STAR 2000™

**STAR FINANCIALS PATIENT ACCOUNTING
REFERENCE GUIDE**
Billing and Claims Volume

Preface

The *STAR Financials Patient Accounting Reference Guide* is a multivolume document written for all users of the system. This volume contains a detailed explanation of the billing and claims processes in the STAR Financials 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 *Billing and Claims* 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 the Canadian version appears in the online version with blue highlighting. Canadian documentation is further identified by (CN) or by (CN Only).

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

Enter patient name--

Field Characteristics

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

- DISPLAY ONLY for a field you cannot edit.

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

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

    - P for a field length determined by a Parameter

    - T for a field length determined by a Table

    - U for a field having an Undefined length

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

    - A for Letters only

    - N for Numerals only

    - C for Characters (including punctuation)

    - AC for Letters and Punctuation only (no numbers)

    - NC for Numerals and Punctuation only (no letters)

    - AN for Numerals and Letters only (no punctuation)

  - Z is the requirement indicator of the field:

    - R if an entry is required to complete the function

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

    - O if an entry is Optional to complete the function

    - C if an entry is Conditionally required or optional

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

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

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

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

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

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

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Introduction

This document contains a detailed explanation of the billing and claims processes in the STAR Financials Patient Accounting System. It is divided in this manner:

Chapter 1: Proration

This chapter discusses proration, which is the process by which total account charges are processed to determine guarantor and carrier liability. The process includes determining covered and non-covered charges. Once covered charges are determined, the system subtracts the deductibles and coinsurance to calculate liability. Proration is done nightly for all accounts in PA as part of midnight processing. It can also be requested on-line using the demand function. Finally, an account is prorated whenever it is billed.

Chapter 2: Patient Billing

This chapter describes all billing functions in the system. It is divided into the Billing Process and Patient Billing. The Billing Process presents an overview of how bills are generated. Patient Billing provides for the maintenance of biller notes and workfiles and is used to generate batch, single and demand bill requests. Canadian customers should also refer to the *Canadian Claims Processing* volume of the *STAR Financials Patient Accounting Reference Guide*.

Chapter 3: Claims

This chapter discusses the claims functions that enable you to review and edit a claim's status, the claim carrier status, claim demographic/visit information, claim attachments, and claim charge data. The system allows you to reload a claim's demographic data and reprint a selected claim. Claim information can be accessed by either account or by biller. The system enables billers and their supervisors to review claims in a biller's workfile that passed edits, failed edits, are not yet submitted, have already been submitted to the carrier, and have been replaced. Canadian customers should also refer to the *Canadian Claims Processing* volume of the *STAR Financials Patient Accounting Reference Guide*.

Chapter 4: Third Party Logs (U.S. Only)

This chapter discusses the group of functions that enable you to enter and maintain log information for the third party payors used by your hospital.

Chapter 5: Notes

This chapter discusses the Notes and Account Notes functions. Notes enables users (billers, collectors, and other personnel) to create, edit, and view notes for accounts. Notes can be created for all accounts for a guarantor or you can choose the accounts that should receive the note. The note function enables you to enter notes selectively for different account types. Notes can also be posted directly to a patient's account. These notes can be free form or standard notes.

The Account Notes function allows you to create, view, and edit notes on a single account.

Chapter 6: DRG Payment Window Processor

This chapter discusses the DRG Payment Window function. This function enables you to do the following tasks related to DRG Payment Windows:

- Deactivate a DPW

- Change a DPW code

- Review and accept system-selected charges for transfer or manually select charges to transfer

- Reverse transferred charges

- Create a DPW

Chapter 7: Contract Account Management

This chapter discusses billing on contract accounts and their associated patient accounts. The Contract Account Management functions allow you to modify the contract account information, produce bills on a periodic basis, and post any monetary transactions necessary to update these accounts.

Chapter 8: PA Integrity Processor

This chapter discusses the PA Integrity Processor function. The PA Integrity Processor function automatically repairs accounts with insurance integrity, balance, or data errors during midnight processing.

Chapter 9: Pre-Bill Edits

This chapter discusses the ability to perform EC2000 CA claim edits before cycle/final billing, for location PA accounts, and maintain synchronization of data between EC2000 CA and STAR Patient Accounting when real claims are produced.

Chapter 1 - PRORATION

Illustrations

OVERVIEW

Proration is the process by which total account charges are processed to determine guarantor and carrier liability. The process includes determining covered and non-covered charges. Once covered charges are determined, the system subtracts the deductibles and coinsurance to calculate liability. Proration is done nightly for all accounts in PA as part of midnight processing. It can also be requested online using the demand function. Finally, an account is prorated whenever it is billed.

The basic steps of proration calculation are:

1. The system processes charges posted to an account to determine which of the charges are eligible for coverage by each insurance plan. These charges and the covered amounts are summarized by both UB code and proration summary code or room accommodation code for efficiency in the subsequent benefit calculations.

2. The system performs benefit calculations, based on the covered charges, to determine any deductible amounts that are the patient's responsibility. After deducting these amounts, the remaining covered charge amount (up to the plan's dollar limits and percentages) are used to calculate the plan's responsibility.

3. The system calculates coordination of benefits (COB) for plans set up as coordinating to ensure the total responsibility for all coordinated plans does not exceed the total charge amount.

4. The system calculates reimbursement nightly as a separate function within proration for primary plans having a contractual arrangement with the provider. The system does this to determine the actual reimbursement amount. Since the plan's responsibility and the actual reimbursement amount are often different, a contractual adjustment amount is calculated to identify the appropriate write-off.

Reimbursement is calculated on the primary carrier only. Estimated reimbursement is performed on PA accounts if reimbursement information exists for the insurance plan.

Contractual adjustments are only done if the Post Contractual Adjustment at Final Bill field contains **Y** for Yes.

Figure 1.1   Proration Calculation

```
       Total Charges
    -  Non-covered Charges
   ========================
       Covered Charges    Room and Bed Covered Charges
                        + Ancillary Covered Charges
    -  Limit Excess
    -  Deductibles
    -  Coinsurance
    -  COB Adjustment
  =    Estimated Liability
   ========================
    -  Reimbursement Amount
  =    Contractual Adjustment

Covered Charges = Total Charges - Non-covered charges

Est. Responsibility = Covered Charges - Deductible - Coinsurance

Contractual Adjustment = Carrier Liability - Reimbursement Amount

Reimbursement Amount = Calculated Reimbursement Amount - Deductibles - Coinsurance
```

Adjustments that are posted at the time of final bill are a result of reimbursement and not proration. The user should be aware of the differences between proration and reimbursement. Adjustments posted at the time of cash posting are separate from reimbursement. Reimbursement contractual adjustments are only posted for primary insurance. Adjustments at cash posting calculates any adjustment necessary to cause the carrier balance to equal zero and are not restricted to primary insurance.

Whether or not an account prorates is determined by the prorate flag on the primary insurance for the account. If this flag is set to Yes, proration occurs for each insurance assigned to the account. If this flag is set to No, the system prorates each insurance at 100% (that is, each insurance is responsible for the total amount of charges entered on the account). In order to balance the account liability, the overage is held in a field called Third Party Excess.

NOTE: If the prorate flag is set to No on the primary insurance, the proration program ignores all insurance coverage information, including the professional fee coverage flag on the Basic Coverage screen of the Insurance Plan Coverage master file.

If the Prorate flag is set to **N** for No for the primary insurance plan of the patient, the COB flag on the Basic Coverage screen of the Insurance Plan is ignored.

The purpose of the COB flag is to indicate whether the plan coordinates with other carriers if you are prorating. Entry options for the COB flag field are **Y** for Yes or **N** for No. A coordinating plan sends covered charges that it does not cover to another coordinating carrier for consideration. A coordinating plan does not pay benefits that are paid by another coordinating carrier.

A non-coordinating plan calculates its own coverage. The coverage of another carrier does not matter. The charges that are not covered by the non-coordinating plan are

not sent to another carrier for consideration. A non-coordinating plan is usually an individual commercial insurance policy.

Third Party Excess is displayed in the Account column above the dotted line. Third Party Excess is calculated when an account with more than one insurance does not prorate. The payments, adjustments, refunds, and balance transfers in this column represent the total amount of each for the account.

The system maintains balances for nine insurances and the patient. The current balance of the nine insurances plus the patient equal the account balance.

If the primary carrier prorate flag contains **N** for No, an additional step in the calculation is required. Third Party Excess must be subtracted in order for the account to balance.

REQUESTING ONLINE PRORATION

After the proration option is selected, the system prompts you to select the desired facility (if this is a multi-facility installation) and then use the FPI Lookup procedure to select a patient and account. The system displays account information in the following format:

```
                    General Hospital Proration Processor
                                            Mon Mar 27, 2006 10:40 am
Account      Name                       FC Typ Admit    Disch       Balance Loc
             LOWMAN,JAMES S                                          0.00
Page:01              PA, AR Patient Accounts
    Account     PT  Admit   Disch    FC   Account    Patient  Insurance Loc
( 1) P8926800001 I/P 09/25/94 10/13/94 85  3305.00-    0.00     3305.00-AR/FCRV
( 2) P8928900004 E/R 10/16/94 10/16/94 85    50.00-   50.00-       0.00 AR/FCRV
( 3) P8931400002 E/R 11/10/94 11/10/94 85   481.23   481.23        0.00 AR/FCRV
( 4) P8932400001 I/P 11/20/94 12/15/94 85  8171.36    10.15     8161.21 PA/FCRV




    Select account--
```

Selecting the desired account automatically begins the proration process. When it is completed, this screen is displayed.

```
                    General Hospital Proration Processor
                                            Mon Mar 27, 2006 10:40 am
Account      Name                       FC Typ Admit    Disch       Balance Loc
89324-00001  LOWMAN,JAMES S              C  I/P 11/20/94 12/15/94    8171.36 PA/FCRV
Prorated:    $9009.91    Last Pymt: 12/08/94   Total charges:    $9009.91
             U/403-999  B/150-998  U/437-990                 Patient     Account
-Non Cvrd      10.15      10.15      10.15
+Room Cvrd   5904.00    5904.00    5904.00
+Anc Cvrd    3095.76    3095.76    3095.76
-Lim Excess     0.00    5904.00       0.00
- Ded/CoPy    100.00     150.00      50.00
- Coins         0.00     500.00       0.00
- COB Adj       0.00    2345.76    8949.76
=Est Liab    8899.76     100.00       0.00              10.15
------------------------------------------------------------------------------
Act. Liab    8899.76     100.00       0.00              10.15
-Payment      838.55       0.00       0.00               0.00      838.55
+Adjust         0.00       0.00       0.00               0.00        0.00
+Refund         0.00       0.00       0.00               0.00        0.00
+Bal Trf        0.00       0.00       0.00               0.00        0.00
==============================================================================
=Balance     8061.21     100.00       0.00              10.15     8171.36
Press NL--
```

NOTE: If there are no additional charges to prorate or if no changes have been made to the patient's insurance coverage, the account does not actually re-prorate. In this case, it merely displays the existing proration information.

NOTE: Press ENTER to view additional insurance information. A second screen is displayed showing COB 5 through 9, if the account has more than nine insurances.

Field Explanations

PRORATED (DISPLAY ONLY)
This field contains the total of all credits and charges assigned to this account since admission or registration. The displayed date and time represent the last time this account was prorated.

LAST PYMT (DISPLAY ONLY)
This field contains the date on which the last payment for the account was made.

TOTAL CHARGES (DISPLAY ONLY)
This field contains the total charges for the account.

Column 1

PLAN ORDER/CARRIER CODE-PLAN CODE (DISPLAY ONLY)
This field contains the COB indicator and the carrier and plan number for the carriers (up to nine). The system then displays the word Patient, which is patient responsibility information, and the word Account, which is account balance information.

-NON CVRD (NON-COVERED CHARGES) (DISPLAY ONLY)
This field contains the charges assigned to this account that are not covered by this insurance plan. Charges that are not covered are items that have 0% coverage.

+ROOM CVRD (COVERED ROOM AND BED CHARGES) (DISPLAY ONLY)
This field contains the total of all room and bed charges covered by this plan.

+ANC CVRD (ANCILLARY CHARGES COVERED) (DISPLAY ONLY)
This field contains the total of all non-room and bed charges covered by this insurance plan. This amount is total covered charges that is added to the covered room and bed charge.

-LIM EXCESS (LIMITED EXCESS) (DISPLAY ONLY)
This field contains the amount of charges exceeding the plan limits set in the Insurance Plan Coverage master. For example, if there is a coverage limit of $10,000, any covered charges over this amount would be limit excess.

-DED/COPY (PLAN DEDUCTIBLE) (DISPLAY ONLY)
This field contains the deductible and co-pay amounts for this plan.

-COINS (COINSURANCE) (DISPLAY ONLY)
This field contains the amount of covered charges for this carrier/plan that are the responsibility of the patient. For example, if coverage is set at 80% of covered charges, the remaining 20% would be coinsurance.

-COB ADJ (COORDINATION OF BENEFITS ADJUSTMENT) (DISPLAY ONLY)
This field contains the amount of charges that have been covered by this plan but are not due because another carrier with a higher COB has already covered this amount. Primary insurance will never have a COB adjustment.

=EST LIABILITY (ESTIMATED LIABILITY) (DISPLAY ONLY)
This field contains the estimated liability of this plan. This field is calculated by subtracting limit excess, deductible, coinsurance, and COB adjustment from covered charges.

ACT. LIABILITY (ACCOUNT LIABILITY) (DISPLAY ONLY)
This field contains the total liability for this carrier/plan. This field equals the estimated liability at the time of final bill and while the account is in account location PA. If the insurance coverage is changed and the account is re-prorated once the account is in AR, the estimated liability may change but the account liability will not change. The balances for insurances and patient are updated on AR and BD accounts through proration only when the account is rebilled.

PAYMENT (DISPLAY ONLY)
This field contains the amount of any payments made by this carrier/plan.

ADJUST (DISPLAY ONLY)
This field contains the amount of any adjustments made by this carrier/plan. An example could be a contractual write-off.

REFUND (DISPLAY ONLY)
This field contains the amount of any refunds issued to this carrier/plan.

BAL TRF (DISPLAY ONLY)
This field contains the total of any liability amounts transferred to or from this carrier to another carrier, this carrier to a patient, or a patient to this carrier.

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

Columns 2 Through 4

The liability of other carrier plans associated with this account (up to nine) is displayed in columns two through nine.

Column 5

The following fields are only updated for the patient liability, estimated liability (which are the patient portion of the account), account liability, payment, adjustment, refund, balance transfer, and balance.

Column 6

The following fields are updated for the Account Column:

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Account Liability - only present if the primary carrier's prorate flag is set to N, there is other insurance, and not all carriers have paid. This will be the Third Party Excess.

Payment, Adjustment, Refund, Balance Transfer - these fields will be the totals for all insurances and the patient.

After you view the proration information and press ENTER, the system displays the following prompt if reimbursement criteria has been defined for the patient through the patient's insurance screen:

Press NL to return, or display Proration reimbursement (P)?--

You can display reimbursement data by entering **P**. If there is no reimbursement data, a message is displayed, and you are returned to the FPI lookup prompt so you can select another account. If reimbursement data does exist, the system displays the following screen:

```
                General Hospital Proration Processor
                               Mon Mar 27, 2007 10:40 am
 Account        Name                 FC Typ Admit    Disch       Balance Loc
 A0504100002  KING, MIKE             O  O/P 02/10/05 02/10/05     171.00  AR/FCRV
  1 Carrier-Plan                     2 Payor
    918100 COMM                        PC PATRICE PCON UB
  3 Covered Days 4 Post Date         5 Error Description
      0             02/10/05
  6 Table No.    7 Reimb. Type       8 Calc. Method     9 Stop Loss
    001            PCON by Claim
 10 Star Rmb Calc Method 11 DRG Tbl No. 12 Error Description


    Covered Charges             496.00
    Payments/Adjustments        340.42
    Balance                     166.00
    Actual Contractual         -491.00
    Expected Reimbursement        5.00


    First ERA Final Payment                      Variance on 04/11/05




 Display Billing reimbursement (B)?--
```

Field Explanations

1. CARRIER-PLAN (DISPLAY ONLY)
This field contains the primary insurance carrier plan code and description.

2. PAYOR (DISPLAY ONLY)
This field contains the reimbursement payor code and description.

3. COVERED DAYS (DISPLAY ONLY)
This field contains the number of days that are a part of this reimbursement.

4. POST DATE (DISPLAY ONLY)
This field contains the date on which the contractual adjustment was posted to the account. Contractual adjustments are posted at the time of final bill, late bill, and rebill.

5. ERROR DESCRIPTION (DISPLAY ONLY)
This field contains the error message regarding the account's reimbursement calculations if an error exists. Possible entries are listed below:

- 1 = No DRG record

- 2 = No DRG Payor

- 3 = No final DRG

- 4 = No DRG Reimb. Amount

- 5 = No effective date (admission/discharge in table)

- 6 = No table found within range of effective date

- 7 = No principal diagnosis (ICD9 - Diagnosis)

- 8 = No medical service (Medical Service)

- 9 = No principal procedure code (ICD9 - Procedure)

An error indicates that reimbursement will not be done at bill time. The error must be corrected in order to generate an automatic contractual adjustment.

6. TABLE NO. (DISPLAY ONLY)
This field contains the table number of the Reimbursement payor that was used to calculate the reimbursement.

7. REIMB. TYPE (DISPLAY ONLY)
This field contains the type of reimbursement associated with this patient for this account.

- DRG Code

- Overall Plan

- Medical Service

- ASC Payment Group

- ICD-9-CM Diagnostic Code

- ICD-9-CM Procedure Code

- Specific DRG Code

- Major Diagnostic Category

- Pathways Contract Management Interface

8. CALC. METHOD (DISPLAY ONLY)
This field contains the reimbursement method of calculation for this account. Possible entries are:

- flat rate

- charge (amount or percentage)

- by day (per diem)

9. STOP LOSS (DISPLAY ONLY)
This field contains the maximum reimbursement amount for this payor. This stop loss calculation can be per diem, flat rate, or charge (amount or percentage). Each payor table can have a separate table for stop loss calculations.

10. STAR RMB CALC METHOD (DISPLAY ONLY)
This field contains the value of the STAR Reimbursement Calculation Method.

- The field contains the value of *New York* if the STAR Reimbursement Calculation Method is used for PAS claims.

- The field contains the value of *OPPS* when the carrier/plan, patient type exception, or account is identified as Outpatient Prospective Payment System and the claim is OPPS.

11. DRG TBL NO. (DISPLAY ONLY)
This field contains the DRG table number.

12. ERROR DESCRIPTION (DISPLAY ONLY)
This field documents incomplete DRG information at the time of billing. The potential messages are as follows:

No DRG record

No DRG payor

No final DRG #

No DRG reimbursement amount

COVERED CHARGES (DISPLAY ONLY)
This field contains the total covered charges for this carrier/plan.

PAYMENTS/ADJUSTMENTS (DISPLAY ONLY)
This field contains the total amount of payments/adjustments posted to this carrier/plan for this account.

BALANCE (DISPLAY ONLY)
This field contains the current liability for this carrier/plan. This is the covered charges minus the payments/adjustments.

ESTIMATED CONTRACTUAL (DISPLAY ONLY)
This field contains the dollar amount of the contractual adjustment to be posted, based on the reimbursement calculation. This field is displayed only if the patient has been discharged and a final DRG has been assigned.

EXPECTED REIMBURSEMENT (DISPLAY ONLY)
This field contains the dollar amount expected from this carrier/plan. It is the difference between the Balance and the Estimated Contractual amounts. This field is displayed only if the patient has been discharged and a final DRG has been assigned.

For more detailed information regarding reimbursement, refer to the documentation on reimbursement.

After you view this screen, you can press ENTER to return to the FPI lookup prompt so you can select another account or you can enter **B** to display Billing Reimbursement information.

NOTE: Billing reimbursement information is displayed only if reimbursement criteria have been defined for the patient through the patient insurance screen and if a bill generating reimbursement has been produced (for example, adjustment, final, or late bill).

If the criteria have been met and you receive a prompt to enter **B**, the system displays the following screen:

```
                    General Hospital Proration Processor
                                        Mon Mar 27, 2006 10:40 am
 Account      Name                  FC Typ Admit    Disch      Balance Loc
 89324-00001  LOWMAN,JAMES S        C  I/P 11/20/94 12/15/94    8171.36 AR/FCRV
  1 Carrier-Plan                    2 Payor
    403999 AETNA/COMM
  3 Covered Days 4 Post Date        5 Error Description
      25
  6 Table No.   7 Reimb. Type       8 Calc. Method     9 Stop Loss
    05           DRG

    Covered Charges              496.00
    Payments/Adjustments         340.42
    Last Elec Rem Transaction/Cont Adj Method      Payment/Variance
    Last Elec Rem Cont Adj Posted                       466.00
    First ERA Final Payment                        Variance on 04/11/05




  Press NL--
```

The information is the reimbursement information that was used by the system at the time of final or late bill or at rebill. This information is used to generate an automatic contractual write-off.

NOTE: The information displayed through this function can also be viewed through the Account Inquiry function.

Field Explanations

1. CARRIER-PLAN (DISPLAY ONLY)
This field contains the primary insurance carrier plan code and description.

2. PAYOR (DISPLAY ONLY)
This field contains the reimbursement payor code and description.

3. COVERED DAYS (DISPLAY ONLY)
This field contains the number of days that are a part of this reimbursement.

4. POST DATE (DISPLAY ONLY)
This field contains the date on which the contractual adjustment was posted to the account. Contractual adjustments are posted at the time of final bill, late bill, and rebill.

5. ERROR DESCRIPTION (DISPLAY ONLY)
This field contains the error message regarding the account's reimbursement calculations if an error exists. Possible entries are listed below:

• 1 = No DRG record

- 2 = No DRG Payor

- 3 = No final DRG

- 4 = No DRG Reimb. Amount

- 5 = No effective date (admission/discharge in table)

- 6 = No table found within range of effective date

- 7 = No principal diagnosis (ICD9 - Diagnosis)

- 8 = No medical service (Medical Service)

- 9 = No principal procedure code (ICD9 - Procedure)

An error indicates that reimbursement will not be done at bill time. The error must be corrected in order to generate an automatic contractual adjustment.

6. TABLE NO. (DISPLAY ONLY)
This field contains the table number of the Reimbursement payor that was used to calculate the reimbursement.

7. REIMB. TYPE (DISPLAY ONLY)
This field contains the type of reimbursement associated with this patient for this account.

- DRG Code

- Overall Plan

- Medical Service

- ASC Payment Group

- ICD-9-CM Diagnostic Code

- ICD-9-CM Procedure Code

- Specific DRG Code

- Major Diagnostic Category

- Pathways Contract Management Interface

8. CALC. METHOD (DISPLAY ONLY)
This field contains the reimbursement method of calculation for this account. Possible entries are:

- flat rate

- charge (amount or percentage)

- by day (per diem)

9. STOP LOSS (DISPLAY ONLY)
This field contains the maximum reimbursement amount for this payor. This stop loss calculation can be per diem, flat rate, or charge (amount or percentage). Each payor table can have a separate table for stop loss calculations.

COVERED CHARGES (DISPLAY ONLY)
This field contains the total covered charges for this carrier/plan.

PAYMENTS/ADJUSTMENTS (DISPLAY ONLY)
This field contains the total amount of payments/adjustments posted to this carrier/plan for this account.

LAST ELECT REM TRANSACTION/CONT ADJ METHOD
This field contains a warning message for the last ERA transaction (payment, takeback, or combined), if the transaction differs from the one posted. The warning message contains the determination of the contractual adjustment.

/DEN is displayed after the ERA transaction type if the last ERA transaction was the payment causing the claim to be tracked as a denial of subsequent denial. /DEN indicates that no contractual adjustment was posted/reported. **/REV** is displayed after the last ERA transaction type if the last ERA transaction was a takeback of the payment, causing the claim to be tracked as a denial. /REV indicates the system did not do a reversal because the previous contractual adjustment wasn't posted/reported. The markings of /DEN and /REV are displayed only if the Post/Rpt C/A if Den field in the ERA Payment File Definition is set to No, do not post (variance method) or No, do not report (report method).

LAST ELEC REM CONT ADJ CALCULATED
This field contains the amount of the last contractual adjustment posted for ERA and a warning message about the calculation of the contractual adjustments.

Chapter 2 - PATIENT BILLING

INTRODUCTION

This chapter describes all billing functions in the system. It is divided into the following subsections:

- The Billing Process

- Patient Billing

The Billing Process presents an overview of how bills are generated.

Patient Billing provides for the maintenance of biller notes and workfiles and is used to generate batch, single, and demand bill requests.

NOTE: 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).

THE BILLING PROCESS

This subsection discusses account transaction history, cycle billing, series billing, final billing, late billing, adjustment billing, reprinting bills, generating bills, demand bills and demand proration, and automatic contractual adjustments.

Account Transaction History

All account transactions are identified by a transaction type and code. Their purpose is to track an account's progression through the system and provide a detailed record of all activity in the transaction history.

A transaction type is a broad category that includes more specific transaction codes. Examples of transaction types could include adjustments, insurance payments, system memos, and notes. A transaction code identifies specific episodes under a transaction type. For example, the transaction type Adjustments could have codes such as Courtesy Discount or Small Balance Write-off associated with it. Transaction types are predefined in the system while transaction codes are user-defined. An account's transaction history is updated with applicable data such as bill type and date each time a bill is produced. Notes also update an account's transaction history.

Cycle Billing

Cycle billing is the generation of a bill for a period of time of a patient's visit. Both inpatients and outpatients can be cycle billed if the patient has not been discharged or dispositioned. While an account is being cycle billed, it is located in PA (unbilled). When the account is final billed, the account location changes from PA to AR (billed).

Cycle billing schedules can be based on one of the following options:

- On a fixed date each month

- At a specific number of days after admission/registration, with subsequent bills generated a specified number of days after the previous bill

- When an account's unbilled balance reaches a specific dollar amount

- At the end of each month

- Each day the patient receives a service (charge)

Admission or registration personnel associate patient accounts with an insurance carrier and plan or (if the patient does not have insurance) a financial class. All insurance plans and financial classes can be assigned a cycle billing parameter. Based on the account's primary insurance plan (or financial class), the system identifies the appropriate cycle billing parameter and billing schedule defined for that parameter.

A billing run scans all patient accounts to determine which accounts should be included for cycle billing based on each account's cycle billing schedule. A cycle bill includes all unbilled charges or charges meeting the service date criteria incurred since the last billing run or, if the bill is the first cycle bill, all charges incurred since the patient's registration or admission. Cycle bills are not subject to the billing edits established for final bills.

Cycle bills can use suspense days that hold the bill for a specified number of days. This provides the various departments time to enter all charges so these charges are included on the bill. Refer to Cycle Billing Parameters in the *Tables, Masters, and Parameters Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information.

Series Billing

Series patients are recurring patient types, used for patients receiving ongoing treatments such as dialysis, physical therapy, or chemotherapy. Since these patients are not *discharged* until their treatment is complete, they are series billed during the course of their *stay*.

The series bill provides a summary recap of the charge, insurance payment, and insurance adjustment activity for an account for each bill sequence. Insurance refunds, patient payments, and patient adjustments are not bill-specific; as such, they are summarized at the end of the bill.

Single and Batch Bill Requests

The system also provides on-line bill request, which enables you to generate bills for individual accounts or entire groups. These are selected by patient indicator (inpatient or outpatient), carrier, and/or carrier plan. You may also request a group of bills by patient type. You can request cycle, final, adjustment, late, and reprint bills using the single bill request. Cycle, end-of-month, late, and final bills can be requested using the batch bill request. Single and batch bill requests are logged and printed during batch.

Final Billing

At the same time each patient account receives a cycle billing parameter, it also receives a final billing parameter controlling the timing of final billing. In addition, each account has hospital-defined final billing requirements assigned that must be met before the system can generate a final bill. Final billing requirements can include:

- Guarantor address

- Patient date of birth

- Insured name

- Verification of insurance coverage

- Final diagnosis

- Insured's name

- PSRO approved indicator

- Verification of health card number

If the system selects an account for final billing (based on suspense days) that fails to meet the final billing requirements, no bill is generated. If the account passes the final billing requirement edits, the system generates the bill and changes the account's location from PA (unbilled accounts) to AR (billed accounts) and loads associated claims for on-line editing by the account's billers.

Non final billed discharged accounts appear on the Unbilled Accounts Report. Non final billed non discharged accounts appear on the Financial Review Report. Both types of accounts appear on the PA Balancing Report.

All billed accounts are included on the Billed Accounts Report, which includes cycle, final, late, and rebilled accounts.

You can also set system options to send accounts through the billing requirements edit process before the account reaches the appropriate number of suspense days. This enables you to identify and provide missing information or edit incorrect information before the account reaches your predefined suspense days limit.

For each billing parameter, you can define a maximum number of hold days. This flag enables the system to automatically bill any accounts that have failed the billing requirements but have exceeded the maximum number of hold days (the maximum number of hold days can be set to **U** - unlimited). Accounts billed in this manner have a Y in the System Generated column on the Billed Accounts report.

Using the request billing function, you can bill individual accounts that have failed billing requirements or have not yet reached their suspense days. You can also use the request billing function to generate bills outside of the normal billing parameters.

Late Billing

Once an account has been final-billed, you can produce a late bill which contains only late charges, that is, charges incurred after the final bill was generated. You can also produce an adjustment bill which contains any late charges in addition to all charges that were billed on the final bill. The single bill request function enables you to bill specific accounts selectively. As a result of late billing, the system automatically loads late claims to the third party claim file (when the claim is released).

The system can generate automatic late bills based on the specifications within the final bill parameters. The parameter specifies the number and dollar amount of late charges for an account that would automatically produce a late bill. If the number of charges and the dollar amount parameter is met, a late or adjustment bill is produced.

Adjustment Bills

Once you have final-billed an account, you may need to rebill that account. The billing request function enables you to generate an adjustment bill. The adjustment bill request can reclassify revenue (if a change in financial class has taken place) and includes all unbilled charges incurred since production of the final bill in addition to all charges billed on the final bill. Charges billed on any previous cycle bills are not included on an adjustment bill.

The billing parameter indicates whether automatic adjustment bills are permitted and specifies the number and dollar amount of late charges for an account which would automatically produce an adjustment bill. If the number of charges and the dollar amount parameter is met, an adjustment bill is produced. Adjustment bills cause a new claim to be loaded for editing.

If the billing parameters are set to produce both a late bill and an adjustment bill and the account meets the criteria for both, only an adjustment bill is produced.

You can also produce an adjustment bill if the DRG, principal diagnosis, or principal procedure is changed, based on the account final bill parameter.

Reprint Bills

A reprint bill is an exact duplicate of a previously produced bill. It does not update statistics, but it does update the account transaction history. You can request a reprint bill for individual accounts using the request bill function. Reprint bill requests are logged and printed during batch. You cannot reprint a bill of an account that has been archived or purged.

Bill Generation

This function is part of the midnight processing procedure. The system selects accounts for the billing run based on billing parameters and any outstanding requests for individual account bills and batch bills. The billing process automatically prorates each account selected for a bill.

You can generate four kinds of bills: detail, prorated, summary, and series. A detail bill itemizes all charge/credit, payment, and adjustment activity that has occurred in the billing cycle (since admission/registration or since the last cycle bill). A summary bill summarizes charge/credit activity and lists detail payment and adjustment activity. Summarization methods include by department, by revenue center, by revenue code, by proration summary code, and by alternate summary codes. The prorated bill

summarizes the proration process and reports carrier and guarantor liability. Series bills are used for recurring patient types and provide a recap of charge, insurance payment, and insurance adjustment activity for each bill sequence. You can generate all, none, or selected kinds of bills by setting the appropriate indicators on the Billing Parameters. If the patient has insurance which requires a claim, the bill also loads the appropriate claim form for the assigned insurance.

In Ontario, Canada, patient bills include only the charges that have been determined to be the full responsibility of the patient. When charges are partially covered, they are excluded from detail and patient bills but appear on the appropriate insurance claim. The prorated bill reflects the specific liability for the patient and the insurance carrier. For more information on charge assignment, refer to the *Canadian Claims Processing Volume* in the *STAR Financials Patient Accounting Reference Guide.*

The bill format code, defined at system implementation, selects the information the system can include on a bill (for example, primary diagnosis, financial class, doctor name, patient's birth date, and previous bill date). This parameter also indicates whether detail, summary, and prorated bills should print together or separately and if demand series bills should spool for printing in midnight processing. Bill sorts are hospital-defined in the Sort Sequence parameter.

NOTE: Charges are assigned as either insurance or patient responsibility based on the proration summary code exceptions established on each insurance plan. The charge summarization parameter should therefore be set to Proration Summary Code.

Automatic Contractual Adjustments

Contractual adjustments are the difference between the insurance liability and the reimbursement amount.

You enter any contractual arrangements with carriers on the Insurance Plan Coverage and Reimbursement masters. As these arrangements change, you can update the Reimbursement master file. These definitions give the system the information it needs to automatically generate contractual adjustments for accounts. The Reimbursement Master file supports DRG, flat fee, percentage, and other types of contractual arrangements.

NOTE: Automatic contractual adjustments are posted at the time of final billing.

Demand Bill/Demand Proration

You can request a detail, summary, prorated, and/or a series demand bill. The demand bill includes current charges-to-date and is summarized according to the charge summarization code on the Bill Format parameters. This request enables you to indicate whether the system should prorate the bill prior to printing. If you choose, the system can prorate an account without generating a bill or produce a bill without

accompanying proration. On-line proration enables the hospital's business office to monitor guarantor liability during the patient's stay.

NOTE: Generating a demand bill does not update the account's transaction history.

PATIENT BILLING

Patient Billing provides these functions:

- Biller Workfiles

- CPTAFB (Change Patient Type After Final Billing) Worklist

- Unbilled Charge Worklist

- Request Batch Bills

- Request Single Bill

- Request Demand Bill

- Transfer Biller Work - Bills

- Transfer Biller Work - Claims

- Combine Bills

Biller Workfiles

This function provides an on-line review of the patient bills by biller or account. Accounts are assigned to a biller based on the billing group associated with the patient's primary carrier/plan or, if the patient does not have any insurance, the patient's financial class.

The biller workfile is intended to help billers complete the work assigned to them. The hospital determines which accounts are included on the list through the Biller/Collector Worklist Control option of the Maintain Facility Information function. Options include all bills assigned to that biller, or only bills that failed the billing requirements.

If a bill passes edits and meets the suspense days, it is generated during the next billing run. If the bill fails edits, it remains in the biller's workfile until all requirements are met, the maximum hold days are exceeded, or the billing supervisor (or a hospital-appointed user with the necessary security level) transfers the bill to another biller's workfile. The system does not generate workfiles daily but adds or updates items in the workfile based on system and user activity.

If the Bills Passing Edits field on the Biller/Collector Worklist Control screen contains Include, bills that fail edits and later pass them have the failed workfile entry replaced with the passed entry. Otherwise, the failed entry is deleted. This provides an accurate audit trail for each biller workfile.

After you select Biller Workfiles from the menu, a second menu is displayed with the following options:

- Patient Bills by Account

- Patient Bills by Biller

PATIENT BILLS BY ACCOUNT

If you choose the Patient Bills by Account option, you can use the FPI lookup procedure. After you choose a specific account, the system displays this screen:

```
           General Hospital Patient Bills by Account Processor
                                        Mon Mar 27, 2006 10:40 am
Account       Name                 FC Typ Admit    Disch    Balance   Loc
89242-00002   CROWLEY,PAUL          M  I/P 08/30/89 09/22/89  6507.00-  AR/FCRV
    Bill Adj   Bill   Bill    Bill     Bill        Bill
    Seq        Type   Date    From     Thru        Amount

Page:01
( 1)  1/7        C  08/30/89 08/30/89  08/30/89      $412.00
( 2)  2/8        C  09/05/89 08/31/89  09/05/89      $115.20
( 3)  3          F  09/22/89 09/06/89  09/22/89    $6,060.39




Enter choice--
```

Field Explanations

BILL SEQ (DISPLAY ONLY)
This field contains the most recent bill sequence number for the bill and the old bill sequence number. The screen includes replaced bills.

ADJ (DISPLAY ONLY)
This field contains the sequence number of the adjustment bill if the final bill has been replaced by an adjustment bill.

BILL TYPE (DISPLAY ONLY)
This field contains the type of bill (cycle, final, adjustment, late, or cycle adjustment) for this account.

BILL DATE (DISPLAY ONLY)
This field contains the date on which the bill was produced. If the bill failed edits, this field contains the last date on which the bill went through the edits.

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

BILL THRU (DISPLAY ONLY)
This field contains the last date covered by this bill.

BILL AMOUNT (DISPLAY ONLY)
This field contains the total dollar amount included on this bill.

All bills that have been generated for this account are displayed. If you choose to view bills by biller, the system displays only the accounts with active workfiles (that is, failed edits and passed edits not yet deleted from the workfile). You can then select a specific bill for the account and, after doing so, the following screen is displayed for bills that passed edits:

```
             General Hospital Patient Bills by Account Processor
                                         Mon Mar 27, 2006 10:40 am
Account       Name                 FC Typ Admit    Disch       Balance   Loc
89242-00002  CROWLEY,PAUL          M  I/P 08/30/89 09/22/89    6507.00-  AR/FCRV
 1 Bill Date          2 Bill Type          3 Bill From       4 Bill Through
   09/22/89             Final                09/06/89           09/22/89
 5 Billed Amount      6 Pymts on Bill      7 Adj. on Bill
   $6,060.39            $0.00                $150.00
 8 Biller                               9 Bill Adj. By   10 Bill Being Adj.
   AILI,EMILY
11 Billed DRG                          12 Stay Outlier   13 Cost Outlier
   183




 Press NL--
```

The patient data displayed at the top of the screen includes the account number, patient name, financial class, patient type, admission date, discharge date, current account balance, and account location/sub location.

Field Explanations

1. BILL DATE (DISPLAY ONLY)
This field contains the date on which the bill was produced.

2. BILL TYPE (DISPLAY ONLY)
This field contains the type of bill (cycle, final, adjustment, late, or cycle adjustment) for this account.

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

4. BILL THROUGH (DISPLAY ONLY)
This field contains the last date covered by this bill.

5. BILLED AMOUNT (DISPLAY ONLY)
This field contains the total dollar amount included on this bill.

6. PYMTS ON BILL (DISPLAY ONLY)
This field contains the total amount of payments included on this bill.

7. ADJ. ON BILL (DISPLAY ONLY)
This field contains the total amount of adjustments included on this bill.

8. BILLER (DISPLAY ONLY)
This field contains the name of the biller responsible for the bill.

9. BILL ADJ. BY (DISPLAY ONLY)
This field contains the sequence number of the adjustment bill if this bill has been replaced by an adjustment bill. If the bill has not been replaced, this field is blank.

10. BILL BEING ADJ. (DISPLAY ONLY)
This field contains the sequence number of the previous bill if this bill is an adjustment bill for another bill. If not, this field is blank.

11. BILLED DRG (DISPLAY ONLY)
This field contains the DRG number if this account was assigned a final DRG when the bill was produced. If no DRG was available, this field is blank.

12. STAY OUTLIER (DISPLAY ONLY)
This field indicates whether or not the patient's stay exceeded the DRG guidelines for length of stay. *Yes* indicates that the stay did exceed the DRG guidelines; *No* indicates that the stay did not exceed the guidelines.

13. COST OUTLIER (DISPLAY ONLY)
This field indicates whether or not the patient's charges exceeded the DRG guidelines for cost. Yes indicates that the charges did exceed the guidelines; No indicates the charges did not exceed the guidelines. This field contains a value only if a DRG is present.

After you view this information, you may be given the option to delete the entry. If the bill has been produced and is in the biller's workfile, the system prompts you to delete the bill with a Yes/No choice. If the bill is in the biller's workfile but has not been produced or the bill is not in the biller workfile, the system does not give you the option to delete the entry.

Pressing ENTER returns you to the page you were previously on in the biller's workfile. You can choose another bill or exit the function.

If any errors exist (based on the defined Billing Requirements) for the selected account, the system displays the following screen:

```
            General Hospital Patient Bills by Account Processor
                                 Mon Mar 27, 2009 10:40 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
90010-00012  HALL,RAYMOND            WC O/P 01/10/09 01/10/09  12,000.00  PA/FCRV
1 Bill Type          2 Bill Parm    3 ICD     4 Rebill Sequence Number
   Final                  99          ICD-10
 5 Bill From Date                    6 Bill Through Date
   01/10/09                            01/10/09
 7 Comment                           8 Requested By
   SYSTEM FINAL

FATAL  -ADMITTING DIAGNOSIS CODE (MR/ADM) is Required
FATAL  -PRINCIPAL DIAG CODE (MR/ADM) is Required
FATAL  -PRINCIPAL PROCEDURE CODE is Required
FATAL  -ABSTRACT COMPLETE DATE is Required






    Press NL--
```

Field Explanations

Refer to the Patient Billing - Biller Workfiles section for these field explanations.

PATIENT BILLS BY BILLER

If you choose the second option, the system prompts you to enter a biller number (if you are a supervisor or manager). You can enter the desired biller's code or a hyphen (-) to display a list of billers that you are authorized to access. If you are not a supervisor, the system immediately displays your workfile according to the user sign-on.

NOTE: Billers using this function can only access their workfile. Billing supervisors can only access the workfiles of the billers in their billing group. Billing managers can access the workfiles of any biller in the facility.

Once a biller is entered or selected, the system displays the following prompt:

View accounts that passed edits (P), failed edits (F) or both (B)?--

Enter **P** to display only accounts that have passed edits. Enter **F** to display only accounts that have failed edits. Enter **B** to display all accounts in the biller's workfile, as in the following screen:

```
                General Hospital Patient Bills by Biller Processor
                                            Tue Dec 05, 1997 09:00 am

Opt  Bill Date  Acct Number  Patient Name                      Errors
( 1) 10/09/89   89268-00006  BRODIE,ALEXANDER                  Fatal
( 2) 10/11/89   89284-00001  LOWMAN,JAMES S                    None
( 3) 10/12/89   89255-00004  SMITH,RICHARD                     None
( 4) 10/12/89   89255-00016  WILSON,JEAN M                     None
( 5) 10/12/89   89256-00007  INGRAM,GRAHAM                     None
( 6) 10/12/89   89268-00007  DEAN,MICHAEL                      None
( 7) 10/15/89   89279-00006  CLAYTON,SAM                       Fatal
( 8) 10/16/89   89289-00004  LOWMAN,JAMES S                    None
( 9) 10/16/89   89279-00006  CLAYTON,SAM                       None
(10) 10/17/89   89289-00004  LOWMAN,JAMES S                    None
(11) 10/18/89   89284-00001  LARSON,MICHAEL                    Fatal
(12) 10/19/89   89262-00004  MCKENZIE,DUNCAN                   None
(13) 10/19/89   89284-00001  LARSON,MICHAEL                    None
(14) 10/19/89   89291-00008  MCALISTER,PAMELA                  None
(15) 10/20/89   89284-00001  LARSON,MICHAEL                    None
(16) 10/22/89   89271-00003  HAMBY,PAUL                        None
(17) 10/22/89   89234-00013  KATZ,MARCUS ROBERT                None

Enter number to view or `D` to delete a date, next pg (/)--
```

Reviewing Bills Passing Edits

Accounts that have passed all billing requirements and, therefore, contain no errors are displayed if the facility options are set to include them in the workfile (as set in the Biller/Collector Worklist Control screen). Warnings may exist on certain accounts, notifying the biller that a category of charges has a credit balance. The system can produce bills that have warnings, but cannot produce bills that have fatal errors. Warnings are always included in the biller workfile even if the Biller/Collector Worklist Control screen is defined to exclude passed entries. Warnings must also be deleted in order to be removed from the biller workfile. If you enter **P** to view the accounts that passed edits, the system displays this screen

```
                General Hospital Patient Bills by Biller Processor
                                            Tue Dec 05, 1997 09:04 am

Opt  Bill Date  Acct Number  Patient Name                      Errors
( 1) 10/11/89   89284-00001  LARSON,MICHAEL                    None
( 2) 10/12/89   89255-00004  SMITH,RICHARD                     None
( 3) 10/12/89   89255-00016  WILSON,JEAN M                     None
( 4) 10/12/89   89256-00007  INGRAM,GRAHAM                     None
( 5) 10/12/89   89268-00007  DEAN,MICHAEL                      None
( 6) 10/16/89   89289-00004  LOWMAN,JAMES S                    None
( 7) 10/16/89   89279-00006  CLAYTON,SAM                       None
( 8) 10/17/89   89289-00004  LOWMAN,JAMES S                    None
( 9) 10/19/89   89262-00004  MCKENZIE,DUNCAN                   None
(10) 10/19/89   89284-00001  LOWMAN,JAMES S                    None
(11) 10/19/89   89291-00008  MCALISTER,PAMELA                  None
(12) 10/20/89   89284-00001  LOWMAN,JAMES S                    None
(13) 10/22/89   89271-00003  HAMBY,PAUL                        None
(14) 10/22/89   89234-00013  KATZ,MARCUS ROBERT                None
(15) 10/22/89   89234-00077  HAMILTON,MARK                     None
(16) 10/23/89   89235-00009  JOHNSON,NANCY                     None
(17) 10/24/89   89236-00017  SCHAL,BABY GIRL                   None

Enter number to view or `D` to delete a date, next pg (/)--
```

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You have the option of selecting an account and viewing detailed information related to it or deleting a group of accounts from the workfile with the same bill date. If you choose the delete option, enter **D**. The system then prompts you to enter a date. This date results in the deletion of all bills that were produced on this date from the biller workfile. If a bill has not been produced, it is not removed from the biller workfile. If you select an account, the next screen displays information related to the selected account.

NOTE: Biller workfile entries are never deleted automatically.

After you select an account, the system displays the following screen:

```
General Hospital Patient Bills by Biller Processor
                                      Mon Mar 27, 2006 10:40 am
Account       Name                   FC Typ Admit    Disch     Balance   Loc
89255-00016   WILSON,JEAN M          C  I/P 09/12/89           19926.00  PA/FCRV
 1 Bill Date         2 Bill Type         3 Bill From      4 Bill Through
   10/12/89            Cycle               09/12/89         10/12/89
 5 Billed Amount     6 Pymts on Bill     7 Adj. on Bill
   $7,872.00           $0.00               $0.00
 8 Biller                              9 Bill Adj. By   10 Bill Being Adj.
   AILI,EMILY
11 Billed DRG                         12 Stay Outlier   13 Cost Outlier
                                         No                No



Remove this entry? [N]--
```

Field Explanations

1.   BILL DATE (DISPLAY ONLY)
This field contains the date on which the bill was produced.

2.   BILL TYPE (DISPLAY ONLY)
This field contains the type of bill (cycle, final, adjustment, late, or cycle adjustment) for this account.

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

4.   BILL THROUGH (DISPLAY ONLY)
This field contains the last date covered by this bill.

5.   BILLED AMOUNT (DISPLAY ONLY)
This field contains the total dollar amount included on this bill.

6.   PYMTS ON BILL (DISPLAY ONLY)
This field contains the total amount of payments included on this bill.

7.   ADJ. ON BILL (DISPLAY ONLY)
This field contains the total amount of adjustments included on this bill.

8.   BILLER (DISPLAY ONLY)
This field contains the name of the biller responsible for the bill.

9.   BILL ADJ. BY (DISPLAY ONLY)
This field contains the sequence number of the adjustment bill if this bill has been replaced by an adjustment bill. If the bill has not been replaced, this field is blank.

10. BILL BEING ADJ. (DISPLAY ONLY)
This field contains the sequence number of the previous bill if this bill is an adjustment bill for another bill. If not, this field is blank.

11. BILLED DRG (DISPLAY ONLY)
This field contains the DRG number if this account was assigned a final DRG when the bill was produced. If no DRG was available, this field is blank.

12. STAY OUTLIER (DISPLAY ONLY)
This field indicates whether or not the patient's stay exceeded the DRG guidelines for length of stay. Yes indicates that the stay did exceed the DRG guidelines; No indicates that the stay did not exceed the guidelines. This field only contains a value if a DRG is present.

13. COST OUTLIER (DISPLAY ONLY)
This field indicates whether or not the patient's charges exceeded the DRG guidelines for cost. Yes indicates that the charges did exceed the guidelines; No indicates the charges did not exceed the guidelines. If there is no billed DRG, this field also contains No. This field only contains a value if a DRG is present.

After this information is displayed, you have the option of deleting the displayed account from this biller's workfile or returning to the list of accounts to select another account. You will not be given the prompt to delete a bill if the bill has not been produced. Instead, the system prompts you to press ENTER. You can delete this account by entering Y for Yes to the Remove this entry? prompt displayed at the bottom of the screen. Deleting the account updates the biller statistics and indicates the bill has been reviewed and is complete.

The following screen is displayed if you selected an account with a bill type of adjustment.

:

```
                    Patient Bills by Biller Processor
                                      Tue May 05, 2009 09:40 am
Account        Name               FC Typ Admit    Disch        Balance Loc
A01183-00001 MAIN, BOB             O                          1418.45 AR /ACCF
 1 Bill Date      2 Bill Type         3 Bill From       4 Bill Through
   10/22/01         Adjustment          07/02/01          07/02/01
 5 Billed Amount  6 Pymts on Bill     7 Adj. on Bill
   $1,391.85        $0.00               $0.00
 8 Biller                             9 Bill Adj. By   10 Bill Being Adj.
   ADAMS,JULIE                          3                1
11 Billed DRG                        12 Stay Outlier   13 Cost Outlier
                                        No                No




Remove this entry? [N]--
```

Field Explanations

1. BILL DATE (DISPLAY ONLY)
This field contains the date of the bill.

2. BILL TYPE (DISPLAY ONLY)
This field contains the type of bill for this account.

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

4. BILL THROUGH (DISPLAY ONLY)
This field contains the last date covered by this bill.

5. BILLED AMOUNT (DISPLAY ONLY)
This field contains the total dollar amount included on this bill.

6. PYMTS ON BILL (DISPLAY ONLY)
This field contains the total amount of payments included on this bill.

7. ADJ. ON BILL (DISPLAY ONLY)
This field contains the total amount of adjustments included on this bill.

8. BILLER (DISPLAY ONLY)
This field contains the name of the biller responsible for the bill.

9. BILL ADJ. BY (DISPLAY ONLY)
This field contains the sequence number of the adjustment bill if this bill has been replaced by an adjustment bill. If the bill has not been replaced, this field is blank.

10. BILL BEING ADJ. (DISPLAY ONLY)
This field contains the sequence number of the previous bill if this bill is an adjustment bill for another bill. If not, this field is blank.

11. BILLED DRG (DISPLAY ONLY)
This field contains the DRG number if this account was assigned a final DRG when the bill was produced. If no DRG was available, this field is blank.

12. STAY OUTLIER (DISPLAY ONLY)
This field indicates whether or not the patient's stay exceeded the DRG guidelines for length of stay. Yes indicates that the stay did exceed the DRG guidelines; No indicates that the stay did not exceed the guidelines. This field only contains a value if a DRG is present.

13. COST OUTLIER (DISPLAY ONLY)
This field indicates whether or not the patient's charges exceeded the DRG guidelines for cost. Yes indicates that the charges did exceed the guidelines; No indicates the charges did not exceed the guidelines. If there is no billed DRG, this field also contains No. This field only contains a value if a DRG is present.

After this information is displayed, you have the option of deleting the displayed account from this biller's workfile or returning to the list of accounts to select another account. You will not be given the prompt to delete a bill if the bill has not been produced. Instead, the system prompts you to press ENTER. You can delete this account by entering Y for Yes to the Remove this entry? prompt displayed at the bottom of the screen. Deleting the account updates the biller statistics and indicates the bill has been reviewed and is complete.

Reviewing Bills Failing Edits

If you choose to view only bills failing edits, the following screen is displayed:

```
                 General Hospital Patient Bills by Biller Processor
                                             Tue Dec 05, 1997 09:04 am

Opt  Bill Date  Acct Number  Patient Name                        Errors
( 1)  10/09/89  89268-00006  BRODIE,ALEXANDER                    Fatal
( 2)  10/15/89  89279-00006  CLAYTON,SAM                         Fatal
( 3)  10/18/89  89284-00001  LOWMAN,JAMES S                      Fatal
( 4)  10/30/89  89268-00001  LEE,SAMUEL                          Fatal
( 5)  10/30/89  89275-00001  CAMERON,MARK                        Fatal
( 6)  10/30/89  89279-00005  CARSON,MARY                         Fatal
( 7)  10/30/89  89283-00006  MAHONEY,MATTHEW                     Fatal
( 8)  10/30/89  89291-00003  BEECH,JASON                         Fatal
( 9)  10/31/89  89290-00001  FRANKLIN,JACK                       Fatal
(10)  11/10/89  89314-00002  MCCARTHY,JOHN R                     Fatal
(11)  12/03/89  89234-00013  KATZ,MARCUS ROBERT                  Fatal
(12)  12/04/89  89236-00019  HAMIL,ROBERT B                      Fatal
(13)  12/04/89  89314-00001  SISNEY,GARY ANDREW                  Fatal
(14)  12/04/89  89319-00003  EASTON,NANCY                        Fatal
(15)  12/04/89  89319-00007  CARLISLE,CHRISTOPHER                Fatal
(16)  12/04/89  89234-00013  KATZ,MARCUS ROBERT                  Fatal
(17)  12/04/89  89234-00077  HAMILTON,MARK                       Fatal


Enter number to view or `D` to delete a date [next page]--
```

You have the option of viewing detail for a selected failed bill or deleting it from this biller's workfile. If you choose to view the detail, the system displays this screen:

```
                 General Hospital Patient Bills by Biller Processor
                                             Mon Mar 27, 2009 10:40 am
Account       Name                   FC Typ Admit    Disch      Balance Loc
89279-00006  CLAYTON,SAM             C  E/R 10/06/09 10/06/09     260.00 AR/FCRV
  1 Bill Type          2 Bill Parm    3 ICD     4 Rebill Sequence Number
    Final                99             ICD-10
 5 Bill From Date                     6 Bill Through Date
   10/06/09                             10/06/09
 7 Comment                            8 Requested By
   SYSTEM FINAL



FATAL  -PRINCIPAL DIAGNOSIS CODE is Required
FATAL  -Admission Type Code is Required
FATAL  -Admission Source Code is Required
FATAL  -SIM: 3112     CHG # 5    DEPT/DESC:  EEG EEG PRO FEE
        HCPCS MISSING DIAGNOSIS MISSING PERFORMING PHYSICIAN MISSING






Press NL--
```

The system displays the patient account number, name, financial class, type, admit and discharge dates, the account balance, and account location/sub location. The other fields on the screen are display only and cannot be edited.

A list of errors is displayed for the billed account selected. These errors are the billing requirements that are incomplete. Corrections to the account must be made in account revision or in the Medical Record Abstract. The Failed Billing Requirements Report lists the accounts, by biller, which have failed the billing requirements. The errors are listed for each account. The Data Control Code table allows you to specify which errors should be included on this report. For example, you can exclude Medical Records requirements. Accounts with warnings are also included on the report.

The biller may not be responsible for correcting some of the billing errors. For example, if the final DRG is required, medical records must make the correction. The Failed Billing Requirements, Controlled By Report sorts the errors on all accounts by the area responsible for correcting the error. The responsible area is determined by the Data Control codes entered on the Billing Requirements for each billing parameter.

Field Explanations

1. BILL TYPE (DISPLAY ONLY)
This field contains the type of bill - final, cycle, late, adjustment, or cycle adjustment - for this account.

2. BILL PARM (DISPLAY ONLY)
This field contains the final billing parameter at the time of billing

3. ICD (DISPLAY ONLY)
This field contains the ICD coding system for diagnosis and procedure codes that were required for the bill. Which code sets are edited is determined by the ICD-10 Effective Date field on the Final Billing Parameter, and the Admission Date or Discharge Date of the patient, at the time of Bill Select/Bill Edit. If the ICD-10 Effective Date field on the Final Billing Parameter is blank, the code set is determined by the USA ICD-10 Effective Date on STAR Patient Processing, the admission date of the patient, and any Insurance Plan, Insurance Carrier, or Financial Class exceptions for the COB 1 plan. By displaying this field, for those data base elements that deal with either diagnosis or procedure codes, the user knows which codes were missing and failed, either ICD-9 or ICD-10.

4. REBILL SEQUENCE NUMBER (DISPLAY ONLY)
This field contains the sequence number of this bill if it is an adjustment bill.

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

6. BILL THROUGH DATE (DISPLAY ONLY)
This field contains the final date of charges included by this bill. For example, if this is a final bill, the Bill To Date would be the discharge date. Depending on the suspense days, the actual bill date may be later than the Bill Through Date.

7.   COMMENT (DISPLAY ONLY)

This field contains a comment if one was entered when the user requested the bill. If the bill was selected by the system, the type of bill is displayed here. Possible system-generated entries include:

System Prebill - a bill that has been edited, but is not ready to be produced based on the Billing Parameters.

System Final - a bill that the system has edited for final production.

Adjustment Rebill - an adjustment bill.

Late Bill - a late bill.

6.   REQUESTED BY (DISPLAY ONLY)

This field contains the name of the user who requested that the bill be generated. If the bill was selected by the system, this field is blank.

In the area below the final two fields, the system displays the reason(s) as to why this bill failed edits. For example:

```
FATAL  -  PRINCIPAL DIAGNOSIS CODE is Required
FATAL  -  Admission Type Code is Required
FATAL  -  Admission Source Code is Required
FATAL  -  SIM: 3112   CHG #: 5        DEPT/DESC:EEG EEG PRO FEE
      HCPCS MISSING DIAGNOSIS MISSING PERFORMING PHYSICIAN
      MISSING
```

Once you have reviewed this information, you can remove this account from the workfile if the bill has already been produced. You can then return to the list of patient accounts to select another account for review or to exit the function.

Removing Individual Accounts From the Workfile

Only produced bills or bills with warnings can be deleted. The user must select an account from the displayed list to delete it.

Entry options are **Y** for Yes or **N** for No; the default is **N**. If you enter **Y**, the account is removed from the biller's workfile. If you enter **N**, the account remains in the biller's workfile.

After you respond to this prompt, the system displays the list of accounts for this biller, reflecting account deletion (if any). You have the option of viewing/deleting another account in your workfile. If you are a billing supervisor, you can select another biller's workfile for review before you exit the workfile function.

Removing Accounts From the Workfile by Billing Date

After you select a biller and display accounts that failed, passed, or both failed and passed edits, you have the option of deleting accounts according to the date on which they were billed. For example, if you want to delete all accounts billed on 06/28/95, you would follow the **D** (delete) prompt displayed at the bottom of the screen with an entry of 062895. The system automatically deletes all accounts that were produced on 06/28/95 from the biller's workfile.

The system does not delete failed accounts. Corrected accounts bill when the billing suspense days have been met. A bill that has not been corrected may be produced if the maximum hold days defined on the Billing Parameters are exceeded. These failed entries also are removed from the workfile by the system.

For example, a biller may elect to verify each bill produced against what is in the biller workfile. As verification occurs, the biller can delete the entry from the workfile or delete the entire day's worth of bills at the end of the day. Another hospital may not want its billers to verify bills that have been produced and will have only those bills that fail edits placed into biller workfiles.

CPTAFB WORKLIST

The CPTAFB (Change Patient Type After Final Bill) Worklist contains accounts that have had the patient type changed after final bill transaction but have not had an adjustment bill requested. The system places accounts on CPTAFB bill hold so that you can review the account in the worklist to determine whether an adjustment bill is needed. When the parameters on the Billing Parameter screen are set to produce automatic adjustment bills for late charges, late credits, or changes to DRG, diagnosis or procedures, the system does not produce an automatic adjustment bill if an account is on CPTAFB bill hold or if there is already an outstanding bill request associated with an account. This worklist allows hospitals to review accounts that had a change patient type after final bill transaction and to perform the functions that are needed, such as requesting a new bill, reviewing for HCPCS codes, or entering late charge/credits before requesting an adjustment bill.

CPTAFB worklist entries can either be removed manually or automatically removed by the system. To manually remove an entry and remove the CPTAFB bill hold, you select the Remove From Worklist option. For details on manually removing an entry, see . A worklist entry is automatically removed when an adjustment bill request is generated for an account through either the Instant Adjustment Bill or Single Bill Request functions from within the CPTAFB worklist. The account archive process also removes any entries that are outstanding.

After you select the CPTAFB Worklist menu option, the system displays the following prompt:

> *Enter biller number or A for All entries--*

You can enter a specific biller number or **A** for All billers. If you enter a biller number, only the CPTAFB worklist entries for the specified biller are displayed. Accounts are displayed according to the biller associated with the new patient type. If you enter A for All Entries, all CPTAFB worklist entries are displayed. The system displays the following screen from which you can select a sequence number to view an account on the worklist:

```
                    General Hospital CPTAFB Worklist Processor
                                          Thu May 13, 2004 09:46 am

 SQ  Account        Name                Admit     FB Date  CPTAFB Dt Old-New PT
( 1) A0401500005    MOORE,PCONYY S      01/15/04 01/16/04 04/19/04   OPC/OPE
( 2) A0405400003    MOORE,PCONF         02/13/04 03/02/04 04/19/04   IPR/IPC
( 3) A0306400010    TEST,ADMDATE        03/05/03 03/07/03 04/20/04   I/P/IPB
( 4) A0309400006    TEST,ADMDATE        04/04/03 04/05/03 04/20/04   ER /OPS
( 5) A0310500009    TEST,ADMDATE        04/15/03 04/23/03 04/20/04   I/P/IPB
( 6) A0322400031    TEST,ADMDATE        08/12/03 08/17/03 04/20/04   I/P/IPB
( 7) A0325400003    TEST,ANT T          09/11/03 09/16/03 04/20/04   I/P/IPB
( 8) A0322400002    MOORE,PCONF         08/12/03 08/12/03 05/05/04   OPC/O/P




 Enter choice--

```

Field Explanations

SQ (DISPLAY ONLY)
This field contains the sequence number of the account, assigned by a counter.

ACCOUNT (DISPLAY ONLY)
This field displays the patient's account number.

NAME (DISPLAY ONLY)
This field displays the patient's name.

ADMIT (DISPLAY ONLY)
This field displays the patient's admission date.

FB DATE (DISPLAY ONLY)
This field displays the account's final billed date.

CPTAFB DT (DISPLAY ONLY)
This field displays the date on which the patient type was changed.

OLD-NEW PT (DISPLAY ONLY)
This field displays the original patient type and the new patient type, after it was changed.

To view more information about an account, enter the sequence number for the account. The following screen is displayed:

```
                    General Hospital CPTAFB Worklist Processor
                                        Mon Mar 27, 2006 10:40 am
 Account      Name                  FC Typ Admit    Disch       Balance Loc
 A03224-00002 MOORE,PCONF           C  O/P 08/12/03 08/12/03     188.00 AR/FCRV
  1 MR HCPCS-DT      2 MR DX Code-DT    3 Abs Complete DT  4 Old-New PT
    Yes               Yes                 04/19/04           OPC-O/P
  5 Prorated R/B Chgs 6 Prorated Anc Chgs 7 Unbilled Chg Amg  8 Comb Bill
    No                Yes                 $10.00
  9 Final Bill Date  10 CPTAFB Date      11 DPW             12 Pre-collect
    08/12/03            05/05/04                              No-No
 13 PCON UB Standard/Pass-through      14 PCON 1500       15 Denial Mgmt Clms
    Yes/No                                No                   Yes
 16 Cycles   17 Activity       18 Old-New Billing Parm   19 Old-New Reimb Type
    No        Yes              1-PM
 20 Old-New Clm Load Edit /Ins Plan    21 Old-New Ins Doll Def/Ins Plan
    02-PM/500700*                         223-2/500700*




 Press NL for worklist, enter code, or `-` for list--
```

Field Explanations

ACCOUNT (DISPLAY ONLY)
This field contains the patient account number.

NAME (DISPLAY ONLY)
This field contains the patient name.

F/C (DISPLAY ONLY)
This field contains the hospital-defined financial class code assigned to this patient's account. Financial class categorizes patients based on fiscal responsibilities and usually includes values such as self-pay, commercial insurance, and Medicare.

TYP (DISPLAY ONLY)
This field contains the patient type code that is associated with the patient after a CPTAFB transaction. The patient type code is used to categorize a specific portion of the patient community. The hospital-defined code represents such patient segments as regular admission, emergency room, outpatient, same day surgery, and series patients.

ADMIT (DISPLAY ONLY)
This field contains the date the patient was admitted.

DISCH (DISPLAY ONLY)
This field contains the date the patient was discharged.

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

LOC (DISPLAY ONLY)
This field contains the location and sub location of the account. The account location of a patient determines which sub locations are available. For more information about sub locations and their corresponding locations, see the McKesson-Maintained Information chapter of the *Tables, Masters and Parameters Volume of the STAR Financials Patient Accounting Reference Guide.*

1. MR HCPCS-DT (DISPLAY ONLY)
This field contains two values separated by a hyphen. The first value indicates whether Medical Records HCPCS codes exist for the account. A value of Yes indicates that Medical Records HCPCS codes exist and a value of No indicates that Medical Records HCPCS codes don't exist. The second value contains a date if the HCPCS were modified after a CPTAFB transaction. The displayed date is the last date the Medical Records HCPCS were modified after a CPTAFB transaction.

2. MR DX CODE-DT (DISPLAY ONLY)
This field contains two values separated by a hyphen. The first value indicates whether Medical Records diagnoses codes exist for the account. A value of Yes indicates that medical records diagnoses codes exist and a value of No indicates that medical record diagnoses codes don't exist. These are the diagnoses that were abstracted in medical

records. The second value contains a date if the diagnoses were modified after a CPTAFB transaction. The date displayed is the last date the diagnoses were modified after a CPTAFB transaction.

3. ABS COMPLETE DT (DISPLAY ONLY)

This field contains the Medical Records Abstract Complete Date. If this field contains a date, it indicates that there is currently an Abstract Complete Date associated with the account. If this field is blank, it indicates that there is not an Abstract Complete Date associated with the account.

4. OLD-NEW PT (DISPLAY ONLY)

This field contains the patient type code that was associated with the patient before and after a CPTAFB transaction. The patient type code is used to categorize a specific portion of the patient community. The hospital-defined code represents patient segments such as regular admission, emergency room, outpatient, same day surgery, and series patients.

5. PRORATED R/B CHGS (DISPLAY ONLY)

This field indicates whether prorated room and bed charges are associated with the patient. A value of Yes indicates that prorated room and bed charges are associated with the patient. A value of No indicates that prorated room and bed charges are not associated with the patient.

6. PRORATED ANC CHGS (DISPLAY ONLY)

This field indicates whether prorated ancillary charges are associated with the patient. A value of Yes indicates that prorated ancillary charges are associated with the patient. A value of No indicates that prorated ancillary charges are not associated with the patient.

7. UNBILLED CHG AMT (DISPLAY ONLY)

This field contains the amount of unbilled charges for the account.

8. COMB BILL (DISPLAY ONLY)

This field indicates whether an account is a Combine To account. The field contains either From, To, or blank. A value of To indicates that the account is a Combine To account. A value of From indicates that the account is a Combine From account.

9. FINAL BILL DATE (DISPLAY ONLY)

This field displays the final billed date for the account.

10. CPTAFB DATE (DISPLAY ONLY)

This field displays the date that the most recent change patient type after final bill transaction occurred.

11. DPW (DISPLAY ONLY)

This field contains two values separated by a hyphen. This field indicates whether an account was a DPW inpatient or outpatient account before and after a CPTAFB transaction. This field contains either a value of I/P (inpatient), O/P (outpatient), or blank.

- A value of I/P in the first position indicates that the account was a DPW inpatient according to the old patient type.

- A value of O/P in the first position indicates that the account was a DPW outpatient according to the old patient type.

- A value of I/P in the second position indicates that the account is a DPW inpatient according to the new patient type.

- A value of O/P in the second position indicates that the account is a DPW outpatient according to the new patient type.

- A value of blank indicates that the account was not associated with DPW.

Valid values are shown in the following table:

First character in field associated with old patient	Second character in field associated with new patient
I/P	O/P
I/P	I/P
O/P	O/P
O/P	I/P
I/P	blank
O/P	blank
blank	blank

12. PRE-COLLECT (DISPLAY ONLY)
This field contains two values separated by a hyphen. This field indicates whether the account was in pre-collection before or after a CPTAFB transaction. Valid values are either Yes or No.

- A value of Yes for the first position indicates that the account was either an Internal or CCI pre-collect account according to the old patient type. A value of Yes for the second position indicates that the account is either an Internal or CCI pre-collect account according to the new patient type

- A value of Yes for the first position indicates that the account was either an Internal or CCI pre-collect account according to the old patient type. A value of No for the second position indicates that the account is neither an Internal nor a CCI pre-collect account according to the new patient type.

- A value of No for the first position indicates that the account was neither an Internal nor a CCI pre-collect account according to the old patient type. A value of Yes for the second position indicates that the account is either an Internal or CCI pre-collect account according to the new patient type.

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- A value of No for the first position indicates that the account was neither an Internal nor a CCI pre-collect account according to the old patient type. A value of No for the second position indicates that the account is neither an Internal nor a CCI pre-collect account according to the new patient type.

Valid values are shown in the following table:

First character in field associated with patient	Second character in field associated with patient
Yes	Yes
Yes	No
No	Yes
No	No

13. PCON UB STANDARD/PASS-THROUGH (DISPLAY ONLY)

This field contains two values separated by a hyphen. This field indicates if any claims exist for the PCON UB Standard Interface and/or the PCON Pass-through Interface. If Yes is displayed in the first position of the field, PCON UB Standard claims exist. If No is displayed in the first position of the field, PCON UB Standard claims don't exist. If Yes is displayed in the second position of the field, PCON UB Pass-through claims exist. If No is displayed in the second position of the field, PCON UB Pass-through claims don't exist.

14. PCON 1500 (DISPLAY ONLY)

This field indicates whether any claims exist for the PCON 1500 Interface. Valid values are Yes and No. If Yes is displayed in the field, PCON 1500 claims exist. If No is displayed in the first position of the field, PCON 1500 claims don't exist.

15. DENIAL MGMT CLAIMS (DISPLAY ONLY)

This field indicates whether any claims exist for denial management. If Yes is displayed in the field, denial management claims exist. If No is displayed in the field, denial management claims don't exist.

16. CYCLES (DISPLAY ONLY)

This field indicates whether cycle bills are associated with the account. If Yes is displayed in the field, cycle bills exist for the account. If No is displayed in the field, cycle bills don't exist for the account.

17. ACTIVITY (DISPLAY ONLY)

This field indicates whether any activity was associated with the account prior to the CPTAFB transaction. Activity includes any claim payments, claim adjustments or refunds. A value of Yes indicates activity was associated with the account prior to the CPTAFB transaction. A value of No indicates activity wasn't associated with the account prior to the CPTAFB transaction.

18. OLD-NEW BILLING PARM (DISPLAY ONLY)
This field indicates if the Billing Parameters were updated as a result of a CPTAFB transaction. If the Billing Parameters were updated, the field displays the old and new Billing Parameters. A value of blank indicates that the Billing Parameters were not updated as a result of a CPTAFB transaction. This is a two-character field where the first and second characters are separated by a dash.

19. OLD-NEW REIMB TYPE (DISPLAY ONLY)
This field indicates if the Reimbursement Type was updated as a result of a CPTAFB transaction. If the Reimbursement Type was updated, the field displays the old and new Reimbursement Type. A value of blank indicates that the Reimbursement Type was not updated as a result of a CPTAFB transaction. This is a two-character field where the first and second characters are separated by a dash.

20. OLD-NEW CLM LOAD EDIT/INS PLAN (DISPLAY ONLY)
This field indicates if the Claim Load and Edit Parameters were updated as a result of a CPTAFB transaction. If the Claim Load and Edit Parameters were updated, the field displays the old and new Claim Load and Edit Parameters. A value of blank indicates that the Claim Load and Edit Parameters were not updated as a result of a CPTAFB transaction. This is a two-character field where the first and second characters are separated by a dash.

21. OLD-NEW INS DOLL DEF/INS PLAN (DISPLAY ONLY)
This field indicates if the Insurance Dollar Definition code was updated as a result of a CPTAFB transaction. If the Insurance Dollar Definition code was updated, the field displays the old and new Insurance Dollar Definition code and the associated Insurance Carrier/Plan code. A value of blank indicates that the Insurance Dollar Definition code was not updated as a result of a CPTAFB transaction. This is a three-character field where the first two characters are separated by a dash and the second and third characters are separated by a forward slash. If the Insurance Dollar Definition has been updated for more than one plan, the field displays only one insurance and the associated Old-New Insurance Dollar Definitions. If more than one insurance had its Insurance Dollar Definition value updated, the system selects the one that is the most primary insurance and displays the Old-New values. If there is more than one insurance that had its Insurance Dollar Definition values updated, an asterisk follows the value in the field for the Insurance plan code. For example:

Old- New Ins Doll Def/ Ins Plan

PMK-2/ 918100*

The system gives you the option of either viewing a list of additional functions that can be performed on the account or exiting the screen. The following prompt is displayed:

Press NL for worklist, enter code, or '-' for list--

You can press ENTER to exit the screen. If you want to view a list of additional functions, enter a CPTAFB worklist function or enter a hyphen (-) for a list of CPTAFB worklist functions.

```
                    General Hospital CPTAFB Worklist Processor
                                          Mon Mar 27, 2007 10:40 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
A03224-00002 MOORE,PCONF             C  O/P 08/12/03 08/12/03     188.00  AR/FCRV
 1 MR HCPCS-DT       2 MR DX Code-DT    3 Abs Complete DT   4 Old-New PT
   Yes                 Yes               04/19/04              OPC-O/P
 5 Prorated R/B Chgs 6 Prorated Anc Chgs 7 Unbilled Chg Amg  8 Comb Bill
   No                  Yes               $10.00
 9 Final Bill Date  10 CPTAFB Date     11 DPW             12 Pre-collect
   08/12/03            05/05/04                              No-No
13 PCON UB Standard/Pass-through      14 PCON 1500       15 Denial Mgmt Clms
   Yes/No                                No                   Yes
16 Cycles   17 Activity        18 Old-New Billing Parm   19 Old-New Reimb Type
   No          Yes             1-PM
20 Old-New Clm Load Edit /Ins Plan    21 Old-New Ins Doll Def/Ins Plan
   02-PM/500700*                         223-2/500700*


Page:01                     CPTAFB Worklist Functions
( 1) BI-Instant Adjustment Bill       (10) J-Single Bill Request
( 2) C-Maintain Claim Information     (11) K-Balance Summary
( 3) CB-Combine Bill                  (12) LC-Late Charge/Credit Function
( 4) D-Review DPW Account             (13) M-Adm Medical Information
( 5) DX-MR Diagnosis Information      (14) N-Notes
( 6) H-Transaction History            (15) PC-Int/Ext Agency Collections
( 7) HC-HCPCS Information             (16) PX-Procedure Information
( 8) HD-Display Charges by Service    (17) R-Remove from worklist
( 9) IR-Insurance Revision            (18) V-Guarantor's Accounts



Enter choice--
```

The functions displayed at the bottom of the screen provide a means to go to a specific function. To display one of these functions, enter the number associated with the function. Each function that can be accessed from the CPTAFB Worklist Screen is described below.

Requesting a Bill Reprint or Adjustment Bill

The Single Bill Request function can be used to request reprints of a bill that is on CPTAFB hold (reprinting the bill does not remove the CPTAFB hold) or to request an adjustment bill after you remove the bill from the worklist and CPTAFB hold.The Instant Adjustment Bill option can be used to request and adjustment bill. When either the Single Bill Request function or the Instant Adjustment Bill option is selected from the CPTAFB Worklist screen, the following prompt is displayed:

To request an adjustment bill, the CPTAFB bill hold must be removed and the account removed from the worklist. Do you want to do that now? (Y/N) [N]--

• If you want to request an adjustment bill, you must first remove the CPTAFB bill hold. To do this, enter **Y** for Yes at the prompt. For further information, see .

- If you do not want to remove the account from the worklist and request an adjustment bill, enter **N** for No. The following prompt is displayed:

  Account on CPTAFB Hold! Processor can be used for reprints only.

You can request reprints of a bill that is on CPTAFB bill hold. for details on the Single Bill Request screen, see .

Requesting an Adjustment Bill

Single Bill Function

When the Single Bill function is selected from the CPTAFB Worklist screen, the following prompt is displayed:

To request an adjustment bill, the CPTAFB bill hold must be removed and the account removed from the worklist. Do you want to do that now? (Y/N) [N]--

Enter **Y** for Yes to remove the bill from CPTAFB hold and to have the account removed from the worklist. The following message is displayed:

Account removed from CPTAFB Worklist

For detailed information regarding this function, see .

Instant Adjustment Bill

The Instant Adjustment Bill function can be accessed from the CPTAFB Worklist. When this function is selected, the following prompt is displayed:

To create an instant adjustment bill, the CPTAFB bill hold must be removed and the account removed from the worklist. Do you want to do that now? (Y/N) [N]--

- You can enter **N** for No to exit the function.

- You can enter **Y** for Yes to remove the bill from CPTAFB hold and to have the account removed from the worklist. The following message is displayed:

  Account removed from CPTAFB Worklist

For detailed information regarding this function, refer to the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Maintain Claim Information

When this function is selected from the CPTAFB Worklist, the Maintain Claim function can be accessed. For detailed information regarding this function, refer to Chapter 3:

Claims in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Combine Bill

When this function is selected from the CPTAFB Worklist, the Combine Bill function can be accessed. For detailed information regarding this function, refer to Chapter 2: Patient Billing in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Review DPW Account

When this function is selected from the CPTAFB Worklist, the DRG Payment function can be accessed. For detailed information regarding this function, refer to Chapter 6: DRG Payment Window in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Diagnosis Information

When this function is selected from the CPTAFB Worklist, diagnosis information can be accessed. For detailed information regarding this function, refer to Chapter 1: Account Inquiry in the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Display Charges by Service Date

When this function is selected from the CPTAFB Worklist, charge information by service date can be accessed. For detailed information regarding this function, refer to Chapter 1: Account Inquiry in the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide*.

HCPCS Information

When this function is selected from the CPTAFB Worklist, HCPCS information can be accessed. For detailed information regarding this function, refer to Chapter 3: PA/AR Parameter File Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Insurance Revision

When this function is selected from the CPTAFB Worklist, insurance revision information can be accessed. For detailed information regarding this function, refer to Chapter 3: Other Account Management Functions in the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Balance Summary

When this function is selected from the CPTAFB Worklist, balance summary information can be accessed. For detailed information regarding this function, refer to Chapter 1: Proration in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Late Charge/Credit Functions

When this function is selected from the CPTAFB Worklist, late charges or credit charges can be applied to the account. For detailed information regarding this function, refer to the *Order Management/Charge Processing, Volume II* of the *STAR Patient Care Reference Guide.*

Adm Medical Information

When this function is selected from the CPTAFB Worklist, medical information can be accessed. For detailed information regarding this function, refer to Chapter 1: Account Inquiry in the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Notes

When this function is selected from the CPTAFB Worklist, account notes can be accessed. For detailed information regarding this function, refer to Chapter 7: Contract Account Management in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Pre-Collection

When this function is selected from the CPTAFB Worklist, pre-collection information for an account can be accessed. For detailed information regarding this function, refer to Chapter 2: Collector Functions in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Procedure Information

When this function is selected from the CPTAFB Worklist, procedure information can be accessed. For detailed information regarding this function, refer to Chapter 1: Account Inquiry in the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Remove From Worklist

This function is used to manually remove an entry from the CPTAFB Worklist and to remove the CPTAFB bill hold. When this function is selected from the CPTAFB Worklist screen, the following prompt is displayed:

Are you sure that you want to remove this account from the CPTAFB Worklist (Y/N) [N]--

- You can enter **N** (No) and exit the function.

- You can enter **Y** (Yes) to remove the account from the worklist. An additional check is performed on an account in the CPTAFB Worklist to verify whether the account is also in the Unbilled Charge Worklist with charges that are flagged as being outside of the Chg Bill Window. If the account meets this criteria, the following prompt is displayed:

    Account qualifies for Bill Hold Type O - Old Chg Hold, do you wish to assign this type to the account (Y/N) - [Y]

    - If you enter **N** (No), the existing bill hold of CPTAFB is removed, and the account is not assigned the new type of O (Old Charge Hold).

    - If you enter **Y** (Yes), the existing bill hold type of CPTAFB is removed, and the new bill hold type of O (Old Charge Hold) is assigned. The following message is displayed:

    Account removed from CPTAFB Worklist

Guarantor's Accounts

When this function is selected from the CPTAFB Worklist, guarantor information for the account can be accessed. For detailed information regarding this function, refer to Chapter 2: Guarantor Functions in the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

BATCH BILLS

This function enables you to request a batch billing during the next bill run. The main use of this function is to receive end-of-year cycle or final bills on a group of accounts. A batch bill is a process by which an extra group of accounts may be billed together. You can request batch bills for any account groups for a specified date up to the previous 30 days. Cycle, end-of-month, final, and late bills are requested using this function. You can make multiple batch requests by insurance carrier, patient type, or financial class. Once a batch is created, the bills involved are generated during the next bill production run.

If a final bill run is requested, all discharged accounts selected in the batch request are processed for billing during the next run. Suspense days entered in the billing parameter for this account are ignored. However, the bills are edited and those failing edits are held for review and correction.

Cycle adjustment bills cannot be requested through this function. If there are unbilled charges on the account for a cycle bill, the following occurs:

* If the batch bill request is for a cycle bill, unbilled cycle charges for a previously billed cycle bill period won't be included on the cycle bills created as a result of the batch bill request. The hospital would need to create a cycle adjustment bill so the unbilled cycle charges are included on a previously billed cycle bill.

* If a final bill request is made, a final bill request would be created, but it wouldn't include unbilled cycle charges, if cycle adjustment processing is active for the account. To review the unbilled cycle charges, the hospital can set the bill edit for unbilled charges/credits on the Billing Requirements table and review the Failed Billing Requirements report and the Unbilled Cycle Charge/Credit report for unbilled cycle charges.

* For a late batch bill request, unbilled cycle charges would not be included on a late bill if cycle adjustment processing is active for an account.

NOTE: This function is not used for immediate billing. The Demand Bill function is for that purpose. While a single or batch billing request updates the account's billing status, generating a demand bill does not. A demand bill does not replace a final bill or cycle bill because a demand bill does not have any effect on the account, including the production of associated insurance claims for the bill.

After you select batch bills, the system prompts you to select the desired facility (if this is a multi-facility installation) and displays a list of billing batches created but not yet run (if any exist). The system prompts you to cancel a current batch request or add a new one.

Adding a Batch Bill Request

If no other batches are waiting to be run, the following prompt is displayed:

Add batch bill request by carrier(C), by patient type(P) or by financial class(F)? [C]

The default is **C**. Next, the system prompts you as to whether or not you want to add a batch bill request. Entry options are **Y** for Yes or **N** for No; the default is **Y**.

The system displays the following screen for the carrier request:

```
                    General Hospital Batch Bills Processor
                                              Thu Jul 16, 1997 09:07 am


 1 Bill Type    Default Parameter      2 Bill Through Date
   Cycle        9-Series Cycle           07/15/97
 3 Patient Indicator                    4 Comment
   Outpatients                            Blue Cross Cycle
 5 Insurance Carrier                    6 Insurance Plan
   005-BLUE CROSS BS OR                   380-BCBSO/UNITED PARCEL SVC








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

Field Explanations

1. BILL TYPE (1-A-R)
This field contains the type of bill for the batch that you are requesting. Entry options are **C** (cycle), **F** (final), or **L** (late). Bill types cannot be mixed in a batch request; however, more than one request can be entered in the same day.

If you enter **C** (cycle), the system displays a table of cycle billing parameters. Select the billing parameter to be used as a default for non-discharged accounts for which no specific cycle bill parameter exists. For example, if you are requesting a batch bill request for cycle bills for all patients with the patient type ONC (oncology), some of these accounts may not have a cycle bill parameter specified. The cycle billing parameter you select from the table would be used for these accounts.

To produce an end-of-month bill, select a Cycle End-of-Month default billing parameter.

After you select the default cycle billing parameter, this field displays the bill type and the selected parameter.

2. BILL THROUGH DATE (6-N-R)

This field contains the cutoff date for this batch bill request. The range of allowable dates is displayed. The default response is the current system date. For example, if you enter 05/25/98, the system identifies all accounts meeting this batch request and produces a bill with this bill through date.

- If the bill type is **F**, all accounts discharged but not yet final billed that meet the batch selection criteria are billed.

- If the bill type is **C** and a Cycle End-of-Month billing parameter is being used, the system produces a cycle bill for all non-discharged accounts meeting the batch selection criteria. Only charges that are posted in the month selected are included on the bill.

- If the bill type is **C** and a Cycle End-of-Month billing parameter is *not* being used, all non-discharged accounts that meet this batch selection criteria receive a cycle bill. The cycle bill includes all charges not previously billed through this date.

- If the bill type is **L**, the system produces a late bill for every account meeting the batch selection criteria that has late charges.

You can enter the current date or less than the current date (up to thirty days) if the bill type is **C**, **F**, or **L**. If the bill type is **C** (End of Month), the system displays the last day of the previous month in this field; you cannot edit this displayed value.

3. PATIENT INDICATOR (1-A-R)

This field contains the patient indicator that is included in this batch bill request. Entry options are **I** (inpatients), **O** (outpatients), or **B** (both inpatients and outpatients); the default is **B**.

4. COMMENT (30-C-O)

This field contains the description or explanation of the purpose of this batch bill request. A typical entry could be *All GA Blue Cross patients*. This comment is displayed with its associated batch request on the Pending Batch Request review screen to aid in identifying the reason for the batch bill request. Once the bills are produced, the system deletes this comment.

5. INSURANCE CARRIER (4-N-R)

This field contains the carrier code (up to four digits) for this batch request. You can enter the code or a hyphen (-) to display a list of valid codes. Only accounts associated with this carrier (and meeting the other selection criteria entered on this screen) are selected. Only one carrier can be selected. You can narrow your account selection by entering a value in the next field.

CN: As of April 1, 2006, for accounts loading Nova Scotia Out of Province claims as the primary insurance, outpatient visit charges that occur on the same day as an inpatient charge are assessed separately, so that the outpatient charge

on those days is also billed. Inpatient charges continue to be identified by
report only.

6.   INSURANCE PLAN (4-N-O)
This field contains the plan code (up to four digits - the carrier code and plan code
combination cannot exceed six digits) if this batch request is intended for a single plan
of the selected carrier. You can enter the code or a hyphen (-) to display a list of plan
codes associated with the entered carrier. If you leave this field blank, all patients with
the selected patient indicator and insurance carrier are billed.

When all fields are completed, the system gives you the option of editing or accepting
the information entered. Accepting the screen completes the addition of a batch bill
request. Once you accept the information, it cannot be edited. You must cancel the
request and re-enter the information if you want to make any edits.

The system displays the following screen for the patient type request:

```
                    General Hospital Batch Bills Processor
                                           Thu Apr 16, 1998 09:41 am



 1 Bill Type                          2 Bill Through Date
   Final                                04/16/98
 3 Patient Type                       4 Financial Class
   CRS C-Reg, Single Occurrence          B
 5 Comment
->








 Enter comment --
```

Field Explanations

1.   BILL TYPE (1-A-R)
This field contains the type of bill for the batch that you are requesting. Entry options
are **C** (cycle), **F** (final), or **L** (late). Bill types cannot be mixed in a batch request;
however, more than one request can be entered in the same day.

If you enter **C** (cycle), the system displays a table of cycle billing parameters. Select
the billing parameter to be used as a default for non-discharged accounts for which no
specific cycle bill parameter exists. For example, if you are requesting a batch bill
request for cycle bills for all patients with the patient type ONC (oncology), some of
these accounts may not have a cycle bill parameter specified. The cycle billing
parameter you select from the table would be used for these accounts.

To produce an end-of-month bill, select a Cycle End-of-Month default billing parameter.

After you select the default cycle billing parameter, this field displays the bill type and the selected parameter.

2. BILL THROUGH DATE (6-N-R)
This field contains the cutoff date for this batch bill request. The range of allowable dates is displayed. The default response is the current system date.

For example, if you enter 05/25/95 is entered, the system identifies all accounts meeting this batch request and produces a bill with this bill through date.

• If the bill type is **F**, all accounts discharged but not yet final billed that meet the batch selection criteria are billed.

• If the bill type is **C** and a Cycle End-of-Month billing parameter is being used, the system produces a cycle bill for all non-discharged accounts meeting the batch selection criteria. Only charges that are posted in the month selected are included on the bill.

• If the bill type is **C** and a Cycle End-of-Month billing parameter is *not* being used, all non-discharged accounts that meet this batch selection criteria receive a cycle bill. The cycle bill includes all charges not previously billed through this date.

• If the bill type is **L**, the system produces a late bill for every account meeting the batch selection criteria that has late charges.

You can enter the current date or less than the current date (up to thirty days) if the bill type is **C**, **F**, or **L**. If the bill type is **C** (End of Month), the system displays the last day of the previous month in this field; you cannot edit this displayed value.

3. PATIENT TYPE (TABLE LOOKUP)
This field contains the patient type for this batch bill request. Only one patient type can be defined for each request.

4. FINANCIAL CLASS (TABLE LOOKUP)
This field contains the financial class for the batch bill request. You can enter one or more financial classes, or you can enter **All**. You choose the financial class code from a table lookup of valid financial classes. This field can be left blank.

5. COMMENT (30-C-O)
This field contains the description or explanation of the purpose of this batch bill request. A typical entry could be *All GA Blue Cross patients*. This comment is displayed with its associated batch request on the Pending Batch Request review screen to aid in identifying the reason for the batch bill request. Once the bills are produced, the system deletes this comment.

When all fields are completed, the system gives you the option of editing or accepting the information entered. Accepting the screen completes the addition of a batch bill request. Once you accept the information, it cannot be edited. You must cancel the request and re-enter the information if you want to make any edits.

The system displays the following screen for the financial class request:

```
                    General Hospital Batch Bills Processor
                                             Thu Apr 16, 1998 09:58 am



 1 Bill Type                          2 Bill Through Date
   Final                                04/16/98
 3 Financial Class                    4 Comment
->

Page:01                        Financial Classes
( 1) B-BLUE CROSS
( 2) C-CHAMPUS
( 3) CR-COMMERCIAL
( 4) H-HMO
( 5) K-MEDICAID
( 6) M-MEDICARE
( 7) O-OTHER COMMERCIAL
( 8) P-PPO (23)
( 9) S-SELF PAY
(10) W-WORKER'S COMPENSATION

Enter choice--
                                next page(/)
```

Field Explanations

1. BILL TYPE (1-A-R)
This field contains the type of bill for the batch that you are requesting. Entry options are **C** (cycle), **F** (final), or **L** (late). Bill types cannot be mixed in a batch request; however, more than one request can be entered in the same day.

If you enter **C** (cycle), the system displays a table of cycle billing parameters. Select the billing parameter to be used as a default for non-discharged accounts for which no specific cycle bill parameter exists. For example, if you are requesting a batch bill request for cycle bills for all patients with the patient type ONC (oncology), some of these accounts may not have a cycle bill parameter specified. The cycle billing parameter you select from the table would be used for these accounts.

To produce an end-of-month bill, select a Cycle End-of-Month default billing parameter.

After you select the default cycle billing parameter, this field displays the bill type and the selected parameter.

2. BILL THROUGH DATE (6-N-R)

This field contains the cutoff date for this batch bill request. The range of allowable dates is displayed. The default response is the current system date.

For example, if you enter 05/25/95, the system identifies all accounts meeting this batch request and produces a bill with this bill through date.

- If the bill type is **F**, all accounts discharged but not yet final billed that meet the batch selection criteria are billed.

- If the bill type is **C** and a Cycle End-of-Month billing parameter is being used, the system produces a cycle bill for all non-discharged accounts meeting the batch selection criteria. Only charges that are posted in the month selected are included on the bill.

- If the bill type is **C** and a Cycle End-of-Month billing parameter is not being used, all non-discharged accounts that meet this batch selection criteria receive a cycle bill. The cycle bill includes all charges not previously billed through this date.

- If the bill type is **L**, the system produces a late bill for every account meeting the batch selection criteria that has late charges.

You can enter the current date or less than the current date (up to thirty days) if the bill type is **C**, **F**, or **L**. If the bill type is **C** (End of Month), the system displays the last day of the previous month in this field; you cannot edit this displayed value.

3. FINANCIAL CLASS (TABLE LOOKUP)

This field contains the financial class of the batch bill request. It is required and allows the entry of one financial class. You choose a financial class code from a table lookup of valid financial classes.

4. COMMENT (30-C-O)

This field contains the description or explanation of the purpose of this batch bill request. A typical entry could be *All GA Blue Cross patients*. This comment is displayed with its associated batch request on the Pending Batch Request review screen to aid in identifying the reason for the batch bill request. Once the bills are produced, the system deletes this comment.

Cancelling a Batch Bill Request

Only batch bill requests that have not been processed through midnight processing can be cancelled. When the Batch Bills option is accessed, the system prompts you to select the desired facility (if this is a multi-facility installation) and either the carrier or patient type batch bills and displays any pending batch bill requests:

```
                    General Hospital Batch Bills Processor
                                            Tue Dec 05, 1997 09:12 am

                    Carrier/  Patient
      Bill Type     Plan      Type        Comment
( 1) Cycle          0005/380  Outpat      Blue Cross Cycle
( 2) Final          0201/005  Outpat      Medicare Series Final










 Enter number to cancel or `A` to add --
```

After the number of the batch that you want to cancel is entered, the system displays
this screen:

```
                    General Hospital Batch Bills Processor
                                            Tue Dec 05, 1997 09:12 am


 1 Bill Type                        2 Bill Through Date
   Final                              12/05/89
 3 Patient Indicator                 4 Comment
   Outpatients                         Medicare Series Final
 5 Insurance Carrier                 6 Insurance Plan
   201-MEDICARE                        005-MEDICARE RENAL (SERIES)








 Cancel this batch? (Y/N) [N]--
```

The system displays this information in order for you to confirm that the selected batch
is the one you want to delete. The system prompts you to enter **Y** for Yes or **N** for No;
the default is N. If you enter **Y**, the batch is cancelled and the list of remaining batch
bill requests is displayed. If you enter N, the list remains the same. This procedure is
followed for each batch bill request to be cancelled.

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SINGLE BILL

This function generates a request for a single account rather than a batch of accounts, enabling you to reprint a bill and rebill an account. It can be used in several situations. For example, an inpatient's account balance has quickly reached a considerable dollar amount. The account's cycle bill parameters are based on 30 days since admission but you need to generate a cycle bill now. This function permits you to do this.

The types of bills you can request for an account depend on the status of that account. For example, if the patient has been discharged and the account final billed, only a reprint, adjustment, or late bill can be requested for this account. The options involved in this function are explained in the following paragraphs.

SINGLE BILL OPTIONS

There are two factors determining what type of single bill can be requested through this function. The first is whether the patient has been discharged and the second is whether a final bill has been generated for this patient account.

- Before a Patient Is Discharged

Two types of bills can be requested for a patient that has not been discharged: a cycle bill or a reprint of a prior cycle bill. You cannot request an adjustment bill for a cycle bill.

- Before a Final Bill Is Issued

After the patient is discharged (but before the final bill is issued), the only types of single bill requests that can be made are for a final bill or a reprint of a prior cycle bill.

- After a Final Bill Is Issued

Once a final bill is issued, you can request a reprint of the final bill or a prior cycle bill, an adjustment to this final bill, or a late bill.

NOTE: Multiple reprint single bill requests can exist for an account, but only one cycle, adjustment, late, or final request on an account can be processed on a given day. For details on requesting single bill reprints after the initial request, see

After the Single Bill function is selected, the system prompts you to select a facility (if this is a multi-facility installation) and then a patient account using the FPI Lookup.

- If the account has a pre-bill edit status of 11 (No Errors/No Bill Req), 12 (No Errors/ Bill Req), or 13 (Final Bill Req Canc), the Pre-bill Edit Status is displayed at the top of the screen, and one of the following prompts is displayed when the bill is accepted:

  PBE status is Final Bill Req Canc. Do you want to continue? (Y/N)

PBE status is No Errors/Bill Req. This request removes the account from the pre-bill edit process. Continue? (Y/N) (N)

• The following prompt is displayed if the patient's address is flagged as invalid:

Invalid Address exists. Do you want to continue? (Y/N) (N)--

If you enter **N** for No, the previous screen is displayed. If you enter **Y** for Yes, the system reviews the account to see if it is on bill hold. If the account is on bill hold, the following message is displayed:

Account on hold! Processor can be used for reprints only.

NOTE: The type of bill hold is also displayed with this prompt. For example, if an account is on Old Charge bill hold, the prompt is as follows: *Account on Old Chg Bill hold! Processor can be used for reprints only!*

The system indicates if there is a bill request for the account and displays the following prompt:

  Cancel pending request? [N]-

If the account is not on bill hold and there is no pending request, the Single Bill Processor is displayed as shown below:

```
                     General Hospital Single Bill Processor
                             Mon Aug 4 2012 10:40 am
 Account       Name                    FC Typ Admit    Disch    Balance    Loc
 A02344-00003 CRANE, ROGER             C  I/P 11/19/08 12/10/08 826149.18  AR/FCRV

  1 Bill Type                         2 Reprint/Adjustment of
    A Adjustment                        1 Final 12/24/08
  3 Bill From     4 Bill Through         5 CycA Chg/Cr/Dys Override for Subs Bills
    11/19/08        12/10/08
  6 Perform Edits                      7 Requested By
    No                                   Billings, Scott
  8 Comment                           9 # of Copies of Bills to Print
    Payer request                        1
 10 CycA Suppress Subsequent Bills/ Do Not Load Clms

 11 Produce Claims?
  CB1-300100-P/N
 12 UB Loc 4 Last Digit               13 1500 Type of Bill

 14 PCON Send




 Enter comment --
```

Field Explanations

1. BILL TYPE (1-A-R)
This field contains the type of bill that you are requesting. When this field is accessed, the following prompt is displayed:

Enter type of bill--

Adjustment (A), Late (L), Reprint (R), CycA (Z)

The options, depending on the account's status, are **C** (cycle), **F** (final), **L** (late), **A** (adjustment), **R** (reprint), or **Z** (cycle bill adjustment). All options are not available for every account, and the fields on this screen that can be edited vary with the bill type requested.

Cycle -Only the Comment, Produce Claim, and # of Copies of Bills to Print fields can be edited. The Reprint/Adjustment of field is blank. The Bill From and Through Date fields are determined automatically by the system, and the Perform Edits field defaults to No and cannot be changed. Cycle bills are never edited by the system.

Final - You can edit the Perform Edits, Comment, Produce Claim, and # of Copies of Bills to Print fields. The Perform Edits field defaults to Yes but can be changed. The Reprint/Adjustment Of field is blank.

Late Bill - Only the Comment, Produce Claim, and # of Copies of Bills to Print fields can be edited. The Reprint/Adjustment Of field is left blank and all other fields are completed by the system. The Perform Edits field defaults to N and cannot be changed.

Adjustment - Only the Comment, Produce Claim, # of Copies of Bills to Print, and Perform Edits fields can be edited. All other fields are completed by the system. Only final bills can be adjusted.

Reprint - Only the Comment and # of Copies of Bills to Print fields can be edited. All other fields are completed by the system when the bill to be reprinted is selected. Reprint bills do not generate reprint claims.

Cycle Bill Adjustment - Only the Comment, Produce Claim, # of Copies of Bills to Print, CycA Suppress Subsequent Bills/ Do Not Load Clms, and Perform Edits fields

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can be edited. All other fields are completed by the system. When the bill type is cycle bill adjustment, the Cycle Adjustment Bill Selection screen is displayed, as follows:

```
Cycle Adjustment Bill Selection


     BS    BT   Bill      Bill     Bill     Bill     Unbill        Unbill
                Date      From     Thru     Amount   Chg Amt/#     Cr Amt/#
( 1)  1    C    01/18/06  01/18/06 01/18/06 $400.84  $1000.00/1    40.00-/1
( 2)  4/2  Z    01/20/06  01/19/06 01/21/06 $700.00
( 3)  5/3  A    01/30/06  01/22/06 01/22/06 $864.16


 Select Cycle Bill to be Adjusted--

```

This screen displays all of the associated bills for the account. The screen is displayed only if there are cycle bills associated with the account and cycle adjustment processing is allowed, if cycle adjustment parameters exist for the account, and if the account is not on bill hold. If a cycle adjustment bill can't be processed because of an error condition, one of the following messages is displayed:

Account on XX Bill hold! Processor can be used for reprints only.

Cycle Adjustment Parameters don't exist

Cycle Adjustment parameters no longer exist for this account. Therefore a Cycle Adjustment Bill cannot be processed. Press Enter.

If you selected a cycle bill (bill type of C) for cycle adjustment billing, and no error conditions exist on the account, you can select a bill sequence from the Cycle Adjustment Bill Selection screen. The system rebills the selected bill sequence and all subsequent bills. All bills that are to be rebilled are displayed in the *Reprint/Adjustment of* field on the Single Bill Request Processor. For example, if bills 1, 2, 3, 4 and 5 are being rebilled, the system displays 1, 2, 3, 4, 5.

Field Explanations

BS (DISPLAY ONLY)
This field displays the current bill sequence number associated with the bill concatenated with the replaced bill sequence number. An example of this is: 4/2.

BT (DISPLAY ONLY)
This field displays the bill type code.

BILL DATE (DISPLAY ONLY)
This field displays the bill date.

BILL FROM (DISPLAY ONLY)
This field displays the bill from date.

BILL THRU (DISPLAY ONLY)
This field displays the bill through date.

BILL AMOUNT (DISPLAY ONLY)
This field displays the bill amount.

UNBILL CHG AMT/# (DISPLAY ONLY)
This field displays the total amount and number of unbilled charges associated with the bill.

UNBILL CR AMT/# (DISPLAY ONLY)
This field displays the total amount and number of unbilled credits associated with the bill.

After selecting the bill on the Cycle Adjustment Selection screen, the Single Bill Request Criteria screen must be completed.

2. REPRINT/ADJUSTMENT OF (TABLE LOOKUP)
This field determines which bill associated with this account is reprinted if you want to reprint a bill. If the Bill Type field contains **R**, the system displays a list of bills associated with this account. You make your selection from this list, and you can select multiple bills. If the Bill Type field contains **A**, the system displays the final bill.

3. BILL FROM DATE (DISPLAY ONLY)
This field contains the beginning billing date for the selected bill. If this account has been cycle billed, the system displays its previous cycle bill through date. If the account has not been cycle-billed, the admission or registration date is displayed. If this is a single reprint bill, the original bill from date is displayed. If multiple reprint bills have been selected, this field displays: *See Reprint/Adjustment of field.*

4. BILL THROUGH DATE (6-N-C)
This field contains the cutoff date for recording charges on this bill, entered in the format MMDDYY or MM/DD/YY. The default entry is the current system date. If the requested bill is a final, late, reprint, or adjustment bill, this field is completed by the system and cannot be edited. If multiple reprint bills have been selected, this field displays: *See Reprint/Adjustment of field.* If the requested bill is a cycle bill, you can complete this field.

5. CYCA CHG/CR/DYS OVERRIDE FOR SUBSEQUENT BILLS (1-A-O)
This field indicates whether the system, when producing subsequent cycle adjustment bills, should override the minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits, Min Unbilled Credit Amt, and CycA Max Days Since Service fields. 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 billing period, all billing periods following the one selected have to be rebilled in order for the selected bill to be processed. For example, if a manual cycle adjustment bill request is

made for a cycle adjustment bill via the Single Bill Request or Instant Adjustment Bill functions, new charge/credits are not added for subsequent cycle adjustment bills unless the criteria for the minimum number and amount for unbilled charges or credits and the CycA Max Days Since Service are satisfied for the billing event.

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

Override Min Chg/Cr/Dys for manual subsequent CycA bills? (Y)es or (N)o--

If you enter **Y** (Yes), the system overrides the 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 the constraint is removed for the subsequent adjustment bills and any new charge/credits are included. If you enter **N** (No), the system does not override those 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.

NOTE: If there are no charge/credit numbers/amounts indicated, and the Manual CycA Chg/Cr Override field isn't set to Yes, new charges/credits are not loaded for a subsequent cycle adjustment bill.

6.   PERFORM EDITS (1-A-C)
This field indicates whether edits are performed on this bill. Entry options are **Y** for Yes or **N** for No. This field must be completed when a final bill is requested. If you are requesting a cycle, reprint, or late bill, this field is completed by the system and cannot be edited.

Adjustment bills can be edited if the Edit Adj Bill field on the PAAR Control Maintenance screen is set to Yes. If an adjustment bill is requested automatically after a Change Patient Type After Final Bill (CPTAFB) transaction, the Perform Edits field defaults to Yes, according to the Edit Adjustment Bill and Edit Adjustment Bill for CPTAFB parameters on PAAR Control. This field can manually be defined for an adjustment bill, regardless of the settings on the PAAR Control Maintenance screen.

NOTE: Automatic adjustment bills due to late charges/credits or a change in DRG, diagnosis code, or procedure code, are not produced if an account is on CPTAFB hold. For a detailed explanation of removing a CPTAFB hold, refer to "Remove From Worklist" on page 2-34.

7.   REQUESTED BY (DISPLAY ONLY)
This field contains the name of the user requesting this single bill.

8.   COMMENT (30-C-O)
This field contains the comment associated with this single bill request. Generally this field is used to explain the reason for requesting a single bill. The system stores the comment in the biller's workfile and maintains it for display in the account's transaction history.

9. # OF COPIES OF BILLS TO PRINT (1-N-O)
This field contains the number of copies of a bill that you want to print. When this field is accessed, the following prompt is displayed:

Enter # of Copies of Bills to Print? [1]-- |

Valid entry options are 0 through 9; the default is 1. If you enter 0, the bill is loaded during Midnight Processing, but no copy of it is printed. The field displays either 1 Copy, X Copies, or None.

10. CYCA SUPPRESS SUBSEQUENT BILLS/ DO NOT LOAD CLMS (1-A-O)
This field indicates, for subsequent cycle adjustment bills, whether bills should be suppressed and claims not loaded if there are no new/qualifying charges for subsequent cycle adjustment bills. If a bill is suppressed because there are no new charges, the billing, proration, and reimbursement information is maintained, but the bill is not printed, and no claims are loaded for the bill. The default value in this field is populated by the value in the corresponding field on the Cycle Bill Parameters or Patient Bill Format. This field is valid only if the bill type is Z for Cycle Adjustment. When this field is accessed, the following prompt is displayed:

Suppress Subsequent Bill/ Do Not Load Clm for Cycle Adj if there are no new Charges? (Y)es, (N)o [N]

You can enter **Y** (Yes), suppress the bills and don't load claims for cycle adjustments, or **N** (No), don't suppress bills, and load claims. 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 a Y for Yes, Suppress subsequent bills and Don't Load claims for cycle adjustments is entered, the field displays *Yes*. If N for No is selected, the field displays *No*.

A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be rebilled in order for the selected bill to be processed. If there are new charges for the subsequent cycle adjustment bill that are eligible to be rebilled, the bill won't be suppressed, and claims are loaded. If there are new unbilled charges, but they don't qualify for the bill (for example, if they don't meet the minimum charge amount), the bill is suppressed and claims are not loaded, if this field is set to Yes.

11. PRODUCE CLAIMS? (1-A-R)
This field indicates whether the claim form should be produced, either electronically or as a printed claim. This field displays the insurance carrier/plan followed by the Produce Claim and Suppress indicators:

• The insurance carrier/plan code is displayed as follows: CBx stands for COB x, where the x is COB 1-9..

- When there is a value in x/x format, the x before the slash (/) represents the Produce Claim indicator. A *P* means Produce, and an *N* means do Not Produce. The x after the slash (/) represents the Suppress indicator. If the Produce indicator is *N* for Do Not Produce, the Suppress indicator is not displayed. If the Produce indicator is *P* for Produce, the Suppress indicator is displayed. An *N* means No Suppression, and an *S* means Suppress.

When this field is accessed, the system displays insurance plans for the account:

```
Page:01                      Account Insurance Plans         ##=Current Choices
( 1) COB 1-918100 NEW PLAN
( 2) COB 2-500200 1500 BASIC PLAN

Highlight all insurances that should load a claim or `-` to remove selection --
```

The following prompt is displayed on the screen:

Highlight insurances that should load claims or key N for Do Not Load Claims--
end select (NL)

The system displays the settings of the Produce Claim and Suppress Claim fields for each insurance selected.

COB 1 500999 GENERAL COMMERCIAL

Produce Claim is YES and Suppress Claim is NO. Override? (Y/N) [N]-- |

If you press ENTER, the settings are retained and copied to the claim. If you enter Yes, you can override the settings as follows:

- If the Produce Claim field is set to Yes, and it is updated to No, the system sets the Suppress field to Yes (since the system does not print the claim regardless of balance) and displays the following message:

    Produce Claim flag set to No and Suppress Claim flag set to Yes for Claim!

- If the Produce Claim field is set to No, and it is updated to Yes, the system displays the following message:

    Produce Claim flag set to Yes for Claim!

- If the Produce Claim flag is not updated, one of the following messages is displayed, depending on the setting of the current Produce Claim flag. Even if the current setting is not updated, if the Produce Claim flag is set to No at the insurance level, the Produce Claim flag is set to No, and the Suppress Claim flag is set to Yes for the claim.

    Produce Claim flag set to No and Suppress Claim flag set to Yes for Claim!

Produce Claim flag set to Yes for Claim!

One of the following prompts is displayed if the Produce Claim flag is Yes. The system displays the Suppress prompts only if the Produce Claim flag is set to Yes.

• Suppress Claim is Yes. Update for claim to No? (Y/N) [N]

Enter Y for Yes to update the Suppress Claim flag to No. The system displays the following message:

Suppress Claim flag set to No for Claim!

• If the Suppress Claim flag is No, the following prompt is displayed:

Suppress Claim is No. Update for claim to Yes? (Y/N) [N]

Enter Y for Yes to update the Suppress Claim flag to Yes.The following prompt is displayed:

Suppress Claim flag set to Yes for Claim!

• If the Suppress Claim flag is not updated for the claim, the system displays one of the following messages depending on the current setting of the field:

Suppress Claim flag set to No for Claim!

Suppress Claim flag set to Yes for Claim!

The system displays the Suppress Suppress prompts only if the Produce Claim flag is set to Yes.

NOTE: If the system determines the secondary insurance is an ASB/Crossover insurance, it sets this field to *Produce No, Suppress Yes*.

12. UB LOC 4 LAST DIGIT (1-N-R)
This field contains the last digit of the UB Locator 4. The default is 7 (Replace). You can access this field if the bill type is adjustment or cycle bill adjustment and the Produce Claims field is completed with Produce Claims or Suppress Claims. For each UB insurance loading a claim (this includes both primary and split UB claims), the system prompts for the type of bill. The following prompt is displayed if the bill type is Adjustment::

For plan 500700 load UB Locator 4 last digit of 1 (admit-disch), 4 (interim-last claim), (adj), 7 (replace), or 8 (void) for ALL claims [7] --

You can enter one of the following::

• 1 - Admit-Disch

- 4 - Interim - Last Claim

- 6 - Adjustment

- 7 - Replace

- 8 - Void

When requesting a cycle bill adjustment, all subsequent bills are also adjustment billed. Therefore, the system prompts for type of bill for the selected bill and the bills that come after. One of the following prompts is displayed, depending on the account location (AR or PA) and based on which cycle bill is selected to load the claim:

- If the account is in the AR file, and the first cycle bill is selected when requesting a Cycle Adjustment bill, the system prompts as follows:

   For plan 500100 load UB Locator 4 last digit for first cycle, interim cycles, and final (e.g., 2,3,4) of 1 (admit-disch), 2 (interim-first), 3 (interim- continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [2,3,4] -- |

   You can take the default 7, or enter the choices for the first cycle, continuing cycles, and the final, each separated by a comma.

- If the account is in the AR file, and the second or subsequent cycle bill is selected when requesting a Cycle Adjustment bill, the system prompts as follows:

   For plan 500100 load UB Locator 4 last digit for interim cycles and final (e.g., 3,4) of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [3,4] --

   You can take the default, or enter the choices for the continuing cycles and the final, separated by a comma.

- If the account is in the PA file, and the first cycle bill is selected when requesting a Cycle Adjustment bill, the system prompts as follows:

   For plan 500100 load UB Locator 4 last digit for first cycle and interim cycle (e.g., 2,3) of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [2,3] -- |

   You can take the default, or enter the choices for the first cycle and continuing cycles, separated by a comma.

- If the account is in the PA file, and the second or subsequent cycle bill is selected when requesting a Cycle Adjustment bill, the system displays the following prompt:

   For plan 500100 load UB Locator 4 last digit for interim cycles (e.g., 3) of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), or 8 (void) [3] -- |

You can can take the default, or enter the choice for the continuing cycles.

• If the account is in the PA file, and the last cycle bill is selected when requesting a Cycle Adjustment bill, the system displays the following prompt:

For plan 500100 load UB Locator 4 last digit of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last), 6 (adj), 7 (replace), 8 (void) [3] -- |

You can take the default, or enter the choice for the cycle bill selected.

STAR Patient Accounting does not actually delete or void a claim with the type of bill last digit of 8. This claim is treated as another claim for the payor. Pathways Contract Management processes claims with a type of bill last digit of 8 (Void) the same as a final claim.

13. 1500 TYPE OF BILL
This field allows you to select the type of bill that prints on the top of the 1500 and Non Pro Fee 1500 adjustment claim. This is used when adding a 1500 or Non Pro Fee 1500 once the account is already in AR.

The top of the 1500 and Non Pro Fee 1500 claim form can print the Account number, the COB of the insurance, the claim sequence, and the bill type of Cycle, Final, Adjustment, or Late. When using Instant Adjustment Bill, Single Bill Request, or Add Claim to Insurance to add a 1500 or Non Pro Fee 1500 adjustment claim, you can select the 1500 "type of bill" that prints on the top of the claim form. The default is Adjustment.

Note that in order for the 1500 or Non Pro Fee 1500 to print the type of bill on the top of the paper claim form, the Claim Load Edit Parameter assigned to the insurance must NOT have the field "Top Line Blank?" set to Yes. If set to Yes, the information will not print, regardless how the prompts are answered in Instant Adjustment Bill, Single Bill Request, or Add Claim to Insurance.

NOTE: The following only affect what is printed in the top of the claim in the print spoolfile, and what is sent to the Electronic Claim System. Changing the bill type that prints on the form does not change how the bill and claim appear when accessing Account Inquiry, Billing Information or Claim Information. In other words, if an Adjustment Bill is used or created in order to load a 1500/Non Pro Fee 1500 claim, and the user overrides the type of bill for the claim so that it prints FINAL on the top of the claim, the claim is still tied to the adjustment bill internally (and not to the Final), and will load the charges that were reflected on that adjustment bill.

If either an Adjustment (A) or Cycle Adjustment (CycA) is requested, then for each 1500 insurance (claim type B), or Non Pro Fee 1500 (claim type Z), the system will prompt as follows in the field (where xxxxxx is the carrier and plan code).

When the account has not cycle billed (where xxxxxx is the carrier and plan code), the prompt is:

For plan xxxxxx load 1500 type of bill of Cycle (C), Final (F), Adjustment (A), or Late (L)
[Adjustment] -- |

When requesting a Cycle Adjustment bill, where there are cycles and a final, the
prompt is:

For plan xxxxxx load 1500 type of bill of Cycle (C), Final (F), Adjustment (A), or Late (L)
(First response is for all cycle bills) [Cycle,Adjustment]-- |

The first response applies to all Cycle Adjustment claims loaded, and the last response
applies to the Final Adjustment claim. In other words, if the field was answered with C,F
and the account had three cycle bills and a final bill, the claims for the cycle adjustment
bills would all have CYCLE and the claim for the final adjustment bill would have
FINAL.

After answering the prompt for each 1500/Non Pro Fee 1500 insurance, the field will
display the one character alpha values, starting with the highest COB, and with a space
between the values for the different insurances. For example, if the field was answered
with Adjustment for COB 2, and with Final for COB 4, the field would display:

A F

If the field was answered with Cycle and Adjustment for COB 2, and Cycle and Final
for COB 4, the field would display:

CA CF

This value will print on the top of the 1500/Non Pro Fee 1500 claim form (in the Print
image only) as long as the Claim Load Edit Parameter for the insurance does not have
the "Top Line Blank?" field set to Yes on the header screen of the parameter. The
format of the top line has NOT changed. The system now simply allows the user to
override the system calculated value with a different value.

14. PCON SEND (1-A-R)
This field determines if primary UB claims whose reimbursement method is Pathways
Contract Management should be queued for processing at the time of claim load, claim
release or both claim load and claim release. When this field is accessed, the following
prompt is displayed:

Send PCON UB claims at (L)oad, (R)elease or (B)oth --

If you choose **L** (Load), claims are queued to be sent to Pathways Contract
Management at the time they are loaded. If you choose **R** (Release), claims are
queued to be sent to Pathways Contract Management at the time they are released on
STAR. If you choose **B** (Both), claims are queued to be sent to Pathways Contract
Management at the time they are loaded and at the time they are released. If this field
is blank, the system uses the values contained in the Pathways Contract Management
screen in the Reimbursement Master to determine when to queue claims to Pathways

Contract Management. For Bill Types of Cycle and Final, if the PCON Send field is blank, the system uses the value associated with the PCON Send for Cycle/Final field from the Pathways Contract Management screen in the Reimbursement Master. For Bill Types of Adjustment and Late, if the PCON Send field is blank, the system uses the value associated with the PCON Send for Adj/Late from the Pathways Contract Management screen in the Reimbursement Master.

After this screen is accepted, the single bill request is saved, and the system generates the bill during the next bill processing run. After the bill is processed, claims associated with it are loaded for editing. Reprinted bills do not generate any type of claim.

ADDITIONAL REQUESTS FOR SINGLE BILLS

Multiple reprint single bill requests can exist for an account, but only one cycle, adjustment, late, or final request on an account can be processed on a given day. After completion of the initial request for a single bill on an account, you can make additional requests for single bills. When placing a request, you can select multiple reprints from the table at the same time. After you select the account you want to request a bill for, the system checks to see if a single bill request already exists for the account. If there is an existing bill or reprint request, the system displays the following prompt:

> *Cancel pending request? Y/N [N]--*

To cancel the pending request and continue to submit your request, enter **Y**. The system displays:

> *Are you sure you want to cancel pending request? (Y/N) [N]--*

To confirm that you want to cancel the pending request and submit your request, enter **Y**. The system displays:

> *Request cancel, logged!*

This message tells you that the request has been cancelled and that the cancellation has been logged on the console printer. The system then displays:

> *Create new request for this account? (Y/N) [Y]--*

To exit from this function without requesting the bill, enter **N**. To submit a new request for a bill, enter **Y** or press ENTER to accept the default.

To exit without cancelling the pending request, enter **N** or press ENTER to accept the default. If the existing request is for a bill and not a reprint, the system displays the following prompt:

> *Create a reprint request for this account? (Y/N) [N]*

Enter **N**, or press ENTER, to return to the FPI Lookup prompt to select a new account. Enter **Y** to enter a bill request on the account.

If both a bill request and a reprint request exist, the system displays the following prompt:

Cancel bill request (B) or reprint bill request (R) [B]

Enter **B** to cancel the bill request. Enter **R** to cancel the reprint request. After you make your selection, the system displays the screen information for the request you have chosen to cancel and the following prompt:

Cancel pending request? Y/N [N]--

To cancel the pending request and continue to submit your request, enter **Y**. The system displays the following prompt:

Are you sure you want to cancel pending request? (Y/N) [N]--

To confirm that you want to cancel the pending request and submit your request, enter **Y**. The system displays:

Request cancel, logged!

This message tells you that the request has been cancelled and that the cancellation has been logged on the console printer. After you cancel this request, the screen information for the other pending request is displayed with the following prompt:

Cancel pending request? Y/N [N]--

To cancel this pending request also and to continue to submit your request, enter **Y**. The system displays the following prompt:

Are you sure you want to cancel pending request? (Y/N) [N]--

To confirm that you want to cancel the pending request and submit your request, enter **Y**. The system displays:

Request cancel, logged!

The system then displays the following prompt:

Create new request for this account? (Y/N) [Y]--

Enter **N,** or press ENTER, to return to the FPI Lookup prompt to select a new account. Enter **Y** to enter a bill request on the account. After you have had the opportunity to cancel any and all requests and have entered **Y** to enter a new request, the system displays the Single Bill Processor screen.

Bill Request for Accounts in Combine Billing

If a bill request is being processed for a charge from account for which combine billing has not completed, the charge to account is determined and combine billing is done for any charge from accounts for that charge to account if it was not done previously. If a bill request is being processed for a charge to account, then combine billing is done for any charge from accounts for that charge to account if it was not done previously. If charges are moved for Combine Billing, the following message is displayed for each pair of accounts processed in this function:

Uncombined charges are being moved now before creating the Inst Adj Bill!

Bill Request for Accounts in Bad Debt

If you attempt to request a single bill for an account that is in bad debt, the system displays the following error, and you are returned to the patient lookup prompt:

Invalid account for this function!

If the account has a bad debt pre-list status, the systems displays the following warning:

Account's pre-list status is XXXXXXXXXXXXX. Do you want to continue? Y/N [Y]

XXXXXXXXXXXXX is the actual pre-list status. Press **ENTER** to accept the default of **Y**. This allows you to continue with the single bill request. If you enter **N**, you are returned to the patient lookup prompt.

NOTE: A bill request can also be placed from Account Inquiry and Revision from the Flash Card screen. If an account is in Bad Debt (BD), the system displays the following error:

Account is in Bad Debt. Bill request not allowed.

You cannot place a bill request on an account in Bad Debt. If an account in Bad Debt needs to be billed, it must first be transferred back to Accounts Receivable (AR) in the function BD to AR Transfer.

If you log a single bill request and the system determines that a bill is required, your request overrides the system selection. For example, if an account has billing parameters requiring a late bill but you request an adjustment bill, the adjustment bill is generated.

DEMAND BILL

This function enables you to print an account's bill on demand. It does not rely on midnight processing but prints the bill immediately. A demand bill does not replace a final or cycle bill. It is simply a list of current charges and transaction activity. Demand bills are not edited, do not generate claims, and do not update the account's transaction history. You can request multiple copies of a bill.

A demand bill can be given to a patient upon discharge. A demand bill can be used as a receipt since posted payments are included on the bill.

After selecting Demand Bill, the system prompts you to select a facility (if this is a multi-facility installation), the patient name, and account for which a demand bill is generated. You can use the FPI lookup procedure to select an account. The following prompt is displayed if the patient's address is flagged as invalid:

Invalid Address exists. Do you want to continue? (Y/N) (N)--

If you enter **N** for No, the previous screen is displayed. If you enter **Y** for Yes, the Demand Bill Processor is displayed as shown below:

```
                   General Hospital Demand Bill Processor
                                          Mon Mar 27, 2006 10:40 am
Account       Name                  FC Typ Admit    Disch       Balance Loc
89243-00009  WILLIAMS,BECKY          C  I/P 08/31/96             180.00  PA/FCRV
 1 Last Bill Type          2 Bill From            3 Bill Through
   Cycle Bill                11/03/96               12/03/96
 4 Bill Balance            5 Total Charges Billed  6 Unbilled Amount
      0.00                   180.00                   0.00
 7 Print Detail Bill       8 Print Summary Bill    9 Print Prorated Bill
   5 Copies                  5 Copies                5 Copies
10 Print Series Bill   11 Prorate First  12 Charge Selection
   0                                      Total Charges
13 Charge Type         14 Bill Message Number




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

Field Explanations

1. LAST BILL TYPE (DISPLAY ONLY)
This field contains the type of any bill - final, cycle, adjustment, or late - prepared for this account before this demand bill was requested. If no bills have been produced, this field is blank. If the patient has received multiple bills, the most recent bill type is displayed.

