameter Code field.

Examples of how these fields can be used is discussed below:

A different biller is used to bill all renal dialysis patients. A patient type exception is needed for the renal patient type. A different final bill parameter can be entered or the same parameter as used in the O/P Final Billing Parameter Code Field can be entered.

If you need a different cycle billing parameter for a particular patient type, this is also possible using these exceptions.

9. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

10. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes this part of the transaction. The system then displays the second screen, which defines the claim parameters associated with this plan. Claim parameters present on patient insurance records at the time of billing are used to process the loading and editing of the patients' claims.

```
            General Hospital Billing/Claims Parameters Processor
               Claim Parameters   Page 2 of 5  Tue Mar 3, 2008 02:46 pm
Carrier:COMMERCIAL                              Facility :Model Hospital C
Plan   :COMMERCIAL BASIC PLAN                   Effective:Current
 1 Claim Form Type           2 Produce Claim?           3 Print on UB?
   UB                          Yes                        Yes
 4 Prorate I/P Claims?       5 Prorate O/P Claims?      6 Load Separate Claim?
   Yes                         Yes                        Yes
 7 Hold Claim for Prior Payment?    8 ASB/Crossover Hold Exceptions
   Yes                                100100,200100,300100,400100,500100,500300,5++
 9 Print Paper Claim Label? 10 Suppress?               11 EOB Indicator
   No                          No                         No
12 Electronic Media         13 Print Electronic Claim Label?

14 Primary Payor            15 Source of Payment

16 Edit by                                    17 Effective date
   New, Nancy                                    12/12/05 01:06pm









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

Field Explanations - Screen 2 of 5

1. CLAIM FORM TYPE (TABLE LOOKUP)
This field indicates the type of claim form that is produced for this carrier plan. Entry options include the UB and 1500, OHIP, WCB and Universal claim forms. If you attempt to modify this field to a non-UB Claim Form Type and the Reimbursement Type in the Reimbursement Facility Options is set to I - Pathways Contract Management, the following error message is displayed:

Error: Claim Type must be UB or Medi-Cal UB for Pathways reimbursement.

2. PRODUCE CLAIM? (1-A-R)
This field indicates whether a claim should be produced, either electronically or as a printed paper claim, regardless of insurance balance. To suppress only when the insurance balance is $0.00, see the Suppress field on this screen.

Entry options are **Y** for Yes or **N** for No; the default is Y.

If you enter Y to this field, the system spools the claim to the appropriate spoolfile (paper or electronic) when the claim is released. If you enter N to this field, the system does not spool the claim to the spoolfile when the claim is released.

Copies of suppressed claims can always be generated using the Reprint Claim option. Suppressed claims appear on the Claim Prints Suppressed Report.

3. PRINT ON UB? (1-A-C)
This field indicates whether the insurance plan information should be printed on the UB claim form in Locators 50 through 66. Entry options are **Y** (Yes) or **N** (No). This field is required if the Claim Form Type field contains UB. If you enter Y, the insurance plan information is printed in form locators 50 through 66 on the UB. If you do not want professional fee plans to print on the UB, this field should be set to No for the professional fee plan. This field is used by the following Setup Routines (linked to Internal Elements) in the Claim Load and Edit Parameters to identify insurance plan information to print on claims:

- UB82/92 Carrier 1
- UB82/92 Carrier 2
- UB82/92 Carrier 3

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

4. PRORATE I/P CLAIMS? (1-A-R)
This field indicates whether inpatient claims should be prorated according to the coverage and limits of this plan. Entry options are **Y** for Yes or **N** for No; the default is Y.

The value (either Y or N) entered in this field for the primary insurance controls how all charges are handled for proration purposes. If you enter Y, all insurance plans are prorated according to the benefit information entered for the plan. If you enter N, all insurance plans are prorated at 100% and any excess amount, if it exists, is carried in a Third Party Excess field.

For example, if a patient has two insurance plans and this field contains Y for the primary insurance and the patient has covered charges of $1000.00 and non-covered charges of $50.00, the result is:

- Plan 1 pays 80%
- Plan 2 pays 90%
- Plan 1 has a plan liability of $800.00
- Plan 2 has a plan liability of $200.00
- Patient has a liability of $50.00

It is assumed both plans are coordinating. Using the same information in the above example but completing this field with N results in this situation:

- Plan 1 has a plan liability of $1050.00
- Plan 2 has a plan liability of $1050.00
- A Third Party Excess field is updated for $1050.00

As an additional example, a patient has a coordinating primary plan and a non-coordinating secondary plan and this field contains Y with charges of $1000.00. (The coordinating flag is located on the Basic Coverage screen.)

- Plan 1 pays 90%
- Plan 2 pays 80%
- Plan 1 has a plan liability of $900.00
- Plan 2 has a plan liability of $800.00
- The patient has a credit liability of $700.00

NOTE: If the patient type of insurance plan changes, this field is properly updated with the value for the patient if applicable.

5. PRORATE O/P CLAIMS? (1-A-R)
This field indicates whether outpatient claims are prorated according to the coverage and limits of the plan. Entry options are **Y** for Yes or **N** for No; the default is Y. Refer to the explanation provided in the Prorate I/P Claims field, which is also valid for outpatients.

6. LOAD SEPARATE CLAIM? (1-A-R)
This field indicates whether a separate claim for this insurance plan is created if the plan does not provide primary coverage. Entry options are **Y** for Yes or **N** for No; the default is Y.

This field enables a secondary insurance (COB 2-9) to share a claim with the primary insurance (COB 1). This can be used when one insurance bills the other insurance directly (as can happen with Blue Cross and Medicare). In order for a secondary insurance to share a claim with the COB 1 insurance, the claim types of the COB 1 plan and this secondary plan have to match (for example, X for UB or B for 1500). When a secondary insurance shares a claim with the primary insurance, the claim(s) load according to the primary insurance parameters (Claim Load Edit Parameter and Charge Control Parameter). When accessing the Carrier Status Information Screen within Claims Management, all carriers sharing the claim are reflected, and these insurances can each post payments to the same claim(s).

For example:

COB 2 and 3 have the Load Separate Claim field set to No.

COB 1 UB, Set to Split to Primary and Therapy claims

COB 2 UB, Set to Not Split claims

COB 3 UB, Set to Split to Primary and Vaccine claims

The system would load according to the COB 1 parameters. Therefore, Claim Sequence 1 would load for Primary, and would be shared with COB 1, 2, and 3 (as can be seen on the Carrier Status Information Screen). Claim Sequence 2 would load for

Therapy (assuming there were charges that matched the Split Claim Criteria), and would be shared with COB 1, 2, and 3 (as can be seen on the Carrier Status Information Screen).

7. HOLD CLAIM FOR PRIOR PAYMENT? (1-A-C)
If this insurance plan does not provide primary coverage, this field determines whether the claim for this plan should be held until prior plans with overlapping coverage pay. Entry options are **Y** for Yes or **N** for No; the default is N. This field is required if the Load Separate Claim field contains Y.

If claims are set up to wait for payment, the system loads the claim in a *Wait* status.

Claims wait for payment based not on the claim type, but on the Basic Coverage screen of the insurance. If the plan is set to Include Pro Fees in the Basic Coverage screen of the insurance, the plan waits on ALL prior plans. If the plan is set to Exclude Pro Fees in the Basic Coverage screen of the insurance, the plan waits on ALL prior plans set to Include or Exclude pro fees. The plan does not wait on plans set to Only cover pro fees. If the plan is set to Only Pro Fees in the Basic Coverage screen of the insurance, the plan waits on ALL prior plans set to Include or Only cover pro fees. The plan does not wait on plans set to Exclude pro fees.

UB plans also wait for payment based on the Claim Split Indicator. If a secondary UB plan is set to Hold Claim for Prior Payment, the system first attempts to hold for higher priority UB claims that have the same Claim Split Indicator. If a match cannot be found on the Claim Split Indicator, the claim is held for all of the UB claims loaded from the same bill sequence for the higher priority UB plans that do not already match up with a claim using the Claim Split Indicator.

CMS 1500 plans also wait on prior 1500 plans by physician. For example, if COB4 loads a claim for Dr. Smith and for Dr. Jones, and COB2 is a 1500 plan that loads a claim for Dr. Smith and for Dr. Jones, if the claims for COB4 are waiting on the claims for COB2, the Dr. Smith claim waits on the Dr. Smith claim and the Dr. Jones claim waits on the Dr. Jones claim. If the CMS 1500 plans both split by department, the claims wait by department for the carrier.

The following release waiting claims:

- When the claim it is waiting on is marked Final Payment, Adjusted to Zero, or Denied through the Balance Transfer & Claim Disposition function, with or without a balance transfer.

- When the claim it is waiting on is marked Final Payment through cash posting.

- When the claim it is waiting on is marked Adjusted to Zero through adjustment posting with an adjustment that brings the carrier or account balance to zero.

- When the claim it is waiting on is marked Adjusted to Zero through insurance time-out.

- When the claim it is waiting on is deleted.
- When the claim it is waiting on is marked completed by the system when the carrier or the account balance goes to zero.

The following are examples of waiting UB claims.

Example where no Primary claim is loaded for COB1 or COB3:

COB	Clm Seq	Claim Form	Claim Split Indicator	Waiting On
1	1	UB	Therapy 08/10/05	
1	2	UB	Therapy 08/11/05	
1	3	UB	Clinic	
1	4	UB	Vaccine	
2	5	1500	103 Jones,Grayson	
2	6	1500	27 Hansen,Viggo	
3	7	UB	Therapy 08/10/05	1,5,6
3	8	UB	Therapy 08/11/05	2,5,6
3	9	UB	Outpatient	3,5,6
3	10	UB	Vaccine	4,5,6

Example where the Claim Split Indicators Match:

If COB 3 loads a claim for Vaccine and a claim for Primary, and the COB 1 UB plan loads a claim for Vaccine and a claim for Primary, if the COB 3 plan is set to Hold for Prior Payment, the Vaccine claim for COB 3 waits on the Vaccine claim for COB 1 and the Primary claim for COB 3 waits on the Primary claim for COB 1. For this example, the COB 3 plan is set to include professional fees on the Basic Coverage screen of the insurance.

COB	Clm Seq	Claim Form	Claim Split Indicator	Waiting On
1	1	UB	Primary	
1	2	UB	Vaccine	
2	3	1500	103 Jones,Grayson	

2	4	1500	27 Hansen,Viggo	
3	5	UB	Primary	1,3,4
3	6	UB	Vaccine	2,3,4

Example where the Claim Split Indicators Do Not Match, Lower Priority Plan has More Claims:

If COB 3 loads a claim for Vaccine, one for RAD, and one for Primary, and the COB 1 UB plan loads a claim for Vaccine and one for Primary, if the COB 3 plan is set to Hold for Prior Payment, the Vaccine claim for COB 3 waits on the Vaccine claim for COB 1 and the Primary claim for COB 3 waits on the Primary claim for COB 1. Since there is no match on the RAD claim, the RAD claim for COB 3 waits on the Primary claim for COB 1. If a Primary claim is not loaded for the higher priority plan, the claim holds for all claim sequence numbers (within that bill sequence) for the higher priority plan(s) that do not already match up with a claim using the Claim Split Indicator. For this example, let's say that the COB 3 plan is set to include professional fees on the Basic Coverage screen of the insurance.

COB	Clm Seq	Claim Form	Claim Split Indicator	Waiting On
1	1	UB	Primary	
1	2	UB	Vaccine	
2	3	1500	103 Jones,Grayson	
2	4	1500	27 Hansen,Viggo	
3	5	UB	Primary	1,3,4
3	6	UB	Vaccine	2,3,4
3	7	UB	Rad	1,3,4

Example where the Claim Split Indicators Do Not Match, Higher Priority Plan has More Claims:

If COB 3 loads a claim for Vaccine, and one for Primary, and the COB 1 UB plan loads a claim for Vaccine, one for RAD, and one for Primary, if the COB 3 plan is set to Hold for Prior Payment, the Vaccine claim for COB 3 waits on the Vaccine claim for COB 1 and the Primary claim for COB 3 waits on BOTH the Primary claim for COB 1, and the RAD claim for COB 1. If the higher priority plan has more claims, the Primary claim for the secondary insurance (COB 2-9) waits on the Primary and on the additional split claim(s) to ensure that the secondary plan does not release the claims before all payments have been received from the more primary plan. If a Primary claim is not loaded for the secondary insurance (COB 2-9), the lower priority claim that does not

already match up with a claim using the Claim Split Indicator holds for all claim sequence numbers (within that bill sequence) for the higher priority plan(s) that do not already match up with a claim using the Claim Split Indicator. If all claims for this secondary insurance have been matched to another claim using the Claim Split Indicator, the lowest claim sequence number for the secondary plan (within the bill sequence) holds for the lowest claim sequence number for the more primary plan. For this example, let's say that the COB 3 plan is set to include professional fees on the Basic Coverage screen of the insurance.

COB	Clm Seq	Claim Form	Claim Split Indicator	Waiting On
1	1	UB	Primary	
1	2	UB	Vaccine	
1	3	UB	Rad	
2	4	1500	103 Jones,Grayson	
2	5	1500	27 Hansen,Viggo	
3	6	UB	Primary	1,3,4,5
3	7	UB	Vaccine	2,4,5

8. ASB CROSSOVER HOLD EXCEPTIONS (TABLE LOOKUP)

In this field, users can select one or more insurance plans, that, when the selected carrier/plan is COB 1, this plan that you are updating, if it is the secondary UB plan (claim type X), does not Hold for Prior Payment, and follows the ASB/Crossover Claim logic. For example, if you have accessed the Insurance Plan Coverage table for plan 500100, and in the ASB/Crossover Hold Exceptions you highlight plans 100100 and 300100, if on an account plan 300100 is COB 1, and the 500100 is the next highest UB plan, then plan 500100 would not be held for prior payment on COB 1 300100. This field is only accessible when the Hold Claim for Prior Payment? field is set to Yes.

If this insurance (the insurance you accessed in the Insurance Coverage Table) does not have the Claim Form Type set to UB (claim type X) on this same screen, the system does not allow you to set the ASB/Crossover Hold Exceptions field.

If on this insurance, field 1 for the Claim Form Type is set to UB (claim type X), you can enter the ASB/Crossover Hold Exceptions. The system displays only other insurance plans that, on the Billing/Claim Parameters, screen 2 of 5 in the Facility options, have the field for Claim Form Type set to UB (claim type X).

The ASB Crossover Hold Exceptions field can be used for crossover claims and accelerated secondary billing claims, which are:

- Crossover Claim: This is when Medicare bills the payer on line 50B of the UB claim by sending the same claim to this secondary payer. Therefore, the demographic and charge data for the COB 1 Medicare claim is the same as the secondary payer claim.

- Accelerated Secondary Billing (ASB): This is when Medicare is again COB 1. With accelerated secondary billing, EC2000 (or another third party billing system) makes an inquiry and receives the estimated payment amount due from Medicare before the actual payment is received. Once the estimated payment amount is received, this is used to update the claim for the payer on line 50B of the UB claim, and this claim is sent to the payer before actually receiving payment from Medicare. The difference between ASB and the crossover situation is that with the ASB claim, EC2000 is creating the claim for the payer on line 50B using the claim information from the COB 1 Medicare claim. This secondary claim can then be modified to differ from the Medicare claim. The same claim is NOT sent from Medicare to the secondary payer. There is a separate claim that is created and sent to the secondary payer.

The crossover or ASB payer should be the Payer in Line 50B of the UB claim form, if your 1500 and Non Pro Fee 1500 insurances have the Print on UB? field set to No in the Facility Options, Billing and Claims, page 2 of 5, of the Insurance Coverage Table.

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

Enter Hold for Payment ASB/Crossover Claim Exceptions? (Y/N) [N]-

If you enter **Y** (Yes), the following prompt is displayed:

Enter insurance plan codes in a list or partial code`-` for list --

You can enter the carrier/plan code such as 100300 or do a partial lookup such as 100- to show all carrier/plan codes that start with 100. When the screen of plan codes is displayed, the system displays the following prompt:

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

The system displays as many selected plans as will fit in the ASB/Crossover Hold Exceptions field, followed by ++ if all selected plans cannot display.

In order to revise the selections in this field, you must access the field, and again enter *Yes* to the prompt: *Enter Hold for Payment ASB/Crossover Claim Exceptions? (Y/N) [N].* The system first displays the insurances already selected with the following prompt:

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

Here you can remove insurance plans previously selected.To select additional insurance plans, hit the ENTER key, and the system prompts:

Enter insurance plan codes in a list or partial code`-` for list--

Crossover and ASB claims are not held for prior payment based on the COB 1 plan. These ASB/Crossover claims are released later, and the print/spool suppressed, but the claims are marked as Produced. This allows the Crossover and ASB claims to be submitted at a later date.

In the following example, the system would consider COB 3 the Next Highest UB plan:

- COB 1 = UB Medicare
- COB 2 = 1500 Medicare
- COB 3 = UB Medicaid
- COB 4 = UB Blue Cross

The system looks for the next highest insurance with a Claim Type of X for the Federal UB.

The system only looks to these exceptions if both the COB 1 plan and the next highest UB plan are set to load a UB claim type X (either the UB92 or the UB04 version). This functionality does not affect the Medi-Cal UB, the 1500 or Non Pro Fee 1500, or any state claim type.

Hospitals may want to list their Medicare carrier/plans in this field, since Medicare can crossover bill to other payers.

NOTE: You must verify with your electronic claims vendor that they are doing this Accelerated Secondary Billing and Crossover Billing.

If the COB 1 plan is not one of the exceptions, the Next Highest UB plan will Hold for Prior Payment, based on the setting of the Hold Claim for Prior Payment field on the insurance.

If the COB 1 plan is one of the exceptions, the Next Highest UB plan will not Hold for Prior Payment from the COB 1 claim. However, the following occurs:

- During Claim Select, if the COB 1 plan is one of the exceptions, the system overwrites the Claim Load Edit Parameter and the Charge Control Parameter on the Next Highest UB plan with the parameters from the COB 1 plan. For example, if COB 1 uses Claim Load Edit Parameter 01, and Charge Control Parameter 11, COB 2 is a 1500 plan, and COB 3 is a UB plan set to use Claim Load Edit Parameter 03 and Charge Control Parameter 33, if the COB 1 plan is an exception, the COB 3 claim(s) load using Claim Load Edit Parameter 01 and Charge Control Parameter 11. This ensures that the Next Highest UB claims match the COB 1 claims (with demographics, charges, and claim splits), since the COB 1 plan bills the next highest UB plan with the same claim detail.

- At claim load, the system writes to Transaction History that the Claim Load Edit and Charge Control Parameter for the Next Highest UB claim was set to the Claim Load Edit and Charge Control Parameter for the linked COB 1 claim. The Status Type field lists *CLE*CCP* to indicate the Old/New Status field and first lists the old/new Claim Load Edit Parameter, an asterisk, and then the old/new Charge Control Parameter. For the old Claim Load Edit Parameter and the old Charge Control Parameter, the system is listing the parameters assigned to the ASB/Crossover insurance. Therefore, if this secondary insurance UB Charge Control Parameter had one or more Split Claim criteria listed, and this Split Claim criteria in turn listed an Alternate Claim Load Edit Parameter and/or Alternate Charge Control Parameter, these alternates are not listed in Transaction History. Only the parameters assigned at the insurance level are listed for the old parameters. The Comment field lists UB Claim Load Edit & Chg Cont set to COB 1.

- The Next Highest UB claims have the Produce Claim node set to No, meaning they do not spool to either the paper or to the electronic spoolfiles, regardless of insurance balance. This setting can be viewed on the Claim Status Information screen, in the Prod/Supp Claim? field. The field will be set to *No/Yes*.

- The Next Highest UB plan claim(s) are given a Work Status of H for Hold. The claim(s) are released with the associated COB 1 claim(s). If you manually release this secondary claim, since the Produce Flag is set to No, the claim does not spool to either the paper or the electronic spoolfile, which means that there is no submit date on the claim. Once the claim is either manually submitted, or the claim receives a Submit Date via the EC2000 interface, insurance follow up starts for the claim.

- The system writes to Transaction History that the claim was put on hold because of ASB/Crossover Claim.

- The system uses the Transaction Code for the claim type (Cycle, Final, Adjustment, or Late) from the Claim Generation Parameters assigned to the insurance. The description is *UB ASB/Crossover Hold,* and the Comment is the current Comment for the Claim Loaded transaction, which lists the claim type, the claim sequence, BILL (for claims added via Midnight Processing or Instant Adjustment Bill), and the Claim Split Indicator. For example: UB ADJUSTMENT CLAIM CS# - 21,BILL,THERAPY.

- The Claim Status Information screen is updated to display the linked claim sequence for the Primary and the ASB/Crossover claim. For example, if the Next Highest UB plan was COB 3, and this loaded a Primary and a Mammography claim, if the Primary claim for COB 3 was claim sequence 4, this may point back to COB 1 CS 1 Primary. The same field, when looking at claim sequence 1, would point forward to COB 3 CS 4 Primary. This field is called ASB/Crossover Link.

- When claim edit runs (which is directly after claim load), the claim index for the Next Highest UB claim(s) is changed from 2 for Failed for any claims in error to 4 for Passed. Since the COB 1 claim(s) are used to send and create the secondary

claims, and since these secondary claims do not actually spool on STAR, there is no need to correct the claim errors. Changing the index to *Passed* removes them from the Failed Claims Requirement Report.

- Any claim modifications for these secondary ASB/Crossover claims should be made on the EC 2000/third party billing side. Changes made to the secondary ASB/Crossover claims on the STAR side may be overwritten with the Backfeed and Credit Note Detail records received from EC2000. Also, the COB 1 claim when released on STAR will overlay the linked ASB/Crossover claim on STAR (see below).

- When the linked COB 1 claim is Released by the system (if there are no errors upon claim edit), or when the COB 1 claim is Manually Released by the user by correcting the errors or Manually Releasing, the claim information (Demographic and Charge) for the COB 1 claim overlays the linked claim information for the Next Highest UB claim. For example, if COB 1 claim sequence 1 for Primary is linked to COB 3 claim sequence 4 for Primary, when claim sequence 1 is released/manually released, the demographic and charge data from claim sequence 1 overlays the demographic and charge data for claim sequence 4.

- If COB 1 claim sequence 2 for Therapy is linked to COB 3 claim sequence 5 for Therapy, when claim sequence 2 is released/manually released, the demographic and charge data from claim sequence 2 will overlay the demographic and charge data for claim sequence 5. This ensures that any manual updates made to the COB 1 claim(s) will be reflected on the Next Highest UB claim(s).

- When the COB 1 claim(s) are released, the system checks the ASB/Crossover Link and releases the associated Next Highest UB claim. For example, using the above, when claim sequence 1 is released, this will release claim sequence 4. When claim sequence 2 is released, this will release claim sequence 5. Releasing the claims will in turn create any Log records (if a Log is linked to the insurance). Therefore, if the linked ASB/Crossover claim was Waiting for payment on a 1500 or Non Pro Fee 1500 claim (or state claim), it no longer waits on these claims once the COB 1 claim is released.

- The claim index on the Next Highest UB claim(s) is updated to Generated (6) once the claims are released and they run through the Claim Print/Spool programs (even though the claims do not actually spool, see below).

- The system writes to Transaction History that the claim was Released because of ASB/Crossover Claim.

- The system uses the Transaction Code for the claim type (Cycle, Final, Adjustment, or Late) from the Claim Generation Parameters assigned to the insurance. The Description is *UB ASB/Crossover Clm Released* and the Comment is the Transaction Code description, then Claim Seq # and the actual claim sequence. For example: UB ADJUSTMENT CLAIM Claim Seq # - 4.

- The system writes to Transaction History that the claim was suppressed (once the claim is released and Midnight Processing runs) because of ASB/Crossover Claim.

- The system uses the Transaction Code for the claim type (Cycle, Final, Adjustment, or Late) from the Claim Generation Parameters assigned to the insurance, with a description of *UB ASB/Crossover Clm Suppress* and a comment that contains the Transaction Code description, Claim Seq # and the actual claim sequence. For example: UB ADJUSTMENT CLAIM Claim Seq # - 4.

- When in the Single Bill Request and the Instant Adjustment Bill functions, and requesting a Bill and Claims, regardless of how you answer the Produce Claims? field, if the system determines the secondary insurance is an ASB/Crossover insurance, the system sets the Produce Claim flag to *No* and the Suppress Claim flag to *Yes* on these secondary ASB/Crossover claims.

  For example, the system displays a prompt such as:

  Produce Claim is YES and Suppress Claim is NO. Override? (Y/N) [N]-- |

  If you kept the settings of Produce Yes and Suppress No, then if the system determines the insurance is a secondary ASB/Crossover insurance, the settings for this insurance's claims are set to *Produce No, Suppress Yes*.

- The Next Highest UB claims are suppressed since the COB 1 claim(s) are used to bill this Next Highest UB plan (in the case of a crossover claim), and are used to create the claim for the Next Highest UB plan (in the case of an ASB claim), and these secondary claims are not needed by EC2000.

- Setting the Produce Claim node to No on the Next Highest UB claim means that there will be no Submit Date for this ASB/Crossover claim after the claim is released and then suppressed on STAR. The claim, however, can be Submitted at a later date with the Credit Note record from EC2000. This can be viewed on the Carrier Status Information screen, in the Claim Submitted field. This is blank until manually updated or updated via EC2000.

- Even though there is no submission date and the claim did not actually spool, when looking at the Claim Status Information screen and the Claim Production Status field, the status is P (Produced). Since the Production Status is Produced, the system allows a Submission Date on the claim (either manually entered, or returned from EC2000 or a third party billing system

9. PRINT PAPER CLAIM LABEL? (1-A-C)

This field indicates whether a claim mailing label should be printed for this insurance plan when the paper claims are generated. Entry options are Y for Yes or N for No; the default is N. This field is required if the Load Separate Claim field contains Y. This field is not used for OHIP or WCB claims.

10. SUPPRESS (1-A-R)
This field indicates whether a claim spools to the paper or to the electronic spoolfile at the time of claim print (spool) selection, if the insurance balance is $0.00. The claim is not suppressed with activity (payment, adjustment, balance transfer, or claim dispositioning).

You can enter **Y** (Yes) to indicate that claims are to be suppressed. When a non-produced claim is evaluated for print/spool (at the selection process), the system looks to the Suppress field. If at that point, the carrier and/or the account balance is zero, the system suppresses the claim, and it does not spool to either paper or the electronic spoolfile. You can enter **N** (No) to indicate that claims are not to be suppressed and should be printed/spooled, regardless of insurance balance. For example, Medicare does not allow secondary claims to be suppressed

If the carrier and/or the account balance at time of claim print/spool is $0.00, and the Suppress field is set to Yes, the claim is suppressed, meaning it does not spool to either the paper or to an electronic claim file, and the system updates the following:

- The Claim Work Status is Updated to a P for Suppressed.
- The Claim Disposition is updated to A for Adjusted to Zero if there is a blank disposition. If there is a disposition already, it is retained.
- The Claim Index is updated to a 10 for Completed only if the claim is suppressed and the disposition is updated to A for Adjusted to Zero.
- The Claim Disposition Date is updated to the current date if the claim disposition is updated to A for Adjusted to Zero.
- The Paid in Full Flag is set to 1 for Yes, Paid in Full for the claim the system is processing in Claim Print/Spool if the claim disposition is updated to A for Adjusted to Zero.
- The Expected Number of Payments is decremented for the carrier if the claim disposition is updated to A for Adjusted to Zero.

If the carrier and/or the account balance at time of claim print (spool) selection is not $0.00, and the Suppress field is set to Yes, the system does not Suppress the claim, the claim spools to either the paper or to an electronic claim file, and the claim and carrier are updated as if the Suppress flag was set to No.

Since the system is looking to the Suppression flag at the time the claim is selected for print/spool, you can have a situation where some of the claims print/spool for the carrier, while others do not. For example, say COB 3 loads a Primary and a Split claim. If the insurance has the Suppress flag set to Yes, if the insurance has a balance when the Primary claim is released, this claim will print/spool. But if in between this claim printing/spooling, and the Split claim being released, the insurance balance goes to $0.00, then the split claim is suppressed. If later the insurance receives a balance (say

from a Balance Transfer), this Suppressed claim can be Un-Suppressed, and marked for Claim Editing. Therefore, a suppressed claim can later print/spool.

The system does not complete an insurance's claims and mark Expected Number of Payments as zero if any of the higher priority plans have a balance. If a secondary claim that is waiting for payment has a payment or adjustment posted to it, or is dispositioned as Final Payment, Adjusted to Zero, or Denied, this one claim is marked complete, but the remaining non-replaced, non-final dispositioned claims for this insurance are not marked completed. This allows balance transfers from a higher priority plan to the lower plan.

When suppressing the claims, the system writes the following Transaction Lines to Transaction History.

- Summary Description: Key Data Changed

  Comment: Claim work status changed from xxxxxx to Suppressed

  Where xxxxxx could be Manually Released

- Summary Description: Key Data Changed

  Comment: Claim Suppressed - Carrier Zero Balance

- Summary Description: Key Data Changed

  Comment: Dispositioned CS X to Adjusted to Zero

11. EOB INDICATOR (1-A-O)
This field indicates whether an explanation of benefits is to be sent to the patient. When this field is accessed, the following prompt is displayed:

Are you requesting a paper EOB? (Y/N) [N]--

If you respond with Y for Yes, the EOB is sent. If you respond with N for No, an EOB is not sent.

12. ELECTRONIC MEDIA (TABLE LOOKUP)
This field indicates what electronic media should be used to communicate a claim to the carrier. This field is not used for OHIP or WCB claims. Entry options are:

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

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

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

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

To send claims electronically, the Claim Media field in the Claim Load and Edit Parameters must be set to B (for Both Paper and Electronic), or E (for Electronic). Also, the Electronic Types field in the Claim Load and Edit Parameters must be set to the claims (Final, Cycle, Adjustment, Late, Reprint, or Tracer) that are to be sent electronically. The system sends claims to the paper spoolfile if they are not marked to send electronically in the Electronic Types field.

If a claim is submitted using electronic media, no paper claim 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 Produce Claim field contains Y.

13. PRINT ELECTRONIC CLAIM LABEL? (1-A-O)
This field indicates whether a claim mailing label should be printed for this insurance plan when the electronic claims are spooled in the system. Entry options are **Y** for Yes or **N** for No; the default is N. This field is only accessible if the Electronic Media field is set to Electronic Media A,B, C, D, E, or T.

14. PRIMARY PAYOR (1-AN-C)
This field is used for McKesson state regulations.

15. SOURCE OF PAYMENT (2-A-C)
This field is used for McKesson state regulations and for UBV92 and 1500 claims.

16. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

17. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes this part of the transaction and displays the third screen dealing with claim processing parameters.

Claim Processing

```
            General Hospital Billing/Claims Parameters Processor
               Claim Processing   Page  3 of  5  Tue Aug. 3, 2004 03:41 pm
Carrier:COLUMBIA HEALTH                          Facility :MODEL HOSPITAL A
Plan   :COLUMBIA HEALTH                          Effective:Current
1 I/P Prim Claim Load/Edit Parameter     2 I/P Sec Claim Load/Edit Parameter
  02-COMMERCIAL I/P                        02-COMMERCIAL I/P
3 I/P Prim Charge Control Parameter      4 I/P Sec Charge Control Parameter
  03-COMMERCIAL I/P                        03-COMMERCIAL I/P
5 I/P Claim Generation Parameter         6 I/P Provider Number
  UB-CLAIM GENERATION                      IP12345
7 O/P Prim Claim Load/Edit Parameter     8 O/P Sec Claim Load/Edit Parameter
  01-COMMERCIAL O/P                        01-COMMERCIAL O/P
9 O/P Prim Charge Control Parameter     10 O/P Sec Charge Control Parameter
  02-COMMERCIAL O/P                        02-COMMERCIAL O/P
11 O/P Claim Generation Parameter        12 O/P Provider Number
   UB-UB92 CLAIM GENERATION                 OP98765
13 I/P Provider Master                   14 O/P Provider Master
   1-MODEL HOSPITAL A                       1-MODEL HOSPITAL A
15 Edit by                               16 Effective date
   Nancy Lewis                          06/11/03
Enter field number or '/' starting field number--
                    next screen(/) or previous screen(/P) [/]
```

When the COBs of the insurances change on an account from resequencing, additions, or deletions, or when the patient type changes, the system does the following:

If the COB1 insurance changes, all insurances on the account are reassigned the claim parameters based on whether the insurance is primary vs. secondary (COB 2-9). Any modifications made to the claim parameters at the account level are lost.

If a UB insurance goes from being a secondary insurance (COB 2-9) to another secondary insurance on the account, the claim parameters are not reassigned.

If any of the 1500 plans (claim type B) are resequenced at all, from secondary to secondary, or from secondary to primary or vice versa, the claim parameters for any 1500 insurance on the account are reassigned. Insurances set to use the CMS 1500 (claim type B) are assigned the primary claim parameters to the most primary, or first, 1500 plan assigned to the account. For example, if the accounts COB 2 and COB 4 plans are both CMS 1500 plans, the COB 2 plan is assigned the primary parameters and COB4 is assigned the secondary parameters.

For example, if COB1 is a UB plan, and COB2 is a 1500 plan, COB3 is a UB plan, and COB4 is a 1500 plan, if COB4 is resequenced to COB3, the account would be as follows:

FROM:		TO:	
	COB1 = UB		COB1 = UB
	COB2 = 1500		COB2 = 1500
	COB3 = UB		COB3 = 1500
	COB4 = 1500		COB4 = UB

When the last two plans are resequenced, since a 1500 plan was resequenced, both 1500 plans are reassigned the claim parameters. Any modifications made to the claim parameters for the 1500's at the account level are lost.

If the patient type changes, the claim parameters are reassigned based on the patient type exceptions and on whether the insurance is primary vs. secondary (COB 2-9). Any modifications made to the claim parameters at the account level are lost.

Field Explanations - Screen 3 of 5

1. I/P PRIM CLAIM LOAD EDIT PARAMETER (3-C-R)
This field contains the code (up to three characters) identifying the primary claim load and edit parameter for inpatients using this plan. This parameter is used to load and edit a claim if this insurance is the primary insurance, if the claim is a shared claim, or if the insurance is secondary and field 2 is not completed. The load and edit parameters determine what information is included or excluded on a claim, and what edits (required or not) are to be performed on the claim for all information except the charges, which are controlled by the charge control parameter.

Shared claims are valid only for UB claims. A shared claim indicates that this insurance plan's data is included on the UB form of the primary carrier and a separate claim form is not required for this carrier.

The primary plan's parameter is used for all carriers sharing a claim. You can enter the parameter code or a hyphen (-) to display a list of valid codes.

2. I/P SEC CLAIM LOAD/EDIT PARAMETER (3-C-O)
This field contains the code (up to three characters) identifying the secondary claim load and edit parameter for inpatients using this plan. This parameter is used to load and edit a claim if this insurance is a secondary plan for a patient. The exception to this is for CMS 1500 claim forms (claim type B). Insurances set to use claim type B for the CMS 1500 assigns the Primary Claim Load and Edit Parameter to the most primary, or first, 1500 plan assigned to the account.

For example, if the accounts COB2 and COB4 plans are both CMS 1500 plans, the COB2 plan is assigned the primary parameters and the COB4 plan is assigned the secondary parameters. If the insurance is secondary and does not require its own claim, it is not necessary to complete this field. If this carrier requires a separate claim but the edits and information contained in the claim are the same as when the plan is primary, it is not necessary to complete this field since the system uses the primary parameter set in field 1. You can enter the code or a hyphen (-) to display a list of valid codes.

3. I/P PRIM CHARGE CONTROL PARAMETER (3-C-R)
This field contains the code (up to three characters) identifying the primary charge control parameter used to load charges on a claim for inpatients using this plan. If this insurance is primary or if a separate claim is required for this insurance when it is secondary and field 4 is blank, this parameter determines the level of detail, what

charges should be included on the claim, and whether HCPCS codes should be included. Refer to the UB and 1500 charge control parameters sections for additional information. The primary plan's parameter is used for all carriers sharing a claim. Only carriers that produce UB claims can share a claim. You can enter the code or a hyphen (-) to display a list of valid codes. Charge control parameters are not used for Canadian claims processing.

4. I/P SEC CHARGE CONTROL PARAMETER (3-C-O)
This field contains the code (up to three characters) identifying the secondary charge control parameter used to load charges on a claim for inpatients using this plan. The exception to this is for CMS 1500 claim forms (claim type B). Insurances set to use claim type B for the CMS 1500 assign the Primary Charge Control Parameter to the most primary, or first, 1500 plan assigned to the account.

For example, if the account's COB2 and COB4 plans are both CMS 1500 plans, the COB2 plan is assigned the primary parameters and the COB4 plan is assigned the secondary parameters. This parameter determines the level of charge detail, what charges should be included on the claim, and whether HCPCS codes should be included. Refer to the UB and 1500 charge control parameters sections for additional information. Charge control parameters are not used for Canadian claims processing.

This parameter should be completed only if this insurance requires a separate claim, if it is a secondary carrier, and if the parameter to be used is different than the one specified in the Primary I/P Charge Control Parameter field. You can enter the code or a hyphen (-) to display a list of valid codes.

5. I/P CLAIM GENERATION PARAMETER (4-C-R)
This field contains the code (up to four characters) identifying the primary claim generation parameter for inpatients using this plan. You can enter the code or a hyphen (-) to display a list of valid codes. Refer to the Claims Generation Parameters documentation for more information.

6. I/P PROVIDER NUMBER (22-AN-O)
This field contains the provider number at the insurance level for when the patient has an inpatient patient indicator. This field is used when the insurance is primary (COB 1) and secondary (COB 2-9), and when the Provider Number - Insurance Level internal element is used.

7. O/P PRIM CLAIM LOAD/EDIT PARAMETER (3-C-R)
This field contains the code (up to three characters) identifying the primary claim load and edit parameter for outpatients using this plan. This parameter is used to load and edit a claim if this insurance is the primary insurance, if the claim is a shared claim, or if the insurance is secondary and field 8 is not completed. The load and edit parameters determine what information is included or excluded on a claim, and what edits (required or not) are to be performed on the claim for all information except the charges, which are controlled by the charge control parameter.

Shared claims are valid only for UB claims. A shared claim indicates that this insurance plan's data is included on the UB form of the primary carrier and a separate claim form is not required for this carrier.

The primary plan's parameter is used for all carriers sharing a claim. You can enter the parameter code or a hyphen (-) to display a list of valid codes.

8. O/P SEC CLAIM LOAD/EDIT PARAMETER (3-C-O)
This field contains the code (up to three characters) identifying the secondary claim load and edit parameter for outpatients using this plan. This parameter is used to load and edit a claim if this insurance is a secondary plan for a patient. The exception to this is for CMS 1500 claim forms (claim type B). Insurances set to use claim type B for the CMS 1500 assign the Primary Claim Load and Edit Parameter to the most primary, or first, 1500 plan assigned to the account.

For example, if the accounts COB2 and COB4 plans are both CMS 1500 plans, the COB2 plan is assigned the primary parameters and the COB4 plan is assigned the secondary parameters. If the insurance is secondary and does not require its own claim, it is not necessary to complete this field. If this carrier requires a separate claim but the edits and information contained in the claim are the same as when the plan is primary, it is not necessary to complete this field since the system uses the primary parameter set in field 1. You can enter the code or a hyphen (-) to display a list of valid codes.

9. O/P PRIM CHARGE CONTROL PARAMETER (3-C-R)
This field contains the code (up to three characters) identifying the primary charge control parameter used to load charges on a claim for outpatients using this plan. If this insurance is primary or if a separate claim is required for this insurance when it is secondary and field 10 is blank, this parameter determines the level of detail, what charges should be included on the claim, and whether HCPCS codes should be included. Refer to the UB and 1500 charge control parameters sections for additional information. The primary plan's parameter is used for all carriers sharing a claim. Only carriers that produce UB claims can share a claim. You can enter the code or a hyphen (-) to display a list of valid codes. Charge control parameters are not used for Canadian claims processing.

10. O/P SEC CHARGE CONTROL PARAMETER (3-C-O)
This field contains the code (up to three characters) identifying the secondary charge control parameter used to load charges on a claim for outpatients using this plan. The exception to this is for CMS 1500 claim forms (claim type B). Insurances set to use claim type B for the CMS 1500 assign the Primary Charge Control Parameter to the most primary, or first, 1500 plan assigned to the account.

For example, if the account’s COB2 and COB4 plans are both CMS 1500 plans, the COB2 plan is assigned the primary parameters and the COB4 plan is assigned the secondary parameters. This parameter determines the level of charge detail, what charges should be included on the claim, and whether HCPCS codes should be

included. Refer to the UB and 1500 charge control parameters sections for additional information. Charge control parameters are not used for Canadian claims processing.

This parameter should be completed only if this insurance requires a separate claim, if it is a secondary carrier, and if the parameter to be used is different than the one specified in the Primary O/P Charge Control Parameter field. You can enter the code or a hyphen (-) to display a list of valid codes.

11. O/P CLAIM GENERATION PARAMETER (4-C-R)
This field contains the code (up to four characters) identifying the primary claim generation parameter for outpatients using this plan. You can enter the code or a hyphen (-) to display a list of valid codes.

12. O/P PROVIDER NUMBER (22-AN-O)
This field contains the provider number at the insurance level for when the patient has an outpatient patient indicator. This field is used when the insurance is primary (COB 1) and secondary (COB 2-9), and when the Provider Number - Insurance Level internal element is used.

13. I/P PROVIDER MASTER (6-N-O)
This field contains the code identifying the provider at the overall account level associated with inpatients using this plan. Providers are assigned to patients based on patient type during admission. This field should be completed only if this carrier has its own unique provider information. You can enter the code or a hyphen (-) to display a list of valid codes. This provider master is only used if the plan is primary, and not when it is secondary.

NOTE: This field should be completed for exceptions only.

14. O/P PROVIDER MASTER (6-N-O)
This field contains the code (up to six digits) identifying the provider at the overall account level associated with outpatients using this plan. Providers are assigned to patients based on patient type during registration. This field should be completed only if this carrier has its own unique provider information. You can enter the code or a hyphen (-) to display a list of valid codes. This provider master is only used if the plan is primary, and not when it is secondary.

NOTE: This field should be completed for exceptions only.

15. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

16. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

Patient Type Exceptions

If the assigned parameters need to be different for a specific patient type, this function enables the hospital to define the parameter values for the patient type. The system displays a list of valid patient types. Select the patient type and complete the fields on the screen.

Providers cannot be varied by insurance plan for patient type exceptions. If that level of detail is needed, the specific claim load and edit parameter can be set with default values for the provider information. If you do not complete at least one field on the patient type exceptions screen, a patient type exception is not created.

PATIENT TYPE EXCEPTIONS (TABLE LOOKUP)
After you select the patient type exceptions from table display, the following screen is displayed:

```
          General Hospital Billing/Claims Parameters Processor
                Claim Exceptions   Page  4 of  5  Tue Aug. 3, 2008 11:57 am
Carrier:COMMERCIAL                                 Facility :MODEL HOSPITAL A
Plan   :COLUMBIA HEALTH                            Effective:Current
               Patient Type Exceptions for PSY - PSYCH PATIENT

 1 Claim Form Type          2 Suppress?   3 Claim Generation Parameter
   UB                      ->
 4 Prim Claim Load/Edit Parameter         5 Sec Claim Load/Edit Parameter

 6 Prim Charge Control Parameter          7 Sec Charge Control Parameter

 8 Provider Number                        9 Provider Master

10 Electronic Media                      11 Print Electronic Claim Label?

12 Edit by                               13 Effective date









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

Field Explanations - Screen 4 of 5

1. CLAIM FORM TYPE (2-A-R)
This field indicates the type of claim form that is produced for this carrier plan and patient type exception. You can enter a claim form type or a hyphen (-) to select from a table of claim form types.

For existing patient type exceptions or added patient type exceptions, the Claim Form Type field defaults to the Claim Form Type for the insurance plan. Since a Claim Form Type can differ for a patient type, if the field is selected and patient type exceptions exist, the following prompt is displayed. The prompt reminds you that patient type

exceptions exist with different claim types and allows you to delay changing the Claim Form Type for the insurance plan if desired.

Patient type exceptions exist for claims. Do you want to remove them first? (Y/N) [Y]--

You can enter **Y** (Yes) to remove the existing patient type exceptions for claims or **N** (No) not to remove them. If you change the Claim Form Type, the following fields are blanked so they can be re-keyed:

- Prim Claim Load/Edit Parameter - If the Claim Form Type for the patient type does not match the Claim Form Type for the insurance plan, the Prim Claim Load/Edit Parameter field is required.
- Sec Claim Load/Edit Parameter
- Prim Charge Control Parameter
- Sec Charge Control Parameter

The Claim Form Type and the Reimbursement Type must be compatible for patient type exceptions. The system edits changes to the Claim Form Type field as follows:

If reimbursement type is.....	Claim Type must be
I (PCON by Bill)	X (UB) or R (Med-Cal UB)
J (PCON by Claim)	X (UB) or R (Med-Cal UB)
H (OPPS)	X (UB)
B (PCON 1500)	B (1500) or Z (Non Pro Fee 1500)
N (Nova Scotia OOP)	5 (OutProv NS)

2. SUPPRESS? (1-A-O)

This field indicates whether a claim spools to the paper or to the electronic spoolfile at the time of claim print (spool) selection, if the insurance balance is $0.00. The claim is not suppressed with activity (payment, adjustment, balance transfer, or claim dispositioning).

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

Suppress pending claim(s) if paid in full? (Y/N)--

You can enter **Y** (Yes) to indicate that claims are to be suppressed. When a non-produced claim is evaluated for print/spool (at the selection process), the system looks to the Suppress field. If at that point, the carrier and/or the account balance is zero, the system suppresses the claim, and it does not spool to either paper or the electronic spoolfile. You can enter **N** (No) to indicate that claims are not to be suppressed and

should be printed/spooled, regardless of insurance balance. For example, Medicare does not allow secondary claims to be suppressed

If the carrier and/or the account balance at time of claim print/spool is $0.00, and the Suppress field is set to Yes, the claim is suppressed, meaning it does not spool to either the paper or to an electronic claim file, and the system updates the following:

- The Claim Work Status is Updated to a P for Suppressed.
- The Claim Disposition is updated to A for Adjusted to Zero if there is a blank disposition. If there is a disposition already, it is retained.
- The Claim Index is updated to a 10 for Completed only if the claim is suppressed and the disposition is updated to A for Adjusted to Zero.

The Claim Disposition Date is updated to the current date if the claim disposition is updated to A for Adjusted to Zero.

3. CLAIM GENERATION PARAMETER (4-C-O)
This field contains the code (up to four characters) identifying the claim generation parameter for the selected patient type exceptions. You can enter the code or a hyphen (-) to display a list of valid codes.

4. PRIMARY CLAIM LOAD EDIT PARAMETER (3-C-R)
This field contains the code (up to three characters) identifying the primary claim load and edit parameter for the selected patient type exceptions. This parameter is used to load and edit a claim if this insurance is the primary insurance or if the insurance is secondary and fields 4-7 for Secondary Charge Control Parameter Secondary Claim Load Edit Parameter are not completed. The load and edit parameters determine what information is included or excluded on a claim, and what edits (required or not) are to be performed on the claim for all information except the charges, which are controlled by the charge control parameter.

Shared claims are valid only for UB claims. A shared claim indicates that this insurance plan's data is included on the UB form of the primary carrier and a separate claim form is not required for this carrier.

The primary plan's parameter is used for all carriers sharing a claim. You can enter the parameter code or a hyphen (-) to display a list of valid codes.

5. SECONDARY CLAIM LOAD/EDIT PARAMETER (3-C-O)
This field contains the code (up to three characters) identifying the secondary claim load and edit parameter for the selected patient type exceptions. The parameter is used to load and edit a claim if this insurance is a secondary plan for a patient. The exception to this is for CMS 1500 claim forms (claim type B). Insurances set to use claim type B for the CMS 1500 assign the Primary Claim Load and Edit Parameter to the most primary, or first, 1500 plan assigned to the account.

For example, if the accounts COB2 and COB4 plans are both CMS 1500 plans, the COB2 plan is assigned the primary parameters and the COB4 plan is assigned the secondary parameters. If the carrier requires a separate claim but the edits and information contained in the claim are the same as when the plan is primary, it is not necessary to complete this field since the system uses the primary parameter set in field 1. You can enter the code or a hyphen (-) to display a list of valid codes.

6. PRIMARY CHARGE CONTROL PARAMETER (3-C-R)
This field contains the code (up to three characters) identifying the primary charge control parameter used to load charges on a claim for the selected patient type exceptions. If this insurance is primary or if a separate claim is required for this insurance when it is secondary and field 4 is blank, this parameter determines the level of detail, what charges should be included on the claim, and whether HCPCS codes should be included. Refer to the UB and 1500 charge control parameters sections for additional information. The primary plan's parameter is used for all carriers sharing a claim. Only carriers that produce UB claims can share a claim. You can enter the code or a hyphen (-) to display a list of valid codes. Charge control parameters are not used for Canadian claims processing.

7. SECONDARY CHARGE CONTROL PARAMETER (3-C-O)
This field contains the code (up to three characters) identifying the secondary charge control parameter used to load charges on a claim for the selected patient type exceptions. The exception to this is for CMS 1500 claim forms (claim type B). Insurances set to use claim type B for the CMS 1500 assign the Primary Charge Control Parameter to the most primary, or first, 1500 plan assigned to the account. For example, if the account’s COB2 and COB4 plans are both CMS 1500 plans, the COB2 plan is assigned the primary parameters and the COB4 plan is assigned the secondary parameters.

This parameter determines the level of charge detail, what charges should be included on the claim, and whether HCPCS codes should be included. Refer to the UB and 1500 charge control parameters sections for additional information. Charge control parameters are not used for Canadian claims processing.

This parameter should be completed only if this insurance requires a separate claim, if it is a secondary carrier, and if the parameter to be used is different than the one specified in the Primary Charge Control Parameter field. You can enter the code or a hyphen (-) to display a list of valid codes.

8. PROVIDER NUMBER (22-AN-O)
This field contains the provider number at the insurance level for when the patient has the specified patient type exception. This field is used when the insurance is primary (COB 1) and secondary (COB 2-9), and when the Internal Element “Provider Number - Insurance Level” is used.

9. PROVIDER MASTER (TABLE LOOKUP)
This field contains the code for the Provider Master for the patient type exception.

10. ELECTRONIC MEDIA (TABLE LOOKUP)
This field contains the electronic media to use for the patient type exception.

Entry options are:

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

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

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

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

To send claims electronically, the Claim Media field in the Claim Load and Edit Parameters must be set to B (for Both Paper and Electronic), or E (for Electronic). Also, the Electronic Types field in the Claim Load and Edit Parameters must be set to the claims (Final, Cycle, Adjustment, Late, Reprint, or Tracer) that are to be sent electronically. The system sends claims to the paper spoolfile if they are not marked to send electronically in the Electronic Types field.

If a claim is submitted using electronic media, no paper claim 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 Produce Claim field contains Y (Yes).

11. PRINT ELECTRONIC CLAIM LABEL? (1-A-O)
This field indicates whether a claim mailing label should be printed for this insurance plan when the electronic claims are spooled in the system. Entry options are Y for Yes or N for No; the default is N. This field is only accessible if the Electronic Media field is set to Electronic Media A,B, C, D, E, or T.

12. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

13. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes this part of the transaction. The system then displays the fifth screen, which defines the pre-bill edit parameters defined for this plan.

Pre-Bill Edit Parameters

```
          General Hospital Billing/Claims Parameters Processor
               Pre-bill Edit Prm   Page  5 of  5  Tue Aug 03, 2004 12:13 pm
Carrier:AARP TYPE INSURANCE                       Facility :Model Hospital A
Plan   :GET A PLAN PLAN (AARP)                    Effective:Current
 1 Perform Pre-bill Edits              2 Final Bill if Pre-bill Edits
   Inpatient                          ->
 3 Perform Pre-bill Edits Pat Type Exceptions
   No
 4 Final Bill with Pre-bill Edits Pat Type Exceptions
   No
 5 Edit by                              6 Effective date
   New, Nancy                             08/03/04 12:12pm
```

Field Explanations - Screen 5 of 5

1. PERFORM PRE-BILL EDITS (TABLE LOOKUP-R)
This field identifies the patient indicators for which pre-bill editing occurs. When the field is accessed, the system displays the list of patient indicators for final bill if pre-bill edits are allowed. You can select one or more patient indicators for pre-bill editing, then press ENTER to return to the original screen.

2. FINAL BILL IF PRE-BILL EDITS (TABLE LOOKUP-R)
This field identifies the patient indicators for which final billing occurs when pre-bill edits exist. When this field is accessed, the system displays the list of patient indicators for final bill if pre-bill edits are allowed. You can select one or more patient indicators for pre-bill editing, then press ENTER to return to the original screen

3. PERFORM PRE-BILL EDITS PAT TYPE EXCEPTIONS (1-A-R)
This field is used to define patient types for which pre-bill edits are not performed. When this field is accessed, the system displays the following prompt:

Define Patient Types to not perform Pre-bill Edits (Y/N)--

You can enter **Y** for Yes to define patient type exceptions or **N** for No if there are no patient type exceptions to be defined. If you enter Y for Yes, the system displays a list

of carrier/plans defined to have pre-bill edits performed. You can select one or more patient type exceptions, then press ENTER to return to the original screen.

4. BILL W/ PRE-BILL EDITS - PATIENT TYPE EXCEPTIONS (1-A-R)
This field identifies the patient types that final bill when pre-bill edits exist. When this field is accessed, the following prompt is displayed:

Define Patient Types where Pre-bill Edits will prevent final billing (Y/N)--

You can enter **Y** for Yes to define patient type exceptions or **N** for No if there are no patient type exceptions to be defined. If you enter Y for Yes, the system displays a list of carrier/plans defined to have pre-bill edit performed. You can select one or more patient type exceptions, then press ENTER to return to the original screen.

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

6. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed.

Accepting this screen completes this transaction.

COLLECTION PARAMETERS

This function defines the insurance follow-up schedules and the payment and adjustment codes used for a specific insurance plan.

After this option and a facility are selected the following screen is displayed:

```
              General Hospital Collection Parameters Processor
              Collection Parameter Page  1 of  2 Tues Feb 17, 2001 01:12 pm
Carrier:BLUE CROSS                               Facility :General Hospital
Plan   :BLUE CROSS BASIC PLAN                    Effective:Current
 1 I/P Payment Transaction Code          2 O/P Payment Transaction Code
   I0003-BLUE CROSS I/P PAYMENT            I0004-BLUE CROSS O/P PAYMENT
 3 I/P Cont Adj Trans Code at Payment    4 O/P Cont Adj Trans Code at Payment
   A0030-I/P OTHER ALLOWANCES              A0031-O/P OTHER ALLOWANCES
 5 I/P Insurance Refund Trans Code       6 O/P Insurance Refund Trans Code
   D0001-INSURANCE REFUND                  D0001-INSURANCE REFUND
 7 I/P Primary F/U Sch Dollar Def        8 O/P Primary F/U Sch Dollar Def
   2-BLUE CROSS INSURANCE SCHEDULE         2-BLUE CROSS INSURANCE SCHEDULE
 9 I/P Secondary F/U Sch Dollar Def     10 O/P Secondary F/U Sch Dollar Def
   2-BLUE CROSS INSURANCE SCHEDULE         2-BLUE CROSS INSURANCE SCHEDULE
11 Collector Group
   1-COLLECTION GROUP
12 Edit by                              13 Effective date
   Owens,Julie M                           02/27/01 03:41pm

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

Field Explanations

1. I/P PAYMENT TRANSACTION CODE (4-N-R)
This field contains the inpatient transaction code (up to four digits) that is used when cash is posted for this insurance plan on a patient who has this insurance. The cash posting function for insurance cash uses the code during the insurance cash posting process. This code is then used to update the hospital's general ledger with the mapping table and to update the patient's transaction history. You can enter the transaction code or a hyphen (-) to display a list of valid codes.

2. O/P PAYMENT TRANSACTION CODE (4-N-R)
This field contains the outpatient transaction code (up to four digits) that is used when cash is posted for this insurance plan on a patient who has this insurance. The cash posting function for insurance cash uses the code during the insurance cash posting process. This code is then used to update the hospital's general ledger with the mapping table and to update the patient's transaction history. This field accepts a valid type I transaction code. You can enter the transaction code or a hyphen (-) to display a list of valid codes.

3. I/P CONT. ADJ. TRANS CODE AT PAYMENT (4-N-O)
This field contains the inpatient transaction code (up to four digits) used if contractual adjustments for this insurance plan are generated at the time of cash posting. This code is used to update the account's transaction history and generate a posting of this adjustment in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid transaction codes under transaction type A used for recording adjustments. If adjustments at time of cash posting are not done for this insurance plan, you should leave this field blank.

4. O/P CONT. ADJ. TRANS CODE AT PAYMENT (4-N-O)
This field contains the outpatient transaction code (up to four digits) used if contractual adjustments for this insurance plan are generated at the time of cash posting. This code is used to update the account's transaction history and generate a posting of this adjustment in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid transaction codes under transaction type A used for recording adjustments. If adjustments at time of cash posting are not done for this insurance plan, you should leave this field blank.

5. I/P INSURANCE REFUND TRANS CODE (4-N-R)
This field contains the inpatient transaction code recording any refunds made to this carrier plan in the account's transaction history and generating a posting in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid codes for transaction type D used for recording insurance refunds.

6. O/P INSURANCE REFUND TRANS CODE (4-N-R)
This field contains the outpatient transaction code recording any refunds made to this carrier plan in the account's transaction history and generating a posting in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid codes for transaction type D used for recording insurance refunds.

7. I/P PRIMARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition used if this insurance is the primary carrier for inpatient accounts under this plan. Insurance follow-up is initially scheduled when the final claim is submitted.

8. O/P PRIMARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition used for the primary carrier for outpatient accounts under this plan. Insurance follow-up is initially scheduled when the final claim is submitted.

9. I/P SECONDARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition used if this insurance is the secondary (non-primary) carrier for inpatient accounts under this plan. This schedule can be the same one used for the primary carrier or it can be different from the primary. Insurance follow up for secondary insurances are scheduled when the primary carrier's final claim is paid or times out.

10. O/P SECONDARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition used if this insurance is the secondary (non-primary) carrier for outpatient accounts under this plan. This schedule can be the same one used for the primary carrier or it can be different from the primary. Insurance follow-up for secondary insurances is scheduled when the primary carrier's final claim is paid or times out.

11. COLLECTOR GROUP (2-N-R)
This field contains the collection group code identifying the collection group assigned to this insurance plan. This collection group determines the collector assigned to this account for insurance follow-up for this insurance plan. Insurance collectors are assigned when the final claim is submitted.

12. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

13. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

When you have accepted this screen, the Patient Type Exceptions screen is displayed.

```
               General Hospital Collection Parameters Processor
              Coll Exceptions     Page  2 of  2  Wed Jun 17, 1998 01:38 pm
Carrier:BLUE CROSS                              Facility :General Hospital
Plan   :BLUE CROSS BASIC PLAN                   Effective:Current
                           Patient Type Exceptions
Page:01                          Patient Types              ##=Current Choices
( 1) ADV-Advance Admission Inpatient     (16) ST2-Contract STAR 2 Page
( 2) BED-Bed Reservation w/Folder        (17) STR-Contract STAR 2 Page W/Rad
( 3) CR1-C-Reg, Bill Client              (18) DIA-Dialysis Series Outpatient
( 4) CR0-C-Reg, Bill Patient             (19) ER-Emergency Room
( 5) CRE-C-Reg, Environmental            (20) ERQ-EMERGENCY ROOM QUICK ADMIT
( 6) CRP-C-Reg, Proficiency              (21) FAS-ER FASTRACK
( 7) CRR-C-Reg, Research
( 8) CRS-C-Reg, Single Occurence
( 9) CRV-C-Reg, Veterinary
(10) CNA-Cancel Admission with Orders-
(11) CSO-CARE SOUTH
(12) CON-Contract Account
(13) NSJ-CONTRACT PATIENT W/O PSEUDO
(14) ST1-Contract STAR 1 page
(15) STL-Contract STAR 1 Page w/Lab

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

For each Patient Type Exception you select, the following screen is displayed to allow you to enter the information for that Patient Type Exception.

```
               General Hospital Collection Parameters Processor
              Coll Exceptions     Page  2 of  2  Wed Jun 17, 2001 01:38 pm
Carrier:BLUE CROSS                              Facility :General Hospital
Plan   :BLUE CROSS BASIC PLAN                   Effective:Current
         Patient Type Exceptions for ADV - Advance Admission Inpatient
 1 Payment Transaction Code              2 Cont. Adj. Trans Code at Payment
->
 3 Insurance Refund Transaction Code

 4 Primary F/U Sch Dollar Definition     5 Secondary F/U Sch Dollar Definition

 6 Collector Group

 7 Edit by                                8 Effective date









Enter transaction code, or '-' for list --
```

Field Explanations

1. PAYMENT TRANSACTION CODE (4-N-R)

This field contains the transaction code (up to four digits) that is used when cash is posted for this insurance plan on a patient who has this insurance and patient type. The cash posting function for insurance cash uses the code during the insurance cash posting process. This code is then used to update the hospital's general ledger with the

mapping table and to update the patient's transaction history. You can enter the transaction code or a hyphen (-) to display a list of valid codes.

2. CONT. ADJ. TRANS CODE AT PAYMENT (4-N-O)
This field contains the transaction code (up to four digits) used if contractual adjustments for this insurance plan and patient type are generated at the time of cash posting. This code is used to update the account's transaction history and generate a posting of this adjustment in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid transaction codes under transaction type A used for recording adjustments. If adjustments at time of cash posting are not done for this insurance plan and patient type, you should leave this field blank.

3. INSURANCE REFUND TRANSACTION CODE (4-N-R)
This field contains the transaction code recording any refunds made to this carrier plan in the account's transaction history and generating a posting in the General Ledger. You can enter the code or a hyphen (-) to display a list of valid codes for transaction type D used for recording insurance refunds.

4. PRIMARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition used for the primary carrier for accounts under this plan and patient type. Insurance follow-up is initially scheduled when the final claim is submitted.

5. SECONDARY F/U SCH DOLLAR DEFINITION (3-N-R)
This field contains the code (up to three characters) identifying the insurance follow-up dollar definition used if this insurance is the secondary (non-primary) carrier for accounts under this plan and patient type. This schedule can be the same one used for the primary carrier or it can be different from the primary. Insurance follow up for secondary insurances are scheduled when the primary carrier's final claim is paid or times out.

6. COLLECTION GROUP (2-N-R)
This field contains the collection group code identifying the collection group assigned to this insurance plan and patient type. This collection group determines the collector assigned to this account for insurance follow-up for this insurance plan and patient type. Insurance collectors are assigned when the final claim is submitted.

7. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

8. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

Accepting this screen completes this transaction.

LOG IDS

NOTE: CN: This function does not apply to Canadian users because logs are not maintained for Canadian claims.

This function enables you to assign log identifiers for third party logs to this insurance plan and controls when and what log should be updated.

After a facility and this option is selected, the system prompts you to enter a Log Identifier. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered or selected, this screen is displayed.

```
        General Hospital Log Id's Processor
                Log Identifiers                  Sat Oct 28, 1997 02:49 pm
Carrier:COLUMBIA HEALTH                          Facility :PROVIDENCE MEDICAL C
Plan   :COLUMBIA HEALTH                          Effective:Current
 1 Log Identifier
   22-COLUMBIA HEALTH
 2 Carrier Status                    3 In/Out/Emergency/All patients
   Primary Only                        All
 4 Excluded patient types

 5 Edit by                                    6 Effective date









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

Field Explanations

1. LOG IDENTIFIER (DISPLAY ONLY)
This field contains the code identifying the Log ID. After you enter or select the code, the system displays the description.

2. CARRIER STATUS (1-A-R)
This field indicates the status the carrier must have for patients using this plan to be included in the log. Entry options are **A** (any), **P** (primary carrier only), or **S** (secondary).

3. IN/OUT/ALL PATIENTS (1-A-R)
This field indicates which patients using this plan should be included in this log. Entry options are I (inpatients only), O (outpatients only), or A (all patients); the default is A.

4. EXCLUDED PATIENT TYPES (TABLE LOOKUP)
This field contains the patient types that should be excluded from this log. When you access this field, the system displays a list of patient types. The ones that are

highlighted are those that have already been selected for exclusion from this log. You can add to the list or delete selections.

For example, if you want to set up a primary carrier log for renal dialysis patients for this carrier plan, you would follow the steps below:

- Identify a Log ID in the Maintain Log ID table.
- Enter **P** (primary carrier only) in the Carrier Status field.
- Enter **O** (outpatients only) in the In/Out/All Patients field.
- Exclude all outpatient patient types except renal in the Excluded Patient Types field.

5. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

6. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

REIMBURSEMENT

If an insurance carrier has special payment arrangements with the hospital, the specifics of those arrangements are defined through the reimbursement tables. This function ties these special arrangements to an insurance plan.

The reimbursement tables should be completed only if the hospital wishes to do automatic contractual write-offs at final bill time and/or the hospital wants special reporting before an account bills on the expected reimbursement. Examples of reimbursement are listed below:

- Medicare - DRG
- Medicaid - (flat rate per day)

Three screens are involved with this function. The first screen deals with inpatients, the second deals with outpatients, and the third deals with patient type exceptions. Because the screen layout is identical for the three, the fields are defined once.

NOTE: When you access the third screen, the system displays a table listing patient types.

After this option is selected, the system prompts you to select the facility for which the fields are defined or updated.

The following screen is displayed:

```
               General Hospital Reimbursement Processor
               Inpatients         Page  1 of  3  Fri May 16, 2003 09:09 am
Carrier:COLUMBIA HEALTH                          Facility :ALL
Plan   :COLUMBIA HEALTH                          Effective:CURRENT
Patient type: Inpatients

 1. Post. Cont. Adj. at Bill             2. Reimbursement Master Payor
    Yes                                     CM-Pathways Contract Management
 3. Reimbursement Type                   4. Contractual Adj. Transaction Code
    I-PCON by Bill                          A0001-I/P MEDICARE PART A ALLOWANCE
 5. Reimbursement Type                   6. Contractual Adj. Transaction Code

 7. Reimbursement Type                   8. Contractual Adj. Transaction Code

 9. Reimbursement Type                  10. Contractual Adj. Transaction Code

11 OPPS Cont. Adj.                      12.  Pass-through
                                             Yes
13. Edit by                             14.  Effective date
   Marsh, Nancy                              05/16/03 01:24pm




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

Field Explanations

1. POST CONT. ADJ. AT BILL (1-A-R)
This field indicates whether contractual adjustments should be posted when the bill is produced. Entry options are **Y** for Yes or **N** for No; the default is N. If you enter N and you complete the other fields on this screen, the results of Reimbursement are shown on the Financial Review Reporting.

2. REIMBURSEMENT MASTER PAYOR (2-A-C)
This field contains the code identifying the reimbursement payor for this insurance plan. You can enter the code or a hyphen (-) to display a list of valid codes from the Reimbursement Payor table. This table contains the payors who have special reimbursement arrangements with the hospital. This field is required if you entered Y to the Post Cont. Adj. At Bill field.

Reimbursement Types and Contractual Adjustments

Because carriers may reimburse charges at different rates depending on the basis of coverage, the system enables you to enter up to four different reimbursement types (per patient indicator or patient type) used by the insurance in determining reimbursement. Reimbursement types are predefined and include:

- A - ASC Payment Group
- D - ICD-9-CM Diagnosis code

- P - ICD-9-CM Procedure code
- G - DRG Code
- M - Medical Service
- O - Overall Plan
- I - PCON by Bill
- H - Medicare Outpatient Prospective Payment System (OPPS)
- J - PCON by Claim
- L - DRG+ALT Level Care
- Q - Claim Amount
- R - Alternate Price

These reimbursement types must be defined in the payor table for the reimbursement payor in order to use them. Each reimbursement type entered has a transaction code associated with it.

The reimbursement fields are updated in order of their hierarchy. For example, a diagnosis code, procedure code, and medical service exceptions are set up for a particular payor. The order in which the types are placed on this screen is how the system checks whether the values of the patient's diagnosis code matches with what is set up in the reimbursement arrangement table. If they do not match the procedure exceptions are checked on and so on.

3. REIMBURSEMENT TYPE (TABLE LOOKUP)
This field contains the basis on which this plan reimburses the hospital. When you access this field, the system displays the reimbursement types defined for the payor. For the Pathways Contract Management system to calculate the reimbursement amount, this field must contain one of the following reimbursement types:

NOTE: Setting the UB PCON Release field to 8.0 on the Pathways Contract Management Parameters from the Interface menu acts as the trigger to convert the I reimbursement type to PCON by Bill and the J reimbursement type to PCON by Claim. In Midnight Processing, on the day the UB PCON Release field is updated to 8.0, the field descriptions are updated. The updated descriptions on the reimbursement types reflect that the Pathways Contract Management interface is now claim driven and claim driven information is sent to Pathways Contract Management for the J reimbursement type.

- **I (PCON by Bill)**—In order to use this reimbursement type, it must first be defined in the payer table definition for the reimbursement payer. The claim type form must be UB. The claim type is entered on the Claim Information page of the insurance plan. If this is not a UB claim form, the following message is displayed on your screen: *Claim Type must be UB*.

  NOTE: This value must be set to I for the carrier/plan to be processed as bill-based. "Bill-based" means that for each final, adjustment or late bill created on STAR, only one event is sent to Pathways Contract Management. Split claims for the primary carrier are not sent to

Pathways Contract Management and interim cycle bills are not sent to Pathways Contract Management.

- **J (PCON by Claim)**—In order to use this reimbursement type, it must first be defined in the Payor table definition for the reimbursement payor. The claim type is entered on the Claim Information page of the insurance plan. If it is not defined in the payer table definition, the following error message is displayed on your screen: *Error: This type not defined for this paye*r. The claim type form must be UB Medi-Cal or UB. If this is not a UB or UB Medi-Cal claim form, **J** cannot be selected, and the following message is displayed on your screen: *Claim Type must be UB or Medi-Cal UB for PCON/Cycle*.

NOTE: For J (PCON by Claim) reimbursement type, specific fields and records in the source file sent to Pathways Contract Management are extracted directly from the claim. Payments and adjustments sent to Pathways Contract Management in the activity file is associated directly with a claim, not just associated with the primary carrier. Contractual adjustments returned from Pathways Contract Management to Patient Accounting is claim-specific. Added claims and claims edited for resubmission are sent to Pathways Contract Management.

The **Post Cont. Adj. at Bill** field must be set to Yes to allow the Reimbursement type to be set to J (PCON by Claim). If the field is not set to Yes, the following message is displayed on your screen: *Error: Must post contractual at bill if PCON/ Cycle reimbursement type*.

If you select J (PCON by Bill) or I (PCON by Claim) as the reimbursement type, the other Reimbursement Type fields on the screen cannot be used.

NOTE: This value must be set to J for the carrier/plan to be processed as claim-based. Split claims and interim cycle bills are sent to Pathways Contract Management if the reimbursement type is J (PCON by Claim).

4. CONTRACTUAL ADJ. TRANSACTION CODE (4-N-R)

This field contains the transaction code associated with the reimbursement type entered in the Reimbursement Type field. This code is used to update the account's transaction history and the General Ledger when an adjustment is made on the account. You can enter the code or a hyphen (-) to display a list of valid transaction codes under transaction type A. This field is required if the Reimbursement Type field is completed.

FIELDS 5 - 10

These fields are for additional Reimbursement Types and Contractual Adj. Transaction Codes.

11. OPPS CONT. ADJ. (1-A-R)
This field indicates whether a contractual adjustment should be posted per claim for the primary insurance plan at the time the 3M interface returns an expected reimbursement on the claim. Entry options are Y for Yes or N for No.

12. PASS-THROUGH (DISPLAY ONLY)
This field indicates if primary UB claims should be sent to Pathways Contract Management as pass-through claims.

Valid values are Y for Yes, send pass-through claims to Pathways Contract Management and N for No, do not send pass-through claims to Pathways Contract Management. The value of this field is dependent on the Pass-through field on the Payor Table Definitions Processor for the associated Reimbursement Master Payor Code and Reimbursement Type combination. For example, for Reimbursement Master Payor Code equal to MC and Reimbursement Type equal to G-DRG, if the Pass-through field on the Payor Table Definition Processor is set to Yes, then this field is set to Yes.

An update to this field on the Payor Table Definitions Table for a payor code/ reimbursement type automatically updates the insurance that is associated with the payor code/reimbursement type. An update to the Pass-through field on the Payor Table Definitions Table does not automatically update the insurance associated with existing accounts and claims.

When the fields on this screen are completed, another identical screen is displayed. The purpose of this second screen is to provide you the opportunity to enter reimbursement parameters for outpatients using this plan. A third screen, also identical to the first, is displayed after the second is completed so patient type exceptions to this plan's reimbursement parameters can be entered. Completing the fields on this third screen completes the transaction.

Dependent On	Reference
Accommodations *	
Claim Attachments	
Billing Groups	
Billing Parameters	
Claim Generation Parameters	
Claim Load and Edit Parameters	
Claim Types	
Collection Groups	
1500 Charge Control Parameters	
Financial Class	

Dependent On	Reference
Hospital Service *	
ICD-9-CM	
Insurance Follow-up Schedules	
Insurance Plan	
Patient Type	
Proration Summary Code	
Providers	
Payor Definition Table	
Reimbursement Payor Code	
Source of Payment	
Third Party Log ID	
Transaction Codes	
UB Charge Control Parameters	
UB Revenue Codes/Insurance Summary Codes	
* This table is a STAR Patient Care table.	

CLAIM ATTACHMENTS

This transaction enables you to identify attachments that must accompany a claim for this plan. These attachments (for example, an Admission Summary, EKG Certification, or Discharge Summary) can be required by specific carriers and specific plans when a claim is submitted. The codes are maintained in the Claim Attachment table. Claims fail edits until required attachments are marked as being received.

After this option is selected, the system displays the screen below.

```
               General Hospital Attachments Processor
               Attachments                      Sat Oct 28, 1997 02:45 pm
Carrier:COLUMBIA HEALTH                         Facility :All
Plan   :COLUMBIA HEALTH                         Effective:Current
Page:01
( 1) CT-CT REPORT
( 2) ER-ER REPORT
( 3) HP-HISTORY & PHYSICAL/DISCHG SUMM
( 4) LR-LAB REPORT
( 5) SN-MEDICARE SNF SUPPLEMENT
( 6) MH-MENTAL HEALTH NOTES
( 7) MR-MRI REPORT
( 8) VR-NON-INVASIVE VASCULAR LAB REPT
( 9) OT-OT PROGRESS NOTES
(10) PA-PACEMAKER FORM
(11) PC-PRIMARY CARE CLINIC NOTES
(12) PT-PT PROGRESS NOTES
(13) ST-ST PROGRESS NOTES
(14) SR-SURGERY REPORT
(15) US-ULTRASOUND REPORT
(16) XR-X-RAY REPORT

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

This screen contains a list of the Claim Attachment codes/descriptions assigned to the insurance plan. You can select one of these or enter **A** to add an attachment code. If you enter **A**, a screen listing valid billing attachment codes is displayed. The codes that are currently assigned to this insurance plan are highlighted. The information on this screen serves as an example only. The attachments used by your hospital may be different.

After you select an attachment code and facility, the following screen is displayed:

```
          General Hospital Attachments Processor
               Attachments                      Sat Oct 28, 1997 02:45 pm
Carrier:COLUMBIA HEALTH                         Facility :All
Plan   :COLUMBIA HEALTH                         Effective:Current
 1 Attachment                                          2 In/Out/All patients
   CT REPORT                                             All
 3 Excluded patient types
   I/P,ADM
 4 Edit by                                       5 Edit date

Page:01                          Patient Types              ##=Current Choices
( 1) C1-CONTRACT - ONE PAGE               (11) OBV-OUTPATIENT OBSERVATION
( 2) C1D-CONTRACT - ONE PAGE DEMO/LAB     (12) OPS-OUTPATIENT SURGERY
( 3) C1L-CONTRACT - ONE PAGE W/LAB        (13) PRA-PREADMISSION - INPATIENT
( 4) C2-CONTRACT - TWO PAGE               (14) PRR-PREADMISSION - OUTPATIENT
( 5) C2R-CONTRACT - TWO PAGE W/RADIOLO    (15) PAT-PREADMISSION TESTING - INPATI
( 6) DAJ-DAJ - TEST PATIENT TYPE UPDAT    (16) OPT-PREADMISSION TESTING - OUTPAT
( 7) E/R-EMERGENCY ROOM                   (17) PSY-PSYCHIATRIC OUTPATIENT
( 8) I/P-INPATIENT                        (18) SER-SERIES
( 9) ADM-INPATIENT - NO BED ASSIGNMENT
(10) ADV-INPATIENT ADVANCE ADMISSION

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

Field Explanations

1. ATTACHMENT (TABLE LOOKUP)
This field contains the description of the selected attachment code.

CN: An attachment of HIGHER PRIORITY UNIV/WCB INS can be used for the Universal (Claim type K) insurance plans to fail the claim if there is a higher priority Universal or WCB (Claim type W) insurance.

2. IN/OUT/ALL PATIENTS (1-A-R)
This field indicates which patients should receive this attachment notification in claims. Entry options are **I** (inpatient only), **O** (outpatient only), or **A** (all patients); the default is **A**.

3. EXCLUDED PATIENT TYPES (TABLE LOOKUP)
This field contains the patient types that should be excluded from receiving this attachment notification in claims. This field is required and should be completed if certain patient types should be excluded, based on your entry to the In/Out/All Patients field.

For example, if the In/Out/All Patients field contains **I** (inpatients only), it is not necessary to exclude any outpatient types since the value in the field has already excluded them. However, if there are specific inpatient types that are excluded, this field allows you to do so. If, for example, an attachment code is defined for a Renal Dialysis outpatient only, the In/Out/All Patients field should contain **O** and this field should contains all outpatient patient types except renal. Once your selections are made, the system displays these patient type exceptions in this field.

4. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this screen. This field is updated only when a field has been changed.

5. EFFECTIVE DATE (DISPLAY ONLY)
This field contains the date that the screen was changed. This field is updated only when a user makes a change or schedules a change.

Denial Tracking - Insurance Carrier/Plan

This function is used to associate a denial tracking payor group with the insurance carrier/plan. If you try to enter denial information for an insurance plan whose claim type is not UB or Medi-Cal UB, the following error message is displayed:

For Denial tracking the claim type must be UB or Medi-Cal UB!

After this option is selected, the system prompts you to select the facility for which the fields are defined or updated. The following screen is displayed:

```
                General Hospital Denial Tracking Processor
              Insurance Plan                      Tues Jun 24, 2003 11:35 am
Carrier:AARP TYPE INSURANCE                       Facility :Model Hospital A
Plan   :GET A PLAN PLAN (AARP)                    Effective:Current

 1 Denial Tracking Payor Code          2 Denial Tracking Reason Group
->
 3 Edit by                             4 Edit date
   Rogers, Amy                           06/24/03 11:09
```

Field Explanations

1. DENIAL TRACKING PAYOR CODE (4-AN-R)
This field is used to establish the link between the insurance plan and denial management. If this field is not defined, denials are not captured for this insurance carrier/plan. When the field is accessed, the Denial Tracking Payor Table is displayed. Select the Denial Tracking Payor Code for the insurance plan.

2. DENIAL TRACKING REASON GROUP (DISPLAY ONLY)
This field displays the name of the reason code group that is used for this insurance carrier/plan. The denial tracking reason group that displays is the one associated with the Denial Tracking Payor Code defined in the Denial Tracking Payor Code field. The reason group contains the denial code set associated with this insurance/carrier plan.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this code was last edited.

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

INSURANCE PLAN COVERAGE COPY

You can copy coverage information from one plan to up to 50 others. To do so, choose the Insurance Plan Coverage Copy from the Master File Maintenance screen. The system displays the following prompt:

Enter FROM carrier code or '-' for a list --

You can select only one FROM carrier at a time. The system displays the following prompt:

Enter FROM plan code or '-' for a list --

After the carrier and plan are selected, the system displays the following prompt:

Enter choice (e.g. 1, 7, 5-9 or '-') choices to remove --

You can select up to 50 TO carriers at a time. Only active plans can be selected. After you select a carrier or carriers, the system displays the following prompt:

Enter choice (e.g. 1, 7, 5-9 or '-') choices to remove --

You can highlight numerous TO plans with the TO carrier(s) selected. The system displays the following screen:

```
          General Hospital Insurance Plan Coverage Copy Processor
                                                Wed Apr 30, 2003 09:29 am



Copy From:
Carrier:COMMERCIAL                              Facility :All
Plan   :1500 BASIC PLAN                         Effective:Current

Copy to: 200100,300200,400600
Page:01                        Coverage Options             ##=Current Choices
( 1) Basic Coverage                     ( 9) Attachments
( 2) Room Coverage                      (10) Billing/Claim Parameters
( 3) Ancillary Coverage                 (11) Collection Parameters
( 4) Major Medical Coverage             (12) LOG ID's
( 5) Daily/Blood Deductibles            (13) Reimbursement
( 6) Flat Rate Coverage                 (14) Denial Tracking
( 7) Summary Code Exceptions
( 8) Plan Comments



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

Select the coverage options that should be copied from the table. The system prompts you for the individual components rather than prompting for all of the coverage options. When copying one plan to another, the system prompts for the facility information if the coverage option selected is facility-specific (Billing/Claim parameters, Collection parameters, Log IDs, Reimbursement, Claim Attachments, and Denial Tracking).

For the following options to process, these conditions must be met:

- If the Billing and Claims parameters and/or the Collection parameters are selected and the FROM plan does not contain information in these tables for a particular facility, the system displays the following prompt:

  Incomplete data for Facility C for FROM plan. Collection, Claim Process, Claim Parm, Billing. Press NL.

- For the Denial Tracking option, the claim form type must be UB or Medi-Cal UB and the reimbursement information must be defined to send claims to Pathways Contract Management for reimbursement calculation or as pass-through claims to Pathways Contract Management. The Denial Tracking option can be used to copy the Denial Tracking Payor for an insurance plan before Denial Tracking is activated. When the Pathways Contract Management interface is used for denials, the Denial Tracking information is not used until Denial Tracking is activated with Pathways Contract Management and the reimbursement information is defined to send information to Pathways Contract Management or to Pass-through Pathways Contract Management. The copy function does not prevent copying information in this scenario even if the reimbursement information does not dictate that claim information be sent to Pathways Contract Management or to Pathways Contract Management Pass-through so the insurance coverage information can be pre-defined.

You can continue or exit the process and begin again. If you choose to continue, the system displays the following prompt:

Copy (I)npatient, (O)utpatient, (P)atient type exceptions, or (A)ll coverage information -- [All]

Enter **A** or press ENTER to copy all of the selected coverage options to the TO plan(s) and completely replace the TO plan(s) with the FROM plan information for the selected coverage options. After the copy is complete, the values for the plans are identical, including the patient types that are set up as exceptions. Enter **I** to copy only the inpatient screens of the selected coverage options of the FROM plan to the inpatient screens of the TO plan(s). Enter **O** to copy only the outpatient screens of the selected coverage options of the FROM plan to the outpatient screens of the TO plan(s). Enter **P** to copy all patient type exceptions defined on the selected coverage options of the FROM plan to the patient type exceptions of the TO plan(s). If you choose **P**, the TO plan(s) patient type exceptions are completely replaced if the attachment exists for the TO plan(s). If the FROM plan has exceptions that the TO plan does not have, those exceptions are added to the TO plan(s). If the TO plan has exceptions that the FROM plan does not, those exceptions are not changed.

Any attachments on the insurance plan is copied from the FROM plan to the TO plan regardless of the patient indicators specified.

If the user selects Patient Type Exceptions and the options being copied include denial tracking, the following message is displayed:

Patient type exceptions do not exist for Denial Tracking!"

If someone is using the Pathways Contract Management Denial Management or Pass-through and copies denial information to an insurance plan not using Pathways Contract Management Denial Management or Pass-through, no denial tracking occurs.

When the system is copying the information, it displays a processing message. When the copy is complete, the system displays *Filed!*

If you want to copy one plan to only one other, refer to the Copy Coverage Information Function in the Insurance Plan Coverage section.

REIMBURSEMENT MASTER

The Reimbursement Master provides the following functions for each payor in the system:

- Payor Table Definition
- DRG Rate Table Generation *
- DRG Rate Master *
- ICD Diagnosis Codes **
- ICD Procedure Codes **
- Medical Services **
- Overall Plan **
- Pathways Contract Management
- ASC Payment Group **
- Alternate Level of Care
- Alternate Price
- Print Reimbursement Table
- Other Payor Code for DRG Mapping

***** STAR Patient Care functions. Please refer to the STAR Patient Care Medical Records Abstracting book for more information.

****** Payor Arrangement Tables.

Payor Table Definition

This table enables the hospital to indicate specific effective from and through dates for the payor selected under the reimbursement type.

After selecting this function from the Reimbursement Master menu, the system prompts you to enter a Payor Code. The third party payor code entered here must be in the Reimbursement Payor table in order for this function to be valid. You can enter the code or a hyphen (-) to display a list of valid codes. After you enter or select a code,

the system prompts you to select or add a payor reimbursement type from the displayed list. The reimbursement types available in the system are:

Code	Description
D	ICD Diagnosis Code
M	Medical Service
O	Overall Plan
P	ICD Procedure Code
S	Specified DRG Codes
C	Major Diagnostic Category
G	DRG
I	PCON by Bill
A	ASC Payment Group
H	Outpatient Prospective Payment System (OPPS)
J	PCON by Claim. This code is available only if I-PCON by Bill has already been selected.
L	DRG+ALT Level Care
V	British Columbia Out of Province
N	Nova Scotia Out of Province
Q	Claim Amount
B	PCON 1500
R	Alternate Price

CN: The NS OOP (Nova Scotia Out of Province) reimbursement type does not allow for any setup, so it is not displayed in the list of available reimbursement options. However, it can be selected in the Payor Table Definition, in order to attach the payor to the insurance plan. The reimbursement works as follows: This reimbursement type is valid only for accounts which have a claim type 5 attached to the insurance carrier/plan. When reimbursement type N - Nova Scotia OOP is attached to an insurance plan, accounts with charges not selected to be included on the out of province diskette and not identified in the NS Misc Parameters as excluded from the calculation, can create a contractual Adjustment. Contractual adjustments are calculated for each bill evaluated for inclusion on the diskette.

After a reimbursement type is selected, the following screen is displayed.

```
            General Hospital Payor Table Definition Processor
                                                  Fri Jul 25, 2006 02:22 pm
Payor: APC TEST
Reimb. Type: DRG
 1 Effective Date Type  2 Edited By                  3 Edit Date
   Discharge            Main, Bill                    01/23/03 04:22pm
4 Pass-through  5 I/P Rmb Calc Meth   6 O/P Rmb Calc Meth  7 OPPS Indicator
                ->
8 Table Definitions

Table Effective Effective Post Reimb. Post Contr'l  Edited By     Edit Time
 #    From      Thru      > Charges   by Dept.
 001 01/01/2001 12/01/2001   Yes        No      Main, Bill      01/23/03 04:22p









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

Field Explanations

1. EFFECTIVE DATE TYPE (1-A-R)
This field contains the effective date of the coverage. Entry options are **A** (admission) or **D** (discharge). The effective date type is used to select the proper table for a patient.

If you enter A (admission date effective), the patient admission date is used to ensure it falls in date range for the table. If it does, the system uses that table; if it does not, the system checks to determine if there is another table for the payor and reimbursement type with the necessary effective dates.

If you enter D (discharge date effective), the patient discharge date is used. If the patient is not discharged, today's date, if the account was prorated on-line, or the midnight processing date, is used to ensure it falls in the date range for the table.

2. EDITED BY (DISPLAY ONLY)
This field contains the name of the user who last edited this code.

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

4. PASS-THROUGH (1-A-R)
This field indicates whether primary UB claims should be sent to Pathways Contract Management as pass-through claims. When this field is accessed, the following prompt is displayed:

Send pass-through UB claims to PCON (Y/N)?—[N]

Entry options are **Y** for Yes, send pass-through claims and **N** for No, do not send pass-through claims. A blank value is equal to No, do not send pass-through claims to Pathways Contract Management. The field defaults to No, do not send pass-through claims.

NOTE: An update to the Pass-through field does not automatically update existing accounts and claims. If the Payor Table Definitions Processor is updated, an account retains the pass-through value that is associated with it. To update an account and associated claims with the current pass-through value in the Payor Table Definitions processor, the insurance must be revised. For example, if the insurance was resequenced on an account, the pass-through value associated with the new primary insurance is associated with the account. To update claims to be pass-through claims, an adjustment bill must be requested for the account and new claims must be loaded. Claims that load for the primary insurance are marked as pass-through claims if the insurance for the account was marked as pass-through.

5. I/P RMB CALC METH (1-A-O

This field is used to indicate, for inpatients, potential values for the STAR Calculated Reimbursement Method field on the insurance plan reimbursement screen for inpatients, on the insurance plan reimbursement screen for patient type exceptions for inpatients, and on an account's insurance plan reimbursement screen when the patient type for the account indicates inpatient.

6. O/P RMB CALC METH (1-A-O

This field is used to indicate, for outpatients, potential values for the STAR Calculated Reimbursement Method field on the insurance plan reimbursement screen for outpatients, on the insurance plan reimbursement screen for patient type exceptions for outpatients, and on an account's insurance plan reimbursement screen when the patient type for the account indicates outpatient.

7. OPPS INDICATOR (1-A-O)

This field is used to indicate whether the reimbursement method is OPPS or TRICARE. When this field is accessed, the following prompt is displayed:

Enter (O)PPS or (T)ricare reimbursement method--

You can enter O for OPPS/APC reimbursement method or T for TRICARE. The default is OPPS/APC. For TRICARE reimbursement method payers, the system does not take an automatic contractual adjustment. Also, even if you set this field to O for OPPS, but the 3M Core Grouping Software with APC's sends back a Type of Payment (output field paytype) for TRICARE, the STAR system does not take an automatic contractual adjustment.

8. TABLE DEFINITION (22-AN-R)

This field contains the table number and effective dates of the plan, indicates whether reimbursement charges should be posted when the reimbursement is greater than the liability and indicates if contractuals should be posted by department.

The table number is assigned by the user. McKesson recommends putting the tables in numerical order starting with 001. If tables exist and you want to change them, select the desired table from those displayed.

After the table number is entered or selected, enter the effective from and through dates for the table. If more than one table is defined for a payor and particular reimbursement type, the effective date cannot overlap. An error message is displayed and you are returned to the last table edited. If there are gaps in the table definition effective dates, an informational message is displayed.

After the dates are entered, indicate whether a contractual adjustment should be set up for this payor if reimbursement exceeds covered charges. The default for this field is Y for Yes.

Multiple dates can be entered by using the INSERT key to add dates prior to the ones already existing in the table. After the dates are entered, indicate whether a contractual adjustment should be set up for this payor if reimbursement exceeds covered charges. The default for this field is Y for Yes.

If this field is set to Y, and, for example, covered charges for the patient are $550.00, the reimbursement is a daily per diem of $450.00, and the patient stayed two days, a contractual adjustment of $350.00 (debit) is done.

If this field is set to N for no, no contractual adjustment is done since the reimbursement amount of $900.00 is greater than the covered charges of $550.00.

When you enter this field, the system displays the operations associated with the function keys at the bottom of this screen. From here you can go to a previous page (F1), insert (F3) or delete (F4) a line, reset the table (F6) if you make an error, and exit (F7) when you are finished to save your changes. As you exit, payor tables are sorted and displayed by effective date. This completes the transaction.

British Columbia Out Of Province

This table is used by British Columbia customers to define the out of province reimbursement type.

After selecting this function from the Reimbursement Master menu, the system prompts you to enter a Payor Code. The third party payor code entered here must be in the Reimbursement Payor table in order for this function to be valid. You can enter the code or a hyphen (-) to display a list of valid codes. After you enter or select a code, the system prompts you to select or add a payor reimbursement type from the

displayed list. After you enter or select a payor reimbursement type, the following screen is displayed:

```
            General Hospital Reimbursement Table Maintenance Processor
                                                  Tue Aug 9, 2004 01:20 pm
Payor: OTHER PROVINCE             Table: 010 From: 2001/01/01 Thru: 2004/12/31
Reimb. Type: Out of Province
 1 Code-Description   2 Maximum Reimbursement Amount    3 Inpatient Per Diem
   V-Out of Province      Unlimited                                    $500.00
 4 Svc Code Items      5 Edited By                                 6 Edit Date
->                       New, Nancy                               04/03/25 14:00
Service Code/Description   Reimb Amount I/P  Edited By             Edited Date
01 OUTPATIENT VISIT            $75.00      N    Means, Tom          04/03/25 14:14
02 INPATIENT VISIT             $75.00      Y    Means, Tom          04/03/29 14:20



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

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)
This field contains the code and description of the selected reimbursement type (Out of Province).

2. MAXIMUM REIMBURSEMENT AMOUNT (10-AN-R)
This field contains the maximum reimbursement amount this payor reimburses the hospital on a per case basis. The range is from $0 to $99,999,999.99, or **U** for Unlimited.

3. INPATIENT PER DIEM (10-AN-R)
This field contains the per diem rate this payor reimburses the hospital on a per case basis for inpatients. The range is from $0 to $99,999,999.99, or **U** for Unlimited

4. SERVICE CODE ITEMS (TABLE LOOKUP)
After this option is selected, the system allows you to define reimbursement amounts by out of province service code.

5. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this reimbursement code.

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

When these fields are completed, you have the option of accepting or editing the information on the screen

ICD Diagnosis and Procedure Codes, Medical Services, Overall Plan

These functions are used to define and maintain payment arrangements between the hospital and a third party payor.

NOTE: Since the mechanics for using these functions are very similar, they are explained collectively.

For payor-specific reimbursement, the diagnosis and procedure codes and the medical service indicate that arrangements were made for a specific diagnosis, procedure, or medical service. If the arrangement is not based on any of the above, the overall plan type should be used.

For example, an agreement was reached such that the hospital is paid a per diem rate of $450.00 per patient. If the patient is a surgical patient, agreement that the per diem is $475.00 was reached. If the patient comes in for a normal delivery, the per diem is $485.00. If the patient comes in for open heart surgery, the per diem is $750.00.

Therefore:

- The $450 per diem is entered in the Overall Plan.
- The $475 is a medical service exception.
- The $485 is a diagnosis code exception.
- The $750 is a procedure code exception.

After selecting any of these functions, the system prompts you to enter a payor code and the number of the payor table for which payment arrangements are to be entered or edited. The table you select must already be established in the system (through the Payor Table Definition function).

If you are working with ICD Diagnosis codes, ICD Procedure codes, or Medical Services, the system prompts you to select the diagnosis, procedure, or service for which this payment arrangement is being defined or edited. You can enter the code or a hyphen (-) to display a list of valid codes.

After the above information is entered or selected, the following screen is displayed.

```
          General Hospital Reimbursement Table Maintenance Processor
                                                  Sun Mar 27, 2009 01:20 pm
Payor: COMMERCIAL REIMBURSE PAYOR CTable: 002 From: 01/01/1992 Thru: 12/31/1996
Reimb. Type: ICD Diagnosis Code
 1 Code-Description                              2 Stop Loss Table
   1234 DIPHYLLOBOTHRIAS INTEST
 3 Maximum Reimbursement Amount   4 Calculation Method      5 Flat Rate Amount
          $20.00                    C-Charge Level
 6 Day/Charge Range  7 Edited By                          8 Edit Date
                        New, Nancy                          08/13/03 12:40pm
   Thru Chg $  %/A  Reimbursement      Edited By               Edit Time
 Unlimited    Amt        $1,000.00     Andrews, Bob            03/14/09 11:50am









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

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)
This field contains the code and description of the reimbursement type (Overall Plan) or the description of the exception category (ICD Diagnosis Codes, ICD Procedure Codes, Medical Services) selected.

2. STOP LOSS TABLE (DISPLAY ONLY)
This field identifies this table as a Stop Loss table. If Yes is displayed in this field, this table is stop loss; if this field is blank, this is not a stop loss table.

3. MAXIMUM REIMBURSEMENT AMOUNT (10-AN-R)
This field contains the maximum reimbursement amount this payor reimburses the hospital on a per case basis. The range is from $0 to $99,999,999.99, or **U** for Unlimited.

4. CALCULATION METHOD (1-A-R)
This field contains the reimbursement calculation method used to calculate the reimbursement amount for this category. Entry options are **F** (flat rate), **D** (per day), or **C** (charges).

If you enter F in this field, you must enter the amount of the single, flat rate payment in the Flat Rate Amount field.

If you enter D in this field, you must enter the amount of the per diem and the through days in the Day/Charge Ranges field.

If you enter C in this field, you must enter the amount or percent and the through amount in the Day/Charge Ranges field.

NOTE: In order to utilize the Fee Schedule exceptions, the calculation method must be based on charges.

5. FLAT RATE AMOUNT (10-N-C)
This field contains the amount of the single, flat rate payment if the Calculation Method field contains F. The entry range is $0 to $99,999,999.99. If Calculation Method field does not contain F, this field cannot be accessed and is left blank.

6. DAY/CHARGE RANGES (U-AN-C)
This field must be completed if the Calculation Method field contains D (per diem) or C (charge level). The entry is unrestricted in length.

If the Calculation Method field contains D (per diem), the amount of the per diem and the through days are entered. The first column of this field is used to enter the through day; the from day is assumed.

For example, the payor pays $350.00 per day, through day three, and then $450.00 for the next five days, and then $500.00 per day after that. This particular arrangement should be set up as follows:

Thru Day	Reim Amt/Day
3	350.00
8	450.00
Unlimited	500.00

If this is the addition of a new arrangement, enter the unlimited dollar range first and then use the **INSERT** key to add the rest of the thru days needed. The unlimited line is provided by the system for all new additions.

If the Calculation Method field contains C (charges), a percent or an amount must be entered. The first column of this field is used to enter the through amount; the from amount is assumed. You must enter a whole number.

For example, the payor pays 60.25% for the first $1000.00, 70.25% for the next $1000.00 and 80% thereafter. This example is entered this way:

Thru Chg $	%/A	Reimbursement
1000	P	60.25
2000	P	70.50
Unlimited	P	80.00

If this is the addition of a new arrangement, enter the unlimited dollar range first and then use the **INSERT** key to add the rest of the through dollars needed. The unlimited line is provided by the system for all new additions.

The second column of this field is completed with a P (percent) or A (flat amount) if the calculation method is C (charges). This value can be mixed within an arrangement. For example, a payor may pay 80% of the first 5000.00 and then pay 600.00 of the next 1000.00 and then 90% after that. This example would be set up as follows:

Thru Chg $	%/A	Reimbursement
5000	P	80
6000	A	600.00
Unlimited	P	90

The maximum percent value that can be entered is 100; two decimal places are supported for percentages under 100 percent.

7. EDITED BY (DISPLAY ONLY)
This field contains the name of the user who last edited this code.

8. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this code was last edited.

After these fields are completed, a menu displaying options used to enter exceptions to this agreement is presented. These options are:

- Stop Loss Tables
- Accommodation Code Exceptions
- Proration Summary Code Exceptions
- Fee Schedule Exceptions

You can define accommodation code, proration summary code and fee schedule exceptions for each payor arrangement table including stop loss tables.

STOP LOSS TABLES

After this option is selected, a list of stop loss tables is displayed. You can select one of these tables or create a new one. After selecting or creating a table, this screen is displayed.

```
               General Hospital Stop Loss Tables Processor
                                                 Tue Jul 14, 1992 12:45 pm
Payor      : AMERIPLAN               Table: 003 From: 01/01/92  Thru: 12/31/92
Reimb. Type: Overall Plan
                                Stop Loss Table
     Stop Loss Table: 001
 1 Code-Description                            2 Stop Loss Table
   Overall Plan                                  Yes
 3 Maximum Reimbursement Amount   4 Calculation Method      5 Flat Rate Amount
    $10,000,000.00                  C-Charge Level
 6 Stop Loss Days 7 Stop Loss Charges 8 Stop Loss Trshld %     9 Add'l Reimb %
     2                   $5,000.00
10 Day/Charge Ranges  11 Edited By                      12 Edit Date









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

A stop loss table can be created if different reimbursement is needed because days or dollar maximums have been reached and this results in different reimbursement amounts being used. Stop loss tables are tied to the main or master table. If the stop loss days or charges are met, the stop loss table goes into effect and replaces all other tables starting with day 1.

The stop loss table number is assigned by the system. Stop loss tables can only be created from the master table. Up to 999 tables can be created.

Stop loss tables use the same effective from and through dates and effective date type as the master table. Multiple stop loss tables can be created under a master table. The system selects the correct table based on the stop loss criteria.

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)

This field contains the code and description of the reimbursement type (Overall Plan) or the description of the exception category (ICD Diagnosis Codes, ICD Procedure Codes, Medical Services) selected. This is a display-only field and cannot be changed.

2. STOP LOSS TABLE (DISPLAY ONLY)

This field identifies this table as a Stop Loss table. If Yes is displayed in this field, this table is stop loss; if this field is blank, this is not a stop loss table. This field cannot be edited.

3. MAXIMUM REIMBURSEMENT AMOUNT (10-AN-R)
This field contains the maximum reimbursement amount this payor reimburses the hospital on a per case basis for this stop loss table. The range is from $0 to $99,999,999.99, or you can choose U for unlimited, from the prompt.

4. CALCULATION METHOD (1-A-R)
This field contains the reimbursement calculation method used to calculate the reimbursement amount for this table. The options are **F** (flat rate), **D** (per day), or **C** (charges).

If you enter F (flat rate), the amount of the single, flat rate payment must be entered in the Flat Rate Amount field.

If you enter D (per day), the amount of the per diem and the through days must be entered in the Day/Charge Ranges field.

If you enter C (charge level), the amount or percent and the through amount be entered in the Day/Charge Ranges field.

5. FLAT RATE AMOUNT (10-N-C)
This field contains the amount of the single, flat rate payment. The entry range is $0 to $99,999,999.99 or you can choose U for unlimited, from the prompt. This field is required if the Calculation Method field contains F.

6. STOP LOSS DAYS (3-N-C)
This field contains the number of patient stay days used to determine when the stop loss table goes into effect. For example, if this field is completed by entering 9, the stop loss table goes into effect when the patient's stay is equal to or greater than nine days. The entry range is 0 to 999 or U for unlimited.

7. STOP LOSS CHARGES (10-N-C)
This field contains the dollar amount of charges that must be met by a patient account before this stop loss table goes into effect. The entry range is $0 to $99,999,999.99 or U for unlimited.

NOTE: If both the Stop Loss Days and Stop Loss Charges fields are completed, only one criteria (either days or dollars) must be met for the stop loss table to be used.

8. STOP LOSS THRSHLD % (5-C-O)
This field identifies the percentage by which the account must exceed the normal reimbursement before the additional reimbursement percent identified in the Add'l Reimb % field goes into effect. When the total charges exceed the normal reimbursement by this percentage, the system replaces the normal reimbursement table with the stop loss table. Enter a value in 999.99 format. You do not have to enter decimal places.

NOTE: You can only access this field if the Stop Loss Days and Stop Loss Charges fields have been set to *Unlimited*.

9. ADD'L REIMB % (5-C-O)
This field contains the percentage that would be added to the normal reimbursement amount if the amount identified in the Stop Loss Thrshld % field is exceeded. When the total charges exceed the normal reimbursement by the percentage identified in the Stop Loss Thrshld % field, the system replaces the normal reimbursement table with the stop loss table. Enter a value in 999.99 format. You do not have to enter decimal places.

NOTE: You can only access this field if the Stop Loss Days and Stop Loss Charges fields have been set to *Unlimited* and the Stop Loss Thrshld % field is completed.

As an example using *Stop Loss Threshld %* and *Add'l Reimb %* fields, assume the contract specifies a per diem rate of $750.00 per day plus 80% of excess charges over 180%. The reimbursement calculation would be $750 x number of days = normal reimbursement; normal reimbursement x 180% = charge threshold; (total charges - charge threshold) x .80 = additional reimbursement; total reimbursement = normal reimbursement + additional reimbursement.

If your account has total charges of $10,000 for a five day stay, and your stop loss has a stop loss threshold of 180%, an additional reimbursement of 80%, and the day/charge range is unlimited at $750.00/day, you would have the following reimbursement calculation:

$750.00 x 5 days = $3750.00
$3750.00 x 180% = $6750.00
$10,000.00 - $6750.00 = $3250.00
$3250.00 x .80 = $2600.00
Total reimbursement = $3750.00 + $2600.00 = $6350.00
Contractual adjustment = $10,000.00 - $6350.00 = $3650.00

If the total charges minus the threshold amount is negative or zero, the stop loss table is still used for the reimbursement, but there is not any additional reimbursement amount. Using the above example, if total charges were $6500.00 instead of $10,000.00, the reimbursement calculation would be:

$750.00 x 5 days = $3750.00
$3750.00 x 180% = $6750.00
$6500.00 - $6750.00 = -$250.00
Total reimbursement = $3750.00
Contractual adjustment is $2750.00

10. DAY/CHARGE RANGES (U-AN-C)
This field is completed if the Calculation Method field contains D (per diem) or C (charge level). The entry range is $0 to $99,999,999.99 or U for unlimited.

This field operates similar to the Day/Charge Ranges field in the ICD-9 Diagnosis Codes, ICD-9 Procedure Codes, Medical Services, and Overall Plan functions, as explained in the Day/Charge Range field (refer to DAY/CHARGE RANGES).

The stop loss option enables the user to set up tables that tie to the master table; allowing an arrangement to be set up for three-, four-, and five-day normal delivery at varied rates. An example of this follows:

A payor pays for a normal delivery for a patient, at a per diem of 350.00 per day, if the patient stays three days or less. If the patient stays four days, the per diem is reduced to 325.00 per day. If the patient stays five days, the per diem is further reduced to 310.00 per day. A stop loss table would be created for the four- and five-day normal delivery in this manner:

The payor would be identified and have an ICD payor table.

The *three-day normal delivery* would be an ICD diagnosis exception for the payor and entered as follows:

Field	Entry
Maximum Reimbursement Amount	1050 or U
Calculation Method	D (per diem)
Stop Loss Days 1050 or U	Thru Day - Unlimited
	Reim Amt/Day - 350.00

The *four-day normal delivery* is created as a stop loss table, of the table defined above. This stop loss table would be set up as follows:

Field	Entry
Maximum Reimbursement Amount	1400 or U
Calculation Method	D (per diem)
Stop Loss Days	4
Stop Loss Charges	U (unlimited)
Day/Charge Ranges	Thru Day - Unlimited
	Reim Amt/Day - 325.00

The *five-day normal delivery* would also be created as a stop loss table, of that same table. This stop loss table would be set up as follows:

Field	Entry
Maximum Reimbursement Amount	1550 or U
Calculation Method	D (per diem)
Stop Loss Days	5

Field	Entry
Stop Loss Charges	U (unlimited)
Day/Charge Ranges	Thru Day - Unlimited
	Reim Amt/Day - 310.00

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

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

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

ACCOMMODATION CODE EXCEPTIONS

Accommodation exceptions can be set up for each payment arrangement table including the stop loss tables. They allow a specific room type to be treated differently within a payment arrangement.

For example, the payor and hospital agree to a per diem arrangement and decide the per diem should be 350.00 for the first 10 days and then 320.00 thereafter. They both realize if the patient is in an intensive care room, more nursing care is required. Therefore, while the patient is in an intensive care room, the per diem is 550.00 for the first 10 days and then 500.00 thereafter.

The accommodation exception allows for this type of arrangement to be entered. The system reimburses the hospital the intensive care per diem for only the days the patient was in intensive care and reimburses the hospital the normal per diem while the patient is in a normal accommodation.

The calculation method for the accommodation code exceptions must be the same as the master table. Only the amount is allowed to be revised for the exception record. If flat rate exceptions exists, the highest flat rate is used as the reimbursement amount.

For example, a payment arrangement is made that pays a flat 1000.00. If the patient is in ICU, the flat rate is 1500.00 or, if in CCU and in ICU and CCU, the flat rate is 1600.00. If a patient was in a normal accommodation, the reimbursement they would receive would be 1600.00, which is the highest reimbursement amount.

After this option is selected, the system displays a list of Accommodation Code Exceptions. Accommodation Code Exception table numbers are assigned by the system. Up to 999 tables can be created.

You can select one of these codes or add a new one from the Accommodation code table. After selecting or adding a code, this screen is displayed.

