McKESSON
Empowering Healthcare

STAR 2000™

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Electronic Payments Volume

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Reader comments

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

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Trademarks

Preface

The *STAR Financials Patient Accounting Reference Guide* is a multi-volume document written for all users of the system. The *Electronic Payments Volume* provides detailed information about the ability to receive electronic payments from insurance carriers in the base STAR Financials Patient Accounting System.

The *General Information Volume* is prerequisite reading to all other volumes of the *STAR Financials Patient Accounting Reference Guide*. Successful use of the *Electronic Payments Volume* depends on your knowledge of the concepts covered in the General Information *Volume*.

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 by McKesson 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 Electronic Payments interface that is used with the STAR Financials Patient Accounting system. The book contains the following chapters:

Chapter 1: Electronic Payments

This chapter provides basic information about using the system to set up and receive electronic payments. Reports produced by the system are described in detail. In addition, descriptions of data elements for Part A 835 and Part B 835 files are provided.

Chapter 1 - ELECTRONIC PAYMENTS

ILLUSTRATIONS

This document contains a detailed explanation of the electronic payments function of the STAR Financials Patient Accounting System.

INTRODUCTION

There are two methods to receive payments electronically. These are:

- Vendors that use the ASCII file layout defined by McKesson.
- ASC X12N 835 Health Care Claim Payment/Advice software (835) which does not use a vendor.

Vendors may be supported by conforming exactly to the standards agreed upon by McKesson. Electronic payments may be received directly from the intermediary by using the 835 standard. McKesson supports the 4010 version of the Part A 835 and the 4010 version of the Part B 835.

The electronic payment information will be received on an IBM-compatible personal computer (PC). The information is subsequently uploaded in ASCII format to the STAR Financials CPU. The record layout for the payment data contains the information needed in the existing cash posting record layout.

Prior to uploading the payment information, you are asked to complete set-up screens similar to the default value screen in insurance cash posting. During this process, you will enter valid carrier codes and define the default values for either partial or full payments. DRG paid, days paid, outlier status, deductible and coinsurance amounts sent from the third party can be posted to the third party logs. The contractual adjustment sent by the intermediary can be posted to the account along with the payments.

The system reads payment records and matches them to claims on the patient accounts using the patient's account number, carrier code, and dates of service. Payments are not posted to claims that have been replaced by an adjustment claim; instead, the system uses the adjustment claim. If a payment cannot be matched to an existing claim or a payment matches more than one claim on the account, the system displays information about the payment on an exception report.

Payments that uniquely match existing claims are placed in an open insurance cash batch. The batch total reflects the total amount of the payments received, including the payments that were rejected and appear only on the exception report. You can view, print, and edit this batch in the existing cash posting function. To be posted, the batch must balance (total payments entered must equal the batch total) and it must be approved. To balance the batch, you can either manually add the rejected accounts into the batch, or adjust the batch total to reflect the number of accounts that were accepted.

Before you begin, review the GL mapping entries for batches posted electronically to ensure cash is posted to the correct general ledger account and the deposit of the funds can be audited against the posted batches. You may need to use a separate holding account for this purpose.

BEFORE YOU BEGIN

Hardware and Software Requirements

To upload electronic payments from a vendor or an intermediary, you must use an IBM-compatible personal computer (PC) equipped with McKesson's Windows Emulator (WEM) software and linked to the STAR Financials central processing unit (CPU).

The PC must be capable of receiving data from your vendor, intermediary, or carrier. Details of the receipt of the payment data should be finalized with your vendor, intermediary, or carrier.

Minimum disk space requirements depend on the amount of payment data received and the length of time the data remains on the PC. A vendor payment file of 400 payments is approximately 20,000 bytes, or roughly 50 bytes per payment. An ANSI payment file of 400 payments is approximately 100,000 bytes. This number, however, can vary significantly based on the volume of service item line data returned by the intermediary. Once a file is uploaded onto the STAR Financials CPU, you can delete it from the PC.

McKesson recommends that your PC use Microsoft® Windows XP or higher to make full use of the Electronic Payment software.

PC Preparation

Note that your PC must meet the hardware requirements stated above.

Vendor PC Preparation

To upload files from a vendor, perform the following steps to prepare your PC to use the Electronic Payment software.

1. Make a directory on drive C. Name it *PAYIN*.

   NOTE: The data files may reside on a drive other than C and in a directory other than PAYIN. However, the default values in the uploading process are drive C and directory PAYIN.

2. Receive a data file into this directory. It is recommended that the ASCII file name be in the format _fmmddis.DAT, where:

_ = _ (underscore)
f = the facility indicator
mm = the month (01-12)
d = the day (01-31)
i = the insurance type (B, C, M, N, O, P, S, X, or Y)
s = a sequence number for the day (0-9, A-Z)

Example: _C0514M1.DAT

NOTE: Although the above format is recommended, the only requirements are that the file begin with an underscore(_) and end with .DAT.

Insurance types are as follows:

B = Blue cross
C = Commercial
M = Medicare Part A
N = HMO
O = Medicare - out of state
P = Medicare Part B
S = CHAMPUS
X = Medicaid
Y = Medicaid - out of state

This naming convention allows receipt of multiple data files each day for each insurance type and provides you with the ability to identify at a glance the content of the data file.

Part A 835 PC Preparation

To upload Medicare A files from an intermediary using the 835 standard, perform the following steps to prepare your PC to use the Electronic Payment software.

1. Make a directory for files that are to be uploaded on drive C. Name the directory *835IN*.

   NOTE: The data files to be uploaded may reside on a drive other than C and in a directory other than 835IN. However, the default values in the uploading process are drive C and directory 835IN.

2. Receive a data file into this directory.

Part B 835 PC Preparation

To upload Medicare B files from a carrier using the 835 standard, perform the following steps to prepare your PC to use the Electronic Payment software:

1. Make a directory for files that are to be uploaded on drive C. Name the directory 835BIN.

NOTE: The data files to be uploaded may reside on a drive other than C and in a directory other than 835BIN. However, the default values in the uploading process are drive C and directory 835BIN.

2. Receive a data file into this directory.

Directory Maintenance

You are responsible for maintaining the directory containing electronic payment files on the PC. McKesson designed the naming conventions shown in the previous examples to help prevent you from deleting data files in error.

The frequency with which you delete files depends on the amount of disk space available on the PC. For greater data security, you also may want to periodically back up data files.

Vendor Directory Maintenance

Directory maintenance can be performed by using standard Windows techniques. For example, you can view all files in the \PAYIN directory using Windows Explorer and delete old data files.

The naming convention also makes it easier to recognize files in specific date ranges. For more information, refer to your Windows user's guide.

835 (Part A and B) Directory Maintenance

Directory maintenance can be performed by using standard Windows techniques. For example, you can view all files in the \835IN or \835BIN directory using Windows Explorer and delete data files with the extension UPL.

The naming convention also makes it easier to recognize files in specific date ranges. For more information, refer to your Windows user's guide.

FINANCIAL TABLE MAINTENANCE

The following tables are used by the Electronic RA Interfaces:

- ERA Bill Type Codes
- ERA CAS Reason Codes
- ERA Claim Adjustment Groups
- ERA Claim Filing Indicator
- ERA Claim Status Codes
- ERA Facility/Provider Mapping
- ERA Payment Analysis Report
- ERA Payment File Definition
- ERA Provider Level Adj Mapping
- ERA Provider Level Adj Reasons
- ERA Remarks Codes
- ERA Segment Matching Rules

These tables can be accessed by selecting Tables from the STAR Financials main menu and then selecting Financial Table Maintenance from the submenu. When you access the Electronic Interface tables, you are prompted to enter a particular code. At this point, you have these options:

- Enter a valid code for this table, if you know one. The system then displays the code and its description along with other pertinent information that can be edited.
- Enter a new code. The system prompts you to confirm your desire to add this code and then displays the screen(s) required to do so.
- Enter a hyphen (-) to display a list of codes already entered for this table. You can then select a code. This is called the Table Lookup feature. For more information on using this feature, refer to the *General Information Volume* in the STAR Financials Patient Accounting Reference Guide.

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

1. Access the table.

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

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

The Payment File Definition Table is required to be used for 835 and vendor electronic payments. All other tables listed are used for the 835, Part A and Part B. These tables must be established prior to processing the 835 Part A and Part B payment files.

NOTE: The Miscellaneous Cash Codes and the Type F Transaction Codes (for Miscellaneous Cash) need to be established to process the provider level adjustments via the Electronic Payments interface.

ERA Facility/Provider Mapping

This table provides the cross-references needed to identify the facility for each provider for which payments are sent. This table is used to determine the facility for the cash batch to be created based on the provider number that is returned from the intermediary using the 835 Health Care Claim Payment/Advice standard. This table is not used for electronic payment files received from a vendor.

This table is not split by facility.

After this table is selected, the system prompts you to enter a provider number and facility code. After the code is entered, this screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                  Mon Apr 29, 2007 02:17 pm
ERA Facility/Provider Mapping

Electronic RA Fac/Prov Mapping
 1 Provider Number   2 Facility            3 Description
   830027              A,B                   FAC A GENERAL HOSPITAL
 4 Last Edit by                            5 Last Edit date
   Smith,Mary A.                           02/20/95 10:57am









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

Field Explanations

1. PROVIDER NUMBER (15-AN-R)
The field contains the provider number. The provider number must be in the same format that is returned by the electronic payment software. The provider number must match the number returned by the electronic payment software so that the facility can be determined.

2. FACILITY (1-A-R)
This field contains the facility code(s) for one provider number. The facilities must be valid STAR facilities that are associated with the provider number. You can enter the facility code or a hyphen (-) to display the facility codes. Select the facility codes that you want from the list of valid facility codes displayed on your screen.

3. DESCRIPTION (24-AN-R)
This field contains the description of the provider number. McKesson recommends that you include the facility code in the description.

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

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

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

Dependent On	Reference
Facility Code	

ERA Bill Type Codes

This table provides a listing of the UB bill types for which you want to establish processing exceptions for the Part A 835 Health Care Claim Payment/Advice standard. The payment file definition allows you to enter bill type exceptions which enable you to create a separate cash batch by bill type.

This table is not split by facility. After this table is selected, the system prompts you to enter a bill type code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the following screen is displayed:

```
              General Hospital Financial Table Maintenance Processor
                                                  Mon Feb 20, 1995 12:52 pm

Bill Type Codes
 1 Code   2 Description               3 Short Description   4 Status
   11       Hospital Inpatient          Hosp I/P              Active
 5 Last Edit by                                             6 Last Edit date
   Smith,Mary A.                                              02/20/95 10:57am









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

Field Explanations

1. CODE (2-N-R)
This field contains the code identifying the UB bill type code. Only the first two digits of the three digit UB bill type code are defined.

2. DESCRIPTION (24-AN-R)
This field contains the description of the UB bill type code.

3. SHORT DESCRIPTION (10-AN-R)
This field contains an abbreviated description of the UB bill type code that is used in the batch description of the resulting insurance cash batch.

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

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

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

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

Dependent On	Reference
	Payment File Definition

ERA Payment File Definition

This table is used to define default values and matching criteria for each payment file. For the 835 A standard, this table also identifies how the payments for each provider are subdivided into individual batches and allows for bill type exceptions to be entered. The values that are entered for this table are displayed and can be modified on the Process Electronic RA Setup Processor screen. Any fields left blank in the Payment File Definition can be completed on the Process Electronic RA Setup Processor screen.

This table is not split by facility.

After this table is selected, the system prompts you to enter a payment file definition code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the following screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                 Wed Apr 25, 2012 11:25 am
ERA Payment File Definition
 1 Code   2 Description                     3 Short Desc  4 Source File Type
   A        MEDICARE PART A                   Part A        835 Part A
                            Matching Criteria
 5 Insurance Type      6 Select Insurance    7 Type of claim form
   COMMERCIAL            Plans Defined         R-MEDI-CAL UB, X-UB
 8 Claim Type          9 Svc Date?      10 Select DTM Recs   11 Accnt# Lengths
   A,C,F,L,Z             Bypass Thru Dt    232,233,472          10,13
12 Matching Criteria  13 Additional Criteria  14 REF Qual
   UB HCPCS/Rev Cod++    1500 Dr,1500 HCP++      1A,1B,1C
                            Electronic RA Defaults
15 Days Paid?    16 DRG Paid?            17 Outlier?       18 BD Pymt
   Yes              Yes                    Yes
19 Default Clm Disposition               20 Denied Clm Disposition
   Partial Payment                        Denied
21 Default Disp for Denial Trk Interface 22 Precedence for Disp from CAS Codes
   Denied
23 Use CAS Code Disp for Denial Trk Int  24 Exclude Suppressed C/A From New Bal


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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the three-character alphanumeric payment file definition code.

2. DESCRIPTION (30-AN-R)
This field contains the payment file description.

3. SHORT DESC (10-AN-R)
This field contains the abbreviated payment file definition description used to create the batch description which is comprised of the payment file short description concatenated with the fiscal period and the bill type.

4. SOURCE FILE TYPE (1-A-R)
This field indicates the type of source file. After you access this field, the following prompt is displayed:

Enter new type of source file 835 (A), 835 (B), (V)endor, or (C)ombined ERA [A]--

Enter **A** to indicate that the source file is in the Part A 835 format. Enter **B** to indicate that the source file is in the Part B 835 format. Enter **V** to indicate that the source file is in the Vendor format. Enter **C** to indicate that UB, Non Pro Fee 1500, 1500, and Medi-Cal UB claims can be processed in the same file. If you enter Combined, the following fields are processed as if 835A were selected:

- C/A for COB1
- Post/Rpt C/A if Den
- Part A LX Format
- Source for Payee Provider Number (third screen)
- Remit Reference Designator

For Part B, claims are matched with payments based on the criteria the hospital uses for generating 1500s. Either one account can generate separate claims based on physician or department, or all charges can be combined on one claim.

If you change the Source File Type from 835 A, 835 B, or Combined to Vendor, any information in the fields that are not applicable for the Vendor format are blanked out by the system. The system displays the following prompt if you change the file type to Vendor:

Changing the Source File Type to Vendor will remove some defined options in this table. Do you want to continue? (Y/N)'

If you enter **N** (No), the file type remains with the current selection. If you enter **Y** (Yes), the source file type changes to Vendor, and the following fields are blanked out: Select DTM Records, Matching Criteria, Additional Criteria, REF Qual, Account # Length, Post/Rpt C/A if Den, Analysis Report Def, Criteria for Splitting Batches, User Defined Criteria for Splitting Batches, ERA Claim Status Table and Facilities.

5. INSURANCE TYPE (1-A-R)
This field contains the insurance type. You can enter the insurance type code or a hyphen (-) to display a list of insurance types. You must complete this field with the insurance type associated with the insurance carrier code for which you are posting payments using this Payment File Definition. For example, if you are posting Medicare B payments, but your Medicare B carrier is the same as your Medicare A carrier (for instance, Medicare A carrier/plan = 100100 and Medicare B carrier/plan = 100200), then you must select the Medicare A insurance type.

6. SELECT INSURANCE (1-4-R)
This field contains the carrier code(s) for the carrier to whom payments are to be matched.

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

Do you want to match payments by Carrier (C) or by Carrier/Plan (P)?

- If you select **C** (Carrier), you can select the carrier from a table lookup.
- If you select **P** (Carrier/Plan), the following prompt is displayed:

Enter insurance plan codes in a list or partial code`-` for list -

For example: user keys in 100- and a list of all carrier/plan codes that begin with 100 are displayed. If Plan is selected, all carriers for this PFD must be selected to the plan level. The table has a multi-selection for plans when a carrier is selected. When plans are selected, all current selections are displayed and highlighted. From here you can add/remove plans.

NOTE: McKesson recommends that you select down to the plan level if there are plans that may be excluded for matching with the carrier. If any plan from the selected carrier is a possibility for matching, it is not recommended to select down to the plan level.

If a carrier/plan code is entered in the prompt (instead of selecting from the dash lookup list), only that carrier/plan is accepted. It is advisable to select carriers and carrier/plans from the dash lookup list.

7. TYPE OF CLAIM FORM (1-A-R)
This field contains the type of claim form. The system supports all types of claim forms from vendors and UB/CMS 1500 claim forms for the 835 (Part A and B). If the Source File Type field is set to C for Combined ERA, Medi-Cal UB claim forms are also supported.

You can enter the type of claim form or a hyphen (-) to display the claim types. Select the claim type that you want from the list of valid claim form types displayed on your screen. Multiple claim form types can be selected at the same time.

8. CLAIM TYPE (1-A-R)
This field identifies the claim type(s) to be included in the batch. Enter the claim type(s) or accept the default of *All* to include all claim types. Multiple claim types may be entered. Valid responses are F - Final, A - Adjustment, C - Cycle, L - Late, or Z - Cycle Adjustment.

9. SVC DATE (1-A-R)
This field identifies whether the service date is to be used as a matching criterion. Depending on whether you use the Vendor File format or the 835 A and 835 B formats, one of the following prompts is displayed:

If you use the Vendor File format, the following prompt is displayed:

Match Srv Dts (E)xactly, (B)ypass Svc Thru Dt or (R)ange of Svc Dts? [E] --

If you use the 835A and 835B formats, the following prompt is displayed:

Match Srv Dts (E)xactly, or (B)ypass Svc Thru Dt? [E] --

If you answer either prompt with Exactly (E), the service through date is used as a matching criterion. If you answer either prompt with Bypass (B), the system bypasses the service through date as a matching criterion. If there is a match on the service from date and a mismatch on the service through date, this claim payment does not appear on the Electronic Remittance Rejection report (FXRERRR). The claim payment is entered as an entry in the insurance cash batch that is created as a result of this processing. For the prompt that is displayed if you use the Vendor File format, if you answer Range (R), the claim is matched for the service date for an inclusive range of dates instead of having to be an exact match on the service from and service thru dates.

10. SELECT DTM RECS (TABLE LOOKUP)
This field contains the qualifier used for selecting dates in the DTM record. When this field is accessed, the table of DTM records is displayed, as follows:

```
ERA Payment File Definition
Page:01               DTM Records for Claim Date Matchups    ##=Current Choices
( 1) DTM(232)
( 2) DTM(233)
( 3) DTM(150)
( 4) DTM(151)
( 5) DTM(472)
```

You can select one or multiple qualifiers from the table. For example, you may want to use the 472 and 150/151 DTM qualifiers to look for dates for non-UB payments.To determine the setup of this field, you need to thoroughly review the files received from the payor.

11. ACCNT# LENGTHS (10-N-O)
This field defines the account number lengths used when STAR Patient Accounting uses the account number in the CLP01 record for matching. The default length for an account number is ten, but account number lengths for numbers assigned during downtime as this account number length may vary. When this field is accessed, the following prompt is displayed:

Enter lengths for account number separated by commas (e.g., 10,13)-

This logic is used when the Payor Claim ID is used to identify the claim. If there is a match for the account number when reviewing both acct number lengths, the payment flows to the Unmatched Payments Worklist, for a user to match.

12. MATCHING CRITERIA (TABLE LOOKUP-O)
This field is used to define criteria for matching claims. When this field is accessed, the following table is displayed:

```
Page:01                Select ERA Items for Clm Matching     ##=Current Choices
( 1) 1500 Dr
( 2) Non Pro Fee 1500 Dr
( 3) 1500 HCPCS
( 4) Non Pro Fee HCPCS
( 5) UB HCPCS
( 6) CLP03/Claim Amount
( 7) CLP06/Claim Filing Indicator
( 8) CLP09/Claim Frequency Type Code
( 9) NM103-5/Name
```

You can select one or multiple items for claim matching. Options selected in the table must be present for a match to occur, while options selected in the Additional Claim Matching Criteria field are those criteria that need to match if there is more than one qualifying claim per claim matching criteria. Options are as follows:

- 1500 Dr

  If a 1500 claim is being considered, the physician code in 24J Lower or 24J Upper for any of the 1500 charges must match the first occurrence of REF02 for the payment where REF01 equals one of the qualifiers as defined in the REF Qual field. An example of the REF segment with a qualifier of 1A would look as follows: REF*1A*1234 (where 1234 represents the Dr number). The 1A qualifier would be defined in the REF Qual field.

- Non Pro Fee 1500 Dr

  If a Non Pro Fee 1500 claim is being considered, the physician code in 24J Lower or 24J Upper for any of the 1500 charges must match the first occurrence of REF02 for the payment where REF01 equals one of the qualifiers as defined in the REF Qual field.

- 1500 HCPCS

  If a 1500 claim is being considered, the first HCPCS code plus up to four modifiers found in the SVC segment must match that information in one of the claim service lines for the claim. If the Payment File Definition table is set to Part B processing, this is selected with the post-processing routine.

- Non Pro Fee 1500 HCPCS

  If a Non Pro Fee 1500 claim is being considered, the first HCPCS code plus up to four modifiers found in the SVC segment must match that information in one of the claim service lines for the claim.

- UB HCPCS

  If a UB claim is being considered, the first HCPCS code (HC or blank for the ID qualifier) plus up to four modifiers found in the SVC segment must match that information in one of the claim service lines for the claim.

- CLP06/Claim Filing Indicator

  For Medicare and Medicare Part B payments, the CLP06/ Claim Filing Indicator should also be used for matching criteria. Medicare sends an MA in CLP06 for Medicare Part A payments so only the UB claims are searched. MB is sent in the CLP06 for Medicare Part B payments, so only 1500 and non-pro fee 1500 claims will be searched. This helps to narrow the search for a matching claim. If this is blank, there is no impact. Include claim type (R) for Medi-Cal.

- CLP09/Claim Frequency Type Code

  The CLP09 record is used to help identify if the payment is for a UB claim. If there is data in the CLP09 record, the system assumes this is a UB claim form type (X) or (R) for Medi-Cal and continues to search for a UB claim for matching to the payment.

- NM103-5/Name

  If this is selected as a matching criteria, the system uses NM103 - NM105 for matching patient names where NM101 = QC or a 74 if there is no QC. The name can also be used to help identify the correct facility if the hospital does not use facility code attached with the account number. Name should be selected as Additional Claim Matching criteria for those sites that have multiple facilities. A single facility does not need this option as the account number in the CLP01 record is sufficient to start the search.

13. ADDITIONAL CRITERIA (TABLE LOOKUP-O)

This field is used to define additional criteria for matching claims. When this field is accessed, the Select ERA Items for Clm Matching table is displayed (see the Matching

Criteria field). Options selected for this field are those criteria that need to match if there is more than one qualifying claim per claim matching criteria.

14. REF QUAL (TABLE LOOKUP-C)
This field is used to enter the qualifiers for the REF segment when the 1500 Dr and Non-Pro Fee 1500 Dr IDs are selected as options in the Matching Criteria or Additional Matching Criteria. When this field is accessed, the following prompt is displayed:

Enter REF qualifiers used to select 1500 physicians separated by commas (e.g.,1C,1G)--

If 1500 Dr and/or Non-Pro Fee 1500 Dr are selected as matching criteria in the previous fields, you need to enter the qualifiers for matching. The qualifiers may be entered into this field as a string (e.g. 1A, 1B, 1D, G2). For complete information on these qualifiers reference the ANSI 835 guide under the Rendering Provider Identification section. Examples of these qualifiers are as follows:

1A Blue Cross Provider Number

1B Blue Shield Provider Number

1C Medicare Provider Number

1D Medicaid Provider Number

1G Provider UPIN Number

1H Champus Provider Number

G2 Provider Commercial Number

15. DAYS PAID? (1-A-R)
Enter **Y** to upload the days paid into the detail record. The default is Y. Enter **N** if the days paid are not to be uploaded.

16. DRG PAID? (1-A-R)
Enter **Y** to upload the DRG into the detail record. The default is Y. Enter **N** if the DRG is not to be uploaded.

17. OUTLIER? (1-A-R)
Enter **Y** to upload the outlier type into the detail record. The default is Y. Enter **N** if the outlier type is not to be uploaded.

18. BD PYMT (1-A-O)
This field indicates whether payments should be posted automatically for accounts in a bad debt location. When this field is accessed, the following prompt is displayed:

Include Bad Debt accounts in ERA batch so payments can be applied? (Y/N) [N]--

You can enter **Y** (Yes) to indicate that payments are posted for accounts in a bad debt location. These accounts are to be included in the ERA Insurance Cash Batch. You can enter **N** (No) to indicate that payments are not posted for accounts in a bad debt location and the accounts are not included in the ERA Insurance Cash Batch. The default is No.

Bad debt accounts are included in the Name/Account Search in the Unmatched Payments Worklist, if this field is set to *Yes*.

19. DEFAULT CLAIM DISPOSITION (1-A-R)
This field contains the claim disposition indicator that is used as the default value for each entry in the resulting cash batches. When this field is accessed, the following prompt is displayed:

Enter new default claim disposition or `-` to list --

You can enter **F** - final payment, **C** - clear disposition, **P** - partial payment, **D** - denied, **T** - transfer, or **A** - adjusted to zero.

20. DENIED CLAIM DISPOSITION (1-A-R)
This field contains the denied claim disposition. If the claim has been denied, the disposition entered in this field is used instead of the default claim disposition from the Default Claim Disposition field. After you enter this option, the following prompt is displayed:

Select the disposition to be assigned for a denied claim. Enter D for Denied or P for Partial disposition--

You can enter the claim disposition of **P** - partial payment, or **D** - denied.

21. DEFAULT DISP FOR DENIAL TRK INTERFACE (1-A-O)
This field contains the claim disposition indicator that is used as the default value for the denial tracking interface. When this field is accessed, the following prompt is displayed:

Select the disposition to be assigned if the claim qualifies for denial tracking

You can enter **F** - final payment, **C** - clear disposition, **P** - partial payment, **D** - denied, **T** - transfer, or **A** - adjusted to zero.

NOTE: For the Denial Tracking Interface, only dispositions of Partial and Denied are valid to qualify for Denial Tracking.

22. PRECEDENCE FOR DISP FROM CAS CODES (1-A-O)
This field is used to determine whether a Partial or Denied disposition should be applied when CAS Reason codes exist with at least one assigned a *Partial* and one assigned *Denied* in the ERA file for a payment (or denial). This field allows you to determine the disposition that is assigned when both exist.

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

Should a disposition of (D)enied or (P)artial take precedence when assigning a claim disposition from CAS Reason Codes?

Entry options are:

D (Denied) - A disposition of Denied is assigned when CAS codes exist in the file which has both a Partial and Denied disposition assigned.

P (Partial) - A disposition of Partial is assigned when CAS codes exist in the file which has both a Partial and Denied disposition assigned.

Leaving the field blank means that a Denied disposition is assigned when CAS codes exist in the file which has both a Partial and Denied disposition assigned.

An example of this is: The field is set to Partial disposition. You upload and process an ERA file with a payment where CAS Reason codes exist and where one of these CAS Reason codes has a Partial disposition and another has a Denied disposition assigned. The payment is marked as Partial in the ERA cash batch.

23. USE CAS CODE DISP FOR DENIAL TRK INT (1-A-R)
This field determines where the disposition for a claim that qualifies for denial tracking should be defined.

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

Should the disposition from CAS codes be used for a claim marked for Denial Tracking? (Y/N)-

Entry options are:

Y (Yes) - The claim is marked for denial tracking and the disposition is determined based upon the CAS Reason codes.

N (No) - The claim is marked for denial tracking and the disposition defined in the Default Disp for Denial Trk field is used.

NOTE: If the Claim Status code in the CLP record points to a Denied disposition (per the Claim Status Code table), this is used rather than the disposition in the Default Disp for Denial Trk Interface field.

24. EXCLUDE SUPPRESSED C/A FROM NEW BAL
This field is used to exclude the contractual adjustment amount from new balances when this is suppressed.The contractual adjustment may be suppressed via denial tracking or the claim disposition rules. When this field is accessed, the following prompt is displayed:

Do you want to exclude the C/A amount from the New Balance on reports if the C/A is being suppressed? (Y/N)-

- If the user selects N for No, then the logic to exclude the suppressed contractual adjustment amount will not be used and there will be no change to the reports as to how the contractual adjustment amount is displayed.
- If the field is left blank and the user .NL out of the field, then no new logic is invoked. This field may be left blank.
- If the user selects Y for Yes, the logic will exclude the contractual adjustment amount from the following fields on the FAR121x, FXRERACDx and FXRERACDMx reports:
  - New Balance
  - New Insurance Balance

With the exclusion of the contractual adjustment amount on the reports, this allows you to review the current balances for the account, patient and insurance and review the potential impacts of not posting the adjustment amount at that time. The user may then make any preferred updates to the payment transaction before the batch is posted.

If the suppressed contractual adjustment amount is excluded, it is not included in the totals at the bottom of the report for Cont. Adj Total and Batch Total. The field Sup Cont Adj Total will be added to the totals at the bottom of the report. If the suppressed contractual amount is not included in new balances, that amount is totaled and appears in Sup Cont Adj Total.

The Other Adjustment amount is not suppressed and will be included in the contractual adjustment amount on the reports. Keep in mind that any ERA CAS Reason codes that are defined as an 'Other Adj' are treated simply as an other adjustment and do not flow through logic for denials or suppression via the claim disposition rules.

The Patient Balance was added to the FAR121x, FXRERACDx and FXRERACDMx reports.

The account and insurance balances on these reports are the expected balances. These come from the cash batch. They are updated before these reports are produced but a subsequent transaction can cause the new balance information on these reports to be out-of-date and therefore incorrect. The patient balance will be the current patient balance.

The following screen is displayed after you press ENTER.

```
                    General Hospital Financial Table Maintenance Processor
                                                  Wed Apr 25, 2012 10:44 am
ERA Payment File Definition
                        Transaction Code Defaults and Exceptions
 1 Payment Trans Code          2 Contr Adj Trans Code  3 Other Adj Trans Code

 4 Transaction Code Exceptions                          5 Rev Sys Adj Trans Code

       Transaction Code Defaults and Exceptions for Secondary Insurance
 6 Use  7 Payment Transc Code  8 Contr Adj Trans Code  9 Other Adj Trans Code

10 Transaction Code Exceptions                         11 Rev Sys Adj Trans Code

                           Contractual Adj Method Defaults
12 C/A for COB1   13 C/A for Prim 1500  14 C/A for Sec    15 C/A for PCON 1500
   Rev Sys Adj
                          Contractual Adj Method Exceptions
16 C/A for COB1   17 C/A for Prim 1500  18 C/A for Sec    19 C/A for PCON 1500

20 Re-calc C/A if Cash Transc is Edited 21 Post/Rpt C/A if Den
                                          Post

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

Field Explanations

TRANSACTION CODE DEFAULTS AND EXCEPTIONS

1. PAYMENT TRANS CODE/DESC (1-A-O)

This field contains the insurance payment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the insurance payment transaction codes. When complete, this code is used as the insurance payment transaction code for the insurance cash batch. If no entry is made in this field, the payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. If the contractual adjustment transaction code is missing from the patient's insurance plan, the payment is displayed on the Electronic Remittance Rejection Report (FXRERRR).

2. CONTR ADJ TRANS CODE/DESC (1-A-O)

This field contains the contractual adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment transaction code for the contractual adjustment that is posted at the time of insurance payment. If no entry is made in this field, the contractual adjustment transaction code from the patient's insurance plan is used for the contractual adjustment. If the contractual adjustment transaction code is missing from the patient's insurance plan, the payment appears on the Electronic Remittance Rejection Report (FXRERRR).

3. OTHER ADJ TRANS CODE/DESC (26-A-N)

This field contains the other adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment

transaction code for any “other” adjustment that is posted at the time of insurance payment. If no entry is made in this field, the contractual adjustment transaction code from the Payment File Definition is used for the other adjustment. If the Contractual Adj Trans Code/Desc is not defined on the Payment File Definition screen, then the contractual adjustment transaction code from the patient’s insurance plan is used. “Other” adjustments are established in the Electronic RA CAS Reason Code table.

4. TRANSACTION CODE EXCEPTIONS (1-AN-O)

This field allows for unique transaction codes to be assigned according to the patient type associated with the account for the following transaction codes:

- Payment Trans Code
- Contr Adj Trans Code
- Other Adj Trans Code

If a patient type exception is defined in the field, the system uses this transaction code instead of the transaction code associated with the payment file definition or insurance carrier plan. The PT exceptions by Transaction Code parameter would be split by facility because the patient type table is facility-split.

If a patient type exception was defined for one or more facilities, this field contains the value *Exceptions Defined,* and the facility is appended to the end. Facilities are separated by a comma. If patient type exceptions were not defined, this field contains the value *Exceptions Not Defined*.

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

Do you wish to add/modify Exceptions for Transaction Codes? (Y/N)[Y]--

You can enter **Y** (Yes**)** to enter transaction code exceptions or enter **N** (No) to remain on the screen to enter bill type exceptions or to exit the screen. If you enter Y (Yes),

the following screen is displayed. The screen requires at least one transaction code to be entered:

```
          General Hospital Financial Table Maintenance Processor
                                                        Mon Mar 24, 2008 10:49 am
ERA Payment File Definition
                            Transaction Code Exceptions
    PI  PT   ERA Segment Rule       Pymt Trans Cd  C/A Trans Cd  Other Trans Cd
1           Rule 1                   I0001          A0001
2           Rule 2                   I0002          A0002         A0033
3           Rule 3                   I0003          A0003
4   I                                I0004          A0004
5      O/P                           I0004          A0004
6      OPB                           I0005          A0005         A0055
7      OPO                           I0009          A0009




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

Field Explanations

PI (PATIENT INDICATOR) (TABLE LOOKUP-O)
This field contains the patient indicator (Inpatient (I), Outpatient (O), or Emergency Room (E). You can enter the patient indicator or a hyphen (-) to select an indicator.

PAT TYPE (TABLE LOOKUP-O)
This field contains the patient type, such as I/P for inpatient. You can enter a patient type or a hypen (-) to select a patient type from the table.

ERA SEGMENT RULE (TABLE LOOKUP-O)
This field is used to associate a payment transaction code with a patient type exception. If you enter a hyphen (-), the system displays a list of ERA segment rules. You can select the code from the table.

PYMT TRANS CD (TABLE LOOKUP-O)
This field is used to associate a payment transaction code with a patient type exception. If you enter a hyphen (-), the system displays a list of payment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the subsequent transaction codes must be specified.

C/A TRANS CD (TABLE LOOKUP-O)
This field is used to associate an adjustment transaction code with a patient type. If you enter a hyphen (-), the system displays a list of adjustment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the subsequent transaction codes must be specified.

OTHER TRANS CD (TABLE LOOKUP-O)
This field is used to associate a patient type with a transaction code for other adjustment. If you enter a hyphen (-), the system displays a list of other adjustment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the previous transaction codes must be specified.

These exceptions for transaction codes are not used for bill type exceptions. Those are entered on a separate screen. For details on that screen, see "Bill Type Exceptions" on page 1-58.

5. REV SYS ADJ TRANS CODE (1-A-O)
This field is used to indicate where the contractual adjustment for the Reverse System transaction is pulled, per the account's reimbursement method (Pathways Contract Management, Outpatient Prospective Payment System or STAR reimbursement). When this field is accessed, the following prompt is displayed:

Do you want to use the transaction code used for the contractual adjustment for the Rev Sys Adj transaction? (Y/N)

If you enter **Y** (Yes), the contractual adjustment code for the reversal is the code used to post the estimated contractual adjustment per the account's reimbursement. The term *Est Cont Adj* is displayed in the field for this option.

If you enter **N (**No), the contractual adjustment code for the reversal comes from the ERA Payment File Definition table. The term *Default Trans Code* is displayed in the field for this option.

NOTE: This field determines where the transaction code for the Reverse System Adjustment is pulled. This only applies if the C/A for COB1 or PCON 1500 fields have Reverse Sys Adj as the selected option.

TRANSACTION CODE DEFAULTS AND EXCEPTIONS FOR SECONDARY INSURANCE

6. USE (1-A-O)

This field is used to activate the functionality to define transaction codes and defaults for secondary insurances. When this field is accessed, the following prompt is displayed:

Maintain transaction code information for secondary insurances? (Y/N) [N]-

- If you enter Y (Yes), the following fields can be used to define transaction codes and defaults for secondary insurances: Payment Trans Code, Contr Adj Trans Code, Other Adj Transaction Codes, Transaction Code Exceptions, Rev Sys Adj Trans Code. If there are transaction codes defined and at a later time this field is set to No, all transaction codes for secondary insurances are removed.

- If you enter N for No, none of the fields listed above can be accessed to define transaction codes and defaults for secondary insurances.

7. PAYMENT TRANS CODE (TABLE LOOKUP-O)
This field contains the payment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the payment transaction codes. When complete, this code is used as the insurance payment transaction code for the insurance cash batch. If transaction code information is being used for secondary insurance, and no code is selected for Payment Trans Code or Contr Adj Trans Code, the transaction code indicated in Billing/Collection Options is used.

8. CONTR ADJ TRANS CODE (TABLE LOOKUP-O)
This field contains the contractual adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment transaction code for the contractual adjustment that is posted at the time of insurance payment. If transaction code information is being used for secondary insurance, and no code is selected for Payment Trans Code or Contr Adj Trans Code, the transaction code indicated in Billing/Collection Options is used.

9. OTHER ADJ TRANS CODE (TABLE LOOKUP-O)
This field is used to associate a patient type with a transaction code for other adjustment. If you enter a hyphen (-), the system displays a list of other adjustment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the previous transaction codes must be specified.

If transaction code information is being used for secondary insurance, and no code is selected for Other Adj Trans Code, the logic uses the code indicated for Contr Adj Trans Code if it exists or the transaction code indicated in Billing/Collection Options.

10. TRANSACTION CODE EXCEPTIONS (TABLE LOOKUP-O)
This field allows for unique transaction codes to be assigned according to the patient type associated with the account for the following transaction codes:

- Payment Trans Code
- Contr Adj Trans Code
- Other Adj Trans Code

If a patient type exception is defined in the field, the system uses this transaction code instead of the transaction code associated with the payment file definition or insurance carrier plan. The PT exceptions by Transaction Code parameter would be split by facility because the patient type table is facility-split.

If a patient type exception was defined for one or more facilities, this field contains the value *Exceptions Defined,* and the facility is appended to the end. Facilities are

separated by a comma. If patient type exceptions were not defined, this field contains the value *Exceptions Not Defined*.

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

Do you wish to add/modify Exceptions for Transaction Codes? (Y/N)[Y]--

You can enter **Y** (Yes**)** to enter transaction code exceptions or enter **N** (No) to remain on the screen to enter bill type exceptions or to exit the screen. If you enter Y (Yes), the following screen is displayed. The screen requires at least one transaction code to be entered:

```
          General Hospital Financial Table Maintenance Processor
                                                        Mon Mar 24, 2008 10:49 am
ERA Payment File Definition
                          Transaction Code Exceptions
    PI  PT   ERA Segment Rule       Pymt Trans Cd  C/A Trans Cd  Other Trans Cd
1           Rule 1                   I0001          A0001
2           Rule 2                   I0002          A0002         A0033
3           Rule 3                   I0003          A0003
4   I                                I0004          A0004
5      O/P                           I0004          A0004
6      OPB                           I0005          A0005         A0055
7      OPO                           I0009          A0009




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

Field Explanations

PAT TYPE (TABLE LOOKUP-O)
This field contains the patient type, such as I/P for inpatient. You can enter a patient type or a hypen (-) to select a patient type from the table.

PYMT TRANS CD (TABLE LOOKUP-O)
This field is used to associate a payment transaction code with a patient type exception. If you enter a hyphen (-), the system displays a list of payment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the subsequent transaction codes must be specified.

PI (PATIENT INDICATOR) (TABLE LOOKUP-O)
This field contains the patient indicator (Inpatient (I), Outpatient (O), or Emergency Room (E). You can enter the patient indicator or a hyphen (-) to select an indicator.

ERA SEGMENT RULE (TABLE LOOKUP-O)
This field is used to associate a payment transaction code with a patient type exception. If you enter a hyphen (-), the system displays a list of ERA segment rules. You can select the code from the table.

C/A TRANS CD (TABLE LOOKUP-O)
This field is used to associate an adjustment transaction code with a patient type. If you enter a hyphen (-), the system displays a list of adjustment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the subsequent transaction codes must be specified.

OTHER TRANS CD (TABLE LOOKUP-O)
This field is used to associate a patient type with a transaction code for other adjustment. If you enter a hyphen (-), the system displays a list of other adjustment transaction codes. You can select the code from the table. This field can be left blank to indicate the transaction code should not be changed. However, either this transaction code or one of the previous transaction codes must be specified.

These exceptions for transaction codes are not used for bill type exceptions. Those are entered on a separate screen. For details on that screen, see "Bill Type Exceptions" on page 1-58.

11. REV SYS ADJ TRANS CODE (1-A-O)
This field is used to determine where the transaction code for the Reverse System Adjustment is pulled. This only applies if the secondary insurance uses PCON 1500 and has Reverse Sys Adj as the selected option for the C/A for PCON 1500 field. When this field is accessed, the following prompt is displayed:

For the Sec Insurance, use the transaction code used for the contractual adjustment for the Rev Sys Adj transaction? (Y/N)-

- If Y is selected the contractual adjustment code for the reversal will be the code used to post the estimated contractual adjustment per the account's reimbursement method. In the case for a secondary insurance the only reimbursement method that applies is PCON 1500 as a secondary insurance. The term 'Est Cont Adj' will display in the field for this option.

- If N is selected the contractual adjustment code for the reversal will come from the ERA PFD table. The term 'Default Trans Code' will display in the field for this option.

NOTE: If the Use field is changed from Yes to No, all exceptions are removed along with the generated code.

12. C/A FOR COB1 (TABLE LOOKUP-O)
This field defines the calculation of the contractual adjustment for the primary insurance. After you access this field, the system displays a table of the contractual adjustment methods. You can select one of the following contractual adjustment methods from the table.

- Select **Post** to post the contractual adjustment as it is received.

- Select **Do Not post** if the contractual adjustment should not be posted. The adjustment is reported on the Electronic RA Audit report (FXRERAR).

- Select **Variance** to post the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is reported as the variance on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Variance is not a valid option for Part B source files.

- Select **Report** if the adjustment or variance should not be posted. The variance is reported on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Report is not a valid option for Part B source files.

- Select **Reverse Sys Adj** for the system to reverse the estimated contractual adjustment and to post the contractual adjustment received from the ERA file. If there is no contractual adjustment found for the claim, the contractual adjustment from the file is posted to the claim. If a contractual adjustment exists for this payor (calculated from STAR reimbursement, Pathways Contract Management, or a previous ERA adjustment), the system reverses the contractual adjustment and posts the adjustment from the ERA file. This reversal also shows in Transaction History with the same posting date/time of the payment and adjustment.

13. C/A FOR PRIM 1500 (TABLE LOOKUP-O)
This field defines the calculation of the contractual adjustment for the primary 1500 insurance. After you access this field, the system displays a table of the contractual adjustment methods. You can select one of the following contractual adjustment methods from the table.

- Do Not Post - You can choose this not to post the contractual adjustment. The adjustment is reported on the Electronic RA Audit report (FXRERAR).

- Post - You can choose this to post the contractual adjustment as it is received.

- Report - If the Report method is selected, the contractual adjustment amount from the remittance file is shown on the reports, but no contractual adjustment is posted.

14. C/A FOR SEC (TABLE LOOKUP-O)
This field is used in the calculation of contractual adjustments for secondary insurances, if the claim is for a non-primary COB. When this field is accessed, the following adjustment methods are displayed. You can select one adjustment method:

- Do Not Post - You can choose this not to post the contractual adjustment. The adjustment is reported on the Electronic RA Audit report (FXRERAR).

- Post - You can choose this to post the contractual adjustment as it is received.

- Report - If the Report method is selected, the contractual adjustment amount from the remittance file is shown on the reports, but no contractual adjustment is posted.

15. C/A FOR PCON 1500 (TABLE LOOKUP-O)
This field is used in the calculation of contractual adjustments for secondary insurances, if the claim is the first 1500 COB with a B reimbursement type for a claim that is marked for PCON 1500 processing. When this field is accessed, the following adjustment methods are displayed. You can select one adjustment method.

- Do Not Post - You can choose this option not to post the contractual adjustment. The adjustment is reported on the Electronic RA Audit report (FXRERAR).

- Post - You can choose this option to post the contractual adjustment as it is received.

- Variance - You can choose this option to post the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is reported as the variance on the Electronic Cash Posting Batch Audit report (FAR121).

- Report - If the Report method is selected, the contractual adjustment amount from the remittance file is shown on the reports, but no contractual adjustment is posted.

- Reverse Sys Adj - This option backs off the estimated contractual adjustment and then posts the contractual adjustment received from the ERA file. If there is no contractual adjustment found for the claim, the contractual adjustment from the file posts to the claim. If a contractual adjustment exists for this payor (calculated from STAR reimbursement, Pathways Contract Management, or a previous ERA adjustment), the system reverses the contractual adjustment and posts the adjustment from the ERA file. This reversal also shows in Transaction History with the same posting date/time of the payment and adjustment.

Contractual Adjustment Methods

The fields below are used to handle exceptions for the contractual adjustment method by patient type or patient indicator:

16. C/A FOR COB1 (TABLE LOOKUP-O)
This field defines patient type exceptions for the calculation of the contractual adjustment for the primary insurance. When this field is accessed, the following prompt is displayed:

Do you wish to add/modify Contractual Adjustment Method Exceptions for COB1? (Y/N) [Y].

If you enter Y (Yes), the following screen is displayed:

```
            General Hospital Financial Table Maintenance Processor
                                                    Mon July 15, 2012

PI    Pat Type    Pat Type Description         Rmb    C/A Method
1     OPO         Outpatient Observation              Variance
2     OPS         Outpatient Surgery           H      Reverse Sys Adj
3     OPB         Outpatient in bed            H      Report









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

Field Explanations

PI (1-A-R)
This field contains the patient indicator. You can enter a patient indicator or a hyphen (-) to display a list of patient indicators.

PAT TYPE (1-A-O)
This field contains the patient type. You can enter a patient type from the Patient Types table or a hyphen (-) to display a list of patient types.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the patient type entered in the Patient Type field.

RMB (DISPLAY ONLY)
This field contains the reimbursement type for the patient type entered in the Patient Type field. You can enter a reimbursement type from the Reimbursement Types table or or a hyphen (-) to display a list of reimbursement types The second screen below shows the available choices when performing the dash lookup.