2.   BILL FROM (DISPLAY ONLY)
This field contains the beginning date for charges and credits on the last bill (indicated by the entry in the Last Bill Type field). If no bill has been produced, the admission/ registration date is displayed.

3.   BILL TO (DISPLAY ONLY)
This field contains the cutoff date for charges and credits on the last bill (indicated by the entry in the Last Bill Type field). If no bill has been produced, the discharge date is displayed.

4.   BILL BALANCE (DISPLAY ONLY)
This field contains the total amount billed on the last bill (indicated by the entry in the Last Bill Type field). If no bill has been produced, the account balance is displayed.

5.   TOTAL BILLED AMOUNT (DISPLAY ONLY)
This field contains the total charges already billed to this account on previous bills.

6.   UNBILLED AMOUNT (DISPLAY ONLY)
This field contains the amount of charges and credits that have not yet been billed to this account. These charges could include late charges or current charges not included on a previous cycle bill. If no bills have been generated for this account, all charges for this account are reflected.

7.   PRINT DETAIL BILL (1-N-R)
This field indicates the number of copies of a detail bill that should be printed for this demand bill request. Entry options are 0 through 9. The default is 0. For this type of bill, selected detail charges are printed and the Charge Selection field defaults to Total Charges. They are sorted according to the criteria established in the Bill Format options.

8.   PRINT SUMMARY BILL (1-N-R)
This field indicates the number of copies of a summary bill that should be printed for this demand bill request. Entry options are 0 through 9; the default is 0. For this type of bill, a summary of each category of charges is printed. Summarization is defined in the Bill Format options.

9.   PRINT PRORATED BILL (1-A-R)
This field indicates the number of copies of a prorated bill that should be printed for this demand bill request. Entry options are 0 through 9; the default is 0. For this type of bill, a summary bill with insurance coverage and information is printed.

10. PRINT SERIES BILL (1-A-R)
This field indicates the number of copies of a series bill that should be printed for this demand bill request. Entry options are 0 through 9; the default is 0. If you print this type of bill, the system does not allow you to edit the Charge Selection field, because the series bill is a cumulative bill.

NOTE: You can select a detail, summary, prorated and/or a series demand bill, or any combination of the four for each request.

11. PRORATE FIRST (1-A-R)

This field indicates whether proration should be initiated and viewed before this demand bill is printed. Entry options are **Y** for Yes or **N** for No; the default is **Y**. If a prorated portion of the bill is requested, it is suggested that this field contain **Y** for Yes.

If you enter **Y**, the system prorates the account and then displays the Balance Summary screen before printing the bill. Please refer to Proration and Requesting On-line Proration located in this section for a detailed explanation of the Balance Summary screen.

12. CHARGE SELECTION (1-A-R)

This field indicates which charges should be printed on this demand bill. Entry options are **A** (all), **U** (unbilled), **T** (total), **R** (range of dates), or **P** (previous bill). If you enter **A**, all detail charges are listed regardless of whether or not they have been billed or unbilled are excluded. If you enter **U**, only the charges incurred since the last bill are listed. Previously billed charges are totalled with the heading *Previously Billed Charges* at the top of the bill. If you enter **T**, a one-line summary of total charges and credits is listed and no detail charges print.

If you enter **R**, you are then prompted for a range of dates to include. Also, if you enter **R**, you can only have detailed bill information (and not summary or prorated) and the system prompts you to enter a range of dates that are included on this bill. The demand bill includes only the charges with a service date that falls within the selected range of dates. You have the option to use the system defaults for the dates, which are earliest to latest dates. If you enter **R** (range of dates), the system issues a warning message informing you that you can only have a detailed bill with the range of dates option. Fields 8, 9, and 10 are changed to No.

If you enter **P**, you are prompted to select a previous bill to print immediately from the list of previously generated bills. If no previous bills exist, the message *"No previous bills for this account"* is displayed. You can select multiple bills, which print separately. If a charge appeared on multiple bills (for example, on a final bill and subsequently on an adjustment bill), the charge prints only on the most recent (the adjustment) bill and does not print on replaced bills.

13. CHARGE TYPE (1-A-R)

This field allows you to identify the type of charges to print on the demand bill. When you access this field, the system displays the following prompt:

> *Include (A)ll charges or only (L)ate charges on the demand bill? [All]*

The default is **All**. This field is not accessible if the Charge Selection entry is Total. If the Charge Type is Late, then the Print Summary Bill field and the Print Prorated Bill field are set to No. Only the Detail Bill can be produced when the Charge type is Late.

14. BILL MESSAGE NUMBER (2-N-O)

This field contains the message that is printed on this demand bill. You can enter the message code or a hyphen (-) to display a list of valid codes. A selected message is

printed on the detail and summary bill but not on the prorated bill. A bill message does not have to be included on the bill.

When you complete these fields, the system prompts you to accept or edit the information entered here. If you indicated that the system should prorate the account prior to printing the bill, the system displays the prorated account for review. Press ENTER after reviewing the information.

After you accept the screen or review the prorated account, the system displays a table of printers on which you can produce the bill. The printer(s) available from this table depend on the setting of the Demand Bill Printer field on the CRT table for the CRT that entered the request and the printer(s) linked to the Demand Bill report (FBR901). Enter the option number of the printer on which you want the bill to print. The system then begins to compile and print the bill on the selected printer.

TRANSFER BILLER WORK - BILLS

This function enables billing supervisors to transfer accounts between billers. Supervisors can only transfer work between billers in their groups while managers can transfer work between all billers to whom they have access.

You can transfer all biller work or selected accounts from one biller to another. If you transfer biller work, the system changes the biller assigned to the account to be the biller to whom the work was transferred.

After you select Transfer Biller Work - Bills, the system displays this screen:

```
                General Hospital Transfer Biller Work - Bills Processor
                                                Thurs Apr 4, 2002 10:25 am

 1 Transfer From                    2 Transfer To
   Baker,Edward                       Young,Myrtle
 3 Bills with Errors?               4 Bills Without Errors?
   Yes                                Yes
 5 Accounts to Transfer
   All







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

Field Explanations

1. TRANSFER FROM (3-N-R)
This field contains the code representing the biller from whom the accounts are being transferred. You can enter the code or a hyphen (-) to display a list of valid biller names and codes.

2. TRANSFER TO (3-N-R)
This field contains the code representing the biller to whom the accounts are being transferred. You can enter the code or a hyphen (-) to display a list of valid biller names and codes.

3. BILLS WITH ERRORS (1-A-R)
This field indicates whether bills in the biller workfile that have failed edits should be transferred. Entry options are **Y** for Yes or **N** for No; the default is **Y**.

4. BILLS W/O ERRORS (1-A-R)
This field indicates whether bills in the biller workfile that have passed edits should be transferred. Entry options are **Y** for Yes or **N** for No; the default is **Y**.

5. ACCOUNTS TO TRANSFER (1-A-R)

This field indicates the accounts that should be transferred. Entry options are **A** (all) or **S** (selected). If you enter **A**, all accounts meeting the selection criteria are transferred. If you enter **S**, the system displays the list of the transfer-from biller's accounts meeting the selection criteria in the following format:

```
Page:01                                              ##=Current Choices
      Bill Date Acct Number    Patient Name          Type  Status
( 1) 05/25/95  88146-00026     Anderson,Walter       Bill  Passed
( 2) 05/25/95  88126-73973     Applegate,Philip      Bill  Passed
( 3) 05/26/95  88187-03830     Bolton,Roger L        Bill  Passed
( 4) 05/26/95  88124-52473     Romanowski,Jan        Bill  Passed
```

You can select accounts to transfer. These accounts are displayed in reverse video.

When you finish editing this screen, press ENTER and select Yes to accept the screen. The transfer occurs immediately and the system returns to the previous menu.

TRANSFER BILLER WORK - CLAIMS

This function enables claim work types to be transferred from one biller to another. You can transfer all claims or selected claims from one biller to another. When claims are transferred, the system changes the biller assigned to the claim to the biller to whom the work was transferred. The new biller's code is updated in the detail claim record and in the biller work list data for the type being transferred. Transaction history reflects the change in billers. The Claim Work Transfer Report (FCRCWTA) is generated to identify accounts whose claims were selected. A summary section of the report identifies the selection criteria.

After you select Transfer Biller Work - Claims, the system displays the following screen:

```
           General Hospital Transfer Biller Work - Claims Processor
                                           Thu Apr 04, 2002 03:17 pm

 1 Transfer From                   2 Transfer To
-> 55                                1
 3 Claims With Errors?             4 Claims Without Errors?
   Yes                               Yes

 5 Claims Generated Not Submitted? 6 Claims Submitted?
   Yes                               Yes
 7 Update Claim Statistics?        8 Carriers
   Yes                               01-AETNA
 9 Starting Date                  10 Ending Date
   01/01/02                          04/30/02
11 Starting Name Range            12 Ending Name Range
   A

13 Accounts to Transfer
   A




 Enter biller code to transfer From --
```

Field Explanations

1. TRANSFER FROM (3-N-R)
This field contains the code representing the biller from whom the claims are being transferred.

When you access this field, the following prompt is displayed:

Enter biller code to transfer From - -

You can enter the code or a hyphen (-) to display a list of valid biller names and codes.

2.   TRANSFER TO (3-N-R)
This field contains the code representing the biller to whom the claims are being transferred.

When you access this field, the following prompt is displayed:

Enter biller code to transfer To - -

You can enter the code or a hyphen (-) to display a list of valid biller names and codes.

3.   CLAIMS WITH ERRORS (1-A-R)
This field indicates whether claims in the biller workfile that have failed edits should be transferred.

When you access this field, the following prompt is displayed:

Transfer claims with errors? (Y/N) [Y]--

Entry options are **Y** for Yes or **N** for No; the default is **Y**.

4.   CLAIMS W/O ERRORS (1-A-R)
This field indicates whether claims in the biller workfile that have passed edits should be transferred.

When you access this field, the following prompt is displayed:

Transfer claims without errors? (Y/N) [Y]--

Entry options are **Y** for Yes or **N** for No; the default is **Y**.

5.   CLAIMS GENERATED NOT SUBMITTED? (1-A-R)
This field indicates whether claims in the biller workfile that have been generated but not yet submitted should be transferred.

When you access this field, the following prompt is displayed:

Transfer claims generated but not submitted? (Y/N) [Y]--

Entry options are **Y** for Yes or **N** for No; the default is **Y**.

6.   CLAIMS SUBMITTED? (1-A-R)
This field indicates whether claims in the biller work file that have been submitted should be transferred.

When you access this field, the following prompt is displayed:

Transfer claims submitted? (Y/N) [Y]--

Entry options are **Y** for Yes or **N** for No; the default is **Y**.

7. UPDATE CLAIM STATISTICS? (1-A-R)
This field indicates whether biller statistics should be updated to reflect the claim work file type transfers.

8. CARRIERS (TABLE LOOKUP)
This field allows for the selection of specific insurance carriers.   When this field is accessed, a list of insurance carriers and codes is displayed. You can select one or more carriers from the list. Active and inactive carriers are displayed for selection. For shared claims, the first carrier (first COB) will be used. If the field is left blank, no carriers are transferred.   The maximum number of carriers which can be selected at a time is dependent on the length of the carrier code (2, 3, or 4). A maximum of 35 characters can be selected inclusive of the comma (,) delimiter.

9. STARTING DATE (DATE-O)
This field allows you to specify the starting date to transfer, in MMDDYY format. The date used is the discharge date, if present. If the discharge date is not present, the cycle bill through date is used. When this field is accessed, the following prompt is displayed:

Enter the starting discharge/cycle bill through date--

If you do not enter a date, accounts with any discharge or cycle bill through date are selected.

10. ENDING DATE (DATE-O)
This field allows you to specify the ending date to transfer, in MMDDYY format. If you do not enter a date, accounts are transferred up through the current day's date.

The date used is the discharge date, if present. If the discharge date is not present, the cycle bill through date is used. When this field is accessed, the following prompt is displayed:

Enter the ending discharge/cycle bill through date--

11. STARTING NAME RANGE (3-A-O)
This field allows you to select the beginning alphabetic range for the last names of accounts to be transferred. Enter up to three letters.

12. ENDING NAME RANGE (3-A-O)
This field allows you to select the ending alphabetic range for the last names of accounts to be transferred. Enter up to three letters. The letters must follow the letters entered in the **Starting Name Range** field.

13. ACCOUNTS TO TRANSFER (1-A-R)
This field indicates the accounts that should be transferred. Entry options are **A** (all) or **S** (selected). If you enter **A**, all claims meeting the selection criteria are transferred. If you

enter **S**, the system displays the list of the transfer-from biller's claims meeting the selection criteria in the following format:

```
Page:01                                              ##=Current Choices
      Bill Date Acct Number    Patient Name          Status
( 1) 05/25/95  88146-00026     Anderson,Walter       Passed
( 2) 05/25/95  88126-73973     Applegate,Philip      Passed
( 3) 05/26/95  88187-03830     Bolton,Roger L        Passed
( 4) 05/26/95  88124-52473     Romanowski,Jan        Passed
```

You can select accounts to transfer. These accounts are displayed in reverse video.

When you finish editing this screen, press ENTER and select Yes to accept the screen. The transfer occurs immediately and the system returns to the previous menu.

COMBINE BILLS

The Combine Bills functionality enables the facility to comply with federal regulations, combining charges for accounts created one after the other (such as when a patient has two emergency room visits in the same day) and combining charges from a baby's account to the mother's account. Multiple charge from accounts may be linked to a charge to account to accommodate multiple births that are combined to the mother. Also, a date range of charges may be specified to allow selected charges from a cycle billed account to be combined to another visit.

The Combine Bills function enables you to establish and remove a charge to/from link between accounts. This link causes the system to transfer charges from one account into another account during Midnight processing, effectively combining the two accounts. The charges for all accounts set to combine bill using the Combine Bill processor or Charge From/To logic, are moved from the From Account(s) to the To Account in Midnight Processing on the day that the combine bill link is created.

Accounts are available to be combined if:

- The accounts are in the same facility, if this is a multi-facility installation. You *cannot* combine accounts from different facilities.

- The accounts are in location PA or AR.

- The account is not a contract patient type.

- The account is not cycle billed by Service Date.

If a bill request is being processed in Midnight Processing for a charge from account for which combine billing has not completed, the charge to account is determined and combine billing is done for any charge from accounts for that charge to account if it was not done previously. If a bill request is being processed in Midnight processing for a charge to account, combine billing is done for any charge from accounts for that charge to account if it was not done previously. Note that this logic is done in billing even if the bill request is for bill edits only.

When combine billing is complete on a PA account, the charge from account can have a zero balance. Two parameters found under the Billing Parameters table can be used to bill zero charge accounts without awaiting bill edits. These fields are the Zero Charge Rpt Days and the Zero Chg Bill Days fields.

If a charge from account is in AR and a charge moving from the charge from account to the charge to account in Combine Billing causes the account balance to be zero, a bill request is made for an adjustment bill and the request includes asking that claims be loaded.

NOTE: No bill requests are placed for cycle adjustment accounts, so bill requests may need to be created manually for cycle adjustment bills.

Internal elements for combine billing can be used as bill requirements to hold Combine To accounts for Medical Records information and to hold Combine To accounts if the associated Combine From Account is on Bill Hold. The addition of new internal elements for combine billing provides a flexible solution which allows hospitals to determine when a Combine To account should be prevented from billing and if specified data has been collected for all of the Charge From Accounts for a Charge To Account.

These internal elements can be added to the Billing Requirements table. For details on the Billing Requirements table, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Patient Accouning Reference Guide*. The internal elements are as follows:

The following five internal elements and the five with "from edit logic" are Medical Record related for combine billing:

COMB BILL ABSTRACT COMPLETE DATE

COMB BILL HCPCS CODE 1

COMB BILL PRINCIPAL DIAG

COMB BILL PRINCIPAL DIAG (MR/ADM)

COMB BILL PRINCIPAL PROCEDURE

The following five are also Medical Record related except they have some additional logic which also edits for a specific bill requirement being present on the billing requirements for the from account.

COMB BILL ABS COMP DT W/FR EDIT

COMB BILL HCPCS CODE 1 W/FR EDIT

 COMB BILL PRIN DX W/FR EDIT

 COMB BILL PRIN DX (MR/ADM) W/FR EDIT

COMB BILL PRIN PROC W/FR EDIT

The following is related to Bill Hold for combine billing:

COMB BILL NO BILL HOLD

The criteria in the internal elements are utilized for Charge To Accounts only, meaning missing information on Charge From Accounts is noted for the Charge To Account. The messages resulting from these billing requirements appear in the biller workfile, on the billing reports FBR210 and FBR220 and on the Combine Bill Edit and Cross

Facility Combine Bill Edit reports (FBR293/298). The bill edits for Combine Billing can be organized into a separate section of FBR220 by creating a new Data Control Code and selecting it for Controlled By field in the Billing Requirements screen. On the FBR210, FBR220 and the billerworkfile, the system will list the Combine To account and the associated edit that it failed. The system won't list the associated Combine From Accounts that are related to the Combine To Account that failed the edit on the FBR210, FBR220 or the biller workfile. The FBR210 and FBR220 reports weren't updated to display associated Combine From accounts for a Combine To account because many hospitals have processes where they pull information from these reports and if these reports were updated then any associated script would have had to have been updated. If a Combine To account is failing a billing requirement and it appears on the FBR210 and FBR220 then it will also appear on the FBR293/FBR298. The Combine Bill Edits report (FBR293/298) lists the Combine To account that is failing a bill requirement and it will list all of the related Combine From accounts. If the bill requirement that the Bill To account is failing is one of the new combine bill requirements then the specific edit message will display under the associated From account that meets the condition for the bill requirement. For details on these reports, refer to the *Reports Volume* of the *STAR Patient Accouning Reference Guide*.

Establishing a Request

When you access this function, the system prompts you to select a facility, if this is a multi-facility installation. The system then prompts you for the account *from which* charges will be transferred.

NOTE: If you are combining mother and baby accounts, the baby's account should be the *from* account. As such, identify the baby's account at this prompt.

After the initial entry of an account number, if the account's cycle billing parameter has the Cycle Bill Selection Method set to **S** (Service Date), the following error message is displayed:

   Error: 'Service Date' billing parameter - function not allowed!

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

```
                    General Hospital Combine Bills Processor
                                              Mon Mar 27, 2006 10:40 am
 Account       Name                    FC Typ Admit    Disch       Balance Loc
 A9700700003  JONES,BABY 2 BOY          B  NEW 01/07/97 01/08/97     0.00   AR/FCRV
  1 Charge To                                 2 Mother Baby Combination
    9700700001 JONES,MOM                        Yes
  3 Service From Date                     4 Service Through Date
    Earliest                               Latest
  5 Combine Bill Status
    Pending
  6 Last Edit By/Date/System
    Smith,Laura M 03/11/97 1155 (Patient Accounting)




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

At the top of the screen, the system displays the following information about the account from which charges are to be transferred: account number, account name, financial class, patient type, admission date, discharge date, account balance, and account location/sub location.

Field Explanations

1. CHARGE TO (10-AN-R)
This field determines the account number to which all charges will be transferred. You can use standard patient lookup techniques to identify this account in this field.

If you access this field after a charge to account has been entered, the following prompt is displayed:

Do you wish to unlink accounts (Y/N) [N]--

To unlink the accounts, enter **Y** for Yes. To leave the charge to link intact, enter **N** for No.

If the Combined Bill Status is Pending/Charges Transferred, the following prompt is displayed:

Do you wish to uncombine the charges (Y/N)—

If you do not want to uncombine the charges, enter **N** for No. If you want to uncombine the charges, enter **Y** for Yes. After you enter **Y**, the following prompts is displayed:

Enter beginning date for uncombining charges [earliest] –

Enter ending date for uncombining charges [latest] –

Enter the beginning and ending dates to be used for uncombining the charges. Select the defaults (earliest and latest) to uncombine all the charges on the accounts. Once the dates are entered the following prompt is displayed:

Are you sure you want to uncombine charges from MM/DD/YY thru MM/DD/YY for accounts A9999999999 and A9999999999? (Y/N) –

The MM/DD/YY can contain a specific date that you entered or the terms earliest to latest. The A9999999999 indicates the account numbers.

To leave the charges intact, enter **N** for No. To uncombine the charges for these dates, enter **Y** for Yes.

2. MOTHER/BABY COMBINATION (1-A-R)
This field identifies whether this account is being combined to place charges for a mother and baby into the same account. Enter **Y** to indicate that charges for these accounts are being combined into a mother/baby account. Your facility's print bill program should mark the charges appropriately. When you generate bills, the system marks the *from* charges as the baby charges on the bill. If this account is not being combined to place charges for a mother and baby into the same account, enter **N** or press ENTER to accept the default. If the identified accounts have been combined previously, the system displays the values entered when the link was created.

3. SERVICE FROM DATE (1-A-R)
This field allows the entry of a service from date to designate a date range of charges to be transferred to the to account. After accessing this field, the following prompt is displayed:

Service from date [Earliest]

Enter the Earliest Service Date for charges to be transferred to the to account. Valid values include any past or current date. Enter **T** for today and **T-#** for past dates. The default is Earliest.

4. SERVICE THROUGH DATE (1-A-R)
This field allows the entry of a service through date to designate a date range of charges to be transferred to the to account. After accessing this field, the following prompt is displayed:

Service through date [Latest]

Enter the Latest Service Date for charges to be transferred to the To account. Valid values include any past or current date. Enter **T** for today and **T-#** for past dates. The default is [Latest] which handles future charges entered on the From account.

5. COMBINE BILL STATUS (DISPLAY ONLY)
The date the combine bill request was completed during midnight processing. This field displays *pending* if the request has been established and has not been completed. This

field displays *pending/chgs transferred* to indicate that the request has been established, has not been completed (the account has not been billed) and there are charges existing on the TO account which originated from the FROM account. If this field contains *pending* or *pending/chgs transferred* and you attempt to unlink the accounts, the system prompts you to uncombine the charges.

6.   LAST EDIT BY/DATE/SYSTEM (DISPLAY ONLY)
The name of the person and the date, time and system of the last edit on this charge from/to link. The system may be either Patient Accounting or Patient Care.

When you complete the fields, the system asks you to accept your changes. When you accept your changes, the system creates the combine billing link between the identified accounts. Once the link is established, all new charges entered on the from account are immediately placed on the to account and do not appear on the from account in Patient Accounting. If you view charges in STAR Patient Care, they still display on the individual account. Charges placed before the link was created remain on the from account until bills are generated, when they are transferred to the to account. Daily Activity Journals between the STAR Patient Care system and the STAR Financials Patient Accounting system have the same overall totals, but patient totals may vary due to the charge to/from links. Charges are only combined on the Patient Accounting system.

Activity from linking and billing accounts using this function is displayed on the Combined Billing report (FBR290). For more information about this report, refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide*.

After the screen is accepted, the system displays the Combine Bill Status screen.

Combine Bill Status

The Combine Bill Status screen within the Combine Bills function provides a summary of all accounts that are linked to the Charge to Account. The Charge to Account is listed first, followed by the Charge From Account(s). The account number, patient name, patient type, admit date, discharge date, current account balance, account location/sub location, and the current billing status and date display for each account. The mother baby indicator, service from date, service through date, and combined status display for each Charge From Account. Combine bill requests may be added and deleted on this screen and single bill requests may be initiated for the displayed accounts.

If the account number entered is for a Charge From Account or an unlinked account, the Combine Bill Request screen initially is displayed. After the Combine Bill Request screen is completed and accepted, the Combine Bill Status screen is displayed.

```
              General Hospital Combine Bills Processor
                                         Mon Mar 27, 2006 10:40 am
Account       Name                  FC Typ Admit    Disch    Balance    Loc
A03066-00006 ADAMS,BOB              S  I/P 03/07/03           156174.76 PA/FCRV

     Acct Number   Patient Name        Type  Admit    Disch    Balance    Loc
      Billing Status             Date  M/B  Svc From Svc Thru    Combined Sts

To   A0306600006   ADAMS,BOB           I/P  03/07/03           $156,174.26PA
      Cycle                     05/07/03

1    A0115500002   ADAMS, TINA         OPS  06/04/01 06/04/01 -$30,869.83 AR
      Adjustment                05/21/03 No  Earliest Latest        Pending


Request bill(B), add account(A), delete account(D), remove all links(R),
    preview comb med info(P), use adm dx's in preview(U), or [NL] to exit --
```

Field Explanations

TO/FROM INDICATOR
This field displays To for the Charge To Account, and a sequence number for each Charge From Account. There is no limit to the number of Charge From Accounts on the request.

ACCOUNT NUMBER
This field displays the patient's account number.

PATIENT NAME
This field displays the patient's name.

TYPE
This field displays the patient's patient type code.

ADMIT
This field displays the patient's admission date.

DISCH
This field displays the patient's discharge date.

BALANCE
This field displays the patient's current account balance.

LOC
This field displays the patient's account location.

BILLING STATUS DATE
This field displays the billing status and date that can be viewed in Account Inquiry / Billing Information. This field remains blank if there is no billing status. If the Account has been previously billed, it displays the last bill type and last bill date. For example:

Adjustment Bill Requested 3/11/97.

M/B
This field displays the Mother/Baby Combination indicator and displays either Yes or No. This field does not display for the Charge To Account.

SVC FROM
This field displays the service from date as entered on the Combine Bill Request screen. This field does not display for the Charge To Account.

SVC THRU
This field displays the charge service through date as entered on the Combine Bill Request screen. This field does not display for the to account.

COMBINED STS
The date the combine bill request was completed during midnight processing. This field displays *pending* if the request has been established and has not been completed. This field displays *pending/chgs transferred* to indicate that the request has been established, has not been completed (the account has not been billed) and there are charges existing on the TO account which originated from the FROM account. If this field contains *pending* or *pending/chgs transferred* and you attempt to unlink the accounts, the system prompts you to uncombine the charges.

If the request has been processed, Completed on is displayed along with the date the request was processed.

If the combined billing request includes more than three Charge From Accounts, you can use F1 to view the Previous Page, F2 to view the next page, or F7 to exit.

The following prompt is displayed on the screen:

   Request bill(B), add account(A), delete account(D), remove all links(R),

      preview comb med info(P), use adm dx's in preview (U), or [NL] to exit --

Entry options are as follows:

• **B** (Request a bill)

• **A** (Add Account)

• **D** (Delete Account)

• **R** (Remove all links)

• **P** (Preview combined medical info)

• **U** (Use Admission diagnoses in preview)

- **ENTER** (Exit the screen)

Each of these options is discussed in the following pages.

Requesting a Bill from the Combine Bill Status Screen

Enter **B** to request a bill on the charge to account or any of the Charge From Accounts. After you enter **B**, the following prompt is displayed:

Select an account. Enter From#, To (T)o or All (A) -- |

Enter the system assigned number next to the Charge From Account as displayed on the Combined Bill Status screen or a **T** for the charge to account or **A** to initiate or review a single bill request for each linked account. After you select an account that is displayed on the Combined Bill Status screen, the system then displays the Single Bill request screen and allows you to place a single bill request on the account. If you select A for all, the system cycles through all of the accounts, displaying the Single Bill request screen for each account.

If you request a rebill of a cycle bill on an account which has unbilled charges or credits qualifying for an existing cycle bill, one of the following warning messages is displayed:

Unbilled cycle charges exist. Press ENTER.

Unbilled cycle credits exist. Press ENTER.

One of the following error messages may be displayed if you request a rebill of a cycle bill on an account with unbilled charges or credits qualifying for an existing bill:

Cycle Adjustment Parameters don't exist

Cycle Adjustment parameters no longer exist for this account. Therefore a Cycle Adjustment Bill cannot be processed. Press Enter.

After you accept this screen, the single bill request is logged. During Midnight Processing, the request is evaluated, and if all other linked accounts have bill requests, the designated charges transfer and the linked accounts bill. You may also cancel a pending bill request. The results of the combine bill request appear on the Combined Billing report, FBR290, following Midnight Processing.

NOTE: In order to move the Final Billed charges, plus any late charges on the From account, an Adjustment Bill must be requested. If a Late Bill is requested, only the unbilled late charges are moved from the From account to the To account.

Adding an Account to a Combine Bill Request

Enter **A** to add another Charge From Account. When you enter **A**, the financial patient look-up prompt is displayed and allows you to select an account. The same edits apply to the account selection here as in the initial entry of the Combine Bill function. When you enter an account number, if the account's cycle billing parameter has the Cycle Bill Selection Method set to **S** (Service Date), the following error message is displayed:

Error: 'Service Date' billing parameter - function not allowed!

After an account has been selected, the Combine Bill Request screen is displayed for entry of fields 2 through 4.

After you accept this screen, a new Charge From Account is added to the combine bill request and the charge from/to link is established for the specified date range. The results of the combine bill request appear on the Combined Billing report, FBR290, following midnight processing.

Deleting One Account from a Combine Bill Request

Enter **D** to delete one of the charge from accounts so that it no longer is linked to the charge to account. The following prompt is displayed:

Enter From # -- |

Enter the system assigned number next to the charge from account as displayed on the Combined Bill Status screen.

If the combined bill status is Pending, no changes to current processing occurs. If the combined bill status is Complete or Pending/Charges Transferred, the following prompt is displayed:

Selecting the "Delete Account" option will cancel the Combine Bill link and move charges immediately back to the originating account. Are you sure you want to delete XX from the combine bill request? (Y/N) --

If you do not want to uncombine the charges, enter **N** for No. If you want to uncombine the charges, enter **Y** for Yes. After you enter **Y**, the following prompts are displayed:

Enter beginning date for uncombining charges [earliest] –

Enter ending date for uncombining charges [latest] –

Enter the beginning and ending dates to be used for uncombining the charges. Select the defaults (earliest and latest) to uncombine all the charges on the accounts. Once the dates are entered the following prompt is displayed:

Are you sure you want to uncombine charges from MM/DD/YY thru MM/DD/YY for accounts A9999999999 and A9999999999? (Y/N) --

The MM/DD/YY can contain a specific date that you entered or the terms earliest to latest. The A9999999999 indicates the account numbers.

To leave the charges intake, enter **N** for No. To uncombine the charges specified and unlink the accounts, enter **Y** for Yes. The following prompt is displayed with either a **Y** or **N** response:

Are you sure you want to delete #A9999999999 from the combine bill request? (Y/N) -- |

Enter **Y** for Yes to remove the charge to/from link and remove the account from the screen. Enter **N** for No to leave the link and the account intact. In addition if you choose to uncombine charges, the charges are immediately transfer back to the account the charge was originally placed. The charges are credited off of the TO account and placed back on the FROM account. The following prompt is displayed with either a **Y** or **N** response:

Do you want to add a bill request? (Y/N) [N] --

Enter **Y** for Yes to add a bill request. The \request screen is displayed. Enter **N** for No to not add a bill request. The following prompt is displayed:

Request bill(B), add account(A), delete account(D), remove all links(R),
[NL] to exit --

If only one charge from account is present, then removing the link for the one account cancels the combine bill request. If the request is canceled as a result of deleting the only charge from account on the request, the following message is displayed:

Combine bill request canceled.

If at least one from account remains on the request, the Combine Bill Status screen is displayed showing the remaining accounts linked to the to account. If the last from account is deleted from the request, exit the function and you are returned to the patient look-up prompt.

If the accounts remain linked to the to account, the combine bill request is processed during midnight processing. If the request was canceled as the result of deleting the last from account from the request, then the charge to/from link is removed and the accounts are not combined during billing.

After you accept this screen, the results of the combine bill request appear on the Combined Billing report, FBR290, following midnight processing. If the request was cancelled, the accounts do not appear on the Combined Billing report.

Removing All Links on a Combine Bill Request

NOTE: You can also remove one charge to/from link on a Combine Bill Request. For details, see .

Enter **R** to remove all charge to/from links on the Combine Bill request.

After you enter **R**, the following prompt is displayed:

Selecting the "Remove all links" option will remove the Combine bill link but leave the charges as combined.Are you sure you want to remove all links and cancel the combine bill request? (Y/N) --

Enter **N** for No to leave all links intact. If you enter **Y** for Yes and if the combined bill status is Pending/Charges Transferred or Complete, then the following prompt is displayed:

If you want to uncombine charges, please use the Delete Account function.
Do you want to continue? (Y/N)

Enter **Y** for yes to remove all charge to/from links without uncombining the charges. This cancels the combine bill request. The following message is displayed:

Combine bill request canceled.

When the request is canceled, the system displays the above prompt and returns you to the patient look-up prompt.

All charge to/from links between accounts are removed. The accounts are not combined for billing during midnight processing if they have not already been combined. Transferred charges by either the charge to/from link or combined billing are not returned to the charge from account.

The results of the combine bill request will not appear on the Combined Bill report FBR290, following midnight processing.

Enter **N** for No to return to the following prompt:

Request bill (B), add account(A), delete account(D), remove all links(R),
        [NL] to exit--

The only time you are able to uncombine the charges is when you unlink the accounts. However, if after the accounts are unlinked and you decide that the charges need to be uncombined, you can link the accounts again. When you unlink the accounts using the Delete Account function, you can then uncombine the charges.

Previewing Combined Medical Information

Enter **P** to preview combined medical information for linked charges. The preview screen does not access the TO account's UB Claim Load Edit Parameter to determine if diagnoses, procedure, and HCPCS information from a FROM account is used on the TO account's claim. The diagnosis information for the charge TO account does not include any diagnoses from charge information and the procedures are not limited by date. The preview screen shows the Medical Record diagnoses, procedure, and HCPCS information that could be used on the TO account's claim if the UB Claim Load Edit Parameter has the following fields set to Diagnoses, Procedures, Both Diagnosis and Procedures, HCPCS, or All::

- Combine Bill Med Info

- DPW Med Info

Charge level diagnoses are not displayed.

NOTE: If the inpatient or outpatient account in the DPW pair was transferred to another patient, the only option which can be used is Deactivate DPW. If you try to select the Preview Combined Medical Information option, the following error message is displayed:

Comb Med Info cannot be previewed because the accounts are for different people. Internal numbers differ. Deactivate DPW. Press NL.

After this option is selected, the following screens are displayed:

```
                   General Hospital Combine Bills Processor
                                         Mon Mar 27, 2009 10:40 am
Account       Name               FC Typ Admit    Disch        Balance Loc
C08018-00002 MARTIN, BOB          C  O/P 01/18/08 01/18/08      290.12 PA /INSR

The medical information displayed below may change prior to the load of
the UB claim.
                         Combined UB Information Review
Type  Code       Description        POA/Dt   Reference     Typ Admit     Disch
ICD-10
PDX   M79.661A TEST DIAGNOSIS       Y
ODX01 M48.50xA YET ANOTHER TEST     U
ODX02 A23.456D MORE TESTING         W
ODX03 B34.56xA TESTINGTESTING       Y        C0801800001   O/P 01/18/08 01/18/08
ODX04 C98.76xD LONGDIAGNOSIS        Y        C0801800001   O/P 01/18/08 01/18/08
ODX05 H34.567A NEWCODE              W        C0801800001   O/P 01/18/08 01/18/08
ADX   M87.65xD SICKDIAGNOSIS
PRCP  0JPT0PZ  SPINAL X-RAY NEC   01/18/08
PRC01 1AB23C4  LUMBOSAC SPINE X-RA 01/18/08
PRC02 2KE34D5  MUSCLE REATTACHMENT 01/18/08 C0801800001   O/P 01/18/08 01/18/08
ICD-9
PDX   850.9    CONCUSSION NOS       Y

                    F1Prev Page F2Next Page F7  Exit
```

```
                    Combined UB Information Review
                 General Hospital Combine Bills Processor
                                         Mon Mar 27, 2009 10:40 am
Account       Name          FC Type Admit    Disch    Balance Loc
C08018-00002 TEST,ICD       C  O/P  01/18/08 01/18/08   290.12 PA /INSR

The medical information displayed below may change prior to the load of
the UB claim.
                    Combined UB Information Review
Type  Code     Description      POA/Dt    Reference     Typ Admit     Disch
ODX01 851.01   CORTEX CONTUSION-NO U
ODX02 851.02   CORTEX CONTUS-BRIEF W
ODX03 900.9    INJ HEAD/NECK VESSE Y      C0801800001   O/P 01/18/08 01/18/08
ODX04 900.1    INJ INTERNL JUGULAR Y      C0801800001   O/P 01/18/08 01/18/08
ODX05 900.82   INJ MLT HEAD/NECK V W      C0801800001   O/P 01/18/08 01/18/08
ADX   850.0    CONCUSSION W/O COMA
PRCP  8729     SPINAL X-RAY NEC    01/18/08
PRC01 8724     LUMBOSAC SPINE X-RA 01/18/08
PRC02 8374     MUSCLE REATTACHMENT 01/18/08 C0801800001   O/P 01/18/08 01/18/08
PRC03 8373     TENDON REATTACHMENT 01/18/08 C0801800001   O/P 01/18/08 01/18/08
ATT   501 TEST,ABC
OTH   2042 SILVA,MD ONE


           F1Prev Page F2Next Page F7 Exit
```

```
             General Hospital Combine Bills Processor
                                         Mon Mar 27, 2009 10:40 am
Account       Name          FC Type Admit    Disch    Balance Loc
C08018-00002 TEST,ICD       C  O/P  01/18/08 01/18/08   290.12 PA /INSR

The medical information displayed below may change prior to the load of
the UB claim.
                    Combined UB Information Review
Type  Code     Description      POA/Dt    Reference     Typ Admit     Disch

Type  Code     Modifier(s)    Rev  Date     Reference     Typ Admit     Disch
HCPCS 11111                   740  01/18/08 C0801800001   O/P 01/18/08 01/18/08
HCPCS 22222                   360  01/18/08 C0801800001   O/P 01/18/08 01/18/08
HCPCS 33333    4780217723     740  01/18/08 C0801800001   O/P 01/18/08 01/18/08




           F1Prev Page F2Next Page F7  Exit
```

Field Explanations

ICD (DISPLAY ONLY)
This field displays ICD-10 when displaying the ICD-10 diagnoses and procedures, and displays ICD-9 when displaying the ICD-9 diagnoses and procedures.

When there are both ICD-10 and ICD-9 diagnosis codes and/or procedure codes, on either or both the FROM account(s) and TO account, the system displays the ICD-10

diagnosis and procedure codes first, and then displays any ICD-9 diagnosis and procedure codes. These are followed by any Medical Records HCPCS. Therefore, if there are two or more FROM accounts, and one FROM account has ICD-10 diagnoses and/or procedures, but another FROM account only has ICD-9 diagnoses and/or procedures, the FROM account with only ICD-9 codes is displayed after the ICD-10 information.

When there are only ICD-10 diagnosis codes and/or procedure codes, on both the FROM account(s) and TO account, the system automatically displays the ICD-10 diagnoses and procedures.

When there are only ICD-9 diagnosis codes and/or procedure codes, on both the FROM account(s) and TO account, the system automatically displays the ICD-9 diagnoses and procedures.

The Preview Combined Medical Information screen and the Use Admission Diagnoses in Preview screen display all possible diagnosis, procedure, and HCPCS information that can be used on the TO account. What is actually used for the TO account's Bill and Claim however is based on the TO account's Bill ICD indicator, and on the TO account's Claim ICD indicator, Claim Load Edit Parameter settings, and internal elements used.

TYPE (DISPLAY ONLY)
This field contains the form locator identifier from the UB claim form. Data is prefaced with the following abbreviations:

- PDX Principal Diagnosis

- ODX01-ODXxx Other Diagnoses (secondary). As many entered are displayed, such as ODX01, ODX02, ODX03.

- ADX Admitting Diagnosis

- ECDxx External Cause of Injury Diagnosis (01, 02, 03)

- PRCP Principal Procedure

- PRC01-PRCxx Other Procedures (secondary). As many entered are displayed, such as PRC01, PRC02, PRC03.

- ATT Attending Physician code and name

- OTH Other Physician code and name on the Principal ICD Procedure

CODE (DISPLAY ONLY)
This field contains the diagnosis or procedure code.

DESCRIPTION (DISPLAY ONLY)
This field contains the abbreviated description of the diagnosis or procedure.

POA/DT (DISPLAY ONLY)
This field contains the present on admission indicator for the diagnosis.

REFERENCE (DISPLAY ONLY)
This field contains the source of the medical information if it is not the Charge To account. The field displays the Charge From account's external account number.

TYP (DISPLAY ONLY)
This field contains the patient type of the charge from account if the source of the medical information is not the Charge To account.

ADMIT (DISPLAY ONLY)
This field contains the admit date of the charge from account if the source of the medical information is not the Charge To account.

DISCH (DISPLAY ONLY)
This field contains the discharge date of the charge from account if the source of the medical information is not the Charge To account.

The following message is displayed on the screen:

The medical information displayed above may change prior to the load of the UB claim.

NOTE: When the preview option is used in the Combine Bills Processor, the DRG Payment Window Processor, or the DRG Payment Window Worklist, the logic for physician information on the Combined UB Procedure/Physician Information Preview is as follows. The display of these fields is not governed by any UB Claim Load and Edit Parameters.

Attend Phys - This is the attending physician for the charge TO account or the DPW inpatient account.

Other Phys - This is the physician for the Principal Procedure displayed on the screen.

HCPCS Information

This screen displays the Medical Records HCPCS that can be used on the TO account's claim based on the settings in the TO account's UB Claim Load Edit parameter. HCPCS from the FROM account can be used on the TO account's claim if the TO account's UB Claim Load Edit Parameter has the following fields set to HCPCS or All:

- Combine Bill Med Info

- DPW Med Info

The HCPCS may or may not be used, based on the TO account's UB Charge Control Parameter.

Field Explanations

TYPE (DISPLAY ONLY)
This field contains the type of code (HCPCS).

CODE (DISPLAY ONLY)
This field contains the five-digit Medical Records HCPCS.

MODIFIER (DISPLAY ONLY)
This field contains up to 5 two-digit HCPCS Modifiers per Medical Records HCPCS.

REV (DISPLAY ONLY
This field contains the UB Revenue Code linked to the Medical Records HCPCS.

DATE (DISPLAY ONLY)
This field contains the service date linked to the Medical Records HCPCS.

REFERENCE (DISPLAY ONLY)
This field contains the FROM account number if the Medical Records HCPCS is from a FROM account.

TYP (DISPLAY ONLY)
This field contains the Patient Type for the FROM account.

ADMIT (DISPLAY ONLY)
This field contains the Admission Date for the FROM account.

DISC (DISPLAY ONLY)
This field contains the Discharge Date for the FROM account.

Use Admission Diagnoses in Preview

Enter **U** to preview combined medical and admissions information for linked accounts. This screen differs from the Preview Combined Medical Info option in that the **P** option displays only the diagnoses information entered on the TO and FROM accounts in Medical Records. The Use Adm Diagnoses in Preview option (U) displays the diagnosis information entered on the To and FROM accounts in Medical Records if it exists. If there is no principal or secondary diagnosis information on the TO or FROM account, the diagnosis information entered on the account in Admissions is displayed.

The Use Adm Diagnoses in Preview screen does not access the TO account's UB Claim Load Edit Parameter to determine if diagnoses, procedure, and HCPCS information from a FROM account is to be used on the TO account's claim. The Use

Adm Diagnoses in Preview shows the Medical Record and Admissions diagnoses and Medical Records ICD procedure and HCPCS information that could be used on the TO account's claim if the UB Claim Load Edit Parameter has the following fields set to Procedures, Both Diagnoses and Procedures, HCPCS, or All:

- Combine Bill Med Info

- DPW Med Info

NOTE: If the inpatient or outpatient account in the DPW pair was transferred to another patient, the only option which can be used is Deactivate DPW. If you try to select the Preview Information option, the following error message is displayed:

Comb Med Info cannot be previewed because the accounts are for different people. Internal numbers differ. Deactivate DPW. Press NL.

Charge level diagnoses are not displayed.

This combined Medical Records and Admissions diagnosis information can be reflected on the TO account's claim (in a Combine Bill) or on the inpatient DPW claim (TO account in linked DPW) if the (MR/ADM) internal elements are used and if the Use Adm Prin/Sec Dx for Combine Bill/DPW Med Info field on the first screen of the TO account's Claim Load and Edit Parameters is set to Yes. Charge level diagnoses are not displayed. For more information, see Claim Load and Edit Parameters documentation in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The same screens display as that in the Previewing Comboned Medical Information above. The only difference is that diagnoses from Admissions can display. See above for screen examples and field definitions.

Exiting the Combine Bill Status Screen

Enter ENTER to exit the Combine Bill Status screen. The system checks to see if any of the pending charge to or charge from accounts are in account location AR with unbilled charges and without a bill request pending. If an AR account has unbilled charges and does not have a bill request, the following prompt is displayed:

Account #A9999999999 does not have a bill request. Do you want to add one? (Y/N) -- [N]

Enter **N** for No to exit the function and to return to the patient look-up prompt. The default is No. Enter **Y** for Yes to display the Single Bill Request screen.

Removing a Charge To/From Link

To remove an existing charge to/from link on a single account, select the charge from account when you first access the function, select the *Charge To Number* field and then press ENTER. The system displays the following prompt:

Do you wish to unlink accounts (Y/N)? [N] --

To unlink the accounts, enter **Y** for Yes. To leave the charge to link intact, enter **N** for No.

If the Combined Bill Status is Pending/Charges Transferred, the following prompt is displayed:

Do you wish to uncombine the charges (Y/N)—

If you do not want to uncombine the charges, enter **N** for No. If you want to uncombine the charges, enter **Y** for Yes. After you enter **Y**, the following prompts are displayed:

Enter beginning date for uncombining charges [earliest] –

Enter ending date for uncombining charges [latest] –

Enter the beginning and ending dates to be used for uncombining the charges. Select the defaults (earliest and latest) to uncombine all the charges on the accounts. Once the dates are entered the following prompt is displayed:

Are you sure you want to uncombine charges from MM/DD/YY thru MM/DD/YY for accounts A9999999999 and A9999999999? (Y/N) –

The MM/DD/YY can contain a specific date that you entered or the terms earliest to latest. The A9999999999 indicates the account numbers.

To leave the charges intact, enter **N** for No. To uncombine the charges for these dates, enter **Y** for Yes.

Impact

After you create or remove the charge to/from link the following events occur:

- All unbilled charges and credits on the charge from account are reversed and applied to the charge to account.

- If the charge to and charge from accounts have already billed separately and the facility wishes to combine bills, an adjustment bill must be requested on both the charge to and the charge from accounts.

- If these accounts are being combined into a mother/baby account, your facility's print bill program should mark the charges appropriately. When you generate bills, the system marks the *from* charges as the baby charges on the bill.

- Combined charges do not display differently on the patient bill, with the exception of marking any baby charges on the mother's bill, based on whether the form currently marks baby charges.

- If the remaining balance on the charge from account is zero, then suppression of the bill is automatically performed for the charge from account. The system displays the account on the Billed Accounts report (FBR200) with a zero balance. The charge to account is displayed on this report with the billed amount (including charges from the from account).

- The Financial Activity Journal Detail report (FARAJR) displays the charge to/from account numbers in the To/From # field. The report displays a T before the charge to account number and an F before the charge from account number.

- If charges are uncombined, the credits are placed on the accounts where the charges were combined to. The charge is then placed on the account where it was originally charged. Transaction History is updated to indicate that charges were uncombined. In addition the accounts appear on the Combined Billing Report (FBR290).

UNBILLED CHARGE WORKLIST

The Unbilled Charge Worklist enables you to view account-level information, to reverse unbilled charges/credits that you do not want to bill, and to perform billing requests on accounts. The Worklist displays the following accounts:

- Accounts in location PA, AR, and BD that have had new charges or credits entered with a date of service in the past, and the date of service on the charge or credit was billed previously.

- Accounts in location AR that are placed in the Unbilled Charge Worklist are evaluated to determine if the charge being placed has exceeded the Chg Bill Window defined for the primary insurance. If the Chg Bill Window has been exceeded, the account qualifies to be placed on automatic bill hold with a type of O (Old Charge).

The setting in the Chg Bill Window field on the Billing Parameters and the Patient Bill Format screens determines the maximum number of days, after the date of service on the charge has passed and been billed, that the system places an AR account on an automatic bill hold with a type of O (Old Charge). When a charge or credit is received, the system uses the value in the Chg Bill Window field in the Billing Parameters assigned to the account's primary insurance to determine the Chg Bill window. If the field is not defined on the Billing Parameters assigned to the account's primary insurance, the system looks to the Chg Bill window defined on the Patient Bill Format. Charges that are placed on an AR account after the date of service has passed and has been billed, but before the Chg Bill Window has expired, also are placed into the Unbilled Charge processor. However, these accounts are not placed on automatic Bill Hold with a type of O. Charges that are placed on a PA account, after the date of service has passed and has been billed, are placed into the Unbilled Charge processor. Accounts leave this portion of the worklist once all overdue unbilled charges have changed from an unbilled to a billed status and/or all overdue unbilled charges in the worklist have been reversed.

Hospitals can elect not to define a Chg Bill Window on the system on either the Billing Parameter or the Patient Bill Format screens. All charges with a date of service in the past that has billed still go into the Unbilled Charge Worklist so these accounts can be reported on and worked, if desired. The bill hold type of O is not used in these hospitals.

Accounts are removed from the worklist once all overdue, unbilled charges/credits have changed from an unbilled to a billed status and/or all overdue unbilled charges/ credits for this account in the worklist have been reversed. Accounts are removed from the worklist when there are no unbilled charges waiting to be billed or the account is archived from the system. If an unbilled charge is reversed, the charge is marked immediately as being reversed, and the charge is removed from the worklist. A request is sent to STAR Order Management to reverse the charge. STAR Order Management sends a charge reversal back to STAR Patient Accounting. All system-generated reversals are marked so they do not go through the logic to determine whether the

charge would qualify for the Unbilled Charge Worklist. These charges are also identified for alternate GL mapping.

If you request an adjustment/late bill and all unbilled charges are billed subsequently, the charges are removed from the worklist. An account remains in the worklist until all of the unbilled charges have been billed or reversed. For example, if an account is in the worklist with charges that need to be billed on a cycle adjustment bill and charges that need to be billed on an adjustment bill, the account remains in the worklist until both adjustment bills have been created to bill the charges or until all charges have been reversed.

When the account is archived by the system, if there are still unbilled charges in the Unbilled Charge Worklist, the account is removed from the worklist so the system can archive and purge the account correctly.

When the Unbilled Charge Worklist function is accessed, the following prompt is displayed:

Enter Acct (L)ookup, Bill Hold (O)nly, (C)hgs past Bill Window, (N)o chgs past Bill Window, (A)ll accts, Comb (B)ill Accts only, (F)ilters, or (R)eport--

You have the following entry options:

- **L** (Lookup) - If you enter L, the system displays the standard patient account lookup prompt:

  Enter account, `C`corporate, `S`social security or `U`unit number,name, `-`name for soundex, or `/`EPN--

  You can enter the specific patient name, social security number, corporate or unit number, or a hyphen (-) and part of the patient's last name. If you enter a name or account number that is not associated with a patient currently in the Unbilled Charge Worklist, the following error message is displayed:

  Account is not in the Unbilled Charge Worklist. Press NL to Continue

  After you press ENTER, the previous prompt is displayed.

  If you enter the account lookup information for an account that is in the Unbilled Charge Worklist, the system displays the Unbilled Charge Worklist - Screen One.

- **O (Bill Hold Type O Only)** - If you enter **O**, the system displays the Unbilled Charge Worklist - Screen One. The display of accounts is limited to accounts that are currently in the worklist and have a Bill Hold Type of O assigned to the account.

- **C (Charges Past Bill Window)** - If you enter **C**, the system displays the Unbilled Charge Worklist - Screen One. The display of accounts is limited to accounts that are currently in the worklist and have at least one charge that currently exceeds the

Chg Bill Window. These accounts may or may not be on Bill Hold with a type of O, as the charge may have been entered prior to the Chg Bill Window being exceeded or the charge may have been entered when the account was in location PA.

- **N (No Charges Past Bill Window)** - If you enter **N**, the system displays the Unbilled Charge Worklist - Screen One. The display of accounts is limited to accounts that are currently in the worklist and have no charges that currently exceed the Chg Bill Window.

- **A (All Accounts)** - If you enter **A**, the system displays the Unbilled Charge Worklist - Screen One. All accounts that are currently in the worklist are displayed.

- **B (Comb (B)ill Accnts only)** - If you enter **B**, the system displays the Unbilled Charge Worklist - Screen One. The display of accounts is limited to charges recorded in the Unbilled Charge Worklist due to logic for combine bill or uncombine bill.

- **F (Define Filters)** - If you enter **F,** you can indicate selection criteria for accounts listed on the Unbilled Charge Worklist. The selection criteria can be billers, financial classes, and/or patient types. If more than one of these fields is used to select options for filtering the Unbilled Charge Worklist, an account is included in the Unbilled Charge Worklist if any of the criteria are met. For example, if selections are made for billers or financial classes, an account is included if its biller is in the list or if its financial class is in the list. The selection lists for billers, financial classes, and patient types are limited to those for which accounts appear in the Unbilled Charge Worklist. When you indicate that you want to define filters, the system displays, each on a separate screen, a list of billers, financial classes, and patient types. You can select one or more from each list.

  When you have finished defining the filters, the system displays a summary of the filter(s) you have selected and allows you to request the Unbilled Charge Worklist report (FBR116) to be printed or to return to the worklist without printing the report. The following prompt is displayed:

  Create a (R)eport before displaying worklist or only access (W)orklist [W]--

  - If you enter **R** (Report), the following prompt is displayed:

    Are you sure that you want to produce FBR116 (Unbilled Charge Worklist)? (N/Y) [N]--

    If you enter **Y** (Yes), the report is printed. The accounts printed on the report and on the worklist are limited to those satisfying the filter criteria.

  - If you enter **W** (Worklist), the Unbilled Charges Worklist is displayed.

- **R (Worklist Report)** - If you enter **R**, the system generates a copy of the Unbilled Charge Worklist Report (FBR116) immediately. This copy of the report contains all

entries that are currently in the worklist. The report spools to the printer defined for the CRT.

The following is the first screen displayed for the Unbilled Charge Worklist.

```
         General Hospital Unbilled Charge Worklist Processor - Screen One
                                                   Tue Mar 07, 2006 08:52 am
             All Accounts

 SQ   Account        Name                  Admit    Disch     Loc Billing status
 ( 1) A0310500009    TAN, BILL             04/15/03 04/23/03  AR   Errors
 ( 2) A0322400031    PORTER, SAM           08/12/03 08/17/03  PA   Hold - Cha
 ( 3) A0325400003    GOLD, ALAN            09/11/03 09/16/03  AR   Hold - DPW
 ( 4) A0322400012    SMITH, BOB            08/12/03 08/14/03  AR   Hold - Unb
 ( 5) A0322400013    PETERS, JANE          08/12/03 08/14/03  AR   Request - A
 ( 6) A0322400014    SMITH, JANET          08/12/03 08/14/03  AR   Request - A
 ( 7) A0322400015    LANE, ALAN            08/12/03 08/14/03  AR   Request - A
 ( 8) A0332200003    HARGU, ENID           11/18/03 11/20/03  AR   Request - A
 ( 9) A0400500002    KANE, CAROLYN         01/05/04 06/01/04  AR   Request - A
 (10) A0405400002    GOULD, MIKE           02/13/04 02/23/04  AR   Hold - Unb


 Enter choice--
```

Before the display of the list of accounts, and after the header at the top of the screen, one of four lines is displayed which reflects the accounts you elected to view:

• Bill Hold type O

• Charges Exceed Chg Bill Window

• No Charges Exceed Chg Bill Window

• All Accounts

Accounts are sorted in account number order for the display regardless of the view selected.

Field Explanations

SQ (DISPLAY ONLY)
This field contains the line sequence number associated with the account in the display.

ACCOUNT (DISPLAY ONLY)
This field contains the account number.

NAME (DISPLAY ONLY)
This field contains the patient's name.

ADMIT (DISPLAY ONLY)
This field contains the admission date.

DISCH (DISPLAY ONLY)
This field contains the discharge date.

LOC (DISPLAY ONLY)
This field contains the account location. Only accounts in location PA, AR, or BD are
displayed.

BILLING STATUS (DISPLAY ONLY)
This field contains the billing status associated with the account. Valid statuses are:

• Blank

• Hold. The description follows the billing status: *The account is on hold.* Bills are not
  produced for accounts with a status of hold.

• Request (with the type following) - The hospital has requested a bill for the account
  to be produced. The word *Request* is followed by the first couple of characters of
  the type of bill request that exists for the account, such as A for Adjustment Bill.

• Errors - The final bill cannot be produced until errors are cleared.

After you select the sequence number for the account you want to view, the following
screen is displayed. This screen displays the unbilled charges for the selected account.
The unbilled charges displayed are limited to charges that are in the Unbilled Charge
Workfile. If an account has unbilled charges that should not have billed yet, they are
not displayed. This screen allows you to review all of the unbilled charges, to reverse
individual charges, to remove the account from bill hold, or to request a bill through the

Single Bill Request function or an adjustment bill through the Instant Adjustment Bill function.

```
                General Hospital Unbilled Charge Processor
                                   -
                               Mon Aug 06, 2012 10:14 pm
Account       Name              FC Typ Admit   Disch        Balance Loc
C1220000003  NEW, JACK          M  SER 07/14/12 07/17/12     4308.38 AR /ACCF

Billing Status     Total Charges      Unbilled Amount  Comb Bill/DPW Link
                     $4,308.38            $2,664.14     FROM C1220000001+ MB/N

Seq  DOS      Post      Dept  Code Description            Qty   Amount  Panel
( 1) 07/09/12 07/19/12  PT    5 EVALUATION III             1    54.52
( 2) 07/09/12 07/19/12  PT    2 EXERCISE III               1    53.20
( 3) 07/09/12 07/19/12  PT    209 EXTREM WHIRLPOOL III     1    61.51
( 4) 07/09/12 07/19/12  PT    1013 BODY WHIRLPOOL II       1    61.51
( 5) 07/09/12 07/19/12  PT    8051 DORSO-LUMBAR CORSETTE   1   174.90
( 6) 07/11/12 07/19/12  OT    15 OT ORDER----------------- 1     0.00
( 7) 07/11/12 07/19/12  OT    6607 THERAPEUTIC MASSAGE     1    17.56
( 8) 07/11/12 07/19/12  OT    6504 OCC THERP EVAL IV       1    64.42
( 9) 07/11/12 07/19/12  OT    6514 OCC THERP IV            1    59.14
(10) 07/17/12 07/19/12  EEG   3200 EEG / EP PORTABLE       1    65.54
(11) 07/17/12 07/19/12  EEG   3106 EEG EP MISCELLANEOUS    1   300.00
(12) 07/17/12 07/19/12  EEG   3100 EEG-------------------- 1   270.60  Mastr

Enter Seq, (U)nb Amt, (I)ns COB inf, (B)ill Inf, Bill Req(J),
Ins Adj Bill(BI), Acct Inq Code or (-), or next page (/)--
```

Field Explanations

The patient data displayed at the top of the screen includes the account number, patient name, financial class, patient type, admission date, discharge date, current account balance, and account location/sub location.

BILLING STATUS (DISPLAY ONLY)
This field contains the account's current billing status. This information is also found on the Billing Information screen in Account Inquiry.

TOTAL CHARGES (DISPLAY ONLY)
This field contains the total value of charges and credits that have been placed on the account.

UNBILLED AMOUNT (DISPLAY ONLY)
This field contains the total value of all unbilled charges and credits that have been placed on the account. All unbilled charges are included in this figure, not only unbilled charges that are in the Unbilled Charges Worklist. This information is also found on the Billing Information Screen in Account Inquiry.

COMB BILL/DPW LINK (DISPLAY ONLY)
This field displays the linked accounts for Combine Billing Accounts, and also Diagnostic Payment Window Links, in the following format:

- If this is a FROM account in a combine billing link, the system will display "TO" followed by the TO account number, and then either MB/Y for Mother/Baby Yes, or MB/N for Mother/Baby No. For example:

  - TO C1127900002 MB/N

  - TO C1213400005 MB/Y

- If this is a TO account in a combine billing link, the system will display "FROM" followed by the FROM account number, and then either MB/Y for Mother/Baby Yes, or MB/N for Mother/Baby No. For example:

  - FROM C1127900001 MB/N

  - FROM C1213400002 MB/Y

- If there is more than one FROM account, the system will print the first FROM account number and then a plus sign (+). For example:

  - FROM C1123400006+ MB/N

- If this is a FROM account in a DPW link, the system will display "TO" followed by the TO account number, and then "DPW". For example:

  - TO C1127900002 DPW

- If this is a TO account in a DPW link, the system will display "FROM" followed by the FROM account number, and then "DPW". For example:

  - FROM C1127900001 DPW

- If there is more than one FROM account, the system will print the first FROM account number and then a plus sign (+). For example:

  - FROM C1123400006+ DPW

SEQ (DISPLAY ONLY)
This field contains the line sequence number associated with an unbilled charge line. This number is used to select individual charges for reversal. The only charges for an account that are displayed on this screen are unbilled charges that are in the worklist. For example, accounts that are still in location PA may have additional unbilled charges on the account, but they are not displayed because the date of service has not yet billed.

DOS (DISPLAY ONLY)
This field contains the Date of Service from the charge detail.

POST (DISPLAY ONLY)
This field contains the Posting Date from the charge detail.

DEPT (DISPLAY ONLY)
This field contains the SIM Department from the charge detail.

CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the SIM code and Description from the charge detail. The description may be truncated to fit into the display of information.

QTY (DISPLAY ONLY)
This field contains the quantity from the charge detail.

AMOUNT (DISPLAY ONLY)
This field contains the dollar amount from the charge detail.

PANEL (DISPLAY ONLY)
If this charge is part of a charge panel, this field displays *Mastr* or *Item* to indicate whether the charge is the top of the panel or an item in the panel. Only the top of the panel chain can be reversed using this process. The Panel Masters are indicated with *Mastr*.

The following prompt is displayed at the bottom of the screen:

> *Enter Seq, (U)nb Amt, (I)ns COB inf, (B)ill Inf, Bill Req(J),Ins Adj Bill(BI), Acct Inq Code or (-), or next page (/)--*

These prompt options allow you to view charges on several different screens or to perform an action on the charge in the Unbilled Worklist, as follows:

Seq # - After you enter a valid sequence number, the Unbilled Charge Worklist - Screen Three is displayed. You can use this screen to request that a charge be reversed. For details on reversing a charge, see "Reverse or Remove a Charge" on page 2-99.

U (Unbilled Charge View) - If you enter U at the prompt, the Unbilled Charge View screen is displayed. Upon exiting the Unbilled Charge View screen, the system redisplays the Unbilled Charge Worklist - Screen Two. For details on this screen, refer to *Unbilled Charge Amounts* in Chapter 1: Account Inquiry in the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide.*

I (Insurance COB Information) - If you enter I at the prompt, the Insurance COB screen is displayed. For details on this screen, refer to the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide*. Upon exiting the Insurance COB screen, the system redisplays the Unbilled Charge Worklist - Screen Two.

B (Billing Info) - If you enter B at the prompt, the system displays the Billing Information screen. For details on this screen, refer to the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide.* Upon exiting the Billing Information screen, the system redisplays the Unbilled Charge Worklist - Screen Two.

BH (Remove from Bill Hold) - If you enter BH at the prompt, the current bill hold that is assigned to the account is removed. After the bill hold is cleared, the following notification prompt is displayed:

> *Bill Hold is cleared, press NL to Continue*

When you press ENTER, the system redisplays the Unbilled Charge Worklist - Screen Two.

J (Bill Request) - If you enter J at the prompt, the Single Bill Request screen is displayed. The bill request defaults to the account that you are currently working on. If the account is on bill hold, you cannot request a bill for the account. After you complete a Single Bill Request, the system redisplays the Unbilled Charge Worklist entry prompt. For details on the Single Bill Request function, see .

BI (Instant Adjustment Bill) - If you enter BI at the prompt, the system displays the Instant Adjustment Bill processor. The processor defaults to the account that you are currently working on. If the account is on bill hold, you cannot request an Instant Adjustment Bill for the account. After you complete an Instant Adjustment Bill request, the system redisplays the Unbilled Charge Worklist entry prompt. For details on the Instant Adjustment Bill function, see *Other Account Management Functions* in the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Acct Inq Code Or (-) Users can key a lookup code directly if they know it, for example, HC for HCPCS Information, or can enter a dash (-) for a lookup of the account inquiry options. Not all options display within the Unbilled Charge Worklist. Additional lookups are available when accessing Account Inquiry directly, such as Medical Record information.

When entering a hyphen (-) for the lookup, the following screen is displayed. From this screen, enter the option number, not the alpha code.

```
                  General Hospital Unbilled Charge Worklist Processor
                                             Tue Aug 07, 2012 12:10 pm
Account        Name                 FC Typ Admit    Disch      Balance Loc
C1220000003  NEW, JACKI              M  SER 07/14/12 07/17/12    4308.38 AR /ACCF


Page:01                            Other Choices
( 1) B-Billing Information         (16) S-Snapshot Screen
( 2) C-Claim Information           (17) V-Guarantor's Accounts
( 3) CE-View Edit PA Charge Log    (18) Z-Guarantor Payment History
( 4) CV-Elec Claim Sys Claim Viewer
( 5) F-Financial Information
( 6) H-Transaction History
( 7) HC-HCPCS Information
( 8) I-Insurance COB Information
( 9) IPC-Insurance Agency Collectio
(10) J-Bill Request
(11) K-Balance Summary
(12) L-Contact Information
(13) N-Notes
(14) PC-Int/Ext Agency Collections
(15) RP-Totals by Responsible Party

Enter choice--
```

After viewing the selected information, the system returns you to the screen you were on in the Unbilled Charge Worklist for the account, with this transaction line (or similar):

> *Enter Seq, (U)nb Amt, (I)ns COB inf, (B)ill Inf, Rem Bill Hold (BH),Bill Req (J), Ins Adj Bill (BI), Acct Inq Code or (-), or next page (/)--*

REVERSE OR REMOVE A CHARGE

The Unbilled Charge Worklist Processor - Screen Three is used to request a charge to be reversed or removed.

```
                  General Hospital Unbilled Charge Worklist Processor
                                                      Fri Apr 07, 2008 04:59 pm
Account        Name                   FC Type Admit    Disch       Balance Loc
A0607400001  SEAL, BOB                B  ER   03/15/06 03/15/06    2753.96 AR/FCRV
SIM: 7450-CT ABDOMEN WO CONTRAST 74150        Service Date:  03/15/06
Qty: 1            Chg/CR Amt: $690.00         Post Date:     03/15/06
 1 Type of Unit                     2 Reference Facility           3 PA Edit

 4 Room/Bed  5 R&B Min   6 Accommodation            7 Charge Type  8 IDE
                                                      Ancillary
 9 Late Chg 10 Baby Chg 11 Fim Code  12 Statistics 13 Order#    14 Rev Dept
                        12127450      Yes           2              1212
15 UB Code                      16 HCPCS/Modifier        17 NDC
   350-CT Scan                     70450
18 Order Dx  19 Charging Physician          20 Performing Physician
             2 LEES,JACK R
21 ABN       22 ABN Reason                  23 Frequency Limit

24 Conflicting HCPCS ~ Override             25 Take Home  26 Old Chg
                                                             Markd


27 From CRT 28 Initials 29 Reference
   FIN         D B

Reverse this Charge (Y/N) or key R to remove from Unbilled Charge Worklist [N]--
```

For field explanations on this screen, refer to the Billing Information screen in the *Account Inquiry and Revision Volume* of the *STAR Patient Accounting Reference Guide.*

- To remove a charge from the Unbilled Charges Worklist:

  The following prompt is displayed on the screen:

  Reverse this Charge (Y/N) or key R to remove from Unbilled Charge Worklist [N]--

  If you enter **R** to remove the charge from the Unbilled Charge Worklist, the following prompt is displayed:

  Are you Sure you want to remove this charge from the Worklist? (Y/N)--

You can enter Y (Yes) to have the charge removed from the Unbilled Charge Worklist along with any associated panel charges. If no unbilled charges remain for the account, the account is removed from the Unbilled Charge Worklist. If the account is removed from the Unbilled Charge Worklist and the Bill Status is Old Chg Hold, that bill hold is removed. and the change is noted in transaction history. If a charge is removed from

the Unbilled Charge Worklist, the value of *Remd* is displayed in the Old Chg field on the detail screen for Edit PA Charge.

- To reverse a charge:

  If the charge is marked as a Panel item, and the associated type is Item, you can view the charge detail information, but you cannot reverse the charge or credit. The following prompt is displayed:

  Cannot reverse this charge/credit as it is an Item on a Panel. Only Master Items on the panel can be reversed using this process. Press NL to Continue.

  If the charge is not marked as a Panel Item, the following prompt is displayed:

  Reverse this Charge (Y/N) or key R to remove from Unbilled Charge Worklist [N]—

  If the selected item is a credit, the following prompt is displayed:

  Reverse this Credit (Y/N) or key R to remove from Unbilled Charge Worklist [N]— -

  - If you enter **N** (No) or press ENTER, the charge or the credit remains in the worklist and is not reversed.

  - If you enter **R** (Reverse), the charge or credit is reversed.

  - If you enter **Y** (Yes), the system displays the next prompt:

    Are you sure you want to reverse this charge/credit?-- Y/N

    The prompt identifies whether the item is a charge or credit. If you enter **Y** (Yes), the system sends a request to STAR Order Management to issue a system-generated charge reversal based on the charge information passed from the existing charge on the account. The charge is marked immediately as being reversed and is removed from the display of unbilled charges for the account. If this is the only unbilled charge for the account in the worklist, the account is also removed from the display of accounts in the Unbilled Charge Worklist.

Chapter 3 - CLAIMS

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INTRODUCTION

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

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

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

NOTE: Canadian users should refer to the *Canadian Claims Processing Volume* in the *STAR Financials Patient Accounting Reference Guide.*

THE CLAIMS PROCESS

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

Claim Load and Edit

If any carrier/plans are assigned to an account when it is billed, the system produces claims to be used for filing with each of the appropriate carriers. Claims may be produced for each carrier or a claim may be shared by more than one carrier. The claim processing codes previously assigned to each carrier/plan define the demographic and charge information included on the claim form. These parameters tell the system which data fields need to be reported, indicate which charge types (based on UB revenue codes) should be reported or excluded from the claim, specifies any additional requirements (for example, whether laboratory charges need to be reported by HCPCS codes), and determines how transaction history is updated by the claims process. For most payors, the UB claim form contains hospital services charges and the 1500 claim form contains professional fee charges. A Non-Professional Fee 1500 Claim Form is also available. This form uses the same demographic claim load information as the Professional Fee 1500 Claim Form except for the diagnosis information. The charge load is also different for this claim.

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

- Claim Load and Edit Parameters

  This parameter determines the information that should print in each field of a claim form and whether or not it is required. For example, if the biller name should print in box 94 of the UB, you would specify this in the claim load and edit parameter. The system may present you with format options on certain fields. If the field is marked as required and the data is not available, the claim, when loaded, fails the edits.

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

- Charge Control Parameters

  This parameter determines the detail charges that are included on the claim form and the way in which they are summarized. This parameter also controls how the charges should be printed - detail or summary by UB code, with or without units of service or quantity, and with or without HCPCS codes.

- Split Claim Criteria Table

  This parameter determines how charges are split to their own UB, based on any combination of the following:

- UB Revenue Code

- Charge Level HCPCS

- Financial Item Master (FIM)

- Service Date of Charge

- Patient Type at Charge Level

    The UB Split Claim Criteria Table is linked to a UB Charge Control Parameter table.

- Claim Generation Parameters

    This parameter controls the transaction codes that are used to update the account's transaction history when claims are loaded, generated, and submitted. This parameter also contains the suspense days for claims.

    The suspense days control how long failed claims remain in the workfile before the system automatically releases them.

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

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

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

Claim Review and Release

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

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

Claim Status

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

PRODUCTION STATUS CODES

Production status codes indicate whether the claim has been:

- Produced (P) - printed or sent electronically.

- Not Produced (NP) - not yet printed or not sent to third party, if electronic claim).

- Archived (AR) - already produced, denied claim, or paid claim that has been archived to microfiche or paper and is ready to be purged.

- Purged (P) - claim data has been archived and data no longer exists on the system.

WORK STATUS CODES

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

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

This status indicates that a claim is waiting for payment from another carrier(s).

- **Delete (D)**

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

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

A claim cannot be deleted if any payments or adjustments have been posted to it. The payment/adjustment must be reversed first.

- **Edit (E)**

  If you want the claim to be edited by the system in the next midnight processing, you should set the status to E (edit). When a claim is first loaded, the system edits the claim. The claim is also edited as changes are made to the claim by the biller. A claim awaiting prior payment is edited, if the status is fail, when the claim it is waiting on is marked Final Payment, Adjusted to Zero, or Denied. All claims with this status are edited during midnight processing and the status is changed as a result of the processing. A claim which had been previously suppressed that is later unsuppressed is assigned a work status of edit.

- **Fail (F)**

  This status indicates that a claim has errors that have not been corrected. This status does not appear on claims awaiting payment.

  Only one work status is valid at a time.

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

  - If HCPCS Procedure codes are required for revenue codes and a patient has charges relating to the revenue code but does not have the HCPCS procedure code.

  - If the units of service for Room and Bed charges are not equal to covered and non-covered days.

  - If the total for summary categories is less than zero.

- **Hold (H)**

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

- **Manually Released (M)**

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

- **System Released (R)**

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

- **System Released Forced (S)**

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

- **Suppressed (P)**

  If an insurance has the Suppress field set to Yes, and the insurance balance is zero at the point the claim would have been printed or spooled, the claim can be suppressed.

The last status is Claim Disposition. Refer to the Claim Disposition explanation for additional information on this status.

OPPS Status Codes

OPPS status codes indicate the current status of an OPPS (Outpatient Prospective Payment) claim. There are several OPPS status codes:

Q (Queued to 3M), A (3M Processed), E (3M Errors/No reimbursement calculated), B (Processed but 3M Errors), C (Not Queued due to errors), or L (Check 3M Log)

For information on the screens that display when you choose any of these values, please refer to the *Outpatient Prospective Payment System* documentation.

SPLIT UB CLAIMS PROCESSING

The system processes the charges in the order the criteria for the Split Claims are listed in the UB Charge Contropl Parameter, Split Claims field. The split claims are processed, followed by the Primary claim for the carrier. Once a charge qualifies for one of the Split Claims criteria, it is not evaluated for use on another claim. Charges that do not qualify for any of the Split Claims that are listed in the UB Charge Control Parameter will be on the Primary UB claim for that carrier and bill sequence. 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 Claim Load and Edit 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 requested, if the Load $0.00 Claim field is set to load for Adjustment claims, the system loads:

Adjustment Claims:

COB 1 Claim Sequence 3 for Primary

COB 1 Claim Sequence 4 for Therapy with NO Claim Charge detail

Existing Accounts and Claims

For existing accounts that possibly had bills and claims before setting up the Split Claim parameters, the system evaluates each bill and Insurance (COB).

When doing an Adjustment/Rebill (an adjustment after the final, or an adjustment after a previous adjustment, and when rebilling a cycle bill), if the original claims for that bill and insurance did not load split claims (as indicated by the UB claims having a blank Claim Split Indicator), even if the UB Charge Control Parameter for that insurance now has Split Claims defined, the system does not load split claims. The system only loads one UB with a blank Claim Split Indicator. If additional claims are needed for this account and insurance, the Add Claim to Insurance function should be used. This is required in order to match up replaced claims correctly on both STAR Patient Accounting and Pathways Contract Management.

When the system loads a Late bill and claims, if the original Final or Last Adjustment bill for the insurance did not load split claims (as indicated by the UB having a blank

Claim Split Indicator), even if the UB Charge Control Parameter for that insurance now has Split Claims defined, the system does not load split claims. The system only loads one UB with a blank Claim Split Indicator. If additional claims are needed for this account and insurance, the Add Claim to Insurance function should be used. This is required in order to match up replaced claims correctly on both STAR Patient Accounting and Pathways Contract Management.

For Adjustment claims, if the original claims for that bill and insurance did load split claims (as indicated by the UB claims having a non-blank Claim Split Indicator), if the UB Charge Control Parameter for that insurance has Split Claims defined, the system loads split claims.

For Late claims, if the original Final or the last Adjustment claims for the insurance did load split claims (as indicated by the UB claims having a non-blank Claim Split Indicator), if the UB Charge Control Parameter for that insurance has Split Claims defined, the system loads split claims.

To give an example, let's say an account has the following insurances and bill sequences:

COB 1 100100 Medicare UB

COB 2 100200 Medicare 1500

COB 3 500100 Medicaid UB

  Bill Sequence 1 = CYCLE

COB 1, Claim Sequence 1, Blank Claim Split Indicator

COB 2, Claim Sequence 2 (1500)

COB 3, Claim Sequence 3, Blank Claim Split Indicator

  Bill Sequence 2 = FINAL

COB 1, Claim Sequence 4, VACCINE Claim Split Indicator

COB 1, Claim Sequence 5, PRIMARY Claim Split Indicator

COB 2, Claim Sequence 6 (1500)

COB 3, Claim Sequence 7, Blank Claim Split Indicator

If in between the Final and the Adjustment bill, Split Claims are defined in the UB Charge Control Parameter for COB 3, since the original final claims did not split for this insurance, the adjustment claims will not split either. The COB 1 insurance loads split claims with the adjustment since the original final claims did split for this insurance.

Bill Sequence 3= ADJUSTMENT

COB 1, Claim Sequence 8, VACCINE Claim Split Indicator

COB 1, Claim Sequence 9, PRIMARY Claim Split Indicator

COB 2, Claim Sequence 10 (1500)

COB 3, Claim Sequence 11, Blank Claim Split Indicator

Similarly, if a new insurance is added after the final or adjustment bill, if Split Claims
are defined in the UB Charge Control Parameter for this insurance, this insurance can
load split claims since these are the first claims to load for the insurance, and there is
no replacement issue.

Claim Split Indicator

Charges that have split to their own claim because of the criteria in the UB Split Claims
Criteria table, display the Split Name, such as MAMM, in the Claim Split Indicator field
on the Claim Status Information screen. This screen is accessed through Claims
Management.

If a UB Split Claims Criteria has the Service Date Split set to Yes, the Claim Split
Indicator displays the Split Name, such as DATE concatenated by the Service Date for
the claim. For example:

DATE 02/18/05

DATE 02/19/05

The remaining charges that have not been split off to their own claim because of the
criteria in the UB Split Claims Criteria table display the word *Primary* in the Claim Split
Indicator field on the Claim Status Information screen.

Claims loaded with the Add Claim to Insurance function can also have a sequence
number in the Claim Split Indicator field. For example, DATE**7** 02/18/05.

If there are no Split criteria listed in the UB Charge Control Parameter for the
insurance, and therefore only one UB claim is loaded for the bill sequence, this claim
has a blank in the Claim Split Indicator field on the Claim Status Information Screen.

The term *Primary* should not be confused with the concept of a *Core* claim on
Pathways Contract Management. A core claim on Pathways Contract Management is
one that loaded with a bill - either in Midnight Processing or in the Instant Adjustment
Bill function. A split claim on Pathways Contract Management is one that was added
through the Add Claim to Insurance function. For STAR Patient Accounting, the
Primary claim is the claim with the remaining charges, after any split claims have
loaded. Both Primary and Split claims can load in Midnight Processing or through the

Instant Adjustment Bill function. If in either of these billing events, a Primary claim is loaded, this claim is sent as the Core claims are sent to Pathways Contract Management, and any split claims are sent to Pathways Contract Management as split claims (which affects the Type of Bill third digit on Pathways Contract Management, and how the reimbursement is handled). If a Primary claim is not loaded in either of these billing events, but a Split claim is loaded, this split claim is still sent to Pathways Contract Management as a split claim, even though it was loaded via a billing event. If a Primary claim is added in the Add Claim to Insurance Function, since this claim did not load via a billing event, it is still sent to Pathways Contract Management as a split claim.

Medical Records and Claim Load

Medical Records HCPCS only appear on one of the claims (either the split or the primary claim). The system first looks for direct matches on the Split claims with the revenue codes on the claims and the revenue codes on the Medical Records HCPCS, in the order of priority for the Split Claims as listed in the UB Charge Control Parameters. The system then looks for direct matches for the Primary claim with the revenue codes on the claim and the revenue codes on the Medical Records HCPCS. The system then goes back to the Split claims to determine if more Medical Records HCPCS can be pulled, based on any linked Med Rec HCPCS UB Rev Code Table. Finally, the system goes back to the Primary claim to determine if more Medical Records HCPCS can be pulled based on any linked Med Rec HCPCS UB Rev Code Table. Once a Medical Records HCPCS is used, it is not evaluated for use on either another split claim or the primary claim for the carrier and bill sequence.

Care should be taken in setting up your UB Charge Control Parameters so that the Medical Records HCPCS appear on the correct claim, primary or split. It is possible that Medical Records HCPCS could qualify for more than one claim. They will appear on the first claim they qualify for as outlined above. To give an example, say that a UB Claim Split Criteria is set to split by a particular FIM Item or FIM HCPCS. Let's also say the charges for this FIM Item or HCPCS code have a revenue code of 490. If the Primary claim also has charges with revenue code 490, since the split claim is processed before the primary claim, any Medical Records HCPCS with revenue code 490 will go to the split claim, not to the primary claim. When a UB Split Claim Criteria is based on the FIM HCPCS, the Alternate UB Charge Control Parameter for this split claim should have the appropriate revenue code set to pull Charge level HCPCS. The same may hold true when a UB Split Claim Criteria is based on a FIM Item. The Alternate UB Charge Control Parameter for this split claim should have the appropriate revenue code set to pull charge-level HCPCS. This is not always the case, and in some cases you may want to pull Medical Records HCPCS to the appropriate revenue code. Each split scenario needs to be evaluated.

Medical Records and Claim Reload

If Medical Records HCPCS are added after the claims have loaded, and the claim is edited either in Midnight Processing or from accessing the Claim Charge Data screen in Claims Management, the system processes as it does when initially loading the

claim: Medical Records HCPCS only appear on one of the claims (either the split or the primary claim). The system first looks for direct matches on the Split claims with the revenue codes on the claims and the revenue codes on the Medical Records HCPCS, in the order of priority for the Split Claims as listed in the UB Charge Control Parameters. The system then looks for direct matches for the Primary claim with the revenue codes on the claim and the revenue codes on the Medical Records HCPCS. The system then goes back to the Split claims to determine if more Medical Records HCPCS can be pulled based on any linked Med Rec HCPCS UB Rev Code Table. Finally, the system will go back to the Primary claim to determine if more Medical Records HCPCS can be pulled based on any linked Med Rec HCPCS UB Rev Code Table. Once a Medical Records HCPCS is used, it is not evaluated for use on either another split claim or the primary claim for the carrier and bill sequence.

The exception to this is with Batch claim reload, where the Primary Claim has Procedure Code errors, but the Split claim does not. If a Medical Records HCPCS is added after claim load, that qualifies for both a Split claim and the Primary claim, if there are no Procedure Code errors on the Split Claim (the claim can have a procedure code error if the HCPCS Required field is set to Yes for a UB Revenue Code in the UB Charge Control Parameter), but the Primary Claim has Procedure Code errors, the Medical Records HCPCS is loaded to the Primary claim. This is because the Batch claim reload first tries to correct any procedure code errors. Had the Split claim had Procedure Code errors, the Medical Records HCPCS would have loaded to this claim. When manually accessing the Claim Charge Data screen within Claims Management, the Medical Records HCPCS would have loaded to the Split claim, not to the Primary claim, regardless of any Procedure Code errors. Because a Medical Records HCPCS can qualify for both a split and a primary claim, it is imperative to have your Medical Records HCPCS entered before the initial claim load to ensure the Medical Records HCPCS are reflected on the correct claim.

If the Medical Records HCPCS that was added after the claims loaded qualifies for a Split Claim, but a user doesn't access this claim, and instead accesses the Claim Charge Data Screen for the Primary or another split claim, even if the HCPCS also qualify for this claim, it is not pulled to this Primary or other split claim. The system processes the HCPCS the same as it would be processed in Midnight Processing, determines the claim the HCPCS should appear on, and does not apply this HCPCS to another claim. Therefore, if the user manually releases the Split claim without this HCPCS, the HCPCS may appear on the Unused Medical Records HCPCS report.

Added claims with a Sequence Number in the Claim Split Indicator field will not Reload HCPCS if they are in a Failed status and the user accesses the Claim Charge Data screen. Meaning, if an added claim has a HCPCS procedure error, and a new Medical Records HCPCS is added, if the user accesses the Claim Charge Data screen for this added claim, it will not pull HCPCS into the claim. This is needed since, when using the Add Claim to Insurance function, the system only loads the HCPCS to the claim that would have loaded if the claim was loading via a billing event. Since the user can select which of the claims to load in Add Claim to Insurance, the newly added HCPCS may qualify for a claim not selected to load.

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Proration Information on Claims

If the Summarize By field on the UB Charge Control Parameter 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 the situations where a portion of what would have printed on this charge line was 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 Summarize By field on the UB Charge Control Parameter, for Split claims:

- The system can print Proration Non Covered amounts for the Split claims when the COB 1 insurance has proration Summary Code Exceptions set as Not Covered or the Professional Fee Coverage field set to Exclude. Split claims cannot print a non covered amount from the COB 1 insurance having one or more of the following fields set: Days Before Coverage Begins from the Basic Coverage screen of the insurance, Days Coverage Active from the Basic Coverage screen of the insurance, Maximum Room/Bed Days, or Maximum Ancillary Days Covered. All other Non Covered charge types are allowed (ABN Non Covered, Duplicate HCPCS, Component/Comprehensive HCPCS Conflict, Mutually Exclusive HCPCS Conflict).

Note that regardless of the setting of the Summarize By field, 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 in UB92 Locators 7 and 8, and as Value Codes 80 and 81 on the UB04. 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 and an Alternate Provider Master can be assigned to the split claims, and this data should not be set to load.

Replacing Split UB Claims

When a Final Claim is replaced by an Adjustment Claim, or an Adjustment Claim is replaced by a subsequent Adjustment Claim, the system replaces the UB based on the Claim Split Indicator, where possible. If the system cannot match the final or adjustment claim to the latest adjustment claims based on the Claim Split Indicator, the Final or Adjustment claim shows as being replaced by the new Primary claim, or by the claim with the blank Claim Split Indicator if not loading split claims, for the carrier from

the latest Adjustment bill. If there is no new Primary or blank claim split indicator claim for the carrier from the latest Adjustment bill, the claims show as being replaced by the first Split claim (loaded in the priority listed in the UB Charge Control Parameter) for the carrier from the latest Adjustment bill.

For claims sent to Pathways Contract Management for reimbursement, if the system cannot match a previous final or adjustment claim loaded during a billing event to one of the latest adjustment claims loaded during a billing event based on the Claim Split Indicator, a deletion record (29D) is sent to Pathways Contract Management. Users in this situation must determine what to do with any payments applied to the deleted claim on Pathways Contract Management.

For Pathways Contract Management and payment posting, the relationship between current and previous claims for a bill must be one-to-one even though it may not be one-to-one in the STAR Patient Accounting replace claim logic.

If an ERA payment is received for a previous final or adjustment claim for which there is no matching current adjustment claim based on the Claim Split Indicator, the claim for the payment is not selected automatically. The payment is reported on FXRERRR as a payment without a matching claim, and the payment must be posted manually.

The following is an example where the Number of Claims and Claim Split Indicators match between the Final/Adj or Adj/Adj:

If COB 1 is a UB plan, and this loads the following Final Claims:

Claim Sequence   Claim Split Indicator

CS 1 Primary

CS 2 Vaccine

If an Adjustment Bill and Claims are requested, and this loads the following Adjustment Claims:

CS 4 Primary

CS 5 Vaccine

Claim Sequence 1 shows as being replaced by claim sequence 4, and Claim Sequence 2 shows as being replaced by claim sequence 5.

For insurances set to use reimbursement type J for PCON by Claim, Pathways Contract Management considers the *Primary* claim the *core* claim, and the VACCINE claim the split claim. This affects the Pathways Contract Management type of bill, UB Locator 4, on the claims in Pathways Contract Management only, and how the reimbursement is calculated on Pathways Contract Management.

Replacement notices (29R record) are sent to Pathways Contract Management for the Primary claim sequence 1 and the Vaccine claim sequence 2 claims, since these claims matched up on the Claim Split Indicator and were replaced by claim sequences 4 and 5.

For insurances set to use reimbursement type I for PCON by Bill, the Primary claim or split claim of highest priority is used to send information to Pathways Contract Management.

For EC2000 (Electronic Commerce 2000) and Electronic Remittance Advice (ERA), the system sends and retains the account number and original claim sequence number. Therefore, if the account number is A0505500009, the account number used for claim sequence 1 for Primary is A05055000091, and for claim sequence 2 for Vaccine is A05055000092. When these claims are replaced by the adjustment claims, claim sequence 4 for Primary uses account number A05055000091, and claim sequence 5 for Vaccine uses account number A05055000092. This is so the payor knows that this is a replacement (adjustment) claim for the same account and claim sequence, and so the payment and claim can be matched automatically.

If a payment comes in for claim sequence 1, if the claim is already replaced by claim sequence 4, the system automatically applies the payment to the claim that replaced it, here claim sequence 4. The same holds true for claim sequence 2. If the claim is already replaced by claim sequence 5, the system automatically applies the payment to the claim that replaced it, here claim sequence 5.

If you had the following scenario with a late claim:

If COB 1 is a UB plan, and this loads the following Final Claims:

Claim Sequence   Claim Split Indicator

CS 1 Primary

CS 2 RAD

If the system then loads the following Late Claim:

CS 3 RAD

If an Adjustment Bill and Claims are requested, and this loads the following Adjustment Claims:

CS 4 Primary

CS 5 RAD

Claim Sequence 1 shows as being replaced by claim sequence 4, and Claim Sequence 2 and Claim Sequence 3 show as being replaced by claim sequence 5. The

charges that were on both claim sequences 2 and 3 may be reflected on claim sequence 5.

For EC2000 (Electronic Commerce 2000) and Electronic Remittance Advice (ERA), the system sends and retains the account number and ORIGINAL claim sequence number. Therefore, if the account number is A0505500009, the account number used for claim sequence 1 for Primary is A05055000091, and for claim sequence 2 for RAD is A05055000092. The Late claim for RAD would use account number A05055000093. When these claims are replaced by the adjustment claims, claim sequence 4 for Primary uses account number A05055000091, and claim sequence 5 for RAD uses account number A05055000092. The Late claim sequence of 3 would not be used. This is so the payor knows that this is a replacement (adjustment) claim for the same account and claim sequence, and so the payment and claim can be matched automatically.

If a payment comes in for claim sequence 1, if the claim is already replaced by claim sequence 4, the system applies the payment to the claim that replaced it, here claim sequence 4. The same holds true for claim sequence 2. If the claim is already replaced by claim sequence 5, the system automatically applies the payment to the claim that replaced it, here claim sequence 5. If a payment is received for claim sequence 3 after it has already been replaced, the system will not find a Non Replaced claim that matches this number, and the payment will be on the ERA Rejection report (FXRERRR).

The following is an example where the Number of Claims and Claim Split Indicator do not match between the Final/Adj or Adj/Adj, where last Adjustment has more claims:

If late charges are entered, and these late charges have a new criteria that splits to its own claim (such as a new revenue code, HCPCS, FIM Item, or Service Date), the Adjustment Bill may load more claims for the carrier than were present on the last Final or Adjustment Bill.

If COB 1 is a UB plan, and this loads the following Final Claims:

CS 1 Primary

CS 2 Vaccine

If an Adjustment Bill and Claims are requested, and this loads the following Adjustment Claims:

CS 4 Primary

CS 5 Vaccine

CS 6 Rad

Claim Sequence 1 shows as being replaced by claim sequence 4, and Claim Sequence 2 shows as being replaced by claim sequence 5. Claim Sequence 6 will not replace another claim.

For insurances set to use reimbursement type J for PCON by Claim, Pathways Contract Management considers the *Primary* claim the *core* claim, and the VACCINE and RAD claims the split claims. This affects the PCON type of bill, UB Locator 4, on the claims in Pathways Contract Management only, and how the reimbursement is calculated on Pathways Contract Management.

Replacement notices (29R record) are sent to Pathways Contract Management for the Primary claim sequence 1 and the Vaccine claim sequence 2 claims, since these claims matched up on the Claim Split Indicator and were replaced by claim sequences 4 and 5. The RAD claim will be a standalone split claim on Pathways Contract Management since it did not replace a previous claim.

For EC2000 (Electronic Commerce 2000) and Electronic Remittance Advice (ERA), the system sends and retains the account number and original claim sequence number. Therefore, if the account number is A0505500009, the account number used for claim sequence 1 for Primary is A05055000091, and for claim sequence 2 for Vaccine is A05055000092. When these claims are replaced by the adjustment claims, claim sequence 4 for Primary uses account number A05055000091, and claim sequence 5 for Vaccine uses account number A05055000092. Claim sequence 6 for Rad uses account number A05055000096, since this is a new claim for the bill and insurance. This logic is needed so the payor knows that this is a replacement (adjustment) claim for the same account and claim sequence, and so the payment and claim can be matched automatically.

If a payment comes in for claim sequence 1, if the claim is already replaced by claim sequence 4, the system automatically applies the payment to the claim that replaced it, here claim sequence 4. The same holds true for claim sequence 2. If the claim is already replaced by claim sequence 5, the system automatically applies the payment to the claim that replaced it, here claim sequence 5. The payment for the Rad claim will apply directly to claim sequence 6.

Example where the Number of Claims and Claim Split Indicator do not match between the Final/Adj or Adj/Adj, where last adjustment has fewer claims:

If late credits are entered, and these late credits remove a criteria that split to its own claim for the last final or adjustment bill (such as a revenue code, HCPCS, FIM Item, or Service Date), the Adjustment Bill may load fewer claims for the carrier than were present on the last Final or Adjustment Bill.

If COB 1 is a UB plan, and this loads the following Final Claims:

CS 1 Primary

CS 2 Vaccine

CS 3 Rad

If an Adjustment Bill and Claims are requested, and this loads the following Adjustment Claims:

CS 4 Primary

CS 5 Vaccine

Claim Sequence 1 shows as being replaced by claim sequence 4, and Claim Sequence 2 shows as being replaced by claim sequence 5. Since the Radiology charges were credited, and there is no new Split Claim for Rad, this claim shows as being replaced by the new Primary claim (CS 4 in this example). Had there been no Primary claim for the adjustment bill, only a Vaccine split claim, the Rad claim would show as being replaced by the Vaccine claim.

When this situation occurs, where there are fewer claims with the Adjustment bill than the Final or last Adjustment bill, the hospital may have to notify the payor. If a payment had already been applied to this claim, a Refund may need to be issued to the payor. If the claim does not load because of offsetting charges and credits, such as when the charges that were on the RAD claim are credited, the system can load a $0.00 claim based on the Load $0.00 Claim field in the Claim Load Edit Parameter assigned to the insurance. If the field is set to load a claim for the bill type (cycle, final, adjustment, late, or reprint), the system loads a claim with demographics, but no charge data. In the example above, if a $0.00 claim loaded for the RAD offsetting charges/credits, let's say claim sequence 6, then claim sequence 3 would have shown as being replaced by claim sequence 6.

If a claim is not replaced with an adjustment claim because the parameters were changed, or the patient type changed, and not because the charges were credited, the system does not load a $0.00 claim to inform the payor that the claim should be deleted. Contacting the payor would be a manual process.

For insurances set to use reimbursement type J for PCON by Claim, Pathways Contract Management considers the *Primary* claim the *core* claim, and the VACCINE and RAD claims the split claims. This affects the PCON type of bill, UB Locator 4, on the claims in Pathways Contract Management only, and how the reimbursement is calculated on Pathways Contract Management.

Replacement notices (29R record) are sent to Pathways Contract Management for the Primary claim sequence 1 and the Vaccine claim sequence 2 claims since these claims matched up on the Claim Split Indicator and were replaced by claim sequences 4 and 5.

For claims sent to Pathways Contract Management for reimbursement, if the system cannot match a previous final or adjustment claim loaded during a billing event to one of the latest adjustment claims loaded during a billing event based on the Claim Split Indicator, in this example, for the RAD claim, then a deletion record (29D) is sent to

Pathways Contract Management. The RAD claim shows as being Replaced on STAR, but is deleted on the Pathways Contract Management side. Even if a $0.00 RAD claim (let's say claim sequence 6) had been loaded on STAR, a deletion record (29D) would have still been sent to Pathways Contract Management for the claim sequence 3 RAD claim. This is because $0.00 claims are not sent to Pathways Contract Management. Users in this situation must determine what to do with any payments applied to the deleted claim on Pathways Contract Management.

For EC2000 (Electronic Commerce 2000) and Electronic Remittance Advice (ERA), the system sends and retains the account number and original claim sequence number. Therefore, if the account number is A0505500009, the account number used for claim sequence 1 for Primary is A05055000091, for claim sequence 2 for Vaccine is A05055000092, and for claim sequence 3 for Rad is A05055000093. When these claims are replaced by the adjustment claims, claim sequence 4 for Primary uses account number A05055000091, and claim sequence 5 for Vaccine uses account number A05055000092. This logic is needed so the payor knows that this is a replacement (adjustment) claim for the same account and claim sequence, and so the payment and claim can be matched automatically. Had the system loaded a $0.00 adjustment RAD claim for the offsetting charges/credits, let's say claim sequence 6, then claim sequence 6 for RAD would use account number A05055000093.

If a payment comes in for claim sequence 1, if the claim is already replaced by claim sequence 4, the system automatically applies the payment to the claim that replaced it, here claim sequence 4. The same holds true for claim sequence 2. If the claim is already replaced by claim sequence 5, the system automatically applies the payment to the claim that replaced it, here claim sequence 5. Since on STAR Patient Accounting, claim sequence 3 for Rad is showing as being replaced (by claim sequence 4 for Primary), but no Rad claim loaded for the Adjustment Bill, if a payment comes in for claim sequence 3, account A05055000093, the system will not find a Non Replaced claim that matches this number, and the payment will be on the ERA Rejection report (FXRERRR). This payment would have to either be refunded to the payor or applied to one of the other claims for the same payor. Had the Claim Load and Edit parameters been set to load a $0.00 claim, the Adjustment Bill could have loaded a $0.00 adjustment claim for the offsetting Rad charges. In this scenario, the new adjustment claim for RAD would use account number A05055000093, and a payment for claim sequence 3 would be applied to the new Rad claim using this account number.