```
            General Hospital Accommodation Code Exceptions Processor
                                                  Tue Jul 14, 1992 12:49 pm
Payor      : AMERIPLAN               Table: 003 From: 01/01/92  Thru: 12/31/92
Reimb. Type: Overall Plan            Accom. Code Exception: 1029

   Thru Day   Reimbursement Amt/Day      Edited By           Edited Date
   Unlimited   $500.00                  Moore,Nancy         05/08/01 15:43




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

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)
This field contains the accommodation code and description.

2. CALCULATION METHOD (DISPLAY ONLY)
This field contains the reimbursement calculation method used to calculate the reimbursement amount for this accommodation code. It is displayed from the previous screen.

3. FLAT RATE AMOUNT (10-N-C)
This field contains the amount of the single, flat rate payment. The entry range is $0 to $99,999,999.99. This field is required if the Calculation Method field contains F.

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

PRORATION SUMMARY CODE EXCEPTIONS

Proration summary code exceptions allow a specific category of charges to be reimbursed differently within a specific payment arrangement, including the Stop Loss tables.

For example, the payor and the hospital may agree on a per diem type of arrangement and decide the per diem should be 350.00 for the first 10 days and then 320.00 thereafter. They both agree any emergency room fees are a special area requiring additional reimbursement. If there are any emergency room fees, they are reimbursed at 80%.

Proration summary exceptions can be a flat rate for the category or charge-based, which can be either a percent of charges or a flat amount. The following is an example of a charge-based proration exception based on percent.

The payor and the hospital may agree on a per diem arrangement and decide that the per diem should be 350.00 for the first 10 days and then 320.00 thereafter. They both agree that any emergency room fees are reimbursed at 80% of the first 1000.00 and then 75% for any amount that exceeds 1000.00.

After this option is selected, the system displays a list of Proration Summary Code Exceptions. You can select one of these codes or add a new one from the Proration Summary code table.

Proration Summary Code Exception table numbers are assigned by the system. Up to 999 tables can be created.

After selecting or adding a code, this screen is displayed.

```
       General Hospital Proration Summary Code Exceptions Processor
                                                 Tue Jul 14, 1992 12:55 pm
Payor      : AMERIPLAN               Table: 003 From: 01/01/92  Thru: 12/31/92
Reimb. Type: Overall Plan
 1 Code-Description                          2 Stop Loss Table
   AID/HOME HEALTH                             Yes
 3 Calculation Method                        4 Flat Rate Amount
   F-Flat Rate                                    $100.00
 5 Charge Ranges   6 Edited By                 7 Edit Date









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

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)
This field contains the Proration Summary code and description.

2. STOP LOSS TABLE (DISPLAY ONLY)
This field indicates whether the table is a Stop Loss table. If this field contains Yes, the table is a Stop Loss one. If this field is blank, this is not a stop loss table.

The value in this field depends on where in the system you selected the Proration Summary Code Exceptions option. If you selected it through the Stop Loss table, this field contains Yes.

3. CALCULATION METHOD (1-A-R)
This field contains the reimbursement calculation method used to calculate the reimbursement amount for this table. Entry options are **F** (flat rate) or **C** (charges).

If you enter F (flat rate), the amount of the single, flat rate payment must be entered in the Flat Rate Amount field. If you enter C (charges), the amount of the per diem and the through days must be entered in the Charge Ranges field.

4. FLAT RATE AMOUNT (10-N-C)
This field contains the amount of the single, flat rate payment. The entry range is $0 to $99,999,999.99. This field is required if the Calculation Method field contains F.

5. CHARGE RANGES (U-AN-C)
This field is completed if the Calculation Method field contains D (per diem). The data entered in this field is dependent on the reimbursement calculation method. If the calculation method field contains charges, you must specify whether the charges are calculated as a percentage (and what the percentage is) or a dollar amount (and what the dollar amount is). If the Calculation Method field contains per diem, you must enter the upper limit of the payor's daily reimbursement amount.

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

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

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

FEE SCHEDULE EXCEPTIONS

Fee Schedule exceptions allow a special SIM charge item to be reimbursed differently within a specific payment arrangement, including the Stop Loss tables. The option is also available to allow contractual adjustments by department to post to the transaction code of your choice.

For example, the payor and hospital may agree that SIM items within the laboratory department are reimbursed differently than the base payment arrangement plan (for example, ICD Diagnosis Codes, ICD Procedure Codes, Medical Services or Overall Plan).

Fee Schedule Exception table numbers are assigned by the system. Up to 999 tables can be created.

After you select this option, the system displays a list of SIM departments. After you select a department, the system displays the following screen:

```
         General Hospital Fee Schedule Exceptions Processor
                                              Tue Jul 14, 1992 12:57 pm
Payor: AMERIPLAN                       Table: 003 From: 01/01/92  Thru: 12/31/92
Reimb. Type: Overall Plan              Exception: Fee Schedule
Department: LABORATORY                 Stop Loss Table:
 1 Non-included SIM Item coverage
   Normal
 2 Calculation Type                     3 Flat amount or Percentage

 4 Contractual Adj Trans Code           5 ProSum cod
   A0099-ADJUSTMENT









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

Field Explanations

1. NON-INCLUDED SIM ITEM COVERAGE (1-A-R)
This field specifies how charges in the selected department with no specific reimbursement attached are reimbursed. Charges are reimbursed based on:

(**N**)ormal - same as the Overall reimbursement if the Overall reimbursement calculation method is Charge Level. If the Overall reimbursement calculation method is Flat Amount or Days, no additional reimbursement is calculated for these charges.

No (**A**)dditional - has no reimbursement

(**P**)roSum Exception - same as the ProSum Exception

(**C**)alculation - uses either flat amount or percent amount

An example of using the Normal calculation is as follows:

A Medical Service reimbursement type is set up for medical service SUR, reimbursing at 80% of charges.

The Medical Service reimbursement has a Fee Schedule Exception for department EKG, SIM items:

1234 Amount150.00
9876 Amount 80.00

The Overall reimbursement method is Charge Level, reimbursing at 70% of charges.

If an account is admitted using medical service SUR, and the COB 1 insurance plan is set to use the reimbursement payor above, for Medical Service and then Overall at time of final billing, if the charges are as follows, the system would calculate the following:

Non EKG charges are $8000.00
One EKG charge (SIM 1234) is $200.00
Other EKG charges (non fee schedule exception items) are $250.00

The reimbursement would be calculated as:

$8000.00 X .80 = $6400.00
EKG item 1234 = $ 150.00
$250.00 X .70 = $ 175.00
$6725.00 Reimbursement

2. CALCULATION TYPE (1-A-C)
If the Non-included SIM Item Coverage field contains Calculation, this field contains the reimbursement calculation method for all charges in the selected department which have no specific SIM code reimbursement attached. This field is required if the Non-included SIM Item Coverage field contains Calculation.

Enter **A** for a flat amount calculation. Enter **P** for a percent of charges calculation. The amount of the flat rate payment or percentage must be entered in the Flat Amount or Percentage field.

3. FLAT AMOUNT OR PERCENTAGE (SPECIAL FORMAT-C)
If the Calculation Type field specifies a flat rate payment, this field contains the flat rate payment amount. If the Calculation Type field specifies a percent of charges payment, this field contains the percent of charges. This field is required if the Non-included SIM Item Coverage field contains Calculation.

4. CONTRACTUAL ADJ TRANS CODE (4-N-C) or (TABLE LOOKUP-C)
This field contains the code and description associated with the reimbursement for this department. The code is used to update the contractual adjustment by department on the General Ledger. A transaction code can be entered in this field only if the Post Contr'l by Dept field under the Payor Tables is set to Yes; this field is required if the Post Contr'l by Dept field under the Payor Tables is set to Yes.

Enter the code or enter a hyphen (-) to display a list of valid transaction codes under transaction type A.

5. PROSUM COD (1-A-C) or (TABLE LOOKUP-C)
This field contains the Proration Summary code and description. This field is required if the Non-included SIM Item Coverage field contains ProSum Exception.

Enter the code or enter a hyphen (-) to display a list of valid proration summary codes.

NOTE: You must set up ProSum Reimbursement Exception for the selected code. If the code is not set up, reimbursement for the Non-included SIM Item Coverage is zero (0).

After you complete this screen, the system displays the following screen:

```
        General Hospital Fee Schedule Exceptions Processor
                                                Tue Jul 14, 1992 12:57 pm
Payor: AMERIPLAN                        Table: 003 From: 01/01/92  Thru: 12/31/92
Reimb. Type: Overall Plan               Exception: Fee Schedule
Department: PHYSICAL THERAPY            Stop Loss Table: 001
       SIM      Description                    % or A       % or Amount
      6044      MASSAGE                          Amt               $30.00
      6060      WHIRLPOOL BODY                   Amt               $40.00









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

On this screen, you can go to a previous page (F1), go to the next page (F2), insert (F3) or delete (F4) a line, reset the table (F6) if you make an error, and exit (F7) when you are finished to save your changes. This completes the transaction.

NOTE: To delete a fee schedule exception you must delete the SIM item page associated with the department prior to deleting the department.

If you press the F3 key to insert a line, you can enter the SIM code or a hyphen (-) to display a list of SIM items associated with the selected department.

Field Explanations

SIM (5-N-R)
This field specifies the SIM code. Enter the SIM code or enter a hyphen (-) and select a SIM code from a list.

DESCRIPTION (DISPLAY ONLY)
This field contains the SIM code description.

% OR A (1-A-R)
This field determines if the fee schedule amount is based on a percentage or a dollar amount. Enter P for percentage or A for a dollar amount. If the fee schedule amount is based on a dollar amount, the quantity on the SIM item is taken into account. For

example, if SIM item 6044 for Massage is reimbursed at $30.00, if a charge for SIM 6044 is entered, with a quantity of 2, the system would reimburse 2 X $30.00 = $60.00.

If the fee schedule amount is based on a percentage, the quantity on the SIM item is not taken into account. For example, if SIM item 6044 for Massage is reimbursed at 25%, if a charge for SIM 6044 is entered, with a quantity of 2 and a total charge of $70.00, the system would reimburse $70.00 X .25 = $17.50.

% OR AMOUNT (9-N-R)
This field specifies the stop loss percentage or amount. Enter the percentage or dollar amount. The maximum entry is $99,999,999.00.

Payor Table Definition:

Dependent On	Reference
Reimbursement Payor Code	ICD Diagnosis Arrangement Table
	ICD Procedure Arrangement Table
	Medical Services Arrangement Table
	Overall Plan Arrangement Table
	Insurance Plan Coverage Master

ICD-9 Diagnosis and Procedure Arrangement Tables:

Dependent On	Reference
ICD Table	Stop Loss Table *
Payor Table Definition	Accommodation Code Exceptions
Accommodation Codes	Proration Summary Code Exceptions
Proration Summary Codes	
* Proration Summary Code Exceptions, Accommodation Code Exceptions, and Fee Schedule exceptions can also be defined for Stop Loss Tables.	

Overall Plan Arrangement Table:

Dependent On	Reference
Payor Table Definition	Stop Loss Table *
Accommodation Codes	Accommodation Code Exceptions
Proration Summary Codes	Proration Summary Code Exceptions
* Proration Summary Code Exceptions, Accommodation Code Exceptions, and Fee Schedule exceptions can also be defined for Stop Loss Tables.	

Medical Service Arrangement Table:

Dependent On	Reference
Medical Service Table	Stop Loss Table *
Payor Table Definition	Accommodation Code Exceptions
Accommodation Codes	Proration Summary Code Exceptions
Proration Summary Codes	
* Proration Summary Code Exceptions, Accommodation Code Exceptions, and Fee Schedule exceptions can also be defined for Stop Loss Tables.	

ASC Payment Group

The ASC Payment Group function is used to define the rates for each Ambulatory Surgical Category (ASC) Group. To determine the reimbursement amount, the ASC Payment Group method uses the ASC Group associated with each HCPCS code that is assigned to a patient by medical records in the Patient Care Abstracting function, HCPCS Procedures. If multiple procedure codes are assigned, the highest ASC group number is reimbursed at 100% and each additional ASC group number is reimbursed at a user-defined percentage rate.

When you select ASC Payment Group from the Reimbursement Master menu, the following screen is displayed:

```
          General Hospital Reimbursement Table Maintenance Processor
                                              Fri Mar 24, 1995 09:32 am
Payor      : COMMERCIAL               Table: 001 From: 01/01/95  Thru: 12/31/96
Reimb. Type: ASC Payment Group
 1 Code-Description                          2 Maximum Reimbursement Amount
    ASC Payment Group                            $40,000.00
 3 Calculation Method                        4 Non Primary Reimb Percentage
    ASC Group                                          50%
 5 Group 00 Reimb Amount                     6 Group 01 Reimb Amount
          $874.00                                    $950.00
 7 Group 02 Reimb Amount                     8 Group 03 Reimb Amount
        $2,010.00                                  $2,795.00
 9 Group 04 Reimb Amount                    10 Group 05 Reimb Amount
        $3,011.00                                  $3,451.00
11 Group 06 Reimb Amount                    12 Group 07 Reimb Amount
        $4,900.00
13 Group 08 Reimb Amount                    14 Group 09 Reimb Amount

15 Edited By                                16 Edit Date
   Smith, Mary Louise                          03/21/95 11:40am

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

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)
This field contains the reimbursement type description.

2. MAXIMUM REIMBURSEMENT AMOUNT (11-NC-R)
This field contains the maximum reimbursement amount. If the calculated reimbursement is greater than the maximum reimbursement amount, then the maximum reimbursement amount is used instead.

3. CALCULATION METHOD (DISPLAY ONLY)
This field always displays the ASC Group.

4. NON PRIMARY REIMB PERCENTAGE (6-NC-R)
This field contains the non-primary reimbursement percentage. For non primary ASC Groups entered on a patient, this is the percentage that is applied to the group rate to determine the reimbursement amount for the HCPCS procedure.

5. GROUP 00 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 00 for reimbursement calculation.

6. GROUP 01 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 01 for reimbursement calculation.

7. GROUP 02 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 02 for reimbursement calculation.

8. GROUP 03 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 03 for reimbursement calculation.

9. GROUP 04 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 04 for reimbursement calculation.

10. GROUP 05 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 05 for reimbursement calculation.

11. GROUP 06 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 06 for reimbursement calculation.

12. GROUP 07 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 07 for reimbursement calculation.

13. GROUP 08 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 08 for reimbursement calculation.

14. GROUP 09 REIMB AMOUNT (11-NC-O)
This field contains the dollar amount assigned to ASC Group 09 for reimbursement calculation.

15. EDITED BY (DISPLAY)
This field contains the name of the person who last edited this table entry.

16. EDIT DATE (DISPLAY)
This field contains the date and the time this table was edited.

ASC REIMBURSEMENT CALCULATION

The ASC Payment Group reimbursement calculation uses the ASC Payment Group to determine the primary procedure. The highest group number is the primary procedure. Every other procedure listed is non-primary and is reimbursed at a percentage of the rate defined for the group. If the highest group occurs more than one time, the first occurrence is reimbursed at 100% and each additional occurrence is reimbursed at the non-primary reimbursement percentage.

Sample Reimbursement Calculation for ASC

For example, the following HCPCS codes are assigned to a patient by Medical Records:

11000	Surgical Cleansing of the Skin	1
32000	Drainage of Chest	5
34001	Removal of Artery Clot	5
11100	Removal of Hang Nail	0

Based on the ASC Payment Group rates defined in the previous Payor Arrangement Table, the following reimbursement amount is calculated:

32000	Primary	100% of	$ 3451	$ 3451.00
34001	Non-primary	50% of	$ 3451	$ 1725.50
11000	Non-primary	50% of	$ 950	$ 475.00
11100	Non-primary	50% of	$ 874	$ 437.00
Calculated Reimbursement				$ 6088.50

Alternate Level of Care

The Alternate Level of Care reimbursement method goes through both the DRG reimbursement calculation as well as the alternate level of care reimbursement calculation. This table is used to set the Maximum Reimbursement Amount (up to 99999999.99 or U for Unlimited) for the ALC reimbursement (excluding the DRG

expected reimbursement amount), the Non-Primary Reimbursement Percentage, and the Per Diem Amount and Maximum Days for each ALC type.

The ALC Reimbursement looks at all of the ALC codes and the associated ALC Types on the account entered through Utilization Management, if there is more than 1, and at the Per Diem Amount for each. The highest paying ALC Type is reimbursed at 100%, and the remaining ALC Types are reimbursed based on the Non Primary Reimb Percentage in the Reimbursement Table Master. If an ALC Type appears multiple times for an account and the first occurrence is selected as the highest reimbursement amount, then for subsequent time frames the reimbursement amount is altered by the Non Primary Reimb Percentage (which can also be set to 100%).

If you do not want an ALC Type to be reimbursed for the payor, the Per Diem Amount for the ALC Type should be set to zero. For each ALC Type on the account, the system looks at the From and Through Dates entered in the Alternate Level of Care Information screen in Utilization Management for the ALC Code/ALC Type to determine the reimbursement (multiplying the Per Diem Amount either by 100%, or the Non Primary Reimb Percent for each day). If the days for the ALC Code/ALC Type go over the Maximum Days field for the ALC Type in the Reimbursement Table Master, those days over the maximum days are not reimbursed. An example of this is an account with the From and Through Days set to 5/1/03 through 5/31/03 for ALC Type 3. If the Maximum Days for the ALC Type 3 in the Reimbursement Table Master is 14, then the system would calculate the reimbursement for only 14 days at the Per Diem Amount for ALC Type 3, and the days from 5/15/03 through 5/31/03 would not have a reimbursement amount.

The discharge date is not included in the calculation of the ALC portion of the reimbursement for reimbursement type L (DRG+Alt Level of Care) unless the admission date equals the discharge date. Therefore, if the ALC days are at the end of the patient's stay and include the day of discharge, the system does not calculate the ALC reimbursement for the day of discharge. The other ALC days calculate the expected ALC reimbursement, and the system calculates the DRG expected reimbursement for the acute care days.

If the ALC days are at the beginning of the patient's stay, with the Acute Care days including the day of discharge, the system calculates the ALC reimbursement for all ALC days and calculates the DRG expected reimbursement for the acute care days.

If the patient had a one-day stay, and the one day was coded as an ALC day, the system calculates the ALC reimbursement for this day (even though this is also the discharge date). No DRG expected reimbursement is calculated.

If the patient had a one-day stay, with no ALC code, the system calculates the DRG expected reimbursement for this day. No ALC expected reimbursement is calculated.

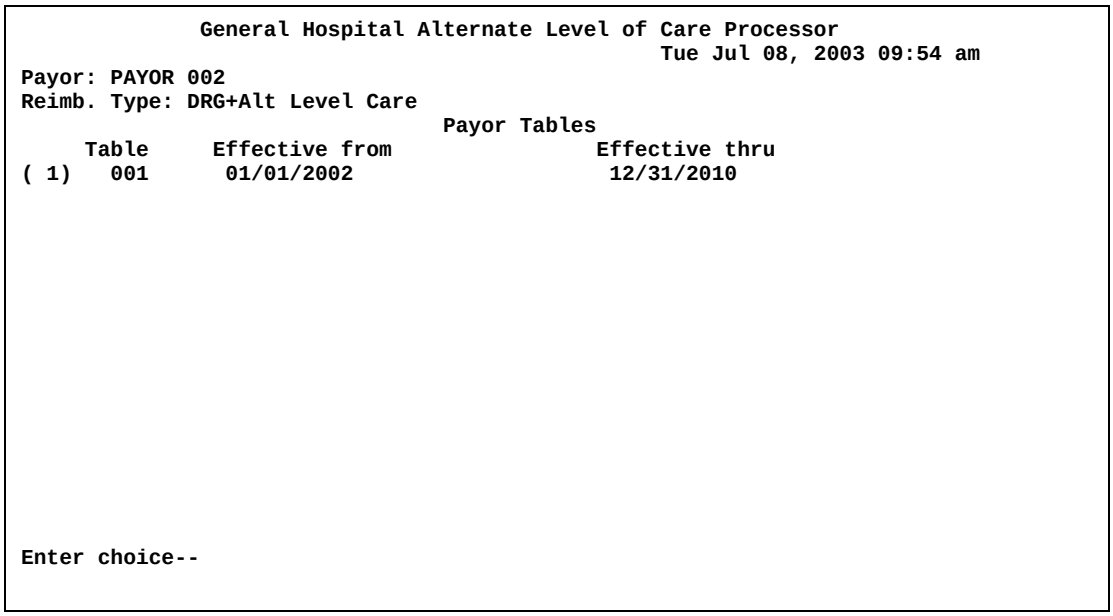
After this table is completed, the Alternate Level of Care reimbursement table must be linked to the appropriate insurance plans by accessing Tables, PA/AR Master File Maintenance, Insurance Plan Coverage. Enter the carrier and plan, then enter

Facility Options, Reimbursement. You can elect to take an automatic contractual adjustment on an account at time of final billing by setting the Post Cont. Adj. at Bill field to Yes on the Reimbursement screen for Inpatients.

If the account has at least one ALC Code entered, but the system cannot determine the ALC Expected Reimbursement for the account (the ALC Type for the ALC Code is not defined in the Reimbursement Alternate Level of Care table or other data is missing), the account has an Error on the Balance Summary screen, and no Expected Reimbursement is displayed. When you are on the Balance Summary screen within Account Inquiry, and enter either P for Proration reimbursement or B for Billing reimbursement, the Error Description field contains the error *Missing ALC Reimbursement*. The missing data must be entered in the reimbursement tables or on the account, and an adjustment bill and claims must be requested.

After selecting this function from the Reimbursement Master menu, the system prompts you to enter a Payor Code. The third party payor code entered here must be in the Reimbursement Payor table in order for this function to be valid. You can enter the code or a hyphen (-) to display a list of valid codes. After you enter or select a code, the following screen is displayed:

```
              General Hospital Alternate Level of Care Processor
                                                    Tue Jul 08, 2003 09:54 am
Payor: PAYOR 002
Reimb. Type: DRG+Alt Level Care
                                  Payor Tables
     Table     Effective from                Effective thru
( 1)   001      01/01/2002                   12/31/2010
```



Select the table for the payor/reimbursement type, press ENTER, and the following screen is displayed:

```
              General Hospital Alternate Level of Care Processor
                                                    Tue Jul 08, 2003 09:51 am
Payor: PAYOR 002                 Table: 001 From: 01/01/2002 Thru: 12/31/2010
Reimb. Type: DRG+Alt Level Care
 1 Code-Description                          2 Maximum Reimbursement Amount
    Alt Level of Care                          Unlimited
 3 Non Primary Reimb Percentage
   80%
 4 Edited By                                    5 Edit Date
   New, Nancy                                    07/08/03 09:56am
 6 ALC Type   Per Diem Amount          Maximum Days

    1               1,000.00                    1
    2               2,000.00                    2
    3               3,000.00                    3
    4               4,000.00                    4
    5               5,000.00                    5
    6               6,000.00                    6
    7               7,000.00                    7
    8               8,000.00                    8
    9               9,000.00                    9

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

Field Explanations

1. CODE-DESCRIPTION (DISPLAY ONLY)
This field contains the code and description for the table selected on the previous screen.

2. MAXIMUM REIMBURSEMENT AMOUNT (10-N-R or 1-A-R)
This field contains the maximum reimbursement amount for the Total Alternate Level of Care reimbursement. This maximum reimbursement amount is only for the ALC expected reimbursement, and excludes the DRG expected reimbursement. When this field is accessed, the following prompt is displayed:

Enter new maximum reimbursement amount (NNNNNNNN.NN)--

You can enter the amount or U for Unlimited.

3. NON PRIMARY REIMB PERCENTAGE (3-N-R)
This field contains the non-primary reimbursement percentage, which can be sent to 100%. When this field is accessed, the following prompt is displayed:

Enter Non Primary Reimb. Percentage--

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

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

6. ALC TYPE (3-AN-R OR TABLE LOOKUP-R)
This field contains the ALC type for which you are defining the per diem reimbursement amount and maximum number of days.

The system prompts you to enter an ALC type or a hyphen to select one from a list of ALC types.

7. PER DIEM AMOUNT (9-N-R)
This field contains the per diem reimbursement amount for the ALC Type. The maximum is 9999999.99.

8. MAXIMUM DAYS (3-N-R)
This field contains the maximum number of days for the ALC Type. The maximum is 999 days.

Print Reimbursement Table

This function is used to print the reimbursement table for a specific payor or all payors. After selecting this function from the Reimbursement Master menu, the system prompts you to enter a Payor Code, A for all payors or a hyphen (-) to display a list of reimbursement payors. After you enter or select a code, the following prompt is displayed:

Only tables in effect? (Y)es or (N)o [Y]--

After you respond Yes or No, the following message is displayed:

Report 'FTR140' compiling.

Other Payor Code for DRG Mapping

The Other Payor Code for DRG Mapping table is used to specify which DRGS, that are grouped outside of STAR Records Management, are defined as Medicare DRGS including MS-DRGs, Medicare Classic DRGS, Tricare/Champus DRGS, or Other DRGS. STAR Patient Accounting uses this table to set the DRG Indicator for accounts that are grouped outside of STAR and to identify which DRG type to send in the Pathways Contract Management 28 record for Tricare/Champus accounts and Reimbursed APR DRG.

When you select Other Payor Code for DRG Mapping from the Reimbursement Master menu, the following screen is displayed:

```
            General Hospital Other Payor Code for DRG Mapping Processor
                                                Fri Jul 2, 2010 08:39 pm


        Select Other Payor Codes Used for DRG Assignment Using Encoder
 1 Other Payor Codes Used for Medicare DRG Assignment (pre and post 10/1/07)
   00
 2 Other Payor Codes Used for Classic DRG Assignment
   42
 3 Other Payor Codes for Tricare/Champus DRG Assignment
   03,18
 4 Other Payor Codes for Reimbursed APR DRG Assignment
   142
 5 Edit Date                          6 Edit By
   11/06/09 09:32am                     New, Nancy







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

Field Explanations

1. OTHER PAYOR CODES USED FOR MEDICARE DRG ASSIGNMENT (PRE AND POST 10/1/07) (1-A-O)
This field contains the value(s) for the Other Payor Code(s) if an account is encoded outside of STAR. This field should contain the Other Payor Code value located on STAR Records Management that you are currently using for Medicare. If you are using the 3M Encoder then the suggested value is 00 for Medicare. This is also the value that 3M uses for Medicare MS DRGS (CMS Version 25) for discharged accounts after 10/01/2007.

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

Enter Other Payor Codes for Medicare DRGs (separated by commas)--

2. OTHER PAYOR CODES USED FOR CLASSIC DRG ASSIGNMENT (1-A-O)
This field contains the value of the Other Payor Code for Classic DRGS. It is assumed this Other Payor Code is used for discharges 10/1/2007. This field contains the value that is assigned to the Medicare Grouper that is known as the Medicare Classic or CMS Version 24 Grouper for Medicare. It is used by payors not using MS-DRGS.

If you are using the 3M Encoder then the suggested value is 42 for the Medicare Classic DRG Grouper (CMS version 24).

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

Enter Other Payor Codes for Classic DRGs (separated by commas)

3. OTHER PAYOR CODES FOR TRICARE/CHAMPUS DRG ASSIGNMENT (1-A-O)
This field contains the value of the Other Payor Code for Tricare/Champus DRGS. If you are using the 3M Encoder, the suggested value is 03 for the Tricare/Champus DRG. When you move this table you need to enter in the Other Payor Code value located on STAR Records Management, that you use for Tricare/Champus.

This field also identifies which DRG type to send to STAR Pathways Contract Management in the PCON 28 record for Tricare/Champus accounts.

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

Enter Other Payor Codes for Tricare/Champus DRGs (separated by commas)--

4. OTHER PAYOR CODES FOR REIMBURSED APR DRG ASSIGNMENT (1-A-O)
This field contains the value of the Other Payor Code for Reimbursed APR DRGS. Enter in the Other Payor Code value located on STAR Records Management that you use for the Reimbursed APR DRG.

The Other Payor Code for the Reimbursed New York APR DRG is 142 when using 3M, and are 142, 143, 144, and 145 when using QuadraMed.

If Other Payor Codes are identified in field 4, a type of A for Reimbursed APR DRG is assigned to those DRGs. The information for the Internal Elements that start with *APR-DRG (Reimb)* are supplied only if the DRG is marked Final and if the Other Payor Code matches one of the Other Payor Codes indicated in the Other Payor Codes for Reimbursed APR DRG Assignment field found on the screen for Other Payor Code for DRG Mapping.

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

Enter Other Payor Codes for reimbursed APR DRGs (separated by commas)--

The Pathways Contract Management (PCON) Interface logic was updated to include a DRG type of R for Reimbursed APR DRG for fields 16 and 20 in the PCON UB record 28-01. This change was made for Source File Fmts of Version 7 and Version 8. Note that the first DRG and Severity of Illness will appear in the field labeled #1 ASC/DRG Code (Access) in record 28-01 of the PCON UB Interface when the STAR DRG Indicator for the first DRG is A for Reimbursed APR DRG. Also note that the second DRG and Severity of Illness will appear in the field labeled #2 ASC/DRG Code in record 28-01 of the PCON UB interface when the STAR DRG Indicator for the second DRG is A for Reimbursed APR DRG. These changes were made for versions 7 and 8 of the Source File Format. Version 8 of the Source File Format is available in Star release 15.0 and above only.

Alternate Price

The Alternate Price reimbursement type looks to the charge detail prices versus the claim price for the same charges, and only writes off the difference of those particular charges that differ. This can be used for 340 hospitals.

When you select Alternate Price from the Reimbursement Master menu, the following screen is displayed:

```
                General Hospital Alternate Price Processor
                                                  Fri Jul 2, 2010 08:39 pm


If contractual adjustments are being posted for accounts using the Alternate Price
reimbursement type, then PA Daily Balancing can be delayed until the time indicated
below. If a time is indicated, then PA Daily Balancing will start after the contractual
adjustment batch is posted or when the time indicated below is reached.

Currently, the value for this time is 08:00


Enter time after which PA Daily Balancing will continue even if contractual
adjustment batch for Alternate Price is not posted--
```

After all claims load in MNP, then there is a subsequent job which calculates write-offs. This screen can be used to hold up daily balancing hoping that the write-offs are posted. This screen does not need to be completed to make the write off logic work.

Reimbursement Type R for Alternate Price looks to the charge detail prices versus the claim price for the same charges, and only writes off the difference of those particular charges that differ. For example, if there was a Pharmacy item 12345678 for $240.00, but the claim price for this item was $170.00 (using the Alternate Price 340B Table), then the system would write off the difference of $70.00 for this charge item. The system would calculate the difference for the charges at the detail charge level versus the discounted prices on the claim, and write off that amount only.

The intent of the logic created for 340B Pricing is to load claims with the 340B Pricing for Pharmacy items and to write off the difference between the charge amount in Star and the charge amount per 340B pricing. The write off occurs by using the reimbursement type of R-Alternate Price. If an ERA payment is received for the primary insurance using the reimbursement type of R and the Contractual Adjustment Method is Variance or Reverse Sys Adj, no contractual adjustment is calculated automatically. For these accounts, the contractual adjustment is calculated per the CAS Reason Codes within the ERA file and is placed into the cash batch. Thus for these accounts the contractual adjustment method is 'Post' even if the ERA Payment File Definition is set to 'Variance' or 'Reverse System Adj'. Since the account already has a contractual adjustment amount that reduced the account balance per the 340B rule, the logic

should not perform a variance or reverse system adjustment using money that was not written off for the estimated reimbursement.

Reimbursement Type R for Alternate Price looks to the charge detail prices versus the claim price for the same charges, and only writes off the difference of those par-ticular charges that differ. For example, if there was a Pharmacy item 12345678 for $240.00, but the claim price for this item was $170.00 (using the Alternate Price 340B Table), then the system would write off the difference of $70.00 for this charge item. The system would calculate the difference for the charges at the detail charge level versus the discounted prices on the claim, and write off that amount only.

Therefore, this reimbursement type is only writing off the difference between the charged price and the discounted price on the claim for the 340B Pharmacy items. The non-discounted items do NOT have a write off of the amount the payer will not reimburse (in other words, you can't state to also write off 20% of the remaining claim charges). You will be expecting to take an additional write off at time of ERA that would be in addition to the write off of the discounted drugs.

The system takes the write off at time of claim LOAD, and only for claims loaded via a billing event (midnight processing, Single Bill Request, Instant Adjustment Bills). Claims added via Add Claim to Insurance will NOT take a write off, even when using the Alternate Price Table. For claims loaded in midnight processing, the job "Reimbursement Processing for Alternate Price Reimbursement Type" runs after claim load completes. For claims loaded in Instant Adjustment Bill, the write-off is made after the claims load in Instant Adjustment Bill.

Claim Amount

Reimbursement Type Q for Claim Amount looks to the Liability for the charges on the Bill that in turn loaded the claim, and writes off the difference between the Liability for the Bill and the Claim. For example, if the Final Bill Liability Amount was $1500.00, and the Final Claim Amount was $1200.00, then the system would write off $300.00. The account liability can be seen on the Balance Summary screen, and takes into account the Non Covered Charges, Deductible, and Coinsurance amounts.

CMS COMPLIANCE MASTER

From this function you can access the DRG Payment Window Parameters function.

This section defines in general terms the process for combining charges due to the Medicare 72 hour rule (DPW). The main controlling force in the process is the DRG Payment Window Parameters screen. If both the outpatient/series account(s) and the inpatient account include insurance carrier plans defined in one of the parameters, the system reviews the accounts for combination/transfer of charges. Other criteria used are financial classes, patient types, excluded FIM departments, and FIM items. If the accounts pass these general criteria, then the system differentiates handling of charges based on the service date of the charges instead of the inpatient admit date.

The I/P Abstract parameter field gives you a choice of using either the inpatient's Primary Medical Records diagnosis codes or All Medical Records diagnosis codes. The I/P Abstract parameter (field 9) determines whether Primary or All diagnoses for the inpatient should be used in comparison to the outpatient's non-diagnostic charges.

The first split is defined by the All Chgs parameter. Outpatient charges with service dates less than or equal to the value defined in the parameter automatically transfer to the inpatient account. Outpatient charges with service dates outside of the All Chgs parameter are split into one of two categories:

Charges considered as Diagnostic (defined in the Diagnostic Revenue Code Table) and having service dates less than or equal to Eval Diag Charges (field 14) of the DRG Payment Window Parameter screen are transferred from the outpatient to the inpatient account.

Charges with a revenue department not in the Diagnostic Revenue Code Table are reviewed by diagnosis codes. This is when the O/P Abstract (field 8) and I/P Abstract (field 9) parameters are used. The O/P Abstract fields determine if the Medical Record or Charge diagnosis should be compared to the inpatient diagnosis codes (I/P Abstract parameter).

- If O/P Abstract = No, the system uses the charge information. Outpatient charges with no diagnosis codes automatically transfer to the inpatient account. If a diagnosis code is present, this information is compared to the I/P Abstract data.

- If O/P Abstract = Yes, the system uses Medical Records diagnosis information to compare with the I/P Abstract data.

DRG Payment Window Parameters

This function enables you to define the criteria for selecting accounts for charge transfer and charge reporting involving DRG Payment Windows (DPW). You can also activate, deactivate, or change the time frame for DPWs when the inpatient account is in AR. DPW is a federal regulation that governs the relationships between an inpatient account and an outpatient account within certain time frames.

NOTE: These relationships may cross facilities.

The DPW regulation identifies the relationship between an inpatient account and outpatient account with the time frame *starting* on the inpatient admission date minus the number of all days and evaluate days and *ending* on the inpatient discharge date. A DPW time frame exists between an inpatient account and an outpatient account when the potential for charges/credits exists and the patient type, financial class, and primary insurance plan exist in the list for the DPW. DPW also signifies the parameters determining if a DPW relationship exists between two accounts.

The following table shows the types of services that are subject to the DPW, the occurrence, the account that is to be billed, and the DPW time frame. One of the time frames may be zero.

Type of Service	Occurrence	Account for Billing	DPW Time Frame
Outpatient	Day prior to admission and throughout the hospital stay	Inpatient	All Charges--number of days before the admission date that charges/credits are transferred.
Outpatient diagnostic	2-3 days prior to admission	Inpatient	Evaluate Diagnostic Charges--number of days including the All time frame that charges/credits are evaluated.
Outpatient non-diagnostic that relates to the admission	2-3 days prior to admission	Inpatient	Evaluate Non-diagnostic Charges--number of days including the All time frame that charges/credits are evaluated.

The following services are not subject to the DRG payment window:

- Physician’s professional service
- Ambulance services
- Chronic maintenance renal dialysis services
- Services provided by home health agencies that are not diagnostic services
- Services provided by skilled nursing facilities that are not diagnostic services
- Services provided by hospices that are not diagnostic services

The parameters in this function determine whether:

- Accounts have the patient type, financial class, and primary insurance plan for the DPW.
- A DPW time frame exists between two accounts, based on admission, discharge, and the outpatient suspense date.
- Charges that meet the criteria are transferred during midnight processing or if they are printed on the DRG Payment Window Report for further review.
- All charges, evaluate diagnostic charges, and evaluate non-diagnostic charges are automatically transferred or are printed on the DRG Payment Window report (FBR072).
- Some charges are excluded from DPW processing.
- The DRG Payment Window report includes detail charges and whether the report prints all DPW accounts in the DPW census or prints only new DPW accounts, revised DPW accounts, or DPW accounts with new, transferred, or changed charges.
- The outpatient abstract is required to identify non-diagnostic charges.

At patient admission when patient type, financial class, or primary insurance plan changes or when the admission or discharge date changes, the system evaluates the Financial Classes, Insurance Carrier/Plan, and Patient Types fields--the preliminary criteria--for the account. Both the inpatient and outpatient accounts must meet the preliminary criteria for the same DPW Code. Also, the potential must exist for the service date of a charge on the outpatient account to appear in the DPW time frame of the inpatient account.

The financial class, insurance plan and patient type do not have to match, but this data must appear in the parameters for the same DPW Code. If the account meets these preliminary criteria, the system either transfers the charges during midnight processing or prints them on the DRG Payment Window report, depending on the parameters. When any of these fields, the admission date, or discharge date are revised, the system re-evaluates the account and a DPW can be established or de-activated. When accounts meet the preliminary criteria, the window is established and both the inpatient and outpatient accounts are placed on DPW billing hold.

During midnight processing the system evaluates the outpatient account’s charges by service date to determine if any charges occurred in the all period, which is typically one day before the inpatient admission through the inpatient discharge. If they occurred in this time frame, the charges are transferred or reported according to the criteria of the DPW Code for the all period.

If the charge service dates occurred in the evaluate period, which is two to three days before the inpatient admission, the charges are evaluated individually to determine if they have a Revenue Code or combination Rev/HCPCS Code, indicating a diagnostic charge. The Diagnostic Revenue Code table and the HCPCS table are used to make this decision. If the charges are evaluated as diagnostic, the charges are transferred or reported according to the criteria of the DPW code for the evaluate diagnostic charge.

If the charge is not diagnostic, the charge is marked Pending until the inpatient account is marked Abstract Complete by Medical Records. If the DPW Code parameters are set to wait for the outpatient abstract, the charges are evaluated when both the inpatient and outpatient abstracts are complete. If the outpatient abstract is not required, the ICD code on each of the outpatient charges marked pending is evaluated to determine if there is a match with the inpatient principal or secondary ICD code. If the outpatient abstract is required, windows with pending charges are evaluated to determine if the outpatient principal ICD code matches the inpatient principal or secondary ICD code.

The O/P Abstract and I/P Abstract fields look to the TO (Inpatient) account's Final Bill Parameter. The system uses the same logic as that in Billing to determine if the TO account's bill requires ICD-10 or ICD-9 diagnosis and procedure codes.

If the TO account's bill edits for the existence of ICD-10 diagnosis and procedure codes, the system looks to the ICD-10 diagnosis codes on both the FROM and the TO accounts when performing the O/P Abstract and the I/P Abstract logic (meaning, the ICD-10 charge diagnoses, or the Principal ICD-10 Diagnosis in Medical Records on the Outpatient Account(s) are compared to the Principal and Secondary ICD-10 Diagnoses codes in Medical Records on the Inpatient Account).

If the TO account's bill edits for the existence of ICD-9 diagnosis and procedure codes, the system looks to the ICD-9 diagnosis codes on both the FROM and the TO accounts when performing the O/P Abstract and the I/P Abstract logic (meaning, the ICD-9 charge diagnoses, or the Principal ICD-9 Diagnosis in Medical Records on the Outpatient Account(s) are compared to the Principal and Secondary ICD-9 Diagnoses codes in Medical Records on the Inpatient Account).

If there is a mismatch between the coding methods on the TO (inpatient) account and any of the FROM accounts, this results in a DPW error which is reflected on the DRG Payment Window Report (FBR072x). For example, if the TO account requires ICD-10 codes, and the FROM account(s) only have ICD-9 codes, this would be a mismatch, and the accounts would be reflected on the report. This could occur when the Inpatient admission date is on or after the ICD-10 Effective Date on the Hospital Facility Options screen in STAR Patient Processing, but the Series account for the same patient is coded only in ICD-9 codes. The opposite would also be true: if the TO account requires ICD-9 codes, and the FROM account(s) only have ICD-10 codes, this would be a mismatch, and the accounts would be reflected on the report.

When there is a mismatch on the TO and FROM account(s) for the coding methods, the accounts are listed on the DRG Payment Window Report with the error message *DPW Hold. ICD9/ICD10 Mismatch*. The accounts are put on DPW Bill Hold (existing bill DPW hold). The system keeps the accounts on DPW bill hold until the mismatch is corrected (meaning, the needed version of the diagnosis codes are coded on the FROM accounts), or charges can be manually selected and moved via the DRG Payment Window Processor from the FROM account(s) to the TO account, and the DPW Bill Hold manually removed on the Account Status screen within Account Revision.

If no charges remain in a pending, report, or previously billed status, and the outpatient account is inactive on STAR Patient Care, the accounts are released from billing hold.

When an *inpatient* is assigned a room and bed, the system searches outpatient accounts for DPWs. If the account meets the criteria, the system evaluates the charges during midnight processing or online through the DRG Payment Window function, and either transfers them reports them, or marks them as pending, excluded, or previously billed, depending on the parameters. The account is re-evaluated if the admission is canceled or revisions are made to the financial class, patient type (before or after discharge), insurance plan (COB1), admission date, and discharge date. After the inpatient account moves to location AR, the accounts are reported, but no charges are transferred or evaluated.

Outpatient registrations are evaluated for DPWs when the account number is assigned or during automatic re-registration for series accounts. Charge evaluation occurs during midnight processing or online through the DRG Payment Window function. The account is re-evaluated if the outpatient registration is canceled, if the patient is auto discharged, when the outpatient is discharged, or if revisions are made to the outpatient's financial class, patient type (before or after discharge), or insurance plan (COB1).

The system evaluates inpatient accounts in location A/R that are modified, MPI merges, transfer visits, and Cross Facility accounts for preliminary criteria, but no charges are transferred or evaluated. These accounts appear on the report the day they meet the preliminary criteria (one day only). DPW windows that could not be established because of a charge to/from relationship or the existence of an inpatient final bill appear also. The report also contains warnings on accounts that need user review.

After you select this function, the system displays the *Building FIM code exclusion matrix* message and displays the following screen:

```
        General Hospital DRG Payment Window Parameters Processor
                                              Fri May 27, 2011 12:08 pm


 1 DPW Code           2 DPW Description                3 Edit Date
   CMS               MEDICARE11/01/10 01:55pm
 4 Financial Classes  5 Patient Types          6 Edit By
   M                   OPB,ER,JER,LEC,LIC++     New, Nancy
 7 Insurance Carrier/Plan
   400100,400200
 8 O/P Abstract   9 O/P Charges with No Diagnosis        10 I/P Abstract
   Yes              Report                                 All
11 Start Trans Code/Desc 12 Exclude FIM Dept             13 Exclude FIM Codes
   S0004-KEY DATA CHANG                                   Yes
14 All Chgs    15 Eval Diag Chgs 16 Eval Non-Diag Chgs   17 Discharge Day Chgs
   Transfer/3               Report/3        Report/3  Report
18 Rpt Detail Charges            19 Rpt Cumulative       20 Rpt Facilities
   Yes                              Yes                    B,C
21 End Trans Code/Desc           22 Chg Trans Code/Desc  23 Effective Date
   S0006-DPW Changed/Mo             S0006-DPW Changed/Mo    06/16/00
```

Field Explanations

1. DPW CODE (3-A-R)
This field contains the three-character code for the criteria identifying that two accounts comprise a DPW pair.

2. DPW DESCRIPTION (30-A-R)
This field contains the descriptive name for the DPW Code. You can enter up to 30 characters.

3. EDIT DATE (DISPLAY ONLY)
This field displays the date and time that a code is added or updated.

4. FINANCIAL CLASS (TABLE LOOKUP-R)
This field enables you to select one or more financial classes. Each account in the DPW pair must have one of these financial classes.

When you access this field, the system displays the financial classes defined for the facility. Enter the numbers for the financial classes you want. The field displays the codes for the classes selected.

5. PATIENT TYPES (TABLE LOOKUP-R)
This field enables you to select one or more patient types. Each account in the DPW pair must have one of these patient types.

When you access this field, the system displays the patient types defined for the facility. Enter the numbers for the patient types you want. The field displays the codes for the types selected.

NOTE: Pre-admission and inpatient pre-admission testing patient types are not included in the selection list.

6. EDIT BY (DISPLAY ONLY)
This field contains the name of the employee who added or last updated the DPW Code.

7. INSURANCE CARRIER/PLAN (TABLE LOOKUP-R)
This field enables you to select up to three insurance carriers/plans. Each account in the DPW pair must have one of these insurance carriers or plans. The field displays the codes for the types selected.

When using this field the first time, you can enter a string of insurance carrier/plan codes separated by commas, or you can enter a hyphen (-) and select from the list. You can select from a partial list by entering the first part of the code followed by a hyphen (-).

If this field already contains entries, the system displays them in a list when you access the field. You can remove entries or add them.

If you attempt to associate more than three DPW codes with an insurance plan, the following message is displayed after the fourth DPW code is entered:

Plan xxxxxx has 3 or more DPW codes already!

If you receive the above error message on one or more plans selected, none of the highlighted plans are selected. You must re-enter your selection, excluding the insurance plans that created the error.

8. O/P ABSTRACT (1-A-O)
This field indicates whether the Principal Diagnosis in the outpatient abstract or the diagnosis in the charge is used to determine if a non-diagnostic charge is admission-related.

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

Use outpatient abstract to determine admission-related charges (Y/N)-- |

If you enter **Y** for Yes, pending charges are evaluated when the outpatient account is abstracted to determine if the outpatient primary ICD-10-CM or ICD-9-CM code matches an inpatient principal or a secondary ICD-10-CM or ICD-9-CM code. The charges are evaluated when both the inpatient and outpatient abstracts are complete. If you enter **N** for No, the charge diagnosis is used in the evaluation. The ICD-10-CM or ICD-9-CM code on each of the outpatient charges marked pending is evaluated to determine if there is a match with the inpatient principal or secondary ICD-10-CM or ICD-9-CM code.

9. O/P CHARGES WITH NO DIAGNOSIS (1-A-O)
This field is used when the outpatient abstract is not used to determine admission-related charges for non-diagnostic HCPCS (determined from the Diagnostic Revenue Code Table) meaning the response for the O/P Abstract is No.

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

If a charge has no diagnosis, then (T)ransfer, (R)eport, Do (N)ot Transfer, or Mark (P)ending? [P]--

- If **T** for Transfer is selected, non-diagnostic outpatient charges qualifying for the evaluation time frame with no charge diagnosis are transferred to the inpatient account.

- If **R** for Report is selected, non-diagnostic outpatient charges qualifying for the evaluation time frame with no charge diagnosis are reported on FBR072x.

- If **N** for Do Not Transfer is selected, then non-diagnostic outpatient charges qualifying for the evaluation time frame with no charge diagnosis remain on the outpatient account.

- If **M** for Mark Pending is selected, then non-diagnostic outpatient charges qualifying for the evaluation time frame with no charge diagnosis are marked as pending, meaning the user needs to determine whether the charge should be transferred using DRG Payment Window Processor or DRG Payment Window Worklist.

NOTE: The Non Diagnostic charges WITH an ordering diagnosis are either reported or transferred, according to the DPW Parameters field Eval Non-Diag Chgs. The ordering diagnosis on the outpatient charges is compared to the Principal Diagnosis or the Principal and Secondary Diagnoses in the Inpatient Abstract (depending on the I/P Abstract field).

10. I/P ABSTRACT (1-A-O)
This field determines which diagnosis codes are used to compare with outpatient diagnosis codes. The parameter settings are **P** for primary diagnosis or **A** for all diagnosis codes from Medical Records on the inpatient visit. When this field is accessed, the following prompt is displayed:

Use (P)rimary Diagnosis or (A)ll Diagnoses from the inpatient abstract to determine admission-related charges-- |

11. START TRANS CODE/DESC (TABLE LOOKUP-R)
This field enables you to select the transaction code for transaction type S (status transfer) to be used when an account meets the preliminary criteria and a DPW is established. You can enter a transaction code, or enter a hyphen (-) and select from the list. This transaction code is also used when you initiate a DPW manually.

12. EXCLUDE FIM DEPT (TABLE LOOKUP-O)
This field enables you to identify any FIM Departments that are excluded from DPW processing. You can select departments for which charges are *never* considered related to the admission, such as ambulance services. This field displays the codes for the excluded FIM departments. This field may be left blank.

13. EXCLUDE FIM CODES (TABLE LOOKUP-O)
This field determines whether the FIM codes for any FIM department are excluded from DPW processing.

Options are:

- Yes - FIM exclusions exist
- No - FIM exclusions do not exist
- Updated - Change was made to FIM exclusion list

Updated is used whenever an addition or deletion is made to the list. The “updated” value is temporary and only appears while the parameter is being maintained. When you go back into the parameter after completing your changes, the field displays Yes or No. The FIM exclusion changes are saved if Y is entered at the Accept Screen prompt. You select the FIM department to exclude and then select the FIM codes to be excluded within that department. This field displays Yes if there are FIM codes that are excluded. This field may be left blank. If FIM codes have been excluded, those departments are highlighted when the department list is displayed.

14. ALL CHGS (2-N-O/1-A-C)
This field enables you to enter the number of days in this time frame and to indicate whether to transfer or report charges in the All period. You can enter from 0 to 31 days. This is the number of days before the admission date. After you enter the number of days, the system prompts you to enter **T** to transfer the charges in this window automatically or **R** to report the charges in this window for further review. The DPW billing hold on the account remains until charges in a report status are handled manually.

The system displays the type of charge, a slash, and the number of days. For example, *Transfer/1* transfers all outpatient charges in the 1-day window. *Report/3* reports all outpatient charges in the 3-day window. In this case, you must transfer the charges manually.

15. EVAL DIAG CHGS (2-N-O/1-A-C)
This field enables you to enter the number of days for the entire DPW time frame and determine whether to transfer or report diagnostic charges in the evaluate period. You can enter a number that is 1 greater than the value in the All Chgs field up to 62 days. Note that the number of days must be greater than the amount in the All Chgs field because the time frame includes it. After you enter the number of days, the system

prompts you to enter **T** to transfer the diagnostic charges in this window automatically or **R** to report the diagnostic charges in this window for further review.

The value in this field fills in the number in the Eval Non-Diag Chgs field.

The system displays the type of charge, a slash, and the number of days. For example, *Transfer/1* transfers all diagnostic charges in the 1 day window. *Report/3* reports all diagnostic charges in the 3-day window. In this case, you must transfer the charges manually.

You can indicate a time frame for the All Chgs field or the Eval Diag Chgs field but not both if desired.

16. EVAL NON-DIAG CHGS (1-A-R)
This field enables you to determine whether to transfer or report non-diagnostic charges in the window. The system prompts you to enter **T** to transfer the admission-related non-diagnostic charges in this window automatically or **R** to report the admission-related non-diagnostic charges in this window for further review. The system fills in the same number of days as contained in the Eval Diag Chgs field.

You cannot access this field unless the Eval Diag Chgs field contains a value.

17. DISCHARGE DAY CHGS (1-A-O)
This parameter determines how charges on the patient account with a service date matching the date on inpatient discharge are handled. Three entry options are available:

- **E** (Exclude) - Charges remain on outpatient account.
- **R** (Report) - User selects charges moving to inpatient account.
- **T** (Transfer) - Charges move to inpatient account.

18. RPT DETAIL CHARGES (1-A-O)
This field determines whether the system prints detail charges on the DRG Payment Window report (FBR072). If you enter **Y**, the system prints the following for each charge that is transferred, pending, or reported, or that requires user review:

- Svc Date
- Dept
- Code
- Rev/HCPCS
- Description
- Qualify/Status
- Quantity
- Price
- Pro Fee Indicator

If you enter **N**, the system prints the account without the transferred or qualifying charges. The default is *Yes*.

See the description for the Rpt Cumulative field for more information about the results of the settings in this field.

19. RPT CUMULATIVE (1-A-O)
This field determines whether the system prints accounts daily on the DRG Payment Window report (FBR072). If you enter **Y**, the system prints the accounts with transferred, reported or pending charges every day until the charges transfer. If you enter **N**, the system prints new DPW accounts and DPW accounts with transferred charge activity. The default is *No*.

The following table shows the results of different combinations of the settings for the Rpt Detail Chg and the Rpt Cumulative fields.

Rpt Detail Chgs?	Rpt Cumulative?	Criteria	Charges
Y	Y	• DPW special conditions • DPW initiated or changed • Active DPW having reported, pending, billed or current charge activity	• Reported • Pending • Billed Charges • Current Charge Activity
Y	N	• DPW special conditions • DPW initiated or changed • Active DPW with current charge activity	• Reported • Pending • Billed Charges • Current Charge Activity
N	Y	• DPW special conditions • DPW initiated or changed • Active DPW with reported, pending, billed, or current charge activity	None
N	N	• DPW special conditions • DPW initiated or changed • Active DPW with current charge activity	None

20. RPT FACILITIES (TABLE LOOKUP-O)
This field determines if accounts across facilities are evaluated for the preliminary criteria. Accounts that meet DPW criteria across facilities are reported as they are identified, and no charges transfer. If no facilities are selected, outpatient accounts are evaluated only against inpatient accounts in the same facility. This field may be left blank.

21. END TRANS CODE/DESC (TABLE LOOKUP-R)
This field enables you to select the transaction code for transaction type S (status transfer) to be used when an account no longer meets the preliminary criteria. You can enter a transaction code, or enter a hyphen (-) and select from the list. This transaction code is also used when you delete a DPW manually. This field displays the code and description.

22. CHG TRANS CODE/DESC (TABLE LOOKUP-R)
This field enables you to select the transaction codes for transaction type S (status transfer) to be used when an account has a data change that affects the window after the preliminary criteria are met. The system displays the code and description.

23. EFFECTIVE DATE (DISPLAY ONLY)
This field displays the date when the conversion program was run. This date is used to determine which accounts are automatically evaluated. The inpatient discharge date determines the evaluation: if the discharge date is prior to the effective date, the account is not evaluated.

If the conversion has not been run, this field is blank.

After you press ENTER, the second screen is displayed. This screen is used to indicate whether DPWs should be activated or deactivated, and whether the time frame for DPWs should be changed when the inpatient account is in AR.

```
         General Hospital DRG Payment Window Parameters Processor
                                                Fri Jul 01, 2005 02:05 pm



 1 AR I/P Processing                  2 Report Chgs for AR I/P
   All                                  No
 3 Detail Charges on FBR072 for AR I/P




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

Field Explanations

1. AR I/P PROCESSING (TABLE LOOKUP-O)
This field indicates how DPWs should be handled when the inpatient account is in location A/R. When this field is accessed, a list of A/R I/P Processing choices is displayed. You can choose one of the following processing choices from the list:

Activate, **Inactivate**, **Change Time Frame**, or type **A** for All.

If Active or All is selected, and if a DPW pair is identified, and the I/P has final billed, the DPW pair is activated, and charges are moved to the inpatient account if appropriate. This means charge activity can occur on both accounts. If neither option is selected, the system continues to report that a DPW was not activated because the inpatient account had a final bill.

If Inactive or All is selected, and if a DPW pair ceases to qualify, and the I/P account has final billed, the DPW is inactivated, and charges return to the outpatient account. This means charge activity can occur on both accounts. If neither option is selected, the system continues to report that a DPW was not inactivated because the inpatient account had a final bill.

If Change Time Frame or All is selected, and if the time frame for a DPW should change, and the I/P has final billed, the change is made. If neither option is selected, the system continues to report that the DPW was not changed because the I/P final billed. If date changes are allowed, and they occur, the following message is displayed:

DPW Changed. I/P Final Billed.

2. REPORT CHGS FOR AR I/P (1-A-CONDITIONAL)
This field can be used if the AR I/P Processing field is used, and transfer is indicated for All Chgs, Eval Diag Chgs, Eval Non-Diag Chgs, or Discharge Day Chgs (on the first screen). This field allows you to determine whether, If a DPW is activated when the inpatient account is in AR and charges are being transferred per the DRG Payment Window Parameters screen, whether charges should be reported rather than transferred for DPWs created after the inpatient account was in AR. When this field is accessed, the following prompt is displayed:

Should charges be reported rather than transferred for AR I/P DPW pairs (Y/N)--

You can enter **Y** (Yes), to have the system report all charges in the four categories rather than transfer if the DPW is created after the inpatient account final billed. If you enter **N** (No), charges are transferred.

3. DETAIL CHARGES ON FBR072 FOR AR I/P
This field can be used if the AR I/P Processing field is used, and Rpt Detail Charges on the first screen is set to N for No. If the Rpt Detail Charges field on the first screen is set to Y for Yes, detail charge information appears on FBR072 if the DPW is created after the inpatient account final billed. When this field is accessed, the following prompt is displayed:

Report detail charge information on FBR072 for AR I/P DPW pairs (Y/N)--

You can enter **Y** (Yes) to report detail charge information on FBR072 or **N** (No) not to report detail charge information on the report.

After you maintain the table, the system displays the following prompt:

Do you want a printed list (Y/N) [N]--

To print a list, enter **Y**. To select not to print a list, press ENTER or enter **N**.

After you enter Y, the system displays the following prompt:

Start DPW conversion for DPWs listed above (Y/N)--

To start the DPW conversion for the listed DPWs, enter **Y**. If you do not want to run the conversion program, enter **N**.

Impact

After the parameters are set, you must run the conversion program to evaluate all active inpatient accounts. You must run the conversion one time for each DPW code. After the conversion program is done, the system updates the Effective Date field for the DPW code.

You cannot rerun the conversion for a single DPW code.

You cannot access the DPW Table until the conversion is complete. If the conversion job is not successful, you must restart the conversion. If changes are made to the parameters after the conversion program runs, the system does not re-evaluate any accounts.

Chapter 3 - PA/AR PARAMETER FILE MAINTENANCE

BILLING PARAMETERS

This parameter is used to indicate the specific timing criteria needed to produce patient bill forms. Four types of bills are produced by the system:

- Cycle or Interim - Patients receive a cycle or interim bill if the patient is an inpatient and is still in the hospital. Recurring (series) patients can also receive cycle bills
- Final - A final bill includes all charges not previously billed and is produced when the patient is discharged or when outpatient services have been completed.
- Late - A late bill contains only those charges that were placed on the account after the final bill was produced.
- Adjustment Bill - An adjustment bill is a replacement bill that contains all charges billed on the final bill as well as any unbilled late charges.
- Cycle Adjustment Bill - A cycle adjustment bill replaces previous cycle or cycle adjustment bills. The following is an example of when a cycle adjustment bill could be created: When billing End of Month, Service Date Charges Only, if the month of January has been billed, and in February, a charge or credit is entered with a January service date, a rebilling of the January cycle bill can be requested automatically or manually to include this unbilled charge/credit. If the month of February has billed when the charge or credit with a January service date was entered, both January and February would be rebilled, when the cycle adjustment bill for the January billing period is requested.

A patient is assigned a final bill parameter at admission or registration to the hospital. This assignment is based on the patient primary carrier billing parameter. If the patient does not have insurance, the billing parameters on the patient financial class are used for the assignment.

The assignment of a cycle bill is optional. If the patient's insurance plan or financial class parameters does not have a cycle bill parameter, the system does not assign a cycle bill to the patient. Recurring (series) patients can receive a special type of cycle bill, called a *series bill*. This bill provides a summary of charges, payments, and adjustments for each bill sequence.

Patient parameters are automatically changed by the system as long as the patient remains in account location PA (not final billed). This change occurs when the patient type changes (for example, from ER to Inpatient) or when the primary insurance of the patient changes.

Two types of billing parameters exist on the system: final and cycle. Late bill and adjustment bill criteria are defined through the final bill parameters.

There are three bill forms on the system. The detail form lists all charges in detail, the summary form provides a summary based on the Charge Summarization field on the

Patient Bill Format screen, and the prorated form lists the results of insurance proration for each insurance plan. The user can choose all or a combination of these forms for each billing parameter. An additional bill form, the *series bill*, is also available on cycle bill parameters.

This parameter is not split by facility.

After this parameter is selected, the system prompts you to enter a billing parameter code. You can enter the code or a hyphen (-) to display a list of valid codes. This list includes the parameter code, description, parameter type (either cycle or final) and the bill selection method if it is a cycle bill parameter.

If you enter a new billing parameter code, the system asks if you want to add the code. Enter **N** to exit; enter **Y** or press ENTER to display the following prompt:

Billing parameter type (C)ycle or (F)inal? --

Enter **C** to add the billing parameter as a cycle bill type. Enter **F** to add the billing parameter as a final bill type.

The screen the system displays next depends on whether you are adding or editing a cycle or final bill type. These screens are discussed separately on the following pages.

Cycle Bill Types

If you are adding/editing a billing parameter that is for a cycle bill type, the system displays the following screen:

```
             General Hospital Billing Parameters Processor
                                                 Mon Jun 08, 1992 11:02 am
Billing Parameters
 1 Code           2 Description                          3 Bill Parm Type
   2                Recurring (Series)                     Cycle
 4 Status         5 Edited By                            6 Edit Date/Time
   Active           Morgan,Wendell                         04/08/92 0919am
 7 Detail Bill    8 Summary Bill         9 Prorated Bill  10 Series Bill
   Yes              Yes                    Yes              Yes
11 Combine Prof. Fees
   No
12 Bill Transaction Code               13 Patient Bill Message
   Y9999-CYCLE BILLED                     Payment Request
14 Series Bill Transaction Code        15 Series Bill Message
   Y0001-Series Bill                      Payment Request









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the billing parameter.

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

3. BILL PARM TYPE (DISPLAY ONLY)
This field indicates whether this parameter is used for final or cycle bills. Entry options are F (final) or C (cycle). This field, which is required at initial set up of the billing parameter, determines the billing parameter type. If you are editing a parameter, this field cannot be changed.

4. STATUS (DISPLAY ONLY)
This field indicates whether the billing parameter code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

5. EDITED BY (DISPLAY ONLY)
This field contains the name of the user who last edited this parameter.

6. EDIT DATE/TIME (DISPLAY ONLY)
This field contains the date and time this parameter was last edited.

7. DETAIL BILL (1-A-R)
This field indicates whether a detail patient bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. A detail bill lists all charges that are billed with the detail charge description, dates, and amounts.

8. SUMMARY BILL (1-A-R)
This field indicates whether a summary patient bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. A summary bill lists the charges which are summarized based on the *Charge Summarization* that you selected on the Patient Bill Format. For an explanation of the Patient Bill Format, refer to the Financial System Management section in the *General Information Volume* in the STAR Financials Patient Accounting Reference Guide.

9. PRORATED BILL (1-A-R)
This field indicates whether a prorated bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. A prorated bill lists charges by proration summary code with the estimated liability of each insurance plan for the patient.

10. SERIES BILL (1-A-R)
This field indicates whether the system should produce a series bill for accounts assigned to this billing parameter. Entry options are **Y** for Yes and **N** for No; the default is N. The series bill displays charges and insurance payments and adjustments by bill

sequence, plus a summary of patient payments and adjustments. This type of bill is intended to be used for recurring patient types. These are typically patients receiving ongoing treatments, such as dialysis, physical therapy, or chemotherapy.

NOTE: If you are sending a series bill, you can avoid sending the patient multiple bill types by selecting **N** for no for Detail Bill, Summary Bill, and Prorated Bill fields.

11. COMBINE PROF. FEES (1-A-R)
This field indicates whether the hospital fee and professional fee for an item is combined as one line item on a detail bill. Entry options are **Y** for Yes and **N** for No; the default is N. If you enter Y, the detail bill displays one charge line for an item that has a corresponding professional fee. The hospital fee description is printed. The amount is the combined total of the hospital and professional fees. If you enter N, the hospital and professional fees are printed as separate line items.

12. BILL TRANSACTION CODE (4-N-R)
This field contains the transaction code indicating that a bill has been produced. The code and description is displayed in the account transaction history. A system-generated comment is also displayed in the account transaction history. While the code and description are defined as generic terms for types of bills, the comment describes the actual type of bill. For example, final, adjustment, and late bills each use the transaction code and description reflecting the produced bill (final) and the comment varies, depending on the actual type of bill that was generated (adjustment).

You can enter the code or a hyphen (-) to display a list of valid codes used for recording patient bills for transaction type Y.

13. PATIENT BILL MESSAGE NUMBER (4-N-O)
This field contains the code identifying the message (from the Patient Bill Messages table) that prints on the last page of the patient detail bill and summary bill.

14. SERIES BILL TRANSACTION CODE (4-N-C)
This field contains the transaction code that updates the account's transaction history when a series bill is produced. The code and description are displayed in the account transaction history. A system-generated comment is also displayed in the account transaction history.

You can enter the code or a hyphen (-) to display a list of valid codes used for recording patient bills for transaction type Y.

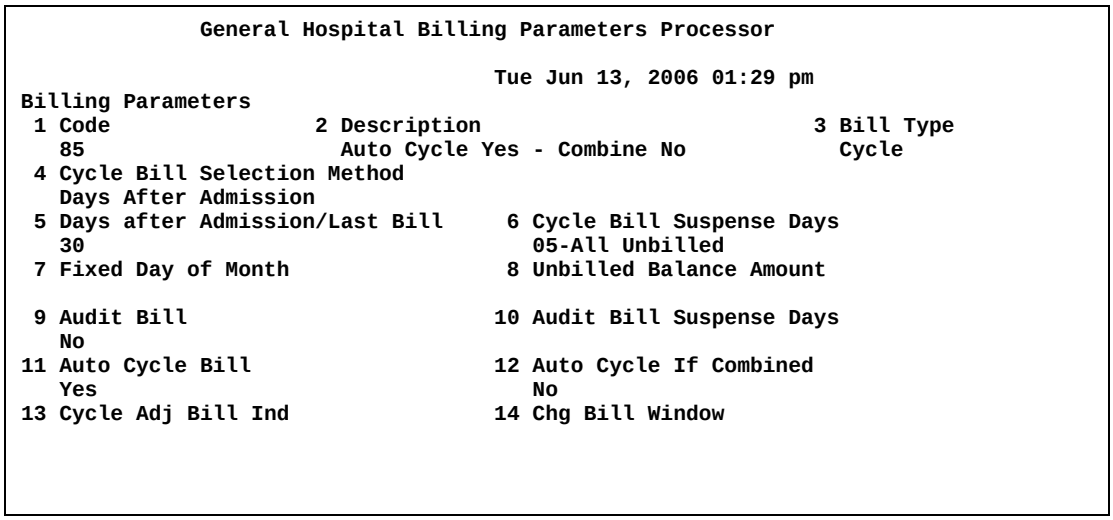
You can only access this field if a Y was entered to the Series Bill field. If Y was entered to the Series Bill field, this field is required.

15. SERIES BILL MESSAGE (4-N-O)
This field contains the code identifying the message (from the Patient Bill Messages table) that prints on the last page of all series bills.

If you are updating an existing parameter and entered Y to the Series Bill field, the system displays the patient bill message you identified in the Patient Bill Message field as a default in this field. If you do not want a message to print on the series bill, you can delete the default entry in this field.

You can only access this field if a Y was entered to the Series Bill field.

When these fields are completed, you have the option of editing or deleting this information, or displaying the second screen of the transaction, as follows.



Field Explanations - Screen 2 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the billing parameter.

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

3. BILL TYPE (DISPLAY ONLY)
This field indicates whether this parameter is used for final or cycle bills. Entry options are **F** (final) or **C** (cycle). This field, which is required at initial set up of the billing parameter, determines the billing parameter type. If you are editing a parameter, this field cannot be changed.

4. CYCLE BILL SELECTION METHOD (1-A-R)
This field determines the method that is used to generate cycle bills. Entry options are **A** (number of days after admission or registration and then number of days since the last bill), **F** (on a fixed day of the month), **E** (at the end of the month), **U** (when there is an unbilled amount), or **S** (service date which generates a bill for each date the patient receives a service/charge.)

5. DAYS AFTER ADMISSION/LAST BILL (3-N-C)
This field contains the number of days after admission that determine when the next cycle bill is generated. This field is required if the Cycle Bill Selection Method field contains A.

6. CYCLE BILL SUSPENSE DAYS (2-N-R)
This field contains the number of suspense days to wait before a cycle bill is produced by the system. The entry range is 0 to 40.

The operation of this field is similar to that of final bill suspense days in that it provides a user-defined number of days to wait before bill production, enabling departments adequate time to post charges. The system selects the account for bill production based on the cycle bill selection method. Once selected, the system waits the number of days specified in this field before producing the bill. For example, a patient registered 1/1/98 with a cycle bill parameter of *Days after Admission - 10 days* would be selected for bill production in batch on 1/10/98. If the cycle bill suspense days for the parameter is set to *5*, the system would not produce the bill until 1/15/98.

After you enter a value to this field, the system displays the following prompt:

Include A (unbilled) or S(ervice Date) charges? (A/S) --

The system uses either the service date criteria or all unbilled charges criteria to determine which charges to include on the bill. Enter **A** to include all unbilled charges on the bill. Enter **S** to use the service date in determining the charges on the bill. For End of Month and Service Date cycle bill types, enter **S** (service date). The system display in this field then reflects your choice as the number of days followed by All unbilled or Service Date.

Using the above example, if you set the parameter to Service Date, the system includes all unbilled charges with a service date of 1/10 or earlier on the bill produced 1/15. If you set the parameter to All unbilled, the system includes all unbilled charges on the account regardless of the date of service.

This field is not used for unbilled amount cycle bills.

7. FIXED DAY OF MONTH (2-N-C)
This field contains the fixed day of the month when cycle bills are generated and is required if the Cycle Bill Selection Method field contains F. The entry range is 1 to 28.

8. UNBILLED BALANCE AMOUNT (6-N-C)
This field contains the minimum unbilled dollar amount that is required to generate a cycle bill and is required if the Cycle Bill Selection Method field contains U. For example, if $500 is entered, a cycle bill is produced when an account accumulates $500 in unbilled charges. The entry range in whole dollar amounts is 0 to $999,999.

9. AUDIT BILL (1-A-R)
This field indicates whether audit bills are produced for this billing parameter. Entry options are **Y** for Yes and **N** for No; the default is N. This option is not available for Unbilled and Service Date cycle bill types.

An audit bill includes all charges that would be included on the cycle bill if it were produced. Audit bills allow the biller to make any necessary corrections to the charges prior to the printing of the cycle bill.

This field is not used for unbilled amount cycle bills.

10. AUDIT BILL SUSPENSE DAYS (2-N-C)
This field contains the number of days after the end of the month the system should wait before producing audit bills for this billing parameter. This field is required if the Audit Bill field contains Y. The entry range is 0 to 31; the default is 0. The value you enter to this field must be at least one less than the value in the Cycle Bill Suspense Days field.

11. AUTO CYCLE BILL (1-A-R)
This field indicates whether an automatic patient bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. If you enter Y, each time a patient is admitted the system checks the billing parameter(s) for the existing active account(s) to determine if the system should generate an automatic cycle bill request. If an automatic cycle bill request is generated, that request is not processed until the cycle bill suspense days are met. PAT patient types are excluded from this process. If an admission's type is changed from a PAT type to a patient type that is not a contract and the account is in PA, requests for automatic cycle bills are created if the table settings indicate that the system should do so.

For example, if the patient has an outpatient series account for ongoing physical therapy and is subsequently admitted as an inpatient, the system can generate an automatic cycle bill request for other active accounts. The system checks the cycle bill parameter for the active accounts to determine if a cycle bill should be generated, based on the response to produce an automatic cycle bill. This option, together with the use of service date internal elements, thus prevents overlapping days on claims. The bill request generated is an automatic cycle bill, so that an account normally receiving an end of month cycle bill in this special scenario receives a cycle bill:

Bill from/thru dates:	Type of Bill:
01/01/95 - 01/31/95	EOM Cycle Bill
02/01/95 - 02/03/95	System-generated Automatic Cycle Bill
02/03/95 - 02/05/95	Inpatient Bill
02/04/95 - 02/28/95	EOM Cycle Bill

When these fields are completed, you have the option of editing or accepting the information entered. Accepting the screen completes the entry of this cycle bill parameter. This option is not available for Service Date cycle bill types. For Service Date cycle bill types, the request for the auto cycle bill remains pending until the suspense period has expired. A request for an auto cycle bill can be removed if the account is discharged during the suspense period.

12. AUTO CYCLE IF COMBINED (1-A-R)
This field indicates how an Auto Cycle Bill request is handled when the account is being combine billed to another account. The field cannot be accessed unless the response to the Auto Cycle Bill field is Yes. When this field is accessed, the following prompt is displayed:

Auto cycle bill even if combine billed? (Y/N) [Y]--

If the response to the prompt is blank or Yes, the Combine Billing process bypasses auto cycle bill requests for a charge from account. This means that the auto cycle bill is produced. If the response to the prompt is No, the Combine Billing process uses the typical combine billing logic. This means that when a bill request exists for the charge to account, charges for the charge from account are moved to the charge to account.

13. CYCLE ADJ BILL IND (1-A-O)
This field determines whether cycle adjustment bill processing is allowed for accounts associated with this billing parameter. When this field is accessed, the following prompt is displayed:

Allow Cycle Adjustment Billing? (Y)es, (N)o or (B)lank

You can enter **Y** (Yes) to allow cycle adjustment billing, **N** (No) to disallow cycle adjustment billing, or **B** (Blank) to leave the field blank. A blank field indicates that the system is to use the value in the Cycle Adj Bill Ind field on the Patient Bill Format Processor to determine if cycle adjustment billing is allowed. To determine whether the rebilling of cycle bills is valid for accounts in location PA and AR, the system looks at the Cycle Adj Bill Ind field on the Billing Parameters screen and the Cycle Adj Bill Ind field on the Patient Bill Format Processor. If the Cycle Adj Bill Ind on the Billing Parameters screen contains a value of *Yes* or *No*, the system uses the value associated with the Billing Parameters for the account's cycle adjustment bill indicator. If the Cycle Adj Bill Ind field on the Billing Parameters contains a blank, the system uses the value for the Cycle Adj Bill Ind field on the Patient Bill Format Processor.

The Cycle Adj Bill Ind field is reviewed when a cycle adjustment bill is requested. This cycle adjustment bill indicator for an account is set at the time of the first cycle bill and subsequent bills must comply with the setting of the indicator. The system uses the cycle adjustment indicator associated with an account to determine if cycle adjustment bill processing is allowed for the account. The cycle adjustment indicator can be manually updated on the Account Status screen after the first cycle bill is produced. The cycle adjustment bill indicator also is included on the Billing Information screen,

but it is a display-only value. The cycle adjustment indicator can be updated only after it is initially set with the first cycle bill.

By having the parameter located on both the Billing Parameter screen and the Patient Bill Format screen, you have the flexibility to have certain cycle billing parameters set to allow cycle adjustment billing and can set the overall system parameter on the Patient Bill Format Processor not to allow cycle adjustment bills. An account uses the value in the Patient Bill Format Processor for the Cycle Adj Bill Ind field if the field is blank on the Cycle Billing Parameters. If an account has existing cycle bills, it is not eligible for cycle adjustment processing, unless the cycle adjustment bill indicator for the account is updated to allow cycle adjustments.

Once the Cycle Adjustment Bill indicator is set for an account, it can be updated only on the Account Status screen. The Cycle Adjustment Bill indicator displays in the CycA field on the Account Status screen and on the Billing Inquiry screen. The cycle adjustment bill indicator for an account can be updated to *No* or to the value in the Cycle Adjustment Bill Indicator field for the cycle bill parameters or, if this is blank, to the value defined on the Patient Bill Format processor for the Cycle Adjustment Bill Indicator. If the Cycle Adjustment Bill Indicator is changed to a value of *No* when it had been a value of *Yes* on the Cycle Bill Parameters or Patient Bill Format, the associated Cycle Adjustment parameters are deleted. Since the Cycle Adjustment parameters have been deleted, cycle adjustment bill processing can't occur for accounts, even if the cycle adjustment bill indicator for the account is set to Yes.

The following table shows how the setting of the Cycle Adj Bill Ind field on the Cycle Bill Parameters and the Patient Bill Format Processor are dependent on each other.

Billing Parameter Setting	Patient Bill Format Setting	Result
Yes	Yes	Allow Cycle Adjustment Billing for accounts associated with the billing parameter and allow Cycle Adjustment Billing for all other accounts.
Yes	Blank or No	Allow Cycle Adjustment Billing for accounts associated with the billing parameter and don't allow Cycle Adjustment Billing for all other accounts.
No	Yes	Don't allow Cycle Adjustment Billing for accounts associated with this billing parameter and allow Cycle Adjustment Billing for all other accounts.

Billing Parameter Setting	Patient Bill Format Setting	Result
No	No	Don't allow Cycle Adjustment Billing for accounts associated with this billing parameter and don't allow Cycle Adjustment Billing for all other accounts.
Blank	Yes	The system looks to the Patient Bill Format setting to determine if Cycle Adjustment Billing is allowed for accounts. Allow Cycle Adjustment Billing for all accounts.
Blank	Blank or No	The system looks to the Patient Bill Format setting to determine if Cycle Adjustment Billing is allowed for accounts. Don't Allow Cycle Adjustment Billing for any accounts.

NOTE: If the value in the Cycle Adj Bill Ind field is changed from a value of *Yes*, the system displays the following message to warn you that it is going to delete the associated cycle adjustment parameters:

Associated Cycle Adj Parms will be deleted. Are you sure? (Y/N)-[N]

If you enter **N** (No), the system takes you back to the first prompt for this field: *Allow Cycle Adjustment Billing? (Y)es, (N)o, or (B)lank.* If you enter **Y** (Yes), the cycle adjustment parameters are deleted when the screen is accepted.

14. CHG BILL WINDOW (3-N-O)

This field indicates the number of days that you can enter a charge on an AR account, after the Date of Service has passed, before the AR account is placed automatically on bill hold with a type of O (Old Charge). This parameter is used on accounts where the date of service on the charge was billed previously. When this field is accessed, the following prompt is displayed:

Enter Chg Bill Window causing AR account to be placed on Old Chg Bill Hold--

You can enter a number of days from **1** to **999** or leave the field blank. If this field is left blank, the system looks at the Patient Bill Format screen to determine if a Chg Bill Window has been defined for the overall facility.This field can be accessed only if the Cycle Adj Bill Ind field is set to No or is blank. If the Cycle Adj Bill Ind field is set to Yes, and you try to access this field, the following error message is displayed:

Error: Cycle Adj Bill is active for this parameter

Only AR Accounts are held before a cycle adjustment, adjustment, or late bill is produced. Cycle bills can still occur.

If no overall facility Chg Bill Window is defined, and an account's primary insurance does not have a billing parameter attached that has a defined Chg Bill Window, charges placed on the AR account are not edited for a Chg Bill Window or placed on bill hold with the type of O (Old Charge). However, these charges are placed in the Unbilled Charge Worklist.

Cycle Adjustment Parameters

If the Cycle Adj Bill Ind field is set to Yes (allow cycle adjustment billing), the following screen is displayed:

```
                    CYCLE ADJUSTMENT PARAMETERS

1 CycA Max Days Since Service      2  CycA Zero Bal
  90                                  No
3 Manual CycA Chg/Cr/Dys Override for Subsequent Bills              4 Auto Cycle Adj
  Yes                                                                  Yes
5 Min Unbilled Charges             6 Min Unbilled Charge Amt
  1                              $10.00
7 Min Unbilled Credits             8 Min Unbilled Credit Amt
   1                                                  $10.00-
9 CycA Suppress Subsequent Bills/ Do Not Load Clms
```

This screen contains the Cycle Adjustment parameters associated with the Billing Parameter.

Field Explanations

1. CYCA MAX DAYS SINCE SERVICE (4-C-O)
This field is used to determine the valid period after the service date of a charge for billing the charge. This field indicates the maximum number of days from charge service date that a charge can be included on a cycle adjustment bill. The field allows you to set a limit on the number of days past the service date of an unbilled charge that the charge can be billed on a cycle bill. When this field is accessed, the following prompt is displayed:

Enter max days past service date that charge can be billed automatically (NNNN) or (U)nlimited--

You can enter a number of days from **0** through **999** or **U** for Unlimited. If you enter U (unlimited), unbilled charges always can be billed automatically. If you enter a zero, unbilled charges can't be billed automatically, since the maximum is set to zero days past the service date. If you enter a number other than zero, the system adds that number to the service date to determine the maximum date that an unbilled charge can

be billed automatically. To qualify for an automatic cycle adjustment bill, the max date must be equal to or less than the date of the unbilled charge that is being reviewed for automatic cycle processing. If the parameter is equal to a value of blank, there is no automatic cycle adjustment billing and no loading of new charges/credits for subsequent cycle adjustment bills.

This field indicates the maximum number of days past the service date that a charge is allowed to be billed. For example, some payors require that a service be billed within 90 days of the service, so you could set this parameter to 90. This field can be used to prevent old charges from automatically billing on a prior cycle bill. If a charge doesn't qualify per the max days defined in the CycA Max Days Since Service field, the charge does not appear on an automatic cycle adjustment bill for the billing period. If the cycle adjustment bill was requested in Single Bill Request or Instant Adjustment Bill, the charge would appear on the selected cycle adjustment bill, but charges outside of the max days wouldn't appear on the subsequent cycle adjustment bills following the cycle adjustment bill selected for the manual rebill unless the override parameter for subsequent cycle adjustment bills is set to Yes.

To calculate the maximum date that a charge can be included on an automatic cycle adjustment bill, the system uses the service date and adds the number of days in the field. For example, if the Service Date is 1/1/06, and this field is set to 90, the last date an unbilled charge for 1/1/06 can be included on an automatic cycle adjustment bill would be 3/31/06. If the parameter is set to 30, and the service date for the charge was 1/1/06, the last date this charge is eligible for an automatic cycle adjustment bill would be on 1/31/06.

The system determines whether to use cycle adjustment parameters at the cycle bill parameter level or at the patient bill format level by the Cycle Adjustment Bill indicator. If the Cycle Adjustment Bill Indicator is set to *Yes* or *No* on the Cycle Billing Parameters associated with the account, the system uses these cycle adjustment parameters. If the Cycle Adjustment Bill Indicator is blank, the system looks at the setting of the Cycle Adjustment Bill Indicator on the Patient Bill Format. To determine if an unbilled charge can be automatically cycle adjustment billed, the system looks at the CycA Max Days Since Service field.

2. CYCA ZERO BAL (1-A-O)
This field indicates whether the system should automatically generate a cycle adjustment bill if the account balance is zero. When this field is accessed, the following prompt is displayed:

Create the automatic cycle adjustment bill if the account is zero balance? (Y/N) [N]-- |

You can enter **Y** (Yes), create automatic cycle adjustment bill even if the account is zero balance. If you enter **N** (No) or leave the field blank, the system does not create automatic cycle adjustment bills for zero balance accounts.

3. MANUAL CYCA CHG/CR/DYS OVERRIDE FOR SUBSEQUENT BILLS (1-A-R)
This field indicates whether the system should override the minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits, Min Unbilled Credit Amt, and CycA Max Days Since Service fields when producing subsequent cycle adjustment bills. When this field is accessed, the following prompt is displayed:

Override Min Chg/Cr/Dys for manual subsequent CycA bills? (Y)es or (N)o

You can enter **Y** (Yes) to override these fields for manual subsequent cycle adjustment bills or **N** (No) in order not to override these fields. A subsequent cycle adjustment bill is one that is loaded automatically, as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be rebilled in order for the selected bill to be processed. For example, if a manual cycle adjustment bill request is made via the Single Bill Request or Instant Adjustment Bill functions, new charges or credits are not added for subsequent cycle adjustment bills, unless the criteria for the minimum number and amount for unbilled charges or credits and the maximum number of days from charge service date are satisfied for the billing event.

If this field is set to Yes, the system overrides the max days and minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits and Min Unbilled Credit Amt fields, when producing subsequent cycle adjustment bills, so that the constraint is removed for the subsequent adjustment bills, and any new charge/credits are included. If the field is set to No, the system won't override the max days and minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits and Min Unbilled Credit Amt fields, when producing subsequent cycle adjustment bills, and any new charges/credits must meet the defined number/amount to be included on the cycle adjustment bill. The system uses the value of this field as the default on the Single Bill Request and Instant Adjustment Bill screens.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields or the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge/credit numbers/amounts indicated, and the Manual CycA Chg/Cr Override isn't set to Yes, new charges/credits aren’t loaded for a subsequent cycle adjustment bill. The CycA Chg/Cr/Dys Override for Subsequent Bills field on both the Single Bill Request and the Instant Adjustment Bill screens can be used by a hospital to override this value for an account.

4. AUTO CYCLE ADJ (1-A-R)
This field indicates whether the system should produce an automatic cycle adjustment bill, based on the entries made in either the Minimum Unbilled Charges and Minimum Unbilled Charge Amount fields and the Minimum Unbilled Credits and Minimum Unbilled Credit Amount fields. A cycle adjustment bill lists charges contained on the cycle bill and unbilled charges. When this field is accessed, the following prompt is displayed:

Produce automatic cycle adjustment bill? (Y/N) [N]-

You can enter **Y** for Yes or **N** for No. A blank value indicates that no auto cycle adjustment processing can occur.

NOTE: An account can get numerous auto cycle adjustment bills for the same time period/original bill sequence, if unbilled cycle charges are entered each day or for many days past the original cycle bill. This makes it very important to set the Minimum Number and Amount of Unbilled Cycle Charges as needed for the payor.

5. MIN UNBILLED CHARGES (2-N-C)
This field contains the minimum number of unbilled charges required to generate an automatic and manual cycle adjustment bill. For manual cycle adjustment bills, the field is used to determine what charges are loaded on a subsequent cycle adjustment bill. If the Manual CycA Chg/Cr/Dys Override for Subsequent Bills parameter is set to *Yes*, the system does not use this field as the minimum number for manual cycle adjustment bills. When this field is accessed, the following prompt is displayed:

Enter minimum number unbilled charges to generate a cycle adj bill--

You can enter the minimum number of unbilled charges. When you enter a value in this field, the system prompts you to enter a value in the Min Unbilled Charge Amount field.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields and the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge/credit numbers/amounts indicated, and the Manual CycA Chg/Cr Override isn't set to *Yes*, new charges/credits aren't loaded for a subsequent cycle adjustment bill.

If an account qualifies for a cycle adjustment bill due to unbilled charges but not credits, the cycle adjustment bill contains all of the unbilled charges and credits for that bill period.

6. MIN UNBILLED CHARGE AMT (4-N-C)
This field contains the minimum unbilled charge amount necessary to generate an automatic and manual cycle adjustment bill. For manual cycle adjustment bills, the field is used to determine what charges are loaded on a subsequent cycle adjustment bill. If the Manual CycA Chg/Cr Override for Subsequent Bills field is set to *Yes*, the system does not use this field as the minimum amount for manual cycle adjustment bills. When this field is accessed, the following prompt is displayed:

Enter minimum unbilled charge amount to generate an automatic cycle adjustment ill-- |

You can enter an amount from **1** to **9,999.00**. Upon exiting the screen, if either the Auto Cycle Adj field is set to *Yes* or the Manual CycA Chg/Cr/Dys Override for Subsequent Bills is set to *No*, the system prompts you to enter values in the Min Unbilled Charges and Min Unbilled Charge Amt fields.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields or the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge/credit numbers/amounts indicated, and the Manual CycA Chg/Cr Override isn't set to *Yes*, new charges/credits aren't loaded for a subsequent cycle adjustment bill.

7. MIN UNBILLED CREDITS (2-N-O)
This field contains the minimum number of unbilled credits required to generate an automatic cycle adjustment bill. When this field is accessed, the following prompt is displayed:

Enter minimum of late credits to generate an automatic cycle adjustment bill-

You can enter from **1** to **99** credits.You can opt to produce cycle adjustment bills due to charges and not to produce cycle adjustments due to credits, or you can set the parameter to produce a cycle adjustment bill for both unbilled charges and credits.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields or the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge/credit numbers/amounts indicated, and the Manual CycA Chg/Cr Override isn't set to *Yes*, new charges/credits aren't loaded for a subsequent cycle adjustment bill.

When you enter a value into the Min Unbilled Credits field, the system prompts you to enter a value in the Minimum Unbilled Credit Amount field. If you blank out either the Min Unbilled Credits field or the Min Unbilled Credit Amount field, both fields are blanked out. If the Min Unbilled Credits field and the Min Unbilled Credit Amt field are blank, no accounts qualify for an automatic cycle adjustment bill due to unbilled credits.

If an account qualifies for a cycle adjustment bill due to unbilled credits but not charges, the cycle adjustment bill contains all of the unbilled charges and credits for that bill period.

8. MIN UNBILLED CREDIT AMT (5-N-O)
This field contains the minimum unbilled credit amount necessary to generate a cycle adjustment bill. When this field is accessed, the following prompt is displayed:

Enter minimum late credit amount to generate an automatic cycle adjustment bill

You can enter an amount in a whole dollar amount preceded by a minus (-) sign (for example -1 to -9999). You can opt to produce cycle adjustment charge bills and not to produce cycle adjustment credit bills, or you can set the parameter to produce a cycle adjustment bill for both unbilled charges and credits. If you leave this field blank, no accounts qualify for cycle adjustment credit bills.

When you enter a value in this field, the system requires you to enter a value in the Minimum Unbilled Credits field. If you blank out either the Min Unbilled Credits field or the Min Unbilled Credit Amount field, the system blanks out both fields. If the Min

Unbilled Credits field and the Min Unbilled Credit Amt field are blank, no accounts qualify for an automatic cycle adjustment bill due to unbilled credits.

9. CYCA SUPPRESS SUBSEQUENT BILLS/ DO NOT LOAD CLMS (1-A-O)
This field indicates, for subsequent cycle adjustments bills, whether bills should be suppressed and claims should not be loaded, if there are no new/qualifying charges for subsequent cycle adjustment bills. If a bill is suppressed because there are no new charges, the billing, proration, and reimbursement information is maintained, but the bill is not printed, and no claims are loaded for the bill. The value in this field populates the CycA Suppress Subsequent Bills/Do Not Load Clms field on the Single Bill Request and Instant Adjustment Bill screens, but you can change the value on those screens. When this field is accessed, the following prompt is displayed:

Suppress Bill/ Do Not Load Clm for Cycle Adj if there are no new Charges? (Y)es, (N)o [N]

You can enter **Y** (Yes) to suppress the bills and not to load claims for cycle adjustments or **N** (No) not to suppress the bills and to load the cycle adjustment claims. A blank is the same as N (No), don't suppress bills and load the claims.

A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be rebilled in order for the selected bill to be processed. If there are new charges for the subsequent cycle adjustment bill that are eligible to be rebilled, the bill won't be suppressed, and claims are loaded. If there are new unbilled charges, but they don't qualify for the bill because, for example, they don't meet the minimum charge amount, the bill is suppressed, and the claim is not loaded, if the field is set to Yes.

This field is used only if cycle adjustment bills are allowed per the setting on the Cycle Adj Bill Ind field in the Cycle Billing Parameters and the Patient Bill Format Processor.

If bills are suppressed, claims are not loaded. For a suppressed bill, a bill sequence is loaded for the bill, but it does not print. When a claim is not loaded, there is not even an associated claim sequence that is loaded. For example, if bills are set to suppress, and claims don't load, the table below shows what you would have in the following scenario where there were two cycle bills, with no new charges for the second cycle bill. If a claim is needed, you can add one through the Add a Claim function for the suppressed bill sequence. The McKesson-recommended process is that you request a new bill through either the Single Bill Request or Instant Adjustment Bill functions and set the suppress bill/do not load claims option to *No* so that bills and claims are loaded.

Example: The Suppress Bill/ Do Not Load Clm for CAdj field is set to Suppress Bills/ Don't Load Claims

Bills	Claims for COB 1
Cycle BS 1	CS 1 loads

Cycle BS 2	CS 2 loads
Cycle Adjustment BS 3 replacing BS 1	CS 3 loads and replaces CS 1
Cycle Adjustment BS 4 replacing BS 2	No claim loads

NOTE: If you exit the screen without completing the required fields, the following error message is displayed:

Cycle Adj Bill Ind defaulted to blank since Cycle Adjustment Parameters are incomplete. Press ENTER.

Final Bill Types

If you are adding/editing a billing parameter that is for a final bill type, the system displays the following screen:

```
          General Hospital Financial Table Maintenance Processor
                                                 Fri May 28, 1999 10:10 am
Billing Parameters
 1 Code           2 Description                          3 Bill Parm Type
   4                COMMERCIAL - FINAL COMBINED            Final
 4 Status         5 Edited By                            6 Edit Date/Time
   Active           Smith,Mary A                           12/30/88 10:10am
 7 Detail Bill    8 Summary Bill      9 Prorated Bill    10 Combine Prof. Fees
   Yes              Yes                 No                 Yes
11 Bill Transaction Code            12 Patient Bill Message Number
   Y9998-FINAL BILLED                  4-INSURANCE MESSAGE
13 Type of Charge                   14 Print Adj Detail
   Both                                Yes









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

Field Explanations - Screen 1 of 2

1. CODE (DISPLAY ONLY)
This field contains the code identifying the billing parameter.

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

3. BILL PARM TYPE (DISPLAY ONLY)
This field indicates whether this parameter is used for final or cycle bills. Entry options are F (final) or C (cycle). This field, which is required at initial set up of the billing

parameter, determines the billing parameter type. If you are editing a parameter, this field cannot be changed.

4. STATUS (DISPLAY ONLY)
This field indicates whether the billing parameter code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

5. EDITED BY (DISPLAY ONLY)
This field contains the name of the user who last edited this parameter.

6. EDIT DATE/TIME (DISPLAY ONLY)
This field contains the date and time this parameter was last edited.

7. DETAIL BILL (1-A-R)
This field indicates whether a detail patient bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. A detail bill lists all charges that are billed with the detail charge description, dates, and amounts.

8. SUMMARY BILL (1-A-R)
This field indicates whether a summary patient bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. A summary bill lists the charges which are summarized based on the *Charge Summarization* that you selected on the Patient Bill Format. For an explanation of the Patient Bill Format, refer to the Financial System Management section in the *General Information Volume* in the STAR Financials Patient Accounting Reference Guide.

9. PRORATED BILL (1-A-R)
This field indicates whether a prorated bill should be produced for accounts assigned to this billing parameter. Entry options are **Y** for Yes or **N** for No; the default is N. A prorated bill lists charges by proration summary code with the estimated liability of each insurance plan for the patient.

10. COMBINE PROF. FEES (1-A-R)
This field indicates whether the hospital fee and professional fee for an item are combined as one line item on a detail bill. Entry options are **Y** for Yes and **N** for No; the default is N. If you enter Y, the detail bill displays one charge line for an item that has a corresponding professional fee. The hospital fee description is printed. The amount is the combined total of the hospital and professional fees. If you enter N, the hospital and professional fees are printed as separate line items.

11. BILL TRANSACTION CODE (4-N-R)
This field contains the transaction code indicating that a bill has been produced. The code and description is displayed in the account transaction history. A system-generated comment is also displayed in the account transaction history. While the code and description are defined as generic terms for types of bills, the comment describes the actual type of bill. For example, final, adjustment, and late bills each use

the transaction code and description reflecting the produced bill (final) and the comment varies, depending on the actual type of bill that was generated (adjustment).

You can enter the code or a hyphen (-) to display a list of valid codes used for recording patient bills for transaction type Y.

12. PATIENT BILL MESSAGE NUMBER (4-N-O)
This field contains the code identifying the message (from the Patient Bill Messages table) that prints on the last page of the patient detail bill and summary bill.

13. TYPE OF CHARGE (1-A-O) (CANADA ONLY)
This field determines whether patient charges only or both patient and insurance charges appear on the Canadian patient bill. The following prompt is displayed:

Print (P)at charges or (B)oth and Ins charges on the bill? [P] --

Enter **P** if you only want patient charges on the bill. Enter **B** if you want both patient and insurance charges on the bill.

14. PRINT ADJ DETAIL (1-A-R) (CN Only)
This field indicates whether or not you want the adjustment detail to print or not print on bills. When this field is accessed, the following prompt is displayed:

Do you want the adjustment detail to print on bills? (Y/N) [N]---

Enter **Y** for Yes if you want detail adjustment information for the specified billing parameter to print on bills. This includes the adjustment transaction code followed by the description. Enter **N** for No if you do not want detail adjustment information for the specified billing parameter to print on bills. The bill remains unchanged and a line with Patient Adjustments is displayed that includes the total adjustments for the account.

When these fields are completed, you have the option of editing or deleting this information, or displaying the next screen in the transaction.

```
               General Hospital Billing Parameters Processor
                                                 Mon Feb 14, 2009 2004 01:11 pm
Billing Parameters
 1 Code                  2 Description                          3 Bill Type
   11                      CHAMPUS I/P FINAL                      Final
 4 Bill Suspense Days    5 ICD-10 Effective Date
   0                       10/01/2013 Discharge Date
 6 Billing Requirements Edit Code     7 Edit Suspense Days  8 Maximum Hold Days
   30-CHAMPUS INPATIENT                 0                     Unlimited
 9 Zero Charge Rpt Days              10 Zero Chg Bill Days  11 Chg Bill Window
   20                                   20
12 Auto Late Bill      13 Minimum Late Charges   14 Minimum Late Charge Amount
   Yes                    1                          $1
15 Zero Bal?           16 Minimum Late Credits   17 Minimum Late Credit Amount
   No
18 Auto Adj Rebill     19 Minimum Late Charges   20 Minimum Late Charge Amount
   Yes                    1                          $1
21 Zero Bal?           22 Minimum Late Credits   23 Minimum Late Credit Amount
   Yes
24 Auto Adj Rebill DRG/Dx/Proc       25 Auto Adj Rebill CPTAFB
   Neither                              Yes/No Indicators Defined


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

Field Explanations - Screen 2 of 2

1. CODE (DISPLAY ONLY)
This field displays the billing parameter code entered or selected from the previous screen.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the billing parameter code entered on the previous screen.

3. BILL TYPE (DISPLAY ONLY)
This field displays the bill type entered on the previous screen.

4. BILL SUSPENSE DAYS (2-N-R)
This field contains the number of days after patient discharge before the final bill is generated. The entry range is 0 to 99 days.

5. ICD-10 EFFECTIVE DATE (8-N-O)
This field specifies the beginning admission date or discharge date of ICD-10 diagnosis and procedure code requirements for payers assigned this Final Bill Parameter.The Billing Parameter is assigned based on the COB 1 insurance plan, and if there are no insurances on the account, on the Financial Class of the account.

ICD-10 diagnosis and procedure codes are collected on the STAR Patient Processing and STAR Medical Records systems based on the Admission Date of the patient. The Billing Parameter field of ICD-10 Effective Date can be used to specify a Discharge

Date requirement for ICD-10, and can also be used for payers that implement ICD-10 codes after Medicare has implemented ICD-10 codes by listing a future date for the payer still using ICD-9 codes.

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

Enter the Effective Date for ICD-10 Diagnosis and Procedure processing (MM/DD/YYYY)--

After you enter the date, the following prompt is displayed:

Is the ICD-10 Effective Date based on Admission Date (A) or Discharge Date (D) [A]--

For the below, in order to collect ICD-10 diagnoses and procedures on the account, the USA ICD-10 Eff Date field on the Admission and General Parameters screen of the Hospital Facility Options on STAR Patient Processing must be a date that is either on or before the account's admission date.

- If the date is set, for the Admission Date, but the patient's admission date is before the ICD-10 Effective Date, the Bill ICD flag is set to 9, and the system continues to edit the ICD-9 codes only for the patient's bill. This means that series patient types that were registered before this ICD-10 Effective Date continue to edit only ICD-9 diagnosis and procedure codes on the bill. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the date is set, for the Admission Date, and the patient's admission date is on or after the ICD-10 Effective Date, the Bill ICD flag is set to 10 and the system will edit the ICD-10 codes only for the patient's bill.

- If the date is set, for the Discharge Date, but the patient's discharge date is before the ICD-10 Effective Date, the Bill ICD flag is set to 9 and the system will continue to edit the ICD-9 codes only for the patient's bill. This means that series patient types that were discharged before this ICD-10 Effective Date will continue to only edit ICD-9 diagnosis and procedure codes to the bill. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required. If the date is set, for the Discharge Date, and the patient's discharge date is on or after the ICD-10 Effective Date, the Bill ICD flag is set to 10 and the system will edit the ICD-10 codes only for the patient's bill.

- If the date is set, for the Discharge Date, and if the Admission Date precedes the USA ICD-10 Effective Date on Patient Processing (so the Account ICD indicator is set to 9), but the account's discharge date, or Bill Through Date if no discharge date, is on or after the USA ICD-10 Effective Date on Patient Processing, the system does the following:

  a) Look to the Billing Parameter. If the billing parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date if no discharge date, to determine the bill ICD indicator. If the billing parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The bill will edit for ICD-9.

b) Look to the Claim Parameter. If the claim parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date of the bill that loaded the claim if no discharge date, to determine the claim ICD indicator. If the claim parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The claim will load and edit for ICD-9.

NOTE: This logic means that you can fail an account's bill and claims for missing ICD-10 information, when ICD-10 information was not entered on the account, and the account has an Account ICD indicator of 9.

In order to correct this situation, the ICD-10 information would need to be entered via Medical Records. As long as the USA ICD-10 Effective Date on Patient Processing is Today or a date in the past, Medical Records allows ICD-10 information to be entered on an account regardless of the Account ICD indicator.

EXAMPLES

**** USA ICD-10 Effective Date is 09/14/2011

Account 1:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-10

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-10

Account 2:

- Admitted 09/01/11

- Account ICD indicator is 9

- Account is Discharged on 9/26/2011

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Final Bill produced with BILL THROUGH DATE of 9/26 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 9/26 loads/edits for ICD-9

Account 3:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to ADMISSION DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to ADMISSION DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-9

NOTE ON BILLS:

Regular bills produced via Midnight Processing or Instant Adjustment Bill look for the existence of a Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date.

For cycle bills, the Bill Thru Date is used when evaluating if the bill or claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date. Since the Cycle Billing Parameters do not have an ICD-10 Effective Date field (and do not edit), the system looks to the

Final Billing Parameters ICD-10 Effective Date. For the cycle bill, it will then compare the Bill Thru Date for the cycle to this ICD-10 Effective Date, to determine if the cycle should load for ICD-9 or ICD-10 data.

