



RESOURCE AND PATIENT MANAGEMENT SYSTEM

Accounts Receivable

(BAR)

User Manual

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Preface

The purpose of this manual is to provide you with the information you need to appropriately understand and use the Accounts Receivable (A/R) package. The A/R package is designed to automate the management of accounts receivables, including the setup of sites to function in parent/satellite relationships and effectively handle collection, billing, posting, and reporting activities.

This manual contains reference information about the A/R package, examples of its processes, and procedures by which you can perform the activities supported by the package. This manual also explains the use of standard keyboard functionality, text editing practices, and other assistance provided to you in the A/R package. Step-by-step procedures are provided for setting up a site as a parent and/or satellite facility and establishing its functional relationships with other sites.

Security: The A/R package is secured by access and verify codes assigned by responsible managers to all users that require entry to the system. In addition, selected menu options can only be accessed through entry of an electronic signature.

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1.0 Introduction

The IHS A/R package is a fully functional financial management system developed by the Indian Health Service (IHS). This software interfaces with the RPMS (Resource and Patient Management System) Patient Registration Package and the IHS Third Party Billing System. It operates on computers at IHS or tribal administrative offices. The IHS A/R package complements the I/T/U goal of collecting monies from third party payers like Medicare/Medicaid and private insurance companies for services rendered at IHS hospitals and clinics and at tribal 638 facilities.

With A/R you can send out bills and track them until they are paid-in-full, adjusted or written-off. You can use the system to compile collection data efficiently. This software makes it possible to set up patient, vendor, insurer, and general ledger accounts.

Managers who are responsible for setting up the system are able to establish parent facilities along with satellite facilities, set up collection points, set up collection point parameters, establish accounts, and enable the parent facilities to receive funds, do the posting, and follow up on accounts for their respective satellite facilities.

IHS Offices have the responsibility of setting up the A/R package and configuring the system by establishing which facilities will serve as parent facilities and which ones will be designated as satellite facilities. Because each IHS facility is different, each area office sets up its own database based on the above configuration. A/R site managers have the responsibility of entering users onto the system. They assign user access levels and approval authorities to those personnel who will be responsible for electronically “signing off” on final batch reports. System setup requires that the area business office coordinator and other executive level staff to work closely together to determine the database and structure for the facility.

Because the A/R package contains computer conventions similar to other Kernel-based RPMS software packages such as ARMS, FileMan and MailMan, users familiar with those computer programs find the A/R package easy to use. You will quickly become familiar with the system’s many standard functions and features.

Please read this manual carefully. It provides step-by-step instructions on the process and tracking of IHS accounts receivable documents.

2.0 Getting Starting

2.1 Security and User Identification

Site managers are responsible for assigning access and verification codes to everyone selected to have entry to the A/R package. These codes serve several functions. It is very important to insure that only authorized individuals access confidential information stored in the system. **NEVER REVEAL YOUR ACCESS CODE TO ANYONE ELSE.** If you believe someone else is using your access code to gain unauthorized entry to the system, inform your supervisor.

Another function of your access code is for easy identification. This makes it easy for the system to take you directly to menus you normally work with.

2.2 Starting Up

If your terminal is a Wyse Video Display Terminal, turn it on using the rocker switch on the base of the monitor. To locate the switch, look near the front right-hand side on the base.

2.3 Login/Logout Procedures

If nothing appears on your screen when you turn on your terminal, press the Return key. Within a few seconds, the following prompt should appear on the screen: (Site Name) Login:

1. The system is prompting you for your UNIX login code provided to you by your Site manager. Type your code and press the Return key.
2. The "Access Code:" prompt will be displayed. The system is prompting for your access code. Type your access code and press the Return key.
3. Note that as you type, nothing appears on the screen. This is to prevent anyone from learning your access code by watching you log onto the system.
4. After you press the Return key, the system will display the "Verify Code:" prompt. The system requires you to enter your verification code. Type your verification code and press the Return key. After a few seconds, one of the A/R menus will appear on the screen. If an unfamiliar menu appears on your screen, contact your supervisor or Site manager at once. The Site manager controls login procedures and access to the system, thus insuring that only authorized personnel gain entry to the system.

5. When the menu appears, make sure the keyboard is in the caps lock position. Do this by making sure that the word *lock* appears at the top of the screen. If it is not present on the screen, press the Caps Lock key.

2.4 Standards And Conventions

The Resource and Patient Management System (RPMS) has established certain terms and operating procedures (conventions) for A/R. The following is a brief discussion on those conventions, knowledge of which will enable you to learn how to use the system quickly. As you read the following explanations, refer to your keyboard. This will insure that you have correctly identified each of the keys and command functions. Refer also to the User Assistance option on the A/R Master Menu for more instructions in editing your work and other valuable information. (section 13.0)

2.4.1 Keyboard Entry

The keyboard has two main sections. The first section contains a keyboard similar to a ten-key adding machine. This section makes up the right end of the keyboard. The left section of the keyboard resembles a typewriter keyboard with the addition of several special keys and symbols. It is this section and its special keys that you will use.

When entering numbers, you may use either the numeric keys at the right end of the main keyboard or the numeric keys on the top of the typewriter-like keyboard.

If you type an incorrect response, the system beeps to alert you to the error. A message following the beep shows the type of error. Another message displays to request the correct information.

2.4.2 Use Capital Letters Only

When entering data onto the system, make sure you type all letters and words in CAPITAL LETTERS. Set up your terminal to type only capital letters. Do this by pressing down the Caps Lock key. This will limit all entries to capital letters only. Note that the Caps Lock key has no effect on the numeric keys. It affects only the letters a-z.

2.4.3 Key Usage

Return/Enter Key: Press the Return key to show the end of an entry such as a number or a word. Press the Return key each time you respond to a computer prompt. If you want to return to the previous screen, simply press the Return key without entering a response. This will take you back to the previous menu screen.

Note: The Return key on some keyboards is marked as the Enter key. Whenever you see [RET] or the Return key, press the Return or Enter key.

Backspace Key: The Backspace key allows you to move the cursor backwards (to the left). It deletes or erases characters as you backspace.

Space Bar: Use the Space bar to tell the system to reuse a previous response. For example, when you are prompted to make a selection from a menu of choices, press the Space bar and the Return key. This causes the system to reuse the last selection you made.

The Caret: Use the caret (^), also known as the up-hat, a special control character, to exit from a particular activity or data entry sequence. Typing the caret at any prompt will usually take you back to the preceding prompt or menu level. Use the caret also to exit from long data displays such as vendor lists that usually involve many screens.

Use the caret by pressing the Shift key+6 located at the top of the typewriter keyboard. Note that pressing the Shift key+6 on the adding machine-like keypad will not create a ^ character.

Hold Screen Key: Use the Hold Screen key to halt the display of data on your terminal screen temporarily. This key is labeled F1 and is located in the upper left corner of the keyboard. Pressing the key once will halt the display, allowing you to read the information on the screen. Pressing it a second time will resume the scrolling of the data. This key is useful when reviewing a long list of data. Never leave your terminal with the Hold Screen key in hold position.

In some modules, the display terminal will beep and stop when information comes on the screen. To continue to the next screen of information, you must press the Return key. To stop, type a caret (^) and press the Return key.

Notice that the Break key is not used in the RPMS system.

Special Delete Character: Use the “at” symbol (@) to delete an existing entry in a file. To type the @ symbol, press Shift key+2 at the top of the keyboard. Type the @ symbol after selecting the record you wish to delete or when positioned at a specific field that you wish to delete. The system prohibits deletion of certain records or deletion of data contained in certain fields.

2.4.4 Text Editing

Certain A/R data entry fields use the FileMan Text editor. An example of such a data entry field is the item description portion of the requisition form. Use FileMan Text Editor conventions to enter new data or change the data contained in such fields.

Of specific interest is the "Replace...With" convention that allows you to replace letters, words, or a *string* of words in a field. To permit you to change a part of a text string, the system displays a prompt that contains the current value. This is followed by a prompt where you can type changes. Refer to the following example.

```
NAME: JOHN JACOB JINGLEHAEMER SMITH
REPLACE:
```

Type the replacement text after the "Replace:" prompt. In this example, the entry would be as follows:

```
NAME: JOHN JACOB JINGLEHAEMER SMITH
REPLACE: AE
```

The system responds with a prompt for replacing the string:

```
REPLACE: AE WITH EI
```

The system then displays the corrected data.

```
NAME: JOHN JACOB JINGLEHEIMER SMITH
```

Pressing the Return key at the Replace prompt ends the correction process.

2.4.5 Text Replacement Conventions

Text replacement conventions are as follows:

- Character sequences may be one or more characters long. For example, consider the following: **ABC...XYZ** means the string beginning with the character sequence **ABC** and ending with the character sequence **XYZ**.
- **ABC...** means the string beginning with the character sequence **ABC** and ending at the end of the line.
- **...XYZ** means the string beginning at the start of the line and ending with the sequence **XYZ**.
- **... (ellipsis)** means replace the entire line.
- **END** means add text at the end of existing text.

Note: The replacement text may be blank, which has the effect of erasing specified text. Type a questions mark (?) for online help with the Replace With function.

2.4.6 Using the Help Display

Special help displays are available for most menu options and data entry prompts. Typing a single question mark (?) at the data entry prompt produces instructions for entering requested data. Typing two question marks (??) causes the system to display a more complete message. Some prompts display a list of available choices.

When choosing from a menu of options, type three question marks (???) after the prompts to bring up a brief explanation on how to respond to each option. The typing of a single question mark (?) followed by the option number or name causes the system to display a detailed description of that particular option. This only occurs if help screens are available.

2.4.7 Previous and Default Responses

Some computer prompts display either a single slash (/) or a double slash (//) at the end. When you see a single slash, type a new response or type a response previously accepted by the system. Press the Space Bar once to enter a previously accepted response, if the prompt will accept it. Names or dates are examples of responses entered through this method to save time in data entry.

If a prompt contains a default value and a double slash, accept the default value by pressing the Return key. For example, when prompted to respond to a Yes or No question, you might see the following display: DO YOU WISH TO CONTINUE? YES//. To accept *Yes* as your answer, press the Return key. If you want to enter a *No* response, you must type N and then press the Return key.

2.4.8 Time And Date Conventions

When a system prompt calls for an entry involving a specific date or time, you may enter the information in several ways:

Date: Type a T at a date prompt and the system will use the current date. Typing T with a plus sign (+) or a minus sign (-) followed by a number causes the system to use today's date plus or minus the indicated number of days. For example, if today's date is May 20, 2003, typing T-10 would cause the system to use the date of May 10, 2003.

You may enter dates several ways. To enter May 20, 2003 you may use: 20 May, 2003, 05/20/03 or 05-20-03. Select one style of date entry and use it consistently. Choose the form that you find easiest to use.

Time: You also may enter time in several ways. Unless otherwise shown, the system assumes that all times fall between the hours of 6:00 a.m. and 6:00 p.m. For example, if you type 3 at the time prompt, the system automatically converts this to 3:00 p.m. The typing of a 9 becomes 9:00 a.m. If you need to enter a time such as 9:00 p.m., you must type the entire entry.

Date/Time: You may enter any valid combinations of date and time by using the above convention with an @ symbol between the date and time. For example, if the current date was May 20, 2004 and you wanted to make an entry using that date and a time of 3:00 p.m., you could enter the information in any of the following ways:

- 5/20/04 @ 3
- 052004 @ 3:00 PM
- T @ 3:00

2.4.9 Clinic and Visit Options

Throughout this document you are asked to enter the codes for clinics or visit types. Instead of providing a list of these options each time the system prompt appears, this section includes these lists.

2.4.9.1 Clinic Codes

Table 2-1 lists the codes used for the various IHS clinics. This list is alphabetical, and reads left to right, instead of top to bottom.

Table 2-1. Clinic Codes

CLINIC	CODE	CLINIC	CODE	CLINIC	CODE
Alcohol & Substance Abuse	43	Audiology	35	Cancer Chemotherapy	62
Cancer Screening	58	Cardiology	02	Case Management Services	77
Cast Room	55	Chart Review/Record Mo	52	Chest/Tb	03
Chronic Disease	50	Colposcopy	C3	Computed Tomography	71
Crippled Children	04	Day Surgery	44	Day Treatment Program	82
Dental	56	Dental (Third Party)	99	Dermatology	05
Developmental Assessment	61	Diabetes Education-Group	98	Diabetes Education-Individual	A1
Diabetic	06	Diabetic Foot Clinic	B7	Dialysis	92
Dietary	67	Education Classes	60	Emergency Medicine	30
Employee Health Unit	68	Endocrinology	69	Ent	07
Epsdt	57	Evening	89	Family Planning	08
Family Practice	28	Fetal Alcohol Syndrome	47	Follow-Up Letter	53
Gastroenterology-Hepatology	B8	General	01	General Preventive	27
Genetics	73	Group Services	09	Gynecology	10
High Risk	26	Home Care	11	Hypertension	31
Immunization	12	Indirect	41	Infant Stimulation	40

CLINIC	CODE	CLINIC	CODE	CLINIC	CODE
Internal Medicine	13	Labor And Delivery	83	Laboratory Services	76
Mail	42	Mammography	72	Medical Social Services	48
Men's Health Screening	81	Mental Health	14	Nephrology	49
Neurology	37	Neurosurgery	C1	Nih Clinic	46
Obesity	15	Observation	87	Obstetrics	16
Occupational Therapy	93	Oncology-Hematology	B9	Ophthalmology	17
Optometry	18	Orthopedic	19	Otc Medications	78
Other	25	Pain Management	84	Pediatric	20
Pharmacy	39	Phn Clinic Visit	45	Physical Therapy	34
Plastic Surgery	29	Podiatry	65	Postpartum	32
Pulmonology	C2	Radio Call	54	Radiology	63
Rehabilitation	21	Respiratory Care	33	Retinopathy	64
Rheumatology	38	Sands(Stop Ather Natv Dia Stdy	3	School	22
Speech Pathology	74	Sports Medicine	88	Std	59
Surgical	23	Teen Clinic	85	Telemedicin	90
Telephone Call	51	Teleradiology	91	Tobacco Cessation Clinic	94
Traditional Medicine	86	Triage	79	Ultrasound	66
Urgent Care	80	Urology	75	Well Child	24
Wic	36	Wisewoman	B4	Women's Health Screening	70

2.4.9.2 Visit Codes

Table 2-2 lists the codes used for the various IHS clinics. IHS clinics also have the option to enter local visit type codes so this list may vary based on your facility.

Table 2-2. Visit Codes

Code	Visit Type
11	EPSDT
111	INPATIENT
121	ANCILLARY (MCR PART B ONLY)
131	OUTPATIENT
831	AMBULATORY SURGERY
901	Pharmacy POS

Code	Visit Type
990	MEDICAL/SURGICAL
991	ACCOMMODATIONS
992	ANESTHESIA
993	MEDICAL SUPPLY
994	OPTOMETRY
995	RADIOLOGY
996	LABORATORY
997	PHARMACY
998	DENTAL
999	PROFESSIONAL COMPONENT

3.0 Required Setup

Before the A/R package can be fully operational for users at a particular facility, the system must be set up. Complete the following eight steps using the menu options indicated for each. These steps are described in detail in their corresponding menu sections

Step 1: Establish the Identity of the Parent Facility

Refer to the Parent Facility Selection (PFS) section in the Manager Menu section 7.1 for instructions on establishing the identity of a parent facility either as a standalone parent or as one of several on the same central machine/CPU.

Step 2: Add a Location as a Parent Facility

Refer to the Parent Facility Addition (PFA) section in the Manager Menu section 7.2 for instructions on adding a location as a parent facility in order to access its existing files and set up your own files and accounts.

Step 3: Identify Users as Business or Fiscal Office persons

Refer to the Switch Service/Section (SVC) section of the A/R Master Menu section 12.0 for instructions on identifying a user(s) as either a *business office person* or a *fiscal office person*.

Step 4: Establish Relationships Between the Parent and Satellite Facilities

Refer to the Parent/Satellite Edit (PSE) section in the Manager Menu section 7.3 for instructions on identifying the functions of each type of facility.

Step 5: Identify Parent/Satellite Relationships Among Other Facilities

Refer to the Site Parameter Edit (SPE) section in the Manager Menu section 7.4 for instructions on indicating Parent/Satellite relationships between your facility and other facilities.

Step 6: Set up A/R Accounts for Tracking of Billing and Collections

Refer to the A/R Account Entry (ACE) section in the Manager Menu section 7.5 for instructions on setting up the A/R accounts in the new location.

Step 7: Set up Collection Points

Refer to the Collection Point Edit (CPE) section in the Manager Menu 7.6 section for instructions on setting up the physical locations where collections are received and accounted for.

Step 8: Pull Existing Bills From Third Party Billing

Refer to the Upload 3P Bills by Approval Date (UPAP) section in the Manager Menu section 7.7 for instructions on uploading bills by approval date or the Upload from Third Party Bill File (UPL) section of the A/R Master Menu section for uploading bills one at a time.

<p>Note: You must complete all eight (8) steps of the system setup for BAR 1.8 to work properly.</p>

Section Help

In addition to the sections in this manual referred to above in each step, refer also to help for specifics on each of these procedures. To access Help, type ? followed by the abbreviation for the option at the menu prompt. For example, type ?PSE to access the help screen on Parent/Satellite Edit.

4.0 Account Management Menu (ACM)

The Accounts Management menu is added to conform to HIPAA regulations regarding Electronic Data Interchange (EDI). HIPAA standardization 276 requires that claim status requests are sent to payers in a specific electronic format. HIPAA standardization 277 requires that claim status inquiry responses are sent back to providers in a specific electronic format.

Through the Accounts Management menu and submenus, you will be able to send a Claim Status Request (CSI) (276) and receive a Claim Status Inquiry Response (CSR) (277) from all EDI payers that are set up in the Site Parameter Edit option (section 7.4).

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Account Management Menu                       +
|          UNSPECIFIED SERVICE UNIT                     |
+-----+
User: USER,GRETA          BUSINESS OFFICE          21-JUL-2004 3:11 PM

CSI   Claim Status Inquiry (276)
CSR   Claim Status Response Inquiry (277)

Select Account Management Menu Option:

```

Figure 4-1: Account management menu

4.1 Claim Status Inquiry (276) (CSI)

Use this option to request a status on an outstanding claim from an EDI payer.

To request a claim status, follow these steps:

1. Type ACM at the “Select A/R Master Menu Option:” prompt.
2. Type CSI at the “Select Account Management Menu Option:” prompt.
3. Select a bill by bill number (3a), patient name (3b), or date of service (3c).
 - a. To run an inquiry using the A/R Bill/IHS IEN, type the A/R Bill/IHS IEN, Bill Number, A/R Account Number, or other bill identifier at the “Select A/R Bill/IHS Bill Number:” prompt.

```

.0          +-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Claim Status Inquiry (276)                   +
|          DEMO HEALTH CENTER                           |
+-----+
User: DEMO,USER          BUSINESS OFFICE          3-OCT-2002 8:38 AM

```

```

*****
*
* NOTE: Not all insurers may be participating in the Claim Status Inquiry.
*
*       Check your EDI PAYER LIST (SPE) for a complete list of insurers.
*
*****
*
Select A/R BILL/IHS BILL NUMBER: 123
    
```

Figure 4-2: Inquiring on Claim Status (step 3a)

- b. To run an inquiry using the patient name, press the Return key at the “Select A/R Bill/IHS Bill Number:” prompt. Type the patient’s name at the “Select Patient Name:” prompt. Type the beginning date at the “Select Beginning Date:” prompt then press the Return key. Type the ending date at the “Select Ending Date:” prompt. Choose a claim and type the line number of that claim at the “Line #:” prompt.

```

Select PATIENT NAME: PATIENT, DEMO
Select Beginning Date: 12 SEP 2002//T-365 (OCT 03, 2001)
Select Ending Date: 3 OCT 2001//T (OCT 03, 2002)

Claims for PATIENT, DEMO from 10/03/2001 to 10/03/2002           Page: 1

Line #  DOS      Claim #      Amount      Billed To      Balance
-----
1  11/19/2001  m 742-AH-0000  158.00      MUTUAL OF OMAHA  158.00
3  12/01/2001  m 744A-AH-0000  124.00      DELTA DENTAL OF NEW MEX -124.00
4  12/01/2001  m 744B-AH-0000   64.00      DELTA DENTAL OF NEW MEX   64.00
5  02/25/2002  m 785A-AH-0000  126.00      UNITED HEALTHCARE  126.00
2  11/28/2001  m 757A-AH-0000  476.00      CALIFORNIA CASUALTY GRP  476.00
7  05/06/2002  m 881A-AH-0000  177.00      CALIFORNIA CASUALTY GRP  177.00
8  05/06/2002  m 881B-AH-0000  177.00      CALIFORNIA CASUALTY GRP  177.00
9  05/06/2002  m 881C-AH-0000  177.00      CALIFORNIA CASUALTY GRP  177.00
10 05/06/2002  m 881D-AH-0000  177.00      CALIFORNIA CASUALTY GRP  177.00
13 06/19/2002  m 905-AH-0000  400.00      MUTUAL OF OMAHA  400.00
11 06/16/2002  m 904A-AH-0000   85.00      UNITED HEALTHCARE   85.00
12 06/16/2002  m 906A-AH-0000   10.00      CAREMARK (RX)      10.00

6  03/20/2002  m 837A-AH-0000   85.00      PATIENT, DEMO      85.00

Line #: 13
    
```

Figure 4-3 Inquiring on Claim Status (step 3b)

- c. To run an inquiry using a date of service, press the Return key at the “Select Patient Name:” prompt. Type the date of service at the “Select Bill DOS:” prompt.

```

Select A/R BILL/IHS BILL NUMBER: [RET]
Select PATIENT NAME: [RET]
    
```

```
Select Bill DOS: T
```

Figure 4-4: Inquiring on Claim status by DOS (step 3c)

- At the “Do you wish to send this bill for status to Practice Insurance?” prompt (the prompt will change to show the name of the patient’s insurance), type Y to send for claim status inquiry, or type N to return to the “Select A/R Bill/IHS Bill Number:” prompt.

```
Patient: PATIENT, DEMO [3644]          Bill: 000-AH-1234
A/R Account: MUTUAL OF OMAHA          Bill Status: BILLED

Visit Date   Visit Type           Date Billed   Amount Billed   Current Balance
-----
06/19/2002   EMERGENCY ROOM       07/17/2002   400.00          400.00

Do you wish to send this bill for status to Practice Insurance? Y
```

Figure 4-5: Inquiring on Claim Status (step 4)

4.2 Claim Status Requests (CSI) Error Messages

Error Message 1: Not an EDI Payer

If you receive the message in Figure 4-6, the payer is not set up as a HIPAA compliant EDI payer and cannot receive the 276 format. If you know that the insurance company in question is 276 compliant, contact your site manager to add the company as an EDI payer.

```
Patient: PATIENT, DAVE [35202]        Bill: 00007A-JSU
A/R Account: MEDICAID PRESBYTERIAN    Bill Status: COMPLETED

Visit Date   Visit Type           Date Billed   Amount Billed   Current Balance
-----
10/21/1998   OUTPATIENT           10/30/1998   105.00          0.00

**UNABLE TO REQUEST CLAIM STATUS FOR THIS BILL**
**MEDICAID PRESBYTERIAN is not in the EDI PAYER LIST.**
**Please check Site Parameters.**

Select A/R BILL/IHS BILL NUMBER:
```

Figure 4-6: Inquiring on Claim Status Error Message 1

Error Message 2: Not an Insurer

If you receive the message in Figure 4-7, the information listed in the insurance section of the patient’s file is not identified as an insurance company, and a claim status inquiry cannot be sent.