```
                General Hospital Financial Table Maintenance Processor
                                                  Wed Apr 25, 2012 04:46 pm
Page:01                        Reimbursement Type
( 1) A-ASC Reimbursement
( 2) B-PCON 1500
( 3) C-Major Diagnostic Category
( 4) D-ICD Diagnosis Code
( 5) E-EAPG
( 6) G-DRG
( 7) H-OPPS
( 8) I-PCON by Bill
( 9) J-PCON by Claim
(10) L-DRG+Alt Level Care
(11) M-Medical Service
(12) N-Nova Scotia OOP
(13) O-Overall Plan
(14) P-ICD Procedure Code
(15) Q-Claim Amount
(16) R-Alternate Price
(17) S-Specified DRG Codes


Enter choice--
```

NOTE: The order of selections in the table will control what is checked first, second, third, etc. The selection is made for the first entry found matching account information.This same logic is how the Claim Disposition Rules logic is applied. The warning here is if the user selects an odd combination or order, the table will need to be readjusted. Here are preferences as to how these exceptions may be combined (i.e. specific scenarios to more generic scenarios):

- Patient Type and Reimbursement
- Patient Indicator and Reimbursement
- Reimbursement
- Patient Type
- Patient Indicator

C/A METHOD

After you access this field, the system displays a table of the contractual adjustment methods. You can select one of the following contractual adjustment methods from the table.

- Select **Post** to post the contractual adjustment as it is received.
- Select **Do Not post** if the contractual adjustment should not be posted. The adjustment is reported on the Electronic RA Audit report (FXRERAR).

- Select **Variance** to post the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is reported as the variance on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Variance is not a valid option for Part B source files.

- Select **Report** if the adjustment or variance should not be posted. The variance is reported on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Report is not a valid option for Part B source files.

- Select **Reverse Sys Adj** for the system to reverse the estimated contractual adjustment and to post the contractual adjustment received from the ERA file. If there is no contractual adjustment found for the claim, the contractual adjustment from the file is posted to the claim. If a contractual adjustment exists for this payor (calculated from STAR reimbursement, Pathways Contract Management, or a previous ERA adjustment), the system reverses the contractual adjustment and posts the adjustment from the ERA file. This reversal also shows in Transaction History with the same posting date/time of the payment and adjustment.

17. C/A FOR PRIM 1500 (1-A-O)
This field defines patient type exceptions for the calculation of the contractual adjustment for the primary 1500 insurance. When this field is accessed, the following prompt is displayed:

Do you wish to add/modify Contractual Adjustment Method Exceptions for PRIM 1500? (Y/N) [Y].

If you answer **Y** (Yes), the screen displayed allows you to enter either a Patient Type or Patient ID and a C/A Method. For details on the screen, see the CA for COB 1 field. Valid C/A Methods for primary 1500 insurance are as follows:

- Select **Post** to post the contractual adjustment as it is received.

- Select **Do Not post** if the contractual adjustment should not be posted. The adjustment is reported on the Electronic RA Audit report (FXRERAR).

- Select **Report** if the adjustment or variance should not be posted. The variance is reported on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Report is not a valid option for Part B source files.

18. C/A FOR SEC (TABLE LOOKUP-O)
This field defines patient type exceptions for the calculation of the contractual adjustment for the secondary insurance. When this field is accessed, the following prompt is displayed:

Do you wish to add/modify Contractual Adjustment Method Exceptions for Secondary Insurances? (Y/N) [Y].

If you answer **Y** (Yes), the screen displayed allows you to enter either a Patient Type or Patient ID and a C/A Method. For details on the screen, see the CA for COB 1 field. Valid C/A Methods for the secondary insurance are as follows:

- Select **Post** to post the contractual adjustment as it is received.
- Select **Do Not post** if the contractual adjustment should not be posted. The adjustment is reported on the Electronic RA Audit report (FXRERAR).
- Select **Report** if the adjustment or variance should not be posted. The variance is reported on the Electronic Cash Posting Batch Audit report (FAR121).

19. C/A FOR PCON 1500 (TABLE LOOKUP-O)
This field defines patient type exceptions for the calculation of the contractual adjustment for the PCON 1500 insurance. When this field is accessed, the following prompt is displayed:

Do you wish to add/modify Contractual Adjustment Method Exceptions for PCON 1500? (Y/N) [Y].

If you answer **Y** (Yes), the screen displayed allows you to enter either a Patient Type or Patient ID and a C/A Method. For details on the screen, see the CA for COB 1 field. Valid C/A Methods for PCON 1500 insurance are as follows:

- Select **Post** to post the contractual adjustment as it is received.
- Select **Do Not post** if the contractual adjustment should not be posted. The adjustment is reported on the Electronic RA Audit report (FXRERAR).
- Select **Variance** to post the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is reported as the variance on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Variance is not a valid option for Part B source files.

- Select **Report** if the adjustment or variance should not be posted. The variance is reported on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Report is not a valid option for Part B source files.

- Select **Reverse Sys Adj** for the system to reverse the estimated contractual adjustment and to post the contractual adjustment received from the ERA file. If there is no contractual adjustment found for the claim, the contractual adjustment from the file is posted to the claim. If a contractual adjustment exists for this payor

(calculated from STAR reimbursement, Pathways Contract Management, or a previous ERA adjustment), the system reverses the contractual adjustment and posts the adjustment from the ERA file. This reversal also shows in Transaction History Re-calculate C/A if Cash Transc is Edited.

20. RE-CALC C/A IF CASH TRANSC IS EDITED (1-A-O)
This field is used to suppress the re-calculation of contractual adjustments for transactions in a cash batch created from an ERA file when the Allow Contr Adj field in the cash batch header has been defaulted to Yes. When this field is accessed, the following prompt is displayed:

Re-calculate Cont Adj when the ERA cash transaction is edited? (Y/N) [Y]--

- You can enter **Y** (Yes) to re-calculate the contractual adjustment if Allow Contr Adj is Yes in the cash batch header.

- You can enter **N** (No) if you don't want the system to re-calculate the contractual adjustment if AllowContr Adj is Yes in the cash batch header.

The value for this field is displayed next to the value for the Allow Contr Adj field on the header screen for an insurance batch, if the Allow Contr Adj field is set to Yes. The display is one of the following:

- Yes/Re-calc=Yes

- Yes/Re-calc=No

21. POST/RPT C/A IF DEN (1-A-O)
This field is used to indicate whether a contractual adjustment or takeback adjustment should be processed (posted or reported) for a denied claim. This field can be accessed only if the value in the C/A COB1 field is *Reverse System Adjustmen*t, *Report,* or *Variance*. If the Denial Method field in the Denial/Appeals Parameters table is set not to track denials for a facility, the system posts or reports the contractual adjustment regardless of how the Post/Rpt C/A if Den field is set, since denial tracking must be used for the contractual not to be posted.

The prompts that are displayed when this field is accessed vary, according to whether the C/A for COB1 field contains Report or Variance:

- If the C/A for COB1 field is set to Reverse Sys Adj or Variance, the following prompt is displayed:

  Do you want to post a contractual adjustment if the claim qualifies for denial tracking? (Y/N)--

- If the C/A for COB1 is Report, the following prompt is displayed:

Do you want to report a contractual adjustment if the claim qualifies for denial tracking? (Y/N)-

Entry options are **Y** (Yes) or **N** (No) for both prompts. You can enter **Y** (Yes) to post a contractual adjustment if a claim qualifies for denial tracking; the system updates the field with the value of *Post* (Post Contractual). You can enter **N** (No) not to post a contractual adjustment for a claim that qualifies for denial tracking; the system updates the field with the value of Do Not Post.

If the C/A for COB1 field is updated from Report to Variance or from Variance to Report, the system automatically updates the Post/Rpt C/A field as follows:

C/A for COB1 Field	Post/Rpt if Den Field
Variance	Do Not Post
If updated to Report, the new value would be Do Not Report.	
Variance	Post
If updated to Report, the new value would be Report.	
Report	Report
If updated to Variance, the new value would be Post.	
Report	Do Not Report
If updated to Variance, the new value would be Do Not Post.	

If you enter **N** for No to either prompt (do not post a contractual adjustment or do not report), the following occurs:

- If the ERA payment would cause the claim to be tracked as a denial, the associated contractual adjustment is not posted or reported.
- If the ERA payment is a takeback for an ERA payment that caused the claim to be tracked as a denial and the associated contractual adjustment for the payment was not posted/reported, the associated contractual adjustment for the takeback is not posted/reported.
- If the subsequent ERA payment is denied again, the associated variant contractual adjustment will not be posted/reported. If the subsequent ERA payment is not denied, the associated variant contractual adjustment is posted/reported and subsequent contractual adjustments calculated by ERA is posted.
- The Electronic RA Audit Report and the Electronic RA Audit Report/Takeback Accounts reflect how the claim is tracked.

- If it appears that the ERA payment will cause the claim to be tracked as a denial, **d** follows the Contr Adj appearing in the first line for the payment. If a claim is denied again, **s** follows the Contr Adj appearing in the first line for the payment. If an ERA payment is a takeback for the ERA payment causing the claim to be tracked as a denial, **t** follows the Contr Adj appearing in the first line for the payment. The Calculated Contractual Adjustment appears when a d, s, or t follows the Contr Adj in the first line.

The following screen is displayed after you press ENTER:

```
                  General Hospital Financial Table Maintenance Processor
                                                          Wed Feb 17, 2010 11:06 am
ERA Payment File Definition
 1 Claim Number?   2 Part A LX Format    3 Part B LX Format
   Yes
                       Source for Payee Provider Number
 4 Provider Reference Designator  5 Position for Qualifier   6 Qualifier

 7 Remit Reference Designator

 8 PLB Reference Designator-Adjustment Reason Code Identifier

 9 ERA Clm Adj Grps Table       10 ERA CAS Reason Codes Table

11 Prov Pymt Tot (BPR02/TS309)  12 Suppress PAS C/A 13 Excl SOI for DRG (CLP11)

       Limit Insurance Carriers/Plans for Matching in Section of ERA File
14 Reference Designator         15 Position for Qualifier   16 Qualifier

17 Insurance Carrier/Plan Matching Table


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

Field Explanations

1. CLAIM NUMBER (1-A-R)
This field contains the claim number update indicator. This is the intermediary's or carrier's claim number. The claim number from the payment file updates the external claim number on the patient's claim information. After you enter this option, the following prompt is displayed:

Update the external claim number (Y/N)? [Y] --

Enter **Y** to update the External Claim Number and the insurance payment transaction history comment with this information. The Carrier's Internal Control Number (ICN) information is inserted in the beginning of the comment for the insurance payment. For example: ICN=9999999999 Final Payment. This option is available for all source file formats, Part A, Part B and Vendor. Enter **N** not to update the External Claim Number and the insurance payment transaction history comment.

The default section is **Y**.

2. PART A LX FORMAT (1-N-O)
This field indicates the format of the Part A LX record. The data format is TTYYMM where TT = bill type, MM = month, and YY = Year. The prompt for the field is as follows:

Enter 1 for YYMMTT, 2 for TTYYMM, and 3 for Neither--

If you enter **1** for YYMMTT, the system assumes the format for LX01 is YYMMTT. If YYMM changes, a new batch is started. If you enter **2** for TTYYMM, it is assumed that the format for LX01 is TTYYMM. If YYMM changes, a new batch is started. TT is the bill type used to determine whether bill type exception logic is used. If you enter **3** for Neither, the value for LX01 is changed to be 000000. This means no new batches are created due to a change in the month and year. If the field is left blank, it is assumed that the format of the field is YYMMTT.

3. PART B LX FORMAT (1-A-R)
This field indicates whether the system should default LX01 to 1 (assigned). When this field is accessed, the following prompt is displayed:

Do you want to default LX01 to 1 (assigned) so batches are not divided by it? (Y/N) [N]-

You can enter **Y** (Yes), default LX01 to 1 or **N** (No), do not default LX01 to 1.

Source for Payee Provider Number

The next fields on the screen are used to indicate which record provides the Payee Provider Number. The Payee Provider Number can be translated to the facility for an ERA batch with the ERA Facility/Provider Mapping table. This functionality exists for both 835 Part A and 835 Part B.

4. PROVIDER REFERENCE DESIGNATOR (4-AN-C)
The Reference Designator is composed of the segment identifier followed by a two-digit number that defines the position of the provider number in that segment. This field determines which of the following records is used for the Payee Provider Number:

GS03 where GS01 is HP

REF02 where REF01 is PQ

N104 where N101 is PE

The Payee Provider Number is determined from the record selected in the ERA Payment File Definition, and it is the last occurrence of the record preceding the LX record. If the provider logic is employed, a facility is assigned if it can be determined from the ERA Facility/Provider Mapping table. For the facility determined from the Payee Provider Number, the system determines whether denied UB claims should be evaluated for denial tracking.

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

Enter Reference Designator containing the Provider Number (GS,REF,N1,TS3) and Position (e.g., GS03)--

You can enter a segment identifier equal to either GS, REF, N1, or TS3 and the position for the identifier.

5. POSITION FOR QUALIFIER (1-N-C)
This field contains the qualifier for the provider number. When this field is accessed, the following prompt is displayed:

Enter the position for the Qualifier for the Provider number--

6. QUALIFIER (1-AN-C)
This field contains the qualifier for the provider number. When this field is accessed, the following prompt is displayed:

Enter the Qualifier for the Provider number--

7. REMIT REFERENCE DESIGNATOR (3-AN-C)
This field contains the Remittance field in Insurance Cash Batch that is created in STAR Financials Patient Accounting from the ERA Interface. For example, this allows you to pull the check number or ERF Trace Number from Reference Designator TRN02. The value extracted for the Remittance number field can be up to 25 characters. The Reference Designator is composed of the segment identifier followed by a two-digit number that defines the position of the Remittance number in that segment. The segment identifier must be equal to either LX, TRN or BPR. If you don't enter a value in this field, and it is blank, the system uses the first four characters of the LX01 Reference Designator. When this field is accessed, the following prompt is displayed:

Enter Reference Designator and Position for the Remittance Number (LX,TRN,BPR) (e.g., TRN02)--

8. PLB REFERENCE DESIGNATOR-ADJUSTMENT REASON CODE IDENTIFIER (1-A-O)
This field contains the source of the Adjustment Reason Code Identifier for the adjustment created from the PLB. This field controls the logic for PLB03, PLB05, PLB07, PLB09, PLB11, and PLB13. When this field is accessed, the following prompt is displayed:

If PLBxx-02 exists, use it and not PLBxx-01 for the Adj Reason Code Identifier for xx=03,05,07,09,11,13? (Y/N)--

If you leave the field blank or enter **N** (No), PLBxx-01 is the source of the Adj Reason Code Identifier for the adjustment created from the PLB. If you enter **Y** (Yes), the first two characters of PLBxx-02 are the source of the Adj Reason Code Identifier when

PLBxx-02 is not blank. If PLBxx-02 is blank, PLBxx-01 is the source of the Adj Reason Code Identifier.

9. ERA CLM ADJ GRPS TABLE (1-A-C)

If the Reason Codes from the ERA Payment File Definition should be used to be payor-specific rather than the reason codes from the ERA CAS Reason Codes table, this field must be completed. This field is used to maintain a Payment File Definition Claim adjustment group table which is specific for this ERA Payment File Definition. When this field is accessed, the following prompt is displayed:

(M)aintain PFD Clm Adj Grp Table, (C)opy from ERA Clm Adj Groups Table to PFD, or (R)emove PFD Clm Adj Grp Table--

Entry options are as follows:

- **M** (Maintain)— If M for maintain is selected, you can add, change, or delete PFD Claim Adjustment Group codes. The following prompt is displayed:

  Enter PFD clm adj grp code or `-` for table lookup--

  You can enter the PDF ERA claim adjustment group table code or a hyphen (-) to select one from a table of codes. The PFD clm adj grp code is alphanumeric and the maximum length is two. If an existing code is selected, the Description field can be altered. If no change is made to these fields, you can delete the code from the table by following the prompts that are displayed after you press ENTER.

- **C** (Copy)— If C (Copy) is selected, all entries in the ERA Claim Adjustment Groups Table which are not marked as inactive are copied to the PFD Clm Adj Grps Table. If entries exist in the PFD Clm Adj Grps Table, the following prompt must be answered with a response of Y (Yes):

  PFD Clm Adj Grp Table exists already. Are you sure that you want to copy the ERA Claim Adjustment Groups Table? (Y/N)--

  When the copy option is used, and an entry exists in the PFD Clm Adj Grp Table but not in the ERA Adjustment Groups Table, the entry remains in the PFD Claim Adj Grp Table. If an entry exists in the PFD Clm Adj Grp Table and in the ERA Claim Adjustment Groups Table, it is updated with information from the ERA Claim Adjustment Groups Table.

  The completion of the copy is affirmed by the following message:

  ERA Claim Adjustment Groups Table copied to PFD Clm Adj Grp Table!

- **R** (Remove)—If R for remove is selected, the following prompt must be answered with a response of Yes for the PFD Clm Adj Grp Table to be removed. If no PFD Clm Adj Grp Table exists, a PFD Reason Codes Table cannot be created.

Are you sure that you want to remove the PFD Clm Adj Grp Table? (Y/N)--

If an attempt to remove the PFD Clm Adj Grp Table is made when a PFD Reason Codes Table exists, the removal is not allowed, and the following prompt is displayed:

Cannot remove PFD Clm Adj Grp Table. PFD Reason Code Table exists!

10. ERA CAS REASON CODES TABLE (1-A-C)
The ERA CAS Reason Codes Table field cannot be used unless the ERA Clm Adj Grps Table field has been used to create a PFD Clm Adj Grps Table. When this field is accessed, the following prompt is displayed:

(M)aintain PFD Reason Code Table, (C)opy from ERA CAS Reason Codes able to PFD, or (R)emove PFD Reason Code Table--

Entry options are as follows:

- **M** (Maintain)— If M for maintain is selected, you can add, change, or delete PFD ERA CAS Reason Codes Table codes. The following prompt is displayed after you enter M (Maintain):

  Enter PFD Reason Code or `-` for table lookup--

  You can enter the PDF Reason Code or a hyphen (-) to select one from a table of codes. The PDF reason code is alphanumeric, and the maximum length is 3. The following screen is displayed:

```
                General Hospital Financial Table Maintenance Processor
                                                 Wed Jun 02, 2010 05:21 pm
ERA Payment File Definition
 1 Code           2 Description                        3 Status
   42               Chgs exceed fee sched/max amt        Active
 4 Type of Adjustment                5 Include In Pymt Transaction
   Denial
 6 Claim Disposition
   Partial Payment
 7 Line 1 for Long Description for ERA CAS Reason Code
   Chgs exceed fee sched/max amt
 8 Line 2 for Long Description for ERA CAS Reason Code

 9 Edit by                                          10 Edit date
  New, Nancy                                           06/17/10 17:38
11   LQ02       Remark Description                              Disposition
```

For field descriptions, please refer to the field descriptions for the ERA CAS Reason Codes screen on page 1-70. If no change is made to these fields, you can delete the code by following the prompts that are displayed after you press ENTER.

- **C** (Copy)— If C for copy is selected, all entries in the ERA CAS Reason Codes table which are not marked as inactive are copied to the PFD ERA CAS Reason Codes Table, including Claim Adj Group exceptions. If entries exist in the PFD Reason Codes Table, the following prompt is displayed and must be answered with a response of Y (Yes):

  PFD ERA CAS Reason Codes Table exists already. Are you sure that you want to copy the ERA CAS Reason Codes Table (Y/N)--

  If the copy option is used, and entries exist in the PFD Reason Codes Table, a copy is not allowed if a description for the PFD Reason Code matches a description in the ERA CAS Reason Codes Table, but a different code is used. If that occurs, each problematic code is identified with the following error message where CD is the code for the item in the PFD Reason Code Table and XX is the description for the item in the PFD Reason Code Table.

  Check description duplicate for CD XX in PFD!

  The fact that the copy was not done is noted again with the following error message:

  Copy not done. PFD description exists in CAS file with different code!

  This problem can be removed by changing the description in one of the files and in most instances that would be the ERA Payment File Definition.

  When the copy option is used, and an entry exists in the PFD CAS Reason Codes Table but not in the ERA CAS Reason Codes Table, it remains in the PFD Reason Codes Table. If an entry exists in the PFD Reason Codes Table and in the ERA CAS Reason Codes Table, it is updated with information from the ERA CAS Reason Codes Table including changing the item in the alpha index to the table if need be.

  The completion of the copy is confirmed by the following message:

  ERA CAS Reason Codes Table copied to PFD Reason Codes Table!

- **R** (Remove)—If R for remove is selected, the following prompt must be answered with a response of Yes, for the PFD Reason Codes Table to be removed.

  Are you sure that you want to remove the PFD Reason Codes Table? (Y/N)--

11. PROV PYMT TOTAL (BPR02/TS309) (1-A-R)

This field is used to indicate whether the system uses the BPR02 field in the ERA file, rather than the TS309 field, to determine provider payment total information. When this field is accessed, the following prompt is displayed:

Use BPR02 for provider payment total? (Y/N) [N]-

If you enter **Y** (Yes), the BPR02 field is used, and the cash batch total comes from the BPR segment of the ERA file in field 02, if it is the first batch created after the BPR segment. If it is not the first batch after the BPR segment, the cash batch total has a value of zero.

If you enter **N** (No), the system uses field 09 in the TS3 segment to determine the cash batch total. The Contractual Adjustment Batch Total field uses the value in the TS311 field in the TS3 segment. The system uses the value in the TS311 field for the Contractual Adjustment Batch Total only when the Contractual Adjustment Method field is set to Yes on the ERA Payment File Definition table. If the Contractual Adjustment Method field on the ERA Payment File definition table is set to *No* or *Report*, the system doesn't take contractual adjustments and it doesn't use the value in TS311 for the contractual adjustment batch total, and the Contractual Adjustment Batch Total field is blank. If the Contractual Adjustment Method field is set to Variance, the system calculates the contractual adjustment batch total from the ERA file.

12. SUPPRESS PAS CONTRACTUAL ADJUSTMENT (1-A-R)
This field indicates whether contractual adjustment is posted for a PAS claim in ERA if the STAR Calculated Reimbursement Method is New York. When this field is accessed, the following prompt is displayed:

Do you want to suppress the PAS Contractual Adjustment? (Y/N) [N]--

If you enter **Y** (Yes), no contractual adjustment is posted for a PAS claim in ERA i

13. EXCL SOI FOR DRG (CLP11) (1-A-O)
This field indicates that DRG and SOI returned in CLP11 (DRG) are to be separated. When this field is accessed, the following prompt is displayed:

Do you want to exclude the SOI from the DRG in CLP11 if the length of the field is 4? (Y/N)--

You can enter **Y** (Yes) to separate the SOI and DRG returned in CLP 11 (DRG). This field must be set to Yes in order for the Cash Posting Exception report (FAR140x) to include payments as an exception when ERA payments are processed where CLP11 (DRG) in the ERA file contains an APR DRG and SOI.

NOTE: This does not work for payments keyed manually.

Limit Insurance Carriers/Plans for Matching in Section of ERA File

The next fields on the screen are used, when the system matches payments to claims, if the insurance plans considered need to be limited for sections of the ERA file because payments for different carriers are in different portions of the file and if, in particular, there are crossover claims in the file. This increases the number of payments in an ERA file that can be matched to a claim when it is a crossover payment. For example, if one section of the ERA file contains payments for Insurance A identified

by N1~PR~INSURANCE A, and a section of the ERA file contains payments for Insurance B identified by N1~PR~INSURANCE B, these parameters can assist in directing the payment to a claim. Otherwise, the payment may not be processed if multiple claims are found for the payment.

14. REFERENCE DESIGNATOR (4-AN-C)
This field identifies the segment and data element that can be used to identify a section of the ERA file containing payments for a group of insurance plans. For example, if the payor name is in N102, you would enter N102 into this field.

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

Enter Reference Designator used for Insurance Carrier/Plan Matching--

This field must contain a segment and the numeric sequential position within the segment. An example of this is N102 (with N1 being the segment and 02 being the sequential position within the segment). You can enter one of the following segment indicators: **GS**, **ST**, **N1**, **LX**, **BPR**, **REF**, or **TS3**, followed by a number from **1** to **99**, which defines the sequential position within the segment.

If this field is changed, the Position for Qualifier and the Qualifier fields are blanked out by the system. If you changed this field and need new values in the Position for Qualifier and Qualifier fields, you can enter the values. If you leave this field blank, the system displays the following message to warn you that if no Reference Designator exists, the system deletes the associated Insurance Carrier/Plan Matching if the screen is saved:

If no Reference Designator for Insurance Carrier/Plan Matching exists, then the Ins Carr/ Plan Matching Tbl will be removed when the screen is saved. Press NL.

15. POSITION FOR QUALIFIER (2-AN-C)
This field indicates the position of a qualifier for Insurance Carrier/Plan Matching, if it exists. This field can’t be used unless information exists in the Reference Designator field. The value of this qualifier is identified in the Qualifier field. When this field is accessed, the following prompt is displayed:

Enter the position for the Qualifier for Insurance Carrier/Plan Matching--

You can enter a number between **1** and **99**.

16. QUALIFIER (14-N-O)
This field contains the value of a qualifier, and the value must exist in the position that was entered in the Position of the Qualifier field. If it matches, the value indicated in the Reference Designator field can be used. If it does not match, the value indicated by the Reference Designator cannot be used. For example, if your payor sends the payor name in N101, and if N102 equals PR, N102 is entered as a Reference Designator, the Position for Qualifier field must be 1, and the Qualifier field must be PR, indicating Payer Identification.

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

Enter the Qualifier for Insurance Carrier/Plan Matching--

You can enter a number in this field or leave the field blank. This field can be entered only if there is a value in the Position for Qualifier field. If a position number is displayed in the Position for Qualifier field, and the value for that position number in the segment matches the value in the Qualifier field, which can be blank, the insurance plans used to match payments to claims are governed by the table maintained in the Insurance Carrier/Plan Matching Table field.

17. INSURANCE CARRIER/PLAN MATCHING TABLE (3-N-C)
This field is used to identify a subset of the insurance plans identified in the Select Insurance field on screen one of the ERA Payment File Definition table, which is used for matching payments to claims. An entry in the Insurance Carrier/Plan Matching Table must exist for each value in the field identified in the Reference Designator field. For the entry in the Insurance Carrier/Plan Matching Table being used, the system determines if one claim can be found which matches the payment. If an entry does not exist in the Insurance Carrier/Plan Matching Table for the field identified in the Reference Designator field, all carriers in the Select Insurance field on the first screen of the ERA Payment File Definition table are considered by the system. The selection of the Insurance Matching Code for an ERA payment is made when the ERA file is uploaded. The Insurance Matching Code is used during Process Electronic RA to assist in matching an ERA Payment to a claim. When an entry in the Insurance Carrier/ Plan Matching Table is used to match a claim to a payment, a payment is matched to a claim if only one claim qualifies for any of the insurance carriers/plans listed in the Insurance Carrier Matching List for the Insurance Matching Code.

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

Enter Insurance Matching Code--

You can enter the code or a hyphen (-) for a table lookup of the insurance matching codes. You can select a code from the table or enter **A** (Add) to add a new code. After you enter or select an insurance matching code, the following screen is displayed:

```
        General Hospital Financial Table Maintenance Processor
                                                Thu Aug 10, 2006 09:24 am
ERA Payment File Definition
Insurance Matching Code Table
 1 Insurance Matching Code               2 Insurance Matching Code Description
   4                                    ->
 3 Last Edit Date                        4 Last Edit By
   08/10/06 9:27                           New, Nancy
 5 Value for Insurance Carrier/Plan Matching

 6 Insurance Carrier/Plan Matching List
```

Field Explanations

1. INSURANCE MATCHING CODE (DISPLAY ONLY)
This field contains the insurance matching code entered previously.

2. INSURANCE MATCHING CODE DESCRIPTION (30-AN-R)
This field contains a description that documents the insurance matching being done. When this field is accessed, the following prompt is displayed:

Enter Insurance Matching Code Description--

You can enter a description for the insurance matching code.

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

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

5. VALUE FOR INSURANCE CARRIER/PLAN MATCHING (75-AN-R)
This is the value in the Reference Designator field on screen two for the ERA Payment File Definition, and it identifies a section of the ERA file containing payments for a subset of the insurance plans per the Select Insurance field on screen one of the ERA Payment File Definition. For example, N102 may be used when N101 equals PR, and this field would contain the insurance payor name.

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

Enter value in ERA segment identifying a group of insurance payments--

6. INSURANCE CARRIER/PLAN MATCHING LIST (TABLE LOOKUP-O)
This field is used to access a screen listing of insurance carriers and/or plans for which payments can appear in the section of the ERA file identified by the Value for Insurance Carrier/Plan Matching field. All claims matching the criteria in the Matching List are compiled. If only one claim is found, the payment is used for that claim. If more than one claim is found per the Matching List, the payment is identified on the Electronic Remittance Rejection report (FXRERRR) with the following message: Multiple claims

(where ### is the Insurance Matching Code in the ERA Payment File Definition). When this field is accessed, the following screen is displayed:

```
    General Hospital Financial Table Maintenance Processor
                                                Thu Aug 10, 2006 09:24 am
ERA Payment File Definition
Insurance Matching Code Table
Seq  Ins Code  Use                Insurance Plans to Crossover From
1


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

Field Explanations

SEQ (DISPLAY ONLY)
This field contains the sequential number assigned by the system to identify the row in the table.

INS CODE (TABLE LOOKUP-R)
This field contains the insurance carrier code or the insurance plan code for payments. The insurance carrier code must appear in the Select Insurance field on screen one of the ERA Payment File Definition table. In this section of the ERA file, the matching of payments to claims is limited to the insurance carriers and/or insurance plan codes indicated in this field.

You can enter a hyphen (-) to display a list of insurance carriers and Insurance plans and select a carrier and/or plan from the list.

USE (1-A-R)
This field indicates the logic used to match payments to claims. You have the following entry options:

- **N** (No crossover logic)

  The typical logic for matching payments to claims is used. If the account number in CLP01 is not a Payor Claim ID, the search for claims is based on date logic, and for Medicare Part B claims, the search for claims is based on date logic, HCPCS code for the first charge, and performing physician for the first charge. If the account number in CLP01 is a Payor Claim ID, the claim identified by the Payor Claim ID is used.

- **C** (Crossover logic)

  When crossover logic is used, the system looks for matches with claims for the insurance plans indicated in the Insurance Plans to Crossover From field. If the account number in CLP01 is not a Payor Claim ID, the search for claims is based on date logic, and for Medicare Part B claims, the search for claims is based on

date logic, HCPCS code for the first charge, and performing physician for the first charge. If the account number in CLP01 is a Payor Claim ID, the claim identified by the Payor Claim ID is used. If one claim is identified in this search, the system looks to see if only one matching claim exists for the Ins Code identified in the table. The claim split indicator is used to make this decision. If the claim split indicator for the original claim is blank or is marked as the primary claim, the claim split indicator for the crossover claim must be blank or marked as the primary claim. If the claim split indicator for the original claim is not blank, and it is not marked as the primary claim, the claim split indicators must match, excluding the counter used for UB claims in Add Claim to Insurance. If only one original claim exists for the bill and only one crossover claim exists for the bill, the payment is associated with the crossover claim even if the claim split indicators are different. If more than one matching claim is found, a crossover claim is not identified.

- **B** (Both)

  If any claims are found using the no crossover logic, those criteria are used to determine if a matching claim for the payment can be found. Otherwise, the crossover logic is used to find a matching claim for the payment.

INSURANCE PLANS TO CROSSOVER FROM (TABLE LOOKUP-O)
This field is used to define the insurance plans from which payment could be transferred. If C (Crossover logic) or B (Both) is indicated in the Use field, the system attempts to match the payment to claims for any of the insurance plans in this list. If only one claim is found, the system looks to see if only one corresponding claim exists for the Ins Code field. Ins Code can be an insurance carrier or an insurance plan. You can enter a hyphen (-) to display a list of insurance plans and to select one from the list.

When these fields are completed, the next screen is displayed:

```
        General Hospital Financial Table Maintenance Processor
                                          Thu Apr 21, 2012 02:18 pm
ERA Payment File Definition
 1 Criteria for Splitting Batches
   Entries Defined
                  User Defined Segment for Splitting Batches
 2 Reference Designator  3 Position for Qualifier   4 Qualifier

 5 Facilities            6 ERA Claim Status Table
   A                       PFD Clm Sts Tbl Exists
 7 FAR121 Adj Ind        8 FAR121 Sort        9 FAR121 With Err/Wrn Only
   Cont Adj                Patient Name
10 Beginning Batch#     11 Cross Facility    12 Analysis Report Def

13 Claim Disp Rule                       14 ERA CAS Codes for Discrepancy Amount

15 Post Payment Evaluation

16 Adjustment Reason Codes to Exclude from FXRERAPLB

17 Last Edit Date         18 Last Edit By
   04/26/12 10:50am          New, Nancy
```

Field Explanations

1. CRITERIA FOR SPLITTING BATCHES (TABLE LOOKUP-O)
This field is used to define how to split ERA batches. One ERA file may split into multiple batches based upon the criteria selected on this table. You can select one or more options from the table:

```
ERA Payment File Definition
Page:01              Select ERA Items for Splitting Batches   ##=Current Choices
( 1) Check/BPR
( 2) Check/TRN02
( 3) Fiscal Period in LX01
( 4) Provider Number
( 5) ST Segment
( 6) Bill Type Exception in LX01
( 7) Claim Type (UB or non-UB)
```

If you select multiple criteria, all selected criteria must be true. Also, if payments for multiple facilities exist in one ERA file, batches are always split by facility.

- If Fiscal Period in LX01 is selected, batches are split on LX01.
- If Bill Type Exception in LX01 is selected, the system always starts a new batch and looks to the setup per the Bill Type Exceptions screen.
- If Provider Number is selected, the system always starts a new batch with each new provider number. If you select this option, you can refer to the defined setup

on the second screen of the ERA Payment File Definition and the fields under the heading, *Source for Payee Provider Number*.

- If Check is selected, you can select one of two options: refer to the TRN02 segment for the check number or split by BPR (which contains payment totals). A new batch is created with each instance of check number.

- If Claim Type is selected, claims are split by UB and non-UB (via the CLP09 record).

- If ST Segment is selected, a new batch is created with each instance of an ST segment - meaning the search is for ST segments, not the ending SE segment.

New batches are created each time a selected criteria is found to be true in the file. If no options are selected, one batch is created for the ERA file. The only exception is if payments/accounts are found in the file for multiple facilities and batches are created for each facility.

NOTE: It is suggested to define minimal batch split criteria, since the more batches that are created, the more difficult it is to balance batches back to an ERA file.

The fields under the screen heading, *User Defined Segment for Splitting Batches*, is used to define one segment for splitting batches in addition to the criteria selected in this field.

2. REFERENCE DESIGNATOR (4-AN-O)
The Reference Designator is composed of the segment identifier followed by a two-digit number that defines the position of the provider number in that segment. When this field is accessed, the following prompt is displayed:

Enter Reference Designator used for splitting batches (e.g., REF02)--

3. POSITION FOR QUALIFIER (1-N-C)
This field contains the qualifier for the provider number. When this field is accessed, the following prompt is displayed:

Enter the position for the Qualifier for splitting batches--

You can enter a number from **1** to **99**, which defines the sequential position within the segment.

4. QUALIFIER (2-AN-C)
This field contains the qualifier for the provider number. When this field is accessed, the following prompt is displayed:

Enter the Qualifier for the Provider number--

You can enter a two-digit number to define the sequential position within the segment.

5. FACILITIES (TABLE LOOKUP-O)
This field is used to define the facilities for review for this ERA Payment File Definition table (for upload). The system uses the defined facilities to determine where to look when matching a claim (based upon the matching criteria selected). You can enter the facility or use the hyphen (-) key to display a table of facilities.

6. ERA CLAIM STATUS TABLE (1-A-R)
This field is used to maintain a Payment File Definition Claim Status table which is specific for this ERA Payment File Definition. When this field is accessed, the following prompt is displayed:

(M)aintain PFD Claim Status Table, (C)opy from ERA Claim Status Table to PFD, or (R)emove PFD Claim Status Table--

Entry options are as follows:

- **M** (Maintain)— If M for maintain is selected, you can add, change, or delete PFD Claim Status codes. The following prompt is displayed after you enter M (Maintain):

  Enter PFD ERA claim status code or `-` for table lookup--

  Enter the PFD ERA claim status code or a hyphen (-) to select one from a table of codes, or enter a claim status code that you want to define. The PFD ERA claim status code is alphanumeric, and the maximum length is 4. After you enter an existing ERA claim status code or a new one, the system displays the ERA Claim Status Code table. If you entered a new code, you can enter information in the fields (for field explanations, see "ERA Claim Status Codes Screen" on page 1-77), then press ENTER to accept the screen and to return to the ERA Payment File Definition screen. If you entered an existing code, the Description, Track Denials, Default Denial Reason Code, and/or Assign Denied Claim Disposition fields on this screen can be altered, and you can press ENTER to accept the changes and return to the ERA Payment File Definition screen. If no change is made to these fields, you can delete the code from the PFD Claim Status Table by entering Y (Yes) at the following prompt that is displayed when you press ENTER:

  Delete? (N)--

  If an ERA Payment File is being processed, and the PFD Claim Status table exists, the Track Denial field from the PFD Claim Status Table determines whether the claim is considered for denial tracking, and the Assign Denied Claim Disposition field from the PFD Claim Status Table determines whether the disposition in Denied Claim Disposition in the ERA Payment File Definition is assigned for the claim. For both of these fields, a blank response equates to N for No.

- **C** (Copy)— If C for copy is selected, all entries in the ERA Claim Status Table which are not marked as inactive are copied to the PFD Claim Status table. If a Payment File Definition Claim Status table exists for the ERA Payment File Definition, the field contains the value of PFD Clm Sts Tbl Exists. If entries exist in the PFD Claim

Status table, the following prompt is displayed and must be answered with a response of Y (Yes):

PFD Claim Status Table exists already. Are you sure that you want to copy the ERA Claim Status Table? (Y/N)--

When the copy option is used and an entry exists in the PFD Claim Status Table but not the ERA Claim Status Table, it remains in the PFD Claim Status Table. If an entry exists in the PFD Claim Status Table and in the ERA Claim Status Table, it is updated with information from the ERA Claim Status Table. The completion of the copy is confirmed by the following message:

ERA Claim Status Table copied to PFD Claim Status Table!

- **R** (Remove)—If R for remove is selected, the following prompt is displayed and must be answered with a response of Y (Yes) for the PFD Claim Status Table to be removed.

  Are you sure that you want to remove the PFD Claim Status Table? (Y/N)--

  If no PFD Claim Status Table exists because it was deleted, the ERA Claim Status Table is used.

7. FAR121 ADJ IND (1-A-R)

This field defines how adjustments are reported on the Electronic RA Cash Batch Audit Report, FAR121. After you enter this option, the following prompt is displayed:

Include (C)ont Adj, (D)etail Adj, or (N)o Added Information on FAR121 [N] --

You have the following options when accessing this field:

- (C)ont Adj - Causes information on contractual adjustments to be included.
- (D)etail Adj - Causes information on contractual adjustments to be included and adjustment detail appears for a transaction if a warning/error was found. The takeback transaction uses the variance method, or the combined takeback/payment uses the variance or post methodology. If an error in the contractual adjustment calculation exists, "***" appears for the ERA contractual adjustment to reinforce that no ERA contractual adjustment can be determined.
- (N)o Added Information - Produces the report without additional information on takebacks, transactions using variance or reporting methodology for contractual adjustments, combined takeback/payment transactions, or transactions with errors/warnings.

8. FAR121 SORT (1-A-R)

This field defines how the Electronic RA Cash Batch Audit Report, FAR121, is sorted. When this field is accessed the following prompt is displayed:

Sort FAR121 report by patient (N)ame, (E)RA file sequence, or batch (S)equence?[S]--

You have the following options when accessing this field:

- (**N**)ame - The report sorts by patient name in alphabetical order.
- (**E**)RA - The report sorts in ERA file sequence number order.
- (**S**)equence - The report sorts in batch sequence number order.

The default response is S.

9. FAR121 WITH ERR/WRN ONLY (1-A-O)
This field indicates whether a second version of the FAR121 report is to be produced listing only payments with warning or error messages. When the field is accessed, the following prompt is displayed:

Do you want to produce a second version of FAR121 limited to payments with edits/errors and related payments? (Y/N)--

If the field is left blank or answered No, there is no impact and no second version of the report is created.

10. ANALYSIS REPORT DEF (TABLE LOOKUP-O)
This field defines the Payment Analysis Report Definition(s) used to generate the Payment Analysis Report(s) for the resulting cash batch. The following prompt is displayed:

Enter ERA Payment Analysis Report code(s) or `-` for list --

You can pick one or more codes from a list of codes established in the ERA Payment Analysis Report Definition table. If this field is left blank, the report is not produced. The ERA Payment Analysis Report is produced automatically when the insurance cash batch is posted. The report may also be requested on demand after the cash batch is approved.

11. BEGINNING BATCH # (2-A-R)
This field allows the user to indicate the first or first and second characters when the system assigns batch numbers from the uploaded ERA file. These are batch numbers for ERA cash batches, ERA unmatched payment batches, ERA provider level adjustment batches, and batches for unmatched provider adjustments.

When this field is used and ERA batches are created, the system attempts to assign a batch number beginning with the keyed characters. The system assigns the first batch number it calculates that is not currently being used.

If one character has been keyed, the system attempts to create batches using that character and ending with 00 through 99 or ending with AA through ZZ. For batches

ending in AA through ZZ, this provides 26 more opportunities to assign a batch. The logic only uses two-character endings where the characters match.

If two characters were keyed, the system attempts to create batches using the two characters and ending with 0 through 9 or ending with A through Z.

12. CROSS FACILITY (1-A-O)
This field is accessible only if Cross Facility is active on the system. The field is used to indicate whether ERA cash batches can be worked through the GUI Cross Facility module. If you allow this, the upload and process functionality remains in character base on the Electronic RA Interfaces Menu, but the batches are written and stored as Cross Facility batches.

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

Process ERA files as Cross Facility batches? Y/N

- If you enter **Y** (Yes), each time an ERA file is uploaded with this PFD table, the default to the question for Cross Facility in the Process Elec RA function is Yes, and batches are accessible via Cross Facility.

- If you enter **N** (No), each time an ERA file is uploaded with this PFD table, the default to the question for Cross Facility in the Process Elec RA function is No, and batches are not accessible via Cross Facility.

When an ERA file is processed, you can still override the default answer to the question, as some sites with Cross Facility may elect to work and process the batches through the character-based system.

If the ERA file is re-split, the Cross Facility question is asked again, so if by chance an incorrect selection was made the first time, this can be corrected without having to delete and re-upload the file.

13. CLAIM DISP RULE (TABLE LOOKUP-O)
This field is used to indicate the claim disposition rule. The Claim Disposition Rules table allows a payment tracking indicator to be defined so that payments can be identified as underpayments and overpayments.

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

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

14. ERA CAS CODES FOR DISCREPANCY AMOUNT (TABLE LOOKUP-O)
This field is used to select or modify ERA CAS Reason codes that are used where there is a possibility of recouping the money being written off per the ERA CAS Reason code. CAS Reason codes may be specific on a payor by payor basis, and if the CAS Reason codes are payor specific, the facility can define these codes within the ERA Payment File Definition table. The user must define those CAS Reason codes used to

determine the discrepancy amount which is the maximum amount which could be recouped if an updated claim was re-submitted.

NOTE: Once ERA CAS Reason codes are defined that are used for evaluation, the next step is to apply these CAS Reason codes from the ERA Payment File Definition table to a Claim Disposition Rule on the Claim Disposition Rules Table. For details on this table, see *Tables, Masters, and Parameters Volume* of the *STAR Patient Accounting Reference Guide*, Chapter 1: Financial Tables. The functionality is not activated until the ERA CAS Reason codes are selected in the ERA PFD table and the ERA PFD table is activated in a Claim Disposition Rule.

The system calculates a discrepancy amount by adding up the amounts associated with the CAS Reason codes defined in ERA CAS Reason Codes for Discrepancy Amount in the ERA PFD. So for CAS Reason codes that are defined with a type of adjustment of Contractual, Other, or Denial, these amounts are totaled to use within formulas within the Claim Disposition Rules. The amount calculated as the discrepancy amount may differ from the amount calculated as the contractual adjustment amount. For exampl,e if there are certain CAS Reason codes where the facility does not expect to recoup this amount (even if the claim is fixed and resubmitted) the CAS Reason code would not be selected in this list. The selected CAS Reason codes should be those where it is expected that a newly resubmitted claim with corrected or additional information may result in payment for this service. Possible examples of these types of CAS Reason codes are as follows:

- Pmt adjusted because the submitted authorization # is missing.
- Claim/svc lacks information which is needed for adjudication.
- Pmt adjusted because requested information was not provided.

When this field is accessed, if this is not an initial setup and CAS Reason codes already exist in this table, the following prompt is displayed:

Enter CAS Reason code, '-' for list or key M to Modify list—

Entry options are:

- **CAS Reason Code or hyphen (-)** - You can enter a CAS Reason Code to select it as an ERA CAS code for discrepancy amount. If you enter a hyphen, the list of ERA CAS reason codes is displayed, and you can select one or more reason codes from the list. If this ERA PFD table has ERA CAS Reason codes defined within the table, this list of CAS Reason codes is displayed. If there are no CAS Reason codes defined within this ERA PFD table, the list of CAS Reason codes from the ERA CAS Reason Codes table is displayed. CAS Reason codes in the list are of the type Contractual, Other, or Denial. The user will key in the sequence number of the CAS Reason code and this is highlighted on the screen. In order to remove an entry the user will key in '-' and the sequence number of the CAS Reason code.

- **M (Modify)** - The following second screen is displayed as shown below. In this screen you can define ERA Claim Adjustment Groups as the second requirement to use the amount in the calculation. It is expected that there will be few overrides, but with this screen the ability exists to define overrides. The ERA CAS Reason codes will display and the user will arrow (up or down) to the sequence number and then arrow to the right to the 'Group Code' field. In the Group Code field the user may key in a '-' lookup to select from ERA Claim Adjustment Groups. Note if no Group codes are selected, then the system looks for the existence of the defined CAS Reason code. If a Group Code is defined, the system looks for the Group Code(s) + the CAS Reason code.

```
                General Hospital Financial Table Maintenance Processor
                                                Tue Mar 15, 2011 11:00 am

Select CAS Codes/Claim Adjustment Group Codes
Seq#  Reason Code                              Group Code(s)
1     AA   DUPLICATE CLAIM/SVC                 PR
2     MD   NOT PAID FOR BY MEDICAID
3     35   BENEFIT MAXIMUM REACHED             CO,OA
```

15. POST PAYMENT EVALUATION (TABLE LOOKUP-O)
This field is used to select evaluations to be performed when ERA batches using the ERA Payment File Definition are posted. The code(s) must be present when the header for the batch is created because the code(s) are defaulted in the batch header. If one or more entries are selected from the Post Payment Evaluation table, each evaluation is performed as soon as the ERA batch posts. This would be in addition to any Post Payment Evaluations scheduled in the Post Payment Evaluation table to be performed after the batch posts.

When this field is accessed, you can enter a hyphen (-) to review the Post Payment Evaluation table and to select one or more entries. If one or more entries are selected from the Post Payment Evaluation table, each evaluation is performed as soon as the ERA batch posts. This would be in addition to any Post Payment Evaluations scheduled in the Post Payment Evaluation table to be performed after the batch posts.

16. ADJUSTMENT REASON CODES TO EXCLUDE FROM FXRERAPLB (TABLE LOOKUP-O)
This field is used to exclude Adjustment Reason Codes from the ERAPLB Report (FXRERAPLB).

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

Enter the Provider Level Adjustment Reason code to be excluded from FXRERAPLB or `-` for list--

You can enter a code or a hyphen (-) to review the Provider Level Adjustment Reason Codes table and to select one or more entries.

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

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

When these fields are completed, the following prompt is displayed if the Bill Type Exception in LX01 was selected as criteria for splitting batches:

Do you want to enter bill type exceptions (Y/N)? [N] --

You may wish to enter additional bill type exceptions in order to force the system to create a separate insurance cash batch for the designated bill type. If bill type separation is not desired, enter **N** and the system returns to the Maintain Tables menu. If bill type separation is desired, enter **Y** and a list of valid bill types and their associated descriptions are displayed. For details, see “Bill Type Exceptions” on page 1-58.

Bill Type Exceptions

The next screen for bill type exceptions on the ERA Payment File Definition table is displayed only if the Bill Type Exception in LX01 is selected as criteria for splitting batches. After you select a bill type exception from the list of valid bill types, the system displays the following screen:

After selecting a bill type that is an exception, the following screen is displayed.

```
            General Hospital Payment File Definition Processor
                                                    Wed Apr 25, 2010 05:44 pm

 Bill Type Exception - 15 -

                              Matching Criteria
 1 Select Insurance     2 Type of claim form    3 Claim Type   4 Svc Date
->

                            Electronic RA Defaults
 5 Allow Days Paid?     6 Allow DRG Paid?       7 Allow Outlier?

