McKESSON
Empowering Healthcare

STAR 2000™

STAR FINANCIALS PATIENT ACCOUNTING REFERENCE GUIDE
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Preface

The *STAR Financials Patient Accounting Reference Guide* is a multi-volume document written for all users of the STAR Financials Patient Accounting System. This volume describes the various components of the base STAR Financials Patient Accounting System. As a supplemental guide to the other volumes of the *Patient Accounting Reference Guide*, it introduces you to the computer environment while explaining the flexibility of information entry and retrieval in this dynamic system.

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

Documentation Conventions

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

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

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

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

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

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

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

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

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

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

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

Enter patient name--

Field Characteristics

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

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

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

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

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Introduction

This document contains general information about the functions and use of the base Patient Accounting system. The book contains the following chapters:

Chapter 1: Using STAR Financials

This chapter provides basic information about using the STAR Financials system. It has been designed to work in concert with your system training.

Chapter 2: Financial System Management

This chapter explains the functions on the Financial System Management menu.

Chapter 3: Process Refunds

This chapter describes parameter and menu setup requirements to process refund checks.

Chapter 4: Reimbursement Overview

This chapter contains information about the reimbursement features of the Patient Accounting system.

Chapter 5: Patient Accounting Customer Tools

This chapter provides information about online and batch tools provided for Patient Accounting customers.

Appendix A: Graphics

This appendix contains information about using the McKesson's WEM and WEMGraph software packages with the Patient Accounting system.

Appendix B: User Preferences

This appendix contains a brief description of McKesson's menus and mnemonics used to navigate between menu screens.

Appendix C: Postings to the General Ledger

This appendix contains a table that shows how the keys are used and postings occur for Patient Accounting financial events.

Glossary

This glossary provides a list of terms used by the STAR FINANCIALS system.

In an effort to provide solutions for the needs of enterprises with multiple financial business units, the STAR system supports a maximum of 26 entities in the Patient Accounting applications. This means that a patient can be assigned up to 26 different medical record numbers. In addition, clinical/financial information can be viewed and used across all facilities in the hospital.

Chapter 1 - USING STAR FINANCIALS

INTRODUCTION

This chapter provides basic information about using the STAR Financials system. It has been designed to work in concert with your system training.

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

SOCIAL SECURITY NUMBER DISPLAY

The Social Security Number for a patient, guarantor, or relative is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

If the Social Security Number is on an editable screen in STAR Patient Accounting, and a user edits the SSN, the following table shows how the Social Security Number is displayed in prompts and on screens:

If user edits a SSN and security is defined as.....	**The screen shows the.....**	**And the prompt shows the....**
filter all or part	filtered SSN	unfiltered SSN
no filter	unfiltered SSN	unfiltered SSN

DATA ENTRY TECHNIQUES

The following are guidelines for entering and accessing information:

- Read the prompt displayed at the bottom of each screen for instructions/prompts before entering information. The prompt is a brief statement explaining what you can do at a particular point in the system. You can select a menu option, display a set of tables, complete a screen field, etc.

- The ENTER key accepts the data entered into the prompt. The ENTER key should be pressed only once to accept the entered data. You are prompted with an Invalid Format error message that appears beneath the prompt if you enter an incorrect format (for example, if a date should be entered in the format 030195 rather than 3195.)

- If the data entered completely fills the field, it is not necessary to press the ENTER key. The data is accepted automatically, and the cursor moves to the next field.

- Use the DEL (Delete) key to remove errors made while entering data.

- The cursor identifies where you are on the screen. The cursor can be a flashing or non-flashing dash or block. It can be changed by pressing the CURSOR TYPE key on the keyboard.

Many fields on screens have default values associated with them. The default value is easily identifiable because it appears on the prompt in brackets []. The value contained in the brackets is the response that the system accepts if you press the ENTER key without entering any data. This key may also be referred to as NEW LINE or NL in the STAR system. Default values eliminate unnecessary keystrokes. Once you press the ENTER key, the system enters the default value in the field, and the cursor moves to the next blank field on the screen.

- To revise incorrect data that has been accepted, enter a slash (/) and the appropriate field name you want to revise, (for example, /4 to revise field 4), and press ENTER. Once the cursor returns to the appropriate field, the prompt asks you to enter new data. By entering two slashes (//) and pressing ENTER, the previously entered data is moved to the prompt so you can edit the data on free-form fields. The Right and Left Arrow keys located on the numeric pad keys move the cursor to the right or left on the prompt. The Up Arrow key allows you to insert characters in the data, and the Down Arrow key deletes characters. If you want to edit an existing answer, enter the new response, and it overwrites the old one.

- Some fields are free-form. A flashing vertical bar (|) to the right of the prompt indicates the maximum length of the data field. You can enter data up to the flashing bar.

- If you do not want to enter data or select one of the choices, press period (.) followed by ENTER in response to a prompt. If you enter period (.) while located in

a screen, a question is displayed asking what field you want to edit. If you are not located in a screen when you enter period (.), you are returned to the previous prompt.

- After the appropriate fields on a screen are filled in, the system displays the following prompt:

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

  Verify that all the information on the screen is correct. Pressing ENTER accepts the data. If N for No is entered, the prompt asks you to select the appropriate field name to edit. The system displays the following prompt:

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

- If you enter the field number only, the system allows you to edit that field, then returns to the *Enter field name* prompt. If you enter a slash (/) followed by a field name, after editing that field the cursor moves to the next empty field on the screen. If you press ENTER, the *Accept this screen* prompt is displayed. If you want to exit the screen without saving the information you just entered, enter a period (.).

- If no empty fields exist, the system prompts you with:

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

  It is very important that you respond to this prompt with a Yes or No answer. If you enter a slash (/), which takes you to the next page, and you did not answer this prompt, the data is lost and must be reentered. If the default is Y for Yes, then press ENTER to accept the screen.

TABLE LOOKUP

Many STAR Financials transactions are table-driven, allowing you to enter data quickly by eliminating unnecessary keystrokes.

1. When the cursor is at a field associated with a table, the prompt reads:

   Enter table code--

   Your response to this prompt can be in one of the following forms:

   - If you know the code, enter it, and press ENTER.
   - Enter a hyphen (-) to display the entire table. When the item you selected is displayed, enter the corresponding option number, and press ENTER. The option number is not a table code but a number to identify the selection. If the item you want is not displayed, enter slash (/) to view the next page, or enter slash-P (/P) to view the previous page.
   - A table entry can be made with a code or an alpha description of that code.

     Since many new users are not familiar with the description codes, it is more advantageous to perform a table lookup. The table search for an entry can be limited by entering the first few characters of the description followed by a hyphen (-) and pressing ENTER. For example, to display Medicare in the Insurance Table, enter MED- and press ENTER. All table entries beginning with MED appear for selection. After the item is selected, its description displays in the field on the screen, often with its code to the left. This code can be used on future entries to eliminate the need to view the table selections.

     Enter table code--

   - Whenever you enter a hyphen (-) to display the entire table and the table is more than one screen in length, the following prompt is displayed:

     Enter choice-- next pg (/ or PG DN) Search (TAB)

     To perform a search, press the **TAB** key to enter into Search mode. Enter a string of characters on which to search. The search always matches letter for letter starting in column one of the table display. Precede the search string with an asterisk (*) to cause the search to look for the string anywhere in the display. The table driver finds the first entry that matches the string of characters.

     To return to Select mode, press the **TAB** key again. Then you can enter the number of the entry you want to select.

   - If more than one item can be selected from a table, the heading line for the table displays ##=*Current choices* on the right. You can enter one number or a range

of numbers (for example, 1,3,5-7,) and press ENTER. The numbers are highlighted next to their descriptions, and the prompt allows you to either enter more selections or go to another page if one is available.

After completing your selections, press ENTER again. If you want to remove a selection already made, enter a hyphen (-) followed by the item you wish to delete. After ENTER is pressed, the item is no longer highlighted.

- In some cases the desired code or description may not be found in the table. Some tables have an override capability. In the case of an override, press hyphen (-) and enter the override description immediately following. When ENTER is pressed, the override description you entered is displayed without the hyphen (-). If overrides occur frequently, you can add new table entries. If an override is not allowed and is entered, then the system displays an error message.

2. When completing a table entry or edit, the system also prompts you to delete the table entry or receive a printed list. To delete a table entry, access the table; press ENTER, and enter **Y** for Yes at the prompt to *delete (N).*

   If you want a printed list of all table entries, enter **Y** for Yes at the prompt. The list prints on the printer designated for this purpose by your STAR Financials Coordinator.

Reactivating a Deleted or Inactive Code

If a code is deleted from a table (by entering Y to delete and Y at the *File as deleted* prompt) and you later decide that it should not be deleted, you can reactivate it by re-entering it at the prompt. If you no longer remember the code, you can print a report of the table and choose **Y** for Yes to the *Include entries filed as deleted?* prompt. The report prints all codes, including those that have been Filed as Deleted. There is no time limit on how Filed as Deleted codes remain in the system. If you enter **N** for No at the *File as deleted* prompt, the code cannot be reactivated.

DATA ENTRY CONVENTIONS

Key In	Result
M, E, D or F	When M is entered at the STAR Bulletin Board, the system displays the CRT's Main Menu. During training, E (for Education ID) is the sign-on key. If Physician's Registry is installed, D is used to sign-on to the system. F is the sign-on for STAR Financials. Other sign-on keys can be used as well; for example, P for Pharmacy or N for Nursing.
Prompt	A reverse video band located at the bottom of the screen that tells you what data to enter into the system.
Delete (DEL)	The Delete key erases errors typed into the prompt before an entry is accepted at a field.
Erase EOL	Deletes all characters keyed into the prompt from the cursor to the end of the line.
ENTER	Pressing the ENTER key accepts data that has been keyed. Advances to the next screen or page.
/P	Advances to the previous screen or page.
Period (.)	Backs out of the system step by step, with the STAR Bulletin Board as the last step.
//	Moves previously entered free-form data to the prompt to be edited.
#	Moves the user back to the original sign-on menu from another menu.
/./	Backs out of the system, directly to the Bulletin Board.
/4	Moves cursor to field #4 on a screen and to all subsequent empty fields on that screen.
4	Moves cursor to field #4 on a screen and then returns to the prompt.
Dash (-)	Displays all entries in a table.
AD	Displays all table entries beginning with AD; used to narrow a table search.
T or N	Displays today's date - the date now.
N	Displays today's time if you are in a time field.

Key In	Result
T+1, T+20, T20, N+1, N+20, N1, N20	Displays the date for tomorrow, twenty days from today. Can be entered with or without the +. Also use N to display the time. N+20 displays the time 20 minutes from now.
T-1, T-2	Displays the date for yesterday, two days ago.
N-1, N-2	Displays the time one minute ago, two minutes ago.
N or T	Displays the current time (now).
N+15, N+60, N15, N60, T+15, T+60, T15, T60	Displays the time fifteen minutes from now, and one hour from now. Can be entered with or without the + (plus sign).
N-15, N-60, T-15, T-60	Displays the time fifteen minutes ago, and one hour ago.
MMDDYY	One format for dates (month, day, year -- each in two figures). No slashes or dashes are necessary.
M/D/YY	When punctuation is used to enter dates, month and day can be single digits if appropriate. Use any punctuation, for example M.D.YY is the same as M/D/YY.
M/DD/YYYY	Enter the full year if it is not 1900.
M/D, MM/DD, MMDD	If the date being entered is the current year, it is not necessary to enter the year.
[Default value]	Default values are displayed in brackets on the prompt. Press ENTER to accept the default value. (This key may also be referred to as NEW LINE or NL in the STAR system).
?	Displays Help Text for a function menu or field. The hospital is responsible for writing and keying the Help Text.

PERFORMING MULTIPLE PROCESSES

If you are using STAR on an IBM-compatible personal computer running McKesson's WEM product, version 2.01 or later and are running on a UNIX® platform, you can simultaneously run an additional process from your workstation using the *function branching* feature.

Using this feature, you can *branch* from one system process, even from the middle of an entry to a system prompt in that process, to another system process. The system freezes everything in the function from which you initiated the branch so that when you exit the branched function the system returns you to the initial process. Any field entries you had made before the branch are still in place. In fact, if you were in the process of typing an entry to a field, the portion of the entry you had typed remains; you can finish typing the entry and press ENTER as usual.

NOTE: Function branching is not available during the following processes:

- Menus
- Tables
- Information Windows
- Help and print screens
- Up/downloads
- File/report WEMGraph
- External programs such as MultiSTAR backups, STAR Pharmacy MICROMEDEX Interface, and STAR Physician View

To branch to another process from a STAR system screen, press **CTRL-G**. If you attempt to branch to another level, the following error message is displayed:

Number of branch levels (Max n) has been exceeded.

If there are not enough jobs available for this function branch, the following error message is displayed:

Insufficient job resources for this function branch. Please retry later.

If you have function keys set up for mnemonics on your system, the system displays a menu of function keys for mnemonics on your system. If you do not have function keys set up for mnemonics on your system, this menu does is not displayed.

The system displays the following prompt:

Enter mnemonic, `-` to list or press function key--

From this prompt, you can branch to any function or menu for which you have created a mnemonic by:

- entering the mnemonic code
- entering a hyphen (-) to display and select from a list of mnemonics
- pressing the function key assigned to the desired mnemonic

When you identify the mnemonic for the process to which you want to branch, the system displays the first screen of the function or menu, as appropriate. The system continues to display the function branch level number, 1.

When you exit level 1, the system removes the function branch level number display and returns to the originating function.

FPI LOOKUP

The Financial Patient Index (FPI) Lookup is a procedure commonly used in STAR Financials to select a patient account. It provides seven options to call up a patient account from the FPI:

- Account number
- Corporate number
- Social security number/*health card number*
- Unit number
- Patient name
- Soundex
- Current patient account
- EPN

The FPI Lookup prompt is displayed when the system function requires that you access a patient's account. Because this line is displayed frequently, subsequent documentation refers you back to this chapter for an explanation of the FPI Lookup.

The following is an example of how the FPI Lookup is used:

The system first asks if you are looking up a patient or guarantor:

Patient (P) or guarantor (G) lookup? [P]--

Enter **G** to search for a guarantor and the system displays the main FPI prompt:

Enter `C`corporate, `S`social security, name or `-` name for soundex--

Enter **P** or press ENTER to search for a patient. What the system next displays depends upon whether this is a multi-facility installation and you are allowed to view more than one facility. If this is a single-facility installation or if this is a multi-facility installation but you have access only to one facility, the system displays the main FPI prompt:

Enter account, `C`corporate, `S`social security or `U`unit number, name, `-`name for soundex, or `/`EPN--

=` for same ACCOUNT, `'` for same PERSON, `"` for same lookup

If yours is a multi-facility installation and you are allowed to view more than one facility, the system displays a list of facilities, as shown below.

```
                  General Hospital Account Inquiry Processor
                                                 Mon Jul 18, 1988 03:50 pm

Page:01                            Facilities
( 1) GENERAL HOSPITAL A
( 2) GENERAL HOSPITAL B
( 3) GENERAL CLINIC 1
( 4) GENERAL CLINIC 2









Enter choice--
```

Option Descriptions

ACCOUNT NUMBER
The system assigns each patient a specific account (episode) number upon admission or registration. All transactions for the hospital stay or visit are recorded by this account number. The system assigns this ten-digit number that consists of the current year, Julian date, and the sequenced admission number for the day. Enter this ten-digit number to pull the patient from the Financial Patient Index.

In Ontario, Canada, the system assigns an eight-digit number as follows:

Inpatients in Bed: institution prefix, followed by a five-digit sequential number (reset to 00001 on April 1 of each year), followed by a two-digit year indicator.

Other Accounts: eight-digit number as defined by the Account Number Groups table on Patient Care.

CORPORATE NUMBER
Corporate numbers are McKesson-defined, eight-digit numbers assigned to the patient and the guarantor. You can enter this number, preceded by the letter C, to call up a patient or guarantor from the FPI. If this is a multifacility installation, patients can have multiple unit numbers (refer to the following definition) if they visit more than one facility; however, that patient has only one corporate number.

(US) SOCIAL SECURITY NUMBER
(CN) HEALTH CARD NUMBER
You can look up a patient by social security/health card number. Enter the letter **S** followed by the patient's social security/health card number.

Once this field is accepted, the Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

UNIT NUMBER
The unit number is a permanent, ten-digit number assigned to the patient (by facility) at admission or registration. This number, which is used by Medical Records and other departments, remains with the patient on subsequent visits to the same facility. Should patients be admitted or registered at another facility (in a multifacility installation), they are assigned a different unit number for that facility. While every patient has a unit number, only the guarantors who have been a patient have a unit number.

NAME
You can look up patients or guarantors by any portion of their name, entering letters of the last name first. The system displays all patients whose names begin with the letters you entered. For example, if you enter *Smi,* the system displays all patients whose last name begins with *Smi*. If you enter *Smith,J,* the system displays all patients whose last name is *Smith* and first name begins with *J.*

You also can specify that the system display only males or females instead of all patients.

SOUNDEX
The Soundex System used in the STAR FPI is a phonetic filing system that uses a code of letters and numbers to identify names. It is most useful for locating names with numerous consonants. Using Soundex facilitates name searches by displaying similar names together. A Soundex search reduces the risk of not finding a record and consequently duplicating an FPI entry because of misspelling since the system displays all like-sounding names in one group. To look up a patient using the Soundex feature, enter a hyphen (-) followed by the last name, that is, how you think it is spelled. All patients who have last names that sound similar to the one you typed are displayed for selection. For example, if you enter -*Smyth*, the patients with the last names Smyth and also Smith are displayed. You can also specify that the system display only males or females instead of all patients with a similar-sounding last name.

EPN
The EPN (enterprise person number) is a number permanently assigned to a patient by Horizon Passport™ and is available for searching when STAR is integrated with Horizon Passport and Point of Service (POS) is turned on. It is a true universal identification number and can be used as the common identifier between disparate systems. To access a patient by EPN, enter a slash (/) followed by the EPN. When the EPN entered is not in the MPI, the following message displays:

Error: Not on File!

SAME ACCOUNT
The system retains the patient account that you previously accessed as long as you have not signed off the system in the meantime. Enter an equals sign (=) to work with the previous patient account.

NOTE: If you are performing an FPI lookup by guarantor, this option allows you to access a list of accounts for the previously accessed guarantor.

(') SAME PERSON
The system retains the patient or guarantor who was previously accessed as long as you have not signed off the system. Enter an apostrophe (') to redisplay this patient or guarantor and a list of their visits.

(“) SAME LOOKUP
The system retains the original FPI lookup previously accessed as long as the user has not signed off the system. Enter a quotation mark (“) to redisplay the entire previous FPI lookup.

The following screen contains a list of patients with the last name Smith. From this screen, select the patient whose account data you want to review. Notice the screen has confirmation data such as birthday, social security, etc.

```
                General Hospital Account Inquiry Processor
                                          Tue Sept 11, 2001 03:50 pm
Search: SMI  Male/Female
No.  Name                                Address                  Unit#
     Birthday  Soc Sec      Last Visit    City       St Zip        Corp #
1    SMITH,JANE                          ADDRESS 1                A000102655
     01/01/50  331-22-2222  07/05/01 I/P  ATLANTA    GA 30309      11001721
2    SMITH,JOHN                          APT 99                   A000102409
     01/01/01                            ATLANTA    GA 30309      11001471
3    SMITH,MARY A                        2222 FOURTH STREET       A000102315
     01/01/22  111-11-1111  05/23/01 ADV  ATLANTA    GA 30309      11001376









End of search
Select a person--
```

NOTE: The Social Security Number is displayed in a filtered or unfiltered format based on parameters set on the STAR Patient Processing Employee Demographic screen. Those parameters define whether you can view all, part, or none of the Social Security Number for the patient, guarantor, or relative.

If eight or fewer names meet the search criteria, only one page of names is displayed with the following prompt:

End of Search

Select a person

If more than eight names meet the search criteria the following prompt is displayed on the first page of names:

Start of Search
Select a person, next pg(/) [next page]- -

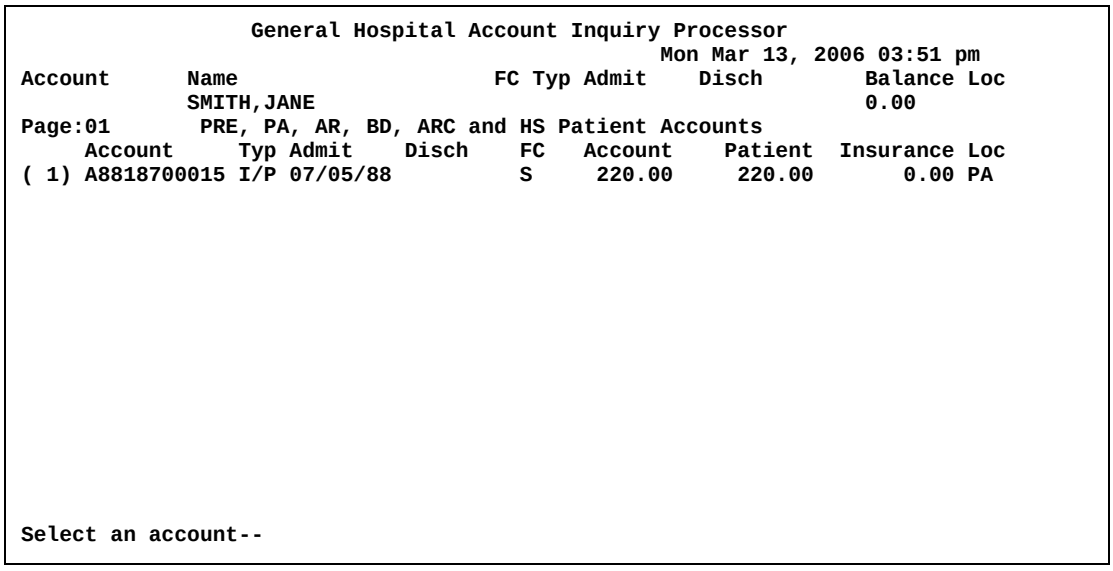
On subsequent pages, the following prompt is displayed:

Select a person, next pg(/) previous pg (/P) [next page]---

On the final page of names the following prompt is displayed:

End of Search
Select a person, previous pg(/P)---

After you access a specific patient, the system displays the patient's account(s) in reverse chronicle order (see the screen below). Each account is identified for selection purposes by a number in parentheses. Enter the option number of the desired account. In many cases, the patient has only one account. Depending on the account location, the visit is displayed in highlighted color, video, reverse video or underline.



```
                General Hospital Account Inquiry Processor
                                                  Mon Mar 13, 2006 03:51 pm
Account      Name                     FC Typ Admit    Disch        Balance Loc
             SMITH,JANE                                             0.00
Page:01       PRE, PA, AR, BD, ARC and HS Patient Accounts
     Account     Typ Admit    Disch    FC   Account    Patient  Insurance Loc
( 1) A8818700015 I/P 07/05/88          S     220.00     220.00       0.00 PA
```

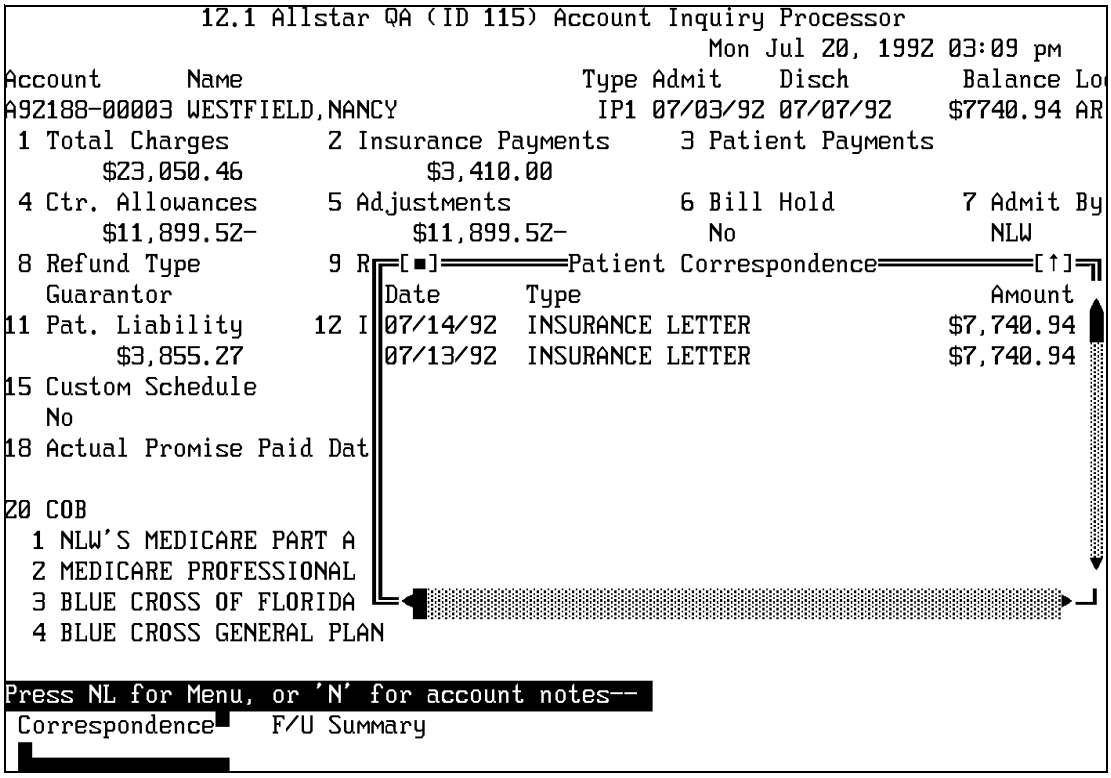
NOTE: Patient-specific functions, such as Billing and Claims, do not prompt you to specify Patient or Guarantor. The system takes you directly to the account lookup to select an account.

Information Windows

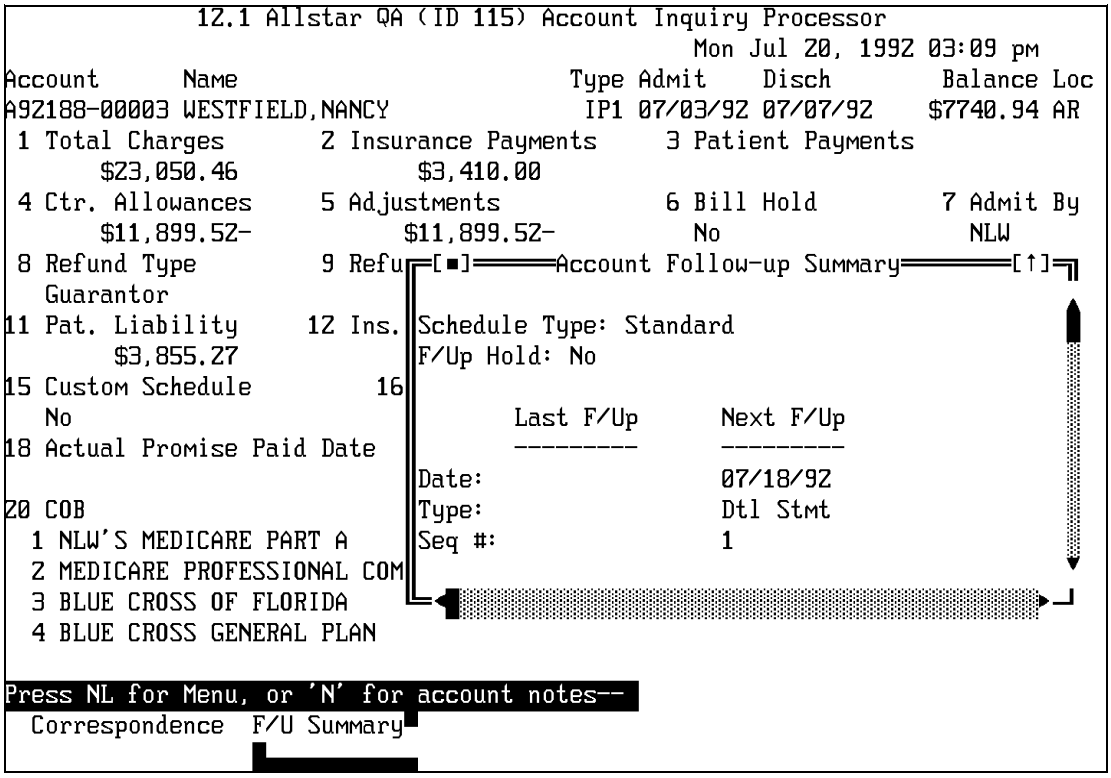
If you are using McKesson's WEM to access the STAR Financials system from an IBM-compatible PC and you have been set up to use the Information Windows feature, the system displays the following message after you select an account:

Downloading information windows! Please wait!

The system downloads patient correspondence and follow-up summary information to your PC. To access the Information Windows containing this information, hold down the **ALT** key on your keyboard, and press the letter **V** (or v) on your keyboard. The system displays the following screen:



This Information Window displays the date, type of correspondence, and associated amount for each transaction. The system only displays entries with a transaction type of T, which includes follow-up letters, statements, and notes. Press **TAB**,and the system displays the Information Window containing follow-up summary information:



This Information Window displays the date, type, and sequence number for the most recent and the next scheduled follow up.

To exit from one of these Information Windows and return to the original screen, press **Esc**.

If information is not fully displayed in the Information Window, use the arrow keys on your keyboard to display additional data. Press the right arrow key to move the display one space to the right, the left arrow key to move the display one space to the left, the up arrow key to move the display one line up, or the down arrow key to move the display one line down. You can also use a mouse or other pointing device to display information that does not fit in the Information Window.

For more information about Information Windows, refer to the *WEM User's Guide*.

MPI SEARCH

For more information on the Master Patient Index (MPI) search function, refer to Chapter 1: Admissions in the *Patient Processing* module in the *STAR Patient Care Reference Guide*.

FUNCTION KEYS

In certain fields, the system provides a series of function keys displayed at the bottom of the screen. The function keys displayed on the prompt line below correspond with the function keys on your keyboard.

F1Prev Page F2Next Page F3 Insert F4 Delete F5Comment F6 Reset F7 Exit ?

The following is an explanation of the functions provided.

F1	PrevPage	moves the cursor to a previous screen page.
F2	NextPage	moves the cursor to the next screen page.
F3	Insert	inserts a blank line above the line the cursor is on. Once you insert a blank line, the appropriate code can be entered here or you can use the hyphen lookup procedure to find the code you need.
F4	Delete	deletes the line that the cursor is on.
F5	Comment	exit an existing comment line or to enter a new comment line.
F6	Reset	resets the line that the cursor is on by erasing data that you just entered.
F7	Exit	saves the current data entered in this field, and exits the field.
?	Help	displays Help Text for a function menu or field. Once pressed, the help function remains active as you move from column to column (on some screens) entering data in a particular field.

SOFT KEY EDITOR

In many system functions, particularly when entering messages or letters, the system provides a series of function keys displayed at the bottom of the screen known as the soft key editor. Its purpose is to assist you in the word processing tasks involved in entering and editing letters and messages. The function keys displayed on the screen correspond with the function keys on your keyboard.

The following is an explanation of the functions provided.

F1 deletes the entire line the cursor is on.

F2 inserts a blank line above the line the cursor is on.

F3 centers the line the cursor is on.

F4 exits the screen and completes word processing activities.

F5 copies the line the cursor is on for later retrieval.

F6 restores the line copied using the F5 key.

F7 packs or moves words so lines begin and end at the margins.

F8 enables you to view the text while you are working on it. No other word processing can be done when the view key is on.

F9 enables you to insert data elements specific to a patient, account, guarantor, carrier, etc. Position the cursor, press **F9**, enter a hyphen (-) to display a list of data elements for selection. With some data elements the system provides a choice of formats. Once selected, the data element is highlighted. Confirm your choice to the system, and the element is added.

F10 offers additional word processing functionality--

SHIFT and <-- deletes a character.

SHIFT and --> inserts a character.

DELETE deletes the characters to the left of the cursor.

ERASE EOL erases all characters from the cursor to the end of the line.

ERASE PAGE deletes all lines on the screen.

TAB tabs to the right.

HOME and <-- moves the cursor to the first character on the line.

HOME and --> move the cursor to the last character on the line.

HOME and UP ARROW move the cursor to the top left corner of the page.

HOME and DOWN ARROW move the cursor to the bottom left corner of the page.

HOME pressed twice also places the cursor in the top left corner of page.

ARROWS move the cursor left, right, up and down.

ENTER send the cursor to the next line.

REPT is used to repeat a line.

HELP TEXT FOR DATA GENERAL DUMB TERMINALS

The help text procedure used by STAR Financials is practically identical to that used by STAR Patient Care.

NOTE: This form of help is not the same as the help files attached to STAR graphical user interface (GUI) applications.

Entering a question mark (?) at any point in a transaction displays whatever help text has been entered for that transaction.

In STAR Financials, entering a slash followed by a question mark (/?) displays help text for each aspect of a transaction. For example, if you are entering a follow-up schedule, entering /? displays help text for each component in the sequence.

Refer to Help Text in the *General Information* module of the *STAR Patient Care Reference Guide* for more information.

BULLETIN BOARD

The Bulletin Board is displayed on all monitors when you sign off. The hospital can use the Bulletin Board to communicate upcoming hospital-wide events, reminders, or activities.

From a menu containing this option, enter **C** to create a new bulletin board, **E** to edit the existing bulletin board, or **D** to delete the existing bulletin board. The bulletin board can be up to 75 characters wide by 17 lines long. A separate bulletin board can be set up for each sign-on key.

The word processing functions displayed at the bottom of the screen correspond to the function keys on the keyboard.

The following is an example Bulletin Board:

```
                General Hospital Bulletin Board Processor
                                                Fri Jan 28, 2000 10:13 am

           1         2         3         4         5         6         7
   12345678901234567890123456789012345678901234567890123456789012345678901234567
01|THIS IS A TEST OF THE BULLETIN BOARD                                          |
02|                                                                              |
03|                                                                              |
04|                                                                              |
05|                                                                              |
06|                                                                              |
07|                                                                              |
08|                                                                              |
09|                                                                              |
10|                                                                              |
11|                                                                              |
12|                                                                              |
13|                                                                              |
14|                                                                              |
15|                                                                              |
16|                                                                              |
17|                                                                              |
   F1           F2           F3      F4    F5          F6            F7    F10
   Delete Line  Insert Line  Center  Exit  Store Line  Restore Line  Pack  Help
```

CENSUS

The Census function is a group of transactions that are displayed and print information regarding station population, physicians and their patients, patient denomination, patient church affiliation, isolation, and hospital-wide bed occupancy, to name a few.

Most options in the Census function contain identical fields. For a detailed description of these fields, see Station Census below. Most options also display the census total at the top of the screen.

After you select this function, the following submenu is displayed:

```
                    General Hospital Census Processor
                                                Thu Jan 27, 2000 02:26 pm
Census Input Options

            Option No.  Option
            ---------------------------------------
   Display      1       Station Census
                2       LOS Census by Patient Type
                3       Physician Patient List
                4       Religious Census
                5       Isolation Census
                6       Precaution Census
                7       IV Therapy Census
                8       Oxygen Therapy Census
                9       Exception Census
               10       Discharge Census
               11       Alphabetic Census
               12       Patient Groups Census
               13       Service Census
               14       Census Summary
               15       Daily Patient Process Review
   Print       16       Print Census
Enter option number--
```

For the purpose of this example, the Station Census is explained.

Station Census

Station Census displays all room/bed combinations defined in the selected station with bed status (if not occupied) or specific patient information (if occupied), as well as a census total, once the desired station has been entered. If only one station can be viewed, that station is displayed immediately. If more than one station can be viewed, you are asked to enter a station code. Enter a hyphen (-) to display a list of the available stations if you do not know the code.

After you select this function, the following screen is displayed:

```
                General Hospital Station Census Processor
1E 1 EAST   18                                  Thu Jan 27, 2000 02:28 pm
Stn Room-Bed Account       Name                 SVC Age S PC  I Attending Phys
1E  2101-01  97-29600001   BARNETT,ALTERNATE EI PSY 68Y F     D CARVER,JOHN
1E  2101-02  99-35700004                        MED58100F       BARE,DENIS L
1E  2102-01  99-06000005   KENTWO,MOM           TPH 19Y F       LABONE,DOCTOR
1E  2102-02  99-35700005   ENGLISH,Z            MED  7M M       BARE,DENIS L
1E  2103-01  98-08500001   TEST,CCRV REG        MED 50Y F       GOLEMAN,MICHEL
1E  2103-02  97-24100001   XRAY,BOB             MED 35Y M       BROWN,WATSON A
1E  2104-01  99-06800004   REED,AMY             ERS 10M F VIP   ADAIR,FRANK K
1E  2104-02  97-34500002   SAS,RETIRE           MED 59Y F       ALAR,MARLAM
1E  2105-01  99-23700002   TEST,OPIE TAYLOR     MED 93Y M CML   ADEL,JUDI A
1E  2105-02  98-26500001   CHUGAEV,PETER V      TPH 46Y M CML   SPIEGEL,RONALD H
1E  2106-01  98-23200001   BOHANNA,ROBERT EDWAR MED 50Y M       DOCTOR,ADMITTI
1E  2107-01  97-24700001   DUCOTE,DANNY MIDDLE  MED 25Y M GOV   COLEMAN,MICHAE
1E  2107-02  98-18900001   BARRA,JESSICA        ERS 40Y F       BOND,JAMES
1E  2108-01  99-15500006   TESTINGTHEALERGIES,V MED 90Y F BRD A BARE,DENIS L
1E  2108-02  99-06000006   KENTWO,BABY 1 BOY    PED 10M M       LABONE,DOCTOR
1E  2109-01  99-06400002   KALETWO,ERTOIN       TPH 29Y M       LILLY,JIM H
1E  2109-02  99-23800003   OUTPATIENT,TWO INPAT MED 89Y M       ADEL,JUDI A
1E  2110-01  98-17700001   BEINKE,DENISE S      PSY 36Y F       GOLEMAN,MICHEL

Press NL --
```

Field Explanations

STN (DISPLAY ONLY)
This field contains the nurse station for this census.

ROOM-BED (DISPLAY ONLY)
This field contains the number of each room and bed on the station.

ACCOUNT (DISPLAY ONLY)
If the bed is occupied, the patient's account number displays here. If the bed is not occupied, one of the hospital defined status codes is displayed (for example, RDY-Bed Ready, N/R-Bed Not Ready, NRR-Not Ready Reserved).

NAME (DISPLAY ONLY)
The patient's name is displayed in the format of LAST NAME,FIRST NAME MIDDLE NAME.

SVC (DISPLAY ONLY)
This field indicates the patient’s hospital service.

AGE (DISPLAY ONLY)
This field contains the patient's age. The following are examples of codes you may see:

41Y - 41 years

13M - 13 months (if under two years old)

4D - 4 days (if under two months old)

S(EX) (DISPLAY ONLY)
This field indicates the sex (M or F) of the patient occupying the bed.

PC (DISPLAY ONLY)
This field contains the patient classification (for example, BRD - Board Member).

I(SOLATION) (DISPLAY ONLY)
If the bed is occupied by a patient requiring isolation, the hospital determined Isolation Code is displayed here (for example, A-BLOOD & ENTERIC, B-BLOOD PRECAUTIONS).

ATTENDING PHYSICIAN (DISPLAY ONLY)
The name of the physician responsible for this patient is displayed from the data entered in the attending physician field on the Revise Patient function.

NOTE:

- An asterisk (*) beside the patient's name indicates that the patient requested a publicity restriction. These restriction codes are hospital-defined and hospital-maintained.
- The system displays 18 beds per screen. The prompt *Press NL--* displays until the entire census has been displayed.
- The census count of the station is displayed to the right of the station name. The count increments as each screen of beds is displayed.
- The last character on the right side of the screen may be a lowercase letter i, which indicates that the patient has an intent to discharge or intent to transfer status.
- The census prints on the CRT default printer defined in the CRT Table, and all census prints are updated online, so they are always accurate.

NAME INQUIRY

The Name Inquiry function is used to locate patients in the hospital and/or to check a patient's condition.

After selecting Name Inquiry, the following prompt is displayed:

Enter acct #, '-' bed code, first chars of name, '=' for same patient--

Enter either the patient's account number, first characters of the patient's name, or an equals sign (=) to display the last patient you viewed. Since this prompt is used as the initial step of many STAR Patient Care functions and the Name Inquiry function is generally used to determine a patient's location or account number, the patient name most likely is entered here.

By entering a few characters of the patient's last name, the following Name Inquiry screen is displayed, containing a list of patients with the same first characters in their last name as the characters you entered.

```
                  General Hospital Name Inquiry Processor
                                                Thu Jan 27, 2000 02:45 pm
No   Pat No       Stn  Rm-Bed    Patient Name                     PC  Cnd
 1 A 98-08400004  PTA  108-01    JONES,BASKETBALL                     OPS
 2 A 99-26700005  ICU  ICU-03    JONES,ROBERT




Select #--
```

At the bottom of the Name Inquiry screen, you are prompted to select a number. If you select a number, you are automatically returned to the previous menu. If you access another option that uses the Name Inquiry screens to take you to actual screens and you press equals sign (=) for current, the information for the patient that you selected above is displayed.

Field Explanations

NO (DISPLAY ONLY)
This field identifies the different patients displayed on the screen.

PAT NO (DISPLAY ONLY)
The patient number is the account number assigned to the patient at the time of admission. This number is displayed in the desired format for the indicated facility. The one-character code prior to the patient number is the facility code.

STN (DISPLAY ONLY)
The station field refers to the nurse station where the patient is located. The codes entered in this field are those entered in the Location File. Type is displayed for outpatients (for example, E/R).

RM-BED (DISPLAY ONLY)
The room-bed number identifies the floor, room and bed where the patient is located. Status is displayed for outpatients (for example, DIS).

PATIENT NAME (DISPLAY ONLY)
The patient's name is displayed in the format of LAST NAME,FIRST NAME MIDDLE NAME.

PC (DISPLAY ONLY)
The patient classification is displayed if it was entered previously. The codes are established and maintained by the hospital (for example, BRD - Board Member).

CND (DISPLAY ONLY)
The patient's condition is represented by codes established by the hospital which are entered in the Condition Table (for example, C - Critical, F - Fair).

The following is a list of the possible entries displayed under STN and RM-BED on the Name Inquiry screen depending on the patient type and the patient status.

STN	RM-BED	Explanation
Station Code	Room & Bed Number	In-house patient
DIS	Discharge Status Abbreviation	Discharged In-house patient
Patient Type	Blank	Active outpatient or preadmission testing patient
Patient Type	Discharge Disposition Abbreviation	Active outpatient who has been dispositioned
Patient Type	DIS	Autodischarged patient

A special character preceding the patient's name indicates that the patient has requested a publicity restriction. These restriction codes are hospital-defined and maintained.

SEND MESSAGE

The Send Message function allows you to send a free-form message from any system CRT to one or more system printers on the same CPU. The Send Message function is included on all system sign-on menus.

After selecting this function, the following screen is displayed:

```
                    General Hospital Send Message Processor
                                          Tue Aug 05, 1999 04:11 pm

SEND MESSAGE
( 1) Printers      :
( 2) Patient       :
( 3) Initials      :
( 3) Message       :

                     |    MESSAGE TEXT (144 CHARACTERS)    |
                     |                                     |
                     |                                     |
                     |                                     |




F1         F2         F3    F4         F5
Del Line   Ins Line   Done  Del Char   Ins Char
```

Field Explanations

PRINTERS (1-A-R)
Enter the specific printer(s) you want to receive the message, or enter an A for the message to be sent to all available printers. This field is table-driven. Enter a hyphen (-) to view the printer choices. If you want more than one printer to receive the message, enter the desired printer codes separated by a comma (,) (for example, 1E,AD1,3S). The printers that are displayed on the screen for each CRT and the ability to send a message to all printers is controlled by the CRT Table.

PATIENT (TABLE LOOKUP)
This is an optional field used if the message refers to a specific patient. Select the patient by using the Name Inquiry function. The following prompt displays:

Enter acct #, first chars of name, '=' for same patient--

To skip this field, press ENTER.

INITIALS (3-A-R)
Your initials are entered or displayed by the system.

MESSAGE (144-C-R)
Enter the message you want to send. This is a free-form field which enables you to send a message of up to 144 characters (divided into four lines). The message displays in the middle of the screen as you enter it.

The word processing functions displayed at the bottom of the screen correspond to the function keys of your CRT keyboard. They enable you to:

F1 Delete lines
F2 Insert lines
F3 Exit the transaction
F4 Delete characters
F5 Insert characters

After accepting this screen, the message prints at the selected printers.

NOTE: This function is used for CRTs and printers connected to the same CPU (central processing unit). If, for example, STAR Financials and STAR Patient Care are located on separate CPUs, you cannot send a message from a CRT on STAR Patient Care to a STAR Financials printer.

Chapter 2 - FINANCIAL SYSTEM MANAGEMENT

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

CHANGE STATION ID

The Change Station ID function allows you to access another CRT station's screens and data. This function is secured and available to only those users specified by the hospital when setting up security in the system. For example, a Data Processing employee may need this function to correct system problems for specific CRT stations, or a nursing administrator may need this function to access information from the different CRT Nursing stations in the hospital.

After you select this function, the system prompts you to either enter the abbreviation of the new CRT you want to access or a hyphen (-) to bring up a display of all the CRT names (stations) available. Following is an example of a table display from which you can select a CRT station:

```
                General Hospital Change Station ID Processor
                                                 Fri Jan 28, 2000 10:49 am
Page:01                               CRT Names
( 1) 1E-1 EAST                             (19) DRT-Dept Prof RT
( 2) 1E-1 EAST CRT                         (20) DTY-DIETARY
( 3) 1N-1 NORTH                            (21) DOC-DOCTOR MENU
( 4) AP-ACCOUNTS PAYABLE                   (22) EEG-EEG
( 5) AD1-ADMISSIONS # 1                    (23) ERN-ER NURSING
( 6) AD2-ADMISSIONS # 2                    (24) FA-FIXED ASSETS
( 7) AD2-ADMITTING #2                      (25) CV5-gateway test
( 8) BO-Business Office                    (26) GEN-General Accounting
( 9) CAR-CARDIOLOGY                        (27) GL-GENERAL LEDGER
(10) CVC-CARDIOVASCULAR DEPT               (28) GIN-GINNY"S TEST
(11) CSR-CENTRAL SUPPLY                    (29) GRP-Group Functions
(12) ORD-clinicom gateway                  (30) HR-HUMAN RESOURCES
(13) CCU-CORONARY CARE UNIT                (31) HRC-HUMAN RESOURCES CANADIAN
(14) CSA-CSA--A                            (32) INF-INFORMATION DESK
(15) DPD-DATA PROC/DEPT                    (33) ICU-INTENSIVE CARE UNIT
(16) DPD-DATA PROC/NURSING                 (34) MM6-Inventory Functions
(17) DP-Data Processing                    (35) LAB-LAB DEFAULT
(18) DPT-Dept Prof PT                      (36) LD-LABOR AND DELIVERY

Enter choice--
                        next pg(/ or PG DN)  Search(TAB)
                                  next page(/)
```

After you select the new CRT station, the menu assigned to that station is displayed. To return to your original menu, press ENTER.

MAINTAIN FACILITY INFORMATION

The Maintain Facility Information function, which is accessed through the Financial System Management menu option, enables you to enter and maintain the following information for your hospital:

- Demographics/Defaults
- PAAR Control
- Patient Bill Format
- Contract Bill Format
- Sort Sequences
- Biller/Collector Worklist Control
- Data Retention Parameters
- Balance Designation Parameters
- Refund Parameters
- Insurance Time Out Parameters
- Active Patient Worklist Control
- Cash Exception Reporting Parameters
- Denial/Appeal Parameters

The system prompts you to enter a facility and then displays the options listed above. Each option is described below.

Demographics/Defaults

The Demographics/Defaults function is used to record this information:

- Your hospital's complete name and address, used throughout the system and printed on all statements, bills, correspondence and follow-up.
- The default financial class, admitting physician and medical service for the admitting and registration process. If these three fields are not entered during admitting or registration, the system automatically completes them using the default information entered here.

- Override codes used to record patient employers and physicians not established in the system.

After you access this function, the system displays the following screen:

```
         General Hospital Demographics/Defaults Maintenance Processor
                                                Mon Jun 05, 2006 09:34 am

Model Hospital A
  1 Hospital Name                       2 Area Code           3 Phone
    Atlanta City Hope                     404                   555-1212
  4 Address                             5 Address (second line)
    301 Perimeter Center Nort             303 Perimeter Center Nort
  6 City                 7 State    8 ZIP Code  9 ZIP Ext.   10 County
    Atlanta                GA         30346       4435          1 FULTON
 11 Geo.Code/Census Tract          12 Country             13 Language
    N NORTH                           U.S.A.                E ENGLISH
 14 FAX Number                         15 Tax Id Number
                                          TAXID#12345466
 16 NPI









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

Field Explanations

1. HOSPITAL NAME (20-AN-R)
Enter the name for this facility. This can be used to print on forms such as Admission forms if they are not preprinted.

2. AREA CODE (3-N-R)
Enter the telephone area code for this facility. This is the area code used as the default area code in the admitting process.

3. PHONE (10-AP-D)
Enter the phone number for this facility. This can be used to print on forms such as Admission forms if they are not preprinted.

4. ADDRESS (25-AN-R)
Enter the street address for this facility. This can be used to print on forms such as Admission forms if they are not preprinted.

5. ADDRESS (SECOND LINE) (25-AN-O)
Enter the second line of the hospital street address for this facility, if necessary. This can be used to print on forms such as Admission forms if they are not preprinted.

6. CITY (18-AN-R)
Enter the city where this facility is located. This is the default city used in the admitting process. This can be used to print on forms such as Admission forms if they are not preprinted.

7. STATE/PROVINCE (2-A-R)
Enter the hospital postal state/province abbreviation for this facility. This is the default state/province used in the admitting process. This can be used to print on forms such as Admission forms if they are not preprinted.

8. (US) ZIP CODE (5-N-R or 6-AN-R)
Enter the facility's five-digit ZIP code. This is the default ZIP code used during the admission process. If you enter a six-digit, alphanumeric Canadian postcode, it is displayed in an “X9X9X9” format.

8. (CN) POSTCODE (6-AN-R or 9-N-R)
Enter the facility's postcode. This is the default postcode used during the admission process. The system displays the postcode in a “X9X9X9” format. You can also enter a U.S. ZIP code in this field. If you enter a nine-digit ZIP code, the system automatically puts a hyphen between the code and the extension.

9. ZIP EXTENSION (4-N-O)
The system enables you to enter the hospital ZIP code extension for this facility. This is used as the default extension in the admitting process. This can be used to print on forms such as Admission forms if they are not preprinted.

10. COUNTY (TABLE LOOKUP)
The system enables you to enter this facility's county. This is used as the default county in the admitting process. This can be used to print on forms such as Admission forms if they are not preprinted.

11. GEO. CODE/CENSUS TRACT/RESIDENCE (TABLE LOOKUP)
Enter the geographic code and census tract/residence code for this facility. You can enter the code, or enter a hyphen (-) to perform a table lookup. This code is used as the default in the admitting process.

12. COUNTRY (TABLE LOOKUP)
Enter the country code for this facility. You can enter the country code, or enter a hyphen (-) to display the Country table for selection. This is used as the default in the admitting process.

13. LANGUAGE (TABLE LOOKUP)
Enter the language code for this facility. You can enter the language code or perform a table lookup. If entered, this will be the language used as the default language in the admitting process. This field defaults to English.

14. FAX NUMBER (12-AN-O)
Enter the hospital’s fax number.

15. TAX ID NUMBER (15-AN-O)
Enter the tax identification number for this facility.

16. NPI (10-N-O)
Enter the National Provider Identifier number for this facility.

When you accept this screen, the system displays a second screen:

```
         General Hospital Demographics/Defaults Maintenance Processor
                                                 Thu May 02, 1996 09:34 am
 Model Hospital A
 Default 1 Financial Class   2 Admitting Physician        3 Medical Service
           S SELF PAY          100 DOCTOR,ADMITTING ONEX    MED MEDICAL
         4 Clinic,Unit,Team (CUT)            5 Provincial Ins Plan


         6 Newborn Adm Type                   7 Newborn Adm Source
           4 NEWBORN                            10 NEWBORN
         8 Newborn Service                    9 Newborn Clinic,Unit,Team (CUT)
           PED PEDIATRICS                       PDMED
        10 Newborn Patient Type              11 Cancellation Reason
           NEW NEWBORN ADMISSION                ADMITTED IN ERROR
        12 I/P Auto Discharge Status         13 O/P Auto Discharge Status
           5                                    H
Override   14 Employer Code  15 Phys Code  16 Insurance Type       17 Ins code
              999               999           COMMERCIAL



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

Field Explanations

Default

1. FINANCIAL CLASS (TABLE LOOKUP)
Enter the default financial class for this facility. You can enter the financial class table code, if you know it, or enter a hyphen (-) to display the table for selection. This is used as the default financial class in admissions.

2. ADMITTING PHYSICIAN (TABLE LOOKUP)
Enter the default admitting physician for this facility. You can enter the physician table code, if you know it, or enter a hyphen (-) to display the table for selection. This physician is then used as the default admitting physician in admissions.

3. MEDICAL SERVICE (TABLE LOOKUP)
Enter the default hospital service for this facility. You can enter the hospital service table code, if you know it, or enter a hyphen (-) to display the table for selection. This is then used as the default medical service in admissions.

4. CLINIC, UNIT, TEAM (CUT) (TABLE LOOKUP)
If using Program Management, enter the default CUT for this facility. You can enter the CUT, if you know it, or enter a hyphen (-) to display the table for selection. This is then used as the default CUT in admissions.

(CN) 5.PROVINCIAL INS PLAN (TABLE LOOKUP)
Enter the default insurance plan for your province. You can enter the insurance plan code, if you know it, or enter a hyphen (-) to display the table for selection. This is then used as the default insurance plan during an admission.

6. NEWBORN ADM TYPE (TABLE LOOKUP-O)
Enter the default newborn admission type. You can enter the code if you know it, or enter a hyphen (-) to display the Admission Types table for selection. This is then used as the default during newborn admissions.

7. NEWBORN ADM SOURCE (TABLE LOOKUP)
Enter the default newborn admission source. You can enter the code if you know it, or enter a hyphen (-) to display the Admission Sources table for selection. This is then used as the default during newborn admissions.

8. NEWBORN SERVICE (TABLE LOOKUP)
Enter the default newborn service. You can enter the code, if you know it, or enter a hyphen (-) to display the Hospital Service table for selection. This is then used as the default service during newborn admissions.

9. NEWBORN CLINIC, UNIT TEAM (CUT) (TABLE LOOKUP)
If using Program Management, enter the Newborn CUT for this facility. You can enter the Newborn CUT, if you know it, or enter a hyphen (-) to display the table for selection. This is then used as the default Newborn CUT in admissions.

10. NEWBORN PATIENT TYPE (TABLE LOOKUP)
Enter the default patient type for a newborn. You can enter the code, if you know it, or enter a hyphen (-) to display the Patient Type table for selection. This is then used as the default patient type during newborn admissions.

11. CANCELLATION REASON (TABLE LOOKUP)
This field is used in an inbound ADT interface to determine Cancellation Reason if one is not sent.

12. I/P AUTO DISCHARGE STATUS (TABLE LOOKUP)
Enter the default auto discharge status for inpatients. You can enter the code, if you know it, or enter a hyphen (-) to display the Discharge Status/Disposition table for selection.

13. O/P AUTO DISCHARGE STATUS
Enter the default auto discharge status for outpatients. You can enter the code, if you know it, or enter a hyphen (-) to display the Discharge Status/Disposition table for selection.

Override

14. EMPLOYER CODE (6-N-R)
Enter an override employer code for this facility. This can be sent in an interface if the receiving system cannot accept a free-form employer and requires a coded entry.

15. PHYS CODE (6-N-R)
Enter an override physician code for this facility. This can be sent in an interface if the receiving system cannot accept a free-form physician and requires a coded entry.

16. INSURANCE TYPE (TABLE LOOKUP)
Enter the override insurance type. You can enter the code, if you know it, or enter a hyphen (-) to display the Insurance Type table for selection.

17. INS CODE (6-N-C)
Enter the IFAS override default code in this field. If insurance plan processing is used, this field is edited against the Insurance Plan table. If it is not used, this field is edited against the Insurance Carrier table. An existing carrier or plan code cannot be entered in this field. It must be a unique number.

Once you have completed these fields, you have the option of accepting or editing the screen. If you accept the screen, the transaction is complete.

PAAR Control

The PAAR Control function enables you to enter standard patient accounting and accounts receivable information used in claims, billing calculations, and statistics throughout the system.

After you access this function, the first screen is displayed.

```
              General Hospital PAAR Control Maintenance Processor


 Sun May 29, 2011 03:29 pm
Model Hospital A

 1 SP Rate/Date 1                  2 SP Rate/Date 2
    $560 01/01/2009                   $549 01/01/2003
 3 WD Rate/Date 1                  4 WD Rate/Date 2
    $300 01/01/2009                   $400 03/01/2010
I/P 5 Pat?      6 Guar?     7 Plan?    O/P  8 Pat?      9 Guar?   10 Plan?
      Yes         Yes         Yes            Yes         Yes         Yes
GL Opts 11 Prior Per 12 Curr Per    Auto Close Days   13 Fiscal Pd 14 Fiscal Yr
           No           Yes/45                          1            1
15 Reclass Default   16 Serv Time     17 Avg Dly Rev       18 Backdate Days
   Earliest            See Entries      90 days             330
19 Days/Sort for Unpaid Rpt      20 Refund Pg Break   21 C/A Batch Bal?
   00 - Carrier/Plan                 No                   Yes
22 UB Loc 54 Prior Pymt Calc        23 UB Loc 55       24 Trans Hist View
   Pymt+Adj+Ded+PatResp                Cur Est Amt Due    Date
25 Take Home RX UB Rev Cd   26 Take Home RX Pro Summ Cd  27 Claims List Order
   998-PT CONV - BEAUTY SH                                 Most Recent First
28 2nd Line for Claim Lookup
   All Transactions
```

Field Explanations

1. SP RATE (4-N-R) DATE 1 (DATE)
This field contains the most common semiprivate room rate. This information is accessed by the insurance master files and applied to those patients who have insurance coverage. It is used to record the value code amount for Value Code 01 on the UB-82 form which represents the hospital's most common semiprivate room rate. For Canadian users, this field also records the semiprivate room rate differential for Universal claims.

The Date field contains the date when the semiprivate room rate 1 goes into effect. This field displays the date in the MM/DD/YY or the MM/DD/YYYY format, depending upon your selected screen display format.

2. SP RATE (4-N-R) DATE 2 (DATE)
This field contains the next most common semiprivate room rate. This information is accessed by the insurance master files and applied to those patients who have insurance coverage. It is used to record the value code amount for Value Code 01 on the UB-82 form which represents the hospital's most common semiprivate room rate. For Canadian users, this field also records the semiprivate room rate differential for Universal claims.

The Date field contains the date when the semiprivate room rate 2 goes into effect. This date is actually the stop date for the SP Rate/Date 1 field. This field displays the date in the MM/DD/YY or the MM/DD/YYYY format, depending upon your selected screen display format.

3. WD RATE (4-N-O) DATE 1 (DATE)
This field contains the most common ward room rate. This information is accessed by the insurance master files and applied to those patients who have insurance coverage.

The Date field contains the date when the ward room rate 1 goes into effect. This field displays the date in the MM/DD/YY or the MM/DD/YYYY format, depending upon your selected screen display format.

4. WD RATE (4-N-O) DATE 2 (DATE)
This field contains the next most common ward room rate. This information is accessed by the insurance master files and applied to those patients who have insurance coverage. You can use this field to enter a price increase that goes into effect on the date specified for this rate.

The Date field contains the date when the ward room rate 2 goes into effect. This date is actually the stop date for the WD Rate/Date 1 field. This field displays the date in the MM/DD/YY or the MM/DD/YYYY format, depending upon your selected screen display format.

I/P

5. PAT? (1-A-R)
This field determines if the system displays financial information regarding previous visits during the initial name entry during admission. The options are **Y** for Yes to display financial information about previous visits for the patient (account balance, etc.) or **N** for No. This feature enables the admission/registration clerk to become familiar with the patient's current financial status with the hospital.

6. GUAR? (1-A-R)
This field determines if the system displays active patient accounts and financial information that are the responsibility of the guarantor entered. The options are **Y** for Yes or **N** for No. This feature enables the admission/registration clerk to become familiar with the guarantor's current financial status with the hospital.

7. PLAN? (1-A-R)
This field determines if the system displays insurance plan information during the admission process. The options are **Y** for Yes or **N** for No. If answered No, the system displays only the insurance demographic pages during admission. If answered Yes, the system displays demographic and all coverage, billing and claims information during admission, to allow the clerk to verify the patient's insurance coverage data.

If the hospital's procedure is to verify insurance at the time of admission, this field should be completed with Y (Yes).

O/P

8. PAT? (1-A-R)
This field determines if the system displays financial information regarding previous visits during the initial name entry at registration. The options are **Y** for Yes to display

financial information about previous visits for the patient (account balance, etc.) or **N** for No. This feature informs the admission/registration clerk regarding the patient's current financial status with the hospital.

9. GUAR? (1-A-R)
This field determines if the system displays active patient accounts and financial information for the guarantor entered. The options are **Y** for Yes or **N** for No. This feature informs the admission/registration clerk regarding the patient's current financial status with the hospital.

10. PLAN? (1-A-R)
This field determines if insurance plan information is displayed during the admission process. The options are **Y** for Yes or **N** for No. If answered No, the system displays the insurance demographic pages only. If answered Yes, the system displays demographic and all coverage, billing and claims information during admission, to allow the clerk to verify the patient's insurance coverage data.

If the hospital's procedure is to verify insurance at the time of admission, this field should be completed with Y for Yes.

GL OPTS

The next fields refer to revenue reclassification transactions that take place as a result of a change in a patient's financial class, medical service or doctor. For patient type changes, the STAR Patient Processing parameters allowing the patient type change govern the reclassification.

The Prior Per field is used to indicate whether the system allows relcassification to closed fiscal periods and the maximum number of prior periods that can be reclassified. The Curr Per field is used to indicate that you want to post General Ledger journal entries and STAR Patient Accounting statistics to the current period.

11. PRIOR PER (1-A-R)
This field determines if the system allows reclassification to closed fiscal periods. This refers to revenue reclassifications in the General Ledger, resulting from changes to a patient's financial class, doctor, medical service, etc.

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

Allow reclassification to closed periods? (Y/N)--

If you enter **Y** (Yes), the following prompt is displayed, in which you can indicate the maximum number of periods prior to allow reclassification:

Enter maximum number of prior periods to allow reclassification--

If this field is set to Yes (allow reclassification to closed periods) and a maximum number of prior periods is indicated, the system defaults the Curr Per field to N for No. If the Curr Per field contains Y for Yes, this field is updated to No.

NOTE: The system does not allow reclass to a prior fiscal year with this option.

Currently, the system does not close fiscal periods automatically. Fiscal periods can be closed by setting the closed flag for specific fiscal periods using the Fiscal Year Definition processor in the General Ledger.

NOTE: If you enter Y for Yes in this field, you could also enter N for No in the Closed Periods field on the Fiscal Year Definition screen, so the journal entries are errored out. If you enter Yes, the journal entries are posted to the prior period.

12. CURR PER (2-N-R)
This field is used to indicate that you want to post all journal entries to the current period. If the Prior Per field is set to Yes (allow reclassification to closed periods), the system defaults this field to N for No.

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

Post all GL J/E and PA stats to the current period? (Y/N) [N]--

If you enter **Y** (Yes), the following prompt is displayed, allowing you to indicate the number of days for reclassification:

Enter number of days to allow reclassification (regardless of fiscal year end)-

You can enter a range from **1** to **999**. Subtracting the response to this prompt from the current date determines the earliest effective date that can be used to reclassify revenue for changes other than patient type. For patient type changes, the STAR Patient Processing parameters allowing the patient type change govern the reclassification.

Auto Close Days

13. FISCAL PD (3-N-R)
This field contains the number of days to pass after the period ends before the system assumes the period as closed. The range is 1 to 366. Fiscal periods are not marked as closed.

14. FISCAL YR (3-N-R)
This field contains the number of days to pass after the fiscal year ends before the system assumes the fiscal year as closed. The range is 1 to 366. Fiscal years are not marked as closed.

15. RECLASS DEFAULT (1-A-R)
This field is used to set the system default prompt for revenue reclassification. Enter **E** for Earliest or **T** for Today. Today is the default.

16. SERV TIME (SPECIAL FORMAT-O)
This field defines whether service time processing is implemented. This field remains blank if service time processing is not active. If the user accesses the field and saves

the service time processor sub-screen with the Service Time Processor Active field set to Yes, *See Entries* is displayed in this field. If the user accesses the field and saves the service time processor sub-screen with the Service Time Processor Active field set to No, *No* is displayed in this field.

CN: Hospitals that are in Canada that attempt to access this field will receive the following prompt:

This function is not valid for Canadian Hospitals

When the user accesses the Serv Time field, the following screen is displayed:

```
              General Hospital PAAR Control Maintenance Processor
                                                  Fri Aug 17, 2007 10:55 am
Model Hospital A

 1 Service Time Processor Active         2 Purge Service Time Data
   Yes                                     Zero Balance-10
 3 Default Serv/Eff Time
   Earliest
 4 Audit Information

Edit By                          Edit Date        Field        Prior Value
Moore,Phil                       07/31/07 13:46   Purge        Claim Purge
Moore,Phil                       07/31/07 12:49   Purge        Zero Balance-321
Share,Loni S                     07/24/07 09:38   Purge        Zero Balance-369
Share,Loni S                     07/24/07 09:37   Purge        Zero Balance-321
Share,Loni S                     07/24/07 09:36   Purge        Zero Balance-321
Share,Loni S                     07/24/07 09:36   Purge        Zero Balance-321
Share,Loni S                     07/24/07 09:35   Purge        Zero Balance-321
Share,Loni S                     07/24/07 09:35   Purge        Zero Balance-2
Share,Loni S                     07/24/07 09:35   Purge        Zero Balance-2
Share,Loni S                     07/24/07 09:34   Purge        Zero Balance-2
Share,Loni S                     07/24/07 09:34   Purge        Zero Balance-2
Enter field number or '/' starting field number--
```

Field Explanations

1. SERVICE TIME PROCESSOR ACTIVE (1-A-R)
This field determines whether service time processing is active for the facility. If the field is set to No or is left blank, service time processing is not active for the facility. If the field is set to Yes, service time processing is active for the facility.

NOTE: After service time processing is activated, it cannot be changed back to be inactive by means of this field. This is due to statistics and revenue being captured in PA and GL under two different sets of rules. If it is determined that service time processing must be inactivated, a Work Order must be submitted so that accounts can be flagged to no longer do service time processing. Statistics and revenue that has already been booked until that time cannot be changed because the mapping had occurred under service time processing rules.

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

Service Time Processor is active? Yes or No --

There is no default value for this field. If the user accesses the field and presses ENTER at the prompt, then the existing value of the field remains because the field is required.

If the field is set to No and is changed to Yes, STAR Patient Accounting sets a flag to allow service time processing to occur and starts collecting service time processing information. STAR Patient Accounting networks an indicator to both STAR Clinical and STAR Patient Processing to turn on service time processing on their respective CPUs.

If the field is set to Yes, the user cannot change the value of the field to No. If a user accesses the field after it is set to Yes, the system displays the following prompt:

This field can not be changed if Service Time Processing has been activated.

2. PURGE SERVICE TIME DATA (1-A-R)
This field defines when the additional account information is purged from the system. Only accounts in location AR or BD are considered for purging the additional account data. After the field is defined, it contains one of three values: Zero Balance - ###, Claim Purge, or Account Purge.

The initial value for this field is blank. When the user accesses the Service Time Processing Active field for the first time and sets the value to Yes, the blank value is no longer valid for this field and the user must select a valid option of when to purge the additional account data.

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

Set Service Time Data purge. (Z)ero Balance, (C)laim Purge, (A)ccount Purge -

If you enter Z to select Zero Balance criteria, the system displays the following prompt:

Enter Number of Days--

You can enter any valid number between 1 and 999. The value defines the number of days after the account has gone to zero balance that the additional account information retained on the account is to be purged. After an account has passed the number of days defined, a program, which runs weekly on Saturday in Midnight Processing, purges the data from the system.

If you enter C for Claim Purge, the system purges the additional account data at the time that the last claim is purged from the system for the account visit when the account is no longer in PA. Claim purge is controlled by defining parameters on the Data Retention Parameters screen along with running the Optional Batch Job, Claim Purge.

NOTE: If the Claim Purge option is selected and an account has no insurances, the key data index is purged when the account is purged.

If you enter A for Account Purge, the system purges the additional account data at the time that the account is purged from the system. Account Purge is controlled by running the Purged Archived Accounts function.

NOTE: If the account is scheduled for purge and the additional data index still exists for the account, then the data is cleared at that time regardless of the value defined on the field.

If a charge is received for an account after this data is purged, the charge is handled as if service time processing was not employed for the account. This means that current information for the key data items is then assigned to the charge.

If a key data item is changed for an account after this data is purged and revenue is reclassed, the revenue is reclassed per the existing rules for using the posting date.

3. DEFAULT SERV/EFF TIME (1-A-O)
This field defines a value that STAR Patient Accounting uses if either an Effective Time for a key data event or a Service Time for a charge event is received that is blank. This field is blank until the user accesses it and defines a value. If the field is blank, the system responds the same as when it is set to Current.

When this field is accessed, the system displays the following prompt:

Set a Default for blank Service Time and Effective Time. (E)arliest or (C)urrent -

If you enter E for Earliest, the system defaults blank Effective time and/or Service time messages to the earliest time for the received date. The earliest time is limited to the admit time if the date received with the event is the admit date, or midnight if the date of the event is not the admit date. If a valid time is sent, that time is used.

If you enter C for Current, the system defaults the Effective time and/or Service time to the current time if the time field received is blank. If the effective date is the date of admission and the current time proceeds the admission time, the admission time is used. If a valid time is sent, that time is used.

4. AUDIT INFORMATION (DISPLAY ONLY)
This section of the screen displays the history of the edits of the Service Time Processor Active, Purge Service Data, and Default Serv/Eff time fields in reverse chronological order. If there is more then one screen of information to display, the user can use PREV PAGE and NEXT PAGE to move between pages. This section of the screen displays four pieces of information:

- Edit By, which displays the name of the user who last saved changes to this screen.
- Edit Date, which displays the date and time that this screen had changes that were saved.

- Field, which displays information indicating which field was last updated and changed. The system displays *Serv Time* for the Service Time Processor Active field, *Purge* for the Purge Service Time Data field, and *Default time* for Default Time.

- Prior Value, which displays the original value of the field that was changed.

When the screen is accepted, the service time processing parameters go immediately into effect.

IMPACT

If service time processing is turned on, the following occurs for new accounts that are initialized on STAR Patient Accounting after the processing has been activated:

- Additional Information is kept for each account to track the account information and status based on the effective date and time of key data changes. These key data changes include modification of Patient Indicator, Patient Type, Medical Service, Financial Class, Admitting Dr, and Attending Dr.

- Account Information stored on the charge records on STAR Patient Accounting contains information that existed on the account at the date and time of the service rather then the current information.

- Service date and time is stored on the charge records; STAR Patient Accounting displays service time when charge information is displayed if a service time was received on the charge, even if service time processing is not active.

- Revenue reclassification is based on the effective date and time instead of the effective date. In addition, revenue reclassification uses the service date and time for determining which revenue to use for reclassification.

- If service time processing **is not turned on**, the system does not accumulate the additional information needed to track the account status based on the effective date and time of key data changes. Charge records on STAR Patient Accounting contain the account information that existed on the account at the time that the charge was received on STAR Patient Accounting. Revenue reclassification uses the effective date to determine what posting date to use for reclassifying information.

17. AVG DLY REV (3-N-O)
This field contains the number of days or months of accounts receivables to be used in the calculation of average daily revenue. This information is reported on the Receivables Analysis report (FSR910) and the Administrative Operating Summary (FSRAOS). The range is 1 to 999.

The system calculates average daily revenue using your entry to this field and the defined number of days in the current month. If your entry to this field exceeds the number of months of data available in STAR Financials, the system calculates average daily revenue using the receivables and the days available on STAR Financials. The system assumes that the data available starts from the beginning of the month.

For example, if you set the average daily revenue months to three and today's date is September 10, the system uses all the data from the months of June, July, and August, plus the first 10 days of September, in calculations. If the hospital does not have data available before August 15, the system uses the data from August 15-31 and the first 10 days of September in calculations. The system assumes that the data available from August is starting from August 1; thus, it looks at receivables from August 15 through September 10 and divides the information by 41 days (rather than 26 days) to calculate average daily revenue.

NOTE: Hospitals need to use the Months option until they have been live the number of days that they want to use in the Average Daily Revenue calculation. Once they have passed the number of days, they should modify the PAAR Control Table to reflect that they wish to use the Days option and then enter the number of days.

18. BACKDATE DAYS (3-N-O)
This field contains the number of days to allow backdated cash/adjustment posting. The system default is 0.

19. DAYS/SORT FOR UNPAID RPT (2-N-R)
This field contains the number of lapsed days after submission that a claim prints on the Unpaid Claims report (FCR280). If a final payment has been received for the claim, or the claim has been denied, replaced, or transferred, it does not print on the Unpaid Claims report.

Enter a number from 0 to 99. The system then displays the following prompt:

Sort by Carrier/Plan or Insurance Collector? (C/I) [C]--

To sort the Unpaid Claims report by carrier/plan, account number, claim submission date, and claim sequence number, enter **C** or press ENTER to accept the default. To sort the Unpaid Claims report by insurance collector, carrier/plan, account number, claim submission date, and claim sequence number, enter **I**. The system displays the value you entered followed by the sort selection (for example, 30-Carrier/Plan or 30-Insurance Collector).

20. REFUND PG BREAK (1-A-R)
This field indicates whether financial classes should print on separate pages of the Pending Refund Report. Enter **Y** to force a new page of the report when the financial class changes and summarize the report by financial class. Enter **N** to display multiple financial classes on the same page and not display summary information by financial class. The default is N.

21. C/A BATCH BAL (1-A-R)
This field is used to determine if the system allows cash batches to be approved if there is a variance in the contractual allowance field. When this field is accessed, the system displays the following prompt:

Should C/A variance amts allow approval of cash batches?

Valid responses are **Y** for Yes or **N** for No. The system default is N. If the field contains an N, the batch does not allow approval if there is a variance in any of the cash posting screens in the field C/A Variance. If the field contains a Y, the system displays a warning when the user exits if there is a variance in any of the cash posting screens in the field C/A Variance but allows the user to approve the batch.

22. UB LOC 54 PRIOR PYMNT CALC (1-A-R)
This field indicates whether UB Locator 54 reflects insurance payments and adjustments, as well as any of the following: Coinsurance from Cash Posting, Deductible from Cash Posting, Co-Pay from Cash Posting, Pat Resp from Cash Posting. If selected, these items from the payment transaction are included in the prior payment total. This field is used if the UB Loc 54 Prior Pymt Calc field in the Claim Load and Edit Parameters is blank.

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

Include other values in prior payment calculation for locator 54 (Y/N)?--

If you enter **N** (No), the value of Payment Only is displayed in the field, and the three fields in locator 54 (lines a, b, and c) for the UB claim contain total payments only. If you enter **Y** (Yes), the following table is displayed:

```
Page:01                      Prior Payment Options          ##=Current Choices
( 1) Adjustments (Auto Cont. and Manual)
( 2) Coinsurance from Cash Posting
( 3) Deductible from Cash Posting
( 4) Co-Pay from Cash Posting
( 5) Pat Resp from Cash Posting

Select items from payment transaction to be included in prior payment total--
                                end select(NL)
```

The screen displays the following prompt:

Select items from payment transaction to be included in prior payment total

You can select one or more items from the table. The selected items are added to the payment amount used to calculate prior payments for locator 54. The system analyzes payment transactions for claims for previous COBs. This logic is used when the Awaiting Payment disposition is removed for a claim because final dispositions have been assigned to all claims for previous COBs associated with the claim per the claim split indicator.

This field displays Payments only or Pymt+x where x is Adj, Coins, Ded, CoPay, and/or PatResp, depending on the other values selected to be added to the Prior Payments field. For example, the field may display Pymt+Adj+Coins+Ded+CoPay+PatResp.

NOTE: The system looks only to the Claim Load and Edit Parameter or PAAR Control for Waiting Claims, and the Claim Load and Edit Parameter must be set as follows for Locators 54 a, b, and c:

Field Type: M Money

Internal Element: Money

The following should also be set:

Print Routine: MONEY 999999900 BLK 0 TRL SIGN

For waiting UB claims, since a UB insurance can load more than one claim sequence per bill sequence, the system totals the payments (and adjustments if indicated) made to the claims the claim was waiting on. For example, if COB 1 loads claims 1 and 2, and COB 3 loads claims 4 and 5, if claim sequence 4 is waiting for payment on claim sequence 1, when claim sequence 4 is released, the system totals the payments made to claim sequence 1, and does not include the payments made to claim sequence 2, even though it is for the same carrier.

If this field is set to Yes to include Adjustments in the Prior Payment amount, if the COB 1 plan had an automatic contractual adjustment from reimbursement, and this reimbursement type is not claim based (is not J for PCON by Claim or H for OPPS), this adjustment is associated with the Primary claim, or the claim with the blank Claim Split Indicator, or if none, with the first (in priority that loads) split claim for the insurance carrier only.Therefore, only the claims waiting on this claim reflect the automatic contractual allowance in the Prior Payments locator.

Manual adjustments that are posted to a specific claim are reflected on the claims waiting on this claim. For claim-based reimbursement (J for PCON by claim and H for OPPS), the automatic contractual adjustment is reflected on that particular claim, and can be included in the Prior Payment amount for any waiting claims.

23. UB LOC 55 (1-A-R)

This field determines whether waiting claims should be updated with the estimated amount due, which is [covered charges - deductible - coinsurance) - payments +- adjustments] for the bill sequence or with the current carrier balance at the time the claim is released from the wait status.

If set to a **C**, the system updates waiting claims with the estimated amount due, and if set to a **B**, the system updates waiting claims with the current carrier balance.

The system initially loads the estimated amount due for the carriers in Locators 55A, 55B, and 55C. Then, the system looks to this field to determine what amount to update these fields with when the waiting claim is released.

Locators 55A, 55B, and 55C are updated each time a claim its waiting on is marked Final Payment, Adjusted to Zero, or Denied through the Cash Posting, Adjustment Posting, or the Balance Transfer Claim Disposition functions.

If the Estimated Amount Due (whether this is estimated amount due or current carrier balance) is greater than the Total Claim Charges for either the Primary or the Split Claim, the system loads the Total Claim Charges as the Estimated Amount Due.

24. TRANS HIST VIEW (1-A-R)
This field controls the default prompt for transaction history view.

When you access this field, the system displays the following prompt:

Transaction History default view? (`D`ate, `B`alance or `P`rompt) [D] -- |

If you press ENTER or enter **D**, the system continues to display transaction history in the Transaction Date format and does not allow users to view the Balance Forward option.

If you enter **B** for the Balance Forward format, the system displays transaction history in the balance forward format for all users.

If you enter **P** for the Prompt format, the system displays the following prompt:

Set the default value to Balance or Date format (B/D) --[D]

If you press ENTER or enter **D**, the default value is set to Transaction Date format. If the balance forward format is selected, the default value for the format view is the new balance format.

NOTE: When the Prompt format is selected, all users must respond to an additional prompt line every time they access transaction history. The Prompt option is the only option that allows both formats to be viewed by the same facility.

25. TAKE HOME RX UB REV CODE (TABLE LOOKUP)
This field designates the UB revenue code that is used for Pharmacy charges entered through the Take Home Medication Charge Processor. If a revenue code is defined here, it overrides the UB revenue code assigned to the charge in the Financial Item Master. This revenue code is used regardless of patient type or insurance plan.

When you access this field, the system displays the following prompt:

Enter UB Revenue Code or `-` to list--

Enter the UB Revenue Code, or enter a hyphen (-) and select from the list.

After you accept the first screen, the next PAAR Control Maintenance screen is displayed.

26. TAKE HOME RX PRO SUMM CD (TABLE LOOKUP)
This field designates the proration summary code that is used for Pharmacy charges entered through the Take Home Medication Charge processor. If a proration summary code is defined here, it overrides the proration summary code ass2igned to the charge in the Financial Item Master. This proration summary code is used regardless of patient type or insurance plan.

When you access this field, the system displays the following prompt:

Enter Proration Summary Code or '-' to list

Enter the Proration Summary Code, or enter a hyphen (-), and select from the list.

27. CLAIMS LIST ORDER (1-A-O)
If this field is set to Most (**R**)ecent, then the most recent claim is displayed first. If this field is set to (**O**)ldest, the oldest claim is displayed first. If this field is left blank, claims continue to be displayed with the oldest claim first. Claims are sorted based on the claim sequence number, and this parameter controls all claims for the facility. This parameter does not control the sort of claims in the graphical user interface applications.

28. 2ND LINE FOR CLAIM LOOKUP (1-A-O)
This field is used to indicate whether the system displays a second line of information in any claim lookup. When set to display a second line the Claim Split Indicator is displayed on this second line.

When this field is accessed, the following options are displayed:

```
Page:01          Activate/De-Activate 2nd Line for Claim Lookup
( 1) Do Not Use
( 2) All But Cash and Adj Trans/Balance Transfer
( 3) All Transactions



Enter choice--
```

Entry options are as follows:

- Do Not Use - This option is the same as leaving the field blank. The system continues to display only the one line claim lookup in all functions.

- All But Cash and Adj Trans/Balance Transfer - The option of All But Cash and Adj Trans/Balance Transfer displays two lines in the claim lookups, except for any Cash, Adjustment, or Balance Transfer Transaction. These functions continue to display the one line claim lookup. For non cash, adjustment, and balance transfer transactions, the prompt displays an option to toggle to (S)ingle line claim display, and from this display, back to the (T)wo line claim display.

  All Transactions - The option of All Transactions displays two lines in all claim lookups, and the prompt allows the user to toggle to a (S)ingle line claim display, and from this screen, back to the (T)wo line claim display. This includes Cash, Adjustment, and Balance Transfer transactions. Note that the second line in the claim display adds more blank space between the claim display and the prompt at the bottom of the screen. If the claim display goes to a next screen, you will see the prompt for "next pg" at the bottom of the screen.

  If the PAAR Control field is set to either All But Cash and Adj Trans/Balance Transfer or All Transactions, the claim lookups that allow a second line in the claim lookup also allow you to enter S for the Single Line display. Once on the Single line display, the prompt allows you to toggle back to the (T)wo Line display.

This field affects claim lookups in character-based system only. The prompts for the varied claim lookups vary depending upon what was available.

The next screen of the PAAR Control option is displayed:

```
          General Hospital PAAR Control Maintenance Processor
                                                Fri May 14, 2011  11:36 am
Model Hospital A

 1 Print Facility                     2 Business Office
   No                                   MH-**Invalid Code**
Bulk Mail  3 Pieces   Delay Days   4 Detail Stmt 5 Coll. Letter   6 Ins. Letter
             30
 7 Guar/Acct F/U    8 Agency Del Act         9 Prepaid Amt
   Guarantor          Account F/U              No
10 Zero Bal F/U?   11 Archive Method        12 Perform Auto PA F/U?
   No                 Paper                    No
13 PA F/U Exception Schedule #              14 Workfile Max Rpt Days
                                               180
15 Ins FC Update Of AR F/U                  16 Collector Assignment Balance
   Yes/Remove from AR Agency F/U               Account
17 Ins Cov for Auto Series Re-Reg           18 Auto Adj Rebill CPTAFB?
   Insurance Coverage Table                    No
19 Edit Adj Bill                            20 Edit Adj Bill for CPTAFB
   Yes
21 BD to AR Transfer in CPTAFB              22 Ins Collector Assignment Bal
   Yes                                      ->
```

Field Explanations

1. PRINT FACILITY (3-A-R)
This field indicates whether the facility indicator should print with the account number when paper follow-up is produced. The options you enter in this field identify the type of follow-up that should include the facility indicator. Enter **D** for detail statements, **L** for collection letters, and **I** for insurance collection letters.

You can enter D, L, and I in any combination. For example, to select detail statements and insurance collection letters, enter DI. To print the facility indicator on all paper follow-up, enter **A** for All. The facility indicator precedes the account number on the type of paper follow-up you select. Enter **N** for No if you do not want the facility indicator to print on any paper follow-up. The default is N.

2. BUSINESS OFFICE (2-A-R)
This field contains the business office for the facility. You can enter the office table code or a hyphen (-) to display a list of valid codes.

Bulk Mail

3. PIECES (3-N-O)
This field contains the number of pieces of mail (statements and letters) to accumulate for bulk mail. This number of pieces is verified before generating statements to allow the hospital to take advantage of bulk mail rates.

Delay Days

4. DETAIL STMT (9-N-O)
This field contains the number of days to delay detail statements for bulk mail, up to nine days. If the number of pieces of mail is not met and the delay days are met, the statements print anyway.

5. COLL. LETTER (9-N-O)
This field contains the number of days to delay collection letters for bulk mail, up to nine days. If the number of pieces of mail is not met and the delay days are met, the statements print anyway.

6. INS. LETTER (9-N-O)
This field contains the number of days to delay insurance follow-up letters for bulk mail, up to nine days. If the number of pieces of mail is not met and the delay days are met, the statements print anyway.

7. GUAR/ACCT F/U (1-A-R)
This field indicates the type of follow-up that is performed for accounts. Entry options are **G** (guarantor) or **A** (account); the default is G. If you enter **G**, the system performs follow-up at the guarantor level for all accounts pertaining to that guarantor; if you enter **A**, follow-up is performed at the account level for individual accounts.

8. AGENC DEL ACT (1-A-R)
This field determines where accounts should move to after they are deleted from either CCI or agency collection. The system refers to this value when automatically deleting accounts from collection. Also, the value in this field is the default value when accounts are manually deleted from either a CCI or Internal Collection Status on the Agency Process Status Screen. The following prompt displays the valid options:

Return to (G)uarantor Level or (A)ccount Level Follow Up? [A]

- If the Guarantor Level F/U option is selected, the system moves accounts that are manually or automatically deleted from agency processing to guarantor level follow-up. If there is not an existing guarantor follow-up schedule, the system assigns the schedule according to the account's financial class, and the schedule type is standard.

- If the Account level F/U option is selected, the system moves accounts that are manually or automatically deleted from agency processing to regular account level follow-up. The schedule type of the follow-up schedule is separate, and the schedule is assigned according to the account's financial class.

NOTE: This field does not control accounts that are finished with Pre-Collection because they have completed the Pre-Collection Follow-Up Schedule. Accounts that are finished with either CCI or Internal agency collections move to the follow-up schedule that is indicated in the Post Agy Sch field on the Pre-Collection Follow-Up Schedule for the accounts.

9. PREPAID AMT (1-A-R)
This field indicates whether a prepaid amount should be calculated and displayed on payment plan accounts. Valid entries are **Y** for Yes or **N** for No. The default is No.

10. ZERO BAL F/U? (1-A-R)
This field indicates whether guarantor follow-up should produce one-time paper follow-up after an account goes to a zero balance. Entry options are **Y** for Yes or **N** for No. The default is No. If you enter **Y** in this field and your guarantor has one account which goes to a zero balance and has other accounts with an existing balance, follow-up occurs on the zero balance account the next time follow-up is scheduled to occur. Payment information shows on Detail Statements. An account balance of zero is shown on the Collection Letters. If you enter N in this field, zero balance accounts are not included during the guarantor follow-up.