Once the account is actually discharged, the true discharge date is used to determine if the bill and claims should load/edit ICD-9 or ICD-10.

Pre-bill Edit bills will use Today's Date as the Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bills are anticipating what will be required when a bill is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

NOTE ON CLAIMS:

Regular claims produced via Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance look for the existence of a Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. If there is no discharge date at the time the claim is created, the Bill Thru Date for the bill that loaded the claim is used when evaluating if the bill or claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date.

Pre-bill Edit claims will use Today's Date as the Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bill Edit claims are anticipating what will be required when a claim is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

- If this final Billing Parameters ICD-10 Effective Date field is blank, the system accesses the ICD-10 Effective Date field in the STAR Patient Processing Hospital Facility Options, and the Insurance Plan table for the COB 1 insurance, the Insurance Carrier table for the COB 1 insurance, and finally the Financial Class table to determine if the final bill should edit for ICD-9 or ICD-10 diagnosis and procedure codes when requiring data elements for diagnosis and/or procedure codes. The logic is outlined below:

  - The system first accesses the Insurance Plan Table for the COB 1 insurance loading the bill to determine if there is an ICD-10 Effective Date for the insurance plan. The ICD-10 Effective Date in the insurance plan is only based on Admission Date. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Insurance Plan ICD-10 Effective Date, then the Bill ICD flag will be set to 9, and the bill will require ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Plan ICD-10 Effective Date, or

the Insurance Plan ICD-10 Effective Date field is blank, then the system looks to the Insurance Carrier Table for the COB 1 insurance loading the bill.

- If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Insurance Carrier Table ICD-10 Effective Date, the Bill ICD flag is set to 9, and the bill requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Carrier ICD-10 Effective Date, or the Insurance Carrier ICD-10 Effective Date field is blank, the system looks to the Financial Class for the account.

- If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Financial Class Table ICD-10 Effective Date, the Bill ICD flag will be set to 9, and the bill requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Financial Class ICD-10 Effective Date, or the Financial Class ICD-10 Effective Date field is blank, the system determines there are no exceptions for the account and sets the Bill ICD flag to 10. The bill requires ICD-10 diagnosis and procedure codes.

Having the ICD-10 Effective Date field on the Billing Parameters screen instead of the Billing Requirements screen allows users to have the same Data Base Elements that are required, such as Principal and Admitting Diagnosis, that can be shared across Billing Parameter Tables. But, one Billing Parameter table (say for Medicare) may require ICD-10 codes for the patient, while another Billing Parameter table (say for Medicaid) may require ICD-9 codes for the same patient.

6. BILLING REQUIREMENTS CODE (2-N-R)
This field contains the code representing information that must be completed on an account before the final bill can be generated. Examples of information represented by a billing requirements code are guarantor address, patient date of birth, final diagnosis, and final DRG. Develop a null billing requirement parameter that contains no defined requirement. This billing requirement code should be attached to a billing parameter that does not require additional information prior to billing.

7. EDIT SUSPENSE DAYS (2-N-O)
This field contains the number of days after patient discharge to begin performing billing requirements edits. The entry range is 0 to 99 days but the number of days entered here cannot be greater than the number entered in the Bill Suspense Days field. If the field is left blank, it is considered to be zero.

8. MAXIMUM HOLD DAYS (2-AN-R)
This field contains the number of days the system holds a final bill if it fails billing requirements. You can enter a range of days from 0 to 99 or **U** for Unlimited. If Unlimited is entered, the bill remains in the system as long as it continues to fail billing edits. This field is also used to indicate the number of days the system holds

adjustment bills due to bill edits. For final bills, if Maximum Hold Days is not Unlimited and the patient's discharge date plus Maximum Hold Days is less than the current date (not the Midnight Processing date), bill edits are not performed. When an adjustment bill is requested and bill edits are to be made, the date of the adjustment bill request is recorded. If Maximum Hold Days is not Unlimited and the date of the adjustment bill request plus Maximum Hold Days is less than the current date (not the Midnight Processing date), bill edits are not performed. For example, if Maximum Hold Days equals 5 and the date of the adjustment bill request is 3/1/04, the system adds 5 to 3/1/04 to calculate 3/6/04. In this example, the system holds an account for bill edits until the current date is greater than the date of 3/06/04. The difference between final and adjustment bills is that final bills use the patient's discharge date and adjustment bills use the date of the adjustment bill request. If bill edits are done and the account fails, the request for the Single Bill Request function is used and the existing adjustment bill request is removed, and hold days for bill edits restart, if a new adjustment bill is requested by setting the Perform Edits field to Yes.

9. ZERO CHARGE RPT DAYS (3-N-R)

This field indicates the number of days after discharge to wait before reporting accounts with zero charges on the Unbilled Accounts with Zero Charges Report (FBR112). When you access this field, the following prompt is displayed:

Enter # of days after disch before 0-chg unbilled accts are reported [U]--

Valid values are from 0 to 999. The default is **U** for unlimited. Entering zero (**0**) indicates that all unbilled accounts with zero charges are always included on FBR112. Entering the default **U** indicates that unbilled accounts with zero charges are never included on FBR112. For example, a response of 3 indicates that the account is included only if 3 days have passed since it was discharged. You may want to set this value at one day less than your suspense days.

10. ZERO CHG BILL DAYS (3-N-R)

This field indicates the number of days after the suspense days have been met that an unbilled account with zero charges is held before forced billing occurs. When you access this field, the following prompt is displayed:

Enter # of days after susp to hold 0-chg accnts before force billing [U] --

Valid values are from 0 to 999. The default is **U** for unlimited. Entering zero (**0**) indicates that all unbilled accounts with zero charges are forced to bill as soon as the suspense days are met. For example, a response of **3** indicates that the account is forced to bill only if 3 days have passed since the suspense days have been met. You may want to set this value to **1** to allow one day to review the Unbilled Accounts Report (FBR110), the Unbilled Accounts with Zero Charges Report (FBR112), and the Failed Billing Requirements Report (FBR210) before forcing the unbilled accounts with zero charges to bill. If this field is set to **U**, these accounts do not appear on FBR112.

11. CHG BILL WINDOW (3-N-O)
This field indicates the number of days after discharge that an AR account is placed on old charge bill hold. When you access this field, the following prompt is displayed:

Enter Chg Bill Window causing AR account to be placed on Old Chg Bill Hold--

Valid values are 0-999.

12. AUTO LATE BILL (1-A-R)
This field indicates whether the system should automatically generate a late bill based on the entries made in either the Minimum Late Charges and Minimum Late Charge Amount fields or the Minimum Late Credits and Minimum Late Credit Amount fields. Entry options are **Y** for Yes or **N** for No; the default is N.

13. MINIMUM LATE CHARGES (2-N-C)
This field contains the minimum number of late charges required to generate a late bill. The entry range is 1 to 99 charges. If the Auto Late Bill field contains Y, this field is required.

14. MINIMUM LATE CHARGE AMOUNT (4-N-C)
This field contains the minimum late charge amount necessary to generate a late bill. The entry range is a whole dollar amount from 1 to $9,999.00. If the Auto Late Bill field contains Y, this field is required.

15. ZERO BAL (1-A-O)
This field indicates whether the system should automatically generate a late bill if the account balance is zero. Entry options are **Y** for Yes, **N** for No, or blank. If the field is set to Yes, the account bills even if the account balance is zero. If the field is set to N or left blank, the account does not bill if the account balance is zero.

NOTE: The automatic bills look to unbilled charges/credits. If “old” accounts have not been archived, they may bill if they qualify for the auto bill. You should take this into consideration when setting the parameter to auto bill late credits

16. MINIMUM LATE CREDITS (2-N-O)
This field contains the minimum number of late credits required to generate a late credit bill. The entry range is 1 to 99 credits. This is an optional field. You can opt to produce late charge bills and not produce late credit bills, or you can set the parameter to produce a late bill for both late charges and late credits. If you leave this field blank, no accounts qualify for late credit bills.

NOTE: When you enter a value in this field, the system requires you to enter a value in the Minimum Late Credit Amount field. However, once you have entered values in both fields and accepted the screen, the system allows you to go back into either field and blank it out. If you do this, no accounts qualify for the late credit bill.

17. MINIMUM LATE CREDIT AMOUNT (5-N-O)
This field contains the minimum late credit amount necessary to generate a late credit bill. The entry range is a whole dollar amount preceded by the "-" sign (for example -1 to -9999). This is an optional field. You can opt to produce late charge bills and not produce late credit bills, or you can set the parameter to produce a late bill for both late charges and late credits. If you leave this field blank, no accounts qualify for late credit bills.

NOTE: When you enter a value in this field, the system requires you to enter a value in the Minimum Late Credits field. However, once you have entered values in both fields and accepted the screen, the system allows you to go back into either field and blank it out. If you do this, no accounts qualify for the late credit bill.

18. AUTO ADJ. REBILL (1-A-R)
This field indicates whether the system should produce an automatic adjustment rebill based on the entries made in either the Minimum Late Charges and Minimum Late Charge Amount fields or the Minimum Late Credits and Minimum Late Credit Amount fields. An adjustment rebill lists charges contained on the final bill and any late charges previously billed or unbilled. Entry options are **Y** for Yes or **N** for No. The default is No.

19. MINIMUM LATE CHARGES (2-N-C)
This field contains the minimum number of late charges required to generate an adjustment bill. If the Auto Adj. Rebill field contains Y, this field is required.

20. MINIMUM LATE CHARGE AMOUNT (4-N-C)
This field contains the minimum late charge amount necessary to generate an adjustment bill. The entry range is a whole dollar amount from 1 to $9,999.00. If the Auto Adj. Rebill field contains Y, this field is required.

21. ZERO BAL (1-A-O)
This field indicates whether the system should automatically generate an adjustment bill if the account balance is zero. Entry options are **Y** for Yes, **N** for No, or blank. If the field is set to Yes, the account bills, even if the account balance is zero. If the field is set to N or left blank, the account does not bill if the account balance is zero.

22. MINIMUM LATE CREDITS (2-N-O)
This field contains the minimum number of late credits required to generate an adjustment bill. The entry range is 1 to 99 credits. This is an optional field. You can opt to produce adjustment charge bills and not produce adjustment credit bills, or you can set the parameter to produce an adjustment bill for both late charges and late credits. If you leave this field blank, no accounts qualify for late credit bills.

NOTE: When you enter a value in this field, the system requires you to enter a value in the Minimum Late Credit Amount field. However, once you have entered values in both fields and accepted the screen, the system allows you to go back into either field and blank it out. If you do this, no accounts qualify for the late credit bill.

23. MINIMUM LATE CREDIT AMOUNT (5-N-O)
This field contains the minimum late credit amount necessary to generate an adjustment bill. The entry range is a whole dollar amount preceded by the "-" sign (for example -1 to -9999). This is an optional field. You can opt to produce adjustment charge bills and not produce adjustment credit bills, or you can set the parameter to produce an adjustment bill for both late charges and late credits. If you leave this field blank, no accounts qualify for late credit bills.

NOTE: When you enter a value in this field, the system requires you to enter a value in the Minimum Late Credits field. However, once you have entered values in both fields and accepted the screen, the system allows you to go back into either field and blank it out. If you do this, no accounts qualify for the late credit bill.

24. AUTO ADJ REBILL DRG/DX/PROC (1-A-R)
This field indicates whether the system should generate an automatic adjustment bill and/or generate the DRG/Procedure/Diagnosis Modification Report if the DRG, any diagnosis code, or any procedure code is changed on a patient. Entry options are **A** for generating an adjustment bill and report, **R** for generating the report only, or **N** if neither is desired. When the field is accessed, the following prompt is displayed:

Produce (A)utomatic adj bill, (R)eport only, or (N)either if DRG, Dx codes or Proc codes change (A/R/N) [N]--

If you select A, an automatic adjustment bill and the DRG/Procedure/Diagnosis Modification Report is generated if the diagnosis codes, procedure codes, or the DRG on the account are changed, and Auto Adj Bill is displayed in the field. If an R is selected, only the DRG/Procedure/Diagnosis Modification Report (FBR400) is generated and Report Only is displayed in the field. If N is selected, no report or bills are generated, and Neither is displayed in the field.

The system looks at the ICD-10 Effective Date field and the bill ICD flag that is in turn set. If the field is set to A for generating an adjustment bill and report, or R for generating the report only, the system generates only the adjustment bill and/or the report if the specified diagnosis or procedure was updated. For example, if the bill ICD flag for the patient is set to ICD-10, and the Auto Adj Rebill DRG/Dx/Proc is set to A for Adjustment Bill and Report, if the Principal ICD-9 Diagnosis Code is updated, this would not generate the adjustment bill and report. Only if an ICD-10 diagnosis code or procedure code (or DRG) is updated would the system produce the adjustment bill and report.

If this field is set to A for Automatic Adjustment Bill, R for Report Only, or B for Both, then if the DRG is updated, this will only produce an adjustment bill and be reflected on the report if the ICD indicator for the changed DRG matches the Bill ICD indicator for the account.

Therefore, if the Bill ICD indicator is a 9 for ICD-9, a change to the ICD-9 Primary DRG will trigger the adjustment bill and/or the report. If the Bill ICD indicator is a 0 for ICD-10, a change to the ICD-10 Primary DRG will trigger the adjustment bill and/or report.

25. AUTO ADJ REBILL CPTAFB (1-A-R)

This field indicates whether an automatic adjustment bill should be generated when a Change Patient Type After Final Bill (CPTAFB) transaction occurs for an account. The system looks at the parameter on the Billing Parameters screen. If that parameter is not completed, the system looks at the parameter on the PAAR Control Maintenance screen. When the field is accessed, the following prompt is displayed:

Produce an Adjustment Bill Request for CPTAFB? (Y/N)--

If you enter **Y** for Yes, automatic adjustment bills are generated when a CPTAFB transaction occurs. If you enter **N** for No, automatic adjustment bills are not generated, and the biller must use the CPTAFB function to generate an adjustment bill. For detailed information on the CPTAFB function, refer to Chapter 1: Billing in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

When these fields are completed, you have the option of editing or accepting the information entered. Accepting the screen completes the entry of this final bill parameter.

Dependent On	Reference
Financial Class	Billing Requirements
Insurance Plan Coverage Master	Transaction Codes

PRE-BILL EDIT PARAMETERS

These parameters are used to define which accounts are affected by the pre-bill edit process. The parameters provide the following information:

- When is the batch process completed?
- Which processes are used to edit patient account visit information?
- Which insurances are sent through the process?
- When does the process begin editing patient account visit information?
- What trigger events cause the accounts to be sent through the process again?
- Do pre-bill edits have to be corrected before actual billing occurs?
- Can accounts final bill when small unbilled charges exist?
- How are edits allocated to people/departments?
- Do you want to request a final bill prior to the expiration of Patient Accounting billing suspense days if there are no pre-bill edits and Patient Processing historization is complete?

After you select this function, then select a facility code, the first screen is displayed.

Screen 1 of 2

```
                General Hospital PBE Parameters Processor
                                                Mon Mar 02, 2010 09:21 am
Facility: Model Hospital A


1 Batch Process  2 Batch Hrs    3 File Purge  4 Stats Purge  5 Active Sources
   Proration        16             5             1              Entries Defined
                        Send Through Pre-Bill Edits
 6 Inpatient               7 Outpatient              8 Emergency
   Entries Defined            Entries Defined          Entries Defined
                         Begin Editing Parameter
 9 Inpatient               10 Outpatient             11 Emergency
   Admit-0                    Admit-0                   Admit-0
12 Bill Edits              13 ICD Edits
   Admit-0                    Admit-0
14 Include All Insurances? 15 Other Ins Edit Excl
   Yes                        No Exclusions
                                Trigger Events
16 Inpatient        17 Outpatient       18 Emergency       19 Bill/ICD Edits
   Entries Defined     Entries Defined     Entries Defined    Entries Defined
                     Start Reviewing Medical Record Edits
20 Inpatient               21 Outpatient             22 Emergency
   Med Rec Info Present       Admit-0                   Admit-0
Enter field number or '/' starting field number--
                      next(/) or previous screen(/P) [/]
```

Field Explanations

1. BATCH PROCESS (1-A-R)
This field defines when the pre-bill accounts are analyzed and interface files generated for them (to be used in the batch process). When this field is accessed, the following prompt is displayed:

Perform batch pre-bill edits with (P)roration or (C)laims complete? (P/C) -

You can enter **P** for Proration (pre-bill edits are performed during proration) or **C** for Claims Complete (pre-bill edits are performed when billing and claims processing completes in Midnight Processing). The system defaults with running after the billing and claims Midnight Processing completes.

This process allows multiple facility customers to define the process for each facility. Accounts which are reedited and pass all edits will final bill during the same day's Midnight Processing when the Proration option is used. If the Claims option is used, the account is delayed one day before final billing. This is because the status of the account is updated to *Passed* after the billing and claims process completes.

2. BATCH HOURS (TABLE LOOKUP-O)
This field indicates the hour(s) when the hourly batch process should be run automatically by the system. When this field is accessed, the system displays a list of hours (1-23). You can highlight the hour(s) to run the batch process.

When accounts are updated, you can manually queue the account through the process or have the accounts automatically re-edited. Setting this parameter facilitates that the account information is up to date when accounts are updated through the STAR Medical Records GUI module. Medical Records does not have the option to re-edit the accounts. In this environment, it may be helpful to define the process to run hourly during normal business hours

3. FILE PURGE (1-N-R)
This field determines how long to maintain the listing of accounts for which pre-bill edits were created. The purpose of this field is to have an audit trail of what occurred to the account for researching support-type questions. When this field is accessed, the following prompt is displayed:

Enter number of days to maintain accounts edited via the batch pre-bill process [5]--

You can enter a number from 1 to 5. The default is 5.

4. STATS PURGE (1-N-R)
This parameter defines how long the system maintains statistical information used in reporting on pre-bill edits. When this field is accessed, the following prompt is displayed:

Enter number of days to maintain statistical information or 0 for no statistical information--

You can enter **0** if you don't want to maintain statistical information or a number of days up to 99.

NOTE: You have the option of downloading data with an SQL/Vista query in order to maintain the statistics longer than this parameter setting.

5. ACTIVE SOURCES (TABLE LOOKUP-R)
This parameter defines which pre-bill edits can be applied to patient visits. These options apply to all patient visits selected for the pre-bill edit process. The exception is 3M OPPS edits and EAPG edits, which are limited to accounts being reimbursed by either the OPPS or EAPG logic. The options are:

- B-Star billing edits
- C-Star claim edits
- E-CA claim edits
- G-EAPG claim edits
- I-ICD charge edits - When highlighted, this edit looks to the ICD flag at the account level to determine if this account requires ICD-10 diagnosis and procedure codes, both ICD-10 and ICD-9 diagnosis and procedure codes, or only ICD-9 diagnosis and procedure codes. This flag at the account level is based on the ICD-10

Effective Date in the Hospital Facility Options of the STAR Patient Processing application, and based on any exceptions in the Insurance Plan Table, Insurance Carrier Table, and the Financial Class Table. A blank ICD flag means that only ICD-9 codes are collected on the account.

- If the ICD flag at the account level is set to B for Both ICD-10 and ICD-9 codes, the PBE edit scans the charges. For any charge with an Ordering Diagnosis, if there is an ICD-9 Ordering Diagnosis but no ICD-10 Ordering Diagnosis, or there is an ICD-10 Ordering Diagnosis but no ICD-9 Ordering Diagnosis, the charge has a Pre Bill Edit charge error if the parameter is set to edit for the Ordering Diagnoses.

- If the ICD flag at the account level is set to 10 for ICD-10 codes, the PBE edit scans the charges. For any charge with an ICD-9 Ordering Diagnosis but no ICD-10 Ordering Diagnosis, the charge has a Pre Bill Edit charge error if the parameter is set to edit the Ordering Diagnoses.

- If the ICD flag at the account level is set to 9 for ICD-9 codes, the PBE edit scans the charges. For any charge with an ICD-10 Ordering Diagnosis but no ICD-9 Ordering Diagnosis, the charge has a Pre Bill Edit charge error if the parameter is set to edit the Ordering Diagnoses.

- Charges with no Ordering Diagnosis will not error in PBE for this edit.

- One of four edit messages can be produced for a charge using the PBE field 1570 (Charge Diagnosis) with the Active Sources option of I-ICD charge edit:

  - Needs ICD-9 diagnosis

  - Needs ICD-10 diagnosis

  - Needs ICD-9 diagnosis not ICD-10 diagnosis

  - Needs ICD-10 diagnosis not ICD-9 diagnosis

  Each of the preceding edits is tallied separately in the PBE reports counting the occurrence of edits.

- O - OPPS edits.

NOTE: The completion of this field activates the pre-bill process on STAR Financials Patient Accounting.

Send Through Pre-bill Edits

These parameters are used to update the Insurance Plan Coverage table in defining which carrier/plans are subjected to the Pre-bill Edit process. The information updated is the Facility Information, Billing /Claims Parameters, page 4 of 4, Perform Pre-bill

Edits field. Patient Type exceptions are reflected in the Perform Pre-bill Edits Patient Type Exceptions field.

6. INPATIENT (6-N-R OR TABLE LOOKUP-R)
This field defines which carrier/plans are eligible to be sent through the pre-bill edit process. When this field is accessed, a table list of insurance carriers is displayed. The option to select all carriers is available or the user may select multiple entries from the table. After selecting the carriers to update, a list of applicable insurance plans is displayed. The user has the option to select all plans for all the selected carriers or to manually select carrier/plans.

After you select an insurance plan, the following prompt is displayed:

Do you want to enter patient type exceptions for selected insurance plans? (Y/N)

You can enter **Y** for Yes to display a list of patient types for the selected insurance plans. Selecting patient types results in applicable accounts being excluded from the pre-bill edit process. If you enter **N** for No, the system displays the Pre-bill Edit Parameters screen

7. OUTPATIENT (6-N-R OR TABLE LOOKUP-R)
This field defines which carrier/plans are eligible to be sent through the pre-bill edit process. When this field is accessed, a table list of insurance carriers is displayed. The option to select all carriers is available or the user may select multiple entries from the table. After selecting the carriers to update, a list of applicable insurance plans is displayed. The user has the option to select all plans for all the selected carriers or to manually select carrier/plans.

After you select an insurance plan, the following prompt is displayed:

Do you want to enter patient type exceptions for selected insurance plans? (Y/N)

You can enter **Y** for Yes to display a list of patient types for the selected insurance plans. Selecting patient types results in applicable accounts being excluded from the pre-bill edit process. If you enter **N** for No, the system displays the Pre-bill Edit Parameters screen

8. EMERGENCY (6-N-R OR TABLE LOOKUP-R)
This field defines which carrier/plans are eligible to be sent through the pre-bill edit process. When this field is accessed, a table list of insurance carriers is displayed. The option to select all carriers is available or the user may select multiple entries from the table. After selecting the carriers to update, a list of applicable insurance plans is displayed. The user has the option to select all plans for all the selected carriers or to manually select carrier/plans.

After you select an insurance plan, the following prompt is displayed:

Do you want to enter patient type exceptions for selected insurance plans? (Y/N)

You can enter **Y** for Yes to display a list of patient types for the selected insurance plans. Selecting patient types results in applicable accounts being excluded from the pre-bill edit process. If you enter **N** for No, the system displays the Pre-bill Edit Parameters screen

Begin Editing Parameters

These parameters define when accounts are to be initially processed through the Pre-bill Edit module on a systematic basis. This does not apply to a user manually queueing them through the process or through the Manual Batch Selection process. After accounts are initially edited, the Trigger events define when the accounts are systematically selected for re-editing.

9. INPATIENT (6-N-R OR TABLE LOOKUP-R)
This parameter defines when the claims editing process begins: Admission Date, Discharge Date, or Medical Record Completion Date. The parameter also defines the number of days after the event that editing begins. The parameter forces the editing process to begin for the first time. Subsequent edits are system-selected based on trigger events. When processing is initiated, all prior trigger events linked to the account are deleted. When this field is accessed, the following prompt is displayed:

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)--

You can enter **A** for admission date, **D** for discharge date, or **M** for medical records completion days. After you enter the event, enter a slash (/) followed by the number of days after the event to begin the editing process. For example, Admission date and two days would be entered as A/2. When this field is completed, the following prompt is displayed:

Do you want to Add/Revise Patient Type Exceptions (Y/N)--

If you enter **Y** for Yes, the following screen is displayed:

```
            General Hospital PBE Parameters Processor
                                              Wed Jul 07, 2007 01:19 pm


P.T.   Description                      Method                    Days
I/P    Regular Inpatient Admission       Admission Date            2
JOE    JOES FOREVER PATIENT TYPE         Med Records Complete      2
LIC    LORI'S I/P - COUNT                Discharge Date            2
LIR    LORI"S INPATIENT RECLASS          Admission Date            3



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

Field Explanations

P.T. (3-AN-R)
This field contains the patient type. To add a patient type exception, place the cursor in this field, press the Insert function key, and enter the patient type or enter a hyphen (-) to select from the list of patient types. To revise a patient type exception, place the cursor in this field and press the Delete function key.

DESCRIPTION (DISPLAY ONLY)
This field contains a description of the patient type.

METHOD (1-A-R)
This field indicates the event type. You can enter **A** for admission date, **D** for discharge date, or **M** for medical records completion days.

DAYS (3-N-R)
This field indicates the number of days editing begins after the event type.

10. OUTPATIENT (6-N-R OR TABLE LOOKUP-R)
This parameter defines when the claims editing process begins: Admission Date, Discharge Date, or Medical Record Completion Date. The parameter also defines the number of days after the event that editing begins. The parameter forces the editing process to begin for the first time. Subsequent edits are system-selected based on trigger events. When this parameter is initiated, all prior trigger events linked to the account are deleted. When this field is accessed, the following prompt is displayed:

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)--

You can enter **A** for admission date, **D** for discharge date, or **M** for medical records completion days. After you enter the event, enter a slash (/) followed by the number of days after the event to begin the editing process. For example, Admission date and two days would be entered as A/2. When this field is accessed, the following prompt is displayed:

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)--

For an explanation of adding or revising patient type exceptions, see the Inpatient Begin Editing Parameter.

11. EMERGENCY (6-N-R OR TABLE LOOKUP-R)
This parameter defines when the claims editing process begins: Admission Date, Discharge Date, or Medical Record Completion Date. The parameter also defines the number of days after the event that editing begins. The parameter forces the editing process to begin for the first time. Subsequent edits are system-selected based on trigger events. When this parameter is initiated, all prior trigger events linked to the account are deleted. When this field is accessed, the following prompt is displayed:

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)--

You can enter **A** for admission date, **D** for discharge date, or **M** for medical records completion days. After you enter the event, enter a slash (/) followed by the number of days after the event to begin the editing process. For example, Admission date and two days would be entered as A/2. When this field is completed, the following prompt is displayed:

Do you want to Add/Revise Patient Type Exceptions (Y/N)--

For an explanation of adding or revising patient type exceptions, see the Inpatient Begin Editing Parameter.

12. BILL EDITS (6-N-R OR TABLE LOOKUP-R)
This parameter defines when the billing requirements editing process begins: Admission Date, Discharge Date, or Medical Record Completion Date. The parameter also defines the number of days after the event that editing begins. The parameter forces the editing process to begin for the first time. Subsequent edits are system-selected based on trigger events. When this parameter is initiated, all prior trigger events linked to the account are deleted. When this field is accessed, the following prompt is displayed:

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)--

You can enter **A** for admission date, **D** for discharge date, or **M** for medical records completion days. After you enter the event, enter a slash (/) followed by the number of days after the event to begin the editing process. For example, Admission date and two days would be entered as A/2. When this field is completed, the following prompt is displayed:

Do you want to Add/Revise Patient Type Exceptions (Y/N)--

For an explanation of adding or revising patient type exceptions, see the Inpatient Begin Editing Parameter.

13. ICD EDITS (TABLE LOOKUP-C)
This parameter defines when the ICD charge requirements editing process begins: Admission Date, Discharge Date, or Medical Record Completion Date. The parameter also defines the number of days after the event that editing begins. This field can be accessed only if one of the options for the Active Sources field is I-ICD. When this field is accessed, the system prompts

Start the editing process based on (A)dmit, (D)ischg, (M)ed Rcd Complete/Days (i.e. A/2)-

You can enter **A** (Admit), **D** (Discharge) or **M** (medical records) and the number of days past this criteria. An example of this is: A/1 to start editing the data one day after admission.

14. INCLUDE ALL INSURANCES (1-A-O)
This field is used to extend the edits done per the selected Active Sources field to include all insurances in addition to the primary insurance and its related 1500 insurance. When this field is accessed, the following prompt is displayed:

Do you want to perform PBE edits on all insurances for an account? (Y/N)-

You can enter **Y** (Yes) to perform PBE edits on all insurances for an account. The editing is dependent on the Active Sources field on the Pre-bill Edit Parameter. The Pre-bill options of O-OPPS and G-EAPG, only process for Claim Type X-UB. The C-Star claim edits and E-CA (EC 2000 electronic claims) only process for Claim Types X-UB, R-Medi-Cal UB, B-1500, Z-Non Pro Fee 1500, L-2360 (Illinois), and J-CA25-1 (California). The B-STAR billing edits and I-ICD charge edits process regardless of claim type.

Note also that these secondary insurances must be set to process in the Pre-bill Edit Parameters and the Send Through Pre-Bill Edits fields, and that the Insurance Plan Coverage Table for the insurance, Facility Options, Billing/Claim Parameters, page 5 of 5, must be set to process through Pre-bill Edit.

When editing all insurances, duplicate errors across COB's are not repeated. For example, if the Claim Load Edit for the COB 1 UB plan requires Value Code 1, and the Claim Load Edit for the COB 3 UB plan requires Value Code 1, if Value Code 1 is missing on the account, the system lists the PBE error only once.

The system takes into account the ICD indicator for any diagnosis or procedure code error. Therefore, if one insurance requires ICD-10 data, and another insurance requires ICD-9 data, the system produces an error for each unique ICD indicator. For example, you can have the following errors for the same account:

ICD10 PRINCIPAL DIAG CODE (MR/ADM) is Required

ICD9 PRINCIPAL DIAG CODE (MR/ADM) is Required

ICD10 PRINCIPAL PROCEDURE CODE is Required

ICD9 PRINCIPAL PROCEDURE CODE is Required

For Billing edits, the system edits according to the COB 1 Billing Parameter and linked Billing Requirements. The system also looks to the Final Billing Parameter and linked Billing Requirements for the secondary insurances, and produces PBE errors as if the secondary insurance was COB 1. This allows users to perform Billing edits on all insurances.

For secondary OPPS (APC and TRICARE) edits, to view the edits per claim, users should access Financial System Management, Interface Functions, 3M OPPS Reimbursement Interface, PBE 3M OPPS Interface, Examine PBE OPPS Information. To view the edits per claim users can also access Financial System Management,

Billing and Claims, Pre-bill Edit, PBE Claim Information, Select an account and claim, and PBE OPPS Information.

For secondary EAPG edits, to view the edits per claim, users should access Financial System Management, Interface Functions, 3M EAPG Reimbursement Interface, PBE 3M EAPG Interface, Examine PBE EAPG Information. To view the edits per claim users can also access Financial System Management, Billing and Claims, Pre-bill Edit, PBE Claim Information, Select an account and claim, and PBE EAPG Information.

When editing secondary insurances, the system uses the existing Pre-bill Edit Parameter settings for the edit days and trigger events.

When in the GUI Pre-bill Edit Workstation, and you have the list of accounts that meet your search criteria, after clicking the Claim Sum button, both the primary (COB 1 and linked 1500 plan) and any secondary pre-bill edit insurances are listed. For each, the system lists the CR/PL (Carrier/Plan), the Claim Type, the CS (Claim Sequence), the STAR Edits status, the EC 2000 Edits status, the OPPS Edits status, and the EAPG Edits status.

When in the GUI Pre-bill Edit Workstation, and selecting an account, then clicking the View Claim button, both the primary (COB 1 and linked 1500 plan) and any secondary pre bill edit claims can be viewed when editing secondary insurances.

15. OTHER INS EDIT EXCL (1-A-O)
If the Include All Insurances field is set to Yes, if you want to exclude some edit sources for the secondary insurances, highlight the edit sources to exclude. This field is looked at for the secondary insurances only and only displays sources that have been selected in the Active Sources field. A secondary insurance is one that is not the primary insurance or its related 1500 insurance.

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

Do you want to select edit sources to be excluded for other insurances? (Y/N)--

If you enter **Y** (Yes), a pop-up screen displays the Active Sources selected in field 5, and allows you to highlight the active sources that should not be performed on the non-primary insurances.

If this field is left blank, the other insurances are edited according to the Active Sources field. This field continues to define the Pre Bill Edit sources for the primary insurance and the linked 1500 plan.

Trigger Events

These parameters define what updates result in the accounts being systematically selected for being re-edited through the process. This occurs after the Send Through Pre-bill Edits parameter is met.

16. INPATIENT (TABLE LOOKUP-R)
This field defines the trigger events such as charge revision, combine bill, and cycle bill which cause patient accounts to be sent through the pre-bill edit process after pre-bill editing has started (according to the parameters defined within the Begin Editing Parameter fields on this screen). When this field is accessed, the following screen is displayed:

```
            General Hospital PBE Parameters Processor
                                              Thu Mar 03, 2009  11:38 am


Page:01                  Pre-bill Edit Trigger Events        ##=Current Choices
( 1) Abstract Flagged as Complete        (17) Update ICD Diagnosis Information
( 2) Charge Revision                     (18) Update ICD Procedure Information
( 3) Combine Bill                        (19) Update Insurance Information
( 4) Cycle Adjustment Bill               (20) Update Medical Information
( 5) Cycle Bill                          (21) Update Medical Records HCPCS
( 6) DPW Addition/Change/Deletion        (22) Update Misc Visit Information
( 7) Patient Discharge/Disposition       (23) Update Patient Employer
( 8) Patient Historization               (24) Update Special Studies Informatio
( 9) Proration                           (25) Update UB Data
(10) Update Abstract General Informati   (26) Update User Defined MPI Fields
(11) Update Abstract Newborn/Death Cla   (27) Update User Defined Visit Fields
(12) Update Addl Demographic Informati   (28) Update Utilization Review Informa
(13) Update Addl Episode Information
(14) Update DRG Information
(15) Update Demographic Information
(16) Update Guarantor Information

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

You can select one or more trigger events for the patient type. Press ENTER to return to the PBE Parameters screen.

15. OUTPATIENT (TABLE LOOKUP-R)
This field defines the trigger events such as charge revision, combine bill, and cycle bill which cause patient accounts to be sent through the pre-bill edit process after pre-bill editing has started (according to the parameters defined within the Begin Editing Parameter fields on this screen). When this field is accessed, the Pre-bill Edit Trigger Events screen is displayed. For a sample of this screen, see the Inpatient field under Trigger Events. You can select one or more trigger events for the patient type. Press ENTER to return to the Pre-bill Edit Parameters screen.

16. EMERGENCY (TABLE LOOKUP-R)
This field defines the trigger events such as charge revision, combine bill, and cycle bill which cause patient accounts to be sent through the pre-bill edit process after pre-bill editing has started (according to the parameters defined within the Begin Editing Parameter fields on this screen). When this field is accessed, the Pre-bill Edit Trigger Events screen is displayed. For a sample of this screen, see the Inpatient field under Trigger Events. You can select one or more trigger events for the patient type. Press ENTER to return to the Pre-bill Edit Parameters screen.

17. BILLING EDITS (TABLE LOOKUP-R)
This field defines the trigger events such as charge revision, combine bill, and cycle bill which cause patient accounts to be sent through the pre-bill edit process after pre-bill editing has started (according to the parameters defined within the Begin Editing Parameter fields on this screen). When this field is accessed, the PBE Trigger Events screen is displayed. For a sample of this screen, see the Inpatient field under Trigger Events. You can select one or more trigger events for the patient type. Press ENTER to return to the PBE Parameters screen.

Start Reviewing Medical Records Edits

This allows the PBE Workstation to filter edits which are to be listed. Medical Record edits may not be abstracted prior to the account being discharged. As a result, edits such as missing Final DRG would not be valid prior to the account being discharged.

18. INPATIENT (1-A-R)
This parameter determines when the system begins displaying Medical Record-type edits in the PBE workstation. The Medical Record type edits are generated but are not displayed in the PBE Workstation. Medical Record errors have two different sources:

- HCPCS codes derived from medical record data on the pre-bill claim
- Medical record abstract information

These edits can originate from any one of the sources: Demographic, Insurance, Charge, Charge/SIM department, or Medical Records. When this field is accessed, the following prompt is displayed:

Start edit process per (A)dm/Days, (D)isch/Days, (M)ed Rec Done/Days, (N)ever, Med (I)nfo exists--

You can indicate when to accept Medical Records edits by entering **A** for Admission Days, **D** for Discharge Days, **M** for Medical Records Done/Days, **N** for Never, or **I** for Medical Info Exists.

19. OUTPATIENT (1-A-R)
This parameter determines when the system begins displaying Medical Record-type edits in the PBE Workstation. Medical Record errors have two different sources:

- HCPCS codes derived from medical record data on the pre-bill claim
- Medical record abstract information

These edits can originate from any one of the following sources: Demographic, Insurance, Charge, Charge/SIM department, or Medical Records. When this field is accessed, the following prompt is displayed:

Start edit process per (A)dm/Days, (D)isch/Days, (M)ed Rec Done/Days, (N)ever,

Med (I)nfo exists--

You can indicate when to accept Medical Records edits by entering **A** for Admission Days, **D** for Discharge Days, **M** for Medical Records Done/Days, **N** for Never, or **I** for Medical Info Exists.

20. EMERGENCY (1-A-R)
This parameter determines when the system begins displaying Medical Record edits in the PBE Workstation. Medical Record errors have two different sources:

- HCPCS codes derived from medical record data on the pre-bill claim
- Medical record abstract information

These edits can originate from any one of the sources: Demographic, Insurance, Charge, Charge/SIM department, or Medical Records. When this field is accessed, the following prompt is displayed:

Start edit process per (A)dm/Days, (D)isch/Days, (M)ed Rec Done/Days, (N)ever, Med (I)nfo exists--

You can indicate when to accept Medical Records edits by entering **A** for Admission Days, **D** for Discharge Days, **M** for Medical Records Done/Days, **N** for Never, or **I** for Medical Info Exists.

When these fields are completed, you have the option of editing or deleting this information, or displaying the second screen.

Screen 2 of 3

```
                General Hospital Pre-bill Edit Parameters Processor
                                                Sat May 08, 2010 06:03 pm

Facility: Model Hospital A
                    Request Final Bill If No Pre-Bill Edits
 1 Inpatient        2 Outpatient        3 Emergency          4 Pt Type Except
   Yes                Yes                 Yes                  Entries Defined
                  Final Bill with Existing Pre-bill Edits
 5 Inpatient               6 Outpatient              7 Emergency
   Entries Defined           Entries Defined           Entries Defined
                Final Bill with Existing Edits Dollar Limit
 8 Inpatient        9 Outpatient       10 Emergency         11 Pt Type Except
   100.00             100.00              100.00









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

Field Explanations

Request Final Bill if No Pre-Bill Edits

These parameters are used to indicate that a request for a final bill should be created prior to the expiration of Patient Accounting billing suspense days if the following criteria are met when the most recent PBE bill was processed:

- No pre-bill edits were found for any of the PBE Active Sources employed by the facility and appropriate for the account
- Charges exist for the account
- Patient Processing historization has occurred. The PBE trigger event titled Patient Historization is significant for this parameter. If this PBE trigger event is used, a request to create a Pre Bill is created during midnight processing for the last day of Patient Processing suspense. When the next run of Pre Bill occurs in Patient Accounting, final bill requests would be placed for accounts meeting the qualifications outlined above. This means a final bill could be created during midnight processing for the first day of the account's Patient Accounting billing suspense
- Patient Accounting billing suspense days have not passed

- No pre-bill edit trigger events for the account indicate another bill with pre-bill edits should be produced due to data updates

Patient Processing historization is complete once the Hold days and the Susp (Suspense days) have passed for the patient as set in the Patient Type Table. Hold days determine when the patient is auto discharged. The Suspense days determine how long the patient can be accessed after the discharge date (where the patient can be auto discharged or manually discharged). The suspense days allow charges to be entered after the discharge date.

The Bill Suspense Days are set in the Final Billing Parameter assigned to the account (based on the COB 1 insurance or financial class of the account). The Bill Suspense Days are on screen 2 of the (Final) Billing Parameters.

To give an example, if the Patient Type Hold days are 1, and the Susp days are 2 in the Patient Type Table, the patient is historized 2 days after discharge. If the Bill Suspense Days for the patient, as set in the Final Billing Parameters, are set to 5 days, once the account has no pre-bill edits, the account can final bill once historized and before the 5 days have elapsed since discharge.

The bill request is placed with the comment *PBE Editing Completed* so the comment appears in transaction history. The bill selection method is Passed PBE Edits and this selection appears on the Billing Information screen. The functionality can be activated for the facility in Pre-bill Edit parameters and then de-activated for select patient types if desired.

If the bill request is placed, the account is assigned to the category of Worked Accounts. This means if accounts are selected for the PBE Worklist using the category of Worked Accounts, accounts are included for which a final bill request was placed early due to no pre-bill edits.

If the request for the final bill is placed from Pre-bill Edit logic and a subsequent Pre-bill Edit trigger event selected for the facility occurs, meaning data was updated and a request for a new PBE was placed, the request for the final bill is removed and the Pre-bill Edit Status is updated to be 13 (Final Bill Req Canc).

NOTE: Any charges that are posted to this account after the Final Bill would have to be billed on an Adjustment or Late claim. Billing before the Bill Suspense Days have elapsed may increase the number of Adjustment or Late claims if charges are not entered in a timely fashion.

Any account that has no pre-bill edits and bills before the Bill Suspense Days in the Final Bill Parameter assigned to the account has a Comment for the Final Bill of *Final Bill - PBE Editing Completed BS1*, where BS is the Bill Sequence followed by the bill sequence number. The comment about the number of copies printed does not appear.

When accessing Account Inquiry, Financial Information, Billing Information, for any account that has no pre-bill edits and bills before the Bill Suspense Days in the Final Bill Parameter assigned to the account, the field Pre-Bill Edit Status contains *Bypassed/Final Bill*.

1. INPATIENT (1-A-O)

This field is used to indicate whether a bill request for a final bill should be placed for an account whose patient indicator is I for Inpatient and the following criteria are met in Pre-bill edit logic when the most recent PBE bill was processed:

- No PBE edits were found for any of the PBE Active Sources employed by the facility and appropriate for the account
- Charges exist for the account
- Patient Processing historization has occurred
- Patient Accounting billing suspense days have not passed
- No PBE trigger events for the account indicate another PBE bill should be produced due to data updates

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

Request final bill if NO PBE edits, Pat Proc historization complete, and before Bill Suspense? (Y/N)-- |

2. OUTPATIENT (1-A-O)

This field is used to indicate whether a bill request for a final bill should be placed for an account whose patient indicator is O for Outpatient and the following criteria are met in Pre-bill edit logic when the most recent PBE bill was processed:

- No PBE edits were found for any of the PBE Active Sources employed by the facility and appropriate for the account
- Charges exist for the account
- Patient Processing historization has occurred
- Patient Accounting billing suspense days have not passed
- No PBE trigger events for the account indicate another PBE bill should be produced due to data updates

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

Request final bill if NO PBE edits, Pat Proc historization complete, and before Bill Suspense? (Y/N)-- |

3. EMERGENCY (1-A-O)
This field is used to indicate whether a bill request for a final bill should be placed for an account whose patient indicator is E for Emergency and the following criteria are met in Pre-bill edit logic when the most recent PBE bill was processed:

- No PBE edits were found for any of the PBE Active Sources employed by the facility and appropriate for the account
- Charges exist for the account
- Patient Processing historization has occurred
- Patient Accounting billing suspense days have not passed
- No PBE trigger events for the account indicate another PBE bill should be produced due to data updates

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

Request final bill if NO PBE edits, Pat Proc historization complete, and before Bill Suspense? (Y/N)-- |

4. PT TYPE EXCEPT (TABLE LOOKUP-O)
This field cannot be used unless a response of Yes was made to one of the three preceding fields for Request Final Bill If No Pre-Bill Edits (Inpatient, Outpatient, or Emergency). If the field is selected, a table lookup of patient types is displayed with the title *NO Final Bill Request from PBE for Patient Types*. The patient types displayed in the table lookup are limited to those for which a value of Yes exists in fields 1 (Inpatient), 2 (Outpatient), and 3 (Emergency) for the associated patient indicator for the patient type.

If patient types are selected, no request is made for a final bill from PBE and a PBE status of 11 (No Errors/No Bill Req) is assigned when the following criteria are met when the most recent PBE bill was processed:

- No PBE edits were found for any of the PBE Active Sources employed by the facility and appropriate for the account
- Charges exist for the account
- Patient Processing historization has occurred
- Patient Accounting billing suspense days have not passed
- No PBE trigger events for the account indicate another PBE bill should be produced due to data updates

Final Bill With Existing Pre-bill Edits

These parameters allow accounts to be final billed even though PBE "worklisted" edits exist (does not apply to edits defined as *Reported*). Without updating this parameter, accounts would not final bill when PBE edits exist. This parameter is used to update the Insurance Plan Coverage Table. The information updated is the Facility Information, Billing /Claims Parameters, page 4 of 4, Final Bill if Pre-bill Edits field. Patient Type exceptions are reflected in the Final bill with Pre-bill edits Pat Type Exceptions field.

5. INPATIENT (6-N-R OR TABLE LOOKUP-R)

This parameter defines which carriers and/or carrier/plans can final bill if pre-bill edits exist. This field defines which carrier/plans are eligible to be sent through the pre-bill edit process. When this field is accessed, a table list of insurance carriers is displayed. The option to select all carriers is available or the user may select multiple entries from the table. After selecting the carriers to update, a list of applicable insurance plans is displayed. The user has the option to select all plans for all the selected carriers or to manually select carrier/plans.

After you select an insurance plan, the following prompt is displayed:

Do you want to enter patient type exceptions for selected insurance plans? (Y/N)

You can enter Y for Yes to display a list of patient types for the selected insurance plans. Selecting patient types results in applicable accounts being excluded from the pre-bill edit process. If you enter N for No, the system displays the Pre-bill Edit Parameters screen

6. OUTPATIENT (6-N-R OR TABLE LOOKUP-R)

This parameter defines which carriers and/or carrier/plans can final bill if pre-bill edits exist. This field defines which carrier/plans are eligible to be sent through the pre-bill edit process. When this field is accessed, a table list of insurance carriers is displayed. The option to select all carriers is available or the user may select multiple entries from the table. After selecting the carriers to update, a list of applicable insurance plans is displayed. The user has the option to select all plans for all the selected carriers or to manually select carrier/plans.

After you select an insurance plan, the following prompt is displayed:

Do you want to enter patient type exceptions for selected insurance plans? (Y/N)

You can enter Y for Yes to display a list of patient types for the selected insurance plans. Selecting patient types results in applicable accounts being excluded from the pre-bill edit process. If you enter N for No, the system displays the Pre-bill Edit

7. EMERGENCY (6-N-R OR TABLE LOOKUP-R)

This parameter defines which carriers and/or carrier/plans can final bill if pre-bill edits exist. This field defines which carrier/plans are eligible to be sent through the pre-bill edit process. When this field is accessed, a table list of insurance carriers is displayed.

The option to select all carriers is available or the user may select multiple entries from the table. After selecting the carriers to update, a list of applicable insurance plans is displayed. The user has the option to select all plans for all the selected carriers or to manually select carrier/plans.

After you select an insurance plan, the following prompt is displayed:

Do you want to enter patient type exceptions for selected insurance plans? (Y/N)

You can enter Y for Yes to display a list of patient types for the selected insurance plans. Selecting patient types results in applicable accounts being excluded from the pre-bill edit process. If you enter N for No, the system displays the Pre-bill Edit

Final Bill with Existing Edits Dollar Limit

8. INPATIENT (11-N-R)
This field defines the minimum dollar amount for which final billing is held when pre-bill edits exist for an inpatient account. This field allows small dollar accounts to be final billed without correcting pre-bill edits. When the field is accessed, the following prompt is displayed:

Enter minimum amount that holds final bill for pre-bill edits--

You can enter a value between **0** and **999,999,999.99**. If the field is blank, the dollar amount for the bill has no impact on whether the final bill is held for the pre-bill edits.

9. OUTPATIENT (11-N-R)
This field defines the minimum dollar amount for which final billing is held when pre-bill edits exist for an oupatient account. This field allows small dollar accounts to be final billed without correcting pre-bill edits. When the field is accessed, the following prompt is displayed:

Enter minimum amount that holds final bill for pre-bill edits--

You can enter a value between **0** and **999,999,999.99**. If the field is blank, the dollar amount for the bill has no impact on whether the final bill is held for the pre-bill edits.

10. EMERGENCY (11-N-R)
This field defines the minimum dollar amount for which final billing is held when pre-bill edits exist for an emergency room account. This field allows small dollar accounts to be final billed without correcting pre-bill edits. When the field is accessed, the following prompt is displayed:

Enter minimum amount that holds final bill for pre-bill edits--

You can enter a value between **0** and **999,999,999.99**. If the field is blank, the dollar amount for the bill has no impact on whether the final bill is held for the pre-bill edits.

11. PT TYPE EXCEPT (1-A-R)
This field defines the minimum dollar amount for which final billing is held when pre-bill edits exist for selected patient types. All patient types can be defined excluding contract type, pre-admission/registration, and inactive patient types. When this field is accessed, the following prompt is displayed:

Do you want to Add/Revise Patient Type Exceptions (Y/N)-

You can enter **N** for No to exit the field. You can enter **Y** for Yes to display a list of patient types from which you can select one or more as patient type exceptions and define the dollar limit for the exception. The following screen is displayed:

```
          General Hospital Pre-bill Edit Parameters Processor
                                                 Fri Jul 09, 2004 12:43 pm


P.T.   Description                                 Limit
1IP    NUMERIC INPATIENT                         $100.00
AAA    TET                                       $200.00
ADV    Advance Admission Inpatient               $300.00
AKB    HAVING TO SELECT FROM ALPHA LI            $400.00
ANC    TEST OF ANC                               $401.00
BBB    TEST PROV                                 $402.00
BEV    TESTJ1799                                 $403.00
BOB    Bob's O/P Admission                       $404.00
BOP    BOB'S O/P TESTER                          $104.00
BPB    Bob's OP in a bed                         $105.00
CAN    test                                      $106.00
CMB    TEST COMBINED FLOW                        $107.00
CNA    Cancel Admission with Orders--              $1.00
CTC    CTC Test Patient Table                     $11.00
CUM    Testing Pat types                         $111.00
DIA    Dialysis Series Outpatient                $112.00
ELI    ELI'S INPATIENT                           $123.00

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

You can enter a hyphen in the Patient Type field (P.T.) to display a table of patient types. Select one or more exceptions for the patient type from the table, then enter the dollar amount for the limit. Press ENTER to return to the Pre-bill Edit Parameters screen.

When these fields are completed, you have the option of editing or deleting this information, or displaying the third screen.

Screen 3 of 3

```
                  General Hospital Pre-bill Edit Parameters Processor
                                                Mon May 23, 2011 04:42 pm

Facility: Model Hospital A
 1 SIM Dept          2 FCRPRERES Report  3 FCRPREACT Report   4 FCRPREANA Report
   Entries Defined     Entries Defined     Entries Defined      3
 5 Aging Categories
   10,20,30,40
                     Pre-bill Edit Worklist Assignment
 6 Inpatient         7 Outpatient        8 Emergency          9 Pt Type Except
   Entries Defined     Entries Defined     Entries Defined      Entries Defined

10 SIM Item for UB Zero-Dollar EC 2000 CA Claims            11 CA Category
   CSA-5621 (3% SODIUM CHLORIDE SOLUTION)                      No
12 Activate Adm GUI Screens            13 Days Before Auto Re-Queue in Billing
   Yes-MLK TESTING ENVIRONMENT             0
14 Edit by                                      15 Edit date
   New, Nancy                                      04/21/11 01:14pm




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

Field Explanations

1. SIM DEPT (1-A-R)
This field defines whether charge-type edits are assigned to the Charge Edits - Generic group rather than the assignment of SIM Departments. When this field is accessed, the following prompt is displayed:

Do you want update SIM depts receiving pre-bill Edits (Y/N) [Y] ? -

You can enter **N** for No to return to the first parameter screen. You can enter **Y** for Yes to display a table of all SIM departments. Those departments highlighted has charge-type edits assigned to the user of SIM department code (i.e. EEG) rather than to the Charge Edits - Generic group.

2. FCRPRERES REPORT (TABLE LOOKUP-R)
This parameter determines which pre-bill edit user groups and users are reported on the FCRPRERES report generated in Midnight Processing. You can also generate the report online from within the Pre-bill Edit Worklist GUI application. This report creates a report for use by Medical Records when the STAR Medical Records GUI module is not used. When the field is accessed, the table of User Groups and Users is displayed. You can select one or more user groups and/or users.

3. FCRPREACT REPORT (1-A-R)
This parameter defines whether the FCRPREACT report is aged by one of the following options:

- PBE Summary Statistics by PBE User
- Edit Messages by Days on PBE Worklist
- Edit Messages by Days Waiting to Final Bill
- Edit Messages by Days on PBE Worklist/SIM Dept Detail
- Edit Messages by Days on PBE Worklist/SIM Dept Detail

When the field is accessed, the options for the FCRPREACT Report are displayed. You can select one or more options for the report.

4. FCRPREANA REPORT (3-N-R)
This field defines how many days before the expected final bill date should pass before the FCRPREANA report is produced with discharged accounts in billing suspense. When this field is accessed, the following prompt is displayed:

Enter days before expected final bill date to select discharged accounts in billing suspense-

You can enter a number of days from 1 to 999.

5. AGING CATEGORIES (TABLE LOOKUP-O)
This field controls the aging category time spans for the pre-bill edit statistics reports. When the field is accessed, the following screen of pre-bill edit aging categories is displayed:

```
                      Pre-bill Edit Aging Categories
 1 Category 1     2 Category 2        3 Category 3        4 Category 4
   1                3                   6                   8
 5 Category 5     6 Category 6        7 Category 7
   10               13                  14+
Enter field number or '/' starting field number--
```

When the category fields are accessed, the following prompt is displayed:

Enter the ending category day--

Enter the ending category day for the category. Each category must have a larger number than the category prior to it. The last category has the last-defined category with a plus sign (+).

Pre-bill Edit Worklist Assignment

6. INPATIENT (TABLE LOOKUP-R)
This parameter is used to allocate work to the appropriate users. The categories to allocate are defined by the Pre-bill Edit Category table. When this field is accessed, the following screen is displayed:

```
Category              Worker Assignment       Default Group/Person    Use CA Cat
C-Charge              Biller - Generic
D-Demographic         Biller - Generic        Banks, John (R)
E-No CA Claim         Biller - Generic
I-Insurance           Biller - Generic
M-Medical Records     Biller - Generic
U-Utilization Manage  Biller - Generic
Z-TESTING FOR CLASS   Biller for first COB    Med Recs - Generic


Do you wish to update this table (Y/N) [N]--
```

The following prompt is displayed on this screen:

Do you wish to update this table (Y/N) [N]--

You can enter **Y** for Yes to define a worker assignment for the category or press F7 to exit the screen.

Field Explanations

CATEGORY (DISPLAY ONLY)
This field contains the categories defined in the Pre-bill Edit Category table.

WORKER ASSIGNMENT (TABLE LOOKUP-R)
This field contains the user assigned to the category. To add or revise the user, enter a hyphen (-) in the field to display the table of Pre-bill Edit User Types. You can select a user type from the table, then press ENTER to return to the screen.

The PBE User Defined Edit Groups can be assigned for the edit Category in the fields Inpatient, Outpatient, Emergency, and Pt Type Exceptions.

DEFAULT GROUP/PERSON (TABLE LOOKUP - R)
This field is required when edits are assigned to an individual (COB 1 biller, registration clerk, or pre-admission clerk) and the person is not defined in the PBE User table. When this field is accessed, the following prompt is displayed:

Enter B for Biller, R for Reg Clerk, or G for Group

You have the following entry options:

- **B** (Biller) - If you enter B (Biller), the system displays the Pre-bill Edit Biller table. You can select one from the table.

- **G** (Group) - If you enter Group, you can select a group from the Pre-bill Edit User Types table or you can select a group from the PBE User Defined Edit Group.

- **R** (Reg Clerk) - If you enter R (Reg Clerk), the system displays a list of PBE Registration Clerks. You can select one from the table.

USE CA OVERRIDE (1-A-R)
This field defines whether the responsible person, as defined by EC 2000 CA, is used to assign the work. You can enter **Y** for Yes or **N** for No.

7. OUTPATIENT (TABLE LOOKUP-R)
This parameter is used to allocate work to the appropriate users. The categories to allocate are defined by the Pre-bill Edit Category table (user controlled). When this field is accessed, the screen shown in the Inpatient field is displayed; you can refer to the Inpatient field for field descriptions.

8. EMERGENCY (TABLE LOOKUP-R)
This parameter is used to allocate work to the appropriate users. The categories to allocate are defined by the Pre-bill Edit Category table (user controlled). When this field is accessed, the screen shown in the Inpatient field is displayed; you can refer to the Inpatient field for field descriptions.

9. PT TYPE EXCEPT (TABLE LOOKUP-O)
This parameter is used to define patient type exceptions for the work assignment. If an item is defined as a patient type exception, the edit category is used. If an item is not defined as a patient type exception, the default parameters are used. The hierarchy of work assignment is:

- Patient type exception

- General definition

- Person override if not present in Pre- bill Edit User table

- Person in Pre- bill Edit User table, but has a person/group defined

When this field is accessed, the Patient Types table is displayed. You can choose a patient type for the exception, then press ENTER to define the work assignment. The following screen is displayed:

```
            General Hospital Pre-bill Edit Parameters Processor
                                                Fri Jun 03, 2007 03:26 pm


I/P - Inpatient
Category           Worker Assignment     Default Group/Person        Use CA Cat
A-HIM Abstract     Med Recs - Generic
C-Charge           SIM Department
D-Demographic      Biller - COB 1       Smish,Barbara
E-No CA Claim      Regist Clerk         Biller -Generic
I-Insurance        Pre-Regist Clerk     Medical Records - Generic       No
M-Medical Records  Biller - Generic
U-Utilization Mgt  Biller - Generic
Z-test medical re  Regist - Generic O/P

               F1Prev Page F2Next Page F6 Reset  F7 Exit   ?
```

Field Explanations

CATEGORY (DISPLAY ONLY)
This field displays the Pre-bill edit category.

WORKER ASSIGNMENT (TABLE LOOKUP-R)
This field is used to define the pre-bill edit user type to assign to the category. You can enter a hyphen (-) in the field to display the Pre-bill Edit User Types table and to select one from the table.

The PBE User Defined Edit Groups can be assigned for the edit Category.

DEFAULT GROUP/PERSON (TABLE LOOKUP-R))
This field is required when edits are assigned to an individual (COB 1 biller, registration clerk, or pre-admission clerk) and the person is not defined in the PBE User table. When this field is accessed, the following prompt is displayed:

Enter B for Biller, R for Reg Clerk, or G for Group

You have the following entry options:

- **B** (Biller) - If you enter B (Biller), the system displays the Pre-bill Edit Biller table. You can select one from the table.
- **G** (Group) - If you enter Group, you can select a group from the Pre-bill Edit User Types table or you can select from the PBE User Defined Edit Group
- **R** (Reg Clerk) - If you enter R (Reg Clerk), the system displays a list of PBE Registration Clerks. You can select one from the table.

USE CA OVERRIDE (1-A-O)
This field defines whether the responsible person, as defined by EC 2000 CA, is used to assign the work. You can enter Y for Yes or N for No

10. SIM ITEM FOR UBZERO DOLLAR EC 2000 CA CLAIMS (TABLE LOOKUP-R)
This field defines the SIM Item to be used for UB zero-dollar claims for EC 2000 Claims Administrator. When this field is accessed, the SIM Departments table is displayed. You can select a SIM department, then press ENTER to select a description from the SIM Descriptions table.

11. CA CATEGORY (1-A-R)
This field is used to indicate whether the STAR category is used or the EC2000 CA category is used. When this field is accessed, the following prompt is displayed:

Override STAR Category with EC 2000 CA Category (Y/N) [N]--

You can enter **Y** (Yes) to override the STAR category or **N** (No) not to override the STAR category.

12. ACTIVATE ADM GUI SCREENS (1-A-R)
This field is used to indicate whether PBE Worklist users can elect to use character-based screens or GUI screens after the STAR Admitting Workstation feature is activated for a facility.

This parameter cannot be accessed if STAR Patient Accounting and STAR Patient Processing are not located on the same CPU. When the field is accessed, and the systems are not located on the same CPU, the following message is displayed:

Parameter cannot be used unless PP and PA reside on same CPU!

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

Activate Admitting GUI Screens? (Y/N)--

If you enter **Y** (Yes), the system displays the PBE GUI Option Group table. You can select the default PBE GUI option from the table.

13. DAYS BEFORE AUTO RE-QUEUE IN BILLING (3-N-O)
If this parameter is completed, a request for a pre-bill edit is not triggered during billing for a pre-bill edit account with no pre-bill edits in the Pre-bill Edit Worklist when the difference between the date of Midnight Processing and the last creation date for a pre-bill edit is less than the value set in this field. This field allows processing to be completed for electronic claims (EC/ePremis), and for the 3M Core Grouping Software with APCs or 3M Core Grouping Software with EAPGs before re-queueing the account in Pre-bill Edit.

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

Number of days before requesting new PBE in billing because account has no PBE edits [3]--

If a value of 0 is indicated for the parameter, a request continues to be triggered whenever a PBE account has no edits on the PBE Worklist. The default value is 3.

An example follows for when the field is set to 3:

- Friday 10/8 the account is in the PBE workfile because of the last PBE Event

- There are no edits in the worklist as of 10/8

- The system looks to the Midnight Processing Date minus the Date of the last PBE event

- On Monday 10/11, the difference between the dates (10/11 minus 10/8) would be 3, so the account is re-queued during Monday's Midnight Processing

PRE-BILL EDIT FIELDS DEFINITIONS

This menu option allows you to revise the base definitions of the Pre-Bill Edit table definition. The functions are as follows:

- PBE Fields
- PBE Fields for STAR Internal Elements
- PBE Fields for OPPS Error Messages
- PBE Fields for CA
- Print PBE Cross Index (report FPBINDx)
- PBE GUI Screen Groups
- View PBE GUI Screen Groups
- PBE GUI Edit Option Groups
- View PBE GUI Edit Option Groups

Each of these functions is discussed below.

PBE Fields

This function is used to customize pre-bill edit fields that are defined on the master listing on the HBO & Co. Table, Pre-bill Edit Fields. When the system returns error messages from Pre-bill Claims Administrator, the field or field(s) that need changes are identified. Each of the fields in the Claims Administrator download files is mapped to a pre-bill edit field. The pre-bill edit field is used in the Pre-bill Edit Worklist (GUI) to take you to the probable option to be used to correct the data.

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

Enter pre-bill edit field, use `-` for table lookup, or key `U` for pre-bill edit user fields-

You can enter a specific code, or enter a hyphen (-) to look up the list of McKesson-controlled definitions, or enter **U** to define a new code which is not part of the master listing. If you enter U, the following prompt is displayed:

Enter user pre-bill edit field or use `-` for user table lookup-

You can enter a user pre-bill edit field or enter a hyphen (-) to display previously defined Pre-bill Edit field definitions.

After you select one of the three options, the following screen is displayed. The fields under the Standard Pre-bill Edit Field Information heading are display only and reflect information from the master listing. The fields at the top of the screen allow the same information as defined with the Pre-bill Edit Fields master table definition.

```
            General Hospital Pre-bill Edit Fields Processor
                                                Fri Jul 16, 2007 10:27 am

 PBE Fields
 1 Code   2 Description                                3 Status
   1734     1500 Diagnosis Box 21 (MR)                   Active
 4 Pre-bill Edit Category                              5 Pre-Bill Edit Type
   M Medical Records                                     Medical Records
 6 Pre-bill Edit Option
   Diagnosis Information (Medical Records)
 7 Pre-bill Edit Comment
   Diagnoses are selected per claim load and edit parameters for 1500.
 8 Edit by                                              9 Edit date
   New, Nancy                                            09/16/07 05:10pm
                  Standard Pre-bill Edit Field Information
10 Pre-bill Edit Category                             11 Pre-Bill Edit Type
   D Demographic                                         Registration
12 Pre-bill Edit Option                               13 Insurance Logic
   Medical Information Page
14 Pre-bill Edit Comment
   Diagnoses are selected per claim load and edit parameters for 1500.
m
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code for the pre-bill edit field.

2. DESCRIPTION (30-AN-O)
This field contains a description of the pre-bill edit field.

3. STATUS (DISPLAY ONLY)
This field reflects whether the table entry is active or filed as deleted.

4. PRE-BILL EDIT CATEGORY (TABLE LOOKUP-R)
This information links to the Category Type used in the Pre-bill Edit Worklist GUI application. The types of categories are: 1) Demographic, 2) Medical Records, 3) Charge, 4) Insurance, and 5) No EC Claim. You can enter the first letter of the category or enter a hyphen (-) to select a category from the table of Pre-bill Edit Categories.

The edits linked to the user-defined medical record type category are viewed when this parameter setting is reached. This parameter overrides the setting in the Edit Type field on the Pre-bill Edit table.

5. PRE-BILL EDIT TYPE (1-A-R)
This field contains the pre-bill edit type for the field. When the field is accessed, the following prompt is displayed:

Enter (R)egistration, (C)harge, or (M)edical Records Pre-Bill Edit Type--

You can enter a pre-bill edit type of **R** (Registration), **C** (Charge) or **M** (Medical Records).

6. PRE-BILL EDIT OPTION (TABLE LOOKUP-R)
This field defines which menu option is used to access the specific field element information. Menu option examples are UB Occurrence Codes Page, Diagnosis Information, and DRG Information. You can enter a pre-bill edit option code or a hyphen (-) to display the Pre-bill Edit Options table.

7. PRE-BILL EDIT COMMENT (30-AN-O)
This field contains a comment that is displayed within the Pre-Bill Edit Worklist GUI module when an error message applies to this data element.

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

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

10. PRE-BILL EDIT CATEGORY (DISPLAY ONLY)
This field contains the pre-bill edit category from the master listing.

11. PRE-BILL EDIT TYPE (DISPLAY ONLY)
This field contains the pre-bill edit type from the master listing.

12. PRE-BILL EDIT OPTION (DISPLAY ONLY)
This field contains the pre-bill edit type from the master listing.

13. INSURANCE LOGIC (DISPLAY ONLY)
This field displays the insurance logic used for the pre-bill edit.

14. PRE-BILL EDIT COMMENT (DISPLAY ONLY)
This field contains the pre-bill edit comment from the master listing.

After the screen is completed and accepted, you can copy the pre-bill edit field override and fields to another facility. The following prompt is displayed:

Do you want to copy PBE field override information and user PBE fields to

another facility? (Y/N)--

If you enter **Y** for Yes, a list of facilities is displayed. Enter the number for the facility and press ENTER. The following message is displayed:

Pre-bill edit field override information copied to Model Hospital B!

If you enter **N** for No, the following prompt is displayed:

Do you want to remove PBE field override information and user PBE fields for

facility Model Hospital A? (YES/N)--

You can enter **YES** to remove the pre-bill edit field override information and user fields or **N** for No to leave the override information and user fields as they are. The next prompt allows you to print reports listing the pre-bill edit fields:

Produce report of (S)tandard PBE Fields, (U)ser overrides/added PBE Fields, or

(A)ll PBE Field Information--

You can enter one of the following:

S (Standard) - This option produces a report of the standard (not user-defined) pre-bill edit fields.

U (User) Overrides/Added PBE Fields - This option produces a report of any user overrides or added pre-bill edit fields.

A (All) - this option produces a report of both standard pre-bill edit fields and user overrides or added pre-bill edit fields.

The next prompt is displayed:

Enter (C)ode sequence or (A)lphabetic [A]--

You can enter **C** for Code Sequence to produce the report by code sequence or **A** for Alphabetic to produce the report alphabetically by pre-bill edit field.

PBE Fields for STAR Internal Elements

This option is used to link an internal element to a worklist category and type. When this option is selected, the following prompt is displayed:

Enter description(-) for Internal Element or description(=) for Current Override List--

You can enter a hyphen (-) to look up the internal element or an equals sign (=) to look up a list of current overrides for internal elements. The following screen is displayed when you enter a hyphen or an equals sign:

```
    General Hospital Pre-bill Edit Fields for Star Internal Elements Processor
                                                Fri Jul 23, 2004 02:09 pm



     Internal Element                    Pre-bill Edit Field
Page:01               Internal Elements * = User Override
( 1) 1443 GROUP
( 2) 1443 H. KIDS
( 3) 1443 INPATIENT WITHIN 60 DAYS
( 4) 1443 NUMBER OF SECTIONS
( 5) 1443 PAYEE NUMBER
( 6) 1443 PRIOR APPROVAL
( 7) 1443 PROVIDER NUMBER
( 8) 1443 PROVIDER REFERENCE
( 9) 1443 TOTAL DEDUCTIONS
(10) 1500 ACCEPT ASSIGNMENT

Enter choice--
```

You can choose an internal element from the list to link it to a worklist category and type. After you choose an internal element and press ENTER, the following screen is displayed:

```
    General Hospital Pre-bill Edit Fields for Star Internal Elements Processor
                                                Tue Aug 03, 2004 08:49 am

Internal Element: 1443 PROVIDER NUMBER

Standard Pre-bill Edit Field: 752-Provider Number, 1443
User Pre-bill Edit Field:







Enter PBE code, enter `U`code for user PBE field, use `-` for lookup in standard
table, or use `=` for lookup in user table
```

Field Explanations

INTERNAL ELEMENT (DISPLAY ONLY)
This field contains the internal element you selected from the previous screen.

STANDARD PRE-BILL EDIT FIELD (DISPLAY ONLY)
This field contains the standard pre-bill edit field that is linked to the internal element displayed in the Internal Element field.

USER PRE-BILL EDIT FIELD (TABLE LOOKUP-R)
This field contains the user pre-bill edit field that is linked to the internal element displayed in the Internal Element field. The prompt displayed on the screen is used to select a new pre-bill edit field or to change an existing one:

Enter PBE code, enter `U`code for user PBE field, use `-` for lookup in standard

table, or use `=` for lookup in user table

You can enter a valid standard pre-bill edit code or a valid user pre-bill edit field, enter a hyphen (-) to display a list of standard pre-bill edit codes, or enter an equals sign (=) to display a list of user pre-bill edit codes. After you select a code from either list, the code is displayed in this field and the following prompt is displayed:

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

Enter **Y** for Yes to accept the changed field or **N** for No to exit.

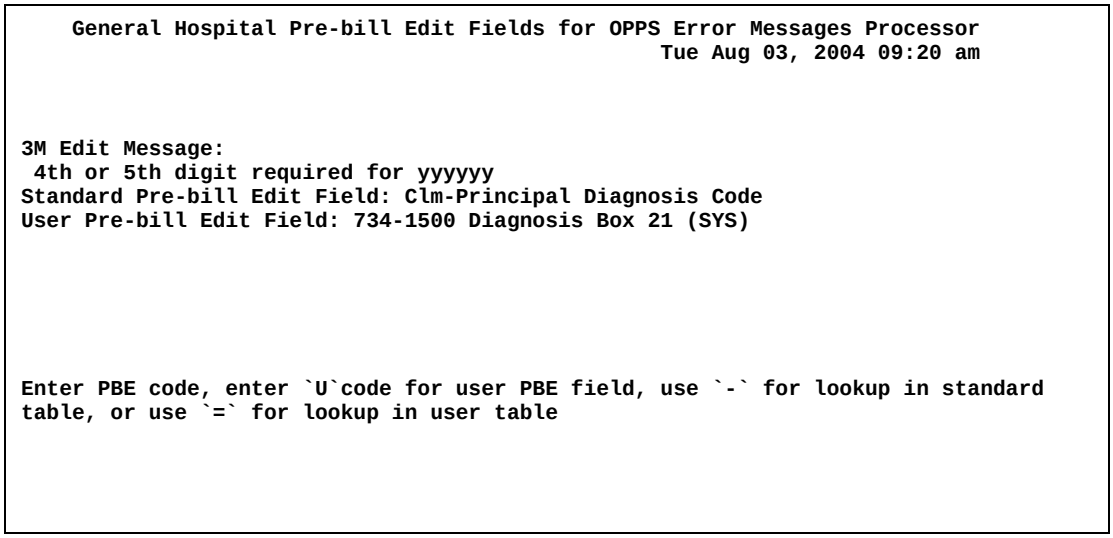
PBE Fields For OPPS Error Messages

This function is used to link OPPS edits with update menu options and user override parameters, where/when possible. This option allows user-defined pre-bill edit field information as well as excluded messages for the FCR250 and FCR446 reports.

When this menu option is selected, the following prompt is displayed:

Enter beginning of 3M Edit Message-

You can enter a hyphen (-) to display a list of 3M Edit messages. Select a message to from the list to link to standard and/or user pre-bill edit fields. After you select a message, the following screen is displayed:



Field Explanations

3M EDIT MESSAGE (DISPLAY ONLY)
This field contains the 3M Edit Message you selected from the previous screen.

STANDARD PRE-BILL EDIT FIELD (DISPLAY ONLY)
This field contains the standard pre-bill edit field that is linked to the 3M Edit Message displayed in the 3M Edit Message field.

USER PRE-BILL EDIT FIELD (TABLE LOOKUP-R)
This field contains the user pre-bill edit field that is linked to the 3M Edit Message displayed in the 3M Edit Message field. The prompt displayed on the screen is used to select a new pre-bill edit field or to change an existing one:

Enter PBE code, enter `U`code for user PBE field, use `-` for lookup in standard

table, or use `=` for lookup in user table

You can enter a valid standard pre-bill edit code or a valid user pre-bill edit field, enter a hyphen (-) to display a list of standard pre-bill edit codes, or enter an equals sign (=) to display a list of user pre-bill edit codes. After you select a code from either list, the code is displayed in this field and the following prompt is displayed:

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

Enter **Y** for Yes to accept the changed field or **N** for No to exit the function.

PBE Fields For CA

This function is used to map the EC 2000 Claims Administrator data file record information to a form locator on the specific claim or to a specific internal element. You must enter a facility code (if applicable), claim form type, and the EC 2000 CA record types. The individual fields sent in the interface records are mapped to a Pre-bill Edit Field. When you choose this option, a list of CA Pre-bill Edit Claim Types is displayed. After you select a claim type and press ENTER, a list of Claims Administrator File Types is displayed. After you select a file type and press ENTER, the following screen is displayed:

```
      General Hospital Pre-bill Edit Fields for CA Processor
                                                 Fri Jul 23, 2004 02:16 pm


 1 CA Column Number                  2 CA Field Description
   001                                 Payer Being Billed Plan Code
 3 Claim Locator                     4 Pre-bill Edit Field
   No                               ->
 5 Insurance Plan Identifier

 6 Copy Information to Other Claim Types


                                Standard Settings

 7 Claim Locator                       8 Pre-bill Edit Field
   No




Enter PBE code, enter `U`code for user PBE field, use `-` for lookup in standard
table, or use `=` for lookup in user table
```

Field Explanations

1. CA COLUMN NUMBER (DISPLAY ONLY)
This field contains the Claims Administrator column number in the interface file.

2. CA FIELD DESCRIPTION (DISPLAY ONLY
This field contains a description of the Claims Administrator field.

3. CLAIM LOCATOR (DISPLAY ONLY)
This field indicates whether the pre-bill edit field is a form locator form. The system displays either YES or NO in the field.

4. PRE-BILL EDIT FIELD (1-A-R)
This field is used to link the correct internal element and subsequently the correct menu item to correct the data edit. When you access this field, the system displays the following prompt:

Enter PBE code, enter `U`code for user PBE field, use `-` for lookup in standard table, or use `=` for lookup in user table

You can enter a valid standard pre-bill edit code or a valid user pre-bill edit field, enter a hyphen (-) to display a list of standard pre-bill edit codes, or enter an equals sign (=) to display a list of user pre-bill edit codes. After you select a code from either list, the code is displayed in this field. If you press ENTER, the following prompt is displayed:

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

This prompt allows you to enter **Y** for Yes to accept the screen, **N** for No to exit the screen, or **D** for Delete to remove the entry from the Pre-bill Edit Claims Administrator Override table. If you enter D for Delete, the following prompt is displayed:

Are you sure that you want to remove this entry from the PBE CA

Override table? (Y/N)--

Enter **Y** for Yes to remove the entry or **N** for No to leave the entry in the table.

5. INSURANCE PLAN IDENTIFIER (1-A-R)
This field specifies which insurance is being referenced in various records. This indicator refers to the insurance(s) in the INSx.TXT file. When this field is accessed, the following prompt is displayed:

Indicate insurance plan (A), (B), or (C)--

You can enter **A**, **B**, or **C** to indicate the insurance plan.

6. COPY INFORMATION TO OTHER CLAIM TYPES (1-A-R)
This field is used to update other claim types with the change made to a specific field. When accessing the field, the following prompt is displayed:

Do you want to copy this information to other claim types? (Y/N)-

You can enter **Y** for **Yes** to display a listing claim types. You can enter **N f**or No to continue on the screen. If you enter Y for Yes, select one or more claim types to copy the field information to the claim type.

7. CLAIM LOCATOR (DISPLAY ONLY)
This field contains the name of the claim locator field.

8. PRE-BILL EDIT FIELD (DISPLAY ONLY)
This field contains the name of the pre-bill edit field.

Print PBE Cross Index (Report FPBINDx)

This option is used to print a listing of Pre-bill Edit Fields information and the source fields that use the specific field. The report spools to file name FPBINDx. When this option is chosen from the menu, the following prompt is displayed:

Produce report of (S)tandard PBE Fields, (U)ser overrides/added PBE Fields, or

(A)ll PBE Field Information--

You can enter one of the following options:

S (Standard) - This option produces a report of the standard (not user-defined) pre-bill edit fields.

U (User) overrides/added PBE Fields - This option produces a report of any user overrides or added pre-bill edit fields.

A (All) - This option produces a report of both standard pre-bill edit fields and user overrides or added pre-bill edit fields.

After you select an option, the following message is displayed:

Report compiling and printing!

PBE GUI Screen Groups

This function organizes a PBE GUI Screen Group for active accounts or inactive accounts, listing the screens to be used to edit Admitting Information. For active accounts, the processor is used to create a list of Admission Form Flows. For inactive accounts, the screen is used to create a list of MPI Review Form Sets.

When this function is accessed, if STAR Patient Processing and STAR Patient Accounting do not reside on the same CPU, the following message is displayed:

Processor cannot be used if PP and PA do not reside on the same CPU

When the function is accessed, if STAR Patient Processing and STAR Patient Accounting reside on the same CPU, a list of PBE GUI Screen Groups is displayed. After you select PBE GUI Screen Group and press ENTER, the following screen is displayed:

NOTE: If Base Screens/Active Accounts or Base Screens/Inactive Accounts is selected by a non-McKesson user, the following message is displayed because the processor cannot be used to edit the base PBE GUI Screen Group.

Editing a Base PBE GUI Screen Group is limited to Mckesson Employees!

```
               General Hospital PBE GUI Screen Groups Processor
                                                  Sun Sep 16, 2007 07:31 pm

 1 Code  2 Description                    3 Active/Inactive Account
   PM      Test Active for Pat              Active
 4 Last Edit Date      5 Last Edit By
   08/14/07 10:37am      Moon, David
Seq  GUI Form Flow Code and Description
 6   PBE Screen Description           STAR Function Used     Screen Exclusions
1    PB-ADJ PBE Base Adjustments Edits - Default
     Base Adjustments Edits           Admission Revision
2    PB-ALL Admission Revision (All screens)
     Admission Revision (All screen   Admission Revision
3    PB-GE  PBE Base Guarantor Employment Information
     Guarantor Employment             Admission Revision
4    PB-GEU PBE Base Guarantor Employment Info - Unemployed
     PBE Base Guarantor Employment    Admission Revision
5    PB-P   PBE Base Patient Information
     PBE Base Patient Information     Admission Revision



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

Field Explanations

CODE (4-N-R)
This field contains the PBE GUI Screen Group code.

DESCRIPTION (30-AN-R)
This field contains the description for the PBE GUI Screen Group code. When this field is accessed, the following prompt is displayed:

Enter description for PBE GUI Screen Group--

ACTIVE/INACTIVE ACCOUNT (1-A-R)
This field is used to indicate whether the PBE GUI Screen Group is used for active or inactive accounts. When this field is accessed, the following prompt is displayed:

Are you selecting screens for (A)ctive or (I)nactive accounts?-

You can enter **A** (Active) or **I** (Inactive).

LAST EDIT DATE (DISPLAY ONLY)
This field contains the date and time for the last update made to the PBE GUI Screen Group.

LAST EDIT BY (DISPLAY ONLY)
This field contains the name of the last user making updates to the PBE GUI Screen Group.

FIELD 6
This field is used to access the next fields on the screen.

SEQ (DISPLAY ONLY)
This is the sequence number for form flows listed in the PBE GUI Screen Group. The value is assigned by the system.

GUI FORM FLOW CODE AND DESCRIPTION (TABLE LOOKUP-R)
This field contains the code for the GUI Form Flow. For active accounts, this is the code for an Admission Form Flow. For inactive accounts, this is the code for an MPI Review Form Set. The corresponding description for the Form Flow is supplied automatically by the system. When this field is accessed, the following prompt is displayed:

Enter Form Flow or use `-` for table lookup--

For GUI Form Flow, the user can key a code or use `-` for a table lookup. If the PBE GUI Screen Group is being used for active accounts, the table lookup displays a list of Admission Form Flows. If the PBE Screen Group is being used for inactive accounts, the table lookup displays a list of MPI Review Form Sets.

PBE SCREEN DESCRIPTION (30-AN-O)
This field contains the description for the Form Flow. For active accounts, this field contains the description for the Admission Form Flow. For inactive accounts, this field contains the description for the MPI Review Form Set. This PBE Screen Description is used in the PBE Worklist in Page Select and in table lookups for PBE GUI Edit Option Groups. When this field is accessed, the following prompt is displayed:

Enter PBE Screen Description (30-character maximum)

STAR FUNCTION USED (DISPLAY ONLY)
For active accounts, this field is defaulted to Admission Review. For inactive accounts, this field is defaulted to MPI Review.

SCREEN EXCLUSIONS (1-A-R)
This field indicates whether the user should be restricted from accessing medical, physician, and/or accident information.

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

Key any combination of (M)edical, (P)hysician, (A)ccident for screen exclusions (i.e. A,P,M)

You can select the choices by keying the first character, using a comma as punctuation. For example, if the choices should be Medical and Physician information, *M,P* should be keyed. If the Medical Page and/or Physician Page is not selected for the user in the GUI function Pre-bill Edit User Access, this option is not provided in Select Page for that user.

View PBE GUI Screen Groups

This screen is used to view a PBE GUI Screen Group created by the user, the base PBE GUI Screen Group supplied for active accounts, and the base PBE GUI Screen Group supplied for inactive accounts.

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

Enter PBE GUI Screen Group or use `-` for a list--

After you enter the PBE GUI Screen Group or choose one from a list that is displayed, the following screen is displayed:

You can use the Prev Page (F1) and and Next Page (F2) keys to view the list of screens in the PBE GUI Screen Group.

```
               General Hospital View PBE GUI Screen Groups Processor
                                                  Sun Sep 16, 2007 07:24 pm

 1 Code  2 Description                    3 Active/Inactive Account
   ACT     TEST ACT ADD                     Active
 4 Last Edit Date      5 Last Edit By
   07/26/07 05:13am      New, Nancy
Seq  GUI Form Flow Code and Description
 6   PBE Screen Description           STAR Function Used     Screen Exclusions
1    BLB    BARB'S INPATIENT
     BARB'S INPATIENT                 Admission Revision
2    CVI    CVI
     CVI                              Admission Revision
3    PB-ACC PBE Base Accident Information
     PBE Base Accident Information    Admission Revision
4    PB-G   PBE Base Guarantor Information
     PBE Base Guarantor Information   Admission Revision
5    PB-GAI PBE Base Guarantor Additional Information
     PBE Base Guarantor Additional    Admission Revision




                     F1Prev Page F2Next Page F7  Exit
```

For details on this screen, refer to “PBE GUI Screen Groups” on page 3-69.

Pre-bill GUI Edit Option Groups

This function is used to establish a PBE GUI Edit Option Group. The first screen is used to select the PBE GUI Screen Group to be used for active accounts and the PBE GUI Screen Group to be used for inactive accounts. The second screen is used to select the option to be used in the PBE Worklist for each PBE field for active and for inactive accounts. The screen includes short cuts so this mapping can be done quickly, capitalizing on existing information for PBE fields.

After this parameter is selected, the system prompts you to enter a code for the Pre-bill GUI Edit Option Group. You can enter the code or a hyphen (-) to display a list of

valid codes. After you enter the code or select one from a list, the following screen is displayed:

```
              General Hospital PBE GUI Edit Option Groups Processor
                                                Mon Sep 17, 2007 08:28 am

1 Code           2 Description
  PMT              TEST FOR DELETION
                              PBE GUI Screen Group
3 Active Accounts                      4 Inactive Accounts
  Test Active for Pat                    Test Inactive for Pat
5 Last Edit Date          6 Last Edit By
  08/14/07 09:53am          Mooney,Pat
                                    Totals for Unmapped PBE Fields
7 # PBE Fields            8 Active Accounts           9 Inactive Accounts
  1199                      1197                        1197
```

Field Explanations

1. CODE (TABLE LOOKUP-R)
This field contains the code for the PBE GUI Edit Option.

2. DESCRIPTION (30-AN-R)
This field contains the description for the PBE GUI Edit Option.

3. ACTIVE ACCOUNTS (TABLE LOOKUP-R)
This field contains the PBE GUI Screen Group for active accounts. When this field is accessed, a list of PBE GUI Screen Groups for Active Accounts is displayed. You can select one from the list.

4. INACTIVE ACCOUNTS (TABLE LOOKUP-R)
This field contains the PBE GUI Screen Group for inactive accounts. When this field is accessed, a list of PBE GUI Screen Groups for Inactive Accounts is displayed. You can select one from the list.

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

6. LAST EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited this table.

7. # PBE FIELDS (DISPLAY ONLY)
This field contains the total number of unmapped PBE fields.

8. ACTIVE ACCOUNTS (DISPLAY ONLY)
This field contains the number of unmapped PBE fields for active accounts.

9. INACTIVE ACCOUNTS (DISPLAY ONLY)
This field contains the number of unmapped PBE fields for active accounts.

The second screen is displayed after you press ENTER. This screen provides varied options to maintain the GUI Edit Options for PBE fields. For each PBE field used to maintain Admitting Information, a PBE GUI Screen to be used for active accounts and a PBE GUI Screen to be used for inactive accounts must be selected.

```
            General Hospital PBE GUI Edit Option Groups Processor
                                                 Mon Sep 17, 2007 08:30 am

                              PBE GUI Screen Group
 1 Active Accounts                      2 Inactive Accounts
   Test Active for Pat                     Base Screens/Inactive Accounts
 3 Select PBE Field for Editing

                         GUI Edit Options for PBE Field List
 4 Active Accounts                      5 Inactive Accounts

                         Create/Maintain PBE Field List
 6 Define Criteria for PBE Field List

 7 Edit Entries in PBE Field List     8 Number of PBE Fields in Current List

 9 Edit Values in PBE Field List     10 Save PBE Field List Information

                          Totals for Unmapped PBE Fields
11 # PBE Fields           12 Active Accounts          13 Inactive Accounts
   1199                      1161                        1164

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

Field Explanations

1. ACTIVE ACCOUNTS (DISPLAY ONLY)
This field contains PBE GUI Screen Group to be used for active accounts.

2. INACTIVE ACCOUNTS (DISPLAY ONLY)
This field contains PBE GUI Screen Group to be used for inactive accounts.

3. SELECT PBE FIELD FOR EDITING (TABLE LOOKUP-R)
This field is used to maintain the GUI Edit Option for Active Accounts and the GUI Edit Option for Inactive Accounts for a single PBE field. Also, this field can be used to remove a PBE field from the PBE GUI Edit Option Group. The field cannot be used if information exists in the Define Criteria for PBE Field List field. When this field is accessed, the following prompt is displayed:

Enter PBE Field or use `-` for alpha lookup-

If you enter a hyphen (-) in response to the prompt, the following screen is displayed:

```
                General Hospital PBE GUI Edit Option Groups Processor
                                                Mon Sep 17, 2007 05:55 pm

Page:01                              PBE Fields
( 1) 1500 24J COB                       (18) Accident Type
( 2) 1500 Diagnosis Box 21 (ADM)        (19) Accident Type, Accident (Acc Code
( 3) 1500 Diagnosis Box 21 (MR)         (20) Accident Type, Accident (Occ Code
( 4) 1500 Diagnosis Box 21 (SYS)        (21) Accident Type, Auto (TI19)
( 5) 1500 Other Insurance Box           (22) Accident Type, Auto Related (Occ)
( 6) 1500 Pat Rel to Ins Actual Value   (23) Accident Type, Auto Related (Type
( 7) 1500 Phy/Dept ID Lower 24K         (24) Accident Type, Crime (Occ)
( 8) 1500 Phy/Dept ID Upper 24K         (25) Accident Type, Employment Related
( 9) 1500 Upper 24D                     (26) Accident Type, Employment Related
(10) 2360/1443 Number of Sections       (27) Accident Type, Michigan 1500 Cond
(11) 3M OPPS Claim Edit Message         (28) Accident Type, Motor Vehicle (Con
(12) Abstract Complete Date             (29) Accident Type, Motor Vehicle (Roa
(13) Accid/Onset Symptoms/LMP Date      (30) Accident Type, Non-employment Rel
(14) Accident Country                   (31) Accident Type, Other Accident Rel
(15) Accident Date/time                 (32) Accident Type, Other Liab (TI19)
(16) Accident Information               (33) Accident/Occurrence Date
(17) Accident State                     (34) Accident/Onset Date (Visit/Occ Co

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

When a PBE field is selected, the PBE GUI Edit Option Groups screen is redisplayed, and the system requires an entry in the Active Accounts field for the GUI Edit Option for Active Accounts. The following prompt is displayed:

Enter GUI Edit Option for Active Accounts,`-` for table lookup, or "@" for None-- -

You can enter the GUI Edit Option or a hyphen (-) to display a table of GUI Edit Options for Active Accounts. After you enter or select a GUI Edit Option, the system requires an entry in the Inactive Accounts field for the GUI Edit Option for Inactive Accounts. The following prompt is displayed:

Enter GUI Edit Option for Inactive Accounts,`-` for table lookup, or "@" for None-- -

After you select a GUI Edit Option for Inactive Accounts, then accept the screen, the system continues to prompt for a PBE Field, then for GUI Edit Options for Active and Inactive Accounts, in a loop, until no PBE field is selected from the list of PBE Fields.

4. ACTIVE ACCOUNTS (TABLE LOOKUP-R)

This field is used to select the GUI Edit Option for Active Accounts to be updated for PBE fields in the PBE Field List defined in the following fields: Define Criteria for PBE Field List, Edit Entries in PBE Field List, and Number of PBE Fields in Current List. This value is used for any PBE field added to the PBE Field List after this field is defined. When this field is accessed, the following prompt is displayed:

Enter GUI Edit Option for Active Accounts, `-` for table lookup, or "@" for None--

If a GUI Edit Option is selected or the *at sign* (@) for None is indicated an @ states the PBE field is not accessible through a STAR Patient Processing GUI screen), the following occurs:

- If a list of PBE fields is defined in the Define Criteria for PBE Field List field, the value for GUI Edit Option for Active Accounts is defaulted to the value selected in the Active Accounts field. This occurs even if a value exists for the field already.

- If PBE fields are added to the list of PBE Fields defined in the Define Criteria for PBE Field List field by using the Edit Entries in PBE Field List, the value for GUI Edit Option for Active Accounts is defaulted to the value selected in Field 4. This occurs even if a value exists for the field already.

- If PBE fields are added to the list of PBE Fields defined in Field 6 in the scrolling screen provided by Field 9, then the value for GUI Edit Option for Active Accounts is defaulted to the value selected in Field 4. This occurs even if a value exists for the field already.

5. INACTIVE ACCOUNTS (TABLE LOOKUP-R)

This field is used to select the GUI Edit Option for Inactive Accounts to be updated for PBE fields in the PBE Field List defined in the following fields: Define Criteria for PBE Field List, Edit Entries in PBE Field List, and Number of PBE Fields in Current List. This value is used for any PBE field added to the PBE Field List after this field is defined. When this field is accessed, the following prompt is displayed:

Enter GUI Edit Option for Inactive Accounts, `-` for table lookup, or "@" for None--

If a GUI Edit Option is selected or the *at sign* (@) for None is indicated (an @ states the PBE field is not accessible through a STAR Patient Processing GUI screen), the following occurs:

- If a list of PBE fields is defined in the Define Criteria for PBE Field List field, the value for GUI Edit Option for Inactive Accounts is defaulted to the value selected in the Active Accounts field. This occurs even if a value exists for the field already.

- If PBE fields are added to the list of PBE Fields defined in the Define Criteria for PBE Field List field by using the Edit Entries in PBE Field List, the value for GUI Edit Option for Inactive Accounts is defaulted to the value selected in Field 4. This occurs even if a value exists for the field already.

- If PBE fields are added to the list of PBE Fields defined in Field 6 in the scrolling screen provided by Field 9, then the value for GUI Edit Option for Active Accounts is defaulted to the value selected in Field 4. This occurs even if a value exists for the field already.

6. DEFINE CRITERIA FOR PBE FIELD LIST (TABLE LOOKUP-O)

This field is used to indicate one selection criteria for starting a list of PBE fields. All PBE fields satisfying the selected criteria are placed in a list. The information for the

list of PBE fields includes the current values for GUI Edit Option for Active Accounts and GUI Edit Option for Inactive Accounts unless fields 4 and/or 5 in the screen have been used. The GUI Edit Option for Active Accounts for PBE fields in the list is updated to the value in field 4 if field 4 is non-blank. The GUI Edit Option for Inactive Accounts for PBE fields in the list is updated to the value in field 5 if field 5 is non-blank.

If this field is selected, the following table look-up is displayed.

```
       General Hospital PBE GUI Edit Option Groups Processor
                                                Wed Jun 27, 2007 10:01 pm

Page:01                   PBE Field Selection Criteria
( 1) GUI Edit Option for Active Accounts
( 2) GUI Edit Option for Inactive Accounts
( 3) Character-Based Edit Option
( 4) PBE Field Description
( 5) PBE Category
( 6) PBE Edit Type
( 7) Unmapped PBE Fields for Active Accounts
( 8) Unmapped PBE Fields for Inactive Accounts
( 9) Base GUI Edit Option for Active Accounts
(10) Base GUI Edit Option for Inactive Accounts
```

Following is an explanation of each option on the screen:

- If GUI Option for Active Accounts is selected, the user selects a GUI Edit Option for Active Accounts from the table lookup provided. These are options from the PBE GUI Screen Group for Active Accounts. All PBE fields currently using that GUI Edit Option for Active Accounts are selected. When this Selection Criteria is used, the system displays the following prompt, with CHOICE representing the option selected.

  GUI Option for Active Accounts - OPTION

- If GUI Edit Option for Inactive Accounts is selected, the user selects a GUI Option for Inactive Accounts from the table lookup provided. These are options from the PBE GUI Screen Group for Inactive Accounts. All PBE fields currently using that GUI Edit Option for Inactive Accounts are selected. When this Selection Criteria is used, the system displays the following prompt, with CHOICE representing the option selected.

  GUI Option for Inactive Accounts - OPTION

- If Character-Based Edit Option is selected, the following prompt is displayed:

  Enter Character-Based Edit Option, `-` for table lookup, or `N` for None--

  The Character-Based Edit Option can be selected by code or from the table lookup. All PBE fields using the Character-Based Edit Option in the base setup for PBE are

selected. When this Selection Criteria is used, the system displays the following prompt, with CHOICE representing the option selected.

Character-Based Edit Option - OPTION

If PBE Field Description is selected, the next prompt is as follows:

Enter beginning of PBE field description to be used for searching-

One or more characters must be keyed. All PBE fields with a description beginning with the keyed characters are selected. All letters in the description and in the selection criteria are converted to upper case for the comparison. When this Selection Criteria is used, the display for the field is as follows, where ABC represents the description keyed.

Description - ABC

- If PBE Category is selected, then the next prompt is as follows:

  Enter Pre-Bill Edit Category or `-` for table lookup-

- If a Pre-Bill Edit Category is selected, all PBE fields using that Pre-Bill Edit Category in the base setup for PBE are selected. When this Selection Criteria is used, then the display for the field is as follows where CHOICE represents the category selected.

  PBE Category - CHOICE

- If PBE Edit Type is selected, the next prompt is as follows:

  Enter (R)egistration, (I)nsurance, (C)harge, or (M)edical Records Pre-Bill Edit Type--

  If a PBE Edit Type is selected, all PBE fields using that PBE Edit Type in the base setup for PBE are selected. When this Selection Criteria is used, the display for the field is as follows where CHOICE represents the Edit Type selected.

  PBE Edit Type - CHOICE

- If Unmapped PBE Fields for Active Accounts is selected, then all PBE fields for which no selection has been made for GUI Edit Option for Active Accounts are selected. When this Selection Criteria is used, the display for the field is as follows:

  Unmapped PBE Fields for Active Accounts

- If Unmapped PBE Fields for Inactive Accounts is selected, then all PBE fields for which no selection has been made for GUI Edit Option for Inactive Accounts are

selected. When this Selection Criteria is used, then the display for the field is as follows:

Unmapped PBE Fields for Inactive Accounts

- If Base GUI Edit Option for Active Accounts is selected, then the use selects a GUI Edit Option for Active Accounts from the base list of options. All PBE fields currently using the GUI Edit Option for Active Accounts in the base setup are selected. When this Selection Criteria is used, the display for the field is as follows where CHOICE represents the option selected.

  Base GUI Edit Option for Active Accounts - CHOICE

- If Base GUI Edit Option for Inactive Accounts is selected, the user selects a GUI Edit Option for Inactive Accounts from the base list of options. All PBE fields currently using the GUI Edit Option for Inactive Accounts in the base setup are selected. When this Selection Criteria is used, the display for the field is as follows where CHOICE represents the option selected.

  Base GUI Edit Option for Inactive Accounts - CHOICE

After the selection criteria are defined, the system builds a list of PBE fields matching the criteria. The start of that process is signaled with the following message:

Selecting PBE fields for list!

After the PBE fields are selected for the list, the Number of PBE Fields in Current List field contains the current number of PBE fields in the list.

7. EDIT ENTRIES IN PBE FIELD LIST

This field can be used to view the current list of PBE fields in the table lookup format. All PBE fields in the list are marked as selected. If the field is selected, then the following prompt is displayed:.

Select items to be deleted, key `A` to add PBE fields, or NL to exit-

Items are removed from the list using the `-` feature for the table lookup. A PBE field can be added by keying A. If A is keyed, the following prompt is displayed.

Enter PBE Field or use `-` for table lookup-

The selected PBE field is added to the list of PBE fields. The list remains in alphabetical order even if a PBE field is added.

8. NUMBER OF PBE FIELDS IN CURRENT LIST (DISPLAY ONLY)

This field documents the current number of fields in the PBE Field List.

9. EDIT VALUES FOR SELECT FIELDS
This field can be used to make updates for the PBE Field List. Fields can be added or removed from the list. The GUI Edit Option for Active or Inactive Accounts can be updated. When F7 is pressed to leave the scrolling screen, the following is displayed:

Do you want to save the GUI edit options for the current PBE Field List? (Y/N)--

If a response of Yes is keyed, the PBE field information in the PBE GUI Edit Option Group is updated per the PBE field information in the PBE Field List.

10. SAVE PBE FIELD LIST INFORMATION
When this field is accessed, the following prompt is displayed:

Do you want to save the GUI edit options for the current PBE Field List? (Y/N)--

If a response of Y is keyed, the PBE field information in the PBE GUI Edit Option Group is updated per the PBE field information in the PBE Field List.

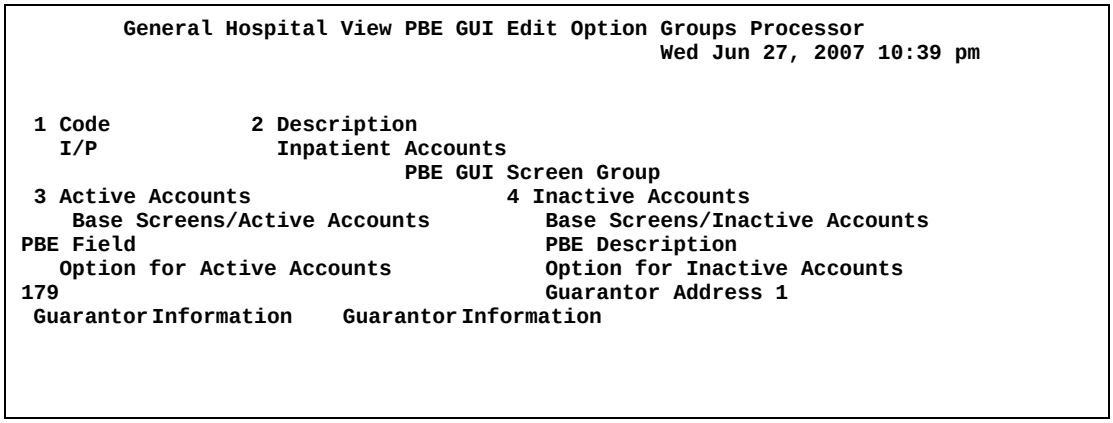
11. # PBE Fields (DISPLAY ONLY)
This field displays the current number of PBE Fields.

12: ACTIVE ACCOUNTS (DISPLAY ONLY)
This field displays the number of PBE fields for which the GUI Edit Option has not been defined for active accounts.

13: ACTIVE ACCOUNTS (DISPLAY ONLY)
This field displays the number of PBE fields for which the GUI Edit Option has not been defined for inactive accounts.

View PBE GUI Edit Option Groups

This option can be used to display information for a PBE GUI Edit Option Group including the base PBE GUI Edit Option Group. When this option is selected, the following screen is displayed:



Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code for the PBE GUI Edit Option.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description for the PBE GUI Edit Option.

3. ACTIVE ACCOUNTS (DISPLAY ONLY)
This field contains the PBE GUI Screen Group for active accounts.

4. INACTIVE ACCOUNTS (DISPLAY ONLY)
This field contains the PBE GUI Screen Group for inactive accounts. When this field is accessed, a list of PBE GUI Screen Groups for Inactive Accounts is displayed. You can select one from the list.

PBE FIELD (DISPLAY ONLY)
This field contains the PBE field.

PBE DESCRIPTION (DISPLAY ONLY)
This field contains the PBE description.

BILLING REQUIREMENTS

This table is used to indicate information that must be present on a patient account before the system generates a final bill. A billing requirements code is assigned to each final bill parameter which, in turn, is assigned to each insurance carrier/plan and each financial class in the system. If a patient does not have a carrier/plan, the billing parameter is assigned from the patient's financial class.

This parameter is not split by facility.

After this table is selected, the system prompts you to enter a billing requirements code. You can enter the code or a hyphen (-) to display a list of valid codes. After the billing requirements code is entered, this screen is displayed.

```
            General Hospital Billing Requirements Processor
                                                        Fri May 12, 2006 11:08 am
Billing Requirements
 1 Code  2 Description                      3 Charge Summary Flag  4 Status
   92      Medicare Requirements              No                     Active
 5 1500 HCPCS Hold          6 1500 Diag Hold           7 1500 Performing DR Hold
   No                         No                         Yes BUSINESS OFFICE
 8 ABN Hold?                9 Cycle Adj Bill Chg-Cr Amt/#
                              Yes. Admissions, Exclude for Prebill
 10 Edit by                       11 Edit date
   Karn, Bailey    L                 05/12/06 8:23
12 Seq Data Base Element                Required/NA   Controlled By
   1   BILL. GTR. ADDRESS 1              Required     BUSINESS OFFICE
   2   BILL. GTR. CITY                   Required     BUSINESS OFFICE
   3   BILL. GTR. STATE                  Required     BUSINESS OFFICE
   4   BILL. GTR. ZIP CODE               Required     BUSINESS OFFICE









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

Field Explanations

1. BILLING REQ CODE (DISPLAY ONLY)
This field contains the code identifying the billing requirements.

2. BILLING REQ DESCRIPTION (30-C-R)
This field contains the description of the billing requirements code.

3. CHARGE SUMMARY FLAG (1-A-R)
This field indicates whether credit summary charges should create a warning message in the biller workfile when a final bill is produced. Entry options are **Y** for Yes and **N** for No; the default is N. If you enter Y, a warning message is generated for bills that have a charge summary group with a credit balance.

4. STATUS (DISPLAY ONLY)
This field indicates whether the billing requirements code is active or inactive. A code that is *filed as deleted* becomes inactive and can be reactivated at any time. The system defaults this field to active when you create the code.

5. 1500 HCPCS HOLD (1-A-R)
This field indicates whether the system should hold a final bill for production if professional fee charges are missing HCPCS codes. Entry options are **Y** for Yes or **N** for No; the default is N. Canadian customers should set this field to No.

If you enter Y, the system displays the Data Control Codes (departments). Select the department responsible for entering the professional fee HCPCS codes. If the final bill fails due to missing HCPCS, the system displays the following message on the Failed Billing Requirements report (FBR210), and the Failed Billing Requirements Controlled By report (FBR220) for the responsible department:

F SIM:3112 CHG #:8 DEPT: EEG DESC: EEG PRO FEE
HCPCS MISSING MEDICAL RECORDS

The online biller workfile has a similar error message as follows:

FATAL -SIM:3112 CHG #:8 DEPT/DESC:EEG EEG PRO FEE
HCPCS MISSING

NOTE: The system can only edit the final bill for charge errors while the account is active on Patient Care. Once inactive on Patient Care, the bill does not hold for charge errors. The claim however can be set to hold for charge errors in the 1500 Charge Control Parameter.

