McKESSON
Empowering Healthcare

STAR 2000™

STAR FINANCIALS PATIENT ACCOUNTING REFERENCE GUIDE
Ontario Electronic Claims and Payments

Release 17.0
October 2011

F17000141

Publication date

October 2011

Produced in Cork, Ireland

Product and version

STAR 2000 Release 17.0

Publication number

F17000141

Reader comments

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

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Preface

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

The *General Information* volume is prerequisite reading for all other volumes of the *STAR Financials Patient Accounting Reference Guide*. Successful use of the *Ontario Electronic Claims and Payments* volume depends on your knowledge of the concepts covered in the *General Information* volume. This volume also references the reader to specific documentation found in the *Tables, Masters, and Parameters* volume of the *STAR Financials Patient Accounting Reference Guide*.

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

Enter patient name--

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

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

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

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

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Introduction

This document contains a detailed explanation of the electronic interface to the Ontario Ministry of Health available in the STAR Financials Patient Accounting System.

Chapter 1: Ontario Electronic Claims and Payments

This chapter discusses the prerequisites, interface functions, and file layouts for claim submissions and remittance advices. Reports that can be produced are also provided in this chapter.

Chapter 1 - ONTARIO ELECTRONIC CLAIMS AND PAYMENTS

Illustrations

INTRODUCTION

This document contains a detailed explanation of the electronic interface to the Ontario Ministry of Health available in the STAR Financials Patient Accounting System. The system has the ability to send claims on diskette and receive diskette payments in accordance with Ontario Ministry of Health specifications.

The claim information is sent on a diskette in the ASCII format specified by the Ontario Ministry of Health and is downloaded from the STAR Financials CPU to an IBM-compatible personal computer. The record layout for the claim data contains the information needed for the Ministry to process the claims.

The payment information is received on a diskette in the ASCII format defined by the Ontario Ministry of Health and is uploaded from an IBM-compatible personal computer to the STAR Financials CPU. The record layout for the payment data contains the information needed for posting the payments. Additional header information is also used for control purposes.

Prior to uploading the payment information, you are asked to complete a *set-up* screen that is similar to the default value screen in insurance cash posting. The valid carrier code is entered and the default value for either partial or full payments is defined. Adjustments are calculated by determining the variance between the amount submitted and the amount paid and can be posted to the account along with the payment.

The payment records are read and matched to claims on the patient accounts, using the patient's account number, carrier code, clinic code, performing physician, SoB code, and dates of service. Payments are not posted to claims that have been replaced by an adjustment claim. The adjustment claim is used instead. Payments that cannot be matched to a charge line within a claim, or match more than one charge line within a claim, are reported on a rejection report.

Payments that uniquely match claim charge detail lines in 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 rejection report. You can view, print, and edit this batch in the existing cash posting function. In order 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 dollar amount of the payments 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.

NOTE: This document uses the terms *electronic remittance* and *electronic payment* interchangeably. The document also refers to storing data files on the hard drive of your personal computer, although you may be using a networked drive or floppy disk drive. If you are using a networked drive, remember to use the drive and directory indicators as appropriate to your environment.

PREREQUISITES

Hardware and Software Requirements

To download electronic claims and upload electronic payments from a third party, 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).

Disk space requirements depend on the amount of claim data sent, the amount of payment data received, and the length of time the data resides on the PC. Claims sent by diskette and payments received by diskette usually do not reside on the hard drive.

You must be on the 15.1 release of STAR Patient Accounting and be configured as a Canadian customer to receive the OHIP Electronic Claim and OHIP Remittance Advice software.

PC Preparation

Your PC must be equipped with a licensed version of PC Director emulation software.

No other preparation is necessary when files are downloaded or uploaded directly to or from a diskette.

If you want to copy your claim files to your hard drive, McKesson recommends that you set up a separate directory, OHIPCLM, to contain those files. If you want to copy your payment files to your hard drive, McKesson recommends that you set up a separate directory, OHIPRA, to contain those files.

NOTE: After you successfully upload the remittance advice file to the STAR Patient Accounting CPU, the name of the file changes. The file name begins with *Z* when the file has been processed on the remittance diskette from the Ministry of Health; for example, ZC8924.001 is the file name after PC8924.001 is processed.

Perform the following steps to prepare your PC to use the Electronic Claim and the Electronic Remittance Advice software. Note that the PC must meet the hardware requirements stated above. If you choose to copy the remittance advice data from the Ministry diskette to your hard drive, the following is recommended:

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

NOTE: The data files may reside on a drive other than C and in a directory other than OHIPRA.

2. Receive a data file into this directory. The ASCII file name must be in the format pfclin.seq, where:

p = original file indicator
f = an alpha identifier
clin = four-digit clinic number
seq = three-digit file sequence number

Example: PE8727.001

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

Downloading of Data

Before you can download data to claim diskettes, you need to verify that your system is set up properly to create claim data and download data. Before beginning, review this checklist and ensure that each step has been completed and verified.

1. The Schedule of Benefits file has been loaded onto the system.

2. The Schedule of Benefits Parameters are correct.

3. The Provider table (Financials) has the correct institution numbers.

4. The Doctor table has the appropriate OHIP number, specialty code and clinic default assignments. The Physician Specialty table should have correct MOH Bill Codes.

5. The Financial table - Physician Bill Codes OHIP - has the correct twelve-digit numbers (Clinic [4] - Doctor [6] - Specialty [2]).

6. The Claim Load and Edit Parameters are set up for Ministry of Health (H).

7. Report definitions are set up for OHIP Daily Billing (FMRPCS_), Diskette submission (FMRPSS_), OHIP Production (FMRPCP_) and Outstanding OHIP A/R (FMRPAR_) reports. Ensure that the retention days for each report are set to a minimum of three days and the reports have been assigned to an appropriate printer.

8. Verify clinic assignments have been made for the following:

   - Doctor
   - Charge location
   - Department
   - Sub-Department
   - FIM item

9. Verify the Service Item Master (SIM) has the correct pricing assignments for each Financial Class and variable price fields, correct ProFee Flags, Professional Fee

Items linked to technical components, correct Sub-Department and FIM Item assignments.

10. Verify the Financial Item Master (FIM) has the correct Proration Summary codes, Alternate Summary Code 2 and 3 assignments, Type of Service, SoB codes and clinic numbers.

    NOTE: Use the SIM/FIM Analysis report (ATSBAR_) to review the relationship of the SIM to the FIM. This report also provides details of the above information.

11. Verify Ministry Insurance Plans are correct, especially the Proration Summary Code Exceptions.

12. Verify that the Patient Type table points to the correct variable price field in the SIM.

13. The Patient Care ICD-9-CM Diagnosis Pointer table should have the appropriate Provincial Diagnosis assignments.

Uploading of Data

Before you can upload and process the payment diskettes from the Ministry, you need to verify that your system is set up to properly receive the data. Before beginning, please review this checklist and ensure that each step has been completed and verified.

1. Set up your Electronic Remittance Parameters. This requires you to establish several Miscellaneous Cash Codes which need to be mapped to the General Ledger. The codes entered on these parameters are used to post any non-patient amounts included on your diskettes, such as Claims Adjustments and Advance Repayments.

2. Verify that your Ministry Insurance Plans have been set up with the appropriate adjustment transaction code required to post the calculated adjustments with the payments. This information may be found in the Facility Information portion for each insurance plan.

3. Verify that the Cash Posting Exception (FAR140_), OHIP Reconciliation (FMRPSR_), Electronic Remittance Audit (FXORAR_), Rejection (FXORRR_), and Exception (FXORER_) reports have been correctly defined in Reports Maintenance. Ensure that the retention days for each report are set to a minimum of three days and that the reports have been assigned to an appropriate printer.

4. Verify that your OHIP Exceptions table has been defined for those exception codes that should be rejected and automatically excluded from the cash batch when the remittance is processed.

HOW UPLOADING WORKS

The Electronic Remittance Advice software uses the PC Director file transfer utilities to upload data files from the PC to a STAR CPU. The system scans the specified directory on the PC for all files beginning with P. You can specify a single file or have the system upload all files beginning with P from the designated drive/directory.

When the system determines that a file has the exact same primary name as a previously uploaded file, then the system appends the second file to the first file. For example, the file PC8924.002 is appended to the file PC8924.001 when it is uploaded.

After the data is uploaded and verified, the name of the data file on the PC changes and begins with Z instead of P; for example, the file PE8727.001 becomes ZE8727.001.Directory Maintenance.

You are responsible for maintaining the directory containing electronic remittance files (\OHIPRA directory) on the PC. McKesson designed the naming convention outlined above to help prevent you from deleting data files in error. By using standard DOS techniques, you can view the \OHIPRA directory and delete data files beginning with Z. For example, from the DOS command line enter DIR C:\OHIPRA Z*.*. This DOS command displays only those files in the \OHIPRA directory on drive C whose names begin with the letter Z. The naming convention also makes it easier to recognize files in specific date ranges. For more information, refer to your DOS user's guide.

The frequency with which you delete files depends on the amount of disk space available on the PC if you choose toload the files on to the hard drive. For greater data security, you may also want to maintain back-ups of data files.

INTERFACE FUNCTIONS

To access the Interface Functions menu, choose the Financial System Management option from the initial menu. Next, choose the Interface Functions option from the Financial System Management menu. The Interface Functions base menu is displayed as follows:

```
                  General Hospital Interface Functions Processor
                                                Sun Jun 11, 1996 12:52 pm

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

  DOWNLOAD      7       Ministry Claim Data
                8       Recreate Download Diskette


Enter option number--
```

NOTE: The menu above is from the base STAR Financials Patient Accounting system. Menus may differ at your facility.

Refer to the Financial System Management section in the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for documentation of the following menu options:

- TRENDSTAR Interfaces
- Charge Summary
- Revenue Service Statistics

This document discusses the remaining menu options from the above screen:

- Electronic RA Interfaces
- Ministry Claim Data
- Recreate Download Diskette

Also discussed in this document are reports specific to the Electronic RA Interfaces, reports specific to Downloading Ministry Claims, file layout (or technical specifications specific to claim downloading), and some common error messages with hints and tips for troubleshooting the cause(s).