11. ARCHIVE METHOD (1-A-R)
This field contains the archive method, paper or tape. The system default is (T)ape. Currently, this field is not used.

12. PERFORM PA F/U? (1-A-R)
This field determines if account level follow-up should automatically occur for PA accounts (whether detail statements and/or collection letters are produced for PA accounts). If this field is switched from a value of No to a Yes, the system begins automatic follow-up that evening if all required tables are completed. If tables have not

been completed and/or the PA follow-up exception schedule is used on any financial class table setup, an error message is displayed, and the PA Follow-up field is set back to No when the screen is accepted.

The update of PA accounts occurs during Midnight Processing. Accounts that were added to follow-up appear on the PA Activity Report (FFRPAR). Accounts may be displayed on this report every night and can be used to verify the initial PA conversion worked as intended. If this field is manually switched from a Yes to a No, the accounts that were already in PA follow-up are removed and are displayed on the PA Activity Report that night. Also, no new PA accounts are automatically added to PA follow-up after the field is switched to a value of No.

When this field is accessed, the following prompts are displayed:

Do you wish to perform Auto PA Follow-Up? Y/(N)

NOTE: The following error message may be displayed after you enter No to the above prompt:

All Inclusions must be deleted before PA/F/U can be deactivated!

If you enter **Y** (Yes) to the prompt, the system displays the following prompt:

Do you wish to Add/Revise Financial Class Inclusions? Y/(N)

If you enter **Y** (Yes), the system displays a list of financial classes and then patient types within each financial class that can be selected for inclusions. An inclusion that is active is highlighted. When patient type inclusions exist, the system performs PA follow-up for the specified patient types. If none are defined, the flag for auto PA Follow-up is automatically switched back to N.

13. PA F/U EXCEPTION SCHEDULE # (3-N-O)
This field is a schedule defined by the user, which has been set up in the PA follow-up schedules. This schedule is assigned manually when an account is not set up as an inclusion but the user has decided to set up the account in follow-up anyway. Once an account is set up on this schedule, it can be customized, but it cannot be changed to another schedule. Any account set up on this schedule will not be removed from follow-up even though it is not an inclusion. Auto included PA accounts cannot be changed to this schedule number, and this schedule number is not available for selection once it has been defined in the PAAR Control table.

14. WORKFILE MAX RPT DAYS (3 -N -O)
This field is used to determine the telephone workfile entries exceeding a specific number of days. The qualifying telephone workfile entries are summarized in two online functions and detailed in the Collector Statistics Telephone Entries Report (FFR275). This field is optional.

15. INS FC UPDATE OF AR F/U (1-A-R)
This field determines if guarantor follow-up information is updated for accounts in AR when a financial class change occurs as a result of an insurance change. The patient types associated with the accounts must be defined as patient type exceptions on the Financial Class table for the automatic update of follow-up information to occur. If an account's new financial class is defined as a patient type exception on the financial class table, the system reassigns the patient's AR follow-up schedule and collector. It changes the schedule type to separate, the next follow-up step to 1, and the next follow-up date is recalculated using the wait days in the new follow-up schedule. When this field is accessed, the following prompt is displayed:

Update AR F/U when FC changes as a result of Insurance Change? (Y/N) [N]--

Entry options are **Y** for Yes and **N** for No. When this field is completed with a Y for Yes, the system updates AR Follow-up when a financial class changes as a result of an insurance change. When this field is completed with an N for No, the system does not update AR Follow-up when a financial class changes as the result of an insurance change.

If you entered Yes at the first prompt, the following prompt is displayed:

Remove from AR Agency F/U? Y/N [N]--

If you enter **N** (No), the system does not remove the account for agency collection. This applies to internal and external AR, but does not apply to CCI agency types. If you enter **Y** (Yes), the system updates the account's follow-up information if the TO financial class has the account's patient type set up as an exception and the TO financial class has a different follow-up schedule and/or collector assignment (Collector Group Assignment). If the account is removed from external collection during the next Midnight Processing, the collection agency receives a delete message for the account.

The field contains the value *Remove from AR Agency F/U* if you entered No at the prompt or the value *Leave at AR Agency F/U* if you entered Yes at the prompt.

16. COLLECTOR ASSIGNMENT BALANCE (1-A-R)
This field determines whether the system uses the account or the patient balance when assigning the PA, AR, agency, and Internal Bad Debt collectors. This field is also used to assign external agencies, for guarantor collections only, through the Collection Agency Group table. Insurance collections are based on carrier balance. When this field is accessed, the following prompt is displayed:

Use (A)ccount or (P)atient balance [A]--

You can enter **P** for Patient or **A** for Account. A value of Patient indicates that the system should use the patient balance when assigning collectors, based on the value

in the Dollar field on the Collector Group table. A value of Account indicates that the system should use the account balance when assigning collectors based on the value in the Dollar field on the Collector Group Table. For Guarantor level follow-up, when the Collector Assignment Balance field is set to Patient, the system adds all the patient balances for the accounts associated with the guarantor to calculate the guarantor's patient balance. For Guarantor level follow-up, when the Collector Assignment Balance field is set to Account, the system adds all of the account balances for the accounts associated with the guarantor to calculate the guarantor's account balance. The default for this field is A for Account.

17. INS COV FOR AUTO SERIES RE-REG

This field determines the source of insurance plan coverage information when an account is registered during midnight processing via auto series re-registration. When this field is accessed, the following prompt is displayed:

Use (A)ccount or (I)nsurance Cov Table for auto series re-reg accounts [A]--

When set to **A** for Account, the system pulls the billing information from the insurance itself, as can be seen by accessing Account Inquiry, Admission Information, Insurance Process, then selecting the Insurance, Billing/Collection Options. The **Billing Group**, **Final Bill Parameter**, and **Cycle Bill Parameter** fields cannot be updated for the insurance at the account level, and therefore reflect the Insurance Plan Coverage table settings at the time the insurance was originally assigned to the patient.

Billing parameter changes (such as changing the Final Bill Parameter) made directly to the Account Status screen by accessing Account Revision, Financial Information, Account Status screen, are not pulled into the new series account.

CN: For the province of British Columbia, the next four fields are displayed on a separate screen.

18. AUTO ADJ REBILL CPTAFB? (1-A-R)

This field indicates whether an automatic adjustment bill should be generated when a Change Patient Type After Final Bill transaction occurs for an account. The system looks at the parameter on the Billing Parameters screen, and if it is not completed, looks at the parameter on PAAR Control Maintenance screen. By having two parameters, you have the flexibility to have certain billing parameters set to produce/ not produce automatic adjustment bills, and you can set the overall system parameter on PAAR Control Maintenance to determine how you want the rest of your bills to generate.

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

Produce an Adjustment Bill Request for CPTAFB? (Y/N)--

If you answer **Y f**or Yes at the prompt, an adjustment bill request is processed in the first Midnight Processing following a CPTAFB transaction. If you answer **N** for No, an automatic CPTAFB adjustment bill is not requested, and the account goes into the

CPTAFB worklist to be reviewed by a biller and is placed on CPTAFB bill hold. The field is populated with No if you enter N for No.

A second prompt is displayed after you complete the first prompt:

Define indicators for adjustment bill? (Y/N) [N]--

If you enter **Y** for Yes, the Table of Adjustment Bill Indicators is displayed:

```
Page:01               Table of Adjustment Bill Indicators    ##=Current Choices
( 1) Basic Coverage
( 2) Room Coverage
( 3) Ancillary Coverage
( 4) Major Medical Coverage
( 5) Daily/Blood Deductibles
( 6) Flat Rate Coverage
( 7) Billing/Claims Parameters
( 8) Collection Parameters
( 9) Reimbursement
(10) Claim Attachments



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

You can select one or more options from this screen to indicate which indicators should trigger an adjustment bill. If at least one indicator is defined, the Auto Adj Rebill for CPTAFB field is completed with *Yes /Indicators Defined*. If you enter **N** for No indicators defined, the system updates the Auto Adj. Rebill for CPTAFB field with *Yes/ No Indicators Defined*. If the account does not qualify for an automatic adjustment bill according to the indicators defined, the system places the account on CPTAFB bill hold and puts it in the CPTAFB worklist.

19. EDIT ADJ BILL (1-A-R)
This field indicates whether bill edits should be performed on adjustment bills. When this field is accessed, the following prompt is displayed:

Perform bill edits on adjustment bills? (Y/N) [N]--

You can leave the field blank or enter **N** for No to indicate that bill edits should not be performed on adjustment bills. You can enter **Y** for Yes to indicate that bill edits should be performed on adjustment bills. Adjustment bill edits occur every night until the bill edits are fixed, you remove the adjustment bill request from Single Bill Request, or you request the adjustment bill with no edits in Single Bill Request. Adjustment bills that are failing billing edits are included on the Failed Billing Requirements report.

20. EDIT ADJ BILL FOR CPTAFB (1-A-R)
This field determines whether bill edits should be performed on the first adjustment bill after a CPTAFB transaction. The default for this parameter is that no edits are to be

performed on the first adjustment bill after a CPTAFB transaction. When this field is accessed, the following prompt is displayed:

Perform bill edits on the first adj bill after a CPTAFB transaction? (Y/N) [N]--

When you enter **Y** for Yes, bill edits are performed on the first adjustment bill after a CPTAFB transaction. When you leave the field blank or enter **N** for No, bill edits are not performed on the first adjustment bill after a CPTAFB transaction.

NOTE: If the Edit Adj Bill field is set to No, the Edit Adj Bill for CPTAFB field can be defined. If the Edit Adj Bill field is set to Yes, any response for the Edit Adj Bill for CPTAFB field is removed by the system.

21. BD TO AR TRANSFER IN CPTAFB

The BD to AR Transfer in CPTAFB parameter allows you to add a request to transfer an account from bad debt (BD) to accounts receivable (AR) within the Change Patient Type After Final Bill (CPTAFB) processor. Within the CPTAFB function, if the user requests to perform a BD to AR transfer, the BD to AR transfer screen is displayed, allowing the addition of a request. The transfer of the account to AR occurs in Midnight Processing. The next day, after the account is transferred to AR, the user can go to the CPTAFB function and change the patient type. When this field is accessed, the following prompt is displayed:

Request BD to AR Transfer in CPTAFB (Y/N) [N]--

If you enter **N** for No, a request to transfer an account from BD to AR is not allowed. If you enter **Y** for Yes, the request is allowed.

22. INS COLLECTOR ASSIGNMENT BAL (1-A-O)

This field is used to indicate whether the claim amount or insurance balance should be used when determining insurance collector assignment. This field is used only for standard insurance collectors. It is not valid for appeal collector assignment or external insurance collector assignment. When this field is accessed, the following prompt is displayed:

Use (C)laim Amount or (I)nsurance Balance [C]-- |

Entry options:

- A value of **C** for claim amount uses the claim amount that is associated with the claim when the claim loads.
- A value of **I** for insurance balance uses the insurance balance associated with the insurance carrier plan at the time the collector is assigned.

The next PAAR Control Maintenance screen provides transaction codes, used by the billing and follow-up process, to update the patient's transaction history. The formats used for follow-up forms are also defined in this function.

```
            General Hospital PAAR Control Maintenance Processor
                                                 Mon Apr 12, 1999 01:31 pm
Model Hospital A

 1 Insurance Letter Format            2 Insurance Letter Transaction Code
   HBO Standard Insurance Letter        T0030-INSURANCE LETTER
 3 PA Detail Statement Format         4 PA Detail Statement Transaction Code
   HBOC Standard PA Detail Stmt         T0006-CLAIM IN AUDIT
 5 PA Collection Letter Format        6 PA Collection Letter Transaction Code
   HBOC Standrd PA Collection Ltr       T0031-COLLECTION LETTER
 7 AR Detail Statement Format         8 AR Detail Statement Transaction Code
   HBO Standard Detail Statement        T0006-CLAIM IN AUDIT
 9 AR Collection Letter Format       10 AR Collection Letter Transaction Code
   HBO Standard Collection Letter       T0031-COLLECTION LETTER
11 BD Detail Statement Format        12 BD Detail Statement Transaction Code
   HBOC Standard BD Detail Stmt         T0039-BAD DEBT DETAIL STATEMENT
13 BD Collection Letter Format       14 BD Collection Letter Transaction Code
   HBOC Standrd BD Collection Ltr       T0040-BAD DEBT COLLECTION LETTER
15 Archive Statement Format          16 Archive Statement Transaction Code
   SPLIT ON TWO STATEMENTS              T0032-ARCHIVE STATEMENT



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

Field Explanations

1. INSURANCE LETTER FORMAT (TABLE LOOKUP)
This field contains the insurance follow-up letter format. Accessing this field prompts the system to display a list of formats established in the system and maintained by McKesson.

WARNING: *Do not change* this format without first verifying the change with McKesson.

2. INSURANCE LETTER TRANSACTION CODE (4-N-R)
This field contains the four-number transaction code recording the sending of an insurance follow-up letter in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a list of transaction type T codes (collector notes).

3. PA DETAIL STATEMENT FORMAT (TABLE LOOKUP)
This field contains the PA detail statement format; accessing this field prompts the system to display a list of formats established in the system and maintained by McKesson. *Do not change* this format without first verifying the change with McKesson.

NOTE: When you are specifying the Detail Statement Format Codes, the Pay This Amt Box field allows you to indicate whether the Pay This Amt Box should be completed on only the first page of the multi-page detail statement or on each page of the multi-page detail statement. The entry options for the Pay This

Amt Box field are A for All or F for First. The default is All. The Pay This Amt field is located under HBOC tables in the Follow-up Format Codes Processor.

4. PA DETAIL STATEMENT TRANSACTION CODE (4-N-R)
This field contains the transaction code for the PA detail statement. When an account is selected for a detail statement, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

5. PA COLLECTION LETTER FORMAT (TABLE LOOKUP)
This field contains the format of the PA collection letter from the table display. The format chosen by the facility is determined during the forms design phase of system implementation. *Do not change* this format without first verifying the change with McKesson.

6. PA COLLECTION LETTER TRANSACTION CODE (4-N-R)
This field contains the transaction code for the PA collection letter. When an account is selected for a collection letter, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

7. AR DETAIL STATEMENT FORMAT (TABLE LOOKUP)
This field contains the AR detail statement format; accessing this field prompts the system to display a list of formats established in the system and maintained by McKesson. *Do not change* this format without first verifying the change with McKesson.

NOTE: When you are specifying the AR Detail Statement Format Codes, the Pay This Amt Box field allows you to indicate whether the Pay This Amt Box should be completed on only the last page of the multi-page detail statement or on each page of the multi-page detail statement. The entry options for the Pay This Amt Box field are A for All or L for Last. The default is All. The Pay This Amt field is located under HBOC tables in the Follow-up Format Codes Processor.

8. AR DETAIL STATEMENT TRANSACTION CODE (4-N-R)
This field contains the AR transaction code for the detail statement. When an account is selected for a detail statement, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

9. AR COLLECTION LETTER FORMAT (TABLE LOOKUP)
This field contains the format of the AR collection letter from the table display. The format chosen by the facility is determined during the forms design phase of system implementation.

WARNING: Do not change this format without first verifying the change with McKesson.

10. AR COLLECTION LETTER TRANSACTION CODE (4-N-R)
This field contains the transaction code for the AR collection letter. When an account is selected for a collection letter, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

11. BD DETAIL STATEMENT FORMAT (TABLE LOOKUP)
This field contains the bad debt detail statement format; accessing this field prompts the system to display a list of formats established in the system and maintained by McKesson. *Do not change* this format without first verifying the change with McKesson.

NOTE: When you are specifying the BD Detail Statement Format Codes, the Pay This Amt Box field allows you to indicate whether the Pay This Amt Box should be completed on only the first page of the multi-page detail statement or on each page of the multi-page detail statement. The entry options for the Pay This Amt Box field are A for All or F for First. The default is All. The Pay This Amt field is located under HBOC tables in the Follow-up Format Codes Processor.

12. BD DETAIL STATEMENT TRANSACTION CODE (4-N-R)
This field contains the bad debt transaction code for the detail statement. When an account is selected for a detail statement, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

13. BD COLLECTION LETTER FORMAT (TABLE LOOKUP)
This field contains the format of the bad debt collection letter from the table display. The format chosen by the facility is determined during the forms design phase of system implementation.

WARNING: Do not change this format without first verifying the change with McKesson.

14. BD COLLECTION LETTER TRANSACTION CODE (4-N-R)
This field contains the transaction code for the bad debt collection letter. When an account is selected for a collection letter, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

15. ARCHIVE STATEMENT FORMAT (TABLE LOOKUP)
This field contains the format of the archive statement from the table display. The Archive Statement prints on the same form as the patient bill. The following choices specify what detail to include on the statement:

- ALL - includes all history transactions, including detail charges, payments, adjustments, refunds and all user and system-generated notes.
- BAL - includes Balance-related transactions only, including detail charges, payments, adjustments and refunds.

- SPLT - prints the history transactions on two forms. Detail charges and balance-related transactions print on one form; all other history prints on the other form.

NOTE: The Archive Statement Formats are maintained by McKesson and cannot be changed.

16. ARCHIVE STATEMENT TRANSACTION CODE (4-N-R)
This field contains the transaction code for the archive statement. When an account is archived, the transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

After the third screen is completed, the fourth screen of the PAAR Control Maintenance Processor is displayed.

```
             General HospitaL PAAR Control Maintenance Processor
                                                  Mon Apr 12, 1999 02:07 pm
Model Hospital A

 1 Cash Receipt Print Format             2 Phone Message For Null F/U Schedule
   HBOC Cash Receipt - B                   11-TELEPHONE NULL MESSAGE
 3 Claim Label Print Format              4 Wait Step Transaction Code
   Print labels two across                 T0041-WAIT STEP
 5 Entry Into Phone Workfile Trans Code  6 Telephone Follow-Up Transction Code
   M0013-Workfile Telephone Entry          T0033-TELEPHONE FOLLOW UP
 7 Key Data Revision Transaction Code    8 Tracer Transaction Code
   S0004-KEY DATA CHANGED                  Z0006-UB82 TRACER CLAIM
 9 Bad Debt Prelist Transaction Code    10 Fin Cl Chnge W/O Reclass Trans Code
   M0003-BAD DEBT PRELIST                  M0002-FINANCIAL CLASS CHANGE W/O REC
11 Free Form Notes Transaction Code     12 Insurance Change Transaction Code
   T0004-FREE FORM NOTE                    M0001-INSURANCE CHANGES
13 User Hold Archive Prelist Tran Code  14 System Archive Prelist Tran Code
   M0006-USER HOLD, ARCHIVE PRELIST        M0005-SYSTEM ARCHIVE PRELIST
15 User Archive Prelist Tran Code       16 User Remove Archive Prelist Tran Cod
   M0007-USER ARCHIVE PRELIST              M0008-USER REMOVE PRELIST
17 Archive W/O Transaction Code         18 FC Repricing Memo Transaction Code
   M0009-SYSTEM ARCHIVE                    M1234-System Memos test
Enter field number or '/' starting field number--
                       next(/) or previous screen(/P) [/]
```

Field Explanations

1. CASH RECEIPT PRINT FORMAT (2-N-R)
This field contains the print format that is used for cash receipts. You can enter the code or a hyphen (-) to display a list of valid codes.

2. PHONE MESSAGE FOR NULL F/U SCHEDULE (4-N-R)
This field contains the telephone message that appears in follow-up for accounts that are on a standard or custom follow-up schedule that has no steps.

3. CLAIM LABEL PRINT FORMAT (TABLE LOOKUP)
This field allows you to specify whether the claim labels should print one, two, or three across.

4. WAIT STEP TRANSACTION CODE
This field contains the transaction code for a wait step. When an account is selected to receive a follow-up type of wait, this transaction code is used to log the event in the account transaction history. This transaction code is used for accounts in an AR and Bad Debt location. It is important to complete this field even if you do not use wait steps in your follow-up schedule for accounts in AR because the Agency follow-up schedules for accounts in Bad Debt use the wait step.

5. ENTRY INTO PHONE WORKFILE TRANS CODE (4-N-R)
This field contains the transaction code for an entry into the telephone workfile. The transaction code is used to log the workfile entry into transaction history. The transaction type is M. You can enter the code, if known, or enter a hyphen (-) to select it from a table lookup.

6. TELEPHONE FOLLOW-UP TRANSACTION CODE (4-N-R)
This field contains the transaction code for telephone follow-up activity. The transaction code is used to log the telephone call in the account's transaction history. The transaction type is T. You can enter the code, if known, or enter a hyphen (-) to select it from a table display.

7. KEY DATA REVISION TRANSACTION CODE (4-N-R)
This field contains the transaction code for the revision of key data. The transaction code is used to log the revision of key data in the account's transaction history. The transaction type is S. Key data that can revised includes Financial Class, Admit Date, Discharge Date, Medical Service and Patient Type. You can enter the code, if known, or enter a hyphen (-) to select it from a table display.

8. TRACER TRANSACTION CODE (4-N-R)
This field contains the transaction code for a tracer claim. The transaction code is used to log the tracer claim in the account's transaction history. The transaction type is Z. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

9. BAD DEBT PRELIST TRANSACTION CODE (4-N-R)
This field contains the transaction code for an account selected for bad debt prelist. The transaction code is used to log the account being placed on the bad debt prelist in the account's transaction history. The transaction type is M. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

10. FIN. CLASS CHANGE W/O RECLASS TRANS CODE (4-N-R)
This field contains the transaction code which records a change in financial class for a patient without revenue being reclassified in the General Ledger. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes. This code is used when you change an account's financial class using Account Revision-Account Status. Accounts in PA cannot have their financial class changed in this manner.

The purpose of this field is to provide an audit trail for the business office and accounting when a patient's financial class is changed without reclassifying revenue.

For example, a financial class might be changed to self-pay for follow-up purposes after insurance has paid.

Financial class changes made in Account Revision-Account Status do not reclassify revenue. Financial class changes made in the Insurance process may reclassify revenue, depending on the effective date entered - a different transaction code will be used to reflect the change if the revenue is reclassified.

11. FREE FORM NOTES TRANSACTION CODE (4-N-R)
This field contains the transaction code for free form notes (both collector and biller notes). The transaction code is used to log all free-form collector notes in the account's transaction history. You can enter the code or enter a hyphen (-) and press ENTER to select from a list of valid codes.

12. INSURANCE CHANGE TRANSACTION CODE (4-N-R)
This transaction code is used when you add, delete, or resequence the insurance for an account. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes. If an account has more than one insurance assigned to it, and resequencing causes multiple resequences, the system reflects each new assignment in Transaction History.

13. USER HOLD ARCHIVE PRELIST TRAN CODE (4-N-R)
This transaction code is used when you put an account, which has been prelisted for account archiving, on hold. It is used only for bad debt accounts. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes.

14. SYSTEM ARCHIVE PRELIST TRAN CODE (4-N-R)
This transaction code is used when the system selects an account to be prelisted for account archiving. It is used only for bad debt accounts. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes.

15. USER ARCHIVE PRELIST TRAN CODE (4-N-R)
This transaction code is used when you manually select an account to be prelisted for account archiving. It is used only for bad debt accounts. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes.

16. USER REMOVE ARCHIVE PRELIST (4-N-R)
This transaction code is used when you remove an account from the Archive Prelist. It is used only for bad debt accounts. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes.

17. ARCHIVE W/O TRANSACTION CODE (4-N-R)
This transaction code is used to write off any remaining balance when the system archives an account. It is used only for bad debt accounts. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes.

The Bad Debt Delete function actually reduces the amount to zero, and the archive function writes off the remaining amount. The transaction code is used as a system memo and updates Transaction History and is written out on the Archive Statement.

NOTE: The system doesn't use this Transaction Code to post to the General Ledger accounts. The actual posting to GL comes from the GL mapping keys, not the transaction code. It uses the key (bad debt asset account).

18. FC REPRICING MEMO TRANSACTION CODE (4-N-R)
This transaction code is used to record that charges have been repriced due to a change in the patient's financial class. It is used by the automatic repricing feature and provides an audit trail of activity for the business office. The transaction type is M. You can enter the code or enter a hyphen (-) to select from a list of codes.

After the fourth screen is completed, the fifth screen of the PAAR Control Maintenance Processor is displayed.

```
            General Hospital PAAR Control Maintenance Processor
                                                  Sun May 4, 2012:43 pm
Model Hospital A

 1 BD to AR Transfer Request Trans Code  2 Patient Friendly Billing
   M0001-INSURANCE CHANGES                 Yes
 3 Keep User Info for Ins Cov            4 Report Ins Changes on FAINSPT
   Entries Defined                         Entries Defined
 5 Allow Non-PA Ins Upd for I/P          6 Allow Non-PA Ins Upd for O/P
   Always Allow                            Disallow after Ins Inf Updated in PA
 7 Invalid Address Hold                  8 Invalid Address Trans Code
   Yes                                     S0001-PA TO AR TRANSFER
 9 Edit PA Charge for Active Accnts      10 Edit PA Charge for Inactive Accnts
   S0100-Edit PA Chg for Active Accnt      S0101-Edit PA Chg for Inactive Accnt
11 Edit PA Charge for SIM Depts          12 Ins Desc/Den App Ind
   Entries Defined                         Den/App Indicator
13 Purge PA Stat Log Info Date           14 Replaced Claims in Cash Batches
15 Ins Sch Assignment Bal                16 PCI or CS for Batch Header
   Claim Amount                            Claim Sequence



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

Field Explanations

1. BD TO AR TRANSFER REQUEST TRANS CODE (1-A-R)
This field indicates the transaction code to be used for the BD to AR Transfer Request within the Change Patient Type After Final Bill (CPTAFB) function. When a request is entered or deleted for a BD to AR Transfer, this transaction code is used to log the event in the account's transaction history. You can enter the code if known, or enter a hyphen (-) to select it from a table display. The transaction code must be an S for System transaction type. The transaction code description is dependent on the action and is as follows:

- If a request for BD to AR Transfer is added through CPTAFB, the description is the transaction code description with CPTAFB appended to it.

- If a request was originally entered through the CPTAFB function and was deleted, the description is the transaction code description with the word Deleted appended to it.

- If a request for BD to AR Transfer is added to the system but not through the CPTAFB function, the description is the transaction code description.

- If a request was originally entered in the system but not through CPTAFB and was deleted, the description is the transaction code description with the word Deleted appended to it.

2. PATIENT FRIENDLY BILLING (1-A-O)

This field is used to activate the Patient Friendly Billing feature, which adds information to patient bills and collection documents. When this field is accessed, the following prompt is displayed:

Do you want to activate Patient Friendly Billing? (Y/N) [N]-- |

You can enter **Y** (Yes) to activate Patient Friendly Billing or **N** (No) to leave it inactive. If Patient Friendly Billing is activated, the following information is printed on patient bills and collection documents:

- Patient bills have birth date, patient phone number, guarantor phone number, insurance group number, and insurance policy number information printed on the bill.

- Collection documents have the Tax ID number (from the Demographics/Defaults screen) and patient type printed on the bill. This applies to both account level and guarantor level collections.

3. KEEP USER INFO FOR INS COV (TABLE LOOKUP-R)

This field identifies whether information keyed by a user should be retained rather than updating the insurance coverage information for an account's insurance plan from the Insurance Coverage table when the patient type changes for the account, including accounts in a pre-collect status. When this field is accessed, and no options were previously selected, the following prompt is displayed:

Do you want to retain user changes to insurance coverage information rather than changes from the table? (Y/N)--

If you enter **N** (No) to the prompt, the field is updated with the value of No. If you enter **Y (**Yes) to the prompt, you can select the options for which the existing screen of information is retained because one or more fields on a screen have been updated by the user. The screens for which this choice is available are: Basic Coverage, Room Coverage (excluding accommodation code exceptions), Ancillary Coverage, Major

Medical Coverage, Daily/Blood Deductibles, and Flag Coverage. When this field is accessed, the first screen of options is displayed:

```
          General Hospital PAAR Control Maintenance Processor
                                                 Mon May 17, 2004 11:15 am
Model Hospital A

Page:01               Keep User Info for Ins Cov Options     ##=Current Choices
( 1) Basic Coverage - I/P after CPI
( 2) Basic Coverage - O/P after CPI
( 3) Basic Coverage - Pt Type Exc after CPI
( 4) Basic Coverage - I/P after CPT/no CPI
( 5) Basic Coverage - O/P after CPT/no CPI
( 6) Basic Coverage - Pt Type Exc after CPT/no CPI
( 7) Room Coverage - I/P after CPI
( 8) Room Coverage - O/P after CPI
( 9) Room Coverage - Pt Type Exc after CPI
(10) Room Coverage - I/P after CPT/no CPI
(11) Room Coverage - O/P after CPT/no CPI
(12) Room Coverage - Pt Type Exc after CPT/no CPI
(13) Ancillary Coverage - I/P after CPI
(14) Ancillary Coverage - O/P after CPI
(15) Ancillary Coverage - Pt Type Exc after CPI
(16) Ancillary Coverage - I/P after CPT/no CPI
```

You can select one or more options from this list to indicate, by screen, which screens of information are to be retained because one or more fields on the screen have been updated by the user. If options are selected, the display for the field is Entries Defined. If no options are selected or all options are removed, the display for the field is blank. If all options are removed, and you want the field to display No, indicating the decision not to select any options, the field must be accessed a second time, so a response of N for No can be made to the prompt for the field.

4. REPORT INS CHANGES ON FAINSPT (TABLE LOOKUP-R)

This field indicates which changes appear on the FAINSP report, which documents changes to insurance coverage information for an account. You can indicate whether all changes appear or whether changes appear because previous and/or new information was keyed. When this field is accessed, and no options were previously selected, the following prompt is displayed:

Do you want to report changes to insurance coverage information on FAINSPT? (Y/N)--

If you enter **N** (No) to the prompt, the field is updated with the value of No. If you enter **Y (**Yes) to the prompt, you can select the options for Basic Coverage, Room Coverage (excluding accommodation code exceptions), Ancillary Coverage,Major Medical

Coverage, Daily/Blood Deductibles, and Flat Rate Coverage. Similar options exist for Claim Attachments. When this field is accessed, the following screen is displayed:

```
          General Hospital PAAR Control Maintenance Processor
                                                 Mon May 17, 2004 11:24 am
Model Hospital A

Page:01                  Report Ins Changes on FAINSPT       ##=Current Choices
( 1) Basic Coverage
( 2) Basic Coverage - Prev info was keyed
( 3) Basic Coverage - New info was keyed
( 4) Room Coverage
( 5) Room Coverage - Prev info was keyed
( 6) Room Coverage - New info was keyed
( 7) Ancillary Coverage
( 8) Ancillary Coverage - Prev info was keyed
( 9) Ancillary Coverage - New info was keyed
(10) Major Medical Coverage
(11) Major Medical Coverage - Prev info was keyed
(12) Major Medical Coverage - New info was keyed
(13) Daily/Blood Deductibles
(14) Daily/Blood Deductibles - Prev info was keyed
(15) Daily/Blood Deductibles - New info was keyed
(16) Flat Rate Coverage
```

You can select one or more options from the list to indicate, by screen, which changes appear on the FAINSP report. If options are selected, the display for the field is Entries Defined. If no options are selected or all options are removed, the display for the field is blank. If all options are removed, and you want the field to display No, indicating the decision not to select any options, the field must be accessed a second time, so a response of N for No can be made to the prompt for the field.

5. ALLOW NON-PA INS UPD FOR I/P (1-A-O)

This field indicates whether changes to insurance for an inpatient can be made by a non-Patient Accounting user after a change to insurance information was made in a Patient Accounting function. The Patient Accounting functions are Account Revision found on the Account Management menu and Insurance Revision found on the Insurance Management menu.

Entry is not required in this field, but if the field is left blank, the system reacts as if Always Allow (see below) was selected, meaning that there are no limitations on changes to insurance by non-PA users.

When this field is accessed, the following screen is displayed with entry options:

```
Page:01           Select Insurance Maintenance Option for I/P
( 1) Disallow after Account Defined in PA
( 2) Disallow after Insurance Updated in PA
( 3) Always Allow
```

- **Disallow after Account Defined in PA** - If this option is selected, no changes to insurance can be made by a non-PA user after the account is on STAR PA. This occurs when the account number is assigned.

- **Disallow after Insurance Updated in PA** - If this option is selected, no changes to insurance can be made by a non-PA user after a change to insurance information has been made in a Patient Accounting function. The STAR PA functions are Account Revision found on the Account Management menu and Insurance Revision found on the Insurance Management menu.

  NOTE: Insurance is defined as being verified and/or updated when a user accesses the Plan Demographics function on STAR Patient Accounting. This function is found as follows:

  Account Management

  Account Revision

  Select a Visit

  Admission Information

  Insurance Information

  Select Insurance

- **Always Allow** - If this option is selected, there are no limitations on changes to insurance by non-PA users as long as the functionality is allowed on the non-PA system, such as the account no longer being active on that system.

5. ALLOW NON-PA INS UPD FOR O/P (1-A-O)

This field indicates whether changes to insurance for an outpatient can be made by a non-Patient Accounting user after a change to insurance information was made in a Patient Accounting function. The Patient Accounting functions are Account Revision found on the Account Management menu and Insurance Revision found on the Insurance Management menu.

Entry is not required in this field, but if the field is left blank, the system reacts as if Always Allow (see below) was selected, meaning that there are no limitations on changes to insurance by non-PA users.

When this field is accessed, the following screen is displayed with entry options:

```
Page:01            Select Insurance Maintenance Option for I/P
( 1) Disallow after Account Defined in PA
( 2) Disallow after Insurance Updated in PA
( 3) Always Allow
```

- **Disallow after Account Defined in PA** - If this option is selected, no changes to insurance can be made by a non-PA user after the account is on STAR PA. This occurs when the account number is assigned.

- **Disallow after Insurance Updated in PA** - If this option is selected, no changes to insurance can be made by a non-PA user after a change to insurance information has been made in a Patient Accounting function. The STAR PA functions are Account Revision found on the Account Management menu and Insurance Revision found on the Insurance Management menu.

  NOTE: Insurance is defined as being verified and/or updated when a user accesses the Plan Demographics function on STAR Patient Accounting. This function is found as follows:

  Account Management

  Account Revision

  Select a Visit

  Admission Information

  Insurance Information

  Select Insurance

- **Always Allow** - If this option is selected, there are no limitations on changes to insurance by non-PA users as long as the functionality is allowed on the non-PA system, such as the account no longer being active on that system.

7. INVALID ADDRESS HOLD (1-A-R)

This field indicates whether the system should remove accounts from follow-up hold if the invalid address flag is cleared and an invalid address no longer exists. This field also applies to accounts that were on follow-up hold due to a blank alternate address. Accounts are placed back into follow-up when the invalid address/phone flag is removed and when a alternate address is updated and considered valid, based on this field. When accounts are taken off follow-up hold, the following logic is used:

1. The next follow-up step remains the same as when placed on follow-up hold.

2. The next follow-up date is the date when the account was placed on hold unless the date is in the past. In this situation, the next follow-up date is revised to the current (today's) date.

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

Place accounts back into follow-up when invalid address flag has been removed? (Y/N) (N)--

You can enter **Y** for Yes, place the account back into follow-up hold or **N** for No, don't place the account back into follow-up hold.

8. INVALID ADDRESS TRANS HOLD (4-N-TABLE LOOKUP-O)
This field contains the transaction code (S code) the system uses when the invalid address flag is added or removed from an account. You can enter a hyphen (-) to access a table of S codes or enter a four-digit S code. If you don't complete this field, the Key Data Changed code is used.

9. EDIT PA CHARGE FOR ACTIVE ACCNTS (4-N-TABLE LOOKUP-O)
This field contains the transaction code the system uses when Patient Accounting charge information for active accounts is edited for HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, or conflicting HCPCS indicators, unless editing is not allowed for a department, as indicated by the department's exclusion in the Edit PA Charge for SIM Depts field. The transaction code is used in transaction history. You can enter a valid transaction code or a hyphen (-) to access a table of transaction codes.

10. EDIT PA CHARGE FOR INACTIVE ACCNTS (4-N-TABLE LOOKUP-O)
This field contains the transaction code the system uses when STAR Patient Accounting charge information for inactive accounts is edited for HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, or conflicting HCPCS indicators, unless editing is not allowed for a department, as indicated by the department's exclusion in the Edit PA Charge for SIM Depts field. The transaction code is used in transaction history. You can enter a valid transaction code or a hyphen (-) to access a table of transaction codes. If the Valid Accounts field in the Transaction Codes table is Bad Debt Accounts only, the transaction code cannot be used for this field.

11. EDIT PA CHARGE FOR SIM DEPTS (4-N-TABLE LOOKUP-O)
This field is used to indicate whether the HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators can be edited in PA charges for a SIM department for active or inactive accounts. The screen is sorted by SIM department. When this field is accessed, the following prompt is displayed:

Do you want to Edit PA Charge for SIM Depts? (Y/N)

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

```
          General Hospital PAAR Control Maintenance Processor
                                                  Tue Feb 21, 2006 02:03 pm
General Hospital A
                SIM Dept Parameters for Edit PA Charge
    SIM Dept  Description            Active Accounts  Inactive Accounts
1   LAB       LABORATORY                 S0001
2   RAD       RADIOLOGY                                   S0002

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

You can enter the SIM Department and a transaction code for Active Accounts and Inactive Accounts or enter a hyphen (-) to select a SIM department and then enter a transaction code for Active Accounts or Inactive Accounts. If you enter a hyphen, a list of SIM departments is displayed, as follows:

```
          General Hospital PAAR Control Maintenance Processor
                                                  Tue Feb 21, 2006 02:03 pm
Model Hospital A


Page:01                         SIM Departments
     SIM                             Selected       Active    Inactive
( 1) ANS-ANESTHESIA                     Yes
( 2) CAR-CARDIOLOGY
( 3) CCU-CORONARY CARE UNIT             Yes         S0001     S0001
( 4) CSR-CENTRAL SERVICES

Select SIM department--
```

If *Yes* is displayed in the SIM department column, a SIM department was selected previously. The transaction codes for active or inactive accounts are listed also. A department can exist in the table with no transaction code listed for active or inactive accounts indicating the functionality is not available for that department. If you attempt to add a department that was defined previously, the following message is displayed:

Edit PA Charge options have been defined already!

You can enter a transaction code in the Active Accounts column or a hyphen (-) to select one from a list of transaction codes. If you enter a transaction code in the Active Accounts column, the HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators can be edited in PA charges for that SIM department, for active accounts. If you do not enter a transaction code in the Active Accounts column, the HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators cannot be edited in PA charges for that SIM department, for active accounts. The absence or presence of the transaction code in the Active Accounts column is used to make the decision, regardless of the response to the Edit PA Charge for Active Accnts field.

You can enter a transaction code in the Inactive Accounts column or a hyphen (-) to select one from a list of transaction codes. If you enter a transaction code in the

Inactive Accounts column, the HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators can be edited in PA charges for that SIM department, for inactive accounts. If you do not enter a transaction code in the Inactive Accounts column, the HCPCS, HCPCS modifiers, diagnosis, ABN indicators, duplicate HCPCS indicators, and conflicting HCPCS indicators cannot be edited in PA charges for that SIM department, for inactive accounts. The absence or presence of the transaction code in the Inactive Accounts column is used to make the decision, regardless of the response to the Edit PA Charge for Inactive Accnts field.

12. INS DESC/DEN APP IND (1-A-O)
This field indicates whether either the Denial/Appeal indicator or the description for the insurance plan code is displayed after the insurance plan code in the header information on the Insurance Cash Posting screen, when maintaining an insurance cash transaction. When this field is accessed, the following prompt is displayed:

Use (I)nsurance Description or (D)en/App Indicator in header for insurance cash batches? [D]--

If you enter **I** (Insurance Description), the system displays the insurance description on the Insurance Cash Posting header screen for an insurance cash batch entry.

If you enter **D** (Denial Appeal Indicator), the system displays the Denial/Appeal Indicator on the Insurance Cash Posting header screen.

13. PURGE PA STAT LOG INFO DATE
You can enter an override date for the yearly purge of PA Stat Log data. When this field is accessed, the following prompt is displayed:

Enter override date for the yearly purge of PA Stat Log data--

14. REPLACED CLAIMS IN CASH BATCHES (1-A-O)
When this field is accessed, the following prompt is displayed:

Update replaced claim in cash batch when (P)ost, when Approve or Post (B), or(N)ever? (P/B/N)-- |

15. INS SCH ASSIGNMENT BAL (1-A-O)
This field defines whether Insurance Balance or Claim Amount should be used for insurance follow-up schedule assignment. The field is not valid for appeal collector assignment or external insurance collector assignment. When this field is accessed, the following prompt is displayed:

Use (C)laim Amount or (I)nsurance Balance [C]-- |

Entry options:

- A value of C for claim amount will use the claim amount that is associated with the claim when the claim loads to determine the insurance follow-up schedule.

- A value of I for insurance balance will use the current insurance balance to determine the insurance follow-up schedule.

16. PCI OR CS FOR BATCH HEADER (1-A-O)
If this parameter is set with a value of C for Claim,the transaction header for an insurance cash transaction will contain the claim sequence number for the claim selected for the payment rather than the Payor Claim ID. If the parameter is set with a value of P for PCI or is blank, the Payor Claim ID is contained in the transaction header.

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

Use (P)CI or (C)laim Sequence in header for insurance cash batches? [P]--

After the fifth screen is completed, the sixth screen of the PAAR Control Maintenance Processor is displayed. The fields on this screen contain the transaction code for auto or manually retiring or un-retiring AR and BD accounts. When an account is retired or un-retired, the selected transaction code is used to log the event in the account's transaction history.

```
            General Hospital PAAR Control Maintenance Processor
                                                  Mon Apr 11, 2011 09:39 pm
Model Hospital A

 1 Auto Retire AR Accnt Transc Code      2 Auto Retire BD Accnt Transc Code
   M0001-INSURANCE CHANGES                 M0002-FINANCIAL CLASS CHANGE W/O REC
 3 Auto UnRetire AR Accnt Transc Code    4 Auto UnRetire BD Accnt Transc Code
   M0003-BAD DEBT PRELIST                  M0004-USER HOLD, BAD DEBT TRANSFER
 5 Auto Return AR Accnt Transc Code (Other Process Required Return to AR)
   M0005-SYSTEM ARCHIVE PRELIST
 6 Auto Return BD Accnt Transc Code (Other Process Required Return to BD)
   M0006-USER HOLD, ARCHIVE PRELIST
 7 Man Retire AR Accnt Transc Code       8 Man Retire BD Accnt Transc Code
   M0007-USER ARCHIVE PRELIST              M0008-USER REMOVE PRELIST
 9 Man UnRetire AR Accnt Transc Code    10 Man UnRetire BD Accnt Transc Code
   M0009-SYSTEM ARCHIVE                    M0010-CARRIER REFUND
11 Edit by                              12 Edit Date
   New, Nancy                              07/06/10 02:46pm




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

Field Explanations

1. AUTO RETIRE AR ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when an AR account is auto retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

2. AUTO RETIRE BD ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when a BD account is auto retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

3. AUTO UNRETIRE AR ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when an AR account is auto unretired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

4. AUTO UNRETIRE BD ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when a BD account is auto un-retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

5. AUTO RETURN AR ACCNT TRANSC CODE (OTHER PROCESS REQUIRED RETURN TO AR) (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when an account is auto auto returned to location AR. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

6. AUTO RETURN BD ACCNT TRANSC CODE (OTHER PROCESS REQUIRED RETURN TO BD) (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when an account is auto returned to location BD. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

7. MAN RETIRE AR ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when an AR account is manually retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

8. MAN RETIRE BD ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when a BED account is manually retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

9. MAN UNRETIRE AR ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when an AR account is manually un-retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

10. MAN UNRETIRE BD ACCNT TRANSC CODE (TABLE LOOKUP-R)
This field contains the code displayed in transaction history when a BD account is manually un-retired. You can enter the code if known, or enter a hyphen (-) to select it from a table display.

Accepting the final PAAR Control screen completes the transaction.

Patient Bill Format

The Patient Bill Format function allows you to specify how patient bills and series bills are formatted. You can print Detail, Summary, and Prorated bills separately or together. This table entry is set up during implementation and is dependent on the patient bill format selected during forms design.

WARNING: Changes to a format code in this function change the form contents and where the information prints on the form. *Do not change* the fields on either screen without first verifying the change with McKesson.

After this function is selected, the system displays the first of two screens if you do not have a state bill. If you have a state bill, there are a total of three screens to complete.

```
         General Hospital Patient Bill Format Maintenance Processor
                                                Tue Apr 15, 2008 12:17 pm
Model Hospital A

Print Separate Bills    1 Detail Bills?   2 Summary Bills?   3 Prorated Bills?
                          No                No                 No
Charge Summarization    4 Summarize By                       5 Number of Digits
                          4-UB Cd                              4
 6 SIM or FIM Desc      7 Amt Due Balance           8 Print Bills with Zero Chg
   SIM                    Total Chgs less Est Ins      No
 9 State Bill          10 Series Amt Due Balance   11 Spool Demand Series Bill
   MD                     Patient                     No
12 Off-setting Charges/Credits           13 Pharmacy Units
   Yes                                      Yes
14 Print Detail Bills on FBR904?         15 Print Summary Bills on FBR905?

16 Print Prorated Bills on FBR906?       17 Cycle Adj Bill Ind

18 Chg Bill Window     19 Stop Unbilled Chg Wrk  20 Unbilled Chg Wrk Zero $ Prm
   2                      No                        Both
21 Edit Date           22 Edit By
   06/09/08 11:30         Knighton,Regina K
h
Enter field number or '/' starting field number--
                       next(/) or previous screen(/P) [/]
```

NOTE: If a charge and a credit have the same SIM# and order number, they cancel each other out, and neither line prints on the detail page of the Patient Bill.

Field Explanations - Screen 1

Print Separate Bills

These fields indicate whether a different spool file should be created for the detail, summary, or prorated bill. If the answer is Yes, the system creates a separate spool file for the bill type. If the answer is No, the summary bill, for example, follows the patient's detail bill in the same spool file.

NOTE: Series bills are automatically spooled separately to report FBR902.

1. DETAIL BILLS (1-A-R)
This field prompts the system to print or not print detail bills separately from summary and prorated bills. Entry options are **Y** for Yes or **N** for No.

2. SUMMARY BILLS (1-A-R)
This field prompts the system to print or not print summary bills separately from detail and prorated bills. Entry options are **Y** for Yes or **N** for No.

3. PRORATED BILLS (1-A-R)
This field prompts the system to print or not print prorated bills separately from detail and summary bills. Entry options are **Y** for Yes or **N** for No.

Charge Summarization

4. SUMMARIZE BY (TABLE LOOKUP)
Select the Bill Charge Group by which you want charges to be summarized within a patient's bill. McKesson maintains the selection choices, listed in a table display. Typical choices include UB Revenue code, Proration Summary Code and Revenue Center.

5. NUMBER OF DIGITS (1-N-R)
This field indicates the number of digits used to summarize charges on the patient bill. In the following example, the system is summarizing by revenue code:

Revenue code	Charge
700	$20
701	$30
710	$10

If you enter 2 in this field, the system selects and summarizes charges for revenue codes with the first two digits of the revenue code alike. In this case, codes 700 and 701 would be combined, and the patient bill would contain one charge for $50 and one for $10.

6. SIM or FIM DESC (1-A-R)
This field specifies whether the detail bill should print the charge description from the Service Item Master (SIM) or the Financial Item Master (FIM). Every item has a SIM and a FIM description.

NOTE: If you select FIM, the system selects the SIM description for manually priced service items so the SIM description, which can be overridden, prints on the bill.

7. AMT DUE BALANCE (1-A-R)
This field determines whether the balance due on the detail, summary, and prorated bills should reflect the patient balance (P), the account balance (A), or calculate as the total charges less the sum of the estimated insurance balances (C). The following prompt is displayed:

Use Patient Balance(P), Account(A) or Total Chgs - Est Ins(C) as amount due? [C]

To print the patient balance on the patient bill as the balance due, enter **P**. The Estimated Amount Due from Insurance is calculated as the Total Charges for the bill minus the Patient Balance. If the Patient Balance is negative, the Amount Due balance prints as $0.00, and the Estimated Amount Due from Insurance is the same as the Total Charges for the bill. To print the account balance on the patient bill as the balance due, enter **A**. To calculate the amount due balance as the total charges less the estimated insurance balances, enter **C**, or press ENTER.

8. PRINT BILLS WITH $0.00 CHGS (1-A-R)
This field indicates whether final, adjustment, and late patient bills should be produced when the total charge amount is $0.00. Enter **Y**, or press ENTER, to produce patient bills if the total charge amount is $0.00. Enter **N** not to produce patient bills if the total charge amount is $0.00. Cycle bills with $0.00 in charges continue to print. Bills with $0.00 charges that are the result of a Single Bill Request print even if this field is set to N.

9. STATE BILL (TABLE LOOKUP)
This field specifies that a state bill is produced in conjunction with your standard bills. McKesson maintains the selection choices, listed in a table display. Selecting the state allows access to the third patient Bill Format screen.

10. SERIES AMOUNT DUE BALANCE (1-A-R)
This field determines whether the balance due on the series bill should reflect the patient balance (P) or the account balance (A). When you access this field, the following prompt is displayed:

Use Patient Balance(P) or Account(A) as amount due? [P]

To print the patient balance on the series bill as the balance due, enter **P** or press ENTER. To print the account balance on the series bill as the balance due, enter **A**.

11. SPOOL DEMAND SERIES BILL (1-A-R)
This field specifies whether the demand series bill should be spooled to print in batch or print on demand. Entry options are Y (yes, spool demand series bills to batch) or N (no, do not spool demand series bills to batch). If you are using a separate form for series bills, enter Y; if you print series bills on the same form as other bills, enter N or press ENTER to accept the default. Demand series bills that are spooled to batch print with the other series bills produced in batch.

12. OFF-SETTING CHARGES/CREDITS (1-A-R)
This field allows you to print or not print off-setting charges and credits on the detail, summary, and prorated patient bills for the facility. After accessing this field the following prompt is displayed:

Exclude off-setting charges/credits from patient bills (Y/N) [N]--

Enter **Y** to suppress the off-setting charges. Enter **N** to continue to print to off-setting charges and credits. The default is No.

Charges and credits are considered to be off-setting if the charges are for the same item and the same amount and have the same service date and SIM description. If off-setting charges and credits have different SIM descriptions, they print on the bill.

13. PHARMACY UNITS (1-A-O)
This field determines whether the system uses the default charge quantity or prints the Pharmacy unit billing quantity on any charges with the RXf department, where f is the facility code (for example, RXA), or where the SIM department is marked as a non-Star Formulary department. If a charge for this SIM Department does not have the pharmacy quantity, the system defaults to the "regular" charge quantity.

When you access this field, the system displays the following prompt:

Do you want to print Pharmacy units on detail bills? (Y/N) [N]--

Enter **Y** to print the Pharmacy units on detail bills or enter **N** for No or leave blank to use the default charge quantity.

The Pharmacy Units field applies to the following standard detail bill formats (as assigned on the second screen of the Patient Bill Format screen):

62-HBOC Patient Bill (Detail)-A

72-HBOC Patient Bill (Detail)-B

52-HBOC Patient Bill (Detail)-C

162-HBOC Patient Bill RF (Dtl)-A

172-HBOC Patient Bill RF (Dtl)-B

152-HBOC Patient Bill RF (Dtl)-C

The "RF" bill formats print Reference Facility information on the patient bill.

14. PRINT DETAIL BILLS ON FBR904? (1-A-O)
This field indicates whether detail bills should spool to their own spoolfile, separately from the FBR900x Patient Bills spoolfile. This field cannot be used unless the Detail Bills? field is set to Yes. When this field is accessed, the following prompt is displayed:

Do you want to print detail bills on FBR904 rather than FBR900? (Y/N) [N]--

If you enter **N** (No) or leave the field blank, the bills continue to spool to FBR900x, where x is the facility indicator. If you enter **Y** (Yes), the bill spools to FBR904. You can have each type of bill spool to its own assigned report name or can leave one or two of the bill types spooling to FRB900x while directing the remaining bill type(s) to their own assigned report name(s).

NOTE: If the Detail Bills? field is set to Yes, and the Print Detail Bills on FBR904? field is set to Yes, and the Detail Bills? field is changed from Yes to No, the system changes the Print Detail Bills on FBR904? field to a blank and the bills continue to spool to FBR900x.

15. PRINT SUMMARY BILLS ON FBR905? (1-A-O)
This field indicates whether summary bills should spool to their own spoolfile, separately from the FBR900x Patient Bills spoolfile. This field cannot be used unless the Summary Bills? field is set to Yes. When this field is accessed, the following prompt is displayed:

Do you want to print summary bills on FBR905 rather than FBR900? (Y/N) [N]--

If you enter **N** (No) or leave the field blank, the bills continue to spool to FBR900x, where x is the facility indicator. If you enter **Y** (Yes), the bill spools to FBR905. You can have each type of bill spool to its own assigned report name or can leave one or two of the bill types spooling to FRB900x while directing the remaining bill type(s) to their own assigned report name(s).

NOTE: If the Summary Bills? field is set to Yes, and the Print Summary Bills on FBR905? field is set to Yes, and the Print Summary Bills? field is changed from Yes to No, the system changes the Print Summary Bills? on FBR905 field to a blank and the bills continue to spool to FBR900x.

16. PRINT PRORATED BILLS ON FBR906? (1-A-O)
This field indicates whether prorated bills should spool to their own spoolfile, separately from the FBR900x Patient Bills spoolfile. This field cannot be used unless the Prorated Bills? field is set to Yes. When this field is accessed, the following prompt is displayed:

Do you want to print prorated bills on FBR906 rather than FBR900? (Y/N) [N]--

If you enter **N** (No) or leave the field blank, the bills continue to spool to FBR900x, where x is the facility indicator. If you enter **Y** (Yes), the bill spools to FBR906. You can have each type of bill spool to its own assigned report name or can leave one or two

of the bill types spooling to FRB900x while directing the remaining bill type(s) to their own assigned report name(s).

NOTE: If the Prorated Bills? field is set to Yes, and the Print Prorated Bills on FBR906? field is set to Yes, and the Prorated Bills? field is changed from Yes to No, the system changes the Print Prorated Bills on FBR906? field to a blank and the bills continue to spool to FBR900x.

17. CYCLE ADJ BILL IND (1-A-O)
This field determines whether cycle adjustment bill processing is allowed for accounts associated with this billing parameter. When this field is accessed, the following prompt is displayed:

Allow Cycle Adjustment Billing? (Y)es, (N)o or (B)lank

You can enter **Y** (Yes) to allow cycle adjustment billing, **N** (No) to disallow cycle adjustment billing, or **B** (Blank) to leave the field blank. A value of Blank indicates that the system is to use the value in the Cycle Adj Bill Ind field on the Patient Bill Format Processor to determine if cycle adjustment billing is allowed. To determine whether the rebilling of cycle bills is valid for accounts in location PA and AR, the system looks at the Cycle Adj Bill Ind field on the Cycle Billing Parameters screen and the Cycle Adj Bill Ind field on the Patient Bill Format Processor. If the Cycle Adj Bill Ind on the Cycle Billing Parameters screen contains a value of Yes or No, the system uses the value associated with the Cycle Billing Parameters for the account's cycle adjustment bill indicator. If the Cycle Adj Bill Ind field on the Cycle Billing Parameters contains a blank, the system uses the value for the Cycle Adj Bill Ind field on the Patient Bill Format Processor.

18. CHG BILL WINDOW (3-N-O)
This field indicates an overall facility level number of days that you can enter a charge on an AR account, after the Date of Service has passed, before the AR account is automatically placed on Bill Hold with a type of O. This parameter is used on AR accounts where the Date of Service has been billed. If no overall facility level Chg Bill Window is defined, any charge placed on an AR account is not placed on Automatic Bill Hold with a type of O. When this field is accessed, the following prompt is displayed:

Enter Chg Bill Window causing AR account to be placed on Old Chg Bill Hold--

You can enter a number of days between **1** and **999** or leave the field blank. The number must be at least 1 greater than the value in the CycA Max Days Since Service field. If you enter a value that is less than the defined value in the Max Days since Service field, the following error message is displayed:

Error: Value must be greater than Max Days since Service.

If the Max Days Since Service field is modified so that it contains a value greater than the Chg Bill Window, the system blanks out the value in the Chg Bill Window.

The value in this field is used only for AR accounts that do not have a Chg Bill Window defined on the Billing Parameter screens. If the Date of Service associated with the charge should have billed on a bill type of cycle and the hospital has entered Yes in the Cycle Adj Bill Ind field on the Patient Bill Format screen, the system uses the Chg Bill Window that is defined on the Cycle Adjustment Parameters attached to the Patient Bill format screen.

19. STOP UNBILLED CHG WRK (1-A-O)
This field indicates whether you want to deactivate the Unbilled Charge Worklist function. When this field is accessed, the following prompt is displayed:

Do you wish to STOP using the Unbilled Charge Worklist? (Y/N)--

If you enter **Y** (Yes), any information in the Chg Bill Window field is cleared, although that information is not removed for any billing parameters, any information in the Unbilled Chg Wrk Zero & Prm field is cleared, and any charges found on the Unbilled Charge Worklist for a facility are removed. If the corresponding account is on Old Chg Hold, that bill status is removed, but the billing status revision is not noted in transaction history. If the Unbilled Chg Worklist has been deactivated and the Unbilled Charge Worklist is accessed by a user, access to the process is not granted and the following message is displayed:

Unbilled Charge Worklist deactivated for facility!

The logic occurs while Bill Select runs on second shift as an hourly job. Since this process runs at the same time as Bill Select, some expected bill requests, occurring because Old Chg Hold was removed, may not appear until bill select runs on the next day. Bill select could run faster than the process removing charges from the Unbilled Charge Worklist. In particular, this could happen on the first day that a facility deactivates the Unbilled Charge Worklist. Therefore, it is recommended that the deactivation not be done for multiple facilities on the same day. When this purge is executing during bill select, it is noted on the console with the following title and it runs concurrent with bill select: Purge Unbilled Charge Worklist Information.

If this field is changed from a value of Yes to a value of No, the Unbilled Charge Worklist function is activated again. This means that the job removing charges from the Unbilled Charge Worklist is not started when Bill Select runs on the second shift. This means that charges recorded in Patient Accounting since the previous analysis of the account for the Unbilled Charge Worklist are not removed. Any charges removed from the Unbilled Charge Worklist automatically are not reinstated to the Unbilled Charge Worklist by this process.

20. UNBILLED CHG WRK ZERO & PRM (1-A-O)
This field is used by a facility to remove accounts automatically from the Unbilled Charge Worklist in one or both of the following categories:

- The account balance is zero and the account is no longer in PA, meaning the account is a zero dollar account.

- The account is no longer in PA and the charge amount is zero for each unbilled charge for the account in the Unbilled Charge Worklist.

The field can be accessed only if the Stop Unbilled Chg Wrk field has a value of blank or No. When the field is accessed, the following prompt is displayed:

Drop (Z)ero $ Accts, Accts with No Non-Zero (C)hgs on worklist, or (B)oth types from Worklist?--

You have the following entry options:

- If **Z** for Zero $ Accts is keyed, accounts not in PA are removed if the account balance is zero.
- If **C** for Accts with No Non-Zero Chgs on worklist is keyed, accounts not in PA are removed only if the charge amount for each unbilled charge appearing on the Unbilled Charge Worklist is zero.
- If **B** for both is keyed, an account is removed if either of the preceding criteria is true.

21. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this bill format was last edited.

22. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last edited this bill format.

After these fields are completed, if the Cycle Adjustment Bill Indicator (Cyc Adj Bill Ind) field is set to Yes (allow cycle adjustment billing), the Cycle Adjustment Parameters screen is displayed. If the Cyc Adj Bill Ind field is set to No (do not allow cycle adjustment billing), the next screen of the Patient Bill Format is displayed (see page 2-67.)

```
         General Hospital Patient Bill Format Maintenance Processor
                                                  Mon Apr 17, 2006 12:57 pm
Model Hospital A

CYCLE ADJUSTMENT PARAMETERS

 1 CycA Max Days Since Service   2 CycA Zero Bal
   999                             No
 3 Manual CycA Chg/Cr/Dys Override for Subsequent Bills   4 Auto Cycle Adj
   No                                                       No
 5 Min Unbilled Charges          6 Min Unbilled Charge Amt
   1                               $1
 7 Min Unbilled Credits          8 Min Unbilled Credit Amt
->
 9 CycA Suppress Subsequent Bills/Do Not Load Clms
   No
10 Chg Bill Window
   91
```

Field Explanations

1. CYCA MAX DAYS SINCE SERVICE (4-C-O)
This field is used to determine the valid period after the service date of a charge for billing the charge. This field indicates the maximum number of days from charge service date that a charge can be included on a cycle adjustment bill. The field allows you to set a limit on the number of days past the service date of an unbilled charge that the charge can be billed on a cycle bill. For example, some payors require that a service be billed within 90 days of the service, so you could set this parameter to 90.

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

> *Enter max days past service date that charge can be billed automatically (NNNN) or (U)nlimited--*

You can enter a number of days between **0** and **999** or **U** for Unlimited. If you enter U (Unlimited), unbilled charges always can be billed automatically. If you enter a zero, unbilled charges can't be billed automatically, since the maximum is set to zero days past the service date. If you enter a number other than zero, the system adds that number to the service date to determine the maximum date that an unbilled charge can be billed automatically. To qualify for an automatic cycle adjustment bill, the max date must be equal to or less than the date of the unbilled charge that is being reviewed for automatic cycle processing. If the parameter is equal to a value of blank, there is no automatic cycle adjustment billing and no loading of new charges/credits for subsequent cycle adjustment bills.

This field can be used to prevent old charges from automatically billing on a prior cycle bill. If a charge doesn't qualify per the max days defined in the CycA Max Days Since Service field, the charge does not appear on an automatic cycle adjustment bill for the billing period. If the cycle adjustment bill was requested in Single Bill Request or Instant

Adjustment Bill, the charge would appear on the selected cycle adjustment bill, but charges outside of the max days wouldn't appear on the subsequent cycle adjustment bills following the cycle adjustment bill selected for the manual rebill, unless the override parameter for subsequent cycle adjustment bills is set to Yes.

To calculate the maximum date that a charge can be included on an automatic cycle adjustment bill, the system uses the service date and adds the number of days in the field. For example, if the Service Date is 1/1/06 and this field is set to 90, the last date an unbilled charge for 1/1/06 can be included on an automatic cycle adjustment bill would be 3/31/06. If the parameter is set to 30 and the service date for the charge was 1/1/06, the last date this charge is eligible for an automatic cycle adjustment bill would be on 1/31/06.

The system determines whether to use cycle adjustment parameters at the cycle bill parameter level or at the patient bill format level by the Cycle Adjustment Bill indicator. If the Cycle Adjustment Bill Indicator is set to Yes or No on the Cycle Billing Parameters associated with the account, the system uses these cycle adjustment parameters. If the Cycle Adjustment Bill Indicator is blank, the system looks at the setting of the Cycle Adjustment Bill Indicator on the Patient Bill Format. To determine if an unbilled charge can be automatically cycle adjustment billed, the system looks at the CycA Max Days Since Service field.

2. CYCA ZERO BAL (1-A-O)
This field indicates whether the system should automatically generate a cycle adjustment bill if the account balance is zero. When this field is accessed, the following prompt is displayed:

Create the automatic cycle adjustment bill if the account is zero balance? (Y/N) [N]-- |

You can enter **Y** (Yes) to create an automatic cycle adjustment bill even if the account is zero balance, **N** (No) not to create an automatic cycle adjustment bill for zero balance accounts, or leave the field blank, which also indicates no automatic cycle adjustment bills should be created for zero balance accounts.

3. MANUAL CYCA CHG/CR/DYS OVERRIDE FOR SUBSEQUENT BILLS (1-A-R)
This field indicates whether the system should override the minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits, Min Unbilled Credit Amt, and CycA Max Days Since Service fields when producing subsequent cycle adjustment bills. When this field is accessed, the following prompt is displayed:

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

You can enter **Y** (Yes) to override these fields for manual subsequent cycle adjustment bills or **N** (No) not to override these fields. A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be rebilled in order for the selected bill to be

processed. For example, if a manual cycle adjustment bill request is made for a cycle adjustment bill through the Single Bill Request or Instant Adjustment Bill functions, new charges or credits are not added for subsequent cycle adjustment bills unless the criteria for the minimum number and amount for unbilled charges or credits and the CycA Max Days Since Service are satisfied for the billing event. If the field is set to Yes, the system overrides the max days and minimum number and amount for unbilled charges or credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits and Min Unbilled Credit Amt fields when producing subsequent cycle adjustment bills, so the constraint is removed for the subsequent adjustment bills and any new charge/credits are included. If the field is set to No, the system won't override the max days and minimum number and amount for unbilled charges/credits defined in the Min Unbilled Charges, Min Unbilled Charge Amt, Min Unbilled Credits and Min Unbilled Credit Amt fields when producing subsequent cycle adjustment bills, and any new charges/credits must meet the defined number/amount to be included on the cycle adjustment bill. The system uses the value of this field as the default on the Single Bill Request and Instant Adjustment Bill screens.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields or the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge or credit numbers or amounts indicated, and the Manual CycA Chg/Cr Override isn't set to Yes, new charges or credits aren’t loaded for a subsequent cycle adjustment bill. The CycA Chg/Cr/Dys Override for Subsequent Bills field on both the Single Bill Request and the Instant Adjustment Bill screens can be used to override this value for an account.

4. AUTO CYCLE ADJ (1-A-R)
This field indicates whether the system should produce an automatic cycle adjustment bill, based on the entries made in either the Minimum Unbilled Charges and Minimum Unbilled Charge Amount fields and the Minimum Unbilled Credits and Minimum Unbilled Credit Amount fields. A cycle adjustment bill lists charges contained on the cycle bill and unbilled charges. When this field is accessed, the following prompt is displayed:

Produce automatic cycle adjustment bill? (Y/N) [N]-

Entry options are **Y** for Yes or **N** for No. A blank value indicates that no auto cycle adjustment processing can occur. If Yes is entered, the field displays a value of *Yes,* and if No is selected, the field displays a value of *No*.

NOTE: An account can get numerous Auto Cycle Adjustment bills for the same time period/original bill sequence if unbilled cycle charges are entered each day or for many days past the original cycle bill. This makes it very important to set the Minimum Number and Amount of Unbilled Cycle Charges as needed for the payor.

5. MIN UNBILLED CHARGES (2-N-C)
This field contains the minimum number of unbilled charges required to generate an automatic and manual cycle adjustment bill. For manual cycle adjustment bills, this

field is used to determine what charges are loaded on a subsequent cycle adjustment bill. If the Manual CycA Chg/Cr/Dys Override for Subsequent Bills parameter is set to Yes, the system does not use this field as the minimum number for manual cycle adjustment bills. When this field is accessed, the following prompt is displayed:

Enter minimum number of unbilled charges to generate a cycle adj bill--

You can enter a number between **1** and **99**. If this field is left blank, no automatic cycle adjustment processing can occur. This field works in conjunction with the Min Unbilled Charge Amt field, and you must enter a value in that field.

6. MIN UNBILLED CHARGE AMT (4-N-C)
This field contains the minimum unbilled charge amount necessary to generate an automatic and manual cycle adjustment bill. For manual cycle adjustment bills, it is used to determine what charges are loaded on a subsequent cycle adjustment bill. If the Manual CycA Chg/Cr Override for Subsequent Bills field is set to Yes, the system does not use this field as the minimum amount for manual cycle adjustment bills. When this field is accessed, the following prompt is displayed:

Enter minimum amount of unbilled charges to generate an automatic cycle adjustment bill--

You can enter a number between **1** and **9,999**. Upon exiting the screen, if either the Auto Cycle Adj field is set to Yes or the Manual CycA Chg/Cr/Dys Override for Subsequent Bills is set to No, the system prompts you to enter values in the Min Unbilled Charges and Min Unbilled Charge Amt fields.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields or the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge or credit numbers or amounts indicated, and the Manual CycA Chg/Cr Override isn't set to Yes, new charges/credits aren’t loaded for a subsequent cycle adjustment bill.

7. MIN UNBILLED CREDITS (2-N-O)
This field contains the minimum number of unbilled credits required to generate an automatic cycle adjustment bill. When this field is accessed, the following prompt is displayed:

Enter minimum of late credits to generate an automatic cycle adjustment bill-

You can enter from **1** to **99** credits.You can opt to produce cycle adjustment bills due to charges and not to produce cycle adjustments due to credits, or you can set the parameter to produce a cycle adjustment bill for both unbilled charges and credits.

If the Min Unbilled Charges and Min Unbilled Charge Amt fields or the Min Unbilled Credits and Min Unbilled Credit Amt fields are blank, no automatic cycle adjustment processing can occur. If there are no charge or credit numbers and amounts indicated, and the Manual CycA Chg/Cr Override field isn't set to Yes, new charges/credits aren’t loaded for a subsequent cycle adjustment bill.

When you enter a value into the Min Unbilled Credits field, the system prompts you to enter a value in the Minimum Unbilled Credit Amount field. If you blank out either the Min Unbilled Credits field or the Min Unbilled Credit Amount field, both fields are blanked out. If the Min Unbilled Credits field and the Min Unbilled Credit Amt field are blank, no accounts qualify for an automatic cycle adjustment bill due to unbilled credits.

If an account qualifies for a cycle adjustment bill due to unbilled credits but not charges, the cycle adjustment bill contains all of the unbilled charges and credits for that bill period.

8. MIN UNBILLED CREDIT AMT (5-N-O)
This field contains the minimum unbilled credit amount necessary to generate a cycle adjustment bill. When this field is accessed, the following prompt is displayed:

Enter minimum late credit amount to generate an automatic cycle adjustment bill (e.g., -50)-

You can enter a number between **-1** and **-999** (the dollar amount must be preceded by a minus (-) sign). You can opt to produce cycle adjustment charge bills and not to produce cycle adjustment credit bills, or you can set the parameter to produce a cycle adjustment bill for both unbilled charges and credits. If you leave this field blank, no accounts qualify for cycle adjustment credit bills.

When you enter a value in this field, the system requires you to enter a value in the Minimum Unbilled Credits field. If you blank out either the Min Unbilled Credits field or the Min Unbilled Credit Amount field, both fields are blanked out. If the Min Unbilled Credits field and the Min Unbilled Credit Amt field are blank, no accounts qualify for an automatic cycle adjustment bill due to unbilled credits.

9. CYCA SUPPRESS SUBSEQUENT BILLS/ DO NOT LOAD CLMS (1-A-R)
This field indicates, for subsequent cycle adjustments bills, whether bills should be suppressed and claims should not be loaded if there are no new/qualifying charges for subsequent cycle adjustment bills. If a bill is suppressed because there are no new charges, the billing, proration, and reimbursement information is maintained, but the bill is not printed, and no claims are loaded for the bill. The value in this field populates the CycA Suppress Subsequent Bills/Do Not Load Clms field on the Single Bill Request and Instant Adjustment Bill screens, but you can change the value on the Single Bill Request screen and the Instant Adjustment Bill Processor. When this field is accessed, the following prompt is displayed:

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

You can enter **Y** (Yes), suppress the bills and don’t load claims for cycle adjustments or **N** (No), don’t suppress bills and load the cycle adjustment claims. A blank is the same as N (No), don't suppress bills and load the claims.

A subsequent cycle adjustment bill is one that is loaded automatically as a result of a manual or automatic cycle adjustment bill request. When requesting a cycle adjustment bill for a bill period, all billing periods following the one selected have to be

rebilled in order for the selected bill to be processed. If there are new charges for the subsequent cycle adjustment bill that are eligible to be rebilled, the bill won't be suppressed and claims are loaded. If there are new unbilled charges, but they don't qualify for the bill, because, for example, they don't meet the minimum charge amount, the bill is suppressed, and the claim is not loaded, if the field is set to Yes.

This field is used only if cycle adjustment bills are allowed per the setting on the Cycle Adj Bill Ind field in the Cycle Billing Parameters and the Patient Bill Format Processor.

If bills are suppressed, claims are not loaded. For a suppressed bill, a bill sequence is loaded for the bill, but it does not print. When a claim is not loaded, there is not even an associated claim sequence that is loaded. For example, if bills are set to suppress and claims don't load, the table below shows what you would have in the following scenario where there were two cycle bills with no new charges for the second cycle bill. If a claim is needed, you can add one through the Add a Claim function for the suppressed bill sequence. The McKesson-recommended process is that you request a new bill through either the Single Bill Request or Instant Adjustment Bill functions and set the suppress bill/do not load claims option to No so that bills and claims are loaded.

Example: The Suppress Bill/ Do Not Load Clm for CAdj field is set to Suppress Bills/ Don't Load Claims

Bills	**Claims for COB 1**
Cycle BS 1	CS 1 loads
Cycle BS 2	CS 2 loads
Cycle Adjustment BS 3 replacing BS 1	CS 3 loads and replaces CS 1
Cycle Adjustment BS 4 replacing BS 2	No claim loads

The system uses the Cycle Billing Parameter that is associated with the account.

10. CHG BILL WINDOW (3-N-O)
This field indicates the number of days that you can enter a charge on an AR account, after the date of service has passed, before the AR account is automatically placed on Bill Hold with a type of O (Old Charge). This parameter is used on AR accounts where the date of service has been billed and the bill type associated with the date of service was a cycle type. If no Chg Bill Window is defined on any level, any charge placed on an AR account is not placed on automatic bill hold with a type of O. When this field is accessed, the following prompt is displayed:

Enter Chg Bill Window causing AR account to be placed on Old Chg Bill Hold--

You can enter a number of days between **1** and **999** or leave the field blank. The number must be at least one greater than the CycA Max Days Since Service field. If

you enter a value that is less than the defined value in the CycA Max Days Since Service field, the following error message is displayed:

Error: Value must be greater than Max Days since Service.

If the Max Days Since Service field is modified so that it contains a value greater than the Chg Bill Window, the system blanks out the value in the Chg Bill Window.

The value in this field is used only for AR accounts that do not have a Chg Bill Window defined on the Billing Parameter screens. If the Date of Service associated with the charge should have billed on a bill type of cycle, and the setting is Yes in the Cycle Adj Bill Ind field on the Patient Bill Format screen, the system uses the Chg Bill Window defined on the Cycle Adjustment Parameters attached to the Patient Bill format screen.

The following screen defines the format header and format body of the three bills.

NOTE: This screen, completed during implementation, should not be changed without permission from McKesson.

```
        General Hospital Patient Bill Format Maintenance Processor
                                              Fri Jan 28, 2008 01:42 pm
Facility A

 1 Detail Bill Header                    2 Start On          3 Stop On
   51-HBOC Patient Bill (Header)-C         1                   14
 4 Detail Bill Body                      5 Start on          6 Stop on
   52-HBOC Patient Bill (Detail)-C         18                  56
 7 Summary Bill Header                   8 Start On          9 Stop On
   51-HBOC Patient Bill (Header)-C         1                   14
10 Summary Bill Body                    11 Start on         12 Stop on
   74-HBOC Patient Bill (Summary)-B        21                  55
13 Prorated Bill Header                 14 Start On         15 Stop On
   71-HBOC Patient Bill (Header)-B         1                   20
16 Prorated Bill Body                   17 Start on         18 Stop on
   73-HBOC Patient Bill (Prorated)-B       21                  55
19 Series Bill Header                   20 Start on         21 Stop on
   2-HBOC Series Bill Header               1                   17
22 Series Bill Body                     23 Start on         24 Stop on
   92-HBOC Series Bill                     24                  61


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

Field Explanations - Screen 2

1. DETAIL BILL HEADER (TABLE LOOKUP)
This field contains the header format for the detail patient bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Detail Bill Header formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

2-HBOC Series Bill Header

12-Canada Patient Bill Header

61-HBOC Patient Bill (Header)-A

71-HBOC Patient Bill (Header)-B

51-HBOC Patient Bill (Header)-C

78-NY Uniform Bill Header

2. START ON (2-N-R)
This field contains the page line number on which the header of the detail bill begins printing.

3. STOP ON (2-N-R)
This field contains the page line number on which the header of the detail bill stops printing.

4. DETAIL BILL BODY (TABLE LOOKUP)
This field contains the body format for the detail patient bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Detail Bill Body formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

29-Canada Patient Bill Detail

62-HBOC Patient Bill (Detail)-A

72-HBOC Patient Bill (Detail)-B

52-HBOC Patient Bill (Detail)-C

162-HBOC Patient Bill RF (Dtl)-A

172-HBOC Patient Bill RF (Dtl)-B

152-HBOC Patient Bill RF (Dtl)-C

79-NY Uniform Bill Detail

NOTE: If charges are associated with a Reference Facility, and the Patient Detail Format is either 152 for Format C, or 162 for Format A, or 172 for Format B, the full name and address of the Reference Facility is displayed on the first associated charge on the patient bill.

The Pharmacy Units field on the first Patient Bill Format screen applies to the following formats for this field:

62-HBOC Patient Bill (Detail)-A

72-HBOC Patient Bill (Detail)-B

52-HBOC Patient Bill (Detail)-C

162-HBOC Patient Bill RF (Dtl)-A

172-HBOC Patient Bill RF (Dtl)-B

152-HBOC Patient Bill RF (Dtl)-C

The "RF" bill formats print Reference Facility information on the patient bill.

5. START ON (2-N-R)
This field contains the page line number on which the body of the detail bill starts printing.

6. STOP ON (2-N-R)
This field contains the page line number on which the body of the detail bill begins printing.

7. SUMMARY BILL HEADER (TABLE LOOKUP)
This field contains the header format for the summary patient bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Summary Bill Header formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

2-HBOC Series Bill Header

12-Canada Patient Bill Header

61-HBOC Patient Bill (Header)-A

71-HBOC Patient Bill (Header)-B

51-HBOC Patient Bill (Header)-C

78-NY Uniform Bill Header

8. START ON (2-N-R)
This field contains the page line number on which the header of the summary bill begins printing.

9. STOP ON (2-N-R)
This field contains the page line number on which the header of the summary bill stops printing.

10. SUMMARY BILL BODY (TABLE LOOKUP)
This field contains the body format for the summary patient bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Summary Bill Body formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

38-Canada Patient Bill Summary

64-HBOC Patient Bill (Summary)-A

74-HBOC Patient Bill (Summary)-B

54-HBOC Patient Bill (Summary)-C

80-NY Uniform Bill Summary

11. START ON (2-N-R)
This field contains the page line number on which the body of the summary bill begins printing.

12. STOP ON (2-N-R)
This field contains the page line number on which the body of the summary bill stops printing.

13. PRORATED BILL HEADER (TABLE LOOKUP)
This field contains the header format for the prorated patient bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Prorated Bill Header formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

2-HBOC Series Bill Header

12-Canada Patient Bill Header

61-HBOC Patient Bill (Header)-A

71-HBOC Patient Bill (Header)-B

51-HBOC Patient Bill (Header)-C

78-NY Uniform Bill Header

14. START ON (2-N-R)
This field contains the page line number on which the header of the prorated bill begins printing.

15. STOP ON (2-N-R)
This field contains the page line number on which the header of the prorated bill stops printing.

16. PRORATED BILL BODY (TABLE LOOKUP)
This field contains the body format for the prorated patient bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Prorated Bill Body formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

39-Canada Patient Prorated Bill

63-HBOC Patient Bill (Prorated)-A

73-HBOC Patient Bill (Prorated)-B

53-HBOC Patient Bill (Prorated)-C

17. START ON (2-N-R)
This field contains the page line number on which the body of the prorated bill begins printing.

18. STOP ON (2-N-R)
This field contains the page line number on which the body of the prorated bill stops printing.

19. SERIES BILL HEADER (TABLE LOOKUP)
This field contains the header format for the series bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Series Bill Header formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

2-HBOC Series Bill Header

12-Canada Patient Bill Header

61-HBOC Patient Bill (Header)-A

71-HBOC Patient Bill (Header)-B

51-HBOC Patient Bill (Header)-C

78-NY Uniform Bill Header

20. START ON (2-N-R)
This field contains the page line number on which the header of the series bill begins printing.

21. STOP ON (2-N-R)
This field contains the page line number on which the header of the series bill stops printing.

22. SERIES BILL BODY (TABLE LOOKUP)
This field contains the body format for the series bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

The following Series Bill Body formats are maintained and supported by McKesson. Other bill formats are considered custom bills.

92-HBOC Series Bill

23. START ON (2-N-R)
This field contains the page line number on which the body of the series bill starts printing.

24. STOP ON (2-N-R)
This field contains the page line number on which the body of the series bill begins printing.

Contract Bill Format

The Contract Bill Format function allows you to specify how contract bills are formatted. Currently, only detail bills are produced. This table entry is set up during implementation and is dependent on the contract bill format selected during forms design. At this time, the contract bill uses the same bill format as the regular patient bill.

WARNING: Changes to a format code in this function will change the form contents and where the information prints on the form. *Do not change* the fields on either screen without first verifying the change with McKesson.

After this function is selected, the system displays the first of two screens.

```
          General Hospital Contract Bill Format Maintenance Processor
                                                 Fri Jan 28, 2000 01:46 pm
Model Hospital A

Print Separate Bills    1 Detail Bills?   2 Summary Bills?   3 Prorated Bills?
                          No                No                 No
Charge Summarization    4 Summarize By                       5 Number of Digits

 6 SIM or FIM Desc      7 Bill Transaction Code
   SIM                    Y0006-CONTRACT BILL
 8 Balance Forward  9 Edit Date           10 Edit By
   Yes                07/08/97 04:22pm       Burr,Johnnie M









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

Field Explanations - Screen 1 of 2

Print Separate Bills

These fields indicate whether a different spool file should be created for the detail, summary or prorated bill. If the answer is Yes, the system creates a separate spool file for the bill type. If the answer is No, the summary bill, for example, follows the contract's detail bill in the same spool file.

NOTE: Currently, only detail bills are generated.

1. DETAIL BILLS (1-A-R)
This field prompts the system to print or not print detail bills separately from summary and prorated bills. Entry options are Y for Yes or N for No.

2. SUMMARY BILLS (1-A-R)
This field is not currently used.

3. PRORATED BILLS (1-A-R)
This field is not currently used.

Charge Summarization

4. SUMMARIZE BY (TABLE LOOKUP)
This field is not used for contract bills.

5. NUMBER OF DIGITS (1-N-O)
This field is not used for contract bills.

6. SIM or FIM DESC (1-A-R)
This field specifies whether the detail bill should print the charge description from the Service Item Master (SIM) or the Financial Item Master (FIM). Every item has a SIM and a FIM description.

7. BILL TRANSACTION CODE (4-N-R)
This field specifies the bill transaction code. The transaction type is Y. Enter the transaction code or enter a hyphen (-) and select a transaction code from a list. This code is used to update the transaction history when a contract bill is produced.

8. BALANCE FORWARD (1-A-R)
This field determines whether the system should print vendor bills in the *balance forward* or *previously billed* format. If *balance forward* bills are required for contract billing, enter **Y**. If *previously billed charges* bills are required for contract billing, enter **N** or press ENTER to accept the default.

If you enter No for this field, the contract bill displays detail of all cash and adjustment posting. The total charges billed less payment and adjustments equal the balance due information on the contract bill. If you enter Yes for this field, balance forward displays information pertinent with the specific contract bill.

9. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this bill format was last edited.

10. EDIT BY (DISPLAY ONLY)
The system displays the name of the user who last edited this bill format.

After these fields are completed, the system displays the second screen of this transaction. This screen defines the format header and format body of the three bills.

NOTE: This screen, completed during implementation, should not be changed without permission from McKesson.

```
        General Hospital Contract Bill Format Maintenance Processor
                                                Fri Jan 28, 2000 01:50 pm
Model Hospital A

 1 Detail Bill Header                      2 Start On          3 Stop On
   56-HBOC Contract Bill (Header)-C          1                   14
 4 Detail Bill Body                        5 Start on          6 Stop on
   55-HBOC Contract Bill (Detail)-C          18                  56
 7 Summary Bill Header                     8 Start On          9 Stop On

10 Summary Bill Body                      11 Start on         12 Stop on

13 Prorated Bill Header                   14 Start On         15 Stop On

16 Prorated Bill Body                     17 Start on         18 Stop on









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

Field Explanations - Screen 2 of 2

1. DETAIL BILL HEADER (TABLE LOOKUP)
This field contains the header format for the detail contract bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

2. START ON (2-N-R)
This field contains the page line number on which the header of the detail bill begins printing.

3. STOP ON (2-N-R)
This field contains the page line number on which the header of the detail bill stops printing.

4. DETAIL BILL BODY (TABLE LOOKUP)
This field contains the body format for the detail contract bill. Enter the code or enter a hyphen (-) to select the format from a table display. McKesson maintains the selection choices.

5. START ON (2-N-R)
This field contains the page line number on which the body of the detail bill begins printing.

6. STOP ON (2-N-R)
This field contains the page line number on which the body of the detail bill stops printing.

7. SUMMARY BILL HEADER (TABLE LOOKUP)
This field is not currently used.

8. START ON (2-N-R)
This field is not currently used.

9. STOP ON (2-N-R)
This field is not currently used.

10. SUMMARY BILL BODY (TABLE LOOKUP)
This field is not currently used.

11. START ON (2-N-R)
This field is not currently used.

12. STOP ON (2-N-R)
This field is not currently used.

13. PRORATED BILL HEADER (TABLE LOOKUP)
This field is not currently used.

14. START ON (2-N-R)
This field is not currently used.

15. STOP ON (2-N-R)
This field is not currently used.

16. PRORATED BILL BODY (TABLE LOOKUP)
This field is not currently used.

17. START ON (2-N-R)
This field is not currently used.

18. STOP ON (2-N-R)
This field is not currently used.

Sort Sequences

The Sort Sequences function allows you to specify how the system sorts special forms and certain reports. The method of sorting can vary with each form.

After you access this function, the system displays a list of forms and reports from which you can select a document for sort sequence definition. This list is maintained by McKesson.

```
                General Hospital Sort Sequences Processor
                                                Mon Mar 17, 1997 02:12 pm
Model Hospital A
Page:01                            Sort Options
( 1) 1500 Claims                      (18) Collector Work - Referral
( 2) 1500 Claims - Archive            (19) Collector Work - Standard
( 3) 2360 Claim                       (20) Contract Bills
( 4) 2360 Claim - Archive             (21) Contract Statements
( 5) Archive Statements               (22) Datamailers
( 6) BD Collection Letters            (23) Detail Statements
( 7) BD Detail Statements             (24) FINANCIAL REVIEW RPT
( 8) Collection Agency Notification   (25) Insurance Follow-Up Letters
( 9) Collection Agency Statements     (26) MA 310 I/P Claim
(10) Collection Letters               (27) MA 310 I/P Claim - Archive
(11) Collector Work - Agency          (28) MA 319 Medical Services - Arch
(12) Collector Work - Focus Acct      (29) MA 319 Medical Services Claim
(13) Collector Work - Focus Agency    (30) MA 319 Physician Invoice - Arc
(14) Collector Work - Focus Ins       (31) MA 319 Physician Invoice Claim
(15) Collector Work - Insurance       (32) Medi-Cal 25-1 Claim
(16) Collector Work - Payment Plan    (33) Medi-Cal 25-1 Claim - Archive
(17) Collector Work - Promise Pay     (34) Medi-Cal I/P Claim

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

After selecting a form, this screen is displayed.