 8 Payment Trans Code   9 Contr Adj Trans Code 10 Other Adj Trans Code

11 C/A for COB1   12 Post/Rpt C/A if Den  13 C/A for Sec   14 C/A for PCON 1500

15 Default Claim Disposition       16 Denied Claim Disposition

17 Beginning Batch#                18 Analysis Report Def
   I                                  ALL - ALL ACCOUNTS



Do you want to match payments by Carrier (C) or by Carrier/Plan (P)?--
```

Field Explanations

1. SELECT INSURANCE (4-AN-R)
This field contains the code for the carrier or the carrier/plan to which payments are to be matched. When this field is accessed, the following prompt is displayed:

Do you want to match payments by Carrier (C) or by Carrier/Plan (P)?--

You can enter **C** (Carrier) to define the carrier code(s) for the carrier to whom payments are to be matched. A list of carrier codes is displayed. You can enter **P** (Plans) to define the carrier/plan code(s) for the carrier to whom payments are to be matched. If you select this option, the following prompt is displayed:

Enter insurance plan codes in a list or partial code`-` for list -

NOTE: McKesson recommends that you only select down to the plan level if there are plans that may be excluded for matching with the carrier. If any plan from the selected carrier is a possibility for matching, it is not recommended to select down to the plan level.

2. TYPE OF CLAIM FORM (1-A-R)
This field contains the type of claim form. You can enter the type of claim form or a hyphen (-) to display the claim form type. Select the claim type that you want from the list of valid Claim Form Types displayed on your screen. Multiple claim types can be selected at the same time.

3. CLAIM TYPE (1-A-R)
This field identifies the claim type(s) to be included in the batch. Enter the claim type(s) or accept the default [All] to include all claim types. Multiple claim types may be entered. Valid responses are **F** - Final, **A** - Adjustment, **C** - Cycle, **L** - Late, or the default of All can be accepted.

4. SVC DATE (1-A-R)
This field identifies whether the service date is to be used as a matching criterion. The following prompt is displayed:

Match Srv Dts (E)xactly, or (B)ypass Svc Thru Dt? [E] --

If you answer the prompt with **E**, the service through date is used as a matching criterion. The default is **E**. If you answer either prompt with **B**, the system bypasses the service through date as a matching criterion. If there is a match on the service from date and a mismatch on the service through date, this claim payment does not appear on the Electronic Remittance Rejection report (FXRERRR). The claim payment is entered as an entry in the insurance cash batch that is created as a result of this processing.

5. ALLOW DAYS PAID? (1-A-R)
Enter **Y** to upload the days paid into the detail record. The default is Y. Enter **N** if the days paid are not to be uploaded.

6. ALLOW DRG PAID? (1-A-R)
Enter **Y** to upload the DRG into the detail record. The default is Y. Enter **N** if the DRG is not to be uploaded.

7. ALLOW OUTLIER? (1-A-R)
Enter **Y** to upload the outlier type into the detail record. The default is Y. Enter **N** if the outlier type is not to be uploaded.

8. PAYMENT TRANS CODE/DESC (1-A-O)
This field contains the insurance payment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the insurance payment transaction codes. When complete, this code is used as the insurance payment transaction code for the insurance cash batch. If this field is left blank, the payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. If the contractual adjustment transaction code is missing on the patient’s insurance policy, the payment is rejected.

9. CONTR ADJ TRANS CODE/DESC (1-A-O)
This field contains the contractual adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment transaction code for the contractual adjustment that is posted at the time of insurance payment. If this field is left blank, the contractual adjustment code from the patient's insurance plan is used for the contractual adjustment. If the contractual adjustment transaction code is missing on the patient’s insurance policy, the payment is rejected.

10. OTHER ADJ TRANS CODE/DESC (36-A-N)
This field contains the other adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment transaction code for an adjustment posted as an "Other" adjustment at the time of insurance payment via ERA. The Electronic RA CAS Reason Codes Table determines if the adjustment from a CAS segment is considered to be an "Other" adjustment. If no entry is made in this field, the contractual adjustment transaction code from the Bill Type Exception screen is used for the other adjustment. If the Contractual Adj Trans Code/Desc is not defined on the Bill Type Exception screen, then the contractual adjustment transaction code from the patient's insurance plan is used. "Other" adjustments are established in the Electronic RA CAS Reason Code table.

11. C/A FOR COB1 (1-A-R)
This field defines the calculation of the contractual adjustment for the primary insurance. After you access this field, the system displays a table of the contractual adjustment methods. You can select one of the following contractual adjustment methods from the table.

- Select **Post** to post the contractual adjustment as it is received.
- Select **Do Not post** if the contractual adjustment should not be posted. The adjustment is reported on the Electronic RA Audit report (FXRERAR).
- Select **Variance** to post the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is reported as the variance on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Variance is not a valid option for Part B source files.

- Select **Report** if the adjustment or variance should not be posted. The variance is reported on the Electronic Cash Posting Batch Audit report (FAR121).

  NOTE: Report is not a valid option for Part B source files.

- Select **Reverse Sys Adj** for the system to reverse the estimated contractual adjustment and to post the contractual adjustment received from the ERA file. If there is no contractual adjustment found for the claim, the contractual adjustment from the file is posted to the claim. If a contractual adjustment exists for this payor (calculated from STAR reimbursement, Pathways Contract Management, or a previous ERA adjustment), the system reverses the contractual adjustment and posts the adjustment from the ERA file. This reversal also shows in Transaction History with the same posting date/time of the payment and adjustment.

12. POST/RPT C/A IF DEN (1-A-O)
This field is used to indicate whether a contractual adjustment or takeback adjustment should be processed (posted or reported) for a denied claim. This field can be

accessed only if the value in the C/A for COB1 field is set to Report or Variance. If the Denial Method field in the Denial/Appeals Parameters table is set not to track denials for a facility, the system posts or reports the contractual adjustment regardless of how the Post/Rpt C/A if Den field is set, since denial tracking must be used for the contractual not to be posted.

13. C/A FOR SEC (TABLE LOOKUP-O)
This field is used in the calculation of contractual adjustments for secondary insurances, if the claim is for a primary COB. When this field is accessed, the following adjustment methods are displayed. You can select one adjustment method:

- Do Not Post - You can choose this not to post the contractual adjustment. The adjustment is reported on the Electronic RA Audit report (FXRERAR).
- Post - You can choose this to post the contractual adjustment as it is received.
- Report - If the Report method is selected, the contractual adjustment amount from the remittance file is shown on the reports, but no contractual adjustment is posted.

14. C/A FOR PCON 1500 (TABLE LOOKUP-O)
This field is used in the calculation of contractual adjustments for secondary insurances, if the claim is the first 1500 COB with a B reimbursement type for a claim that is marked for PCON 1500 processing. When this field is accessed, the following adjustment methods are displayed. You can select one adjustment method.

- Do Not Post - You can choose this option not to post the contractual adjustment. The adjustment is reported on the Electronic RA Audit report (FXRERAR).
- Post - You can choose this option to post the contractual adjustment as it is received.
- Variance - You can choose this option to post the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is reported as the variance on the Electronic Cash Posting Batch Audit report (FAR121).
- Report - If the Report method is selected, the contractual adjustment amount from the remittance file is shown on the reports, but no contractual adjustment is posted.
- Reverse Sys Adj - This option backs off the estimated contractual adjustment and then posts the contractual adjustment received from the ERA file. If there is no contractual adjustment found for the claim, the contractual adjustment from the file posts to the claim. If a contractual adjustment exists for this payor (calculated from STAR reimbursement, Pathways Contract Management, or a previous ERA adjustment), the system reverses the contractual adjustment and then posts the adjustment from the ERA file. This reversal also shows in Transaction History with the same posting date/time of the payment and adjustment.

15. DEFAULT CLAIM DISPOSITION (1-A-R)
This field contains the claim disposition indicator that is used as the default value for each entry in the resulting cash batches. This field is accessible only if the Final Disposition Criteria field is not defined.When this field is accessed, the following prompt is displayed:

Enter new default claim disposition or `-` to list --

You can enter **F** - final payment, **C** - clear disposition, **P** - partial payment, **D** - denied, **T** - transfer, or **A** - adjusted to zero.

16. DENIED CLAIM DISPOSITION (1-A-R)
This field contains the denied claim disposition. If the claim has been denied, the disposition entered in this field is used instead of the default claim disposition from field 19. After you enter this option, the following prompt is displayed:

Enter D for Denied or P for Partial disposition--

You can enter the claim disposition of **P** - partial payment or **D** - denied.

17. BEGINNING BATCH # (2-A-R)
This field allows the user to indicate the first or first and second characters when the system assigns batch numbers from the uploaded ERA file. These are batch numbers for ERA cash batches, ERA unmatched payment batches, ERA provider level adjustment batches, and batches for unmatched provider adjustments. If an ERA cash batch is created due to a bill type exception, the system assigns the batch number based upon the character(s) defined in this field.

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

Enter the beginning of the ERA Batch Number-

When this field is used and ERA batches are created, the system attempts to assign a batch number beginning with the keyed characters. The system assigns the first batch number it calculates that is not currently being used.

If one character has been keyed, the system attempts to create batches using that character and ending with 00 through 99 or ending with AA through ZZ. For batches ending in AA through ZZ, this provides 26 more opportunities to assign a batch. The logic only uses two-character endings where the characters match.

If two characters were keyed, the system attempts to create batches using the two characters and ending with 0 through 9 or ending with A through Z.

18. ANALYSIS REPORT DEF (TABLE LOOKUP)
This field defines the Payment Analysis Report Definition(s) used to generate the Payment Analysis Report(s) for the resulting cash batch. The following prompt is displayed:

Enter ERA Payment Analysis Report code(s) or `-` for list --

You can pick one or more codes from a list of codes established in the ERA Payment Analysis Report Definition table. If this field is left blank, the Analysis Report Definition Code entered on the initial Payment File Definition screen is used. If the Analysis Report Definition is not defined on the Payment File Definition, the report is not produced. The ERA Payment Analysis Report is produced automatically when the insurance cash batch is posted. The report may also be requested on demand after the cash batch is approved and before Midnight Processing.

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

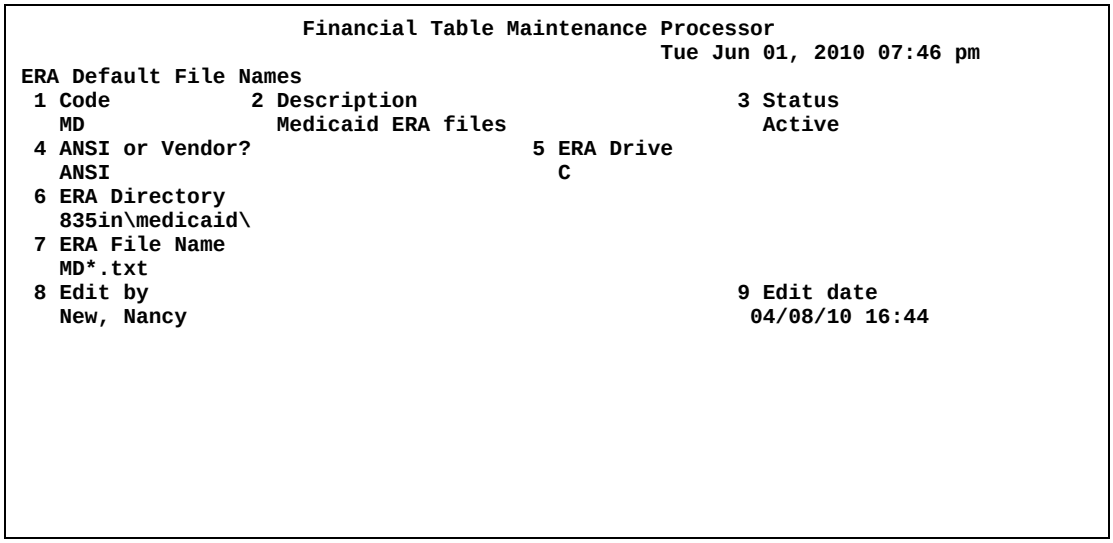
Dependent On	Reference
Insurance Type	Provider Level Adjustment Mapping
Insurance Carrier	
Transaction Codes (Type I)	
Transaction Codes (Type A)	
Bill Type Codes	

ERA Default File Names

This table is used to define the path name of the server used to store ERA files. The file(s) must be saved to a network drive or a pc as this does not support uploading files from the UNIX level. The table also is used to define the beginning characters of the file name. This supports the upload for both ANSI and Vendor file types.

If only one default file name is defined in the table for a type of file (ANSI or Vendor), this default is provided as the default drive, directory and file name when that type of file is uploaded. If multiple entries are defined in the table, you can select the default to be used. Otherwise, the user may press Enter to continue with the prompts as the system currently works. Below is the prompt:

After this table is selected, the system prompts you to enter the code for an ERA Default File Name. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the following screen is displayed:



Field Explanations

1. CODE (2-AN-R)
This field contains the user-defined code for the ERA Default File Name.

2. DESCRIPTION (24-AN-R)
This field contains the description of the code for the ERA Default File Name.

3. STATUS (DISPLAY ONLY)
This field contains the status of the ERA Default Files Name code defined above. The status may be Active or Inactive. An Inactive status would result if this code has been previously filed as deleted. To file an existing code as deleted, choose **Y** to delete the code when exiting the above screen. You are then prompted to either delete (D) the code from the file or to file the code as deleted (F). Once Inactive (Filed as Deleted), the user may choose to reactivate this code. This can be accomplished by choosing the inactive code at the prompt and selecting A to activate.

4. ANSI OR VENDOR? (1-A-R)
This field defines if the defaults in this defined code are for ANSI file formats or Vendor file formats.

Is this a default for (A)NSI or (V)endor files? |

5. ERA Drive (1-A-R)
This field contains the default drive where the ERA files are stored.The following prompt is displayed:

Enter the default drive for the ERA file--

6. ERA DIRECTORY (35-AN-R)
This field contains the directory where the ERA files are stored.The following prompt is displayed:

Enter the default directory for the ERA file--

7. ERA FILE NAME (35-AN-R
This field defines the beginning characters of how the ERA file is named. The following prompt is displayed:

Enter the file name for the ERA file--

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

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

ERA Provider Level Adj Reasons Codes

This table provides a listing of the two-character reason codes adopted for the National Health Care Claim Payment/Advice (835 A and 835 B). This table is not split by facility.

After this table is selected, the system prompts you to enter a provider level adjustment reason code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, the following screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                  Mon Apr 29, 2002 12:52 pm

ERA Provider Level Adj Reasons Codes
 1 Code                                  2 Description
   AP                                      Accelerated Payment Amt
 3 Last Edit by                          4 Last Edit date
   Smith,Mary E                            02/20/95 05:14pm









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

Field Explanations1.CODE (DISPLAY ONLY)

This field contains the two-character alphanumeric 835 provider level adjustment reason code.

2. DESCRIPTION (24-AN-R)
This field contains the provider level adjustment reason code description.

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

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

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

Dependent On	Reference
	Provider Level Adjustment Mapping

ERA Provider Level Adjustment Mapping

This table is used to direct non-patient adjustments to the appropriate General Ledger accounts based on the reason codes sent by the intermediary/carrier.

This table is split by facility.

After this table is selected, the system prompts you to enter a facility code and then a payment file code. You can enter the code or a hyphen (-) to display a list of valid codes. After the code is entered, this screen is displayed.

```
              General Hospital Financial Table Maintenance Processor
                                                  Thu May 3, 2011 03:44 pm
ERA Provider Level Adj Mapping
 1 Payment File Code/Description         2 Last Edit by
   1 - MARYLAND MEDICARE                   Mills,Laura C
 3 Non-patient Payments                  4 Last Edit date
   1 - MEDICARE NON-PT PAY                 01/31/95 01:31pm
 5 Default
   3 - ERA DEFAULT
 6 Mapping
   Adjustment Reason                  Miscellaneous Cash Code           Info Only

 1 IR - Lump-sum Interim RateAdj       IR - Medicare Interim Rate Adj
 2 PP - PIP Payment                    PP - Medicare PIP Payment
 3 GR - Gramm-Rudman Sequestrat        2 - Gramm-Rudman Sequestrat
 4 CP - Capital Pass-thru Amt          4 - Capital Pass-thru Amt









    F1 Prev Page F2 Next Page F3 Insert  F4 Delete  F6 Reset  F7  Exit   ?
```

Field Explanations

1. PAYMENT FILE CODE/DESCRIPTION (DISPLAY ONLY)
This field contains the payment file code and payment file description.

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

3. NON-PATIENT PAYMENTS (2-AN-R)
This field contains the two-character miscellaneous cash code that is used to post the amount for any non-patient related payment sent by the intermediary/carrier. You can enter the miscellaneous cash code or a hyphen (-) to display the table lookup of miscellaneous cash codes.

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

5. DEFAULT (2-AN-R)
This field contains the two-character miscellaneous cash code that is used to post the amount for any adjustment reason code that is not defined in the subsequent table. You can enter the miscellaneous cash code or a hyphen (-) to display the table lookup of miscellaneous cash codes.

6. MAPPING (4-AN-R)
Access to this field presents the scrolling screen that allows you to map the adjustment reason codes to the appropriate miscellaneous cash code.

ADJUSTMENT REASON/DESC
This field contains the two-character adjustment reason code and adjustment reason code description. You can enter the code or a hyphen (-) for a table lookup to display the adjustment reason codes.

MISCELLANEOUS CASH CODE/DESC
This field contains the two-character miscellaneous cash code and the miscellaneous cash code description. You can enter the code or a hyphen (-) for a table lookup to display the miscellaneous cash codes.

INFO ONLY
This field indicates whether an adjustment reason code is informational only and the amount should not be applied to the cash batch. If the field is left blank, the reason code along with the amount is applied to the cash batch.

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

Dependent On	Reference
Payment File Definition	

Miscellaneous Cash Codes
GL Accounts
Transaction Codes (Type F)
Provider Level Adjustment Reason Codes

ERA CAS Reason Codes

This table provides the cross-references needed to identify associated contractual adjustments, denials, other adjustments, payor-specific reason groups for Electronic Remittance payors, and transaction history notations by CAS Reason code when posting adjustment transactions using the 835 Electronic RA version 3051 and higher. To ensure the software supports the current use of code A2 for a contractual adjustment, the base table automatically includes CAS Reason Code A2. You are able to add additional CAS Reason codes, as appropriate. The system refers to the table when analyzing CAS segments. Each CAS Reason Code in the table must be designated as one of the following:

- Contractual Adjustment
- Other Adjustment
- Transaction History Notation
- Denial

This table is also used to link an ERA CAS Reason code with an ERA Remarks code to select a claim disposition. If the ERA CAS Reason Code and Remark Code are linked, the system assigns the disposition indicated in the table.

This table is not split by facility.

After the table is selected, the system prompts you to enter a CAS Reason Code. After the code is entered, the following screen is displayed:

```
          General Hospital Financial Table Maintenance Processor
                                                 Thurs Apr 07, 2010 04:10 pm
ERA CAS Reason Codes
 1 Code           2 Description                        3 Status
   45               Charges exceed fee arrangement       Active
 4 Type of Adjustment               5 Include In Pymt Transaction
   Contractual
 6 Claim Disposition

 7 Line 1 for Long Description for ERA CAS Reason Code
   CAS LONG DESCRIPTION
 8 Line 2 for Long Description for ERA CAS Reason Code
->
 9 Edit by                                          10 Edit date
  New, Nancy                                         04/07/08 10:43
11   LQ02       Remark Description                              Disposition
1    M15        Separately billed svcs/tests have been bundled/Sep Denied









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field contains the CAS Reason Code for this table entry. This code must match that indicated in CAS segments using the 835 Electronic RA version 3051 or higher.

2. DESCRIPTION (30-A-R)
This field contains the description associated with the CAS Reason Code defined above.

3. STATUS (DISPLAY ONLY)
This field contains the status of the ERA code defined above. The status may be Active or Inactive. An Inactive status would result if this code has been previously filed as deleted. To file an existing code as deleted, choose **Y** to delete the code when exiting the above screen. You are then prompted to either delete (D) the code from the file or to file the code as deleted (F). Once Inactive (Filed as Deleted), the user may choose to reactivate this code. This can be accomplished by choosing the inactive code at the prompt and selecting A to activate.

4. TYPE OF ADJUSTMENT (76-A-R)

This field contains the type of adjustment for the CAS Reason Code defined above. The type of adjustment is defined by the user when setting up this table entry. When entering this field, the following prompt is displayed:

Enter adj type of (C)ontractual, (O)ther, (D)enial, or (T)rans History Notation [C]--

You have the following options:

- Contractual - All Contractual adjustment reason codes are combined to obtain a combined contractual adjustment amount which is posted using the transaction code defined in the Payment File Definition Table for contractual adjustments or the contractual adjustment code for the account's COB. If there is a denial in the ERA Interface File, a contractual adjustment is not posted.

- Other - Other adjustments can be used to write off denied line item charges (for example, CAS Reason Code 45) prior to posting the contractual adjustment. The sum of other adjustments is reported separately on the Electronic RA Audit Report (FXRERAR) and can be written off using the separate transaction code defined in the Payment File Definition Table, the transaction code defined in the Payment File Definition Table for contractual adjustment, or the contractual adjustment code for the account's insurance plan. Other adjustments are posted separately, but for reporting purposes on the Electronic Cash Posting Audit Report (FAR121), they are combined with the Contractual Adjustments.

- Transaction History Notation - If a CAS segment uses a CAS Reason Code defined as Transaction History Notations, an adjustment amount is not posted to the account balance, but a Type Z (claim) note is added to Transaction History which is cross-referenced to the insurance payment from the electronic batch.

- Denial - Denial codes are used to track denials, but not write off the denial amount automatically. When a denial is entered in Electronic Payments, the money stays on the insurance and moves to the next carrier or patient, depending on how the Balance Designation Parameters are set. For example, the following would occur if your system is set up for denial tracking and you post an ERA file that has an account with four CAS reason codes set up for denial tracking, three set up with an Adjustment Type as Denial, and one set up with an Adjustment Type of Contractual:

Denial Reason Code	Adjustment Type	Amount
5	Denial	$100
6	Denial	$200
7	Denial	$100
8	Contractual	$1000

The total denial amount would include all of the denial codes and would be $1400.00. The system wouldn't automatically write off the $400.00 that is associated with the adjustment type of Denial.

NOTE: If the only CAS reason code(s) for the claim are codes that have been marked as Filed as Deleted in the Denial Tracking Reason Groups table, the denial is not tracked. The system won't use the default denial code to track the denial in the scenario where the only denial code associated with the claim is one that is marked as inactive.

5. INCLUDE IN PYMT TRANSACTION (1-A-O)

This field indicates whether the calculation for the payment transaction includes the deductible, coinsurance, patient responsibility, or none of those items. When this field is accessed, the following prompt is displayed:

Include as (D)eductible, (C)oinsurance, Co(P)ay, Patient (R)esp or (N)ot include in pymt transaction--

Entry options are as follows:

- **D** (Deductible) - If D is entered, the reason code amount is included in the deductible calculated for the payment transaction from the ERA file.
- **C** (Coinsurance) - If C is entered, the reason code amount is included in the coinsurance calculated for the payment transaction from the ERA file.
- **P** (Co-Pay) - If P is entered, the reason code amount is included in the co-payment calculated for the payment transaction from the ERA file.
- **R** (Patient Responsibility) - If R is entered, the reason code amount is included in the patient responsibility calculated for the payment transaction from the ERA file.
- **N** (None) - If N is entered, the deductible, coinsurance, co-payment, and patient responsibility are not included in the calculation for the payment transaction from the ERA file.

NOTE: If CAS Reason Code 1 appears in the ERA CAS Reason Codes table, the system defaults D (Deductible) in this field. If CAS Reason Code 1 does not appear in the ERA CAS Reason Codes table, it is added to the table with a description of Deductible, with Type of Adjustment equal to N (None), and with Include In Pymt Transaction equal to D (Deductible). If CAS Reason Code 1 has been inactivated in the ERA CAS Reason Codes table, the code and any Claim Adj Group Exceptions are deleted. Then CAS Reason Code 1 is added to the table with no Claim Adj Group Exceptions.

If CAS Reason Code 2 appears in the ERA CAS Reason Codes table, the system defaults C (Coinsurance) in this field. If CAS Reason Code 2 does not appear in the ERA CAS Reason Codes table, it is added to the table with a

description of Coinsurance, with Type of Adjustment equal to N (None), and with Include In Pymt Transaction equal to C (Coinsurance). If CAS Reason Code 2 has been inactivated in the ERA CAS Reason Codes table, the code and any Claim Adj Group Exceptions are deleted. Then CAS Reason Code 2 is added to the table with no Claim Adj Group Exceptions.

6. ASSIGN CLAIM DISPOSITION (1-A-O)
This field is used to define the assignment of a claim disposition.

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

Select (P)artial or (D)enied Disposition--

You can enter **P** (partial payment) or **D** (denied).

NOTE: The intent of this field is to select only those CAS Reason codes in which a partial or denied disposition should always be assigned (it is expected that only a few codes will be defined here). When the ERA file is processed, if there are any CAS Reason codes where a partial or denied disposition is defined, that disposition overrides the default disposition in the ERA Payment File Definition table.

7. LINE 1 FOR LONG DESCRIPTION FOR ERA CAS REASON CODE (50-AN-O)
This field is used to enter 50 characters of the description associated with the CAS Reason code.

8. LINE 2 FOR LONG DESCRIPTION FOR ERA CAS REASON CODE (50-AN-O)
This field is used to enter 50 more characters of the description associated with the CAS Reason code.

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

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

11. THIS LINE CONTAINS THE FOLLOWING FIELDS:

NOTE: You can use the tab key to move from field to field:

LQ02 (TABLE LOOKUP-R)
You can enter a claim remarks code or a hyphen (-) to display a list of claim remarks codes.

REMARK DESCRIPTION (DISPLAY ONLY)
This is the description stored with the claim remark.

DISPOSITION (1-A-R)
You can enter Partial (P) or Denied (D) for the claim disposition.

When these fields are completed, or if you accept the screen without modifications, the following prompt is displayed:

Do you want to enter Claim Adj Group exceptions? (Y/N) [N] --

If you enter No, the transaction is complete. If you enter Yes, the list of ERA Claim Adjustment Groups is displayed, allowing you to select a group code for a defined exception. If an ERA Claim Adjustment Group exception has been defined, the type of adjustment displays next to the group. You can define exceptions for how adjustments are posted based on the ERA Claim Adjustment Group associated with the ERA CAS Reason Code in the Electronic Remittance Advice. Claim Adjustment Groups that are not defined as exceptions are processed according to the Type of Adjustment defined on the ERA CAS Reason Code Table.

```
          General Hospital Financial Table Maintenance Processor
                                                Wed May 1, 2002  11:56 am
ERA CAS Reason Codes

Page:01           Adjustment Group Code and Type of Adjustment
( 1) Contractual Obligation         Contractual
( 2) Correction and Reversals       None
( 3) Other Adjustments
( 4) Payor Initiated Reductions     Transc History Notation
( 5) Patient Responsibility         Other




Enter choice--
```

After selecting an ERA Claim Adjustment Group, the following screen is displayed:

```
           General Hospital CAS Reason Code 45 Processor
                                                Fri June 4, 2010 06:10 pm


Claim Adjust Group Exception - CO - Contractual Obligation

 1 Type of Adjustment                2 Include In Pymt Transaction
   Contractual
 3 Edit by                                              4 Edit date
   Sanders,Sheila M                                       09/02/05 15:09

 6   LQ02       Remark Description                                  Disposition
```

Field Explanations

1. TYPE OF ADJUSTMENT (1-A-R)
This field allows the entry of a different posting method for the adjustment based on the Claim Adjustment Group. The following prompt is displayed:

Enter adj type of (C)ontractual, (O)ther, (D)enial, (T)rans History Notation, or (N)one [C]--

This field contains the type of adjustment for the CAS Reason Code defined above. The type of adjustment is defined by the user when setting up this table entry. Options are:

- (C) Contractual - All **Contractual** adjustment reason codes are combined to obtain a combined contractual adjustment amount which is posted using the transaction code defined in the Payment File Definition Table for contractual adjustments or the contractual adjustment code for the account's COB.

- (O) Other - **Other** adjustments can be used to write-off denied line item charges (for example, CAS Reason Code 45) prior to posting the contractual adjustment. The sum of Other adjustments is reported separately on the Electronic RA Audit Report (FXRERAR) and can be written off using the separate transaction code defined in the Payment File Definition Table, the transaction code defined in the Payment File Definition Table for contractual adjustment, or the contractual adjustment code for the account's insurance plan. **Other** adjustments are posted separately, but for reporting purposes on the Electronic Cash Posting Audit Report (FAR121), they are combined with the Contractual Adjustments.

- (D) (Denial) - If this option is selected, the denial reason code is used for the adjustment.

- (T) Transaction History Notation - If a CAS segment uses a CAS Reason Code defined as Transaction History Notation, an adjustment amount is not posted to the account balance, but a Type Z (claim) note is added to Transaction History which is cross-referenced to the insurance payment from the electronic batch.

- (N) None - If **None** is indicated, the ERA CAS Reason Code is not used for adjustment processing.

3. INCLUDE IN PYMT TRANSACTION (1-A-O)
This field indicates whether the calculation for the payment transaction includes the deductible, coinsurance, patient responsibility, or none of those items. When this field is accessed, the following prompt is displayed:

Include as (D)eductible, (C)oinsurance, Co(P)ay, Patient (R)esp or (N)ot include in pymt transaction--

Entry options are as follows:

- **D** (Deductible) - If D is entered, the reason code amount is included in the deductible calculated for the payment transaction from the ERA file.

- **C** (Coinsurance) - If C is entered, the reason code amount is included in the coinsurance calculated for the payment transaction from the ERA file.

- **P** (Co-Pay) - If P is entered, the reason code amount is included in the co-payment calculated for the payment transaction from the ERA file.

- **R** (Patient Responsibility) - If R is entered, the reason code amount is included in the patient responsibility calculated for the payment transaction from the ERA file.

- **N** (None) - If N is entered, the deductible, coinsurance, co-payment, and patient responsibility are not included in the calculation for the payment transaction from the ERA file. This selection is not allowed if, in the Denial Tracking Reason Group table, a reason code was selected with the type of None; the following error message is displayed:

  Type of Adjustment cannot be None

NOTE: If CAS Reason Code 1 appears in the ERA CAS Reason Codes table, the system defaults D (Deductible) in this field. If CAS Reason Code 1 does not appear in the ERA CAS Reason Codes table, it is added to the table with a description of Deductible, with Type of Adjustment equal to N (None), and with Include In Pymt Transaction equal to D (Deductible). If CAS Reason Code 1 has been inactivated in the ERA CAS Reason Codes table, the code and any Claim Adj Group Exceptions are deleted. Then CAS Reason Code 1 is added to the table with no Claim Adj Group Exceptions.

If CAS Reason Code 2 appears in the ERA CAS Reason Codes table, the system defaults C (Coinsurance) in this field. If CAS Reason Code 2 does not appear in the ERA CAS Reason Codes table, it is added to the table with a description of Coinsurance, with Type of Adjustment equal to N (None), and with Include In Pymt Transaction equal to C (Coinsurance). If CAS Reason Code 2 has been inactivated in the ERA CAS Reason Codes table, the code and any Claim Adj Group Exceptions are deleted. Then CAS Reason Code 2 is added to the table with no Claim Adj Group Exceptions.

4. EDIT BY (DISPLAY ONLY)

This field contains the name of the person who last edited this table entry.

5. EDIT DATE (DISPLAY ONLY)

This field contains the date and time this table entry was last edited.

6. THIS LINE CONTAINS THE FOLLOWING FIELDS:

NOTE: You can use the tab key to move from field to field:

LQ02 (TABLE LOOKUP-R)
You can enter a claim remarks code or a hyphen (-) to display a list of claim remarks codes.

REMARK DESCRIPTION (DISPLAY ONLY)
This is the description stored with the claim remark.

DISPOSITION
You can enter Partial (P) or Denied (D) for the claim disposition.

After accepting the screen, you can enter another exception or exit. The following prompt is displayed:

Do you want to enter another Claim Adj Group exception? (Y/N) [N] --

If you answer Yes, the list of Claim Adjustment Groups is displayed with codes highlighted which have existing exceptions. You can select another code to edit or add. If you answer No, the table information is updated.

ERA Claim Status Codes Screen

This table allows you to maintain the ERA Claim Status Codes received in electronic payment files. McKesson initially provides the ERA Claim Status codes defined in the 835 Claim Payment Advise v.4010 Implementation Guide. Subsequent updates to this table are the responsibility of the user. You can also use the ERA Claim Status codes to select payments with the selected claim status codes to be included or excluded on the ERA Payment Analysis Reports, FAR122 and FAR123. This table is not split by facility.

The ERA Claim Status Codes are also used in Denial Management to indicate the claim status codes that are Denial types.

After the table is selected, you can enter the code or a hyphen (-) for a table lookup of existing codes. After the code is entered or selected, the following screen is displayed:

```
                              General Hospital
                                            Tue Aug 14, 2012 04:19 pm
ERA Claim Status Codes
 1 Code           2 Description                      3 Status
   27               Reviewed                           Active
 4 Track Denials  5 Default Denial Reason Code  6 Track Denials by Reason Code

 7 Assign Denied Claim Disposition
   No
 8 Limit Insurances Checked for Pymt

 9 Edit by                                          10 Edit date
   New, Nancy                                          09/12/05 09:43am



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

Field Explanations

1. CODE (2-N-R)

The one or two digit value of the 835 ERA Claim Status Code. Following are the codes and descriptions initially provided by McKesson:

01—Processed as Primary

02—Processed as Secondary

03—Processed as Tertiary

04—Denied

05—Pended

10—Received, but not in process

13 —Suspended

15—Suspended-investigation/field

16—Suspended with material

17— Suspended-review pending

19—Processed Primary, Forwarded

20—Processed Secondary,Forwarded

21—Processed Tertiary,Forwarded

22—Reversal of Previous Payment

23—Not our Claim,Forwarded

25—Predetermination Pricing Only

27—Reviewed

2. DESCRIPTION (35-AN-R)
This field contains the description of the ERA Claim Status Code.

3. STATUS (DISPLAY ONLY)
This field contains the status of the CAS Claim Status Code defined above. The status may be Active or Inactive. An Inactive status would result if this code has been previously filed as deleted. To file an existing code as deleted, choose **Y** to delete the code when exiting the above screen. You are then prompted to either delete (D) the code from the file or to file the code as deleted (F). Once Inactive (Filed as Deleted), you can choose to reactivate this code. This can be accomplished by choosing the inactive code at the prompt and selecting **A** to activate.

4. TRACK DENIALS? (1-A-O)
This field allows you to identify the ERA claim payment statuses that are used for denial tracking. The value in this field is only used if the Denial Method field in the Denial/Appeals Parameter Processor is set to Live. When this field is accessed, the following prompt is displayed:

Track denials for this claim status (Y/N)--

Valid entries are **Y** for Yes or **N** for No. Blank is interpreted as N for No. If completed with a Yes, denial information for Electronic Remittance Advice (ERA) payments received with the designated claim status is evaluated for denial tracking. Claims that should be evaluated for denial tracking use the parameters defined on the Denial Tracking Payor Code for the associated insurance carrier/plan to determine if the claim qualifies as a denial and possible appeal to track. If this field is completed with an N for No, the system doesn't track denials by claim status code but looks to the Track Denials by Reason Code field to determine if it should track denials by reason code.

5. DEFAULT DENIAL REASON CODE (1-A-O)
This field is used when the batch created from an ERA file is evaluated for denials. When this field is accessed, the following prompt is displayed:

Use(U) or Do Not Use(N) the default denial tracking reason code if no CAS codes are found for denial tracking [U]--

If you leave the field blank or enter **U** (Use), and the claim status is set to track denials, but there are no CAS reason codes defined to track denials in the Denial Tracking Reason Group for the claim, the denial is tracked, and the default denial tracking reason code is used. If you enter **N** (No), and the claim status is set to track denials,

but there are no CAS reason codes defined to track denials in the Denial Tracking Reason Group for the claim, the denial is not tracked.

6. TRACK DENIALS BY REASON CODE (1-A-O)
This parameter allows the hospital to use the denial tracking module to track denials when the claim status associated with a claim is set to *No* for denial tracking. The Track Denials field must be set to *No* in order to access the Track Denials by Reason Code field. For example, if the claim status is 1 for primary, the hospital could elect to track denials for a claim status if denials existed in the ERA file for the claim, even though the Claim Status table has the Track Denial field set to *No*. The system looks for the presence of CAS codes in the ERA file to determine if the denial should be tracked and does not use a default code if no CAS codes exist for denial tracking.

NOTE: If the Claim Status code has the Track Denials field set to Yes, the default denial code logic is valid.

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

Do you want to track denials if a reason code appears in the Denial Tracking Reason Group Table? (Y/N)-- |

If you enter **Y** (Yes), the system completes the field with a value of *Yes* to indicate that denials are tracked if a reason code is included in an ERA file for a claim and that a reason code(s) is also set up in the Denial Tracking Reason Group. If you enter **N** (No), the system completes the field with a value of *No* to indicate that denials should not be tracked if a reason code(s) is included in your ERA file, included in the associated Denial Tracking Reason Group table, and the associated Claim Status is set not to track denials.

7. ASSIGN DENIED CLAIM DISPOSITION (1-A-R)
This field is used to identify which claim statuses should use the Denied Disposition Code on the ERA Payment File Definition table. When this field is accessed, the following prompt is displayed:

Do you want to assign the Denied Claim Disposition if this ERA Claim Status is used for the ERA Payment? (Y/N) [N]--

You can enter **Y** (Yes) to have the claim's disposition code determined from the Denied Claim Disposition maintained in screen one for the ERA Payment File Definition table or in the screen for the bill type exception for the ERA Payment File Definition. Also, if the Source File Type is Vendor in the ERA Payment File Definition and Denial Tracking is used by the facility, the claim is marked to be evaluated for denial tracking when the payment posts, and claim denial Info for the insurance cash payment contains a Yes followed by the primary reason code and denial amount if they were determined.

The system defaults Assign Denied Claim Disposition to Y for Yes for ERA Claim Status Code 4 (Denied) if it exists in the ERA Claim Status Codes table.

8. LIMIT INSURANCES CHECKED FOR PYMT (1-A-O)
This field determines whether the insurance plans evaluated for an ERA payment are limited per the order of the insurance plan on the account.The prompt for the field is as follows:

Limit the evaluation of claims to (P)rimary, (S)econdary, or (T)ertiary Insurances or (N)o limit [N]--

- If the value for the field is N or blank, ERA Claim Status Code is not used to limit the insurance plans considered. The logic for the values of P, S, and T is as follows:
- If P for Primary is indicated and UB claims are being considered, the search is limited to claims for the first plan found for the account which is using a claim type of X (UB). The plans are searched per the COB order.
- If P for primary is indicated and claims of type B (1500) and/or Z (Non Pro Fee 1500) are being considered, then the search is limited to claims for the first plan found for the account which is using a claim type of B or Z. The plans are searched per the COB order.
- If S for Secondary is indicated and UB claims are being considered, then the search is limited to claims for the second plan found for the account which is using a claim type of X (UB). The plans are searched per the COB order.
- If S for Secondary is indicated and claims of type B (1500) and/or Z (Non Pro Fee 1500) are being considered, then the search is limited to claims for the second plan found for the account which is using a claim type of B or Z. The plans are searched per the COB order.
- If T for Tertiary is indicated and UB claims are being considered, then the search is limited to claims using a claim type of X (UB) not qualifying to be the Primary or Secondary UB plan. The plans are searched per the COB order.
- If T for Tertiary is indicated and claims of type B (1500) and/or B (Non Pro Fee 1500) are being considered, then the search is limited to claims using a claim type of B or Z not qualifying to be the Primary or Secondary 1500 plan. The plans are searched per the COB order.

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

10. EDIT DATE (DISPLAY ONLY)
This field contains the date the table was last updated.

ERA Claim Filing Indicator

This table allows you to maintain the ERA Claim Filing Indicators sent in an 835 electronic payment file. You can also use these codes to select payments with the

selected claim filing indicators to be included or excluded on the ERA Payment Analysis Reports, FAR122 and FAR123. McKesson initially provides the ERA Claim Filing Indicators defined in the 835 Claim Payment Advice v.4010 Implementation Guide. Subsequent updates to this table are the responsibility of the user.

This table is not split by facility. After the table is selected, you can enter the code or a hyphen (-) for a table lookup of existing codes. After the code is entered or selected, the following screen is displayed:

```
            General Hospital Financial Table Maintenance Processor
                                                  Thurs May 3, 2002 11:31 am
ERA Claim Filing Indicator
  1 Code           2 Description                      3 Status
    MA              Medicare Part A                     Active
 4 Edit by                                           5 Edit date
   Sanders,Sheila M                                     01/25/02 08:56pm

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

Field Explanations

1. CODE (2-N-R)
The two-digit value of the 835 ERA Claim Filing Indicator. Following are the codes initially provided by McKesson:

12 Preferred Provider Org (PPO)

13 Point of Service (POS)

14 Exclusive Provider Org (EPO)

15 Indemnity Insurance

16 Health Maintenance Org (HMO)

AM Automobile Medical

CH CHAMPUS

DS Disability

HM Health Maintenance Org

LM Liability Medical

MA Medicare Part A

MB Medicare Part B

MC Medicaid

OF Other Federal Program

TV Title V

VA Veteran Administration Plan

WC Workers' Compensation Plan

2. DESCRIPTION (35-AN-R)
This field contains the description of the ERA Claim Filing Indicator.

3. STATUS (DISPLAY ONLY)
This field contains the status of the CAS Reason Code defined above. The status may be Active or Inactive. An Inactive status would result if this code has been previously filed as deleted. To file an existing code as deleted, choose **Y** to delete the code when exiting the above screen. You are then prompted to either delete (D) the code from the file or to file the code as deleted (F). Once Inactive (Filed as Deleted), you can choose to reactivate this code. This can be accomplished by choosing the inactive code at the prompt and selecting **A** to activate.

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

5. EDIT DATE (DISPLAY ONLY)
This field contains the date the table was last updated.

ERA Remarks Codes Screen

This table allows users to define a code and description for the Remarks returned in the Electronic Remittance Advice. This table can also be used to select payments to be included or excluded on the ERA Payment Analysis Reports, FAR122 and FAR123. This table is not split by facility.

This table contains the Remarks codes that are maintained by the Centers for Medicare & Medicaid Services (CMS). The descriptions can be quite lengthy, and have been abbreviated to 72 characters in the STAR table.

NOTE: McKesson initially provides the Remarks Codes maintained by CMS. Subsequent updates to this table on STAR are the responsibility of the user.

Some examples of the Remarks codes are as follows:

MA01 If you do not agree w/approved amt for svcs you may appeal within 6 mo

M78 You did not complete or enter accurately appropriate HCPCS modifier(s)

N3 Required/consent form incomplete, incorrect, or not on file

MA130 Claim incomplete and/or invalid/ unprocessable /submit a new claim

After the table is selected, you can enter the code or a hyphen (-) for a table lookup of existing codes. After the code is entered or selected, the following screen is displayed:

```
             General Hospital Financial Table Maintenance Processor
                                                 Sat Sep 08, 2010 06:10 pm
1 Code        2 Description                                        3 Status
   MA95          A "not otherwise classified/unlisted" proc billed     Active
 4 Line 1 for Long Description for ERA Remarks Codes
   A "not otherwise classified/unlisted" proc billed
 5 Line 2 for Long Description for ERA Remarks Codes
   Item 19 HCFA-1500
 6 Edit by                                              7 Edit date
   New, Nancy                                            11/30/10 14:34

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

Field Explanations

1. CODE (5-A-R)
This field contains the 835 ERA Remarks Code.

2. DESCRIPTION (72-AN-R)
This field contains the description of the ERA Remarks code.

3. STATUS (DISPLAY ONLY)
This field displays Inactive when the entry has been filed as deleted.This field is blank for active entries.

4. LINE 1 FOR LONG DESCRIPTION FOR ERA REMARKS CODES
This field is used to enter 50 characters of the description associated with the ERA Remarks code.

5. LINE 2 FOR LONG DESCRIPTION FOR ERA REMARKS CODES
This field is used to enter 50 more characters of the description associated with the ERA Remarks code.

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

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

ERA Payment Analysis Report

This table is used to define selection requirements or formats for the ERA Payment Analysis Report by Account and the ERA Payment Analysis Report by Revenue Code. After the table is selected, you can enter the code or a hyphen (-) for a table lookup of existing codes. After the code is entered or selected, the following screen is displayed:

```
            General Hospital Request ERA Payment Analysis Report Processor
                                                Wed Apr 17, 2007 06:29 pm



1 Code  2 Description                  3 Report by       4 Acct Loc
   ALL     ALL ACCOUNTS                   Account           PA,AR
 5 Sort of Accounts                     6 Sort of Detail
   Patient Name                           Revenue Code, HCPCS, Date
 7 Svc Line Print Selection             8 Service line format
   All service lines                      Expanded
 9 Claim Payment Variance Amount        10 Claim Payment Variance Percentage
          $10.00                          2
11 Svc Line Payment Variance Amount     12 Svc Line Payment Variance Percentage
          $10.00                          2
13 Claim Status                         14 Claim Filing Indicator (CLP06)
   1,2,3,4,5,19,20,21,22
15 CAS Reason Code Print Selection
    ALL
16 Status   17 Edit by                                  18 Edit date
               Adair,Justin                                02/23/07 13:51



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

Field Explanations

1. CODE (3-A-R)
The code for the ERA Payment Analysis Report Definition entry.

2. DESCRIPTION (24-AN-R)
The description of the ERA Payment Analysis Report Definition Entry.

3. REPORT BY (1-A-R)
This field is used to request the ERA Payment Analysis Report by Account or by Revenue Code. The following prompt is displayed:

Produce Payment Analysis Report by (A)ccount or (R)evenue Code? --

There is no default. Account (A) produces only the ERA Payment Analysis Report by Account, FAR122. Revenue Code (R) produces only the ERA Payment Analysis Report by Revenue Code, FAR123.

4. ACCT LOC (TABLE LOOKUP-R)
This field indicates which accounts, according to their account location, should be included on the report. A lookup screen is displayed which lists the account locations of PA, AR and BD. You can select one or all of these values. The field displays all of the values selected from the lookup screen.

5. SORT OF ACCOUNTS (SELECT FROM LIST)
This field defines the order of the accounts on the ERA Payment Analysis Report by Account, FAR122. This field is only accessible if the Report By field is set to Account. The sort options are as follows:

(1) Biller, Patient Name
(2) Biller, Patient Number
(3) Patient Name
(4) Patient Number
(5) Cash Batch Sequence

Only one option can be selected.

6. SORT OF DETAIL (SELECT FROM LIST)
This field determines the order the service line detail prints on the ERA Payment Analysis Report.

- If the Report By field is set to Account, the following options display:

  (1) Revenue Code, HCPCS, Date
  (2) Revenue Code, Date, HCPCS
  (3) Date, Revenue Code, HCPCS
  (4) Date, HCPCS, Revenue Code
  (5) HCPCS, Revenue Code, Date
  (6) HCPCS, Date, Revenue Code
  (7) APC, Date, Revenue Code
  (8) APC, Revenue Code, Date

  Only one option can be selected.

- If the Report By field is set to Revenue Code, the following options display:

  (1) HCPCS, Date
  (2) Date, HCPCS
  (3) APC, Date
  (4) Date, APC

Only one option can be selected.

NOTE: When sorted by HCPCS code, the modifiers are not included as part of the sort.

7. SVC LINE PRINT SELECTION (1-A-R)
This field identifies which service lines are to be printed on the ERA Payment Analysis Report by Account and the ERA Payment Analysis Report by Revenue Code. If the report is by Account, the following prompt is displayed:

Include (A)ll, (N)one, or (O)nly selected service lines [O] --

The default is Only. The options are: include all service lines (A), do not include any service lines (N), and include only selected service lines (O).

If the report is by Revenue Code, the following prompt is displayed:

Include (A)ll or (O)nly selected [O] --

The default is Only. The options are: include all service lines (A) or include only selected service lines (O).

8. SERVICE LINE FORMAT (1-A-R)
This field identifies the format of the service lines that print on the ERA Payment Analysis Report by Account or the ERA Payment Analysis Report by Revenue Code. This field is not accessible when the Service Line Print Selection field is set to None. The following prompt is displayed:

Print service lines in (C)oncise or (E)xpanded format [C] --

The default is Concise.

CLAIM PAYMENT VARIANCE FIELDS

The next two fields define the claim payment variance calculation parameters. If both claim payment fields are completed, an account qualifies if either of the requirements is met. It does not have to meet both requirements. The variance is calculated as the difference between the actual and expected claim payment amounts.

9. CLAIM PAYMENT VARIANCE AMOUNT (8-N-O))
This field identifies the dollar amount for the claim payment variance calculation and is accessible if the Report By field is set to Account. The following prompt is displayed:

Enter the dollar amount for the claim payment variance ---

10. CLAIM PAYMENT VARIANCE PERCENTAGE (3-N-O)
This field identifies the percentage amount for the claim payment variance calculation and is accessible if the Report By field is set to Account. The following prompt is displayed:

Enter the percentage amount for the claim payment variance ---

SERVICE LINE PAYMENT VARIANCE FIELDS

The next two fields define the service line payment variance calculation parameters. If both service line payment fields are completed, then an account qualifies if either of the requirements is met. It does not have to meet both requirements. The Service Line Payment Variance is used in the identification of service line variances on the ERA Payment Analysis Report by Account and on the ERA Payment Analysis Report by Revenue Code. The variance is calculated as the difference between the actual and expected service line payment amounts.

11. SVC LINE PAYMENT VARIANCE AMOUNT (8-N-O)

This field identifies the dollar amount for the service line payment variance calculation. The following prompt is displayed:

Enter the dollar amount for the service line payment variance ---

12. SVC LINE PAYMENT VARIANCE PERCENTAGE (8-N-O)

This field identifies the percentage amount for the service line payment variance calculation. The following prompt is displayed:

Enter the percentage amount for the service line payment variance ---

13. CLAIM STATUS (TABLE LOOKUP-O)

This field is used to select accounts based on the ERA Claim Status returned in the Electronic Remittance Advice in CLP04. You can select one or more status codes from the ERA Claim Status Code Table.

14. CLAIM FILING INDICATOR (TABLE LOOKUP-O)

This field is used to select accounts based on the ERA Claim Filing Indicator returned in the Electronic Remittance Advice in CLP06. You can select one or more codes from the table.

15. CAS REASON CODE PRINT SELECTION (1-A-O)

This field is used to indicate whether all CAS codes are displayed on the FAR122 and FAR123 reports. This field is accessible only if the Service Line Format field is set for the expanded format. When this field is accessed, the following prompt is displayed:

Print all CAS Reason codes? (Y/N)

If you enter **Y** (Yes), the system prints all CAS Reason codes (for each CLP record) on the FAR122 and FAR123 reports. If you enter **N** (No), the additional information for CAS Reason codes is not displayed on the reports.

If there is a defined CAS Code table for the ERA Payment File Definition table that is used for uploading the file, the CAS codes from the ERA Payment File Definition table are used for reporting. These reports reflect the CAS Reason code setup at the time of analysis, as when the ERA file was processed.

16. STATUS (DISPLAY ONLY)
This field displays Inactive when the entry has been filed as deleted. This field is blank for active entries.

After the screen is accepted, the following prompt is displayed:

Do you want to add service line limits? (Y/N) --

If you answer No, the system exits to the table lookup for this table. If You answer Yes, the following screen is displayed which allows you to add or update the service line limits:

```
         General Hospital Request Financial Table Maintenance Processor
                                                    Fri Apr 26, 2002 03:12 pm
ERA Payment Analysis Report
                         Service Line Limits
 1 Revenue Codes           2 Selections
   Include                   320,360
 3 CAS Adj Reason Codes    4 Selections
   Include                   123,19,36,45,46,55,97,A2,A20,B13
 5 Adj Group Codes         6 Selections
   Exclude                   PI,PR
 7 Remarks Codes           8 Selections
   Include
 9 APC Codes              10 Selections
   Include                   00800-00899
11 HCPCS Codes            12 Selections
   Exclude                   96000-99999
13 Mismatched Svc Lines
   Charge Amount

Press NL--
```

1. REVENUE CODE (1-A-O)
This field is used to include or exclude service lines from the report based on the revenue code. The following prompt is displayed:

Do you want to (I)nclude or (E)xclude service lines by Rev Code? --

Valid responses are Include (I) and Exclude (E). There is no default. If this field is left blank, the code is not used as a selection limit.

2. SELECTIONS (TABLE LOOK-UP - C)
If the Revenue Code field is I (Include) or E (Exclude)**,** a list of revenue codes and descriptions is displayed. You can select one or more revenue codes. The UB Revenue Codes are displayed unless the Type of Claim Form on the Payment File Definition Table associated with the ERA Cash Batch is Medi-Cal UB. In that case, the Medi-Cal UB Revenue Codes are displayed.