Example where None of the Split Claims or Claim Split Indicators Match Between the Final/Adj or Adj/Adj:

If none of the split claims can be replaced by the Claim Split Indicator, such as when the patient type is changed from Outpatient to Inpatient, or Inpatient to Outpatient, and the claim parameters do not match, the claims all show as being replaced by the new Primary claim for the latest adjustment, or the claim with the blank Claim Split Indicator. If there is no new Primary claim for the carrier from the latest Adjustment bill, the claims show as being replaced by the first Split claim (loaded in the priority listed in the UB Charge Control Parameter) for the carrier from the latest Adjustment bill.

For example:

If COB 1 is a UB plan, and this loads the following Final Claims:

CS 1 Primary

CS 2 Vaccine

CS 3 Rad

If an Adjustment Bill and Claims are requested, and this loads the following Adjustment Claims:

CS 4 Primary

CS 5 ER

Claim Sequence 1 shows as being replaced by claim sequence 4, and Claim Sequences 2 and 3 show as being replaced by claim sequence 4, since there was no match on the Claim Split Indicator. Claim Sequence 5 does not replace another claim. Had there been no Primary claim for the adjustment bill, only an ER split claim, claim sequences 1, 2, and 3 would show as being replaced by the ER claim.

When this situation occurs, where there are fewer claims with the Adjustment bill than the Final or last Adjustment bill, the hospital may have to notify the payor. If a payment had already been applied to this claim, then a refund may need to be issued to the payor. If the claim does not load because of offsetting charges and credits, the system can load a $0.00 claim based on the field Load $0.00 Claim in the Claim Load Edit Parameter assigned to the insurance. If the field is set to load a claim for the bill type (cycle, final, adjustment, late, or reprint), the system will load a claim with demographics, but no charge data. If a claim is not replaced with an adjustment claim because the parameters were changed, or the patient type changed, and not because the charges were credited, the system does not load a $0.00 claim to inform the payor that the claim should be deleted. Contacting the payor would be a manual process.

For insurances set to use reimbursement type J for PCON by Claim, Pathways Contract Management considers the *Primary* claim the *core* claim, and the VACCINE and RAD claims (for the Final Bill), and the ER claim (for the Adjustment Bill) as the split claims. This affects the PCON type of bill, UB Locator 4, on the claims in Pathways Contract Management only, and how the reimbursement is calculated on Pathways Contract Management.

A replacement notice (29R record) is sent to Pathways Contract Management for the Primary claim sequence 1 since this claim matched up on the Claim Split Indicator and was replaced by claim sequence 4.

For claims sent to Pathways Contract Management for reimbursement, if the system cannot match a previous final or adjustment claim loaded during a billing event to one

of the latest adjustment claims loaded during a billing event based on the Claim Split Indicator, in this example, for the VACCINE and RAD claims, a deletion record (29D) is sent to Pathways Contract Management. The VACCINE and RAD claim both show as being Replaced on STAR, but are deleted on the Pathways Contract Management side. Users in this situation must determine what to do with any payments applied to the deleted claim on Pathways Contract Management. The ER claim will be a standalone split claim on Pathways Contract Management since it did not replace a previous claim.

For EC2000 (Electronic Commerce 2000) and Electronic Remittance Advice (ERA), the system sends and retains the account number and original claim sequence number. Therefore, if the account number is A0505500009, the account number used for claim sequence 1 for Primary is A05055000091, for claim sequence 2 for Vaccine is A05055000092, and for claim sequence 3 for Rad is A05055000093. When these claims are replaced by the adjustment claims, claim sequence 4 for Primary uses account number A05055000091. Claim sequence 5 for ER uses account number A05055000095 since this is a new claim for the bill and insurance. This logic is needed so the payor knows that this is a replacement (adjustment) claim for the same account and claim sequence, and so the payment and claim can be matched automatically.

If a payment comes in for claim sequence 1, if the claim is already replaced by claim sequence 4, the system automatically applies the payment to the claim that replaced it, here claim sequence 4. Since on STAR Patient Accounting, claim sequence 2 for Vaccine and claim sequence 3 for Rad are showing as being replaced (by claim sequence 4 for Primary), but no Vaccine or Rad claims loaded for the Adjustment Bill, if a payment comes in for claim sequence 2 (A05055000092) or 3 (A05055000093), the system will not find a Non Replaced claim that matches either number, and the payments are on the ERA Rejection report (FXRERRR). The payments would have to either be refunded to the payor, or applied to one of the other claims for the same payor.

Example where None of the Claim Split Indicators Match Between the Final/Adj or Adj/Adj when the Final/Adj Loaded Split Claims, but the Subsequent Adjustment Does Not:

If the original bill for the insurance did not load split claims (as indicated by a blank claim split indicator on the UB claims), the adjustment bill does not load split claims.

However, the reverse situation could occur. The original Final bill for the insurance can load split claims, but then the split claims criteria could be removed from the UB Charge Control Parameter assigned to the insurance, and only 1 UB claim could load for the adjustment bill.

The claims all show as being replaced by the new claim with the blank Claim Split Indicator for the latest adjustment.

For example:

If COB 1 is a UB plan, and this loads the following Final Claims:

CS 1 Primary

CS 2 Mamm

If an Adjustment Bill and Claims are requested, and this loads the following Adjustment Claim:

CS 3   (blank claim split indicator)

Claim Sequences 1 and 2 show as being replaced by claim sequence 3 (with the blank Claim Split Indicator).

When this situation occurs, where there are fewer claims with the Adjustment bill than the Final or last Adjustment bill, the hospital may have to notify the payor. If a payment had already been applied to this claim, then a Refund may need to be issued to the payor. If the claim does not load because of offsetting charges and credits, the system can load a $0.00 claim based on the field Load $0.00 Claim in the Claim Load Edit Parameter assigned to the insurance. If the field is set to load a claim for the bill type (cycle, final, adjustment, late, or reprint), the system will load a claim with demographics, but no charge data. If a claim is not replaced with an adjustment claim because the parameters were changed, or the patient type changed, and not because the charges were credited, the system does not load a $0.00 claim to inform the payor that the claim should be deleted. Contacting the payor would be a manual process.

For insurances set to use reimbursement type J for PCON by Claim, Pathways Contract Management considers the *primary* claim and the claim with the blank Claim Split Indicator as the *core* claim, and the MAMM claim as the split claim. This affects the PCON type of bill, UB Locator 4, on the claims in Pathways Contract Management only, and how the reimbursement is calculated on Pathways Contract Management.

A replacement notice (29R record) is sent to Pathways Contract Management for the Primary claim sequence 1. If the system cannot match the claims based on the Claim Split Indicator, a blank Claim Split Indicator will replace a Primary Claim Split Indicator.

For claims sent to Pathways Contract Management for reimbursement, if the system cannot match a previous final or adjustment claim loaded during a billing event to one of the latest adjustment claims loaded during a billing event based on the Claim Split Indicator, in this example, for the MAMM claim, a deletion record (29D) is sent to PCON. The MAMM claim will show as being Replaced on STAR Patient Accounting, but is deleted on the Pathways Contract Management side. Users in this situation must determine what to do with any payments applied to the deleted claim on Pathways Contract Management.

For EC2000 (Electronic Commerce 2000) and Electronic Remittance Advice (ERA), the system sends and retains the account number and original claim sequence number. Therefore, if the account number is A0505500009, the account number used for claim sequence 1 for Primary is A05055000091, and for claim sequence 2 for MAMM is A05055000092. When these claims are replaced by the adjustment claim,

claim sequence 3 for the blank Claim Split Indicator uses account number A05055000091, since when no match can be found, a blank Claim Split Indicator replaces a Primary Claim Split Indicator. This logic is needed so the payor knows that this is a replacement (adjustment) claim for the same account and claim sequence and so the payment and claim can be matched automatically.

If a payment comes in for claim sequence 1, if the claim is already replaced by claim sequence 3, the system automatically applies the payment to the claim that replaced it, here claim sequence 3. Since on STAR Patient Accounting, claim sequence 2 for MAMM is showing as being replaced (by claim sequence 3 with the blank Claim Split Indicator), but no MAMM claim loaded for the Adjustment Bill, if a payment comes in for claim sequence 2, account A05055000092, the system does not find a Non Replaced claim that matches this number, and the payment is on the ERA Rejection report (FXRERRR). This payment would have to either be refunded to the payor, or applied to one of the other claims for the same payor.

Split Claims and Pathways Contract Management

The term Primary should not be confused with the concept of a Core claim on Pathways Contract Management. A core claim on Pathways Contract Management is a claim with a primary or blank Claim Split Indicator that loaded via a bill either in Midnight Processing or in Instant Adjustment Bill. A split claim on Pathways Contract Management is a claim with a Claim Split Indicator other than Primary or blank that loaded via a bill, or a claim (regardless of Claim Split Indicator) that was added via the Add Claim to Insurance function. For STAR, the Primary claim is the claim with the remaining charges, after any split claims have loaded. Both Primary and Split claims can load in Midnight Processing or via the Instant Adjustment Bill function. If in either of these billing events, a Primary claim is loaded, this claim is sent as the core claim to Pathways Contract Management, and any split claims are sent to Pathways Contract Management as split claims (which affects the Type of Bill third digit on Pathways Contract Management, and how the reimbursement is handled). If a Primary claim is not loaded in either of these billing events, but a Split claim is loaded, this split claim still is sent to Pathways Contract Management as a split claim, even though it was loaded via a billing event. If a Primary claim is added in the Add Claim to Insurance Function, since this claim did not load via a billing event, it is still sent to Pathways Contract Management as a split claim (Type of Bill third digit of a 1).

The Type of Bill in Locator 4 for the split claims is updated in the Pathways Contract Management interface in order for Pathways Contract Management to process the claims correctly. The third digit in Locator 4 of the UB for Type of Bill is for the Frequency.

NOTE: The Type of Bill Third Digit is updated only in the Pathways Contract Management interface itself. The Patient Accounting claim, as seen in Claims Management, and the claim sent to EC2000, retains the Type of Bill as indicated in the UB Claim Load Edit Parameter for the insurance. This type of bill can be determined either by the use of an internal element or hard set in the Claim Load and Edit Parameter.

The following are some of the valid codes for Frequency:

1 Admit Thru Discharge

2 Interim - First Claim

3 Interim - Continuing Claim

4 Interim - Last Claim (which on STAR Patient Accounting is the final claim when there has been at least 1 cycle claim before the final).

7 Replacement of Prior Claim (on STAR, this is an Adjustment claim)

Any claim loaded via a billing event (Midnight Processing or Instant Adjustment Bill) with a Claim Split Indicator of Primary or blank is sent to Pathways Contract Management as a core claim. Claims loaded via a billing event (Midnight Processing or Instant Adjustment Bill) with a Claim Split Indicator other than Primary or blank are sent to Pathways Contract Management as a split claim. All claims loaded via the Add Claim to Insurance function, regardless of the Claim Split Indicator, are sent to Pathways Contract Management as split claims.

If the account has only a Final Primary and Split claim, the Final Primary claim is sent in the Pathways Contract Management interface with a Type of Bill third digit of a 1 for Admit Thru Discharge Claim, and any Final Split claims are sent in the Pathways Contract Management interface with a Type of Bill third digit of a 1 for Admit Thru Discharge Claim. If the account has no cycle bills, all claims are sent to Pathways Contract Management with a Type of Bill third digit of 1 for Admit Thru Discharge Claim.

If the account has only a Final Split claim, with no Final Primary claim loading, this split claim is sent in the Pathways Contract Management interface with a Type of Bill third digit of a 1 for Admit Thru Discharge Claim, and is still sent as a split, and not a core claim.

If the account has two Cycle claims and then a Final claim, with automatically added splits for both the Cycles and the Final, the Primary first Cycle is sent in the Pathways Contract Management interface with a Type of Bill third digit of a 2 for Interim - First Claim, the second Primary Cycle is sent with a Type of Bill third digit of a 3 for Interim - Continuing Claim, and the Final is sent with a Type of Bill third digit of a 4 for Interim - Last Claim. Any split claims for the Cycles or Final are sent with a Type of Bill third digit of a 1 for Admit Thru Discharge Claim. Any cycle or final claim loaded via a billing event with a Claim Split Indicator of Primary or blank is sent to Pathways Contract Management as a core claim. Claims loaded via a billing event with a Claim Split Indicator other than Primary or blank are sent to Pathways Contract Management as a split claim.

If the first cycle has only a Cycle Split claim, with no Cycle Primary claim loading, this split claim is sent in the Pathways Contract Management interface with a type of Bill

third digit of a 1 for Admit Thru Discharge Claim, and is still sent as a split, and not a core claim. In this situation, if the account then receives a Final PRIMARY claim, which would have been sent in the Pathways Contract Management interface with a Type of Bill Third Digit of a 4 for Interim - Last Claim, it is sent in the Pathways Contract Management interface with a Type of Bill Third Digit of a 1 for Admit Thru Discharge Claim. This is because Pathways Contract Management cannot process a Type of Bill third digit of a 4 for Interim - Last Claim without first receiving a Type of Bill third digit of a 2 for Interim - First Claim.

If the first Cycle has only a Cycle Split claim, with no Cycle Primary claim loading, this split claim is sent in the Pathways Contract Management interface with a Type of Bill third digit of a 1 for Admit Thru Discharge Claim, and still is sent as a split, and not a core claim. If the account has a subsequent Cycle claim, this time with a Primary claim loading, this claim is sent in the Pathways Contract Management interface with a Type of Bill third digit of a 2 for Interim - First Claim (instead of a third digit of a 3 for Interim-Continuing Claim). If the account then has a Final claim, with a Primary claim loading, this claim is sent in the Pathways Contract Management interface with a Type of Bill third digit of a 4 for Interim - Last Claim. The change to the first Primary Cycle type of bill is needed because Pathways Contract Management cannot process a Type of Bill third digit of a 4 for Interim - Last Claim without first receiving a Type of Bill third digit of a 2 for Interim - First Claim.

Another situation to note is when Cycle claims are sent to Pathways Contract Management with a Type of Bill third digit of a 2 for Interim - First Claim and then a 3 for Interim - Continuing Claim. If the Final bill does not load a primary claim, no claim is sent to Pathways Contract Management with a Type of Bill third digit of a 4 for Interim - Last Claim. Any split claims for the Final bill are sent to Pathways Contract Management with a Type of Bill third digit of a 1 for Admit Thru Discharge Claim. Therefore, Pathways Contract Management does not know that the account is complete.

CLAIMS PROCESSING

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

• Maintain Claims by Account

• Maintain Claims by Biller

• Add Claim to Insurance

• Balance Transfer and Claim Disposition

• Archive Claims

• Purge Archived Claims

• Print Pending Claims Report

• OPPS Claim Functions

Accessing Claims By Account

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

The system displays the following information for the selected account: patient account number, patient name, financial class, patient type, admission and discharge dates, account balance, and account location/sub location. All claims associated with this account are displayed in this format:

```
          General Hospital Maintain Claims by Account Processor
                                        Mon Mar 27, 2006 10:40 am
Account       Name                    FC Typ Admit    Disch     Balance   Loc
A98239-00001 RANIER,WANDA             99 I/P 08/27/98 08/30/99  175075.00 AR/FCRV


     Clm Adj   Bill    Bill    Clm   Prd Wk  OPPS Clm
     Seq Clm   From    Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
Page:01                              All Claims
( 1)   1      06/12/01 06/12/01 UB   NP   S   E    C  500700,MEDICARE




Enter choice or (I)ncomplete, (C)omplete, (L)ist All, or (O)ther --
                    next pg(/ or PG DN)  Search(TAB)
```

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

Field Explanations

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

ADJ. CLM (DISPLAY ONLY)
If this claim has been replaced by a subsequent claim, the claim sequence number of the claim that replaced it is displayed in this field. In this example, claim sequences 1 and 2 have been replaced by claim sequence 3 and 4.

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

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

CLM TYPE (DISPLAY ONLY)
This field contains the type of claim form for this claim. Examples are UB and 1500.

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

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

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

OPPS STS
This field indicates the status of an OPPS claim. Values are **Q** (Queued to 3M), **A** (3M Processed), **E** (3M Errors/No reimbursement calculated), **B** (Processed but 3M Errors), **C** (Not Queued due to errors), or **L** (Check 3M Log).

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

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

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

If you select O, the following prompt is displayed:

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

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

```
              General Hospital Maintain Claims by Account Processor
                                          Mon Mar 27, 2006 10:40 am
Account        Name                   FC Typ Admit    Disch     Balance    Loc
A98239-00001 LANIER,RHONDA            99  I/P 08/27/98 08/30/99  175075.00 AR/FCRV

Page:01                          Claim Types              ##=Current Choices
( 1) A-MA 310                          (16) P-BC MSP
( 2) B-1500                            (17) Q-BC WORKER'S COMP ELEC
( 3) C-MA 319 PI                       (18) R-MEDI-CAL UB
( 4) D-MA 319 MS                       (19) S-BC WORKER'S COMP PAPER
( 5) E-MI1645                          (20) T-TI19
( 6) F-MI1649                          (21) U-UB82
( 7) G-MI1500                          (22) V-BC Out of Prov.
( 8) H-MOH                             (23) W-WCB
( 9) I-MCLI                            (24) X-UB
(10) J-CA25-1                          (25) Y-CPBC
(11) K-UNV                             (26) Z-NON PRO FEE 1500
(12) L-2360
(13) M-MA 319 DENTAL FORM
(14) N-NJ MC19
(15) O-MCLO

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

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

```
         General Hospital Maintain Claims by Account Processor
                                      Mon Mar 27, 2006 10:40 am
Account     Name                  FC Typ Admit    Disch     Balance   Loc
A98239-00001 LANIER,RHONDA         99 I/P 08/27/98 08/30/99  175075.00 AR/FCRV

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




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

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

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

Enter earliest bill thru date [Earliest] --

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

Enter latest bill thru date [Latest] --

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

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

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

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

> *Enter latest submission date [Latest] --*

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

If you select C, then you may select from the insurance plans on the account. One or more COBs may be selected.

After entering the additional limits in each of the above options, the system displays the claims list screen for the account. Only the claims meeting the selection criteria are included in the claims list.

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

```
          General Hospital Maintain Claims by Account Processor
                                        Mon Mar 27, 2006 10:40 am
 Account      Name                    FC Typ Admit    Disch    Balance    Loc
 A98239-00001 RANIER,WANDA            99 I/P 08/27/98 08/30/99 175075.00  AR/FCRV

     Clm Adj  Bill    Bill    Clm   Prd Wk  OPPS Clm
     Seq Clm  From    Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
      1        06/12/01 06/12/01 UB    P   M        C   500700,MEDICARE

             Option No.  Option
             ----------------------------------------
                 1       Claim Status Information
                 2       Carrier Status Information
                 3       Claim Demographic/Visit Data - Errors Only
                 4       Claim Demographic/Visit Data - All Screens
                 5       Claim Demographic/Visit Data - Select Screens
                 6       Claim Attachments
                 7       Claim Charge Data
                 8       Unused/Applied Med Rec HCPCS
                 9       Claim Disposition
                10       Re-Print Claim
                11       Account Inquiry/Revision
                12       Claim Charge Reconciliation
                13       EC 2000 CA Claim Viewer


  Enter option number--
```

NOTE: The menu varies as follows:

- The menu as shown above is for a claim that has already been produced or manually released. If this claim had not been produced or manually released, the Reload Claim Demographic/Visit Errors option would display,

rather than the Re-Print Claim option. The Reload Claim Demographic/Visit Errors option is only available until the claim is produced or manually released. Following one of these events, the Re-Print Claim option becomes available.

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

- The OPPS Information option may be displayed on this screen, if there is room. This option allows you to view either OPPS Information (see "OPPS Information" on page 3-200) or Claim Charge Reconciliation (see "Claim Charge Reconciliation" on page 3-201) for details.

- EC2000 CA Claim Viewer is displayed only when the system parameter is activated, which is facility-specific. This menu option also is not displayed if the HIPAA Data Extract process is activated.

- If EC2000 CA Claim Viewer is used, the Account Inquiry and Account Revision options are combined into one menu option named Account Inquiry/Revision. When you select this menu option, the system displays a sub-menu that lists Account Inquiry and Account Revision separately. If you do not have EC2000 CA Claim Viewer, the Account Inquiry and Account Revision options are separate options on the menu.

Accessing Claims by Biller

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

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

After this option is selected, the system prompts the supervisor or manager to select a biller. Billers are immediately presented with the workfile options by the system. When a biller code is entered or selected, the system displays this screen and presents these options:

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








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

- Claims that Failed Edits

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

- Claims that Passed Edits

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

- Generated Claims not Yet Submitted

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

  The system prompts you to submit (S) or edit (E) the generated claims. If you enter **E**, the system displays each claim and enables you to select specific claim records for submission. If you enter **S**, the system displays one or more screen listings of claims generated but not submitted, and enables you to select one claim, multiple claims, or all claims from *each* screen and submit the selected claims as a group. Selected claims are displayed in reverse video based on your Windows Emulator properties. After you select the claims to submit, the system displays the following prompt:

  Enter the claim submission date

The default is the current system date. After you enter a submission date or accept the current system date, press ENTER to submit the claims selected on the screen. The system displays the following message:

Claims Submitted

The system displays the next screen of claims. You can continue to select claims to submit.

It is important to submit a claim for several reasons:

- Biller statistics are updated when claims are submitted.
- Insurance follow-up is scheduled based on the claim submission date.

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

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

- Claims Already Submitted

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

- Claim Replaced by Adjustment Claims

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

- Completed Claims

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

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

The next step is to enter a range of search dates for the claims you want to review. You are asked to enter a Begin Search Date and an End Search Date. You can enter each date in the format MMDDYY or MM/DD/YY or use the default options. The default for the begin date is F (the date of the oldest claim in this biller's workfile). The default for the end date is L (the date of the most recent claim in this biller's workfile). After

accepting the dates entered, the system displays either sort options (these are documented below) or the claims selected (by the sort options where applicable) within date for each account.

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

SORT OPTIONS

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

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

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

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

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

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

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

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

```
              General Hospital Claims by Biller Processor
                                        Tue Dec 05, 1993 10:27 am
     Biller:ASHLAND,MARY
                                                         Page:01

        Clm Adj Bill Date  Account   Type Status Carrier/Plan(*Shared) Name
     ( 1)  6      10/22/93 89234-00007 Gen    Rel   ADJUSTCO/W.C.        SCHALLIP,
     ( 2)  1      11/01/93 89299-00003 Comp   Rel   EBI/W.C.             ROHDE,C L
     ( 3)  6      11/02/93 89268-00001 Fail   Wait  ADJUSTCO/W.C.        LOWENSTEI
     ( 4)  9      11/02/93 89234-00007 Gen    Rel   ADJUSTCO/W.C.        SCHALLIP,
     ( 5)  1      11/05/93 89305-00001 Gen    Rel   ALEXSIS RISK MGMT/W ROHDE,J A
     ( 6) 11      11/13/93 89270-00003 Fail   Wait  ADJUSTCO/W.C.        CURNICK,T
     ( 7)  3      11/28/93 89332-00007 Fail   Wait  EBI/W.C.             HALL,F B
     ( 8)  6      11/29/93 89332-00007 Fail   Wait  EBI/W.C.             HALL,F B
     ( 9) 12      12/03/93 89234-00007 Fail   Wait  ADJUSTCO/W.C.        SCHALLIP,




     Enter choice--
```

Field Explanations

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

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

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

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

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

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

STATUS (DISPLAY ONLY)
This field contains the work status of this claim. Possible entries are explained in the Work Status Codes definition.

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

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

CLAIM FUNCTIONS

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

```
              General Hospital Claims by Account Processor
                                       Mon Mar 27, 2006 10:40 am
Account      Name                 FC Typ Admit    Disch      Balance   Loc
89242-00002  CURNANE,JOHN M       M  I/P 04/30/01 05/01/01   6507.00-  AR/FCRV

    Clm Adj   Bill     Bill    Clm   Prd Wk  OPPS Clm
    Seq Clm   From     Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
     1        06/12/01 06/12/01 UB    P   M         C  500700,MEDICARE


          Option No.  Option
               1      Claim Status Information
               2      Carrier Status Information
               3      Claim Demographic/Visit Data - Errors Only
               4      Claim Demographic/Visit Data - All Screens
               5      Claim Demographic/Visit Data - Select Screens
               6      Claim Attachments
               7      Claim Charge Data
               8      Unused/Applied Med Rec HCPCS
               9      Claim Disposition
              10      Re-Print Claim
              11      Account Inquiry/Revision
              12      Claim Charge Reconciliation
              13      EC 2000 CA Claim Viewer


Enter option number --
```

NOTE: If you select a claim that has not been produced or manually released, instead of having the Re-Print Claim option, the screen would have the Reload Claim Demographic/Visit Errors option. The Reload Claim Demographic/Visit Errors option is only available until the claim is produced or manually released. Following one of these events, the Re-Print Claim option becomes available

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

EC2000 CA Claim Viewer is displayed only when the system parameter is activated, which is facility-specific. This menu option also is not displayed if the HIPAA Data Extract process is activated.

If EC2000 CA Claim Viewer is used, the Account Inquiry and Account Revision options are combined into one menu option named Account Inquiry/Revision. When you select this menu option, the system displays a sub-menu that lists Account Inquiry and Account Revision separately. If you do not have EC2000 CA Claim Viewer, the Account Inquiry and Account Revision options are separate options on the menu.

Claim Status Information

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

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

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

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

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

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

If EC2000 is active, the system displays the following prompt:

Claim produced -- Edit to sync with EC 2000 CA? (Y/N) [N]-- |

For any of these prompts if you enter **Y** for Yes, the Claim Work Status is changed to Hold and the production indicator is changed to Not Produced. You can then update the Claim Demographics and/or the Claim Charge Data. The claim appears on the Hold report (FCR320) and the Pending Claims report (FCR260) with a Hold status. If the claim is for the primary insurance plan and is defined to interface with Pathways Contract Management, the system displays the following prompt:

Send updated Claim to PCON? (Y/N) [Y] -

In order for the claim to be included in the next source file to Pathways Contract Management, the Claim Work Status must be changed to Manually Released. When the claim is marked Manually Released, if the insurance is defined to go to Pathways Contract Management and you responded **Yes** to the above prompt, the claim is included in the source file to Pathways Contract Management. Transaction History is updated with a note stating that the claim was re-submitted to Pathways Contract Management. The system generates a replacement notice to Pathways Contract Management and the unique claim number identifier for the original claim is retained. The contractual adjustment amount associated with the original reimbursement calculation is backed out if a new contractual adjustment amount with the same claim identifier is returned by Pathways Contract Management.

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

Reload function not valid for claims marked for resubmission

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

In order for the claim to spool to the paper or to the electronic spool file again, the Claim
Work Status must be changed to Manually Released. When the claim is marked
Manually Released, if the insurance is tied to a Log, the Log records for the claim are
updated.

If a claim is edited for resubmission, the system writes to Transaction History "xxxx
Claim Edited Resubmission" where xxxx is the claim type, such as UB.

After resubmitting the claim, you can change insurance follow up for the claim.

- If the claim is no longer receiving follow up, the system displays the following
  prompt:

  Start Insurance Follow Up? (Y/N) [N]--

If you answer **Yes** to this prompt, the system restarts the insurance follow up by
assigning a new insurance schedule, a next follow up date, and a step. A transaction
history message is created, and the Insurance Follow Up revision screen is displayed,
allowing you to update the follow up. After completing the follow up changes, the
Maintain Claim Processor is displayed.

- If the claim is receiving follow up, the system displays the following prompt:

  Update Follow Up? (Y/N) [N]--

If you answer Yes to this prompt, the insurance follow up revision screen is displayed,
allowing you to update the follow up. After completing the follow-up changes, the
Maintain Claim Processor is displayed. For more information on the Follow-Up
Processor screen, refer to the *Account Inquiry and Revision Volume* in the *STAR*

Financials Patient Accounting Reference Guide.

```
                   General Hospital Claims by Biller Processor
                                           Fri Mar 07, 2010 09:11 am
Account       Name                 FC Typ Admit    Disch       Balance Loc
A03141-00004 CRANE, MIKE           M  I/P 04/30/03 05/21/03      345.71 AR
 1 Bill Sq    2 Clm Sq  3 Claim Type  4 Claim Format  5 Load/Edit Parameter
    6           30        X UB          UB04            99 MEDICARE I/P
 6 Bill Date  7 Bill From  8 Bill Through 9 ICD   10 Chg Control Parameter
   05/22/03     04/30/03     05/21/03       ICD-9    01 MEDICARE CHG I/P
11 Biller                             12 Last System Edit Date
   5 - BILLERFIVE,BILLER                 05/22/03 11:34am
13 Last Editing User                  14 Last User Edit Date/Time

15 Edit Failures 16 Claim Production Status   17 ASB/Crossover Link
                   P Produced                   COB 1 CS 1 Primary

18 Claim Work Status        19 Claim Amount   20 Archive Date  21 Purge Date
   R Released                   $842.20
22 Prod/Supp Claim?  23 Electronic Media   24 Claim Split Indicator
   Yes/No                         Primary
25 Alternate Provider Master           26 Payor Claim ID       27 CA UB




Press NL--
```

Field Explanations

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

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

3.   CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type. Examples of Claim Types are X for UB, B for 1500, and Z for Non Pro (Fee 1500).

4. CLAIM FORMAT (DISPLAY ONLY)
This field contains the claim format for those claim types that can have more than one format. Some examples of claim formats are UB92 and UB04 for the UB Claim Type, and 1992 and 08/05 for the 1500 and Non Pro Fee 1500 Claim Types.

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

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

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

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

9. ICD (DISPLAY ONLY)
This field displays ICD-9 if ICD-9 diagnosis and procedure codes were edited and loaded to the claim, or ICD-10 if ICD-10 diagnosis and procedure codes were edited and loaded to the claim. Which code set is loaded is determined by the ICD-10 Effective Date field on the Claim Load Edit Parameter, and the Admission Date or Discharge Date of the patient. If the ICD-10 Effective Date field on the Claim Load Edit Parameter is blank, the code set used is dependent on the USA ICD-10 Effective Date field on STAR Patient Processing, on the Admission Date of the patient, and on any exceptions for the Insurance Plan, Insurance Carrier, or Financial Class. The ICD flag is set for the claim at time of Claim Load, and does not change for the life of the claim. Therefore, if the ICD-10 Effective Date field is updated on the Claim Load Edit Parameter, this does not update the ICD flag of previously-loaded claims.

10. CHG CONTROL PARAMETER (DISPLAY ONLY)
This field contains the charge control parameter code and description used for the claim. The charge control parameters are assigned through the Insurance Plan Coverage Master file.

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

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

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

- The biller enters a new date on the claim.

- A payment is made on a carrier and secondary carriers are waiting for payment.

- The reload option is used.

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

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

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

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

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

17. ASB/CROSSOVER LINK (DISPLAY ONLY)
This field displays the COB, the Claim Sequence (CS), and the Claim Split Indicator, if splits are defined, for any ASB (Accelerated Secondary Billing) link set on the secondary (COB 2-9) insurance in the Insurance Coverage Table. The ASB/Crossover Link points forward from the COB 1 claim to the Next Highest UB linked claim, and it also points backward from this Next Highest UB claim to the linked COB 1 claim. For example, if the Next Highest UB plan was COB 3, and this loaded a Primary and a Mammography claim, if the Primary claim for COB 3 was claim sequence 4, this may point back to COB 1 CS 1 Primary. The same field, when looking at claim sequence 1 would point forward to COB 3 CS 4 Primary.

During Claim Load, if the COB 1 plan is one of the ASB/Crossover Hold Exceptions, the Next Highest UB claims has the Produce/Suppress Claim field set as follows:

- The Produce Claim field is set to No, meaning the claim(s) do not spool to either the paper or to the electronic spoolfiles, regardless of insurance balance.

- The Suppress Claim flag set to Yes.

The Next Highest UB plan claim(s) is given a Work Status of *H (Hold)*. When the claim(s) are released with the associated COB 1 claim(s), the claim work status is updated to *Released*.

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 overlays the demographic and charge data for claim sequence 5. This ensures that any manual updates made to the COB 1 claim(s) are reflected on the Next Highest UB claim(s).

Once this Next Highest UB claim is released, even though the Print/Spool is suppressed, the Production Indicator is changed to P Produced. This allows the claim to be Submitted at a later date.

For more information on the ASB/Crossover Hold Exceptions field, see the *Tables, Masters, and Parameters* Volume of the *STAR Financials Patient Accounting Reference Guide,* under the heading of PA/AR Master File Maintenance, Insurance Plan Coverage, Facility Options, Billing and Claims.

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

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

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

  Error: Status can only be changed to Manually Released

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

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

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

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

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

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•   ASB/Crossover claims that have a work status of **H** (hold) can be changed to **M** (manually released), **H** (hold), **D** (delete), or **E** (edit). If you try to change the work status, the following prompt is displayed:

ASB/Crossover Claim. Are you sure that you want to update the Claim Work Status (Y/N)?-

If you enter **Y** (Yes), the system allows the Claim Work Status to be updated and displays the following prompt:

Manually Release(M), hold(H), delete(D), or edit(E) --

If you manually release an ASB/Crossover claim that previously was on hold, when the linked COB 1 claim is manually released/released on STAR, the system does not attempt to manually release the secondary linked claim and does not overlay the secondary claim information with the linked COB 1 claim information (demographics and charges). This means that any manual changes made to the COB 1 claim are not reflected on the secondary linked claim.

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 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 (or from another third party claims vendor). Once the claim is either manually submitted, or the claim receives a Submit Date via the EC2000 interface, insurance follow up can start for the claim.

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 will overlay 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 will overlay 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) are reflected on the Next Highest UB claim(s).

Once this Next Highest UB claim is released, even though the Print/Spool is suppressed, the Production Indicator is changed to P Produced. This allows the claim to be Submitted at a later date.

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

20. ARCHIVE DATE (DISPLAY ONLY)

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

21. PURGE DATE (DISPLAY ONLY)

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

22. PROD/SUPP CLAIM? (1-A-O)

This field indicates whether a claim should be produced, either electronically or as a printed paper claim, and whether a claim should be suppressed if, at the time of claim print/spool, the insurance plan balance is $0.00. When setting the Produce Claim indicator to No, the claim does not print/spool, regardless of insurance or account balance. When setting the Suppress Claim indicator to Yes, the claim is only suppressed if, at the time of claim print/spool, the insurance plan balance is $0.00. If the insurance plan balance is greater than $0.00, the claim would print/spool even when the suppress flag is set to Yes. Initial entry in this field is determined by information for this claim in the Insurance Plan Coverage master. Copies of suppressed claims can always be generated using the Reprint Claim option.

The first part of this field displays the setting of the Produce Claim field from the insurance level on the account (Claim/Proration Control screen), and the second part of this field displays the setting of the Suppress Claim field from the insurance level on the account (Claim/Proration Control screen). Both settings can be updated for the claim if the Claim Production Status field on the same screen for the claim is N Not Produced. If the Claim Production Status field is P Produced, then neither setting in this field can be updated.

When accessing the field, the system prompts if the claim should be produced as follows:

> *Produce claim (Y/N) [Y]?-- |*

If this field is set to Yes, the system displays the following prompt:

> *Suppress claim (Y/N) [Y]?-- |*

The system displays this prompt only if the Produce Claim field/prompt is answered with a Yes, since if set to No, the claim does not print/spool regardless of plan or account balance.

NOTE: If a claim is suppressed at time of claim print select, the field for Claim Production Status will be "N Not Produced" and the field for Claim Work Status will have "P Suppressed". However, if a claim is not produced because

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the "Produce Claim" is set to No, as can be seen in the field Prod/Supp Claim when the first piece is set to No, the claim at time of claim print select will have a value of "P Produced" for Claim Production Status, and will have a value of "M Manually Released", "R Released", or "S Suspense Days" for Claim Work Status.

23. ELECTRONIC MEDIA (1-A-O)

This field indicates what electronic media should be used to communicate a claim to the carrier. Entry options are:

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

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

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

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

To send claims electronically, the Claim Media field in the Claim Load and Edit Parameters must be set to **B** (for Both Paper and Electronic), or **E** (for Electronic). Also, the Electronic Types field in the Claim Load and Edit Parameters must be set to the claims (Final, Cycle, Adjustment, Late, or Reprint) that are to be sent electronically. The system sends claims to the paper spoolfile if they are not marked to send electronically in the Electronic Types field.

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

24. CLAIM SPLIT INDICATOR (DISPLAY ONLY)

This field displays the physician or the department the claim is for with a CMS 1500 claim, and the physician the claim is for with a Pennsylvania MA319 Physician Invoice claim. This field displays the department the claim is for with a Non Professional Fee 1500 claim or a New York Title XIX claim when split by department. If not split by department, this field is blank. The field displays either the type of service or physician number and name if this is an Illinois 2360 claim. If not split by Type of Service or Physician, this field is blank. This field displays either an O# or S#, where # represents a number and represents speech, and O represents occupational therapy, if this is an Illinois 1443 claim type.

For UB claims, this field displays either the Split Claim name from the UB Split Claims Criteria Table or the word Primary, for the primary claim, or is blank when not spitting UB claims. If the split claim criteria include splitting by date, the service date follows the Split Claim Name. If the claim was added with the Add Claim to Insurance function, the sequence number follows the Split Claim name.

The following are examples:

- Split claim, not split by service date: VACCINE

- Split claim, not split by service date, added with the Add Claim to Insurance function: VACCINE2

- Primary claim: PRIMARY

- Primary claim added with the Add Claim to Insurance function: PRIMARY1

- Split claim, split by service date, where CAH is the Split Name: CAH 05/03/05

- Split claim, split by service date, where CAH is the Split Name, added with the Add Claim to Insurance function: CAH7 05/03/05

25. ALTERNATE PROVIDER MASTER (DISPLAY ONLY)
This field displays the alternate provider master for a split claim, if one is defined in the Split Claims Criteria table. If no alternate Provider Master is defined for the Split Claim Criteria, the Provider Master assigned to the insurance is used. This field is blank for Primary claims and for claims with a blank Claim Split Indicator field, as these claims use the Provider Master assigned to the insurance.

26. PAYOR CLAIM ID (DISPLAY ONLY)
This field displays the Payor Claim ID for the claim, which is the Facility Indicator + Account Number + Original Claim Sequence Number. UB claims must be set to use the Internal Element *Payor Claim ID* (FACILITY + ACCT + ORIG CLM#) in Locator 3 of the Claim Load Edit Parameter for Patient Control Number. 1500 claims must be set to use Internal Element *Payor Claim ID* (FACILITY + ACCT + ORIG CLM#) in Locator 26 of the Claim Load Edit Parameter for Patient Account Number.

27. CA UB (DISPLAY ONLY)
If the CA UB field in the UB Charge Control Parameter used to load the claim is set to *Yes* to process for California Medicaid, then *Yes* is displayed in this field. If the CA Modifier Table is set in the UB Charge Control Parameter used to load the claim, the field displays YES, a dash, and the table number for the California Modifier Table.

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

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

Delete Claim (Y/N)--

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

Carrier Status Information

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

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

```
               General Hospital Claims by Biller Processor
                                        Mon Mar 27, 2006 10:40 am
Account      Name                  FC Typ Admit    Disch      Balance Loc
89305-00001  ROHDE,JERRY A         WC O/P 11/01/89 11/01/89   4239.50 AR/FCRV

   COB      Carriers                                          Page:01
( 1) 6  152998 ALEXSIS RISK MGMT/W.C.
( 2) 7  150998 BLUE CROSS








 Enter choice--
```

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

```
              General Hospital Claims by Biller Processor
                                        Mon Mar 27, 2007 10:40 am
Account       Name                   FC Typ Admit    Disch     Balance  Loc
89305-00001  ROHDE,JERRY A           WC O/P 05/01/97 05/06/97   4239.50  AR/FCRV

             COB: 6  Carrier/Plan: 152998 ALEXSIS RISK MGMT/W.C.
   Attn: Claims Department                         Phone: (987)123-4567
Mail To: ALEXSIS RISK MGMT/W.C.
         1500 SW 1ST AVE, STE 900
         PORTLAND OR 97201

 1 Claim Type      2 Claim Loaded    3 Claim Generated  4 Est Amount Due
   X UB              05/12/97          05/13/97            $4,239.50
 5 Payment Amount  6 First Payment   7 Last Payment      8 Adjustment Amt

 9 Net Transfers   10 Ext Claim #     11 Claim Seq's Waiting On
   $0.00              5555              2,3,4,5

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


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

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

Field Explanations

1. CLAIM TYPE (DISPLAY ONLY)
This field contains this claim's type code and description. Some examples are B (1500)
and X (UB).

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

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

4. EST AMOUNT DUE (10-N-O)
This field, which can be edited, contains the estimated amount due from the carrier for
the bill sequence that loaded the claim. This amount is the result of the proration
process. The system subtracts out the carrier's liability that has already been billed on
previous bills. For example, if the COB2 plan's estimated liability is $100.00 when bill
sequence 1, a cycle bill, is loaded, the Est Amount Due field will have $100.00. If the
account has further charges, and the COB2 plan's estimated liability is now $500.00,
when bill sequence 2, a final bill, loads the Est Amount Due field will have a $400.00
($500.00 minus $100.00). This field cannot be edited for an archived or purged claim.

5. PAYMENT AMOUNT (DISPLAY ONLY)

This field contains the amount of payments received for this claim from the carrier. If no carrier payments have been received for this claim, this field is blank.

6. FIRST PAYMENT (DISPLAY ONLY)

This field contains the date of the first payment received from the carrier for this claim. If no payment has been received, this field is blank.

7. LAST PAYMENT (DISPLAY ONLY)

This field contains the date of the most recent payment received from the carrier for this claim. If no payment has been received, this field is blank.

8. ADJUSTMENT AMT (DISPLAY ONLY)

This field contains the amount of any adjustments to this claim. If there are no adjustments, this field is blank.

9. NET TRANSFERS (DISPLAY ONLY)

This field contains the total of any balance transfers to and from the carrier.

10. EXT CLAIM # (15-AN-O)

This field contains the hospital-defined number identifying this claim for external purposes. For a UB92 claim, if this information was entered on the patient's insurance Plan Demographic screen, in the Claim/Case # field, it is displayed here. This field can be used to store a number issued to this claim by the carrier. This field cannot be edited for an archived or purged claim.

The Document Control Number (DCN) is saved from the Electronic Remittance Advice (ERA), and can be viewed and edited, and a DCN can be manually entered in an Insurance cash batch (the batch header record must have the field Use Pyr Clm Cont # set to Yes). For UB04 claims, if the DCN number was retained for a payment made to this claim, the DCN number is displayed in this field. If an adjustment claim is later produced, that replaces this claim, the DCN number carries forward to Locator 64 of the UB04 Adjustment claim, but is not displayed in the Ext Claim # field. The number is only visible on the claim posted to in Insurance Cash. This DCN number is used for UB04 Locator 64 for the Document Control Number (payer A, B, and C). The DCN is required when the type of bill frequency code indicates the claim is a replacement to a previously adjudicated claim.

11. CLAIM SEQ'S WAITING ON (DISPLAY ONLY)

This field contains the claim sequences that this claim is waiting for payment, if this claim's work status is Awaiting Payment. This field is updated as the claims it's waiting on are dispositioned as final payment, adjusted to zero, or denied.

12. CLAIM SUBMITTED (6-N-O)

This field contains the date on which the claim was submitted to the carrier, entered in the format MMDDYY or MM/DD/YY. If the claim has not been submitted, this field is left blank. The claim submission date must be equal to or greater than the claim load date. You can enter a claim submission date at any time. However, once you enter the

date, you can change it, but you cannot leave the field blank. If you change the date, the assigned follow-up schedule information is not altered.

When accessing the Claim Submitted field on the Carrier Status Information screen for a non-produced claim, the system displays the following message and moves to the next field:

NOTE: Claim not yet Produced!

Only claims with a status of P (Produced) can be submitted manually. Note that any claims that spool to one of the STAR electronic spoolfiles are automatically given a submission date of the date they spooled on STAR. Therefore, if you are attempting to submit a crossover secondary claim in order to start follow up before the primary pays, you first have to access the Claim Status Information screen for the secondary claim, update the Prod/Supp Claim? field to *Produce No* if you do not want the claim to go to the paper or electronic spoolfile, and then Manually Release the claim in the Claim Work Status field. The next day, once the claim status is Produced, you can enter a Submission Date.

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

NOTE: If you try to submit a claim that has a future date, the following message is displayed: *Error: Can't be future date!*. If you enter a claim submission date that is less than the date the claim was loaded, the following message is displayed: *Error: Must be same or after claim load date!*.

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

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

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

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

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

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

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

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

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

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

Claim Demographic/Visit Data

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

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

The screens that follow are examples of the UB and 1500 claim forms. The UB claim form displayed is the UB04 version. The 1500 claim form displayed is the 08/05 version. For more information, refer to the discussion of Claim Load and Edit Parameters in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*. This function enables you to review and edit the information associated with the selected claim.

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

You can review and edit all pages of the claim by selecting Claim Demographic/ Visit Data - All Screens. You can review and edit only the screens with errors by selecting Claim Demographic/Visit Data - Errors Only. In this case, the system presents only the screens that have failed edits.

If there are no errors, the system displays the message: *No Errors to Display.* The system displays *the* Claim Selection Menu.

You can also review and edit only selected screens using the Demographic/Visit Data - Select Screens option.

• If you select this option and the selected claim is a UB claim type that used any medical information from the charge from accounts linked to the selected account, the following prompt is displayed:

View Combined Medical Information? (Y/N) [N]-- |

If you answer **Y** for Yes, you can preview combined medical information on linked accounts and combined UB procedure/physician information. For details on reviewing this information, see the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference* Guide.If you answer **N** for No (the default), the following screen is displayed:

• When you select a UB claim or a 1500 claim, if there is electronic only data and the hospital is using EC 2000 or the HIPAA Data Extract, the following prompt is displayed:

View added fields saved for electronic UB04 (Y/N) [N]--

If you answer Y (Yes), you can view the maximum number of diagnoses (24), ICD procedures (24), condition codes (24), occurrence codes (24), occurrence span codes (24), value codes (24), and IDE codes (5) that could be sent on the account. This number includes the codes on both the paper portion of the claim and the electronic only data for the claim. The 1500/Non Pro Fee 1500 claims also send/ display more diagnoses (up to 24), but those claim forms do not use Condition Codes, Occurrence Codes, Occurrence Span Codes, or ICD Procedures.

If you enter Y (Yes), the following screen is displayed:

```
                  General Hospital Maintain Claims by Account Processor
                                            Sun Jun 27, 2010 11:15 am
Account      Name               FC Typ Admit    Disch        Balance Loc
C0919100001  JONES,ERIC         M  I/P 07/01/09 01/04/10   163160.27 PA /INSR

Type    Code      Description                          Value1   Value2
IDE1    IDEBAER1234
IDE2    IDE WAKE 52
IDE3    IDE CPAP 12
IDE4    IDEBRAIN 99
DX18    821.00    FX FEMUR NOS                              W
DX19    821.01    FX FEMUR SHAFT                            N
DX20    821.10    FX FEMUR NOS                              Y
DX21    821.11    FX FEMUR SHAFT                            1
DX22    821.20    FX LOW END FEMUR NOS                      W
DX23    821.21    FX FEMORAL CONDYLE                        U
DX24    821.23    SUPRACONDYL FX FEMUR                      Y
PRC06   8312      ADDUCTOR TENOTOMY OF HIP        07/12/09
PRC07   8313      OTHER TENOTOMY                 07/12/09
PRC08   8314      FASCIOTOMY                     07/12/09
PRC09   8319      SOFT TISSUE DIVISION NEC       07/12/09




                    F1Prev Page F2Next Page F7  Exit
```

Field Explanations

TYPE
This field displays the type of electronic data that is being sent. Valid values are: DX18-DX24 for Diagnosis Codes 18-24, PRC06-PRC24 for Procedure Codes 6-24, OCC09-OCC24 for Occurrence Codes 09-24, SPN05-SPN24 for Occurrence Span Codes 05-24, CND12-CND24 for Condition Codes 12-24, VAL13-VAL24 for Value Codes 13-24, IDE1-IDE5 for Investigational Device Exemption code 1-5.

CODE
This field contains the code for the electronic data. Possible values are the diagnosis code, the procedure code, the Occurrence Code, the Occurrence Span Code, the Condition Code, the Value Code, and the IDE number.

DESCRIPTION
This field contains the description of the code if it exists. Possible values are the diagnosis description, the procedure description, the occurrence code description, the occurrence span code description, the condition code description, and the value code description. There is no description for the IDE number.

VALUE 1
This field contains the value for the electronic data. Possible values are the POA (present on admission indicator) for the diagnosis, the procedure code date, the occurrence code date, the occurrence span code From date, and the value code amount.

VALUE 2
This field contains the second value for the electronic data. Possible values are the occurrence span code Through date.

After the electronic data for the claim is viewed, the following screen is displayed:

```
         General Hospital Maintain Claims by Account Processor
                                          Fri Oct 05, 2007 10:25 am
Account       Name                  FC Type Admit    Disch      Balance Loc
C0720500001   HANSEN,VICTORIA       B   O/P 07/24/07 07/24/07   $3385.46 AR

Page:01                                              ##=Current Choices
    From Field                      Thru Field                       Errors
( 1) 1-Provider Name                2-Pay To City
( 2) 2-Pay To State                 5-Federal Tax ID # - U
( 3) 5-Federal Tax ID # - L         9-Patient State
( 4) 9-Patient Zip Code             18-Condition Code 1
( 5) 19-Condition Code 2            30-Reserved Future Use
( 6) 30-Reserved Future Use         33-Occurrence Code 33a
( 7) 33-Occurrence Date 33a         35-Occurrence Span Thru
( 8) 35-Occurrence Span Code        36-Occurrence Span Thru
( 9) 37-Reserved Future Use         39-Value Code 39a
(10) 39-Value Code Amount 39        40-Value Code 40b
(11) 40-Value Code Amount 40        41-Value Code 41c
(12) 41-Value Code Amount 41        52-Payer Release Inform
(13) 52-Payer Release Inform        55-Payer Estimated Amou
(14) 55-Payer Estimated Amou        59-Pat. Relation to Ins

Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
             end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

This screen displays the names of the fields of information and their form locator for each screen of claim information. Note that there may be multiple fields for the same form locator. For example, in the screen, the Statement From Date and the Statement Through Date fields are both part of Form Locator 6 — Statement Covers Period. Form locators are defined in the Claim Load and Edit Parameters, as discussed in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.* The data contained on each screen may vary from these illustrations. For example, the Principal Diagnosis Description might be the last item on screen 14, or it might be the first item on screen 15.

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

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

With any of these selections, any existing errors appear at the bottom of the screen. You can correct any errors as long as the claim has not been produced. Once a claim

has been produced, you must mark the claim for resubmission in the Claim Status Information screen. When all errors, including attachments, have been corrected, the claim is released. The system displays the following message:

Claim Manually Released

The work status of the claim is changed from Fail to Mrel. The claim is then produced during the next Midnight Processing.

Claim Demographic/Visit Data Initial Screen

This screen displays the names of the fields of information and their form locator for each screen of claim information. Note that there may be multiple fields for the same form locator. For example, in the screen, the Statement From Date and the Statement Through Date fields are both part of Form Locator 6 — Statement Covers Period. Form locators are defined in the Claim Load and Edit Parameters, as discussed in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.* The data contained on each screen may vary from these illustrations. For example, the Principal Diagnosis Description might be the last item on screen 14, or it might be the first item on screen 15.

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

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

With any of these selections, any existing errors appear at the bottom of the screen. You can correct any errors as long as the claim has not been produced. Once a claim has been produced, you must mark the claim for resubmission in the Claim Status Information screen. When all errors, including attachments, have been corrected, the claim is released. The system displays the following message:

Claim Manually Released

The work status of the claim is changed from Fail to Mrel. The claim is then produced during the next Midnight Processing.

```
                  General Hospital Maintain Claims by Account Processor
                                               Fri Oct 05, 2007 10:25 am
Account       Name                    FC Type Admit    Disch       Balance Loc
C0720500001  HANSEN,VICTORIA          B   O/P 07/24/07 07/24/07    $3385.46 AR

Page:01                                                   ##=Current Choices
     From Field                       Thru Field                        Errors
( 1) 1-Provider Name                  2-Pay To City
( 2) 2-Pay To State                   5-Federal Tax ID # - U
( 3) 5-Federal Tax ID # - L           9-Patient State
( 4) 9-Patient Zip Code               18-Condition Code 1
( 5) 19-Condition Code 2              30-Reserved Future Use
( 6) 30-Reserved Future Use           33-Occurrence Code 33a
( 7) 33-Occurrence Date 33a           35-Occurrence Span Thru
( 8) 35-Occurrence Span Code          36-Occurrence Span Thru
( 9) 37-Reserved Future Use           39-Value Code 39a
(10) 39-Value Code Amount 39          40-Value Code 40b
(11) 40-Value Code Amount 40          41-Value Code 41c
(12) 41-Value Code Amount 41          52-Payer Release Inform
(13) 52-Payer Release Inform          55-Payer Estimated Amou
(14) 55-Payer Estimated Amou          59-Pat. Relation to Ins


Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
              end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

UB CLAIM FORM - SCREEN 1 OF 26

```
                  General Hospital Claims by Account Processor
                         Page 1 of 26    Mon Mar 27, 2006 10:40 am
Account      Name                   FC Typ Admit    Disch      Balance  Loc
A9316600001  JONES,DORENE           C  O/P 06/15/93 06/15/93   1310.72  AR/FCRV
 1 Provider Name                   2 Provider Street Address
   PROV 2 UB CLAIM NAMEEEEE          PROV 2 UB ADDRESSSSSSSSSS
 3 Provider City       4 Provider State      5 Provider Zip
   ATLANTA             GA                     34567-9999
 6 Provider Telephone Number       7 Provider Fax Number
   (404) 555-1212                    (222) 222-2222
 8 Provider Country Code           9 Pay to Name
   FR                               GENERAL HOSPITAL
10 Pay To Address                 11 Pay To City
   PO BOX 123                       ATLANTA
12 Error Messages



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

Field Explanations

1. PROVIDER NAME (24-AN-O)

This field contains the name of the provider submitting the claim. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type).

2. PROVIDER STREET ADDRESS (25-AN-O)

This field contains the street address, which is loaded from the Provider Master, to which the provider wants the payment sent. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type).

3. PROVIDER CITY (12-AN-O)

This field contains the provider's city, which is loaded from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type).

4. PROVIDER STATE (2-AN-O)

This field contains the provider's state, which is loaded from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type). You can enter the code or a hyphen (-) to display a list of valid codes.

5. PROVIDER ZIP CODE (10-AN-O)

This field contains the five- or nine-digit ZIP code or six-alphanumeric ZIP code, which is loaded from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type).

6. PROVIDER TELEPHONE NUMBER (13-AN-O)

This field contains the provider's phone number, which is loaded from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type). The system automatically formats the entry as 1112223333.

7. PROVIDER FAX NUMBER (13-AN-O)

This field contains the provider's fax phone number, which is loaded from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type). The system automatically formats the entry as 4445551234.

8. PROVIDER COUNTRY CODE (2-A-O)

This field contains the provider's country code, which is loaded from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type).

9. PAY TO NAME (24-AN-O)

This field contains the name of the person to whom payment is sent when this differs from the information in Locator 1. The UB04 claim Master is not set to automatically pull data to Locator 2 for Pay To information. Hospitals can use existing internal

elements to pull data to the fields, or can instead set the "Default Value" to what should always load to the locator (such as PO Box information).

10. PAY TO ADDRESS (25-AN-O)
This field contains the address where payment is sent when this differs from the information in Locator 1. The UB04 claim Master is not set to automatically pull data to Locator 2 for Pay To information. Hospitals can use existing internal elements to pull data to the fields, or can instead set the "Default Value" to what should always load to the locator (such as PO Box information).

11. PAY TO CITY (16-AN-O)
This field contains the city where payment is sent when this differs from the information in Locator 1. The UB04 claim Master is not set to automatically pull data to Locator 2 for Pay To information. Hospitals can use existing internal elements to pull data to the fields, or can instead set the "Default Value" to what should always load to the locator (such as PO Box information).

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 2 OF 26

```
                        General Hospital Claims by Account Processor
                              Page  2 of 26      Mon Mar 27, 2006 10:40 am
Account         Name                      FC Typ Admit    Disch      Balance Loc
A9316600001  JONES,DORENE                 C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV
   AL                      30209
 1 Pay To State         2 Pay to Zip Code       3 Reserved Future Use-2
   GA                     30062
 4 Patient Control Number          5 Medical Record Number
   0701800001                        000000-0056
 6 Type of Bill - Leading Digit    7 Type of Bill - First Digit
   0                                 1
 8 Type of Bill - Second Digit     9 Type of Bill - Third Digit
   3                                 1
10 Federal Tax ID # - Upper Line
   SUB1
11 Error Messages




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

Field Explanations

1. PAY TO STATE (2-AN-O)
This field contains the state where payment is sent when this differs from the information in Locator 1. The UB04 claim Master is not set to automatically pull data to Locator 2 for Pay To information. Hospitals can use existing internal elements to pull data to the fields, or can instead set the "Default Value" to what should always load to the locator (such as PO Box information).

2. PAY TO ZIP (25-AN-O)
This field contains the ZIP code where payment is sent when this differs from the information in Locator 1. The UB04 claim Master is not set to automatically pull data to Locator 2 for Pay To information. Hospitals can use existing internal elements to pull data to the fields, or can instead set the Default Value to what should always load to the locator (such as PO Box information).

3. RESERVED FUTURE USE-2 (30-AN-O)
This field is an unlabeled field and is reserved for future use.

4. PATIENT CONTROL NUMBER (20-AN-O)
This field contains the patient's account number, which is the visit-specific account number assigned to this patient.

5. MEDICAL RECORD NUMBER (17-AN-O)
This field contains the medical/health record number used to audit the history of treatment for the patient. This entry is loaded from Medical Records.

6. TYPE OF BILL - LEADING DIGIT (1-N-O)
This field contains the leading digit of zero for the type of bill code.

7. TYPE OF BILL - FIRST DIGIT (1-N-O)
This field contains the code specifying the type of facility. The type of facility code is entered as a default value on the Claim Load and Edit Parameters. A type of bill first digit of eight can also be loaded using the internal element *UB ASC Bill Type/1st Digit (8xx)*. This internal element looks at the patient's HCPCS codes assigned in Medical Records. If one or more of the HCPCS codes on the account have the field 8xx Ambulatory Procedure set to Yes in the HCPCS Master, the system prints a type of bill first digit of 8. If none of the HCPCS Codes on the account have the 8xx Ambulatory Procedure field set to Yes in the HCPCS Master the system prints the default value from the Claim Load and Edit Parameter.

8. TYPE OF BILL - SECOND DIGIT (1-N-O)
This field contains the code specifying the type of the bill classification (for example, inpatient or outpatient). The bill classification is entered as a default value on the Claim Load and Edit Parameters. A type of bill second digit of 4 can also be loaded using the Diagnostic Revenue Code Table (see Tables, Masters, and Parameters volume).

9. TYPE OF BILL - THIRD DIGIT (1-N-O)
This field contains the code specifying the type of claim (cycle, final, late, or adjustment). The type of claim is automatically calculated for the UB but can be edited.

NOTE: When a claim is reprinted (or when a tracer claim is produced through insurance follow-up), the bill type printed on the UB claim form indicates the bill type of the original claim.

10. FEDERAL TAX ID # - UPPER LINE (4-AN-O)
The upper portion of this locator is optional and varies based on hospital use. The UB04 claim Master is set to pull the Federal Tax Sub ID from the Provider Master. The system looks to the Provider Master assigned to the insurance, or if blank, to the Provider Master assigned to the account (which is based on the COB 1 insurance, or the patient type).

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 3 OF 26

```
                     General Hospital Claims by Account Processor
                        Page  3 of 26     Mon Mar 27, 2006 10:40 am
Account       Name                     FC Typ Admit    Disch      Balance  Loc
A9316600001  JONES,DORENE              C  O/P 06/15/07 06/15/07   1310.72  AR/FCRV
 1 Federal Tax ID # - Lower Line    2 Statement Covers From Date
   FED2222222                          12/31/06
 3 Statement Covers Through Date    4 Reserved Future Use Upper-7
   01/30/07
 5 Reserved Future Use Lower-7      6 Patient ID

 7 Patient Name                     8 Patient Address
   CRANE MD,BARB,L                     123 OCEAN VIEW
 9 Patient City                    10 Patient State
   PALOS VERDES                        CA
11 Error Messages








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

Field Explanations

1.   FEDERAL TAX ID # - LOWER LINE (10-AN-O)
This field contains the number assigned to the provider by the federal government for
tax reporting purposes. It is also known as the tax identification number (TIN) or the
employer identification number (EIN). This number is loaded from the Provider Master.
The system looks to the Provider Master assigned to the insurance, or if blank, to the
Provider Master assigned to the account (which is based on the COB 1 insurance, or
the patient type).

2.   STATEMENT COVERS FROM DATE (10-C-O)
This field contains the beginning service date for the period included on this claim. The
date can be entered in the format MMDDYY or MM/DD/YY. This date can either be the
admission or registration date if this is the first claim, or the beginning date of service
since the last claim. If the internal element *Bill From Date* is used, the system prints the
beginning date of the billing period. If the internal element *Service From Date* is used,
the system prints the earliest service date from the charges that appear on the claim.
You can also print the effective date of a change patient type from an outpatient type
to an inpatient type by using internal element *Admit Date For I/P Stay From O/P*. If
there is no change patient type from an outpatient type to an inpatient type, the internal
element defaults to the admission date. This internal element was added for use with
your inpatient Medicare Claim and Edit Parameters.

3.   STATEMENT COVERS THROUGH DATE (10-C-O)
This field contains the ending service date for the period included on this claim. The
date can be entered in the format MMDDYY or MM/DD/YY. This date can be the

discharge date if this is a final claim, or the last date of service if this is a cycle claim. If the internal element *Bill Thru Date* is used, the system prints the ending date of the billing period. If the internal element *Service To Date* is used, the system prints the latest service date from the charges that appear on the claim.

4. RESERVED FUTURE USE UPPER-7 (7-AN-O)
This field is an unlabeled field and is reserved for future use.

5. RESERVED FUTURE USE LOWER-7 (7-AN-O)
This field is an unlabeled field and is reserved for future use.

6. PATIENT ID (19-AN-O)
This field contains the patient insurance ID. The UB04 claim Master is set to pull the Patient ID from the Insurance Plan Demographics screen, which can only be entered if the patient is not the insured (based on the Same As field of the insurance Plan Demographics screen). The field is required when the patient ID differs from the Insured's ID.

7. PATIENT NAME (29-AN-O)
This field contains the patient's name. The format is determined in the Claim Load and Edit parameters. Since the actual claim form specifies Last, First, Middle, most users also choose to format the patient name in this format.

8. PATIENT ADDRESS (40-AN-O)
This field contains the patient's street address, which is loaded from the patient's demographic file. The UB04 claim Master is set to use Internal Element *PATIENT ADDRESS 1 & 2*. This Internal Element takes the Patient Address 1 and concatenates as much of Patient Address 2 as will fit in 40 characters.

9. PATIENT CITY (30-AN-O)
This field contains the patient's city, which is loaded from the patient's demographic file.

10. PATIENT STATE (2-AN-O)
This field contains the patient's state, which is loaded from the patient demographic file. You can enter the code or a hyphen (-) to display a list of valid codes.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 4 OF 26

```
                General Hospital Claims by Account Processor
                          Page  4 of 26      Mon Mar 27, 2006 10:40 am
Account        Name                  FC Typ Admit    Disch       Balance Loc
A9316600001    JONES,DORENE          C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV

 1 Patient Zip Code     2 Patient Country Code
   12345                  AS
 3 Patient Birthdate    4 Patient Sex          5 Admission Date
   01/19/1963             F                      01/18/07
 6 Admission Hour       7 Admit Type           8 Admit Source
   09                     2                      1
 9 Discharge Hour      10 Discharge Status    11 Condition Code 1
   09                     30
12 Error Messages




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

Field Explanations

1.   PATIENT ZIP CODE (10-AN-O)
This field contains the patient's five- or nine-digit ZIP code or six-alphanumeric ZIP code, which is loaded from the patient's demographic file.

2.   PATIENT COUNTRY CODE (25-AN-O)
This field contains the patient's country code, which is entered in the Patient Page of the admission, and is stored in the patient's demographic file.

3.   PATIENT BIRTHDATE (10-C-O)
This field contains the patient's date of birth, which can be entered in the format MMDDYY, MM/DD/YY, MMDDYYYY, or MM/DD/YYYY.

4.   PATIENT SEX (1-AN-O)
This field contains the sex of the patient at the time the claim is loaded, recorded on the date of admission, outpatient service, or the start of care. Entry options are **M** (male), **F** (female), or **U** (unknown).

5.   ADMISSION DATE (8-C-O)
This field contains the date the patient was admitted or registered to the provider for care. The date can be entered in the format MMDDYY or MM/DD/YY. You can also print the effective date of a change patient type from an outpatient type to an inpatient type by using internal element *Admit Date for I/P Stay From O/P*. If there is no change patient type from an outpatient type to an inpatient type, the internal element defaults to the admission date. This internal element was added for use with your inpatient Medicare Claim Load and Edit Parameters.

6. ADMISSION HOUR (2-N-O)
This field contains the hour during which the patient was admitted or registered for care. The entry range is 00 (12:00 - 12:59 midnight) to 23 (11:00 - 11:59 pm); 99 serves as the code for an unknown time.

7. ADMISSION TYPE (1-N-O)
This field contains the code indicating the priority of this admission. Entry options include (please see the National Uniform Billing Committee manual): 1 (emergency), 2 (urgent), 3 (elective), and 4 (newborn). A separate table is used to define the valid admission type codes.

8. ADMIT SOURCE (1-N-O)
This field contains the code indicating the source of this admission. Entry options include (please see the National Uniform Billing Committee manual): **1** (physician referral), **2** (clinic referral), **3** (HMO referral), **4** (transfer from a hospital), **5** (transfer from a skilled nursing facility), **6** (transfer from another healthcare facility), **7** (emergency room), **8** (court/law enforcement), and **9** (information not available). The Newborn coding structure is **1** (Normal delivery), **2** (Premature delivery), **3** (Sick baby), **4** (Extramural birth). A separate table is used to define the valid admission source codes.

9. DISCHARGE HOUR (2-N-O)
This field contains the hour when the patient was discharged from the hospital. The entry range is **00** (12:00 - 12:59 midnight) to **23** (11:00 - 11:59 pm); enter **99** when the hour is unknown.

Cycle and Cycle Adjustment claims look to the Statement Covers Through Date in determining the UB Discharge Status and the Discharge Hour. If the Statement Covers Through Date loaded for the claim, and Statement Covers Through Date precedes the discharge date, no value is loaded for Discharge Hour from the internal element.

10. DISCHARGE STATUS (2-AN-O)
This field contains the code indicating the patient's discharge status. Please see the National Uniform Billing Committee manual for valid codes. The UB claim uses the mapped "UB Code" value for the hospital discharge status/disposition in the Discharge Status/Disposition Table.

Cycle and Cycle Adjustment claims look to the Statement Covers Through Date in determining the UB Discharge Status and the Discharge Hour. If the Statement Covers Through Date loaded for the claim, and Statement Covers Through Date precedes the discharge date, then no value is loaded for Discharge Status from the internal element. If a Default Value exists in the Claim Load and Edit Parameters, then it will be used since no value loaded from the internal element (for example, 30 for Still Patient).

Final, Adjustment, and Late claims pull the Discharge Status from the account to look up the UB Code in the Discharge Status/Disposition table for the claim, and do not look to the Statement Covers Through Date.

Condition Codes 02, 09, 10, 26, 28, 40, 60, 61, and Y5 can be automatically loaded based on the patient's provider. The information prints if indicated on the assigned provider table, and if it is appropriate for the account. Refer to the documentation on the Provider Master in the *Tables, Masters, and Parameters Volume* in the *STAR Financials Patient Accounting Reference Guide*. When editing the condition codes, once you accept a screen, the condition codes are re-sorted in numeric order (01 through 99) followed by alphanumeric order (A0 through Z9).

11. CONDITION CODE 1 (2-AN-O)
This field contains the code identifying the first condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 5 OF 26

```
                  General Hospital Claims by Account Processor
                          Page  5 of 26      Mon Mar 27, 2006 10:40 am
Account      Name                     FC Typ Admit    Disch     Balance Loc
A9316600001  JONES,DORENE             C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV

 1 Condition Code 2     2 Condition Code 3      3 Condition Code 4

 4 Condition Code 5     5 Condition Code 6      6 Condition Code 7

 7 Condition Code 8     8 Condition Code 9      9 Condition Code 10

10 Condition Code 11   11 Accident State       12 Reserved Future Use Upper-30

13 Error Messages




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

Field Explanations

1. CONDITION CODE 2 (2-AN-O)
This field contains the code identifying the second condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

2. CONDITION CODE 3 (2-AN-O)
This field contains the code identifying the third condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

3. CONDITION CODE 4 (2-AN-O)
This field contains the code identifying the fourth condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

4. CONDITION CODE 5 (2-AN-O)
This field contains the code identifying the fifth condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

5. CONDITION CODE 6 (2-AN-O)
This field contains the code identifying the sixth condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition

codes are loaded from the patient's UB information file and can be generated from the Provider Master.

6.   CONDITION CODE 7 (2-AN-O)
This field contains the code identifying the seventh condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

7.   CONDITION CODE 8 (2-AN-O)
This field contains the code identifying the eighth condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

8.   CONDITION CODE 9 (2-AN-O)
This field contains the code identifying the ninth condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

9.   CONDITION CODE 10 (2-AN-O)
This field contains the code identifying the tenth condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

10. CONDITION CODE 11 (2-AN-O)
This field contains the code identifying the eleventh condition relating to this claim that may affect payor processing. A separate table is used to define condition codes. Condition codes are loaded from the patient's UB information file and can be generated from the Provider Master.

11. ACCIDENT STATE (2-AN-O)
This field contains the state where the accident occurred. The accident information is entered via the Medical page of the admissions by entering Y for Yes to the Acc? field for Accident Related.

12. RESERVED FUTURE USE UPPER-30 (11-AN-O)
This is an unlabeled field and is reserved for future use.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 6 OF 26

```
                General Hospital Claims by Account Processor
                             Page  6 of 26      Mon Mar 27, 2006 10:40 am
Account       Name                     FC Typ Admit    Disch       Balance Loc
A9316600001  JONES,DORENE              C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV
 1 Reserved Future Use Lower-30        2 Occurrence Code 31a
                                         42
 3 Occurrence Date 31a                 4 Occurrence Code 31b
   01/30/07
 5 Occurrence Date 31b                 6 Occurrence Code 32a
                                         A1
 7 Occurrence Date 32a                 8 Occurrence Code 32b
   01/01/40
 9 Occurrence Date 32b                10 Occurrence Code 33a
                                         B1
11 Error Messages




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

Field Explanations

1.   RESERVED FUTURE USE LOWER-30 (13-AN-O)
This field is an unlabeled field and is reserved for future use.

2.   OCCURRENCE CODE 31A (2-AN-O)
This field contains the code identifying a significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

Occurrence Codes and Dates for occurrence codes 01, 02, 03, 04, 05, 06, 10, 18, 19, 31, 32, 35, 42, 44, 45, 46, A1, B1, and C1 can be automatically loaded based on the patient's provider table. This information prints if indicated on the assigned provider table and if it is appropriate for the account. Refer to the documentation on the Provider Master in the *Tables, Masters, and Parameters Volume* in the *STAR Financials Patient Accounting Reference Guide*. When editing the occurrence codes, once you accept a screen, the occurrence codes are re-sorted in numeric order (01 through 99) followed by alphanumeric order (A0 through Z9).

3.   OCCURRENCE DATE 31A (10-AN-O)
This field contains the date associated with the first Occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

4.   OCCURRENCE CODE 31B (2-AN-O)
This field contains the code identifying a fifth significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

5.   OCCURRENCE DATE 31B (2-AN-O)
This field contains the date associated with the fifth occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

6.   OCCURRENCE CODE 32A (2-AN-O)
This field contains the code identifying a second significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

7.   OCCURRENCE DATE 32A (8-C-O)
This field contains the date associated with the second occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

8.   OCCURRENCE CODE 32B (2-AN-O)
This field contains the code identifying the sixth significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

9.   OCCURRENCE DATE 32B (8-C-O)
This field contains the date associated with the sixth occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

10. OCCURRENCE CODE 33A (2-AN-O)
This field contains the code identifying a third significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

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

UB CLAIM FORM - SCREEN 7 OF 26

```
                    General Hospital Claims by Account Processor
                        Page  7 of 26     Mon Mar 27, 2006 10:40 am
Account       Name                       FC Typ Admit    Disch      Balance Loc
A9316600001   JONES,DORENE               C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV
 1 Occurrence Date 33a                  2 Occurrence Code 33b
   01/19/63
 3 Occurrence Date 33b                  4 Occurrence Code 34a

 5 Occurrence Date 34a                  6 Occurrence Code 34b

 7 Occurrence Date 34b                  8 Occurrence Span Code 35a

 9 Occurrence Span From Date 35a   10 Occurrence Span Thru Date 35a

11 Error Messages




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

1. OCCURRENCE DATE 33A (10-C-O)
This field contains the date associated with the third occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

2. OCCURRENCE CODE 33B (2-AN-O)
This field contains the code identifying a seventh significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

3. OCCURRENCE DATE 33B (10-C-O)
This field contains the date associated with the seventh occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

4. OCCURRENCE CODE 34A (2-AN-O)
This field contains the code identifying a fourth significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

5. OCCURRENCE DATE 34A (10-C-O)
This field contains the date associated with the fourth occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

6. OCCURRENCE CODE 34B (2-AN-O)
This field contains the code identifying the eighth significant event relating to this claim that may affect payor processing. A separate table is used to define occurrence codes. Occurrence codes and dates are loaded from the patient's UB information file and can be generated from the Provider Master.

7.   OCCURRENCE DATE 34B (10-D-O)
This field contains the date associated with the eighth occurrence code. The date can be entered in the format MMDDYY or MM/DD/YY.

The Occurrence Span Code and Dates for occurrence span codes 72, 74, 75 and M0 can be automatically loaded based on the patient's provider table. This information prints if indicated based on the provider table and if it is appropriate for the account. Refer to the documentation on the Provider Master in the Tables, Masters, and Parameters Volume in the STAR Financials Patient Accounting Reference Guide. When editing the occurrence span codes, once you accept a screen, the occurrence span codes are resorted in numeric order (01 through 99) followed by alphanumeric order (A0 through Z9).

8.   OCCURRENCE SPAN CODE 35A (2-AN-O)
This field contains the code identifying an event relating to the payment of the claim. Occurrence Span Codes are loaded from the patient's UB information file and can be generated from the Provider Master.

9.   OCCURRENCE SPAN FROM DATE 35A (10-D-O)
This field contains the beginning date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

10. OCCURRENCE SPAN THROUGH DATE 35A (10-D-O)
This field contains the ending date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 8 OF 26

```
                    General Hospital Claims by Account Processor
                            Page  8 of 26     Mon Mar 27, 2006 10:40 am
Account        Name                    FC Typ Admit    Disch      Balance Loc
A9316600001   JONES,DORENE             C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV
 1 Occurrence Span Code 35b           2 Occurrence Span From Date 35b

 3 Occurrence Span Thru Date 35b      4 Occurrence Span Code 36a

 5 Occurrence Span From Date 36a      6 Occurrence Span Thru Date 36a

 7 Occurrence Span Code 36b           8 Occurrence Span From Date 36b

 9 Occurrence Span Thru Date 36b

10 Error Messages




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

Field Explanations

1. OCCURRENCE SPAN CODE 35B (2-AN-O)
This field contains the code identifying an event relating to the payment of the claim. Occurrence Span Codes are loaded from the patient's UB information file and can be generated from the Provider Master.

2. OCCURRENCE SPAN FROM DATE 35B (10-D-O)
This field contains the beginning date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

3. OCCURRENCE SPAN THROUGH DATE 35B (10-D-O)
This field contains the ending date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

4. OCCURRENCE SPAN CODE 36A (2-AN-O)
This field contains the code identifying an event relating to the payment of the claim. Occurrence Span codes are loaded from the patient's UB information file and can be generated from the Provider Master.

5. OCCURRENCE SPAN FROM DATE 36A (10-D-O)
This field contains the beginning date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

6. OCCURRENCE SPAN THROUGH DATE 36A (10-D-O)
This field contains the ending date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

7. OCCURRENCE SPAN CODE 36B (2-AN-O)
This field contains the code identifying an event relating to the payment of the claim. Occurrence Span Codes are loaded from the patient's UB information file and can be generated from the Provider Master.

8. OCCURRENCE SPAN FROM DATE 36B (10-D-O)
This field contains the beginning date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

9. OCCURRENCE SPAN THROUGH DATE 36B (10-D-O)
This field contains the ending date of the event associated with the entered Occurrence Span code. The date can be entered in the format MMDDYY or MM/DD/YY.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 9 OF 26

```
                    General Hospital Claims by Account Processor
                         Page  9 of 26     Mon Mar 27, 2006 10:40 am
Account       Name                     FC Typ Admit    Disch      Balance Loc
A9316600001  JONES,DORENE              C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV

 1 Reserved Future Use Upper-37     2 Reserved Future Use Lower-37


 3 Guarantor Name
   CRANE, BOB
 4 Guarantor Address Line 1
   456 GUARANTOR ADDRESS
 5 Guarantor Address Line 2                6 Guarantor City
   GUARANTOR ADDRESS LINE 2                  ALPHARETTA
 7 Guarantor State      8 Guarantor Zip Code
   GA                     40404
 9 Guarantor Phone Number                10 Value Code 39a
   (770) 111-2222                           31
11 Error Messages




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

Field Explanations

1. RESERVED FUTURE USE UPPER-37 (8-AN-O)
This field is an unlabeled field. It is reserved for future use.

2. RESERVED FUTURE USE LOWER-37 (8-AN-O)
This field is an unlabeled field. It is reserved for future use.

3. GUARANTOR NAME (40-AN-O)
This field contains the name of the party responsible for this bill. The entry in this field
is loaded from the patient's admission data file.

4. GUARANTOR ADDRESS LINE 1 (40-AN-O)
This field contains the guarantor's street address, which is loaded from the patient's
admission data file.

5. GUARANTOR ADDRESS LINE 2 (40-AN-O)
This field contains the guarantor's street address, which is loaded from the patient's
admission data file.

6. GUARANTOR CITY (27-AN-O)
This field contains the guarantor's city, which is loaded from the patient's admission
data file.

7. GUARANTOR STATE (2-AN-O)
This field contains the guarantor's state, which is loaded from the patient's admission
data file.

8. GUARANTOR ZIP CODE (10-AN-O)
This field contains the guarantor's five- or nine-digit ZIP code or six-alphanumeric ZIP code, which is loaded from the patient's admission data file.

9. GUARANTOR TELEPHONE NUMBER (40-AN-O)
This field contains the guarantor's 7 or 10 digit telephone number, which is loaded from the patient's admission data file.

Value Codes and Amounts for value codes 01, 02, 05, 07, 08, 09, 12, 14, 16, 24, 24I, 31, 37, 38, 39, 45, 46, 50, 51, 52, 53, 80, 81, 82, 83, A1, B1, C1, A2, B2, C2, A3, B3, C3, and D3, as well as state-specific codes, can be automatically loaded based on the patient's provider table. The information prints if indicated on the assigned provider table and if it is appropriate for the account. Refer to the documentation on the Provider Master in the *Tables, Masters, and Parameters Volume* in the *STAR Financials Patient Accounting Reference Guide*. When editing the value codes, once you accept a screen, the value codes are re-sorted in numeric order (01 through 99) followed by alphanumeric order (A0 through Z9).

10. VALUE CODE 39A (2-AN-O)
This field contains the first value code relating to this claim that may affect payor processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 10 OF 26

```
                    General Hospital Claims by Account Processor
                         Page 10 of 26      Mon Mar 27, 2007 10:40 am
Account       Name                     FC Typ Admit    Disch      Balance Loc
A9316600001  JONES,DORENE             C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV

1 Value Code Amount 39a           2 Value Code 39b
   141.58
3 Value Code Amount 39b           4 Value Code 39c

5 Value Code Amount 39c           6 Value Code 39d

7 Value Code Amount 39d           8 Value Code 40a

9 Value Code Amount 40a          10 Value Code 40b

11 Error Messages




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

Field Explanations

1. VALUE CODE AMOUNT 39A (10-N-O)
This field contains the dollar amount associated with the first value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

2. VALUE CODE 39B (2-AN-O)
This field contains the fourth value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

3. VALUE CODE AMOUNT 39B (10-N-O)
This field contains the dollar amount associated with the fourth value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

4. VALUE CODE 39C (2-AN-O)
This field contains the seventh value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

5. VALUE CODE AMOUNT 39C (10-N-O)
This field contains the dollar amount associated with the seventh value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

6.   VALUE CODE 39D (2-AN-O)
This field contains the tenth value code relating to this claim that may affect payer
processing. A separate table is used to define value codes. Value codes and amounts
are loaded from the patient's UB information file and can be generated from the
Provider Master.

7.   VALUE CODE AMOUNT 39D (10-N-O)
This field contains the dollar amount associated with the tenth value code. The entry
range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

8.   VALUE CODE 40A (2-AN-O)
This field contains the second value code relating to this claim that may affect payer
processing. A separate table is used to define value codes. Value codes and amounts
are loaded from the patient's UB information file and can be generated from the
Provider Master.

9.   VALUE CODE AMOUNT 40A (10-N-O)
This field contains the dollar amount associated with the second value code. The range
is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

10. VALUE CODE 40B (2-AN-O)
This field contains the fifth value code relating to this claim that may affect payer
processing. A separate table is used to define value codes. Value codes and amounts
are loaded from the patient's UB information file and can be generated from the
Provider Master.

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

When all fields have been reviewed and/or edited, you have the option of moving
forward or backward through the 26 screens included in this function. Before doing so,
you must accept the screen you are currently accessing, which can be done even if
there are errors or omissions in the information it contains. After you accept the screen,
the system displays the next screen.

UB CLAIM FORM - SCREEN 11 OF 26

```
                    General Hospital Claims by Account Processor
                          Page 11 of 26      Mon Mar 27, 2006 10:40 am
Account       Name                     FC Typ Admit    Disch     Balance Loc
A9316600001   JONES,DORENE              C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV
1 Value Code Amount 40b            2 Value Code 40c

 3 Value Code Amount 40c            4 Value Code 40d

 5 Value Code Amount 40d            6 Value Code 41a

 7 Value Code Amount 41a            8 Value Code 41b

 9 Value Code Amount 41b           10 Value Code 41c

11 Error Messages




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

Field Explanations

1.   VALUE CODE AMOUNT 40B (10-N-O)
This field contains the dollar amount associated with the fifth value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

2.   VALUE CODE 40C (2-AN-O)
This field contains the eighth value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

3.   VALUE CODE AMOUNT 40C (10-N-O)
This field contains the dollar amount associated with the eighth value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

4.   VALUE CODE 40D (2-AN-O)
This field contains the eleventh value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

5.   VALUE CODE AMOUNT 40D (10-N-O)
This field contains the dollar amount associated with the eleventh value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

6.   VALUE CODE 41A (2-AN-O)
This field contains the third value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts

are loaded from the patient's UB information file and can be generated from the Provider Master.

7. VALUE CODE AMOUNT 41A (10-N-O)
This field contains the dollar amount associated with the third value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$.CC format.

8. VALUE CODE 41B (2-AN-O)
This field contains the sixth value code relating to this claim that may affect payor processing. A separate table is used to define value codes. All value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

9. VALUE CODE AMOUNT 41B (10-N-O)
This field contains the dollar amount associated with the sixth value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$.CC format.

10. VALUE CODE 41C (2-AN-O)
This field contains the ninth value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 12 OF 26

```
                          General Hospital Claims by Account Processor
                                Page 12 of 26      Mon Mar 27, 2006 10:40 am
Account       Name                       FC Typ Admit    Disch      Balance Loc
A9316600001   JONES,DORENE                C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV
 1 Value Code Amount 41c              2 Value Code 41d

 3 Value Code Amount 41d              4 Payer Name 50a
                                        BARB' WAITING COMMERCIA
 5 Payer Name 50b                     6 Payer Name 50c
   BLUE CROSS BASIC PLAN
 7 Health Plan ID 51a   8 Health Plan ID 51b    9 Health Plan ID 51c
   9999999999             IPBX11111111111
10 Payer Release Information 52a   11 Payer Release Information 52b
   Y                                 Y
12 Error Messages




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

Field Explanations

1. VALUE CODE AMOUNT 41C (10-N-O)
This field contains the dollar amount associated with the ninth value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

2. VALUE CODE 41D (2-AN-O)
This field contains the twelfth value code relating to this claim that may affect payer processing. A separate table is used to define value codes. Value codes and amounts are loaded from the patient's UB information file and can be generated from the Provider Master.

3. VALUE CODE AMOUNT 41D (10-N-O)
This field contains the dollar amount associated with the twelfth value code. The entry range is **0** to **$9,999,999.99**, entered in $$$$$$$.CC format.

4. PAYER NAME 50A (23-AN-O)
This field contains the description of the primary payor of this claim. The number that prints above the hospital name in locator 1 corresponds to the payer that the claim is for. If the claim is for the payer listed in line A of form locator 50, then the number 1 is printed. If the claim is for the payer listed in line B, a 2 is printed, and if the claim is for the payer listed in line C, then a 3 is printed. A number 4 is printed if the claim is for the payer that would have printed in line D of form locator 50 had there been another line of detail. This number corresponds to the line number in form locator 50 of the claim form and is not necessarily the COB of the plan if pro fee plans are set up not to print on the UB claim.

5. PAYER NAME 50B (23-AN-O)

This field contains the description of the secondary payor of this claim. The number that prints above the hospital name in locator 1 corresponds to the payer that the claim is for. If the claim is for the payer listed in line A of form locator 50, then the number 1 is printed. If the claim is for the payer listed in line B, a 2 is printed, and if the claim is for the payer listed in line C, then a 3 is printed. A number 4 is printed if the claim is for the payer that would have printed in line D of form locator 50 had there been another line of detail. This number corresponds to the line number in form locator 50 of the claim form and is not necessarily the COB of the plan if pro fee plans are set up not to print on the UB claim.

6. PAYER NAME 50C (23-AN-O)

This field contains the description of the tertiary payor of this claim. The number that prints above the hospital name in locator 1 corresponds to the payer that the claim is for. If the claim is for the payer listed in line A of form locator 50, then the number 1 is printed. If the claim is for the payer listed in line B, a 2 is printed, and if the claim is for the payer listed in line C, then a 3 is printed. A number 4 is printed if the claim is for the payer that would have printed in line D of form locator 50 had there been another line of detail. This number corresponds to the line number in form locator 50 of the claim form and is not necessarily the COB of the plan if pro fee plans are set up not to print on the UB claim.

7. HEALTH PLAN ID 51A (15-AN-O)

This field contains the health plan ID for the primary group health plan. This number is assigned to the provider by Blue Cross, Medicare, or Medicaid. This field is loaded from the Provider Number field of the insurance Claim/Proration Control screen at the account level, and defaults to the hospital Provider Master, based on the Insurance Type of the carrier/plan. If the provider master at the overall account level is used, insurances that have a Medicare or Champus insurance type print the provider number from the UB Provider Number field in the Provider Master. Insurances that have a Blue Cross insurance type print the provider number from the Blue Cross Provider Number field, and insurances that have a Medicaid/Welfare insurance type print the provider number from the Medicaid Provider Number 1, 2, or 3 field, depending on the patient's home state. If the patient is not from one of the three states listed for Medicaid in the Provider Master, then the provider number from the Medicaid Provider Number 1 field is printed. Commercial/HMO plans do not print a provider number from the Provider Master. If one is needed, the number must be entered in the Provider Number field in the Insurance Plan Coverage Master for the insurance.

8. HEALTH PLAN ID 51B (15-AN-O)

This field contains the health plan ID for the secondary group health plan. This number is assigned to the provider by Blue Cross, Medicare, or Medicaid. This field is loaded from the Provider Number field of the insurance Claim/Proration Control screen at the account level, and defaults to the hospital Provider Master, based on the Insurance Type of the carrier/plan. If the provider master at the overall account level is used, insurances that have a Medicare or Champus insurance type print the provider number from the UB Provider Number field in the Provider Master. Insurances that have a Blue Cross insurance type print the provider number from the Blue Cross Provider Number

field, and insurances that have a Medicaid/Welfare insurance type print the provider number from the Medicaid Provider Number 1, 2, or 3 field, depending on the patient's home state. If the patient is not from one of the three states listed for Medicaid in the Provider Master, then the provider number from the Medicaid Provider Number 1 field is printed. Commercial/HMO plans do not print a provider number from the Provider Master. If one is needed, the number must be entered in the Provider Number field in the Insurance Plan Coverage Master for the insurance.

9. HEALTH PLAN ID 51C (15-AN-O)
This field contains the health plan ID for the tertiary group health plan. This number is assigned to the provider by Blue Cross, Medicare, or Medicaid. This field is loaded from the Provider Number field of the insurance Claim/Proration Control screen at the account level, and defaults to the hospital Provider Master, based on the Insurance Type of the carrier/plan. If the provider master at the overall account level is used, insurances that have a Medicare or Champus insurance type print the provider number from the UB Provider Number field in the Provider Master. Insurances that have a Blue Cross insurance type print the provider number from the Blue Cross Provider Number field, and insurances that have a Medicaid/ Welfare insurance type print the provider number from the Medicaid Provider Number 1, 2, or 3 field, depending on the patient's home state. If the patient is not from one of the three states listed for Medicaid in the Provider Master, then the provider number from the Medicaid Provider Number 1 field is printed. Commercial/HMO plans do not print a provider number from the Provider Master. If one is needed, the number must be entered in the Provider Number field in the Insurance Plan Coverage Master for the insurance.

10. PAYER RELEASE INFORMATION 52A (1-AN-O)
This field contains the code indicating whether the provider has a signed statement (on file) from the patient permitting the provider to release data to the primary carrier for claim processing. The entry in this field is loaded from the Claim Load and Edit parameters for this carrier/plan, or from utilization management if the ROI Consent internal element is used.

11. PAYER RELEASE INFORMATION 52B (1-AN-O)
This field contains the code indicating whether the provider has a signed statement (on file) from the patient permitting the provider to release data to the secondary carrier for claim processing. The entry in this field is loaded from the Claim Load and Edit parameters for this carrier/plan, or from utilization management if the ROI Consent internal element is used.

UB CLAIM FORM - SCREEN 13 OF 26

```
                        General Hospital Claims by Account Processor
                           Page 13 of 26      Mon Mar 27, 2007 10:40 am
Account       Name                       FC Typ Admit    Disch      Balance Loc
A9316600001   JONES,DORENE               C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV
 1 Payer Release Information 52c          2 Payer Benefits Assigned 53a
                                            Y
 3 Payer Benefits Assigned 53b           4 Payer Benefits Assigned 53c
   Y
 5 Payer Prior Payments 54a              6 Payer Prior Payments 54b

 7 Payer Prior Payments 54c              8 Payer Estimated Amount Due 55a
                                            7180.00
 9 Payer Estimated Amount Due 55b
   7595.00
10 Error Messages




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

Field Explanations

1. PAYER RELEASE INFORMATION 52C (1-AN-O)
This field contains the code indicating whether the provider has a signed statement (on file) from the patient permitting the provider to release data to the tertiary carrier for claim processing. The entry in this field is loaded from the Claim Load and Edit parameters for this carrier/plan, or from utilization management if the ROI Consent internal element is used.

2. PAYER BENEFITS ASSIGNED 53A (1-AN-O)
This field contains the code indicating whether the provider has a signed form from the patient authorizing the primary payor to pay the provider. Entry options are **Y** for Yes or **N** for No.

3. PAYER BENEFITS ASSIGNED 53B (1-AN-O)
This field contains the code indicating whether the provider has a signed form from the patient authorizing the secondary payor to pay the provider. Entry options are **Y** for Yes or **N** for No.

4. PAYER BENEFITS ASSIGNED 53C (1-AN-O)
This field contains the code indicating whether the provider has a signed form from the patient authorizing the tertiary payor to pay the provider. Entry options are **Y** for Yes or **N** for No.

5. PAYER PRIOR PAYMENTS 54A (11-N-O)
This field contains the amount the hospital has received toward payment of this claim by the payor listed in Locator 50a. The system looks to theUB92 Loc 54 Prior Pymt Calc field on the header screen of the UB Claim Load Edit Parameter. This field indicates whether UB Locator 54 reflects insurance payments only, 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. 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. Therefore, only claims waiting for prior payment are updated with the payment information. Also, the Claim Load Edit Parameter must be set as follows: Field Type: M Money, Internal Element: MONEY, Print Routine: MONEY 999999900 BLK 0 BEG SIGN. The entry in this field is entered in -$$$$$$$.CC format.

6.   PAYER PRIOR PAYMENTS 54B (11-N-O)
This field contains the amount the hospital has received toward payment of this claim by the payor listed in Locator 50b. The system looks to the UB92 Loc 54 Prior Pymt Calc field on the header screen of the UB Claim Load Edit Parameter. This field indicates whether UB Locator 54 reflects insurance payments only, 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. 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. Therefore, only claims waiting for prior payment are updated with the payment information. Also, the Claim Load Edit Parameter must be set as follows: Field Type: M Money, Internal Element: MONEY, Print Routine: MONEY 999999900 BLK 0 BEG SIGN. The entry in this field is entered in -$$$$$$$.CC format.

7.   PAYER PRIOR PAYMENTS 54C (11-N-O)
This field contains the amount the hospital has received toward payment of this claim by the payor listed in Locator 50c. The system looks to the UB92 Loc 54 Prior Pymt Calc field on the header screen of the UB Claim Load Edit Parameter. This field indicates whether UB Locator 54 reflects insurance payments only, 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. 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. Therefore, only claims waiting for prior payment are updated with the payment information. Also, the Claim Load Edit Parameter must be set as follows: Field Type: M Money, Internal Element: MONEY, Print Routine: MONEY 999999900 BLK 0 BEG SIGN. The entry in this field is entered in -$$$$$$$.CC format.

8.   PAYER ESTIMATED AMOUNT DUE 55A (10-N-O)

This field contains the amount estimated by the hospital to be due from the payer for this bill sequence. The entry in this field is entered in -$$$$$$$.CC format. Claims waiting for payment are updated with the estimated amount due for the payers in Locator 55A, B, and C each time the system attempts to release the waiting claim. The system can update Locator 55A, B, and C on the waiting claims with either the estimated amount due, or the current carrier balance of the payers, depending on the setting of the UB LOC 55 field in the PAAR Control table. If this field is set to C for Cur Est Amt Due (current estimated amount due), the system makes the following calculation per bill sequence: (Covered charges - deductible -coinsurance) - payments +/- adjustments. The system does not take into account any COB adjustment or balance transfers.

If the field is set to B for Cur Carrier Bal (current carrier balance), the system updates Locator 55A, B, and C with the current balances of the payers each time the system attempts to release the waiting claim. For example, if claim sequence 3 for COB3 is waiting on claim sequence 1 and 2, when claim sequence 1 is marked Final Payment, Adjusted to Zero, or Denied through Cash Posting, Adjustment Posting, or Balance Transfer & Claim Disposition, the system attempts to release claim sequence 3. The claim is not released since it is still waiting on claim sequence 2, but Locator 55A, B, and C on claim sequence 3 are updated. When claim sequence 2 is then marked Final Payment, Adjusted to Zero, or Denied, the system again attempts to release claim sequence 3. Locators 55A, B, and C are updated again for claim sequence 3.

When claims load, Locator 55A, B, and C are initially updated with the estimated amount due. How the system updates these fields for waiting claims is determined by the UB LOC 55 field in the PAAR Control table.

9.   PAYER ESTIMATED AMOUNT DUE 55B (10-N-O)

This field contains the amount estimated by the hospital to be due from the payer for this bill sequence. The entry in this field is entered in -$$$$$$$.CC format. Claims waiting for payment are updated with the estimated amount due for the payers in Locator 55A, B, and C each time the system attempts to release the waiting claim. The system can update Locator 55A, B, and C on the waiting claims with either the estimated amount due, or the current carrier balance of the payers, depending on the setting of the UB LOC 55 field in the PAAR Control table. If this field is set to C for Cur Est Amt Due (current estimated amount due), the system makes the following calculation per bill sequence: (Covered charges - deductible -coinsurance) - payments +/- adjustments. The system does not take into account any COB adjustment or balance transfers.

If the field is set to B for Cur Carrier Bal (current carrier balance), the system updates Locator 55A, B, and C with the current balances of the payers each time the system attempts to release the waiting claim. For example, if claim sequence 3 for COB3 is waiting on claim sequence 1 and 2, when claim sequence 1 is marked Final Payment, Adjusted to Zero, or Denied through Cash Posting, Adjustment Posting, or Balance Transfer & Claim Disposition, the system attempts to release claim sequence 3. The claim is not released since it is still waiting on claim sequence 2, but Locator 55A, B,

and C on claim sequence 3 are updated. When claim sequence 2 is then marked Final Payment, Adjusted to Zero, or Denied, the system again attempts to release claim sequence 3. Locators 55A, B, and C are updated again for claim sequence 3.

When claims load, Locator 55A, B, and C are initially updated with the estimated amount due. How the system updates these fields for waiting claims is determined by the UB LOC 55 field in the PAAR Control table.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 14 OF 26

```
                    General Hospital Claims by Account Processor
                         Page 14 of 26      Mon Mar 27, 2006 10:40 am
Account       Name                    FC Typ Admit    Disch      Balance Loc
A9316600001   JONES,DORENE            C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV

 1 Payer Estimated Amount Due 55c   2 Provider NPI
   0.00                               2342342342
  3 Other Prov ID 57A     4 Other Prov ID 57B     5 Other Prov ID 57C
   UB11111111            UB22222222
  6 Insured's Name 58a                7 Insured's Name 58b
   AUNTIE,EM                            CRANE,BARB,L
  8 Insured's Name 58c                9 Pat. Relation to Insured 59a
                                       1
10 Pat. Relation to Insured 59b
   1
11 Error Messages





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

Field Explanations

1.   PAYER ESTIMATED AMOUNT DUE 55C (11-N-O)

This field contains the amount estimated by the hospital to be due from the payer for this bill sequence. The entry in this field is entered in -$$$$$$$.CC format. Claims waiting for payment are updated with the estimated amount due for the payers in Locator 55A, B, and C each time the system attempts to release the waiting claim. The system can update Locator 55A, B, and C on the waiting claims with either the estimated amount due, or the current carrier balance of the payers, depending on the setting of the UB LOC 55 field in the PAAR Control table. If this field is set to C for Cur Est Amt Due (current estimated amount due), the system makes the following calculation per bill sequence: (Covered charges - deductible -coinsurance) - payments +/- adjustments. The system does not take into account any COB adjustment or balance transfers.

If the field is set to B for Cur Carrier Bal (current carrier balance), the system updates Locator 55A, B, and C with the current balances of the payers each time the system attempts to release the waiting claim. For example, if claim sequence 3 for COB3 is waiting on claim sequence 1 and 2, when claim sequence 1 is marked Final Payment, Adjusted to Zero, or Denied through Cash Posting, Adjustment Posting, or Balance Transfer & Claim Disposition, the system attempts to release claim sequence 3. The claim is not released since it is still waiting on claim sequence 2, but Locator 55A, B, and C on claim sequence 3 are updated. When claim sequence 2 is then marked Final Payment, Adjusted to Zero, or Denied, the system again attempts to release claim sequence 3. Locators 55A, B, and C are updated again for claim sequence 3.

When claims load, Locator 55A, B, and C are initially updated with the estimated amount due. How the system updates these fields for waiting claims is determined by the UB LOC 55 field in the PAAR Control table.

An example of what prints in locator 55 if the field UB Loc 55 in the PAAR Control table is set to print current estimated amount due follows. If COB1 and COB2 are both UB plans, and COB2 is set to wait for payment from COB1, assume the following is displayed on the Balance Summary screen after each bill:

	After Cycle Bill Sequence 1		After Final Bill Sequence 2	
	COB1 Claim Seq 1	COB2 Claim Seq 2	COB1 Claim Seq 3	COB2 Claim Seq 4
Room Covered	500.00	500.00	750.00	750.00
Ancillary Covered	20,000.00	20,000.00	30,000.00	30,000.00
Deductible	300.00	100.00	300.00	100.00
Coinsurance	4,100.00	2,050.00	6,150.00	3,075.00
Payment	12,000.00	0	18,000.00	0
Adjustment	400.00	0	1,000.00	0

For bill sequence 1, claim sequence 2, if the COB1 plan first makes a credit adjustment of $400.00 and then makes a final payment of $12,000.00, the Estimated Amount Due in locator 55A will be (500.00 + 20,000.00 - 300.00 - 4,100.00) - 12,000.00 - 400.00 = $3700.00. The Estimated Amount Due in Locator 55B will be (500.00 + 20,000.00 - 100.00 - 2,050.00) - 0 - 0 = $18,350.00.

For bill sequence 2, claim sequence 4, if the COB1 plan first makes a credit adjustment of $600.00 and then makes a final payment of $6,000.00, the Estimated Amount Due in locator 55A will subtract what was already accounted for on previous bills. The system makes the following calculation:

[(750.00 + 30,000.00 - 300.00 -6150.00) - (500.00 + 20,000.00 - 300.00 -4,100.00)] - payment this bill sequence of 6,000 - adjustment this bill sequence of 600.00 = $1600.00.

The Estimated Amount Due in locator 55B will be [(750.00 + 30,000.00 - 100.00 - 3,075.00) - (500.00 + 20,000.00 - 100.00 - 2,050.00) - payment this bill sequence of 0 - adjustment this bill sequence of 0 = $9,225.00.

2. PROVIDER NPI (15-AN-O)

This field contains the national provider identification number. The system looks to the insurance for which the claim was loaded and uses the Provider Master assigned to this insurance to look up the Provider NPI #. If there is no Provider Master assigned to the insurance, the Provider Master assigned to the account is used.

3. OTHER PROV ID 57A (15-AN-O)
This field contains the Other Provider ID (legacy) for payer A. The claim Master is set to load the UB Provider Nmbr from the Provider Master assigned to the insurance or, if blank, the Provider Master assigned to the account. As with other locators, this can be updated to pull a different legacy number by updating the Internal Element in the Claim Load Edit Parameter.

4. OTHER PROV ID 57B (15-AN-O)
This field contains the Other Provider ID (legacy) for payer B. The claim Master is set to load the UB Provider Nmbr from the Provider Master assigned to the insurance, or if blank, the Provider Master assigned to the account. As with other locators, this can be updated to pull a different legacy number by updating the Internal Element in the Claim Load Edit Parameter.

5. OTHER PROV ID 57C (15-AN-O)
This field contains the Other Provider ID (legacy) for payer C. The claim Master is set to load the UB Provider Nmbr from the Provider Master assigned to the insurance, or if blank, the Provider Master assigned to the account. As with other locators, this can be updated to pull a different legacy number by updating the Internal Element in the Claim Load Edit Parameter.

6. INSURED'S NAME 58A (26-AN-O)
This field contains the name of the individual in whose name the primary insurance is carried. The entry in this field is loaded from this carrier/plan's demographic data.

7. INSURED'S NAME 58B (26-AN-O)
This field contains the name of the individual in whose name the secondary insurance is carried. The entry in this field is loaded from this carrier/plan's demographic data.

8. INSURED'S NAME 58C (26-AN-O)
This field contains the name of the individual in whose name the tertiary insurance is carried. The entry in this field is loaded from this carrier/plan's demographic data.

PATIENT RELATION TO INSURED

The UB04 accepts nine Patient Relation to Insured codes. The UB92 accepts sixteen more Patient Relation to Insured codes. These codes are subject to change. Please check your National Uniform Billing Committee manual.

• HIPAA Insured Relation Table

    The Valid UB04 Code field indicates if the HIPAA code is valid for the UB04.

    The following HIPAA Insured Relationship Codes should have the Valid UB04 Code field set to YES:

    • 01 Spouse

    • 18 Self

- 19 Child

- 20 Employee

- 21 Unknown

- 39 Organ Donor

- 40 Cadaver Donor

- 53 Life Partner

- G8 Other Relationship

- Insured Relation Table

  - The field of HIPAA UB04 Relationship Code is for use on the UB04 claim.

  - For each table code, which displays in Field 1 and is what is entered in the Relation to Insured field of the Plan Demographics screen for the account, users must set the HIPAA UB04 Relationship Code.

  - The only codes that can be entered are those that have the Valid UB04 Code field set to Yes in the HIPAA Insured Relation table.

  - If the HIPAA UB04 Relationship Code field is blank, the UB04 may reject on the payer side for a blank Patient Relation to Insured.

9. PATIENT RELATION TO INSURED 59A (2-AN-O)
This field contains the code indicating the relationship of the patient to the identified insured for the primary carrier. The entry in this field is loaded from this carrier/plan's demographic data. See Patient Relation to Insured information above.

10. PAT. RELATION TO INSURED 59B (2-AN-O)
This field contains the code indicating the relationship of the patient to the identified insured for the secondary carrier. The entry in this field is loaded from this carrier/plan's demographic data. See Patient Relation to Insured information above.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if

there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 15 OF 26

```
            General Hospital Maintain Claims by Account Processor
                            Page 15 of 26     Mon Mar 27, 2006 10:40 am
Account      Name                     FC Typ Admit    Disch      Balance Loc
A97-07700004 CRANE,AARON              C  SER 03/18/07 03/22/07   1902.50 AR/FCRV
 1 Pat. Relation to Insured 59c       2 Cert/SS#/HIC/ID # 60a
                                        POLICYCOMM1234567890
 3 Cert/SS#/HIC/ID # 60b              4 Cert/SS#/HIC/ID # 60c

 5 Group Name 61a        6 Group Name 61b        7 Group Name 61c
   COMGROUPNAMEEEE         GROUP NAME FOR
 8 Insurance Group Number 62a         9 Insurance Group Number 62b
   COMGR123456789012                   GR34567
10 Insurance Group Number 62c

11 Error Messages




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

Field Explanations

1. PAT. RELATION TO INSURED 59C (2-AN-O)

This field contains the code indicating the relationship of the patient to the identified insured for the tertiary carrier. The entry in this field is loaded from this carrier/plan's demographic data. See .

2. CERT/SS#/HIC/ID # 60A (20-AN-O)

This field contains the certificate, social security number, health insurance claim, or identification number used by the primary payor to identify the insured. The entry in this field is loaded from the carrier/plans demographic data. Medicare A and B plans pull the Claim Number. Blue Cross plans pull the Subscriber ID Number. Champus plans pull the ID Card Number. Commercial and HMO plans pull the Policy Number. Medicaid and Welfare plans pull the Recipient Number.

3. CERT/SS#/HIC/ID # 60B (20-AN-O)

This field contains the certificate, social security number, health insurance claim, or identification number used by the secondary payor to identify the insured. The entry in this field is loaded from the carrier/plans demographic data. Medicare A and B plans pull the Claim Number. Blue Cross plans pull the Subscriber ID Number. Champus plans pull the ID Card Number. Commercial and HMO plans pull the Policy Number. Medicaid and Welfare plans pull the Recipient Number.

4. CERT/SS#/HIC/ID # 60C (20-AN-O)

This field contains the certificate, social security number, health insurance claim, or identification number used by the tertiary payor to identify the insured. The entry in this field is loaded from the carrier/plans demographic data. Medicare A and B plans pull the Claim Number. Blue Cross plans pull the Subscriber ID Number. Champus plans pull the ID Card Number. Commercial and HMO plans pull the Policy Number. Medicaid and Welfare plans pull the Recipient Number.

5. GROUP NAME 61A (15-AN-O)

This field contains the name of the group or plan through which the primary insurance coverage is provided to the insured. The entry in this field is loaded from this carrier/plan's demographic data.

6. GROUP NAME 61B (15-AN-O)

This field contains the name of the group or plan through which the secondary insurance coverage is provided to the insured. The entry in this field is loaded from this carrier/plan's demographic data.

7. GROUP NAME 61C (15-AN-O)

This field contains the name of the group or plan through which the tertiary insurance coverage is provided to the insured. The entry in this field is loaded from this carrier/plan's demographic data.

8. INSURANCE GROUP NUMBER 62A (18-AN-O)

This field contains the identification number, control number, or code assigned by the primary carrier to identify the group under which the insured is covered. The entry in this field is loaded from this carrier/plan's demographic data.

9. INSURANCE GROUP NUMBER 62B (18-AN-O)

This field contains the identification number, control number, or code assigned by the secondary carrier to identify the group under which the insured is covered. The entry in this field is loaded from this carrier/plan's demographic data.

10. INSURANCE GROUP NUMBER 62C (18-AN-O)

This field contains the identification number, control number, or code assigned by the tertiary carrier to identify the group under which the insured is covered. The entry in this field is loaded from this carrier/plan's demographic data.

11. ERROR MESSAGES (DISPLAY ONLY)

The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Phone Number field is required but was not completed, the error message *Provider Phone Number is Required* is displayed in this field.