```
Patient: PATIENT, DEMO [3644]        Bill: 837A-AH-3644
A/R Account: PATIENT, DEMO           Bill Status: CANCELLED
```

Visit Date	Visit Type	Date Billed	Amount Billed	Current Balance
03/20/2002	DENTAL	08/30/2002	85.00	85.00
UNABLE TO REQUEST CLAIM STATUS FOR THIS BILL **PATIENT, DEMO is not an Insurer.**				
Select A/R BILL/IHS BILL NUMBER:				

Figure 4-7: Inquiring on Claim Status Error Message 2

Error Message 3: Not a Positive Balance

If you receive the message in Figure 4-8, the listed claim does not have an open balance. You will only want to send this request under special circumstances.

Patient: PATIENT, RENEE [6484]		Bill: 006A-AH-6484		
A/R Account: UNITED HEALTHCARE		Bill Status: PARTIAL PAYMENT		
Visit Date	Visit Type	Date Billed	Amount Billed	Current Balance
06/24/2002	OUTPATIENT	10/03/2002	23.26	0.00
NOTE: 006A-AH-6484 does NOT have a positive balance.				
Do you wish to send this bill for status to UNITED HEALTHCARE? Yes//				

Figure 4-8: Inquiring on Claim Status Error Message 3

Error Message 4: Unable to Process

If you receive the message in Figure 4-9, GIS is not operational. Contact your Site manager for assistance.

Patient: PATIENT, DEMO [3644]		Bill: 005-AH-3644		
A/R Account: MUTUAL OF OMAHA		Bill Status: BILLED		
Visit Date	Visit Type	Date Billed	Amount Billed	Current Balance
06/19/2002	EMERGENCY ROOM	07/17/2002	400.00	400.00
Do you wish to send this bill for status to MUTUAL OF OMAHA? Yes// YES				
*****UNABLE TO PROCESS REQUEST FOR 005-AH-3644 ***** *****GIS TRIGGER EVENT NOT IN PLACE*****				
Select A/R BILL/IHS BILL NUMBER:				

Figure 4-9: Inquiring on Claim Status Error Message 4

4.3 Claim Status Response Inquiry (277)

Use this option to review an insurer's response to your claim status inquiry.

To review an insurer's response, follow these steps:

1. To access the Claim Status Response Inquiry option, type ACM at the "Select A/R Master Menu Option:" prompt (**Error! Reference source not found.**).
2. Type CSR at the "Select Account Management Menu Option:" prompt.
3. If you want to review all received responses, type Y at the "Do you wish to look at all responses?" prompt.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Claim Status Response Inquiry (277)           +
|           DEMO HEALTH CENTER                             |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: DEMO,USER           BUSINESS OFFICE           1-OCT-2002 2:29 PM

Do you wish to look at all responses? Y

```

Figure 4-10: Checking on Claim Status Inquiry Response (step 3)

4. If you only want to look at a specific entry, type N at the "Do you wish to look at all responses?" prompt. Type the A/R EDI claim status trace number at the "Lookup which Entry:" prompt, or type a question mark (?) to view a list of available selections.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Claim Status Response Inquiry (277)           +
|           DEMO HOSPITAL                                 |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: DEMO,USER           BUSINESS OFFICE           4-OCT-2002 12:27 PM
Do you wish to look at all responses? N
Lookup which Entry: ?

Choose from:
  1
  2
  3
  4
  5
  6
  7

Lookup which Entry: 1

```

Figure 4-11: Checking on Claim Status Inquiry Response (step 4)

5. The Browser Output screen will display the claim status inquiry responses that you selected. A list of options will be displayed at the bottom of the screen.

OUTPUT BROWSER	Oct 04, 2002 12:26:58	Page: 1 of 1
----------------	-----------------------	--------------

```
TRACE NUMBER: 1                                A/R BILL: 004A-AH-1072
A/R DUZ(2): 1546                               REQUEST DATE: OCT 02, 2002
PAYER ID # ON REQUEST: 400

          Enter ?? for more actions                                >>>
+   Next Screen
-   Previous Screen
D   Delete Entry
Q   Quit
Select Action:
```

Figure 4-12: Checking on Claim Status Inquiry Response (step 5)

5.0 Collection Menu (COL)

This Master Menu option provides a menu that supports collection entry, tabulation, accounting, management, and reporting of all funds received at your facility. This portion of the A/R Software package is used by the designated collection clerk. This module was designed to provide a more efficient and accurate way of handling the following functions:

- Recording and managing all funds received
- Establishing accountability and responsibility
- Reporting collections/distribution for different facilities
- Depositing and Reconciling
- Managing Accounts

To select the Collection menu, type COL at the “Select A/R Master Menu Option:” prompt.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
|                   Collection Menu                       |
|                   UNSPECIFIED SERVICE UNIT              |
+-----+
User: USER,GRETA                BUSINESS OFFICE        21-JUL-2004 3:12 PM

EN   Collections Entry
CR   Collections Reports ...
CPS  Check Posting Summary

Select Collection Menu Option:

```

Figure 5-1: Collection menu

The Collections menu will be displayed. Sections 5.1 through 5.1.7 explain each option. Sections 5.1 through 5.3 will explain how to use each option in the Collection menu.

5.1 Collections Entry (EN)

Use this option to enter collection data into the A/R package. This data then supports the documentation and accountability of all funds received for payment or reimbursement for services provided at your facility as well as denials. It also assists in the deposit and reconciliation process.

- Type of payment (cash, credit card, EOB check, and personal checks) maintain their identity for management purposes.
- An audit trail is created and started at this point of the A/R process.

- Collection Batches are established. A Collection Batch is the receipt of all transactions that occurred in a given time period (usually a day), for a given collection point, by a specific user. These batches are used to maintain an audit trail during the posting process (see the Posting Menu, section 9.0) as well as assisting management in workload and productivity statistics.
- A Batch Identification number consists of the Collection Point Name-today's date-sequence number. Example: Business Office-05/01/2005-1. This example batch was created by the Business Office Collection Point on May 1, 192005 and was the first (1st) batch for that day.
- Each transaction (entry) has a corresponding Item number to be used in posting.
- The system allows a user to split one check between facilities. The Site Parameter Edit must be flagged *yes* to allow this to happen. (See the Site Parameters menu in section 7.4 for this option.)

To access the Collections Entry option, type EN at the “Select Collection Menu Option:” prompt at the Collection menu.

5.1.1 Internal Controls

The following functionality has been incorporated to establish Internal Control measures:

- Electronic Signatures are required to enter this phase of A/R data entry.
- Only one Collection Batch per Collection Point can be open at one time. You must put your batch in Review status in order to open another Batch.
- Once the data is entered and reviewed, the final step is finalizing the batch. Once finalized, you cannot edit the batch or delete the batch. It is important for the end user to follow the process of reviewing the batch so that errors will not be finalized on the batch.

5.1.2 Entry Process

The process for entering EOB checks differs from entering other types of payment (cash, credit card, personal check). Use the correct process (Process 1 for EOB or Process 2 for all others) as described below to assist in data entry.

5.1.2.1 Process 1

Use the following process to enter All EOB collection data:

1. Type your electronic signature code at the “Enter your Current Signature Code:” prompt.

2. Type the name of a collection point at the “Select A/R Collection Point/IHS Name:” prompt. The system assigns a batch identification at the top of the screen and you can exit by typing the caret (^).
3. Type the payment type (see section 5.1.3). In this case, type EOB CHECK or 51.
4. Type the number or name of the Payer as it exists in the system (see 5.1.4 below).
5. Type the check number shown on the Payer’s check. It must be 3-30 characters long.
6. Type the payment amount. In SPE, if specific questions were flagged as *Yes*, the system prompts for responses. Type in the appropriate response to each question. If your facility serves multiple locations, the system displays CR=amount BAL=amount Select Location? (see Multiple Facilities, section 5.1.6 below.)
7. Distribute the credit amount by typing each facility (by suffix or name) and the appropriate amount belonging to that facility. The system retains a balance so you know how much is still not distributed (see Undistributed Funds, section 5.1.6 below).
8. When the system displays the transaction that you just entered, select from among the following three options: (see Edit/Cancel with Audit, section 5.1.7 below.)
 - E** = Edit without an audit trail: make changes at each prompt as required. If you change the dollar amount, change the distribution between multiple facilities as well.
 - D** = Delete the entire entry and start over: the system displays the “Check Number:” prompt for re-entry of your transaction.
 - C** = Continue to next item number: the system displays the “Check Number:” prompt for the next item number.
9. Repeat steps 1-8 until all transactions are entered. To exit this batch, type the caret (^) twice at the “Check Number:” prompt.
10. Select one of the following:
 - A** = To add another entry to the batch: repeat from Step 2.
 - M** = For more questions
 - E** = To edit entries (with an audit)
 - Q** = To exit: return to Collections Menu.

5.1.2.2 Process 2

Use this process to enter all Other Payment Types (cash, credit cards, personal checks) collection data:

1. Type your electronic signature code at the “Enter your Current Signature Code:” prompt.
2. Type the name of a collection point at the “Select A/R Collection Point/IHS Name:” prompt. The system assigns a batch identification at the top of the screen and you can exit by typing the caret (^).
3. When prompted, select the Payment Type.
4. If payment is by personal check, type in the check number then type in the amount of the payment or credit.
5. At the A/R Account prompt, type the name of the entity or individual responsible for payment (the name you billed for services rendered).
6. At the “Visit Location:” prompt, type in the location where the payment should be distributed. Use its full name or suffix.
7. At the “Payer:” prompt, type the name of the individual or entity you actually received the payment from or just press the Return key to accept the name you entered earlier.
8. At the “Auto Print Receipt:” prompt, type Y or press the Return key to accept the default of N. The response allows a receipt to be printed for each individual transaction.
9. At the “Comments:” prompt, type any comments and press the Return key, then press the Return key at the “Re-Edit Item?” prompt to continue or type YES at this prompt to edit individual entries in this transaction. The system returns to Step 1 for entry of more payments.
10. Type the caret (^) and Q (Quit) to end the session.

Notes:

1. When you are continually entering EOBs, the Payer remains the same from item to item and can be changed using the caret (^) when necessary.
2. When you are continually entering cash, credit cards, or personal checks, the system holds all data (default to) entered in the previous transaction. Make sure to change the fields when necessary.

5.1.3 Payment Type

The Payment Type can be described as the actual form of payment received at the facility for reimbursement for services rendered. To obtain a list of payment types available, type ?? at the prompt and the following list is displayed:

51	EOB Check
52	Cash
53	Credit Card
81	Personal Check
99	General Ledger

Figure 5-2: Displaying a list of payment types

The different payment types are briefly described below:

- **EOB Check** - That payment that is received usually from an insurance company for the reimbursement for services rendered and is accompanied by an Explanation of Benefits.
- **Cash** – A Cash payment.
- **Credit Card** – A credit card payment.
- **Personal Check** - The check received by individuals responsible for payment for services rendered. This payment is not accompanied by an Explanation of Benefit.
- **General Ledger** - Used to manage accounts.

5.1.4 Entering Payers

When the system prompts you to enter a Payer, it is asking for the name of the insurance company or the name of the person who is making the payment. Display a list of Payers for selection by typing ???. The system prompts you to make a selection on the following screen:

```

PAYER: ??

Choose from:
  1          MEDICARE
  2          MEDICAID
  3          NEW MEXICO MEDICAID
 13         NON-BENEFICIARY PATIENT
 14         UNITED HEALTHCARE
 15         ARIZONA MEDICAID
 16         NEW MEXICO BC/BS INC

PAYER: UNITED HEALTHCARE( HEALTHCARE UNITED ).
UNITED HEALTHCARE          - PO BOX 30555
                           SALT LAKE CITY, UT 84130-0555

OK? Y//

```

Figure 5-3: Entering payers

Note: If a payer does not exist, you must add it using the A/R Account Entry function.

5.1.5 More Option

With the More option, you can further identify the collections being made. By flagging these questions *Yes* during the Collection Point Edit, the system automatically asks you to respond to the questions for each transaction. Although you may have flagged these questions *No*, you may want to capture this information on an individual basis. By typing M or More, the system asks these questions for a particular item that you entered. See Collection Point Edit, section 7.6, for detailed explanation of each question.

5.1.6 Multiple Facilities and Undistributed Funds

Multiple Facilities

In the Site Parameter Edit (section 7.4), the Site manager is able to designate their facility as belonging to a group of more than one facility that share a common staff, administration, or duties. The manager also has established parent/satellite relationships between two or more facilities.

During the process of entering funds received into the A/R package, you have the option of distributing the receipt between one or more of those facilities.

For example: You received one check from BC/BS for \$1000 for both ANMC and Barrow (\$500 to each). At Step 7 of Process 1, the system displays:

```
CR=1000 BAL=$1000 Select Location? ANMC
PAID AMOUNT: 1000//500
CR=1000 BAL=$500 Select Location? BARROW
PAID AMOUNT: 500// [RET]
```

Figure 5-4: Using multiple facilities and undistributed funds

Note: The Paid Amount always defaults to the balance remaining to be distributed.

5.1.7 Edit/Cancel with Audit

The system allows you to Edit or Cancel an entry after it has been completely entered. This editing or cancellation creates an audit trail that can be used to manage all activity within the system and to protect against fraudulent activities.

At Step 9 of Process 1, follow these steps:

1. Type E for Edit at the “Select one of the following (E, D, or C):” prompt.
2. Type the item number you want to edit at the “Item:” prompt.

3. Type E for Edit, C for Cancel, or Q for Quit at the “Select one of the following:” prompt.
4. Type a short explanation for the edit or cancellation at the “Error Comments:” prompt.
5. Type Y or N at the “Is this comment correct?” prompt. Typing N will allow you to edit the comment. Edit any other necessary fields.
6. Type Y or N at the “Above is Correct?” prompt. You are prompted to select another item number if necessary.

```

Select one of the following (E,D, or C): E
ITEM: 4
Select one of the following: E
E = Edit with Audit
C = Cancel
Q = Quit

ERROR COMMENTS: [Comment entered here]
Is this comment correct?? YES// Y

ABOVE IS CORRECT?? YES// [RET]
ITEM:

```

Figure 5-5: Editing/canceling with audit

Note: Every time an Edit with Audit or Cancel takes place, the original item number disappears and is not used again. A new transaction is created. Therefore, a new item number corresponds to the changes you made. See the Section on Exception reports.

5.2 Collections Reports (CR)

The Collections Registers (Collections Reports) provide information on cash, credit card, personal checks, and EOB checks (insurance checks) used to make payments against bills. Each Collection Register represents a *batch*. A batch is a collection of payments entered by a single user. There are three different Collection Registers with a reprint option for the Final Report.

To access the Collections Reports menu, type CR at the “Select Collection Menu Option:” prompt at the Collection menu.

The Collection Reports menu will be displayed. A brief description of each report is provided below. A detailed explanation of how to use each report will be provided in sections 5.2.1 through 5.2.4 .

Detailed Report: (DT): This report shows what has been entered into the Collection Batch. This report also puts the batch into review status. When the report is in review status, the document can be edited by each item with an audit trail or someone else may start a batch at the collection point.

Final Report: (FL): This report provides the same information as the Detailed Report along with a receipt letter that will be sent to Finance along with the actual monies. When a batch is finalized, it is put into Postable Status. This allows those monies to be posted against specific bills. When the batch is put is finalized, it cannot be edited.

Exceptions Report (EX): This report provides a display showing the errors that were corrected in Collections Entry. This report shows collections entries that were cancelled or rolled up into other entries.

Collection Report Final Reprint (RFL): This is the same report as Collection Report Final. It is provided to allow the Users to reprint the final report

5.2.1 Collections Report: Detailed (DT)

This report provides the batch name and date, the total collected, the payment type, the name of the A/R account, and the distribution of funds (Location or Undistributed). Upon entering the Collection Batch information, the system asks you if you want to place this batch into review status. Once it is in review status, you have the option to make corrections to this batch or another user may create a different batch. It is strongly recommended that you review your batches with this option to ensure all items and related fields are correct and accurate. During this step, you can have the option to edit the items before finalizing your batch.

To generate a detailed collections report:

1. Type DT (Detailed RPT) at the “Select Reports Option:” prompt.
2. Type the name-date of batch or type ?? to obtain a list of all batches at the “Select A/R Collection Batch/IHS Name:” prompt.
3. Type Y or N at the “Do You Wish to Put this Batch in Review Status?” prompt.
4. Type printer name or H (Home) to print report on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin: 80//” prompt.

```
Select Collections Reports Option: DT  Collection Report Detail
Select A/R COLLECTION BATCH/IHS NAME: NO  FEB 11, 2003@14:33:55N BEN-
09/19/2002-1
DO YOU WISH TO PUT THIS BATCH IN REVIEW STATUS? NO// Y [RET]
DEVICE: HOME  Right Margin: 80// [RET]
```

Figure 5-6: Printing a detailed collections report (steps 1-4)

- The system prints or displays the report. If there are no records to print for the given report, the system will prompt you to put the batch in review status.

DATE:	COLLECTIONS REPORT -- DETAILED				PAGE	1
01/14/03	DEMO HEALTH CENTER					
	BATCH:	PVT INS IPV-01/17/2002-1				
	TOTAL:	10.00				
ITEM	RECEIVED	CHECK #	A/R ACCOUNT	DISTRIBUTION	AMOUNT	
=====						
	PAYMENT TYPE: EOB CHECK					
1	07/31/02	KLDJ	MEDICARE			10.00
			DEMO HEALTH CE	10.00		
SUBTOTAL						10.00
TOTAL						10.00

Figure 5-7: Printing a detailed collections report (step 5)

5.2.2 Collection Report: Final (FL)

This option enables Collections Personnel to print out a Final Collections Report to the Financial Manager. This report provides the batch name and date, and the total amount collected.

This report, illustrated on the next page, details total funds collected and serves as a cover memo to Financial Management officials. There is a space on this document where the Financial Manager may sign to acknowledge receipt of funds.

Note: Once a batch is finalized, editing is no longer possible.

To generate a final collections report:

- Type FL at the “Select Collections Reports Option:” prompt.
- Type the name-date of batch or type ?? to obtain a list of all batches at the “Select A/R Collection Batch/IHS Name:” prompt.
- Type Y to generate the report or press the Return key to accept the default No at the “Are You Sure You Want to Finalize This Batch?” prompt.
- Type printer name or H (Home) to print report on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin: 80//” prompt.

Select Collections Reports Option: **FL** Collection Report Final
 Select A/R COLLECTION BATCH/IHS NAME: ??

5.2.3 Collections Report: Exceptions (EX)

This option enables users to display or print Collections Report Exceptions. Exceptions display the edits that a User has entered when entering the Collection Batch. This report provides the information shown in Figure 5-11.

To generate a collection exception report:

1. Type EX at the “Select Collection Reports Option:” prompt.
2. Type the batch name and date or ?? to select from a list of all batches at the “Select A/R Collection Batch/IHS Name:” prompt.
3. Type printer name or H (Home) to print report on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin: 80//” prompt.

```

Select Collections Reports Option: EX Collection Report Exceptions
Select A/R COLLECTION BATCH/IHS NAME: PVT
  1  PVT INS DENTAL-10/19/2001-1
  2  PVT INS IPV-01/17/2002-1
  3  PVT INS OPV-05/15/2002-1
  4  PVT INS OPV-06/25/2002-1
  5  PVT INS OPV-06/25/2002-2
Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1 PVT INS DENTAL-10/19/2001-1
DEVICE: Home Right Margin: 80// [RET]
    
```

Figure 5-10: Printing collection report exemptions (steps 1-3)

4. The system prints or displays the report.

DATE:	COLLECTIONS REPORT -- EXCEPTIONS	PAGE	1
06/20/00	DEMO HOSPITAL		
	BATCH: AAOBO-05/12/2000-1		
ITEM	RECEIVED	CHECK #	A/R ACCOUNT
			AMOUNT
=====			
STATUS: CANCELED			
1	05/12/00	23739	NEW MEXICO BC/BS INC
	COMMENTS: wrong check information		

Figure 5-11: Printing collection report exemptions (step 4)

5.2.4 Collection Report- Final Reprint (RFL)

This option allows for the End User to Reprint the Final Collection Report in the same format. Refer to the figure in the Collection Report: Final section for a sample.

To display or reprint a final collection report:

1. Type RFL (Collection Report Final) at the “Select Collection Reports Option:” prompt.
2. Type the name-date of batch or type ?? to select from a list of all batches at the “Select A/R Collection Batch/IHS Name:” prompt.
3. Type the name of the device to which you want to print at the “Device:” prompt. You can also press the Return key to display the report onscreen.
4. Press the Return key to accept 80 characters/inch or type a new number at the “Right Margin:” prompt.

```

Select Collections Reports Option: RFL  COLLECTION RPT FINAL REPRINT

Select A/R COLLECTION BATCH/IHS NAME: PVT
  1  PVT INS DENTAL-10/19/2001-1
  2  PVT INS IPV-01/17/2002-1
  3  PVT INS OPV-05/15/2002-1
  4  PVT INS OPV-06/25/2002-1
  5  PVT INS OPV-06/25/2002-2

Press <RETURN> to see more, '^' to exit this list, OR
CHOOSE 1-5: 1  PVT INS DENTAL-10/19/2001-1
DEVICE: HOME   Right Margin: 80//[RET]
    
```

Figure 5-12: Printing the collection report final reprint (steps 1-4)

5. The system prints or displays the report.

DATE:	COLLECTIONS REPORT -- FINAL (REPRINT)	PAGE	1		
01/14/03	DEMO HEALTH CENTER				
	BATCH: PVT INS DENTAL-10/19/2001-1				
	TOTAL: 27.00				
ITEM	RECEIVED	CHECK #	A/R ACCOUNT	DISTRIBUTION	AMOUNT
=====					
	EOB CHECK				
1	10/19/01	309389	DELTA DENTAL OF NEW MEXICO INC		27.00
			DEMO HEALTH CE	27.00	
SUBTOTAL					27.00
TOTAL					27.00

Figure 5-13: Printing the collection report final reprint (step 5)

5.3 Check Posting Summary (CPS)

This option is used to display a listing of patients sorted by check number. The summary lists bills that have been posted and can assist the End User with reviewing the different bills that have already been posted to verify accuracy.

To generate a check posting summary:

1. Type CPS at “Select Collection Menu Option:” prompt.
2. Type the check number or ?? to select from a list at the “Select Check Number:” prompt. The system displays the check information.
3. Press the Return key to accept the check information at the “Correct?” prompt.
4. Type P or B at the “Do You Wish To:” prompt.
5. Type printer name or H (Home) to print report on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin: 80//” prompt.

```

Select Check Number: 1
    1  1457876-655302  MEDICAID OPV-08/16/2002-1
    2  1541857-99.25.12  DEMO-08/31/1999-3
CHOOSE 1-2: 1  MEDICAID OPV-08/16/2002-1
Check No: 1457876-655302 From: NEW MEXICO MEDICAID           For:   7669.91

CORRECT ? YES// [RET]

Select one of the following:

    P          PRINT Output
    B          BROWSE Output on Screen

Do you wish to : P// BROWSE Output on Screen

```

Figure 5-14: Printing a check-posting summary (steps 1-5)

6. The system prints or displays the report.

```

                                Check Posting Summary
MAR 02, 1999, 11:56:24                PAGE: 1
-----
Collection Batch: guestsix-02/04/1999-2 Item Number: 1
Check Number: 1111          Issued By: NEW MEXICO MEDICAID
Check Amount: 336.00        Amount Posted: 0.00          Balance: 0.00
Un-Allocated: 0.00          Refunded: 0.00
Patient Name      Bill Name          DOS          Paid Amt.
CAT, TAN          000A-AH-12266    01/19/1998-01/19/1998    168.00
PATIENT, BEVERLY 00000A-AH-7479   01/01/1998-01/01/1998    168.00
                                TOTALS:          336.00

```

Figure 5-15: Printing a check-posting summary (step 6)

6.0 Debt Collection Menu (DCM)

The Debt Collection Menu options allow the facility to electronically send data on past due accounts to a collection agency. Tasks performed using the options on this menu sends an electronic file of bill information meeting specified criteria to a centralized server at OIT. The OIT Server will in turn send the files to the Transworld collection agency. Note: To have success in using this option, the Business Office will have to process an agreement with Transworld via the purchasing department. Contact the OIT Helpdesk for additional information.