6. 1500 DIAG HOLD (1-A-R)
This field indicates whether the system should hold a final bill for production if professional fee charges are missing diagnosis codes. Entry options are **Y** for Yes or **N** for No; the default is N. Canadian customers should set this field to No.

If you enter Y, the system displays the Data Control Codes (departments). Select the department responsible for entering the professional fee diagnosis codes. If the final bill fails due to missing diagnosis, the system displays the following message on the Failed Billing Requirements report (FBR210), and the Failed Billing Requirements Controlled By report (FBR220) for the responsible department:

F SIM:3112 CHG #:8 DEPT : EEG DESC: EEG PRO FEE
DIAGNOSIS MISSING MEDICAL RECORDS

The online biller workfile has a similar error message as follows:

FATAL -SIM:3112 CHG #:8 DEPT/DESC:EEG EEG PRO FEE
DIAGNOSIS MISSING

NOTE: The system can only edit the final bill for charge errors while the account is active on Patient Care. Once inactive on Patient Care, the bill does not hold for charge errors. The claim however can be set to hold for charge errors in the 1500 Charge Control Parameter.

7. 1500 PERFORMING DR HOLD (1-A-R)

This field indicates whether the system should hold a final bill for production if professional fee charges are missing performing physicians. Entry options are **Y** for Yes or **N** for No; the default is N. Canadian customers should set this field to No.

If you enter Y, the system displays the Data Control Codes (departments). Select the department responsible for entering the professional fee performing physician. If the final bill fails due to missing performing physician, the system displays the following message on the Failed Billing Requirements report (FBR210), and the Failed Billing Requirements Controlled By report (FBR220) for the responsible department:

F SIM:3112 CHG #:8 DEPT: EEG DESC: EEG PRO FEE
PERFORMING PHYSICIAN MISSING MEDICAL RECORDS

The online biller workfile has a similar error message as follows:

FATAL -SIM:3112 CHG #:8 DEPT/DESC:EEG EEG PRO FEE
PERFORMING PHYSICIAN MISSING

NOTE: The system can only edit the final bill for charge errors while the account is active on Patient Care. Once inactive on Patient Care, the bill does not hold for charge errors. The claim however can be set to hold for charge errors in the 1500 Charge Control Parameter.

The system edits for missing diagnosis and missing performing physician if fields 6 and 7 are set to Yes, even if the 1500 Charge Control Parameter is set to default the diagnosis and physician on the charge, and regardless of the physician the departments are set to use in the 1500 Department/Supplier Override table.

8. ABN HOLD? (1-A-R)

This field determines whether the system holds bills for charges that are not determined to be medically necessary based on user-entered ICD diagnoses defined in the STAR Medical Records HCPCS Table. In order for a charge to be processed for the ABN (Advance Beneficiary Notice) logic, at least one of the insurances on the account has to have the CMS Compliant field set to Yes in the Insurance Plan Table. Also, the SIM Department table for the charging department has to have the CMS Compliant field set to ABN Processing or Both ABN Processing and Duplicate HCPCS. The HCPCS table has to then list valid diagnosis codes for that HCPCS. When entering a charge, if the Ordering Diagnosis that is entered is not a valid diagnosis for the HCPCS on the charge, the charge then goes through ABN Processing.

The field allows the user to select which ABN flags should hold the bill. When accessing the field, users must highlight the ABN indicators that should hold the bill. When you access this field, the system displays the following prompt:

Do you want to edit charges for ABN values? (Y/N) [N]-

When entering Y for Yes, the system then displays the ABN options that can be selected to hold the bill. The system looks to the Bill ICD flag of 9 for ICD-9 or 10 for ICD-10, and will only look for charges with an ABN ICD flag that matches the Bill ICD flag. In other words, if the Bill ICD flag is a 9, and the bill is editing for ICD-9 data, even if all ABN flags are highlighted as a Billing Requirement, if the ABN ICD flags on the charges are a 10 for ICD-10, these charge ABN's would not hold the bill. The bill would only hold for highlighted ABN types that also had an ABN ICD indicator of 9.

The following screen is displayed for the user to highlight the ABN indicators that should hold the bill:

```
               General Hospital Billing Requirements Processor
                                                    Fri May 12, 2008 11:08 am
Billing Requirements
 1 Code  2 Description                      3 Charge Summary Flag  4 Status
   3       Medicare                           Yes                    Active
 5 1500 HCPCS Hold          6 1500 Diag Hold           7 1500 Performing DR Hold
   Yes ADMISSIONS             Yes ADMISSIONS             Yes ADMISSIONS
 8 ABN Hold?                9 Cycle Adj Bill Chg-Cr Amt/#
-> Yes MEDICAL RECORDS        No
Page:01                   ABN Non Covered Edit Choices        ##=Current Choices
( 1) ABN Yes Signed
( 2) ABN Not Signed
( 3) ABN Freq Yes Signed
( 4) ABN Freq Not Signed
( 5) ABN Self Pay Yes Signed
( 6) ABN Self Pay Not Signed
( 7) ANB Self Pay Freq Yes Signed
( 8) ABN Self Pay Freq Not Signed



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

After selecting the ABN indicators that should hold the bill, the system prompts for the Data Control Code of the department that is responsible for entering/reviewing the required data.

ABN errors hold bills for the user-defined number of suspense days and prevents the account from transferring from PA to AR. The errors appear on the Failed Billing Report (FBR210), the Failed Billing Controlled By Report (FBR220), and in the Biller Workfile. You can verify the ordering diagnosis with the physician's office and edit the charge, if necessary, as long as the charge is still active on STAR Patient Processing. Once the

charge becomes inactive on STAR Patient Processing, you can edit the information on the claim *only*.

The ABN Bill Edits are displayed in the following format for the Biller Workfile, the FBR210 Failed Billing Requirement Report, and the FBR220 Failed Billing Requirement Controlled By Report: The first line of the error has "FATAL" followed by the SIM (Service Item Master) number, the charge number, the charge Department, and the charge description. The second line of the error lists the ABN flag. The valid values are:

- No - ABN Not Signed
- Yes - ABN Signed
- FQ/Y - Frequency ABN Signed
- FQ/N - Frequency ABN Not Signed
- SP/Y - Self Pay ABN Signed
- SP/N - Self Pay ABN Not Signed
- SP/FQ/Y - Self Pay Frequency ABN Signed
- SP/FQ/N - Self Pay Frequency ABN Not Signed

For example:

FATAL -SIM: 3112 CHG #: 4 DEPT/DESC: EEG EEG PRO FEE

ABN INDICATOR=SP/N

FATAL -SIM: 3112 CHG #: 3 DEPT/DESC: EEG EEG PRO FEE

ABN INDICATOR=SP/Y

FATAL -SIM: 3130 CHG #: 2 DEPT/DESC: EEG EEG / BRAINMAPPING

ABN INDICATOR=FQ/N

9. CYCLE ADJ BILL CHG-CR AMT/# (1-A-O)

This field indicates if a bill should be edited for unbilled cycle charges and credits and if the edit should be excluded for accounts using the Pre-bill Edit functionality. The edit is only for final bills and for final adjustment bills, if the hospital is performing edits for final adjustment bills. When this field is accessed, the following prompt is displayed:

Should bill edit for unbilled cycle adjustment charges/credits? (Y/N)[N]

If you enter **N** (No), the system does not prompt for more information and bills are not edited for unbilled charges/credits. If you enter **Y** (Yes), the Data Control Code table is displayed, and you can select a code from the table. After you select a data control code, the system prompts for including/excluding the edit in Pre-bill Edit. The following prompt is displayed:

(I)nclude or (E)xclude edit for Prebill [E]

You can enter **I** to include the edit in Pre-bill Edit or **E** to exclude the edit for Pre-bill Edit.

For example, if you indicated that the system should perform bill edits for unbilled charges/credits, and the data control code was set to Admissions, and you elected to exclude the edit from the Pre-bill Edit functionality, the field would be completed as follows: Yes, Admissions, Exclude from PBE Edits.

If the field is changed from a value of Yes to a value of No, the field displays No, and the Data Control Code and the value for Pre-bill Edit are deleted.

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

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

12. SEQ DATA BASE ELEMENT (1-N-O)
This field allows the user to choose the elements that must be present for a patient before a final bill can be produced. The selection is made from a table display. Examples are Final DRG, Principal Diagnosis, Health Card Number, and Treatment Authorization Code. If a billing requirements code does not require elements, this field may be left blank. You may choose as many elements as necessary. Billing Requirements are documented in the Internal Element Information Processor (Tables, Internal Element Information Processor).

NOTE: The system looks to the Bill ICD flag (based on the Final Billing Parameters ICD-10 Effective Date and the admission date or discharge date of the account) for any billing Data Base Element in the Billing Requirements table that looks to either diagnosis or procedure codes. If the Bill ICD flag is set to 9 for ICD-9, then only the ICD-9 diagnoses and procedures are accessed for the appropriate data base elements. If the Bill ICD flag is set to 10 for ICD-10, then only the ICD-10 diagnoses and procedures are accessed for the appropriate data base elements. The Billing Requirements Edit Code (table), which in turn lists all required data elements, is linked to the final bill Billing Requirements table on the second screen.

NOTE: For any Billing Requirements that use the Data Element "Final DRG" or "Secondary DRG" and that have the data element set as Required, the system looks to the Final Bill ICD indicator for the account. If the Final Bill ICD indicator is 9, the system will require a Primary DRG or a Secondary DRG

(depending on Billing Requirement) with an ICD-9 indicator (9) in order to pass. If the Final Bill ICD indicator is 10, the system will require a Primary DRG or a Secondary DRG (depending on Billing Requirement) with an ICD-10 indicator (0) in order to pass.

REQUIRED/NA (1-A-C)
This field indicates whether the selected element is required or not allowed in order to produce a final bill. Entry options are **R** for required and **N** for not allowed. This field is required if you selected a data element in the previous field. An entry of R (required) does not necessarily mean the data element prints on the final bill - it means that the information selected must be present in the system for the bill to be generated.

CONTROLLED BY (3-N-C)
This field contains the code of the department responsible for supplying specific information for the selected data element. You can enter the code or a hyphen (-) to display a list of valid data control codes. A nightly report is produced which lists all bills being held up by data control codes.

When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction. You can generate a printout of the Billing Requirements Table by entering Y for Yes at the following prompt:

Do you want a printed list (Y/N)?

CLAIM GENERATION PARAMETERS

NOTE: **CN:**Canadian customers should refer to the *Canadian Claims Processing Volume* of the STAR Financials Patient Accounting Reference Guide.

This parameter defines the transaction codes used when a claim is loaded (created), produced (printed), and submitted (mailed) to the carrier and the number of days it can be held before the system releases the claim automatically.

After this parameter is selected, the system prompts you to enter a Claim Generation Parameter code. You can enter a code or a hyphen (-) to display a list of valid codes. When a code is entered or selected, this 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-UB LATE CHARGES CLAIM              Z0004-UB ADJUSTMENT CLAIM









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying this claim generation parameter.

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

3. STATUS (DISPLAY ONLY)
This field indicates whether the code is active or inactive. A code that is *filed as deleted* by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

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

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

6. SUSPENSE DAYS (2-AN-R)
This field contains the number of days this claim should be held with errors before it is automatically released. Entry options are 0 to 99 days or U for unlimited. Claims are released automatically when all errors are corrected or if no errors exist.

7. CYCLE CLAIM TRANSACTION CODE (4-N-R)
This field contains the transaction code that is used to update the account transaction history with a cycle 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.

8. FINAL CLAIM TRANSACTION CODE (4-N-R)
This field contains the transaction code that is used to update the account transaction history with a final 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.

9. ADJUSTMENT CLAIM TRANSACTION CODE (4-N-R)
This field contains the transaction code that is used to update the account transaction history with an 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.

10. REPRINT CLAIM TRANSACTION CODE (4-N-R)
This field contains the transaction code that is used to update the account transaction history with a claim reprint. 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.

11. LATE CLAIM TRANSACTION CODE (4-N-R)
This field contains the transaction code that is used to update the account transaction history with a late 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.

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.

When all fields are completed, the system prompts you to accept, edit or delete the information entered on this screen. Accepting the screen completes the transaction.

You can enter/edit another claim generation parameter, request a printed list of the claim generation parameters in the system, or return to the claim parameters options.

Dependent On	Reference
Transaction Codes	Insurance Plan Coverage Master

CLAIM LOAD AND EDIT PARAMETERS

NOTE: **CN:**Canadian customers should refer to the *Canadian Claims Processing Volume* of the STAR Financials Patient Accounting Reference Guide.

This parameter allows the hospital to set up UB, 1500, and state claim form load and claim form edit criteria. It also allows the hospital to define different variations of the claim forms depending on the specific requirements of the carrier. The charge section of the forms is not covered by the Claim Load and Edit Parameters but is discussed in the Charge Control Parameters section. A master set of parameters was developed by McKesson that can be used as the basis for creating facility-specific parameters.

Claim load and edit parameters are entered for inpatients and outpatients as the primary and secondary insurance for each insurance plan. The hospital can also define parameters for an insurance plan for patient type exceptions.

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. For the UB claim type (claim type X), you can choose either the UB92 format or the UB04 format. For the 1500 claim type (Claim Type B) and the Non Pro Fee 1500 claim type (claim type Z), you can choose either the 1992 1500 format or the 08/05 1500 format. 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 carrier. The selected claim type determines the prompts that are displayed, as discussed below.

1500 Claim Type

If you select a 1500 claim type (B for 1500 or Z for Non Pro Fee 1500), the system prompts you for the version of the claim form you want to view or update, as follows:

Select which version to view/update:

1) 1992 1500 Format

2) 08/05 1500 Format

If you select the 08/05 1500 Format option, and this is the first time you have accessed this format for the Claim Load Edit Parameter, the system displays the following prompt, if a 1992 1500 Format exists, where xxx is the parameter number:

Do you want to load the 1500 parameters from the old 1992 1500 Format (O) code xxx or from the new 08/05 1500 Claim Master (N)? [O]--

If you select **O** (Old), the parameters are converted from the existing parameters for the 1992 1500 format, and the following prompt is displayed:

Initializing 08/05 1500 Format for Claim Load Edit Parameter XXX from 1992 1500 format -

If you select **N** (New), or no parameters exist for the 1992 1500 Format, the parameters are loaded from the Claim Master for the 08/05 1500. and the following prompt is displayed, where xxx is the parameter number:

Initializing 08/05 1500 Format for Claim Load Edit Parameter XXX from 08/05 1500 Claim Master -

After you enter the parameter number, the first screen of the Claim Load Edit Parameter is displayed.

The following fields are copied from the 1992 1500 Format of the same Claim Load Edit Parameter (if a 1992 Format exists) into the 08/05 1500 Format of the Claim Load Edit Parameter when copying from either the Old parameters or the New master. If there is no 1992 Format for the Claim Load Edit Parameter, the following fields must be set by the user when copying from the New master.

1 - Code

2 - Claim Form

4 - Description

7 - Claim Media

9 - Electronic Types

12 - Load $0.00 Claim

13 - Top Line Blank?

15 - Diagnoses for 1500 Locator 21 (only for Claim Type B 1500, not for Claim Type Z - Non Pro Fee 1500)

16 - Combine Bill Med Info (NA, blank for claim types B and Z)

17 - DPW Med Info (NA, blank for claim types B and Z)

18 - Use Adm Prin/Sec Dx for Combine Bill/DPW Med Info (NA, blank for claim types B and Z)

19 - NY Claim Type (NA, blank for claim types B and Z)

20 - UB92 Loc 54 Prior Pymt Calc (NA, blank for claim types B and Z)

The following fields are set by the system:

3 - 1500 Format are set to 08/05 1500 Format

10 - Start Detail

11 - Stop Detail

14 - Generation Pending? This field contains a value of Yes after the system initializes the 08/05 1500 Format, until the Claim Load Edit Parameter is generated.

22 - Last Generated Date

23 - Edit Date. This field contains the current date after initializing the 08/05 1500 Format. If edits are made after the initialization, the date is reflected.

24 - Edit By. This field contains the user name of the person who initialized the 08/05 1500 Format. If edits are made after the initialization, the user name of the person making the edits is reflected.

The following fields are blank until you set them:

5 - Begin Date

The 08/05 1500 Format of the claim is not used before the Begin Date in field 5 of the first screen of the Claim Load Edit Parameter. Any 1500/Non Pro Fee 1500 claim loaded (either through Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance) on or after this date uses the 08/05 1500 Format. Therefore, an original claim may load in the 1992 1500 Format, but it would be replaced on the system with the 08/05 1500 Format, if an Adjustment claim is loaded for the payer.

6 - End Date

The End Date on the Claim Load Edit Parameter does not affect which version of the claim loads. The end date only affects if this Claim Load Edit Parameter can be manually assigned to an insurance at the account level, or in the Insurance Plan Coverage table. If the End Date on the parameter is a date in the past, the Claim Load Edit Parameter cannot be assigned to the insurance. If there are two or more formats for the same Claim Load Edit Parameter, as long as one of the End Dates is not a date in the past, the Claim Load Edit Parameter can be assigned to the insurance. If all End Dates on the parameter are in the past, when attempting to assign this parameter to an insurance, the system displays the following error, where the YYYY is the claim type, such as UB or 1500:

Error: Invalid YYYY claim load/edit code

21 - 1500 Loc 29 Amount Paid Calc

When selecting either claim type B for 1500 or Z for Non Pro Fee 1500, the system displays the following prompt:

Enter claim parameter or '-' for a list-- |

If a new parameter number is entered, the system displays the following prompt:

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

If **Y** for Yes is entered, the system prompts:

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

If entering either the code to copy from, or '=' to copy from the masters, the system prompts:

Copy 1992 Legacy Format (L) or 08/05 Revised Format (R)? [R] --

When adding a new parameter, and selecting to copy either the Legacy or the Revised Format, the system displays and allows you to update the first screen for the Claim Load Edit Parameter. You must enter the Begin Date and any other required fields. If both formats of the claim form are needed, once the first format selected has been added, and the parameters regenerated, you must access the Claim Load Edit Parameters again, select the Claim Type, enter the parameter number, and select the format that was not previously selected. Again, you must enter the Begin Date and any other required fields for this format, and regenerate the parameters.

1500 and Non Pro Fee 1500 Claim Load Edit Parameters

If the source of the Claim Load and Edit information is the Claim Master for the 08/05 1500 Format, information for the Claim Load and Edit Parameters is determined from the Claim Master. If the source of the Claim Load and Edit information is the copy of the 1992 parameters into the 08/05 1500 parameters, the current Locators and information such as Internal Elements, Set Up Routines, and Print Routines assigned in the 1992 1500 Format of the Claim Load Edit Parameter are copied to the same Locator in the 08/05 1500 Format, with the exception of locators that are new or revised for the 08/05 1500 claim form. If the Internal Element, Set Up Routine, Print Routine, or Default Value of any field was revised so that it no longer matches the Claim Master, the hospital settings are copied into the 08/05 1500 Format of the Claim Load Edit Parameter. All locators can be updated (for example, with alternate Internal Elements, or the Internal Elements can be deleted). The following is a list of new or revised locators for the 08/05 1500 format:

NOTE: To compare the 1992 1500 Format to the 08/05 1500 Format, users can add a new Claim Load Edit Parameter. When creating the 1992 version, copy from the claim Master, and when creating the 08/05 version, copy from the claim Master. Regenerate your parameters. As you exit, say Yes to the prompt "*Do you want a printed list*", and enter **B** for Both formats. The report spools to FCRCP.

- Locator 0 Insurance Address Information (revised)

- Locator 1 Applicable Program (revised)
- Locator 2 Patient Name (revised)
- Locator 4 Insured's Name (revised)
- Locator 5 Patient's Address (revised)
- Locator 7 Insured's Address (revised)
- Locator 17 Refer Physician Name (revised and new fields)
- Locator 20 Outside Lab Work (revised)
- Locator 21 Diagnosis Information (revised)
- The Form Length for each diagnosis has been changed from 6 to 8.
- The Print Routine logic has been updated to print as follows:
    - 3 digits, a space for the decimal, and up to 4 digits after the space for the decimal. For example, diagnosis code 825.1 prints as 825 1.
    - For diagnosis codes with more than 3 beginning digits, for example, E878.8, the fourth beginning digit prints over the decimal instead of there being a space such as E8788.
- Locator 22 Medicaid Resubmission Information (revised)
- Locator 25 - Federal Tax ID Number (revised)
- Locator 26 Patient Account Number (revised)
- Locator 28 Total Charges (revised)
- The Total Charges is for the total claim amount, and is not per page of a multi-page claim. When printing/spooling the claim, any page before the last page for the claim has a blank Total Charges amount. The last page of the claim has a Total Charges amount that is the total of the claim charges.
- Locator 29 Amount Paid (revised)
    - The 1500 Loc 29 Amount Paid Calc field was added to the header screen of the Claim Load Edit Parameter. This field can be accessed for claim types B-1500 and Z-Non Pro Fee 1500. In this field, users can indicate if the Amount Paid should be calculated, and if so, if any amounts should be added to the Payment amount for the payer. Options are Adjustments, Coinsurance from Cash Posting, Deductible from Cash Posting, Co-Pay from Cash Posting, and

Patient Responsibility from Cash Posting. Highlight any that should be added to the payment amount. If none of these options are highlighted, only the payment is reflected in the Amount Paid locator.

Note that the Amount Paid is for all payments made to claims that this claim was Waiting for Payment on. When printing/spooling a multi-page, any page before the last page for the claim has a blank Balance Due amount.

Since the Balance Due is calculated at time of claim print/spool, any amount manually entered for the locator will be overlaid at time of claim print/spool.

- Locator 31 Physician Signature (revised)
- Locator 32 Facility Name and Address (revised and new fields)
- Locator 33 Supplier Name and Address (revised and new fields)

UB Claim Type

If you select a UB claim type (claim type X), the system prompts you for the version of the claim form you want to view/update, as follows:

Select which version to view/update:

1) UB92 Format

2) UB04 Format

NOTE: This prompt is displayed only when you select Claim Type X (UB). The prompt is not displayed when you select Claim Type U for UB82 or Claim Type R for Medi-Cal UB92.

If the UB04 Format option is selected, and this is the first time you have accessed this format for the Claim Load Edit Parameter, the system displays the following prompt, if a UB92 Format exists, where xxx is the parameter number:

Do you want to load the UB04 parameters from the UB92 Format (O) code xxx or from the UB04 Claim Master (N)?

If you select **O** (Old), the parameters are converted from the existing parameters for the UB92 format and the following prompt is displayed:

Initializing UB04 Format for Claim Load Edit Parameter XXX from UB92 format -

When copying the UB92 parameters into the UB04 format, information from the locators is copied where the data is the same. For example, the system can copy the Medical Record Number field from Locator 23 of the UB92 to Locator 3b of the UB04. This means if the Internal Element, Set Up Routine, Print Routine, or Default Value of

any field was revised so that it no longer matches the Claim Master, the hospital settings are copied into the UB04 Format of the Claim Load Edit Parameter.

When the UB92 format exists for the claim load edit parameter, but when creating the UB04 format, you select **N** for the UB04 Claim Master, the following prompt is displayed:

Initializing UB04 Format for Claim Load Edit Parameter XXX from UB04 Claim Master

If you are adding a new parameter (that has neither the UB92 or the UB04 format), the following prompts are displayed:

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

If entering either the code to copy from, or '=' to copy from the masters, the system prompts:

Copy UB92 Legacy Format (L) or UB04 Revised Format (R)? [R] --

When adding a new parameter, and selecting to copy either the Legacy or the Revised Format, the system displays and allows you to update the first screen for the Claim Load Edit Parameter. You must enter the Begin Date and any other required fields. If both formats of the claim form are needed, once the first format selected has been added, and the parameters are regenerated, you must access the Claim Load Edit Parameters again, select the Claim Type, enter the parameter number, and select the format that was not previously selected. Again, you must enter the Begin Date and any other required fields for this format and regenerate the parameters.

Information from unlabeled locators from the UB92 is not copied into unlabeled locators of the UB04. Therefore, any data that is set to load to these unlabeled locators must be re-set for the UB04 version of the parameter if this data is not loading in one of the UB04 locators.

The following are the Unlabeled Locators for the UB92:

- Locator 2 Upper (29 characters)
- Locator 2 Lower (30 characters)
- Locator 11 Upper (12 characters)
- Locator 11 Lower (13 characters)
- Locator 31 Upper (5 characters)
- Locator 31 Lower (6 characters)
- Locator 56 Line 1 (13 characters)

- Locator 56 Line 2 (14 characters)
- Locator 56 Line 3 (14 characters)
- Locator 56 Line 4 (14 characters)
- Locator 56 Line 5 (14 characters)
- Locator 57 (27 characters)
- Locator 78 Upper (2 characters)
- Locator 78 Lower (3 characters)

The following are the Unlabeled Locators for the UB04:

- Locator 7 Upper (7 characters)
- Locator 7 Lower (8 characters)
- Locator 30 Upper (12 characters)
- Locator 30 Lower (13 characters)
- Locator 37 Upper (8 characters)
- Locator 37 Lower (8 characters)
- Locator 68 Upper (8 characters)
- Locator 68 Lower (9 characters)
- Locator 73 (9 characters)
- Locator 75 Line 1 (4 characters)
- Locator 75 Line 2 (5 characters)
- Locator 75 Line 3 (5 characters)
- Locator 75 Line 4 (5 characters)

The following UB92 Locators are Value Codes with the UB04:

- UB92 Locator 7 for Covered Days is Value Code 80
- UB92 Locator 8 for Non Covered Days is Value Code 81

- UB92 Locator 9 for Coinsurance Days is Value Code 82
- UB92 Locator 10 for Lifetime Reserve Days is Value Code 83

These Value Codes have been added to the Provider Master and can be highlighted to auto load to a claim.

The following information from the UB92 does not load to the UB04:

- UB92 Locator 16 Patient Marital Status
- UB92 Locator 54 Prior Payments Patient
- UB92 Locator 55 Estimated Amount Due Patient
- UB92 Locator 64 A, B, and C Employment Status Code
- UB92 Locator 66 A, B, and C Employer Location

The following fields are automatically copied from the UB92 Format of the same Claim Load Edit Parameter into the UB04 Format of the Claim Load Edit Parameter, regardless if the UB04 format of the claim load edit parameter was copied from the (O)ld UB92 version, or from the (N)ew claim Master:

1 - Code

4 - Description

7 - Claim Media

9 - Electronic Types

12 - Load $0.00 Claim

13 - Top Line Blank?

15 - Diagnoses for 1500 Locator 21 (NA for UB92/04. ONLY for Claim Type B 1500)

16 - Combine Bill Med Info

17 - DPW Med Info

18 - Use Adm Prin/Sec Dx for Combine Bill/DPW Med Info

19 - NY Claim Type

20 - UB92 Loc 54 Prior Pymt Calc

The following fields are set by the system:

2 - Claim Form

3 - Claim Format will be set to UB04 Format

10 - Start Detail

11 - Stop Detail

14 - Generation Pending? This field has Yes after initializing the UB04 Format until the Claim Load Edit Parameter is generated.

22 - Last Generated Date

23 - Edit Date. This field has the current date after initializing the UB04 Format. If edits are made after the initialization, the date will be reflected here.

24 - Edit By. This field has the user name of the person who initialized the UB04 Format. If edits are made after the initialization, the user name of the person making the edits will be reflected here.

The following fields are blank until set by the user:

5 - Begin Date. Claims loaded on or after this date with this UB Claim Load Edit Parameter load the UB04 format of the claim.

The UB04 Format of the claim is not used before the Begin Date in field 5 of the first screen of the Claim Load Edit Parameter. Any UB claim loaded (either through Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance) on or after this date uses the UB04 Format. Therefore, an original claim may load in the UB92 Format, but it is replaced on the system with the UB04 Format if an Adjustment claim is loaded for the payer.

6 - End Date (can be left blank)

The End Date on the Claim Load Edit Parameter does not affect which version of the claim loads. The end date only affects if this Claim Load Edit Parameter can be manually assigned to an insurance at the account level, or in the Insurance Plan Coverage table. If the End Date on the parameter is a date in the past, the Claim Load Edit Parameter cannot be assigned to the insurance. If there are two or more formats for the same Claim Load Edit Parameter, as long as one of the End Dates is not a date in the past, the Claim Load Edit Parameter can be assigned to the insurance. If all End Dates on the parameter are in the past, when attempting to assign this parameter to an insurance, the system displays the following error, where the YYYY is the claim type, such as UB or 1500:

Error: Invalid YYYY claim load/edit code

After a claim parameter is selected, the following screen is displayed.

```
        General Hospital Claim Load and Edit Parameters Processor
                                            Fri May 27, 2011 05:27 pm


 1 Code  2 Claim Form          3 Claim Format  4 Description
   PM      3 Comm NS                           TEST
 5 Begin Date   6 End Date     7 Claim Media                  8 1500 Format
   01/01/2002  ->                B Paper and Electronic
 9 Electronic Types  10 Start Detail    11 Stop Detail 12 Load $0.00 Claim
                        38                 47
13 Top Line Blank?   14 Generation Pending? 15 Diagnoses for 1500 Locator 21

16 ICD-10 Effective Date 17 Erroneous Surgery Diagnosis Codes ICD9/ICD10

18 NY Claim Type                            19 ICD Procedure Dates for UBs

20 UB Loc 54 Prior Pymt Calc          21 1500 Loc 29 Amount Paid Calc

22 1500 Condition Codes

23 Last Generated      24 Edit Date           25 Edit By
   04/25/2009 08:09am     04/25/2009 08:09am     New, Nancy
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the claim parameter. The code can be any number or combination of characters. If you are adding a code, you must copy the information from either the McKesson master set of parameters or an existing set. In the latter case, you would enter the code of the parameters you want to copy.

2. CLAIM FORM (DISPLAY ONLY)
This field contains the type of claim that was selected (UB or 1500).

3. CLAIM FORMAT (DISPLAY ONLY)
This field contains either the claim format, depending on which version of the claim is selected for the Claim Load Edit Parameter. For those claim types with more than one version, the version displays in this field.

- Claim Type B - 1500 claims can display 1992 or 08/05.
- Claim Type Z - Non Pro Fee 1500 claims can display 1992 or 08/05.
- Claim Type X - UB claims can display UB92 or UB04.

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

5. BEGIN DATE (6-N-R)
This field contains the date on which this parameter becomes effective in the system. The date is entered in the format MMDDYYYY and displayed as MM/DD/YYYY. This field defaults to the current date.

The 08/05 1500 Format of the claim is not used before the Begin Date. Any 1500/Non Pro Fee 1500 claim loaded (either through Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance), on or after this date, uses the 08/05 1500 Format. Therefore, an original claim may load in the 1992 1500 Format, but is replaced on the system with the 08/05 1500 Format based on the Begin Date of the 08/05 Format, if an adjustment claim is loaded for the payer.

The UB04 Format of the claim is not used before the Begin Date. Any UB claim loaded (either through Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance) on or after this date uses the UB04 Format. Therefore, an original claim may load in the UB92 format, but it is replaced on the system with the UB04 Format based on the Begin Date of the UB04 Format, if an adjustment claim is loaded for the payer.

6. END DATE (6-N-O)
This field can contain the date on which this parameter becomes inactive. The date is entered in the format MMDDYYYY and displayed as MM/DD/YYYY. You should only enter a date if there is an end date to the parameter.

7. CLAIM MEDIA (1-A-R)
This field identifies the medium by which the claim is transmitted to the carrier. The options are **P** (paper only), **E** (electronic only), or **B** (both paper and electronically). The default is B.

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

8. 1500 FORMAT (DISPLAY ONLY)
This field displays one of the following claim formats:

For 1500 claims: 1992 1500 Format, 08/05 1500 Format, or the NJ 1500 Format (New Jersey).

9. ELECTRONIC TYPES (TABLE LOOKUP-O)
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, Cycle Adjustment Claims, and Tracer Claims. This field is not required.

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

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

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

10. START DETAIL (3-N-O)
This field indicates the line number on the claim form where the printing of detail charge information begins printing. The range is 0 to 999.

11. STOP DETAIL (3-N-O)
This field contains the line number on the claim form where the printing of detail charge information stops printing. The range is 0 to 999.

NOTE: The information in the Start Detail and Stop Detail fields should be standard from the parameter being copied and should not require modification.

12. LOAD $0.00 CLAIM (TABLE LOOKUP-O)
This field contains the claim types that can be loaded even when there are no charges to load on the claim. The options are Adjustment Claims, Cycle Claims, Final Claims, Late Claims, Reprint Claims, Cycle Adjustment Claims, and Tracer Claims. If a claim type is selected, if there are no charges for the claim, the system loads the claim with the claim demographics, but no charges. Claim types not highlighted do not load a zero dollar claim.

13. TOP LINE BLANK? (1-A-O)
This field indicates whether to print a blank top margin for UB, 1500 or Non Professional Fee 1500 claim types. If this field is blank or set to No, the system prints the following on the top line of the claim:

UB Claim Type

The Facility Indicator and Account Number print, followed by two spaces, followed by the Payer Indicator, followed by three spaces, followed by the claim sequence number. The Payer Indicator informs you which payer, in Locator 50A, 50B, 50C, or 50D, if there was a line D, the claim is for. If the claim is for the payer in 50A, a *1* prints. If the claim is for the payer in 50B, a *2* prints. If the claim is for the payer in 50C, a *3* prints. And, if the claim is for the payer that would have printed in 50D, if there was a 4th line, a *4* prints. The following is an example of the top line of the UB.

A0201400001 2 8

If you do not want any data (account number, payer/COB, or claim sequence number) printing on the top line of a claim, you must access the appropriate Claim Load and Edit Parameter for the claim type, and on the first screen, set the Top Line Blank field to Yes. No data is printed on the top line.

1500 and Non Pro Fee 1500 Claim Types

When the claim is printed, the Facility Indicator and Account Number print, followed by two spaces, followed by the COB of the insurance, followed by three spaces, followed by the claim sequence number. The following is an example of the top line of the 1500 claim.

A0201400001 4 10 FINAL

If you do not want any data (account number, payer/COB, or claim sequence number) printing on the top line of a claim, you must access the appropriate Claim Load and Edit Parameter for the claim type, and on the first screen, set the Top Line Blank field to Yes. No data is printed on the top line.

14. GENERATION PENDING (DISPLAY ONLY)
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] --

15. DIAGNOSES FOR 1500 LOCATOR 21 (TABLE LOOKUP-O)
This field is used to indicate the order that Medical Records, Admissions, and Charge level diagnoses should be loaded into Locator 21 of the 1500 claim form. This field can be accessed only for the HCFA 1500 claim and requires that at least one of the diagnosis code fields in Locator 21 uses one of the 1500 Diagnosis Box 21 - Field X internal elements. When you access this field, a screen is displayed which allows you to state the order for the system to pull diagnosis into the locators using the 1500 Diagnosis for Box 21 - Field X internal elements. Only these internal elements reference this field.

Based on the ICD-10 Effective Date field and the admission date or discharge date of the patient loading the 1500 claim, the ICD flag for the claim will be set to either a 9 for ICD-9, or a 10 for ICD-10. When loading diagnosis codes to Locator 21, the system will load either ICD-9 or ICD-10 diagnosis codes based on the claim ICD flag. If the ICD flag is blank, the system assumes ICD-9.

The system checks the Internal Elements used in Locator 21-1, 21-3, 21-5, and 21-7 of the Claim Load Edit Parameter. If at least one is not set to use the internal element

1500 Diagnosis Box 21 - Field X, the system displays the following error message and does not allow you to update the field.

1500 Diagnosis Box 21 - Field X must be used at least once in Locator 21 (Fields 1,3,5,7) to use Diagnoses for 1500 Locator 21. Press NL.

If you do not receive the error message, the following screen is displayed:

```
          General Hospital Claim Load and Edit Parameters Processor
                                                  Wed Jan 21, 2004 09:29 am


 1 First Choice for 1500 Diagnosis     2 Second Choice for 1500 Diagnosis
->
 3 Third Choice for 1500 Diagnosis     4 Fourth Choice for 1500 Diagnosis

 5 Fifth Choice for 1500 Diagnosis     6 Sixth Choice for 1500 Diagnosis

 7 Seventh Choice for 1500 Diagnosis



Select diagnosis for 1500 Locator 21 or `-` for lookup--
```

In each field, you can do a table lookup of the diagnosis options not used already. Enter a hyphen (-) to display the Types of Diagnoses for 1500 Loc 21 table, as follows:

```
Page:01               Types of Diagnoses for 1500 Loc 21
( 1) Principal/Admitting from Admission
( 2) Principal/Working from Admission
( 3) Admitting from Admission
( 4) Admitting from Medical Records
( 5) Working from Admission
( 6) Secondary Diagnoses 1-4
( 7) Charge Diagnoses


Enter choice--
```

Once you have selected the order of the diagnoses, the selections appear in the Diagnoses for 1500 Locator 21 field with the following acronyms:

- PR/AD = Principal/Admitting from Admission
- PR/WK = Principal/Working from Admission
- AD/AD = Admitting from Admission
- AD/MR = Admitting from Medical Records

- WK = Working from Admission
- SC = Secondary Diagnoses 1-4
- CH = Charge Diagnoses

If you access an existing Choice for 1500 Diagnosis field, and press ENTER to delete the entry, the diagnosis choices listed after move up in the fields.

- If the above table is not entered, when using the internal element 1500 DIAGNOSIS BOX 21 - FIELD X, the system continues to pull only the diagnosis codes from the charge level. However, if you set at least the First Choice for 1500 Diagnosis, you must set one of the other Choice for 1500 Diagnosis fields to Charge Diagnosis in order to pull the ordering diagnoses from the charges.
- If Principal/Admitting from Admission is used, the principal diagnosis from Medical Records is used. If no principal diagnosis in Medical Records exists, the admitting diagnosis from the admission is used if an ICD code is being used to identify it (a freeform diagnosis is not used).
- If Principal/Working from Admission is used, the principal diagnosis from Medical Records is used. If no principal diagnosis in Medical Records exists, the working diagnosis from the admission is used if an ICD code is being used to identify it (a freeform diagnosis is not used).
- If Admitting from Admission is used, the admitting diagnosis from the admission is used, if an ICD code is being used to identify it (a freeform diagnosis is not used).
- If Admitting from Medical Records is used, the admitting diagnosis from Medical Records is used.
- If Working from Admission is used, the working diagnosis from the admission is used if an ICD code is being used to identify it (a freeform diagnosis is not used).
- If Secondary Diagnoses 1-4 is used, then secondary diagnoses from Medical Records are used. The software would not use more than four of these diagnoses.
- If Charge Diagnoses is used, then diagnoses from the charges are used.

Once four unique diagnosis codes (freeform diagnoses are ignored) are pulled into Locator 21, the system does not continue down the selection of diagnosis codes for the claim. When using the internal element 1500 Diagnosis Box 21 - Field X and the Diagnoses for 1500 Locator 21 field, the system tries to fill each field using the internal element. For example: say that the First Choice for the 1500 Diagnosis was Admitting from Admissions and the Second Choice for the 1500 Diagnosis was Principal/ Admitting from Admission. If the Admitting Diagnosis from Admissions was a freeform entry and therefore was not used, but there was a Principal Diagnosis Code, the Principal Diagnosis Code would shift up in the diagnosis code fields in Locator 21.

When printing the Reference number in Locator 24E for each charge line, the correct reference number, 1, 2, 3, or 4, is pulled to the claim if the diagnosis on the charge matches one of the four diagnosis codes in Locator 21, regardless if the diagnosis in Locator 21 was pulled from Medical Records, Admitting, or the Charge record. When pulling in diagnosis codes from Medical Records into Locator 21 of the 1500 claim form, if no charge diagnosis matches the diagnosis code, that reference number is not used. For example, if the First Choice for 1500 Diagnosis is Principal/Admitting from Admission, and the Second Choice for 1500 Diagnosis is Charge Diagnoses, if there is a Principal Diagnosis code, but none of the charge level diagnosis codes matches the Principal, no charge line has reference number 1 in Locator 24E. When printing the Reference Number in Locator 24E of the 1500 claim form for each charge line, if there is no charge level diagnosis for the charge line, and the 1500 Charge Control Parameter does not have the field Default Diagnosis set, Locator 24E is blank for the charge line. If the Edit Pro Fee Charges field in the 1500 Charge Control Parameter is set to edit for the Diagnosis Code/Reference Number, this charge line has an error.

When printing the Reference Number in Locator 24E of the 1500 claim form for each charge line, if there is a charge level diagnosis for the charge line, but it is not one of the diagnosis codes listed in Locator 21 (1-4) of the claim form, Locator 24E will either be blank for the charge line or will contain a number (1-4) of a blank diagnosis field in Locator 21. For example, if Locator 21 loads a diagnosis in 21-1 and in 21-2, and 21-3 and 21-4 are blank, if there are two charge lines that have a diagnosis, but they do not match the diagnosis in 21-1 or in 21-2, one charge line can have reference number 3, and another charge line can have reference number 4. If the reference number for the charge line is blank when there are no blank fields in Locator 21, and if the field Edit Pro Fee Charges in the 1500 Charge Control Parameter is set to edit for the Diagnosis Code/Reference Number, this charge line has an error. Note that even if the Default Diagnosis field is set in the 1500 Charge Control Parameter, the system does not default in this diagnosis when the charge has a diagnosis, but it does not match one of the diagnoses codes in Locator 21. The system only defaults in a diagnosis if there is no charge level diagnosis and the Default Diagnosis field is set in the 1500 Charge Control Parameter.

Using the 1500 Diagnosis Box 21 - Field X internal elements, if diagnoses are selected in the Diagnoses for 1500 Locator 21 field, the system adds a diagnosis in the field of Locator 21 if it has not been used previously in the locator. If no diagnoses are selected in Diagnoses for 1500 Locator 21, the system adds a diagnosis in the field of Locator 21 from the ordering diagnosis at the charge level if it has not been used previously in the locator.

For example, the following internal element setup can be used in Locator 21:

Use Admitting Diagnosis for first diagnosis in Loc 21.

Use Principal Diagnosis for second diagnosis in Loc 21.

Use 1500 Diagnosis Box 21 - Field 3 for third diagnosis in Loc 21.

Use 1500 Diagnosis Box 21 - Field 4 for fourth diagnosis in Loc 21.

If the account has an admitting diagnosis of A, a principal diagnosis of P, and charge diagnoses of P, C1, C2, and C3, the diagnosis in Locator 21 will be A, P, C1, and C2 when Diagnoses for 1500 Locator 21 is not used or contains charges only. The system does not use the Principal Diagnosis (P) twice in Locator 21. If printing the Reference number in Locator 24E of the 1500 claim charge line, these reference numbers (1-4) are assigned per a matching diagnosis in the charge.

Since no charge uses the admitting diagnosis (A), reference number 1 will not appear. The charge line with the principal diagnosis (P) would print reference number 2, and the charge lines with diagnosis C1 and C2 would print reference number 3 and 4.

Sill using the example with the internal element settings for Locator 21 above, if Diagnoses for 1500 Locator 21 contains secondary diagnoses followed by charge diagnoses, and the account has an admitting diagnosis of A, a principal diagnosis of P, a secondary diagnosis of S, and charge diagnoses of P, C1, C2, and C3, the diagnoses in Locator 21 are A, P, S, and C1. Remember that only the 1500 Diagnosis Box 21-Field X internal elements look to the Diagnoses for 1500 Locator 21 field. Reference numbers 1-4 are assigned per a matching diagnosis in the charge. Since no charge uses the admitting diagnosis (A), reference number 1 does not appear. Since no charge uses the secondary diagnosis (S), reference number 3 also does not appear.

When Diagnoses for 1500 Locator 21 is used, the system expects 1500 Diagnosis Box 21 - Field X to appear at the end of the list of internal elements for diagnosis codes in Locator 21. The rationale is that the beginning fields would be used for set diagnoses such as the admitting or principal diagnosis and the remaining fields could be filled with other diagnoses such as diagnoses from charges or secondary diagnoses from Medical Records.

To give an example, if the payor requires the Admitting Diagnosis in Locator 21-1 and the Principal Diagnosis in Locator 21-2, you should set these locators to Required, and use the internal elements Admitting Diagnosis Code (in 21-1) and Principal Diagnosis Code (in 21-2) instead of using the 1500 Diagnosis Box 21 - Field 1 and the 1500 Diagnosis Box 21 - Field 2 internal elements. The reason for this is when using the Medical Records internal elements, if the data does not exist on the account, the field is blank and you have a claim error. If you use the internal elements 1500 Diagnosis Box 21 - Field X and set the Diagnosis for 1500 Locator 21 field, the system shifts diagnosis up when there are missing diagnosis codes. For example, if you had the following:

First Choice for 1500 Diagnosis
Admitting from Admissions

Second Choice for 1500 Diagnosis
Principal/Admitting from Admission

Third Choice for 1500 Diagnosis
Charge Diagnoses

When using the internal elements 1500 Diagnosis Box 21 - Field X in Locator 21, if there is no Admitting Diagnosis, the system would shift the existing diagnosis codes up in the list. Therefore, if there was no Admitting Diagnosis, but there was a Principal Diagnosis, the Principal would shift into Locator 21-1, and the remaining charge diagnosis codes would be in 21-2 through 21-4. There would be no error for missing information since the remaining diagnosis codes shift.

Also, when using the internal elements 1500 Diagnosis Box 21 - Field X and the Diagnoses for 1500 Locator 21 field, the system does not load duplicate codes. Therefore, if the payor requires the Admitting Diagnosis Code in Locator 21-1, and the Principal Diagnosis Code in Locator 21-2 (for example), and if these are the same diagnosis code, the system would not load the second occurrence. You must use the Medical Records internal elements of Admitting Diagnosis Code and Principal Diagnosis Code to not only edit for missing codes, but to pull a duplicate code.

If the field Diagnoses for 1500 Locator 21 is being used, two edits are performed after the opportunity is provided to make updates to specific fields in the Claim Load and Edit parameters. If Diagnoses for 1500 Locator 21 is used but internal element 1500 Diagnosis Box 21 - Field X is not used for any of the diagnosis codes in Locator 21, the following message appears and Diagnoses for 1500 Locator 21 is set to be blank.

Internal Element 1500 Diagnosis Box 21 - Field X not used in field 1,3,5 or 7 of Loc 21. Diagnosis for 1500 Locator 21 was changed to be blank. Press NL.

If 1500 Diagnosis Box 21 - Field X is used, and it is not used for a subsequent diagnosis code, the following message appears and the Diagnoses for 1500 Locator 21 is set to be blank.

Internal Element 1500 Diagnoses Box 21 - Field X are not sequential in Loc 21. Diagnoses for 1500 Locator 21 was changed to be blank.Fix Loc. Press NL.

Again, if using a mix of Medical Records internal elements and the 1500 Diagnosis Box 21 - Field X internal elements in Locator 21, the 1500 Diagnosis Box 21 - Field X internal elements must follow the ones for medical records. You cannot have a Medical Records internal element after the 1500 Diagnosis Box 21 - Field X internal elements in Locator 21.

These edits are done when you back out of the locator, and hit your ENTER key at the prompt *Enter form locator or `-` to list--*. Locator 21 should be updated so the edit message does not appear.

The software assumes that the correct 1500 diagnosis is selected. For example, if the 1500 Diagnosis Box - Field X internal element is being used for the third diagnosis code in Locator 21, the internal element must be 1500 Diagnosis Box - Field 3 and the internal element for the fourth diagnosis code must be 1500 Diagnosis Box - Field 4.

1500 LOCATOR 21 PRINT

When the Claim Load Edit Parameter, Locator 21-1, 21-2, 21-3, and 21-4 are set to use the Print Routine of 1500 DIAGNOSIS PRINT, when printing ICD-9 diagnosis codes in Locator 21 of the claim, the system formats as follows: if the diagnosis code begins with *E*, such as E821.1 the system prints *E8211*. The decimal is removed because the logic assumes 4 characters before the decimal. If the diagnosis code does not begin with *E* such as 800.12, the system inserts a space and prints: 800 12. When printing ICD-10 diagnosis codes in Locator 21 of the claim, the system prints a space where the decimal would be. For example, code M84.872 prints as *M84 872*.

When the Claim Load Edit Parameter, Locator 21-1, 21-2, 21-3, and 21-4 are set to use the Print Routine of ICD DIAGNOSIS CODE, when printing either ICD-9 or ICD-10 diagnosis codes, the system retains the decimal. Therefore, ICD-9 codes E821.1 and 825.1 print as E821.1 and 825.1. ICD-10 codes M84.872 and Y08.02xA print as M84.872 and Y08.02xA.

16. ICD 10 EFFECTIVE DATE (N-8-O)
This field specifies the beginning admission date or discharge date of ICD-10 diagnosis and procedure code requirements for payers assigned this Claim Load Edit Parameter.

ICD-10 diagnosis and procedure codes are collected on the STAR Patient Processing and STAR Medical Records systems based on the Admission Date of the patient. The Claim Load Edit Parameter field of ICD-10 Effective Date can be used to specify a Discharge Date requirement for ICD-10, and can also be used for payers that implement ICD-10 codes after Medicare has implemented ICD-10 codes by listing a future date for the payer still using ICD-9 codes.

This field can be accessed only for the following claim types: Claim Type X for the Federal UB in the UB04 format, Claim Type B for the Federal 1500 in the 08/05 format, Claim Type Z for the Non Pro Fee 1500 in the 08/05 format, and Claim Type R for the Medi-Cal UB in the UB04 format.

The ICD-10 Effective Date field on the Hospital Facility Options screen in STAR Patient Processing determines when ICD-10 diagnosis and procedure codes are collected and reported. In addition, exceptions can be listed in the Insurance Plan Table, the Insurance Coverage Table, and the Financial Class Table to collect ICD-9 diagnosis and procedure codes, in addition to the ICD-10 diagnosis and procedure codes, after the ICD-10 Effective Date.

While STAR Patient Processing determines when the ICD-10 codes are collected and reported, the ICD-10 Effective Date field on the Claim Load Edit Parameter determines which patients are identified by the claims function to load and edit these ICD-10 diagnoses and procedures.

NOTE: The STAR Patient Processing and the STAR Patient Accounting tables and parameters should complement each other, and it is the hospital's responsibility to verify that the tables are in sync for the payers.

When the ICD-10 Effective Date field is accessed, the following prompt is displayed:

Enter the Effective Date for ICD-10 Diagnosis and Procedure processing (MM/DD/YYYY) -

The ICD-10 Effective Date can be based on either Admission Date or Discharge Date (whereas the STAR Patient Processing USA ICD-10 Effective Date, the Insurance Plan ICD-10 Effective Date, the Insurance Carrier ICD-10 Effective Date, and the Financial Class ICD-10 Effective Date are all based on Admission Date only). After you enter the effective date, the following prompt is displayed:

Is the ICD-10 Effective Date based on Admission Date (A) or Discharge Date (D) [A]--

You can enter **A** (Admission Date) or **D** (Discharge Date) for the ICD-10 effective date. Depending on your entry, the system displays the date and either *Admission* or *Discharge*. For example: 01/01/2011 Admission or 10/01/2011 Discharge.

- If the date is set for the Admission Date, but the patient's admission date is before the ICD-10 Effective Date, the Claim ICD flag is set to 9 and the system continues to load and edit the ICD-9 codes only for the patient's claim. This means that series patient types that were registered before this ICD-10 Effective Date continue to load and edit only ICD-9 diagnosis and procedure codes to the claim. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required.

- If the date is set for the Admission Date, and the patient's admission date is on or after the ICD-10 Effective Date, the Claim ICD flag is set to 10, and the system loads and edits the ICD-10 codes only for the patient's claim.

- If the date is set for the Discharge Date and if the Admission Date precedes the USA ICD-10 Effective Date on Patient Processing (so the Account ICD indicator is set to 9), but the account's discharge date, or Bill Through Date if no discharge date, is on or after the USA ICD-10 Effective Date on Patient Processing, the system does the following:

  a) Look to the Billing Parameter. If the billing parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date if no discharge date, to determine the bill ICD indicator. If the billing parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The bill will edit for ICD-9.

  b) Look to the Claim Parameter. If the claim parameter ICD-10 Effective Date is based on Discharge Date, then use the account's discharge date, or the Bill Through Date of the bill that loaded the claim if no discharge date, to determine the claim ICD indicator. If the claim parameter ICD-10 Effective Date is based on Admission Date, then do no further analysis. The claim will load and edit for ICD-9.

NOTE: This logic means that you can fail an account's bill and claims for missing ICD-10 information, when ICD-10 information was not entered on the account, and the account has an Account ICD indicator of 9.

In order to correct this situation, the ICD-10 information would need to be entered via Medical Records. As long as the USA ICD-10 Effective Date on Patient Processing is Today or a date in the past, Medical Records allows ICD-10 information to be entered on an account regardless of the Account ICD indicator.

EXAMPLES

**** USA ICD-10 Effective Date is 09/14/2011

Account 1:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-10

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-10

Account 2:

- Admitted 09/01/11

- Account ICD indicator is 9

- Account is Discharged on 9/26/2011

- Final Bill Parm is set to DISCHARGE DATE 10/01/2011

- Claim Load Edit is set to DISCHARGE DATE 10/01/2011

- Final Bill produced with BILL THROUGH DATE of 9/26 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 9/26 loads/edits for ICD-9

Account 3:

- Admitted 09/01/11

- Account ICD indicator is 9

- Final Bill Parm is set to ADMISSION DATE 10/01/2011

- Cycle 1, produced with BILL THROUGH DATE of 9/30, cycle does not edit but is loaded with Bill ICD of 9.

- Claim Load Edit is set to ADMISSION DATE 10/01/2011

- Cycle Claim, produced with BILL THROUGH DATE of 9/30 (bill that loads claim) loads/edits for ICD-9

- Account discharged 10/5/2011.

- Final Bill produced with BILL THROUGH DATE of 10/5 edits for ICD-9

- Final Claim produced with BILL THROUGH DATE of 10/5 loads/edits for ICD-9

NOTE ON BILLS:

Regular bills produced via Midnight Processing or Instant Adjustment Bill look for the existence of a Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date.

For cycle bills, the Bill Thru Date is used when evaluating if the bill or claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date. Since the Cycle Billing Parameters do not have an ICD-10 Effective Date field (and do not edit), the system looks to the Final Billing Parameters ICD-10 Effective Date. For the cycle bill, it will then compare the Bill Thru Date for the cycle to this ICD-10 Effective Date, to determine if the cycle should load for ICD-9 or ICD-10 data.

Once the account is actually discharged, the true discharge date is used to determine if the bill and claims should load/edit ICD-9 or ICD-10.

Pre-bill Edit bills will use Today's Date as the Discharge Date when evaluating the Billing ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bills are anticipating what will be required when a bill is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

NOTE ON CLAIMS:

Regular claims produced via Midnight Processing, Instant Adjustment Bill, or Add Claim to Insurance look for the existence of a Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. If there is no discharge date at the time the claim is created, the Bill Thru Date of the bill that loaded the claim is used when evaluating if the claim should be ICD-9 or ICD-10 based on an ICD Effective Date that uses Discharge Date.

Pre-bill Edit claims will use Today's Date as the Discharge Date when evaluating the Claim ICD-10 Effective Date when based on Discharge Date. This is because the Pre-bill Edit claims are anticipating what will be required when a claim is produced. Each time the account is re-evaluated for Pre-bill Edits, the system will use Today's Date if there is no Discharge Date.

- If the date is set for the Discharge Date, but the patient's discharge date is before the ICD-10 Effective Date, the Claim ICD flag is set to 9 and the system continues to load and edit the ICD-9 codes only for the patient's claim. This means that series patient types that were discharged before this ICD-10 Effective Date continue to load and edit only ICD-9 diagnosis and procedure codes to the claim. These series patient types may need to be discharged and re-admitted once ICD-10 codes are required.

- If the date is set for the Discharge Date and the patient's discharge date is on or after the ICD-10 Effective Date, the Claim ICD flag is set to 10 and the system load and edits the ICD-10 codes only for the patient's claim.

NOTE: Using Discharge Date, your series accounts may load and edit ICD-9 diagnosis and procedure codes for the Cycle Claims loaded prior to discharge date, but then may load (if present) and edit ICD-10 diagnosis and procedure codes for the final claim once the account is discharged. The payer must determine if Series accounts should only reflect one type of coding method for the life of the account for reporting, editing, and reimbursement reasons.

Exceptions for Insurance Plan, Insurance Carrier, or Financial Class

If the Claim Load Edit Parameter ICD-10 Effective Date field is left blank, the system checks the USA ICD-10 Effective Date on the Hospital Facility Options on STAR Patient Processing.

- If the admission date of the account is before the USA ICD-10 Effective Date, the Claim ICD flag is set to 9, and the claim will prompt and require ICD-9 diagnosis and procedure codes.

- If the admission date of the account is on or after the USA ICD-10 Effective Date, the system looks for Exceptions to the ICD-10 coding as follows:

- The system first accesses the Insurance Plan Table for the insurance loading the claim to determine if there is an ICD-10 Effective Date for the insurance plan. The ICD-10 Effective Date in the insurance plan is based only on Admission Date. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Insurance Plan ICD-10 Effective Date, the Claim ICD flag is set to 9, and the claim prompts and requires ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Plan ICD-10 Effective Date, or the Insurance Plan ICD-10 Effective Date field is blank, then the system will look to the Insurance Carrier Table for the insurance loading the claim.

- If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Insurance Carrier Table ICD-10 Effective Date, then the Claim ICD flag will be set to 9, and the claim will prompt and require ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Insurance Carrier ICD-10 Effective Date, or the Insurance Carrier ICD-10 Effective Date field is blank, then the system will look to the default Financial Class for the insurance loading the claim.

- If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, but is before the Financial Class Table ICD-10 Effective Date, then the Claim ICD flag will be set to 9, and the claim will prompt and require ICD-9 diagnosis and procedure codes. If the Admission Date of the patient is on or after the USA ICD-10 Effective Date on the Hospital Facility Options, and is on or after the Financial Class ICD-10 Effective Date, or the Financial Class ICD-10 Effective Date field is blank, then the system will determine there are no exceptions for the account, and set the Claim ICD flag to 10. The claim will prompt and require ICD-10 diagnosis and procedure codes.

FINANCIAL CLASS EXCEPTIONS

STAR Patient Processing sets the Account ICD flag based on the Financial Class at the account level. Therefore, if the COB 1 insurance has an exception for the Financial Class, or the Self Pay Financial Class has an exception, the Account ICD flag will be set to *B* for *Both* in order to collect both ICD-10 codes and ICD-9 codes.

The claims process looks to the Default Financial Class for each insurance loading a claim. At the time the insurance is assigned to the account, this is stored at the account level for the insurance. This is taken from the Default Financial Class field when accessing Tables, PA/AR Master File Maintenance, Insurance Plan Coverage, enter the carrier and plan, Facility Options, Billing/Claim Parameters, screen 1, Default Financial Class field. This allows some claims for the account to load ICD-9 diagnosis and procedure codes based on the financial class exception, while other claims load ICD-10 diagnosis and procedure codes.

For example, if Financial Class H was set as a Financial Class Exception, then for an account with the below insurances, COB 1 and COB 2 would load ICD-9 codes, and COB 3 and COB 4 would load ICD-10 codes:

COB 1	900100	UB	Default Financial Class H
COB 2	900200	1500	Default Financial Class H
COB 3	444111	UB	Default Financial Class O
COB 4	444222	1500	Default Financial Class O

By looking to the ICD-10 Effective Date fields on the Insurance Plan Table, the Insurance Carrier Table, and the Financial Class Table, instead of looking to the actual account ICD flag, the claims process can catch those situations where:

- The account was registered on or after the USA ICD-10 Effective Date field on the Hospital Facility Parameters, there were no exceptions in the Insurance Plan Table, the Insurance Carrier Table, or Financial Class Table, only ICD-10 Diagnoses and Procedure codes were collected on the account, and then the Insurance Plan Table, the Insurance Carrier Table, or the Financial Class Table is set with an ICD-10 Effective Date that WOULD HAVE set the account ICD to require BOTH ICD-10 codes and ICD-9 codes. The Claim ICD will be set to 9 for ICD-9. If any of the diagnosis or procedure fields are required, the claim will fail. At this point, either the ICD-9 codes can be added to Medical Records, and the claim reloaded, or the claim can be edited to have these ICD-9 codes.

- The account was registered on or after the USA ICD-10 Effective Date field on the Hospital Facility Parameters, there were no exceptions in the Insurance Plan Table, the Insurance Carrier Table, or Financial Class Table, only ICD-10 Diagnoses and Procedure codes were collected on the account, and then the USA ICD-10 Effective Date field on the Hospital Facility Parameters was changed to be a date in the future (past the admission date of the account). The Claim ICD will be set to 9 for ICD-9. If any of the diagnosis or procedure fields are required, the claim will fail. At this point, either the ICD-9 codes can be added to Medical Records, and the claim reloaded, or the claim can be edited to have these ICD-9 codes.

- The account was registered before the USA ICD-10 Effective Date field on the Hospital Facility Parameters, and only ICD-9 Diagnoses and Procedure codes

were collected on the account. The USA ICD-10 Effective Date field on the Hospital Facility Parameters is then changed to be a past date (that is on or before the admission date of the account). The Claim ICD will be set to 10 for ICD-10 (if there are no exceptions for the account at the Insurance Plan, Insurance Carrier, or Financial Class level). If any of the diagnosis or procedure fields are required, the claim will fail. At this point, either the ICD-10 codes can be added to Medical Records, and the claim reloaded, or the claim can be edited to have these ICD-10 codes.

CLAIM RELOAD

Based on the Claim ICD flag, the claim loads and edits either ICD-9 diagnosis and procedure codes or ICD-10 diagnosis and procedure codes.

The system sets an ICD flag at time of Claim Select. This flag is set to either 9 for ICD-9 or 10 for ICD-10. The claim MAINTAINS this flag for the life of the claim. Therefore, if the claim is Failing for any internal element that is requiring a diagnosis or procedure code, the Claim Reload function will only look for and load the information from either the ICD-9 data or the ICD-10 data, depending on the ICD flag on the claim.

1500 Claims (Claim Type B)

The ICD-10 Effective Date field on the Claim Load Edit Parameter not only affects any demographic locator that is set to load diagnosis or procedure information; it also affects which charge Ordering Diagnosis is used for the 1500 claim form. The system will load either the ICD-9 or the ICD-10 Ordering Diagnosis for each charge, and use the current logic to match the Ordering Diagnosis on the charge (locator 24E), to the diagnosis codes in Locator 21-1, 21-2, 21-3, and 21-4.

NOTE: Users can continue to edit for the existence of the diagnosis/reference number at the claim charge level by setting the 1500 Charge Control Parameter field "Edit Pro Fee Charges" to have "Diagnosis Code/Reference Number" highlighted. The system will again look to either the ICD-9 or the ICD-10 diagnosis information based on the claim ICD flag. Note also that the 08/05 format of the 1500 claim form does not allow an actual diagnosis code in Locator 24E of the claim charge line. Only a reference number is allowed. Therefore, when editing or inserting a 1500 claim charge line, the system does not prompt for either an ICD-9 or ICD-10 diagnosis code. The system prompts for one or more reference numbers to link the charge to the diagnoses in Locator 21.

17. ERRONEOUS SURGERY DIAGNOSIS CODES ICD9/ICD10 (TABLE LOOKUP-O)
This field can be accessed only for UB claim types (claim type X) in the UB04 format. Users can enter the External Cause of Injury Diagnosis Codes that normally would appear in UB04 Locator 72 if they are one of the first three external cause of injury codes, that should instead appear in UB04 Locator 67 for the Secondary/Other Diagnosis Codes. These codes are not repeated in Locator 72 for External Cause of Injury.

This field contains external cause of injury diagnosis codes that are excluded from loading to Locator 72 A, B, and C and are only available to load to Locator 67 for the Secondary/Other Diagnosis Code fields.

This field is used to set the codes only for this claim load and edit parameter. The codes can also be set at the facility level and affect all UB04 Claim Load Edit Parameters. If the field is not set at the UB04 Claim Load Edit Parameter level, the system looks to the Facility level table for Erroneous Surgery Diagnosis Code Table. If neither is set, the system does not edit/process for the erroneous surgery diagnosis codes.

External cause of injury codes for ICD-9 begin with E. External cause of injury codes for ICD-10 are in the range of V01-Y98.

The system prompts as follows for STAR Patient Accounting releases prior to 15.0:

Select ICD9 (I) or do not process ICD9 (NI) for Erroneous Surgery Dx Codes--

The system prompts as follows for STAR Patient Accounting releases 15.0 and higher:

Select ICD9 (I), ICD10 (T), do not process ICD9 (NI), or do not process ICD10 (NT) diagnoses for Erroneous Surgery Dx Codes--

- If I for ICD9 is selected, the next prompt is as follows:

  Key ICD9 diagnosis codes for Erroneous Surgery or key N for do Not process --

  Users can enter in the diagnosis codes. When entering ICD-9 External Cause of Injury Diagnosis Codes, the system edits that the first digit of the diagnosis code begins with the letter E. The diagnosis codes can be entered with or without the decimal, and are displayed in the table without a decimal.

  If NI for Do Not Process ICD9 is selected, the system does not process for Erroneous Surgery diagnosis codes for ICD-9.

- If T for ICD10 is selected, the next prompt is as follows:

  Key ICD10 diagnosis codes for Erroneous Surgery or key N for do Not process --

  Note that external cause of injury codes for ICD-10 diagnoses do not start with the letter E. External cause of injury codes for ICD-10 are in the range of V01-Y98.

  Users can enter in the diagnosis codes. When entering ICD-10 External Cause of Injury Diagnosis Codes, the system edits that the first digit of the diagnosis code begins with a "V", "W", "X", or "Y". The diagnosis codes can be entered with or without the decimal, and are displayed in the table without a decimal. Note also that the ICD-10 diagnosis codes are case sensitive and must be entered with upper and lower case as they appear in the ICD Master.

If NT for Do Not Process ICD10 is selected, the system does not process for Erroneous Surgery diagnosis codes for ICD-10.

Any external cause of injury diagnosis code listed in this table will be excluded from loading to Locator 72 A, B, and C, and will only be available to load to Locator 67 for the Secondary/Other Diagnosis Code fields.

You should list only those external cause of injury codes that CMS has stated must be reported in Locator 67 as one of the first nine Secondary/Other Diagnosis Codes. These external cause of injury codes will be loaded to Locator 67 according to the order they are coded in Medical Records.

If one of the listed external cause of injury diagnosis codes loads to Locator 67 1/A through Locator 67 9/I, the system does not produce an error.

If one of the listed external cause of injury diagnosis codes loads to Locator 67 10/J through Locator 67 17/Q, the system does produce an error for the diagnosis in the following format, where # identifies the number of the secondary diagnosis.

Claims Workfile: Error: Erroneous Surgery Dx Flagged for Review (#)

Failed Claims Requirement Report: 67-21 Error: Erroneous Surgery Dx Flagged for Review Contents: E876.7

If the listed external cause of injury diagnosis code is in electronic only data, because the diagnosis is past the first 17 secondary diagnosis codes, STAR does not edit for the erroneous surgery diagnosis code.

When an Erroneous Surgery Diagnosis Code loads to the UB04 claim in Locator 67 Other DX Code 1/A through 17/Q, the system edits the Type of Bill Locator 4 last digit. If the last digit of the type of bill is not a 0 for a No Pay Claim, the field will error with the following edit message. This gives you the opportunity to review the claim and to update the type of bill:

Erroneous Surg Dx TOB Last Digit Not 0

For details on selecting external cause of injury diagnosis codes at the facility level, see “ERRONEOUS SURGERY DIAGNOSIS CODE TABLE” on page 3-337.

18. NY CLAIM TYPE (1-A-O)
This field indicates, for New York claims, the reimbursement rate used for the claim. When this field is accessed, the following prompt is displayed:

New York (A)LC, NY (P)AS/Clinic Rate, NY PA(S)/No Clinic Rate, NY (O)ther, NY AP(G), or (N)one [N]--

You have the following entry options:

- If you enter **A** (ALC) or NY **O (**Other), a NY Medicaid Billing Codes Table must be assigned for the Claim Load and Edit Parameter. The following prompt is displayed:

  Enter NY Medicaid Billing Code Table or `-` for list--

  You can key the NY Medicaid Billing Code or enter a hyphen (-) to select a code from the NY Medicaid Billing Code Table. For more information on this table, refer to the documentation for New York State.

- If you enter **P** (PAS/Clinic Rate)**,** and no PAS HCPCS codes are identified in the Medical Records HCPCS for the account, the Default Clinic Access Code and the Default Clinic Rate from the first screen in the New York PAS HCPCS Procedures Table are used for the account.

- If you enter **S** (NY PAS/No Clinic Rate), and no PAS HCPCS codes are identified in the Medical Records HCPCS for the account, the Default Clinic Access Code and the Default Clinic Rate from the first screen in the New York PAS HCPCS Procedures Table are not used for the account. The claim loads as a conventional UB claim rather than as a PAS UB claim.

  If you enter **S** (NY PAS/No Clinic Rate), and PAS HCPCS codes are identified in the Medical Records HCPCS for the account, the Alternate UB screen is displayed, as follows:

```
          General Hospital Claim Load and Edit Parameters Processor
                                                 Fri Jun 16, 2007 06:34 pm


Alternate UB Claim
 1 Claim Load/Edit Parameter             2 Charge Control Parameter
->
 3 Edit by                               4 Effective date
```

If a Claim Load/Edit Parameter is indicated on the screen, it is used to load the conventional UB claim, when a PAS UB claim is not loading, due to the lack of PAS HCPCS in Medical Records HCPCS codes. Otherwise, the original Claim Load/Edit Parameter is used. If a Charge Control Parameter is indicated on the screen, it is used to load the conventional UB claim, when a PAS UB claim is not loading, due to the lack of PAS HCPCS in Medical Records HCPCS codes. Otherwise, the Charge Control Parameter indicated for the account's insurance is used.

- If you enter **G** (APG), a NY APG Rate Code Table must be assigned for the Claim Load and Edit Parameter. The following prompt is displayed:

  Enter New York APG Rate Code Table or `-` for list--

You can key the NY APG Rate Code Table or enter a hyphen (-) to select a code from the NY APG Rate Code Table.

The New York APG Rate Code Table listed in the UB Claim Load Edit Parameter is used for the following cases:

- For the Primary claim when there are UB Split Claim Criteria tables listed on the UB Charge Control Parameter linked to the Medicaid APG insurance.
- No UB Split Claims Criteria tables are listed on the UB Charge Control Parameter linked to the Medicaid APG insurance.
- UB Split Claims Criteria tables are listed on the UB Charge Control Parameter linked to the Medicaid APG insurance, but no NY APG Rate Code Table is listed for the split in the UB Split Claims Criteria Table.

The New York APG Rate Code Table is used when the Provider Master linked to the insurance has Value Code 24 - NY Medicaid Rate Code highlighted.

The NY Claim Type field can only be accessed for claim type X-UB.

NOTE: For more information on this table, refer to the documentation for New York State.

19. ICD PROCEDURE DATES FOR UB (1-A-O)

This field defines whether ICD procedures are loaded by service date or by account.This field is accessible for UB's in the UB04 format only. When this field is accessed, the following prompt is displayed:

Load ICD procedures by Service Date (S) or by Account (A) [A]--

- If the field is left blank or is set to A for Account, the system loads all ICD Procedures to each claim loading from the Claim Load Edit Parameter.
- If the field is set to S for Service Date, the system loads those ICD Procedures that have a Procedure Date within the From and Through Dates of the bill that in turn loads the claim.
- When set to S for Service Date, if the Principal (or first) ICD Procedure is not within the From and Through Dates of the bill that in turn loads the claim, it is not used for the claim, and the ICD Procedures that are within the From and Through Dates move up on the claim only.

This affects the ICD Procedures loading to the paper claim locators, and the electronic only procedures (up through 24 procedures total).

This can be used for your series Claim Load Edit Parameters for payers that require only that month's procedures on the cycle bills.

NOTE: DPW inpatient claims look to the following fields on the second screen of the Inpatient Claim Load Edit Parameter:

- DPW Med Info
- DPW OP POA
- DPW ICD Proc Timeframe
- DPW Exclude ICD9/ICD10 Proc

Therefore, when pulling procedure information from the FROM account to the TO (Inpatient) account in a DPW pair, the system looks to these fields, including the DPW ICD Proc Timeframe, and not to the ICD Procedure Dates for UB field on the Claim Load Edit Parameter.

For Combine Billing, the procedure on the FROM account still must be within the Bill From and Through Dates for the bill that loads the TO account's claim in order to appear on the TO claim. Procedures can be excluded based on the Claim Load Edit field, Comb Bill Exclude ICD9/ICD10 Proc on the second screen.

20. UB LOC 54 PRIOR PYMT CALC (1-A-R)
This field indicates whether UB Locator 54 reflects insurance payments and adjustments, as well as any of the following: Coinsurance from Cash Posting, Deductible from Cash Posting, Co-Pay from Cash Posting, Pat Resp from Cash Posting. If this field is blank, the UB Loc 54 Prior Pymt Calc field on the PAAR Control screen is used.

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

Include other values in prior payment calculation for locator 54 (Y/N)?--

If you enter **N (No)**, the value of *Payment Only* is displayed in the field, and the three fields in locator 54 (lines a, b, and c) for the UB claim contain total payments only. If you enter **Y (Yes)**, the following table is displayed:

```
Page:01                      Prior Payment Options          ##=Current Choices
( 1) Adjustments (Auto Cont. and Manual)
( 2) Coinsurance from Cash Posting
( 3) Deductible from Cash Posting
( 4) Co-Pay from Cash Posting
( 5) Pat Resp from Cash Posting

Select items from payment transaction to be included in prior payment total--
                                end select(NL)
```

The screen displays the following prompt:

Select items from payment transaction to be included in prior payment total--

You can select one or more items from the table. The selected items are added to the payment amount used to calculate prior payments for locator 54. The system analyzes payment transactions for claims for previous COBs. This logic is used when the Awaiting Payment disposition is removed for a claim because final dispositions have been assigned to all claims for previous COBs associated with the claim, per the claim split indicator.

This field displays *Payments only* or *Pymt+x,* where x is Adj, Coins, Ded, CoPay, and/or PatResp, depending on the other values selected to be added to the Prior Payments field. For example, the field may display *Pymt+Adj+Coins+Ded+CoPay+PatResp*.

NOTE: The system looks only to the Claim Load and Edit Parameter or PAAR Control for waiting claims, and only if the Claim Load and Edit Parameter is set as follows for Locators 54 a, b, and c:

Field Type: M Money

Internal Element: Money

The following should also be set:

Print Routine: MONEY 999999900 BLK 0 TRL SIGN

21. 1500 LOC 29 AMOUNT PAID CALC (1-A-O)

This field can be accessed for claim types B-1500 and Z-Non Pro Fee 1500. This field is used to indicate whether the information in the Amount Paid locator is printed on claims waiting for payment and what is included in this amount paid locator (adjustments, coinsurance, deductible from cash posting, co-pay from cash posting, and patient responsibility from cash posting. When this field is accessed, the following prompt is displayed:

Calculate Amount Paid for 1500 Locator 29 (Y/N)?-

This field is used for both the 1500 (claim type B) and the Non Pro Fee 1500 (claim type Z) loading in the 08/05 version only. This field is not used for a 1500 or Non Pro Fee 1500 loading in the 1992 version. You can enter **Y** (Yes) to have the system calculate the amount paid. If you enter Yes, the system displays the following screen of options that can be included in the Amount Paid locator:

```
Page:01                      Amount Paid Options          ##=Current Choices
( 1) Adjustments (Auto Cont. and Manual)
( 2) Coinsurance from Cash Posting
( 3) Deductible from Cash Posting
( 4) Co-Pay from Cash Posting
( 5) Pat Resp from Cash Posting
```

You can highlight one, many, or all options to include in the Amount Paid locator. If none of these options is highlighted, only Payments are reflected in the Amount Paid

locator. The field must still be set to Yes to calculate the Amount Paid and Balance Due amounts on a waiting claim.

NOTE that the Amount Paid is for all payments made to claims that this claim was Waiting for Payment on. When printing/spooling a multi-page claim, any page before the last page for the claim will have a BLANK Amount Paid amount. The last page of the claim will have an Amount Paid for the payments made to claims that this claim was Waiting for Payment on.

When setting this field, the Claim Load Edit Parameter for the Waiting claim also has to have the following locators set, in order to update the Amount Paid and Balance Due amounts:

Locator 28 Total Charges

Print = Yes

Internal Element = TOTAL CHARGES FOR 08/05 1500

Print Routine = MONEY (999999900 BLK IF NULL)

Locator 29 Amount Paid

Print = Yes

Internal Element = MONEY

Print Routine = MONEY (99999900 BLK IF NULL)

Locator 30 Balance Due

Print = Yes

Internal Element = MONEY

Print Routine = MONEY (99999900 BLK IF NULL)

When this field is set, each time the waiting claim is updated to no longer wait on a previous claim (meaning the previous claim was dispositioned either as Final Payment, Adjusted to Zero, or Denied via Cash Posting, Adjustment Posting, Claim Disposition, or Balance Transfer), the Amount Paid and Balance Due on the waiting claim are updated. For example, if claim sequence 5 is waiting for payment on claim sequences 2 and 4, when claim sequence 2 is dispositioned as Final Payment, Adjusted to Zero, or Denied, this updates the Amount Paid and Balance Due on claim sequence 5. When claim sequence 4 is dispositioned as Final Payment, Adjusted to Zero, or Denied, this again updates the Amount Paid and Balance due on claim sequence 5.

Once the Waiting Claim is updated to no longer wait for a higher priority claim, any payments (partial or final) or adjustments made to this higher priority claim after this point are not reflected on the Waiting Claim. For example, say that claim sequence 2 is waiting for payment on claim sequence 1. A partial payment of $100 is made to claim sequence 1. A final payment of $200 is then made to claim sequence 1, which updates claim sequence 2 to no longer be waiting on claim sequence 1. The Amount Paid on claim sequence 2 is set to $300.00. If the higher priority claim is given a claim disposition of Final Payment, Adjusted to Zero, or Denied, through Cash Posting, Adjustment Posting, Balance Transfer or Claim Disposition, this updates the lower priority claims to no longer wait on it. If after this point, another payment or adjustment is made to claim sequence 1, this is not reflected on claim sequence 2.

The system takes the Total Charge amount that is in Locator 28, minus the Amount Paid (which can include Adjustments, Coinsurance amount from cash posting, Deductible amount from cash posting, Co-Pay amount from cash posting, and Pat Resp from cash posting) on the claims this claim was waiting on in Locator 29, to arrive at the amount for Locator 30 Balance Due. If the Total Charge amount (Locator 28) - the Amount Paid (Locator 29) is a negative amount, the system automatically sets the Balance Due (Locator 30) to 0.00.

The system performs this logic only if the 1500 Loc 29 Amount Paid Calc field is set to Yes in the Claim Load Edit Parameter for the waiting claim, at the point the claim is updated to no longer be waiting for payment, and only if the Internal Elements and Print Routines are set as listed above. If you do not want the system to print this amount, you can either a) not set the 1500 Loc 29 Amount Paid Calc field, b) remove the Internal Elements in Locators 28-30 for the claim load edit parameter linked to the insurance waiting for payment, or c) update the Internal Elements to other internal elements, or d) set the "Print" field for Locator 29 and Locator 30 to No.

NOTE: Since the system is updating the Amount Paid and Balance Due and the Balance Due at the point the claim is updated to no longer be waiting for payment on the higher priority claim, these locators initially load $0.00 and are updated as the Waiting claim is updated. If a Balance Due amount is manually entered on the claim, this amount can be overlaid with the system-calculated amount.

22. 1500 CONDITION CODES

This field can be accessed only for claim type B (1500) and claim type Z (Non Pro Fee 1500) in the 08/05 format. The field is used to select those condition codes that qualify to load to Locator 10D of the 1500 claim form.

When this field is accessed, the Condition Code table is displayed. You can do a table lookup on the Condition Code table. You can highlight one or more condition codes that qualify to load to Locator 10D.

Internal Element *1500 Condition Code* works with the 1500 Condition Code field on the Claim Load Edit Parameter. When a 1500/Non Pro Fee 1500 claim loads for an account, if the Internal Element *1500 Condition Code* is assigned to a locator, the

system looks to the Condition Codes at the account level. If the account has one of the condition codes listed in the 1500 Condition Codes field on the Claim Load and Edit, this loads to Locator 10D of the claim (or to the Locator assigned internal element "1500 Condition Code"). If more than one listed exists on the account, the system pulls the first one encountered to Locator 10D. Only the Condition Code loads, and not the Condition Code Description.

The system looks to the Condition Codes at the Account level only, and not to the auto loaded Condition Codes for the UB, as the auto loaded Condition Codes from the Provider Master do not apply to the 1500. The system is also looking to the Condition Codes in the order entered at the account level. The system does not sort the condition codes before loading the first that qualifies to the claim.

The current list of Condition Codes for the 1500 are as follows (which are subject to change):

The following is the list of Condition Codes for abortion that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

- AA Abortion Performed due to Rape
- AB Abortion Performed due to Incest
- AC Abortion Performed due to Serious Fetal Genetic Defect, Deformity, or Abnormality
- AD Abortion Performed due to a Life Endangering Physical Condition Caused by, Arising from or Exacerbated by the Pregnancy Itself
- AE Abortion Performed due to Physical Health of Mother that is not Life Endangering
- AF Abortion Performed due to Emotional/psychological Health of the Mother
- AG Abortion Performed due to Social or Economic Reasons
- AH Elective Abortion
- AI Sterilization

The following is the list of Condition Codes for worker's compensation claims that are valid for use on the 1500 Health Care Claim Form and in the 837 Professional.

- W2 Duplicate of original bill
- W3 Level 1 appeal
- W4 Level 2 appeal

- W5 Level 3 appeal

21. LAST GENERATED (DISPLAY ONLY)
This field contains the date and time this claim was last generated.

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

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

You can press ENTER to access the UB Combine Billing and DPW Parameters screen.

UB Combine Billing and DPW Parameters

After you press ENTER from the first screen for Claim Charge and Edit Parameters, the following screen is displayed for UB Combine Billing and DPW Parameters:

```
              General Hospital Claim Load and Edit Parameters Processor
                                                  Wed Mar 31, 2010 02:34 pm

UB Combine Billing and DPW Parameters
 1 Combine Bill Med Info                    2 Comb Bill OP POA
   Prc, DX (Med Rec then Chgs)             ->
 3 Comb Bill Exclude ICD9/ICD10 Proc
   ICD9/ICD10
 4 DPW Med Info                             5 DPW OP POA
   All (To Accnt then From Accnt)             Y
 6 DPW ICD Proc Timeframe
  All Charges
 7 DPW Exclude ICD9/ICD10 Proc
   ICD9/ICD10
 8 Adm Prin/Sec Dx for Comb Bill/DPW
   Yes




Enter the default POA value for outpatient diagnoses on inpatient claim
(Y, N, U, W, E, 1)-- r|
```

1. COMBINE BILL MED INFO (1-A-R)
This field indicates the type(s) of additional medical information to be extracted to complete a combined bill claim for a Charge To account. The option is available to extract additional diagnosis, additional procedure codes, and HCPCS codes from the Charge From account(s) to complete the Charge To claim. Diagnosis, procedure, and HCPCS information from the FROM account are used only on the TO account's claim

if the FROM and the TO account are the same person (but different account numbers). If the accounts are not for the same person, as can be seen when looking at MPI Inquiry, the FROM account information is not used on the TO account's claim. This could happen if you combine two accounts with a name difference, that were accepted in the MPI as two different people (for example, Lori Jones and Laurie Jones). For diagnosis information, the Admitting and the Principal diagnosis is always taken from the TO account. If the TO account does not have a Principal Diagnosis code, the system does not use any FROM account diagnoses as secondary diagnoses on the TO account's claim. Depending on this field, the FROM account's information can be used for the Secondary Diagnosis information on the TO account's claim (locators 68-75, and also locator 77 for the E code on the hardcopy UB92 claim form, locator 67A-Q for Secondary and Locator 72A-C for the External Cause of Injury codes on the hardcopy UB04 claim). When using the FROM account's diagnosis information on the TO account's claim, the system starts with the Principal on the FROM account to fill a Secondary Diagnosis locator, and continues to use the Secondary diagnosis codes on the FROM account to fill any remaining Secondary Diagnosis locators. Duplicate diagnoses between the FROM and TO accounts and free-form diagnoses are not used.

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

Extract additional (D)iagnoses, (P)rocedures, (B)oth DX and Proc, HCPCS (H), (A)ll, or (N)one for Combine Billed accounts [N]--

The default is (N)one. If the field has not been completed, a blank is interpreted as (N)one. Other values are:

- **D** (Diagnoses) indicates that UB92 Form Locators 68 - 75 for Secondary, and Locator 77 for the E code, and UB04 Locator 67A-Q for Secondary and Locator 72A-C for the External Cause of Injury codes, are to be populated with diagnoses from the Charge From account(s) after extracting all available diagnosis codes from the Charge To account.

- **P** (Procedures) indicates that UB92 Form Locators 80 and 81 and UB04 Form Locator 74/74A-E are to be populated with procedures from the Charge From account(s) after extracting all available procedure codes from the Charge To account. If the principal procedure in FL 80 is extracted from a Charge From account, the Other Physician reported in FL 83 is the physician associated with the principal procedure on the Charge From account.

- **B** (Both) indicates that both diagnoses and procedures are to be populated with the medical information from the Charge From account(s) after extracting all available codes from the Charge To account. If the principal procedure in FL 80 (UB92) or FL 74 (UB04) is extracted from a Charge From account, the Other Physician reported in FL 83 (UB92 for the Primary Procedure Physician) and the Operating Physician reported in FL 77 (UB04 for the Primary Procedure Physician) is the physician associated with the principal procedure on the Charge From account.

- **H** (HCPCS) indicates that Locator 44 is to be populated with the Medical HCPCS codes from the Charge From account(s) after extracting all available codes from the Charge To account.

  The system pulls the HCPCS from the FROM account(s) based on the following:

  When combining the FROM account to the TO account, the user enters the Service From Date and Service Through Date of charges to move to the TO account. The user can enter specific dates, or can take the defaults of Earliest to Latest. Based on these dates, the system only pulls in HCPCS codes with a Service Date in this range.

  Therefore, if you are combining specific service dates FROM a Series account to either an Inpatient or an Outpatient account, if you entered for example a Service From Date of 05/03/2007 and a Service Through Date of 05/31/2007, only HCPCS codes within these dates would be used on the TO account's claim. If there were HCPCS codes on the FROM account with service dates outside of these, they would not be used on the TO account's claim. This is especially important if the TO account's UB Charge Control Parameter is editing for Unused Medical Records HCPCS. All HCPCS pulled from the FROM account to the TO account's claim is also edited.

  When using Medical Records HCPCS on the FROM account on the TO account's claim, the system appends the FROM account's HCPCS to the end of the TO's account's HCPCS (when processing the claim only, the Medical Records HCPCS are not actually moved to the TO account), and process as current logic. The claims process starts at the top of the list and works down. For example, say the accounts had the following Medical Records HCPCS:

  TO account:

  Rev 360 11111

  Rev 360 98765

  Rev 450 22222

  Rev 986 44444

  FROM account:

  Rev 360 77777

  Rev 360 66666

  Rev 985 12345

The CLAIM programs append the FROM account HCPCS to the TO account's HCPCS as follows:

Rev 360 11111

Rev 360 98765

Rev 450 22222

Rev 986 44444

Rev 360 77777

Rev 360 66666

Rev 985 12345

Therefore, if the TO account's UB Charge Control Parameter had the HCPCS Proc field set to Medical Records for Revenue Code 360, then HCPCS 11111 would end up on the dollar line, HCPCS 98765 would be the first $0.00 line, HCPCS 77777 would be on the next $0.00 line, and HCPCS 66666 would be on the last $0.00 line (assuming the HCPCS also matched on Service Date).

The system looks for duplicate HCPCS on the FROM and the TO account. The system compares the HCPCS Code + Modifiers, the Service Date, and the Revenue Code. If these match between the From and the To account, then the From account MR HCPCS are not used.

- **A** (All) indicates that the ICD Diagnosis Codes, the ICD Procedure Codes, and the Medical Records HCPCS Codes are to be populated with the medical information from the Charge From account(s) after extracting all available codes from the Charge To account.

- **N** (None) indicates that diagnosis and procedure codes and Medical Records HCPCS codes are not to be extracted from Charge From accounts when bills have been combined.

- If the response is either **D** (Diagnosis), **B** (Both) or **A** (All), a table is displayed, allowing you to select the order in which diagnosis codes are extracted:

```
Page:01          Options For Combining Diagnoses from Charges
( 1) To Accnt Diagnoses (MR then Chgs) then From Accnt Diagnoses (MR then Chgs)
( 2) Med Rec Diagnoses (To then From) then Charge Diagnoses (To then From)

Enter choice-
```

If (1) To Accnt Diagnoses then From Accnt Diagnoses is selected, all diagnoses from the To Account are extracted prior to extracting any diagnoses from the From Account(s). Diagnoses are extracted as follows:

- Diagnoses from Medical Records entered on the To Account
- Diagnoses from Charges entered directly on the To Account (only if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)
- Diagnoses from Medical Records entered on the earliest From Account
- Diagnoses from Charges originating on the earliest From Account (if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)
- Diagnoses from Medical Records entered on the next earliest From Account
- Diagnoses from Charges originating on the next earliest From Account (if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)

If (2) Med Rec Diagnoses then Charge Diagnoses is selected, the medical records diagnoses are extracted from all accounts prior to extracting any diagnoses from the charges. Diagnoses are extracted as follows:

- Diagnoses from Medical Records entered on the To Account
- Diagnoses from Medical Records entered on the earliest From Account
- Diagnoses from Medical Records entered on additional From Accounts
- Diagnoses from Charges entered directly on the To Account (only if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)
- Diagnoses from Charges originating on From Accounts (only if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)

NOTE: Diagnoses from charges are extracted only if the internal element for the diagnosis form locator has the setup routine defined as MED REC & CHARGE DIAGNOSIS.

2. COMB BILL OP POA (1-A-O)
This field contains the default POA value for outpatient diagnoses used on an inpatient claim. This field can be accessed only if the Combine Bill Med Info field is set to D for Diagnoses, B for Both Diagnoses and Procedures, or A for All.

When entering a value, the value must be one that is listed on the prompt. If any other value is entered, the system displays the error message: Invalid Entry! The default value also must be listed in the Present on Admission table as the hospital value. The

claims system takes the default value selected (Y, N, W, U, E or 1) and looks it up in the Present on Admission table. The claim uses use the mapped NUBC value.

When a valid value is entered, for outpatient/series Medical Records diagnoses that are used on the inpatient claim, if the POA indicator is blank, only the inpatient claim uses this POA default indicator. If there are inpatient diagnoses that are missing the POA indicator, this field is not used as the POA, and the inpatient diagnoses with a blank POA default to a POA of U for Unknown on the inpatient claim.

This field is used only for outpatient Medical Records diagnoses that have a blank POA value, and is defaulted only on the inpatient claim. Therefore, when viewing the diagnoses on the outpatient account, you will not see this defaulted (claim) value. Finally, this field is used only when loading/editing the Inpatient claim in a DPW situation or a Combine Bill situation. Therefore, when using Combine Bill to move information from one outpatient/series account to another outpatient/series account, the Comb Bill OP POA value is not used.

The following logic holds true for the POA internal elements that can be used on the UB claim:

If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, the POA indicator is set to Y for Yes. Otherwise, if the diagnosis is pulled from Admitting, the POA is set to Y for Yes. If the diagnosis is pulled from Medical Records, the NUBC value that is mapped to the POA in the Present on Admission table is used for the POA assigned to the Medical Records diagnosis.

If there is no POA value for the diagnosis, the claim defaults to a U for Unknown for the POA indicator.

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

Enter the default POA value for outpatient diagnoses on inpatient claim (Y, N,U, W, E, 1)--

Entry options for the default value are:

- **Y** (Yes), the condition was present at the time of inpatient admission.
- **N** (No), the condition was not present at the time of inpatient admission.
- **U** (Unknown), the documentation is insufficient to determine if the condition was present at the time of inpatient admission.
- **W** (Clinically Undetermined), the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.
- **1** (Exempt from POA Reporting), the condition is exempt from Present on Admission reporting. This is equivalent to a blank on the UB04 claim.

3. COMB BILL EXCLUDE ICD9/ICD10 PROC
This field is used to list those ICD Procedures on the From account that should not be used on the To account's claim, even if they fall within the To account's bill From and Through Dates that load the To account's claim.

This field can only be accessed if the Combine Bill Med Info is set to P for Procedures, B for Both Diagnoses and Procedures, or A for All.

If this field is left blank, all ICD Procedures on the From account are available to be used on the To account's claim.

NOTE: For Combined Billing, only From account ICD Procedures that fall within the Bill From and Through Dates for the bill that loads the To account's claim can be used on the To account's claim.

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

Select ICD9 (I) for exclusion, ICD10 (T) for exclusion, do not exclude ICD9 (NI), or do not exclude ICD10 (NT)--

You have the following entry options:

- Enter **I** for ICD9, or **T** for ICD10. The system prompts as follows:

  Key List of Code/Code Ranges (e.g., 2001,2009-2039,2041), or Key Partial Procedure Code Followed by `-` to Select Codes from Table, or Key V to View/Edit/Add/Delete Codes-

  You can enter the codes directly as in the example in the prompt or key a partial procedure code lookup, such as 82- or 005- to see a list of codes starting with this number. When the list is displayed, one or many codes can be highlighted to be excluded. You can also enter.**V** (view, edit, add, or delete codes). The codes already entered as exclusions are displayed. Individual codes can be deleted by using the F4 Delete key. Individual codes can also be added by using the F3 Insert key, or by paging to the last screen of codes, hitting the down arrow or ENTER key, and adding a code on the new line. A table look up is allowed when adding individual codes. However, only one code can be selected from this table lookup. To select a range of codes, do a table lookup or partial table lookup with the above prompt (do not enter V), and select the range from the table.

  The system edits that the ICD codes are valid against either the ICD-9-CM list or the ICD-10-PCS list, depending on if the user accessed the screen for (I) ICD-9 or (T) ICD-10.

  The system prompts you to save the changes with the prompt:

  Record these changes? (Y/N)

  You must enter Y for Yes to record the changes.

- Enter **NI** for Do Not Exclude ICD-9 Procedures to clear any ICD-9 procedures previously entered.

- Enter **NT** for Do Not Exclude ICD-10 Procedures to clear any ICD-10 procedures previously entered.

4. DPW MED INFO (1-A-R)

This field indicates the type(s) of additional medical information to be extracted to complete a DPW combined bill claim for a Charge To (inpatient) account. The option is available to extract additional diagnosis, additional procedure codes, and HCPCS codes from the Charge From account(s) (which for DPW, would be the outpatient and series accounts) to complete the Charge To claim.

Diagnosis, procedure information, and HCPCS codes from the FROM account is used only on the TO account's claim if the FROM and the TO account are the same person (but different account numbers). If the accounts are not for the same person, as can be seen when looking at MPI Inquiry, the FROM account information is not used on the TO account's claim. This could happen if you combine two accounts with a name difference that were accepted in the MPI as two different people (for example, Lori Jones and Laurie Jones). For diagnosis information, the Admitting and the Principal diagnosis is always taken from the TO account. If the TO account does not have a Principal Diagnosis code, the system does not use any FROM account diagnoses as secondary diagnoses on the TO account’s claim. Depending on this field, the FROM account's information can be used for the Secondary Diagnosis information on the TO account's claim (locators 68-75, and also locator 77 for the E code on the hardcopy UB92 claim form UB92 claim form, locator 67A-Q for Secondary and Locator 72A-C for the External Cause of Injury codes on the hardcopy UB04 claim). When using the FROM account's diagnosis information on the TO account's claim, the system starts with the Principal on the FROM account to fill a Secondary Diagnosis locator, and continues to use the Secondary diagnosis codes on the FROM account to fill any remaining Secondary Diagnosis locators. Duplicate diagnoses between the FROM and TO accounts and freeform diagnoses are not used.

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

Extract additional (D)iagnoses, (P)rocedures, (B)oth DX and Proc, HCPCS (H), (A)ll, or (N)one for DPW accounts [N]--

The default is (N)one. If the field has not been completed, a blank is interpreted as (N)one. Other values are:

- **D** (Diagnoses) indicates that UB92 Form Locators 68 - 75 for Secondary, and Locator 77 for the E code, and UB04 Locator 67A-Q for Secondary and Locator 72A-C for the External Cause of Injury codes, are to be populated with diagnoses from the Charge From account(s) after extracting all available diagnosis codes from the Charge To account.

- **P** (Procedures) indicates that UB92 Form Locators 80 and 81 and UB04 Form Locator 74/74A-E, are to be populated with procedures from the Charge From account(s) after extracting all available procedure codes from the Charge To account. If the principal procedure in FL 80 (UB92) or FL 74 (UB04) is extracted from a Charge From account, the Other Physician reported in FL 83 (UB92 for the Primary Procedure Physician) and the Operating Physician reported in FL 77 (UB04 for the Primary Procedure Physician) is the physician associated with the principal procedure on the Charge From account.

- **B** (Both) indicates that both diagnoses and procedures are to be populated with the medical information from the Charge From account(s) after extracting all available codes from the Charge To account.

- **H** (HCPCS) indicates that Locator 44 is to be populated with the Medical HCPCS codes from the Charge From account(s) after extracting all available codes from the Charge To account.

  The system pulls the HCPCS from the FROM account(s) based on the following:

  When combining the FROM account to the TO account, the user enters the Service From Date and Service Through Date of charges to move to the TO account. The user can enter specific dates, or can take the defaults of Earliest to Latest. Based on these dates, the system only pulls in HCPCS codes with a Service Date in this range.

  Therefore, if you are combining specific service dates FROM a Series account to either an Inpatient or an Outpatient account, if you entered for example a Service From Date of 05/03/2007 and a Service Through Date of 05/31/2007, only HCPCS codes within these dates would be used on the TO account's claim. If there were HCPCS codes on the FROM account with service dates outside of these, they would not be used on the TO account's claim. This is especially important if the TO account's UB Charge Control Parameter is editing for Unused Medical Records HCPCS. All HCPCS pulled from the FROM account to the TO account's claim is also edited.

  When using Medical Records HCPCS on the FROM account on the TO account's claim, the system appends the FROM account's HCPCS to the end of the TO's account's HCPCS (when processing the claim only, the Medical Records HCPCS are not actually moved to the TO account), and process as current logic. The claims process starts at the top of the list and works down. For example, say the accounts had the following Medical Records HCPCS:

  TO account:

  Rev 360 11111

  Rev 360 98765

Rev 450 22222

Rev 986 44444

FROM account:

Rev 360 77777

Rev 360 66666

Rev 985 12345

The CLAIM programs append the FROM account HCPCS to the TO account's HCPCS as follows:

Rev 360 11111

Rev 360 98765

Rev 450 22222

Rev 986 44444

Rev 360 77777

Rev 360 66666

Rev 985 12345

Therefore, if the TO account's UB Charge Control Parameter had the HCPCS Proc field set to Medical Records for Revenue Code 360, then HCPCS 11111 would end up on the dollar line, HCPCS 98765 would be the first $0.00 line, HCPCS 77777 would be on the next $0.00 line, and HCPCS 66666 would be on the last $0.00 line (assuming the HCPCS also matched on Service Date).

The system looks for duplicate HCPCS on the FROM and the TO account. The system compares the HCPCS Code + Modifiers, the Service Date, and the Revenue Code. If these match between the From and the To account, then the From account MR HCPCS are not used.

- **A** (All) indicates that the ICD Diagnosis Codes, the ICD Procedure Codes, and the Medical Records HCPCS Codes are to be populated with the medical information from the Charge From account(s) after extracting all available codes from the Charge To account.

- **N** (None) indicates that diagnosis and procedure codes and Medical Records HCPCS codes are not to be extracted from Charge From accounts when bills have been combined.

- If the response is either **D** (Diagnosis), **B** (Both) or **A** (All), a table is displayed, allowing you to select the order in which diagnosis codes are extracted:

```
Page:01          Options For Combining Diagnoses from Charges
( 1) To Accnt Diagnoses (MR then Chgs) then From Accnt Diagnoses (MR then Chgs)
( 2) Med Rec DX (To then From) then Charge Diagnoses (To then From)

Enter choice-
```

If (1) To Accnt Diagnoses then From Accnt Diagnoses is selected, all diagnoses from the To Account are extracted prior to extracting any diagnoses from the From Account(s). Diagnoses are extracted as follows:

- Diagnoses from Medical Records entered on the To Account
- Diagnoses from Charges entered directly on the To Account (only if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)
- Diagnoses from Medical Records entered on the earliest From Account
- Diagnoses from Charges originating on the earliest From Account (if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)
- Diagnoses from Medical Records entered on the next earliest From Account
- Diagnoses from Charges originating on the next earliest From Account (if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)

If (2) Med Rec Diagnoses then Charge Diagnoses is selected, the medical records diagnoses are extracted from all accounts prior to extracting any diagnoses from the charges. Diagnoses are extracted as follows:

- Diagnoses from Medical Records entered on the To Account
- Diagnoses from Medical Records entered on the earliest From Account
- Diagnoses from Medical Records entered on additional From Accounts
- Diagnoses from Charges entered directly on the To Account (only if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)
- Diagnoses from Charges originating on From Accounts (only if the Secondary Diagnosis internal element is used with the Med Rec & Charge Diagnosis set up routine.)

NOTE: Diagnoses from charges are extracted only if the internal element for the diagnosis form locator has the setup routine defined as MED REC & CHARGE DIAGNOSIS.

5. DPW OP POA (1-A-O)
This field contains the default POA value for outpatient diagnoses used on an inpatient claim. This field can be accessed only if the DPW Med Info field is set to D for Diagnoses, B for Both Diagnoses and Procedures, or A for All.

When entering a value, the value must be one that is listed on the prompt. If any other value is entered, the system displays the error message: Invalid Entry! The default value also must be listed in the Present on Admission table as the hospital value. The claims system takes the default value selected (Y, N, W, U, E or 1) and looks it up in the Present on Admission table. The claim uses use the mapped NUBC value.

When a valid value is entered, for outpatient/series Medical Records diagnoses that are used on the inpatient claim, if the POA indicator is blank, only the inpatient claim uses this POA default indicator. If there are inpatient diagnoses that are missing the POA indicator, this field is not used as the POA, and the inpatient diagnoses with a blank POA default to a POA of U for Unknown on the inpatient claim.

This field is used only for outpatient Medical Records diagnoses that have a blank POA value, and is defaulted only on the inpatient claim. Therefore, when viewing the diagnoses on the outpatient account, you will not see this defaulted (claim) value. Finally, this field is used only when loading/editing the Inpatient claim in a DPW situation or a Combine Bill situation. Therefore, when using Combine Bill to move information from one outpatient/series account to another outpatient/series account, the Comb Bill OP POA value is not used.

The following logic holds true for the POA internal elements that can be used on the UB claim:

If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, the POA indicator is set to Y for Yes. Otherwise, if the diagnosis is pulled from Admitting, the POA is set to Y for Yes. If the diagnosis is pulled from Medical Records, the NUBC value that is mapped to the POA in the Present on Admission table is used for the POA assigned to the Medical Records diagnosis.

If there is no POA value for the diagnosis, the claim defaults to a U for Unknown for the POA indicator.

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

Enter the default POA value for outpatient diagnoses on inpatient claim (Y, N,U, W, E, 1)--

Entry options for the default value are:

- **Y** (Yes), the condition was present at the time of inpatient admission.

- **N** (No), the condition was not present at the time of inpatient admission.

- **U** (Unknown), the documentation is insufficient to determine if the condition was present at the time of inpatient admission.

- **W** (Clinically Undetermined), the provider is unable to clinically determine whether the condition was present at the time of inpatient admission.

- **1** (Exempt from POA Reporting), the condition is exempt from Present on Admission reporting. This is equivalent to a blank on the UB04 claim.

6. DPW ICD PROC TIMEFRAME (1-A-O)

This field can be accessed only if the DPW Med Info field is set to P for Procedures, B for Both Diagnoses and Procedures, or A for All. When the field is accessed, the following prompt is displayed:

Use FROM ICD proc's based on (A)ll Charges or (E)ntire DPW timeframe? (A/E)--

You have the following entry options:

- If an **A** for All Charges is entered, the system looks to the DPW Parameters screen and the All Chgs field. The system uses the number of days in this field and looks for any FROM outpatient/series accounts with ICD procedures in this timeframe, and uses them on the TO inpatient claim. For example, if the DPW Parameters screen has the All Chgs field set to Transfer/3, any FROM account ICD procedures that are within 3 days of the TO inpatient admission will be used on the To inpatient account's claim.

- If an **E** for Entire DPW timeframe is entered, the system looks to the DPW Parameters screen and the All Chgs, Eval Diag Chgs, and Eval Non-Diag Charges fields. The system uses the maximum number of days in any of the fields and looks for any FROM outpatient/series accounts with ICD procedures in this timeframe, and uses them on the TO inpatient claim. For example, if the DPW Parameters screen has the All Chgs field set to Transfer/3, the Eval Diag Chgs set to Report/7, and the Eval Non-Diag Chgs set to Report/7, then any FROM account ICD procedures that are within 7 days of the TO inpatient admission will be used on the To inpatient account's claim.

- If this field is left blank, the system will continue to look to the Bill From and Through Dates for the inpatient bill that loads the claim. Only FROM account ICD procedures that are within the TO account's Bill From and Through dates will load to the inpatient claim.