```
                General Hospital Sort Sequences Processor
                                                Fri Jan 28, 2000 01:54 pm
Model Hospital A
1500 Claims
 1 Edit Date            2 Edit By
   12/05/97 11:17am       Craft,Kris E
 3 Sort Field                  Sequence
   Biller Code Bill
   Biller Code Claim
   Carrier Code
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number          2
   Patient Indicator
   Patient Name                    1
   Patient Type




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

Field Explanations

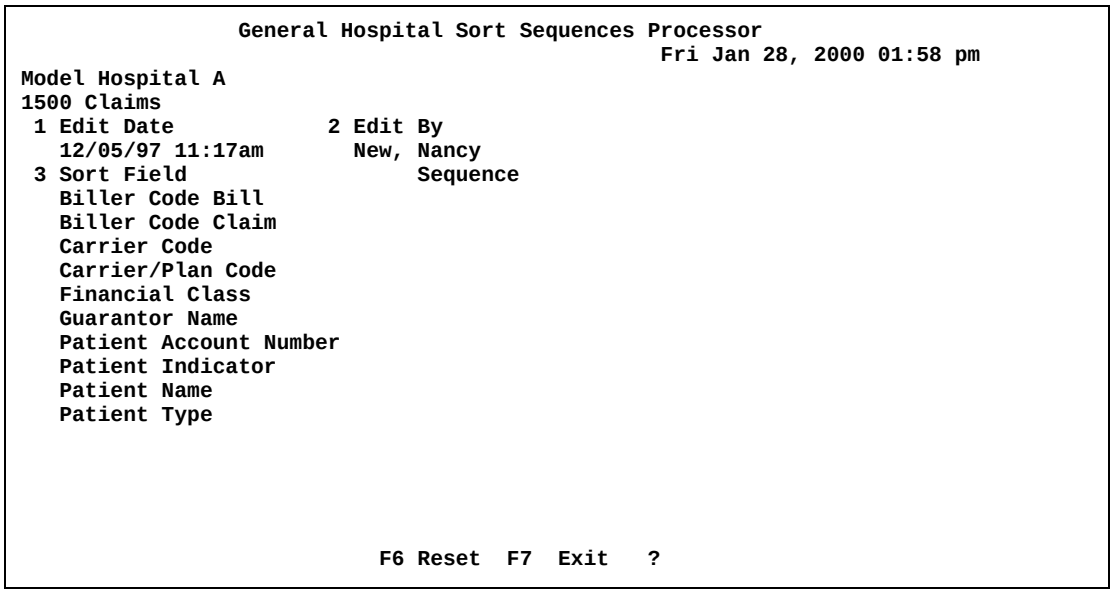
1. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this sort sequence was last edited.

2. EDIT BY (DISPLAY ONLY)
The system displays the name of the user who last edited this sort sequence.

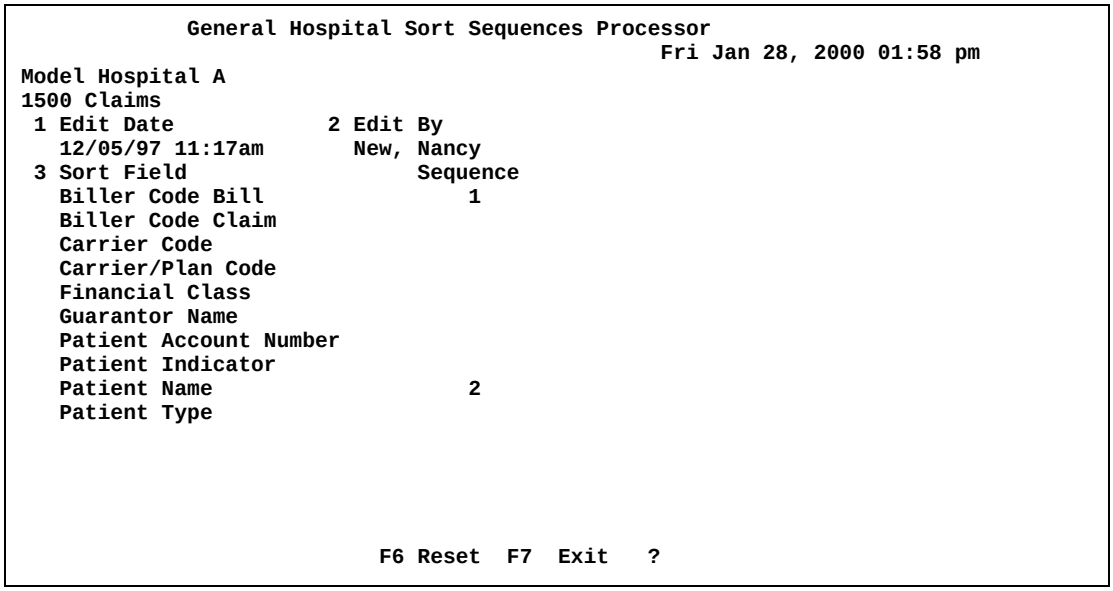
3. SORT FIELD/SEQUENCE (9-N-R)

A list of the fields by which a form can be sorted is displayed. You can enter up to nine ways, depending on the form type, to sort from one form to the next form. For example, if you want to sort the forms first by the account biller, enter **1** under *Sequence* next to *Biller Code Bill.* If you want to sort the forms secondly by patient name, enter **2** under *Sequence* next to *Patient Name*, and so on. The sequence elements are defined by McKesson.

The entry screens displaying the sort sequence options for each of the non-state specific forms listed follows.



```
                General Hospital Sort Sequences Processor
                                                 Fri Jan 28, 2000 01:58 pm
Model Hospital A
1500 Claims
 1 Edit Date            2 Edit By
   12/05/97 11:17am       New, Nancy
 3 Sort Field                 Sequence
   Biller Code Bill
   Biller Code Claim
   Carrier Code
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number
   Patient Indicator
   Patient Name
   Patient Type




                          F6 Reset  F7  Exit   ?
```



```
            General Hospital Sort Sequences Processor
                                                 Fri Jan 28, 2000 01:58 pm
Model Hospital A
1500 Claims
 1 Edit Date            2 Edit By
   12/05/97 11:17am       New, Nancy
 3 Sort Field                 Sequence
   Biller Code Bill               1
   Biller Code Claim
   Carrier Code
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number
   Patient Indicator
   Patient Name                   2
   Patient Type




                          F6 Reset  F7  Exit   ?
```

```
                General Hospital Sort Sequences Processor
                                                Mon Mar 17, 1997 02:12 pm
Model Hospital A
BD Collection Letters
 1 Edit Date            2 Edit By
   03/17/97 10:15am       Smith,Mary A
 3 Sort Field                Sequence
   Collection Schedule           4
   Collector Code                1
   Guarantor Name                2
   Guarantor Zip Code            3









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

```
                General Hospital Sort Sequences Processor
                                                Mon Mar 17, 1997 02:23 pm
Model Hospital A
BD Detail Statements
 1 Edit Date            2 Edit By
   03/06/97 03:56pm       Smith,Mary A
 3 Sort Field                Sequence
   Collection Schedule           1
   Collector Code
   Guarantor Name
   Guarantor Zip Code            2









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

```
            General Hospital Sort Sequence Maintenance Processor
                                                  Fri Nov 10, 1997 03:52 pm
GENERAL HOSPITAL
BD Detail Statements
 1 Edit Date            2 Edit By
   02/02/97 15:44         Smith,Mary A
 3 Sort Field                Sequence
   Collector Code                1
   Financial Class
   Guarantor Name                2
   Patient Account Number
   Patient Indicator
   Patient Name
   Patient Type









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

```
            General Hospital Sort Sequence Maintenance Processor
                                                  Fri Nov 10, 1989 03:52 pm
GENERAL HOSPITAL
Collection Letters
 1 Edit Date            2 Edit By
   02/02/89 15:44         Smith,Mary A
 3 Sort Field                Sequence
   Collector Code                1
   Financial Class
   Guarantor Name                2
   Guarantor Zip Code









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

```
            General Hospital Sort Sequence Maintenance Processor
                                                 Fri Nov 10, 1989 03:52 pm
GENERAL HOSPITAL
Datamailers
 1 Edit Date            2 Edit By
   11/10/89 15:53         Smith,Mary A
 3 Sort Field                Sequence
   Collector Code
   Financial Class
   Guarantor Name
   Guarantor Zip Code
   Patient Account Number
   Patient Indicator
   Patient Name
   Patient Type




                          F6 Reset  F7  Exit   ?
```

```
            General Hospital Sort Sequence Maintenance Processor
                                                 Fri Nov 10, 1989 03:53 pm
GENERAL HOSPITAL
Detail Statements
 1 Edit Date            2 Edit By
   06/07/89 11:46         Smith,Mary A
 3 Sort Field                Sequence
   Collector Code               2
   Financial Class              1
   Guarantor Name               3
   Guarantor Zip Code




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

```
            General Hospital Sort Sequence Maintenance Processor
                                                 Fri Nov 10, 1989 03:53 pm
GENERAL HOSPITAL
FINANCIAL REVIEW RPT
 1 Edit Date            2 Edit By
   08/30/89 14:52         Smith,Mary A
 3 Sort Field                Sequence
   Patient Account Number
   Patient Indicator
   Patient Name                 1









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

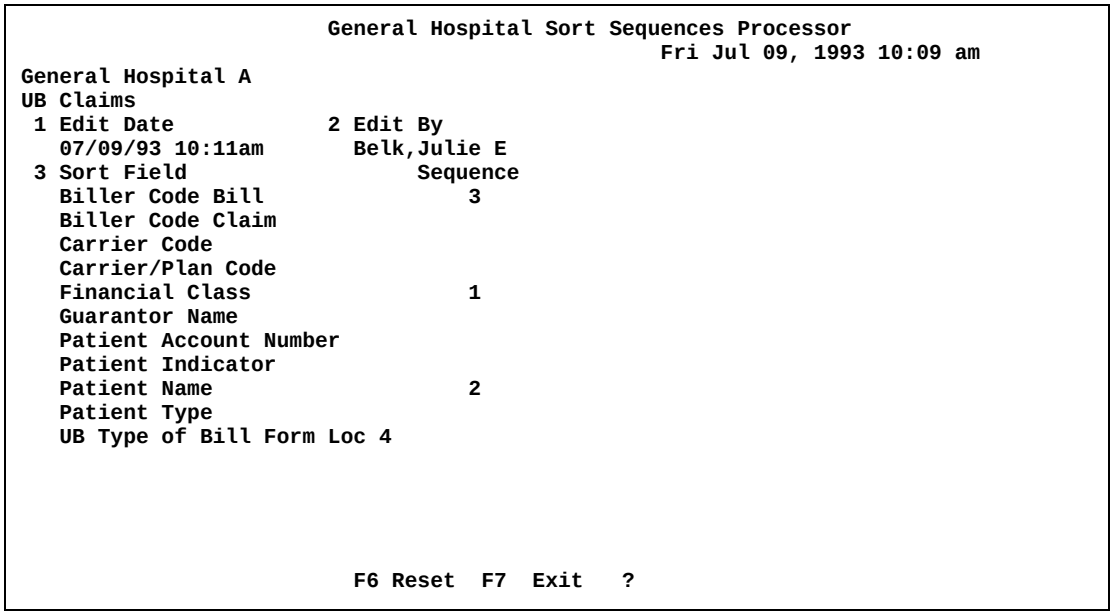
```
                General Hospital Sort Sequences Processor
                                                 Wed Apr 10, 1991 02:53 pm
GENERAL HOSPITAL                                                        016
Insurance Follow-Up Letters
 1 Edit Date            2 Edit By
   06/01/90 11:01         Smith,Mary
 3 Sort Field                Sequence
   Collector Code               1
   Financial Class
   Insurance Carrier Zip Code   3
   Patient Account Number
   Patient Indicator
   Patient Name                 2
   Patient Type









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

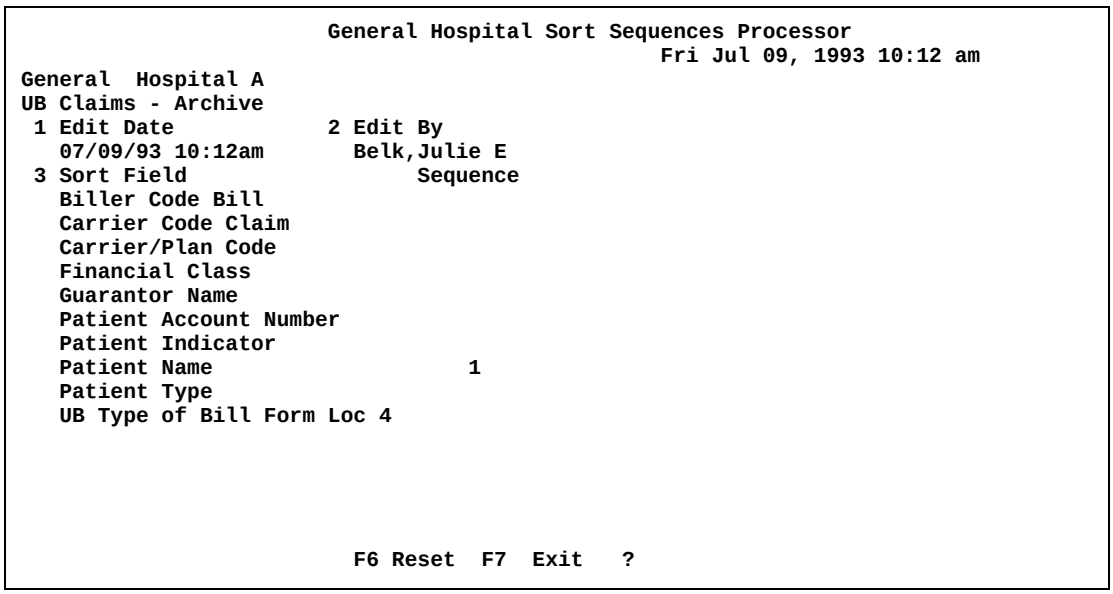
```
            General Hospital Sort Sequence Maintenance Processor
                                                 Mon Oct 26, 1992 10:10 am
GENERAL HOSPITAL A
Patient Bills
 1 Edit Date            2 Edit By
   10/05/92 3:36pm        McCoy,Dick
 3 Sort Field                Sequence
   Biller Code
   Carrier Code
   Carrier/Plan Code
   Discharge Date                1
   Financial Class
   Guarantor Zip Code
   Patient Account Number        2
   Patient Indicator
   Patient Name
   Patient Type




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

```
            General Hospital Sort Sequence Maintenance Processor
                                                 Fri Nov 10, 1989 03:56 pm
GENERAL HOSPITAL
UB82 Claims
 1 Edit Date            2 Edit By
   05/30/89 09:10         Smith,Mary A
 3 Sort Field                Sequence
   Biller Code Bill              1
   Biller Code Claim
   Carrier Code                  3
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number        4
   Patient Indicator             2
   Patient Name
   Patient Type




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

```
            General Hospital Sort Sequence Maintenance Processor
                                                  Fri Nov 10, 1989 03:56 pm
GENERAL HOSPITAL
UB82 Claims - Archive
 1 Edit Date            2 Edit By
   11/10/89 15:56         Smith,Mary A
 3 Sort Field                Sequence
   Biller Code Bill
      Biller Code Claim
   Carrier Code
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number
   Patient Indicator
   Patient Name
   Patient Type




                          F6 Reset  F7  Exit   ?
```

```
            General Hospital Sort Sequence Maintenance Processor
                                                  Fri Nov 10, 1989 03:57 pm
GENERAL HOSPITAL
Vendor Bills
 1 Edit Date            2 Edit By
   11/10/89 15:57         Smith,Mary A
 3 Sort Field                Sequence
   Biller Code
   Financial Class
   Vendor Code









                          F6 Reset  F7  Exit   ?
```


General Hospital Sort Sequences Processor
Fri Jul 09, 1993 10:09 am
General Hospital A
UB Claims
1 Edit Date
07/09/93 10:11am
2 Edit By
Belk,Julie E
3 Sort Field
Sequence
Biller Code Bill 3
Biller Code Claim
Carrier Code
Carrier/Plan Code
Financial Class 1
Guarantor Name
Patient Account Number
Patient Indicator
Patient Name 2
Patient Type
UB Type of Bill Form Loc 4
F6 Reset F7 Exit ?


General Hospital Sort Sequences Processor
Fri Jul 09, 1993 10:12 am
General Hospital A
UB Claims - Archive
1 Edit Date
07/09/93 10:12am
2 Edit By
Belk,Julie E
3 Sort Field
Sequence
Biller Code Bill
Carrier Code Claim
Carrier/Plan Code
Financial Class
Guarantor Name
Patient Account Number
Patient Indicator
Patient Name 1
Patient Type
UB Type of Bill Form Loc 4
F6 Reset F7 Exit ?

Biller/Collector Worklist Control

This function enables you to set parameters for the online worklists used by the hospital's billers and collectors. After you access this function, this screen is displayed:

```
General Hospital Biller/Collector Worklist Control Maintenance Processor
                                                Wed Jun 15, 2006 02:14 pm
General Hospital A

 1 Bills passing edits      2 Bills failing edits    3 Bills w/$0.00 Charges
   Exclude                    Include                  Exclude
 4 Claims passing edits                      5 Claims failing edits
   Exclude                                     Include
 6 Include replaced claims                   7 Insurance worklist sub-group
   Include
 8 Insurance worklist primary sort           9 Insurance worklist secondary sort
   Descending balance - carrier
10 Guarantor worklist primary sort          11 Guarantor worklist secondary sort
   Descending dollar balance
12 Contract worklist primary sort           13 Contract worklist secondary sort

14 Edit Notes?                              15 Confidential Notes?
   Yes                                         No




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

Field Explanations

1. BILLS PASSING EDITS (1-A-R)

This field prompts the system to include or exclude bills that passed edits in the worklist. Enter **Y** if the online worklist of bills produced by the system needs to include bills that have already printed. Enter **N** to exclude these bills. This enables the online worklist to serve as an audit of the bills produced for each biller. This also allows the worklist to serve as a worklist for accounts waiting to be billed. In either case, the system includes warnings in the online worklist.

2. BILLS FAILING EDITS (1-A-R)

This field indicates if bills that failed edits should be included in the worklist. Enter **Y** if you want the biller to receive an online worklist of those accounts being held for billing because they have not met requirements.

3. BILLS W/$0.00 CHARGES (1-A-R)

This field indicates whether bills that have $0.00 as the total charge amount should be included in the online workfile. Enter **Y**, or press ENTER, to provide the biller with an online worklist of those accounts with $0.00 total charges, and the system displays “Include” in this field. Enter **N** not to provide the biller with an online worklist of those accounts with $0.00 total charges, and the system displays “Exclude” in this field.

4. CLAIMS PASSING EDITS (1-A-R)
This field indicates if bills that passed edits should be included in the worklist. Enter **Y** to include bills that passed edits; enter **N,** or press ENTER to exclude bills that passed edits.

If you set this field to exclude bills passing edits (you enter N to this field), claims that have passed edits and have not yet been produced are not accessible from the Claims by Biller function when using the Claims That Passed Edits option. These claims *are* displayed using the Claims by Account function.

If you set this field to include bills passing edits (you enter Y to this field), claims that have passed edits are accessible from the Claims by Biller and Claims by Account functions.

5. CLAIMS FAILING EDITS (1-A-R)
This field indicates if bills that failed claim edits should be included in the worklist. Enter **Y** to include bills that failed edits; enter **N**, or press ENTER to exclude bills that failed edits.

If you set this field to exclude bills failing edits (you enter N to this field), claims that have failed edits are not accessible from the Claims by Biller function when using the Claims That Failed Edits option. These claims *are* displayed using the Claims by Account function. These claims *do not* print on the Failed Claims Requirement report (FCR250).

If you set this field to include bills failing edits (you enter Y to this field), claims that have failed edits are accessible from the Claims by Biller and Claims by Account functions. These claims also print on the Failed Claims Requirement report (FCR250).

NOTE: Fields 6-10 are valid for the Receivables Workstation Module and Release 15.1 without the Receivables Workstation.

6. INCLUDE REPLACED CLAIMS (1-A-R)
This field indicates if the account lookup for claims should display both original and cycle/final adjusted claims or only cycle/final adjustment (replacement) claims. When this field is accessed, the following prompt is displayed:

Include Claims Replaced by Adjustment Claims in Lookup? (Y/N) [N]--

You can enter **Y** (Yes) to include replaced claims or **N** (No) to exclude them. If you enter Yes, the system highlights original claims on the worklist to differentiate them from adjustment claims.

7. INSURANCE WORKLIST SUB-GROUP (1-N-O)
This field contains the sub-grouping of work by carrier/plan. Options are by contact name, group number, group name, or blank. On the Main Worklist View screen on the Receivables Workstation, Work By Carrier/Plan automatically groups by the carrier code and the plan code. If you enter a sub-group, entries are also grouped by either

the contact name, group number, or group name. On STAR, the sub-group is also used to further divide the groupings of Work By Carrier/Plan. If this field is blank, work is grouped by carrier/plan codes only.

8. INSURANCE WORKLIST PRIMARY SORT (1-N-O)
This field contains the primary sort of all insurance work. This field indicates which is the primary sort within the account list for Insurance Carrier/Plan Worklist entries. Options are by descending dollar balance (claim amount), patient name, days since claim submission, days since final bill, days since last follow-up, number of days in workfile, financial class, or blank. On the Receivables Workstation, this controls Insurance and Focus Insurance types of work. On STAR, this controls only Insurance work. If this field is blank, insurance work is sorted by the carrier/plan code and the date it was placed in the worklist.

9. INSURANCE WORKLIST SECONDARY SORT (1-N-O)
This field contains the secondary sort of all insurance work. This field indicates which is the secondary sort within the account list for Insurance Carrier/Plan Worklist entries. Options are by descending dollar balance (claim amount), patient name, days since claim submission, days since final bill, days since last follow-up, number of days in workfile, financial class, or blank. On the Receivables Workstation, this controls Insurance and Focus Insurance types of work. On STAR, this controls only Insurance work. If this field is blank, insurance work does not have a secondary sort.

10. GUARANTOR WORKLIST PRIMARY SORT (1-N-O)
This field contains the primary sort of all guarantor and account level work. This field indicates which is the primary sort within the Guarantor Worklist. Options are by descending dollar balance, guarantor name, days since final bill, days since last follow-up, number of days in workfile, financial class, or blank. On the Receivables Workstation, this controls Active Patient, Delinquent, Focus Patient, Partial Payment, Promise to Pay, and Standard types of work. On STAR, this controls Active Patient, Delinquent, Business Office, Partial Payment, Promise to Pay, and Standard types of work. If this field is blank, guarantor work is sorted by the date it was placed in the worklist.

11. GUARANTOR WORKLIST SECONDARY SORT (1-N-O)
This field contains the secondary sort of all guarantor and account level work. This field indicates which is the secondary sort within the Guarantor Worklist. Options are by descending dollar balance, guarantor name, days since final bill, days since last follow-up, number of days in workfile, financial class, or blank. On the Receivables Workstation, this controls Active Patient, Delinquent, Focus Patient, Partial Payment, Promise to Pay, and Standard types of work. On STAR, this controls Active Patient, Delinquent, Business Office, Partial Payment, Promise to Pay, and Standard types of work. If this field is blank, guarantor work does not have a secondary sort.

NOTE: Fields 12 and 13 are only used if you have the Receivables Workstation module.

12. CONTRACT WORKFILE PRIMARY SORT (1-N-O)
This field identifies how Contract Telephone workfile entries should be sorted and displayed in the Workstation Receivables module. This field indicates which is the primary sort with the Contract Follow-up Worklist. Options are by bill date, contract code, descending dollar balance, number of days in the workfile, or blank. The option you select for this field cannot be the same as the option selected for the Contract Workfile Secondary Sort field.

13. CONTRACT WORKFILE SECONDARY SORT (1-N-O)
This field identifies how Contract Telephone workfile entries should be sorted and displayed in the Workstation Receivables module. This field indicates which is the secondary sort with the Contract Follow-up Worklist. Options are by bill date, contract code, descending dollar balance, number of days in the workfile, or blank. The option you select for this field cannot be the same as the option selected for the Contract Workfile Primary Sort field.

14. EDIT NOTES? (1-A-R)
This field indicates whether account notes can be edited by the person who originally entered them. Enter **Y** or press ENTER to allow editing. Enter **N** to disallow editing of account notes.

15. CONFIDENTIAL NOTES (1-A-R)
This field indicates whether confidentiality of account notes based on security level should be activated. If activated, text of free-form notes is displayed only to users with security levels equal to or higher than that of the note's creator. Enter **Y** to activate confidentiality. Enter **N** or press ENTER to deactivate confidentiality.

When you finish editing these fields, the system prompts you to edit or accept the fields. Accepting the screen completes the transaction.

Data Retention Parameters

The Data Retention Parameters are used during the purge and archive routines to indicate how long an account remains on the system after reaching zero balance, how long an account remains in the financial patient index (FPI), how long claims remain in the system, and when SQL transaction history indices are to be purged/created.

In completing this parameter, you can enter/edit financial class exceptions and patient type within financial class exceptions. Once the basic parameter is completed, the system prompts you concerning these options. After you select this menu option, the system displays this screen.

```
           General Hospital Data Retention Parameters Processor
                                                 Fri Sep 09, 2011 10:06 am
Model Hospital A

 1 AR Archive Days            2 AR End Disch Dt      3 AR Max Accts
   1000                         01/01/1998             1
 4 BD Archive Days            5 BD End Disch Dt      6 BD Max Accts
   1000                         01/01/1998             0
 7 BD Charge Delete Days      8 BD Charge Delete Transaction Code
   120                          M0002-FINANCIAL CLASS CHANGE W/O REC
 9 Carrier Pay Days   10 Claim End Disch Dt  11 Max Claims   12 Disp Claims?
   1000                  12/31/2000            40              No
13 FPI Months                                 14 Contract Charge Delete Days
   12                                            0
15 Retain Guarantor Payment History           16 SQL Tran Hist Index
   Yes/1000                                      Yes/9999/B STOPPED
17 Service Line Info Days                     18 SQL Charge Posting Index
   5                                             Yes/30/ STOPPED
19 Remittance Data Days      20 Stop Time for ERA Remit Purge
   2                            11:00pm
21 Unapplied Cash Log        22 Retain Pymt/Adj Detail after Batch Posting
   Payment/2                    10

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

Field Explanations

1. AR ARCHIVE DAYS (4-N-R)
This field contains the number of days after an account reaches zero balance before it is considered for archiving. When an account is archived, its data — specifically detail insurance information, charge detail and transaction history — is purged. The entry range is 1 to 9999 days. This applies to accounts in Location AR only. Accounts are archived by running the Account Archive Optional Batch job.

For more information on Account Archiving, see “ACCOUNT ARCHIVE/PURGE” on page 2-291.

2. AR END DISCH DT (SPECIAL FORMAT-O)
This field contains the ending discharge date for AR accounts. Enter the date in MM/DD/YYYY format. Accounts with a discharge date past the date entered in this field are not considered for archiving.

3. AR MAX ACCTS (5-N-R)
This field identifies the maximum number of AR accounts that the system can archive at a time. Entry options are a number from 0 through 99999 or U for unlimited; the default is U. When the system archives AR accounts, it checks this number during the process. The system does not archive more than this number of accounts, even if additional AR accounts are eligible to be archived.

NOTE: Accounts that are not archived due to the setting of this parameter are not reported.

4. BD ARCHIVE DAYS (4-N-R)
This field contains the number of days after an account reaches zero balance before it is considered for archiving. When an account is archived, its data — specifically detail insurance information, charge detail and transaction history — is purged. The entry range is 1 to 9999 days. This applies to accounts in Location BD only. Accounts are archived by running the Account Archive Optional Batch job.

For more information on Account Archiving, see "ACCOUNT ARCHIVE/PURGE" on page 2-291.

5. BD END DISCH DT (SPECIAL FORMAT-O)
This field contains the ending discharge date for BD accounts. Enter the date in MM/DD/YYYY format. Accounts with a discharge date past the date entered in this field are not considered for archiving.

6. BD MAX ACCTS (5-N-R)
This field identifies the maximum number of BD accounts that the system can archive at a time. Entry options are a number from 0 through 99999 or U for unlimited; the default is U. When the system archives BD accounts, it checks this number during the process. The system does not archive more than this number of accounts, even if additional BD accounts are eligible to be archived.

NOTE: Accounts that are not archived due to the setting of this parameter are not reported.

7. BD CHARGE DELETE DAYS (3-N-R)
This field defines the number of days detail charges are retained once an account transfers to bad debt. The maximum number of days allowed is 365; the default is 0 days. If you attempt to enter a number greater than 365, the system displays the warning message: *Error: Entry out of range!*.

8. BD CHARGE DELETE TRANSACTION CODE (4-N-R)
This field specifies the transaction code to record in the transaction history once detail charges are purged. The transaction type is M. Enter the transaction code.

9. CARRIER PAY DAYS (4-N-R)
This field contains the number of days, from 1 to 9999, after the claim is denied or completely paid before an account's claim data is purged and archived from the system. At this point, a claim form cannot be reprinted. However, basic claim information is retained, and payments/adjustments can be posted to archived claims. Claims are archived and purged by running the Claim Archive and Purge functions on demand. For more information, refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

10. CLAIM END DISCH DATE (DATE-O)
This field defines the claim ending discharge date. This date must be defined to initiate a claim archive process. If the date is not defined and a user attempts to archive a claim, the system displays the following error message:

Error: Claim Ending Discharge Date not defined in Data Retention Parameters

11. MAX CLAIMS (5-N-R)
This field identifies the maximum number of claims that the system can archive at a time. Entry options are a number from 0 through 99999 or U for unlimited; the default is U. When the system archives claims, it checks this number during the process. The system does not archive more than this number of claims, even if additional claims are eligible to be archived.

NOTE: Claims that are not archived due to the setting of this parameter are not reported.

12. DISP CLAIMS? (DISPLAY ONLY)
This field indicates whether claims are dispositioned during the next archive run. The field contains the value of *Yes* if you selected and answered *Yes* to the following prompt on the Disposition Claims - Account Archive Select function under the Purge/ Other Archive Options menu:

Do you wish to disposition claims during the next archive run? (Y/N) [N]--
Facility-- Model Hospital A

For more details, see "Disposition Claims - Account Archive Select" on page 2-301.

13. FPI MONTHS (2-N-R)
This field specifies the number of months an account is retained in the FPI after it has been archived. This field is not currently used.

14. CONTRACT CHARGE DELETE DAYS (2-N-R)
This field contains the number of days charges should be maintained on the system after a contract transfers to location AR and the contract balance equals zero. The valid ranges are 0 through 99. No audit of transaction is maintained after the information is purged.

15. RETAIN GUARANTOR PAYMENT HISTORY (4-N-R)
This field specifies whether to retain the guarantor payment history. Enter **N** for No, or press ENTER (No is the default) to continue to delete payment information. Enter **Y** for Yes, and the archive and purge process does not delete payment history. If you enter Y, you are given the following prompt:

Enter number of days to retain payment information --

Valid entries are 0 - 9999.

NOTE: 9999 is more than 27 years, so be careful in setting the number of days to retain.

When Midnight Processing runs nightly, all previously purged accounts are evaluated to determine if payment history exists. If payment history exists and the account was purged prior to the maximum number of retention days, the system purges payment

information. If you enter 0 for the number of retention days, data is retained until the next Midnight Processing run. Then the system purges the payment history that night.

NOTE: It is important not to keep changing the value of this field from Yes to No. Once the payment information has been purged from the system, it is gone and cannot be retrieved. Payment history information is still archived when the account is archived. This only affects purging the data.

If a purged account is added back to AR or BD, any payment history that was retained during the original purge process does not move back to the account. The retained history can still be viewed in Guarantor Payment History until it is purged. This information is purged based on the latest account purge delete.

16. SQL TRAN HIST INDEX (4-N-R)

This field determines whether the SQL Transaction History indices are created, the number of days the additional indices are to be maintained on the system, and the type of indices that are created. If the field is left blank, the system does not create an index. Since the screen is facility-specific, the parameter can be defined differently for different facilities (if applicable). The prompts that are displayed when you access this field can differ, depending on whether you are accessing the field for the first time, updating the field, or resuming the process after pausing. See each scenario as follows:

First Time Accessing the Field

When you access the field for the first time, the following prompt is displayed:

Do you want to activate the SQL Transaction History index (Y/N) [Y] --

If this prompt is answered with No or ENTER is pressed, the system returns to the prompt:

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

If this prompt is answered with Yes, the following prompt displays:

Enter number of days to retain SQL index (1/9999) --

If this prompt is answered with a period (.) ENTER, the system returns to the prompt:

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

If the number of days is entered, the following prompt is displayed:

Create a (T)ransaction date, (P)osting date or (B)oth indices (T/P/B) [T] --

Depending on whether you respond with a T (transaction date), P (posting date), or B (both transaction and posting date), one of the following prompts is displayed, upon accepting the screen:

Build SQL Post Date Index and SQL Tran Date index? (Y/N)

Build SQL Tran Date Index? (Y/N)

Build SQL Post Date Index (Y/N)

If the prompt is answered with a Y, a conversion program begins creating/deleting the index(s). For information on the next prompt displayed, see "Revising/Deleting/Adding Financial Class Exceptions" on page 2-99.

Updating the Field, Starting or Stopping the Build

The following chart shows other prompts that are displayed when you take actions such as changing this field's values, stopping the index build process, or restarting the index build:

Action	Prompt Displayed
Change transaction type from one type to both types for the same number of days.	Change Transaction to Both: *Build SQL Post Date index? (Y/N*) Change Posting to Both: *Build SQL Tran Date index? (Y/N)*
Increase number of days in the process	Transaction only: *Add xxx days to SQL Tran Date index? (Y/N*) Posting only: *Add xxx days to SQL Post Date index? (Y/N*) Both: *Add xxx days to SQL Post Date index and SQL Tran Date index? (Y/N)*
Decrease number of days in the process	Transaction only: *Remove xxx days from SQL Tran Date index? (Y/N)* Posting only: *Remove xxx days from SQL Post Date index? (Y/N)* Both: *Remove xxx days from SQL Post Date index and SQL Tran Date index? (Y/N)*
One index does not exist and the other has an increase in number of days	Posting exists and Transaction created: *Build SQL Tran Date index, and add xxx days to SQL Post Date index? (Y/N*) Transaction exists and Posting created: *Build SQL Post Date index, and add xxx days to SQL Tran Date index? (Y/N*)

Action	Prompt Displayed
Both indices exist but only one index will be maintained with a reduction of days	Both to Transaction only: *Delete SQL Post Date index, and remove xxx days from SQL Tran Date index? (Y/N)* Both to Posting only: *Delete SQL Tran Date index, and remove xxx days from SQL Post Date index? (Y/N)*
Both indices exist and only one index will be maintained with no change in days.	Both to only Transaction: *Delete SQL Post Date index? (Y/N)* Both to only Posting: *Delete SQL Transaction Date index? (Y/N)*
The process is restarted	After stopping the process and going back into the Data Retention Parameter screen, field 12 displays: **Yes/9999/B STOPPED**. The following prompt is displayed: *Prior index build has been stopped, would you like to restart? (Y/N) [N]*. A response of No or pressing ENTER does not restart the process. A response of Yes results in the following prompt: *Are you sure you want to restart below index build? (Y/N) Build SQL Post Date index and SQL Tran Date index.* If the response is Yes, the system starts building the indices where it left off when the process was stopped. If the process aborted for any reason, such as the job is zapped, you have the option to restart the process. The Data Retention Parameter screen reflects the process aborted and displays the following prompt when accessing field 12: *Prior index build has been aborted , would you like to restart? (Y/N) [N] -- .*
The process is stopped.	When field 12 (SQL Tran Hist Index) on the Data Retention Parameter screen is accessed, the following prompt is displayed: *Index build currently running, would you like to stop? (Y/N) [N] -*. If the answer is Yes, the index build is halted. If the prompt is answered with a No, no change in processing occurs. If the prompt is completed with a Y and the process stopped on its own (for example, the process completed prior to accepting the screen), the following message displays: *Unable to stop index build at this time*. When the process is stopped for a second time, the following prompt displays: *Are you sure you want to stop below index build? (Y/N) Y* Build SQL Post Date index and SQL Tran Date index

Action	Prompt Displayed
The Process is stopped and the index(s) are to be deleted	When the screen is reentered, field 12 (SQL Tran Hist Index) is completed with "Yes/9999/B STOPPED". When accessing the field, the following prompt displays: *Prior Index build has been stopped, would you like to restart? (Y/N) [N]--*. Completing the prompt with N results in the following prompt: D*o you want to activate the SQL Transaction History Index? (Y/N) [Y]*. Responding with a N results in the following prompt: *Delete SQL Post Date index and SQL Tran Date Index" (Y/N)*. A response of Y deletes the index(s) built prior to being stopped. The last prompt reflects the index(s) built rather than both as per the example prompt.
The Index(s) are requested to be deleted	The prompt to delete is displayed: *Delete SQL Tran Date index? (Y/N).* If the response is Y, the system deletes any index present on the system (transaction and posting).

17. SERVICE LINE INFO DAYS (2-N-O)
This field contains the number of days to retain the service line information. When this field is accessed, the following prompt is displayed:

Enter the number of days after approval that insurance cash batch service line information will be available [5]--

The default is five days. You can enter up to 99 days to retain the service line information.

18. SQL CHARGE POSTING INDEX (1-A-O)
This field is used to define whether the SQL charge index process is active and the number of days the system should retain the index.

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

Do you want to activate the SQL Charge Posting index? (Y/N) [Y]

You can enter **N** (No) to exit the field or **Y** (Yes) to activate the index. If you enter Yes, the following prompt is displayed:

Enter number of days to retain SQL index (1/9999) --

You can enter a number of days from 1 to 9999. After the number of days is defined, the value is displayed in the field. When you exit the field, the following prompt is displayed:

Add xxx days to SQL Charge Posting Index? (Y/N)

You can enter **Y** (Yes) to initiate the index build. If you initiate the build, the following messages are displayed:

Parameters Filed

Index build/delete started

While the index is building, the field contains a status of Running. If you access the field before the index build completes, the following prompt is displayed:

Index build currently running, would you like to stop? (Y/N) [N]

You can enter **N** (No) to continue the process or **Y** (Yes) to stop the process. If you enter Yes, the following message is displayed:

Index build/delete flagged to stop

If the process was previously stopped, the following prompt is displayed.

Prior index build has been stopped, would you like to restart? (Y/N) [N]

You can enter **Y** (Yes) to restart the build or **N** (No) not to restart the build. If you enter Yes, the following prompt is displayed:

Are you sure you want to restart below index build? (Y/N)

If you enter **Y** (Yes), the following messages are displayed:

Add xxxx days to SQL Charge Posting Index

Index build/delete restarted

19. REMITTANCE DATA DAYS (3-N-O)
This field is used to define the number of days that remittance data is retained on the system. When this field is accessed, the following prompt is displayed:

Enter the number of days after zero account balance that remittance data will be available.

You can enter the number of days, from **1** to **999**, to keep this data (after the account reaches a zero balance) before purging. However, if the account is archived before the number of days are met, the remittance detail is purged.

NOTE: The remittance data is not purged if the claim is currently in the appeal process. The account must also be in location AR.

The Remittance Data purge runs via Optional Batch Job 125, ERA Data Purge.

20. STOP TIME FOR ERA REMIT PURGE (5-N-R)
This field is used to define a stop time for Optional Batch Job 125, ERA Data Purge. The ERA Data Purge can use many system resources and slow the system. You can use this field to decide when to finish the job. When the job runs again, it picks up where the job last stopped.

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

Enter the stop time for the purge of ERA remittance data [11:00P]

You can enter the stop time in military time.

21. UNAPPLIED CASH LOG (1-A-O)
This field determines the retention of information in the Unapplied Cash Log. You select whether the system uses the received, payment, or post date for purging entries in the cash log and select the number of days after the selected index date the system is to purge the entries. When an entry is purged, the three date indexes for the entry are purged, making the information no longer available.

An item is purged when the index date selected in the first prompt precedes or equals the date of midnight processing and the following calculation produces a number equal to or greater than the number of days selected in the second prompt:

Midnight Processing Date minus the index date

When you access this field, the system displays the following prompt:

Use (R)eceived, P(A)yment, or P(O)st date for purging?--

Enter **R** for received date, **A** for payment date, or **O** for post date.

After you enter your selection, the system displays the following prompt:

Enter number of days after selected date to purge items from log-- |

Enter a number between 0 and 9999 to define the number of days after the selected index date to purge items from the log.

The system displays the type of date to use for purging, a slash (/), and the number of days you entered.

22. RETAIN PYMT/ADJ DETAIL AFTER BATCH POSTING (4-N-O)
Information from cash and adjustment batches is retained for the number of days indicated in this parameter in a separate global for SQL reporting. This parameter must be completed before batches can be retained for SQL/Vista reporting.

The prompt for the parameter is as follows:

Enter number of days after cash/adjustment batch posts to retain batch information or key N to not save--

Revising/Deleting/Adding Financial Class Exceptions

Financial class and patient type exceptions enable the hospital to establish different retention parameters for different payors.

Once the fields of the Data Retention parameter are completed, you have the option to edit or accept the screen. Accepting the screen completes this part of the transaction and establishes the parameter in the system.

You now have the option of revising and adding financial class exceptions to the parameter entered and also adding patient type exceptions within the financial classes selected. The transaction flow is:

1. Revise financial class exceptions already entered in the system.
2. Add new patient type exceptions to the revised financial classes.
3. Add new financial class exceptions to the parameter.
4. Add patient type exceptions to the new financial classes selected.

The exception screen allows you to make changes to the Archive Days, FPI Months, and Carrier Pay Days fields.

To revise financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial class exceptions assigned to this parameter.
- Select the financial class(es) you want to edit. The system displays the same screen used in completing the Data Retention Parameters with the fields completed for the financial class selected. Each financial class selected is displayed in order.
- Edit the fields as necessary, and accept the screen to complete the transaction.

To delete financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial class exceptions assigned to this parameter.
- Select the financial class(es) to remove by entering them in this format: -1, -1-3, etc., following the instruction provided by the prompt at the bottom of the screen.

To add financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial classes.
- Select the financial class(es) you want to add. The system displays the Data Retention Parameters screen again, with the fields blank for each financial class selected.
- Complete the fields as necessary, and accept the screen to complete the transaction.

To add or edit patient type exceptions within financial class:

- Select the financial class to add or edit its patient type exceptions.
- Respond **Y** for Yes to the prompt. The system displays a list of patient types.
- Select the patient type(s) you wish to add or edit. The system displays the Data Retention Parameters screen again.
- Modify the parameter fields if necessary, and accept the screen to complete the transaction.

Balance Designation Parameters

This parameter is used during insurance cash posting to indicate how the outstanding carrier balance remaining after a final carrier payment should be handled. Financial class exceptions and patient type within financial class exceptions can be also be entered.

The functionality of the Balance Designation Parameters is similar to the Time Out Parameters described later in this chapter. In each case, the system can transfer carrier liability to either another carrier or to the patient and change the financial class assigned. The hospital can set these parameters with the same data or separate data. If they are set up with the same data, all system-generated carrier liability transfers function in the same way.

Automatic balance transfers and financial class changes look to see if the following conditions apply before processing a balance transfer on prorated accounts:

- The payment from a carrier must be flagged as a final payment. (For Canadian OHIP claims, final payment is determined when all claim charge detail lines have been paid or adjusted.)
- Expected number of payments must be zero to transfer money off a carrier. The system expects a payment for each cycle, final, and late claim loaded; therefore, if the carrier received a cycle and a final claim, the system expects two payments. Adjustment claims do not increment expected number of

payments since they replace the final claim, and EP was already incremented with the final claim.

- Expected number of payments must be greater than zero to transfer money to a carrier. Expected number of payments is decremented for each cycle, final, late, and adjustment claim dispositioned as Final Payment, Adjusted to Zero, or Denied through Cash Posting, Adjustment Posting, or the Balance Transfer Claim Disposition function.

- If the insurance you are transferring *from* is set to Include Pro Fees in the Basic Coverage screen of the insurance, the plan will transfer *to* the next carrier that meets the Claim Type field that is set to either Include, Exclude, or Only include pro fees.

- If the insurance you are transferring *from* is set to Exclude Pro Fees in the Basic Coverage screen of the insurance, the plan will transfer *to* the next carrier that meets the Claim Type field that is set to either Include or Exclude pro fees. For example, if the Claim Type field is set to No, meaning transfer regardless of claim type, if the COB 1 plan is a UB plan set to Exclude Pro Fees, the COB 2 plan is a 1500 plan set to Only pro fees, and COB 3 is a UB plan set to Include pro fees, if COB 1 makes a final payment, the system does a balance transfer from COB 1 to COB 3. The system skips over COB 2 not because it is a 1500 plan, but because it Only covers pro fees. If COB 2 was set to Include pro fees, the system would have transferred to COB 2.

- If the insurance you are transferring *from* is set to Only Pro Fees in the Basic Coverage screen of the insurance, the plan will transfer *to* the next carrier that meets the Claim Type field that is set to either Include or Only pro fees. For example, if the Claim Type field is set to No, meaning transfer regardless of claim type, if the COB 2 plan is a 1500 plan set to Only Pro Fees, the COB 3 plan is a UB plan set to Exclude pro fees, and COB 4 is a UB plan set to Include pro fees, if COB 2 makes a final payment, the system does a balance transfer from COB 2 to COB 4. The system skips over COB 3 not because it is a UB plan, but because it Excludes pro fees. If COB 3 was set to Include or Only pro fees, the system would have transferred to COB 3.

- The system does not do a balance transfer if the account is still in the PA (not AR) file.

- The system does not do a balance transfer if a final payment is posted to an insurance carrier where the overall account balance is a credit amount.

- If there is any other insurance liability on another carrier for the account, the balance transfer can still occur if it meets the above conditions, but the financial class change does not occur. This enables the financial class to not change to self pay while there is still insurance pending.

For example, if the hospital uses proration, and the primary insurance receives a payment, then the remaining balance would probably be transferred to the next carrier. For a hospital that does not prorate, the remaining balance is sent to the patient because additional carriers assigned to the account have already been billed for 100% of the charges. In both cases, the patient's financial class may change.

```
       General Hospital Balance Designation Parameters Processor
                                                  Fri May 30, 2010 02:27 pm
Model Hospital A

1 Transfer Liability To  2 Claim Type   3 Transfer Transaction Code
   Next Carrier             Yes           B0001-Bal Transfer After Insur Pymt
 4 New Financial Class                   5 FC Change Transaction Code
   S2-PATRICE'S SELF PAY                   M0002-FINANCIAL CLASS CHANGE W/O RE
 6 Use Ins Financial Class?              7 Ins FC Change Transaction Code
   No
 8 Clear Balances  9 Xfer to Pat AB<=0  10 Bal FC Update Of AR F/U
   No               Report                Yes/Leave at AR Agency F/U
              ZERO INSURANCE LIABILITY FOLLOW-UP FOR GUARANTOR
11 Guarantor Follow-Up Type             12 Guarantor Follow-Up Message Code
   Detail Statement                        1 DETAIL STATE 1ST STATEMENT
13 Agency Follow-Up Type(int/ext)       14 Agency Follow-Up Message Code
   Letter                                  4 collection letter (Review)
15 CCI Follow-Up Type                   16 CCI Follow-Up Message Code
   Detail Statement                        5 DETAIL STATE PARTIAL PAY
17 Zero Insurance Follow-Up Day Range
   1

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

Field Explanations

1. TRANSFER LIABILITY TO (1-A-R)

This field determines who is responsible for the unpaid insurance liability on this account when the payment is posted as final and a residual balance remains. Optional entries are **C** (the next carrier) or **P** (the patient). If C is entered, the unpaid insurance liability is transferred to the next insurance for this account. Once the benefits of the plan(s) associated with this account are exhausted, remaining liability is transferred to the patient. If you enter the carrier and the account does not have additional insurance, then the system transfers the remaining balance to the patient.

2. CLAIM TYPE (1-A-R)

This field determines whether the system should only transfer balances resulting from insurance cash posting to carriers of the same claim type classification. Entry options are **Y** for Yes or **N** for No; the default is Y.

If you enter N to this field, the system transfers balances resulting from insurance cash posting to the next COB if it passes all of the conditions outlined above. If you enter Y to this field, the system checks the claim type when transferring balances between carriers. As such, if COB 1 is a UB claim type, COB 2 is a 1500 claim type, and COB 3 is a UB claim type, then when a payment is posted from COB 1 the system transfers any remaining balance to COB 3 and not COB 2, since COB 2 is a different claim type classification.

You can only access this field if you entered C (next carrier) to the Transfer Liability To field.

3. TRANSFER TRANSACTION CODE (4-N-R)
This field contains the transaction code recording the liability transfer in the account's transaction history. The transaction type is B (balance transfer). You can enter the code or enter a hyphen (-) to select from a list of codes.

4. NEW FINANCIAL CLASS (4-N-R)
This field contains the self-pay financial class assigned to this account if liability is transferred to the patient. You have the option of entering a new financial class code or leaving this field blank to retain the code originally assigned to this account at admission or registration. You can enter the code or enter a hyphen (-) to select from a list of codes. Changing the financial class in this field does not reclassify revenue. While the system provides the ability to change an account's financial class, doing so is based on individual hospital procedures.

NOTE: The financial class does not change until all insurance liability has been met.

5. FC CHANGE TRANSACTION CODE (4-N-R)
This field contains the transaction code used to update this change in financial class in the account transaction history. If the New Financial Class field is left blank, this field should also be left blank. The transaction type is S. You can enter the code or enter a hyphen (-) to select from a list of codes.

6. USE INS FINANCIAL CLASS? (1-A-R)
This field determines if the financial class should change to the financial class of the current insurance on an account after a final carrier payment. The current insurance on an account is the insurance with the highest COB that has a balance. Entry options are **Y** for Yes or **N** for No. The default is No.

7. INS FC CHANGE TRANSACTION CODE (4-N-R)
This field contains the transaction type and code identifying the current insurance financial class change. You can enter a transaction type and code directly into the field, or you can enter a hyphen (-) and select one from the table lookup. The transaction type is M.

8. CLEAR BALANCES? (1-A-R)
This field indicates whether the system should clear off-setting debits and credits when the account balance goes to zero due to cash or adjustment postings. Enter **Y** for Yes to clear all balances if a payment or adjustment brings an account balance to zero. The default is Yes. Enter **N** for No if an off-setting dollar amount remains in the insurance and/or patient balance fields. The balance is not cleared when the account balance is brought to zero due to a payment or adjustment.

9. XFER TO PAT AB<=0 (1-A-R)
This parameter is used to allow balance transfers (for AR accounts only) if the overall account balance is a credit, but the insurance balance is not a credit. The parameter

directs the system as to how to handle an account with a remaining insurance balance when the following criteria are met:

- AB<=0
- Disposition for the claim for the activity (payment or adjustment) is a final
- Disposition for other remaining claims for all insurances listed on the account is final
- Account is not in location PA
- Third Party Excess is zero

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

Enter (R eport Only, (T)ransfer/Report, or Do (N)ot Transfer balance to patient if non-PA account, AB<=0, and all claims marked as paid? ---

Your entry options are:

- **R (Report only)** - If the account balance is <=0 and all other criteria for the money to be transferred are met when the payment or adjustment is posted, the transaction is reported on the Accounts with Insurance Balance > Zero and Account Balance <=0 report (FAR170).
- **T (Transfer/Report)** - If the account balance is <=0 and all other criteria for the money to be transferred are met when the payment or adjustment is posted, the insurance balance is transferred to the patient and the transaction is printed on the Accounts with Insurance Balance > Zero and Account Balance <=0 report (FAR170). The assumption here is that once all insurance claims have been final dispositioned, it appears the patient paid too much at the time of service. This money is transferred to the patient so a refund can be issued.
- **N (Do Not Transfer) -** The insurance balance is not transferred to the patient even if the account balance is <=0 and all other criteria for the money to be transferred are met when the payment or adjustment is posted, and the account is not included on the Accounts with Insurance Balance > Zero and Account Balance <=0 report (FAR170).

10. BAL FC UPDATE OF AR F/U (1-A-R)

This field determines if guarantor follow-up information is updated when a financial class change occurs as a result of the settings on the Balance Designation Parameters or the financial change function on the Balance Transfer Processor. The patient types associated with the accounts must be defined as patient type exceptions on the Financial Class table for the automatic update of follow-up information to occur. If an account's new financial class is defined as a patient type exception on the financial class table, the system reassigns the patient's AR follow-up schedule and collector. It

changes the schedule type to separate, the next follow-up step to 1, and the next follow-up date is recalculated using the wait days in the new follow-up schedule. when this field is accessed, the following prompt is displayed:

Update AR F/U when FC changes? Y/N [N]--

Entry options are **Y** for Yes and **N** for No. When this field is completed with a Y for Yes, the system updates AR Follow-up when a financial class changes as a result of the settings on the Balance Designation Parameters or the financial class change function on the Balance Transfer Processor. When this field is completed with an N for No, the system does not update AR Follow-up when a financial class changes as a result of the settings on the Balance Designation Parameters or the financial class change function on the Balance Transfer Processor.

If you entered Yes at the first prompt, the following prompt is displayed:

Remove from AR Agency F/U? Y/N [N]--

If you enter **N** (No), the system does not remove the account for AR agency follow-up. This applies to internal and external AR, but does not apply to CCI agency types. If you enter **Y** (Yes), the system updates the account's follow-up information if the TO financial class has the account's patient type set up as an exception and the TO financial class has a different follow-up schedule and/or collector assignment (Collector Group Assignment). If the account is removed from external collections during the next Midnight Processing, the collection agency receives a delete message for the account.

The field contains the value *Remove from Agency Collect* if you entered No at the prompt or the value *Leave at Agency Collect* if you entered Yes at the prompt.

11. GUARANTOR FOLLOW-UP TYPE (1-A-N)
This field contains the code identifying the follow-up that is sent at the time an insurance payment or adjustment results in no insurance liability for any of the insurances associated with an account. If this field is blank, then no follow-up is generated when the insurance liability becomes zero.

12. GUARANTOR FOLLOW-UP MESSAGE CODE (3-N-R)
This field determines which message prints on the follow-up specified in the Guarantor F/U Type field. You can enter a code or a hyphen (-) to display a list of valid codes. The list of valid codes is dependent on what type of Guarantor F/U Type was specified. For example, Letter Follow-Up Types display collection letter message code and detail statement message codes display detail statement message codes.

13. AGENCY FOLLOW-UP TYPE (1-A-N)
This field contains the code identifying the agency follow-up that is sent at the time of final insurance payment if there is no outstanding insurance liability for any of the insurances associated with an account. If this field is blank, no follow-up is generated

when the insurance liability becomes zero. This pertains to internal and external agency collection accounts, excluding accounts assigned to a CCI-type agency.

14. AGENCY FOLLOW-UP MESSAGE CODE (3-N-R)
This field determines which message prints on the follow-up specified in the PC F/U Type field. You can enter a code or a hyphen (-) to display a list of valid codes. The list of valid codes is dependent on what type of Guarantor F/U Type is specified. For example, Letter Follow-Up Types display collection letter message code, and detail statement message codes display detail statement message codes.

15. CCI FOLLOW-UP TYPE (1-A-N)
This field contains the code identifying the follow-up that is sent at the time of final insurance payment if there is no outstanding insurance liability for any of the insurances associated with an account. If this field is blank, then no follow-up is generated when the insurance liability becomes zero for accounts that are at CCI Collection.

16. CCI FOLLOW-UP MESSAGE CODE (3-N-R)
This field determines which message prints on the follow-up specified in the CCI F/U Type field. You can enter a code or a hyphen (-) to display a list of valid codes. The list of valid codes is dependent on what type of CCI F/U Type was specified. For example, Letter Follow-Up Types display collection letter message codes, and detail statement message codes display detail statement message codes.

17. ZERO INSURANCE LIABILITY FOLLOW-UP DAY RANGE (2-N-N)
The field contains the number of days from zero insurance liability that the system should not produce zero insurance liability follow-up. The system checks the next schedule guarantor follow-up date, and if this date is within the zero insurance liability follow-up range, then the system does not produce the zero insurance liability follow-up. For example, if this field is set to 10, and the zero insurance liability date was 9/1, the system would verify there was not a guarantor follow-up scheduled to be produced between 9/1 and 9/10. If there was a guarantor follow-up scheduled to be produced on 9/9, then the zero insurance liability follow-up would not be produced.

Once you accept this screen, the collection letters and detail statements spool to the appropriate spoolfile. For example, no insurance liability follow-up is included for accounts in the guarantor spoolfiles for accounts in guarantor follow-up, and accounts at internal collection are included in the collection spoolfile. Follow-Up for accounts at CCI are included in the pre-collection spoolfile.

REVISING/DELETING/ADDING FINANCIAL CLASS EXCEPTIONS

Once the fields of the Data Retention parameter are completed, you have the option of editing and/or accepting the screen. Accepting the screen completes this part of the transaction and establishes the parameter in the system.

You now have the option of revising and adding financial class exceptions to the parameter entered and also adding patient type exceptions within the financial classes selected. The transaction flow is:

1. Revise financial class exceptions already entered in the system.

2. Add new patient type exceptions to the revised financial classes.

3. Add new financial class exceptions to the parameter.

4. Add patient type exceptions to the new financial classes selected.

The system uses the same basic screen for each of these transactions with the financial class and then the patient type exceptions displayed.

To revise financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial class exceptions assigned to this parameter.

- Select the financial class(es) you want to edit. The system displays the same screen used in completing the Balance Designation Parameters with the fields completed for the financial class selected. Each financial class selected is displayed in order.

- Edit the fields as necessary and accept the screen to complete the transaction.

To delete financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial class exceptions assigned to this parameter.

- Select the financial class(es) to remove by entering them in this format: -1, -1-3, etc., following the instruction provided by the prompt at the bottom of the screen.

To add financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial classes.

- Select the financial class(es) you want to add. The system displays the Balance Designation Parameters screen again, with the fields blank for each financial class selected.

- Complete the fields as necessary, and accept the screen to complete the transaction.

To add or edit patient type exceptions within financial class:

- Select the financial class to add or edit its patient type exceptions.
- Respond **Y** for Yes to the prompt. The system displays a list of patient types.
- Select the patient type(s) you wish to add or edit. The system displays the Balance Designation Parameters screen again.
- Modify the parameter fields if necessary and accept the screen to complete the transaction.

Refund Parameters

This parameter defines the edits the system performs for refunds and is used during refund processing. This parameter is split by facility.

NOTE: The system verifies a guarantor does not have other outstanding balances before a refund is issued. This information is contained in the Refund Exception report (FPREFEXC).

After selecting a facility and this option, this screen is displayed.

```
                General Hospital Refund Parameters Processor
                                                Wed Apr 22, 1998 09:47 am
General Hospital A
                          Carrier Refund Parameters
 1 Ins Bal?  2 Accnt Bal?  3 Prt Facility?  4 Acct Bal Cut-Off  5 Min Amount
   Yes         Yes                           $5,000,000.0         $20.00
 6 Refund Check Message                     7 Memo Transaction Code
   1-Insurance Refund                         M0010-CARRIER REFUND

                         Guarantor Refund Parameters
 8 Pat Bal?  9 Ins Bal?   10 Prt Facility?                    11 Min Amount
   Yes         Yes           Yes                                $5.00
12 Refund Check Message                    13 Memo Transaction Code
   6-GUARANTOR REFUND                         M0011-GUARANTOR REFUND
14 Process Checks?        15 Retry Days    16 Refund Check Format
   Yes                       3               HBOC Refund Check - B

                       Unapplied Cash Refund Parameters
17 Refund Check Message                    18 Transaction Code
   7-UNAPPLIED CASH                           J5000-UNAPPLIED CASH


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

Field Explanations

Carrier Refund Parameters

1. INS BALANCE (1-A-R)
This field specifies whether or not the insurance balance must cover the carrier refund for a refund to be issued. The options are **Y** for Yes or **N** for No. If the response is Yes,

the carrier refund cannot exceed the carrier balance. If the response is No, the carrier refund can exceed the carrier balance. The system uses this field as an online edit during the approval process; however, the system does not use this field in determining which accounts display for refund approval. For example, if this field is Yes and the carrier balance is less than the carrier refund, the system first displays an error message when you select the account and then proceeds to the approval screen. If you (A)pprove the refund, the system warns you that this account does not pass the balance criteria, and gives you the option to accept it anyway.

2. ACCOUNT BALANCE (1-A-R)
This field specifies whether the account balance must cover the carrier refund for a refund to be issued. The options are **Y** for Yes or **N** for No. If the response is Yes, the carrier refund cannot exceed the account balance. If the response is No, the carrier refund can exceed the account balance. The system uses this field to determine who gets selected for a refund. The system also uses this field as an online edit during the approval process. Accounts that do not pass the balance criteria display on the Refund Exception report (FPREFEXC) with a message *Refund Parms not met*. For example, if this field is set to Yes and the account balance is -$5.00 and the carrier balance is -$45.00, the account displays on the Refund Exception report with a message *Refund Parms not met*. The account can then be manually selected for a refund, but the system displays an error message when the account is first selected. If you (A)pprove the refund, the system warns you that this account does not pass the balance criteria, and gives you the option to accept it anyway.

3. PRT FACILITY? (1-A-R)
This field indicates whether the facility should be printed on the Guarantor refund check. Entry options are **Y** for Yes or **N** for No. The default is No.

4. ACCT BAL CUT-OFF AMT (9-N-R)
This field contains the maximum account balance to be eligible for a refund. The entry range is -$99,999.99 to $99,999.99. A debit or credit balance can be entered.

NOTE: This applies *only* to carrier refunds.

5. MIN AMT (9-N-R)
This field contains the minimum amount that can be refunded to a carrier, entered in a dollars and cents format. The system does not select carrier credit balances below this amount for a refund. This field is also the lower limit for insurance small balance write-offs. Insurance credit balances that are less than this amount are considered for an insurance small balance write-off.

6. REFUND CHECK MESSAGE (4-N-R)
This field contains the code and description of the message printed on a refund check stub sent to a carrier. This message is selected from the list of messages in the Refund Check Messages table, located in Financial Table Maintenance. You can override check messages on specific checks.

7. MEMO TRANSACTION CODE (4-N-R)
This field contains the transaction code recording this refund to a carrier in the account's transaction history. The transaction type is M (system memo). You can enter the code or enter a hyphen (-) to select from a list of codes.

Guarantor Refund Parameters

8. PAT BALANCE (1-A-R)
This field specifies whether the patient balance must cover the guarantor refund for a refund to be issued. The options are **Y** for Yes or **N** for No. If the response is Yes, the guarantor refund cannot exceed the patient balance. If the response is No, the guarantor refund can exceed the patient balance. The system uses this field to determine who gets selected for a refund. The system also uses this field as an online edit during the approval process. Accounts that do not pass the balance criteria display on the Refund Exception report (FPREFEXC) with a message *Refund Parms not met*. For example, if this field is set to Yes and the account balance is less than the guarantor refund, the account is displayed on the Refund Exception report with a message *Refund Parms not met*. The account can then be manually selected for a refund, but the system displays an error message when the account is first selected. If you (A)pprove the refund, the system warns you that this account does not pass the balance criteria and gives you the option to accept it anyway.

9. INS BALANCE (1-A-R)
This field is used to determine if all insurance liability must be satisfied before a refund is issued. The options are **Y** for Yes or **N** for No. If the response is Yes, the system does not display a guarantor account for a refund unless the carrier balance for the account is equal to zero. If the response is No, the system displays a guarantor account for a refund even if the insurance balance is not equal to zero.

10. PRT FACILITY? (1-A-R)
This field indicates whether the facility should be printed on the Guarantor Refund check. Entry options are **Y** for Yes or **N** for No. The default is No.

11. MIN AMOUNT (9-N-R)
This field contains the minimum amount that can be refunded to a guarantor, entered in a dollars and cents format. The system does not select guarantor credit balances below this amount for a refund.

NOTE: The amount entered to this field should correspond to the Small Balance Writeoff Amount in the Follow-Up Schedules.

12. REFUND CHECK MESSAGE (4-N-R)
This field contains the code and description of the message printed on a refund check sent to a guarantor. The message is selected from the list of messages in the Refund Check Messages table, located in Financial Table Maintenance. You can override check messages on specific checks.

13. MEMO TRANSACTION CODE (4-N-R)
This field contains the transaction code recording this refund to a guarantor in the account's transaction history. The transaction type is M (system memo). You can enter the code or enter a hyphen (-) to select from a list of codes. The transaction code used to indicate the approval or deletion of the refund is loaded from the patient's financial class.

14. PROCESS CHECKS? (1-A-R)
This field is used to determine if any eligible refund checks are to be processed by the Patient Accounting system. The options are **Y** for Yes or **N** for No with a default entry of N. Enter **Y** in this field if the hospital has the PA portion of STAR Financials, but not Accounts Payable. Enter **N** if the hospital has STAR Financials Accounts Payable and processes refund checks through Accounts Payable.

15. RETRY DAYS (3-N-R)
This field contains the number of days to wait before an account deleted from the refund file can be again selected for a refund if it still meets the refund selection criteria.

16. REFUND CHECK FORMAT (3-N-R)
This field specifies the print format for the refund check. This format controls the print layout of the check and check remittance. Enter the code, or enter a hyphen (-) to select from a list of codes. McKesson defines these formats during implementation.

NOTE: Do not change this field without first consulting McKesson.

Unapplied Cash Refund Parameters

17. REFUND CHECK MESSAGE (4-N-R)
This field contains the code and description of the message printed on a refund check for Unapplied Cash. Enter the default message code, or enter a hyphen (-), and select one from the table. These codes are defined by the user.

18. TRANSACTION CODE (4-N-R)
This field contains the transaction code recording this Unapplied Cash refund. The transaction type is J. Enter the default transaction code, or enter a hyphen (-) and select one from the table. These codes are defined by the user.

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

Insurance Time Out Parameters

The Insurance Time Out Parameters set guidelines for transfer of account liability from the carrier when the number of days allowed for carrier payment is exceeded.

Specifics include the transfer of account liability from the carrier, the change in the account's financial class, and the transaction codes used to record these events in this

account's transaction history. You can add and revise financial class exceptions to this parameter, as well as patient type exceptions within financial class.

Insurance time out and financial class changes look to see if the following conditions apply before processing a balance transfer:

- Expected number of payments must be zero to transfer money off a carrier. The system expects a payment for each cycle, final, and late claim loaded; therefore, if the carrier received a cycle and a final claim, the system expects two payments. Adjustment claims do not increment expected number of payments since they replace the final claim and EP was already incremented with the final claim.

- Expected number of payments must be greater than zero to transfer money to a carrier. Expected number of payments is decremented for each cycle, final, late, and adjustment claim dispositioned as Final Payment, Adjusted to Zero, or Denied through Cash Posting, Adjustment Posting, or the Balance Transfer Claim Disposition function.

- If the insurance you are transferring *from* is set to Include Pro Fees in the Basic Coverage screen of the insurance, the plan transfers *to* the next carrier that meets the Claim Type field that is set to either Include, Exclude, or Only include pro fees.

- If the insurance you are transferring *from* is set to Exclude Pro Fees in the Basic Coverage screen of the insurance, the plan transfers *to* the next carrier that meets the Claim Type field that is set to either Include or Exclude pro fees. For example, if the Claim Type field is set to No, meaning transfer regardless of claim type, if the COB 1 plan is a UB plan set to Exclude Pro Fees, the COB 2 plan is a 1500 plan set to Only pro fees, and COB 3 is a UB plan set to Include pro fees, if COB 1 makes a final payment, the system does a balance transfer from COB 1 to COB 3. The system skips over COB 2, not because it is a 1500 plan, but because it Only covers pro fees. If COB 2 was set to Include pro fees, the system would have transferred to COB 2.

- If the insurance you are transferring *from* is set to Only Pro Fees in the Basic Coverage screen of the insurance, the plan transfers *to* the next carrier that meets the Claim Type field that is set to either Include or Only pro fees. For example, if the Claim Type field is set to No, meaning transfer regardless of claim type, if the COB 2 plan is a 1500 plan set to Only Pro Fees, the COB 3 plan is a UB plan set to Exclude pro fees, and COB 4 is a UB plan set to Include pro fees, if COB 2 makes a final payment, the system does a balance transfer from COB 2 to COB 4. The system skips over COB 3, not because it is a UB plan, but because it Excludes pro fees. If COB 3 was set to Include or Only pro fees, the system would have transferred to COB 3.

- The system does not do a balance transfer if the account is still in the PA (not AR) file.

- If there is any other insurance liability on another carrier for the account, the balance transfer can still occur if it meets the above conditions, but the financial class change do not occur. This enables the financial class to not change to self pay while there is still insurance pending.

After selecting a facility and this option, the system displays this screen:

```
          General Hospital Insurance Time Out Parameters Processor
                                                Fri Apr 14, 2006 02:36 pm
Model Hospital A

 1 Transfer Liability To  2 Claim Type  3 Transfer Transaction Code
   Next Carrier             Yes           B0010-INSURANCE TIME OUT/TRANSF LIA
 4 New Financial Class                  5 FC Change Transaction Code
   S-SELF PAY                             M0002-FINANCIAL CLASS CHANGE W/O RE
 6 Timeout FC Update Of AR F/U
   Yes Exclude External PC Accts









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

Field Explanations

1. TRANSFER LIABILITY TO (1-A-R)
This field specifies who is responsible for the unpaid insurance liability on this account when the insurance follow-up reaches the end of the follow-up schedule and is denied. The options are C (next carrier) or P (patient). If C is entered, the unpaid insurance liability is transferred to the next insurance for this account, up through all plans on the account. Once the benefits of the plan(s) associated with this account are exhausted, remaining liability is transferred to the patient. If you enter the carrier and the account does not have additional insurance, the system transfers the remaining balance to the patient.

If P is entered, the unpaid liability is transferred to the patient. Generally, prorated accounts transfer the unpaid liability to the patient, whereas non-prorated accounts transfer the unpaid liability to the next carrier.

2. CLAIM TYPE (1-A-R)
This field determines whether the system should only transfer balances resulting from insurance time out to carriers of the same claim type classification. Entry options are **Y** for Yes or **N** for No; the default is Y.

If you enter N to this field, the system transfers balances resulting from insurance time out to the next COB if it passes all of the conditions outlined above. If you enter Y to this field, the system checks the claim type when transferring balances between

carriers. As such, if COB 1 is a UB-82 claim type, COB 2 is a 1500 claim type, and COB 3 is a UB-82 claim type, then when a payment is posted from COB 1 the system transfers any remaining balance to COB 3 and not COB 2, since COB 2 is a different claim type classification.

You can only access this field if you entered C (next carrier) to the Transfer Liability To field.

3. TRANSFER TRANSACTION CODE (4-N-R)
This field contains the transaction code recording the liability transfer in the account's transaction history. The transaction type is B (balance transfer). You can enter the code or enter a hyphen (-) to select from a list of codes.

4. NEW FINANCIAL CLASS (4-N-R)
This field contains the self-pay financial class assigned to this account if liability is transferred to the patient. You have the option of entering a new financial class code or leaving this field blank to retain the code originally assigned to this account at admission or registration. You can enter the code or enter a hyphen (-) to select from a list of codes. Changing the financial class in this field does not reclassify revenue. While the system provides the ability to change an account's financial class, doing so is based on individual hospital procedures.

5. FC CHANGE TRANSACTION CODE (4-N-R)
This field contains the transaction code used to update this change in financial class in the account transaction history. If the New Financial Class field is left blank, this field should also be left blank. The transaction type is S. You can enter the code or enter a hyphen (-) to select from a list of codes.

6. TIMEOUT FC UPDATE OF AR F/U (1-A-R)
This field determines if AR follow-up information is updated when a financial class change occurs as a result of the settings on the Insurance Time Out Parameters Processor. The patient types associated with the accounts must be defined as patient type exceptions for AR follow-up on the Financial Class table for the automatic update of follow-up information to occur for AR follow-up. The system uses the account’s new financial class to determine if a patient type exception for AR follow-up exists. The system reassigns the patient’s AR follow-up schedule and collector. It changes the schedule type to separate, the next follow-up step to 1, and the next follow-up date is recalculated using the wait days in the new follow-up schedule. When this field is accessed, the following prompt is displayed:

Update AR F/U when FC changes? Y/N [N]--

Entry options are **Y** for Yes and **N** for No. When this field is completed with a Y for Yes, the system updates AR Follow-up when a financial class changes as a result of the settings on the Insurance Time Out Parameters Processor. When this field is completed with an N for No, the system does not update AR Follow-up when a financial class changes as a result of the settings on the Insurance Time Out Parameters Processor.

If you entered Yes at the first prompt, the following prompt is displayed:

Remove from AR Agency F/U? Y/N [N]--

If you enter **N** (No), the system does not remove the account for AR agency follow-up. This applies to internal and external AR, but does not apply to CCI agency types. If you enter Y (Yes), the system updates the account's follow-up information if the TO financial class has the account's patient type set up as an exception and the TO financial class has a different follow-up schedule and/or collector assignment (Collector Group Assignment). If the account is removed from external collection during the next Midnight Processing, the collection agency receives a delete message for the account.

The field contains the value *Remove from AR Agency Follow-up* if you entered No at the prompt or the value *Leave at AR Agency Follow-up* if you entered Yes at the prompt.

REVISING/DELETING/ADDING FINANCIAL CLASS EXCEPTIONS

Once the fields of the Insurance Time-Out parameter are completed, you have the option of editing and/or accepting the screen. Accepting the screen completes this part of the transaction and establishes the parameter in the system.

You now have the option of revising and adding financial class exceptions to the parameter entered and adding patient type exceptions within the financial classes selected. The transaction flow is:

1. Revise financial class exceptions already entered in the system.

2. Add new patient type exceptions to the revised financial classes.

3. Add new financial class exceptions to the parameter.

4. Add patient type exceptions to the new financial classes selected.

The system uses the same basic screen for each of these transactions with the financial class and then the patient type exceptions displayed.

To revise financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial class exceptions assigned to this parameter.

- Select the financial class(es) you want to edit. The system displays the same screen used in completing the Balance Designation Parameters with the fields completed for the financial class selected. Each financial class selected is displayed in order.

- Edit the fields as necessary, and accept the screen to complete the transaction.

To delete financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial class exceptions assigned to this parameter.
- Select the financial class(es) to remove by entering them in this format: -1, -1-3, etc., following the instruction provided by the prompt at the bottom of the screen.

To add financial class exceptions:

- Respond **Y** for Yes to the prompt. The system displays a list of financial classes.
- Select the financial class(es) you want to add. The system displays the Balance Designation Parameters screen again, with the fields blank for each financial class selected.
- Complete the fields as necessary, and accept the screen to complete the transaction.

To add or edit patient type exceptions within financial class:

- Select the financial class to add or edit its patient type exceptions.
- Respond **Y** for Yes to the prompt. The system displays a list of patient types.
- Select the patient type(s) you wish to add or edit. The system displays the Balance Designation Parameters screen again.
- Modify the parameter fields if necessary, and accept the screen to complete the transaction.

Active Patient Worklist Control

This function enables you to set parameters for the online worklists for active patient (PA) accounts. Collector assignment based on financial class exception is allowed.

When you access this function, the system prompts you to enter a facility if this is a multifacility installation. The system then displays the following screen:

```
            General Hospital Active Patient Worklist Control Processor
                                                  Tue Jun 09, 1992 08:27 am
GENERAL HOSPITAL A

 1 Minimum Balance                    2 Payment Days
   $50.00 - Patient                     60
 3 Last Bill Sequence                 4 Telephone Follow-Up Transaction Code
   4                                    T9998-Series Telephone Follow-Up
 5 Excluded Patient Types
   AAA
 6 Excluded Financial Classes
   13,C
 7 Default Telephone Collector     8 Edit By               9 Edit Date
   1-Anderson,Amy                    Dewitt,Joyce L          05/22/92 0109pm
10 Last Name  Telephone Collector
   FZZ        11-Elllis,Janice
   MZZ        9-LEDBETTER,ARDEL
   ZZZ        13-LEDBETTER,MARCI



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

Field Explanations

1. MINIMUM BALANCE (11-NC-R)
This field contains the minimum balance to be considered for inclusion in the active patient account telephone workfile. This amount can be a dollar amount from 0 to 999,999,999.99.

After you enter an amount, the system displays the following prompt:

Use Patient (P) or Account (A) Balance [P]?--

Enter **P** or press ENTER to use the patient balance in creating the workfile. Enter **A** to use the account balance in creating the workfile. This enables you to set the balance to use in creating the workfile. For example, if you are primarily interested in monitoring series accounts, use the patient balance. If the primary focus for the workfile is active inpatient accounts, use the account balance. The system displays the amount and balance to use, for example $500.00 - Account or $500.00 - Patient. If this is a whole dollar amount, you do not need to enter the decimal.

2. PAYMENT DAYS (3-N-R)
This field contains the minimum number of days since the last payment date to be considered for inclusion in the active patient telephone workfile. Entry options are from 0 to 999.

NOTE: If no payment has been received, the system uses the admission date as the last payment date.

3. LAST BILL SEQUENCE (2-N-R)
This field contains the minimum bill sequence number to be considered for inclusion in the active patient telephone workfile. Entry options are from 0 to 99.

4. TELEPHONE FOLLOW-UP TRANSACTION CODE (4-N-R)
This field identifies the transaction code that updates account transaction history when the active patient telephone workfile entry is completed. Enter the number or use a hyphen (-) to display a table of transaction type T.

5. EXCLUDED PATIENT TYPES (TABLE SELECTION)
This field identifies the patient types that are excluded from the workfile. When you access this field, the system displays the patient type table. Select one or more patient type(s) to exclude from the workfile.

6. EXCLUDED FINANCIAL CLASSES (TABLE SELECTION)
This field identifies the financial classes that are excluded from the workfile. When you access this field, the system displays the financial class table. Select one or more financial class(es) to exclude from the workfile. The system displays *only* financial classes valid for this facility.

Financial classes that have been defined as an exception do not display in the table. To change a financial class from an exception to an exclusion, you must first delete the exception record. The financial class is then available from this field.

7. DEFAULT TELEPHONE COLLECTOR (TABLE SELECTION)
This field identifies the default collector to be assigned to this worklist. When you access this field, the system displays the collector table (including managers/ supervisors). Select a collector from the table. The system then displays the collector code and name in this field. There is no restriction in collector assignment; managers/ supervisors can be assigned as the default collector.

This field is required.

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

9. EDIT DATE (DISPLAY ONLY)
This field contains the date and time of the last edit to this table.

The remaining fields on this screen are in a scrolling screen. These fields enable you to define alphabetic categories, based on the patient last name, for active patient workfile telephone follow-up. This is used to divide the work by patient name up among the appropriate collectors.

These fields are optional. If no entry is made to these fields all active patient workfile entries will go to the default telephone collector.

10. LAST NAME (3-A-O)
This field identifies the ending alphabetic range for the last names of patients assigned to this collector. Enter up to three letters. For example, if the first entry in this field is GZZ, all patients with last names AAA-GZZ would be assigned to the collector identified in the Telephone Collector field.

TELEPHONE COLLECTOR (3-N-O)
This field identifies the collector to be assigned the patients whose last names match the criteria defined in the Last Name field. When you access this field, the system displays the collector table (including managers/supervisor). Enter a valid collector code or select a collector from the table. The system then displays the collector code and name in this field. There is no restriction in collector assignment; managers/ supervisors can be assigned as the default collector.

REVISING/DELETING/ADDING FINANCIAL CLASS EXCEPTIONS

Once the fields of the Active Patient Worklist Control parameters are completed, you have the option of editing and/or accepting the screen. Accepting the screen completes this part of the transaction and establishes the parameter in the system.

If financial class exceptions have been set for this parameter, the system then displays the following prompt:

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

If no financial class exceptions exist, the system instead displays:

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

Enter **Y** to revise and/or add financial class exceptions. Enter **N** or press ENTER to exit the processor. Financial class exceptions are used to make exceptions according to financial class, such as assigning Medicare accounts to a different collector (or collectors) than the rest of the accounts.

If you are revising financial class exceptions, the system displays a list of financial class exceptions assigned to this parameter. Select the financial class(es) you want to edit. The system displays the screen that follows, with the fields completed for the financial class selected. Each financial class selected is displayed in order.

If you are adding financial class exceptions, the system displays a table of financial classes. Select the financial class(es) for which you want to create exceptions. The

system displays the following screen, with all fields other than the Financial Class field blank. Each financial class selected is displayed in order.

```
          General Hospital Active Patient Worklist Control Processor
                                                 Tue Jun 09, 1992 12:46 pm
GENERAL HOSPITAL A

 1 Financial Class
    18 - MED
 2 Default Telephone Collector    3 Edit By                4 Edit Date
   1-Anderson,Amy                   DeWitt,Joyce M           05/22/92 0436pm
 5 Last Name  Telephone Collector
   ZZZ        9-LEDBETTER,ARDEL









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

Field Explanations

1. FINANCIAL CLASS (DISPLAY ONLY)
This field displays the financial class you selected earlier for which you are adding/ revising exceptions.

2. DEFAULT TELEPHONE COLLECTOR (TABLE SELECTION)
This field identifies the default collector to be assigned to this worklist exception. When you access this field, the system displays the collector table (including managers/ supervisors). Select a collector from the table. The system then displays the collector code and name in this field. There is no restriction in collector assignment; managers/ supervisors can be assigned as the default collector.

This field is required.

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

4. EDIT DATE (DISPLAY ONLY)
This field contains the date and time of the last edit to this table.

The remaining fields on this screen are in a scrolling screen. These fields enable you to define alphabetic categories, based on the patient last name, for exceptions for the selected financial class to normal patient workfile telephone follow-up. This is used to identify the collector meant to receive patients with the appropriate financial class and last name.

These fields are optional. If no entry is made to these fields, all active patient workfile entries for this financial class go to the default telephone collector.

5. LAST NAME (3-A-O)
This field identifies the ending alphabetic range for the last names of patients in the selected financial class assigned to this collector. Enter up to three letters. For example, if the first entry in this field is GZZ, all patients with last names AAA-GZZ in this financial class would be assigned to the collector identified in the Telephone Collector field.

TELEPHONE COLLECTOR (3-N-O)
This field identifies the collector to be assigned the patients whose last names match the criteria defined in the Last Name field and who have been assigned the selected financial class. When you access this field, the system displays the collector table (including managers/supervisor). Enter a valid collector code or select a collector from the table. The system then displays the collector code and name in this field. There is no restriction in collector assignment; managers/supervisors can be assigned as the default collector.

If you make no entries to this screen and press only ENTER, the system displays the following prompt:

Delete? (Y/N) [N]--

Enter **N** or press ENTER to exit the screen without deleting the financial class exception. Enter **Y** and the system displays the following prompt:

Are you sure? (Y/N) [N]--

Enter **N** or press ENTER to exit the screen without deleting the financial class exception. Enter **Y** and the system deletes the financial class message, displaying the following message:

Exceptions Deleted

If you make changes to this screen, the system asks you to accept your entries. Once the screen is accepted the following message is displayed:

Exceptions Filed

Cash Exception Reporting Parameters

This function enables you to determine which exceptions are included or excluded on the Cash Posting Exception report (FAR140) and the Guarantor Cash Posting Exception report (FAR145).