To access the Debt Collection menu, type DCM at the “Select A/R MASTER MENU Option:” prompt. Figure 6-1 shows the available options.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.7          |
+-----+-----+
|          Debt Collection Menu                          |
+-----+-----+
|          UNSPECIFIED SERVICE UNIT                      |
+-----+-----+

User: USER,GRETA          BUSINESS OFFICE          21-JUL-2004 3:13 PM

DCP   Debt Collection Process (TSI)
SPM   Debt Collection Site Parameters
RPM   Restricted Payers Maintenance
DCI   View Debt Collection Site Parameters
REP   Reports ...

Select Debt Collection Menu Option:
    
```

Figure 6-1: Debt collection menu

You must perform the tasks listed as options on the Debt Collection menu in the following order to process and send the necessary files to Transworld:

SPM - Debt Collection Site Parameters (section 6.2)

This option allows you to initially set up and modify existing Site Parameters. You need to set the Site Parameters before performing you can send information to the Collection agency. DCI - View Debt collection Site Parameters (section 0)

DCI - View Debt Collection Site Parameters (section 6.4)

This option displays the contents of the Site Parameters setup so you can verify the Site Parameters before performing any other DCM functions.

RPM - Restricted Payers Maintenance (section 6.3)

The Debt Collection module is set up to send all specified transactions for ALL payers. To limit the payers to send transactions to, this option allows you to select an Insurer to be removed from any transmission to TSI.

DCP - Debt collection Process (section 6.1)

This option allows you to initiate a process that searches the A/R Bill file for accounts that meet user-defined criteria to be sent to Transworld for collections.

REP – Reports (section 6.5)

This option allows you to run various debt collection reports. You can run the reports in section 0 at any time during the Debt Collection process.

6.1 Debt Collection Process (TSI) (DCP)

This option searches the A/R Bill file for accounts that meet criteria you define. This information is then transmitted to Transworld automatically for debt collection using the VA Fileman ZISH SEND parameters. (Note: The Site manager will need to set up the ZISH SEND parameters as specified in the Accounts Receivable Technical Manual version 1.8.)

To search for delinquent accounts, follow these steps:

1. Type DCP at the “Select Debt Collection Menu Option:” prompt.

The screen shown in Figure 6-13 is displayed.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+-----+
|          Debt Collection Process                        |
+-----+-----+
|          NOT-A-REAL FACILITY                          |
+-----+-----+
User: USER,NAME                                     5-OCT-2005 12:56 PM
BUS
NOTE: You must be logged into the facility for which you wish to process
Debt Collection.  You are logged into <facility name>

Continue? Y//
    
```

Figure 6-2: Debt collection process report (steps 1 and 2)

2. Type Y or N at the “Continue?” prompt to verify or change your location.
 - If you type N, you are returned to the Debt Collection Menu.
 - If you type Y, the following message is displayed that lists the last chosen 3P (third-party) Approval date range.

```

The last chosen 3P Approval date range was...
Starting Date: <date>
Ending Date: <date>
    
```

3. Type the new beginning date for the 3P Approval date range at the “Select Beginning Date:” prompt.

4. Type the new ending date for the 3P Approval date range at the “Select Ending Date:” prompt.
5. Type the minimum bill balance amount at the “Enter the Debt Collection Minimum Bill Balance Amount: (20-5000):” prompt.

Note: The minimum amount is \$20 and the maximum is \$5000.
The amount you enter must be within this range.

A message appears that shows you the date range and minimum balance you selected. An example of this message is shown in Figure 6-9.

```
Start Date: 01/01/2004
End Date: 12/31/2004

$$ Limit: 200.00
```

Figure 6-3: Date range and dollar limit message example

6. Type Y or N at the “Do you want to proceed?” prompt.
 - If you type N, you are returned to the Debt Collection Menu.
 - If you type Y, the system searches for records on which to stop and start collections and displays messages that show the number of bills found that match your selection criteria.

Note: If you did not set up the Debt Collection Parameters in the Site Parameters option, the transmission fails and the error message shown in Figure 6-10 is displayed.

```
Creation/Send of file START-INS-0917.141 was unsuccessful.
Missing local directory/recieving system. Please check Debt
Collection Parameters
```

Figure 6-4: Debt collection error message

This completes the procedure for selecting accounts to send to Transworld for processing.

6.2 Debt Collection Site Parameters (SPM)

This option allows you to set and modify Site Parameters. Before you perform any other debt collection functions listed on the DCM, you must set these parameters based on information received from Transworld.

To display and modify the Site Parameters file:

1. Type SPM at the “Select Debt Collection Menu Option:” prompt.

The screen shown in Figure 6-2 is displayed.


```

Select Debt Collection Menu Option: SPM Debt Collection Site Parameters

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +-----+ Debt Collection Site Parameters +-----+
      |          UNSPECIFIED SERVICE UNIT                     |
      +-----+
User: USER,NAME          BUSINESS OFFICE          20-MAY-2004 9:18 AM

Select A/R SITE PARAMETER/IHS RPMS SITE: UNSPECIFIED SERVICE UNIT    NM
HEADQUARTERS WEST          01
...OK? Yes// Y

EXTRACT DIRECTORY: /usr/spool/BBM/xmit/ Replace
REPORT DIRECTORY: /usr/spool/BBM/REPORTS/ Replace
TSI INSURANCE CLIENT NUMBER: 1575A// [RET]
MAXIMUM INSURANCE TRANSACTIONS: 800// [RET]
TSI SELF PAY CLIENT NUMBER: [RET]
MINIMUM PRINCIPLE AMOUNT: [RET]
EARLIEST DATE TO SEARCH: JAN 1,2001// [RET]
MINIMUM BILL AGE DAYS: 90// [RET]
EARLIEST DOS ALLOWED: JAN 1,2001// [RET]

RUN AUTO PROCESS?: Y
START DATE USED AUTO: 05/01/2004

```

Figure 6-5: Debt collection site parameters sample

2. Type the name of the site you want to use as your default site at the “Select A/R SITE PARAMETER/IHS RPMS SITE:” prompt. Type ?? to view a list of sites.
3. Type Y or N at the “...OK?” prompt to confirm your site choice.
 - If you type Y, go to step 4.
 - If you type N, you are returned to step 2.
4. Type the path name of the directory where you want to send extracted debt information at the “EXTRACT DIRECTORY:” prompt or press the Return key to accept the current directory. This directory will need to be coordinated with your local Sitemanager.
5. Type the path name of the directory where you want debt collection reports sent at the “REPORT DIRECTORY:” prompt or press the Return key to accept the current directory.
6. Type the client number at the “TSI INSURANCE CLIENT NUMBER:” prompt or press the Return key to accept the current client number.

This is the client number assigned to the facility by Transworld for processing to Transworld and ultimately sending collections letters to payers (insurance companies).

7. Type the number of maximum of transactions at the “MAXIMUM INSURANCE TRANSACTIONS:” prompt or press the Return key to accept the current number.

This number is based on the total number of transactions that are noted on the facility Purchase Order. You can find this number in the facilities purchase order with Transworld.

Once this number is entered into A/R, the system will recognize when the maximum number is met and files will not be created for transmission to Transworld.

8. Type the self-pay number at the “TSI SELF PAY CLIENT NUMBER:” prompt or press the Return key to accept the current number.

This is the client number assigned to the facility for sending collections letters to non-beneficiary patients (self pay).

9. Type the maximum number of self-pay transactions at the “MAXIMUM SELF PAY TRANSACTIONS:” prompt or press the Return key to accept the current number.

If this prompt does not appear, go to step 10.

10. Type the dollar amount between 10 and 1000 at the “MINIMUM PRINCIPLE AMOUNT:” prompt or press the Return key to accept the current amount.

This prompt will allow the End User to define the least amount a bill should have to send to Transworld for collection.

11. Type the beginning search date at the “EARLIEST DATE TO SEARCH:” prompt or press the Return key to accept the date displayed.

This field should be based on the payers back limit as far as receiving payments on the pursuit of old accounts.

12. Type the minimum days in arrears of the bill at the “MINIMUM BILL AGE DAYS:” prompt or press the Return key to accept the current number.

The minimum must be between 30 and 180 days. If this prompt does not appear, go to step 13.

13. Type the earliest date of service (DOS) you want at the “EARLIEST DOS ALLOWED:” prompt or press the Return key to accept the current amount.

14. Type Y or N at the “RUN AUTO PROCESS?” prompt.

- If you type Y, go to step 15.
- If you type N, you are returned to the prompt at step 1.

15. Type Y or N at the “START DATE USED AUTO: <date>” prompt or press the Return key to accept the date displayed.

You are returned to step 2 where you can make changes to any information you entered in this task...

Figure 6-3 provides an example of the prompts and responses described in this task. You must also set up the ZISH SEND parameters so that the debt data collected based on the parameters you set in this task are automatically sent. See the Accounts Receivable Technical Manual version 1.8 for instructions.

This completes the procedure for setting default debt collection parameters for a site you specify.

6.3 Restricted Payers Maintenance (RPM)

This option allows you to select an Insurer that is restricted from any transmission to TSI.

To select an Insurer to omit from the transmission, follow these steps:

1. Type RPM at the “Select Debt Collection Menu Option:” prompt.

The screen shown in Figure 6-9 is displayed.

```

Select Debt Collection Menu Option: RPM Restricted Payers Maintenance

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +-----+
      |          Restricted Payers Maintenance                  |
      |          UNSPECIFIED SERVICE UNIT                      |
      +-----+
User: USER,GRETA          BUSINESS OFFICE          20-MAY-2004 9:20 AM

Select A/R SITE PARAMETER/IHS RPMS SITE: UNSPECIFIED SERVICE UNIT    NM
HEADQUARTERS WEST          01

Select A/R Account to Restrict Transmission: ??

Choose from:
MEDICARE
RAILROAD RETIREMENT

      You may enter a new Debt Collection Restrictd Payers, if you wish

Choose from:
1          MEDICARE
2          MEDICAID
3          NEW MEXICO MEDICAID
4          UNSPECIFIED SERVICE UNIT
6          BIGHOSPITAL SERVICE UNIT
    
```

```

7          U R SPECIAL WELLNESS CENTER
8          DEMONSTRATION GENERAL HOSPITAL
9          GET WELL SOON HEALTH CENTER
10         PEOPLE'S CARE CENTER
11         SUPERFAST GENERAL HOSPITAL
12         UN-ALLOCATED
13         NON-BENEFICIARY PATIENT
14         UNITED HEALTHCARE
          ^
Select A/R Account to Restrict Transmission: MEDICARE
A/R Account: MEDICARE// [RET]
STATUS: RESTRICT TRANSMISSION TO TSI// [RET]

Select Another A/R Account to Restrict Transmission: ??

Choose from:
DEMONSTRATION GENERAL HOSPITAL
RAILROAD RETIREMENT
LOVELACE
MEDICARE
RAILROAD RETIREMENT
    You may enter a new Debt Collection Restrictd Payers, if you wish

Choose from:
1          MEDICARE
2          MEDICAID
3          NEW MEXICO MEDICAID
4          UNSPECIFIED SERVICE UNIT
5          BIGHOSPITAL SERVICE UNIT
6          U R SPECIAL WELLNESS CENTER
7          DEMONSTRATION GENERAL HOSPITAL
8          GET WELL SOON HEALTH CENTER
9          PEOPLE'S CARE CENTER
10         SUPERFAST GENERAL HOSPITAL
11         ^
A/R Account: UNSPECIFIED SERVICE UNIT//

```

Figure 6-6: Restricted payers maintenance steps 1 and 2)

2. Type the name of the site you want at the “Select A/R SITE PARAMETERS/IHS RPMS SITE:” prompt.

To view a list of sites, type??

3. Type the name of the insurer account you want to restrict from transmission at the “Select A/R Account to Restrict Transmission:” prompt.

Type ?? to display a list of accounts. You can also add a new insurer account to the list. See 7.5 A/R Account Entry (ACE) on page 52 for instructions.

4. Press the Return key at the “OK?:” prompt to confirm your choice to restrict the displayed account or type N to reject your choice.

If you typed, N, you are returned to step 3 where you can select another account to restrict from transmission.

5. Press the Return key at the “A/R Account:” prompt to restrict the displayed account or type N to allow the displayed account

If you typed, N, you are returned to step 3 where you can select another account to restrict from transmission.

6. Press the Return key to restrict or allow the insurer displayed at the “STATUS: RESTRICT (or ALLOW) TRANSMISSION TO TSI/” prompt.

Note: The actual prompt that is displayed depends on whether you choose to restrict or allow transmission in step 4.

This completes the procedure for restricting an insurer from submission to TSI.

6.4 View Debt Collection Site Parameters (DCI)

This option displays the current defaults of the Site Parameters file. It is recommended that you verify the current Site Parameter defaults before performing any other debt collection functions.

To view the Site Parameters file:

1. Type DCI at the “Select Debt Collection Menu Option:” prompt.

The screen shown in Figure 6-5 is displayed.

```

Select Debt Collection Menu Option: DCI View Debt Collection Site Parameters

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +-----+-----+-----+-----+-----+-----+-----+-----+
      |          View Debt Collection Site Parameters          |
      |          UNSPECIFIED SERVICE UNIT                      |
      +-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,GRETA                BUSINESS OFFICE                20-MAY-2004 9:21 AM

Select A/R SITE PARAMETER/IHS RPMS SITE: UNSPECIFIED SERVICE UNIT    NM
HEADQUARTERS WEST                01

DEVICE: [RET]    Right Margin: 80// [RET]
A/R SITE PARAMETER/IHS LIST                MAY 20,2004 09:21    PAGE 1
-----
TSI INSURANCE CLIENT NUMBER: 1575A    MAXIMUM INSURANCE TRANSACTIONS: 800
EXTRACT DIRECTORY: /usr/spool/BBM/xmit/
REPORT DIRECTORY: /usr/spool/BBM/REPROTS/
MINIMUM BILL AGE DAYS: 90    EARLIEST DOS ALLOWED: JAN 01, 2001
EARLIEST DATE TO SEARCH: JAN 01, 2001
SCHEDULE FOR AUTO PROCESSING?: NO
    
```

```
Select A/R SITE PARAMETER/IHS RPMS SITE:
```

Figure 6-7: View debt collection site parameters sample

2. Type the name of the site whose default parameters you want to view at the “Select A/R SITE PARAMETER/IHS RPMS Site:” prompt.

To view a list of sites, type??
3. Type the name of the device to which you want to send the list of default site parameters at the “Device:” prompt or press the Return key to view the current defaults on your screen.
4. Press the Return key at the “Right Margin:” prompt to accept the default for the current printer’s margin.

This completes the procedure for viewing the list of default site parameters.

6.5 Reports (REP)

In addition to setting site parameters for debt collection, the Debt Collection Menu also contains options for creating reports. To access these options, type REP at the “Select Debt Collection Menu Option:” prompt.

The screen shown in Figure 6-11 is displayed.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
|                                Reports                                |
|                NOT-A-REAL FACILITY                                |
+-----+
User: USER,NAME                                     5-OCT-2005 2:51 PM

LOG      Debt Collection Log Report
DCPR     Debt Collection Payment Report
BIR      Bill Inquiry

Select Reports Option:
    
```

Figure 6-8: Debt collection reports menu

The sections that follow provide instructions for creating Debt Collection Log, Payment, and Bill Inquiry reports.

6.5.1 Debt Collection Log Report (LOG)

This report is used to print the data from the Debt Collection Log file which provides information on what accounts were sent. It is used to reconcile with Transworld monthly reports of the accounts that were received by Transworld for processing.

To run the debt collection log report, follow these steps:

1. Type REP at the “Select Debt Collection Menu Option:” prompt and press the Return key.
2. Type LOG at the “Select Reports Option:” prompt and press the Return key.

The screen shown in Figure 6-12 is displayed.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
|                Debt Collection Payment Report                        |
|                NOT-A-REAL FACILITY                                  |
+-----+
User: USER,NAME                                26-SEP-2005 1:44 PM
BUS
Enter Transmission Date Range...
Select Beginning Date:
    
```

Figure 6-9: Debt collection log report (steps 1 and 2)

3. Type the transmission start date at the “Select Beginning Date:” prompt and press the Return key.
4. Type the transmission end date at the “Select Ending Date:” prompt and press the Return key.
5. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report
 - Press the return key to view this report on your monitor

Figure 6-13 shows an example of this report.

DEBT COLLECTION LOG				
Run Date: OCT 27,2005@09:04			Page: 1	
DATE SENT	AR BILL	DOS	AR BALANCE	ACTION CODE

A/R Account: AAG-MEDICARE SUPPLEMENT				
07/09/2004	1465306A-SH-66405	02/09/2004	202.33	STARTS

			202.33	(1)
A/R Account: AARP HEALTHCARE OPTIONS				
07/09/2004	1459699A-SH-35245	01/30/2004	91.68	STARTS
07/09/2004	1481899A-SH-18094	02/26/2004	201.76	STARTS
07/09/2004	1526999A-SH-18094	03/29/2004	55.58	STARTS
07/09/2004	1526899A-SH-35245	03/30/2004	341.00	STARTS

			690.02	(4)

A/R Account: ADMINISTRATIVE ENTERPRISES					
07/09/2004	1438399A-SH-55586	12/31/2003	88.56	STARTS	
07/09/2004	1449399A-SH-57501	01/15/2004	66.96	STARTS	
07/09/2004	1488199A-SH-214303	03/08/2004	114.10	STARTS	
07/09/2004	1526999A-SH-31016	03/22/2004	341.00	STARTS	
07/09/2004	1526999A-SH-42963	03/23/2004	541.00	STARTS	
07/09/2004	1521999A-SH-38791	04/06/2004	109.27	STARTS	
07/09/2004	1531899A-SH-214303	04/12/2004	67.66	STARTS	
07/09/2004	1531899A-SH-214303	04/12/2004	50.00	STARTS	
07/09/2004	1528599A-SH-214303	04/14/2004	203.16	STARTS	
07/09/2004	1528599A-SH-214303	04/14/2004	64.00	STARTS	

			1645.71	(10)	

			2538.06	(15)	

Figure 6-10: Debt collection log report

This completes the procedure for creating the debt collection log report.

6.5.2 Debt Collection Payment Report (DCPR)

This report provides the actual payment amounts that were posted on the accounts that were sent to Transworld using the Debt Collection module. Managers have used this report to show the return on investment for using this agency.

The report provides the same information and is in the same format as the existing Debt Collection Log Report except it has a Payment column. These payments are retrieved from the payment dollar amounts from the A/R Bills listed on the report. You can run this report any time and it is updated as payments are posted to each AR Bill. The payment amounts are subtotaled by Payer and include a total amount with each report that is listed on the bottom of the report.

To run the debt collection payment report, follow these steps:

1. Type REP at the “Select Debt Collection Menu Option:” prompt and press the Return key.

The screen shown in Figure 6-14 is displayed.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|                                     ACCOUNTS RECEIVABLE SYSTEM - VER 1.8   |
|                                     Debt Collection Payment Report           |
|                                     NOT-A-REAL FACILITY                       |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,NAME                                     26-SEP-2005 1:44 PM
BUS

Enter Transmission Date Range...

Select Beginning Date:
    
```

Figure 6-11: Debt collection log report (steps 1 and 2)

2. Type DCPR at the “Select Reports Option:” prompt and press the Return key.
3. Type the transmission start date at the “Select Beginning Date:” prompt and press the Return key.
4. Type the transmission end date at the “Select Ending Date:” prompt and press the Return key.
5. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report
 - Press the return key to view this report on your monitor

Figure 6-16 shows an example of this report.

DEBT COLLECTION PAYMENT REPORT					
Run Date: OCT 27,2005@09:07			Page: 1		
DATE SENT	AR BILL	DOS	AR BALANCE	ACTION CODE	PAYMENT

A/R Account: AAG-MEDICARE SUPPLEMENT					
07/09/2004	1465306A-SH-664	02/09/2004	202.33	STARTS	0.00
			-----		-----
			202.33	(1)	0.00
A/R Account: AARP HEALTHCARE OPTIONS					
07/09/2004	1459688A-SH-352	01/30/2004	91.68	STARTS	0.00
07/09/2004	1481888A-SH-180	02/26/2004	201.76	STARTS	0.00
07/09/2004	1526988A-SH-180	03/29/2004	55.58	STARTS	0.00
07/09/2004	1526888A-SH-352	03/30/2004	341.00	STARTS	0.00
			-----		-----
			690.02	(4)	0.00
A/R Account: ADMINISTRATIVE ENTERPRISES					
07/09/2004	1438388A-SH-555	12/31/2003	88.56	STARTS	0.00
07/09/2004	1449388A-SH-575	01/15/2004	66.96	STARTS	0.00
07/09/2004	1488188A-SH-214	03/08/2004	114.10	STARTS	0.00
07/09/2004	1526988A-SH-310	03/22/2004	341.00	STARTS	341.00
07/09/2004	1526988A-SH-429	03/23/2004	541.00	STARTS	500.00
07/09/2004	1521988A-SH-387	04/06/2004	109.27	STARTS	0.00
07/09/2004	1531888A-SH-214	04/12/2004	67.66	STARTS	35.20
07/09/2004	1531888B-SH-214	04/12/2004	50.00	STARTS	40.00
07/09/2004	1528588A-SH-214	04/14/2004	203.16	STARTS	40.00
07/09/2004	1528588B-SH-214	04/14/2004	64.00	STARTS	51.20
			-----		-----
			1645.71	(10)	1007.40
			-----		-----
			2538.06	(15)	1007.40

Figure 6-12: Debt collection payment sample report

This completes the procedure for creating the debt collection payment report.

6.5.3 Bill Inquiry (BIR)

The AR package allows the Users to research individual bills on accounts that were sent to TSI. This report enables you to make inquiries by bill number, patient name, or both, as well as by date range of the TSI transaction.

Figure 6-18 shows one bill with one patient, but the bill was sent to a secondary Insurer via TSI transmission. This report includes subtotals of payments received by each Payer and the last line shows the Total dollar amount paid for all Payers included in the Debt Collection transmission.

To run a bill inquiry, follow these steps:

1. Type BIR at the “Select Reports Option:” prompt.

The screen shown in Figure 6-17 is displayed.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+
|                   Bill Inquiry                          |
|                   NOT-A-REAL FACILITY                   |
+-----+
User: USER,NAME                                     5-OCT-2005 3:50 PM
BUS
Select A/R BILL/IHS BILL NUMBER:
    
```

Figure 6-13: Bill inquiry (steps 1 and 2)

2. Type the A/R BILL/IHS IEN, or BILL NUMBER, or A/R ACCOUNT, or BILLED DATE, or CURRENT BILL AMOUNT, or 3P PRINT DATE, or PATIENT, or DOS BEGIN, or PATIENT NAME (FT), or OTHER BILL IDENTIFIER at the “Select A/R BILL/IHS BILL NUMBER:” prompt.

After you type this information, the following prompt appears:

```

Enter Transmission Date Range...
    
```

3. Type the transmission start date at the “Select Beginning Date:” prompt.
4. Type the transmission end date at the “Select Ending Date:” prompt.
5. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report
 - Press the return key to view this report on your monitor

Figure 6-18 shows an example of this report. This report needs to be reformatted based on the columns. It does not look like the report.

DEBT COLLECTION BILL INQUIRY REPORT					
Run Date: OCT 27,2005@09:20			Page: 1		
DATE SENT	AR BILL	DOS	AR BALANCE	ACTION CODE	PAYMENT

Patient Name: SMITH,JAMES					
A/R Account: UNITED HEALTH CARE					
07/09/2004	1498765B-SH-102	03/05/2004	2658.54	STARTS	2035.61
07/30/2004	1498765B-SH-102	03/05/2004	0.00	CANCEL	
			-----	-----	

	2658.54 (2)	2035.61
	-----	-----
	2658.54 (2)	2035.61

Figure 6-14: Bill inquiry sample report

This completes the procedure for creating the bill inquiry report.

7.0 Manager Menu (MAN)

This Master Menu option is available for A/R managers or site managers responsible for setting up and maintaining the A/R package. The manager is responsible for assigning access keys to all users of the system, for the initial set up of the system, and maintaining and trouble-shooting the system.