Electronic RA Interfaces

When you select the Electronic RA Interfaces option, the system displays the following submenu:

```
              General Hospital Interface Functions Processor
                                                Sun Jun 11, 1996 12:51 pm

Electronic RA Interfaces Input Options

            Option No.  Option
            ---------------------------------------
                1       Upload Electronic RA files from PC
                2       Process Electronic RA
                3       Print OHIP RA Audit Rpt
                4       Purge Electronic RA files
                5       Delete Electronic RA files from STAR
                6       OHIP RA Parameters









Enter option number--
```

UPLOAD ELECTRONIC RA FILES FROM PC

When you are ready to upload and process your payment diskettes, there are several steps you need to take. The following is an outline of the suggested steps. Each business office should develop its own hospital-specific guidelines regarding diskette processing for the staff to follow.

Step 1. Upload the diskette.
Step 2. Process the file.
Step 3. Work the rejections.
Step 4. Balance the reports.
Step 5. Post the batch.
Step 6. Run Midnight Processing.

For detailed information of each outline step, refer to the Suggested Procedure for Processing Electronic RA discussion.

To begin the upload of your payment diskettes, select the Upload Electronic RA Files from PC menu option from the Interface Functions Processor menu.

The system prompts you to select a facility, if applicable. After you select the desired facility, the following prompt is displayed:

Enter the drive [A]--

To accept the default of A, press **ENTER**. If the data file is on a drive different from A, enter the letter that designates the drive. Next, the system displays the following prompt:

Enter the directory --

Press **ENTER** if you want to accept the default of no specified directory. Ministry diskettes need no directory to be specified. If the data file is in a directory, enter the full path name of the directory. After you enter the full path of the directory, the following prompt is displayed:

Enter the file name to upload [All]--

To upload all data files from the specified directory, press **ENTER** for the default. To upload a specific data file, enter the name of the data file. The system only uploads data files beginning with the letter P.

After you enter a specific file or the default of All, the system begins to upload the file(s) to the STAR Patient Accounting CPU. An information window displays the status of the files as they upload to the CPU. This process simply copies the payment file from the diskette onto the system.

Reports are not automatically produced when a file is uploaded; however, after a file is uploaded, you can manually request the Remittance Audit report from the menu. When you run the Audit Report, the system automatically generates the OHIP Remittance Exception Report. Refer to the Print OHIP RA Audit Rpt function for information regarding the review of data file contents.

NOTE: McKesson recommends that you print these reports and compare the total amount on the Audit Report to the total amount deposited into your bank account from the Ministry.

The Remittance Audit report lists *each* entry on the diskette in the order that it is received. Often, a diskette includes both patient payments as well as non-patient adjustments. The non-patient adjustments are posted as miscellaneous cash entries.

If the Audit Report total does not equal the total amount deposited by the Ministry, STOP! You need to call your McKesson representative before continuing with your remittance.

PROCESS ELECTRONIC RA

The Process Electronic RA function enables you to create an insurance cash batch from an uploaded file, identify matching criteria, and assign default values for posting. When you access this function, the system prompts you to select a facility, if applicable.

After you select the desired facility, the uploaded files display. Only files that have been uploaded, but not posted, display:

```
                General Hospital Process Electronic RA Processor
                                                Tue Jun 20, 1996 12:54 pm
Page:01                          Uploaded Files
     File name    Payment Dt   Upload Dt   Current Status     Batch#

( 1) PC0808.001     Dec 30      Aug 05     Uploaded
( 2) PC8924.001     Dec 09      Dec 09     Uploaded









Enter choice--
```

Field Explanations

FILE NAME (DISPLAY ONLY)
The system displays the name of the file sent from the Ontario Ministry of Health.

PAYMENT DT (DISPLAY ONLY)
This column shows the payment date sent in the file from the Ontario Ministry of Health.

UPLOAD DT (DISPLAY ONLY)
The date the file was uploaded to the STAR Patient Accounting CPU is displayed in this column.

CURRENT STATUS (DISPLAY ONLY)
If a batch has been created, the status of the batch is displayed. Files that have been uploaded, but not yet processed, have a status of *Uploaded*. If a batch has already been created, the cash batch status is displayed as either Balanced, Unbalanced, or On Hold.

BATCH # (DISPLAY ONLY)
The number of the associated insurance cash batch is displayed. Files with an Uploaded status have a blank batch number.

Select the desired data file. The file can have an Uploaded status, which indicates that the insurance cash batch has not yet been created. The file can have a Batch Unbalanced, Batch Balanced, or Batch On Hold status, which indicates that the batch has been created, but not yet approved. If a batch has been created and not approved, you can recreate the batch. If you select a file that has already been processed, the

existing insurance cash batch will be deleted, and replaced by the data in the uploaded file. You cannot select a batch for recreation if the batch has been approved and posted. Approved and posted batches do not display with the list of data files.

When you select an Uploaded data file, the system prompts you to enter a batch number or you can have the system auto-assign the batch number. The system checks the currently assigned cash batch numbers to avoid assigning a duplicate number.

After you assign the batch number, the system displays the following screen:

```
                    General Hospital OHIP RA Setup Processor
                                          Tue Dec 12, 1995 12:54 pm

 1 Batch #                  2 Batch Description               3 # of Trans
   805                        OHIP RA - 95/05/08                10
 4 Posting Date             5 Payment Date        6 Batch Total
   95/12/12                   95/12/03              $45,353.61

                              Matching Criteria
 7 Match carrier            8 Type of claim form  9 Claim Type
   099-CANADIAN PROVINCIAL    OHIP                  A,C,F

                            Electronic RA Defaults
10 Payment Date     11 Payment Trans Code/Description      12 Allow Contr Adj?
   95/12/03           I1002-General Insurance Payment        Yes
13 Alt Contr Adj Trans Code/Desc        14 Remittance #    15 Claim Disposition
   A0001-CONTRACTUAL ADJUSTMENT           8924-000000-13     Partial Payment
16 Post non-patient adjustments?
   Yes


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

Field Explanations

1. BATCH # (DISPLAY ONLY)
The previously assigned batch number is displayed.

2. BATCH DESCRIPTION (DISPLAY)
The batch description is displayed as entered by the user.

3. # OF TRANS (DISPLAY ONLY)
The total number of detail payment records that were sent is displayed.

4. POSTING DATE (DISPLAY ONLY)
The system displays the current date.

5. PAYMENT DATE (DISPLAY ONLY)
The payment date from the source file is displayed.

6. BATCH TOTAL (DISPLAY ONLY)
This field displays the total payments sent by the third party carrier.

Matching Criteria

7. MATCH CARRIER (4-C-R)
Enter the carrier code of the third party carrier for whom payments are to match.

8. TYPE OF CLAIM FORM (1-A-R)
Enter **H**, for OHIP claim type.

9. CLAIM TYPE (SPECIAL FORMAT-R)
You can enter multiple claim types separated by commas (,). Enter F for Final, **A** for Adjustment, and/or **C** for Cycle. If you leave this field blank, all claim types are included.

Electronic RA Defaults

10. PAYMENT DATE (SPECIAL FORMAT-R)
The payment date from the payment date field is displayed; however, you can modify the date.

11. PAYMENT TRANS CODE/DESCRIPTION (TABLE LOOKUP-R)
Enter the transaction code used to post the payments if you know it, or a hyphen (-) to select from the displayed list. Ifyou leave this field blank, the system uses the payment transaction code from the insurance plan for the claim.

12. ALLOW CONTR ADJ? (1-A-R)
When you enter **Y**, the adjustment amount is determined by subtracting the amount paid from the amount submitted and posting the difference as a contractual adjustment. If you enter **N**, the contractual adjustment field is not auto-filled but can be entered manually with each entry via cash posting. Remittance posting for OHIP claims requires this response to be Y. Otherwise, you receive an error message *OHIP adjustments must be posted*.

13. ALT CONTR ADJ TRANS CODE/DESC (TABLE LOOKUP-O)
Enter an alternate contractual adjustment transaction code to be used for this cash batch instead of using the contractual adjustment transaction code on the patient's insurance plan. Enter the code, if you know it, or a hyphen (-) to select from the displayed list. When you leave this field blank, the patient's insurance plan contractual adjustment code is used. The cursor does not automatically stop at this field. To access this field, enter /13 from any field on the screen.

14. REMITTANCE # (DISPLAY-O)
This field displays the physician billing number sent by the Ontario Ministry of Health. You can modify the billing number. The billing number is a combination of the Group Number (9999), the Health Care Provider (NNNNNN) or all 0's for multiple physicians in the same clinic, and the specialty (NN) sent in the HR1 record.

15. CLAIM DISPOSITION (1-A-R)
Since each claim can have multiple payments from the Ontario Ministry of Health, the Claim Disposition field always defaults to P, for partial payment.

16. POST NON-PATIENT ADJUSTMENTS? (1-A-R)
When you enter **Y**, the deductions and accounting transactions sent by the Ontario Ministry of Health in HR6 and HR7 records are posted as miscellaneous cash entries. You must set up miscellaneous cash codes and the OHIP RA Parameters before using this feature. Enter **N** if you do not want to post deductions as miscellaneous cash entries.

When you accept this screen, the system begins to create the insurance cash batch from the uploaded file. If an insurance batch exists for the uploaded file, the system displays the following error message:

Insurance cash batch already exists. Rerun? (Y/N) --

Enter **Y** to delete the existing batch and recreate it from the uploaded file. Enter **N** to return to the set-up screen to edit the fields.

Matching Criteria

The uploaded payment data is used to create the insurance cash posting file. As the system reads each record, the patient data base is scanned for a matching claim record. Matching criteria includes:

- SoB Code
- Patient Account Number
- Carrier Code
- Dates of Service
- Type of Claim Form
- Claim Type (final, cycle, and/or adjustment)
- Performing Physician Billing Number
- Submitted Amount

Payments must be posted to a valid charge line within a claim. If there is no matching claim charge, it will be reported on the OHIP Remittance Rejection report with a *No Matching Charge* reason. If a payment matches more than one claim on the account, the payment will be reported on the OHIP Remittance Rejection report with a *Multiple Claims Match* reason. Other reasons for rejection include:

- No matching SoB Code
- Account not found
- Account in BD
- Missing Adj Trans Code
- Account Archived
- No Matching Physician Number

The system does not use claims replaced by other claims as matching claims. It only uses the newer claim, or adjustment claim, in the matching process.

Posting Payments

Payments are sent by the Ontario Ministry of Health at the charge level. Payments that uniquely match claim charge detail lines in existing claims are placed in an open insurance cash batch. When the payment is processed, the charge line within the claim is updated along with the overall carrier/claim information.

Posting Adjustments

You can calculate and post adjustments in conjunction with the payments. The value entered in the Allow Contr Adj? field on the set-up screen determines if an adjustment should be posted to the account. When the value of the Allow Contr Adj? field is set to Yes, the adjustment amount is calculated by subtracting the charge item amount paid from the charge item amount submitted and loaded in the insurance cash batch. When the value of the Allow Contr Adj? field is set to No, only the payment is posted.

When the value of the Allow Contr Adj? field is set to Yes and the Alt Contr Adj Trans Code/Desc field is left blank, the insurance plan associated with the claim is checked for the presence of a contractual adjustment transaction code. If the contractual adjustment transaction code does not exist, the system rejects the payment with a Missing Adj Trans Code reason. If the Alt Contr Adj Trans Code/Desc field contains a transaction code, then this code is used and the insurance plan check is not performed.

Batch Status

You can manually assign a batch number to the newly created insurance batch, or you can have the system automatically generate a batch number. The Batch Total is the total amount of the payments sent by the third party carrier, including rejected payments. The Total Entered is the sum of the payments that were entered into the batch. When the Batch Total and the Total Entered match, the batch status is Balanced. When the Batch Total and the Total Entered do not match, the batch status is Unbalanced.

As you exit the Process Electronic RA function, the following screen is displayed:

```
                General Hospital Exit Batch Processor
                                              Fri Mar 18, 1996 10:33 am

 1 Batch #            2 Batch Description                  3 # of Trans
   2                    OHIP RA - 96/03/18                   10
 4 Total Matched      5 Batch Total       6 Variance       7 Batch Status
   1,229,808.00         1,230,000           1,212.00         Unbalanced









Batch is out of balance - Accept (A), Print (P), or Edit (E)? --
```

Enter **A** to accept the screen and return to the Interface Functions menu. Enter **P** to print a hard copy of the screen to your local printer. Enter **E** to edit the fields on the screen.

You can view, edit, print, and process the newly created insurance batch via the Cash Posting Processor. If the batch status is Balanced and you approve the batch, the approval causes the batch to be posted. If the batch status is Unbalanced, you can print the OHIP Remittance Rejection report (FXRORRR) to review the reasons payments were rejected.

You can manually enter rejected payments into the newly created batch, or you can edit the Batch Total to force a match to the Total Entered followed by processing the rejections separately. The Batch Total must match the Total Entered in order for the batch to be approved.

If you want to adjust the matching criteria in order to reduce the number of rejected payments, the entire batch can be recreated by re-entering the processed file in the Process Electronic RA menu option. When you re-process the uploaded file, the system deletes the corresponding insurance cash batch and recreates it from the uploaded data. The system also deletes any manual edits you made to the original insurance cash batch.

NOTE: After processing the Electronic Remittance Advice, each detail record is listed on either the Cash Posting Audit report if it passed all matching criteria, or on the OHIP Remittance Rejection report if it did not pass all matching criteria. All records are combined on the OHIP RA Audit report.

Batch Approval

When the batch is approved, the system deletes the uploaded file from the STAR Patient Accounting CPU. Deleting the uploaded file prevents the recreation of an insurance batch for payments that have already been posted, and prevents the file from displaying in the uploaded files look-up screen. Deleting uploaded files also prevents unnecessary use of disk storage space.

TRANSFER OF FUNDS

The notification and transfer of funds to cover the OHIP remittance advice is handled outside of this process. It is the facility's responsibility to ensure that the funds to cover the electronic remittance advice are received by the facility.

You can keep account of the payments received by maintaining separate PA/GL mapping and general ledger account numbers for the payments received. To maintain separate PA/GL mapping and general ledger account numbers, you can set up a separate transaction code for the batch, which you enter on the set-up screen, and map the transaction code to a separate account in the general ledger.

PRINT OHIP RA AUDIT RPT

When you want to view the contents of a data file uploaded to the STAR Patient Accounting CPU, select the Print OHIP RA Audit Rpt menu option. The OHIP RA Audt report enables you to verify the file data and note any variance between the expected number of records and the amount of payments reported by the Ontario Ministry of Health. You can print this report at any time after the file is uploaded to the STAR Patient Accounting CPU and before being posted to the associated cash batch.

The Print OHIP RA Audit Rpt function also generates the OHIP RA Exceptions report. The Exceptions report lists all claims that were returned from the Ministry with an exception code.

When you select the Print OHIP RA Audit Rpt menu option, the system prompts you to enter a facility, if applicable.

After you enter the desired facility, the system displays a list of the uploaded files:

```
          General Hospital Print Electronic RA Audit Rpt Processor
                                                 Tue Dec 12, 1995 12:54 pm
Page:01                          Uploaded Files
     File name    Payment Dt   Upload Dt   Current Status     Batch#

( 1) PC0808.001     Jul 30      Aug 05     Uploaded
( 2) PC8924.001     Dec 09      Dec 09     Uploaded
( 3) PC7654.001     Dec 11      Dec 11     Batch unbalanced   329
( 4) PC3421.001     Dec 11      Dec 11     Batch balanced     330









Enter choice--
```

Field Explanations

FILE NAME (DISPLAY ONLY)
The system displays the name of the uploaded data file.

PAYMENT DT (DISPLAY ONLY)
The date that the Ontario Ministry of Health pays the claim is displayed in this column.

UPLOAD DT (DISPLAY ONLY)
This column displays the date that the data file is uploaded to the STAR Patient Accounting CPU.

CURRENT STATUS (DISPLAY ONLY)
This column displays the status of batch, if it has been created. Files that have been uploaded but not yet processed have a status of *Uploaded*.

BATCH # (DISPLAY ONLY)
The insurance cash batch number is displayed in this column. This column is blank for files with a status of uploaded.

To print any of the available data files, enter the number corresponding to the desired file. The report information comes directly from the uploaded file and can be used to check for variances and/or validate the information received. Refer to an example of the OHIP RA Audit report (FXRORAR) and an example of the OHIP RA Exceptions report (FXRORER).

PURGE ELECTRONIC RA FILES

If you store your OHIP payment files on the hard drive of your PC, you can use the Purge Electronic RA Files function to remove them. You can run the purge function any time you want to increase available disk space on your PC system. The Purge Electronic RA Files function displays uploaded files that begin with the letter Z for purging.

When you access the Purge Electronic RA Files menu option, the system displays the following prompt:

Enter the drive [C]--

To accept the default of C, press **ENTER**. If the desired file is on a drive different from C, enter the letter that designates the drive. Next, the system displays the following prompt:

Enter the directory [\OHIPRA]--

Press **ENTER** if you want to accept the default of the specified directory. If your data files are in a different directory, enter the full path name of the directory.

When you press **ENTER** or enter the full path of the directory, the system displays a list of all uploaded files. Select the file(s) that you want to purge. After you make your selection(s) the system displays the following prompt:

Are you sure you want to purge selected files? (Y/N) [N]--

Enter **N**, or press **ENTER**, to exit this function without purging the file(s) and return to the Electronic RA Interfaces menu. Enter **Y** to proceed with the 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 uploaded files as on the following screen:

```
       General Hospital Delete Electronic RA Files from STAR Processor
                                                 Mon Jan 22, 1996 12:54 pm

Page:01                          Uploaded Files
    File Name   Trns Dt  Upld Dt    Status       Batch  SRC   Batch Description

( 1) PE8821.001 Dec 30   Aug 30     Uploaded            MOH
( 2) PL4912.001 Mar 10   Mar 12     Unbalanced     97   MOH









Enter choice--
```

Field Explanations

FILE NAME
This column displays the name 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, which is MOH for Ministry of Health.

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.

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 report:

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]--

Where **###** is the cash batch number.

Enter **N** if you do not wish to delete the file. The system displays the list of files to delete. Enter **Y** if you do wish to delete the file. The system displays the list of files to delete.

NOTE: To upload a source file, the file on the PC may need to be renamed.

OHIP RA PARAMETERS

The OHIP RA parameters use the Miscellaneous Cash posting functionality to direct the non-patient deductions and accounting transactions, which are found in the HR6 and HR7 records, to the appropriate GL accounts.

Before you complete the OHIP RA parameter screen, you must establish Transaction Codes for Miscellaneous Cash table entries, Miscellaneous Cash Codes table entries, and the associated PA/GL mapping entries for the non-patient adjustments sent in the OHIP RA.

When you create your Miscellaneous Cash Code table entries, remember that the GL account number you enter is credited the amount that the Transaction Code debits from the corresponding mapped GL account.

The deductions from the amount sent on the remittance advice are found in the HR6 record. These amounts are always negative because they are adjustments to the account for a surplus of funds sent on an earlier remittance advice and reduce the Total

Entered amount on the cash batch. The deductions need to be processed as negative payments. There are three deductions in the HR6 record:

- Claims adjustments
- Advances
- Reductions.

The HR7 record contains additional adjustments that are processed as Miscellaneous Cash entries. There can be multiple HR7 records. The transaction code indicates which type of adjustment is being processed. The amount can be positive or negative; therefore, the cash batch *Total Entered* amount can either increase or decrease. The Miscellaneous Cash Codes entered on the OHIP RA parameter screen must match the OHIP transaction code sent for processing.

For information regarding Miscellaneous Cash Code table entries and Transaction Code table entries, refer to the Financial Table Maintenance chapter in the *Tables, Masters and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*. For information regarding GL mapping, refer to the GL Mapping Maintenance chapter in the *Tables, Masters and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

When you select the OHIP RA Parameters menu option, the system prompts you to select the desired facility, if applicable. After you select the desired facility, the following screen is displayed:

```
                General Hospital OHIP RA Parameters Processor
                                              Tue Nov 15, 1995 04:34 pm

                    Deductions for Amounts Brought Forward
 1 Claims Adj                2 Advances                3 Reductions
   61-CLAIMS ADJUSTMENTS B     62-ADVANCE B/FORWARD      63-REDUCTION B/FORWARD

                             Accounting Transactions
 4 Advance (10)              5 Reduction (20)          6 Advance Repayment (40)
   10-ADVANCE (10) OHIP        20-REDUCTION (20) OHIP    40-ADVANCE REPAY (40)

 7 Accounting Adj (50)       8 Attachments (70)        9 Default
   50-ACCOUNTING ADJUSTME      70-ATTACHMENTS            99-DEFAULT FOR OHIP RA




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

Field Explanations

Deductions for Amounts Brought Forward

1. CLAIMS ADJ (TABLE LOOKUP-R)

Enter the appropriate Miscellaneous Cash Code table entry for this deduction. The corresponding mapped GL account is credited the amount that the Transaction Code

debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

2. ADVANCES (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this deduction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

3. REDUCTIONS (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this deduction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

Accounting Transactions

4. ADVANCE (10) (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this account transaction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

5. REDUCTION (20) (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this account transaction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

6. ADVANCE REPAYMENT (40) (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this account transaction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

7. ACCOUNTING ADJ (50) (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this account transaction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

8. ATTACHMENTS (70) (TABLE LOOKUP-R)
Enter the appropriate Miscellaneous Cash Code table entry for this account transaction. The corresponding mapped GL account is credited the amount that the Transaction Code debits the GL account. If the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes in the Transaction Code table, the system uses the default transaction code for the debit. You can enter the Miscellaneous Cash Code table entry code if you know it, or a hyphen (-) to select from the displayed list.