When you access this function, the system displays the following screen:

```
         General Hospital Cash Exception Reporting Parameters Processor
                                                 Wed Jun 02, 2010 12:23 pm


 1 Account Balance        2 Patient Balance        3 Carrier Balance
   Include    25%           Include    25%           Include    25%
 4 Pat Pymt Less Than Exptd              5 Ins Pymt Less Than Exptd
   Include    25%                      Include    25%
 6 Paid Claim         7 Paid DRG          8 Paid DRG+SOI
   Include              Include             Include
 9 No Bal Xfr Due to EP                  10 No Bal Xfr Due to Accnt Bal
   Include                                  Include
11 Day Outlier       12 Cost Outlier
   Include              Include
13 RA Adj Bal Xfr    14 Agency not BD
   Exclude              Include
15 Window Batch      16 Batch Total
   Include              Include




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

Field Explanations

1. ACCOUNT BALANCE (1-A-R)
This field is used to determine if a payment that exceeds the account balance should be included or excluded on the Cash Posting Exception report. For example, an account has a credit balance after a payment is posted. The specific exception message that is displayed on this report is *Payment amount exceeds account balance*.

When Account Balance is entered, the following prompt is displayed on your screen:

Include account balance exceptions? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**.

NOTE: If the Amount Balance field is defined as Exclude, then any cash payment that qualifies for this exception message is omitted from the Cash Posting Exception report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or press ENTER. The system then displays two additional prompts. The first prompt that is displayed is:

Enter variance percentage --

Enter the variance percentage from 0 to 100, or press ENTER to leave the variance amount blank. You do not have to enter the percentage sign (%). The variance percentage is displayed followed by the % sign. To be included on the report with this exception message, payments must exceed the account balance by this percentage.

The second prompt that is displayed is:

Enter variance amount --

Enter the variance amount from 0 to 999 in whole dollars, or press ENTER to leave the variance amount blank. You do not have to enter the dollar sign ($). The variance amount is displayed preceded by the dollar sign ($). To be included on the report with this exception message, payments must exceed the account balance by this amount.

If the Account Balance field is defined as Include, any cash payment that qualifies for this exception message is included on the Cash Posting Exception report if it meets the variance percentage or variance amount that you defined. If the variance percent and amount are blank, then the message is displayed on the report with any payment which qualifies for this exception. If both the variance percent and amount are completed, the payment is then included on the report if it falls within either range established. The percentage variance is checked first. If only one variance criteria is established, the payment must then meet that criteria to be included.

2. PATIENT BALANCE (1-A-R)

This field is used to determine if a payment that exceeds the patient balance should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Payment amount exceeds patient balance*. For example, a patient has a credit balance after a payment is posted.

When Patient Balance is entered, the following prompt appears on your screen:

Include patient balance exceptions? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**.

NOTE: If the Patient Balance field is defined as Exclude then any cash payment which qualifies for this exception message is omitted from the Cash Posting Exception report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or press ENTER. The system then displays two additional prompts. The first prompt that is displayed is:

Enter variance percentage --

Enter the variance percentage from 0 to 100, or press ENTER to leave the variance amount blank. You do not have to enter the percentage sign (%). The variance percentage is displayed followed by the percentage sign (%). To be included on the report with this exception message, patient payments must exceed the patient balance by this percentage.

The second prompt that is displayed is:

Enter variance amount --

Enter the variance amount from 0 to 999 in whole dollars, or press ENTER to leave the variance amount blank. You do not have to enter the dollar sign ($). The variance amount is displayed preceded by the dollar sign ($). To be included on the report with this exception message, payments must exceed the account balance by this amount.

If the Patient Balance field is defined as Include, any cash payment that qualifies for this exception message is included on the Cash Posting Exception report if it meets the variance percentage or variance amount that you defined. If the variance percent and amount are blank, then the message is displayed on the report with any payment which qualified for this exception. If both the variance percent and amount are completed, the payment is then included on the report if it falls within either range established. The percent variance is checked first. If only one variance criteria is established, the payment must then meet that criteria to be included.

3. CARRIER BALANCE (1-A-R)

This field is used to determine if a payment which exceeds the carrier should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Payment amount exceeds carrier balance*. For example, a carrier balance is a credit after a payment is posted.

When Carrier Balance is entered, the following prompt appears on your screen:

Include carrier balance exceptions? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**.

NOTE: If the Carrier Balance field is defined as Exclude then any cash payment which qualifies for this exception message is omitted from the Cash Posting Exception report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or press ENTER. The system then displays two additional prompts. The first prompt that is displayed is:

Enter variance percentage --

Enter the variance percentage from 0 to 100, or press ENTER to leave the variance amount blank. You do not have to enter the dollar sign ($). The variance percentage is displayed followed by the percentage sign (%). To be included on this report with this exception message, insurance payments must exceed the carrier balance by this percentage.

The second prompt that is displayed is:

Enter variance amount --

Enter the variance amount from 0 to 999 in whole dollars, or press ENTER to leave the variance amount blank. You do not have to enter the dollar sign ($). The variance amount is displayed preceded by the dollar sign ($). To be included on the report with this exception message, the insurance payment must exceed the carrier balance by this amount.

If the Carrier Balance field is defined as Include, any cash payment that qualifies for this exception message is included on the Cash Posting Exception report if it meets the variance percentage or variance amount that you defined. If the variance percent and amount are blank, then the message is displayed on the report with any payment which qualifies for this exception. If both the variance percent and amount are completed, the payment is then included on the report if it falls within either range established. The percentage variance is checked first. If only one variance criteria is established, the payment must then meet that criteria to be included.

If either the Variance Percentage or the Variance Amount field is blank only the criteria entered is used to determine if the account should be included on the Cash Posting Exception report. If both fields are blank, it is assumed then that the account should be included on the report regardless of the variance.

4. PAT PYMT LESS THAN EXPTD (1-A-R)

This field is used to determine if a payment that is less than expected should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Patient payment amount less than expected*. For example, the patient payment amount is less than the patient liability and the remaining patient balance is greater than zero.

When Pat Pymt Less Than Exptd is entered, the following prompt appears on your screen:

Include patient payments less than expected? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**.

NOTE: If the Pat Pymt Less Than Exptd field is defined as Exclude then any cash payment which qualifies for this exception message is omitted from the Cash Posting Exception report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or press ENTER. The system then displays two additional prompts. The first prompt that is displayed is:

Enter variance percentage --

Enter the variance percentage from 0 to 100, or press ENTER to leave the variance blank. You do not have to enter the percentage sign (%). The variance percentage is displayed followed by the percentage sign (%). To be included on the report with this

exception message, the patient payment must be less than the patient balance by this percentage.

The second prompt that is displayed is:

Enter variance amount --

Enter the variance amount from 0 to 999 in whole dollars, or press ENTER to leave the variance amount blank. You do not have to enter the dollar sign ($). The variance amount is displayed preceded by the dollar sign ($). To be included on the report with this exception message, the patient payment must be less than the patient balance by this amount.

If the Pay Pymt Less Than Exptd field is defined as Include, any cash payment that qualifies for this exception message is included on the Cash Posting Exception report if it meets the variance percentage or variance amount that you defined. If the variance percent and amount are blank, then the message is displayed on the report with any payment which qualifies for this exception. If both the variance percent and amount are completed, the payment is then included on the report if it falls within either range established. The percentage variance is checked first. If only one variance criteria is established, the payment must then meet that criteria to be included.

If either the Variance Percentage or the Variance Amount field is blank, only the criteria entered is used to determine if the account should be included on the Cash Posting Exception report. If both fields are blank, it is then assumed that the account should be included on the report regardless of the variance.

The variance is determined by the following calculation:

Amount owed less the amount paid equals the remainder.

If the remainder is greater than the zero and the exception message is set to include, then the amount is included. If a percentage or amount is entered, the system divides the remainder by the original amount, and if this amount is greater than the variance entered, the account is included on the exception report.

5. INS PYMT LESS THAN EXPTD (1-A-R)

This field is used to determine if an insurance payment that is less than expected should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Insurance payment amount less than expected.* For example, the insurance payment is less than the carrier liability and the remaining carrier liability is greater than zero.

When Ins Pymt Less Than Exptd is entered, the following prompt appears on your screen:

Include insurance payments less than expected? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**.

NOTE: If the Ins Pymt Less Than Exptd field is defined as Exclude then any cash payment which qualifies for this exception message is omitted from the Cash Posting Exception report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or press ENTER. The system then displays two additional prompts.

The first prompt that is displayed is:

Enter variance percentage --

Enter the variance percentage from 0 to 100, or press ENTER to leave the variance amount blank. You do not have to enter the percentage sign (%). The variance percentage is displayed followed by the percentage sign (%). To be included on the report with this exception message, the insurance payment must be less than the carrier liability by this percentage.

The second prompt that is displayed is:

Enter variance amount --

Enter the variance amount from 0 to 999 in whole dollars, or press ENTER to leave the variance amount blank. You do not have to enter the dollar sign ($). The variance amount is displayed preceded by the dollar sign ($). To be included on the report with this exception message, the insurance payment must be less than the carrier liability by this amount.

If the Ins Pymt Less Than Exptd field is defined as Include, any cash payment which qualifies for this exception message is included on the Cash Posting Exception report if it meets the variance percentage or variance amount that you defined. If the variance percent and amount are blank, then the message is displayed on the report with any payment which has this exception. If both the variance percent and amount are completed, the payment is then included on the report if it falls within either range established. The percentage variance is checked first. If only one variance criteria is established, the payment must then meet that criteria to be included.

If either the Variance Percentage or the Variance Amount field is blank only the criteria entered is used to determine if the account should be included on the Cash Posting Exception report. If both fields are blank, it is then assumed that the account should be included on the report regardless of the variance.

The variance is determined by the following calculation:

Amount owed less the amount paid equals the remainder.

If the remainder is greater than the zero and the exception message is set to include, then the amount is included. If a percentage or amount is entered, the system divides the remainder by the original amount and if this amount is greater than the variance entered, the account is included on the exception report.

6. PAID CLAIM (1-A-R)
This field is used to determine if payments made to paid claims should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Payment made to a paid claim*.

When Paid Claim is entered, the following prompt appears on your screen:

Include payments to paid claims? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments which meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments which meet this criteria are included this report.

7. PAID DRG (1-A-R)
This field is used to determine if a paid DRG that does not match the final DRG should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Paid DRG does not match final DRG*.

When Paid DRG is entered, the following prompt appears on your screen:

Include payments with DRG mismatch? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments which meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments which meet this criteria are included this report.

8. PAID DRG+SOI (1-A-R)
This field indicates whether payments can be included as an exception on FAR140x when processing ERA payments where CLP11 (DRG) in the ERA file contains an APR DRG and SOI when Paid DRG + SOI does not equal the Billed DRG + SOI. When this field is accessed, the following prompt is displayed:

Include payments with DRG+SOI mismatch? (Y/N)--

You can enter Y (Yes) to include payments with DRG+SOI mismatch.

This logic works only if the Excl SOI for DRG (CLP11) is set to Yes on the ERA Payment File Definition table, indicating that the DRG and SOI returned in CLP11 (DRG) are separated.

9. NO BAL XFR DUE TO EP?(1-A-R)
This field is used to determine if insurance payments that do not result in a balance transfer due to the carrier's number of expected payments should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *No balance transfer - Expected payments greater than one*.

When No Bal Xfr is entered, the following prompt appears on your screen:

Include no balance transfer due to EP? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

10. NO BAL XFR DUE TO ACCNT BAL (1-A-R)
This field indicates whether to include accounts on the FAR140 report, if they meet the following criteria:

- Payment is marked as final
- Insurance balance is not zero after the payment is posted
- Account is not in PA
- Account Balance <=0
- Third Party Excess may or may not be zero
- Insurance may or may not have remaining expected insurance payments

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

Include no balance transfer due to account balance? (Y/N) [Y]-

If Yes is selected, the account is inluded on the FAR140 report with the following message:

No balance transfer - Account Balance is 0 or less

11. DAY OUTLIER (1-A-R)
This field is used to determine if day outlier payments should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Day outlier*.

When Day Outlier is entered, the following prompt appears on your screen:

Include day outlier payments? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

12. COST OUTLIER (1-A-R)
This field is used to determine if cost outlier payments should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Cost outlier*.

When Cost Outlier is entered, the following prompt appears on your screen:

Include cost outlier payments? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

13. RA ADJ BAL XFR (1-A-R)
This field is used to determine if balance transfers due to the posting of Electronic Remittance Advice payments and adjustments should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *RA Adj forced balance xfr*.

When RA Adj Bal Xfr is entered, the following prompt appears on your screen:

Include balance transfers due to RA Adjustments? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

14. AGENCY NOT BD (1-A-R)
This field is used to determine if agency payments for accounts not in BD should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Agency Cash Posted to Account not in BD*.

When Agency Not BD is entered, the following prompt appears on your screen:

Include agency payments for account not in BD? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

15. WINDOW BATCH (1-A-R)
This field is used to determine if unbalanced window cash batches should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Window batch out of balance*.

When Window Batch is entered, the following prompt appears on your screen:

Include unbalanced window cash batches? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

16. BATCH TOTAL (1-A-R)
This field is used to determine if batches with changed totals should be included or excluded on the Cash Posting Exception report. The specific exception message that is displayed on this report is *Batch total changed*.

When Batch Totals is entered, the following prompt appears on your screen:

Include batches with changed totals? (Y/N) {Y}--

If you want to exclude these exceptions on the Cash Posting Exception report, enter **N**. The payments that meet this criteria are omitted from this report.

If you want to include these exceptions on the Cash Posting Exception report, enter **Y** or ENTER. The payments that meet this criteria are included this report.

Denial/Appeal Parameters

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

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

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


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


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

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









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

Field Explanations

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

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

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

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

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

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

When PCON UB Is Not Active Or Is Active for PCON Release Less Than PCON 8.0

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

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

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

Valid values are **Y** for Yes and **N** for No. A setting of No does not change the setting of this field. If you enter Yes, the following prompt is displayed:

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

Valid values are **Y** for Yes and **N** for No. There is no default. [Enter] or No leaves the field as *Do not capture denials*. A setting of Yes changes the setting of this field to Live without PCON and the PCON Release field continues to display *Not installed*.

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

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

NOTE: Field 9 on the Pathways Parameters Interface screen contains the current release of PCON being used for UB's. The field also contains the effective date for PCON 8.0.

Valid values are **Y** for Yes and **N** for No. A value of No does not change the setting of this field. If you enter Yes, the following prompt is displayed:

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

Valid values are Y for Yes and N for No. If you enter [.] [Enter] or No, the field is set as *Do not capture denials*. If you enter Yes, this changes the setting of this field to Live without PCON and the PCON Release field displays the current release of Pathways Contract Management along with the reminder *without denial tracking*.

When PCON UB Is Active for PCON Release 8.0 or higher

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

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

Valid values are Y for Yes and N for No. No is the default. If you enter No, the following prompt is displayed:

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

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

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

Valid values are Y for Yes and N for No. There is no default. Enter or No leaves the field as Do not capture denials. Yes changes the setting of this field to Live without PCON and the PCON Release field displays the current PCON release and the phrase *without denial tracking*. For example: 8.0 without denial tracking.

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

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

If you enter Yes, the following message is displayed:

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

Pressing ENTER does not change the setting of this field.

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

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

Valid values are Y for Yes and N for No. There is no default. If you enter [.] [Enter] or No, the field is set as Do not capture denials. A setting of Yes changes the setting of this field to Live with PCON, and the PCON Release field displays the release number

with the phrase *with denial tracking*. For example: 8.0 with denial tracking. Once this field is set to Live with PCON, it cannot be changed to any other setting.

2. PCON RELEASE (DISPLAY ONLY)
This field displays the PCON Release as displayed on the Pathways Parameter Interface screen in the UB PCON Release field. If PCON denial tracking is not turned on, but a release of PCON is installed, the display will show, for example, 8.0 without denial tracking. If PCON is installed and denial tracking is turned on, the field displays *8.0 with denial tracking*.

3. APPEAL TRACKING STATUS (1-A-R)
This field allows you to choose whether or not to track appeals, build tracking tables prior to going Live, or to go Live with Appeal tracking.

The following prompt displays:

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

None suppresses the display of the appeal tracking fields in the Denial tracking payor table. The appeal tracking fields in the insurance follow up and in the insurance follow-up schedule dollar definition table can't be updated for appeal tracking if this field is set to None.

A value of L for Live is only accepted if the Denial Method field is set to Live with PCON or Live without PCON and the Receivables Workstation is installed.

The following prompt is displayed when the value is set to Live:

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

You cannot change from Live to Build or Live to None. If attempted, the following message is displayed:

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

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

You cannot change from None to Live. The following prompt will display:

Must be in Build Status prior to going Live!

You can change from Build to None. Any information set up on the Payor table related to appeal tracking will not be seen once the parameter has been turned off. On appeal insurance follow-up schedules or the insurance follow-up schedule dollar definition

table, the appeal fields will still be set for appeal tracking if these have been built by the user, but will not be assigned to any accounts.

4. RECEIVABLES WORKSTATION STATUS (DISPLAY ONLY)
This field indicates if the Receivables Workstation is installed. Valid values for the field are Installed and Not Installed.

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

The following prompt displays:

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

6. DEFAULT APPEAL COLLECTION GROUP (2-N-R)
This field displays the pre-defined collection group that has already been set up in the collection group table for accounts that are appealed. This collection group will be automatically assigned to any account that is manually appealed and the appeal collection group cannot be determined from the payor table. This field must be populated prior to going Live with Appeal Tracking.

The following prompt displays when the field is accessed:

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

DAILY BALANCING FUNCTIONS

The Daily Balancing Functions serve as management tools for Patient Accounting, Accounts Receivable, Bad Debt, and Contract Accounts. From here, subsidiary balances can be checked to see if they are equal to the daily activity and to the General Ledger for each location.

NOTE: The Contract PA Daily Balancing and Contract AR Daily Balancing functions are documented in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*.

You can print balancing reports with these functions. When you exit the balance screens described on the next pages, the system gives you the option of printing the report. Enter **Y** for Yes to print the report and the system displays the available months for this report. You can select only one month to print at a time for the specified location (PA, AR, BD). The system names for the reports are: FARBAL1 for PA, FARBAL2 for AR, and FARBAL3 for BD. These reports include all data for each day of the month and can be used to replace the hospital's manual audit trail. Refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system calculates all balancing for the day during midnight processing. In addition to this system balancing for each location and the General Ledger, you should balance revenue and census activity between STAR Patient Care and STAR Financials, as explained below.

STAR Patient Care and STAR Financials Revenue

Each processing day, all revenue transactions (charges and credits) are recorded in the STAR Patient Care Daily Activity Journal (FAJS). To verify the STAR Patient Care system passes all revenue transactions to STAR Financials accurately, you need to reconcile this journal activity with the revenue activity on STAR Financials (FARAJR). If a discrepancy exists, it may be because of unposted charges that went to the Unapplied Charge file. Look at the Unapplied Charge Log report (FAR010) to locate and verify unposted charges.

Unapplied charges occur when STAR Financials receives a charge or credit for an account that does not have a complete admission. When the admission is complete, the system automatically moves the unapplied charge to the appropriate account and updates all necessary General Ledger accounts.

STAR Financials and the General Ledger

STAR Financials maintains a separate subsidiary balance for each location: Patient Accounting, Accounts Receivable, Bad Debt, Unapplied Cash and Vendor Balances. The hospital may decide to map each subsidiary to the same GL account, but it is best for each subsidiary to have its own GL account.

It is important to reconcile Patient Accounting activity to the General Ledger to ensure the system accurately maps each transaction type in the PA-GL Mapping table. The system generates one PA Daily Journal entry each day. If the GL Daily Posting Summary report (FGL260) does not include this journal entry, look on the GL Daily Posting Validation report (FGL259P) for posting errors - an unbalanced journal entry does not post, but it prints on this report. If this occurs, you need to contact McKesson. Also, if more than one PA Daily Journal entry exists for the processing date, contact McKesson.

You can investigate and correct other errors not mentioned above. Each Patient Accounting transaction posted to the General Ledger contains the data required to select the correct account. Examples of ways the hospital can map various transactions include mapping by Revenue Department, Patient Class, Medical Service or Patient Type. The mapping method is established through the PA-GL Mapping table.

When the system processes a transaction with characteristics not defined in the PA-GL Mapping table, the transaction posts to a default account. You should investigate every entry in the default account and correct the PA-GL Mapping table to avoid additional default postings. You should clear all other default postings on a regular basis. The end of this chapter includes a troubleshooting guide to aid in reconciling balancing discrepancies.

After you select Financial System Management from the Main Menu, the system displays the following menu:

```
                General Hospital Daily Balancing Functions Processor
                                                Fri Mar 13, 1992 02:11 pm

            Option No.  Option
            ---------------------------------------
                1       PA Daily Balancing
                2       AR Daily Balancing
                3       BD Daily Balancing

                4       Contract PA Daily Balancing
                5       Contract AR Daily Balancing

                6       Unapplied Cash Daily Balancing




Enter option number--
```

These options are explained below.

PA Daily Balancing

Patient Accounting totals are displayed as a tool for viewing the financial position of PA. Accounts which do not have final bills are also a part of Patient Accounting. The

information presented on this screen is also available in your financial reports. You use this information to reconcile the ending balance to the subsidiary opening balance. From here you can also determine if your account keys are set to properly map the data to the General Ledger. For more information on the General Ledger, refer to GL Mapping Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system determines the extent to which you can edit the fields on this screen according to your security level and whether the system is in balance. The system uses the following criteria:

- If your security is less than 80 and the system is in balance, you cannot edit any field on this screen.
- If your security is less than 80 and the system is out of balance, you can edit the Comments fields only.
- If your security is 80 or above, you can edit any field on this screen, regardless of whether the system is in balance or out of balance.

After selecting PA Daily Balancing, you are prompted to select a facility and enter the control date (the default is yesterday's date), and the following balancing screen is displayed:

```
                General Hospital PA Daily Balancing Processor
                                                 Wed June 19, 2002  11:52 am

( 1) Control Date       : 06/18/02              A - Model Hospital A

( 2) Opening Balance   :  30,869,179.34
( 3) Revenue           :     145,198.96
( 4) Final Bill Total  :           0.00
( 5) Cash              :
( 6) Adjustments       :
( 7) Refunds           :
( 8) Late Charges    :             0.00
( 9) Post M'nite Activ :           0.00
(10) Facility Transfer :            N/A
(11) Ending Balance    :  31,014,378.30

(12) Subsidiary Balance:  31,014,378.30
(13) GL Control Balance:           0.00
(14) Comments          :
(15)                   :
(16) Reconciled by     :


Enter comments--
```

NOTE: PA is in balance if the Ending Balance, Subsidiary Balance and GL Control Balance are equal. Identify and correct out-of-balance conditions, if necessary.

Field Explanations

1. CONTROL DATE (DISPLAY ONLY)
This field contains the user-supplied date for which the daily balancing is displayed.

2. OPENING BALANCE (DISPLAY ONLY)
This field contains the system-supplied prior day's subsidiary balance from the financial balancing routine.

NOTE: The amounts in fields 3 through 9 can be edited *only* by users with a security level of 80 or greater.

3. REVENUE (12-N-O)
The amount displayed in this field represents the total charges and credits for the control day and is added to the opening balance. You can verify this figure and that the total revenue on STAR Financials equals the total revenue on STAR Patient Care by looking at the total on the Activity Journal report (FARAJR2).

Unapplied charges are not included in this field and should be used as a reconciliation item between the STAR Financials and STAR Patient Care revenue reports.

4. FINAL BILL TOTAL (12-N-O)
This figure represents the dollar amount transferred to AR (those accounts final billed) and is subtracted from the opening balance. You can verify this figure by looking at the total final-billed account balance on the Billed Accounts report (FBR200).

5. CASH (12-N-O)
This figure represents cash posted to Patient Accounting and is subtracted from the opening balance. You can verify this figure by looking at the total PA cash on Cash Posting Detail report (FAR130) and the Guarantor Cash Posting Detail Report (FAR135).

6. ADJUSTMENTS (12-N-O)
This figure represents any adjustments, such as courtesy discounts, administrative adjustments, employee discounts, charity write-off, to an account in PA, and is added/ subtracted to the opening balance. You can verify this figure by adding the PA totals on Adjustment Posting Detail report (FAR210).

7. REFUNDS (12-N-O)
This figure represents the amount of refunds approved and deleted for accounts in PA. This figure is added or subtracted from the opening balance. You can verify this figure on Refund Approval/Deleted report (FPREPPRP). Refunds print on the Balancing report in the adjustments column.

8. LATE CHARGES (12-N-O)
This figure represents the dollar amount of any charges for Accounts Receivable or Bad Debt accounts. It is part of the revenue amount contained in the REVENUE field and is subtracted from the opening balance. You can verify the total late charge

amount on the Financial Activity Journal (FARAJR) and Financial Late Charge (FARAJR1) reports. Late credits are added (rather than subtracted) from this amount.

9. POST MIDNIGHT ACTIVITY (12-N-O)
This field represents the revenue that has already updated accounts in PA but is not reported as revenue until the next midnight processing. You can verify the amount on the Charge Overflow report (FCRCHG). This situation occurs in a network environment between STAR Patient Care and STAR Financials. Revenue is reported on the Financial Late Charge report (FARAJR1) by the actual charge date. Since midnight processing runs after midnight, the system often generates some charges on an account after midnight that are applied prior to closing the network charge line.

10. FACILITY TRANSFER (12-N-C)
This field represents the intercompany transfer of money which originates from the combined billing process in the STAR Cross Facility module. This field contains N/A if you do not have the Cross Facility module. If you have the module, enter the dollar amount of charges for the patient(s).

11. ENDING BALANCE (DISPLAY ONLY)
This field contains the system-supplied ending balance, which is the total of the above-described fields. For example:

Opening Balance + Revenue - Final Bill Total - Cash +/- Adjustments +/-

Refunds - Late Charges + Today's Charges and Credits = Ending Balance

12. SUBSIDIARY BALANCE (DISPLAY ONLY)
This field contains the system-calculated subsidiary balance. This figure should equal the figure displayed in the Ending Balance field. If there is a discrepancy, then PA needs to be reconciled. The system calculates this balance by adding the account balance of every account in PA (in-house and discharged, but not final-billed / Account Location 1).

13. GL CONTROL BALANCE (DISPLAY ONLY)
This figure represents the General Ledger control balance which is the ending balance of the GL account indicated in the GL mapping keys as the PA control account. This amount should equal the subsidiary balance. You need to investigate and reconcile unknown variances. An example of a known variance is the balance-forward of accounts during conversions.

14. COMMENTS (54-AN-C)
This field can contain a comment explaining why Patient Accounting has a discrepancy and the resolution. If PA balances for the day, this field cannot be accessed.

15. COMMENTS (54-AN-C)
This field displays the second line of comments.

16. RECONCILED BY (DISPLAY ONLY)
This field displays the name of the individual who reconciled Patient Accounting. If PA is in balance, the system displays three asterisks (***) in this field.

AR Daily Balancing

Accounts Receivable totals are displayed as a tool for viewing the financial position of AR. The information presented on this screen is available in your financial reports. However, to facilitate the process of searching through many reports to obtain the information, it is displayed here in one location. You use this information to reconcile the ending balance to the subsidiary opening balance. From here you can also determine if your account keys set are properly set to map the data to the General Ledger. For more information on the General Ledger, refer to GL Mapping Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system determines the extent to which you can edit the fields on this screen according to your security level and whether the system is in balance. The system uses the following criteria:

- If your security is less than 80 and the system is in balance, you cannot edit any field on this screen.
- If your security is less than 80 and the system is out of balance, you can edit the Comments fields only.
- If your security is 80 or above, you can edit any field on this screen, regardless of whether the system is in balance or out of balance.

After selecting AR Daily Balancing, you are prompted to select a facility and enter the control date (the default is yesterday's date), and the following balancing screen is displayed:

```
               General Hospital AR Daily Balancing Processor
                                                 Wed. June 19, 2002 11:52 am

( 1) Control Date       : 06/18/02              A - Model Hospital A
( 2) Opening Balance      18,417,526.89
( 3) Final Bill Total  :           0.00
( 4) Cash              :
( 5) Adjustments       :
( 6) Refunds           :
( 7) Late Charges      :
( 8) Post M'nite Activ :
( 9) AR To BD Transfer :
(10) BD To AR Transfer :
(11) Facility Transfer :             N/A
(12) Ending Balance    :  18,417,526.89

(13) Subsidiary Balance:  18,417,526.89
(14) GL Control Balance:   6,496,792.51
(15) Comments          :
(16)                   :
(17) Reconciled by     :

Enter comments--
```

NOTE: AR is in balance if the Ending Balance, AR Subsidiary Balance, and GL Control Balance are equal. Identify and correct out-of-balance conditions, if necessary.

Field Explanations

1. CONTROL DATE (DISPLAY ONLY)
The user-supplied date for which the daily balancing is displayed.

2. OPENING BALANCE (DISPLAY ONLY)
This field contains the system-supplied prior day's subsidiary balance from the Financial Balance routines.

NOTE: The amounts in fields 3 through 10 can be edited *only* by users with a security level of 80 or greater.

3. FINAL BILL TOTAL (12-N-O)
This figure represents the dollar amount transferred to AR, (those accounts final billed) and is subtracted from the opening balance. You can verify this figure by looking at the total final-billed account balance on the Billed Accounts report (FBR200).

4. CASH (12-N-O)
This figure represents cash posted to AR, and it is subtracted from the opening balance. You can verify this figure by looking at the total AR cash on the Cash Posting Detail report (FAR130) and the Guarantor Cash Posting Detail report (FAR135).

5. ADJUSTMENTS (12-N-O)
This figure represents any adjustments, such as courtesy discounts, administrative adjustments, employee discounts, charity write-off, to an account in AR, and is added/ subtracted to the opening balance. You can verify this figure by adding the AR totals on the Adjustment Posting Detail report (FAR210).

6. REFUNDS (12-N-O)
This figure represents the amount of refunds approved and deleted for accounts in AR. This figure is added or subtracted from the opening balance. You can verify this figure on the Refund Approval/Deleted report (FPREPPRP). Refunds print on the Balancing report in the adjustments column.

7. LATE CHARGES (12-N-O)
This figure represents the dollar amount of any charges for Accounts Receivable or Bad Debt accounts. It is part of the revenue amount contained in the Revenue field and is subtracted from the opening balance. You can verify the total late charge amount on the Financial Activity Journal (FARAJR) and Financial Late Charge (FARAJR1) reports. Late credits are added (rather than subtracted) from this amount.

8. POST MIDNIGHT ACTIVITY (12-N-O)
This field represents the revenue that has already updated accounts in AR but is not reported as revenue until the next midnight processing. You can verify the amount on the Charge Overflow report (FCRCHG). This situation occurs in a network environment between STAR Patient Care and STAR Financials. Revenue is reported on the Financial Late Charge report (FARAJR1) by the actual charge date. Since midnight processing runs after midnight, the system often generates some charges on an account after midnight that are applied prior to closing the network charge line.

9. AR TO BD TRANSFER (12-N-O)
This figure represents the dollar amount transferred from accounts in Accounts Receivable to Bad Debt and is subtracted from the opening subsidiary balance.

10. BD TO AR TRANSFER (12-N-O)
This figure represents the dollar amount transferred from accounts in Bad Debt back to Accounts Receivables and is added to the opening subsidiary balance.

11. FACILITY TRANSFER (12-N-C)
This field represents the intercompany transfer of money which originates from the combined billing process in the STAR Financials Cross Facility module. This field contains N/A if you do not have the STAR Financials Cross Facility module. If you have the module, enter the dollar amount of charges for the patient(s).

12. ENDING BALANCE (DISPLAY ONLY)
This field contains the system-supplied ending balance, which is the total of the above-described fields. For example:

```
Opening Balance + Final Bill Total - Cash +/- Adjustments +/- Refunds + Late
Charges + Post Midnight Charges/Credits - AR to BD Transfer + BD to AR
Transfer = Ending Balance
```

13. SUBSIDIARY BALANCE (DISPLAY ONLY)
This field contains the system-calculated subsidiary balance. This figure should equal the figure displayed in the Ending Balance field. If there is a discrepancy, then AR needs to be reconciled. The system calculates this balance by adding the account balance of every account in AR (Account Location 2).

14. GL CONTROL BALANCE (DISPLAY ONLY)
This figure represents the General Ledger control balance which is the ending balance of the GL account indicated in the GL mapping keys as the AR control account. This amount should equal the subsidiary balance. You need to investigate and reconcile unknown variances. An example of a known variance is the balance-forward of accounts during conversions.

15. COMMENTS (54-AN-C)
This field can contain a comment explaining why Patient Accounting has a discrepancy and the resolution. If AR balances for the day, this field cannot be edited.

16. COMMENTS (54-AN-C)
This field displays the second line of comments.

17. RECONCILED BY (DISPLAY ONLY)
This field displays the name of the individual who reconciled Accounts Receivable. If AR is in balance, the system displays three asterisks (***) in this field.

BD Daily Balancing

Bad Debt totals are displayed as a tool for viewing the financial position of Bad Debt. The information presented on this screen is also available in your financial reports. You use this information to reconcile the ending balance to the subsidiary opening balance. From here you can also determine if your account keys are set to properly map the data to the General Ledger. For more information on this function, refer to GL Mapping Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system determines the extent to which you can edit the fields on this screen according to your security level and whether the system is in balance. The system uses the following criteria:

- If your security is less than 80 and the system is in balance, you cannot edit any field on this screen.
- If your security is less than 80 and the system is out of balance, you can edit the Comments fields only.
- If your security is 80 or above, you can edit any field on this screen, regardless of whether the system is in balance or out of balance.

After selecting BD Daily Balancing, you are prompted to select a facility and enter the control date (the default is yesterday's date), and the following balancing screen is displayed:

```
               General Hospital BD Daily Balancing Processor
                                                 Thu May 14, 1992 08:50 am

( 1)Control Date       : 05/13/92

( 2) Opening Balance   :       2,600.94
( 3) Cash              :
( 4) Adjustments       :
( 5) Refunds           :
( 6) Late Charges      :
( 7) Post M'nite Activ :
( 8) BD Archived Accts :
( 9) AR To BD Transfer :
(10) BD To AR Transfer :
(11) Ending Balance    :       2,600.94

(12) Subsidiary Balance:       2,600.94
(13) GL Control Balance:       2,600.94
(14)Comments           :
(15)                   :
(16)Reconciled by      : ***

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

NOTE: BD is in balance if the Ending Balance, Subsidiary Balance, and GL Control Balance are equal. Identify and correct out-of-balance conditions, if necessary.

Field Explanations

1. CONTROL DATE (DISPLAY ONLY)
This field contains the user-supplied date for which the daily balancing is displayed.

2. OPENING BALANCE (DISPLAY ONLY)
This field contains the system-supplied prior day's subsidiary balance from the Financial Balance routines.

NOTE: The amounts in fields 3 through 10 can be edited *only* by users with a security level of 80 or greater.

3. CASH (12-N-O)
This figure represents cash posted to Bad Debt, and it is subtracted from the opening balance. You can verify this figure by looking at the total BD cash on the Cash Posting Detail report (FAR130).

4. ADJUSTMENTS (12-N-O)
This figure represents any adjustments, such as courtesy discounts, administrative adjustments, employee discounts, charity write-off, to an account in BD, and is added/subtracted to the opening balance. You can verify this figure by adding the BD totals on the Adjustment Posting Detail report (FAR210).

5. REFUNDS (12-N-O)
This figure represents the amount of refunds approved and deleted for accounts in BD. This figure is added or subtracted from the opening balance. You can verify this figure on the Refund Approval/Deleted report (FPREPPRP). Refunds print on the Balancing report in the adjustments column.

6. LATE CHARGES (12-N-O)
This figure represents the dollar amount of any charges for Accounts Receivable or Bad Debt accounts. It is part of the revenue amount contained in the Revenue field and is subtracted from the opening balance. You can verify the total late charge amount on the Financial Activity Journal (FARAJR) and Financial Late Charge (FARAJR1) reports. Late credits are added (rather than subtracted) from this amount.

7. POST MIDNIGHT ACTIVITY (12-N-O)
This field represents the revenue that has already updated accounts in BD but is not reported as revenue until the next midnight processing. You can verify the amount on the Charge Overflow report (FCRCHG). This situation occurs in a network environment between STAR Patient Care and STAR Financials. Revenue is reported on the Financial Late Charge report (FARAJR1) by the actual charge date. Since midnight processing runs after midnight, the system often generates some charges on an account after midnight that are applied prior to closing the network charge line.

8. BD ARCHIVED ACCOUNTS (12-N-O)
This figure represents the dollar amount which is written off due to archiving of BD accounts with a balance. This amount may be positive or negative; the subsidiary balance is adjusted by this amount.

9. AR TO BD TRANSFER (12-N-O)
This figure represents the dollar amount transferred from accounts in Accounts Receivable to Bad Debt, and is subtracted from the opening subsidiary balance.

10. BD TO AR TRANSFER (12-N-O)
This figure represents the dollar amount transferred from accounts in Bad Debt back to Accounts Receivables, and is added to the opening subsidiary balance.

11. ENDING BALANCE (DISPLAY ONLY)
This field contains the system-supplied ending balance, which is the total of the above-described fields. For example,

```
Opening Balance - Cash +/- Adjustments +/- Refunds - Deletions + Late
Charges + Post Midnight Charges/Credits + AR to BD Transfer - BD to AR
Transfer = Ending Balance
```

12. SUBSIDIARY BALANCE (DISPLAY ONLY)
This field contains the system-calculated subsidiary balance. This figure should equal the figure displayed in the Ending Balance field. If there is a discrepancy, then BD needs to be reconciled. The system calculates this balance by adding the account balance of every account in BD (Account Location 3).

13. GL CONTROL BALANCE (DISPLAY ONLY)
This figure represents the General Ledger control balance which is the ending balance of the GL account indicated in the GL mapping keys as the BD control account. This amount should equal the subsidiary balance. You need to investigate and reconcile unknown variances. An example of a known variance is the balance-forward of accounts during conversions.

14. COMMENTS (54-AN-C)
This field can contain a comment explaining why Patient Accounting has a discrepancy and the resolution. If BD balances for the day, this field cannot be edited.

15. COMMENTS (54-AN-C)
This field displays the second line of comments.

16. RECONCILED BY (DISPLAY ONLY)
This field displays the name of the individual who reconciled Bad Debt. If BD is in balance, the system displays three asterisks (***) in this field.

Unapplied Cash Daily Balancing

Unapplied Cash totals are displayed as a tool for viewing the financial position of the unapplied cash accounts. The information presented on this screen is available in your financial reports. However, to facilitate the process of searching through many reports to obtain the information, it is displayed here in one location.

Use this information to reconcile the ending balance to the subsidiary opening balance. From here you can also determine if your account keys are set to properly map the data to the General Ledger. For more information on this function, refer to GL Mapping Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

The system determines the extent to which you can edit the fields on this screen according to your security level and whether the system is in balance. The system uses the following criteria:

- If your security is less than 80 and the system is in balance, you cannot edit any field on this screen.
- If your security is less than 80 and the system is out of balance, you can edit the Comments fields only.
- If your security is 80 or above, you can edit any field on this screen, regardless of whether the system is in balance or out of balance.

After selecting Unapplied Cash Daily Balancing, you are prompted to select a facility and enter the control date (the default is yesterday's date), and the following balancing screen is displayed:

```
          General Hospital Unapplied Cash Daily Balancing Processor
                                                 Tues May 26, 2002 10:18 am

( 1) Control Date      : 05/20/02               1 - FACILITY 1

( 2) Opening Balance   :       1,494.13
( 3) Unapplied Cash    :
( 4) Cash Applied      :
( 5) Refunds
( 6) Ending Balance    :       1,494.13

( 6) Subsidiary Balance:       1,602.69
( 7) GL Control Balance:         108.56-

( 8) Comments          : Corrected by JE #55
( 9)                   :

(10) Reconciled by     : Jones,Robert S




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

Field Explanations

1. CONTROL DATE (DISPLAY ONLY)
This field contains the user-supplied date for which the daily balancing is displayed.

2. OPENING BALANCE (DISPLAY ONLY)
This field contains the system-supplied prior day's subsidiary balance from the Financial Balance routines.

3. UNAPPLIED CASH (8-N-O)
This figure represents cash which is unapplied to any accounts for that day. An example is an insurance check without the name of the person to whose account it is to be applied. It might go here until the insurance company can be contacted.

4. CASH APPLIED (8-N-O)
This figure represents cash applied to the proper accounts for that day.

5. REFUNDS (8-N-O)
This figure represents refunds to any accounts for that day.

6. ENDING BALANCE (DISPLAY ONLY)
The system-supplied ending balance, which is the total of the above-described fields. For example:

Opening Balance + Unapplied Cash - Cash Applied = Ending Balance

6. SUBSIDIARY BALANCE (DISPLAY ONLY)
This field contains the system-calculated subsidiary balance. This figure should equal the figure displayed in the Ending Balance field. If there is a discrepancy, then Unapplied Cash needs to be reconciled. The system calculates this balance by adding the account balance of every account in Unapplied Cash.

7. GL CONTROL BALANCE (DISPLAY ONLY)
This figure represents the General Ledger control balance which is the ending balance of the GL account indicated in the GL mapping keys as the Unapplied Cash control account. This amount should equal the subsidiary balance. You need to investigate and reconcile unknown variances. An example of a known variance is the balance-forward of accounts during conversions. The journal entry made is the ending balance of the Unapplied Cash control account.

8. COMMENTS (54-AN-C)
This field can contain a comment explaining why Unapplied Cash has a discrepancy and the resolution. If UC balances for the day, this field cannot be accessed.

9. COMMENTS (54-AN-C)
This field displays the second line of comments.

10. RECONCILED BY (DISPLAY ONLY)
This field displays the name of the individual who reconciled Unapplied Cash. If Unapplied Cash is in balance, then three asterisks (***) display in this field.

Common Balancing Errors

If the Ending Balance does not equal the Subsidiary Balance to the General Ledger Total, use the steps listed below to reconcile the errors. Before beginning, calculate the actual variance and note which figure is greater. Next, verify the figures displayed for each area match the corresponding report. If they do not match, compare the variance to the out-of-balance total. If no variances exist, then begin analyzing each report, looking for errors.

1. If you access the Balancing screen prior to updating, then the Ending Balance calculates incorrectly. If each figure matches the report, but the calculation of the Ending Balance is not correct, then the screen was probably accessed early. Enter the correct calculation in the Comments field.

2. If the revenue on the Daily Activity Journal (FARAJR2) does not match the screen, check the Unapplied Charge Log report (FAR010). There are two versions of this report:

   - Unapplied Charges for the Day
   - Total Unapplied Charges.

   You can use either report, but include only the unapplied charges for the day in your balance routines. If the revenue does not balance between STAR Patient

Care and STAR Financials, verify each Department subtotal. If you cannot locate the variance, you may need to compare the individual charges for each patient.

If the revenue between STAR Patient Care and STAR Financials balances, and you cannot find the variance between the STAR Financials Revenue report and the Balance screen, or the Unapplied Charge report (FAR010), you need to verify the revenue posted on each account. You can do this by comparing the previous day's PA Balancing report (FORBPA) with the processing day's PA Balancing Report. Verify the revenue on the Daily Activity Journal was posted to the account on the correct day. Revenue reported in the field Post Midnight Activity appears to be on the patient account a day early which may be confusing when trying to balance revenue.

3. If the cash or adjustment totals do not match the reports, verify that the subtotals for each location equal the grand total on the report. On occasion, cash or adjustments may be posted to an account without a location and are left out of the subtotals on the report and screen. However, the posted amount is included in the Subsidiary calculation. The most likely place this situation occurs is in the Adjustment Batch 0, the system-generated batch which includes small balance write-offs.

4. Sometimes cash and adjustment postings are postdated to a prior fiscal period. This causes the General Ledger to appear out-of-balance. Always check the GL Posting Summary report for prior fiscal period postings.

5. If the hospital uses a transaction code to debit and credit a control account, the General Ledger appears out-of-balance. For example, the hospital establishes a transaction code used during the initial system conversion to update the account balance, but it does not really effect the GL entries because the hospital is planning to convert the GL later. If this situation occurs, a journal entry is necessary to correct the GL.

6. If the hospital uses a transaction code which is mapped to a specific control account to post money to an account in a different location, the General Ledger appears out-of-balance. For example, a transaction code *AR Balance Forward* is mapped to the AR control account. If the system uses this code on an account in PA, the PA control account appears out-of-balance. A journal entry is necessary to correct the GL.

7. If AR and BD are out-of-balance by the same amount, check the AR to BD Transfer report (FFR210) and then the BD to AR Transfer report (FFR220). Occasionally, accounts which already reside in location BD print on the AR-BD Transfer report, causing the report total to be too high and resulting in an incorrect Ending Balance. If the Subsidiary and GL balances are correct for AR and BD, then make a notation in the Comments field to indicate the accounts in error. The reverse situation also can occur: accounts which already reside in location AR print on the BD-AR Transfer report.

8. If the refunds do not match, verify that each refund has an account location. Make sure your calculations include approved and deleted refunds. If the refunds in the GL do not match, confirm that the refund checks were processed. Compare the total on the Refund Check Register (FPREFREG) to the amount on the GL Posting Summary report.

9. If the Ending Balance equals the Subsidiary Balance, but the General Ledger does not match, look at the GL Posting report for default postings. If necessary, check individual journal entries by printing the General Ledger Detail report.

OPTIONAL BATCH JOBS

This function provides a way to schedule additional batch jobs, such as the AR to Bad Debt Transfer or the Receivable Analysis Report, to report on all schedules or non-scheduled optional batch jobs, and to schedule Agency Processing Batch Jobs. The optional batch jobs available are defined by McKesson. The agency processing batch jobs available to be scheduled are dependent on the Collection Agency Code table.

```
        General Hospital Optional Batch Jobs Processor
                                                Tue June 16, 2010 10:01 am
Option No.  Option
               ---------------------------------------
                   1       Optional Batch Jobs Processor
                   2       Optional Batch Jobs Report
                   3       Optional Batch Jobs Re-Start/Stop/Clear Processor
                   4       View Optional Batch Job Re-Start/Stop/Clear Info
                   5       Agency Processing Batch Job Processor




Enter option number--
```

Optional Batch Jobs Processor

This function provides a way to schedule additional batch jobs, such as the AR to Bad Debt Transfer or the Receivable Analysis Report, as well as to report on all, scheduled, or non-scheduled optional batch jobs. The optional batch jobs available are defined by McKesson. However, the frequency with which they are run is controlled by the user.

The following optional batch jobs are available for scheduling through the Optional Batch Jobs Processor function:

- Active Patient Workfile
- Agency Cash and Adjustment Report
- AP Daily Distribution Register
- AP PO Distr. Invoice Report
- AP Recurring Invoice Request
- AP Refund Invoice
- AR to Bad Debt Transfer
- Archive Selection
- Bad Debt Charge Deletion
- Auto Series Discharge/Re-Registration PA Accounts Report
- Bad Debt Pre-List Report
- Bad Debt Pre-List Selection

- Bad Debt to Archive Pre-List Report
- Bad Debt to Archive Pre-List Selection
- Billed Accounts Report by Financial Class
- British Columbia Invoice Report
- CCA Interface
- Cash and Adjustment Batch Report
- Charge Summary Interface
- Claim Audit Report
- Claim Index and Workfile Repair
- Claim Prints Suppressed
- Claim Reload
- Claims Generated but Not Submitted Report
- Claims on Hold Report
- Claims Submitted but Unpaid Report
- Coll Agency Analysis - Detail
- Coll Agency Analysis - Summary
- Coll Agency Analysis Report
- Collector Max Workfile Entries
- Collector Reassignment - Guarantor
- Collector Reassignment - Insurance
- Contract Accounts Report
- Contract Department Logs
- Credit Balance Report by Carrier/Plan
- Credit Balance Report by Financial Class
- Cross Facility Bad Debt Prelist Report
- Cross Facility Claims Generated - Not Submitted
- Cross Facility Claims on Hold Report
- Cross Facility Claims Submitted but Unpaid
- Cross Facility Unverified Insurance Report
- Department Logs Report
- Final Claims with Ins Balances
- Estimate Accounts/Claims to be Archived
- Financial Review Report
- Guarantor Collector Reassignment
- Insurance Small Balance Writeoff Exceptions

- Journal Entry Interface
- NYHCRA Surcharge Report
- PA Fee Sch Reimb Report-Patient Specific
- PA Fee Schedule Exceptions Report by Departm
- Pathways Pre-list Report
- Patient Compass - Full
- Patient Compass - Incremental
- Pending Claims Report
- Pending/Candidate Workfile Report
- Recalculate Workfile Sorts
- Receivable Analysis Report
- Unbilled Accnts with Zero Chg
- Unbilled Accounts Report
- Unbilled Accounts Report by Financial Class
- Unbilled Contract Accounts
- Unverified Insurance Report

The system also offers an optional batch job for each of the statistics reports available in the system. When you set up the optional batch job to process these reports, it is necessary to indicate the fiscal period to process. The system provides a detail report for each statistic group:

- Biller Statistics
- Biller Statistics Summary Rpt
- Collection Agency Stat Summary
- Collection Agency Statistics
- Collector Statistics
- Collector Statistics Summary Report
- Contract Revenue by Rev Dept Statistics
- Contract Revenue by Rev Dept Statistics Summary
- Contract Revenue Statistics
- Contract Revenue Statistics Summary
- Discharge Statistics Report
- Discharge Statistics Summary Rpt
- Doctor Census Admitting Stat Summary
- Doctor Census Admitting Statistics
- Doctor Census Attending Stat Summary

- Doctor Census Attending Statistics
- Doctor Revenue Admitting Stat Summary
- Doctor Revenue Admitting Statistics
- Doctor Revenue Attending Stat Summary
- Doctor Revenue Attending Statistics
- Doctor Revenue Ordering Stat Summary
- Doctor Revenue Ordering Statistics
- Employer Census Statistics
- Employer Census Statistics Summary
- Employer Revenue Statistics
- Employer Revenue Statistics Summary
- Financial Class Census Stat Summary
- Financial Class Census Statistics
- Financial Class Revenue Stat Summary
- Financial Class Revenue Statistics
- Insurance Statistics
- Insurance Statistics Summary
- Late Charge Statistics
- Medical Service Census Statistics
- Medical Service Census Statistics Summary
- Medical Service Revenue Statistics
- Medical Service Revenue Statistics Summary
- Nurse Station Statistics
- Nurse Station Statistics Summary
- Patient Type Census Statistics
- Patient Type Census Statistics Summary
- Patient Type Revenue
- Patient Type Revenue Summary
- Revenue by Financial Group - Summary
- Revenue Center by Financial Group
- Revenue Center Stat Summary
- Revenue Center Statistics
- Transaction Statistics
- Transaction Statistics Summary
- ZIP Code Statistics

- ZIP Code Statistics Summary

The system also provides a summary report for each statistic group *except* the Late Charge Statistics (LCP) group. The statistics reports optional batch jobs are discussed under Financial Statistics.

Each of these jobs should be set up and tested during system implementation. When these optional batch jobs are run, the system produces an appropriate report. The report is specific to a facility, so that you must add the facility indicator when requesting the report to print.

The following topics briefly describe the optional batch jobs relating to STAR Patient Accounting.

Active Patient Workfile

This optional batch job selects accounts in location PA to have specific telephone follow-up. Accounts are selected based on criteria established in the Facility options. The focus of the follow-up for these accounts is usually high dollar balance/long term stay patients.

Agency Cash and Adjustment Report

This optional batch job lists those bad debt accounts that have had payments and adjustments posted through STAR Financials. This report (FAR150) prints by collection agency code and is used to update the agency regarding any hospital based payment and/or adjustment activity. The report can also be requested online. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information on this report.

AR to Bad Debt Transfer

This optional batch job transfers all selected accounts from Accounts Receivable to Bad Debt. Accounts can be selected manually by the user or automatically by the system using the Bad Debt Pre-List Selection optional batch job.

When this optional batch job is run, the system does not delete any information, but instead updates the general ledger and the account location (moving the account from Accounts Receivable to Bad Debt). The system also creates the AR to Bad Debt Transfer report (FFR210) when this job is run.

Archive Selection

This job performs archiving for accounts in Accounts Receivable and Bad Debt. Before running this job, the Bad Debt to Archive Pre-List Selection optional batch job should be run.

Accounts in AR become eligible for archiving when the account has had a zero balance for the number of days specified in the Archive Days field of the Data Retention Parameters (located on the Maintain Facility Information menu). Bad Debt accounts become eligible for archiving as described in the optional batch job Bad Debt to Archive Pre-List Selection.

In order for accounts to be selected for archiving, you must enter an ending discharge date for both AR and BD accounts. These fields are located in the Data Retention Parameters screen. If no date is entered in the AR Ending Disch Dt or the BD Ending Disch Dt fields, a message is displayed on the screen when the optional batch job for archive selection is run, and no accounts are selected.

When Archive Selection is run, the system creates the following reports:

- Archive Selection report (FBRAR)
- Bad Debt Archive Selection report (FBRBDA)
- Archive Statements (FBRAST or FBRASTH or FBRASTHA)

Three formats are available for the Archive Statements. The facility can specify the format they use via the PAAR Control Parameters (located on the Maintain Facility Information menu). The three formats are:

FBRAST	Prints all history transactions.
FBRASTH	Prints balance-related transactions only.
FBRASTHA	Prints all transactions, but splits them on two statements. Balance-related transactions print on one statement, and non-balance-related transactions print on another statement.

These archive statements and reports can be printed or written to tape for transfer to microfiche.

After running this job and verifying any output, you will need to run the Purge Archived Accounts option (located on the Financial System Management menu) to remove archived account information from your system and regain disk space.

For more information on the account archive process refer to the *Account Transactions Volume* in the *STAR Financials Patient Accounting Reference Guide* or Archive/Purge in this chapter of this book.

Auto Series Discharge/Re-Registration PA Accounts Report

This optional batch job produces a listing of all accounts which are part of an auto series discharge and registration chain existing in location PA.

Bad Debt Charge Deletion

When this job is run, the system selects accounts qualifying for deletion of detail charges. To accomplish this, the system reviews the Data Retention Parameters (located on the Maintain Facility Information menu), checking the contents of the Bad Debt Charge Delete Days field. This field determines the number of days since an account was transferred to bad debt that the system will retain the detail charges for each account. Charges can be retained for up to 365 days.

After selecting accounts as appropriate, the system produces the Purge Archived Account Charges report (FARBDP) and Bad Debt Charge Delete Statements (FARBDST). The system sorts Bad Debt Charge Delete Statements using the sort selection criteria defined for Archive Statements. For more information on setting and maintaining these sort criteria, see Sort Sequences in this chapter.

The actual purge of the detail charge records occurs online. For more information, see Archive Purge.

Bad Debt Pre-List Report

This optional batch job produces the following reports:

- **Bad Debt Pre-List Report (FFR300)**, which lists patients that have been selected, either automatically by the system or manually by a user, for transfer to Bad Debt. This report also lists patients put on user hold or system hold.

- **Bad Debt Pre-List Exception Report (FFR385)**, which lists patients that have been selected for transfer to bad debt based on their follow-up schedule and financial class, but have been flagged for exception, due to a credit balance, pending insurance or account balance too large for automatic flagging.

This job can be run without the optional batch job Bad Debt Pre-List Selection, so that any new manually selected accounts can be viewed on the report. When Bad Debt Pre-List Report is run instead of Bad Debt Pre-List Selection, the system will not automatically select new accounts — it will only produce the reports.

Bad Debt Pre-List Selection

This optional batch job selects patients to be transferred to Bad Debt based on their follow-up schedule and financial class. Patients are later transferred to Bad Debt when the optional batch job AR to Bad Debt Transfer is run, unless the account is manually placed on hold, placed on hold by the system due to an invalid address/phone on the account, or a payment or adjustment is received.

NOTE: This job can be run as many times as needed before running AR to Bad Debt Transfer. However, you should allow patient accounting personnel sufficient time to review patients selected for transfer before running the transfer function.

This job automatically creates the Bad Debt Pre-List report (FFR300) and the Bad Debt Pre-List Exception report (FFR385).

For more information about Bad Debt Prelist Selection refer to the *Account Transactions* and *Follow-Up Functions* volumes of the *STAR Financials Patient Accounting Reference Guide*.

Bad Debt to Archive Pre-List Report

This optional batch job creates the Bad Debt to Archive Pre-List Report, which lists all accounts in Bad Debt that have met the criteria for archiving.

This report is also created by the optional batch job Bad Debt to Archive Pre-List Selection. By running the Bad Debt to Archive Pre-List Report separately (for example, before running Bad Debt to Archive Pre-List Selection), you can list any manually selected accounts without the system automatically selecting additional accounts.

For more information on the account archive process refer to the *Account Transactions Volume* in the *STAR Financials Patient Accounting Reference Guide* or Archive/Purge in this chapter of this book.

Bad Debt to Archive Pre-List Selection

Bad Debt to Archive Pre-List Selection pre-lists patients in Bad Debt for archiving based on the following criteria:

- The follow-up date has been reached, based on the days set on the Agency Follow-Up Schedule.
- The account balance on this date is below the maximum delete balance specified in the Agency Follow-Up Schedule.

Accounts in Bad Debt that meet this criteria are pre-listed for archive.

This job automatically creates the Bad Debt to Archive Pre-List report (FBRBDPL).

This OBJ should be turned off if your facility does not archive Bad Debt Accounts. This job runs through the location index or all accounts, so this may cause midnight processing to run longer. In addition, check all facilities when turning this off.

For more information on the account archive process refer to the *Account Transactions Volume* in the *STAR Financials Patient Accounting Reference Guide* or Archive/Purge in this chapter of this book.

Billed Accounts Report by Financial Class

This job produces the Billed Accounts by Financial Class Report (FBR211). This report lists all inpatient, outpatient, and emergency room accounts selected for billing. Accounts included are either hospital-selected or system-selected accounts.

British Columbia Invoice Report

This job produces the British Columbia Invoice Report (FMRBCIV), which is sorted by Insurance Plan. This report can be downloaded for Invoice Billing at the end of each period for British Columbia users. These invoices are needed for the Royal Mounted Canadian Police (RMCP), Indian Affairs, and Veteran's Affairs.

CCA/RUA/CPA Interface

This job creates the interface file, the CCA/RUA Audit report (FARCML) and the CPA Audit report (FARCPA) if the CPA interface file is created. The CCA/RUA Audit Report lists all accounts processed for transfer to the TRENDSTAR® system. The CPA Audit report (FARCPA) lists all accounts processed for transfer to TRENDSTAR Contract Payment Advisor.

Cash and Adjustment Batch Report

This optional batch job produces the Cash and Adjustment Batch report (FAR160). This report provides information by cash batch number as to whether the batch is in balance or not and if in balance, if the batch has not been posted.

Charge Summary Interface

This optional batch job creates a file of daily detail charges to be transmitted to another system. Before running this optional batch job, contact your McKesson representative to insure that the interface is installed on your system.

Claim Audit Report

This job produces the Claims Charge Data Audit report (FCR290). This report can be used as an audit trail for any additions, deletions or changes to the charge dollars on claims for the previous day.

Claim Index and Workfile Repair

This job corrects any incorrect claim indexes for failed, passed, generated, submitted, replaced, or completed. The cleanup also corrects claims that are appearing for the wrong biller or that are appearing for more than one biller. Any claims corrected appear on the Claim Biller Index Repairs Report, FCRFXBLx, where x is the facility indicator.

Claim Prints Suppressed

This job produces the Claim Prints Suppressed report (FCR310), which lists all claims, by insurance carrier/plan, that were released but not printed because the Produce Claim indicator was set to No. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information on this report.

Claim Reload

This job edits all failed claims and attempts to reload any necessary data on the patient record into the claim. This job does not produce a report. Be aware that midnight processing may run longer as a result of this job as each claim is edited and reloaded.

Claims Generated But Not Submitted Report

This job produces the Claims Generated But Not Submitted report (FCR300), which lists all claims, by biller, that have been generated but not marked as submitted.

Claims on Hold Report

This job produces the Claims on Hold report (FCR320), which lists all claims, by insurance carrier/plan, that have been put on hold. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for more information on this report.

Claims Submitted But Unpaid Report

This job produces the Claims Released Unpaid report (FCR280). The system uses the entry to the Days for Unpaid Report field on the PAAR Control (located on the Financial System Management menu) to determine when a claim lists on this report.

Collection Agency Analysis Report

This job produces the Collection Agency Analysis report (FFR250), which provides detail and summary information about accounts assigned to a collection agency and any recoveries made.

Collection Agency Analysis Report - Detail

The Collection Agency Analysis Report - Detail (FFR251) provides only detail information about accounts assigned to a collection agency and any recoveries made.

Collection Agency Analysis Report - Summary

The Collection Agency Analysis Report - Summary (FFR252) provides only summary information about accounts assigned to a collection agency and any recoveries made.

Collector Max Workfile Entries

This job produces the Receivables Workstation Guarantor Collector Workfile Statistics Report (FFR275) and the Receivables Workstation Insurance Collector Workfile Statistics Report (FFR475). These reports display the detail information associated with the Weekly Workfile Entries by Collector Group functions.

Collector Reassignment - Guarantor

The Guarantor Collector Reassignment Optional Batch Job is a good tool to assist in the task of changing collector assignment. This tool saves time because you do not have to manually change collectors when tables affecting collector assignment are updated. This optional batch job reassigns collectors based on the collector group that is assigned to the account. The Collection Group field on this optional batch job screen is used to indicate whether you want to use the collector group currently associated with the account or if you want to reassign the collector group according to the financial class.

The Guarantor Collector Reassignment Job should not be scheduled to run every night due to the length of time it takes to run. It uses a lot of system resources because of the large number of accounts that it reviews.

Effects of the Collector Reassignment Job on Collector Workfiles

If hospitals manually transfer work to another collector, the Collector Reassignment Job could transfer work back to the original collector. This would occur if the original collector is the one the work should be assigned to according to the collection group.

RWS Transfer Permanent

In the Receivables Workstation there is an option to permanently transfer accounts to a specified collector. Once an account is permanently transferred to a collector, the Collector Reassignment Optional Batch Job will not update the account and reassign the collector according to the collection group table.

After you select the collector, the following screen is displayed

```
        General Hospital Optional Batch Jobs Processor Processor
                                                  Wed Aug 26, 2001 09:53 am
  1 Code           2 Description
    7                 Collector Reassignment Guarantor
 3 Frequency Type                                  4 Starting/Next Date
-> One Time Only                                     09/01/01
 5 Daily Interval/Day of Month/Day-Week of Month

 6 Follow-Up Group                7.  Collector Group
    All                               Table

 7 Edit by                        8 Edit date
  New, Nancy                        08/26/01 0954
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE(1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month and **O** for One Time Only. The One Time Only option does not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, you should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The Next Starting Date field will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. Enter the starting date to establish a Guarantor Collector Reassignment Optional Batch Job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of *1* means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or *L* for the last day of the month. An entry of *15* means that the batch job will run on the 15th of every month. If you selected Day Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from **1-4** or **L** for the last week of the month. For example, an entry of *2* for the day of the week and *L* for the week of the month means that the batch job will run on the last Monday of the month.

6. FOLLOW-UP GROUP (1-N-R)
This field identifies which accounts by follow-up group to transfer to a new collector. When a follow-up group is selected the system displays the description of the group in the field. Select from one of the following options or enter an **A** for All. By reassigning

collectors by a specified Follow-Up group, you can limit the scope of the reassignment job so that it will not review as many accounts as the All option.

PA Follow-up Group

AR Follow-up Group

Internal Collection Follow-up Group

CCI Collection Follow-up Group

BD Follow-up Group

7. COLLECTOR GROUP (1-A-R)
This field determines which collector group the system uses when reassigning collectors. The entry options are **A** for Account/Guarantor or **T** for Table. Both the Account and Table options reassign the collector and existing workfile entries.

The **A** for Account/Guarantor provides the option of reassigning the collector based on the current collection group associated with an account. If a hospital would like to only update the collector on accounts based on modifications such as alpha split or dollar amount to the Collection Group table currently associated with the accounts then the Account/Guarantor option should be used. Selecting the Account/Guarantor option will improve the run time for the job because it will not have to always reassign the collection group before determining which collector to assign to the account.

The **T** for Table option always reassigns the collection group to determine which collector to assign to an account. Accounts in PA and AR Follow-Up use the financial class to assign the collection group code. For example, if an account originally had a financial class of *C* for Commercial, it was assigned a collector based on the collection group associated with the 'C ' financial class. If the financial class changed to *S* for Self Pay, the Collector Reassignment Job would use this new financial class when determining which collection group to assign to the account. Accounts in Internal, CCI and Internal Bad Debt Follow-Up use the Collection Agency Code table to determine the Collection Group.

When using the Table option, the system reassigns the collector group. Following is a list of the various follow-up types and the location of the corresponding collection group code. When the Account option is selected, the system uses the collection group code currently associated with the account to determine which collector to assign to the account and existing workfile entries.

Type of Follow-Up	Location of Collection Group Code when the Table Option is used
PA Follow-Up	Financial Class Table
AR Follow-Up	Financial Class Table
Internal Collection Follow-up	Collection Agency Code Table

Type of Follow-Up	Location of Collection Group Code when the Table Option is used
CCI Collection Follow-up	Collection Agency Code Table
Internal Bad Debt Follow-up	Collection Agency Code Table

PA Follow-up

When the Table option is selected the Collector Reassignment Optional Batch Job (OBJ) uses the financial class from Patient Accounting to obtain the Collection Group. The financial class on the Patient Accounting system could be different than the financial class on Patient Care. For example, if the Balance Designation Parameters change the financial class, the update only occurs on Patient Accounting. The Patient Accounting financial class displays on the Account Status screen.

If a hospital wants to update only the collector on accounts based on modifications such as alpha split or dollar amount to the Collection Group table then the Account/ Guarantor option should be used. The Account/Guarantor option utilizes less system resources than the Table option.

AR Follow-Up

When the Table option is selected the Collector Reassignment Optional Batch Job uses the financial class from Patient Accounting to obtain the Collection Group. The financial class on the Patient Accounting system could be different from the financial class on Patient Care for an account. For example, if the Balance Designation Parameters change the financial class, the update only occurs on Patient Accounting. The Patient Accounting financial class displays on the Account Status screen.

For Account Level F/U, the Collector Reassignment OBJ will obtain the financial class from the account and then get the Collection Group associated with the FC. For Guarantor Level F/U it will obtain the financial class from the oldest active account associated with the guarantor and then get the Collection Group associated with the FC.

If a hospital would like to only update the collector on accounts based on modifications such as alpha split or dollar amount to the Collection Group table then the Account/ Guarantor option should be used. The Account/Guarantor option utilizes less system resources than the Table option.

Internal Collection Follow-Up

The Collector Reassignment Optional Batch Job reviews an account at internal collection, accesses the collection agency associated with the account to obtain the collection group to assign the collector.

CCI Collection Follow-Up

The Collector Reassignment Optional Batch Job reviews an account at CCI collection, accesses the collection agency associated with the account to obtain the collection group to assign the collector.

Internal Bad Debt Follow-Up

The Collector Reassignment Optional Batch Job reviews an account at an internal bad debt agency and will go to the collection agency associated with the account to determine which collection group to use for collector assignment.

8. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who performed the last edit.

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

Collector Reassignment - Insurance

The Insurance Collector Reassignment Optional Batch Job (38) is a good tool to assist in the task of changing insurance collector assignment. This tool saves time because you do not have to manually change collectors when tables affecting collector assignment are updated. This optional batch job reassigns collectors based on the collector group that is assigned to the account.

A facility must be selected and the associated parameters completed for collector reassignment. If multiple facilities are selected the insurance collector reassignment job for each facility runs concurrently.

If this optional batch job is accessed, and the job hasn't completed processing, the following message is displayed:

Cannot change run parameters until previous run completes or is cleared. Press Enter.

If you press ENTER, the screen is displayed, but the following fields can’t be updated: Collector Group, Follow-up Group, Account Locations, Zero Balance Days, BD Transfer Date, Carrier(s), Plan(s).

NOTE: The job could stop processing due to either the setting of the MNP Run Until Time field or because of a manual stop on the Optional Batch Jobs Re-start/ Stop/Clear Processor.

For accounts associated with standard insurance follow-up, the Collection Group field on this optional batch job screen determines if you want to reassign the collector group according to what is associated with the master insurance plan collection parameters or if you want to use the insurance collector group already associated with the account. The assignment of insurance external agency collectors uses the collector group that

is in the associated agency code table to reassign the collector. The assignment of appeal collector uses what is internally stored in McKesson's FTDENL file, which is the collector group that was associated with the denial tracking payor code when the claim was denied.

The Insurance Collector Reassignment Job should not be scheduled to run every night due to the length of time it takes to run.

Effects of the Collector Reassignment Job on Collector Workfiles

If hospitals manually transfer work to another collector, the Collector Reassignment Job could transfer work back to the original collector. This would occur if the original collector were the one the work should be assigned to according to the collection group. The Insurance Collector Reassignment optional batch job reassigns the collector associated with both the insurance and with existing insurance workfile entries.

RWS Transfer Permanent

In the Receivables Workstation there is an option to permanently transfer accounts to a specified collector. Once an account is permanently transferred to an insurance collector, the optional batch job does not update the collector. If the permanent flag is cleared, the optional batch job reviews the account to reassign the insurance collector.

When this optional batch job is selected, the following screen is displayed:

```
       General Hospital Optional Batch Jobs Processor
                                                 Tue Jun 21, 2011 04:40 pm

 1 Code           2 Description
   38               Collector Reassignment - Insurance
 3 Frequency Type                                    4 Starting/Next Date
->
 5 Daily Interval/Day of Month/Day-Week of Month     6 MNP Run Until Time

 7 Collection Group        8 Follow-Up Group
   Account                   Insurance
 9 Account Locations      10 Zero Balance Days      11 BD Transfer Date
   All                       400                       01/01/2001
12 Days Past Bill Date    13 Reselect Days for Days Past Bill

14 Carrier(s)                            15 Plan(s)
   None                                     None
16 Edit by                                          17 Edit date
   New, Nancy                                          06/21/2011 4:40 pm
```

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE (1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month, and **O** for One Time Only. The One Time Only option will not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, the user should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The next starting date will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. Enter the starting date to establish a Guarantor Collector Reassignment Optional Batch Job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of 1 means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or L for the last day of the month. An entry of 15 means that the batch job will run on the 15th of every month. If you selected Day- Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from 1-4 or L for the last week of the month. For example, an entry of 2 for the day of the week and L for the week of the month means that the batch job will run on the last Monday of the month.

6. MNP RUN UNTIL TIME (6-N-O)
This field contains the time that the facility wants to stop the processing for the Collector Reassignment (OBJ 38). The optional batch job is stopped automatically during Midnight Processing .at the time indicated in the MNP Run Until Time field.

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

Enter time to stop processing for job 38 when run in MNP

Time can be entered in military or standard time followed by a.m. or p.m.

The intent of this field is to provide a way for a facility to control how long the job should run. If the job is stopped because it meets the time entered in the field, the job continues to process the next time it runs or if it is re-started through the Re-start/Stop/Clear Processor. For example, if this field contains the value of 5 AM, the the job stops at 5 AM. The job continues processing the next time the job is scheduled to run or if the job is manually re-started by the hospital through the Re-start/Stop/Clear processor. If the job is scheduled to run once a week then the job would run automatically in a week and continue to process where it stopped previously. The time entered in this field is displayed on the Optional Batch Job Re-Start/Stop/Clear processor.

7. COLLECTION GROUP (1-A-R)

This field determines which collector group the system uses when reassigning collectors associated with standard insurance follow-up. The Follow-Up Group field value of Insurance must be selected to re-assign collectors associated with insurance follow-up. The entry options are A for Account or T for Table.

A value of **Account** results in the collector reassignment job using the collection group associated with the account under Insurance Process, Billing/Collection Options, to reassign the collector. The Account option should be used if a client has just changed options within a collector group that is already associated with an account, such as alpha split or dollar. The Account option should also be used if a hospital has added a new collector group to a master insurance but wants only new accounts to use the new collector group and existing accounts to use the collector group already associated with them.

A value of **Table** results in the collector reassignment job accessing the Insurance Plan Coverage, Facility Options, Collection Parameters to reassign the collection group. The system uses the new collection group to reassign the collector. The system does not update the collector group associated with the account level insurance with what is in the Master Insurance when the Account option is selected. The Table option should be used if the client updated their master files with a new collector group and wants new accounts and existing accounts to be updated with this new collector group or if they updated their master files with PT exceptions. The system would reassign the collector group according to these exceptions.

8. FOLLOW-UP GROUP (1-A-O)

This field identifies which accounts by follow-up group to transfer to a new collector. By reassigning collectors by a specified Follow-Up group, you can limit the scope of the reassignment job so that it does not include as many accounts as the All option.

You can select one or more of the following options or enter A for All. The options are: Insurance, External Insurance Pre-collect, and Appeal.

- Insurance - If the value of Insurance is selected, all claims in standard insurance follow-up are reviewed for insurance collector reassignment. Note, claims must also meet the other criteria defined for reassignment to occur. The transaction description contains the following if the insurance collector was updated:

Change Ins Collector.

The transaction comment indicates if only the assignment of collector was updated or if both assignment and work were updated.

The system reassigns existing collector work if it exists.

- External Insurance Pre-Collect - If this is selected, all claims associated with an external insurance pre-collect agency are reviewed for insurance collector reassignment. Note, claims must also meet the other criteria defined for reassignment to occur. If an external insurance agency collector is reassigned, the following message is written in transaction history: Change Ext Agn Collector.

  The transaction comment indicates if only the assignment of collector was updated or if both assignment and work were updated. The system assigns existing collector work if it exists.

  Appeal - If Appeal is selected, all claims associated with insurance appeal follow up are reviewed for insurance collector reassignment. Note, claims must also meet the other criteria defined for reassignment to occur. If an appeal collector is reassigned, the following message is written in transaction history: Change Appl Collector.

  The transaction comment indicates if only the assignment of collector was updated or if both assignment and work were updated. The system reassigns existing collector work if it exists.

9. ACCOUNT LOCATIONS

The Location field determines which location the account should be associated with in order for the collector for the claim to be updated. The valid values for location are PA, AR and BD. Valid values for this field are PA, AR and BD. For the BD locations, there is a qualifier called *BD Transfer Date*, and an account must meet what is defined in this field to qualify for a collector update.

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

Select from one of the following location options or enter an A for All.

10. ZERO DAYS (4-N-O)

This field determines if accounts that are zero balance should be included in the collector reassignment process. Accounts that have active appeals that are a zero or credit balance are not included in this parameter. If this field isn't completed, all zero balance accounts are reviewed for collector reassignment. If this field is completed the system takes the number of days in the field and adds it to the zero balance date associated with a zero balance account to determine if the account qualifies for collector reassignment.

Following is an example where the zero balance date associated with an account is 01/01/2010 and this parameter is set to 90:

01/01/2010 + 90 = 04/01/2010

In this example, the account would not be considered for collector reassignment after 04/01/2010.

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

Define the number of days after zero balance to stop including--

11. BD TRANSFER DATE (DATE-AN-O)
This field determines which accounts in the bad debt index are reviewed for collector reassignment. If this field isn't completed, all accounts in bad debt are reviewed for collector reassignment. If this field is completed, the hospital can limit the number of accounts in bad debt that are reviewed for collector reassignment.

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

Update Collector for accounts with BD Transfer Date on or after (enter date)-

12. DAYS PAST BILL DATE (4-N-O)
This field contains the number of days past bill date for a claim to qualify for the re-assignment of the collector. If the claim associated with the bill is a cycle claim, the system uses the associated cycle bill date. If the claim associated with the bill is a final claim, the system uses the associated final bill. If the cycle or final claim has been adjustment billed, it still uses the first cycle bill date and the final bill date in the calculation for Days Past Bill. For example, if the field contains a value of 90 and the claim is a final claim, the system uses the final bill date and determines if an account is 90 days past the bill date. If the account final billed on 12/01/10, 90 days past 12/01/10 is 3/1/11. On 3/01/11, the claim qualifies to have the collector reassigned.

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

Update Ins Collector if Days Past Bill Date for Claim is greater than--

Enter the number of days after the Days Past Bill Date to reassign the collector.

13. RESELECT DAYS FOR DAYS PAST BILL (4-N-O)
This field allows you to control when the claim should be reselected for collector reassignment when it meets the Days Past Bill field.

Update Ins Collector if Reselect Days for Days Past Bill Date for Claim is greater than-- |

Enter the number of days after the Days Past Bill Date to reassign the collector.

14. CARRIER(S) (3-N-O)
This field is used to limit collector reassignment to specified insurance carriers. When this field is accessed, the following prompt is displayed:

Enter carrier code or - for a list

You can enter the code or a hyphen (-) to display a list of the valid codes. Valid values are selected insurance carrier(s) or **N** for None. A value of N for None is the default value. If N for None is entered, the hospital is not limiting collector reassignment to specific insurance carriers.The hospital can enter in a value in the field or select multiple values by selecting from a list. Selected carriers display in the field per field length and a ++ value following the carrier code indicates that more carriers are defined. To see all carriers that were selected, you must review the table by entering a dash to display the table.

13. PLAN(S) (6-AN-O)
This field is used to limit collector reassignment to specified insurance plans. Valid values are selected insurance plans(s). The hospital can enter in a value in the field or select multiple values by selecting from a list. Selected plans display in the field per field length and a ++ value following the plan will indicate that more plans are defined. To see all plans that were selected, you must review the table by entering a dash to display the table.

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

Enter insurance plan code or - for a list

You can enter the insurance plan code or a hyphen (-) to display a list of the insurance plans.

Contract Account Report

This job produces the Contract Accounts report (FDRAAR), which lists all active contract accounts in the system. The report displays the current balance and location of the account and can be used to verify the subsidiary balance of contract accounts.

Contract Department Logs

This job produces the Contract Department Logs report (FDRDLR). The system creates this report in both detail and summary formats. The detail format lists, by department, all charges placed on contract accounts for the day. The summary format lists the total quantity and price for each item.

Credit Balance Report by Carrier/Plan

This job produces the Credit Balance Report by Carrier/Plan Report (FARCBCP) which sorts and totals by carrier/plan with a page break by carrier. The report requires

that the account be in AR and have a credit balance in at leas one of the insurance buckets.

Credit Balance Report by Financial Class

This job produces the Credit Balance Report by Financial Class (FARCBFC) which sorts, totals, and page breaks in Financial Class order. The report requires that the account be in AR and have a credit balance in one of the insurance or patient buckets.

Cross Facility Bad Debt Prelist Report

This job produces the FFR300 which lists patients for all facilities that have been selected, either automatically by the system or manually by a user, for transfer to Bad Debt. This report also lists patients put on user hold or system hold.

Cross Facility Claims Generated - Not Submitted

This job produces the Cross Facility Claims Generated but Not Submitted Report (FCR300), which lists all claims for all facilities, by biller, that have been generated but not marked as submitted.

Cross Facility Claims on Hold

This job produces the Cross Facility Claims on Hold Report (FCR320), which lists all claims for all facilities, by insurance carrier/plan, that have been put on hold.

Cross Facility Claims Submitted but Unpaid

This job produces the Cross Facility Claims Submitted Unpaid Report for all facilities. They system used the entry to the Days for Unpaid Report field on the PAAR Control screen (accessible from the Financial System Management menu) to determine when a claim lists on this report.

Cross Facility Unverified Insurance

This job produces the Cross Facility Unverified Insurance Report (FAR310) for both inpatients and outpatients for all facilities. This report lists all accounts requiring insurance verification, certification, or approval.

Department Logs Report

This job produces the Department Logs report (FARDLR), which lists, by department, all charges for the day.

Estimate Accounts/Claims To Be Archived

This optional batch job (129) can be requested to produce the report FAARCCTx (Estimate of Accounts/Claims to be Archived). For AR and/or BD accounts four numbers are provided:

- Number of accounts in account location. This is labeled Existing Accounts.
- Number of claims for accounts in account location where the account discharge date precedes or equals the Claim End Disch Dt found on the Data Retention Parameters screen for Maintain Facility Information. This is labeled Existing Claims.
- Number of accounts qualifying for archiving if the archive program was run using the date of the report. This includes accounts selected for archiving already. This is labeled Qualifying Accounts.
- Number of claims qualifying for archiving if the archive program was run using the date of the report. This is labeled Qualifying Claims.

If this optional batch job is selected, it runs for the selected facility. It is started as a background job during up time processing for PA's batch processing. When the optional batch job is selected,the user can determine whether to calculate statistics for AR and/or BD accounts.

Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of the Estimate of Accounts/Claims to be Archived report.

Final Claims with Ins Balances

The Final Claims with Insurance Balance report is used to identify the insurance carrier/plans on an account that have an insurance balance but do not have any outstanding claims.

Financial Review Report

This job produces the Financial Review report (FARFRR), which lists all non-discharged inpatients, pre-admit testing and outpatient accounts. The selection criteria can be set up in the Account Reports menu, located under Account Management.

Insurance Small Balance Write-off Daily Exception Report

This report (FFR375) lists all carrier/plans with accounts in AR that meet an ISBWO exception when their scheduled insurance follow-up is processed. It lists accounts that meet the insurance small balance write-off amount but for which the write-off has not occurred due to an exception. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

Insurance Small Balance Write-Off Exception Report

This report (FFR380) lists all carrier/plans with accounts in AR that meet an ISBWO exception regardless of the carrier/plans' scheduled insurance follow-up date. It lists accounts that meet the insurance small balance write-off amount but for which the write-off has not occurred due to an exception. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

NYHCRA Surcharge Report

This job produces the NYHCRA Surcharge report (FARFRR), which can be used to assist in completing the Public Goods Pool Report that is submitted to the state of New York on a monthly basis. Identifying when a final version of the report is run allows you to use functionality to identify subsequent changes to data.

Pathways Pre-list Report

This report (FBR284) lists accounts that are targeted for Pathways Contract Management reimbursement calculation. This includes accounts in PA that have not been final billed, and accounts in AR that have not passed all claim edits. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

Patient Accounting Fee Schedule Exception Report by Department

This job produces the Fee Schedule Exception Report by Department (FBR260), which lists all SIM items actually charged that have fee schedule amounts assigned.

For more information on Reimbursement, see Chapter 4, Reimbursement Overview, in this volume.

Patient Accounting Fee Schedule Report - Patient Specific

This job produces the Patient Specific report (FBR270), which is displayed, for each patient, all SIM items actually charged that have fee schedule amounts assigned, one-line department totals with all non-included SIM items. The report prints the number of charges, actual charge amount, reimbursement amount and contractual adjustment amount.

For more information on Reimbursement, see Chapter 4: Reimbursement Overview, in this volume.

Patient Compass - Full File

This job generates summary and detail files and is created through the Patient Compass Classic Interface. The full file is based on user-defined parameters for PA, AR, and BD and gives information on the accounts that have positive account

balances. For more information on the interface, please refer to the *Follow-up Functions Volume* of the *STAR Patient Accounting Reference Guide*.

Patient Compass - Incremental File

This job generates summary and detail files and is created through the Patient Compass Classic Interface. The incremental file is based on user-defined parameters for PA, AR, and BD and gives information on the accounts that have positive account balances. The incremental process sends only accounts that have had an update based on trigger events. For more information on the interface, please refer to the *Follow-up Functions Volume* of the *STAR Patient Accounting Reference Guide*.

Horizon Performance ManagerTM Interface

This job creates Horizon Performance Manager interface files and audit reports. For more information on the interface, please refer to the *Horizon Performance Manager Interface Volume* of the *STAR Patient Accounting Reference Guide*.

Pending/Candidate Workfile Report

This job produces the FFR650, which includes all of the accounts that are in the Pending/Candidate Workfile. Refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on this report.

Pending Claims Report

This optional batch lists all claims that have been loaded by the system but have not been released for printing or electronic submission to the insurance carrier. The report (FCR260) includes a summary page by carrier/plan. This report can also be requested online. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

Recalculate Workfile Sort

This job rebuilds collector worklists based on the parameters set in the Collector Worklist Control. This job may take a long time to run and should be run on weekends if at all possible. For more information on this function, refer to the *Follow-Up Functions Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Receivable Analysis Report

This job produces the Receivable Analysis report (FSR910), which provides a daily analysis of the hospital's receivables. This report is sorted by financial class and subsorted by patient indicator. This report includes average daily revenue, percent of total revenue, unbilled PA pre-discharge, unbilled PA discharged, billed PA, billed A/R, total A/R, AR days and facility totals.

Unbilled Accounts Report

This optional batch job lists all accounts in account location PA that have been discharged but not yet final billed. This report (FBR110) can be used by the hospital to monitor unbilled accounts. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

Unbilled Accounts Report by Financial Class

This job produces the FBR111 report and provides a list of discharged accounts not final billed. This can be used to help the hospital monitor unbilled accounts.

Unbilled Accounts with Zero Charges Report

This optional batch job (FBR112) provides a list of unbilled accounts with zero charges that are pending forced billing based on the Zero Charge Bill Days parameter on the Billing Parameters screen. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

Unbilled Contract Accounts Report

This optional batch job lists all contract accounts in account location PA that have been discharged but not yet final billed. This report (FDR110) can be used by the hospital to monitor contract accounts. Refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide* for a description of this report.

Unverified Insurance Report

This job produces the Unverified Insurance Report for inpatients (FAR310) and outpatients (FAR3100). These reports list all accounts requiring insurance verification, certification or approval.

These are the functions available in Optional Batch Jobs:

- Optional Batch Jobs Processor
- Optional Batch Jobs Report

Agency Processing Batch Job Processor

This function enables you to schedule or cancel an agency collection batch job run. After you select this option, the system prompts you to enter an agency code or leading characters and a hyphen (-) to display a list of agency codes. You can specify the batch job by entering the specific agency code, or by doing a look-up using any portion of the agency code description followed by a hyphen (-). Using the look-up capability, the system displays the agency code and description for all the agencies beginning with the letters that were entered.

After you select the agency and the desired facility (if this is a multi-facility installation), the following screen is displayed:

```
            General Hospital Optional Batch Jobs Processor
                                                 Mon Apr 17, 2007 10:20 am

 1 Code           2 Description
   3                AR to Bad Debt Transfer
 3 Frequency Type                                4 Starting/Next Date
   Day of Month                                    06/28/2000
 5 Daily Interval/Day of Month/Day-Week of Month
   On the 11th of every month

 6 Last Run Date
   05/23/2000

 7 Edit by                                       8 Edit date
   New, Nancy                                      06/29/2000 10:17 a



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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the agency code for this agency processing batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the agency selected.

3. FREQUENCY TYPE (1-A-R)
This field determines the frequency type with which the job should be run. Entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month, and **O** for One Time Only. If you select O, you must enter a next starting date for the optional batch job to run. The job only runs on the next starting date and is not rescheduled by the system. The next starting date is blank after the job runs for the One Time Only option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the agency processing batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. Enter the starting date to establish an agency processing batch job. To change the next run date, enter the new date on which the job should be run.

NOTE: In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter **Y** to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the agency processing batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of **1** means that the agency processing batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or L for the last day of the month. An entry of **15** means that the agency processing batch job will run on the 15th of every month. If you selected Day- Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from 1-4 or L for the last week of the month. For example, an entry of **2** for the day of the week and L for the week of the month means that the agency processing batch job will run on the last Monday of the month.

6. EDIT BY (DISPLAY ONLY)
This field contains the name of the person who performed the last edit.

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

Optional Batch Jobs Report

This function enables you to request a report of all, scheduled, or non-scheduled optional batch jobs. A detail or summary option and a date range selection are also available for the Scheduled Optional Batch Jobs Report.

After you select this function and a facility (if this is a multi-facility installation), the system displays the following prompt:

Enter type of report - (S)cheduled, (N)on-Scheduled or (A)ll [S]--

This determines the type of report being requested. The default is **S** for scheduled. A scheduled report includes optional batch jobs, ATB reports, and Contract ATB reports that have been scheduled to run within a specified timeframe. A non-scheduled report includes only those optional batch jobs that have not been scheduled to run. Selecting **A** for All produces a report that includes both scheduled and non-scheduled optional batch jobs. Scheduled ATB and Contract ATB reports also show if you select All.

If you enter **S** for a scheduled report, the system displays the following prompt:

Produce (D)etail or (S)ummary report [D]--

This determines if the scheduled report is produced in detail or summary format. The default is **D** for detail. The detail report is a 132-column report that lists all of the pertinent information regarding the job request, including such items as period to process for statistical reports, and the sort criteria, suppression, monthly request, and period end date for the ATB reports. The summary report is an 80-column report that

lists the run date, optional batch job code and description, frequency, and interval. After the report format is selected, the system displays a series of prompts for specifying a timeframe for the scheduled report:

Enter Begin Date [TODAY]--

Enter the starting date for the scheduled report. The default is today's date.

Enter End Date [TODAY]--

Enter the ending date for the scheduled report. The default is today's date.

For each type of report, the following prompt is displayed by the system:

Enter sort - (A)lpha or (C)ode [A]--

This determines whether the optional batch jobs are listed in alphabetic or optional batch job code sequence. The default is alphabetic. Remember, if you are running a scheduled report, the primary sort is run date. Therefore, the alpha or code sequence sort would be the secondary sort within run date.

After you respond to the preceding prompts, you are asked to accept the screen:

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

Enter **Y** to print. The message *Compiling and Printing* appears on the screen.

Enter **N** if you do not want to print. You return to the previous menu.

For more information on these reports, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide.*

Retire Zero Balance AR/BD Accounts (Optional Batch Job 130)

Optional batch job 130 (Retire Zero Balance AR/BD Accounts) can be used to produce reports on accounts to be retired and to retire the accounts. The job can be run in a report mode before using the optional batch job to retire accounts. If a BD account with a balance qualifies for BD Archive Pre-List, the account is pre-listed for archive, so optional batch job 132 can be used to write off the small balance. This happens when OBJ 130 is running in the report mode or is being used to retire accounts, unless the parameter *Exclude BD Accnts with Bal* is set to Yes.

Considerations

- For the first run it is suggested to run this in Report Only mode (set the Report Only field to Yes). This will produce the reports but make no updates to patient information. This optional batch job may also be run for location AR or BD accts only (or both). In order to set up the parameters, set the Frequency Type field to

One Time Only. Patient Type exceptions, financial class exceptions and financial class/patient type exceptions can be defined for Days Past Zero Balance for AR and BD. The opportunity to do that is provided after the first screen is accepted. You can choose whether to report these exceptions on the FBRRTEx report (in fields 14 and 18). If fields 14 and 18 are set to No, accounts with exceptions for pat type, fin class and/or pat type/fin class will not appear on the exceptions report.

- Field 8 can be used to limit the number of exceptions reported in FBRRTEx. If the value of the field is 0, then no exceptions are reported.

- If field 9 (Suppress Production of FBRRTT) is Yes, then FBRRTTx is not produced.

- OBJ 130 produces the FBRRTTx report which shows all accounts moved to retirement (either by the OBJ or manually moved by a user). If the OBJ 130 is defined to run on a Monday the FBRRTTx report will be spooled on Wednesday. The day lag time is due to the fact that this report also shows accounts manually moved to ARR or BDR that occur within the day.

- If an account is evaluated for retirement and does not qualify due to a data issue not related to the parameters for the OBJ, the issue will be reported in FBRRTEx and in transaction history. A message is created in transaction history each time an attempt is made to retire a job. If an account is encountered with a zero balance but no zero balance date, then the zero balance date is assigned so the account will qualify to be retired in the future. If a date exists for an adjustment, payment, refund, or charge then the most recent transaction date is used. Otherwise, the last bill date is used. When this occurs, the message on FBRRTEx is "Balance=0 but No Zero Bal Date" and the message in transaction history and returned to an online user is "Account with No Balance and No Zero Balance Date". Similarly if an account has a balance and a zero balance date, then the zero balance date is removed. When this occurs, the message on FBRRTEx is "Balance but Zero Bal Date" and the message in transaction history and returned to an online attempt to retire the accounts is "Account with Balance and Zero Balance Date".

- You need a sufficient initial sample to review exceptions

- Max Accnts to Retire vs Max Exceptions to Report. Each is reported in an index so keep these numbers small if disk space is tight.

- Suppress FBRRTT to conserve disk space. Index will still be created for stats.

- If disk space is tight consider limiting Max Exceptions to Report or not producing FBRRTE.

- Days Past 0 Bal vs End Disch. This process can add a zero balance date based on account data.

- Exclude BD accnts with Bal. This will make the job run faster initially but will not identify accounts qualifying for a BD SMB W/O.