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB Claim Form - Screen 16 of 26

```
                    General Hospital Claims by Account Processor
                         Page 16 of 26     Mon Mar 27, 2007 10:40 am
Account        Name                  FC Typ Admit    Disch      Balance Loc
A9316600001    JONES,DORENE          C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV
 1 Treatment Authorization 63a

 2 Treatment Authorization 63b

 3 Treatment Authorization 63c                  4 Document Control Number 64a

 5 Document Control Number 64b     6 Document Control Number 64c

 7 Employer Name 65a               8 Employer Name 65b
                                     HALLMARK
 9 Employer Name 65c

10 Error Messages




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

Field Explanations

1.   TREATMENT AUTHORIZATION 63A (31-AN-O)
This field contains a number or other indicator designating that the treatment covered
by this bill is authorized by the primary payor. The entry in this field is loaded from the
Approval # field on the second page of the Insurance Demographics screen of the
insurance.

2.   TREATMENT AUTHORIZATION 63B (31-AN-O)
This field contains a number or other indicator designating that the treatment covered
by this bill is authorized by the secondary payor. The entry in this field is loaded from
the Approval # field on the second page of the Insurance Demographics screen of the
insurance.

3.   TREATMENT AUTHORIZATION 63C (31-AN-O)
This field contains a number or other indicator designating that the treatment covered
by this bill is authorized by the tertiary payor. The entry in this field is loaded from the
Approval # field on the second page of the Insurance Demographics screen of the
insurance.

4.   DOCUMENT CONTROL NUMBER 64A (26-N-O)
The field contains the document control number for payer A. This field is required when
the type of bill frequency code indicates the claim is a replacement to a previously
adjudicated claim. The UB04 pulls this field from insurance cash posting. The
Electronic Remittance Advice pulls this from the CLP07 record. Users can also
manually enter this number in Insurance Cash, in the field Payor Claim Control
Number. Note that the header record of the insurance cash batch must have the field
"Use Pyr Clm Cont#" set to Yes. If the claim posted to in insurance cash is later

replaced by an adjustment claim, this adjustment claim contains the document control number in locator 64. This document control number also displays on the Carrier Status Information screen, field Ext Claim #, within Claims Management for the original claim posted to (not the adjustment claim).

5. DOCUMENT CONTROL NUMBER 64B (26-N-O)
This field contains the document control number for payer B. This field is required when the type of bill frequency code indicates the claim is a replacement to a previously adjudicated claim. The UB04 pulls this field from insurance cash posting. The Electronic Remittance Advice pulls this from the CLP07 record. Users can also manually enter this number in Insurance Cash, in the field Payor Claim Control Number. Note that the header record of the insurance cash batch must have the field "Use Pyr Clm Cont#" set to Yes. If the claim posted to in insurance cash is later replaced by an adjustment claim, this adjustment claim contains the document control number in locator 64. This document control number also displays on the Carrier Status Information screen, field Ext Claim #, within Claims Management for the original claim posted to (not the adjustment claim).

6. DOCUMENT CONTROL NUMBER 64C (26-N-O)
This field contains the document control number for payer B. This field is required when the type of bill frequency code indicates the claim is a replacement to a previously adjudicated claim. The UB04 pulls this field from insurance cash posting. The Electronic Remittance Advice pulls this from the CLP07 record. Users can also manually enter this number in Insurance Cash, in the field Payor Claim Control Number. Note that the header record of the insurance cash batch must have the field "Use Pyr Clm Cont#" set to Yes. If the claim posted to in insurance cash is later replaced by an adjustment claim, this adjustment claim contains the document control number in locator 64. This document control number also displays on the Carrier Status Information screen, field Ext Claim #, within Claims Management for the original claim posted to (not the adjustment claim).

7. EMPLOYER NAME 65A (25-AN-O)
This field contains the name of the employer that might or does provide healthcare coverage for the individual identified in Form Locator 58 for the primary payor. The entry in this field is loaded from the employment information of the insurance demographic data.

8. EMPLOYER NAME 65B (25-AN-O)
This field contains the name of the employer that might or does provide healthcare coverage for the individual identified in Form Locator 58 for the secondary payor. The entry in this field is loaded from the employment information of the insurance demographic data.

9. EMPLOYER NAME 65C (25-AN-O)
This field contains the name of the employer that might or does provide healthcare coverage for the individual identified in Form Locator 58 for the tertiary payor. The entry in this field is loaded from the employment information of the insurance demographic data.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 17 OF 26

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                     General Hospital Claims by Account Processor
                          Page 17 of 26     Mon Mar 27, 2007 10:40 am
Account      Name                     FC Typ Admit    Disch       Balance  Loc
A9316600001  JONES,DORENE              C  O/P 06/15/07 06/15/07    1310.72  AR/FCRV
 1 Procedure Coding Method           2 Principal Diagnosis Code
   9                                    8251
 3 Princ Dx POA        4 Other DX Code 1/A     5 Other DX 1/A POA
   Y
 6 Other DX Code 2/B    7 Other DX 2/B POA      8 Other DX Code 3/C

 9 Other DX 3/C POA   10 Other DX Code 4/D    11 Other DX 4/D POA

12 Error Messages





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

1. DIAGNOSIS AND PROCEDURE CODING METHOD (1-AN-O)
This field contains the code identifying the coding method used to identify diagnosis and procedure codes entered in Form Locators 67 (Principal and Secondary Diagnosis Codes), 69 (Admitting Diagnosis Code), 70 (Reason for Visit Diagnoses), 72 (External Cause of Injury Diagnoses), and 74 (Principal and Other Procedures). Valid entries are 9 for ICD9 or 0 for ICD10.

2. PRINCIPAL DIAGNOSIS CODE (7-AN-O)
This field contains the code describing the principal diagnosis. The entry in this field is loaded from the patient's medical information or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If

the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

3. PRINC DX POA (1-AN-O)
This field contains the present on admission indicator for the Principal Diagnosis.

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 hospital 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 a U for Unknown for the POA indicator.

4. OTHER DX CODE 1/A (7-AN-O)
This field contains the first diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

5. OTHER DX 41/A POA (1-AN-O)
This field contains present on admission indicator for the first other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

6. OTHER DX CODE 2/B (7-AN-O)
This field contains the second diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/

ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

7. OTHER DX 2/B POA (1-AN-O)
This field contains present on admission indicator for the second other diagnosis code. 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 hospital 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 a *U* for Unknown for the POA indicator.

8. OTHER DX CODE 3/C (7-AN-O)
This field contains the third diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

9. OTHER DX 3/C POA (1-AN-O)
This field contains present on admission indicator for the third other diagnosis code. 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 hospital 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 a U for Unknown for the POA indicator.

10. OTHER DX CODE 4/D (7-AN-O)
This field contains the fourth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary

Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

11. OTHER DX 4D POA (1-AN-O)

This field contains present on admission indicator for the fourth other diagnosis code. 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 hospital 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 a U for Unknown for the POA indicator.

12. ERROR MESSAGES (DISPLAY ONLY)

The system displays the error messages pertaining to the information displayed on this screen. For example, if the Provider Phone Number field is required but was not completed, the error message *Provider Phone Number is Required* is displayed in this field.

UB CLAIM FORM - SCREEN 18 OF 26

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                    General Hospital Claims by Account Processor
                         Page 18 of 26     Mon Mar 27, 2007 10:40 am
Account       Name                    FC Typ Admit     Disch      Balance Loc
A9316600001   JONES,DORENE            C  O/P 06/15/07 06/15/07    1310.72 AR/FCRV
 1 Other DX Code 5/E    2 Other DX 5/E POA      3 Other DX Code 6/F

 4 Other DX 6/F POA     5 Other DX Code 7/G     6 Other DX 7/G POA

 7 Other DX Code 8/H    8 Other DX 8/H POA      9 Other DX Code 9/I

10 Other DX 9/I POA    11 Other DX Code 10/J   12 Other DX 10/J POA

13 Error Messages




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

1.   OTHER DX CODE 5/E (7-AN-O)

This field contains the fifth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/

ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

2.   OTHER DX 5/E POA (1-AN-O)
This field contains present on admission indicator for the fifth other diagnosis code. 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 hospital 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 a U for Unknown for the POA indicator.

3.   OTHER DX CODE 6/F (7-AN-O)
This field contains the sixth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

4.   OTHER DX 6/F POA (1-AN-O)
This field contains present on admission indicator for the sixth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

5.   OTHER DX CODE 7/G (7-AN-O)
This field contains the seventh diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary

Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

6. OTHER DX 7/G POA (1-AN-O)

This field contains present on admission indicator for the seventh other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

7. OTHER DX 8/M (7-AN-O)

This field contains the eighth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

8. OTHER DX 8/H POA (1-AN-O)

This field contains present on admission indicator for the eighth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

9. OTHER DX 9/I (7-AN-O)

This field contains the ninth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end

of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

10. OTHER DX 9/I POA (1-AN-O)
This field contains present on admission indicator for the ninth other diagnosis code. 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 hospital 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 a U for Unknown for the POA indicator.

11. OTHER DX 10/J (7-AN-O)
This field contains the tenth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

12. OTHER DX 10/J POA (1-AN-O)
This field contains present on admission indicator for the tenth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 19 OF 26

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                        General Hospital Claims by Account Processor
                            Page 19 of 26       Mon Mar 27, 2007 10:40 am
Account       Name                   FC Typ Admit    Disch      Balance Loc
A9316600001   JONES,DORENE            C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV
 1 Other DX Code 11/K    2 Other DX 11/K POA      3 Other DX Code 12/L

 4 Other DX 12/L POA     5 Other DX Code 13/M     6 Other DX 13/M POA

 7 Other DX Code 14/N    8 Other DX 14/N POA      9 Other DX Code 15/O

10 Other DX 15/O POA    11 Other DX Code 16/P    12 Other DX 16/P POA

13 Error Messages




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

1. OTHER DX 11/K (7-AN-O)
This field contains the eleventh diagnosis code corresponding to additional conditions
that coexist at the time of admission or develop subsequently and have an effect on
the treatment received or the length of stay. The entry in this field is loaded from the
patient's medical information, or from the patient's admission information, based on
which internal element is used in the Claim Load Edit Parameter. Internal Elements
that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/
ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does
not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary
Diagnosis information in Medical Records, the system then looks for the diagnosis
information in Admissions. Internal Elements that do not have the (MR/ADM) at the end
of the name only look to Medical Records for the diagnosis information. Only coded
diagnosis (not freeform) are pulled to the claim.

2. OTHER DX 11/K POA (1-AN-O)
This field contains present on admission indicator for the eleventh other diagnosis
code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

3. OTHER DX 12/L (7-AN-O)
This field contains the twelfth diagnosis code corresponding to additional conditions
that coexist at the time of admission or develop subsequently and have an effect on
the treatment received or the length of stay. The entry in this field is loaded from the
patient's medical information, or from the patient's admission information, based on

which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

4.   OTHER DX 12/L POA (1-AN-O)

This field contains present on admission indicator for the twelfth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

5.   OTHER DX 13/M (7-AN-O)

This field contains the thirteenth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

6.   OTHER DX13/M POA (1-AN-O)

This field contains present on admission indicator for the thirteenth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

7.   OTHER DX 14/N (7-AN-O)

This field contains the fourteenth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG

CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

8. OTHER DX 14/N POA (1-AN-O)
This field contains present on admission indicator for the fourteenth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

9. OTHER DX 15/O (7-AN-O)
This field contains the fifteenth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

10. OTHER DX 15/O POA (1-AN-O)
This field contains present on admission indicator for the fifteenth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

11. OTHER DX 16/P (7-AN-O)
This field contains the sixteenth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary

Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

12. OTHER DX 16/P POA (1-AN-O)
This field contains present on admission indicator for the sixteenth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system displays the next screen.

UB CLAIM FORM - SCREEN 20 OF 26

```
                      General Hospital Claims by Account Processor
                            Page 20 of 26      Mon Mar 27, 2009 10:40 am
Account      Name                    FC Typ Admit    Disch     Balance Loc
A9316600001  JONES,DORENE             C  O/P 06/15/07 06/15/07   1310.72 AR/FCRV
 1 Other DX Code 17/Q   2 Other DX 17/Q POA    3 Reserved Future Use Upper-68

 4 Reserved Future Use Lower-68     5 Admit Diagnosis Code
                                      8251
 6 Reason for Visit DX A            7 Reason for Visit DX B
   8251
  8 Reason for Visit DX C           9 PPS Code

10 Ext Cause Inj Dx Code 1         11 Ext Cause Inj Dx Code 1 POA

12 Error Messages






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

Field Explanations

1.   OTHER DX 17/Q (7-AN-O)
This field contains the seventeenth diagnosis code corresponding to additional conditions that coexist at the time of admission or develop subsequently and have an effect on the treatment received or the length of stay. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

2.   OTHER DX 17/Q POA (1-AN-O)
This field contains present on admission indicator for the seventeenth other diagnosis code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

3. RESERVED FUTURE USE UPPER-68 (8-AN-O)
This field is reserved for future use for Locator 68 upper.

4,   RESERVED FUTURE USE LOWER-68 (9-AN-O)
This field is reserved for future use for Locator 68 lower.

5. ADMIT DIAG CODE (7-AN-O)
This field contains the diagnosis code entered when the patient was admitted. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "SECONDARY DIAG CODE (MR/ADM)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim.

6. REASON FOR VISIT DX A (7-AN-O)
This field contains the first reason for visit diagnosis code which is reported in UB Locator 70a. When the patient has Reason for Visit Diagnosis Codes entered in the Diagnosis screen of Medical Records Abstracting, or entered via the Disposition screen, these coded diagnoses pull to the UB04 claim.

If using the Internal Elements "REASON FOR VISIT DX A", "REASON FOR VISIT DX B", and "REASON FOR VISIT DX C", if there are no Reason for Visit diagnoses for the patient, and the Type of Bill in Locator 4 of the claim is a 013x for Hospital Outpatient or 07xx for Clinic, the system derives the Reason for Visit diagnoses. The first Reason for Visit Dx pulls from the Principal Diagnosis from Medical Records, or if none, the Principal Diagnosis from Admissions. The second Reason for Visit Dx, or the first if there is no Principal Diagnosis in either Medical Records or Admission, pulls from the Admitting Diagnosis from Medical Records, or if none, from the Admitting Diagnosis from Admission. The third Reason for Visit Dx pulls from the first Secondary Diagnosis from Medical Records, or if none, from the first Secondary Diagnosis from Admissions. The system does not repeat the admitting diagnosis if it matches the principal diagnosis and it does not repeat the first secondary diagnosis if it matches the admitting diagnosis.

If using the internal elements "REASON FOR VISIT CODED DX A", "REASON FOR VISIT CODED DX B", and "REASON FOR VISIT CODED DX C", only coded Reason for Visit Diagnosis Codes pull to the UB04. The system does not derive any reason for visit diagnosis codes. Therefore, if there are no coded Reason for Visit Diagnosis Codes, then using these internal elements, Locators 70 a, b, and c will be blank.

If using the internal element of "REASON FOR VISIT A/ADMITTING DX" this internal element first looks for a coded Reason for Visit diagnosis code. If there are no coded reason for visit diagnosis codes, the system pulls the Medical Records Admitting

Diagnosis Code, and if blank, the system pulls the Admissions Admitting Diagnosis Code.

7.   REASON FOR VISIT DX B (7-AN-O)
This field contains the second reason for visit diagnosis code which is reported in UB Locator 70b. When the patient has Reason for Visit Diagnosis Codes entered in the Diagnosis screen of Medical Records Abstracting, or entered via the Disposition screen, these coded diagnoses pull to the UB04 claim.

If using the Internal Elements "REASON FOR VISIT DX A", "REASON FOR VISIT DX B", and "REASON FOR VISIT DX C", if there are no Reason for Visit diagnoses for the patient, and the Type of Bill in Locator 4 of the claim is a 013x for Hospital Outpatient or 07xx for Clinic, the system derives the Reason for Visit diagnoses. The first Reason for Visit Dx pulls from the Principal Diagnosis from Medical Records, or if none, the Principal Diagnosis from Admissions. The second Reason for Visit Dx, or the first if there is no Principal Diagnosis in either Medical Records or Admission, pulls from the Admitting Diagnosis from Medical Records, or if none, from the Admitting Diagnosis from Admission. The third Reason for Visit Dx pulls from the first Secondary Diagnosis from Medical Records, or if none, from the first Secondary Diagnosis from Admissions. The system does not repeat the admitting diagnosis if it matches the principal diagnosis and it does not repeat the first secondary diagnosis if it matches the admitting diagnosis.

If using the internal elements "REASON FOR VISIT CODED DX A", "REASON FOR VISIT CODED DX B", and "REASON FOR VISIT CODED DX C", only coded Reason for Visit Diagnosis Codes pull to the UB04. The system does not derive any reason for visit diagnosis codes. Therefore, if there are no coded Reason for Visit Diagnosis Codes, then using these internal elements, Locators 70 a, b, and c will be blank. If using the internal element of "REASON FOR VISIT A/ADMITTING DX" this internal element first looks for a coded Reason for Visit diagnosis code. If there are no coded reason for visit diagnosis codes, the system pulls the Medical Records Admitting Diagnosis Code, and if blank, the system pulls the Admissions Admitting Diagnosis Code.

8.   REASON FOR VISIT DX C (7-AN-O)
This field contains the third reason for visit diagnosis code which is reported in UB04 Locator 70c. When the patient has Reason for Visit Diagnosis Codes entered in the Diagnosis screen of Medical Records Abstracting, or entered via the Disposition screen, these coded diagnoses pull to the UB04 claim.

If using the Internal Elements "REASON FOR VISIT DX A", "REASON FOR VISIT DX B", and "REASON FOR VISIT DX C", if there are no Reason for Visit diagnoses for the patient, and the Type of Bill in Locator 4 of the claim is a 013x for Hospital Outpatient or 07xx for Clinic, the system derives the Reason for Visit diagnoses. The first Reason for Visit Dx pulls from the Principal Diagnosis from Medical Records, or if none, the Principal Diagnosis from Admissions. The second Reason for Visit Dx, or the first if there is no Principal Diagnosis in either Medical Records or Admission, pulls from the Admitting Diagnosis from Medical Records, or if none, from the Admitting Diagnosis

from Admission. The third Reason for Visit Dx pulls from the first Secondary Diagnosis from Medical Records, or if none, from the first Secondary Diagnosis from Admissions. The system does not repeat the admitting diagnosis if it matches the principal diagnosis and it does not repeat the first secondary diagnosis if it matches the admitting diagnosis.

If using the internal elements "REASON FOR VISIT CODED DX A", "REASON FOR VISIT CODED DX B", and "REASON FOR VISIT CODED DX C", only coded Reason for Visit Diagnosis Codes pull to the UB04. The system does not derive any reason for visit diagnosis codes. Therefore, if there are no coded Reason for Visit Diagnosis Codes, then using these internal elements, Locators 70 a, b, and c will be blank.

If using the internal element of "REASON FOR VISIT A/ADMITTING DX" this internal element first looks for a coded Reason for Visit diagnosis code. If there are no coded reason for visit diagnosis codes, the system pulls the Medical Records Admitting Diagnosis Code, and if blank, the system pulls the Admissions Admitting Diagnosis Code.

9. PPS CODE (5-N-O)
This field contains the DRG code. The UB04 Claim Master is set to use the Internal Element of "FINAL DRG". This internal element pulls the first/primary final DRG code at the account level, which could be the classic DRG, the MS-DRG, or another DRG type.

Other internal element options include:

DRG,MS ONLY

This internal element pulls the MS-DRG if it exists. If the MS-DRG does not exist, then the locator will be blank. If the first DRG was grouped in Star, then the DRG would have been grouped using Version 25.0 of the DRG Grouper or beyond and marked as an MS DRG. If the DRG is not marked as an MS DRG, then no DRG is supplied for the locator. If the DRG was not grouped in Star, then a DRG is used if the Other Payor Code used to determine the DRG (first or second) appears in the "Other Payor Codes Used for Medicare DRG Assignment (pre and post 10/1/07)" field on the "Other Payor Code for DRG Mapping" found on the menu for the Reimbursement Master and Medical Records logic has marked the DRG as an MS DRG.

DRG,CLASSIC ONLY

This internal element pulls the Classic DRG (version 24 or earlier) if it exists. If the classic DRG does not exist, then the locator will be blank. If the first DRG was grouped in Star, then the DRG would have been grouped using Version 24.0 of the DRG Grouper or earlier and would not have been marked as an MS DRG. If the first DRG was grouped in Star and is marked as an MS DRG, then no DRG is supplied for the locator. If the DRG was not grouped in Star, then a DRG is used if the Other   Payor Code used to determine the DRG (first or second) appears in the "Other Payor Codes Used for Medicare DRG Assignment (pre and post 10/1/07)" field or in the "Other

Payor Codes Used for Classic DRG Assignment" field on the "Other Payor Code for DRG Mapping" found on the menu for the Reimbursement Master and Medical Records logic has not marked the DRG as an MS DRG.   If the DRG was not grouped in Star and the Other Payor Code was not recorded by this process for the first DRG, (for example a customized interface was used), then the first DRG will be supplied for the internal element. The logic is assuming that the DRG was assigned before the assignment of an MS DRG was an option, the Other Payor Code field was not being populated, and is therefore a classic DRG.

This internal element can be used for carriers not starting to use MS DRGs on 10/1/07.

DRG,MS/CLASSIC

This internal element pulls the appropriate DRG, either the MS-DRG, or the Classic, depending on how the insurance plan table, insurance carrier table, or the DRG Payor Table, are set up. If, according to the table, the MS-DRG should be pulled, but it does not exist on the account, the system will default to the Classic DRG. If neither the MS-DRG nor the Classic DRG exist, the locator will be blank.

If the first DRG was grouped in Star, then that DRG would be supplied. STAR Medical Records provides a Medicare DRG based on the version of the grouper used. If the DRG was not grouped in Star, then the logic uses the Medical Records logic for the insurance plan for which the claim is loading to determine the Other Payor Code that would be used to calculate the DRG. The Other Payor Code to be used is determined per the insurance plan, per the insurance carrier, or per the DRG Payor table where the financial class identifies the DRG Payor. If the account has not been discharged, then the midnight processing date or the current date is used to determine information from the Other Payor Codes by Facility screen. If the Other Payor Code defined from that selection appears in the "Other Payor Codes Used for Medicare DRG Assigment (pre and post 10/1/07)" field on the "Other Payor Code for DRG Mapping" found on the menu for the Reimbursement Master, then the DRG is supplied. If the Other Payor Code defined from that selection appears in the "Other Payor Codes used for Classic DRG Assignment" field on the "Other Payor Code for DRG Mapping" found on the menu for the Reimbursement Master and the DRG is not marked as an MS DRG, then the DRG is supplied, meaning an MS DRG or a classic DRG can be assigned.

If the DRG was not grouped in STAR and the Other Payor Code was not recorded by this process for the first DRG, (for example a customized interface was used), the first DRG will be supplied for the internal element. The logic is assuming that the DRG was assigned before the assignment of an MS DRG was an option and is therefore a classic DRG.

DRG,APR (NO REIMBURSEMENT)

This internal element pulls the existing APR-DRG code if it exists. Currently, no reimbursement is returned for this DRG. When/if 3M begins to return reimbursement for this type of DRG, a new internal element will be added. If the APR-DRG does not exist, the locator will be blank.

10. EXT CAUSE INJ DX CODE 1 (7-AN-O)
This field contains the first external cause of injury code. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, "EXT CAUSE INJ DX CD 1 (MR/ADM-UB04)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim. For UB claims loading ICD-9 diagnoses, the first E code found is used, if there is more than one E code for the account. This E Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For UB claims loading ICD-10 diagnoses, the first diagnosis code in the V01-Y98 range is used, if there is more than one external cause of injury code for the account. This external cause of injury diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields

11. EXT CAUSE INJ DX POA (1-AN-O)
This field contains the present on admission indicator for the first external cause of injury code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

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

When all fields have been reviewed and/or edited, you have the option of moving forward or backward through the 26 screens included in this function. Before doing so, you must accept the screen you are currently accessing, which can be done even if there are errors or omissions in the information it contains. After you accept the screen, the system returns to the Maintain Claims menu.

UB CLAIM FORM - SCREEN 21 OF 26

```
            General Hospital Maintain Claims by Account Processor
                           Page 21 of 26      Thu Feb 15, 2007 10:52 am
Account       Name                  FC Type Admit    Disch       Balance Loc
C0703000001   CRANE,BARB L          O   I/P 12/31/07 01/30/07   $47698.70 AR
 1 Ext Cause Inj Dx Code 2        2 Ext Cause Inj Dx Code 2 POA

 3 Ext Cause Inj Dx Code 3        4 Ext Cause Inj Dx Code 3 POA

 5 Reserved Future Use-73         6 Principal Procedure Code

 7 Principal Procedure Date       8 Other Procedure Code A

 9 Other Procedure Date A        10 Other Procedure Code B

11 Other Procedure Date B

12 Error Messages


```

1. EXT CAUSE INJ DX- CODE 2 (7-AN-O)
This field contains the second external cause of injury code. The entry in this field is
loaded from the patient's medical information, or from the patient's admission
information, based on which internal element is used in the Claim Load Edit Parameter.
Internal Elements that have the (MR/ADM) at the end, for example, " EXT CAUSE INJ
DX CD 2 (MR/ADM-UB04)ECODE DIAGNOSIS CODE 2 (MR/ADM-UB04)", first look
for the diagnosis information in Medical Records. If the diagnosis does not exist in
Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis
information in Medical Records, the system then looks for the diagnosis information in
Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name
only look to Medical Records for the diagnosis information. Only coded diagnosis (not
freeform) are pulled to the claim. For UB claims loading ICD-9 diagnoses, The second
E code found is used, if there is more than one E code for the account. This E
Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For
UB claims loading ICD-10 diagnoses, the second diagnosis code in the V01-Y98 range
is used, if there is more than one external cause of injury code for the account. This
external cause of injury diagnosis code does not repeat in Locator 67 for the
Secondary Diagnosis fields.

2. EXT CAUSE INJ DX- CODE 2 POA (1-AN-O)
This field contains the present on admission indicator for the second external cause of
injury code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then
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 hospital 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 a U for Unknown for the POA indicator.

3. EXT CAUSE INJ DX -CODE 3 (7-AN-O)

This field contains the third external cause of injury code. The entry in this field is loaded from the patient's medical information, or from the patient's admission information, based on which internal element is used in the Claim Load Edit Parameter. Internal Elements that have the (MR/ADM) at the end, for example, " EXT CAUSE INJ DX CD 3 (MR/ADM-UB04)", first look for the diagnosis information in Medical Records. If the diagnosis does not exist in Medical Records, and if there is no Principal Diagnosis and no Secondary Diagnosis information in Medical Records, the system then looks for the diagnosis information in Admissions. Internal Elements that do not have the (MR/ADM) at the end of the name only look to Medical Records for the diagnosis information. Only coded diagnosis (not freeform) are pulled to the claim. For UB claims loading ICD-9 diagnoses, Tthe third E code found is used, if there is more than one E code for the account. This E Diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields. For UB claims loading ICD-10 diagnoses, the third diagnosis code in the V01-Y98 range is used, if there is more than one external cause of injury code for the account. This external cause of injury diagnosis code does not repeat in Locator 67 for the Secondary Diagnosis fields.

4. EXT CAUSE INJ DX -CODE 3 POA (1-AN-O)

This field contains the present on admission indicator for the third external cause of injury code. If the Type of Bill in Locator 4 is 013x for Outpatient or 07xx for Clinic, then 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 hospital 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 a U for Unknown for the POA indicator.

5. RESERVED FUTURE USE-73 (9-AN-O)

This field is reserved for future use.

6. PRINCIPAL PROCEDURE CODE (8-AN-O)

This field contains the principal procedure code.

7. PRINCIPAL PROCEDURE DATE (10-D-O)

This field contains the date, entered in the format MM/DD/YY or MMDDYY, on which the principal procedure was performed.

8. OTHER PROCEDURE CODE A (8-AN-O)

This field contains the code identifying the first procedure, other than the principal procedure. The entry in this field is loaded from the patient's medical information.

9. OTHER PROCEDURE DATE A (10-D-O)

This field contains the date, entered in the format MM/DD/YY or MMDDYY, on which the first procedure, other than the principal procedure, was performed. The entry in this field is loaded from the patient's medical information.

10. OTHER PROCEDURE CODE B (8-AN-O)

This field contains the code identifying a second procedure, other than the principal procedure. The entry in this field is loaded from the patient's medical information.

11. OTHER PROCEDURE DATE B (10-D-O)
This field contains the date, entered in the format MM/DD/YY or MMDDYY, on which
a second procedure, other than the principal procedure, was performed. The entry in
this field is loaded from the patient's medical information.

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

When all fields have been reviewed and/or edited, you have the option of moving
forward or backward through the 26 screens included in this function. Before doing so,
you must accept the screen you are currently accessing, which can be done even if
there are errors or omissions in the information it contains. After you accept the screen,
the system displays the next screen.

UB CLAIM FORM - SCREEN 22 OF 26

```
                 General Hospital Maintain Claims by Account Processor
                          Page 22 of 26        Thu Feb 15, 2007 10:52 am
Account       Name                      FC Type Admit     Disch        Balance Loc
C0703000001  CRANE,BARB L                O  I/P 12/31/07 01/30/07    $47698.70 AR
 1 Other Procedure Code C           2 Other Procedure Date C

 3 Other Procedure Code D           4 Other Procedure Date D

 5 Other Procedure Code E           6 Other Procedure Date E

 7 Reserved Future Use-75 Line 1    8 Reserved Future Use-75 Line 2

 9 Reserved Future Use-75 Line 3   10 Reserved Future Use-75 Line 4

11 Error Messages
```

1. OTHER PROCEDURE CODE C (8-AN-O)
This field contains the code identifying a third procedure, other then the principal
procedure. The entry in this field is loaded from the patient's medical information.

2. OTHER PROCEDURE DATE C (10-D-O)
This field contains the date, entered in the format MM/DD/YY or MMDDYY, on which
a third procedure, other than the principal procedure, was performed. The entry in this
field is loaded from the patient's medical information.

3. OTHER PROCEDURE CODE D (8-AN-O)
This field contains the code identifying a fourth procedure, other then the principal
procedure. The entry in this field is loaded from the patient's medical information.

4. OTHER PROCEDURE DATE D (10-D-O)
This field contains the date, entered in the format MM/DD/YY or MMDDYY, on which a fourth procedure, other than the principal procedure, was performed. The entry in this field is loaded from the patient's medical information.

5. OTHER PROCEDURE CODE E (8-AN-O)
This field contains the code identifying a fifth procedure, other then the principal procedure. The entry in this field is loaded from the patient's medical information.

6. OTHER PROCEDURE DATE E (10-D-O)
This field contains the date, entered in the format MM/DD/YY or MMDDYY, on which a fifth procedure, other than the principal procedure, was performed. The entry in this field is loaded from the patient's medical information.

7. RESERVED FUTURE USE-75 LINE 1 (4-AN-O)
This field is reserved for future use.

8. RESERVED FUTURE USE-75 LINE 2 (5-AN-O)
This field is reserved for future use.

9. RESERVED FUTURE USE-75 LINE 3 (5-AN-O)
This field is reserved for future use.

10. RESERVED FUTURE USE-75 LINE 4 (5-AN-O)
This field is reserved for future use.

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

UB CLAIM FORM - SCREEN 23 OF 26

```
                    General Hospital Maintain Claims by Account Processor
                              Page 23 of 26       Thu Feb 15, 2007 10:53 am
Account        Name                    FC Type Admit    Disch      Balance Loc
C0703000001  CRANE,BARB L              O   I/P 12/31/07 01/30/07   $47698.70 AR
 1 Attend Physician NPI                2 Attend Phys ID Qual
                                         1G
 3 Attend Physician ID                 4 Attend Physician Last Name
   upin12345                             ADAMS
 5 Attend Physician First Name         6 Operating Physician NPI
   JAY M                                 2574156156
 7 Operating Phys ID Qual              8 Operating Physician ID
   1G
 9 Operating Physician Last Name      10 Operating Physician First Name


11 Error Messages
   Attend Physician NPI is Required


```

Field Explanations

1.   ATTEND PHYSICIAN NPI (11-AN-O)
This field contains the National Provider Idenfication number for the attending
physician.

2.   ATTEND PHYS ID QUALIFIER (2-AN-O)
This field contains the code indicating the qualifier for the attending physician's legacy
ID. The possible values include: 0B=State License Number, 1G=Provider UPIN
Number, G2=Provider Commercial Number.

3.   ATTEND PHYSICIAN ID (9-AN-O)
This field contains the Attending physician's ID. The Attending physician is the licensed
physician who would normally be expected to certify and recertify the medical
necessity of the services rendered and/or who has the primary responsibility for the
patient's medical care and treatment. The entry in this field is loaded from the patient's
medical information and the physician table. The ID loading to this field should
correlate with the ID Qualifier in the field preceding. Based on the Internal Element
selected for the locator, users can pull the ID from one of the following fields in the
physician table: State License #, NPI, UB Physician ID #, Medicare ID #, Medicaid ID
#, Blue Cross ID #, Commercial ID #, PIN #, UPIN #, Fin Interface #, Tax ID #, Other
ID #1, Other ID #2 (enter "DOCTOR-" for a list of internal elements pulling from the
physician table).

4.   ATTEND PHYSICIAN LAST NAME (16-AN-O)
This field contains the attending physician's last name.

5.   ATTEND PHYSICIAN FIRST NAME (12-AN-O)
This field contains the attending physician's first name.

6. OPERATING PHYSICIAN NPI (11-AN-R)
This field contains the NPI number for the operating physician. The Operating physician is the Surgeon listed on the Primary ICD Procedure Code.

7. OPERATING PHYS ID QUAL (2-AN-R)
This field contains the code indicating the qualifier for the operating physician's legacy ID. The possible values include: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number.

8. OPERATING PHYSICIAN ID (9-AN-O)
This field contains the Operating physician's ID. The Operating physician is the Surgeon listed on the Primary ICD Procedure Code. The entry in this field is loaded from the patient's medical information and the physician table. The ID loading to this field should correlate with the ID Qualifier in the field preceding. Based on the Internal Element selected for the locator, users can pull the ID from one of the following fields in the physician table: State License #, NPI, UB Physician ID #, Medicare ID #, Medicaid ID #, Blue Cross ID #, Commercial ID #, PIN #, UPIN #, Fin Interface #, Tax ID #, Other ID #1, Other ID #2 (enter "DOCTOR-" for a list of internal elements pulling from the physician table).

9. OPERATING PHYSICIAN LAST NAME (16-AN-O)
This field contains the operating physician's last name.

10. OPERATING PHYSICIAN FIRST NAME (12-AN-O)
This field contains the operating physician's first name.

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

UB CLAIM FORM - SCREEN 24 OF 26

```
                 General Hospital Maintain Claims by Account Processor
                              Page 24 of 26       Thu Feb 15, 2007 10:53 am
Account        Name                      FC Type Admit    Disch      Balance Loc
C0703000001   CRANE,BARB L               O   I/P 12/31/07 01/30/07  $47698.70 AR
 1 Other Phy Loc 78 Type                2 Other Phy Loc 78 NPI
   DN                                     2574156156
 3 Other Phy Loc 78 ID Qual             4 Other Phy Loc 78 ID
   1G
 5 Other Phy Loc 78 Last Name           6 Other Phy Loc 78 First Name

 7 Other Phy Loc 79 Type                8 Other Phy Loc 79 NPI

 9 Other Phy Loc 79 ID Qual           10 Other Phy Loc 79 ID

11 Error Messages
```

1.   OTHER PHY LOC 78 TYPE (2-AN-O)
This field contains the type of the licensed physician other than the attending or primary operating physician as defined by the payor organization. Possible values include: DN=Referring Provider, 82 =Rendering Provider, ZZ=Other Operating Physician. The field has to be hard set as the Default Value in the Claim Load Edit Parameter.

The UB04 Claim Master has this field set to DN for Referring Provider, and pulls the Referring Physician information ONLY IF the Referring Physician is not the Attending Physician.

2.   OTHER PHY LOC 78 NPI (11-AN-O)
This field contains the National Provider Number of the licensed physician other than the attending or primary operating physician as defined by the payor organization.

The UB04 Claim Master has this field set to use internal element "PHYSICIAN,REFER (NOT ATTEND)", and pulls the Referring Physician information ONLY IF the Referring Physician is not the Attending Physician.

3.   OTHER PHY LOC 78 ID QUAL (2-AN-O)
This field contains the code indicating the qualifier for the other physician locator 78 legacy ID. The possible values include: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number.

4.   OTHER PHY LOC 78 ID (9-AN-O)
This field contains the Other Physician Locator 78 physician ID. The entry in this field is loaded from the patient's medical information and the physician table. The ID loading to this field should correlate with the ID Qualifier in the field preceding. Based on the Internal Element selected for the locator, users can pull the ID from one of the following fields in the physician table: State License #, NPI, UB Physician ID #, Medicare ID #, Medicaid ID #, Blue Cross ID #, Commercial ID #, PIN #, UPIN #, Fin Interface #, Tax ID #, Other ID #1, Other ID #2 (enter "DOCTOR-" for a list of internal elements pulling from the physician table).

The UB04 Claim Master has this field set to use Setup Routine "PHYSICIAN,REFER (NOT ATTEND)", and pulls the Referring Physician information ONLY IF the Referring Physician is not the Attending Physician.

5.   OTHER PHY LOC 78 LAST NAME (16-AN-O)
This field contains the last name of the licensed physician other than the attending or primary operating physician as defined by the payor organization.

The UB04 Claim Master has this field set to use Setup Routine "PHYSICIAN,REFER (NOT ATTEND)", and pulls the Referring Physician information ONLY IF the Referring Physician is not the Attending Physician.

6.   OTHER PHY LOC 78 FIRST NAME (12-AN-O)
This field contains the first name of the licensed physician other than the attending or primary operating physician as defined by the payor organization.

The UB04 Claim Master has this field set to use Setup Routine "PHYSICIAN,REFER (NOT ATTEND)", and pulls the Referring Physician information only if the Referring Physician is not the Attending Physician.

7.   OTHER PHY LOC 79 TYPE (2-AN-O)
This field contains the type of the licensed physician other than the attending or primary operating physician as defined by the payor organization. Possible values are: DN=Referring Provider, 82 =Rendering Provider, ZZ=Other Operating Physician. The field has to be hard set as the Default Value in the Claim Load Edit Parameter.

8.   OTHER PHY LOC 79 NPI (11-AN-O)
This field contains the National Provider Number of the licensed physician other than the attending physician or primary operating physician as defined by the payor organization.

9.   OTHER PHY LOC 79 ID QUAL (2-AN-O)
This field contains the code indicating the qualifier for the other physician locator 79 legacy ID. The possible values include: 0B=State License Number, 1G=Provider UPIN Number, G2=Provider Commercial Number.

10. OTHER PHY LOC 79 ID (9-AN-O)
This field contains the Other Physician Locator 79 physician ID. The entry in this field is loaded from the patient's medical information and the physician table.The ID loading to this field should correlate with the ID Qualifier in the field preceding. Based on the Internal Element selected for the locator, users can pull the ID from one of the following fields in the physician table: State License #, NPI, UB Physician ID #, Medicare ID #, Medicaid ID #, Blue Cross ID #, Commercial ID #, PIN #, UPIN #, Fin Interface #, Tax ID #, Other ID #1, Other ID #2 (enter "DOCTOR-" for a list of internal elements pulling from the physician table).

UB CLAIM FORM - SCREEN 25 OF 26

```
                   General Hospital Maintain Claims by Account Processor
                            Page 25 of 26        Thu Feb 15, 2007 10:53 am


Account       Name                    FC Type Admit    Disch      Balance Loc
C0703000001  CRANE, BOB               O   I/P 12/31/07 01/30/07   $47698.70 AR
 1 Other Phy Loc 79 Last Name       2 Other Phy Loc 79 First Name

 3 Remarks - Line 1                 4 Remarks - Line 2

 5 Remarks - Line 3                 6 Remarks - Line 4

 7 Code-Code Line 1 Qual            8 Code-Code Line 1 Code
   B3                                 IP23423423
 9 Code-Code Line 1 Value          10 Code-Code Line 2 Qual

11 Error Messages

```

Field Explanations

1.   OTHER PHY LOC 79 LAST NAME (16-AN-O)
This field contains the last name of the Other Physician Locator 79.

2.   OTHER PHY LOC 79 FIRST NAME (12-AN-O)
This field contains the first name of the Other Physician Locator 79 .

3.   REMARKS - LINE 1 (19-AN-O)
This field contains notations relating to specific state and local needs that provide additional information necessary to adjudicate the claim or otherwise fulfill reporting requirements.

4.   REMARKS - LINE 2 (24-AN-O)
This field contains notations relating to specific state and local needs that provide additional information necessary to adjudicate the claim or otherwise fulfill reporting requirements.

5.   REMARKS - LINE 3 (24-AN-O)
This field contains notations relating to specific state and local needs that provide additional information necessary to adjudicate the claim or otherwise fulfill reporting requirements.

6.   REMARKS - LINE 4 (24-AN-O)
This field contains notations relating to specific state and local needs that provide additional information necessary to adjudicate the claim or otherwise fulfill reporting requirements.

Locator 81 Code-Code Field Processing

Locator 81 Lines A, B, C, and D use the Code-Code Fields. Each line has a code Qualifier, a Code, and a Value (number or value). This locator can be used for "overflow" information.

The Qualifiers are (subject to change):

- A1 for Condition Code. The actual Condition Code loads to the Code field with the Value field blank.

- A2 for Occurrence Code. The actual Occurrence Code loads to the Code field with the date loading in the Value field (right justified in MMDDYY format).

- A3 for Occurrence Span Code. The actual Occurrence Span Code loads to the Code field with the dates loading in the Value field (in MMDDYYMMDDYY format).

- A4 for Value Code. The actual Value Code loads to the Code field with the amount/number loading in the Value field (in $$$$$$$$$cc format).

- B1 for Race & Ethnicity. For Public Health Data Reporting Only. If set on STAR, the system will load the B1 code, followed by R and then the hospital Race code, followed by E and then the Ethnicity code. The actual STAR Race and Ethnicity Code (and not the ASC X12 External Code Source 859 value) loads to the Code field with the Value field blank.

- For example, if the Race code was 1 and the Ethnicity was 2, the system would load:

  B1 R1E2

  If the account only had the Race code and not the Ethnicity, the system would load:

  B1 R1

  If the account only had the Ethnicity and not the Race code, the system would load:

  B1 E2

- B2 for Marital Status. For Public Health Data Reporting Only. The actual Marital Status code loads to the Code field with the Value field blank.

- B3 for Health Care Provider Taxonomy Code. The actual Taxonomy Code loads to the Code field with the Value field blank.

NOTE: The Qualifier must be set as the Default Value in the claim load edit parameter.

Internal Elements

The Internal Elements must be set as follows:

Line 1: Qualifier field = UB04 Loc 81/1

Code field   = UB04 Loc 81/2

Value field   = UB04 Loc 81/3

Line 2: Qualifier field = UB04 Loc 81/4

Code field   = UB04 Loc 81/5

Value field   = UB04 Loc 81/6

Line 3: Qualifier field = UB04 Loc 81/7

Code field   = UB04 Loc 81/8

Value field   = UB04 Loc 81/9

Line 4: Qualifier field = UB04 Loc 81/10

Code field   = UB04 Loc 81/11

Value field   = UB04 Loc 81/12

Set Up Routines

When setting Locator 81 in the Claim Load Edit Parameter, the Set Up Routine assigned to the Internal Element actually determines what data loads to the field. The Internal Elements should remain as outlined above.

The Qualifier that is set as the Default Value must match the data that is loading, although the system does not edit the association within the Claim Load Edit Parameter. The system does edit the Code and Value fields against the Qualifier when manually editing the claim in Claims Management. The Set Up Routine needs to be assigned to both the Code and the Value fields.

Valid Set Up Routines for Locator 81:

UB04 LOC 81 OCC CODE 9

UB04 LOC 81 OCC CODE 10

UB04 LOC 81 OCC CODE 11

UB04 LOC 81 OCC CODE 12

UB04 LOC 81 OCC SPAN CODE 5

UB04 LOC 81 OCC SPAN CODE 6

UB04 LOC 81 OCC SPAN CODE 7

UB04 LOC 81 OCC SPAN CODE 8

UB04 LOC 81 CONDITION CODE 12

UB04 LOC 81 CONDITION CODE 13

UB04 LOC 81 CONDITION CODE 14

UB04 LOC 81 CONDITION CODE 15

UB04 LOC 81 VALUE CODE 13

UB04 LOC 81 VALUE CODE 14

UB04 LOC 81 VALUE CODE 15

UB04 LOC 81 VALUE CODE 16

UB04 LOC 81 RACE & ETHNICITY

UB04 LOC 81 MARITAL STATUS

UB04 LOC 81 PROV TAXONOMY CODE

UB04 LOC 81 NO SELECTION

Claim Master Settings :

Line A is set to:

Qualifier B3 for Health Care Provider Taxonomy Code, with the Code and Value using Set Up Routine "UB04 Loc 81 Prov Taxonomy code".

Line B is set to:

Qualifier A2 for Occurrence Code, with the Code and Value using Set Up Routine "UB04 Loc 81 Occurrence Code 9".

Line C is set to:

Qualifier A2 for Occurrence Code, with the Code and Value using Set Up Routine "UB04 Loc 81 Occurrence Code 10".

Line D is set to:

A blank Qualifier code, with the Code and Value using Set Up Routine "UB04 Loc 81 No Selection". The UB04 LOC 81 NO SELECTION can be used when no data is loaded by the system, but you want to allow the user to manually key something in within Claims Management.

Processing of Codes in Upper Portion of Claim and Locator 81

If a Condition Code, Occurrence Code, Occurrence Span Code, or Value Code is deleted in the "regular" UB04 claim locators, this may move a code from Locator 81 up into the main part of the claim. For example, if Locators 18-28 contained Condition Codes, and Locator 81 Line "A" and Locator 81 Line "B" contained Condition Codes, if a condition code is deleted in Locator 18-28, the code in Locator 81 Line "A" would move up into Locators 18-28 (after being re-sorted numerically and then alpha-numerically).

If a Condition Code, Occurrence Code, Occurrence Span Code, or Value Code is Modified in either the "regular" UB04 claim locators, or in Locator 81, the system will re-sort the codes numerically and then alpha-numerically. Therefore, which codes appear in the regular locators versus locator 81 may change.

For example, if Locator 23 was Condition Code 17, and it is updated to be Condition Code A6, the system will re-sort all condition codes before assigning them to Locators 18-28 and Locator 81 lines A-D. Modifying a code will NOT "push" codes after it to the Electronic Only fields. It overlays the existing code.

When modifying either the Code or the Value for a line in Locator 81, the system allows a table lookup in the Code field based on the Qualifier Code. For example, if the Qualifier Code is A1 for Condition Codes, the Code field allows a table lookup on the Condition Codes Table. The system also edits that the Value field is appropriate for the Qualifier Code (whether the Value field should be blank, a date, or an amount).

7. CODE-CODE LINE 1 QUAL (2-AN-O)
This field contains the qualifier for the Condition, Occurrence, Occurrence Span, or Value Code, Race and Ethnicity, Marital Status, or Taxonomy code in Line A of Locator 81. Possible values are:

A1=Condition Codes, A2=Occurrence Codes, A3=Occurrence Span Codes, A4=Value Codes, B1=Race and Ethnicity, B2=Marital Status, B3=Provider Taxonomy Code. If no Code actually loads for the Code Qualifier, or the Code is deleted, the system blanks out the Code Qualifier. See "Locator 81 Code-Code Field Processing" on page 3-125.

8. CODE-CODE LINE 1 CODE (10-AN-O)
This field contains the actual Condition, Occurrence, Occurrence Span, or Value Code, Race and Ethnicity, Marital Status, or Taxonomy Code for Line A of Locator 81. See "Locator 81 Code-Code Field Processing" on page 3-125.

9. CODE-CODE LINE 1 VALUE (12-AN-O)
This field contains the Date for an Occurrence Code (right justified in MMDDYY
format), the Dates for an Occurrence Span Code (in MMDDYYMMDDYY format), or
an Amount for a Value Code (in $$$$$$$$$$cc format) for Line A of Locator 81. See
"Locator 81 Code-Code Field Processing" on page 3-125.

10. CODE-CODE LINE 2 QUAL (2-AN-O)
This field contains the qualifier for the Condition, Occurrence, Occurrence Span, or
Value Code, Race and Ethnicity, Marital Status, or Taxonomy code in Line B of Locator
81. Possible values are:

A1=Condition Codes, A2=Occurrence Codes, A3=Occurrence Span Codes, A4=Value
Codes, B1=Race and Ethnicity, B2=Marital Status, B3=Provider Taxonomy Code. If no
Code actually loads for the Code Qualifier, or the Code is deleted, the system blanks
out the Code Qualifier. See "Locator 81 Code-Code Field Processing" on page 3-125.

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

UB CLAIM FORM - SCREEN 26 OF 26

```
                General Hospital Maintain Claims by Account Processor
                         Page 26 of 26      Thu Feb 15, 2007 10:55 am
Account       Name                    FC Type Admit    Disch       Balance Loc
C0703000001  CRANE, BOB               O   I/P 12/31/07 01/30/07   $47698.70 AR
 1 Code-Code Line 2 Code             2 Code-Code Line 2 Value

 3 Code-Code Line 3 Qual             4 Code-Code Line 3 Code

 5 Code-Code Line 3 Value            6 Code-Code Line 4 Qual

 7 Code-Code Line 4 Code             8 Code-Code Line 4 Value

 9 Error Messages
```

Field Explanations

1. CODE-CODE LINE 2 CODE (10-AN-O)
This field contains the actual Condition, Occurrence, Occurrence Span, or Value Code,
Race and Ethnicity, Marital Status, or Taxonomy Code for Line B of Locator 81. See
"Locator 81 Code-Code Field Processing" on page 3-125.

2. CODE-CODE LINE 2 VALUE (12-AN-O)
This field contains the Date for an Occurrence Code (right justified in MMDDYY format), the Dates for an Occurrence Span Code (in MMDDYYMMDDYY format), or an Amount for a Value Code (in $$$$$$$$$$cc format) for Line B of Locator 81. See "Locator 81 Code-Code Field Processing" on page 3-125.

3. CODE-CODE LINE 3 QUAL (2-AN-O)
This field contains the qualifier for the Condition, Occurrence, Occurrence Span, or Value Code, Race and Ethnicity, Marital Status, or Taxonomy code in Line C of Locator 81. Possible values are:

A1=Condition Codes, A2=Occurrence Codes, A3=Occurrence Span Codes, A4=Value Codes, B1=Race and Ethnicity, B2=Marital Status, B3=Provider Taxonomy Code. If no Code actually loads for the Code Qualifier, or the Code is deleted, the system blanks out the Code Qualifier. See "Locator 81 Code-Code Field Processing" on page 3-125.

4. CODE-CODE LINE 3 CODE (10-AN-O)
This field contains the actual Condition, Occurrence, Occurrence Span, or Value Code, Race and Ethnicity, Marital Status, or Taxonomy Code for Line C of Locator 81. See "Locator 81 Code-Code Field Processing" on page 3-125.

5. CODE-CODE LINE 3 VALUE (12-AN-O)
This field contains the Date for an Occurrence Code (right justified in MMDDYY format), the Dates for an Occurrence Span Code (in MMDDYYMMDDYY format), or an Amount for a Value Code (in $$$$$$$$$$cc format) for Line C of Locator 81. See "Locator 81 Code-Code Field Processing" on page 3-125.

6. CODE-CODE LINE 4 QUAL (2-AN-O)
This field contains the qualifier for the Condition, Occurrence, Occurrence Span, or Value Code, Race and Ethnicity, Marital Status, or Taxonomy code in Line D of Locator 81. Possible values are:

A1=Condition Codes, A2=Occurrence Codes, A3=Occurrence Span Codes, A4=Value Codes, B1=Race and Ethnicity, B2=Marital Status, B3=Provider Taxonomy Code. If no Code actually loads for the Code Qualifier, or the Code is deleted, the system blanks out the Code Qualifier. See "Locator 81 Code-Code Field Processing" on page 3-125.

7. CODE-CODE LINE 4 CODE (10-AN-O)
This field contains the actual Condition, Occurrence, Occurrence Span, or Value Code, Race and Ethnicity, Marital Status, or Taxonomy Code for Line D of Locator 81. See "Locator 81 Code-Code Field Processing" on page 3-125.

8. CODE-CODE LINE 4 VALUE (12-AN-O)
This field contains the Date for an Occurrence Code (right justified in MMDDYY format), the Dates for an Occurrence Span Code (in MMDDYYMMDDYY format), or an Amount for a Value Code (in $$$$$$$$$$cc format) for Line D of Locator 81. See "Locator 81 Code-Code Field Processing" on page 3-125.

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 1 OF 11

```
            General Hospital Maintain Claims by Account Processor
                            Page  1 of 11     Mon Jan 08, 2007 12:44 pm
Account      Name                    FC Type Admit    Disch       Balance Loc
C0625800001  CRANE,LEAH L             O    O/P 09/15/06 09/15/06  $554388.58-AR
 1 Insurance Company FL 0
   1500 BASIC PLAN
 2 Insurance Address Line 1 FL 0
   PLAN ADDRESS LINE 1
 3 Insurance Address Line 2 FL 0              4 Insurance City FL 0
   PLAN ADDRESS LINE 2                          ATLANTA
 5 Insurance State FL 0            6 Insurance Zip Code FL 0
   GA                               30068
 7 Medicare Box FL 1    8 Medicaid Box FL 1    9 Tricare Champus Box FL 1
   X
10 Champva Box FL 1

11 Error Messages




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

Field Explanations

1. INSURANCE COMPANY (38-AN-0)
This field contains the insurance carrier plan name from the Insurance Demographics screen.

2. INSURANCE ADDRESS LINE 1 (38-AN-O)
This field contains the address line 1 from the Insurance Demographics screen.

3. INSURANCE ADDRESS LINE 2 (38-A-O)
This field contains the address line 2 from the Insurance Demographics screen.

4. INSURANCE CITY (20-AN-O)
This field contains the insurance city from the Insurance Demographics screen.

5. INSURANCE STATE (2-A-O)
This field contains the state from the Insurance Demographics screen.

6. INSURANCE ZIP CODE (10-AN-O)
This field contains the ZIP code from the Insurance Demographics screen.

NOTE: The insurance company and address print in the top right corner of the 1500 claim form for use with window envelopes.

7. MEDICARE BOX (1-A-O)
This field indicates that the patient's claim is sent to Medicare. Valid entries are **X** or blank. The CMS 1500 Master has a default value of X for this locator.

8. MEDICAID BOX (1-A-O)
This field indicates that the patient's claim is sent to Medicaid. Valid entries are **X** or blank. The Non Professional Fee 1500 Master has a default value of X for this locator.

9. TRICARE CHAMPUS BOX (1-A-O)
This field indicates that the patient's claim is sent to CHAMPUS. Valid entries are **X** or blank.

10. CHAMPVA BOX (1-A-O)
This field indicates that the patient's claim is sent to ChampVA. Valid entries are **X** or blank.

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

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

CMS 1500 Claim Form and Non Professional Fee 1500 Claim Form - Screen 2 of 11

```
            General Hospital Maintain Claims by Account Processor
                             Page  2 of 11      Tue Jan 02, 2007 10:32 am
Account       Name                     FC Type Admit    Disch        Balance Loc
C0625800001  CRANE, MARK               O   O/P 09/15/06 09/15/06  $554388.58-AR/FCRV
 1 Group Box FL 1       2 FECA Box FL 1          3 Other Box FL 1

 4 Insured's Policy # FL 1         5 Patient Name FL 2
   12345                             JONES,ANNE
 6 Patient's Birthdate FL 3        7 Patient's Sex FL 3
   01/19/1963                        F
 8 Insured's Name FL 4             9 Patient's Address 1 FL 5
   JONES,ANNE                        123 OCEAN VIEW
10 Patient's City FL 5            11 Patient's State FL 5
   PALOS VERDES                      CA
12 Error Messages




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

Field Explanations

1. GROUP BOX (1-A-O)

This field indicates that the patient's claim is sent to a group health plan. Valid entries are **X** or blank.

2. FECA BOX (1-A-O)

This field indicates that the patient's claim is sent to FECA. Valid entries are **X** or blank.

3. OTHER BOX (1-A-O)

This field indicates that the patient's claim is sent to another program. Valid entries are **X** or blank.

4. INSURED'S POLICY # (29-AN-O)

This field contain's the number of the insured's policy.

5. PATIENT NAME (28-AN-R)

This field contains the patient's name. The format is Last, First, MI.

6. PATIENT'S BIRTHDATE (10-DATE-O)

This field contains the patient's date of birth, entered in the format MMDDYY or MM/DD/YY.

7. PATIENT'S SEX (6-AN-O)

This field contains the sex of the patient. Entries are **M** or **F**.

8. INSURED'S NAME (29-AN-O)
This field contains the insured's name for the insurance primary to Medicare. This is the insured's name for the COB1 plan if the COB1 plan is not a Medicare plan. The format is Last, First, MI.

9. PATIENT'S ADDRESS 1 (28-AN-O)
This field contains the first line of the patient's address.

10. PATIENT'S CITY (24-AN-O)
This field contains the city portion of the patient's address.

11. PATIENT'S STATE (2-AN-O)
This field contains the state portion of the patient's address.

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 3 OF 11

```
          General Hospital Maintain Claims by Account Processor
                         Page  3 of 11      Fri Sep 28, 2007 09:02 pm
Account      Name               FC Typ Admit    Disch       Balance Loc
A03079-00001 CRANE,LEAH          C  SER 03/13/03 03/20/03    43160.00 AR
 1 Patient's Zip FL 5   2 Patient's Phone FL 5
   30005
 3 Patient Rel to Insured FL 6     4 Insured's Address Line FL 7
   Patient                           123 PATIENT ADDRESS
 5 Insured's City FL 7             6 Insured's State FL 7
   ATLANTA                           GA
 7 Insured's Zip Code FL 7         8 Insured's Phone FL 7
   30005
 9 Marital Status FL 8           10 Employment FL 8
   Married                          X
11 Error Messages




 Press NL--


```

Field Explanations

1. PATIENT'S ZIP (10-AN-O)
This field contains the ZIP code portion of the patient's address.

2. PATIENT'S PHONE (14-AN-O)
This field contains the patient's telephone number in (999) 999-9999 format.

3. PATIENT REL TO INSURED (16-AN-O)
This field describes the relationship of the patient to the insured. The valid relationship code is indicated by an X on the paper form. The STAR Patient Care Insured Relation table has a field to indicate the applicable 1500 relationship code. Valid entries are **P** (patient), **S** (spouse), **C** (child), or **O** (other).

4. INSURED'S ADDRESS LINE (29-AN-O)
This field contains the first line of the insured's address for the insurance primary to Medicare. This is the insured's address for the COB 1 plan if the COB 1 plan is not a Medicare plan.

5. INSURED'S CITY (23-AN-O)
This field contains the insured's city for the insurance primary to Medicare. This is the insured's city for the COB 1 plan if the COB 1 plan is not a Medicare plan.

6. INSURED'S STATE (2-A-O)
This field contains the insured's state for the insurance primary to Medicare. This is the insured's state for the COB 1 plan if the COB 1 plan is not a Medicare plan.

7. INSURED'S ZIP CODE (10-AN-O)
This field contains the insured's ZIP code for the insurance primary to Medicare. This is the insured's ZIP code for the COB 1 plan if the COB 1 plan is not a Medicare plan.

8. INSURED'S PHONE (14-AN-O)
This field contains the insured's phone for the insurance primary to Medicare. This is the insured's phone for the COB 1 plan if the COB 1 plan is not a Medicare plan.

9. MARITAL STATUS (1-AN-O)
This field contains the patient's marital status. Valid entries are **M** (married), **S** (single), **O** (other), **D** (divorced), **P** (life partner), **U** (unknown), **W** (widowed), or **X** (separated).

10. EMPLOYMENT (1-AN-O)
This field contains an X if the patient has an employment status on the Patient Employer Page of the Admission screens, and the employment status indicator for retired/unemployed is blank in the Employment Status table. Valid entries are **X** (employed) or blank (unemployed).

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 4 OF 11

```
            General Hospital Maintain Claims by Account Processor
                            Page  4 of 11    Thu Sep 27, 2007 09:04 pm
Account      Name               FC Typ Admit    Disch        Balance Loc
A03079-00001 CRANE,LEAH          C  SER 03/13/03 03/20/03    43160.00 AR
 1 Full Time Student FL 8           2 Part Time Student FL 8

 3 Other Insured's Name FL 9       4 Other Insur. Policy/Grp # FL 9

 5 Other Insured Birthdate FL 9    6 Other Insured's Sex FL 9

 7 Oth Insured Employ/School FL 9  8 Other Insurance Plan Name FL 9

 9 Employment Related FL 10        10 Auto Accident Related FL 10

11 Error Messages




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

Field Explanations

1. FULL TIME STUDENT (1-AN-O)
This field contains an X if the patient has UB Condition Code 31 (Full Time Student-Day) or 33 (Full Time Student Night). Valid entries are **X** (full-time student) or blank (not a full-time student).

2. PART TIME STUDENT (1-AN-O)
This field contains an X if the patient has UB Condition Code 34 (Part Time Student). Valid entries are **X** (part-time student) or blank (not a part-time student).

3. OTHER INSURED'S NAME (28-AN-O)
Refer to your intermediary's instructions for completing this field.

4. OTHER INSURED POLICY/GROUP # (28-AN-O)
Refer to your intermediary's instructions for completing this field.

5. OTHER INSURED BIRTHDATE (10-DATE-O)
Refer to your intermediary's instructions for completing this field.

6.   OTHER INSURED'S SEX (7-A-O)
Refer to your intermediary's instructions for completing this field.

7.   OTH INSURED'S EMPLOY/SCHOOL (28-AN-O)
Refer to your intermediary's instructions for completing this field.

8.   OTHER INSURANCE PLAN NAME (28-AN-O)
Refer to your intermediary's instructions for completing this field.

9.   EMPLOYMENT RELATED (1-A-O)
This field indicates whether the patient's illness or injury is employment-related. Entry options are **Y** for Yes or **N** for No. The Yes box is checked if an employment accident type is entered on the patient's account. An employment accident type is designated by a UB occurrence code 04 in the accident type table. In order for the No box to be checked when the account does not have an accident type that qualifies to check the Yes box, a default value of **N** needs to be entered in the Claim Load and Edit Parameter.

10. AUTO ACCIDENT RELATED (1-A-O)
This field indicates whether the patient's illness or injury is auto-related. Entry options are **Y** for Yes or **N** for No. The Yes box is checked if an auto accident type is entered on the patient's account. An auto accident type is designated by a UB occurrence code 01 or 02 in the accident type table. In order for the No box to be checked when the account does not have an accident type that qualifies to check the Yes box, a default value of **N** needs to be entered in the Claim Load and Edit Parameter.

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 5 OF 11

```
              General Hospital Maintain Claims by Account Processor
                       Page  5 of 11       Wed Jan 10, 2007 08:39 am
 Account       Name                  FC Type Admit     Disch      Balance Loc
 C0625800001  CRANE,LEAH L           O   O/P 09/15/06 09/15/06  $554388.58-AR
  1 Accident Place State FL 10      2 Other Accident FL 10
    GA
  3 Reserved - Local Use FL 10      4 Insured's Group Number FL 11
                                      919191
  5 Insured's Birthdate FL 11       6 Insured's Sex FL 11
    01/19/1963                        F
  7 Insured Employ/School Nm FL 11  8 Insurance Plan Name FL 11
    HALLMARK                          COMMERCIAL PLAN
  9 Another Health Plan FL 11      10 Patient Signature FL 12
    Yes                               SIGNATURE ON FILE
 11 Error Messages
```

Field Explanations

1.   ACCIDENT PLACE STATE (2-A-O)
This field contains the state where the accident occurred.

2.   OTHER ACCIDENT (2-A-O)
This field indicates whether there was another accident.

3.   RESERVED - LOCAL USE (18-AN-O)
This field is reserved for local use. Refer to your intermediary's instructions for completing this field.

4.   INSURED'S GROUP NUMBER (29-AN-O)
This field contains the insurance group number of the insurance primary to Medicare. This is the insurance group number of the COB 1 plan if the COB 1 plan is not a Medicare plan.

5.   INSURED'S BIRTHDATE (10-DATE-O)
This field contains the insured's birthdate for the insurance primary to Medicare. This is the insured's birthdate for the COB 1 plan if the COB 1 plan is not a Medicare plan.

6.   INSURED'S SEX (8-A-O)
This field contains the insured's sex for the insurance primary to Medicare. This is the insured's sex for the COB 1 plan if the COB 1 plan is not a Medicare plan. Valid entries are **F** or **M**.

7.   INSURED'S EMPLOY/SCHOOL NAME (29-AN-O)
This field contains the insured's employer name for the insurance primary to Medicare. This is the insured's employer name for the COB 1 plan if the COB 1 plan is not a Medicare plan.

8. INSURANCE PLAN NAME (29-AN-O)
This field contains the insurance carrier/plan name for the insurance primary to Medicare. This is the insurance carrier/plan name for the COB 1 plan if the COB 1 plan is not a Medicare plan.

9. ANOTHER HEALTH PLAN (1-A-O)
This field indicates if there is an insurance primary to Medicare. If the COB 1 plan is a Medicare plan, this field is set to No. If the COB1 plan is not a Medicare plan, this field is set to yes.

10. PATIENT SIGNATURE (27-AN-O)
This field indicates whether the patient has authorized the provider to release any information necessary for filing the claim. The Claim Master loads *Signature on File* as a default value.

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

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

CMS 1500 Claim Form and Non Professional Fee 1500 Claim Form - Screen 6 of 11

```
              General Hospital Maintain Claims by Account Processor
                            Page  6 of 11     Thu Sep 27, 2007 09:05 pm
Account        Name                FC Typ Admit     Disch       Balance Loc
A03079-00001 CRANE,LEAH            C  SER 03/13/03 03/20/03    43160.00 AR
 1 Signature Date FL 12              2 Auth Payment Signature FL 13
   11/03/2007                          SIGNATURE ON FILE
 3 Date Onset of Symptoms FL 14     4 Prev Condition Date FL 15

 5 Dt Pat Unable Work Fr FL 16      6 Dt Pat Unable Work Th FL 16

 7 Referring Physician Name FL 17   8 Refer Phy ID Qual Upper FL 17
   ANTHONY RHODES                     1G
 9 Refer Phy ID Upper FL 17
   UPINRHODES12345
10 Error Messages
```

Field Explanations

1. SIGNATURE DATE (10-DATE-O)
This field contains the date on which the patient's signature was filed. The Claim Master loads the current system date. You can change the Claim Load Edit Parameters to load a different date.

2. AUTH PAYMENT SIGNATURE (20-AN-O)
This field indicates that the patient has authorized the insurance carrier to send the payment directly to the provider. The Claim Master loads *Signature on File* as a default value.

3. DATE OF ONSET OF SYMPTOMS (10-DATE-O)
This field contains the date entered with Occurrence Code 11 if Occurrence Code 11 and the date is entered on the account before the claim is loaded.

4. PREV CONDITION DATE (10-DATE-O)
This field contains the previous condition date of the illness. You can enter this date through the claim edit process. There is no automatic load of this date.

5. DT PAT UNABLE WORK FR (10-DATE-O)
This field contains the first date the patient is unable to work. This date is not automatically updated and can be entered through claim edit.

6. DT PAT UNABLE TO WORK TH (10-DATE-O)
This field contains the last date the patient is unable to work. This date is not automatically updated and can be entered through claim edit.

7. REFERRING PHYSICIAN NAME (26-AN-O)
This field contains the name of the appropriate physician. The Claim Master loads the referring physician's name for the CMS 1500 Claim Form and the attending physician's name for the Non Professional Fee 1500 Claim Form in this field. You can change this

and have the system load the admitting, referring, or attending physician, the primary procedure, the 1500 physician (supplier), or the 1500 physician group.

8. REFER PHY ID QUAL UPPER (2-AN-O)
This field identifies the type of legacy ID that is reported for the physician in the Referring Physician ID Upper locator following.

The NUCC defines the following qualifiers (subject to change). One of the below values should be entered as the Default Value based on the internal element used in the next field, Referring Physician ID Upper.

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 (the social security number may not be used for Medicare)

X5 State Industrial Accident Provider Number

ZZ Provider Taxonomy

9. REFER PHY ID UPPER (17-AN-O)
This field contains the legacy referring physician identification number that prints in the upper line of Locator 17. The referring physician ID Upper should correspond to the Physician ID Qualifier Upper based on the data that is being pulled to this locator.

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 7 OF 11

```
           General Hospital Maintain Claims by Account Processor
                            Page  7 of 11      Wed Jan 10, 2007 08:41 am
Account       Name                   FC Type Admit    Disch        Balance Loc
C0625800001  CRANE,LEAH L             O   O/P 09/15/06 09/15/06  $554388.58-AR
 1 Refer Phy ID Qual Lower FL 17    2 Refer Phy ID Lower FL 17
                                      5251435413
 3 Admission Date FL 18             4 Discharge Date FL 18
   09/15/2006                         09/15/2006
 5 Reserved for Local Use FL 19

 6 Outside Lab Work FL 20           7 Outside Lab Charges FL 20

 8 Diagnosis Code - 1 FL 21         9 Diagnosis Desc - 1 FL 21
   9110
10 Diagnosis Code - 2 FL 21
   00841
11 Error Messages
```

Field Explanations

1.   REFER PHY ID QUAL LOWER (2-AN-O)
This field contains the qualifier for the physician identification number that prints in the lower line of Locator 17. The Internal Element and Default Values for this locator are blank in the Claim Master since the paper claim form has *NPI* pre-printed on it.

2.   REFER PHY ID LOWER (17-AN-O)
This field contains the physician identification number that prints in the lower line of Locator 17. The Doctor's NPI Number should be pulled to this locator.

3.   ADMISSION DATE (10-DATE-O)
This field contains the patient's admission date. It is loaded from the patient's demographic data.

4.   DISCHARGE DATE (10-DATE-O)
This field contains the patient's discharge date. It is loaded from the patient's demographic data.

5.   RESERVED FOR LOCAL USE (48-AN-O)
This field is reserved for local use. Refer to your intermediary's instructions for completing this field.

6.   OUTSIDE LAB WORK (6-A-O)
This field indicates whether outside lab work was performed. Entry options are **Y** for Yes or **N** for No. This field is not automatically loaded. You can add this information through the claim edit process or enter a **Y** or **N** as a default value in the Claim load and Edit Parameter.

7.   OUTSIDE LAB CHARGES (11-N-O)
This field contains the amount of any outside lab work. This field is not automatically loaded. You can add this information through the claim edit process.

8.   DIAGNOSIS CODE - 1 (8-AN-R)
This field contains the ICD-9-CM or ICD-10-CM code for the diagnosis that relates to the injury or illness.

The system loads either ICD-9-CM or ICD-10-CM diagnoses for the claim based on the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter used to load the claim, and on the admission or discharge date of the patient. If the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter is blank, the code set used is dependent on the USA ICD-10 Effective Date field on STAR Patient Processing, on the admission date of the patient, and on any Insurance Plan, Insurance Carrier, or Financial Class exceptions for the account.

For the CMS 1500 Claim Form, this can be a diagnosis from either Medical Records, Admitting, or the Charge level, depending on the Internal Elements used in Locator 21 of the Claim Load and Edit Parameter, and based on the setting of the Diagnoses for 1500 Locator 21 field on the first screen of the 1500 Claim Load and Edit   Parameter. For additional information on this field, refer to the documentation for 1500 Claim Load Edit Parameter in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

For the Non Professional Fee 1500 Claim Form, the Claim Master is set to pull the principal or working diagnosis (if the principal is blank) into Locator 21-1. Hospitals can elect to use a different internal element, however, in this field.

The following Print Routines are available:

PRINT ROUTINES

1500 DIAGNOSIS CODE

The Print Routine of 1500 DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form.

1500 DIAGNOSIS PRINT

The Print Routine of 1500 DIAGNOSIS PRINT is assigned to the Internal Elements 1500 DIAGNOSIS BOX 21 - FIELD X, where X is the number 1, 2, 3, or 4. This print

routine places a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form. If instead, the STANDARD PRINT (NO FORMATTING) print routine is used for the same internal element, the diagnosis code would print without either a decimal or a space, as K9876xS.

DIAGNOSIS PRINT

The Print Routine DIAGNOSIS PRINT also prints a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form.

ICD DIAGNOSIS CODE

The Print Routine ICD DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form.

9. DIAGNOSIS DESC 1 (18-C-O)
This field does not print on the CMS 1500 form or the Non Professional Fee 1500 form.

10. DIAGNOSIS CODE 2 (6-AN-O)
This field contains the ICD 9-CM or ICD-10-CM code for the diagnosis that relates to the injury or illness.

The system loads either ICD-9-CM or ICD-10-CM diagnoses for the claim based on the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter used to load the claim, and on the admission or discharge date of the patient. If the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter is blank, the code set used is dependent on the USA ICD-10 Effective Date field on STAR Patient Processing, on the admission date of the patient, and on any Insurance Plan, Insurance Carrier, or Financial Class exceptions for the account.

For the CMS 1500 Claim Form, this can be a diagnosis from either Medical Records, Admitting, or the charge level, depending on the Internal Elements used in Locator 21 of the Claim Load and Edit Parameter, and based on the setting of the Diagnoses for 1500 Locator 21 field on the first screen of the 1500 Claim Load and Edit   Parameter. For additional information on this field, refer to the documentation for 1500 Claim Load and Edit Parameters in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

For the Non Professional Fee 1500 Claim Form, the Claim Master is set to pull the secondary diagnosis code into Locator 21-2. Hospitals can elect to use a different internal element, however, in this field.

The following Print Routines are available:

PRINT ROUTINES

STAR Financials Patient Accounting Reference Guide - Billing and Claims
3–144   *Release 18.0*   *October 2012*
Proprietary to McKesson - Subject to Confidentiality Agreement

1500 DIAGNOSIS PRINT

The Print Routine of 1500 DIAGNOSIS PRINT is assigned to the Internal Elements 1500 DIAGNOSIS BOX 21 - FIELD X, where X is the number 1, 2, 3, or 4. This print routine places a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form. If instead, the STANDARD PRINT (NO FORMATTING) print routine is used for the same internal element, the diagnosis code would print without either a decimal or a space, as K9876xS.

DIAGNOSIS PRINT

The Print Routine DIAGNOSIS PRINT also prints a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form.

ICD DIAGNOSIS CODE

The Print Routine ICD DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 8 OF 11

```
             General Hospital Maintain Claims by Account Processor
                          Page  8 of 11      Wed Jan 10, 2007 08:42 am
Account      Name                    FC Type Admit    Disch       Balance Loc
C0625800001  CRANE,LEAH L            O   O/P 09/15/06 09/15/06  $554388.58-AR
 1 Diagnosis Desc - 2 FL 21         2 Diagnosis Code - 3 FL 21
                                       40490
 3 Diagnosis Desc - 3 FL 21         4 Diagnosis Code - 4 FL 21
                                       92320
 5 Diagnosis Desc - 4 FL 21         6 Medicaid Resubmission Cd FL 22

 7 Original Reference Nmbr FL 22    8 Prior Authorization # FL 23

 9 Physician Tax ID Number FL 25   10 SSN - EIN Box FL 25
   410-99-2322                        SSN
11 Error Messages




 Press NL--

```

Field Explanations

1.   DIAGNOSIS DESC - 2 (18-C-O)
This field does not print on the CMS 1500 form or the Non Professional Fee 1500 form.

2.   DIAGNOSIS CODE - 3 (6-AN-O)
This field contains the ICD ICD-9-CM or ICD-10-CM code for the diagnosis that relates to the injury or illness.

The system loads either ICD-9-CM or ICD-10-CM diagnoses for the claim based on the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter used to load the claim, and on the admission or discharge date of the patient. If the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter is blank, the code set used is dependent on the USA ICD-10 Effective Date field on STAR Patient Processing, on the admission date of the patient, and on any Insurance Plan, Insurance Carrier, or Financial Class exceptions for the account.

For the CMS 1500 Claim Form, this can be a diagnosis from either Medical Records, Admitting, or the Charge level, depending on the Internal Elements used in Locator 21 of the Claim Load and Edit Parameter, and based on the setting of the Diagnoses for 1500 Locator 21 field on the first screen of the 1500 Claim Load and Edit   Parameter. For additional information on this field, refer to the documentation for 1500 Claim Load Edit Parameter in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

For the Non Professional Fee 1500 Claim Form, the Claim Master is set to pull the Other Diagnosis Code 2 (secondary) into Locator 21-3. Hospitals can elect to use a different internal element, however, in this field.

The following Print Routines are available:

PRINT ROUTINES

1500 DIAGNOSIS CODE

The Print Routine of 1500 DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form.

1500 DIAGNOSIS PRINT

The Print Routine of 1500 DIAGNOSIS PRINT is assigned to the Internal Elements 1500 DIAGNOSIS BOX 21 - FIELD X, where X is the number 1, 2, 3, or 4. This print routine places a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form. If instead, the STANDARD PRINT (NO FORMATTING) print routine is used for the same internal element, the diagnosis code would print without either a decimal or a space, as K9876xS.

DIAGNOSIS PRINT

The Print Routine DIAGNOSIS PRINT also prints a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form.

ICD DIAGNOSIS CODE

The Print Routine ICD DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form.

3. DIAGNOSIS DESC - 3 (18-C-O)
This field does not print on the CMS 1500 form or the Non Professional Fee 1500 form.

4. DIAGNOSIS CODE - 4 (8-AN-O)
This field contains the ICD9-CM or ICD-10-CM code for the diagnosis that relates to the injury or illness.

The system loads either ICD-9-CM or ICD-10-CM diagnoses for the claim based on the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter used to load the claim, and on the admission or discharge date of the patient. If the ICD-10 Effective Date field on the 1500 Claim Load Edit Parameter is blank, the code set used is dependent on the USA ICD-10 Effective Date field on STAR Patient Processing, on the

admission date of the patient, and on any Insurance Plan, Insurance Carrier, or Financial Class exceptions for the account.

For the CMS 1500 Claim Form, this can be a diagnosis from either Medical Records, Admitting, or the Charge level, depending on the Internal Elements used in Locator 21 of the Claim Load and Edit Parameter, and based on the setting of the Diagnoses for 1500 Locator 21 field on the first screen of the 1500 Claim Load and Edit   Parameter. For additional information on this field, refer to the documentation for 1500 Claim Load Edit Parameter in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

For the Non Professional Fee 1500 Claim Form, the Claim Master is set to pull the Other Diagnosis Code 3 (secondary) into Locator 21-4. Hospitals can elect to use a different internal element, however, in this field.

The following Print Routines are available:

PRINT ROUTINES

1500 DIAGNOSIS CODE

The Print Routine of 1500 DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form.

1500 DIAGNOSIS PRINT

The Print Routine of 1500 DIAGNOSIS PRINT is assigned to the Internal Elements 1500 DIAGNOSIS BOX 21 - FIELD X, where X is the number 1, 2, 3, or 4. This print routine places a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form. If instead, the STANDARD PRINT (NO FORMATTING) print routine is used for the same internal element, the diagnosis code would print without either a decimal or a space, as K9876xS.

DIAGNOSIS PRINT

The Print Routine DIAGNOSIS PRINT also prints a space where the decimal would be for the diagnosis code. For example, ICD-10 diagnosis code K98.76xS would print as K98 76xS on the claim form.

ICD DIAGNOSIS CODE

The Print Routine ICD DIAGNOSIS CODE prints the decimal for the diagnosis code. Therefore, ICD-10 diagnosis code K98.76xS would print as K98.76xS on the claim form.

5. DIAGNOSIS DESC - 4 (11-C-O)
This field does not print on the CMS 1500 form or the Non Professional Fee 1500 form.

6. MEDICAID RESUBMISSION CODE (18-AN-O)
Refer to your intermediary's instructions for completing this field. The system does not automatically load this information.

7. ORIGINAL REFERENCE NUMBER (13-AN-O)
Refer to your intermediary's instructions for completing this field. The system does not automatically load this information.

8. PRIOR AUTHORIZATION # (29-AN-O)
This field contains any authorization number previously given. You can update this field manually through the claim edit process. You can also enter the treatment authorization, policy number, or appropriate code. The system does not automatically load this information.

9. PHYSICIAN TAX ID NUMBER (15-AN-O)
This field loads the social security number of the physician for the CMS 1500 Claim Form and the federal tax ID number for the Non Professional Fee 1500 Claim Form. The social security number is loaded from the STAR Patient Care Physician Table. The Federal Tax ID is loaded from the Provider Master assigned to the account.

10. SSN - EIN BOX (1-AN-O)
This field indicates whether the ID number in form locator 25 is the physician's social security number or federal tax ID number. Valid entries are **S** for the social security number of the physician or **E** for the employer identification number. The CMS 1500 Claim Master loads the default value of **S** to this field and the Non Professional Fee 1500 Claim Master loads the default value of **E** to this field.

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 9 OF 11

```
        General Hospital Maintain Claims by Account Processor
                          Page  9 of 11     Wed Jan 10, 2007 08:43 am
Account      Name                    FC Type Admit    Disch       Balance Loc
C0625800001  CRANE,LEAH L            O   O/P 09/15/06 09/15/06  $554388.58-AR
 1 Patient Account Number FL 26      2 Accept Assignment FL 27
   0625800001                          Yes
 3 Total Charges FL 28               4 Amount Paid FL 29
   6.38
 5 Balance Due FL 30    6 Physician Name FL 31
                          AKER,THOMAS
 7 Signature Date FL 31              8 Provider Name FL 32
   11/03/2006                          PROV 1 1500 NAMEEEEEEEEEE
 9 Provider Address FL 32           10 Provider City FL 32
   PROV 1 1500 ADDRESSSSSSSS           ATLANTA
11 Error Messages



 Press NL--
```

Field Explanations

1. PATIENT ACCOUNT NUMBER (14-AN-R)
This field contains the patient's account number, which is loaded from the patient's demographic data.

2. ACCEPT ASSIGNMENT (6-A-O)
This field indicates whether the physician or supplier accepts assignment. Optional responses are **Y** for Yes or **N** for No. The Claim Master loads a default value of **Y** to this field.

3. TOTAL CHARGES (10-N-O)
When using the internal element of "TOTAL CHARGES FOR 08/05 1500", and the print routine of "MONEY (999999900) BLK IF NULL", 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 will have a blank Total Charges amount. The last page of the claim will have a Total Charges amount that is the total of the claim charges. When using the internal element of "TOTAL CHARGES FOR 08/05 1500" and the print routine of "1500 PAGE TOTAL", each page will have a total charge amount for that page only.

4. AMOUNT PAID (10-N-O)
This field contains the amount of any prior payments for this claim. This field defaults to $0; any amount entered prints on each page of the 1500.

The field "1500 Loc 29 Amount Paid Calc" on the header screen of the Claim Load Edit Parameter 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: 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.

5. BALANCE DUE (10-N-O)
The Balance Due is a calculated field and is only reflected on the last page of a multi-page claim. The system takes the Total Charges in Locator 28 (last page of claim) minus the Amount Paid in Locator 29 (last page of claim) to arrive at the Balance Due in Locator 30 (also last page of claim). When printing/spooling a multi-page claim, any page before the last page for the claim will have 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 overlayed at time of claim print/spool.

This Balance Due locator is updated for Claims Waiting for Payment. It is the Total Charges minus any payments reflected in Locator 29 for Amount Paid. If this amount is less than $0.00, the Balance Due is updated to be 0 00.

6. PHYSICIAN NAME (11-AN-O)
This field contains the name of the physician or group for which the 1500 claim is being produced. For the CMS 1500 form, if loading separate claims by physician as set in the 1500 Change Control Parameters, you indicate the physician who will be used for each department's 1500 in the 1500 Department/Supplier Override table.

7. SIGNATURE DATE (10-DATE-O)
This field contains the date on which the claim was loaded.

8. PROVIDER NAME (25-AN-O)
This field contains the name of the provider to which the patient was assigned at time of admission. This information can be loaded from the Provider Master (1500 information) or be loaded as a default value.

9. PROVIDER ADDRESS (25-AN-O)
This field contains the street address portion of the provider's address. This information can be loaded from the Provider Master (1500 information) or be loaded as a default value.

10. PROVIDER CITY (11-AN-O)
This field contains the city portion of the provider's address. This information can be loaded from the Provider Master or can be loaded as a default value.

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM SCREEN 10 OF 11

```
          General Hospital Maintain Claims by Account Processor
                          Page 10 of 11      Wed Jan 10, 2007 08:45 am
Account       Name                  FC Type Admit    Disch       Balance Loc
C0625800001   CRANE,LEAH L          O   O/P 09/15/06 09/15/06  $554388.58-AR
 1 Provider State FL 32            2 Provider Zip Code FL 32
   GA                                30342
 3 Provider NPI FL 32   4 Provider Other ID Qual FL 32
   1010101010              ZZ
 5 Provider Other ID FL 32         6 Supplier Phone FL 33
   TAX1111111                        404 3256565
 7 Supplier Name FL 33             8 Supplier Address FL 33
   Johnnie English & Associa         303 PERIMETER CENTER N.
 9 Supplier City FL 33             10 Supplier State FL 33
   Atlanta                           GA
11 Error Messages




 Press NL--
```

Field Explanations

1. PROVIDER STATE (2-A-O)
This field contains the state portion of the provider's address. You can enter the 2-digit abbreviation for the state or a hyphen (-) to display a list of valid state codes. This information can be loaded from the Provider Master or be loaded as a default value.

2. PROVIDER ZIP CODE (10-N-O)
This field contains the ZIP code portion of the provider's address. This information can be loaded from the Provider Master or be loaded as a default value.

3. PROVIDER NPI (10-N-O)
This field contains the National Provider ID (NPI). The system uses the Provider Master at the insurance level to look up the Provider NPI #. If there is no Provider Master assigned to the insurance, then the Provider Master assigned to the account is used to look up the Provider NPI #. The Provider Master is assigned at the account level based on the Provider Master assigned to the COB 1 plan, or if blank, to the

Patient Type in the Patient Type Table. Patient Type Exceptions can also be entered in the Provider Master for both the Provider NPI # and the Taxonomy Code.

4. PROVIDER OTHER ID QUAL (2-AN-O)
The ID Qualifier identifies what type of legacy ID is in the following locator for Provider Other ID. The qualifier must be set as the Default Value for this locator. Valid qualifiers are as follows (subject to change):

0B State License Number

1A Blue Cross Provider Number

1B Blue Shield Provider Number

1C Medicare Provider Number

1D Medicaid Provider Number

1G Provider UPIN Number

1H CHAMPUS Identification Number

G2 Provider Commercial Number

LU Location Number

N5 Provider Plan Network Identification Number

TJ Federal Taxpayer's Identification Number

X4 Clinical Laboratory Improvement Amendment Number

X5 State Industrial Accident Provider Number

ZZ Provider Taxonomy

5. PROVIDER OTHER ID (13-AN-O)
This field contains the other provider ID. The number loading to this field should correspond to the Provider Other ID Qualifier in the preceding field.

6. SUPPLIER PHONE (14-N-O)
This field contains the telephone number of the supplier.

7. SUPPLIER NAME (29-AN-R)
This field contains the name of the supplier. For the CMS 1500 Claim Form, the system loads the doctor name from the 1500 Physician Group. For the Non Professional Fee 1500 Claim Form, the system loads the Medicaid claim name from the Provider Master assigned to the account.

8. SUPPLIER ADDRESS (29-AN-O)
This field contains the address of the supplier. For the CMS 1500 Claim Form, the system loads the doctor address line 1 from the 1500 Physician Group. For the Non Professional Fee 1500 Claim Form, the system loads the Medicaid street address from the Provider Master assigned to the account.

9. SUPPLIER CITY (15-AN-O)
This field contains the city portion of the supplier's address. For the CMS 1500 Claim Form, the system loads the doctor city from the 1500 Physician Group. For the Non Professional Fee 1500 Claim Form, the system loads the provider city from the Provider Master assigned to the account.

10. SUPPLIER STATE (15-AN-O)
This field contains the state portion of the supplier's address. For the CMS 1500 Claim Form, the system loads the doctor city from the 1500 Physician Group. For the Non Professional Fee 1500 Claim Form, the system loads the provider city from the Provider Master assigned to the account.

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

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

CMS 1500 CLAIM FORM AND NON PROFESSIONAL FEE 1500 CLAIM FORM - SCREEN 11 OF 11

```
                General Hospital Maintain Claims by Account Processor
                            Page 11 of 11       Wed Jan 10, 2007 08:45 am
 Account      Name                    FC Type Admit    Disch        Balance Loc
 C0625800001  CRANE,LEAH L            O   O/P 09/15/06 09/15/06  $554388.58-AR
  1 Supplier Zip Code FL 33          2 Supplier NPI FL 33
    30346-9999                         1231231238
  3 Supplier Other ID Qual FL 33     4 Supplier Other ID FL 33
    1G                                 upinaker12345
  5 Remarks FL 34

  6 Error Messages




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

Field Explanations

1. SUPPLIER ZIP CODE (10-AN-O)

This field contains the ZIP code portion of the supplier's address. For the CMS 1500 Claim Form, the system loads the doctor's ZIP code from the 1500 Physician Group. For the Non Professional Fee 1500 Claim Form, the system loads the Provider ZIP code from the Provider Master assigned to the account.

2. SUPPLIER NPI (10-AN-O)

For the 1500 claim, this field contains the supplier's National Provider ID (NPI).

For the Non Pro Fee 1500, this field contains the National Provider ID (NPI). The system uses the Provider Master at the insurance level to look up the Provider NPI #. If there is no Provider Master assigned to the insurance, then the Provider Master assigned to the account is used to look up the Provider NPI #. The Provider Master is assigned at the account level based on the Provider Master assigned to the COB 1 plan, or if blank, to the Patient Type in the Patient Type Table. Patient Type Exceptions can also be entered in the Provider Master for both the Provider NPI # and the Taxonomy Code.

3. SUPPLIER OTHER ID QUAL (2-AN-O)

The ID Qualifier identifies what type of legacy ID is in the following locator for Supplier Other ID. The qualifier must be set as the Default Value for this locator. Valid qualifiers are as follows (subject to change):

0B State License Number

1A Blue Cross Provider Number

1B Blue Shield Provider Number

1C Medicare Provider Number

1D Medicaid Provider Number

1G Provider UPIN Number

1H CHAMPUS Identification Number

1J Facility ID Number

B3 Preferred Provider Organization Number

BQ Health Maintenance Organization Code Number

FH Clinic Number

G2 Provider Commercial Number

G5 Provider Site Number

LU Location Number

U3 Unique Supplier Identification Number (USIN)

X5 State Industrial Accident Provider Number

ZZ Provider Taxonomy

4.   SUPPLIER OTHER ID (130-AN-OR)
This field contains the supplier other ID. The number loading to this field should correspond to the Supplier Other ID Qualifier in the preceding field.

5.   REMARKS (30-C-O)
This field contains free form text regarding the claim. This field does not automatically print on the CMS 1500 form or the Non Professional Fee 1500 form.

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

Claim Attachments

This function enables you to confirm that required attachments have been sent with the claim. The attachments are hospital-defined and entered into the system through the Insurance Plan Coverage master. Claim attachments can be charge specific; that is, they can be required only if a specific charge exists on the account. In addition, it is possible to have patient type exceptions for claim attachments. For more detailed

information regarding attachments, refer to the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

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

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

```
                     General Hospital Edit Claims Processor
                                        Mon Mar 27, 2007 10:40 am
Account      Name                  FC Typ Admit   Disch      Balance  Loc
88147-00001  NEWMAN,HENRY           C  I/P 05/26/88           1294.80  PA/FCRV

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










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

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

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

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

Accepting the screen completes the transaction.

Claim Charge Data

Charge data on a claim form is determined by the Charge Control parameters for the specific carrier/plan. This function enables you to add, edit, and delete claim charge information included on the claim form prior to the production of the claim. Once the claim is produced, in order to edit the charges, the claim must be edited for resubmission in the Claim Status Information screen. The Claim Charge Data screens for the UB and 1500 Claim forms are discussed below.

UB CLAIM

The following screen is for a UB claim.

```
                  General Hospital Maintain Claims by Account Processor
                                               Mon Aug 06, 2012 01:27 pm
Account       Name                 FC Typ Admit    Disch      Balance Loc
C1219500001  NEW, TOM             M  O/P 07/13/12 07/13/12     337.86 AR /ACCF
Room Units Error:                             No  Charge Summary Errors: None
Procedure Code Errors:                      None       3M OPPS Errors: None
Non Spec HCPCS Err: None    HCPCS Sum Qty Err: None  Rehab Rev Code Errors:   No
Duplicate HCPCS Same Service Date Errors:     None Charge Srv Date Errors: None
Addtl Srv Date Err: None   Rev Cd Req Prc Err: No     Unused MR HCPCS Err: None
Req Rev Codes Error:                              NDC Cd/Qual/Unit Errors:   1
Seq  Rev HCPCS Ind HCPCS M1 M2 M3 M4 Serv Date   Units     Charges Non Covered
 Description            Loc 49 NDC       Qual  NDC UOS         RF IDE
 Error
1    985 C      12345             07/13/12      1      16.09       16.09
 ECG PROFESSIONAL FEE
 NDC Code
2    985 C      93042             07/13/12      1       8.05        8.05
 RHYTHM STRIP PROFESSIONA


3    986 D      95819             07/13/12      2      72.16       72.16
 EEG PRO FEE


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

Field Explanations

ROOM UNITS ERROR (DISPLAY ONLY)
An error is displayed in this field if the following occurs:

The units of service for the room charges do not equal the sum of the covered days and the non-covered days (UB92 Locator 7 for Covered Days + UB92 Locator 8 for Non Covered Days) or (UB04 Value Code 80 for Covered Days + UB04 Value Code 81 for Non Covered Days), and the Charge Control Parameter has the Edit Room Charges field set to Yes.

The claim fails edits and is not released until the errors are corrected. Units of service or covered and non-covered days (either in the locators for the UB92 or in the Value Codes for the UB04) must be changed in order for the error to be corrected.

If the Edit Room Charges field is set to Yes and there is no Value Code 80 (Covered Days) and/or Value Code 81 (Non Covered Days) when the UB04 format is loaded, the claim sets the missing value code to equal days of 0. 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.

CHARGE SUMMARY ERRORS (DISPLAY ONLY)
If any summary category has a negative amount, the resulting error is displayed in this field. The claim fails edits and is not released until the negative amounts are changed to positive amounts, the charge line is deleted, or the claim is manually released with the negative charge amounts.

PROCEDURE CODE ERRORS (DISPLAY ONLY)
This field contains the number of procedure coding errors of omission made on this claim at the time the claim was loaded. The claim fails edits and is not released until the procedure codes are entered, or the claim is manually released. Procedure errors are indicated if a UB revenue code has been set up in the UB Charge Control Parameters to require HCPCS coding and the HCPCS coding has not been performed. These errors are corrected by entering the code in the HCPCS field.

3M OPPS ERRORS (DISPLAY ONLY)
This field contains the number of 3M OPPS errors on a claim that was processed in the 3M OPPS interface. For a list of the edits, review the 3M OPPS Err Msg/Codes Report (FCR450).

NON-SPECIFIC HCPCS ERRS (DISPLAY ONLY)
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 "Charge 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. The Error field at the claim charge line level will have "NS HCPCS" for Non-Specific HCPCS.

NOTE: When manually adding a claim charge line with one of the Non Specific HCPCS, if a Description is entered, the system assumes this is the detailed description for the HCPCS, and will not error the charge line. However, if a claim charge line is manually added with one of the Non Specific HCPCS, and the Description is left blank, then the system will error the charge line.

HCPCS SUM QTY ERR (DISPLAY ONLY)
This field contains the number of charge lines containing the HCPCS Summarization code G0060, where the quantity on the charges is greater than 22. The system looks at the quantity on the charges themselves for the charges that are summarized to this HCPCS code, and not to the Units field on the UB. The claim fails edits and is not released until the claim is manually released. Before manually releasing the claim, additional charge lines for the revenue code can be entered to list the HCPCS codes for the charges greater than 22.

REHAB REV CODE ERROR
This field indicates whether there are any rehab revenue code errors. The valid values are Yes or No. If a claim is set up to be edited for the UB Charge Control Parameter, I/P Rehab Revenue Code 0024, and the claim does not have revenue code 024 or 0024 in the claim charge data, the claim fails. To clear the error, a charge with revenue code 024 or 0024 must be entered on the account, or a charge must be entered on the account with revenue code 024/0024 and an adjustment bill and claim requested, or the claim can be manually released with the error.

DUPLICATE HCPCS SAME SERVICE DATE (DISPLAY ONLY)
This field contains the number of Duplicate HCPCS Same Service Date errors. The claim fails edits and is not released until the Duplicate HCPCS Same Service Date errors are cleared on each charge for which they exist or until the claim is manually released. Duplicate HCPCS Same Service Date errors indicate that more than one occurrence of a HCPCS code for the same service code appears on the claim. This error is dependent on what is defined in the Non Duplicating HCPCS Range Table and the HCPCS Panel Code Table and on the Date field being set to Edit (Yes) for the revenue code.

CHARGE SRV DATE ERRORS (DISPLAY ONLY)
This field contains the number of claim charge lines with a service date defined in the Edit Chg Srv Dates field of the UB Charge Control Parameter screen. The claim fails edits and is not released until either the edit is removed in the UB Charge Control Parameter, or the dates are changed in the Edit Chg Srv Dates field so that the claim charge service dates no longer qualify for the edit, or the user manually updates the claim charge service dates to no longer qualify. When updating the Edit Chg Srv Dates field in the UB Charge Control Parameter, the claim must go through Claim Reload in Midnight Processing, or you must access the Claim Charge Data screen within Claims Management and respond with *Yes* to either of the following prompts:

• *Accept?* - Respond with Yes if changes were made to the charge screen

• *Re-evaluate Claim for Charge Service Date Errors*-Respond with Yes if no changes were made to the charge screen, in order to update the charge service date errors.

ADDTL SRV DATE ERR (DISPLAY ONLY)
This field displays service date charge errors. If a claim charge line has more than one additional charge service date error, for example, the claim charge line has an error for the service date being after the discharge date, and also an error for the service date being outside the statement covers period, this will still only count 1 error in the top of the screen for the Addtl Srv Date Err count. The errors are broken out however on the Failed Claims Requirement Report.

• 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

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being outside the Statement Covers Period, the claim charge line edit will be "Proc Code/ ChgStmt". The charge statement edit can be cleared by updating the claim charge service date to be within the UB Statement Covers Period.

   NOTE: This does not update the actual charge service date at the account level.

- 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.

- 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". The charge date before admit date edit can be cleared by updating the claim charge service date to be on or after the Admission Date (and should also be within the UB Statement Covers Period).

   NOTE: This does not update the actual charge service date at the account level.

- 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.

- 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". The charge date after disch date edit can be cleared by updating the claim charge service date to be on or before the Discharge Date (and should also be within the UB Statement Covers Period).

   NOTE: This does not update the actual charge service date at the account level.

NOTE: When the UB Charge Control Parameter has the field "Edit Chg Srv Dates?" set to edit charges with a specified service date range, the Error field at the charge line level has one of the following:

- SvDt - for a charge line with a charge service date error

- Proc CodeSvD - for a charge line with both a procedure code (missing HCPCS) error and a charge service date error.

When hitting F7 to exit the UB Claim Charge Data Screen, if the claim has any of the charge service date errors (the Edit Chg Srv Dates, or any of the Charge Service Date Before Admit Date, Charge Service Date After Discharge Date, or Charge Service Date Outside Stmt Covers Period), the system displays the following prompt. If Y for Yes is entered, the system re-evaluates all of the claim charge lines with one of the charge service date errors.

Re-evaluate Claim for Charge Service Date Errors (Y/N)? --

REV CD REQ PRC ERR (DISPLAY ONLY)
This field indicates whether there are any Revenue Code Requires Procedure Code errors. The valid values are Yes or No. The claim fails edits and is not released until the procedure code and date are entered or until the claim is manually released. Revenue Code Requires Procedure Code errors are indicated if a UB revenue code has been defined in a Principal Procedure Code Table that is associated with the UB Charge Control Parameter that is used by the claim. These errors are corrected by entering the procedure code and date in form locator 80 (for the UB92), or by entering the procedure code and date in form locator 74 (for the UB04) which is where the Principal Procedure Code and Principal Procedure Code Date fields are located.

NOTE: The Principal Procedure is Locator 80 on the UB92. The UB04 looks for the Principal Procedure in Locator 74.

UNUSED MR HCPCS ERR (DISPLAY ONLY)
This field reports on the number of Medical Records HCPCS that are not reflected on the claim. This field appears on the top portion of the Claim Charge Data screen, and not in the individual claim charge lines. To investigate the unused Medical Records HCPCS, you can access the Unused/Applied Med Rec HCPCS option on the Claims Management menu.

The Claim Reload function (both online when accessing the Claim Charge Data screen, and within Midnight Processing), re-evaluates the Unused Medical Records HCPCS error. Since Medical Records HCPCS that were coded after the claim initially loaded can be pulled into the claim, the system re-evaluates the error, and updates where appropriate. This updates the Unused MR HCPCS Error message at the top of the Claim Charge Data screen.

In order for the Claim Charge Data screen to reevaluate the Unused Medical Records HCPCS, the revenue code must be set to pull Medical Records HCPCS in the UB

Charge Control Parameter. This means the HCPCS Proc field must be set to either Charge/Default MR (F), Medical Records (M), Both/Detail (D), Both/Summary (S), or Override (O) where there were Medical Records HCPCS when the claim initially loaded. Only claim charge data lines that have a HCP indicator in the Claim Charge Data screen of F, M, D, S, or O will attempt to reload Medical Records HCPCS into the claim charges.

REQ REV CODES ERROR (DISPLAY ONLY)
This field contains the revenue code(s) that are required on the claim but do not exist on the claim. The claim fails edits and is not released until the revenue code(s) are entered or the claim is manually released. Required Revenue Code errors are indicated if the Req Rev Codes field in the UB Charge Control Parameter has one or more revenue codes listed as required, and all listed revenue codes do not exist on the claim. If more than one revenue code is missing on the claim, the system lists all that are required and missing, separated by commas.

NDC CD/QUAL/UNIT ERRORS (DISPLAY ONLY)
This field contains the number of errors for NDC Code, NDC Qualifier and NDC Unit. The system edits the NDC Qualifier and the NDC Unit in the following cases: there is a charge line with an NDC code, there is no unit qualifier for the charge line with the NDC code, and/or there is no NDC unit value, and the field Unit Qual/Units in the NDC Parameters section of the UB Charge Control Parameters is set to Edit.

The Error field displays any errors concerning NDC, NDC Qualifier or NDC Units:

- NDC Code for charge lines with the missing NDC Code error. Note that if the charge line has an edit for NDC Code, the system does not further edit for NDC Unit Qualifier or NDC Units.

- If the user edits the claim charge line to have an NDC code, if the NDC Units and Unit Qualifier are not entered at the same time, the system will not edit for the data. When a claim charge line fails for missing NDC Code, all the NDC information should be manually entered by the user when revising the charge line.

- NDC Unit Qual for charge lines with the missing NDC Unit Qualifier error

- NDC Units for charge lines with the missing NDC Units error

- NDC Qual+Units for charge lines with the missing NDC Unit Qualifier and NDC Units errors.

Users can clear the NDC code error by hitting the F5 key to Edit, and then entering the NDC code (and NDC Unit Qualifier and NDC UOS) into the existing NDC fields in Claims Management.

REV (DISPLAY ONLY)
This field contains the UB revenue code for the account.

HCPCS INDICATOR (DISPLAY ONLY)
This field displays the HCPCS Procedure indicator, as set in the UB Charge Control
Parameter, for the revenue code. Valid values are C (FIM/Charge), D (Both/Detail), F
(Charge/Default Medical Records), M (Medical Records), N (None), O (Override), S
(Both/Summary) or E for charge lines updated by EC 2000.

HCPCS (DISPLAY ONLY)
This field contains the HCPCS Procedure code that is charge-related (from the FIM/
Charge) or procedure-related (from Medical Records).

M1 (DISPLAY ONLY)
This field contains the first HCPCS Modifier.

M2 (DISPLAY ONLY)
This field contains the second HCPCS Modifier.

M3 (DISPLAY ONLY)
This field contains the third HCPCS Modifier.

M4 (DISPLAY ONLY)
This field contains the fourth HCPCS Modifier.

SERVICE DATE (SERVICE DATE) (DISPLAY ONLY)
If the UB claim form is set to print by Service Date or Service Date within Revenue
Code in the UB Charge Control Parameter, this field contains the service date for the
charge line. If the UB claim form is set to print by UB revenue code, the service date
for the charge line loads for revenue codes that have the Date field set to Yes or Use.

UNITS (DISPLAY ONLY)
This field contains the units of service, which is a quantitative measure of services
rendered by revenue category to or for the patient.

CHARGES (DISPLAY ONLY)
This field contains the total charge pertaining to this line of detail (in $$$$$$$cc
format).

NON COVERED (DISPLAY ONLY)
This field contains the amount of the charge line that is considered non-covered (in
$$$$$$$cc format).

DESCRIPTION (DISPLAY ONLY)
This field displays the description for the claim charge line. The description varies,
depending on whether the charge line prints in detail or in summary. If the charge line
prints in detail, the description is for that charge item. If the charge line prints in
summary, the UB revenue code description prints.

LOC 49 (DISPLAY ONLY)
This field is not loaded by the system and therefore must be manually entered, if required. The value entered in this field prints in Locator 49 for the charge line. Locator 49 is an unlabeled field and is currently reserved for national use.

NDC (DISPLAY ONLY)
This field contains the National Drug Code (NDC) pertaining to this line of detail.

When this field is added or updated, if the new or revised claim charge line matches another claim charge line for Revenue Code, HCPCS Code and Modifiers, Service Date, and NDC Code, the charges are not summarized together after the screen is accepted. The new or revised claim charge line remains on separate lines.

QUAL (NDC UNIT QUALIFIER) (DISPLAY ONLY)
This field displays the NDC Unit Qualifier for the charge. Valid values are: F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter), or ME (Milligrams).

NDC UOS (DISPLAY ONLY)
This field displays the NDC units of service (UOS) for the charge.

REFERENCE FACILITY (DISPLAY ONLY)
This field displays the Reference Facility code for any charges that further sorted on Reference Facility code, based on the UB Charge Control Parameters.

IDE (DISPLAY ONLY)
This field displays the Investigational Device Exemption code for any charges that further sorted on IDE,

ERROR (DISPLAY ONLY)
This field indicates whether an error was detected for this item during claim edits. If an error was detected, one of the following error messages is displayed:

Proc Code - for a charge line with a procedure code (missing HCPCS) error.
Chg Summ - for a charge line with a charge summary error.
Proc&Sum - for a charge line with both a procedure code error and a charge summary error.
SvDt - for a charge line with a charge service date error.
Proc CodeSvD - for a charge line with both a procedure code (missing HCPCS) error and a charge service date error.