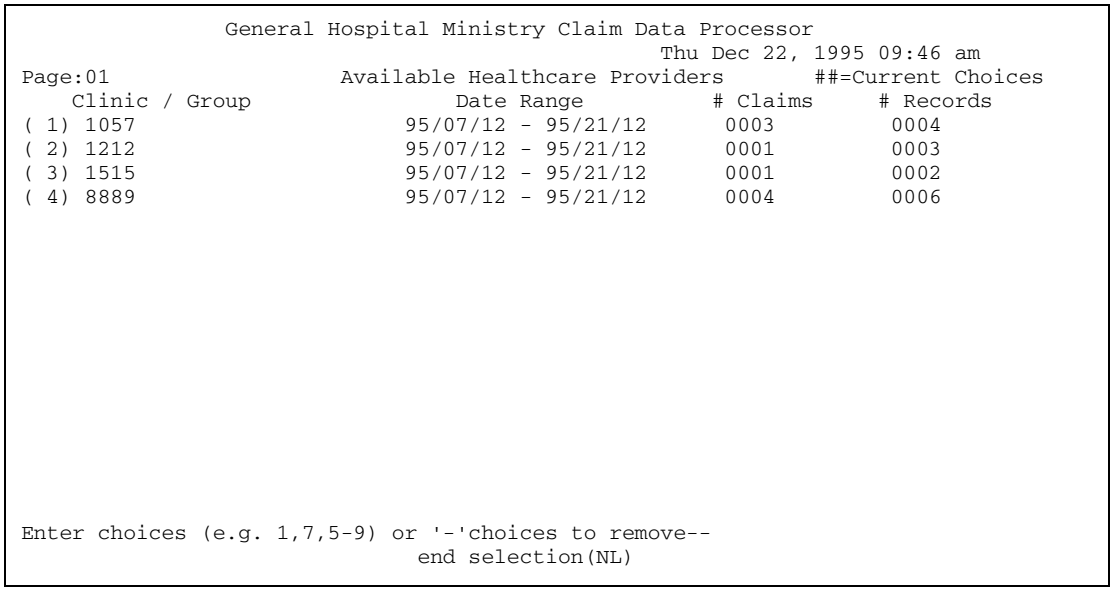
9. DEFAULT (TABLE LOOKUP-R)
Enter the default Transaction Code Miscellaneous Cash table entry code for the system to use when the Transaction Code sent by the Ontario Ministry of Health does not match one of the defined codes. You can enter the Transaction Code Miscellaneous Cash table entry code if you know it, or a hyphen (-) to select from the displayed list.

When you accept the screen, the transaction is complete.

Download Ministry Claim Data

The Download Ministry Claim Data function is used to download OHIP claim information from the STAR system to a diskette for submission to the Ontario Ministry of Health. The diskette is formatted according to specifications provided by the Ontario Ministry of Health. The claims are available for download after they are released. When you select the Download Ministry Claim Data menu option from the Interface Functions menu, the system prompts you to enter a facility, if applicable.

After you select the desired facility, the system displays a screen similar to the following with a list of data files that are available for downloading:



Each data file displays the following information:

CLINIC/GROUP (DISPLAY ONLY)
The clinic number or group number which has claims to be downloaded is displayed in this column.

DATE RANGE (DISPLAY ONLY)
This column displays the beginning and end dates for the claims.

 # CLAIMS (DISPLAY ONLY)
The system displays the number of claims for this clinic or group.

 # RECORDS (DISPLAY ONLY)
The number of records is displayed for this clinic or group.

Select the clinics that you want to download. After you select the desired clinics, the system displays the following prompt:

Enter Drive to output data (A/B) [A]--

To accept the default of A, press **ENTER**. If you want to download the desired file(s) to a drive different from A, enter the letter that designates the drive. Next, the system displays the following prompt:

Enter Directory Path A:\ [Root]--

Press **ENTER** if you want to accept the default of the specified directory. If your data files are in a different directory, enter the full path name of the directory.

NOTE: The responses to the above two prompts are joined to determine the location for the file. If *C* is keyed for the drive, and *download\msp* is keyed for the directory path, the location of the file is as follows: c:\download\msp. The name for the file is send.dat, and the complete name for the file would be as follows: c:\download\msp\send.dat.

When you press **ENTER** or enter the full path of the directory, the system displays a brief message as follows:

Combining doctors into clinics!

When the system is finished combining doctors into clinics, the following prompt is displayed for each clinic or group created:

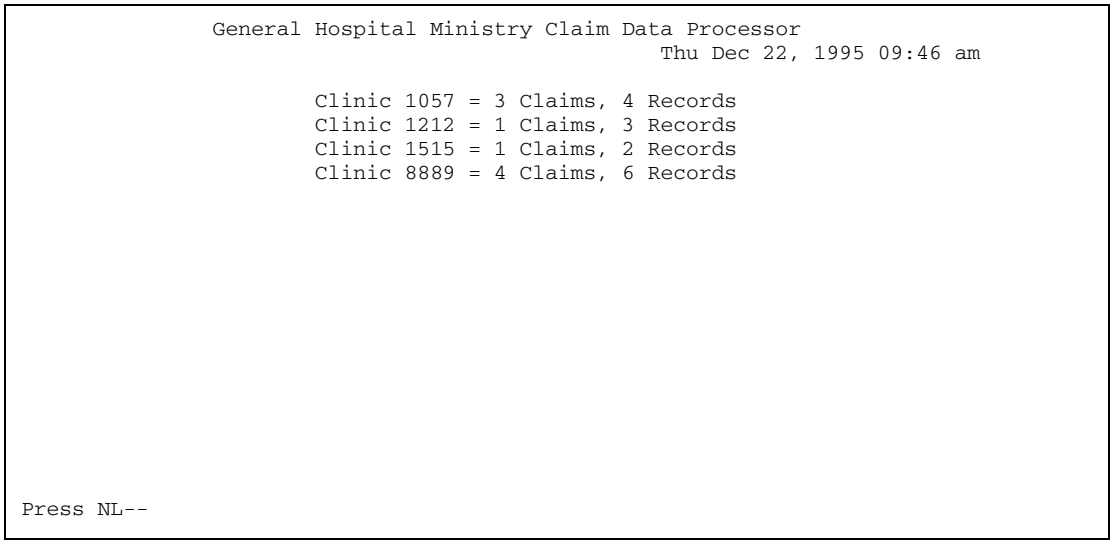
Load diskette for Clinic 1057, Press Enter when ready --

Place a blank diskette in the designated drive, and press **ENTER**.

The system begins to download the file to the diskette. An information window displays the status of the file as it is downloaded to the diskette. This process copies the system file to the diskette.

When the system finishes downloading the clinic information to the diskette, the screen displays the clinic number and its corresponding number of claims and records that have been downloaded. These numbers must be recorded on the diskette label, along with the hospital name and clinic number.

If you chose several data files to download, you are prompted to load a diskette for each individual clinic. As each download is completed, the system displays the clinic number and its corresponding number of claims and records that have been downloaded to a diskette as follows:



The number of the clinic is displayed in addition to the number of claims and records downloaded. This data should be transferred to the diskette label. Press **ENTER** to continue with the download process.

When you have downloaded all selected data files, the system copies the data files to an archive directory and displays the following verification message:

Archiving downloaded data! Please wait!

When the archive process is complete the Diskette Submission report (FMRPSS_) is auto started and printed. You are then returned to the Interface Functions menu.

Recreate Download Diskettes

The Recreate Download Diskettes function provides the capability to reproduce a previously created diskette from archived data files.