```
                  General Hospital Optional Batch Jobs Processor Processor
                                                 Sun Oct 31, 2010 04:23 pm

 1 Code           2 Description
   130              Retire Zero Balance AR/BD Accounts
 3 Frequency Type                                    4 Starting/Next Date
   One Time Only                                       12/01/2010
 5 Daily Interval/Day of Month/Day-Week of Month     6 MNP Run Until Time
                                                       6:00
 7 Report Only  8 Max Exceptions to Report   9 Suppress FBRRTT  10 FBRRTE Sort
   No             1,000                        No                  Error/Name
                        Parameters for AR Accounts
11 Days Past 0 Bal 12 End Disch   13 Max Accts to Retire 14 Accnt Exc on FBRRTE
   1                  09/28/2010     1,000                  Yes
                        Parameters for BD Accounts
15 Days Past 0 Bal 16 End Disch   17 Max Accts to Retire 18 Accnt Exc on FBRRTE
   1                  07/01/2010     1,000                  No
19 Exclude BD Accnts with Bal
   Yes
20 Edit by                                          21 Edit date
   Adams,Julie                                         10/28/2010 2:50 pm

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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE(1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month and **O** for One Time Only. The One Time Only option does not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, you should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The Next Starting Date field will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of *1* means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or *L* for the last day of the month. An entry of *15* means that the batch job will run on the 15th of every month. If you selected Day Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from **1-4** or **L** for the last week of the month. For example, an entry of *2* for the day of the week and *L* for the week of the month means that the batch job will run on the last Monday of the month.

6. MNP RUN UNTIL TIME (TIME-O)
This parameter can be used to stop execution of the job at a specific time. The job stops when the next check point is taken after that time. Restart information is saved for the next run.

7. REPORT ONLY (1-A-O)
The optional batch job can be used to report accounts but not retire them. The suggested initial setting for this is *Yes*.

8. MAX EXCEPTIONS TO REPORT
Non-qualifying accounts are reported in FBRRTEx. This parameter can be used to limit the number of accounts appearing in this report so the size of the report is not excessive. Reaching this parameter does not cause the job to stop.

9. SUPPRESS FBRRTT
FBRRTTx lists accounts eligible to be retired. After initial testing is completed, the expected setting of this parameter is N for No, so large reports are not produced.

10. FBRRTE SORT
Non-qualifying accounts are reported in FBRRTEx. This parameter can be used to sort the report by error code followed by name/account number if you want all accounts with the same error message to appear together on the report. Otherwise, the report is sorted by name/account number.

11. DAYS PAST ZERO BALANCE (AR)
AR accounts can be excluded from the evaluation for retirement or the selection is limited by the number of days beyond the zero balance date assigned by the system. This number is entered at the facility level and then overrides can be indicated for financial class, financial class/patient type, or patient type.

If an account qualifies for patient type and for one of the two financial class exceptions (financial class or financial class and patient type), then the maximum number is used.

If no financial class exception is found, then the patient type exception is used if it exists. Otherwise, the number recorded for the facility is used.

12. END DISCH DT (AR)
If AR accounts are not being excluded from the evaluation, then AR accounts with a discharge date after this date are not evaluated for retirement.

13. MAX ACCTS TO RETIRE IN RUN (AR)
The maximum number of AR accounts to be retired or reported in a run is defined by this parameter.

14. ACCNT EXC ON FBRRTE
AR accounts may be excluded from retirement per patient type/financial class and will not print on the FBRRTEx report.

15. DAYS PAST ZERO BALANCE (BD)
BD accounts can be excluded from the evaluation for retirement or the selection is limited by the number of days beyond the zero balance date assigned by the system. This parameter is used for BD accounts with a zero balance. This number is entered at the facility level and then overrides can be indicated for financial class, financial class/patient type, or patient type. If an account qualifies for patient type and for one of the two financial class exceptions (financial class or financial class and patient type), then the maximum number is used. If no financial class exception is found, then the patient type exception is used if it exists. Otherwise, the number recorded for the facility is used.

16. END DISCH DT (BD)
If BD accounts are not being excluded from the evaluation, then BD accounts with a discharge date after this date are not evaluated for retirement.

17. MAX ACCTS TO RETIRE IN RUN (BD)
The maximum number of BD accounts to be retired or reported in a run is defined by this parameter.

18. ACCNT EXC ON FBRRTE (1-A-O)
BD accounts may be excluded from retirement per patient type/financial class and will not print on the FBRRTEx report.

19. EXCLUDE BD ACCNTS WITH BAL (1-A-O)
This parameter can be used to indicate whether BD accounts with a balance are evaluated.If the response is Yes, then qualifying BD accounts with a balance are not-prelisted from this optional batch job. Setting this parameter to Yes initially would allow a facility to concentrate on BD accounts with a balance of zero.

20. OPPS/EAPG (1-A-O)
This parameter determines if the OPPS/EAPG processing information is retained after the account is retired.If this parameter is set to Yes, then if a retired account is unretired the OPPS/EAPG processing information will be visible. If this parameter is set to No, then when a zero balance account is retired the OPPS/EAPG processing information

is removed. This is only the information that was returned via OPPS/EAPG at the time the account/claim was processed through the OPPS/EAPG interface.

21. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last edited this optional batch job.

22. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this optional batch job was last edited.

Return ARR/BDR (Retired) Accounts to AR/BD (OBJ 131)

Optional batch job 131 (Retire Zero Balance AR/BD Accounts) can be used to produce reports on accounts to be un-retired and to un-retire them. When an account is un-retired, it is returned to the location from which it was retired. The intent of the job is allowing accounts to be returned to AR and BD which were retired previously. The job can be run in a report mode before using the optional batch job to un-retire accounts.

When optional batch job 131 is selected, the following screen is displayed:

```
       General Hospital Optional Batch Jobs Processor Processor
                                              Mon Nov 01, 2010 10:47 am

 1 Code           2 Description
   131              Return ARR/BDR (Retired) Accounts to AR/BD
 3 Frequency Type                                    4 Starting/Next Date
   One Time Only                                       01/02/2011
 5 Daily Interval/Day of Month/Day-Week of Month     6 MNP Run Until Time
                                                       7:00
 7 Report Only    8 Suppress Production of FBRRTF
   No               No
                         Parameters for AR Accounts
 9 Max Accts to Return in Run    10 From Ret Date     11 To Ret Date
   20                               07/15/10            08/06/10
                         Parameters for BD Accounts
12 Max Accts to Return in Run    13 From Ret Date     14 To Ret Date
   20                               07/15/10            08/06/10
15 Edit by                                          16 Edit date
   New, Nancy                                          10/21/2010 3:56 pm



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

FIELD EXPLANATIONS

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE(1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month and **O** for One Time Only. The One Time Only option does not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, you should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The Next Starting Date field will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of *1* means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or *L* for the last day of the month. An entry of *15* means that the batch job will run on the 15th of every month. If you selected Day Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from **1-4** or **L** for the last week of the month. For example, an entry of *2* for the day of the week and *L* for the week of the month means that the batch job will run on the last Monday of the month.

6. MNP RUN UNTIL TIME
This parameter can be used to stop execution of the job at a specific time. The job stops when the next check point is taken after that time. Restart information is saved for the next run.

7. REPORT ONLY
The optional batch job can be used to report accounts but not change the account location. The suggested initial setting for this is *Yes*.

8. SUPPRESS PRODUCTION OF FBRRTF
FBRRTFx lists accounts eligible to be returned to AR or BD. After initial testing is completed, the expected setting of this parameter is **N** for No so large reports are not produced.

9. MAX ACCTS TO RETURN IN RUN (AR)
The maximum number of ARR accounts to be un-retired or reported in a run is defined by this parameter.If the value is 0, no accounts in location ARR are evaluated.

10. FROM RET DATE (AR)
The date on which an account was retired to ARR must equal or follow this date to be eligible for the change in account location to AR.

11. TO RET DATE (AR)
The date on which an account was retired to ARR must equal or precede this date to be eligible for the change in account location to AR.

12. MAX ACCTS TO RETURN IN RUN (BD)
The maximum number of BDR accounts to be un-retired or reported in a run is defined by this parameter. If the value is 0, then no accounts in location BDR are evaluated.

13. FROM RET DATE (BD)
The date on which an account was retired to BDR must equal or follow this date to be eligible for the change in account location to BD.

14. TO RET DATE (BD)
The date on which an account was retired to BDR must equal or precede this date to be eligible for the change in account location to BD.

15. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last edited this optional batch job.

16. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this optional batch job was last edited.

Process BD Accnts with Bal Pre-Listed for Archive (OBJ 132)

Optional batch job 132 (Process BD Accnts with Bal Pre-Listed for Archive) can be used to process accounts in the BD Archive Pre-List with a balance qualifying for the small balance write-off. The qualifying balance for the small balance write-off is determined from Max Delete Bal in the Agency Follow-up Schedule. The qualifying accounts can be reported or the job can be used to write off the remaining balance. When the remaining balance is written off, a zero balance date is assigned, which is one of the criteria for retiring an account. The job can be run in a report mode before using the optional batch job to write off the small balance. Also, the job can be parameterized so the amount is not written off until the account is selected to appear in the report produced by this job which is FBRRTB. The logic assumes that the detail report is being produced.

Secondly, the OBJ can be used to count the current number of accounts in the BD Archive Pre-List.

Considerations

- The Report Only and Write Off Balance? fields must both be answered to cause a write off.
- From Reported Date and To Reported Date can be used to limit the write off to accounts previously reported.
- The Count Accounts in BD Archive Pre-List Index field can be used to count existing BD accounts ready to be retired. Initially, the account has been pre-listed due to the zero balance or due to the BD SMB W/O per existing system functionality for account archive and purge. Eventually, the counts would be due to Retired Accounts logic.

```
              General Hospital Optional Batch Jobs Processor Processor
                                                Mon Nov 01, 2010 11:17 am

 1 Code           2 Description
   132              Process BD Accnts with Bal Pre-Listed for Archive
 3 Frequency Type                                    4 Starting/Next Date
   One Time Only                                       11/01/2010
 5 Daily Interval/Day of Month/Day-Week of Month     6 MNP Run Until Time
                                                       7:00
 7 Report Only    8 Suppress Production of FBRRTB
   Yes              No
      Parameters for BD Accounts with Balance Pre-Listed for Archive
 9 Max Accts to Process in Run                    10 End Disch Dt
   10                                                01/01/10
11 Write off Balance?      12 From Reported Date 13 To Reported Date
   No                         01/01/10             10/21/10
14 Count Accounts in BD Archive Pre-List Index
   Yes
15 Edit by                                          16 Edit date
   New, Nancy                                          10/21/2010 3:58 pm
```

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE(1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month and **O** for One Time Only. The One Time Only option does not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, you should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The Next Starting Date field will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of *1* means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or *L* for the last day of the month. An entry of *15* means that the batch job will run on the 15th of every month. If you selected Day Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from **1-4** or **L** for the last week of the month. For example, an entry of *2* for the day of the week and *L* for the week of the month means that the batch job will run on the last Monday of the month.

6. MNP RUN UNTIL TIME
This parameter can be used to stop execution of the job at a specific time. The job stops when the next check point is taken after that time. Restart information is saved for the next run.

7. REPORT ONLY
The optional batch job can be used to report accounts but not change the account location. The suggested initial setting for this is *Yes*.

8. SUPPRESS PRODUCTION OF FBRRTB
FBRRTBx lists accounts eligible for the small balance write off or for which the write-off was taken. After initial testing is completed, the expected setting of this parameter is N for No so large reports are not produced.

9. MAX ACCTS TO PROCESS IN RUN
The maximum number of accounts for which the write-off is placed or reported in a run is defined by this parameter. If the value is 0, then no accounts on the BD Archive Pre-List are evaluated.

10. END DISCH DT
Accounts on the BD Archive Pre-list are excluded if the discharge date follows this date.

11. WRITE OFF BALANCE?
Unless this value is Yes and the Report Only field is not set to Yes, no write off balance is taken. Please note that both parameters need to be set correctly for the write off to be taken.

12. FROM REPORT DATE
If desired, the selection of accounts can be limited to those reported on FBRRTB already on or after this date. The intent of this field is allowing the user to review accounts before the write off is taken.

13. TO REPORT DATE
If desired, the selection of accounts can be limited to those reported on FBRRTB already on or after this date. The intent of this field is allowing the user to review accounts before the write off is taken.

14. ACCOUNT ACCOUNTS IN BD ARCHIVE PRE-LIST INDEX
This parameter provides a second option for this OBJ. If the parameter has a value of Y for Yes, the number of accounts in the BD Archive Pre-List is determined.

15. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last edited this optional batch job.

16. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this optional batch job was last edited.

Reverse SMB Write-Off Posted by Job 132 (Optional Batch Job 133)

The OBJ 133 can be used to reverse the small balances that were written off with OBJ code 132. If the user wishes to reverse the small balance write offs then the parameters for OBJ 133 would be filled in based upon how OBJ 132 was run.

If the account is in BDR, the account is returned to BD first. The reversal is done for the write-offs done per the From SMB W/O Date and To SMB W/O Date. The most recent adjustment for the account must be used and that must be a BD SMB W/O. The Report Only and Reverse Balance? fields must be answered for the reversal to occur.

```
            General Information Optional Batch Jobs Processor
                                                 Thu Nov 04, 2010 11:37 am

 1 Code           2 Description
   133              Reverse SMB Write-Off Posted by Job 132
 3 Frequency Type                                          4 Starting/Next Date
   One Time Only                                             11/15/2010
 5 Daily Interval/Day of Month/Day-Week of Month           6 MNP Run Until Time
                                                             7:00
 7 Report Only    8 Suppress Production of FBRRTV
   Yes              No
         Parameters for BD/BDR Accounts with Small Balance Writeoff
 9 Max Accts to Process in Run  10 From SMB W/O Date    11 To SMB W/O Date
   100                             10/01/10                10/03/10
12 Reverse Balance?
   No
13 Edit by                                               14 Edit date
   New, Nancy                                              10/21/2010 3:59 pm



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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE(1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month and **O** for One Time Only. The One Time Only option does not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, you should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The Next Starting Date field will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of *1* means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or *L* for the last day of the month. An entry of *15* means that the batch job will run on the 15th of every month. If you selected Day Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from **1-4** or **L** for the last week of the month. For example, an entry of *2* for the day of the week and *L* for the week of the month means that the batch job will run on the last Monday of the month.

6. MNP RUN UNTIL TIME
This parameter can be used to stop execution of the job at a specific time. The job stops when the next check point is taken after that time. Restart information is saved for the next run.

7. REPORT ONLY
The optional batch job can be used to report accounts but not retire them. The suggested initial setting for this is *Yes*.

8. SUPPRESS PRODUCTION OF FBRRTT
FBRRTTx lists accounts eligible to be retired. After initial testing is completed, the expected setting of this parameter is N for No, so large reports are not produced.

9. MAX ACCTS TO PROCESS IN RUN
Enter the maximum number of accounts to process in the run, up to 1,000 accounts.

10. FROM SMB W/O DATE
Enter the beginning post date for small balance write-offs by OBJ 132 (SMB W/O's before date are not processed).

11. TO SMB W/O DATE
Enter the ending post date for small balance write-offs by OBJ 132 (SMB W/O's before date are not processed).

12. REVERSE BALANCE?
To reverse balances for qualifying accounts, enter Yes at the prompt.

13. EDIT BY (DISPLAY ONLY)
The system displays the name of the person who last edited this optional batch job.

14. EDIT DATE (DISPLAY ONLY)
The system displays the date and time this optional batch job was last edited.

Estimate Accounts to be Retired (OBJ 134)

This optional batch job can be used to estimate the number of accounts qualifying to be retired in AR and BD and satisfying the following criteria which are used to select accounts for retirement.

- Discharge date does not follow 12/31 of the preceding year
- Number of days beyond the Zero Balance Date is greater than 180

The following numbers are provided by year of discharge for AR accounts:

- Number of Accounts
- Number of Accounts Not Qualifying to be Retired

The following numbers are provided by year of discharge for BD accounts:

- Number of Accounts
- Number of Accounts Qualifying to be Retired
- Number of Accounts Qualifying to be Retired after Small Balance W/O
- Number of Accounts Not Qualifying to be Retired

```
                 General Hospital Optional Batch Jobs Processor Processor
                                                 Thu Nov 04, 2010 09:55 am

 1 Code           2 Description
   134              Estimate Accounts to be Retired
 3 Frequency Type                                      4 Starting/Next Date
   Interval                                              11/04/2010
 5 Daily Interval/Day of Month/Day-Week of Month
   Every other day.
 6 Analyze AR Accounts               7 Analyze BD Accounts
   Yes                                 Yes
 8 Edit by                                             9 Edit date
   New, Nancy                                           10/29/2010 8:46 am









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

Field Explanations

1. CODE (DISPLAY ONLY)
This field displays the code for this optional batch job.

2. DESCRIPTION (DISPLAY ONLY)
This field displays the description of the optional batch job selected.

3. FREQUENCY TYPE(1-A-R)
This field determines the frequency type with which the job should be run. The entry options are **I** for interval, **D** for a specified day of the month, **W** for a specified day within a certain week of the month and **O** for One Time Only. The One Time Only option does not prompt for the Daily Interval/Day of Month/Day-Week of Month field. If the One Time Only option is selected, you should enter a next starting date for the optional batch job to run. The job will only run on the next starting date and will not be rescheduled by the system. The Next Starting Date field will be blank after the job runs for the One Time Only Option.

4. STARTING/NEXT DATE (DATE-R)
This field contains the starting date or the next date on which the optional batch job is scheduled to run. This date is automatically incremented after the job is run based on the frequency defined for the job. To change the next run date, enter the new date on which the job should be run.

In order to cancel an existing job, access this field and press ENTER when you are prompted for the new starting/next run date. You will then receive the following prompt:

Do you wish to discontinue this job? (Y/N)

Enter Y to discontinue the job. Cancel appears as the Starting/Next Date. Once the screen is accepted, the batch job is cancelled.

5. DAILY INTERVAL/DAY OF MONTH/DAY-WEEK OF MONTH (1-AN-R)
Entry options for this field are determined based on the frequency type selected. If you select Interval, you are prompted to enter a daily interval from 1-365. An entry of *1* means that the batch job will run every day. If you select Day of Month, you are prompted to enter the day of the month from 1-28 or *L* for the last day of the month. An entry of *15* means that the batch job will run on the 15th of every month. If you selected Day Week of Month, you are first prompted to enter the day of the week (1=Sun, 2=Mon, for example), and then for the week of the month from **1-4** or **L** for the last week of the month. For example, an entry of *2* for the day of the week and *L* for the week of the month means that the batch job will run on the last Monday of the month.

6. ANALYZE AR ACCOUNTS
Enter Yes at the prompt to analyze AR accounts.

7. ANALYZE BD ACCOUNTS
Enter Yes at the prompt to analyze BD accounts.

Optional Batch Jobs Re-Start/Stop/Clear Processor

The Optional Batch Job Re-Start/Stop/Clear Processor is used to manually re-start, clear and stop an optional batch job. The processor can be used with the following optional batch jobs:

- 38 Collector Reassignment - Insurance
- 130 Retire Zero Balance AR/BD Accounts
- 131 Return ARR/BDR (Retired) Accounts to AR/BD
- 132 Process BD Accnts with Bal Pre-Listed for Archive
- 133 Reverse SMB Write-Off Posted by Job 132

Note, in order to stop a job, system operator access is needed or if a call is placed to McKesson Support, the job can be stopped using this menu option.

To access this processor:

Financial System Management

Optional Batch Jobs

Optional Batch Jobs Re-start/Stop/Clear Processor

One of the following prompts is displayed on the Re-start/Stop/Clear Processor when this option is chosen:

NOTE: The Collector Reassignment - Insurance job is used as an example in the following text.

- If there is no run data for the selection, the following prompt is displayed where XX represents the description for the job:

  No run data exists for Collector Reassignment - Insurance!

- If the optional batch job is complete, the following prompt is displayed:

  Optional batch job is complete. Press ENTER.

- If midnight processing uptime has not completed, no activity can occur and the following message is displayed:

  MNP is in progress. Please try later!

- If the optional batch job was stopped in the middle of processing, the following message is displayed:

  Collector Reassignment - Insurance is not running. Do you want to (R)estart Job from where it stopped or (C)lear this job?-

Clear Option

The Clear option removes information on partial runs so that when the optional batch job runs again, it starts as a new run. The Clear option doesn't set the data back to what it was prior to the run, so any updates to collector that occurred before the job was stopped would remain. If the Clear option is used prior to the next scheduled optional batch job run, the system starts a new run and does not continue where the job previously stopped on an incomplete run. The following message is displayed:

Optional batch job cleared!

The following message is displayed if you can't restart or clear due to a lock.

Unable to lock resource for optional batch job. Please try later.

Re-start Option

The Re-start option continues the job previously stopped on an incomplete run. The Restart option is a manual option from this screen. The facility can also have the job automatically restarted when the next scheduled optional batch job runs. Note, if a clear occurs prior to the next scheduled optional batch job, then the system would start a new run and not continue where the job previously stopped on an incomplete run. If the restart option is selected, the following message is displayed:

Optional batch job restarted!

The following prompt is displayed if you can't restart due to a lock.

Unable to lock resource for optional batch job. Please try later.

STOP Option

The option of Stop allows the facility to stop the optional batch job before it has finished. The optional batch job can be manually stopped from the Optional Batch Job Re-Start/Stop/Clear Processor or it can be stopped automatically through a parameter on the Optional Batch Job processor called MNP Run Until Time.

If the facility accesses the Optional Batch Job Re-Start/Stop/Clear Processor for Job 38 and the job is still running the following prompt displays:

Collector Reassignment - Insurance is running. Do you want to stop this job? (Y/N)-

The following message is displayed if you can't stop the job due to a lock.

Unable to lock resource for optional batch job. Please try later.

If the Insurance Collector Re-assignment job is stopped either manually by the user or automatically in MNP the following messages are displayed on the console log: IM Collector Reassignment - Insur for Fac X stopped by user (ID Y)

IM Collector Reassignment - Insur for Fac X stopped in MNP (ID Y)

The following status screen is displayed for the optional batch job:

```
   General Hospital Optional Batch Job Re-Start/Stop/Clear Processor
                                                 Tue Jun 15, 2010 11:09 am


 1 Code           2 Description
   38               Collector Reassignment - Insurance
 3 MNP Run Started       4 Run Completed   5 Elapsed Run Time          6 # Runs
   06/10/10 02:04          06/10/10 02:04    0 dy 0 hr 0 mn 10 sec       1
 7 Accounts Examined
   PA/1257,AR/6123,BD/507
 8 MNP Run Until Time   9 MNP Job Stopped
   19:00
10 Stop Requested      11 Stop Requested By                  12 Run Stopped

13 Run Re-started      14 Re-started by

15 Run Cleared         16 Cleared by

17 Job Running Since
```

1. CODE (DISPLAY ONLY)
This field contains the code of the optional batch job that was selected from the Optional Batch Jobs with Restart Logic prompt. The system displays the optional batch jobs that can be restarted, stopped or cleared through this processor by the hospital.

2. DESCRIPTION (DISPLAY ONLY)
This field contains the description the optional batch job.

3. MNP RUN STARTED (DISPLAY ONLY)
This field contains the date and time when the job began running in Midnight Processing.

4. RUN COMPLETED (DISPLAY ONLY)
This field is completed if the optional batch job ran and completed processing.

5. ELAPSED RUN TIME (DISPLAY ONLY)
This field is updated with the elapsed time each time the job stops normally.This field indicates how long the job ran in days, hours and minutes. It is updated each time the job stops.

6. # RUNS (DISPLAY ONLY)
This field contains the number of runs that are associated with the OBJ. For example, if it took 3 runs before an OBJ completed processing then the field would contain a value of 3. This field is updated each time the job starts.

7. ACCOUNTS EXAMINED (DISPLAY ONLY)
This field contains a running count of progress and is updated periodically.This field contains the number of accounts that were reviewed by location. For example if 1000 accounts were examined for location PA,1000 for location AR and 5000 for location BD, the field would reflect PA/1000,AR/5000,BD/5000. This field can assist hospitals in determining how many accounts the OBJ is reviewing. If the number is large and the job is taking a long time to complete the hospital could refine its parameters so that not as many accounts were examined.

Note, the number of accounts examined is not the number of claims that are updated with new collectors. This OBJ keeps a running count of progress and updates the tally for the number of accounts examined after every 1000 accounts that it reviews.

8. MNP RUN UNTIL TIME (DISPLAY ONLY)
This field is determined from the MNP Run Until Time field on the optional batch job screen.

9. MNP JOB STOPPED (DISPLAY ONLY)
This field contains the date and time if the job stopped in Midnight Processing.

10. STOP REQUESTED (DISPLAY ONLY)
This field contains the date and time the job was stopped, if it was stopped manually.

11. STOP REQUESTED BY (DISPLAY ONLY)
This field contains the name of the person who requested that the job stop.

12. RUN STOPPED (DISPLAY ONLY)
This field contains the date and time the job was stopped manually.

13. RUN RESTARTED (DISPLAY ONLY)
This field contains the date and time (displayed in military time) the job was re-started, for example 6/15/10 20:23

.14. RE-STARTED BY (DISPLAY ONLY)
This field contains the name of the person who requested that the job re-start. This field contains the name of the person who re-started the job. If the job is restarted, then fields 13 and 14 are updated.

15. RUN CLEARED (DISPLAY ONLY)
This field contains the date and time (displayed in military time for example 6/15/10 20:23) that the job was cleared. If a job is cleared, fields 15 and 16 are updated and no further restarts can be done manually.This field contains the date and time the job was cleared.

16. CLEARED BY (DISPLAY ONLY)
If a job is cleared, no further restarts can be done manually.This field contains the name of the person who cleared the job. If the job is cleared then fields 15 and 16 are updated and no further restarts can be done manually.

17. JOB RUNNING SINCE (DISPLAY ONLY)
When the job starts (MNP or restart), this field contains the start date and time. This will only have a value if the job is actively running in MNP.

FINANCIAL STATISTICS FUNCTIONS

This function provides an online display of current statistics maintained for a master statistic group by its selected statistic keys. Both year-to-date and current period statistics are displayed. This information cannot be edited.

This function allows you to inquire and report on the various statistics maintained by the system. The manner in which financial statistics accumulate is defined in Statistics Maintenance in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

These are the functions available in Financial Statistics functions:

- Financial Statistics Inquiry
- Create Statistical Reports
- Financial Statistics Purge

After you select any of the functions and the desired facility (if this is a multi-facility installation), the system prompts you to enter a statistic group code or a hyphen (-) to display a list of groups. The master statistic groups, which are maintained by McKesson, are listed below:

Code	Description
AGY	Collection Agency Statistics
BIL	Biller Statistics
COL	Collector Statistics
CON	Contract Statistics (Contract Sort)
COR	Contract by Revenue Department Statistics
DIS	Discharge Statistics
DCA	Doctor Census Admitting Statistics
DCT	Doctor Census Attending Statistics
DRA	Doctor Revenue Admitting Statistics
DRO	Doctor Revenue Ordering Statistics
DRT	Doctor Revenue Attending Statistics
EMP	Employer Census Statistics
EMR	Employer Revenue Statistics
FCC	Financial Class Census Statistics
FCR	Financial Class Revenue Statistics
IST	Insurance Statistics

Code	Description
LCP	Late Charge Statistics
MED	Medical Service Census Statistics
MER	Medical Service Revenue Statistics
NUR	Nurse Station Statistics
PAT	Patient Type Census Statistics
PTR	Patient Type Revenue Statistics
REV	Revenue Center Statistics
TRC	Transaction Statistics
ZIP	ZIP Code Statistics

Financial Statistics Inquiry

After you enter the group code, the first of two screens is displayed.

```
          General Hospital Financial Statistics Inquiry Processor
                                              Thu Feb 17, 2000 10:13 am

 1 Statistic Group/Name                                2 Fiscal Year  3 Period
   Collection Agency Statistics                          00             1
 4 Key Description                          Key Value
   Collection Agency Code
   Patient Indicator
   Financial Class

           F2Next Page F5View Statistics F6 Reset  F7  Exit   ?
```

This first screen is the same for each statistical group. It displays the group name, current fiscal year and period, and the statistic keys used for this statistic group.

The purpose of the screen is to enable you to select values for each key assigned by entering the desired code for the key displayed or displaying and selecting from a list of codes in the Key Description field. Each key must be assigned a valid value to complete this phase of the transaction.

Field Explanations

1. STATISTIC GROUP/NAME (DISPLAY ONLY)
This field displays the code and description of the statistic group entered.

2. FISCAL YEAR (2-N-O) or (TABLE LOOKUP-O)
This field displays the current fiscal year. Enter a fiscal year in the format YY or select a fiscal year from a list. The new fiscal year must already be established in the system.

3. PERIOD (2-N-O)
This field displays the number of the current accounting period. Enter an accounting period or select an accounting period from a list. The new accounting period must already be established in the system.

4. KEY DESCRIPTION (DISPLAY ONLY)
Each statistic group has statistic keys assigned to it by McKesson. Statistic keys are categories of data elements (such as financial class or patient type) used as the basis for collecting statistical information for the group. The system displays the keys selected for use with this group. The primary key is displayed first followed by the remaining keys in order of selection. This is also the order in which the keys display on the statistics reports.

KEY VALUE (TABLE LOOKUP-R)
The key value is a specific value assigned to the key involved. For example, if the key description is Financial Class, the key value can be any valid financial class code. When assigning values to key descriptions, you can enter the desired code or display and select from a list of codes.

If you attempt to view statistics for keys where the key value is either missing or has been set as inactive in Statistics Maintenance, you can enter the following as the key value:

~ (1 tilde)	If the key is inactive.
~~ (2 tildes)	If the key value is missing.
~~ (8 tildes)	If the primary key is missing.

These tildes are used to identify these missing values to the STAR KB_SQL system.

When values are assigned, pressing the **F5** key (from the display of function keys at the bottom of the screen) prompts the system to display a second screen containing statistical data, by the selected fiscal period and year, for the statistic group by the selected key values. The system displays information according to the key values defined. As such, if the cursor is on the first key when you press the F5 key, the system displays information for that key value. If the cursor is on the Collection Agency Code and you press F5, the system displays Collection Agency Statistics for the defined Collection Agency Code for all patient indicators and financial classes. If key values have been assigned and the cursor is on Patient Indicator, the system displays

Collection Agency Statistics for the defined Collection Agency Code for the defined Patient Indicator for all financial classes.

The statistic screen for each statistic group is presented in the listed order. You can view only one selection at a time.

COLLECTION AGENCY STATISTICS

```
        General Hospital Financial Statistics Inquiry Processor
                                            Wed Jul 19, 2000 03:30 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Collector Statistics                                00             7
 4 Key Description                        Key Value
   Collector Code                 55 ARDEN,JULIE
   Patient Indicator              O Outpatient
   Patient Type                   O/P Regular Outpatient Admission
   Financial Class                JA JULIE'S FIN CLASS
                                 Number                        Amount
Accounts Added              1 Period      YTD    2 Period            YTD
                                  0          1              0.00          406.18
Accounts Paid               3 Period      YTD    4 Period            YTD
                                  0          0              0.00            0.00
Accounts Transferred to BD  5 Period      YTD    6 Period            YTD
                                  0          0              0.00            0.00
Accounts Adjusted           7 Period      YTD    8 Period            YTD
                                  0          0              0.00            0.00
Accounts Transferred Out    9 Period      YTD   10 Period            YTD
                                  0          0              0.00            0.00
                           11 Stmts-Period/YTD  12 Calls-Period/YTD
Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

NUMBER OF ACCOUNTS ADDED (DISPLAY ONLY)
The system displays the number of selected accounts added to this collector's workfile during the selected accounting period and year-to-date.

ACCOUNTS ADDED AMOUNT (DISPLAY ONLY)
The system displays the total dollar balance of all selected accounts added to this collector's workfile during the selected accounting period and year-to-date.

NUMBER OF ACCOUNTS PAID (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile paid in full during the selected accounting period and year-to-date.

ACCOUNTS PAID AMOUNT (DISPLAY ONLY)
The system displays the total dollar amount of all selected accounts in this collector's workfile paid in full during the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED TO BD (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile transferred from AR to bad debt during the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED TO BD AMOUNT (DISPLAY ONLY)
The system displays the total dollar amount of selected accounts in this collector's workfile transferred from AR to bad debt during the selected accounting period and year-to-date.

ACCOUNTS ADJUSTED (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile whose balances were adjusted during the selected accounting period and year-to-date.

ACCOUNTS ADJUSTED AMOUNT (DISPLAY ONLY)
The system displays the total dollar amount of adjustments made to selected accounts in this collector's workfile during the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED OUT (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile that have been transferred to other collectors for the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED OUT AMOUNT (DISPLAY ONLY)
This field displays the total dollar amount of the accounts which have been transferred to other collectors for the selected accounting period and year-to-date.

STMTS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of follow-up statements and telephone follow-up the system has generated in this collector's workfile for the selected accounting period and year-to-date. This field is updated by insurance follow-up.

CALLS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of telephone calls added to this collector's workfile for the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction. The system returns to the Key Value field for you to select another key. Press the F7 key to exit.

BILLER STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                          Thu Feb 17, 2000 10:18 am

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Biller Statistics                                   00              1
 4 Key Description                        Key Value
   Biller Code                       ~~~~~~~~ Missing Key
                                Number                          Amount
New Claims                1 Period      YTD       2   Period              YTD
                                  0         0                   0.00          0.00
Claims Released           3 Period      YTD       4   Period              YTD
                                  0         0                   0.00          0.00
Claims Failing Edits      5 Period      YTD       6   Period              YTD
                                  0         0                   0.00          0.00
Claims Transferred Out    7 Period      YTD       8   Period              YTD
                                  0         0                   0.00          0.00
Claims Transferred In     9 Period      YTD      10   Period              YTD
                                  0         0                   0.00          0.00




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

NUMBER OF NEW CLAIMS (DISPLAY ONLY)

The system displays the number of new claims assigned to this biller during the selected accounting period and year-to-date. This number is incremented when a claim is loaded or transferred to this biller.

NEW CLAIMS AMOUNT (DISPLAY ONLY)

The system displays the total dollar amount of new claims loaded to this biller during the selected accounting period and year-to-date. This amount represents the total of the claim amounts, not the carrier liability. This amount is incremented when a claim is loaded or transferred to this biller.

NUMBER OF CLAIMS RELEASED (DISPLAY ONLY)

The system displays the number of claims assigned to this biller, having the specified key values, released to all carriers. It displays the number of claims for the selected accounting period and year-to-date.

CLAIMS RELEASED AMOUNT (DISPLAY ONLY)

The system displays the total dollar amount of claims released to all carriers during the selected accounting period and year-to-date.

NUMBER OF CLAIMS FAILING EDITS (DISPLAY ONLY)
The system displays the number of claims having the specified key values failing edits during the selected accounting period and year-to-date. A claim failing edits is only counted once.

AMOUNT OF CLAIMS FAILING EDITS (DISPLAY ONLY)
The system displays the total dollar amount of claims failing edits during the selected accounting period and year-to-date.

NUMBER OF CLAIMS TRANSFERRED OUT (DISPLAY ONLY)
The system displays the number of claims transferred from this biller to another biller during the selected accounting period and year-to-date. This number is incremented via the Transfer Biller Work function when the Update Claim Statistics field is set to Yes. The update takes place for the fiscal period selected when the claim is transferred. Refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information.

AMOUNT OF CLAIMS TRANSFERRED OUT (DISPLAY ONLY)
The system displays the total dollar amount of claims transferred from this biller to another biller during this accounting period and year-to-date. This amount is incremented via the Transfer Biller Work function when the Update Claim Statistics field is set to Yes. The update takes place for the fiscal period selected when the claim is transferred. Refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information.

NUMBER OF CLAIMS TRANSFERRED IN (DISPLAY ONLY)
The system displays the number of claims transferred to this biller from another biller during the selected accounting period and year-to-date. This number is incremented via the Transfer Biller Work function when the Update Claim Statistics field is set to Yes. The update takes place for the fiscal period selected when the claim is transferred. Refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information.

AMOUNT OF CLAIMS TRANSFERRED IN (DISPLAY ONLY)
The system displays the total dollar amount of claims transferred to this biller from another biller during this accounting period and year-to-date. This amount is incremented via the Transfer Biller Work function when the Update Claim Statistics field is set to Yes. The update takes place for the fiscal period selected when the claim is transferred. Refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information

When you finish viewing the screen, press the ENTER key to complete the transaction.

COLLECTOR STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                          Tue Sep 08, 1992 02:20 pm

 1 Statistic Group/Name                          2 Fiscal Year  3 Period
   Collector Statistics                            92             9
 4 Key Description                      Key Value
   Collector Code                 70 Anderson,Amy
   Patient Indicator              E Emergency
   Patient Type                   I/P Inpatient
   Financial Class                T Blue Cross

                                Number                        Amount
Accounts Added              1 Period      YTD    2 Period            YTD
                                   6       15         1000.00      11000.00
Accounts Paid               3 Period      YTD    4 Period            YTD
                                   4        5          811.15       8000.00
Accounts Transferred to BD  5 Period      YTD    6 Period            YTD
                                   2        2          418.50        561.19
Accounts Adjusted           7 Period      YTD    8 Period            YTD
                                   0        1           59.00          59.00
Accounts Transferred Out    9 Period      YTD   10 Period            YTD
                                   0        0            0.00           0.00
                           11 Stmts-Period/YTD  12 Calls-Period/YTD
Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

NUMBER OF ACCOUNTS ADDED (DISPLAY ONLY)
The system displays the number of selected accounts added to this collector's workfile during the selected accounting period and year-to-date.

ACCOUNTS ADDED AMOUNT (DISPLAY ONLY)
The system displays the total dollar balance of all selected accounts added to this collector's workfile during the selected accounting period and year-to-date.

NUMBER OF ACCOUNTS PAID (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile paid in full during the selected accounting period and year-to-date.

ACCOUNTS PAID AMOUNT (DISPLAY ONLY)
The system displays the total dollar amount of all selected accounts in this collector's workfile paid in full during the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED TO BD (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile transferred from AR to bad debt during the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED TO BD AMOUNT (DISPLAY ONLY)
The system displays the total dollar amount of selected accounts in this collector's workfile transferred from AR to bad debt during the selected accounting period and year-to-date.

ACCOUNTS ADJUSTED (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile whose balances were adjusted during the selected accounting period and year-to-date.

ACCOUNTS ADJUSTED AMOUNT (DISPLAY ONLY)
The system displays the total dollar amount of adjustments made to selected accounts in this collector's workfile during the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED OUT (DISPLAY ONLY)
The system displays the number of selected accounts in this collector's workfile that have been transferred to other collectors for the selected accounting period and year-to-date.

ACCOUNTS TRANSFERRED OUT AMOUNT (DISPLAY ONLY)
This field displays the total dollar amount of the accounts which have been transferred to other collectors for the selected accounting period and year-to-date.

STMTS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of follow-up statements and telephone follow-up the system has generated in this collector's workfile for the selected accounting period and year-to-date. This field is updated by insurance follow-up.

CALLS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of telephone calls added to this collector's workfile for the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

CONTRACT BY REVENUE DEPARTMENT STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 21, 1992 10:16 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   Contract by Revenue Department                 92             4
 4 Key Description                           Key Value
   Revenue Department              7380 ANESTHESIA
   SIM Department                  ANS
   SIM Item Number                 1999 ANESTHESIA

 1 Charges-Period/YTD        2 Charge Amt-Period/YTD
         30       60                  6000    12000
 3 RVU's-Period/YTD          4 UOS-Period/YTD









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges associated with this revenue center during the selected accounting period and year-to-date.

2. CHARGE AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges associated with this revenue center during the selected accounting period and year-to-date.

3. RVUs-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of relative value units associated with this revenue center during the selected accounting period and year-to-date.

4. UOS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of units of service associated with this revenue center during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

CONTRACT STATISTICS (SORT BY CONTRACT)

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 21, 1992 10:16 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   Contract                                      92             4
 4 Key Description                            Key Value
   Contract Code                    2 TEST 2 ADDR NO ATTN
   Revenue Department               7380 ANESTHESIA
   SIM Department                   ANS
   SIM Item Number                  1999 ANESTHESIA

 1 Charges-Period/YTD          2 Charge Amt-Period/YTD
          30       60                    6000    12000
 3 RVU's-Period/YTD            4 UOS-Period/YTD









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges associated with this contract during the selected accounting period and year-to-date.

2. CHARGE AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges associated with this contract during the selected accounting period and year-to-date.

3. RVUs-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of relative value units associated with this contract during the selected accounting period and year-to-date.

4. UOS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of units of service associated with this contract during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

DISCHARGE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:20 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Discharge                                           92             9
 4 Key Description                          Key Value
   Nurse Station                            3W 3 West
   Financial Class                          T Blue Cross
   Patient Type                             I/P Inpatient
 1 Discharges-Period/YTD              2 Dis Days-Period/YTD
         57      264                          2        3









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of discharges for this nurse station during the selected accounting period and year-to-date.

2. DIS DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the discharge days for accounts discharged for this nurse station during the selected accounting period and year-to-date. This is the length of stay of accounts discharged during the selected accounting period and year to date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

DOCTOR CENSUS ADMITTING STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 21, 1988 09:56 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   DCA Doctor Census Admitting Statistic          88             9
 4 Key Description                            Key Value
   Admitting Physician             500 ADAMS,LEES ET AL.
   Patient Indicator               E Emergency
   Medical Service                 CCU CORONARY CARE

 1 Admits-Period/YTD         2 Regs-Period/YTD            3 OP Visits-Period/YT
        4        16                        2
 4 Discharges-Period/YTD     5 Pat Days-Period/YTD        6 Deaths-Period/YTD
        3           15              46       111
 7 CA Accts-Period/YTD       8 CA Accts Amt-Period/YTD




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

When a patient is admitted or registered, both the admitting and attending physicians can be entered. This function maintains statistics for the admitting physician only.

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of selected patients admitted by this physician during the selected accounting period and year-to-date.

2. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of selected patients registered by this physician during the selected accounting period and year-to-date.

3. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of selected outpatient visits associated with this physician during the selected accounting period and year-to-date.

4. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of selected patients discharged by this physician during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of inpatient patient days for this physician during the selected accounting period and year-to-date. This field is blank for outpatients.

6. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of selected patients admitted by this physician who expired during their stay. The totals displayed represent the selected accounting period and year-to-date.

7. CA ACCTS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of accounts admitted by this physician, sent to a collection agency during the selected accounting period and year-to-date.

8. CA ACCTS AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar balance of accounts admitted by this physician, sent to a collection agency during the selected accounting period and year-to-date.

After you finish viewing this screen, press the ENTER key to complete the transaction.

DOCTOR CENSUS ATTENDING STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 21, 1988 09:58 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   DC Doctor Census Attending Statistic          88             9
 4 Key Description                           Key Value
   Attending Physician             500 ADAMS,LEES ETAL
   Patient Indicator               E Emergency
   Medical Service                 CCU CORONARY CARE

 1 Admits-Period/YTD         2 Regs-Period/YTD            3 OP Visits-Period/YT
   14            40
 4 Discharges-Period/YTD     5 Pat Days-Period/YTD        6 Deaths-Period/YTD
   9             31                                       1             3
 7 CA Accts-Period/YTD       8 CA Accts Amt-Period/YTD
   3             5             30,279.82           58,419.64




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of selected patients admitted by this attending physician during the selected accounting period and year-to-date.

2. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients registered by this attending physician during the selected accounting period and year-to-date.

3. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of outpatient visits associated with this attending physician during the selected accounting period and year-to-date.

4. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients discharged by this attending physician during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of inpatient patient days for this physician during the selected accounting period and year-to-date. This field is blank for outpatients.

6. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients admitted by this attending physician who expired during their stay. The totals displayed represent the selected accounting period and year-to-date.

7. CA ACCTS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of accounts associated with this attending physician, sent to a collection agency during the selected accounting period and year-to-date.

8. CA ACCTS AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar balance of accounts associated with this attending physician, sent to a collection agency during the selected accounting period and year-to-date.

After you finish viewing this screen, press the ENTER key to complete the transaction.

DOCTOR REVENUE ADMITTING STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 09, 1992 09:59 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   Doctor Revenue Admitting Statist              92             9
 4 Key Description                            Key Value
   Admitting Physician             500 *ADAMS,LEES ETAL
   Revenue Dept.                   7380 Anesthesia
   Patient Indicator               E Emergency
   Financial Class                 T Blue Cross
 1 Total Charges-Period/YTD          2 Quantity-Period/YTD
       8,192.12     27,302.88              171      899









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. TOTAL CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed on the accounts of patients admitted by this physician. This amount is presented for the selected accounting period and year-to-date.

2. QUANTITY-PERIOD/YTD (DISPLAY ONLY)
This field displays the total number of charges placed on the accounts of patients admitted by this physician for the selected accounting period and year-to-date.

In doctor revenue statistics, the same item can be statistically tracked for the admitting, attending and ordering physician. There is a separate statistic key for each of these statistics.

After you finish viewing the screen, press the ENTER key to complete the transaction.

DOCTOR REVENUE ORDERING STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:20 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Doctor Revenue Ordering Statistics                  92             9
 4 Key Description                          Key Value
   Ordering Physician              700 *ADAMS,JONES,SMITH ETAL
   Revenue Department              7380 ANESTHESIA
   Patient Indicator               E Emergency
   Financial Class                 B BLACK CROSS X
 1 Total Charges-Period/YTD           2 Quantity-Period/YTD
         910.73       3,109.25               26      241









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. TOTAL CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed on the accounts of selected patients by this physician during the selected accounting period and year-to-date.

2. QUANTITY-PERIOD/YTD (DISPLAY ONLY)
This field displays the total number of charges placed on the accounts of patients associated with this attending physician for the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

DOCTOR REVENUE ATTENDING STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:20 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Doctor Revenue Attending Statistics                 92             9
 4 Key Description                          Key Value
   Attending Physician             700 *ADAMS,JONES,SMITH ETAL
   Revenue Department              7380 ANESTHESIA
   Patient Indicator               E Emergency
   Financial Class                 T BLUE CROSS X
 1 Total Charges-Period/YTD           2 Quantity-Period/YTD
       1,009.16     12,949.17               37      893









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. TOTAL CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed on patient accounts associated with this attending physician during the selected accounting period and year-to-date.

2. QUANTITY-PERIOD/YTD (DISPLAY ONLY)
This field displays the total number of charges placed on the accounts of selected patients by this physician for the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

EMPLOYER CENSUS STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Employer Census Statistics                          92             9
 4 Key Description                          Key Value
   Employer Code                  1 HBO & COMPANY
   Patient Type                   ADV Advance Admission Inpatient
   Financial Class                C COMMERCIAL
 1 Admits-Period/YTD         2 Discharges-Period/YTD     3 Regs-Period/YTD
       11    185                   10    181                   12     86
 4 OP Visits-Period/YTD                 5 Pat Days-Period/YTD
       23    722                                 2        3
 6 CA Accts Amt-Period/YTD              7 CA Accts-Period/YTD
          623.12      2,843.40                   6       38









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

Employer statistics are based on the insured's employer which may be different than the patient's employer.

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients working for this employer who were admitted during the selected accounting period and year-to-date.

2. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients working for this employer who were discharged during the selected accounting period and year-to-date.

3. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients working for this employer who were registered during the selected accounting period and year-to-date.

4. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients working for this employer who made outpatient visits to the hospital during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of inpatient days recorded during the selected accounting period and year-to-date for patients working for this employer.

6. CA ACCTS AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar balance of accounts for patients working for this employer that were sent to a collection agency during the selected accounting period and year-to-date.

7. CA ACCTS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of accounts for patients working for this employer that were sent to a collection agency during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

EMPLOYER REVENUE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Employer Revenue Statistics                         92             9
 4 Key Description                          Key Value
   Employer Code                    1 HBO & COMPANY
   Revenue Department               7200 CARDIOLOGY
   Patient Type                     CON Contract account
 1 Total Charges-Period/YTD            2 Quantity-Period/YTD
           0.00     18,941.64                 0        1









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

NOTE: Employer statistics are based on the insured's employer, which may be different from the patient's employer.

1. TOTAL CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed on accounts of patients, employed by this employer, during the selected accounting period and year-to-date.

2. QUANTITY-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges placed on accounts of patients, employed by this employer, during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

FINANCIAL CLASS CENSUS STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                                2 Fiscal Year  3 Period
   Financial Class Census                                92             9
 4 Key Description                          Key Value
   Financial Class                     C COMMERCIAL
   Patient Type                        ER Emergency Room
 1 Admits-Period/YTD          2 Regs-Period/YTD             3 OP Visits-Period/YT
      12    436                    5     17                      23     84
 4 Discharges-Period/YTD      5 Pat Days-Period/YTD         6 Deaths-Period/YTD
      25    723                      3        2                      0        3









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients admitted to the facility for this financial class during the selected accounting period and year-to-date.

2. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients discharged from the facility for this financial class during the selected accounting period and year-to-date.

3. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients registered to the facility for this financial class during the selected accounting period and year-to-date.

4. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of outpatient visits for this financial class during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patient days for this financial class during the selected accounting period and year-to-date.

6. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patient deaths for this financial class during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

FINANCIAL CLASS REVENUE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Financial Class Revenue                             92             9
 4 Key Description                        Key Value
   Financial Class                 C COMMERCIAL
   Patient Type                    ER Emergency Room
 1 Total Charges-Period/YTD           2 Quantity-Period/YTD
         291.23      9,102.37                15       90









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. TOTAL CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed for this financial class during the selected accounting period and year-to-date.

2. QUANTITY-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges placed for this financial class during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

INSURANCE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Insurance                                           92             9
 4 Key Description                          Key Value
   Carrier/Plan Code                500005 BLUE CROSS 1500
   Patient Indicator                E Emergency
                           Number                              Amount
Claims                1 Period      YTD          2 Period            YTD
                             28       956               2,874.07  5,235,780.87
Payments              3 Period      YTD          4 Period            YTD
                             36       899               2,876.99  5,375,078.22
Adjustments           5 Period      YTD          6 Period            YTD
                             23       239                688.75     12,876.25









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. CLAIMS NUMBER-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of claims submitted for this insurance carrier/plan during the selected accounting period and year-to-date.

2. CLAIMS AMOUNT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of claims submitted for this insurance carrier/plan during the selected accounting period and year-to-date.

3. PAYMENTS NUMBER-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of payments received for claims submitted for this insurance carrier/plan during the selected accounting period and year-to-date.

4. PAYMENTS AMOUNT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount paid on claims submitted for this insurance carrier/plan during the selected accounting period and year-to-date.

5. ADJUSTMENT NUMBER-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of adjustments made on claims submitted for this insurance carrier/plan during the selected accounting period and year-to-date.

6. ADJUSTMENT AMOUNT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of adjustments for claims submitted for this insurance carrier/plan during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

LATE CHARGE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Oct 03, 1990 04:17 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Late Charge Statistics                              90             10
 4 Key Description                          Key Value
   Revenue Department              7800 PHARMACY
   Patient Indicator               I Inpatient


 1 Charges-Period/YTD        2 Charge Amt-Period/YTD









Press NL--
```

Field Explanations

1. CHARGES-PERIOD/YTD (DISPLAY ONLY)
This field displays the number of charges associated with the specified revenue department during the selected accounting period and year-to-date.

2. CHARGE AMT-PERIOD/YTD (DISPLAY ONLY)
This field displays the amount of charges associated with the specified revenue department during the selected accounting period and year-to-date.

MEDICAL SERVICE CENSUS STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Oct 11, 1988 02:48 pm

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   MED Medical Service Census Statistic          88             10
 4 Key Description                           Key Value
   Medical Service                 001 ANESTHESIA
   Patient Indicator               E Emergency
   Financial Class                 03 BLUE CROSS

 1 Admits-Period/YTD         2 Regs-Period/YTD            3 OP Visits-Period/YT
        14        60
 4 Discharges-Period/YTD     5 Pat Days-Period/YTD        6 Deaths-Period/YTD
        14            60              148      600




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients admitted for this medical service during the selected accounting period and year-to-date.

2. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients registered for this medical service during the selected accounting period and year-to-date.

3. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of outpatient visits associated with this medical service during the selected accounting period and year-to-date.

4. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients discharged under this medical service during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of inpatient days associated with this medical service during the selected accounting period and year-to-date. This field is blank for outpatients.

6. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of patients admitted for this medical service who expired during their stay. The totals displayed represent the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

MEDICAL SERVICE REVENUE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Medical Service Revenue Statistics                  92             9
 4 Key Description                          Key Value
   Medical Service                CCU CORONARY CARE
   Revenue Department             7200 CARDIOLOGY
   Patient Indicator              E Emergency
 1 Charges-Period/YTD       2 Charge Amount-Period/YTD
       272    3,109             180,298.23  2,409,329.94
 3 UOS-Period/YTD           4 RVU's-Period/YTD
       291    4,102             48,298.83    938,198.27









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges placed for this medical service during the selected accounting period and year-to-date.

2. CHARGE AMOUNT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed for this medical service during the selected accounting period and year-to-date.

3. UOS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of units of service associated with this medical service during the selected accounting period and year-to-date.

4. RVU'S-PERIOD/YTD (DISPLAY ONLY)
This field displays the number of Relative Value Units associated with this medical service during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

NURSE STATION STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Nurse Station Statistics                            92             9
 4 Key Description                          Key Value
   Nurse Station                  2M 2 MAIN
   Financial Class                C COMMERCIAL
   Patient Type                   ER Emergency Room
   Medical Service                CCU CORONARY CARE
 1 Admits-Period/YTD         2 Discharges-Period/YTD
         2       35                  2       30
 3 OP in Bed-Period/YTD      4 1 Day Stays-Period/YTD
         0        3                  0        0
 5 Pat Days-Period/YTD       6 Transfers Out-Period/YTD
         2        3                  0       12
 7 Transfers In-Period/YTD   8 Internal Trans-Period/YTD
         1       14                  0        9
 9 Deaths-Period/YTD        10 Bed Charges-Period/YTD
         0        1                  0        5


Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of admissions to this nurse station during the selected accounting period and year-to-date.

2. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of discharges from this nurse station during the selected accounting period and year-to-date.

3. OP IN BED-PERIOD/YTD
The system displays the number of outpatients in bed on this nurse station during the selected accounting period and year-to-date. It applies to outpatients in beds only.

4. 1 DAY STAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of one-day patient stays on this nurse station during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patient stay days recorded for this nurse station during the selected accounting period and year-to-date. This number of days includes one-day stays defined as: admit date - discharge date + 1.

6. TRANSFERS OUT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patient transfers out of this nurse station during the selected accounting period and year-to-date.

7. TRANSFERS IN-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patient transfers into this nurse station during the selected accounting period and year-to-date.

8. INTERNAL TRANSFERS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of internal patient transfers on this nurse station during the selected accounting period and year-to-date.

9. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patient deaths having taken place on this nurse station during the selected accounting period and year-to-date.

10. BED CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total amount of bed charges accrued by patients on this nurse station during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

PATIENT TYPE CENSUS STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                                2 Fiscal Year  3 Period
   Patient Type Census Statistics                        92             9
 4 Key Description                          Key Value
   Patient Type                       ER Emergency Room
   Medical Service                    CCU CORONARY CARE
   Financial Class                    C COMMERCIAL
 1 Admits-Period/YTD                2 Discharges-Period/YTD
         18      112                        19      105
 3 Regs-Period/YTD                  4 OP Visits-Period/YTD
          7       83                        20      143
 5 Pat Days-Period/YTD              6 Deaths-Period/YTD
          2        3                         0        3
 7 Patient Type transfer in         8 Patient Type transfer out
          0       12                         2       18




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of admissions of patients assigned this patient type, during the selected accounting period and year-to-date.

2. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of discharges of patients assigned this patient type, during the selected accounting period and year-to-date.

3. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of registrations of patients assigned this patient type, during the selected accounting period and year-to-date.

4. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of outpatient visits, made by patients assigned this patient type, during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patient stay days of patients assigned this patient type, during the selected accounting period and year-to-date.

6. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patients, assigned this patient type, who expired during their stay. This information is displayed for the selected accounting period and year-to-date.

7. PATIENT TYPE TRANSFER IN (DISPLAY ONLY)
The system displays the number of patients transferred from another patient type to this patient type.

8. PATIENT TYPE TRANSFER OUT (DISPLAY ONLY)
This system displays the number of patients transferred from this patient type to another patient type.

After you finish viewing the screen, press the ENTER key to complete the transaction.

PATIENT TYPE REVENUE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 02:59 pm

 1 Statistic Group/Name                              2 Fiscal Year  3 Period
   Patient Type                                        92             9
 4 Key Description                          Key Value
   Patient Type                    CON Contract account
   Medical Service                 CCU CORONARY CARE
   Financial Class                 C COMMERCIAL
 1 Total Charges-Period/YTD           2 Quantity-Period/YTD
       1,045.20     14,927.45                12       70









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. TOTAL CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges placed for this patient type during the selected accounting period and year-to-date.

2. QUANTITY-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges placed for this patient type during the selected accounting period and year-to-date.

After you finish viewing the screen, press ENTER to complete the transaction.

REVENUE CENTER STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 09, 1992 10:20 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   REV Revenue Center Statistics                 92             9
 4 Key Description                            Key Value
   Revenue Department              7380 ANESTHESIA
   Financial Class                 A CHAMPUS
   SIM Department                  ANS
   SIM Item Number                 1999 ANESTHESIA
   Patient Indicator               E Emergency
 1 Quantity-Period/YTD       2 Charge Amt-Period/YTD
         30       60                  6000    12000
 3 RVU's-Period/YTD          4 UOS-Period/YTD




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges associated with this revenue center during the selected accounting period and year-to-date.

2. CHARGE AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of charges associated with this revenue center during the selected accounting period and year-to-date.

3. RVUs-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of relative value units associated with this revenue center during the selected accounting period and year-to-date.

4. UOS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of units of service associated with this revenue center during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

TRANSACTION STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Wed Sep 21, 1988 10:22 am

 1 Statistic Group/Name                        2 Fiscal Year  3 Period
   TRC Transaction Statistics                    88             9
 4 Key Description                            Key Value
   Transaction Type                 A Adjustment
   Transaction Code                 1002 CONTRACTUAL ADJUSTMENT
   Financial Class                  C COMMERCIAL
   Patient Type                     IP1 Admission

 1 # Transactions-Period/YTD          2 Transaction Amt-Period/YTD
              196        216                  12916.15         12916.15









Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts. Individual transaction code statistics are kept only if the Statistics Mapping key is defined to accumulate stats for specific transaction types and if you specify, on the Transaction Code Master, to keep stats for the specific code.

If you are keeping transaction statistics for non-patient transactions, the only inquiry options available for the Key Description field are Transaction Type and Transaction Code, since these transactions have no patient indicator or financial class associated with them. Non-patient transactions include: V-Collection Agency Fees, F-Misc Cash, O-Misc Notes, N-Non-patient Cash, G-Other Adjustments, J-Other Refunds, and U-Unapplied Cash.

Field Explanations

1. TRANSACTIONS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of transactions associated with the specified transaction type during the selected accounting period and year-to-date.

2. TRANSACTION AMT-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount of the transactions associated with the specified transaction type during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

ZIP CODE STATISTICS

```
          General Hospital Financial Statistics Inquiry Processor
                                              Tue Sep 08, 1992 04:53 pm

 1 Statistic Group/Name                                2 Fiscal Year  3 Period
   Zip Code Statistics                                   92             9
 4 Key Description                          Key Value
   Zip Code                          30346 ATLANTA,GA 30346
   Patient Type                      ER Emergency Room
   Medical Service                   CCU CORONARY CARE
   Financial Class                   C COMMERCIAL
 1 Admits-Period/YTD          2 Discharges-Period/YTD
        1      8                      2            10
 3 Regs-Period/YTD            4 OP Visits-Period/YTD
        0      7                      2            17
 5 Pat Days-Period/YTD        6 Charges-Period/YTD
        1      1                  1,209.51     30,092.84
 7 Deaths-Period/YTD          8 Charge Qty-Period/YTD
        0      0                     81           241