INSERTING AND EDITING CLAIM CHARGE LINES

In order to insert a charge line or to edit an existing charge line, you must use your function keys. If you press F3 (Insert), the following screen is displayed with the fields blank, in order to enter the charge line data. If you press F5 (Edit), the following screen is displayed with the fields set as seen on the Claim Charge Data screen, and you can edit the existing charge line data.

```
             General Hospital Maintain Claims by Account Processor
                                              Tue Apr 08, 2008 11:27 am
 Account        Name                FC Typ Admit     Disch       Balance Loc
 A06321-00004 MOORE,UPFIRST SEC TH S  OPC 11/17/06 11/17/06   109781.05-AR /ACCF
  1 Revenue Code                       2 HCPC Ind
    270                                  M
  3 HCPCS                              4 M1    5 M2     6 M3     7 M4
    31622-DX BRONCHOSCOPE/WASH           11
  8 Service Date     9 Units          10 Charges       11 Non-Covered
                     8                       63.26
 12 Description                        13 Loc 49
    MEDICAL/SURGICAL SUPPLIE
 14 NDC                                15 NDC Unit Qualifier   16 NDC UOS

 17 NDC Loc 43 Description

 18 Reference Facility                19 IDE

 20 Errors




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

Field Explanations

1. REVENUE CODE (4-N-R)
This field contains the UB revenue code for this line of information. You can enter a code or a hyphen (-) to display a list of valid codes.

2. HCPC INDICATOR (DISPLAY ONLY)
This field displays the HCPCS Procedure indicator, as set in the UB Charge Control Parameter, for the revenue code. Valid values are C (FIM/Charge), D (Both/Detail), F (Charge/Default Medical Records), M (Medical Records), N (None), O (Override) or S (Both/Summary). Charges that are entered directly into the Claim Charge Data screen have a blank HCPCS indicator.

In Claims Management, when accessing the Claim Charge Data Screen, and when Claim Reload runs in Midnight Processing, the system pulls in Medical Records HCPCS that do not exist on the claim for any revenue code with the HCPCS Indicator field set to Medical Records, Both/Summary, Both/Detail, Override, or Charge/Default Medical Records. This occurs regardless of whether a code is failing for a procedure code error. This enables Medical Records HCPCS that were coded after the claim was initially loaded to be loaded to the claim.

The Add Claim to Insurance function adds a sequence number to any claim loaded with a non-blank Claim Split Indicator. This is needed to identify a claim loaded via a billing event versus an added claim.

Added claims with a Sequence Number in the Claim Split Indicator field do not reload HCPCS if they are in a Failed status and the user accesses the Claim Charge Data

screen. This means that if an added claim has a HCPCS procedure error, and a new Medical Records HCPCS is added, if the user accesses the Claim Charge Data screen for this added claim, the system will not pull HCPCS into the claim. This is needed since, when using the Add Claim to Insurance function, the system only loads the HCPCS to the claim that would have loaded if the claim was loaded through a billing event. Since the user can select which of the claims to load in Add Claim to Insurance, the newly added HCPCS may qualify for a claim not selected to load.

When using Add Claim to Insurance, and only loading some of the possible claims (primary or split), if the Charge Control Parameter is set to Edit for Unused Medical Records HCPCS, the error may appear when the claim the HCPCS would have loaded to is not selected to load in Add a Claim to Insurance.

NOTE: If you delete a claim charge line that had a Medical Records HCPCS code and accept the screen, to verify that your change was completed, you should access the Claim Charge Data screen via Account Inquiry. If you access the Claim Charge Data screen via Claims Management or Account Revision, the system pulls the Medical Records HCPCS back into the claim.

3. HCPCS (5-C-O)
This field contains the HCPCS Procedure code that is charge-related (from the FIM/ Charge) or procedure-related (from Medical Records). It is also used for the room rate for room charges. Room rates can be manually entered by entering the rate with the decimal (for example, 450.00). When this field is accessed, the following prompt is displayed:

Enter Room Rate, HCPCS procedure code, `U`ser procedure code, or `-` for a list-

You can enter a partial lookup such as 8-, enter the HCPCS code directly, enter a dash (-) for a list, or enter an alpha such as M- for a user list. To delete a HCPCS code, access the field and then hit the Enter key. Any modifiers for the HCPCS are also deleted.

4. M1 (2-C-O)
This field contains the first HCPCS Modifier. The field allows a table lookup on the HCPCS Modifier table. When this field is accessed, the following prompt is displayed:

Enter HCPCS Modifier 1 or '-' for list --

To delete a modifier, press the space key and then press the Enter key. Any modifiers listed after the deleted modifier are moved up.

5. M2 (2-C-O)
This field contains the second HCPCS Modifier. The field allows a table lookup on the HCPCS Modifier table. When this field is accessed, the following prompt is displayed:

Enter HCPCS Modifier 2 or '-' for list --

To delete a modifier, press the space key and then press the Enter key. Any modifiers listed after the deleted modifier are moved up.

6. M3 (2-C-O)
This field contains the third HCPCS Modifier. The field allows a table lookup on the HCPCS Modifier table. When this field is accessed, the following prompt is displayed:

Enter HCPCS Modifier 3 or '-' for list --

To delete a modifier, press the space key and then press the Enter key. Any modifiers listed after the deleted modifier are moved up.

7. M4 (2-C-O)
This field contains the fourth HCPCS Modifier. The field allows a table lookup on the HCPCS Modifier table. When this field is accessed, the following prompt is displayed:

Enter HCPCS Modifier 4 or '-' for list --

To delete a modifier, press the space key and then press ENTER. Any modifiers listed after the deleted modifier are moved up.

Adding/Changing Modifiers to Medical Records HCPCS

If a revenue code has the HCPCS Procedure field in the UB Charge Control Parameter set to either Medical Records, Both/Summary, Both/Detail, or Override, and the claim is in a Failed or Awaiting Payment status, if the Medical Records HCPCS that initially loaded is updated only to have a modifier, then the system updates the claim HCPCS to have this modifier instead of adding a new $0.00 charge line for this HCPCS and modifier. This updating can occur in the Midnight Processing Claim Edit or online when you access the Claim Charge Data screen within Claims Management. The system continues to match the Revenue Code and Service Date for the charge line with the HCPCS to the Revenue Code and Service Date for the HCPCS in Medical Records.

The following is an example. If the claim initially loaded the following:

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	12345	1	$1200.00

If this HCPCS was updated to have Modifier 78, and you access the Claim Charge Data screen within Claim Management, this claim charge line would be updated to be:

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	1234578	1	$1200.00

This updating occurs only for Medical Records HCPCS that were initially loaded when the claim loaded. If you add a Medical Records HCPCS after the claim loads, and this

HCPCS is pulled into the claim, if this HCPCS is in turn updated, the system adds a new $0.00 charge line for the HCPCS/Modifier.

For example, if when the claim initially loaded, you had the following:

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	12345	1	$1200.00

If you access Medical Records and add HCPCS 1234599 for 09/15/03, then the system adds a $0.00 charge line to the claim as follows:

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	12345	1	$1200.00
490	09/15/03	1234599	1	$ 0.00

If this HCPCS was then updated to have a second modifer, such as 88, the system adds an additional $0.00 charge line to the claim as follows below (after the NOTE).

NOTE: In the above example, the same HCPCS code (5 digits) would appear in Medical Records twice for the same service date. Once the HCPCS code appears in Medical Records two or more times for the same service date, any updates or revisions after that point are added as a new line to the claim rather than an update. This is necessary since the system would not know which HCPCS line for the service date to update on the claim.

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	12345	1	$1200.00
490	09/15/03	1234599	1	$ 0.00
490	09/15/03	123459988	1	$ 0.00

Another example of this is when the claim initially loads duplicate HCPCS codes for the same service date, as follows:

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	12345	1	$1200.00
490	09/15/03	12345	1	$ 0.00

If one of these HCPCS codes is updated in Medical Records with a modifier of 99, since the same HCPCS code exists in Medical Records (not necessarily the claim) two

or more times for the same service date, the system adds a new claim charge line as follows:

REV	Srv Date	HCPCS	Units	Chg Amount
490	09/15/03	12345	1	$1200.00
490	09/15/03	12345	1	$ 0.00
490	09/15/03	1234599	1	$ 0.00

These duplicate HCPCS errors can be found on the front-end Order Management, Laboratory, and Radiology applications if Outpatient Charge Documentation is implemented on STAR. By catching the errors up front, the appropriate modifier can be assigned to one of the HCPCS before the claim loads.

For the UB04 version of a claim, the system looks at the HCPCS code and the first four two-digit modifiers when comparing, since four modifiers can load to the UB04 claim. Therefore, if a HCPCS and four modifiers already exist in Medical Records, and you add the same HCPCS and four modifiers, plus a fifth modifier for the same service date, the system does not recognize that this code differs from the existing and does not add it to the claim. For example, if the following existed in Medical Records:

REV	Srv Date	HCPCS	M1	M2	M3	M4	M5
490	09/15/07	12345	99	88	77	66	

If HCPCS 12345 and modifiers 99, 88, 77, 66, and 55 (five modifiers) are added to Medical Records, it would not be added to the claim, since the system would not recognize that these additions differ from the existing HCPCS and modifiers for the same service date.

In the above example, Medical Records would have:

REV	Srv Date	HCPCS	M1	M2	M3	M4	M5
490	09/15/07	12345	99	88	77	66	
490	09/15/07	12345	99	88	77	66	55

The claim would only have:

REV	Srv Date	HCPCS	M1	M2	M3	M4
490	09/15/07	12345	99	88	77	66

For claims that do not load the service date, such as when the Summarize By field is set to UB Code, and the Date field for the Revenue Code is set to No in the UB Charge

Control Parameter, if the same HCPCS is loaded more than once for the revenue code, and one of the duplicate HCPCS is updated only to have a modifier, the system adds this as a new claim charge line. For example, if the claim initially loaded the following:

REV	Srv Date	HCPCS	Units	Chg Amount
490		12345	1	$1200.00
490		12345	1	$1200.00

If one of these HCPCS is updated to 1234599, the claim is updated as follows when accessing the Claim Charge Data screen:

REV	Srv Date	HCPCS	Units	Chg Amount
490		12345	1	$1200.00
490		12345	1	$1200.00
490		1234599	1	$ 0.00

There are some exceptions to the above rules as shown below:

- HCPCS Procedure set to Both/Detail

  The above rules hold true. Note that if, when the claim initially loads, for a revenue code, the charge level HCPCS is a duplicate of a Medical Records HCPCS, the system uses the charge level HCPCS. For example, if the account has:

REV	HCPCS	$
490 Repair Laceration	12345	540.00

Medical Records	HCPCS
490	12345

  The claim would have the HCPCS only once from the charge level:

REV	HCPCS	$
490 Repair Laceration	12345	540.00

  If the Medical Records HCPCS is updated with a modifier of 99, the claim would have:

REV	HCPCS	$

490 Repair Laceration   12345   540.00

490 Ambulatory Surgery   1234599   0.00

- HCPCS Procedure set to Both/Summary

  If the claim originally loaded using Both/Summary, and the HCPCS code was found in both the charge and in Medical Records, the HCPCS is loaded from the charge as a $0.00 claim charge line. In this instance, if the Medical Records HCPCS is changed and then added (rather than updated), it is added (not updated) to the claim when the HCPCS codes in the claim charges are evaluated.

- HCPCS Procedure set to Override

  In order to update the claim with changes to Medical Records HCPCS, there must be Medical Records HCPCS for the revenue code (and date, if loading date) when the claim initially loads. If there are no Medical Records HCPCS for the revenue code/date when the claim initially loads, the HCPCS Procedure field is set to **C** for FIM/Charge for the Claim Charge line, and no updates are made.

8. SERVICE DATE (SERVICE DATE) (8-C-O)
If the UB claim form is set to print by Service Date or Service Date within Revenue Code in the UB Charge Control Parameter, this field contains the service date for the charge line. If the UB claim form is set to print by UB revenue code, the service date for the charge line loads for revenue codes that have the Date field set to Yes or Use.

9. UNITS (7-N-O)
This field contains the units of service, which is a quantitative measure of services rendered by revenue category to or for the patient. The units field can print units of service, the true quantity on these charges, the number of visits (visits always equal 1 for the revenue category), the number of hours, the number of days, or can be blank based on how the revenue category is set up in the UB Charge Control Parameters. Units can be items such as the number of accommodation days and the number of pints of blood.

10. CHARGES (10-N-0)
This field contains the total charge pertaining to this line of detail (in $$$$$$$cc format). If you enter an amount with no decimal, the system assumes all dollar positions (e.g. 12345 becomes 12345.00). Only 7 dollar positions are allowed. If you enter the decimal, this is accepted as is (for example, 1234567.25 remains as entered). Do not enter commas.

If the total charges equal the total credits, the system omits this line from the UB claim form.

11. NON COVERED (10-N-O)
This field contains the amount of the charge line that is considered non-covered (in $$$$$$$cc format). You can enter a number without the decimal. The system displays

as 9999999.cc. Professional fees and summary code exceptions can be identified as non-covered in the Insurance Plan Coverage master. Duplicate HCPCS and ABN (Advanced Beneficiary Notice) Non Covered charges can also print in the Non Covered locator.

12. DESCRIPTION (24-C-O)
This field displays the description for the claim charge line. The description varies, depending on whether the charge line prints in detail or in summary. If the charge line prints in detail, the description is for that charge item. If the charge line prints in summary, the UB revenue code description prints.

13. LOC 49 (4-C-O)
This field is not loaded by the system and therefore must be manually entered, if required. The value entered in this field prints in Locator 49 for the charge line. Locator 49 is an unlabeled field and is currently reserved for national use.

14. NDC (11-N-O)
This field contains the National Drug Code (NDC) pertaining to this line of detail. When this field is added or updated, only the claim charge data is updated. The actual charges at the account level are not updated with the NDC code.

When this field is added or updated, if the new or revised claim charge line matches another claim charge line for Revenue Code, HCPCS Code and Modifiers, Service Date, and NDC Code, the charges are not summarized together after the screen is accepted. The new or revised claim charge line remains on separate lines.

15. NDC UNIT QUALIFIER (2-AN-O)
This field displays the NDC Unit Qualifier for the charge and can be edited. When you access the field, the system displays the following prompt:

> *Enter NDC Unit Qualifier of F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter), or ME (Milligrams)--*

If you enter a value other than F2, UN, GR, ML or ME, the system displays the following error message:

> *Error! Invalid Entry*

16. NDC UOS (10- N-O)
This field displays the NDC units of service (UOS) for the charge and can be edited.

17. NDC LOC 43 DESCRIPTION (DISPLAY ONLY)
This is a system-derived field that cannot be edited. The field displays what prints for the claim charge description in Locator 43 of the UB04 if the UB Charge Control Parameters has the field Override Rev Desc set to Yes. The system formats and updates the data based on the data in fields NDC, NDC Unit Qualifier, and NDC UOS. The data is left justified, with a leading N4, then the actual NDC code, then the unit qualifier, and finally the NDC units. For example: N412345678901UN1234.567

18.REFERENCE FACILITY (4-AN-O)
This field displays the Reference Facility code for any charges that further sorted on Reference Facility code, based on the UB Charge Control Parameters. This code can be sent to EC2000 and the HIPAA Data Extract. If an RF code exists on one or more charges, but the UB claim is not sorting further for this revenue code or all revenue codes based on the RF Rev Codes field, this field is blank. When this field is accessed, the Reference Facility Table from STAR Order Management is displayed. You can select a code from the table.

When either adding or updating an RF code in the Claim Charge Data Screen, only the claim data is updated. The actual charges at the account level are not updated to have this RF code. Also, when adding or updating an RF code in the Claim Charge Data Screen, if the new/revised claim charge line matches another claim charge line for Revenue Code, HCPCS Code and Modifiers, Service Date, and RF Code, the charges are not summarized together after you accept the screen. The new/revised claim charge line remains on its own line. To delete an RF code, enter a space, then press the ENTER key.

19. IDE (11-AN-O)
This field displays the Investigational Device Exemption code for any charges that further sorted on IDE, based on the UB Charge Control Parameters. This code can be sent to EC2000 and the HIPAA Data Extract. If an IDE code exists on one or more charges, but the UB claim is not further sorting for this revenue code or for all revenue codes based on the IDE Rev Codes field, this field is blank. You can enter an IDE code in the field. To delete an IDE code, enter a space, then press the ENTER key.

When either adding or updating an IDE code in the Claim Charge Data screen, only the claim data is updated. The actual charges at the account level are not updated to have this IDE code. Also, when adding or updating an IDE code in the Claim Charge Data Screen, if the new/revised claim charge line matches another claim charge line for Revenue Code, HCPCS Code and Modifiers, Service Date, and IDE Code, the charges are not summarized together after the screen is accepted. The new/revised claim charge line remains on its own line.

20. ERROR (DISPLAY ONLY)
This field indicates whether an error was detected for this item during claim edits. If an error was detected, one of the following error messages is displayed:

Proc Code - for a charge line with a procedure code (missing HCPCS) error.
Chg Summ - for a charge line with a charge summary error.
Proc&Sum - for a charge line with both a procedure code error and a charge summary error.
SvDt - for a charge line with a charge service date error.
Proc CodeSvD - for a charge line with both a procedure code (missing HCPCS) error and a charge service date error.

When you have completed your review and changes, press **F7** to exit the Claim Charge Data screen. The following prompt is displayed:

Accept (Y/N)?

Enter **Y** to save the changes and to re-evaluate the charges for any Charge Service date errors; enter **N** and the changes are not saved. The system returns you to the Claims Options menu.

If the claim you are reviewing has charge service date errors, and you do not make any changes to the screen, but use this key to exit the screen, the following prompt is displayed:

Re-evaluate Claim for Charge Service Date Errors (Y/N)? - -

If you enter **Y** for Yes, the system evaluates the claim charges to see if they still qualify for the claim charge service date error. The system displays the following message:

Claim Re-evaluated and Filed

If some charges no longer apply, the edit is cleared on those charge lines. You have to re-access the Claim Charge Data screen to view the updates that occurred.

If you enter **N** for No, the system does not evaluate the claim charges to see if they still qualify for the claim charge service date error. The charges are evaluated the next time the Claim Reload optional batch job runs, or the next time the user accesses the Claim Charge Data screen for the claim and enter **Y** for Yes to the prompt above.

Any changes, additions, and/or deletions made in this screen are reported on the Claim Charge Data Audit report (FCR290). An entry of *UB Charges Modified* is also entered in the patient's Transaction History file. Both of the above transactions provide an audit trail of the biller who changed charge information on a patient's claim form. Changes in this screen do not update the account balance. You can make changes to the claim charge data until the claim is produced.

CMS 1500 CLAIM - 1992 1500 FORMAT

The 1992 1500 Format of the CMS 1500 claim has two Claim Charge Data Screens, one for when you are not loading Anesthesia times and one when loading Anesthesia times. The following screen is for a CMS 1500 claim in the 1992 1500 format (with Anesthesia Start and Anesthesia Stop fields).

```
                    General Hospital Maintain Claims by Account Processor
                                                        Fri Jun 02, 2006 01:40 pm
Account      Name                       FC Type Admit    Disch         Balance Loc
C0612900001  HANSEN,ERIC                O    O/P 05/09/06 05/09/06    $1095.05 AR
                                                        HCPCS Procedure Errors:None
                                                   Diagnosis/Reference # Errors:None
                                                       Locator 24K ID Errors:   3
Seq     Srv Dt Fr   Srv Dt To  POS  TOS   Procedure   Diag    Charge      UOS
Loc 24K Lower/Upper   EPSDT EMG  COB                          Error
Charge Description      Anes Start  Anes Stop   RF    IDE
1       05/09/06    05/09/06    21   3   11111        2        36.08       1
          180565957                                      ID# Missing
EEG PRO FEE                 11:08A      14:13P
2       05/09/06    05/09/06    21   3   93042        1         8.05       1
          180565957                                      ID# Missing
RHYTHM STRIP PROFESSIONAL
3       05/09/06    05/09/06    21   3   95819        1        36.08       1
          180565957                                      ID# Missing
EEG PRO FEE




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

The following is a 1500 non professional claim form in the 1992 Non Pro Fee 1500 Format.

```
                    General Hospital Claim Information Processor
                                              Mon Mar 27, 2006  11:15 am
                                               HCPCS Procedure Errors:None
                                          Diagnosis/Reference # Errors:None
                                               Locator 24K ID Errors:None

Account      Name                       FC Typ Admit    Disch      Balance Loc
A90060-00001 JONES,ANNE                  I/P 03/01/03 03/01/03     101.00  AR/FCRV

Seq     Srv Dt Fr   Srv Dt To  POS  TOS   Procedure    Diag     Charge      UOS
Loc 24K Lower/Upper     EPSDT EMG  COB    Charge Desc  RF       IDE
1       10/19/2005 10/19/2005 21   3   95819        8251     36.08    1
UPIN1234                                   LAB PRO FEE     SK1
2       10/19/2005 10/19/2005 21   3   95819        8251     76.45    1
UPIN1234                                   DEVICE                    G990155 A




                    F1Prev Page F2Next Page F7  Exit
```

HCPCS PROCEDURE ERRORS (DISPLAY ONLY)
This error is displayed for the CMS 1500 claim only. If the 1500 Charge Control Parameter has the Edit Pro Fee Charges field set to include H to edit for HCPCS Procedure Codes, if a charge is missing a HCPCS code, the resulting error is displayed in this field. The claim fails edits and is not released until the HCPCS Procedure Codes are entered, or the claim is manually released.

DIAGNOSIS/REFERENCE # ERRORS (DISPLAY ONLY)
This error is displayed for the CMS 1500 claim only. If the 1500 Charge Control Parameter has the Edit Pro Fee Charges field set to include D to edit for diagnosis codes, if a charge is missing a diagnosis code, the resulting error is displayed in this field. The claim fails edits and is not released until the diagnosis codes are entered, or the claim is manually released.

LOCATOR 24K ID ERRORS (DISPLAY ONLY)
This error is displayed for the CMS 1500 claim only. If the 1500 Charge Control Parameter has the Edit Pro Fee Charges field set to (Y)es, edit for the physician ID, if a charge is missing a physician ID the resulting error is displayed in this field. The claim fails edits and is not released until the physician ID's are entered, or the claim is manually released.

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

SRV DT FR (6-N-O)
This field contains the first date on which the service was performed.

SRV DT TO (6-N-O)
This field contains the last date on which the service was performed.

POS (2-AN-O)
For the CMS 1500 claim, this field contains the place of service code from the 1500 Department/Supplier Override table or from the 1500 Charge Control Parameter. For the Non Professional Fee 1500, this field contains the place of service code from the Non Pro Fee 1500 Charge Control Parameter. You can change the code or enter a hyphen (-) to display and select from a list of valid codes. The system edits your entry against the Place of Service table. If you enter an invalid code the system displays the following message:

  Error: Not on File

TOS (1-AN-O)
This field contains the type of service that was performed. This field is updated if present on the patient charge record.

The Type of Service code must be entered on the Financial Item Master in order to update the patient charge record. This field does not print on the 1500 charge lines unless the Print TOS field in the 1500 Charge Control Parameter or the Non Pro Fee 1500 Charge Control Parameter is set to Yes.

To change the default, enter a value by entering the code or enter a hyphen (-) to display and select from a list of valid codes. The system edits your entry against the Type of Service table. If you enter an invalid code the system displays the following message:

  Error: Not on File

PROCEDURE (12-AN-R)
This field contains the HCPCS code associated with the charge. This code is loaded initially from the patient's charge if the HCPCS code is present on the charge. If the code is not initially loaded from the charge, the HCPCS code from the Financial Item Master, if present, defaults to the patient charge record.

To change the HCPCS code, enter the code or enter a hyphen (-) to display and select from a list of codes. You can enter modifiers when applicable.

DIAG (7-AN-O)
For the Professional Fee 1500 (CMS) Claim Form, this field identifies either the ICD diagnosis code or the reference number for the diagnosis code, depending on the setting of the Diagnosis Print field in the 1500 Charge Control Parameters. The reference number works in conjunction with the Diagnoses for 1500 Locator 21 field on the first screen of the 1500 Claim Load and Edit Parameter. For more information about the settings of this parameter, refer to the PA/AR Parameter Maintenance section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*. For the Non Professional Fee 1500 Claim Form, this field is the principal or if blank, the working diagnosis code, or is the admitting, or if blank, the working diagnosis code, or is the reference number 1 for each charge, depending on the setting of the Diagnosis to be Printed field in the Non Pro Fee 1500 Charge Control Parameter. For more information about the settings of this parameter, refer to the PA/AR Parameter Maintenance section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The diagnosis code or reference number can be defaulted if the Default Diagnosis field is set in the 1500 Charge Control Parameter. The diagnosis in Locator 24E can default to either Reference Number 1, the Principal/Admitting Diagnosis, or the Principal/ Working Diagnosis.

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 Default Diagnosis field 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 contains 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 is either blank for the charge line or contains 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, then if the field Edit Pro Fee Charges in the 1500 Charge Control Parameter is set to edit for the Diagnosis Code/Reference Number, then 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.

CHARGE (10-N-O)
This field contains the charge for the performed procedure. Include the decimal and cents when entering this amount (for example 12345.67, which the system displays as 12,345.67). The system removes decimals and commas when the 1500 form prints.

UOS (5-N-O)
This field contains the number of days or units for the item performed for the patient. The system reports anesthesia units in minutes if you are using timed charges. If the UOS exceeds 99, the remaining digits print in FL24H.

LOC 24K LOWER/UPPER (10-C-O)
For the CMS 1500 Claim form and the Non Professional Fee 1500 Claim form, this field contains the physician ID number from the STAR Patient Care Physicians table. The system displays either the UB ID Number, Medicare ID Number, Medicaid ID Number, Blue Cross ID Number, Commercial ID Number, PIN Number, UPIN Number, Other ID Number 1, Other ID Number 2, Tax ID Number, FIN Interface ID Number, or Social Security Number, depending on the settings of the 1500 Charge Control Parameters. 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.*

To change the default, enter a partial last name lookup and a hyphen (for example Ander-) or just a hyphen (-) to display and select from a table of valid physician IDs. The system displays the appropriate ID number based on the setting of the 1500 Charge Control Parameters, as discussed above.

EPSDT (2-C-O)
This field displays the Early and Periodical Screening Diagnosis and Treatment indicator. This field does not load for the CMS 1500 Claim Form. The Non Professional Fee 1500 claim form prints the value entered in the EPSDT Value field of the Non Pro Fee 1500 Charge Control Parameter.

EMG (2-C-O)
This field contains the EMG code from the Insurance Plan Demographics screen if the Print EMG field is set to Yes in the 1500 Charge Control Parameter or in the Non Pro Fee 1500 Charge Control Parameter.

COB (2-C-O)
This field does not load for the CMS 1500 Claim Form or the Non Professional Fee 1500 Claim Form.

CHARGE DESC (20-C-O)
This field contains the charge description associated with the professional charge. This description does not print on the CMS 1500 Claim Form or the Non Professional Fee 1500 Claim Form.

When the Charge Description field is accessed, the following prompt is displayed:

> *Enter charge description [existing description]--*

If you press ENTER, the existing charge description is retained. To exit the field, type a period and press ENTER. Otherwise a charge description can be keyed.

RF (4-AN-O)
This field displays the Reference Facility (RF) code for any charges that further sorted on Reference Facility code, based on the 1500 or Non Pro Fee 1500 Charge Control Parameters. If a Reference Facility code exists on one or more charges, but the 1500 claim is not sorting further for this revenue code or for all revenue codes, based on the RF Rev Codes field, this field is blank. When this field is accessed, the Reference Facility Table from STAR Order Management is displayed. You can select a code from the table. To delete an RF code, enter a space and then press ENTER.

When either adding or updating an RF code in the Claim Charge Data Screen, only the claim data is updated. The actual charges at the account level are not updated to have this RF code. Also, when adding or updating an RF code, if the new/revised claim charge line matches another claim charge line for Service Date, HCPCS/Modifier, Ordering Diagnosis, Physician, and RF of the 1500 claim, or for Service Date, HCPCS/ Modifier, and RF for the Non Pro Fee 1500 claim, the charges do not summarize together after the screen is accepted. The new/revised claim charge line remains on its own line.

IDE (10-AN-O)
This field displays the Investigational Device Exemption (IDE) code for any charges that further sorted on IDE, based on the 1500 or Non Pro Fee 1500 Charge Control Parameters. If an IDE code exists on one or more charges, but the 1500 claim is not further sorting for this revenue code or for all revenue codes, based on the IDE Rev Codes field, this field is blank. You can enter an IDE code in the field. To delete an IDE code, enter a space, and then press the ENTER key.

When either adding or updating an IDE code on this screen, only the claim data is updated. The actual charges at the account level are not updated to have this IDE code. Also, when adding or updating an IDE code in the Claim Charge Data Screen, if the new/revised claim charge line matches another claim charge line for Service Date, HCPCS/Modifier, Ordering Diagnosis, Physician, and IDE of the 1500 claim, or for Service Date, HCPCS/Modifier, and IDE for the Non Pro Fee 1500 claim, the charges are not summarized together after the screen is accepted. The new/revised claim charge line remains on its own line.

ANES TIMES (4-N-O)

NOTE: If the 1500 Charge Control Parameter for the claim has the Print Anesth Time field set to No, or if the field is blank, the 1500 Claim Charge Data screen is displayed without the Anes Times field, and the Error message field is on the second line, instead of the third.

This field contains the anesthesia start and stop times. When this field is accessed, the following prompt is displayed if, when the claim loaded, the Print Anesth Time field was set to Yes in the 1500 Charge Control Parameter:

Enter anesthesia start time (HHMM) or space to delete [0900]--

You have the following entry options:

- To retain the existing anesthesia start time, press ENTER.

- To exit the field, type a period and press ENTER.

- Key a valid start time in the space.

- Key a space and press ENTER to remove the existing anesthesia start time.

After you enter a valid start time (or retain the existing one), the following prompt is displayed:

Enter anesthesia stop time (HHMM) or space to delete [1300]--

You have the following entry options:

- To retain the existing anesthesia stop time, press ENTER.

- To exit the field, type a period and press ENTER.

- Key a valid stop time in the space.

- Key a space and press ENTER to remove the existing anesthesia stop time.

ERROR (DISPLAY ONLY)
For the CMS 1500 claim, this field indicates whether an error was detected for this item during claim edits. If an error was detected, one or any combination of the following error messages display:

Proc Missing - for a charge line with a HCPCS procedure code error.

Diag Missing - for a charge line with a diagnosis code error.

CMS 1500 CLAIM AND NON PRO FEE 1500 CLAIM - 08/05 1500 FORMAT

The following screen is for a CMS 1500 claim in the 08/05 Revised 1500 format.

```
            General Hospital Maintain Claims by Account Processor
                                        Tue Aug 5, 2012 02:04 pm
Account      Name               FC Typ Admit    Disch        Balance Loc
A00005-00833 MOORE,STEVE         A  OPC 03/28/08 03/28/08     8096.82-AR /ACCF

Chg Sum Errors:None        Non Specific HCPCS:None   HCPCS Procedure Errors:None
24J Up/Low ID Errors:   7/  7 NDC Cd/Qual/Unt Errs: None  DX/Ref # Errors:   7
Seq   Srv Dt Fr   Srv Dt To   POS EMG Proc  M1 M2 M3 M4 DX Ref    Charge    UOS
 24J Lower  24J Upper    Qual EPSDT    Anes Start & Stop RX UOS    NDC Qual/UOS
 Charge Desc           NDC          RF   IDE          Error
 24D Upper
1     03/28/08   03/28/08   31      93010                         16.09      1
 9080706051 COMMID       1B   A
 ECG PROFESSIONAL FEE                                  Dx

2     03/28/08   03/28/08   31      93010                         16.09      1
 9080706051 COMMID       1B   A
 ECG PROFESSIONAL FEE                                  Dx




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

The following is a 1500 non professional claim form in the 08/05 Revised Non Pro Fee 1500 Format:

```
            General Hospital Maintain Claims by Account Processor
                                        Wed Aug 6, 2012 10:14 am
Account      Name               FC Typ Admit    Disch        Balance Loc
A00005-00833 MOORE,STEVE         A  OPC 03/28/08 03/28/08     8096.82-AR /ACCF
Chg Sum Errors:None        Non Specific HCPCS:None   HCPCS Procedure Errors:None
24J Up/Low ID Errors:   7/  7 NDC Cd/Qual/Unt Errs: None  DX/Ref # Errors:   7

Seq   Srv Dt Fr   Srv Dt To   POS EMG Proc  M1 M2 M3 M4 DX Ref    Charge    UOS
 24J Lower  24J Upper    Qual EPSDT    Anes Start & Stop RX UOS    NDC Qual/UOS
 Charge Desc           NDC          RF   IDE          Error
 24D Upper
1     03/28/08   03/28/08   53      10022             1          32.18      2
 9080706051 COMMID       1B   EE
 ECG PROFESSIONAL FEE

2     03/28/08   03/28/08   53      93015             1         219.00      2
 9080706051 COMMID       1B   EE
 DUPLICATE ECG 12 LEA




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

Field Explanations

CHG SUM ERRORS (DISPLAY ONLY)

This error is displayed for the CMS 1500 claim and the Non Pro Fee 1500 claim for any claim charge line with a credit charge amount. This is an automatic 1500 claim edit and is not set in the 1500 Charge Control Parameters or the 1500 Non Pro Fee Charge Control Parameters. The claim fails edits and is not released until the claim charge line amount is changed to a positive amount or the claim charge line is deleted.

NON-SPECIFIC HCPCS (DISPLAY ONLY)

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 "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. The Error field at the detail claim line level will have "NS HCPCS" for Non-Specific HCPCS.

HCPCS PROCEDURE ERRORS (DISPLAY ONLY)

This error is displayed for the CMS 1500 claim and the Non Pro Fee 1500 claim if the 1500 Charge Control Parameter or the 1500 Non Pro Fee Charge Control Parameter has the Edit Pro Fee Charges field set to include H to edit for HCPCS Procedure Codes, and if a charge is missing a HCPCS code. The claim fails edits and is not released until the HCPCS Procedure Codes are entered, or the claim is manually released.

DX/REF # ERRORS (DISPLAY ONLY)

This error is displayed for the 1500 claim and the Non Pro Fee 1500 claim if the 1500 Charge Control Parameter or the 1500 Non Pro Fee Charge Control Parameter has the Edit Pro Fee Charges field set to include D to edit for diagnosis codes, and if a charge is missing a diagnosis code reference number (to link the charge to the appropriate diagnosis in Locator 21). The claim fails edits and is not released until the diagnosis reference number is entered, or the claim is manually released.

24J UP/LOW ID ERRORS (DISPLAY ONLY)

This error is displayed for the 1500 claim and the Non Pro Fee 1500 claim if the 1500 Charge Control Parameter or the 1500 Non Pro Fee Charge Control Parameter has the Edit Pro Fee Charges field set to include U to edit for Physician/Department ID Upper, and/or set to include L to edit for Physician/Department ID Lower, and if a charge is missing a physician ID in 24J Upper or 24J Lower. The claim fails edits and is not released until the physician/department ID is entered, or the claim is manually released.

NDC CD/QUAL/UNT ERRS (DISPLAY ONLY)

This field contains the number of errors for NDC Code, NDC Qualifier and NDC Unit in the following cases:

- There are revenue codes or revenue code and HCPCS requirements for NDC codes, and the claim charge line is missing the NDC code. Note that if the charge

line has an edit for NDC Code, the system does not further edit for NDC Unit Qualifier or NDC Units.

Or all of the below apply:

• There are charges with an NDC code, and the revenue code for the charge is set to pull the NDC code for the claim in the 1500/Non Pro Fee 1500 Charge Control Parameters.

• There is no Unit Qualifier for the charge, and/or there is no NDC Units value.

• The NDC Unit Qual/Units field in the 1500/Non Pro Fee 1500 Charge Control Parameter is set to Edit.

The Error field displays any errors concerning NDC Qualifier or NDC Units:

• NDC Code for charge lines with the missing NDC Code error

• NDC Unit Qual for charge lines with the missing NDC Unit Qualifier error

• NDC Units for charge lines with the missing NDC Units error

• NDC Qual+Units for charge lines with the missing NDC Unit Qualifier and NDC Units errors.

Users can clear the NDC code error by hitting the F5 key to Edit and entering the NDC code (and NDC Unit Qualifier and NDC UOS) into the existing NDC fields in Claims Management.

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

SRV DT FR (6-N-R)
This field contains the first date on which the service was performed.

SRV DT TO (6-N-R)
This field contains the last date on which the service was performed.

POS (2-AN-O)
This field is used on both the CMS 1500 Claim and the Non Pro Fee 1500 claim. The field contains the place of service code from the 1500 Department/Supplier Override table or from the 1500 Charge Control Parameter (or the Non Pro Fee 1500 Charge Control Parameter). You can change the code or enter a hyphen (-) to display and select from a list of valid codes. The system edits your entry against the Place of Service table. If you enter an invalid code, the system displays the following message:

Error: Not on File

EMG (2-C-O)
This field contains the EMG code from the Insurance Plan Demographics screen if the Print EMG field is set to Yes in the 1500 Charge Control Parameter (for the 1500 Claim) or the Non Pro Fee 1500 Parameter (for the Non Pro Fee 1500 claim).

PROC (5-AN-O)
This field contains the HCPCS code procedure for the claim charge line. The 1500 claim accepts one HCPCS up to five digits and up to four two digit modifiers (for example, 12345M1M2M3M4) per charge line. This code is loaded initially from the patient's charge if the HCPCS code is present on the charge. If there is no HCPCS at the charge level, and the Use Med Recs HCPCS field is set to Yes in the 1500 Charge Control Parameter (for the CMS 1500 Claim) or the Non Pro Fee 1500 Parameter (for the Non Pro Fee 1500 Claim), and if a Medical Records HCPCS matches on Service Date, Physician, and Revenue Code, or has an indirect match on Revenue Code if the M/R HCPCS UB Rev Code field is set in the 1500 Charge Control Parameter, this Medical Records HCPCS can load to the 1500 claim or the Non Pro Fee 1500 claim.

To change the HCPCS code, enter the code or enter a hyphen (-) to display and select from a list of codes. You can enter modifiers when applicable.

M1 (2-AN-O)
This field contains the first HCPCS modifier for the claim charge line. You can update the first modifier without updating either the HCPCS code or any other modifiers for the claim charge line. When updating the HCPCS modifier in the Claim Charge Data screen, the system does not validate that the modifier is appropriate for the charge department, does not validate that the modifier is appropriate for a professional fee (versus an ancillary charge), and does not edit for duplicate HCPCS modifiers.

To change the modifier code, enter the code or enter a hyphen (-) to display and select from a list of codes from the HCPCS Modifier table.

M2 (2-AN-O)
This field contains the second HCPCS modifier for the claim charge line. You can update the second modifier without updating either the HCPCS code or any other modifiers for the claim charge line. When updating the HCPCS modifier in the Claim Charge Data screen, the system does not validate that the modifier is appropriate for the charge department, does not validate that the modifier is appropriate for a professional fee (versus an ancillary charge), and does not edit for duplicate HCPCS modifiers.

To change the modifier code, enter the code or enter a hyphen (-) to display and select from a list of codes from the HCPCS Modifier table. A second modifier cannot be entered unless the first modifier is entered. If the second modifier is deleted, any modifiers after it are moved up.

M3 (2-AN-O)
This field contains the third HCPCS modifier for the claim charge line. You can update the third modifier without updating either the HCPCS code or any other modifiers for the claim charge line. When updating the HCPCS modifier in the Claim Charge Data

screen, the system does not validate that the modifier is appropriate for the charge department, does not validate that the modifier is appropriate for a professional fee (versus an ancillary charge), and does not edit for duplicate HCPCS modifiers.

To change the modifier code, enter the code or enter a hyphen (-) to display and select from a list of codes from the HCPCS Modifier table. A third modifier cannot be entered unless the first and second modifiers are entered. If the third modifier is deleted, any modifier after it is moved up.

M4 (2-AN-O)
This field contains the fourth HCPCS modifier for the claim charge line. You can update the fourth modifier without updating either the HCPCS code or any other modifiers for the claim charge line. When updating the HCPCS modifier in the Claim Charge Data screen, the system does not validate that the modifier is appropriate for the charge department, does not validate that the modifier is appropriate for a professional fee (versus an ancillary charge), and does not edit for duplicate HCPCS modifiers.

To change the modifier code, enter the code or enter a hyphen (-) to display and select from a list of codes from the HCPCS Modifier table. A fourth modifier cannot be entered unless the first, second, and third modifiers are entered.

DX REF (4-N-O)
For the 1500 Claim Form and the 1500 Non Pro Fee Claim Form, this field identifies the reference number for the diagnosis code. The reference number works in conjunction with the Diagnoses for 1500 Locator 21 field on the first screen of the 1500 Claim Load and Edit Parameter. For more information about the settings of this parameter, refer to the PA/AR Parameter Maintenance section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The reference number can be defaulted to Reference Number 1 if the Default Diagnosis field is set in the 1500 Charge Control Parameter. 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 Default Diagnosis field 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 contains 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 is either blank for the charge line or contains 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 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. 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.

The system can attempt only to match the Ordering Diagnosis at the charge level to 1 of the Diagnosis Codes in Locator 21. Therefore, the system only has a single number (number 1, 2, 3 or 4) when finding a match. However, the DX Ref field allows a 1 to 4 digit number to reflect all matches. No commas should be entered and are not allowed. The system edits for a 1, 2, 3 and/or 4, and does not allow duplicates. If a charge line relates to the Diagnoses Codes 21-1, 21-2, and 21-4 in Locator 21, for the charge line, you can enter *124*. If the charge line relates to all diagnoses codes in Locator 21, for the charge line, you can enter *1234*.

The 1500 claim loads and edits the charge Ordering Diagnosis based on the Claim ICD indicator. If the claim ICD indicator is ICD-9, the claim uses the ICD-9 Ordering Diagnosis on the charges. If the claim ICD indicator is ICD-10, the claim uses the ICD-10 Ordering Diagnosis on the charges.

CHARGE (10-N-O)
This field contains the charge for the performed procedure. You should Include the decimal and cents when entering this amount (for example 123456.98, which the system displays as 123,456.98). The system removes decimals and commas when the 1500 form prints.

UOS (5-N-O)
This field contains the number of days or units for the item performed for the patient.

The system reports anesthesia units in minutes if you are using timed charges. 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 5 digit units of service. When printing a 5 character units of service, the EPSDT value is therefore overridden.

24J LOWER (10-C-O)
For the CMS 1500 Claim form and the Non Pro Fee 1500 Claim form, this field contains the physician ID number from the STAR Patient Care Physicians table. The system displays either the UB ID Number, Medicare ID Number, Medicaid ID Number, Blue Cross ID Number, Commercial ID Number, PIN Number, UPIN Number, Other ID Number 1, Other ID Number 2, Tax ID Number, FIN Interface ID Number, Social Security Number, or NPI, depending on the settings of the 1500 Charge Control Parameter or the Non Pro Fee 1500 Charge Control Parameter. For the 08/05 1500 Format, users should set the 1500 Charge Control Parameters to load the NPI (National Provider ID) to 24J Lower. 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.*

To change the default, enter a partial last name lookup and a hyphen (for example Ander-) or just a hyphen (-) to display and select from a table of valid physician IDs.

The system displays the appropriate ID number based on the setting of the 1500 Charge Control Parameters or the Non Pro Fee 1500 Charge Control Parameters, as discussed above.

24J UPPER (11-C-O)
For the CMS 1500 Claim form, this field contains the physician ID number from the STAR Patient Care Physicians table. The system displays either the UB ID Number, Medicare ID Number, Medicaid ID Number, Blue Cross ID Number, Commercial ID Number, PIN Number, UPIN Number, Other ID Number 1, Other ID Number 2, Tax ID Number, FIN Interface ID Number, Social Security Number, or NPI, depending on the settings of the 1500 Charge Control Parameters (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameters (for the Non Pro Fee 1500 claim). The number pulled to 24J Upper should match to the ID Qualifier field that identifies it. 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.*

To change the default, enter a partial last name lookup and a hyphen (for example Ander-) or just a hyphen (-) to display and select from a table of valid physician IDs. The system displays the appropriate ID number based on the setting of the 1500 Charge Control Parameters or the Non Pro Fee 1500 Charge Control Parameters, as discussed above.

ID QUAL (2-AN-O)
This field contains the ID Qualifier for the provider number reported in 24J Upper. This ID Qualifier loads from the setting of the 24J Upper ID Qual field in the 1500 Charge Control Parameter (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameters (for the Non Pro Fee 1500 claim). A table lookup on the 1500 Physician ID Qualifiers table is allowed. An incorrect ID Qualifier results in the claim being rejected by the payer.

When manually entering in the 24J Upper field for a physician within the Claim Charge Data screen, this ID Qualifier has to be manually entered also.

EPSDT (1-C-O)
This field displays the Early and Periodical Screening Diagnosis and Treatment indicator. The 1500 claim form prints the value entered in the EPSDT Value field of the 1500 Charge Control Parameter (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameter (for the Non Pro Fee 1500 claim).

ANES START (4-N-O)
This field contains the anesthesia start time. When this field is accessed, the following prompt is displayed if, when the claim loaded, the Print Anesth Time field was set to Yes in the 1500 Charge Control Parameter (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameter (for the Non Pro Fee 1500 claim):

   Enter anesthesia start time --

ANES STOP (4-N-O)
This field contains the anesthesia stop time. When this field is accessed, the following prompt is displayed if, when the claim loaded, the Print Anesth Time field was set to Yes in the 1500 Charge Control Parameter (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameter (for the Non Pro Fee 1500 claim):

   Enter anesthesia stop time --

RX UOS (5-N-O)
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.

CHARGE DESC (20-AN-O)
This field contains the charge description associated with the charge. This description does not print on the CMS 1500 Claim Form or on the Non Pro Fee 1500 Claim Form.

When the Charge Description field is accessed, the following prompt is displayed:

   Enter charge description -

NDC (11-N-O)
This field displays the NDC code for any charges that further sorted on NDC based on the 1500 Charge Control Parameters (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameter (for the Non Pro Fee 1500 claim). If an NDC code exists on one or more charges, but the 1500 claim is not further sorting for this revenue code or All revenue codes based on the NDC Rev Codes field, this field will be blank. This field can be edited. To delete an NDC code, access the field and press ENTER.

When either adding or updating an NDC code in the Claim Charge Data Screen, only the claim data is updated. The actual charges at the account level are not updated to have this NDC code. Also, when adding or updating an NDC code in the Claim Charge Data Screen, if the new/revised claim charge line matches another claim charge line for Service Date, HCPCS/Modifier, Ordering Diagnosis, and Physician, the charges are not summarized together after accepting the screen. The new/revised claim charge line remains on its own line.

NDC QUAL (2-AN-O)
This field displays the NDC Unit Qualifier for the charge and can be edited. When you access the field, the system displays the following prompt:

Enter NDC Unit Qualifier of F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter) or ME (Milligrams)

If you enter a value other than F2, UN, GR, ML or ME, the system displays the following error message:

Error! Invalid Entry

NDC UOS (10- N- O)
This field displays the NDC units of service for the charge and can be edited.

RF (3-AN-O)
This field displays the Reference Facility code for any charges that further sorted on RF based on the 1500 Charge Control Parameters (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameter (for the Non Pro Fee 1500 claim). If an RF code exists on one or more charges, but the 1500 claim is not further sorting for this revenue code or All revenue codes based on the RF Rev Codes field, this field is blank.   A table lookup on the Reference Facility Table on Star Order Management/Star Lab is allowed. Only valid codes from this table are allowed. To delete an RF code, access the field, then press ENTER. When revising the field, the system prompts as follows:

Enter RF code or '-' for list --

When either adding or updating an RF code in the Claim Charge Data Screen, only the claim data is updated. The actual charges at the account level are not updated to have this RF code. Also, when adding or updating an RF code in the Claim Charge Data Screen, if the new/revised claim charge line matches another claim charge line for Service Date, HCPCS/Modifier, Ordering Diagnosis, and Physician, the charges are not summarized together after accepting the screen. The new/revised claim charge line remains on its own line.

IDE (11-AN-O)
This field displays the Investigational Device Exemption code for any charges that further sorted on IDE based on the 1500 Charge Control Parameters (for the CMS 1500 claim) or the Non Pro Fee 1500 Charge Control Parameter (for the Non Pro Fee 1500 claim). If an IDE code exists on one or more charges, but the 1500 claim is not further sorting for this revenue code or All revenue codes based on the IDE Rev Codes field, this field is blank. There is no table lookup. To delete an IDE code, access the field, then press ENTER. When revising the field, the system prompts as follows:

Enter IDE --

When either adding or updating an IDE code in the Claim Charge Data Screen, only the claim data is updated. The actual charges at the account level are not updated to have this IDE code. Also, when adding or updating an IDE code in the Claim Charge Data Screen, if the new/revised claim charge line matches another claim charge line for Service Date, HCPCS/Modifier, Ordering Diagnosis, and Physician, the charges

are not summarized together after accepting the screen. The new/revised claim charge line remains on its own line.

ERROR (DISPLAY ONLY)
This field indicates whether an error was detected for this item during claim edits. If an error was detected, one or any combination of the following error messages are displayed:

Prc - for a charge line with a HCPCS procedure code error.

Dx - for a charge line with a diagnosis reference error.

ID-U - for a charge line with a locator 24J ID Upper number error.

ID-L - for a charge line with a locator 24J ID Lower number error.

ChgSum - for a charge line with a credit amount

These errors appear on the Failed Claims Requirement Report (FCR250x) as follows:

Loc-Fld: 24   Error: Charge Summarizations are negative Quantity 1

Loc-Fld: 24D   Error: HCPCS Code is Required Quantity 2

Loc-Fld: 24E   Error: Diagnosis Code/Ref# is Required Quantity 2

Loc-Fld: 24J Up Error: Physician ID is Required Quantity 4

Loc-Fld: 24J Low Error: Physician ID is Required Quantity 4

Loc-Fld: 24D   Error: NDC Qual/Unit Errors Quantity 1 Required

24D UPPER (DISPLAY ONLY)
This is a system-derived field that cannot be edited. The system prints either the Anesthesia Start and Stop times and Number of Minutes, or the NDC Information. If a charge line has both Anesthesia Time and NDC Information, the NDC Information loads to the claim line in 24D Upper. When printing NDC Information, the system formats and updates the data based on the data in the NDC, NDC Unit Qualifier, and NDC UOS fields. The field 24D Upper displays the NDC information in this format: the N4 qualifier, the NDC code, a space, the NDC Unit Qualifier, and the NDC units. For example:

NDC Information:

N455555444422 ML12345

Anesthesia:

BEGIN 1020 END 1540 TIME 320 MINUTES

Unused/Applied Med Rec HCPCS

This screen displays both applied and unapplied Medical Records HCPCS. The top section of the screen displays Unused Medical Records HCPCS errors, and the bottom section displays the Applied Medical Records HCPCS.

Unapplied Medical Records HCPCS errors are displayed if the Edit Unused Med Recs HCPCS and Med Rec HCPCS Revenue Codes fields on the UB Charge Control Parameter table are set to edit for unused Medical Records HCPCS and a claim is failed due to unused Medical Records HCPCS. The system uses the UB Charge Control Parameter assigned to the UB insurance on the account to determine whether to edit for unused Medical Records HCPCS. The setting in this parameter applies to the primary and any split claims loaded for the account and insurance. Only the claims failing for the Unused Medical Records HCPCS error display the Unapplied Medical Records HCPCS portion of the screen.

The reasons a Medical Records HCPCS may be unused on the claim are as follows:

- There is no charge for the revenue code on the Medical Records HCPCS and no link for a charge and this Medical Records HCPCS in the Med Recs HCPCS UB Rev Code Table.

- There was a charge for this Medical Records HCPCS, but the UB Charge Control Parameter did not have the HCPCS Proc field set to pull Medical Records HCPCS for the revenue code.

- The Service Date on the Medical Records HCPCS does not match the Service Date on the charge(s).

- The Medical Records HCPCS has a blank UB revenue code.

The charges and the Medical Records HCPCS need to be reviewed to determine the appropriate action, such as:

- Updating the revenue code on the Medical Records HCPCS and re-accessing the Claim Charge Data Screen.

- Updating the service date on the Medical Records HCPCS and re-accessing the Claim Charge Data screen.

- Updating the UB Charge Control Parameter to pull Medical Records HCPCS for the revenue code and entering an Adjustment Bill and Claim request, or using the Add Claim to Insurance function to load a new claim.

- Entering a charge for the service provided and entering an Adjustment Bill and Claim request to load a new claim.

Applied Medical Records HCPCS are displayed for claims regardless if the system is editing for Unused Medical Records HCPCS. The screen displays all applied Medical Records HCPCS (not limited by Revenue Code). After a claim is purged, or if a claim is deleted, the Medical Records HCPCS information is not displayed on the screen in the Applied Medical Records HCPCS section.

If the UB Claim Load Edit Parameter has the Claim Split field set to P for New York PAS claims, since all charges for the bill sequence print on each PAS claim, and therefore, the same Medical Records HCPCS, for the Applied Medical Records HCPCS section of the screen, the HCPCS are reported on the first PAS claim that loaded the HCPCS. 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, the Applied Medical Records HCPCS section of the screen does not display. However, if the UB Claim Load Edit Parameter has the Claim Split field set to A for New York ALC claims, and there are no ALC Codes on the account, the Applied Medical Records HCPCS section of the screen is displayed.

After you select this option from the menu, the following screen is displayed:

```
              General Hospital Maintain Claims by Account Processor
                                                    Mon Mar 27, 2008 10:40 am
Account      Name                      FC Typ Admit    Disch       Balance Loc
C0501700001  SNOW,VICTORIA             C  O/P 01/17/05 01/17/05     1600.00 AR/FCRV

UNAPPLIED MEDICAL RECORDS HCPCS
   HCPCS  Modifier   HCPCS Srv Dt    Rev Cd    Reference
   12345  11223344     07/20/07        740
   22222                07/20/07        430     C07201000010

APPLIED MEDICAL RECORDS HCPCS
   HCPCS  Modifier   HCPCS Srv Dt    Rev Cd  CS  Claim Split Ind
                                                 Reference
   99999 11223344     07/20/07         360    6  PRIMARY
   44444                07/20/07         730    7  CAR
                                                 C0720100001




                      F1Prev Page F2Next Page F7  Exit
```

Field Explanations

NOTE: The following field definitions are for both the Unapplied Medical Records HCPCS and the Applied Medical Records HCPCS, which are shown under separate headings on the screen.

HCPCS (DISPLAY ONLY)
This field contains either the applied or unused Medical Records HCPCS. If a Medical Records HCPCS is changed to another HCPCS on the claim because of a Payer HCPCS Cross Reference Table, the HCPCS code as seen in Medical Records is displayed on this screen.

MODIFIER (DISPLAY ONLY)
This field contains modifiers for the HCPCS. For the Unapplied Medical Records HCPCS section, up to five modifiers of two digits each can be displayed. For the Applied Medical Records HCPCS section, up to two modifiers of two digits each can be displayed.

HCPCS SRV DT (DISPLAY ONLY)
This field contains the service date for the Medical Records HCPCS.

REV CD (DISPLAY ONLY)
This field contains the revenue code entered for the Medical Records HCPCS. For Unapplied, this is the revenue code entered for the Medical Records HCPCS. For Applied, if the revenue code entered for the Medical Records HCPCS is one revenue code such as 360, but it pulls to the claim for another revenue code such as 490 because of a Med Recs HCPCS UB Rev Code Table, the system displays the revenue code entered with the Medical Records HCPCS (in this example, 360).

REFERENCE (DISPLAY ONLY)
This field displays the FROM Account Number for HCPCS taken from the FROM/ Outpatient account.

CS (DISPLAY ONLY)
This field contains the claim sequence that the Medical Records HCPCS was loaded to. This field is displayed only for Applied Medical Records HCPCS.

CLAIM SPLIT IND (DISPLAY ONLY)
This field contains the claim split indicator for the claim that the Medical Records HCPCS was loaded to. This field is displayed only for Applied Medical Records HCPCS. This field can be blank.

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Claim Disposition

This function allows you to change the disposition of a claim. When you select the Claim Disposition option, the system displays the claim disposition balance transfer screen (displayed below).

```
            General Hospital Maintain Claims by Account Processor
                                            Mon Mar 27, 2006 10:40 am
Account       Name                  FC Typ Admit    Disch      Balance Loc
A93033-00004 SOUTHERN,D M           C  I/P 02/02/93 02/02/93    819.00  AR/FCRV

 1 C  2 Carrier/Plan       3 EP    4 Pd    5 Orig Balance  6 New Balance
   1    100001 PRUDENTIAL 1   1       5              10.00          10.00
   P                                                 809.00         809.00
                                             =============   ==============
                      Total                          819.00         819.00




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




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

Field Explanations

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

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

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

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

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

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

Denied - The claim has been denied by the carrier. This flag is set by the user and removes the claim from Insurance Follow-up.

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

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

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

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

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

When you enter a valid disposition for the claim, you have the option to transfer the carrier balance. If you are entering a disposition which completes the claim (D, F, or A) and this is the last claim final dispositioned for the carrier, you must transfer the entire balance. When a claim is given a disposition of Final Payment, Adjusted to Zero, or Denied, waiting claims are updated to no longer wait on this claim.

If the claim disposition is changed to D (denied), the claim is removed from insurance follow-up. If the disposition is changed to F (final payment) or A (adjustment to zero), it is also removed from insurance follow-up. If you transfer the balance to another carrier, the claim and carrier record is added to insurance follow-up. Any other claim disposition does not affect insurance follow-up for the claim. However, if you enter a balance transfer with the new disposition and leave the carrier with a zero balance, insurance follow-up stops for that carrier.

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

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

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

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

COB (1-AN-R)
This field indicates the portion of the account's liability dollars to which the transfer is being made. Entry options are 1 through 9 from the COB field, P for Patient, or T for Third Party excess. The COB field displays the eligible indicators that can have balance transferred to them.

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

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

COMMENT (1-A-R) and (60-C-C)
This field provides space for comments regarding this balance transfer. You must first respond to a prompt asking if you want to enter a comment concerning this balance transfer. Entry options are **Y** for Yes or **N** for No; the default is **N**. You can enter up to 60 characters of comment. Comments entered display in the account's transaction history under Comment.

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

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

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

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

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

Reprinting a Claim

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

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

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

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

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

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

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

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

Reload Claim Demographic/Visit Errors

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

After you select this function, which only is displayed on the claims options menu if the claim has not been produced, the system displays the message: Reloading Claim Demographics. The system accesses the information, loads it, and freezes your terminal for the duration of the process. After the process is complete, the system returns you to the claims options menu.

You cannot use this function under the following conditions:

- If the claim is a replaced claim, the Reload Claim Demographic/Visit Errors option is not allowed for the claim. The system displays the following error message:

   Error: Reload function not valid for Replaced claim!

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

   Reload function not valid for claims marked for resubmission

- If you select this option and no errors exist, the system displays the message:

   No errors found to reload.

The claims options menu is displayed again. Information that already exists in the claim record is not overlaid by selecting this option. Only locators with a Failed status are reloaded.

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

If a 1500 claim is reloaded due to the Claim Reload optional batch job, which runs during Midnight Processing, or due to the Reload Claim Demographic/Visit Errors processor, and if one of the diagnosis code fields in Locator 21 is blank, and Diagnoses for 1500 Locator 21 is used in the claim load and edit parameters, the diagnosis logic is re-done. All four of the diagnosis codes and diagnosis descriptions in locator 21 are reloaded per current data. The diagnosis reference numbers for the charges are recalculated. All manual updates to Locator 21 and 24E would be lost. To employ this

logic, the Diagnosis for 1500 Locator 21 field must be updated to contain information even if the only option is charge diagnoses.

Account Inquiry

When you choose Account Inquiry, you get the Snapshot screen, and when you pass this screen, your options are for Admission Information, Medical Information, Financial Information, Account Notes, and Insurance Eligibility Response Inquiry. You can then access these screens as you do through the regular Account Inquiry function. When you press ENTER at the screen with the options for Admission Information, Medical Information, Financial Information, and Account Notes, the system returns you to the claim you were on in Claims Management. Refer to the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide* for more detailed information.

Account Revision

When you choose Account Revision, you get the Snapshot screen, and when you pass this screen, your options for Admission Information and Financial Information. You can then access these screens as you do through the regular Account Revision function. When you press ENTER at the screen with the options for Admission Information and Financial Information, the system returns you to the claim you were on in Claims Management. Refer to the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide* for more detailed information.

Claim Reimbursement Reconciliation

After you select this function, the following prompt is displayed:

> *Select (O)PPS Information or (C)laim Charge Reconciliation [O]-- |*

If you choose OPPS (O), you can view OPPS claim information. See "OPPS Information" on page 3-200 for details.

If you choose Claim Charge Reconciliation (C), the screen that is displayed depends on whether the claim is a CMS 1500 or Non Professional Fee 1500 claim or a UB claim. See "Claim Charge Reconciliation" on page 3-201 for details.

OPPS Information

When you choose the OPPS Information option, the following options for OPPS information can be selected:

(E)rrors—STAR and/or 3M OPPS edit messages

(O)PPS—OPPS information

OPPS Chg(OC)—OPPS charge information (Detailed information for each charge line on the claim).

(L)ine—Line item information (Key information for each charge line.)

(LI)ne—Line items per claim

C(P)rc—Claim processing data

(C)lm Chg—Claim charge information

Reim(B)—Reimbursement information

Pai(D)—Reimbursement information reconciled with the insurance payment.

These options are discussed in detail in the *Outpatient Prospective Payment System* volume of the *STAR Patient Accounting Reference Guide*.

Claim Charge Reconciliation

This function allows you to view actual line item payment information reconciled to the submitted claim charge lines. This function is only available if a payment with service line detail has been posted to a UB or 1500 claim.

CMS 1500 and Non-Professional fee 1500 claims

The following screen is displayed for CMS 1500 claims and the Non Professional Fee 1500 claim:

```
              General Hospital Maintain Claims by Account Processor
                                          Mon Mar 27, 2006 10:40 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
A01155-00002 ATKINSON,SUSAN          KE OPS 06/04/01 06/04/01     839.21  AR/FCRV


Seq     Srv Dt Fr   Srv Dt To  POS  TOS  Procedure   Diag     Charge      UOS
Loc 24K Lower/Upper  EPSDT EMG  COB  Charge Decription     Comment
1       06/04/2001  06/04/2001 11     82003        1         10.00      1
UPIN99                              ACETAMINOPHEN       Paid 10/21/01 BN#123
2       06/04/2001  06/04/2001 11     83586        1         65.22      1
UPIN99                              LAB PRO FEE         Paid 10/21/01 BN#123
3       06/04/2001  06/04/2001 42     94014475180  1        363.41      1
UPIN99                              EPIDURAL            Paid 10/21/01 BN#123







            F1Prev Page F2Next Page F7  Exit   ?
```

Field Explanations

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

SRV DT FR (DISPLAY ONLY)
This field contains the first date on which the service was performed.

SRV DT TO (DISPLAY ONLY)
This field contains the last date on which the service was performed.

POS (DISPLAY ONLY)
For the CMS 1500 claim, this field contains the place of service code from the 1500 Department/Supplier Override table or from the 1500 Charge Control Parameter. For the Non Professional Fee 1500, this field contains the place of service code from the Non Pro Fee 1500 Charge Control Parameter.

TOS (DISPLAY ONLY)
This field contains the type of service that was performed.

PROCEDURE (DISPLAY ONLY)
This field contains the HCPCS code associated with the charge. This code is loaded initially from the patient's charge if the HCPCS code is present on the charge. If the code is not initially loaded from the charge, the HCPCS code from the Financial Item Master, if present, defaults to the patient charge record.

DIAG (DISPLAY ONLY)
For the Professional Fee 1500 (CMS) Claim Form, this field identifies either the ICD diagnosis code or the reference number for the diagnosis code, depending on the setting of the Diagnosis Print field in the 1500 Charge Control Parameters. For the Non Professional Fee 1500 Claim Form, this field is the principal or if blank, the working diagnosis code, or is the admitting, or if blank, the working diagnosis code for each charge, depending on the setting of the Diagnosis to be Printed field in the Non Pro Fee 1500 Charge Control Parameter.

CHARGE (DISPLAY ONLY)
This field contains the charge for the performed procedure.

UOS (DISPLAY ONLY)
This field contains the number of days or units for the item performed for the patient.

LOC 24K (DISPLAY ONLY)
For the CMS 1500 Claim form and the Non Professional Fee 1500 Claim form, this field contains the physician ID number from the STAR Patient Care Physicians table. The system displays either the UB ID Number, Medicare ID Number, Medicaid ID Number, Blue Cross ID Number, Commercial ID Number, PIN Number, UPIN Number, Other ID Number 1, Other ID Number 2, Tax ID Number, or FIN Interface ID Number, depending on the settings of the 1500 Charge Control Parameters. 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* in the *STAR Financials Patient Accounting Reference Guide*.

LOWER/UPPER (DISPLAY ONLY)
This field indicates whether the physician number in 24K appears in the upper or lower box.

EPSDT (DISPLAY ONLY)
This field displays the Early and Periodical Screening Diagnosis and Treatment indicator.

EMG (DISPLAY ONLY)
This field contains the EMG code from the Insurance Plan Demographics screen if the Print EMG field is set to Yes in the 1500 Charge Control Parameter or in the Non Pro Fee 1500 Charge Control Parameter.

COB (DISPLAY ONLY)
This field does not load for the CMS 1500 Claim Form or the Non Professional Fee 1500 Claim Form.

CHARGE DESCRIPTION (DISPLAY ONLY)
This field contains the charge description associated with the professional charge. This description does not print on the CMS 1500 Claim Form or the Non Professional Fee 1500 Claim Form.

COMMENT (DISPLAY ONLY)
For matched payments, the following comment is displayed:

> Paid MM/DD/YY BN # XXX

MM/DD/YY is the payment date, and XXX is the batch number for the payment.

UB Claims

The following screen is displayed for UB claims:

```
            General Hospital Maintain Claims by Account Processor
                                         Mon Mar 27, 2006 10:40 am
Account       Name                 FC Typ Admit    Disch       Balance Loc
A0323800002  KANE, BOB            S2 O/P 08/26/03 08/26/03    1221.54 AR/FCRV

Seq Rev HCP  Error        Modifier   Serv Date   Units      Charges  Non Covered
Description               Col 49  Comment                       Paid
1   301 C                 84520                    6        132.00       132.00
CREATININE, SERUM
2   301 C                 84520GA                  3         66.00        66.00
CREATININE, SERUM
3   305 N                                          2         74.46
Hematology




                    F1Prev Page F2Next Page F7  Exit

```

Field Explanations

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

REV (REVENUE CODE) (DISPLAY ONLY)
This field contains the UB revenue code for this line of information.

HCP (HCPCS INDICATOR) (DISPLAY ONLY)
This field displays the HCPCS Procedure indicator, as set in the UB Charge Control
Parameter, for the revenue code. Valid values are C (FIM/Charge), D (Both/Detail), F
(Charge/Default Medical Records), M (Medical Records), N (None), O (Override) or S
(Both/Summary). Charges that are entered directly into the Claim Charge Data screen
will have a blank HCPCS indicator.

When in Claims Management, when accessing the Claim Charge Data Screen, and
when Claim Reload runs in Midnight Processing, the system pulls in Medical Records
HCPCS that were entered since the claim was loaded for any revenue code with the
HCPCS Indicator field set to Medical Records, Both/Summary, Both/Detail, Override,
or Charge/Default Medical Records. This occurs regardless of whether a code is
failing for a procedure code error.

MODIFIER (DISPLAY ONLY)
This field contains the HCPCS Procedure codes that are charge related (from the FIM/
Charge) or procedure related (from Medical Records). It is also used for the room rate
for room charges.

SERV DATE (SERVICE DATE) (DISPLAY ONLY)
If the UB claim form is set to print by Service Date or Service Date within Revenue
Code in the UB Charge Control Parameter, this field contains the service date for the

charge line. If the UB claim form is set to print by UB revenue code, the service date for the charge line loads for revenue codes that have the Date field set to Yes or Use.

UNITS (DISPLAY ONLY)
This field contains the units of service, which is a quantitative measure of services rendered by revenue category to or for the patient. The units field can print units of service, the true quantity on these charges, the number of visits (visits always equal 1 for the revenue category), the number of hours, the number of days, or can be blank based on how the revenue category is set up in the UB Charge Control Parameters. Units can be items such as the number of accommodation days and the number of pints of blood.

CHARGES (DISPLAY ONLY)
This field contains the total charge pertaining to this line of detail.

NON COVERED (DISPLAY ONLY)
This field contains the amount of the charge line that is considered non-covered. Professional fees and summary code exceptions can be identified as non-covered in the Insurance Plan Coverage master. Duplicate HCPCS and ABN (Advanced Beneficiary Notice) Non Covered charges can also print in the Non Covered locator.

DESCRIPTION (DISPLAY ONLY)
This field, which can be edited, displays the description of the related UB revenue code for this line of detail. The description varies depending on if the charge line prints in detail or in summary. If in detail, you get the description for that charge item. If it prints in summary, the UB revenue code description prints.

COLUMN 49 (DISPLAY ONLY)
This field is not loaded by the system and therefore must be manually entered by the user if required. The value entered in this field prints in Locator 49 for the charge line. Locator 49 is an unlabeled field and is currently reserved for national use.

COMMENT (DISPLAY ONLY)
For matched payments, the following comment is displayed:

> Paid MM/DD/YY BN # XXX

MM/DD/YY is the payment date, and XXX is the batch number for the payment.

PAID (DISPLAY ONLY)
This field contains the amount paid on the specific line item.

EC2000 CA Claim Viewer

This option allows you to view claims stored on EC2000 Claims Administrator. In order to view claims, you must have EC2000 Claims Administrator installed and have completed the parameter screen in the EC2000 Claims Administrator interface. For

information on the parameter screen, refer to the *EC2000 CA Interface Guide* in the *STAR Financials Patient Accounting Reference Guide*.

After you select this option, then enter a facility and patient account number at the prompt, the following screen is displayed for sorting claims by carrier/plan, a specific billing period (service through date), and/or claim sequence. The following sort combinations are allowed:

- by carrier/plan and claims sequence

- by carrier/plan and billing period

- by carrier/plan only

- by billing period only

- all claims without a specified carrier/plan, claims sequence, or billing period

```
                    General Hospital Billing Information Processor
                                                    Mon Mar 27, 2006 10:40 am
Account       Name                      FC Typ Admit    Disch       Balance Loc
A0204200001  Smith, Bob                  B  PAT 02/11/03 03/26/03     744.89  AR/FCRV
1  Carrier/Plan                              2 Claim Sequence Number
   100/100 Blue Cross HMO                      2 - 2/11/03 thru 2/28/03
3  Service Through Date



 Accept the screen (Y/N) [Y]--  |
```

Field Explanations

1. CARRIER/ PLAN (3-AN-O)
This field allows you to sort claims for viewing by carrier/plan. If the field is left blank, all claims for the account are displayed. If the field is completed, only claims for the carrier/plan are displayed.

When this field is accessed, the following screen is displayed from which one carrier/plan can be selected.

```
    COB    Carrier                              Plan
( 1) 1  888-BADILLO                     111-BADILLO PLAN PRIMARY
( 2) 2  400-BLUE CROSS                  100-BLUE CROSS INSURANCE CO OF GA
( 3) 3  400-BLUE CROSS                  600-PLAN NUMBER 3
( 4) 4  300-CHAMPUS                     100-CHAMPUS BASIC PLAN
( 5) 5  300-CHAMPUS                     200-CHAMPUS 1500
( 6) 6  500-COMMERCIAL                  100-COMMERCIAL PART A
( 7) 7  500-COMMERCIAL                  200-COMMERCIAL PART B
( 8) 8  750-JULIE'S COMMERCIAL          100-JULIE COMMER
(9)9 750-JULIE'S COMMERCIAL    200-JULIE'S SECONDARY 1500

Select a plan--
```

2. CLAIM SEQUENCE NUMBER (3-AN-O)

This field is accessible only if field 1 is completed. When a specific carrier plan is selected and this field is accessed, the following screen is displayed, reflecting all the claims for the carrier plan indicated in Field 1. The screen reflects the claim sequence number, from date, and through date of the claim.

```
              Bill            Service
       CS     From/Thru       From/Thru
( 1)   42     02/11 02/28/03  02/18 02/18/03
( 2)   40     02/11 02/28/03  02/18 02/18/03
( 3)   31     02/11 02/28/03  02/18 02/18/03
( 4)   29     02/11 02/28/03  02/18 02/18/03
( 5)   27     03/01 03/26/03
( 6)   24     02/11 02/28/03  02/18 02/18/03
( 7)   13     03/01 03/26/03
( 8)    2     02/11 02/28/03  02/18 02/18/03

Enter choice—
 Enter / NL for next page or /P for prior page
```

3. SERVICE THROUGH DATE (3-AN-O)

This field is used to sort claims by a specific billing period. If this field is completed, nothing can be entered in the Claim Sequence Number field. After this field is accessed, the following screen is displayed:

```
              Service
              Through
( 1)          02/18/02
( 2)          03/18/02
( 3)          04/18/02
( 4)          04/30/02
( 5)          05/26/02
( 6)          05/31/02

Enter choice—
 Enter / NL for next page or /P for prior page
```

ADD CLAIM TO INSURANCE

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

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

The steps for this procedure are:

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

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

After a claim is generated from the Add A Claim function, the system generates a transaction history message for the claim. The word *ADD* is displayed in the transaction comment line to indicate that the claim was created through the Add a Claim Function. For example: Trans Comment: UB FINAL CLAIM CS# - 3,ADD,Primary 1.

The system uses the corresponding transaction codes defined in the Claim Generation Parameters to document the claim load. For example, if the claim is a cycle adjustment claim, the Cycle Adjustment Claim Transaction Code defined in the Claim Generation Parameters would be used.

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

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

> *Error: No Insurance exists for Account!*

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

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

```
              General Hospital Add Claim to Insurance Processor
                                          Mon Mar 27, 2006 10:40 am
    Account        Name                 FC Typ Admit    Disch     Balance   Loc
    C0113000001  New, Nancy             M  O/P 05/10/01 05/10/01  10644.40  AR/FCRV




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

The system displays the account number, financial class, patient name, patient type, admission date, discharge date, current account balance, and account location/sub location. The screen asks if you want to add a new/additional claim, or a combined claim. The default is to add a new or additional claim. After you answer the prompt at the bottom of the screen (*Add new/additional claim (N), or add combined claim (C) (N/ C) [N]--*), the system displays the following screen:-

```
              General Hospital Add Claim to Insurance Processor
                                         Mon Mar 27, 2006 10:40 am
    Account        Name                 FC Typ Admit    Disch      Balance Loc
    89268-00001  LARSON,LAWRENCE        C  I/P 09/25/89 10/13/89   1349.00 AR/FCRV

        Bill   Date    Type    From     Thru         Amount           Page:01
    ( 1) 1   10/02/89  Cycle  09/25/89  10/02/89      1,722.00
    ( 2) 2   10/02/89  Cycle  09/25/89  10/02/89          0.00
    ( 3) 3   10/02/89  Cycle  09/25/89  10/02/89          0.00
    ( 4) 4   10/10/89  Cycle  10/03/89  10/10/89      1,968.00
    ( 5) 5   11/02/89  Cycle  10/11/89  11/02/89        738.00
    ( 6) 6   11/12/89  Final  11/03/89  10/13/89          0.00






    Enter bill sequence(s)(e.g. 1,2) or (A)ll to use to load combined claim --
                            end select (NL)
```

The system prompts you to enter the bill sequence if there are multiple claims.

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

Field Explanations

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

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

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

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

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

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

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

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

  Can only create combined claims for UB's

For the combined UB claim that loads, Form Locator 6 - Bill From and Through Dates, Form Locator 7 - Covered Days, and Form Locator 8 - Non Covered Days will reflect the information for the latest bill sequence only. Therefore, these form locators may have to be manually updated with the correct information. Combined claims do not replace the existing claims.

After you enter your choice, the system displays each carrier assigned to the account and any existing claims for the selected bill.

```
            General Hospital Add Claim to Insurance Processor
                                      Mon Mar 27, 2006 10:40 am
Account       Name                   FC Typ Admit   Disch      Balance Loc
89268-00001   LARSON,LAWRENCE        C  I/P 09/25/89 10/13/89   1349.00 AR/FCRV

COB  Carrier/Plan                         Type    Claim
 1   403999 AETNA/COMM                    UB      1           WAITING
 2   150998 ADJUSTCO/W.C.






Add a claim for COB 1? (Y/N) [N]--
```

Field Explanations

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

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

TYPE (DISPLAY ONLY)
This column displays the type of claim form that was generated. Examples are UB and 1500.

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

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

Create Claim for COB XX? (Y/N) [N]--

If you do not want to add a claim record for this COB, enter **N** or press ENTER. The system continues to the next COB and displays the above prompt for that COB. You can only create combined claims for UB claim types. To add a claim record for this COB, enter **Y** (Yes). The system displays the settings for the Produce Claim and

Suppress Claim fields for the insurance at the account level. These fields indicate whether the claim form should be produced, either electronically or as a printed claim. The following prompt is displayed on the screen:

Produce Claim is YES and Suppress Claim is YES. Overide? (Y/N) [N]--

If you enter N (No), the settings are retained and copied to the claim, and the system continues with the current Add Claim to Insurance prompts. If you enter Y (Yes), two more prompts are displayed:

Produce Claim is Yes. Update for claim to No? (Y/N) [N]

or

Produce Claim is No. Update for claim to Yes? (Y/N) [N]

If the Produce Claim flag is Yes, and you update the Produce Claim flag to No, the system automatically sets the Suppress flag to Yes (since the system does not print the claim regardless of balance) and displays the following message:

Produce Claim flag set to No and Suppress Claim flag set to Yes for Claim!

If the Produce Claim flag is No, and updating the Produce Claim flag to to Yes, the system gives the following message:

Produce Claim flag set to Yes for Claim!

If the Produce Claim flag is not updated, one of the following messages is displayed, depending on the setting of the current Produce Claim flag. Even if the current setting is not updated, if the Produce Claim flag is set to No at the insurance level, the Produce Claim flag is set to No and the Suppress Claim flag is set to Yes for the claim.

Produce Claim flag set to No and Suppress Claim flag set to Yes for Claim!

Produce Claim flag set to Yes for Claim!

One of the following prompts is displayed if the Produce Claim flag is Yes:

Suppress Claim is Yes. Update for claim to No? (Y/N) [N]

 Enter Y for Yes to update the Suppress Claim flag to No. The system displays the message:

Suppress Claim flag set to No for Claim!

  Or, if the Suppress Claim flag is No, the following prompt displays:

Suppress Claim is No. Update for claim to Yes? (Y/N) [N]

Enter Y for Yes to update the Suppress Claim flag to Yes. The system displays the message:

Suppress Claim flag set to Yes for Claim!

If the Suppress Claim flag is not updated for the claim, the system displays one of the following messages depending on the current setting of the field:

Suppress Claim flag set to No for Claim!

Suppress Claim flag set to Yes for Claim!

When loading a claim for the COB 1 insurance, if the reimbursement type is J for PCON by Claim and the UB PCON Release on the UB Pathways Parameters screen is 8.0 or higher, the system prompts:

Send Claim(s) to PCON? (Y/N) [Y]-

When loading a claim for the COB 1 insurance, if Pass-through is marked on the reimbursement screen, the system continues to prompt:

Send Pass-through Claim(s) to PCON? (Y/N)[Y] --

The only time you are prompted to send an added/split claim to Pathways Contract Management is when adding a claim for a COB 1 insurance that has PCON by Claim (reimbursement type J) set up, and if the last Final/Adjustment or Late Bill had claims loaded that were sent to Pathways Contract Management. The claim loaded with the Final/Adjustment/Late bill is considered the core claim on Pathways Contract Management. The claim added from the Add Claim to Insurance function is considered a split claim. This allows you to add a claim, manually release (or system release) the claim, and also to post a payment to the claim in the same day without the activity rejecting from Pathways Contract Management. The added claim must be released on the same day as posting the payment (or before) in order for the new claim and the payment to be processed correctly in Pathways Contract Management. If the claim is being sent to EC2000, the claim must have appeared in the EC2000 Credit Note/Detail return file and processed on the same day as posting the payment (or before). When answering Yes to the *Send Claim(s) to PCON* prompt, the claim is sent in the next source file sent to Pathways Contract Management after the claim is Released/ Manually Released and, if warranted, STAR Patient Accounting processes a claim appearing in the EC2000 Credit Note/Detail return file. The *Send Claim to PCON* prompt is displayed only for new/additional claims added for the primary carrier, and not for combined claims added for the primary carrier.

You are not prompted to send the claim to Pathways Contract Management at load or release. If a claim for the primary carrier is produced or suppressed, and the primary carrier is designated to pass claims to Pathways Contract Management, the system

sends the claim to Pathways Contract Management at claim release. If EC2000 is active, a claim that is produced is not sent to Pathways Contract Management until it is returned from EC2000. A claim that is suppressed does not wait on EC2000, since it is loaded but not sent to EC2000.

Any claims loaded in Add Claim to Insurance are assigned a new number for ERA processing. This is the account number and the claim sequence number, for example, A05055000094 where 4 is the claim sequence.

Any claims added with the Add Claim to Insurance function are sent to Pathways Contract Management as split, not core claims. The term Primary should not be confused with the concept of a Core claim on Pathways Contract Management. A core claim on Pathways Contract Management is a claim with a Primary or blank Claim Split Indicator that loaded via a bill - either in Midnight Processing or in Instant Adjustment Bill. A split claim on Pathways Contract Management is a claim with a Claim Split Indicator other than Primary or blank that loaded via a bill, or a claim (regardless of Claim Split Indicator) that was added via the Add Claim to Insurance function. For STAR, the Primary claim is the claim with the remaining charges, after any split claims have loaded. Both Primary and Split claims can load in Midnight Processing or via the Instant Adjustment Bill function. If in either of these billing events, a Primary claim is loaded, this claim is sent as the core claim to Pathways Contract Management, and any split claims are sent to Pathways Contract Management as split claims (which affects the Type of Bill third digit on Pathways Contract Management, and how the reimbursement is handled). If a Primary claim is not loaded in either of these billing events, but a Split claim is loaded, this split claim still is sent to Pathways Contract Management as a split claim, even though it was loaded via a billing event. If a Primary claim is added in the Add Claim to Insurance Function, since this claim did not load via a billing event, it is still sent to Pathways Contract Management as a split claim (Type of Bill third digit of a 1).

When the system gives the option of which claims to load, it displays the Split Name, and the Primary name, if the account has charges that qualify for the split or primary claim. If split claims are defined in the UB Charge Control Parameter for the insurance, but the account does not have charges that qualify for that split, the split name does not display on the screen. If the account does not have charges that qualify for the Primary claim, this Primary name does not display on the screen. Finally, if split claims are defined in the UB Charge Control Parameter for the insurance, but the account qualifies for only one of the claims (either the Primary or a Split), the system does not display the screen. The one claim that qualifies to load will load.

Since the system first loads charges to determine the claims the account/insurance qualify for, the system may pause while it's processing. The following is an example of the selection screen:

```
              COB 1 500100 Medicare Insurance
(1) VACCINE
(2) PRIMARY
Highlight all claims that should load for COB 1 --
```

You can select one, many, or all claims displayed. If at least one of the claims is not selected, the system displays the following error message, and the screen is redisplayed:

Error: Must select at least one claim to load

If specific claims are not selected for the insurance, the claim sequence number that would have been assigned will be skipped.

Once the claims are selected for the insurance, the system processes as if all the claims were loaded for the insurance. This means that if only one or some of the claims were selected to load for the insurance, if a Medical Records HCPCS would have loaded to one of the claims not selected, it is still not available to load to one of the claims selected. For example, if you selected only the Primary claim in the above screen, if a Medical Records HCPCS would have loaded to the Vaccine claim, this Medical Records HCPCS is not available to load on the Primary claim. The processing logic is the same as when loading all claims in Midnight Processing. However, you control, in the Add Claim to Insurance function, which of these claims actually loads for the insurance.

If you had selected an adjustment bill or cycle adjustment bill to use to load the claim, the system displays the following prompt:

Load UB Locator 4 last digit of 1 (admit-disch), 2 (interim-first), 3 (interim-continue), 4 (interim-last claim), 6 (adj), 7 (replace), or 8 (void) [7] --

You can enter one of the following:

- 1 - Admit-Disch

- 2 - Interim-first

- 3 - Interim-continue

- 4-Interim - last claim

- 6 - Adjustment

- 7 - Replace

- 8 - Void

STAR Patient Accounting does not actually delete or void a claim with the type of bill last digit of 8. This claim is treated as another claim for the payor. Pathways Contract Management processes claims with a type of bill last digit of 8 (Void) the same as a final claim.

The top of the 1500 and Non Pro Fee 1500 claim form can print the Account number, the COB of the insurance, the claim sequence, and the bill type of Cycle, Final, Adjustment, or Late. The default is Adjustment.

If an Adjustment bill, or a Cycle Adjustment bill is selected in order to load the claim, once the COB has been selected, if this is a 1500 claim (type B), or a Non Pro Fee 1500 claim (type Z), the system will prompt as follows where xxxxxx is the carrier and plan. The user can take the default value listed in the brackets, or enter another type of bill to print on the claim. This "type of bill" is only seen in the print image of the claim, on the top line of the claim, as long as the 1500 or Non Pro Fee 1500 Claim Load Edit Parameter does not have the field "Top Line Blank?" set to Yes.

The following prompt is displayed:

> *For plan xxxxxx load 1500 type of bill of Cycle (C), Final (F), Adjustment (A), or Late (L) [Adjustment]--*

The answer to this prompt only affects what is printed in the top of the claim in the print spoolfile, and what is sent to the Electronic Claim System. Changing the bill type that prints on the form does not change how the bill and claim appear when accessing Account Inquiry, Billing Information or Claim Information. In other words, if an Adjustment Bill is used or created in order to load a 1500/Non Pro Fee 1500 claim, and the user overrides the type of bill for the claim so that it prints FINAL on the top of the claim, the claim is still tied to the adjustment bill internally (and not to the Final), and will load the charges that were reflected on that adjustment bill.

When loading claims for a 1500 or a Non Pro Fee 1500 that is set to load separate claims, you can select the claims to load so that a claim can be added for a specific physician or department, but not all. The system displays the available splits for the insurance as follows:

Page:01 COB 2 500200 1500 BASIC PLAN ##=Current Choices

(1) 2707-HANSEN,VIGGO

(2) 630-PITSTOP,PENELOPE

> *Highlight all claims that should load for COB 2-- end select(NL)*

The screen lists either the 1500 or the Non Pro Fee 1500 splits. For example, for a 1500, the system may display a physician split:

(1) 1234-HANSEN,ERIC

(2) 9876-MACGREGOR,LIAM

For a Non Pro Fee 1500, the system may display a department split:

(1) CAR-Cardiology

(2) RAD-Radiology

The system gives the prompt:

   Highlight all claims that should load for COB x --

The system then continues with the current prompts (such as the below), with the claim split indicator in parenthesis.

   Claim failed edits! Manually release claim sequence x (1234 Hansen,Victor)? (Y/N) [N]--

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

   xxxx claim loaded. Hold claim for prior payment?

The xxxx is the claim type, for example, UB. If you are adding a new or additional claim, 1500 claim types can be produced. For 1500 claims that split by physician or by department, the system displays which physician or department the claim is for, for example:

   1500 claim loaded (Hansen,Viggo). Hold claim for prior payment?

For UB insurances that have a Split Claim criteria defined, the system displays the claim split indicator in parentheses for this UB claim as shown in the following example:

   UB claim loaded (VACCINE1). Hold claim for prior payment? (Y/N) [N]--

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

- the claim is not replaced

- the claim is not completed (is not dispositioned as Final Payment, Adjusted to Zero, or Denied)

- the claim is for the same bill sequence as the added claim

- for combined claims, the system will only display claims for higher priority plans that were loaded from the latest bill sequence that was chosen to load the combined claim

- the claim is for a higher priority insurance plan

- for 1500 claims that split by physician or by department, the system will display which physician or department the claim is for, so that users can pick the

appropriate claim to wait on. However, the system will allow users to pick a claim that is not for the same physician or department.

- the Pro Fee Coverage Indicator of the Basic Coverage Screen determines which higher priority insurance the added claim can wait on. If the insurance you are adding a claim for "Includes" Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on all prior plans. If the insurance you are adding a claim for "Excludes" Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on prior plans set to Include or Exclude Pro Fees in the Basic Coverage Screen. It does not allow the plan to wait on prior plans set to Only Pro Fees in the Basic Coverage Screen. If the insurance you are adding a claim for "Only" Covers Pro Fees in the Basic Coverage Screen of the insurance, it allows the plan to wait on prior plans set to Include or Only Cover Pro Fees in the Basic Coverage Screen. It does not allow the plan to wait on prior plans set to Exclude Pro Fees in the Basic Coverage Screen.

- For UB claims that split, the system displays the Claim Split indicator, so that you can pick the appropriate claim to wait on. However, the system allows you to pick a claim that is not for the same claim split indicator.

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

```
                  General Hospital Add Claim to Insurance Processor
                                       Mon Mar 27, 2006 10:40 am
Account       Name                  FC Typ Admit    Disch       Balance Loc
C0507300001  JONES,ERIC              M  O/P 03/14/05 03/14/05    1156.32 AR/FCRV


    COB Carrier/Plan        Type In/Ex/On  CS  Claim Split
Page:01                                                      ##=Current Choices
( 1) 1  500100 COMMERCIAL   UB    Incl      10  PRIMARY
( 2) 1  500100 COMMERCIAL   UB    Incl      11  VACCINE
( 3) 3  999100 COMMERCIAL   UB    Excl      14  PRIMARY3
( 4) 3  999100 COMMERCIAL   UB    Excl      15  PSYCHDATE3 05/03/05
( 5) 3  999100 COMMERCIAL   UB    Excl      16  PSYCHDATE3 05/04/05




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

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

Field Explanations

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

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

TYPE (DISPLAY ONLY)
This column displays the type of claim form that was generated. Examples are UB and 1500.

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

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

CLAIM SPLIT (DISPLAY ONLY)
For 1500 claims that can split by physician or by department, this shows which physician or which department the claim is for. For UB claims, this field displays the claim split name or the word Primary, or is blank if not splitting UB claims.

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

If you are loading a Professional Fee claim and no professional fee charges exist for this claim, either because none were generated, they had offsetting debits and credits, or this is a converted account, the system displays:

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

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

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

If you are loading a claim other than a Professional Fee claim and no charge detail exists for this claim, either because no charges were generated, they had offsetting debits and credits, or this is a converted account, the system displays:

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

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

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

When the process is completed, the claim type and claim number columns are updated. If the claim passes all edits, it is automatically released and the system gives you the option to submit and print the claim as described below. You can print the claim immediately or file a request for it to be printed during Midnight Processing.

If the claim fails edits and is not waiting for prior payment, the system displays the following prompt:

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

X is the claim sequence number.

- When loading split UB claims the Split Criteria name displays in parentheses, such as:

> *Claim failed edits! Manually release claim sequence X (VACCINE1)? (Y/N) [N].*

- When loading 1500 claims with a physician or department split, the claim split indicator displays in parentheses, such as:

> *Claim failed edits! Manually release claim sequence x (1234 Hansen,Victor)? (Y/N) [N]--*

If you enter **Y**, the system displays the message:

> *Claim manually released*

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

> *Do You Wish to Submit Claim Sequence X Using Today's Date? (Y/N) [N]--*

When loading split UB claims, the Split Criteria name displays in parentheses, such as:

> *Do You Wish to Submit Claim Sequence X (VACCINE1) Using Today's Date? (Y/N) [N]--.*

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

The following prompt is then displayed which allows you to request multiple copies of the claim. When loading split UB claims, the Split Criteria name is displayed in parentheses.

> *Print number of claims for claim sequence xx? [1] --*

Print number of claims for claim sequence xx (VACCINE1)? [1] --

The default is 1. You can enter 0 through 9 as the number of claims to print.

The system then displays the following prompt. When loading UB claims, the Split Criteria name is displayed in parentheses.

Print this claim sequence X Immediately (I), during tonight's Batch (B),
or Both (O)? (I/B/O)--[I]

Print this claim sequence X (VACCINE1) Immediately (I), during tonight's Batch (B), or Both (O)? (I/B/O)--[I]

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

Claim Print Started

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

Claim Print Filed

Enter O to print the claim immediately and to spool the claim for printing during the next midnight processing.

One of the following prompts is then displayed if there is no possible match-up between the added claim and a claim added via a billing event:

Claim loaded from bill required to replace claims in PCON. Press NL.

Claim loaded from bill required to replace claims in PCON Pass-Through. Press NL.

The system then prompts with one of the following when loading a claim for the COB 1 insurance, and if the COB 1 insurance has a reimbursement type of J for PCON by Claim, where the Split Criteria name displays in parentheses:

Does this PCON claim (CAH4 05/03/05) replace a previous claim? (Y/N)-

OR

Does this Pass-Through (CAH4 05/03/05) claim replace a previous claim? (Y/N) -

In the prompt above, CAH is the Split Name, one of the criteria is to split by service date and the date is displayed, and 4 is the sequence number for the added claim. If one of the criteria had not been service date, the Split Name and the claim sequence number only would have displayed (for example, VACCINE4).

If you enter **Y** for Yes to either of the prompts, the following screen is displayed. The top headers are for the newly-added split claim. The bottom headers are for existing claims for the same insurance plan to select from as being replaced. The claim split

indicator displays in the Clm Split field to more easily identify the correct claim to replace. Because of a space limitation on this screen, only nine characters of the Claim Split Indicator are displayed.

```
                    General Hospital Add Claim to Insurance Processor
                                                          Mon Mar 27, 2006 07:12 pm
Account      Name                      FC Typ Admit    Disch       Balance Loc
A05032-00001 JONES,ERIC                 A  OPC 01/31/05 01/31/05    930.00  AR/FCRV
     Bil Clm Adj   Bill    Bill   Prd Wk  Clm
     Seq Seq Clm   From     Thru  Sts Sts Dsp      CarPl            Chgs          Clm Split
      3  23        01/31/05 01/31/05 NP   F         500700          135.00        PRIMARY

     Bil Clm Adj   Bill    Bill   Prd Wk  Clm
     Seq Seq Clm   From     Thru  Sts Sts Dsp     Payments          Chgs          Clm Split
Page:01                       Claims for Primary Insurance
( 1)  3  22        01/31/05 01/31/05 P    M                          135.00        PRIMARY
( 2)  3  21        01/31/05 01/31/05 NP   F                           45.00        VACCINE
( 3)  3  20        01/31/05 01/31/05 NP   F                          135.00
( 4)  3  18        01/31/05 01/31/05 NP   F                          135.00
( 5)  2  17 22     01/31/05 01/31/05 NP   F   R                      135.00        PRIMARY
( 6)  2  15 21     01/31/05 01/31/05 NP   F   R                       45.00        VACCINE
( 7)  1  13 18     01/31/05 01/31/05 NP   H   R                      135.00
( 8)  1   9 18     01/31/05 01/31/05 NP   H   R                      135.00
( 9)  1   8 18     01/31/05 01/31/05 P    S   R                      135.00
(10)  1   7 18     01/31/05 01/31/05 P    S   R                      135.00

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

When you select a claim that the split claim replaces, the following prompt is displayed:

(V)iew claim charges or (R)eplace previous claim--

If you enter **V** to View claim charges, you can view the charges on the claim you selected to replace to verify you have selected the correct claim. After viewing the claim charges, the function keys at the bottom of the screen allow you to exit. This brings you back to the following prompt:

(V)iew claim charges or (R)eplace previous claim

If you enter **R** to Replace claim charges, the selected previous claim is replaced by the current claim in Pathways Contract Management, and STAR Patient Accounting sends a replace notice to Pathways Contract Management for the claim. This has no impact on how claims are replaced in STAR Patient Accounting. If you had selected a non-added split claim (one that was loaded in Add Claim to Insurance) as being replaced by this split claim (you selected a claim that was loaded by the system either through Midnight Processing or through the Instant Adjustment Bill function and was not one added by a user), the following message is displayed:

Claim created by Add Claim to Insurance must be selected!

For split UB claims, a claim created with the Add Claim to Insurance function can be identified by the numeric in the Claim Split Indicator field.

You also cannot select a claim that was loaded from the same bill sequence, or a cycle claim. If you select one of these, one of the following messages is displayed:

Cannot select a claim for the same bill. Press NL.

Cannot select a cycle claim. Press NL.

If you press ENTER at these error messages, you are returned to the claims list for the insurance and can select another claim.

If you select a valid split claim, the following prompt is displayed.

Replace Claim Seq XX (YYYYYYYYYYYYYY) with Claim Seq XX (YYYYYYYYYYYYYY)? Y/N-

In the above prompt, XX is the Claim Sequence Number, and YYYYYYYYYYYYYY is the Claim Split Indicator. If you enter **Y** for Yes, the following message is displayed.

Claim sequence XX (YYYYYYYYYYYYYY) replaced by claim sequence XX (YYYYYYYYYYYYYY)

If you entered **N** for No to the following prompt:

Does this PCON claim replace a previous claim?

the system prompts whether you want to add a claim for the next insurance on the account, and repeats the above until the insurance list is exhausted.

Create Claim for COB X? (Y/N) [N] -

Enter add/suppress (A) or add/produce(P) a claim for COB X--

Again, if a UB claim is loaded for a secondary insurance, and the UB Charge Control Parameters have Split Claims defined, and the original claims for the bill sequence and insurance split, the system displays the screen to allow you to select which of the claims (split and/or primary) to load for the insurance.

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

BALANCE TRANSFER & CLAIM DISPOSITION

The Balance Transfer and Claim Disposition function enables you to transfer account balance liability amounts between one or more carriers and the patient balance for an account, disposition claims, and change the financial class of an account in accounts receivable and bad debt. For detailed information regarding this function, refer to the Posting Transaction section in the *Accounts Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

ARCHIVE CLAIMS

The general flow of archive claims process is to set up related parameters, select the claims for archiving, send the claims to a backup medium, verify the data on the back-up medium to make sure all the claims are present, and purge the claim. Different types of backup medium include optical disk and microfiche. Claims can be selected for accounts in location PA, AR, and BD. The format of the spool files is that of the original claim as reflected on STAR Financials Patient Accounting. Updates to claims made outside of STAR Patient Accounting are not reflected on the claim archive spool files. The claim archive process is not date-specific, so the above process must be followed. Running two claim select processes without a purge process in between results in virtually the same claims being reselected a second time and in duplicate data in the associated spool files. If this occurs, the spool files from the first run will reflect invalid data. Claim archiving is a process separate from account archiving and Bad Debt Charge archiving and should be run independently. The link between claim archiving and account archiving is that accounts cannot be selected for archiving if all of the claims have not been archived and purged. As a result, the claim archive/purge process needs to be run multiple times prior to running account archiving. This allows the account archive select process to run more efficiently. Note that the claim data exists until the claim is purged. If the claim is archived, and the spooler files are deleted before they can be backed up, the claim archive process can be rerun, resulting in virtually the same claims being reselected.

Claim archiving uses the location index for selecting claims rather than the billing file. The BD location is traversed first, then the AR location.

When first starting this process, the number of claims to select should be set to 500-1000 claims. Benefits of this are the ability to see the results of the process, to verify spool files are set up correctly and to more easily verify the number of claims printed and 'adjusted by' claims not printed. The process can run, and end results are viewable in a condensed time frame expediting the testing/verification process. After the process is initially completed, the number of claims archived can be increased to an amount which can be processed in an appropriate length of time. This time will differ by customer. Time frame limits to consider include system down time for computer maintenance and ESD (software) moves. If you want to archive claims for only one facility (multi-facility environment), the other facilities' maximum number of claim parameters (Data Retention parameters) need to be set to zero.

If you want to archive claims for only one facility (multi-facility environment), the maximum number of claim parameter (Data Retention parameter) for the other facilities needs to be set to zero.

This function should be displayed on a menu accessible by data processing or a manager in the business office. When the menu option is selected, the system displays the following prompt:

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

If the prompt is answered with Y for Yes, the claim archive select process is initiated. The system displays the message Claim archive started and starts the process as a background job. You are returned to the Claims Management menu. If you enter N, the system returns you to the Claims Management menu without starting the background job.

If the Claim End Disch Dt field on the Data Retention Parameters screen does not define a date, the system does not initiate the claim archive process. The system displays the following error message:

Error: Claim Ending Discharge Date not defined in Data Retention Parameters

The disk space requirement is estimated to be four claims per disk block. Of the required disk space, half pertains to the spool file creation and half pertains to temporary work file space. When the claim archive process is initiated, the temporary disk space will be deleted and then rebuilt based on new claims selected.

An example of the disk space requirements is: 40,000 claims are selected for archiving. 10,000 blocks of disk space are required (40,000 / 4). Of the 10,000 blocks used, approximately 5,000 will be used for spool file space and 5,000 blocks will be used for temporary work file space. On the second run of 40,000 claims, only 5,000 blocks will be used since the prior run temporary work file space is deleted and then rebuilt, netting no change in disk space requirements. The disk space required for the spool files will be recouped when the Report Maintenance retention days are met and the spool file(s) are deleted.

NOTE: The Claim Purge must be run before achiving can take place. If a prior run was not purged, the system displays the following message:

Prior archive run has NOT been purged. Do you wish to Archive claims? (Y/N) [N]--

Prior to running the Claim Archive process, the following parameters need to be initialized. The Data Retention Parameters screen (within the Maintain Facility Information menu option) need to have the following parameters defined:

- Carrier Pay Days

- Max Claims for AR and BD

- Claim End Disch Dt

The Carrier Pay Days parameter may also be defined at a financial class or financial class/patient type level. Also within the Maintain Facility Information menu option is the Sort Options menu option; applicable claim type Sort Options are required.

In order for a claim to be selected for archiving, the claim's final disposition date must meet the Carrier Pay Days Parameter noted above. The hierarchy used to compute the disposition date is:

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Proprietary to McKesson - Subject to Confidentiality Agreement

- Disposition date

- Last payment date

- Last adjustment date

- First payment date

- Submission date

- Claim load date

The disposition date must be less than the day the claim archive process is initiated less the Carrier Pay Days parameter. For example, if the process is initiated on the 30th of a month with the Carrier Pay Days parameter is set to 20 days, the claim must be final dispositioned prior to the 10th of the month.

There are several claim disposition statuses which qualify a claim to be selected for archiving:

- The claim has been paid in full; the final payment flag must be set to Y and the claim disposition status is Final Payment (F).

- The claim has been denied; the claim disposition status is Denied (D).

- The claim has been adjusted to zero; the claim disposition is Adjusted to Zero (A) .

- The claim has had the money transferred to another carrier or to the patient; the claim disposition status is Transfer (T).

- The claim has been flagged as completed when the carrier or the account balance goes to zero.

Claims which have been replaced by an adjustment bill's claims are automatically selected to be archived when analyzed by the select process. Replaced claims do not need to meet the Carrier Pay Days parameter or the claim disposition statuses noted above. Adjusted claims are not included in any claim archive spool files and subsequent back up files. When considering claim records for archive, the system looks at each claim as if it is a shared claim. In order to be considered, the first claim in the shared claim list must meet the archive requirements. In other words, even if a claim is stand-alone, it is looked at as if it is a shared claim for the first test of archive eligibility. If the claim is a shared claim, each claim is checked for a disposition code and date. If there is no disposition date, the system checks for a last payment or an adjustment date, a first payment date, or a claim submission date. If each shared claim has a valid disposition code or a zero or negative balance and one of the above dates, it is selected for archiving. If any of the shared claims do not qualify for archiving, none of the claims are selected for archiving.

Before a claim can be selected for archiving, the system checks the refund file to determine if an approved refund exists. If one does, the claim is not selected for archiving. If a claim refund exists and has a Hold or Exclude status, the claim is selected for archiving and the refund request is deleted.

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

NOTE: Cash and adjustments can be posted to a claim after it is archived or purged. Balance transfers can also be performed.

Follow-up does not occur on archived claims. Claim status and carrier status screens will be retained. All other screens associated with the claim no longer appear, including the Claim Demographic screens, Claim Attachment, and Claim Charge Data.

It is possible to post cash, adjustments and balance transfers to an archived or purged claim. Archive status is a temporary status. Its purpose is to send the report produced by the system to a backup medium, receive the microfiche from the vendor, verify the microfiche, and run purge if the microfiche is verified. If the backup medium cannot be read or any other problems exist, the archive process can be re-run. There are many claim archive spooler reports. Some of these include:

- FCR1927x - 1500 Revision 1992 Archive

- FCR1947x - 1500 08/05 Format Archive

- FMRACXx - UB92 Claims Archived

- FMR1ACXXx - UB04 Claims Archived

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

Transaction history has a separate entry for a claim selected for archiving and when the claim is purged.

To set up the sort for archived claims in the Sort Sequences table, access menu items of Financial System Management, Maintain Facility Information, and Sort Sequences.

The system then displays the screen shown next. Multiple sort definitions are listed, one for each generic type of claim.

```
                              Sort Sequences Processor
                                              Wed May 15, 2002 11:04 am
GENERAL HOSPITAL
1500 Claims - Archive
 1 Edit Date            2 Edit By
   05/15/02 11:04          Smith,John
 3 Sort Field              Sequence
   Biller Code Bill
   Biller Code Claims
   Carrier Code
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number
   Patient Indicator
   Patient Name


                       F6 Reset  F7  Exit   ?
```

A recommendation is to sort claims either by patient name or account number so the account can be easily accessed on the backup medium.

1. After setting the claim sort, when it is time for the claims to be archived, select the menu option Archive Claims. To select this option select Billing & Claims from the initial menu, then select Claims Management, then select Archive Claims. The system immediately begins to archive the claims.

2. Verify that the report or microfiche is valid.

3. Select the menu option Purge Archived Claims.

    NOTE: The functions Claim Archive and Purge Archive Claims should only be assigned to the DP menu; users should not have this option. Also, a claim archive should only be done after the previous archive run has been purged.

After the claims have been archived, the system also updates the Transaction History. Claim information is displayed as archived. If the archived claim was shared the system displays an asterisk (*) in front of the name and code of the carrier/plan.

Follow-up does not occur on archived claims. Claim Status and Carrier Status screens will be retained. All other screens associated with the claim no longer appear, including the Claim Demographic Screens, Claim Attachments and Claim Charge Data.

When claims are purged, the system updates the Transaction History. Claim information is displayed as purged, and space is gained.

PURGE ARCHIVED CLAIMS

The Purge Archived Claims function deletes claim data from the system. The purge process should be initiated after the archived claims are stored on a back-up medium and both the back-up medium and the back-up data are verified with the quantity and type of claims selected. Limited free disk space will result from this process.

The Purge Archived Claims function is selected from the menu. After you select this option, the system displays the following prompt:

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

If you enter Y, the system starts a background job to purge all claims which were selected through the last Archive Claims select process.

If there are no claims to be purged, the system displays the following message:

Error: There are no archived claims to purge

If there are claims available to be purged, the claim purge process is initiated. The process deletes the claim demographic/visit data and charge detail for the claim. Transaction history reflects that the claim was purged. Payments, adjustments, and balance transfers can be posted to a purged claim. The claim can no longer be reprinted since the demographic and charge detail were deleted. For more information, refer to "ARCHIVE CLAIMS" on page 3-225.

Deleting Pathways Contract Management Claims

For claims with reimbursement type of I-Pathways Contract Management or J-PCON/ Cycle, the system determines whether any claims from the claim sequence being requested to delete forward has had an ERA posted using the variance method. If this has occurred, the system displays the following prompt:

ERA Variance method has been used on this account, do you wish to continue (Y/N) –

Valid options are Yes and No; there is no default. If you respond with N for No, the claim deletion request is not processed. If you respond with Y for Yes, the system verifies whether any Pathways Contract Management claims have been archived or purged. If this has occurred, the system displays the following prompt:

Archived/Purged PCON claims exist. Archived/Purged claims will not be re-sent to PCON. Continue (Y/N) --

Valid options are Yes and No; there is no default. If you respond with N for No then the claim deletion request is not processed. If there are no archived claims to be purged, the system displays the following message:

Error: There are no archived claims to purge.

For more information on deleting Pathways Contract Management claims, refer to the *Pathways Contract Management Interface Guide* of the *STAR Financials Patient Accounting Reference Guide*.

PENDING CLAIMS REPORT (FCR260)

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

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

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

OPPS CLAIM FUNCTIONS

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

```
           General Hospital OPPS Claim Functions Processor
                                        Mon Aug 20, 2001 11:42 am
OPPS Claim Functions Input Options


          Option No.  Option
          --------------------------------------
REVIEW         1        Examine OPPS Information
               2        3M OPPS Interface Status
               3        Identify Account/Claim for 3M OPPS Record Number

PROCESS        4        OPPS Claim Maintenance
               5        Exclude Claims from OPPS Reimbursement Calculation


Enter option number--
```

For more detailed information regarding these options, refer to the *Outpatient Prospective Payment System Volume* of the *STAR Financials Patient Accounting Reference Guide.*

EDIT PA CHARGE

The Edit PA Charge function allows you to edit the HCPCS code, HCPCS modifiers, ABN information, and the order/charge diagnosis stored for the charge in STAR Patient Accounting. Included in the HCPCS modifier field are the ABN indicators, CPT Level I and CPT Level II Modifiers which may be used in duplicate HCPCS processing and cross-reference code set conflict processing. The edits to the STAR Patient Accounting charge data do not generate any updates for the charge record maintained in STAR Order Management or in ancillary department systems. If the HCPCS, HCPCS modifiers, or diagnosis for a charge are changed in STAR Patient Accounting, the STAR Order Management HCPCS, HCPCS modifiers, and diagnosis are retained for viewing, but all STAR Patient Accounting functions use the STAR Patient Accounting HCPCS, HCPCS modifiers, and diagnosis. If the STAR Patient Accounting charge is edited, and the account has not final billed, the pre-bill edit trigger event of Charge Revision determines whether a new pre-bill is created for the account.

The entry or edit of HCPCS and/or diagnosis does not include the STAR Order Management logic for ABN processing, checking for duplicate HCPCS, checking for cross-reference HCPCS code set conflicts, or checking for a frequency limit for the HCPCS. The diagnosis for the charge is selected from the entire table of diagnoses. The fields maintained in STAR Patient Accounting that indicate the outcome from STAR Order Management logic can be edited, so non-covered amounts for UB claims can be calculated properly and the charges can be reported on CMS reports.

The departments for which edits can be made, whether the edits are made for active and/or inactive accounts, and the transaction code documenting the event are maintained in PAAR Control parameters. The time frames for active and inactive accounts are determined from the number of suspense days indicated on the Patient Type table in STAR Patient Processing.

If a charge revision is made in STAR Order Management, the HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators from STAR Order Management for the charge would replace the Patient Accounting HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators. If the charge was edited in STAR Patient Accounting previously, the changes are recorded in transaction history and included on the nightly activity journals.

Parameters on the PAAR Control screen indicate the departments and types of accounts for which the charges can be edited:

- If the SIM department for the charge is included in the list of departments maintained in the Edit PA Charge for SIM Depts parameter, the HCPCS, HCPCS modifiers, diagnosis, and the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/Component HCPCS can be edited for the Patient Accounting charge for active accounts and/or inactive accounts, per the parameters for that department.

- If a transaction code is displayed in the Active Accounts column for the SIM department, the HCPCS, HCPCS modifiers, diagnosis, and the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/ Component HCPCS can be edited for active accounts. If a transaction code is displayed in the Inactive Accounts column for the SIM department, the HCPCS, HCPCS modifiers, diagnosis, and the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/Component HCPCS can be edited for inactive accounts.

- If the SIM department for the charge is not included in the list of departments maintained in Edit PA Charge for SIM Depts, the HCPCS, HCPCS modifiers, diagnosis, and the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/Component HCPCS can be edited for the STAR Patient Accounting charge for active accounts and inactive accounts, per the Edit PA Charge for Active Accnts and Edit PA Charge for Inactive Accnts fields on the PAAR Control table. If a transaction code appears in the Edit PA Charge for Active Accnts field, the HCPCS, HCPCS modifiers, diagnosis, and the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/ Comprehensive/Component HCPCS can be edited for active accounts. If a transaction code appears in the Edit PA Charge for Inactive Accnts field, the HCPCS, HCPCS modifiers, diagnosis, and the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/Component HCPCS can be edited for inactive accounts.

If a change is made to the HCPCS, HCPCS modifiers, diagnosis, or indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/ Component HCPCS for a charge in Patient Accounting, using the Edit PA Charge function, the transaction is recorded in transaction history using the transaction code indicated in the PAAR Control parameters. The transaction type is Status Transfer (S), and the Summary Transaction Type is Memo (M). In the two activity journals produced daily, the charges are listed with changes to the Patient Accounting HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/Compre/Comp HCPCS. If the account has not final billed and the Pre-bill Edit module is used, PBE Trigger Event 17 (Charge Revision) may cause another pre-bill to be created.

After you select this function, if no parameters were established in PAAR Control for editing PA charges, the following message is displayed, and the process is exited:

> *PA Changes cannot be edited for this account!*

If parameters were established in PAAR Control for editing Patient Accounting charges, you can select an account in location PA or AR. If no charges exist for an active account which can be edited, per the Edit PA Charge parameters in PAAR Control for active accounts, the following message is displayed, and the selection process for an account starts again:

> *PA charges cannot be edited for this account!*

If no charges exist for an inactive account which can be edited per the Edit PA Charge parameter in PAAR Control for inactive accounts, the following message is displayed, and the selection process for an account starts again:

PA charges cannot be edited for this account!

If Patient Accounting charges can be edited, the following screen is displayed. You can select the SIM departments for charges to be edited or enter **A** to select all SIM departments:

```
                    General Hospital Edit PA Charge Processor
                                          Thu Aug 23, 2007 10:36 am
Account      Name                  FC Typ Admit    Disch       Balance Loc
A0711300003  SHORE,JAN             L  I/P 04/23/07 04/24/07    1029.30-AR /PCA1
Page:01                            SIM Departments             ##=Current Choices
( 1) CSR-CENTRAL SERVICES
( 2) EDP-EMER DPT PHYSICIANS
( 3) RMB-ROOM AND BED






Select SIM department(s) or key A for All [A]--
                             end select(NL)
```

If SIM departments are selected for Patient Accounting charge editing, the following screen is displayed so the service date(s) for charges to be edited can be selected:

```
                    General Hospital Edit PA Charge Processor
                                              Thu Aug 23, 2007 10:36 am
Account      Name                 FC Typ Admit    Disch       Balance Loc
A0711300003  SHORE,JAN             L  I/P 04/23/07 04/24/07   1029.30-AR /PCA1
Page:01                        Charge Service Dates          ##=Current Choices
( 1) 04/24/07








Select charge service date(s) or key A for All [A]--
                           end select(NL)
```

The charges that can be edited are displayed next in a table lookup, for the charge service dates selected. A charge appears if its department satisfies the criteria for Edit PA Charge in PAAR Control. For an active account, at least one of the following must be true:

• Parameters exist for the department, and a transaction code exists for Active Accounts.

• Parameters do not exist for the department, and a transaction code exists for Edit PA Charge for Active Accnts.

For an inactive account, at least one of the following must be true:

• Parameters exist for the department, and a transaction code exists for Inactive Accounts.

• Parameters do not exist for the department, and a transaction code exists for Edit PA Charge for Inactive Accnts.

The following screen is displayed, showing charges sorted by SIM department, service date, HCPCS/modifiers per STAR Order Management, and SIM code. One or more

charges can be selected from the list for the STAR Patient Accounting charge data to be edited.

```
                    General Hospital Edit PA Charge Processor
                                            Thu Mar 25, 2009 09:44 am
Account       Name                   FC Typ Admit     Disch        Balance Loc
A0720000004  SHORE,JAN                O  LIR 07/15/07               27778.56 PA /INSR
                                Charge Summary
    Dpt SIM   Description                      Srv Date Time   PA HCPCS/Mod
         Billed    Price     Qty   PA Dx    OM Dx            OM HCPCS/Mod
( 1) ED  344   3 WAY STOPCOCK                  07/15/07 06:02A
         CYCA       $5.69      1
( 2) ED  187   ABG SUPPLIES                    07/15/07 06:02A  57502
         CYCA       $7.79      1
( 3) CAR 1104  ECG PROFESSIONAL FEE            01/18/08        93010
     FIN      $16.09      1  M48.50xD/123.4  M12.34xA/567.8  9301099887766




Select charges to be edited--
```

Field Explanations

DPT (DISPLAY ONLY)
This field contains the SIM department for the charge.