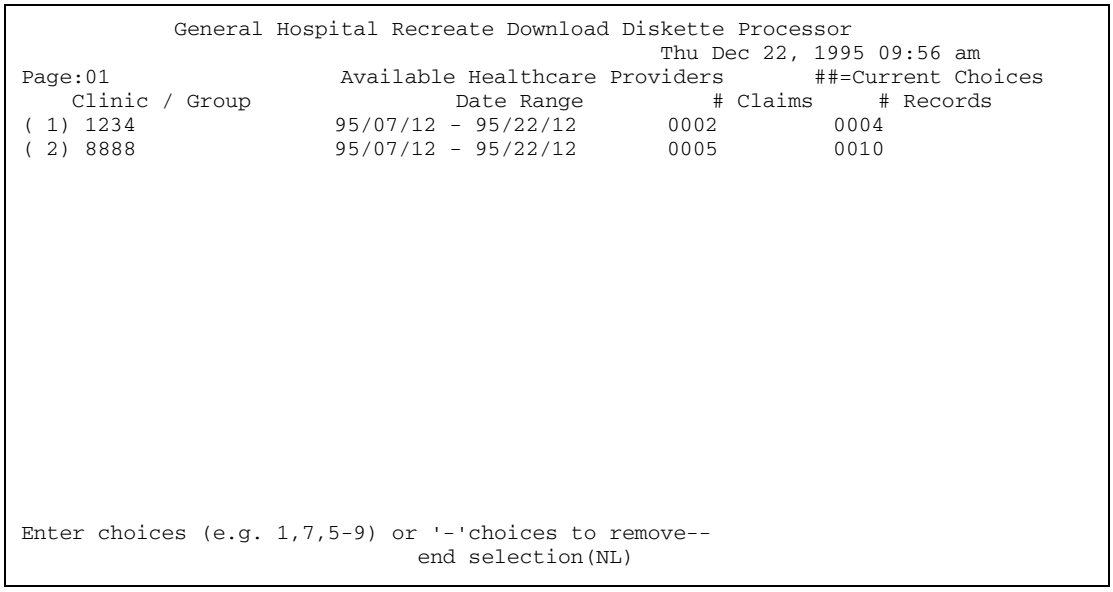
When you choose the Recreate Download Diskettes menu option, the system takes you through the process of downloading data files onto diskettes in much the same manner as discussed in the previous subsection Download Ministry Claim Data. Instead of displaying data files from which you can select, the system displays dates of previously downloaded data files as follows:

```
                  General Hospital Recreate Download Diskette Processor
                                              Thu Dec 22, 1995 09:51 am
Page:01                          Download Dates              ##=Current Choices

( 1) 95/11/17
( 2) 95/12/22









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

Enter the date for which you want to reproduce a downloaded diskette.

After you select the desired date, the system displays the detail for the data file you want to reproduce.

The clinic or group number, date range for which claims are included, the number of claims, and the number of records are displayed:



Select the data file(s) that you want to download.

The system prompts you to enter the drive and path of the loaded diskette for each clinic or group data file that is selected to download. As each clinic or group data file is downloaded, the system displays the clinic number and its corresponding number of claims and records in the same manner as previously discussed in the Download Ministry Claim Data subsection.

ONTARIO RECIPROCAL CLAIMS

This facility-specific option is used to download the reciprocal billing, out of province claim information from the STAR system to a file for submission to the Ontario Ministry of Health. The claims are available for download after they are released.

This processor is used to download accumulated claim information to a PC directory. When a claim of type 10 or 12 loads, imported Medical Records information is saved for this download. When a claim of type 10 or 12 is printed, the claim information is formatted for the download file. The information is downloaded when the user elects to create the download file. Each claim service line appears in a separate record and its status is updated to DWN when the record is downloaded. When the file is downloaded, report FMRONRCSx is created.

Once the field has been accepted, the temporary download file, created when the claims are released through the claim Print process, is processed. Error message if there are no claims to download.

The following types of claims are included in a new data submission:

- Original Claim
- Resubmitted claim

The download consists of the following data:

- 1 header record
- 1 or more detail records, containing patient data
- 1 trailer record

The file is a standard dos text file, with each line ending with a carriage return/line feed, and the file ends with an end of file character. The filename used in the output is as follows:

"I" or "O" followed by a dash "-" followed by the Hospital Number followed by a dash "-" followed by the billing date in YYYYMMDD format, ending with the extension ".txt"

The file can be downloaded again using Recreate Ont Reciprocal Data found on the Interface Functions menu. A copy of FMRONRCSx is created again.

When this function is accessed, a series of prompts is displayed on the screen.

- *Create (I)npatient or (O)utpatient Out of Province Claim diskette? (I/O)--*

  This prompt is displayed since inpatient and outpatient claims must be submitted in separate files, with different formats. Selecting I specifies that the Inpatient

Layout should be used. Selecting O specifies that the Outpatient Layout should be used.

You can enter **I** to create an inpatient diskette or **O** to create an outpatient diskette.

- *Enter Default MOHLTC Hospital Code [987]--*

  The MOHLTC Hospital Code is used to name the download file. The value from the Download Parameters screen displays. It may be overridden. This value is used to complete the Hospital Number field of the Common Header. It is also used as the 1st 3 positions of the Batch ID field.

- *Enter bill date [T]--*

  The bill date is used to name the download file. You can enter the date in YY/MM/DD format or accept the default of T (Today).

- *Enter Drive to output data (A/B/C) [C]--*

  You can accept **C** as the drive for ouput data or enter another drive (**A or B**).

- *Enter Directory Path C:\ [\IHA\]--*

  You can accept the default directory path or enter another one in the same format as shown in the prompt.

After the last prompt, the next prompt displayed is:

Press ENTER to begin download to PC for Hospital Code 987--

You can press ENTER to begin the download. The system notifies you when the download is successful.

RECREATE ONTARIO RECIPROCAL DATA

If there is a problem with a data file after transmission and loading to the RHBS (Reciprocal Hospital Billing System), Ministry staff contacts the hospital and requests a new file be transmitted. This might be necessary if the file was corrupted. This function submits data which was previously submitted. The report FMRONRCS is created, and the title reflects it was a re-creation run.

Re-create without modifying the file

After you select the function, the following prompt is displayed:

Re-create (I)npatient or (O)utpatient Out of Province Claim diskette? (I/O)--

You can enter **I** to re-create an inpatient diskette or **O** to re-create an outpatient diskette. The next prompt is:

(M)odify existing data or (R)e-create without modification (M/R)--

You can enter **R** to recreate the file without modification.

The system displays a list of download files by date and hospital code. You can select the file to download. The system prompts as follows:

Enter Drive to output data (A/B/C) [C]--

You can accept **C** as the drive for ouput data or enter another drive (**A or B**).

Enter Directory Path C:\ [\IHA\]--

You can accept the default directory path or enter another one in the same format as shown in the prompt.

The system notifies you when the download is complete.

Modify Existing Data and Download

After you select the function, the following prompt is displayed:

Re-create (I)npatient or (O)utpatient Out of Province Claim diskette? (I/O)--

You can enter **I** to re-create an inpatient diskette or **O** to re-create an outpatient diskette. The next prompt is:

(M)odify existing data or (R)e-create without modification (M/R)--

You can enter **M** to modify and download the file**.** If (M) is keyed, the list of files available to be downloaded are listed for selection. After a file is selected, all claims in

the original download are listed in a table lookup where the account number and claim sequence number appear. If a claim was marked to be excluded previously, an asterisk is displayed after the account number and claim sequence number. Selected claims that were not excluded previously, are marked to be excluded from the download. Selected claims that were excluded previously, are marked to be included. This provides the opportunity to correct the incorrect section of a claim for exclusion.

After all choices are made from the list of claims and ENTER is pressed, the following prompt is displayed:

Accept changes and process download? (Y/N)--

If Y is keyed, the following messages appear documenting the updates being made.

Updating the exclusion indicator for selected claims!

Recalculating totals for trailer record!

After you select one or more claims, the next prompt is:

Enter Drive to output data (A/B/C) [C]--

You can accept **C** as the drive for ouput data or enter another drive (**A or B**).

Enter Directory Path C:\ [\IHA\]--

You can accept the default directory path or enter another one in the same format as shown in the prompt.

The system notifies you when the download is complete.

REPORTS

The following reports relate to Electronic Claims and Remittance:

- OHIP Bill Summary report
- OHIP Diskette Submission report
- OHIP Production report
- Outstanding OHIP A/R report
- OHIP Remittance Advice (RA) Audit report
- OHIP Remittance Advice Exceptions report
- OHIP Remittance Rejection report
- OHIP Reconciliation report

OHIP Diskette Submission Report - FMRPSS

The OHIP Diskette Submission report (FMRPSS) provides an audit of the claim detail data submitted to the Ontario Ministry of Health.

The report is automatically generated by downloading claim data to diskette for submission. This includes recreating previously created diskettes. The report prints on 132-character width paper.

The report header includes the following information:

- Facility
- Report title
- Date/time the report was compiled
- Report name
- Page number
- Diskette submission date

The report body includes the following information within each Performing Physician Billing Code:

- Bill number (bill sequence - claim sequence)
- Patient's account number
- Patient name
- Patient health card number and version code
- Patient birthdate
- Patient sex
- Referring physician OHIP number
- Admit date
- Date of service
- Diagnosis code
- SoB code
- Number of services
- Fee - detail component total for patient
- Total fees per performing physician billing code

The report summary includes the following information:

- Clinic total fees
- Total fees for each performing physician within this clinic
- Number of clinics
- Total fees for all clinics

The following is an example of a OHIP Diskette Submission Report.

Figure 1.1 FMRPSS - OHIP Diskette Submission Report

```
Date: 07/07/23                                    GENERAL HOSPITAL                                    Page  : 1
Time: 14:52                                OHIP Diskette Submissions for 07/07/23                     Report: FMRPSSJ


                          For  ALI,MAHMOUD A          Phys ID:99       Physician Number: J987-554678-84

      Patient       Patient Name     Patient         Birth       Ref     Admit      Service    Diag    Benef   #              Bill
Bill #    ID        Last     First   Health #        Date    Sex Phys#   Date       Date       Code    Code    Ser     Fee    Fee

1-1    J1-0000106    MERRICK,JUSTINE  1234-567-890    54/06/22 F  251827  06/12/14   2006/12/14         G530A     1    5.50   5.50
1-1    J1-0000206    MERRICK,OWEN     1998-744-511    66/05/21 M  251827  07/01/02   2007/01/02         X211A     1   15.00  15.00

                                                                                                                    ---------
                                                                                                 Total Fees:          20.50



Date: 07/07/23                                    ST.JOSEPHS HOSPITAL                                 Page  : 2
Time: 14:52                                OHIP Diskette Submissions for 07/07/23                     Report: FMRPSSJ


-------------------------------------------------------------------------------------------------------------------------------
Clinic J987         Total Fees:      20.50


     For                              Phys ID:         Physician Number: J987-554678-84  Total Fees:       20.50


===============================================================================================================================
1 Clinics                                                          Total Fees:                20.50