Note: Limited access to the Manager menu is strongly recommended. The keys should only be assigned to Managers or a person who fully understands the complete functionality of the A/R package.

To select the Manager menu, type MAN at the “Select A/R MASTER MENU Option:” prompt.

The Manager Menu displays the following options, all of which are described in detail in the following sections.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
|                   Manager                               |
|          UNSPECIFIED SERVICE UNIT                       |
+-----+
User: USER,GRETA                BUSINESS OFFICE        21-JUL-2004 9:11 AM

PFS  Parent Facility Selection
PFA  Parent Facility Addition
PSE  Parent/Satellite Edit
SPE  Site Parameter Edit
ACE  A/R Account Entry
CPE  Collection Point Edit
UPAP Upload Third Party Bills by Approval Date(s)
LET  Insurer Age Cover Letter Edit
FM   Fileman reports ...
PFK  Parent Facility Kill
RPT  Management Reports ...
STE  Standard Table Edits
VHF  View Host File
IG   IG REPORT
FRD  Delete Flat Rate Posting Batch
AWO  Automatic Write-off
BES  Bill File Error Scan
ERAD ERA Import Delete
REV  Auto Write-off (2000) Reversal
EISS Manual Resend of Unsent Files

Select Manager Option:

```

Figure 7-1: Manager Menu

7.1 Parent Facility Selection (PFS)

This Manager Menu option, step 1 in Setup, is used to establish an identity when a facility user is involved in regionalization.

- Regionalization is a term used to describe the situation in which several parent facilities co-exist in one central machine or CPU (central processing unit). This allows two or more parent facilities to use the same machine, side by side, without ever interfering with each other's files or data.
- After the selection has been made, the user is able to access only those files (both parent and satellite) for that particular location selected.
- If your site is a standalone (just a parent), you will only have one option to choose from.
- Through this option, a user is able to select a regionalized facility by either the facility name or corresponding number. Note that the facilities shown reflect the information stored in User Management in CORE under Select Division. Not all users have the same facilities from which to select. Refer to example below:

To select a parent facility, follow these steps:

1. Type PFS at the "Select Manager Option:" prompt.
2. Type your facility name or press the Return key to accept the default at the "Enter your facility's name:" prompt. This completes the process.

```
Select Manager Option: PFS Parent Facility Selection

Enter your facility's name: DEMO HOSPITAL// ??
    1546                DEMO HOSPITAL

Enter your facility's name: DEMO HOSPITAL// [RET] 999 DEMO
DEMO                01
```

Figure 7-2: Selecting a parent facility

7.2 Parent Facility Addition (PFA)

With this Manager Menu option, step 2 in Setup, you establish (open) files for a parent or regionalized location. By selecting the appropriate location and adding it as a regional site, you are then allowed access to the existing files for that location (parent and satellite), and you are allowed to set up your files and accounts for the A/R package.

Note: This is a one-time setup only.

```
DEMO HOSPITAL to be added/updated as an A/R Regional Site?? NO// YES
```

```

ADDED:      A/R COLLECTION BATCH/IHS
ADDED:      A/R COLLECTION POINT/IHS
ADDED:      A/R ACCOUNTS/IHS
ADDED:      A/R BILL/IHS
ADDED:      A/R PARENT/SATELITE/IHS
ADDED:      A/R SITE PARAMETER/IHS
ADDED:      A/R SPECIAL ACCOUNTS
ADDED:      A/R TRANSACTIONS/IHS

DEMO HOSPITAL Has been added

Enter RETURN to continue or '^' to exit:

```

Figure 7-3: Example of the PFA

Note: If, during setup, the system prompts you because your facility already exists in the system, continue to the next step of the setup function.

To add a new parent facility and setup new files, follow these steps:

1. Type PFA at the “Select Manager Option:” prompt.
2. If your facility already exists in the system, it is displayed and you are prompted to continue or exit. When you press the Return key to continue, the system prompts you to add or update the Regional Site.
3. If your site is new: type Y.
4. The system creates new files for the site and lists them for your review.
5. If your site exists: type Y.
6. The system creates new files for a new site under your existing region. The system then displays the new files for your review.

```

Select Manager Option: PFA Parent Facility Addition

      DEMO HOSPITAL EXISTS

Enter RETURN to continue or '^' to exit: [RET]
DEMO HOSPITAL to be added/updated as an A/R Regional Site?? NO// YES

DEMO HOSPITAL Has been added

```

Figure 7-4: Making a parent facility addition

Note: If you are doing an initial setup, go to step 3 of the Switch Service/Section section 12.0.

7.3 Parent/Satellite Edit (PSE)

Use this Manager Menu option, step 4 in setup, to establish or edit relationships between parent and satellite facilities. At some locations, one facility (parent) may perform such functions as billing, collecting, posting, and reconciling for another facility (satellite).

Parent/satellite relationships need to be established if your Site Parameter in Third Party Billing table maintenance has been set to *Yes*. If a facility does not have any satellite facilities, they still have to be set up as their own parent facility. Example: Trenton Health Center has to be set up as the parent for Trenton Health Center. Note that only those facilities that are located in the IHS Facility File can be selected.

Version 2.5 of Third Party Billing uses parent/satellite relationships to bill for locations not set up in the Third Party Location File. Such locations may be home or school visits. Please refer to the Third Party Billing Version 2.5 manual - Table Maintenance (Site Parameters).

A shortcut suffix can be set up and used in selecting a facility from the file. Use the shortcut Key as an easier method to typing the whole facility name. The suffix should be a one to four alpha/ numeric abbreviation for that facility. Type the shortcut suffix using all CAPS. Once you have entered the suffix, you can use it immediately throughout the system. For example: Klamath Tribal Health Dept. could use KL, or 1234, or KL12 as a suffix.

To establish parent/satellite relationships, follow these steps:

1. Type PSE at the "Select Manager Option:" prompt.
2. Type the name of the facility or ?? to select from a list of facilities at the "Select A/R Parent/ Satellite/IHS Location:" prompt.
3. Press the Return key at the "OK?" prompt to confirm your selection.
4. If the location name is correct, press the Return key; otherwise, type the correct facility name at the "Location:" prompt.
5. The system will prompt you for a suffix (a 2-letter abbreviation for the facility) and may display a default suffix. Type the two-letter abbreviation for the facility or press the Return key to accept the default at the "Suffix:" prompt.
6. Type the name of the parent facility or press the Return key to accept the default at the "Parent:" prompt.
7. The facility and its parent are displayed with an indication of whether it is *Usable* or *Not Usable*. Press the Return key at the "Parent-Satellite Usable:" prompt.
8. Type the start date or press the Return key to accept the default at the "Satellite Start Date:" prompt.

9. Type the end date or press the Return key to accept the default at the “Satellite End Date:” prompt. The system prompts for entry of another A/R parent/satellite/IHS Location.
10. Repeat the previous steps for another location or press the Return key at a blank “Select A/R Parent/Satellite/IHS Location:” prompt. This completes the process.

```

Select Manager Option: PSE  Parent/Satellite Edit

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +                Parent/Satellite Edit                                +
      |                DEMO HOSPITAL                                        |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER, DEMO                BUSINESS OFFICE                11-FEB-2003 3:49 PM

Select A/R PARENT/SATELLITE/IHS LOCATION: DEMO HOSPITAL                999
DEMO                DEMO                01
      ...OK? Yes// [RET]  (Yes)

LOCATION: DEMO HOSPITAL// [RET]
SUFFIX: AHS//[RET]
PARENT: DEMO HOSPITAL// PARENT HEALTH CENTER DEMO TRIBE/638 DEMO                11

PARENT - SATELLITE USABLE: USABLE//[RET]
SATELLITE START DATE: JAN 1,1990//[RET]
SATELLITE END DATE: 020205

Select A/R PARENT/SATELLITE/IHS LOCATION: [RET]

```

Figure 7-5: Editing/entering parent satellite

7.4 Site Parameter Edit (SPE)

The Site Parameter Edit option has the ability to ask for multiple EDI Payer Lists. Every payer that is HIPAA compliant (can receive a 276 export) must be added as an EDI payer and must be entered here with at least an effective date in order to use the CSI option (section 4.1 Claim Status Inquiry (276) (CSI)).

To edit a site parameter, follow these steps:

1. Type MAN at the “Select A/R Master Menu Option:” prompt.
2. Type SPE at the “Select Manager Option:” prompt.
3. Type the name of the site you want to edit at the “Select A/R Site Parameter/IHS RPMS Site:” prompt. Type two question marks (??) for a list of sites (Figure 7-8).
4. Press the Return key if you want multiple 3P EOB sites or type N at the “Multiple 3P EOB Locations:” prompt. If you select no, see the note below
5. Press the Return key if you want multiple fiscal EOB sites or type N if not at the “Multiple Fiscal EOB Locations:” prompt. If you select *No*, see the note below.

Note: With the MULTIPLE 3P EOB LOCATIONS and MULTIPLE FISCAL EOB LOCATIONS, you have the capability of splitting a single collection between multiple facilities. Example: Blue Cross sends one check for the reimbursement for four different facilities. This allows you to identify and distribute among those four facilities. The multiple facility relationship must be defined in the A/R Parent/Satellite File. (See Parent/Satellite Edit section 7.3.)

6. Press the Return key if you want to indicate Usable (that this is a valid configuration for Uploading Bills from Third Party Billing into the A/R Package.) at the “Usable:” prompt. This prompt must be answered in order for bills to appear in this parent.
7. If the Accept 3p Bills flag is set, bills from the RPMS Third Party Billing system are uploaded to the A/R bill file. If the prompt is set to *Do Not Accept*, the approval screen freezes when approving claims in Third Party Billing and bills are not uploaded.
8. The “Rollover During Posting:” prompt may be answered by three responses: Yes, No, or Ask. If you type Y, the system automatically rolls over every payment into Third Party Billing and also looks for eligibility. If you type N, the user has to manually roll over claims with the ROL option in the main menu. If you type Ask, the system prompts the user to answer this question upon entering the Posting or Adjustment menus.
9. The “Small Balance:” prompt is no longer used in version 1.8. To set the small balance amount, go to 11.2.4, Small Balance List (SBL), on page 148.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Site Parameter Edit                             +
|           DEMO HEALTH CENTER                             |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: DEMO,USER           BUSINESS OFFICE           1-OCT-2002 1:14 PM

Select A/R SITE PARAMETER/IHS RPMS SITE:           DEMO HEALTH CENTER
...OK? Yes// (Yes)

MULTIPLE 3P EOB LOCATIONS: NO// [RET]
MULTIPLE FISCAL EOB LOCATIONS: NO// [RET]
USABLE: USABLE// [RET]
ACCEPT 3P BILLS: ACCEPT// [RET]
    
```

```
ROLL OVER DURING POSTING: YES// [RET]
SMALL BALANCE: 5.00// [RET]
```

Figure 7-6: Editing site parameters (steps 3-9)

10. At the “Location Type for Reports:” prompt, type B (Billing) or V (Visit). This parameter was created in A/R V1.6 Patch 2 in order to obtain data by visit location or billing location (DUZ(2)). This became necessary for balancing the Period Summary Report to any of the others. In order to balance, the value of this field must be *visit*. This parameter affects the "Select Location:" prompt. If the parameter is left blank it will be treated as though the user typed *visit*. If the parameter says *billing location* then the meaning of the "Select Location:" prompt on the following reports is DUZ(2) and not visit location:

- Age Detail Report
- Age Summary Report
- Bills Listing Report
- A/R Statistical Report
- Transaction Report

```
Location Type For Reports: VISIT// ?

Age Detail Report
Age Summary Report
Bills Listing Report
A/R Statistical Report
Transaction Report
Choose from:
  B          BILLING
  V          VISIT
Location Type For Reports: VISIT//[RET]
```

Figure 7-7: Editing site parameters (step 10)

11. At the “Default Path:” prompt, type location of EDI ERA (Electronic Remittance Advice) file (i.e. /usr/spool/uucppublic/edi.txt).
12. At the “Select EDI Payer:” prompt, type the insurers prepared to accept EDI claims status inquiries. Type two question marks (??) for a list of payers. This option works with the CSI menu option (see section 4.1).
13. Type the effective date for the EDI payer at the “Effective Date:” prompt. This date is the date that the payer began accepting the HIPAA compliant claims.
14. Type an end date or press the Return key to bypass the “End Date:” prompt. Only use an end date when you wish to inactivate an EDI payer.

```
Default Path: c:\rload// [RET]
Select EDI PAYER: LOVELACE HEALTH PLAN// ??
```

```

Choose from:
  LOVELACE HEALTH PLAN
  MEDICARE
  BCBS OF NEW MEXICO

Choose from:
  1          DEMO, EMT
  2          DEMO HEALTH CENTER
  3          UN-ALLOCATED
  4          NEW MEXICO BC/BS INC
  5          NM BC/BS DENTAL CLASSIC
  6          NEW MEXICO MEDICAID
  7          BCBS OF NEW MEXICO (FEP)
  8          MAIL HANDLERS BENEFIT PLAN
  9          US DEPT OF LABOR OWCP
Select EDI PAYER: LOVELACE HEALTH PLAN//[RET]
  EDI PAYER: LOVELACE HEALTH PLAN//[RET]
  EFFECTIVE DATE: NOV 10,2002// [RET]
  END DATE: [RET]
Select EDI PAYER:

```

Figure 7-8: Editing Site Parameters (steps 11-14)

7.5 A/R Account Entry (ACE)

With this Manager Menu option, step 6 in Setup, you establish A/R accounts to be used to keep track of all billing and collection activities. These accounts may be established for a new person, patient, vendor, and insurer. Accounts need to be added to the system when they currently do not exist.

General Ledger accounts also need to be established. These general ledger accounts are financial, non-billable accounts.

- Accounts are screened by Service/Section, i.e., Business Office/Entries and Fiscal Service. Entries are separate and cannot be seen by each other.
- Accounts are either billable or financial (general ledger). Financial accounts must be entered manually.
- Third Party will automatically load their accounts from 3P bills.
- The account being added to the system must first exist in the corresponding IHS File. For example, any patient being added must exist in the IHS Patient File.

To add an account, follow these steps:

1. Type ACE at the “Select Manager Option:” prompt and press the Return key.
2. Type the name of the A/R Account or ?? at the “Select A/R Accounts/IHS:” prompt to select from a list of accounts

3. If the account already exists in A/R, the system displays the account name; otherwise, it displays a "Name:" and "Address:" prompt.
4. If the account exists, press the Return key to continue; otherwise type the name of the account at the prompt and press the Return key to continue. Continue until all accounts are added.
5. Type a caret (^) to stop and exit. This completes the process.

```

Select Manager Option: ACE  A/R Account Entry

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
      +           A/R Account Entry                             +
      |           DEMO HOSPITAL                                 |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User:  USER, DEMO                BUSINESS OFFICE                21-FEB-2003 3:45 PM
Select A/R ACCOUNTS/IHS: ??

Choose from:
105          ADAM, ADAM
106          ADAM, ELEANOR P
107          ADAM, DORENE A
108          HOME
109          UN-ALLOCATED

Select A/R ACCOUNTS/IHS: 106
ACCOUNT: ADAM, ELEANOR P// [RET]
Select A/R ACCOUNTS/IHS: ^
    
```

Figure 7-9: Adding an account

Format for added accounts: when entering an account name, use the letter that corresponds to that type of account followed by a period (.) and the account name. This assists the system in identifying the IHS file in which to search for this particular account.

- N. Entry Name (to select a New Person)
- P. Entry Name (to select a Patient)
- V. Entry Name (to select a Vendor)
- I. Entry Name (to select an Insurance)
- L. Entry Name (to select a General Ledger Location)
- S. Entry Name (to select a General Ledger Special)

Figure 7-10 shows what happens if you enter an unrecognized account name:

```

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
      +           A/R Account Entry                             +
      |           DEMO HOSPITAL                                 |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
    
```

```

User: User, Demo          BUSINESS OFFICE          19-JUN-2000 11:40 AM

Select A/R ACCOUNTS/IHS: I.MEDICARE
ACCOUNT: MEDICARE//
Select A/R ACCOUNTS/IHS: I.BC/BS OF ARIZONA
ACCOUNT: BC/BS OF ARIZONA INC//
Select A/R ACCOUNTS/IHS: I.MAINE MEDICAID

Since the KEYWORD LOOKUP failed lets try a NON-KEYWORD LOOKUP...

      MAINE MEDICAID
ACCOUNT: MAINE MEDICAID//
Select A/R ACCOUNTS/IHS:

```

Figure 7-10: Using the format for added accounts

7.5.1 General Ledger Location Account

These accounts are created for those facilities identified in the A/R parent/satellite file. The accounts are used to automatically track the distribution of monies between more than one facility as they are identified and entered into the collection batches or posted. Reports will be available and used to determine the amount of collections received per facility for a given time period.

Note: Accounts must be established for all locations set up in the parent/ satellite file using A/R Account Entry option.

Example: Type L.ANMC to establish an account for all transactions for ANMC. Note that you can use the suffix that you created in Setup step 4. (See section 7.3)

7.5.2 General Ledger Special Account

These accounts consist of locations where monies are placed when not enough identifying information is available to complete the transaction at the time. This situation could occur either in the Collection or Posting stages of the A/R process.

- **Unallocated Funds Account:** Funds that are ready for posting but have not been posted. This account enables users to close (complete) a batch without posting every item within the batch. Items can be placed in this account and processed at a later date.
- **Refund Account:** This account is set up to help users better track refunds. The user may have to refund money to patients, vendors, insurance companies, etc. This account keeps track of all refund transactions for reporting purposes.

In the actual system, there is only one choice: Unallocated.

Note: Accounts must be set up for both of the special accounts using the A/R Account Entry option.

7.6 Collection Point Edit (CPE)

With this Manager Menu option, step 7 in setup, you can set up and edit collection points at each facility. A collection point can be described as the actual physical location where collections (cash, credit card, personal checks, Explanation of Benefits (EOB) checks) are received and accounted for. Some Areas chose to set up their collection points by payer type and facility location. An example would be MEDICAID – AAO. Once the collection point name is set up in AR, the system will assign the name, date of entry and the sequential number of the batches created for the facility. These numbers are used for accounting and monitoring completion of posting activities.

- A facility may have one or more collection points.
- Certain users are assigned accessibility for certain collection points. The Site manager must add the collection points to each individual user designated for them to access the collection points.
- Collection point editing is displayed in ScreenMan format. Use the Tab key or Arrow keys to move between fields. Type over existing data to make changes.
- Collection points have unique characteristics (Service/Section, Name, Users, etc.).

You must Save your collection point data (press Tab down to the end of the fields and type S for Save and the Return key) in order for your collection point to actually be established or edited.

To access the Collection Point Edit option, type CPE at the “Select Manager Option:” prompt.

```

Select Manager Option: CPE

      +---+-----+-----+-----+-----+-----+-----+-----+-----+-----+
      |           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
      +           Collection Point Edit                           +
      |           DEMO HOSPITAL                                   |
      +---+-----+-----+-----+-----+-----+-----+-----+
User: USER, DEMO           BUSINESS OFFICE           12-FEB-2003 9:55 AM

Select A/R COLLECTION POINT/IHS NAME:
    
```

Figure 7-11: Accessing the CPE option

Figure 7-12 illustrates what you actually see in ScreenMan format.

```

              COLLECTION BATCH IDENTIFICATION
NAME:                MEDICAL RECORDS
LAST COLLECTION BATCH DATE:  MAR 21, 2002
LAST SEQUENCE NUMBER:      2
CURRENT COLLECTION BATCH:  MEDICAL RECORDS-03/21/2002-2
LOCATION:                DEMO HOSPITAL
A/R SECTION:           BUSINESS OFFICE
BATCH TYPE:            ALL TYPES
    
```

AUTO PRINT CASH RECEIPT:	NO		
RECEIPT PRINTER:			
Select USERS:		USER, DEMO	
Select SUPERVISOR(S):			
ASK CHECK BANK NUMBER:	NO	ASK INPATIENT/OUTPATIENT:	NO
CC ask Patient Name on Bill:	YES	CC ask Patient Name:	YES
CA ask Patient Name on Bill:	YES	CA ask Patient Name:	YES
CK ask Patient Name on Bill:	YES	CK ask Patient Name:	YES
NON EOB DATA REVIEW/EDIT:	YES	EOB DATA REVIEW/EDIT:	YES
<hr/>			
COMMAND:		Press <PF1>H for help	
Insert			

Figure 7-12: Collection point edit example

To add or edit a collection point, follow these steps:

1. Type CPE at the “Select Manager Option:” prompt, then type in the name of the Collection Point. If you are adding a new Collection Point, press the Return key to confirm the addition. If you are editing an existing Collection Point, the system displays current information for your review.
2. **To Edit an existing Point:** type over the existing information at each prompt. Pressing the Return key will keep the field unchanged.
3. **To Add a New Point:** enter data at every prompt, using the information below:
 - a. At the “Batch Type:” prompt, you have two options:

EOB Only means that the only type of reimbursements that will be entered into the Collection Register for this Collection Point are Explanation of Benefits (EOB) checks from insurance companies.

All Types means all types of payments (cash, credit cards, personal checks, and EOB checks) may be entered.
 - b. At the “Auto Print:” prompt, you instruct the system to print a receipt for all types of payments received. If the field is flagged as *No*, the system still allows for an individual receipt to be printed for a particular transaction.
 - c. At the “Receipt Printer:” prompt, enter the Device.
 - d. At the “Select User:” prompt, type the user’s name to allow the A/R manager to designate who will have access to this particular Collection Point. Only those individuals who are identified here can create, edit, or enter transaction at this collection point. This provides internal control.
 - e. At the “Select Supervisor:” prompt, type the name of the Supervisor (last name first) of the users for this particular Collection Point. Use caution when adding users, because users can override entries in a collection batch.

- f. At the “Check Bank Number:” prompt, type *Yes* if you want the system to ask for this information for every transaction in this Collection Point.
- g. At the “Ask Inpatient/Outpatient:” prompt, type *Yes* if you want the system to ask for this information for every transaction in this Collection Point. This allows for early identification of what type of service was provided for this particular reimbursement.
- h. At the “CC Ask Patient Name On Bill:” prompt, if the entry is *Yes* and the type of payment is credit card, the system asks for entry of the patient name and links it to an existing bill in the system.
- i. At the “CC Ask Patient Name:” prompt, if the entry is *Yes* and the type of payment is credit card, the system asks for entry of the patient name.
- j. At the “CA Ask Patient Name On Bill:” prompt, if the entry is *Yes* and the type of payment is cash, the system asks for entry of the patient name and links it to an existing bill in the system.
- k. At the “CA Ask Patient Name On Bill:” prompt, if the entry is *Yes* and the type of payment is cash, the system asks for entry of the patient name.
- l. At the “CK Ask Patient Name On Bill:” prompt, if the entry is *Yes* and the type of payment is personal check, the system asks for entry of the patient name and links it to an existing bill in the system.
- m. At the “CK Ask Patient Name:” prompt, if the entry is *Yes* and the type of payment is personal check, the system asks for entry of the patient name.

Note: If any or all of Check Bank Number thru CK Ask Patient Name On Bill prompts are flagged as NO, the capability of capturing this data for one or more specific transactions is not lost. You can use the MORE option.

- n. At the “Non EOB Data Review/Edit:” and “EOB Data Review/Edit:” prompts, indicate whether you want to view and edit the transaction that was just entered into the Collection Register for this Collection Point. It is recommended that this field be flagged to *Yes*.
4. When you are done editing or adding, press the Tab key until you reach the bottom of the screen and save your work. If you do not want to add another Collection Point, type E for Exit to return to Manager Menu. The system returns to the beginning prompt.

Note: Remember to save any additions or changes to a collection point.

7.7 Upload Third Party Bills by Approval Date(s) (UPAP)

With this Manager Menu option, step 8 in Setup, you automatically pull in existing bills from the Third Party Billing package. You may pull up (upload) bills by approval dates using this option or one by one (see the A/R Master Menu: Upload from Third Party Bill File section).