Press NL--
```

NOTE: The statistical information displayed in the following fields represents only those accounts selected according to the key values entered — not all accounts.

Field Explanations

1. ADMITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of admissions of patients residing in this ZIP code, during the selected accounting period and year-to-date.

2. DISCHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of discharges of patients residing in this ZIP code, during the selected accounting period and year-to-date.

3. REGS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of registrations of patients residing in this ZIP code, during the selected accounting period and year-to-date.

4. OP VISITS-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of outpatient visits, made by patients residing in this ZIP code, during the selected accounting period and year-to-date.

5. PAT DAYS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patient stay days of patients residing in this ZIP code during the selected accounting period and year-to-date.

6. CHARGES-PERIOD/YTD (DISPLAY ONLY)
The system displays the total dollar amount for charges incurred by patients residing in this ZIP code during the selected accounting period and year-to-date.

7. DEATHS-PERIOD/YTD (DISPLAY ONLY)
The system displays the total number of patients with this ZIP code, who expired during their stay. This information is displayed for the selected accounting period and year-to-date.

8. CHARGE QTY-PERIOD/YTD (DISPLAY ONLY)
The system displays the number of charges incurred by patients residing in this ZIP code during the selected accounting period and year-to-date.

After you finish viewing the screen, press the ENTER key to complete the transaction.

Create Statistical Reports

This function allows you to compile and print various statistical reports. Statistical reports print data in the same format the system uses to accumulate the data.

Refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on statistical reports and how to generate them.

Financial Statistics Purge

This function allows you to purge statistics by fiscal year in order to conserve disk space. Since statistics cannot be reclassified for a prior fiscal year, statistics are retained on the system for inquiry purposes only. Most of the online data is available on reports and it is suggested that you print a hard copy of the statistics reports prior to running the purge. If the reports do not contain year-to-date figures, you may want to print a report for each fiscal period.

Statistic retention parameters must be defined for each statistic group prior to running the purge process, which is demanded online. If no retention parameter exists, the statistics will not be purged. Refer to the Maintain Statistics Retention section in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

When you select this option, the system prompts you to select a facility and then the statistics group code. Enter the code or a hyphen (-) to display a list of the valid codes.

The system then displays the following prompt:

Do you wish to purge selected statistics? (Y/N) [N]--

If you do not want to purge the statistics, enter **N** or press ENTER. If you want to purge the statistics, enter **Y**. The system displays the following prompt:

Did you print Financial Statistic Report(s)? (Y/N) [N]--

This prompt serves as a reminder to print the Financial Statistic Reports. Enter **N** or press ENTER to return to the submenu; enter **Y** if you want to continue. The system displays the following prompt after you enter Y:

Do you wish to continue? (Y/N) [N]--

Press ENTER or enter **N** if you do not want to continue. Enter **Y** to begin the purge. The system displays the following message:

PURGING FINANCIAL STATISTICS

The system checks the Statistics Retention Parameter to determine if statistics are eligible for purging. If no parameter exists, the system displays a message on the Data Processing console informing the operator that the statistics were not purged because the retention parameter does not exist.

CHANGE YOUR SECRET CODE

This function enables you to change the secret code assigned to you as a STAR system user. Access to this function is based on your security level.

Once this function is selected, the system displays your user name and asks you to enter your current secret code. As the letters or numbers are entered, they do not display on the screen. When the code is entered, press the ENTER key. After your code is entered, the system prompts you to enter your new secret code. Entering the code updates the security files and completes the transaction.

STARBASE and MultiSTAR Users

STARBASE or MultiSTAR users change their secret code using the procedure described below.

When you select the Change Your Secret code option one of the following prompts is displayed:

The following prompt is displayed for STARBASE users:

Enter current secret code--

Follow the procedure explained above.

The following prompt is displayed for MultiSTAR users:

Edit secret code for (A)pplication or host (O)perating system--

Choose the password you want to change:

- Enter **O** when you want to change your operating system password.

  The function to change the password for your operating system is displayed. If any of your entries do not follow the password change guidelines for your operating system, the appropriate error message is displayed. At the *Press NL-* prompt, press ENTER to return to the previous screen. Refer to your operating system's reference guide for more information.

- Enter **A** when you want to change the secret code for the STAR application. The system displays the following prompt:

  Enter current secret code--

Follow the procedure explained above.

VERIFY YOUR SECRET CODE

This function is used to identify the secret codes of all system users. Access to this function is based on your system security level.

When this function is selected, the system prompts you to enter the system ID number, the employee number, employee last name or display a list of all employees using the system. When an employee is selected, the system displays the secret code for this employee in this format:

*Secret code for Smith,Mary is **100***

Pressing the ENTER key enables you to select another employee or exit the function.

INTERFACE FILE FUNCTIONS

The Interface File functions create and build the interfaces for STAR Financials systems. The file interfaces include:

- Charge Summary Interface File
- Revenue Service Statistics Interface File
- TRENDSTAR Interface Files

The functions used by the hospital vary, depending on the STAR Financials modules purchased by the hospital.

Following a brief description of the first two functions. The TRENDSTAR interface functions are explained in the *STAR Patient Accounting to TRENDSTAR Interface Volume* in the *STAR Financials Patient Accounting Reference Guide*.

WARNING: The hospital should verify that each file layout is correct before implementing the system.

Charge Summary Interface File

This function creates a file containing charges which can be loaded on another system for additional reporting and analysis. When the account is billed, the system writes charge detail to the interface file. Charges are sent for final bills, adjustment bills and late bills. Information contained in the Charge Summary Interface includes patient account number, total charges and insurance carrier/plan. Charges are divided into room and bed charges and ancillary charges. Ancillary charges are separated by proration summary code. See the following pages for specific file content and the format of this interface program.

When you select this option, the system displays a list of available dates for which you can create a Charge Summary Interface Tape. The current system date is the default date, or you can select a date from the displayed list. After you select the desired date, the system instructs you to mount a tape on the appropriate tape drive. The system stores the interface file for seven days and then automatically purges it.

When the system finishes writing data to the tape, you can select another date to create or build charge summary data, or you can exit from the function and return to the Interface Tape submenu. If you want a printed copy of the Interface file, the system can generate a report of the tape data. When you create the tape, the system provides an option to produce a report that includes patient name, number and total charges.

CHARGE SUMMARY INTERFACE FILE SPECIFICATIONS

File Created By:

FXICST: Reads BPC and SUMM records in ^FB and writes a workfile

FXICST1: Writes Tape and Report (Report can easily be turned off)

The nodes needed for this report are purged at the end of the billing run during the nightly batch process. Patients have one record type 01 and multiple 02 and 03 records.

Description	Location	Characteristics
Record type (01)	1-2	01
External Patient Number	3-12	N
Total Charges	13-22	9(8)V99
Total Charges Sign	23-23	+ or -
Insurance Carrier	24-25	N, RJ, ZF
Insurance Plan	26-29	N
Billing Type	30-30	F=Final A=Adjustment L=Late Charge C=Cycle
Filler	31-49	Blanks
Facility	50-50	AN

Description	Location	Characteristics
Record Type (02)	1-2	02
External Patient Number	3-12	N
Accommodation Code*	13-15	AN, LJ
Accommodation Days	16-20	9 (5)
Accommodation Dollars	21-28	N, RJ, ZF, 2 implied decimal points
Accommodation $ Sign	29-29	+ or -
Filler	30-49	Blanks
Facility	50-50	AN

Description	Location	Characteristics
Record Type (03)	1-2	03
External Patient Number	3-12	N
Proration Summary Code	13-18	N, RJ, ZF
Proration Summary Code Amt	19-28	N, RJ, ZF
Proration Sum Code Amt Sign	29-29	+ or -
Filler	30-49	Blanks
Facility	50-50	AN

*****Accommodation Code on STAR Financials is one character; the field on the tape contains the one-character code, left justified and two blanks.

FXPCSTO can be called from a menu to request FXICST1 to run and create the tape. The system asks you for the date and whether you want a hard copy of the data.

Tape Specifications

- Unlabeled
- EBCDIC
- 1600 BPI
- 9-Track
- Records per Block: 1
- Record Size: 30
- Block Size: 30

Revenue Service Statistics Interface Tape

This function creates a tape containing daily revenue statistics, which allows you to accumulate revenue statistics on another system for additional reporting and analysis. The Statistics Mapping Tape entry for revenue determines how the system stores and passes revenue statistics. For example, one hospital may accumulate revenue statistics by medical service and financial class while another hospital may accumulate statistics by patient type. All revenue statistics are separated by revenue department and service item. See the following table for specific file content and the format of this interface program.

Selecting this option displays a list of available dates for which you can create a Revenue Service Statistics Interface Tape. The current system date is the default date, or you can select a date from the displayed list. When you select the desired date, the system instructs you to mount a tape on the appropriate tape drive. The system stores the interface file for seven days and then automatically purges the file.

When the system finishes writing data to the tape, you can select another date to create or build charge summary data, or you can exit from the function and return to the Interface Tape Submenu. If you want a printed copy of the Interface file, the system can generate a report of the tape data. When you create the tape, the system provides an option to produce a report that includes patient name, number and total charges.

REVENUE SERVICE STATISTICS INTERFACE SPECIFICATIONS

The system passes Revenue Service Statistics from STAR Financials through an online function on a monthly basis. The hospital has the option to choose the key for the statistics node from the following fields within Revenue Department:

- SIM Department
- SIM Item
- Patient Type
- Patient Indicator
- Medical Service
- Financial Class

The data passed using the interface includes:

Description	Location	Format
Revenue Center	1-4	9999
SIM Department	5-7	AAA
SIM Item	8-13	999999
Patient Type	14-16	AAA
Financial Class	17-18	XX
Medical Service	19-21	XXX
Quantity of Items	22-29	9999999-
Units of Service	30-37	9999999-
Relative Value	38-45	99999.9-
Amount Charged	46-57	99999999.99-
Patient Indicator	58	A

Tape Specifications

- EBCDIC
- Record Size: 58
- Records per Block: 1
- Block Size: 58

Collection Agency Tape Four Insurance Format

The collection agency tape contains account information that is transferred to a collection agency. The functions used to create this tape are located on the Collection Agency Functions menu, which is available from the Bad Debt Management menu under Account Management.

The following table contains the record layout for the collection agency tape if the four insurance format is being used.

Description	Location	Length
Record (01)		
Patient Number	1-10	10
Facility ID	11	1
Patient Type	12-14	3
Guarantor Name	15-51	37
Patient Name	52-88	37
Guarantor Address 1	89-113	25
Guarantor Address 2	114-138	25
Guarantor City	139-156	18
Guarantor State	157-158	2
Guarantor ZIP Code	159-167	9
Relative 1 Name	168-195	28
Relative 1 Phone	196-208	13
Patient Birthdate	209-214	6
Patient Indicator	215	1
Guarantor Birthdate	216-221	6
Guarantor Work Phone	222-234	13
Guarantor Soc Sec No	235-245	11
Filler	246-247	2
Confidential Guarantor Addr	248	1
Record Type	249-250	2

Description	Location	Length
Record (02)		
Patient Number	1-10	10
Admitting Diagnosis	11-15	5
Patient Phone Number	16-28	13
Patient Soc Sec No	29-39	11
Patient Employer Name	40-69	30
Patient Employer Phone #	70-82	13
Discharge Date	83-88	6
Last Payment Date	89-94	6
Last Payment Amount	95-104	10
Transfer Balance	105-114	10
Financial Class	115-116	2
Transfer Date	117-122	6
Patient Address	123-147	25
Patient City	148-165	18
Patient State	166-167	2
Patient ZIP	168-176	9
Guarantor Phone	177-189	13
Admit Date	190-195	6
Admit Time	196-197	2
Medical Record Number	198-207	10
Patient Age	208-210	3
Patient Race	211	1
Patient Sex	212	1
Attending Phy Name/No	213-237	25
Patient Marital Status	238	1
Filler	239-243	5
Guarantor Phone Message OK	244	1
Confidential Guarantor Phone	245	1
Patient Phone Message OK	246	1

Description	Location	Length
Confidential Patient Phone	247	1
Confidential Patient Address	248	1
Record Type	249-250	2

Description	Location	Length
Record (03)		
Patient Number	1-10	10
Pat Employer Address 1	11-35	25
Pat Employer Address 2	36-60	25
Patient Employer City	61-78	18
Patient Employer State	79-80	2
Patient Employer ZIP	81-89	9
Patient Job Description	90-114	25
Relative 1 Address 1	115-139	25
Relative 1 Address 2	140-164	25
Relative 1 City	165-182	18
Relative 1 State	183-184	2
Relative 1 ZIP Code	185-193	9
Relative 1 Description	194-212	19
Mother's Name	213-237	25
ICD10 Working Diagnosis	238-244	7
Filler	245-248	11
Record Type	249-250	2

Description	Location	Length
Record (04)		
Patient Number	1-10	10
Father's Name	11-35	25
Guar Employer Name	36-65	30

Description	Location	Length
Guar Employer Address 1	66-90	25
GuarEmployer Address 2	91-115	25
Guarantor Employer City	116-133	18
Guarantor Employer State	134-135	2
Guarantor Employer ZIP	136-144	9
Pat Insurance 1 Description	145-167	23
Pat Insurance 1 Policy No	168-187	20
Pat Insurance 1 Approval No	188-202	15
Patient Insurance 2 Description	203-225	23
Patient Insurance 2		
Policy Number		
Filler	246-248	3
Record Type	249-250	2

Description	Location	Length
Record (05)		
Patient Number	1-10	10
Patient Insurance 2 Approval Number	11-25	15
Patient Insurance 3 Description	26-48	23
Patient Insurance 3 Policy Number	49-68	20
Patient Insurance 3 Approval Number	69-83	15
Patient Insurance 4 Description	84-106	23
Patient Insurance 4 Policy Number	107-126	20
Patient Insurance 4 Approval Number	127-141	15

Description	Location	Length
Filler	142-148	107
Record Type	249-250	2

Description	Location	Length
Record (06) **Note**: Record (06) has four charges per record and can occur as many times as there are charges, credits, payments, or adjustments. Charges, payments, and adjustments are only included in the file for when accounts were in an AR location.		
Patient Number	1-10	10
Transaction Type	11-12	2
Transaction Date	13-18	6
Transaction Description	19-58	40
Transaction Amount	59-68	10
Transaction Type	69-70	2
Transaction Date	71-76	6
Transaction Description	77-116	40
Transaction Amount	117-126	10
Transaction Type	127-128	2
Transaction Date	129-134	6
Transaction Description	135-174	40
Transaction Amount	175-184	10
Transaction Type	185-186	2
Transaction Date	187-192	6
Transaction Description	193-232	40
Transaction Amount	233-242	10
Filler	243-248	6
Record Type	249-250	2

TAPE SPECIFICATIONS

- Unlabeled
- 1600 BPI
- 9 Track
- EBCDIC
- Record Size: 250
- Records per Block: 1
- Block Size: 250

Collection Agency Tape Nine Insurance Format

The collection agency tape contains account information that is transferred to a collection agency. The functions used to create this tape are located on the Collection Agency Functions menu, which is available from the Bad Debt Management menu under Account Management.

The following table contains the record layout for the collection agency tape if the nine insurance format is being used.

Description	Location	Length
Rec (01)		
Pat Number	1-10	10
Facility ID	11	1
Pat Type	12-14	3
Guar Name	15-51	37
Pat Name	52-88	37
Guar Addr 1	89-113	25
Guar Addr 2	114-138	25
Guar City	139-156	18
Guar State	157-158	2
Guar ZIP	159-167	9
Relative 1 Name	168-195	28
Relative 1 Phone	196-208	13
Pat Birthdate	209-214	6
Pat Indicator	215	1
Guar Birthdate	216-221	6
Guar Work Phone	222-234	13
Guar SS#	235-245	11
Filler	246-247	2
Confidential Guarantor Addr	248	1
Record Type	249-250	2

Description	Location	Length
Rec (02)		
Pat Number	1-10	10
Adm Diag	11-15	5
Pat Phone#	16-28	13
Pat Soc Sec#	29-39	11
Pat Emp Name	40-69	30
Pat Emp PhoneE	70-82	13
Discharge Date	83-88	6
Last Pay Date	89-94	6
Last Payment Amt	95-104	10
Transfer BALANCE	105-114	10
Financial Class	115-116	2
Transfer Date	117-122	6
Pat Address	123-147	25
Pat City	148-165	18
Pat States	166-167	2
Pat ZIP	168-176	9
Guar Phone	177-189	13
Admit Date	190-195	6
Admit Time	196-197	2
Med Rec#	198-207	10
Pat Age	208-210	3
Pat Race	211	1
Pat Sex	212	1
Att Phy Name/Num	213-237	25
Pat Martial Stat	238	1
Filler	239-243	5
Guarantor Phone Message OK	244	1
Confidential Guarantor Phone	245	1
Patient Phone Message OK	246	1

Description	Location	Length
Confidential Patient Phone	247	1
Confidential Patient Address	248	1
Record Type	249-250	2

Description	Location	Length
Rec (03)		
Pat Number	1-10	10
Pat Emp Addr 1	11-35	25
Pat Emp Addr 2	36-60	25
Pat Emp City	61-78	18
Pat Emp State	79-80	2
Pat Emp ZIP	81-89	9
Pat Job Desc	90-114	25
Filler	115-212	98
Mother's Name	213-237	25
ICD10 Working Diagnosis	238-244	7
Filler	245-248	4
Record Type	249-250	2

Description	Location	Length
Rec (04)		
Pat Number	1-10	10
Father’s Name	11-35	25
Guar Emp Name	36-65	30
Guar Emp Add 1	66-90	25
Guar Emp Add 2	91-115	25
Guar Emp City	116-133	18
Guar EmpP State	134-135	2
Guar Emp ZIP	136-144	9
Pat Ins 1 Desc	145-167	23
Pat Ins Policy #	168-187	20
Pat Ins 1 Apprv#	188-202	15
Pat Ins 2 Descr	203-225	23
Pat Ins2 Policy#	226-245	20
Filler	246-248	3

Description	Location	Length
Rec Type	249-250	2

Description	Location	Length
Rec (05)		
Pat Number	1-10	10
Pat Ins2 App #	11-25	15
Pat Ins3 Desc	26-48	23
Pat Ins3 Policy#	49-68	20
Pat Ins3 App #	69-83	15
Pat Ins4 Desc	84-106	23
Pat Ins4 Policy#	107-126	20
Pat Ins4 App#	127-141	15
Pat Ins5 Desc	142-164	23
Pat Ins5 Policy#	165-184	20
Pat Ins5 App#	185-199	15
Pat Ins6 Desc	200-222	23
Pat Ins6 Policy#	223-243	20
Filler	244-248	5
Rec Type	249-250	2

Description	Location	Length
Rec (06) **Note**: Record (06) has four charges per record and can occur as many times as there are charges, credits, payments, or adjustments. Charges, payments, and adjustments are only included in the file for when accounts were in an AR location.		
Pat Number	1-10	10
Pat Ins6 App #	11-25	15
Pat Ins7 Desc	26-48	23
Pat Ins7 Policy#	49-68	20
Pat Ins7 App #	69-83	15
Pat Ins8 Desc	84-106	23
Pat Ins8 Policy#	106-125	20
Pat Ins8 App #	126-140	15

Description	Location	Length
Pat Ins8 Desc	141-163	23
Pat Ins9 Policy#	164-183	20
Pat Inss9 App#	184-198	15
Filler	199-248	50
Rec Type	249-250	2

Description	Location	Length
Rec (07)		
Pat Number	1-10	10
Trans Type	11-12	2
Trans Date	13-18	6
Trans Desc	19-58	4
Trans Amt	59-68	10
Trans Type	69-70	2
Trans Date	71-76	6
Trans Desc	77-116	40
Trans Amt	117-126	10
Trans Type	127-128	2
Trans Date	129-134	6
Trans Desc	135-174	40
Trans Amt	175-184	10
Trans Type	185-186	2
Trans Date	187-192	6
Trans Desc	193-232	40
Trans Amt	233-242	10
Filler	243-248	6
Rec Type	249-250	2

TAPE SPECIFICATIONS

- ASCII or EBCDIC
- Record Length: 250
- Block Size: 250

Bad Debt Agency Payment File Format

The bad debt payment agency file contains payment information for BD accounts that have made payments to directly to the collection agency.

The following tables contain the record layout for the collection agency payment files.

TAPE SPECIFICATIONS

- EBCDIC
- Record Length: 250
- Block Size: 250
- Record per Block: 1

Description	Location	Length	Value/Format
Record Type	1-2	2	01
Pat Account Number	3-12	10	Right Justified/ Zero Filled
Facility Indicator	13	1	Upper Case
Patient Last Name	14-28	15	Left/Just/Upper Case
Patient First Name	29-40	12	Left/Just/Upper Case
Patient Middle Initial	41	1	Left/Just/Upper Case
Trans Type	42	1	P=Payment, A=Adjustment/ Upper Case
Date Paid	43-48	6	MMDDYY
Payment Amt Indicator	49	1	-=negative amt, 0=positive amt
Payment Amt	50-59	10	Right Justified/ Zero Filled, No decimal (Two places assumed)
Filler	60-250	191	Left Justified/ Space Filled

Description	Location	Length	Value/Format
Record Type	1-2	2	02
Agency Fee	3-12	10	Right Justified/ Zero Filled, No Decimal (two places assumed)
Facility Indicator	13	1	Upper Case
Filler	14-250	237	Blanks

The following tables contain the record layout for the collection agency payment UNIX and PC file. Each record should be followed by the standard end-of-record marker (CR *13 LF *10).

File Specifications

- ASCII
- Record Length: 250

Description	Location	Length	Value/Format
Record Type	1-2	2	01
Pat Account Number	3-12	10	Right Justified/Zero Filled
Facility Indicator	13	1	Upper Case
Patient Last Name	14-28	15	Left/Just/Upper Case
Patient First Name	29-40	12	Left/Just/Upper Case
Patient Middle Initial	41	1	Left/Just/Upper Case
Trans Type	42	1	P=Payment, A=Adjustment/ Upper Case
Date Paid	43-48	6	MMDDYY
Payment Amt Indicator	49	1	-=negative,0=positive
Payment Amt	50-59	10	Right Justified/Zero Filled, No Decimal (Two places assumed)
Filler	60-250	191	Blanks

Description	Location	Length	Value/Format
Record 2			
Record Type	1-2	2	02
Agency Fee	3-12	10	Right Justified/Zero Filled, No Decimal (two places assumed)
Facility Indicator	13	1	Upper Case
Filler	14-250	237	Blanks

Notes Upload File Format

The notes upload file contains the necessary information for the automated upload of freeform and standard notes, as well as contract type notes, into patient accounts notes and transaction history data for a specific facility.

The following tables contain the record layout for the notes upload file.

FILE SPECIFICATIONS

Description	Location	Length	Value/Format
NOTES FILE - INBOUND (Record N1)			
Collection Agency Code	1-6	X(6)	Verified with information from the Collection Agency Code table.
Record Type	7-8	N1	Hard coded.
Note Level	9	X	P=patient, G=Guarantor's accounts in location AR, A=all of the Guarantor's accounts, C=contract.
Filler	10	X	Space for future use.
Facility Code	11	X	
Recipient Information	12-22	X(11)	Patient Account number for P note level, Contract Code for C contract note level, or Corporate Number for G note level. Right Justified/ Space Filled.
Filler	23-78	X(56)	Spaces for future use.
Date of Note	79-86	X(8)	Date note was created by vendor. Populates the Posting Date field in the note's detail screen.
Time of Note	87-90	X(4)	Time note was created by vendor. Populates the Posting Date field in the note's detail screen.
Note Type	91	X	F=freeform notes, S =standard notes.
Standard Note Code	92-95	N(4)	Represents the **T** Transaction code to be used in Transaction History. If the note is a freeform note, the PAAR control default code for freeform notes is used.
Freeform Note Description	96-125	X(30)	Only used (required) when the Note Type is F. Not used for S note types.

Description	Location	Length	Value/Format
Freeform Note Detail	126-200	X(75)	First line of freeform note detail. Only text characters allowed. No control characters are allowed. Lines 2 through 13 of detail are sent in the N2 record(s).

Description	Location	Length	Value/Format
NOTES FILE - INBOUND (Record N2)			
Collection Agency Code	1-6	X(6)	Verified with information from the Collection Agency Code table.
Record Type	7-8	N2	Hard coded.
Note Level	9	X	P=patient, G=Guarantor, C=contract.
Filler	10	X	Space for future use.
Facility Code	11	X	
Recipient Information	12-22	X(11)	Patient Account number for P note level, Contract Code for C contract note level, or Corporate Number for G note level.
Filler	23-50	X(28)	Spaces for future use.
Freeform Note Detail	51-125	X(75)	First line of freeform note detail. Only text characters are allowed. No control characters are allowed. Lines 2 through 13 of detail are sent in the N2 record(s) as subsequent N2 records.
Freeform Note Detail	126-200	X(75)	First line of freeform note detail. Only text characters are allowed. No control characters are allowed. Lines 2 through 13 of detail are sent in the N2 record(s) as subsequent N2 records.

Data File Formats Sent To External Agencies

The section defines the format of information which is sent to the external agencies for use in guarantor collections. Below are the file specifications for the different record types. The data records are grouped by like information (patient, guarantor, insurance).

Carrier data is not sent for items which are not applicable. An example of this is a person with two insurances attached to an account. INS3 through INS9 records are not

sent. The same concept applies to the REL1 records, as another example. The claim information is sent only if the claim is assigned to the agency.

New accounts are sent to the agency based on the interval days defined in the AR Agency Processing Optional Batch processor. Updates and deletes are generated on a daily basis.

The data files are sent only to a UNIX directory because of the automatic download during Midnight Processing. This does not work with a drive/directory process. The name of the file is **facility code_agency code_mmdd_sq_STAR ID.dat**. This allows for multiple files to be transferred on a specific day for a collection agency code.

A separate index is created in order to accommodate updates to the agency and also deletions from the agency for the guarantor collections and the insurance collections. To identify updates to be sent, an index is maintained defining the:

(1) last transaction history entry sent

(2) last note

(3) last charge/credit

Transaction history includes transactions such as payments, adjustments, refunds, and balance transfers. Deletes can be initiated from a manual request or a transfer based on follow-up schedules (guarantor and/or insurance), transfer of location (BD), accounts falling below minimum balances or above the maximum balance based on Pre-Collect Information parameters, accounts prelisted for BD, accounts placed on follow-up hold on STAR Patient Accounting or patient classification status, or zero balance accounts. A single data file is generated, which includes the additions, updates, and deletions.

FILE SPECIFICATIONS

PATIENT DATA

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
PATI		Record Type	4	1-4		Hard-coded to PATI
PATI		Facility Code	1	5	A;MP;13	First character
PATI		Account Number	10	6-15	A;MP;13	
PATI		Process Indicator	1	16		D = Deleted from agency N = New Account Added U = Information Updated
PATI	01	Patient Name	37	17-53	A;DP;2	Last, First, MI
PATI	02	Patient Name Entitle	5	54-58	A;DP;26	
PATI	03	Pat Address 1	25	59-83	A;AL;12 A;DP;9	Alternate or Regular address
PATI	04	Pat Address 2	25	84-108	A;AL;13 A;AL;1	Alternate or Regular address
PATI	05	Patient City	18	109-126	A;AL;14 A;DP;10	Alternate or Regular address
PATI	06	Patient State	2	127-128	A;AL;15 A;DP;11	Alternate or Regular address
PATI	07	Patient Zip Code	9	129-137	A;AL;16 ADP;12	Alternate or Regular address
PATI	08	Patient Country	3	138-140	A;AJ;1	
PATI	09	Patient SSN	11	141-151	A;DP;5	Numeric, no formatting
PATI	10	Patient Race	1	152-152	A;DP;6	
PATI	11	Patient Marital status	1	153-153	A;DP;14	
PATI	12	Patient Sex	1	154-154	A;DP;4	
PATI	13	Patient Birthday	8	155-162	A;DP;3	
PATI	14	Patient Age	3	163-165		Calculated value based on birthday
PATI	15	Pat Phone #-Home	13	166-178	A;DP;13	
PATI	16	Patient Alt Address	1	179-179		
PATI	17	Patient Invalid Address	1	180-180		
PATI	18	Patient Alt phone	1	181-181		

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
PATI	19	Patient Invalid Phone	1	182-182		
PATI	20	Patient leave message	1	183-183		
PATI	21	Pat Fathers Name	37	184-220		Same as BD 04 rcd data.
PATI	22	Pat Medical Record #	10	221-230	A;DP;1	Facility specific
PATI	23	Primary Language code	2	231-232		Language code
PATI	24	Filler	18	233-250		Space filled

GUARANTOR DATA

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
GUAR		Record Type	4	1-4		Hard-coded to GUAR
GUAR		Facility Code	1	5	A;MP;13	First character
GUAR		Account Number	10	6-15	A;MP;13	
GUAR		Process Indicator	1	16		D = Deleted from agency N = New Account Added U = Information Updated
GUAR	01	Guarantor Name	37	17-53	A;DP;2	Last, First, MI
GUAR	08	Guarantor Name Entitle	5	54-58	A;DP;26	
GUAR	02	Guar Address 1	25	59-83	A;AL;12 A;DP;9	Alternate or Regular address
GUAR	03	Guar Address 2	25	84-108	A;AL;13 A;AL;1	Alternate or Regular address
GUAR	04	Guar City	18	109-126	A;AL;14 A;DP;10	Alternate or Regular address
GUAR	05	Guar State	2	127-128	A;AL;15 A;DP;11	Alternate or Regular address
GUAR	06	Guar Zip Code	9	129-137	A;AL;16 ADP;12	Alternate or Regular address
GUAR	07	Guar Country	3	138-140	A;AJ;1	
GUAR	09	Guar SSN	11	141-151	A;DP;5	Numeric, no formatting
GUAR	10	Guar Bday	8	152-159	A;DP;3	Format is mmddyyyy
GUAR	11	Guar Phone#- Home	13	160-172	A;AL;18 A;DP;13	Alternate or Regular address

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
GUAR	12	Guar Alt Address	1	173-173		1 = Yes, blank or 0 = No
GUAR	13	Guar Invalid Address	1	174-174		1 = Yes, blank or 0 = No
GUAR	14	Guar Alternate Phone	1	175-175		1 = Yes, blank or 0 = No
GUAR	15	Guar Invalid Phone	1	176-176		1 = Yes, blank or 0 = No
GUAR	16	Guar leave phone msg	1	177-177		1 = Yes, blank or 0 = No
GUAR	17	Guar Med Rcd Number	9	178-186	A;DP;1	Facility specific number to be used.
GUAR	18	Guar Corp Number	8	187-194	A;DP;25	
GUAR	19	Primary Language Code	2	195-196		
GUAR	20	Filler	56	197-250		Space Filled

EMPLOYER DATA - GUARANTOR

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
GEMP		Record Type	4	1-4		Hard-coded to GEMP
GEMP		Facility Code	1	5-5	A;MP;13	First character
GEMP		Account Number	10	6-15	A;MP;13	
GEMP		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
GEMP	01	Guar Emp Name	30	17-46	A;UP;3	First character of ";" represents a freeform company
GEMP	02	Guar Emp Addr 1	25	47-71	A;UP;4	
GEMP	03	Guar Emp Addr 2	25	72-96	A;UP;11	
GEMP	04	Guar Emp City	18	97-114	A;UP;5	
GEMP	05	Guar Emp ST	2	115-116	A;UP;6	
GEMP	06	Guar Emp Zip Code	9	117-125	A;UP;7	
GEMP	07	Guar Emp Country	3	126-128	A;UP;19	
GEMP	08	Guar Emp Work Phone	13	129-141	A;UP;8	
GEMP	09	Guar Emp Phone Ext	5	142-146	A;UP;10	
GEMP	10	Filler	104	147-250		Spaces

EMPLOYER DATA – PATIENT

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
PEMP		Record Type	4	1-4		Hard-coded to EMPR
PEMP		Facility Code	1	5-5	A;MP;13	First character
PEMP		Account Number	10	6-15	A;MP;13	
PEMP		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
PEMP	01	Pat Employer Name	30	17-46	A;EP;3	
PEMP	02	Pat Emp Address 1	25	47-71	A;EP;4	
PEMP	03	Pat Emp Address 2	25	72-96	A;EP;11	
PEMP	04	Pat Emp City	18	97-114	A;EP;5	
PEMP	05	Pat Emp ST	2	115-116	A;EP;6	
PEMP	06	Pat Emp Zip Code	9	117-125	A;EP;7	
PEMP	07	Pat Emp Country	3	126-128	A;EP;19	
PEMP	08	Pat Emp Phone #	13	129-141	A;EP;8	
PEMP	09	Guar Emp Phone Ext	5	142-146	A;EP;10	
PEMP	10	Pat Emp Job Occupation	25	147-171	A;EP;17	Result is code and description from table lookup
PEMP	11	Filler	79	172-250		Space filled.

RELATIVE INFORMATION

NOTE: This record applies only if the relative information is stored on the STAR Patient Accounting system. In networked environments, the relative information is not normally networked from the STAR Patient Processing CPU to the STAR Patient Accounting CPU. This does not apply to single CPU environments.

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
REL1		Record Type	4	1-4		Hard-coded to REL1
REL1		Facility Code	1	5-5	A;MP;13	First character
REL1		Account Number	10	6-15	A;MP;13	
REL1		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
REL1	01	Relative 1 Name	37	17-53	A;R1;3	
REL1	02	Relative 1 Address 1	25	54-78	A;R1;4	
REL1	03	Relative 1 Address 2	25	79-103	A;R1;12	
REL1	04	Relative 1 City	18	104-121	A;R1;5	
REL1	05	Relative 1 State	2	122-123	A;R1;6	
REL1	06	Relative 1 Zip Code	9	124-132	A;R1;7	
REL1	07	Relative 1 Country	3	133-135	A;R1;18	
REL1	08	Relative 1 Phone	13	136-148	A;R1;8	
REL1	09	Relative 1 Phone Ext	5	149-153	A;R1;11	
REL1	10	Relative 1 Description	25	154-178	A;R1;2	Relative code with a table look up for the description
REL1	11	Relative 1 Work phone	13	179-191	A;L1;8	
REL1	12	Relative 1 work phone ext		192-195	A;L1;10	
REL1	13	Filler	72	196-250		Space filled

INSURANCE DATA – COB 1

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS1		Record Type	4	1-4		Hard-coded to INS1
INS1		Facility Code	1	5-5	A;MP;13	First character
INS1		Account Number	10	6-15	A;MP;13	
INS1		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS1	01	Pat Ins 1 Desc	23	17-39	A;I1;2	
INS1	02	Pat Ins 1 Address 1	25	40-64	A;I2;2	
INS1	03	Pat Ins 1 Address 2	25	65-89	A;I2;3	
INS1	04	Pat Ins 1 City	18	90-107	A;I2;4	
INS1	05	Pat Ins 1 State	2	108-109	A;I2;5	
INS1	06	Pat Ins 1 Zip Code	9	110-118	A;I2;6	
INS1	07	Pat Ins 1 Policy #	20	119-138	A;I1;5	
INS1	08	Pat Ins 1 Apprvl #	15	139-153	A;I3;2	
INS1	09	Pat Ins 1 Phone #	13	154-166	A;I2;7	

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS1	10	Pat Ins 1 Current Bal	11	167-177	FA;FAB;13	
INS1	11	Pat Ins 1 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS1	12	Pat Ins 1 Last Adj Date	8	189-196	FA;FAB;5	
INS1	13	Pat Ins 1 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS1	14	Pat Ins 1 Last Pay Date	8	208-215	FA;FAB;2	
INS1	15	Pat Ins 1 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS1	16	Pat Ins 1 Last Refund Dt	8	227-234	FA;FAB;8	
INS1	17	Ins 1 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS1	18	Filler	16	237-250		

INSURANCE DATA – COB 2

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS2		Record Type	4	1-4		Hard-coded to INS2
INS2		Facility Code	1	5-5	A;MP;13	First character
INS2		Account Number	10	6-15	A;MP;13	
INS2		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS2	01	Pat Ins 2 Desc	23	17-39	A;I1;2	
INS2	02	Pat Ins 2 Address 1	25	40-64	A;I2;2	
INS2	03	Pat Ins 2 Address 2	25	65-89	A;I2;3	
INS2	04	Pat Ins 2 City	18	90-107	A;I2;4	
INS2	05	Pat Ins 2 State	2	108-109	A;I2;5	
INS2	06	Pat Ins 2 Zip Code	9	110-118	A;I2;6	
INS2	07	Pat Ins 2 Policy #	20	119-138	A;I1;5	
INS2	08	Pat Ins 2 Apprvl #	15	139-153	A;I3;2	

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS2	09	Pat Ins 2 Phone #	13	154-166	A;I2;7	
INS2	10	Pat Ins 2 Current Bal	11	167-177	FA;FAB;13	
INS2	11	Pat Ins 2 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS2	12	Pat Ins 2 Last Adj Date	8	189-196	FA;FAB;5	
INS2	13	Pat Ins 2 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS2	14	Pat Ins 2 Last Pay Date	8	208-215	FA;FAB;2	
INS2	15	Pat Ins 2 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS2	16	Pat Ins 2 Last Refund Dt	8	227-234	FA;FAB;8	
INS2	17	Ins 2 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS2	18	Filler	16	237-250		

INSURANCE DATA – COB 3

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS3		Record Type	4	1-4		Hard-coded to “INS3”
INS3		Facility Code	1	5-5	A;MP;13	First character
INS3		Account Number	10	6-15	A;MP;13	
INS3		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS3	01	Pat Ins 3 Desc	23	17-39	A;I1;2	
INS3	02	Pat Ins 3 Address 1	25	40-64	A;I2;2	
INS3	03	Pat Ins 3 Address 2	25	65-89	A;I2;3	
INS3	04	Pat Ins 3 City	18	90-107	A;I2;4	
INS3	05	Pat Ins 3 State	2	108-109	A;I2;5	
INS3	06	Pat Ins 3 Zip Code	9	110-118	A;I2;6	
INS3	07	Pat Ins 3 Policy #	20	119-138	A;I1;5	

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS3	08	Pat Ins 3 Apprvl #	15	139-153	A;I3;2	
INS3	09	Pat Ins 3 Phone #	13	154-166	A;I2;7	
INS3	10	Pat Ins 3 Current Bal	11	167-177	FA;FAB;13	
INS3	11	Pat Ins 3 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS3	12	Pat Ins 3 Last Adj Date	8	189-196	FA;FAB;5	
INS3	13	Pat Ins 3 Total Pays	11	197-207	FA;FAB;1	Payments are reflected as positive values
INS3	14	Pat Ins 3 Last Pay Date	8	208-215	FA;FAB;2	
INS3	15	Pat Ins 3 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS3	16	Pat Ins 3 Last Refund Dt	8	227-234	FA;FAB;8	
INS3	17	Ins 3 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS3	18	Filler	16	237-250		

INSURANCE DATA – COB 4

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS4		Record Type	4	1-4		Hard-coded to INS4
INS4		Facility Code	1	5-5	A;MP;13	First character
INS4		Account Number	10	6-15	A;MP;13	
INS4		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS4	01	Pat Ins 4 Desc	23	17-39	A;I1;2	
INS4	02	Pat Ins 4 Address 1	25	40-64	A;I2;2	
INS4	03	Pat Ins 4 Address 2	25	65-89	A;I2;3	
INS4	04	Pat Ins 4 City	18	90-107	A;I2;4	
INS4	05	Pat Ins 4 State	2	108-109	A;I2;5	
INS4	06	Pat Ins 4 Zip Code	9	110-118	A;I2;6	

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS4	07	Pat Ins 4 Policy #	20	119-138	A;I1;5	
INS4	08	Pat Ins 4 Apprvl #	15	139-153	A;I3;2	
INS4	09	Pat Ins 4 Phone #	13	154-166	A;I2;7	
INS4	10	Pat Ins 4 Current Bal	11	167-177	FA;FAB;13	
INS4	11	Pat Ins 4 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS4	12	Pat Ins 4 Last Adj Date	8	189-196	FA;FAB;5	
INS4	13	Pat Ins 4 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS4	14	Pat Ins 4 Last Pay Date	8	208-215	FA;FAB;2	
INS4	15	Pat Ins 4 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS4	16	Pat Ins 4 Last Refund Dt	8	227-234	FA;FAB;8	
INS4	17	Ins 4 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS4	18	Filler	16	237-250		

INSURANCE DATA – COB 5

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS5		Record Type	4	1-4		Hard-coded to INS5
INS5		Facility Code	1	5-5	A;MP;13	First character
INS5		Account Number	10	6-15	A;MP;13	
INS5		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS5	01	Pat Ins 5 Desc	23	17-39	A;I1;2	
INS5	02	Pat Ins 5 Address 1	25	40-64	A;I2;2	
INS5	03	Pat Ins 5 Address 2	25	65-89	A;I2;3	
INS5	04	Pat Ins 5 City	18	90-107	A;I2;4	

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS5	05	Pat Ins 5 State	2	108-109	A;I2;5	
INS5	06	Pat Ins 5 Zip Code	9	110-118	A;I2;6	
INS5	07	Pat Ins 5 Policy #	20	119-138	A;I1;5	
INS5	08	Pat Ins 5 Apprvl #	15	139-153	A;I3;2	
INS5	09	Pat Ins 5 Phone #	13	154-166	A;I2;7	
INS5	10	Pat Ins 5 Current Bal	11	167-177	FA;FAB;13	
INS5	11	Pat Ins 5 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS5	12	Pat Ins 5 Last Adj Date	8	189-196	FA;FAB;5	
INS5	13	Pat Ins 5 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS5	14	Pat Ins 5 Last Pay Date	8	208-215	FA;FAB;2	
INS5	15	Pat Ins 5 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS5	16	Pat Ins 5 Last Refund Dt	8	227-234	FA;FAB;8	
INS5	17	Ins 5 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS5	18	Filler	16	237-250		

INSURANCE DATA – COB 6

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS6		Record Type	4	1-4		Hard-coded to INS6
INS6		Facility Code	1	5-5	A;MP;13	First character
INS6		Account Number	10	6-15	A;MP;13	
INS6		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS6	01	Pat Ins 6 Desc	23	17-39	A;I1;2	
INS6	02	Pat Ins 6 Address 1	25	40-64	A;I2;2	
INS6	03	Pat Ins 6 Address 2	25	65-89	A;I2;3	
INS6	04	Pat Ins 6 City	18	90-107	A;I2;4	
INS6	05	Pat Ins 6 State	2	108-109	A;I2;5	
INS6	06	Pat Ins 6 Zip Code	9	110-118	A;I2;6	
INS6	07	Pat Ins 6 Policy #	20	119-138	A;I1;5	
INS6	08	Pat Ins 6 Apprvl #	15	139-153	A;I3;2	
INS6	09	Pat Ins 6 Phone #	13	154-166	A;I2;7	
INS6	10	Pat Ins 6 Current Bal	11	167-177	FA;FAB;13	
INS6	11	Pat Ins 6 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS6	12	Pat Ins 6 Last Adj Date	8	189-196	FA;FAB;5	
INS6	13	Pat Ins 6 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS6	14	Pat Ins 6 Last Pay Date	8	208-215	FA;FAB;2	
INS6	15	Pat Ins 6 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS6	16	Pat Ins 6 Last Refund Dt	8	227-234	FA;FAB;8	
INS6	17	Ins 6 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS6	18	Filler	16	237-250		

INSURANCE DATA – COB 7

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS7		Record Type	4	1-4		Hard-coded to “INS7”
INS7		Facility Code	1	5-5	A;MP;13	First character
INS7		Account Number	10	6-15	A;MP;13	
INS7		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS7	01	Pat Ins 7 Desc	23	17-39	A;I1;2	
INS7	02	Pat Ins 7 Address 1	25	40-64	A;I2;2	
INS7	03	Pat Ins 7 Address 2	25	65-89	A;I2;3	
INS7	04	Pat Ins 7 City	18	90-107	A;I2;4	
INS7	05	Pat Ins 7 State	2	108-109	A;I2;5	
INS7	06	Pat Ins 7 Zip Code	9	110-118	A;I2;6	
INS7	07	Pat Ins 7 Policy #	20	119-138	A;I1;5	
INS7	08	Pat Ins 7 Apprvl #	15	139-153	A;I3;2	
INS7	09	Pat Ins 7 Phone #	13	154-166	A;I2;7	
INS7	10	Pat Ins 7 Current Bal	11	167-177	FA;FAB;13	
INS7	11	Pat Ins 7 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS7	12	Pat Ins 7 Last Adj Date	8	189-196	FA;FAB;5	
INS7	13	Pat Ins 7 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS7	14	Pat Ins 7 Last Pay Date	8	208-215	FA;FAB;2	
INS7	15	Pat Ins 7 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS7	16	Pat Ins 7 Last Refund Dt	8	227-234	FA;FAB;8	
INS7	17	Ins 7 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS7	18	Filler	16	237-250		

INSURANCE DATA – COB 8

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS8		Record Type	4	1-4		Hard-coded to INS8
INS8		Facility Code	1	5-5	A;MP;13	First character
INS8		Account Number	10	6-15	A;MP;13	
INS8		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS8	01	Pat Ins 8 Desc	23	17-39	A;I1;2	
INS8	02	Pat Ins 8 Address 1	25	40-64	A;I2;2	
INS8	03	Pat Ins 8 Address 2	25	65-89	A;I2;3	
INS8	04	Pat Ins 8 City	18	90-107	A;I2;4	
INS8	05	Pat Ins 8 State	2	108-109	A;I2;5	
INS8	06	Pat Ins 8 Zip Code	9	110-118	A;I2;6	
INS8	07	Pat Ins 8 Policy #	20	119-138	A;I1;5	
INS8	08	Pat Ins 8 Apprvl #	15	139-153	A;I3;2	
INS8	09	Pat Ins 8 Phone #	13	154-166	A;I2;7	
INS8	10	Pat Ins 8 Current Bal	11	167-177	FA;FAB;13	
INS8	11	Pat Ins 8 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS8	12	Pat Ins 8 Last Adj Date	8	189-196	FA;FAB;5	
INS8	13	Pat Ins 8 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS8	14	Pat Ins 8 Last Pay Date	8	208-215	FA;FAB;2	
INS8	15	Pat Ins 8 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS8	16	Pat Ins 8 Last Refund Dt	8	227-234	FA;FAB;8	
INS8	17	Ins 8 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS8	18	Filler	16	237-250		

INSURANCE DATA – COB 9

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
INS9		Record Type	4	1-4		Hard-coded to INS9
INS9		Facility Code	1	5-5	A;MP;13	First character
INS9		Account Number	10	6-15	A;MP;13	
INS9		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
INS9	01	Pat Ins 9 Desc	23	17-39	A;I1;2	
INS9	02	Pat Ins 9 Address 1	25	40-64	A;I2;2	
INS9	03	Pat Ins 9 Address 2	25	65-89	A;I2;3	
INS9	04	Pat Ins 9 City	18	90-107	A;I2;4	
INS9	05	Pat Ins 9 State	2	108-109	A;I2;5	
INS9	06	Pat Ins 9 Zip Code	9	110-118	A;I2;6	
INS9	07	Pat Ins 9 Policy #	20	119-138	A;I1;5	
INS9	08	Pat Ins 9 Apprvl #	15	139-153	A;I3;2	
INS9	09	Pat Ins 9 Phone #	13	154-166	A;I2;7	
INS9	10	Pat Ins 9 Current Bal	11	167-177	FA;FAB;13	
INS9	11	Pat Ins 9 Total Adjs	11	178-188	FA;FAB;4	Adjustments posted as CR are reflected as negative values. DB type adjustments are reflected as positive balances.
INS9	12	Pat Ins 9 Last Adj Date	8	189-196	FA;FAB;5	
INS9	13	Pat Ins 9 Total Pays	11	197-207	FA;FAB;1	Payments are reflected positive values
INS9	14	Pat Ins 9 Last Pay Date	8	208-215	FA;FAB;2	
INS9	15	Pat Ins 9 Total Refunds	11	216-226	FA;FAB;7	Refunds are reflected as positive values
INS9	16	Pat Ins 9 Last Refund Dt	8	227-234	FA;FAB;8	
INS9	17	Ins 9 Expected Payments	2	235-236	FA;FAB;11	This represents the number of claims not final dispositioned for the COB.
INS9	18	Filler	16	237-250		

LATE CHARGE INFORMATION (INTENDED TO GUARANTOR COLLECTIONS)

The updates sent are only for those charges not sent previously through the interface. The initial run sends all late charge/credits up to the specific point in time.

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
LCHG		Record Type	4	1-4		Hard-coded to LCHG
LCHG		Facility Code	1	5-5	A;MP;13	First character
LCHG		Account Number	10	6-15	A;MP;13	
LCHG		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
LCHG	01	Charge/Credit 1 Ind	2	17-18		CH for charge / CR for credit
LCHG	02	Charge/Credit Date	8	19-26		
LCHG	03	Charge/Credit Descript	30	27-56		
LCHG	04	Charge/Credit Amount	11	57-67		
LCHG	05	Charge/Credit 1 Ind	2	68-69		CH for charge / CR for credit
LCHG	06	Charge/Credit Date	8	70-77		
LCHG	07	Charge/Credit Descript	30	78-107		
LCHG	08	Charge/Credit Amount	11	108-118		
LCHG	09	Charge/Credit 1 Ind	2	119-120		CH for charge / CR for credit
LCHG	10	Charge/Credit Date	8	121-128		
LCHG	11	Charge/Credit Descript	30	129-158		
LCHG	12	Charge/Credit Amount	11	159-169		
LCHG	13	Charge/Credit 1 Ind	2	170-171		CH for charge / CR for credit
LCHG	14	Charge/Credit Date	8	172-179		
LCHG	15	Charge/Credit Descript	30	180-209		
LCHG	16	Charge/Credit Amount	11	210-220		
LCHG	17	Filler	30	221-250		

FINANCIAL INFORMATION

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
FINA		Record Type	4	1-4		Hard-coded to FINA
FINA		Facility Code	1	5-5	A;MP;13	First character
FINA		Account Number	10	6-15	A;MP;13	
FINA		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
FINA	01	Pat Patient Balance	11	17-27	FA;FAP;11	
FINA	02	Pat Account Balance	11	28-38	FA;FAP;33	
FINA	03	Total Acct Payment Amt	10	39-48	FA;FAP;23	
FINA	04	Last Acct Payment Date	8	49-56	FA;FAP;24	
FINA	05	Pat Last Pay Date	8	57-64	FA;FAP;2	
FINA	06	Pat Total Acct Payments	11	65-75	FA;FAP;1	
FINA	07	Pat Total Charges	11	76-86	FA;FAP; 21+22	
FINA	08	Transfer Balance	11	87-97	FF;FFD1;3	
FINA	09	Transfer Date	6	98-103	FF;FFD1;2	
FINA	10	Pre-collect F/U Sched	3	104-106	FF;FFD;26	
FINA	11	Collector Code	3	107-109	FF;FFD;30	
FINA	12	Collection Agency Code	6	110-115	FF;FFD1;1	
FINA	13	Deleted Reason	26	116-141		
FINA	17	Pat Ins 1 – Carrier/Plan Code	6	142-147	A;I1;1	
FINA	18	Filler	105	148-250		

MISCELLANEOUS INFORMATION

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
MISC		Record Type	4	1-4		Hard-coded to MISC
MISC		Facility Code	1	5-5	A;MP;13	First character
MISC		Account Number	10	6-15	A;MP;13	

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
MISC		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
MISC	01	Admit Date	8	17-24	A;MP;8 (1)	
MISC	02	Admit Time	4	25-28	A;MP;8 (2)	
MISC	03	Discharge Date	8	29-36	A;MP;14	
MISC	04	Patient Location	1	37-37	FA;FAA;5	1 = PA 2 = AR 3 = BD
MISC	05	Patient Indicator	1	38-38	FA;FAA;20	
MISC	06	Patient Type	3	39-41	FA;FAA;18	
MISC	07	Financial Class	2	42-43	FA;FAA;21	
MISC	08	Attending Phy Name	37	44-80	D;PC;2	Based on doctor table and doctor code defined in next field
MISC	09	Attending Phys Number	12	81-92	A;MP;12	
MISC	10	ICD-9 Diagnosis - Admit	5	93-97	A;HK;1	
MISC	11	ICD-9 Diag Principal Code	5	98-102	A;HK;2	
MISC	12	ICD-9 Diag Principal Descr	30	103-132		Table lookup
MISC	13	NPI Number	10	133-142		NPI value from Demographics / Default screen.
MISC	14	ICD-10 Diagnosis - Admit	5	143-149		
MISC	15	ICD-10 Diag Principal Code	5	150-156		
MISC	16	ICD-10 Diag Principal Descr	30	157-186		Table lookup
MISC	17	Filler	63	187-250		

FREEFORM NOTES OUTBOUND

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
NOTE		Record Type	4	1-4		Hard-coded to NOTE
NOTE		Facility Code	1	5-5	A;MP;13	First character
NOTE		Account Number	10	6-15	A;MP;13	
NOTE		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
NOTE	01	Note Sequence Num	3	17-19	FF;FFN; 1	
NOTE	02	Notes - Date	8	20-27	FF;FFN; 6	
NOTE	03	Notes - Description	30	28-57	FF;FFN; 2	
NOTE	04	Notes text detail line1	75	58-132	FF;FFO;	
NOTE	05	Notes text detail line 2	75	132-207	FF;FFO	
NOTE	06	Filler	43	208-250		

FREEFORM NOTES OUTBOUND – ADDITIONAL LINES

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
NOT1		Record Type	4	1-4		Hard-coded to NOT1
NOT1		Facility Code	1	5-5	A;MP;13	First character
NOT1		Account Number	10	6-15	A;MP;13	
NOT1		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
NOT1	01	Note Sequence Num	3	17-19	FF;FFN; 1	
NOT1	02	Notes text detail line 3	75	20-94	FF;FFO	
NOT1	03	Notes text detail line 4	75	95-169	FF;FFO	
NOT1	04	Notes text detail line 5	75	170-244	FF;FFO	
NOT1	05	Filler	6	245-250		

FREEFORM NOTES OUTBOUND – ADDITIONAL LINES

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
NOT2		Record Type	4	1-4		Hard-coded to “NOT2”
NOT2		Facility Code	1	5-5	A;MP;13	First character
NOT2		Account Number	10	6-15	A;MP;13	
NOT2		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
NOT2	01	Note Sequence Num	3	17-19	FF;FFN1	
NOT2	02	Notes text detail line 6	75	20-94	FF;FFO	
NOT2	03	Notes text detail line 7	75	95-169	FF;FFO	
NOT2	04	Notes text detail line 8	75	170-244	FF;FFO	
NOT2	05	Filler	6	245-250		

FREEFORM NOTES OUTBOUND – ADDITIONAL LINES

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
NOT3		Record Type	4	1-4		Hard-coded to NOT3
NOT3		Facility Code	1	5-5	A;MP;13	First character
NOT3		Account Number	10	6-15	A;MP;13	
NOT3		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
NOT3	01	Note Sequence Num	3	17-19	FF;FFN;1	
NOT3	02	Notes text detail line 9	75	20-94	FF;FFO	
NOT3	03	Notes text detail line10	75	95-169	FF;FFO	
NOT3	04	Notes text detail line 11	75	170-244	FF;FFO	
NOT3	05	Filler	6	245-250		

FREEFORM NOTES OUTBOUND – ADDITIONAL LINES

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
NOT4		Record Type	4	1-4		Hard-coded to NOT4
NOT4		Facility Code	1	5-5	A;MP;13	First character
NOT4		Account Number	10	6-15	A;MP;13	
NOT4		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
NOT4	01	Note Sequence Num	3	17-19	FF;FFN;1	
NOT4	02	Notes text detail line 12	75	20-94	FF;FFO	
NOT4	03	Notes text detail line 13	75	95-169	FF;FFO	
NOT4	05	Filler	81	170-250		

TRANSACTION HISTORY

The updates to transaction history are only for those entries added since the last update to the agency. The process for a new account reflects all transaction history entries (as defined by the user – not excluded) up through the point in time of generating the data file.

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
THIS		Record Type	4	1-4		Hard-coded to THIS
THIS		Facility Code	1	5-5	A;MP;13	First character
THIS		Account Number	10	6-15	A;MP;13	
THIS		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
THIS	01	STAR's Internal Seq #	7	17-23		

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
THIS	02	Transaction Type	3	24-26		A = Adjustments (FTA) B = Billing/Claims (FTB) C = Cash (FTG) M = Memo (FTD) N = Notes (FTI) R = Refunds (FTH) T = Status Transfers (FTJ)
THIS	03	Tran type/code	5	27-31	FT;;1	
THIS	04	Trans Description	30	32-61	FT;;2	
THIS	05	Trans Hist-Tran Date	8	62-69	FT;;3	
THIS	06	Transaction $ Amt	11	70-80	FT;;14	
THIS	07	Account location	2	81-82	FT;;11	1 = PA 2 = AR 3 = BD
THIS	08	Prior Balance	11	83-93	FT;;10	
THIS	09	New Balance	11	94-104	FT;;12	
THIS	10	Old Status	7	105-111	FT;;28	
THIS	11	New Status	7	112-118	FT;;29	
THIS	12	Post Date	8	119-126	FT;;13	
THIS	13	Comment	40	127-166	FT;;32	
THIS	14	From Carrier/Plan	6	167-172	FT;;23	
THIS	15	To Carrier/Plan	6	173-177	FT;;24	
THIS	16	Sub Location	4	179-182		
THIS	17	Filler	74	183-250		

AGENCY RECONCILIATION FILE

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
RCON		Record Type	4	1-4		Hard-coded to RCON
RCON		Facility Code	1	5-5		User defined facility
RCON		Agency Code	6	6-11		User defined agency
RCON		Account number	10	12-21	A;MP;13	
RCON		Patient Name	37	22-58		
RCON		Patient Address 1	25	59-83		

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
RCON		Patient Address 2	25	84-108		
RCON		Patient City	18	109-126		
RCON		Patient State	2	127-128		
RCON		Patient Zip Code	9	129-137		
RCON		Patient Phone	13	138-150		
RCON		Patient SSN	11	151-161		
RCON		Guarantor Name	37	162-198		
RCON		Guarantor Phone	13	199-211		
RCON		Guarantor SSN	11	212-222		
RCON		Insurance COB	1	223-223		Only applicable for insurance pre-collect.
RCON		COB claim #	3	224-226		One record for each claim with an agency. Not applicable guarantor pre-collect
RCON		Financial Class	3	227-229	FA;FAA;21	
RCON		Account Balance or Carrier Balance applicable to the claim	11	230-240	FA;FAP;33 FA;FAB;13	Account Balance for guarantor and carrier balance for insurance claims
RCON		Transfer Date	6	241-246	FF;FFD1;2	
RCON		Filler	4	247-250		

CLAIM DATA FORM LOCATOR (EXCLUDING CHARGE LINES – CLMC)

NOTE: Since this format has one form locator per line of information, it may be used for the claim types of B, Z, X, R, J, L, 1, N, and T. STAR's master definition is used to identify the description of each locator. This eliminates any problems which may arise due to length the data record. The print programs used to display claim information online are utilized in populating the external file. The charge lines for the specific claims are also delimited by a binary 9 (tab) and are versatile as to changes in the future claim forms updates/changes.

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
CLAM		Record Type	4	1-4		Hard-coded to CLAM

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
CLAM		Facility Code	1	5-5	A;MP;13	First character of account number
CLAM		Account Number	10	6-15	A;MP;13	
CLAM		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
CLAM		COB indicator	1	17-17		Value of 1 through 9
CLAM		Carrier/plan	8	18-25		
CLAM		Claim sequence number	4	26-29		Claim sequence number
CLAM		Claim Type	2	30-31		Claim type (i.e. X= UB, B = 1500, Z = nonprofee 1500), R = CA UB, J = CA25, L = IL 2360, 1 = IL 1443, N = NJ MC19, T = NY T19.
CLAM		Claim type version number	1	32-32		For use with the new and old UB's, 1500, and non-profee claim types.
CLAM		Claim Load & Edit Parm		33-36		For use by STAR only as an audit trail for how the data in this record was generated.
CLAM		Form locator information Locator and Locator description taken from McKesson Master copy.		Variable length records		Variable length record. Excludes form locators applicable to charge lines. Format = form locator : description : value(s) Data is delimited by a binary 9 (tab). Format is locator (tab) description (tab) data1 (tab) data2 (tab) ….

CLAIM CHARGE DATA (MULTIPLE/REPEATABLE RECORDS)

Rcd Type	Col	Description	Size	Cols	Data Element	Comments
CLMC		Record Type	4	1-4		Hard-coded to CLMC
CLMC		Facility Code	1	5-5	A;MP;13	First character of account number
CLMC		Account Number	10	6-15	A;MP;13	
CLMC		Process Indicator	1	16-16		D = Deleted from agency N = New Account Added U = Information Updated
CLMC		COB indicator	1	17-17		Value of 1 through 9
CLMC		Carrier/plan	8	18-25		
CLMC		Claim sequence number	4	26-29		Claim sequence number
CLMC		Claim type	2	30-31		X = UB, B=1500, Z=nonprofee 1500, R = CA UB, J = CA25, L = IL 2360, 1 = IL 1443, N = NJ MC19, T = NY T19.
CLMC		Claim Version	1	32-32		
CLMC		Claim line				Variable length record with data elements delimited by Binary 9 (tabs).

Agency Payment File

The agency payment file contains payment information for accounts that have made payments directly to the collection agency.

The following tables contain the record layout for the agency payment file (UNIX and/or PC file).

FILE SPECIFICATIONS

- ASCII
- Record Length: 250

Field	Description	Size	Cols	Value/Format
1	Record Type	2	1-2	00=Header record, one per file
2	Agency Code	6	3-8	Agency Code
3	Agency Fee	10	9-18	Right Justified/Zero Filled, No Decimal (two places assumed)
4	Total Number Of Payments	6	19-24	Right Justified/Zero Filled
5	Total Payment Amounts	10	25-34	Right Justified/Zero Filled, No Decimal (two places assumed)
6	Patient Payment Transaction Code	5	35-39	P####
7	Total Number of Adjustments	6	40-45	Right Justified/zero filled
8	Total Adjustment Amount	10	46-55	Right Justified/Zero Filled, No Decimal (two places assumed)
9	Patient Adjustment Transaction Code	5	56-60	A####
10	Filler	190	61-250	Spaces

Field	Description	Size	Cols	Value/Format
1	Record Type	2	1-2	01=Transaction record, one or more per file
2	Patient Account Number	10	3-12	Right Justified/Zero Filled
3	Facility Indicator	1	13	Upper Case
4	Patient Last Name	15	14-28	Left Justified/Upper Case
5	Patient First Name	12	29-40	Left Justified/Upper Case
6	Patient Middle Initial	1	41	Upper Case
7	Transaction Type	1	42	P=Payment A=Adjustment
8	Date Paid	6	43-48	MMDDYY
9	Payment Amount Indicator	1	49	0=Positive -=Negative
10	Payment Amount	10	50-59	Right Justified/Zero Filled, No Decimal (two places assumed)

Field	Description	Size	Cols	Value/Format
11	Payment Type	1	60	C=Credit Card A=ACH e-check
12	Credit Card or Bank Account Owner Name	40	61-100	If Field 11 =C, this is Credit Card Owner's name. If Field 11 =A, this Bank Account Owner's name. Left Justified
13	Credit Card Type	25	101-125	If Field 11 = C, this is Credit Card Type Left Justified
14	Credit Card or Bank Account Number (last 4 digits)	4	126-129	If Field 11 = C, this is last four digits of the Credit Card If Field 11 =A, this is the last four digits of the Bank Account
15	Confirmation Code	30	130-159	If Field 11 = C or A, this is the payment confirmation message
16	Filler	91	160-250	Spaces

REVIEW PROGRAM STATISTICS

This function allows you to review processing information about financial programs run on a specified date. Information provided includes job start and stop time, total run time, and the number and rate of records processed.

After you select this function, the system prompts you to enter an ID number to review. The default is the ID you are currently logged on to, but you can enter any valid ID number.

After you select an ID number, the system displays the following prompt:

Enter RUN date or '-' for a list [Today]--

Enter the date for which you want to review program statistics, or press ENTER to accept the default of today.

After you select a date, the system prompts you to enter the specific batch program to review. Enter the program name or enter a hyphen (-) to display and select from a list of program names.

If you enter a hyphen (-), the system displays a screen listing program names and information about them, as in the example screen below:

```
             General Hospital Daily Program Statistics Processor
                                                Tue Jan 14, 1992 02:42 pm
ID 97              Program Statistics for Jan 14, 1992
Page:01                                                 Elapsed   Rate  Number
     Program  F/E Description                           HH:MM:SS  /Sec  Records
( 1) FABART       System Balancing                            25
( 2) FABARTP      PA Balancing Reports                        12
( 3) FABARTU      Unapplied Balancing                         03
( 4) FABASR       Account Selection Reports [Batch]           02
( 5) FABCAK       Purge adjustment batches                    01
( 6) FABCAS       Create system adjustment batch              00
( 7) FABCPK       Purge cash batches                          01
( 8) FABCPW       Post window batches                         00
( 9) FABPRGC      Kill previous charge posting date in        01
(10) FABPTD       Count Patient Days as of Midnight         1 19
(11) FAR010       Unapplied Charge Log                        07
(12) FAR012       Print Applied Charge Log                    01
(13) FAR310       Unverified insurance reports - (Inpa        31
(14) FARAJR       Daily Activity Journal                    2 45
(15) FARCA        Adjustment detail report                    02
(16) FARCAE       Adjustment exception report                 01

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

Select the desired program name.

Field Explanations

1. PROGRAM (DISPLAY ONLY)
This field contains the name of the program which ran in midnight processing.

2. F/E (DISPLAY ONLY)
This field displays the facility/entity called by the program. If a program calls a facility and runs separately for each facility, the system displays the facility code in this field. If the program does not call a particular facility, this field is blank.

3. DESCRIPTION (DISPLAY ONLY)
This field contains the description of the program which ran in midnight processing.

4. ELAPSED (DISPLAY ONLY)
This field contains the run time of the program which ran in midnight processing. The time elapsed is displayed in hours, minutes and seconds.

5. RATE/SEC (DISPLAY ONLY)
This field contains the rate at which records are processed per second. For example, the program for billing selection may process 100 records per second. This statistic is not maintained for every program in midnight processing.

6. NUMBER RECORDS (DISPLAY ONLY)
This field contains the number of records processed for this program during midnight processing. This statistic is not maintained for every program in midnight processing.

Once you select a program name, the system displays the statistics for the ID and date selected. The system displays the same information as that displayed on the program name list screen (see example on the previous page), but the format is different and the information is only for the selected program and not for all programs.

Following is an example of the Midnight Processing Statistics screen:

```
              General Hospital Daily Program Statistics Processor
                                                    Thu Apr 17, 2008 12:24 pm
ID 9                Program Statistics for Apr 17,2008

Program :  FABART - SYSTEM BALANCING FOR BD

Started :  02:02:52
Stopped :  02:02:53
Elapsed :  1 Second

Records :
Rate/Sec:

H% Date :  04/16/08
Facility :  C









Press NL--
```

Field Explanations

PROGRAM (DISPLAY ONLY)
This field contains the name and description of the program that ran in midnight processing.

DESCRIPTION (DISPLAY ONLY)
This field contains the description of the program that ran in midnight processing.

STARTED (DISPLAY ONLY)
This field contains the time, in hours, minutes, and seconds when the program began running.

STOPPED (DISPLAY ONLY)
This field contains the time, in hours, minutes, and seconds when the program completed.

NUMBER RECORDS (DISPLAY ONLY)
This field contains the number of records processed for this program during midnight processing. This statistic is not maintained for every program in midnight processing.

RATE/SEC (DISPLAY ONLY)
This field contains the rate at which records are processed per second. For example, the program for billing selection may process 100 records per second. This statistic is not maintained for every program in midnight processing.

H% DATE (DISPLAY ONLY)
This field displays the system date, if the date is sent in the program. If no date is sent, this field is blank.

FACILITY (DISPLAY ONLY)
For certain programs used in claim and account archiving, the system displays facility code information. Otherwise, the field is not displayed.

When you finish reviewing statistics for the selected program, the system returns you to the beginning of this function.

VIEW FINANCIAL CHARGES

The View Financial Charges function enables you to view information about the charges being processed for the day. This screen serves as a tool for monitoring charges being processed from the STAR Patient Care and STAR Financials Patient Accounting systems.

To access the View Financial Charges processor, select HBO & Company Tables from the Financial System Management Processor. Then select View Financial Charges from the HBO & Company Tables Processor and the system displays the following prompt:

Select ID [##]--

Where ## is the number of the current system ID. Enter the number of the ID for which you want to view financials charges, or press ENTER to view charges for the current ID. The system then displays the following screen:

```
              General Hospital View Financial Charges Processor
                                                  Thu Jan 16, 1992 11:22 pm

 1 Last Charge Date               2 Number of Charges Received
   0/16/92                          826
```

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

Field Explanations

1. LAST CHARGE DATE (DISPLAY ONLY)
This field displays the last date on which charges were received from the STAR Patient Care System for processing.

2. NUMBER OF CHARGES RECEIVED (DISPLAY ONLY)
This field displays the number of charges received on the date displayed in the Last Charge Date field.

After you finish viewing the financial charge information, press ENTER twice to return to the Select ID prompt. Enter another ID if you want to display financial charge information for that ID, or press period (.) ENTER to return to the HBO & Company Tables Processor.

ACCOUNT ARCHIVE/PURGE

This section discusses the procedures used in the STAR Financials Patient Accounting system to archive and purge patient account data from the system.

Overview

There are three types of data that can be archived in the STAR Patient Accounting module. The types of data are claims, accounts (AR and BD), and bad debt charges. The claim archiving/purging process is described in the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide*. The account and bad debt charge processes are defined below. Archiving patient account data in the STAR Financials Patient Accounting system is a two-step process. The first step is to select accounts to be archived, and the second step is to purge the data. The Archive selection process does not remove data from the system. The process changes the account location from AR or BD to ARC so financial transactions cannot be posted to the account such as payments, adjustments, refunds or demographic revisions. The accounts are not allowed to be added to AR or BD through the Add AR Master or Add BD Master functions until the account(s) is purged. Archive select also produces a spool file which is stored on a backup medium such as microfiche or optical disk. The spool file report names are FBRAST_facility and/or FBRASTH_facility. Refer to "PAAR Control" on page 2-14 for information on the Archive Statement format.

Although the archive select does not purge data, only limited information can be viewed on the account. For example, you cannot view charges or transaction history.

The archive statement includes all charges for the patient. The archive statement does not separate the charges by bill. The Purge process removes data from the system. The Purge process does not produce any reports. After the purge is run, space is regained for system use, and the account location changes to HS (history). No financial activity can be applied to these accounts, although AR and BD adds can be accomplished.

General Process

The general flow of the process is:

- Set up the parameters associated with the process
    - Sort criteria
    - PAAR Control
- Set up the optional batch job (Archive Select) to run on a specific day (the process is facility specific)
- Allow the select process to finish

- Transfer the spool file(s) to the backup medium

- Review report FARAERx to see quantity of claims present on accounts and not allowing the accounts to be selected for account archiving (manually disposition the claims listed on this report as deemed appropriate). A large quantity of claims listed reflects claim archiving needs to be run more frequently.

- Send the accounts through the TRENDSTAR/Horizon Performance Manager interfaces (if applicable) and verify all the accounts transferred to Horizon Performance Manager/TRENDSTAR. Multiple runs may be required; for example, 10,000 accounts are archived while 5,000 accounts are sent through the TRENDSTAR/Horizon Performance Manager interfaces each time, resulting in two interface files to be run. The receipt and updating of the accounts to Horizon Performance Manager/TRENDSTAR need to be confirmed with the appropriate staff prior to purging the accounts.

- Verify the spool report now located on the backup medium, then purge the accounts (an online/real time process).

During this cycle, claim archiving and purging will also be taking place. Refer to the *Billing and Claims Volume* of the *STAR Financials Patient Accounting Reference Guide* for more information on the claim archive/purge process. Account archive select is date-specific, which allows the select process to run multiple times without running the account purge process. The select process reviews only AR and/or BD accounts.

NOTE: The Claim Purge must be run before achiving can take place. If a prior run was not purged, the system displays the following message:

Prior archive run has NOT been purged. Do you wish to Archive claims? (Y/N) [N]--

To allow the account archive select process to run most efficiently, the claim archive/ purge process needs to be run multiple times before starting the account archive process. It can be determined when claim archiving reviewed the entire data base when the maximum number of claims selected is less than the quantity defined in the Data Retention Parameters screen. At this point in time, the account archive process will have less exceptions defined on the FARAER report. If claim archiving never ran, only self pay accounts will be eligible for account archiving select. It is very important to get a sign-off on the backed up files before purging. Purging is PERMANENT.

Parameters which are involved in the account archive process are:

- PAAR Control - Archive Statement Format

- Data Retention Parameters - These determine the maximum number of AR and BD accounts to select each run, archive days determines the number of days after the account goes to a zero account balance in order to be selected, end discharge dates determines the discharge ending date. The archive days parameter can be defined by financial class and financial class/patient type exceptions.

- Sort options (within Maintain Facility Information) to determine the spool file sort method

- TRENDSTAR/Horizon Performance Manager Trigger Event parameters (if applicable)

- Report Maintenance to verify the reports FBRASTx, FARAERx, FBRARx, FBRBDx and FBRASTHx are set up and the appropriate number of retention days are defined. The printer assignment may also be important if the report is to be automatically sent to an output device such as an optical disk system. The Maximum Number of Pages parameter also needs to be reviewed. An estimated number of pages per account for FBRASTx is 10 pages. When the maximum number of pages is reached, a console message reflects this. At this point, the Maximum Number of Pages parameter will need to be increased.

WARNING: The Account Archive select process temporarily uses additional system space used in generating the associated spool files. Therefore, do not wait until the system is dangerously low on space to archive/purge accounts. For example (an estimate only), for every 1,000 accounts archived, the system will require a minimum of 2,000 to 3,000 blocks of space (assuming an 8K block). Of the space used, half is used for the spool reports and the other half is used for temporary workfile space. The second time account archiving is run selecting 1,000 accounts, the disk space requirements will only 1,000 to 1,500 blocks of space used for the spool files. The disk space used for the temporary work file space will be zero since the prior archive temporary work file will be deleted and then rebuilt with the current account archive process. The disk space used by the spool files will be regained as free space after the number of days retained, per Report Maintenance, is reached. The purge process will return net disk space of about 1 to 1 ½ blocks per account.

ACCOUNT ARCHIVE/PURGE

AR and BD Accounts are archived at the same time. Accounts having claims not yet archived and purged will not be archived. These accounts display on the Archive Exceptions report (FARAER). Accounts that are reviewed for archiving are listed on the report with an *Acct on Archive Hold* status.

The following information is purged from the system for purged accounts:

- Charges
- Transactions
- Billing Records
- Account-specific statistics
- Guarantor Financial Information (not contained in the MPI)
- Follow-up Information

The system does not purge information held in the MPI. This information is pulled forward onto the new admission (such as guarantor, demographic, or information). The system also does not purge statistics or third party log data.

NOTE: The maximum number of AR and BD accounts archived at a time is defined in the Data Retention Parameters. If more AR accounts are available to be archived than the value in the Max AR Accts field in the Data Retention Parameters, the system will only archive the number of accounts set in the Max AR Accts field.'All' is equivalent to 99,999 accounts. Similarly, if you attempt to archive more BD accounts at a time than the value in the Max BD Accts field in the Data Retention Parameters, the system only archives up to the value in the Max BD Accts field. 'All' is equivalent to 99,999 accounts.

If you want to archive accounts for only one facility in a multifacility environment, then only define the Optional Batch Job of Archive Selection to run on the specific day for a specific facility.

AR Accounts

AR accounts qualify for archiving when the account has a zero balance for the number of days defined in the AR Archive Days field in the Data Retention Parameters. Different archive days can be specified for Financial Class and Financial Class/Patient Type exceptions.

To suspend an AR account from being archived, set the Archive Status field to Y (Yes) in the Account Status screen. This screen is shown below, and is accessed through the Account Revision process.

```
                  General Hospital Account Status Processor
                                                Wed Jun 7, 2006 03:51 pm
Account      Name                    FC Typ Admit    Disch     Balance   Loc
A9807200003  DAVIS,Kenneth           S  I/P 03/13/01           152861.62 PA/FCRV
 1 Final Bill Parameter                2 Cycle Bill Parameter          3 CycA
   927-Patrice Final Bill Outpatient     929-Patrice Outpatient cycle    Yes
 4 Biller                               5 Provider
   3-BILLERTHREE,BILLER                   1-MODEL HOSPITAL A
 6 Billing Status             7 Status Date       8 On Hold By
   CycA Bill Requested          01/30/06
 9 CPTAFB DT                 10 Pre-bill Edit Status     11 PBE Status Date
                                Bypassed/Suspense Days      01/20/06
12 Financial Class           13 Pat Class        14 Pat Class Suppress F/Up
   O-OTHER COMMERCIAL
15 Archive Status        16 Archive Date  17 Sub location
   Yes                                    AR/FCRV









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

Bad Debt Accounts

Bad Debt accounts qualify for archiving when the account reaches the end of the schedule as defined in the Collection Agency Follow-Up Schedule and no unpurged claims exist. The system requires the BD accounts to be listed on report FBRBDPLx. Refer to the Agency Follow-up table description for additional information.

To suspend a BD account from being archived, set the Archive Pre-list Flag on the Archive Pre-list screen to User Hold. An example of this screen follows:

```
               General Hospital BD Archive Pre-List Processor
                                                  Mon Mar 13, 2006 03:51 pm
Account      Name                     FC Typ Admit    Disch        Balance Loc
00015-68     LOWMAN,SUSAN L              PSY 11/01/01 11/03/01     80.00-  BD/FCRV

 1 Collection Agency Code                        2 Archive Pre-List Flag
   CBI-CBI COLLECTION AGENCY                       User Hold
 3 Archive Prelist Transaction Code/Description
   M0084-BD ARCHIVE PRE-LIST HOLD
 4 Comments
   PUT ACCOUNT ON HOLD-PENDING GUAR. CALL









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

PAAR Control Archive Statement Format Parameter

The hospital must decide what information must be retained on the backup medium. Three options are available:

All Produces FBRAST. Three pages are produced per account:
- Page 1 - Contains balance transactions
- Page 2 - Contains non-balance transaction
- Page 3 - Contains notes

Split Produces two spoolfiles: FBRAST and FBRASTH. FBRAST contains balance related items. FBRASTH contains non-balance related items.

Bal Produces FBRAST. Only balance related transactions are spooled.

Archive Statement Transaction Code

Appears in transaction history when an account is archived.

BD User Hold Archive Prelist Transaction Code

Appears in transaction history when the user has suspended a bad debt account from being archived.

BD System Archive Prelist Transaction Code

Appears in transaction history when system prelists a bad debt account for archive.

BD User Archive Prelist Transaction Code

Appears in transaction history when user selects a bad debt account for archive.

BD User Remove Archive Prelist Transaction Code

Appears in transaction history when a bad debt account is selected to be archived by the system but the user then removes the account from being archived.

BD Archive Write-off Transaction Code

Appears on the archive statement as a transaction if the account has been archived and the remaining balance was written off.

NOTE: For more information on these fields, refer to PAAR Control in the *Tables, Masters, and Parameters Volume* of the *STAR Financials Patient Accounting Reference Guide*.

1. Verify sort options are set up for archive statements via the Sort Sequences table. To access this table, select Financial System Management from the initial menu; then select Maintain Facility Information.

From this menu you can select Sort Sequence, and the following screen is displayed:

```
                              Sort Sequences Processor
                                                Wed May 15, 2002 11:15 am

Archive Statements
 1 Edit Date            2 Edit By
   02/02/01 15:43         SMITH,JOHN
 3 Sort Field                Sequence
   Carrier Code                  3
   Carrier/Plan Code
   Financial Class
   Guarantor Name
   Patient Account Number        2
   Patient Indicator
   Patient Name                  1
   Patient Type




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

NOTE: It is recommended to sort by account number or patient name so the account can be easily accessed on the backup medium.

2. Verify the setting of the Archive Days field in the Data Retention Parameters. This field specifies the days after zero balance before an AR account can be archived. The Data Retention Parameters screen follows.

```
            General Hospital Data Retention Parameters Processor
                                                      Tue Apr 15, 2008 03:31 pm
Model Hospital A

 1 AR Archive Days            2 AR End Disch Dt      3 AR Max Accts
   20                           01/01/2000             40
 4 BD Archive Days            5 BD End Disch Dt      6 BD Max Accts
   30                           12/31/1999             0
 7 BD Charge Delete Days      8 BD Charge Delete Transaction Code
   120                          M0002-FINANCIAL CLASS CHANGE W/O REC
 9 Carrier Pay Days   10 Claim End Disch Dt  11 Max Claims   12 Disp Claims?
   99                    12/31/2000            40              No
13 FPI Months                                 14 Contract Charge Delete Days
   12                                            0
15 Retain Guarantor Payment History           16 SQL Tran Hist Index
   Yes/1000                                      Yes/1020/B
17 Service Line Info Days                     18 SQL Charge Posting Index
   5                                             No
19 Remittance Data Days      20 Stop Time for ERA Remit Purge
   2                            11:00pm


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

To access the Data Retention Parameters, select the menu options of Financial System Management, then Maintain Facility Information, and the desired facility.

NOTE: Also of interest on this screen are the settings for the Max AR Accts and Max BD Accts fields. Note that is possible that an account will meet all above criteria but, due to the setting of this parameter, it may not be archived immediately.

3. Run the Bad Debt Archive Pre-List optional batch job. To run this job, select Financial System Management from the initial menu, then select Optional Batch Jobs. The system then prompts you for the optional batch job to run. Enter a hyphen (-) to display the following menu:

```
                          Optional Batch Jobs Processor
                                              Wed May 13, 2002 11:17 am

Page:01                        Optional Batch Jobs
( 1)  14 - 13.2 CCA/RUA/CPA Interface
( 2)  20 - 15.1 CCA/RUA/CPA Interface
( 3)  27 - Active Patient Workfile
( 4)  18 - Agency Cash and Adjustment Report
( 5)  31 - AP Daily Distribution Register
( 6)  11 - AP PO Distr. Invoice Report
( 7)  32 - AP Recurring Invoice Request
( 8)  10 - AP Refund Invoice
( 9)   3 - AR to Bad Debt Transfer
(10)  12 - Archive Selection
(11)  37 - Bad Debt Charge Deletion
(12)   4 - Bad Debt Pre-List Report
(13)   8 - Bad Debt Pre-List Selection
(14)  13 - Bad Debt to Archive Pre-List Report
(15)   2 - Bad Debt to Archive Pre-List Selection
(16)  54 - Biller Statistics
(17)  80 - Biller Statistics Summary Rpt

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

Select Bad Debt Pre-List Selection.

NOTE: Archive Bad Debt Pre-List Selection must be set up.

When you run this optional batch job the system generates the Bad Debt Archive Pre-List Report and pre-lists BD accounts. This Pre-List uses the location index, not the follow up index, to select accounts. AR Accounts are not pre-listed.

4. View the report and *unprelist* any accounts that should not be archived using the BD Archive Pre-List function.

5. Set up the Optional Batch Job Archive Selection to archive accounts.

6. Validate the report(s) or backup medium. This optional batch job creates the following reports:

   Archive Selection Report (FBRARx, which lists all AR accounts that have been archived. FBRBD lists all BD accounts selected for archiving.

BD Archive Selection Report (FBRBDAx), which lists all accounts in bad debt that have been archived. The report is separated by collection agency and is provided so that collection agencies know to delete the archived accounts from their files.

Archive Statement (FBRAST or FBRASTH), which prints each account and each account's transaction history as defined by the Archive Statement Format field in PAAR Control.

The patient bill format is used to print the detailed charges section of the archive statement.

7. Select the Purge Archived Accounts function and select the date of accounts to be purged. To access this function, select Financial System Management from the initial menu, then select Purge. The system displays the following menu. The options on this menu enable you to purge archived accounts and/or bad debt charges. You can purge data for one or more dates at a time.

```
                General Hospital Purge/Other Archive Options Processor
                                                    Wed Sept 5, 2010 03:56 pm
Purge/Other Archive Options Input Options

            Option No.  Option
            ---------------------------------------
                1       Archived Accounts
      PURGE     2       Bad Debt Charges
                3       Active Patient Workfile

                4       Disposition Claims - Account Archive Select
                5       Unarchive Archived Accts by Date
                6       Unarchive One Account

                7       Unarchive Archived/Not Purged Claims for Account
                8       Unarchive All Archived/Not Purged Claims









Enter option number--
```

Select either the Purge Archived Accounts or Purge Bad Debt Charges option. The system functions identically for either process. After you select the desired function, the system displays a screen of available dates:

```
              General Hospital Purge Archived Accounts Processor
                                                Wed May 15, 1991 11:18 am

Page: 01                            Archive Dates             ##=Current Choices
( 1) 05/10/91
( 2) 05/11/91
( 3) 05/12/91
( 4) 05/13/91
( 5) 05/14/91
( 6) 05/15/91









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

Enter the option number of the desired dates to purge. Selected options are displayed on the screen in reverse video.

After you select the dates to purge, the system displays the following prompt:

Are you sure you wish to purge all accounts archived on mm/dd/yy? (Y/N) [N]--

To purge accounts archived on the dates you selected, enter Y. The system purges all account data. This includes all detail charges and credits, transaction history, notes, billing and claim information, TRENDSTAR and Horizon Performance Manager information, and financial patient data. Patient MPI information is not affected by the purge process. The account location is altered from ARC to HS. Other than the change in account location, you will not see a difference between archived and purged accounts.

NOTE: If you are purging bad debt charges, the Non-revenue Stat Detail Transactions are purged at the same time. This is done as a space-saving measure and requires that any statistic or revenue reclassifications attempted are flagged on the Reclassification report (FSREVC) and GL Revenue Reclassification report (FSRVRCG) with the message *Reclassification not allowed for BD accounts.*

To return to the beginning of the function without purging any accounts, enter **N** or press ENTER.

Results of Archiving/Purging

Archiving of Bad Debt accounts will:

- Make appropriate GL entries for bad debt accounts:
  Debit Bad Debt Contra Asset Account
  Credit Bad Debt Asset Account
- Update the system balancing screen
- Display adjustments to Bad Debt on the Adjustment Report
- Change the account location to ARC for archived accounts or HS for purged accounts
- Allow you to view archived accounts using the one-page Account Inquiry screen developed for archived accounts.

Purge Active Patient Workfile

The Purge Active Patient Workfile function purges the contents of the active patient workfile, deleting all workfile entries. This function enables you to clear workfile entries before redefining the selection criteria to target different PA accounts for collection activity.

When you select this option, the system displays the following prompt:

Are you sure you wish to purge the active patient workfile? (Y/N) [N] --

Enter **N** or press ENTER to exit without purging the active patient workfile. Enter **Y** to begin purging the active patient workfile; the system displays:

Processing purge request!

Disposition Claims - Account Archive Select

You can select the Disposition Claims - Account Archive Select function from the Purge/Other Archive Options screen.

This function allows you to set the account archiving process to disposition claims on accounts that are identified on the Archive Exceptions Report (FARAERx) report as having unarchived claims. The system acts on claims that have a status of Adjusted to Zero with the current date minus the value in the Carrier Pay Days field on the Data Retention Parameters screen. Dispositioning takes place on the next archive run.

When you select this function, the system displays a prompt similar to the following, also indicating the facility:

Do you wish to disposition claims during the next archive run? (Y/N) [N]--
Facility-- Model Hospital A

Enter **Y** to disposition claims during the next archive run. If you do not want to disposition claims, enter **N** or press ENTER.

Once the user answers this prompt, the result is displayed on the Data Retention Parameters screen in the Disp Claims? field. This is so the user can easily identify if claims are to be dispositioned with the next archive run.

Unarchive Archived Accts by Date

You can select the Unarchive Archived Accts by Date function from the Purge/Other Archive Options screen.

This function allows staff members who have a security level of 80 or above to unarchive a complete account archive run that is in an archive or unpurged status.

When you access this function and choose a facility, the system displays a list of available archive dates. Select your choices, and press ENTER.

Unarchive One Account

You can select the Unarchive One Account function from the Purge/Other Archive Options screen.

This function allows staff members who have a security level of 80 or above to unarchive a single account.

When you access this function and choose a facility, the system displays the following prompt:

Enter account, `C`corporate, `S`social security or `U`unit number,
name or `-`name for soundex--

Enter the account you want to unarchive. If the system cannot unarchive the account entered, due to a data integrity issue with the account, one of the following messages is displayed:

Archived account not found!

Archive Date is missing!

Archive Location is missing!

Archive information is missing!

Unarchive Archived/Not Purged Claims for Account

You can select the Unarchive Archived/Not Purged Claims function from the Purge/ Other Archive Options screen. This function can be used to unarchive all claims for a selected account which are archived but not purged.

When the processor is selected, a facility is selected if need be. If a job is running to archive, unarchive, or purge accounts for the facility, the following message is displayed, and the processor can be used at a different time.

Job for claim archive/purge is running. Please try later!

If the job is not running, you can select an account after the following prompt:

Enter account, `C`corporate, `S`social security or `U`unit number, name or `-`name for soundex--

A list of the claims archived but not purged is displayed for the entered account. If no claims are found that qualify, the following prompt is displayed:

No Entries Defined

If archived/not purged claims are found for the account, the next prompt is:

Key Y (Yes) Key Y to unarchive claims archived but not purged--

If Y is keyed, a background job is started. Any claims displayed for the selected account are unarchived. This means all information for the claim can be viewed, and a message appears in transaction history for the claim using the description *xx Claim Unarchived,* where the xx is the claim type such as UB or 1500, and the stat for the transaction code is decremented.

NOTE: The system writes to Transaction History only for non-replaced claims when archiving and unarchiving.

When the background job starts, the following message is displayed:

Background job started to unarchive claims!

The job processes one account at a time for the current process. If a previous request is not complete, the following prompt appears.

Previous job to unarchive claims is incomplete. Do you want to wait? (Y/N)--

You can enter Y (Yes) to wait. If a response of Y is not made, the program exits the process for the facility.

Unarchive All Archived/Not Purged Claims

You can select the Unarchive All Archived/Not Purged Claims function from the Purge/ Other Archive Options screen.This function can be used to unarchive all claims for a facility which are archived but not purged.

When the processor is selected, a facility is selected if need be. If a job is running to archive, unarchive, or purge accounts for the facility, the following message is displayed, and the processor should be used at a different time.

Job for claim archive/purge is running. Please try later!

Otherwise, the following message and prompt are displayed:

This background job will unarchive any claims archived but not purged.

Start the background job to unarchive claims not purged? (Y/N)--

If a response of Y (Yes) is keyed, the background job starts, and the following message is displayed:

Background job started to unarchive claims!

Each claim appearing in the list to be archived is examined and unarchived. This means all information for the claim can be viewed. A message appears in transaction history for the claim using the description of *xx Claim Unarchived*, where the xx is the claim type such as UB or 1500, and the stat for the transaction code is decremented.

NOTE: The system writes to Transaction History only for non-replaced claims when archiving and unarchiving.

The start and end of the job are displayed on the console with the program name of FCSCUA and the description of *Claim Unarchive*. The processor Review Program Statistics can be used to determine the number of claims unarchived.

The start and end of the batch job is recorded in the Log of PA Customer Tools Run. No other information is retained for this tool. The background job pauses for system freezes and the down time portion of Midnight Processing for Patient Accounting.

Chapter 3 - PROCESS REFUNDS

OVERVIEW

This collection of functions is used to handle the selection, approval, and issuance of refund checks to carriers and guarantors. The functions included are the following:

- **Refund Selection Parameters**
  These parameters are used to define the account balance cutoff and minimum refund amounts for carrier refunds and the minimum refund amount for guarantors. This parameter enables you to determine which guarantor and carrier accounts are selected for pending refunds in the next selection process. The information is filled in from the Refund Parameters, which set facility refund selection criteria for carrier and guarantor accounts. These parameters can be overridden by changing the values displayed. For more information about the Refund Parameters, refer to Maintain Facility Information in Chapter 2, Financial System Management, in this manual.

- **Approve Refunds**
  This function enables you to review refund information for a selected guarantor and/or carrier and indicate what action should be taken on the proposed refund.

- **Manual Refund Selection**
  This function enables you to select accounts that are not selected in the batch process or that need to be selected before a batch can be run. You can exclude the account from future refunds, put the account on hold, or delete the account from the batch run.

- **Pending Refund Report**
  This function enables you to generate a report which lists refund information for those accounts with pending refunds.

- **Pending Refund Detail Report**
  This function enables you to print detail information for each account in the Refund file.

- **Pre-Check List**
  This function is used to print a report detailing all accounts approved for refunds before the refund checks are generated.

- **Process Refund Checks**
  This function enables you to print refund checks.

Each item is described below.

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

REFUND SELECTION PARAMETERS

This function defines basic refund parameters for carriers and guarantors. Once a facility and this function are selected, this screen is displayed:

NOTE: This function cannot be accessed while another user is saving refund changes or while refund checks are being printed. The system displays the following message: *A refund is being processed currently. Retry (Y/N)*.

```
          General Hospital Refund Selection Parameters Processor
                                                 Thu Feb 17, 2000 12:55 pm
General Hospital A

                              Carrier Refunds
 1 Account Balance Cut-Off              2 Minimum Refund Amount
   $5,000.00                               $500.00

                             Guarantor Refunds
 3 Minimum Refund Amount
    $5.00









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

Field Explanations

1. ACCOUNT BALANCE CUT-OFF (9-N-R)
If the account balance is greater than the amount entered in this field, then a carrier with a credit balance will not be selected for a refund.

2. MINIMUM REFUND AMOUNT (4-N-R)
This field contains the minimum amount refunded to a carrier. The entry range is 0 to $99.99. Carrier balances less than this amount are not selected for refunds.

3. MINIMUM REFUND AMOUNT (4-N-R)
This field contains the minimum amount refunded to a guarantor. The entry range is 0 to $99.99. Patient balances less than this amount are not selected for refunds.

NOTE: On each of these fields, the amounts are displayed from the Facility Refund Parameters. Any of this information can be overridden for a specific refund parameters selection process.

After these fields are completed, the system displays the following prompt:

Do you wish to run Refunds now? (Y/N) [N]--

Enter **N** if you do not want to begin the refund selection process; the system exits the function. Enter **Y** to begin the refund selection process now. The system displays the following prompt:

Do you wish to produce the Pending Refund Detail Report? (Y/N) [N]--

Enter **Y** to generate both the Refund Exception (FPREFEXC) and Pending Refund Detail (FPREFDE) reports when the process completes. Enter **N** to generate only the Refund Exception (FPREFEXC) report. If you do not wait for these reports to be generated and printed, but immediately go into the refund approval selection, you may not get a complete list of pending refunds since the selection process may not be complete.

All refunds selected by the system are given a status of H (Hold) and print on the Pending Refund Detail report which is automatically generated during this process. The system does not read all AR (Accounts Receivable) and BD (Bad Debt) files but reads a special index of credit balance accounts, then selects accounts according to the criteria you have set. Accounts in PA (Patient Accounting) are never system-selected for refunds.

Accounts with a credit balance that do not meet the refund parameters print on the Refund Exception report. The Refund Exception report is automatically generated in this process and includes accounts with a credit balance that do not meet refund criteria, accounts with a credit balance where the guarantor has other outstanding accounts with a debit balance (in the same facility), and any refund records previously excluded from the refund file.

Previously deleted refund records are selected if they have met the Refund Retry Days established in the Refund Parameters. If these refund records do not meet the retry days, the records are included on the Refund Exception report.

APPROVE REFUNDS

This function allows you to approve, hold, exclude, or delete refunds on an account basis for both guarantors and carriers. The refund approval process is limited by a maximum dollar amount, by collector, and by an organizational hierarchy of 1) collector, 2) supervisor, and 3) manager. Different dollar values are assigned by type of refunds (guarantor, carrier, and unapplied cash). The Collector table is used to define the maximum dollar limit for refund approvals by type of refund and the organizational hierarchy, as follows:

- If the dollar value is not met, the person cannot access the account to approve the refund. The maximum dollar amount is not by facility, but instead is a generic value, since the Collector table is not facility specific.

NOTE: Collectors can be limited access to specific facilities by the Employee sign-on process and/or the CRT Names table definition.

- The hierarchy for refund requests is based on the Refund Collector information defined in the Collector table.

- Refunds which were approved can be deleted only by the collector who approved the refund or by an individual higher in the hierarchy chain, as defined on the Collector table.

When two refund checks are approved for the same carrier/plan on the same account on the same day, only the last refund is produced. The other refunds display on the Exception Report (FPREFEXC) with a message that the carrier/plan or guarantor has a pending refund.

NOTE: Refund changes cannot be made while another user is saving refund changes or while refund checks are being printed. The system displays the following message: *A refund is being processed currently. Retry (Y/N)*.

When a refund is approved, the account is immediately updated as follows:

- The account balance is affected by the amount of the approved refund. If it is a guarantor refund, the patient liability is updated. For carrier refunds, the specific carrier liability is updated.

- Transaction history is updated by the appropriate refund entry.

- The Pending Refund flag is set to Y and Last Refund Date is displayed in the Refund Approval Date field.

All of the changes are reflected in Account Inquiry.

If the refund is deleted after being approved, each of these entries is reversed in a separate transaction.

Any changes made to an invoice are reflected on the Refund Approval/Deleted report (FPREPPRP).

When a refund is approved or deleted, the following general ledger entries are made:

- Approved:
  - Credit control account (PA, AR, or BD)
  - Debit transaction account (TRAND or TRANR)
- Deleted:
  - Debit control account (PA, AR, or BD)
  - Credit transaction account (TRAND or TRANR)

When refund checks are printed, the following general ledger entries are made:

- Credit RFCASH
- Debit Transaction Account (TRAND or TRANR)

After this function is selected, the system prompts you to enter an account name or number. You can see all accounts by entering a hyphen (-) or you can enter an entire name in the last name, first name format, part of a name, or an account number:

Enter Account or Name--

When you press ENTER, the system displays every account in the file from the name entered forward. If you enter a hyphen (-), the following screen is displayed:

```
                General Hospital Approve Refunds Processor
                                          Tue Mar 28, 2006 04:56 pm

Page:01                                                 ##=Current Choices
     Patient Name          Type Vendor # Name        Stat  Col # Refund Ant Gen
( 1) ANDERSON,CRAIG         G   3010 CRG ANDERSON     H     111        5.00  S
( 2) ANDERSON,MIKE A        G   3320 MGFR AT ANDERSO  A     222       15.00  S
( 3) ANDERSON,MIKE T        G   3400 MGFR AZ ANDERSO  A     156       15.00  S




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

You can select one, or some accounts displayed. If you attempt to select an account

Field Explanations

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

TYPE (DISPLAY ONLY)
This field contains one of the following refund types:

- G-guarantor
- C-carrier
- U-unapplied cash)

VENDOR # (DISPLAY ONLY)
This field contains the guarantor internal number or insurance carrier and plan number.

NOTE: For guarantor refunds, the vendor internal number is assigned by McKesson and is separate from the guarantor corporate number. The vendor internal number is not used for look up purposes.

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

STAT (DISPLAY ONLY)
This field contains one of the following refund statuses:

- A - Approved
- H - Hold
- D - Delete
- E - Excluded

COL # (DISPLAY ONLY)
This field contains the number of the collector who requested the refund. *SYS* represents a system-selected entry, and *N/A* represents a person who is not defined as a collector.

REFUND AMT (DISPLAY ONLY)
This field contains the dollar amount of the refund.

GEN (DISPLAY ONLY)
This field contains the generation status of the refund (M-manual or S-system).

After you select an account from this screen, the following screen is displayed:

```
               General Hospital Approve Refunds Processor
                                                 Tue Mar 27, 2006 01:13 pm
General Hospital A


 1 Refund Type       2 Vendor #         3 Vendor Name
   GUARANTOR           960                CURNI,JUDY
 4 Vendor Address, Line 1               5 Vendor Address, Line 2
   123 EAST AVE
 6 Vendor City                          7 Vendor State      8 ZIP Code
   ROSWELL                              GA                  30087
 9 Invoice Date     10 Invoice Amount  11 Invoice Description
   11/24/99           14.00              REFUND FOR A9719700005 CURNI,JUDY
12 Account Balance                     13 Carrier/Guarantor Balance
   14.00-                               14.00-
14 Comment

15 Refund Transaction Type/Code        16 Refund Check Message
   R0001-GUARANTOR REFUND
17 Request Status                      18 Action
   HOLD
19 Guarantor Address Status


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

NOTE: Except for the Comment, Check Message, and Action fields, the system completes all fields from information previously entered.

Field Explanations

1. REFUND TYPE (DISPLAY ONLY)

The system displays whether this is a carrier/plan or guarantor refund. This field cannot be edited. The information that prints on the refund check stub can vary depending on the refund type.

NOTE: The vendor fields in this transaction refer to a carrier/plan if this refund is directed to a carrier or the guarantor if this refund is directed to a guarantor.

If the Mail-To field on the insurance demographics page of the patient's admitting process is completed by E, then the insured employer's information is displayed in the Vendor Name, Address (2), City, State/Province, and ZIP Code/Post Code fields.

If the Mail-To field is completed by G, then the plan group's information is displayed in the Vendor Name, Address (2), City, State/Province, and ZIP Code/Post Code fields. The vendor name is the group name indicated on the insurance demographics. Address information is loaded from Mail-To information.

If the Mail-To field is completed by P, the insurance carrier's information from the patient insurance record is displayed in the Vendor Name, Address (2), City, State/Province, and ZIP Code/Post Code fields. Name and address is loaded from Mail-To

information. If the Mail-To field is completed by entering C, the information is taken from the Insurance Carrier table and not from the patient record.

2. VENDOR # (DISPLAY ONLY)
The system displays the vendor number (either the carrier/plan code or McKesson-assigned internal guarantor number, depending on the type of refund) associated with this refund. For Unapplied Cash refunds, this number is pulled from the unapplied cash sequence number from the Maintain Unapplied Cash processor.

3. VENDOR NAME (24-A-R)
The system displays the vendor name (either the patient's employer, the group name, the carrier name, or the guarantor's name), depending on the type of refund. For Unapplied Cash refunds, this information is pulled from the Payment By field from the Maintain Unapplied Cash processor. This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report. If an account is scheduled for a refund and the guarantor name is changed, the new name will be reflected in this field.

4. VENDOR ADDRESS, LINE 1 (25-AN-R)
The system displays the first line of the vendor's address (either the patient's employer's address, the group address, the carrier's address, or the guarantor's address), depending on the type of refund. For Unapplied Cash refunds, this information is pulled from the Maintain Unapplied Cash processor. This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report.

5. VENDOR ADDRESS, LINE 2 (25-AN-O)
The system displays the second line of the vendor's address (either the patient's employer's address, the group address, the carrier's address, or the guarantor's address), depending on the type of refund. For Unapplied Cash refunds, this information is pulled from the Maintain Unapplied Cash processor. This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report.

6. VENDOR CITY (18-AN-R)
The system displays the city in which the patient's employer, the group, the carrier, or the guarantor (depending on the type of refund), is located. For Unapplied Cash refunds, this information is pulled from the Maintain Unapplied Cash processor. This field can be edited until the refund is approved.

(US) 7.VENDOR STATE (2-A-R)
(CN) 7.VENDOR PROVINCE (2-A-R)
The system displays the state/province in which the patient's employer, the group, the carrier, or the guarantor (depending on the type of refund), is located. For Unapplied Cash refunds, this information is pulled from the Maintain Unapplied Cash processor. This field can be edited until the refund is approved.

(US) 8.ZIP CODE (10-N-R)
(CN) 8.POST CODE (10-AN-R)
The system displays ZIP code/post code in which the patient's employer, the group, or the carrier, (depending on the account selected), is located. For Unapplied Cash refunds, this information is pulled from the Maintain Unapplied Cash processor. This field can be edited until the refund is approved.

9. INVOICE DATE (DISPLAY ONLY)
This field contains the date the refund record was generated.

10. INVOICE AMOUNT (9-N-R)
This field contains the refund amount. The entry range is 0 to $9,999,999.99. It is the credit liability for the patient or carrier, depending on the type of refund. This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report.

11. INVOICE DESCRIPTION (37-AN-O)
The system completes this field with a description consisting of the word REFUND followed by the patient account number and patient name. If the refund is a carrier refund, the policy number is included in the record, but does not display. For example, REFUND FOR A1234567890 SMITH,MARY A. The information in this field does not display in account transaction history.

12. ACCOUNT BALANCE (DISPLAY ONLY)
The system displays the total balance for the account at the time it was selected.

13. CARRIER/GUARANTOR BALANCE (DISPLAY ONLY)
The system displays the liability of the carrier or guarantor, depending on the type of refund selected. The current liability is displayed. For example, if the refund is re-accessed after approval, the amount reflects the approval amount for the refund.

14. COMMENT (60-AN-O)
This is a free-form field containing any comments to be made about this refund. This field is maintained in the transaction history.

15. REFUND TRAN CODE/TYPE (4-N-R)
This is the transaction type and code identifying this refund. This field is displayed from the Refund Parameters - Facility Information for the type of refund selected (carrier or guarantor). It can be overridden by entering a transaction code or selecting a transaction code from a table lookup. For guarantor refunds the transaction type is R. For carrier refunds, the transaction type is D. For unapplied cash refunds, the transaction type is J.

16. REFUND CHECK MESSAGE (4-N-O)
This field contains the code identifying the refund check message (if any) printed on this refund check's remittance advisory. You can override the refund check message from the Refund Parameters by entering a refund check message in this field. Enter a code or use the table lookup for a valid code. Entry of a check message in this field causes the refund to print on a separate check form.

17. REQUEST STATUS (DISPLAY ONLY)
This field contains the current status of this refund request, either A (approve), D (delete), H (hold), or E (exclude).

NOTE: E is not a valid option if the Refund Type is Unapplied Cash.

18. ACTION (1-A-R)
This field is used to approve, delete, hold, or exclude a refund. When this field is accessed, the following prompt is displayed when the refund is updated from a requested status to an approved status:

Approve Refund (Y/N) or (E)dit (Y/N/E) --

- You can enter **A** (Approve) to approve the refund or **N** for No not to approve the refund. If you enter No, the refund remains on hold until further action is taken. When you approve the refund, the system checks for maximum dollar value and the organizational hierarchy set in the Collector table. If the maximum dollar value is not met or the collector approving the refund was not the collector who created the refund, one of the following error messages is displayed:

  You are not the Refund creator, supervisor, or manager. Access is denied.

  Refund exceeds maximum dollar value. Refer the refund to your supervisor or manager as appropriate. Access is denied.

  Refund must be approved by a Supervisor or Manager.

  Once a refund has been approved, the following prompt is displayed if the person is the same individual who approved the refund or is higher in the hierarchy and is defined as an approving collector in the Refund Collectors parameter in the Collector Table:

  Delete approved refund? (Y/N) [N] -- -" .

  You can enter **Y** (Yes) to delete the refund or **N** (No) to approve it.

- You can enter **N** (No) to cancel the refund approval. The system displays the previous screen.

- You can enter **E** (Edit) to make changes on the screen.

There are separate refund parameters for guarantor and carrier refunds. For more information on establishing refund approval criteria, refer to *Refund Parameters* in the Financial System Management section of this document.

- Approving a refund request makes that request eligible for a refund check and updates the account balance and the general ledger. The account is updated immediately, while the general ledger is updated during midnight processing. If the

status is already A, deleting the refund request is the only available action. If the vendor name, address, or invoice amount has been changed, an indication is made on the Refunds Approved/Deleted report.

If this is a guarantor refund:

- The Patient Refund Pending flag is increased by 1.
- The invoice amount is added to the patient balance.
- The invoice amount is added to the patient refund amount.
- The Patient Last Refund Date field is set to the approval date.

If this is a carrier refund:

- The Carrier Refund Pending flag is increased by 1.
- The invoice amount is added to the current carrier balance.
- The invoice amount is added to the carrier refund amount.
- The Carrier Last Refund Date field is set to the approval date.

Whether this is either a guarantor or a carrier refund:

- The Account Refund Pending flag is increased by 1.
- The invoice amount is added to the account balance.
- The invoice amount is added to the account refund amount.
- The Account Last Refund Date field is set to the approval date.
- Transaction history is updated to reflect the refund.

All of this can be viewed in Account Inquiry.

- Deleting a request deletes the refund request from the system. If an approved refund is deleted, the appropriate account and general ledger entries are backed-out automatically. All account updates are repeated in the exact opposite manner and the account prints on the Refund Approved/Deleted report (FPREPPRP). The account is updated immediately. The general ledger is updated during midnight processing.

  If the refund record has not been previously approved, then the deleted request prints on the Refund Exceptions report (FPREFEXC). The record is available for possible re-selection when the retry days in the refund parameters are met.

- Holding a request keeps the refund record in the system, and no further action is taken by the system.

- Excluding a refund request excludes this patient/guarantor from ever being automatically selected for a refund. Excluded refunds print on the Refund Exception report.

When the above fields are completed, you have the option of accepting, editing or deleting the information entered. Accepting the screen completes the transaction.

NOTE: Approved refunds print on the Refunds Approved/Deleted report which is produced daily by midnight processing. Deleted refunds print on the Refunds Approved/Deleted report if they were first approved, then deleted. The amounts of refunds approved and deleted are displayed on the Daily Balancing screen.

Any account previously selected for a refund where the account balance is no longer a credit account, has to be manually deleted from the workfile. The system only removes zero balance accounts from the refund workfile when the account is archived/ purged.

MANUAL REFUND SELECTION

This function allows you to delete, hold, or exclude refunds on an account basis for both guarantors and carriers.

NOTE: Refund selection cannot be made while another user is saving refund changes or while refund checks are being printed. The system displays the following message: *A refund is being processed currently. Retry (Y/N)*.

After this function is selected, you are asked if you want to process guarantor or carrier accounts for refunds. In either case, the system prompts you to use the FPI lookup procedure to select an account from either PA, AR, or BD.

You must specify the refund type (guarantor or carrier) so that the refund process can determine which type of transaction to generate. If you specify guarantor, the following prompt is displayed:

Enter `C`corporate, `S`social security, name or `-` name for soundex--

You can enter the specific patient name, social security/health card number, corporate or unit number, or you can view all of the accounts for a specific guarantor by entering the guarantor's name or number, and then choosing the specific account to refund.

If you specify carrier, you select the account to delete, hold, or exclude, using the same FPI lookup procedure, and the system displays the insurance records for this account for which you can choose the appropriate action.

```
              General Hospital Manual Refund Selection Processor
                                                Mon Mar 13, 2006 03:51 pm
Account      Name                      FC Typ Admit    Disch        Balance Loc
A99-27100001 CALDWELL,BABY 2 BOY       KE I/P 09/28/99 09/29/99     0.00    AR/FCRV

Page:01
        Carrier                                Plan
( 1) 1  500-COMMERCIAL                        200-1500 BASIC PLAN









Enter choice--
```

For a given account, only one guarantor and one carrier refund per insurance can exist in the refund file at a time. For example, an account with two insurance carrier/plans

assigned can have three refund records in the refund file: one guarantor refund and one carrier refund for each assigned insurance.

Existing refunds can only be accessed using the Approve Refund function. If you select an account with a guarantor that has other accounts with an outstanding balance, this account prints on the Refund Exception report (FPREFEXC).

```
          General Hospital Manual Refund Selection Processor
                                                 Mon Mar 13, 2006 03:51 pm
Account      Name                    FC Typ Admit    Disch        Balance Loc
A99-27100001 CALDWELL,BABY 2 BOY     KE I/P 09/28/99 09/29/99     0.00    AR/FCRV
 1 Refund Type       2 Vendor #         3 Vendor Name
   CARRIER/PLAN        500200             1500 BASIC PLAN

 4 Vendor Address, Line 1               5 Vendor Address, Line 2
 6 Vendor City                          7 Vendor State      8 ZIP Code
   CityForModelHosp.A                     FL                  30209
 9 Invoice Date     10 Invoice Amount  11 Invoice Description
   02/17/00            0.00              REFUND FOR A9927100001 CALDWELL,BABY

12 Account Balance                     13 Carrier/Guarantor Balance
                                          0.00
14 Comment

15 Refund Transaction Type/Code        16 Refund Check Message
   D0001-INSURANCE REFUND
17 Request Status                      18 Action
   HOLD
19 Guarantor Invalid Address               20 Created By
                                              Caldwell, Mike

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

NOTE: Except for the Comment, Check Message, and Action fields, the system completes all fields from information previously entered.

Field Explanations

1. REFUND TYPE (DISPLAY ONLY)
The system displays whether this is a carrier/plan or guarantor refund. This field cannot be edited. The information that prints on the refund check stub can vary depending on the refund type.

NOTE: The vendor fields in this transaction refer to a carrier/plan if this refund is directed to a carrier or the guarantor if this refund is directed to a guarantor.

If the Mail-To field on the insurance demographics page of the patient's admitting process is completed by E, then the insured employer's information is displayed in the Vendor Name, Address (2), City, State/Province, and ZIP Code/Post Code fields.

If the Mail-To field is completed by G, then the plan group's information is displayed in the Vendor Name, Address (2), City, State/Province, and ZIP Code/Post Code fields. The vendor name is the group name indicated on the insurance demographics. Address information is loaded from Mail-To information.

If the Mail-To field is completed by P, the insurance carrier's information from the patient insurance record is displayed in the Vendor Name, Address (2), City, State/ Province, and ZIP Code/Post Code fields. Name and address is loaded from Mail-To information. If the Mail-To field is completed by entering C, the information is taken from the Insurance Carrier table and not from the patient record.

2. VENDOR # (DISPLAY ONLY)
The system displays the vendor number (either the carrier/plan code or McKesson-assigned internal guarantor number, depending on the type of refund) associated with this refund.

3. VENDOR NAME (24-A-R)
The system displays the vendor name (either the patient's employer, the group name, the carrier name, or the guarantor's name), depending on the type of refund. This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report (FPREPPRP).

4. VENDOR ADDRESS, LINE 1 (25-A-R)
The system displays the first line of the vendor's address (either the patient's employer's address, the group address, the carrier's address, or the guarantor's address), depending on the type of refund. The confidential address is displayed, if applicable.

This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report.

5. VENDOR ADDRESS, LINE 2 (25-AN-O)
The system displays the second line of the vendor's address (either the patient's employer's address, the group address, the carrier's address, or the guarantor's address), depending on the type of refund. The confidential address is displayed, if applicable.

This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report.

6. VENDOR CITY (18-AN-R)
The system displays the city in which the patient's employer, the group, the carrier, or the guarantor (depending on the type of refund), is located. This field can be edited until the refund is approved. The city in the confidential address is displayed, if applicable.