                                                  End of Report
```

OHIP Remittance Rejection Report - FXRORRR

The OHIP Remittance Rejection report (FXRORRR) identifies payments received by the STAR Patient Accounting CPU that cannot be uniquely matched to a claim on a patient account and is sorted by patient name.

The report is automatically generated as a result of creating an insurance cash batch via the Process Electronic RA function and can be printed via the Demand Print function. The report prints on 132-character width paper.

The report heading includes the following information:

- Facility
- Report title
- Date/time the report was compiled
- Report name
- Page number

The report body includes the following information:

- Total amount of rejected payments
- Total amount of adjustments
- The batch number (of the newly created insurance cash batch)
- The batch description (as entered on the set-up screen)
- Patient's account number
- Patient's name
- OHIP Health Card Number
- OHIP claim number
- Date of service (sent in the payment record)
- Service Code (SoB)
- Sum of payments sent for the account
- Sum of variances between the submitted amount and paid amount
- Eligibility Indicator
- Reason the account is listed on this report:
  - No matching charge
  - Multiple claims match
  - Account not found
  - Account in BD
  - Missing Adj Trans Code
  - No matching physician

The following is an example of an OHIP Remittance Rejection report.

Figure 1.2 FXRORRR - OHIP Remittance Rejection Report

Date:96/03/01 GENERAL HOSPITAL Page : 1
Time: 21.30 OHIP Remittance Rejection Report Report: FXRORRRA

Batch: 805

Patient #	Patient name	OHIP Reg #	OHIP Claim #	Service Date	SvcCd	Payment Amt	Adjustment	Elig	Reason
0-04535-30		8974652123	G3422366234	96/02/03	J001C	15.50	0.00		Account not found
0-04535-61		6589784521	G3422366235	96/01/29	X065A	15.50	0.00		Account not found
0-04535-91		8974587888	G3422366236	96/02/03	C065A	15.50	0.00		Account not found
0-08000-37	MEDICAL,OUTPATIENT	3978654567	G3422366227	96/02/10	C065A	87.30	0.00		No matching charge
1-00010-93	OBSTETRICS,OP	8975878989	G3422366231	96/02/05	X066A	227.60	0.00		No matching charge
8-00000-01	OBSTETRICS,OP	6578934567	G3422366229	96/02/10	X111A	227.60	0.00		No matching charge
8-00000-04	SELF,OUTPATIENT	4563723456	G3422366230	96/02/10	X114A	227.60	0.00		No matching charge
0-08000-38	SURGICAL,OUTPATIENT	8976534212	G3422366228	96/02/13	X115A	287.50	0.00		No matching charge
0-70000-04	T0M,OP	7654987321	G3422366233	96/02/02	J001C	15.50	0.00		No matching charge

Total Rejected Payments : 1119.60

Total Rejected Adjustments: 0.00

Total Rejected Accounts : 9

End of Report

OHIP Remittance Advice Audit Report - FXRORAR

The OHIP Remittance Advice (RA) Audit report (FXRORAR) provides an audit of payment data uploaded to the STAR Patient Accounting CPU.

The report is manually generated on demand via the Print OHIP RA Audit report function. The report can be generated after the payment file has been successfully uploaded and before the resulting cash batch has been approved and posted. The report is basically a formatted dump of the uploaded data and prints in the order the data is received. The report prints on 132-character width paper.

The total amount of payments is calculated and compared to the amounts reported by the Ontario Ministry of Health. Additional subtotals are provided by unique physician billing number. The OHIP RA Audit report is comprised of four sections:

- General information (records HR1, HR2, and HR3)
- The patient claim detail (records HR4 and HR5)
- The non-patient adjustments (records HR6 and HR7)
- The message facility (records HR8)

The claim information section contains additional page breaks and subtotals that are not directly reported in the source file. Page breaks occur for each unique billing physician number. For each HR5 record, the variance between the fee submitted and the amount paid is calculated and reported. A subtotal is provided for the fee submitted, the amount paid, and the variance for each patient and each billing number.

NOTE: The calculated variance is the amount posted as the adjustment.

The OHIP RA Audit report heading includes the following information:

- Facility
- Report title
- Date/time the report was compiled
- Report name
- Page number

GENERAL INFORMATION

The OHIP RA Audit report general information section includes the following information:

- Group/Clinic number
- Health care provider number (000000 if more than one provider for this group)
- Specialty code
- Ontario Ministry of Health office code
- Payment date sent by the Ontario Ministry of Health
- Payee
- Amount paid

- Cheque number (99999999 for electronic deposit)
- Billing agent (hospital name)
- Billing agent's address

PATIENT CLAIM DETAIL

The claim section of the report body includes the following information:

- Physician billing number
- Patient's account number
- Patient's name
- Province code
- Patient's OHIP number and version code
- Converted health number (reported by the Ontario Ministry of Health)
- Program indicator (reported by the Ontario Ministry of Health)
- Ministry of Health claim number (reported by the Ontario Ministry of Health)
- Service date
- Quantity of services
- Fee amount submitted to the Ontario Ministry of Health
- Amount paid by the Ontario Ministry of Health
- Explanatory code sent by the Ontario Ministry of Health
- Variance of amount paid minus the fee amount submitted
- Eligibility Indicator

NOTE: The variance will be totalled by each account and posted as a contractual adjustment if the value of the Allow Contr Adj? field is set to Yes on the OHIP RA Setup Processor screen.

Remember, payments are reported at the charge level and subtotalled by account. Subtotals are also provided by each unique physician billing number.

NON-PATIENT ADJUSTMENTS

The non-patient adjustments are itemized as deductions and accounting transactions as sent from the Ontario Ministry of Health.

The deductions and accounting transactions are summarized and reported as Total Non-patient Adjustments.

The Total Non-patient Adjustments plus the Total Claims Paid should equal the Reported Batch Total. If the system calculation of the Batch Total does not equal the Reported Batch Total from the Ontario Ministry of Health, a variance is reported.

Message Facility

The last section of the report contains any messages sent by the Ontario Ministry of Health regarding the remittance.

The following is an example of an OHIP RA Audit Report.

Figure 1.3 FXRORAR - OHIP RA Audit Report - General Information Section

```
Date: 96/04/06                                GENERAL HOSPITAL                                Page  : 1
Time: 21.50                          OHIP REMITTANCE ADVICE AUDIT REPORT                     Report: FXRORARA

                                                 General Information

Group Number:        8924
Health Care Prov:    000000
Specialty:           13

MOH Office Code:     H

Payment Date:        95/03/12

Payee:               SJH .   CARDIO DPT

Amount Payable:       45,353.61

Cheque Number:       99999999

Billing Agent:       General Hospital

Address:             PO BOX 2043
                     50 CHARLTON AVE E
                     HAMILTON        ONT L5N1Y4
```

Figure 1.4 FXRORAR - OHIP RA Audit Report - Claim Information Section

Date: 96/04/08 GENERAL HOSPITAL Page : 2
Time: 21.50 OHIP REMITTANCE ADVICE AUDIT REPORT Report: FXRORARA

Claim Information
Billing Number: 8924-261164-60

Acct #	Patient name	Prov OHIP Reg#/Vers	Conv	HN	Prg	Claim Number	ServDt	Qty	Fee Sub	Amount Pd	Ex	Variance	Elig
00444444	HUFFSTETLER,NADINE	ON 9976869090 /			HCP	G3422366226	930420	01	40.10	40.15		0.05	
							930420	01	62.80	62.85		0.05	
							Totals:	02	102.90	103.00		0.10	
00800037	PAGE,LORETTA	ON 1149349878 /			HCP	G3422366227	930210	01	32.80	32.80		0.00	8
							930210	01	54.50	54.50		0.00	8
							Totals:	02	87.30	87.30		0.00	
00800038	PRYOR,PEGGY	N5 273239854 H/			HCP	G3422366228	930213	01	74.60	74.60		0.00	
							930213	01	68.20	68.20		0.00	
							930213	01	24.00	24.00		0.00	
							930213	01	44.05	44.05		0.00	
							930213	01	34.00	34.00		0.00	
							930213	01	26.60	26.60		0.00	
							930213	01	16.05	16.05		0.00	
							Totals:	07	287.50	287.50		0.00	
80000001		ON 7245199554 /			HCP	G3422366229	930210	01	74.60	74.60	EV	0.00	
							930210	01	50.95	50.95	EV	0.00	
							930210	01	24.00	24.00	EV	0.00	
							930210	01	44.05	44.05	EV	0.00	
							930210	01	34.00	34.00	EV	0.00	
							Totals:	05	227.60	227.60		0.00	

Figure 1.5 FXRORAR - OHIP RA Audit Report - Non-patient Adjustments Section

```
Date: 96/04/08                                    GENERAL HOSPITAL                                    Page  : 4

                                                Non-patient Adjustments

Amounts Brought Forward (Deductions):

     Claims Adjustment                 -1,000,000.00
     Advances                            -200,000.00
     Reductions                           -30,000.00
     Other                                      0.00

Accounting Transactions:

     Advance (10)          930226              -10.00   ADVANCE CODE 10 (NEGATIVE)
     Reduction (20)        930227              -20.00   REDUCTION CODE 20 (NEGATIVE)
     Advance Repay (40)    930224               40.00   ADVANCE REPAYMENT CODE 40 (POSITIVE)
     Accounting Adj (50)   930803               50.00   ACCOUNTING ADJUSTMENT CODE 50 (POSITIVE)
     Attachments (70)      930803               70.00   ATTACHMENTS CODE 70 (POS OR NEG - THIS CASEIS POSI
                           930803               99.00   CODE 99 IS NOT DEFINED AND SHOULD USE THE DEFAULT

Total Non-patient Adjustments:           -1,229,771.00

Total Claims Paid:                            1,238.10

Reported Batch Total:                        45,353.61
Calculated Batch Total:                  -1,228,532.90
Variance:                                 1,273,886.51

FXRORAR - OHIP RA Audit Report - Message Facility Section

Date: 96/04/08                                    GENERAL HOSPITAL                                    Page  : 5
Time: 21.50                                 OHIP REMITTANCE ADVICE AUDIT REPORT                       Report: FXRORARA

                                                    Messages

              ****MUCH SHORTER LIST OF MESSAGES*** JMC NEWS ***
              SPECIALIST RETENTION INITIATIVE (SRI)
              ************************************************************
               THE PAYMENT AMOUNT INDICATED MAY BE SUBJECT TO ADJUSTMENT
               DUE TO THIRD PARTY REQUEST(S).  EG: COURT ORDERS,ASSIGNMENTS, ETC.
               IF YOUR PAYMENT AMOUNT IS CHANGED, YOU WILL BE NOTIFIED WITHIN
               FIVE BUSINESS DAYS FROM THE DATE OF THIS REMITTANCE.