The system may detect a prior run. If a prior run has been detected, the system provides information on the last run such as the date span of the last run, the last bill number to be uploaded, the status of the last run then when the last run was done (time and date), and the last upload count. This status loops every 10 seconds. If a prior run has not been detected, the system prompts you to enter the date span for the upload.

```

A PREVIOUS RUN HAS BEEN DETECTED

PREVIOUS START DATE  2980701
PREVIOUS END DATE    2990219
LAST BILL NAME 44128A
LAST BILL IEN  0
STATUS OF LAST RUN   COMPLETE
LAST TRANSACTION TIME      FEB 19, 1999, 16:30:35
UPLOAD COUNT  62
PAST BAD BILLS ARE:
You must note the above as the >BAD< Bill(s) above did not cross
over to A/R and will have to be manually uploaded after being
researched as to why they broke.
Status will loop every 10 seconds. ^ to exit:

```

Figure 7-13: Upload third party bills by approval dates example

To upload third party bills grouped by approval dates, follow these steps:

1. Type UPAP at the “Select Manager Option:” prompt. The system displays the screen in Figure 7-13 if it detects a previous run. Otherwise, it prompts for your electronic signature.
2. Type your electronic signature code at the “Enter your Current Signature Code:” prompt.
3. Type the date that the third party billing staff approved for submitting the bill to the third party payer at the “Enter The Beginning Approval Date:” prompt.
4. Type the date of the last approval at the “Enter The Ending Approval Date:” prompt. (The system defaults to the Beginning date.)
5. This process scans the 3P Bill file and extracts all bills with approval dates between those entered. The process checks to make sure that a bill that has already been up-loaded is not duplicated.

6. Type Y to start the process or press the Return key to accept the default response *No* and return to the Manager Menu at the “Are You Ready To Start?” prompt.
7. The system displays the screen illustrated in Figure 7-14: Upload from 3P bill.

```

Enter your Current Signature Code:      SIGNATURE VERIFIED

Select Beginning Date: 060100  (JUN 01, 2000)
Select Ending Date: T  (JUN 19, 2000)

This process will scan the 3P BILL file and extract all bills with approval
dates between 06/01/2000 and 06/19/2000. The process will check to make sure
that a bill that has already been uploaded will not be duplicated.
Are you ready to start?? NO// YES
Starting scan process...
DEVICE: HOME// [RET]   Right Margin: 80//

44652A-ASU-1072 previously loaded .. deleting existing A/R Bill items
44652A-ASU-1072 Now adding 3P Bill items to A/R Bill

44653A-ASU-1072 Previously loaded .. deleting existing A/R Bill items
44653A-ASU-1072 Now adding 3P Bill items to A/R Bill

44654A-ASU-1072 Previously loaded .. deleting existing A/R Bill items
44654A-ASU-1072 Now adding 3P Bill items to A/R Bill

44655A-ASU-1072 Previously loaded .. deleting existing A/R Bill items
44655A-ASU-1072 Now adding 3P Bill items to A/R Bill

4 3P Bills updated to A/R

```

Figure 7-14: Upload from 3P bill

7.8 Insurer Age Cover Letter Edit (LET)

The AR package provides for a preformatted letter that can be edited to each site’s specific information including facility name, contact information as well as the contents in the letter. The letter can be used to follow-up on accounts that have not been paid by specific insurers. With this Manager Menu option, you display a form letter that may be sent to insurance companies. You must first edit the form letter to suit your individual needs, using FileMan editing conventions.

```

Department of Health and Human Services
Indian Health Service
Alaska Native Medical Center
Business Office

<DO NOT Remove this marker for > Insurer Address Information
FROM: ANMC/BO

<DO NOT Remove this marker for > Age and Amount Due Information

```

The above past due has been calculated as of this date. A detailed listing of claims is attached for your reference and information. Please review and advise us as to the status of the past due claims.

If you have questions or concerns, please call Mr. Glen Fowler at 907-345-3456. We appreciate your cooperation.

Sincerely

Figure 7-15: Insurer Age Cover Letter Edit Example

To edit the insurer age cover letter, follow these steps:

1. Type LET at the “Select Manager Option:” prompt.
2. Type Cover Letter Age Days Past Due at the “Select A/R Letters and Text Name:” or ?? to select from a list of letters.
3. Type Y or N at the “Edit?” prompt.

```

Select Manager Option: LET  Insurer Age Cover Letter Edit

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +                Insurer Age Cover Letter Edit                       +
      |                DEMO HOSPITAL                                         |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER, DEMO                BUSINESS OFFICE                12-FEB-2003 10:09 AM

Select A/R LETTERS & TEXT NAME: COVER LETTER AGE DAYS PAST DUE
TEXT:  . . .
      . . .

If you have questions or concerns, please call the Busines Office at
928-289-6189. We appreciate your cooperation.

                        Sincerely,

                        Joe Business
                        Chief of Business Operations

Edit? NO// Y
    
```

Figure 7-16: Editing letter text (steps 1-3)

4. Edit the letter as appropriate. For more information on text editing see sections 2.4.4 and 2.4.5.

```

=[ WRAP ]==[ INSERT ]===== < TEXT >===== [ <PF1>H=Help ]====

                        Department of Health and Human Services
                        Indian Health Service
                        DEMO Indian Hospital
                        Business Office
    
```

```

~<DO NOT Remove this marker for > Insurer Address & Billing Address

~<DO NOT Remove this marker for > Age and Amount Due Information

The above past due has been calculated as of this date. A detailed listing
of claims is attached for your reference and information. Please review
and advise us as to the status of the past due claims.
<====T=====T=====T=====T=====T=====T=====T=====T=====T=====T=>=====T
    
```

Figure 7-17: Editing letter text (step 4)

Note: Do not remove the fields that contain the marker <DO NOT REMOVE THIS MARKER FOR > ... as this is how the AR package will retrieve the data based on pre-specified criteria defined by the Users at the time the letters are printed.

7.9 FileMan Reports (FM)

Many sites requested FileMan access directly within the AR package. This has been accommodated for in the AR package. With this Manager Menu option managers can generate reports and do the following functions:

- Search for specific files and print them
- Sort files by multiple fields and print reports
- Access FileMan Data Dictionaries
- Access addition on-line help while using FileMan

To select the FileMan Reports option, type FM at the “Select Manager Option:” prompt on the Manager menu.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Fileman reports          +
|          UNSPECIFIED SERVICE UNIT          |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,GRETA          BUSINESS OFFICE          21-JUL-2004 9:17 AM

SHP   Search & Print
STP   Sort & Print
DD    FM Data Dictionaries
HLP   Fileman Print & Sort Tips

Select Fileman reports Option:
    
```

A list of available reports will be displayed. Sections 7.9.1 through 7.9.4 explain how to use each report.

7.9.1 Search and Print (SHP)

With this FileMan option, you can find a file and print the file.

To perform a FileMan search and print, follow these steps:

1. At the FileMan menu, type SHP at the “Select FileMan Reports Option:” prompt.
2. Type BAR for A/R at the “Select Package Name:” prompt.
3. Type A/R Bill/IHS, A/R Accounts/IHS, A/R Transactions/IHS, or A/R Collection Batch/IHS at the “Select File:” prompt.
4. Type a field or type ?? to select a field the list of available fields at the “A- Search for <your entry> Field:” prompt.
5. Type Null, Contains, Matches, Less Than, Equals or Greater Than at the “-A- Condition:” prompt.

Note: You can negate any of these conditions by preceding them with "" or "-" so that "null" means not null.

6. Type what the items retrieved must contain, match, be less than, equal to, or greater than (depending on your entry in Step 5) at the “-A- <your entry>” prompt.

```

Select Fileman reports Option: SHP  Search & Print

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      |                   Search & Print                       |
      |                   DEMO HOSPITAL                        |
      +-----+
User: USER, DEMO                BUSINESS OFFICE          12-FEB-2003 10:34 AM
Select PACKAGE NAME: BAR  IHS ACCOUNTS RECEIVABLE      BAR

Select *FILE: A/R ACCOUNTS/IHS

-A- SEARCH FOR A/R ACCOUNTS/IHS FIELD: 1  VP FILE NUMBER
-A- CONDITION: CONTAINS
-A- CONTAINS: THE

```

Figure 7-18: Using the SHP option (steps 1-6)

7. Type another field at the “-B- Search for (your selection) field:” prompt. If you do not have another field, then press the Return key. If you do have another field to enter, follow the remaining prompts as they appear on your screen.
8. Press the Return key at the “If:” prompt to accept the default entry.
9. Press the Return key to indicate *Yes* at the “Store in ‘Sort’ Template:” prompt.
10. Type your selection or type two question marks for help at the “Sort By:” prompt.

11. Press the Return key if you want the field displayed at the “Start with (Field):” prompt.
12. Type the next field of your choice at the “First Print Field:” prompt.
13. Press the Return key if you agree with the heading that is displayed at the “Heading:” prompt.
14. Type the name of your printer or H (home) for display on your screen at the “Device:” prompt. The system displays or print the report.

```

-B- SEARCH FOR A/R ACCOUNTS/IHS FIELD: [RET]

IF: A// [RET]    VP FILE NUMBER CONTAINS "THE"

STORE RESULTS OF SEARCH IN TEMPLATE: [RET]

SORT BY: IEN// [RET]
START WITH IEN: FIRST//[RET]
FIRST PRINT FIELD: [RET]

*****
Heading (S/C): A/R ACCOUNTS/IHS SEARCH  Replace[RET]
DEVICE: [RET]
    
```

Figure 7-19: Using the SHP option (steps 7-14)

7.9.2 Sort and Print (STP)

With this FileMan option, you can pick two or more fields and print a report.

To select two or more fields to print, follow these steps:

1. Type STP at the “Select FileMan Reports Option:” prompt.
2. Type BAR at the “Select Package Name:” prompt.
3. Type A/R Bill/IHS, A/R Accounts/IHS, A/R Transactions/IHS, or A/R Collection Batch/IHS at the “Select File:” prompt.

```

Select Fileman reports Option: STP  Sort & Print

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
      +           Sort & Print           +
      |           DEMO HOSPITAL           |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER, DEMO           BUSINESS OFFICE           12-FEB-2003 10:51 AM

Select PACKAGE NAME: BAR  IHS ACCOUNTS RECEIVABLE           BAR
Select *FILE: A/R ACCOUNTS/IHS
    
```

Figure 7-20: Using the STP option (steps 1-3)

4. Type your selection or type two question marks for help at the “Sort By:” prompt.

5. Press the Return key if you want the field displayed at the “Start with (Field): First//” prompt.
6. Type the next field of your choice at the “Then Print Field:” prompt. .
7. Type the name of the device to which you want to print at the “Device:” prompt. You can also press the Return key to display the report onscreen.

```

SORT BY: IEN// [RET]
START WITH IEN: FIRST// [RET]
FIRST PRINT FIELD: name??
FIRST PRINT FIELD: 1  VP FILE NUMBER
THEN PRINT FIELD: 2  TYPE
THEN PRINT FIELD: 3  ACTIVATION DATE
THEN PRINT FIELD:
DEVICE: [RET]

```

Figure 7-21: Using the STP option (steps 4-7)

7.9.3 FM Data Dictionaries (DD)

With this FileMan option, you can display the XB Utility that automatically generates data dictionaries. Data dictionaries show what files are available in the application. Example: A/R Bill File. This utility shows the content of each file.

Access Data Dictionaries Through FileMan

At the FileMan menu, type DD at the “Select FileMan Report Option:” prompt. The system prompts you to select one of the following:

- O One file only
- S Selected files
- R Range of files
- P Package
- B Build

You can print the results of each of the listed options or browse them onscreen by typing B or P at the “Do You Wish To:” prompt. You will be prompted to type the name of a print device if you selected P.

7.9.3.1 One File Only

To print information for One File Only, follow these steps:

1. Type O for One file only at the “Choose one, or ^ to cancel:” prompt.
2. Type the file at the “Select File:” prompt.

3. Type any additional format you would like or press the Return key to bypass this field at the “Select Format Combination:” prompt.

```

Choose one, or ^ to cancel: O// One file only

Select FILE: 1  FILE

Addition resolution of fields is available
V - VARIABLE POINTER
P - POINTER
S - SET OF CODES
C - COMPUTED EXPRESSION
X - CROSS-REFERENCES
A - ALL

Select Format Combination: X

        Select one of the following:

                P          PRINT Output
                B          BROWSE Output on Screen

Do you wish to : P// PRINT Output
DEVICE: HOME// [RET]

```

Figure 7-22: Printing DD for one file

7.9.3.2 Selected Files

To list selected files, follow these steps:

1. Type S at the “Choose one, or ^ to cancel:” prompt.
2. Type the file at the “Select File:” prompt, or ?? to select from a list of file types.
3. Type another file at the next “Select File:” prompt. Continue selecting files in this manner until all you need are listed, then press the Return key at a blank “Select File:” prompt.
4. Press the Return key at the “Choose One, Return to Continue, or ^ to Cancel:” prompt. The system offers options for additional resolution of the fields. Refer to the FileMan User manual for information about these resolutions.
5. Type any additional format you would like or press the return key to bypass this field at the “Select Format Combination:” prompt.

```

Choose one, or ^ to cancel: O// Selected files

Select FILE: 1  FILE
Select FILE: 2  VA PATIENT
Select FILE: 3  USER
Select FILE: [RET]

```



```

Select one of the following:

      S      Selected files
      R      Range of files
      P      Package
      B      Build
      L      List of files already selected

Choose one, RETURN to continue, or ^ to cancel: [RET]

Addition resolution of fields is available
V - VARIABLE POINTER
P - POINTER
S - SET OF CODES
C - COMPUTED EXPRESSION
X - CROSS-REFERENCES
A - ALL

Select Format Combination: [RET]

Select one of the following:

      P      PRINT Output
      B      BROWSE Output on Screen

Do you wish to : P// PRINT Output
DEVICE: HOME// [RET]

```

Figure 7-23: Selecting selected files

7.9.3.3 Range of Files

To list a range of files, follow these steps:

1. Type R for Range of files at the “Choose one, or ^ to cancel:” prompt.
2. Type the number of the first file to be included at the “From File Number:” prompt.
3. Type the number of the last file to be included at the “Thru File Number:” prompt.
4. Press the Return key at the “Choose One, Return to Continue, or ^ to Cancel:” prompt. The system offers options for additional resolution of the fields. Refer to the FileMan User manual for information about these resolutions.
5. Type any additional format you would like or press the return key to bypass this field at the “Select Format Combination:” prompt.

```
Choose one, or ^ to cancel: O// R Range of files
```

```

From file number:  (1-99999999):  1
Thru file number:  (1-99999999):  99

    249 files selected

    Select one of the following:

        S          Selected files
        R          Range of files
        P          Package
        B          Build
        L          List of files already selected

Choose one, RETURN to continue, or ^ to cancel: [RET]

Addition resolution of fields is available
V - VARIABLE POINTER
P - POINTER
S - SET OF CODES
C - COMPUTED EXPRESSION
X - CROSS-REFERENCES
A - ALL

Select Format Combination: [RET]

    Select one of the following:

        P          PRINT Output
        B          BROWSE Output on Screen

Do you wish to : P// [RET]

```

Figure 7-24: Selecting files by range

7.9.3.4 Package

To list file for an entire package, follow these steps:

1. Type P at the “Choose one, or ^ to cancel:” prompt.
2. Type the name of the package or ?? to select from a list of packages at the “Select Package:” prompt.
3. Press the Return key at the “Choose One, Return to Continue, or ^ to Cancel:” prompt. The system offers options for additional resolution of the fields. Refer to the FileMan User manual for information about these resolutions.
4. Type any additional format you would like or press the return key to bypass this field at the “Select Format Combination:” prompt.

```

Choose one, or ^ to cancel: O// Package
Select PACKAGE NAME: BAR IHS ACCOUNTS RECEIVABLE BAR

Select one of the following:
S Selected files
R Range of files
P Package
B Build
L List of files already selected

Choose one, RETURN to continue, or ^ to cancel: [RET]

Addition resolution of fields is available
V - VARIABLE POINTER
P - POINTER
S - SET OF CODES
C - COMPUTED EXPRESSION
X - CROSS-REFERENCES
A - ALL

Select Format Combination: [RET]

Select one of the following:
P PRINT Output
B BROWSE Output on Screen

Do you wish to : P// [RET] RINT Output
DEVICE: HOME// [RET]

```

Figure 7-25: Listing files by package

7.9.3.5 Build

To list file for specific build, follow these steps:

1. Type B at the “Choose one, or ^ to cancel:” prompt.
2. Type the name of the build or ?? to select from a list of builds at the “Select Build:” prompt.
3. Press the Return key at the “Choose One, Return to Continue, or ^ to Cancel:” prompt. The system offers options for additional resolution of the fields. Refer to the FileMan User manual for information about these resolutions.
4. Type any additional format you would like or press the return key to bypass this field at the “Select Format Combination:” prompt.

```

Choose one, or ^ to cancel: O// B Build

Select BUILD NAME: BAR 1.2          IHS ACCOUNTS RECEIVABLE      IHS
ACCOUNTS RECEIVABLE

      Select one of the following:

          S          Selected files
          R          Range of files
          P          Package
          B          Build
          L          List of files already selected

Choose one, RETURN to continue, or ^ to cancel: [RET]

Addition resolution of fields is available
V - VARIABLE POINTER
P - POINTER
S - SET OF CODES
C - COMPUTED EXPRESSION
X - CROSS-REFERENCES
A - ALL

Select Format Combination: [RET]

      Select one of the following:

          P          PRINT Output
          B          BROWSE Output on Screen

Do you wish to : P// [RET] RINT Output
DEVICE: HOME// [RET]

```

Figure 7-26: Listing files by build

7.9.4 Print & Sort Tips (HLP)

This FileMan option provides on-line help for formatting FileMan Reports. It provides a list of formatting codes, examples, and explanations that will assist you in structuring FileMan reports. Once activated, you may scroll down the list to find the information you need. The Crib Sheet (Figure 7-27) is used as a learning aid for users who are new to FileMan.

To access FileMan help, follow these steps:

1. Type HLP at the “Select FileMan Report Option:” prompt in FileMan menu. The Crib Sheet screen is displayed.
2. Use the commands noted on the screen to move from screen to screen or to exit.

Select Fileman reports Option: HLP Fileman Print & Sort Tips		
OUTPUT BROWSER	Jun 19, 2000 16:21:08	Page: 1 of 13
	CRIB SHEET	
PRINT OPTIONS		
Formatting Codes:	Examples:	Explanation:
C-Column Assignment	FIRST PRINT FIELD: Name;C10	Print Name in column 10
	FIRST PRINT FIELD: Name;C-30	Print Name 30 columns from the right margin
S-Skip Lines before printing	FIRST PRINT FIELD: Name;S1	Skip 1 line the next name
L-Left Justify	FIRST PRINT FIELD: Name;L8	Print only the first 8 characters of the name
R-Right Justify	FIRST PRINT FIELD: Name;R30	Right justify the columns from the end of the last value plus 2 column spaces
W-Word Wrap	FIRST PRINT FIELD: Text;W20	Wrap after 20 columns of text but will not split words
D-Decimal Points	FIRST PRINT FIELD: Cost;D1	Use only one decimal place
N-No Repeat occurrence of the	FIRST PRINT FIELD: Nursing;N	Will not repeat consecutive same name

Figure 7-27: Using FM help

7.10 Parent Facility Kill (PFK)

This Manager Menu option deletes a parent facility from the list of A/R Regional Sites. It is recommended that this key be delegated only to the Site manager. When proceeding with the PFK option, ALL files that contain transaction information will be deleted.

Note: Use this option with caution: It requests confirmation and, if confirmed, removes the facility from the system.

To kill a parent site, follow these steps:

1. Type PFK at the "Select Manager Option:" prompt. The system displays the "<Facility Name> to be Deleted as an A/R Regional Site??" prompt.
2. If you are sure you want to remove the named site, type Y. If not, press the Return key to accept the *No* default. The system redisplay the Manager menu.

DEMO HOSPITAL to be DELETED as an A/R Regional Site?? NO// **YES**

```

DELETED: A/R COLLECTION BATCH/IHS
DELETED: A/R COLLECTION POINT/IHS
DELETED: A/R ACCOUNTS/IHS
DELETED: A/R BILL/IHS
DELETED: A/R PARENT/SATELITE/IHS
DELETED: A/R SITE PARAMETER/IHS
DELETED: A/R SPECIAL ACCOUNTS
DELETED: A/R TRANSACTIONS/IHS

DEMO HOSPITAL Has been DELETED

Enter RETURN to continue or '^' to exit:
    
```

Figure 7-28: Killing a parent facility

7.11 Management Reports (RPT)

This Manager Menu option allows you to generate and either display reports directly on your computer screen or print reports using a designated printer. This menu contains the Auto Sync report (SYNC).

To select the Management Reports option, type RPT at the “Select Manager Option:” prompt on the Manager menu.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Management Reports                             +
|           UNSPECIFIED SERVICE UNIT                       |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,GRETA           BUSINESS OFFICE           21-JUL-2004 9:21 AM

PSP   Parent/Satellite Print
STP   Standard Table Entry Print
CPP   Collection Point Print
CXL   Cancelled Bills Report
SYNC  Auto Sync Report

Select Management Reports Option:
    
```

7.11.1 Collection Point Print (CPP)

This Management Report option lists each Collection Point (name/location) along with the names of all users and supervisors who have access to accounts. Users are listed and classified as either business office or fiscal management personnel.

To list collection points, follow these steps:

1. Type CPP at the “Select Management Reports Option:” prompt.
2. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin:” prompt. The system prints/displays the report.

A/R COLLECTION ID/IHS LIST		JUN 20,2000	09:00	PAGE 1
A/R SECTION				
NAME	USER NAME	SERVICE/SECTION		
APPROVING OFFICIAL(S)				

BUSINESS OFFICE				
AAOBO				
USER(S):				
	USER, DEMO	BUSINESS		
	USER2, TOMMY	BUSINESS		
	USER3, LITA	BUSINESS		
SUPERVISOR(S):				
	USER, DEMO			
	USER3, LITA			
MEDICARE OUTPT				
USER(S):				
	GUEST, NINE	BUSINESS		
SUPERVISOR(S):				
BUSINESS OFFICE				
No Pay				
USER(S):				
	USER, ANNA M	BUSINESS		
SUPERVISOR(S):				
	USER, ANNA M			

Figure 7-29: Collection point print screen

7.11.2 Parent/Satellite Print (PSP)

This report lists parent facilities and their satellites. For example, the parent facility, Billings Administration, may be displayed with its satellite facilities, Lame Deer, Fort Yates, etc. Note that because the way the A/R Software is defined in the Setup, the Billings Administration would be listed as its own satellite.

To generate a list of parent facilities and their satellites, follow these steps:

1. Type PSP at the “Select Management Reports Option:” prompt.
2. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin:” prompt. The system prints/displays the report.

A/R PARENT/SATELLITE/IHS LIST		MAR 27,1995	11:30	PAGE 1
PARENT	SUFFIX	LOCATION		

BILLINGS ADMINISTRATION	BA	BILLINGS ADMINISTRATION		
	BH	BROWNING HO		
	CH	CROW HO		
	FW	FORT WASHAKIE HC		
	HH	HARLEM HO		

LD	LAME DEER HC
RB	ROCKY BOY HC

Figure 7-30: Parent/satellite print screen

7.11.3 Standard Table Entry Print (STP)

This option shows a) each table type (archived, closed, hold, etc.), b) its acronym or shortcut, c) each subcategory and its acronyms plus local and area codes.

To print/display the A/R Table Entry List, follow these steps:

1. Type STP at the “Select Management Reports Option:” prompt.
2. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin:” prompt. The system prints/displays the report.