SIM (DISPLAY ONLY)
This field contains the SIM code.

DESCRIPTION (DISPLAY ONLY)
This field contains the description for the charge. This is the SIM description or the manually-entered charge description.

SRV DATE TIME (DISPLAY ONLY)
This field contains the service date and time for the charge.

BILLED (DISPLAY ONLY)
This field indicates if the charge has been billed and the type of bill. The potential values are as follows:

* CYC - This indicates the charge was billed on a cycle bill. If a Cycle Adjustment bill is created, the Patient Accounting HCPCS, HCPCS modifiers, and diagnosis for the charge are used in billing and claims, along with the indicators for ABNs, duplicate HCPCS, and conflicting HCPCS.

- FIN - This indicates the last bill using the charge is a final bill. If an adjustment bill is created, the Patient Accounting HCPCS, HCPCS modifiers, and diagnosis for the charge are used in billing and claims, along with the indicators for ABNs, duplicate HCPCS, and conflicting HCPCS.

- ADJ - This indicates the last bill using the charge is an adjustment bill. If another adjustment bill is created, the STAR Patient Accounting HCPCS, HCPCS modifiers, and diagnosis for the charge are used in billing and claims, along with the indicators for ABNs, duplicate HCPCS, and conflicting HCPCS.

- LAT - This indicates the last bill using the charge is a late bill. If an adjustment bill is created, the STAR Patient Accounting HCPCS, HCPCS modifiers, and diagnosis for the charge are used in billing and claims, along with the indicators for ABNs, duplicate HCPCS, and conflicting HCPCS.

PRICE (DISPLAY ONLY)
This field contains the charge amount.

QTY (DISPLAY ONLY)
This field contains the charge quantity.

PA DX (DISPLAY ONLY)
This field displays the ICD-10 Ordering Diagnosis if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this code and the slash, such as "A12.34xD/" if the charge has not been edited, or "A12.34xD/None" if the charge had been edited in Edit PA Charge. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as "/825.1" if the charge has not been edited, or "None/825.1" if the charge had been edited in Edit PA Charge. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows "A12.34xD/825.1".

PA HCPCS/MOD (DISPLAY ONLY)
If Patient Accounting charge data has been edited, the current Patient Accounting HCPCS and HCPCS modifiers are displayed in this column. The value of *None* is displayed if there is no Patient Accounting HCPCS/Mod. Otherwise, the information received from STAR Order Management is displayed, or the field is blank if there are no HCPCS/Modifiers.

OM DX (DISPLAY ONLY)
This field contains the diagnosis for the charge which is received when the charge is posted in STAR Patient Accounting or when a charge is revised in STAR Order Management. If a charge is revised in STAR Order Management, the STAR Patient Accounting diagnosis is updated per the charge information and the STAR Order Management charge diagnosis, indicating a change of information in STAR Patient Accounting is removed. This field is populated only if charge data has been edited in STAR Patient Accounting subsequent to the last receipt of information from STAR Order Management. If there is no charge diagnosis, the value of *None* is displayed.

This field displays the ICD-10 Ordering Diagnosis if present, followed by a slash (/) and the ICD-9 Ordering Diagnosis if present. If there is only an ICD-10 Ordering Diagnosis, the screen displays this code and the slash, such as "A12.34xD/" if the charge has not been edited, or "A12.34xD/None" if the charge had been edited in Edit PA Charge. If there is only an ICD-9 Ordering Diagnosis, the screen displays the slash and then the code, such as "/825.1" if the charge has not been edited, or "None/825.1" if the charge had been edited in Edit PA Charge. If there is an ICD-10 Ordering Diagnosis and an ICD-9 Ordering Diagnosis, both are displayed as follows "A12.34xD/825.1".

OM HCPCS/MOD (DISPLAY ONLY)
This field contains the HCPCS and HCPCS modifiers which are received when the charge is posted in STAR Patient Accounting or when a charge is revised in STAR Order Management. If a charge is revised in STAR Order Management, the STAR Patient Accounting HCPCS and HCPCS modifiers are updated per the charge information, and the STAR Order Management HCPCS/Mod field, indicating a change of information in STAR Patient Accounting, is removed. This field is populated only if charge data was edited in STAR Patient Accounting subsequent to the last receipt of information from STAR Order Management. If there is no HCPCS/modifier, the value of *None* is displayed in the field.

After you select a charge, one of the following prompts is displayed if a charge was added:

• If the bill type for the last bill that the charge appeared on is Z (Cycle Adjustment Bill), the following prompt is displayed:

  Charge was billed on cycle adj bill ##. Continue? (Y/N)-

• If the last bill on which the charge appeared is a final bill, the following prompt is displayed:

  Charge was billed on final bill ##. Continue? (Y/N)-

  Final bills can be rebilled. Therefore, if the Patient Accounting HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/ Reason, or Mutual Excl/Compre/Comp HCPCS for a charge which has final billed is changed, the HCPCS, HCPCS modifiers, diagnosis, or non-covered amount may need to be edited on an existing claim, Add Claim to Insurance may need to be used to create another claim, an Instant Adjustment Bill may need to be created, or an adjustment bill may need to be created during Midnight Processing billing.

• If the last bill on which the charge appeared is an adjustment bill, the following prompt is displayed:

  Charge was billed on adjustment bill ##. Continue? (Y/N)-

Adjustment bills can be rebilled. Therefore, if the STAR Patient Accounting HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/Compre/Comp HCPCS for a charge which has adjustment billed is changed, the HCPCS, HCPCS modifiers, diagnosis, or non-covered amount may need to be edited on an existing claim, Add Claim to Insurance may need to be used to create another claim, an Instant Adjustment Bill may need to be created, or an adjustment bill may need to be created during Midnight Processing billing.

• If the last bill on which the charge appeared is a late bill, the following prompt is displayed:

Charge was billed on late bill ##. Continue? (Y/N)--

Charges on a late bill can be rebilled in an adjustment bill. Therefore, if there is a change to the STAR Patient Accounting HCPCS, HCPCS modifiers, diagnosis, ABN/ABN Reason, Freq ABN/Freq Limit, Dup HCPCS/Reason, or Mutual Excl/ Compre/Comp HCPCS for a charge which appeared on a late bill, the HCPCS, HCPCS modifiers, diagnosis, or non-covered amount may need to be edited on an existing claim, Add Claim to Insurance may need to be used to create another claim, an Instant Adjustment Bill may need to be created, or an adjustment bill may need to be created during Midnight Processing billing.

After you respond Yes (Continue) to these prompts, if the item was changed previously, the following screen is displayed:

```
                  General Hospital Edit PA Charge Processor
                                               Thu Mar 22, 2009 09:44 am
Account      Name                   FC Typ Admit    Disch       Balance Loc
A0720000004  TEST,JAN          O  LIR 01/28/08              27778.56 PA /INSR
Ord#  Dpt/SIM Cd/Desc      Serv Dt   Qty      Price  Chg/Ord Dr.  Bill  Old Chg
   5  CAR/1112/ELECTRODES  01/29/08   1      $16.50   32/32       FIN
      CRT/Int/Ref: DP/T C/Comb From :  A0813200004 SNOW,FLAKE
OM Data                            PA Data
 1 Serv Time        2 NDC Qty/Qual     3 Serv Time       4 NDC Qty/Qual
   13:38            None
 5 ICD-9 DX         6 ICD-10 DX        7 ICD-9 DX        8 ICD-10 DX
826.1    A12.34xD   825.1    A45.67xD
 9 HCPCS/Modifier                     10 HCPCS     11 HCPCS Modifier
   93010
12 ICD/ABN/ABN Reason                 13 ICD/ABN/ABN Reason
10/Yes/ABNY-Patient signed and witne 10/No/ABNN-Patient unconscious
14 ICD/Freq ABN/Freq Limit            15 ICD/Freq ABN/Freq Limit

16 Dup HCPCS/Reason     17 Ref Fac    18 Dup HCPCS/Reason     19 Ref Fac
     SK-Smith KLi           AB-Abbott La
20 Mutual Excl/Compre/Comp HCPCS       21 Mutual Excl/Compre/Comp HCPCS
Enter field number or '/' starting field number--
```

The screen has an OM (STAR Order Management) Data header on the left, and a PA (STAR Patient Accounting) Data header on the right. The PA fields on the right side of the screen are highlighted in blue (with white letters), while the OM fields on the left side of the screen are displayed in black lettering, no highlights.

Field Explanations

The following information is contained in the header line:

ORD#
This field contains the order number from STAR Order Management.

DPT/SIM CD/DESC
This field contains the charge department, SIM code, and description for the charge.

CRT/INT/REF
This field displays the CRT from which the STAR Patient Accounting charge information was updated, the Initials of the person who updated STAR Patient Accounting charge information, and the account number and name if this charge is from a FROM account in Combine Billing. The three fields display in a string, as follows:

CRT/Int/Ref: DP/K E/Comb From : A 0813500002 SNOW,ALICE

SERV DT
This field contains the service date for the charge.

QTY
This field contains the quantity of the items for the charge.

PRICE (DISPLAY ONLY)
This field contains the price of the item charged.

CHG/ORD DR. (DISPLAY ONLY)
This field contains the number of the charging/ordering physician.

BILL (DISPLAY ONLY)
This field indicates if the charge has been billed and the type of bill. The potential values are as follows:

CYC - This indicates the charge was billed on a cycle bill.

FIN - This indicates the last bill using the charge is a final bill.

ADJ - This indicates the last bill using the charge is an adjustment bill.

LAT - This indicates the last bill using the charge is a late bill.

OLD CHG (DISPLAY ONLY)
This field can contain one of the following, relating to charges in the Unbilled Charge Worklist:

• Blank - A blank indicates that when this charge was received in STAR Patient Accounting, the charge did not have a date of service that was billed previously.

• Yes - This value indicates the charge has a posting date in the past, and it qualified for the Unbilled Charge Worklist. This status remains unless the charge is marked by the user to be reversed.

• Markd - This value indicates that the charge was worked in the Unbilled Charge Worklist and marked by the user to be reversed. This charge information was then passed to STAR Order Management to issue a system-generated charge reversal.

• Revsd - This value indicates that the charge is a system-generated charge reversal from STAR Order Management.

Field Explanations

NOTE: Data displays for the PA (Patient Accounting) Data only if has been revised after receiving the OM (Order Management) data.

1. (OM) SERV TIME (DISPLAY ONLY)
This field contains the service time that is contained on the charge information passed from STAR Order Management.

2. (OM) NDC QTY/QUAL (DISPLAY ONLY)
This field displays the NDC quantity and qualifier that are contained on the charge information passed from STAR Order Management.

3. (PA)SERV TIME (4-N-O)
This field contains the current service time. The service time can be edited for accounts that are no longer active for charge processing.

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

Enter new Service Time--

Enter a time in hhmm format. The new time cannot be earlier than the admit time or after the discharge time for the visit.

If you press ENTER without entering a new time, the existing time is retained.

If you access this field for an account that is active for charge processing, the system displays the following error message:

Error: Service time can be edited for inactive accounts only!

Impact

Upon changing the service time on a charge in Patient Accounting using the Edit PA Charge function, a system message is logged to Transaction History for the visit.

Revenue statistic updates and reclassification occur, if appropriate, due to the changing of a service time.

The service time for the charge in STAR Order Management remains unchanged.

4.   (PA) NDC QTY/QUAL (10-N-O)
This field contains the STAR Patient Accounting NDC quantity and qualifier. When this field is accessed, the following prompt is displayed:

   Enter NDC Quantity--

A maximum of six digits can appear before the optional decimal point. A maximum of three digits can appear after the optional decimal point. If a decimal point is keyed, at least one number must be keyed following it. If you press ENTER, the existing NDC Quantity and Unit Qualifier are blanked out.

If you enter an NDC Quantity, the following prompt is dipslayed for the NDC unit qualifier:

   Enter NDC Unit Qualifier of F2 (International Unit), UN (Unit such as tablet or capsule), GR (Grams), ML (Milliliter), or ME (Milligrams)--

You can enter one of the four indicated qualifiers.

5.   (OM) ICD-9 DX (DISPLAY ONLY)
This field contains the ICD-9 ordering diagnosis for the charge which is received when the charge is posted in STAR Patient Accounting or when a charge is revised in STAR Order Management.

6.   (OM) ICD-10 DX (DISPLAY ONLY)
This field contains the ICD-10 ordering diagnosis for the charge which is received when the charge is posted in STAR Patient Accounting or when a charge is revised in STAR Order Management.

7.   (PA) ICD-9 DX (7-AN-O)
This field contains the current ICD-9-CM diagnosis for the charge. If a charge is revised in STAR Order Management, the STAR Patient Accounting diagnosis is updated per the charge information, and the STAR Order Management charge diagnosis, indicating a change of information in STAR Patient Accounting, is removed. This field is populated only if charge data has been edited in STAR Patient Accounting subsequent to the last receipt of information from STAR Order Management. If there is no charge diagnosis, the value of None is displayed in the field..

When this field is accessed, the system prompts as follows:

   Enter ICD-9-CM diagnosis code-- |

      U-`ser Dx, `-` for list

If you enter a diagnosis code, it is validated against the table of ICD-9 diagnosis codes. You can enter an ICD-9 Diagnosis code or select one from a table by entering **U** (User DX Code), followed by the beginning of the diagnosis description, and ending with a hyphen (-). To select a diagnosis from the Diagnosis Table, key the beginning of the diagnosis code followed by hyphen (-).

If the charge service date for the selected or keyed diagnosis code precedes the effective date for the diagnosis code indicated in the Diagnosis Table, the following prompt must be answered with **Y** for Yes to use the diagnosis code:

This code valid for service dates after MM/DD/YY! Accept? (Y/N) [N]--

If a diagnosis code is indicated for PA ICD-9 Diagnosis or it is changed to be blank (None), and STAR Patient Accounting charge data was not edited previously, Order Management data is populated for OM HCPCS/Modifier, OM Freq ABN/Freq Limit, OM Dup HCPCS/Reason, and OM mutual Excl/Compre/Comp HCPCS by copying from the PA fields.

If the PA ICD-9 Diagnosis field is used, no PA charge data was changed, and the (OM) ICD/ABN/ABN Reason field is used, the information is not copied to (PA) ICD/ABN/ ABN Reason, and the following prompt is displayed:

PA ICD/ABN/ABN Reason is not being updated from OM ICD/ABN/ABN Reason. Press ENTER.

If the PA ICD-9 Diagnosis field is changed, PA charge data was changed, and the (PA) ICD/ABN/ABN Reason field is used, information in the (PA) ICD/ABN/ABN Reason field and the ABN flag for ICD-10 or ICD-9 is removed and the following prompt is displayed:

PA ICD/ABN/ABN Reason information is being removed due to change in PA Diagnosis. Press ENTER.

If an ABN code/ABN Reason is then entered in the PA ICD/ABN/ABN Reason field, the system sets the ICD flag for the ABN based on which ordering diagnoses exist on the charge.

8. (PA) ICD-10 DX (7-AN-O)
This field contains the current ICD-10-CM diagnosis for the charge. Access is allowed to this field only if the USA ICD-10 Effective Date on the Hospital Facility Options of STAR Patient Processing is today or a date in the past. If a charge is revised in STAR Order Management, the STAR Patient Accounting diagnosis is updated per the charge information, and the STAR Order Management charge diagnosis, indicating a change of information in STAR Patient Accounting, is removed. This field is populated only if charge data has been edited in STAR Patient Accounting subsequent to the last receipt of information from STAR Order Management. If there is no charge diagnosis, the value of *None* is displayed in the field.

When this field is accessed, the system prompts as follows:

Enter ICD-10-CM diagnosis code-- |

      U-`ser Dx, `-` for list

If you enter a diagnosis code, it is validated against the table of ICD-10 diagnosis codes. You can enter an ICD-10 Diagnosis code or select one from a table by entering **U** (User DX Code), followed by the beginning of the diagnosis description, and ending with a hyphen (-). To select a diagnosis from the Diagnosis Table, key the beginning of the diagnosis code followed by hyphen (-).

If the charge service date for the selected or keyed diagnosis code precedes the effective date for the diagnosis code indicated in the Diagnosis Table, the following prompt must be answered with **Y** for Yes to use the diagnosis code:

This code valid for service dates after MM/DD/YY! Accept? (Y/N) [N]--

If a diagnosis code is indicated for PA ICD-10 Diagnosis or it is changed to be blank (None), and STAR Patient Accounting charge data was not edited previously, Order Management data is populated for OM HCPCS/Modifier, OM Freq ABN/Freq Limit, OM Dup HCPCS/Reason, and OM mutual Excl/Compre/Comp HCPCS by copying from the PA fields.

If the PA ICD-10 Diagnosis field is used, no PA charge data was changed, and the (OM) ICD/ABN/ABN Reason field is used, the information is not copied to (PA) ICD/ABN/ABN Reason, and the following prompt is displayed:

PA ICD/ABN/ABN Reason is not being updated from OM ICD/ABN/ABN Reason. Press ENTER.

If the PA ICD-10 Diagnosis field is changed, PA charge data was changed, and the (PA) ICD/ABN/ABN Reason field is used, information in the (PA) ICD/ABN/ABN Reason field and the ABN flag for ICD-10 or ICD-9 is removed and the following prompt is displayed:

PA ICD/ABN/ABN Reason information is being removed due to change in PA Diagnosis. Press ENTER.

If an ABN code/ABN Reason is then entered in the PA ICD/ABN/ABN Reason field, the system sets the ICD flag for the ABN based on which ordering diagnoses exist on the charge.

9. (OM) HCPCS/MODIFIER (DISPLAY ONLY)
This field contains the HCPCS code and modifier from STAR Order Management.

10. (PA) HCPCS (5-AN-O)
This field contains the HCPCS on the charge. When this field is accessed, the prompt that is displayed depends on whether the SIM item is the Rehab SIM Item indicated on the STAR Order Management and Charging Parameters screen found under Hospital Facility Options.

- If the SIM item is the Rehab SIM Item, the prompt is as follows:

  Enter HIPPS Rate/CMG Code or `N` for no code--

  You can enter a five-digit code in response to the prompt, leave the prompt blank, or enter **N** for No to indicate that the HCPCS and HCPCS modifiers received from STAR Order Management should not be used in STAR Patient Accounting.

- If the SIM item is not the Rehab SIM Item indicated on the STAR Order Management Charging Parameters screen found under Hospital Facility Options, the following prompt is displayed:

  Enter PA HCPCS procedure code,`U-`user procedure code, `-`for list, or `N` for no HCPCS-

You have the following entry options:

- You can enter a Patient Accounting HCPCS procedure code. If the HCPCS procedure code is inactive in the HCPCS Table, the following warning and prompt are displayed:

  WARNING: HCPCS code is inactive as of MM/DD/YY. Do you accept the xxxxx HCPCS Code? (Y/N)-

  You can enter **Y** (Yes) to use the inactive HCPCS code. If you enter **N** (No), the prompt for the HCPCS code is repeated.

- You can enter **U** (User Procedure Code) and the beginning of the HCPCS code followed by a hyphen (-), to select a code from the HCPCS Procedure table. The system displays the first HCPCS matching the partially-keyed HCPCS, followed by any subsequent HCPCS. You can select the HCPCS from the table lookup. If the HCPCS procedure code is inactive in the HCPCS Table, the following warning and prompt are displayed:

  WARNING: HCPCS code is inactive as of MM/DD/YY Do you accept the xxxxx HCPCS Code? (Y/N)-

  You can enter **Y** (Yes) to use the inactive HCPCS code. If you enter **N** (No), the prompt for the HCPCS code is repeated.

- You can enter **N** (No HCPCS) or press ENTER to remove an existing Patient Accounting HCPCS; any data in STAR Patient Accounting HCPCS Modifier, PA ABN/ABN Reason, PA Freq ABN/Freq Limit, PA Dup HCCPS/Reason, and PA

Mutual Excl/Compre/Comp HCPCS fields is removed. *No HCPCS* could be used if a HCPCS was received from STAR Order Management and no HCPCS should be used for the charge. If N (No HCPCS) is keyed, or an existing PA HCPCS is removed because ENTER was pressed, the value *None* is displayed in this field, if STAR Patient Accounting edits were done previously.

If a HCPCS code is indicated for PA HCPCS or it is changed to be blank (None), and STAR Patient Accounting charge data was not edited previously, OM Diagnosis is defaulted to equal the existing PA Diagnosis. If a HCPCS code is indicated for PA HCPCS, PA HCPCS did not exist, and the OM HCPCS/Modifier had HCPCS modifiers, the PA Modifier is blank after the PA HCPCS is indicated. If a PA HCPCS Modifier exists, and a different PA HCPCS is indicated, the PA HCPCS Modifier is blanked out. If the PA HCPCS code changes, the appropriate HCPCS modifiers must be keyed.

If the PA HCPCS is used to change the OM HCPCS, information on ABNs, duplicate HCPCS, and conflicting HCPCS is not copied to the new PA information being maintained. One of the following messages can be displayed:

PA ABN/ABN Reason information is not being updated from OM ABN/ABN Reason. Press ENTER.

PA Freq ABN/Freq Limit information is not being updated from OM Freq ABN/Freq Limit. Press ENTER.

PA Dup HCPCS/Reason is not being updated from OM Dup HCPCS/Reason. Press ENTER.

PA Mutual Excl/Compre/Comp HCPCS is not being updated from OM Mutual Excl/Compre/ Comp HCPCS. Press ENTER.

If the PA HCPCS field is changed, information on ABNs, duplicate HCPCS, and conflicting HCPCS can be removed. One of the following messages can be displayed:

PA ABN/ABN Reason information is being removed due to change in PA HCPCS. Press ENTER.

PA Freq ABN/Freq Limit information is being removed due to change in PA HCPCS. Press ENTER.

PA Dup HCPCS/Reason is being removed due to change in PA HCPCS. Press ENTER.

PA Mutual Excl/Compre/Comp HCPCS is being removed due to change in PA HCPCS. Press ENTER.

11. (PA) HCPCS MODIFIER (10-AN-O)

This field cannot be used if the PA HCPCS and OM HCPCS/Modifier fields are blank. When this field is accessed, the following screen is displayed. If the PA HCPCS Modifier field was not blank, each modifier is displayed in a separate field.

```
                    General Hospital Edit PA Charge Processor
                                          Mon Mar 27, 2006 10:40 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
A05256-00001 TESTA,SPLIT             A  OPC 09/13/05 09/20/05    1474.75 AR/FCRV
 1 HCPCS Modifier # 1                 2 HCPCS Modifier # 2
->
 3 HCPCS Modifier # 3                 4 HCPCS Modifier # 4

 5 HCPCS Modifier # 5



 Enter HCPCS modifier code or `-` for table--
```

A subsequent HCPCS Modifier field cannot be used unless the previous field has been used. If a HCPCS Modifier is removed, and subsequent HCPCS Modifiers exist, the system moves the HCPCS modifiers to previous fields. The system does not prevent the duplication of a HCPCS Modifier.

You can enter a HCPCS Modifier or a hyphen (-) to select one from a table, if HCPCS modifiers are associated with the SIM item. The HCPCS Modifiers for the SIM Item are ordered by priority as established in Order/Requisition Information in the Service Item Master.

```
                    General Hospital Edit PA Charge Processor
                                          Mon Mar 27, 2006 10:40 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
A05256-00001 MOON, TOM               A  OPC 09/13/05 09/20/05    1474.75 AR/FCRV
1 Item   2 Description                              3 Department
  3120       24 HOUR AMBULATORY EEG / SCAN                       EEG

Page:01        HCPCS Modifiers for SIM Item by Priority     ##=Current Choices
( 1) 21-PROLONGED EVAL/MGMT SERV
( 2) 32-MANDATED SERVICES
( 3) 47-MAXIMUM LENGTH..........X
( 4) 50-BILATERAL PROCEDURE
( 5) 51-MULTIPLE PROCEDURES
( 6) 55-POST-OP MANGMNT ONLY
( 7) 77-REPEAT PROC ANOTHER PHYSI
( 8) 80-ASSISTANT SURGEON
( 9) 81-MINIMUM ASSISTANT SURGEON
(10) 82-ASST SURG WHEN OTHER SURG
(11) CV-TEST CVERBRA
(12) GZ-UNABLE TO GIVE ABN
(13) JG-JANS HCPCS MODIFIER


Select HCPCS Modifier or key `T` to select from HCPCS modifier table--
                           end select(NL)
```

The following prompt is displayed:

Select HCPCS Modifier or key `T` to select from HCPCS modifier table--

You can select a HCPCS modifier or enter **T** (Table) so HCPCS modifiers can be selected from the entire HCPCS modifier table. This table is also displayed if no HCPCS modifiers are associated with the SIM item. If a PA HCPCS Modifier is added and no Patient Accounting charge edits were done previously, the OM HCPCS field is updated to match the PA HCPCS field, the OM Diagnosis field is updated to match the PA Diagnosis field, and the following reminder is displayed:

PA HCPCS updated from Order Management HCPCS!

- If a PA HCPCS Modifier is added, and no STAR Patient Accounting charge edits were done previously, the existing STAR Order Management modifiers are not copied forward.

- If a PA HCPCS Modifier is added, and no STAR Patient Accounting charge edits were done previously, none of the information for OM ABN/ABN Reason, OM Freq ABN/Freq Limit, OM Dup HCPCS/Reason, or OM Mutual Excl/Compre/Comp HCPCS is copied forward. One of the following messages can be displayed:

  PA ABN/ABN Reason information is not being updated from OM ABN/ABN Reason. Press ENTER.

  PA Freq ABN/Freq Limit information is not being updated from OM Freq ABN/Freq Limit. Press ENTER.

  PA Dup HCPCS/Reason is not being updated from OM Dup HCPCS/Reason. Press ENTER.

  PA Mutual Excl/Compre/Comp HCPCS is not being updated from OM Mutual Excl/Compre/ Comp HCPCS. Press ENTER.

- If a GA modifier is added or removed, the following message is displayed and requires a response of ENTER.

  GA indicates that an ABN was signed acknowledging patient liability. Press ENTER.

- If a GZ modifier is added or removed, the following message is displayed and requires a response of ENTER.

  GZ indicates that an ABN was not signed because patient was not available. Press ENTER.

- If a 91 modifier is added or removed, the following message is displayed and requires a response of ENTER.

  91 indicates medically necessary duplicate HCPCS. Press ENTER.

• If a QR modifier is added or removed, the following message is displayed, requiring a response of ENTER.

   QR indicates medically necessary duplicate HCPCS. Press ENTER.

• If a 76 modifier is added or removed, the following message is displayed, requiring a response of ENTER.

   76 indicates repeat procedure by same physician. Press ENTER.

• If a 77 modifier is added or removed, the following message is displayed, requiring a response of ENTER.

   77 indicates repeat procedure by another physician. Press ENTER.

12. (OM) ICD/ABN/ABN REASON (DISPLAY ONLY)
This field contains the ICD flag for the ABN, the ABN code and ABN reason from STAR Order Management. The ICD flag of 10 or 9 indicates if the ABN processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. If both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

13. (PA) ICD/ABN/ABN REASON (1-A-O)
This field contains the ICD flag for the ABN, the ABN code and ABN reason from STAR Patient Accounting. The ICD flag of 10 or 9 indicates if the ABN processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. If both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

This field indicates whether the ABN flag is set to ABN Not signed, ABN Signed, Self Pay ABN Signed, Self Pay ABN Not Signed, or ABN Approved and also displays the ABN Reason from the ABN Modifier and Reason Table in STAR Order Management. The ABN Reason is displayed when the PA ABN is Signed (Yes), Not Signed (No), Self Pay ABN Signed (SP/Y), and Self Pay ABN Not Signed (SP/N). This field cannot be edited unless STAR Patient Accounting HCPCS and an Ordering Diagnosis exist and the STAR Patient Accounting charge data has been edited. The field cannot be edited if the STAR Patient Accounting Freq ABN/Freq Limit field contains information.. When this field is accessed, the following prompt is displayed:

   Enter (A) for approved diagnosis, (Y) for ABN signed, (N) for ABN not signed, (S) for self pay signed, and (X) for self pay not signed--

You can enter **A** (Approved Diagnosis) if an ABN is not required. You can enter Y (Yes), ABN signed or N (No), ABN not signed. If you enter **Y** (ABN signed), the system displays the list of reasons defined for the GA modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the

screen. If there are no entries in the ABN Modifier and Reason Table for the GA Modifier, and the PA ABN is set to Yes, the system automatically assigns Modifier GA.

If you enter **N** (no signed ABN), the system displays the list of reasons defined for the GZ modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GZ Modifier, and the PA ABN is set to No, the system automatically assigns Modifier GZ.

If you enter **Y** (ABN Signed) or **N** (ABN Not Signed), any information in the PA Dup HCPCS/Reason field and in the PA Mutual Excl/Compre/Comp HCPCS field is removed. If either ABN Signed or ABN Not Signed is entered, and the ABN flag is selected for the field "Print Non-Covered Chgs?" for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If ABN Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services with Signed Advanced Beneficiary Notification (FAHCFAYx). If ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services without Signed Advanced Beneficiary Notification (FAHCFANx).

When entering **S** for self pay signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to PS (Self Pay/Patient/Witness Signed). When in the ABN Modifier and Reason Table, and selecting PS, the Self Pay Indicator displays SPS. If the ABN flag is selected for the field "Print Non-Covered Chgs?" for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay ABN Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services with Signed Advanced Beneficiary Notification (FAHCFSYx).

When entering **X** for self pay not signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to NS (Self Pay/No Signature). When in the ABN Modifier and Reason Table, and selecting NS, the Self Pay Indicator displays SPNS. If the ABN flag is selected for the field "Print Non-Covered Chgs?" for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services without Signed Advanced Beneficiary Notification (FAHCFSNx).

If the ABN code/reason is updated in the (PA) ICD/ABN/ABN Reason field, the system automatically sets the ICD flag for the ABN as follows. The ABN flag tells you if the ICD-10 or the ICD-9 Ordering Diagnosis on the charge was used for ABN processing. The field displays "10" for ICD-10 and a "9" for ICD-9 before the ABN code itself in the following format:

10/Yes/ABNY-Patient signed and witnessed

 9/Yes/ABNY-Patient signed and witnessed

10/No/ABNN-Patient unconscious or refused

9/No/ABNN-Patient unconscious or refused.

ABN ICD FLAG LOGIC FOR THE FIELD (PA) ICD/ABN/ABN REASON

The following scenarios outline the ABN ICD flag. This logic is in effect for the field (PA) ICD/ABN/ABN REASON. The field (PA) ICD/FREQ ABN/FREQ LIMIT does not follow this logic, and only verifies that the HCPCS entered has a Frequency Limit defined in the HCPCS Master.

*   The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. An ICD-9 Ordering Diagnosis is added. The system retains the ABN flag of 10 and ABN Code/Reason.

*   The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. The ICD-10 Diagnosis is deleted. The system clears the ABN flag and ABN Code/Reason.

*   If an ICD-9 Ordering Diagnosis is then entered, if an ABN Code/Reason is entered, the system will automatically set the flag to 9.

*   The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. The ICD-10 Ordering Diagnosis is updated. The system clears the ABN flag and ABN Reason.

*   The charge has an ICD-10 Ordering Diagnosis only, and an ABN flag of 10 and ABN Reason. The ABN Reason is updated. The system retains the ABN flag of 10.

*   The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. An ICD-10 Ordering Diagnosis is added. The system clears the ABN flag of 9 and ABN Reason since ABN processing is for Medicare, and a more current, ICD-10 diagnosis was entered.

*   The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. The ICD-9 Diagnosis is deleted. The system clears the ABN flag and ABN Reason.

*   If an ICD-10 Ordering Diagnosis is then entered, if an ABN Reason is entered, the system will automatically set the flag to 10.

*   The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. The ICD-9 Ordering Diagnosis is updated. The system clears the ABN flag and ABN Reason.

*   The charge has an ICD-9 Ordering Diagnosis only, and an ABN flag of 9 and ABN Reason. The ABN Reason is updated. The system retains the ABN flag of 9.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-9 Ordering Diagnosis is deleted. The system retains the ABN flag of 10 and ABN Reason.

The system gives the message:

PA ICD/ABN/ABN Reason information is not being removed because ICD-10 diagnosis exists. Press ENTER

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-10 Ordering Diagnosis is deleted. The system clears the ABN flag and ABN Reason.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ABN Reason is updated. The system retains the ABN flag of 10.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-9 Ordering Diagnosis is updated. The system retains the ABN flag of 10 and ABN Reason.

- The charge has BOTH an ICD-10 Ordering Diagnosis and ICD-9 Ordering Diagnosis, and an ABN flag of 10 and ABN Reason. The ICD-10 Ordering Diagnosis is updated. The system clears the ABN flag and ABN Reason.

14. (OM) ICD/FREQ ABN/FREQ LIMIT (DISPLAY ONLY)
This field contains the ICD flag for the frequency ABN, the frequency ABN code and ABN reason from STAR Order Management. The ICD flag of 10 or 9 indicates if the ABN processing was performed using the ICD-10 Ordering Diagnosis or the ICD-9 Ordering Diagnosis. NOTE, if both the ICD-10 and the ICD-9 Ordering Diagnosis exist on a charge, STAR Order Management, STAR Laboratory, and STAR Radiology use the ICD-10 Ordering Diagnosis only for ABN processing.

- The (OM) "ICD/Freq ABN/Freq Limit" field will display the ABN codes and then will display the Frequency Limit. Self Pay ABN codes are represented by SP and then Y for Yes or N for No. For example:

9/SP/Y/365 DAYS/SPFY-SELF PAY FREQ SIGNED

15. (PA) ICD/FREQ ABN/FREQ LIMIT (1-A-O)
This field contains the frequency ABN and limit from STAR Patient Accounting. The Freq ABN flag must be set to ABN Freq Not Signed, ABN Freq Signed, Self Pay ABN Freq Not Signed, or Self Pay ABN Freq Signed. If the Freq ABN flag is set, the frequency limit from the Medical Records HCPCS table is the second part of this field. This field cannot be edited unless PA HCPCS exists and the PA charge data has been edited. The field cannot be edited if PA ABN/ABN Reason has information. The field cannot be edited unless Frequency Limitation has been defined for the PA HCPCS code in the Medical Records HCPCS code table. If the field is accessed and no

Frequency Limitation has been defined for the PA HCPCS code in the Medical Records HCPCS code table, the following message is displayed:

Frequency Limitation is not defined in Medical Records HCPCS code table!

If the field is accessed, and a Frequency Limitation was defined for the PA HCPCS code in the Medical Records HCPCS code table, the following prompt is displayed:

To document a frequency limit for a procedure, enter (Y) for ABN signed, (N) for ABN not signed, (S) for self pay signed, and (X) for self pay not signed--

If you enter **Y** for ABN signed or **N** for ABN not signed, any information in PA Dup HCPCS/Reason and in PA Mutual Excl/Compre/Comp HCPCS is removed. Also, the frequency limit is provided from the HCPCS table.

You can enter Y (Yes), ABN signed or N (No), ABN not signed. If you enter Y (ABN signed) or the PA ABN is FQ/Y Frequency with Signed ABN, the system displays the list of reasons defined for the GA modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GA Modifier, and the PA ABN is set to either Yes or FQ/Y for Frequency with Signed ABN, the system automatically assigns Modifier GA.

If you enter N (no signed ABN) or the PA ABN is set to FQ/No for Frequency Limit with no signed ABN, the system displays the list of reasons defined for the GZ modifier in the ABN Modifier and Reason Table from STAR Order Management. You can select the ABN Reason from the screen. If there are no entries in the ABN Modifier and Reason Table for the GZ Modifier, and the PA ABN is set to either No or FQ/N for Frequency and No Signed ABN, the system automatically assigns Modifier GZ.

If either ABN Signed or ABN Not Signed is entered, and the ABN flag

is selected for the field "Print Non-Covered Chgs?" for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Frequency ABN Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services Subject to Frequency Limit with Signed Advanced Beneficiary Notification (FAHCFAYx). If Frequency ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Non-covered Services Subject to Frequency Limit without Signed Advanced Beneficiary Notification (FAHCFANx).

When entering S for self pay signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to PS (Self Pay/Patient/Witness Signed). When in the ABN Modifier and Reason Table, and selecting PS, the Self Pay Indicator displays SPS. If the ABN flag is selected for the field "Print Non-Covered Chgs?" for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay Frequency ABN Signed is indicated, the charge is marked to appear on the nightly report, Self Pay

Services Subject to Frequency Limit with Signed Advanced Beneficiary Notification (FAHCFSFYx).

When entering X for self pay not signed, the system displays the ABN Reasons in the ABN Modifier and Reason Table that have the field for Self Pay Indicator set to NS (Self Pay/No Signature). When in the ABN Modifier and Reason Table, and selecting NS, the Self Pay Indicator displays SPNS. If the ABN flag is selected for the field "Print Non-Covered Chgs?" for the UB Charge Control Parameter, the charge amount is displayed in the non-covered column for the UB claim. If Self Pay Frequency ABN Not Signed is indicated, the charge is marked to appear on the nightly report, Self Pay Services Subject to Frequency Limit without Signed Advanced Beneficiary Notification (FAHCFSFNx).

16. (OM) DUP HCPCS/REASON (DISPLAY ONLY)
This field contains the STAR Order Management duplicate HCPCS reason code.

17. (OM) REF FAC (DISPLAY ONLY)
This field contains the STAR Order Management Reference Facility code.

18. (PA) DUP HCPCS/REASON (1-A-O)
The first part of this field indicates whether the duplicate HCPCS is medically necessary. If the duplicate HCPCS is medically necessary, a coded or text duplicate HCPCS override reason is provided.This field cannot be edited unless PA HCPCS exists and the PA charge data has been edited. If Y or N for ABN signed or not signed is indicated in PA ICD/ABN/ABN Reason or PA Freq ICD/ABN/Freq Limit fields, the field cannot be edited. If PA Mutual Excl/Compre/Comp HCPCS has information, this field cannot be edited. When this field is accessed, the following prompt is displayed:

To document a duplicate HCPCS, enter (M) for medically necessary or (U) for medically unnecessary--

If you enter **M** (Medically Necessary), the Duplicate HCPCS Override Reason table is displayed, showing the override reasons in the Duplicate HCPCS Override Reason table, along with a suggested modifier. The entries appearing are limited to those for which the reason type is Duplicate HCPCS. The suggested modifier can be added manually if desired.

If you enter **U** (Medically Unnecessary), and Duplicate HCPCS is selected for Print Non-Covered Chgs? in the UB Charge Control Parameters, the charge amount is displayed in the non-covered column for the UB, and the charge is marked to appear on the nightly report, Conflicting HCPCS w/o Modifier Documentation (FAHCFAD).

19. (PA) REF FAC (12-AN-O)
This field contains the STAR Patient Accounting Reference Facility code. When this field is accessed, you can enter a code from the Reference Facility table or a hyphen (-) to select a code from the table. If you enter a code that does not exist in the Reference Facility table, the following message is displayed:

Error: Not on File

20. (OM) MUTUAL EXCL/COMPRE/COMP HCPCS (DISPLAY ONLY)
This field contains the STAR Order Management conflicting HCPCS. The second part of the field indicates the type of conflict. The third part of the field indicates whether a modifier can be used to differentiate services.

21. (PA) MUTUAL EXCL/COMPRE/COMP HCPCS (1-A-O)
The first part of this field indicates the conflicting HCPCS. The second part indicates the type of conflict. The third part indicates whether a modifier can be used to differentiate services. This field cannot be edited unless a PA HCPCS exists and the PA charge data has been edited. If Y or N for ABN signed or not signed is indicated in the PA ICD/ABN/ABN Reason or PA ICD/Freq ABN/Freq Limit fields, this field cannot be edited. If PA Dup HCPCS/Reason has information, this field cannot be edited. When this field is accessed, the following prompt is displayed:

> *Enter the conflicting HCPCS-*

If you enter the conflicting HCPCS code, the second prompt is as follows:

> *To document a conflicting HCPCS, enter (M) for mutually exclusive, (H) for comprehensive, or (T) for component --*

You can enter **M** for a mutually exclusive HCPCS with a previous charge, **H** for comprehensive of a previous charge, or **T** for component of a previous charge.

After you respond to the above prompt, the system displays the following prompt:

> *Can a modifier be indicated to differentiate services? (Y/N)-*

If **N** for No is entered, the charge may be used to identify uncovered charges on a UB claim. If **Y** for Yes is entered, the Duplicate HCPCS Override Reason table is displayed, showing the override reasons. The entries displayed are limited to those for which the reason type is *conflict.* The suggested modifier can be added manually if desired.

If Component/Comprehensive HCPCS Conflict and/or Mutually Exclusive HCPCS Conflict is selected for Print Non-Covered Chgs? in the UB Charge Control Parameters, the charge amount is displayed in the non-covered column for the UB.

EDIT PA CHARGE BY DEPARTMENT

This function allows the HCPCS, HCPCS modifiers, and diagnosis to be changed in charge information retained in STAR Patient Accounting for charging departments indicated in the CRT table. If one of these fields has been updated, the indicators for ABN, Frequency Limit ABN, Duplicate HCPCS, and Mutually Exclusive/Comprehensive/Component HCPCS can be edited. The functionality is the same as the Edit PA Charge function with the added criteria that the SIM department must be indicated for charging for the user's CRT. The charging departments for the CRT and the department parameters in PAAR Control determine if a department's charges can be edited for active and inactive accounts. For details on this function, refer to .

PA CHARGE REVERSAL

This function can be used to select a charge or credit to be reversed on a PA location account. The following types of charges cannot be reversed:

- A credit / late credit.

- A charge that is part of a panel.

- A charge in the Unbilled Charge Worklist. If the situation occurs where the charge to be credited exists in the Unbilled Charge Worklist function and also in the PBE worklist, the controlling functionality is the Unbilled Charge Worklist. When the PBE user tries to credit the charge, the system prevents the transaction and displays the message: *This Charge is also in the Unbilled Charge Worklist. You may not reverse this charge through PBE*.

- A charge that is an item on a panel. Only Master items on the panel can be reversed using this process.

- A charge for which the Master cannot be determined.

When this function is selected from the Billing and Claims menu, the system prompts you to select a facility (if this is a multi-facility installation), a patient account, and a SIM department. The system displays a screen with the applicable charge service dates for the account/SIM department. When a service date is selected, the listing of applicable charges is displayed.

```
               General Hospital PA Charge Reversal Processor
                                          Thu Aug 23, 2007 10:59 am
Account      Name                 FC Typ Admit    Disch        Balance Loc
A0704700001  SHORE,RONNY           S  CNA 02/16/07 02/16/07      75.90-AR /ACCF
                              Charge Summary
    Dpt SIM   Description                   Srv Date Time    PA HCPCS/Mod
        Billed     Price     Qty   PA Dx
( 1) CSR 1     ENEMA, OIL RETENTION---------- 02/16/07 07:22
        FIN      $6.83       1
( 2) CSR 1     ENEMA, OIL RETENTION---------- 02/16/07 07:23
        FIN     -$6.83      -1
( 3) CSR 2     MATTRESS, ROHO                 02/16/07 07:24
        FIN      $75.90      1
( 4) CSR 2     MATTRESS, ROHO                 02/16/07 07:25
        FIN     -$75.90     -1
( 5) CSR 2     MATTRESS, ROHO                 02/16/07 07:25
        FIN     -$75.90     -1




Select charges to be credited--
```

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After you choose a charge to be credited, the following screen is displayed:

```
                      General Hospital PA Charge Reversal Processor
                                        Thu Aug 23, 2007 11:00 am
Account        Name              FC Typ Admit    Disch      Balance Loc
A0704700001  SHORE,RONNY         S  CNA 02/16/07 02/16/07     75.90-AR /ACCF




Net Charge Total                  0.00
Number of Charge Transactions        2










Multiple charge transactions exist for SIM item and date. Press ENTER--
```

Field Explanations

NET CHARGE TOTAL (DISPLAY ONLY)
This field contains the net charge total for the selected charge(s). If there are multiple charge transactions for the SIM item and date, the total of all transactions is displayed.

NUMBER OF TRANSACTIONS (DISPLAY ONLY)
This field contains the number of charge transactions for the selected charge.

After you press ENTER, the Billing Information screen is displayed:

```
                 General Hospital PA Charge Reversal Processor
                                          Wed Jul 01, 2009 12:45 pm
Account      Name                  FC Typ Admit    Disch        Balance Loc
C0916800002  TEST,ICDTEN           M  O/P 06/17/09 06/17/09      623.94 PA /INSR
SIM: 3112-EEG PRO FEE                                  Serv:  06/17/09
Qty: 1                             Amt: $34.58         Post:  06/17/09 O/P
 1 Type of Unit                    2 Reference Facility          3 PA Edit

 4 Room/Bed  5 R&B Min   6 Accommodation         7 Charge Type 8 IDE
                                                   Prof. Fee
 9 Late Chg 10 Baby Chg 11 Fim Code  12 Statistics 13 Order#      14 Rev Dept
                        70333112      Yes           3              7033
15 UB Code                        16 HCPCS/Modifier          17 NDC
   986-Professional Fees EEG          9581926GA
18 ICD-9 DX    19 ICD-10 DX 20 Charging Physician    21 Performing Physician
               M00.252       630 SCOTT,EDWARD D          630 SCOTT,EDWARD D
22 ICD ABN/ABN 23 ABN Reason                     24 Frequency Limit
   10/Yes       ABNY-ABN SIGNED
25 Conflicting HCPCS ~ Override                  26 Take Home   27 Old Chg
28 From CRT 29 Initials 30 Reference
   DP          KEC

Reverse this Charge? (Y/N) [N]--
```

For details on this screen, refer to the Billing Information screen in the *Account inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide*.

You can reverse the charge by entering **Y** (Yes) to the following prompt:

> *Reverse this Charge? (Y/N)*

If you enter **N** (No), the charge is not reversed. If you enter **Y** (Yes), the following message is displayed:

> *Request sent to reverse Charge!*

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Chapter 4 - THIRD PARTY LOGS (U.S. ONLY)

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OVERVIEW

This chapter describes the functions that you use to enter and maintain log information for the third party payors used by your hospital.

All third party logs are user-defined and are identified by a two-character code and an up to 30-character description.

The carrier plan codes updating a log are contained in the Insurance Plan Coverage master with a cross reference maintained in the log. A given log can be established for any individual carrier or a combination of carriers. A given carrier plan code can also be included in multiple logs. Log IDs are entered in the facility options for individual carrier plans. When you enter a log ID, you specify whether the log is updated for the primary insurance, secondary insurance, or both. You also specify whether inpatients, outpatients, emergency room, or all patients should update the log. In addition, you can establish patient type exceptions for each log ID. For detailed instructions on linking log IDs to insurance plans, refer to the Insurance Plan Coverage Master - Facility Options section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

It is important to note that log records are created when a claim is released and not when it is loaded. A claim is loaded when an account is billed but it may not be produced right away. The log record is not automatically created until the claim is released.

Once a claim has been loaded, a log record can be manually added. Log records cannot exist without an associated claim record. When log records are manually added and a claim is later released, the log record is overlaid with a new log record. For this reason, it is recommended that you do not manually add log records for existing claims or for accounts that are expected to receive a claim. Generation of a claim for an associated carrier plan to a patient's account triggers that account to be reported in the log.

Automatic Log Account Generation

Log records are associated with claims. Log account records are automatically generated as a result of claims from a cycle bill, final bill, late bill, or adjustment bill. In the case of an adjustment bill, the previous log record for that billing period is replaced with a new log record for that billing period. A bill reprint does not cause a new log record to be established.

Summarization Of Log Charges/Credits

Charges are updated in the log in the same way that the UB or other claims are updated. Once the charges are loaded, you can edit the log record charge detail without affecting the original claim form record.

Late charges that are billed via late or adjustment bills create records. Adjustment claims replace final bill claim log records. Late claims create a log record for the late charges only. If late charges are not billed, they are not reflected in the log record but can be manually added at any time. You can manually edit the Late Charge Amount and the Number of Late Charges fields on the log record. These fields are never automatically updated by the system.

Accumulation Of Log Cash Receipts

By selecting the claim with the appropriate *from* and *through* dates when the cash receipt is posted, the payment can be applied to the appropriate log account record. If a log record with these dates does not exist, the payment does not update the log for the account. If the remittance date and number, the number of days paid, the outlier and the DRG code are specified at the time the carrier payment is posted, these data elements are maintained as a part of the log record. Carrier payments to patient accounts update the log account records on a daily basis.

Accumulation Of Log Adjustments

Log carrier adjustments can result either from manual carrier adjustments or from automatic contractual adjustments. Selecting the billing *from* and *through* dates (to which a carrier adjustment should be applied) when manual carrier adjustments are entered allows the adjustment to be posted to the correct log record. If a log record does not exist for the selected claim, no log update occurs when the adjustment is posted. System-generated contractual adjustments automatically update the appropriate log record. Carrier adjustments posted to logged patient accounts update the log records when the adjustment batch is approved.

Log Accounts Review/Maintenance/Reporting

Through the online Log Account Data function, you can select any log record and view or revise all data corresponding to any bill kept in the log. Multiple log records for a single patient account can be accessed in order to select the appropriate record. You can change/correct certain data retained in the log so that the log correctly reflects events not routed through the system or events inappropriately handled on the system (for example, late charges billed manually rather than through a late bill need to be summarized in the log, or carrier payments incorrectly posted to the patient liability rather than to the carrier liability need to be reflected in the log carrier payment amount). It is also possible, when necessary, to add a log account record directly to the file or to delete a specific log account record.

You can generate the Selected Log Accounts report, listing all log accounts which meet the criteria established at the time the report is requested. These criteria can include log ID, patient indicator, range of bill through dates, range of remittance dates, or status, (for example, payment made or not made, non-summarized late charges/ credits, or zero log account record). Selection can be based on whether the log records

are reconciled or unreconciled. Either a detail listing or a summary-only report can be obtained.

Storing And Deleting Log Accounts

Deletion of Log Accounts is done on a demand basis and when adjustment bills are processed. Log accounts can be selected by log ID, and then by carrier or account. Deleted log accounts can be stored before deletion by producing a log report. A group of logs may be purged by setting the Purge flag in Log Report Selection. Access to this field is controlled by security.

REVISE LOG ACCOUNT

This function enables you to enter and maintain demographic, record, DRG and summary charge information for accounts using a specific carrier and plan under one log ID.

After you select this function, the system prompts you to select a facility (if this is a multi-facility installation). You are then prompted to enter a two-character log ID or a hyphen (-) to display a list of valid log IDs. Log IDs must be tied to the insurance plan in Facility Options under Insurance Plan Coverage in PA/AR Master File Maintenance before you can access them. You have the option of accessing log information by account or carrier.

If you access log information by account, the FPI Lookup procedure is used to select a patient account. The system then displays the carrier(s) and plan(s) associated with this account.

If you access log information by carrier, the system displays a list of carriers and related plans included in this log ID. After a carrier/plan is selected, the system displays a list of patient accounts associated with the selected carrier, as shown below:

```
               General Hospital Revise Log Account Processor
Log: A Commercial                                 Fri Dec 08, 1989 11:28 am
Carrier               Plan                  Log
20-LINCOLN NATIONAL   0001-HBO & CO - MEDI  A Commercial
Page:01
      Account       Type  Admit    Disch        Balance Name
( 1) 89238-00007    OB  08/26/89             7,881.45 BARNETT,BABY GIRL
( 2) 89241-00011    I/P 08/29/89 09/27/89      75.45 BUTLER,BENJAMIN
( 3) 89243-00003    SDS 08/31/89 08/31/89       0.00 BYERS,RAYMOND
( 4) 89243-00015    I/P 08/31/89            10,731.67 MEYERS,DAVID A
( 5) 89285-00001    I/P 10/12/89 10/31/89   1,555.20 MEIGHER,MARK
( 6) 89313-00001    O/P 11/08/89 11/08/89       0.00 ANDERSON,TIMOTHY
( 7) 89248-00007    I/P 09/05/89 09/06/89       0.00 MCGRATH,MICHAEL
( 8) 89248-00007    I/P 09/05/89 09/06/89       0.00 SMITH,ROGER
( 9) 89226-00001    I/P 08/14/89          157,663.60 BARNES,MICHELLE
(10) 89319-00002    O/P 11/15/89 11/15/89       0.00 COLLINS,CHARLES
(11) 89319-00002    O/P 11/15/89 11/15/89       0.00 DUNCAN,DANIEL
(12) 89252-00001    I/P 09/09/89             7,277.50 BROOKS,ROBERT




 Enter choice--
```

Information displayed includes the carrier, plan, log, patient account number, patient type, the admission and discharge dates, the account balance and the patient name.

After you select an account (from either the carrier or patient option), the system displays the following screen:

```
              General Hospital Revise Log Account Processor
Log: A Commercial                              Mon Mar 27, 2006 10:40 am
Account      Name                FC Typ Admit    Disch       Balance Loc
A92182-00002 BUTLER, BENJAMIN     C  I/P 05/30/92 05/31/92   1123.45 AR/FCRV
Carrier/Plan                           Log
20-LINCOLN NATI  0001-HBO & CO - MEDI    A Commercial
                                                           Page:01

    Claim Dates                 Bill Date    Type       Seq
( 1) 06/15/92  Thru  07/01/92   06/20/92     UB82        1




















 Enter choice--
```

Claim dates associated with the selected account display, with any dates outside the date range of this log identified with an asterisk. The From and Thru dates for this claim record are displayed. It is possible for an account to have multiple claim records. The Bill Date is the date on which the bill was actually generated. The Type column specifies the type of claim form that was generated, such as UB or 1500. The Sequence column displays the claim sequence number of this claim.

If there are no claims for the selected account, the system displays *No Entries Defined* and returns you to the FPI Lookup prompt. If you press ENTER, the system displays the list of accounts.

If there is no log for the selected claim, the system prompts you to add one for the selected claim:

   Log does not exist for these dates. Add? (Y/N)[N]--

If you enter **N**, the system returns you to the FPI Lookup prompt so you can select a new account. If you enter **Y**, the system displays the following screen. A log record is created and you can manually enter the appropriate log data.

After a claim is selected (for both the carrier and patient options), the system displays the screen below.

```
                General Hospital Revise Log Account Processor
Log: A Commercial                              Mon Mar 27, 2006 10:40 am
Account     Name                    FC Typ Admit    Disch     Balance Loc
92241-00011  BUTLER,BENJAMIN         C  I/P 03/29/92 04/02/92   123.45  AR/FCRV
Carrier/Plan                         Log
20-LINCOLN NATI 0001-HBO & CO - MEDI    A Commercial

Log Edit Options

          Option No.  Option
          --------------------------------------
            1         Log Demographics
            2         Log Record Maintenance
            3         Log Reconciliation
            4         Summary Charges




Enter option number--
```

Each of these menu options is explained below.

Remember that a log record is not created until the claim is actually released. All available data is copied from the patient demographics file and claim form. After it is created, the log becomes an independent record; changes made to log records are not reflected on the account or the account's claims. For this reason, it is possible that a claim record is displayed but no log record exists. You can manually create a log in this instance, but when the claim is released, it overlays your entry.

Log Demographics

This function enables you to revise log information and enter additional log data. After you select this function, the system displays the following screen:

```
                General Hospital Revise Log Account Processor
Log: A Commercial                               Mon Mar 27, 2009 10:40 am
Account      Name                    FC Typ Admit    Disch       Balance Loc
A92017-00003 BUTLER,BENJAMIN         C  I/P 01/17/92 01/24/92     716.34  AR/FCRV
Carrier/Plan                             Log
20-HARRISON MUTUAL                       A Commercial
 1 Bill From           2 Bill Through    3 Bill Type            4 Rebill?
   01/17/92              01/24/92           Cycle                  No
 5 Patient Birthday    6 Patient Age     7 Aged Flag            8 Disch Status
   01/01/10             82Y                 Aged
 9 Attending Physician                  10 Medical Service
   TRUCKLE,MARK K                          MEDICAL
11 Primary Diagnosis                    12 Primary Procedure
   9/426.11-*ATRIOVENT BLK-1ST DEGR        9/36.14-AORTCOR BYPAS-4+ COR ART
13 Policy Number                        14 Blood Deductible Pints
   121558P                                 0
15 Blood Deductible Amount              16 Nbr of Late Charges

17 Late Charges       18 Primary Payor  19 Active Flag
                         Yes               Yes

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

Field Explanations

The patient account number selected and its associated patient name, financial class, patient type, admit and discharge dates, account balance, account location/sub location, carrier, plan, and log ID display at the top of the screen.

1.   BILL FROM (6-N-R)
This field contains the bill from date of the log record (entered in the format MMDDYY or MM/DD/YY).

2.   BILL THROUGH (6-N-R)
This field contains the bill through date of the log record (entered in the format MMDDYY or MM/DD/YY).

3.   BILL TYPE (1-A-R)
This field contains the type of bill issued for this account. Entry options are **C** (cycle), **F** (final), **L** (late), **A** (adjustment), **R** (reprint) or **S** (Series). You can enter the type or a hyphen
(-) to display a list of valid bill types.

4.   REBILL? (1-A-R)
This field indicates whether the log entry represents an adjustment bill. Entry options are **Y** for Yes or **N** for No. This field contains Y if an adjustment bill has been generated and this log record is the result. Once a bill has been replaced by a late or adjustment bill, you are not allowed to view the original log record and it is not included on reports.

5. PATIENT BIRTHDAY (DISPLAY ONLY)
This field contains the patient's birthday.

6. PATIENT AGE (DISPLAY ONLY)
This field contains the patient's age, which is calculated by the system by subtracting the patient's date of birth from the current system date.

7. AGED FLAG (DISPLAY ONLY)
If this log is a Medicare log (this determination is based on the DRG Based Payor field on the Log ID) and the patient is under 65 years of age, the system displays Disabled in this field. If the patient is over 65, the system displays Aged. Otherwise, it is blank.

8. DISCH STATUS (DISPLAY ONLY)
This field displays the discharge status of the patient. The system completes this field using information entered through the STAR Patient Care system.

9. ATTENDING PHYSICIAN (DISPLAY ONLY)
This field contains the Attending Physician and is completed by the system using admitting information entered through STAR Patient Care.

10. MEDICAL SERVICE (DISPLAY ONLY)
This field contains the type of service provided to this patient at admission/registration and is completed by the system using admitting information entered through STAR Patient Care.

11. PRIMARY DIAGNOSIS (DISPLAY ONLY)
This field contains the patient's primary diagnosis and is completed by the system as outlined below.

The field displays either a leading 10 for ICD-10 or a leading 9 for ICD-9, a slash (/) and then the Primary Diagnosis code and description An example is: 9/827.1-FX LOWER LIMB NEC-OPEN. This field cannot be revised in Revise Log Account.

If the claim type is X for the Federal UB, B for the 1500, or Z for the Non Pro Fee 1500, and a primary diagnosis exists in the claim, it is used. The system looks to UB04 Locator 67-1 for the Principal Diagnosis, and to Locator 21-1 for the Principal Diagnosis on a 1500 or Non Pro Fee 1500 claim. The log field displays the claim ICD indicator of 9 or 10 before the claim Primary Diagnosis.

Next the logic uses the Primary Diagnosis from Medical Records if it exists. The ICD-9 or ICD-10 primary diagnosis from Medical Records is used based on the ICD flag for the claim.

Next the logic uses the admitting diagnosis from Medical Records if it exists. The ICD-9 or ICD-10 admitting diagnosis from Medical Records is used based on the ICD flag for the claim.

Next the logic uses the admitting diagnosis from Patient Processing if it exists. The ICD-9 or ICD-10 admitting diagnosis from Patient Processing is used based on the ICD

flag for the claim. The diagnosis is used only if the format is correct and if the diagnosis exists in the ICD-9 or ICD-10 diagnosis table.

Next the logic uses the working diagnosis from Patient Processing if it exists. The ICD-9 or ICD-10 working diagnosis from Patient Processing is used based on the ICD flag for the claim. The diagnosis is used only if the format is correct and if the diagnosis exists in the ICD-9 or ICD-10 diagnosis table.

 If no diagnosis is found, then the field is set to "-".

12. PRIMARY PROCEDURE (DISPLAY ONLY)
This field contains the primary procedure performed on the patient and is completed by the system as outlined below. This field cannot be revised in Revise Log Account.

The field displays either a leading 10 for ICD-10 or a leading 9 for ICD-9, a slash (/) and then the Primary Procedure code and description. An example is: 9/83.74 MUSCLE REATTACHMENT.

If the claim type is X for the Federal UB and a primary procedure exists in the claim, it is used. This is UB04 Locator 74-1 and UB92 Locator 80.

Next the logic uses the principal procedure from Medical Records if it exists. The ICD-9 or ICD-10 principal procedure from Medical Records is used based on the ICD flag for the claim. If no procedure is found, then the field is set to "-".

13. POLICY NUMBER (20-AN-O)
This field contains the number of the policy associated with this patient's carrier plan.

14. BLOOD DEDUCTIBLE PINTS (2-N-O)
This field contains the number of pints of blood furnished (if any) for which the patient is responsible. The entry range is 0 to 99. This field is not updated automatically by the system.

15. BLOOD DEDUCTIBLE AMOUNT (11-N-O)
This field contains the dollar amount of blood furnished for which the patient is responsible. This field is not updated automatically by the system.

16. NBR OF LATE CHARGES (3-N-O)
This field contains the number of late charges placed against this account. The range is 0 to 999. This field is not updated automatically by the system.

17. LATE CHARGES (11-N-O)
This field contains the total dollar amount of late charges placed against this account. This field is not updated automatically by the system.

18. PRIMARY PAYOR (1-A-R)
This field indicates whether the carrier is the primary payor for this account. Entry options are **Y** for Yes or **N** for No; the default is Y. The system completes this field using information from the patient insurance record.

19. ACTIVE FLAG (1-A-R)
This field indicates whether the account is active. Entry options are **Y** for Yes or **N** for No; the default is Y. This field is used to inactivate a log record without deleting it. If you enter N, this log record is excluded from all log reports.

When all fields are completed, the system prompts you to accept or edit the information entered. Accepting the screen completes the transaction.

Log Record Maintenance

This function enables you to review and edit total billed amounts as well as payment and adjustment data.

If you are accessing log information by account, the patient account number selected and its associated patient name, financial class, patient type, admit and discharge dates, account balance, account location/sub location, carrier, plan, and log display at the top of the screen.

If you are accessing log information by carrier, only the carrier name, plan code and name, and log name display at the top of the screen.

After you select the desired claim and access function, the system displays the following screen:

```
                 General Hospital Revise Log Account Processor
Log: A Commercial                                Mon Mar 27, 2006 10:40 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
89241-00011  BUTLER,BENJAMIN          C  I/P 08/29/89 09/27/89     123.45  AR/FCRV
Carrier        Plan                  Log
20-LINCOLN NATI  0001-HBO & CO -      A Commercial
 1 Cvd Anc Chgs             2 Non-cvd Anc Chgs        3 Covered Days
   $2,159.95                  $325.50                   17
 4 Cvd Room Chgs            5 Non-cvd Room Chgs       6 Non-cvd Days
   $6,300.00                  $80.00                    0
 7 Total Covered           8 Total Non-Cvd           9 Deductible
   $8,459.95                  $405.50                   $150.00
10 Coinsurance            11 Days Paid              12 Carrier Liability
    $0.00                    17                        $8,459.95
13 Number Payments        14 Payment Amount         15 Last Payment Date
   1                         $8,054.45                 11/05/89
16 Number of Adjustments  17 Adjustment Amount      18 Last Adjustment Date
                             $0.00
19 Manually Added         20 Claim Split Indicator
   No                         PRIMARY

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

Field Explanations

1. CVD ANC CHGS (DISPLAY ONLY)
This field contains the amount of non-room and bed charges for this patient account covered by this carrier. For UB claim forms, the contents of this field reflect the total covered ancillary charges. Covered ancillary charges are calculated by subtracting the total non-covered charges from the total charges billed on the claim. Changes made

to the summary ancillary charges are reflected in this field. For 1500 claim forms, this field reflects the total charges on the claim.

2. NON-CVD ANC CHGS (DISPLAY ONLY)
This field contains the total non-room and bed charges that are not covered by the carrier. This field is only valid for UB claims and is blank for other claims. Changes made to summary charges are reflected in this field.

3. COVERED DAYS (5-N-O)
This field contains the number of patient stay days covered by this plan. These days are calculated by proration and this field is loaded from the UB claim form. The entry range is 0 to 99999 days.

4. CVD ROOM CHGS (DISPLAY ONLY)
This field contains the amount of room and bed charges covered by the carrier for this patient. For UB claim forms, the contents of this field reflect the covered room and bed charges. Covered room and bed charges are calculated by subtracting the total non-covered room and bed charges from the total room and bed charges. Changes made to the summary room and bed charges are reflected in this field. This field is valid only for UB type claims and is blank for 1500 type claims.

5. NON-CVD ROOM CHGS (DISPLAY ONLY)
This field contains the amount of room and bed charges accrued for this billing period by this patient account but not covered by this carrier. This field is valid for UB claims forms and is blank for other claims. Changes made to the summary page are reflected in this field.

6. NON-CVD DAYS (5-N-O)
This field contains the number of patient stay days not covered by this plan. The range is 0 to 99999 days. These days are calculated by proration and loaded from the UB claim form.

7. TOTAL COVERED (DISPLAY ONLY)
This field contains the total amount of covered ancillary charges and covered room charges.

8. TOTAL NON-CVD (DISPLAY ONLY)
This field, which is valid only for UB claims, contains the total amount of non-covered ancillary charges and non-covered room charges.

9. DEDUCTIBLE (10-N-O)
This field contains the deductible amount for this plan. This field is originally loaded onto the patient's insurance plan and is loaded into the log record from the UB claim form. The entry range is 0 to $9,999,999.99. This field is zero (0) for claims added using the Add a Claim function.

10. COINSURANCE (10-N-O)
This field contains the amount of patient charges assumed by the hospital to be applied to the patient's coinsurance amount. This amount is calculated by proration and is

loaded from the UB claim form. The entry range is 0 to $9,999,999.99. This field is zero (0) for claims added using the Add a Claim function.

11. DAYS PAID (3-N-O)
This field contains the number of patient stay days paid by this carrier and is updated during cash posting. The entry range is 0 to 999 days.

12. CARRIER LIABILITY (10-N-O)
This field contains the carrier liability for this claim record. This amount is calculated by proration and is loaded from the UB claim form. The entry range is 0 to $9,999,999.99. This field is zero (0) for claims added using the Add a Claim function.

13. NUMBER PAYMENTS (3-N-O)
This field contains the number of payments (if any) made on this claim record. This field is updated during cash posting. Both final and partial payments are counted in this field. The entry range is 0 to 999.

14. PAYMENT AMOUNT (10-N-O)
This field contains the total amount of payments made on this claim record. This field is updated during cash posting. Both final and partial payments are counted in this field. The entry range is 0 to $9,999,999.99.

15. LAST PAYMENT DATE (6-N-O)
This field contains the date of the most recent payment made on this claim entered in the format MMDDYY or MM/DD/YY.

16. NUMBER OF ADJUSTMENTS (3-N-O)
This field contains the total number of adjustments made to this claim record. This field is updated by adjustment processing. The entry range is 0 to 999.

17. ADJUSTMENT AMOUNT (10-N-O)
This field contains the system-calculated total amount of all adjustments made to this claim record. Debit and credit adjustments are displayed, including contractual adjustments posted at final bill. This field is updated by adjustment processing. The entry range is 0 to $9,999,999.99.

If the COB 1 plan had an automatic contractual adjustment from reimbursement, and this reimbursement type is not claim based (is not J for PCON by Claim or H for OPPS), this adjustment is associated with the Primary claim, or the claim with the blank Claim Split Indicator, or if none, with the first (in priority that loads) split claim for the insurance carrier only.

For claim based reimbursement types (J for PCON by Claim and H for OPPS) the contractual adjustments continue to be reported on the appropriate claim, since there can be an adjustment amount for each non-replaced claim.

For UB claims split by New York ALC codes or by New York PAS criteria, the lowest claim sequence number for the bill and insurance plan is used to report the automatic contractual adjustment.

18. LAST ADJUSTMENT DATE (6-N-O)
This field contains the date of the most recent adjustment to this claim record, entered in the format MMDDYY or MM/DD/YY.

NOTE: When a claim is a replacement claim, the system completes fields 13-18 using information from the claim being replaced.

19. MANUALLY ADDED (DISPLAY ONLY)
This field indicates whether this log record was added manually or automatically by the system. Yes indicates the claim was added manually; No indicates the claim was updated by the system.

20. CLAIM SPLIT INDICATOR (DISPLAY ONLY)
This field displays the Claim Split Indicator for the claim and can be blank for non-split claims.

When all fields are completed or reviewed, the system prompts you to accept or edit the information on the screen. Accepting the screen completes the transaction.

Reimbursement and Log Reconciliation

This function enables the user to maintain and display all information relating to the reconciliation of this log record. The following items can be reconciled for each log record:

- DRG Code billed vs. paid
- Billled DRG Reimbursement vs. Paid Reimbursement
- Billed Reimbursement vs. Paid Reimbursement
- Outlier billed vs. paid

The screen for this function contains the billed and paid code or amount for each of the above items. In addition, the screen displays whether liability and days are reconciled.

The Log ID table determines whether reconciliation is required for each of the four items. However, the log record attempts reconciliation in each area regardless of whether or not it is required on the log ID. This screen is updated every time insurance cash is posted. For example, if the billed DRG is 121 and two insurance payments are posted, the DRG entered the second time overlays the DRG entered with the first payment. However, if a DRG is entered with the first payment but no DRG is entered with the second payment, the original entry remains. Depending on the DRG entered, the DRG may or may not be reconciled. This is true for each bill that is updated by cash posting. Thus, it is possible that a log record may change from unreconciled to reconciled and vice versa.

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

```
                General Hospital Revise Log Account Processor
Log: KE KRIS' TEST LOG                         Mon Mar 27, 2012 10:40 am
Account      Name                FC Typ Admit     Disch     Balance      Loc
A03038-00002 ENGLISH,NEWGUAR     B  I/P 02/07/03 01/30/04  2898055.47  AR/FCRV
Carrier/Plan                           Log
300-CHAMPUS                            A LOG
 1 DRG Billed      2 DRG Paid       3 Liab Unreconciled  4 Days Unreconciled
                                       $14,240.00           Yes
  5 Billed DRG Reimbursement  6 Billed Reimbursement    7 Paid Reimbursement
    $185,501.03
  8 Estimated Payment      9 Payment Amount        10 Variance
    $185,501.03           $1.00                    $185,500.03
11 Outlier Billed       12 Outlier Paid         13 Remittance Number
    Cost
Medical Records View:                    Billed              Paid
   Operating DRG Amount                $16,340.59           $0.00
   Capital Amount                       $1,611.10           $0.00
   Operating Outlier                  $151,610.02           $0.00
   Capital Outlier                     $15,939.31           $0.00
   Add-On Technology Amount            $34,000.00           $0.00
Final DRG:


                     F6 Reset  F7  Exit   ?
```

Field Explanations

The selected patient account number and its associated patient name, financial class, patient type, admission and discharge dates, account balance, account location/sub location, carrier, plan, and log display at the top of the screen.

1. DRG BILLED (3-N-O)
This field contains the DRG code for the account at the time the account was billed. This field is loaded when the account is billed. If a DRG was not present at bill time, the user can enter the billed DRG code. The field displays the ICD indicator for the DRG, such as:

 470/9/M/29.0

 470/10/M/31.0

This is the DRG, the ICD version (9 or 10), the type (M-MS DRG, C-Classic DRG, O-Other DRG, T-TRICARE/Champus DRG, A-Reimbursed APR DRG), and the DRG version.

2. DRG PAID (3-N-O)
This field contains the DRG code paid by the carrier. This field is updated from cash posting when a payment is entered for the claim record and a paid DRG is entered.

3. LIAB UNRECONCILED (DISPLAY ONLY)

This field indicates whether there is a difference between the DRG Billed and the DRG Paid. The system compares the billed DRG and the paid DRG when cash is posted and when you access this screen. If they are not the same, the system displays Y for Yes in this field.

4. DAYS UNRECONCILED (DISPLAY ONLY)

This field indicates whether there are unreconciled patient stay days associated with this claim record. This field is loaded when cash is posted. The entry is calculated by comparing the days billed to the days paid. If these days are not the same, there are unreconciled days and the system displays Y for Yes in this field.

5. BILLED DRG REIMBURSEMENT (10-N-O)

This field contains the expected reimbursement amount for this carrier. The DRG reimbursement amount is loaded at the time of log creation. This field can also be updated manually. The entry range is 0 to $9,999,999.99.

6. BILLED REIMBURSEMENT (10-N-O)

This field contains the expected reimbursement amount for this carrier. The reimbursement amount is loaded at the time of log creation.

7. PAID REIMBURSEMENT (10-N-O)

This field contains the net amount of all insurance payments and deductibles paid on this claim record. The system loads this information from proration and cash posting. This field can also be updated manually. The entry range is 0 to $9,999,999.99.

8. ESTIMATED PAYMENT (10-N-O)

This field contains the amount of money expected from the carrier minus the deductible and coinsurance from the reimbursement amount.

9. PAYMENT AMOUNT (10-N-O)

This field contains the total insurance payments for the claim.

10. VARIANCE (10-N-O)

This field contains the dollar amount equaling the difference between estimated payment and payment amount.

11. OUTLIER BILLED (1-A-O)

This field contains the code identifying the outlier billed for this claim record (if any). This field is updated from DRG assignment in STAR Patient Care. Possible entries are **C** (cost) or **D** (day). Outlier codes are not reconciled and, therefore, this field is for memo purposes only. This field can be manually entered.

12. OUTLIER PAID (1-A-O)

This field contains the code identifying the outlier paid for this claim record (if any). This field is loaded when cash is posted. Possible entries are **C** (cost) or **D** (day). This field can be manually entered.

13. REMITTANCE NUMBER (25-C-O)
This field contains the remittance number (if available) for this payment. It is generally a check or remittance advice number.

When all fields are completed or reviewed, the system prompts you to accept or edit the information on the screen. The system then displays the following prompt:

View Reimbursement Detail? (Y/N) [Y]--

Enter **N** to complete the transaction. Enter **Y** to view the Reimbursement Detail. If you enter **Y**, the system displays the following information.

```
Medical Records View:                      Billed              Paid
   Operating DRG Amount                 $16,340.59            $0.00
   Capital Amount                        $1,611.10            $0.00
   Operating Outlier                   $151,610.02            $0.00
   Capital Outlier                      $15,939.31            $0.00
   Add-On Technology Amount             $34,000.00            $0.00
                         F6  Reset     F7   Exit
```

The billed information is retained in Medical Records. The paid information is not updated at this time, but you can enter it manually. Manually entered paid amounts are displayed in Log Inquiry and in the totals of the selected log reports (FLRx, where x is the facility indicator). For further information about field definitions under Reimbursement Detail, refer to the *Patient Care Medical Records Abstracting Reference Guide*.

Summary Charges

This function enables the user to review and edit summarized charges placed on the log at the time of billing. Charge data is copied from the charge information on the associated claim form. This screen is formatted according to the type of claim form produced. Once loaded, you can make any changes to the charge data in the log without affecting the original claim record on the patient account. Changes on these screens are reflected in the totals on the Log Record Maintenance screen for this account's log record.

For state-specific claims, summary charges are all considered to be covered. Any charges added using the Summary Charges function are considered ancillary charges. To update room and bed charges on state-specific claims, enter the amount in the column reflecting these charges.

The system displays the following screen for a UB claim.

```
          General Hospital Revise Log Account Processor
Log: CO COMMERCIAL                           Mon Mar 27, 2006 10:40 am
Account      Name                FC Typ Admit    Disch      Balance Loc
A9316600001  JONES,ANNE          C  O/P 06/15/01 06/15/01   1310.72 AR/FCRV
Carrier/Plan                        Log
901901-PRUCARE OF ATLANTA           CO COMMERCIAL

Seq  Rev HCP Error       Modifier  Serv Date  Units     Charges   Non Covered
     Description                    Column 49
1    270  C                                  5      741.00       0.00
     Medical/Surgical Supplies      TEST
2    450  D                                  1       43.00       0.00
     Emergency Room
3    480  C           80020                  2      135.00       0.00
     Cardiology
4    730  F           82057                  2      278.50       0.00
     EKG/ECG
5    985  C                                  1       58.54      58.54
     Professional Fees EKG
6    986  C                                  1       54.68      54.68
     Professional Fees EEG

   F1 Prev Page F2 Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Field Explanations

The patient account number selected and its associated patient name, financial class, patient type, admit and discharge dates, account balance, account location/sub location, carrier, plan, and log display at the top of the screen.

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

REV (REVENUE CODE) (3-N-R)
This field contains the UB revenue code for this line of information. You can enter a code or a hyphen (-) to display a list of valid codes.

HCP (HCPCS INDICATOR) (DISPLAY ONLY)
This field displays the HCPCS Procedure indicator, as set in the UB Charge Control Parameter, for the revenue code. Valid values are C (FIM/Charge), D (Both/Detail), F (Charge/Default Medical Records), M (Medical Records), N (None), O (Override), or S (Both/Summary). Charge lines that are entered directly into the Log Summary Charges screen will have a blank HCPCS indicator.

ERROR (DISPLAY ONLY)
This field indicates whether an error was detected for this item during claim edits. If an error was detected, one the following error messages is displayed:

• Proc Code - for a charge line with a procedure code error.

• Chg Summ - for a charge line with a charge summary error.

• Proc&Sum - for a charge line with both a procedure code error and a charge summary error.

MODIFIER (9-C-O)
This field contains the HCPCS Procedure codes that are charge related (from the FIM/ Charge) or procedure related (from Medical Records). It is also used for the room rate for room charges.

SERV DATE (SERVICE DATE) (8-C-O)
If the UB claim form is set to print by service date or service date within revenue code in the UB Charge Control Parameter, this field contains the service date for the charge line. If the UB claim form is set to print by UB revenue code, the service date for the charge line loads for revenue codes that have the Date field set to Yes or Use.

UNITS (7-N-O)
This field contains the units of service, which is a quantitative measure of services rendered by revenue category to or for the patient. The units field can print units of service, the true quantity on these charges, the number of visits (visits always equal 1 for the revenue category), or can be blank based on how the revenue category is set up in the UB Charge Control Parameters. Units can be items such as the number of accommodation days and the number of pints of blood.

CHARGES (9-N-0)
This field contains the total charge pertaining to this line of detail. Charges minus the non-covered charges determines the total covered charges on the Log Record Maintenance screen.

NOTE: If the total charges equal the total credits, the system omits this line from the UB claim form.

NON COVERED (9-N-O)
This field contains the amount of the charge line that is considered non-covered. Professional fees and summary code exceptions can be identified as non-covered in the Insurance Plan Coverage master. Duplicate HCPCS and ABN non-covered charges can also print in the Non Covered locator.

Updates to the Charges and the Non Covered fields are reflected in the Log Record Maintenance screen.

DESCRIPTION (24-C-O)
This field, which can be edited, displays the description of the related UB revenue code for this line of detail. The description varies depending on if the charge line prints in detail or in summary. If in detail, you get the description for that charge item. If it prints in summary, the UB revenue code description prints.

COLUMN 49 (4-C-O)
This field is not loaded by the system and therefore must be manually entered by the user if required. The value entered in this field prints in Locator 49 for the charge line. Locator 49 is an unlabeled field and is currently reserved for national use.

The system displays the following screen for a 1500 claim.

```
                General Hospital Revise Log Account Processor
Log: 30 MEDICARE PRO FEES                        Mon Mar 27, 2006 10:40 am
Account      Name                    FC Typ Admit    Disch      Balance Loc
90011-00010  WEIR,JONATHAN            M  E/R 01/11/90 01/11/90   3560.08 AR/FCRV
Carrier         Plan                    Log
201-MEDICARE    003-PRO FEES            30 MEDICARE PRO FEES
    Date of  Place  Proc   Diag                          Charge        Ser
Seq Service  Service Code   Code   Charge Description     Amount   UOS Typ
1   01/11/90   1           789.0  EEG SERVICE DESCRIPTIO   15.00    5   1




       F1 Prev Page F2 Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Field Explanations

The patient account number selected and its associated patient name, financial class, patient type, admit and discharge dates, account balance, account location/sub location, carrier, plan, and log display at the top of the screen.

SEQ (DISPLAY ONLY)
This field contains the number identifying the line entry on this screen. The numbers begin with one and increment as necessary. This field is changed through resequencing, adding, or deleting charge data.

DATE OF SERVICE (6-N-R)
This field contains the date on which the service was performed.

PLACE SERVICE (1-AN-R)
This field contains the place of service from the 1500 Charge Control Parameters. You can change the code or enter a hyphen (-) to display a list of valid codes.

PROC CODE (12-C-O)
This field contains the HCPCS code associated with the charge. This code is loaded initially from the patient's charge if the HCPCS code is present on the charge. You can enter the code or a hyphen (-) to display a list of valid HCPCS codes.

DIAG CODE (4-N-O)
This field contains the ordering diagnosis code for the charge line. You can enter the code or a hyphen (-) to display a list of valid diagnosis codes..

CHARGE DESCRIPTION (42-AN-O)
This field contains the charge description associated with the professional fee charges.

CHARGE AMOUNT (10-N-O)
This field contains the charge of the performed procedure.

UOS (3-N-O)
This field contains the units of service associated with the charges for this item.

SER TYP (1-AN-O)
This field contains the type of service that was performed. This field is updated if present on the patient charge record. You can also enter a value manually by entering the code or a hyphen (-) to display a list of valid codes.

NOTE: The system reflects any modifications you make to these fields in the Log Record Maintenance. Charges entered here are considered to be covered ancillary-type charges and, as such, are added to the Covered Anc Chgs field.

LOG INQUIRY

This transaction is identical in format to the Revise Log Account function with the addition of HCPCS procedures. Since HCPCS procedures are displayed from the medical record abstract and not copied to the log record, they cannot be revised through the Revise Log Account function. The HCPCS Procedures function enables you to inquire into HCPCS information via the third party log system. Unlike Revise Log Account, the information accessed through this transaction cannot be edited. All screen fields are display only.

NOTE: For accounts in history (purged accounts), only claims with an associated log record is displayed.

After you select the Log Inquiry function and select the account, through either the carrier or account option, the system displays the following screen:

```
                   General Hospital Log Inquiry Processor
Log: A Commercial                          Mon Mar 27, 2006 10:40 am
Account      Name                   FC Typ Admit    Disch       Balance Loc
9735200001   SMEDLEAN,AUGUSTUS      C  I/P 08/29/89 09/27/89     123.45 AR/FCRV
Carrier        Plan                 Log
20-LINCOLN NATI  0001-HBO & CO -    A Commercial

Log Edit Options


         Option No.  Option
         ---------------------------------------
            1        Log Demographics
            2        Log Record Inquiry
            3        Log Reconciliation
            4        Summary Charges
            5        HCPCS Procedures




Enter option number--   |
```

Please refer to Revise Log Account for information regarding the following functions:

• Log Demographics
• Log Record Inquiry
• Log Reconciliation
• Summary Charges

HCPCS Procedures

The following is an example of the Log Inquiry screen that is displayed when you select the HCPCS Procedures option. You can use this function to review detail information for HCPCS procedures.

```
                    General Hospital Log Inquiry Processor
                                          Fri Apr 09, 1999 01:07 pm
     Account No     Name                              Unit No        Corp No
     9735200001     SMEDLEAN,AUGUSTUS                 000001065      00001183
        Code  Description              Grp UB Rev Code          Amount
    (1) 10061 DRAINAGE OF SKIN ABSCESS   0   360-OR Services        $2.50
    (2) 00215 ANESTH, SKULL FRACTURE     1   270-Medical/Surgical $314.00
                                             Total  --            $316.50




   NEWLINE, or selection to view [NL]--
```

The screen lists each HCPCS procedure for the patient's account number, indicating the HCPCS code, the description, the ASC group number, the UB Revenue Code, and the estimated reimbursement amount. The total estimated reimbursement amount for all procedures for the account is also included.

Press ENTER to exit the screen, or enter the number to the left of the HCPCS procedure code for which you want to review detail.

If you select to view detail, the system displays the detail screen.

```
                    General Hospital Log Inquiry Processor
                                                    Fri Apr 09, 1999 01:21 pm
     Account No      Name                            Unit No         Corp No
     9735200001      SMEDLEAN,AUGUSTUS               000001065       00001183
  1 Epis Date & Time     2 Procedure Code                   3 Modifier
    02/17/99 06:57         10061-DRAINAGE OF SKIN ABSCESS      Entries Defined
  4 UB Revenue Code       5 ASC Group     6 Amount          7 Tissue Code
    360-OR Services          0              $5.00             DEGENERATION &
  8 Surgeon                              9 Specialty
    ADAIR,FRANK C                          NEP NEPHROLOGY
 10 Anesth Code          11 Anesth Start Time  12 Anesth End Time 13 Anesth Dura
    HALOTHANE               05:00                 06:00              60 minutes
 14 ASA-PS Class         15 Other Institution
    P1 NORMAL HEALTHY PT    11 REGIONAL HOSPITAL
 16 Epis Location        17 Epis End Date/Time          18 Episode Duration

 19 Rec Location         20 Rec Start Date/Time         21 Rec End Date/Time

 22 Procedure Team Information



 Enter view modifiers(M), team information(T) or enter to continue--
```

Field Explanations

1. EPIS DATE & TIME (DISPLAY ONLY)
This field displays the episode date and time associated with the procedure.

2. PROCEDURE CODE (DISPLAY ONLY)
This field displays the procedure code and description.

3. MODIFIER (DISPLAY ONLY))
This field accesses a subscreen that contains up to 5 modifier codes and descriptions.
If modifiers exist for this HCPCS code, the field displays *Entries Defined*. If no modifiers
have been associated with this HCPCS code, this field is blank. To view this
information, enter **M** at the prompt.

4. UB REVENUE CODE (DISPLAY ONLY)
This field displays the UB revenue code.

5. ASC GROUP (DISPLAY ONLY)
This field displays the ASC group code associated with the selected HCPCS code.

6. AMOUNT (DISPLAY ONLY)
This field displays the expected reimbursement amount for this procedure based on
the associated ASC group code and HCPCS payor code.

7. TISSUE CODE (DISPLAY ONLY)
This field identifies the pathological status of the tissue (if any) removed during this
procedure.

8. SURGEON (DISPLAY ONLY)
This field contains the primary surgeon for this procedure.

9. SPECIALTY (DISPLAY ONLY)
This field identifies the specialty associated with the surgeon.

10. ANESTH CODE (DISPLAY ONLY)
This field identifies the type of anesthesia used for this procedure.

11. ANESTH START TIME (DISPLAY ONLY)
This field contains the time the administration of the anesthesia began.

12. ANESTH END TIME (DISPLAY ONLY))
This field contains the time the administration of the anesthesia ended.

13. DURATION (DISPLAY ONLY)
This field displays the total duration time (in minutes) of the anesthesia.

14. ASA-PS CLASS (DISPLAY ONLY)
This field contains the ASA-PS Class associated with the Anesthesia code.

15. OTHER INSTITUTION (DISPLAY ONLY)
This field indicates if this procedure was performed at another institution during the patient's stay at your facility.

16. EPIS LOCATION (DISPLAY ONLY)
This field identifies the room/location where the procedure(s) was performed.

17. EPIS END DATE/TIME (DISPLAY ONLY)
This field identifies the date and time this episode ended.

18. EPIS DURATION (DISPLAY ONLY)
This field contains the number of minutes of this episode based on the difference between the Epis Date & Time and Epis End Date/Time fields.

19. REC LOCATION (DISPLAY ONLY)
This field identifies the room/location where the patient recovered from the procedure episode.

20. REC START DATE/TIME (DISPLAY ONLY)
This field identifies the date and time the recovery began.

21. REC END DATE/TIME (DISPLAY ONLY)
This field identifies the date and time the recovery ended.

22. PROCEDURE TEAM INFORMATION (DISPLAY ONLY)
This field accesses a scrolling screen that contains members of the procedure team. If team information exists for this procedure, this field displays *Entries Defined*. If no team

information has been associated with this procedure, this field is blank. To view this information, enter **T** at the prompt.

To view HCPCS modifiers, enter **M**. To view team information, enter **T**. To return to the summary screen, press ENTER.

If you enter **M**, the system displays a screen with up to five modifiers:

```
                    General Hospital Log Inquiry Processor
                                            Tue Apr 13, 1999 12:25 pm
     Account No      Name                            Unit No       Corp No
     9735200001      SMEDLEAN,AUGUSTUS               000001065     00001183
  1 HCPCS Modifier # 1                   2 HCPCS Modifier # 2
    32 MANDATED SERVICES                   20 MICROSURGERY
  3 HCPCS Modifier # 3                   4 HCPCS Modifier # 4
    21 PROLONGED EVAL/MGMT SERV            23 UNUSUAL ANESTHESIA
  5 HCPCS Modifier # 5
    24 UNRELATED EVAL/MGMT SERV




   Press NL--
```

Press ENTER to return to the detail screen.

If you enter **T**, the system displays a screen that shows the team information:

```
                  General Hospital Log Inquiry Processor
                                          Tue Apr 13, 1999 12:25 pm
     Account No      Name                          Unit No       Corp No
     9735200001      SMEDLEAN,AUGUSTUS             000001065     00001183
  1 Epis Date & Time    2 Procedure Code                    3 Suffix
    02/17/99 06:57        45.13-SM BOWEL ENDOSCOPY NEC
No       Procedure Team Member          Specialty            Type
1        ALEXANDER, RALPH               Surgical             CONSULTANT
2        FREEMAN,ROBERTA                Surgery Division      SURGICAL A




       Enter Doctor code or '-' for table, or name- for partial table--
                 F1Prev Page F2Next Page F7  Exit
```

You cannot edit while in this function.

To move to a previous page, press F1. To move to the next page, press F2. To return to the detail screen, press F7.

LOG REPORTS

This function enables you to define and generate reports on one, some or all log IDs established in the system. The first transaction enables the user to select a log ID and define reporting criteria. The second transaction generates the report.

After this function is selected, the system displays a menu with the following options:

• Report Selection (Define a report)

• Report Request (Print the report)

Defining a Report

After selecting the Report Selection option, the system prompts you to enter a facility code (if this is a multi-facility installation). The system then displays a list of log reports that currently are set up for printing but have not yet been requested for printing.

You can select one of these reports or add a new one. If no reports are defined, the system prompts you to define a report. After you make your selection, the system displays the following screen. This screen contains the log ID; user initials of the person who made the request; and the day, date, and time of the request.

```
                    General Hospital Report Selection Processor
                                              Wed Dec 13, 1989 04:02 pm

Page:01                        Current Report Selections
     Log Id                    User               Date
( 1) A                         MAS                Wed. Dec 13,1989 0948am
( 2) 2                         PAM                Tue. Dec 12,1989 0422pm













 Enter choice or `A` to add--
```

After you select an existing report or enter **A** to add a new report, the system displays the following screen:

```
                    General Hospital Report Selection Processor
                                           Fri Apr 1, 2009 12:54 pm

1 Log ID                 2 Pat Ind  3 Pat Type              4 Report Form
   CH CHAMPUS                 I         BED                     Detail
5 HCPCS    6 HCPCS Range          7 UB Rev Code Range
    Yes       Beginning thru Ending     All
8 Primary ICD Procedure   9 Paid/Unpaid?   10 Bill Type?   11 Late Charges?
  9/8311 ACHILLOTENOTOMY     Both             All              No

12 Primary Payor  13 Adjustment Detail? 14 Purge? 15 DRG Based 16 OPPS Based
  All        No            No     No        No
Reconciled/Unreconciled
17 DRG          18 DRG Reim Amt  19 Outlier     20 Days         21 OPPS Reim
   N/A            N/A            N/A            N/A              Both
22 Reim Amount  23 Liability    24 Payment     25 Reconciliation Allowance
   Both          Both           Both            5.00
                              Date Ranges
26 Bill Thru                        27 Remittance
   Earliest thru Latest

28 Discharge
   Earliest thru Latest




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

Field Explanations

1. LOG ID (2-AN-R)
This field contains the code representing the Log ID for which this report is being defined. A list of valid codes automatically is displayed. After you select a Log ID(s), the system completes fields 11 through 14 based on the reconciliation criteria defined in the log ID record. If more than one log request is selected, fields 11 through 14 default to both.

2. PAT IND (TABLE LOOKUP)
This field contains the patient indicator types that are included on this log report (Inpatient, Outpatient, Emergency Room, etc.). You make your selections from the displayed table.

3. PAT TYPE (TABLE LOOKUP)
This field displays the patient types that are valid for the patient indicators selected. Make your selections from the table displayed.

4. REPORT FORM (1-A-R)
This field contains the format that is used for the report. Entry options are **T** (Totals), **D** (Detail), **S** (Summary), **O** (OPPS), or **OT** (OPPS Total); the default is S.

5. HCPCS (1-A-R)

This field indicates whether the report should include patients with HCPCS Procedure codes. HCPCS codes are loaded from the patient's medical record abstract. Entry options are **Y** for Yes, **N** for No, or **O** for Only; the default is **Y**. If you enter **O**, the report includes only those accounts with HCPCS codes entered on their medical record abstract. If you enter **Y**, the report includes HCPCS and detail charge information. If you enter **N**, the report includes charge detail.

6. HCPCS RANGE (7-N-C)

This field identifies the range of HCPCS codes to include on the report. This field is accessible only if the Report Form is Detail and the response to the HCPCS field is Yes. When you access this field, the system displays the following prompt:

Enter starting HCPCS code [beginning of file]--

Enter up to seven numbers that the system should use to determine the first HCPCS code numerically to include on the report, or press ENTER to start with the first HCPCS code in the file. The system then displays:

Enter ending HCPCS code [end of file]--

Enter up to seven numbers that the system should use to determine the last HCPCS code numerically to include on the report, or press ENTER to include HCPCS codes to the last code in the file.

NOTE: The system only includes accounts on the report that have assigned HCPCS codes within the specified range. Selecting a range of codes can increase the run time for your report.

7. UB REV CODE RANGE (TABLE LOOKUP)

This field contains the range of UB revenue codes that should be included on the report. This field is accessible only if the Report Form is Detail. Make your selections from the table lookup.

8. PRIMARY ICD PROCEDURE (TABLE LOOKUP)

This field contains the primary ICD procedure code to report on. You can highlight the code(s) from the resulting table or enter the code(s) directly. You can also enter a range of codes.

When accessing the field, if the ICD-10 Effective Date on the Hospital Facility Options, Admission and General Parameters screen of STAR Patient Processing is today or a date in the past, the system prompts for ICD-9 or ICD-10 procedures. Before this date, the system assumes ICD-9. The system prompts:

Select ICD-9 (I) or ICD-10 (T) procedure (I/T) -

You can enter **I** to look up and enter one or more ICD-9-CM procedure codes, or enter **T** to look up and enter one or more ICD-10-PCS procedure codes.

- When entering I for ICD-9, the system prompts as follows:

  Enter one or more ICD-9-CM procedure codes, `U`ser procedure code, `-` for list, or beginning-ending ICD-9-CM procedure code--

- When entering T for ICD-10, the system prompts as follows:

  Enter one or more ICD-10-PCS procedure codes, `U`ser procedure code, `-` for list, or beginning-ending ICD-10-PCS procedure code--

  For UB claims (claim type X), the system first searches for the Principal Procedure in UB92 Locator 80, and in UB04 Locator 74. If the claim does not have a Principal Procedure Code, the system then looks for the Principal Procedure Code in Medical Records at the account level. All other claim types look for the Principal Procedure only in Medical Records at the account level.

  In order for the claim to appear on the Selected Log Report, the claim/account must have one of the entered Principal Procedure Codes, as well as the other entered criteria. If an ICD-9 procedure code is entered, the system searches UB claims only if the claim ICD indicator is 9, and searches in Medical Records only on the entered ICD-9 procedure codes. If an ICD-10 procedure code is entered, the system searches UB claims only if the claim ICD indicator is 10, and searches in Medical Records only on the entered ICD-10 procedure codes.

9. PAID/UNPAID? (1-A-R)
This field indicates whether the report contains paid accounts, unpaid accounts, or both. Entry options are **P** (paid), **U** (unpaid), or **B** (both); the default is **B**. If you enter **P**, the system prompts you to define a range of remittance dates to include on the report. If you enter **U** or **B**, you do not need to define remittance dates.

10. BILL TYPE (1-A-R)
This field indicates the bill types that are included on the report. Entry options are **C** (cycle), **F** (final), **L** (late), **R** (rebill), or **A** (all); the default is **A**.

11. LATE CHARGES? (1-A-R)
This field indicates whether late charge logs only are included on the report. Entry options are **Y** for Yes or **N** for No; the default is **N**.

12. PRIMARY PAYOR? (1-A-R)
This field indicates whether the system should include logs for the primary payor only on the report or include logs for all payors. Entry options are **O** (include only log records that have been set as primary payors in Log Demographics) or **A** (include all log records); the default is **A**.

13. ADJUSTMENT DETAIL? (1-A-R)
This field indicates whether the system should include the adjustment detail on the report. Entry options are **Y** (yes) or **N** (no). The default is **N**. If set to Yes, adjustments are broken out in the log by Transaction Code by each account, and in totals for an audit trail. If set to No, only the adjustment total is printed on the Log Summary Report.

14. PURGE? (1-A-O)
This field enables you to purge a selected group of log records by log ID. Entry options are **Y** for Yes or **N** for No; the system defaults to N. If you enter **Y**, any log selected for the report is purged when the report is printed. If you enter **Y**, the report is printed in detail format. (If summary format is selected, the field automatically changes to detail when the purge indicator is changed to Yes.) You must have an appropriate security level to access this field.

The Third Party Log Purge Summary report (FLRSLAP) provides a summary by log ID of the log records purged. This report does not contain detail information about purged logs. When logs are purged, the system also creates an FLR report containing detailed information about the purged log(s). To retain a hard copy of purged log information, print this FLR report after purging one or more logs.

NOTE: If you enter Earliest as a date selection criteria, the system selects accounts without a date. For example, if you enter Earliest for the discharge date, the system selects accounts without a discharge date. This selection could include accounts in PA with cycle bill log records. If you do not want these records to be included on the report and purged, you must enter a specific date in the Earliest criteria for the Bill Thru and Discharge fields.

15. DRG BASED PAYOR (1-A-R)
This field indicates the type of reimbursement for a particular log ID. Entry options are Y for Yes and N for No. If you enter **Y**, any person under 65 is displayed as disabled, and the aged or disabled field is displayed on log reports. The Reim Amount field cannot be accessed. If you enter **N**, the aged or disabled field does not display on log reports, and you cannot access the DRG, DRG Reim Amount, Outlier, and Days fields because the do not apply.

16. OPPS BASED (1-A-R)
This field indicates whether the log is OPPS-based. Entry options are Y for Yes or N for No. This field also controls access to the OPPS Reimb Amount field on this screen.

Reconciled/Unreconciled

Fields 17 through 23 determine the accounts of the selected log ID that are included on the report. These fields are initially completed with reconciliation requirements that were entered on the log ID master file. You can change each field so that your report includes the desired accounts. Since outlier codes are not indicated on the log ID, the Outlier field defaults to B.

17. DRG (1-A-R)
This field indicates whether the report includes accounts where the billed DRG differs from the paid DRG. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

18. DRG REIM AMOUNT (1-A-R)

This field indicates whether the report includes accounts where the billed DRG amount differs from the paid DRG amount. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

19. OUTLIER (1-A-R)

This field indicates whether the report includes accounts where the billed outlier code differs from the paid outlier code. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

20. DAYS (1-A-R)

This field indicates whether the reports includes accounts where the billed DRG days differs from the paid DRG days. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

21. OPPS REIMB (1-A-R)

This field indicates whether the report should select accounts based on the billed and paid OPPS amounts. It may be accessed only if the OPPS Based Payor field above is set to Yes. Entry options are R (Reconciled), U (Unreconciled) or B (print both reconciled and unreconciled on the report). The default is B.

22. REIM AMOUNT (1-A-R)

This field indicates whether the report includes accounts based on the reconciliation of reimbursement for a payor not DRG-based. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

23. LIABILITY (1-A-R)

This field indicates whether the report includes accounts where the carrier liability differs from the total payments and adjustments. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

24. PAYMENT (DISPLAY ONLY)

This field This field indicates whether the report includes accounts where billed versus paid. Entry options are R (reconciled), U (unreconciled), or B (both); the default is B.

25. RECONCILIATION ALLOWANCE (4-N-R)

This field contains the amount that the accounts can be off and still be considered reconciled. This field works in conjunction with the DRG Reim. Amount, Liability, and Payment fields. The maximum amount that you can enter in this field is $99.99. If you have entered a value in the Maintain Log ID, Reconciliation Allowance field for the log in question, this field automatically displays that value.

Date Ranges

Fields 26 through 28 determine the range of Bill Thru, Remittance, and Discharge dates of accounts in the selected log ID that are included on the report. If you enter earliest to latest (system defaults) or leave the fields blank, all accounts are included. For example, if you enter 12/01/95 through 12/15/95 as the discharge dates, only accounts within this range of dates are selected. If you leave the Discharge field blank

or enter earliest to latest, all accounts are selected, including those without a discharge date. If you enter multiple date ranges, an account must meet each date range criteria in order to be included on the report.

26. BILL THRU (12-N-O)
This field contains the bill through date for the accounts that are wanted on the report. For example, if the date entered here is 05/25/95, all accounts in this log ID with bills that cover billing periods through this date and meet the other report criteria are included. All accounts billed after this date are not included. Entry options are a range of dates, entered in the format MMDDYY or MM/DD/YY, or the default of the earliest billing date through the latest billing date for accounts included in this Log ID. If you enter the default, all accounts are selected because the Bill Thru date is not a criterion for the report.

27. REMITTANCE (12-N-O)
This field contains the carrier payment date for the accounts that are wanted on the report. For example, if the date entered here is 05/25/95, all accounts in this log ID that receive carrier payments on or before 05/25/95 and meet the other report criteria, are included. All accounts receiving carrier payments after this date are not included. Entry options are a range of dates, entered in the format MMDDYY or MM/DD/YY, or the default of the earliest remittance date through the latest remittance date for accounts included in this log ID. If you enter the default, all accounts are selected because the Remittance date is not a criterion for the report.

NOTE: This field can be accessed only if the entry in the Paid/Unpaid field is P.

28. DISCHARGE (12-N-O)
This field contains the patient discharge date for the accounts that are wanted on the report. For example, if the date entered here is 05/25/95, all accounts that have a discharge date on or before 05/25/95 and meet the other report criteria are included. All accounts with discharge dates after this date are not included. Entry options are a range of dates, entered in the format MMDDYY or MM/DD/YY, or the default of the earliest discharge date through the latest discharge date for accounts included in this log ID. If you enter the default, all accounts are selected because the Discharge date is not a criterion for the report.

When all fields are completed, you have the option of editing or accepting the information on the screen. Accepting the screen completes this transaction and enables you to enter report criteria for another Log ID or immediately process this report request.

NOTE: To delete an existing report, press only ENTER to the *Enter field number or '/ ' starting field number--* prompt when you first access the report. The system displays the following prompt:

> *Delete? (N)--*

Enter **Y** to delete the report. Enter **N** or press ENTER to keep the report on the system.

Processing A Report Request

This function is used to print all existing log report requests. If you want to request and print a single report request, you can do so through the Report Selection function. Accessing this function and then selecting a facility (if this is a multi-facility installation) immediately processes all existing report requests. After a report request has been processed, the report is removed from the list of current report selections.

Examples and descriptions of log reports can be found in the Third Party Log Reports section in the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide.*

MAINTAIN LOG ID

This option enables you to create, maintain and delete log IDs. A log ID is used to identify particular log records in the system. The hospital can establish many different logs for each carrier or carriers can share the same logs. Log IDs should be established according to the level of detail required for each carrier. For example, you might want to set up log IDs for Medicare inpatients and outpatients or have one log ID for all Medicare patients.

After this function is selected, the system prompts you to enter a facility (if this is a multi-facility installation) and the log ID code or a hyphen (-) to display a list of valid codes. The log ID is a two-character alphanumeric field. The log ID and description are required fields for initial setup. After a log ID code is entered or selected, the system displays this screen:

```
          General Hospital Log Reimbursement and Reconcil Processor
                                          Tue Sept 3, 2002 11:45 am

 1 Log ID Code        2 Description                    3 DRG Based Payor
   MC                   MEDICAID INPATIENT                 No
 4 OPPS Based Payor


                      Reconciled/Unreconciled

 5 DRG              6 DRG Reim Amount    7 OPPS Reim Amount   8 Outlier
   N/A                N/A                                      N/A
 9 Days            10 Reim Amount       11 Liability        12 Payment
   N/A                                     Reconciled

13 Reconciliation Allowance            14 Column 54          15 Column 56

16 Edit By                                  17 Edit Date
   Simmons,Lane                                02/25/92 1520




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

Field Explanations

1. LOG ID CODE (DISPLAY ONLY)
This field contains the code identifying the log ID. This log ID is required when you are entering a new log.

2. DESCRIPTION (30-C-R)
This field contains the description associated with the Log ID. This description is displayed on all inquiry and revision screens and prints on reports. If you are editing the description, you can enter two slashes (//) to display the existing description and then type any changes.

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3.   DRG BASED PAYOR (1-A-R)
This field indicates whether the log ID is a DRG based log. Entry options are **Y** for Yes or **N** for No; the default is **N**. If you enter **Y**, the Aged Flag field on the Log Selection Report is used to identify patients over 65 years old. This field also controls access to the DRG, DRG Reim Amount, Outlier, Days, Reim Amount, and Liability fields on this screen.

4. OPPS BASED PAYOR (1-A-R)
This field indicates whether the log is OPPS-based. Entry options are Y for yes or N for no. This field also controls access to the OPPS Reimb Amount field on this screen.

Fields 5 though 15 are used by the Log Reports process. When you create a log report request for this log, the system completes these fields on the Log Report Selection screen based on reconciliation requirements defined for the log ID. You can override these entries when you define your report criteria. The reconciliation flags on the Log ID screen do not control whether or not the log record is reconciled. Each log record is reconciled as the report is processed.

5. DRG (1-A-R)
This field indicates whether the report should select accounts based on the billed and paid DRG. It may be accessed only if the DRG Based Payor field above is set to Yes. Entry options are R (print reconciled DRGs on the report), U (print unreconciled DRGs on the report) or B (print both reconciled and unreconciled DRGs on the report). The default is B.

6. DRG REIM AMOUNT (1-A-R)
This field indicates whether the report should select accounts based on the billed and paid DRG amounts. It may be accessed only if the DRG Based Payor field above is set to Yes. Entry options are R (print reconciled DRGs on the report), U (print unreconciled DRGs on the report) or B (print both reconciled and unreconciled DRGs on the report). The default is B.

7. OPPS REIM AMOUNT (!-A-R)
This field indicates whether the report should select accounts based on the billed and paid OPPS amounts. It may be accessed only if the OPPS Based Payor field above is set to Yes. Entry options are R (print reconciled DRGs on the report), U (print unreconciled DRGs on the report) or B (print both reconciled and unreconciled DRGs on the report). The default is B.

8.   OUTLIER (1-A-R)
This field indicates whether the report should include reconciled, unreconciled or all outliers. Entry options are R (reconciled), U (unreconciled) or B (both). The default is both.

9.   DAYS (1-A-R)
This field indicates whether the report should select accounts based on the days billed and paid. Entry options are **R** (print reconciled days on the report), **U** (print unreconciled days on the report), or **B** (print both reconciled and unreconciled days on the report); the default is B.

10. REIM AMOUNT (1-A-R)
This field indicates whether the report should select accounts based on the billed and paid amounts. Entry options are **R** (print reconciled amounts on the report), **U** (print unreconciled amounts on the report), or **B** (print both reconciled and unreconciled amounts on the report); the default is B. This field is not applicable if the DRG based payor field is set to Yes.

11. LIABILITY (1-A-R)
This field indicates whether the report should select accounts based on the carrier's liability and payments and adjustments. Entry options are **R** (print reconciled liability, payments, and adjustments on the report), **U** (print unreconciled liability, payments, and adjustments on the report), or **B** (print both reconciled and unreconciled liability, payments, and adjustments on the report); the default is B.

12. PAYMENT (1-A-R)
This field indicates whether the report should include reconciled, unreconciled, or all payments. Enter options are **R** (reconciled), **U** (unreconciled), or **B** (both). The default is B.

13. RECONCILIATION ALLOWANCE (4-N-R)
This field contains the amount that the accounts can be off and still be considered reconciled. This field works in conjunction with the DRG Reim. Amount, Liability, and Payment fields. The maximum amount that you can enter in this field is $9.99.

14. COLUMN 54 (1-A-O)
This field indicates whether covered or non-covered charges for the claim are printed on the UB in column 54 for each line. Entry options are **C** (covered), **N** (non-covered), or **NL**. This field may be left blank for non-UB type claims. This log field is not used for the UB claim form.

Covered or non-covered charge information only prints for lines that print summary data.

15. COLUMN 56 (1-A-O)
This field indicates whether covered or non-covered charges for the claim are printed on the UB in column 56 for each line. Entry options are **C** (covered), **N** (non-covered), or **NL**. This field may be left blank for non-UB type claims. This log field is not used for the UB claim form.

Covered or non-covered charge information only prints for lines that print summary data.

NOTE: Proration is calculated based on proration summary codes and not on individual charge detail. Therefore, if the Charge Control Parameters specify that detail charge data and not summary data should be printed, column 56 is blank.

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

17. EDIT DATE (DISPLAY ONLY)
This field contains the date and time this log ID was last edited.

When all fields have been completed and edited, the system prompts you to accept or delete the log. Entry options are **Y** for Yes or **N** for No; the default is Y. If you enter Y, the Log ID is filed and the transaction is completed. If you enter **D**, the system prompts you to enter **F** (file) to delete the log.

NOTE: When you delete a log, the system files it. A deleted log can be reactivated at any time. You would enter the code of the Log ID and enter A to activate the log. The log ID appears again on the list of existing log IDs.

If a log is deleted, log records that remain with this log are still maintained in the system. You can access and report on these deleted logs by entering the specific log ID code. You must remember the code because deleted log ID codes are not displayed on the table lookup. Log records are not created for deleted log IDs.

DELETE LOG

This function enables the user to delete individual log records. This function is not used to delete or inactivate a log ID but it is used to delete individual account records. If you need to delete a log ID, you should use the Maintain Log ID function. Remember to remove deleted log IDs from the Insurance Plan Coverage for log IDs that are no longer used.