                                                  End of Report
```

OHIP Remittance Advice Exceptions Report - FXRORER

The OHIP Remittance Advice Exceptions report (FXRORER) is generated at the time the OHIP Remittance Audit report is requested to print. The Exceptions Report lists the claims and their corresponding exception code that were returned from the Ministry. Some exceptions will be processed into the cash batch, and others are rejected. Exception codes that are automatically excluded from the cash batch are reported on both the Exceptions and Rejection reports. The exception codes to be excluded are defined in the OHIP Exceptions table.

All other exceptions are included in the cash batch (unless they are rejected for some other reason, such as invalid account or multiple claims).

The OHIP Remittance Advice Exception report only contains the entries from the audit report that have a corresponding explanatory code listed. The report cortains subtotals by provider.

The following is an example of an OHIP Remittance Advice Exceptions Report.

Figure 1.6 FXRORER - OHIP Remittance Advice Exceptions Report

Date: 96/04/08 GENERAL HOSPITAL Page : 23
Time: 12.54 OHIP REMITTANCE ADVICE EXCEPTIONS REPORT Report: FXRORERA

Claim Information
Billing Number: 8924-261164-60

Acct #	Patient name	Prov OHIP Reg#/Vers	Conv HN	Prg Claim Number	ServDt	Qty	Fee Sub	Amount Pd	Ex	VarianceElig
00444132	CHEPP,ALYSE	ON 2244029134 /		HCP G3021129705	930118	1	73.90	74.60	EV	0.70
					930118	1	50.50	50.95	EV	0.45
					930118	1	23.80	24.00	EV	0.20
					930118	1	43.60	44.05	EV	0.45
					930118	1	33.65	34.00	EV	0.35
					Totals:	5	225.45	227.60		2.15
00447805	DEY,ANGIE	ON 9099671639 /		HCP G3021129725	930119	1	6.55	6.60	EV	0.05
					930119	1	8.80	8.90	EV	0.10
					Totals:	2	15.35	15.50		0.15

OHIP Reconciliation Report - FMRPCR

The OHIP Reconciliation report (FMRPCR) is generated on demand through the Provincial Claims Report Processor screen. Refer to the *Canadian Claims Processing Volume* in the *STAR Financials Patient Accounting Reference Guide* for an explanation of the report criteria.

The following is an example of an OHIP Reconciliation Report.

Figure 1.7 FMRPCR - OHIP Reconciliation Report - Page 1

```
Date: 06/01/17                          GENERAL HOSPITAL                    Page  : 1
Time: 09:14                         OHIP Reconciliation Report          Report: FMRPCRJ

                                        REPORT CRITERIA
        Format: Aged

        Sort: Physician ID

        Patient Indicator: All

        Physician ID(s): 1126-6,2655-1,42920-399252-4
                         4292-043679-24,4292-046862-47,4292-067926-13
                         4292-106443-24,4292-114157-13,4292-117770-13
                         4292-132571-13,4292-141945-13,4292-143750-13
                         4292-154740-47,4292-155838-13,4292-192377-13
                         4292-196568-13,4292-202291-13,4292-202978-13
                         4292-236257-47,4292-252502-47,4292-256271-13
                         4292-276378-13,4292-285809-13,4292-292771-13

        Clinic(s):

        Doctor(s):

        Reconciled: Include

        Status Code(s): All

        Aging Code: 1 - STANDARD AGING

        Service Dates: Earliest thru 06/01/17

        Submit Dates: Earliest thru 06/01/17

TOTALS FOR PHYSICIAN:                                          0.00
        Aging Days 0 to 30                      0.00
        Aging Days 31 to 60                     0.00
        Aging Days 61 to 90                     0.00
        Aging Days 91 to 120                    0.00
        Aging Days 121 to 150                   0.00
        Aging Days 151 to 180                   0.00
        Aging Days 181 to 210                   0.00
        Aging Days 211 to 240                   0.00
        Aging Days 241+                         0.00
```

Figure 1.8 FMRPCR - OHIP Reconciliation Report - Page 2

```
Date: 06/01/17                          GENERAL HOSPITAL                    Page  : 2
Time: 09:14                       OHIP Reconciliation Report            Report: FMRPCRJ

                                       REPORT TOTALS


        Aging Days 0 to 30                    0.00

        Aging Days 31 to 60                   0.00

        Aging Days 61 to 90                   0.00

        Aging Days 91 to 120                  0.00

        Aging Days 121 to 150                 0.00

        Aging Days 151 to 180                 0.00

        Aging Days 181 to 210                 0.00

        Aging Days 211 to 240                 0.00

        Aging Days 241+                       0.00


        Total Outstanding                     0.00


                                       End of Report
```

FILE LAYOUT

Claim Submissions

File name: HA1234.001

where H indicates Claims Submission File Type.
A indicates month claims being submitted for (A=Jan, B=Feb, ...).
1234 indicates the clinic code.
001 indicates the unique file identifier.

The OHIP claims submission file is in ASCII format. Each record contains 81 characters in length (79 display). The following is an example ASCII file.

```
HEH5024455510  63100490000395HCPP1235551234950411
HETX001A  00500001950411                X002A  00230001950411
HETX004A  00635001950411                X003A  00500001950411
HETX005A  01400001950411                A002A  00950001950411
HETA025A  00200001950411                B910A  02000002950411
HEH5024455510  63100490000495HCPP5678901234950411
HETX111A  02031403950411
HEH5024455510  63100480000243HCPP5678901234950411
HETX004A  00635001950411                B910A  01000001950411
HEH122222220 1154071690000595HCPP1235551234950411
HETA002A  01100001950411                A025A  00200001950411
HEE00040000000070000
HEH5024455510  63100490000395HCPP1235551234950411
HETX111A  02765003950411                X002A  00500001950411
HETX199A  00050001950411                A005A  00540001950411
HETB910A  00000000950411
HEE00010000000030000
HEH5024455510  63100490000495HCPP5678901234950411
HETB910A  05500001950411
HEH5024455510  63100480000243HCPP5678901234950411
HETX111A  20625015950411
HEE00020000000020000
HEH5024455510  63100490000395HCPP1235551234950411
HETX112A  01375001950411
HEE00010000000010000
```

Remittance Advice

File name:P9999.001 or P999999.001

The OHIP payment data file is in ASCII format. The following is a sample ASCII file:

```
HR10892400000013H7930312SJH. CARDIO DPT (TESTING DATA)004535361 99999999
HR2                     PO BOX 2043
HR123 ANYSTREET            ATLANTA             C1D2E4
HR4G342236622612611646000444444                   ON9976869090  HCP
HR5G34223662261930420O1G111A   004010004015
HR5G34223662261930420O1G112A   006280006285
HR4G342236622712611646000800037                   ON1149349878  HCP
HR5G34223662271930210O1G315A   003280003280
HR5G34223662271930210O1G319A   005450005450
```