7. DPW EXCLUDE ICD9/ICD10 PROC (1-A-O)

This field is used to list those ICD Procedures on the From account that should not be used on the To account's claim, even if they fall within the To account's bill From and Through Dates that load the To account's claim and even if they fall within the To

account's DPW ICD procedures timeframe as outlined above in the DPW ICD Proc Timeframe field.

This field can only be accessed if the DPW Med Info is set to P for Procedures, B for Both Diagnoses and Procedures, or A for All.

If this field is left blank, all ICD Procedures on the From account are available to be used on the To account's claim.

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

Select ICD9 (I) for exclusion, ICD10 (T) for exclusion, do not exclude ICD9 (NI), or do not exclude ICD10 (NT)--

You have the following entry options:

- Enter **I** for ICD9, or **T** for ICD10. The system prompts as follows:

  Key List of Code/Code Ranges (e.g., 2001,2009-2039,2041), or Key Partial Procedure Code Followed by `-` to Select Codes from Table, or Key V to View/Edit/Add/Delete Codes-

  You can enter the codes directly as in the example in the prompt or key a partial procedure code lookup, such as 82- or 005- to see a list of codes starting with this number. When the list is displayed, one or many codes can be highlighted to be excluded. You can also enter.**V** (view, edit, add, or delete codes). The codes already entered as exclusions are displayed. Individual codes can be deleted by using the F4 Delete key. Individual codes can also be added by using the F3 Insert key, or by paging to the last screen of codes, hitting the down arrow or ENTER key, and adding a code on the new line. A table look up is allowed when adding individual codes. However, only one code can be selected from this table lookup. To select a range of codes, do a table lookup or partial table lookup with the above prompt (do not enter V), and select the range from the table.

  The system edits that the ICD codes are valid against either the ICD-9-CM list or the ICD-10-PCS list, depending on if the user accessed the screen for (I) ICD-9 or (T) ICD-10.

  The system prompts you to save the changes with the prompt:

  Record these changes? (Y/N)

  You must enter Y for Yes to record the changes.

- Enter **NI** for Do Not Exclude ICD-9 Procedures to clear any ICD-9 procedures previously entered.

- Enter **NT** for Do Not Exclude ICD-10 Procedures to clear any ICD-10 procedures previously entered.

8. USE ADM PRIN/SEC DX FOR COMBINE BILL/DPW MED INFO (1-A-O)
This field indicates whether, if there is no Principal and no Secondary Diagnoses in Medical Records on the FROM account for a Combine Bill or DPW-linked account, the Principal and Secondary Diagnosis information from Admissions should be used on the TO account's claim. When this field is accessed, the following prompt is displayed:

Use Admission Prin/Sec Dx for Med Info if no Med Recs Prin/Sec Dx for From Account (Y/N)--

If you enter **Y** for Yes, the system uses the diagnosis information from Admissions on the FROM account if the Combine Bill Med Info field is set to Diagnosis or Both Diagnosis and Procedure if a Combine Bill, and if the DPW Med Info field is set to Diagnosis or Both Diagnosis and Procedure if a DPW combined bill. If this field is set to Yes, but there is either a Principal or a Secondary diagnosis on the FROM account in Medical Records, the Admission diagnoses are not used. The Medical Records diagnoses on the FROM account are used. Admission diagnoses are used when there is no Principal and no Secondary diagnosis information on the FROM account. If you enter **N** for No, the system does not use the diagnosis information from Admissions.

In order to pull the Admission diagnosis information when there is no Medical Records diagnosis information, the following MR/ADM internal elements must be assigned to UB92 Locators 68-75 for the Secondary Diagnosis fields, UB04 Locator 67A-Q for the Secondary Diagnosis fields, and UB92 Locator 77 for the E Diagnosis code field, UB04 Locator 72A-C for the External Cause of Injury Diagnosis Code fields, on the UB Claim Load and Edit Parameter assigned to the TO account's insurance:

- Principal Diag Code (MR/ADM)
- Principal Diag Description (MR/ADM)
- Prin Diag Desc CH 19-36 (MR/ADM)

  This internal element prints characters 19-36 of the principal diagnosis description. If no principal diagnosis is available per logic using Medical Records, the Principal diagnosis from Admissions is used to pull the diagnosis description.

- Prin Diag(MR/ADM) or Adm Dx (MR/ADM)

  This internal element looks to the principal diagnosis in Medical Records. If there is no principal or secondary diagnoses in Medical Records, it uses the principal diagnosis in Admissions. If there is no principal diagnosis in Admissions, it uses the admitting diagnosis in Medical Records. If there is no admitting diagnosis in Medical Records, it uses the admitting diagnosis in Admissions.

- Prin (MR/ADM) or Working Diag Code

  If there is no principal diagnosis available per logic using Medical Records or Admissions diagnosis information, the working diagnosis is used.

- Prin (MR/ADM) or Working Diag Desc

  If no principal diagnosis is available per logic using Medical Records or Admissions diagnosis information, the working diagnosis description is used.

- Prin or Admit Diag Code (MR/ADM)

  If no principal diagnosis is available per logic using Medical Records, and there are no secondary diagnoses in Medical Records, the Principal diagnosis in Admissions is used. If there is no principal diagnosis in Admissions, the admitting diagnosis in Admission is used. This internal element does not look to Medical Records for the admitting diagnosis.

- Prin or Admit Diag Desc (MR/ADM)

  If no principal diagnosis description is available per logic using Medical Records, the admitting diagnosis description in Medical Record is used. If there is no admitting diagnosis description in Medical Records, the admitting diagnosis description from Admissions is used.

- Secondary Diag Code (MR/ADM)

  For the secondary diagnosis, if there is no Principal or Secondary diagnosis information in Medical Records, the Secondary diagnosis from Admissions is used.

For the Other diagnosis internal elements below, if there is no Principal or Other (Secondary) diagnosis information in Medical Records, the Secondary diagnosis from Admissions is used.

- Other Diag Code 2 (MR/ADM)
- Other Diag Code 3 (MR/ADM)
- Other Diag Code 4 (MR/ADM)
- Other Diag Code 5 (MR/ADM)
- Other Diag Code 6 (MR/ADM)
- Other Diag Code 7 (MR/ADM)
- Other Diag Code 8 (MR/ADM)
- Other Diag Code 9 (MR/ADM)
- Other Diag Code 10 (MR/ADM)
- Other Diag Code 11 (MR/ADM)

- Other Diag Code 12 (MR/ADM)
- Other Diag Code 13 (MR/ADM)
- Other Diag Code 14 (MR/ADM)
- Other Diag Code 15 (MR/ADM)
- Other Diag Code 16 (MR/ADM)
- Other Diag Description 1 (MR/ADM)
- Other Diag Description 2 (MR/ADM)
- Other Diag Description 3 (MR/ADM)
- Other Diag Description 4 (MR/ADM)
- Other Diag 1 Desc Ch 19-36 (MR/ADM)

  This internal element prints characters 19-36 of the other 1 (secondary) diagnosis description. If no other 1 (secondary) diagnosis is available per logic using Medical Records, the Other 1 (secondary) diagnosis from Admissions is used to pull the diagnosis description.

- ECode Diag Code (MR/ADM)

  For the ECode Diag Code, the ECode is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. The first E code found is used if there is more than one E code for the account. The system searches for an E code from admissions until all secondary (UB92 locators 68-75) are filled. Once the secondary diagnosis positions are filled, the system does not continue to search for an E code on any remaining secondary diagnosis codes.

- Ext Cause of Injury DX Code 1 (MR/ADM-UB04)

  For the Ext Cause Inj DX CD 1 (MR/ADM-UB04), the External Cause of Injury Code is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. For Internal Element EXT CAUSE INJ DX CD 1 (MR/ADM-UB04), the first External Cause of Injury code found is used, if there is more than one code for the account. This External Cause of Injury Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For ICD-9 diagnosis codes, external cause of injury codes start with the letter "E". However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98.

- Ext Cause Inj DX CD 2 (MR/ADM-UB04)

For the Ext Cause Inj DX CD 2 (MR/ADM-UB04), the External Cause of Injury Code is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. For Internal Element EXT CAUSE INJ DX CD 2 (MR/ADM-UB04), the second External Cause of Injury code found is used, if there is more than one code for the account. This External Cause of Injury Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For ICD-9 diagnosis codes, external cause of injury codes start with the letter "E". However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98.

- Ext Cause Inj DX CD 3 (MR/ADM-UB04)

  For the Ext Cause Inj DX CD 3 (MR/ADM-UB04), the External Cause of Injury Code is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. For Internal Element EXT CAUSE INJ DX CD 3 (MR/ADM-UB04), the third External Cause of Injury code found is used, if there is more than one code for the account. This External Cause of Injury Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For ICD-9 diagnosis codes, external cause of injury codes start with the letter "E". However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98.

18. USE ADM PRIN/SEC DX FOR COMBINE BILL/DPW MED INFO (1-A-O)
This field indicates whether, if there is no Principal and no Secondary Diagnoses in Medical Records on the FROM account for a Combine Bill or DPW-linked account, the Principal and Secondary Diagnosis information from Admissions should be used on the TO account's claim. When this field is accessed, the following prompt is displayed:

Use Admission Prin/Sec Dx for Med Info if no Med Recs Prin/Sec Dx for From Account (Y/N)--

If you enter **Y** for Yes, the system uses the diagnosis information from Admissions on the FROM account if the Combine Bill Med Info field is set to Diagnosis or Both Diagnosis and Procedure if a Combine Bill, and if the DPW Med Info field is set to Diagnosis or Both Diagnosis and Procedure if a DPW combined bill. If this field is set to Yes, but there is either a Principal or a Secondary diagnosis on the FROM account in Medical Records, the Admission diagnoses are not used. The Medical Records diagnoses on the FROM account are used. Admission diagnoses are used when there is no Principal and no Secondary diagnosis information on the FROM account. If you enter **N** for No, the system does not use the diagnosis information from Admissions.

In order to pull the Admission diagnosis information when there is no Medical Records diagnosis information, the following MR/ADM internal elements must be assigned to UB92 Locators 68-75 for the Secondary Diagnosis fields, UB04 Locator 67A-Q for the Secondary Diagnosis fields, and UB92 Locator 77 for the E Diagnosis code field, UB04 Locator 72A-C for the External Cause of Injury Diagnosis Code fields, on the UB Claim Load and Edit Parameter assigned to the TO account's insurance:

- Principal Diag Code (MR/ADM)
- Principal Diag Description (MR/ADM)
- Prin Diag Desc CH 19-36 (MR/ADM)

  This internal element prints characters 19-36 of the principal diagnosis description. If no principal diagnosis is available per logic using Medical Records, the Principal diagnosis from Admissions is used to pull the diagnosis description.

- Prin Diag(MR/ADM) or Adm Dx (MR/ADM)

  This internal element looks to the principal diagnosis in Medical Records. If there is no principal or secondary diagnoses in Medical Records, it uses the principal diagnosis in Admissions. If there is no principal diagnosis in Admissions, it uses the admitting diagnosis in Medical Records. If there is no admitting diagnosis in Medical Records, it uses the admitting diagnosis in Admissions.

- Prin (MR/ADM) or Working Diag Code

  If there is no principal diagnosis available per logic using Medical Records or Admissions diagnosis information, the working diagnosis is used.

- Prin (MR/ADM) or Working Diag Desc

  If no principal diagnosis is available per logic using Medical Records or Admissions diagnosis information, the working diagnosis description is used.

- Prin or Admit Diag Code (MR/ADM)

  If no principal diagnosis is available per logic using Medical Records, and there are no secondary diagnoses in Medical Records, the Principal diagnosis in Admissions is used. If there is no principal diagnosis in Admissions, the admitting diagnosis in Admission is used. This internal element does not look to Medical Records for the admitting diagnosis.

- Prin or Admit Diag Desc (MR/ADM)

  If no principal diagnosis description is available per logic using Medical Records, the admitting diagnosis description in Medical Record is used. If there is no admitting diagnosis description in Medical Records, the admitting diagnosis description from Admissions is used.

- Secondary Diag Code (MR/ADM)

  For the secondary diagnosis, if there is no Principal or Secondary diagnosis information in Medical Records, the Secondary diagnosis from Admissions is used.

For the Other diagnosis internal elements below, if there is no Principal or Other (Secondary) diagnosis information in Medical Records, the Secondary diagnosis from Admissions is used.

- Other Diag Code 2 (MR/ADM)
- Other Diag Code 3 (MR/ADM)
- Other Diag Code 4 (MR/ADM)
- Other Diag Code 5 (MR/ADM)
- Other Diag Code 6 (MR/ADM)
- Other Diag Code 7 (MR/ADM)
- Other Diag Code 8 (MR/ADM)
- Other Diag Code 9 (MR/ADM)
- Other Diag Code 10 (MR/ADM)
- Other Diag Code 11 (MR/ADM)
- Other Diag Code 12 (MR/ADM)
- Other Diag Code 13 (MR/ADM)
- Other Diag Code 14 (MR/ADM)
- Other Diag Code 15 (MR/ADM)
- Other Diag Code 16 (MR/ADM)
- Other Diag Description 1 (MR/ADM)
- Other Diag Description 2 (MR/ADM)
- Other Diag Description 3 (MR/ADM)
- Other Diag Description 4 (MR/ADM)
- Other Diag 1 Desc Ch 19-36 (MR/ADM)

  This internal element prints characters 19-36 of the other 1 (secondary) diagnosis description. If no other 1 (secondary) diagnosis is available per logic using Medical Records, the Other 1 (secondary) diagnosis from Admissions is used to pull the diagnosis description.

- ECode Diag Code (MR/ADM)

  For the ECode Diag Code, the ECode is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. The first E code found is used if there is more than one E code for the account. The system searches for an E code from admissions until all secondary (UB92 locators 68-75) are filled. Once the secondary diagnosis positions are filled, the system does not continue to search for an E code on any remaining secondary diagnosis codes.

- Ext Cause of Injury DX Code 1 (MR/ADM-UB04)

  For the Ext Cause Inj DX CD 1 (MR/ADM-UB04), the External Cause of Injury Code is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. For Internal Element EXT CAUSE INJ DX CD 1 (MR/ADM-UB04), the first External Cause of Injury code found is used, if there is more than one code for the account. This External Cause of Injury Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For ICD-9 diagnosis codes, external cause of injury codes start with the letter "E". However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98.

- Ext Cause Inj DX CD 2 (MR/ADM-UB04)

  For the Ext Cause Inj DX CD 2 (MR/ADM-UB04), the External Cause of Injury Code is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. For Internal Element EXT CAUSE INJ DX CD 2 (MR/ADM-UB04), the second External Cause of Injury code found is used, if there is more than one code for the account. This External Cause of Injury Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For ICD-9 diagnosis codes, external cause of injury codes start with the letter "E". However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98.

- Ext Cause Inj DX CD 3 (MR/ADM-UB04)

  For the Ext Cause Inj DX CD 3 (MR/ADM-UB04), the External Cause of Injury Code is selected from secondary diagnoses from admission information only if no principal and no secondary diagnoses exist in Medical Records. For Internal Element EXT CAUSE INJ DX CD 3 (MR/ADM-UB04), the third External Cause of Injury code found is used, if there is more than one code for the account. This External Cause of Injury Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For ICD-9 diagnosis codes, external cause of injury codes start with the letter "E". However, for ICD-10 diagnosis codes, external cause of injury codes are in the range of V01-Y98.

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 on the claim forms. For a list of locators, see “UB AND 1500 CLAIM FORM LOCATOR SCREENS” on page 3-154.

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. For example, six fields are identified for the claim form locator *Provider Information* for the UB, while a single field is identified for the claim form locator *Admission Date.*

All Claim Types

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

This is a sample of the UB claim form locator number 1.

```
          General Hospital Claim Load and Edit Parameters Processor
                                                Fri Jun 01, 2007 04:00 pm
Claim Parameters: 1 UB MEDICARE I/P-UB04
Claim Locator   : 1 PROVIDER INFORMATION
 1 Field #      2 Description                          3 Required?     4 Print?
   1              Provider Name                          Yes             Yes
 5 Form Row     6 Form Column            7 Form Length        8 Field Type
   2              4                        24                   X Alphanumeric
 9 Valid Entries                        10 Default Value

11 Internal Element                     12 Set Up Routine
   UB PROVIDER CLAIM NAME
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 1 for Provider Information contains eight fields dealing with the provider on the UB claim form. The field Provider Name is the first field definition in this locator group and is assigned #1 by the system. This field is set up by McKesson.

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

NOTE: For the 1500 Claim Master and the Non Pro Fee 1500 Claim Master, this field includes a locator number at the end of the description in the format *FL #* where *FL* is Form Locator and # is the form locator number.

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. This field enables the hospital to set up exception criteria.

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

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

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

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

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

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

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

9. VALID ENTRIES (2-A-O)
This field enables the hospital to indicate the values accepted by the carrier for this form locator. The system edits a claim having valid values set up against these fields and, if a match is not found, an error is generated for the patient's claim.

An example of valid values could be used for Occurrence codes. All valid Occurrence codes are set up in the Occurrence code table. If a carrier does not allow certain Occurrence codes to be used, the valid codes for this parameter can be entered. If a value that is not included in this field exists for the patient, an error occurs for the claim.

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 first and second digit of the bill type. It can also be used when the hospital always wants a certain value loaded, such as *Yes* to *Insurance Benefits Assigned*.

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. For example, on the McKesson claim master, the principal diagnosis code (form locator 67 on the UB04) was taken from the medical record abstract. You can keep this element or change it to the admitting or working diagnosis code element.

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 you enter DOCTOR UPIN # in the Internal Element field so that the doctor's UPIN number loads and prints in form locator 78 on the UB04, the system prompts you to select the type of doctor. You can enter a hyphen (-) to display a list of your choices. In the example here, you can select attending, admitting, referring, primary procedure, primary care, ER, shared care, or the referring, if not the attending physician, 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.

Upon exiting the Claim Load and Parameter screen, the system displays the following prompt:

Do you want a printed list (Y/N) [N] -

If you enter Yes, and the Claim Load Edit Parameter is for a UB (claim type X), a 1500 (claim type B), or a Non Pro Fee 1500 (claim type Z), the system displays one of the following prompts:

For a UB claim type:

Print UB92 Legacy Format (L), Print UB04 Revised Format (R), or Both (B)? (L/R/B) [R] -

You can enter **L** (Legacy Format) to print the UB92 Legacy Format, **R** (UB04 Revised Format) to print the UB04 Revised Format or **B** (Both) to print both formats. All claim load and edit parameter reports spool to FCRCP without a facility indicator.

For a 1500 or Non Pro Fee 1500 claim type:

Print 1992 Legacy Format (L), Print 08/05 Revised Format (R), or Both (B)? (L/R/B) [R] --

You can enter **L** (Legacy Format) to print the 1992 Legacy Format, **R** to print the 08/05 Revised Format or **B** (Both) to print both formats. All claim load and edit parameter reports spool to FCRCP without a facility indicator.

UB AND 1500 CLAIM FORM LOCATOR SCREENS

The system presents the following screens for you to use in defining claim locators for the UB claims, in the UB04 format:

```
          General Hospital Claim Load and Edit Parameters Processor
                                                 Fri Jun 01, 2007 04:00 pm
Claim Parameters: 54 UB COPY MASTER-UB04
Page:01                          Claim Locators
( 1) 1-PROVIDER INFORMATION              (17) 17-DISCHARGE PATIENT STATUS
( 2) 2-PAY TO INFORMATION                (18) 18-CONDITION CODE 1
( 3) 3-PATIENT ID'S                      (19) 19-CONDITION CODE 2
( 4) 4-TYPE OF BILL                      (20) 20-CONDITION CODE 3
( 5) 5-FEDERAL TAX ID                    (21) 21-CONDITION CODE 4
( 6) 6-STATEMENT COVERS PERIOD           (22) 22-CONDITION CODE 5
( 7) 7-RESERVED BY NUBC                  (23) 23-CONDITION CODE 6
( 8) 8-PATIENT ID AND NAME               (24) 24-CONDITION CODE 7
( 9) 9-PATIENT ADDRESS                   (25) 25-CONDITION CODE 8
(10) 10-PATIENT BIRTHDATE                (26) 26-CONDITION CODE 9
(11) 11-PATIENT SEX                      (27) 27-CONDITION CODE 10
(12) 12-ADMISSION DATE                   (28) 28-CONDITION CODE 11
(13) 13-ADMISSION HOUR                   (29) 29-ACCIDENT STATE
(14) 14-ADMISSION TYPE                   (30) 30-RESERVED BY NUBC
(15) 15-ADMISSION SOURCE                 (31) 31-OCCURRENCE INFORMATION 31
(16) 16-DISCHARGE HOUR                   (32) 32-OCCURRENCE CODE 32

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

```
      General Hospital Claim Load and Edit Parameters Processor
                                                 Fri Jun 01, 2007 04:00 pm
Claim Parameters: 54 UB COPY MASTER-UB04
Page:02                          Claim Locators
( 1) 33-OCCURRENCE CODE 33               (17) 57-OTHER PROVIDER ID'S
( 2) 34-OCCURRENCE CODE 34               (18) 58-INSURED'S NAME INFORMATION
( 3) 35-OCCURRENCE SPAN INFORMATION 35   (19) 59-PATIENT'S RELATION TO INSURED
( 4) 36-OCCURRENCE SPAN INFORMATION 36   (20) 60-CERT/SSN/HIC/ID NO
( 5) 37-RESERVED BY NUBC                 (21) 61-GROUP NAME INFORMATION
( 6) 38-GUARANTOR INFORMATION            (22) 62-INSURANCE GROUP NUMBER INFORMA
( 7) 39-VALUE CODE INFORMATION 39        (23) 63-TREATMENT AUTHORIZATION CODE
( 8) 40-VALUE CODE INFORMATION 40        (24) 64-DOCUMENT CONTROL NUMBER
( 9) 41-VALUE CODE INFORMATION 41        (25) 65-EMPLOYER NAME INFORMATION
(10) 50-PAYER NAME                       (26) 66-PROCEDURE CODING METHOD
(11) 51-HEALTH PLAN ID                   (27) 67-DIAGNOSIS CODES
(12) 52-PAYER RELEASE INFORMATION        (28) 68-RESERVED BY NUBC
(13) 53-PAYER BENEFITS ASSIGNED          (29) 69-ADMIT DIAGNOSIS CODE
(14) 54-PRIOR PAYMENTS                   (30) 70-PATIENT REASON FOR VISIT
(15) 55-ESTIMATED AMOUNT DUE             (31) 71-PPS CODE
(16) 56-PROVIDER NPI                     (32) 72-EXTERNAL CAUSE OF INJURY CODES

Enter choice--
```

```
      General Hospital Claim Load and Edit Parameters Processor
                                                Fri Jun 01, 2007 04:00 pm
Claim Parameters: 54 UB COPY MASTER-UB04
Page:03                        Claim Locators
( 1) 73-RESERVED BY NUBC
( 2) 74-PROCEDURE CODE INFORMATION
( 3) 75-RESERVED BY NUBC
( 4) 76-ATTENDING PHYSICIAN INFORMATIO
( 5) 77-OPERATING PHYSICIAN INFORMATIO
( 6) 78-OTHER PHYSICIAN LOC 78 INFO
( 7) 79-OTHER PHYSICIAN LOC 79 INFO
( 8) 80-REMARKS INFORMATION
( 9) 81-CODE-CODE OVERFLOW INFORMATION









Enter choice--
```

The system presents the following screens for you to use in defining claim locators for Professional Fee 1500 Claim Forms and Non Professional Fee 1500 Claim Forms in the 08/05 Format.

```
        General Hospital Claim Load and Edit Parameters Processor
                                                Fri Jun 01, 2007 04:00 pm
Claim Parameters: 99 Medicare Pro Fee

Page:01                        Claim Locators
( 1) 0-INSURANCE ADDRESS INFORMATION     (17) 16-DISABILITY DATES
( 2) 1-APPLICABLE PROGRAM                (18) 17-REFER PHYSICIAN NAME
( 3) 2-PATIENT NAME                      (19) 18-DATES OF HOSPITALIZATION
( 4) 3-PATIENT'S BIRTHDATE               (20) 19-RESERVED FOR LOCAL USE
( 5) 4-INSURED'S NAME                    (21) 20-OUTSIDE LAB WORK
( 6) 5-PATIENT'S ADDRESS                 (22) 21-DIAGNOSIS INFORMATION
( 7) 6-PATIENT'S REL TO INSURED          (23) 22-MEDICAID RESUBMISSION INFORMAT
( 8) 7-INSURED'S ADDRESS                 (24) 23-PRIOR AUTHORIZATION
( 9) 8-PATIENT STATUS                    (25) 25-FEDERAL TAX ID NUMBER
(10) 9-OTHER HEALTH INS COVERAGE         (26) 26-PATIENT ACCOUNT NUMBER
(11) 10-EMPLOYMENT/ACCIDENT RELATED      (27) 27-ACCEPT ASSIGNMENT IND
(12) 11-INSURED'S COVERAGE               (28) 28-TOTAL CHARGES
(13) 12-PATIENT SIGNATURE                (29) 29-AMOUNT PAID
(14) 13-PAYMENT AUTHORIZATION            (30) 30-BALANCE DUE
(15) 14-DATE OF ONSET OF SYMPTOMS        (31) 31-PHYSICIAN SIGNATURE
(16) 15-PREVIOUS CONDITION DATE          (32) 32-FACILITY NAME & ADDRESS



Enter choice--
```

```
         General Hospital Claim Load and Edit Parameters Processor
                                                  Fri Jun 01, 2007 04:00 pm
Claim Parameters: 99 Medicare Pro Fee

Page:02                          Claim Locators
( 1) 33-SUPPLIER NAME & ADDR
( 2) 34-REMARKS









Enter choice--
                              previous pg(/P or PG UP)
```

When you complete the fields on these screens, the system gives you the option of accepting or editing the information entered. Once the screen is accepted, the system displays the list of field definitions included in the claim form locator selected. You can select another field definition to edit (if there are multiple fields), select another claim form locator to edit, or exit the transaction.

Before you exit the transaction, the system gives you the Yes/No option of regenerating the appropriate claims programs to reflect the changes made. If you enter Y, the system updates the programs and completes the transaction. A response of N (no) holds the changes but does not generate the new claims programs. The changes you made are not effective until you regenerate.

Dependent On	Reference
Internal Elements	Insurance Plan Coverage Master
Claim Masters	

UB CHARGE CONTROL PARAMETERS

The UB Charge Control Parameters define how charges load on the UB claim form, in both the UB92 and UB04 formats of the claim.

NOTE: When a UB claim loads, either in Midnight Processing or the Instant Adjustment Bill or Add Claim to Insurance functions, the system determines if the claim loaded in the UB92 Format or in the UB04 Format. This is controlled by the Begin Date for the UB04 format in the hospital-defined UB Claim Load and Edit Parameters. If the Begin Date for the UB04 Format of the Claim Load and Edit Parameter is today or a date in the past, the claim loads in the UB04 Format, and the charge data is in the UB04 Format as defined on the UB Charge Control Parameters, as described below. The Claim Format is displayed for the claim when accessing the Claim Status Information screen within Claims Management, and field 4 for Claim Format.

There are multiple parts to setting up this table.

- Overall Settings—The first part of the parameter defines the overall settings for the Charge Control parameter. The UB Charge Control Processor (screen 1) is used to define these settings.

- Defaults—The second part of the parameter defines the default parameters associated with loading charges for UB revenue codes that do not exist in this parameter. For example, if a new UB revenue code is added to the UB Revenue Code table, and this parameter is not updated, default fields indicate how this new undefined revenue code is processed. The UB Charge Control Processor (Screen 2) is used to define these settings.

- Detailed Revenue Code Setups—The third part of the parameter indicates how the charges for individual UB revenue codes are loaded, or not loaded, for those UB claims assigned to this parameter. The UB Charge Control Processor (Screen 3) is used to define how charges are loaded.

- SIM Item Exclusions—The fourth part of the parameter allows you to enter SIM Item exclusions. SIM Item Exclusions enable you to define specific SIM items which do not print on the UB claim form.

- FIM Item Modifications—The fifth part of the parameter allows you to enter FIM Item Modifications. FIM Item Modifications enable you to change the UB Revenue Code which is used on the UB for specific FIM items.

- Loading FIM Items with Zero Dollar Charges—The sixth part of the parameter allows you to define specific FIM items that have zero dollars in charges associated with them that should load to the UB claim form.

After you select the UB Charge Control Parameters menu option, the system prompts you to enter a UB charge control code. You can enter the code or a hyphen (-) to display a list of the valid codes.

If a new parameter code is entered, the system displays the following prompt:

Add UB charge control code 'xx'? (Y/N) [N] --

XX indicates the new parameter code. If you answer Y for yes to this prompt, the system displays the following prompt:

Copy charge control information from another parameter? (Y/N) [N] --

When copying from another parameter, the overall settings and the default settings are always copied to the new parameter. This screen allows you to select additional information to copy to the new parameter. The required fields must then be completed for the new parameter, such as the parameter description, and the new parameter must be accepted.

If you answer Y for Yes to this prompt, the system displays the following prompt:

Enter parameter to copy from or '-' for a list --

Once a parameter is entered, the system prompts you to indicate what information to copy.

(1) UB Revenue Code Setup
(2) SIM Exclusions
(3) FIM Modifications
Enter choices (e.g. 1, 7, 5-9) or '-' choices to remove --

If you are adding or editing a parameter, the system displays the following screen:

```
                General Hospital UB Charge Control Processor
                                                Tue Aug 7, 2012 12:21 pm

 1 Code  2 Description                          3 Summarize By        4 EC2000
   43      MEDICARE OUTPATIENT                    Srv Date/No Supp      Claim
 5 Edit Room Chgs?          6 HCPCS Cross Reference     7 Prin Proc Rev Code
   No                         02 - HCPCS CROSS REFE       1 - MEDICARE PRINCIPA
 8 M/R HCPCS UB Rev Code    9 Print Non-Covered Chgs?  10 Non Cvd Separate Line
   1 - MEDICARE MED RECS      See Entries Defined         No
11 Comb Pro Fees? 12 001/0001 Total Rev Code & Desc 13 Total First? 14 NY Claim
   No               0001-TOTAL CHARGES                No
15 Use RX Qty?    16 I/P Rehab 17 Edit Chg Srv Dates?  18 Zero Fill UB Rev Cd?
   Yes               No           No                     Yes
19 Reference Facility  20 RF Rev Codes                  21 Exclude ABN Self Pay?
   No                                                      See Entries Defined
22 IDE Code 23 IDE Rev Codes   24 Edit Unused MR HCPCS 25 Edit MR HCPCS Rev Cd
   No                             Yes                     All
26 Unused Med Rec HCPCS Prim or Prim/Split   27 Earliest Serv Date UB Rev Codes
   Primary and Split
28 Req Rev Codes                             29 Addtl Chg Srv Date Edits?
                                                Chg<AdmDt,Chg>DisDt,ChgStmt



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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the user defined code identifying the UB charge control parameter.

2. DESCRIPTION (30-C-R)
This field contains the user defined description of the UB charge control parameter.

3. SUMMARIZE BY (1-A-R)
This field indicates how the charge detail on the UB claim is summarized.

If the field is set to UB Code, and the system loads split claims, the following applies:

- If the claim charge line has the HCPCS Procedure field set to M for Medical Records, S for Both/Summary, or N for None, the system adds up the claim charge totals instead of looking to the proration information for the revenue code. This is needed in situations where a portion of what would have printed on this charge line is directed to a split claim.

- The Primary claim can load all types of Non Covered amounts, including Proration Non Covered. However, if the Non Covered amount for the claim charge line is greater than the Total Charges amount for the claim charge line, the Non Covered amount is set to the Total Charges amount.

Regardless of the setting of the Summarize By field:

- The system does not print Proration Non Covered amounts for the split claims. Therefore, if the Print Non-Covered Chgs field is set to load Proration Non Covered (which includes Proration Summary Codes set to Not Covered in the Summary Codes Exception screen of the insurance, Days Before Coverage Begins from the Basic Coverage screen of the insurance, Days Coverage Active from the Basic Coverage screen of the insurance, or Professional Fees when the field Professional Fee Coverage is set to Exclude on the Basic Coverage Screen of the insurance), this non-covered amount does not print. All other Non Covered charge types are allowed (ABN Non Covered, Duplicate HCPCS, Component/ Comprehensive HCPCS Conflict, Mutually Exclusive HCPCS Conflict).

- When loading split claims, care should be taken when loading information that is derived from proration. For example, Covered and Non Covered Days are derived from proration and can print as Value Code 80 for Covered Days and Value Code 81 for Non Covered Days (on the UB04 format). Since this information is at the account level, there is no way for the system to split the information between the primary and split claims. In most cases, you would not want information from proration printing on a split claim. Therefore, an Alternate Claim Load and Edit Parameter can be assigned to the split claims, and this data should not be set to load.

Entry options are **S** - revenue code within service date, **R** - service date within revenue code, or **U** - UB code; the default is U. If you enter S for revenue code within service date, or R for service date within revenue code, the service date for each charge line prints in Locator 45, Serv Date, of the UB claim. If you enter U for UB code, the service date only prints for UB revenue codes that have the Date field set to Use or Edit (Yes). After answering the Summarize By field with either an S for revenue code within service date, an R for service date within revenue code, or a U for UB code, the system displays the following prompt:

Suppress service date if no HCPCS is present? (Y/N) [N]--

If answered with a Yes, charge lines on the claim with no HCPCS Code and no procedure code error have the service date removed. If the charge line has a procedure code error, the service date is not removed, since it is assumed that the charge line has a HCPCS code, once corrected. This affects charge lines printing either FIM/Charge HCPCS, or Medical Records HCPCS.

NOTE: If the charge line does not have a procedure code error, and a HCPCS code is keyed into the HCPCS field for the claim, you have to key in the service date since this would have already been suppressed by the system.

When loading the service date in Locator 45 of the UB (using either the S or R option or the U option where the Date field is set to Use or Yes), the Medical Records HCPCS date must match the date of service on the claim charge line in order to load to the claim. If you enter U for UB code, the service date only prints for revenue codes that have the Date field set to Yes or Use. If the HCPCS code is not required, and there is no Medical Records HCPCS for that date, and the date is suppressed from the claim

based on the Summarize By field, the system does not pull in Medical Records HCPCS coded after the claim was loaded when accessing the Claim Charge Data Screen, or when the claim is reloaded via the Claim Reload Optional batch job. SIM Exceptions and FIM Modifications (discussed below) are allowed with UB claims by revenue code within service date, service date within revenue code, and UB claims by UB code. Once the Summarize By field is answered, the field has one of the following: Srv Date/ Supp, Srv Date/No Supp, Srv in Rev/Supp, Srv in Rev/No Supp, UB Code/Supp, UB Code/No Supp; the default is UB Code/No Supp.

As an example, if the patient had two physical therapy treatments during the month and also had lab tests done during those treatments, the claim would print as follows:

By Revenue Code within Service Date (S):

UB Revenue Code	Serv Date	Units	Total Charges
300 Laboratory	11/15/00	1	30.00
420 Physical Therapy	11/15/00	1	50.00
300 Laboratory	11/20/00	1	30.00
420 Physical Therapy	11/20/00	1	50.00

By Service Date within Revenue Code (R):

UB Revenue Code	Serv Date	Units	Total Charges
300 Laboratory	11/15/00	1	30.00
300 Laboratory	11/20/00	1	30.00
420 Physical Therapy	11/15/00	1	50.00
420 Physical Therapy	11/20/00	1	50.00

By UB Revenue Code (U):

UB Revenue Code	Serv Date	Units	Total Charges
300 Laboratory		2	60.00
420 Physical Therapy		2	100.00

4. ECS CHG (1-A-O)

This field indicates whether the account or claim level charges should be sent to EC2000 CA. When you access this field, the following prompt displays:

Send (A)ccount or (C)laim level charges to Elec Claim System? [A]

Entry options are **A** for Account or **C** for Claim; the default is A for account.

- If this field is set to Claim, meaning send charges to the Electronic Claim System Interface from the claim level, and if the NDC field is blank or set to No, the system cannot send the appropriate NDC Code to E2000 or the Data Extract. Therefore, if the NDC information is required for this payor, the ECS Chg field should be set to Claim, and the NDC code field should be set to Yes, and either specific revenue codes listed, or A for All codes.

- If this field is set to Account, meaning send charges to EC2000 from the account level, NDC information for the charges at the account level are also sent to EC2000.

- If the field is set to Account, if the UB, 1500, or Non Pro Fee 1500 has a non-blank Claim Split Indicator (for a UB, the Claim Split Indicator is Primary or a split name, and for the 1500/Non Pro Fee 1500, the Claim Split Indicator is either a Physician or a Department), the charges are sent from the account level. However, only the charges that initially loaded to the particular claim are sent. For example, if a UB insurance loads a Primary and a Therapy UB claim, the charges that loaded to the Primary claim only are sent for that claim sequence, and the charges that loaded to the Therapy claim only are sent for that claim sequence. This prevents duplicate charges from being sent on more than one claim. The charges still are sent from the account. Therefore, no claim charge modifications are reflected.

- If the field is set to Claim, the charges from the claim level are sent to EC2000. Therefore, claim charge modifications will be reflected.

5. EDIT ROOM CHGS? (1-A-R)

This field indicates whether the UB claim is edited to determine if the total covered days plus the non covered days equal the room and bed charges on the claim. Entry options are **Y** for Yes or **N** for No; the default is **N**. Covered days are in Locator 7 and non-covered days are in Locator 8 of the UB92 claim format, and can load as Value Code 80 for Covered Days and Value Code 81 for Non Covered Days on the UB04. If a **Y** for Yes is entered, the following prompt is displayed:

UB Room & Bed Revenue Codes to exclude (nnnn,nnnn) or '-' for lookup--

To the right of the prompt, enter the room and bed UB revenue codes that you want to exclude from the edit. You can also enter a hyphen (-) for a list of the UB revenue codes in the UB Revenue Code Table. Select the UB revenue codes to exclude from the edit. Codes already selected to be excluded are highlighted by the system. The outpatient room and bed revenue codes should be listed. If the field is answered with a Yes, but no UB revenue codes are specified to edit, the system edits all room and bed charges, including any outpatient room and bed charges, against the total covered and non covered days. If this field is set to Yes to edit, and for the UB04 there is no Value Code 80 (Covered Days) and/or Value Code 81 (Non Covered Days), the claim sets the missing value code to equal days of 0, and if the units on the room charges do not equal the total of Value Code 80 + Value Code 81, the claim fails the room unit error. If the claim fails for the number of room charges, the error appears as a Room Units Error on the Claim Charge screen. To correct the error, you can: a) manually enter the missing room charges in the Claim Charge Data screen of the claim and Manually Release the claim, b) charge the missing room and bed charges and request an adjustment bill and claims, c) edit the number of units for the existing room charges on the claim, or d) edit the covered and non covered days fields on the UB92 or the Covered Days Value Code 80 and Non Covered Days Value Code 81 on the UB04 so that the days match the number of units. Once the days or the units are updated, you must access the Claim Charge Data screen in Claims Management and accept the

screen in order for the error to be cleared. This field should only be set to Yes for your inpatient charge control parameters.

6. HCPCS CROSS REFERENCE (2-N-O)
This field indicates whether a Payer HCPCS Cross Reference Table should be used in conjunction with this charge control parameter. The Payer HCPCS Cross Reference Table is used to point both FIM/Charge HCPCS codes and Medical Records HCPCS codes to Alternate HCPCS codes to use on the UB claim form for the payer. When the HCPCS code is encountered on a charge for the payer, the alternate HCPCS code loads and prints on the UB claim form. McKesson does not recommend that you enter HCPCS codes that are coded by Medical Records into the HCPCS Cross Reference Table. HCPCS codes created through the HCPCS Summarization Master (lab charges) do not print an alternate HCPCS Code on the claim. The Payer HCPCS Cross Reference Table only affects the UB claim forms, and does not affect the patient bill.

7. PRIN PROC REV CODE (TABLE LOOKUP)
This field indicates whether a Principal Procedure Revenue Code Table should be used in conjunction with this charge control parameter. The Principal Procedure Revenue Code Table contains the UB Revenue Codes that require an ICD Procedure Code and Date in Locator 80 of the UB92 claim form or in Locator 74 of the UB04 claim form. This table is further detailed in the “PRINCIPAL PROCEDURE REVENUE CODE TABLE (US Only)” on page 3-318 in this chapter.

8. M/R HCPCS UB REV CODE (5-N-O)
This field indicates whether a Medical Records HCPCS UB Revenue Code Table should be used in conjunction with this charge control parameter. You are prompted to enter the Medical Records HCPCS UB Revenue Table code or enter a hyphen (-) for a table lookup. This table is used to enhance the matching of Medical Record HCPCS to charges on a UB claim form. Ranges of UB revenue codes can be defined for use in matching the Medical Records HCPCS UB revenue code to the charge line on the UB. Using the specified range, the system includes HCPCS on the UB claim even if there is not an exact match between the charge’s UB revenue code loading on the claim and the Medical Records HCPCS UB revenue code. Once a Medical Records HCPCS is used for that service date, it is not used for another revenue code on the same service date. The system loads Medical Records HCPCS for the claim using the following hierarchy:

1) Revenue codes with the HCPCS Procedure field set to Medical Records that have a direct match to the Medical Records HCPCS UB revenue code.

2) Revenue codes with the HCPCS Procedure field set to Both/Summary that have a direct match to the Medical Records HCPCS UB revenue code.

3) Revenue codes with the HCPCS Procedure field set to Both/Detail that have a direct match to the Medical Records HCPCS UB revenue code.

4) Revenue codes with the HCPCS Procedure field set to Override that have a direct match to the Medical Records HCPCS UB revenue code.

5) Revenue codes with the HCPCS Procedure field set to Charge/Default Medical Records that have a direct match to the Medical Records HCPCS UB revenue code.

6) Revenue codes with the HCPCS Procedure field set to Medical Records that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

7) Revenue codes with the HCPCS Procedure field set to Both/Summary that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

8) Revenue codes with the HCPCS Procedure field set to Both/Detail that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

9) Revenue codes with the HCPCS Procedure field set to Override that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

10) Revenue codes with the HCPCS Procedure field set to Charge/Default Medical Records that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

For example, revenue codes 361 and 762 both have the range 360-769. Medical Records HCPCS 11111 and 22222 are linked to revenue code 360. Medical Records HCPCS 33333 is linked to revenue code 361, and 44444 is linked to revenue code 762. Both revenue codes 361 and 762 have the HCPCS Procedures field set to Medical Records, with either a Yes or No to HCPCS Required. There are charges for both revenue codes, 361 and 762. The system first searches for Medical Records HCPCS that match the UB code exactly. Then the system searches based on the Medical Records HCPCS UB Revenue Code Table. Once a Medical Records HCPCS code is used, it is off the list for this search. The system assigns the HCPCS starting with the lowest number UB revenue code. In this example, the claim would print the following:

361 Operating Room	33333	11/15/00	1	$100.00
361 Operating Room	11111	11/15/00	1	0.00
361 Operating Room	22222	11/15/00	1	0.00
762 Observation Room	44444	11/15/00	1	200.00

As another example, there are 5 charges for revenue code 760, each for $100.00. Revenue Code 760 has the HCPCS Procedures field set to Charge/Default Medical Records. Three of the charges have a FIM HCPCS code, but two do not. The FIM HCPCS codes are 11111, 22222, and 33333. Revenue code 760 has the range 490,760. There is one Medical Records HCPCS for revenue code 490 of 99999. The system uses HCPCS 99999 on the first charge missing a FIM HCPCS and leaves the HCPCS code missing a FIM HCPCS on the second charge blank. In this example, the claim would print the following:

760 Cauterize Vein	33333	11/15/00	1	$100.00
760 Repair Achilles	11111	11/15/00	1	100.00
760 Laceration Repair	99999	11/15/00	1	100.00 (defaulted)
760 Suture	22222	11/15/00	1	100.00
760 Cast Full Foot		11/15/00	1	100.00

During this process, no Medical Records HCPCS appears more than once on the claim unless it appears more than once in Medical Records. Once the Medical Records HCPCS has found a match, it is no longer included in the list to be processed.

9. PRINT NON-COVERED CHGS? (1-A-R)

This field indicates which non-covered charges, if any, should print in Locator 48 of the claim form. When you access this field, the system displays the following prompt:

Print charges for non covered locator 48 (Y/N) ?

Entry options are **Y** for Yes or **N** for No; there is no default. If you enter **Y**, the system displays the following subscreen on which you can enter one or more choices.

```
Page:01                  Charges to load to Non Covered       ##=Current Choices
                                 Form Locator 48
   ( 1) Proration Non Covered
   ( 2) ABN Yes Signed
   ( 3) ABN Not Signed
   ( 4) ABN Freq Yes Signed
   ( 5) ABN Freq Not Signed
   ( 6) ABN Self Pay Yes Signed
   ( 7) ABN Self Pay Not Signed
   ( 8) ABN Self Pay Freq Yes Signed
   ( 9) ABN Self Pay Freq Not Signed
   (10) Duplicate HCPCS
   (11) Component/Comprehensive HCPCS Conflict
   (12) Mutually Exclusive HCPCS Conflict


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

NOTE: When any of the ABN charges are highlighted to print as Non Covered, the charges are printed as non covered only if the ICD flag for the ABN matches

the ICD flag for the claim. If there is a mismatch, the charges are printed only in the Total Charges column on the claim form.

If you select Proration Non Covered, the charges that are non-covered based on the insurance plan as a result of proration are printed in the non-covered charges column on the UB. Professional fees and summary code exceptions can be identified as non-covered in the Insurance Plan Coverage master. The insurance must go through proration for the system to calculate the Proration Non Covered amount.

If you select any of the ABN Non Covered options, the charges that have the indicated ABN indicator in the charge detail information print in the non-covered charge column on the UB. In order for a charge to be processed for the ABN (Advance Beneficiary Notice) logic, at least one of the insurances on the account has to have the CMS Compliant field set to Yes in the Insurance Plan Table. Also, the SIM Department table for the charging department has to have the field CMS Compliant set to ABN Processing or Both ABN Processing and Duplicate HCPCS. The HCPCS table has to then list valid diagnosis codes for that HCPCS. When entering a charge, if the Ordering Diagnosis that is entered is not a valid diagnosis for the HCPCS on the charge, the charge then goes through ABN processing. The ABN Non Covered options are:

- ABN Yes Signed
- ABN Not Signed
- ABN Freq Yes Signed
- ABN Freq Not Signed
- ABN Self Pay Yes Signed
- ABN Self Pay Not Signed
- ABN Self Pay Freq Yes Signed
- ABN Self Pay Freq Not Signed

When any of the ABN charges are highlighted to print as Non Covered, the charges print only as non covered if the ICD flag for the ABN matches the ICD flag for the claim. Therefore, if the Claim ICD is 10, but the particular charge ABN ICD flag is 9, this charge does not print in the Non Covered column. It continues to print in the Total Charges column. If the Claim ICD is 9, but the particular charge ABN ICD flag is 10, this charge does not print in the Non Covered column. It continues to print in the Total Charges column.

If you select Duplicate HCPCS, the charges identified as not medically necessary duplicate procedures are printed in the non-covered charges column on the UB. In order for a charge to be processed for the Duplicate HCPCS logic, at least one of the insurances on the account has to have the CMS Compliant field set to Yes in the

Insurance Plan Table. Also, the SIM Department table for the charging department has to have the field CMS Compliant set to Duplicate HCPCS or Both ABN Processing and Duplicate HCPCS.

If you select Component/Comprehensive HCPCS Conflict, the charges identified as having either a Component HCPCS Conflict or a Comprehensive HCPCS Conflict prints in the non-covered charge column on the UB. In order for a charge to be processed for the Component/Comprehensive HCPCS Conflict, at least one of the insurances on the account has to have the CMS Compliant field set to Yes in the Insurance Plan Table. Also, the SIM Department table for the charging department has to have the field CMS Compliant set to Duplicate Cross Reference HCPCS Check or Both ABN Processing and Duplicate HCPCS. In order for a charge to be processed to the HCPCS Conflict logic the charge would have to be identified at the time of charge/ order entry as having a conflict. The type of conflict can not be identified as a duplicate HCPCS.

If you select Mutually Exclusive HCPCS Conflict, the charges identified as having a Mutually Exclusive HCPCS Conflict are printed in the non-covered charge column on the UB. In order for a charge to be processed for the Mutually Exclusive HCPCS Conflict, at least one of the insurances on the account has to have the CMS Compliant field set to Yes in the Insurance Plan Table. Also, the SIM Department table for the charging department has to have the field CMS Compliant set to Duplicate Cross Reference HCPCS Check or Both ABN Processing and Duplicate HCPCS. In order for a charge to be processed to the HCPCS Conflict logic the charge would have to be identified at the time of charge/order entry as having a conflict. The type of conflict can not be identified as a duplicate HCPCS.

When the HCPCS Procedure field is set to Medical Records, Both/Summary, or None, and the service date is not printing in Locator 45 of the UB claim, the only Non Covered amount that can print is the Proration Non Covered Amount. The system cannot print Duplicate HCPCS, ABN Non Covered, Comprehensive/Component, or Mutually Exclusive non covered amounts. If the HCPCS Procedure field is set to Medical Records, Both/Summary, or None, and the service date is printing in Locator 45 of the UB claim, all Non Covered amounts can print, except for non covered charges by day (Days Before Coverage Begins, Days Coverage is Active, Maximum Room/Bed Days, Maximum Ancillary Days Covered). See below for non covered charges by day.

For FIM Modifications, if you are pointing a FIM item from a UB Revenue Code that has the HCPCS Procedure field set to M for Medical Records, S for Both/Summary, or N for None, and the service date is not printing in Locator 45 for this revenue code, none of the non-covered amount is backed out of the original revenue code with the FIM Modification. The new revenue code for the FIM Modification does not reflect any non-covered amount for the charge. If you are pointing a FIM item from a UB Revenue Code that has the HCPCS Procedure field set to M, S, or N, and the service date is printing in Locator 45 for the revenue code, if the FIM Modification has a non-covered amount, it is backed out of the original revenue code and re-directed to the new revenue code. This is true only for the following Non Covered Charges: Proration Summary Code Exceptions, Excluded Pro Fees, ABN Non Covered, Duplicate

HCPCS, Component/Comprehensive HCPCS Conflict, and Mutually Exclusive HCPCS Conflict. The system cannot print a Non Covered Amount for the following types of Days Non Covered Charges when using FIM Modifications: Days Before Coverage Begins, Days Coverage is Active, Maximum Room/Bed Days Covered, or Maximum Ancillary Days Covered.

If the insurance has the Professional Fee Coverage field on the Basic Coverage Screen set to Exclude pro fees or has Summary Code Exceptions that are set to Not Covered, these non-covered amounts can print on the UB regardless of the HCPCS Procedure field and of the Service Date printing for the claim charge line.

The system does not print Proration Non Covered amounts for the Split claims. Therefore, if the Print Non-Covered Chgs field is set to load Proration Non Covered (which includes Proration Summary Codes set to Not Covered in the Summary Codes Exception screen of the insurance, Days Before Coverage Begins from the Basic Coverage screen of the insurance, Days Coverage Active from the Basic Coverage screen of the insurance, or Professional Fees when the field Professional Fee Coverage is set to Exclude on the Basic Coverage Screen of the insurance), this non-covered amount does not print. All other Non Covered charge types are allowed (ABN Non Covered, Duplicate HCPCS, Component/Comprehensive HCPCS Conflict, Mutually Exclusive HCPCS Conflict).

The Primary claim can load all types of Non Covered amounts, including Proration Non Covered. However, if the Non Covered amount for the claim charge line is greater than the Total Charges amount for the claim charge line, the Non Covered amount is set to the Total Charges amount.

If the insurance has the Days Before Coverage Begins field set, the Days Coverage is Active field set, the Maximum Room/Bed Days Covered field set, and/or the Max Ancillary Days Covered field set, which creates a non-covered amount, this non-covered amount only can print on the UB claim with the following settings:

- The Non Covered Amount can only print on the UB claim with the Primary or blank Claim Split Indicator. Split claims (as indicated by the non-blank and non- Primary Claim Split Indicator) cannot print non covered charges created by day limitations.

- The UB Charge Control Parameter must have the Summarize By field set to UB Code.

- The UB Revenue Code for the non-covered charges must have the HCPCS procedure field set to Medical Records, Both/Summary, or None, with the Date field set to No.

- If the HCPCS procedure field is set to Medical Records, Both/Summary, or None, but the service date is printing for the claim charge line, the proration non-covered days amount cannot be determined since the amount is not stored by date.

HCPCS VALUE	CHARGE SERVICE DATE PRINTS	LOADS PRORATION NON COVERED DAYS?
C-FIM/CHARGE	NO	NO
C-FIM/CHARGE	YES	NO
D-BOTH/DETAIL	NO	NO
D-BOTH/DETAIL	YES	NO
F-CHG/DEF MED RECS	NO	NO
F-CHG/DEF MED RECS	YES	NO
O-OVERRIDE	NO	NO
O-OVERRIDE	YES	NO
M-MED RECS	NO	YES
M-MED RECS	YES	NO
S-BOTH/SUMMARY	NO	YES
S-BOTH/SUMMARY	YES	NO
N-NONE	NO	YES
N-NONE	YES	NO

10. NON CVD SEPARATE LINE (1-A-O)

This field indicates whether the non-covered portion of the charge should print on its own charge line. This field is only accessible if the Print Non-Covered Chgs field is set to print non-covered charges. When the field is accessed, the following prompt is displayed:

Should the Non Covered portion of the charge print on it's own charge line?

(Y/N) [N]--

If the field is left blank or is answered with No, the non-covered portion of the charge line (Locator 48, as determined by the Print Non-covered Chgs field) prints with the Total Charge amount for the charge. If the field is set to Yes, the non-covered portion

of the charge line is broken out to its own line. This is done after all other processing has taken place on the claim, including looking at the HCPCS Procedures field, the HCPCS Rollup, the Med Recs HCPCS UB Rev Code Table, FIM Modifications, and the Payor HCPCS Cross Reference Table. The last step in the claim processing is to look at the Non Cvd Separate Line field, and then split the non-covered portion to its own charge line.

When splitting the non-covered portion of a charge line to its own claim charge line, the system copies the Revenue Code, Description, Service Date, and the HCPCS/Rate. This means that if a HCPCS code existed for the claim charge line when the claim was initially loaded, the same HCPCS code appears on both the covered and non-covered claim charge line. The Units for the Non Covered Charges are tracked and used on the Non Covered line. Therefore, for both the Covered and the Non Covered line, the system load/prints the correct units based on how the Units field is set for the revenue code in the UB Charge Control Parameter (set to Quantity, Service, Hours, Visits, or Days).

The Non Covered dollar amount of the charge line is taken out of the Total Charge amount for the charge line remaining. For example, if you had the following charge line:

REV CD	DESC	HCPCS/RATE	SRV. DATE	UNITS	TOT CHGS	NON CVD
300	Laboratory	81111	11/15/02	4	$100.00	$ 25.00

The system would split the charge line as follows:

REV CD	DESC	HCPCS/RATE	SRV. DATE	UNITS	TOT CHGS	NON CVD
300	Laboratory	81111	11/15/02	3	$ 75.00	$ 0.00
300	Laboratory	81111	11/15/02	1	$ 25.00	$ 25.00

For revenue codes that have claim charge lines with a Non Covered amount, that also have $0.00 claim charge lines when loading Medical Records HCPCS, only the HCPCS that is on the non-zero dollar line is copied to the Non Covered Charge line. For example, if the revenue code non split appears as:

REV CD	DESC	HCPCS/RATE	SRV. DATE	UNITS	TOT CHGS	NON CVD
450	ER Visit	9928325	11/15/02	4	$ 1000.00	500.00
450	ER	23525	11/15/02	1	$ 0.00	
450	ER	24577	11/15/02	1	$ 0.00	

If the UB Charge Control Parameter is set to split Non Covered Charges to their own claim charge line, the revenue code would appear as follows on the claim:

REV CD	DESC	HCPCS/RATE	SRV. DATE	UNITS	TOT CHGS	NON CVD
450	ER Visit	9928325	11/15/02	2	$ 500.00	
450	ER Visit	9928325	11/15/02	2	$ 500.00	500.00
450	ER	23525	11/15/02	1	$ 0.00	
450	ER	24577	11/15/02	1	$ 0.00	

The revenue code can have Medical Records HCPCS loading to $0.00 charge lines when the revenue code has the HCPCS Procedures field set to either Medical Records, Both/Summary, Both/Detail, or Override in the UB Charge Control Parameter.

If the revenue code initially loads to the claim with no HCPCS, and the UB Charge Control Parameter is set to split the non-covered charges to their own line, these charges are still split out. If the HCPCS Procedure field for the Revenue Code is set to pull Medical Records HCPCS in the UB Charge Control Parameter (set to FIM/Default, Medical Records, Both/Detail, Both/Summary, or Override), if a user enters Medical Records HCPCS, and accesses the Claim Charge Data screen, or Claim Reload runs, the system plugs the Medical Records HCPCS from the first charge line for the revenue code and service date (if loading date) top-down. In other words, if there was a Medical Records HCPCS initially when the claim was loaded, the same HCPCS would be repeated on both the Covered and the Non Covered line. However, if Medical Records HCPCS are entered after the claim initially loads and pulled into the claim with the Reload function, the Covered and the Non Covered charge lines can have different HCPCS codes. For example, if you had the following charge lines load to the claim:

REV CD	DESC	HCPCS/RATE	SRV. DATE	UNITS	TOT CHGS	NON CVD
450	ER Visit	Proc Code	11/15/02	1	$ 1200.00	
450	ER Visit	Proc Code	11/15/02	1	$ 200.00	200.00

If Medical Records HCPCS 11111, 22222, and 33333 were entered, and the claim reloaded, the claim may look as follows when adding additional Medical Records HCPCS to $0.00 lines:

450	ER Visit	11111	11/15/02	1	$ 1200.00	
450	ER Visit	22222	11/15/02	1	$ 200.00	200.00
450	ER Visit	33333	11/15/02	1	0.00	

Had Medical Records HCPCS 11111, 22222, and 33333 existed on the account when the claim initially loaded, the claim would appear as follows:

450	ER Visit	11111	11/15/02	1	$ 1200.00	
450	ER Visit	11111	11/15/02	1	$ 200.00	200.00
450	ER Visit	22222	11/15/02	1	$ 0.00	
450	ER Visit	33333	11/15/02	1	$ 0.00	

The only exception to this rule is when the Summarize By field is set to UB Code (no service dates loading), the Non Cvd Separate Line field is set to Yes, and the HCPCS Procedure field is set to Both/Summary or to Medical Records. In this case, if Medical Records HCPCS are added after the claim loads, and the claim is reloaded, the first Medical Records HCPCS is loaded to both the Covered and the Non Covered lines, and the remaining Medical Records HCPCS is added to $0.00 lines.

When the HCPCS Procedure field is set to Medical Records, Both/Summary, or None, and the service date is not printing in Locator 45 of the UB claim, the only Non Covered amount that can print is the Proration Non Covered Amount. The system cannot print Duplicate HCPCS, ABN Non Covered, Comprehensive/Component, or Mutually Exclusive non covered amounts. If the HCPCS Procedure field is set to Medical Records, Both/Summary, or None, and the service date is printing in Locator 45 of the UB claim, all Non Covered amounts can print.

For FIM Modifications, if you are pointing a FIM item FROM a UB Revenue Code that has the HCPCS Procedure field set to M for Medical Records, S for Both/Summary, or N for None, and the service date is not printing in Locator 45 for this revenue code, none of the non-covered amount is backed out of the original revenue code with the FIM Modification. The new revenue code for the FIM Modification does not reflect any non-covered amount for the charge. If you are pointing a FIM item from a UB Revenue Code that has the HCPCS Procedure field set to M, S, or N, and the service date is printing in Locator 45 for the revenue code, then if the FIM Modification has a non-covered amount, it is backed out of the original revenue code and re-directed to the new revenue code.

NOTE: DUPLICATE HCPCS: If in the UB Charge Control Parameter, you have the Date field set to Yes/Edit for a revenue code, and the Non Cvd Separate Line field is set to Yes, if the system splits out the covered and the non covered charges for the revenue code, and the HCPCS code is listed in the Non Duplicating HCPCS Range Table, since they have the same HCPCS Code and Service Date, the second charge line with the HCPCS code and service date have a Duplicate HCPCS error.

OPPS: If you are using the 3M APC Grouper Plus interface with STAR Financials Patient Accounting, and splitting the non-covered portion of a charge line to its own line on the claim, upon processing the claim through the interface, the output field bill_incl is set to 4 for "Line item is denied or rejected by FI" for the non covered charge line.

11. COMB PRO FEES? (1-A-R)

This field indicates whether the professional fee should roll up into the ancillary charge on the claim form. Entry options are **Y** for Yes or **N** for No; the default is N. This field is only used when the *Summarize By* field is set to **S** for Service Date or **R** for Service Date within Revenue Code. If this field is set to Yes, the professional fee rolls up to the ancillary UB revenue code that caused the professional fee to be created. Professional fees that have no ancillary charge tied to them print on the claim under the original UB revenue code. If this field is set to No, the professional fees do not roll up to the ancillary charge that they are tied to. They load on the claim as defined in the UB charge control parameter.

If the UB Charge Control Parameter has the Comb Pro Fees? field set to Yes, if the ancillary charge is moved to a split claim, the linked professional fee charge also moves to the same split claim. This is true even if the Alternate UB Charge Control Parameter for the split claim (if one is listed) has the Comb Pro Fees field set to No or blank.

When combining the pro fees to the ancillary charge on the claim, the system uses the units for the ancillary charge only.

An example, if the patient had the following charges:

ECG	3/20/95	Rev = 730	Units = 2	$300.00
ECG Pro Fee	3/20/95	Rev = 985	Units = 2	20.00
EEG Pro Fee	3/21/95	Rev = 985	Units = 1	10.00

If the Combine Pro Fees flag is set to Yes and the Units on the revenue codes are set to Quantity, if the ECG is linked to the ECG Pro Fee, and the EEG Pro Fee is not linked to an ancillary charge, the claim prints as follows:

Rev	Srv Dt	Units	Total Charges
730 ECG	3/20/95	2	320.00
985 EEG Pro Fee	3/21/95	1	10.00

If the Combine Pro Fees flag is set to No, and the units on the revenue codes are set to quantity, the claim prints as follows:

Rev	Srv Dt	Units	Total Charges
730 ECG	3/20/95	2	300.00
985 ECG Pro Fee	3/20/95	2	20.00
985 EEG Pro Fee	3/21/95	1	10.00

12. 001/0001 TOTAL REV CODE (4-N-R) & DESCRIPTION (24-A-R)

This field determines if the Total line in the charge area of the UB should be reported using revenue code 001 or using 0001. The default is 001. If set to 001, the claim print program prints revenue code 001 for the Total line. If set to 0001, the claim print

program prints revenue code 0001 for the Total line. If you want the description of the UB Revenue Code 001 or 0001 to be something other than the default of Total Charges, enter a new description after selecting either 001 or 0001 for the total line on the UB.

13. TOTAL FIRST? (1-A-R)
This field indicates whether to print the 001 or 0001 revenue code for total charges as the first or last revenue code on the claim. Enter **Y** to print the total charges revenue code first. Enter **N** to print the 001 or 0001 revenue code for total charges as the last revenue code on the claim. The default is N.

14. NY CLAIM (1-A-O)
This field identifies whether the NY HCPCS and NY Prices should be used instead of the standard prices. When this field is accessed, the following prompt is displayed:

Use NY SIM/FIM price and HCPCS logic(Y) or use NY Alt Price Table (A)? [N]--

If you enter **Y** (Use NY SIM/FIM Price and HCPCS logic), the system uses the NY Price in the SIM and the NY HCPCS in the FIM for the unit price and HCPCS for the claim. If you enter **A** (use NY Alt Price Table), the system displays the New York Alternate Price Tables and allows you to select one for use on claims that use this UB Charge Control Parameter. If instead of using the NY Price and NY HCPCS from the SIM/FIM, you want to use the Payer HCPCS Cross Reference Table tied to the UB Charge Control Parameter and the New York Alternate Price table, enter the table number of the New York Alternate Price Table. For more information on this table, refer to the New York State documentation.

NOTE: Insurances set to use the New York Alternate Price Table should be set to use Reimbursement Type of Q (Claim Amount). This reimbursement writes off the difference between the estimated amount due for COB1 on the final bill and the final claim amount for COB1, which reflects the New York Alternate Prices.

15. USE RX QTY? (1-A-R)
This field indicates whether the units of service on the claim for pharmacy charges display the quantity calculated by Pharmacy or the quantity that was placed with the pharmacy charge. This can be used when the units in which the drug is dispensed does not match the units used to calculate the reimbursement. Enter Y to indicate that units of service displays the quantity calculated by Pharmacy. Enter N to indicate that units of service display the quantity that was placed with the pharmacy charge. The Ancillary Units field for the revenue code associated with the pharmacy charge must be set to Q for Quantity for the units of service to print the quantity calculated by Pharmacy. Pharmacy charges must be associated with a pharmacy department named RXf, where f is the facility code, or the Pharmacy item must be marked as Non-STAR Formulary, and there must be a HCPCS code at the charge level.

16. I/P REHAB (1-A-R)
This field indicates whether the system should check if Rehab Rev Code 0024 or 024 was loaded to the claim. When you access this field, the following prompt is displayed:

Edit for I/P Rehab Rev Code 0024/024? (Y/N) [N] --

Entry options are **Y** for Yes, check for Rehab Revenue Code 0024/024 or **N** for No, do not check for the code; the default is No. If this field is set to Yes, and the claim does not have Revenue Code 0024, 024, or 24 in the Claim Charge Data area, the claim fails, and the Claim Charge Data screen displays **Yes** in the Rehab Rev Code Error field. To clear the error, you must do one of the following:

- Enter a charge with revenue code 0024, 024, or 24 on the claim.
- Enter a charge on the account with revenue code 0024, 024, or 24 and request an adjustment bill and claim.
- Manually release the claim with an error.

If the I/P Rehab field is set to Yes, and revenue code 0024, 024, or 24 exists on the UB claim, the claim does not fail for a Rehab Revenue Code error.

17. EDIT CHG SRV DATES? (1-A-O)
This field is used to indicate if the system is to fail claims with service dates within a specified time frame. When this field is accessed, the following prompt is displayed:

Fail the claim for charges with defined service dates? (Y/N) [N]

Entry option are **Y** for Yes and **N** for No. The default is No. If you enter Yes, the next prompts require you to specify starting and ending dates for charges:

Enter starting charge edit service date--

Enter ending charge edit service date [No Limit]

Enter the starting and ending dates in any of the following formats:

MMDDYY

MM/DD/YY

MMDDYYYY

MM/DD/YYYY

If the ending date is before the starting date, the system displays the following message and requires you to enter in both the starting and the ending date again:

End date precedes start date!

When claim charge data is edited by the system, claim service dates in UB locator 45 are checked. If a date falls within the time frame specified for editing charge service dates, a claim edit is produced. The system looks to this edit with Claim Load, Claim Edit (the Claim Reload optional batch job should be set to run nightly), and when you access the Claim Charge Data screen within Claims Management for the claim. If the time frame does not exist or the claim service date no longer falls within the time frame, the service date claim edit for this charge line is removed. For example, if in the UB Charge Control Parameter, you enter a charge service date range of 01/01/03 - 03/31/03, and a claim fails for the charge service date error, if the UB Charge Control Parameter is then updated to remove the charge service date edit or the dates are pushed out to the future, the next time the Claim Reload optional batch job runs or the next time you access the Claim Charge Data screen for the claim, the charge service date errors are removed.

One use of this edit is to hold claims until the 3M Core Grouping Software with APCs Interface software is installed for the quarter. Once the software is installed, the Edit Charge Service Dates can be removed or changed to future dates.

18. ZERO FILL UB REV CD? (1-A-O)
This field is used to indicate whether the system should zero fill the UB Revenue Code on the UB claim in Claim Print/Spool. The zero filling is done when the claim goes to the paper or the electronic spoolfile, and are not seen when looking at the claim online in Claims Management. When this field is accessed, the following prompt is displayed:

Do you want to zero fill UB revenue codes in the paper and electronic spool files? (Y/N)

The default is No. If the field is blank, it is treated as No, do not zero fill the UB revenue codes.

NOTE: Since only the claim image is updated in Claim Print/Spool, if your hospital has a combination of 3 and 4 digit revenue codes, for example, a 300 and a 0300, these load to the UB claim as unique codes. When the claim prints/spools, the 300 code would be zero filled to be 0300, but even if this claim charge line has the same Service Date and HCPCS code as the other claim charge lines with revenue code 0300, they are not summarized together. No summarization logic is done. The revenue codes are simply zero filled in the claim print/spool.

19. REFERENCE FACILITY (1-A-O)
This field indicates whether the system further sorts claim charge lines by the Reference Facility codes. When this field is accessed, the following prompt is displayed:

Further sort claim charge lines by Reference Facility code? (Y/N) [N]--

If you enter **Y** for Yes, the system further sorts the claim charge lines by Reference Facility Codes. For UB Revenue codes selected in the RF Rev Codes field, if the revenue code has the HCPCS procedure set to FIM/Charge, Both/Detail, Chg/Default MR, or Override, the system further sorts by Reference Facility code in addition to the sorting/splitting by Revenue Code, Service Date, and HCPCS/Modifier Code. Note that if a revenue code is listed in the RF Rev Codes field, but this Reference Facility code has the HCPCS Procedure field set to Medical Records, Both/Summary, or None, the charges are not further sorted by Reference Facility codes, since they are loading in a summarized format.

When sorting by Reference Facility Codes, if there are two or more charges with the same UB Revenue Code, Service Date, HCPCS Code/Modifier, but different Reference Facility Codes, these charges are split to their own claim charge line within the claim. Since the Reference Facility code does not print on the paper UB claim form, it is not apparent to the payor why there are two charge lines for what appear to be the same charges. In this scenario, the claim may be rejected from the 3M Core Grouping Software with APCs as a duplicate charge.

NOTE: Hospitals should enter the HCPCS Modifier of 90 for these reference/send out lab tests.

The system performs this additional sort only for claims loaded after the UB Charge Control Parameters are updated. Previously loaded claims are not updated with the sort if they are reloaded because of errors or reloaded manually.

20. RF REV CODES (1-A-O)
This field can be accessed only if the Reference Facility field is set to *Yes*. When this field is accessed, the table of UB Revenue Codes is displayed with the following prompt:

Select UB Revenue Codes or key A for All--

You can select which UB revenue codes are sorted further by Reference Facility codes, or enter **A** (All) to select all UB revenue codes. If one or more revenue codes are selected, the RF Rev Codes field displays *Entries Defined*. If A for All is entered, the RF Rev Codes field displays *All*. If a revenue code is not defined in the parameter, you must access the Detail Revenue Code setups, press F5 to pull in the new revenue code, set the fields for the revenue code, and accept the screen. You must then re-access the RF Rev Codes field on the UB Charge Control Parameter to select this revenue code. If only some revenue codes are selected, the system further sorts the charges by Reference Facility code only for those charges with the selected revenue code. Even if other revenue codes not selected have a Reference Facility code, these charges are not further sorted by Reference Facility code.

21. EXCLUDE ABN SELF PAY (1-A-R)
This field contains ABN Self Pay charges that can be pointed off the UB claims. When this field is accessed, the following prompt is displayed:

Exclude ABN Self Pay (Y/N)?--

If you enter Y (Yes), the system displays the following ABN Self Pay charges that can be pointed off the UB claim:

```
Page:01                      ABN Self Pay Categories
 ##=Current Choices
 ( 1) ABN Self Pay Yes Signed
 ( 2) ABN Self Pay Not Signed
 ( 3) ABN Self Pay Freq Yes Signed
 ( 4) ABN Self Pay Freq Not Signed
```

You can highlight the type(s) of ABN Self Pay charges that should be pointed off of the UB claim.

Once you make your selection(s), the field displays *See Entries Defined*. In order to see the selections, you must access the field again and enter Yes at the prompt.

If an ABN Self Pay option is highlighted, and this same ABN Self Pay option has been highlighted in the Print Non-Covered Chgs field of the UB Charge Control Parameter, the exclusion takes precedence, and the charge(s) are excluded from the UB04. If the Exclude ABN Self Pay field is blank or set to No, the ABN Self Pay charges can print in the Non Covered Charges locator of the UB04, if highlighted.

The Exclude ABN Self Pay field does not affect proration. In other words, the charge amount for these ABN Self Pay charges is not automatically transferred to the Patient Balance. This would be a manual process.

22. IDE CODE (1-A-O)

This field indicates whether the system should further sort claim charge lines by IDE Code (Investigational Device Exemption code). When this field is accessed, the following prompt is displayed:

Further sort claim charge lines by Investigational Device Exemption code? (Y/N) [N]--

If you enter **Y** for Yes, the system further sorts the claim charge lines by IDE codes. For revenue codes selected in the IDE Rev Codes field, if any revenue code has the HCPCS procedure set to FIM/Charge, Both/Detail, Chg/Default MR, or Override, the system further sorts by Investigational Device Exemption code, in addition to the sorting/splitting by Revenue Code, Service Date, and HCPCS/Modifier Code. Note that if a revenue code is listed in the IDE Rev Code field, but this revenue code has the HCPCS Procedure field set to Medical Records, Both/Summary, or None, the charges are not further sorted by IDE code, since they are loading in a summarized format.

When sorting by IDE code, if there are two or more charges with the same UB Revenue Code, Service Date, HCPCS Code/Modifier, but different IDE codes, these charges are split to their own claim charge line within the claim. Since the IDE code does not print on the paper UB claim form, it is not apparent to the payor why there are two

charge lines for what appear to be the same charges. In this scenario, the claim may be rejected from the 3M Core Grouping software with APCs interface as a duplicate charge.

NOTE: Hospitals should be using Revenue Code 0624/624 and the HCPCS Modifier of QV on the IDE charges.

The system performs this additional IDE Code sort only for claims loaded after the UB Charge Control Parameters are updated. Previously loaded claims are not updated with the sort if they are reloaded because of errors or reloaded manually.

23. IDE REV CODES (TABLE LOOKUP-O)
This field can be accessed only if the IDE Code field is set to Yes. When this field is accessed, the table of UB Revenue Codes is displayed with the following prompt:

Select UB Revenue Codes or key A for All--

A table of UB Revenue Codes is displayed. You can select which UB revenue codes are sorted further by IDE codes, or enter **A** (All) to select all UB revenue codes. If one or more revenue codes are selected, the IDE Rev Codes field displays *Entries Defined*. If A for All is entered, the IDE Codes field displays *All*. If an IDE code is not defined in the parameter, you must access the Detail Revenue Code setups, press F5 to pull in the new revenue code, set the fields for the revenue code, and accept the screen. You must then re-access the UB Charge Control Parameter and access the IDE Rev Codes field to select this revenue code. If only some revenue codes are selected, the system further sorts the charges by IDE Rev code only for those charges with the selected revenue code. Even if other revenue codes not selected have an IDE code, these charges are not further sorted by IDE code.

24. EDIT UNUSED MR HCPCS (1-A-O)
This field is used to indicate whether the system is to edit and fail claims for medical records HCPCS not reflected on the claim. When this field is accessed, the following prompt is displayed:

Edit for unused Medical Records HCPCS? (Y/N) [N]--

You can enter **Y** (Yes) to have the system perform this edit or **N** (No) not to have the system perform this edit. If you enter Yes in this field, the Med Rec HCPCS Revenue Code field is used to specify the revenue codes that are linked to Medical Records HCPCS that should be edited for their appearance on the UB claim.

25. EDIT MR HCPCS REV CDS (TABLE LOOKUP-C)
This field can be accessed only if the value in the Edit Unused Med Rec HCPCS field is Yes. This field is used to specify the revenue codes that are linked to Medical Records HCPCS that should be edited for their appearance on the UB claim. You can highlight one or more revenue codes or enter A for All on the Select Med Rec HCPCS Revenue Codes screen that is displayed when you access this field.

For example, you can select revenue codes 360, 490, and 760. If a Medical Records HCPCS is coded that is linked to one of these revenue codes in the Medical Records HCPCS Procedure screen, and the HCPCS does not appear on the UB claim, the claim will have a charge error. If there are Medical Records HCPCS linked to other revenue codes not selected in the UB Charge Control Parameters, even if the Medical Records HCPCS does not appear on the claim, there won't be an error for the HCPCS.

To give some scenarios, if the Med Rec HCPCS Revenue Codes field has revenue code 360 set:

- If there are charges for revenue code 360, but there are no Medical Records HCPCS linked to revenue code 360, there will not be an error for Unused Medical Records HCPCS.

- If there are no charges for revenue code 360, but there are Medical Records HCPCS linked to revenue code 360, there will be an error for Unused Medical Records HCPCS (as long as this HCPCS is not pulled to the claim for another revenue code).

This edit compares the UB claim (which can have HCPCS from the Charge level, Medical Records, or Both) to those Medical Records HCPCS set to edit (based on the UB Revenue Codes). If the Medical Records HCPCS appears on the UB claim, even if under a different revenue code than that linked to it in Medical Records, an error does not occur for this Medical Records HCPCS. For example, say that the Edit Unused Med Recs HCPCS field is set to Yes, and revenue codes 360 and 490 are highlighted. If the Medical Records HCPCS is linked to revenue code 360, but it pulls to the UB claim for revenue code 490 because of the Med Recs HCPCS UB Rev Code Table, an error does not occur.

The Payer HCPCS Cross Reference Table also is taken into account when determining this Unused Medical Records HCPCS error. If a Medical Records HCPCS is pulled to the claim, but then changed to an alternate HCPCS because of the Payer HCPCS Cross Reference Table (say code 11111 was changed to code 22222), the system does not give an error message for unused Medical Records HCPCS since the HCPCS was in fact used, and then changed to an alternate.

The system also looks at the first two modifiers on the HCPCS for the UB92 and the first four modifiers on the HCPCS for the UB04 to determine if the Medical Records HCPCS is reflected on the claim. Since only two modifiers can load to the paper UB92, and four modifiers can load to the paper UB04, modifiers beyond this are not considered. If the Medical Records HCPCS is 1111199, but the claim HCPCS is 11111, then HCPCS and modifier 1111199 is reported as an Unused Medical Records HCPCS. The reverse also causes an error: if the Medical Records HCPCS is 11111, but the claim HCPCS is 1111199, HCPCS 11111 is reported as an Unused Medical Records HCPCS. Along these same lines, a 111119988 and a 1111199 would not be considered a match, and would have an Unused Medical Records HCPCS error. For the UB92, since only the first two modifiers are taken into consideration, if the Medical Records HCPCS is 11111998877, but the claim HCPCS is 111119988, an error does

not occur for this HCPCS and modifier since the first nine positions match. For the UB04, since only the first four modifiers are taken into consideration, if the Medical Records HCPCS is 222229988776655, but the claim HCPCS is 2222299887766, an error does not occur for this HCPCS and modifier, since the first thirteen positions match.

Finally, the Episode/Service Date on the HCPCS is used to determine if the HCPCS appears on the claim. If the claim has HCPCS code 11111 for 8/20/04, but in Medical Records, HCPCS code 11111 has an Episode/Service Date of 8/21/04, HCPCS 11111 is reported as an Unused Medical Records HCPCS.

Note that this edit is in addition to the HCPCS Required edit in the UB Charge Control Parameter. You can still set revenue codes as requiring HCPCS, and if there is no HCPCS for the claim charge line, a claim charge Procedure Code Error occurs. The Unused Medical Records HCPCS edit is over and above this edit, and can catch situations where the HCPCS were coded, but the charges were not entered, and can catch situations where the revenue code pulled a charge HCPCS, but not the Medical Records HCPCS.

26. UNUSED MED REC HCPCS PRIM OR PRIM/SPLIT? (1-A-O)
This field indicates whether an Unused Medical Records HCPCS error fails both the primary and any split claims that load for that carrier and bill sequence or fails only the primary claim. This field can only be accessed if the Edit Unused Med Rec HCPCS field is set to Yes. When the field is accessed, the following prompt is displayed:

Fail Primary (P) claim or Primary and Split (S) claims for Unused Med Rec HCPCS Error? (P/S) [S] -

You can enter **P**, fail primary claims only, or **S**, fail both primary and split claims, for an unused medical records HCPCS error. If Primary is entered, but no primary claim loads for the insurance and bill sequence, the error fails the first split claim loaded (in priority order as listed in the UB Charge Control Parameters). If the field is left blank, the system defaults to an S, meaning that the Primary and any Split claims for the carrier fail if there is an Unused Medical Records HCPCS error. When the field is set to Primary/Split or left blank, once the Medical Records HCPCS loads to one of the claims (primary or split), the error is removed for all of the claims.

The system uses the UB Charge Control Parameter assigned to the UB insurance on the account and does not use any alternate UB Charge Control Parameter assigned to the Split claims, when looking to the Unused Med Rec HCPCS Prim or Prim/Split field.

27. EARLIEST SERV DATE UB REV CODES (TABLE LOOKUP-C)
This field is used to specify the revenue codes that should summarize to the earliest service date for charges with the same Revenue Code, HCPCS code or Room Rate, but different Service Dates. When this field is accessed, the following prompt is displayed:

Enter the revenue codes that should summarize using the earliest service date (xxxx,xxxx,xxxx-xxxxx) or dash (-) for table lookup -"

For any UB revenue code listed in this field, if there are charges with the same Revenue Code, HCPCS Code or Room Rate, but different service dates, these charges can summarize to one claim charge line. The system looks to either the HCPCS Code or the Room Rate depending on how the field HCPCS/Room is set for the revenue code in the UB Charge Control Parameter. Observation charges should be set to HCPCS. As long as the Observation charges have the same HCPCS code and revenue code, they can qualify to summarize together. If the revenue code is set in the UB Charge Control Parameter to print the Room Rate, then the rates will most likely differ, and the charges do not qualify to summarize together. The charges are evaluated after any HCPCS is determined for the charge line, either from the FIM/ Charge level, or from Medical Records.

The Service Dates on the charges have to be sequential. This means that a gap in service date creates a new claim charge line. To give an example, if the account had the following charges, the system would create two claim charge lines:

Account level charges:

REV CODE	SERVICE DATE	HCPCS	UNITS
762	2/4/05	11111	120
762	2/5/05	11111	360
762	2/7/05	11111	90

The UB Claim would have the following charge lines:

REV CODE	SERVICE DATE	HCPCS	UNITS
762	2/4/05	11111	480
762	2/7/05	11111	90

NOTE: If the Earliest Serv Date UB Rev Codes field is defined (a revenue code or codes are listed), this UB Charge Control Parameter should not list a Split Claims criteria that is set to split by Service Date. When splitting by Service Date, the charges would be on separate UB claims, and therefore would not be summarized together.

The charges are summarized based on the Earliest Serv Date UB Rev Codes field at time of claim load. Claim charge lines are not unrolled or rolled with claim reload. For the first example, say that the UB Charge Control Parameter has revenue code 762 set to pull Medical Records HCPCS and that the account has the following:

Account level charges:

REV CODE	SERVICE DATE	CHARGE HCPCS	UNITS
762	2/4/05	blank	120
762	2/5/05	blank	360

Medical Records HCPCS of:

- 12345 2/4/05 Rev Code 762
- 12345 2/5/05 Rev Code 762

The UB Claim would have the following charge lines:

REV CODE	SERVICE DATE	HCPCS	UNITS
762	2/4/05	12345	480

If the Medical Records HCPCS for 2/5/05 is then changed from 12345 to 22222, and you access the Claim Charge Data screen in Claims Management, the system does not un-roll the two claim charge lines (so that there is a claim charge line for revenue code 762 on 2/5/05 with HCPCS 22222). The claim charge lines remain summarized to the earliest service date with HCPCS 12345.

For the second example, say that the UB Charge Control Parameter has revenue code 762 set to pull Medical Records HCPCS and that the account has the following:

Account level charges:

REV CODE	SERVICE DATE	CHARGE HCPCS	UNITS
762	2/4/05	blank	120
762	2/5/05	blank	360

Medical Records HCPCS of:

- 12345 2/4/05 Rev Code 762
- No Medical Records HCPCS for 2/5/05.

The UB Claim would have the following charge lines:

REV CODE	SERVICE DATE	HCPCS	UNITS
762	2/4/05	12345	120

762 2/5/05 360

If a Medical Records HCPCS of 12345 is entered for 2/5/05, and you access the Claim Charge Data screen in Claims Management, the system does not roll the two claim charge lines to one claim charge line (so that there is a claim charge line for revenue code 762 on 2/4/05 with HCPCS 12345 and units of 480). The claim charge lines remain separate as:

REV CODE	SERVICE DATE	HCPCS	UNITS
762	2/4/05	12345	120
762	2/5/05	12345	360

If the charges have the same Revenue Code, but a blank HCPCS/Room Rate and different service dates, these charges do not roll together across service dates based on the Earliest Serv Date UB Rev Codes field. They can, however, roll together with other charges that have the same Revenue Code, Service Date, and blank HCPCS/ Room Rate based on the field HCPCS Rollup in the UB Charge Control Parameters.

The HCPCS Rollup field does not cross charge service dates when printing the service date on the claim.

28. REQ REV CODES (REQUIRED REVENUE CODES) (TABLE LOOKUP-O)
This field is valid only for UB claims loading in the UB04 format. Claims loading in the UB92 format ignore this field. The field contains the revenue code(s) that are required on the claim. When this field is accessed, the list of the UB Revenue Codes defined in the Detail Revenue Code setup of the UB Charge Control Parameter is displayed, in numeric order. You can highlight the revenue code(s) that are required on the claim. If the required revenue codes do not exist on the claim, the claim fails with a Req Rev Code error. This error can be seen within Claims Management on the Claim Charge Data screen and is reflected on the Failed Claims Requirement Report. If more than one revenue code is entered in this field, each revenue code listed is required on the claim. For example, if revenue codes 111 and 222 are listed, both revenue codes 111 and 222 are required on the claim. If one or more revenue codes is selected, the Req Rev Codes field displays the phrase *Entries Defined*.

For example, if this UB Charge Control Parameter is linked to the ER Patient Type for particular Insurance Plans, revenue code 450 could be listed as required.

When this field is blank, there are no required revenue codes for the claim.

Claims failing for Required Revenue Codes report this on the Failed Claims Requirement Report (FCR250x) as follows, where xxx would be the actual revenue code(s) required:

Loc-Fld: 42 Rev Code xxx,xxx Required

29. ADDTL CHG SRV DATE EDITS? (1-A-O)
This field is used to edit charges outside the billing dates. When this field is accessed, the following prompt is displayed:

Further edit claim charge service dates (Y/N)? -

If Y for Yes is entered, the system displays the following:

```
                  General Hospital UB Charge Control Processor
                                                  Mon Aug 06, 2012 12:50 pm

Page:01          Options for Editing Claim Charge Service Date##=Current Choices
( 1) Charge Service Date Before Admit Date
( 2) Charge Service Date After Discharge Date
( 3) Charge Service Outside Stmt Covers Period



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

You can highlight one, two, or all three edit options. The edits selected then display in the field as follows:

"Chg<AdmDt" for Charge Service Date Before Admit Date,

"Chg>DisDt" for Charge Service Date After Discharge Date,

"ChgStmt" for Charge Service Outside Stmt Covers Period.

The options selected display with a comma in between. Therefore, if all three edits are selected, the field displays:

Chg<AdmDt,Chg>DisDt,ChgStmt

- If the option of Charge Service Date Before Admit Date is highlighted, any claim charge line with a Service Date (Posting Date is not edited) that is prior to the Admission Date at the account level will have a claim charge line edit of "Chg<AdmDt". If the claim charge line has a procedure code error (missing HCPCS) and an error for the service date being prior to the Admission Date, the claim charge line edit will be "Proc Code/Chg<AdmDt". If the claim charge line has a procedure code error (missing HCPCS) and an error for the service date being prior to the Admission Date, and an error for the service date being outside the Statement Covers Period, the claim charge line edit will be "Proc Code/ Chg<AdmDt/ChgStmt".

In a DPW (Diagnostic Payment Window) link, the charge TO account will NOT edit for Charge Service Date Before Admit Date, regardless of the setting of the UB Charge Control Parameter.

In a Combine Bill link, the charge TO account will NOT edit for Charge Service Date Before Admit Date, regardless of the setting of the UB Charge Control Parameter.

- If the option of Charge Service Date After Discharge Date is highlighted, any claim charge line with a Service Date (Posting Date is not edited) that is after the Discharge Date at the account level will have a claim charge line edit of "Chg>DisDt". If the claim charge line has a procedure code error (missing HCPCS) and an error for the service date being after the Discharge Date, the claim charge line edit will be "Proc Code/Chg>DisDt". If the claim charge line has a procedure code error (missing HCPCS) and an error for the service date being after the Discharge Date, and an error for the service date being outside the Statement Covers Period, the claim charge line edit will be "Proc Code/Chg>DisDt/ChgStmt".

- If the option of Charge Service Outside Stmt Covers Period is highlighted, any claim charge line with a Service Date (Posting Date is not edited) outside of the Statement Covers From Date and Statement Covers Through Date in Locator 6 of the UB will have a claim charge line edit of "ChgStmt". If the claim charge line has a procedure code error (missing HCPCS) and an error for the service date being outside the Statement Covers Period, the claim charge line edit will be "Proc Code/ChgStmt".

  In a DPW (Diagnostic Payment Window) link, the charge TO account will NOT edit for Charge Service Date Outside Stmt Covers Period, regardless of the setting of the UB Charge Control Parameter.

  In a Combine Bill link, the charge TO account will NOT edit for Charge Service Date Outside Stmt Covers Period, regardless of the setting of the UB Charge Control Parameter.

NDC Parameters, Default UB Revenue Code Setups, and Miscellaneous Setups

This screen is used to indicate if NDC information loads to the claim and if it is edited, how charges are loaded or not loaded, for those UB revenue codes not defined in the

detail section of the UB Charge Control Parameter, and some miscellaneous claim settings.

```
                  General Hospital UB Charge Control Processor
                                                 Mon Aug 4, 2012 11:52 am

NDC PARAMETERS-
 1 NDC Code  2 Rev Codes        3 HCPCS  4 Override Rev Desc  5 Unit Qual/Units
   Yes/Edit     Entries Defined    Yes      Yes                  Edit All

 DEFAULTS-
 6 Print Chgs?   7 HCPCS Proced's  8 HCPCS Required     9 HCPCS Rollup
   Yes             Med Rec           No                   FIM Dept/Code
10 HCPCS Summary                  11 Ancillary Units   12 R&B Units  13 Total?
   No                                Quantity             Days          No
14 Date Loc 45? 15 HCPCS/Room
   Use             Room Rate
MISCELLANEOUS-
16 Itemize Charges?   17 Loc 45 Creation Date   18 Load Adm Dt  19 Load Dis Dt
                           Generated Date         No              No

20 Split Claim?         21 CA UB? 22 CA Modifier Table   23 Non-Specific HCPCS
   THERAPY                                                  1-CMS NON SPECIFIC
24 Alternate Pricing (340B)       25 Edit by              26 Edit date
                                     Jones,Tom               08/12/12 04:15pm
```

Field Explanations

1. NDC CODE (1-A-O)
This field defines whether charge lines are sorted by National Drug Code (NDC) and whether the system edits for the existence of an NDC Code. When this field is accessed, the following prompt is displayed:

Further sort claim charge lines by NDC Code? (Y/N) [N]--

- If you enter **Y** for Yes, charge lines can be sorted by NDC codes, and you can access the Rev Codes field to define revenue codes that should look for NDC codes.

- If you entered Yes to the previous prompt, the following prompt is displayed:

  Edit for NDC Code? (Y/N) [N] -

  The default, if left blank or if set to N, is to not edit for an NDC code, but to load if present.

If the second prompt is answered with a Y for Yes, the system will edit as follows:

- If the field Rev Codes is set to All and the HCPCS field is not set, the system will edit All revenue codes on the claim for the NDC code.

- If the field Rev Codes is set to specific revenue codes and the HCPCS field is not set, the system will edit the highlighted revenue codes on the claim for the NDC code.

- If the field Rev Codes is set to All and the HCPCS field is set to specific HCPCS, then those HCPCS only on the claim will edit for the NDC code.

- If the field Rev Codes is set to specific revenue codes and the HCPCS field is set to specific HCPCS, then those claim charge lines with a highlighted revenue code AND a selected HCPCS on the claim will edit for the NDC code.

The NDC Code field will display Yes/Edit, Yes, or No.

The system gives an error for each claim charge line that qualifies for the edit. These edits are displayed on the UB Claim Charge Data Screen. For more information, see Claim Charge Data Screen in the *Billing and Claims Volume*, Chapter 3: Claims.

NOTE: In order for a UB claim charge line to edit for the NDC code (and in order to load NDC information for the claim charge line), the revenue code for the charge line has to have the HCPCS field in the UB Charge Control Parameter set to FIM/Charge, Both/Detail, Chg/Default MR, or Override. If the revenue code has the HCPCS field set to Medical Records, Both/Summary, or None, the charges are not edited for NDC code, nor will they load NDC information, since they are loading in a summarized format.

When the HCPCS field on this screen has specific HCPCS set for the NDC Parameters, and when the revenue code for the charge line has the HCPCS field set to Both/Detail, Charge/Default MR, or Override, the system will only edit for the existence of an NDC code for the charges that have a charge level HCPCS (even if the charge level HCPCS is overriden by the Medical Records HCPCS on the claim). The system will not edit the charge lines that do not have a charge level HCPCS code.

Also, $0.00 claim charge lines will not edit for NDC information.

2. REV CODES (TABLE LOOKUP-O)
If the NDC Code field contains Yes, you can access this field to define UB revenue codes that should look for NDC codes. When this field is accessed, the list of the UB Revenue Codes defined in the Detail Revenue Code setup of the UB Charge Control Parameter is displayed, in numeric order. You can highlight the revenue codes that should look for NDC codes, or enter **A** for All. If one or more revenue codes are selected, the Rev Codes field displays the phrase *Entries Defined*. If A for All is entered, the Rev Codes field displays the word *All*.

NOTE: If a revenue code is not defined in the parameter, you must access the Detail Revenue Code Setup screen of the UB Charge Control Parameter, press the F5 key to pull in the new revenue code, set the fields for the revenue code, and accept the screen. You must then re-access the UB Charge Control Parameter and access the Rev Codes field to select this revenue code.

For revenue codes selected, or if A for All is entered, for any revenue code where the HCPCS procedure is set to FIM/Charge, Both/Detail, Chg/Default MR, or Override, the system does a further sort by NDC code in addition to the sorting/splitting by Revenue Code, Service Date, and HCPCS Code. This means that if two or more charges have the same Revenue Code, Service Date, and HCPCS Code, but different NDC codes, the charges load to separate lines on the UB claim form. If a revenue code is listed in the NDC Rev Code field, but this revenue code has the HCPCS Procedure field set to Medical Records, Both/Summary, or None, the charges are not further sorted by NDC code since they are loading in a summarized format.

3. HCPCS (1-A-CONDITIONAL)

This field is used to indicate HCPCS that should load NDC codes. When this field is accessed, the following prompt is displayed:

Select HCPCS that should load NDC information? (Y/N) [N]--

You can enter **Y** (Yes) Yes to select HCPCS or **N** (No) if you don't want to select HCPCS. When leaving the field blank or entering N for No, the system loads NDC information according to the Rev Code field under the NDC Parameters section of the screen.

When entering Y for Yes, the following prompt is displayed:

Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

The system is looking at the claim HCPCS, after using any Payer HCPCS Cross Reference Table. Therefore, you should list the final claim HCPCS in this table that should load the NDC information.

Once the ranges are entered, the system prompts as follows:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

Enter **Y** for Yes to view or edit the HCPCS codes or A (Add) to add HCPCS.. If you enter Add, you can enter a valid HCPCS code. If you enter Yes, the system prompts:

Enter Partial Code to start lookup--

You can enter a partial lookup, such as J-, press ENTER to view all HCPCS already selected to load the NDC information. The system displays the HCPCS such as in the following example:

```
NDC PARAMETERS-

Page:01              Collect NDC Information for these HCPCS
##=Current Choices

( 1) J0120-TETRACYCLIN INJECTION
( 2) J0128-ABARELIX INJECTION
( 3) J0129-ABATACEPT INJECTION
( 4) J0130-ABCIXIMAB INJECTION
( 5) J0132-ACETYLCYSTEINE INJECTION
( 6) J0133-ACYCLOVIR INJECTION


   Select HCPCS to be deleted from the list or A to Add--
         end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

You can delete HCPCS codes or add them to the list. When you select one of the codes to delete, the system prompts you to verify the delete action. If you enter **A** to Add a HCPCS, the system prompts:

Enter HCPCS code to add to the list--

You can enter only a single HCPCS code (not a range).

Once the HCPCS field in the UB Charge Control Parameters is set, in order to update the HCPCS list, access the HCPCS field again. The following prompt is displayed:

Select HCPCS that should load NDC information? (Y/N) [N]--

You can enter **Y** (Yes), and the system displays the following prompt:

Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

Press ENTER past this prompt. The following prompt is displayed:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

You can enter **Y** (Yes), and the system displays the following prompt:

Enter Partial Code to start lookup-

You can enter a partial lookup, such as J-, or press ENTER to get the full list of HCPCS already selected. From here, you can delete or add HCPCS.

4. OVERRIDE REV DESC (1-A-O)
If the NDC Code field contains Yes, you can access this field to define whether the system overrides the Revenue Code/Charge Description.

If you enter Y for Yes, for any claim charge line with an NDC code, the system overrides the revenue code/charge description that usually prints in UB Locator 43 with the NDC information, in the following format:

The NDC qualifier of N4 prints, left justified, followed immediately by the 11-digit NDC number without the dashes, followed immediately (no spaces) by the unit qualifier and the metric decimal quantity or unit for the administered amount. For example: 636 N412345678901UN1234.567

For the NDC units, the system automatically uses the calculated NDC units. The NDC units are derived from the Billing Units in the Financial Item Master (FIM) and the NDC Qty Conv field in the FIM.

The Use RX Qty field on the UB Charge Control Parameters affects only what prints in Locator 46 Service Units, for charges with the RXf department (where *f* is the facility code) when the CMS/Rx units differ from the billing units. The pharmacy units do not print in the NDC information when printing this NDC information in Locator 43.

Only the Print image, as seen in the spooler, is altered. When you view the claim in the Claim Charge Data screen of the Claims Workfile, the revenue code/charge description is still displayed in the Description field.

If set to No, the NDC code, the Unit Qualifier, and the NDC units are sent in the EC2000 interface, but the paper UB04 print image continues to contain the revenue code/ charge description for charge lines with NDC codes.

NOTE: The system prints NDC information only if the UB revenue code has the HCPCS Proc field set to either C-FIM/Chg, D-Both/Detail, F-Chg/Default Med Recs, or O-Override. When set to M-Medical Records, S-Both/Summary, or N-None, the NDC information does not print because the data is in a summarized format.

When set to D for Both/Detail, and there is a FIM HCPCS code in addition to at least 1 Medical Records HCPCS, the $0.00 claim charge lines with the Medical Records HCPCS do **not** print NDC information. Only the claim charge lines with charge amounts greater than $0.00 print the NDC information.

5. UNIT QUAL/UNITS (1-A-O)

If the NDC Code field contains Yes, you can access this field. The system displays the following prompt:

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B] --

If the field is set to B for Blank and there is not a unit qualifier for the charge line with the NDC code, but there is an NDC unit value, the system leaves 2 blank spaces where the unit qualifier would have appeared. For example: 636 N412345678901 1234.567

If the field is set to B for Blank and there is a unit qualifier for the charge line with the NDC code, but there is no NDC unit value, the system leaves the NDC units blank. For example: 636 N412345678901ML

If the field is set to B for Blank and there is no unit qualifier and no NDC unit value for the charge line with the NDC code, the system leaves 2 blank spaces where the unit qualifier would have appeared and there are no NDC units. For example:

636 N412345678901

When the Unit Qual/Units field is set to Blank, the field displays *Blank*.

Enter **E** for Edit at the field prompt, and the system displays the following prompt:

Select (H)CPCS items to edit or key A for All--

Enter **A** for All if you want the system to edit for the NDC Unit Qualifier and the NDC Unit value for the revenue codes specified in the Rev Codes field and the HCPCS specified in the HCPCS field. When using the NDC field of HCPCS for loading NDC information only for particular revenue codes and HCPCS, the Unit Qual/Units field should be set to A for ALL. When set to All, the system edits only those claim charge lines that are set to load NDC information. Therefore, if you set the HCPCS field to list specific HCPCS codes, when you edit All, only those HCPCS listed are edited since these are the only HCPCS set to load NDC information.

If you set the Unit Qual/Units field to specific HCPCS codes, these may not match the HCPCS codes in the HCPCS field.

. If you enter **H**, (HCPCS) the following prompt is displayed:

Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

After you enter a range of HCPCS, the following prompt is displayed:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

Enter **Y** for Yes to view or edit the HCPCS codes or A (Add) to add HCPCS.. If you enter Add, you can enter a valid HCPCS code. If you enter Yes, the system prompts:

Enter Partial Code to start lookup--

You can enter a partial lookup, such as J-, or press ENTER to view all HCPCS already selected to edit the NDC information. The system displays the HCPCS codes. .

The system is looking at the claim HCPCS, after using any Payer HCPCS Cross Reference Table. Therefore, you should list the final claim HCPCS in this table that should edit for the NDC information.

You can delete HCPCS codes or add them to the list. When you select one of the codes to delete, the system prompts you to verify the delete action. If you enter A to Add a HCPCS, the system prompts:

Enter HCPCS code to add to the list--

You can enter only a single HCPCS code (not a range).

If the field is set to E for leave blank and edit and there is no unit qualifier for the charge line with the NDC code, and/or there is no NDC unit value, the system fails the claim with one of the following error messages:

- *NDC Unit Qual*, if the charge line is missing only the unit qualifier
- *NDC Units*, if the charge line is missing only the NDC units

  NOTE: If two or more charge lines summarize together because they have the same Revenue Code, Service Date, HCPCS Code, NDC code, and NDC unit Qualifier, and one charge has NDC Units, but one or more charges does not, the Claim charge line may still have an error for NDC Units, even though the NDC units field has a value. This is telling you that at least 1 of the summarized charges was missing the NDC units, and therefore the claim NDC units may not be accurate. When hitting F5 to edit the claim charge line, if a new NDC UOS value is entered and accepted, this clears the NDC Units error.

- *NDC Qual+Units*, if the charge line is missing both the unit qualifier and the NDC units

Once the HCPCS are set in the Unit Qual/Units field to Edit, in order to update the HCPCS list, access the Unit Qual/Units field again. The system prompts:

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B]-

If you enter **E** for Edit, the following prompt is displayed:

Select (H)CPCS items to edit or key A for All--

If you enter **H** for HCPCS, the following prompt is displayed:

Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

Press ENTER past the prompt, and the system prompts:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

Enter Y for Yes, and the system prompts:

Enter Partial Code to start lookup-

You can enter a partial lookup, such as J-, or press ENTER to get the full list of HCPCS already selected. From here, you can delete or add HCPCS.

The Failed Claims Requirement Report (FCR250x) displays the NDC error in the following format and does not list the detail charge lines.

Loc-Fld: 43 Error: NDC Qual/Unit Errors Quantity 2 Required

NOTE: Claim Reload does not clear these NDC errors. To correct the errors, users can do one of the following:

- Edit the data on the claim
- Use Edit PA Charges to enter the PA NDC Qty/Qual, and then use Instant Adjustment Bill to load an adjustment claim for the insurance, or use Add Claim to Insurance to load an adjustment claim for the insurance.

If you enter D for Default Unit Qualifier at the field prompt, the system displays the following prompt:

Default to F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter), or ME (Milligrams) --

Enter **F2**, **UN**, **GR**, **ML, or ME**. If an invalid value is entered, the system gives the *Error! Invalid Entry* error message.

When you set the NDC Unit Qual/Units field to Default, the field displays *Default* and the default unit qualifier. For example: *Default UN*

The claim defaults in the Unit Qualifier only if the claim charge line loading the NDC information also has the NDC Units. If the claim charge line loading the NDC information has only the NDC code and is missing both the Unit Qualifier and the NDC Units, the claim does not default in the Unit Qualifier.

For defaults, the system uses the value for the claim only and does not update the charges at the account level to have this Unit Qualifier.

6. PRINT CHGS? (1-A-R)
This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates whether charges for the revenue code should be loaded to the UB claim form. Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter N, no charges for the revenue code are loaded to print on the claim form. This field corresponds to the field Print Chgs in the detail portion by UB revenue code of the charge control parameter.

7. HCPCS PROCED'S (1-A-R)
This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates whether HCPCS codes should be loaded for the revenue code. Entry options are **C** (FIM/Charge), **F** (Charge/Default Med Recs), **M** (Medical Records), **D** (Both/Detail), **S** (Both/Summary), **O** (Override), or **N** (None) as outlined below. The default is N for None. This field corresponds to the field HCPCS Procs in the detail portion by UB revenue code of the Charge Control Parameter. If the revenue code is set to pull HCPCS (if set to C-FIM/Chg, D-Both/Detl, F-Chg/Def MR, M-Med Recs, O-Override, or S-Both/Sum), the UB92 loads the 5 digit HCPCS and up to 2 two digit HCPCS Modifiers. The UB04 loads the five-digit HCPCS and up to four, two-digit HCPCS Modifiers.

FIM/Charge Procedures (C), Field displays FIM/Charge

This option pulls either the HCPCS from the FIM or the HCPCS that was entered via charge entry. Charges with the same FIM/Charge HCPCS and the same revenue code are summarized together. When printing the service date in Locator 45 of the UB, charges with the same FIM/Charge HCPCS, the same revenue code, and the same service date are summarized together. Therefore, if two different SIM/FIM items have the same HCPCS, the same revenue code, and the same service date, they would be summarized together. The charge description prints as the revenue code description. The following is an example:

740 Audiology Brain Response	96410	11/15/00	1	$ 170.00
740 CPAP	95826	11/15/00	2	1300.00
740 Multiple Sleep Latency	95828	11/15/00	1	785.00

Revenue codes set to FIM/Charge procedures can print HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fee non-covered charges when the Professional Fee Coverage field is set to Exclude on the Basic Coverage screen. Proration non-covered days charges cannot print the non-covered amount (since this proration is not stored at the detail charge level) if the insurance has the following fields set: Days Before Coverage Begins, Days Coverage is Active, Maximum Room/Bed Days Covered, and/or the Max Ancillary Days Covered.