(US)7.VENDOR STATE (2-A-R)
(CN)7.VENDOR PROVINCE (2-A-R)
The system displays the state/province in which the patient's employer, the group, the carrier, or the guarantor (depending on the type of refund), is located. This field can be edited until the refund is approved. The state in the confidential address is displayed, if applicable

(US)8.ZIP CODE (10-N-R)
(CN)8.POST CODE (10-AN-R)
The system displays ZIP code/post code in which the patient's employer, the group, or the carrier (depending on the account selected), is located. This field can be edited until the refund is approved. The zip code in the confidential address is displayed, if applicable

9. INVOICE DATE (DISPLAY ONLY)
This field contains the date the refund record was generated.

10. INVOICE AMOUNT (9-N-R)
This is the refund amount. The entry range is 0 to $9,999,999.99. It is the credit liability for the patient or carrier, depending on the type of refund. This field can be edited until the refund is approved. If this field is changed, a notation is made on the Refunds Approved/Deleted report (FPREPPRP).

11. INVOICE DESCRIPTION (37-AN-O)
The system completes this field with a description consisting of the word REFUND followed by the patient account number and patient name. If the refund is a carrier refund, the policy number is included in the record, but does not display. For example, REFUND FOR A1234567890 SMITH,MARY A. The information entered in this field does not display in this account's transaction history.

12. ACCOUNT BALANCE (DISPLAY ONLY)
The system displays the total balance for the account at the time it was selected.

13. CARRIER/GUARANTOR BALANCE (DISPLAY ONLY)
The system displays the liability of the carrier or guarantor, depending on the type of refund selected. The current liability is displayed. For example, if the refund is re-accessed after approval, the amount reflects the approval amount for the refund.

14. COMMENT (60-AN-O)
This is a free-form field containing any comments to be made about this refund. This field accepts up to 60 characters and is maintained in the transaction history. This comment does not print on the check or check stub.

15. REFUND TRAN CODE/TYPE (4-N-R)
This code is displayed from the insurance plan master of the carrier selected, or from the financial class for the account of the guarantor selected. This code is used to reflect the refund in the transaction history for this account. This code is also used to map the entry to the general ledger. It can be overridden with another transaction code with transaction type D for insurance refunds or transaction type R for guarantor refunds.

16. REFUND CHECK MESSAGE (4-N-O)
In this field you can enter a specific message to print on the refund check. An entry in this field causes this check to print separately, that is, on a check by itself and not combined with other refunds to this guarantor or carrier plan. If you leave this field blank, the message is loaded from the Refund Parameters.

17. REQUEST STATUS (DISPLAY ONLY)
The field displays the current status of the refund. If the refund selected does not meet the refund criteria established in the refund parameters, then Delete is displayed in this field. If the refund criteria are met, then Hold is displayed in this field. For carrier refunds, *Delete* is displayed in this field if the carrier account balance is set to Yes, and the account balance is less than the carrier balance. For guarantor refunds, *Delete* is displayed in this field if the guarantor insurance balance for this account is greater than zero.

18. ACTION (1-A-R)
This field describes whether the refund is to be deleted, held, or excluded. Refunds are approved only through the Approve Refunds function. When this field is accessed, the following prompt is displayed:

Enter (D)elete, (H)old, or (E)xclude--

You can enter **D** to delete the refund, **H** to put it on hold, or **E** to exclude it.

- Deleting a request deletes the refund request from the system. If an approved refund is deleted, the appropriate account and general ledger entries are backed out automatically. All account updates are repeated in the exact opposite manner and the account prints on the Refund Approved/Deleted report (FPREPPRP). The account is updated immediately. The general ledger is updated during Midnight Processing.

  If the refund record has not been approved previously, the deleted request prints on the Refund Exceptions report (FPREFEXC). The record is available for possible re-selection when the retry days in the refund parameters are met.

- Holding a request keeps the refund record in the system, and no further action is taken by the system.

- Excluding a refund request excludes this patient/guarantor from ever being automatically selected for a refund. Excluded refunds print on the Refund Exception report. Unapplied cash refunds cannot have the status of excluded.

19. GUARANTOR INVALID ADDRESS (DISPLAY ONLY)
When an address is flagged as invalid, the system reviews all refunds applicable to the person and places the refund item on hold. However, the refund can still be processed manually on this screen.

20. CREATED BY (DISPLAY ONLY)
This field displays the name of the user who created the refund request.

PENDING REFUND REPORT

This function is used to compile and print the Pending Refund report (FPRENREF). After it is selected, the system prompts you if you wish to print the report. The options are **Y** for Yes or **N** for No with a default entry of Y. Entering Y completes the transaction and begins the compilation and printing of the report at the designated printer.

This report prints each refund in the refund file with a status of H (hold) and A (approve). It includes refunds selected by the system as well as those manually selected.

For an example and detailed information about the Pending Refund report, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide.*

PENDING REFUND DETAIL REPORT

This function is used to compile and print the Pending Refund Detail report (FPREFDE).

When you select this function, the system prompts you to ask if you want to include all invoices. Enter **Y** if you want the report to include every invoice record in the refund file. Enter **N** if you want the report to include only those refund records selected in the last refund selection process. As such, if you enter N this report is identical to the Pending Refund Detail report generated by the system during the previous refund selection process.

NOTE: Manually selected and excluded refunds do not display on this report.

The Pending Refund Detail report provides full account detail, including transaction history for each account. This provides a means for the Accounting department to review each account prior to approving or deleting a refund.

For an example and detailed information about the Pending Refund Detail report, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide*.

PRE-CHECK LIST

This function is used to generate the Pre-Check List report (FPRCKLST), which is a list of approved refunds before the refund checks are generated. After it is selected, the system asks you if you wish to print the report. The options are Y for Yes or N for No with a default entry of Y. Entering Y completes the transaction and begins the compilation and printing of the report at the designated printer.

This report should be used to verify refund checks to print in the next run as well as available cash. If there is not enough cash in the appropriate general ledger account, you can put certain refunds on hold (H) until a future check run.

For an example and detailed information about the Pre-Check/Pre-Cheque List report, refer to the *Reports Volume* of the *STAR Financials Patient Accounting Reference Guide.*

PROCESS REFUND CHECKS

This function processes the generation or printing of refund check requests and the check register.

NOTE: This function cannot be accessed while a check print is in progress. The system displays the following message: *Check Print is in progress currently. Please try later*.

After you select this option, the system reads through the refund file to process all approved refunds and then prompts you to mount the check forms in the printer designated for this task. Once the checks are mounted, enter READY. The system then asks for the beginning check number and whether you want to use the printing pattern alignment to be sure the checks are properly mounted in the printer (Y or N). Entering **Y** prompts the system to print individual check patterns until you enter **N**. At this point, the checks print automatically.

When all of the checks are printed, the system asks if all printed properly. Entering **Y** for Yes completes the transaction. Entering **N** for No results in the system prompting you to enter the number of the first check to void. You are then prompted to enter the check number to restart printing. When this information is entered, a message is displayed confirming the check numbers to void and at which check number to restart printing. Confirming this statement results in these checks being reprinted. This is used in case of a printer jam or some other problem where the checks do not print properly.

Printing Refund Checks

Selecting the Process Refund Checks option prompts the system to read the refund file and locate all approved refund requests. While doing so, the system displays this prompt:

Processing Refund Requests

If no refunds are ready to print, this message is displayed:

No checks to print -- Press NL

If this message is displayed, there are no refunds to print and the transaction is complete.

If refund checks are processing, you will not be allowed to save

If approved refund requests do exist in the system, this message is displayed:

Mount patient refund checks reply [READY]

Load the refund check forms on the assigned printer, and enter READY. The system then displays this message to prompt you for the beginning check number:

Beginning check number

Enter the first check number to be used. This includes any checks to be used for print patterns to ensure proper alignment. After the beginning check number is entered, the system displays this prompt:

Pattern alignment (Y/N)

Entering **Y** causes the system to print a series of alignment characters on the first check to be sure the paper checks are properly aligned in the printer (this voids the first check). While the pattern is printing, this message is displayed:

Pattern printing

After the first pattern prints, you are prompted to for additional patterns with this message:

Another pattern (Y/N)

You can print as many patterns as necessary until the forms are properly aligned. When the alignment is correct, enter **N** to the above prompt to begin the check printing run. While the checks are printing, this message is displayed:

Checks printing

This message flashes on the screen until all the checks print. When all checks are printed for this run, the system displays this message:

Did all checks print OK? (Y/N)

If all checks printed properly, enter **Y**. The system then prompts you to remove the check forms from the printer and load stock paper with this message:

Please dismount checks and reply [READY]

Entering READY signals the system to print the check register accompanying this check run, completing the transaction.

If all checks did not print properly, enter **N** to the Did all checks print OK? prompt. The system then voids the spoiled checks and print new ones. The first prompt displayed calls for:

First check to void

Enter the number of the first spoiled check. This prompt then is displayed:

Restart at check number

Enter the check number at which to restart printing. The system allows for any additional print patterns required. When you are ready to print, the system displays this message:

Void check numbers ###### to ###### Restart at check ###### (Y/N)

This prompt displays the range of checks to void and the first check number for restarting the printing process. Verify the check numbers, and enter **Y** or **N**. If you enter **N**, the system prompts you to again enter the check numbers to void and restart. If you enter **Y** for Yes, the system prompts you regarding the print pattern, and when you are ready, begins the print run. When the print run is completed, the check register should be printed. It includes all checks printed including any voided checks.

When all checks are printed, the system prompts you to dismount the check forms from the designated printer. A check register is always produced when refund checks are processed.

NOTE: Refund checks print *hot*. In other words, they are not spooled in the system. This is a security feature which prevents them from being reprinted after processing. If the designated printer is in use when this function is selected, the checks are not processed and the following message is displayed:

Printer Busy

When the printer is free, you may re-access this function to process and print the refund checks.

There is no sort option for refund checks. The sort sequence is as follows:

- Facility
- Account Number
- Vendor Number

Note that if a guarantor or carrier is receiving refunds for multiple accounts, the checks are combined. The check stub reflects each account receiving the refund and the amount is for the sum of the refund on each account. The first account number prints with the other accounts for this guarantor on the first check. The next check begins with the next lowest account number, excluding those accounts that were included on the previous check(s).

Separate check messages override this feature and cause individual checks to print. These checks print following the other accounts for the guarantor or carrier.

NOTE: For checks to be combined in the printing process, the vendor name, address, city, state/province, and ZIP code/post code must match.

The information printing on the check voucher included basic insurance information such as insured's name, policy number, group number, group name, patient number, guarantor name, and refund amount.

Guarantor refund checks include account number, patient name, discharge date, guarantor name, and refund amount.

There is a check format for refund checks which is entered on the Refund Parameter screen. This controls the actual print format of the checks for each facility. Since this selection controls the actual check printing process, this option should only be available to personnel responsible for the generation of refund checks.

Chapter 4 - REIMBURSEMENT OVERVIEW

REIMBURSEMENT TYPES

The STAR system enables you to calculate reimbursement using the following reimbursement types:

- A - ASC Payment Group
- D - ICD-9-CM Diagnosis Code
- P - ICD-9-CM Procedure Code
- G - DRG Code
- M - Medical Service
- O - Overall Plan
- S - Specific DRG Codes
- C - Major Diagnostic Category
- I - Pathways Contract Management Interface
- J - PCON/Cycle
- N - Nova Scotia Out of Province
- R - Alternate Price

Reimbursement based on DRG code is calculated by the Patient Care system (Medical Records Module) using the DRG payors and rate masters assigned for the financial class. The expected DRG reimbursement amount is networked to the financial system for its use in calculating the contractual adjustment amount.

Reimbursement calculated by Pathways Contract Management is returned to the financial system by way of an interface during midnight processing.

All other types of reimbursement calculations are done by the financial system using the reimbursement tables set up on the system.

TABLE SETUP AND PARAMETERS

DRG-based Reimbursement

To set up DRG-based reimbursement, you must perform the following steps:

1. Define DRG Payors (on Patient Care system).
    - Assign financial classes.
    - Medicare or non-Medicare
2. Generate DRG Rate Table (on Patient Care system).
    - Creates DRG rate master used in calculating DRG reimbursement
3. Maintain DRG rate master if payor does not use Medicare calculations.
4. Set up Reimbursement Payor Code (on Financial System).
5. Set up Payor Table Definition (on Financial system).
    - Define one table for reimbursement type G (DRG Code.
6. Assign reimbursement to insurance plan (on Financial System).

NOTE: Since STAR Financials does not calculate the expected reimbursement for DRG-based payors, a single DRG Reimbursement Payor Code may be set up on Financials, along with a single G-type table, and assigned to each insurance plan using the DRG method for reimbursement calculation. It is not necessary to set up separate Reimbursement Payor Codes for each DRG Payor defined on Patient Care.

Pathways Contract Management Reimbursement

1. Define Reimbursement Payor Code.
2. Set up Payor Table Definitions.
    - Define reimbursement type I.
    - Define effective dates.
3. Set up Pathways Contract Management interface function in the Reimbursement Master.
4. Attach payor code and reimbursement type I to the insurance plan (facility options).

STAR Financials Reimbursements

To set up reimbursement when it is not DRG-based or calculated by Pathways Contract Management, you must perform the following steps on STAR Financials.

1. Define Reimbursement Payor Code.

2. Set up Payor Table Definitions.

    - Define Reimbursement Type (D, P, M, O, S, A, or C).

    - Define Effective Dates.

3. Set up Payor Arrangement Tables.

    - For each payor table define the reimbursement method (flat, daily, charge level) and the maximum reimbursement amounts.

4. If necessary, attach stop loss tables, accommodation code exceptions, proration summary code exceptions or fee schedule exceptions to each payor table.

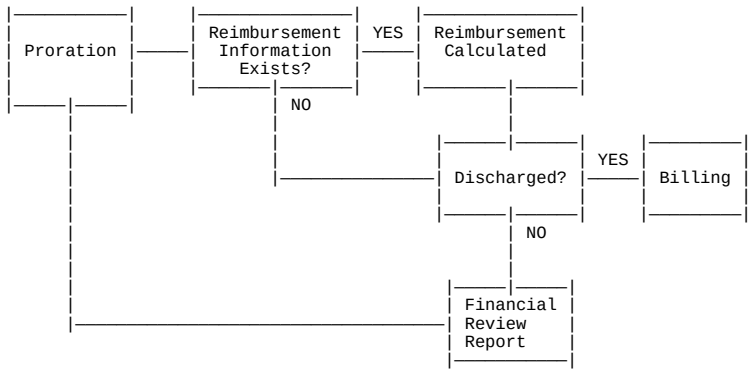
5. If necessary, attach accommodation code exceptions, proration code exceptions and fee schedule exceptions to each stop loss table.

6. Attach payor code and applicable payor tables for that payor code to the insurance plan (facility options).

REIMBURSEMENT FLOW

Daily Reimbursement Process

Reimbursement calculations are performed nightly as a separate function within proration for primary plans having a contractual agreement with the provider. The purpose is to determine the expected reimbursement amount. The system calculates reimbursement on the primary carrier only. Estimated reimbursement is performed on PA accounts if reimbursement information exists for the insurance plan.



Proration determines the estimated carrier liability based on the insurance plan coverage for the patient:

Total Charges
- Non-covered Charges

= Covered Charges
- Limit Excess
- Deductible
- Coinsurance
- COB Adjustment

= Estimated Carrier Liability

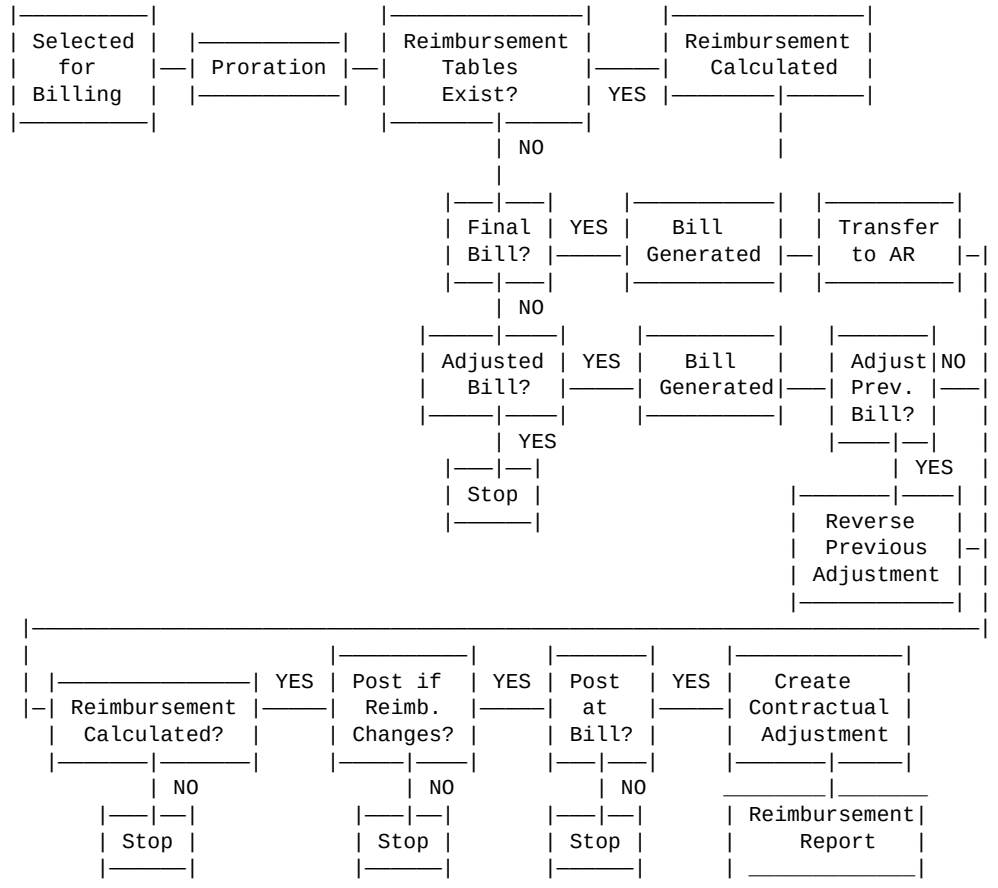
If reimbursement information exists (primary carrier only), the estimated reimbursement is calculated based on the defined reimbursement tables. DRG-based reimbursement is not available on a daily basis since this is calculated when a patient is abstracted via Medical Records. Reimbursement calculated on Pathways Contract Management is not available on a daily basis since it is calculated after the account is final billed. The expected reimbursement amount is calculated by subtracting the deductible and any coinsurance from the calculated reimbursement amount. The expected contractual adjustment equals the estimated carrier liability minus the expected reimbursement amount.

The reimbursement amounts calculated prior to patient discharge and billing are strictly informational and do not affect the actual insurance and account balances. When the system calculates reimbursement, it appears on the Financial Review Report and via the Proration Reimbursement inquiry on the Balance Summary screen. It is not until billing that reimbursement information updates the account.

Reimbursement Process During Billing

- Proration
- Final or Adjustment Bill
- Contractual Adjustment
- Reimbursement Audit Report (FBR250)
- Adjustment Posting Detail Report (FAR210)

If an account has been selected for billing, the function within proration is still used to calculate the reimbursement amount based on either the expected DRG reimbursement provided by Patient Care for DRG based payors, the reimbursement tables defined on Pathways Contract Management, or the reimbursement tables defined on the STAR Financial system. The reimbursement process during billing calculates and posts the contractual adjustment amount if the facility option for reimbursement for the insurance plan, the Post Contractual At Final Bill field, is set to Yes.



If the hospital elects to have automatic contractual adjustments posted at final bill, the system calculates the amount to be written off and creates the contractual adjustment.

Total Charges
- Non-covered Charges

= Covered Charges
- Limit Excess
- Deductible
- Coinsurance
- COB Adjustment

= Estimated Carrier Liability
- Reimbursement Amount

= Contractual Adjustment

In this formula:

Reimbursement Amount = Calculated Reimbursement Amt - Deductible - Coinsurance

For DRG-based reimbursement, the Calculated Reimbursement Amount is provided to STAR Financials via the Patient Care Medical Records DRG Assignment Module. For Pathways Contract Management reimbursement, the Calculated Reimbursement Amount is provided to STAR Financials via the Pathways Contract Management interface in midnight processing. Otherwise, this amount is calculated based on the reimbursement tables defined on STAR Financials.

Each account receiving an automatic contractual adjustment appears on the Reimbursement Audit report (FBR250). The automatic contractual adjustment transactions appear in Batch 0 of the Adjustment Posting Detail report (FAR210). Separate automatic contractual adjustment transaction codes should be defined and mapped to unique General Ledger account numbers for major payors, such as Medicare and Medicaid. These transaction codes are assigned to the insurance plans via the facility options (reimbursement).

POSTING CONTRACTUALS AT FINAL PAYMENT

There is an option in the system to post automatic contractuals at time of final payment via the cash posting process. This function is not linked in any way to the reimbursement tables and calculations; the contractual adjustment amount calculated is the amount required to bring the carrier balance to zero.

For example, assume the insurance carrier balance is $1,000, and a final payment of $750 is received. The amount of the contractual adjustment would be a $250 credit:

1,000 Carrier Balance
- 750 Payment
======
= 250 Remaining Balance
- 250 Contractual Adjustment
======
0 Carrier Balance

Using the same carrier balance, assume the final payment amount was $1100. A $100 debit contractual adjustment amount would be calculated:

1,000 Carrier Balance
- 1,100 Payment
======
= <100> Remaining Balance
+ 100 Contractual Adjustment
======
= 0 Carrier Balance

SCREENS

The following screens are used in setting up reimbursement in the STAR systems. For more information on these screens, refer to your STAR Patient Care tables documentation or your *Tables, Masters, and Parameters Volume* in the *STAR Financials Patient Accounting Reference Guide.*

- DRG PAYORS (Medical Records table in STAR Patient Care)
- DRG RATE TABLE GENERATION (DRG Maintenance Functions in STAR Patient Care)
- DRG RATE TABLE GENERATION (DRG Maintenance Functions in STAR Patient Care)
- DRG RATE MASTER (DRG Maintenance Functions in STAR Patient Care)
- REIMBURSEMENT PAYOR CODES (Financial Table Maintenance in STAR Financials)
- PAYOR TABLE DEFINITION (PA/AR Master File Maintenance on STAR Financials)
- PAYOR ARRANGEMENT TABLES (PA/AR Master File Maintenance on STAR Financials). It is not necessary to establish this table for DRG-based payors.
- STOP LOSS TABLES (PA/AR Master File Maintenance on STAR Financials). It is not necessary to establish this table for DRG-based payors.
- FACILITY OPTIONS-INSURANCE-REIMBURSEMENT (PA/AR Master File Maintenance on STAR Financials). The reimbursement option is used to link insurance plans to reimbursement payors. These tables should be completed if the hospital wishes to do automatic contractual write-offs at final bill time and/or if the hospital wants special reporting before an account bills on the expected reimbursement (via the Financial Review Report and the proration reimbursement inquiry on the Balance Summary screen.)

REPORTS

The following reports display valuable reimbursement information. For more information on these reports, refer to the *Reports Volume* in the *STAR Financials Patient Accounting Reference Guide.*

- **Reimbursement Table Report (FTR140)**

  The Reimbursement Table Report displays payor tables for all or selected payors. The report can be limited to only those tables currently in effect or can include all tables. If all tables are included, you can select whether you want to include payors filed as deleted on the report.

- **Financial Review Report (FARFRR)**

  The Financial Review Report shows estimated reimbursement information for the primary carrier if reimbursement tables have been linked to the insurance via the reimbursement facility options of insurance plan coverage. Since the Patient Care system calculates DRG reimbursement amounts during Medical Records abstracting, DRG based calculations are not available on a daily basis.

- **Reimbursement Audit Report (FBR250)**

  The Reimbursement Audit Report provides a list of accounts that have had automatic contractual adjustments done at billing (final/adjustment).

- **Adjustment Posting Detail Report (FAR210)**

  Automatic Contractual Adjustment transactions (system-generated during billing) appear in Batch 0.

- **Fee Schedule Report by Department (FBR260)**

  The Fee Schedule Report by Department provides a list of SIM items charged to accounts that have been final or adjustment billed during midnight processing.

- **Patient-specific Fee Schedule Reimbursement (FBR270)**

  The Patient-specific Fee Schedule Reimbursement report provides a list of all Fee Schedule service items charged to accounts that have been final or adjustment billed during midnight processing.

Chapter 5 - PATIENT ACCOUNTING CUSTOMER TOOLS

OVERVIEW

The functionality in Customer Tools is used to perform a repair on a single account or several accounts, using online and batch tools. The batch tools analyze accounts, and problematic accounts are reported and/or repaired. A report can be produced by a batch tool, the FPATOOL report. The online tools are used to perform a repair on a single account.

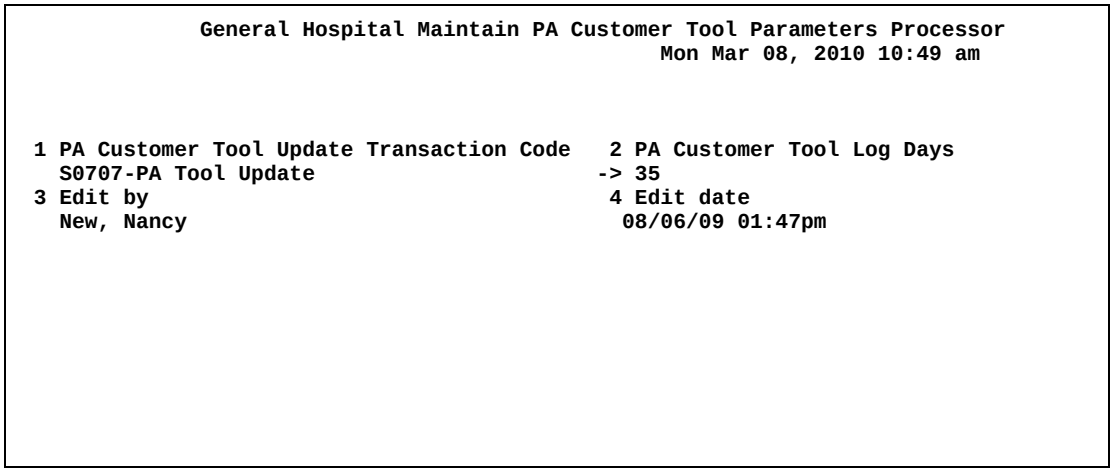
The use of Patient Accounting Customer Tools is maintained in the PA Customer Tool Log which can be viewed until it is purged. The log contains information on Patient Accounting tools and on Patient Processing tools of interest to Patient Accounting. If an account is updated using a Patient Accounting Customer Tool or a Patient Processing tool of interest to Patient Accounting, the occurrence is recorded in transaction history. For each tool, a separate transaction code description is used in transaction history and details on the update are recorded in the comment for the transaction. The transaction code will be the Key Data Revision Transaction Code from PAAR Control unless a PA Customer Tool Update Transaction Code is indicated in Maintain PA Customer Tool Parameters.

The Patient Accounting Customer Tools function is accessed through the Financial System Management menu which is accessed from the main menu for Patient Accounting.

Each option is discussed on the following pages.

MAINTAIN PA CUSTOMER TOOL PARAMETERS

After the option is selected, you can enter a facility. The following screen is displayed:



Field Explanations

1. PA CUSTOMER TOOL UPDATE TRANSACTION CODE (LOOKUP-O)
The transaction code indicated in this field is used in transaction history to document updates to an account from a Patient Accounting Customer Tool or Patient Processing Customer Tool of interest to Patient Accounting. You can enter a transaction tool or enter a hyphen (-) to select one from a list of transaction codes. If no transaction code is indicated in this field, the Key Data Revision Transaction Code from PAAR Control is used. A separate transaction code description is used for each tool.

2. PA CUSTOMER TOOL LOG DAYS (3-N-O)
A log is maintained documenting the use of PA Customer Tools and of PP Customer Tools of interest to Patient Accounting. The log records the use of a tool along with a list of accounts updated. This field indicates how long the log should be maintained.

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

Enter number of days that PA Tool Log information will be available--

You can enter the number of days or leave the field blank. If you do not enter a value, the information is retained for 60 days. The purging of this information occurs in the Midnight Processing step which is *PA Uptime Rpts*. When the purge program runs, it is identified on the console as Purge Log Files for PA Customer Tools.

LOG OF PA CUSTOMER TOOLS RUN

This option provides a list, by date, of both online and batch tools used. The list includes tools for STAR Patient Accounting and tools for STAR Patient Processing of interest to Patient Accounting. When the option is selected, a facility can be selected, and the following prompt appears requesting a start date for viewing:

Enter starting date for display or `E` for earliest date [E]--

The list beginning with the date selected in the prompt is sorted by start date and for batch tools by start time. The online tools appear first in the list for a date. One entry is made in the log for any day that an online tool is used. This lookup list appears as follows. An item can be selected to view more information about the use of the tool:

```
Page:01         PA Tools Used by Date or Date/Time if Batch Tool
   ( 1) Repair Chg Discrepancies/Menu            08/05/09
   ( 2) Repair Chg Discrepancies/Menu            08/06/09
   ( 3) Rpt Charge/Balancing Issues              08/06/09   00 01 40
   ( 4) Repair Chg Discrepancies/Menu            08/07/09
   ( 5) Repair Chg Discrepancies/Menu            08/11/09
```

The screens that are displayed next are different for a batch tool and an online tool. The online tool screen is discussed first (see “Online Tool” on page 5-5). The batch tool is discussed next (see “Batch Tool” on page 5-7).

Online Tool

If an online tool is selected, the following screen is displayed:

```
             General Hospital Log of PA Customer Tools Run Processor
                                              Mon Mar 17, 2010 10:31 am

                            Statistics for Online Tool
  1 Tool Code  2 Tool Description               3 Original STI for Tool
    F-BL         Repair Chg Discrepancies/Menu    F10320
  4 Comment1
    For the selected account, counts, totals, and indexes related to
  5 Comment2
    charges can be repaired.  Typically, these would need to be updated
  6 Comment3
    so billing occurs correctly.

  7 Last User                                8 Date Used
    Slick,Tom                                  08/05/09
  9 Number of Evaluations Done             10 Number of Updates Made
    PA/10 AR/2                                 PA/8 AR/2
```

Field Explanations

1. TOOL CODE FOR PA TOOL (DISPLAY ONLY)
This field identifies the feature used. There are two identifiers which are separated by a hyphen. The first identifier equals C for a tool initiated in Patient Processing or F for a tool initiated in Patient Accounting. The second identifier contains the unique key for the tool.

2. TOOL DESCRIPTION (DISPLAY ONLY)
This field contains a description for the tool used.

3. ORIGINAL STI FOR TOOL (DISPLAY ONLY)
This field contains the STI number which introduced the tool. It is provided so the documentation for the tool in that STI can be reviewed as needed.

4. COMMENT1 (DISPLAY ONLY)
This field contains a brief description of the functionality provided by the tool. The description may be continued in the Comment2 field.

5. COMMENT2 (DISPLAY ONLY)
This field contains a brief description of the functionality provided by the tool. The description may be continued in the Comment3 field.

6. COMMENT3 (DISPLAY ONLY)
This field contains a brief description of the functionality provided by the tool. The description may be continued from the Comment2 field.

7. **LAST USER (DISPLAY ONLY)**
This field identifies the last person accessing an account using the tool. This may not be an account updated with the tool.

8. DATE USED (DISPLAY ONLY)
This field contains the date on which the tool was used.

9. NUMBER OF EVALUATIONS DONE (DISPLAY ONLY)
This field contains the number of examinations of accounts performed using the tool. The count includes each time an account was viewed in the tool meaning an account can be counted multiple times for a tool and date. The statistics are provided by account locations PA, AR, BD, and ARC for Patient Accounting tools.

10. NUMBER OF UPDATES MADE (DISPLAY ONLY)
This field contains the number of account updates made using the tool. The statistics are provided by account locations PA, AR, BD, and ARC for Patient Accounting tools.

One of the following prompts is displayed on the screen:

- If no accounts were updated by the tool, the following prompt is displayed:

  No accounts updated by this use of the tool. Press ENTER.

- If accounts were updated by the tool, the following prompt is displayed:

  View accounts updated by this use of the tool? (Y/N) [Y]--

You can enter **Y** (Yes) to view the list of accounts updated by the use of the tool. A lookup list is displayed. The header for the list is the title for the tool. For each account, the account number, patient name, admission date, and discharge date are displayed.

```
Patient Name                  Adm Dt   Disch Dt
  Page:01        Accounts updated by Repair Chg Discrepancies/Menu
  ( 1) A0902100001     LNM,FNM A                     01/21/09 01/21/09
  ( 2) A0915300002     SNOW,FLAKE                    06/02/09 06/02/09
 Select account to access Account Inquiry--
```

If an account is selected from the list, the Account Inquiry screen is displayed for the account. When you exit Account Inquiry, the selection list of accounts is redisplayed.

Batch Tool

If a batch tool is selected, the following screen is displayed:

```
          General Hospital Log of PA Customer Tools Run Processor
                                              Mon Mar 17, 2010 05:05 pm

                           Statistics for Batch Tool
  1 Tool Code   2 Tool Description              3 Original STI for Tool
    F-RCB         Rpt Charge/Balancing Issues     F10319
  4 Comment1
    Two reports are produced.  One lists accounts with charge
  5 Comment2
    discrepancies.  The second lists accounts with balancing issues.
  6 Comment3

  7 Started By                 8 Date/Time Started   9 Date/Time Ended
    Slick,Tom                    08/06/09 00:01        08/06/12 12:12
 10 Accounts Examined         11 Accounts Updated
    PA,3                         PA,2
 12 Stopped By                   13 Date/Time Stopped

 14 Restarted By              15 Date/Time Restarted

 16 Parameters for Run
    TYPE-P
```

Field Explanations

1. TOOL CODE (DISPLAY ONLY)
This field identifies the feature used. It has two identifiers which are separated by a hyphen. The first identifier equals C for a tool initiated in Patient Processing and F for a tool initiated in Patient Accounting. The second identifier contains the unique key for the tool.

2. TOOL DESCRIPTION (DISPLAY ONLY)
This field contains a description for the tool used.

3. ORIGINAL STI FOR TOOL (DISPLAY ONLY)
This field contains the STI number which introduced the tool. It is provided so the documentation for the tool in that STI can be reviewed as needed.

4. COMMENT1
Comment1, Comment2, and Comment3 provide a brief description of the functionality provided by the tool.

5. COMMENT2
Comment1, Comment2, and Comment3 provide a brief description of the functionality provided by the tool.

6. COMMENT3
Comment1, Comment2, and Comment3 provide a brief description of the functionality provided by the tool.

7. STARTED BY
This field contains the name of the user who started the batch run of the tool.

8. DATE/TIME STARTED
This field contains the date and time when the batch run of the tool started.

9. DATE/TIME ENDED
This field contains the date and time when the batch run of the tool ended.

10. ACCOUNTS EXAMINED
This field contains the number of accounts examined using the batch run of the tool. The statistics are provided by account locations PA, AR, BD, and ARC for Patient Accounting tools. If the tool does not finish before midnight processing occurs, some accounts can be examined multiple times due to changes in account location.

11. ACCOUNTS UPDATED
This field contains the number of account updates made using the batch run of the tool. The statistics are provided by account locations PA, AR, BD, and ARC.

12. STOPPED BY
The batch run of some tools can be stopped and restarted later if desired. This field contains the name of the person who stopped the batch run of the tool.

13. DATE/TIME STOPPED
The batch run of some tools can be stopped and restarted later if desired. This field contains the date and time when the batch run of the tool was stopped by a user.

14. RESTARTED BY
The batch run of some tools can be stopped and restarted later if desired. Also, the batch run of some tools can be restarted if the job aborts due to a system outage or

other occurrence. This field contains the name of the person who restarted the batch run of the tool.

15, DATE/TIME RESTARTED
This field contains the date and time the batch run of the tool was restarted.

16. PARAMETERS FOR RUN
It other parameters were requested to determine how the job should be run, the parameters are displayed in this field. A short label for the parameter is displayed, followed by a hyphen and its value. There is a space between each parameter.

For example, the values are as follows with the batch tool of Rpt Charge/Balancing Issues: the field contains the variable name TYPE indicating the types of reports requested: *C* signifies Charge Discrepancies, *B* signifies Balancing Discrepancies, and *P* signifies both reports. If the job was initiated by a McKesson user, the second variable name *MCKFX* is displayed, and *Y* or *N* indicates whether reported charge discrepancies are repaired.

One of the following prompts is displayed on the screen:

- If no accounts were updated by the tool, the following prompt is displayed:

  No accounts updated by this use of the tool. Press ENTER.

- If accounts were updated by the tool, the following prompt is displayed:

  View accounts updated by this use of the tool? (Y/N) [Y]--

You can enter **Y** (Yes) to view the list of accounts updated by the use of the tool, a lookup list is displayed. The header for the list is the title for the tool. For each account, the account number, patient name, admission date, and discharge date are displayed.

```
Patient Name                    Adm Dt   Disch Dt
 Page:01         Accounts updated by Repair Chg Discrepancies/Menu
 ( 1) A0902100001     LNM,FNM A                      01/21/09 01/21/09
 ( 2) A0915300002     SNOW,FLAKE                     06/02/09 06/02/09
Select account to access Account Inquiry--
```

If an account is selected from the list, the Account Inquiry screen is displayed for the account. When you exit Account Inquiry, the selection list of accounts is redisplayed. For information on Account Inquiry, refer to the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide*.

LOG OF ACCOUNTS UPDATED BY PA CUST TOOL

This function is used to view the list of accounts updated by the use of the tool, a lookup list is displayed. For each account updated by the tool, the account number, patient name, admission date, and discharge date are displayed. A short name for the first tool which updated the account in the selected time frame is displayed also

```
   General Hospital Log of Accounts Upd by PA Cust Tool Processor
                                                 Thu Mar 11, 2010 11:35 am



                   Patient Name         Adm Dt   Dis Dt   First Update
Page:01       Accounts Updated by Customer Tools with First Update
( 1) A0000500756   HELM,MATT            02/14/08          Rbld Pat Bed
( 2) A0735200002   MOORE,CMB            12/18/07 12/18/07 Rpt Chg/Bal Iss
( 3) A0735200003   MOORE,CMB            12/18/07 12/18/07 Rpt Chg/Bal Iss
( 4) A0831600002   TEST,RANDY           11/11/08          Rpt Chg/Bal Iss
( 5) A0835900003   GREENE,ED            12/24/08 12/24/08 Rpt Chg/Bal Iss
( 6) A0900600006   MOORE,CMB            01/04/09 01/07/09 Rpt Chg/Bal Iss
( 7) A0900600007   MOORE,OPC            01/04/09 01/07/09 Rpt Chg/Bal Iss
( 8) A0911200003   MOORE,CMB            04/22/09 04/23/09 Rpt Chg/Bal Iss
( 9) A1005500001   MOORE,CHGDISC        02/24/10 02/25/10 Chg Info/Menu




Select account to access Account Inquiry--
```

If an account is selected from the list, the Account Inquiry screen is displayed for the account. When you exit Account Inquiry, the selection list of accounts is redisplayed. For information on Account Inquiry, refer to the *Account Inquiry and Revision Volume* of the *STAR Financials Patient Accounting Reference Guide*.

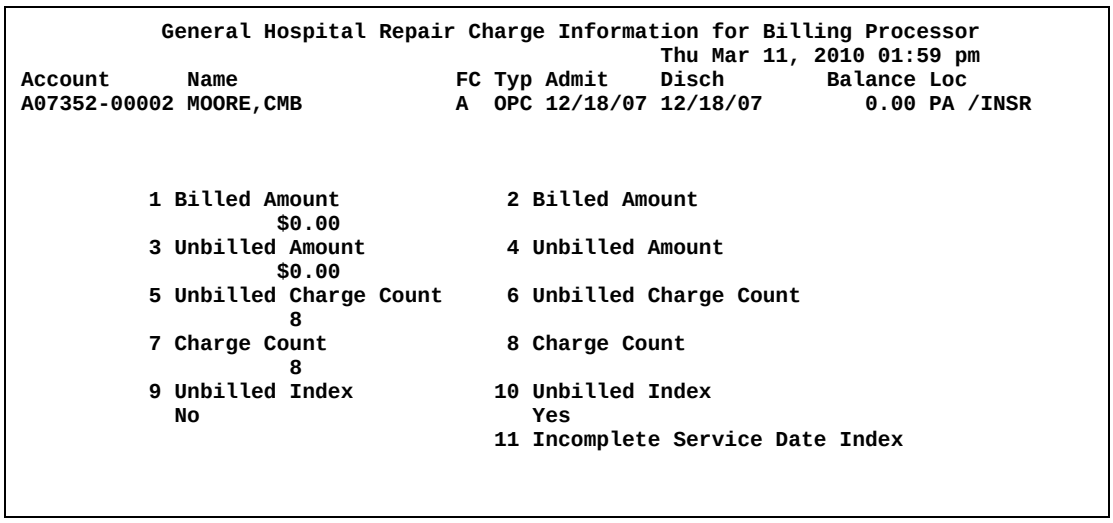
ONLINE PA CUSTOMER TOOLS

Repair Charge Information for Billing

The option can be used to fix discrepancies in the indexes and totals for charge information which can cause requests for adjustment bills to be made inappropriately. Typically, when this occurs, an adjustment bill would be produced automatically daily.

Accounts needing this repair are identified on the report titled Accounts with Charge Discrepancies which is produced using option Rpt Charge/Balancing Issues. If an account is viewed in Repair Charge Information for Billing, the number of Evaluations Done which is recorded in the Log of PA Customer Tools Run is incremented by one for the account location. If an account is updated in Repair Charge Information for Billing, the number of Updates Made is incremented by one for the account information.

After the feature is selected, the patient account to be repaired is selected next. The following screen is displayed. The current information per the system appears on the left side of the screen. If the program determines that an update is needed, the change to be made is documented on the right side of the screen.



```
          General Hospital Repair Charge Information for Billing Processor
                                                  Thu Mar 11, 2010 01:59 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A07352-00002 MOORE,CMB            A  OPC 12/18/07 12/18/07        0.00 PA /INSR



         1 Billed Amount             2 Billed Amount
                   $0.00
         3 Unbilled Amount           4 Unbilled Amount
                   $0.00
         5 Unbilled Charge Count     6 Unbilled Charge Count
                    8
         7 Charge Count              8 Charge Count
                    8
         9 Unbilled Index           10 Unbilled Index
           No                          Yes
                                   11 Incomplete Service Date Index
```

- If no changes are identified, the following prompt is displayed:

  No differences exist for Current and Expected values. Press ENTER to continue.

- If changes are identified, the following prompt is displayed:

  Differences exist for the Current and Expected values. Do you want to update the current values to match the expected values? (Y/N)--

You can enter **Y** (Yes) to have the system update the current values. If you do so, a note is retained in transaction history using the Transaction Code Description "Charge Info Repair". The comment for the transaction history message documents the changes made. More then one change can be made. The changes which can be made and the message appearing in the comment for transaction history are as follows:

Change	Transc His Comment
Update Billed Amount	Bill $
Update Unbilled Amount	Unb $
Update Unbilled Charge Count	Unb Ct
Update Charge Count	Chg Ct
Note account in Unbilled Index	Add Unb Idx
Remove account from Unbilled Index	Rem Unb Idx
Add charge to Service Date Index	Srv Dt Idx

NOTE: This feature cannot be used for an AR Converted account. If such an account is selected, the following message is displayed: *Function cannot be used because AR Converted Account. Press ENTER to continue.*

Display Census Stat Information

This function is used to display census statistics information from STAR Patient Processing, for an individual account. The two types of information to be displayed are as follows:

- STAR maintains a log of Patient Processing events used to maintain census statistics. Entries can be viewed for an account for the past 35 days.
- STAR maintains PA Stat Log Information for accounts documenting census statistics information for the account. This includes account information which has not been removed in the yearly purge of information.

The Display Census Stat Information function provides two types of detailed information for an account documenting how the census statistics are determined for the account. The two types of information can be summarized are as follows:

- Daily Stat Log (FS-FSK) displays the items which are recorded as varied Patient Processing transactions occur. For the current date, the transactions logged are available. For previous dates, the transactions logged are available as are

transactions created by midnight processing during the step titled PA Census Stats. This information is available for 35 days.

- Stats by Date (FA-FAY) displays the census stats for an account per the effective date. This information is used when past statistics are updated due to a change in information such as patient type or medical service. This information is purged yearly. The information is purged during midnight processing running for the first date of the new fiscal year unless an override has been indicated in the Purge PA Stat Log Info Date parameter on the PAAR Control table.

When this option is selected, you can select a facility and an account. After the account is selected, the following prompt is displayed:

Display (D)aily Stat Log (FS-FSK) or (S)tats by Date (FA-FAY)--

For details on Daily Stat Log, see “Daily Stat Log” on page 5-13. For details on Stats by Date, see “Stats by Date” on page 5-18.

Daily Stat Log

Daily Stat Log is one of the options under Display Census Stat Information. After you select that option and enter **D** (Daily Stat Log) at the prompt, you can enter a beginning date for the start of the display or press ENTER to review all information for the account.

Beginning Date for Review [Earliest]--

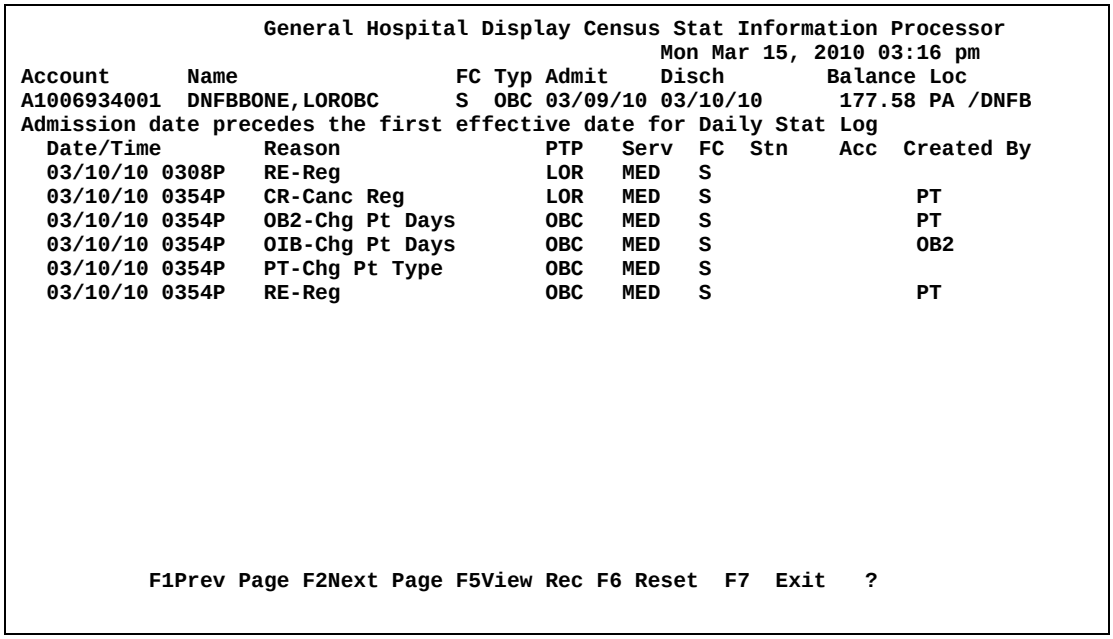
After a date is selected, if no transactions for the account are found, the following prompt is displayed:

No Daily Stat Log (FS-FSK) information found for account. Press ENTER.

If transactions are found, a list of transactions impacting PA census stats occurring on or after the beginning date for review are displayed. If the effective date for the first transaction follows the current admission date for the account, the following warning message is displayed above the screen:

Admission date precedes the first effective date for Daily Stat Log

The message is displayed because some data may be purged already or because of the keyed start date for the display.



Field Explanations

DATE/TIME (DISPLAY ONLY)
This field contains the date and time that the transaction was created.

REASON (DISPLAY ONLY)
This field contains a reason code and short description.

PTP (DISPLAY ONLY)
This field contains the patient type recorded in the transaction.

SERV (DISPLAY ONLY)
This field contains the medical service recorded in the transaction.

STN (DISPLAY ONLY)
This field contains the nurse station recorded in the transaction.This field can be blank.

ACC (DISPLAY ONLY)
This field contains the accommodation code recorded in the transaction. This field can be blank.

CREATED BY (DISPLAY ONLY)
This field contains the reason code causing the transaction to be created during midnight processing logic for census statistics.

You can press F5 (View Rec) to review all of the fields in the transaction for a line. Depending upon the patient transaction being displayed, varied fields in the following list will have information. The following screen is displayed:

```
                  General Hospital Display Census Stat Information Processor
                                                    Mon Mar 15, 2010 03:16 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A1006934001  DNFBBONE,LOROBC      S  OBC 03/09/10 03/10/10      177.58 PA /DNFB
 1 Date/Time         2 Reason               3 Stp1 Proc Done  4 Stp2 Proc Done
   03/10/10 03:08pm    RE-Reg                                    Yes
 5 Pt Type           6 Med Serv        7 Pt Ind             8 Fin Class
   LOR                 MED               O                    S
 9 Att Dr           10 Adm Dr         11 Emp               12 Zip
   100                 100                                    12603
13 Station          14 Acc Code       15 Adm Date          16 Dis Date
                                         03/09/10 03:07pm
17 Prev Pt Ind      18 Change From    19 Rsn for Transc    20 Days Changed

21 Spawned          22 Created By     23 Dis Type for PT

24 Do Not Proc PT Chg From Non-Bedded I/P                  25 Effective Dt

26 Prev Acc Code    27 Prev Med Serv  28 Account Loc
                                         PA


(N)ext Record(N) or (E)xit? [N]--
```

Field Explanations

DATE/TIME
This field contains the date and time that the transaction was recorded.

REASON
This field contains the reason code for the transaction that caused the entry.

STP1 PROC DONE
This field is marked for PT transactions and contains Yes when the transaction has been evaluated in midnight processing to determine if other transactions need to be added.

STP2 PROC DONE
This field is marked after a transaction is evaluated in midnight processing. This occurs after the evaluation for patient type changes occurs.

PT TYPE
This field contains the patient type at the time of the transaction.

MED SERV
This field contains the medical service at the time of the transaction.

PT IND
This field contains the patient indicator at the time of the transaction.

FIN CLASS
This field contains the financial class at the time of the transaction.

ATT DR.
This field contains the code for the attending doctor at the time of the transaction.

ADM DR.
This field contains the code for the admitting doctor at the time of the transaction.

EMP
This field contains the code for the employer at the time of the transaction.

ZIP
This field contains the ZIP code at the time of the transaction.

STATION
This field contains the nurse station at the time of the transaction.

ACC CODE
This field contains the accommodation code at the time of the transaction.

ADM DATE
This field contains the admission date at the time of the transaction.

DIS DATE
This field contains the discharge date at the time of the transaction.

PREV PT IND
For some transactions, this field contains the previous patient indicator.

CHANGE FROM
For some transactions, this field contains the value for the item being changed.

RSN FOR TRANSC
This field contains the reason a transaction was created. Values include the following:

PT for Charge Patient Type

OS for ODS (One Day Stay)

MS for Medical Service

FC for Financial Class

DA for Admitting Doctor

DT for Attending Doctor

BT for Transfer With No Change in Station

NS for Transfer With Change in Station

CT for Cancel Transfer

PD2 indicating the addition of inpatient patient days

PD1 indicating the subtraction of inpatient patient days

OB2 indicating the addition of outpatient patient days

OB1 indicating the subtraction of outpatient patient days

DAYS CHANGED
This field contains the number of inpatient or outpatient days added due to the transaction. This can be a negative number due to changes.

SPAWNED
When some transactions are created from other transactions, they are marked as a spawned transaction. If this field contains Yes, the transaction was created due to another transaction. Note that some transactions are created due to existing transactions and the Spawned field is not set.

CREATED BY
This field contains the reason code for which the transaction was created when a transaction is added during midnight processing.

DIS TYPE FOR PT
This field contains the discharge disposition when the patient type is changed for a discharged patient. It determines if an expiration needs to be counted.

DO NOT PROC PT CHG FROM NON-BEDDED I/P
For inpatients, some of the census statistics do not start accumulating until the inpatient is placed in a bed. If a change in patient type occurs for an inpatient which is not bedded, then Yes appears in Do Not Proc PT Chg From Non-Bedded I/P. This means some stats are not subtracted and added due to the change in patient type.

EFFECTIVE DT
Effective Dt provides the effective date for the transaction.

PREV ACC CODE
For some transactions, the previous accommodation code appears in Prev Acc Code.

PREV MED SERV
For some transactions, the previous medical service appears in Prev Med Serv.

ACCOUNT LOC
The location for the account in Patient Accounting appears in Account Loc. The values are PA, AR, and BD although a value of BD should not appear.

You can view the next record in the list (N), the previous record (P), or exit (E).

Stats by Date

Stats by Date is one of the options under Display Census Stat Information. After you select that option and enter **S** (Stats by Date) at the prompt, you can enter a beginning date for the start of the display or press ENTER to review all information for the account.

Beginning Date for Review [Earliest]--

After a date is selected, if no transactions for the account are found, the following prompt is displayed:

No Stats by Date (FA-FAY) information found for account. Press ENTER.

If transactions are found, the list of PA census statistics for the account by effective date is displayed. This list represents all additions and subtractions of PA census stats per the effective date for the stat. If the effective date for the first transaction follows the current admission date for the account, the following warning appears at the top of the screen. The message appears because some data may be purged already.

Admission date precedes the first effective date for Stats by Date

```
                General Hospital Display Census Stat Information Processor
                                                    Mon Mar 15, 2010 03:16 pm
Account      Name                FC Typ Admit    Disch        Balance Loc
A1006934001  DNFBBONE,LOROBC     S  OBC 03/09/10 03/10/10      177.58 PA /DNFB

  Date      Stat FY    FP  Stat Keys
  03/09/10  DCA  10    03  100 O MED
  03/09/10  DCT  10    03  100 O MED
  03/09/10  EMP  10    03  ~~~~~~~~ LOR S
  03/09/10  EMP  10    03  ~~~~~~~~ OBC S
  03/09/10  FCC  10    03  S LOR
  03/09/10  FCC  10    03  S OBC
  03/09/10  MED  10    03  MED O S
  03/09/10  NUR  10    03  ~~~~~~~~ S OBC MED
  03/09/10  PAT  10    03  LOR MED S
  03/09/10  PAT  10    03  OBC MED S
  03/09/10  ZIP  10    03  12603 LOR MED S
  03/09/10  ZIP  10    03  12603 OBC MED S
  03/10/10  PAT  10    03  LOR MED S
  03/10/10  PAT  10    03  OBC MED S
  03/10/10  ZIP  10    03  12603 LOR MED S


         F1Prev Page F2Next Page F5View Rec F6 Reset  F7  Exit   ?
```

Field Explanations

DATE
This field contains the effective date for the statistic.

STAT
Stat provides the item for which stats are collected. The stats vary by item. The list of items is as follows:

DCA Admitting Doctor

DCT Attending Doctor

DIS Discharge

EMP Employer

FCC Financial Class

MED Medical Service

NUR Nurse Station

PAT Patient Type

ZIP Zip Code

FY
FY provides the last two digits of the fiscal year.

STAT KEYS
Stat Keys provides the keys to the statistic. The multiple stat keys for the item are separated by a space. The Stat Keys are as follows for each of the previous stats.

DCA Doctor, Patient Indicator, Medical Service

DCT Doctor, Patient Indicator, Medical Service

DIS Nurse Station, Financial Class, Patient Type

EMP Employer, Patient Type, Financial Class

FCC Financial Class, Patient Type

MED Medical Service, Patient Indicator, Financial Class

NUR Nurse Station, Financial Class, Patient Type, Medical Service

Patient Type, Medical Service, Financial Class

ZIP ZIP, Patient Type, Medical Service,

NOTE: A tilde (~) means the key is blank.

F5 (View Rec) can be used to review all of the fields for the statistic for a line. You can use the arrow keys to position the cursor on the desired line and then press F5. The following screen is displayed:

```
                General Hospital Display Census Stat Information Processor
                                                    Mon Mar 15, 2010 03:16 pm
Account      Name                 FC Typ Admit    Disch        Balance Loc
A1006934001  DNFBBONE,LOROBC      S  OBC 03/09/10 03/10/10      177.58 PA /DNFB
Statistic
 1 Stat
   DCA-Admitting Dr

Date Information
 2 Date                  3 Fiscal Year             4 Fiscal Period
   03/09/10                10                        03

Stat Keys
 5 Doctor                6 Patient Indicator       7 Medical Service
   100                     O                         MED

Values
 8 # Admissions      9 # Discharges    10 # Patient Days   11 # Deaths

12 Collection $'s   13 # Collections   14 # Registrations  15 # OP Visits
                                          1                   1

(N)ext Record(/) or (E)xit? [N]--
```

Field Explanations

1. STAT
This field contains the stat and description.

2. DATE
This field contains the date the stat was collected.

3. FISCAL YEAR
This field contains the fiscal year in which the stat was collected.

4. FISCAL PERIOD
This field contains the fiscal period in which the stat was collected.

STAT KEYS

5. DOCTOR
This field contains the code for the doctor.

6. PATIENT INDICATOR
This field contains the patient indicator.

7. MEDICAL SERVICE
This field contains the code for the medical service.

VALUES

8. # ADMISSIONS
This field contains the total number of admissions in the statistics collected for the item.

9. # DISCHARGES
This field contains the total number of discharges in the statistics collected for the item.

10. # PATIENT DAYS
This field contains the total number of patient days in the statistics collected for the item.

11. # DEATHS
This field contains the total number of deaths in the statistics collected for the item.

12. COLLECTION $'S
This field contains the total collection dollars in the statistics collected for the item.

13. # COLLECTIONS
This field contains the total number of collections in the statistics collected for the item.

14. # REGISTRATIONS
This field contains the total number of registrations in the statistics collected for the item.

15. # OP Visits
This field contains the total number of outpatient visits in the statistics collected for the item.

BATCH PA CUST TOOLS

This function contains the following options:

- Report Charge/Balancing Issues - This option is used to produce a report of accounts with billing charge discrepancies and a report of accounts with balance discrepancies/
- Repair Refund Index - This option is used to remove blank line entries in the Approve Refunds function.

Each of these options is discussed in the following pages.

Report Charge/Balancing Issues

The option can be used to produce one or both of the following reports which spool to FPATOOLx.

Accounts with Billing Charge Discrepancies Report (FPATOOLx)

This report displays accounts with billing charge discrepancies for which one or more of the following data discrepancies exists:

- Total Billed Amount does not match charge detail
- Total Unbilled Amount does not match charge detail
- Unbilled Charge Count does not match charge detail
- Charge Count does not match charge detail
- Unbilled Index is set incorrectly
- Service Date Index is incomplete

The report spools to FPATOOLx where x is the Facility Indicator. The report has a description in the Comment area of the report, when in View Spooled Reports, of *Unsupported Account Balances*.

Discrepancies in unbilled amounts, unbilled charge counts, or the unbilled index can impact the correct creation of automatic bill requests. Such discrepancies can be repaired using Repair Charge Information for Billing tool. See “Repair Charge Information for Billing” on page 5-11.

Accounts with Balance Discrepancies

This report shows accounts for which the account balance does not match the account balance calculated from charges and account activity.

After the feature is selected, the facility is selected if need be. If no run of this job is in progress, the following prompt is displayed:

Report (C)harge Discrepancies, (B)alancing Discrepancies, or (P)roduce Both Reports?-

If a McKesson user (Support) answers the above prompt with either a C for Charge or a P for Produce both reports, the following prompt is displayed:

Do you want to Repair Charge Information for Billing while Generating the report? (Y/N) [N]-

This prompt is displayed only for a McKesson user in order to repair the charge information for a batch of accounts. The Balancing Discrepancies are not corrected with this batch report tool. They can be corrected online with the tool Repair Charge Information for Billing. Once this prompt is answered, the following message is displayed:

Background job started. Report name is FPATOOLx.

Monitoring the Job

The progress of the program can be monitored using the Log of PA Customer Tools Run processor. For this job, the Parameters for Run field contains the variable name TYPE indicating the types of reports requested: "C" signifies Charge Discrepancies, "B" signifies Balancing Discrepancies, and "P" signifies both reports. If the job was initiated by a McKesson user, the second variable name *MCKFX* is displayed, and Y or N indicates whether reported charge discrepancies are repaired. See "LOG OF ACCOUNTS UPDATED BY PA CUST TOOL" on page 5-10 for more details.

Stopping the Job

The processor Rpt Charge/Balancing Issues within the Batch PA Customer Tools allows the execution of the job to be managed if need be. If the processor is being used to stop or re-start jobs, only one person should be using the processor. The program logic cannot prevent that in all instances. If the processor is selected, and the job is running already for the facility, the following prompt is displayed. The appearance of the prompt is based on a lock declared when the job starts.

Rpt Charge/Balancing Issues in use by Job xxx, Batch Job.

Press ENTER.

The ENTER key should be pressed to acknowledge the message. Next, the display screen for Log of PA Customer Tools Run is displayed with the following prompt:

Rpt Charge/Balancing Issues appears to be running. Do you want to stop it? (Y/N)--

In this instance, the expected response would be Y to stop the job or N not to stop the job.

You can key **N** if you want the execution of the job to continue. If N is keyed, the main menu is displayed. One intended use of the N option is providing the ability to see if the batch job is still running, which is indicated by a lock on the process by a batch job.

You can key **Y** if the job needs to be stopped. This may be needed if a scheduled system outage is occurring and the job needs to be stopped temporarily. When Y is keyed, the following message is displayed:

Waiting for job to stop!

When the job is stopped, the main menu is displayed. Stopping the job may take some time because the program checks for this occurrence periodically and saves variables required to restart the program.

When stopping a tool, the console log displays a message that it was stopped before the message that the tool was completed. For example:

11:18:31 IM FBTLRBAL-Rpt Charge/Balancing Issues Stopped for Facility C

11:18:31 ID 1 FBTLRBAL-Rpt Charge/Balancing Issues completed 09/03/09 11:18:31

Restarting a Stopped Job

If Rpt Charge/Balancing Issues is accessed for a facility where the last run of the job was stopped, the screen for Log of PA Customer Tools Run is displayed, and the following prompt appears:

Previous run of Rpt Charge/Balancing Issues did not complete. Do you want to continue that run (Y/N) or (S)tart a new run?

If **N** is keyed, the main menu is displayed. If Y is keyed, the job continues, using the restart information saved when the job was stopped previously. If a long time has elapsed since the job was stopped, it may be advisable to start a new run. Note that information on repaired accounts is available in Transaction History, Log of PA Customer Tools Run, and Log of Accounts Updated by PA Customer Tool. If a job is restarted, the following message is displayed on the screen:

Background job restarted. Report name is FPATOOLx.

When restarting a tool, the console log displays a message that it was re-started after the message that the tool was started. For example:

11:18:31 ID 1 FBTLRBAL-Rpt Charge/Balancing Issues started 09/03/09 11:18:31

11:18:31 IM FBTLRBAL-Rpt Charge/Balancing Issues Re-started for Facility C

If **S** is keyed, a new run of the job is started if the required prompts for the job are completed. Note that log information on the previous run of the job is not updated if a

new job is started. If a new job is started, the following message is displayed on the screen:

Background job started. Report name is FPATOOLx.

Restarting a Zapped/Aborted Job before a System Reboot

The processor also includes the ability to restart a job that was not terminated using this processor. When this option is employed, the process restarts per the last copy of restart information made by the program. If the job was zapped or aborted and the system has not been rebooted, the status screen from Log of PA Customer Tools Run is displayed with the following prompt:

Rpt Charge/Balancing Issues is marked as running. Do you want to mark the job as not running so it can be restarted? (Y/N)--

If **N** is keyed, the main menu is displayed. If **Y** is keyed, the following prompt is displayed:

Are you sure that you have determined that FBTLRBAL is no longer running? (Y/N)--

If N is keyed, the main menu is displayed. If Y is keyed, the job is marked as not running and the following message is displayed:

Job marked as not running!

After the job is marked as not running, Rpt Charge/Balancing Issues should be selected again to restart the job. If that occurs, the following prompt is displayed on the screen:

Previous run of Rpt Charge/Balancing Issues did not complete. Do you want to continue that run (Y/N) or (S)tart a new run?-

See "Restarting a Stopped Job" on page 5-24 for documentation of processing per responses to the previous prompt.

Restarting After a System Reboot

The processor also includes the ability to restart a job that was not terminated using this processor. When this option is employed, the process restarts per the last copy of restart information made by the program. If the job was zapped or aborted, and the system has been rebooted, the status screen from Log of PA Customer Tools Run is displayed with the following prompt:

Previous run of Rpt Charge/Balancing Issues did not complete.

Do you want to continue that run (Y/N) or (S)tart a new run?--

See "Restarting a Stopped Job" on page 5-24 for documentation of processing per responses to the previous prompt.

Locked Process

The restart feature relies on locking to determine whether the job is running. If two users access the processor Rpt Charge/Balancing Issues when no batch job is running, the following message is displayed for the second user where yyy is the user name.

Rpt Charge/Balancing Issues is in use by Job xxx, yyy. Press ENTER.

The software cannot prevent multiple users who attempt to stop the same job concurrently, in all instances. If that occurs, McKesson Support may need to be contacted to update the required restart information.

Repair Refund Index

The option can be used to remove blank line entries in the Approve Refunds function. This tool removes the blank lines and rebuilds the refund name index.

After the tool is selected, you can select a facility (if applicable). The following prompt is displayed:

Do you want to Rebuild the Refund Index? (Y/N) [N]

You can enter Y (Yes) to have the system start a background job to rebuild the index. Refunds cannot be approved while this job is running. If run, this job should take anywhere from a few seconds to a few minutes to run, depending on how large the refund name index is on your system. Since this job should not take long to run, it is advised to let the job finish instead of stopping the job. The following prompt is displayed:

No accounts updated by this use of the tool. Press ENTER.

This job does not update any accounts, it is rebuilding an index. If you access the stats of this job in the Log of PA Customer Tools Run, the Accounts Examined and Accounts Updated fields are blank.

Compare PCON Appeal Status

The option is used to determine if there are appeals open in Pathways Contract Management but closed in STAR Patient Accounting. If this situation exits, a download file is created, which can be used in Pathways Contract Management to update appeal information not matching appeal information in STAR. The Compare PCON Appeal Status tool also can be run to validate that the appeal status for the STAR and PCON systems are in synch or to provide example accounts for researching problems.

Proces for Runing the Tool

To run this tool both PCON and STAR resources at the hospital need to be engaged. Also to obtain the openappeal.txt file, the hospital needs to contact PCON support to have a query run to generate the file.

1. PCON needs to create a file for hospitals called openappeal.txt

This file should be put in the PCON directory in UNIX. This file will contain all of the open appeals on PCON. If PCON does a new run and creates a new openappeal.txt file then it should overwrite the old file.

2. Next, hospitals will run the Compare PCON Appeal Status tool.

After running the Compare PCON Appeal Status tool the STAR system will generate three UNIX files for PCON to use to update their system. The files are called clsappeal(y).txt, noappeal(y).txt and nopcon(y).txt. The (y) in the files is equal to the facility code at the hospital.generate three UNIX files for PCON to use to update their system. The files are called clsappeal(y).txt, noappeal(y).txt and nopcon(y).txt. The (y) in the files is equal to the facility code at the hospital. So for example, if the facility code is A the file would be called clsappeala.txt. The tool generates eports for each file by facility that will spool to Fin(y).

3. After the hospital is ready for PCON to update their accounts, PCON will take the UNIX files generated in STAR(clsappeal(y).txt, noappeal(y).txt and nopcon(y).txt)and update the claims so that the appeals on STAR and PCON systems are in synch.

- PCON will take the clsappeal(y).txt file and close the appeal on PCON. These are appeals that are closed in STAR but open on PCON.
- PCON will take the noappeal(y).txt file and close the appeals on PCON. These are appeals that don't exist in Star and so they would be closed in PCON.
- PCON will take the nopcon(y).txt files and delete the claims from PCON. The claims in this file are no longer PCON claims in STAR so PCON will delete them so that STAR and PCON will be in synch.

4. After updating claims in PCON, the hospital would need to delete the files from STAR through the Remove option in the tool. The Remove option renames the clsappeal(y).txt, noappeal(y).txt and nopcon(y).txt to ".old" and it deletes files(globals) in STAR related to the run.

Using the Compare PCON Appeal Status Tool

After selecting Compare PCON Appeal Status, one of three error messages can appear indicating the tool cannot be used at the current time. These messages are as follows:

PCON directory is not defined in UB Pathways Parameters!

MNP is in progress. Please try later!

Interface with PCON is in use. Please try later!

If you do not receive error messages, the following prompt is displayed:

Do you want to start the upload for Compare PCON Appeal Status? (Y/N)-

You can enter Y (Yes) , the following message is displayed, and the upload starts.

Upload started for Compare PCON Appeal Status!

The number of records read appears on the screen in increments of 500. If a problem is encountered with the upload, the following message is displayed, and the processor closes:

Unable to upload open appeal.txt!

Otherwise, the Facilities for Compare PCON Appeal Status sceen is displayed, which allows you to select facilities for which the comparison should be performed. You can select any or all facilities. If you elect to run one facility, you can go back into the processor and run the other facilities at a later point.

The comparison runs as a background job. The start and completion of the job for each facility is displayed on the console. Also, the run of the job is documented in Log of PA Customer Tools Run as processing for a facility completes. For details, see “LOG OF PA CUSTOMER TOOLS RUN” on page 5-5.

When the tool is run, three files are created: clsappeal(y%).txt, noappeal(y%).txt, and nopcon(y%).txt where y% represents the facility code. Also a report will spool under Fin(y%) with the associated data.

What To Expect When Going Back Into The Tool After the File Has Already Been Uploaded

If information from the previous PCON file remains in STAR, the following prompt is displayed:

Upload file for Compare PCON Appeal Status exists already. Select (R)emove the file, select (F)acilities for comparison, or (S)tart a new run--

- If R for Remove the file is keyed, files from the previous run of this processor are removed. This includes nodes created in STAR and the three Unix files created for PCON which are titled clsappealY.txt, noappealY.txt, and nopconY.txt where Y signifies the facility. The three UNIX files are renamed so the extension of the file becomes "old". This option should be used when processing for a file is complete.

Otherwise nodes/files created in STAR remain until another new run of the tool occurs. Hospitals also need to manage their .old files in their UNIX directories. When this option is selected, a confirmation prompt is displayed:

Files from previous run have been removed! .

- If F for select (F)acilities for comparison is selected, comparisons of the appeal status are done for the selected facilities using the files previously uploaded. The Facilities for Compare PCON Appeal Status sceen is displayed, which allows you to select facilities for which the comparison should be performed. You can select any or all facilities. If you elect to run one facility, you can go back into the processor and run the other facilities at a later point.

- If S for (S)tart a new run is selected, files from the previous run of this processor are removed or the process starts with a new run because no files exist for the process. The process runs as described under "Compare PCON Appeal Status" on page 5-26.

Update Hold and ASB/Crossover Information

The option is used to update the fields titled "Load Separate Claim?", "Hold for Pmt?", and "ASB/Crossover Hold Exceptions" found on the Claim/Proration Control screen for each insurance for the account. The fields are updated per current information found in the Insurance Plan Coverage Table:

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

```
                  General Hospital Update Hold and ASB/Crossover Information Processor
                                                 Wed Aug 15, 2012 11:56 am

 1 Type of Account
->
 2 Admission Dates                        3 Discharge Dates

 4 Patient Indicators   5 Patient Types

 6 Primary Insurance Carrier/Plan

 7 ASB/Crossover Hold Exception









Enter (P)A, (A)R, or (B)oth PA/AR accounts--   |
```

Field Explanations

1. TYPE OF ACCCOUNT
This field indicates the type of accounts for which the fields "Load Separate Claim?", "Hold for Pmt?", and "ASB/Crossover Hold Exceptions" are updated using this tool. Options are PA, AR, or Both PA/AR accounts.

2. ADMISSION DATES (8-N-R OR 1-A-R)
This field can be used to limit the AR accounts for which the update is considered. The field is not accessible if PA is the only account type selected in the Type of Account field. The two prompts for the field, which are as follows, identify the inclusive time frame for account selection. If a response of ENTER is made, then the default response is used. If a response of N for None is made for the first prompt, then the second prompt does not appear.

Enter admission date or (N)one [Earliest] --

Enter admission date [Latest] --

3. DISCHARGE DATES (8-N-R OR 1-A-R)
This field can be used to limit the AR accounts for which the update is considered. The field is not accessible if PA is the only account type selected in the Type of Account field. The two prompts for the field, which are as follows, identify the inclusive time frame for account selection. If a response of ENTER is made, then the default response is used. If a response of N for None is made for the first prompt, then the second prompt does not appear.

Enter discharge date or (N)one [Earliest] --

Enter discharge date [Latest] --

4. PATIENT INDICATORS (TABLE LOOKUP-O)
When this field is accessed, the system displays a list of patient indicators. The accounts considered for the update can be limited by the Patient Indicator retained in Patient Accounting. If this is not a criteria for limiting the update, then press ENTER rather than selecting entries from the table for Patient Indicators.

5. PATIENT TYPES (TABLE LOOKUP-O)
When this field is accessed, the system displays a list of patient types. The accounts considered for the update can be limited by the Patient Types retained in Patient Accounting. If a Patient Indicator was selected, then the table lookup of Patient Types is limited per Patient Indicator. If this is not a criteria for limiting the update, then press ENTER rather than selecting entries from the table for Patient Indicators.

6. PRIMARY INSURANCE CARRIER/PLAN (TABLE LOOKUP-O)
The accounts considered for the update can be limited by the primary insurance plan for the account. For this field, a list of insurance plan codes can be keyed in a string

separated by commas or insurance plans can be selected from a table lookup. The table lookup can be limited by the beginning of the insurance plan code. If this is not a criteria for limiting the update, then press ENTER rather than selecting entries from the table for insurance plans.

7. ASB/CROSSOVER HOLD EXCEPTION (1-A-O)
When this field is accessed, the prompt is:

Set (A)ll accounts to Use List from Insurance Coverage Table or (O)nly set if ASB field for Account/Ins is None or Blank --

If the claim type is not X for the insurance/account, then ASB/Crossover Hold Exceptions is cleared if it happens to be populated and no further processing occurs for the insurance/account.

All - If the user answers All accounts to the above prompt, the accounts/insurances that meet the other criteria will have the ASB/Crossover Hold Exception field set to *Use List from Insurance Coverage Table*. This setting will clear any previous setting.

Only - If the user answers Only accounts that have the ASB field at the account/ insurance level set to None or Blank, then only those accounts/insurances that meet the other criteria and that had an ASB/Crossover Hold Exception field that was set to None or was blank will have the field set to Use List from Insurance Coverage Table. Accounts/insurances that met the other criteria but had insurances listed in the ASB/ Crossover Hold Exception field will not be updated.

For accounts that meet all criteria, the field "Load Separate Claim?" is set to Yes, "Hold for Pmt?" is set to Yes, and the "ASB/Crossover Hold Exceptions" is set to Use List from Insurance Coverage Table. This means the list of insurance plans from the Insurance Plan Coverage Table will be used when claims are selected for loading due to a billing event.

After the selection screen is completed, the following prompt appears. If a response of Y for Yes is made, then a background job starts which analyzes accounts in PA and/ or AR and updates the responses to "Hold for Pmt?" and "ASB/Crossover Hold Exceptions" per current information in the Insurance Plan Coverage table.

Start background job to update Account ASB/Crossover Information? (Y/N)--

After the background job starts, the following confirmation prompt appears:

Background job started!

Appendix A - GRAPHICS

INTRODUCTION

The Graphics option displays only if you are signed on to the system as a business office manager, accounting supervisor or billing supervisor.

The graphics function works in conjunction with WEMGraph, WEM's graphics package, to create charts for the following areas in Patient Accounting:

- **Inpatient Liability by Payor** - This graph uses a vertical column chart to show a breakdown of the inpatient accounts receivables by payor.

- **Failed Billing Requirements - Controlled by** - This graph represents the dollars of claims unbilled as a result of failed edits. Each area of responsibility and the associated dollars are shown on this graph. The graph is presented in a vertical column format.

- **Revenue Breakdown by Payor** - This graph depicts (in a vertical column format) revenue by inpatient, outpatient, and emergency room revenue.

- **Percent of Total Revenue by Department** - This graph uses a pie chart to depict the daily percentage of total revenue by department. This information comes from the Daily Activity Journal.

The graphs created for each of these options are predefined. However, once the graph is downloaded to the PC, you can use WEMGraph to edit the chart to suit your needs.

When you select one of the graph options, the system compiles the information for the chart and downloads the data to the PC. The graph displays on the screen. At this point, WEMGraph has been launched on the PC. You can change the appearance of the chart, print it out, or translate it into a number of different formats. Refer to the WEMGraph section of WEM's online documentation for detailed information about using WEMGraph. To return to the Patient Accounting system, select **Exit** from WEMGraph's file menu.

The steps to reach the Graphics option differ slightly depending on whether you are signed on to the system as a business office manager, accounting supervisor or billing supervisor. The following screen sequences show the steps for each. Once the Graphics option is displayed, the system operates the same for all three.

GRAPHICS

Business Office Manager

To reach the graphics option, first access the following menu screen:

```
                    General Hospital B14 Station ID Processor
                                                Mon May 20, 1991 09:49 am
B14 Station ID Input Options

            Option No.  Option
            ---------------------------------------
                1       Account Inquiry
                2       Notes
                3       Account Revision

                4       Business Office Account Management
                5       Balance Transfers and Adjustments
                6       Late Charge/Credit Functions
                7       Charge/Credit Functions

                8       Patient Billing
                9       Claims
               10       Collector Functions

               11       Miscellaneous Functions

Enter option number--
```

From this menu, select the Business Office Account Management option. The following screen is displayed:

```
    General Hospital Business Office Account Management Processor
                                                Mon May 20, 1991 09:49 am
Business Office Account Management Input Options

            Option No.  Option
            ---------------------------------------
                1       Proration
                2       Notes
                3       Guarantor Functions

                4       Add AR Master
                5       Add BD Master
                6       BD to AR Transfer
                7       Bad Debt Pre-List
                8       BD Archive Pre-List
                9       Collection Agency Transfer

               10       Account Reports

               11       Graphics

Enter option number--
```

Select the Graphics option and the following screen is displayed:

```
                General Hospital Graphics Processor
                                                Mon May 20, 1991 09:49 am
Graphics Input Options

            Option No.  Option
            ---------------------------------------
                1       Inpatient Liability by Payor
                2       Failed Billing Requirements - Controlled by
                3       Revenue Breakdown by Payor









Enter option number--
```

The options shown on the Graphics Processor screen represent the predefined graphs available. After you select one of these options, the system begins compiling the data to create the chart and downloads the information to WEMGraph on the PC. The chart displays on the screen. You can edit or print the graph using WEMGraph or close the WEMGraph window to return to the Patient Accounting system.

Accounting Supervisor

If you are signed on to the system as an accounting supervisor, the Graphics option displays on the following menu:

```
               General Hospital B17 Station ID Processor
                                                Mon May 20, 1991 09:50 am
B17 Station ID Input Options

            Option No.  Option
            ---------------------------------------
                1       Account Inquiry
                2       Guarantor Functions
                3       Account Revision
                4       Demand Bill

                5       Post Cash
                6       Post Window Cash
                7       Maintain Unapplied Cash
                8       Print Unapplied Cash Log
                9       Balance Transfers and Adjustments
               10       AR and BD Account Management
               11       Journal Entries
               12       Process Refunds

               13       Graphics
               14       Miscellaneous Functions

Enter option number--
```

Once you select the Graphics option, the following screen is displayed:

```
                  General Hospital Graphics Processor
                                                Mon May 20, 1991 09:50 am
Graphics Input Options

            Option No.  Option
            ---------------------------------------
                1       Percent of Total Revenue by Department
                2       Revenue Breakdown by Payor









Enter option number--
```

The options shown on the Graphics Processor screen represent the predefined graphs available. After you select one of these options, the system begins compiling the data to create the chart and downloads the information to WEMGraph on the PC. The chart is displayed on the screen. You can edit or print the graph using WEMGraph or close the WEMGraph window to return to the Patient Accounting system.

Billing Supervisor

To reach the graphics option, first access the following menu screen:

```
                  General Hospital B21 Station ID Processor
                                                Mon May 20, 1991 09:50 am
B21 Station ID Input Options

            Option No.  Option
            ---------------------------------------
                1       Account Inquiry
                2       Account Revision

                3       Patient Billing
                4       Claims
                5       Collector Functions
                6       Proration

                7       Late Charge/Credit Functions
                8       Charge/Credit Functions
                9       Post Balance Transfers
               10       Post Adjustments

               11       AR and BD Account Management

               12       Miscellaneous Functions

Enter option number--
```

From this menu, select the Patient Billing option. The following screen is displayed:

```
                  General Hospital Patient Billing Processor
                                                  Mon May 20, 1991 09:50 am
Patient Billing Input Options

            Option No.  Option
            ---------------------------------------
Maintain        1       Biller Workfiles

                2       Single Bill
Request         3       Demand Bill
                4       Batch Bills
                5       Transfer Biller Work

                6       Form Eject

                7       Graphics




Enter option number--
```

When you select the Graphics option, the following screen is displayed:

```
                     General Hospital Graphics Processor
                                                  Mon May 20, 1991 09:50 am
Graphics Input Options

            Option No.  Option
            ---------------------------------------
                1       Failed Billing Requirements - Controlled by
```

The options shown on the Graphics Processor screen represent the predefined graphs available. After you select one of these options, the system begins compiling the data to create the chart and downloads the information to WEMGraph on the PC. The chart is displayed on the screen. You can edit or print the graph using WEMGraph or close the WEMGraph window to return to the Patient Accounting system.

Appendix B - USER PREFERENCES

Illustrations

INTRODUCTION

This chapter contains information about user preferences such as setting up and maintaining menus and mnemonics, assigning function keys, selecting menu types, and selecting CRT colors.

When you access the User Preferences option, the system displays the following screen:

```
                  General Hospital User Preferences Processor
                                                 Wed Mar 31, 1999 03:00 pm
User Preferences Input Options

            Option No.  Option
            ---------------------------------------
                1       Menu and Mnemonic Functions

                2       Function Key Definition
                3       Menu Type Selection
                4       CRT Color Selection

                5       Windows Word Processing User Preferences
                6       Download Windows Word Processor Macros

                7       Information Windows Administration
                8       Information Windows Preference

                9       Select Alternate STAR Environment


Enter option number--
```

On the User Preferences menu you can access the following functions for setting up user preferences:

- **Menu and Mnemonic Functions**, which you use to set up and maintain menus and mnemonics. For more information, see “MENUS AND MNEMONICS FUNCTIONS” on page B-12.

- **Function Key Definition**, which you use to assign and change the function key assignments for your mnemonics. For more information, see “FUNCTION KEY DEFINITION” on page B-31.

- **Menu Type Selection**, which you use to select the menu type you want displayed on your STAR terminal. For more information, see “MENU TYPE SELECTION” on page B-33.

- **CRT Color Selection**, which you use to maintain the colors and attributes displayed on your color terminal. For more information, see “CRT COLOR SELECTION” on page B-34.

NOTE: For information about the Windows Word Processing functions and the Information Windows functions available on the User Preferences menu, see

the *STAR Navigator User's Guide*. For information about the Select Alternate STAR Environment function, see the *ALLSTAR Signon User's Guide*.

Using Menus

McKesson's STAR line of computer products is a menu-driven system, meaning that you navigate to functions by selecting options from menu screens. Menu screens are system displays consisting of a list of functions and submenus that you can access. Many menu screens display a prompt at the bottom of the screen that you use to identify the menu option you want. When you select an option from the menu, the system either displays the first prompt or screen of a function or an additional menu of selections.

You can bypass menus and go directly to a STAR function or menu by using a mnemonic. When you enter a mnemonic code in a menu screen, the system displays the first prompt or screen of the function or the menu linked to that mnemonic. By linking the mnemonics you use most often to the function keys on your keyboard, you can navigate directly to a function with just a keystroke. When you exit the function, the system returns you to your initial menu (the first menu you see when you sign on to the system).

The system enables you to select from two different types of menus, depending on the terminal you typically use to access STAR functions. Set this menu type according to your system ID, so that the same menu type displays for you on any STAR terminal. The two menu types are:

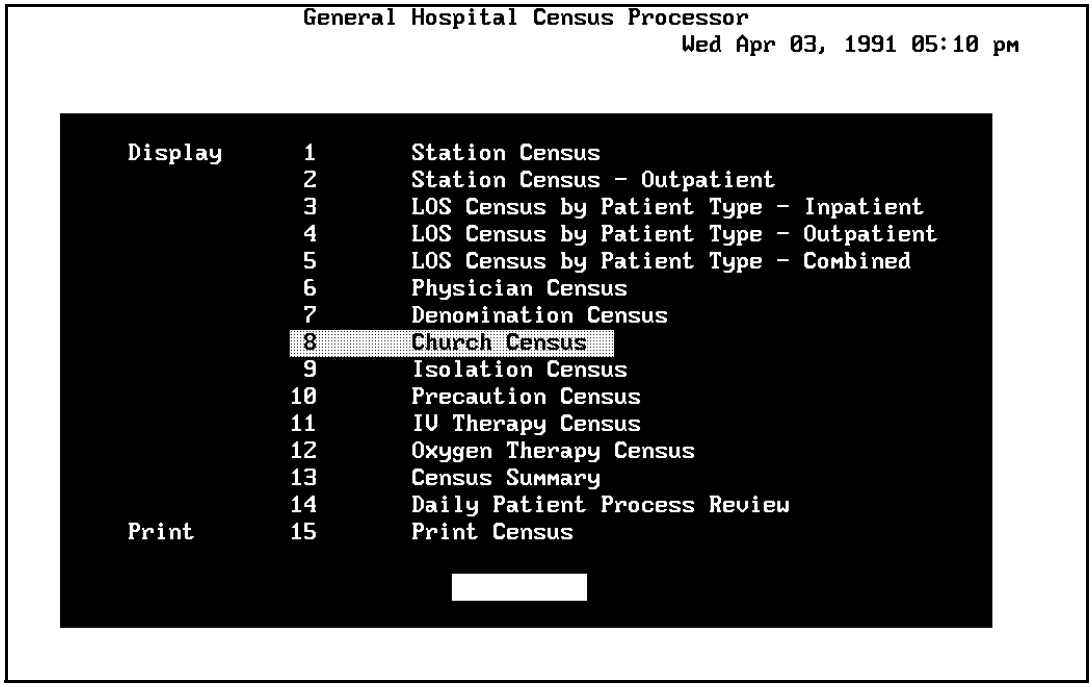
- **Host-based menus** (also called Original Menus), which display only the text elements of the menu, without any graphic element other than a line under the menu header. The following is an example of a host-based menu:

```
       General Hospital Initial STAR Patient Care Menu Processor
                                                 Wed Mar 24, 1999 11:58 am
Initial STAR Patient Care Menu Input Options

            Option No.  Option
            ---------------------------------------
                1       System Management
                2       Tables
                3       Service Item Maintenance
                4       Location File Maintenance
                5       Print Labels
                6       Charge/Credit/Inquiry/Auto
                7       Name Inquiry
                8       Census
                9       Bulletin Board
               10       Load Patient
               11       Send Message
               12       Revise Patient Nursing
               13       Statistical Reports


Enter option number--
```

If you are using host-based menus (original menus), you select an option from the menu by entering the option number at the prompt at the bottom of the menu and pressing the **ENTER** key. The system then displays the first prompt or screen of the selected function or a submenu.

To exit from a menu and return to the preceding menu or prompt, press **ENTER** or press period (.) and the **ENTER** key.