3. CAS ADJ REASON CODES (1-A-O)
This field is used to include or exclude service lines from the report based on the ERA CAS adjustment reason code. The following prompt is displayed:

Do you want to (I)nclude or (E)xclude service lines by CAS Reason Code? --

Valid responses are Include (I) and Exclude (E). There is no default. If left blank, this code is not used as a selection limit.

4. SELECTIONS (TABLE LOOKUP - C)
If the CAS Adj Reason Code field is Include (I) or Exclude (E), the list of ERA CAS Reason codes and descriptions is displayed. You can select one or more CAS Reason codes.

NOTE: The ERA CAS Reason Code table contains only those codes defined for adjustment posting.

5. CLAIM ADJ GROUPS (1-A-O)
This field is used to include or exclude service lines from the report based on the adjustment group code. The following prompt is displayed:

Do you want to (I)nclude or (E)xclude service lines by Adj Group Code? --

Valid responses are I and E. There is no default. If the field is left blank, this code is not used as a selection limit.

6. SELECTIONS (TABLE LOOKUP - C)
If Adj Group Code field is I or E, the list of Adjustment Group codes and descriptions is displayed. You can select one or more Adjustment Group codes from the table.

7. REMARKS CODES (1-A-O)
This field is used to include or exclude service lines from the report based on the remarks code. The following prompt is displayed:

Do you want to (I)nclude or (E)xclude service lines by Remarks Code? --

Valid responses are Include (I) and Exclude (E). There is no default. If left blank, this code is not used as a selection limit.

8. SELECTIONS (TABLE LOOKUP - C)
If the Remarks Codes field is Include (I) or Exclude (E), the list of Remarks codes and descriptions from the ERA Remarks Codes table is displayed. You can select one or more Remarks codes from the table, use Table Lookup to locate a code, or enter a minus (-) to remove a code. You can also key in codes as well as ranges of codes, separated by commas.

9. APC CODES (1-A-O)
This field is used to include or exclude service lines from the report based on the APC code. The following prompt is displayed:

Do you want to (I)nclude or (E)xclude service lines by APC Code? --

Valid responses are Include (I) and Exclude (E). There is no default. If left blank, this code is not used as a selection limit.

10. SELECTIONS (TABLE LOOKUP - C)
If the APC Codes field is Include (I) or Exclude (E), the list of APC codes is displayed. You can select one or more APC codes from the table, use Table Lookup to locate a code, or enter a minus (-) to remove a code. You can also key in codes, and ranges of codes, separated by commas.

11. HCPCS CODES (1-A-O)
This field is used to include or exclude service lines from the report based on the HCPCS code. The following prompt is displayed:

Do you want to (I)nclude or (E)xclude service lines by HCPCS Code? --

Valid responses are Include (I) and Exclude (E). There is no default. If left blank, this code is not used as a selection limit.

12. SELECTIONS (TABLE LOOKUP - C)
If the HCPCS Codes field is Include (I) or Exclude (E), the list of HCPCS codes is displayed. You can select one or more HCPCS codes from the table, use the alpha lookup to locate a code, or use the minus(-) to remove a code. You can also key in codes, and ranges of codes, separated by commas.

13. MISMATCHED SVC LINES (TABLE LOOKUP - O)
This field is used to limit service lines on the report to line items where the value received in the payment does not match the value on the charge line on the STAR claim. The following options display:

1 Charge Amount (Amount)
2 Units of Service (UOS)
3 Service Date (Service Date)
4 HCPCS (HCPCS)
5 HCPCS Modifiers (HCPCS Mod)
6 Revenue Code (Rev Code)
7 APC (APC)
8 No Claim Service Line (No Claim Srv)
9 No Payment Service Line (No Pmt Srv)1
10 Payment is zero

If multiple entries are selected, the service line qualifies for inclusion if it meets only one of the selected mismatches. The service line may, but does not have to, meet all mismatches selected.

ERA Claim Adjustment Groups

This table allows you to maintain the Claim Adjustment Groups received in the 835 electronic payment file. McKesson initially provides the Claim Adjustment Groups defined in the 835 Claim Payment Advice v.4010 Implementation Guide. Subsequent updates to this table are the responsibility of the user. This table also allows you to define adjustment posting instructions based on the Claim Adjustment Group Code received in the 835 Electronic Remittance Advice and to select payments with the selected Claim Adjustment Group to be included or excluded on the ERA Payment Analysis Reports, FAR122 and FAR123. Types of adjustments include:

- Contractual Obligation
- Corrections and Reversals
- Other Adjustments
- Payor Initiated Reductions
- Patient Responsibility

This table is not split by facility.

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

Enter electronic RA claim adjustment group code ---

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

```
            General Hospital Financial Table Maintenance Processor
                                                  Wed May 1, 2002 06:10 pm
ERA Claim Adjustment Groups
 1 Code            2 Description                      3 Status
   CO                Contractual Obligation             Active
 4 Edit by                                            5 Edit date
   Henderson,Lucy                                       08/20/01 15:09



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

Field Explanations

1. CODE (2-A-R)
This field contains the two-character code of the 835 Electronic RA Claim Adjustment Group Code.

2. DESCRIPTION (30-AN-R)
This field contains the description of the CAS reason group code.

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

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

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

ERA Segment Matching Rules

This optional table is used to identify the ERA segment, designator, and qualifier to define rules for exceptions to payment and adjustment transaction codes based upon REF segments. The ERA Segment Matching Rules are used in the ERA Payment File Definition table for defining exceptions for the payment and adjustment transaction codes.

The following example illustrates how a facility would define a rule in order to assign transaction codes per the information in the REF*1L*OOA and REF*CE*11 (or REF*CE*15) segments. One rule would be created with two criteria. For the first criteria listed below using 1L, an REF segment matches the criteria if REF01 equals 1L and REF02 begins with an OO. For the second criteria listed below using CE, an REF segment matches the criteria if REF01 equals CE and REF02 begins with 11 or 15.

Both statements are saved as one ERA Segment Matching Rule and each of the criteria must be true for an ERA payment to qualify. The ERA Segment Matching Rules can be used in the ERA PFD table for defining exceptions for the payment and adjustment transaction codes.

After this table is selected, you can enter a code or a hyphen (-) to display a list of valid codes. After the code is entered, the following screen is displayed:

```
ERA Segment Matching Rules

Page:01                    ERA Segment Matching Rules
( 1) R1-RULE 1
( 2) R2-RULE 2
( 3) BC1-BLUE CROSS RULE 1



Enter choice --
```

After a rule is added or selected, the following screen is displayed:

```
        General Hospital Financial Table Maintenance Processor
                                                Fri Jan 04, 2008 04:15 pm
ERA Segment Matching Rules
 1 Code           2 Name for Rule                      3 Status
   R1               BCBS Inpatient In Network            Active
 4 Short Name     5 Edit by                            6 Edit date
   BCBS             Smith,Joe                            12/17/07 06:50am
 7 Selection Rules

        Field                                 Qualifier     Qualifier
Crit    Desig  Operator  Field Value          Position      Value
   1    REF02  NB        OO                   REF01         1L
   2    REF02  BEL       11,15                REF01         CE
```

Field Explanations

1. CODE
This field contains the code for the ERA segment mathching rule.

2. NAME FOR RULE
This field contains the user-defined name for the rule.

3. STATUS
This field contains the status of the rule, Active or Inactive.

4. SHORT NAME
This field contains a short name for the rule.

5. EDIT BY
This field contains the name of the user who last updated the table.

6. EDIT DATE
This field contains the date this table was last updated.

7. SELECTION RULES
The fields below are used to establish selection rules.

CRITERIA #
This field contains the user-defined sequences.

FIELD DESIGNATOR
This field must contain a segment and the numeric sequential position within the segment. An example of this is REF02 (with REF being the segment and 02 being the sequential position within the segment). You can enter the segment indicator REF,

followed by a number from 1 to 99, which defines the sequential position within the segment.

OPERATOR
You can enter a valid operator or a hyphen (-) to choose one from the list. Values are:

E Equal

NE Not Equal

BE Beginning Characters Equal

NBE Beginning Characters Not Equal

EL Equal Selection from List

NEL Not Equal Selection from List

BEL Beginning Characters Equal from List

NBEL Beginning Characters Not Equal from List

FIELD VALUE (40-AN)
This field contains data returned by the payor to indicate something unique about the payment via a specific code. For example, *OO* indicates the claim was paid out of network. The logic looks for the existence of the code/data entered, in conjunction with the Operator and Field Designator.

QUALIFIER POSITION (2-N)
This field contain the location or data piece in the REF segment where the logic looks to for the Qualifier Value.

QUALIFIER VALUE (5-AN)
This field contains the unique code returned by the payor. The presence of this code is required for a match to the overall rule. An example of this is: CE1L

ELECTRONIC RA INTERFACES MENUS

When you select Interface Functions from the Financial System Management base menu, the system displays the following menu:

```
              General Hospital Interface Functions Processor
                                                  Mon Apr 12, 1999 11:34 am
Interface Functions Input Options

            Option No.  Option
            ---------------------------------------
                1       TRENDSTAR Interfaces
                2       REPLICA Interface

  TAPE PROCESS  3       Charge Summary
                4       Revenue Service Statistics

  MAINTAIN      5       Electronic RA Interfaces
                6       Pathways Contr Mgmt Interface

                7       Computer Credit Inc. Interface
                8       EC 2000 CA Interface

  IMPORT BALS   9       Import Titan GL Control Totals


Enter option number--
```

NOTE: The menu above is from the base STAR Financials Patient Accounting system. Menus may differ at your facility.

When you select Electronic RA Interfaces, the system displays the following menu:

```
              General Hospital Electronic RA Interfaces Processor
                                                  Mon Apr 12, 2007 11:39 am
Electronic RA Interfaces Input Options

            Option No.  Option
            ---------------------------------------
                1       Upload Electronic RA files from PC
                2       Process Electronic RA
                3       Print Electronic RA Audit Rpt
                4       Purge Electronic RA files from PC
                5       Delete Electronic RA files from STAR
                6       Print Electronic RA Audit Rpt/Takeback Accounts
                7       Request ERA Payment Analysis Report









Enter option number--
```

USER PROCESSING

Uploading the Data File From the PC

To upload one or more data file(s) from the PC to the STAR Financials Patient Accounting CPU, select the Upload Electronic RA files from PC function. After you access this function, the system displays the following prompt:

Enter the payment file definition code or '-' for list--

You can enter the payment file definition code or a hyphen (-) to display a list of valid codes. Refer to the appropriate set of instructions below for a description of uploading a Vendor, Part A 835, or Part B 835 file from the PC.

Vendor File

When you access the Upload Electronic RA files from PC option, the following message may appear, indicating that the previous run of Upload Electronic RA files from PC did not complete, and the system is automatically deleting the invalid index files.

Deleting ERA index files for incomplete uploads!

The system deletes the invalid index files so that the next upload does not have a problem resulting from these invalid indices. If you had any ERA batch files created from the previous upload that didn't complete correctly, the system won't delete these automatically. You'll need to go to the Delete Electronic RA Files from STAR function and delete the files.

After the system deletes the invalid index files, if the file format in the payment file definition is a vendor payment file, the system displays the following prompt:

Enter the drive [C]--

This prompt identifies the drive containing the data file(s) to be uploaded. To accept the default of drive C, press ENTER. If the data file(s) is on a different drive from C, enter the letter designating the drive. The system then displays the following prompt:

Enter the directory [\PAYIN]--

This prompt identifies the directory containing the data file(s) to be uploaded. To accept the default of \PAYIN, press ENTER. If the data file(s) is in a different directory from \PAYIN, enter the full path of the directory. The system then displays the following prompt:

Enter the file name to upload --

To upload a specific data file, enter the name of the data file. You may also use the wildcard characters of question mark (?) and an asterisk (*) to upload multiple files at one time. For example, entering *.DAT uploads all files with the suffix of DAT. The system only uploads data files starting with an underscore (_).

When you complete your entry to this prompt, the system begins uploading the file(s) to the STAR Financials Patient Accounting CPU. A window is displayed that monitors the progress of the upload process until the upload process is complete.

Part A 835 File

When you access the Upload Electronic RA files from PC option, the following message may appear, indicating that the previous run of Upload Electronic RA files from PC did not complete, and the system is automatically deleting the invalid index files.

Deleting ERA index files for incomplete uploads!

The system deletes the invalid index files so that the next upload does not have a problem resulting from these invalid indices. If you had any ERA batch files created from the previous upload that didn't complete correctly, the system won't automatically delete these. You'll need to go to the Delete Electronic RA Files from STAR function and delete the files.

After the system deletes the invalid index files, if the file format in the payment file definition code is Part A 835 format, the system displays the following prompt:

Enter the payment file definition code or '-' for list --

You can enter or select the ERA Payment File Definition table code to use for uploading the file. This table defines parameters that determine how the system reads the file, defaults for the payments and adjustments, as well as defaults for reports. If a default drive is defined in the ERA Default File Names table, the following prompt is displayed:

Select ERA Default File Name or press Enter for prompts for file name-

If no defaults are defined in the ERA Default File Names table, the above prompt is not displayed, and the following prompt is displayed:

Enter the drive [C]-

This prompt identifies the input directory for the data file(s). To accept the default of 835IN, press ENTER. If the data file(s) is in a different directory other than 835IN, enter the name designating the input directory. The system then displays the following prompt:

Enter the file name to upload --

To upload a specific data file, enter the name of the data file. You may also use the DOS wildcard characters of question mark (?) and an asterisk (*) to upload multiple files at one time. For example, entering *.835 uploads all files with the suffix of 835. The system does not upload a file with a suffix of UPL.

If no files are found in the designated path, the following error message is displayed:

File does not exist

The STAR ERA software accepts ERA files in the 4010 format and also uploads and processes ERA files in the in the 5010 format. If your ERA PFD table is set to pull the total from the TS3 segment and this no longer exists in the file, the following prompt is displayed:

TS309 (Provider Payment Total) is blank for 5010. Press ENTER.

If your payor sends the provider payment total information in the TS3 segment and your ERA PFD table is set to pull the total from this segment, you will need to verify if the payor will continue to send the total in this segment. If not, you will need to see if the payment total is sent in the BPR02 segment and if so make the change in the ERA PFD table (this is on the 3rd page in the table).

If no total is sent and TS309 is selected in the ERA PFD table, the total information will be blank on the FXRERABB report as well as in the Display of ERA batch information in Post Cash. Again, your payor may continue to send the total information in this segment and all 5010 files will need to be reviewed to determine if this is still being sent.

The system returns to the main menu.

If Part A 835 files are found, the system begins uploading the files to the STAR Financial Patient Accounting CPU. A window is displayed that monitors the progress of the upload process until the upload process is complete. After the upload process is complete, the system displays the following messages:

** * Please wait * * Files are being transferred*

Update is complete for XX! XX is the name of the file being processed

Update is Complete!

If bill type exceptions are defined for the 835 Part A file, the source file is split into smaller files by provider, fiscal period, and bill type (as defined in the payment file definition.) These smaller files are then available to be processed into an Insurance Cash Batch using the Process Electronic RA function.

For a Part A 835 File, an ERA batch is maintained when the first four characters of LX01 are different or when the provider changes. A separate batch is maintained if a

bill type exception exists in the ERA Payment File Definition for characters five and six in LX01. The appearance of an LX record in the ERA file triggers the system to determine whether a new ERA batch should be created or whether transactions should be added to an existing ERA batch.

Part B 835 File

When you access the Upload Electronic RA files from PC option, the following message may appear, indicating that the previous run of Upload Electronic RA files from PC did not complete, and the system automatically is deleting the invalid index files.

Deleting ERA index files for incomplete uploads!

The system deletes the invalid index files so that the next upload does not have a problem resulting from these invalid indices. If you had any ERA batch files created from the previous upload that didn't complete correctly, the system won't automatically delete these. You'll need to go to the Delete Electronic RA Files from STAR function and delete the files.

After the system deletes the invalid index files, if the file format in the payment file definition code is Part B 835, the system displays the following prompt:

Enter the drive [C] –

This prompt identifies the drive containing the data file(s) to be uploaded. To accept the default of drive C, press ENTER. If the data file(s) is on a different drive from C, enter the letter designating the drive. The system then displays the following prompt:

Enter the input directory [\835BIN] –

This prompt identifies the input directory for the data file(s). To accept the default of 835BIN, press ENTER. If the data file(s) is in a different directory other than 835BIN, enter the name designating the input directory. The system then displays the following prompt:

Enter the file name to upload –

To upload a specific data file, enter the name of the data file. You may also use the wildcard characters of questions mark (?) and an asterisk (*) to upload multiple files at one time. For example, entering *.835 uploads all files with the file extension of.835. The system does not upload a file with an extension of.UPL.

If no files are found in the designated path, the following error message is displayed:

File does not exist

The system returns to the main menu.

If Part B 835 files are found, the system begins uploading the files to the STAR Financials Patient Accounting CPU. A window is displayed that monitors the progress of the upload process until the upload process is complete. After the upload process is complete, the system displays the following message:

***Please wait ** Files are being transferred*

The source file is now available to be processed into an Insurance Cash Batch using the Process Electronic RA function.

For a Part B 835 File, an ERA batch is maintained when the first four characters of LX01 are different or when the provider changes. A separate batch is maintained if a bill type exception exists in the ERA Payment File Definition for characters five and six in LX01. The appearance of an LX record in the ERA file triggers the system to determine whether a new ERA batch should be created or whether transactions should be added to an existing ERA batch.

Requesting the Electronic Remittance Audit Report

You can review the contents of the data file on the STAR Financials Patient Accounting CPU by requesting the Electronic RA Audit report (FXRERAR). This report allows you to verify the data, reporting any variance between the data uploaded and the expected number of records and amount of payments as reported in the payment file. You can request this report after the file has been uploaded onto the STAR Financials Patient Accounting CPU and before approving the associated cash batch.

When you select the Print Electronic RA Audit Rpt function the system prompts you to enter a facility. After you identify the facility, the system displays a list of uploaded files, as on the following screen:

```
   General Hospital Print Electronic RA Audit Rpt/Takeback Accounts Processor
                                                 Thu May 3, 2002 07:59 am


Page:01                          Uploaded Files
    Ins Seq  Trns Dt Upld Dt  Status     Batch  Src   Batch Description
( 1) C   39  Jun 08  Aug 07   Balanced    912   835 A A/MEDICARE/0000/HOS0023H
( 2) C   9   Jun 08  Aug 07   Uploaded    913   835 A A/MEDICARE/Unmatched Pymt
( 3) C   12  Apr 24  Aug 20   Uploaded    119   CMB   A/CIGNA/2034958
( 4) C   13  Apr 24  Aug 20   Uploaded    120   CMB   A/CIGNA/B0345838
( 5) C   17  Apr 24  Aug 20   Uploaded    123   CMB   A/CIGNA/28203458


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

For each uploaded file the system displays the following information:

INS
This column displays the insurance type code.

SEQ
This column displays the sequence number of the uploaded file.

TRNS DT
This column displays the transmission date of the uploaded file.

UPLD DT
This column displays the date the file was uploaded on the STAR CPU.

STATUS
This column displays the status of the batch, if it has been created. The status of the batches include uploaded, unbalanced, or balanced. Files that have been uploaded and not processed have a status of *uploaded*.

BATCH
This column displays the insurance cash batch number. This field is blank for files with a status of uploaded.

SRC
This field contains the source of the payment file. This is defined in the payment file definition parameter. This field displays 835 A, 835 B, or VEN for Vendor file format.

BATCH DESCRIPTION
This field contains the description associated with the cash batch.

To print one of the files, enter the option number of the file. The system creates a report using data directly from the uploaded file, enabling you to use this report to validate the information received.

Requesting Electronic Remittance Audit Report/Takeback Accounts Only

The Electronic Remittance Audit Report can be limited to report only those accounts in the ERA transaction file with one or more of the following conditions:

- A takeback
- A combined takeback/payment
- A payment transaction with a takeback or combined takeback/payment in the file

You can concentrate on takebacks by reviewing this subset of the contents of the ERA transaction file on the STAR Financials Patient Accounting CPU using the Electronic RA Audit Report/Takeback Accounts Only (FXRERAR). The report provides the opportunity to confirm that the contractual adjustment resulting from the takeback and any payment in the file is correct.

You can request this report after the file has been uploaded onto the STAR Financials Patient Accounting CPU and before approving the associated cash batch.

When you select the Print Electronic RA Audit Rpt/Takeback Accounts function, the system prompts you to enter a facility. After you identify the facility, the system displays a list of uploaded files, as on the following screen:

```
                General Hospital Print Electronic RA
                                                    Mon Jun 23, 2007 07:59 am

Page:01                          Uploaded Files
    Ins Seq  Trns Dt Upld Dt  Status      Src   Batch Description
( 1) C   1   Aug 30  Jul 25   Uploaded    835 A PAT'S ANSI 09/00
( 2) C   1   Aug 30  Aug 21   Uploaded    835 A PAT'S ANSI 09/00
( 3) C   2   Aug 30  Aug 21   Uploaded    835 A PAT'S ANSI 09/00
( 4) C   1   Aug 30  Oct 30   Processed   835 A PAT'S ANSI 09/00
( 5) C   1   Nov 03  Nov 03   Processed   835 A PAT'S ANSI 06/00
( 6) M   1   Jan 30  Feb 21   Uploaded    835 A MEDICARE


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

For each uploaded file the system displays the following information:

INS
This column displays the insurance type code of the uploaded file.

SEQ
This column displays the sequence number of the uploaded file.

TRNS DT
This column displays the transmission date of the uploaded file.

UPLD DT
This column displays the date the file was uploaded on the STAR CPU.

STATUS
This column displays the status of the batch, if it has been created. The status of the batches include uploaded, unbalanced, or balanced. Files that have been uploaded and not processed have a status of uploaded.

SRC
This field contains the source of the payment file. This is defined in the payment file definition parameter. This field displays 835 A, 835 B, or VEN for Vendor file format.

BATCH DESCRIPTION
This field contains the description associated with the cash batch. To print one of the files, enter the option number of the file. The system creates a report using data directly

from the uploaded file, enabling you to use this report to validate the information received.

Only those accounts with takebacks, combined takeback/payments, and payment transactions with a takeback or combined takeback/payment in the ERA transaction file print when using the menu option Print Electronic RA Audit Rpt/Takeback Accounts.

Creation of the Cash Batches

The Process Electronic RA function is used to create the cash batches from the uploaded payment file.

Mapping Files to a Facility (For Vendor Format Files Only)

After you access this function, the system checks to see if there are batches with no facility indicator (Vendor files only). If unmapped files exist, the following prompt is displayed:

There are batches with no facility indicator, map these now (Y/N) [Y]--

Enter **N** for No if you do not want to map the files to a facility at this time. The system prompts you for a facility and then displays a list of uploaded files (to see example of the screen refer to Creating the Insurance Cash Batch). Entering **N** allows you to access the files that have been mapped to a facility. You can re-enter the Process Electronic RA function at a later time to map the unmapped files to a facility.

Enter **Y** for Yes to map the unmapped files to a facility. The default is Y. The system displays a list of unmapped files.

NOTE: When the file source is an 835 format and the provider numbers have not been defined in the ERA Facility/Provider Mapping table, all payments flow to the Unmatched Payment Worklist. If this happens, the 835 file must be reviewed to determine all provider numbers in the file, the provider numbers must be mapped accordingly in the table, and the file must be re-split.

Select one file at a time from the list displayed on the screen:

```
            General Hospital Process Electronic RA Processor
                                                  Mon Apr 19, 2007 09:47 am

    Ins Seq  Trns Dt Upld Dt  Status      Src   Batch Description
( 1) C   1   Aug 30  Jul 25   Uploaded    835 A MEDICAID 09/07
( 2) C   1   Aug 30  Aug 21   Uploaded    835 A BLUE CROSS 09/07
( 3) C   2   Aug 30  Aug 21   Uploaded    835 A MEDICARE 08/07


Enter choice--
```

For each unmapped file, the system displays the following information:

INS
This column displays the insurance type code.

SEQ
This column displays the sequence number of the uploaded file.

TRNS DT
This column displays the transmission date of the uploaded file.

UPLD DT
This column displays the date the file was uploaded on the STAR CPU.

STATUS
This column displays the status of the batch. *Uploaded* is always displayed for an unmapped file.

SRC
This field contains the source of the payment file. This is defined in the payment file definition parameter. This field displays 835 A, 835 B, or VEN for the Vendor file format.

BATCH DESCRIPTION
This field contains the description associated with the cash batch. The batch description contains the facility code, description from the ERA Payment File Definition, the first split criteria, the second split criteria, etc. The display shows up to 30 characters. For example: facility code = A, Medicare from the PFD, the check number = 12345 (check number is selected as a batch split criteria) so the description would look as follows:

A/Medicare/12345

When both vendor and ANSI files have been uploaded into the system, the system displays the following prompt which asks you to select which file type to process:

Vendor and ANSI files exist. Do you want to process (V)endor or (A)NSI 835 files?--

The following prompt is for vendor files only. If you enter **V** (Vendor), the following prompt is displayed:

Map to which facility or '-' to list--

Enter the facility or use the hyphen (-) key to display a table of facilities. Once you choose an unmapped file, it no longer is displayed on the screen. You can press ENTER to go from this screen to the list of facilities.

Select the file for which you want to create an insurance batch. You can select files with a status of *Uploaded*, indicating that the insurance cash batch has not been created, *Unbalanced*, or *Balanced*.

If a batch has been created but has not yet been approved, you can re-create the batch. You cannot re-create a batch if it has been approved. If you select a file that has already been processed, the system deletes the existing insurance cash batch, replacing it with information from the uploaded file. Batches that have been approved and posted cannot be selected for re-creation; the system does not display these batches on the screen.

If you select a file with a status of uploaded, the system prompts you to enter a batch number. You can enter this number or allow the system to assign the batch number. The system checks your entry against currently assigned cash batch numbers to make sure that a duplicate number is not assigned.

The following information follows an ANSI 835 file. If you entered **A** (ANSI) after selecting an ERA file, the system displays the following prompt:

Process (Y/N) or (D)elete the file--

If you enter **Y**(Yes) to process the file, the following prompt is displayed:

Select facilities for matching with this ERA file -

The screen displays all facilities defined on the system. You can select or de-select facilities to consider for matching claims to payments. An unmatched payment batch is created for each facility selected when unmatched payments exist. For example: if facilities A and B are selected, an unmatched payment batch is created for both A and B if any unmatched payments exist.

If the file was not processed previously, the file is processed and split into appropriate cash batches. If the file was processed previously and a change has been made to the ERA Payment File Definition table (for example to the split criteria), select the file from the list and the file is re-split into new the batches if no batches have been posted. The following prompt is displayed:

Would you like to re-run the split criteria for this uploaded file? (Y/N)

You can enter Yes to have the system re-split the uploaded file into new batches. If you answer No, the following screen is displayed:

```
                        Unmatched Payments Exist
                      Unmatched PLB Records Do Not Exist
                      File Uploaded (Part A) on 08/13/07
Batch Number-Facility/PFD Desc/Split Criteria
Page:01                         Split Criteria Prv#
( 1) 459-B/Part A/Unmatched Pymt
( 2) 869-A/Part A/Unmatched Pymt
( 3) 870-A/Part A/B123
( 4) 871-A/Part A/123
```

In the above screen example, the Medicare file split into two batches, based upon facilities and provider numbers. The other two batches were opened by the system, and this also alerts the user that there are unmatched payments on the worklist for review. These Unmatched Pymt batches do not have to be used, but it is important that all payments received via the ERA file are posted to an ERA cash batch. The unmatched payment batches are created in the chance that the facility may want to post the payments that matched and then work the items on the worklist. If the facility elects to work all items off the worklist and not use the unmatched payment batches, these batches can be deleted from the system.

The split criteria (as selected in the ERA PFD) is displayed in the header of this screen so the user can easily interpret why the batches split into what is shown. So, if too many batches were created, you can note the split criteria, go back into the ERA PFD table, apply changes to the split criteria, then re-process the file into new cash batches.

NOTE: McKesson recommends that only a few criteria are selected for splitting batches. The more options that are selected, the more batches that are created, and the more difficult it can be to trace back and balance the batches back to the ERA file.

After the file uploads, if you want to redefine the split criteria, the ERA Payment File Definition table should be updated before processing the file again. This should be done only if no batches have been approved/posted. If any batch has been approved/posted, the process may not be re-run for new split criteria. It is suggested that the splits are defined, and a file is uploaded and reviewed before any batches are approved/posted.

If you want to change a selection or option (for example, assign a different transaction code or Payment Date) for the cash batch, the file must be re-selected. Once the file has been re-selected, the following prompt is displayed:

Would you like to re-run the split criteria for this uploaded file? (Y/N)-

If you enter **Yes**, the previous cash batches are deleted and new cash batches are created. If you enter **No**, the next step is to select the cash batch. The following prompt is displayed:

Insurance cash batch already exists. Apply updates? (Y/N)-

If you enter **Yes**, the following screen is displayed:

```
              General Hospital Process Electronic RA Processor
                                                 Thu Jul 26, 2011 02:05 pm

                        Unmatched Payments Do Not Exist
                      Unmatched PLB Records Do Not Exist
                       File Uploaded (PM ANSI) on 09/13/11 5010: Yes

Batch Number-Facility/PFD Desc/Split Criteria
 1 Batch #                  2 Batch Description              3 # of Trans
   744                        A/MEDICARE/0000/HOS0023H          1
 4 Posting Date   5 Payment Date   6 Batch Total - Cash  7 Batch Total - C/A
   07/26/07         07/23/07          $193.18              $0.00
                          Electronic RA Defaults
 8 Payment Date   9 Analysis Rpt Def               10 Remittance #
   06/08/07         12 - MEDICARE REVENUE
11 Payment Trans Code/Desc              12 Contr Adj Trans Code/Desc
   I0001-M'CARE PART A I/P PAYMENT         A0001-I/P MEDICARE PART A ALLOWANCE
13 Other Adj Trans Code
   A0001-I/P MEDICARE PART A ALLOWANCE




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

NOTE: Fields on this screen are automatically filled in based on the values entered in the Payment File Definition table. These fields are blank if the payment file definition is blank.

The 5010 indicator displays Yes if the uploaded file is in the 5010 or No if the uploaded file is not a 5010 format.

Field Explanations

1. BATCH # (DISPLAY ONLY)
This field displays the previously assigned batch number.

2. BATCH DESCRIPTION (30-AN-R)
This field describes the batch. For 835 A files, the description is automatically created by concatenating the Payment File Definition Table Short Description field with the fiscal period (MM/YY) and the Bill Type Description. If the batches are not separated by bill type, the description contains the Payment File Short Description concatenated with the fiscal period.

For 835 B files, the description is automatically created to use the Short Description defined in the Payment File Definition Table.

This field can be edited.

3. # OF TRANSACTIONS (DISPLAY ONLY)
This field initially displays the total number of detail payment records that were sent. Once the insurance batch is created, this field displays the total number of payments that were accepted into the batch (excluding rejections.) This field cannot be edited.

4. POSTING DATE (DISPLAY ONLY)
This field displays the current date.

5. PAYMENT DATE (DISPLAY ONLY)
This field displays the payment date from the uploaded file.

6. BATCH TOTAL - CASH (DISPLAY ONLY)
This field displays the total payments received in the payment file.

7. BATCH TOTAL - C/A (DISPLAY ONLY)
This field displays the calculated Contractual Adjustments that are in the batch. It is displayed only if the Electronic RA Default field Contr Adj Method is set to Yes on the Payment File Definition Table.

8. PAYMENT DATE (6-N-R)
This field displays the date used for posting the payment. The system displays your entry to the first Payment Date field as a default; you can change this date if desired.

9. ANALYSIS RPT DEF (TABLE LOOKUP-O)
This field defines the Payment Analysis Report Definition(s) used to generate the Payment Analysis Report(s) for the resulting cash batch. The following prompt is displayed:

Enter ERA Payment Analysis Report code(s) or `-` for list -- |

You can pick one or more codes from a list of codes established in the ERA Payment Analysis Report Definition table. If this field is left blank, the report is not produced. The ERA Payment Analysis Report is produced automatically when the insurance cash batch is posted. The report may also be requested on demand after the cash batch is approved.

10. REMITTANCE # (25-AN-O)
This field contains the remittance number.

11. PAYMENT TRANS CODE/DESC (4-N-O)
This field contains the insurance payment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the insurance payment transaction codes. When complete, this code is used as the insurance payment transaction code for the insurance cash batch. If this field is left blank, the

payment transaction code from the patient's insurance plan is used on the payment entry in the insurance cash batch. This field can be edited.

12. CONTR ADJ TRANS CODE/DESC (4-N-O)
This field contains the contractual adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment transaction code for the contractual adjustment that is posted at the time of insurance payment. If this field is left blank, the contractual adjustment code from the patient's insurance plan is used for the contractual adjustment. If the contractual adjustment transaction code is missing in the patient's insurance plan, the insurance payment is rejected if the contractual posting method is set to Yes, Variance, or Report. This field can be edited.

13. OTHER ADJ TRANSACTION CODE (4-N-O)
This field contains the other adjustment transaction code and the description for the code. You can enter the code or a hyphen (-) for a table lookup of the contractual adjustment transaction code. When complete, this code is used as the adjustment transaction code for any other adjustment(s) that is posted at the time of insurance payment. If no entry is made in this field, the contractual adjustment transaction code from the Payment File Definition is used for the other adjustment. If the Contractual Adj Trans Code is not defined on the Payment File Definition screen, then the contractual adjustment transaction code from the patient's insurance plan is used. If the contractual adjustment transaction code is missing in the patient's insurance plan, the insurance payment is rejected if the contractual posting method is set to Yes, Variance, or Report. *Other* adjustments are established in the Electronic RA CAS Reason Code table.

Once all updates have been made to this screen, press ENTER to accept the screen changes. After the system creates the insurance cash batch, you are notified as to whether the batch is in balance or not. The Exit Cash Batch Processor screen is displayed with the following prompt, for an ANSI file:

Batch is balanced - (A)pprove, (H)old, (P)rint Batch, Print F(X)RERABB, (D)isplay ERA batch information, or press [NL] to exit -

The system displays one of the following prompts for a Vendor file, depending on whether the batch is balanced or unbalanced:

Batch is balanced - (A)pprove, (H)old, (P)rint Batch, or press [NL] to exit --

Batch is out of balance - (A)ccept or (P)rint Batch --

If the batch is in balance, you can approve it, put it on hold, or print the Cash Posting Audit report (FAR121). ANSI batches have two additional options to print the FXRERABB balancing report or to view the display of the batch balancing information.

If the batch is out of balance, you can accept it or print the Cash Posting Audit report (FAR121). For more information, see “Batch Status” on page 1-115.

NOTE: The Electronic Cash Posting Audit Report, FAR121, is automatically generated each time the payment file is processed in the Process Electronic RA function. The Electronic Cash Posting Audit Report provides additional electronic payment information that is not available on the Cash Batch Audit Report, FAR120.

Creating Miscellaneous Cash Batches for Provider Level Adjustments

When the intermediary/carrier sends provider level adjustments (in the PLB segment) in the 835 A and 835 B payment files, the STAR Patient Accounting system creates a separate miscellaneous cash batch to post the adjustments. For this to occur you must first establish entries in the following tables:

- Type F (Misc Cash) Transaction Codes
- Miscellaneous Cash Codes
- Payment File Definition
- Provider Level Adjustment Reason Codes
- Provider Level Adjustment Mapping
- ERA Facility/Provider Mapping

If an entry is filed as deleted in the ERA Facility/Provider Mapping table for a facility, the entry cannot be used to process PLB segments in an ANSI ERA file. If there are PLB segments in an ERA file and the ERA Facility/Provider Mapping table selected per the code for the ERA Payment File Definition, and the facility is filed as deleted, two prompts are displayed. Each requires ENTER to be pressed. The prompts are as follows:

Provider Level Adj Mapping table entry for ZZ for facility Y filed as deleted! Press NL.

No entries added to batch XX for Facility Y! Press NL.

For a cross facility batch, the second prompt is as follows:

No entries added to cross facility batch! Press NL.

In the preceding messages, ZZ signifies the code for the ERA Payment File Definition, XX signifies the batch code, and Y signifies the facility.

If there is no entry in the ERA Facility/Provider Mapping table for the ERA Payment File Definition and the facility, the following two prompts are displayed

Missing Provider Adjustment Mapping table entry for ZZ for facility Y. Press NL.

No entries added to batch XX for Facility Y! Press NL.

For a cross facility batch, the second prompt is as follows:

No entries added to cross facility batch! Press NL.

In the preceding messages, ZZ signifies the code for the ERA Payment File Definition, XX signifies the batch code, and Y signifies the facility.

If a PLB batch was added to the Unmatched PLB Worklist and the ERA Facility/ Provider Mapping table determined per the code for the ERA Payment File Definition and the facility is filed as deleted, the Unmatched PLB Worklist cannot be used for that option. The following message is displayed, and the lookup list of files in the worklist is redisplayed:

Provider Level Adj Mapping table entry for ZZ for facility Y filed as deleted. Press ENTER.

In the preceding message, ZZ signifies the code for the ERA Payment File Definition and Y signifies the facility.

After you have successfully uploaded an 835 payment file that contains provider level adjustments and you are using the Process Electronic RA function, the system displays all batches created from the ERA file.

```
                General Hospital Process Electronic RA Processor
                                                Tue Aug 14, 2007 12:53 pm

                          Unmatched Payments Do Not Exist
                        Unmatched PLB Records Do Not Exist
                        File Uploaded (MEDICARE) on 08/10/07
Batch Number-Facility/PFD Desc/Split Criteria
Page:01                          Split Criteria PRV#
( 1) 857-A/MEDICARE/1534523
( 2) 858-A/MEDICARE/Prov Adj




Enter choice, Print F(X)RERABB, (D)isplay ERA batch information, or press [NL]
to exit--
```

For each file, the system displays the following information:

SEQ (DISPLAY ONLY)
This column displays the sequence number of the uploaded file.

BATCH # (DISPLAY ONLY)
This column displays the cash batch number. This field is blank for files with a status of uploaded.

BATCH DESCRIPTION (DISPLAY ONLY)
This field displays the Facility code, Batch Description (from the ERA Payment File Definition Table) and split criteria.

NOTE: If the Provider Number from the PLB segment is not defined in the ERA Facility/Provider Mapping Table, the entry flows to the Unmatched PLB Worklist. If this is unmapped, the description is: *Unmatched Prov Adj*.

If the provider level adjustment mapping table entry is found, the following screen is displayed:

```
              General Hospital Exit Batch Processor
                                                  Thu Sep 27, 2007 06:17 am

UNMATCHED PAYMENTS for PM ANSI uploaded 04/17/07 - Yes

 1 Batch #            2 Batch Description                    3 # of Trans
   741                  B/PM ANSI/Unmatched Pymt
CASH                     4 Total Matched    5 Batch Total     6 Variance
                                                               0.00
CONTRACTUAL ADJUSTMENTS  7 Total Matched    8 Batch Total     9 Variance

10 Batch Status
   Balanced




Batch is balanced - (A)pprove, (H)old, (P)rint Batch, Print F(X)RERABB, (D)isplay ERA
batch information, or press [NL] to exit --
```

You can select the sequence number and the next option. You can enter **A** to approve the batch if it is in balance, **H** for hold if you want to view or edit the batch prior to posting the batch, or **P** to print the Cash Posting Audit Report, FAR120. Press ENTER to exit the function.

Background Processing

Matching Criteria

The system uses the uploaded payment data to create the insurance cash posting file. As it reads each record, the system scans the patient database for a matching claim record. Payments must be posted to a valid claim. The system uses the following criteria to identify a matching claim:

- Patient account number
- Carrier or Carrier/Plan code (as defined in the ERA Payment File Definition

- Dates of service (from and through)
- Type of claim form
- Claim type (final, cycle, adjustment, and/or late)

For Part B payments, claims are matched with payments based on the criteria the hospital uses for generating 1500s. One account can generate separate claims based on physician or department, or all charges can be combined on one claim. The system can receive multiple Part B payments and adjustments for one account by checking physician numbers and procedure codes.

Part B payments require additional matching criteria. The system first follows the matching logic that is used for Part A payments. If dates of service are not present at the claim level in the 835 payment file, the system scans the dates of service for the service lines to determine the range of actual service dates. For part B payments, the system then compares the first charge line of the Part B source file (which is the first SVC segment for the account) to each charge line of the claim on the Patient Accounting system, looking for a match.

- The performing provider number (REF02, when REF01-1C, in the source file) must match the doctor number in locator 24K of the 1500 claim form.

- The procedure (SVC02 in the source file) must match the procedure code in locator 24D of the 1500 claim form.

For those payments where a matching claim cannot be located for reasons such as *No matching claim, Multiple claims match,* and *Account not found,* these payments are sent to the Unmatched Payments Worklist. Users can then match the payments to the correct claim and move the entries into the ERA cash batch. The Electronic Remittance Rejection report (FXRERRR) is produced when the file is uploaded, and the report displays the rejections with reasons such as: *Account in BD, Missing Adj Trans Code, Missing Payment Trans Code, and Account Archived*.

Claims replaced by other claims cannot be used as a matching claim. The system uses only the newer claim (adjustment claim) in the matching process.

Posting Adjustments

You can receive adjustments in conjunction with electronic payments. The system uses the codes defined in the ERA CAS Reason Codes table to determine the contractual adjustment amount. The system uses the entry to the Contr. Adj Method? field on the User Set-Up screen to determine if the adjustment amounts that may be present on each payment are to be posted to the account.

You can specify the contractual adjustment method. The system uses the entry in the Contr Adj Method? field on the Payment File Definition screen. The system prompts you to select a contractual adjustment method from one of the following options:

- Post

- Do Not Post
- Report
- Variance
- Reverse System Adjustment

If Post if selected, the contractual adjustment is posted as received. If Do Not Post is selected, the contractual adjustment is not posted, and the adjustment is only reported on the Electronic RA Audit report (FXRERAR.) If Variance is selected, the contractual adjustment is posted as the variance between the adjustment received and the adjustment posted at final billing. If no adjustment is posted at final billing, the entire amount of the adjustment received is posted as the variance and reported on the Electronic Cash Posting Audit report (FAR121.) If Report is selected, the adjustment variance is calculated but not posted. The variance is reported on the Electronic Cash Posting Audit report (FAR121.) Variance and Report are not valid options for Part B source files. The only valid options for Part B source files are Post, to post the contractual adjustment as received, and Do Not Post, and the contractual adjustment is not posted. If Reverse System Adjustment is selected, the previous contractual adjustment taken at the billing event is reversed back onto the account, and the contractual adjustment from the ERA file is posted to the account.

If adjustments are uploaded, the system uses the contractual adjustment from the Process Electronic RA Setup processor or the code from the insurance plan associated with the claim. If “other adjustments are established in the Electronic RA Reason Code table, the system uses the Other Adjustment Transaction code from the Process Electronic RA Setup processor or defaults to the code used for the contractual adjustments. If a transaction code does not exist, the record is rejected with a reason of Missing Adj Trans Code.

Contractual adjustments can be posted regardless of the setting of the Final Payment field.

Batch Status

The system allows you to either manually assign a batch number to the insurance batch created (for Vendor files only) or assigns a system-generated batch number. The batch total is the total amount of the payments sent by the carrier (including rejected payments.) The total entered is the sum of the payments entered into the batch. If the batch total and the total entered are in balance, the batch has a status of batch balanced. If the batch total and the total entered do not match, the batch has a status of unbalanced, as shown on the following screen:

```
                    General Hospital Exit Batch Processor
                                    Thurs June 16, 2007 12:53 pm

 1 Batch #            2 Batch Description                    3 # of Trans
   387                  MEDICARE A RA                          11
CASH                     4 Total Matched    5 Batch Total     6 Variance
                           3565.00            3585.00           20.00
CONTRACTUAL ADJUSTMENTS  7 Total Matched    8 Batch Total     9 Variance
                                             0.00
10 Batch Status
   Unbalanced









Batch is out of balance - Accept (A) or Print Batch (P)--
```

If the batch is unbalanced, the following prompt is displayed:

Batch is out of balance - Accept (A) or Print Batch (P)? [A]--

Enter **A**, or press ENTER to accept the batch. The default is **A**. Enter **P** to print the Cash Posting Audit Report, FAR120, for the newly created batch.

If the batch is in balance, the following prompt is displayed:

Batch is in balance - Approve (A), Hold (H), or Print Batch (P)? [A]--

Enter **A**, or press ENTER to approve the batch. The default is **A**. Enter **H** for Hold if you want to review the batch in the Post Cash function in Account Transactions. Enter **P** to print the Cash Posting Audit Report, FAR121, for the newly created batch.

Working the Cash Batch

The system permits you to view, edit, print, and process the newly created insurance batch using the cash posting processor.

If the batch is in balance, approving the batch causes the batch to be posted.

If the batch is not in balance, you can review the reasons certain payments were rejected by printing the Electronic Remittance Rejection report (FXRERRR). You can manually enter rejected payments into the newly created batch or edit the batch total to force it to match the total entered. The batch total must match the total entered in order for the batch to be approved.

For those payments where a match cannot be made to a claim, these flow into the Unmatched Payments Worklist. By adjusting the matching criteria, you may be able to reduce the number of unmatched and rejected payments. After you adjust the

matching criteria, re-split the file by re-entering the processed file in the Process Electronic RA menu option. Answer Yes to the prompt to re-split the file. When the file is re-processed, the system deletes the previously created insurance cash batch for that file and then re-creates it from the uploaded data. Any manual edits made to the initial insurance cash batch are lost.

NOTE: After processing the Electronic RA, the system lists each detail record on either the Electronic Cash Posting Audit report (FAR121) if it passed all matching criteria or on the Electronic Remittance Rejection report (FXRERRR) if it did not pass all matching criteria. The system lists all records on the Electronic RA Audit report (FXRERAR).

Batch Approval

Once the batch is approved, the system deletes the uploaded file from the STAR Financials Patient Accounting CPU. This prevents the recreation of an insurance batch for payments that have already been posted and prevents this file from displaying in the Uploaded Files lookup screen. This also accomplishes the disk maintenance on the STAR CPU for this function. Approving the insurance cash batch also makes the batch available for the ERA Payment Analysis Report.

For those facilities tracking denials, once the ERA cash batch is approved, denials are tracked for all denials in the batch. ERA denials are tracked as soon as the batch is posted.

Updating Third Party Logs

At the time the cash batch is approved and posted, the third party logs are also updated. The payment amount, adjustment amount, coinsurance amount, deductible amount, days paid, DRG paid, and outlier status paid update the Third Party Log record.

Updating the External Claim Number

At the time the cash batch is approved and posted, if the intermediary's external claim number is available in the payment file, it updates the patient's claim record. The claim number can be viewed from Account Inquiry/Financial Information/Claim Information/ Carrier Status Information/Ext. Claim # field.

The external claim number is also included in the patient’s Transaction History in the comment for the insurance payment.

Request ERA Payment Analysis Report

The Request ERA Payment Analysis Report screen allows you to place a demand request for the ERA Payment Analysis Report by Account and the ERA Payment Analysis Report by Revenue Code to be generated for an approved RA and

designated manually entered insurance cash batches. Although the reports are automatically generated at the time the ERA cash batch is approved, you can generate additional ERA Payment Analysis Reports.

NOTE: A manually entered insurance cash batch can be designated for payment analysis processing if the Svc Dtl field is set to Yes on the Insurance Cash Posting Setup screen prior to the approval of the insurance cash batch.