Charge/Default Medical Records (F), field displays Chg/Def MR

This option pulls the HCPCS from the FIM, or the HCPCS that was entered via charge entry. If there is no charge level HCPCS, the system defaults to the Medical Records HCPCS. Charges with the same FIM/Charge HCPCS and the same revenue code summarize together. When printing the service date in Locator 45 of the UB, charges with the same FIM/Charge HCPCS, the same revenue code, and the same service date summarize together. When defaulting to the Medical Records HCPCS, only Medical Records HCPCS that have not been used for revenue codes set to Medical Records, Both/Summary, Both/Detail, or Override are available to load on the detail charge lines. If there are more detail charge lines that are missing HCPCS than there are available Medical Records HCPCS, these detail charge lines in excess of the

Medical Records HCPCS print on the UB with no HCPCS. If there are more available Medical Records HCPCS than there are detail charge lines that are missing HCPCS, the system does not print $0.00 dollar lines on the UB claim in order to list these additional Medical Records HCPCS. They are not used on the claim for this revenue code. The system first tries to find a match between the revenue code defaulting to Medical Records HCPCS, and the revenue codes linked to these HCPCS. If there is no match between the revenue code defaulting to the Medical Records HCPCS, and the revenue codes linked to these Medical Records HCPCS, the system uses the Med Rec HCPCS UB Rev Code Table, if one is linked to this UB Charge Control Parameter. When using the Med Rec HCPCS UB Rev Code Table, the system loads the Medical Record HCPCS with a UB revenue code that falls into the range defined for it in the table. When printing the service date in Locator 45 of the UB claim, the service date on the charge must match the service date on the Medical Records HCPCS in order for the HCPCS to pull to the claim. The charges print in the same format as the above FIM/ Charge procedure's option, with the charge description printing.

Revenue codes set to Charge/Default Medical Records procedures can print HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fee non-covered charges when the Professional Fee Coverage field is set to Exclude on the Basic Coverage screen. Proration non-covered days charges cannot print the non-covered amount (since this proration is not stored at the detail charge level) if the insurance has the following fields set: Days Before Coverage Begins, Days Coverage is Active, Maximum Room/Bed Days Covered, and/or the Max Ancillary Days Covered.

Medical Records (M), field displays Med Rec

This option pulls the Medical Records HCPCS for the revenue code. When printing Medical Records HCPCS only, all of the charge lines for the revenue code roll up to one dollar line, with the first Medical Records HCPCS. The remaining Medical Records HCPCS print on $0.00 dollar lines. If there is a modifier on the Medical Records HCPCS for the revenue code, the modifier prints with the HCPCS code. Only two modifiers can print on the paper UB claim form. The system pulls the first two listed for the HCPCS. The UB04 can print up to four modifiers. The system pulls the first four listed for the HCPCS. The revenue code description from the UB Revenue Code Table prints on each charge line for the revenue code. The system prints a Units value of "1" for the $0.00 dollar lines.

When printing the service date in Locator 45 of the UB claim, the service date on the charge must match the service date on the Medical Records HCPCS in order for the HCPCS to pull to the claim. When pulling Medical Record HCPCS, the system first tries to find a match between the revenue code set to Medical Records and the revenue codes linked to the Medical Records HCPCS. If there is no match between the revenue code set to Medical Records, and the revenue codes linked to the Medical Records HCPCS, the system uses the Med Rec HCPCS UB Rev Code Table, if one is linked to this UB Charge Control Parameter. When using the Med Rec HCPCS UB Rev Code

Table, the system loads the Medical Records HCPCS with a UB revenue code that falls into the range defined for it in the table.

When a revenue code has the HCPCS Procedures field set to Medical Records and is not loading the service date in Locator 45 of the UB, the only non-covered charges that can print for the revenue code are proration non-covered charges (Summary Code Exceptions that are set to Not Covered, pro fees when the Professional Fee Coverage field is set to Exclude, and non-covered day charges resulting from the insurance having the Days Before Coverage Begins field set, the Days Coverage is Active field set, the Maximum Room/Bed Days Covered field set, and/or the Max Ancillary Days Covered field set). Duplicate HCPCS and ABN non-covered charges cannot be printed. When a revenue code has the HCPCS Procedures field set to Medical Records, but the service date is printing in Locator 45 of the UB, HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fees when the Professional Fee Coverage field is set to Exclude, can be printed. Proration non-covered day charges cannot print when the insurance has the Days Before Coverage Begins field set, the Days Coverage is Active field set, the Maximum Room/Bed Days Covered field set, and/or the Max Ancillary Days Covered field set. This is because proration non-covered day amounts are not stored by date.

For Room and Bed Charges, you can print the Room Rate, the HCPCS code, or leave the HCPCS/Rate locator Blank, as determined by the HCPCS/Room field. When printing the room rate, a separate charge line prints for each unique rate.

The following is an example of printing Medical Records HCPCS:

360 Operating Room	48550	11/15/00	1	$3500.00
360 Operating Room	11111	11/15/00	1	0.00
360 Operating Room	22222	11/15/00	1	0.00

Both/Detail (D), field displays Both/Detail

This option prints both the charge level HCPCS (from the FIM, or entered when the charge was placed) and the Medical Records HCPCS. The system prints as follows: the charges with a charge level HCPCS print with the FIM item description. Then, if there are Medical Records HCPCS, the system plugs these into the detail charge lines that are missing a HCPCS code. Finally, if this still leaves Medical Records HCPCS for the revenue code, the system loads these to the claim with a $0.00 charge line, and the revenue code description from the UB Revenue Code Table. The system prints a Units value of 1 for the $0.00 dollar lines. If there is a modifier on the Medical Records HCPCS for the revenue code, the modifier prints with the HCPCS code. Only two modifiers can print on the paper UB claim form. The system pulls the first two listed for the HCPCS. The UB04 can print up to four modifiers. The system pulls the first four listed for the HCPCS. When printing the service date in Locator 45 of the UB claim, the service date on the charge must match the service date on the Medical Records HCPCS in order for the HCPCS to pull to the claim. When pulling Medical Record HCPCS, the system first tries to find a match between the revenue code set to Both/

Detail and the revenue codes linked to the Medical Records HCPCS. If there is no match between the revenue code set to Both/Detail, and the revenue codes linked to the Medical Records HCPCS, the system uses the Med Rec HCPCS UB Rev Code Table, if one is linked to this UB Charge Control Parameter. When using the Med Rec HCPCS UB Rev Code Table, the system loads the Medical Record HCPCS with a UB revenue code that falls into the range defined for it in the table. The following is an example, where there was a charge for the ER Visit of $150.00, and when the charge was placed, HCPCS code 99283 was entered with Modifier 25. Another charge of $600.00 was entered with no HCPCS, and two Medical Records HCPCS were entered, 23525 and 24577.

450	ER Visit	9928325	11/15/00	1	$150.00
450	Emergency Procedure	23525	11/15/00	1	600.00
450	Emergency Room	24577	11/15/00	1	0.00

When pulling both the Medical Records HCPCS and the charge level HCPCS, if there are duplicate Medical Records HCPCS/Modifiers for the same date of service, the duplicates are used. However, if a charge level HCPCS and modifier is a duplicate of the Medical Records HCPCS and modifier for the same date of service, the HCPCS is only used once.

If the HCPCS Procedure field is set to either Both/Detail or Both/Summary, when the claim initially loads, if there is only a charge level HCPCS for the revenue code, this loads to the claim. If a Medical Records HCPCS is then entered which matches the charge level HCPCS, except that there is a modifier attached, this HCPCS and modifier are added as a $0.00 charge line on the claim. For example, if the following loaded:

REV	HCPCS	Total Chgs
450	11111	$ 5,000.00

If a Medical Records HCPCS of 1111125 was then entered for the same revenue code (here, 450), the claim would look as follows:

REV	HCPCS	Total Chgs
450	11111	$ 5,000.00
450	1111125	$ 0.00

If a claim charge line is manually keyed into the Claim Charge Data screen within Claims Management, and it is a duplicate HCPCS for the revenue code and date, it is retained. Any manual changes/additions are retained if the user accepts the screen.

If the system pulls to the claim a Medical Records HCPCS that has the same HCPCS Code, Service Date, and Revenue Code as a detail charge HCPCS, except that the Medical Records HCPCS has a modifier, if this modifier is later deleted, and the user

accesses the Claim Charge Data screen, the system does not delete the claim charge line. For example, if the claim loaded:

REV	HCPCS	Total Chgs
450	11111	$ 5,000.00
450	1111125	$ 0.00

If you go into Medical Records and update the HCPCS code so that it no longer has modifier 25, then re-access the Claim Charge Data screen, the system does not re-evaluate for duplicate Charge/Medical Records HCPCS or delete the charge line with HCPCS 1111125. The Claim Charge Data screen only pulls in additional Medical Records HCPCS and possibly adds charge lines. It does not delete charge lines.

The system tries to match on Charge level/Medical Records HCPCS and modifiers with an exact match on revenue code, and also uses the Med Recs HCPCS UB92 Rev Code Table, if one is linked to the UB Charge Control Parameter. If, when using the Med Recs HCPCS UB Rev Code Table, there is a match between the HCPCS/Modifier at the charge level and the HCPCS/Modifier in Medical Records, the Medical Records HCPCS is then unavailable for use with another claim charge line. For example, Revenue Code 490 has the following:

REV	Serv Date	HCPCS
490	10/15/02	11111

The UB Charge Control Parameter is linked to a Med Recs HCPCS UB92 Rev Code Table that links revenue code 490 to revenue codes 360 and 762.

If in Medical Records, you have the following:

REV	Serv Date	HCPCS
360	10/15/02	11111

This Medical Records HCPCS would be considered a duplicate and would not be pulled to the claim for revenue code 490 or for any other revenue code.

Revenue codes set to Both/Detail procedures can print HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fee non-covered charges when the Professional Fee Coverage field is set to Exclude on the Basic Coverage screen. Proration non-covered days charges cannot print the non-covered amount (since this proration is not stored at the detail charge level) if the insurance has the following fields set: Days Before Coverage Begins, Days Coverage is Active, Maximum Room/Bed Days Covered, and/or the Max Ancillary Days Covered.

Both/Summary (S), field displays Both/Summ

This option prints both the charge level HCPCS (from the FIM, or entered when the charge was placed) and the Medical Records HCPCS. The system prints as follows:

All of the charges for the revenue code are summarized to 1 charge line, using the first Medical Records HCPCS code.

$0.00 charge lines are added for the additional Medical Records HCPCS, and the FIM HCPCS. The system prints a Units value of "1" for the $0.00 dollar lines.

The system prints the first Medical Records HCPCS on the dollar charge line, followed by the remaining Medical Records HCPCS, followed by the FIM HCPCS. If there were no Medical Records HCPCS when the claim originally loaded, but there were FIM/ Charge level HCPCS for the charges in the revenue code, you would see the first FIM/ Charge level HCPCS on the dollar line. If Medical Records HCPCS were then added, and you re-accessed the Claim Charge Data screen, or the claim was re-loaded via the Claim Reload optional batch job, these Medical Records HCPCS would be added as $0.00 dollar lines.

If, when the claim loads, the first medical records HCPCS listed for the service date is also a duplicate of a charge HCPCS, instead of pulling this first HCPCS to the dollar line for the service date, the HCPCS is listed on one of the $0.00 dollar lines. The system uses the first Medical Records HCPCS that is not a duplicate on the dollar line.

If there is a modifier on the Medical Records HCPCS for the revenue code, the modifier prints with the HCPCS code. Only two modifiers can print on the paper UB92 claim form. The system pulls the first two listed for the HCPCS. The UB04 can print up to four modifiers. The system pulls the first four listed for the HCPCS.

All the charge lines have the revenue code description from the UB Revenue Code Table.

When printing the service date in Locator 45 of the UB92 claim, the service date on the charge must match the service date on the Medical Records HCPCS in order for the HCPCS to pull to the claim. When pulling Medical Record HCPCS, the system first tries to find a match between the revenue code set to Both/Summary and the revenue codes linked to the Medical Records HCPCS. If there is no match between the revenue code set to Both/Summary and the revenue codes linked to the Medical Records HCPCS, the system uses the Med Rec HCPCS UB Rev Code Table, if one is linked to this UB Charge Control Parameter. When using the Med Rec HCPCS UB Rev Code Table, the system loads the Medical Record HCPCS with a UB revenue code that falls into the range defined for it in the table.

When a revenue code has the HCPCS Procedures field set to Both/Summary and is not loading the service date in Locator 45 of the UB, the only non-covered charges that can print for the revenue code are proration non-covered charges (Summary Code Exceptions that are set to Not Covered, pro fees when the Professional Fee Coverage

field is set to Exclude, and non-covered day charges resulting from the insurance having the Days Before Coverage Begins field set, the Days Coverage is Active field set, the Maximum Room/Bed Days Covered field set, and/or the Max Ancillary Days Covered field set). HCPCS and ABN non-covered charges cannot be printed. When a revenue code has the HCPCS Procedures field set to Both/Summary, but the service date is printing in Locator 45 of the UB, HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fees when the Professional Fee Coverage field is set to Exclude can be printed. Proration non-covered day charges cannot be printed when the insurance has the Days Before Coverage Begins field set, the Days Coverage is Active field set, the Maximum Room/Bed Days Covered field set, and/or the Max Ancillary Days Covered field set. This is because proration non-covered day amounts are not stored by date.

For Room and Bed Charges, you can print the Room Rate, the HCPCS code, or leave the HCPCS/Rate locator Blank, as determined by the HCPCS/Room field. When printing the room rate, a separate charge line prints for each unique rate.

The following is an example:

760	Treatment/Observation	11111	11/15/00	1	$2,000.00
760	Treatment/Observation	22222	11/15/00	1	0.00
760	Treatment/Observation	33333	11/15/00	1	0.00
760	Treatment/Observation	44444	11/15/00	1	0.00

When pulling both the Medical Records HCPCS and the charge level HCPCS, if there are duplicate Medical Records HCPCS/Modifiers for the same date of service, the duplicates are used. However, if a charge level HCPCS and modifier is a duplicate of the Medical Records HCPCS and modifier for the same date of service, the HCPCS is used only once.

If the HCPCS Procedure field is set to either Both/Detail or Both/Summary when the claim initially loads, if there is only a charge level HCPCS for the revenue code, this loads to the claim. If a Medical Records HCPCS is then entered which matches the charge level HCPCS, except that there is a modifier attached, this HCPCS and modifier are added as a $0.00 charge line on the claim. For example, if the following loaded:

REV	HCPCS	Total Chgs
450	11111	$ 5,000.00

If a Medical Records HCPCS of 1111125 was then entered for the same revenue code (here, 450), the claim would look as follows:

REV	HCPCS	Total Chgs
450	11111	$ 5,000.00

450 1111125 $ 0.00

If a claim charge line is manually keyed into the Claim Charge Data screen within Claims Management, and it is a duplicate HCPCS for the revenue code and date, it is retained. Any manual changes/additions are retained if the user accepts the screen.

If the system pulls to the claim a Medical Records HCPCS that has the same HCPCS Code, Service Date, and Revenue Code as a detail charge HCPCS, except that the Medical Records HCPCS has a modifier, if this modifier is later deleted, and the user accesses the Claim Charge Data screen, the system does not delete the claim charge line. For example, if the claim loaded:

REV	HCPCS	Total Chgs
450	11111	$ 5,000.00
450	1111125	$ 0.00

If the user goes into Medical Records, and updates the HCPCS code so that it no longer has modifier 25, and re-accesses the Claim Charge Data screen, the system does not re-evaluate for duplicate Charge/Medical Records HCPCS or delete the charge line with HCPCS 1111125. The Claim Charge Data screen only pulls in additional Medical Records HCPCS, and possibly adds charge lines. It does not delete charge lines.

The system tries to match on Charge level/Medical Records HCPCS and modifiers with an exact match on revenue code, and uses the Med Recs HCPCS UB Rev Code Table, if one is linked to the UB Charge Control Parameter. If, when using the Med Recs HCPCS UB Rev Code Table, there is a match between the HCPCS/Modifier at the charge level and the HCPCS/Modifier in Medical Records, the Medical Records HCPCS is then unavailable for use with another claim charge line. For example, Revenue Code 490 has the following:

REV	Serv Date	HCPCS
490	10/15/02	11111

The UB Charge Control Parameter is linked to a Med Recs HCPCS UB Rev Code Table that links revenue code 490 to revenue codes 360 and 762.

If in Medical Records, you have the following:

REV	Serv Date	HCPCS
360	10/15/02	11111

This Medical Records HCPCS would be considered a duplicate and would not be pulled to the claim for revenue code 490 or for any other revenue code.

Override (O), field displays Override

This option prints the FIM/charge level HCPCS if there is one, and there is no Medical Records HCPCS. However, if there is BOTH a charge level HCPCS (from the FIM, or entered with charge entry), and a Medical Records HCPCS, none of the FIM HCPCS print, and the system overrides the charge level HCPCS with the Medical Records HCPCS.

For example, if there are 5 charges, 3 of which have a FIM HCPCS, and 2 that have a blank FIM HCPCS, if there are 2 Medical Records HCPCS for the revenue code, none of the FIM HCPCS would be used. The system would use the Medical Records HCPCS on the first 2 charges, and the remaining 3 charges for the revenue code would roll up according to the HCPCS Rollup field. If there is more than one Medical Records HCPCS, they all print. The Medical Records HCPCS are inserted into the detail charge lines, with the FIM item description.

Once the charge lines have all been updated, if there are remaining Medical Records HCPCS, they print on $0.00 charge lines, with the UB revenue code description from the UB Revenue Code Table.

The system prints a Units value of "1" for the $0.00 dollar lines.

If there is a modifier on the Medical Records HCPCS for the revenue code, the modifier prints with the HCPCS code. Only two modifiers can print on the paper UB92 claim form. The system pulls the first two listed for the HCPCS. The UB04 can print up to four modifiers. The system pulls the first four listed for the HCPCS.

When printing the service date in Locator 45 of the UB92 claim, the service date on the charge must match the service date on the Medical Records HCPCS in order for the HCPCS to pull to the claim. When pulling Medical Record HCPCS, the system first tries to find a match between the revenue code set to Override and the revenue codes linked to the Medical Records HCPCS. If there is no match between the revenue code set to Override, and the revenue codes linked to the Medical Records HCPCS, the system uses the Med Rec HCPCS UB Rev Code Table, if one is linked to this UB Charge Control Parameter. When using the Med Rec HCPCS UB92 Rev Code Table, the system loads the Medical Record HCPCS with a UB revenue code that falls into the range defined for it in the table.

The charges print in the same format as the above Both/Detail option, except that all of the HCPCS are either from the FIM/Charge level (if there are no Medical Records HCPCS for that revenue code and service date), or from Medical Records (if there are Medical Records HCPCS for that revenue code and service date).

When printing the service date in Locator 45 of the UB claim, the Override option is looked at within service date. Therefore, if one service date within the revenue code has Medical Records HCPCS, these override any FIM/Charge HCPCS for that service date. However, if another service date within the revenue code does not have any

Medical Records HCPCS, any FIM/Charge level HCPCS would be used for that service date.

When using the Override option and the system cannot find a Medical Records HCPCS for the revenue code, or revenue code and date, the HCPCS Indicator (HCP field for UB92 claims or HCPC Ind field for UB04 claims) on the Claim Charge Data screen is set to a C for FIM/Charge rather than an O for Override. If Medical Records HCPCS are later added for the revenue code, or revenue code and date with the HCPCS Indicator of C, they are not loaded to the claim.

Revenue codes set to Override procedures can print HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fee non-covered charges when the Professional Fee Coverage field is set to Exclude on the Basic Coverage screen. Proration non-covered days charges cannot print the non-covered amount (since this proration is not stored at the detail charge level) if the insurance has the following fields set: Days Before Coverage Begins, Days Coverage is Active, Maximum Room/Bed Days Covered, and/or the Max Ancillary Days Covered.

None (N), field displays None

This option prints one charge line for the revenue code (rollup), and does not print HCPCS for the ancillary charges. When printing the service date in Locator 45 of the UB, one charge line prints for each service date for the revenue code. For Room and Bed Charges, you can print the Room Rate, the HCPCS code, or leave the HCPCS/ Rate locator Blank, as determined by the HCPCS/Room field. When printing the room rate, a separate charge line prints for each unique rate.

This is the Default value for revenue codes when a new UB Charge Control Parameter is added that was not copied from an existing UB Charge Control Parameter. Also, when you use the F5 Select key while in the UB Charge Control Parameter, detail section by revenue code, any new UB revenue codes pulled into the parameter are set to None. When a revenue code has the HCPCS Procedures field set to None and is not loading the service date in Locator 45 of the UB, the only non-covered charges that can print for the revenue code are proration non-covered charges (Summary Code Exceptions that are set to Not Covered, pro fees when the Professional Fee Coverage field is set to Exclude, and non-covered day charges resulting from the insurance having the following fields set: Days Before Coverage Begins, the Days Coverage is Active, the Maximum Room/Bed Days Covered, and/or the Max Ancillary Days Covered). HCPCS and ABN non-covered charges cannot be printed.

When a revenue code has the HCPCS Procedures field set to None, but the service date is printing in Locator 45 of the UB, HCPCS non-covered charges (Duplicate, Component/Comprehensive, Mutually Exclusive), ABN non-covered charges, Summary Code Exceptions that are set to Not Covered, and pro fees when the Professional Fee Coverage field is set to Exclude can be printed. Proration non-covered day charges cannot be printed when the insurance has the Days Before Coverage Begins field set, the Days Coverage is Active field set, the Maximum Room/

Bed Days Covered field set, and/or the Max Ancillary Days Covered field set. This is because proration non-covered day amounts are not stored by date.

8. HCPCS REQUIRED (1-A-O)
This field can only be accessed if the HCPCS Procedure was answered with anything but an N for None. Entry options are Yes, HCPCS are required, or No, HCPCS are not required; the default is No. If HCPCS are Required (Yes), if the claim does not have a HCPCS for the charge line, you have a "Procedure Code Error" on the Claim Charge Data screen within Claims Management. The revenue code missing the required HCPCS has Proc Missing in the error field of the Claim Charge Data screen. The Failed Claims Requirement Report, FCR250x, lists the HCPCS procedure errors as Procedure Code is Required Quantity #.

If HCPCS are Not Required (No), the revenue code may still pull a HCPCS, but if there is no HCPCS for the revenue code, the claim charge line does not have a procedure code error.

This field corresponds to the field HCPCS Req'd in the detail portion by UB revenue code of the Charge Control Parameter.

9. HCPCS ROLLUP (1-A-R)
This field determines how charges without a HCPCS procedure in Locator 44 should be summarized. Entry options are **F** to roll up ancillary charges without a HCPCS by FIM Department and Code, and room and bed charges without a room rate (printing in Locator 44) by room rate, or **R** to roll up ancillary and room and bed charges without a HCPCS or room rate together in one line for the Revenue Code. The default is **F** for FIM Department/Code.

If you entered an R for Revenue Code, the room charges with no HCPCS/room rate would summarize with the other room charges with no HCPCS/room rate that had the same UB revenue code, and date if loading service date to the claim. The ancillary charges with no HCPCS would summarize with the other ancillary charges with no HCPCS that had the same UB revenue code and date if loading service date to the claim. Therefore, if a revenue code has both room and bed and ancillary charges, and you roll by revenue code, the room and bed and the ancillary charges roll to separate lines.

If you entered an F for FIM Department/Code, or the field is left blank, the ancillary charges with no HCPCS would summarize with the other charges with no HCPCS that had the same FIM Department and FIM Code, UB revenue code, and date if loading service date to the claim. The room and bed charges with no room rate printing would summarize with the other room charges with no rate printing that had the same room rate, UB revenue code, and date if loading service date to the claim.

This field is used when the Summarize By field is set to either UB Code, Revenue Code within Service Date, or Service Date within Revenue Code. The charges are not summarized until the system has done all other processing, such as defaulting to the Medical Records HCPCS, using the Med Rec HCPCS UB Rev Code Table, and using

the Payer HCPCS Cross Reference Table. This field is especially useful for your Pharmacy UB revenue code(s). When setting the Pharmacy revenue code to R for Revenue Code for the HCPCS Rollup, all of the Pharmacy charges with no HCPCS code for that revenue code and service date (if printing service date in Locator 45 of the UB claim), would roll up into one claim charge line.

This field corresponds to the field HCPCS Rollup in the detail portion by UB Revenue Code of the Charge Control Parameter.

For example, assume the following charges were for the same service date, or the service date was not printing on the claim:

REV CODE	FIM CODE/DESC	CHARGE AMOUNT
250	11112222 Tylenol	1.00
250	11112222 Tylenol	1.00
250	11112222 Tylenol	1.00
250	11114444 Motrin	2.00
250	11114444 Motrin	2.00
250	11114444 Motrin	2.00

If the HCPCS Rollup field is set to FIM Department/Code, the charges print as follows:

250	Tylenol	3.00
250	Motrin	6.00

If the HCPCS Rollup field is set to Revenue Code, the charges print as follows:

250	Tylenol	9.00

Notice that when rolling up by Revenue Code, the system uses the Charge description of the first charge line for the revenue code or revenue code/date.

The system rolls up the charges regardless of any procedure code error on the charge line (where the HCPCS Required field is set to Yes for the revenue code). Using the above examples, if revenue code 250 was set to require HCPCS, then if the HCPCS Rollup field was set to FIM Department/Code, you would have two Proc Code errors for the revenue code. If the HCPCS Rollup field was set to Revenue Code, you would have one Proc Code error for the revenue code.

If the HCPCS Rollup is set to FIM Cd, if two or more charges have the same Revenue Code, the same FIM item code, the same Service Date, no HCPCS, and the same NDC, RF, and IDE code, these charges roll up together.

If the HCPCS Rollup is set to FIM Cd, if two or more charges have the same Revenue Code, the same FIM item code, the same Service Date, no HCPCS, and different NDC, RF, or IDE codes, these charges do not roll up together.

If the HCPCS Rollup is set to REV Cd, if two or more charges have the same Revenue Code, the same Service Date, no HCPCS, and the same NDC, RF, and IDE code, these charges roll up together, but the NDC, RF, or IDE code is lost. This is because, when rolling up by revenue code, different charge items could roll up together, making any NDC, RF, or IDE code possibly invalid.

If the HCPCS Rollup is set to REV Cd, if two or more charges have the same Revenue Code, the same Service Date, no HCPCS, and different NDC, RF, or IDE codes, these charges still roll up together, but the NDC, RF, or IDE code are lost. This is because, when rolling up by revenue code, different charge items could roll up together, making any NDC, RF, or IDE code possibly invalid.

The system sorts first on Revenue Code, HCPCS code/blank HCPCS Code, Service Date, and NDC, RF, or IDE code. The system may then plug Medical Records HCPCS into detail charge lines when using the Both/Detail, Charge/Default Medical Records, or Override option in the HCPCS Procedure field in the Detail Revenue Code Setups. Finally, the system rolls up those charge lines with no HPCS code, based on the HCPCS Rollup setting of FIM code or REV code.

10. HCPCS SUMMARY (1-A-R)

This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates if the HCPCS Summarization Master should be used for revenue codes that have the HCPCS Procedures field set to C for FIM/ Charge Procedures. This table should no longer be used for your Medicare Lab panels, as Medicare is not accepting these HCPCS rollups anymore. Instead, the appropriate panels and HCPCS codes should be built into your Service Item Master/Financial Item Master, and the individual charges should also be entered into the SIM/FIM with the appropriate HCPCS code for when the service is performed individually. When accessing this field, your entry options are **Y** for Yes or **N** for No; the default is **N**. If the charge is not set to print FIM/Charge Procedures, you cannot access this field. This field corresponds to the field HCPCS Summary in the detail portion by UB revenue code of the charge control parameter.

When the HCPCS Procedures field is set to FIM/Charge Procedures, the HCPCS codes are loaded automatically to the claim if the code is present with the charge record. The purpose of this field is to indicate whether these HCPCS codes should be summarized. For example, in the case of a Lab profile, several HCPCS codes make up a profile. If the patient has one or more charges with HCPCS codes that match what is in the HCPCS Summarization Master, these charges are summarized as one line on the UB claim form.

The charge description is the description from the HCPCS Summarization Master. The HCPCS Summarization Master determines the number of HCPCS codes that must exist before the summarization can take place. In most cases, the HCPCS code for the

charge is changed to the table ID of the HCPCS Summarization Master table and the quantity on the charges. For example, the Lab profile in the HCPCS Summarization Master should have a table ID of 800 and a description such as Lab Profile. If the patient has four lab charges, each with a quantity of 2, that have HCPCS codes that match the HCPCS codes in the HCPCS Summarization Master for the Lab profile, if the Unit field prints Visit, the charge line on the UB claim form would be as follows:

Rev Cd	Description	Modifier	Units	Total Charges
300	Lab Profile	80008	1	120.00

For information on the HCPCS Summarization Master table, refer to Chapter 2 of this book.

11. ANCILLARY UNITS (1-A-O)
This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates whether units of service should print for the ancillary charge line in Locator 46. Entry options are **S** (Units of Service), **Q** (Quantity), **V** (Visits), **H** (Hours), or **D** (days).

If you enter **H** for number of hours, the system converts the quantity on the charges into hours. If the quantity on the charges is less than 60, the units round to 1. For quantities greater than 60, the system rounds down if the quantity is 1 to 30 minutes over the hour, and rounds up if the quantity is 31 to 59 minutes over the hour. For example, a quantity of 90 is reported as 1 hour and a quantity of 91 is reported as 2 hours. When calculating number of hours, the system calculates the hours for each charge line within the revenue code. If you then roll up the charges by revenue code (in the HCPCS Rollup field), the individual hours are totaled up. For example, if you had the following:

Revenue Code 760 Charge 1, Quantity 100, hours = 2
Revenue Code 760 Charge 2, Quantity 18, hours = 1
Revenue Code 760 Charge 3, Quantity 24, hours = 1

when the system rolls the charges by revenue code, the hours would be 4, not 2, as you would expect, since the quantity is 142.

If you enter **D**, the system adds up the unique number of service days for the charge line.

If you enter **S**, the occurrence of the charge or credit prints. If you enter Q, the actual quantities on the charges print, and if you enter V, a 1 prints as the units. For example, if I entered the following charges:

Charge 1: Rev Code 300, quantity = 2, $200.00
Charge 2: Rev Code 300, quantity = 5, $500.00

Printing units = Service would print:

Rev Code Description	Units	Total Charges
300 Laboratory	2	700.00

Printing units = Quantity would print:

300 Laboratory	7	700.00

Printing units = Visit would print:

300 Laboratory	1	700.00

When a FIM Item has the Statistic Flag in the Financial Item Master set to Stats Only, if the charge amount is $0.00, and the item is not listed as a $0.00 dollar item to print on the claim, the units are not included for the charge item.

When a FIM Item has the Statistic Flag in the Financial Item Master set to Stats Only, if the charge amount is $0.00, and the item is listed as a $0.00 dollar item to print on the claim, the units are included for the charge item.

When a FIM Item has the Statistic Flag in the Financial Item Master set to Stats Only, if the charge amount is greater than $0.00, the units are included for the charge item.

There are no defaults to the units field. If the field is left blank, units do not print in Locator 46 for the charge line. This field corresponds to the field Ancil Units in the detail portion by UB revenue code of the charge control parameter.

12. R&B UNITS (ROOM AND BED UNITS) (1-A-O)
This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates whether units of service should print for the room and bed charge line in Locator 46. Entry options are **S** (Units of Service), **Q** (Quantity), **V** (Visits), **H** (Hours), or **D** (days).

If you enter **H** for number of Hours in the Units field, the system converts the quantity on the charges into hours. If the quantity on the charges is less than 60, the units round to 1. For quantities greater than 60, the system rounds down if the quantity is 1 to 30 minutes over the hour, and rounds up if the quantity is 31 to 59 minutes over the hour. For example, a quantity of 90 is reported as 1 hour and a quantity of 01 is reported as 2 hours. When calculating number of hours, the system calculates the hours for each charge line within the revenue code. If you then roll up the charges by revenue code (in the HCPCS Rollup field), the individual hours are totaled up. For example, if you had the following:

Revenue Code 760 Charge 1, Quantity 100, hours = 2
Revenue Code 760 Charge 2, Quantity 18, hours = 1
Revenue Code 760 Charge 3, Quantity 24, hours = 1

When the system rolls the charges by revenue code, the hours would be 4, not 2, as you would expect, since the quantity is 142.

If you enter **D**, the system adds up the unique number of service days for the charge line.

If you enter **S**, the occurrence of the charge or credit prints. If you enter **Q**, the actual quantities on the charges print, and if you enter V, a 1 prints as the units. For example, if I entered the following charges:

Charge 1: Rev Code 300, quantity = 2, $200.00
Charge 2: Rev Code 300, quantity = 5, $500.00

Printing units = Service would print:

Rev Code Description	Units	Total Charges
300 Laboratory	2	700.00

Printing units = Quantity would print:

300 Laboratory	7	700.00

Printing units = Visit would print:

300 Laboratory	1	700.00

When a FIM Item has the Statistic Flag in the Financial Item Master set to Stats Only, if the charge amount is $0.00, and the item is not listed as a $0.00 dollar item to print on the claim, the units are not included for the charge item.

When a FIM Item has the Statistic Flag in the Financial Item Master set to Stats Only, if the charge amount is $0.00, and the item is listed as a $0.00 dollar item to print on the claim, then the units are included for the charge item.

When a FIM Item has the Statistic Flag in the Financial Item Master set to Stats Only, if the charge amount is greater than $0.00, the units are included for the charge item.

There are no defaults to the units field. If the field is left blank, units do not print in Locator 46 for the charge line. This field corresponds to the field R&B Units in the detail portion by UB revenue code of the charge control parameter.

NOTE: The system uses the R&B Units field when calculating units for room and bed charges, regardless of the setting of the HCPCS/Room field for the room and bed charges.

13. TOTAL? (1-A-R)
This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates whether the units for this charge line should be included in the units for the 001 or 0001 Total line. Entry options are **Y** for Yes or **N** for No; the default is N. The type of units is determined by the entry in the Units field. This field corresponds to the field Total in the detail portion by UB revenue code of the charge control parameter.

14. DATE LOC 45? (1-A-O)
This field, which is used as a default value for UB revenue codes that are not set up in the charge control parameter, indicates whether the charges should print the service date in Locator 45 of the UB. Entry options are Y for Yes to edit the HCPCS for the same date of service and load the service date, U for Use to load the service date but not edit, or N for No, do not load the service date. When the Summarize By field is set to UB Code, your options are Y (Edit), U (Use), and N (No), with No being the default. If the Summarize By field is set to either Revenue Code within Service Date, or Service Date within Revenue Code, your only options are Y (Edit) and U (Use), with Use being the default, since the service date automatically prints for the charge line in Locator 45 of the UB. This field corresponds to the Date field in the detail portion by UB revenue code of the charge control parameter.

When the Date Loc 45? field is set to Yes (Edit), the system references the Non Duplicating HCPCS Range Table to determine the range of HCPCS that should not have duplicates for the same date of service. The system also references the HCPCS Panel Codes Table to determine the components of a panel, so that if the panel and one of its components is charged for the same date of service, the system identifies the duplicate and reports it on the claim. If the Date Loc 45 field is set to Yes/Edit, and there is only one claim charge line for the service date and HCPCS code, if the units are greater than 1, you still receive a duplicate HCPCS error.

When loading a UB and summarizing by UB Code (vs. by Date), revenue codes set to print the date sort by date and HCPCS within the revenue code. Therefore, the same type of charge, performed on different days, may not print together. For example, you could have the following for revenue code 300 if revenue code 300 has the HCPCS Procedures field set to FIM/Charge, No to the HCPCS Summarization, and Yes to Date. The Units field is set to print Quantity in the following examples:

Rev	HCPCS	Date	Units	Total Charge
300 Urinalysis	81003	11/15/00	1	15.00
300 Amino Acids Test	82128	11/15/00	1	20.00
300 Urinalysis	81003	11/20/00	1	15.00
300 Amino Acids Test	82128	11/20/00	1	20.00

If revenue code 300 for the above account has the HCPCS Procedures field set to FIM/Charge, No to the HCPCS Summarization, and No to Date, the revenue code prints as follows:

Rev	HCPCS	Date	Units	Total Charge
300 Urinalysis	81003		2	30.00
300 Amino Acids Test	82128		2	40.00

If revenue code 300 has the HCPCS Procedures field set to FIM/Charge, Yes to the HCPCS Summarization, and Yes to Date, if HCPCS Codes 81003 and 82128 are in the HCPCS Summarization Master, the revenue code prints as follows:

Rev	HCPCS	Date	Units	Total Charge
300 Lab Profile	80002	11/15/00	2	35.00
300 Lab Profile	80002	11/20/00	2	35.00

If revenue code 300 has the HCPCS Procedures field set to FIM/Charge, Yes to the HCPCS Summarization, and No to Date, if HCPCS Codes 81003 and 82128 are in the HCPCS Summarization Master, the revenue code prints as follows:

Rev	HCPCS	Date	Units	Total Charge
300 Lab Profile	80004		4	70.00

15. HCPCS/ROOM (1-A-0)
This field, which is used as a default value for UB revenue codes that are not set up in this charge control parameter, indicates whether room and bed charges should print the room rate, the HCPCS code from the FIM, or a blank in Locator 44 of the UB.

Entry options are **R** for Room Rate, **H** for HCPCS code, or **B** for Blank rate. If this field is left blank, or an R is entered, the room rate prints for the room and bed charges with this revenue code, even if there is a HCPCS for this room and bed charge. If the HCPCS/Room field is set to B for Blank rate, the room charges have a HCPCS Indicator (HCP) of N for None on the Claim Charge Data screen, and do not pull either the room rate or a HCPCS code.

This field only effects how the room and bed charges print on the claim. Ancillary charges look to the HCPCS Procedures field to determine if HCPCS should print for the ancillary charges with this revenue code. If the HCPCS Procedure field is set to FIM/Charge Procedures, and the HCPCS Summary field is set to Yes, the HCPCS/ Room field defaults to HCPCS, and the system processes the HCPCS code on the room and bed charges as it does the HCPCS codes on the ancillary charges when using the HCPCS Summarization Master.

NOTE: This should not be an issue since you should not have room and bed charges going to a revenue code set to use the HCPCS Summarization Master, since this table is used for your Lab profiles.

If the HCPCS Summary field is set to No, and the HCPCS/Room field is left blank or is not set to HCPCS (the user presses ENTER to go past the field), the HCPCS/Room

field defaults to Room Rate. The system prints the charges for the revenue code based on how the Date and the HCPCS/Room fields are answered. The most used scenarios are outlined below:

A). When printing HCPCS for room and bed charges, if the Date field for the revenue code is set to No, the system prints a charge line for each unique HCPCS code. For example, if an account has the following charges for revenue code 760:

760 Treatment Room, room charge, rate = $450.00, service date = 01/19/96, HCPCS = 99220

760 Treatment Room, room charge, rate = $100.00, service date = 01/20/96, HCPCS = 99220

760 Treatment Room, ancillary charges, 5 for $600.00, service date = 01/19/96, HCPCS = 99220

A1). If revenue code 760 for Treatment Room has the HCPCS Procedures field set to FIM/Charge Procedures, No to the HCPCS Summarization Master, Units = Visit, Date = No, and the HCPCS/Room field is set to HCPCS, the claim prints for the revenue code:

Rev Description	HCPCS/Rate	Srv Date	Units	Tot Charge
760 Treatment Room	99220		1	1150.00

A2). Using the above example, if revenue code 760 has the HCPCS Procedures field set to FIM/Charge Procedures, No to the HCPCS Summarization Master, Units = Visit, Date = No, and the HCPCS/Room field is set to Room Rate, the claim prints for the revenue code:

Rev Description	HCPCS/Rate	Srv Date	Units	Tot Charge
760 Treatment Room	450.00		1	450.00
760 Treatment Room	100.00		1	100.00
760 Treatment Room	99220		1	600.00

B). When printing HCPCS for room and bed charges, if the Date field for the revenue code is set to Yes, the system prints a charge line for each unique date and HCPCS code.

B1). Using the above example, if revenue code 760 has the HCPCS Procedures field set to FIM/Charge Procedures, No to the HCPCS Summarization Master, Units = Visit, Date = Yes, and the HCPCS/Room field is set to HCPCS, the claim prints for the revenue code:

Rev Description	HCPCS/Rate	Srv Date	Units	Tot Charge

760 Treatment Room	99220	011996	1	1050.00
760 Treatment Room	99220	012096	1	100.00

B2). Using the above example, if revenue code 760 has the HCPCS Procedures field set to FIM/Charge Procedures, No to the HCPCS Summarization Master, Units = Visit, Date = Yes, and the HCPCS/Room field is set to Room Rate, the claim prints for the revenue code:

Rev Description	HCPCS/Rate	Srv Date	Units	Tot Charge
760 Treatment Room	99220	011996	1	600.00
760 Treatment Room	450.00	011996	1	450.00
760 Treatment Room	100.00	012096	1	100.00

The HCPCS/Room field corresponds to the field HCPCS/Room in the detail portion by UB revenue code of the charge control parameter.

16. ITEMIZE CHARGES (1-A-O)
This field indicates whether specific FIM items are itemized and printed in detail. When this field is accessed, the following prompt is displayed:

Itemize specific FIM items? (Y/N) -

If you enter **Y** (Yes), the system takes you to the following screen in order to identify the FIM Department(s) and the FIM Items within the department(s) that should print in detail.

```
   UB Itemized Charges
 Seq   FIM Department               FIM Item
 1     EEG-EEG DEPT                 18000050:BRAINMAPPING
 2     RXA-PHARMACY - A             NDC
 3     PSY-PSYCH                    All

Enter FIM item code, A for All, N for NDC items, or `-` for table--
```

You can enter the FIM Department or a hyphen (-) to display the list of FIM Departments and select one from the list.

After you tab to the FIM Item field, the following prompt is displayed:

Enter FIM item code, A for All, N for NDC items, or `-` for table--

- You can enter a hyphen (-) to display the list of FIM Items for the FIM Department and select one from the list.
- If you enter **A** (All), all FIM Items for the FIM Department are itemized on the UB claim. If you enter **N** (NDC), all FIM Items for the FIM Department that have an NDC

code are itemized on the UB claim. Either an A for All or an N for NDC can be selected for a given department, but not both. Error messages are displayed if you try to enter both options for a department. If you enter A for a department, and individual FIM items were previously defined, individual FIM items are removed for the department, the system displays **A** in this field, and the following message is displayed: *FIM item codes will be removed when results are saved!*. If N for NDC is keyed for a department, individual FIM items can be selected also for the department.

When set, if two or more charges have the same Revenue Code, Service Date, HCPCS Code and Modifiers (and Reference Facility Code, Investigational Device Exemption Code, or NDC code if you have the system set to do any additional sorts by this information), the charges would not summarize together and would print on their own claim charge line. For example, you could have the following on the claim:

REV CODE	SERVICE DATE	HCPCS/MODIFIER	TOTAL CHARGE
250	12/05/06	11111/22334455	1,000.00
250	12/05/06	11111/22334455	1,000.00

In this scenario, the claim may be rejected from the 3M Core Grouping Software with APC's as a duplicate charge.

The system further breaks out the charges if the revenue code assigned to the FIM Item has the HCPCS Proc (Procedure) field set to one of the following in the UB Charge Control Parameter:

- FIM/Charge
- Both/Detail
- Chg/Default MR
- Override

Note that if a FIM Item is listed in the Itemized Charges field, but the revenue code for the charge has the HCPCS Procedure field set to Medical Records, Both/Summary, or None, that the charges are not itemized out on the claim since they are loading in a summarized format.

NOTE: Any FIM items listed in the itemized charges field are not summarized as a result of the HCPCS Rollup field for the revenue code assigned to the charge, regardless of whether the HCPCS Rollup field is set to FIM code or revenue code.

Once the FIM Departments and FIM Items are entered, the field displays *Entries Defined*. When re-accessing the field, the system automatically brings you to the screen to enter/revise the FIM Departments and FIM Items.

If you already have Itemized Charges defined, and you access this field and press ENTER at the prompt, *Itemize Specific FIM Items? (Y/N)*, the system prompts:

Do you want to remove existing FIM items selected to be itemized? (Y/N) [N]--

If you take the default of **N** for No, the system moves to the next field. If you enter **Y** for Yes, all FIM Departments and FIM Items in the Itemized Charges screen are removed. If you want to delete only specific FIM Departments and Items, you should instead enter Y for Yes to the *Itemize Specific FIM Items?* prompt, and then use the F5 key to delete specific items in the list.

17. LOC 45 CREATION DATE (1-A-O)
This field determines whether your hospital uses and prints the claim load date or the claim spool date for the UB04 creation date.

When you access this field, the system displays the following prompt:

Print the claim (L)oad date or the claim (G)enerated date in UB04 Locator 45,line 23 [L]-- |

Enter **L** for Load Date or leave the field blank for the system to print the claim load date in Locator 45, line 23, starting in position 48 for 6 characters (MMDDYY). If the field is defined as L, it displays *Load Date*.

Enter **G** for Generated Date for the system to print the claim spool date, regardless if the claim spools to the paper or to one of the electronic spool files. The generated date prints in Locator 45, line 23, starting in position 48 for 6 characters (MMDDYY). If the field is defined as G (generated data), the field contains *Generated Date*. The spool date (generated date) can be used when comparing the spool files for the date against the creation date on the actual UB04 claims sent to the electronic vendor.

This field is used only for the UB claim in the UB04 format. This field is ignored for the UB claim in the UB92 format.

18. LOAD ADM DATE (1-A-R)
This field gives you the option of overriding the claim charge Service Date with the Admission Date after all claim charge processing has been done. This feature can be used for payers that cannot process multiple service dates on an ER or Outpatient claim. When this field is accessed, the following prompt is displayed:

Load Admit Date for Charges (Y/N)--

You can enter **Y** (Yes) to load the admission date for charges or **N** (No) to load the service date.

In order to set this field to Yes, the Earliest Serv Date UB Rev Codes and the Itemize Charges fields must be blank. If those fields contain values, the Load Admit Date for Charges field cannot be used. Also, the Summarize By field cannot be set to UB Code. If it is set to UB Code, you cannot set the Load Admit Date for Charges field.

When this field is set to Yes, after the system processes the charge lines for the HCPCS codes, from Medical Records and from the Charge level, the system updates the service date on the claim charge lines only to be the Admission Date, and then rolls up like charges (by Revenue Code, Service Date, HCPCS/Modifier, NDC Code, Reference Facility Code, IDE Code). With this functionality, if the same claim service line would appear multiple times with different dates, the claim service lines are combined into one line using the admission date. This field can be used for payers that require all charges to reflect the admission date when the patient has two or more charge service dates. For example, if the payer requires all Emergency patients to reflect only one date of service, and the patient stays over Midnight, the claim charge lines can be updated where needed to reflect the admission date.

When using this option, you should also update the UB Claim Load Edit Parameter for the payer. Locator 6 for the Statement From Date and the Statement Through Date can both be set to use the date Internal Element of Admission Date. Remember to regenerate your parameters upon exiting if updates are made.

NOTE: The raw charges at the account level are not updated for the service date. The true Service Date remains. Medical Records HCPCS should therefore be coded using the true Service Date for the service.

The following are examples to display the difference between the Earliest Service Date UB Revenue Codes field and the Load Admit Date for Charges field on the UB Charge Control Parameter. For this example, the Admission Date of the patient is 05/03/08.

Raw Charges (seen at the account level)

REV CODE	SERV DATE	HCPCS	CHARGE
300	05/03/08	81234	$100.00
300	05/04/08	81234	100.00
300	05/04/08	89999	75.00

Claim Using the Earliest Service Date UB Rev Codes field:

REV CODE	SERV DATE	HCPCS	CHARGE
300	05/03/08	81234	$200.00
300	05/04/08	89999	75.00

Note that, since there was no charge for revenue code 300, HCPCS 89999 for 05/03/08, the claim uses the earliest service date it can find for the Revenue Code, Service Date, HCPCS/Modifiers, NDC Code, Reference Facility Code, and IDE (Investigational Device Exemption). Therefore, the charge line in this example loads for 05/04/08, and there are multiple dates of service for the claim.

Claim Using the Load Admit Date for Charges field:

REV CODE	SERV DATE	HCPCS	CHARGE
300	05/03/08	81234	$200.00
300	05/03/08	89999	75.00

Note that the system uses the Admission Date for the Service Date for all of the charges on the claim, and there is only one service date reflected on the claim. The system uses the admission date for the service date on the claim only after the HCPCS are determined for the charges using charge level HCPCS or Medical Records HCPCS. The true service date should be used when coding Medical Records HCPCS. For example, say you had the following charges for a patient with an Admission Date of 05/03/08:

REV CODE	SERV DATE	HCPCS	CHARGE
450	05/03/08	blank in FIM	$500.00
450	05/04/08	blank in FIM	600.00

If Medical Records is coding the HCPCS for these two days, then the true service date should be entered. For example, HCPCS 99222 may be coded for 05/03/08 and HCPCS 99111 may be coded for 05/04/08. When setting the field "Load Admit Date for Charges" to Yes, and when setting the Revenue Code to load HCPCS from Medical Records (for example, revenue code 450 can have the HCPCS Proc field set to Both/Detail) the claim would load:

REV CODE	SERV DATE	HCPCS	CHARGE
450	05/03/08	99222	$500.00
450	05/03/08	99111	600.00

Note that the Service Date was updated for the charge line with HCPCS 99111. However, if the user had coded both Medical Records HCPCS using the admission date of 05/03/08, the second charge would not have matched up on Revenue Code and Service Date, and therefore would not have loaded a Medical Records HCPCS. It would instead be linked to the first charge in this example as follows

REV CODE	SERV DATE	HCPCS	CHARGE

450	05/03/08	99222	$500.00
450	05/03/08	99111 =	0.00
450	05/03/08		600.00

Claim Reload with example:

Continuing with the example above, if Medical Records codes a HCPCS for Revenue Code 450, for Service Date 05/04/08 AFTER the claim has loaded and updated the claim Service Date to be 05/03/08, then the newly coded HCPCS would NOT load to the claim via Claim Reload for the claim charge line missing a HCPCS. This is because the charge service dates do not match between Medical Records and the charge line on the claim.

If Medical Records codes a HCPCS for Revenue Code 450, for Service Date 05/03/08 AFTER the claim has loaded and updated the Service Date to be 05/03/08, then if the claim charge line without a HCPCS is failing for missing HCPCS, then the newly coded HCPCS would load to the claim via Claim Reload. Again using the above example, if after the claim loaded, Medical Records HCPCS 55555 was entered for revenue code 450, Service Date 05/03/08, and Claim Reload occurred, then the claim would be as follows:

REV CODE	SERV DATE	HCPCS	CHARGE
450	05/03/08	99222	$500.00
450	05/03/08	99111	0.00
450	05/03/08	55555	600.00

It is imperative that all Medical Records HCPCS be coded for the account before the UB claim loads when using the new field of "Load Admit Date for Charges".

There is another scenario for Medical Record HCPCS that needs to be considered using the following charges where the admission date is 5/3/08. For this example, say there is one Medical Records HCPCS of 99222 with a date of 5/3/08.

REV CODE	SERV DATE	HCPCS	CHARGE
450	05/04/08	blank in FIM	$500.00
450	05/04/08	blank in FIM	200.00

When the claim loads, it will load as follows:

REV CODE	SERV DATE	HCPCS	CHARGE

450 05/03/08 $700.00

Since the system pulls in the Medical Records HCPCS to the claim charge lines before updating the Service Date to be the Admission Date, the service date on the Medical Records HCPCS did not match the claim charge service dates, and therefore did not load to the claim.

If HCPCS codes are reloaded because the claim charge line is failing for missing HCPCS, then HCPCS 99222 will load to the claim at that point and the claim will appear as follows. Again, the HCPCS did not load to the claim originally because the charge date was 5/4/08 but the HCPCS date was 5/3/08.

REV CODE SERV DATE HCPCS CHARGE

450 05/03/08 99222 $700.00

NOTE on UNUSED/APPLIED MED REC HCPCS

When the Load Admit Date for Charges field is set to Yes, and the Edit Unused MR HCPCS field is also set to Yes in the Charge Control Parameter, the system will ignore the Service Date on the Medical Records HCPCS ONLY when determining the Unused/Applied Med Rec HCPCS. This is needed since the claim service dates will be updated to be the Admission Date for the patient, and this may result in the Service Date on the Medical Records HCPCS to differ from the Service Date on the claim charge line using the Medical Records HCPCS. Therefore, the system looks only to the HCPCS codes in Medical Records and compares these to the HCPCS codes on the Claim to determine which were Unused and/or Applied.

19. LOAD DIS DATE (1-A-O)

This field gives you the option of overriding the claim charge Service Date with the Discharge Date after all claim charge processing has been done. This field can be used when splitting out a vaccine to its own UB04. When an Inpatient account receives a vaccine at any point of the inpatient stay, CMS requires the vaccine to be on its own UB04 claim, using the Discharge Date of the inpatient account as the Service Date for the vaccine. The Split Claims Criteria screen for the vaccine split can therefore list a UB Charge Control Parameter that has the field Load Dis Date set to yes.

This field affects only the UB04 claim, and does not update the actual service date for the charges at the account level. If this field is set to Yes and the patient is not discharged, the true service date loads for the charges. If the field is set to Yes and the patient is discharged, the discharge date is used for the UB charge line service date after all claim charge processing has been done. If the field is set to No or left blank, the true service date loads for the charges.

In order to set this field to Yes, the Earliest Serv Date UB Rev Codes, the Load Admit Date for Charges, and the Itemize Charges fields must be blank. If those fields contain values, the Load Discharge Date for Charges field cannot be used. Also, the

Summarize By field cannot be set to UB Code. If it is set to UB Code, you cannot set the Load Discharge Date for Charges field.

When this field is set to Yes, after the system processes the charge lines for the HCPCS codes, from Medical Records and from the Charge level, the system updates the service date on the claim charge lines only to be the Discharge Date, and then rolls up like charges (by Revenue Code, Service Date, HCPCS/Modifier, NDC Code, Reference Facility Code, IDE Code). With this functionality, if the same claim service line would appear multiple times with different dates, the claim service lines are combined into one line using the discharge date.

When using this option, you should also update the UB Claim Load Edit Parameter for the payer. Locator 6 for the Statement From Date and the Statement Through Date can both be set to use the date Internal Element of Discharge Date. Remember to regenerate your parameters upon exiting, if updates are made.

NOTE: The raw charges at the account level are not updated for the service date. The true Service Date remains. Medical Records HCPCS should therefore be coded using the true Service Date for the service.

20. SPLIT CLAIMS? (1-A-O)

This field indicates if split UB claims should be loaded for any insurances assigned to this Charge Control Parameter. Split claims are processed by the system in the order the criteria for the split claims are listed in this field. When this field is accessed, the following prompt is displayed:

Split UB Claims? (Y/N) [N]--

If you enter **N** for No, only one UB claim is loaded for the payer/insurance per bill sequence. See "Detailed UB Revenue Code Setups" on page 3-226 to continue with UB Charge Control Parameters setup. If you enter **Y** for Yes, the following screen is displayed which allows you to enter the name of the split claim criteria in priority order. You can either enter the name or enter a hyphen (-) to display the list of names for split claim criteria.

```
                          General Hospital UB Charge Control Processor

Fri June 4, 2005 09:30 pm
Seq     Split Name                Description
 1      MAMM                      Mammography
 2      VACCINE                   Vaccines
 3      AMB                       Ambulance
 4
 5
 6
 7
 8
 9
10
11
12
13
14
15
16
17
18

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

The system processes the charges in the order the criteria for the Split Claims are listed on this screen. The split claims are processed, followed by the primary claim for the carrier. Once a charge and/or a HCPCS (charge level HCPCS or Medical Records HCPCS) code qualifies for one of the claims (either the primary claim or one of the split claims), the charge and/or HCPCS code is not evaluated for another claim split. For example, if a charge qualifies for the Split Claim MAMM, and also for Split Claim DATE that is listed as a lower priority, it appears on the split claim for MAMM, and is not evaluated for the split claim DATE.

Charges that do not qualify for any of the Split Claims that are listed in the UB Charge Control Parameter are on the Primary UB claim for that carrier and bill sequence.

The system looks to the facility indicator on the account when determining if there is a Split Name Criteria table for that facility. For example, if in the UB Split Claims Criteria table, a split name of Vaccine is set for Facilities B and C only, if the system processes an account for facility A, this Vaccine split is bypassed, and the system continues to the next Split Claim criteria listed.

If there are no remaining charges because all of the charges went to a split claim, a primary UB claim is not created for zero charges. This differs from the scenario where there are no charges at all for the bill sequence. In this case, the system determines whether to load a $0.00 claim based on the Load $0.00 Claim field in the UB Parameter. A claim can also load if the Load $0.00 Claim field is set for offsetting charges and credits. For example:

Final Claims:

COB 1 Claim Sequence 1 for Primary

COB 1 Claim Sequence 2 for Therapy

If the charges on the Therapy split claim are then credited, and an Adjustment Bill and claims are requested, if the Load $0.00 Claim field is set to load for Adjustment claims, the system loads the following:

Adjustment Claims:

COB 1 Claim Sequence 3 for Primary

COB 1 Claim Sequence 4 for Therapy with no Claim Charge detail

Field Explanations (Continued)

20.) CA UB? (1-A-O)
This field is used to specify if the UB claim should be processed for California Medicaid requirements. When accessing the field, the following prompt is displayed:

Process for California Medicaid requirements? (Y/N) [N]--

If **Y** for Yes is entered, the system scans the Medi-Cal Alternate Code Table(s) to determine which to use for the UB04 based on the Statement Covers From Date in Locator 6 of the UB04. If the claim From Date is not within an Effective From and Effective Through dates of a Medi-Cal Alternate Code Table, the claim continues to use the federal HCPCS only for the claim.

In the Medi-Cal Alternate Code Table, hospitals should list those FIM Departments, and within the Department, the FIM Items or A for All FIM Items for the department, that should use the charge level "Alternate Code" from the Financial Item Master in place of the (federal) HCPCS code from the Financial Item Master on the UB claim.

In the following scenarios, the Alternate Code in the FIM will not be used on the federal UB04 (claim type X), and will be substituted with a blank HCPCS for claim processing only:

a) If the Medi-Cal Alternate HCPCS Table lists a FIM Department and FIM Code that should use the Alternate Code for the HCPCS, if the Alternate Code field is blank in the FIM, the blank HCPCS would be used for UB04 processing. This is regardless if the FIM Item has a federal HCPCS code listed.

b) If the Medi-Cal Alternate Code HCPCS is not a length of 5, 7, or 9, the Alternate Code is not used for the HCPCS on the UB04. Instead, a blank HCPCS would be used for UB04 processing. The system is expecting a 5 digit HCPCS code, and two digit modifiers. The Alternate Code field in the FIM is 10 digits long, allowing a five-digit HCPCS and 2 two-digit modifiers.

This Alternate Code (state HCPCS) is only used on the UB claim and does not replace the federal HCPCS when looking at the charge in Charge Inquiry.

Also, whether this alternate code is ultimately used on the UB claim depends on how the Revenue Code for the charge is set in this UB Charge Control Parameter. In the detail section by Revenue Code, the HCPCS field must be set to C=FIM/Chg,D=Both/Det, or F=Chg/Def MR, in order for the charge HCPCS to appear on the claim.

PROCESSING:

The system is replacing the (federal) HCPCS with the Alternate Code (state HCPCS) for use on the claim before any further claims processing is done. From this point on, the system sees this code as a standard code. Therefore, this is the code that would be used on the claim and the one that the system would be looking to when using the following:

- The Payer HCPCS Cross Reference Table
- When on the second screen of the UB Charge Control Parameters, NDC codes are set to load/edit by HCPCS code.

When the CA UB field is set to Yes, the UB Charge Control Parameter allows you to enter HCPCS that are not in the HCPCS table in the NDC HCPCS field on the second screen of the UB Charge Control Parameter.

When setting the NDC HCPCS field to Yes, it is suggested that you first enter your federal HCPCS ranges (for example, your J HCPCS codes).

The system does edit that HCPCS entered in a range existing in the HCPCS Table.

Once you have entered the federal ranges, when you receive the below prompt, enter **A** to Add:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

At this point, add the state (alternate code) HCPCS that should load NDC codes. You must enter these HCPCS individually, and answer yes to the following prompt:

Warning! HCPCS Code does not appear in HCPCS table. Accept code anyway? (Y/N)--

The STAR claim can therefore load both federal and state HCPCS codes. FIM Departments and FIM Items not listed in the Medi-Cal Alternate Code Table continue to load the federal HCPCS to the claim. Only the State exceptions should be listed in the Medi-Cal Alternate Code Table.

21.) CA MODIFIER TABLE (TABLE LOOKUP-O)
This field can be accessed only if the CA UB field is set to Yes to indicate that the California Modifier Table is to be used for claims loading in the California Medicaid format. When this field is accessed, the following prompt is displayed:

Enter California Modifier Table number --

The Medi-Cal HCPCS Modifier Table option can be seen on the California Charge Control Parms menu. In this table, you can map the UB Revenue Code, and the HCPCS, and the modifier that should be created for the HCPCS on the claim only. The detail charges and HCPCS are not modified.

The system looks to the claim revenue code after any FIM Modifications and to the claim HCPCS (which could be either a state code, a federal code, a HCPCS from the charge or from Medical Records).

HCPCS	HCPCS Description	Existence of Rev	Modifier
11111	TEST ONE	490	99
11111	TEST ONE	360	88
22222	TEST TWO	370	ZN
22222	TEST TWO	280	ZM

The system looks for the HCPCS on the UB04 claim (which can be a federal HCPCS, an Alternate Code, and can be a HCPCS from either the charge level or Medical Records). The system then looks for the existence of the revenue code listed for this HCPCS. The HCPCS and the existence of the revenue code can be on the same UB charge line, or on a different UB charge line to qualify for the modifier on that HCPCS.

If the HCPCS already has one or more modifiers, this auto generated modifier is added to the end of the HCPCS modifier list. For example, HCPCS 1111122 may become 111112299 on the claim. If the auto generated modifier would be a duplicate of a modifier that already exists for the HCPCS, it is not added again.

For more information on the California Modifier Table, refer to the California State documentation.

23. NON-SPECIFIC HCPCS (1-A-O)
This field is used to select the table of non-specific HCPCS codes for this UB Charge Control Parameter.

When accessing the field, the system prompts:

Enter Non Specific HCPCS table or '-' for lookup--

You can enter the table number for the Non Specific HCPCS table that should be used for this UB Charge Control Parameter. The system displays a list of Non Specific HCPCS tables. After you select a table, the field displays the table number and description.

When the UB claim loads, if the claim has one or more of the listed HCPCS, after all HCPCS processing, including Payer HCPCS Cross Reference Tables, then the claim charge lines with a listed HCPCS will have a new error of Non Spec HCPCS, and the system will blank out the claim charge line description.

NOTE: The system is looking to the 5 digit HCPCS, and will edit regardless of modifiers.

The number of Non Specific HCPCS errors can be seen on the top of the Claim Charge Data screen after the field heading of "Non Spec HCPCS Err". The Error field for the claim charge line will also have "NS HCPCS".

For any claim charge line with one of the Non Specific HCPCS errors, the system will CLEAR the claim charge line description. In order to clear the claim charge line error, the user must use the F5 key to Edit the charge line, and enter in the "Description" field the detailed HCPCS description. Do not enter the generic, non specific HCPCS description or else the claim will be rejected on the payer side.

24. ALTERNATE PRICING (340B) (5-AN-O)
If 340B pricing should be used for claims loading with this UB Charge Control parameter, the number of the table for Alternate Pricing (340B Pricing) is indicated in this field. The Alternate Pricing table can then be used to define the pricing for Pharmacy items per FIM department code and effective dates. Please see “ALTERNATE PRICING (340B PRICING)” on page 3-340 for details on the Alternate Pricing (340B) table.

25. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this UB charge control parameter.

26. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this UB charge control parameter was last edited.

Press F7 to accept the screen and to save the split claims priority. See “Detailed UB Revenue Code Setups” on page 3-226 to continue with UB Charge Control Parameters setup.

Detailed UB Revenue Code Setups

Completing the fields on the UB Charge Control Processor (Screen 2) completes the default portion of the UB charge control parameter. After you complete this screen, the following prompt is displayed:

Do you wish to revise detail UB Revenue Code Setups (Y) (N)--

If you respond **N** (No), the system asks if you want to add SIM Item Exclusions. For more information, see "SIM Item Exclusions" on page 3-230. If you respond **Y** (Yes), the UB Charge Control Processor (Screen 2) displays. This screen determines how charges associated with specific UB revenue codes are printed on the UB claim form. For more details, refer to the associated default field from the first screen of the UB Charge Control Parameter.

```
                General Hospital UB Charge Control Processor
                                                  Thu Jan 18, 2007 01:24 pm
Seq  REV   Print HCPCS     HCPCS   HCPCS    HCPCS   Ancil  R&B  Total Date HCPCS
           Chgs  Procs     Req'd   Rollup   Summary  Units Units            Room
1
2     001  Yes   FIM/Chg   No      Rev Cd   No       Qnty
3     002  Yes
4     004  Yes
5    0022  No    FIM/Chg   No      FIM Cd           Qnty
6      24  Yes   FIM/Chg   No                       Qnty
7    0033  Yes   None      No      Rev Cd   No      Qnty
8     071  Yes   FIM/Chg   No      Rev Cd           Qnty
9     073  Yes   None      No      Rev Cd           Qnty
10   0100  Yes   None      No      Rev Cd           Qnty
11    101  Yes   None      No      Rev Cd           Qnty
12    110  Yes   None      No      Rev Cd           Qnty
13    111  Yes
14    112  Yes   None                               Qnty
15    120  Yes   None      No      Rev Cd           Qnty
16    123  Yes   None      No      Rev Cd           Qnty
17    130  Yes   None      No      Rev Cd           Qnty
18    140  Yes   None      No      Rev Cd           Qnty
```

The system displays a series of function keys at the bottom of the screen to help you enter/edit information. Enter a question mark (?) within a field to display the valid options for the field.

If you want to add UB revenue codes to the charge control table, press **F5** (the Select key). The system displays the following prompt:

Reinitialize parameters? (Y/N) [N]--
Edits to parms for this session will be lost!

If you enter **Y**, the system reads the UB Revenue Code table and inserts any new revenue codes. The reinitializing process also deletes any UB revenue codes that have been deleted from the UB Revenue Code table from this charge control table.

NOTE: Any changes made to the UB Charge Control Parameter that were not previously saved before the reinitialization are lost.

You do not need to reinitialize these parameters every time you access them. Reinitialize only when you want to add new UB revenue codes.

SQ (DISPLAY ONLY)
This field contains the sequential number identifying the line items in the charge control parameter.

REV (4-C-R)
This field contains the UB revenue code. When a UB Charge Control Parameter is created, all UB revenue codes entered in the UB Revenue Code table are loaded into this table.

PRINT CHGS (1-A-R)
This field indicates whether the UB revenue code should be loaded to the UB claim form. Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter N, then no charges for this revenue code are loaded to print on the claim form. This field can be used to exclude your professional fees from printing on the UB Claim Form if they are not covered by the payor.

HCPCS PROCS (HCPCS PROCEDURES) (1-A-R)
This field indicates where to pull HCPCS from for the UB revenue code. If the revenue code is set to pull HCPCS (if set to C-FIM/Chg, D-Both/Detl, F-Chg/Def MR, M-Med Recs, O-Override, or S-Both/Sum), a claim in the UB92 format loads the 5 digit HCPCS and up to 2 two digit HCPCS Modifiers. A claim in the UB04 format loads the five-digit HCPCS and up to four two-digit HCPCS Modifiers.

Entry options are:

- **C** (FIM/Charge)—This option prints the HCPCS from the FIM or the HCPCS that was entered via charge entry.
- **F** (Charge/Default Medical Records)—This option prints the HCPCS from the FIM/Charge but defaults to Medical Records HCPCS.
- **M (**Medical Records)—This option prints the HCPCS from Medical Records.
- **D** (Both/Detail)—This option prints both the charge level HCPCS (from the FIM, or entered when the charge was placed) and the Medical Records HCPCS in a detail format.
- **S** (Both/Summary)—This option prints both the charge level HCPCS (from the FIM, or entered when the charge was placed) and the Medical Records HCPCS in a summary format.
- **O** (Override)—This option prints the FIM/Charge level HCPCS if there is one, and there is no Medical Records HCPCS. If there is both a charge level HCPCS (from the FIM or entered with charge entry), and a Medical Records HCPCS, none of the FIM HCPCS print, and the system overrides the charge level HCPCS with the Medical Records HCPCS.

- **N** (None)—This option does not print HCPCS for the charge line. The default is None.

HCPCS REQ'D (HCPCS REQUIRED) (1-A-R)
This field indicates whether the HCPCS are required for the revenue code line. Valid entries are **Yes** (Required) or **No** (Not Required); the default is No. If HCPCS procedures are required for a revenue code (this field is set to Yes), and there is no HCPCS code for the claim charge line, the claim fails edits. The error appears on the Claim Charge Data screen and on the Failed Claims Requirement Report as a Procedure Code Error.

HCPCS ROLLUP (1-A-R)
This field determines how charges without a HCPCS procedure in Locator 44 should be summarized. Entry options are **F (FIM/Department/Code)** or **R (Revenue Code)**; the default is **F**.

- If the HCPCS Rollup field is set to FIM Cd, and if two or more charges have the same Revenue Code, the same FIM item code, the same Service Date, no HCPCS, and the same NDC, RF, or IDE code, these charges are rolled up together. If the HCPCS Rollup is set to FIM Cd, and if two or more charges have the same Revenue Code, the same FIM item code, the same Service Date, no HCPCS, and different NDC, RF, or IDE codes, these charges are not rolled up together.

- If the HCPCS Rollup field is set to REV Cd, and if two or more charges have the same Revenue Code, the same Service Date, no HCPCS, and the same NDC, RF, or IDE code, these charges are rolled up together, but the NDC, RF, or IDE code will be lost. This is because, when rolling up by revenue code, different charge items could roll up together, making any NDC, RF, or IDE code possibly invalid. If the HCPCS Rollup field is set to REV Cd, and if two or more charges have the same Revenue Code, the same Service Date, no HCPCS, and different NDC, RF, or IDE codes, these charges are still rolled up together, but the NDC, RF, or IDE code are lost. This is because, when rolling up by revenue code, different charge items could roll together, making any NDC, RF, or IDE code possibly invalid.

The system first sorts on Revenue Code, HCPCS code/blank HCPCS Code, Service Date, and NDC, RF, or IDE code. The system may then plug Medical Records HCPCS into detail charge lines when using the Both/Detail, Charge/Default Medical Records, or Override option in the HCPCS Procedure field (in the Detail Revenue Code Setups). Finally, the system rolls up those charge lines with no HCPCS code, based on the HCPCS Rollup setting of FIM code or REV code.

HCPCS SUMMARY (1-A-R)
This field indicates if the HCPCS Summarization Master should be used for revenue codes that have the HCPCS Procedures field set to FIM/Charge Procedures. Entry options are **Y** for Yes or **N** for No; the default is N.

ANCIL UNITS (1-A-O)
This field indicates whether units of service should print for the revenue code in Locator 46. Entry options are **S** (Units of Service), **Q** (Quantity), **V** (Visits), **H** (Hours), or **D** (Days). If you enter S, the occurrence of the charge or credit prints. If you enter Q, the actual quantities on the charges print, and if you enter V, a 1 prints as the units. If you enter H, the quantity on the charges is converted into hours. If you enter D, the number of unique service days print as the units. There are no defaults to the units field. If the field is left blank, units do not print for the revenue code.

R&B UNITS (1-A-O)
This field indicates whether units of service should print for the revenue code in Locator 46. Entry options are **S** (Units of Service), **Q** (Quantity), **V** (Visits), **H** (Hours), or **D** (Days). If you enter S, the occurrence of the charge or credit prints. If you enter Q, the actual quantities on the charges print, and if you enter V, a 1 prints as the units. If you enter H, the quantity on the charges is converted into hours. If you enter D, the number of unique service days print as the units. There are no defaults to the units field. If the field is left blank, units do not print for the revenue code.

TOTAL (1-A-R)
This field indicates whether the units for this revenue code should be included in the units for the 001 or 0001 Total line. Entry options are **Y** for Yes or **N** for No; the default is N. The type of units is determined by the entry in the Units field. In order for the 001 or 0001 Total line to print the units of service, this field must be set to Y for the 001 or 0001 revenue code line.

DATE (1-A-O)
This field indicates whether the charges should print the service date in Locator 45 of the UB. Entry options are Y for Yes to edit the HCPCS for the same date of service and load the service date, U for Use to load the service date but not edit, or N for No, do not load the service date. When the Summarize By field is set to UB Code, your options are Y (Edit), U (Use), and N (No), with No being the default. If the Summarize By field is set to either Revenue Code within Service Date, or Service Date within Revenue Code, your options are Y (Edit) and U (Use), with Use being the default, since the service date automatically prints for the charge line in Locator 45 of the UB.

HCPCS/ROOM (1-A-0)
This field indicates whether room and bed charges should print the room rate, the HCPCS code from the FIM, or a blank in Locator 44 of the UB. Entry options are R for Room Rate (Room), H for HCPCS code (HCPCS), or B for Blank rate (Blank). If this field is left blank, or an R is entered, then the room rate prints for the room and bed charges with this revenue code, even if there is a HCPCS for this room and bed charge.

SIM Item Exclusions

The system allows you to add or revise SIM items for which the system suppresses printing on the UB claim form, regardless of the setting of the HCPCS Procedures field. When a charge is excluded from printing on the UB claim form, if the Print Non Covered Charges field is set to Yes, the charge that is excluded is evaluated to determine if it is

one of the non covered types of charges listed in the Print Non Covered Charges field. If the HCPCS Procedures field is set to either Medical Records, Both/Summary, or None, and if this revenue code line is printing a non covered amount on the UB, the SIM Item Exclusion is not backed out of non covered. This is because, when looking at the summarized proration information, the system cannot determine if the SIM item exclusion was part of the non covered amount. If the HCPCS Procedures field is set to either Medical Records, Both/Summary, or None, but the service date is printing in Locator 45 of the UB, if this revenue code line is printing a non covered amount on the UB, the SIM Item Exclusion can be backed out of non covered. This is because, when the date is being printed, the detail charge lines are reviewed, and the system can determine if this is a non covered charge. If the HCPCS Procedure field is set to FIM/Charge, Charge/Default Medical Records, Both/Detail, or Override, the SIM item exclusion is not added into the Non Covered locator if the claim is printing non covered and this is a non covered charge. If no SIM item exclusions have been created for this parameter, the system displays:

Do you wish to add SIM items for exclusion? (Y/N) [N]-- |

If SIM items exclusion exist for this parameter, the system displays:

Do you wish to revise SIM items for exclusion? (Y/N) [N]--

Enter **N** or press ENTER if you do not want to suppress charges from printing on the UB claim form. Enter **Y** if you want to add or revise SIM item exclusions. The system displays the following screen:

```
              General Hospital UB Charge Control Processor
                                                  Thu Jan 18, 2007 01:29 pm
Code      Description
707       MEDICARE OUTPATIENT
                          UB Sim Exclusion Items
 Seq           SIM Department                        SIM Item
 1             PT-PHYSICAL THERAPY                1254-BRACE MEASURE

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

Field Explanations

CODE (DISPLAY ONLY)
This field displays the UB Charge Control Parameter code.

DESCRIPTION (DISPLAY ONLY)
This field displays the UB Charge Control Parameter description.

SEQ (DISPLAY ONLY)
This field contains a sequential line number that is maintained by the system.

SIM DEPARTMENT (3-A-R)
This field contains the charge department associated with the selected SIM item. You can enter the code or a hyphen (-) to display a list of valid SIM departments.

SIM ITEM (4-N-R)
This field contains the SIM item that is excluded from printing on the UB claim form. You can enter up to 50 items for each SIM department.

The function keys at the bottom of the screen allow you to access the next and previous pages of information, insert a new line, delete a line, reset the lines, and exit the screen. After you complete these fields, press the **F7** key to exit the screen. The system files the information.

Modifying UB Revenue Codes for FIM Items

After you finish adding/revising SIM item exclusions, or if you decline to add/revise SIM item exclusions, the system enables you to modify the UB revenue code used for FIM items. This feature enables you to direct specific FIM items to a different UB revenue code for processing, thus overriding the mapping of the FIM item to a revenue code as established in the Financial Item Master. The system uses the parameters of the new UB revenue code for the charges, as established in the UB Charge Control Parameter, including:

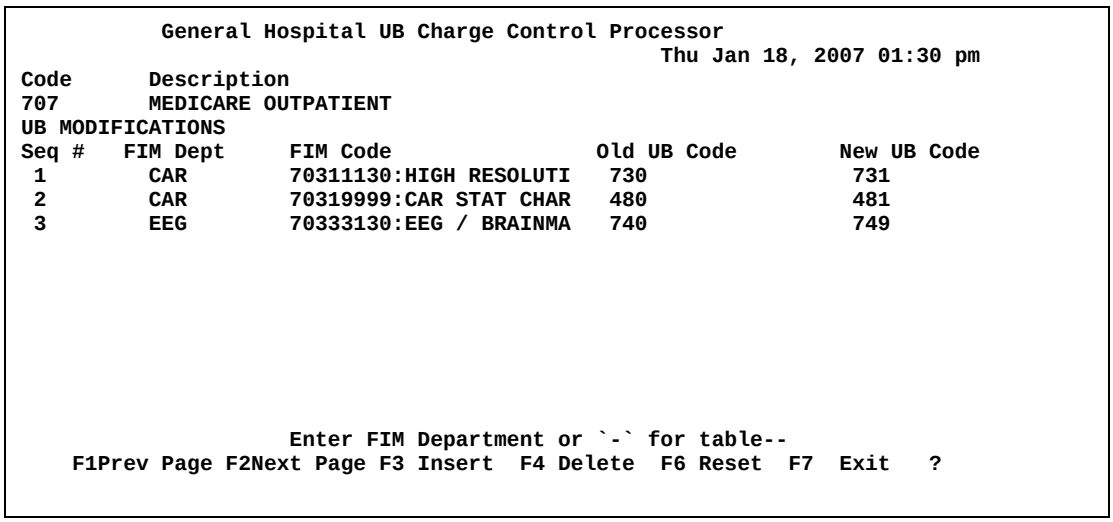
- Print Yes/No
- HCPCS Procedures
- HCPCS Required
- HCPCS Rollup
- Ancillary Units
- Room and Bed Units
- Total Units
- Date
- HCPCS/Room

The redirection(s) you define here effect only the claim; they do not change the actual UB revenue code at the charge level nor do they effect bills or the Billing Summary screen.

The system displays the following prompt:

Do you wish to revise UB Code for FIM Items? (Y/N) [N]--

Enter **N** or press ENTER if you do not want to modify UB revenue codes for FIM items. Enter **Y** if you want to add or revise UB revenue code mappings for FIM items. The system displays the following screen:



Field Explanations

CODE (DISPLAY ONLY)
This field displays the UB Charge Control Parameter code.

DESCRIPTION (DISPLAY ONLY)
This field displays the UB Charge Control Parameter description.

SEQ (DISPLAY ONLY)
This field contains a sequential line number that is maintained by the system.

FIM DEPT (3-A-R)
This field contains the FIM department associated with the selected FIM item. You can enter the department code or a hyphen (-) to display and select from a list of valid FIM departments.

FIM CODE (8-N-R)
This field contains the specific FIM item to be directed to a different UB revenue code, or you can enter A for all. When entering a specific FIM code, you can enter the FIM item code or a hyphen (-) to display and select from a list of valid FIM items for the department specified in the FIM Dept field. When the All option is used, the system searches for any charges with the FIM department and Old UB Code specified.

OLD UB CODE (DISPLAY ONLY)
If a specific FIM code is entered in the FIM Code field, this field displays the UB revenue code assigned to the FIM item in the Financial Item Master. If the All option is used in the FIM Code field, you must enter the Old UB Code field with the revenue code

to search on. Any charge with the specified department and Old UB Code entered points to the New UB Code for claims processing.

NEW UB CODE (3-N-R)
This field contains the UB revenue code to which you want to direct charges and credits for the FIM code identified in the FIM Code field, or, if the All option is used in the FIM Code field, for charges with the specified department and Old UB Code entered. You can enter the UB revenue code or a hyphen (**-**) to display and select from a list of valid revenue codes from the UB Revenue Codes table. Charges and credits directed to the identified UB revenue code use the parameters assigned to the specified revenue code.

If an individual FIM item is pointed to a new revenue code in the FIM Modifications screen, and also qualifies to be pointed to a new revenue code because of an All option in the FIM Modifications screen, the charge is processed according to the individual charge. For example if you had the following:

FIM Dept	FIM Code	Old UB Code	New UB Code
LAB	All	301	300
LAB	70116030:Nucleotidase	301	302

The charge is processed according to the individual charge and is pointed to revenue code 302 for the claim.

If you are pointing a FIM item FROM a UB Revenue Code that has the HCPCS Procedure field set to M for Medical Records, S for Both/Summary, or N for None, and the service date is not printing in Locator 44 for this revenue code, then none of the non-covered amount is backed out of the original revenue code with the FIM Modification. The new revenue code for the FIM Modification does not reflect any non-covered amount for the charge. If you are pointing a FIM item FROM a UB Revenue Code that has the HCPCS Procedure field set to M, S, or N, and the service date is printing in Locator 44 for the revenue code, then if the FIM Modification has a non-covered amount, it is backed out of the original revenue code and re-directed to the new revenue code.

If a FIM Modification makes the Total Charges on the original revenue code less than the non-covered amount on the original revenue code, the system sets the non-covered amount to equal the total charges on the original revenue code. For example, if the Total Charges for the revenue code was $100.00, and the non-covered amount for the revenue code was $165.00, the system sets the non-covered amount for the revenue code to $100.00.

The function keys at the bottom of the screen allow you to access the next and previous pages of information, insert a new line, delete a line, reset the lines, and exit the screen. After you complete these fields, press the **F7** key to exit the screen. The system files the information.

Loading FIM Items with Zero Dollar Charges

After you finish adding/revising FIM Item Modifications, or if you decline to add/revise FIM Item Modifications, the system enables you to identify specific FIM items, which have zero dollars in charges, that you would like to load to the UB claim form.

The following prompt is displayed:

Do you wish to revise FIM items to load zero dollar charges to the UB? (Y/N) [N] --

If you enter the default, **N** for **No**, the system files the information without revising FIM items to load zero dollar charges. You can enter **Y** for Yes to enter a department and FIM code for each item that should load on the UB, even when the dollar amount of the item is zero. If zero-dollar FIM items are loaded, the net of the charge and credit quantities for the zero-dollar FIM items for the claim service line is zero, and the total charge amount for the claim service line is zero, the claim service line does not appear on the claim. The scenarios where the net of the quantities for charges and credits for zero-dollar FIM items can be zero include the following:

- Charges move to another account due to Combine Billing
- Charges move to another account due to a DPW
- Charge and credit are issued for an item

Zero-dollar FIM items that are indicated to load to the claim are loaded if the net of the quantity on the charges is not zero. For example, if two charges were entered for a $0 item, but only one credit was entered, the claim would load the zero-dollar item with a quantity of 1. If one charge was entered for a zero-dollar item, but two credits were entered, the claim would load the zero-dollar item with a quantity of -1.

The following screen is displayed after Y for Yes is entered at the prompt:

```
                    General Hospital UB Charge Control Processor
                                                 Thu Jan 18, 2007 01:32 pm
Code      Description
707       MEDICARE OUTPATIENT
                        UB FIM Zero Dollar Items to Load
 Seq            FIM Department                        FIM Item
 1     CSR-CENTRAL SERVICES                62510002:MATTRESS, ROH









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

Field Explanations

CODE (DISPLAY ONLY)
This field displays the UB Charge Control Parameter code.

DESCRIPTION (DISPLAY ONLY)
This field displays the UB Charge Control Parameter description.

SEQ (DISPLAY ONLY)
This field contains a sequential line number that is maintained by the system.

FIM DEPT (3-A-R)
This field contains the FIM department associated with the selected FIM item. You can enter the department code or a hyphen (**-**) to display and select from a list of valid FIM departments.

FIM ITEM (TABLE LOOKUP)
This field contains the zero dollar FIM item that should appear on the UB claim form as a zero dollar charge. Enter the FIM item code or a hyphen (**-**) to display and select from a list of valid FIM items.

The function keys at the bottom of the screen allow you to access the next and previous pages of information, insert a new line, delete a line, reset the lines, and exit the screen. After you complete these fields, press the **F7** key to exit the screen and file the information.

UB SPLIT CLAIMS CRITERIA

This table allows you to split UB claims at the charge level, based on the following:

- UB Revenue Code
- Charge Level HCPCS
- FIM Item (Financial Item Master)
- Service Date of Charge
- Patient Type at the Charge Level

In the table, enter the criteria that should split to its own UB claim. The conditions are AND conditions, meaning that they all have to hold true in order to split to their own claim. For example, if a UB Revenue Code is listed, such as 740, and a HCPCS is listed, such as 55555, and the account has numerous charges for revenue code 740, only those charges for 740 with HCPCS 55555 are split to their own UB claim.

If more than one criterion is listed in a field, for example, say the UB Revenue Codes field has revenue code 420, and the FIM HCPCS field has HCPCS 11111 and 22222, and if the account has both charges with revenue code 420 and HCPCS 11111 and revenue code 420 with HCPCS 22222, these charges are reflected together on the split claim. If instead, each HCPCS needs to be on its own split claim, they need their own criteria. One claim split should list revenue code 420 and only HCPCS 11111 and another claim split should list revenue code 420 and HCPCS 22222.

After UB Split Claim Criteria Tables are built, they should be linked to the appropriate UB Charge Control Parameters. The Split Claims Criteria table (which is accessed through the Split Claims? field on the UB Charge Control Parameter defaults screen) is used to list the split claims criteria in priority order.

When this screen is accessed, the system checks the UB PCON Release field on the UB Pathways Parameter Screen. This field must either be blank or set to Pathways Contract Management Release 8.0 or higher with an effective date of the current date or earlier in order for the system to allow you to build UB Split Claims Criteria tables. The following error message is displayed if the Pathways Contract Management Release is not 8.0 or higher:

Must be using PCON release 8.0 or higher for UB Split Claims--

If the UB PCON Release field is either blank or set to Release 8.0 or higher, after you select the UB Split Claims Criteria menu option, the system displays the following prompt:

Enter Split Name or '-' for table list--

You can enter a hyphen lookup for a list of existing criteria tables, or enter the split name directly. The system accepts alphabetic only characters, 1-14 characters in length. For example, MAMM for mammography. The system automatically up-shifts the characters, and therefore only uppercase letters are accepted. This name displays in the Claim Split Indicator field within Claims Management, Claim Status Information screen, so it should be descriptive enough to allow the user to know which claim this is. This name is stored for each split claim. If you enter a name that is not already in the UB Split Claims Criteria Table, the system prompts:

Add Split Name Criteria XXXXXXXXXXXXX? (Y/N) [Y] -

X is the new split name.

Next, the system prompts for the description of the Split Claim Criteria. This description is used for all facilities using the Split Claim Criteria name.

Enter description for Split Name Criteria xx -

The following prompt is displayed after you enter a new split claim criteria:

UB Split Claim Criteria Initiated!

The system then prompts for the facility, and access is given to facilities appropriate for the CRT being used. Within each Split Name criteria, such as Vaccine, the user sets the appropriate facility-specific information.

If no split claim criteria existed previously for the selected facility and Split Name Criteria, then the following message appears:

Split Claim Criteria Initiated for Facility x!

The system then displays the screen where the criteria can be entered. This screen with criteria is for the facility entered above. A criteria screen can exist for one, all, or a subset of the facilities for each Split Name. For example, for the Split Name *Vaccine*, there may be a criteria screen for Facilities A, B, and C. For another Split Name, such as *Ambulance*, there may be only a criteria screen for Facility C.

The criteria are the UB Revenue Codes, FIM HCPCS, FIM Departments/Items, Service Date Split, and Charge Level PT Split. The Alternate Claim Load Edit Parameter, Alternate Charge Control Parameter, and Alternate Provider Master (explained below) are used for charges that qualify for that claim split criteria table.

Following is an example of the Split Claims Crtieria screen:

```
                General Hospital UB Split Claims Criteria
                                        Tue May 31, 2009 12:42 pm
1 Split Name          2 Description             3 Facility
   Mamm                  Mammography               A - Main General Hospital
 4 UB Revenue Codes
   401,403
 5 FIM HCPCS

 6 FIM Departments/Items
   RAD
 7 Service Date Split
   No
 8 Charge Level PT Split

 9 Alternate Claim Load Edit Parameter       10 Alternate Charge Control Parameter
   45 - Mammography                             95 - Mammography
11 Alternate Provider Master                 12 NY APG Rate Code Table
   06 - Mammography
13 Edit Date                                 14 Edited By
   05/31/05 04:45pm                             Hansen,Viggo


 Enter revenue codes (xxxx,xxxx,xxxx-xxxx) or dash (-) for table lookup--
```

Field Explanations

1. SPLIT NAME (A-14-R)
This field contains the name of the claim split. Duplicate names are not allowed. The name Primary also is not allowed, since the system names the claim with the non-split charges the Primary claim. If you enter Primary for the name, the system displays the following error message:

Split Name of "Primary" Not Allowed!

This name is displayed when accessing Claims Management, selecting the claim, selecting Claim Status Information, and reviewing the Claim Split Indicator for any split claim. The Split Name is also listed in the appropriate Charge Control Parameter.

If a Split Name is entered, but no criteria are entered in the UB Revenue Codes, FIM HCPCS, FIM Departments/Items, Service Date Split Y/N, or Charge Level PT Split Y/N fields, the system won't accept the table when you try to save it, and the following message is displayed:

No criteria entered, claim split "AAAAAAAAAAAAA" Not Accepted

2. DESCRIPTION (AN-25-R)
This field contains a user-defined description of the split name. This description applies to all facilities. The description must be one that is not already in use, or the system displays the following error message:

Description in use for xx already!

3. FACILITY (DISPLAY ONLY)
The system displays the facility indicator and description for the facility selected upon accessing this screen.

4. UB REVENUE CODES (4-N OR TABLE LOOKUP-O)
This field contains the UB revenue code(s) that are to be on a separate claim. When this field is accessed, the following prompt is displayed:

Enter revenue codes (xxxx,xxxx,xxxx-xxxx) or dash (-) for table lookup

You can enter one or multiple revenue codes separated by a comma (for example, 420,430,440), a range of revenue codes (401-403), or enter a hyphen (-) to display the UB Revenue Code Table and select codes from the table. Each time you update the UB Revenue Codes field, these selections overlay, and are not added to, the existing entries. To deselect a revenue code that you have selected from the table, enter a hyphen (-) before the table number (for example, -4).

If you enter codes rather than selecting them from the table, the system treats a revenue code with no leading zero and a revenue code with a leading zero as two unique codes. For example, 0300 is not the same as 300. Therefore, the codes must be entered as they exist in the UB Revenue Code Table (for example, either 0300 or 300).

If a claim split criterion is based on a UB Revenue Code, the system looks to the UB Revenue Code at the charge level. The system does not look to any FIM Modifications in the UB Charge Control Parameter. For example, if the charge level UB Revenue Code is 636, and this revenue code is pointed to Revenue Code 250 as a FIM Modification, if a Split Claims Criteria Table has UB Revenue Code 250 splitting to its own claim, this charge item would not be one of the charges split to the claim. The Split Claims Criteria Table would have to list UB Revenue Code 636.

If you enter a revenue code that does not exist in the UB Revenue Code Table, the system displays the following message:

Revenue Code xxxx Not in UB Revenue Code Table

This check is made for individual revenue codes keyed, and for the beginning and ending revenue codes in a range. If a range of revenue codes is keyed and the ending code does not follow the beginning code, the system displays the following message:

xxxx does not follow xxxx!

5. FIM HCPCS (5-AN-O OR TABLE LOOKUP-O)
This field contains the FIM HCPCS code(s) that should be split to a separate claim. If a claim split criterion is based on a FIM (charge) level HCPCS, the system looks to the HCPCS at the charge level. The system does not look to a revised HCPCS from any Payer HCPCS Cross Reference Table. For example, if the FIM HCPCS is 11111, and this HCPCS is pointed to HCPCS 22222 in a Payer HCPCS Cross Reference Table, if

a Split Claims Criteria Table has HCPCS 22222 splitting to its own claim, this charge item would not be one of the charges split to the claim. The Split Claims Criteria Table would have to list HCPCS 11111. When determining if the HCPCS code should be split to its own UB claim, the system ignores modifiers. Only the code up to five digits is considered (although codes less than five digits can be entered).

When this field is accessed, two prompts are displayed, in the following order:

The first prompt displays any FIM HCPCS previously entered for the Split Claim Criteria.

Current FIM HCPCS. Key `-` to see complete list.

The second prompt indicates how the FIM HCPCS can be entered or listed.

Enter the FIM HCPCS (xxxxx,xxxxx,xxxxx-xxxxx) to add to the list,`-` for current list of FIM HCPCS codes in the UB Split Claim Criteria Table, or `Partial Code-` to select HCPCS beginning with Partial Code.

You can respond to this prompt as follows:

- You can enter a single HCPCS code (for example, 11111), numerous HCPCS codes separated by a comma (for example, 11111, 22222, 33333), or a range of HCPCS codes (for example, 80000-89999). A single HCPCS that is entered is edited against the HCPCS Master.

- You can enter a partial HCPCS code and hyphen for a search on HCPCS that begin with the numbers entered (for example, 014-). Inactive HCPCS codes are not included when doing a partial HCPCS lookup.

- You can enter a range of HCPCS codes. When entering a range of HCPCS, the beginning and ending HCPCS codes are edited against the HCPCS Master. The beginning and ending HCPCS codes must also be the same length in each range entered. For example, if a five-digit beginning HCPCS is entered, a five-digit ending HCPCS must be entered (for example, 80000-89999). If a three-digit beginning HCPCS is entered, a three-digit ending HCPCS must be entered (for example, 111-155).

The system allows a table lookup on the HCPCS previously entered when you enter a hyphen (-). To remove a HCPCS or range, the hyphen (-) can be entered before the HCPCS table sequence number. For example, if one of the HCPCS was listed as the sixth HCPCS, such as 6) 01472, to remove this HCPCS, you would enter -6. Each time you update the FIM HCPCS field, these selections are added to, and do not overlay, the existing entries.

When entering FIM HCPCS, the system may display error messages if the codes are entered incorrectly:

- When entering a HCPCS that is greater than five digits, the following error message is displayed:

  Error! Length of HCPCS cannot be greater than 5!

- When entering a code that is five digits or less, and when entering a range and the beginning and ending HCPCS are edited against the HCPCS Master, if the code is marked Inactive in the HCPCS Master, the following warning message is displayed:

  Warning! HCPCS Code xxxxx is Inactive. Accept criteria anyway? (Y/N)-

- When entering in a code that is 5 digits or less, and when entering a range and the beginning and ending HCPCS are edited against the HCPCS Master, if the code does not exist in the HCPCS Master, the following warning message is displayed:

  Warning! xxxxx Is not a valid HCPCS code. Accept criteria anyway? (Y/N) --

- When entering a range of HCPCS codes, and the beginning and ending HCPCS do not have the same number of characters, the following error message is displayed:

  Beginning and Ending HCPCS in Range Must Have Same Number of Characters

- When entering in a range of HCPCS, and the range overlaps with an existing range or individual HCPCS code in the same Split Name Criteria table, the following error message is displayed (for example, a range of 80000-85555 exists, and the user enters a range of 82222-89999):

  Error: 82222-89999 Criteria Overlaps with Existing Criteria 80000-85555

  Or, for an individual HCPCS:

  Error: 82222-89999 Criteria Overlaps with Existing Criteria 83333

- If the partial lookup feature is used to select a HCPCS from the HCPCS Master, and this HCPCS has been selected previously due to a range, the individual HCPCS is not saved, and the following error message is displayed:

  xxxxx exists in xxxxx-xxxxx and is not being saved! Press NL.

  The above message may be displayed numerous times, once for each selected HCPCS that is already in a range.

- When entering in a range of HCPCS, and the ending HCPCS precedes the beginning HCPCS, the following error message is displayed:

  xxxxx does not follow xxxxx

- If a duplicate HCPCS criteria is entered, one of the following error messages is displayed:

  xxxxx selected already for Claim Split Criteria!

  xxxxx-xxxxx selected already for Claim Split Criteria!

6. FIM DEPARTMENTS/ITEMS (5-N-O OR TABLE LOOKUP-O)

This field contains the FIM departments/items that should be split to a separate claim. You can enter a single FIM department and item or numerous FIM departments and items. The system first prompts for the FIM Department valid for the Facility displayed in field 3 or allows a FIM Department and Item to be keyed together. Once the FIM department is entered, individual FIM items can be keyed or you can display a list of the FIM Items for that FIM Department to select from. More than one FIM item can be selected. Once the FIM Items are selected or keyed, the system again prompts for the FIM department or FIM department and item. If the ENTER key is pressed, the user exits the field. To de-select a FIM Item when using a table lookup, the hyphen (-) is used before the table number. Once the field is accepted, only the FIM Departments, and not the FIM Items, are displayed in the field. To view existing FIM Departments and Items, you can enter an asterisk (*). Each time the user updates the FIM Departments/Items field, these selections are added to, and do not overlay, the existing entries.

If a selection criterion is entered that does not exist, the system displays the following error message:

FIM Department xxxx Not in Financial Item Master

FIM Item xxxxxxxx Not in Financial Item Master

When deleting a FIM Department and Item, the system displays the following message, where DEPT is the department and ITEM is the Financial Item:

DEPT/ITEM removed as Claim Split Criteria!

7. SERVICE DATE SPLIT (1-A-O)

This field indicates whether the system should load a split UB claim for each unique date of service on the charges. For example, if revenue codes 420 and 430 are listed in the UB Revenue Codes field, and HCPCS 11111 and 22222 are listed in the FIM HCPCS field, and the Service Date Split is set to Yes, if there are charges for revenue code 420 on 5/7/05 with HCPCS 11111, revenue code 420 on 5/14/05 with HCPCS 11111, revenue code 430 on 5/7/05 with HCPCS 22222, and revenue code 430 on 5/14/05 with HCPCS 22222, there will be two split claims. One will have the charges for 5/7/05 – both the Rev 420 HCPCS 11111 and the Rev 430 HCPCS 22222 charges, and another claim will have the charges for 5/14/05 – both the Rev 420 HCPCS 11111 and the Rev 430 HCPCS 22222 charges. Users can state that the service date split is the only criterion, without listing any other criteria such as UB Revenue Code or FIM

HCPCS. If the service date split is the only criterion, the insurance receives a split/ separate claim for each date of service.

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

Should the system load split claims by charge service date? (Y/N) [N]

You can enter **Y** for Yes, load a split UB claim for each unique date of service on the charges or **N** for No, don't load a split UB claim by unique service date on the charges.

8. CHARGE LEVEL PT SPLIT (TABLE LOOKUP-O)

The Charge Level PT Split field allows you to load a split claim for specific patient types at the charge level. As charges are entered on the system, the current patient type is retained at the charge level. The patient type used for the claim split is the current patient type associated with the charge. If the charge has not been reclassed due to revenue, it will be the patient type when the charge posted in PA. If the charge does reclass due to revenue, it will be the latest patient type associated with the charge. If you need a separate UB based on the charge level patient type, enter the patient types that should group to their own claim. If more than one patient type should be reflected on the same claim, such as ER and OP, these patient types should be listed together under the same claim Split Name. Any charges with these patient types are split to their own UB claim. If other criteria are listed in addition to the Charge Level PT Split field, these are AND conditions, and could create an additional split. For example, if the UB Revenue Codes field is set to 510, and the Charge Level PT Split field is set to ER, if the account has charges with the ER patient type for non 510 revenue codes, charges with the ER patient type for the 510 revenue code, and charges for NON ER patient types with non 510 and 510 revenue codes, the system will load two claims. The Split claim will have the ER patient type charges with the 510 revenue code only. The Primary claim with the *left over charges* will have the ER patient type charges with the NON 510 revenue codes and the NON ER patient type charges with both 510 and NON 510 revenue codes.

When this field is accessed, the Patient Type Table for the facility is displayed. You can select a single patient type or numerous patient types separated by a comma. If each patient type needs to be on its own claim, separate Split Name criteria should be set. The patient type at the charge level is used to split the charges, not the patient type at the account level. To deselect the patient type that you have selected, enter a hyphen (-) before the sequence number in the Patient Type Table display; for example, -5 to remove AMB in this example: 5)AMB.

9. ALTERNATE CLAIM LOAD EDIT PARAMETER (TABLE LOOKUP-O)

This field contains the UB Claim Load and Edit parameter to use for this split claim. This is useful if the split claim should list a different Type of Bill in Locator 4 of the UB or if it should load different data to the claim. If no alternate UB Claim Load and Edit Parameter is listed, the Claim Load Edit Parameter that is linked to the insurance plan is used for the primary claim and for the split claims.

10. ALTERNATE CHARGE CONTROL PARAMETER (TABLE LOOKUP-O)
This field contains the alternate UB Charge Control Parameter to use for this split claim. This is useful if the split claim should not edit the same as the primary UB claim or if the charge formatting has different requirements for the split claim. For example, the primary claim may have the Edit Room Chgs field set to Yes, whereas you would probably have this field set to No for the split claim parameter. If no alternate UB Charge Control Parameter is listed, the Charge Control Parameter that is linked to the insurance plan is used for the primary claim and for the split claims.

NOTE: All claims, both primary and any split claims, use the (Payer) HCPCS Cross Reference Table assigned to the UB Charge Control Parameter on the insurance at the account level. Also, both primary and any split claims use the NY Claim setting on the UB Charge Control Parameter assigned to the insurance at the account level. Therefore, if the UB Charge Control Parameter assigned to the insurance at the account level is set to use Payer HCPCS Cross Reference Table 01, but the alternate UB Charge Control Parameter assigned to the split claim(s) is set to use Payer HCPCS Cross Reference Table 05, both the primary and the split claims use Payer HCPCS Cross Reference Table 01. This is necessary since Medical Records HCPCS are cross referenced prior to any claim splitting.

11. ALTERNATE PROVIDER MASTER (TABLE LOOKUP-O)
This field contains the alternate Provider Master to use for this split claim. The system only allows a Provider Master for the facility displayed on the screen. This is useful if the split claim should auto load different Condition, Occurrence, Occurrence Span, or Value Codes to the claim or if a different Provider address should be loaded to the claim. If no alternate Provider Master is listed, the Provider Master that is linked to the insurance plan is used for the primary claim and for the split claims. If an alternate Provider Master is used for the split claim, this is displayed in the Alternate Provider Master field on the Claim Status Information screen within Claims Management.

12. NY APG RATE CODE TABLE (TABLE LOOKUP-O)
This field determines the New York APG Rate Code Table to be used for the Split Claim(s). Note that the UB Claim Load Edit Parameter for the Insurance must have the NY Claim Type field set to *G* for NY APG, and the Provider Master assigned to the insurance should have Value Code 24-NY Medicaid Rate Code highlighted.

The Split claim uses this table to determine the APG Rate Code for Value Code 24. If there is no NY APG Rate Code Table linked to the UB Split Claims Criteria Table, the system looks to the NY APG Rate Code Table linked to the UB Claim Load Edit Parameter.

- If the UB Split Claim Criteria table is set to use an Alternate Claim Load Edit Parameter, and the NY APG Rate Code Table field is left blank on the Split Claim Criteria table, the system looks to this alternate Claim Load Edit Parameter and to the NY Claim Type field to determine if the claim is a NY APG and which NY APG Rate Code Table to use.

- If the UB Split Claim Criteria table does not have either the NY APG Rate Code Table field set or the Alternate Claim Load Edit Parameter field set, the system looks to the Claim Load Edit Parameter assigned to the insurance. It then looks to the NY Claim Type field to determine if the claim is a NY APG and which NY APG Rate Code Table to use.

- If the UB Split Claim Criteria table is set to use an Alternate Provider Master, this alternate Provider Master must have Value Code 24 - NY Medicaid Rate Code highlighted in order to look to the New York APG Rate Code Table.

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

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

Once the criteria screen is entered for this facility, the system displays the following prompt:

Accept (Y/N) [Y] -

Any additions/changes to FIM HCPCS and FIM Departments/Items are recorded/ saved as data is keyed into the field. Other items on the screen are not saved unless you answer Yes to the Accept prompt.

If Y for Yes is entered or defaulted, the system accepts the screen and continues as outlined below. If N for No is entered, the system displays the following prompt, allowing you to update the criteria:

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

If you enter a period and then press the ENTER key, none of the data is accepted, and the following prompt is displayed:

Enter Split Name or '-' for table list --

If Y for Yes is entered to the Accept prompt, the system continues with:

Enter/Maintain criteria for another facility? (Y/N) [N] -

If N for No is entered, the system displays the following prompt:

Enter Split Name or '-' for table list --

If a Y for Yes is entered, the system displays the available facilities:

```
UB Split Claim Criteria
Page:01                          Facilities
( 1) Model Hospital A
( 2) Model Hospital B
( 3) Model Hospital C
```

The following prompt is displayed:

Enter choice-

Once you select the facility, the system then prompts:

Copy non facility specific information within Split Name criteria from another facility? (Y/N) [N] -

If N for No is entered, the system displays the criteria screen as shown above, and you must enter the appropriate data fields.

If Y for Yes is entered, the system displays the list of facilities:

```
UB Split Claim Criteria
Select facility to copy from
Page:01                          Facilities
( 1) Model Hospital A
( 2) Model Hospital B
( 3) Model Hospital C
( 4) Facility D (cloned from A)
```

The following prompt is displayed:

Enter choice -

Once the copy From facility is selected, the system copies the non-facility specific data from this facility into the current facility's table and displays the criteria screen. These fields are: Split Name, Description, UB Revenue Codes, FIM HCPCS, Service Date Split, Alternate Claim Load Edit Parameter, and Alternate Charge Control Parameter. The FIM Departments/Items and the charge level Patient Type items can copy from one facility to another if they exist in both facilities. If only some of the FIM Departments/Items or Patient Types exist in the facility you are copying to, these are the only ones that will copy. For example, if the FIM Departments/Items has Departments CAR and ER for Facility A, and Facility B has Department CAR, but not

ER, the CAR Department/Items can copy to Facility B, but not the ER Department/ Items.

Note that when copying from another facility into the current facility, data is added to the following fields: UB Revenue Codes, FIM HCPCS, FIM Departments/Items, Charge Level PT Split. The following fields are overlaid with the data you are copying from: Service Date Split, Alternate Claim Load Edit Parameter, Alternate Charge Control Parameter. The Alternate Provider Master does not copy since it is facility-specific.

The system displays the message:

Copying FROM facility X TO facility Y!

When exiting a table where no revisions were made, the system prompts:

Delete? (N)-

If a Y for Yes is entered, the system first checks if any UB Charge Control Parameters have this Split Claims Criteria table linked. The system responds with:

Checking for use of split claim criteria!

If there are UB Charge Control Parameters that have this Split Claims Criteria linked to them, the system displays the following message (once for each UB Charge Control Parameter that has this Split Claims Criteria linked to it, where X is the parameter number):

Split claim criteria must be removed from UB Chg Ctrl Prm X. Press NL.

The system then responds with:

Split claim criteria not deleted because it is being used!

If there are no UB Charge Control Parameters with this Split Claims Criteria table linked to them, the system prompts:

Are you sure you want to delete Split Claim Criteria x for Facility y? (Y/N) [N]-

If a response of Y for Yes is entered, the UB Split Claim Criteria are removed for the facility. The removal of the criteria for the facility is confirmed with the following message:

Split claim criteria X deleted for facility Y

If split claim criteria are deleted for a facility and no facilities are using the criteria, it can be removed from the table by responding Y for Yes to the following prompt:

No facilities have defined this split claim criteria. Do you want to delete it? (Y/N) [Y]-

If a response of Y for Yes is entered, the Split Name is removed, and this is confirmed with the following message:

Split Claim Criteria x deleted from table!

Once the criteria tables are built, the appropriate split claims criteria can be listed in the UB Charge Control Parameters in priority order.

1500 CHARGE CONTROL PARAMETERS (US ONLY)

This parameter defines how charges are printed on the 1500 claim form, indicates if separate forms are necessary for each physician or for each department, and determines whether charges should be detailed or summarized by date. Only professional fees load and print on the 1500 claim.

The 1500 Charge Control Parameter is defined in the Insurance Plan Coverage Master. The Insurance Plan Master allows Patient Type exceptions for claim parameters. As many charge control parameters as necessary can be set up to meet intermediary requirements.

This table is not split by facility.

The sort for a 1500 loading in the 08/05 1500 Format, loading either in Midnight Processing or using the Add Claim to Insurance function is by Physician, Service Date, HCPCS Code, Reference Facility, IDE Code, NDC Code, SIM Code and Charge Number.

When a 1500 claim loads, either in Midnight Processing, in Instant Adjustment Bill, or in Add Claim to Insurance, the system determines if the claim loaded in the 1992 1500 Format or in the 08/05 1500 Format. This is controlled by the Begin Date for the 08/05 1500 format in the hospital-defined 1500 Claim Load and Edit Parameters. If the Begin Date for the 08/05 1500 Format of the Claim Load and Edit Parameter is today or is a date in the past, the claim loads in the 08/05 1500 Format, and the charge data is in the 08/05 1500 Format as defined for the fields below. The Claim Format is displayed for the claim when accessing the Claim Status Information screen within Claims Management and the Claim Format field.

After the 1500 Charge Control Parameters menu option is selected, the system prompts you to enter a 1500 charge control code. You can enter a code or a hyphen to display a list of valid codes. When a code is entered or selected, the first screen is displayed.