IHS A/R TABLE ENTRY LIST				JUN 20,2000 09:39	
PAGE 1					
TABLE TYPE	TABLE ACRONYM	ACRONYM	NAME	LOCAL CODE	AREA CODE
ACCOUNT STATUS	ACST		ARCHIVED	AR	AR
			CLOSED		
			HOLD	HO	HO
			OPEN	OP	OP
		CK	PER CHECK		
			TAGGED FOR ARCHIVE	TAR	TAR
ACCOUNT TYPE	ACTY	B	BILLABLE		
			EMPLOYEE		
		F	FINANCIAL		
			INSTITUTION		
			INSURANCE		
			PATIENT		
			VENDOR		
BATCH ERRORS	BTER		BILL ERROR		
			CANCELLED		
CHECK/BANK DATA			ERROR		
			CREDIT/CARD ERROR		
			DEBTOR ERROR		
			OTHER		
			PATIENT ERROR		
			PAY AMOUNT ERROR		
			PAYER ERROR		
		R	REFUND		
BILL ED/ER TYPE	BLEDTP		CANCELLED		

EDIT ENTERED IN ERROR

Figure 7-31: A/R table entry list

7.11.4 Cancelled Bills Report (CXL)

This report lists bills that were cancelled in the Third Party Billing package but were previously transmitted to AR as an open bill with a balance. Because the billers cancelled the bills, the bills were not sent to the Payer and this report should be run to identify those bills that need to be adjusted in AR.

Reports for multiple locations can be printed separately. In addition, you can sort cancelled bills on this report by the following parameters:

- Visit Date
- Visit Location
- Open Balance Bill Only
- Approval Date

For more information about inclusion parameters, please see section 11.1, Reporting Basics.

To run the Cancelled Bills Report, follow these steps:

1. Type CXL at the “Select Management Reports Option:” prompt from the Management Reports menu.

The screen shown in Figure 7-32 is displayed.

```

+++++-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
+                Cancelled Bills Report                               +
|                NOT-A-REAL FACILITY                                  |
+++++-----+
User: USER NAME                                           28-SEP-2005 1:09 PM

NOTE: This report will contain data for VISIT location(s) regardless of
      BILLING location.

Select Visit LOCATION:
    
```

Figure 7-32 Cancelled Bills Report (step 1)

2. Type the name of the location at the “Select Visit Location:” prompt or press the Return key to select all available locations.

To see the complete list of locations, type ?? or go to Table 2-1 and Table 2-2. in this document to see the list of visit types and clinic codes, respectively.

3. Type Y or N at the “Include Only bills with an open balance?” prompt.

- If you type Y, go to step 4. (Y is the default.)
- If you type N, respond to each of the following prompts or press the Return key to accept the default.
 - a. Type 1 for Approval Date (default selection) or 2 for Visit Date at the “Select Type of Date Desired:” prompt.
 - b. Type the beginning date for the report at the “Enter Beginning [Approval/Visit] Date:” prompt.
 - c. Type the ending date for the report at the “Enter Ending [Approval/Visit] Date:” prompt.
- 4. Type 1 for Detailed (this is the default) or 2 for Summary at the “Select Type of Report Desired:” prompt.

After you make your selection, a message similar to the one that follows is displayed. (Note that your message shows the selections you made.)

Note: You have selected to produce a Detail Cancelled Bills Report For ALL Visit Locations containing ALL bills with APPROVAL Dates of 10/00/2004 to 12/00/2004

5. Type Y or N at the “Proceed?” prompt.
6. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - type the name of the printer to print this report
 - press the Return key to view this report on your monitor

Figure 7-33 provides an example of this report.

WARNING: Confidential Patient Information, Privacy Act Applies				
=====				
Detail Cancelled Bills Report		MAY 18, 2004@12:01		Page 1
For UNSPECIFIED SERVICE UNIT Visit Locations				
containing ALL bills with APPROVAL Dates of 04/01/2003 to 04/30/2004				
=====				
BILL	PATIENT NAME	AMT BILLED	DOS	BALANCE
=====				
VISIT Location: UNSPECIFIED SERVICE UNIT				
A/R Account: ARIZONA MEDICAID				
1259C-AH-99092	GEORGE, MARY	31.70	01/09/2003	31.70
1395A-AH-43566	JONES, CHIPPER	1,526.00	11/02/2003	1,526.00
1398A-AH-43566	JONES, CHIPPER	18,312.00	01/01/2004	18,312.00
		-----		-----
		19,869.70	(3 bills)	19,869.70
A/R Account: BC/BS OF KC				
1681A-AH-43567	SHEFFIELD, GARY	250.00	04/18/2004	250.00
		-----		-----
		250.00	(1 bills)	250.00
A/R Account: BC/BS OF MARYLAND INC				

1654A-AH-43566	JONES,CHIPPER	67.00	03/31/2004	67.00
		-----		-----
		67.00	(1 bills)	67.00
	A/R Account: CIMARRON SALUD			
1377A-AH-990985	NORTH,STAR	205.00	10/16/2003	205.00
1377B-AH-990985	NORTH,STAR	340.00	10/16/2003	340.00
		-----		-----
		545.00	(2 bills)	545.00
	A/R Account: DELTA DENTAL OF NEW MEXICO INC			
1392A-AH-109537	VALDEZ,DELLA	98.00	11/03/2003	98.00
		-----		-----
		98.00	(1 bills)	98.00
	A/R Account: KIDS CARE			
1630A-AH-99097	HANDLER,MAIL	67.00	03/02/2004	67.00
		-----		-----
		67.00	(1 bills)	67.00
	A/R Account: KIDSCARE			
1632A-AH-99088	CABBAGE,GREEN	67.00	04/01/2004	67.00
		-----		-----
		67.00	(1 bills)	67.00
	A/R Account: MEDICARE			
1259A-AH-99092	GEORGE,MARY	175.00	01/09/2003	15.00
1308A-AH-109560	SIMMS,MARISSA RENA	175.00	05/19/2003	175.00
1667A-AH-99096	OLDAGE,LADY	175.00	12/02/2003	175.00
1667B-AH-99096	OLDAGE,LADY	175.00	12/02/2003	175.00
1667C-AH-99096	OLDAGE,LADY	175.00	12/02/2003	175.00
1668A-AH-99096	OLDAGE,LADY	231.00	03/15/2004	231.00
1679A-AH-99096	OLDAGE,LADY	688.00	04/07/2004	688.00
		-----		-----
		1,794.00	(7 bills)	1,634.00
	A/R Account: NEW MEXICO MEDICAID			
1322A-AH-99091	STEELE,DANIELLE	466.00	05/18/2003	0.00
1664B-AH-99102	MEDICAID,TWO	206.00	03/16/2004	206.00
1663A-AH-99102	MEDICAID,TWO	206.00	03/28/2004	0.00
1662A-AH-99102	MEDICAID,TWO	206.00	03/29/2004	206.00
		-----		-----
		1,084.00	(4 bills)	412.00
	A/R Account: PAID PRESCRIPTIONS			
1009A-AH-461023	GARDUNO,FREDDY	71.92	09/05/2002	71.92
		-----		-----
		71.92	(1 bills)	71.92
		-----		-----
** VISIT Location Subtotal		23,913.62	(22 bills)	23,081.62
		=====		=====
*** REPORT TOTAL		23,913.62	(22 bills)	23,081.62

Enter RETURN to continue or '^' to exit:

Figure 7-33: Cancelled bill report (sample report)

This completes the procedure for creating the cancelled bill report.

7.11.5 Auto Sync Report (SYNC)

A Auto Sync report (SYNC) has been added to allow management to view and work those bills that received the Auto Sync transaction when patch 3 of A/R v1.6 was installed. The report will display the bill balance and transaction history balance (before the Auto Sync transaction addition) and the difference between the two. If there are bills listed on this report, contact your local IT department to place a call into the OIT Service Center. It is important to correct these bills because the balances on both the ASM and PSR reports will not reconcile during the month end process.

To print the New Auto Sync Report, follow these steps:

1. Type SYNC at the "Select Management Reports Option:" prompt.
2. Type the name of the visit location for which you are accessing information or leave blank for all locations at the "Select Visit Location:" prompt
3. Type the name of your printer or H (Home) to display on your screen at the "Device:" prompt. Then press the Return key at the "Right Margin:" prompt. The system prints/displays the report.

WARNING: Confidential Patient Information, Privacy Act Applies						
=====						
Auto Sync Management Report			JUL 16, 2002		Page 1	
at ALL Visit location(s) regardless of Billing Location						
=====						
A/R BILL	DOS	A/R ACCOUNT	BILL BALANCE	TRANSACTION HISTORY BAL	DIFFERENCE	
=====						
(Data from Auto Sync run date of JUN 10, 2002)						
Visit Location: DEMO HEALTH CENTER						
202810-2001-	10/02/2001	AETNA LIFE AND	1,020.00	20.00	1,000.00	
17147B-JSU	11/23/1998	BCBS OF NEW MEX	36.56	0.00	36.56	
15550A-JSU	02/11/1997	CIGNA	-22.00	151.00	-173.00	
14152A-JSU	09/21/1998	NEW MEXICO MEDI	-136.00	-152.00	16.00	
** Visit Location Total (Bill cnt: 4)			898.56	19.00	879.56	
*** REPORT TOTAL (Bill cnt: 4)			898.56	19.00	879.56	

Figure 7-34: New Auto Sync Report

7.12 Standard Table Edits (STE)

With this Manager Menu option, you enter/edit the standard table entries that come with the package. Once these options are entered into the system, they may be used for transactions used in the A/R package.

To edit the Standard Table Entries, follow these steps:

1. Type STE at the “Select Manager Option:” prompt.

The A/R package is installed with the following list of table types from which you can select. You cannot add new table types.

Account Type	Bill ED/ER Type
Account Status	Billing Service
Write Off	Deductible
Non Payment	Co-Pay
Charges	Penalty
Transmiss Status	Groupier Allowance
Transaction Type	Service/Selection
Check	Bill Type
Bill Status	Refund
Batch Errors	Payment Credit
Pending	General Information

2. Press the Return key to confirm your selection at the “Name:” prompt.
3. Type the table entry (Note that the list of table entries through ?? differs according to the table type you selected) at the “Table Entry:” prompt. Then press the Return key to confirm your entry.
4. Type a local code of 1-3 characters at the “Local Code:” prompt.
5. Type an area code of 1-3 characters at the “Area Code:” prompt.
6. Type an acronym of 1-6 characters at the “Acronym:” prompt.
7. An acronym in this case is considered a shortcut or a *Hot Key*. You may want to add an acronym to use as a shortcut.
8. When the system redisplay the “Table Entry:” prompt, repeat the process for another table entry or type a caret (^) to exit.

```

Select Manager Option: STE Standard Table Edits

+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+-----+-----+-----+-----+-----+-----+-----+
|          Standard Table Edits          |
|          DEMO HOSPITAL          |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER, DEMO          BUSINESS OFFICE          12-FEB-2003 1:24 PM

TYPE OF TABLE: CHECK          PAYTYP
NAME: CHECK//[RET]

TABLE ENTRY: ??

Choose from:
    
```

```

51          EOB CHECK
52          CASH
53          CREDIT CARD
54          MONEY ORDER
81          PERSONAL CHECK
99          GENERAL LEDGER
604        CODING ERROR

TABLE ENTRY: 51  EOB CHECK
NAME: EOB CHECK//[RET]
LOCAL CODE: 1
AREA CODE: 505
ACRONYM: EOB// [RET]

TABLE ENTRY: [RET]

TYPE OF TABLE: [RET]
    
```

Figure 7-35: Editing the standard table

7.13 View Host File (VHF)

With this Manager Menu option, you can view host files. Once the directory is selected, you may use RPMS wild card key to aid in the search and selection of a file. The '*' wild card cannot be the first character in the file name. Note that the file is viewed using the List Manager utility.

To open and display a Host File, follow these steps:

1. Type VHF at the “Select Manager Option:” prompt. The system prompts for a directory and shows /tmp as the default.
2. Type the directory or press the Return key to accept the /default directory at the “Replace:” prompt. Note that the default may also be setup in SPE option under “Default path.”
3. Type the file name, using the wild card (*) for any character in the name except the first at the “File Name:” prompt. The system displays the indicated file.

```

Select Manager Option: VHF  View Host File

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |                View Host File                +---+---+---+---+---+
      |                DEMO HOSPITAL                |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER, DEMO                BUSINESS OFFICE                12-FEB-2003 1:42 PM

Directory: /usr/spool/uucppublic/  Replace [RET]
File name: a*
    
```

Figure 7-36: Using the VHF option

7.14 IG Report (IG)

This report was made available for a specific IG request that was requested a few years ago. The report is functional but other reports are available in the AR package that might meet the manager’s specific needs.

With this Manager Menu option you can display or print a list of bills that have outstanding balances, by insurer, as of a specified date. Keep in mind when printing this report that it does report back to when transactions first appeared in the A/R system. You can also queue this report to generate at the Area Office.

Outstanding Balances by Insurer for Bills approved by 09/30/97			
MAY 06, 1993, 15:59:38		PAGE: 1	
Insurer	Billed Amt	Accounted For	Outstanding
DELTA DENTAL PLAN OF ILLI	703.95 693.95	10.00	
NEW MEXICO BC/BS INC	12,755.40	0.00	12,755.40
NEW MEXICO MEDICAID	381.00 345.00	36.00	
MAIL HANDLERS BENEFIT PLA	33,371.36	20.00	33,351.36
MEDICARE	3,809.16	169.57	3,639.59
TOTALS:	52,815.37	1,300.52	51,514.85

Figure 7-37: IG Report Screen

To generate and display the IG Report, follow these steps:

1. Type IG at the “Select Manager Option:” prompt.
2. Type Y or N at the “Send an electronic copy to the area office?” prompt.
3. Type the date for which the report data should end or press the Return key to accept the default date at the “Enter the Ending Date:” prompt. The system indicates that it will take awhile and will be automatically queued.
4. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin:” prompt. The system prints/displays the report.

```

Select Manager Option: IG  IG REPORT

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |          DEMO HOSPITAL          |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER, DEMO          BUSINESS OFFICE          12-FEB-2003 1:53 PM

Send an electronic copy to the area office ? N NO
Enter the ending date: SEP 30, 1997// 020203 (2 FEB 2003)
    
```

```
>> This report takes a while and will be automatically queued! <<
DEVICE: HOME// [RET]      Right Margin: 80// [RET]
```

Figure 7-38: Printing the IG report

7.15 Delete Flat Rate Posting Batch (FRD)

With this Manager Menu option, you can delete a Flat Rate Posting Batch that has been previously posted. Note that this option deletes only posted batches and should only be used with Management direction. Once the batch is deleted, you will not be able to retrieve it.

Deleting the flat rate batch does not delete the transactions previously posted.

To delete the Flat Rate Posting Batch, follow these steps:

1. Type FRD at the “Select Manager Option:” prompt.
2. Type the name of the FRP batch to be deleted or type ? at the “Select FRP Batch:” prompt to select from the list.
3. Confirm your selection by typing Y at the “Delete (batch selected)?” prompt. The system displays Deleted, and then returns you to the Manager menu.

```
Select Manager Option: FRD Delete Flat Rate Posting Batch

      +---+-----+-----+-----+-----+-----+-----+-----+-----+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +-----+ Delete Flat Rate Posting Batch +-----+
      |                DEMO HOSPITAL                |
      +---+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER, DEMO                BUSINESS OFFICE                12-FEB-2003 1:59 PM

Select FRP Batch: AML-AUG 9,2001@15:48:02
Delete AML-AUG 9,2001@15:48:02? No// YES
Deleted!
```

Figure 7-39: Deleting a batch

7.16 Automatic Write-Off (AWO)

This option does not function and was used for a brief time period to allow sites the ability to meet the 2000 A/R Interim Policy clean-up deadline. To access this functionality, you will need to contact your Area Business Office Coordinator to begin the approval process.

To use this option, you may write off bills up to and including a certain Date of Service (DOS). However, a date of service of less than 3 years old may not be entered. Bills found within the specified DOS are written off to code 502 Auto Write-off 2001 if the following conditions are met:

- The DOS on the bill is at least three (3) years old.
- The amount billed is less than \$20,000.00
- The A/R Account tied to the bill is in the list specified and not Non-Beneficiary.
- There is a positive balance left on the bill
- The Visit Location tied to the bill is in the list specified

Note: This menu option expires on February 15, 2002.

```

Enter Date of Service:  JAN 1, 1997
Select A/R Account:  ALL// ??
1B-ASU                for    6,437.70 written off.
43548B-ASU            for    671.00 written off.
43593A-ASU            for    344.18 written off.
3 Bills written off to Auto Write Off 2001.

```

Figure 7-40: Automatic Write-Off Screen

To write off approved accounts with AWO, follow these steps:

1. Type AWO at the “Select Manager Option:” prompt.
2. Type in the date of service on and before which bills are to be written off.
3. At the “Select A/R Account:” prompt, type in an A/R Account, type ?? to select it from a list, or press the Return key to write off bills in all A/R accounts. (If you enter or select one A/R account, the system continues to prompt for another account until you press the Return key through a blank field.) The system displays the bills that are being written off, then, when the process is completed; a message indicates how many bills were written off to code Auto Write Off 2001, as shown below.

7.17 Bill File Error Scan (BES)

With this Manager Menu option you scan the A/R Bill files for possible technical problems that can occur because bills are being sent over from the Third Party billing package and there are sometimes differences in the bill data. Note that this option must be run before printing any of the synchronization reports under the A/R Master Menu Reports option. When this scan is run, it first gives you the date of the last A/R Bill File error check.

Understanding the structure of how the bills are received by the A/R package is important to understanding why the BES option is in place. Both Third Party Billing and A/R have a bill file. The Third Party Billing bill file is called the 3P Bill file and the A/R bill file is called the A/R Bill/IHS file. When a claim is approved in Third Party Billing, it becomes a bill, thus creating an entry in the 3P Bill file. An entry also gets created in the A/R Bill/IHS file. Bill information from the Third Party Bill file is entered into the A/R bill file. This is how Third Party Billing “talks” to A/R.

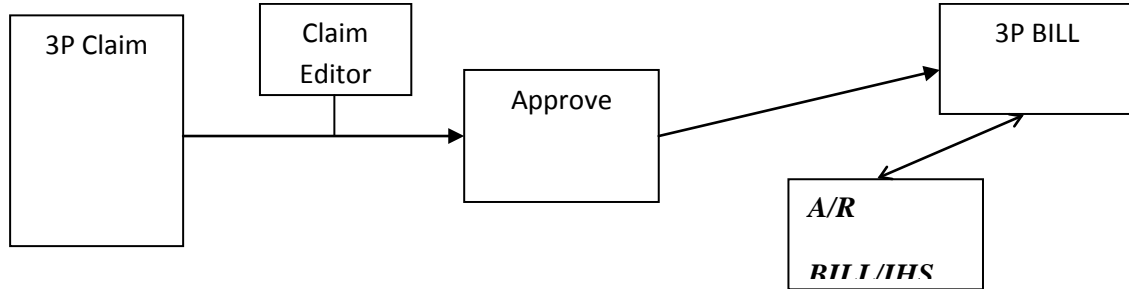


Figure 7-41: Creating bill file

To scan the Bill File for errors, follow these steps:

1. Type BES at the “Select Manager Option:” prompt.
2. Type Y at the “Re-Run:” prompt.
3. Type the first date in the date range for the scan at the “Select Beginning Date:” prompt.
4. Type the last date in the date range for the scan at the “Select Ending Date:” prompt.
5. Press the Return key to accept *Now* to start the scan or type a date in the future at the “Requested Start Time:” prompt.
6. The system indicates that the request is queued.
7. Press the Return key to exit at the “Enter Return to continue:” prompt. This completes the process.

```

Select Manager Option: BES  Bill File Error Scan

      +---+-----+-----+-----+-----+-----+-----+-----+-----+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +-----+-----+-----+-----+-----+-----+-----+-----+
      |                Bill File Error Scan                                +
      |                DEMO HOSPITAL                                       |
      +---+-----+-----+-----+-----+-----+-----+-----+
User: USER, DEMO                BUSINESS OFFICE                12-FEB-2003 2:10 PM

This option will scan the A/R Bill file for problems and must be
run before printing any of the synchronization reports

A/R Bill File error check was last run on 5-FEB-2003.

Re-run? NO// YES

Select A/R Bills by DOS Date Range.
Select Beginning Date: 010101  (JAN 01, 2001)
Select Ending Date: 020202  (FEB 02, 2002)
Requested Start Time: NOW// [RET] (FEB 12, 2003@14:10:57)
Task# 13076 queued.
  
```

```
Enter RETURN to continue: [RET]
```

Figure 7-42: Scanning the bill file for errors

7.18 ERA Import Delete (ERAD)

With this Manager Menu option, you can delete Electronic Remittance Advice (ERA) imported files that are no longer necessary to keep on file based on Records Management guidelines.

To delete an ERA Import, follow these steps:

1. Type ERAD at the “Select Manager Option:” prompt.
2. Type name of the ERA file to be deleted or type ?? to view the list of ERA files that exist in the system at the “Select A/R EDI Import Name” prompt. The system displays the import file name, its EDI, and batch name and item number, then prompts you to indicate whether or not (Yes or No) you want to proceed with the deletion.
3. Type Y to continue the deletion or press the Return key to accept the default response of N. A message indicates whether or not the import was deleted and the “Select A/R EDI Import Name:” prompt is displayed again for entry of another import to be deleted.

7.19 Automatic Write-off Reversal (REV)

Through this option, all transactions (at all facilities) of transaction type 43 (Adjustment) with Adjustment Category 3 (Write Off) and Adjustment Type 501 (Auto Write-off 2000) will be reversed by creating a new transaction of the same type, but negative dollar amount. The bill(s) will be re-opened in AR with a balance due.

Note: If the option has been run previously, this option is disabled. A text message will state that the option has already been run and post the date that the run occurred. If you feel that this message is received as a result of an error, contact the RPMS support center.

If the option has not been run, a message will appear prompting you to continue (type Y) or not continue (type N) with the write-off reversal. If you choose to continue, a list of the bill numbers that are being reversed will cross the screen. This list is presented so that it may be captured for office records. Once all appropriate write-offs have been reversed, the program will summarize the number of write-offs reversed through the REV option. After the summary appears you will be returned to the Manager’s menu.

```

The bill number and amount written off will scroll by on the screen
if you wish to capture this information.

Continue? No// YES
1A-ASU                      for  -6,360.20 written off (reversed).
(list has been truncated for screen shot display only)

44090A-ASU-384759          for    100.00 written off (reversed).??
43552A-AH-234123          for    -29.55 written off (reversed).
43641A-AH-234123          for     -5.00 written off (reversed).
43552A-AH-234123          for     29.55 written off (reversed).
43641A-AH-234123          for      5.00 written off (reversed).

54 Bills with Auto Write off 2000 (501) reversed.

```

Figure 7-43: Automatic write-off reversal screen

7.20 Manual Resend of Unsent Files (EISS)

This option is for those sites that are sending files to EISS. You can use this option to check the local folder on the Site reporting machine and attempt to resend any unsent files.

To resend any unsent file manually, follow these steps:

1. Type EISS at the “Select Manager Option:” prompt.

A list of available files to resend is displayed.

2. Type the number for that corresponds to the file you want to resend at the “Please enter the LINE # of the EISS file to be resent:” prompt.
3. Type Y to resend the file or N to cancel sending the selected file at the “Would you like to resend <FILENAME.EXT> now?” prompt.

If you typed Y, a message similar to the one shown in Figure 7-44 is displayed at the bottom of the screen indicating that the selected file is ready to be sent automatically.

```

Select Manager Option: EISS  Manual Resend of Unsent Files

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
      +           Manual Resend of Unsent Files                   +
      |           QUICK ATTENTION HEALTH CENTER                   |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User:  USER,NAME           BUSINESS OFFICE           5-MAY-2004 4:27 PM

1  BARPSR202110200311012003113020040426085714_000003.TXT
2  BARPSR202110200311012003113020040426085946_000003.TXT
3  BARPSR202110200311012003113020040426102348_000003.TXT
4  BARPSR202110200311012004042320040423154731_000003.TXT

```

```
5  bar_0170.05t1k
6  E0040007.113

Please enter the LINE # of the EISS file to be resent: 6

Would you like to resend E0040007.113 now? Y// YES

Export file C:\INETPUB\FTPROOT\Pub\E0040007.113 queued up to be sent to -il
"bardata:1bardat/" 161.223.90.5...
```

Figure 7-44: Manual resend of any unsent files

This completes the procedure for resending a unsent file manually.