When you select the Request ERA Payment Analysis Report function, the following screen is displayed, showing all approved ERA cash batches for the current day. Approved ERA Provider Level Adjustment batches are not displayed.

```
      General Hospital Request ERA Payment Analysis Report Processor
                                                  Sat Sep 08, 2002 04:47 pm

Page:01                    Approved ERA Cash Batches
    Ins Seq  Trns Dt Created  Batch  Src    Batch Description
( 1) B   1   Jul 27  Aug 20      1   835 A  4010 12/00
( 2) B   2   Jul 27  Aug 20      2   835 A  4010 12/01
( 3) B   3   Jul 27  Aug 20     19   835 A  Mcare A 01/01
( 4) B   1   Aug 06  Aug 21     21   835 A  Mcare A 12/00
( 5) B   2   Aug 06  Aug 21     22   835 A  Mcare A 01/01
( 6) B   3   Aug 06  Aug 21     23   835 A  Blue Cross 12/00
( 7) B   4   Aug 06  Aug 21     24   835 A  Blue Cross 12/99
( 8) B   5   Aug 06  Aug 21     25   835 A  BLUE CROSS 01/01
( 9) B   5           Aug 22     28   MAN    FIREMAN'S FUND


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

Field Explanations

INS
This column displays the insurance type code.This column is blank for manually entered insurance cash batches.

SEQ
This column displays the sequence number of the uploaded file. This column is blank for manually entered insurance cash batches.

TRNS DT
This column displays the transmission date of the uploaded file. This column is blank for manually entered insurance cash batches.

CREATED
This column displays the date the file was uploaded to STAR Patient Accounting. For manually entered insurance cash batches, this is the date the batch was created.

BATCH
This column displays the insurance cash batch number.

SRC
This field contains the source of the payment file, 835 A, 835 B, VEN, or MAN.

BATCH DESCRIPTION
This field contains the description associated with the cash batch.

To select a cash batch, enter the option number of the batch. You can select multiple cash batches to print. The following prompt is displayed:

Produce (C)ombined or (S)eparate reports? [C] -- |

If you enter Combined (C), all selected batches are merged together for the resulting report(s). If you select Separate (S), a separate report is generated for each selected cash batch. The following prompt is displayed:

Enter ERA Payment Analysis Report code or `-` for list --

You can enter the code or a hyphen (-) for a table lookup of the Payment Analysis Report Definition table. After the code is entered or selected, the following screen is displayed:

```
            General Hospital Request ERA Payment Analysis Report Processor
                                                Wed Jan 30, 2007 06:29 pm



 1 Code  2 Description                  3 Report by       4 Acct Loc
   ALL     ALL ACCOUNTS                   Account           PA,AR
 5 Sort of Accounts                     6 Sort of Detail
   Patient Name                           Revenue Code, HCPCS, Date
 7 Svc Line Print Selection             8 Service line format
   All service lines                      Expanded
 9 Claim Payment Variance Amount       10 Claim Payment Variance Percentage
           $10.00                         2
11 Svc Line Payment Variance Amount    12 Svc Line Payment Variance Percentage
           $10.00                         2
13 Claim Status                        14 Claim Filing Indicator (CLP06)
   1,2,3,4,5,19,20,21,22
15 CAS Reason Code Print Selection

16 Status   17 Edit by                                  18 Edit date
               Adair,Justin                                02/23/07 13:51

Press NL-
```

This screen is a copy of Page 1 of the ERA Payment Analysis Report Definition Table. All fields are display only. For field explanations, see “ERA Payment Analysis Report” on page 1-84.

If ENTER is pressed, the following screen is displayed:

```
          General Hospital Request ERA Payment Analysis Report Processor
                                                 Wed Jan 30, 2002 06:29 pm



                        Service Line Limits
 1 Revenue Codes          2 Selections
   Include                  320,360
 3 CAS Adj Reason Codes   4 Selections
   Include                  123,19,36,45,46,55,97,A2,A20,B13
 5 Adj Group Codes        6 Selections
   Exclude                  PI,PR
 7 Remarks Codes          8 Selections
   Include
 9 APC Codes             10 Selections
   Include                  00800-00899
11 HCPCS Codes           12 Selections
   Exclude                  96000-99999
13 Mismatched Svc Lines
  Charge Amount

Press NL--
```

This screen is a copy of Page 2 of the ERA Payment Analysis Report Definition table. All fields are display only. For field explanations, see “ERA Payment Analysis Report” on page 1-84.

After pressing ENTER to continue, the following prompt is displayed:

Produce Report? (Y/N) [Y] - -

Enter Yes (Y) to generate the report.

Purging Electronic RA Files From Your PC

You are responsible for maintaining the directory containing electronic payment files on the PC. McKesson designed the file naming conventions to help prevent you from deleting data files in error. The frequency with which you delete files depends on the amount of disk space available on the PC. For greater data security, you also may want to periodically back up data files.

Selecting Files To Purge

To purge files on your PC, access the menu option Purge Electronic RA files. The system displays the following screen:

```
                General Hospital Purge Electronic RA files Processor
                                        Thurs June 13, 2002 11:31 am









Enter 835 (A), 835 (B) or (V)endor [A]--
```

Press ENTER to accept the default of C, or enter the letter of a different drive if your electronic payment data files are not stored on drive C. The system then displays the following prompt:

Enter 835 (A), 835 (B) or (V)endor [A]--

Enter **A** to indicate that the files are 835 A. Enter **B** to indicate 835 B. Enter **V** to indicate that the files are Vendor files.

The system next prompts you for the directory in which electronic payment files are stored.

If you are using a vendor, the system displays the following prompt:

Enter the directory [\PAYIN]--

If you are using Part A, the system displays the following prompt:

Enter the directory [\835IN]--

If you are using Part B, the system displays the following prompt:

Enter the directory [\835BIN] -

Press ENTER to accept the default directory or enter a different directory if your electronic payment data files are not located in the default location. If there are no files available for purging, the system displays the message *Files not found!*

The system displays a list of all uploaded electronic payment files. For a vendor payment file, once a file has been uploaded to the STAR Financials Patient Accounting CPU, the system changes the first character in the file name from an underscore (_) to a P. The system uses this naming convention to determine the list of files to display; therefore, the screen only displays files in the specified drive and directory whose names begin with P. For Part A and B 835, the system displays all files in the specified directory on the PC. These file names contain the extension of .UPL.

NOTE: Even though a file has been uploaded, the resulting cash batch may not have been balanced and posted.

You may want to purge data files monthly or quarterly after you have verified that all the uploaded files for that period have been processed, balanced, and posted. The system displays the following screen:

```
                General Hospital Purge Electronic RA files Processor
                                   Thu Feb 16, 1995 01:49 pm

Page:01                            Uploaded Files              ##=Current Choices
( 1) PA0115M1.DAT
( 2) PA0115M2.DAT
( 3) PA0115M3.DAT









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

The naming conventions for the vendor payment files are:

- P = indicates the file has been uploaded.
- F = the facility indicator (A in the above example)
- MM = the month (01 in the above example)
- DD = the day (15 in the above example)
- I = the insurance type (M in the above example)
- S = a sequence number for the day (1, 2, 3 in the above examples)

The naming convention for the Part A and B 835 files that have been uploaded is FILENAME.UPL, where FILENAME is the name of the file that was received from the intermediary/carrier, and .UPL is the file extension. STAR Patient Accounting

overwrites the extension on the intermediary's/carrier's file with .UPL at the time the file is uploaded.

After you select the file(s) to purge, the following screen is displayed:

```
                General Hospital Purge Electronic RA files Processor
                                Thu Feb 16, 1995 02:09 pm









Are you sure you wish to purge selected files? (Y/N) [N]--
```

Enter **N** to return to the menu. Enter **Y** to proceed with the purge; the system displays the following screen, indicating the purge request is being processed:

```
                General Hospital Purge Electronic RA files Processor
                                Thu Feb 16, 1995 02:09 pm









Are you sure you wish to purge selected files? (Y/N) [N]-- Y
                            Processing purge request!
```

Deleting Electronic RA Files from STAR

To remove payment files from the STAR system that were uploaded in error, use the Delete Electronic RA Files from STAR function. If an error occurs during the upload process, you need to use the Delete Electronic RA Files from STAR function to remove any partial files residing in the STAR CPU.

After you access this function, the system prompts you to enter a facility. After you identify the facility the system displays a list of files to delete as on the following screen:

```
        General Hospital Delete Electronic RA files from STAR Processor
                                                  Mon Apr 19, 1999 11:49 am


Page:01                          Files to Delete
    Ins Seq  Trns Dt Upld Dt  Status      Batch Src    Batch Description
( 1) B   2   Aug 15  Mar 17   Uploaded          835 A  Medicare A
( 2) B   3   Aug 15  Mar 17   Uploaded          835 B  Medicare B
( 3) B   4   Aug 15  Mar 17   Uploaded          835 A  Medicare A
( 4) B   5   Aug 15  Mar 17   Uploaded          835 B  Medicare B
( 5) B   6   Aug 15  Mar 17   Uploaded          835 A  Medicare A
( 6) B   7   Aug 15  Mar 17   Uploaded          835 B  Medicare B
( 7) B   8   Aug 15  Mar 17   Uploaded          835 A  Medicare A
( 8) B   9   Aug 15  Mar 17   Balanced     10   835 A  Medicare A
( 9) X   1   Jun 04  Jun 04   Uploaded          VEN    Commercial
(10) C   1   Apr 15  Jul 15   Balanced    492   835 A  Medicare A
(11) C   2   Apr 15  Jul 15   Unbalanced  493   835 B  Medicare B
(12) X   1   Jul 20  Aug 11   Uploaded          VEN    Commercial
(13) X   1   Sep 11  Dec 16   Unbalanced  727   VEN    Commercial
(14) C   1   Nov 18  Jan 07   Unbalanced  729   835 A  Medicare A
(15) C   2   Nov 18  Jan 07   Unbalanced  731   835 B  Medicare B

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

For each uploaded file, the system displays the following information:

INS
This column displays the insurance type code.

SEQ
This column displays the sequence number of the uploaded file.

TRNS DT
This column displays the transmission date of the uploaded file.

UPLD DT
This column displays the date the file was uploaded on the STAR CPU.

STATUS
This column displays the status of the batch. The status of the batches include uploaded, unbalanced, or balanced. Files that have been uploaded and not processed have a status of uploaded.

BATCH
This column displays the insurance cash batch number. This field is blank for files with a status of uploaded.

SRC
This column contains the source of the payment file. This is defined in the payment file definition parameter. This column displays 835 A, 835 B, or VEN for the Vendor file format.

BATCH DESCRIPTION
This column contains the description associated with the cash batch.

To delete one of the files, enter the option number of the file. If the file has the status of uploaded, the system displays the following prompt:

Are you sure you wish to delete this Electronic Remittance batch? (Y/N) [N] --

Enter **N** if you do not wish to delete the selected file. You are returned to the list of files to delete. Enter **Y** to delete the uploaded file. You are returned to the list of files to delete.

If the file has a status of balanced, unbalanced, or hold, a batch number has been assigned to the payment file, and a cash batch exists. To delete a file and its cash batch, enter the option number of the file. The system displays the following prompt:

Cash Batch [###] will also be deleted. Continue? (Y/N) [N]--

Enter **N** if you do not want to delete the file. The system redisplays the list of files to delete. Enter **Y** if you want to delete the file. The system redisplays the list of files to delete.

If you select an ERA file to be deleted, and the status of the associated cash batch is either approved or posted, the following message is displayed, and the deletion does not occur:

ERA file cannot be deleted. Batch status for cash batch is Approved!

NOTE: Caution should be exercised in deleting and reloading 835 files. Multiple payment files are typically created from one 835 source file. Deleting one payment file does not delete other payment files created from the 835 source file. Re-uploading an 835 source file creates duplicate payment files if all previously uploaded files were not deleted.

Also, to upload a source file, the file on the PC may need to be renamed. An 835 file cannot be uploaded if a file with the same name with a .UPL extension exists in the same directory.

ERA WORKLISTS AND REPORTS

This function under the Account Transactions menu, allows you to access the following options:

- Unmatched Payments Worklist
- Unmatched PLB Worklist
- View/Process ERA Files
- Print Electronic RA Audit Rpt
- Request ERA Payment Analysis Report

Each of these options is discussed below.

Unmatched Payments Worklist

This function is used when a payment cannot be matched to a claim based upon the criteria selected for matching. The remittance information is saved in the Unmatched Payments Worklist. This worklist is accessible through the ERA Worklists and Reports menu.

In order to keep all of the remittance detail, the payments must be applied to an ERA batch. So, at the time of uploading an ERA file, if there are any unmatched payments, the system creates an ERA batch for each facility defined in the ERA Payment File Definition table. The unmatched payments must be matched and moved into an ERA batch associated with the ERA file in order to save all of the remittance data. These batches are an *unmatched batch* for each facility with no entries until the user begins with the worklist. The user may also select from the list of unposted ERA batches from the uploaded ERA file. Any batches from the uploaded ERA file that have already been Approved/Posted are not displayed in the list.

When all worklist items have been matched, any unused, unmatched ERA batches created are removed. For example, if all unmatched payments were matched and moved into the batches with the appropriate splits, the unmatched ERA batch is removed from the system.

Once the batch is selected, the match is considered complete (payment matched to a claim and a batch is selected), and the payment is removed from the Unmatched Payments Worklist and into the ERA batch. All appropriate batch totals are updated when the payment is moved, such as the number of transactions, batch totals, and contractual adjustment totals.

NOTE: It is not advisable to post any ERA batches until entries in the worklist have been matched and/or deleted. Once a cash batch from an ERA file has been approved, you no longer have the option to re-split a file or to work any

approved cash batches. Once the worklist is empty, you should balance all ERA batches back to the one ERA file before approving any batches.

After you select this function, the system displays the following screen which lists uploaded ERA files:

```
          General Hospital Unmatched Payments Worklist Processor
                                              Wed Apr 25, 2007 08:37 am


Page:01                  Uploaded and Processed Files
     Ins Seq  Trns Dt  Upld Dt  Src   Batch Description
( 1)     1    Apr 25   Mar 06   VEN   Remit Test
( 2)   C 1    Aug 30   Apr 13   CMB   PM ANSI
( 3)     1    Apr 25   Apr 14   VEN
( 4)   C 1    Aug 30   Apr 16   CMB   PM ANSI
( 5)   M 2    Apr 04   Apr 18   835 A MEDICARE
( 6)   C 11   Aug 30   Apr 20   CMB   PM ANSI
( 7)   C 1    Aug 30   Apr 21   CMB   PM ANSI
( 8)   C 1    Aug 30   Apr 22   CMB   PM ANSI
( 9)   C 13   Aug 30   Apr 22   CMB   PM ANSI
(10)   C 14   Aug 30   Apr 22   CMB   PM ANSI
(11)   C 21   Aug 30   Apr 22   CMB   PM ANSI
(12)   C 5    Aug 30   Apr 22   CMB   PM ANSI
(13)   C 9    Aug 30   Apr 22   CMB   PM ANSI
(14)   C 30   Aug 30   Apr 23   CMB   PM ANSI
(15)   C 43   Aug 30   Apr 23   CMB   PM ANSI


Enter choice--
```

You can select the ERA file in which to review/work the unmatched payments. Approved and posted batches cannot be selected. Once a file is selected, the system displays the following prompt:

Do you want to exclude payments that appear to be from a different facility? (Y/N)

- If Yes is entered, only accounts that appear to be for the chosen facility are displayed. For instance, if the chosen facility is A, and a payment with a CLP01 record contains *Illegible* instead of an account number, this payment is not displayed in the worklist.

- If No is entered, all worklist entries are displayed for matching.

The following screen is displayed listing all unmatched payments from the ERA file. The worklist displays account numbers, patient names, from and through claim dates, claim amount, and the reason the payment could not be matched to a claim.

NOTE: For multi-facility sites, the worklist is accessed by facility, and all entries are shown. Once a match is made, the entry is moved to the cash batch and is removed from all worklists.

```
        General Hospital Unmatched Payments Worklist Processor
                                                Wed Apr 25, 2007 08:37 am


     Pt Ctrl#      Name from File   From Dt   Claim Amount Reason
( 1) A0715100004   BILLS,ANN        05/21/07     $4,009.50 No claims found
( 2) A0913300003   HENRY,JASON      05/13/07     $3,009.50 Multiple claims match
( 3) A0915100002   SMITH,RON        05/31/07     $3,241.00 Account not found
( 4) A0715300003   TYLER,MARKT      06/01/07     $3,009.50 No account matches name


Select an unmatched payment for review or enter NL to exit--
```

The system displays the following prompt:

Select an unmatched payment for review or enter NL to exit

Entry options are:

- Press ENTER to exit the screen and to delete all remaining entries from the worklist. The following prompt is displayed:

  Do you wish to delete the remaining entries from the worklist? (Y/N) [N]--

- Select an unmatched payment from the list. Once selected, a name/account number search is performed to find the correct patient and visit. The result is shown on the following screen:

```
          General Hospital Unmatched Payments Worklist Processor
                                                Thu Aug 16, 2007 03:33 pm


 1 Pt Control#      2 Name from QC (or 74 if no QC)         3 From/To Dates
   A0715300003        TYLER,MARK T                            06/01/07 06/02/07
 4 Claim Amount     5 Clm Filing Ind       6 UB Claim       7 First HCPCS
   $3,009.50          MA                     Yes
 8 DR ID

Account      Name                 FC Typ Admit    Disch        Balance Loc
             ADAMS,JATEST                                         0.00
Page:01                  PA, AR Patient Accounts
      Account    PT  Admit  Disch  FC   Account   Patient Insurance  Loc
( 1) A0718600003 OP  070507 070507 JA      0.00      0.00      0.00  AR/ACCF
( 2) A0715500001 O/P 060407 060407 JA   3241.00      0.00   3241.00  AR/ACCF
( 3) A0715300003 O/P 060207 060207 JA   2106.65      0.00   2106.65  AR/ACCF
( 4) A0715000001 O/P 053007 053007 JA   2430.75      0.00   2430.75  AR/ACCF
( 5) A0713700006 I/P 051707 052307 JA   7099.81    600.00   6499.81  AR/ACCF
( 6) A0713000004 O/P 051007 051007 JA      0.00      0.00      0.00  AR/ACCF
( 7) A0712800025 O/P 050807 050807 JA   2430.75      0.00   2430.75  AR/ACCF

Select account--
                      next pg(/ or PG DN)  Search(TAB)
```

Once a selection is made, the following remittance details are shown along with all claims for the account. The following screen is displayed:

```
               General Hospital Unmatched Payments Worklist Processor
                                                 Thu Aug 16, 2010 03:33 pm

 1 Pt Control#      2 Name from QC (or 74 if no QC)         3 From/To Dates
   A0715300003        TYLER,MARK T                            06/01/07 06/02/07
 4 Claim Amount     5 Clm Filing Ind       6 UB Claim       7 First HCPCS
   $3,009.50          MA                     Yes
 8 DR ID

Page:01  Bill           Service              Claim C
      CS From/Thru      From/Thru           Amount D  Insurance Plan
( 1)   7 06/18 06/18/08 06/18 06/18/08      798.00 D  777000,PRIMARY PLAN
( 2)   5 06/18 06/18/08 06/18 06/18/08      798.00 A  400100,BLUE CROSS OF G
( 3)   4 06/18 06/18/08 06/18 06/18/08      673.00 A  777088,TESTING




Select claim, (R)emit, (I)ns Rev, Ins Adj (B)ill, (A)dd claim, or (D)elete-----
```

Field Explanations

CS
This field contains the claim sequence number.

BILL FROM/THRU
This field contains the Bill From and Bill Thru dates for the bill for which the claim was loaded.

SERVICE FROM/THRU
If the claim type is X (UB) or R (Medi-Cal UB), the Statement Covers From Date and the Statement Covers Through Date from Locator 6 (Statement Covers Period) are displayed. Varied internal elements can be used to load data to those fields. If Service From Date and Service To Date are used for a claim of type X (UB), the service from and to dates per the charges selected for the claim load to these fields. Otherwise, the service from and service thru dates from the bill for which the claim loaded are provided.

CLAIM AMOUNT
This field contains the total amount for charges appearing on claim.

CD
This field contains the claim disposition.

INSURANCE PLAN
This field contains the description for Insurance Plan retained in Patient Processing when the insurance plan was selected for the account.

The system displays the following prompt:

Select claim, (R)emit, (I)ns Rev, Ins Adj (B)ill, (A)dd claim, or (D)elete-----

You have the following entry options:

- Enter **I** for Insurance Revision. You can use this function to add an insurance plan or to make other updates to insurance information. If you are on a multi-CPU system, you may need to wait for the insurance information to be updated in Patient Accounting before using Add a Claim.

- Enter **R** to view remittance data. If this option is selected, remittance data is displayed. For details, see "VIEW REMITTANCE DATA" on page 1-140.

- Enter **D** (Delete) to delete the claim from the Unmatched Payments Worklist. If you enter this option, the following prompt is displayed:

  Do you wish to remove this worklist entry? (Y/N)--

  If you enter Yes, the system notifies you that the worklist payment was deleted by displaying the following message:

  UNMATCHED PAYMENT REMOVED FROM WORKLIST

- Enter **B** for Instant Adjustment Bill to create a cycle adjustment bill or an adjustment bill.

- Enter **A** (Add Claim) to add a claim to the account.

- Enter the claim sequence number to select the claim for processing:

  If a replaced claim is selected, the following message is displayed (and the selection list is repeated):

  Replaced claim cannot be selected for matching!'

  If a non-replaced claim is selected, the payment information is shown along with the list of available claims.

The following screen is displayed:

```
              General Hospital Unmatched Payments Worklist Processor
                                                    Thu May 6, 2010 03:44 pm

A07093-00001 ARNE, MARK          C  O/P 04/03/07 04/03/07     1248.44 AR /ACCF
 1 Pt Control#      2 Name from QC (or 74 if no QC)         3 From/To Dates
   A0632100004        MOORE,REVSYSADJ,                        11/17/06 11/17/06
 4 Claim Amount     5 Clm Filing Ind       6 UB Claim       7 First HCPCS
   $268.85            MA                     Yes              11000
 8 DR ID
   UPINID
 9 Bill Sq         10 Clm Sq      11 Claim Type    12 Claim Format
   2                  4              B 1500           1992
13 Bill Date       14 Bill From   15 Bill Through   16 Srv From   17 Srv To
   06/23/08           06/18/08       06/18/08          06/18/08      06/18/08
18 Claim Production Status   19 Claim Work Status         20 Claim Amount
   P Produced                S Released-Suspense Days     $798.00
21 Claim Split Indicator                                 22 Payor Claim ID
   Primary
23 Insurance Plan                                        24 Policy Number
   COB 2 777000-777000 PRIMARY PLAN


Enter (C)laim data, (R)emittance data, (M)atch payment to claim, (D)elete entry,
or NL for previous screen--
```

The following prompt is displayed:

Enter (C)laim data, (R)emittance data, (M)atch payment to claim, (D)elete entry, or NL for previous screen--

You have the following entry options:

- Enter **C** (Claim Data) to review claim information. You can choose the type of claim data to review from the menu, such as Claim Status Information.
- Enter **D** (Delete) to delete the claim from the Unmatched Payments Worklist. If you enter this option, the following prompt is displayed:

  Do you wish to remove this worklist entry? (Y/N)--

  If you enter Yes, the system notifies you that the worklist payment was deleted by displaying the following message:

  UNMATCHED PAYMENT REMOVED FROM WORKLIST

- Enter **R** to view remittance data. If this option is selected, remittance data is displayed. For details, see “VIEW REMITTANCE DATA” on page 1-140.
- Enter **M** to match the payment to a claim. If (M) is selected, the following prompt is displayed:

Enter batch number to apply this payment to or '-' for a list of open ERA batches from this file - '

You can enter a valid batch number to apply a payment or a hyphen (-) for a list of open ERA batches in the file. If you enter a hyphen, the following screen is displayed:

```
          General Hospital Unmatched Payments Worklist Processor
                                                    Thu Mar 12, 2008 03:44 pm

Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715300003  TYLER,MARK T         JA O/P 06/02/07 06/02/07     2106.65 AR /ACCF
                           Claim Split Values: A/55667788
Page:01                     Batches for ERA File
( 1) J01-A/JA COMM/Unmatched Pymt
( 2) J03-A/JA COMM/11223344
( 3) J04->A/JA COMM/55667788
```

The screen displays open batches in the ERA file, and unmatched entries in a batch are noted. An entry is considered unmatched when a payment cannot be matched to a unique claim. The ERA file in the example above contained payments for two provider numbers: provider # 11223344 and provider # 55667788. The payment for A071530000S is for provider # 55667788, and if the payment had matched to a claim correctly, the system would have placed this payment in batch J04. You can move this payment to any of the 3 batches displayed in the list, and the information line helps you to move the unmatched payment to the desired batch (especially if the facility does not use the unmatched payment batch). An arrow (*) (>) is displayed in front of the suggested batch based on the values for the split criteria for the payment.

NOTE: When the ERA file is processed a cash batch is created for each split criteria. There is a possibility that one or more of these batches may be empty (due to payments hitting the worklist).If any system-created batch is empty at the time the last workfile entry is worked, the system removes all empty batches.

SCREEN HEADING EXPLANATIONS

CLAIM SPLIT VALUES
This heading displays the batch number, facility, ERA PFD short description, and the split criteria. The heading displays the claim information and values based upon where the payment (or CLP record) is located in the ERA file and how the ERA file was split. For example: A/55667788, where A is the facility and 5566788 is the provider number.

Below are the split criteria options from the PFD table:

Check/BPR

Check/TRN02

Fiscal Period in LX01

Provider Number

ST Segment

Bill Type Exception in LX01

Claim Type (UB or non-UB)

User Defined Criteria

For split criteria options Check/BPR, Check/TRN02, or ST Segment, the claim split value heading shows the batch marker; for example:

J03-A/JA COMM/1

J04-A/JA COMM/2

For the split criteria option Provider Number, the claim split value heading shows the provider number for the unmatched claim. An example of this is: Claim Split Values: A/JA COMM/55667788, where 55667788 is the

Once a batch is selected, the following screen is displayed:

```
            General Hospital Unmatched Payments Worklist Processor
                                                Thu Aug 16, 2007 03:45 pm

Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715300003  TYLER,MARK T         JA O/P 06/02/07 06/02/07     2106.65 AR /ACCF
Clm Liab:      2,859.50    Bill Dts: 06/02/07-06/02/07  Ins Bal:      1,956.65
Ins:  750/100 Den-App Ind: Never Denied     Billed DRG:                  PCI:
 1 Batch Seq #        2 Pt Class           3 Payor Claim Control Number
   2                                         ICNNUMBER
 4 Payment Amount     5 Receipt #          6 Remittance #
   1,200.00
 7 Payment Date       8 Posting Date       9 New Account Balance
   07/01/07             08/16/07
10 Trans Code/Description                 11 Cont Adj Trans Code/Description
   I0008-COMMERCIAL INSURANCE PAYMENT        A0029-O/P COMMERCIAL ALLOWANCE
12 Expected Reimbursement                 13 Outlier  14 Days Paid  15 DRG Paid
   2,106.65          COB1 RMB O                        6             462
16 Coinsurance   17 Deductible            18 Co-Pay         19 Pat Resp
   200.00           100.00                   150.00            50.00
20 Claim Disp 21 Claim Denial Info        22 ERA Other Adj  23 Rev Sys Adj CA
   Final                                                       902.85 j
 Contractual Adj     24 Prior Balance     25 Payment Amount 26 Cont Adj Amount
                        1,956.65             1,200.00          1,000.00-

Do you want to record this payment (Y/N) or (E)dit?--
```

For explanations of the fields on this screen, refer to the *Account Transactions Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system displays the following prompt:

Do you want to record this payment (Y/N) or (E)dit? -

- If you enter N (No), the system displays the list of payments in the worklist.
- If you enter E (Edit), you can change data on the screen, except for the following fields: Batch Seq#, Pt Class, New Account Balance, ERA Other Adjustment, Expected Reimbursement, and Prior Balance.
- If you enter Y (Yes), the payment is moved into the cash batch and the entry is removed from the worklist. The following message is displayed:

  Payment Transaction Created And Removed From Worklist

When the last payment is matched and moved to the appropriate batch, the worklist is no longer accessible for the ERA file. The intent is for all worklist entries to be matched to the correct claim before the ERA batches are approved.

The system displays the screen showing the list of ERA files. When you press ENTER to exit the screen, the following prompt is displayed:

Do you wish to delete the remaining entries from the worklist? (Y/N) [N]-

- If you enter **N** (No), the next prompt allows you to indicate whether you want to print the ERA Unmatched Payments Worklist, in expanded, summary, or both expanded and summary format:

  Print the Worklist (S)ummary rpt, (E)xpanded rpt, (B)oth rpts or NL to exit--

  You can enter **S** to print the summary report, **E** to print the expanded report, **B** to print both reports or press ENTER to exit and not print any reports.

- If you enter **Y** (Yes), the next prompt allows you to indicate whether you want to delete the remaining entries and print the ERA Unmatched Payments Worklist, in expanded, summary, or both expanded and summary format:

  Print the Worklist (S)ummary rpt, (E)xpanded rpt, (B)oth rpts, or (N)o rpts before deleting the remaining entries? -

  You can enter **S** to print the summary report, **E** to print the expanded report, **B** to print both reports, or **N** (No) to not print reports. The remaining worklist entries are then deleted, and if a report (or reports) option was selected the report(s) are spooled for printing. You can return to the worklist in order to select another ERA file or exit the worklist.

Each time you exit the worklist, the ERA Batch Balancing Report (FXRERABB) automatically spools. This report shows all batch totals and all entries that have been deleted from the worklist. The report must be queued each time a user exits so there is a real-time view of what remains in the worklist.

If a transaction in the Unmatched Payments Worklist updates information in an ERA batch, the following prompt is displayed.

Produce reports (FAR121, FXRERACD, and FXRERRR)? (Y/N) [N]--

You can enter Y (Yes) to produce the reports.

Unmatched PLB Worklist

This function is used when there is a mapping issue with the PLB segment in the 835 A and 835 B payment files, and the entries flow to the Unmatched PLB Worklist. This worklist is accessible through the ERA Worklists and Reports menu.

When this option is selected, the system displays a list of uploaded and processed ERA files. You can select one from the list. The system displays the following screen, with unmatched PLB segments from the selected ERA batch:

```
            General Hospital Unmatched PLB Worklist Processor
                                                Tue Jun 19, 2007 01:33 pm


              Select PLB Record for Facility Model Hospital A
( 1) PLB*HH0103*20061231*WO;0200530657318040X*634.41*WO;0200613++









Select Unmatched PLB--
```

After you select the unmatched PLB record, the entry flows to the batch created for the unmatched PLB entry. The following message is displayed on the screen:

Batch XXX has been updated. Any manual entries have been removed!

You can access the batch through the Cash Posting function and select the batch for approval and posting.

View/Process ERA Files

This function is used to view and process ERA files that have a status of Processed. This function does not allow for the re-splitting of a file, but you can make changes to the file through this function and apply it to an existing cash batch. If you want to re-split a file and get a new cash batch number, you can use the Process Electronic RA function (see “Creation of the Cash Batches” on page 1-104).

When this function is accessed, the system displays a list of uploaded ANSI files. You can select one from the list to view or process the file. If there are unmatched payments or unmatched PLB records in the file, the following screen is displayed:

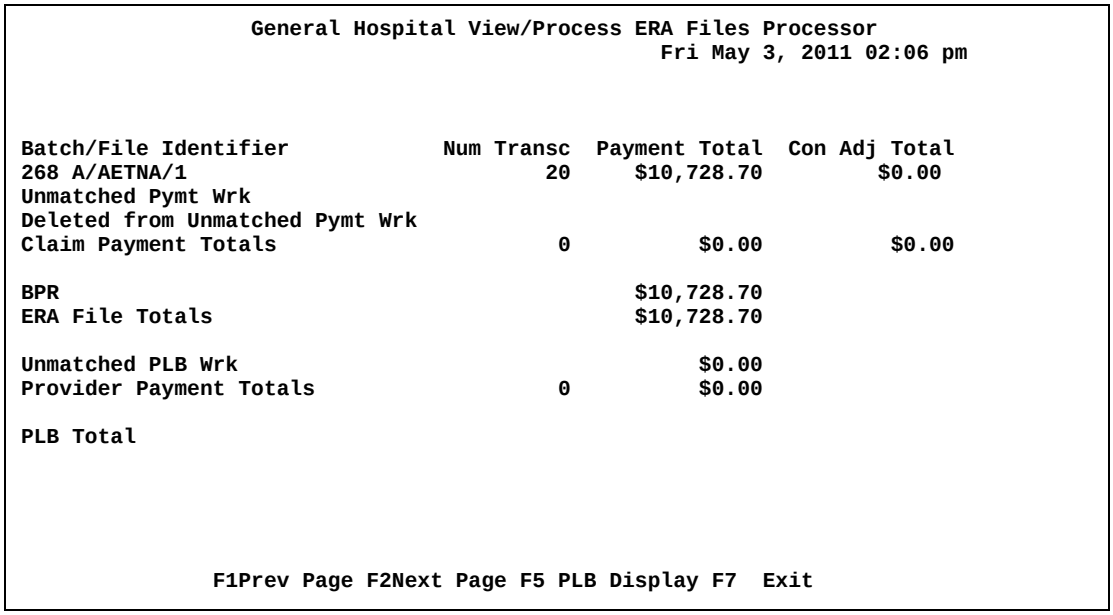
```
              General Hospital View/Process ERA Files Processor
                                                Wed Jun 20, 2007 06:54 am

                           Unmatched Payments Exist
                       Unmatched PLB Records Do Not Exist
                       File Uploaded (MEDICARE) on 04/17/07
Batch Number-Facility/PFD Desc/Split Criteria
Page:01                   Split Criteria FP,BT,Clm Typ
( 1) 170-A/MEDICARE/Unmatched Pymt
( 2) 741-B/MEDICARE/Unmatched Pymt









Enter choice, Print F(X)RERABB, (D)isplay ERA batch information, or press [NL]
to exit--
```

The following prompt is displayed:

Enter choice, Print F(X)RERABB, (D)isplay ERA batch information, or press [NL] to exit--

You have the following entry options:

- Enter the sequence number for the unmatched payment in order to update the batch and approve it.
- Press **ENTER** to exit the batch.
- Enter **X** to print the ERA Batch Balancing report (FXRERABB). This reports aids in balancing across batches so all dollars can be accounted for.
- Enter **D** (Display) to display ERA batch information. This information helps to balance across batches back to the ERA file. The following screen is displayed:



Field Explanations

BATCH/FILE IDENTIFIER (DISPLAY ONLY)
This field displays the batch and file identifiers. Both posted and non-posted batches are displayed.

UNMATCHED PYMT WRK (DISPLAY ONLY)
This field displays, for the batch, the number of transactions, payment total, and contractual adjustment totals for unmatched payments that were placed in the Unmatched Payments Worklist.

DELETED FROM UNMATCHED PYMT WRK (DISPLAY ONLY)
This field displays, for the batch, the number of transactions, payment total, and contractual adjustment totals for unmatched payments that were deleted from the Unmatched Payments Worklist.

CLAIM PAYMENT TOTALS (DISPLAY ONLY)
This field displays, for the batch, the number of transactions, payment total, and contractual adjustment totals for all claims.

BPR (DISPLAY ONLY)
This field displays the payment total from the BPR segment of the file.

ERA FILE TOTALS (DISPLAY ONLY)
Totals for each batch are displayed, but totals from the ERA file are derived from the following segments.

TS304 - Total # of records

TS309 or BPR02 (as defined in ERA PFD table) - Total Provider Payments

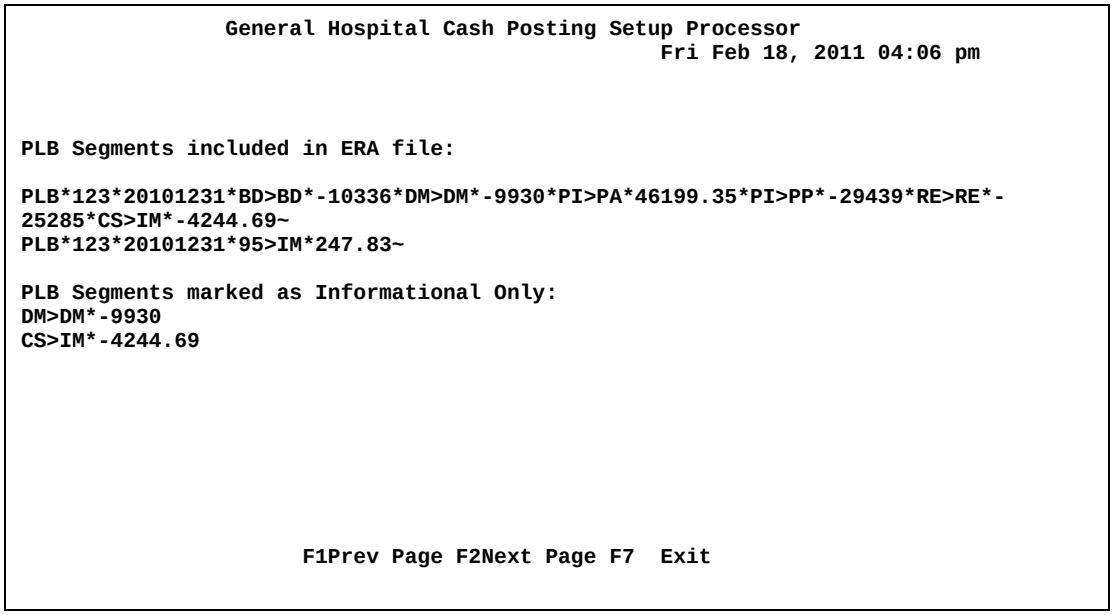
TS311 - Total Contractual Adjustments

UNMATCHED PLB WRK (DISPLAY ONLY)
This field displays the PLB segment totals in the Unmatched PLB Worklist. The PLB Worklist contains entries when there is a mapping issue with the PLB segment in the 835 A and 835 B payment files, and the entries flow to the Unmatched PLB Worklist.

PROVIDER PAYMENT TOTALS (DISPLAY ONLY)
This field displays the provider payment total from the PLB segment in the ERA file.

PLB TOTAL (DISPLAY ONLY)
This field displays the total of all PLB segments from the ERA file.

Press F5 to display all PLB segments from the ERA file. This screen displays all PLB Segments included in the ERA file as well as any PLB segments that are marked as Informational Only.The following screen is displayed:



Field Explanations

PLB SEGMENTS INCLUDED IN ERA FILE (DISPLAY ONLY)
This field contains a list of all PLB segments included in the ERA file.

PLB SEGMENTS MARKED AS INFORMATIONAL ONLY (DISPLAY ONLY)
This field contains a list of all PLB segments marked as informational only.

Print Electronic RA Audit Rpt

This function is used to request the RA Audit Report to be printed.For details on this function, see “Electronic RA Audit Report - FXRERAR” on page 1-155.

Request ERA Payment Analysis Report

This function is used to request the ERA Payment Analysis Report to be printed. For details on this function, see “ERA Payment Analysis Report by Revenue Code - FAR123” on page 1-181 and “Electronic RA Payment Analysis Report by Account - FAR122” on page 1-173.

VIEW REMITTANCE DATA

This function provides the ability to review the remittance data received via the ERA files for information on what portion is left for the patient, how to make decisions on what disposition should be assigned, data for secondary billing, etc. This remittance data is stored for each payment received via an ANSI 835 file. The data is for your review.

NOTE: This function does not apply for payments received via a Vendor file format.

When this function is accessed, the following screen is displayed. You can select the account via a name or account number lookup, then select the claim.

```
               General Hospital View Remittance Data
                                                 Thu Aug 16, 2007 5:20pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,JAY             JA O/P 06/04/07 06/04/07      472.50 AR /ACCF
     Clm Adj   Bill     Bill   Clm   Prd Wk  OPPS Clm
     Seq Clm   From     Thru   Type  Sts Sts Sts  Dsp Carrier/Plan(*Shared)

Page:01                        Non-Replaced Claims
( 1)   2     06/04/07 06/04/07 1500  P    S           750200,AETNA 1500
( 2)   1     06/04/07 06/04/07 UB    P    M        P  750100,AETNA




Enter choice- 2
```

The next screen displays all applicable payments received via ERA.

```
                  General Hospital View Remittance Data
                                              Thu Aug 16, 2007 5:20pm

                                                Thu Aug 16, 2007 05:20 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,JAY             JA O/P 06/04/07 06/04/07      472.50 AR /ACCF

Trans Comment: ICN=20710100244904

Seq   Tran  Description                Tran     Post       Tran  Loc Tran  Bat
Nbr   Code                             Date     Date      Amount     Type  Nbr
1     I0008 COMMERCIAL INSURANCE PAYME 06/06/07 06/06/07   1900.00- AR Cash 529









     F1Prev Page F2Next Page F5View Detail Trans F6 Reset  F7  Exit
```

You can use the arrow key to access the requested payment, then press the F5 key to view detail transactions.

```
              General Hospital View Remittance Data
                                              Thu Aug 16, 2007 5:20pm

 Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,MARK            JA O/P 06/04/07 06/04/07      472.50 AR /ACCF
 1 Trans Code/Description               2 Origin         3 Trans Date/Time
   I0008-COMMERCIAL INSURANCE PAYMENT     ERA              06/06/07 22:20
 4 User ID                          5 Terminal Location    6 BS/CS      7 PCI
   Walls,Julie                        STAR FINANCIALS      1/1
 8 Prior Location  9 Prior Balance  10 New Balance       11 Bill Seq Printed On
   AR/ACCF           $2,430.75        $530.75
12 Posting Date   13 Trans Amount   14 From Carrier/Plan             15 Days Pd
   06/06/07          $1,900.00-       750/100-AETNA 1500               4
16 Cash Post Type 17 Batch Number   18 To Carrier/Plan               19 DRG Pd
   Insurance         529              I/I-                             430
20 Receipt Number 21 Remit Date 22 Remit Advice Number       23 Outlier Type
                     06/01/07      EFT123456
24 Coin/Ded/Co-Pay/Pat Resp                                  25 Claim Disposition
   /$150.00                                                     Partial Payment
26 Status Type    27 Old/New Status        28 Note Type/No 29 ERA Clm Status
                                                              Processed as Prim
30 Ref Trans?   31 Comment
                   ICN=20710100244904
Press NL to return, (R)emittance Data, (V)iew Remit Summary, Service Line
(D)etail-
```

For field descriptions, please refer to the *Account Inquiry and Revision Volume* of the *STAR Patient Accounting Reference Guide,* Chapter 1:Account Inquiry, heading: Transaction History.

To view the Remittance data as received from the ERA file, select **R.**

Each ERA record received is shown on a line-by-line basis. If the information received for the ERA record is longer than the screen width, the display shows as many characters as possible. The remittance data is displayed in a set order after the cash batch is posted. Before the batch is posted, the data is displayed in the order received via the ERA file.

In order to view the entire segment (with headings), you can use the arrow keys to select a segment and then press the F5 key. The following screen is displayed:

NOTE: For definitions and details on these segments, refer to the ANSI 835 Health Care Claim / Payment Advice manual..

```
                    General Hospital View Remittance Data
                                                 Thu Aug 16, 2007 5:20pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,MARK            JA O/P 06/04/07 06/04/07      472.50 AR /ACCF

 CLP:A0715500005:1:3472.50:1900::MA:20710100244904:11:1::430:1
 NM1:QC:1:ADAMS:JAY::::HN:242042664A
 MIA:0:::3316.59:MA02:::::::::1904.49:4:1412.1::::MA13
 DTM:232:20070604
 DTM:233:20070604
 AMT:AU:3314.75
 QTY:CA:4
 SVC:NU;0320:1200:770::1
 CAS:CO:A2:430
 DTM:472:20070604
 AMT:B6:225.75
 SVC:NU;0481:950:500::1
 CAS:CO:A2:300
 CAS:PR:1:150
 DTM:472:20070604
 AMT:B6:17
 SVC:NU;0300:50:30::1:HC;83582

         F1Prev Page F2Next Page F5 Select  F6 Reset  F7  Exit   ?
```

There is another level of detail to define the pieces of each segment as defined in the ASC X12 ANSI 835 manual. Use the arrow keys to move up or down to a segment and then press the F5 key. The screen shown below is an example of the expanded view of the CLP segment.The descriptions for each field come from the 835 manual.

Once a segment is selected, the patient header is displayed at the top of each screen. The value of *CLM appears at the top right side of the screen to alert you that there is an undocumented piece at the end of the record at the claim level. The rule for the * also applies to the service level data. For example, if there is an undocumented piece at the end of the record for the service level, *SRV is displayed at the top right side of

the screen. The CLM and SRV are displayed always, as this designates whether the data is for the claim level or the service level.

```
                General Hospital View Remittance Data
                                                Thu Aug 16, 2007 5:20pm
 Account      Name                  FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,JAY             JA O/P 06/04/07 06/04/07      472.50 AR /ACCF

CLP  Claim Payment                                                        CLM
 1 Pt Control#                                2 Status Code
   A0715500005                                  1
 3 Tot Clm Chg Amt     4 Tot Pmt Amt          5 Pt Resp Amt
   3472.50               1900.00
 6 Filing Ind                                 7 Pyr Clm Cont#
   MA                                           20710100244904
 8 Fac Code Value      9 Freq Type           10 Pt Status Code
   11                    1
11 DRG
   430
12 DRG Weight                               13 Dischg Fraction
   1




Press ENTER for next record or any key to exit
```

Once this view is exited, the options are re-displayed. The following screen is an example of (V)iew Remit Summary.

```
              General Hospital View Remittance Data
                                                Thu Aug 16, 2010 5:20pm
 Account      Name                  FC Typ Admit    Disch        Balance Loc

A0715500005  ADAMS,JAY             JA O/P 06/04/07 06/04/07      472.50 AR /ACCF
1 Claim Liability  2 Bill From     3 Bill Through  4 Carrier Balance   5 5010
   $294.80            03/03/10        03/03/10               $0.00
 6 Carrier/Plan                          7 ICN
   400/100-BLUE CROSS BASIC PLAN           1570715975 0040719590
 8 Posted Pymt Amt   9 Posted Adj Amt   10 RA Pymt Amt      11 RA Adj Amt
   $200.00             $70.00-             $200.00             $70.00-
12 Coinsurance      13 Deductible       14 Co-Pay           15 Pt Resp

16 Total Claim Charges                  17 Submitted Charges per ERA
   $392.56                                 $392.56
18 RA Claim Status                      19 RA Claim Filing Ind
   1 Processed as Primary                  12 Preferred Provider Org (PPO
20 Claim Level Remarks

21 Claim Level Adjustment Codes
   94:50


Key `Y` to view service line information--
```

Field Explanations

1. CLAIM LIABILITY (DISPLAY ONLY)
This field displays the claim liability amount for the claim.

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

3. BILL THROUGH (DISPLAY ONLY)
This field displays the bill through date for the claim.

4. CARRIER BALANCE (DISPLAY ONLY)
This field displays the carrier balance for the carrier associated with the claim.

5. 5010 (DISPLAY ONLY)
This field indicates whether the payment was received from a 5010 file. *Yes* is displayed if the payment was from a 5010 file; *No* is displayed if the payment was from another file.

6. CARRIER/PLAN (DISPLAY ONLY)
This field displays the carrier/plan for the claim.

7. ICN (DISPLAY ONLY)
This field displays the Internal Control Number associated with the insurance payment for the claim.

8. POSTED PAYMENT AMOUNT (DISPLAY ONLY)
This field displays the insurance payment amount for the claim.

9. POSTED ADJ AMOUNT (DISPLAY ONLY)
This field displays the total contractual adjustment amount associated with the insurance payment for the claim.

10. RA PAYMENT AMOUNT (DISPLAY ONLY)
This field displays the ERA payment amount for the claim.

11. RA PAYMENT AMOUNT (DISPLAY ONLY)
This field displays the ERA adjustment amount for the claim.

12. COINSURANCE (DISPLAY ONLY)
This field displays the coinsurance amount associated with the insurance payment for the claim.

13. DEDUCTIBLE (DISPLAY ONLY)
This field displays the deductible amount associated with the insurance payment for the claim.

14. CO-PAY
This field displays the co-payment amount associated with the insurance payment for the claim.

15. PAT RESP
This field displays the patient responsibility amount associated with the insurance payment for the claim.

16. TOTAL CLAIM CHARGES
This field displays the amount of submitted charges for the claim.

17. SUBMITTED CHARGES PER ERA (DISPLAY ONLY)
This field contains the charges submitted to ERA.

18. RA CLAIM STATUS (DISPLAY ONLY)
The claim status code associated with this claim.

19. RA CLAIM FILING IND (DISPLAY ONLY)
This field contains the claim filing indicator associated with this claim.

20. CLAIM LEVEL REMARKS (DISPLAY ONLY)
This field contains the claim level remarks codes associated with the insurance payment for the claim.

21. CLAIM LEVEL ADJUSTMENT CODES (DISPLAY ONLY)
This field displays the adjustment group, the adjustment reason code, and the amount associated with the claim level adjustments for the insurance payment.

The following prompt is displayed:

Key `Y` to view service line information-

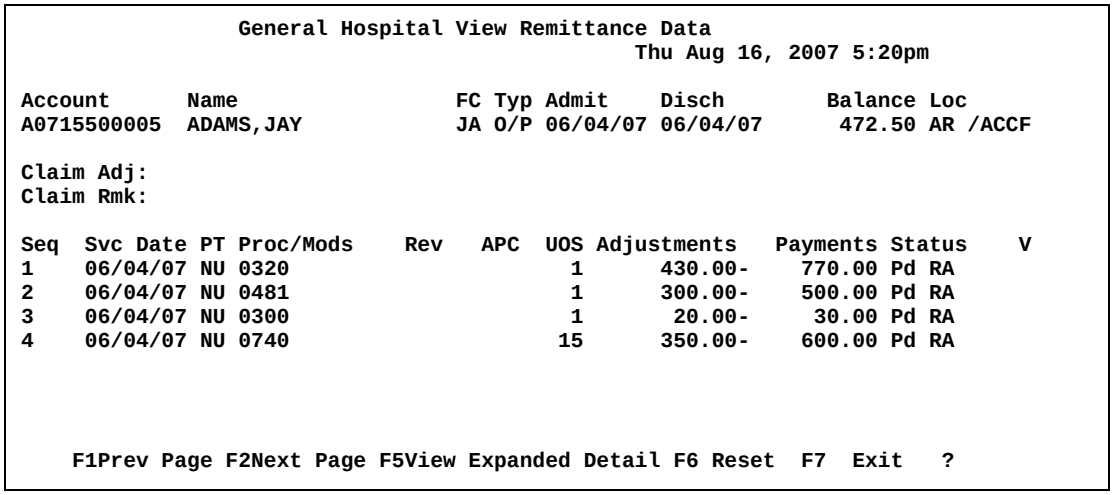
You can enter **Y** to display the service line information: The following screen shows the detail for a matched service line payment to a claim line.

```
              General Hospital View Remittance Data
                                              Thu Aug 16, 2007 5:20pm

Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,MARK            JA O/P 06/04/07 06/04/07      472.50 AR /ACCF
Seq Rev   PT  Proc Mod   APC    Serv Date    Units  SubCharges  Sts RelHCPCS
       Payment     Adjustment       Coins  Deductible     SubHCPMods   ClmHCMods
CAS Reason Codes followed by Remarks
  1       NU  0320               06/04/07        1     1200.00  M
        770.00        -430.00                                          0320
    CO*A2*430


  2       NU  0481               06/04/07        1      950.00  M
        500.00        -300.00                  150.00                  0481
    CO*A2*300 PR*1*150


  3       NU  0300               06/04/07        1       50.00  M
         30.00         -20.00                            83582        0300
    CO*A2*20



                     F1Prev Page F2Next Page F7  Exit
```

The following screen is displayed when a service line payment cannot be matched to a claim line. This can occur if the claim data is scrubbed on a 3rd party system and the changes are not sent back to STAR Patient Accounting.