Boxed menus, which display the menu options enclosed in a box. The following is an example of a boxed menu:



If you are using boxed menus, select an option from the menu using one of the following methods:

Method	Result
Option Number Entry	As with host-based menus, you can enter the number of the desired option in response to the prompt at the bottom of the menu and press **ENTER**. The system then displays the first prompt or screen of the selected function or a submenu.
Highlight And Select Entry	When the system displays a boxed menu, the first option on the menu displays in a reverse (darkened letters on a lit background) bar. This reverse bar indicates that this option is highlighted. You can move this bar up and down on the menu, changing the highlighted option, using the up arrow and down arrow keys on your keyboard. Once you highlight the desired option, you can select it by pressing **ENTER**.

To exit from a boxed menu and return to the preceding menu or prompt, press the period (.) key followed by the ENTER key. Note that you cannot exit from a boxed menu by pressing only the ENTER key, as you can with host-based menus, since this selects the currently highlighted menu option.

Using Mnemonics

The mnemonics feature offers you a fast, easy way to access the functions you use most often. By entering a mnemonic code to a menu screen, you command the system to directly access the function linked to that mnemonic code. The system then either displays the first screen, prompt, or menu of that function or prompts you for any information the system needs to have before the function can be processed. You can also assign mnemonic codes to each of the first ten function keys on your keyboard, enabling you to navigate directly to the functions you use most with just a keystroke.

The system stores mnemonics by the type of system user so that similar users have access to the same mnemonics. In this way, admitting clerks would use a mnemonic to access the Admit Patient function in the STAR Patient Care system while laboratory department secretaries would be more likely to use a mnemonic to access the Patient Inquiry function in the STAR Laboratory system. Authorized personnel can add mnemonics as needed, using the procedures discussed in the Creating a New Mnemonic subsection.

The system enables each user to define the links between their function keys and mnemonics. This allows one admitting clerk to use the F1 key to access the Admit Patient function, while another uses the F10 key to access the same function. The procedure used to define this link is discussed in Function Key Definition. For more information, see “FUNCTION KEY DEFINITION” on page B-31.

When you exit from a function you accessed using a mnemonic, the system returns you to your initial menu. This is the menu the system displays when you first sign on.

NOTE: In the STAR Laboratory product, when you exit a mnemonic, the system returns you to the main menu if you have main menu return.

USING A KNOWN MNEMONIC

To use a mnemonic to access a function, enter the mnemonic code or press the function key linked to the mnemonic. Remember that you can only use a mnemonic from a menu screen.

When you press ENTER after typing the mnemonic or when you press the appropriate function key, the system begins to access the function linked to the mnemonic. If this function needs pre-processing information that you would typically define in accessing it using menus, the system displays any prompt(s) needed to identify this information. Otherwise, the system displays the first screen, prompt or menu of the function. If the mnemonic does not exist, the system displays:

Invalid mnemonic!

If a security level is required to access the mnemonic, the system displays:

Enter ID code --

To access the mnemonic, enter the authorizing ID code. The system then prompts you to enter the authorizing secret code. If the ID code does not meet or exceed the minimum security level required for the function, the system displays:

Not authorized for this function!

The system then returns you to the menu where your originally entered the mnemonic code.

Mnemonic authorization is established using the Mnemonic Assignment function. For more information, see "Mnemonic Assignment" on page B-16. Functions for which mnemonics cannot be assigned are listed in the Menu and Mnemonics Considerations subsection.

LOOKING UP AND USING A MNEMONIC

If you do not know the mnemonic code you want to use, you can display a list of mnemonic codes available to you and select one to use. To display the mnemonic list, enter a hyphen (-) in response to the prompt at the bottom of the menu.

The mnemonic list displays the mnemonic code and the name of the function accessed by it. This list includes all mnemonic codes available for your user type. An asterisk (*) precedes all mnemonics that you cannot use due to security level. Select the desired mnemonic using the technique appropriate to the menu type you are using, as discussed in the Using Menus subsection.

If there are more mnemonics than can display on the screen, the system displays one of the following messages, depending on the menu type you are using:

- **If you are using boxed menus**, the system displays *...more* in the bottom right corner of the mnemonic list. This message displays on all but the last screen of mnemonics.

- **If you are using host-based menus**, the system displays *next page (/)* centered at the bottom of the first screen of the mnemonic list. On subsequent screens, the message *next page (/) previous page (/P)* displays. On the last screen of the list, the message *previous page (/P)* displays.

To view the next screen of mnemonics, press slash (/) and **ENTER**. Enter a slash (/) followed by P to display the preceding screen of options.

If you know the first letter(s) of the mnemonic description, you can display and select from a partial list of mnemonics. To do this, enter one or more of the first letters of the mnemonic description, followed by a hyphen (-). The system displays the mnemonic list, which now shows only those mnemonics whose descriptions start with the letter(s) entered. You can select from this list and display multiple pages of the list using the techniques explained above.

CREATING A NEW MNEMONIC

In order to create a new mnemonic and make it available in the system, you must perform the following steps:

1. Create the mnemonic. An appropriate user can create a mnemonic from any system menu. Only system users identified in the Employee Mnemonic Build Access field of the Menu and Mnemonic Parameters function can create new mnemonics. For more information on this parameter, see the definition of the Employee Mnemonic Build Access field in “Menu and Mnemonic Parameters” on page B-15.

2. Assign the mnemonic. A mnemonic is not available for use by any user type until it has been assigned to that user type. You do this using the Mnemonic Assignment function: for more information, see “Mnemonic Assignment” on page B-16. Note that you cannot access this function unless you have been assigned access in the Employee Mnemonic Assignment Access field of the Menu and Mnemonic Parameters Processor. For more information, see the Employee Mnemonic Assignment Access field in “Menu and Mnemonic Parameters” on page B-15.

3. Optionally, you may want to link the new mnemonic to a function key. You can do this during the mnemonic creation process, as explained below, or by using the Function Key Definitions function (“FUNCTION KEY DEFINITION” on page B-31).

This section discusses only the first step of this process, creating the mnemonic. For information on the other steps, see the cross-references above.

If you are a user to whom mnemonic build access has been granted, you can create or edit a mnemonic from any menu in a STAR product. These steps differ slightly depending upon which menu type you use at your terminal.

If you are using host-based or boxed menus you can:

1. On your terminal, display the menu containing the function that you want to access using a mnemonic.

2. Enter an asterisk (*), followed by the option number of the function on the menu.

If you are using boxed menus you can also:

1. Display on your terminal the menu containing the function that you want to access using a mnemonic.

2. Move the highlight bar down to highlight the desired function.

3. Enter an asterisk (*).

NOTE: If the highlight bar is not over the desired function, you can also enter an asterisk (*) followed by the option number of the function for which you want to create a mnemonic. This is similar to the method used to define mnemonics for host-based and boxed menus.

The system then displays the following screen:

```
               General Hospital Mnemonic Build Processor
                                                Wed Mar 24, 1999 10:15 am


( 1)Option Number           : 1
( 2)Option Description      : Financial Item Master

    Mnemonic Definition
( 3)Mnemonic Code           :
( 4)Mnemonic Description    :
( 5)Default Security Level  :

( 6)Edit ID                 :
( 7)Edit Date               :









Enter mnemonic code--
```

Field Explanations

1. OPTION NUMBER (DISPLAY ONLY)
This field displays the option number of the function or menu accessed using this mnemonic. This is the number you would enter to the menu to access this function or menu manually.

2. OPTION DESCRIPTION (DISPLAY ONLY)
This field displays the name of the function or menu accessed using this mnemonic.

Mnemonic Definition

3. MNEMONIC CODE (10-C-R)
This field contains the code used to invoke this mnemonic at a STAR menu. This code should be long enough to allow the user to easily recognize the function it accesses, yet short enough to minimize keystrokes.

4. MNEMONIC DESCRIPTION (40-C-R)
This field contains a description of the mnemonic. The system defaults to the function name as it displays on the menu. Press **ENTER** to use the function name, or enter another name if desired.

5. DEFAULT SECURITY LEVEL (TABLE LOOKUP)
This field contains the minimum security level required for the type of user to access the mnemonic.

The security level displayed in this field is used as a default security level for this mnemonic for all user types. You can override this security level by establishing a specific security level for a user type as explained in the Mnemonic Assignment subsection.

NOTE: If an asterisk (*) displays next to this field, the minimum security level has been set by McKesson and cannot be changed.

6. EDIT ID (DISPLAY ONLY)
This field contains the name of the user who last modified the mnemonic.

7. EDIT DATE (DISPLAY ONLY)
This field contains the date on which the mnemonic was last modified.

If you have been granted mnemonic assignment access (that is, you have been identified in the Employee Mnemonic Assignment Access field of the Menu and Mnemonic Parameters processor), when you complete and accept the mnemonic, the system displays the following prompt:

Update user type assignments? (Y/N) [Y]--

Enter **Y**, or press **ENTER** to access the Mnemonic Assignment Processor and assign the mnemonic to one or more user types. See “Mnemonic Assignment” on page B-16 for more information on this function. Enter **N** in response to this prompt if you do not want to assign user types to this mnemonic at this time.

When you finish assigning user types or if you enter **N** at this prompt, the system displays:

Update function keys? (Y/N) [N]--

Enter **Y** to access the Function Key Definition processor and edit your function key assignments. For more information on the Function Key Definition processor, see

"FUNCTION KEY DEFINITION" on page B-31. Enter **N**, or press **ENTER** to maintain the current function key definitions.

When you exit this function, the system returns you to the menu from which you accessed the Mnemonic Build Processor.

MENUS AND MNEMONICS FUNCTIONS

You establish and maintain guidelines for both menus and mnemonics using the options on the Menu and Mnemonic Functions menu, shown below:

```
            General Hospital Menu and Mnemonic Functions Processor
                                                  Wed Mar 24, 1999 11:18 am
Menu and Mnemonic Functions Input Options

            Option No.  Option
            ---------------------------------------
                1       Menu and Mnemonic Parameters
                2       Mnemonic Assignment
                3       Mnemonic Maintenance

                4       View Boxed Menus
                5       Mnemonics Report









Enter option number--
```

Accessing the Menu and Mnemonic Functions Processor

You access the Menu and Mnemonic Functions processor differently according to the STAR system you are using. The steps below show how a system administrator can access the Menu and Mnemonics Functions processor for each STAR system.

STAR Laboratory:

1. Choose Maintenance Functions.

2. From the Maintenance Functions processor, choose Maintenance - User Preferences.

3. From the Maintenance - User Preferences processor, choose Menu and Mnemonic Functions.

4. The system displays the Menu and Mnemonic Functions processor.

STAR Patient Care:

1. Choose System Management.

2. From the System Management processor, choose User Preferences Functions.

3. From the User Preferences processor, choose Menu and Mnemonic Functions.

4. The system displays the Menu and Mnemonic Functions processor.

STAR Pharmacy:

1. Choose System Management.
2. From the System Management processor, choose System Management - Pharmacy.
3. From the System Management processor, choose User Preferences Functions.
4. From the User Preferences processor, choose Menu and Mnemonic Functions.
5. The system displays the Menu and Mnemonic Functions processor.

STAR Radiology:

1. Choose Maintenance Functions.
2. From the Maintenance Functions processor, choose User Preferences.
3. From the User Preferences processor, choose Menu and Mnemonic Functions.
4. The system displays the Menu and Mnemonic Functions processor.

STAR General Accounting:

1. Choose System Management.
2. From the System Management processor, choose User Preferences Functions.
3. From the User Preferences processor, choose Menu and Mnemonic Functions.
4. The system displays the Menu and Mnemonic Functions processor.

STAR Patient Accounting:

1. Choose Financial System Management.
2. From the Financial System Management processor, choose User Preferences Functions.
3. From the User Preferences processor, choose Menu and Mnemonic Functions.
4. The system displays the Menu and Mnemonic Functions processor.

You use the Menu and Mnemonic Functions processor to access the following functions:

- **Menu and Mnemonic Parameters**, which you use to set and change access and availability parameters for menu types and mnemonics. This function is only available to system managers. For more information, see “Menu and Mnemonic Parameters” on page B-15.

- **Mnemonic Assignment**, which you use to maintain the availability of selected mnemonics by user type. This function is only available to system managers. For more information, see “Mnemonic Assignment” on page B-16.

- **Mnemonic Maintenance**, which you use to edit mnemonic codes, descriptions and security levels. This function is only available to system managers. For more information, see “Mnemonic Maintenance” on page B-22.

- **View Boxed Menus**, which you use to display selected boxed menus. This function is only available to system managers. For more information, see “View Boxed Menus” on page B-24.

- **Mnemonics Report**, which you use to create a report about your mnemonics. This function is only available to system managers. For more information, see “Mnemonics Report” on page B-25.

Menu and Mnemonic Parameters

You use the Menu and Mnemonic Parameters processor to establish and maintain access and availability parameters for menu types and mnemonics. This function determines whether boxed and PC-based menu types are available for use, identifies the applications with which mnemonics are available, and determines to whom mnemonic build and mnemonic assignment access is permitted.

When you select the Menus and Mnemonics Parameters processor, the system displays the following screen:

```
    General Hospital Menu and Mnemonic Parameters Processor
                                                Wed Mar 24, 1999 09:56 am


 1 Boxed Menus                          2 PC Based Menus
   Available                              Available
 3 Applications With Mnemonic Build Access
   See Table
 4 Employee Mnemonic Build Access     5 Employee Mnemonic Assignment Access
   System Managers Only                 System Managers Only









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

NOTE: The first three fields of this screen are controlled by McKesson.

Field Explanations

4. MNEMONIC BUILD ACCESS (1-A-Y)
This field determines the employees that can create mnemonics. The field initially displays either System Managers Only or See Table.

If mnemonic build access is limited to system managers, when you access this field the system displays the following prompt:

Add employees who may build mnemonics? (Y/N) --

Enter **N** if you do not want to enable additional employees to build mnemonics. Enter **Y** to give additional employees the ability to build mnemonics, and the system prompts you to identify the individual employee(s) being granted mnemonic build access. After you finish identifying the employee(s) being granted access, this field displays See Table. The system displays this table when you access this field, allowing you to maintain this employee list as desired.

5. SECURITY FOR MNEMONIC ASSIGNMENTS (1-A-Y)
This field determines the employees who can access the Mnemonic Assignment function, which is used to assign mnemonics to other types of users. The field initially displays either System Managers Only or See Table.

If Mnemonic Assignment access is limited to system managers, when you access this field the system displays the following prompt:

Add employees who may assign mnemonics? (Y/N) --

Enter **N** if you do not want to enable additional employees to assign mnemonics. Enter **Y** to give additional employees the ability to assign mnemonics, and the system prompts you to identify the individual employee(s) being granted mnemonic assignment access. After you finish identifying the employee(s) being granted access, this field displays See Table. The system displays this table when you access this field, allowing you to maintain this employee list as desired.

Mnemonic Assignment

You use the Mnemonic Assignment processor to create and maintain assignment of mnemonics to users. Whether you have access to a mnemonic depends on two factors:

- The type of user you are classified as on the system
- Your security level

This function determines the type of user that can access a particular mnemonic, first by assigning the types of users that can use the mnemonic then, if desired, by setting a minimum security level for access to the mnemonic. In this way, only appropriate types of users with the minimum security level or above can access the mnemonic.

NOTE: For information on creating a mnemonic, see “Creating a New Mnemonic” on page B-8.

When you access the Mnemonic Assignment function, the system displays the following prompt:

Enter the mnemonic code or partial name'-' --

Enter the code for the mnemonic that you want to enable or disable access for a type of user or security level. Use a hyphen (-) to display and select from a list of mnemonics for the STAR system.

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

```
                  General Hospital Mnemonic Assignment Processor
                                                Wed Mar 24, 1999 09:59 am


    Mnemonic Definition
( 1)Mnemonic Code           : AMF
( 2)Mnemonic Description    : Abstracting Maintenance Functions
( 3)Default Security Level  :

( 4)Edit ID                 : Andersen, Michael L
( 5)Edit Date               : 11/08/95 01:23pm

Page:01                        Current Assignments            ##=Current Choices
       User Type                                Security Level
( 1)   ADMITTING                                None
( 2)   MEDICAL RECORDS (I)                      None




Enter the option number(s) to edit or (A)dd--
                                  end select(NL)
```

Field Explanations

1. MNEMONIC CODE (DISPLAY ONLY)
This field contains the mnemonic code. This is the code you enter on a STAR menu to use this mnemonic.

2. MNEMONIC DESCRIPTION (DISPLAY ONLY)
This field contains the description for this mnemonic. This is typically the name of the function accessed using this mnemonic.

3. DEFAULT SECURITY LEVEL (DISPLAY ONLY)
This field determines the security level displayed as a default when assigning this mnemonic to user types. This information is maintained using the Default Security Level field in the Mnemonic Maintenance function; for more information, see the explanation of the Default Security Level field in “Mnemonic Maintenance” on page B-22.

The security level displayed in this field is used as a default security level for this mnemonic for all user types. You can override this security level by establishing a specific security level for a user type, as explained below.

NOTE: If an asterisk (*) is displayed next to this field the minimum security level has been set by McKesson and cannot be changed.

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

5. EDIT DATE (DISPLAY ONLY)
This field contains the date on which this mnemonic was last edited.

The information displayed at the bottom of the screen differs, depending on whether types of users and security levels have been assigned for the mnemonic.

IF NO USER TYPES HAVE BEEN ASSIGNED

If no user types have been assigned to this mnemonic, the screen displays as shown in the Mnemonic Assignment subsection. At the bottom of the screen, the system displays:

Select the user types to be assigned--
end selection (NL) next page(/)

Enter the option number(s) of the type(s) of users to which you want to grant access to this mnemonic. The system highlights the option number(s) to indicate your choice. After you have selected all of the desired types of users, press **ENTER**. The system then begins the process used to identify minimum security levels for access to the mnemonic. For information on this process, see the discussion in "If No Security Level Has Been Assigned" on page B-19.

NOTE: The system displays a greater than sign (>) next to your user type in the tables. To add or remove access to this mnemonic for you and other users with your initial menu code, select the user type with the greater than sign (>) next to it.

IF USER TYPES HAVE BEEN ASSIGNED

If user types have been assigned to this mnemonic, the system displays a table of the user type assignments in the lower portion of the screen. At the bottom of the screen the system displays:

Enter the option number(s) to edit or (A)dd--
end selection (NL)

You can add or delete access for the types of users assigned to the mnemonic. If security has been assigned, you can also edit the minimum security level required to access the mnemonic. For information on editing minimum security levels, see "If A Security Level Has Been Assigned" on page B-21.

NOTE: The system displays a greater than sign (>) next to your user type in the tables. To add or remove access to this mnemonic for you and other users with your initial menu code, select the user type with the greater than sign (>) next to it.

To delete access for a type of user, enter the option number(s) of the type(s) of users whose access you want to remove. The system highlights the option number(s) to

indicate your choice. After you have selected all of the desired types of users, press **ENTER**. The system then displays the table used to edit security level access, with the following prompt at the bottom of the screen:

Enter option number--

Press **ENTER**, and the system displays:

Enter field number of '/' starting field number--

Press **ENTER**, and the system displays:

Delete? (N)--

Enter **Y**, and the system displays:

Remove the assignment of this user type? (Y/N) [N]--

Enter **Y** to delete access for the selected type of user. The system then displays:

Assignment removed!

To add access for a type of user, enter the option number(s) of the type(s) of users to which you want to grant access to the mnemonic. The system highlights the option number(s) to indicate your choice. After you have selected all of the desired types of users, press **ENTER**. The system then displays the table used to edit security level access, with the following prompt at the bottom of the screen:

Enter option number--

The process used to add security level restrictions to a type of user follows.

IF NO SECURITY LEVEL HAS BEEN ASSIGNED

If a user type has been granted access to the mnemonic, but no security level has been set for the user type, the system displays a table of the user type assignments in the lower portion of the screen. At the bottom of the screen the system displays:

Enter the option number(s) to edit or (A)dd--
end selection (NL)

To add a minimum security level for one or more type(s) of users, enter the option number(s) of the type(s) of users. The system highlights the option number(s) to indicate your choice. After you have selected all of the desired types of users, press **ENTER**. The system then displays two additional fields under the heading Assignment Information, as in the following screen:

```
               General Hospital Mnemonic Assignment Processor
                                                Wed Mar 24, 1999 10:07 am


    Mnemonic Definition
( 1)Mnemonic Code           : AMF
( 2)Mnemonic Description    : Abstracting Maintenance Functions
( 3)Default Security Level  :

( 4)Edit ID                 : Andersen,Michael L
( 5)Edit Date               : 11/08/95 01:23pm

Assignment Information
( 1)User Type      : ADMISSIONS-MGR
( 2)Security Level :









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

Field Explanations

Assignment Information

1. USER TYPE (DISPLAY ONLY)

This field displays the selected type of user.

2. SECURITY LEVEL (TABLE LOOKUP)

This field contains the minimum security level required for the type of user to access the mnemonic. The default for this field is the contents of the Default Security Level field from the Mnemonic Definition section of the screen.

NOTE: If an asterisk (*) displays next to this field the minimum security level has been set by McKesson and cannot be changed.

At the bottom of the screen, a table of the security levels available within the system displays, followed by the following prompt:

Enter option number --

Enter the option number of the minimum security level that this type of user must have in order to access this mnemonic. The system displays your entry in the Security Level field. To use the default security level, press **ENTER**. At the bottom of the screen, the system displays:

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

Enter **Y**, or press **ENTER** to assign the security level to the type of user. Enter **N** to edit the security level assignment for the type of user. Enter **D** to exit from this prompt without assigning the minimum security level to the type of user.

IF A SECURITY LEVEL HAS BEEN ASSIGNED

If a security level has been assigned to one or more of the types of users who have access to the mnemonic, the system displays a table of the user type and security level assignments in the lower portion of the screen. At the bottom of the screen the system displays:

Enter the option number(s) to edit or (A)dd--
end selection (NL)

NOTE: You cannot edit security for a mnemonic if that mnemonic is used to access a function on a menu for which security has been defined.

To edit the minimum security level for one or more type(s) of users, enter the option number(s) of the type(s) of users. The system highlights the option number(s) to indicate your choice. After you have selected all of the desired types of users, press **ENTER**. The system then displays the Assignment Information fields, as explained in If No Security Level Has Been Assigned above. At the bottom of the screen the system displays:

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

To edit the minimum security level required for this type of user to access the mnemonic, access the Security Level field from the Mnemonic Assignment portion of the screen. The system displays a table of security levels available within the system, followed by the following prompt:

Enter option number --

Enter the option number of the minimum security level that this type of user must have in order to access this mnemonic. The system displays your entry in the Security Level field and redisplays the Enter field number or slash (/) starting field number prompt. Press **ENTER,** and the system displays:

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

Enter **Y**, or press **ENTER** to assign the minimum security level to the type of user. Enter **N** to edit the security level assignment for the type of user. Enter **D** to exit from this prompt without assigning the minimum security level to the type of user.

Mnemonic Maintenance

You use the Mnemonic Maintenance processor to maintain mnemonic codes, descriptions, and minimum security levels.

When you access the Mnemonic Maintenance function, the system prompts you for the mnemonic you want to maintain:

Enter the mnemonic code or partial name'-' --

Enter the code or enter a hyphen (-) to display and select from a list of mnemonic codes. After you identify the mnemonic you want to maintain, the system displays the following screen:

```
               General Hospital Mnemonic Maintenance Processor
                                                Wed Mar 24, 1999 10:15 am


    Mnemonic Definition
( 1)Mnemonic Code           : AMF
( 2)Mnemonic Description    : Abstracting Maintenance Function
( 3)Default Security Level  :

( 4)Edit ID                 : Andersen,Michael L
( 5)Edit Date               : 11/08/95 01:23pm









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

Field Explanations

1. MNEMONIC CODE (10-C-R)
This field contains the code used to invoke this mnemonic at a STAR menu. This code should be long enough to allow the user to easily recognize the function it accesses, yet short enough to minimize keystrokes.

2. MNEMONIC DESCRIPTION (40-C-R)
This field contains a description of the mnemonic. The system defaults to the function name as it displays on the menu. Press **ENTER** to use the function name, or enter another name if desired.

3. DEFAULT SECURITY LEVEL (TABLE LOOKUP-R)
This field determines the security level displayed as a default when assigning this mnemonic to user types. If this field is blank there are no default security limitations for accessing the function using a mnemonic.

NOTE: If an asterisk (*) is displayed next to this field the minimum security level has been set by McKesson and cannot be changed.

When you access this field, the system displays a table at the bottom of the screen listing the security levels available within this STAR application.

If a security level has been defined for this mnemonic, the system shades the option number with a reverse blinking area and displays, below the table:

Enter option number or (R)emove security level [Current Level]--

To set a new minimum security level needed to access this mnemonic, enter the option number of the security level from the table. To remove a security level restriction for this mnemonic, enter **R**. Press **ENTER** to keep the current minimum security level.

4. EDIT ID (DISPLAY ONLY)
This field contains the name of the user who last modified the mnemonic.

5. EDIT DATE (DISPLAY ONLY)
This field contains the date on which the mnemonic was last modified.

If you change the security level assignment for a mnemonic, when you accept your changes to this processor the system displays:

Update security level for all user types assigned? (Y/N) [N]--

Enter **N**, or press **ENTER** to maintain current security levels for user types. Enter **Y** to add the security level you defined to the user types, and the system displays:

Updating the mnemonic security! Please Wait!

When the system finishes updating the mnemonic security, it displays:

Filed!

DELETING A MNEMONIC

You can also use this processor to delete a mnemonic from the system. If you edit information about a mnemonic using this processor, when you exit the processor the system displays:

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

To delete the mnemonic, enter **D**.

Similarly, if you exit this processor without editing any of the fields of information, the system displays:

Delete? (N)--

To delete the mnemonic, enter **Y**.

After you begin the process of deleting the mnemonic from the system, the system displays:

(D)elete this mnemonic, (F)ile as deleted or (R)emove from your list?--

To delete this mnemonic from the system, enter **D**. To deactivate the mnemonic, but leave it in the system for later reactivation, enter **F**. Note that filing a mnemonic as deleted does not remove user type assignments for the mnemonic, but only makes the mnemonic inactive. The mnemonic will not display on mnemonic lists for the user. To remove the mnemonic from the list available to your user type, enter **R**.

NOTE: Only users granted build and assign access to a mnemonic can delete mnemonics or remove them from the user type list.

View Boxed Menus

You use the View Boxed Menus function to display one or more boxed menus. This enables you to identify menus to which you need to make changes, such as menus with headers on the right side of the menu that must be moved to the left or menus with special characters. In this manner, this function is primarily an installation tool used to identify potential problems caused by a change from host-based (original) menus to boxed menus.

NOTE: You must be using the boxed menu type to use this function. If you are using host-based menus, the system displays the following error message when you attempt to access this function:

You are not set up for boxed menus!

Since this processor is primarily an installation tool, the options available to users from it vary depending on whether you are a McKesson employee.

If you are not a McKesson employee, the system displays all menus in your ID, in alphabetic and numeric order. To quit displaying menus, press period (.) then the **ENTER** key. The system then displays:

Press NL to continue

Press **ENTER** to return to the Menus and Mnemonics Parameters menu. If you display all of the menus, the system displays the following after the last menu:

All menus selected have been displayed! Press NL--

Press **ENTER** to return to the Menus and Mnemonics Parameters menu.

If you are a McKesson employee, when you select the View Boxed Menus function, the system displays the following prompt:

Enter the ID to display menus from [9]--

The system defaults to the ID you are currently using. To view boxed menus for the current ID, press **ENTER**. To view boxed menus for another ID, enter the number of the ID.

The system then displays the following prompt:

Enter initial characters of menu name to begin with [All Menus]--

Enter one or more of the initial characters of the menu's system name (for example, lsmaf) to display only selected boxed menus. Press **ENTER** to display all menus for the ID in alphabetic order.

The system then displays the first boxed menu. The menu header includes the menu's system name. After viewing the first menu, press **ENTER** to display each subsequent menu. To stop viewing the menus, enter a period (.) and press **ENTER**. The system then returns you to the ID prompt.

After the system has displayed all menus, the following message is displayed:

All menus selected have been displayed! Press NL--

To exit from the processor, press **ENTER**.

Mnemonics Report

You use the Mnemonics Report function to create a report containing the following information about each mnemonic in your system:

- Code you enter at a menu to invoke the mnemonic
- Description of the mnemonic, typically the function it accesses
- Status (Active or Inactive) of the mnemonic
- Security level required to use the mnemonic

NOTE: The system displays an asterisk (*) next to security levels that have been set by McKesson. These security levels cannot be changed.

When you select the Mnemonics Report function, the system displays the following prompt:

Print list of mnemonics? (Y/N) [Y]--

To exit from the function without creating the Mnemonics Report, enter **N**. To create the mnemonics report, enter **Y**, or press **ENTER**. The system then displays the following prompt:

Sort by mnemonic (C)ode or (D)escription? [D]--

To list the mnemonics on the report in order of their code, enter **C**. To list the mnemonics on the report in order of their description, enter **D** or press **ENTER**. After you make your selection, the system displays:

Enter report name of first letters'-' --

Enter the name of the output device for the report. Use a hyphen (-) to display and select from a list of output devices. After you complete this field the system displays:

Report compiling!

The system then returns you to the Menu and Mnemonic Parameters Processor.

The following is an example of a Mnemonics Report.

Figure B.1 Mnemonics Report

```
                                    General Hospital            Page:  1
                                    Mnemonics Report            Date:  06/27/91
                                 For STAR Laboratory            Time:  10:01am

                  Mnemonic Description
      Code        Security Level                          Status
-------------------------------------------------------------------------------
( 1)  CIW       Chemistry Incomplete Work                 Active
                * Technologist

( 2)  CPI       Chemistry Patient Inquiry                 Active
                * Clerical/Phlebotomist

( 3)  CRR       Chemistry Result Reporting                Active
                * Technologist

( 4)  CWP       Chemistry Workload Peak Analysis          Active
                Technologist

( 5)  LO        LAB ORDER                                 Active
                * Clerical/Phlebotomist

( 6)  MCF       Menu type/Color/Function Keys             Active
                * Clerical/Phlebotomist

( 7)  MRR       Microbiology *Adv. Micro Result Reportin  Active
                * Technologist

( 8)  OI        Order Inquiry                             Active
                No Security Defined

( 9)  PI        Patient Inquiry - All                     Active
                * Clerical/Phlebotomist

(10)  SO        Send Out                                  Active
                * Clerical/Phlebotomist

(11)  SER       SEROLOGY MENU                             Active
                * Clerical/Phlebotomist

(12)  MAGSQCLA  SQL Activity Log Summary                  Active
                No Security Defined

(13)  SPRR      Surgical Pathology Result Reporting       Active
                * Transcriptionist

(14)  URI       Urinalysis                                Active
                * Technologist

(15)  WKL       Workload                                  Active
                No Security Defined

(16)  WSS       Workload Summary by Section               Active
                Clerical/Phlebotomist

                                        End of Report
```

MNEMONICS WORKSHEETS

This section contains worksheets to help you create and maintain your mnemonics. These worksheets are:

- Mnemonic Function Key Definitions
- Mnemonic Build and Assignment

These worksheets are below. You can make copies of these worksheets as needed.

MNEMONIC FUNCTION KEY DEFINITIONS

User Name:_____Type:_____

F Key	Function Accessed	Mnemonic Code
F1		
F2		
F3		
F4		
F5		
F6		
F7		
F9		
F10		

MNEMONIC BUILD AND ASSIGNMENT

System:_____ Type of User:_____ Security Level:_____

Function/Menu Name	Mnemonic Code

MENU AND MNEMONICS CONSIDERATIONS

For each STAR product, there are considerations for menu and mnemonic use that must be taken into account. This section discusses those considerations.

STAR Financials Patient Accounting Mnemonic Considerations

You can build mnemonics to access the following STAR Financials Patient Accounting functions. All Patient Accounting functions that can be accessed through STAR are Mnemonics accessible.

FUNCTION KEY DEFINITION

You use the Function Key Definition Processor to maintain the assignment of mnemonic codes to function keys on your keyboard. Mnemonics enable you to access a system function from a menu by typing the mnemonic code and pressing the ENTER key. By linking the mnemonic to a function key, you can access the function from a menu by merely pressing the assigned function key. Since many terminals have only 10 function keys, the system only allows you to use the first 10 function keys on a keyboard.

Function key definitions are user-specific. This means you can define your own function key assignments.

NOTE: You can access this function from any menu in the system by pressing C1 on your Data General keyboard or pressing ALT-1 on the keyboard of your IBM-compatible personal computer.

When you access this function, the system displays the following screen:

```
              General Hospital Function Key Definition Processor
                                                  Wed Apr 03, 1991 05:16 pm


( 1)Function Key One    (F1): SB          - Single Bill
( 2)Function Key Two    (F2): AI          - Account Inquiry
( 3)Function Key Three  (F3): AR          - Account Revision
( 4)Function Key Four   (F4): B           - Daily Balancing Functions
( 5)Function Key Five   (F5): C           - Post Cash
( 6)Function Key Six    (F6): DB          - Demand Bill
( 7)Function Key Seven  (F7): GF          - Guarantor Demand Follow Up
( 8)Function Key Eight  (F8): CAI         - Contract Account Information
( 9)Function Key Nine   (F9): GS          - Guarantor Summary
(10)Function Key Ten   (F10): MPI         - MPI Inquiry

Page:01
     Mnemonic    Menu Option                                  Security Level
( 1) A           Post Adjustments                             None
( 2) AI          Account Inquiry                              None
( 3) AR          Account Revision                             None
( 4) B           Daily Balancing Functions                    None

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

The fields on this screen display, respectively, the code and description of the mnemonic assigned to the function key.

To add or edit a function key assignment:

1. Enter the field number of the function key you want to assign. The system highlights the field and displays the following prompt:

   Enter mnemonic code or partial name'-' for list --

2. Enter the mnemonic code you want to assign to the function key. If you do not know the code, entering a hyphen (-) displays a list of mnemonic codes available for your user type and security level.

When you identify the mnemonic, either by entering it or by selecting it from the list, the system displays the mnemonic code and the function it accesses in the field.

For more information on using mnemonics, see “Using Mnemonics” on page B-6.

MENU TYPE SELECTION

You use the Menu Type Selection Processor to select the menu type you want displayed on your STAR terminal. You can choose between host-based or boxed, depending on your STAR terminal.

When you access the Menu Type Selection option, the system displays the following screen:

```
                General Hospital Menu Type Selection Processor
                                                    Thu Mar 04, 1999 04:56 pm
Menu Type Input Options

             Option No.  Option
             ----------------------------------------
                 1       Original Menus

                 2       Boxed Menus









Enter option number [Original Menus]--
```

This screen displays the menu types available to you from your STAR terminal.

To change the menu type displayed on your STAR terminal, select the desired menu type. The system files your selection and returns you to the Menu and Mnemonic Parameters menu, using the menu type you selected.

CRT COLOR SELECTION

You use the CRT Color Selection options to modify the colors displayed on your color CRT. You can only access this function from a color Data General terminal. If you attempt to access this function from any other type of terminal, the system displays:

Color settings not available for this CRT!

When you select CRT Color Selection from the Menus and Mnemonics Parameters processor, the system displays the CRT Color Selection processor.

CRT Color Selection - Color DG Terminals

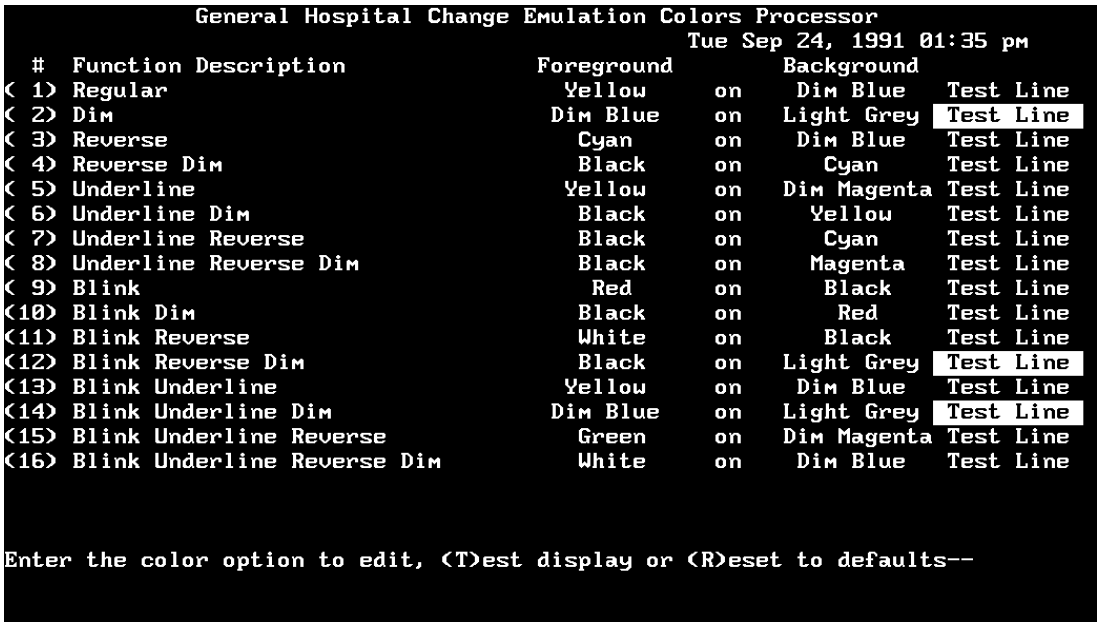
The STAR system enables you to use a variety of methods to highlight information on a processor screen. Depending on the CRT with which you sign-on, these methods can include reverse (dark letters on a bright background), dim, underline, and blinking. You can also combine these methods so that information displays blinking reverse or even blinking reverse underline dim.

The CRT Color Selection processor enables you to additionally modify colors for these highlight methods so that the reverse dim information mentioned above could display as red letters on a blue background. This function also enables you to select the colors for regular text and background on a screen.

The Data General D430C terminal offers different color options from that of the Data General D220 and D230C terminals. Therefore, this function operates differently depending upon which of these Data General color terminals you are using. Each of these terminal types is discussed separately.

D430C TERMINALS

When you select the CRT Color Selection function from a Data General D430C color terminal, the system displays the following screen:



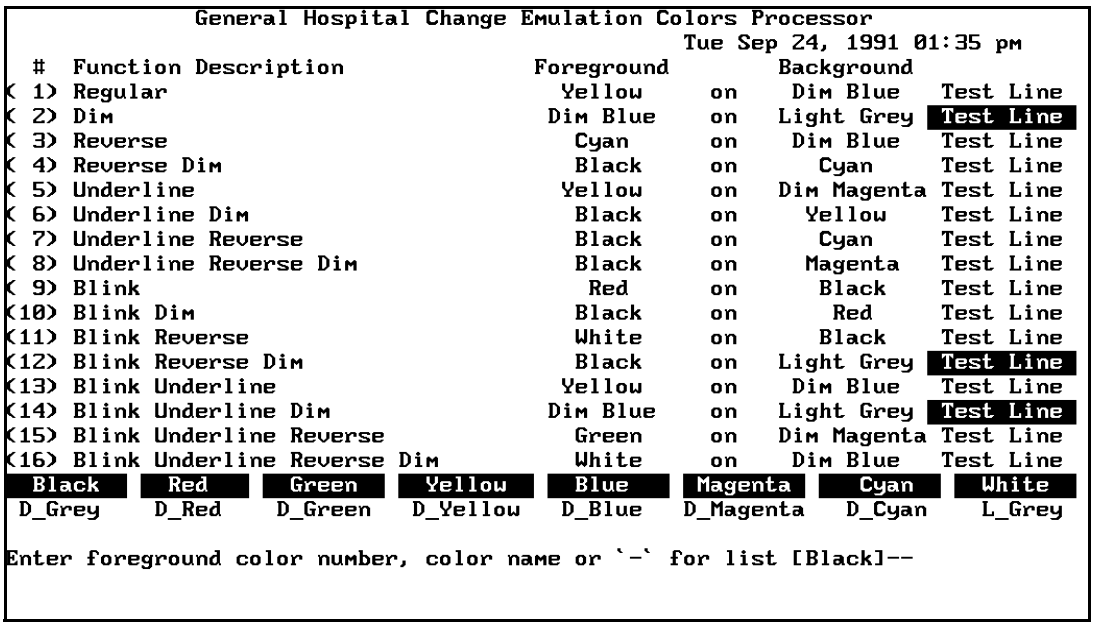
NOTE: The system displays this screen in color. In the Test Line column at the right of the screen, the system displays each highlighting method using the colors currently selected. Thus, the example above under Test Line for Reverse could display as cyan letters on a dim blue background.

EDITING PROCESSOR COLORS

You can change the text and background color for any of the 16 displayed highlighting methods. To change the text and background colors for a highlighting method:

1. Enter the number of the method for which you want to change colors.

   The system highlights your selection and displays, at the bottom of the screen, the color options available on your CRT, as in the following example:



2. Select the color in which you want the text to display using one of the following techniques:

   - Enter the name of the color exactly as it displays on the screen (including underlines, where applicable).
   - Enter a hyphen (-) to display and select from a list of available colors.
   - Press **ENTER** to accept the default color. This is the color in which the text is currently displayed.

   After you enter the new color the system displays your selection below the following prompt, Where *Current* is the name of the background color currently used for the selected option:

   Enter background color number, color name or `-` for list [Current]--

3. Select the color in which you want the text background to display. You can identify this color to the system using any of the methods you used to identify the foreground color.

   After you enter the new color, or press **ENTER** to retain the current color, the system displays an example of what the style looks like using the colors you selected. It then asks if you want to change the style to the new colors. The optional responses are:

   N - No, leave the colors as they existed before.

Y - Yes, change the colors as displayed.

The default is Y.

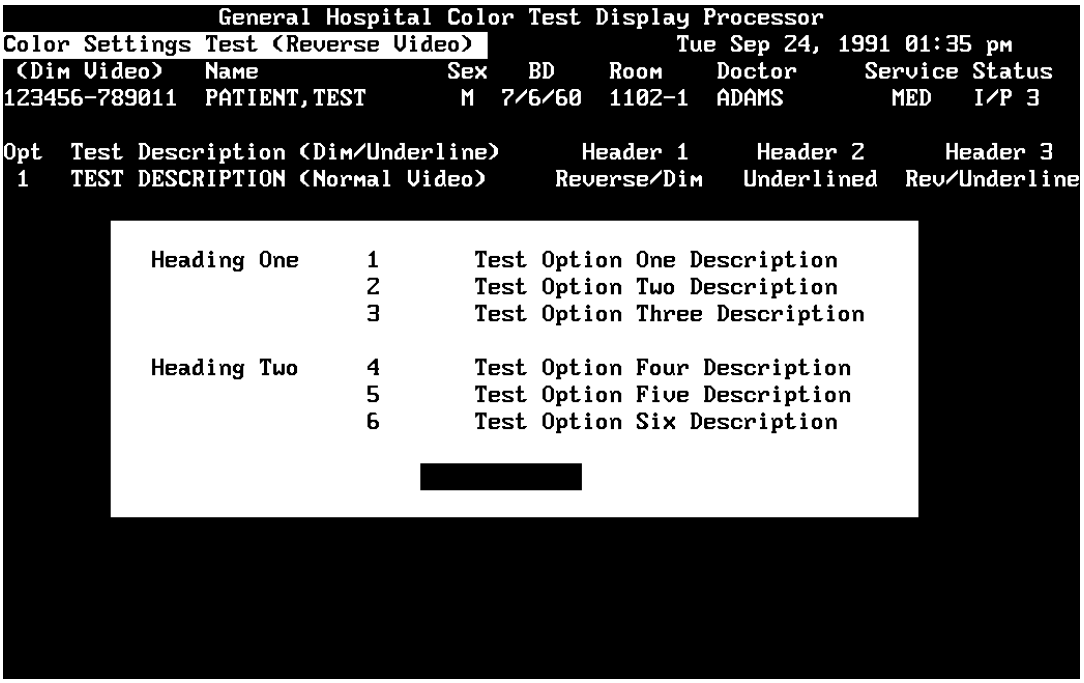
TESTING PROCESSOR COLORS

To display examples of current color settings for menus and screens on your CRT, enter **T** to the *Enter the color option to edit ...* prompt. The system displays the following prompt:

Enter test for a (M)enu or a (S)creen--

Test Menu Colors

To display an example of how menus display on your CRT according to the current settings for colors and menu type, enter **M**. The system displays a screen similar to the following:



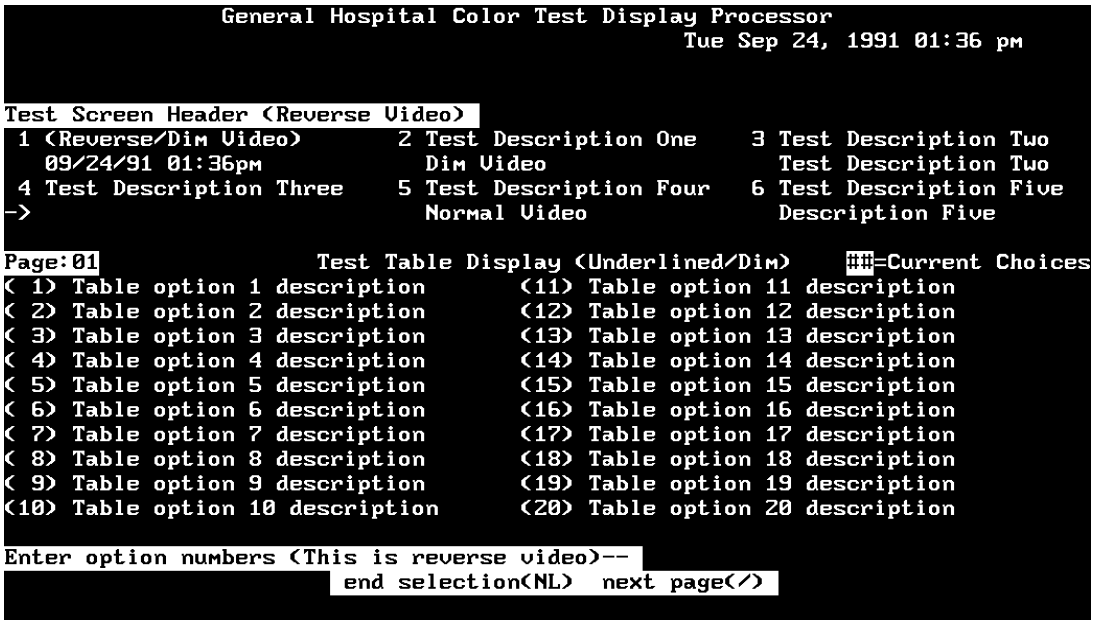
NOTE: The type of menu displayed on this screen depends on the current menu type selected. For more information on setting menu types, see "MENU TYPE SELECTION" on page B-33.

This screen displays the current settings for methods used to highlight information on STAR application menus. You cannot edit these settings from this screen.

Press **ENTER** to return to the *Enter test for a ...* prompt.

TEST SCREEN COLORS

To display an example of how processor screens display on your PC according to the current settings for colors, enter **S**. The system displays a screen similar to the following:



This screen displays the current settings for highlighting methods used by STAR applications. You cannot edit these settings from this screen.

The fields and table on this screen operate like a normal processor screen, even though your entries to this screen have no impact on color settings or other operations of the system. Thus, to view how the system highlights a table selection, enter the number of an option on the table. In this example, after you finish selecting options from the table, the system places your entries in the Test Description Three field and displays the following prompt:

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

To view how the system highlights a field, enter the number of one of the fields on the screen. If you press **ENTER** to this prompt, the system asks if you want to accept the screen. Enter **Y**, or press **ENTER** to exit the example screen and return to the *Enter test for a ...* prompt.

RESETTING COLOR SETTINGS

The system enables you to select from two sets of default colors, one using the Data General factory settings for D430C terminals and one using the settings originally

supplied by McKesson. The Data General default color set for the D430C uses the following color settings:

Text Type	Foreground Color	Background Color
Regular	Green	Black
Reverse	Black	Green
Dim	Dim Green	Black
Reverse Dim	Black	Dim Green
Underline	Green	Black
Underline Dim	Dim Green	Black
Underline Reverse	Black	Green
Underline Dim Reverse	Black	Dim Green
Blink	Red	Black
Blink Dim	Dim Green	Black
Blink Reverse	Black	Green
Blink Dim Reverse	Black	Dim Green
Blink Underline	Green	Black
Blink Underline Dim	Dim Green	Black
Blink Underline Reverse	Black	Green
Blink Underline Reverse Dim	Black	Dim Green

The McKesson default color set uses the following color settings:

Text Type	Foreground Color	Background Color
Regular	Yellow	Dim Blue
Reverse	Cyan	Dim Blue
Dim	Dim Blue	Light Gray
Reverse Dim	Black	Cyan
Underline	Yellow	Dim Magenta
Underline Dim	Black	Yellow
Underline Reverse	Black	Cyan
Underline Dim Reverse	Black	Magenta
Blink	Red	Black
Blink Dim	Black	Red
Blink Reverse	White	Black
Blink Dim Reverse	Black	Light Grey

Text Type	Foreground Color	Background Color
Blink Underline	Yellow	Dim Blue
Blink Underline Dim	Dim Blue	Light Gray
Blink Underline Reverse	Green	Dim Magenta
Blink Underline Reverse Dim	White	Dim Blue

To reset screen colors to one of the default color sets:

1. From the *Enter the color option ...* prompt displayed when you first access the function, enter **R**.

   The system displays the following prompt:

   Reset to (F)actory or (H)BO defaults [H] --

2. Enter **F** to use the default set for Data General D430C terminals. Enter **H**, or press **ENTER** to use the McKesson default set for these terminals.

   The system redisplays the screen using the selected default color set.

D220 AND D230C TERMINALS

When you select the CRT Color Selection function from a Data General D220 or D230C color terminal, the system displays the following prompt:

Enter (E)dit color settings, (T)est display or (R)eset to defaults--

To edit the color settings for your DG color terminal, enter **E**. To view the color settings for your DG color terminal, enter **T**. The test option is discussed following the edit option in this section. To reset your color settings to either the factory or McKesson original settings, enter **R**. The reset option is discussed following the test option in this section.

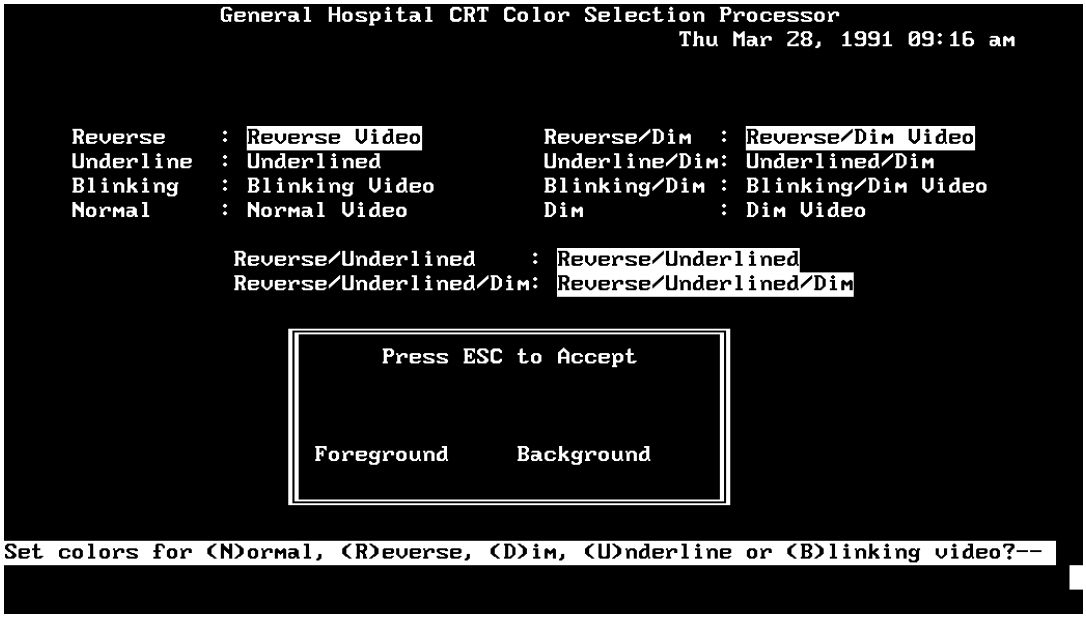
Editing color settings

When you enter **E** to access the edit option, the system displays the following screen:

NOTE: The system displays this screen in color. For each highlighting method (such as Reverse, Underline), the screen displays the current settings for the highlighting method colors. For example, the text *Reverse Video* next to Reverse could display as red letters on a black background.

At the bottom of the screen the system displays:

Set colors for (N)ormal, (R)everse, (D)im, (U)nderline or (B)linking video?--



To change the text and background color for any of the ten displayed highlighting methods:

1. Enter the first letter of the highlighting method (N for normal, R for reverse, etc.) you want to change, and press **ENTER**. The system displays a small window on the screen. In this window, the system displays the name of the highlighting method you are changing (for example, Normal Color Display) in the colors currently defined. At the bottom of the window, the current foreground and background settings for this method display. The cursor is in the Foreground color selection.

2. To change the current color setting for the Foreground text in the window, cycle through the available colors by pressing:

   - The SPACE BAR or right arrow key to display the text in the next available color
   - The left arrow key to display the text in the preceding available color

   When the system displays the Foreground text in the desired color, press **ENTER** or **TAB**. The cursor then moves to the Background color selection.

3. Repeat step 2 to change the color setting for the background. You can switch between the foreground and background fields by pressing the **ENTER** key or **TAB**.

4. To accept the color settings for the foreground and background, press **ESC**. The system returns to the highlighting method prompt at the bottom of the screen.

Testing color settings

When you enter **T** in response to the *Enter (E)dit color settings, (T)est display or (R)eset to defaults*-- prompt, the system displays the following prompt:

Enter test for a (M)enu or a (S)creen--

To view the current color settings for a menu on your DG color terminal, enter **M**. To view the current color settings for a processor screen on your DG color terminal, enter **S**.

The test menu and screen display each of the highlighting method settings available on a DG color terminal, including:

- Normal text
- Reverse
- Underlined
- Blinking
- Dim
- Dim Reverse
- Dim Underlined
- Dim Blinking
- Reverse Underlined
- Reverse Underlined Dim

The test menu and screen are example screens only. You cannot edit any of the color settings or make any other impact on the STAR system from these screens.

Resetting color defaults

When you enter **R** in response to the *Enter (E)dit color settings, (T)est display or (R)eset to defaults--* prompt, the system displays the following prompt:

Reset to (F)actory or (H)BOC defaults? [H]--

To reset your color display to the Data General defaults, enter **F**. To view a table of default color settings, see "Resetting Color Settings" on page B-38. To reset your color display to the McKesson defaults, enter **H**, or press **ENTER**. The following table displays the colors used in the McKesson default settings:

Text Type	Foreground Color	Background Color
Regular	White	Blue
Reverse	White	Red
Dim	Black	Blue
Reverse Dim	Red	Magenta
Underline	Green	Blue
Underline Reverse	Light Magenta	Magenta
Underline Dim	Blue	Black
Underline Dim Reverse	Yellow	Brown

Text Type	Foreground Color	Background Color
Blink	Red	Black
Blink Reverse	Light Blue	Brown
Blink Dim	White	Blue
Blink Dim Reverse	Black	Magenta
Blink Underline	Yellow	Blue
Blink Underline Reverse	Blue	Magenta
Blink Underline Dim	Magenta	Black
Blink Underline Reverse Dim	Green	Brown

Appendix C - PATIENT ACCOUNTING POSTINGS TO THE GENERAL LEDGER

EVENTS GL POSTING

Event	Keys Used to Obtain Accounts	GL Posting
Charge	PA	Debit-PA Control
	DPRV	Credit-Department Revenue
Credit	DPRV	Debit-Department Revenue
	PA	Credit-PA Control
Professional Fee Charge	PA	Debit-PA Control
	DPRF	Credit-Professional Dept Revenue
Professional Fee Credit	DPRF	Debit-Professional Dept Revenue
	PA	Credit-PA Control
Late Charge-Account in AR	AR	Debit-AR Control
	DPRV	Credit-Department Revenue
Late Credit-Account in AR	DPRV	Debit-Department Revenue
	AR	Credit-AR Control
Late Professional Fee Charge-Account in AR	AR	Debit-AR Control
	DPRF	Credit-Professional Dept Revenue
Late Professional Fee Credit-Account in AR	DPRF	Debit-Professional Dept Revenue
	AR	Credit-AR Control
Late Charge-Account in BD	BDAL	Debit-Bad Debt Allowance
	DPRV	Credit-Department Revenue
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Late Credit-Account in BD	DPRV	Debit-Department Revenue
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt control
Late Professional Fee Charge-Account in BD	BDAL	Debit-Bad Debt Allowance
	DPRF	Credit-Professional Dept Revenue
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control

Event	Keys Used to Obtain Accounts	GL Posting
Late Professional Fee Credit-Account in BD	DPRF	Debit-Professional Dept Revenue
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Final Bill-Account Balance Greater than Zero	AR	Debit-AR Control Account
	PA	Credit-PA Control Account
Final Bill-Account Balance Less Than Zero	PA	Debit-PA Control Account
	AR	Credit-AR Control Account
Cash Payment-Account in PA	TRANP	Debit-Cash Account
	PA	Credit-PA Control Account
Cash Payment-Account in AR	TRANP	Debit-Cash Account
	AR	Credit-AR Control Account
Cash Payment-Account in BD	TRANP	Debit-Cash Account
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-BD Control
Cash Reversal-Account in PA	PA	Debit-PA Control
	TRANP	Credit-Cash Account
Cash Reversal-Account in AR	AR	Debit-AR Control
	TRANP	Credit-Cash Account
Cash Reversal-Account in BD	BDRC	Debit-Bad Debt Recovery
	TRANP	Credit-Cash Account
	BD	Debit-Bad Debt Control
	BDWO	Credit-BD Contra Control
Insurance Pymt-Account in PA	TRANI	Debit-Cash Account
	PA	Credit-PA Control Account
Insurance Pymt-Account in AR	TRANI	Debit-Cash Account
	AR	Credit-AR Control Account
Insurance Pymt-Account in BD	TRANI	Debit-Cash Account
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-BD Control

Event	Keys Used to Obtain Accounts	GL Posting
Ins Pymt Reversal-Account in PA	PA	Debit-PA Control
	TRANI	Credit-Cash Account
Ins Pymt Reversal-Account in AR	AR	Debit-AR Control
	TRANI	Credit-Cash Account
Ins Pymt Reversal-Account in BD	BDRC	Debit-Bad Debt Recovery
	TRANI	Credit-Cash Account
	BD	Debit-Bad Debt Control
	BDWO	Credit-BD Contra Control
Agency Cash-Fee not Deducted from Agency Check	TRANE	Debit-Cash Account
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Agency Cash Reversal	BDRC	Debit-Bad Debt Recovery
	TRANE	Credit-Cash Account
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Agency Cash-Fee Deducted from Agency Check	TRANE	Debit-Cash Account
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
	Above per patient. Below for the batch in total.	
	TRANV	Debit-Agency Fee
	TRANE	Credit-Cash Account
	TRANE is used to update the patient account for each posting entered for the agency cash function. After the cash posting batch is balanced, the system will see if there is an agency fee for the batch. The amount of the fee will become a credit to the cash account and a debit to the agency fee account.	
Miscellaneous Cash	TRANF	Debit-Cash Account
	Misc Cash Code Table	Credit-Other Revenue Account

Event	Keys Used to Obtain Accounts	GL Posting
Miscellaneous Cash Reversal	Misc Cash Code Table	Debit-Other Revenue Account
	TRANF	Credit-Cash Account
	The general ledger account number for the credit is resident in the miscellaneous cash code table.	
Unapplied Cash	TRANU	Debit-Cash Account
	UACASH	Credit-Unapplied Cash Control
Unapplied Cash Reversal	UACASH	Debit-Unapplied Cash Control
	TRANU	Credit-Cash Account
Apply Unapplied Cash to Patient-Account in PA	TRANP	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	PA	Credit-PA Control
Apply Unapplied Cash to Patient-Account in AR	TRANP	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	AR	Credit-AR Control
Apply Unapplied Cash to Patient-Account in BD	TRANP	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Apply Unapplied Cash to Insurance-Account in PA	TRANI	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	PA	Credit-PA Control
Apply Unapplied Cash to Insurance- Account in AR	TRANI	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	AR	Credit-AR Control

Event	Keys Used to Obtain Accounts	GL Posting
Apply Unapplied Cash to Insurance-Account in BD	TRANI	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Apply Unapplied Cash to Miscellaneous Cash	TRANF	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	Misc Cash Code Table	Credit-Other Revenue
Apply Unapplied Cash to Agency Cash	TRANE	Debit-Cash Account
	TRANU	Credit-Cash Account
	UACASH	Debit-Unapplied Cash Control
	BDRC	Credit-Bad Debt Recovery
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Apply Unapplied Cash Reversal Patient Cash-Account in PA	TRANU	Debit-Cash Account
	TRANP	Credit-Cash Account
	PA	Debit-PA Control
	UACASH	Credit-Unapplied Cash Control
Apply Unapplied Cash Reversal Patient Cash-Account in AR	TRANU	Debit-Cash Account
	TRANP	Credit-Cash Account
	AR	Debit-AR Control
	UACASH	Credit-Unapplied Cash Control
Apply Unapplied Cash Reversal Patient Cash-Account in BD	TRANU	Debit-Cash Account
	TRANP	Credit-Cash Account
	BDRC	Debit-Bad Debt Recovery
	UACASH	Credit-Unapplied Cash Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control

Event	Keys Used to Obtain Accounts	GL Posting
Apply Unapplied Cash Reversal Insurance Cash-Account in PA	TRANU	Debit-Cash Account
	TRANI	Credit-Cash Account
	PA	Debit-PA Control
	UACASH	Credit-Unapplied Cash Control
Apply Unapplied Cash Reversal Insurance Cash-Account in AR	TRANU	Debit-Cash Account
	TRANI	Credit-Cash Account
	AR	Debit-AR control
	UACASH	Credit-Unapplied Cash Control
Apply Unapplied Cash Reversal Insurance Cash-Account in BD	TRANU	Debit-Cash Account
	TRANI	Credit-Cash Account
	BDRC	Debit-Bad Debt Recovery
	UACASH	Credit-Unapplied Cash Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Apply Unapplied Cash Reversal	TRANU	Debit-Cash Account Miscellaneous Cash
	TRANF	Credit-Cash Account
	Misc Cash Code Table	Debit-Other Revenue
	UACASH	Credit-Unapplied Cash Control
Apply Unapplied Cash Reversal Agency Cash	TRANU	Debit-Cash Account
	TRANE	Credit-Cash Account
	BDRC	Debit-Bad Debt Recovery
	UACASH	Credit-Unapplied Cash Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Unapplied Charge	UACHRG	Debit-Unapplied Charge Control
	*DPRV	Credit-Department Revenue
Unapplied Credit	*DPRV	Debit-Department Revenue
	UACHRG	Credit-Unapplied Charge Control
Unapplied Professional Charge	UACHRG	Debit-Unapplied Charge Control
	*DPRF	Credit-Professional Dept Revenue
Unapplied Professional Credit	*DPRF	Debit-Professional Dept Revenue
	UACHRG	Credit-Unapplied Charge Control

Event	Keys Used to Obtain Accounts	GL Posting
Apply Unapplied Charge-Account in PA	*DPRV	Debit-Department Revenue
	DPRV	Credit-Department Revenue
	PA	Debit-PA Control
	UACHRG	Credit- Unapplied Charge Control
Apply Unapplied Charge-Account in AR	*DPRV	Debit-Department Revenue
	DPRV	Credit-Department Revenue
	AR	Debit-AR Control
	UACHRG	Credit-Unapplied Charge Control
Apply Unapplied Charge-Account in BD	*DPRV	Debit-Department Revenue
	DPRV	Credit-Department Revenue
	BDAL	Debit-Bad Debt Allowance
	UACHRG	Credit-Unapplied Charge Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Apply Unapplied Professional Charge-Account in PA	*DPRF	Debit-Professional Dept Revenue
	DPRF	Credit-Professional Dept Revenue
	PA	Debit-PA Control
	UACHRG	Credit-Unapplied Charge Control
Apply Unapplied Professional Charge-Account in AR	*DPRF	Debit-Professional Dept Revenue
	DPRF	Credit-Professional Dept Revenue
	AR	Debit-PA Control
	UACHRG	Credit-Unapplied Charge Control
Apply Unapplied Professional Charge-Account in BD	*DPRF	Debit-Professional Dept Revenue
	DPRF	Credit-Professional Dept Revenue
	BDAL	Debit-Bad Debt Allowance
	UACHRG	Credit-Unapplied Charge Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Apply Unapplied Credit-Account in PA	DPRV	Debit-Department Revenue
	*DPRV	Credit-Department Revenue
	UACHRG	Debit-Unapplied Charge Control
	PA	Credit-PA Control

Event	Keys Used to Obtain Accounts	GL Posting
Apply Unapplied Credit-Account in AR	DPRV	Debit-Department Revenue
	*DPRV	Credit-Department Revenue
	UACHRG	Debit-Unapplied Charge Control
	AR	Credit-AR Control
Apply Unapplied Credit-Account in BD	DPRV	Debit-Department Revenue
	*DPRV	Credit-Department Revenue
	UACHRG	Debit-Unapplied Charge Control
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Apply Unapplied Professional Credit-Account in PA	DPRF	Debit-Professional Dept Revenue
	*DPRF	Credit-Professional Dept Revenue
	UACHRG	Debit-Unapplied Charge Control
	PA	Credit-PA Control
Apply Unapplied Professional Credit-Account in AR	DPRF	Debit-Professional Dept Revenue
	*DPRF	Credit-Professional Dept Revenue
	UACHRG	Debit-Unapplied Charge Control
	AR	Credit-AR Control
Apply Unapplied Professional Credit-Account in BD	DPRF	Debit-Professional Dept Revenue
	*DPRF	Credit-Professional Dept Revenue
	UACHRG	Debit-Unapplied Charge Control
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
	*Most likely will default and use the DFDPRV or DFDPRF. The only way unapplied charges will not default is if revenue center is the only key used when building the components for DPRV and DPRF.	
Approve Patient Refund-Account in PA	PA	Debit-PA Control
	TRANR	Credit-AP Liability
Approve Patient Refund-Account in AR	AR	Debit-AR Control
	TRANR	Credit-AP Liability

Event	Keys Used to Obtain Accounts	GL Posting
Approve Patient Refund-Account in BD	BDAL	Debit-Bad Debt Allowance
	TRANR	Credit-AP Liability
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Approve Insurance Refund-Account in PA	PA	Debit-PA Control
	TRAND	Credit-AP Liability
Approve Insurance Refund-Account in AR	AR	Debit-AR Control
	TRAND	Credit-AP Liability
Approve Insurance Refund-Account in BD	BDAL	Debit-Bad Debt Allowance
	TRAND	Credit-AP Liability
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Approve Unapplied Cash Refund	UACASH	Debit - Unapplied Cash Control
	TRANJ	Credit - AP Liability
Delete Approved Patient Refund-Account in PA	TRANR	Debit-AP Liability
	PA	Credit-PA Control
Delete Approved Patient Refund-Account in AR	TRANR	Debit-AP Liability
	AR	Credit-AR Control
Delete Approved Patient Refund-Account in BD	TRANR	Debit-AP Liability
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Approve Patient Refund-Account in PA	PA	Debit-PA Control
	TRANR	Credit-AP Liability
Delete Approved Insurance Refund-Account in PA	TRAND	Debit-AP Liability
	PA	Credit-PA Control
Delete Approved Insurance Refund-Account in AR	TRAND	Debit-AP Liability
	AR	Credit-AR Control
Delete Approved Insurance Refund-Account in BD	TRAND	Debit-AP Liability
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control

Event	Keys Used to Obtain Accounts	GL Posting
Delete Approved Unapplied Cash Refund	TRANJ	Debit - AP Liability
	UACASH	Credit - Unapplied Cash Control
Print Patient Checks	TRANR	Debit-AP Liability
	RFCASH	Credit-Cash Account
Print Insurance Checks	TRAND	Debit-AP Liability
	RFCASH	Credit-Cash Account
Print Unapplied Cash Checks	TRANJ	Debit - AP Liability
	RFCASH	Credit - Cash Account
	Refund check print updates general ledger by total dollars for patient and insurance. This check print update to the general ledger does not occur patient specific.	
Debit Adjustment-Account in PA	PA	Debit-PA Control
	TRANA	Credit-Deductions from Revenue
Debit Adjustment-Account in AR	AR	Debit-AR Control
	TRANA	Credit-Deductions from Revenue
Debit Adjustment-Account in BD	BDAL	Debit-Bad Debt Allowance
	TRANA	Credit-Deductions from Revenue
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Credit Adjustment-Account in PA	TRANA	Debit-Deductions from Revenue
	PA	Credit-PA Control
Credit Adjustment-Account in AR	TRANA	Debit-Deductions from Revenue
	AR	Credit-AR Control
Credit Adjustment-Account in BD	TRANA	Debit-Deductions from Revenue
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
	Deductions from revenue is just an example of the type of account that an adjustment can effect. Mapping can be set to effect all types of accounts such as expense, revenue, assets and liability accounts.	
AR to BD Transfer-Balance Greater than Zero	BDAL	Debit-Bad Debt Allowance
	AR	Credit-AR Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control

Event	Keys Used to Obtain Accounts	GL Posting
AR to BD Transfer-Balance Less than Zero	AR	Debit-AR Control
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Bad Debt to AR Transfer-Balance Greater than Zero	AR	Debit-AR Control
	BDAL	Credit-Bad Debt Allowance
	BDWO	Debit-Bad Debt Contra Control
	BD	Credit-Bad Debt Control
Bad Debt to AR Transfer-Balance Less than Zero	BDAL	Debit-Bad Debt Allowance
	AR	Credit-AR Control
	BD	Debit-Bad Debt Control
	BDWO	Credit-Bad Debt Contra Control
Contract Charge	VA	Debit-PA Contract Control
	VR	Credit-Department Revenue
Contract Credit	VR	Debit-Department Revenue
	VA	Credit-PA Contract Control
Contract Cash Payment-Contract in PA	TRANN	Debit-Cash Account
	VA	Credit-PA Contract Control
Contract Cash Payment-Contract in AR	TRANN	Debit-Cash Account
	VB	Credit-AR Contract Control
Debit Adjustment-Contract in PA	VA	Debit-PA Contract Control
	TRANG	Credit-Deductions from Revenue
Debit Adjustment-Contract in AR	VB	Debit-AR Contract Control
	TRANG	Credit-Deductions from Revenue
Credit Adjustment-Contract in PA	TRANG	Debit-Deductions from Revenue
	VA	Credit-PA Contract Control
Credit Adjustment-Contract in AR	TRANG	Debit-Deductions from Revenue
	VB	Credit-AR Contract Control
Final Bill Contract Account Balance Greater than Zero	VB	Debit-AR Contract Control
	VA	Credit-PA Contract Control
Final Bill Contract Account-Balance Less than Zero	VA	Debit-PA Contract Control
	VB	Credit-AR Contract Control

Event	Keys Used to Obtain Accounts	GL Posting
Apply Unapplied Charge Contract	DPRV	Debit-Department Revenue
	VR	Credit-Department Revenue
	VA	Debit-PA Contract Control
	UACHRG	Credit-Unapplied Charge Control
Apply Unapplied Professional Charge Contract	DPRF	Debit-Professional Dept Revenue
	VR	Credit-Department Revenue
	VA	Debit-PA Contract Control
	UACHRG	Credit-Unapplied Charge Control
Apply Unapplied Credit Contract	VR	Debit-Department Revenue
	*DPRV	Credit-Department Revenue
	UACHRG	Debit-Unapplied Charge Control
	VA	Credit-PA Contract Control
Apply Unapplied Professional Credit Contract	VR	Debit-Department Revenue
	*DPRF	Credit-Professional Dept Revenue
	UACHRG	Debit-Unapplied Charge Control
	VA	Credit-PA Contract Control
	*Most likely will be default keys used DFDPRV and DFDPRF.	
Reclass Charge and Late Charge	DPRV	Debit-Department Revenue
	DPRV	Credit-Department Revenue
Reclass Credit and Late Credit	DPRV	Debit-Department Revenue
	DPRV	Credit-Department Revenue
Reclass Professional Fee Charge and Late Charge	DPRF	Debit-Professional Dept Revenue
	DPRF	Credit-Professional Dept Revenue
Reclass Professional Fee Charge and Late Credit	DPRF	Debit-Professional Dept Revenue
	DPRF	Credit-Professional Dept Revenue
	Stats are also updated in the general ledger via the mapping table. Counts for charges, units of service and relative value are updated based on the mapping of DPRV and DPRF. There are also statistics kept on patient days, number of outpatient registrations and number of outpatient visits. These are updated based on the mapping below.	
Patient Days	PTD	Debit - Department Patient Days
Registration	REG	Debit-Registration Count
Visits	OPV	Debit - Visit Count

Event	Keys Used to Obtain Accounts	GL Posting
Remove Patient Day	PTD	Credit - Department Patient
	This is done due to change admit or discharge date, change patient type, cancel admission and credit room charge.	
Cancel Registrations	REG	Credit -Registration Count
Cancel Registration	OPV	Credit -Visit Count
	If the system cannot find the mapping key in the table, the system will use the default mapping key which is the same key except it will start with DF.	

GLOSSARY

This is a list of terms used by the STAR Financials system. This glossary does not include all terms used by the system but is merely a representative sample.

-A-

AC
Accommodation Code. A STAR Patient Care code identifying the type of room a patient is in - private, semiprivate, or ICU.

ACCOUNT LOCATION
A two-character code that identifies the patient's account status:

PA = account not final-billed, both in-house and discharged patients
AR = account final-billed and transferred to AR
BD = account final-billed and sent to a collection agency, both internal and external
HS = account purged from the system. It still exists in the MPI.
ARC = account archived

ACCOUNT SUB LOCATION
A code (up to 4 characters) that identifies the patient's account status at a more detailed level than Account Location. The Account Location determines valid sub locations for the patient:

INSR = insurance verification not completed (valid for PA)
FCRV = financial counseling (valid for PA, AR, BD)
ND = not discharged (valid for PA)
DNFB = discharged, not final billed (valid for PA)
ACCF = active internal guarantor collections (valid for AR)
PCA# = # of pre-collect agency (valid for AR)
RFBD = reinstated from bad debt (valid for AR)
BDP = bad debt prelisted (valid for AR)
BDI = bad debt internal collections (valid for BD)
BDE = bad debt external agency (valid for BD)

AGED TRIAL BALANCE REPORT
A report on the financial status of accounts in the Accounts Receivable module. An ATB report can be produced monthly or on demand. This report includes the account's aging category, financial class, and patient and carrier liabilities. Through the sort parameters, you can specify whether the report should be aged by discharge date, final bill date, bill mail date, last carrier payment date or last patient payment date. You can print a detail ATB or a summary report.

ADJUSTMENT BILL
A bill which includes all charges, billed and unbilled, since the final or last adjusted bill was produced. The system automatically can generate an adjustment bill based on

the patient billing parameter, and it also can be manually requested. This parameter is the number of late charges and corresponding dollar amount that would trigger an automatic adjusted bill.

ADMISSION TYPE CODE
A hospital-defined code which usually corresponds to the UB82 source of admission code. The code assigned to the patient can be included on the UB82 claim form.

-B-

BILL GENERATION
The billing process in which bills are produced at the hospital's request. These can include detail, summary, and proration bills.

BILLING REQUIREMENTS PARAMETER
A parameter that defines specific information which must be present on a patient account before a final bill can be generated. A billing requirement code is given to each final bill parameter. The required information does not necessarily print on the bill.

-C-

CMS
Centers for Medicaid and Medicare Services.

CHAMPUS
Civilian Health and Medical Programs of the Uniformed Services.

CLAIM
A third party billing form, for example, a UB92 for hospital charges and professional fees, and a 1500 for professional fees. Claims are loaded and edited when bills are generated, based on the insurance assigned to the patient.

CLAIM EDIT
The process of editing, verifying and cross-checking an account's claim by the biller.

CLAIM GENERATION PARAMETER
A parameter indicating the transaction codes used when a claim is loaded, produced and submitted. This parameter also defines the number of days that a claim remains in *suspense* before being released.

COB
Coordination of Benefits for a patient who has more than one insurance. The plans may allow coordination of benefits. This flag is set in the Carrier/Plan Master file.

COB ADJUSTMENT
The amount calculated when coordination of benefits is done for secondary plans. The calculation is performed to insure that a secondary plan will not pay more than the difference between total charges and total amount paid by prior plans. It is calculated as the amount of coverage already covered by a prior plan. The system uses COB

Adjustment when the Coordinate Benefits flag is set to Yes in the insurance Carrier/ Plan Master file.

COB (PLAN)
Plan coordinating benefits:

- Calculates its liability and passes on any remaining liability to another coordinating plan for consideration
- Does not cover liability accepted by another carrier

The order that the coverages display for the patient determines which insurance is primary, secondary, and so forth.

Plan not coordinating benefits:

- Prorates its liability and does not pass on remaining liability to another carrier
- Can cover what another carrier is also covering

If the amount that a coordinating and non-coordinating plan covers exceeds the patient's account balance, a credit balance is shown for the patient's liability when an account is prorated.

COINSURANCE
The amount of covered charges which must be paid by the patient after a plan begins paying benefits -- usually a percentage of the charge amount. For example, if an insurance plan covers 80% of covered charges then the remaining 20% is the patient's responsibility.

COLLECTION LETTER
An account follow-up form used to bill the guarantor or insurance carrier for outstanding balances due on one or more patient accounts for which the guarantor or insurance carrier is responsible. Letters are made up of hospital-defined collection letter messages.

CONTRACTUAL ALLOWANCE
The difference between the total patient charges and the third party payment, or the actual cash received. This difference is written off the patient's account and accounts receivable. The difference is the result of an agreement between the hospital and the third party payor as the result of a formula arrangement or prospective rate determined by the third party payor before the service is rendered. The contractual allowance adjustment can be posted at final billing or when the payment is received.

CORPORATE NUMBER
A number the corporation assigns to a patient to identify previous visit records in the same facility and, if applicable, to identify visits across facilities.

CORPORATION
More than one facility or entity managed by a central managing group.

COST OUTLIER
Extraordinary costs associated with a case that are incurred over a short period of time that do not qualify as a day outlier. Cost outliers are associated with DRGs. See Day Outlier.

COVERED
A category or overall total of charge amounts that are eligible for benefits by each plan. If no charges are excluded from coverage, total charges would equal covered charges.

COMMON NON-COVERED
A charge or total amount that is non-covered by multiple plans, for the same reasons as listed for Non-covered. This can only occur if there are secondary plans when the primary plan is COB 1, the secondary plans are coordinating benefits, and no plans cover the amount. In this case, the amount is always passed to the patient liability during coordination of benefits.

CYCLE BILL
An interim bill of the account which the system generates based on the individual billing parameters of the account, such as a specified number of days after admission/ registration, a specified dollar amount, or the end of the month.

-D-

DATA MAILER
An account follow-up form used to notify the guarantor of pending insurance claims or outstanding guarantor liabilities. The data mailer is usually an automated-production carbonless form that includes a return envelope.

DATA MAILER MESSAGE
Any hospital-defined message that is printed with the data mailer.

DAY OUTLIER
A per diem payment adjustment made on an individual case-by case determination for each covered day of care beyond the LOS outlier threshold associated with a particular DRG. See Stay Outlier.

DEDUCTIBLE
The amount of covered charges which a patient must pay before a plan begins paying benefits. There are initial deductible amounts for each section of a plan, as well as daily deductible amounts (for example, deductibles which must be satisfied for each day they are in effect).

DEMAND BILL
A type of bill produced on demand (either in summary or proration or detail) for an account. The hospital may prorate the bill when it is printed. You can specify a range

of successive dates to be included on the bill. Demand bills do not update GL or PA/AR information.

DEPARTMENT
A division within a facility for which financial data is maintained. A department can service more than on facility. The revenue for the department is directed to the proper facility and GL account, based on where the patient was admitted or registered, and the GL Mapping table.

DETAIL STATEMENT
A statement the system generates for the guarantor from guarantor follow-up or insurance follow-up schedules. Detail statements include detail charge activity not previously billed.

DETAIL STATEMENT MESSAGE
Any message which prints on the detail statement.

DRG
Diagnosis Related Group. A method (developed by Yale University) of classifying patient admission into clinically coherent and homogeneous groups with respect to resources used. There are approximately 743 DRGs separated into 23 major diagnostic categories (MDC). See MDC.

-E-

ESTIMATED RESPONSIBILITY
The amount calculated as being due from the insurance plan before coordination of benefits. It is equal to the total charges minus non-covered, not covered, deductible, and coinsurance amounts.

-F-

FIM
Financial Item Master. The FIM contains all entries of each department for which a coded order or charge might be placed. The FIM primarily stores information necessary for billing and reimbursement. There does not need to be a one-to-one correspondence between the SIM and FIM. SIM entries may share the same FIM entry. See SIM.

FINAL BILL
An itemized account of the separate charge of services performed, which has passed from patient accounting to accounts receivable.

FINANCIAL CLASS
An identification code assigned to each patient that indicates the main source of payment for the patient account. An example is Blue Cross.

FINANCIAL PATIENT INDEX (FPI)
An index of all patients and guarantors who have visited the hospital. The system has a parameter to control the length of time accounts are maintained in the Financial Patient Index.

FOLLOW-UP
A detail statement, paper follow-up, collection letter, telephone call, or other method used to collect a debt. The steps taken and the frequency of these steps is parameter driven. Follow-up refers to both guarantor and insurance follow-up.

-G-

GUARANTOR
The person responsible for the patient, including balance liability.

GUARANTOR FOLLOW-UP
The process of following the steps outlined in the hospital collection schedule for collecting debts on self-pay balances. This follow-up is generated for each guarantor and includes all the active accounts assigned to a specific guarantor.

GUARANTOR FOLLOW-UP SCHEDULE
The hospital-defined schedule for collection of the outstanding balance on a patient account. Follow-up schedules are assigned based on the financial class of the guarantor. They do not change as subsequent accounts are admitted or registered for the guarantor.

-H-

HCPCS
Health Care Procedure Coding System. HCPCS codes can be attached to individual charges in the SIM (Service Item Master), or they can be keyed directly into the Medical Record abstract.

HFMA
Healthcare Financial Management Association.

-I-

ICD-9-CM
International Classification of Diseases - 9th Revision - Clinical Modification.

INSURANCE COLLECTION LETTER
A letter from the hospital to the insurance carrier requesting payment on the outstanding carrier balance due on patient's accounts. You can print collection letters for a specific account, or you can print all accounts for the same carrier.

INSURANCE FOLLOW-UP SCHEDULE
The hospital-defined schedule for collection of the outstanding insurance balance on patients' accounts. Insurance follow-up schedules are assigned to each insurance carrier/plan.

INSURANCE TIME-OUT
Insurance time out is used to transfer the insurance balance to the next carrier, or to the patient liability. Insurance may time out when an insurance claim reaches the end of the insurance follow-up schedule. Insurance time-out is based on the insurance follow-up schedule assigned to the carrier/plan.

-L-

LATE BILL
A type of bill that contains late charges. An automatic late bill can be generated according to the account's final bill parameters, based on the number of late charges and their dollar amount. A late bill contains only late charges as compared with an adjustment bill. See Adjustment Bill.

LIABILITY
The computed amount to be paid by a plan. This amount is estimated responsibility minus the COB adjustment. For the COB 1 plan, it would be equal to the estimated responsibility.

-M-

MDC
Major Diagnostic Category. A broad clinical category differentiated from all others based on body system involved and disease etiology. MDCs are broken down further into DRGs (diagnosis related categories) for the purpose of reimbursement as part of the hospital's prospective payment system (PPS). See DRG and PPS.

MPI
Master Patient Index. The MPI records patient and guarantor ADT information storing the data for future visits and historical reasons. Patient items such as name, demographics, financial and limited medical information, corporate, unit or account number, and room and bed are stored in the MPI, until the information is purged by the demand MPI purge procedure.

-N-

NON-COVERED
A charge or a total amount never covered by a carrier/plan's benefits. These typically are patient comfort items such as telephone or TV charges. This amount is passed either to the next plan or to the patient. Total charges minus covered charges should equal non-covered charges.

NOT COVERED
A charge or a total amount normally covered by a carrier/plan's benefits, but which is not being covered, typically due to plan limits being exceeded. This amount is passed either to the next plan or to the patient.

-P-

PATIENT BILL
A list of charges billed to the patient account for a specific billing period. The bill can be either detailed, summarized or prorated - then sent to the guarantor (as a notification of services received), to the insurance carrier (as detailed documentation of a claim) or kept within the hospital (as an internal audit documenting charges billed). Audit, Cycle and Final bills can be produced.

PATIENT BILL MESSAGE
A hospital-defined message which prints on the patient's bill.

PATIENT INDICATOR
A hospital-defined one-digit code indicating whether the patient is an (I)npatient, (O)utpatient, (E)mergency room patient or a (V)endor account. Patient types are associated with a patient indicator.

PRORATION
The process of assessing proportionately who is responsible for the patient's charges. The steps include separating covered from non-covered charges, performing benefits calculations, performing COB adjustments (as necessary) and calculating reimbursement.

PROVIDER
The hospital or other health-care facility providing the patient care. Providers are assigned based on patient type. Insurance carrier/plan exceptions may be assigned.

-R-

REIMBURSEMENT
The amount determined by the reimbursement module calculations to be paid the primary plan. In the simplest cases, the reimbursement amount is the same as the liability amount. In other cases where the payor has made arrangements with the hospital to reimburse on a basis other than cost of services, the reimbursement amount may not be equal to the liability. Contractual adjustments are calculated based on the reimbursement calculation.

REPRINT BILL
A duplicate of a previous bill. Reprint bills are printed during midnight processing. Transaction history will reflect the reprint request.

REVENUE RECLASSIFICATION
During midnight processing, the system's general ledger component reclassifies revenue and statistics (as will as any statistics applications) whenever affected data, such as financial class or medical service, is revised.

-S-

SIM
Service Item Master. The SIM contains all entries of each department for which a coded order or charge might be placed. The SIM primarily stores information necessary for patient care and charges. See FIM.

STAY OUTLIER
A per diem payment adjustment made on an individual case-by case determination for each covered day of care beyond the LOS outlier threshold associated with a particular DRG. See Day Outlier.

SUB LOCATION
See Account Sub Location.

SUMMARY BILL
A bill which summarizes charge/credit activity which has occurred in the billing cycle. See Detail Statement.

SUSPENSE
Bills which have passed edit and are awaiting system or manual release are assigned the status of suspense. These bills then remain in the Biller Work File until released. Claims which fail edits are held in suspense status until they are released.

SUSPENSE DAYS
The time period assigned to a claim before it can be released. This release is triggered by the Claim Generation Parameter for claims and the Billing Parameters for bills.

SYSTEM-RELEASED
The status assigned to a claim which has been released by the system to the carrier.

-T-

TRANSACTION CODE
The hospital-assigned four-digit alpha code assigned to transactions such as cash and adjustment posting, balance and location transfers and memo notations. Transaction codes record events in account transaction history and the General Ledger, and are associated with broader-based transaction types, which are groupings of transaction codes.

-U-

UB
The standard hospital bill form used by most third-party payors.

UOS
Units of Service. This is not the same as quantity which is the actual number of charges ordered. Units of Service refers to the order itself. For example, an order placed for three aspirin has a UOS of 1 and a quantity of 3.

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■ Reader Comment Form ■

We value your suggestions for improving our documentation. Please use this form to evaluate the *General Information Volume* of the *STAR Financials Patient Accounting Reference Guide* for Release 18.0.

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

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

_____

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Other Comments:

_____

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Thanks for your help in improving the documentation.

Your Name and Position _____

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May we contact you? Yes or No (circle one)

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