8.0 Patient Account Statement Menu (PAS)

This is a menu option that allows you to print Patient Account statements. To setup the option of printing the statements, there are three steps. You should edit the header of the statements specific to your facility information, flag specific patient accounts and then print the statements through RPMS TaskMan.

You can flag specific patient accounts to receive statements and then print those statements either by a batch or individually. Through RPMS TaskMan you can schedule the statements to be run at specific dates and times. The statement contains all the account activity for a given date range. The statements queued to run through TaskMan can then be run using the PRA option.

See Figure 8-1 for a breakdown of each of the listed fields in the Patient Account statement.

1. The statement header shows your site information. The header will be shown on the top of each page of the statement.
2. This field shows the patient's information, including name and address. This information will be shown on the top of each page of the statement.
3. This field shows the dates of service in which a bill has been submitted.
4. **DOS:** The dates of service.
5. **Trans Date:** The transaction dates, or the dates that the noted transaction took place (i.e. payment received).
6. **Bill Number:** The bill number for each of the dates of service.
7. **Service Type:** The abbreviation for each type of service.
8. **Description:** A brief description of each of the transactions (i.e. billed Medicare).
9. **Chrg:** The amount of each of the charges.
10. **Credit:** This field shows the amount of any credit or payment made to the account.
11. **Patient Bal:** The amount that is due from the patient.
12. Summary by days due: This section gives a break down of the age of the patient balance portion of the statement.

<p style="text-align: center;"> 1 Indian Health Service PHS Unspecified Indian Hospital 1234 Main St Anywhere, USA 12345 (555) 555-0123 </p>							
<p> 2 PATIENT, DELLA P.O. BOX 123 08/21/2003 ANYWHERE, USA, 23456 </p>			<p> 3 STATEMENT PERIOD 08/21/2002 - </p>				
<p> 4 6 7 8 9 10 11 </p>							
DOS	Trans Date	Bill Num	Service Type	Description	Chrg	Credit	Patient Bal
01/01/2001	07/26/2001	44827	IMM	BIL/BIGHO	272.10		272.10
01/01/2001	07/26/2001	44828	IMM	BIL/NEW M	15.00		**
11/28/2001	02/21/2002	44856	GEN	BIL/GREAT	142.20		**
	02/27/2002			BIL/METRO	142.20		**
<p> 12 ** SUMMARY by days due** </p>							
0-29 Days	30-59 Days	60-89 Days	90-120+ Days	TOTAL DUE			
\$ 0.00	\$ 0.00	\$ 0.00	\$ 272.10	\$ 272.10			
<p>+++PAYMENT DUE UPON RECEIPT+++</p>							
<p>** Your Insurance has been billed. You may be responsible for all or a portion of the billed amount based on your scheduled benefits. Statement reflects all transactions up to statement date.</p>							
<p>This statement is intended for the above named patient, if you have received this statement in error please notify us immediately.</p>							

Figure 8-1: Breakdown of fields on the patient account statements

To access the Patient Account Statement menu, type PAS at the "Select A/R Master Menu Option:" prompt.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+
|          Patient Account Statement Menu                 |
+-----+
|          UNSPECIFIED SERVICE UNIT                       |
+-----+
    
```

```

User: USER,GRETA                BUSINESS OFFICE        21-JUL-2004 3:16 PM

SHDR  Enter/Edit Statement Header Text
FLAG  Flag Patient Accounts for Statements
PRA   Print All Flagged Patients' Account Statements
PRO   Print One Flagged Patient's Account Statement

Select Patient Account Statement Menu Option:

```

Figure 8-2: Patient account statement menu

Sections 8.1 through 8.5 explain how to use each of the menu options in the Patient Account Statement menu.

8.1 Setting up TaskMan to Run Patient Statements

To run a batch of the Patient Account statements, you must first schedule the statements to be queued.

To schedule the statements, follow these steps:

1. Access TaskMan through the IHS Core menu.
2. Type SCHEDULE at the “Select TaskMan Management Option:” prompt.
3. Type BAR ACCOUNT STATEMENT at the “Select Option to Schedule or Reschedule:” prompt.
4. Type Y at the “OK?” prompt.

```

Schedule/Unschedule Options
One-time Option Queue
TaskMan Management Utilities ...
List Tasks
Dequeue Tasks
Requeue Tasks
Delete Tasks
Print Options that are Scheduled to run
Cleanup Task List
Print Options Recommended for Queueing

Select TaskMan Management Option: Schedule/Unschedule Options

Select OPTION to schedule or reschedule: bar account STATEMENT      Patient
Account Statement
...OK? Yes// [RET] (Yes)

```

Figure 8-3: Scheduling the patient account statements (steps 1-4)

5. The system will open the Edit Option Schedule screen.
6. Use the arrow keys or the Tab key to move between the prompts.
7. Type the date and time you would like the statements run at the “Queued To Run At What Time:” prompt.

8. Type the scheduling frequency for when you would like the statement queued at the “Rescheduling Frequency:” prompt.
9. Type SAVE and the press the Return key at the “Command:” prompt
10. Then type EXIT and the “Command:” prompt to exit TaskMan.

```

                                Edit Option Schedule

Option Name: BAR ACCOUNT STATEMENT
Menu Text: Patient Account Statement                TASK ID: 9090
-----

QUEUED TO RUN AT WHAT TIME:  SEP 18,2003@18:00

DEVICE FOR QUEUED JOB OUTPUT:

QUEUED TO RUN ON VOLUME SET:

    RESCHEDULING FREQUENCY:  1M(18@18:00)

        TASK PARAMETERS:

            SPECIAL QUEUEING:

-----
Exit      Save      Next Page      Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                     Press <PF1>H for help      Insert

```

Figure 8-4: Scheduling the patient account statements (steps 5-10)

8.2 Enter/Edit Statement Header Text (SHDR)

Use this option to enter or edit the statement header. The header will be displayed at the top of all statements. You will want to include the facility name and address, business office phone number, point of contact, and special messages. The statements will print up to 10 lines of text.

To edit or enter the statement header, follow these steps:

1. Type SHDR at the “Select Patient Account Statement Menu Option:” prompt.
2. The system will display the current statement header.
3. Type Y at the “Edit?” prompt.
4. The system will open the header in your default text editor. Edit or enter the text as appropriate.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Enter/Edit Statement Header Text              +
|          UNSPECIFIED SERVICE UNIT                      |
+-----+
User: USER, DEMO          BUSINESS OFFICE          21-AUG-2003 10:07 AM

You may enter text that will appear at the top of the account
statements. Typically this will be facility name and address,
business office phone number, point of contact, and special
messages. The statements will print up to 10 lines of text.

TEXT:

                Indian Health Service
                PHS UNSPECIFIED Indian Hospital
                1234 MAIN ST
                ANYWHERE, USA 87000
                (555) 555-1234

Edit? NO// Y YES

==[ WRAP ]==[ INSERT ]===== < TEXT >===== [ <PF1>H=Help ]====
                Indian Health Service
                PHS UNSPECIFIED Indian Hospital
                1234 MAIN ST
                ANYWHERE, USA 87000
                (555) 555-1234

<=====T=====T=====T=====T=====T=====T=====T=====T=====

```

Figure 8-5: Editing header text (steps 2-4)

8.3 Flag Patient Accounts for Statements (FLAG)

Use this option to flag for which patients you would like a statement run. This is a one-time option that allows you to chose which patients will receive a statement.

To flag patient accounts, follow these steps:

1. Type FLAG at the “Select Patient Account Statement Menu Option:” prompt.
2. Either type the name or number of patient at the “Select A/R Account/IHS:” prompt, or type ?? to see a list of patients.
3. The system will display a *Yes* or *No* to the right of the patient’s name. *Yes* means the patient is flagged to receive patient statements, while a *No* means that the patient is not receiving patient statements.
4. Type Y or N at the “Pat Acct Stmt:” prompt.

5. You can repeat this process until you have flagged all patients who need to receive statements.

```

Select Patient Account Statement Menu Option: FLAG  Flag Patient Accounts
for Statements

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +          Flag Patient Accounts for Statements          +
      |          UNSPECIFIED SERVICE UNIT                      |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,DEMO                BUSINESS OFFICE        21-AUG-2003 10:31 AM

Select A/R ACCOUNTS/IHS: ??

Choose from:
19          PATIENT,DELLA                YES
25          PATIENT,NED S
48          PATIENT,FREDDY                YES
51          PATIENT,CAROLYN
71          PATIENT,ANTHONY J
73          PATIENT,JACOB JOSEPH
88          PATIENT,SHARON                YES
122         PATIENT,LANDREE               NO
126         PATIENT,CARMEN                NO

Select A/R ACCOUNTS/IHS: 19  VALDEZ,DELLA        YES
PAT ACCT STMT: NO
    
```

Figure 8-6: Flagging patient accounts

8.4 Print All Flagged Patients' Account Statements (PRA)

Use this option to print the statements that have been queued by TaskMan or reprint those statements already printed through the PRO option.

To print the queued statements, follow these steps:

1. Type PRA at the “Select Patient Account Statement Menu Option:” prompt. The system will display all dates and times of the jobs that are ready to print.
2. Type the number of the job you would like to print at the “Enter a Number:” prompt.
3. Type Y or N at the “Do You Wish to Retain the Run to Print Again? Enter Yes or No:” prompt.
4. Type the name of a print device at the “Output Device:” prompt.

```

Select Patient Account Statement Menu Option: PRA  Print All Flagged
Patients' Account Statements

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +          Print All Flagged Patients' Account Statements  +
    
```



```
Select Patient-Account: 71 PATIENT,ANTHONY J  
Select Beginning Date: T-900 (MAR 04, 2001)  
Select Ending Date: T (AUG 21, 2003)
```

```
Output DEVICE: HOME// [RET]
```

Figure 8-8: Printing One Flagged Patient's Account Statement

9.0 Posting Menu (PST)

This Master Menu option is provided for those individuals responsible for the individual and overall account management of all third party resources. This menu option is used to post and reconcile all payments received for existing bills. This allows the users and managers to track all activity in reference to outstanding claims, ensure maximum collections, provide follow up information, and provide data needed to conduct management reviews and quality assurance. Reports can be generated using the information entered in this module. The following functions are provided in this menu:

- Post payments, adjustments, unallocated cash, and refunds, enabling you to fully manage all Third Party Resource accounts.
- Post in a review and final step process. As you enter the transactions, the updates to particular accounts do not automatically take place. You must instruct the system to “post” to the accounts as a final step; after all necessary transactions are entered for a particular batch item. The system then updates the bill in which all the posting occurred.
- Rollback to the Third Party Billing software from the Posting Menu options that post to A/R Accounts.

To select the Posting menu, type PST at the “Select A/R Master Menu Option:” prompt.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+
|                   Posting Menu                   +-----+
|                   UNSPECIFIED SERVICE UNIT           |
+-----+
User: USER,GRETA                BUSINESS OFFICE        21-JUL-2004 10:32 AM

PAY   Post Payments and Adjustments
ADJ   Post Adjustments
FRP   Flat Rate Posting
FBL   View Flat Rate Bills
PUC   Post Unallocated Cash
REF   Post Refunds
RMK   Post Remark Codes
RX    Post NCPDP Reject/Payment Codes
BPS   Bill Posting Summary
PRT   Adjustment Categories & Types
IADJ  Standard Adjustment Reason Inquiry
IRMK  Remittance Advice Remark Code Inquiry
BEN   Auto Post Beneficiary
ERA   ERA Posting ...
Select Posting Menu Option:

```

Figure 9-1: Posting menu

The Posting menu will be displayed. These reports will be explained in sections 9.1 through 9.14.6.

To accommodate the different levels of detail a Payer can provide denials and adjustments, an A/R EDI Remark Codes file has been created and populated to accommodate these new codes. The file reflects Remark Codes as of the February 2004 Code List Updates as published by The Washington Publishing Company (wpc-edi.com) (refer to Appendix C: Remittance Advice Remark Codes). These Remark Codes are automatically posted to A/R during the ERA Post Claims process. The new codes will be posted as a new Transaction Type called “Remark Code.” The new Transaction Type field will hold up to 80 characters of the Remark Code description. To see the full, long description of a Remark Code, use the Remittance Advice Remark Code Inquiry (IRMK) option (section 9.12). Please refer to Appendix C: Remittance Advice Remark Codes to see a complete list of Remark codes.

9.1 Post Payments and Adjustments (PAY)

This Posting Menu option is used to post payments and adjustments that are related to a Collection Batch. When working on a particular batch, it is usually easier to have the hard copy of the Collection Batch available for reference. The batch name is displayed when listing batches at the Collection Batch prompt.

- **Payments:** Any revenue collected from patients, insurance companies, guarantors, etc. that can be applied to A/R accounts and have been entered in the Collection Entry section of this package, and exist on a Collection Batch..
- **Adjustments:** Non-payment by a third party resource. Insurance companies may not reimburse due to the following reasons:
 - Write-Offs (uncollectible)
 - Deductibles
 - Co-Pay (patient responsibility)
 - Non-Pay (reimbursement denied for various reasons, bad debt; the person refuses to pay, etc.)
 - Penalty (an extra charged amount imposed)

To post payments and make adjustments, follow these steps:

1. Type PAY at the “Select Posting Menu Option:” prompt.
2. Type your electronic signature at the “Enter your Signature Code:” prompt.
3. Type Y to rollover to Third Party Billing as you post or press the Return key to accept the default response of *No* at the “Roll-Over as You Post?” prompt.

4. Type the collection batch or ?? to display a list of batches to select from at the “Select Batch:” prompt. The system displays the Total Posted and the Remaining Balance of the Batch selected.

```

Select Posting Menu Option: PAY  Post Payments and Adjustments

Enter your Current Signature Code:      SIGNATURE VERIFIED

Roll-over as you post? NO// Y  YES

Select Batch: ??

Select Batch: MEDICAL RECORDS-03/21/2002-1          DEMO HOSPITAL
====> Total Posted: $ 0.00          ====> Remaining Balance: $ 35.00

```

Figure 9-2: Posting payments (steps 1-4)

5. Type the batch item, or ?? to display a list of items to select from at the “Select Batch Item:” prompt. (See section 9.1.1). The system displays the Item Total Posted and Item Remaining Balance and if multiple facilities are selected, then facility balance displays. If not multiple facilities, go to Step 7.
6. If prompted, type the visit location (see section 9.1.1) or ?? to display the locations where the checks were distributed at the “Select Visit Location:” prompt. The system displays the Sub-Item Total Posted, the Sub-Item Remaining Balance.
7. Type the bill number or ?? to display a list to choose from at the “Select A/R Bill/IHS Bill Number:” prompt. If you entered or selected a bill number, go to Step 11.
8. If you do not know the bill number, type the patient name (See section 9.1.3) or ?? to display a list to choose from at the “Select Patient Name:” prompt. If you do not know the patient name, press the Return key and continue to Step 11.
9. If you entered or selected a name, type a beginning date and ending date, then go to Step 11. If you pressed the Return key, the system displays the “Select BILL DOS:” prompt.
10. Type a DOS. (See section 9.1.4) The system displays the account and prompts you to choose a line.
11. At the “Line #” prompt, type the number of the bill to which you want to post.
12. Type P for Payment or ? to display a list of commands to chose from at the “Select Command:” prompt. (see section 9.1.5)
13. Type the payment amount at the “Payment Amount:” prompt.
14. Type another command or Q to Quit at the “Select Command:” prompt.

15. The system displays the "Select Action (P,M,C):" prompt. (see section 9.1.1)
16. Type P for Post to A/R. Select another location or item and continue steps 7 through 13. If the total amount is not distributed, the system prompts: "Do you want to Post any of the un-posted balance to Unallocated Cash?". (see section 9.5)

Note: See Adjustments (section 9.2) for more information on adjustments.

```

Select Batch Item: 1 1
    ===> Item Total Posted: $ 0.00          ===> Item Remaining Balance: $ 35.00

Select A/R BILL/IHS BILL NUMBER: 21 252B-ASU-6484

Claims for GARCIA,RENEE from 11/15/1999 to 11/15/1999          Page: 1

Batch : MEDICAL RECORDS   Item : 1
Amount : 35.00             Amount : 35.00
Posted : 0.00              Posted : 0.00
Unalloc: 0.00              Unalloc: 0.00
Balance: 35.00             Balance: 35.00

                                Billed   Current   Current
Current
Line  #DOS      Claim #      Amount   Paymnts   Adjust   Balance
-----
1  11/15/1999  000A-ASU-6484   155.00    0.00    0.00    155.00
2  11/15/1999  000B-ASU-6484   155.00    0.00    0.00    155.00
3  11/15/1999  000C-ASU-6484   172.00    0.00    0.00   -155.00

Line #: 1
Select Command (Line # 1) : P
Payment Amount: 2.00

Claims for PATIENT,RENEE from 11/15/1999 to 11/15/1999          Page: 1

Batch : MEDICAL RECORDS   Item : 1
Amount : 35.00             Amount : 35.00
Posted : 2.00              Posted : 2.00
Unalloc: 0.00              Unalloc: 0.00
Balance: 33.00             Balance: 33.00

                                Billed   Current   Current
Current
Line  #DOS      Claim #      Amount   Paymnts   Adjust   Balance
-----
1  11/15/1999  000A-ASU-6484   155.00    2.00    0.00    153.00
2  11/15/1999  000B-ASU-6484   155.00    0.00    0.00    155.00
3  11/15/1999  000C-ASU-6484   172.00    0.00    0.00   -155.00

Select Command (Line # 1) : Q

Select Action (P/M/C): P POST TO A/R
    
```

```

Please wait... Posting Transactions..

Select Batch: MEDICAL RECORDS-03/21/2002-1MEDICAL RECORDS-03/21/2002-1 DEMO
HOSPITAL
    ===> Total Posted: $ 2.00          ===> Remaining Balance: $ 33.00

Select Item: 1
    ===> Item Total Posted: $ 2.00      ===> Item Remaining Balance: $ 33.00
Select A/R BILL/IHS BILL NUMBER:

```

Figure 9-3: Posting payments (steps 5-16)

9.1.1 Field Explanations

Batch Item: When selecting an item, it is best to refer to your Final Collection Batch Report. Select only those items that exist on this report. If an item has been edited or cancelled, the original item does not exist, but the "rolled to" item must be used in posting. If you do not know the bill number, press the Return key and type the patient name to bring up all bills for that patient. Select one bill or type DOS and all claims for that DOS display for your selection.

Multiple Facility: If multiple facilities have been identified in the System Set-Up AND the individual batch item has been distributed between two or more facilities, you must identify what facility you are posting this amount to. The system only lets you select a facility that had a distribution in the Collection Entry process.

Patient and Bill Information: After you select a bill(s) to post to, the system displays the following data for that particular patient and bill:

- Patient Name
- DOS (Date Of Service) Range
- Batch, Item, and Sub-Item (including Location being posted to) Amount, Posted, and Balance.
- For each bill, the system displays:
 - Line #
 - DOS
 - Claim #
 - Billed Amount: The amount of the original bill.
 - Current Payments: The amount of payments that have been entered during THIS transaction. This amount has not been "Posted" to update the accounts yet.
 - Current Adjustments: The amount of Adjustments that have been entered during THIS transaction. This amount has not been "Posted" to update the accounts yet.

- **Current Balance:** The difference between the Billed Amount and all Transactions (including current ones) posted against the bill. If the Current Balance = Zero (0), the entire billed amount has been posted. There is nothing left due on this bill.

P,M,C (located at the bottom of the AR screen during posting process):

- **P (Post):** When selected, all current transactions (just completed) are "Posted" to the appropriate accounts.
- **M (More):** When selected, the system returns to the Command Prompt and allows you to enter more transactions for this particular item.
- **C (Cancel):** When selected, the transactions that have been entered but not "Posted" are cancelled and the system returns to the Bill Number Select Prompt.

Note: The system does not let you out of this option until you select one of the options. A response is required before you may move to the next item.

9.1.2 Selecting A Batch

If you do not know which batch to choose, type ?? after the "Select Batch:" prompt. The system lists all batches (by Collection Point) for your review.

```
Select Batch Item: ??
Choose from:
  1      1      345  200.00ARIZONA MEDICAID      EO
  2      2      345  300.00ARIZONA MEDICAID      EO
  3      3      876  432.00ARIZONA MEDICAID      EO

Select Batch Item:
```

Figure 9-4: Select a collection batch screen A

If you already know the name of your Collection Batch but are not sure of the exact date of the batch, type the first word of the batch name. The system displays the Collection Batches for that Point, by date. Choose a batch by typing in the corresponding number after the prompt. You can also type in the date of the batch.

```
Select Batch: Business <Return>

      1 Business-10/08/94-1
      2 Business-10/08/94-2
      3 Business-05/08/95-1

CHOOSE 1-3: 1 <Return> Business-10/08/94-1
```

Figure 9-5: Select a collection batch screen B

9.1.3 Selecting A Patient

When the system prompts you to select a patient, type the last name of the patient and press the Return key.

- If there is more than one patient with the same last name, the system provides a list of those patients, along with the prompt to make a choice.
- If you do not know the name of the patient and you want the system to list all patients alphabetically, type ??? after the “Select Patient:” prompt.

```
Select Patient:  PATIENT,A

      1. PATIENT, ALBERT
      2. PATIENT, ALICE

Select Patient: 1 Patient, Albert  M 01-19
```

Figure 9-6: Selecting a patient screen

9.1.4 Selecting a DOS (Date of Service):

When selecting a DOS, you may enter a range of dates. Insurance companies often lump together their payment for more than one bill for more than one date of service. If you enter a range of dates, the system displays more than one Line #, each corresponding to a particular bill. You must select the Line # of the bill against which a payment is being made.

Claims for PATIENT,PAUL from 06/14/90 to 02/08/95 Pg:1						
Line #	DOS	Billed Claim #	Current Amount	Current Payments	Current Adjust.	Balance
1	10/23/94	95-13	105.00	0.00	0.00	105.00
2	11/01/94	95-89	100.00	0.00	0.00	50.00
Line #: 1 <Return>						

Figure 9-7: Selecting a DOS screen

9.1.5 Selecting A Command Option

The A/R package is designed to make the process of posting payments as efficient as possible. The system allows you to have as much information as possible. The following is a brief explanation of the functions that can be performed at the Select Command Prompt:

- **A or 2** = Adjustments (Write-Off, Deductible, Non-Covered, Non-Pay, Penalty)
- **B** = Bill Inquire -Displays the Third Party Billing Package Bill information for that bill that is selected.
- **C** = Itemized Charge: allows posting by line item.

- **D** = Patient Demographics: Displays the Face Sheet (Patient Registration) for the Patient Selected.
- **E** = Edit a transaction not yet posted to A/R: Allows the user to edit/change those current transactions (not "Posted") for a particular bill.
- **H** = History of BILL Transactions (\$ only): Displays ALL transactions for a particular bill. This includes current and "Posted" transactions.
- **I** = Insurer Demographics
- **M** = Message: You may create three types of messages:
 - One about a particular bill
 - One about a particular patient
 - One about a particular account

The system prompts you to select one of the categories, view existing messages, or create new message. When viewing, the messages are listed in chronological order and display the date in which they were created.
- **P or 1** = Payment
- **Q or 3** = Quit: Ends the data entry for this Patient and allows for posting to A/R.
- **R** = Rollback
- **T** = Toggle (Temporary) Display: Displays the Current transactions for a particular bill. (Before Transactions have been Posted).

The system does not let you out of this option until you select one of the options. A response is required before you may move to the next item.

9.2 Post Adjustments (ADJ)

With this Posting Menu option, you work with adjustments; that is, the reasons an insurance company will not pay. By posting adjustments, you are able to fully account for all outstanding account receivables and identify the discrepancies between the *billed* and *collected* amounts.

Adjustment tables have been set up to further identify the reasons for insurance company denials. These tables provide a *reason code* for each adjustment made. System reports can be generated to produce cumulative totals on each reason code that assists in managing the bill process.

Through implementation, the package provides standard tables. Management is able to add to these tables to further identify specific problems at facilities. (See the STE: Standard Table Edits, section 7.12 in the Manager Menu.)

The different types and explanations of adjustments are as follows:

- **Write-Offs:** These amounts are identified as being uncollectible. A facility will never be able to collect this dollar amount, even if there is a secondary insurance company.
- **Non-Pay:** Amount denied by Third Party Payor for various reasons.
- **Deductibles:** The portion not covered by insurance.
- **Co-Pay:** The portion for which the patient is responsible.
- **Penalty:** An amount denied due to certain requirements not being met.
- **Groupier Allowance:** Amount over original billed amount that is paid by Medicare and Medicaid. This is reflected as a negative amount.
- **Payment Credit:** Payments received but not put on a collection batch. (Used for posting payments received before the A/R package was implemented)

For detailed information on how to post adjustments, refer to Help Frame for the Post Adjustments (?ADJ) option.

To post adjustments, follow these steps:

1. Type ADJ at the “Select Posting Menu Option:” prompt.
2. Type your electronic signature at the “Enter your Signature Code:” prompt.
3. Type Y to rollover to Third Party Billing as you post or press the Return key to accept the default response of No at the “Roll-Over as You Post?” prompt.
4. Type the Bill Number or ?? to display a list to choose from (it can be very long) at the “Select A/R Bill/IHS Bill Number:” prompt. If you do not know the Bill Number, press the Return key and continue to Step 5. If you entered or selected a bill number, go to Step 7.