```
              General Hospital View Remittance Data
                                              Thu Aug 16, 2007 5:20pm

Account      Name                 FC Typ Admit    Disch        Balance Loc
A0714300003  SMITH,BOB            JA O/P 05/23/07 05/23/07      878.00 AR /ACCF
Seq Rev   PT  Proc Mod   APC    Serv Date    Units  SubCharges  Sts RelHCPCS
       Payment     Adjustment       Coins  Deductible     SubHCPMods   ClmHCMods
CAS Reason Codes followed by Remarks
  1                                                  X
                                                                       92585



  2 0306  HC  92585              05/24/07                563.00  M
        400.00        -900.00      200.00      100.00
    CO*94*900 PR*1*100 PR*2*200 PR*3*150 PR*95*50
    N14




                     F1Prev Page F2Next Page F7  Exit
```

The final screen shown below is the Service Line (D)etail option to display a quick view of payment and adjustments received for each claim line.



```
                General Hospital View Remittance Data
                                              Thu Aug 16, 2007 5:20pm

Account      Name                 FC Typ Admit    Disch        Balance Loc
A0715500005  ADAMS,JAY            JA O/P 06/04/07 06/04/07      472.50 AR /ACCF

Claim Adj:
Claim Rmk:

Seq  Svc Date PT Proc/Mods    Rev   APC  UOS Adjustments   Payments Status    V
1    06/04/07 NU 0320                    1      430.00-    770.00 Pd RA
2    06/04/07 NU 0481                    1      300.00-    500.00 Pd RA
3    06/04/07 NU 0300                    1       20.00-     30.00 Pd RA
4    06/04/07 NU 0740                   15      350.00-    600.00 Pd RA




    F1Prev Page F2Next Page F5View Expanded Detail F6 Reset  F7  Exit   ?
```

REPORTING

Electronic Remittance Rejection Report - FXRERRR

Description/Purpose

The Electronic Remittance Rejection report (FXRERRR) is used to help track rejected payments and to document errors or warnings concerning the calculation of the contractual adjustment.

In the first section of FXRERRR titled “Rejected Payments/Adjustments,” the report displays the patient name, account number, HIC ID #, type of bill, dates of service, payment amount, adjustment amount, coinsurance amount, deductible amount, and reason the payment was rejected. Report totals appear after the list of transactions.

In the second section of FXRERRR titled “Contractual Adjustment Warnings and Errors,” the report displays patient name, account number, HIC ID #, type of bill, dates of service, payment amount, adjustment, coinsurance amount, and deductible amount, the warning or error message, the adjustment calculated by the system, and data documenting the last ERA transaction posted to the account for the ERA transaction’s insurance plan before the report was produced.

The system sorts this report into two sections, and within each section, by patient name.

The system displays the total amount of rejected payments and adjustments and the total number of rejected accounts on this report.

NOTE: The Rejection report should be used in conjunction with the Unmatched Payments Worklist to ensure that all payments from the ERA file are identified and posted.

Generating and Printing This Report

The system generates this report when an insurance cash batch is created using the Process Electronic RA function. You can also print this report using the Demand Print function.

An example of the Electronic Remittance Rejection Report is shown on the following two pages.

Figure 1.1 Electronic Remittance Rejection Report - FXRERRR (page 1)

```
Date: 06/02/05                                  General Hospital A                                    Page  : 1
Time: 14:09                          Electronic Remittance Rejection Report                          Report: FXRERRRA
                                          Rejected Payments/Adjustments
                                                  Batch: 201

Patient #     Loc  Patient Name                Type of Bill   Dates of Service   Payment Amt   Adjustment   Reason
                          HIC #                                                 Coinsurance   Deductible     Comment

A0411200010   BD   KES    ,CPTAFB                            04/21/04-04/21/04      2000.00      -300.00   Account in BD
                          HICNO                                                       0.00       300.00     Service lines present
0506600003    AR   MERT,ADMISSION                          03/07/05-03/07/05      2000.00    -14769.04   No matching claim
                          HICNO                                                       0.00       100.00     Service lines present
0506600003    AR   MET,ADMISSION                           03/07/05-03/07/05      2000.00    -14769.04   No matching claim
                          HICNO                                                       0.00       100.00     Service lines present


                                    Total Rejected Payments   :       6000.00

                                    Total Rejected Adjustments:     -29838.08

                                    Total Rejected Accounts   :             3

                                                End of Report

<Page Break>
```

Figure 1.2 Electronic Remittance Rejection Report - FXRERRR (page 2)

```
Date: 04/14/00                                    Model Hospital A                                    Page  : 2
Time: 14:51P                              Electronic Remittance Rejection Report                      Report: FXRERRRA
                                        Contractual Adjustment Warnings and Errors
                                                    Batch: 283

Patient #     Patient Name    HIC#            Type of Bill   Dates of Service   Payment Amt   Adjustment
                                                                                  Coinsurance   Deductible
          Warning/Error Message                                                 Calc ERA Cont Adj
          Reim Cont Adj   Post Date   Last ERA Trans/Cont Adj                   Last ERA Cont Adj Last ERA Calc Cont Adj  Current COB Adj

9909800004    ALLEN,LAURA       HIC #                        04/08/99-04/08/99     -2000.00      1100.00
                                                                                        0.00      -760.00
          WRN  Cont adj method mismatches previous cont adj method                        1100
               -949.20               Payment/Var**                                    -800.00                                  -800.00
Transaction                              Amount   Posted      Bill/Clm   Claim Disposition    Remittance
A0001-I/P MEDICARE PART A ALLOWANCE       -800.00  04/09/99    2/3                          980611
A0001-I/P MEDICARE PART A ALLOWANCE       1100.00  04/09/99    2/3                          980611
A0001-I/P MEDICARE PART A ALLOWANCE      -1100.00  04/08/99    1/1                          980611
A0001-I/P MEDICARE PART A ALLOWANCE       1000.00  04/08/99    1/1                          980611
A0001-I/P MEDICARE PART A ALLOWANCE        -50.80  04/08/99    1/1                          980611
A0001-I/P MEDICARE PART A ALLOWANCE       -949.20  04/08/99    1/

9909800004    ALLEN,LAURA                                    04/08/99-04/08/99      2200.00      -800.00
                                                                                        0.00       760.00
          WRN  Cont adj method mismatches previous cont adj method                        -800
               -949.20               Payment/Var**                                    -800.00                                  -800.00
Transaction                              Amount   Posted      Bill/Clm   Claim Disposition    Remittance
A0001-I/P MEDICARE PART A ALLOWANCE       -800.00  04/09/99    2/3                          980611
A0001-I/P MEDICARE PART A ALLOWANCE       1100.00  04/09/99    2/3                          980611
A0001-I/P MEDICARE PART A ALLOWANCE      -1100.00  04/08/99    1/1                          980611
A0001-I/P MEDICARE PART A ALLOWANCE       1000.00  04/08/99    1/1                          980611
A0001-I/P MEDICARE PART A ALLOWANCE        -50.80  04/08/99    1/1                          980611
A0001-I/P MEDICARE PART A ALLOWANCE       -949.20  04/08/99    1/



                                                    End of Report
```

This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system. This report is 132 characters wide.

Field Explanations

Section 1 - Rejected payments adjustments

BATCH NUMBER
This column displays the batch number of the newly created insurance cash batch.

HIC #
This column displays the patient's HIC ID #, when available in the source file.

TYPE OF BILL
This column displays the UB bill type. This data prints only for UB claims that are rejected for the following reasons: Missing Adj Trans Code or Missing Payment Trans Code. This information is not available to print for other rejected payments and does not print for professional fee claim types.

COINSURANCE
This column displays the coinsurance amount sent in the uploaded file.

DEDUCTIBLE
This column displays the deductible amount sent in the uploaded file.

REASON
This column displays the reason the account is displayed on the report. Valid reasons are:

- Account in BD
- Missing Adj Trans Code
- No Payment Transaction Code
- Account archived

COMMENTS
The following comment may print for rejected accounts:

Service lines present

This comment indicates that the rejected account has service line detail available from the 835 electronic remittance advice. The comment does not apply to payments uploaded from vendor format source files. You should make every possible effort to add payments for these accounts to the batch created for the 835 source file. The batch number is printed in the title of the report. If an exact payment amount for the

account number is manually entered into the batch, the service lines are uploaded, posted and reconciled with the claim as if it had matched the claim during the Process Electronic RA function.

Section 2 - Contractual adjustment warnings and errors

PATIENT #
This column displays the patient account number.

PATIENT NAME
This column displays the patient name.

LOC
This column indicates one of the following account locations for the patient: PA, AR, or BD.

TYPE OF BILL
This column displays the UB bill type. This data prints only for UB claims that are not professional fee claim types.

DATES OF SERVICE
This column displays the dates of service from the uploaded file sent in the payment record.

PAYMENT AMOUNT
This column displays the amount of the payment from the uploaded file sent with the payment record.

ADJUSTMENT
This column displays the amount of the adjustment sent in the uploaded file.

HIC #
This column displays the patient's HIC ID #, when available in the source file.

COINSURANCE
This column displays the coinsurance amount sent in the uploaded file.

DEDUCTIBLE
This column displays the deductible amount sent in the uploaded file.

WARNING/ERROR MESSAGE
In the second line for the ERA transaction, this column displays the condition (i.e. the warning or error) causing the account and COB to appear on the FXRERRR. If an error is found, no contractual adjustment posts unless you edit the cash batch. For a warning, the contractual adjustment determined by the system is used unless you edit the cash batch to change it. In that case, the user-edited amount appears.

The following are the potential error/warning messages that may appear when applicable:

Error Messages (Adj amounts will not post)

1. Combined takeback/payment processed already

   This ERA transaction is a combined takeback/payment, and the system will not post the adjustment since the previous ERA transaction was a combined takeback/payment for this account.

2. Takeback using variance but no payment

   This ERA transaction is a takeback using the Variance method, but an ERA payment has not been posted to this account using the new F6629 logic.

3. Second combined takeback/payment for acct and COB in file

   This ERA transaction is a second combined takeback/payment for the account and COB in the same file.

4. Second payment for acct and COB in file

   This ERA transaction is a second payment for the account and COB in the same file.

5. Second takeback for the acct and COB in file

   This ERA transaction is a second takeback for the account and COB in the same file.

6. Combined takeback/payment for cycle bill

   This ERA transaction is a combined takeback/payment for a cycle bill account; the system does not store previous ERA transaction information for cycle bill accounts.

Warning Messages (You need to review these adj amounts)

1. Variance needs reimbursement which is not posted

   No variance contractual adjustment can be determined since no contractual adjustment was posted at time of final bill by reimbursement.

2. Takeback using report but no payment using new F6629 logic

   This ERA transaction is a takeback using the Report method, and no payment has been posted to this acct using the new F6629 logic.

3. Takeback cont adj differs from reimb cont adj + variance

This ERA transaction is a takeback, and the contractual adjustment in the file does not equal the previously posted reimbursement contractual adjustment and the variance adjustment.

4. Takeback adj does not equal reim cont adj

   This ERA transaction is a takeback, and this amount does not equal the contractual adjustment that was posted at the time of final bill.

5. Takeback adj does not equal ERA cont adj

   This ERA transaction is a takeback, and the takeback adjustment amount does not equal the ERA contractual adjustment amount that was previously posted to the account.

6. Cont adj method mismatches previous cont adj method

   The contractual adjustment method defined in the Payment File Definition is different than the contractual adjustment method that was used to previously post an ERA transaction to this account.

7. Combined takeback/payment

   This ERA transaction is identified when the claim status code is 22 and a CAS reason code of B13 appears as an adjustment. In this transaction, no adjustment information appears to reverse the original contractual adjustment.

CALC ERA CONT ADJ
This column displays the amount that the system calculates as the appropriate contractual adjustment based upon the data in the ERA file. If no contractual adjustment was determined due to an error, "***" appears.

REIM CONT ADJ
When the payment's insurance plan is primary, this column displays the last reimbursement adjustment amount calculated by STAR Patient Accounting or the reimbursement adjustment amount calculated by Pathways Contract Management. STAR's calculation is based upon the user-defined information contained within the Reimbursement Master.

POST DATE
This column contains the date on which the last reimbursement adjustment was posted to the account for this payment's COB if the payment's COB is primary.

LAST ERA TRANS/CONT ADJ
This column contains information about the last ERA transaction posted to the account for this ERA transaction's insurance plan before this report was produced. The first part of this column contains the last ERA transaction type (Payment, Takeback, or Combined Payment/Takeback). The second part of this column contains the

methodology used to determine the adjustment amount. These include the four methods that can be selected by the user in the *Cont Adj Method?* field on the Payment File Definition screen to determine the adjustment amount to be posted to the account (Variance, Report, Post/Adj., No Post). In addition, the identifier, Var** or Report**, indicates the last ERA transaction was processed after a payment on a final bill was received from an electronic remittance advice, and, therefore, the contractual adjustment in the ERA file is used rather than calculating a new variance.

LAST ERA CONT ADJ
This column displays the amount of the ERA contractual adjustment posted to the account for the ERA transaction's insurance plan for the last ERA transaction before this report was produced. Typically, this is the amount determined from the ERA file. If you edited the amount in the cash batch, then the user-revised amount appears. If you did not edit the file and an error was determined when the last ERA transaction was processed, E follows this amount.

LAST ERA CALC CONT ADJ
This column displays if the calculated adjustment differs from that posted for the contractual adjustment calculated. This is for the last ERA payment or takeback posted to the account for the insurance plan of the ERA transaction before the report was produced. This occurs if the contractual adjustment in the cash batch was changed by the user or if the contractual adjustment methodology was R for Report and no contractual adjustment was indicated by the user in the cash batch.

CURRENT COB ADJ
This column displays the sum of all adjustments posted to the account for the insurance plan of the ERA transaction.

TRANSACTION
This column contains the transaction code and description for adjustments posted to the account for the insurance plan of the ERA transaction.

AMOUNT
This column contains the amount of adjustments posted to the account for the insurance plan of the ERA transaction.

POSTED
This column contains the date on which the adjustment was posted to the account for the insurance plan of the ERA transaction.

Electronic RA Audit Report - FXRERAR

Description/Purpose

The Electronic RA Audit report (FXRERAR) is used to document uploaded data from an electronic remittance advice. Also, when the contractual adjustment methodology is Yes, Variance, or Report, it provide errors or warnings about the transaction and

further detail on the contractual adjustment for takebacks and combined takeback/payments.

The audit report can be produced for the entire batch using Print Electronic RA Audit Rpt, or, using Print Electronic RA Audit Rpt/Takeback Accounts, it can be limited to include all transactions for an account if one of the transactions is a takeback or a combined takeback/payment.

The report displays the insurance batch number, payment date, account number, patient name, dates of service, claim covered charges, payment amount, contractual adjustment amount, other adjustment amount, coinsurance amount, deductible amount, days paid, DRG paid, and outlier type. If a contractual adjustment warning/error message is determined or if the variance or report method is used for contractual adjustment and the calculated contractual adjustment in the cash batch does not match that in the ERA transaction, then the error/warning message, calculated contractual adjustment amount, and bill type appear.

If the transaction is a takeback or combined takeback/payment, then reimbursement contractual adjustment, post date, last ERA transaction type and contractual adjustment method, last ERA contractual adjustment amount, last ERA calculated contractual adjustment amount, and the current COB adjustment appear so the contractual adjustment in the transaction can be verified.

This report provides an audit of payment data uploaded onto the STAR Financials Patient Accounting CPU. The report displays all uploaded data formatted for easy review. The report also allows the user to review the contractual adjustment for any takebacks or combined takeback/payments and to examine warnings or errors resulting from the contractual adjustment calculation prior to processing the batch. The analysis of the contractual adjustment for takebacks and combined takeback/payments can be simplified using the separate menu option to limit the report to accounts with a takeback or combined takeback/payment in the file.

Generating and Printing This Report

The system generates this report on demand through the Print Electronic RA Audit Report function. A subset of this report, which includes only accounts with takeback activity, can be generated on demand through the Print Electronic RA Audit Report/Takeback Accounts function.

Examples of the Electronic RA Audit Report and the Electronic RA Audit Report/Takeback Accounts appear on the following two pages.

Figure 1.3 Electronic RA Audit Report - FXRERAR

```
Date: 04/13/10                                  Model Hospital A                                  Page  : 1
Time: 15:18                                Electronic RA Audit Report                             Report: FXRERARA

                                                  Batch: J08

                                               RA:  A/MCARE/12345
                                               Payment Dt: Apr 1, 2010          Contractual Adj Method: Rev Sys Adj

Patient #    Loc Patient name        Dates of Service  Clm Cov Chgs   Payment  Contr Adj  Other Adj   Coins  Deduct Days DRG  Out
Payor Claim ID   Clm Status                          Clm Subm Chgs                                  Co-Pay Pt Resp
     Clm Disp    CAS Reason Codes
     Warning/Error Message                                          Calc Contr Adj  Bill Type
          Reim Cont Adj   Post Date   Last ERA Trans/Cont Adj       Last ERA Cont Adj  Last ERA Calc Cont Adj Current COB Adj

A1007500002  AR  ADAMS,ONE           03/16/10-03/16/10       71.86    150.00    -233.00       0.00  112.00  150.00   6  462
                 1-Processed as Primary                     710.00                                    0.00    0.00
     Partial     CO:A2:200::AA:33 PR:1:150::2:112
A1007500003  AR  ADAMS,TWO           03/16/10-03/16/10       71.86    100.00     -33.00       0.00  210.00  150.00   6  462
                 1-Processed as Primary                    1200.00                                    0.00    0.00
     Partial     CO:AA:33 PR:1:150::2:210
A1007500003  AR  ADAMS,TWO           03/16/10-03/16/10       71.86    200.00    -200.00       0.00  210.00  150.00   6  462
                 1-Processed as Primary                    1200.00                                    0.00    0.00
     Partial     CO:A2:200 PR:1:150::2:210

                      Records    Covered Charges    Payments    Adjustments   Other Adjustments   Coinsurance  Deductible

Calculated totals:          3             215.58      450.00        -466.00                0.00        532.00      450.00
Reported totals:            3            3110.00      450.00        -466.00                0.00          0.00        0.00

Variance:                   0           -2894.42        0.00           0.00                0.00        532.00      450.00

                                                                                                    Co-Pay     Pt Resp

Calculated totals:                                                                                    0.00        0.00


                                                  End of Report
```

Figure 1.4 Electronic RA Audit Report/Takeback Accounts Only Report - (FXRERAR

```
Date: 04/22/99                                    General Hospital A                                    Page  : 1
Time: 10:31am                          Electronic RA Audit Report/Takeback Accounts Only                Report: FXRERARA

                                                  Batch: 830

                                               RA: ANSI 06/98
                                               Payment Dt: Jul 8, 1998          Contractual Adj Method: Variance

Patient #    Patient name            Dates of Service  Clm Cov Chgs   Payment  Contr Adj  Other Adj   Coins  Deduct Days DRG  Out
     Warning/Error Message                                              Calc Contr Adj  Bill Type
          Reim Cont Adj   Post Date   Last ERA Trans/Cont Adj             Last ERA Cont Adj  Last ERA Calc Cont Adj Current COB Adj

A9-725200173 BROUSSARD,STELLA         09/09/97-09/09/97         0.00   -152.74     720.06       0.00 -218.20    0.00
     ERR  Unable to identify account to report previous payment
A9-812700273 FRUGE,RUFUS              05/08/98-05/08/98         0.00  -1410.74    -643.23       0.00    0.00 -764.00  -1  181
     ERR  Unable to identify account to report previous payment
A9-732800187 GIROUARD,RAY             11/24/97-11/24/97         0.00    -73.12      21.88       0.00    0.00    0.00
     ERR  Unable to identify account to report previous payment
A9-732800187 GIROUARD,RAY J           11/24/97-11/24/97         0.00     73.12     -69.88       0.00    0.00    0.00
A9-802600035 HIGGINS, JAMES           01/26/98-01/31/98         0.00   -474.55    3643.14       0.00-1024.02    0.00
     ERR  Unable to identify account to report previous payment
A9-802600035 HIGGINS, JAMES           01/26/98-01/30/98         0.00    407.64   -3574.52       0.00  992.24    0.00
A9-812800001 KESLER,KURT              05/08/98-05/08/98         0.00    -50.00     100.00       0.00    0.00 -760.00 -14   14
     WRN  Cont adj method mismatches previous cont adj method                     100.00  Adjustment
                    Errors
A9-812800001 KESLER,KURT              05/08/98-05/08/98         0.00     50.00    -125.00       0.00    0.00  760.00   1   14
     WRN  Cont adj method mismatches previous cont adj method                    -125.00  Adjustment
A9-718800267 LOPEZ,LAWRENCE           07/11/97-07/11/97         0.00  -1653.98    5760.74       0.00-1853.68    0.00
     ERR  Unable to identify account to report previous payment
A9-718800267 LOPEZ,LAWRENCE           07/11/97-07/11/97         0.00    356.40   -2811.60       0.00  792.00    0.00
A9-806300220 MILTON,PATRICK           03/09/98-03/09/98         0.00   -925.74    7016.40       0.00-1910.75    0.00
     ERR  Unable to identify account to report previous payment
A9-806300220 MILTON,PATRICK           03/09/98-03/09/98         0.00    374.80   -2924.63       0.00  736.57    0.00
A9-730700270 SHEPPARD, HOPE           11/03/97-11/19/97         0.00  -4208.36   14429.97       0.00    0.00 -760.00 -16   14
     ERR  Unable to identify account to report previous payment
A9-730700270 SHEPPARD, HOPE           11/03/97-11/19/97         0.00   4208.36  -12542.97       0.00    0.00  760.00   1   14

                      Records    Covered Charges    Payments    Adjustments   Other Adjustments   Coinsurance  Deductible

Calculated totals:         14              0.00    -3478.91        8802.91                0.00      -2485.84     -764.00
Reported totals:          492        1548197.24   581978.35     -821179.15                0.00      57988.93    56685.78

Variance:                -478       -1548197.24  -585457.26      829982.06                0.00     -60474.77   -57449.78


                                                  End of Report
```

This report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

Field Explanations

BATCH
This column displays the batch number for the insurance cash batch created from this file. If the insurance cash batch has not been created, the report prints *Unprocessed* in this field.

RA DESCRIPTION
The column displays the insurance type code and the transmission date.

PAYMENT DT
The column displays the payment date from the uploaded file.

PATIENT #
This column displays the patient's account number.

PATIENT NAME
This column displays the patient's name. For vendor files, this information does not display if the account could not be found in the STAR Financials Patient Accounting system. For 835 files, the information is obtained from the 835 file if the account could not be found on the STAR Financials PA system.

LOC
This column indicates one of the following account locations for the patient: PA, AR, or BD.

DATES OF SERVICE
This column displays the dates of service from the uploaded file sent in the payment record.

CLM COV CHGS
This column displays the amount of the claim covered charges from the uploaded file sent with the payment record.

PAYMENT
This column displays the amount of the payment from the uploaded file sent with the payment record.

CNTR ADJ
This column displays the amount of the contractual adjustment sent in the uploaded file.

OTHER ADJ
This column displays the total amount of any other adjustment(s) sent in the uploaded file. For the Electronic RA version 3051 and higher, the Electronic RA CAS Reason Codes table identifies CAS segments used to total other adjustments.

COINSURANCE
This column contains the coinsurance amount sent in the uploaded file.

DEDUCTIBLE
This column contains the deductible amount sent in the uploaded file.

DAYS
This column displays the days paid, if this information is sent in the payment file. This information prints on the report regardless of your entry to the *Outlier?* field on the Electronic RA Setup screen.

DRG
This column displays the DRG paid, if this information is sent in the payment file. This information prints on the report regardless of your entry to the *Allow DRG Paid?* field on the Electronic RA Setup screen.

OUT
This column displays the outlier type, either D (LOS) or C (cost). This information prints on the report regardless of your entry to the *Allow Outlier?* field on the Electronic RA Setup screen.

The report then displays the following totals information:

CALCULATED TOTALS
This column displays the total number of accounts, the sum of the covered charges, payments, adjustments, coinsurance and deductible amounts.

REPORTED TOTALS
This column displays the values sent in the payment file.

VARIANCE
This column displays the calculated totals minus the reported totals. If this column is not zero, there is a discrepancy between what the intermediary intended to send and what was received.

WARNING/ERROR MESSAGE

In the second line for the ERA transaction, this column displays the warning or error condition. If an error is found, no contractual adjustment posts unless you edit the cash batch. For a warning, the contractual adjustment determined by the system is used unless you edit the cash batch to change it. In that case, the user-edited amount is displayed.

The following are the potential error/warning messages that may appear when applicable:

The following are the potential error/warning messages that may appear when applicable:

Error Messages (Adj amounts will not post)

1. Combined takeback/payment processed already

   This ERA transaction is a combined takeback/payment, and the system will not post the adjustment since the previous ERA transaction was a combined takeback/payment for this account.

2. Takeback using variance but no payment

   This ERA transaction is a takeback using the Variance method, but an ERA payment has not been posted to this account using the new F6629 logic.

3. Second combined takeback/payment for acct and COB in file

   This ERA transaction is a second combined takeback/payment for the account and COB in the same file.

4. Second payment for acct and COB in file

   This ERA transaction is a second payment for the account and COB in the same file.

5. Second takeback for the acct and COB in file

   This ERA transaction is a second takeback for the account and COB in the same file.

6. Combined takeback/payment for cycle bill

   This ERA transaction is a combined takeback/payment for a cycle bill account; the system does not store previous ERA transaction information for cycle bill accounts.

Warning Messages (You need to review these adj amounts)

1. Variance needs reimbursement which is not posted

   No variance contractual adjustment can be determined since no contractual adjustment was posted at time of final bill by reimbursement.

2. Takeback using report but no payment using new F6629 logic

This ERA transaction is a takeback using the Report method, and no payment has been posted to this acct using the new F6629 logic.

3. Takeback cont adj differs from reimb cont adj + variance

   This ERA transaction is a takeback, and the contractual adjustment in the file does not equal the previously posted reimbursement contractual adjustment and the variance adjustment.

4. Takeback adj does not equal reim cont adj

   This ERA transaction is a takeback, and this amount does not equal the contractual adjustment that was posted at the time of final bill.

5. Takeback adj does not equal ERA cont adj

   This ERA transaction is a takeback, and the takeback adjustment amount does not equal the ERA contractual adjustment amount that was previously posted to the account.

6. Cont adj method mismatches previous cont adj method

   The contractual adjustment method defined in the Payment File Definition is different than the contractual adjustment method that was used to previously post an ERA transaction to this account.

7. Combined takeback/payment

   This ERA transaction is identified when the claim status code is 22 and a CAS reason code of B13 appears as an adjustment. In this transaction, no adjustment information appears to reverse the original contractual adjustment.

CALC ERA CONT ADJ
This column displays the amount that the system calculates as the appropriate contractual adjustment based upon the data in the ERA file. The field appears when the calculated ERA contractual adjustment differs from that in the ERA transaction and the variance or report method is being used to determine the contractual adjustment or a warning or error was identified for a combined takeback/transaction. If no contractual adjustment was determined due to an error, "***" is displayed.

BILL TYPE
This column displays Cycle, Final, Late, or Adjustment to identify the bill type for the claim being paid. The column appears when the calculated ERA contractual adjustment differs from that in the ERA transaction and the variance or report method is being used to determine the contractual adjustment or a warning or error was identified for a combined takeback/transaction.

The remaining columns appear in the third line in the report used when the transaction is a takeback or combined takeback/payment. One of three messages can appear rather than the third line. The third message can appear when the COB is not primary. The following are the three messages that may appear:

- ERR Unable to identify account to report previous payment
- ERR Unable to determine insurance to report previous payment
- No reimbursement information to report previous payment

REIMB CONT ADJ
When the payment's COB is primary, then this column displays the last reimbursement adjustment amount calculated by STAR Patient Accounting or the reimbursement adjustment amount calculated by Pathways Contract Management. STAR's calculation is based upon the user-defined information contained within the Reimbursement Master.

POST DATE
This column contains the date on which the last reimbursement adjustment was posted to the account for this payment's COB, if the payment's COB is primary. Note that if an ERA payment is posted using the variance method for the contractual adjustment, then subsequent reimbursement contractual adjustments for that COB from STAR Patient Account or Pathways Contract Management are calculated but not posted to the account.

LAST ERA TRANS/CONT ADJ
This column contains information about the last ERA transaction posted to the account for this ERA transaction’s COB before this report was produced. The first part of this field contains the last ERA transaction type (Payment, Takeback, or Combined Payment/Takeback). The second part of this field contains the methodology used to determine the adjustment amount. These include the four methods which can be selected by the user in the *Cont Adj Method?* field on the Payment File Definition screen to determine the adjustment amount to be posted to the account (Variance, Report, Post/Adj., No Post). In addition, the identifier, Var** or Report**, indicates the last ERA transaction was processed after a payment on a final bill was received from an electronic remittance advice, and, therefore, the contractual adjustment in the ERA file is used rather than calculating a new variance.

LAST ERA CONT ADJ
This column displays the amount of the ERA contractual adjustment posted to the account for the ERA transaction’s COB for the last ERA transaction before this report was produced. Typically, this is the amount determined from the ERA file. If you edited the amount in the cash batch, then the user-revised amount appears. If you did not edit the file and an error was determined when the last ERA transaction was processed, E follows this amount.

LAST ERA CALC CONT ADJ
This column displays if the calculated adjustment differs from that posted for the contractual adjustment calculated. This is for the last ERA payment or takeback posted to the account for the COB of the ERA transaction before the report was produced. This occurs if the contractual adjustment in the cash batch was changed by the user or if the contractual adjustment methodology was R for Report and no contractual adjustment was indicated by the user in the cash batch.

CURRENT COB ADJ
This column displays the sum of all adjustments posted to the account for the COB of the ERA transaction.

Electronic Cash Posting Audit Report - FAR121

Description/Purpose

The Electronic Cash Posting Audit report (FAR121) is used to document the insurance cash batch entries that are automatically created by the Process Electronic RA function. The report lists all cash batch entries created by processing an uploaded file. Calculated variances for contractual adjustments are included on this report.

The FAR121 report can also be expanded to contain information on the following:

- associated contractual adjustment information
- existing adjustments for the insurance.

If you would like this additional information to appear on the FAR121, the *FAR121 Adj Ind* field in the appropriate Payment File Definition should be set to contain either a C or D.

- C causes information on contractual adjustments to be reported including warning and error messages.
- D causes information on contractual adjustments to be reported including warning and error messages, and adjustment detail to appear for the COB of a transaction in the following instances:
  - if a warning/error was found
  - the takeback transaction uses the variance method
  - the combined takeback/payment uses the variance or post methodology.

A second version of the report can be produced that includes only payments with warning and error messages, if the FAR121 With Err/Wrn Only field on the ERA Payment File Definition table is set to Yes. The report layout is the same as the FAR121 report that includes errors and warnings. The report spools as the FAR121x

and displays in the spooler with *Err/Wrn* to alert you that this is the version with warnings and errors only.

This report can be sorted by patient name in alphabetical order, by ERA file sequence number order, or by batch sequence number order as defined by the FAR121 Sort field in the associated Payment File definition.

Totals are provided for the total number of payments and adjustments for the batch.

Generating and Printing This Report

The system generates this report when an insurance cash batch is created or reprocessed using the Process Electronic RA function. You can print this report using the Demand Print function.

Examples of the Electronic Cash Posting Report and the Electronic Cash Posting Report LImited to Errors/Warnings Only are displayed on the following two pages.

Figure 1.5 Electronic Cash Posting Audit Report (FAR121)

```
Date: 07/11/12                                    Model Hospital A                                          Page  : 1
Time: 17:36                          Electronic Cash Posting Audit - Batch P1K - A/PK COMM                   Report: FAR121A

Seq Cash Type      Account Trans Amount   --Date-- Remittance - Check #       Trans Description           --Paid--     F  CS# PtCls
Loc Patient Name          Contract Adj  Rev Sys Adj CA         C/A per CAS    Expected Reim              Days DRG Out
    Payor Claim ID       Clm Subm Chgs   Clm Status                           C/A Method                   Co-Pay         Pt Resp
        Accnt Bal       New Accnt Bal   Post/Pay Carrier/Plan             Ins Bal       New Ins Bal       Deductible     Coinsurance
Claim Disposition      Patient Balance   CAS Reason Codes
                                         Last ERA Trans/Cont Adj Last ERA Cont Adj  Last ERA Calc Cont Adj   Reim Cont Adj   Posted
-------------------------------------------------------------------------------------------------------------------------------------
1   Insurance 1213900001          55.55   07/11/12 12345                       COMMERCIAL INSURANCE PAYMENT                  1
 AR SMITH,BOB               100.00-d         80.00             100.00-          320.00
                                 400.00   1-Processed as Primary                Prim COB/RSA
             4.01                 51.54-  06/23/11 918100-PATRICE PCON       304.99-           360.54-
Partial Payment                  309.00   CO:18:5::A2:100:0 PI:18:5
                                                                                                          80.00-  Yes
2   Insurance 1213900001          44.44   07/11/12 12345                       COMMERCIAL INSURANCE PAYMENT                  1
 AR WHITE, GABE                 *** d                          100.00-          320.00
                                 400.00   1-Processed as Primary                Prim COB/RSA
            51.54-                95.98-  06/23/11 918100-PATRICE PCON       360.54-           404.98-
Partial Payment                  309.00   CO:18:5::A2:100:0 PI:18:5
                                                                                                          80.00-  Yes
    ERA Cont Adj Error: Second payment for account and COB in file

Transaction                              Amount   Posted      Bill/Clm   Claim Disposition    Remittance
A0049-O/P HOSPICE ALLOWANCE              100.00-  07/11/12    1/1                             12345
A0049-O/P HOSPICE ALLOWANCE              100.00-  07/11/12    1/1                             12345
A0002-O/P M'CARE B HOSPITAL ALLOW          1.00-  06/28/12    1/1
A0080-ADJUSTMENT                          80.00-  05/22/12    1/1
------------- Batch Status -------------
         Starting Balance:          0.00
Unbalanced  Total Entered:         99.99
           Cont Adj Total:          0.00
       Sup Cont Adj Total:         20.00-
             Batch Total:         99.99

C/A for COB1:      Variance*
C/A for Prim 1500: Post
C/A for Sec:       Post
C/A for PCON 1500: Rev Sys Adj*

Legend for Contractual Adjustment Call Letters:

f - Post
j - Reverse System Adj                          k - Subsequent Reverse System Adj
v - Variance                                    o - Subsequent Variance Adj
r - Report                                      c - Cycle/Cycle Adj - Report/Variance
d - Denial C/A Suppressed                       s - Subsequent Denial CA Suppressed
a - Suppressed per Claim Disposition Rule       b - Takeback for Previously Suppressed Payment

                                                        End of Report
```

Field Explanations

SEQ
This column contains the system-generated sequence assigned to the cash item in the batch.

CASH TYPE
This column specifies the cash type (for example, insurance, patient, guarantor, unapplied, or miscellaneous cash).

ACCOUNT
This column contains the patient's account number.

TRANS AMOUNT
This column contains the total dollar amount of the transaction posted for this account.

DATE
This column contains the date on which this cash item will be posted.

REMITTANCE - CHECK #
This column contains the remittance check number.

PAY DATE
This column indicates the date the payment was received.

TRANSACTION DESCRIPTION
This column contains the transaction description of the cash item.

F
This column contains Y for Yes if this transaction is a final insurance payment.

CS #
For insurance cash, this column indicates the sequence in which the claim was paid.

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

- a = alert only; follow-up is not suppressed
- c = suppression of follow-up has been cleared by a user

s = follow-up is currently being suppressed

LOC
This column indicates one of the following account locations for the patient: PA, AR, or BD.

PATIENT NAME
This column contains the patient name.

CONTRACT ADJ
This column indicates the total adjustment from ERA and provides information on calculating the contractual adjustment. This column is used if a contractual adjustment, a reported adjustment, or other adjustments exist; if an error or warning was determined for the ERA transaction; or if the method used to determine the contractual adjustment is R for Report or V for Variance.

- A V indicates that this amount is the variance between the contractual adjustment at final billing and the contractual adjustment in the electronic payment file. This amount is posted because the system assumes that the contractual adjustment known at final billing is posted at final billing.
- An R indicates that the variance is being reported only and does not post.
- A C indicates that the claim being paid was generated from a cycle bill. For payment of these claims, no variance adjustment is calculated.
- An O indicates that this ERA transaction is being processed after a payment was received in an earlier ERA transaction file for a final bill, and the Variance method was used to determine that contractual adjustment. For the current ERA transaction, the adjustment in the ERA transaction is used unless it is changed in the cash batch.
- '***' appears if an error in the contractual adjustment calculation exists to reinforce that no ERA contractual adjustment can be determined.

REV SYS ADJ CA
If the ERA Payment File Definition is defined to use the Reverse System Adjustment method, this column provides the contractual adjustment amount that will be reversed per the contractual adjustment that was posted at the time of billing.

C/A PER CAS
This field contains the adjustment amount per the CAS Reason Codes in the ERA file for this account/CLP. This amount is a total of the CAS Reason Code amounts for each CAS Reason Code.

EXPECTED REIMB
This column provides the expected reimbursement as calculated per STAR Reimbursement, PCON, OPPS, etc.

PAID DAYS
This column provides the number of DRG days paid for insurance cash.

PAID DRG
This column provides the DRG code paid for insurance cash.

OUT
This column indicates whether Day (D) or Cost Outlier (C) is used for insurance cash.

PAYOR CLAIM ID
This field displays the Payor Claim ID for the claim, which is the Facility Indicator + Account Number + Original Claim Sequence Number.

CLM SUBM CHGS
This field displays the submitted charge amount.

CLM STATUS
This field contains the Claim Status Code from the ERA file in the CLP02 record. This code corresponds back to the ERA Claim Status Code table.

C/A METHOD
This field contains the contractual adjustment method: Post, Do Not Post, Reverse System Adjustment or Variance.

CO PAY
This field displays the co-payment amount associated with the insurance payment for the claim.

PT RESP
This field displays the patient responsibility amount associated with the insurance payment for the claim.

ACCNT BAL
The current account balance.

NEW ACCT BAL
This column contains the new account balance after the cash batch is approved and takes into consideration the payment and adjustment amounts in the cash batch.

POST/PAY
This column contains the date the payment was posted.

CARRIER/PLAN
This column contains the carrier and plan number.

INS BAL
This column contains the insurance balance.

NEW INS BAL
This column contains the new insurance balance after the cash batch is approved and takes into consideration the payment and adjustment amounts in the cash batch.

DEDUCTIBLE
This column contains the amount of the insurance deductible

COINSURANCE
This column contains the amount of the insurance coinsurance.

CLAIM DISPOSITION
This column contains the claim disposition assigned to this claim for this payment. This may be assigned via defaults, parameters or the Claim Disposition Rules. The Claim Disposition Rules table also allows a payment tracking indicator to be defined so that payments can be identified as underpayments and overpayments.

PATIENT BALANCE
This column contains the current patient balance.

CAS REASON CODES
This column lists the ERA CAS Reason Codes.

LAST ERA TRANS/CONT ADJ
This column contains information about the last ERA transaction posted to the account for this ERA transaction's COB before this report was produced. The first part of this column contains the last ERA transaction type (Payment, Takeback, or Combined Payment/Takeback). The second part of this column contains the methodology used to determine the adjustment amount. These include the four methods that can be selected by the user in the *Cont Adj Method?* field on the Payment File Definition screen to determine the adjustment amount to be posted to the account (Variance, Report, Post/Adj., No Post). In addition, the identifier, 'Var**' or "Report**", indicates the last ERA transaction was processed after a payment on a final bill was received from an electronic remittance advice, and therefore the contractual adjustment in the ERA file is used rather than calculating a new variance.

LAST ERA CONT ADJ
This column displays the amount of the ERA contractual adjustment posted to the account for the ERA transaction's COB for the last ERA transaction before this report was produced. Typically, this is the amount determined from the ERA file. If you edit the amount in the cash batch, then the user-revised amount appears. If you did not edit the file and an error was determined when the last ERA transaction was processed, E follows this amount.

LAST ERA CALC CONT ADJ
This column displays if the calculated adjustment differs from that posted for the contractual adjustment calculated. This is for the last ERA payment or takeback posted to the account for the COB of the ERA transaction before the report was produced. This occurs if the contractual adjustment in the cash batch was changed by the user or if the contractual adjustment methodology was R for Report and no contractual adjustment was indicated by the user in the cash batch. An E appears in this column if an error concerning the contractual adjustment for the last transaction was reported.

REIM CONT ADJ
When the payment's COB is primary, this column displays the last reimbursement adjustment amount calculated by STAR Patient Accounting or the reimbursement adjustment amount calculated by Pathways Contract Management. STAR's calculation is based upon the user-defined information contained within the Reimbursement Master.

POSTED
This column contains a Yes or No to indicate whether or not the reimbursement contractual adjustment was posted to the account.

STARTING BALANCE
This column contains the starting balance that was entered on the set up screen.

UNBALANCED TOTAL ENTERED
This column contains the total amount entered during this batch.

CONT ADJ TOTAL
This column contains the total amount of adjustments entered for this batch. If the contractual adjustment method from the Process Electronic RA function is V, the message *Calculated Variance - will post* is displayed beside the adjustment amount. If the contractual adjustment method from the Process Electronic RA function is R, the message *Calculated Variance - will not post* is displayed beside the adjustment amount.

BATCH TOTAL
This column contains the total amount entered during this batch plus the starting balance.

The following columns only appear on the FAR121 report if the user selects C or D in the FAR121 Adj Ind field in the appropriate Payment File Definition.

Errors/Warnings

If the system uncovers an error or a warning when processing the ERA transactions, the condition is reported on the Electronic Cash Posting Audit Report (FAR121) at the bottom of the report. If an error or warning exists for an account, these are printed with each account on the Electronic Cash Posting Audit Limited to Payments with Errors/ Warnings Report (FAR121).

If an error is found, no contractual adjustment posts unless the user edits the cash batch. For a warning, the contractual adjustment determined by the system is used unless the user edits the cash batch to change it. In that case, the user-edited amount appears. For detailed explanations of each message, see page 1-152.

The following are the potential error/warning messages that may appear when applicable:

ERROR MESSAGES

- Combined takeback/payment processed already
- Takeback using variance but no payment using new F6629 logic
- Second combined takeback/payment for account and COB in file
- Second payment for account and COB in file
- Second takeback for the account and COB in file
- Combined takeback/payment for cycle bill

WARNING MESSAGES

- Variance needs reimbursement which is not posted
- Takeback using report but no payment using new F6629 logic
- Takeback cont adj differs from reimb cont adj + variance
- Takeback adj does not equal reim cont adj
- Takeback adj does not equal ERA cont adj
- Cont adj method mismatches previous cont adj method
- Combined takeback/payment
- Combined takeback/payment but no payment cont adj

The following columns only appear on the FAR121 report if the user selects D in the *FAR121 Adj Ind* field in the appropriate Payment File Definition. Detailed information appears for this insurance for all adjustments which were posted before this report was produced. The information only appears if an error or warning exists for the ERA transaction or if the ERA transaction is one of the following types:

- Takebacks/Variance
- Combined Payment/Takeback/Variance
- Combined Payment/Takeback and Post = ‘Yes’

TRANSACTION

This column contains the transaction code and description for adjustments posted to the account for the COB of the ERA transaction.

AMOUNT
This column contains the amount of the adjustments posted to the account for the COB of the ERA transaction.

POSTED
This column contains the date on which the adjustment was posted to the account for the COB of the ERA transaction.

BILL/CLM
This column contains the bill and claim sequence to which the adjustment was applied to the account for the COB of the ERA transaction.

CLAIM DISPOSITION
This column contains the disposition for the claim to which the adjustment was posted to the account for the COB of the ERA transaction.

REMITTANCE
This column contains the adjustment remittance advice number which is contained within the electronic remittance advice file or is entered by the user. It is for an adjustment posted to the account for the COB of the ERA transaction.

Electronic RA Payment Analysis Report by Account - FAR122

Description/Purpose

This report is a reconciliation report by account for each electronic remittance advice cash batch that is approved.

The report can include all accounts, or only accounts with an overall claim payment variance, or only accounts with service line payment variances. If overall claim payment variance is selected, then offsetting service line payment variances are not included if there is not claim payment variance.

The report may include all service line detail, no service line detail, or only service lines meeting selection criteria. In addition, service line detail may be concise or expanded.

The payment variance can be defined as a flat rate dollar or percentage amount at the claim level and a flat rate dollar or percentage amount at the service line level.

If the difference between the actual payment amount and the expected payment amount for the claim is greater than the claim payment dollar amount specified, the account qualifies for inclusion on the report. Actual claim payments outside the range of the specified percentage variance of the expected payment qualify as a claim payment variance for the report. For example, if the expected payment is $100.00 and the claim payment variance percentage is 10%, then payments of $90.00 through $110.00 will not qualify as variance payments for the report. Payments less than $90.00 and payments greater than $110.00 will qualify for inclusion on the report.

If the difference between the actual payment amount minus the expected payment amount for the service line is greater than to the service line payment dollar amount specified, then the service line qualifies for inclusion on the report. Service line payments outside the range of the service line percentage variance qualify for the report.

This report can be sorted by patient name or by the cash batch sequence. The report can also sort by the biller for the claim. If sorted by biller, there will be a page break for each new biller.

Generating and Printing This Report

This report is automatically generated at the time the Electronic RA cash batch is approved, if the Analysis Report Def field has been completed. The report may also be requested on demand after its approval.

Two examples of the report are shown on the following pages. The first example shows concise service line report. The second example shows expanded service line reporting.

Figure 1.6 Electronic RA Cash Batch Payment Analysis Report by Account - FAR122 (concise service line format)

```
Date: 04/17/02                                    General Hospital                                    Page  : 1
Time: 13:00                    Electronic RA Cash Batch Payment Analysis Report by Account            Report: FAR122A
                                        Batch 110 - Mcare A 06/00 Type 13 - AC


ATKINSON,ALICE        Acct#: A0204400002        Submitted Chgs    BN      Coinsurance    Deductible     Adjustments       Payment
Svc From: 02/13/2002   HIC#: 299226259B      Pd:      6,792.60   110       1,326.92                    2,822.51-     1,500.17
Svc Thru: 02/13/2002    ICN: 20129010563504  Exp:      6,792.60
Car/Plan: 100/100     BS/CS:    1/   3       BT: F   Sts:  1      Var:
 Remarks: MA01                               PT: O/P Adj:

Serv Dt    PT Proc  Mods RevCd   APC Units    Adj    Rem    Subm'd Chgs    Coinsurance    Deductible     Adjustments       Payment
02/13/02           c       250           3                        258.00
02/13/02   NU      p       255           3    CO45                258.00                        51.60          149.64          56.76
02/13/02   HC 80048        300           1                         46.00                                                     10.14
02/13/02   HC 85025        300           1                         40.00                                                     10.74
02/13/02   HC 85730        300           1                         25.00                                                      8.30
02/13/02   HC G0001        301           1                         19.00                                                      3.00
02/13/02   HC 88300c       310           1                         20.00
03/13/00   HC 88300p       310           1    CO45                 20.00                         4.00           11.60          4.40
02/13/02   HC 71010c       320           1                        168.00
03/13/00   HC 71010p       320           1    CO45                168.00                        33.60           97.44         36.96
02/13/02   HC 75961        320           1    CO45              1,381.00                       276.20          800.98        303.82
02/13/02   HC 36535        360           1                      1,755.00                       351.00                        386.10
02/13/02   NU              370          45    CO45                270.00                        54.00          156.60         59.40
02/13/02   HC 99284c       450           1                        514.00
03/13/00   HC 99284p       450           1    CO45                514.00                       102.80          298.12        113.08
02/13/02           c       610           9                        831.00
02/13/02   NU      p       621           9    CO45                831.00                       166.20          481.98        182.82
02/13/02   HC J2175        636           1                          6.55                         1.31                          1.44
02/13/02   HC J2912        636           2    CO45                 12.40                         2.48            7.19          2.73
02/13/02   NU              710           1    CO45                333.00                        66.60          193.14         73.26
02/13/02   HC 93005        730           1    CO45                 90.00                        18.00           52.20         19.80
02/13/02           c       760           1                         19.00
03/13/00   NU      p       761           1    CO45                 19.00                         3.80           11.02          4.18
02/13/02   HC 99234        762           5    CO45                243.00                        48.60          140.94         53.46

ATKINSON,COLIN        Acct#: A0204400004        Submitted Chgs    BN      Coinsurance    Deductible     Adjustments       Payment
Svc From: 02/13/2002   HIC#: 298100176D      Pd:      6,513.95   110       1,206.83                    3,353.47-     1,392.63
Svc Thru: 02/13/2002    ICN: 20128909355204  Exp:      5,947.59
Car/Plan: 100/100     BS/CS:    1/   1       BT: F   Sts: 19      Var:
 Remarks: MA01                               PT: O/P Adj:

Serv Dt    PT Proc  Mods RevCd   APC Units    Adj    Rem    Subm'd Chgs    Coinsurance    Deductible     Adjustments       Payment
02/27/02   NU              250          24    CO45                930.85                       186.17          539.89        204.79
02/27/02   HC      c       258          52                      1,729.00
02/27/02   NU      p       258          52    CO45              1,729.00                       345.80        1,002.82
```

Figure 1.7 Electronic RA Cash Batch Payment Analysis Report by Account - FAR122 (expanded service line format)