```
                  General Hospital 1500 Charge Control Processor
                                                Thu Jul 26, 2012 12:06 pm

 1 Code  2 Description                    3 Separate Clms  4 EC2000   5 EPSDT
   45      MEDICAID 1500                    Physician        Claim
 6 Detail/Summarize Items     7 Diagnosis Print    8 HCPCS Cross Reference
   Detail                       Reference Number     01-MEDICAID HCPCS
 9 Use Med Rec HCPCS         10 M/R HCPCS UB Rev Code              11 Print UOS
   Yes                          98 - MEDICAID MR HCPCS                Yes
1992 (24K)    12 Phys/Dept ID Upper                13 Phys/Dept ID Lower
                 Medicare, State Lic                  NPI
08/05 (24J)   14 Phys/Dept ID Upper                15 Phys/Dept ID Lower
                 Upin-1G, State Lic-0B                NPI
16 Print TOS 17 TOS Cross Ref   18 Place of Service               19 Print EMG
   Yes                             Inpatient Hospital                Yes
20 Default Diagnosis            21 Default Physician   22 Edit Pro Fee Charges?
                                   No                      Yes H,D,I,U,L
23 24A Date Print               24 Print Anesth Time   25 PCON Phy/Dept ID
   MM  DD  YY                      Yes                    Lower/Lower
26 Non-Specific HCPCS           27 Edit Date           28 Edit By
                                   07/11/12 12:02pm       Pitstop,Penelope


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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the 1500 charge control parameter.

2. DESCRIPTION (30-C-R)
This field contains the description of the 1500 charge control parameter.

3. SEPARATE CLMS? (1-A-R)
This field indicates whether all 1500 charges should be included on one 1500 claim or whether a separate claim is needed for each physician or for each department. Entry options are **P** for Physician, **D** for Department, or **N** for Do Not Load Separate Claims. If you enter P, a separate form is created for each physician. The physicians to use by department is determined in the 1500 Department/Supplier Override table. The system first calculates how many physicians there are for the account based on the 1500 Department/Supplier Override table, and then loads separate claims by physician or not, depending on this field. If you enter a D, a separate claim form is created for each department.

For the 1992 1500 Format, the system uses the 1500 Department/Supplier Override table to determine the physician to use to load a PIN number in locator 24K. If a department is set to use Performing or Charging Physician in the 1500 Department/ Supplier Override table, the claim prints the appropriate PIN number in locator 24K depending on the charge. The system, however, uses the physician on the last charge processed for locators 25 (Federal Tax ID and EIN/SSN), 31 (Physician Signature),

and 33 (Physician Supplier Billing Name, Address, PIN#, and Group#). If the last charge processed does not have a physician, these fields are blank.

For the 08/05 1500 Format, the system uses the 1500 Department/Supplier Override table to determine the physician to use to load an NPI and/or legacy number in locator 24J. If a department is set to use Performing or Charging Physician in the 1500 Department/Supplier Override table, the claim prints the appropriate number(s) in locator 24J, depending on the charge. The system, however, uses the physician on the last charge processed for locators 25 (Federal Tax ID and EIN/SSN), 31 (Physician Signature), and 33 (Physician Supplier Billing Name, Address, 33a NPI, 33b Legacy Number). If the last charge processed does not have a physician, these fields are blank.

If you enter N, all charges are included on the same 1500 claim form.

4. EC2000 (1-A-O)
This field indicates whether the account or claim level charges should be sent to EC2000 CA. When you access this field, the following prompt displays:

Send (A)ccount or (C)laim level charges to EC2000 CA? [A]

You can enter **A** for Account or **C** for Claim. If the field is set to Claim, the system sends the NPI code from the claim charge data from Locator 24J Lower.

5. EPSDT VALUE (1-A-O)
This field contains the Early and Periodic Screening, Diagnosis, and Treatment value that should print for every charge line of the 1500 in Locator 24H. When this field is accessed, the following prompt is displayed:

Enter EPSDT value--

6. DETAIL/SUMMARIZE ITEMS? (1-A-R)
This field indicates whether professional service charges should be printed on the 1500 claim form in detail or in summary. When set to summarize like items, the system summarizes charges with the same service date, HCPCS Code, Diagnosis, and Physician. Entry options are **D** (detail) or **S** (summarized). The default is D.

For example, if the patient receives two chest X-rays on the same date and D is entered to this field, if the charges also had the same HCPCS Code, Diagnosis, and Physician, two line items would display. If S had been entered to this field, the charges would be summarized into one charge line.

If a claim loads in the 08/05 1500 Format, and the Detail/Summarize Items field is set to Detail, but the charge has an offsetting credit that matches on Revenue Code (which is not on the 1500 claim), Service Date, HCPCS Code/Modifiers, Quantity, Amount, Performing Physician, and Ordering Diagnosis, neither the charge nor the credit is loaded to the claim.

If the offsetting charge and credit are the only charge/credit that qualify for the claim, the claim is loaded according to the Load $0.00 Claim field in the Claim Load Edit Parameter.

7. DIAGNOSIS PRINT (1-A-R)

This field determines whether the system should print the diagnosis code from the charge line or the reference number (number 1, 2, 3, or 4) from form locator 21 in form locator 24E on the 1500 claim form. Enter D or press ENTER to print the diagnosis code; enter R to print the reference number.

The 1992 1500 Format of the claim can accommodate either the actual diagnosis code or a reference number. The 08/05 1500 Format cannot accommodate an actual diagnosis code. The 08/05 1500 Format can only take 1 to 4 reference numbers, without punctuation/commas. For example, if only reference number 1 applies to the charge line, a 1 should be entered in locator 24E. If reference numbers 1, 2, and 4 apply to the charge line, 124 should be entered in locator 24E. Therefore, if the claim loads in the 08/05 1500 Format, regardless of the setting of this field, the system reflects the Reference Number in locator 24E. STAR Patient Accounting can only automatically load a single reference number in this field. However, users can enter 1 to 4 characters in the DX Ref field within Claims Management, Claim Charge Data screen, to reflect additional reference numbers.

The system only prints four unique diagnoses in form locator 21. If more than four diagnoses exist, the system does not print the reference in form locator 24E for charges relating to a diagnosis that does not display on the form in locator 21.

For the 1500 in the 08/05 format, the ICD-10 Effective Date field on the Claim Load Edit Parameter is also used by the Claim Load Edit Parameter field "Diagnosis for 1500 Locator 21". Based on the ICD-10 Effective Date field and the admission date or discharge date of the patient loading the 1500 claim, the ICD flag for the claim will be set to either a 9 for ICD-9, or a 10 for ICD-10. When loading diagnosis codes to Locator 21, the system will load either ICD-9 or ICD-10 diagnosis codes based on the ICD flag. If the ICD flag is blank, the system assumes ICD-9. The logic for loading diagnosis codes to Locator 21 has not changed. The user continues to enter the choices and order for loading diagnoses to Locator 21 (which can be loaded from Medical Records, Admissions, and the charge level).

The Diagnosis Codes that load to Locator 21 are dependent on the Diagnosis for 1500 Locator 21 field on the header screen of the 1500 Claim Load Edit Parameter when using internal elements 1500 Diagnosis Box 21 - Field 1, 1500 Diagnosis Box 21 - Field 2, 1500 Diagnosis Box 21 - Field 3, and 1500 Diagnosis Box 21 - Field 4. If using another internal element in the diagnosis code fields in Locator 21, the system does not access the Diagnosis for 1500 Locator 21 field on the Claim Load and Edit Parameter. It pulls the diagnosis code, depending on the internal element only.

NOTE: If more than one page of a 1500 claim form is required, the system prints the same diagnoses in form locator 21 on all pages of the claim.

8. HCPCS CROSS REFERENCE (2-N-O)

This field indicates whether or not a Reference Table should be used in conjunction with this Charge Control Parameter. Enter the table number or a hyphen (-) to display a list of Payer HCPCS Cross Reference Tables. The Payer HCPCS Cross Reference Table is used to point FIM HCPCS Codes to alternate HCPCS Codes to use on the claim form for the payer. When the FIM HCPCS Code is encountered on a charge for the payer, the alternate HCPCS Code loads and prints on the claim form. The HCPCS Code is changed only on the claim form. The patient bill is not affected, nor are the actual HCPCS Codes at the account level.

9. USE MED REC HCPCS (1-A-O)

This field indicates whether the system should look to the Medical Records HCPCS to see if there is a HCPCS entered for the revenue code if there is no HCPCS on the FIM/charge record. The Medical Records HCPCS prints on the charge line for the claim. Entry options are **Y** for yes and **N** for no. A Medical Record HCPCS loads to the 1500 claim form if the following criteria are met:

- This field is set to Y.
- The professional fee charge has no FIM/charge HCPCS.
- The UB revenue code of the charge matches the Medical Records HCPCS UB revenue code.
- The doctor tied to the 1500 claim matches the Surgeon on the Medical Records HCPCS.
- The date of service of the professional fee charge matches the date on the Medical Records HCPCS.

10. M/R HCPCS UB REV CODE (5-N-C)

This field indicates whether the system should use a Med Rec HCPCS UB Rev Code Table when loading Medical Records HCPCS codes to professional fee charges that have no FIM/charge HCPCS codes. Enter the Medical Records HCPCS UB Range Table code to use, or enter a hyphen (-) for a table lookup of available codes. This field is accessible only if the Use Med Rec HCPCS field is set to Y. The Medical Records HCPCS UB Revenue Code Table allows you to list for a UB Revenue Code, additional UB Revenue Codes to search on when pulling Medical Records HCPCS to the claim. The system first tries to find a Medical Records HCPCS tied to the same UB Revenue Code as the charge. If one is not found, it searches for Medical Records HCPCS tied to one of the other UB Revenue Codes listed for the charge UB Revenue Code in the Med Recs HCPCS UB Rev Code Table. A Medical Records HCPCS loads only if the following criteria are met:

- The professional fee charge has no FIM/charge HCPCS.
- The UB revenue code of the charge matches the Medical Records HCPCS UB revenue code or the UB Revenue Code on the Medical Records HCPCS matches a revenue code listed in the Med Rec HCPCS UB Rev Code Table for the UB Revenue Code on the charge.
- The doctor tied to the 1500 claim matches the Surgeon on the Medical Records HCPCS.

- The date of service of the professional fee charge matches the date on the Medical Records HCPCS.

Once a Medical Records HCPCS Code has printed on a 1500 claim for the carrier, it cannot be used again, even on another claim sequence for the same carrier. For example, if carrier 100200 is set to load a separate claim for each physician, and if for the final bill it loads 1500 claim sequence 2 and 1500 claim sequence 3 for the same carrier/plan, the Medical Records HCPCS that print on claim sequence 2 would not be repeated on claim sequence 3.

11. PRINT UOS? (1-A-R)
This field indicates whether units of service print on the 1500 form in locator 24G. Entry options are **Y** for Yes or **N** for No; the default is Y.

For the 08/05 1500 Format, the Units of Service prints in Locator 24G Lower. If the units of service field exceeds 999, the fourth digit prints on the line dividing locator 24G and 24H, and the fifth digit prints in 24H for EPSDT, allowing up to a 5 digit units of service. When printing a 5 character units of service, the EPSDT value is therefore overridden. If the Pharmacy units of service differs from the billing units of service, the Pharmacy units of service prints in Locator 24G Upper. If the units of service exceeds 999, the fourth digit prints on the line dividing locator 24G and 24H, and the fifth digit prints in 24H for EPSDT, allowing up to a 5 digit units of service.

12. PHYS/DEPT ID UPPER (1-AN-O) (1992 FORMAT, LOCATOR 24K)
This field indicates whether the physician/department ID prints in the upper line of Box 24K on the 1992 version of the 1500 claim form. If this field is set to Yes, the system allows a first and second choice for the ID. When this field is accessed, the following prompt is displayed:

Print Phys/Dept ID in upper part of locator 24K (1992 Format)? (Y/N) [N]--

You can enter **Y** for Yes or **N** for No; the default is N. If you enter Y, the system displays a table of physician identification numbers for your first choice. After you select the first choice, the system displays the table for your second choice for physician identification number (which cannot be the same as the first choice). If a physician identification number cannot be identified from the first choice when the claim loads, the system attempts to define a physician identification number from the second choice. Based on the field you wish to use (from the STAR Patient Care Physician Table), select one or two of the following, separately:

- UB ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number

- Commercial ID Number
- PIN ID Number
- UPIN ID Number
- Other ID Number 1
- Other ID Number 2
- Doctor Name
- Tax ID Number
- FIN Interface ID Number
- Physician's Social Security Number
- State License ID Number
- National Provider ID (NPI #)
- Taxonomy No

If you respond with **Y** (Yes) to the prompt, but do not make a selection from the table lookup for physician identification numbers, the system changes to field to N (no) and displays the following message:

Response for Print Phys/Dept ID Upper defaulted to No!

If loading separate claims by physician, the physician to use to pull the ID number is based on the 1500 Department/Supplier Override table. If you are not loading separate claims by physician, the system uses the physician, based on the 1500 Department/ Supplier Override table, on the first charge processed for the claim.

13. PHYS/DEPT ID CODE LOWER (1-AN-O) (1992 FORMAT, LOCATOR 24K)
This field indicates whether the physician/department ID prints in the lower line of Box 24K on the 1992 version of the 1500 claim form. If this field is set to Yes, the system allows a first and second choice for the ID. When this field is accessed, the following prompt is displayed:

Print Phys/Dept ID in lower part of locator 24K (1992 Format)? (Y/N) [N]--

You can enter **Y** for Yes or **N** for No; the default is N. If you enter Y, the system displays a table of physician identification numbers for your first choice. After you select the first choice, the system displays the table for your second choice for physician identification number (which cannot be the same as the first choice). If a physician identification number cannot be identified from the first choice when the claim loads, the system

attempts to define a physician identification number from the second choice. Based on the field you wish to use (from the STAR Patient Care Physician Table), select one or two of the following, separately:

- UB ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number
- Commercial ID Number
- PIN ID Number
- UPIN ID Number
- Other ID Number 1
- Other ID Number 2
- Doctor Name
- Tax ID Number
- FIN Interface ID Number
- Physician's Social Security Number
- State LIcense ID Number
- National Provider ID (NPI #)
- Taxonomy No

If you respond with Y (Yes) to the prompt, but do not make a selection from the table lookup for physician identification numbers, the system changes the field to N (no) and displays the following message:

Response for Print Phys/Dept ID Lower defaulted to No!

If loading separate claims by physician, the physician to use to pull the ID number is based on the 1500 Department/Supplier Override table. If you are not loading separate claims by physician, the system uses the physician, based on the 1500 Department/ Supplier Override table, on the first charge processed for the claim.

14. PHYS/DEPT ID UPPER (1-AN-O) (08/05 FORMAT, LOCATOR 24J)
This field indicates whether the physician/department ID prints in the upper line of Box 24J for the 08/05 format. If this field is set to Yes, the system allows a first and second choice for the ID. The system prompts for your first choice for physician identification number, then the ID Qualifier for this number, followed by the second choice for physician identification number, and the ID Qualifier for this second choice.

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

Print Phys/Dept ID in upper part of locator 24J (08/05 Format)? (Y/N) [N]--

If you enter **Y** (Yes), the system prompts you to select the physician ID to print on the 1500 claim form. Values are as follows:

- UB ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number
- Commercial ID Number
- PIN ID Number
- UPIN ID Number
- Other ID Number 1
- Other ID Number 2
- Doctor Name
- Tax ID Number
- FIN Interface ID Number
- Physician’s Social Security Number
- State LIcense ID Number
- National Provider ID (NPI #)
- Taxonomy No

When entering your first choice for your physician ID, or when entering both a first and second choice for your physician ID, the system prompts for an ID Qualifier for each

number. This ID Qualifier prints in Locator 24I Upper on the 08/05 1500 Format. This field is not used for the 1992 1500 Format of the 1500 claim. The ID Qualifier entered here is used for each charge line in 24I Upper for the 1500 claim, and should correlate to the physician ID set to load in the Phys/Dept ID Upper field. A table lookup on the 1500 Physician ID Qualifier Table outlined below is allowed. Valid values are as follows:

NOTE: These values are subject to change. Please check your electronic 837 Professional specifications.

0B STATE LICENSE NUMBER

1B BLUE SHIELD PROVIDER NUMBER

1C MEDICARE PROVIDER NUMBER

1D MEDICAID PROVIDER NUMBER

1G PROVIDER UPIN NUMBER

1H CHAMPUS IDENTIFICATION NUMBER

E1 EMPLOYER'S IDENTIFICATION NUMBER

G2 PROVIDER COMMERCIAL NUMBER

LU LOCATION NUMBER

N5 PROVIDER PLAN NETWORK IDENTIFICATION NUMBER

SY SOCIAL SECURITY NUMBER (MAY NOT BE USED FOR MEDICARE)

X5 STATE INDUSTRIAL ACCIDENT PROVIDER NUMBER

ZZ PROVIDER TAXONOMY

If loading separate claims by physician, the physician to use to pull the ID number is based on the 1500 Department/Supplier Override table. If you are not loading separate claims by physician, the system uses the physician, based on the 1500 Department/ Supplier Override table, on the first charge processed for the claim.

If you respond with **Y** (Yes) to the prompt, but do not make a selection from the table lookup for physician identification numbers, the system changes to field to N (no) and displays the following message:

Response for Print Phys/Dept ID Upper defaulted to No!

15. PHYS/DEPT ID CODE LOWER (1-AN-O) (08/05 FORMAT, LOCATOR 24J)
This field indicates whether the physician/department ID code is printed in the lower portion of Box 24J, for the 08/05 1500 format. For the 08/05 1500 format, this field should be set to pull the Physician's NPI number.

Print Phys/Dept ID in lower part of locator 24J (08/05 Format)? (Y/N) [N]-- |

You can enter **Y** for Yes or **N** for No. If you enter Y, the system prompts you to select the physician ID to print on the 1500 claim form. The system prompts for your first choice for physician identification number, followed by the second choice for physician identification number. The system does not prompt for an ID Qualifier for either the first or second choice for 24J Lower since the hard copy claim form has *NPI* printed on the form.

If loading separate claims by physician, the physician to use to pull the ID number is based on the 1500 Department/Supplier Override table. If you are not loading separate claims by physician, the system uses the physician, based on the 1500 Department/ Supplier Override table, on the first charge processed for the claim.

16. PRINT TOS? (1-A-R)
This field indicates whether the type of service from the FIM should print on the 1992 Format of the 1500 claim form in locator 24C. The 08/05 Format of the 1500 claim does not have a type of service field. Therefore, even if this field is set to Yes, the type of service does not load on the 08/05 Format of the 1500 claim. Entry options are **Y** for Yes or **N** for No.

17. TOS CROSS REF (2-AN-O)
This field indicates whether a Type of Service Cross Reference Table should be used in conjunction with this Charge Control Parameter. Enter the table number or a hyphen (-) to display a list of Type of Service Cross Reference Tables. The Type of Service Cross Reference Table points a FIM Type of Service Code to an alternate Type of Service. When the FIM TOS Code is encountered on a charge for the payer, the alternate TOS Code loads and prints on the claim if a Type of Service Cross Reference table has been defined in this field.

NOTE: A Type of Service locator only exists on the 1992 Format of the 1500 claim form in locator 24C. The 08/05 Format of the 1500 claim does not have a type of service field.

18. PLACE OF SERVICE (2-AN-R)
This field contains the default value that updates the place of service in locator 24B for each charge department without a place of service code defined in the 1500 Department/Supplier Override table. For each charge line, the system pulls the place of service from the 1500 Department/Supplier Override table before defaulting to this POS. If charges from different departments summarize together, the system uses the POS for the department on the last charge processed for the charge line. You can enter the place of service code or a hyphen (-) to display a list of valid codes from the Place of Service table.

19. PRINT EMG? (1-A-R)
This field indicates whether the EMG Code entered on the second screen of the Plan Demographics at the account level should print for each charge line in locator 24I for the 1992 Format of the 1500 claim, or in locator 24C for the 08/05 Format of the 1500 claim. Entry options are **Y** for Yes or **N** for No; the default is Y.

20. DEFAULT DIAGNOSIS (1-A-O)
This field indicates whether the system should default a diagnosis in locator 24E for any charge without a diagnosis at the charge level. Entry options for the default are **R** for Reference Number 1, **A** for the principal, or if blank, the admitting diagnosis, or **P** for the principal, or if blank, the working diagnosis.

An entry of R for Reference Number 1 is only allowed if the field Diagnosis Print is set to Reference Number in the 1500 Charge Control Parameter. If the field Diagnosis Print is set to Diagnosis Code, and you try to use the default of Reference Number 1 in the Default Diagnosis field, the system displays the following error message:

Error: Can't load reference number when loading diagnosis codes

When loading diagnosis codes, valid entries for the Default Diagnosis are A, P, or blank. When loading reference numbers, valid entries for the Default Diagnosis are R, A, P, or blank. There is no default for this field.

The 1992 1500 Format of the claim can accommodate either the actual diagnosis code or a reference number. The 08/05 1500 Format cannot accommodate an actual diagnosis code. The 08/05 1500 Format can only take 1 to 4 reference numbers, without punctuation/commas.

08/05 Format

For the 1500 claim, the 08/05 version can only print the diagnosis reference number in locator 24E. Therefore, if the charge has an Ordering Diagnosis, but it does not match any of the Diagnosis Codes in Locator 21-1, 21-2, 21-3, or 21-4, the charge line does not have a reference number and can have a Dx (diagnosis) error in the Claim Charge Data screen. The charge line only has a charge diagnosis error if the field Edit Pro Fee Charges is set to include Diagnosis Code/Reference Number in the 1500 Charge Control Parameters.

For charges without an Ordering Diagnosis, these charges can default the Diagnosis Code/Reference Number by setting the field Default Diagnosis on the 1500 Charge Control Parameter screen to either Reference Number 1, Principal/Admitting Diagnosis, or Principal/Working Diagnosis. If set to either Principal/Admitting Diagnosis or Principal/Working Diagnosis, if this diagnosis matches one of the diagnosis codes in Locator 21, the appropriate reference number is used.

The Diagnosis Codes that load to Locator 21 are dependent on the Diagnosis for 1500 Locator 21 field on the header screen of the 1500 Claim Load Edit Parameter when using internal elements 1500 Diagnosis Box 21 - Field 1, 1500 Diagnosis Box 21 - Field

2, 1500 Diagnosis Box 21 - Field 3, and 1500 Diagnosis Box 21 - Field 4. If using another internal element in the diagnosis code fields in Locator 21, the system does not access the Diagnosis for 1500 Locator 21 field on the Claim Load and Edit Parameter. It pulls the diagnosis code, depending on the internal element only.

1992 Format

If you are using the internal elements in locator 21 for diagnosis as is set up in the 1500 Claim Master, for any claims loading in the 1992 Format of the 1500, locator 21 is also updated with the default diagnosis if it does not exist in locator 21 already. The internal elements that are used in the 1500 Claim Master are:

- 1500 Diagnosis Box 21 - Field 1
- 1500 Diagnosis Box 21 - Field 2
- 1500 Diagnosis Box 21 - Field 3
- 1500 Diagnosis Box 21 - Field 4

If, for example, you are defaulting to the Principal or Admitting Diagnosis Code in 24E, if the Principal Diagnosis Code is not one of the Diagnosis in locator 21, it is added to locator 21. This happens for all default settings (Principal/Admitting, Principal/Working, or Reference Number 1). As another example, if the field Diagnosis Print is set to Reference Number, and the field Default Diagnosis is set to Principal/Admitting diagnosis, if there is a charge line that is missing the diagnosis code, it defaults. If this default diagnosis is not already one of the diagnosis codes in locator 21, it is added to locator 21. If the added diagnosis prints in locator 21-3, the charge line itself prints a 3 in locator 24E. Since the 08/05 Format of the 1500 can only default to Reference Number 1, the system cannot add diagnoses codes to Locator 21 for this version of the claim form.

21. DEFAULT PHYSICIAN? (1-A-O)
This field indicates whether the Physician ID number of the Pro Fee physician listed in the Service Item Master (SIM) for the charge should print in Locator 24K for the 1992 Format of the 1500 or Locator 24J for the 08/05 Format of the 1500 if a performing physician is not attached to the charge. When the field is accessed, the following prompt is displayed:

Default to the pro fee physician in the Pricing Information screen of the SIM? (Y/N) [N]--

You can enter Y (Yes) or N (No).

The system prints the ID number according to the Phys/Dept ID Upper and Phys/Dept ID Lower for 24K fields on the 1992 1500 format, or according to the Phys/Dept ID Upper and Phys/Dept ID Lower for 24J fields on the 08/05 1500 format. For example, if the Phys/Dept ID Upper field is set to Yes and the UPIN number, and the Phys/Dept ID Lower field is set to Yes and the NPI number, if this field is set to Yes to default to the pro fee physician in the SIM, the pro fee physician's UPIN number is printed in locator 24J Upper and the pro fee physician's NPI number is printed in locator 24J Lower.

NOTE: This field works in conjunction with the 1500 Department Supplier Override Table. The physician that is used for the 1500 claim form is defined in the 1500 Department/Supplier Override table (Admitting, Attending, Referring, Performing, Charging, or Other). Therefore, even if the system defaults to the pro fee physician from the SIM for the charge, the physician for the claim may be another physician. For example, if the charge has the physician Hansen, Victor, but the 1500 Department/Supplier Override table states to use the Attending Physician for the department, who is Jones, Ann, the claim would load for Jones, Ann and have this physician's information.

22. EDIT PRO FEE CHARGES? (TABLE LOOKUP)
This field indicates if the system should edit professional fee charges for missing information on the claim. If answered with a Yes, the system displays the information you can edit for. The options are:

(1) HCPCS Procedure Code

(2) Diagnosis Code/Reference Number

(3) Locator 24K Lower (1992 Format)

(4) Locator 24J Upper (08/05 Format)

(5) Locator 24J Lower (08/05 Format)

You can highlight any or all options to edit for. The field displays an H if editing for HCPCS Procedure Code, a D if editing for Diagnosis Code/Reference, an I if editing for Locator 24K Lower (1992 Format), a U for Locator 24J Upper (08/05 Format), and an L for Locator 24J Lower (08/05 Format). For example, if editing for all options, the field displays *H,D,I,U,L*. The errors are on the Failed Claims Requirement report (FCR250) in the following format:

LOC-FLD: 24D Error: HCPCS Code is Required Quantity 1

LOC-FLD: 24E Error: Diagnosis Code/Ref # is Required Quantity 2

LOC-FLD: 24K Error: Physician ID is Required Quantity 1

LOC-FLD: 24J Upper Error: Physician ID is Required Quantity 1

LOC-FLD: 24J Lower Error: Physician ID is Required Quantity 1

Within Claims Management, Charge Data, the claim displays the charge errors in the upper portion of the screen as follows:

HCPCS Procedure Errors: 1

Diagnosis/Reference # Errors: 2

Charge Summary Errors:

24J Upper/Lower ID Errors: 1/ 1

The charge line itself also has an error message such as:

Prc/DX/ID-U/ID-L/Chg Summ.

23. 24A DATE PRINT (1-A-O)
This field determines in what format the date prints on the 1500 charge detail lines for Form Locator 24A. The choices for this field are **C** for the MMDDYYYY format or **S** for the MM DD YY format. The default is S.

24. PRINT ANESTHESIA TIME? (1-A-O)
This field indicates whether the system should print the anesthesia start and end times on the CMS 1500 claim, if the times were entered in Medical Records for the HCPCS code. This field cannot be accessed unless the Use Med Rec HCPCS field has a response of Yes. When this field is accessed, the following prompt is displayed:

Print anesthesia times with charge information (Y/N) [N]--

If you enter **Y** for Yes, and the source of a HCPCS code for a 1500 service line is Medical Records, the anesthesia start and end times are loaded with the HCPCS. This includes HCPCS selected from Medical Records due to the Medical Records HCPCS UB Revenue Code Table.

For the 1992 Format of the 1500, the Anesthesia start and end times print in the lower section of Locator 24 and takes up a charge line (no other information prints on the charge line). The information prints starting under the HCPCS field in Locator 24D in the following format:

TIME: 10:30-12:45

For the 08/05 Format of the 1500, the Anesthesia start and end times print in the upper section of Locator 24 for the charge line with the anesthesia HCPCS code (the HCPCS code with the Anesthesia Start and Stop Times is entered in the Medical Records HCPCS screen). The information prints starting in the upper shaded portion of Locator 24, above the HCPCS in Locator 24D in the following format, where b is a blank, and 00770 is the HCPCS code (therefore the word BEGIN starts above the 3rd digit of the HCPCS code in 24D):

BEGIN 1030 END 1245 TIME 135 MINUTES

00770

Anesthesia start and end times can be edited under Claim Charge Data, and anesthesia start and end times print on the 1500 claim, if they exist. The ability to edit and print anesthesia start and end times is not provided for a claim unless this

parameter was set to Yes when the claim loaded. If a 1500 claim loads during Midnight Processing or is loaded by the Add Claim to Insurance function, reloaded during Midnight Processing, or edited, and Print Anesthesia Time is set to Yes in the 1500 Charge Control Parameters, the following occurs:

- If the claim is edited in Claim Charge Data and a HCPCS code from Medical Records is added automatically to a service line missing a HCPCS code, the anesthesia start and end times are added from Medical Records if they exist. This includes HCPCS selected from Medical Records due to the Medical Records HCPCS UB Revenue Code Table. Medical Records HCPCS can be added to a 1500 charge line with a procedure code error if the claim splits by Physician, and the charge line and the Medical Records HCPCS match on revenue code, service date, and physician.

- If the claim is edited in Claim Charge Data, the anesthesia start time and the anesthesia end time can be maintained for any claim service line.

- If there are two or more professional fee charges with the same Service Date, Ordering Diagnosis, Physician, and HCPCS code, and if the Medical Records HCPCS is listed two or more times with an Anesthesia Start and End time, the charges are split on the 1500 claim form and are not summarized, even if the Detail/Summarize Items field is set to Summarize Like Items in the 1500 Charge Control Parameter.

25. PCON PHY/DEPT ID (1-A-O)

This field indicates whether the Physician ID Upper (24K Upper for the 1992 1500 Format, or 24J Upper for the 08/05 1500 Format), or Physician ID Lower (24K Lower for the 1992 1500 Format, or 24J Lower for the 08/05 1500 Format) should be sent in the 1500 PCON interface for the rendering provider. When this field is accessed, the system displays two prompts: one for the 1992 format and one for the 08/05 format as follows:

Select (U)pper or (L)ower Phy/Dept ID for PCON 1500 rendering provider for 1992 Format-

Select (U)pper or (L)ower Phy/Dept ID for PCON 1500 rendering provider for 08/05 Format-

STAR Patient Accounting loads a physician/department ID into the upper, lower, or both parts of form locator 24K/24J and truncates the value to a length of ten. If the claim has not been returned by EC2000, and if a value exists in the field used to record the physician/department ID for the lower part of form locator 24K/24J, that value is provided. Otherwise, the value for the upper part of form locator 24K/24J is used.

If both the lower and upper part of form locator 24K/24J are used, and you want the value in the upper part of form locator 24K/24J to be used, this field can be used to indicate this.

If the claim has been returned by EC2000, and values exist in both the upper part of form locator 24K/24J and the lower part of form locator 24K/24J, both values are used.

Otherwise, the value in the lower part of form locator 24K/24J is used. If the length of the provider number is greater than 9, then the first 9 characters are saved in the field for the upper part of form locator 24K/24J and characters 10-15 are saved in the field for the lower part of form locator 24K/24J. Characters beyond 15 are truncated.

26. NON-SPECIFIC HCPCS (1-AN-O)
This field is used to select the table of non-specific HCPCS codes for this 1500 Charge Control Parameter.

When accessing the field, the system prompts:

Enter Non Specific HCPCS table or '-' for lookup--

You can enter the table number for the Non Specific HCPCS table that should be used for this 1500 Charge Control Parameter. The system displays a list of Non Specific HCPCS tables. After you select a table, the field displays the table number and description.

When the 1500 claim loads, if the claim has one or more of the listed HCPCS, after all HCPCS processing, including Payer HCPCS Cross Reference Tables, then the claim charge lines with a listed HCPCS will have a new error of Non Spec HCPCS, and the system will blank out the claim charge line description. In order to clear the claim charge line error, the user must use the F5 key to Edit the charge line, and enter in the "Charge Desc" field the detailed HCPCS description. Do not enter the generic, non specific HCPCS description or else the claim will be rejected on the payer side.

NOTE: The system is looking to the 5 digit HCPCS, and will edit regardless of modifiers.

The number of errors can be seen on the Claim Charge Data screen within Claims Management in the line below the account number, in the field "Non Specific HCPCS". The Error field at the charge level will have "NS HCPCS" for Non Specific HCPCS.

These errors appear on the Failed Claims Requirement Report (FCR250x) as:

Loc-Fld: 24D Error: Non Specific HCPCS Errors Quantity x

27. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this 1500 charge control parameter was last edited.

28. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this 1500 charge control parameter.

You can press ENTER to display the second screen of the 1500 Charge Control Parameters.

```
            General Hospital 1500 Charge Control Processor
                                                Fri Aug 1,2012 04:15 pm


 1 Reference Facility    2 RF Rev Codes       3 IDE     4 IDE Rev Codes
   All                     All                  All       All
 5 NDC       6 NDC Rev Codes                  7 NDC Unit Qual/Units
   Yes/Edit    Entries Defined                    Edit HCPCS









Further sort claim charge lines by Reference Facility code? (Y/N) [N]--
```

1. REFERENCE FACILITY (1-A-O)

This field indicates whether claim charge lines should be sorted further by the Reference Facility Code. When the field is accessed, the following prompt is displayed:

Further sort claim charge lines by Reference Service Facility code? (Y/N) [N]--

If you enter **Y** for Yes, the system sorts the claim charge lines by the Reference Facility code. Therefore, the system sorts the charges as follows:

- If the Detail/Summarize Items field is set to Detail, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has a Reference Facility code, the claim breaks this out to three charge lines.

- If the Detail/Summarize Items field is set to Summary, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has a Reference Facility code, the claim breaks this out to two charge lines.The one charge line with the RF code breaks out to its own claim charge line. Since the Reference Facility code does not print on the paper 1500 claim form, it is not apparent to the payor why there are two charge lines for what appear to be the same charges.

NOTE: The hospital should be entering in the HCPCS Modifier of 90 for these reference/send out lab tests.

2. RF REV CODES (1-A-O)

This field is used to indicate which revenue codes should further sort by the Reference Facility Code. This field can be accessed only if the field Reference Facility field is set to Yes. When this field is accessed, the following prompt is displayed:

Select UB Revenue Codes or key A for All--

The UB Revenue Codes table is displayed. You can enter **A** for All or enter a hyphen (-) to select codes. If only some revenue codes are selected, the system further sorts the charges by RF code only for those charges with the selected revenue code. Even if other revenue codes not selected have a Reference Facility code, these charges are not sorted by Reference Facility code. Note that the UB revenue code does not load/ print to the HCFA 1500 claim. However, it is used as a criteria for further sorting the charges by Reference Facility code.

3. IDE (1-A-O)
This field indicates whether the system should further sort claim charge lines by Investigational Device Exemption (IDE) code. When this field is accessed, the following prompt is displayed:

Further sort claim charge lines by Investigational Device Exemption code? (Y/N) [N]--

If you enter **Y** for Yes, the system further sorts the claim charge lines by Investigational Device Exemption code. Therefore, the system sorts the charges as follows:

- If the Detail/Summarize Items field is set to Detail, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has an IDE code, the claim breaks this out to three charge lines.

- If the Detail/Summarize Items field is set to Summary, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has an IDE code, the claim breaks this out to two charge lines.The one charge line with the IDE code breaks out to its own claim charge line. Since the IDE code does not print on the paper 1500 claim form, it is not apparent to the payor why there are two charge lines for what appear to be the same charges.

4. IDE REV CODES (TABLE LOOKUP-O)
This field is used to indicate which revenue codes should further sort by the IDE code. This field can be accessed only if the IDE field is set to Yes. When this field is accessed, the following prompt is displayed:

Select UB Revenue Codes or key A for All

The UB Revenue Code Table is displayed. You can select one or more UB revenue codes that should further sort by IDE code or enter **A** for All. If only some revenue codes are selected, the system further sorts the charges by IDE code only for those charges with the selected revenue code. Even if other revenue codes not selected have an IDE code, these charges are not further sorted by IDE code. Note that the UB revenue codes do not load/print to the HCFA 1500 claim. However, it is used as a criteria for further sorting the charges by IDE code.

5. NDC CODE (1-A-O)

This field defines whether charge lines are sorted by National Drug Control (NDC) codes and whether the system edits for the existence of an NDC Code. The NDC field only applies to 1500 claims loading in the 08/05 1500 Format. The NDC field does not apply to 1500 claims loading in the 1992 1500 Format.

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

Further sort claim charge lines by National Drug Code? (Y/N) [N]--

- If you enter N for No, charge lines cannot be sorted by NDC codes.
- If you enter **Y** for Yes, charge lines can be sorted by NDC codes, and you can access the NDC Rev Codes field to define revenue codes that should look for NDC codes.
- If you enter Yes, the system sorts the charges as follows:
  - If the Detail/Summarize Items field on this screen is set to Detail, if there are 3 charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but 1 of the charges has an NDC code, the claim will break this out to 3 charge lines.
  - If the Detail/Summarize Items field on this screen is set to Summary, if there are 3 charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but 1 of the charges has an NDC code, the claim will break this out to 2 charge lines. The one charge line with the NDC code will break out to it's own claim charge line.

  The NDC Code prints on the hardcopy 1500 claim form in the shaded, upper portion of locator 24 for the charge line. The system first prints the identifier N4 followed by the 11-digit NDC number, (space), and the unit of measurement, followed by the metric decimal quantity or unit. There is no space or hyphen in between the N4 and the actual code. The N of N4 starts printing above the first digit of the HCPCS code in Locator 24D as follows, where J1563 is the HCPCS code:

  N454236324135 UN123.5

  J1563

  The system only does this additional NDC sort for claims loaded after the 1500 Charge Control parameters have been updated. Previously loaded claims are not updated with this sort if they are reloaded because of errors, or reloaded manually.

If the first prompt is set to Y for Yes, the following prompt is displayed:

Edit for NDC Code? (Y/N) [N] -

The default, if left blank or if set to N, is to NOT edit for an NDC code, but to load if present.

- If the Edit for NDC Code? prompt is answered with a Y for Yes, then the system will edit as follows:
  - If the field NDC Rev Codes is set to All and the NDC Unit Qual/Units field is set to either "Edit All", "leave Blank" or "Default" unit qualifier, the system will edit All revenue codes on the claim for the NDC code.
  - If the field NDC Rev Codes is set to All and the NDC Unit Qual/Units field is set to Edit specific HCPCS, the system will edit All revenue codes that have one of the listed HCPCS codes on the claim for the NDC code.
  - If the field NDC Rev Codes is set to specific revenue codes, and the NDC Unit Qual/Units field is set to either "Edit All", "leave Blank" or "Default" unit qualifier, the system will edit claim charge lines with a listed revenue code for the NDC code.
  - If the field NDC Rev Codes is set to specific revenue codes, and the NDC Unit Qual/Units field is set to Edit specific HCPCS, the system will edit claim charge lines that have BOTH a listed revenue code and one of the listed HCPCS codes for the NDC code.

    The NDC field will display Yes/Edit, Yes, No, or blank.

    The system gives an error for each claim charge line that qualifies for the edit. These edits are displayed on the 1500 Claim Charge Data Screen. For more information, see Claim Charge Data Screen in the *Billing and Claims Volume*, Chapter 3: Claims.

6. NDC REV CODES (TABLE LOOKUP-O)

This field can only be accessed if the NDC field is set to Yes. The field is a table lookup of the UB Revenue Code Table.

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

Select UB Revenue Codes or key A for All--

You can select which UB revenue codes should further sort by NDC code, or enter **A** for All. If one or more revenue codes is selected, the NDC Rev Codes field displays *Entries Defined*. If A for All is entered, the NDC Rev Codes field displays *All.* If only some revenue codes are selected, the system further sorts the charges by NDC code only for those charges with the selected revenue code. Even if other revenue codes not selected have an NDC code, these charges are not further sorted by NDC code.

Note that the UB revenue code does not load/print to the1500 claim. However, it is used as a criteria for further sorting the charges by NDC code.

7. NDC UNIT QUAL/UNITS (1-A-O)
If the NDC Code field contains Yes, you can access this field. The system displays the following prompt:

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B] --

You have the following entry options:

- You can enter **B** (Blank):
  - If the field is set to B for Blank and there is not a unit qualifier for the charge line with the NDC code, but there is an NDC unit value, the system leaves two blank spaces where the unit qualifier would have appeared. For example: N412345678901 1234.567.
  - If the field is set to B for Blank and there is a unit qualifier for the charge line with the NDC code, but there is no NDC unit value, the system leaves the NDC units blank. For example: N412345678901 ML.
  - If the field is set to B for Blank and there is no unit qualifier and no NDC unit value for the charge line with the NDC code, the system leaves 2 blank spaces where the unit qualifier would have appeared and there are no NDC units. For example: N412345678901

  When the NDC Unit Qual/Units field is set to Blank, the field displays *Blank*.
- You can enter **E (**Edit**).** The following prompt is displayed:

  Select (H)CPCS items to edit or key A for All--

  Enter **A** for All if you want the system to edit for the NDC Unit Qualifier and the NDC Unit value for the revenue codes specified in the NDC Rev Codes field.

  If you enter **H**, (HCPCS) the following prompt is displayed:

  Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

  After you enter a range of HCPCS, the following prompt is displayed:

  View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

  You can enter **Y** (Yes) to view or edit the HCPCS codes or **A** (Add) to add HCPCS. If you enter Add, you can enter a valid HCPCS code. If you enter Yes, the system prompts:

Enter Partial Code to start lookup--

You can enter a partial lookup, such as J-, or press ENTER to view all HCPCS already selected to edit the NDC information. The system displays the HCPCS codes. The system is looking at the claim HCPCS, after using any Payer HCPCS Cross Reference Table. Therefore, you should list the final claim HCPCS in this table that should edit for the NDC information.

You can delete HCPCS codes or add them to the list. When you select one of the codes to delete, the system prompts you to verify the delete action. If you enter A to Add a HCPCS, the system prompts:

Enter HCPCS code to add to the list--

You can enter only a single HCPCS code (not a range).

If the field is set to E for leave blank and edit and there is no unit qualifier for the charge line with the NDC code, and/or there is no NDC unit value, the system fails the claim with one of the following error messages:

- NDC Unit Qual, if the charge line is missing only the unit qualifier
- NDC Units, if the charge line is missing only the NDC units

NOTE: If two or more charge lines summarize together because they have the same Revenue Code, Service Date, HCPCS Code, NDC code, and NDC unit Qualifier, and one charge has NDC Units, but one or more charges do not, the Claim charge line may still have an error for NDC Units, even though the NDC units field has a value. This is telling you that at least 1 of the summarized charges was missing the NDC units, and therefore the claim NDC units may not be accurate. If you press F5 to edit the claim charge line, if a new NDC UOS value is entered and accepted, this clears the NDC Units error.

- NDC Qual+Units, if the charge line is missing both the unit qualifier and the NDC units

Once the HCPCS are set in the NDC Unit Qual/Units field to Edit, in order to update the HCPCS list, access the NDC Unit Qual/Units field again. The system prompts:

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B]-

- Enter **E** for Edit. The system then prompts:

  Select (H)CPCS items to edit or key A for All-

- Enter **H** for HCPCS. The system then prompts:

Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

Press ENTER past this prompt, and the following prompt is displayed:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

- Enter **Y** for Yes. The system prompts:

  Enter Partial Code to start lookup-

  You can enter a partial lookup, such as J-, or press ENTER to get the full list of HCPCS already selected. From here, you can delete or add HCPCS.

The Failed Claims Requirement Report (FCR250x) displays the NDC error in the following format and does not list the detail charge lines.

Loc-Fld: 24D Error: NDC Qual/Unit Errors Quantity 2 Required

Claim Reload does not clear these NDC errors. To correct the errors, you can do one of the following:

Edit the data on the claim

Use Edit PA Charges to enter the PA NDC Qty/Qual, and then use Instant Adjustment Bill to load an adjustment claim for the insurance, or use Add Claim to Insurance to load an adjustment claim for the insurance.

- If you enter D for Default Unit Qualifier at the field prompt, the system displays the following prompt:

  Default to F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter), or ME (Milligrams) --

  You can enter F2, UN, GR, ML, or ME. If an invalid value is entered, the system displays the following error message: Error! Invalid Entry.

  When you set the NDC Unit Qual/Units field to Default, the field displays Default and the default unit qualifier. For example: Default UN

  The claim defaults in the Unit Qualifier only if the claim charge line loading the NDC information also has the NDC Units. If the claim charge line loading the NDC information has only the NDC code and is missing both the Unit Qualifier and the NDC Units, the claim does not default in the Unit Qualifier.

  There is no default for the NDC unit value (only the qualifier).

  For defaults, the system uses the value for the claim only and does not update the charges at the account level to have this Unit Qualifier.

When all fields are completed, you have the option of accepting, editing or deleting this charge control parameter. After you accept the screen, the following prompt is displayed:

Do you wish to revise Pro Fee charge exceptions? (Y/N) [N]--

If you accept the default of No, you are returned to the following prompt:

Enter 1500 charge control code or '-' for a list--

If you enter Y for Yes, the following prompt is displayed.

Do you wish to revise UB Revenue Code Pro Fee exclusions? (Y/N) [N]--

If you answer yes, the following screen is displayed;

```
            General Hospital 1500 Charge Control Processor
                                                          Tue Apr 11, 2000 11:50 am

Code: 200
Description: BLUE CROSS IP
   Seq   UB2 Code/Description           Exclude?
   1     540 Ambulance                   No
   2     960 Professional Fees           No
   3     961 Professional Fees Psychiat  No
   4     962 Professional Fees Opthalmo  No
   5     963 Professional Fees Anes MD   No
   6     964 Professional Fees Anes CRN  No
   7     969 Professional Fees Other     No
   8     971 Professional Fees Laborato  No
   9     972 Professional Fees RAD Diag  No
   10    973 Professional Fees RAD Ther  No
   11    974 Professional Fees RAD NUC   No
   12    975 Professional Fees O/R       No
   13    976 Professional Fees R/T       No
   14    977 Professional Fees P/T       No
   15    978 Professional Fees O/T       No
   16    979 Professional Fees S/P       No

              F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

Field Explanations

SEQ (DISPLAY ONLY)
The only UB codes that are displayed here are codes that have field 4 of the UB Revenue Code table set to either P for Pro Fee Only or B for Both.

UB CODE/DESCRIPTION (DISPLAY ONLY)
This field is a display of the UB Revenue Codes. When a new code is added to the UB Revenue code table, it is displayed here. The only UB Revenue Codes that are displayed are codes that have the Charge Group field in the UB Revenue Code table set to either P for Pro Fee Only or B for Both.

EXCLUDE (1-A-O)
This field accepts two values, **Y**es and **N**o. The default value is No. This field is used to determine if all professional fee charges for this UB Revenue Code are excluded from printing on the 1500 claim form. If you enter **N** for No, then all Professional Fee charges for that revenue code are printed on the 1500 claim being loaded. If you enter **Y** for Yes, then all Professional Fee charges for the UB Revenue Code are excluded from printing on the 1500 claim form.

After you have completed the setup for the UB Revenue Code Pro Fee exclusions or if you answered No to the previous prompt, the following prompt is displayed:

Do you wish to revise Pro Fee SIM items for exclusion? (Y/N) [N]--

If you accept the default of No, the following prompt is displayed:

Do you wish to revise FIM items to load $0.00 charges on the 1500? (Y/N) [N]--

If zero-dollar FIM items are indicated to load for a 1500 claim, and the net of the charge and credit quantities for the zero-dollar FIM items for the claim service line is zero, and the total charge amount for the claim service line is zero, the claim service line does not appear on the claim. The scenarios where the net of the quantities for charges and credits for zero-dollar FIM items can be zero include the following:

- Charges move to another account due to Combine Billing
- Charges move to another account due to a DPW
- Charge and credit are issued for an item

Zero-dollar FIM items that are indicated to load to the claim are loaded to the claim if the net of the quantity on the charges is not zero. For example, if two charges were entered for a zero-dollar item, but only one credit was entered, the claim would load the zero-dollar item with a quantity of 1. If one charge was entered for a zero-dollar item, but two credits were entered, the claim would load the zero-dollar item with a quantity of -1.

If you enter **Y** for Yes at the prompt, the following screen is displayed:

```
                          General Hospital 1500 Charge Control Processor

Tue Apr 11, 2000 12:17 pm

Code: 707
Description: MEDICARE OUTPATIENT
                     1500 Pro Fee SIM Item Exclusions
 Seq          SIM Department                          SIM Item
 1            EEG-EEG                                 3112-EEG PRO FEE
 2            EEG-EEG                                 3125-24 HR EEG/VIDEO









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

Field Explanations

SEQ (DISPLAY ONLY)
This field displays the line sequence number for the screen.

SIM DEPARTMENT (TABLE LOOKUP)
This field allows entry of any valid SIM department that is defined.

SIM ITEM (TABLE LOOKUP)
This field is only accessible if a SIM department has been selected. You may enter any valid Professional Fee SIM Item for the designated department. If you modify a selected Professional Fee SIM Item so that it is no longer a Professional Fee, subsequent charges using the SIM Item are not treated as a Professional Fee. The SIM charge type stored in the charge determines how the charge is processed.

After you have completed setting up SIM Item exclusions, the following prompt is displayed:

Do you wish to revise FIM items to load $0.00 charges on the 1500? (Y/N) [N]--

If you accept the default of No, you are returned to the following prompt:

Enter 1500 charge control code or '-' for a list--

If you enter **Y** for Yes, the following screen is displayed:

```
                              General Hospital 1500 Charge Control Processor
                                                          Tue Apr 11, 2000 12:33 pm

Code: 707
Description: MEDICARE OUTPATIENT
                        1500 FIM Zero Dollar Items to Load
 Seq           FIM Department                          FIM Item
 1     EEG-EEG                               70333112:EEG PRO FEE
 2     LAB-HBOC Laboratory      70111000:ACETAMINOPHEN




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

Field Explanations

SEQ (DISPLAY ONLY)
This field displays the line sequence number for the screen.

FIM DEPARTMENT (TABLE LOOKUP)
This field allows entry of any valid FIM department that is defined.

FIM ITEM (TABLE LOOKUP)
This field is only accessible if a FIM department has been selected. Enter any valid FIM Item for the selected FIM department. If you select either an ancillary charge or a non-zero priced professional fee charge, the system accepts the entry, but the charge load program excludes any ancillary charges from loading on the 1500 claim.

Accepting the screen completes the transaction.

Dependent On	Reference
Place of Service	Insurance Plan Coverage Master

NON PRO FEE 1500 CHARGE CONTROL PARAMETERS (US ONLY)

This parameter defines how charges are printed on the 1500 Non-Professional Claim Form, indicates if separate forms are necessary for each department, and determines whether charges should be detailed or summarized by date. Professional and non-professional fees can load and print on this claim form.

This table is not split by facility.

The sort for a Non Pro Fee 1500 loading in the 08/05 1500 Format, loading either in Midnight Processing or using the Add Claim to Insurance function is by Service Date, HCPCS Code, Reference Facility, IDE Code, NDC Code, and Charge Number.

When a Non Pro Fee 1500 claim loads, either in Midnight Processing, in Instant Adjustment Bill, or in Add Claim to Insurance, the system determines if the claim loaded in the 1992 1500 Format, or in the 08/05 1500 Format. This is controlled by the Begin Date for the 08/05 1500 format in the hospital defined Non Pro Fee 1500 Claim Load and Edit Parameters. If the Begin Date for the 08/05 1500 Format of the Claim Load and Edit Parameter is today or is a date in the past, the claim will load in the 08/05 1500 Format, and the charge data will be in the 08/05 1500 Format as defined for the fields below. The 1500 Format is displayed for the claim when accessing the Claim Status Information screen within Claims Management, and field Claim Format.

For the 08/05 Format of the Non Pro Fee 1500, the system loads automatically:

- A HCPCS and up to 4 two digit modifiers
- Charges in the format of $$$$$$cc (6 digits for the dollar amount versus 5 digits for the 1992 Format)

After the Non Pro Fee 1500 Charge Control menu option is selected, the system prompts you to enter a 1500 Non Professional Fee Charge Control code. You can enter a code or hyphen (-) to display a list of valid codes. When a code is entered or selected, the following screen is displayed:

```
        General Hospital Non Pro Fee 1500 Charge Control Processor
                                                Mon Aug 14, 2012 12:45 pm

 1 Code  2 Description                    3 Separate Claim by Dept?  4 EC2000
   99      TEST NON PRO FEE                 Yes                        Claim
 5 Detail/Summarize?         6 Print UOS?  7 Place of Service  8 24A Date Print
   Detail                      Yes           Inpatient Hospit    MM  DD  YY
 9 Departments to Include   10 Print TOS? 11 TOS Cross Ref    12 Print EMG?
   Entries Defined             Yes           99-TEST TOS CROS    Yes
13 Diag to be Printed       14 HCPCS Cross Reference          15 EPSDT Value
   Principal/Working           99-ALT HCPCS                      N
1992 (24K)   16 Phys/Dept ID Upper                17 Phys/Dept ID Lower
                Upin, State Lic                     NPI
08/05 (24J)  18 Phys/Dept ID Upper                19 Phys/Dept ID Lower
                Upin-1G, State Lic-0B               NPI, Medicare
20 Default Physician        21 Use Med Rec HCPCS   22 M/R HCPCS UB Rev Code
                               Yes                    99 - MED REC HCPCS
23 Print Anesth Time        24 Edit Charges?       25 PCON Phy/Dept ID
   Yes                         Yes H,D,U,L            Lower/Lower
26 Non-Specific HCPCS       27 Edit Date           28 Edit By
                               08/14/12               New, Nancy

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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the Non Professional Fee 1500 Charge Control Parameter.

2. DESCRIPTION (30-C-R)
This field contains the description of the Non Professional Fee 1500 Charge Control Parameter.

3. SEPARATE CLAIM BY DEPT (1-A-R)
This field indicates whether all charges should be included on one Non Professional Fee 1500 claim or whether a separate claim is needed for each department. Enter **Y** to indicate that claims should be loaded by department. The default is Y. Enter **N** to indicate that the claim should not be separated by department.

4. EC2000 (1-A-O)
This field indicates whether the account-level charges or the claim-level charges should be sent to EC2000 CA. When you access this field, the following prompt is displayed:

Send (A)ccount or (C)laim level charges to EC2000 CA? [A]

Entry options are **A** for Account or **C** for Claim; the default is A for account.

5. DETAIL/SUMMARIZE? (1-A-R)
This field indicates whether the charges printed on the Non Professional Fee 1500 claim form should be in detail or summarized. When set to summarize like items, the system summarizes charges with the same service date and HCPCS code. Entry options are **D** (detail) or **S** (summarized). The default is D.

For example, if the patient receives two chest X-rays on the same date with the same HCPCS code or lack of HCPCS code, and D is entered in this field, two line items are displayed. If S was entered, the charges are summarized into one charge line.

NOTE: If a Non Pro Fee 1500 claim loads in the 08/05 1500 Format, and the Detail/ Summarize Items field is set to Detail, but the charge has an offsetting credit that matches on Revenue Code (which is not on the Non Pro Fee 1500 claim), Service Date, HCPCS Code/Modifiers, Quantity, and Amount, neither the charge nor the credit are loaded to the claim. If the offsetting charge and credit are the only charge/credit that qualify for the claim, the claim loads according to the Load $0.00 Claim field in the Claim Load Edit Parameter.

6. PRINT UOS? (1-A-R)
This field indicates whether units of service print on the 1500 form in locator 24G. Entry options are **Y** for Yes or **N** for No; the default is Y.

NOTE: For the 08/05 1500 Format, the Units of Service prints in Locator 24G Lower. If the units of service exceeds 999, the fourth digit prints on the line dividing locator 24G and 24H, and the fifth digit prints in 24H for EPSDT, allowing up to a five-digit units of service. When printing a five-character units of service, the EPSDT value is therefore overridden. If the Pharmacy units of service differs from the billing units of service, the Pharmacy units of service prints in Locator 24G Upper. If the units of service exceeds 999, the fourth digit prints on the line dividing locator 24G and 24H, and the fifth digit prints in 24H for EPSDT, allowing up to a 5 digit units of service.

7. PLACE OF SERVICE (2-AN-R)
This field contains the value that updates the place of service in locator 24B which prints with each charge line. You can enter the place of service code or a hyphen (-) to display a list of valid codes from the Place of Service Table.

8. 24A DATE PRINT (1-A-R)
This field determines in what format the date prints on the 1500 charge detail lines for Form Locator 24A. The choices for this field are C for the MMDDYYYY format or S for the MM DD YY format. The default is S.

9. DEPARTMENTS TO INCLUDE (3-A-R)
This field contains the SIM departments to be included on the claim form. You can enter the department code or a hyphen (-) to display and select from a valid list of departments. This field and the UB revenue code must both be selected and match for a charge to be included on the claim form. When selecting the departments to include, and accepting, the field displays *Entries Defined.* To view the selected departments,

re-access the field. The system automatically displays the SIM Departments list. Selected departments are highlighted.

10. PRINT TOS? (1-A-R)
This field indicates whether the type of service from the FIM should print on the 1992 Format of the Non Pro Fee 1500 claim form in locator 24C. The 08/05 Format of the Non Pro Fee 1500 claim does not have a type of service field. Therefore, even if this field is set to Yes, the type of service does not load on the 08/05 Format of the Non Pro Fee 1500 claim. Entry options are Y for Yes or N for No; the default is Y.

NOTE: If the Detail/Summarize? field is set to Summarize, and two or more charges with the same Service Date and HCPCS code summarize together, the system uses the Type of Service code on the last charge processed. Therefore, if 2 charges summarize together, and only 1 of the charges has a type of service code, if the last charge processed does not have a type of service code, but the Print TOS? field is set to Yes, the type of service is still blank for the claim charge line. If two or more charges summarize that have different type of service codes, and the Print TOS? field is set to Yes, the system uses the type of service code on the last charge processed.

11. TOS CROSS REF (2-AN-O)
This field indicates whether or not a Type of Service Cross Reference Table should be used in conjunction with this Charge Control Parameter. Enter the table number or a hyphen (-) to display a list of Type of Service Cross Reference Tables. The Type of Service Cross Reference Table points a FIM Type of Service Code to an alternate Type of Service. When the FIM TOS Code is encountered on a charge for the payer, the alternate TOS Code loads and prints on the claim if a Type of Service Cross Reference table has been defined in this field.

NOTE: A Type of Service locator only exists on the 1992 Format of the Non Pro Fee 1500 claim form in locator 24C. The 08/05 Format of the Non Pro Fee 1500 claim does not have a type of service field.

12. PRINT EMG? (1-A-R)
This field indicates whether the EMG code entered on the second screen of the Plan Demographics at the account level should print for each charge line in locator 24I for the Non Pro Fee 1992 Format of the 1500 claim, or in locator 24C for the 08/05 Format of the Non Pro Fee 1500 claim. Entry options are **Y** for Yes or **N** for No; the default is Y.

13. DIAG TO BE PRINTED (1-A-R)
This field determines whether the admitting, or if blank, the working diagnosis, should print for each charge line in locator 24E, or if the principal, or if blank, the working diagnosis should print for each line in locator 24E. Entry options are **A** for Admitting/ Working, **P** for Principal/Working or **R** for Reference Number 1.

NOTE: The 1992 1500 Format of the Non Pro Fee 1500 claim can accommodate either the actual diagnosis code or a reference number. The 08/05 1500 Format cannot accommodate an actual diagnosis code. The 08/05 1500

Format can only take 1 to 4 reference numbers, without punctuation/commas. Therefore, if the claim loads in the 08/05 1500 Format, and this field is set to A for Admitting/Working Diagnosis or P for Principal/Working Diagnosis, the system determines if this diagnosis is in Locator 21-1, 21-2, 21-3, or 21-4. If the diagnosis exists in one of these locators, say locator 21-2, each charge line would reflect this reference number, here, reference number 2. For the 08/05 1500 Format of the Non Pro Fee 1500 claim, if this field is set to A for Admitting/Working or P for Principal/Working, and if the diagnosis that is set to load is not one that exists in Locator 21-1, 21-2, 21-3, or 21-4 (based on the internal elements used for Locator 21 in the Claim Load Edit Parameter), the claim can have a DX error if the field Edit Charges includes D for Diagnosis/ Reference Number.

The system only prints four unique diagnoses in form locator 21. If more than four diagnoses exist, the system does not print the reference in form locator 24E for charges relating to a diagnosis that does not display on the form in locator 21.

For the Non Professional Fee 1500 (claim type Z), format 08/05, the ICD-10 Effective Date field on the Claim Load Edit Parameter is used by the Non Pro Fee 1500 Charge Control Parameters Diag To Be Printed field. Based on the ICD-10 Effective Date field and the admission date or discharge date of the patient loading the Non Professional fee 1500 claim, the ICD flag for the claim is set to either a 9 for ICD-9, or a 10 for ICD-10. When loading diagnosis codes/reference numbers to the claim charge lines in Locator 24E, the system loads either ICD-9 or ICD-10 diagnosis codes based on the ICD flag. If the ICD flag is blank, the system assumes ICD-9.

14. HCPCS CROSS REFERENCE (2-N-O)

This field indicates whether a Payer HCPCS Cross Reference Table should be used in conjunction with this Non Professional Fee 1500 Charge Control Parameter. Enter the table number or a hyphen (-) to display a list of Payer HCPCS Cross Reference Tables. The Payer HCPCS Cross Reference Table is used to point FIM HCPCS Codes to alternate HCPCS Codes to use on the claim form for the payer. When the FIM HCPCS code is encountered on a charge for the payer, the alternate HCPCS code loads and prints on the claim form. The HCPCS code is changed only on the claim form. The patient bill is not affected, nor are the actual HCPCS codes at the account level.

15. EPSDT VALUE (2-A-O)

This field contains the Early and Periodic Screening, Diagnosis, and Treatment value that should print for every charge line of the Non Pro Fee 1500 in Locator 24H. When this field is accessed, the following prompt is displayed:

Enter EPSDT value--

NOTE: The following fields, Print Phys/Dept ID Upper, Print Phys/Dept ID Lower, and Default Physician, work in conjunction with the 1500 Department Supplier Override Table.

16. PHYS/DEPT ID UPPER (33-AN-O) (1992 FORMAT, LOCATOR 24K)
This field indicates whether the physician/department ID prints in the upper line of Box 24K for the 1992 1500 format. If this field is set to Yes, the system allows a first and second choice for the ID. When this field is accessed, the following prompt is displayed:

Print Phys/Dept ID in upper part of locator 24K (1992 Format)? (Y/N) [N]--

You can enter **Y** for Yes or **N** for No; the default is N. If you enter Y, the system displays a table of physician identification numbers for your first choice. After you select the first choice, the system displays the table for your second choice for physician identification number (which cannot be the same as the first choice). If a physician identification number cannot be identified from the first choice when the claim loads, the system attempts to define a physician identification number from the second choice. Based on the field you wish to use (from the STAR Patient Care Physician Table), select one or two of the following, separately:

- UB ID Number
- Commercial ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number
- UPIN ID Number
- PIN ID Number
- Fin Interface ID Number
- Tax ID Number
- Other ID Number 1
- Other ID Number 2
- Doctor Name
- Physician’s Social Security Number
- State License ID Number
- National Provider ID (NPI #)
- Taxonomy No

If you respond with Y (Yes) to the prompt, but do not make a selection from the table lookup for physician identification numbers, the system changes the field to N (no) and displays the following message:

Response for Print Phys/Dept ID Upper defaulted to No!

17. PHYS/DEPT ID LOWER (33-AN-O) (1992 FORMAT, LOCATOR 24K)
This field indicates whether the physician/department ID prints in the lower line of Box 24K for the 1992 1500 format. If this field is set to Yes, the system allows a first and second choice for the ID. When this field is accessed, the following prompt is displayed:

Print Phys/Dept ID in lower part of locator 24K (1992 Format)? (Y/N) [N]-- |

You can enter **Y** for Yes or **N** for No; the default is N. If you enter Y, the system displays a table of physician identification numbers for your first choice. After you select the first choice, the system displays the table for your second choice for physician identification number (which cannot be the same as the first choice). If a physician identification number cannot be identified from the first choice when the claim loads, the system attempts to define a physician identification number from the second choice. Based on the field you want to use (from the STAR Patient Care Physician Table), select one or two of the following, separately:

- UB ID Number
- Commercial ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number
- UPIN ID Number
- PIN ID Number
- Fin Interface ID Number
- Tax ID Number
- Other ID Number 1
- Other ID Number 2
- Doctor Name
- Physician’s Social Security Number

- State License ID Number
- National Provider ID (NPI)
- Taxonomy No

If you respond with **Y** (Yes) to the prompt, but do not make a selection from the table lookup for physician identification numbers, the system changes the field to N (no) and displays the following message:

Response for Print Phys/Dept ID Lower defaulted to No!

18. PHYS/DEPT ID UPPER (1-AN-O) (08/05 FORMAT, LOCATOR 24J)
This field indicates whether the physician ID code is printed on the Non Pro Fee 1500 claim form in the upper portion of Box 24J for the 08/05 1500 format. The physician used for the ID number can be either the admitting, attending, referring, performing, charging, or other physician, depending on the settings of the 1500 Department/ Supplier Override table. For more information on these parameters, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system prompts for your first choice for physician identification number, then the ID Qualifier for this number, followed by the second choice for physician identification number, and the ID Qualifier for this second choice.

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

Print Phys/Dept ID in upper part of locator 24J (08/05 Format)? (Y/N) [N]-- |

You can enter **Y** (Yes) or **N** (No). If you enter Y, the system prompts you to select the physician ID to print on the Non Pro Fee 1500 claim form. Values are as follows:

- UB ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number
- Commercial ID Number
- PIN ID Number
- UPIN ID Number
- Other ID Number 1

- Other ID Number 2
- Doctor Name
- Tax ID Number
- FIN Interface ID Number
- Physician's Social Security Number
- State License ID Number
- National Provider ID (NPI #)
- Taxonomy No

When entering your first choice for your physician ID, or when entering both a first and second choice for your physician ID, the system prompts for an ID Qualifier for each number. This ID Qualifier prints in Locator 24I Upper on the 08/05 1500 Format. This field is not used for the 1992 1500 Format of the Non Pro Fee 1500 claim. The ID Qualifier entered here is used for each charge line in 24I Upper for the Non Pro Fee 1500 claim, and should correlate to the physician ID set to load in the Phys/Dept ID Upper field. A table lookup on the 1500 Physician ID Qualifier Table outlined below is allowed. Valid values are as follows:

NOTE: These values are subject to change. Please check your electronic 837 Professional specifications.

0B STATE LICENSE NUMBER

1B BLUE SHIELD PROVIDER NUMBER

1C MEDICARE PROVIDER NUMBER

1D MEDICAID PROVIDER NUMBER

1G PROVIDER UPIN NUMBER

1H CHAMPUS IDENTIFICATION NUMBER

E1 EMPLOYER'S IDENTIFICATION NUMBER

G2 PROVIDER COMMERCIAL NUMBER

LU LOCATION NUMBER

N5 PROVIDER PLAN NETWORK IDENTIFICATION NUMBER

SY SOCIAL SECURITY NUMBER (MAY NOT BE USED FOR MEDICARE)

X5 STATE INDUSTRIAL ACCIDENT PROVIDER NUMBER

ZZ PROVIDER TAXONOMY

19. PHYS/DEPT ID LOWER (1-AN-O) (08/05 FORMAT, LOCATOR 24J)
This field indicates whether the physician ID code is printed on the Non Pro Fee 1500 claim form in the lower portion of Box 24J for the 08/05 1500 format. When this field is accessed, the following prompt is displayed:

Print Phys/Dept ID in lower part of locator 24J (08/05 Format)? (Y/N) [N]-- |

You can enter **Y** (Yes) or **N** (No). For the 08/05 1500 format, this field should be set to pull the Physician's NPI number. The physician used for the ID number can be either the admitting, attending, referring, performing, charging, or other physician, depending on the settings of the 1500 Department/Supplier Override table. For more information on these parameters, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

If you enter Y, the system prompts you to select the physician ID to print on the Non Pro Fee 1500 claim form. The system prompts for your first choice for physician identification number, followed by the second choice for physician identification number. The system does not prompt for an ID Qualifier for either the first or second choice for 24J Lower since the hard copy claim form has *NPI* pre-printed on the form.

You can enter Y for Yes or N for No; the default is N. If you enter Y, the system displays a table of physician identification numbers for your first choice. After you select the first choice, the system displays the table for your second choice for physician identification number (which cannot be the same as the first choice). If a physician identification number cannot be identified from the first choice when the claim loads, the system attempts to define a physician identification number from the second choice. Based on the field you wish to use (from the STAR Patient Care Physician Table), select one or two of the following, separately:

- UB ID Number
- Commercial ID Number
- Medicare ID Number
- Medicaid ID Number
- Blue Cross ID Number
- UPIN ID Number
- PIN ID Number

- Fin Interface ID Number
- Tax ID Number
- Other ID Number 1
- Other ID Number 1
- Other ID Number 2
- Doctor Name
- Physician's Social Security Number
- State License ID Number
- National Provider ID (NPI #)
- Taxonomy No

20. DEFAULT PHYSICIAN (23-AN-O)
This field indicates whether the Charging or Attending Physician/Dept ID number should print in Locator 24K for the 1992 Format of the Non Pro Fee 1500 or Locator 24J for the 08/05 Format of the Non Pro Fee 1500, in the event that a performing physician is not attached to the charge. If there is a performing physician attached to the charge, but the specified ID number is blank in the Physician Table, the system does not print the default physician information in Box 24K or 24J. When this field is accessed, the following prompt is displayed:

Default to the Attending (A) or Charging (C) Physician/Dept ID (A/C)?-

Entry options are (**A**) Attending or (**C**) Charging. A response of A or C results in the Attending or Charging Physician ID code printing in Box 24K (1992 Format) or 24J (08/05 Format) if there is no performing physician attached to the charge.

NOTE: The system prints the ID number according to the Print Phys/Dept ID Upper and the Print Phys/Dept ID Lower fields. For example, if the Print Phys/Dept ID Upper field is set to Yes and the UPIN number, and the Print Phys/Dept ID Lower field is set to Yes and the NPI number, if this field is set to A to default to the Attending physician, the Attending physician's UPIN number prints in locator 24J Upper, and the Attending physician's NPI number prints in locator 24J Lower.

21. USE MED REC HCPCS (1-A-O)
This field is only used for Non Pro Fee 1500 claims loading in the 08/05 1500 format and indicates whether the system should look to the Medical Records HCPCS to see if there is a HCPCS entered for the revenue code if there is no HCPCS on the FIM/charge record. The Medical Records HCPCS prints on the charge line for the claim.

Entry options are Y for yes and N for no. A Medical Record HCPCS loads to the Non Pro Fee 1500 claim form if the following criteria are met:

- This field is set to Y.
- The charge line has no FIM/charge HCPCS.
- The UB revenue code of the charge matches the Medical Records HCPCS UB revenue code.
- The date of service of the charge line matches the date on the Medical Records HCPCS.

22. M/R HCPCS UB REV CODE (5-N-C)

This field is only used for Non Pro Fee 1500 claims loading in the 08/05 1500 format, and indicates whether the system should use a Med Rec HCPCS UB Rev Code Table when loading Medical Records HCPCS codes to charge lines that have no FIM/charge HCPCS codes. Enter the Medical Records HCPCS UB Range Table code to use, or enter a hyphen (-) for a table lookup of available codes. This field is accessible only if the Use Med Rec HCPCS field is set to Yes.

The Medical Records HCPCS UB Revenue Code Table allows you to list for a UB Revenue Code, additional UB Revenue Codes to search on when pulling Medical Records HCPCS to the claim. The system first tries to find a Medical Records HCPCS tied to the same UB Revenue Code as the charge. If one is not found, it searches for Medical Records HCPCS tied to one of the other UB Revenue Codes listed for the charge UB Revenue Code in the Med Recs HCPCS UB Rev Code Table. A Medical Records HCPCS loads only if the following criteria are met:

- The charge line has no FIM/charge HCPCS.
- The UB revenue code of the charge matches the Medical Records HCPCS UB revenue code or the UB revenue code on the Medical Records HCPCS matches a revenue code listed in the Med Rec HCPCS UB Rev Code Table for the UB Revenue Code on the charge.
- The date of service of the charge line matches the date on the Medical Records HCPCS.

Once a Medical Records HCPCS Code has printed on a Non Pro Fee 1500 claim for the carrier, it cannot be used again, even on another claim sequence for the same carrier. For example, if carrier 100200 is set to load a separate claim for each department, and if for the final bill, the system loads Non Pro Fee 1500 claim sequence 2 and Non Pro Fee 1500 claim sequence 3 for the same carrier/plan, the Medical Records HCPCS that print on claim sequence 2 would not be repeated on claim sequence 3.

23. PRINT ANESTHESIA TIME? (1-A-O)
This field is only used for Non Pro Fee 1500 claims loading in the 08/05 1500 format and indicates whether the system should print the anesthesia start and end times on the Non Pro Fee 1500 claim, if the times were entered in Medical Records for the HCPCS code. This field cannot be accessed unless the Use Med Rec HCPCS field has a response of Yes, and the time loads only for the 08/05 1500 Format of the Non Pro Fee 1500 claim form. When this field is accessed, the following prompt is displayed:

Print anesthesia times with charge information (Y/N) [N]--

If you enter **Y** for Yes, and the source of a HCPCS code for a Non Pro Fee 1500 service line is Medical Records, the anesthesia start and end times are loaded with the HCPCS. This includes HCPCS selected from Medical Records due to the Medical Records HCPCS UB Revenue Code Table.

For the 08/05 Format of the 1500, the Anesthesia start and end times prints in the upper section of Locator 24 for the charge line with the anesthesia HCPCS code (the HCPCS code with the Anesthesia Start and Stop Times is entered in the Medical Records HCPCS screen). The information prints starting in the upper shaded portion of Locator 24, above the HCPCS in Locator 24D in the following format, where b is a blank, and 00770 is the HCPCS code (therefore the word *BEGIN* starts above the 3rd digit of the HCPCS code in 24D):

bbBEGIN 1030 END 1245 TIME 135 MINUTES

00770

Anesthesia start and end times can be edited under Claim Charge Data, and anesthesia start and end times print on the Non Pro Fee 1500 claim, if they exist. The ability to edit and print anesthesia start and end times is not provided for a claim unless this parameter was set to Yes when the claim loaded. If a Non Pro Fee 1500 claim loads during Midnight Processing or is loaded by the Add Claim to Insurance function, reloaded during Midnight Processing, or edited, and Print Anesthesia Time is set to Yes in the Non Pro Fee 1500 Charge Control Parameters, the following occurs:

If the claim is edited in Claim Charge Data and a HCPCS code from Medical Records is added automatically to a service line missing a HCPCS code, the anesthesia start and end times are added from Medical Records, if they exist. This includes HCPCS selected from Medical Records due to the Medical Records HCPCS UB Revenue Code Table.

24. EDIT CHARGES? (TABLE LOOKUP)
This field is used only for Non Pro Fee 1500 claims loading in the 08/05 1500 format. The field indicates if the system should edit charges for missing information on the claim. If answered with a Yes, the system displays the information you can edit for. Options are HCPCS Procedure Code, Diagnosis Code/Reference, Locator 24J Upper and Locator 24J Lower (08/05 Format) Physician ID. You can highlight any or all options to edit for. The field displays an H if editing for HCPCS Procedure Code, a D if

editing for Diagnosis Code/Reference, a U if editing for 24J Upper, and an L if editing for Locator 24J Lower. For example, if editing for all four options, the field displays *H,D,U,L*.

Claims with errors are reported on the Failed Claims Requirement report (FCR250) and can also be viewed within Claims Management, Charge Data. The Failed Claims Requirement Report prints the errors in the following format:

LOC-FLD: 24D Error: HCPCS Code is Required Quantity 1

LOC-FLD: 24E Error: Diagnosis Code/Ref # is Required Quantity 2

LOC-FLD: 24J Upper Error: Physician ID is Required Quantity 1

LOC-FLD: 24J Lower Error: Physician ID is Required Quantity 1

The Claim Charge Data screen within Claims Management displays the errors in the following format, in the upper portion of the screen:

HCPCS Procedure Errors: 1

Diagnosis/Reference # Errors: 2

Charge Summary Errors: 1

24J Upper/Lower ID Errors: 1/ 1

The charge line itself also has an error message such as:

Prc/DX/ID-U/ID-L/Chg Summ.

When editing for Diagnosis Code/Reference Number, the system looks to either the ICD-9 or the ICD-10 diagnosis information based on the claim ICD flag. Note also that the 08/05 format of the Non Pro Fee 1500 claim form does not allow an actual diagnosis code in Locator 24E of the claim charge line. Only a reference number is allowed. Therefore, when editing or inserting a Non Pro Fee 1500 claim charge line, the system does not prompt for either an ICD-9 or ICD-10 diagnosis code. The system prompts for one or more reference numbers to link the charge to the diagnoses in Locator 21.

25. PCON PHY/DEPT ID (1-A-O)

This field indicates whether the Physician ID Upper (24K Upper for the 1992 1500 Format, or 24J Upper for the 08/05 1500 Format), or Physician ID Lower (24K Lower for the 1992 1500 Format, or 24J Lower for the 08/05 1500 Format) should be sent in the 1500 PCON interface for the rendering provider.

When this field is accessed, the system displays one of the following prompts. One is for the 1992 format, and one is for the 08/05 format:

Select (U)pper or (L)ower Phy/Dept ID for PCON 1500 rendering provider for 1992 Format-

Select (U)pper or (L)ower Phy/Dept ID for PCON 1500 rendering provider for 08/05 Format-

STAR Patient Accounting loads a physician/department ID into the upper, lower, or both parts of form locator 24K/24J and truncates the value to a length of 10. If the claim has not been returned by EC2000, and if a value exists in the field used to record the physician/department ID for the lower part of form locator 24K/24J, that value is provided. Otherwise, the value for the upper part of form locator 24K/24J is used.

If both the lower and upper part of form locator 24K/24J are used, and the user wants the value in the upper part of form locator 24K/24J to be used, the PCON Phy/Dept ID field can be used to indicate this.

If the claim has been returned by EC2000, and values exist in both, both values are used. Otherwise, the value in the lower part of form locator 24K/24J is used. If the length of the provider number is greater than 9, the first 9 characters are saved in the field for the upper part of form locator 24K/24J and characters 10-15 are saved in the field for the lower part of form locator 24K/24J. Characters beyond 15 are truncated.

26. NON-SPECIFIC HCPCS (1-A-O)
This field is used to select the table of non-specific HCPCS codes for this Non Pro Fee 1500 Charge Control Parameter.

When accessing the field, the system prompts:

Enter Non Specific HCPCS table or '-' for lookup--

You can enter the table number for the Non Specific HCPCS table that should be used for this Non Pro Fee 1500 Charge Control Parameter. The system displays a list of Non Specific HCPCS tables. After you select a table, the field displays the table number and description.

When the Non Pro Fee 1500 claim loads, if the claim has one or more of the listed HCPCS, after all HCPCS processing, including Payer HCPCS Cross Reference Tables, then the claim charge lines with a listed HCPCS will have a new error of Non Spec HCPCS, and the system will blank out the claim charge line description. In order to clear the claim charge line error, the user must use the F5 key to Edit the charge line, and enter in the "Charge Desc" field the detailed HCPCS description. Do not enter the generic, non specific HCPCS description or else the claim will be rejected on the payer side.

NOTE: The system is looking to the 5 digit HCPCS, and will edit regardless of modifiers.

The number of errors can be seen on the Claim Charge Data screen within Claims Management in the line below the account number, in the field "Non Specific HCPCS". The Error field at the charge level will have "NS HCPCS" for Non Specific HCPCS.

These errors appear on the Failed Claims Requirement Report (FCR250x) as:

Loc-Fld: 24D Error: Non Specific HCPCS Errors Quantity x

27. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this Non Professional Fee 1500 Charge Control Parameter was last edited.

28. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited this Non Professional Fee1500 Charge Control Parameter.

You can press ENTER to display the second screen of the 1500 Charge Control Parameters.

```
            General Hospital Non Pro Fee 1500 Charge Control Processor
                                                 Fri Apr 04, 2008 04:53 pm

 1 Reference Facility   2 RF Rev Codes      3 IDE   4 IDE Rev Codes
   Yes                    Entries Defined     Yes     All
 5 NDC    6 NDC Rev Codes                   7 NDC Unit Qual/Units
   Yes      Entries Defined                   Edit HCPCS









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

1. REFERENCE FACILITY (1-A-O)
This field indicates whether claim charge lines should be sorted further by the Reference Facility Code. When the field is accessed, the following prompt is displayed:

Further sort claim charge lines by Reference Service Facility code? (Y/N) [N]--

If you enter **Y** for Yes, the system sorts the claim charge lines by the Reference Facility code. Therefore, the system sorts the charges as follows:

- If the Detail/Summarize Items field is set to Detail, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has a Reference Facility code, the claim breaks this out to three charge lines.

- If the Detail/Summarize Items field is set to Summary, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has a Reference Facility code, the claim breaks this out to two charge lines.The one charge line with the RF code breaks out to its own claim charge line. Since the Reference Facility code does not print on the paper Non Pro Fee 1500 claim form, it is not apparent to the payor why there are two charge lines for what appear to be the same charges.

NOTE: The hospital should be entering in the HCPCS Modifier of 90 for these reference/send out lab tests.

2. RF REV CODES (1-A-O)

This field is used to indicate which revenue codes should further sort by the Reference Facility Code. This field can be accessed only if the field Reference Facility field is set to Yes. When this field is accessed, the following prompt is displayed:

Select UB Revenue Codes or key A for All--

The UB Revenue Codes table is displayed. You can enter **A** for All or enter a hyphen (-) to select codes. If only some revenue codes are selected, the system further sorts the charges by RF code only for those charges with the selected revenue code. Even if other revenue codes not selected have a Reference Facility code, these charges are not sorted by Reference Facility code. Note that the UB revenue code does not load/ print to the Non Pro Fee 1500 claim. However, it is used as a criteria for further sorting the charges by Reference Facility code.

3. IDE (1-A-O)

This field indicates whether the system should further sort claim charge lines by Investigational Device Exemption (IDE) code. When this field is accessed, the following prompt is displayed:

Further sort claim charge lines by Investigational Device Exemption code? (Y/N) [N]--

If you enter **Y** for Yes, the system further sorts the claim charge lines by Investigational Device Exemption code. Therefore, the system sorts the charges as follows:

- If the Detail/Summarize Items field is set to Detail, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but one of the charges has an IDE code, the claim breaks this out to three charge lines.

- If the Detail/Summarize Items field is set to Summary, and if there are three charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the

charge level) and Physician, but one of the charges has an IDE code, the claim breaks this out to two charge lines.The one charge line with the IDE code breaks out to its own claim charge line. Since the IDE code does not print on the paper Non Pro Fee 1500 claim form, it is not apparent to the payor why there are two charge lines for what appear to be the same charges.

4. IDE REV CODES (TABLE LOOKUP-O)

This field is used to indicate which revenue codes should further sort by the IDE code. This field can be accessed only if the IDE field is set to Yes. When this field is accessed, the following prompt is displayed:

Select UB Revenue Codes or key A for All

The UB Revenue Code Table is displayed. You can select one or more UB revenue codes that should further sort by IDE code or enter **A** for All. If only some revenue codes are selected, the system further sorts the charges by IDE code only for those charges with the selected revenue code. Even if other revenue codes not selected have an IDE code, these charges are not further sorted by IDE code. Note that the UB Revenue Codes do not load/print to the HCFA 1500 claim. However, it is used as a crtieria for further sorting the charges by IDE code.

5. NDC CODE (1-A-O)

This field defines whether charge lines are sorted by National Drug Code (NDC). This field only applies to Non Pro Fee 1500 claims loading in the 08/05 1500 Format. The NDC field does not apply to Non Pro Fee 1500 claims loading in the 1992 1500 Format. When this field is accessed, the following prompt is displayed:

Further sort claim charge lines by National Drug Code? (Y/N) [N]--

- If you enter **N** for No, charge lines cannot be sorted by NDC codes.
- If you enter **Y** for Yes, charge lines can be sorted by NDC codes, and you can access the NDC Rev Codes field to define revenue codes that should look for NDC codes.
- If you enter Yes, the system sorts the charges as follows:
  - If the Detail/Summarize Items field on this screen is set to Detail, if there are 3 charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but 1 of the charges has an NDC code, the claim will break this out to 3 charge lines.
  - If the Detail/Summarize Items field on this screen is set to Summary, if there are 3 charges with the same Service Date, HCPCS code, Ordering Diagnosis (at the charge level) and Physician, but 1 of the charges has an NDC code, the claim will break this out to 2 charge lines. The one charge line with the NDC code will break out to it's own claim charge line.

The NDC Code prints on the hardcopy 1500 claim form in the shaded, upper portion of locator 24 for the charge line. The system first prints the identifier N4 followed by the 11-digit NDC number, (space), and the unit of measurement, followed by the metric decimal quantity or unit. There is no space or hyphen in between the N4 and the actual code. The N of N4 starts printing above the first digit of the HCPCS code in Locator 24D as follows, where J1563 is the HCPCS code:

N454236324135 UN123.5

J1563

The system only does this additional NDC sort for claims loaded after the 1500 Charge Control parameters have been updated. Previously loaded claims are not updated with this sort if they are reloaded because of errors, or reloaded manually.

If the first prompt is set to Y for Yes, the following prompt is displayed:

Edit for NDC Code? (Y/N) [N] -

The default, if left blank or if set to N, is to NOT edit for an NDC code, but to load if present.

- If the Edit for NDC Code? prompt is answered with a Y for Yes, then the system will edit as follows:
  - If the field NDC Rev Codes is set to All and the NDC Unit Qual/Units field is set to either "Edit All", "leave Blank" or "Default" unit qualifier, the system will edit All revenue codes on the claim for the NDC code.
  - If the field NDC Rev Codes is set to All and the NDC Unit Qual/Units field is set to Edit specific HCPCS, the system will edit All revenue codes that have one of the listed HCPCS codes on the claim for the NDC code.
  - If the field NDC Rev Codes is set to specific revenue codes, and the NDC Unit Qual/Units field is set to either "Edit All", "leave Blank" or "Default" unit qualifier, the system will edit claim charge lines with a listed revenue code for the NDC code.
  - If the field NDC Rev Codes is set to specific revenue codes, and the NDC Unit Qual/Units field is set to Edit specific HCPCS, the system will edit claim charge lines that have BOTH a listed revenue code and one of the listed HCPCS codes for the NDC code.

    The NDC field will display Yes/Edit, Yes, No, or blank.

The system gives an error for each claim charge line that qualifies for the edit. These edits are displayed on the 1500 Claim Charge Data Screen. For more information, see Claim Charge Data Screen in the *Billing and Claims Volume*, Chapter 3: Claims.

6. NDC REV CODES (TABLE LOOKUP-O)

This field is used to define which UB revenue codes should further sort by NDC code. This field can be accessed only if the NDC field is set to a Y for Yes. When this field is accessed, the UB Revenue Code Table is displayed with the following prompt:

Select UB Revenue Codes or key A for All--

You can select which UB revenue codes should further sort by NDC code, or enter **A** for All. If one or more revenue codes is selected, the NDC Rev Codes field displays *Entries Defined*. If A for All is entered, the NDC Rev Codes field displays *All*. If only some revenue codes are selected, the system further sorts the charges by NDC code only for those charges with the selected revenue code. Even if other revenue codes not selected have an NDC code, these charges are not further sorted by NDC code. Note that the UB revenue code does not load/print to the Non Pro Fee 1500 claim. However, it is used as a criteria for further sorting the charges by NDC code.

7. NDC UNITS QUAL/UNIT (1-A-O)

If the NDC Code field contains Yes, you can access this field. The system displays the following prompt:

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B] --

You have the following entry options:

- You can enter **B** (Blank):
  - If the field is set to B for Blank and there is not a unit qualifier for the charge line with the NDC code, but there is an NDC unit value, the system leaves two blank spaces where the unit qualifier would have appeared. For example: N412345678901 1234.567.
  - If the field is set to B for Blank and there is a unit qualifier for the charge line with the NDC code, but there is no NDC unit value, the system leaves the NDC units blank. For example: N412345678901 ML.
  - If the field is set to B for Blank and there is no unit qualifier and no NDC unit value for the charge line with the NDC code, the system leaves 2 blank spaces where the unit qualifier would have appeared and there are no NDC units. For example: N412345678901

  When the NDC Unit Qual/Units field is set to Blank, the field displays *Blank*.

- You can enter **E (**Edit**).** The following prompt is displayed:

  Select (H)CPCS items to edit or key A for All--

  Enter **A** for All if you want the system to edit for the NDC Unit Qualifier and the NDC Unit value for the revenue codes specified in the NDC Rev Codes field.

  If you enter **H**, (HCPCS) the following prompt is displayed:

  Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

  After you enter a range of HCPCS, the following prompt is displayed:

  View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

  You can enter **Y** (Yes) to view or edit the HCPCS codes or **A** (Add) to add HCPCS. If you enter Add, you can enter a valid HCPCS code. If you enter Yes, the system prompts:

  Enter Partial Code to start lookup--

  You can enter a partial lookup, such as J-, or press ENTER to view all HCPCS already selected to edit the NDC information. The system displays the HCPCS codes. The system is looking at the claim HCPCS, after using any Payer HCPCS Cross Reference Table. Therefore, you should list the final claim HCPCS in this table that should edit for the NDC information.

  You can delete HCPCS codes or add them to the list. When you select one of the codes to delete, the system prompts you to verify the delete action. If you enter A to Add a HCPCS, the system prompts:

  Enter HCPCS code to add to the list--

  You can enter only a single HCPCS code (not a range).

If the field is set to E for leave blank and edit and there is no unit qualifier for the charge line with the NDC code, and/or there is no NDC unit value, the system fails the claim with one of the following error messages:

- NDC Unit Qual, if the charge line is missing only the unit qualifier
- NDC Units, if the charge line is missing only the NDC units

NOTE: If two or more charge lines summarize together because they have the same Revenue Code, Service Date, HCPCS Code, NDC code, and NDC unit Qualifier, and one charge has NDC Units, but one or more charges do not, the Claim charge line may still have an error for NDC Units, even though the NDC units field has a value. This is telling you that at least 1

of the summarized charges was missing the NDC units, and therefore the claim NDC units may not be accurate. If you press F5 to edit the claim charge line, if a new NDC UOS value is entered and accepted, this clears the NDC Units error.

- NDC Qual+Units, if the charge line is missing both the unit qualifier and the NDC units

Once the HCPCS are set in the NDC Unit Qual/Units field to Edit, in order to update the HCPCS list, access the NDC Unit Qual/Units field again. The system prompts:

If no Unit Qualifier and/or no NDC Units for NDC, leave (B)lank, leave blank and (E)dit, or (D)efault Unit Qualifier? (B/E/D) [B]-

- Enter **E** for Edit. The system then prompts:

  Select (H)CPCS items to edit or key A for All-

- Enter **H** for HCPCS. The system then prompts:

  Enter Range(s) of HCPCS (e.g., J1111-J1112,J2000-J2999)--

  Press ENTER past this prompt, and the following prompt is displayed:

  View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

- Enter **Y** for Yes. The system prompts:

  Enter Partial Code to start lookup-

  You can enter a partial lookup, such as J-, or press ENTER to get the full list of HCPCS already selected. From here, you can delete or add HCPCS.

The Failed Claims Requirement Report (FCR250x) displays the NDC error in the following format and does not list the detail charge lines.

Loc-Fld: 24D Error: NDC Qual/Unit Errors Quantity 2 Required

Claim Reload does not clear these NDC errors. To correct the errors, you can do one of the following:

Edit the data on the claim

Use Edit PA Charges to enter the PA NDC Qty/Qual, and then use Instant Adjustment Bill to load an adjustment claim for the insurance, or use Add Claim to Insurance to load an adjustment claim for the insurance.

- If you enter D for Default Unit Qualifier at the field prompt, the system displays the following prompt:

  Default to F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter), or ME (Milligrams) --

  You can enter F2, UN, GR, ML, or ME. If an invalid value is entered, the system displays the following error message: Error! Invalid Entry.

  When you set the NDC Unit Qual/Units field to Default, the field displays Default and the default unit qualifier. For example: Default UN

  The claim defaults in the Unit Qualifier only if the claim charge line loading the NDC information also has the NDC Units. If the claim charge line loading the NDC information has only the NDC code and is missing both the Unit Qualifier and the NDC Units, the claim does not default in the Unit Qualifier.

  There is no default for the NDC unit value (only the qualifier).

  For defaults, the system uses the value for the claim only and does not update the charges at the account level to have this Unit Qualifier.

When all fields are completed, you have the option of accepting, editing or deleting this charge control parameter. After you accept the screen, the following prompt is displayed:

Do you wish to revise Pro Fee charge exceptions? (Y/N) [N]--

If you accept the default of No, you are returned to the following prompt:

Enter 1500 charge control code or '-' for a list--

If you enter Y for Yes, the following prompt is displayed.

Do you wish to revise UB Revenue Code Pro Fee exclusions? (Y/N) [N]--

If you answer yes, the following screen is displayed;

```
  General Hospital Non Pro Fee 1500 Charge Control Processor
                                                Thu Apr 13, 2007 11:43 am

Seq  UB Code/Description           Include?     HCPCS
1     000 REVENUE CODE 000            Yes
2     001 Total Charge                Yes
3     002 002 TEST                    Yes
4     004 004 TEST                    Yes
5     044 044 NEW REV CODE            Yes
6     073 Blue Cross Rehab            Yes
7     100 All Inclusive Room/Brd + A  Yes
8     101 All Inclusive Room & Board  Yes
9     110 Room and Bed Private Gen    Yes
10    111 111 TEST                    Yes
11    112 112 test for TSR            Yes
12    120 Room and Bed Semi-Private   Yes
13    123 TEST REV CODE               Yes
14    130 Semi Private Three/four Be  Yes
15    140 Private Deluxe              Yes
16    150 Room And Bed Ward Gen Clas  Yes
17    160 Other Room And Bed          Yes
18    170 Nursery                     Yes
19    180 Leave Of Absence            Yes


      F1Prev Page F2Next Page F5 Select  F6 Reset  F7  Exit   ?
```

Field Explanations

SEQ (DISPLAY ONLY)
This field is initially loaded with the UB Revenue Code Table for a new parameter or displays previously entered values.

UB CODE/DESCRIPTION (30-C-R)
This field contains the UB revenue code and the user defined description of the revenue code. When a Non Professional Fee 1500 Charge Control Parameter is created, all UB revenue codes and descriptions entered in the UB Revenue Code Table are loaded into this table. The description can be modified.

INCLUDE (1-A-R)
This field indicates if the specific revenue codes are to be included or not included on the Non Professional Fee 1500 claim form. Entry options are **Y** for Yes or **N** for No. The initial load makes all of the codes a No to not include. To include UB codes, change the value to Yes. The UB code and department of charge items must both be set to include and must both match for charges to print on the claim form.

HCPCS (7-AN-O)
This field allows the entry of a default HCPCS code to use for charges with the UB revenue code that do not have a HCPCS code in the FIM. This field is only accessible if the revenue code has the Include field set to Yes. A one- to seven-digit HCPCS code is allowed. The code is not edited against the HCPCS Table on Medical Records and can be left blank. Charges within the revenue code that do have a HCPCS from the FIM continue to use the HCPCS code from the FIM and is not updated to this HCPCS

code on the claim. The system assigns the HCPCS codes to the charges where appropriate, and then prints the charges in detail or in summary (HCPCS code within date) based on the setting of the Detail/Summarize Items field.

When you exit from this screen, the following prompt is displayed:

Do you wish to revise Pro Fee charge exceptions? (Y/N) [N]--

If you answer Yes, the following prompt is displayed:

Do you wish to revise UB Revenue Code Pro Fee exclusions? (Y/N) [N]--

If you answer yes, the following screen is displayed:

```
      General Hospital Non Pro Fee 1500 Charge Control Processor
                                                 Tue Apr 11, 2000 11:50 am

Code: 200
Description: BLUE CROSS IP
   Seq   UB Code/Description           Exclude?
   1     540 Ambulance                   No
   2     960 Professional Fees           No
   3     961 Professional Fees Psychiat  No
   4     962 Professional Fees Opthalmo  No
   5     963 Professional Fees Anes MD   No
   6     964 Professional Fees Anes CRN  No
   7     969 Professional Fees Other     No
   8     971 Professional Fees Laborato  No
   9     972 Professional Fees RAD Diag  No
   10    973 Professional Fees RAD Ther  No
   11    974 Professional Fees RAD NUC   No
   12    975 Professional Fees O/R       No
   13    976 Professional Fees R/T       No
   14    977 Professional Fees P/T       No
   15    978 Professional Fees O/T       No
   16    979 Professional Fees S/P       No

              F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

Field Explanations

SEQ (DISPLAY ONLY)
The only UB codes that are displayed here are codes that have field 4 of the UB Revenue Code table set to either P for Pro Fee Only or B for Both.

UB CODE/DESCRIPTION (DISPLAY ONLY)
This field is a display of the UB Revenue Codes. When a new code is added to the UB Revenue code table, it is displayed here. The only UB Revenue Codes that are displayed are codes that have field 4 of the UB Revenue Code table set to either P for Pro Fee Only or B for Both.

EXCLUDE (1-A-O)
This field accepts two values, **Y**es and **N**o. The default value is No. This field is used to determine if all professional fee charges for this UB Revenue Code are excluded

from printing on the 1500 claim form. If you enter **N** for No, then all Professional Fee charges for that revenue code are printed on the 1500 claim being loaded. If you enter **Y** for Yes, then all Professional Fee charges for the UB Revenue Code are excluded from printing on the 1500 claim form.

After you have completed the setup for the UB Revenue Code Pro Fee exclusions or if you answered No to the previous prompt, the following prompt is displayed:

Do you wish to revise Pro Fee SIM items for exclusion? (Y/N) [N]--

If you accept the default of No, the following prompt is displayed:

Do you wish to revise FIM items to load $0.00 charges on the 1500? (Y/N) [N]--

If zero-dollar FIM items are loaded for a Non Pro Fee 1500 claim, and the net of the charge and credit quantities for the zero-dollar FIM items for the claim service line is zero, and the total charge amount for the claim service line is zero, the claim service line does not appear on the claim. The scenarios where the net of the quantities for charges and credits for zero-dollar FIM items can be zero include the following:

- Charges move to another account due to Combine Billing
- Charges move to another account due to a DPW
- Charge and credit are issued for an item

Zero-dollar FIM items that are indicated to load to the claim are loaded if the net of the quantity on the charges is not zero. For example, if two charges were entered for a zero-dollar item, but only one credit was entered, the claim would load the zero-dollar item with a quantity of 1. If one charge was entered for a zero-dollar item, but two credits were entered, the claim would load the zero-dollar item with a quantity of -1.

If you enter **Y** for Yes at the prompt, the following screen is displayed:

SIM Item Exclusions

```
                General Hospital Non Pro Fee 1500 Charge Control Processor
                                                  Tue Apr 11, 2000 12:17 pm

Code: 707
Description: MEDICARE OUTPATIENT
                     1500 Pro Fee SIM Item Exclusions
 Seq           SIM Department                          SIM Item
 1             EEG-EEG                                 3112-EEG PRO FEE
 2             EEG-EEG                                 3125-24 HR EEG/VIDEO









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

Field Explanations

SEQ (DISPLAY ONLY)
This field displays the line sequence number for the screen.

SIM DEPARTMENT (TABLE LOOKUP)
This field allows entry of any valid SIM department that is defined.

SIM ITEM (TABLE LOOKUP)
This field is only accessible if a SIM department has been selected. You may enter any valid Professional Fee SIM Item for the designated department. If you modify a selected Professional Fee SIM Item so that it is no longer a Professional Fee, subsequent charges using the SIM Item are not treated as a Professional Fee. The SIM charge type stored in the charge determines how the charge is processed.

After you have completed setting up SIM Item exclusions, the following prompt is displayed:

Do you wish to revise FIM items to load $0.00 charges on the 1500? (Y/N) [N]--

If you accept the default of No, you are returned to the following prompt:

Enter 1500 charge control code or '-' for a list--

If you enter **Y** for Yes, the following screen is displayed:

Zero Dollar Items to Load

```
              General Hospital Non Pro Fee 1500 Charge Control Processor
                                                    Tue Apr 11, 2000 12:33 pm

Code: 707
Description: MEDICARE OUTPATIENT
                        1500 FIM Zero Dollar Items to Load
 Seq           FIM Department                          FIM Item
 1     EEG-EEG                                70333112:EEG CONVENIEN









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

Field Explanations

SEQ (DISPLAY ONLY)
This field displays the line sequence number for the screen.

FIM DEPARTMENT (TABLE LOOKUP)
This field allows entry of any valid FIM department that is defined.

FIM ITEM (TABLE LOOKUP)
This field is only accessible if a FIM department has been selected. Enter any valid FIM Item for the selected FIM department. If you select either an ancillary charge or a non-zero priced professional fee charge, the system accepts the entry, but the charge load program excludes any ancillary charges from loading on the 1500 claim.

When all fields are completed, you have the option of accepting, editing or deleting this charge control parameter. Accepting the screen completes the transaction.