After you select this function, the system prompts you to enter or select a facility (if this is a multi-facility installation). Next, you are then prompted to enter a log ID code or a hyphen (-) to display a list of valid codes. The system then prompts you with the following question:

Delete Log by (A)ccount or (C)arrier--

If you enter **C**, the system displays a list of carriers and plans associated with this log ID. After you select a carrier/plan, the system displays a list of patients associated with the selected carrier/plan as shown below. The information on this list includes the carrier, plan, and log; patient account number; patient type; admission and discharge dates; account balance; and the patient name.

```
                General Hospital Revise Log Account Processor
Log: A Commercial                              Fri Dec 08, 1989 11:28 am
Carrier                 Plan                   Log
20-LINCOLN NATIONAL    0001-HBO & CO - MEDI    A Commercial
Page:01
     Account       Type  Admit    Disch        Balance Name
( 1) 89238-00007   OB  08/26/89              7,881.45 BARNETT,BABY GIRL
( 2) 89241-00011   I/P 08/29/89 09/27/89       75.45 BUTLER,BENJAMIN
( 3) 89243-00003   SDS 08/31/89 08/31/89        0.00 BYERS,RAYMOND
( 4) 89243-00015   I/P 08/31/89             10,731.67 MEYERS,DAVID A
( 5) 89285-00001   I/P 10/12/89 10/31/89    1,555.20 MEIGHER,MARK
( 6) 89313-00001   O/P 11/08/89 11/08/89        0.00 ANDERSON,TIMOTHY
( 7) 89248-00007   I/P 09/05/89 09/06/89        0.00 MCGRATH,MICHAEL
( 8) 89248-00007   I/P 09/05/89 09/06/89        0.00 SMITH,ROGER
( 9) 89226-00001   I/P 08/14/89           157,663.60 BARNES,MICHELLE
(10) 89319-00002   O/P 11/15/89 11/15/89        0.00 COLLINS,CHARLES
(11) 89319-00002   O/P 11/15/89 11/15/89        0.00 DUNCAN,DANIEL
(12) 89252-00001   I/P 09/09/89             7,277.50 BROOKS,ROBERT



Enter choice--
```

After you select an account, the system prompts you with the following message:

Are you sure you want to DELETE (Y/N) [N]--

If you enter **N**, the system returns to the list of carriers/plans for the selected log ID. If you enter **Y**, the system deletes the log record for the account and displays the following message:

DELETION IN PROGRESS

If you select the Delete Log by Account option, the system displays the FPI Lookup prompt. After you select an account, the system displays a list of carriers/plans associated with the log ID. After you select a carrier, if the account has insurance the system prompts you with the following message:

Are you sure you want to DELETE (Y/N) [N]--

If you enter **N**, the system returns you to the FPI Lookup prompt so you can select another account. If you enter **Y**, the system deletes the log record for the selected account and displays the following message:

DELETION IN PROGRESS

If the account has no insurance, the system displays an error message to this effect and returns you to the prompt where you enter or select the log ID.

NOTE: If you want to inactivate a log record without deleting it, you can do so by setting the Active field on the Log Demographics screen to **N** (no).

After you delete the log record, the system returns you to the FPI Lookup prompt so you can select another account. If you press ENTER, the system returns you to the prompt where you specify if you want to delete the log by account or carrier. If you press ENTER from this point, the system returns you to the prompt where you enter or select the log ID. Finally, if you again press ENTER, you exit the function and the system displays the Third Party Logs options.

The system prints deleted logs on the Deleted Logs report (FLRDEL) during Midnight Processing.

Chapter 5 - NOTES

OVERVIEW

This function enables users (billers, collectors, and other personnel) to create, edit, and view notes for accounts. Notes can be created for all accounts for a guarantor or you can choose the accounts that should receive the note. For example, a guarantor may have accounts for family members covered by commercial insurance while his own account is covered by Workers Compensation. The Notes function enables you to enter notes selectively for different account types. Notes can also be posted directly to a patient's account. These notes can be free-form or standard notes.

Standard notes are system-defined and contain a brief description of a particular account event. An example of a standard note could be *Sent claim - claim returned - wrong address.* Standard notes are assigned a transaction type of T and are recorded in the account's transaction history. The hospital can define any number of standard notes in the system.

Free-form notes are made up of two parts. The first part is a brief, one-line description of the contents of the note as summarized by the user. This line description can be used in the future to locate the note. The second part can be up to 13 lines of 75 characters. Here, you can fully describe the account event. Free-form notes are also recorded in the account transaction history using the transaction code specified in PA/AR Control. Access to and editing of free-form notes depends on the parameters established in the Biller/Collector Worklist Control table. For details on these parameters, refer to the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide.*

After you select this function, the system prompts you to select accounts by patient or guarantor. The screens that are subsequently displayed by the system are determined by this choice.

Patient Lookup

This option is normally used to enter a note directly on an account or to view existing notes on the account. After you enter **P** for patient lookup, the system prompts you to enter a facility code (is this is a multi-facility installation) and then prompts you with the FPI Lookup feature.

After you select an account, the system displays the following screen:

```
                General Hospital NEW NOTES [ALL TYPES] Processor
                                       Mon Mar 27, 2006 10:40 am
Account       Name                     FC Typ Admit    Disch      Balance Loc
89334-00001  HALL,RUTH A               C  I/P 11/25/89 11/30/89     60.00  AR/FCRV
Page:01                              Notes                  ##=Current Choices
( 1) BILLER NOTE 1/RFH                 11/30/89 [F] Smith,Mary A
( 2) WAITING FOR ATTACHMENTS - MR      11/30/89 [S] Smith,Mary A
( 3) FF BILLER NOTE FOR RAH            12/04/89 [F] Smith,Mary A
( 4) CLAIM RETURNED - WRONG ADDRESS    12/04/89 [S] Smith,Mary A
( 5) CREDIT CHECK REQUESTED            06/17/03 [F] Smith,Mary A
( 6) ADDRESS CHECK REQUESTED           06/17/03 [F] Smith,Mary A
( 7) ADDRESS/CREDIT CHECK REQUESTED    06/17/03 [F] Smith,Mary A




Enter choice, view all(V), add free form(F) or standard(S) notes--
                        end selection(NL)
```

Information displayed on this screen includes the patient account number, patient name, financial class, patient type, admit and discharge dates, account balance, and account location/sub location. Note information includes the note and description, the date it was assigned to this account, whether the note is free-form [F] or standard [S], and the name of the system user who assigned this standard or created this free-form note.

When this screen is displayed, you have several options:

• You can select a note or notes to view or edit. Only a free-form note can be edited and only by the original creator of the note. The Edit Notes field in the Biller/ Collector Worklist Control table must be set to Yes.

• You can view all account notes by entering **V** (view all). You can also edit the free-form notes. A free-form note can be edited only by its original creator. The Edit Notes field in the Biller/Collector Worklist Control table must be set to Yes.

• You can add a free-form note by entering **F** (free-form).

• You can add a standard note by entering **S** (standard).

You can view all or selected choices of notes. As the notes are displayed:

• You can press ENTER to take you to the next note.

• You can type **/P** to take you back to the previous note.

- You can type **/** to take you to the next note.

- You can enter **. ENTER** to exit the Note function.

NOTE: If note confidentiality has been activated, only users with a security code equal to or greater than the security attached to the free-form note have access to the note text. If you do not have the appropriate security, the note text is displayed as ****Account Note is Confidential****.

Adding a Standard Note

After you enter **S** (standard notes), the system prompts you to enter the transaction code used to record this note in the account transaction history. You can enter the code (up to four digits) or a hyphen (-) to display a list of valid codes. If you enter a hyphen (-), the system displays the following screen:

```
               General Hospital NEW NOTES [ALL TYPES] Processor
                                        Mon Mar 27, 2006 10:40 am
Account       Name                  FC Typ Admit    Disch      Balance Loc
89334-00001  HALL,RUTH A            C  I/P 11/25/89 11/30/89    60.00   AR/FCRV
   Transaction                            Valid          Combined to
   Type  Code  Description               Accts    Combine  Type  Code
( 1) T - 0007  SENT DATA MAILER           A/R
( 2) T - 0008  Telephone Follow Up        Any
( 3) T - 0010  SENT COLLECTION LETTER     A/R
( 4) T - 0011  SENT DETAILED STATEMENT    A/R
( 5) T - 0099  NOTES                      Any







 Enter choice--
```

Along with basic patient account data, information displayed includes the transaction type, transaction code, a description of the note, and the type of accounts for which this note is valid. The combine print function is not valid for this transaction type.

After you enter or select the transaction code, the note associated with the code is added to the account and the transaction is completed.

NOTE: Editing and confidentiality do not apply to standard notes.

Adding a Free-form Note

After you enter **F** (free-form notes), the system displays the following screen:

```
                General Hospital NEW NOTES [ALL TYPES] Processor
                                           Mon Mar 27, 2006 10:40 am
 Account       Name                    FC Typ Admit    Disch      Balance Loc
 89334-00001   HALL,RUTH A             C  I/P 11/25/89 11/30/89     60.00   AR/FCRV
  1 Code       2 Description                            3 Last Edit date
    NEW                                                   12/06/89  11:11am
  4 Created By                      5 Creation Date   6 Edit text?    7 Security
    Smith,Mary A                       12/06/89






 Press NL--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the word NEW in this field. Once the message is completed and accepted, the system assigns a code number. Each free-form note is assigned a code number corresponding to the order of its creation. The first note is 1, the second 2, and so on.

2. DESCRIPTION (30-C-R)
This field contains the description of the purpose of the note. This description is displayed in the account's transaction history and on the first screen of the Account Notes function.

3. LAST EDIT DATE (DISPLAY ONLY)
This field contains the date and time this note was last edited. When a new note is being created, the system displays the current date and time.

4. CREATED BY (DISPLAY ONLY)
This field contains the name of the user creating this note.

5. CREATION DATE (DISPLAY ONLY)
This field contains the date on which the note was created. This date is used as the note creation date in the account's transaction history and is displayed on the list of Account notes.

6. EDIT TEXT? (1-A-R)

This field indicates whether the length of a new free-form note exceeds the 30-character description. If it does, enter **Y**; if it does not, enter **N**. The default is **N**. If you enter **Y**, the system displays the following screen:

```
                 General Hospital NEW NOTES [ALL TYPES] Processor
                                           Mon Mar 27, 2006 10:40 am
 Account        Name                    FC Typ Admit    Disch       Balance Loc
 89334-00001  HALL,RUTH A               C  I/P 11/25/89 11/30/89      60.00    AR/FCRV
  1 Code       2 Description                           3 Last Edit date
     NEW                                                  12/06/89  11:11am
  4 Created By                   5 Creation Date   6 Edit text?    7 Security
     Smith,Mary A                    12/06/89
     ------------------------------------------------------------------------
 01| Patient's employer called to advise that insurance coverage is being   |
 02| terminated at end of month.  Patient notified and will make financial   |
 03| arrangements, if necessary, but anticipates being discharged prior to   |
 04| end of month.  Attending physician's office notified.                   |
 05|                                                                         |
 06|                                                                         |
 07|                                                                         |
 08|                                                                         |
 09|                                                                         |
 10|                                                                         |
 11|                                                                         |
 12|                                                                         |
 13|                                                                         |
    F1           F2          F3      F4    F5          F6          F7    F10
    Delete Line  Insert Line Center  Exit  Store Line  Restore Line Pack  Help
```

The function keys listed at the bottom of this screen are used to help you enter this message. Pressing **F4** exits the extended message text. The system then prompts you to accept the screen.

7. SECURITY (2-N-R)

This field contains the two-digit security code assigned to the note. This can be any number from 0 to 80. It defaults to the security level of the user entering the note. Since the security assigned to the note is changed only on an exception basis, the cursor does not automatically enter this field. You can access the field by entering a slash (/) and the field number. When you access this field, the prompt to enter the new security level of the note is displayed. Enter any security level from 0 to 80. If note confidentiality has been activated, only users with a security level equal to or greater than the security on the note may view the note text.

Editing a Free-form Note

A free-form note may be modified if the Edit Notes field in the Biller/Collector Worklist Control table is set to Yes. However, you can edit only the notes that you created. Select the note to be edited and then the Description, Edit Text?, or Security fields. Once all editing is completed, accepting the screen completes the transaction.

NOTE: Once you add a free-form or standard note to an account, you cannot delete the note. When the account is archived, the associated notes are also archived.

Guarantor Lookup

This option is used to enter notes on multiple accounts for the same guarantor. This enables the biller or collector to update notes on several accounts at the same time. If the guarantor has a large number of accounts, it may be necessary to select a portion of the accounts and then repeat the procedure since there is a system limit on the number of accounts that can be updated at one time. Notes are stored at the Account level. Notes cannot be viewed at the Guarantor level.

After you enter **G** (guarantor), the system displays the FPI Lookup prompt. After you select the guarantor, the system displays the following screen:

```
             General Hospital NEW NOTES [ALL TYPES] Processor
                                         Wed Jun 7, 2006 08:46 am
Corporate   Guarantor Name              Birthdate   Phone             PC
00002899    HALL,RUTH A                 03/17/54    (404)664-1532
Guarantor/Account - * Custom Sched, # Pymt Plan, @ Separate Schedule
Page:01           PRE, PA, AR, BD Guarantor Accounts      ##=Current Choices
      Account      Patient Name  PT  Disch    FC    Account  Patient Loc     P
( 1)  A9218100003  HALL,RUTH A   I/P           C    134.00     0.00 PA/FCRV
( 2)  A921810018   SMITH,RICHARD I/P 11/30/89  M    130.25   130.25 AR/FCRV  D




 Select account(s) or (A)ll--
                              end selection(NL)
```

Information displayed on this screen includes the corporate number, guarantor name, date of birth, and phone number. Information specific to the account includes the patient name, patient type, discharge date, financial class, account balance, patient balance, insurance balance, and account location/sub location.

You can select all accounts or specific accounts to add a note. After you select the account(s), the system prompts you to add a free-form or standard note. The procedure from this point is the same as the adding notes procedures documented in the adding and editing notes sections. Notes are stored at the Account level and cannot be viewed under the Guarantor lookup.

Chapter 6 - DRG PAYMENT WINDOW PROCESSOR

DRG PAYMENT WINDOW

The DRG Payment Window is used to combine charges due to the Medicare 72 hour rule (DPW). The DRG Payment Window Parameters enable you to define the criteria for selecting accounts for charge transfer and charge reporting involving DRG Payment Windows (DPW). DPW is a federal regulation that governs the relationships between an inpatient account and an outpatient account within certain time frames. The parameters are discussed in detail in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

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. When the DPW pair is established within a facility, the Patient Account system assists in ensuring that appropriate charges, originally placed on the outpatient account, are moved to the inpatient account because the patient was admitted to the hospital. When the DPW pair is established across facilities, it is reported. The DPW pair remains until one of the accounts is archived. If a DPW pair exists, inappropriate transactions such as Charge To/From, Combine Billing, Cross Facility Combine Billing, and Transfer Visit are not allowed. Likewise a potential DPW is reported but not established if a Charge To/From or Combine Billing relationship interferes.

This function enables you to do the following tasks related to DRG Payment Windows:

- Deactivate a DPW

- Change a DPW code

- Review and accept system-selected charges for transfer or manually select charges to transfer

- Reverse transferred charges

- Create a DPW

When you access this function, the system displays the following screen, listing all DPWs for the selected account:

```
              General Hospital DRG Payment Window Processor Processor
                                         Wed Jan 30, 2008 11:54 am
 Account        Name                 FC Typ Admit    Disch        Balance Loc
 C08029-00001 TEST,DRG               C  O/P 01/29/08 01/29/08       350.75 PA /INSR
                                                  Last Cycle Date:
 ------------------------------------------------------------------------------
    Account        To ICD          FC Type Admit    Disch         Balance Loc
    DPW/Status     From ICD                Suspense  # of Chgs    DPW Amount

 1  C0802900002    ICD-10          C   I/P  01/29/08                $2255.93  PA
    KEC/Active     ICD-10                             6              $126.98




 Select an account, (A)dd a DPW, or previous screen(/P)--
```

Field Explanations

ACCOUNT (DISPLAY ONLY)
This field displays the account number.

TO ICD/FROM ICD (DISPLAY)
The *To ICD* portion of this field displays the calculated To account's final bill ICD indicator at the time the DPW pair is established or updated. The *From ICD* portion displays the calculated From account's final bill ICD indicator at the time the DPW pair is established or updated. Valid values are ICD-9 and ICD-10.

If there is a mismatch between the coding methods on the TO (inpatient) account and any of the FROM accounts, the result is a DPW error that is reflected on the DRG Payment Window Report (FBR072x) with an ICD9/ICD10 Mismatch error. 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 can be manually removed on the Account Status screen within Account Revision.

FC (DISPLAY ONLY)
This field displays the financial class.

TYP (DISPLAY ONLY)
This field displays the patient type.

ADMIT (DISPLAY ONLY)
This field displays the admit date.

DISCH (DISPLAY ONLY)
This field displays the discharge date. This field may be blank if the patient is not discharged.

BALANCE (DISPLAY ONLY)
This field displays the account balance. This field may be blank if there are no charges.

LOC (DISPLAY ONLY)
This field displays the location and sub location of the account. The account location of a patient determines which sub locations are available. For more information about sub locations and their corresponding locations, see the McKesson-Maintained Information chapter of the *Tables, Masters and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

DPW CODE (DISPLAY ONLY)
This field displays the DRG Payment Window code for the DPW pair.

DPW STATUS (DISPLAY ONLY)
This field displays the DRG Payment Window status for the DPW pair. The status may be Active or Inactive.

SUSPENSE (DISPLAY ONLY)
This field displays the last date the account will be in suspense on the STAR Patient Care system. If this field is blank, the account has not been discharged.

 # OF CHARGES (DISPLAY ONLY)
This field displays the number of charges transferred, reported, and pending. This field may be blank.

DPW AMOUNT (DISPLAY ONLY)
This field displays the total amount of charges transferred, reported, and pending. This field may be blank.

When you select an account, the system displays the following screen:

```
          General Hospital DRG Payment Window Processor Processor
                                        Wed Mar 30, 2009 11:54 am
Account      Name                FC Typ Admit    Disch       Balance Loc
C08029-00001 TEST,DRG            C  O/P 01/29/08 01/29/08      350.75 PA /INSR
                                              Last Cycle Date:
-------------------------------------------------------------------------------
   Account            To ICD    FC Type Admit    Disch         Balance Loc
   DPW/Status         From ICD           Suspense  # of Chgs    DPW Amount
    C0802900002       ICD-10       C  I/P 01/29/08              $2255.93  PA
   KEC/Active         ICD-10                          6         $126.98
    Last Cycle Date  Billed Amount    Final Billed Amount      Unbilled Amount
                                                               $2255.93




(D)eactivate DPW, (C)hange DPW, (E)valuate Charges, (R)eview Charges, or
(P)review Combined Medical Info, (U)se adm dx's in Preview Comb Med Info--
```

LAST CYCLE DATE
This field displays the date of the last cycle bill for this account.

BILLED AMOUNT
This field displays the amount of charges that have been billed.

FINAL BILLED AMOUNT
This field displays the balance that was billed on the final bill.

UNBILLED AMOUNT
This field displays the balance that was billed on the final bill.

The system displays the following prompt:

> *(D)eactivate DPW, (C)hange DPW, (E)valuate Charges, (R)eview Charges, or*

> *(P)review Combined Medical Info--*

The options in this prompt are explained in the following pages.

Deactivating a DPW

You can use this option to deactivate a DPW when bills are denied or parameters are incorrect.

If you enter **D** to deactivate a window, the system stops checking for the DPW and the DPW Billing hold and displays the *DPW Deactivated* message. If you deactivate the

DPW, the system transfers the charges real-time. If you do not deactivate the DPW, the charges are reversed during midnight processing.

Changing a DPW

You can use this option to change a DPW.

NOTE: If the inpatient or outpatient account in the DPW pair was transferred to another patient, you cannot use this option. If you try to select the Change DPW option, the following error message is displayed:

DPW cannot be changed because the accounts are for different people. Internal numbers differ. Deactivate DPW. Press NL.

If you enter **C** to change a window, the system displays a list of potential DRG Payment Window Codes per the primary insurance for the first COB. Enter the number for the code you want. The system evaluates the two accounts to determine if they meet the preliminary criteria. If the accounts meet the preliminary criteria, the system changes the DPW code, logs a message in transaction history, and confirms the change with *DPW Changed*. If they do not meet the preliminary criteria, the system displays one of the following error messages:

Account [account number] is not an inpatient per Patient Accounting!

Account [account number] is not an outpatient per Patient Accounting!

Primary COB for inpatient account [account number] is not valid!

Primary COB for outpatient account [account number] is not valid!

Patient Type for inpatient account [account number] is not valid!

Patient Type for outpatient account [account number] is not valid!

Financial class for inpatient account [account number] is not valid!

Financial class for outpatient account [account number] is not valid!

Time frame is not valid!

Charge from on IP conflicts with DPW

Charge from on OP conflicts with DPW

Charge to on OP conflicts with DPW

Evaluating Charges on a Window

If you enter **E** to evaluate charges on a window, the system evaluates each charge according to the DPW parameters and transfers charges that meet the transfer charge criteria. The system displays the following prompt:

Charge Evaluation Completed

All other charges are marked pending, reported, excluded, or manual review. Charges with a status of report or manual review must be transferred through Charge Review.

NOTE: If the inpatient or outpatient account in the DPW pair was transferred to another patient, you cannot use this option. If you try to select the Evaluate Charges option, the following error message is displayed:

Evaluate Charges cannot be done because the accounts are for different people. Internal numbers differ. Deactivate DPW. Press NL.

Reviewing Charges

You can use this option to review charges for DPWs with reported, pending, and/or billed charges. You can also manually select charges or deselect system-marked charges individually. The following error messages may be displayed on the screen:

*   If the To (Inpatient) account does not match the From (Outpatient) account on the ICD indicator, based on the To account's calculated Final Bill ICD indicator, the screen may display the following error message: Charge evaluation cannot be done due to ICD9/ICD10 Mismatch. Press NL.

*   If the inpatient or outpatient account in the DPW pair was transferred to another patient, you cannot use this option. If you try to select the Review Charges option, the following error message is displayed:

Review Charges cannot be done because the accounts are for different people. Internal numbers differ. Deactivate DPW. Press NL.

If you enter **R** to review charges, the system displays the following prompt:

Use (I)npatient or (O)utpatient DPW account [O]--

If you enter **I** for inpatient account, the system displays the charges transferred for this DPW from the outpatient account to the inpatient account. For information about entering I, see "Inpatient Accounts" on page 6-11. Press ENTER to page down through the charges. The charges are pre-selected to be returned to the outpatient account.

If you enter **O** for outpatient account, the system displays charges on the outpatient account in the DPW time frame. For information about entering O, see "Outpatient Accounts" on page 6-12. Press ENTER to page down through the charges. Charges

in a pending, report, or billed status are pre-selected to move to the inpatient account.

```
          General Hospital DRG Payment Window Processor Processor
                                          Wed Mar 30, 2008 11:54 am
Account        Name              FC Typ Admit    Disch        Balance Loc
C08029-00001 TEST,DRG            C  O/P 01/29/08 01/29/08       0.00 PA /INSR

 1 DPW Code                                2 # of Chgs  3 DPW Amount
   KEC                                         0             $0.00
 4 No. Cycles     5 Billed Amount     6 Final Bill Amount    7 Unbilled Amount
                                                                $0.00
Chg# Dept Description           Rev/HCPCS  Svc Date Qty      Price  Qualify/Sts
   1 CAR   RHYTHM STRIP PROFESS  985/93042  01/29/08   1     $8.05    All/OATx
   2 CAR   ELECTRODES           480/00914 T01/29/08   1    $16.50    All/OATx
   3 CAR   RHYTHM STRIP PROFESS  985/93042 P01/29/08   1     $8.05    All/OATx
   4 EEG   EEG PRO FEE          986/95819 P01/29/08   1    $36.08    All/OATx
   5 CAR   RHYTHM STRIP         730/93015 T01/29/08   1    $50.25    All/OATx
   6 CAR   RHYTHM STRIP PROFESS  985/93042 P01/29/08   1     $8.05    All/OATx
   7 CAR   RHYTHM STRIP PROFESS  985/93042  01/29/08  -1     $8.05-   All/OARv
   8 CAR   ELECTRODES           480/00914 T01/29/08  -1    $16.50-   All/OARv
   9 CAR   RHYTHM STRIP PROFESS  985/93042 P01/29/08  -1     $8.05-   All/OARv
  10 EEG   EEG PRO FEE          986/95819 P01/29/08  -1    $36.08-   All/OARv


Enter NL to continue display
```

Field Explanations

1. DPW CODE (DISPLAY ONLY)
This field displays the DRG Payment Window code for the DPW.

2. # OF CHGS (DISPLAY ONLY)
This field displays the count for the number of charges transferred, reported, or pending. This field may be blank.

3. DPW AMOUNT (DISPLAY ONLY)
This field displays the total amount of charges transferred, reported or pending. This field may be blank.

4. NO. CYCLES (DISPLAY ONLY)
This field displays the number of cycle bills generated for this account.

5. BILLED AMOUNT (DISPLAY ONLY)
This field displays the amount of charges that have been billed.

6. FINAL BILL AMOUNT (DISPLAY ONLY)
This field displays the balance that was billed on the final bill.

7. UNBILLED AMOUNT (DISPLAY ONLY)
This field displays the amount of charges that have not been billed.

CHG # (DISPLAY ONLY)
This column displays the number of the charge.

DEPT (DISPLAY ONLY)
This column displays the department for the charge.

DESCRIPTION (DISPLAY ONLY)
This column displays the description of the charge.

REV/HCPCS (DISPLAY ONLY)
This column displays the revenue and the HCPCS code for the charge.

SVC DATE (DISPLAY ONLY)
This column displays the service date for the charge. The date is preceded by a T if the charge is the top of a pro fee chain, and it is preceded by a P if the charge is in a pro fee chain.

QTY (DISPLAY ONLY)
This column displays the quantity for the charge.

PRICE (DISPLAY ONLY)
This column displays the price for the charge.

QUALIFY/STS (DISPLAY ONLY)
This column displays the DPW group for the charge along with the DPW status of the charge. If this column is preceded by an asterisk (*), the charge is associated with a DPW other than the one being reported. Charges appear based on service date and the DPW time frame.

The DPW groups are

* All = All

* Diag = Evaluate Diagnostic

* NDiag = Evaluate Non-Diagnostic

DPW status codes are identified in the following table:

DPW Status Code	DPW Status
Pnd	Pending
NAdm	Not admission related
Rpt	Report
Bill	Billed
NTrx	Not transferred
Exc	Excluded
Man	Manual review

DPW Status Code	DPW Status
ATrx	Automatic transfer IP
MTrx	Manual transfer IP
OATx	Transferred to IP automatically
OMTx	Transferred to IP manually
OARv	Automatic reversal for transfer to IP
OMRv	Manual reversal for transfer to IP
IATx	Transferred to OP automatically
IMTx	Transferred to OP manually
IARv	Automatic reversal for transfer to OP
IMRv	Manual reversal for transfer to OP
OARt	Automatic return from IP
OMRt	Manual return from IP

Inpatient Accounts

When you reach the last page for an inpatient account, the system displays the following prompt:

> *Return (A)ll Chg or (S)elect chgs--*

If you enter **A**, the system displays the following prompt:

> *All inpatient charges returned*

If you enter **S**, the system displays the following screen and you can select and deselect charges individually. The list displays the charges transferred from the outpatient account that have not already been returned to the outpatient account.

```
Chg# Dept Description              Rev/HCPCS  Svc Date Qty     Price  Qualify/Sts
Page:01                                                      ##=Current Choices
( 1) CAR  HOLTER MONITOR/WMC     730/93015 T01/11/99   1     $30.00    All/ATrx
( 2) CAR  ECG 12 LEAD---------   480/00914 P01/11/99  20  $3,213.40    All/ATrx
( 3) CAR  HOLTER MONITOR/WMC     730/93015 P01/11/99   1     $30.00    All/ATrx
( 4) CAR  CARDIOLOGY CHARGE PA   480/00914  01/11/99   2      $0.00    All/ATrx
( 5) CAR  ECG 12 LEAD---------   480/00914 P01/11/99   2    $591.34    All/ATrx
( 6) CAR  ELECTRODES            2000/12345P01/11/99   2     $30.00    All/ATrx
( 7) CSR  CATHETER, ANGIOCATH    270/       01/11/99   2     $24.00    All/ATrx
( 8) EEG  CPAP                   740/95826  01/11/99   2  $1,300.00    All/ATrx
( 9) EEG  AUDIOLOGY BRAIN RESP   740/96410  01/11/99   2    $170.00    All/ATrx
(10) RAD  XR ABD SERIES W/PA C   324/25252 P01/11/99   2    $628.00    All/ATrx


Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
              end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

Enter the number for the choices you want to add or remove, and press ENTER twice. The system returns you to the following prompt:

Use (I)npatient or (O)utpatient DPW account [O]--

OUTPATIENT ACCOUNTS

A charge review cannot be done unless all charges have been evaluated. If charges exist in the DPW time frame without DPW status information, the system displays the following prompt:

Evaluate charge is needed to continue. Do it now? (Y/N)--

If you enter **Y**, the system performs the evaluation of charges and displays the following prompt:

Charge Evaluation Completed

If you enter **N**, the system returns you to the previous screen and the system evaluates the charges during midnight processing.

When you select outpatient accounts and you reach the last page for outpatient or all charges, the system displays the following prompt:

Accept (A)ll, (P)ending, (R)eported, (B)illed, or (S)elect chgs--

To accept all charges, enter **A**. The system displays the following prompt and transfers all pending and reported charges:

All outpatient charges accepted

To accept only pending charges, enter **P**. The system displays the following prompt and transfers charges with a system-assigned status of Pending:

Pending outpatient charges accepted

To accept only reported charges, enter **R**. The system displays the following prompt and transfers charges with a system-assigned status of Rpt:

Reported outpatient charges accepted

To accept only charges that have appeared on the outpatient bill, enter **B**. Note that for a series account the credit may not appear until the final bill. The system displays the following prompt and transfers charges with a system-assigned status of Bill:

Billed outpatient charges accepted

To accept only select charges, enter **S**.

If you enter **S**, the system displays the following screen and you can select and deselect charges individually. Charges with a status of pending, report, or billed are pre-selected to transfer to the inpatient account.

```
Chg# Dept Description             Rev/HCPCS   Svc Date Qty      Price  Qualify/Sts
Page:01                                                       ##=Current Choices
( 1) CAR  HOLTER MONITOR/WMC      730/93015 T01/11/99   1    $30.00     All/ATrx
( 2) CAR  ECG 12 LEAD---------    480/00914 P01/11/99  20 $3,213.40     All/ATrx
( 3) CAR  HOLTER MONITOR/WMC      730/93015 P01/11/99   1    $30.00     All/ATrx
( 4) CAR  CARDIOLOGY CHARGE PA    480/00914  01/11/99   2     $0.00     All/ATrx
( 5) CAR  ECG 12 LEAD---------    480/00914 P01/11/99   2   $591.34     All/ATrx
( 6) CAR  ELECTRODES             2000/12345P01/11/99    2    $30.00     All/ATrx
( 7) CSR  CATHETER, ANGIOCATH     270/       01/11/99   2    $24.00     All/ATrx
( 8) EEG  CPAP                    740/95826  01/11/99   2 $1,300.00     All/ATrx
( 9) EEG  AUDIOLOGY BRAIN RESP    740/96410  01/11/99   2   $170.00     All/ATrx
(10) RAD  XR ABD SERIES W/PA C    324/25252 P01/11/99   2   $628.00     All/ATrx


Enter choices (e.g. 1,7,5-9) or '-'choices to remove--
            end select(NL)  next pg(/ or PG DN)  Search(TAB)
```

Enter the number for the choices you want to add or remove, and press ENTER twice. The system debits and credits the charges and returns you to the following prompt:

> *Use (I)npatient or (O)utpatient DPW account [O]--*

Reviewing Combined Medical Information

You can use this option to preview combined medical information on linked accounts and combined UB diagnosis and procedure information. For details on reviewing this information, see "Previewing Combined Medical Information" on page 2-80 and "Use Admission Diagnoses in Preview" on page 2-84 of the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Output

The DRG Payment Window Report (FBR072) lists the DPW accounts and their transferred, pending, and reported charges as defined in the DRG Payment Window Parameters.

Adding a DPW

You can use this option to add a DPW when the inpatient is discharged before the date in the Effective Date field or if the system fails to create a DPW automatically.

If you enter **A** to add a DPW, the system displays the following prompt.

> *Select an account to add DPW or previous screen (/P)--*

If you enter **/P**, the system displays the previous screen.

If you enter the number for an account, the system displays the DRG Payment Window Codes. Enter the account number you want. The system displays the *DPW added* message.

The system evaluates the two accounts to determine if they meet the preliminary criteria. If the account is invalid, the system does not add the DPW.

If you enter an account that already has a DPW, the system displays the following prompt:

> *DPW exists. Review charges? (Y/N)--*

If you enter **Y**, the system returns you to the prompt for reviewing charges. For more information, see "Reviewing Charges" on page 6-8.

If you enter **N**, the system returns you to the following prompt:

> *Select an account, key `A` to add a DPW, or previous screen(/P)--*

DRG PAYMENT WINDOW WORKLIST

The DRG Payment Window Worklist enables you to perform the functions in the DRG Payment Window (DPW) function for DPWs for which one account is still in suspense or for DPWs that have charges in a report, pending, and/or billed status.

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

```
            General Hospital DRG Payment Window Worklist Processor
                                        Mon Jan 18, 1999 09:50 am

 SQ      Account          Name                       Admit    Discharge  Chg
 ( 1) +A9901100002    NELSON,SALLY                  01/11/99             Yes
 ( 2)  A9901500003    MOORE,LISA                    01/15/99             No
 ( 3)  A9901800001    MOORE,MARY                    01/18/99  01/18/99   Yes




 Enter choice--
```

Field Explanations

SQ (DISPLAY ONLY)
This field contains the sequential number identifying the items in the worklist.

ACCOUNT (DISPLAY ONLY)
This field displays the patient's account number.

NAME (DISPLAY ONLY)
This field displays the patient's name.

ADMIT (DISPLAY ONLY)
This field displays the admit date for the patient.

DISCHARGE (DISPLAY ONLY)
This field displays the discharge date for the patient if the patient has been discharged.

CHG (DISPLAY ONLY)
This field displays Yes or No. Yes indicates charges have been posted to the outpatient account today, or pending, report, or billed charges exist.

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Enter the number for the account you want to review. The system displays the following screen:

```
              General Hospital DRG Payment Window Worklist Processor
                                        Mon Mar 27, 2006 10:40 am


Account       Name                  FC Typ Admit    Disch      Balance Loc
C0910600002   TEST,ICDTEN           M  I/P 04/16/09 04/21/09    3984.30 PA /INSR
                                                    Last Cycle Date:
--------------------------------------------------------------------------------
   Account               To ICD      FC Type Admit    Disch       Balance Loc
   DPW/Status            From ICD            Suspense  # of Chgs    DPW Amount

1  C0900600001           ICD-10      M   SER 12/07/08 04/16/09     $2090.45  PA
   KEC/Active            ICD-9               04/18/09    0
2  C0910600001           ICD-10      M   SER 04/12/09 04/21/09      $893.27  PA
   KEC/Active            ICD-9               04/23/09    5         $1251.13

```

The fields are the same as those appearing on the DRG Payment Window Processor. Refer to the field explanations on page 6-4.

After you select an account, the system displays the following screen:

```
              General Hospital DRG Payment Window Worklist Processor
                                       Mon Mar 27, 2009 10:40 am
Account       Name                  FC Typ Admit    Disch      Balance Loc
A99-01500003 MOORE,LISA             C  IPC 01/15/99             5006.10 PA/FCRV
                                                   Last Cycle Date: 09/25/98
   --------------------------------------------------------------------------

   Account               To ICD      FC Type Admit    Disch       Balance Loc
   DPW/Status            From ICD            Suspense  # of Chgs    DPW Amount
    C0900600001          ICD-10      M   SER 12/07/08 04/16/09     $2090.45  PA
   KEC/Active            ICD-9               04/18/09    0
    Last Cycle Date  Billed Amount    Final Billed Amount    Unbilled Amount
                                                                   $2090.45




(D)eactivate DPW, (C)hange DPW, (E)valuate Charges, or (R)eview Charges--
```

The choices you can enter at the prompt are the same as for the DRG Payment Window function. For more information about this prompt, see the description on page 6-6.

The following table shows the page location for documentation about these options:

Option	Page Number
Deactivate DPW	6-6
Change DPW	6-7
Evaluate charges	6-8

Option	Page Number
Review charges	6-8

Output

The DRG Payment Window Report (FBR072) lists the DPW accounts and their transferred, pending, and reported charges as defined in the DRG Payment Window Parameters.

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Chapter 7 - CONTRACT ACCOUNT MANAGEMENT

OVERVIEW

The STAR Financials Patient Accounting system allows for the following options:

- Billing on contract accounts and their associated patient accounts.

- Modifying contract account information.

- Producing bills on a periodic basis.

- Posting of monetary transactions (cash and adjustments) necessary to update these accounts.

- Creating freeform and standard notes assisting in the collection of contract balances in the form of telephone workfiles and detail statements. Telephone workfiles is an option only if the Collector Workstation module is used.

- Posting of contractual adjustment automatically as part of the billing process.

- Creating an Aged Trial Balance (ATB) report.

The general flow of the contract account management process is:

1. A contract is entered into the system (Contact Names table on Patient Care).

2. The Contract Financial Information table is completed.

3. A patient is registered and linked to the contract (Patient Cares Contract Management Functions and Contract Registration menu options).

4. A charge is placed on the patient and/or on the contract.

5. The contract is billed based on the parameter specified in the Contract Names table or through the Demand Bill function.

6. An automatically generated contractual adjustment is created posting to the general ledger and contract balance. The calculation is based on one of three methods: charge level dollar amount, percentage write-off based on a specific SIM department, or an overall percentage applicable to any charge or SIM department not previously defined. The adjustment is linked to the specific bill.

7. ATB reports can be created to give a picture of where money is located and age of the receivable.

8. The collection process takes place using statements and/or telephone workfiles (only if the Collector Workstation module is used). Follow up is initiated via a demand follow up function or through a user defined schedule.

9. Cash or adjustment postings are made and linked to a specific bill which in turn affects the cumulative contract balance.

10. Notes are placed on the contract (not at a patient account level) documenting what is occurring with the contract.

The way the Contract Account Management module works is summarized below:

1. Cash and adjustments are posted to specific bills rather than to the cumulative contract balance. If a bill does not exist, the cash needs to be posted as unapplied cash. Once a bill exists corresponding with the unapplied cash, the cash can be applied.

2. The collection process has two methods. The first is to have the collection process completed on individual bill balances. The second theory is to collect on the cumulative contract balance which consist of multiple bills. This is identified through the Contract Financial Information table through the Multiple? field parameter setting. Changing this flag changes the follow up theory from one to the other. Completing the follow up process in the Multiple? field as No does not allow for a customization of a specific bill. The contract level schedule can also not be customized other than specifying a Next Follow up type and message through the Contact Follow Up menu option. On the other hand, having the collection process completed on individual bills does have more versatility. You can change collectors and schedules for specific bills. This revision does not alter the information for other contract bills. Follow up is only initiated on bill balances greater than $0.00 (for example, collections stop on credit or zero balances).

    When you change the collection process from bill level to contract level, the system assigns the next follow up step of one and the next follow up date as today plus the number of wait days per the schedule linked to the contract. You are expected to change the next follow up step and date to what is desired.

    When you change the collection process from a contract level to a bill level, the contract level step and date is transferred to all of the bills with a positive balance. Changing the follow up information, if needed, is a manual process.

3. The system does not automatically resequence the collection schedule step. This is a manual process performed by the collector. The reasoning behind this is the collection process on individual bills stops when paid in full or the last step is looped. If the collection process takes place on multiple bills, it would be difficult to identify how to resequence the next follow up step.

4. Telephone workfiles can only be used in the collection process if the Collector Workstation module is used. This applies in the creation of follow up schedules and in the demand follow up processes.

5. The contract lookup prompt is completed by knowing the contract code, contract description, or a patient account number. The patient lookup includes all patient

names matching the pattern designated by you. After a patient name is selected, the system only display patient account numbers for the persons selected if they are considered a contract patient account. If the patient account number lookup is used, the system verifies it is a contract patient account number. If it is not, a system error message displays. If it is, the system automatically locates the contract code the patient account number is associated with. This allows faster access to the contract or patient information.

6. It is a manual procedure to complete the Contract Financial Information screen on STAR Patient Accounting when a new Contract is entered through the Contract Names table. The Contract Financial Information table controls how the Patient Accounting system handles the contract.

The Contract Account Management function can have many uses. The most common use is the billing of patient related charges to a company such as drug testing or employee physicals. Another use of this function is maintaining information for services rendered such as snow removal, laundry services, or billing an attorney for a receivable on a lawsuit. Some of these services may be maintained manually by the accounting department. To use the system, a miscellaneous type contract level charge can be placed with a user entered dollar amount. After this point, the Contract Account Management function treats the contract as any other type.

Once a contract is established in the STAR Patient Care system, the contract account is considered active. Patients who are admitted through the Contract Registration function on the STAR Patient Care system are not assigned a patient indicator or account location. Contract patient accounts are not billed individually and these patients do not have individual financial data, such as financial class or biller. Cycle and final bills are automatically generated according to the billing criteria established in the STAR Patient Care Contract Names table. In addition, patients registered to the contract account are considered part of the contract and are included in any activity generated for the contract account.

Contract Patient Types can be subclassed as a Medical - Bill Patient. In this case, the patient is registered to the contract but the patient receives the bill as do non-contract patients. The Patient Classification Codes of Medical - Bill Client, Single Occurrence, Veterinary, Research, Environmental, and Proficiency bills charges to the contract.

A system parameter determines whether the Contract Management feature is available at your facility. If this parameter is not enabled, the STAR Patient Care system does not send charge or credit information for contract accounts to STAR Financials, which, in turn, does not generate contract account bills or inactivate any contract accounts. Contract accounts in STAR Patient Care continue to update STAR Financials, thus ensuring that the two systems maintain accurate data. If Contract Management is not currently active for your facility and you would like to begin using this feature, contact your McKesson representative.

When a patient is registered to a contract account, the system checks to determine if the patient has been admitted to the hospital previously. The MPI look-up procedure is

the same process used for regular patient admissions. As a result, some data may exist on a patient that is not needed for the contract registration. To avoid any confusion between existing patient accounts and contract account visits, it is not possible to view a contract patient account in either the Account Inquiry or Account Revision functions. If a contract patient account number is entered in either of these functions, or in any other patient-specific function, the system displays the following message:

> *This is a contract account - use Contract Account Inquiry.*

You should then exit the function and select the separate inquiry process that exists for contract accounts.

CONTRACT ACCOUNT INFORMATION

Select the Contract Account Information option from the STAR Financials Patient
Accounting main menu. The system displays the following submenu:

```
              General Hospital Contract Account Management Processor
                                          Wed Feb 21, 1996 09:33 am
  Contract Account Management Input Options

              Option No.  Option
              ---------------------------------------
                  1        Contract Account Information

                  2        Contract Charge Functions

                  3        Contract Notes
                  4        Contract Follow Up

                  5        Contract Account Bill Request
                  6        Contract Reports




  Enter option number--
```

NOTE: Option 2 is a STAR Patient Care function.

The Contract Account Information option allows you to view information about contract
accounts. This information includes transaction history, billing information, charge
detail, and contract patients.

Select the Contract Account Management option. The system prompts you to select a
facility if this is a multi-facility installation. The system then prompts you to:

*Enter contract code, `-` contract names,`*`patient name, `#`social security, or `*`account
number --*

You can enter the code if it is known. You can use a hyphen (-) to perform a table
lookup. After the you enter a hyphen, the system displays all contracts. A partial name
lookup is not accepted by the system and creates the following message *Error: Invalid
format for this field!*. Entries highlighted are those contracts which are active (in
location PA) while the un-highlighted contracts are inactive (in location AR).

You can also enter an asterisk (*) plus the patient name which is similar to the non-
contract patient lookup. All accounts matching the pattern identified is displayed. After
selecting a specific person, only contract patient account numbers for the person are
displayed and accessible. After selecting a specific patient account number, the
system identifies and uses the applicable contract information.

You can also enter a contract through a person's social security number (SSN). After
entering the # SSN, the system displays all contract patient account numbers. After

selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter an asterisk (*) plus a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract.

After you enter or select the code, the system displays the following screen:

```
         General Hospital Contract Account Information Processor
                                           Thu Feb 22, 1996 02:44 pm

Account ID        Code    Description                      Balance    Loc
A7703992640       MDK     MDk CONTRACT MGT                $3603.12      PA
 1 Cycle Bill Type        2 Cycle Bill Days    3 Suspense   4 Active Date
   End of Month             3                    999 Days     11/21/95
 5 No. Cycles  6 Last Cycle  7 Suppressed    8 Final Bill 9 Final Bill Amount
   5            12/06/95     12/31/95
10 Unbilled Charge Amount   11 Billed Charge Amount    12 Zero Balance
   $0.00                    $4,625.67
13 Last Payment  14 Total Payments     15 Last Adj.    16 Total Adjustments
   12/06/95         $201.00            12/06/95          $821.55-




Proceed to Transaction History(T) or Billing Information(B) --
          Charge Detail(D), Notes(N), or Contract Patients(P)
```

The information on the screen is display only. If you want to view any of the detail information relating to this contract account, select one of the options as indicated by the prompt.

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract. This field is an accumulation of bill balances and unbilled charges.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

1. CYCLE BILL TYPE (DISPLAY ONLY)
This field contains the type of cycle bill to be generated while the contract remains in location PA, which is defined for the contract in the STAR Patient Care Contract Names table (Contract Bill Type field). Access to this table is through the Patient Accounting system through the Tables and Table Maintenance menu options.

2. CYCLE BILL DAYS (DISPLAY ONLY)
This field contains the number of days or the day of the month used for generating cycle bills. This information is defined for the contract in the STAR Patient Care Contract Names table.

3. SUSPENSE (DISPLAY ONLY)
This field contains the number of suspense days for the final bill. This is the number of days of no activity that must be met before the system final bills the contract automatically. This information is defined for the contract on the STAR Patient Care Contract Names table.

4. ACTIVE DATE (DISPLAY ONLY)
This field contains the date on which the contract was activated.

5. NO. CYCLES (DISPLAY ONLY)
This field contains the number of cycle bills generated for this account.

6. LAST CYCLE (DISPLAY ONLY)
This field contains the date of the last cycle bill.

7. SUPPRESSED (DISPLAY ONLY)
This field contains the date in which the cycle bill was suppressed. If the last bill date created a cycle or final bill, this field is blank.

8. FINAL BILL (DISPLAY ONLY)
This field contains the final bill date.

9. FINAL BILL AMOUNT (DISPLAY ONLY)
This field contains the balance that was billed on the final bill.

10. UNBILLED CHARGE AMOUNT (DISPLAY ONLY)
This field contains the amount of charges that have not been billed.

11. BILLED CHARGE AMOUNT (DISPLAY ONLY)
This field contains the amount of charges that have been billed.

12. ZERO BALANCE (DISPLAY ONLY)
This field contains the date on which the account balance of the contract became zero.

13. LAST PAYMENT (DISPLAY ONLY)
This field contains the date on which the last payment was made on this contract.

14. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of payments made on this contract.

15. LAST ADJ (DISPLAY ONLY)
This field contains the date on which the last adjustment was made on this contract.

16. TOTAL ADJUSTMENTS (DISPLAY ONLY)
This field contains the total dollar amount of adjustments made on this contract.

Transaction History

If you select the transaction history option, the system displays the following prompt:

Search by posting date(P) or transaction type(T), or display all(A) [A]--

If you enter **P** (posting date), the system prompts you to enter begin and end search dates. If you enter **T** (transaction type), the system displays a table of transaction types from which you make your selections. If you want to display all components of the transaction history, press ENTER. Valid transaction types are adjustments (**A**), billing/claim (**B**), cash (**C**), memo (**M**), notes (**N**), and status transfer (**T**).

The system then displays a screen with the requested information like the one below, which is an example of all transactions.

```
          General Hospital Contract Account Information Processor
                                          Wed Jun 6, 1989 10:17 am
Account ID        Code    Description                     Balance    Loc
P12232234         WLI     WEBSTER LAB INC                 6358.44    PA
Trans Comment: Cycle Bill

Seq   Tran  Description            Tran      Post      Tran     Loc     Tran  Bat
Nbr   Code                        Date      Date      Amount           Type  Nbr
1     Y0001 CONTRACT BILL         09/17/90  09/17/90  1399.64  PA Bill
2     G0001 OTHER ADJUSTMENTS     08/30/90  08/30/90     5.00- PA Adj         61
3     Y0001 CONTRACT BILL         08/24/90  08/24/90     0.00  PA Bill
4     Y0001 CONTRACT BILL         08/23/90  08/23/90  3933.94  PA Bill
5     N0001 NON PATIENT CASH      08/22/90  08/22/90    10.00- PA Cash        89
6     N0001 NON PATIENT CASH      08/21/90  08/19/90    25.50- PA Cash        87
7     Y0001 CONTRACT BILL         08/17/90  08/17/90  1065.36  PA Bill




      F1 Prev Page F2 Next Page F5 View Detail Trans F6 Reset  F7  Exit   ?
```

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance of the contract.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

SEQ # (DISPLAY ONLY)
This field contains the number assigned by the system to the transaction event. These events are displayed in reverse chronological order.

TRAN CODE (DISPLAY ONLY)
This field contains the transaction type and code associated with the transaction.

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the transaction code.

TRAN DATE (DISPLAY ONLY)
This field contains the date on which the transaction was processed.

POST DATE (DISPLAY ONLY)
This field contains the date on which the transaction was posted.

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

LOC (DISPLAY ONLY)
This field contains the account location of the contract at the time the transaction occurred.

TRAN TYPE (DISPLAY ONLY)
This field contains the type of transaction.

BAT NBR (DISPLAY ONLY)
This field contains the batch number of the cash or adjustment transaction.

The function keys found at the bottom of the screen are defined below:

Key	Function
Arrow Keys	Use these keys to move to the line you want to view.
F1	Use this key to access a previous page of information.
F2	Use this function key to access the next page of information.
F5	Use this function key to view detailed information for a particular line.
F6	Use this function key to reset the displayed information.
F7	Use this function key to exit the screen.

You can view detailed information for a line by selecting the line, then pressing F5. The following screen is displayed:

```
                    General Hospital Contract Account Information Processor
                                                 Fri Nov 16, 2007 09:20 am
Account ID         Code    Description                        Balance      Loc
A1650              AAA     CONAA                              $1994.06       AR
 1 Trans Code/Description              2 Origin          3 Trans Date/Time
   N0001-CONTRACT CASH                   User              11/09/07 11:49am
 4 User ID                      5 Terminal Location    6 Bill Sequence
   New, Nany                          FIN                    1
 7 Prior Location               8 Prior Balance        9 New Balance
   AR                             $1,995.06               $1,994.06
10 Posting Date   11 Pay Date   12 Trans Amount        13 Batch Number
   11/09/07          11/09/07      $1.00-                  145
14 Status Type    15 Old Status  16 New Status   17 Note Type   18 Note Number

19 Remittance no
   365650
20 Comment



```

Field Explanations

1. TRANS CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the one-letter transaction type, four-digit transaction code number, and accompanying description associated with the transaction selected.

2. ORIGIN (DISPLAY ONLY)
This field indicates where the transaction originated, either System or User.

3. TRANS DATE/TIME (DISPLAY ONLY)
This field contains the date and time this transaction was entered or system-generated.

4. USER ID (DISPLAY ONLY)
This field contains the ID number of the person responsible for entering this transaction or System if it is system-generated.

5. TERMINAL LOCATION (DISPLAY ONLY)
This field contains the location of the terminal used to enter this transaction.

6. BILL SEQUENCE (DISPLAY ONLY)
This field displays the bill sequence number.

7. PRIOR LOCATION (DISPLAY ONLY)
This field indicates the account location and sub location of the account prior to entering the transaction. The account location of a patient determines which sub locations are available. For more information about sub locations and their corresponding locations, see the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

8. PRIOR BALANCE (DISPLAY ONLY)
This field contains this account's balance prior to entering the transaction.

9. NEW BALANCE (DISPLAY ONLY)
This field contains this account's balance after the transaction was entered.

10. POSTING DATE (DISPLAY ONLY)
This field contains the date the transaction was posted to the account's transaction history.

11. PAY DATE (DISPLAY ONLY)
This field contains the dollar amount paid.

12. TRANS AMOUNT (DISPLAY ONLY)
This field contains the dollar amount, if any, associated with this transaction.

13. BATCH NUMBER (DISPLAY ONLY)
This field contains the batch number for this transaction.

14. STATUS TYPE (DISPLAY ONLY)
If a status changes, this field records the type of change. For example, when an account is final billed, this field will display Account Loc indicating a change from Patient Accounting to Accounts Receivable. If you change a key field such as Medical Service, Financial Class, or Admitting and Attending Physician, the acronym for the name is displayed in this field.

15. OLD STATUS (DISPLAY ONLY)
This field contains the Old Status of the key field. For example, the old status field would display the name of the old admitting physician and the new status field would display the name of the new admitting physician. Another example would be if an account changed location from PA to AR or from AR to BD.

16. NEW STATUS (DISPLAY ONLY)
This field contains the new status of the key field. For example, the old status field would display the name of the old admitting physician and the new status field would display the name of the new admitting physician. Another example would be if an account changed location from PA to AR or from AR to BD.

If billing status changed, and there was a value in the field previously, the field displays one of the following statuses:

H   On Hold

E   Errors

D   DPW Hold

B   CPTAFB HOLD

F   Final bill Req

C   Cycle Bill Req

L   Late Bill Req

A   Adj Bill Req

R   Reprint Bill Req

The Comment field contains the new value and comment, such as: Changed to D-DPW bill hold.

If the field contains *Edit PA Chg,* charge information was changed in the STAR Patient Accounting data. The Old/New Status field contains both the previous HCPCS code and the new HCPCS code. The previous HCPCS can be the HCPCS from Order Management or it can be the STAR Patient Accounting HCPCS code previously edited. The HCPCS codes can be the same if other fields were edited in the STAR Patient Accounting charge.

The Comment field contains the SIM department and SIM code followed by the list of fields changed. If the transaction was created due to a charge revision, *-OM Rev* is displayed at the end of the Comment field.

17. NOTE TYPE (DISPLAY ONLY)
This field displays Guar Acct, indicating a note was added either on the guarantor or the account. The sequence number assigned with the note is also displayed.

18. NOTE NUMBER (DISPLAY ONLY)
This field displays the sequence number assigned to the note on the account.

19. REMITTANCE NUMBER (DISPLAY ONLY)
This field contains the remittance advice number for this transaction.

20. COMMENT (DISPLAY ONLY)
This field contains any comments associated with this transaction.

Billing Information

If you select the Billing Information option, the system displays a table at the bottom of the Contract Account Information screen that lists billing information for this contract. This information is presented in the following format:

```
                                        Billing Information
   Option              Number         Billed      From      Thru       Balance
 ────────────────────────────────
    ( 1) Cycle          3             08/17/95   08/08/95   08/17/95     52.71
    ( 2) Cycle          2             08/22/95   08/18/95   08/22/95       .00
    ( 3) Cycle          1             09/15/95   08/23/95   09/15/95     10.00
Enter choice--
```

After you select one of the options, the system displays the following screen:

```
        General Hospital Contract Account Information Processor
                                      Wed Jan 17, 1996 03:13 pm
Account ID       Code    Description                     Balance      Loc
A852369741       MLK1    MLK1 CONTRACT MGT ONE          $124010.99     PA
1 Bill Sequence  2 Bill Date   3 Bill Type        4 Biller
  4              01/15/96      Cycle
5 Selection          6 Billed From     7 Billed Thru    8 Amount Due
  Single Request       12/07/95          01/15/96         $124,010.99
9 New Charges Billed   10 Payments      11 Adjustments   12 Bill Balance




Review charges for this bill sequence? (Y/N) [N] --
```

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

1. BILL SEQUENCE (DISPLAY ONLY)
This field contains the sequence number of the bill selected.

2. BILL DATE (DISPLAY ONLY)
This field contains the date on which the bill was produced.

3. BILL TYPE (DISPLAY ONLY)
This field contains the bill type, which is either cycle or final.

4. BILLER (DISPLAY ONLY)
This field contains the biller assigned to this contract. At the present time, this field is blank.

5. SELECTION (DISPLAY ONLY)
This field contains the selection criteria used to select the contract for billing, as defined on the STAR Patient Care Contract Names table.

6. BILLED FROM (DISPLAY ONLY)
This field contains the beginning date of charges that are included on this bill.

7. BILLED THRU (DISPLAY ONLY)
This field contains the ending date of charges that are included on this bill.

8. AMOUNT DUE (DISPLAY ONLY)
This field contains the contract balance at the time the bill was produced.

9. NEW CHARGES BILLED (DISPLAY ONLY)
This field contains the contract of charges billed for the specific bill prior to the automatic contractual adjustment calculation which is part of the billing process.

10. PAYMENTS (DISPLAY ONLY)
This field contains the accumulated amount of payments made on the specific bill selected.

11. ADJUSTMENTS (DISPLAY ONLY)
This field contains the accumulated amount of adjustments made on the specific bill selected. This field contains the automatically calculated contractual adjustment at the time of billing as well as adjustments made by you.

12. BILL BALANCE (DISPLAY ONLY)
This field contains the balance remaining on the bill. It represents the gross charge amount less payments and adjustments.

After you enter the fields the following prompt displays:

Review charges for this bill sequence? (Y/N) [N] --

Enter **N** for No if you do not want to review charges for the bill sequence. The default is No. Enter **Y** for Yes if you want to review charges for the bill sequence. After you enter Yes, a screen similar to below displays.

```
            General Hospital Contract Account Information Processor
                             Wed Jan 17, 1996 03:29 pm
Account ID        Code    Description                      Balance      Loc
A7703992640       MDK     MDK CONTRACT MGT                 $3603.12     PA
 1 Bill Sequence  2 Bill Date   3 Bill Type          4 Biller
   3              11/29/95      Cycle
 5 Selection          6 Billed From    7 Billed Thru    8 Amount Due
   Single Request       11/23/95        11/29/95         $3,360.49
 9 New Charges Billed  10 Payments     11 Adjustments   12 Bill Balance
   $860.20               $51.00         $77.35-          $731.85


Page:01                     Charge Summary [Dim = Unbilled]    ##=Current Choices
      SIM  Dept Charge Description   Chg Date     Charge  Write Off Net Charge
( 1) 5900 ST   DYSPHAGIA ASSESSMENT 11/29/95      71.40      6.42      64.98
( 2) 5900 ST   DYSPHAGIA ASSESSMENT 11/29/95      71.40      6.42      64.98
( 3) 5900 ST   DYSPHAGIA ASSESSMENT 11/29/95      71.40      6.42      64.98
( 4) 5907 ST   LANG LEARNING EVAL   11/29/95      17.00      1.53      15.47
( 5) 5900 ST   DYSPHAGIA ASSESSMENT 11/29/95      71.40      6.42      64.98
( 6) 5905 ST   SPCH/LANG CONSULT    11/29/95      15.80      1.42      14.38
( 7) 5904 ST   SPCH/LANG EVALUATION 11/29/95      16.20      1.46      14.74
( 8) 9999 ST   SPCH/LANG MISCELLEAN 11/29/95      50.00      4.50      45.50

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

Field Explanations

SIM (DISPLAY ONLY)
This represents the SIM item of the charge.

DEPT (DISPLAY ONLY)
This represents the SIM department applicable to the specific charge.

CHARGE DESCRIPTION (DISPLAY ONLY)
This field displays the charge description from the Financial Item Master (FIM).

CHARGE DATE (DISPLAY ONLY)
This field represents the date the charge was entered on the contract or the patient account.

CHARGE (DISPLAY ONLY)
This field represents the charge that was entered on the contract or the patient account.

WRITE OFF (DISPLAY ONLY)
This field displays the contractual adjustment write off as calculated at the time of billing.

NET CHARGE (DISPLAY ONLY)
This field represents the amount actually charged to the contract. It represents the gross charge amount less the automatically calculated contractual adjustment at time of billing.

When you select a charge to review, a screen similar to below displays:

```
             General Hospital Contract Account Information Processor
                             Wed Jan 17, 1996 03:50 pm
 Account ID        Code    Description                        Balance     Loc
 A852369741        MLK1    MLK1 CONTRACT MGT ONE             $124010.99    PA
  1 Service Date    2 Post Date      3 SIM Item
    12/06/95          12/06/95         224-GAUZE, SPONGE 4 X 3 STERILE P
  4 Quantity  5 Charge/CR Amt  6 Write Off Amt  7 Type of Unit
    10          $6.00            $0.48
  8 Room #          9 Bed #         10 Accommodation

 11 Charge Type     12 Late Charge     13 Patient
    Ancillary                            KASS,CONTRACT TWO   9534000005
 14 Statistics                        15 UB Code
    Yes                                  270-Medical/Surgical Supplies
 16 Order #                           17 Ordering Physician
    8                                    3232 CASPER,DAVID
 18 Servicing Physician                      19 From CRT   20 Initials
                                               OP1            MLK



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

Charge Detail

If you select the Charge Detail option, the system displays the following prompt:

Review (P)atient charges, (C)ontract charges, or (A)ll charges? --

Enter **P** for patient charges. When you enter **P** for patient charges the following prompt displays:

Enter `*`patient name, `#`social security, or `*`account number --

You can also enter an asterisk (*) plus the patient name which is similar to the non-contract patient lookup. All accounts matching the pattern identified is displayed. After selecting a specific person, only contract patient account numbers associated with the previously selected contract for the person are displayed and accessible. After selecting a specific patient account number, the system identifies and uses the applicable contract information. If you select someone who does not have associated contract accounts, you will receive an error message.

You can also enter a contract through a persons social security number (SSN). After entering the # SSN, the system displays all contract patient account numbers associated with the previously selected contract. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter an asterisk (*) plus a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract. The patient number must be associated with the contract code previously selected.

Enter **C** for contract charges.

Enter **A** for all charges. The system displays the following table:

```
                         Charge Service Dates
              _____
( 1) 10/04/95
( 2) 09/11/95
( 3) 08/23/95
( 4) 08/21/95
( 5) 08/17/95
( 6) 08/10/95
( 7) 08/09/95
Select service date to begin--
```

After you select the patient charge, contract charge, or charge service date, the system displays the associated charges. Following is an example of the Contract Charges screen.

```
         General Hospital Contract Account Information Processor
                                         Wed Mar 10, 1996 09:21 am
Account ID       Code    Description                       Balance     Loc
P12232234        WLI     WEBSTER LAB INC                   $6358.44     PA
 1 Cycle Bill Type        2 Cycle Bill Days    3 Suspense    4 Active Date
   Fixed Day of Month        13                  999 Days      11/21/95
 5 No. Cycles  6 Last Cycle  7 Suppressed    8 Final Bill  9 Final Bill Amount
   8             02/13/96
10 Unbilled Charge Amount   11 Billed Charge Amount    12 Zero Balance
   $682.50-               $4,687.07
13 Last Payment  14 Total Payments      15 Last Adj.    16 Total Adjustments
   02/01/96        $1,201.00            02/13/96         $827.07-


Page:01                  Charge Summary [Dim = Unbilled]     ##=Current Choices
     SIM  Dept Charge Description   Chg Date     Charge  Write Off Net Charge
( 1) 3120 EEG  24 HOUR AMBULATORY E 02/14/96      607.00       .00     607.00
( 2) 3125 EEG  24 HR EEG / VIDEO--- 02/14/96      682.50       .00     682.50
( 3) 3120 EEG  24 HOUR AMBULATORY E 02/14/96      607.00-      .00     607.00-
( 4) 3125 EEG  24 HR EEG / VIDEO--- 02/14/96      682.50-      .00     682.50-
( 5) 3125 EEG  24 HR EEG / VIDEO--- 02/14/96      682.50-      .00     682.50-

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

The system displays information associated with the selected patient charge, contract charge, or charge service date and prompts you to select one or more items.

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract.

LOC (DISPLAY ONLY)
This field contains the account location of the contract.

1. CYCLE BILL TYPE (DISPLAY ONLY)
This field contains the type of cycle bill to be generated while the contract remains in location PA, which is defined for the contract in the STAR Patient Care Contract Names table.

2. CYCLE BILL DAYS (DISPLAY ONLY)
This field contains the number of days or the day of the month used for generating cycle bills. This information is defined on the STAR Patient Care Contract Names table.

3. SUSPENSE (DISPLAY ONLY)
This field contains the number of suspense days for the final bill. This is the number of days of no activity that must be met before the system final bills the contract. This information is defined for the contract on the STAR Patient Care Contract Names table.

4. ACTIVE DATE (DISPLAY ONLY)
This field contains the date on which the contract was activated.

5. NO. CYCLES (DISPLAY ONLY)
This field contains the number of cycle bills generated for this account.

6. LAST CYCLE (DISPLAY ONLY)
This field contains the date of the last cycle bill.

7. FINAL BILL (DISPLAY ONLY)
This field contains the final bill date.

8. FINAL BILL AMOUNT (DISPLAY ONLY)
This field contains the balance that was billed on the final bill.

9. UNBILLED CHARGE AMOUNT (DISPLAY ONLY)
This field contains the amount of charges that have not been billed.

10. BILLED CHARGE AMOUNT (DISPLAY ONLY)
This field contains the amount of charges that have been billed.

11. ZERO BALANCE (DISPLAY ONLY)
This field contains the date on which the account balance of the contract became zero.

12. LAST PAYMENT (DISPLAY ONLY)
This field contains the date on which the last payment was made on this contract.

13. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of payments made on this contract.

14. LAST ADJ (DISPLAY ONLY)
This field contains the date on which the last adjustment was made on this contract.

15. TOTAL ADJUSTMENTS (DISPLAY ONLY)
This field contains the total dollar amount of adjustments made on this contract.

CHG # (DISPLAY ONLY)
This field contains the number assigned to the charge at the time it was entered.

SIM DEPT (DISPLAY ONLY)
This field contains the SIM department associated with this charge.

CHARGE DESCRIPTION (DISPLAY ONLY)
This field contains the charge description associated with the SIM item.

CHG DATE (DISPLAY ONLY)
This field contains the date on which the charge was provided.

CHARGE (DISPLAY ONLY)
This field contains the amount charged to the contract.

WRITE OFF (DISPLAY ONLY)
This field displays the amount calculated as the contractual adjustment at the time of billing.

NET CHARGE (DISPLAY ONLY)
This field contains the net amount of the charge.

After you select the charge item(s), the system displays the following screen:

```
              General Hospital Contract Account Information Processor
                                            Wed Oct 10, 1990 09:21 am
Account ID          Code    Description                        Balance      Loc
P12232234           WLI     WEBSTER LAB INC                    $6358.44     PA
 1 Service Date      2 Post Date      3 SIM Item
   08/09/90            08/09/90         9420-VALPORIC ACID
 4 Quantity          5 Charge/CR Amt  6 Write Off Amt  7 Type of Unit
   3                   $80.25
 8 Room #            9 Bed #          10 Accommodation

11 Charge Type      12 Late Charge    13 Patient
   Ancillary
14 Statistics                         15 UB82 Code
   Yes                                   300-LABORATORY OR LAB
16 Order #                            17 Ordering Physician
   1                                     689 ALMENDINGER,HERBERT WILLIS
18 Servicing Physician                       19 From CRT   20 Initials
                                                OP1            WLI



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

Field Explanations

1. SERVICE DATE (DISPLAY ONLY)
This field contains the date on which the service was provided.

2. POST DATE (DISPLAY ONLY)
This field contains the date on which the charge was posted to the contract.

3. SIM ITEM (DISPLAY ONLY)
This field contains the SIM item number and description.

4. QUANTITY (DISPLAY ONLY)
This field contains the quantity of the item ordered for which the contract is charged.

5. CHARGE/CR AMT (DISPLAY ONLY)
This field contains the amount charged for the item.

6. WRITE OFF AMT (DISPLAY ONLY)
This field displays the amount calculated as the contractual adjustment at the time of billing.

7. TYPE OF UNIT (DISPLAY ONLY)
This field contains the type of unit on which the patient assigned to the contract is located (if the patient was occupying a bed when the item was charged).

8. ROOM # (DISPLAY ONLY)
This field contains the patient's room number (if the patient assigned to the contract was occupying a bed when the item was charged).

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9. BED # (DISPLAY ONLY)
This field contains the patient's bed number (if the patient assigned to the contract was occupying a bed when the item was charged).

10. ACCOMMODATION (DISPLAY ONLY)
This field contains the patient's room type (if the patient assigned to the contract was occupying a bed when the item was charged).

11. CHARGE TYPE (DISPLAY ONLY)
This field contains the charge type. Valid charge types are room and bed, ancillary, or professional fee.

12. LATE CHARGE (DISPLAY ONLY)
This field contains Yes if the charge is a late charge. A late charge is one entered on the contract after the final bill was generated.

13. PATIENT (DISPLAY ONLY)
This field contains the name of the patient if this charge was entered as a patient charge for the contract.

14. STATISTICS (DISPLAY ONLY)
This field indicates whether the charge updates statistics.

15. UB82/92 CODE (DISPLAY ONLY)
This field contains the UB-82/92 revenue code associated with the item charged to the contract.

16. ORDER # (DISPLAY ONLY)
This field contains the order number for the item charged to the contract.

17. ORDERING PHYSICIAN (DISPLAY ONLY)
This field contains the name and number of the physician who ordered this item. If this charge was entered directly on the contract (that is, not patient-specific), the ordering physician is the physician entered on the STAR Patient Care Contract Names table as the contract physician.

18. SERVICING PHYSICIAN (DISPLAY ONLY)
This field contains the name and number of the physician who interpreted the results of the exam or test.

19. FROM CRT (DISPLAY ONLY)
This field contains the code for the CRT on which the charge was entered.

20. INITIALS (DISPLAY ONLY)
This field contains the initials of the person who entered the charge.

Notes

After you select the Notes option, the system allows you to create and view notes for contracts.

Contract Notes allows you to create and view notes for contracts. These notes can be free-form or standard notes. Once a note is entered, the note can not be edited. Adding notes to a contract can be accomplished by either knowing the applicable contract or by entering a patient attached to the contract. If more than one person is attempting to enter notes on the same contract, the second person receives the message *Account data in use. Retry!*. The system does not allow multiple access to Notes concurrently to prevent notes from being incorrectly deleted.

Standard notes are user-defined and contain a brief description of a particular account event. An example of a standard note could be *Sent claim - claim returned -wrong address.* Standard notes are assigned a transaction type of T and are recorded in the account's transaction history. The hospital can define any number of standard notes in the system.

format for this field!. Entries highlighted are those contracts which are active (in location PA) while the un-highlighted contracts are inactive (in location AR).

After you enter this option, the system displays the following screen:

```
            General Hospital NEW NOTES [ALL TYPES] Processor
                                          Fri Jun 27, 2003 10:15 am
Account ID        Code    Description                     Balance      Loc
A7703992640       MKD     MKD CONTRACT MGT                $1976.50      PA
Page:01                              Notes           ##=Current Choices
( 1) CLAIM RETURNED - WRONG ADDRESS   12/04/94 [S] Smith,Mary A
( 2) FF BILLER NOTE FOR RAH           12/04/94 [F] Smith,Mary A
( 3) WAITING FOR ATTACHMENTS - MR     11/30/94 [S] Smith,Mary A
( 4) BILLER NOTE 1/RFH                11/30/94 [F] Smith,Mary A









 Enter choice, view all(V), add free form(F) or standard(S) notes--
                         end selection(NL)
```

Information displayed on this screen includes the contract account ID number, contract code, contract description, the contract balance and contract location. Note information includes the note and description, the date it was assigned to this account, whether the note is free-form [F] or standard [S], and the name of the system user who assigned this standard or created this free-form note.

When this screen displays, you have several options:

• You can view all account notes by entering **V** (view all).

• You can add a free-form note by entering **F** (free-form).

• You can add a standard note by entering **S** (standard).

To enter a standard note, enter **S**. The system prompts you to enter the transaction code used to record this note in transaction history. You can enter the code (up to four digits) or a hyphen (-) to display a list of valid codes.

If you enter a hyphen (-), the system displays the following screen:

```
              General Hospital NEW NOTES [ALL TYPES] Processor
                                            Wed Dec 06, 1995 11:43 am
 Account ID        Code    Description                      Balance      Loc
 A7703992640       MKD     MKD CONTRACT MGT                 $1976.50     PA
    Transaction                             Valid           Combined to
    Type  Code  Description                 Accts   Combine  Type  Code
 ( 1) T - 0007  SENT DATA MAILER            A/R
 ( 2) T - 0008  Telephone Follow Up         Any
 ( 3) T - 0010  SENT COLLECTION LETTER      A/R
 ( 4) T - 0011  SENT DETAILED STATEMENT     A/R
 ( 5) T - 0099  NOTES                       Any




 Enter choice--
```

Along with basic contract data, information displayed includes the transaction type, transaction code, a description of the note, and the type of accounts for which this note is valid. The combine print function is not valid for this transaction type.

After you enter or select the transaction code, the note associated with the code is added to the contract and the transaction is completed.

To add a free-form note, enter **F**. The system displays the following screen:

```
              General Hospital NEW NOTES [ALL TYPES] Processor
                                            Wed Dec 06, 1995 11:07 am
 Account ID         Code    Description                        Balance     Loc
 A7703992640        MDK     MDK CONTRACT MGT                   $1976.50    PA
  1 Code     2 Description                   3 Creation Date
    NEW                                         12/06/95
  4 Created By                      5 Last Edit date        6 Edit text?
    Smith,Mary A                      12/06/95 11:52am




 Press NL--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the word NEW in this field. Once the message is completed and accepted, the system assigns a code number. Each free-form note is assigned a code number corresponding to the order of its creation. The first note is 1, the second 2, and so on.

2. DESCRIPTION (30-C-R)
This field contains the description of the purpose of the note. This description is displayed in the account's transaction history and on the first screen of the Account Notes function.

3. CREATION DATE (DISPLAY ONLY)
This field contains the date on which the note was created. This date is used as the note creation date in the account's transaction history and displays on the list of Account notes. Account notes are displayed in reverse chronological order.

4. CREATED BY (DISPLAY ONLY)
This field contains the name of the user creating this note.

5. LAST EDIT DATE (DISPLAY ONLY)
This field contains the date and time this note was created. When a new note is being created, the system displays the current date and time.

6. EDIT TEXT? (1-A-R)

This field indicates whether the length of a new free-form note exceeds the 30-character description. If it does, enter **Y**; if it does not, enter **N**. The default is **N**. If you enter **Y**, the system displays the following screen:

```
                General Hospital NEW NOTES [ALL TYPES] Processor
                                         Mon Mar 27, 2006 10:40 am
 Account       Name                   FC Typ Admit    Disch       Balance Loc
 89334-00001  HALL,RUTH A               I/P 11/25/95 11/30/95      60.00   AR/FCRV
  1 Code      2 Description                      3 Creation Date
    NEW         Ins. Coverage Terminated          12/06/95
  4 Created By                         5 Last Edit date       6 Edit text?
    Smith,Mary A                         12/06/95 11:52am          Yes
 --------------------------------------------------------------------------
 01| Patient's employer called to advise that insurance coverage is being  |
 02| terminated at end of month.  Patient notified and will make financial  |
 03| arrangements, if necessary, but anticipates being discharged prior to  |
 04| end of month.  Attending physician's office notified.                  |
 05|                                                                        |
 06|                                                                        |
 07|                                                                        |
 08|                                                                        |
 09|                                                                        |
 10|                                                                        |
 11|                                                                        |
 12|                                                                        |
 13|                                                                        |
    F1          F2          F3      F4    F5          F6         F7    F10
    Delete Line Insert Line Center  Exit  Store Line  Restore Line Pack  Help
```

The function keys listed at the bottom of this screen are used to help you enter this message. Pressing F4 exits the extended message text. The system then prompts you to accept the screen.

Contract Patients

After you select the Contract Patients option, the system displays a table listing the patients assigned to the contract in reverse chronological order:

```
     Patient Name           PT    Admit    Discharge  Account #    ID

( 1) JACKSON,JANIE S         C1   08/23/95  08/23/95  9023500007

( 2) ADAMSON,NANCY L         C1   08/21/95  08/21/95  9023300020

( 3) LOWE, MARSHALL          C1   08/17/95  08/17/95  9022900002

( 4) WEBSTER,BENJAMIN        C1D  08/17/95  08/17/95  9022900003

( 5) LEWIS,MARY W            C1D  08/10/95  08/10/95  9022200006

( 6) MORRIS,SUSAN            C1   08/10/95  08/10/95  9022200007

( 7) MEYERS,SAMUEL           C1   08/10/95  08/10/95  9022200008  28392389AP

Select account to view detail--

                          next page(/)
```

After you select an account, the system displays the following screen:

```
           General Hospital Contract Account Information Processor
                                        Thu Oct 11, 1995 02:44 pm
Account ID         Code    Description                      Balance      Loc
P12232234          WLI     WEISSMANN LAB INC                $6358.44      PA
 1 Patient Type                           2 Identification
   CONTRACT - ONE PAGE
 3 Name                              4 Sex           5 Soc Sec Number
   JACKSON,JANIE S                     FEMALE
 6 Birthdate    Age        7 Birthplace                8 Race
   05/01/25     65Y                                      W WHITE
 9 Marital Status          10 Mailing Address Line 1
   S SINGLE
11 Mailing Address Line 2   12 City               13 State   14 ZIP Code

15 OP Admission Date        16 OP Admission Time
   08/23/95                    14:32
17 Unit Number              18 Corporate Number    19 Registration Number
   99-90-0006-0                00311515               90235-00007



Press NL--
```

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

1. PATIENT TYPE (DISPLAY ONLY)
This field contains the patient type.

2. IDENTIFICATION (DISPLAY ONLY)
This field contains the patient identification number.

3. NAME (DISPLAY ONLY)
This field contains the patient's name, displayed in the format:

LAST NAME,FIRST NAME MIDDLE INITIAL.

4.   SEX (DISPLAY ONLY)
This field contains the sex of the patient.

5.   SOC SEC NUMBER (DISPLAY ONLY)
This field contains the patient's social security number.

6.   BIRTHDATE AGE (DISPLAY ONLY)
This field contains the patient's date of birth in the format of MM/DD/YYYY and the patient's age (system-calculated based on the date of birth).

7.   BIRTHPLACE (DISPLAY ONLY)
This field contains the patient's birthplace.

8.   RACE (DISPLAY ONLY)
This field contains the patient's race (for example, White, Oriental, etc.).

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

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

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

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

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

14. ZIP CODE (DISPLAY ONLY)
This field contains the ZIP code portion of the patient's address.

15. OP ADMISSION DATE (DISPLAY ONLY)
This field contains the date on which the patient was registered to the contract.

16. OP ADMISSION TIME (DISPLAY ONLY)
This field contains the time at which the patient was registered to the contract.

17. UNIT NUMBER (DISPLAY ONLY)
This field contains the medical record number assigned to the patient.

18. CORPORATE NUMBER (DISPLAY ONLY)
This field contains the corporate number assigned to the patient.

19. REGISTRATION NUMBER (DISPLAY ONLY)
This field contains the patient account number assigned to the patient.

CONTRACT CHARGE FUNCTIONS

This function is part of the Contract Account Management process to allow you easy access to the charging/credit process. Without this menu option, you are forced to either access the Patient Care system to complete the charge/credit function or rely on Patient Care staff to enter the information. By having direct access to contract or patient charging functions, charges or credits can be quickly and easily entered while auditing a contract bill or having a phone conversation with a contract representative.

Contract Charge

The Contract Charge function is used when a service is provided by the hospital to an institution or company and is not directly related to a patient. Orders for patients are not applicable; therefore, these contracts are not accessed through the normal Name Inquiry function. Patient-related charges, even for contract patients, are input using the normal STAR Patient Care Charge and Order screens. When charges are to be placed for contract services that are patient-related, the patients must be registered using Contract Registration. Once this is accomplished, the charges are placed through STAR Patient Care's normal order, charge, and credit functions. Refer to the *Departmental Order Management and Charge Processing* volume in the *STAR Patient Care Reference Guide* for detailed information regarding these patient-related charge and order functions.

Examples of this type of charge are services that the hospital performs routinely and contracts out if resources or equipment are available. Following are some specific examples:

- Housekeeping providing laundering services for other institutions or businesses.

- Switchboard providing answering services for physicians.

- Snow removal for nearby businesses and institutions.

- Delivery fees for specimens.

After you select the Contract Charge option, the system prompts you to select a facility (if this is a multi-facility installation). The system then prompts you to enter a contract name with the following prompt:

> *Enter first letter(s)'-' or code--*

Enter the contract code or use a hyphen (-) to display and select from a list of valid contract codes. This is the contract that is billed for the service.

The system then prompts you to:

> *Enter charge department ('-' to list)--*

NOTE: The system allows you to select the department if your terminal has the capability to enter charges for more than one department. If your terminal only has the capability to charge for one department, the system assumes that department and bypasses the department selection.

Enter the three-character code for the department or a hyphen (-) to list the charge departments that are available to this CRT. Control of the available charge departments per CRT is determined by the CRT table. Refer to the *Tables* volume of the *STAR Patient Care Reference Guide* for more information.

After you select the department, the system displays the Charge Screen for entry of the appropriate service.

```
                 General Hospital Contract Charge Processor
 Cardiology Charge                              Thu Dec 17, 1992 04:06 pm
           Code        Description                    Account ID
            1          NEW DESCRIPTION                   111111
                                   AKA: CARDIOGRAM
  1 Item    2 Description                               3 Initials
    8068      RHINO ANGIOPLASTY                           MEL
  4 Quantity/Minutes                           5 Charging Physician  PRI
    1                                           1 A1 ADAMS,HAROLD R
  6 Price        7 Date of Service   8 Charge Location         9 Serial Number
    $547.54       12/17/92             1E 1 EAST




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

Field Explanations

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number.

1. ITEM (TABLE LOOKUP)
This field displays the Service Item Master code. Enter the code or a portion or all of the description. If an alphabetic lookup is used, all matching items are displayed in the bottom portion of the screen. Select the appropriate item(s) from the display. Enter a slash (/) to access the next page of items, or press ENTER to end the selection. If an error is made during the selection process, the selected item can be deleted by entering a hyphen (-) preceding the option number. This field is required.

2. DESCRIPTION (DISPLAY ONLY or 33-C-R)

The system displays the item description automatically based on the item selection. If the item entered is a manually priced item in the Service Item Master, the displayed description can be overridden with a more appropriate 33-character description by returning to the description field. The revised description prints on all appropriate midnight processing reports, and may be sent to the financial system.

3. INITIALS (3-A-R)

If security is implemented for the person placing the charge, the initials automatically display and cannot be edited. If security is not implemented, the system requires entry of the initials of the person placing the charge.

4. DATE OF SERVICE (8-C-R)

Enter the date the service was actually performed. The default is the system date. A future date cannot be entered. The date can be a previous date, but not prior to the patient's admission or registration date. The number of days a charge can be backdated is controlled by a hospital-defined parameter in the SIM Department table.

5. CHARGING PHYSICIAN (DISPLAY ONLY)

This field is automatically completed by the system with the name of the physician in the Contract Name table.

6. QUANTITY/MINUTES (3-N-R or 4-N-R)

The appropriate quantity for the charge is entered. The default quantity is 1. If the item is a timed charge, the correct number of minutes can be entered or the start and stop time can be entered and the system calculates the appropriate number of minutes.

7. PRICE (DISPLAY ONLY or 10-NC-R)

If the item selected is a Simple, Timed, or Incremental priced item, the price is displayed based on the quantity entered. If the item is a Manually priced item, you can enter the price in one of three formats:

- Enter the total price without a decimal point (for example, 99900 = $999.00).

- Enter @ followed by the price for an individual item. The system automatically multiplies the previously entered quantity times the price entered, and displays the product (for example, @400 with a quantity of   2 = $8.00).

- Enter a number @ a given price. The system automatically calculates the per item price and multiplies it by the previously entered quantity (for example, 4@1200 with a quantity of 2 = $6.00).

The appropriate patient price is displayed upon completion of this field.

For more information regarding contract price levels, refer to Appendix A in the *Tables* volume of the *STAR Patient Care Reference Guide*.

8. CHARGE LOCATION (TABLE LOOKUP)

This field is table-driven. It represents the location where the charge is incurred. The default charge location is defined in the prompt. This is based on the entry in the CRT Names table. Either select an entry from the table or press ENTER to accept the default. The revenue for this charge item may be redirected to a different revenue center as a result of this field. This revenue redirection is hospital-controlled by using combinations of the Revenue Department table and the Charge Location table. This field is required.

9. SERIAL NUMBER (7-AN-O)

This field is accessed only when charging for an automatic daily charge item. It can be used to identify the charged item (such as the serial number for a piece of equipment). If this field is entered, it appears on the Midnight Processing Equipment report. This field assists in tracking equipment locations.

As each charge is processed, the previous charge entry and sequential order/charge number displays above the first line of the screen. When you enter multiple charges, the previous charge entry and sequential order/charge number displays above the first line of the screen. For multiple charge entry, the charging physician, charge location, and initials are retained for ease of entry; however, these fields can be revised, if necessary. Once charging for that department is completed, the option exists to charge the same account for another charge department, if applicable.

Impact

Upon acceptance of this screen, the following occurs:

- All charges are sent to the financial system.

- The master contract's name or identification number is sent in the charge records Charge Description field to the financial system.

- The master contract is charged the discounted rate as indicated in the SIM for the items charged. The appropriate price level is determined in the Contract Name table. If there is no charge indicated in the appropriate price level, then the outpatient price is charged. If there is no outpatient price, then the normal charge amount is charged.

- The billing code (FIM #) sent to the financial system is the billing code (FIM #) entered in the appropriate price level of the SIM item. If there is none entered, the normal billing code (FIM #) for the item is sent.

- Charges are reflected in the Contract Charge Inquiry function with the contract name or identification number displaying as the account which received the service.

- An order or charge number is assigned to each charge as an audit trail.

Output

Contract Charges print on the following reports:

- Charges entered are reflected in the Contract Activity Log Detail and Summary Reports for the appropriate charge department under the *patient* of the contract name or identification number.

- Charges are reflected in the Contract Activity Journal Detail and Summary Reports under the *patient* of the contract name or identification number.

- Charges are reflected in the interface transmission control report under the Contract Charges section.

- Charges are reflected on the Contract Year-To-Date Charge Summary report.

Contract Credit

The Contract Credit function is used when an account is provided by the hospital to an institution or company for services that are not patient related. In this situation, the account is resident within the system and charges and credits are placed directly to that contract. Orders for patients are not applicable; therefore, these contracts are not accessed through the normal Name Inquiry function. Patient-related credits, even for contract patients, are input using the normal STAR Patient Care Credit function. Refer to the *STAR Patient Care Reference Guide Departmental Order Management and Charge Processing* volume for details regarding the patient-related charge and order screens.

Since issuing a credit or an account for an entire charge transaction can be performed using the Charge Inquiry function, thus keeping the charge audit trail in place, it is suggested that Charge Inquiry cancellation be used whenever possible. Typically, the credit screen is used to credit partial charge amounts. An example of this would be eight units of blood charged to the patient, and the patient only uses six of the units. Rather than credit eight units of blood and charge for six units of blood, depending on hospital procedures, a credit can be placed for two units of blood, which is the unused portion of the original order.

Examples of this type of account are services that the hospital performs routinely and contracts out if resources or equipment are available. The following are some specific examples:

- Housekeeping providing laundering services for other institutions or businesses

- Switchboard providing answering services for physicians

- Snow removal for nearby businesses and institutions

- Delivery fees for specimens

When credits are to be placed for contract services that are patient related, the patients must be registered using Contract Registration. Once this is accomplished, the credits are placed through STAR Patient Care's normal credit functions.

After you select the Contract Credit option, the system prompts you to select a facility (if this is a multi-facility installation). The system then prompts you to enter the contract name or code with the following prompt:

Enter first letter(s)'-' or code--

Enter the contract code, a partial name followed by a hyphen (-), or a hyphen (-) to display a list of valid contract codes. This entry is the account that is billed for the service.

The system displays the following prompt:

Are you sure you want to enter CREDITS (Y/N) [N]--

Enter **Y** for Yes if you want to continue; press ENTER to return to the submenu.

The system then prompts you to:

Enter charge department ('-' to list)--

NOTE: The system allows you to select the department if your terminal has the capability to enter charges for more than one department. If your terminal only has the capability to charge for one department, the system assumes that department and bypasses the department selection.

Enter the three-character code for the department or a hyphen (-) to list the charge departments that are available to this CRT. Control of the available charge departments per CRT is determined by the CRT table. Refer to the *Tables* volume of the *STAR Patient Care Reference Guide* for more information.

After you select the department, the system displays the Credit Screen for entry of the appropriate service.

```
                    General Hospital Contract Credit Processor
 Cardiology Credit                                Thu Dec 17, 1992 04:10 pm
           Code        Description                     Account ID
           1           NEW DESCRIPTION                 111111

 1 Item    2 Description                                      3 Initials
   8068       RHINO ANGIOPLASTY                                 MEL
 4 Quantity/Minutes                             5 Charging Physician  PRI
   1                                            1 ADAMS,HAROLD R
 6 Price       7 Date of Service   8 Charge Location       9 Serial Number
   $547.54      12/17/92            1E 1 EAST






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

Field Explanations

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number.

1.   ITEM (TABLE LOOKUP)
This field displays the Service Item Master code. Enter the code or a portion or all of the description. If an alphabetic lookup is used, all matching items are displayed in the bottom portion of the screen. Select the appropriate item(s) from the display. Enter a slash (/) to access the next page of items, or press ENTER to end the selection. If an error is made during the selection process, the selected item can be deleted by entering a hyphen (-) preceding the option number. This field is required.

2.   DESCRIPTION (DISPLAY ONLY or 33-C-R)
The system displays the item description automatically based on the item selection. If the item entered is a manually priced item in the Service Item Master, the displayed description can be overridden with a more appropriate 33-character description by returning to the description field. The revised description prints on all appropriate midnight processing reports, and may be sent to the financial system.

3. INITIALS (3-A-R)

If security is implemented for the person placing the charge, the initials automatically displays and cannot be edited. If security is not implemented, the system requires entry of the initials of the person placing the charge.

4. QUANTITY/MINUTES (3-N-R or 4-N-R)

The appropriate quantity for the credit is entered. The default quantity is 1 (one). If the item is a timed credit, the correct number of minutes can be entered or the start and stop time can be entered and the system calculates the appropriate number of minutes.

5. CHARGING PHYSICIAN (DISPLAY ONLY)

This field is automatically completed by the system with the name of the physician in the Contract Name table.

6. PRICE (DISPLAY ONLY or 10-NC-R)

If the item selected is a Simple, Timed, or Incremental priced item, the price is displayed based on the quantity entered. If the item is a Manually priced item, you can enter the price in one of three formats:

- Enter the total price without a decimal point (for example, 99900 = $999.00).

- Enter @ followed by the price for an individual item. The system automatically multiplies the previously entered quantity times the price entered, and displays the product (for example, @400 with a quantity of 2 = $8.00).

- Enter a number @ a given price. The system automatically calculates the per item price and multiplies it by the previously entered quantity (for example, 4@1200 with a quantity of 2 = $6.00).

The appropriate patient price is displayed upon completion of this field.

7. DATE OF SERVICE (8-C-R)

Enter the date associated with this credit. The default is the system date. A future date cannot be entered. The date can be a previous date. The number of days a credit can be backdated is controlled by a hospital-defined parameter in the SIM Department table. The system retains the date on the screen for multiple charges or credits within a department. When another department is chosen, the field is cleared.

8. CHARGE LOCATION (TABLE LOOKUP)

This field is table-driven. It represents the location where the charge is incurred. The default charge location is defined in the prompt. This is based on the entry in the CRT Names table. Either select an entry from the table or press ENTER to accept the default. The revenue for this charge item may be redirected to a different revenue center as a result of this field. This revenue redirection is hospital-controlled by using combinations of the Revenue Department table and the Charge Location table. This field is required.

9. SERIAL NUMBER (7-AN-O)

This field is accessed only when crediting for an automatic daily charge item. It can be used to identify the credited item (such as the serial number for a piece of equipment). If this field is entered, it appears on the Midnight Processing Equipment Report. This field assists in tracking equipment locations.

As each credit is processed, the previous credit entry and sequential order/charge number is displayed above the first line of the screen. When multiple credits are entered, the charging physician, charge location, and initials are retained for ease of entry. These fields can be revised during the process if necessary. Once all crediting for that department is completed, the option exists to credit the same account for another charge department, if applicable.

Impact

Upon acceptance of this screen, the following occurs:

- All credits are sent to the financial system.

- The master contract's name or identification number is sent in the charge records Charge Description field to the financial system.

- The master contract is credited the discounted rate as indicated in the SIM for the items credited. The appropriate price level is determined in the Contract Name table. If there is no charge amount indicated in the appropriate price level, then the outpatient price is credited. If there is no outpatient price, then the normal charge amount is credited.

- The billing code (FIM #) sent to the financial system is the billing code (FIM #) entered in the appropriate price level of the SIM item. If there is none entered, the normal billing code (FIM #) for the item is sent.

- Credits are reflected in the Contract Charge Inquiry function with the contract name or identification number displaying as the account which received the service.

- An order or charge number for each credit is assigned to each credit as an audit trail.

Output

Contract Credits are reflected in the following reports:

- Credits entered are reflected in the Contract Activity Log Detail and Summary Reports for the appropriate charge department under the *patient* of the contract name or identification number.

- Credits are reflected in the Contract Activity Journal Detail and Summary Reports under the *patient* of the contract name or identification number.

- Credits are reflected in the Interface Transmission Control Report under the Contract Charges section.

- Credits are reflected on the Contract Year-To-Date Charge Summary report.

Contract Charge Inquiry

The Contract Charge Inquiry function reflects all charges, chargeable orders, and credits that have been applied to a specific contract and allows for cancellation of orders/charges previously placed, maintaining an audit trail. This would be charges placed directly to the account through the contract charge and credit screens, as well as charges, orders, and credits applied to patients that are associated with this contract through the contract registration sequence. Since these patient charges are actually charges to the master account, or Patient Care Charge Inquiry.

After you select the Contract Credit option, the system prompts you to select a facility (if this is a multi-facility installation). The system then prompts you to enter a contract name or code with the following prompt:

Enter first letter(s)'-' or code--

Enter the contract code, a partial name followed by a hyphen (-), or a hyphen (-) to display a list of valid contract codes.

You are then prompted to:

Enter summary(S) or date to begin charge review [TODAY]--

Enter **S** if you want to review a summary of the charges associated with the contract; enter a specific beginning date to review charges, or press ENTER to use the default of TODAY in order to review today's activity.

SELECTING TODAY FOR CHARGE REVIEW

After selecting the appropriate date, you are able to view only the charges associated with the charge departments indicated for your terminal in the CRT table. Refer to the Tables volume of the STAR Patient Care Reference Guide for more information. If S is entered, the summary screen displays. If a date is entered, the detail screens display, with the summary screen displaying after all charges are viewed.

After the date is entered, the following screen displays listing all charges, chargeable orders, credits, or cancellations placed during the entered date.

```
         General Hospital Contract Charge Inquiry Processor
                                        Fri Jun 16, 1989 12:18 pm
         Code        Description                 Account ID
         3           REFERENCE LAB XYZ           1231234

  Charges for All Departments      During the 24 Hours Ending  Midnight Tonight

  No  Chg#  Dept Description          Account          Srv Date  Qty    Price
   1    2   LAB  LAB STAT CHARGE      HOLMES,LARRY HENDR 06/16/89  -1    -.57
   2    1   LAB  LAB STAT CHARGE      HOLMES,LARRY HENDR 06/16/89  -1    -.57
   3    2   LAB  LAB STAT CHARGE      HOLMES,LARRY HENDR 06/16/89   1     .57
   4    2   LAB  BLOOD CULTURE        HOLMES,LARRY HENDR 06/16/89   1   42.20
   5    1   LAB  LAB STAT CHARGE      HOLMES,LARRY HENDR 06/16/89   1     .57
   6    1   LAB  ARSENIC,BLOOD        HOLMES,LARRY HENDR 06/16/89   1   59.00
   7    1   LAB  LAB STAT CHARGE      BENNETT,BARBARA LU 06/16/89  -1    -.57
   8    2   LAB  URINALYSIS, ROUTIN   BENNETT,BARBARA LU 06/16/89   1   14.40
   9    1   LAB  LAB STAT CHARGE      BENNETT,BARBARA LU 06/16/89   1     .57
  10    1   LAB  CBC & PLATELET COU   BENNETT,BARBARA LU 06/16/89   1   34.80
  11    1   MSC  DELIVERY FEE - SPE   REFERENCE LAB XYZ  06/16/89   1   53.00


             All charges have been listed for the date shown!
  Enter number [summary]--
```

Field Explanations

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number.

1. NO (2-N-O)
This is the number you select to view more detail for the charge line item, to cancel a charge or order, or to issue a credit to the patient's bill.

2. CHG# (DISPLAY ONLY)
This is the number assigned to this line item when the charge or order was generated.

3. DEPT (DISPLAY ONLY)
This is the Service Item department from which the charge or order was generated.

4. DESCRIPTION (DISPLAY ONLY)
This is the description of the item that was charged or ordered.

5. ACCOUNT (DISPLAY ONLY)
The name or identification number of the individual who received the charges, credits, cancellations, or orders is displayed. If the charge or credit was placed directly to the account through Contract Charge or Credit, then the contract's name or identification

number displays. Whether or not the name or identification number display is controlled in the Contract Name table.

6. SRV DATE (DISPLAY ONLY)
This is the date the actual service was performed as entered in the charge\credit screen.

7. QTY (DISPLAY ONLY)
This is the quantity of the item charged, credited, or cancelled. Items that are ordered are a quantity of one. A hyphen (-) to the left of the quantity indicates a credit or cancellation.

8. PRICE (DISPLAY ONLY)
This is the extended price for the item that was charged, ordered, credited, or cancelled. A hyphen (-) to the left of the quantity indicates a credit or cancellation.

When the line items for charges listed on the Charge Inquiry Screen exceed one page, you can scroll through the additional charges/credits by pressing ENTER.

When all charges have been displayed for the date indicated, the system displays the following message above the prompt:

All charges have been listed for the date shown!

You can select a line item and obtain more detail about that charge, or place a credit to the account for that charge providing an audit trail. Enter the line number of the item to review.

The Charge Inquiry Detail Screen, shown following, provides additional information about the original charge/credit/cancellation. All fields are display only. You can cancel a charge from this screen depending on the entries. The charge was either placed as a result of an item being ordered that was a Charge-on-Order item, the charge function, or through the Contract Charge function. Cancellations are not allowed from the STAR Patient Care system when the STAR Radiology or STAR Laboratory system is in the network.

```
                 General Hospital Contract Charge Inquiry Processor
                                                    Sat Sept 14, 2002  04:09 pm


        Code          Description                      Account ID
        EPI1          EPIDEMIOLOGY CONTRACT 1          4128
  1 Charge Number  2 From CRT            3 Department            4 Type
   1               AD1 ADMITTING 1       Laboratory              Credit
  5 Charge Location        6 Date Charged          7 Charged By
   OP                        08/13/02 22:13           ***
  8 Code   Bill Code        9 Description
   1200    7011-1200          ACETONE
 10 Quantity 11 Price      12 Date of Service  13 Order Diagnosis
   -1          -$1.10         08/12/02
 14 Charging Physician  15 Performing Physician      16 Revenue Code
    432 BABB,GARY H                                   LAB/CHEMISTRY
 17 Accommodation Code      18 HCPCS Code        19 HCPCS Modifiers

 20 AdV Panel                      21 ABN   22 ABN Override

 23 Med Nec Dup HCPCS   24 Med Nec Dup/Conflict HCPCS Override 25 Take Home Drug

 26 Conflict Code/Category    27 CCE Mod Allowed   28 Frequency Limit



 Cancel(C) charge?--
                  next charge(/) or previous charge(/P) [/]
```

Enter **C** when you want to Cancel the charge. The prompt allows you to display the
next charge, by entering slash (/) or pressing ENTER. You can display the previous
charge by entering slash and **P** (/P).

Field Explanations

1. CHARGE NUMBER (DISPLAY ONLY)
This is the transaction number originally assigned to this charge/credit or order.

2. FROM CRT (DISPLAY ONLY)
This is the CRT from which the original charge/credit or order was generated.

3. DEPARTMENT (DISPLAY ONLY)
This is the Service Item Master charge department from which the item was charged,
credited, or ordered.

4. TYPE (DISPLAY ONLY)
This is the type of transaction that was generated; Admission Order, Cancel, Credit,
Charge, or Order.

5. CHARGE LOCATION (DISPLAY ONLY)
This is the charge location entered or displayed during the charging, crediting, or
ordering process.

6. DATE CHARGED (DISPLAY ONLY)
This is the date and time the charge, credit, or order was entered in the system.

7. CHARGED BY (DISPLAY ONLY)
This is the initials of the person who entered the transaction.

8. CODE and BILL CODE (DISPLAY ONLY)
This is the four digit STAR Patient Care Service Item Master item code associated with this charge or order, and the financial system Financial Item Master (FIM) billing code associated with this charge, credit, or order.

9. DESCRIPTION (DISPLAY ONLY)
This is the description associated with this item being charged, credited, or ordered.

10. QUANTITY (DISPLAY ONLY)
This is the quantity of the item charged, credited, or ordered.

11. PRICE (DISPLAY ONLY)
This is the extended price for the item charged, credited, or ordered.

12. DATE OF SERVICE (DISPLAY ONLY)
This is the actual date the service or item was provided for the account. The number of days the system allowed backdating upon initial entry is a hospital-defined parameter that is located in the SIM Department table.

13. ORDER DIAGNOSIS
This field is related to 1500 billing. Since 1500 billing does not apply to contract patients, the field does not display an entry.

14. CHARGING PHYSICIAN (DISPLAY ONLY)
This is the physician from the Contract Name table who requested the service or item for the patient.

15. PERFORMING PHYSICIAN
This field is related to 1500 billing. Since 1500 billing does not apply to contract patients, the field does not display an entry.

16. REVENUE CODE (DISPLAY ONLY)
This is the revenue department to which the charge/credit was applied.

17. ACCOMMODATION CODE
This field is related to 1500 billing. Since 1500 billing does not apply to contract patients, the field does not display an entry.

18. HCPCS CODE
This field is related to 1500 billing. Since 1500 billing does not apply to contract patients, the field does not display an entry.

19. HCPCS MODIFIERS (DISPLAY ONLY)
This field contains the HCPCS modifiers that apply to the SIM item display. For professional fee charges and CMS-compliant outpatients, up to ten modifiers can be selected, but on the claim for the UB only two display, and for the 1500 only four modifiers display. The modifiers are built in the Medical Records HCPCS Modifiers Table. The user can indicate which department the modifier(s) applies to as well as whether the modifiers are used for Pro Fees, Non Pro Fees, or both, and their display priority.

20. ADV PANEL (DISPLAY ONLY)
This field is used only if AdVantage Laboratory is the networked laboratory system.

21. ABN (DISPLAY ONLY)
This field displays data entered in STAR Patient Care. It indicates whether an Advanced Beneficiary Notification (ABN) form was signed, based upon the patient's patient type, plan, patient's diagnosis, and procedure code. This field may be blank or contain one of the following:

Yes	An ABN is required and has been printed and signed by the patient for this charge.
No	An ABN is required and has *not* been printed and signed by the patient for this charge; an override reason has been entered instead of a signed ABN form.
App	An ABN is not required. The SIM item ordered has an approved diagnosis, or approved diagnoses have not been defined for this procedure in the STAR Medical Records HCPCS Table.

If the ABN is designated as printed and signed, the designated charge can be defined in the UB Charge Control Parameters to print in the non-covered column of the UB claim form. If a HCPCS modifier or modifiers have been defined in the STAR Patient Care SIM Department Table in Table Maintenance, this modifier is appended to the HCPCS procedure code in STAR Patient Care and printed on the appropriate claim form.

22. ABN OVERRIDE (DISPLAY ONLY)
This field displays data entered in STAR Patient Care. It indicates why the ABN was not signed if the test was not determined to be medically necessary based on the ICD diagnostic codes defined in the STAR Medical Records HCPCS Table. This field displays an Override Reason code from a user-defined table or freeform text up to 33 characters.

23. MED NEC DUP HCPCS (DISPLAY ONLY)
This field displays data entered in STAR Patient Care. It indicates whether a duplicate HCPCS procedure has been ordered for this patient within a single calendar day. This field contains one of the following:

Yes	A duplicate procedure has been ordered and has been determined to be medically necessary.
N0	A duplicate procedure has been ordered and has *not* been determined to be medically necessary.
Null	The procedure is *not* indicated to be a duplicate of any previously ordered procedures within the same calendar day.

The response in the Med Nec Dup HCPCS field is stored in the charge record as follows.

If **Yes**, the appropriate modifier to indicate medical necessity, as defined by the user in the STAR Patient Care SIM Department table, is added to the HCPCS code in the STAR Patient Care charge record. The HCPCS plus modifier combination then prints on the applicable claim form.

If **No**, the charge can be defined in the appropriate UB Charge Control Parameter to print in the non-covered column on the UB claim form (FL 48).

If **Null**, the charge is not indicated as a duplicate, and the HCPCS does not print in the non-covered column of the UB claim form.

24. MED NEC DUP/CONFLICT HCPCS OVERRIDE (DISPLAY ONLY)
This field is populated by the reason selected from the Duplicate HCPCS Override Reason table during charge entry, if a modifier is allowed. If a modifier is not allowed, the field is populated with the default, No, from the CCE Modifier Allowed field. If No is displayed, this indicates that the item is not defined to allow a modifier, and the item is non-covered.

25. TAKE HOME DRUG (DISPLAY ONLY)
This field displays data entered in STAR Pharmacy. It indicates whether an item was designated as a take home medication at the time the charge was entered.

If a charge is received that has the take home indicator set to Yes, then the UB Revenue Code is changed on the charge to the user-defined revenue code specific to take home medications. This revenue code may be defined as non-covered in the insurance plan, thus causing it to appear in the non-covered column of the UB claim form.

26. CONFLICT CODE/CATEGORY (DISPLAY ONLY)
This field is populated by the XREF HCPCS Function definitions. The HCPCS code and category displayed in this field are the code and category detected as a conflict during order entry.

27. CCE MOD ALLOWED (DISPLAY ONLY)
This field is populated by the definition entered in the HCPCS Processor Table within the XREF HCPCS/CPT option. If a conflict is detected, the field displays Yes or No. If Yes is displayed, the Med Nec Dup/Conflict HCPCS Override field displays an override reason entered during Order Entry or Charge Entry. If No is displayed, there is no override reason in the Med Ned Dup/Conflict HCPCS Override field.

28. FREQUENCY LIMIT (DISPLAY ONLY)
This field displays the frequency limit associated with the HCPCS procedure. The field is displayed from the Medical Records HCPCS table in STAR Patient Care.

If you enter **C** to cancel an item and credit the patient, the following screen displays:

```
                General Hospital Contract Charge Inquiry Processor
                                              Fri Jun 16, 1989 12:18 pm
             Code          Description                    Account ID
             3             REFERENCE LAB XYZ               1231234


             The quantity and price below will be credited to the patient

( 1)Charge Number: 3
( 2)Description  : CBC & PLATELET COUNT
( 3)Quantity     : 1
( 4)Price        :  $34.80
( 5)Initials     : KLG






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

The cancel option keeps the same charge/order number that was originally assigned in the charge or order function, providing an accurate audit trail. The cancel option cancels the order in its entirety, that is, the quantity and price cannot be modified from the original charge or order.

If the item selected to be cancelled was generated as a by-product of an order and priority or transportation method charges were also generated, the system warns you that cancellation of the main item does not automatically cancel the additional charges. These charges, if they need to be cancelled, should be cancelled prior to cancelling the main item. The following prompt displays:

Stat and/or Portable Charges exist and should be cancelled first without cancelling extra charges (Y/N)--

If you enter No, the system does not cancel the item and returns you to the summary listing of charges.

If you enter Yes, the system asks for acceptance by displaying the following prompt:

Accept (Y/N) [Y]--

If you enter **Y**, the default, the system displays the follow message prior to displaying the next item in sequence:

Cancelled!

Field Explanations

1. CHARGE NUMBER (DISPLAY ONLY)
This is the transaction number originally assigned to this charge or order.

2. DESCRIPTION (DISPLAY ONLY)
This is the item description associated with this transaction.

3. QUANTITY (DISPLAY ONLY)
This is the quantity of the item ordered or charged.

4. PRICE (DISPLAY ONLY)
This is the extended price for the item ordered or charged.

5. INITIALS (3-A-R)
If security is implemented for the person placing the charge, the initials automatically display and cannot be edited. If security is not implemented, the system requires entry of the initials of the person placing the cancellation. The initials of the individual cancelling this charge or order are displayed or entered.

After the item is cancelled, the system returns to the Charge Inquiry screen to view or access other charges. You may choose to view only the summary page of the Charge Inquiry function, or the summary screen displays once all the detail charges have been viewed.

```
               General Hospital Contract Charge Inquiry Processor
                                                  Fri Jun 16, 1989 12:18 pm
            Code          Description                    Account ID
            3             REFERENCE LAB XYZ              1231234

Department                 Today     All   Department              Today    All
LABORATORY                -34.80  150.40
OTHER                       0.00   53.00

            *** Total     -34.80  203.40













   Press NL--
```

The charges are summarized according to the Charge Summary name assigned to a particular Service Item Master Department in the hospital maintained SIM department table.

Field Explanations

1. DEPARTMENT (DISPLAY ONLY)
This field lists the departments with associated charges/credits for this contract.

2. TODAY (DISPLAY ONLY)
This is the total of the current day's charges/credits for the department associated with the selected contract.

3. ALL (DISPLAY ONLY)
This is the total active charges for the department for this contract.

Impact

Contract Cancellations are reflected in the following reports:

*   All cancels are sent to the financial system.

*   The master contract's name or identification number is sent in the charge records Charge Description field to the financial system.

*   The master contract is credited the discounted rate as indicated in the SIM for the items credited. The appropriate price level is determined in the Contract Name table. If there is no charge amount indicated in the appropriate price level, then the

outpatient price is credited. If there is no outpatient price, then the normal charge amount is credited.

- The billing code (FIM #) sent to the financial system is the billing code (FIM #) entered in the appropriate price level of the SIM item. If there is none entered, the normal billing code (FIM #) for the item is sent.

- Cancellations are reflected in the Contract Charge Inquiry function with the contract name or identification number displaying as the account which received the service.

- The audit trail is maintained because each cancellation maintains the original charge or orders charge number.