```
Time: 17:07                                    General Hospital                                    Report: FAR122A
                          Electronic RA Cash Batch Payment Analysis Report by Account
                                        Batch  97 - Mcare A 06/00 Type 13


MORGAN,CHARLENE       Acct#: A0114300007         Submitted Chgs          Coinsurance    Deductible     Adjustments       Payment
Svc From: 05/23/2001   HIC#: 275036869A      Pd:      2,927.15     Pd:                                   594.53         594.53
Svc Thru: 05/23/2001    ICN: 20129010562004  Exp:      3,107.98    Exp:                                3,107.98-
Car/Plan: 917/001     BS/CS:    1/   1       BT: F   Sts: 19      Var:                                3,702.51-
 Remarks: MA01                               PT: O/P Adj:

Serv Dt    PT Proc  Mods RevCd   APC Units                          Coinsurance    Deductible     Adjustments       Payment
05/24/01   NU              258           5    Pd:        147.90     Pd:                29.58           85.78          32.54
                                             Exp:                   Exp:
 Remarks:                                    Adj: CO45              Var:                 0.00            0.00           0.00

05/24/01   NU              270          11    Pd:        432.10     Pd:                86.42          250.62          95.06
05/24/01                   270          11    Exp:       432.10     Exp:               86.42            0.00          95.06
 Remarks:                                    Adj: CO45              Var:                              250.62-

05/24/01   HC 83540        300           1    Pd:         39.00     Pd:                                                 8.95
05/24/01   HC 83540        300           1    Exp:        39.00     Exp:                                39.00-          8.95
 Remarks:                                    Adj:                   Var:                                39.00-

05/23/01   HC 84484        300           1    Pd:         62.00     Pd:                                                13.60
05/23/01   HC 84484        300           1    Exp:        62.97     Exp:                                62.97-         13.60
 Remarks:                                    Adj:                   Var:                                62.97-

05/23/01   HC 99284 25     450           1    Pd:        591.00     Pd:                118.20          342.78         130.02
05/23/01   HC 99284        450   612     1    Exp:       591.00     Exp:               118.20          591.00-         130.02
 Remarks:                                    Adj: CO45              Var:                              933.78-

05/23/01   HC 93005        730           1    Pd:        104.00     Pd:                 20.80           60.32          22.88
05/23/01   HC 93005        730    99     1    Exp:       104.00     Exp:                20.80          104.00-         22.88
 Remarks:                                    Adj: CO45              Var:                              164.32-

05/23/01   HC 99234        762           8    Pd:        351.00     Pd:                 70.20          203.58          77.22
05/23/01   HC 99234        760           1    Exp:       351.00     Exp:                70.20          351.00-         77.22
 Remarks:                                    Adj: CO45              Var:                              554.58-

05/24/01   HC 99234        762          21    Pd:        504.00     Pd:                100.80          292.32         110.88
05/24/01   HC 99234        760           1    Exp:       504.00     Exp:               100.80          504.00-         110.88
 Remarks:                                    Adj: CO45              Var:                              796.32-
```

Field Explanations

For the claim summary information shown on both reports, the following fields are reported:

PATIENT NAME
This column displays the patient name.

ACCT#
This column displays the account number for the patient.

SUBMITTED CHGS (PD)
This column displays the amount of the claim covered charges that were paid.

SUBMITTED CHGS (EXP)
This column displays the amount of the claim covered charges that were expected.

BN (BATCH NUMBER)
This column displays the insurance cash batch number.

COINSURANCE (PD)
This column displays the coinsurance amount that was paid for the claim.

COINSURANCE (EXP)
This column displays the coinsurance amount for the service line.

COINSURANCE (VAR)
This column displays any variance between the expected and paid coinsurance amount for the claim.

DEDUCTIBLE (PD)
This column displays the amount of the deductible for the service line.

DEDUCTIBLE (EXP)
This column displays the amount of the deductible for the claim.

DEDUCTIBLE (VAR)
This column displays any variance between the deductible paid and the deductible expected amount for the claim.

ADJUSTMENTS (PD)
This column displays any adjustments that were paid for the claim.

ADJUSTMENTS (EXP)
This column displays any adjustments that were expected for the claim.

ADJUSTMENTS (VAR)
This column displays any variance between the deductible paid and the deductible expected amount for the claim.

PAYMENT PD (PD)
This column displays the payment amount for the claim.

NOTE: * an asterisk following the Payment Amount indicates the received payment does not match the expected payment.

PAYMENT (EXP)
This column displays the expected payment for the claim.

PAYMENT (VAR)
This column displays any variance between the amount paid and the amount expected to be paid for the claim.

SVC FROM
The beginning service date for the claim.

HIC#
This column displays the health insurance claim number.

SVC THRU
The ending service date for the claim.

ICN
This column displays the internal control number.

CAR/PLAN
This column displays the carrier and plan for the claim.

BT
This column displays the bill type for the claim. Bill types are: F - Final, A - Adjustment, L - Late, or C - Cycle.

STS
This column displays the status of the service line in regard to reconciliation with the claim.

REMARKS
This column displays the remarks code(s) that were entered on the claim.

PT
This column displays the type of procedure. HC indicates a HCPCS code. Blank or NU indicates a NUBC UB code.

ADJ
This column displays an adjustment amount for the claim.

For the service line expanded format, the following fields are reported. Amount fields show the expected and paid amounts and any variance between the expected and paid amounts.

SERV DT
This field displays the service date for the charge line.

PT (EXPECTED AND PAID)
This column displays the type of procedure. HC indicates a HCPCS code. Blank or NU indicates a NUBC UB code.

PROC (EXPECTED AND PAID)
This column displays the procedure code for the service line, typically the HCPCS code.

MODS (EXPECTED AND PAID)
This column displays the first two modifiers associated with the HCPCS code.

REVCD (EXPECTED)
This column displays the revenue code for the service line.

APC (EXPECTED AND PAID)
This field displays the APC code for the charge, expected and paid.

UNITS (EXPECTED AND PAID)
This field displays the units of service for this service line.

COINSURANCE (PD, EXPECTED, AND VARIANCE)
The paid, expected and variance between paid and expected are displayed for the coinsurance for the service line.

DEDUCTIBLE (EXPECTED, PAID, AND VARIANCE)
The paid, expected and variance between paid and expected are displayed for the deductible for the service line.

ADJUSTMENTS (EXPECTED, PAID, AND VARIANCE)
The paid, expected and variance between paid and expected are displayed for the adjustments for the service line.

PAYMENT (EXPECTED, PAID, AND VARIANCE)
The paid, expected and variance between paid and expected are displayed for the payment amount for the service line.

REMARKS
This column displays the remarks code(s).

For the service line concise format, the following fields are reported. Amount fields show the paid amounts in most instances. Expected amounts are reported when claim information is present without a matching payment. A lower case c (c) following the procedure code indicates that the line is reporting claim information.

SERV DT
This field displays the service date for the charge line.

PT (EXPECTED AND PAID)
This column displays the type of procedure. HC indicates a HCPCS code. Blank or NU indicates a NUBC UB code.

PROC (EXPECTED AND PAID)
This field displays the Principal Procedure Revenue Code Table code.

STATUS
This column displays the status of the service line in regard to reconciliation with the claim.

NOTE: A "c" following the procedure code indicates this is claim information that did not match to a payment. A "p" following the procedure code indicates this is payment information that did not match to a claim.

MODS
This column displays the first two modifiers associated with the HCPCS code.

REVCD
This column displays the revenue code for the service line.

APC
This field displays the APC code for the charge service line.

UNITS
This field displays the units of service for this service line.

COINSURANCE (PAID)
This field displays the coinsurance for the service line.

DEDUCTIBLE (PAID)
The deductible that was paid for the service line.

ADJUSTMENTS (PAID)
The adjustments for the service line.

PAYMENT (PAID)
This column displays the payment for the claim.

NOTE: An asterisk (*) following the Payment Amount indicates the received payment does not match the expected payment.

ERA Payment Analysis Report by Revenue Code - FAR123

Description/Purpose

This report is a reconciliation report by revenue code that is produced for each electronic remittance advice cash batch that is approved.

This report is sorted by revenue code. The report is further sorted by procedure code (without modifiers), APC code, or date as defined on the Payment Analysis Report Definition.

This report may include all service lines in the batch or only service lines with a payment variance. The service line payment variance is defined as a dollar or percentage amount at the service line level.

If the difference between the actual payment amount and the expected payment amount for the service line is greater than the service line payment dollar amount specified, then the service line qualifies for inclusion on the report. If a service line payment variance cannot be determined because expected payment information is not available at the service line level, then the report will be produced with only actual service line payment information and a variance analysis will not be provided.

Generating and Printing This report

This report is automatically generated at the time the Electronic RA cash batch is approved. It can be re-run on demand by way of the Request ERA Payment Analysis Report function. When requested on demand, this report can consolidate multiple approved cash batches into one report.

Examples of the report follow. The first example demonstrates a concise service line report. The second example demonstrates an expanded service line reporting.

Figure 1.8 ERA Payment Analysis Report by Revenue Code - FAR123 (concise service line format)

Date: 04/10/02 Model Hospital A Page : 3
Time: 13:20 ERA Payment Analysis Report by Revenue Code Report: FAR123A
Batch 108 - Mcare A 06/00 Type 13 - RC

Service: HC 84703

Account #	Name	SvcFrom	Proc	Mods	APC	Units	Adj	Submitted Chgs	Coins/Ded	Adjustments	Payment
A0128400007	JORDAN,JAMIE K	10/01/01	HC 84703			1		51.00			10.38

Service: HC 85025

Account #	Name	SvcFrom	Proc	Mods	APC	Units	Adj	Submitted Chgs	Coins/Ded	Adjustments	Payment
A0128400007	JORDAN,JAMIE K	10/01/01	HC 85025			1		46.00			10.74
A0204400004	ATKINSON,COLIN	02/06/02	HC 85025			1		36.00			10.74
A0204400002	ATKINSON,ALICE	02/13/02	HC 85025			1		40.00			10.74
A0204400004	ATKINSON,COLIN	02/13/02	HC 85025			1		36.00			10.74
A0204400004	ATKINSON,COLIN	02/21/02	HC 85025			1		36.00			10.74

Service: HC 85384

Account #	Name	SvcFrom	Proc	Mods	APC	Units	Adj	Submitted Chgs	Coins/Ded	Adjustments	Payment
A0128400007	JORDAN,JAMIE K	10/01/01	HC 85384			1		48.00			11.74

Service: HC 85651

Account #	Name	SvcFrom	Proc	Mods	APC	Units	Adj	Submitted Chgs	Coins/Ded	Adjustments	Payment
A0204400004	ATKINSON,COLIN	02/06/02	HC 85651			1		23.00			4.91
A0204400004	ATKINSON,COLIN	02/13/02	HC 85651			1		23.00			4.91
A0204400004	ATKINSON,COLIN	02/14/02	HC 85651			1		23.00			4.91

Figure 1.9 ERA Payment Analysis Report by Revenue Code - FAR 123 (expanded service line format)

```
Date: 01/23/02                                  General Hospital                                    Page  : 2
Time: 10:27am                          ERA Payment Analysis Report by Revenue Code                 Report: FAR123A



Revenue Code: 222
Service: 02/18/96 01772

Serv Dt   PT Proc  Mods  RevCD   APC Units      Submitted Chgs          Coinsurance   Deductible    Adjustments      Payment
02/20/96  HC 01770 1 2     222  0012   23 Sub'd:      100.00    Act:         10.00         5.00          20.00        50.00
          HC 01770  2     222  0012   23 Chg:        100.00    Exp:
                                                                Var:

 Patient:   A0109200013  O'BRIEN,FRED
 Remarks:                                                                          Adjustments:         20.00

Revenue Code: 232
Service: 02/18/96 01772

Serv Dt   PT Proc  Mods  RevCD   APC Units      Submitted Chgs          Coinsurance   Deductible    Adjustments      Payment
02/18/96  HC 01772 1 2     232  0012   23 Sub'd:    100.00    Act:         10.00         5.00          20.00        50.00
          HC 01772 1 2    232  0012   23   Chg:    100.00    Exp:
                                                                Var:

 Patient:   A0109200013  O'BRIEN,FRED
 Remarks:                                                                          Adjustments:         20.00

                                                  End of Report
```

Field Explanations

For Field explanations, refer to "Field Explanations" on page 1-177. These are the Field Explanations for the ERA Payment Analysis Report by Account.

Electronic RA Payment Analysis Report Parameters Report - FTFERR

Description/Purpose

This report provides a detailed listing of the Payment Analysis Reports Definitions that are created. The system sorts this report in code or description order.

Generating and Printing This Report

This report is requested through the ERA Payment Analysis Report Definition table. After you access a user-defined code for the report, the system displays the screens used in the table build process. When you exit this function, the system displays the following prompt:

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

Enter **Y** if you want to generate the report. The system references the spooler report definition to determine if the report is printed immediately or on demand and what printer is used for output.

The following is an example of the report.

Figure 1.10 ERA Payment Analysis Report - FTFERR

```
Date: 05/15/05                                  General Hospital                                  Page  : 1
Time: 11:58am                                ERA PAYMENT ANALYSIS REPORT                          Report: FTFERR


Code/Desc: 1-FIRST ONE

Report by             : Account                                  Acct Loc:                          : AR,BD
Sort of Accounts      : Biller, Patient Name                     Claim Payment Variance Amount      :
Sort of Detail        : Revenue Code, HCPCS, Date                Claim Payment Variance Percentage  :
Service Line Print Sel: All service lines                        Svc Line Payment Variance Amount   :         $10.00
Service Line Format   : Concise                                  Svc Line Payment Variance Percent  :           10.0%
Claim Status (CLP04)  : 4                                        Claim Filing Indicator (CLP06)     : MA
Edit by               : Sanders,Sheila M                         Edit Date/Time                     : 01/14/02 06:35pm
Status                : Active


Service Line Limits    Type     Selections
--------------------   -------  ------------------------------------------------------------------------------------
--------------
Revenue Codes          Include  320,360
CAS Adj Reason Codes   Include  123,19,36,45,46,55,97,A2,A20,B13
Adj Group Codes        Exclude  PI,PR
Remarks Codes          Include
APC Codes              Include  00800-00899
HCPCS Codes            Exclude  96000-99999
Mismatched Svc Lines   Amount, HCPCS, Service Date
```

Field Explanations

CODE
This field displays the code for the ERA Payment Analysis Report Definition entry.

DESCRIPTION
This field contains a description of the ERA Payment Analysis Report Definition Entry.

REPORT BY
This field defines whether the ERA Payment Analysis Reportis printed by Account or by Revenue Code.

ACCT LOC
This field defines the account location for the patient. Valid values are PA, AR or BD.

SORT OF ACCOUNTS
This field defines the order of the accounts on the ERA Payment Analysis Report by Account, FAR122. The sort options are as follows:

(1) Biller, Patient Name
(2) Biller, Patient Number
(3) Patient Name
(4) Patient Number
(5) Cash Batch Sequence

SORT OF DETAIL
This field determines the order the service line detail prints on the ERA Payment Analysis Report.

- If the Report By field is set to Account, the following options display:

  (1) Revenue Code, HCPCS, Date
  (2) Revenue Code, Date, HCPCS
  (3) Date, Revenue Code, HCPCS
  (4) Date, HCPCS, Revenue Code
  (5) HCPCS, Revenue Code, Date
  (6) HCPCS, Date, Revenue Code
  (7) APC, Date, Revenue Code
  (8) APC, Revenue Code, Date
- If the Report By field is set to Revenue Code, the following options display:

  (1) HCPCS, Date
  (2) Date, HCPCS

(3) APC, Date

(4) Date, APC

SVC LINE PRINT SELECTION
This field identifies which service lines are to be printed on the ERA Payment Analysis Report by Account and the ERA Payment Analysis Report by Revenue Code. The options are: all service lines, no service lines, and selected service lines (O).

SERVICE LINE FORMAT
This field identifies the format of the service lines that print on the ERA Payment Analysis Report by Account. Options are Concise or Expanded.

STATUS
This field defines the status of the ERA Payment Analysis Report Definition code, either Active or Inactive.

CLAIM PAYMENT VARIANCE AMOUNT
This field identifies the dollar amount for the claim payment variance calculation and is included if the Report By field is set to Account. This calculation is limited to payments for claims where the OPPS or EAPG interface was used to estimate reimbursement.

CLAIM PAYMENT VARIANCE PERCENTAGE
This field identifies the percentage amount for the claim payment variance calculation and is included if the Report By field is set to Account. This calculation is limited to payments for claims where the OPPS or EAPG interface was used to estimate reimbursement.

SVC LINE PAYMENT VARIANCE AMOUNT
This field identifies the dollar amount for the service line payment variance calculation.

SVC LINE PAYMENT VARIANCE PERCENTAGE
This field identifies the percentage amount for the service line payment variance calculation.

CLAIM STATUS
This field defines the accounts selected based on the ERA Claim Status returned in the Electronic Remittance Advice in CLP04.

CLAIM FILING INDICATOR
This field defines the accounts selected based on the ERA Claim Filing Indicator returned in the Electronic Remittance Advice in CLP06.

The next section of the report contains the selections for Service Line Limits. Options are Include, Exclude, or None. The options are:

Revenue Codes

CAS Adj Reason Codes

Remarks Codes

APC Codes

HCPC Codes

Mismatched Service Lines

ERA CAS Reason Code Table Report - FTFERC

Description/Purpose

This report provides a detailed listing of the ERA CAS Reason Codes and the exceptions by ERA Claim Adjustment Group. The report is sorted in code or description order and spools to FIN in the spooler.

Generating and Printing This Report

This report can be requested when exiting the ERA CAS Reason Code Table.

The following is an example of the report.

Figure 1.11 ERA CAS Reason Code Table Report - FTFERC

```
Date: 04/20/10               General Hospital                 Page  : 1
Time: 15:03                  ERA CAS REASON CODES             Report: FTFERC

Code Description                    Adj Type     Incl in Pymt Claim Disp
Line 1 for Long Description
Line 2 for Long Description
  LQ02        Remark Description                                  Clm Disp

36   Balance does not exceed co-pay Trans Note
LN#1: Balance does not exceed co-pay
LN#2:

35   Benefit maximum reached        Contractual
LN#1: Benefit maximum reached
LN#2:

45   Charges exceed fee arrangement Contractual  Co-Pay
LN#1: Charges exceed fee arrangement
LN#2:
  M15         Separately billed svcs/tests have been bundled/Separate Denied
 PR   Patient Responsibility         Trans Note

42   Chgs exceed fee sched/max amt  Denial                   Partial Payme
LN#1: Chgs exceed fee sched/max amt
LN#2:
 OA   Other Adjustments              Contractual
 PR   Patient Responsibility         Trans Note

A1   Claim Denied Charges          Contractual              Denied
LN#1: Claim Denied Charges
LN#2:
  M135        Claim lacked indication that the plan of treatment is o Denied
  M136        Claim lacked indication that svc was supervised/evaluat Denied
  N54         Claim information is inconsistent with pre-certified/au Partial
```

Field Explanations

CODE
This column lists the ERA CAS Reason Code.

DESCRIPTION/EXCEPTION
This column lists the description of the ERA CAS Reason Code. This column also lists the description of each ERA Adjustment Group exception that exists for the ERA CAS Reason Code.

ADJ TYPE
This column lists the Type of Adjustment for the ERA CAS Reason Code. Values are Contractual, Other, or Transaction History Notation (Trans Note).

This column also lists the Type of Adjustment for each Group exception that exists for the CAS Reason Code. Values are Contractual, Other, Transaction History Notation (Trans Note), and None.

INCLUDE IN PAYMENT
This field lists the items that are included in the calculation for the payment transaction from the ERA file. The items are deductible, coinsurance, co-pay, and payment responsibility.

ERA Remarks Code Table Report - FTFERM

Description/Purpose

This report provides a detailed listing of the ERA Remarks Codes. The report is sorted in code order.

Generating/Printing This Report

This report is generated on demand.

Following is an example of the report.

Figure 1.12 ERA Remarks Code Table Report - FTFERM

```
Date: 04/20/10                                  STAR Development System                                  Page  : 1
Time: 15:08                                        ERA REMARKS CODES                                     Report: FTFERM

CODE  DESCRIPTION
Line 1 for Long Description                     Line 2 for Long Description

MA95  A "not otherwise classified/unlisted" proc billed
A "not otherwise classified/unlisted" proc billed      Item 19 HCFA-1500

N73   A SNF is resp for pymt of outside prov of these
A SNF is resp for pymt of outside prov of these        svcs/supplies

MA101 A SNF is responsible for payment of outside
A SNF is responsible for payment of outside            providers

N86   A failed trial of pelvic muscle exercise training
A failed trial of pelvic muscle exercise training      is required

N93   A separate claim must be submitted for each place
A separate claim must be submitted for each place      of service

N9    Adjustment represents the estimated amt the
Adjustment represents the estimated amt the            primary payer may have pd

MA132 Adjustment to the pre-demonstration
Adjustment to the pre-demonstration                    rate

N2    Allowance made in accordance w/most appropriate
Allowance made in accordance w/most appropriate        course of treatment

M75   Allowed amount adj/ Multiple automated
Allowed amount adj/ Multiple automated                 multichannel tests same day

M112  Approved amt based on max allow under DMEPOS Comp
Approved amt based on max allow under DMEPOS Comp      Bidding Demo

MA45  As previously advised, a portion or all of pymt
As previously advised, a portion or all of pymt        held in special acct

N41   Authorization request denied (inactive effective
Authorization request denied (inactive effective       with 4010)
```

Field Explanations

CODE
This column lists the ERA Remarks Code.

DESCRIPTION
This column lists the description of the ERA Remarks Code.

INACTIVE
This column appears when requesting the report to include entries filed as deleted. This column displays **Yes** if the ERA Remarks Code has been filed as deleted.

Cash Posting Exception Report - FAR140

The system creates this report as a result of approving a cash batch. The report can be obtained following Midnight Processing.

The report contains an entry if the contractual adjustment posted to the account is greater than or equal to the carrier balance (after the payment). The contractual adjustment sent by the intermediary forces an insurance transfer on the account. This is valid only for Electronic RA cash batches. The system displays the message *RA Adj forced bal xfer of $[9,999,999.99]*, where 9,999,999.99 is the transferred amount.

ERA Batch Balancing Report - FXRERABB

Description/Purpose

This report is produced for each ERA ANSI 835 file where multiple batches are created.The intent of the report is to aid in balancing across batches so all dollars can be accounted for. The report provides payment and adjustment totals from the ERA file, totals for each batch created, along with a total for all created batches. The total from all batches can be compared with the totals from the ERA file. There may be multiple detail lines from the ERA file, as there may be multiple TS309 or BPR02 records. If there are multiples, each line is displayed, and an ERA File Totals line is displayed at the bottom of the report. This totals line is for the entire file.

NOTE: This report is not created for Vendor format files.

The report is not facility specific, as batches are created for facilities based upon split criteria.

There is a grand total for all cash batches and worklist items, as this total is compared to the ERA file totals at the bottom of the screen. If there are multiple TS3 or BPR records, totals are listed from each and compiled into the grand total for the ERA file at the bottom of the report.

For worklist items, the contractual adjustment amount is from the ERA file. This is if the variance or reverse system adj methods are used, as the system does not know what amounts to reverse or how to calculate a variance until the payment is matched to a claim.

There is an option to delete entries from the Unmatched Payments Worklist for entries that cannot be matched or incomplete entries from the ERA file. All deleted worklist entries are accounted for on the FXRERABB report. These entries are displayed just below those accounts/payments that are in the worklist.

NOTE: If an ERA file splits into many batches for multiple facilities, it may be more difficult to balance the batches back to the ERA file. McKesson recommends that minimal split criteria are defined so as to reduce the number of batches created.

Generating/Printing This Report

The report is produced automatically upon creation of the cash batches. The report can be generated on demand from the Account Transactions Report menu.

Following is an example of the report.

Figure 1.13 ERA Batch Balancing Report - FXRERABB

```
Date: 04/13/10                                    Model Hospital A                                    Page  : 1
Time: 15:18                                  Electronic RA Audit Report                               Report: FXRERARA

                                                     Batch: J08

                                                  RA:  A/MCARE/12345
                                                  Payment Dt: Apr 1, 2010              Contractual Adj Method: Rev Sys Adj

Patient #    Loc Patient name        Dates of Service  Clm Cov Chgs   Payment  Contr Adj  Other Adj   Coins  Deduct Days DRG  Out
Payor Claim ID   Clm Status                           Clm Subm Chgs                                 Co-Pay Pt Resp
     Clm Disp    CAS Reason Codes
     Warning/Error Message                                                 Calc Contr Adj  Bill Type
          Reim Cont Adj   Post Date   Last ERA Trans/Cont Adj              Last ERA Cont Adj  Last ERA Calc Cont Adj Current COB Adj

A1007500002  AR  ADAMS,ONE           03/16/10-03/16/10        71.86    150.00    -233.00       0.00  112.00  150.00   6  462
                 1-Processed as Primary                      710.00                                      0.00    0.00
     Partial     CO:A2:200::AA:33 PR:1:150::2:112
A1007500003  AR  ADAMS,TWO           03/16/10-03/16/10        71.86    100.00     -33.00       0.00  210.00  150.00   6  462
                 1-Processed as Primary                     1200.00                                      0.00    0.00
     Partial     CO:AA:33 PR:1:150::2:210
A1007500003  AR  ADAMS,TWO           03/16/10-03/16/10        71.86    200.00    -200.00       0.00  210.00  150.00   6  462
                 1-Processed as Primary                     1200.00                                      0.00    0.00
     Partial     CO:A2:200 PR:1:150::2:210

                      Records    Covered Charges    Payments    Adjustments   Other Adjustments   Coinsurance  Deductible

Calculated totals:          3             215.58      450.00        -466.00                0.00        532.00      450.00
Reported totals:            3            3110.00      450.00        -466.00                0.00          0.00        0.00

Variance:                   0           -2894.42        0.00           0.00                0.00        532.00      450.00

                                                                                                     Co-Pay     Pt Resp

Calculated totals:                                                                                     0.00        0.00


                                                     End of Report
```

Field Explanations

BATCH/FILE IDENTIFIER
This field displays the batch and file identifiers.

TOTAL # OF PAYMENTS
This field displays the total number of payments received in the payment file.

TOTAL PAYMENTS
This field displays the total dollars for payments received in the payment file.

TOTAL CONT ADJ
This field displays the contractual adjustment totals received in the payment file.

OTHER CONT ADJ
This field displays the totals for other contractual adjustments that are defined in the CAS Reason Code table.

COMBINED BATCH TOTALS
This field displays the totals all batches in the payment file, for the number of payments, total payments, total contractual adjustments, and other contractual adjustments.

UNMATCHED PAYMENTS WORKLIST
This field displays, by patient account, the number, payment total, and contractual adjustment totals for unmatched payments that were placed in the Unmatched Payments Worklist.

PAYMENTS DELETED FROM WORKLIST
This field displays, by patient account, the number, payment total, and contractual adjustment totals for unmatched payments that were deleted from the Unmatched Payments Worklist.

BALANCING RECORDS FOR ERA FILE
This field displays the total number of payments, payment total, and contractual adjustment totals for the TS3 and BPR segments of the file.

Totals for each batch are displayed, but totals from the ERA file are derived from the following segments.

TS304 - Total # of records

TS309 or BPR02 (as defined in ERA PFD table) - Total Provider Payments

TS311 - Total Contractual Adjustments

PLB TOTAL (DISPLAY ONLY)
This field displays, for the batch, the number, payment total, and contractual adjustment totals of all claims in the PLB record in the file.

ERA Unmatched Payments Worklist Report - FXRERAWL/FXRERAWE

Description/Purpose

These reports show accounts and payments that are in the Unmatched Payments Worklist.

Generating/Printing This Report

The reports can be generated in summary and detail view:

- The summary view (FXRERAWL) displays the ERA file information along with the patient account number, name, claim dates, payment amount and reason included in the worklist. The report is not facility specific, as worklist entries are not tied to a facility code. The report includes a payment total along with the total number of entries remaining in the worklist.

- The detail report (FXRERAWE) displays an expanded view of accounts/payments in the worklist. The report uses the same layout as the detail in the FXRERAUWL report for the worklist entries along with the ERA file information at the top of the report. This report is also not facility specific, as worklist entries are not tied to a facility. The intent of this report is to provide enough detail for these unmatched payments so if these are for another facility, the report may be handed off for posting outside of STAR.

- Both reports are generated from the Unmatched Payments Worklist function and when the ERA file is processed through the Process Electronic RA function.

Following is an example of each report.

Figure 1.14 ERA Unmatched Payments Worklist Report (FXRERAWL)

```
Date: 12/19/07                              STAR Development System                              Page  : 1
Time: 09:46am                       ERA Unmatched Payments Worklist Report                     Report: FXRERAWL


                                                  RA: MEDICARE
                                          Payment Dt: Dec 19, 2007
                                        File Upload Dt: Dec 19, 2007

                                      Total # of Payments    Total Payments      Total Cont Adj     Other Cont Adj
Batch Z56      A/ MEDICARE /Unmatched Pymt
Batch Z57     A/ MEDICARE /0009/U                    1             $3,000.00                              -$25.00
Batch Z58      A/ MEDICARE /Prov Adj                 2                $1,000.00

Pt Ctrl #      Name from File                From/Thru Date         Payment Amount      Reason
0832100001     MASON,JONATHAN                11/17/06 - 11/17/06          $100.00      Account not found
0832100002     MASON,JONATHAN                11/17/06 - 11/17/06          $100.00      Account not found
0832100003     JACKSON,JOE                   11/17/06 - 11/17/06          $100.00      Account not found
0832100004     MORGAN,WILLIAM                11/17/06 - 11/17/06          $100.00      Account not found
0832100005     MILLS,ROGER                   11/17/06 - 11/17/06          $100.00      Account not found
0832100006     MILLER,HEATHER                11/17/06 - 11/17/06          $100.00      Account not found
0832100007     WARING,BRIAN                  11/17/06 - 11/17/06          $100.00      Account not found
0832100008     WALTER,LYNNE                  11/17/06 - 11/17/06          $100.00      Account not found

Worklist Total # of Entries :            8
Worklist Total Payments :          $800.00

      PLB Amounts   PLB Records
```

Field Explanations

PT CTRL #
This field displays the patient's account number, which is the visit-specific number assigned to the patient.

BATCH/FILE IDENTIFIER
This field displays the batch and file identifiers.

TOTAL # OF PAYMENTS
This field displays the total number of payments received in the payment file.

TOTAL PAYMENTS
This field displays the total dollars for payments received in the payment file.

TOTAL CONT ADJ
This field displays the contractual adjustment totals received in the payment file.

OTHER CONT ADJ
This field displays the totals for other contractual adjustments that are defined in the CAS Reason Code table.

FROM/THRU DATES
This column displays the dates of service from the uploaded file sent in the payment record.

PAYMENT AMOUNT
This column displays the amount of the payment from the uploaded file sent with the payment record.

ADJUSTMENT
This column displays the amount of the adjustment sent in the uploaded file.

REASON
This column displays the reason the account is displayed on the report, such as Account Not Found.

WORKLIST TOTAL # OF ENTRIES
This column displays the total number of payments listed in the Unmatched Payments Worklist.

WORKLIST TOTAL PAYMENTS
This column displays the total amount of payments listed in the Unmatched Payments Worklist.

Figure 1.15 ERA Unmatched Payments Worklist Report (FXRERAWE)

```
Date: 12/19/07                                  General Hospital                                  Page  : 1
Time: 09:46am                  ERA Unmatched Payments Worklist Report - Expanded                  Report: FXRERAWE


                                                RA: MEDICARE
                                            Payment Dt: Dec 19, 2007
                                          File Upload Dt: Dec 19, 2007

                                          Total # of Payments    Total Payments       Total Cont Adj      Other Cont Adj
Batch Z56      A/MEDICARE/Unmatched Pymt
Batch Z57      A/MEDICARE/0009/U                        1              $3,000.00            -$275.00             -$25.00
Batch Z58      A/MEDICARE/Prov Adj                      2              $1,000.00

Patient #         Patient Name                    Dates of Service          Payment    Adj per CAS            Coins      Deductible
                  Clm Status                                          Clm Sub Chgs                          Co-Pay       Pat Resp
                                                                      Remarks                CAS Reason Codes
Procedure         Dates of Service  Sub Chg & Qty             Payment  Remarks                CAS Reason Codes

0832100001        MASON,JONATHAN                  11/17/06-11/17/06         100.00         260.00             4.00            6.00
                  1-Processed as Primary                                    239.35                                           10.00
                                                                      MA02                   CO:OTH:25.00
                                                                                             CO:A2:100.00
                                                                                             CO:PMP:1
                                                                                             CO:2:2
                                                                                             CO:1:3
                                                                                             CO:AA:4
HC 11000          11/17/06-11/17/06       63.26       8        50.00                       CO:A2:100.00
                                                                                             CO:PMP:1
                                                                                             CO:2:2
                                                                                             CO:1:3
                                                                                             CO:AA:4
HC 11001          11/17/06-11/17/06       80.00       1        20.00                       CO:A2:20
HC 11001          11/17/06-11/17/06       80.00       1        20.00                       CO:A2:20
HC 11004          11/17/06-11/17/06       16.09       1         5.00                       CO:A2:20
```

Field Explanations

BATCH/FILE IDENTIFIER
This field displays the batch and file identifiers.

TOTAL # OF PAYMENTS
This field displays the total number of payments received in the payment file.

TOTAL PAYMENTS
This field displays the total dollars for payments received in the payment file.

TOTAL CONT ADJ
This field displays the contractual adjustment totals received in the payment file.

OTHER CONT ADJ
This field displays the totals for other contractual adjustments that are defined in the CAS Reason Code table.

PATIENT #
This column displays the patient's account number.

PATIENT NAME
This column displays the patient's name. For vendor files, this information does not display if the account could not be found in the STAR Financials Patient Accounting system. For 835 files, the information is obtained from the 835 file if the account could not be found on the STAR Financials PA system.

DATES OF SERVICE
This column displays the dates of service from the uploaded file sent in the payment record.

PAYMENT
This column displays the amount of the payment from the uploaded file sent with the payment record.

CNTR ADJ
This column displays the amount of the contractual adjustment sent in the uploaded file.

OTHER ADJ
This column displays the total amount of any other adjustment(s) sent in the uploaded file. For the Electronic RA version 3051 and higher, the Electronic RA CAS Reason Codes table identifies CAS segments used to total other adjustments.

COINSURANCE
This column contains the coinsurance amount sent in the uploaded file.

DEDUCTIBLE
This column contains the deductible amount sent in the uploaded file.

ERA PLB REPORT (FXRERAPLB)

Description/Purpose

This report provides the ability to tie a PLB segment back to an account via the information in the CLP07 record. The report will also display PLB segment reason codes and amounts.

The report information is sorted by the check number (TRN02), by the adjustment reason code (PLBxx-01), by Provider Identifier (PLB01), by Provider Adjustment Identified (PLBxx-02), and by Date (PLB02).

Adjustment reason codes can be excluded from the report by specifying the ones to exclude in the Adjustment Reason Codes to Exclude from FXRERAPLB field on the fourth screen for the ERA Payment File Definition table.

Generating/Printing This Report

This report spools automatically as a by-product of the ERA upload process. When matches are found, these are included in the report. The report is not split by facility.

Two versions of the report will be produced. The second version of report may be downloaded into Excel or similar software packages. For the Excel report, the fields will be delimited by semicolons so they may translate into columns in Excel. The user may then size the columns, hide columns, etc. in Excel.

The following is a sample of the report:

Figure 1.16 ERA PLB Report (FXRERAPLB)

```
Date: 09/14/12                                  General Hospital                                  Page  : 1
Time: 11:27                                    ERA PLB Report                                  Report: FXRERAPLB


                                                RA: COMM PAYOR
                                            Payment Dt: Sep 14, 2012
                                          File Upload Dt: Sep 14, 2012


Check Amount from BPR02=100.00
Check Number from TRN02=123412341234

Prov#                                Date      Adj Rsn Cd/Provider Identifier                                    Adj Amt
  CLP01/Acct#    Name                              Clm St       Claim Amount  Payment Amount  DTM Dates
123                                  20120601   BD;20090223 0904200397                                            50.00
123                                  20120601   CA;20090223 0904200397                                           100.00
123                                  20120601   FB;112233                                                        -10.00
  A1213500003    ADAMS,CANDY                       1                  650.00          100.00  05/14/12-05/14/12
123                                  20120601   LS;333555                                                      -5000.00
123                                 20120601   WO;20090223 0904200397                                            20.00

Grand Total                                                                                                    -4840.00

                                                End of Report
```

Field Explanations

CHECK AMOUNT FROM BPR02
The PLB transaction check amount from BPR02.

CHECK NUMBER FROM TRN02
The PLB transaction check number from TRN02.

PROV #
This field contains the provider adjustment identifier.

DATE
This field contains the date of the adjustment.

ADJ RSN CD/PROVIDER IDENTIFIER
This field contains the Provider Level Adjustment Reason code and the provider identifier.

ADJ AMT
This field contains the adjustment amount.

CLP01/ACCT#
This field contains the account number in the CLP01 segment.

NAME
This field contains the patient's first and last name.

CLM ST
This field contains the Claim Status Code from the ERA file in the CLP02 record. This code corresponds back to the ERA Claim Status Code table.

CLAIM AMOUNT
This field contains the claim amount from the CLP03 record in the ERA file.

PAYMENT AMOUNT
This field displays the insurance payment amount from the CLP04 record in the ERA file.

DTM DATES
This field contains the beginning and ending service dates from the ERA file.

SUBTOTAL
This field contains the subtotal of payment amounts from the PLB segments.

GRAND TOTAL
This field contains the grand total of payment amounts from the PLB segments.

ERA ASSIGNED CLAIM DISPOSITION REPORT (FXRERACD)

Description/Purpose

Users can assign a claim disposition based upon CAS Reason code. They can use this report to see what dispositions have been assigned before approving ERA cash batches. This report shows what disposition has been assigned by the system. Users still have the ability to change the system-assigned disposition by editing the cash batch before it is approved/posted.

A second report (FXRERACDM) will also show only those accounts with multiple payments in the same batch. This subset report will include takebacks and is automatically generated when the batches are created.

This report displays what claim disposition was selected, along with a message as to why the claim disposition was selected. These messages are based upon the options selected in the ERA PFD table. The following are potential messages for the report:

Partial: No expected reimbursement available

Partial: Default Claim Disposition

Denied: Default Claim Disposition

Denied: Denied per Claim Status code

Partial: CAS Reason Code 'x'

Denied: CAS Reason Code 'x'

Note: for CAS Reason Code the 'x' will be replaced with the code that caused the assignment of the disposition.

On both of these reports the CAS Reason codes will be totaled (if multiples appear for the same code) in order to limit the data on this report. Users will still have access to the Remittance Data or other reports to see the full detail. For example if there are 2 or more instances of a CAS*CO*42 then the amounts and quantities will be summed.

CAS*CO*42*112*1

CAS*CO*42*113*1

Will display on the report as:

CAS*CO*42*225*2

Generating the Report

The ERA Claim Disposition Assignment report will be automatically created as soon as the batches are created from the ERA process. Each time an ERA file is uploaded and processed into batches this report will be automatically generated. If batches are reprocessed then the report will be automatically generated again. The report will be queued as FXRERACDY% and users may define in Reports Maintenance how long to keep this report available. Users will select the report for viewing/printing by selecting the appropriate batch number along with the ERA PFD description (in the Comment). The report will sort as the order of the payments listed in the ERA cash batch.

Following is a sample of the reports.

Figure 1.17 ERA Assigned Claim Disposition Report (FXRERACDx)

```
Date: 07/11/12                                    Model Hospital A                                          Page  : 1
Time: 17:36                    ERA Assigned Claim Disposition Rpt - Batch P1K - A/PK COMM                    Report: FXRERACDA

Seq Cash Type      Account Trans Amount   --Date-- Remittance - Check #       Trans Description           --Paid--     F  CS# PtCls
Loc Patient Name           Contract Adj  Rev Sys Adj CA         C/A per CAS    Expected Reim              Days DRG Out
    Payor Claim ID        Clm Subm Chgs   Clm Status                          C/A Method                   Co-Pay          Pt Resp
        Accnt Bal         New Accnt Bal   Post/Pay Carrier/Plan            Ins Bal       New Ins Bal       Deductible     Coinsurance
Claim Disp Assigned     Patient Balance   CAS Reason Codes
-------------------------------------------------------------------------------------------------------------------------------
1   Insurance 1213900001          55.55   07/11/12 12345                      COMMERCIAL INSURANCE PAYMENT                   1
 AR SMITH,STEVE                100.00-d         80.00              100.00-          320.00
                               400.00   1-Processed as Primary                  Prim COB/RSA
              4.01              51.54-  06/23/11 918100-PATRICE PCON       304.99-          360.54-
Partial Payment                309.00 Default Claim Disposition
                                      CO:18:5::A2:100:0 PI:18:5

2   Insurance 1213900001          44.44   07/11/12 12345                      COMMERCIAL INSURANCE PAYMENT                   1
 AR WHITE,BOB                   *** d                                 100.00-          320.00
                               400.00   1-Processed as Primary                  Prim COB/RSA
            71.54-             115.98-  06/23/11 918100-PATRICE PCON       380.54-          424.98-
Partial Payment                309.00 Default Claim Disposition
                                      CO:18:5::A2:100:0 PI:18:5


------------- Batch Status -------------
         Starting Balance:          0.00
Unbalanced  Total Entered:         99.99
          Cont Adj Total:          0.00
       Sup Cont Adj Total:         20.00-
             Batch Total:         99.99

C/A for COB1:      Variance*
C/A for Prim 1500: Post
C/A for Sec:       Post
C/A for PCON 1500: Rev Sys Adj*

Legend for Contractual Adjustment Call Letters:

f - Post
j - Reverse System Adj                          k - Subsequent Reverse System Adj
v - Variance                                    o - Subsequent Variance Adj
r - Report                                      c - Cycle/Cycle Adj - Report/Variance
d - Denial C/A Suppressed                       s - Subsequent Denial CA Suppressed
a - Suppressed per Claim Disposition Rule       b - Takeback for Previously Suppressed Payment
```

Figure 1.18 ERA Assigned Claim Disposition Report (for Accts with Multiple Payments in a Batch

```
Date: 07/11/12                                    Model Hospital A                                                Page  : 1
Time: 17:36          ERA Claim Disposition for Accts with Multiple Payments in a Batch - Batch P1K - A/PK COMM     Report: FXRERACDMA

Seq Cash Type      Account Trans Amount   --Date-- Remittance - Check #       Trans Description            --Paid--     F  CS# PtCls
Loc Patient Name           Contract Adj  Rev Sys Adj CA         C/A per CAS    Expected Reim               Days DRG Out
    Payor Claim ID        Clm Subm Chgs   Clm Status                          C/A Method                    Co-Pay          Pt Resp
        Accnt Bal         New Accnt Bal   Post/Pay Carrier/Plan             Ins Bal       New Ins Bal       Deductible     Coinsurance
Claim Disp Assigned     Patient Balance   CAS Reason Codes
-------------------------------------------------------------------------------------------------------------------------------------
1   Insurance 1213900001          55.55   07/11/12 12345                      COMMERCIAL INSURANCE PAYMENT                   1
 AR KING, BOB                  100.00-d         80.00              100.00-          320.00
                                400.00   1-Processed as Primary                  Prim COB/RSA
              4.01               51.54-  06/23/11 918100-PATRICE PCON       304.99-          360.54-
Partial Payment                 309.00 Default Claim Disposition

2   Insurance 1213900001          44.44   07/11/12 12345                      COMMERCIAL INSURANCE PAYMENT                   1
 AR SMTIH,BOB                   *** d                                100.00-          320.00
                                400.00   1-Processed as Primary                  Prim COB/RSA
            71.54-              115.98-  06/23/11 918100-PATRICE PCON       380.54-          424.98-
Partial Payment                 309.00 Default Claim Disposition


------------ Batch Status ------------
         Starting Balance:          0.00
Unbalanced  Total Entered:         99.99 Cont Adj Total:          0.00   Calculated Variance - will post
             Batch Total:          99.99


                                                  End of Report
```

Field Explanations

The report contains a header that includes the date and time the report is generated, your hospital's name, the report title, the page number, and the report name as used in the system.

SEQ
This column contains the system-generated sequence assigned to the cash item in the batch.

CASH TYPE
This column specifies the cash type (for example, insurance, patient, guarantor, unapplied, or miscellaneous cash).

ACCOUNT
This column contains the patient's account number.

TRANS AMOUNT
This column contains the total dollar amount of the transaction posted for this account.

DATE
This column contains the date on which this cash item will be posted.

REMITTANCE - CHECK #
This column contains the remittance check number.

PAY DATE
This column indicates the date the payment was received.

TRANSACTION DESCRIPTION
This column contains the transaction description of the cash item.

F
This column contains Y for Yes if this transaction is a final insurance payment.

CS #
For insurance cash, this column indicates the sequence in which the claim was paid.

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

- a = alert only; follow-up is not suppressed
- c = suppression of follow-up has been cleared by a user

s = follow-up is currently being suppressed

LOC
This column indicates one of the following account locations for the patient: PA, AR, or BD.

PATIENT NAME
This column contains the patient name.

CONTRACT ADJ
This column indicates the total adjustment from ERA and provides information on calculating the contractual adjustment. This column is used if a contractual adjustment, a reported adjustment, or other adjustments exist; if an error or warning was determined for the ERA transaction; or if the method used to determine the contractual adjustment is R for Report or V for Variance.

- A V indicates that this amount is the variance between the contractual adjustment at final billing and the contractual adjustment in the electronic payment file. This amount is posted because the system assumes that the contractual adjustment known at final billing is posted at final billing.

- An R indicates that the variance is being reported only and does not post.

- A C indicates that the claim being paid was generated from a cycle bill. For payment of these claims, no variance adjustment is calculated.

- An O indicates that this ERA transaction is being processed after a payment was received in an earlier ERA transaction file for a final bill, and the Variance method was used to determine that contractual adjustment. For the current ERA transaction, the adjustment in the ERA transaction is used unless it is changed in the cash batch.

- '***' appears if an error in the contractual adjustment calculation exists to reinforce that no ERA contractual adjustment can be determined.

REV SYS ADJ CA
If the ERA Payment File Definition is defined to use the Reverse System Adjustment method, this column provides the contractual adjustment amount that will be reversed per the contractual adjustment that was posted at the time of billing.

C/A PER CAS
This field contains the adjustment amount per the CAS Reason Codes in the ERA file for this account/CLP. This amount is a total of the CAS Reason Code amounts for each CAS Reason Code.

EXPECTED REIMB
This column provides the expected reimbursement as calculated per STAR Reimbursement, PCON, OPPS, etc.

PAID DAYS
This column provides the number of DRG days paid for insurance cash.

PAID DRG
This column provides the DRG code paid for insurance cash.

OUT
This column indicates whether Day (D) or Cost Outlier (C) is used for insurance cash.

PAYOR CLAIM ID
This field displays the Payor Claim ID for the claim, which is the Facility Indicator + Account Number + Original Claim Sequence Number.

CLM SUBM CHGS
This field displays the submitted charge amount.

CLM STATUS
This field contains the Claim Status Code from the ERA file in the CLP02 record. This code corresponds back to the ERA Claim Status Code table.

C/A METHOD
This field contains the contractual adjustment method: Post, Do Not Post, Reverse System Adjustment or Variance.

CO PAY
This field displays the co-payment amount associated with the insurance payment for the claim.

PT RESP
This field displays the patient responsibility amount associated with the insurance payment for the claim.

ACCNT BAL
The current account balance.

NEW ACCT BAL
This column contains the new account balance after the cash batch is approved and takes into consideration the payment and adjustment amounts in the cash batch.

POST/PAY
This column contains the date the payment was posted.

CARRIER/PLAN
This column contains the carrier and plan number.

INS BAL
This column contains the insurance balance.

NEW INS BAL
This column contains the new insurance balance after the cash batch is approved and takes into consideration the payment and adjustment amounts in the cash batch.

DEDUCTIBLE
This column contains the amount of the insurance deductible

COINSURANCE
This column contains the amount of the insurance coinsurance.

CLAIM DISPOSITION
This column contains the claim disposition assigned to this claim for this payment. This may be assigned via defaults, parameters or the Claim Disposition Rules. The Claim Disposition Rules table also allows a payment tracking indicator to be defined so that payments can be identified as underpayments and overpayments.

PATIENT BALANCE
This column contains the current patient balance.

CAS REASON CODES
This column lists the ERA CAS Reason Code.

LAST ERA TRANS/CONT ADJ
This column contains information about the last ERA transaction posted to the account for this ERA transaction's COB before this report was produced. The first part of this column contains the last ERA transaction type (Payment, Takeback, or Combined Payment/Takeback). The second part of this column contains the methodology used to determine the adjustment amount. These include the four methods that can be selected by the user in the *Cont Adj Method?* field on the Payment File Definition screen to determine the adjustment amount to be posted to the account (Variance, Report, Post/Adj., No Post). In addition, the identifier, 'Var**' or "Report**", indicates the last ERA transaction was processed after a payment on a final bill was received from an electronic remittance advice, and therefore the contractual adjustment in the ERA file is used rather than calculating a new variance.

LAST ERA CONT ADJ
This column displays the amount of the ERA contractual adjustment posted to the account for the ERA transaction's COB for the last ERA transaction before this report was produced. Typically, this is the amount determined from the ERA file. If you edit the amount in the cash batch, then the user-revised amount appears. If you did not edit the file and an error was determined when the last ERA transaction was processed, E follows this amount.

LAST ERA CALC CONT ADJ
This column displays if the calculated adjustment differs from that posted for the contractual adjustment calculated. This is for the last ERA payment or takeback posted to the account for the COB of the ERA transaction before the report was produced. This occurs if the contractual adjustment in the cash batch was changed by the user or if the contractual adjustment methodology was R for Report and no contractual

adjustment was indicated by the user in the cash batch. An E appears in this column if an error concerning the contractual adjustment for the last transaction was reported.

REIM CONT ADJ
When the payment's COB is primary, this column displays the last reimbursement adjustment amount calculated by STAR Patient Accounting or the reimbursement adjustment amount calculated by Pathways Contract Management. STAR's calculation is based upon the user-defined information contained within the Reimbursement Master.

POSTED
This column contains a Yes or No to indicate whether or not the reimbursement contractual adjustment was posted to the account.

STARTING BALANCE
This column contains the starting balance that was entered on the set up screen.

UNBALANCED TOTAL ENTERED
This column contains the total amount entered during this batch.

CONT ADJ TOTAL
This column contains the total amount of adjustments entered for this batch. If the contractual adjustment method from the Process Electronic RA function is V, the message *Calculated Variance - will post* is displayed beside the adjustment amount. If the contractual adjustment method from the Process Electronic RA function is R, the message *Calculated Variance - will not post* is displayed beside the adjustment amount.

BATCH TOTAL
This column contains the total amount entered during this batch plus the starting balance.

STARTING BALANCE
This column contains the starting batch balance.

TOTAL ENTERED
This column contains the total payments entered.

BATCH TOTAL
This column contains the current batch total.

TRANSFER OF FUNDS

The system does not handle the notification and transfer of funds to cover the electronic payment. You must ensure that the funds to cover the electronic payment are received by the facility.

An accounting of payments received electronically may be obtained by maintaining separate GL mapping and general ledger account numbers for the electronically received payments. This can be accomplished by setting up a separate transaction code entered on the user set-up screen for the batch and mapping the transaction code to a separate account in the general ledger.

VENDOR FILE LAYOUT

The electronic payment data file is in ASCII format. Each record is separated by a carriage return, line feed; each data element is separated by a colon (:). There is one header record and multiple detail records. The last detail record must be followed by an end-of-file mark of ASCII 26.

It is recommended that the ASCII file name be in the format _fmmddis.DAT, where:

- _ = _ (underscore)
- f = the facility indicator
- mm = the month (01-12)
- dd = the day (01-31)
- i = the insurance type (B,C,M,N,O,P,S,X OR Y)
- s = a sequence number for the day (0-9, A-Z)

Example: _C0514M1.DAT

Although the above format is recommended, the only requirements are that the file begin with an underscore (_) and end with .DAT.

Header Record Elements

The header record contains the following elements:

Field No.	Element	Format	Notes
1	Transmission date	MMDDYY	
2	Facility indicator	X	Varies
3	Type of insurance	X	
4	Number of records sent	99999	
5	Total payments	999999999.99	
6	Total adjustments	999999999.99	
7	Remittance number	25 A/N	Optional
8	Payment date	MMDDYY	

Notes for the header record include:

1. Field 3 - Insurance types are as follows:

   B = Blue cross
   C = Commercial
   M = Medicare Part A
   N = HMO
   O = Medicare - out of state
   P = Medicare Part B

S = CHAMPUS
X = Medicaid
Y = Medicaid - out of state

Detail Record Elements

The detail record contains the following elements:

Field No.	Element	Format	Notes
1	Account number	9999999999	
2	Payment amount	999999999.99	
3	Adjustment amount	999999999.99	
4	Date of service -from	MMDDYY	
5	Date of service -through	MMDDYY	
6	Days paid	999	Optional
7	DRG paid	999	Optional
8	Outlier type	X (either C or D)	Optional
9	Denied Payment Indicator	1 or null	Optional
10	External Claim Number	99999999999999	Optional
11	Coinsurance Amount	9999999999.99	Optional
12	Deductible Amount	9999999999.99	Optional
13	Patient Name	28 alpha-numeric character LAST, FM	Optional
14	Claim Covered Charges	9999999999999.99	Optional
15	HIC # (Health Insurance Claim Number)	20 AN	Optional
16	Denial Reason Code	6AN For payors using ERA CAS Reason Codes as their denial codes, the format of the field should be the denial reason code*ERA claim adjustment code. For example, XXX*XX.	Optional

Notes for the detail record include:

1. Field 2 - Payment Amount

The payment field must be zero-filled if no payment is sent. Payment reversals must have a negative sign (-) in front of the dollar amount (for example, -1234.56).

2. Field 3 - Adjustment Amount

   The adjustment field must be zero-filled if no adjustment is sent. Debit adjustments must have a negative sign in front of the dollar amount (for example, -1001.01). For electronic payment processing, the system assumes the adjustment amount to be a credit and reduces the patient's account balance by that amount. Therefore, a negative adjustment amount actually increases the patient's account balance. For example, if you enter an adjustment amount of $100.00, the system changes a $500.00 account balance to $400.00. If you enter an adjustment amount of -$100.00, the system changes a $500.00 Account balance to $600.00.

3. Field 8 - Outlier Type

   If an account meets both cost and day outlier thresholds, the system sends only the cost (C).

4. Field 9 - Denied Payment Indicator

   - 1 - Claim was denied.
   - Blank or null - Claim was not denied.

5. Field 10 - External Claim Number

   The external claim number is the intermediary's or carrier’s claim number. This number updates the patient’s claim information and the patient’s transaction history.

6. Field 13 - Patient Name

   This is the name that prints on the Electronic RA Audit report if the account can not be found on the STAR Patient Accounting System.

7. Field 14 - Claim Covered Charges

   These are the charges covered by the insurance carrier.

8. Field 15 - HIC # (Health Insurance Claim Number)

   The HIC number appears on the Electronic Remittance Rejection Report (FXRERRR).

9. Field 16 - Denial Reason Code

   Vendors may optionally enter a denial reason code for each denied insurance payment.

For payors using Non-ERA CAS reason codes as their denial codes, the field should be completed with the denial reason code from the payor. For payors using ERA CAS Reason codes as their denial codes, the format of the field should be the denial reason code*era claim adjustment code. Denied insurance payments are identified by the Denied Payment Indicator field being set to 1. For insurance payments processed from the ERA vendor file, STAR identifies potential denials to be tracked using the denied payment indicator from the ERA Vendor File. If the denied payment indicator is set to 1 for the claim, the system compares the denial reason code in the file to the denial reason codes that are contained in the denial tracking reason group for the claim. If the denial reason code in the file is defined in the denial tracking reason group, then this denial reason code is used for denial tracking. If the code is not contained in the denial tracking reason group, the default denial reason code associated with the denial tracking payor code is used for denial tracking. If the claim denial indicator is set to 1 and the denial reason code is not included in the file, the system uses the default denial reason associated with the denial tracking payor code for denial tracking. If the claim denial indicator is not set to 1, the system does not evaluate for denials even if there is a denial reason code included in the file.

The denial reason code is associated with a denial tracking reason group, which is associated with a denial tracking payor code. There can be a reason code, patient type, and reason code/patient type exceptions defined on the denial tracking payor code that could impact whether the denial reason code is tracked for denials.

Sample Vendor File

A sample vendor file follows.