```
HR4G342236622912611646080000001                    ON7245199554   HCP
HR5G34223662291930210O1G570A   007460007460 EV
HR5G34223662291930210O1G572A   005095005095 EV
HR5G34223662291930210O1G576A   002400002400 EV
HR5G34223662291930210O1G577A   004405004405 EV
HR5G34223662291930210O1G578A   003400003400 EV
HR4G342236623012611646080000004                    ON8467396431   HCP
HR5G34223662301930210O1G570A   007460007460
HR5G34223662301930210O1G572A   005095005095
HR5G34223662301930210O1G576A   002400002400
HR5G34223662301930210O1G577A   004405004405
HR5G34223662301930210O1G578A   003400003400
HR4G342236623612611646000453591                    ON9379186019  QHCP
HR5G3422366236193020301G310A   000660000660
HR5G3422366236193020301G313A   000890000890
HR4G342236623712611646000453600                    ON9318908812  HCP
HR5G3422366237193020901G310A   000660000660 EV
HR5G3422366237193020901G313A   000890000890 EV
HR6100000000-020000000-003000000-
HR710I93022600001000-ADVANCE CODE 10 (NEGATIVE)
HR720 93022700002000-REDUCTION CODE 20 (NEGATIVE)
HR740 93022400004000 ADVANCE REPAYMENT CODE 40 (POSITIVE)
HR750 93080300005000 ACCOUNTING ADJUSTMENT CODE 50 (POSITIVE)
HR770 93080300007000 ATTACHMENTS CODE 70 (POS OR NEG - THIS CASEIS POSITIVE)
HR799 93080300009900 CODE 99 IS NOT DEFINED AND SHOULD USE THE DEFAULT MISC CD!
HR8****MUCH SHORTER LIST OF MESSAGES*** JMC NEWS ***
HR8SPECIALIST RETENTION INITIATIVE (SRI)
HR8************************************************************
HR8 THE PAYMENT AMOUNT INDICATED MAY BE SUBJECT TO ADJUSTMENT
HR8 DUE TO THIRD PARTY REQUEST(S).  EG: COURT ORDERS,ASSIGNMENTS, ETC.
HR8 IF YOUR PAYMENT AMOUNT IS CHANGED, YOU WILL BE NOTIFIED WITHIN
HR8 FIVE BUSINESS DAYS FROM THE DATE OF THIS REMITTANCE.
HR8 ****END OF MESSAGES************************************************
```

ERROR MESSAGES

During the compilation of the remittance advice rejection report, the system displays various error messages. Shown below are some error messages, possible causes, and resolutions for the error messages.

Account not found!

Cause:
The account could have been purged from the system, merged with another account, or the account number could contain an error as sent by the third party. Another possible explanation is that the account was billed from a different system and was not converted to STAR Patient Accounting when your facility implemented the system.

Resolution:
Search for the account by name in the MPI Inquiry function to determine if the account was purged, merged, or the account number was distorted in any way. If the account was purged, you can 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. If the account does not and should not exist on STAR, then you need to handle the payment manually.

Account in BD!

Cause:
The account is in Bad Debt.

Resolution:
You can post the payment directly to the account in the open cash batch. You might 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.

No matching claim!

Cause:
A matching claim cannot be found because the dates of service do not match, the claim was purged, or the claim was not loaded.

Resolution:
You can post the payments for these claims in the Cash Posting function. Claims that were purged can have payments posted to them without any additional action required. 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 additional information is required, review the claims in the Claims by Account function and create a claim, if necessary, using the Add a Claim function.

Multiple claims match!

Cause:
More than one claim exists on the account for the specified carrier and date of service.

Resolution:
You can 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. Choose the claim to which you want to post the payment. If additional information is needed, review the claims in the Claims by Account function.

Missing Adj Trans code!

Cause:
The adjustment transaction code is not on the patient's insurance plan for the claim.

Resolution:
Access the account via 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 Control screen of the patient's insurance plan. You only receive this message if the amount is to be posted as a contractual adjustment and the Alt Contr Adj Trans Code/Desc field is left blank on the set-up screen. You can reprocess the entire batch with the Post Adjustment flag set to No if you do not want to post adjustments to any of the accounts in the batch. You can also reprocess the batch assigning the alternate adjustment transaction code for all accounts in that batch.

SUGGESTED PROCEDURE FOR PROCESSING ELECTRONIC RA

The following outline is a suggested procedure for uploading and posting the electronic remittance payment.

Step 1. Upload the diskette.

The upload process copies the payment file from the diskette onto the system. After the payment file is uploaded, manually request the OHIP Remittance Audit report to print. When you request the OHIP RA Audit report (FXRORAR) to print, the system also generates the OHIP Remittance Advice Exceptions report (FXRORRR). When these reports have printed, compare the total amount on the OHIP RA Audit report to the total amount deposited into your bank account from the Ministry.

The OHIP RA Audit report (FXRORAR) lists each entry on the diskette in the order that it is received. A diskette can include both patient payments as well as non-patient adjustments. The non-patient adjustments are posted as miscellaneous cash entries.

If the OHIP RA Audit report total does not equal the total amount deposited by the Ministry, stop and call your McKesson representative before continuing with your remittance.

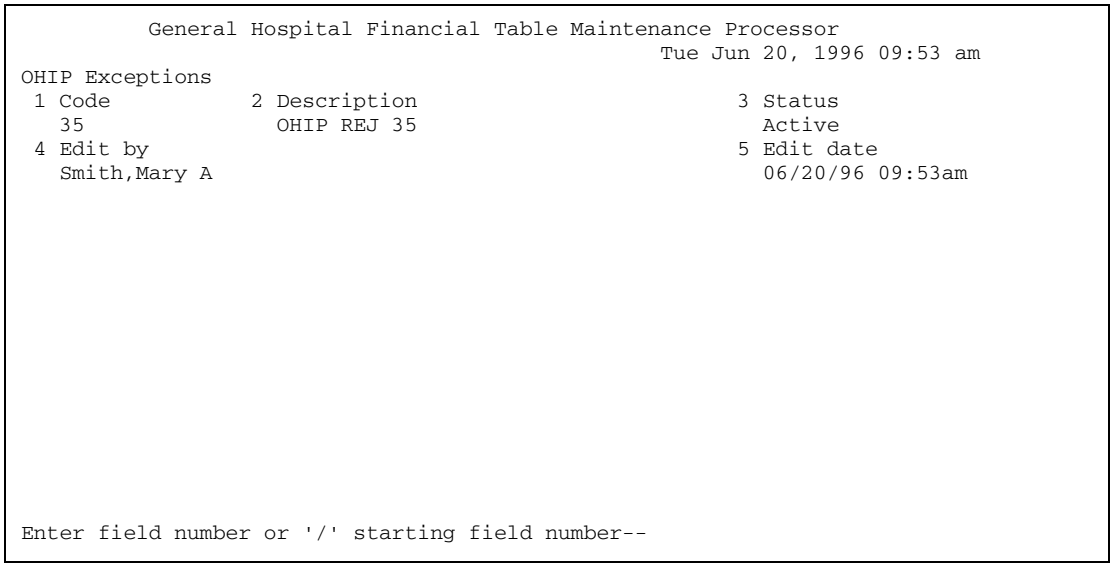
The OHIP Remittance Advice Exceptions report lists the claims with their corresponding exception codes that were returned from the Ministry. Some exceptions are processed into the cash batch, and others are rejected. Exception codes that are automatically excluded from the cash batch are reported on both the Exceptions and Rejection reports. The exception codes to be excluded are defined in the OHIP Exceptions table. Only those exceptions which should be excluded from the cash batch should be defined in the table. All other exceptions are included in the cash batch (unless they are rejected for some other reason, such as invalid account or multiple claims.)

To access the OHIP Exceptions table perform the following:

1. Select Tables from the Initial Menu Processor screen.

2. Select Financial Table Maintenance from the Tables Processor screen.

3. Select the OHIP Exceptions Code. Enter the OHIP exceptions 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 (DISPLAY ONLY)
This field contains the code identifying the OHIP exceptions code.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the OHIP exceptions 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. EDITED BY (DISPLAY ONLY)
The field contains the name of the person who last edited this table entry.

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

Step 2. Process the file.

The system takes the uploaded file and creates a cash batch using the information that you key into the setup screen. The information in the setup screen determines the matching criteria to use in the identification process for claims, thus causing some entries in the uploaded file to be rejected during processing. For example, the system may not be able to locate the patient's account in the STAR system, or perhaps there are multiple claims for the listed dates of service and the system cannot determine which claim to use. These rejections are listed on the OHIP Remittance Rejection report (FXRORR), which is automatically generated when you process the uploaded

file. As noted above, the OHIP Remittance Rejection report includes those payments with exception codes that are defined in the OHIP Exceptions table.

When you process the file, you have the option to have the system calculate adjustment write-offs. The system calculates the adjustment amount by comparing the submitted claim amount to the amount paid. The adjustment amount can be calculated and posted for each appropriate claim and is indicated on the Cash Batch Audit report.

You need to print the Cash Batch Audit report (FAR120_) after the file is processed and the cash batch has been created. This report shows you every cash entry that the STAR system accepted and processed from the uploaded file, including non-patient adjustments.

Add the total amount on the Cash Batch Audit report to the total amount on the OHIP Remittance Advice Exceptions report (FXRORER). This combined total amount should equal the total amount on the OHIP RA Audit report. If this calculation is not accurate, stop and call your McKesson representative to determine why the remittance is not properly balanced.

Step 3. Work the rejections.

You need to evaluate each rejected payment on the OHIP Remittance Rejection report and make the necessary corrections. For example, if the claim does not exist, but you determine that it should exist, then you can create the claim using the Add a Claim function. If a claim was rejected with an exception code defined in the OHIP Exceptions table but you determine that the payment should be processed, then you can add that entry into the batch. After you have made all corrections, you can repeat Step 2, Process the file. You can reprocess an uploaded file as many times as necessary.

NOTE: While you can reprocess an uploaded file multiple times, you cannot upload a diskette multiple times without assistance from McKesson. After a file is uploaded, the system changes the file's name to prevent you from accidentally uploading the same file multiple times.

Every time you reprocess an uploaded file, the system deletes the original cash batch and creates a new one. For this reason, make all of your system corrections first. Reprocess the file, and then add any manual entries into the batch.

Decide how you will address various rejections; for example, when a claim is denied, you have the option of either posting a zero payment or using the Claim Disposition and Balance Transfer process. Either method is acceptable, but you need to be consistent. If you decide to post a zero payment, you can either manually enter the adjusted amount or have the system transfer the remaining amount to the next carrier or to the patient. Since other payments may be expected for this claim, you may not want to transfer the balance to the patient; therefore, you would use the manual entry method. Also, the system could calculate the adjustment or transfer amount to be higher than you want because the Ministry may send multiple payments for a claim or

an account may have multiple claims on record; therefore once again, you may want to use the manual entry method.

You might consider creating a separate cash batch for all manual entries for the file. You could use a predetermined naming convention for the batch descriptions to assist you in reconciliation. For example, when you upload the file P2232.001, you could name the cash batch P2232.001 and then create a separate cash batch for the rejections that are processed manually naming that cash batch P2232.REJECTIONS. This decision should be made based on your business office operations.

Step 4. Balance the reports.

Before posting the cash batch, you should balance the remittance to the reports.

The total amount paid = (processed entries + rejected entries)

or FXRORAR=FAR120+FXRORRR

The exception codes automatically rejected by the system are reported on both the Exception and Rejection report.

NOTE: The adjustment amount is currently not printed on the Cash Batch Audit report, although it is calculated. It is printed on the Adjustment Detail report, which is generated in Midnight Processing, after the batch is approved. This figure is not required to balance your remittance.

Step 5. Post the batch.

After you have worked your rejections, either through cash posting or balance transfer, you need to balance your batch and approve it. Approving the batch automatically updates your accounts.

Step 6. Run midnight processing.

After the batch is posted, the system updates the accounts. During midnight processing, the system generates the Cash Detail report, the Adjustment Detail report, and the General Ledger Posting reports. In addition, the system updates your Daily Balancing screens. Be sure to verify the balancing screens in addition to these reports.

NOTE: Balancing your system should be a daily routine!

The following example outline uses these six steps:

The Ministry has deposited $1000 into your bank account for clinic 2232, and you have received the associated diskette in the mail.

1. Upload the file.

2. Print the OHIP RA Auditreport (FXRORAR), and verify that the total amount on the diskette is $1000.

3. Print the OHIP RA Exceptions report (FXRORER). In this example, there are $50 of exceptions (and $25 of these exceptions are also on the rejection report).

4. Process the file to create a cash batch. In this example, the system processed $550.

5. Print the OHIP Remittance Rejection report (FXRORRR). In this example, $450 was rejected. Of this $450, $25 are exceptions. The rest of the rejections are account related, such as Invalid Account or Multiple Claims errors.

6. Balance the remittance:

Diskette Total =	Cash Batch Total +	Rejection Total
$1000 =	$550 +	$450

7. Using the OHIP Remittance Rejection report as your guide, make as many corrections to the accounts as possible.

8. Reprocess the cash batch to use your corrections in step 6.

9. Process all other rejections manually as necessary, such as Multiple claims errors. Remember, do this last so that when you reprocess the file your entries are not overwritten! (Or, you can create a separate cash batch for these entries.)

10. Print the Cash Batch Audit report (FAR120).

11. Balance and approve your cash batch.

12. After midnight processing, verify the following:

    - Cash Detail report
    - Adjustment Detail report
    - General Ledger postings generated from your cash batch
    - Balancing screens

NOTE: As you work your rejections, the Batch Total and the Rejection Total number will change. The objective is to have the Rejection Total truly reflect those payments that should be rejected, such as payment denials.

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■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *Ontario Electronic Claims and Payments* of the *STAR Financials Patient Accounting Reference Guide* for Release 17.0.

Topic	Poor	Fair	Good	Excellent
Organization of information	❑	❑	❑	❑
Accuracy of information	❑	❑	❑	❑
Completeness of information	❑	❑	❑	❑
Clarity of information	❑	❑	❑	❑
Amount of overview information	❑	❑	❑	❑
Explanation of processes	❑	❑	❑	❑

Are there parts of this manual that could be made more helpful to you? Please explain.

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