Output

Upon acceptance of this screen, the following prints:

- Cancellations entered are reflected in the Contract Activity Log Detail and Summary Reports for the appropriate charge department under the *patient* of the contract name or identification number.

- Cancellations are reflected in the Contract Activity Journal Detail and Summary Reports under the *patient* of the contract name or identification number.

- Cancellations are reflected in the Interface Transmission Control Report under the Contract Charges section.

- Cancellations are reflected on the Contract Year-To-Date Charge Summary Report.

Patient Charge

This function is a STAR Patient Care function. This function is used to place charges for services provided to a patient's account. For more information on this function, refer to the Charge write-up in the Charge Processing section in the *Order Management Charge Processing Module* of the *STAR Patient Care Reference Guide*.

Patient Credit

This function is a STAR Patient Care function. This function is used to place credits for services provided to a patient's account. For more information on this function, refer to the Credit write-up in the Charge Processing section in the *Order Management Charge Processing Module* of the *STAR Patient Care Reference Guide*.

Patient Charge Inquiry

This function reflects all charges, chargeable orders, and credits that have been applied to a specific contract and allows for cancellation of orders/charges previously placed, maintaining an audit trail. For more information on this function, refer to the Charge Inquiry write-up in the Charge Processing section in the *Order Management Charge Processing Module* of the *STAR Patient Care Reference Guide*.

TRANSACTIONS

Transaction types available to the Contract Account Management function are cash posting, adjustment posting and apply unapplied cash. These functions are accessible by entering the menu options of Account Management, followed by Account Transactions. All of these functions require the money to be applied to a specific bill sequence number. After the batch is accepted, the system automatically revises the Contract's cumulative balance and the Contracts specific bill sequence balance. The system requires a bill sequence number to post cash, if no bill has been generated for a specific contract at a point in time, the user is required to post the money to Unapplied Cash. Therefore, at a later point in time, the user is required to Apply Unapplied Cash when a bill is generated. Since a balance transfer function is not available for contracts, any money which may have been posted to an incorrect bill sequence number requires the user to post a negative cash or adjustment amount to the incorrect bill sequence and a positive entry to the correct bill sequence.

Contract Cash Posting

Contract Cash Posting initially follows the same process as other types of cash posting, which are explained in the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

After you select the Post Cash function, the system prompts you to select a facility (if this is a multi-facility installation). The system then prompts you to add a new batch or edit an existing batch. After you select the batch number, the system displays the following screen:

```
                  General Hospital Cash Posting Setup Processor
                                              Mon Oct 08, 1990 10:19 am

 1 Batch #             2 Batch Description                    3 # of Trans
   135                   WEBSTER LAB INC CASH
 4 Posting Date        5 Payment Date       6 Mixed Transactions?
   10/03/90              10/03/90               Yes
 7 Print Receipts?     8 Beginning Receipt #
   Yes                   Auto
CASH   9 Starting Balance 10 Total Entered  11 Batch Total    12 Variance
     ->                                         100.00
CONTRACTUAL ADJUSTMENTS   13 Total Entered  14 Batch Total     15 Variance




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

Field Explanations

1. BATCH # (DISPLAY ONLY)
This field contains either the batch number you entered or the system-assigned identification number for this batch. If the system assigns a number to this batch, the word Auto displays until you edit this screen and a system-assigned number then displays when you enter this screen.

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

3. # OF TRANS (DISPLAY ONLY)
If you are editing a batch, this field contains the number of component transactions within the batch. This field cannot be edited. If you are creating a batch, this field is blank.

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

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

6. MIXED TRANSACTIONS? (1-A-R)
This field indicates whether this batch contains more than one type of transaction. Entry options are **Y** for Yes or **N** for No; the default is **Y**. If you are only posting contract cash, you can enter N in this field. If the field contains **N**, you can only enter the type of cash initially selected from the next menu.

7. PRINT RECEIPTS? (1-A-R)
This field indicates whether receipts should print. Entry options are **Y** for Yes or **N** for No; the default is **Y**. If receipts have not been designed during the installation process, this field can be set to Yes or No since receipts do not print in either case.

8. BEGINNING RECEIPT # (10-N-R)
This field contains the beginning receipt number if you have decided to print receipts. You can enter a specific receipt number or allow the system to assign one. The range for receipt numbers is 0 to 9999999999. If the system assigns a receipt number, the word Auto is displayed.

CASH

9. STARTING BALANCE (10-N-O)
This field contains the opening dollars for reconciliation of a starting bank for cashiers. You can enter up to $99,999,999.99. This field is not required but it allows the Amount Posted plus Starting Balance to balance to the Batch Total.

10. TOTAL ENTERED (DISPLAY ONLY)
If you are editing a batch, this field contains the total amount of all transactions entered. If you are creating a batch, this field is blank.

11. BATCH TOTAL (10-N-R)
This field contains the total of the batch according to your adding machine/ calculator tape. An amount up to $99,999,999.99 can be entered. You can only complete this field if you have a security level of 50 or higher. The Total Entered amount plus the Starting Balance must equal the batch total in order to approve a batch.

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

CONTRACTUAL ADJUSTMENT

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

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

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

After you complete this screen, you have the option of accepting or editing the entered information. If you accept the screen, the system displays a list of options for posting cash, as shown in the following screen.

```
              General Hospital Cash Posting Selection Processor
                                       Mon Oct 08, 1990 10:19 am
Cash Posting Selection Input Options


            Option No.  Option
            ---------------------------------------
Post            1       Insurance Cash
                2       Patient Cash
                3       Miscellaneous Cash
                4       Unapplied Cash
                5       Contract Cash
                6       Balance Transfer & Claim Disposition

                7       Exit Batch






Enter option number--
```

After you select the Contract Cash option, the system displays the following screen:

```
          General Hospital Contract Cash Posting Setup Processor
                                       Mon Oct 08, 1990 10:19 am

 1 Batch #             2 Batch Description                  3 # of Trans
   135                   WEBSTER LAB INC PAYMENTS
 4 Starting Balance    5 Total Entered    6 Batch Total     7 Variance
   100.00

                        Contract Cash Defaults
 8 Trans Code/Description







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

Field Explanations

Fields 1 through 7 - Batch #, Description, # Of Trans, Starting Balance, Total Entered, Batch Total, and Variance - are displayed from the Batch Header information.

1. BATCH # (DISPLAY ONLY)
This field contains either the batch number you entered or the system-assigned identification number for this batch.

2. BATCH DESCRIPTION (DISPLAY ONLY)
This field contains the description of this batch.

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

4. STARTING BALANCE (DISPLAY ONLY)
This field contains the opening dollars for reconciliation of a starting bank for cashiers.

5. TOTAL ENTERED (DISPLAY ONLY)
If you are editing a batch, this field contains the total amount of all transactions entered.

6. BATCH TOTAL (DISPLAY ONLY)
This field contains the total of you adding machine/calculator tape.

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

Contract Cash Defaults

8. TRANS CODE/DESCRIPTION (4-N-O)
This field contains the transaction code and description that can be used for all contract payments if you want to use the same transaction code for all or the majority of the payments being posted. This transaction code is repeated for each contract in the batch. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type N (non-patient cash).

After you complete the fields on this screen and you accept the screen, the system prompts you to:

> *Enter contract code, `-` contract names, `*`patient name, `#`social security, or `*`account number --*

You can enter the code if it is known. You can use a hyphen (-) to perform a table lookup. After the you enter a hyphen, the system displays all contracts. Entries highlighted are those contracts which are active (in location PA) while the un-highlighted contracts are inactive (in location AR).

You can also enter an asterisk (*) plus the patient name which is similar to the non-contract patient lookup. All accounts matching the pattern identified is displayed. After selecting a specific person, only contract patient account numbers for the person are displayed and accessible. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter a contract through a persons social security number (SSN). After entering the # SSN, the system displays all contract patient account numbers. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can enter an asterisk (*) plus a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract.

After the contract code is selected, the system displays the following screen which asks you to select a specific bill to post the cash.

```
                General Hospital Contract Cash Posting Processor
                                                    Thu Feb 29, 1996 09:03 am
Account ID         Code     Description                        Balance     Loc
A7703992640        MDK      MDK CONTRACT MGT                    $1976.50    PA
Page:01 Bill #     Billed   From      Thru     Bill Amount  Bill Balance
( 1)    8          02/13/96 01/25/96  02/13/96     61.40        55.88
( 2)    7          01/24/96 01/24/96  01/24/96       .00          .00
( 3)    6          01/23/96 12/07/95  01/23/96       .00          .00
( 4)    5          12/06/95 12/01/95  12/06/95    458.20       343.63
( 5)    4          11/30/95 11/30/95  11/30/95       .00        50.00-
( 6)    3          11/29/95 11/23/95  11/29/95    860.20       731.85
( 7)    2          11/22/95 11/22/95  11/22/95    318.70       221.42
( 8)    1          11/21/95 11/21/95  11/21/95  2,988.57     1,456.22
( 9)    A0         02/29/96 02/29/96  02/29/96       .00       100.00-




Enter choice--
```

After you select a bill, the following cash posting screen is displayed:

```
              General Hospital Contract Cash Posting Processor
                              Cash Posting Processor
                                                   Fri Nov 16, 2008 09:45 am
Account ID         Code     Description                        Balance     Loc
A123980980089      MLK2     Smith Co.                          $6220.19    PA
 1 Contract Last Paid        2 Total # of Payments      3 Total Payments
   11/02/07                      2                         2.00
 4 Bill Seq #     5 Bill Date      6 Bill Last Paid     7 Bill Payments
   15               09/01/07         11/02/07             2.00
 8 Batch Seq #
   3

 9 Payment Date             10 Posting Date        11 Current Bill Balance
   10/30/07                    10/30/07                145.05
12 Payment Amount       13 Trans Code/Description  14 Remittance no
  1.00             N0001-CONTRACT CASH       654618
15 Comments


  Enter payment amount--
```

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract.

LOC (DISPLAY ONLY)
This field contains the account location of the contract.

1. CONTRACT LAST PAID (DISPLAY ONLY)
This field contains the last date on which a payment was posted on this contract.

2. TOTAL # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments made on this contract.

3. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of all payments made on this contract.

4. BILL SEQ # (DISPLAY ONLY)
This field contains the bill sequence number the payment will be posted against. This should agree with the option selected on the previous screen.

5. BILL DATE (DISPLAY ONLY)
This field displays the bill date coinciding with the bill sequence number in the Bill Seq # field.

6. BILL LAST PAID (DISPLAY ONLY)
This field contains the last payment date to this specific bill. If no prior payments have been made, this field is blank.

7. BILL PAYMENTS (DISPLAY ONLY)
This field contains the total payments made to this specific bill. If no previous payments have been made, the field is blank.

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

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

10. POSTING DATE (6-N-R)

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

11. CURRENT BILL BALANCE (DISPLAY ONLY)

This field contains the balance on the specific bill. It is automatically adjusted to reflect the amount of payments posted through field 12.

12. PAYMENT AMOUNT (9-N-R)

This field contains the amount of this payment. The entry range is 0 to $9,999,999.99. If the payment amount exceeds the account balance, a message is displayed to that effect. The system accepts payments that exceed the balance. If you want to enter a payment reversal for any reason, such as an NSF check, enter a hyphen (-) before the dollar amount.

13. TRANS CODE/DESCRIPTION (4-N-R)

This field contains the transaction type and code used to record this payment in the contract's transaction history and on contract bills. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type N (non-patient cash).

14. REMITTANCE (25-AN-O)

This field contains remittance information that is relevant to the payment; for example, invoice number, check number, or remittance number.

15. COMMENTS (1-A-O)

This field contains any comments pertaining to this contract payment that you want to enter. You can enter up to 180 characters. When you access this field, the system displays the following prompt:

Enter comments? (Y/N) [N}

If you enter **Y** for Yes, you are prompted to enter a comment about this payment. You can enter up to three lines of comments for this payment. Press F4 when you finish entering your comments. If a comment is not necessary, press ENTER.

NOTE: The comment that is entered is displayed in the Comment field on the Contract Account Information Processor screen.

When all fields are completed, you have the option of accepting or editing the information entered on this screen. Accepting the screen completes this adjustment entry. You have the option of entering another adjustment for this account, selecting another account or another carrier, or returning to the list of adjustment posting options.

Once you have entered the contract cash transactions, the cash posting program proceeds the same with all other types of cash posting. You can edit, approve, hold, and print the batch detail, as with any other cash batch established in the system.

Contract Adjustment Posting

Contract Adjustment Posting initially follows the same process as other types of adjustment posting, which are explained in the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

After you select the Post Adjustments function, the system prompts you to select a facility (if this is a multi-facility installation). The system then prompts you to add a new batch or edit an existing batch.

After you select the batch number, the system displays the following screen:

```
            General Hospital Adjustment Posting Setup Processor
                                          Mon Oct 08, 1990 03:44 pm

 1 Batch #               2 Batch Description               3 # of Trans
   83                      WEBSTER LAB INC ADJ
 4 Posting Date          5 Mixed Transactions?
   10/08/90                Yes
 6 Total Entered         7 Batch Total                     8 Variance

 9 Adjustment Type      10 Adjustment Percent
   Flat amount
11 Ins Balance to Use   12 Patient Balance to Use
   Account                 Account




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

Field Explanations

1. BATCH # (DISPLAY ONLY)
This field contains the entered batch number or Auto if automatic assignment was chosen.

2. BATCH DESCRIPTION (30-C-R)
This field contains the description of the purpose or contents of this batch.

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

4. POSTING DATE (6-N-R)

This field contains the date on which the batch is posted. You can enter a prior date or use the current system date as a default. The date is used to select the proper G/L period to direct the postings. Backdate days in PAAR Control ensure dates too far in the past cannot be used.

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

This field indicates whether this batch contains more than one type of transaction. A batch of adjustments can contain contractual, other insurance, patient discount, and other patient in any combination. Entry options are **Y** for Yes or **N** for No; the default is **Y**.

6. TOTAL ENTERED (DISPLAY ONLY)

This field contains the total amount of adjustments entered for this batch. If you are creating a new batch, this field is blank.

7. BATCH TOTAL (10-N-R)

This field contains the batch total from your adding machine or calculator tape that you intend to post in this batch. To enter a credit batch, enter a hyphen (-) prior to the amount.

8. VARIANCE (DISPLAY ONLY)

This field contains the difference between the total entered and the batch total. If this is a new batch, this field is blank.

9. ADJUSTMENT TYPE (1-A-R)

This field indicates the adjustment procedure that is used in this batch. Entry options are **F** (flat rate) or **P** (percent); the default is F. Enter **P** if you want the system to calculate the amount based on a percentage.

NOTE: Contract adjustments can only be a flat type.

10. ADJUSTMENT PERCENT (3-N-O)

This field contains the adjustment percent if the Adjustment Type field contains P. The entry range is 1 to 100. Entries are made without the % sign. If the percentage changes for each adjustment being added, this field can be left blank and completed for each posting.

NOTE: This field is not applicable to contracts.

11. INS BALANCE TO USE (TABLE LOOKUP)

This field contains the balance type used in calculating the write-off percentage for Insurance Contractual Adjustments. Your choices are:

• Account Balance - the current balance of the account

• Current Carrier Balance - the current carrier balance

• Original Bill Balance - the estimated liability for the carrier (prorated)

• Manually Entered Balance - a user-defined balance

NOTE: This field is not applicable to contracts.

12. PATIENT BALANCE TO USE (TABLE LOOKUP))
This field contains the balance type used in calculating the write-off percentage for
Patient Discount Adjustments. Your choices are:

• Account Balance - the current balance of the account

• Patient Balance - the patient's balance for the account

• Manually Entered Balance - a user-defined balance

NOTE: This field is not applicable to contracts.

After you complete this screen, you have the option of accepting or editing the entered
information. If you accept the screen, the system displays a list of options for posting
cash:

```
          General Hospital Adjustment Posting Selection Processor
                                              Mon Oct 08, 1990 03:36 pm
 Adjustment Posting Selection Input Options

           Option No.  Option
           --------------------------------------
 Post          1        Contractual Adjustments
               2        Other Insurance Adjustments
               3        Patient Discount Adjustments
               4        Other Patient Adjustments
               5        Contract Adjustments
               6        Balance Transfer & Claim Disposition

               7        Exit Batch




 Enter option number--
```

After you select the Contract Adjustments option, the system displays the following screen:

```
                    General Hospital Contract Setup Processor
                                            Mon Oct 08, 1990 03:36 pm

 1 Batch #            2 Batch Description
   83                   WEBSTER LAB INC ADJ
 3 # of Trans         4 Total Entered       5 Batch Total        6 Variance

                       Contract Adjustment Default
 7 Trans Code/Description







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

Field Explanations

Fields 1 through 6 - Batch #, Batch Description, # Of Trans, Total Entered, Batch Total, and Variance - are displayed from the Batch Header information.

7. TRANS CODE/DESCRIPTION (4-N-O)
This field contains the transaction code and description that can be used for all contract adjustments if you want to use the same transaction code for all or a majority of the adjustments being posted. This transaction code is repeated for each contract in the batch. You can enter the code or a hyphen (-) to display a list of valid codes under transaction type G (other adjustments).

After you complete these fields and accept the screen, the system prompts you to:

Enter contract code, `-` contract names, `*`patient name, `#`social security, or `*`account number --

You can enter the code if it is known. You can use a hyphen (-) to perform a table lookup. After the you enter a hyphen, the system displays all contracts. Entries highlighted are those contracts which are active (in location PA) while the un-highlighted contracts are inactive (in location AR).

You can also enter an asterisk (*) plus a patient name which is similar to the non-contract patient lookup. All accounts matching the pattern identified is displayed. After selecting a specific person, only contract patient account numbers for the person are displayed and accessible. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter a contract through a persons social security number (SSN). After entering the # SSN, the system displays all contract patient account numbers. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can enter an asterisk (*) plus a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract.

After the contract code is selected, the system displays the following screen, which asks you to select a specific bill to post the cash.

```
        General Hospital Contract Cash Posting Processor
                                         Thu Feb 29, 1996 09:03 am
Account ID       Code    Description                       Balance      Loc
A7703992640      MDK     MDK CONTRACT MGT                  $1976.50      PA
Page:01 Bill #   Billed    From      Thru     Bill Amount  Bill Balance
( 1)    8        02/13/96  01/25/96  02/13/96     61.40        55.88
( 2)    7        01/24/96  01/24/96  01/24/96       .00          .00
( 3)    6        01/23/96  12/07/95  01/23/96       .00          .00
( 4)    5        12/06/95  12/01/95  12/06/95    458.20       343.63
( 5)    4        11/30/95  11/30/95  11/30/95       .00        50.00-
( 6)    3        11/29/95  11/23/95  11/29/95    860.20       731.85
( 7)    2        11/22/95  11/22/95  11/22/95    318.70       221.42
( 8)    1        11/21/95  11/21/95  11/21/95  2,988.57     1,456.22
( 9)    A0       02/29/96  02/29/96  02/29/96       .00       100.00-




Enter choice--
```

After you select the specific bill to post an adjustment, the system displays the following screen:

```
            General Hospital Contract Adjustment Posting Processor
                                              Thu Jan 18, 1996 10:46 am
Account ID        Code    Description                        Balance     Loc
 A43654354        SMI     SMITH LAB                          $0.00       AR
 1 Last Payment Date        2 # of Payments       3 Total Payments

 4 Last Adjustment Date     5 # of Adjustments    6 Total Adjustments

 7 Bill Seq #   8 Bill Date    9 Bill Last Adjusted  10 Bill Adjustments
    1            11/24/94
11 Batch Seq #    1

12 Adjustment Date  13 DB/CR? 14 Adjustment Amount    15 New Bill Balance
    01/18/96           -> 16 Trans Code/Description
17 Comments





Enter `D`ebit or `C`redit adjustment? (D/C) [C] --
```

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

1. LAST PAYMENT DATE (DISPLAY ONLY)
This field contains the date on which the last payment was made on this contract.

2. # OF PAYMENTS (DISPLAY ONLY)
This field contains the number of payments made on this contract.

3. TOTAL PAYMENTS (DISPLAY ONLY)
This field contains the total dollar amount of payments made on this contract.

4. LAST ADJUSTMENT DATE (DISPLAY ONLY)
This field contains the date on which the last adjustment was made to the contract.

5. # OF ADJUSTMENTS (DISPLAY ONLY)
This field contains the total number of adjustments made on this contract.

6. TOTAL ADJUSTMENTS (DISPLAY ONLY)
This field contains the total dollar amount of adjustments made on this contract.

7. BILL SEQ # (DISPLAY ONLY)
This field contains the bill sequence number the adjustment will be posted against. This should agree with the option selected on the previous screen.

8. BILL DATE (DISPLAY ONLY)
This field displays the bill date coinciding with the bill sequence number in the Bill Seq # field.

9. BILL LAST ADJUSTED (DISPLAY ONLY)
This field contains the last adjustment date to this specific bill. If no prior adjustments have been made, this field is blank.

10. BILL ADJUSTMENTS (DISPLAY ONLY)
This field contains the total adjustments made to this specific bill. If no previous adjustments have been made, the field is blank.

11. BATCH SEQ # (DISPLAY ONLY)
This field contains the sequence number of this adjustment within the batch.

12. ADJUSTMENT DATE (6-N-R)
This field contains the date on which this adjustment is posted. The default is from the batch header. This field is used in the transaction history and to select the appropriate General Ledger fiscal period for posting.

13. DB/CR? (1-A-R)
This field indicates whether this is a debit or credit entry. Entry options are **D** (debit) or **C** (credit); the default is **C**. The system assumes a credit adjustment unless you override it. A credit adjustment decreases the balance of the account, while a debit increases the balance of the account.

14. ADJUSTMENT AMOUNT (9-N-C)
This field contains the adjustment amount.

15. NEW BILL BALANCE (DISPLAY ONLY)
This field contains the bill balance. It displays what the balance will be when the adjustment is applied.

16. TRANS CODE/DESCRIPTION (4-N-O)
This field contains the transaction code that is used to record this adjustment in the contract account's transaction history and in the GL. You can enter the code or a

hyphen (-) to display a list of valid codes under transaction type G (other adjustments). This field is from the batch header and can be changed.

17. COMMENTS (180-C-O)

This field contains any comments pertaining to this adjustment transaction that you want to enter. You can enter up to 180 characters. When you access this field, the system displays function keys that aid you in entering the information. This transaction is displayed in the contract's transaction history.

Once you have entered the contract adjustment transactions, the cash posting program proceeds the same as with all other types of adjustment posting. You can edit, approve, hold, and print the batch detail, as with other adjustment batch established in the system.

Auto Posting of Contractual Adjustments

This option of posting contractual adjustments is completed automatically as part of the contract billing process. Adjusting charges to contractually agreed rates can be completed using this option or by using pricing levels within Financial Item Master (FIM). If pricing levels are used to bill charges at the agreed rates, the Auto Posting of Contractual Adjustments are not be computed. To not use the Auto Posting function, you need to not specify a write-off percent/amount on the Patient Accounting process defined within the Contract Financial Information table. The auto posting of contractuals is using the charge value being sent to the Patient Accounting system.

The information required to compute the contractual is located in the Contract Financial Information table. The field controlling the write off percent is the W/O Percent field on an overall system level. Exceptions can be added on the SIM department and the specific SIM department charge item. The calculation is made by using the following hierarchy: (first criteria) - charge level dollar exception; (second criteria) - SIM department exception; then (third criteria) - overall system write off percent.

As part of the billing process, the system automatically posts a general ledger journal entry, creates a Automatic Write Off report (FDR300) giving detail for the journal entry, and generates a transaction history entry for the specific contract.

The general ledger journal entry is generated using the mapping key for VB or VA (Contract A/R and Contract PA respectively) creating the credit side of the journal entry. The Debit side of the journal entry is generated using the transaction code located Auto Adjustment Transaction Code field in the Contract Financial Information table. The transaction code is created using Patient Accounting's Transaction Codes table located within the Table and Financial Table Maintenance menu options. After establishing the transaction code in Patient Accounting, it must be mapped to the general ledger. This is accomplished by entering the General Ledger processor using the following menu options: GL Mapping Maintenance; GL Mapping Table Entry; TRANG mapping table; and Transaction code mapped to a General Ledger account. The summary of the journal entry made is as follows:

TRANG code mapping   xxxx
VA mapping (cycle bills)   xxxxor
VB mapping (final bills)   xxxx

The contractual adjustments is accumulated using an Adjustment Batch Number and is posted during the downtime section of midnight processing. On the part of the contract, the adjustment is linked to the specific contract bill as well as adjusting the cumulative contract balance.

An example of how the contractual adjustment is calculated follows. Criteria used are:

```
Example 1:   Charge item                      knee X-ray
      Dollar amount of charge
       sent to Patient Accounting            $100.00
      Overall percentage W/0                   10.00%
      RAD SIM Department W/O %                 25.00%
      knee X-ray dollar exception for the
      specific contract                       $ 50.00
      Gross Charge Amount                      100.00
      Net Charge Amount                         50.00
                                             ------
      W/O Amount                                50.00


Example 2:
      Charge item                             knee X-ray
      Dollar amount of charge
       sent to Patient Accounting            $100.00
      Overall percentage W/0                   10.00%
      RAD SIM Department W/O %                 25.00%
      knee X-ray dollar exception for
         the specific contract              Not Defined
      Gross Charge Amount                      100.00
      W/O Percentage                           25.00%
                                             ------
      W/O Amount                                25.00
      Net Charge Amount                         75.00

Example 3:
       Charge item                            knee X-ray
       Dollar amount of charge
        sent to Patient Accounting           $100.00
       Overall percentage W/0                  10.00%
       RAD SIM Department W/O %              Not Defined
       knee X-ray dollar exception for
       the specific contract                Not Defined
          Gross Charge Amount                  100.00
      W/O Percentage                           10.00%
                                             ------
      W/O Amount                                10.00
      Net Charge Amount                         90.00
```

CONTRACT NOTES

Contract Notes allows you to create and view notes for contracts. These notes can be free-form or standard notes. Once a note is entered, the note can not be edited. Adding notes to a contract can be accomplished by either knowing the applicable contract or by entering a patient attached to the contract. If more than one person is attempting to enter notes on the same contract, the second person receives the message *Account data in use. Retry!*. The system does not allow multiple access to Notes concurrently to prevent notes from being incorrectly deleted.

Standard notes are user-defined and contain a brief description of a particular account event. An example of a standard note could be *Sent claim - claim returned -wrong address.* Standard notes are assigned a transaction type of T and are recorded in the account's transaction history. The hospital can define any number of standard notes in the system.

Free-form notes are made up of two parts. The first part is a brief one line description of the contents of the note as summarized by you. This line description can be used in the future to locate the note. The second part can be up to 13 lines of 75 characters.

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

> *Enter contract code, `-` contract names, `*`patient name, `#`social security, or `*`account number --*

You can enter the code if it is known. You can use a hyphen (-) to perform a table lookup. After the you enter a hyphen, the system displays all contracts. A partial name lookup is not accepted by the system and creates the following message *Error: Invalid format for this field!*. Entries highlighted are those contracts which are active (in location PA) while the un-highlighted contracts are inactive (in location AR).

You can also enter an asterisk (*) plus the patient name which is similar to the non-contract patient lookup. All accounts matching the pattern identified is displayed. After selecting a specific person, only contract patient account numbers for the person are displayed and accessible. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter a contract through a persons social security number (SSN). After entering the # SSN, the system displays all contract patient account numbers. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter an asterisk (*) followed by a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract.

After you enter or select the code, the system displays the following screen:

```
                General Hospital NEW NOTES [ALL TYPES] Processor
                                            Fri Jun 27, 2003 10:15 am
Account ID        Code    Description                   Balance    Loc
A7703992640       MKD     MKD CONTRACT MGT              $1976.50    PA
Page:01                            Notes            ##=Current Choices
( 1) CLAIM RETURNED - WRONG ADDRESS   12/04/94 [S] Smith,Mary A
( 2) FF BILLER NOTE FOR RAH           12/04/94 [F] Smith,Mary A
( 3) WAITING FOR ATTACHMENTS - MR     11/30/94 [S] Smith,Mary A
( 4) BILLER NOTE 1/RFH                11/30/94 [F] Smith,Mary A







 Enter choice, view all(V), add free form(F) or standard(S) notes--
                        end selection(NL)
```

Information displayed on this screen includes the contract account number, contract code, contract description, the contract balance and contract location. Note information includes the note and description, the date it was assigned to this account, whether the note is free-form [F] or standard [S], and the name of the system user who assigned this standard or created this free-form note.

When this screen displays, you have several options:

• You can view all account notes by entering **V** (view all).

• You can add a free-form note by entering **F** (free-form).

• You can add a standard note by entering **S** (standard).

You can view all or selected choices of notes. As the notes are displayed:

• You can press ENTER to take you to the next note.

• You can enter **/P** to take you back to the previous note.

• You can enter **/** to take you to the next note.

• You can press (.) ENTER to exit the Note function.

To enter a standard note, enter **S**. The system prompts you to enter the transaction code used to record this note in transaction history. You can enter the code (up to four

digits) or a hyphen (-) to display a list of valid codes. If you enter a hyphen (-), the system displays the following screen:

```
                 General Hospital NEW NOTES [ALL TYPES] Processor
                                                 Wed Dec 06, 1995 11:43 am
Account ID          Code     Description                       Balance      Loc
A7703992640         MKD      MKD CONTRACT MGT                  $1976.50     PA
   Transaction                                Valid            Combined to
   Type  Code  Description                    Accts   Combine  Type  Code
( 1) T - 0007  SENT DATA MAILER               A/R
( 2) T - 0008  Telephone Follow Up            Any
( 3) T - 0010  SENT COLLECTION LETTER         A/R
( 4) T - 0011  SENT DETAILED STATEMENT        A/R
( 5) T - 0099  NOTES                          Any




   Enter choice--
```

Along with basic contract data, information displayed includes the transaction type, transaction code, a description of the note, and the type of accounts for which this note is valid. The combine print function is not valid for this transaction type.

After you enter or select the transaction code, the note associated with the code is added to the contract and the transaction is completed.

To add a free-form note, enter **F**. The system displays the following screen:

```
                 General Hospital NEW NOTES [ALL TYPES] Processor
                                                 Wed Dec 06, 1995 11:07 am
Account ID          Code     Description                       Balance      Loc
A7703992640         MDK      MDK CONTRACT MGT                  $1976.50     PA
 1 Code      2 Description                    3 Creation Date
   NEW                                          12/06/95
 4 Created By                     5 Last Edit date        6 Edit text?
   Smith,Mary A                     12/06/95 11:52am




   Press NL--
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the word NEW in this field. Once the message is completed and accepted, the system assigns a code number. Each free-form note is assigned a code number corresponding to the order of its creation. The first note is 1, the second 2, and so on.

2. DESCRIPTION (30-C-R)
This field contains the description of the purpose of the note. This description is displayed in the account's transaction history and on the first screen of the Account Notes function.

3. CREATION DATE (DISPLAY ONLY)
This field contains the date on which the note was created. This date is used as the note creation date in the account's transaction history and displays on the list of Account notes. Account notes are displayed in reverse chronological order.

4. CREATED BY (DISPLAY ONLY)
This field contains the name of the user creating this note.

5. LAST EDIT DATE (DISPLAY ONLY)
This field contains the date and time this note was created. When a new note is being created, the system displays the current date and time.

6. EDIT TEXT? (1-A-R)
This field indicates whether the length of a new free-form note exceeds the 30-character description. If it does, enter **Y**; if it does not, enter **N**. The default is **N**.

If you enter Y, the system displays the following screen:

```
              General Hospital NEW NOTES [ALL TYPES] Processor
                                    Mon Mar 27, 2006 10:40 am
 Account       Name                  FC Typ Admit    Disch       Balance Loc
 89334-00001  HALL,RUTH A               I/P 11/25/95 11/30/95      60.00   AR/FCRV
  1 Code      2 Description                 3 Creation Date
    NEW         Ins. Coverage Terminated        12/06/95
  4 Created By                       5 Last Edit date       6 Edit text?
    Smith,Mary A                       12/06/95 11:52am         Yes
 -----------------------------------------------------------------------------
 01| Patient's employer called to advise that insurance coverage is being    |
 02| terminated at end of month.  Patient notified and will make financial    |
 03| arrangements, if necessary, but anticipates being discharged prior to    |
 04| end of month.  Attending physician's office notified.                    |
 05|                                                                          |
 06|                                                                          |
 07|                                                                          |
 08|                                                                          |
 09|                                                                          |
 10|                                                                          |
 11|                                                                          |
 12|                                                                          |
 13|                                                                          |
    F1           F2            F3       F4       F5          F6         F7    F10
    Delete Line  Insert Line  Center   Exit   Store Line  Restore Line Pack  Help
```

The function keys listed at the bottom of this screen are used to help you enter this message. Pressing F4 exits the extended message text. The system then prompts you to accept the screen.

CONTRACT FOLLOW UP

The collection process can be initiated through the use of telephone work file entries or detail statements. Telephone work files are only allowed if the user uses the Receivables Workstation module. You define the different messages that print on the detail statements or display as part of the telephone work file entries. You control whether the collection process is completed on the contract level or at a specific contract bill level. The system does not allow a mixture of the two methods. If you change the method, the system converts all follow up to the new methodology without your intervention.

The two different ways the collection process can be initiated is by a demand follow up request or through the follow up schedule steps. The specific follow up schedule is linked to a specific Contract through the Contract Financial Information table. The follow up schedule in turn uses predefined contract statement and telephone messages. Any changes to the follow up schedule are effective the next time follow up is processed. Customized schedules are not allowed for contracts.

The two reports created as part of contract follow up are the Contract Detail Statements (FDR400) and the Contract Collector Work file Report (FFR500). Both of these reports are created as part of midnight processing. The sort sequences for the detail statements are defined within the Sort Sequences menu within the Maintain Facility Information menu option. The sort sequence for the Telephone work files are controlled by a primary sort sequence and an optional secondary sort key. Access for the sort sequences is through the Maintain Facility Information followed by the Biller/ Collector Work List Control menu option. A change in the sort sequences are effective during the next midnight processing. Telephone work files are resorted in the entirety through a midnight processing job based on current sort criteria. The newly sorted work files are then printed on report FFR500.

The follow up process can be completed using two different theories. The first theory is collecting on the cumulative contract balance. The second theory is by collecting on individual contract bills with a positive balance. If the method of collection is changed from bill level to contract level, the system automatically deletes the individual bill(s) follow up requests and follow up information and link them to the contract. The system assigns the next follow up date as today plus the wait days on the collection schedule. The next follow up step is set to one. This information needs to be reviewed by the collector and revised as appropriate. On the other hand, if the collection process is changed from contract level to bill level, the system creates individual bill follow up information using the collector, collection schedule, next follow up date, and next follow up step as noted at the contract level follow up for any bill with a positive balance. The collector needs to manually review the individual bills and make appropriate changes as needed. The specific bill follow up information can be changed for the schedule and collector. Specific collection schedule information can not be customized.

The system only allows one demand telephone and one demand detail statement per day. A demand follow up is not allowed if follow up is scheduled for tonight. This would apply for each individual bill if the collection process is at the bill level or to the contract

if the collection process is at the contract level. If demand follow up is requested for a statement and/or telephone work file entry, and later the next follow up date is changed to today, the demand request(s) are deleted.

Follow up is automatically terminated by the system for a bill when the balance goes to a negative or zero balance because of a cash or adjustment posting. If a cash or adjustment entry brings a bill balance to a positive balance, the system automatically initiates the collection process for the contract or bill.

The next follow up date is calculated when a bill is generated and the collection process is on a bill basis as today plus the wait days per the collection schedule. If follow up is at the contract level, the first bill generated for the contract calculates the next follow up date as today plus the wait days per the collection schedule. Subsequent bills attach to the contract and the next follow up date is not recalculated.

The follow up step is never automatically resequenced by the system. This has to be completed manually. If follow up processes through all of the steps, the system loops the last step automatically.

Contract Follow Up

This function allows the collector to monitor the collection process and revise the next follow up information if needed. This system does not automatically resequence next follow up steps as is the case with Guarantor level follow up. The process does not also allow for any time out process. If the collection process crosses the follow up steps, and goes off the end of the schedule, the system continually completes the last step of the schedule.

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

Enter contract code, `-` contract names, `*`patient name, `#`social security, or `*`account number --

You can enter the code if it is known. You can use a hyphen (-) to perform a table lookup. After the you enter a hyphen, the system displays all contracts. A partial name lookup is not accepted by the system and creates the following message *Error: Invalid format for this field!*. Entries highlighted are those contracts which are active (in location PA) while the un-highlighted contracts are inactive (in location AR).

You can also enter an asterisk (*) plus the patient name which is similar to the non-contract patient lookup. All accounts matching the pattern identified is displayed. After selecting a specific person, only contract patient account numbers for the person are displayed and accessible. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter a contract through a persons social security number (SSN). After entering the # SSN, the system displays all contract patient account numbers. After

selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter an asterisk (*) plus a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract.

After you enter or select the code, the system displays one of two screens which shows information that pertains to the follow up for a specific contract or bill. The screen that displays depends on the Multiple? field in the Contract Financial Information table. Both screens are described below. If the Multiple? field is set to No, you are completing follow up on individual bill levels rather than at a contract level. The following screen displays:

```
             General Hospital Contract Cash Posting Processor
                                             Thu Feb 29, 1996 09:03 am
 Account ID        Code    Description                     Balance      Loc
 A7703992640       MDK     MDK CONTRACT MGT                $1976.50      PA
 Page:01 Bill #    Billed    From      Thru     Bill Amount  Bill Balance
 ( 1)     8        02/13/96  01/25/96  02/13/96      61.40        55.88
 ( 2)     7        01/24/96  01/24/96  01/24/96        .00          .00
 ( 3)     6        01/23/96  12/07/95  01/23/96        .00          .00
 ( 4)     5        12/06/95  12/01/95  12/06/95      458.20       343.63
 ( 5)     4        11/30/95  11/30/95  11/30/95        .00        50.00-
 ( 6)     3        11/29/95  11/23/95  11/29/95      860.20       731.85
 ( 7)     2        11/22/95  11/22/95  11/22/95      318.70       221.42
 ( 8)     1        11/21/95  11/21/95  11/21/95    2,988.57     1,456.22
 ( 9)     A0       02/29/96  02/29/96  02/29/96        .00       100.00-




 Enter choice--
```

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility which the contract is associated.

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

CONTRACT 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.

BALANCE (DISPLAY ONLY)
This fields displays the current balance on the contract. It is a cumulation of all bill balances and unbilled charges.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

SEQUENCE # (DISPLAY ONLY)
This field is a sequential number listing.

BILL # (DISPLAY ONLY)
This field contains the bill sequence number in reverse chronological order.

BILLED (DISPLAY ONLY)
This field displays the billing date for the specific bill sequence number.

FROM (DISPLAY ONLY)
This field displays the from dates of service of charges included.

THRU (DISPLAY ONLY)
This field displays the through service date of charges included on the specific bill.

BILL AMOUNT (DISPLAY ONLY)
This field displays the total dollar amount of charges billed. The value is stated at the gross charge amount not including any automatically calculated contractual adjustments.

BILL BALANCE (DISPLAY ONLY)
This field displays the current bill balance which is net of any payments and adjustments.

After a specific bill sequence is selected with the Multiple? field set to No or if the Multiple? field is set to Yes, the following screen is displayed:

```
                    General Hospital Contract Follow Up Processor
                                        Thu Feb 22, 1996 07:27 am
 Code Contract Description            Bill #  Bill Date          Balance     Loc
 MD1 MD1 INDUSTRIES                   1       02/01/96          21,566.70      PA
  1 Collector Name                            2 Hold F/U?   3 F/U Schedule
    98-KASS,MICK L                                          6
  4 Next F/U Date  5 Next Sequence  6 Next Type   7 Next Message
    02/29/96    2
  8 Last F/U Date  9 Last Sequence 10 Last Type  11 Last Message
                  2
 12 Last F/U Balance

 13 Seq #              Paper Code                  Phone Code
    1            2-STATEMENT MESSAGE          1-TELEPHONE MESSAGE
    2            2-STATEMENT MESSAGE          1-TELEPHONE MESSAGE




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

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field displays only if the follow up Multiple? field is set to Yes in the Contract
Financial Information table. This field, if displayed, contains the contract ID number.
The letter preceding the number indicates the facility which the contract is associated.

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

CONTRACT 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.

BILL # (DISPLAY ONLY)
This field displays the bill sequence number selected on the prior screen. This only
applies if the follow up Multiple? field in the Contract Financial Information table is set
to No. If this field is set to Yes, this field does not display

BILL DATE (DISPLAY ONLY)
This field displays the bill date applicable to the specific bill sequence noted above.
This field does not display if the Multiple? field in the Contact Financial Information
table is set to No.

BALANCE (DISPLAY ONLY)
This fields displays the current balance on the contract. It is a cumulation of all bill
balances and unbilled charges.

LOC (DISPLAY ONLY)
This field contains the location of the contract.

1.   COLLECTOR NAME (2-N-R)
This field contains the follow up collector for the contract or bill. If the collection process
is at the contract level, this field displays the collector as identified in the Contract
Financial Information table. In this situation changing the collector also updates the
Collector in the Contract Financial Information table. If you are completing follow up on
specific bills individually, changing the collector information on this field only applies to
the specific bill selected before displaying this screen.

2.   HOLD F/U? (1-C-O)
This field states whether the follow up process has been stopped on the contract or the
specific bill. If follow up is performed on individual bills, only the specific bill is taken out
of follow up and does not affect the collection process on any other bills associated with
the contract. Placing follow up on hold also deletes any telephone workfile entries
associated with the contract/bill.

3. F/U SCHEDULE (3-N-R)
This field contains the follow up schedule assigned to the contract or bill. If the collection process is on a individual bill basis (Multiple? is No), changing this information only affects the individual bill sequence.

If the collection process is on a contract level (Multiple? is No), changing this information also changes the F/U Schedule information within the Contract Financial Information table.

4. NEXT F/U DATE (6-N-R)
This information contains the next follow up date for the contract/bill. Valid dates are today or future dates of not more than 365 days.

5. NEXT SEQUENCE (2-N-R)
This field contains the next follow up step to be processed. The sequence is limited to a value of 1 through the maximum number of steps in the schedule as displayed in the Follow Up Schedules field.

6. NEXT TYPE (1-A-O)
This field completed if you prefer to complete a different type and/or message of follow up the next time it is scheduled to process. If this field is completed, the Next Message field is required and takes precedence over information in the follow up schedule steps. Valid options are detail statements and telephone workfile (only if the Receivables Workstation is used).

7. NEXT MESSAGE (4-N-O)
This field can only be accessed if Next Type field is completed. If Next Type field is later blanked out, this field is blanked out. If the Next Type field is completed, completion of this field is required. This specific message, if completed, is generated the next time follow up is generated.

8. LAST F/U DATE (DISPLAY ONLY)
This field displays the last time follow up was completed for the contract/bill.

9. LAST SEQUENCE (DISPLAY ONLY)
This field displays the last follow up step/sequence processed.

10. LAST TYPE (DISPLAY ONLY)
This field displays the last follow up type (D - statement or T - telephone) processed.

11. LAST MESSAGE(DISPLAY ONLY)
This field displays the last message number processed for the contract/bill

12. LAST F/U BALANCE (DISPLAY ONLY)
This field contains the balance of the contract when follow up was last processed.

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13. **FOLLOW UP SCHEDULE STEPS (DISPLAY ONLY)**

SEQ # (DISPLAY ONLY)
This field lists the steps of the schedule.

PAPER CODE (DISPLAY ONLY)
This field displays the message which is completed for this step unless otherwise noted in the Next Type and Next Message fields. If this field is blank, it represents only telephone follow up is generated.

NOTE: Telephone follow up is generated if the Collector Workstation module is used. Information from the Contract Follow up Schedule table is displayed based on the follow up schedule in the F/U Schedule field.

PHONE CODE (DISPLAY ONLY)
This field is valid only if the Collector Workstation module is used. Information from the Contract Follow up Schedule table is displayed based on the follow up schedule in the F/U Schedule field.

Contract Demand Follow Up

This function allows you to initiate a collection process separate from the regular follow up schedule. This request may be a contract statement or contract telephone workfile entry. Only one demand request per type can be made per day. Only one demand telephone workfile entry and/or one demand statement can be requested in one day. If follow up is scheduled for today, a demand request is not allowed for a telephone or a statement. This was completed to prevent multiple follow up for a specific type (for example, statement or telephone) to be generated. If a demand request already exists for a specific type, the system notifies you by displaying the following message *Phone request for contract currently exists!*. After this message displays, the prior request is displayed on the Contract Demand Follow up screen. At this point you can change the prior request message and transaction history type/code.

Upon exiting the screen, you have the option to delete a previous request of the specific type detail statement (D) or telephone (T).

```
                General Hospital Contract Demand Follow Up Processor
                                           Wed Feb 21, 1996 05:33 pm
Account ID          Code    Description                        Balance      Loc
A12345              121     A                                  $21.25       PA
1 Follow Up Type                          2 Message Number
  Detail Statement                          2-STATEMENT MESSAGE
3 Transaction Type/Code
  T0013-PATIENT CALLED, QUEST IN




















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

Field Explanations

1.   FOLLOW UP TYPE (1-C-R)
This field determines if you prefer to request a Telephone workfile entry or a Detail
Statement.

2.   MESSAGE NUMBER (4-N-R)
This field identifies which message applies to the demand request. If field one was a
Telephone type, this field only allows entries identified in the Contract Telephone
Message table. On the other hand, if the Follow Up Type field is a Detail Statement,
only the Contract Statement Messages are allowed. These entries have been
previously defined through the Contract Statement Messages table. The Contract
Statement Messages and Contract Telephone Message table are located within the
Patient Accounting system through the Tables and Financial Table Maintenance menu
options.

3.   TRANSACTION TYPE/CODE (4-N-R)
This field identifies which message should be placed in Transaction History when the
request is processed. The transaction type in this message is dependent on how field
one was completed. If the Follow Up Type field is completed as a Telephone Workfile
entry, the transaction code for this field is of the M type. On the other hand, if the Follow
Up Type field is completed as a Detail Statement, the transaction code for this field is
the T type. These transaction codes are defined within the Patient Accounting process
through the Tables, Financial Table Maintenance, and Transaction Code Table menu
options.

CONTRACT ACCOUNT BILL REQUEST

Contract cycle and final bills are automatically generated according to the parameters entered on each STAR Patient Care Contract Names table. In addition to these system-generated bills, you can choose to manually select a contract account to be billed using the Contract Account Bill request function. This function allows you to produce a reprint of a previously produced bill. You can also request a cycle or a final bill at any time through this function. A bill is generated even if the Suppress 0 Bills parameter in the Financial Information table is set to Yes.

When a contract account has been inactive for the number of days specified in the STAR Patient Care Contract Names table, an *inactivate flag/notice* is sent to the STAR Patient Care system. The contract is marked to be deleted by the system and it becomes inactive. At the same time, all associated accounts are auto-discharged (if they have not been discharged already) and the charge-until dates are set to the batch date. No additional registrations or charges can be entered on the contract or associated contract accounts after this point. The contract is final billed during the next midnight processing, at which point the contract changes from account location PA to location AR and the contract table entry is filed as deleted. If the contract account has been cycle billed previously, the final bill only prints detail unbilled charges and the previously billed amount is printed as the balance forward. This is consistent with the existing process for final bills.

The contract bill form is the existing patient bill form used by the hospital and is sorted based on the sort parameters entered for each facility. The charges on the bill are separated by patient account and appear in chronological order. The patient charges print with either the patient ID number or patient name, depending on the entry in the STAR Patient Care Contract Names table. Charges not associated with a specific patient print first. Payments and adjustments print at the end of the bill.

NOTE: Contract accounts are not associated with insurance plans. As a result, claim forms are not generated for these accounts.

After you select the Contract Account Bill Request option, the system prompts you to select a facility (if this is a multi-facility installation) and then displays the following prompt:

> *Enter contract code, `-` contract names, `*`patient name, `#`social security, or `*`account number --*

You can enter the code if it is known. You can use a hyphen (-) to perform a table lookup. After the you enter a hyphen, the system displays all contracts. Entries highlighted are those contracts which are active (in location PA) while the un-highlighted contracts are inactive (in location AR).

You can also enter an asterisk (*) plus the patient name which is similar to the non-contract patient lookup. All accounts matching the pattern identified is displayed. After selecting a specific person, only contract patient account numbers for the person is

displayed and accessible. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter a contract through a persons social security number (SSN). After entering the # SSN, the system displays all contract patient account numbers. After selecting a specific patient account number, the system identifies and uses the applicable contract information.

You can also enter an asterisk (*) plus a specific patient account number. If the patient account number is not a contract account number, the system displays the following message *Error: Account is not a contract account* followed by the prompt to select a contract.

Enter the code, partial name followed by a hyphen (-), or a hyphen (-) to display a list of valid contract name codes. After you enter or select the code, the system displays the following screen:

```
            General Hospital Contract Account Bill Request Processor
                                               Fri Oct 12, 1990 04:59 pm
Account ID        Code    Description                       Balance     Loc
P12232234         WLI     WEBSTER LAB INC                   $6579.39     PA

 1 Total Amt Billed            2 Unbilled Amount
   $6,398.94                     $220.95
 3 Bill Type                   4 Reprint of
   R Reprint                     1 Cycle 08/29/90
 5 Bill From Date              6 Bill Through Date
   09/16/90                      10/12/90
 7 Last Bill Date              8 Last Bill Type
   09/15/90                      Cycle
 9 Comment                    10 Requested By
   LAB REQUESTED EXTRA COPY      Smith,Mary A




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

When the bill request is accepted, it is filed until midnight processing.

Field Explanations

ACCOUNT ID (DISPLAY ONLY)
This field contains the contract ID number. The letter preceding the number indicates the facility with which the contract is associated.

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

DESCRIPTION (DISPLAY ONLY)
This field contains the description associated with the contract code.

BALANCE (DISPLAY ONLY)
This field contains the current balance on the contract.

LOC (DISPLAY ONLY)
This field contains the account location of the contract.

1. TOTAL AMT BILLED (DISPLAY ONLY)
This field contains the total dollar amount billed to the contract.

2. UNBILLED AMOUNT (DISPLAY ONLY)
This field contains the total dollar amount unbilled to the contract.

3. BILL TYPE (1-A-R)
This field contains the type of bill that is requested. Options are:

    C - cycle
    E - end of month cycle
    F - final
    R - reprint

If the contract is already in location AR, this field automatically displays R - Reprint.

If the Contract Financial Information table, which provides data required for bill production, is not completed, the following error message is displayed:

Contract financial information missing - bill request not allowed

You must complete the Contract Financial Information table prior to contract bill production.

4. REPRINT OF (TABLE LOOKUP-C)
This field specifies the bill that you want to reprint. If the Bill Type field contains R, the system displays a table of previously produced bills.

If you select the final bill, and contract charges have already been purged based on the number of days set in the Data Retention Parameters, the following error message displays:

Account is final billed without charges - reprints not allowed

5. BILL FROM DATE (DISPLAY ONLY)
This field contains the beginning date of charges that are included on the bill.

6. BILL THROUGH DATE (DISPLAY ONLY)
This field contains the ending date of charges that are included on the bill.

7. LAST BILL DATE (DISPLAY ONLY)
This field contains the date on which the last bill was generated.

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8.   LAST BILL TYPE (DISPLAY ONLY)
This field contains the type of bill that was last generated.

9.   COMMENT (30-C-O)
This field contains comments regarding the bill request. The system deletes the comments when the bill is produced.

10. REQUESTED BY (DISPLAY ONLY)
This field contains the name of the user who initiated the request.

CONTRACT REPORTS

Contract Year-To-Date Report

The Contract Year-To-Date Report function provides a summary of contract activity by contract account for a specified year. For more details and an example of this report, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide.* After selecting this option from the menu, the following prompt displays:

Print Contract Year to Date Report? (Y/N) [N]--

If you enter **Y**, you are prompted to enter the year you want printed. Enter only the last two digits (for example, to print the report for 1989, enter 89). After entering the year, the report begins printing immediately on the designated printer. The following message displays after the year is entered:

Compiling and Printing

To enter the default, which is No, press ENTER or **N**.

NOTE: This report is called on a year-to-date basis and produced in the STAR Patient Care system under the system name YTD*, where * is the facility designation. This report does not exist within the STAR Financials system.

Contract ATB Reports

The Contract Aged Trial Balance (ATB) report (FDRATB) function provides a listing of all contract bills with a non-zero balance. The report can be generated at month end through midnight processing, a specific date through midnight processing, or online. For more details and an example of this report, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide.*

NOTE: You can use the STAR Audit Service to audit user requests for this report. The Audit Service collects and stores information such as report request date and time, the name of the user requesting the report and the criteria selected for the report. For more information, see the *STAR Audit Service Reference Guide.*

This report provides information pertaining to contracts with a non-zero bill balance. Zero bill balances are not reflected on the report to eliminate potentially large quantities of irrelevant information. The information listed on the report can be requested using current balances or balances as of midnight. The report(s) can be requested to run as part of midnight processing tonight, midnight processing at month end, and/or now. Unlike the Non-contract Management Aged Trial Balance (ATB), the definition (Define ATB Report) and request (Request ATB Report) is combined under one function.

This report can be sorted by bill date, contract code by bill date, descending balance or follow up collector code. Page breaking by the contract code by bill date or follow up collector code are user controlled options. A request is facility specific. The billing information is aged using the Report Aging Codes defined within the Financial Table Maintenance menu option. The reserve percentages defined in the Report Aging Code table do not apply to the Contract ATB reports.

GL UPDATES

Contract postings to the general ledger occur the same way as patient-related postings, by summarizing during the day and posting to the general ledger during midnight processing (batch). The contract postings appear on the same general ledger reports as the patient-related postings.

General ledger statistics are not created for contract accounts.

Separate PA and AR control accounts exist for balancing.

Revenue

The key to the mapping table for revenue for the contract charges is VR. The default key for revenue is DFVR. The only key component that makes up the entry for general ledger is the revenue center. There are no user options for keys in the general ledger for contract accounts.

The other side of the entry for the charge is based on whether the contract account is in PA or AR. The PA mapping table key is VA; the AR mapping table key is VB.

```
        Charge                               Credit

  Debit      Credit                    Debit      Credit
  -------|--------                      -------|--------
  VA     | VR                          VR     | VA
  or     |                                    | or
  VB     |                                    | VB
```

Cash and Adjustments

Transaction type N (non-Patient Cash) is used for cash posting and transaction type G (other Adjustments) is used for adjustments. The default key for contract cash is DFTRANN; the default key for contract adjustments is DFTRANG. The transaction code is a required key component for the general ledger entry in the mapping table. There are no user options for the key components for the transaction codes.

The other side of the entry for cash and adjustments use VA or VB depending on the account location of the contract at the time the transaction is posted.

```
     Cash Payment                        Payment Reversal

   Debit  | Credit            Debit  | Credit
   ----------------           ----------------
 TRANN   | VA                VA      | TRANN
         | or                or      |
         |   VB                VB    |
```

```
      Debit Adjustment                      Credit Adjustment

      Debit  |  Credit                      Debit  |  Credit
      ----------------                      ----------------
      VA     | TRANG                        TRANG  | VA
      or     |                                     | or
      VB     |                                     | VB
```

Control Account

The PA and AR Control Accounts are defined in the PA/GL Mapping table. The key for the PA Control Account is VA. The AR Control Account key is VB. There are no key components for these control accounts.

BALANCING

Contract accounts are not included in the daily subsidiary totals for PA and AR patient accounts. There is a separate subsidiary total for contract PA and AR accounts. There is no BD location for contract accounts. There are separate General Ledger control accounts for contract PA and AR balances. The set up and updating of these control accounts is discussed in the GL section of this document.

To calculate the subsidiary total for contract accounts in PA, the balancing programs must total all contract accounts and their associated patient accounts in location PA. To calculate the subsidiary total for contract accounts in AR, the balancing programs must total all contract accounts and their associated patient accounts in location AR.

There are separate balancing screens for contract subsidiary totals which are updated daily. The opening balance always equals the previous day's subsidiary total. Revenue, cash, adjustments and final bill amounts update the balancing screens in the same manner as the existing patient PA and AR balancing screens. Since there are no system-generated refunds for contract accounts, this field is always zero. There is also a balancing report which can be printed. You are prompted to print the balancing report as you exit the screen.

Contract PA Daily Balancing

Contract Patient Accounting totals are displayed as a tool for viewing the financial position of Contract PA. The information presented on this screen is available in your financial reports. However, to facilitate the process of searching through many reports to obtain the information, it is displayed here.

You use this information to reconcile the ending balance to the subsidiary opening balance. From here you can also determine if your account keys are set to properly map the data to the General Ledger. For more information on this function, refer to the GL Mapping Maintenance section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

NOTE: The Contract PA Daily Balancing function is selected from the Financial System Management menu and the Daily Balancing Functions submenu.

The system determines the extent to which you can edit the fields on this screen according to your security level and whether the system is in balance. The system uses the following criteria:

- If your security is less than 80 and the system is in balance, you cannot edit any field on this screen.

- If your security is less than 80 and the system is out of balance, you can edit the Comments fields only.

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- If your security is 80 or above, you can edit any field on this screen, regardless of whether the system is in balance or out of balance.

After selecting the Contract PA Daily Balancing, the system prompts you to select a facility (if this is a multi-facility installation. The system then displays the following prompt:

Enter control date. (Yesterday)--

The following screen is displayed:

```
              General Hospital Contract PA Daily Balancing Processor
                                              Wed June 19, 2002 10:22 am

( 1)Control Date      : 11/07/90               1 - Facility 1

( 2) Opening Balance  :        8,333.07
( 3) Revenue          :          195.35
( 4) Final Bill Total :
( 5) Cash             :
( 6) Adjustments      :
( 7) Late Charges     :            0.00
( 8) Ending Balance   :        8,528.42

( 9) Subsidiary Balance:       8,528.42
(10) GL Control Balance:       6,097.12

(11)Comments          :Corrected by JE #26
(12)
(13)Reconciled by     :Smith,Mary A


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

NOTE: Contract PA is in balance if the Ending Balance, Subsidiary Balance and GL Control Balance are equal.

Field Explanations

1. CONTROL DATE (DISPLAY ONLY)
This field contains the date for which the daily balancing is displayed.

2. OPENING BALANCE (DISPLAY ONLY)
This field contains the system-supplied prior day's subsidiary balance from the Financial Balance routines.

3. REVENUE (DISPLAY ONLY)
This figure represents the total contract charges and credits for the control day. This figure is added to the opening balance. You can verify this figure by looking at the total on report FDRAJR. You should also verify that the total revenue on STAR Financials equals the total revenue on STAR Patient Care.

4. FINAL BILL TOTAL (DISPLAY ONLY)
This figure represents the dollar amount transferred to AR, (those contract accounts final billed) and is subtracted from the opening balance. You can verify this figure by looking at the total final-billed account balance on report FDR200.

5. CASH (DISPLAY ONLY)
This figure represents cash posted to Contract PA; it is subtracted from the opening balance. You can verify this figure by looking at the total Contract PA cash on report FAR130.

6. ADJUSTMENTS (DISPLAY ONLY)
This figure represents any adjustments, such as courtesy discounts, administrative adjustments, employee discounts, charity write-off, to an account in Contract PA. This amount is added/subtracted to the opening balance. You can verify this figure by adding the Contract PA totals on report FAR210.

7. LATE CHARGES (DISPLAY ONLY)
This figure represents the dollar amount of any late charges billed in Contract PA. This figure is part of the Revenue field and is subtracted from the opening balance. You can verify the total late charge amount on reports FDRAJR and FDRAJR1. Late charges are not currently allowed on contract accounts, so this field always contains zero (0).

8. ENDING BALANCE (DISPLAY ONLY)
This field contains the system-supplied ending balance, which is the total of the previous fields.

For example:

```
Opening Balance + Revenue - Final Bill Total - Cash +/- Adjustments - Late
Charges = Ending Balance.
```

---

9. SUBSIDIARY BALANCE (DISPLAY ONLY)
This field contains the system-calculated subsidiary balance. This figure should equal the figure displayed in the Ending Balance field. If there is a discrepancy, then Contract PA needs to be reconciled. The system calculates this balance by adding the account balance of every account in Contract PA.

10. GL CONTROL BALANCE (DISPLAY ONLY)
This figure represents the General Ledger control balance, which should equal the subsidiary balance. This is the journal entry *Contract PA Daily Journal Entry* from the Patient Accounting system. You need to verify that the total GL activity for Contract PA matches the total activity reflected on the Daily Report. You should investigate and reconcile unknown variances. An example of a known variance is the balance-forward of accounts during conversions.

11. COMMENTS (54-AN-C)
This field contains comments explaining why Contract Patient Accounting does not balance and describing the solution to solve the discrepancy. If Contract PA balances for the day, this field cannot be accessed.

12. COMMENTS (54-AN-C)
This field displays the second line of comments.

13. RECONCILED BY (DISPLAY ONLY)
This field displays the name of the individual who reconciled Contract PA. If Contract PA is in balance, the system displays XXX in this field.

Contract AR Daily Balancing

Contract Accounts Receivable totals are displayed as a tool for viewing the financial position of Contract AR. The information presented on this screen is available in your financial reports. However, to facilitate the process of searching through many reports to obtain the information, it is displayed here in one location. You use this information to reconcile the ending balance to the subsidiary opening balance. From here you can also determine if your account keys set are properly set to map the data to the General Ledger. For more information on this function, refer to the GL Mapping Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide.*

NOTE: The Contract AR Daily Balancing function is selected from the Financial System Management menu and the Daily Balancing Functions submenu.

The system determines the extent to which you can edit the fields on this screen according to your security level and whether the system is in balance. The system uses the following criteria:

- If your security is less than 80 and the system is in balance, you cannot edit any field on this screen.

- If your security is less than 80 and the system is out of balance, you can edit the Comments fields only.

- If your security is 80 or above, you can edit any field on this screen, regardless of whether the system is in balance or out of balance.

After selecting the Contract AR Daily Balancing, the system prompts you to select a facility if this is a multi-facility installation. The system then displays the following prompt:

 Enter control date. (Yesterday)--

The following screen is displayed:

```
              General Hospital Contract AR Daily Balancing Processor
                                                Wed June 19, 2002 10:23 am

( 1)Control Date      : 06/19/02

              1 - Facility 1

( 2) Opening Balance  :          910.21
( 3) Final Bill Total :
( 4) Cash             :
( 5) Adjustments      :
( 6) Late Charges     :
( 7) AR To BD Transfer :
( 8) BD To AR Transfer :
( 9) Ending Balance   :          910.21

(10) Subsidiary Balance:         910.21
(11) GL Control Balance:         718.10

(12)Comments          : Corrected by JE #44 (13)               :
(13)
(14)Reconciled by     : Smith,Mary A

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

NOTE: Contract AR is in balance if the Ending Balance, AR Subsidiary Balance and
GL Control Balance are equal.

Field Explanations

1. CONTROL DATE (DISPLAY ONLY)
This field contains the date for which the daily balancing is displayed.

2. OPENING BALANCE (DISPLAY ONLY)
This field contains the system-supplied prior day's subsidiary balance from the
Financial Balance routines.

3. FINAL BILL TOTAL (DISPLAY ONLY)
This figure represents the dollar amount transferred to Contract AR, (those contract
accounts final billed) and is subtracted from the opening balance. You can verify this
figure by looking at the total final-billed account balance on report FDR200.

4. CASH (DISPLAY ONLY)
This figure represents cash posted to Contract AR, and it is subtracted from the
opening balance. You can verify this figure by looking at the total Contract AR cash on
report FAR130.

5. ADJUSTMENTS (DISPLAY ONLY)
This figure represents any adjustments, such as courtesy discounts, administrative
adjustments, employee discounts, charity write-off, to an account in Contract PA. This
amount is added/subtracted to the opening balance. You can verify this figure by
adding the Contract AR totals on report FAR210.

6. LATE CHARGES (DISPLAY ONLY)

This figure represents the dollar amount of any late charges billed in Vendor AR. This figure is part of the Revenue field and is subtracted from the opening balance. You can verify the total late charge amount on reports FDRAJR and FDRAJR1. Late charges are not currently allowed on contract accounts, so this field always contains zero (0).

7. AR TO BD TRANSFER (DISPLAY ONLY)

This field is not currently used.

8. BD TO AR TRANSFER (DISPLAY ONLY)

This field is not currently used.

9. ENDING BALANCE (DISPLAY ONLY)

This field contains the system-supplied ending balance, which is the total of the above-described fields.

For example:

```
Opening Balance + Final Bill Total - Cash +/- Adjustments + Late
Charges = Ending Balance
```

10. SUBSIDIARY BALANCE (DISPLAY ONLY)

This field contains the system-calculated subsidiary balance. This figure should equal the figure displayed in the Ending Balance field. If there is a discrepancy, then Contract AR needs to be reconciled. The system calculates this balance by adding the account balance of every account in Contract AR.

11. GL CONTROL BALANCE (DISPLAY ONLY)

This figure represents the General Ledger control balance, which should equal the subsidiary balance. This is the journal entry *Contract AR Daily Journal Entry* from the Patient Accounting system. You need to verify that the total GL activity for Contract AR matches the total activity reflected on the Daily Report. You should investigate and reconcile unknown variances. An example of a known variance is the balance-forward of accounts during conversions.

12. COMMENTS (54-AN-C)

This field contains comments explaining why Contract AR does not balance and describing the solution to solve the discrepancy. If Contract AR balances for the day, this field cannot be accessed.

13. COMMENTS (54-AN-C)

This field displays the second line of comments.

14. RECONCILED BY (DISPLAY ONLY)

This field displays the name of the individual who reconciled Contract AR. If Contract AR is in balance, the system displays XXX in this field.

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REPORTS

Eleven reports are produced from the Contract Billing function:

Contract Accounts - FDRAAR
Activity Journal - FDRAJR, FDRAJR1, FDRAJR2
PA Contract Balancing Report - FARBAL11
AR Contract Balancing Report - FARBAL12
Unbilled Contract Accounts - FDR110
Contract Department Log - FDRDLR
Billed Contract Accounts - FDR200
Contract Bills - FDR900
Contract Collector Workfile - FFR500
Contract FollowUp Statements - FDR400
Contract Aged Trial Balance - FDRATB

These reports are fully documented in the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide*. Please refer to that volume for additional information.

NOTE: The Contract Bills report is not documented because this bill always follows the layout of your hospital's patient bill. These bills may vary from hospital to hospital.

You can produce contract bills on a *balance forward* or *previously billed charges* format, depending on the setting of the Balance Forward field in the Contract Bill Format parameters. For information on this field, see the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide*.

Chapter 8 - PA INTEGRITY PROCESSOR

PA INTEGRITY PROCESSOR

Examine all accounts that have had activity (payment, adjustment, refund, or bill) weekly for insurance integrity, balance, and key data errors.

If an insurance integrity error is found when you are attempting to use the Insurance Process or as a by-product of updating insurance information in Patient Accounting because the update introduced an insurance integrity error, then repair the account immediately if no claims or bills exist using the PA Integrity Processor.

This function repairs accounts (without claims or cycle bills) with insurance integrity, balance, or key data errors automatically during midnight processing. In some instances, accounts with claims may be repaired if the error is due to inappropriate duplication of carrier plans. Some accounts will still need McKesson intervention to correct, however, and the function will indicate this. This function also

- Adds balance information to FAIIERx (Patient Accounting Integrity Errors Repaired Report)

- Refines the utility repairing insurance integrity, balance, and key data errors

- Updates third party excess and/or patient balance depending on whether the first COB indicates insurance is prorated

Access this function from the Billing and Claims Input Options menu.

```
          General Hospital Billing and Claims Processor
                                        Fri Mar 26, 1999 02:25 pm
 Billing and Claims Input Options


          Option No.  Option
          ---------------------------------------
              1       Proration
              2       Patient Billing
              3       Account Inquiry
              4       Claims Management

              5       Third Party Logs


              6       Late Charge/Credit Functions
              7       Charge/Credit Functions
              8       DRG Payment Window Functions

              9       Notes

             10       PA Integrity Processor


 Enter option number--
```

When you select this function from the Billing and Claims Input Options Menu, the following prompts are displayed:

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

If patient lookup is selected, the next prompt is:

Enter account, `C`corporate, `S`social security or `U`unit number,name, `-`name for soundex, or `/`EPN--

Enter Sex (M/F) or [all]--

When you have responded to these prompts, the following screen is displayed:

```
                    General Hospital PA Integrity Processor
                                         Fri Mar 26, 1999 02:29 pm
Patient Search:  `C`, Male/Female
No.  Name                                   Address                Unit#
     Birthday  Soc Sec      Last Visit      City       St Zip      Corp #
1    CALDWELL,DEBBI                          123 MAIN ST            A000003729
     05/06/60                 05/12/98 I/P   TUCKER      GA 30084   00003960
2  x CAMBUL,BRIAN K                          408 THE FALLS PARKWAY  A000003188
     04/15/97  493-49-7078  08/15/97 I/P     ATLANTA     GA 30775   00003344
3  x CAMPBELL,BRIAN K                        408 THE FALLS PARKWAY  A000003188
     04/15/97  493-49-7078  08/15/97 I/P     ATLANTA     GA 30775   00003344
4    CAMPBELL,BRIAN K                        408 THE FALLS PARKWAY  A000003189
     04/15/74  444-33-2121  02/12/98 A1      ATLANTA     GA 30775   00003345
5    CANCEL,DISCHARGE                        FIRST MAILING ADDRESS  A000003777
     06/06/73                 07/07/98 I/P   ATLANTA     GA 30345   00004014
6    CARLA,GUARANTOR                         123 GUARANTOR PL
     01/01/49                                ATLANTA     GA 30346   00004332
7    CARLA,MSP                               123 MAIN ST            A000003976
     08/03/62                 01/19/99 OB    KNOXVILLE   TN 37919   00004330
8    CARLA,MSP                               123 MAIN ST
     01/02/19                                ATLANTA     GA 30346   00004348
Start of Search
Select a person, next pg(/ or PG DN) [next page]--
```

When you make your selection, the following screen is displayed:

```
                    General Hospital PA Integrity Processor
                                         Mon Mar 27, 2006 10:40 am
Account       Name              FC Typ Admit    Disch       Balance Loc
              CALDWELL,DEBBI                                 580.00
Page:01       PRE, PA, AR, BD, ARC, HS Patient Accounts
    Account      PT  Admit   Disch    FC   Account   Patient  Insurance Loc
( 1) A9813200004 I/P 05/12/98          V   4891.87   4891.87      0.00 PA










Select account--
```

Select the account you want to repair. The following screen is displayed:

```
                  General Hospital PA Integrity Processor
                                          Mon Mar 27, 2006 10:40 am
Account       Name                 FC Typ Admit    Disch      Balance  Loc
A98-15600002 NEWTON,ANNALISA       B  PSY 06/05/98 09/09/98   18160.00 AR/FCRV



Ins on FIN:

 444004-1          444555-2                  444055-3

Expected Outcome:

 444004-1          444555-2                  444055-3




Make Repair (YES/N) [N]--
```

Type **Yes**. You must type the full word, not just the first letter. One of the following messages is then displayed:

> *Insurance Integrity repaired.*

or

> *Account not repaired. Contact HBOC for assistance.*

Chapter 9 - PRE-BILL EDITS

STAR Financials Patient Accounting Reference Guide - Billing and Claims
October 2012   *Release 18.0*   *9–1*
Proprietary to McKesson - Subject to Confidentiality Agreement

OVERVIEW

This function provides the ability to perform STAR and EC2000 CA claim edits before cycle/final billing, for location PA accounts, and to maintain synchronization of data between EC2000 CA and STAR Patient Accounting when real claims are produced. Pre-bill bills and claims are edited/analyzed for STAR billing edits, STAR claim edits, STAR ICD edits, 3M OPPS edits, and/or 3M EAPG edits as defined by the customer, prior to the patient being cycle/final billed and the associated loading of actual bills and claims. The parameters to be used, when the account bills, determine the edit specifics. The updating of demographic, medical record, charge record, and insurance data for the visit is part of the pre-bill edit process. You can control the final billing process if pre-bill edits exist on an account.

The following parameters need to be set up to run the interface:

- General Pre-bill Edit Parameters - These parameters are defined on the Billing Parameters menu option. For details, refer to the PA/AR Parameter File Maintenance chapter in the *Tables, Masters, and Parameters Volume* of the *STAR Patient Accounting Reference Guide*.

- EC2000 CA Parameters - This parameter defines the communication link between STAR and EC2000 CA and the retention days for maintaining files sent to EC2000 CA. This parameter does not include edits that can be completed on STAR such as billing edits, claim edits and OPPS edits. To activate the EC2000 CA process, McKesson creates inbound and outbound communication line definitions. These definitions are then used to link a STAR system port number to the IP address and network port number of the EC2000 CA system. The EC2000 CA Interface menu includes options to activate/inactivate the communication lines, to display accounts queued to be sent, and to display accounts received from EC2000 CA along with the information applicable to the sent and received records. For details, refer to the User Functions chapter in the *EC2000 CA Integration Guide* of the *STAR Patient Accounting Reference Guide*.

- Pre-bill 3M OPPS Interface - The 3M OPPS Facility Parameters option on STAR is used to review the OPPS edit files sent/processed. This option allows you to define the hours when the Pre-bill Edit process is completed for OPPS edits. You need to schedule the 3M OPPS .bat files to run. This process is similar to the one for real claims. The process of Command Program Generation must be completed by the users. After the process is completed, the .bat file to be run is defined by "facility code _ cgsp _ ID #.bat (i.e. acgsp1.bat)." For details, refer to the *Outpatient Prospective Payment System Interface Guide* of the *STAR Patient Accounting Reference Guide*.

- Pre-bill 3M EAPG Interface - The 3M EAPG Facility Parameters menu option on STAR is used to review the EAPG edit files sent/processed. This option allows you to define the hours when the Pre-bill Edit process is completed for EAPG edits. You need to schedule the 3M EAPG .bat files to run. This process is similar to the one for real claims. The process of Command Program Generation must be

completed by the users. After the process is completed, the .bat file to be run is defined by "facility code _ epgp _ ID #.bat (i.e. aepgp1.bat)."

- Financial Table Maintenance - The following tables are used to define Pre-bill Edit parameters: Pre-bill Edit User table, Pre-bill Edit User Defined Edit Groups, Pre-bill Edit Categories table, and Pre-bill Edit EC2000 CA Edit Messages table. For details, refer to the Financial Table Maintenance chapter in the *Tables, Masters, and Parameters Volume* of the *STAR Patient Accounting Reference Guide*.

- Navigator User Views need to be updated to include the Pre-bill Edit option. Application system managers also need to have the option for Pre-bill Edit User Access. Please contact your McKesson representative for more information on setting up Navigator User Views.

- Within the Billing Parameters menu option is the functionality to allow you to override Pre-bill Edit mappings. This function should be used infrequently. For details, refer to the PA/AR Parameter File Maintenance chapter in the *Tables, Masters, and Parameters Volume* of the *STAR Patient Accounting Reference Guide*.

- Insurance Plan Coverage table - This table has a page specific to the Pre-bill Edit process and related parameters. For details, refer to the Financial Table Maintenance chapter in the *Tables, Masters, and Parameters Volume* of the *STAR Patient Accounting Reference Guide*.

General Process Flow

The general process flow of the Pre-bill Edit process is as follows. Keep in mind this is a generalized scenario.

- Account admitted (location PA)

  - Accounts to process are systematically defined by Insurance plan COB 1 and related 1500 or Non-pro fee 1500.

- Secondary insurances (which are the insurances other than the COB 1 and linked 1500 plan) can also process through Pre-bill Edit based on the Include All Insurances field in the Pre-bill Edit Parameters.

- Accounts process through the Pre-bill Edit process based on:

  - System selected

  - Manual Queued

  - Manual Batch Selection

- Editing begins during the next Midnight Processing based on the user-defined Begin parameter for system-selected accounts. The following is an example of how editing sequence may be defined:

    - STAR Billing

    - STAR Claim

    - 3M OPPS

    - EC2000 CA

- GUI Worklist is created, defined by the following categories:

    - Demographics

    - Insurance

    - Charge

    - Medical Records

    - Utilization Review

    - No EC2000 Claims

- Edits are assigned to responsible parties by patient indicator, such as the following:

    - Groups

        - Registration

        - Pre-admission

        - SIM departments

    - Billers

        - Utilization Management

        - Medical Records

    - People

        - Billers

        - Registration staff

- Pre-registration staff

- Edits are assigned statuses of Worklisted or Reported:

  - Reported does not prevent final billing (like warning edits)

    - EC 2000 CA status of:

      - Reported

      - Excluded

  - Worklisted does not prevent billing (like fatal edits) (user defined parameter):

  - EC2000 CA status of:

    - Worklisted

    - Both

  - Edits are worked (Patient Data, not Claim information, is updated).

    - Updates Master MPI. Updates are available for next admission.

- Accounts are sent back through edit process by one of the following means:

  - System generated

  - User Re-edit request tools

  - Manual selection

  - System Manual Batch selection

  - Account is discharged.

  - Medical Record edits and other types of edits are displayed in the GUI Pre-bill Edit Worklist, according to a user-defined parameter that specifies when to begin to display the edits.

- Final Bill Suspense Days are reached:

  - Pre-bill edits can prevent final billing (user-defined parameter)

  - Final billing can occur when edits exist and are below the minimum claim amount (user-defined parameter).

PRE-BILL EDIT FUNCTIONS

The pre-bill edit functions are accessed through the menu options of Billing and Claims>Pre-bill Edit. This functionality also exists within the GUI Pre-Bill Edit Workstation module. When the Pre-bill Edit function is accessed, the following screen is displayed:

```
            General Hospital Pre-bill Edit Processor
                                        Sun Aug 08, 2009 09:45 pm
 Pre-bill Edit Input Options

           Option No.  Option
           ---------------------------------------
               1        PBE Claim Information
               2        PBE Status Information
               3        PBE Manual Queue
               4        Update PBE Account Information Automatically
```



```
 Enter option number--
```

The functions on this screen are discussed below.

PBE Claim Information

After you select this function, then enter a facility and an account that qualifies for pre-bill edits, the following screen is displayed:

```
       General Hospital PBE Claim Information Processor
                                          Mon Mar 27, 2006 10:40 am
Account      Name                    FC Typ Admit    Disch     Balance  Loc
A04153-00005 MOORE,PREBILL           A  IPC 06/01/04           21382.00 PA/FCRV
    Clm Adj  Bill     Bill    Clm   Prd Wk  OPPS Clm
    Seq Clm  From     Thru    Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)
    614      08/08/04 08/08/04 UB    NP   R        500700,TEST PLAN FOR P
        Option No.  Option
        ---------------------------------------
            1       PBE Claim Status Information
            2       PBE Claim Demographic/Visit Data - Errors Only
            3       PBE Claim Demographic/Visit Data - All Screens
            4       PBE Claim Demographic/Visit Data - Select Screens
            5       PBE Claim Attachments
            6       PBE Claim Charge Data
            7       PBE OPPS Information
            8       PBE CA EC 2000 Information




Enter option number--
```

These functions allow you to view the following pre-bill edit information on an account. The information on these screens is for viewing only. Accounts with errors are corrected through the Pre-bill Edit Worklist (GUI module).

Information on these screens can be found in other volumes of the *STAR Patient Accounting Reference Guide*: For details on the following screens, please refer to *Accessing Claims By Account* in the *Billing and Claims Volume of the STAR Patient Accounting Reference Guide.* These screens contain the same information as the screens accessed through either the Maintain Claims by Account function or the Maintain Claims by Biller function:

- Pre-bill Edit Claim Status Information

- Pre-bill Edit Claim Demographic Data - Errors Only

- Pre-bill Edit Claim Demographic Data - All screens

- Pre-bill Edit Claim Demographic/Visit Data - Select Screens

- Pre-bill Edit Claim Attachments

- Pre-bill Edit Claim Charge Data

- Pre-bill Edit OPPS Information

- Pre-bill Edit CA EC2000 Information

- For details on the Pre-bill Edit OPPS Information screens, please refer to the *Outpatient Prospective Payment System Interface Guide* of the *STAR Patient Accounting Reference Guide.* The Pre-bill Edit OPPS Information screens contain the same information as the screens accessed through the Examine OPPS Information function.

- For details on the Pre-bill Edit CA EC2000 Information, please refer to Pre-bill Edit CA EC2000 Information.

Pre-bill Edit CA EC2000 Information

This function is used to view information on pre-bill edit records that were sent and received through the EC2000 CA Interface and STAR Patient Accounting. When this option is selected, the following prompt is displayed:

View records (S)ent or (R)eceived--

You can enter **S** for Sent to view records sent by the EC2000 CA interface to STAR Patient Accounting or **R** for Received to view records received by STAR Patient Accounting.

View Records Sent

If you enter S for Sent to view records sent, a list of record types is displayed. Select a record type to view or enter **A** for All to review all record types. The following screen is displayed:

```
         General Hospital PBE Claim Information Processor
                                   Mon Mar 27, 2006 10:40 am
Account      Name             FC Typ Admit    Disch      Balance   Loc
A04153-00005 MOON, BOB         A  IPC 06/01/04            21382.00  PA/FCRV

Sent: 08/08/04 00:51:17           Received: 08/08/04 00:53:43
Clm Seq: 614                       Clm Type: UB
Fld#  Field Description          Field Value
PAT   Payer Being Billed Plan Code   500700
  2   Patient Type               IPC
  3   COB - Payer Being Billed   1
  4   Patient Control Number     A0415300005
  5   Bill Date                  08/08/2004
  6   Admission Date             06012004
  8   Admission Hour             20
  9   Discharge Hour             00
 10   Financial Class            A
 12   Patient - Last Name        MOORE
 13   Patient - First Name       PREBILL
 15   Patient - Address 1        ADDRESS1
 16   Patient - Address 2        CHG ADDRESS 2
 17   Patient - Address City     DEFAULT CITY


               F1Prev Page F2Next Page F7  Exit
```

Field Explanations

SENT (DISPLAY ONLY)
This field contains the date and time the record was sent to STAR Patient Accounting.

RECEIVED (DISPLAY ONLY)
This field contains the date and time the record was received by STAR Patient Accounting.

CLM SEQ (DISPLAY ONLY)
This field contains the claim sequence number for the record.

CLM TYPE (DISPLAY ONLY)
This field contains the claim type for the account, such as UB.

FLD # (DISPLAY ONLY)
This field contains the field number on the record.

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

FIELD VALUE (DISPLAY ONLY)
This field contains the value in the field.

View Records Received

If you enter R for Received to view records received, a list of record types is displayed. Select a record type to view or enter **A** for All to review all record types. The following screen is displayed:

```
          General Hospital PBE Claim Information Processor
                                      Mon Mar 27, 2006 10:40 am
Account      Name                  FC Typ Admit    Disch     Balance   Loc
A04153-00005 MOORE,PREBILL          A  IPC 06/01/04           21382.00  PA/FCRV

Sent: 08/08/04 00:51:17                 Received: 08/08/04 00:53:43
Clm Seq: 614                            Clm Type: UB
F#  Field Description    Field Value
 1  Rec Type            CLM
 2  Account#            A0415300005
 3  Serv Through Date   8/8/2004
 4  Entity              A
 5  Plan Code           500700
 6  Clm Seq             614
 7  CA Encounter#       64780
 8  CA Claim#           84403
 9  Status              F
10  Claim Form          F4500WYCOI

 1  Rec Type            ERR
 2  CA Claim#           84403
 3  Category            I

                     F1Prev Page F2Next Page F7  Exit
```

Field Explanations

SENT (DISPLAY ONLY)
This field contains the date and time the record was sent to STAR Patient Accounting.

RECEIVED (DISPLAY ONLY)
This field contains the date and time the record was received by STAR Patient Accounting.

CLM SEQ (DISPLAY ONLY)
This field contains the claim sequence number for the record.

CLM TYPE (DISPLAY ONLY)
This field contains the claim type for the account, such as UB.

FLD # (DISPLAY ONLY)
This field contains the field number on the record.

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

FIELD VALUE (DISPLAY ONLY)
This field contains the value in the field.

Pre-Bill Edit Status Information

This option enables you to view pre-bill information on accounts as follows:

- Trigger Events

- Account Selection Criteria

- Pre-bill Edit Status

- Edits and Detailed Edits

- Charge Edit Information

After you select this option, then enter a facility and a patient account number at the prompt, the following screen is displayed:

```
                    General Hospital PBE Status Information Processor
                                          Mon Mar 27, 2006 10:40 am
Account     Name                    FC Typ Admit    Disch       Balance Loc
A04210-00002 MOORE,PREBILL          M  OPC 07/28/04 07/28/04     0.00   PA/FCRV

PBE Status: Manually Queued               PBE Status Date: 07/28/04




















 Select (A)ccount, (T)rigger Events, Account Selection (C)riteria, PBE (S)tatus,
 (E)dits, (D)etailed Edits, (G)UI Information, Charge Edit (I)nformation--
```

Field Explanations

PBE STATUS (DISPLAY ONLY)
This field displays the pre-bill status for the account. Pre-bill statuses are:

• Pre-bill account (Selected for Pre-bill) - The pre-bill edit status for an account is 1 when account information is initiated in STAR Patient Accounting, the primary insurance carrier changes, or the patient type changes. The account also has to qualify for pre-bill editing.

• Flagged for Pre-bill batch process (In progress) - This status indicates the creation of a pre-bill is pending. This can occur when the account is initiated into the process or when a trigger event occurs.

• Manually queued for pre-bill (Manually queued) - This status is set if a pre-bill is requested through the GUI worklist (Pre-bill Edit Worklist).

• Processed - no edits (Processed/no edits) - This status indicates the current pre-bill processed without edits. This does not indicate that the account is ready to final bill because the Medical Records edits might not have been employed yet or the account does not qualify for a final bill as yet. A trigger event can cause the process to be repeated.

• Processed - with edits (Processed/edits) - This status indicates that the current pre-bill processed with edits.

- Queued for another pre-bill (Edits existed or re-queued for pre-bill) - When all edits are removed from the worklist by the user, another pre-bill request is triggered automatically and the pre-bill edit status is changed to six (6).

- Pre-bill edit process completed (Complete) - If the latest pre-bill was created with no edits and Medical Records edits have been performed if appropriate, the account is marked with this status when the pre-bill batch process occurs. These types of accounts are ready to final bill and should not have any bill/claim edits on the actual bill.

- Pre-bill edits bypassed - suspense day. (Bypassed/suspense days) - If billing suspense days for the account have expired, the pre-bill edit status is changed to eight (8) when the request for the final bill is created.

- Pre-bill edits bypassed - manual bill request (Bypassed/single bill request) - If a single bill request is made when the account cannot have pre-bill edits (Perform Edits field is set to No) and the pre-bill edit process for the account is incomplete, the pre-bill edit status is changed to nine (9).

PBE STATUS DATE (DISPLAY ONLY)
This field displays the date the account was sent through the pre-bill edit process.

The following prompt allows you to view additional pre-bill information for the account:

Select (A)ccount, (T)rigger Events, Account Selection (C)riteria, PBE (S)tatus, (E)dits, (D)etailed Edits, (G) GUI Information, Charge Edit (I)nformation--

You can enter one of the following options:

- **A** - Account

- **T** - Trigger Events

- **C** - Account Selection Criteria

- **S -** PBE Status

- **E** - Edits

- **D** - Detailed Edits

- **G** - GUI Information

- **I** - Charge Detail Information

Each of these options is discussed below.

Account

> When you enter **A** from the prompt on the PBE Status Information Processor, three screens of information can be displayed. These screens display the pre-bill edit status for the account, the date the account was sent through the pre-bill edit process, and other types of information such as the patient type at last update, patient indicator at last update, primary insurance at last update, the date pre-bill edits began, and whether the account can be final billed if pre-bill edits exist.

> **NOTE:** If the Last Prorated Chg field has the value of Old Cyc Chg, this indicates an unbilled cycle charge that should be included on a prior bill.

> Following is an example of each screen

```
              General Hospital PBE Status Information Processor
                                         Sun May 09, 2010 08:01 pm
Account      Name               FC Typ Admit    Disch       Balance Loc
A10097-00006 MOORE,PREBILL       A  OPC 04/07/10 04/08/10     822.34 PA /INSR

PBE Status: Processed/Errors           PBE Status Date: 04/14/10

1    Pt Type at Last Upd      OPC
2    Pt Ind at Last Upd       O
3    Prim Ins at Last Upd     500700
4    1500 Ins at Last Upd     500200
5    Other Ins at Last Upd    500100,500200
6    Src Excl for Other Ins   None
7    Oth Ins Bill Req Edits   Yes
8    Begin PBE Bill Edits     A-0   04/07/10
9    Begin PBE ICD Edits      A-0   04/07/10
10   Begin PBE Clm Edits      A-0   04/07/10
11   Include Med Recs         A-0   04/07/10
12   Final Bill if PBE        No
13   Req Fin Bill if no PBE   Yes
14   Exp Bill Date            04/09/10
15   Unbilled Chgs            822.34

                   F1Prev Page F2Next Page F7  Exit
```

> On the first screen:

> The Other Ins at Last Upd field lists the carrier/plan numbers that are not the primary or associated 1500 plan that were edited due to the Include All Insurances field being set in the Pre-bill Edit Parameters screen.

> The Src Excl for Other Ins field lists any Active Sources edits that were excluded for the secondary insurances in the field "Other Ins Edit Excl" on the Pre-bill Edit Parameters. If no Active Sources were excluded, the field contains a value of *None.* If an active source was excluded, the field displays one or more of the following single letters: B (STAR Billing), C (STAR Claims), E (EC 2000 CA), O (OPPS), G (EAPG), I (ICD).

The Oth Ins Bill Req Edits field displays either a Yes or No that Billing Requirements were performed on the secondary insurances, and that these billing edits differed from the current billing edits for COB 1.

The fields "Begin PBE Bill Edits", "Begin PBE ICD Edits", "Begin Clm Edits", and "Include Med Recs", will list an A for Admission Date, D for Discharge Date, or M for Med Record Complete, and the number of days after this event to start editing

```
              General Hospital PBE Status Information Processor
                                          Sun May 09, 2010 08:01 pm
Account      Name               FC Typ Admit    Disch       Balance Loc
A10097-00006 MOORE,PREBILL       A  OPC 04/07/10 04/08/10      822.34 PA /INSR

PBE Status: Processed/Errors              PBE Status Date: 04/14/10

16  Last Prorated Chg
17  Bill Edits w/o MR       Eligible 04/07/10   Edits Performed 04/14/10
18  Bill Edits with MR      Eligible 04/07/10   Edits Performed 04/14/10
19  ICD Edits w/o MR        Eligible 04/07/10   Edits Performed 04/14/10
20  ICD Edits with MR       Eligible 04/07/10   Edits Performed 04/14/10
21  Clm Edits w/o MR        Eligible 04/07/10   Edits Performed 04/14/10
22  Clm Edits with MR       Eligible 04/07/10   Edits Performed 04/14/10
23  Num Bill Edits Only
24  Lst Bill Edit Only
25  Num of PBE Bills        34
26  Lst Clm Edit            04/14/10 1600     Batch
27  Num of PBE Clms         127
28  Last PBE Type           Batch
29  Last Worklist Edit Req
30  Chg Seq for Last PBE    1-6

                    F1Prev Page F2Next Page F7  Exit
```

On screen two, the system lists the Bill Edits with and without Medical Records, the ICD Edits with and without Medical Records, and the Claim Edits with and without Medical Records. The system is looking to the Pre-bill Edit Parameters, and the fields for Bill Edits, ICD Edits, and the Begin Editing Parameter fields for Inpatient, Outpatient, and Emergency for Claim Edits. These edits can start before any Medical Records edits are performed, based on the "Start Reviewing Medical Records Edits" and the fields Inpatient, Outpatient, and Emergency. For example, Bill Edits may be set to A-0, meaning start editing on the date of Admission. If the Start Reviewing Medical Records Edits for the patient indicator is set to A-2, then the Bill Edits w/o MR would start before the Bill Edits with MR.

```
                    General Hospital PBE Status Information Processor
                                            Sun May 09, 2010 08:01 pm
Account       Name                FC Typ Admit    Disch        Balance Loc
A10097-00006 MOORE,PREBILL        A  OPC 04/07/10 04/08/10      822.34 PA /INSR

PBE Status: Processed/Errors           PBE Status Date: 04/14/10

31  Deleted Edits
32  PBE Sources            BCGIO
33  Await Clm Edits
34  FB Dollar Limit        100.00
35  PBE Discharge Date
36  Trigger Events         No






                    F1Prev Page F2Next Page F7  Exit
```

On the third screen, the PBE Sources listed can include the following:

B-Star billing edits

C-Star claim edits

E-CA claim edits

G-EAPG claim edits

I-ICD charge edits

O-OPPS claim edits

Trigger Events

When you enter **T** from the prompt on the PBE Status Information Processor, the following screen is displayed:

STAR Financials Patient Accounting Reference Guide - Billing and Claims
9–16   *Release 18.0*   *October 2012*
Proprietary to McKesson - Subject to Confidentiality Agreement

```
             General Hospital PBE Status Information Processor
                                          Mon Mar 27, 2006 10:40 am
Account      Name                  FC Typ Admit    Disch      Balance Loc
A04210-00002 MOORE,PREBILL         M  OPC 07/28/04 07/28/04    0.00   PA/FCRV

PBE Status: Manually Queued        PBE Status Date: 07/28/04

1   Bill Edit Triggers
2   Proration
3   Claim Edit Triggers




               F1Prev Page F2Next Page F7  Exit
```

The screen displays the pre-bill edit status for the account, the date the account was sent through the pre-bill edit process, and the bill and claim edit triggers. Trigger events are as follows:

• Proration (handles charges and credits)

• Charge revision

• Combine Billed

• After Cycle Bill

• Patient discharge/disposition

• Update abstract general information

• Update Abstract Newborn/Death

• Update of additional demographic information

• Update of additional episode information

• Abstract flagged as complete

• Update of DRG information

• Update of demographic information

• Update of guarantor information

• Update of ICD Diagnosis information - If either the ICD-9 or the ICD-10 diagnosis information is updated, the account triggers to Pre-bill Edit.

- Update of ICD Procedure information - If either the ICD-9 or the ICD-10 procedure information is updated, the account triggers to PBE.

- Update of insurance information

- Update of medical information

- Update of medical record HCPCS (Procedure information)

- Update misc visit information

- Update patient employer

- Update special studies information

- Update UB data

- Update User Defined MPI fields

- Update User Defined visit fields

- Update of utilization review information

- Update misc visit information

- Patient historization

- DPW process (addition/change/deletion)

- Cancel Admission

- Billing parameter changed

- Claim parameters changed

- Account has no pre-bill edits but cannot final bill

- Medical Records abstracting is completed

- Online request for pre-bill edits

- All edits for an account are completed

Account Selection Criteria

This screen displays the criteria used to select pre-bill accounts.

When you enter **C** from the prompt on the PBE Status Information Processor, the following screen is displayed:

```
           General Hospital PBE Status Information Processor
                                    Mon Mar 27, 2006 10:40 am
Account      Name                   FC Typ Admit    Disch      Balance Loc
A04210-00002 MOORE,PREBILL          M  OPC 07/28/04 07/28/04     0.00    PA/FCRV

PBE Status: Manually Queued              PBE Status Date: 07/28/04

1    Prim Ins              500123
2    1500 Ins              500124
3    Patient Type          OPC
4    Patient Ind           E
5    Orig Edit Types       W
6    Orig PBE Cat          M,I,C
7    Orig PBE Src          B
8    Orig PBE Users        GMR,GRGG,GBLL
9    Curr Edit Types       W
10   Curr PBE Cat          I,M
11   Curr PBE Src          B
12   Curr PBE Users        GRGG,GMR
13   Orig Num of Edits     4
14   Curr Num of Edits     3
15   Exp Bill Date         07/31/04


                   F1Prev Page F2Next Page F7  Exit
```

The Edit Types are: W-Worklisted, R-Reported, and B-Both. These apply to EC 2000 edits only.

The Categories (Cat) are: the standard categories of C (Charge), D (Demographic), E (No CA Claim), I (Insurance), M (Medical Records) and U (Utilization Management). Users can also add categories.

The Sources (Src) are: B (STAR Billing), C (STAR Claims), E (EC 2000 CA), O (OPPS), G (EAPG), I (ICD).

Pre-bill Edit Status

When you enter S from the prompt on the PBE Status Information Processor, the following screens are displayed. When the Include All Insurances field is set to Yes in the Pre-Bill Edit Parameters, the status of each insurance edited in PBE is displayed.

:

```
          General Hospital PBE Status Information Processor
                                        Tue Jun 29, 2010 06:25 pm
Account       Name              FC Typ Admit    Disch       Balance Loc
A1011600001  CRAFT,PBE          M  O/P 04/26/10 04/26/10    1275.33 PA /INSR

PBE Status: Processed/Errors          PBE Status Date: 06/28/10

1    Account              Dates/06/28/10

3    Bill                 Dates/06/28/10          Status Failed
                          Orig Num of Edits 7     Curr Num of Edits 7

6    ICD                  Dates/06/28/10          Status Failed
                          Orig Num of Edits 10    Curr Num of Edits 10

9    100100 COB/1 UB CS/892   Orig Num of Edits 32    Curr Num of Edits 32
10   STAR 32 Edits        Dates 06/28/10          Status 32 Edits Remain
11   OPPS                 Dates 06/28/10-06/28/10  Status N/A
12   EAPG                 Dates 06/28/10-06/28/10  Status N/A
13   CA                   Dates 06/28/10-06/28/10  Status N/A

15   100100 COB/1 UB CS/893   Orig Num of Edits 9     Curr Num of Edits 9

                    F1Prev Page F2Next Page F7  Exit
```

```
         General Hospital PBE Status Information Processor
                                          Tue Jun 29, 2010 06:25 pm
Account      Name                  FC Typ Admit    Disch       Balance Loc
A1011600001  CRAFT,PBE             M  O/P 04/26/10 04/26/10    1275.33 PA /INSR

PBE Status: Processed/Errors          PBE Status Date: 06/28/10

16   STAR 9 Edits            Dates 06/28/10           Status 9 Edits Remain
17   OPPS                    Dates 06/28/10-06/28/10  Status N/A
18   EAPG                    Dates 06/28/10-06/28/10  Status N/A
19   CA                      Dates 06/28/10-06/28/10  Status N/A

21   100200 COB/2 1500 CS/894 Orig Num of Edits 11    Curr Num of Edits 11
22   STAR 11 Edits           Dates 06/28/10           Status 11 Edits Remain
23   OPPS                    Dates 06/28/10-06/28/10  Status N/A
24   EAPG                    Dates 06/28/10-06/28/10  Status N/A
25   CA                      Dates 06/28/10-06/28/10  Status N/A
         General Hospital PBE Status Information Processor
                                          Tue Jun 29, 2010 06:25 pm
Account      Name                  FC Typ Admit    Disch       Balance Loc
A1011600001  CRAFT,PBE             M  O/P 04/26/10 04/26/10    1275.33 PA /INSR

PBE Status: Processed/Errors          PBE Status Date: 06/28/10

16   STAR 9 Edits            Dates 06/28/10           Status 9 Edits Remain
17   OPPS                    Dates 06/28/10-06/28/10  Status N/A
18   EAPG                    Dates 06/28/10-06/28/10  Status N/A
19   CA                      Dates 06/28/10-06/28/10  Status N/A

21   100200 COB/2 1500 CS/894 Orig Num of Edits 11    Curr Num of Edits 11
22   STAR 11 Edits           Dates 06/28/10           Status 11 Edits Remain
23   OPPS                    Dates 06/28/10-06/28/10  Status N/A
24   EAPG                    Dates 06/28/10-06/28/10  Status N/A
25   CA                      Dates 06/28/10-06/28/10  Status N/A

27   100200 COB/2 1500 CS/895 Orig Num of Edits 0     Curr Num of Edits 0
28   STAR 0 Edits            Dates 06/28/10-06/28/10  Status Passed
29   OPPS                    Dates 06/28/10-06/28/10  Status N/A
30   EAPG                    Dates 06/28/10-06/28/10  Status N/A


                     F1Prev Page F2Next Page F7  Exit
```

```
            General Hospital PBE Status Information Processor
                                       Tue Jun 29, 2010 07:02 pm
Account       Name               FC Typ Admit    Disch       Balance Loc
A1011600001  CRAFT,PBE           M  O/P 04/26/10 04/26/10    1275.33 PA /INSR

PBE Status: Processed/Errors          PBE Status Date: 06/28/10

31  CA                      Dates 06/28/10-06/28/10  Status N/A

33  500100 COB/3 UB CS/896  Orig Num of Edits 14     Curr Num of Edits 14
34  STAR 14 Edits           Dates 06/28/10           Status 14 Edits Remain
35  OPPS Pending            Dates Pending            Status Pending
36  EAPG                    Dates 06/28/10-06/28/10  Status N/A
37  CA                      Dates 06/28/10-06/28/10  Status N/A

39  500200 COB/4 1500 CS/897 Orig Num of Edits 7     Curr Num of Edits 7
40  STAR 7 Edits            Dates 06/28/10           Status 7 Edits Remain
41  OPPS                    Dates 06/28/10-06/28/10  Status N/A
42  EAPG                    Dates 06/28/10-06/28/10  Status N/A
43  CA                      Dates 06/28/10-06/28/10  Status N/A
```

The screens show the status of an account with pre-bill edits, including the number of edits, the date(s) the account was sent through the pre-bill edit process, and whether the account failed or passed pre-bill edits. The number of Bill Edits is displayed for the COB 1 insurance, the number of ICD charge edits are displayed at the account level, and for each insurance, the Claim Edits are displayed, broken out by STAR claim edits, OPPS edits, EAPG edits, and CA (Claims Administrator) edits.

Edits

When you enter **E** from the prompt on the PBE Status Information Processor, the following screen is displayed:

```
              General Hospital PBE Status Information Processor
                                          Mon Mar 27, 2010 10:40 am
Account      Name                  FC Typ Admit    Disch      Balance Loc
A04210-00002 MOORE,PREBILL          M  OPC 07/28/09 07/28/09    0.00   PA/FCRV

PBE Status: Manually Queued           PBE Status Date: 07/28/09

BILL. INS. CERT/SSN/HIC ID NUMBER is Required (COB 1 500123)
BILL. INS. CERT/SSN/HIC ID NUMBER is Required (COB 2 500124)
ICD9 PRINCIPAL DIAGNOSIS CODE is Required
ICD10 Diagnosis Code - 2 FL 21 is Required
ICD9 Diagnosis Code - 2 FL 21 is Required
ICD10 PRINCIPAL PROCEDURE CODE is Required
ICD9 PRINCIPAL PROCEDURE CODE is Required
ICD10 Needs ICD-9 diagnosis (CHG 10 CAR/1105/RHYTHM STRIP PROFESSIONAL FEE) (PA




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```

This screen shows the edits that were returned on the account in a summarized format.

Detailed Edits

When you enter **D** from the prompt on the PBE Status Information Processor, the following screen is displayed:

```
                 General Hospital PBE Status Information Processor
                                              Mon Mar 27, 2006 10:40 am
Account       Name                     FC Typ Admit    Disch      Balance Loc
A04210-00002 MOORE,PREBILL             M  OPC 07/28/04 07/28/04    0.00    PA/FCRV

PBE Status: Manually Queued              PBE Status Date: 07/28/04

BILL. INS. CERT/SSN/HIC ID NUMBER is Required (COB 1 500123)
  CAT/I   SRC/B  USR/RGG (GRP)  OPT/Insurance
  FLD/126   Insurance Policy/Cert/SSN/HIC Number      LOC/
  ECD/B#;;BI_SSN#R
  Ins IK/1

BILL. INS. CERT/SSN/HIC ID NUMBER is Required (COB 2 500124)
  CAT/I   SRC/B  USR/RGG (GRP)  OPT/Insurance
  FLD/126   Insurance Policy/Cert/SSN/HIC Number      LOC/
  ECD/B#;;BI_SSN#R
  Ins IK/2

PRINCIPAL DIAGNOSIS CODE is Required
  CAT/M  SRC/B  USR/MR  (GRP)  OPT/Diagnosis Information (Medical
  FLD/96    Principal Diagnosis (Medical Records)     LOC/

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```

The Categories (CAT) are: Standard categories of C (Charge), D (Demographic), E (No CA Claim), I (Insurance), M (Medical Records) and U (Utilization Management). Users can also add categories.

The Sources (SRC) are: B (STAR Billing), C (STAR Claims), E (EC 2000 CA), O (OPPS), G (EAPG), I (ICD).

The LOC field will display, for claim edits, the claim type indicator (X-UB, B-1500, Z-Non Pro Fee 1500) and the locator number where applicable. For example:

 LOC/X-76-1

 LOC/B-17-3

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, 2010 10:40 am
Account      Name                   FC Typ Admit    Disch       Balance Loc
A04155-00002 NEW, NANCY              M  O/P 06/03/09 06/03/09      516.48 PA/FCRV

PBE Status: Processed/Errors            PBE Status Date: 08/10/09
  Message followed by claim line and accounts charges comprising the claim line
ICD10 Needs ICD-9 diagnosis (CHG 10 CAR/1105/RHYTHM STRIP PROFESSIONAL FEE) (PA
  SRC/I
  B10 CAR/1105  RHYTHM STRIP PROFESSIONAL 93042     04/26/10 1           7.72

     93042     04/26/10 ICD9 Diagnosis/Reference # required for Locator 24E on
  SRC/C 985  Professional Fees EKG      M  93042     04/26/10 1           7.72
  B10 CAR/1105  RHYTHM STRIP PROFESSIONAL 93042     04/26/10 1           7.72

     93042     04/26/10 Physician ID required for 24J Upper on 1500 Claim (Upin
  SRC/C 985  Professional Fees EKG      M  93042     04/26/10 1           7.72
B10 CAR/1105 RHYTHM STRIP PROFESSIONAL 93042 04/26/10 1   7.72

0430          04/26/10 Charge Summary Error for UB Claim (CHG  OT/6500)
  SRC/C 430  Occupational Therapy      N            04/26/10          -59.93
  B14 OT/6500   OCC THERAPY I                       04/26/10 -1       -14.17
  B14 OT/6500   OCC THERAPY I                       04/26/10 -1       -14.17



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```

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.

PBE Manual Queue

This function allows you instruct the system to run a pre-bill edit of an account immediately using all edit sources selected the Active Sources field on the Pre-bill Edit Parameters for the facility.

When this function is selected, you are asked to select an account using the typical selection options in STAR Patient Accounting. If an account is selected, the following prompt is displayed:

Do you want to perform pre-bill edits on this account? (Y/N) [N]--

If you enter Y (Yes), the following message is displayed:

Processing PBE Edits!

Update PBE Account Information Automatically

This function can be used to select a group of accounts for a facility for which the PBE information for the account is updated per the current information for the facility's Pre-bill Edit Parameters and to re-trigger any of the selected accounts processed in PBE already.

For example, if the Pre-bill Edit Sources were changed because a source such as OPPS was added or removed, this processor could be used to update selected accounts in location PA which are in the PBE process When the updated accounts are processed in the Pre-bill Edit process again, OPPS edits would be included or excluded as warranted. Also, the start dates on which the types of edits start (bill edits without Medical Records edits, bill edit with Medical Records edits, claim edits without Medical Records, and claim edits with Medical Records edits) are re-calculated. Therefore, if the inclusion of Medical Records edits is too late, this process can update the accounts so the inclusion of Medical Records edits starts sooner.

Using this process, you can select accounts for the Perform Pre-bill Edits and the Bill if Pre-bill Edits Exist fields for all of an account's insurance plans are updated per current information for insurance plans. This can include removing an account from PBE processing but not adding new accounts to PBE processing.

When this function is selected, you enter a facility if appropriate, and the following screen is displayed:

```
              General Hospital PBE Account Information Automatically Processor
                                            Sun Jan 31, 2010 05:22 pm

 1 Admission Dates
->
 2 Patient Indicators     3 Patient Types

 4 Insurance Carrier/Plan

 5 Discharged                        6 Eligible for Final Bill?

 7 Update PBE Fields for Insurance     8 Trigger Accounts



 Enter admission date or (N)one [Earliest] --

```

Field Explanations

1. ADMISSION DATES (1-A-O)
A beginning and an ending date for dates of admission can be indicated using the following prompts. The prompt for the beginning date is as follows.

Enter admission date or (N)one [Earliest] --

If the default of Earliest is used, the beginning date is the current date -minus 1000. If N for no date is keyed, there is no limit on the admission date and no prompt for ending date is given.

> *Enter admission date [Latest] --*

If the default of Latest is used, the ending date is the current date.

2. PATIENT INDICATORS (1-A-O)
The accounts used can be limited by the patient indicators of O (Outpatient), E (Emergency), and/or I (Inpatient). If patient indicators are selected, they determine the Patient Types selected in the Patient Types field.

3. PATIENT TYPES (1-A-O)
The accounts used can be limited by patient type. A table lookup of patient types is provided.

4. INSURANCE CARRIER/PLAN (1-A-O)
 Insurance plans can be selected by insurance plan code. Insurance plan codes can be keyed in a list separated by commas or they can be selected from a table lookup.

5. DISCHARGED (1-A-O)
The accounts can be limited to discharged, non-discharged accounts or both types of accounts. The prompt is as follows:

> *Include (D)ischarged, (N)on-discharged, or (B)oth types of accounts? [B]--*

6. ELIGIBLE FOR FINAL BILL? (1-A-O)
The accounts can be limited to those where the expected bill date matches the current date or a previous date. The intent of this field is to allow accounts already eligible for billing to be processed. The prompt for this field is as follows:

> *Exclude accounts that are not eligible for a final bill tonight?   (Y/N) [N]--*

7.   UPDATE PBE FIELDS FOR INSURANCE (1-R-A)
If changes have been made to either of the indicators for an insurance plan (Perform Pre-bill Edits and Final Bill if Pre-bill Edits Exist), and if the response for this field is Y for Yes, those parameters are updated for all insurance plans for any selected accounts. This is done only if neither of the two fields have been edited for the insurance plan for the account. The prompt for this field is as follows:

> *Do you want to update PBE insurance information for the account if the user has not updated the information? (Y/N)--*

The expected use of this field is to change the setting for Final Bill if Pre-bill Edits Exist.

8. TRIGGER ACCOUNTS
If the response to this field is Y for Yes, then if an account is selected, the account has been processed in the pre-bill process already, and the account continues to qualify

for pre-bill edit processing, then a trigger event is created for the account so the account will be processed when pre-bills are created. The prompt for this field is as follows.

Do you want to trigger accounts for which pre-bill edits were done previously? (Y/N) [Y]--

The default response is Y because that is the anticipated response. If you remove some of the edit sources, you will want to re-trigger accounts to expedite their processing through the pre-bill edit process.

If an account has been triggered due to this process, *Automatic Account Update* is displayed as a trigger event in the (T)rigger Events option found in the PBE Status Information option on the Pre-bill Edit menu found on the Billing and Claims menu.

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■ R e a d e r   C o m m e n t   F o r m ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Billing and Claims 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)

Fold here

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