Dependent On	Reference
Place of Service	Insurance Coverage Table
SIM Departments	
UB Revenue Codes	
HCPCS Cross Reference Table	

PAYER HCPCS CROSS REFERENCE TABLE (US ONLY)

The Payer HCPCS Cross Reference Table defines which Financial Item Master HCPCS and Medical Records HCPCS are to use an alternate HCPCS or ICD-9-CM code on the UB, CMS 1500, or Non Professional Fee 1500 claim form for the payer. You can enter numerous Payer HCPCS Cross Reference tables for the payers that require alternate HCPCS/ICD-9-CM codes and then link these tables to the appropriate Charge Control Parameters for the payers. When the HCPCS code is encountered on a charge for the payer, the alternate HCPCS code or ICD-9-CM code loads and prints on the claim form. For UB claims, HCPCS Codes created through the HCPCS Summarization Master do not print an alternate HCPCS code on the claim. This table does not affect the patient bill nor does it affect the actual HCPCS codes on the charges in the database.

After this parameter is selected, the system prompts you to enter a Payer HCPCS Cross Reference table number. You can enter a code or a hyphen (-) to display a list of valid codes. When a code is entered or selected, the following screen is displayed:

```
     General Hospital Payer HCPCS Cross Reference Table Processor
                                                 Thu Jan 29, 2007 10:03 am


 1 Code      2 Description                  3 Status        4 HCPCS or ICD-9-CM
   1          MEDICAID HCPCS                  Active          HCPCS Master
 5 Partial Matches    6 Edit Date           7 Edited By
   Yes                  02/11/03 11:47am      Johnson,Sue

 8 Seq HCPCS                                Alternate HCPCS/ICD-9-CM
   1   00190   ANESTH, FACIAL BONE SURGE  00192   ANESTH, FACIAL BONE SURGE
   2   12345   TEST HCPCS                 1234599


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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code identifying the Payer HCPCS Cross Reference table.

2. DESCRIPTION (30-C-R)
This field contains the user defined description of the Payer HCPCS Cross Reference table.

3. STATUS (DISPLAY ONLY)
This field displays whether the Payer HCPCS Cross Reference table is active or inactive. A code that is filed as deleted by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

4. HCPCS OR ICD-9-CM (1-A-R)
This field determines if the alternate code references the HCPCS Table Master or the ICD-9-CM Table Master. Valid options are H for HCPCS Master or I for ICD-9-CM

Master. The system defaults to H for HCPCS Master. The answer to this field affects the table lookup when in the Alternate HCPCS/ICD-9-CM field.

If the Payer HCPCS Cross Reference Table is already set up, and you change the value of the HCPCS or ICD-9-CM field, once the table is accepted and you enter the table again, the alternate code may display without a description. This is because the description is pulled from either the HCPCS Master or the ICD-9-CM Master. If the code can not be found in the table now assigned, the code is displayed without a description.

5. PARTIAL MATCHES (1-A-O)

This field indicates whether the system should look for partial matches (in addition to exact matches) between the HCPCS and modifiers in the table and the HCPCS and modifiers on the claim. This field can be accessed only when the HCPCS or ICD-9-CM field is set to H for HCPCS. When this field is accessed, the following prompt is displayed:

If an exact match does not exist for a HCPCS code/modifier, then attempt a partial match on a HCPCS code/modifier or HCPCS code (Y/N)?--

This field is used only for the UB and the 1500 claim forms and is not used by Horizon Performance Manager, TRENDSTAR, or state claims and tapes.

You can enter **Y** for **Yes** to cause the system to look for partial matches. You can enter **N** for **No** or leave the field blank to cause the system to look for an exact match on both the HCPCS code and the modifiers when determining whether to change the HCPCS code to the Alternate code. If the field is set to Yes, the system works as follows:

The system first tries to match on any nine-digit, and then on any seven-digit codes (5 digit HCPCS plus one or two 2 digit modifiers) that are set up in the Payer HCPCS Cross Reference Table.

- If HCPCS and Modifier 1111122 point to an Alternate HCPCS and Modifier of 3333344, and the claim has HCPCS and Modifier 1111122, this is changed to the alternate of 3333344. This allows you to enter an alternate modifier code.

- If HCPCS and Modifier 111112233 point to an Alternate HCPCS and Modifier of 999994455, and the claim has HCPCS and Modifier 111112233, this is changed to the alternate of 999994455. This allows you to enter two alternate modifier codes.

- If the HCPCS and first modifier, or HCPCS and first and second modifier, on the claim match the HCPCS and modifier(s) in the Payer HCPCS Cross Reference Table and if there are additional modifiers on the HCPCS at the claim level, the additional modifiers are appended to the alternate HCPCS and Modifier code(s).

  For example, if HCPCS and Modifier 1111122 point to an Alternate HCPCS and Modifier of 3333344, and the claim has HCPCS and Modifiers of 111112299, the system changes this to the alternate of 333334499 on the claim form.

If HCPCS and Modifier 1111122 point to an Alternate HCPCS and Modifier of 999994455, and the claim has HCPCS and Modifiers of 111112299, the system changes this to the alternate of 99999445599 on the claim form.

If HCPCS and Modifier 111112233 point to an Alternate HCPCS and Modifier of 999994455, and the claim has HCPCS and Modifiers of 11111223388, the system changes this to the alternate of 99999445588 on the claim form.

The system tries to match on any five-digit HCPCS codes that are set up in the Payer HCPCS Cross Reference Table AFTER trying to match on 9 digit mappings (HCPCS code plus two 2-digit modifiers) and then trying to match on 7 digit mappings (HCPCS code plus one 2-digit modifier).

NOTE: The order of the HCPCS modifiers is taken into consideration. In other words, HCPCS and modifiers 111112233 is NOT the same as HCPCS and modifiers 111113322. BOTH would need to be entered into the table and mapped to the Alternate HCPCS if needed.

- If HCPCS code 22222 points to an alternate HCPCS code of 77777, and the claim has a HCPCS code and modifier of 2222244, and 2222244 is not mapped in the Payer HCPCS Cross Reference Table, the code is changed to 7777744 on the claim form. However, since the system first looks for exact matches on nine character and then seven character codes in the Payer HCPCS Cross Reference Table, if HCPCS code and modifier 2222244 were mapped to an Alternate HCPCS code and modifier of 5555588, this alternate HCPCS code and modifier would have taken precedence and would be used for the claim form.

If the following Payer HCPCS Cross Reference Table was built, and the Partial Matches field was set to Yes, the system processes as follows:

HCPCS	ALTERNATE HCPCS
11111	22222
1111199	2222288
111119944	222228877

The system first tries to match on the nine-digit code of 111119944 to the alternate of 222228877. Any HCPCS code and modifier of 111119944 (or 111119944xx or 111119944xxyy where xx and yy are additional modifiers), are changed to 222228877. For example, 11111994455 becomes 22222887755.

The system then tries to match on the seven-digit code of 1111199 to the alternate of 2222288. Any HCPCS code and modifier of 1111199, or starting with 1111199 (when the HCPCS code has more than one modifier, and this second modifier does NOT match on the nine digit HCPCS field in the table), are changed to 2222288. For example, 1111199 becomes 2222288, and 111119933 becomes 222228833.

The system then tries to match on the five-digit HCPCS code of 11111 to the alternate of 22222. Any HCPCS code of 11111, or 11111 with a first modifier other than 99, or first two modifiers other than 9944, would be changed to the alternate. For example, 11111 becomes 22222, and 111115566 becomes 222225566.

NOTE: If the Payer HCPCS Cross Reference Table would introduce a duplicate HCPCS modifier on the claim, the duplicate HCPCS modifier will be dropped before loading to the claim.

6. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this Payer HCPCS Cross Reference table was last edited.

7. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this Payer HCPCS Cross Reference table.

Field 8 contains the following:

SEQ (DISPLAY ONLY)
This field contains the number identifying the line number for the FIM HCPCS in this table.

HCPCS (9-AN-R)
This field contains the Financial Item Master HCPCS code and description or the Medical Records HCPCS code and description that is to use an alternate HCPCS/ICD-9-CM code on the claim form. You can enter a code or a hyphen (-) to display a list of valid HCPCS codes. The system allows a HCPCS code of five digits or a seven-digit code (a five-digit HCPCS and a two-digit modifier) or a nine-digit code (a five-digit HCPCS and 2 two-digit modifiers). Entries to this field are edited as follows:

- If you enter a code that is not five, seven, or nine characters long, the system displays the following error message and does not retain the code:

  Error: Length must be 5, 7, or 9!

- The system does not let you add a HCPCS code more than once in the table. If you enter a code that is already listed as a HCPCS, the system displays the error:

  Error: Duplicate HCPCS Code!

- The system does not let you add a HCPCS code that already exists as an alternate HCPCS code. If you enter a HCPCS code that exists as an alternate, the system displays the error:

  Error: Code Exists as Alternate!

- The system displays the following warning prompt if you enter or select (using the table lookup feature) inactive HCPCS or Alternate HCPCS codes:

  Warning! HCPCS Code is Inactive. Accept Code anyway? (Y/N)

  Enter **Y** for Yes to accept the inactive code or **N** for No if you do not want to accept the inactive code. If you accept an inactive code that has a modifier, the HCPCS code in the first five characters is checked to see if it is inactive.

ALTERNATE HCPCS/ICD-9-CM (9-AN-R)
This field contains the alternate HCPCS code or ICD-9-CM code and description to use on the claim form. The system allows a HCPCS code of five digits or a seven-digit code (a five-digit HCPCS and a two-digit modifier) or a nine-digit code (a five-digit HCPCS and 2 two-digit modifiers). Entries to this field are edited as follows:

- If you enter a code that is not five, seven, or nine characters long, the system displays the following error message and does not retain the code:

  Error: Length must be 5, 7, or 9!

If the HCPCS or ICD-9-CM field is set to ICD-9-CM Master, the system allows a one to nine digit code and does not edit the field.

You can enter a code or a hyphen (-) to display a list of valid HCPCS/ICD-9-CM codes.

The system does not let you add an alternate HCPCS code that already exists as a HCPCS. If you enter a code as an alternate HCPCS that exists as a HCPCS, the system displays the error:

Error: Code Exists as a Primary HCPCS!

After you complete these fields, the system files the information. The Payer HCPCS Cross Reference Tables must be linked to the appropriate Charge Control Parameters in order to load and print the alternate HCPCS codes on the claim form.

You can generate a printout of the Payer HCPCS Cross Reference Table by entering **Y** at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRHCP.

DIAGNOSTIC REVENUE CODES TABLE (US ONLY)

The Diagnostic Revenue Codes Table defines which UB Revenue Codes qualify for a Type of Bill second digit of 4 (diagnostic) in Locator 4 of the UB claim form and identifies diagnostic charges for evaluating charges for DRG Payment Windows (DPWs). Only patients with an outpatient patient indicator use this table. If the account has only revenue codes listed in this table on the UB, has an outpatient patient indicator, uses the Internal Element of *UB Bill Type for O/P - 2nd Digit* for the second digit of the type of bill in the UB Claim Load and Edit Parameter, and has an admission source on the account other than 2 for clinic referral or 7 for emergency room, the system prints a type of bill second digit of 4. If the account does not have an outpatient patient indicator, or has UB revenue codes on the claim that are not listed in this table, or has an admission source on the account of a 2 for clinic referral or 7 for emergency room, the system prints the default value for the second digit of the type of bill from the UB Claim Load and Edit Parameter. The default should be set to 3 for outpatient claim load and edit parameters. If the UB claim uses FIM Modifications in the Charge Control Parameter, the system looks to the original and the new UB revenue code on the charge to determine if the claim qualifies for a diagnostic type of bill.

If a charge in the evaluate period of a DPW has a UB revenue code in this table, it is considered to be diagnostic. If Yes is indicated in the Requires HCPCS for DPW Program column, the HCPCS code in the charge must be marked as a DPW diagnostic procedure in the HCPCS Table Maintenance screen for the charge to be considered diagnostic.

After this parameter is selected, the following screen is displayed. Only one table per facility may be entered.

```
        General Hospital Diagnostic Revenue Codes Processor
                                                Fri Feb 05, 1999 05:21 pm

                Diagnostic Revenue Codes for UB Claim Forms
Seq  Revenue Code                              Requires HCPCS for DPW Program
1    320    Radiology Diagnostic               Yes
2    401    Diagnostic Mammography             Yes
3    402    Ultrasound                         Yes
4    403    Screening Mammography              Yes
5    920    Other Diagnostic Services          Yes









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

Field Explanations

SEQ (DISPLAY ONLY)
This column contains the number identifying the line number for the UB revenue code in this table.

REVENUE CODE (3-N-R)
This column contains the UB revenue code and description of the revenue codes that are considered to be outpatient diagnostic revenue codes. You can enter a code or a hyphen (-) to display a list of valid UB revenue codes.

REQUIRES HCPCS FOR DPW PROGRAM (1-A-O)
This column contains Yes if the revenue code requires the HCPCS code for DPW processing. Enter **Y** to display Yes in this field.

After you complete these columns, the system files the information.

You can generate a printout of the Diagnostic Revenue Code Table by entering Y for Yes at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRDRCf, where f is the facility indicator.

NON DUPLICATING HCPCS RANGE TABLE (US ONLY)

The Non Duplicating HCPCS Range Table contains the HCPCS Procedures codes that the system uses to edit for duplicate HCPCS codes on the same day of service. This table allows the user to enter a range of HCPCS that cannot be duplicated for the same date of service for a claim. Any HCPCS that fall under this guideline must be defined in this table. Individual HCPCS may be defined as well as ranges of HCPCS. To define a single HCPCS that does not fall into a range, the Starting HCPCS and Ending HCPCS are the same. For HCPCS that contain an alpha character, no range can be defined.

The system uses this table to edit for duplicate HCPCS only if the value in the UB Charge Control Parameter for the Date field is set to Edit. Duplicate HCPCS Same Service Date Errors appear on the Failed Claims Requirement Report (FCR250) and on the claim Charge Data screen. Only one table per facility may be entered. The following is an example of a Non Duplicating HCPCS Range Table.

```
          General Hospital Non Duplicating HCPCS Range Table Processor
                                                  Tue Apr 21, 1998 03:58 pm

                        Non Duplicating HCPCS Range Table
Seq  Starting HCPCS          Ending HCPCS
1    A5555                   A5555
2    00100                   00100
3    00102                   00102
4    00103                   00124
5    00145                   00148
6    00147                   00162
7    00914                   00914
8    11010                   11010
9    82600                   82700
10   84060                   84075
11   93010                   93220









Do you want a printed list? (Y/N) [N]--
```

Field Explanations

SEQ (DISPLAY ONLY)
This field contains the number identifying the line number for the HCPCS Code in this table.

STARTING HCPCS (5-AN-O)
This field contains the HCPCS procedure code that starts the range of HCPCS codes that cannot be duplicated for the same date of service.

ENDING HCPCS (5-AN-O)
This field contains the HCPCS procedure code that ends the range of HCPCS codes that cannot be duplicated for the same date of service.

You can generate a print out of this table by entering a **Y** for Yes at the prompt,

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRVHCP. The facility indicator is concatenated to the end of the report name. When these fields are completed, you have the option of accepting or editing the information on the screen. Accepting the screen completes the transaction.

HCPCS PANEL CODE TABLE (US ONLY)

This table contains the HCPCS Panel Codes and their components that cannot appear more than once on a UB claim for the same date of service. McKesson has provided the HCPCS codes based on information from CMS for the HCPCS Panel Codes Table. If a panel code included in this table appears on a charge line, the system uses this table when editing for other charges for the same date of service that have the same HCPCS code. The HCPCS Panel Codes table is used in conjunction with the following tables to produce a Duplicate HCPCS Same Service Date error for the UB claim.

- Non Duplicating HCPCS Range table.

  The panel code as well as the HCPCS codes that make up the panel must be defined in the Non Duplicating HCPCS Range table for the system to identify a Duplicate HCPCS Same Service Date error for the UB claim.

- UB Charge Control Parameter

  The Date field is completed with a value of Edit if the user enters **Y** to edit for duplicate HCPCS by service date. The Date field by revenue code must be set to Edit for the revenue codes that should edit for duplicate HCPCS codes.

The system compares the HCPCS panel codes and their associated components to determine if a duplicate HCPCS error should occur on the claim. For example, if the HCPCS panel code of 80051 for an Electrolyte panel was charged twice on the same day, the system would report a Duplicate HCPCS Same Service Date error for the UB claim. Also, if the HCPCS panel code of 80051 for an Electrolyte panel was charged, and a component of the Electrolyte panel was also charged, the system would report a Duplicate HCPCS Same Service Date error for the UB claim. The following is an example of a HCPCS Panel Codes Table:

```
               General Hospital HCPCS Panel Code Processor
                                                 Thu May 21, 1998 10:04 am

 1 Code      2 Description                          3 Status
   80054       COMPREHEN METABOLIC PANEL              Active
 4 Edit Date                    5 Edit By
   02/02/98 12:53pm               Markum,Taylor L

 6 Seq HCPCS Description                  Seq HCPCS Description
   1   82040 ASSAY SERUM ALBUMIN
   2   82250 ASSAY BILIRUBIN
   3   82310 ASSAY CALCIUM
   4   82435 ASSAY BLOOD CHLORIDE
   5   82565 ASSAY CREATININE
   6   82947 ASSAY QUANTITATIVE, GLUCOSE
   7   84075 ASSAY ALKALINE PHOSPHATASE
   8   84132 ASSAY SERUM POTASSIUM
   9   84155 ASSAY PROTEIN
   10  84295 ASSAY SERUM SODIUM
   11  84450 TRANSFERASE (AST) (SGOT)
   12  84520 ASSAY UREA NITROGEN

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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the HCPCS Panel code.

2. DESCRIPTION (30-C-R)
This field contains the description of the HCPCS Panel code.

3. STATUS (DISPLAY ONLY)
This field indicates whether the HCPCS Panel Code Table is active or inactive. A code that is filed as deleted by the user becomes inactive and may be reactivated at any time. When you create a code, this field defaults to active.

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

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

6. SEQ (DISPLAY ONLY)
This field contains the sequential number associated with the data you enter.

HCPCS (5-AN-R)
This field contains a HCPCS procedure code that is contained in the HCPCS Panel code. You can enter a HCPCS procedure code, or enter a hyphen (-) for a table lookup to select a HCPCS procedure code from the Medical Record HCPCS Procedure Code Table.

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the HCPCS procedure code.

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

You can generate a print out of the HCPCS Panel Code Table by entering **Y** for Yes at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRHPC. The facility indicator is concatenated to the end of the report name.

PRINCIPAL PROCEDURE REVENUE CODE TABLE (US ONLY)

The Principal Procedure Revenue Code Table contains the UB Revenue Codes that require an ICD Procedure Code and Date for UB Form Locator 80 and UB04 Form Locator 74. Each insurance that requires a different set of UB Revenue Codes to determine if an ICD Procedure Code and Date is necessary should have its own Principal Procedure Revenue Code. In this table you enter the UB revenue codes that require a Principal Procedure in UB92 Locator 80 and UB04 Locator 74. The Principal Procedure Revenue Code must be linked to the UB Charge Control Parameter in the Princ Proc Rev Code Table field. If the claim has any of the revenue codes listed, but does not have a Principal Procedure Code and Date in UB92 Locator 80 or UB04 Locator 74 (depending on which version of the claim loads), the system reports a charge error in Claims Management and on the Failed Claims Report (FCR250). The error for the UB92 is listed as "Revenue Code Requires Procedure Loc 80." The error for the UB04 is listed as "Revenue Code Requires Procedure Loc 74."The Error Field Per Charge line has the error "Null Loc 80" or "Null Loc 74". To correct the error, enter a Principal Procedure Code and Date on the claim in UB92 Form Locator 80 or UB04 Form Locator 74.

For a UB in the UB04 format, the system looks to the claim ICD indicator to determine if an ICD-9-CM Procedure or an ICD-10-PCS Procedure is required. If the claim ICD indicator is a 9 or is blank, an ICD-9-CM procedure is required. If the claim ICD indicator is a 10, an ICD-10-PCS procedure is required.

The following is an example of a Principal Procedure Revenue Code Table:

```
            General Hospital Procedure Revenue Code Table Processor
                                                  Thu May 21, 2007 10:32 am

 1 Code   2 Description                           3 Status
   12       PROC CODE TABLE                        Active
 4 Edit Date                5 Edited By
   05/21/98 10:32am           Markum,Taylor L

6 Seq    UB       Description
   1     361     Operating Room
   2     490     Ambulatory Surgical Care
   3     761     Treatment Room









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the code associated with the Principal Procedure Revenue Code Table.

2. DESCRIPTION (30-C-R)
This field contains the descriptions of the Principal Procedure Revenue Code Table.

3. STATUS (DISPLAY ONLY)
This field indicates whether the Principal Procedure Revenue Code Table is active or inactive. A code that is filed as deleted by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

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

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

6. SEQ (DISPLAY ONLY)
This field contains the sequential number associated with the data you enter.

UB (3-N-R)
This field contains the UB revenue code. You can enter a code or a hyphen (-) for a table lookup to select a UB revenue code from a list of valid codes.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the UB revenue code

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

You can generate a print out of the Principal Procedure Revenue Code Table by entering **Y** for Yes at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRPRC.

UB THERAPY REVENUE CODE TABLE (US ONLY)

The UB Therapy Revenue Code Table defines which UB Revenue Codes the system should search on to determine if the account has had a physical therapy, occupational therapy, or speech therapy visit.

After you select this parameter, the following screen is displayed:

```
        General Hospital UB Therapy Revenue Codes Table Processor
                                                Mon Jul 28, 2003 12:28 pm

 1 Physical Therapy UB Revenue Codes
   420, 421, 422, 423
 2 Occupational Therapy UB Revenue Codes
   430, 431, 432, 433
 3 Speech Therapy UB Revenue Codes
   440, 441, 442, 443
 4 Cardiac Rehab Therapy UB Revenue Codes
   480
 5 Add Manual Value Code Amount
   No
 6 Edit Date                          7 Edited By
   07/28/03 09:32am                     Bell,Judi




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

Field Explanations

1. PHYSICAL THERAPY UB REVENUE CODE
This field contains the UB revenue code identifying a physical therapy visit. You can enter a code or a hyphen (-) to display a list of valid UB revenue codes from the UB Revenue Code table.

The system spans the charge information for each account. Physical therapy charges are identified by the UB revenue code entered for Physical Therapy in the UB Therapy Revenue Codes table. If Value Code 50 for Physical Therapy # Visits is highlighted in the Provider Master assigned to the account, for each unique service date for the charges going to the revenue code specified, the system counts 1 visit. Occurrence code 35 for Physical Therapy Start Dt is also created if it is highlighted in the Provider Master assigned to the account, using the earliest service date found for the revenue code.

2. OCCUPATIONAL THERAPY UB REVENUE CODE
This field contains the UB revenue code identifying an occupational therapy visit. You can enter a code or a hyphen (-) to display a list of valid UB revenue codes from the UB Revenue Code table.

The system spans the charge information for each account. Occupational therapy charges are identified by the UB revenue code entered for Occupational Therapy in the

UB Therapy Revenue Codes table. If Value Code 51 for Occupational Therapy # Visits is highlighted in the Provider Master assigned to the account, for each unique service date for the charges going to the revenue code specified, the system counts 1 visit. Occurrence code 44 for Occupational Therapy Start Dt is also created if it is highlighted in the Provider Master assigned to the account, using the earliest service date found for the revenue code.

3. SPEECH THERAPY UB REVENUE CODE

This field contains the UB revenue code identifying a speech therapy visit. You can enter a code or a hyphen (-) to display a list of valid UB revenue codes from the UB Revenue Code table.

The system spans the charge information for each account. Speech therapy charges are identified by the UB revenue code entered for Speech Therapy in the UB Therapy Revenue Codes table. If Value Code 52 for Speech Therapy # Visits is highlighted in the Provider Master assigned to the account, for each unique service date for the charges going to the revenue code specified, the system counts 1 visit. Occurrence code 45 for Speech Therapy Start Dt is also created if it is highlighted in the Provider Master assigned to the account, using the earliest service date found for the revenue code.

4. CARDIAC REHAB THERAPY UB REVENUE CODE

This field contains the UB revenue code identifying a cardiac rehab therapy visit. You can enter a code or a hyphen (-) to display a list of valid UB revenue codes from the UB Revenue Code table.

The system spans the charge information for each account. Cardiac rehab therapy charges are identified by the UB revenue code entered for Cardiac Rehab Therapy in the UB Therapy Revenue Codes table. If Value Code 53 for Cardiac Rehab Therapy # Visits is highlighted in the Provider Master assigned to the account, for each unique service date for the charges going to the revenue code specified, the system counts 1 visit. Occurrence code 46 for Cardiac Rehab Therapy Start Dt is also created if it is highlighted in the Provider Master assigned to the account, using the earliest service date found for the revenue code.

5. ADD MANUAL VALUE CODE AMOUNT (1-A-O)

This field is used to indicate whether, if either Value Code 50, 51, 52, or 53 and the amounts are manually entered and the system attempts to auto generate the same code on the UB92, the Value Code Amount entered by the user (or copied over from a previous series auto discharge and re-reg account) on the account loading the claim is added to the system-calculated amount for the same value code. By doing this, past visits for the patient, that were either not in an auto series discharge and re-registration link or that were on another system, can be added to the STAR Patient Accounting-calculated number of visits. Enter **Y** for Yes to have the system add the manual value code amount to the system-calculated amount. If this field is left blank or you enter **N** for No, any manually entered Value Code 50, 51, 52 or 53 and Amount overrides the system calculated value code and amount.

If any of the following value codes are highlighted in the Provider Master to auto generate on the UB92 claim form, the system looks to the UB Therapy Revenue Code Table to determine the revenue codes that qualify for PT/OT/ST/Cardiac, for the account loading the claim, and any "linked" series accounts that were set to auto discharge and re-register.

50-Physical Therapy # Visits

51-Occupational Therapy # Visits

52-Speech Therapy # Visits

53-Cardiac Rehab Therapy # Visits

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

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

You can generate a printout of the UB Therapy Revenue Code Table by entering Y at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRTRCf, where f is the facility indicator.

MED REC HCPCS UB REV CODE RANGE TABLE (US ONLY)

When a revenue code is set to pull Medical Records HCPCS in the Charge Control Parameter, the system first looks for a Medical Records HCPCS code that is linked to the revenue code. If a HCPCS is not found for the revenue code, the Med Rec HCPCS UB Rev Code Table can be used. In this table, you can enter a UB Revenue Code, and then a range of revenue codes to look for when pulling HCPCS codes to the claim. For example, revenue code 360 for Operating Room might list Med Rec HCPCS Rev Codes 361, 490, 760-761. The system, when looking for a Medical Records HCPCS for revenue code 360, would try to find a HCPCS linked to revenue code 360, and if there wasn't one, then would look for a HCPCS linked to revenue code 361, and if there wasn't one, would look for a HCPCS linked to 490, then 760-761. If it finds a HCPCS code linked to one of the above revenue codes, the HCPCS code prints on the claim on the charge line for revenue code 360. Therefore, this table allows hospitals to print HCPCS codes on claims even when there is not an exact match with the revenue code on the claim and the revenue code linked to the HCPCS code. Once a Med Rec HCPCS UB Rev Code Table is set up, it must be linked to the appropriate charge control parameter.

Once a Medical Records HCPCS is used for a service date, it is not used for another revenue code on the same service date. The system loads Medical Records HCPCS for the claim using the following hierarchy:

1) Revenue codes with the HCPCS Procedure field set to Medical Records that have a direct match to the Medical Records HCPCS UB revenue code.

2) Revenue codes with the HCPCS Procedure field set to Both/Summary that have a direct match to the Medical Records HCPCS UB revenue code.

3) Revenue codes with the HCPCS Procedure field set to Both/Detail that have a direct match to the Medical Records HCPCS UB revenue code.

4) Revenue codes with the HCPCS Procedure field set to Override that have a direct match to the Medical Records HCPCS UB revenue code.

5 Revenue codes with the HCPCS Procedure field set to Charge/Default Medical Records that have a direct match to the Medical Records HCPCS UB revenue code.

6) Revenue codes with the HCPCS Procedure field set to Medical Records that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

7) Revenue codes with the HCPCS Procedure field set to Both/Summary that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

8) Revenue codes with the HCPCS Procedure field set to Both/Detail that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

9) Revenue codes with the HCPCS Procedure field set to Override that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

10) Revenue codes with the HCPCS Procedure field set to Charge/Default Medical Records that do not have a direct match to a Medical Records HCPCS UB revenue code, but find a Medical Records HCPCS with a UB revenue code that falls into the range defined.

For example, revenue codes 361 and 762 both have the range 360-769. Medical Records HCPCS 11111 and 22222 are linked to revenue code 360. Medical Records HCPCS 33333 is linked to revenue code 361, and 44444 is linked to revenue code 762. Both revenue codes 361 and 762 have the HCPCS Procedures field set to Medical Records, with either a Yes or No to HCPCS Required. There are charges for both revenue codes, 361 and 762. The system first searches for Medical Records HCPCS that match the UB code exactly. Then the system searches based on the Medical Records HCPCS UB Revenue Code Table. Once a Medical Records HCPCS code is used, it is off the list for this search. The system assigns the HCPCS starting with the lowest number UB revenue code. In this example, the claim would print the following:

361 Operating Room	33333	11/15/00	1	$100.00
361 Operating Room	11111	11/15/00	1	0.00
361 Operating Room	22222	11/15/00	1	0.00
762 Observation Room	44444	11/15/00	1	200.00

If there were no Medical Records HCPCS for revenue code 762, the system still would not use the Medical Records HCPCS linked to revenue code 360 since these HCPCS are already used for revenue code 361.

As another example, there are 5 charges for revenue code 760, each for $100.00. Revenue Code 760 has the HCPCS Procedures field set to Charge/Default Medical Records. Three of the charges have a FIM HCPCS code, but two do not. The FIM HCPCS codes are 11111, 22222, and 33333. Revenue code 760 has the range 490,760. There is one Medical Records HCPCS for revenue code 490 of 99999. The system uses HCPCS 99999 on the first charge missing a FIM HCPCS and leaves the HCPCS code missing a FIM HCPCS on the second charge blank. In this example, the claim would print the following:

760 Cauterize Vein	33333	11/15/00	1	$100.00
760 Repair Achilles	11111	11/15/00	1	100.00

760 Laceration Repair	99999	11/15/00	1	100.00 (defaulted)
760 Suture	22222	11/15/00	1	100.00
760 Cast Full Foot		11/15/00	1	100.00

During this process, no Medical Records HCPCS appears more than once on the claim unless it appears more than once in Medical Records. Once the Medical Records HCPCS has found a match, it is no longer included in the list to be processed.

A code without a leading zero and the same code with a leading zero is considered two different codes. Therefore, if the charge on the claim has revenue code 0450, and the revenue code on the Medical Records HCPCS is 450, then the Medical Records HCPCS would not pull to the claim. This is true in reverse: if the charge has revenue code 450, and the Medical Records HCPCS has revenue code 0450, then the Medical Records HCPCS would not pull to the claim.

When you have leading 0's on your UB Revenue Codes, and you are using the Med Rec HCPCS UB Rev Code Table, you cannot use ranges of UB Revenue Codes to search on in this table. You must list the individual UB revenue codes. For example, for revenue code 0360:

CORRECT:

UB	Med Rec HCPCS Rev Codes
0360	0360,0490,0762

INCORRECT:

UB	Med Rec HCPCS Rev Codes
0360	0360-0762

After you select this parameter, the following screen is displayed:

```
         General Hospital MR HCPCS UB Rev Code Range Code Processor
                                                 Mon May 5, 2003 10:58 am

 1 Code      2 Description                          3 Status
   1           MEDICARE MED RECS HCPCS                 Active
 4 Edit Date                    5 Edit By
   05/05/03 10:59am               Owens,Julie M

   Seq UB   Revenue Description

 6 Med  Rec  HCPCS Rev Codes
   1   361     OPERATING ROOM
   360,490,760-761
   2   490     AMBULATORY SURGICAL CARE
   360-361,760-761
   3   760     TREATMENT OR OBSERVATION ROOM
   360-361,490









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

Field Explanations

1. CODE (5-N-R)
This field contains the table code associated with the Med Rec HCPCS UB Rev Code Range Table.

2. DESCRIPTION (30-AN-R)
This field contains the description of the Med Rec HCPCS UB Rev Code Range Table.

3. STATUS (DISPLAY ONLY)
This field indicates whether the Med Rec HCPCS UB Rev Code Table is active or inactive. A code that is filed as deleted by the user becomes inactive and may be reactivated at any time. The system defaults this field to active when you create the code.

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

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

6. SEQ (DISPLAY ONLY)
This field contains the sequential number associated with the data you enter.

UB (4-N-R)
This field contains the UB revenue code. You can enter a code or a hyphen (-) for a table lookup to select a UB revenue code from the UB Revenue Code Table.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the UB revenue code.

MED REC HCPCS REV CODE (29-N-R)
After selecting the UB Rev Code/Description, the user enters the Medical Records HCPCS code or range of codes in this field to search for Medical Records HCPCS.

NOTE: You can enter more than one range per line. For example, you can choose a range from 100-300, 301-399, 500-570, etc.,up to 29 characters.

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

You can generate a printout of the Med Rec HCPCS UB Rev Code Range Table by entering Y for Yes at the following prompt:

Do you want a printed list (Y/N)?

The name of the report that this command generates is FCRMRUB.

1500 DEPARTMENT/SUPPLIER OVERRIDE (US ONLY)

This parameter allows the user to choose the physician who is associated with a department for the 1500 claim form. The table default indicates that the performing physician from the charge is used on the 1500 claim form as the physician who performed or interpreted the services.

For each department that has professional fees, the user has the choice of changing the physician to admitting, attending, referring, emergency, performing, or charging, or choosing a physician or group from the physician table. The selected physician is always used for that department.

This table must be split by facility.

After 1500 Department/Supplier Override menu option is selected, this screen is displayed:

```
        General Hospital 1500 Department/Supplier Processor
                                              Thu Jun 27, 1996 10:17 am

       Departmental Override of Servicing Physician for 1500 Claim Forms
Seq  Department Name        Override    Physician Name            POS  Minutes
1    CONSULTATIONS          Admitting                              34    No
2    CLINICAL NUTRITION     Performing                                   No
3    ADL'S (SIM BASED)      Performing                                   No
4    ANESTHESIA             Admitting                              42    No
5    PHYSICIAN CONSULT      Attending                                    No
6    CARDIOLOGY             Performing                             31    No
7    CENTRAL SERVICES       Performing                                   No
8    DIETARY                Other        Adams,Harold                    No
9    EEG                    Performing                             22    No
10   CORONARY CARE UNIT     Other                                        No
11   INTENSIVE CARE UNIT    Charging                               21    No
12   HBOC Laboratory        Performing                             11    No
13   LABOR & DELIVERY       Performing
14   MISCELLANEOUS          Performing
15   NURSERY                Performing
16   OCCUPATIONAL THERAPY   Performing
17   PHYSICAL THERAPY       Charging

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

Field Explanations

SEQ (DISPLAY ONLY)
This field contains the sequential number associated with the data you enter.

DEPARTMENT NAME (3-C-O)
This field contains the STAR Patient Care department to which the entered physician is associated. You can enter the department code or a hyphen (-) to display a list of valid codes. If a department is not set up, the system uses the performing physician for the department.

OVERRIDE (1-A-R)
This field contains the physician that loads and prints on the 1500 claim form for this department. Entry options are **A** (admitting), **T** (attending), **R** (referring), **E** (ER), **P** (performing), **C** (charging), or **O** (other). The system automatically defaults the Performing physician in this field. If the Separate Claims field is set to Physician in the 1500 Charge Control Parameter, the system first calculates how many physicians there are for the account based on the charge departments and the settings to this field, and then loads a separate claim for each physician. If two or more departments are set to use the same physician, the system loads one claim for the physician, with the charges for all appropriate departments on the same claim.

NOTE: The Performing physician and the Charging physician are entered by the user on the charge screen for professional fees.

PHYSICIAN NAME (5-N-O)
This field is used only when the Override field is set to Other to specify the name of the physician or physician group that is used on the 1500 claim form. You can enter the physician code or a hyphen (-) to display a list of valid codes.

POS (2-AN-O)
This field contains the Place of Service code that prints in Locator 24B for each charge line with the specified department. If more than one department summarizes to one charge line, the system prints the place of service code for the department on the last charge processed. If a department does not have a place of service code specified in the 1500 Department/Supplier Override table, the Place of Service code from the 1500 Charge Control Parameter is used for the charge line. You can enter the Place of Service Code or a hyphen (-) to display a list of valid codes from the Place of Service table.

MINUTES (1-A-O)
This field determines if the charge description should be updated to the charge description, one space, the quantity on the charge, one space, and the literal “MIN” (for example, “Anesthesia 60 MIN”). Entry options are **Y** for Yes to print minutes or **N** for No to print minutes; the default is N. The charge has to be a timed professional fee charge to load the description in this format.

NOTE: The charge description does not print on the CMS 1500 claim form. The charge description does however display in the Claim Charge Data screen within Claims Management.

When all desired departments have the correct servicing physician assigned, pressing the F7 key prompts the system to offer you the option of accepting or editing the information on this screen. Accepting the screen completes the transaction.

Dependent On	Reference
SIM Departments	
Physician Table	

TYPE OF SERVICE CROSS REFERENCE TABLE

The Type of Service (TOS) Cross Reference Table allows you to print an alternate TOS code on the 1500 claim in Locator 24C. Anytime the FIM TOS is encountered on a charge for the 1500 claim, the alternate TOS code loads and prints on the 1500 claim form. Since the Financial Item Master allows only one TOS code per FIM item, use the Type of Service Cross Reference table for payers that require alternate Type of Service Codes. You can enter as many Type of Service Cross Reference tables as needed for payers that require alternate Type of Service Codes. Link these tables to the appropriate 1500 Charge Control Parameters for the payers.

After you select this parameter, the following screen is displayed:

```
       General Hospital Type of Service Cross Reference Table Processor
                                                  Tue Jun 16, 1998 11:46 am

 1 Code   2 Description                          3 Status
   AA       AA DESCRIPTION                       Active
 4 Edit Date                5 Edited By
   06/03/98 11:16am           Bartow,Johnny L

 6 Seq FIM TOS                          Alternate TOS
   1   1 - Medical Care                 M - Medicaid Medical Care
   2   2 - Surgery                      S - Medicaid Surgery
   3   3 - Consultation                 C - Medicaid Consultation
   4   7 - Anesthesia                   A - Medicaid Anesthesia
   5   9 - Other                        5 - Medicaid Other




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

Field Explanations

1. CODE (2-AN-R)
This field contains the Type of Service Cross Reference Code.

2. DESCRIPTION (30-AN-R)
This field contains the description of the Type of Service Cross Reference Code.

3. STATUS (DISPLAY ONLY)
This field displays whether the Type of Service Cross Reference Code table is active or inactive. A code that is filed as deleted by the user becomes inactive and may be reactivated at any time. This field defaults to Active when you create the code.

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

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

6. SEQ (DISPLAY ONLY)
This field contains the sequential number associated with the data you enter.

FIM TOS (2-AN-R)
This field contains Type of Service code that is contained on the FIM. A Type of Service code can be entered or a hyphen (-) lookup can be performed to select a Type of Service code from the Type of Service Code Table that is located on Patient Care.

ALTERNATE TOS (2-AN-R)
This field contains Type of Service code to be used instead of the Type of Service that is in the FIM on the 1500 claim form. A Type of Service code can be entered or a hyphen (-) look up can be performed to select a Type of Service code from the Type of Service Code Table that is located on Patient Care.

1500 PHYSICIAN QUALIFIER ID

This table lists the possible values for use in the 08/05 1500 Claim Form, Locator 24J, to identify the Physician ID in 24J Upper. The values are subject to change, and entries can be added or deleted by the user. Hospitals should reference the Electronic 837 Professional specifications for valid values.

After you select this parameter, the following screen is displayed:

```
         General Hospital 1500 Physician ID Qualifier Table Processor
                                                  Thu Nov 02, 2006 11:57 am
1500 Physician ID Qualifier
 1 Code   2 Description                                              3 Status
   0B       STATE LICENSE NUMBER                                      Active
 4 Edit by                                          5 Edit date
   New, Nancy                                         07/27/06 12:33




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

Field Explanations

1. CODE (2-AN-R)
This field contains the Qualifier ID code that is loaded to the 08/05 version of the 1500 claim in Locator 24J Upper. You can enter the code or a hyphen (-) to display a list of valid codes.

2. DESCRIPTION (50-A-R)
This field contains a description for the ID Qualifier code. This description does not load to the 1500 claim. Only the ID Code is loaded to the 1500 claim in Locator 24J Upper.

3. STATUS (DISPLAY ONLY)
The system displays either Active, or Inactive for table entries filed for deletion. Inactive table entries are not displayed in a table lookup on the 1500 Physician ID Qualifier table.

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

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

CLAIM LOAD EDIT TO INSURANCE PLANS REPORT

This option is used to set up the Claim Load Edit to Insurance Plans Report, which lists all insurances that have one of the Claim Load Edit Parameters listed in the Facility Options, Billing and Claims Parameters, page 3 of 5, or in the Facility Options, Billing and Claims Parameters, Patient Type Exceptions for Claims on page 4 and 5. This allows a hospital to know which insurances are affected by updates to the Claim Load Edit Parameters. This report identifies only the plans that are linked to the identified Claim Load Edit Parameter(s) in the Insurance Plan Coverage Table. The report does not identify the accounts that have already been assigned this insurance plan.

Since Claim Load Edit Parameters can be used across facilities, the system produces a report for each facility. For example, if Claim Type B is entered, for Claim Load Edit Parameter MED, and if Insurance Plan 100100 is linked to Claim Load Edit Parameter MED for Facility A and for Facility B, a report is produced for Facility A (FCRCLEA) and for Facility C (FCRCLEC).

After you select this parameter, the following screen is displayed:

```
       General Information Claim Load Edit to Insurance Plans Rpt Processor
                                                 Thu Dec 14, 2006 09:52 am


 1 Claim Type               2 Claim Load Edit Parameters
   UB                      ->


Enter claim parameters, enter A for All, or enter `-` to select from list--
```

FIELD EXPLANATIONS

1. CLAIM TYPE (1-AN-R)
This field contains the claim type for the claim load edit parameter. You can enter a claim type or a hyphen (-) to select the claim type from a list of available claim types.

2. CLAIM LOAD EDIT PARAMETERS (3-AN-R)
This field contains the claim load edit parameter that the system will report on. When this field is accessed, the following prompt is displayed:

Enter claim parameters, enter A for All, or enter '-' to select from list-- |

You can enter one claim load edit parameter or more than one separated by commas, an **A** (All) to select all parameters, or a hyphen (-) to select one or more parameters from a list of claim load edit parameters. Only Claim Load Edit Parameters valid for the Claim Type in field 1 are displayed.

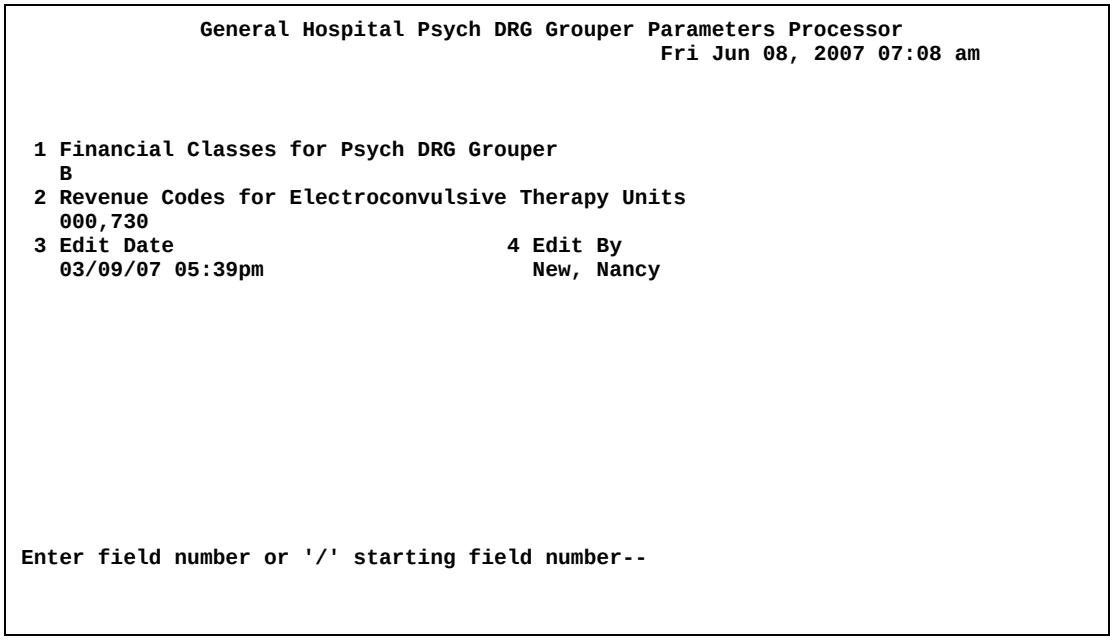
If multiple Claim Load Edit Parameters are listed, the report lists all insurances linked to the first Claim Load Edit Parameter listed, then lists all insurances linked to the second Claim Load Edit Parameter listed, and so on.

PSYCH DRG GROUPER PARAMETERS

This function is used to define parameters for 3M Psychiatric Grouper. These parameters are used by STAR Patient Accounting to accumulate the non-covered charge amount and the electroconvulsive therapy units for the 3M Psychiatric Grouper.

The calculations for electroconvulsive therapy units and non-covered charges are made when an account is prorated or when a request is received from STAR Medical Records for the information and is incomplete. The calculation is done for new charges only unless the primary insurance for the account has changed since the previous calculation or if an update was made to the Psych DRG Grouper Parameters after the last calculation of data was done for the account. Therefore, if the Edit Date in the Psych DRG Grouper Parameters is changed, the next calculation for an account is performed starting with the first charge.

Once an account is processed through the 3M Psych DRG interface, the returned information is displayed when you access the account through the Account Inquiry function, DRG information.



Field Explanations

FINANCIAL CLASSES FOR PSYCH DRG GROUPER (TABLE LOOKUP-R)
This field is used to select the financial classes for which the information should be accumulated because the Psych DRG Grouper is being used. When this field is accessed, the system displays the Financial Classes table. You can select one or more financial classes from the table.

REVENUE CODES FOR ELECTROCONVULSIVE THERAPY UNITS (TABLE LOOKUP-R)
This field is used to indicate the revenue code(s) used to accumulate the electroconvulsive therapy units. If a charge has one of the selected revenue codes from this list, the charge quantity is added to the accumulation of electroconvulsive therapy units for the account. This should be the revenue code as it appears in the Financial Item Master for the charge(s). If the revenue code is 901, make sure that you enter 901, not 0901, for the system to make a match.

When this field is accessed, the system displays the UB Revenue Codes table. You can select one or more UB revenue codes from the table.

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

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

ERRONEOUS SURGERY DIAGNOSIS CODE TABLE

Users can enter the External Cause of Injury Diagnosis Codes that normally would appear in UB04 Locator 72 if they are one of the first three external cause of injury codes, that should instead appear in UB04 Locator 67 for the Secondary/Other Diagnosis Codes. These codes are not repeated in Locator 72 for External Cause of Injury. Erroneous surgery diagnosis codes entered in this table affect all UB04 Claim Load Edit Parameters that load claims for the facility. If only specific payers should process for erroneous surgery diagnosis codes, then the Erroneous Surgery Diagnosis Codes ICD9/ICD10 field should be set for the payer(s) on the first screen of the UB Claim Load Edit Parameter, and this table can be left blank. Any external cause of injury diagnosis codes listed in this table are excluded from loading to Locator 72 A, B, and C and are only available to load to Locator 67 for the Secondary/Other Diagnosis Code fields.

You can enter a code or a hyphen (-) to select a code from a list of external cause of injury codes. The diagnosis code list should include only those external cause of injury codes that Medicare has stated must be reported in Locator 67 as one of the first nine Secondary/Other Diagnosis Codes. These external cause of injury codes are loaded to Locator 67 according to the order they are coded in STAR Medical Records.

If one of the listed external cause of injury diagnosis codes loads to Locator 67 1/A through Locator 67 9/I, the system does not produce an error. If one of the listed external cause of injury diagnosis codes loads to Locator 67 10/J through Locator 67 17/Q, the system produces an error for the diagnosis in the following format (# identifies the number of the secondary diagnosis):

Claims Workfile Error: Erroneous Surgery Dx Flagged for Review (#)

Failed Claims Requirement Report: 67-21 Error: Erroneous Surgery Dx Flagged for Review Contents: E876.7

If the listed external cause of injury diagnosis code is in electronic only data, because the diagnosis is past the first 17 secondary diagnosis codes, STAR does not edit for the erroneous surgery diagnosis code.

When an Erroneous Surgery Diagnosis Code loads to the UB04 claim in Locator 67 Other DX Code 1/A through 17/Q, the system edits the Type of Bill Locator 4 last digit. If the last digit of the type of bill is not a zero for a No Pay Claim, the field errors with the following edit message: Erroneous Surg Dx TOB Last Digit Not 0. This gives you the opportunity to review the claim and to update the type of bill.

NOTE: This table is at the facility level and affects all UB04 Claim Load Edit Parameters. If you do not want to edit/process for these Erroneous Surgery Diagnosis Codes for all UB04 Claim Load Edit Parameters, this table can be left blank. Instead, on individual UB04 Claim Load Edit Parameters, you can set the Erroneous Surgery Diagnosis Codes field. If the field is not set at the UB04 Claim Load Edit Parameter level, the system looks to the Facility level

table for Erroneous Surgery Diagnosis Code Table. If neither is set, the system does not edit/process for the erroneous surgery diagnosis codes.

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

Select ICD9 (I), ICD10 (T), do not process ICD9 (NI), or do not process ICD10 (NT) diagnoses for Erroneous Surgery Dx Codes--

- If **I** for ICD9 is selected the next prompt is as follows:

  Key ICD9 diagnosis codes for Erroneous Surgery or key N for do Not process --

  You can enter in the diagnosis codes. When entering ICD-9 External Cause of Injury Diagnosis Codes, the system edits that the first digit of the diagnosis code begins with an *E*. The diagnosis codes can be entered with or without the decimal, and display in the table without a decimal. The three current ICD-9 erroneous surgery diagnosis codes are as follows:

  E876.5 Performing the wrong operation on the correct patient

  E876.6 Performing a procedure on a patient not scheduled for surgery

  E876.7 Performing the correct operation on the wrong side or body part

  If **NI** for Do Not Process ICD9 is selected, the system does not process for Erroneous Surgery diagnosis codes for ICD-9.

- If **T** for ICD10 is selected the next prompt is as follows:

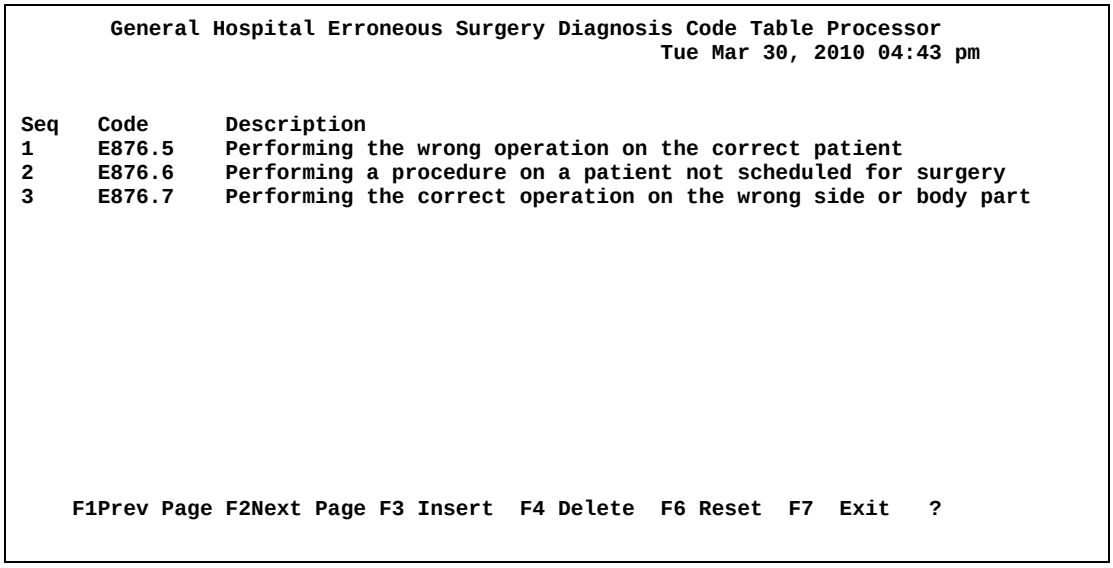
  Key ICD10 diagnosis codes for Erroneous Surgery or key N for do Not process --

  Note that external cause of injury codes for ICD-10 diagnoses do not start with the letter **E**. External cause of injury codes for ICD-10 are in the range of V01-Y98.

  You can enter in the diagnosis codes. When entering ICD-10 External Cause of Injury Diagnosis Codes, the system edits that the first digit of the diagnosis code begins with a V, W, X, or Y. The diagnosis codes can be entered with or without the decimal, and display in the table without a decimal. The ICD-10 diagnosis codes are case sensitive and must be entered with upper and lower case as they appear in the ICD Master.

  If **NT** for Do Not Process ICD10 is selected the system does not process for Erroneous Surgery diagnosis codes for ICD-10.

The following screen is displayed:



Field Explanations

SEQ (DISPLAY ONLY)
This is the sequence number assigned by the system.

CODE (7-N-R)
This field contains the diagnosis code. You can enter a code or a hyphen (-) in the field to display the codes.

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

ALTERNATE PRICING (340B PRICING)

340B hospitals need to report the discounted purchase price for particular drugs for the Medicaid claim. The "regular" price can be charged and reflected on the claims for other payers, but the Medicaid claim must reflect the discounted purchase price and will not qualify for a further rebate.

This table is used to define the pricing for pharmacy items per FIM department code. Multiple prices can be indicated for a FIM Item per effective dates. When accessing this table, you can add different tables per payer/requirement, and then link them to the appropriate UB Charge Control Parameters.

- Add a claim Alternate Price Table that can be linked to the appropriate UB Charge Control Parameters.

- Users can point specific insurance plans and even Patient Types within those insurance plans to the appropriate UB Charge Control Parameters, so they can list it only on the appropriate Medicaid plans.

- The alternate price is listed by FIM item, with Effective From and Through Dates for that FIM Item alternate price (numerous alternate prices can be listed by dates for the FIM item). This alternate price lists the alternate Unit price, and the Dispensing Fee (which can be left blank). The Dispensing Fee is per charge. For example, if PA receives 1 charge, with Units of 3, if the Alternate Unit Price is $23.00 and the Dispensing Fee is $7.50, the alternate price for the claim only would be: (3*23)+7.50=$76.50.

- The system provides an Excel report of the Alternate Price Table so that hospitals can sort on different fields and track the prices.

- Users have the option of using the Pharmacy Quantity (units) for the charge, or the "regular" Quantity for the charge when multiplying this by the Alternate Price. If the table is set to use Pharmacy Quantity, and this field is blank for the charge, the regular Quantity is used.

- The price does not alter the charge actually placed to the patient. Therefore, if there are other insurances on the account, the claims for these insurances would reflect the "regular" price charges.

- The Alternate Price Table can list the HCPCS Modifier that should be appended to the HCPCS for any charge with an Alternate Price (for example, the UD modifier).

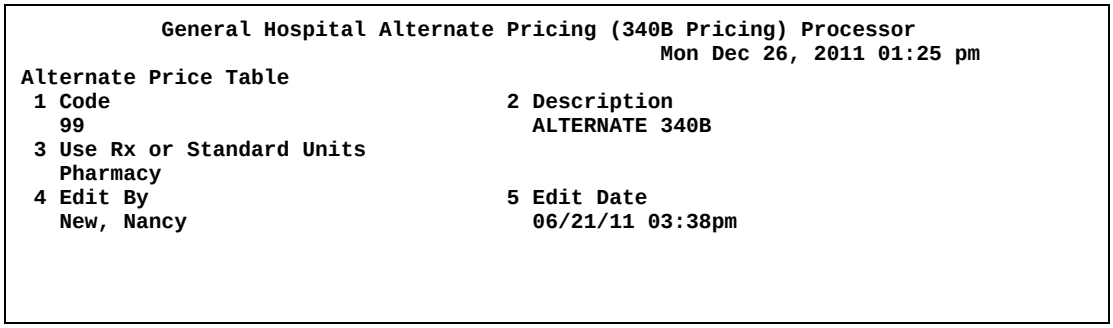
- The intent of the logic created for 340B Pricing is to load claims with the 340B Pricing for Pharmacy items and to write off the difference between the charge amount in Star and the charge amount per 340B pricing. The write off occurs by using the reimbursement type of R-Alternate Price. If an ERA payment is received for the primary insurance using the reimbursement type of R and the Contractual Adjustment Method is Variance or Reverse Sys Adj, no contractual adjustment is

calculated automatically. For these accounts, the contractual adjustment is calculated per the CAS Reason Codes within the ERA file and is placed into the cash batch. Thus for these accounts the contractual adjustment method is 'Post' even if the ERA Payment File Definition is set to 'Variance' or 'Reverse System Adj'. Since the account already has a contractual adjustment amount that reduced the account balance per the 340B rule, the logic should not perform a variance or reverse system adjustment using money that was not written off for the estimated reimbursement.

Reimbursement Type R for Alternate Price looks to the charge detail prices versus the claim price for the same charges, and only writes off the difference of those particular charges that differ. For example, if there was a Pharmacy item 12345678 for $240.00, but the claim price for this item was $170.00 (using the Alternate Price 340B Table), then the system would write off the difference of $70.00 for this charge item. The system would calculate the difference for the charges at the detail charge level versus the discounted prices on the claim, and write off that amount only.

Therefore, this reimbursement type is only writting off the difference between the charged price and the discounted price on the claim for the 340B Pharmacy items. The non-discounted items do NOT have a write off of the amount the payer will not reimburse (in other words, you can't state to also write off 20% of the remaining claim charges). You will be expecting to take an additional write off at time of ERA that would be in addition to the write off of the discounted drugs.

The system takes the write off at time of claim LOAD, and only for claims loaded via a billing event (midnight processing, Single Bill Request, Instant Adjustment Bills). Claims added via Add Claim to Insurance will NOT take a write off, even when using the Alternate Price Table. For claims loaded in midnight processing, the job "Reimbursement Processing for Alternate Price Reimbursement Type" runs after claim load completes. For claims loaded in Instant Adjustment Bill, the write-off is made after the claims load in Instant Adjustment Bill.



Field Explanations

1.CODE (DISPLAY ONLY)
This field contains the code identifying the table.

2. DESCRIPTION (30-C-R)
This field contains the user defined description of the table.

3. USE RX OR STANDARD UNITS (1-A-R)
This field defines whether the system should use the Pharmacy units or the standard units when calculating the alternate price for the claim. When using the Pharmacy units, the claim loads the Pharmacy units to the claim charge line. If the field is set to Pharmacy units, but there are no Pharmacy units for the charge item, the system defaults to using the standard units for the charge line. The Pharmacy units should not be confused with the NDC units. NDC units are not used for the alternate price.

Once the header screen is completed, you are prompted to select a Facility in order to access the valid FIM items for that facility. Then, you can select the FIM Department, and the FIM Item to update with the Alternate Price and modifier information. The following screen is displayed:

```
              Alternate Pricing (340B Pricing) Processor
                                                    Mon Dec 26, 2011 01:31 pm
Alternate Price Table                    99-MEDICAID
RXA-11119876-PHARMACY TEST ITEM
Sq    Unit Price  Dispensing Fee  Modifier  Effective From   Effective Thru
1      75.00000   7.50  UD                  01/01/2011       12/31/2011









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

Field Explanations

1. SQ
This field contains the sequence number generated by the system.

2. UNIT PRICE (9-N-R)
This field contains the alternate unit price for the item. The Unit Price is multiplied by the Pharmacy units or Standard units (based on the first screen of the parameter and what exists for the charge).

3. DISPENSING FEE (8-N-O)
This field contains the dispensing fee for the item, and can be left blank. The dispensing fee is added to the alternate price.

4. MODIFIER (TABLE LOOKUP-R)
This field contains the HCPCS modifier that should be appended to the HCPCS for any charge with an Alternate Price (for example, the UD modifier). This modifier is added to the claim only, and does not update the charge at the account level. Users can do a dash for a table lookup on the HCPCS Modifier Table.

5. EFFECTIVE FROM DATE (10-N-R)
This field contains the from date for which the FIM Item alternate price is effective. The system looks to the charge Service Date to find the appropriate line in the table. Numerous time frames with different Unit Price/Dispensing Fee/Modifier can be listed.

6. EFFECTIVE THRU DATE (10-N-R)
This field contains the through date for which the FIM Item alternate price is effective. The system looks to the charge Service Date to find the appropriate line in the table. Numerous time frames with different Unit Price/Dispensing Fee/Modifier can be listed.

When updating the claim with the alternate price, the system will round up with .005 and will round down with anything less than this. For example, $540.125 becomes $540.13, and $760.344 becomes $760.34.

To give an example, let's say that for RXA, FIM Item 11119876, the Unit Price is $75.60, the Dispensing Fee is $7.50, and the modifier is UD. Let's also say the table is set to use Pharmacy Units. If the patient had:

111119876 Standard Units = 1, Pharmacy Units = 2, HCPCS J1234, price at account $320.00

The claim would have:
($75.60 x 2)+ $7.50 = $158.70

HCPCS would be J1234UD, Units would be 2

The write off when using R - Alternate Price (for this charge item only, although the system would total the difference in the detail charges and the alternate prices on the claim before taking the write off) would be:

$320.00 - $158.70 = $161.30

When entering the Alternate Price information for a FIM item in the table, if there are overlapping effective dates for lines in the table, when hitting F7 to Exit the table, and answering Y for Yes to Record Changes? (Y/N), the system will give an error message that the dates overlap, and will return the user to the table to correct the issue. For example:

01/01/09-12/31/09 overlaps 06/01/09-01/01/10. Press ENTER.

The system prompts whether you still want to record the changes as follows:

Record Changes with Discrepancies Noted? (Y/N)--

When exiting the Alternate Price (340B) table, the system prompts as follows:

Do you want to create a (S)tandard Report, a Report to Download to (E)xcel, or (B)oth Reports for this table?

The Excel report and the Standard report both spool to View Spooled Reports with the report name of FMRRXP Alternate Price (340B). The Excel report will have a Comment of "Excel Format for xx" where xx is the table number. The standard report will have a Comment of "Standard Format for xx" where xx is the table number.

NON-SPECIFIC HCPCS TABLE

This table is used to enter Non-Specific Procedure Codes as codes that may include, in their descriptor, terms such as: "Not Otherwise Classified (NOC); Unlisted; Unspecified; Unclassified; Other; Miscellaneous; Prescription Drug Generic; or Prescription Drug, Brand Name". The appropriate Non-Specific HCPCS table can be linked to the UB Charge Control Parameter, the 1500 Charge Control Parameter, and the Non Pro Fee 1500 Charge Control Parameter.

Upon accessing the table, the system prompts:

Enter Non Specific HCPCS Table or '-' for a list --

A new table number can be entered here. When a new table is entered, the system prompts:

Add Non Specific HCPCS Table xx? (Y/N) [N] --

When entering Y for Yes to add the table, the system prompts:

Enter description for Non Specific HCPCS Table xx --

Once the description is entered, the system prompts for a date range for the table:

Enter Effective From and Effective Through Date Range (MM/DD/YYYY-MM/DD/YYYY)--

A date range can be entered that continues well into the future if only one table is needed, such as 01/01/2012-12/31/2099.

The system looks to the Bill FROM date for the bill that loads the claim in order to access the appropriate table.

The system then allows the user to enter in those HCPCS that are Non Specific, and that, when used on a claim, should fail the claim. The list from CMS for January 2012 has been added as table number 1 with a description of CMS Non Specific HCPCS. This table can be used or not, at the users' discretion.

If the user enters a time frame that overlaps with an existing time frame, the system gives the below error and does not accept the entry:

Error! Time frame overlaps existing time frame of MM/DD/YYYY-MM/DD/YYYY!

If time frames have already been established for the table, then the below prompt appears. Hitting the Enter key displays the current time frames:

Enter next Effective From and Effective Through Date Range (MM/DD/YYYY-MM/DD/YYYY) or Enter for current settings--

Users can also copy HCPCS from one table to another, or from one time period to another within the same table. The system only gives this prompt when adding a time period for a Non Specific HCPCS table, and not when editing an existing time period.

When the time period is established and then selected, the system first displays the time period as follows:

```
                                  General Hospital Non Specific HCPCS Table Processor
                                                  Thu Aug 09, 2012 01:56 pm
Non Specific HCPCS Table
63-TEST NON SPEC HCPCS
 1 Table Description
   TEST NON SPEC HCPCS
 2 From Date      3 To Date
   01/01/2012       12/31/2012
 4 Edit By                              5 Edit Date
   New, Nancy                             04/02/12 01:43pm


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

When hitting your Enter key, the system prompts "Delete? (N)--"

Hitting Enter again brings you to the following prompt:

Do you want to copy HCPCS from another table? (Y/N)--

When entering Y for Yes, the system prompts as follows:

Enter Non Specific HCPCS Table or `-` for a list--

Users can directly type in the table number, or do a lookup of the existing Non Specific HCPCS tables. Users can then either select to copy FROM the same table, or a different table. Once the table is selected, the user must select the time frame to copy FROM. The table you are copying TO is listed in the top left of the screen. The system lists the table you are copying FROM in the line "Time Frames for Table xx".

Once you select the time frame, the system verifies that you in fact want to copy from the table as follows:

Are you sure that you want to copy from 63 for 01/01/2012-12/31/2013? (Y/N)--

Enter Y for Yes to start the copy, or N for No to exit from the copy.

When accessing a Non Specific HCPCS table, and selecting a time frame within the table that already has HCPCS defined, the system prompts:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

When entering A to Add HCPCS, the system prompts as follows:

Enter Range(s) of HCPCS (e.g., A9152-A9153, A9279-A9280) or hit Enter for HCPCS lookup--

Users can enter HCPCS ranges, separated by a comma, or can hit the Enter key to enter HCPCS using the table lookup. The range prompt above does not allow lookups on the HCPCS master. When hitting the Enter key, the system prompts:

Enter HCPCS code to add to the list or use `-` for lookup--

Here the user can enter a direct table lookup (-), or can do a partial search such as "9-" in order to do a lookup on the HCPCS master. Once the table displays, users can highlight numerous HCPCS codes to add to the Non Specific HCPCS table.

If the user adds HCPCS with the above prompt, once the Enter key is pressed to add the selected HCPCS, the user returns to the prompt for entering a range of HCPCS. If you are finished entering HCPCS into the table, then you should continue to hit Enter until you receive the following prompt:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

When entering Y to View/Edit the HCPCS Codes, the system displays the prompt:

Enter Partial Code or `-` to start lookup of existing codes--

You can enter a dash (-) to view all of the HCPCS listed in the Non Specific HCPCS table for that date range, or enter a partial lookup to see the codes that start with the character entered, such as "9-". The system displays the HCPCS already added to that table. From this list, the user can delete or add codes. The system prompts:

Select HCPCS to be deleted from the list or A to Add--

When highlighting HCPCS to delete, and hitting your Enter key, the system verifies that you in fact want to delete the HCPCS codes:

Are you sure that you want to delete this HCPCS from the list? (Y/N)--

Enter Y for Yes to confirm the deletion.

If entering an A to Add at either of the below prompts, the system again allows you to enter ranges of HCPCS, or allows you to select HCPCS after using a table lookup:

View/Edit the HCPCS Codes (Y/N) or (A)dd HCPCS--

Select HCPCS to be deleted from the list or A to Add--

MAINTAIN ASB/CROSSOVER INSURANCE PLAN INFORMATION

For a given primary insurance, this table can be used to add or remove an insurance plan from the list of insurance plans maintained in the ASB/Crossover Hold Exceptions field on the second screen for Billing/Claims Parameters. The ASB/Crossover Hold Exceptions field is used to indicate the primary insurances creating crossover claims for the given insurance. Also, if an ASB/Crossover Hold Exception is declared in this processor, the following fields on the same screen are updated to contain a value of Yes, if that is not the current value. These fields must contain a value of Yes to create ASB/Crossover Hold Exceptions:

- Load Separate Claim?
- Hold Claim for Prior Pymt?

NOTE: If all insurances in ASB/Crossover Hold Exceptions are removed due to this processor, no other fields on the screen for Claim Parameters change. The display for the field titled ASB/Crossover Hold Exceptions will contain *No Insurances Selected*.

The Maintain ASB/Crossover Insurance Plan Information Processor operates as follows.

When the option is selected, the facility is selected if need be. If updates are being made to the Insurance Plan Coverage table meaning the table is locked, the following message appears:

Insurance table is locked. Please try later.

If Pending Insurance Updates exist for any of the insurance plans for the facility, then the processor cannot be used. Each insurance plan is identified with the following message:

Pending Insurance Updates for xxxxxx!

Before the user is returned to the prior menu, the following message appears:

Processor cannot be used for a facility with pending insurance update!

If the processor can be used, an insurance carrier and plan code are selected. In this processor, for the selected insurance you are selecting subsequent insurances for which the Electronic Claim System (ECS) will be creating claims meaning claims should not be sent to ECS and other related logic should occur in STAR. This logic is limited to claims of type X (UB) so the following error message appears if the claim type is not X for the selected insurance plan.

Claim type must be X!

After the insurance plan is selected, the response to the following prompt determines whether insurance plans are added or removed from the list.

Do you want to (A)dd or (R)emove secondary insurances for ASB/Crossover Hold Exceptions?

- If **A** for Add is selected, the following reminder prompt appears.

  Load Separate Claims? and Hold Claim for Prior Pymt? will be set to Yes for selected insurances. Do you want to continue? (Y/N)--

  The processor will update Load Separate Claims? and Hold Claim for Prior Pymt? to Yes for any insurances updated in this processor meaning those fields apply in all uses of the insurance plan.

The next prompt is used to identify how insurance plans will be identified to create the relationship.

Key A for All, `-` for look-up list, or use `-` for a partial list to select secondary insurances--

- If A for All is keyed, a response of Y must be made to the following prompt before ASB/Crossover Hold Exceptions is set for all insurance plans.

  Are you sure that you want to add all secondary insurances for xxxxxx? (Y/N)--

After all appropriate insurance plans are updated, the following message appears:

ASB/Crossover Added for xxxxxx for all insurances with claim type X!

If you want to view a lookup list of all insurance plans, you can key a hyphen (-). If you want to view a lookup list starting with a particular insurance plan, you can key the beginning of the code (e.g. 500-) followed by a dash.

After the desired insurance plans are selected, the following message appears:

ASB/Crossover Added for Selected Plans!

- If **R** for Remove is selected, the next prompt is used to identify how insurance plans will be identified to remove the relationship.

  Key A for All, `-` for look-up list, or use `-` for a partial list to remove secondary insurances--

  - If **A** for All is keyed, then a response of Y must be made to the following prompt before the insurance plan selected initially is removed from any lists for ASB/ Crossover Hold Exceptions.

Are you sure that you want to remove all secondary insurances for xxxxxx? (Y/N)--

After all appropriate insurance plans are updated, the following message appears:

ASB/Crossovers Removed for xxxxxx for all insurances with claim type X!

If you want to view a lookup list of all insurance plans for which the ASB/Crossover Hold Exceptions exists for the insurance plan selected originally, key a hyphen (-). If you want to view a lookup list of existing ASB/Crossover Hold Exceptions for the insurance plan selected originally starting with a particular insurance plan, then key the beginning of that code (e.g. 500-) followed by a dash.

After the desired insurance plans are selected, the following message appears:

ASB/Crossovers Removed for Selected Plans!

ONTARIO ELECTRONIC RECIPROCAL BILLING PARAMETERS

The Ontario Electronic Reciprocal Billing Parameters are used for Claim type 10 (ON OOP ICD10) and claim type 12 (ON OOP ICD10 OP). When this option is selected from the PA/AR Parameter Maintenance menu, the following screen is displayed:

```
          Ontario Electronic Reciprocal Billing Parameters Input Options

            Option No.  Option
            ---------------------------------------
                1       Upload Parameters
                2       Reciprocal Billing Mapping Tables
                3       Patient Types for OOP Data Entry
                4       High Cost Procedures
                5       Accident Codes
                6       Download Parameters
                7       Unit Price Overrides









Enter option number--
```

Each of these parameters is discussed in detail below.

Upload Parameters

This function is used to maintain parameters for the import for Medical Records data. Since this is custom code, access to this feature must be activated by McKesson. The parameters include the default Unix Directory for the import and the number of days that data for these claims should be retained after an account reaches a zero balance. The data is the imported data from Medical Records found under Ontario Reciprocal Billing Information and the data entered under Out of Province Patient Information. Also, the screen contains the last file name plus the date/time of import for both inpatient and outpatient data.

When this option is selected, the following screen is displayed:

```
                  General Hospital Upload Parameters Processor
                                                Tue Jun 09, 2009 07:23 am


 1 Active?
   Yes
 2 UNIX Directory                          3 Header Record
   hbo/tmp/ec2ca/                            No
 4 Inpatient Header Length                 5 Outpatient Header Length

 6 Last I/P Data File Imported             7 Last Import Date/Time for I/P File
   /hbo/tmp/ec2ca/ONT_OOP_IP02041.txt        09/02/04 13:02
 8 Last O/P Data File Imported             9 Last Import Date/Time for O/P File
   /hbo/tmp/ec2ca/ONT_OOP_OP01072.txt        09/01/07 15:01
10 Retention Days
   9999
11 Edit By                                12 Edit Date
   New, Nancy                             09/02/04 12:58



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

Field Explanations

1 ACTIVE? (DISPLAY ONLY)
This field indicates whether the parameter code is active or inactive. Yes indicates the code is active, No indicates the code is inactive.

2. UNIX DIRECTORY (14-AN-R)
This field contains the UNIX directory path containing the files to be uploaded.

3. HEADER RECORD (1-A-O)
When this field is accessed, the following prompt is displayed:

Does the upload file include a header record? (Y/N)--

If the response to this prompt is Y for Yes, then the upload program for inpatients and for outpatients reads one record before starting to process account information.

4. INPATIENT HEADER LENGTH (4-N-C)
This field contains the length for the Inpatient Header Record. The field can be accessd only if the Header Record field is set to Yes.

5. OUTPATIENT HEADER LENGTH (4-N-C)
This field contains the length for the Outpatient Header Record. The field can be accessed only if the Header Record field is set to Yes.

6. LAST I/P DATA FILE IMPORTED (DISPLAY ONLY)
This field contains the directory path where the most recent inpatient file was imported.

7. LAST IMPORT DATE/TIME FOR I/P FILE (DISPLAY ONLY)
This field contains the date and time when the most recent inpatient data file was imported.

8. LAST O/P DATA FILE IMPORTED (DISPLAY ONLY)
This field contains the directory path where the most recent outpatient file was imported.

9. LAST IMPORT DATE/TIME FOR O/P FILE (DISPLAY ONLY)
This field contains the date and time when the most recent inpatient data file was imported.

10. RETENTION DAYS (4-N-O)
This field contains the number of days the system retains imported medical records data after the account has reached a zero balance.|

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

12. LAST EDIT BY (DISPLAY ONLY)
This field contains the name of the person who last edited this table.

Patient Types for OOP Data Entry

This table is used to select the patient types for which Medical Records abstract data is not expected, meaning data entry in the Out of Province Patient Information processor is expected.

When this option is selected, the following screen is displayed:

```
              Patient Types for OOP Data Entry Processor
                                          Tue Jun 09, 2009 07:28 am


Page:01               Select Non-Abstracted Patient Types    ##=Current Choices
( 1) API-PED INPATIENT DIFFERENT CL   (17) EMD-AEMERGENCY MEDICINE
( 2) APS-ADMISSION-PEDIATRIC INPATI   (18) EMP-OUTPATIENT - EMPLOYEE
( 3) ASH-ADMISSION-ADULT SHORT STAY   (19) END-D ENDOSCOPY
( 4) BIL-ZBILLING USE ONLY            (20) ENS-D ENDOSCOPY SERIES
( 5) BPS-D OUTPT BOOKED PROC-ADULT    (21) EPS-AEMERGENCY PSYCH TEAM SERI
( 6) CAS-COM.DISORDER AUDIOLOGY SER   (22) EPT-AEMERGENCY PSYCH TEAM
( 7) CDS-AZCAPD SERIES                (23) EYE-OUTPT EYE CLINIC
( 8) CNJ-CANCEL ADMIT W/ ORDERS (J)   (24) EYS-OUTPT EYE CLINIC SERIES
( 9) CON-ADMISSION-CONTINUING CARE    (25) FRC-FIRESTONE CHEST & ALLERGY
(10) COS-COMMUNICATION DISORDERS SE   (26) FRS-OUTPT FRACTURE CLINIC SERI
(11) CPS-PCOMM.PSYCH/WOMEN'S HEALTH   (27) FSS-FIRESTONE SERIES
(12) CSS-COM.DISORDER SPEECH SERIES   (28) HES-AZHEMODIALYSIS SERIES
(13) CW2-ADMISSION - CW2              (29) HHS-AZHOME DIALYSIS
(14) DSP-ADMISSION-DAY SURGERY PEDI   (30) HOD-HODSI
(15) DSU-ADMISSION-DAY SURGERY UNIT   (31) I/P-*ADMISSION-REGULAR INPATIE
(16) ECS-AECT-4 PSYCHIATRY SERIES     (32) IPS-AZIPD SERIES

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
               end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

A list of hospital inpatient and outpatient patient types is displayed, highlighting those patient types which are not abstracted by the hospital's medical record system. Discharged patients with patient types selected in this table allow data entry for all fields in the Out of Province Patient Info screen. You can select more patient types by entering the number next to the patient type. To remove patient types, enter the number of the patient type as in the following example: ’1’.

High Cost Procedures

For out of province processing, this table provides the ability to identify high cost procedures which should look at since unit, not total of units associated with a claim, for high cost analysis.

After an effective date range is entered for the table, you can enter or modify ICD-10 Intervention codes and associated information identifying a high cost item. There is not an ICD-10 Intervention code table to edit against.

When this table is accessed, the following screen is displayed

```
              General Hospital High Cost Procedures Processor
                                                  Tue Jun 09, 2009 07:29 am
High Cost Procedures Table


 1 High Cost Procedures Table Code    2 Description
   1                                    SUSAN'S JUNE 30 TBL
 3 Effective From Date                4 Effective Thru Date
   00/01/01                             09/03/31
 5 Edit By                            6 Edit Date
   New, Nancy                        08/06/30 13:53









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

Field Explanations

1. HIGH COST PROCEDURES TABLE CODE (5-N-R)

This field contains the table code associated with the High Cost Procedures Table.

2. DESCRIPTION (30-AN-R)

This field contains the description of the High Cost Procedures Table.

3. EFFECTIVE FROM DATE

This field contains the date from which the table is effective.

4. EFFECTIVE THRU DATE
This field contains the date through which the table is effective.

When these fields are completed, the system displays the following screen:

```
                  General Hospital High Cost Procedures Processor
                                                Sat Jun 20, 2009 09:24 pm
High Cost Procedures Table
          ICD-10                SIM    SIM                High Cost   Ward Rate
   Seq#   Intervention Code     Dept   Code               Code        Allowed
    1     123123                CD     16                 16          Yes
    2     A12BB6789             DIA    90009              200         No
    3     222222                OR     3048               300         Yes
    4     123                   PSY    90                 90          No
    5

Record changes to High Cost Procedures table 1 for facility J? (Y/N)--
```

Field Explanations

1. ICD-10 INTERVENTION CODE (10-AN-R)
You can enter the ICD-10 procedure code which indicates a high cost procedure was preformed for the patient. Codes may be duplicated, in case you are entering data for existing SIM departments and codes.

2. SIM DEPT (TABLE LOOKUP-R)
You can enter the SIM department associated with the ICD-10 high cost procedure or choose a SIM department by entering a hyphen (-) in the field to display a list of SIM Departments.

3. SIM CODE (TABLE LOOKUP-r)
You can enter the code for the SIM department associated with the ICD-10 high cost procedure or choose a code for the SIM department by entering a hyphen (-) in the field to display a list of SIM codes.

4. HIGH COST CODE (4-N-R)
The SIM Item number entered in the SIM Code field is copied into this field, if it is less than 4 characters in length. If you do not have your SIM set up so that the SIM Item reflects the High Cost Code, enter the High Cost Code here. This value prints on the claim, in the High Cost Code field.

5. WARD RATE ALLOWED (1-A-R)
You can enter **Y** (Yes) to allow both the ward rate and high cost procedure claims when the claim loads. If you enter **N** (No) only a High Cost Procedure claim is loaded.

Accident Codes

The Accident Codes table is used to indicate ranges of ICD-10 diagnosis codeswhich indicate that the patient visit is accident-related. There is not an ICD-10 Diagnosis code table to edit against.

For abstracted patients, if a secondary diagnosis field contains a value from this table, the accident code field is populated and the accident indicator set to Y for yes. The values are displayed in the OOP Patient Data Info screen.

A printout for this table is available and the report name is FMRONACx.

```
                  General Hospital Accident Codes Processor
                                                Tue Jun 09, 2009 07:31 am
Accident Codes Table
Seq #    Beginning ICD-10 Accident Code    Ending ICD-10 Accident Code
    1              V01                          V99
    2              X10                          X99









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

Field Explanations

BEGINNING ICD-10 ACCIDENT CODE (TABLE LOOKUP-R)
This field contains the beginning ICD-10 code identifying the range of diagnoses which indicate the patient was involved in an accident. You can enter a hyphen (-) in this field to display ICD accident codes.

ENDING ICD-10 ACCIDENT CODE (TABLE LOOKUP-R
This field contains the ending ICD-10 code identifying the range of diagnoses which indicate the patient was involved in an accident.

Download Parameters

This table provides default parameters for the download of claim information, including the default drive and the default PC directory for downloads.

```
                    General Hospital Download Parameters Processor
                                                 Tue Jun 09, 2009 07:32 am


 1 Hospital Code
   987
 2 Default Drive for Download
   C
 3 Default PC Directory for Download
   IHA\
 4 Edit By                              5 Edit Date
   New, Nancy                          08/08/21 13:13









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

Field Explanations

1. HOSPITAL CODE

This field contains the code for the hospital.

2. DEFAULT DRIVE FOR DOWNLOAD

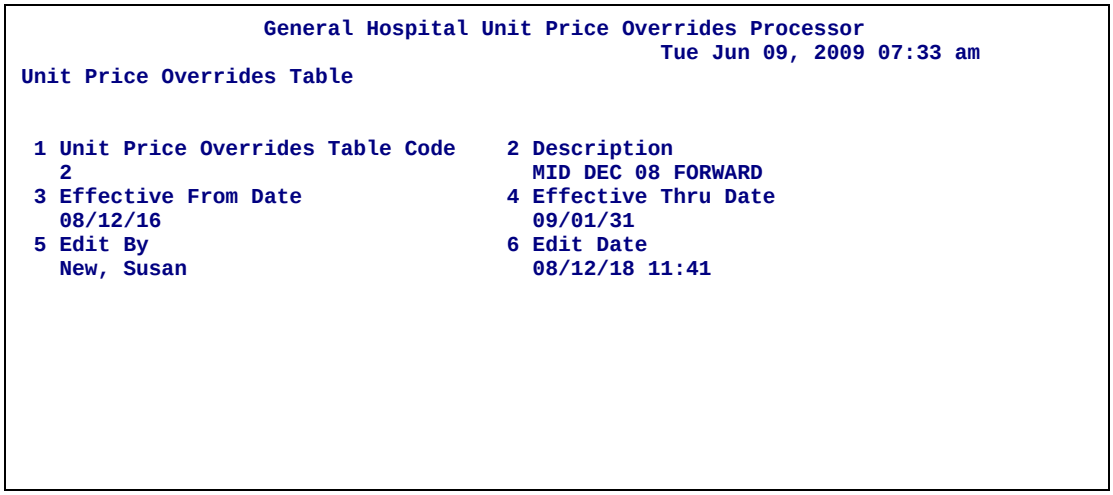
This field contains the default drive where claim information is downloaded.

3. DEFAULT PC DIRECTORY FOR DOWNLOAD

This field contains the default PC directory where claim information is downloaded.

Unit Price Overrides

This table is used to select SIM items for which the unit price calculation is not done, according to the following logic: the determination of the claim service line information for claim type 12 (ON OOP ICD10 OP) and for high cost procedure procedures for claim type 10 (ON OOP ICD10) are as follows: if the absolute value for the quantity is greater then one, the amount is calculated as total charges divided by the absolute value for the quantity and the quantity is changed to be 1 (or -1 if need be). This calculation does not occur if the SIM item is identified in the Unit Price Overrides table.



Field Explanations

1. UNIT PRICE OVERRIDES TABLE CODE (5-N-R)
This field contains the table code associated with the Unit Price Overrides Table.

2. DESCRIPTION (30-AN-R)
This field contains the description of the Unit Price Overrides Table.

3. EFFECTIVE FROM DATE
This field contains the date from which the table is effective.

4. EFFECTIVE THRU DATE
This field contains the date through which the table is effective.

When the fields on this screen are completed, the following screen is displayed:

```
              Geneal Hospital Unit Price Overrides Processor
                                                  Sat Jun 20, 2009 10:15 pm
Unit Price Overrides Table

                    SIM Items Not Using Per Unit Calculation
 Seq           SIM Department                          SIM Item
 1     CD-Comm Disorders                   16:ADVANCED TESTING -
 2     PSY-Psychology                      90:A-BEHAVIOURAL




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

FIELD EXPLANATIONS

1. SIM DEPT (TABLE LOOKUP-R)
You can enter the SIM department for items not using per unit calculations.or choose a SIM department by entering a hyphen (-) in the field to display a list of SIM Departments.

2. SIM ITEM (TABLE LOOKUP-r)
You can enter the SIM item that does not use the per unit calculations.or choose a SIM Item by entering a hyphen (-) in the field to display a list of SIM items.

Reciprocal Billng Mapping Tables

This function provides access to one mapping table for Discharge Status/Disposition. This table is used to convert the Discharge Status/Disposition recorded in STAR Patient Accounting. A report for this mapping table is available and the report name is FMRONDDS.

When this menu is selected, the following screen is displayed:

```
          General Hospital Reciprocal Billing Mapping Tables Processor
                                                  Tue Jun 09, 2009 07:25 am
Reciprocal Billing Mapping Tables Input Options

            Option No.  Option
            ---------------------------------------
                1       Discharge Status/Disposition
                2       Hospital Codes for Patient Types
```

Each of these options is discussed below.

Discharge Status/Disposition

This table is used to convert the Discharge Status/Disposition recorded in STAR. A report for this mapping table is available and the report name is FMRONDDS. When this option is selected, the following screen is displayed:

```
                Discharge Status/Disposition Processor
                                              Mon Jun 15, 2009 11:07 pm

Discharge Status/Disposition
Page:01                  Discharge Status/Disposition
( 1) AD-ADMITTED                        (17) UD-UNPLANNED DISCHARGE
( 2) AG-AGAINST MEDICAL ADVICE I/P      (18) WS-WOMEN'S SHELTER
( 3) AM-AGAINST MEDICAL ADVICE O/P      (19) 03-X-4 PSYCHIATRY
( 4) CI-CHART INCOMPLETE                (20) 02-X-BACK TO E.R.
( 5) DA-DEAD ON ARRIVAL                 (21) 24-X-C.A.S.
( 6) HO-HOME - O/P                      (22) 11-X-C.P.S.
( 7) EX-I/P EXPIRED                     (23) 22-X-CATHOLIC SOCIAL SERVICES
( 8) LW-LEFT WITHOUT BEING SEEN         (24) 19-X-CHEDOKE ALCOHOL OUTREACH
( 9) OC-O.R. CANCELLED                  (25) 16-X-CHEDOKE CHILD & FAMILY
(10) CA-O.R. CANCELLED - I/P            (26) 20-X-CHEDOKE GERIATRIC OUTREACH
(11) XD-O/P EXPIRED                     (27) 23-X-DETOX
(12) TR-OTHER INSTIT'N DIS - ER         (28) 12-X-E.R.M.H.S.
(13) NS-OTHER INSTIT'N DIS - I/P        (29) 13-X-EPS F/U
(14) RT-RETURNED TO OTHER HOSPITAL      (30) 27-X-FAMILY SERVICES
(15) RO-ROUTINE - I/P                   (31) 17-X-G.P. FOLLOW-UP
(16) UA-UNPLANNED ADMISSION             (32) 07-X-H.P.H.

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

You can select a discharge status from the screen. The next screen is displayed with your selection shown in the STAR Code field. The system prompts you to enter the conversion code.

.

```
                                          Tue Jun 09, 2009 07:26 am

Discharge Status/Disposition
( 1)STAR Code              : HO : HOME - O/P
( 2)Conversion Code        : DS



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

Field Explanations

1. STAR CODE (TABLE LOOKUP-R)
This field contains the STAR code for the patient type and the desciption.

2. CONVERSION CODE (4-AN-R)
This field is used to map STAR discharge statuses to those acceptable to the Ministry.

Hospital Codes for Patient Types

This table is used to indicate patient types for which the hospital code should not match the code indicated in the Download Parameters. All patient types are presented in a scrolling screen. Hospital codes can be added as needed. An existing hospital code is deleted by keying one space.

```
              General Hospital Hospital Codes for Patient Types Processor
                                                  Mon Jun 22, 2009 07:19 am

Seq #   Patient Type and Description          Hosp Code
91      PT  THERAPY-PHYSIOTHERAPY
92      PTS THERAPY-PHYSIOTHERAPY SERIES
93      PYS APSYCH.DAY CARE SERIES
94      RCH RESEARCH OP - CONTRACT
95      REF REFERRED IN OP - CONTRACT
96      RES reservation
97      RHS RHEUMATOLOGY SERIES
98      RSS RADIOLOGY SHORT STAY
99      S/B ADMISSION-STILLBORN
100     SDA ADMISSION-SAME DAY
101     SOS SOCIAL WORK SERIES
102     SWS SOCIAL WORK SERIES OUTPATIENT
103     THE THERAPIES
104     THS THERAPY SERIES
105     XXX oupt - for conversion
106     ZFR Z FRACTURE-SURGICAL PROCEDURE         555


              F1Prev Page F2Next Page F6 Reset  F7  Exit   ?
```

When you exit the screen, and a code was added or changed the following prompt is displayed:

Record changes to Patient Type Hospital Code table for facility J? (Y/N)--

You can enter Y (Yes) to record the change in the table.

Chapter 4 - GL MAPPING MAINTENANCE

INTRODUCTION

GL Mapping Maintenance is a collection of functions used to establish and maintain the mechanism mapping patient accounting events to the general ledger. Using hospital-defined map structures, the system selects the proper mapping path (or key) for each PA event.

This option does not display on a STAR Financials Patient Accounting screen but is instead an option available in the STAR Financials General Ledger system. For information on the GL Mapping options, please refer to the *General Ledger Volume* of the *STAR Financials General Accounting Reference Guid*e.

Chapter 5 - STATISTICS MAINTENANCE

INTRODUCTION

These transactions are used to determine the type of statistics collected and how long they are retained by the system. All statistics are maintained by fiscal period and year.

HOW STATISTICS ARE ACCUMULATED

Statistic keys are data elements and serve as the basic unit of statistic generation. The allowable statistic keys are established and maintained by McKesson.

Statistics are organized into statistic groups.

Statistic Groups

Code	Description
AGY	Collection Agency Statistics
BIL	Biller Statistics
COL	Collector Statistics
CON	Contract Statistics (Contract Sort)
COR	Contract by Revenue Department Statistics
DCA	Doctor Census Admitting Statistics
DCT	Doctor Census Attending Statistics
DIS	Discharge Statistics
DRA	Doctor Revenue Admitting Statistics
DRO	Doctor Revenue Ordering Statistics
DRT	Doctor Revenue Attending Statistics
EMP	Employer Census Statistics
EMR	Employer Revenue Statistics
FCC	Financial Class Census Statistics
FCR	Financial Class Revenue Statistics
IST	Insurance Statistics
LCP	Late Charge Statistics
MED	Medical Service Census Statistics
MER	Medical Service Revenue Statistics
NUR	Nurse Station Statistics
PAT	Patient Type Census Statistics
PTR	Patient Type Revenue Statistics
REV	Revenue Center Statistics
TRC	Transaction Statistics
ZIP	Zip Code Statistics

Collection Agency Statistics

For each collection agency, the system maintains:

- Number of accounts placed
- Dollars of accounts placed
- Number of returned accounts
- Dollars of returned accounts
- Number of accounts deleted

- Dollars of deleted accounts
- Dollars collected
- Dollars adjusted

The keys for this statistic are Contract Code, Collection Agency Code, Patient Indicator, and Financial Class.

Biller Statistics

For each biller, the system maintains:

- Number of new claims
- Dollars of new claims
- Number of claims released
- Dollars of claims released
- Number of accounts that failed edits
- Dollars of accounts that failed edits
- Number of claims transferring out
- Dollars of claims transferring out
- Number of claims transferring in
- Dollars of claims transferring in

The keys for this statistic are Biller Code, Patient Indicator and/or Patient Type, and Financial Class.

Collector Statistics

For each collector, the system maintains:

- Number of new accounts
- Dollars of new accounts
- Number of accounts paid
- Dollars of accounts paid
- Number of accounts transferred to bad debt
- Dollars of accounts transferred to bad debt
- Number of accounts adjusted
- Dollars of accounts adjusted
- Number of accounts transferred out
- Dollars of accounts transferred out
- Number of statements
- Number of phone calls

The keys for this statistic are Collector Code, Patient Indicator and/or Patient Type, and Financial Class.

Contract by Revenue Department Statistics

For each revenue department, the system maintains:

- Total charge amount
- Total charge quantity
- Relative value units
- Units of service

The keys for this statistic are Contract Code, Revenue Department, SIM Department, and SIM Item.

Contract Statistics (Sort by Contract)

For each contract, the system maintains:

- Total charge amount
- Total charge quantity
- Relative value units
- Units of service

The keys for this statistic are Revenue Department, SIM Department, and SIM Item.

Discharge Statistics

For each nursing station, the system maintains:

- Number of discharges
- Discharged Days

The keys for this statistic are Nurse Station, Financial Class, and Patient Type.

Doctor Census Admitting Statistics

For each admitting physician, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of deaths
- Number of registrations
- Number of outpatient visits
- Number of accounts sent to a collection agency
- Amounts sent to a collection agency

The keys for this statistic are Admitting Physician, Patient Indicator, and Medical Service.

Doctor Revenue Admitting Statistics

For each admitting physician, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Admitting Physician, Revenue Department, Patient Indicator, and Financial Class.

Doctor Census Attending Statistics

For each attending physician, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of deaths
- Number of registrations
- Number of outpatient visits
- Number of accounts sent to a collection agency
- Amounts sent to a collection agency

The keys for this statistic are Attending Physician, Patient Indicator, and Medical Service.

Doctor Revenue Attending Statistics

For each attending physician, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Attending Physician, Revenue Department, Patient Indicator, and Financial Class.

Doctor Revenue Ordering Statistics

For each ordering physician, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Ordering Physician, Revenue Department, Patient Indicator, and Financial Class.

Employer Census Statistics

For each employer associated with the patient's primary carrier, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of registrations
- Number of outpatient visits
- Number of accounts sent to a collection agency
- Amounts sent to a collection agency

The keys for this statistic are Employer of Primary Insurer, Patient Type, and Financial Class.

Employer Revenue Statistics

For each employer associated with the patient's primary carrier, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Employer of Primary Insurer, Revenue Department, and Patient Type.

Financial Class Census Statistics

For each financial class, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of deaths
- Number of registrations
- Number of outpatient visits

The keys for this statistic are Financial Class and Patient Type.

Financial Class Revenue Statistics

For each financial class, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Financial Class and Patient Type.

Insurance Statistics

For each primary insurance carrier/plan, the system maintains:

- Number of claims
- Dollar amount of claims
- Number of payments
- Dollar amount of payments
- Number of adjustments
- Dollar amount of adjustments

The keys for this statistic are Primary Insurance Carrier/Plan and Patient Indicator.

Late Charge Statistics

For each late charge, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Revenue Department and Patient Indicator.

Medical Service Census Statistics

For each medical service, the system maintains:

- Number of admissions
- Number of discharges
- Number of registrations
- Number of outpatient visits
- Number of patient days
- Number of deaths

The keys for this statistic are Medical Service, Patient Indicator, and Financial Class.

Medical Service Revenue Statistics

For each medical service, the system maintains:

- Total charge amount
- Total charge quantity
- Relative value units
- Units of service

The keys for this statistic are Medical Service, Revenue Department, and Patient Indicator.

Nurse Station Statistics

For each nursing station, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of deaths
- Number of transfers into department
- Number of transfers out of department
- Number of internal transfers
- Number of one-day stays
- Number of bed charges
- Number of outpatients in bed

The keys for this statistic are Nurse Station, Financial Class, Patient Type, and Medical Service.

Patient Type Census Statistics

For each patient type, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of deaths
- Number of registrations
- Number of outpatient visits
- Patient type transfers in
- Patient type transfers out

The keys for this statistic are Patient Type, Medical Service, and Financial Class.

Patient Type Revenue Statistics

For each patient type, the system maintains:

- Total charge amount
- Total charge quantity

The keys for this statistic are Patient Type, Medical Service, and Financial Class.

Revenue Center Statistics

For each revenue department, the system maintains the following statistics reflecting the revenue generated by each individual service item, and the usage of that charge item:

- Total quantity charged
- Relative value units
- Units of service
- Total charge amount

The keys for this statistic are Revenue Center, Financial Class, SIM Department, SIM Item, and Patient Indicator.

Transaction Statistics

The system maintains the number of transactions and the transaction amount for each of the following transaction types:

- Account notes
- Adjustments
- Agency cash agency collected
- Balance transfers
- Claims processing
- Collection agency fees
- Insurance payments
- Insurance refunds
- Miscellaneous cash
- Miscellaneous notes
- Non-patient cash
- Other adjustments
- Other refunds
- Patient bills
- Patient payments
- Patient/guarantor refunds
- Status transfers
- System memos
- Unapplied cash

The posting date is used to determine the period in which the transaction is recorded. The keys for this statistic are Transaction Type, Transaction Code, Financial Class, and Patient Type. Statistics are captured only if the specific type is highlighted on the initial screen.

ZIP Code Statistics

For each patient ZIP code, the system maintains:

- Number of admissions
- Number of discharges
- Number of patient days
- Number of deaths
- Total charge amount
- Number of registrations

- Number of outpatient visits
- Total charge quantity

The keys for this statistic are Patient ZIP Code, Patient Type, Medical Service, and Financial Class.

MAINTAIN STATISTIC GROUPS/KEYS

This function enables you to view information about statistic groups. This function also enables you to make the Patient Indicator and/or Patient Type keys active or inactive. The system does not accumulate statistics for an inactive statistic key. Any statistics that have been accumulated are not deleted by this function if the statistic key is made inactive.

After selecting this option, the system prompts you to select a facility (if this is a multi-facility installation). Next a fiscal year is selected. You can select the current fiscal year or the fiscal year established for this facility (entity) in the General Ledger. Enter a statistic group code (it must already exist) or a hyphen (-) to display a list of valid codes.

The system displays the following screen:

```
          General Hospital Maintain Statistic Groups/Keys Processor
                                                 Wed Jul 29, 1992 10:07 am
Facility: P         Fiscal Year: 92
 1 Group               2 Description                    3 Statistic Type
   AGY                   Collection Agency Statistics     Neither
 4 Edit date           5 Edit by
   06/26/92 08:55        Smith,John
 6 Active?             7 Primary Key
   Yes                   Collection Agency Code

 8 ## Key        Description               Active
   1  PI         Patient Indicator         Yes
   2  FC         Financial Class           Yes









Press NL--
```

Field Explanations

1. GROUP (DISPLAY ONLY)
This field contains the code identifying the statistic group.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the selected statistics group.

3. STATISTIC TYPE (DISPLAY ONLY)
This field contains the type of statistics represented by this group: Revenue, Census, Both (revenue and census), or Neither.

4. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this statistic group was last edited.

5. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this statistic group.

6. ACTIVE ? (DISPLAY ONLY)
This field indicates whether the statistic group is active or inactive.

7. PRIMARY KEY (DISPLAY ONLY)
This field contains the primary statistic key assigned to this statistic group.

8. ## KEY, DESCRIPTION (DISPLAY ONLY)
This field displays the secondary keys for the statistic group in the order in which statistics can be sorted.

The BIL and COL statistics groups offer both Patient Indicator and Patient Type as secondary sorts. You can make either Patient Indicator or Patient Type inactive for these statistics groups. To do this, enter N to either the Patient Indicator or Patient Type key. The system continues to collect the statistics, with the inactive keys being assigned a tilde (~) as the key value.

At the bottom of the screen, the system prompts you to press ENTER after you have finished reviewing the fields of this screen. When you press ENTER, the system returns to the statistic group prompt.

MAINTAIN STATISTIC RETENTION

This function defines the amount of time statistics are retained for a particular statistic group.

After this option is selected, the system prompts you to select a facility (if this is a multi-facility installation), and then enter a statistic group code. You can enter the code (it must already exist) or a hyphen (-) to display a list of valid codes. Once a facility and code is entered or selected, this screen is displayed:

```
          General Hospital Maintain Statistic Retention Processor
                                                 Fri Jul 22, 1989 01:57 pm
Facility: A
 1 Group                    2 Description
   AGY                        Collection Agency Statistics
 3 Edit date                4 Edit by
   07/19/89 04:34pm           Lawrence,Matilda D
 5 Fiscal Year Retention    6 Fiscal Period Retention
   1 years









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

Field Explanations

1. GROUP (3-N-R)
This field contains the code identifying the statistics group. You can enter the code, which must already exist, or a hyphen (-) to display a list of valid codes.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the statistics group. This description is displayed upon entry of the statistics group code.

3. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this statistic group was last edited.

4. EDIT BY (DISPLAY ONLY)
This field contains the name of the user who last edited this statistics group.

5. FISCAL YEAR RETENTION (2-N-R)
This field contains the number of years the system retains information for this statistic group when the Financial Statistic Purge function is run. For example, setting this field to one year and you currently maintain two years of statistics data, the system purges the first year of data, leaving the most recent year's data intact.

Enter the number of years, from 0 to 99. The default is 0.

6. FISCAL PERIOD RETENTION (2-N-R)
This field is not currently in use.

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

Chapter 6 - MCKESSON-MAINTAINED INFORMATION

INTRODUCTION

This chapter contains information about McKesson-maintained tables and parameters that you need in order to enter correct information into patient accounts and to operate your system efficiently. McKesson-specific information that is not essential for your usage is not provided.

SUB LOCATIONS TABLE

The Sub Locations table contains entries that are subsets for, and are more specific designators than, PA, AR or BD. Certain STAR character-based and GUI applications allow you to enter sub locations when you enter information in the Location field.

The information from the Sub Locations table that is pertinent to you is listed in the following table. It includes sub locations available for each location and how that sub location can be assigned to a patient account:

LOCATION	SUB LOCATION CODE AND DESCRIPTION	ENTRY SOURCE FOR SUB LOCATION	UPDATE PROCESS INFORMATION
PA, AR, BD	Blank code or field	Manual	You can manually blank out the sub location code when you access the Location field.
PA	INSR - Insurance Verification Not Completed	System	Patient Care performs the Insurance Verification menu option on Patient Processing, then the status is changed to ND (Not Discharged). The Verification process is based on the Verify date for COB1. This status is applied only if the account is in location PA, has one or more insurances, and qualifies based on COB 1 information only. If updates occur (such as add, delete and resequence), the status can toggle between ND to INSR. If you delete all insurances, the status is moved from INSR to ND. If you move the patient from Self Pay to having a single insurance, status is updated to INSR, unless the verified date is completed.
PA, AR, BD	FCRV - Financial Counseling	Manual	The only way to assign this sub location is to enter it on the account manually.
PA	ND - Not Discharged	System	The account number is assigned during the admission process. No insurances are attached at that time. When the insurance verification process is completed, a verified date is entered, causing status update. Cancel Discharges are automatically updated to this status.

LOCATION	SUB LOCATION CODE AND DESCRIPTION	ENTRY SOURCE FOR SUB LOCATION	UPDATE PROCESS INFORMATION
PA	DNFB - Discharged, Not Final Billed	System	The account is discharged on Patient Care. The three sources of updates are: 1) manual discharges, 2) auto discharges, and 3) auto series re-regs. Revise admission /discharge menu option may also cancel a discharge which causes the sub location to be updated to ND.
AR	ACCF - Active Internal Guarantor Collections	System	Guarantor classification - the final billing process only. Transferred from a pre-collect process and not bad debt prelisted to an internal collections schedule.
AR	PCA# - # Pre-collect agency	System	The account is transferred to a Pre-collect agency. The # represents an incremental number based on the number of pre-collect agencies transferred to in succession.
AR	RFBD - Reinstated from Bad Debt	System	Bad Debt (BD) to Accounts Receivables (AR) transfer Midnight Processing job.
AR	BDP - Bad Debt Prelisted	System	Bad Debt Prelist OBJ or manual selection.
BD	BDI - Bad Debt Internal Collections	System	AR to BD transfer Midnight Processing job. Manual transfer to internal collections.
BD	BDE - Bad Debt External agency	System	Guarantor Follow Up selection Midnight Processing job. Manual transfer to external agency.

Index

■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide* for Release 18.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

Other Comments:

Thanks for your help in improving the documentation.

Your Name and Position _____

Hospital/Organization Name _____

Telephone Number _____

May we contact you? Yes or No (circle one)

■

McKesson
STAR 2000 Documentation Team

Fold here

Place
Stamp
Here

STAR 2000 Documentation Team
McKesson
Mail Stop ATHQ-3302
5995 Windward Parkway
Alpharetta, GA 30005

Fold here