```
010993:P:M:05:515.00:65.00:TEST ON SEPTEMBER 10, 1994!:011093
9214100012:1101.00:11.00:052092:052192:001:468::::::
9216400014:2102.00:12.00:061292:061592:003:128:C::::::
9220200011:3103.00:13.00:071892:072192:003:301:C::::::
9206300011:4104.00:14.00:030392:040792:034:225:D::::::
9212800014:5105.00:15.00:050792:050792:001:468:::::::
9402900076:1001.00:100:012994:013094:002:123::1:1278:35.23:592
9403000005:2000:125:0123094:013094:::::12345679:200::
```

The first line of the file is the header record. The remaining lines are detail records. Each line, except the last line, is followed by a carriage return (ASCII 13), line feed (ASCII 10). The last line must be followed by an end-of-file mark (ASCII 26.) Delimiter colons are recommended, but not required, at the end of each detail line if the optional data elements (6-12) are not available.

NOTE: Most ASCII text file editors automatically place the ASCII 26 character at the end of the file.

PART A 835 DATA ELEMENTS

Header Record Elements

The STAR PA header record is created from the following elements:

Element	Part A 835 Location	STAR Location	Notes
Transmission date	ISA09	FY-FERA-1	
Provider	GS03		Provider number is for each numbered functional group. Match this number against the provider number in the Payment File Definition table to determine the facility.
Loop Indicator	LX01	FY-FERA1-6	Format = a unique number or yymmtt, where yy= year, mm=month, and tt = type of bill summary code. When the format is yymmtt, the system can automatically subdivide the payment file into smaller batches using the bill type exceptions in the payment file definition table. The presence of this field indicates that subtotals follow in TS3. If this record is null, the preceding BPR02 record is referenced for the non-patient payment total.
Facility	None	FY-FERA-2	Determined from indicator in the Provider/Facility mapping table or from user designation if unmapped.
Type of insurance	None	FY-FERA-3	Comes from payment file definition table.
Number of records sent	TS304	FY FERA-4	
Provider Payment Total	TS309 or BPR02 (non-patient payments)	FY-FERA-5	Insurance cash batch payment total which can be by yymmtt if bill type exceptions are defined. See the Loop Indicator Notes, above.

Element	Part A 835 Location	STAR Location	Notes
Provider Adjustment Total	TS311	FY-FERA-6	Insurance cash batch adjustment total which can be by yymmtt if bill type exceptions are defined. See the Loop Indicator Notes, above.
Remittance Number	LX01	FY-FERA-7	Insurance cash batch remittance number.
Payment date	BPR16	FY-FERA-8	
Element Separator ISA +1	ISA +1		The first character following "ISA" is the element separator.
Sub-element Separator	ISA 16		Used in the SVC and PLB records.
Record Terminator	ISA 16+ 1		The first character following ISA 16 is the record terminator.

Claim Level Detail Record Elements

The STAR PA claim level detail record is created from the following data elements that are extracted from the Part A 835:

Element	Part A 835 Location	STAR Location	Notes
Account	CLP01	FY-FERA1-1	Patient control number (EN)
Claim payment amount	CLP04	FY-FERA1-2	
Adjustment amount	CAS03, 06, 09, 12, 15, or 18	FY-FERA1-3	Preceding code will have a value of A2.
Date of service - from	DTM02	FY-FERA1-4	DTM01 = 232
Date of service - through	DTM02	FY-FERA1-5	DTM01 = 233
Days paid	QTY02	FY-FERA1-6	QTY01 = CA
DRG paid	CLP11	FY-FERA1-7	

Element	Part A 835 Location	STAR Location	Notes
Outlier type	CAS03, 08, 09, 12, 15, Or 18	FY-FERA1-8	Preceding code in the CAS segment has a value of: 69 = operating day outlier 70 = operating cost outlier A4 = capital day outlier A5 = capital cost outlier
Claim status code	CLP02	FY-FERA1-9	If the CLP02 is equal to 4 which is the denied claim, then the system sets the FY-FERA1-9 = 1.
Internal control number	CLP07	FY-FERA1-10	Update FB-FBL piece 2 (external claim number when posting insurance cash batch). The insurance cash batch payment record in transaction history will display the ICN on the comment line.
Coinsurance amount	CAS03, 06, 09, 12, 15, Or 18	FY-FERA1-11	Preceding Code = 2, send to FT-FTE-33. Can occur multiple times.
Deductible amount	CAS03, 06, 09, 12, 15, Or 18	FY-FERA1-12	Preceding Code = 1, send to FT-FTE-34. Can occur multiple times.
Patient name	NM103, NM104, & NM105	FY-FERA1-13	Prints on FXRERAR and FXRERRR if account is not found on STAR Patient Accounting.
Claim covered charges	AMT02	FY-FERA1-14	AMT01=AU
Other adjustment amount	CAS03, 06, 09, 12	FY-FERA1-15	Codes defined as (O)ther in the Electronic RA CAS Reason Code table.
HIC Number	NM109	FY-FERA1-22	Preceding code=HN. The HIC number is displayed on the Electronic RA Rejection Report (FXRERRR).
Fiscal period	PBL02		Use for fiscal period separation.
Adjustment code	PLB03, 05, 07, or 09	FY-FERA1-1	Use to find miscellaneous cash code for posting provider level adjustments. The first sub-element.

Element	Part A 835 Location	STAR Location	Notes
Adjustment amount	PLB06, 08, or 10	FY-FERA1-2	This is the transaction amount. Do not reverse the sign.
Provider payment total	BPR02	FY-FERA-5	Occurs one time for each provider in file. Use this as the amount of the non-patient payment if the subsequent loop indicator record is null.
Reported Adjustment amount	calculated	FY-FERA1-16	
Claim Status Code	CLP02	FY-FERA1-23	
Claim Filing Indicator	CLP06	FY-FERA1-24	
Total Claim Charge Amount	CLP03	FY-FERA1-25	The amount of submitted charges for this claim.
Payer Claim Control Number	CLP07	FY-FERA1-26	The Internal Control Number (ICN).
Claim Level Remarks Codes	MIA05, MIA20, MIA21, MIA22, and MIA23 for inpatients MOA03, MOA04, MOA05, MOA06, MOA07 for outpatients	FY-FERA1-27	There may be up to 5.

Service Level Detail Record Elements

The STAR PA service level detail record is created from the following data elements that are extracted from the Part A 835:

Element	Part A 835 Location	STAR Location	Notes
Revenue Code	SVC04 or SVC01-2	FY-FERA2-1	If SVC01-1=HC, then Rev Code is in SVC04. If SVC01-1=NU, then Rev Code is in SVC01-2. STAR uses up to 4 AN. Leading zeroes are removed.
Service Date	DTM02	FY-FERA2-2	DTM01 = 472 or 150

Element	Part A 835 Location	STAR Location	Notes
HCPCS Code Paid	SVC01-2	FY-FERA2-3	When SVC01-1 = HC
HCPCS Modifiers Paid	SVC01-3 and SVC01-4	FY-FERA2-4	When SVC01-1 = HC
Procedure Type Paid	SVC01-1	FY-FERA2-5	HC = HCPCS NU = UB
Units of Service Paid	SVC05	FY-FERA2-6	If blank, then the units of service = 1
Line Item Submitted Charge Amount	SVC02	FY-FERA2-7	
Line Item Payment Amount	SVC03	FY-FERA2-8	
Line Item Coinsurance Amount	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	FY-FERA2-9	When CAS02, CAS05, CAS08, CAS11, CAS14 or CAS17 = 2
Line Item Deductible Amount	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	FY-FERA2-10	When CAS02, CAS05, CAS08, CAS11, CAS14 or CAS17 = 1
Line Item Contractual and Other Adjustment Amounts	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	FY-FERA2-11	CAS02, CAS05, CAS08, CAS11, CAS14 or CAS17 is defined in the CAS Reason Code Table as a Contractual or an Other Adjustment. Multiple adjustment codes may be present.
Paid APC if available	REF02	FY-FERA2-12	When REF01=1S
Transaction History Notation	CAS	FY-FERA2-13	

Element	Part A 835 Location	STAR Location	Notes
Line Item CAS codes for Adjustments	CAS01 (Group) and CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	FY-FERA2-14	When defined in the CAS Reason Code Table as a Contractual or an Other Adjustment. Multiple adjustment codes may be present
Line Item Remarks Codes	LQ02	FY-FERA2-15	When LQ01 = HE Remarks may occur multiple times.
ERA Result and related HCPCS	none	FY-FERA2-16	STAR internal status value
HCPCS Code Submitted if different from paid	SVC06-2	FY-FERA2-17	When SVC06-1 = HC
HCPCS Modifiers Submitted if different from paid	SVC06-3 and SVC06-4	FY-FERA2-18	When SVC06-1 = HC
Procedure Type Submitted if different from paid	SVC06-1	FY-FERA2-19	When SVC06-1 = HC
Original Units of Service (Submitted)	SVC07	FY-FERA2-20	If blank, then the units of service = 1

Provider Level Adjustment Elements

For provider level adjustments, the following data elements are extracted from the Part A 835.

Element	Part A 835 Location	STAR Location	Notes
Fiscal period	PBL02		Use for fiscal period separation.
Adjustment code	PLB03, 05, 07, or 09	FY-FERA1-1-	Use to find miscellaneous cash code for posting provider level adjustments. The first sub-element.
Adjustment amount	PLB04, 06, 08, or 10	FY-FERA1-2	This is the transaction amount. Do not reverse the sign.

Element	Part A 835 Location	STAR Location	Notes
Provider payment total	BPR02	FY-FERA-5	Occurs one time for each provider in file. Use this as the amount of the non-patient payment if the subsequent loop indicator record is null.

Sample Part A 835 File, Version 3051.4a

```
ISA*00*          *00*          *ZZ*9000000060     *ZZ*060023 *970815*2157*U*00305*970818001*0*P*>~
GS*HP*9000000060*060023*970815*215727*000097211*X*003051.4a~
ST*835*970818028~
BPR*I*197463.01*C*CHK************970818~
TRN*1*0000142331*9000000060~
REF*F5*97.3-0~
DTM*405*970818~
N1*PE*GENERAL HOSPITAL*MP*060023~
N1*PR*CT MEDICARE-A~
N3*156 GOVERNMENT STREET*CONTROLLER~
N4*ANYWHERE*GA*06702~
LX*950911~
TS3*060023*11*950930*2*0****716*********-716~
TS2***************74.84~
CLP*9602900001*19*2535.41*2912.2***2508651665*11*G*03*143*.51*1~
CAS*CO*A2*-376.79*0~
NM1*QC*1*CYR*ALPHIE BETA****HN*005124394A~
NM1*TT*2*DEPT. OF SOCIAL SERVICES*****PI*D06106001~
MIA*1***2912.2*MA02*62.03*37.42*252.08*92.38*150.77*2.91**6.02**1*2297.51**306.6~
REF*EA*0052109~
DTM*232*960201~
DTM*233*960219~
AMT*AU*2535.41~
QTY*CA*1~
CLP*9602900001*22*-2535.41*-2196.2***3508651665*11*1*03*143*-.51*1~
CAS*CR*1*-716*0*A2*376.79*0~
NM1*QC*1*CYR*ALPHIE BETA****HN*005124394A~
NM1*TT*2*DEPT. OF SOCIAL SERVICES*****PI*D06106001~
MIA*-1***-2912.2*MA02*-62.03*37.42*-252.08*-92.38*-150.77*-2.91**-6.02**-1*-2297.51**-306.6~
REF*EA*0052109~
DTM*232*960201~
DTM*233*960219~
AMT*AU*-2535.41~
QTY*CA*-1~

LX*960913~
TS3*060023*13*960930*5*1677.99*1437.99**240*335.45**919.8****1153.69*182.74*524.3*13443~
CLP*A9902500002*19*94.59*20.81***1707951313*13*1*01~
CAS*PR*2*18.92*0~
CAS*CO*A2*54.86*0~
NM1*QC*1*ANDERSON*DIANE****HN*725070006C1~
NM1*TT*2*DEPT. OF SOCIAL SERVICES*****PI*D06106001~
MOA*.42**MA01~
REF*EA*0114161~
DTM*232*990101~
DTM*233*990101~
AMT*AU*94.59~

PLB*060023*970930*BD*-24*GM*-60865*DM*-19141~
SE*5848*970818028~
GE*1*000097211~
IEA*1*970818001~
```

Sample Medicare A File, Version 4010

```
ISA*00*          *00*          *ZZ*00308          *ZZ*111829567      *000606*131
8*U*00303*000001220*0*P*>~
GS*HP*00308*22R206*000606*1318*1303*X*004010X091D~
ST*835*1303~
BPR*C*4046.37*C*ACH*CCP*01*074000052*DA*0030015987*9000000308**01*021000021*DA*2611036274*20000605~
TRN*1*EFT0308550*9000000308~
REF*F5*APPL01~
N1*1P*GENERAL HOSPITAL~
N3*123 MAIN STREET~
N4*ANYTOWN*GA*31220~
GS*HP*00308*22T206*000606*1318*1304*X*004010F~
ST*835*1304~
BPR*C*149667*C*ACH*CCP*01*074000052*DA*0030015987*9000000308**01*021000021*DA*2611036274*20000605~
TRN*1*EFT0308597*9000000308~
REF*F5*APPL01~
N1*1P*GENERAL HOSPITAL~
N3*REHABILITATION UNIT*123 MAIN STREET~
N4*ANYTOWN*GA*31220~
PLB*22T206*20001231*PP>011111*-149667~
SE*9*1304~GE*1*1304~
GS*HP*00308*220206*000606*1319*1305*X*004010F~
ST*835*1305~
BPR*C*2012370.34*C*ACH*CCP*01*074000052*DA*0030015987*9000000308**01*021000021*DA*2611036274*20000605~
TRN*1*EFT0308739*9000000308~
REF*F5*APPL01~
N1*1P*GENERAL HOSPITAL~
N3*123 MAIN STREET~
N4*ANYTOWN*GA*31220~
LX*001212~
TS3*220206*12*001231*3*36862*36862***11425.02**18104.94****23325*7332.04*325*123.19~
CLP*9935401472*1*32047*9934.57***20014400303101*12*4*20~
CAS*CO*A2*15703.03~
CAS*OA*B3*32047~
CAS*PR*2*6409.4~
NM1*QC*1*CHAMBERS*ALICIA****N*078681424M~
MOA*0.51**MA01~
REF*EA*0000815861~
DTM*232*20000101~
DTM*233*20000323~
SVC*RB*301 *4487*4487*301~
DTM*472*20000323~
SVC*RB*305 *3738*3738*305~
DTM*472*20000323~
SVC*RB*306 *3090*3090*306~
DTM*472*20000323~
SVC*RB*307 *138*138*307~
DTM*472*20000323~
SVC*RB*309 *60*60*309~
DTM*472*20000323~
SVC*RB*320 *788*788*320~
DTM*472*20000323~
SVC*RB*324 *2758*2758*324~
DTM*472*20000323~
SVC*RB*341 *1534*1534*341~
DTM*472*20000323~
SVC*RB*351 *2211*2211*351~
DTM*472*20000323~
SVC*RB*352 *2408*2408*352~
DTM*472*20000323~
SVC*RB*730 *335*335*730~
DTM*472*20000323~
SVC*RB*740 *500*500*740~
DTM*472*20000323~
SVC*RB*801 *10000*10000*801~
DTM*472*20000323~

Etc…

PLB*330306*20001231*BD>11*-2866*DM>2222*-218330*PA>333*25416.83*PP>444*-1732416~
PLB*330306*20001231*CA>555*-4528.06~
SE*2967*1305~
GE*1*1305~
IEA*3*000001220~
```

Part B 835 DATA ELEMENTS

Header Record Elements

The STAR PA header record is created from the following elements:

Element	Part B 835 Location	STAR Location	Notes
Transmission Date	ISA09	FY-FERA-1	Occurs one time
Provider	GS03		Provider number is for each numbered functional group.Match this number against the provider number in the Electronic RA Fac/Proc Mapping Table to determine the facility.
Loop indicator	LX01	FY-FERA-19	The values for this field are 1 for assigned claims and a 0 for unassigned claims. All claims contained in the unassigned claims loop will not be processed and will appear on the Electronic RA Rejection report (FXRERRR) with the error “Benefits Unassigned.”
Facility indicator	None	FY-FERA-2	Determined by Provider/Facility mapping table or by user designation if unmapped.
Type of insurance	None	FY-FERA-3	Determined by Payment Definition file.
Number of records sent	None	FY-FERA-4	Calculated during the upload process.
Provider payment total	BPR02	FY-FERA-5	This is the total actual check or EFT payment to the billing provider.
Provider contractual adjustment total	None	FY-FERA-6	Calculated during the upload process.
Remittance number	None	FY-FERA-7	The remittance number will be comprised of the words “PART B” and the transmission date in ISA09.
Payment date	BPR16	FY-FERA-8	
Sub-element separator	ISA16		Used in PLB and SVC records.

Element	Part B 835 Location	STAR Location	Notes
Element separator	ISA+1		The first character following “ISA” is the element separator.
Record terminator	ISA16+1		The first character following ISA16 is the record terminator.

Claim Level Detail Record Elements

The STAR PA claim level detail record is created from the following data elements that are extracted from the Part B 835 file:

Element	Part B 835 location	STAR Location	Notes
Account	CLP01	FY-FERA1-1	Patient control number
Claim Payment Amount	CLP04	FY-FERA1-2	
Adjustment Amount	CAS03, 06, 09, 12, 15,or 18	FY-FERA1-3	Preceding adjustment code will be evaluated and if it is found in the Electronic RA CAS Reason Code table, the adjustment type indicated by the table will be processed.
Days Paid	QTY02	FY-FERA1-6	QTY01=CA
Date of service - from	DTM02	FY-FERA1-14	DTM01=150, DTM01=472 All the dates associated with each service line on the claim will be evaluated and the earliest date found will be used.
Date of service - through	DTM02	FY-FERA1-15	DTM01-150, DTM01=472 All the dates associated with each service line on the claim will be evaluated and the latest date found will be used.
Claim status code	CLP02	FY-FERA1-9	If the CLP02 is equal to 4, which is a denied claim, then the system sets the FY-FERA1-9 to 1.
Internal control number	CLP07	FY-FERA1-10	Update FB-FBL piece2 (external claim number when posting insurance cash batch). The insurance cash payment record in transaction history will display the ICN on the comment line

Element	Part B 835 location	STAR Location	Notes
Patient name	NM103, NM104, NM105	FY-FERA1-13	Prints on the FXRERAR and FXRERRR if account is not found on STAR Patient Accounting.
Claim covered charges	AMT02	FY-FERA1-14	AMT01 = AU.
Performing provider no. from claim's first service line	REF02	FY-FERA1-19	This information will be used to match the claim. Preceding code = 1C.
Procedure code from claim's first service line	SVC02	FY-FERA1-20	This information will be used to match the claim.
HIC Number	NM109	FY-FERA1-22	Preceding code = HN. The HIC number is displayed on the Elec RA Rejection Report FXRERRR.
Reported Adjustment amount	calculated	FY-FERA1-16	
Total Claim Charge Amount	CLP03	FY-FERA1-18	The amount of submitted charges for this claim.
Date of service from first service	DTM02	FY-FERA1-21	DTM01=150 or 472
HIC number	NM1	FY-FERA1-22	
Claim Status Code	CLP02	FY-FERA1-23	
Claim Filing Indicator	CLP06	FY-FERA1-24	
Total Claim Charge Amount	CLP03	FY-FERA1-25	The amount of submitted charges reported in the ERA.
Payer Claim Control Number	CLP07	FY-FERA1-26	Internal Control Number (ICN).
Claim Level Remarks Codes	MIA05, MIA20, MIA21, MIA22, and MIA23 for inpatients MOA03, MOA04, MOA05, MOA06, MOA07 for outpatients	FY-FERA1-27	There may be up to 5.

Service Level Detail Record Elements

The STAR PA service level detail record is created from the following data elements that are extracted from the Part B 835 file:

Element	Part B 835 location	STAR Location	Notes
Revenue Code	SVC04 or SVC01-2	FY-FERA2-1	If SVC01-1=HC, then Rev Code is in SVC04. If SVC01-1=NU, then Rev Code is in SVC01-2. STAR uses up to 4 AN. Leading zeroes are removed.
Service Date	DTM02	FY-FERA2-2	DTM01 = 472 or 150
HCPCS Code Paid	SVC01-2	FY-FERA2-3	When SVC01-1 = HC
HCPCS Modifiers Paid	SVC01-3 and SVC01-4	FY-FERA2-4	When SVC01-1 = HC
Procedure Type Paid	SVC01-1	FY-FERA2-5	HC = HCPCS NU = UB
Units of Service Paid	SVC05	FY-FERA2-6	If blank, then the units of service = 1
Line Item Submitted Charge Amount	SVC02	FY-FERA2-7	
Line Item Payment Amount	SVC03	FY-FERA2-8	
Line Item Coinsurance Amount	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	FY-FERA2-9	When CAS02, CAS05, CAS08, CAS11, CAS14 or CAS17 = 2
Line Item Deductible Amount	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	FY-FERA2-10	When CAS02, CAS05, CAS08, CAS11, CAS14 or CAS17 = 1

Element	Part B 835 location	STAR Location	Notes
Line Item Contractual and Other Adjustment Amounts	CAS03 CAS06 CAS09 CAS12 CAS15 CAS18	FY-FERA2-11	CAS02, CAS05, CAS08, CAS11, CAS14 or CAS17 is defined in the CAS Reason Code Table as a Contractual or an Other Adjustment. Multiple adjustment codes may be present.
Paid APC if available	REF02	FY-FERA2-12	When REF01=1S
Transaction History Notation	CAS	FY-FERA2-13	
Line Item CAS codes for Adjustments	CAS01 (Group) and CAS02 CAS05 CAS08 CAS11 CAS14 CAS17	FY-FERA2-14	When defined in the CAS Reason Code Table as a Contractual or an Other Adjustment. Multiple adjustment codes may be present
Line Item Remarks Codes	LQ02	FY-FERA2-15	When LQ01 = HE Remarks may occur multiple times.
ERA Result and related HCPCS	none	FY-FERA2-16	STAR internal status value
HCPCS Code Submitted if different from paid	SVC06-2	FY-FERA2-17	When SVC06-1 = HC
HCPCS Modifiers Submitted if different from paid	SVC06-3 and SVC06-4	FY-FERA2-18	When SVC06-1 = HC
Procedure Type Submitted if different from paid	SVC06-1	FY-FERA2-19	When SVC06-1 = HC
Original Units of Service (Submitted)	SVC07	FY-FERA2-20	If blank, then the units of service = 1

Provider Level Adjustment Elements

For provider level adjustments, the following data elements are extracted from the Part B 835 file:

Element	Part B 835 location	STAR Location	Notes
Adjustment Code	PLB03, 05, 07, or 09	FY-FERA1-1	Used to find the miscellaneous cash code for posting provider level adjustments.
Adjustment Amount	PLB04, 06, 08, or 10	FY-FERA1-2	This is the transaction amount. Do not reverse the sign.

Sample Part B 835 File

A sample Part B 835 file follows:

```
ISA*00*0         *00*0         *ZZ*10230          *ZZ*009025055
*990127*0151*U*00303*902706720*0*P*>~
GS*HP*10230*009025055*990127*0151*902706721*X*003030~
ST*835*902706722~
BPR*I*5619.38*C*CHK**01*38785827**38850668*******990126~
TRN*1*990260900010000~
REF*F5*2B~
REF*EO*10230~
REF*EV*009025055~
DTM*405*990127~
N1*PE*GENERAL HOSPITAL*MP*00011~
LX*1~
CLP*9828500249*19*13.46*10.66*2.66**983652092900~
CAS*OA*93*0~
NM1*QC*1*ABEL*JODI****HN*048103596A~
DTM*050*981231~
SVC*HC*93010*13.46*10.66*93010~
DTM*472*981012~
CAS*PR*2*2.66~
CAS*CO*42*.14~
REF*1C*060000911~
REF*LU*21~
REF*SV*1~
REF*ZZ*13.32~
CLP*990050051001*19*14*9.89*2.47**990144486000~
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```

USER TEST PLAN

Vendor Test Plan

1. Before testing the upload capability, you must first have a PC linked to the STAR Financials Patient Accounting CPU through McKesson's Window Emulator (WEM) software.

2. On that PC, make a directory/folder called PAYIN on drive C. This is the recommended storage location for the ASCII payment files received from your vendor. Other drives and directories/folders may be accessed by overriding the default values in the upload function.

3. Establish a payment file definition entry.

4. Gather test data to be uploaded into the test ID. To do this, select accounts in the test ID to which you would like to post insurance payments. For each account, you need:

   - the account number
   - the dates of service for the claim

   Choose several accounts for the same carrier, making sure that a claim has been loaded. You may want to test the following conditions:

   - account not found
   - account in bad debt
   - no matching claim
   - multiple claims match
   - missing adjustment transaction code
   - account archived

5. Use this information to create the ASCII file on the PC. You may do this in a text editor that will create ASCII text files.

   When entering the data, follow the test file layout below. You must create a header record, followed by a hard return. Follow this with each detail record, inserting the account number, dates of service, and making up the payment amount, adjustment amount, DRG days, outlier status paid, denied payment indicator, external claim number, coinsurance amount, deductible amount, patient name and claim covered charges for each detail record. Do not follow the last line with a hard return. When saving the file, be sure to save it in the \PAYIN directory/folder on drive C and follow the naming convention in naming the file. The system will only upload files whose names begin with an underscore (_).

6. Access the Upload Electronic RA files from PC function on the Electronic RA Interfaces menu (under the Interface Functions menu.) If your ASCII file is in the \PAYIN directory/folder on drive C, accept the defaults to upload the file to your test

ID. Once it has successfully uploaded the file, the system changes the file name on the PC to begin with *P*, indicating that the file has been uploaded.

7. Request the Electronic RA Audit report (FXRERAR) to make sure your data was uploaded correctly. To create this report, select the Print Electronic RA Audit Rpt function; then print it using the Demand Print function or view and/or print it using the View Spooled Reports function.

8. Select the Process Electronic RA function, and complete any fields necessary to identify default values and matching criteria. When you accept this screen, the system creates an insurance cash batch.

9. View the rejected payments on the Electronic Remittance Rejection report (FXRERRR). The system generates this report when the Process Electronic RA function is run. You can print the report using the Demand Print function or view and/or print it using the View Spooled Reports function.

10. View the accepted payments on the Electronic Cash Posting Audit report (FAR121). The system generates this report when the Process Electronic RA function is run. You can print the report using the Demand Print function or view and/or print it using the View Spooled Reports function.

11. Access the Post Cash function and select the batch created. You can view, edit, print, delete, and approve this batch as you would any other insurance cash batch. You can also manipulate batch totals to force the batch to be in balance.

12. View the information on the Cash Posting Audit report (FAR120) to make sure payments were entered correctly.

13. Approve the cash batch, and review the Cash Posting Exception report (FAR140) for the message *RA Adj forced bal xfer*.

14. View transaction history for each account to confirm the dollar amounts and transaction codes for the insurance payments and contractual adjustments and to view the ICN on the insurance payment comment.

15. View the Adjustment Posting Detail report (FAR210) and the Cash Posting Detail report (FAR130) that are generated during midnight processing to confirm the posting of the insurance payments and contractual adjustments.

16. Additional testing should include:

    - reprocessing batches that have been created to modify the matching criteria and defaults
    - purging uploaded files
    - testing for specific rejection messages
    - posting of provider level adjustments.

Part A 835 Test Plan

1. Before testing the upload capability, you must first have a PC linked to the STAR Financials Patient Accounting CPU through McKesson's Windows Emulator (WEM) software.

2. On that PC, make a directory/folder called 835IN on drive C. This is the recommended storage location for the Part A payment files received from your intermediary. Other drives and directories/folders may be accessed by overriding the default values in the upload function.

3. Establish entries for the following tables:

   - Electronic RA Provider/Facility Mapping
   - Bill Type Codes
   - Payment File Definition
   - Provider Level Adjustment Reason Codes
   - Provider Level Adjustment Mapping
   - Transaction Codes (Type I, A, and F as needed)
   - Miscellaneous Cash Codes (for Provider Level Adjustment Mapping)
   - GL Accounts (for Provider Level Adjustment Mapping)
   - Electronic RA CAS Reason Codes

   Refer to the Financials Tables Maintenance section of this document for a description of these tables.

4. Prepare data for your test ID. You may test the Part A 835 in two ways:

   - Modify a Part A 835 payment file on your PC to match data in your test ID. Go to steps 5 and 6.

   - Create accounts in your test ID to match data sent in an existing Part A 835 payment file. Go to step 7.

5. Gather test data to be uploaded into the test ID. To do this, select accounts in the test ID to which you would like to post insurance payments. For each account, you need:

   - the account number
   - the dates of service for the claim

   Choose several accounts with the same insurance carrier code, making sure that the claim is loaded. You may want to test the following conditions:

   - account not found
   - account in bad debt
   - no matching claim
   - multiple claims match

- missing adjustment transaction code
- account archived

6. Obtain a test Part A 835 data file from your intermediary, and modify the CLP and DTM records with the information gathered in Step 5 in order to match accounts in your test ID. You may do this in a text editor that creates text files.

   The following 835 data elements must match in order for a claim to be found in the test ID.

Element	835 Location
Account Number	CLP02
Service from date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=232
Service through date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=233

   When editing the file, do not insert additional hard returns in the file.

7. To create accounts in your test ID to match data sent in the Part A 835 payment file, you need to do the following:

   NOTE: Step 7 must be done at least one day prior to uploading your payment file.

   a. Admit accounts into the system.

      - Assign an insurance carrier that matches the one defined in the payment file definition that you plan to use to upload the payment file.
      - On some accounts set up reimbursement parameters to do a contractual adjustment at final billing. These accounts can be used to test the variance contractual adjustment method.
      - Manually assign the account number (CLP02) to match the Part A 835 payment file.

   b. Discharge the patient.

   c. Revise the admit and discharge dates to match the Part A 835 payment file.

Element	ANSI Location
Service from date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=232
Service through date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=233

d. Enter some charges so that the account has a balance.

e. On STAR PA enter a single bill request for a final bill. Specify on the single bill request to bypass the edits (Perform edits = N) to force the account into accounts receivables during midnight processing.

8. Access the Upload Electronic RA files from PC function on the Electronic RA Interfaces menu (under the Interface Functions menu.) If your ASCII file is in the \835IN directory on drive C, accept the defaults to upload the file to your test ID. Once it has successfully uploaded the file, the system changes the file name on the PC to end with *.UPL*, indicating that the file has been uploaded. The upload process subdivides the Part A source file into separate files by provider number, fiscal period, and bill type.

9. Request the Electronic RA Audit report (FXRERAR) to make sure your data was uploaded correctly. To create this report, select the Print Electronic RA Audit Rpt function. Print it using the Demand Print function, or view and/or print it using the View Spooled Reports function.

10. Select the Process Electronic RA function, and complete any fields necessary to identify default values and matching criteria. When you accept this screen, the system creates an insurance cash batch for each subdivision of the source file as defined in the Payment File Definition table.

11. View the rejected payments on the Electronic Remittance Rejection report (FXRERRR.) The system generates this report when the Process Electronic RA function is run. You can print the report using the Demand Print function or view and/or print it using the View Spooled Reports function.

12. View the accepted payments on the Electronic Cash Posting Audit report (FAR121). The system generates this report when the Process Electronic RA function is run. You can print the report using the Demand Print function, or view and/or print it using the View Spooled Reports function.

13. Access the Post Cash function and select the batch created. You can view, edit, print, delete, and approve this batch as you would any other insurance cash batch. You can also manipulate batch totals to force the batch to be in balance.

14. View the information on the Cash Posting Audit report (FAR120) to make sure payments were entered correctly.

15. Approve the cash batch and review the Cash Posting Exception report (FAR140) for the message *RA Adj forced bal xfer*.

16. View transaction history for each account to confirm the dollar amounts and transaction codes for the insurance payments and contractual adjustments and to View the ICN on the insurance payment comment.

17. View the Adjustment Posting Detail report (FAR210) and the Cash Posting Detail report (FAR130) that are generated during midnight processing to confirm the posting of the insurance payments and contractual adjustments.

18. Additional testing should include:

    - reprocessing batches that have been created to modify the matching criteria and defaults
    - purging uploaded files
    - testing for specific rejection messages
    - posting of provider level adjustments.

Part B 835 Test Plan

1. Before testing the upload capability, you must first have a PC linked to the STAR Financials Patient Accounting CPU through McKesson's Windows Emulator (WEM) software.

2. On that PC, make a directory/folder called 835BIN on drive C. This is the recommended storage location for the Part B payment files received from your intermediary. Other drives and directories/folders may be accessed by overriding the default values in the upload function.

3. Establish entries for the following tables:

    - Electronic RA Provider/Facility Mapping
    - Bill Type Codes
    - Payment File Definition
    - Provider Level Adjustment Reason Codes
    - Provider Level Adjustment Mapping
    - Transaction Codes (Type I, A, and F as needed)
    - Miscellaneous Cash Codes (for Provider Level Adjustment Mapping)
    - GL Accounts (for Provider Level Adjustment Mapping)
    - Electronic RA CAS Reason Codes

    Refer to the Financials Tables Maintenance section of this document for a description of these tables.

4. Prepare data for your test ID. You may test the Part B 835 in two ways:

    - Modify an Part B 835 payment file on your PC to match data in your test ID. Go to steps 5 and 6.

    - Create accounts in your test ID to match data sent in an existing Part B 835 payment file. Go to step 7.

5. Gather test data to be uploaded into the test ID. To do this, select accounts in the test ID to which you would like to post insurance payments. For each account, you need:

   - the account number
   - the dates of service for the claim
   - the doctor number in Box 24K of the 1500 claim form
   - the service codes in Box 24D for each service line of the 1500 claim form

   Choose several accounts with the same insurance carrier code, making sure that the claim is loaded. You may want to test the following conditions:

   - account not found
   - account in bad debt
   - no matching claim
   - multiple claims match
   - missing adjustment transaction code
   - account archived
   - benefits unassigned
   - no match on service line

6. Obtain a test Part B 835 data file from your carrier, and modify the CLP, DTM, REF, and SVC records with the information gathered in Step 5 in order to match accounts in your test ID. You may do this in a text editor that creates ASCII text files. You may also modify the files using a word processor, being sure to save the files as a text file.

   The following 835 data elements must match in order for a claim to be found in the test ID.

Element	ANSI Location
Account Number	CLP01
Service from date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=151 or 472
Service through date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=151 or 472
Performing Provider	REF02
Procedure	SVC02

   NOTE: The performing provider number (REF02 in the source file) must match the doctor number in Box 24K of the CMS 1500 claim form. The procedure (SVC02 in the source file) must match the procedure code in Box 24D of the CMS 1500 claim form.

   When editing the file, do not insert additional hard returns in the file.

7. To create accounts in your test ID to match data sent in the Part B 835 payment file, you need to do the following:

   NOTE: Step 7 must be done at least one day prior to uploading your payment file.

   a. Admit accounts into the system.

      - Assign an insurance carrier that matches the one defined in the payment file definition that you plan to use to upload the payment file.
      - Ensure the performing provider number in Box 24K of the CMS 1500 claim form matches the performing provider in REF02 of the Part B file.
      - Ensure the procedure code in Box 24D of the CMS 1500 claim form matches the procedure code in SVC02 of the Part B file.
      - Manually assign the account number (CLP01) to match the Part B 835 payment file.

   b. Discharge the patient.

   c. Revise the admit and discharge dates to match the Part B 835 payment file.

Element	ANSI Location
Service from date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=150 or 472
Service through date	DTM02 (YYMMDD or CCYYMMDD) when DTM01=150 or 472

   d. Enter some charges so that the account has a balance.

   e. On STAR PA, enter a single bill request for a final bill. Specify on the single bill request to bypass the edits (Perform edits = N) to force the account into accounts receivables during midnight processing.

8. Access the Upload Electronic RA files from PC function on the Electronic RA Interfaces menu (under the Interface Functions menu.) If your ASCII file is in the \835BIN directory on drive C, accept the defaults to upload the file to your test ID. Once it has successfully uploaded the file, the system changes the file name on the PC to end with *.UPL*, indicating that the file has been uploaded.

9. Request the Electronic RA Audit report (FXRERAR) to make sure your data was uploaded correctly. To create this report, select the Print Electronic RA Audit Rpt function. Print it using the Demand Print function, or view and/or print it using the View Spooled Reports function.

10. Select the Process Electronic RA function, and complete any fields necessary to identify default values and matching criteria. When you accept this screen, the system creates an insurance cash batch for each subdivision of the source file.

11. View the rejected payments on the Electronic Remittance Rejection report (FXRERRR.) The system generates this report when the Process Electronic RA function is run. You can print the report using the Demand Print function or view and/or print it using the View Spooled Reports function.

12. View the accepted payments on the Electronic Cash Posting Audit report (FAR121). The system generates this report when the Process Electronic RA function is run. You can print the report using the Demand Print function or view and/or print it using the View Spooled Reports function.

13. Access the Post Cash function, and select the batch created. You can view, edit, print, delete, and approve this batch as you would any other insurance cash batch. You can also manipulate batch totals to force the batch to be in balance.

14. View the information on the Cash Posting Audit report (FAR120) to make sure payments were entered correctly.

15. Approve the cash batch, and review the Cash Posting Exception report (FAR140) for the message *RA Adj forced bal xfer*.

16. View transaction history for each account to confirm the dollar amounts and transaction codes for the insurance payments and contractual adjustments and to view the ICN in the insurance payment comment.

17. View the Adjustment Posting Detail report (FAR210) and the Cash Posting Detail report (FAR130) that are generated during midnight processing to confirm the posting of the insurance payments and contractual adjustments.

18. Additional testing should include:

    - reprocessing batches that have been created to modify the matching criteria and defaults
    - purging uploaded files
    - testing for specific rejection messages
    - posting of provider level adjustments.

SUPPORT PROCEDURES

When you receive this software, you are also assigned an McKesson contact person for support. This person is your primary support contact for any questions or problems you may have regarding uploading payment information and processing the information on the STAR Financials Patient Accounting system.

Direct questions or problems regarding the receipt of the data file to the appropriate person at your vendor or intermediary.

HOW TO USE ELECTRONIC REMITTANCE REJECTION REPORT

The following gives additional information on the messages you may receive on the rejection report and some tips for resolving these problems.

Message
Account not found

Cause
The account may have been purged off of the system, merged with another account, or there may be an error in the account number sent by the third party.

Resolution
Refer to the paper copy of the audit report sent by the third party or your vendor. Search for the account by name in the MPI inquiry function to determine if the account has been purged, merged, or the account number has been distorted in any way. If the account was purged, you may add the account to AR to post the payment. If the account was merged, you can post the payment to the merged account or add the account to AR. If the account number was distorted, post the payment to the correct account number in the open cash batch.

Message
Account in BD

Cause
The account is in Bad Debt.

Resolution
Post the payment directly to the account in the open cash batch. You may also want to review this account for follow-up processing, possibly transfer the account back to AR, and notify the collection agency of the change in the status of this account.

Message
No matching claim

Cause
A matching claim could not be found due to a mismatch in the dates of service, the claim was not loaded, or the claim type (for example, final or cycle) did not match.

Resolution
You can attempt to post the payments for these claims in the cash posting function. If the service dates do not match, you can review the claims available for each account in the cash posting function to determine if a payment can be posted. If the service through date is not matching, you can reprocess the batch, electing to bypass the service through date edit. This may occur if the third party vendor is incrementing the service through date on selected accounts. If additional information is required, review the claims using the Claims by Account function and create a claim, if necessary, using

the Add a Claim to Insurance function. If the claim type does not match, post the payment using the Post Cash function or reprocess the batch, adding additional claim types on the setup screen using the Process Electronic RA function.

Message
Multiple claims match

Cause
More than one claim exists on the account for the specified carrier and dates of service.

Resolution
You can attempt to post the payments for these claims in the cash posting function. When you enter the account number the system displays all available claims for the account; select the one to which you want the payment to post. If additional information is needed, review the claims using the Claims by Account function.

Message
Missing Adj Trans Code

Cause
The adjustment transaction code is not on the patient's insurance plan for the claim.

Resolution
Access the account using the Account Revision function, and modify the patient's insurance plan. There must be a valid transaction code in the Contr Adj Trans Code field on the Billing/Collection screen on the patient's insurance plan. This message is only received if there is an adjustment amount present on the detail record and the amount is to be posted as a contractual adjustment. You can also reprocess the entire batch with the Post Adjustment flag set to N if you do not wish to post adjustments to any of the accounts in the batch.

Message
Benefits Unassigned (Part B only)

Cause
If the LX segment’s field LX01 in the 835 payment file is set to 0, then the claims are unassigned. If the LX loop indicates that the claims are unassigned, then all claims are rejected and reported in the payment file. The error message, Benefits Unassigned, is reported on the Electronic Remittance Rejection Report, FXRERRR.

Resolution
No payment is made to the provider due to an assignment of benefits not being made by the patient/insured/responsible party. If benefits were actually assigned to the provider by the patient/insured/responsible party, you may use the Add a Claim to Insurance function to create a new claim ensuring that the Payer Benefits Assigned field on the claim is set to Y. If benefits were not assigned to the provider, manually disposition the claim, and transfer the balance as appropriate.

Message
No Match on Service Line (835 B only)

Cause
Additional matching criteria is in place for Part B 835 payment files. When each 1500 type claim is encountered, the first charge line on the claim will be compared to the first charge service line encountered in the SVC segment on the payment file. The performing provider number captured for the first service line will be matched to the doctor number on the first charge line in Box 24K of the CMS 1500. In addition, the procedure captured for the first service line will be matched to the procedure code on the first charge line in Box 24D of the CMS 1500 claim form. If the physician or procedure code does not match, then the claim is rejected and reported on the Electronic Remittance Rejection Report, FXRERRR.

Resolution
You can attempt to post the payments for these claims in the cash posting function. If the provider or procedure does not match, you can review the claims available for each account in the cash posting function to determine if a payment should be posted. If additional information is required, review the claims using the Claims by Account function, and create a claim with the appropriate physician/procedure information, if necessary, using the Add a Claim to Insurance function.

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■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Electronic Payments 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)

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