```
Select Posting Menu Option: ADJ Post Adjustments
Enter your Current Signature Code: SIGNATURE VERIFIED
Roll-over as you post? NO// YES
Select A/R BILL/IHS BILL NUMBER: 2 262A-ASU-461023
```

Figure 9-8: Posting adjustments (steps 1-4)

5. Type the Patient Name or ?? to display a list to choose from (it can be very long) (see section 9.1.3) at the “Select Patient Name:” prompt. If you do not know the patient name, press the Return key and continue to Step 6. If you entered or selected a patient name, type a beginning date and an ending date, then go to Step 6.
6. If you pressed the Return key, type the DOS (see section 9.1.4) at the “Select Bill DOS:” prompt. The system displays the account and prompts you to choose a line. Go to Step 7.

7. Select the appropriate bill to post to at the “Line #:” prompt. The system displays the unique patient and bill information.
8. Type A for Adjustment at the “Select Command:” prompt.
9. Type the amount of the adjustment at the “Adjustment Amount:” prompt.
10. Type the Adjustment Category by name or corresponding number, or type ?? to display a list of options at the “Adjustment Category:” prompt.
11. If a table exists for the category selected, type the Adjustment Type by name or corresponding number, or type ?? to display a list of options at the “Adjustment Type:” prompt. If no table exists, go to step 12.

```

Claims for (msg) PATIENT,HOWARD from 09/15/1999 to 09/15/1999 Page: 1

```

Line #	DOS	Claim #	Billed Amount	Current Payments	Current Adjust.	Current Balance
1	09/15/1999	000A-ASU-461023	63.00	0.00	0.00	-172.00
2	09/15/1999	000B-ASU-461023	61.00	0.00	0.00	61.00
3	09/15/1999	000C-ASU-461023	45.58	0.00	0.00	45.58

```

Line #: 1
Select Command (Line # 1) : A
Adjustment Amount: 10
Adjustment Category: 3 WRITE OFF WO
Adjustment Type: 14 OVER UCR ALLOWANCE

```

Figure 9-9: Posting adjustments (steps 5-11)

12. The system returns for the selection of another line item or to quit, type Q to at the “Select Command (Line #):” prompt.
13. Type P to post the transaction at the “Select Action (P,M,C):” prompt. This completes the process.

Note: Adjustments can be done in connection to a collection register. Use the pay option for those adjustments that are received with an EOB with monetary value.

```

Claims for (msg) PATIENT,HOWARD from 09/15/1999 to 09/15/1999 Page: 1

```

Line #	DOS	Claim #	Billed Amount	Current Payments	Current Adjust.	Current Balance
1	09/15/1999	000A-ASU-461023	63.00	0.00	10.00	-182.00
2	09/15/1999	000B-ASU-461023	61.00	0.00	0.00	61.00
3	09/15/1999	000C-ASU-461023	45.58	0.00	0.00	45.58

```

Select Command (Line # 1) : Q

```

```
Select Action (P/M/C): POST TO A/R
Please wait... Posting Transactions..
```

Figure 9-10: Posting adjustments (steps 12-13)

9.2.1 Reversing (Correcting) Entries

After a transaction has been posted, it is still possible to correct or reverse the entry. Simply follow the same format as the normal posting process but use a negative dollar amount. These correcting/reversing entries become an actual transaction and part of the history on a particular bill. The original entry remains a transaction. Nothing disappears. After the entry has been reversed, you must re-enter the correct entry.

- If you find a mistake on a Payment, make the correcting entry in the PAY module.
- If you find a mistake on an Adjustment, make the correcting entry in the ADJ module.

If a table exists for a certain type of Adjustment, use the reason code established for the error situation you are adjusting. For example: You posted an adjustment as a deductible instead of a co-pay.

Note: Be sure to make the correction entry. For example: you post a payment of \$50 in error. Use the PAY menu option to perform an operation similar to the example above:

Select Command: P

Payment Amount: \$50.00

9.3 Flat Rate Posting (FRP)

Use this Posting Menu option when you need to post multiple payments for outpatient visits that have the same payment amount or the same adjustment amount. Before using this 'batch' method, the payments that need to be posted must be sorted into groups that have a common amount and the same adjustments, and result in the same write-off amounts. Refer to Appendix B. Summary of Flat Rate Posting (FRP) Process for more information and examples of Flat Rate Posting.

The system provides the following preventative measures:

- **Prevention of a Negative Balance on the FRP Batch:** It is possible to get a negative balance on the FRP batch if you enter a higher payment to an existing FRP batch than its previous balance. If changing the Payment Amount will result in a negative batch balance, you are notified and returned to the payment prompt. Then you must enter a different payment amount. Note that you are not allowed to continue adding bills if posting of the payment will result in a negative FRP batch balance.
- **Prevention of a Negative Balance on the A/R Bill:** If posting the payment to the A/R bill selected will result in a negative balance on the bill (not the FRP batch); a message notifies you and prompts if you wish to continue. If you answer *Yes*, the bill is added to the FRP batch. If you answer *No*, the bill is not added to the FRP batch and you are returned to A/R bill prompt.
- **Prevention of Posting Duplicate Bills:** If, when you are entering bills, the system finds a bill that is the same as the one you are entering, it notifies you by displaying the FRP batch name and indicates whether or not it has been posted. The system then prompts if you want to continue. If you answer *Yes*, the bill is added to the FRP batch. If you answer *No*, the bill is not added and you are returned to A/R bill prompt. Note that the system makes sure an A/R Bill cannot be entered more than once into a specific FRP Batch.
- **Prevention of Different Payors:** If the payor on the check differs from the payor billed, the system displays a warning to that effect but allows you to continue if you so indicate.

To post multiple payments, follow these steps:

1. Type FRP at the “Select Posting Menu Option:” prompt.
2. Type your signature code at the “Enter Your Current Signature Code:” prompt. The “Select Previously Opened FRP Batch:” prompt is displayed.
3. If you wish to create a new FRP batch, leave this field blank and press the Return key, and the system displays the “Create New Entry?” prompt. Go to Step 4 in these instructions. If you wish to work with an existing FRP batch, either type the FRP Posting Name or type ? and select from the list. The system displays the “Select Batch Item:” prompt. Go to Step 6 in these instructions.
4. Types Y to create a new FRP batch, or type N if you do not want to create a new batch. A *Yes* response displays the “Select Batch:” prompt. A *No* response exits you from this option.
5. Identify the batch by A/R Collection Batch/IHS Name, Opened Date/Time, or Check Number, or type ? (to select it.) The system displays the “Select Batch Item:” prompt.

6. Type the batch item by Item(s) Number, A/R Account, or Check Number, or type ? To select from a list of items. The system displays the “Select Visit Location:” prompt.

```

Select Posting Menu Option: FRP Flat Rate Posting

      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +                Flat Rate Posting                +
      |                DEMO HOSPITAL                |
      +---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER, DEMO                BUSINESS OFFICE                20-FEB-2003 10:39 AM

Enter your Current Signature Code: SIGNATURE VERIFIED
Select previously opened FRP batch: G10-MAR 21,2002@13:59:33

Select Batch Item: 2// 2
    ==> Item Total Posted: $ 0.00                ==> Item Remaining Balance: $
100.00

Select Visit Location: ??
    
```

Figure 9-11: Using the FRP option (steps 1-6)

7. Type the name of the Visit Location or type ? to select from the list of locations. The system displays the “Select Command (P/A/Q)” prompt.
8. Type P or 1 (for Payment). The system displays the “Payment Amount:” prompt.
9. Type the amount of the payment or press the Return key through the blank field if there is no payment or you are just posting an adjustment. The system displays the “Select Command (P/A/Q)” prompt again.
10. If you need to enter one or more adjustments, type A or 2 (for Adjustment) and the system displays the “Adjustment Amount:” prompt. Go to Step 11.
11. If there are no adjustments to enter and you are ready to identify the bill numbers posting the payment amounts, type Q or 3 (for Quit). The system displays the Amount to Post and the Remaining Balance, and then the “Select A/R Bill/IHS Bill Number” prompt is displayed. Go to Step 17 to bill by Bill Number, Step 18 to bill by Patient Name, or Step 19 to bill by Date of Service.

```

Select Visit Location: DEMO HOSPITAL                999                DEMO                DEMO
01                100.00

    PAYMENT:    100

ADJUSTMENTS:    27.6                CO-PAY                CO-PAYMENT
                27.6                CO-PAY                CO-PAYMENT
                5                WRITE OFF                INS ADJ

Select Command (P/A/Q): P

PAYMENT AMOUNT: 100// [RET]
    
```

```
Select Command (P/A/Q): A
```

Figure 9-12: Using the FRP option (steps 7-11)

12. Type the amount of the adjustment without the dollar sign or type ?? to display the list of existing adjustments. The system displays the “Adjustment Category:” prompt.
13. Type the category by A/R Table Type/ IHS IEN, Name, or Acronym, or type ? to select from the list of categories. (Note that, if the category exists and has a different adjustment amount, you are asked if this one is a replacement.) The system displays the “Adjustment Type:” prompt. Note that if only one Adjustment type exists for the Adjustment Category, the system knows this and does not prompt for type.
14. Enter the type by A/R Table Entry/IHS IEN, Name, Table Type, or Acronym or type ? to select from a list of Types. The system displays the “Adjustment Amount:” prompt.
15. Type another adjustment amount, and repeat steps 11-13 or type ?? to review the adjustments that have been entered and/or press the Return key on the blank field. The system displays the “Select Command (P/A/Q)” prompt.
16. Type Q (for Quit). The system displays the amount to post and the “Select A/R Bill/IHS Bill Number:” prompt. Go to Step 17 to bill by Bill Number, Step 18 to bill by Patient Name, or Step 19 to bill by Date of Service.

```
ADJUSTMENT AMOUNT: 10
Adjustment Category: 4 NON PAYMENT          NONPAY
Adjustment Type: 17 ELIGIBILITY DENIED

ADJUSTMENT AMOUNT: [RET]

Select Command (P/A/Q): Q

      PAYMENT:      100

ADJUSTMENTS:      27.6          CO-PAY          CO-PAYMENT
                  27.6          CO-PAY          CO-PAYMENT
                   5           WRITE OFF      INS ADJ
                   10          NON PAYMENT      ELIGIBILITY DENIED
                   15          NON PAYMENT      ELIGIBILITY DENIED

Amount To Post: 0          Remaining Balance: 100
Select A/R BILL/IHS BILL NUMBER:
```

Figure 9-13: Using the FRP option (steps 11-16)

17. To Bill by Bill Number:

- a. Type the bill number or type ? to select it from a list. (If a message says the payor on the bill doesn't match the payor on the item, go ahead and continue.) The system repeats the amount to post showing the indicated payment and the "Select A/R Bill/IHS Bill Number:" prompts for additional allocations.
- b. Repeat Steps 16 and 17a. until done, then press the Return key at a blank "Select A/R Bill/IHS Bill Number" prompt. The system displays the "Select Patient Name:" prompt. Go to Step 18b.

```
Select A/R BILL/IHS BILL NUMBER: 1 249A-ASU-4919
Amount To Post: 100 Remaining Balance: 0
Select A/R BILL/IHS BILL NUMBER:
```

Figure 9-14: Billing by bill number (step 17)

18. To Bill by Patient Name:

- a. Press the Return key at a blank "Select A/R Bill/IHS Bill Number:" prompt. The system displays the "Select Patient Name:" prompt.
- b. Type the patient's name or record number, or type ? to select from a list. The system displays prompts for the beginning date and the ending date.
- c. Type the beginning and ending dates of the desired time period. The system displays the patient's claims within the date range indicated (see Figure 9-15), followed by a "LINE #" prompt.
- d. Type the line number of the desired patient name. The system repeats the amount to post showing the indicated payment and the "Select A/R Bill/IHS Bill Number:" prompts for additional allocations.

Claims for CAT,CALICO from 01/01/1999 to 01/26/2000 Page: 1

Line #	DOS	Claim #	Amount	Billed To	Balance
2	01/10/1999	44026A-ASU-00000	60.00	CIMMERON MEDICAID	-130.00
3	01/10/1999	44026B-ASU-00000	198.00	CIMMERON MEDICAID	103.00
10	01/20/1999	44027A-ASU-00000	114.00	CIMMERON MEDICAID	-86.00
5	01/11/1999	44028A-ASU-00000	245.00	CIMMERON MEDICAID	155.00
12	01/30/1999	44031A-ASU-00000	124.00	CIMMERON MEDICAID	124.00
6	01/13/1999	44029A-ASU-00000	45.00	CIMMERON MEDICAID	45.00
11	01/24/1999	44033A-ASU-00000	265.00	CIMMERON MEDICAID	265.00
4	01/10/1999	44050A-ASU-00000	304.00	MEDICARE	0.00
7	01/15/1999	44052A-ASU-00000	172.00	MEDICARE	150.00
8	01/17/1999	44054A-ASU-00000	172.00	MEDICARE	77.00
1	01/02/1999	44055A-ASU-00000	48.00	MEDICARE	48.00
9	01/18/1999	44056A-ASU-00000	172.00	MEDICARE	87.00

Line #:

Figure 9-15: Bill by patient display

19. To Bill by Date of Service (DOS):

- a. Press the Return key at the “Select A/R Bill/IHS Bill Number” prompt and a blank “Select Patient Name:” prompt. The system displays the “Select Bill DOS:” prompt.
- b. Type the date of service. The system displays the claims for this date of service and the “Line #” prompt.
- c. Type the line number of the desired patient name or date of service. The system repeats the amount to post showing the indicated payment and the “Select A/R Bill/IHS Bill Number:” prompt displays again.

Claims for CAT,CALICO from 01/10/1999 to 01/10/1999					Page: 1
Line #	DOS	Claim #	Amount	Billed To	Balance
1	01/10/1999	44026A-ASU-00000	60.00	CIMMERON MEDICAID	-130.00
2	01/10/1999	44026B-ASU-00000	198.00	CIMMERON MEDICAID	103.00
3	01/10/1999	44050A-ASU-00000	304.00	MEDICARE	0.00

Line #:

Figure 9-16: Bill by DOS screen

20. After you have entered the bill (either by Bill Number, Patient Name, or DOS), two prompts may display:
 - If the Medicare payor on the check differs from the payor on the bill, the system displays a warning and asks if you want to continue. The default response is *No*.
 - If the Site Parameter, Multiple 3P EOB, is answered *Yes*, the “Select Visit Location:” prompt is displayed for you to type or select a location. If the indicated site parameter is answered *No*, the system uses the DUZ(2) (parent Facility) and does not prompt for the visit location.
21. Press the Return key at the “Select A/R Bill/IHS Bill Number:”, “Select Patient Name:”, “Select Bill DOS:”, and “Select Visit Location:” prompts. The system displays the “Select Command (R/E/C/Q)” prompt.
22. At the “Select Command (R/E/C/Q):” prompt, you have four options: Review, Edit, Cancel, and Post.
 - If you wish to **Review** the batch (required before posting), continue to step 23.
 - If you wish to **Edit** the batch, continue to step 24.
 - If you wish to **Cancel** the batch, continue to step 25.
 - If you wish to **Post** the batch (and you have reviewed it), continue to step 26.

```
Select PATIENT NAME: [RET]
Select Bill DOS: [RET]
```

Select Visit Location: [RET]
 You must Review the bills before posting.
 Select Command (R/E/C/Q):

Figure 9-17: Using the FRP option (steps 20-22)

23. If you wish to **R – Review**, you must always review the batch before you are allowed to post it. This is a preventative measure built into the system to reduce the incidence of error during the posting process. To review the batch, type R at the “Select Command (R/E/C/Q):” prompt to display the A/R Flat Rate Posting Summary (Figure 9-18). After it is displayed for your review, the “Select Command (P/R/E/C/Q):” prompt provides an option to post the batch (P).

```
Select Command (R/E/C/Q): R REVIEW
...HMMM, HOLD ON...
OUTPUT BROWSER          Feb 20, 2003 11:14:48          Page:    1 of    1
A/R Flat Rate Posting Summary

      Batch Name: MEDICAID-08/09/2001-1          Starting Balance:    100.00
      Item Number: 2                               Ending Balance:      0.00
      Check Number: 329879387                     # of Bills to Post:    1
      Payor: PRESBYTERIAN SALUD
      Payment Amount:    100.00
      Adjustment Amount:    27.60          Category: CO-PAY          Type: CO-PAYMENT
      Adjustment Amount:    27.60          Category: CO-PAY          Type: CO-PAYMENT
      Adjustment Amount:     5.00          Category: WRITE OFF       Type: INS ADJ
      Adjustment Amount:    10.00          Category: NON PAYMENT     Type: ELIGIBILITY
      DE
      Adjustment Amount:    15.00          Category: NON PAYMENT     Type: ELIGIBILITY
      DE

Bill #          Patient Name          Billed Amt          DOS          Payor
Billed

          DEMO HOSPITAL

249A-ASU-4919    PATIENT,JAMIE M          172.00    11/01/1999    NEW MEXICO MED

      Enter ?? for more actions
>>>
+   NEXT SCREEN          -   PREVIOUS SCREEN          Q   QUIT
Select Action: +// q   QUIT
```

Figure 9-18: Using the FRP option (step 23)

24. If you wish to **E – Edit**, this option makes it possible for you to edit the batch before posting it. You have two courses of action at the Edit prompt: add or delete an FRP bill. To edit a batch, type E at the “Select Command (R/E/C/Q):” prompt, then perform either of the procedures as follows:

- a. **To Delete a Bill:** At the “Flat Rate Post Bill:” prompt, type the Flat Rate Post Bill or type ? to select it from the list, then confirm the deletion. The system displays the Amount to Post and Remaining Balance for the selected Flat Rate Post Bill, then redisplay the “Flat Rate Post Bill:” prompt. Press the Return key through the blank field to exit.
- b. **To Add a Bill:** At the “Flat Rate Post Bill:” prompt, press the Return key, then at the “Select A/R Bill/IHS Bill:” prompt, do one of the following things:
 - Type the new bill by Bill Number at this prompt, or
 - Press the Return key and enter the bill by Patient Name at the “Select Patient Name:” prompt, or
 - Press the Return key and enter it by Date of Service at the “Select Bill DOS:” prompt.

After editing a batch you must review it again before you are allowed to post it.

25. If you wish to **C – Cancel**, only Flat Rate Posting batches that have Not been posted can be cancelled. Canceling a collection batch deletes everything from the system that has been entered into the A/R Flat Rate Posting file for the indicated batch. To cancel a batch, type C at the prompt, and then confirm the deletion.
26. If you wish to **P – Post**, only after you have reviewed the collection batch are you able to select this option at the “Select Command (P/R/E/C/Q):” prompt to post the batch. When you type P at the prompt, the batch is posted and a message tells you it is done, then you are returned to the Posting Menu.

9.4 View Flat Rate Bills (FBL)

Use this Posting Menu option to access the review portion of the Flat Rate Posting without having to enter the Flat Rate Bills option. Whereas the Review option under Flat Rate Posting accesses only un-posted bills, this option accesses both posted and un-posted bills.

To review the Flat Rate Posting, follow these steps:

1. Type FBL at “Select Posting Menu Option:” prompt. The system displays the “Select FRP Batch:” prompt.
2. Type the name given to the flat rate posting batch you want to view and press the Return key or type ? at the prompt to select from the list. The system indicates that it is working on your request, and then the batch is displayed.

```

Select Posting Menu Option: FBL  View Flat Rate Bills

+++++
|                                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                                |
+++++

```

```

+          View Flat Rate Bills          +
|          DEMO HOSPITAL                 |
+-----+
User: USER, DEMO          BUSINESS OFFICE          20-FEB-2003 11:34 AM

Select FRP batch: 1      249A-ASU-4919  G10-MAR 21,2002@13:59:33

OUTPUT BROWSER          Feb 09, 2000 17:08:19          Page: 1 of 2
A/R Flat Rate Posting Summary
  Batch Name: AAOBO-01/13/2000-1          Starting Balance: 5002.20
  Item Number: 1          Ending Balance: 3802.20
  Check Number: EFT2308743          # of Bills to Post: 6
  Payor: MEDICARE
  Payment Amount: 200.00
Adjustment Amount: 10.00          Category: CO-PAY          Type: CO-PAYMENT
Adjustment Amount: 50.00          Category: DEDUCTIBLE          Type: DEDUCTIBLE
Bill #          Patient Name          Billed Amt          DOS          Payor Billed
  DEMO HOSPITAL
43487R-ASU-44362          TESTPATIENT,BILL W          3376.92  12/12/1992  MAIL
HANDLERS
43540A-ASU-153507          NICKLE,PENNY          106.95  12/05/1994  MEDICARE
44121A-ASU-50028          NONAME,PAULINE          264.00  01/25/1998  MEDICARE
+          Enter ?? for more actions
>>>
+  NEXT SCREEN          -  PREVIOUS SCREEN          Q  QUIT
Select Action: +// Q  QUIT
Figure 9-19: Viewing flat rate bills

```

9.5 Post Unallocated Cash (PUC)

Use this Posting Menu option when you are not able to post an amount to a particular bill, but do not want it to remain on the Collection Batch as unprocessed. When a balance remains on an item (not all has been posted), the system asks if you want to post any of the un-posted balance to unallocated cash. If you type *Yes*, the system asks how much you want placed in the Unallocated bucket. The amount you select is then placed in a temporary General Ledger Account and the item status is changed to *fully processed*. When you have all the necessary information, post the amount to an individual account as follows: (See Help Frame Unallocated Cash-Help (?PUC) for instructions on how to post unallocated cash.)

To post unallocated cash, follow these steps:

1. Type PUC at the “Select Posting Menu Option:” prompt.
2. Type your signature code at the “Enter Your Current Signature Code:” prompt.
3. Type Y to rollover to Third Party Billing as you post or press the Return key to accept the default response of *No* at the “Roll-Over as You Post?” prompt.

4. Type the number of the line item to be processed at the “Enter a Number (1-12)” prompt. The system displays the individual item and the prompt “Action (1=Post to an A/R Bill, 2=Refund, 3=Exit)”.
5. Follow the same process as in Post Adjustments (section 9.2) beginning with step 4.

```

Select Posting Menu Option: PUC Post Unallocated Cash
Enter your Current Signature Code: SIGNATURE VERIFIED
Roll-over as you post? NO// Y
#   Credit   Account                               Batch
-----
1.  3958.00   UNITED HEALTHCARE                       PI OPV-04/08/2002-1

Enter a number (1-1): 1
#   Credit   Account                               Batch
-----
      3958.00   UNITED HEALTHCARE                       PI OPV-04/08/2002-1

Action (1=Post to an A/R Bill, 2=Refund, 3=Exit): 1 Post to A/R Bill
Select A/R BILL/IHS BILL NUMBER:

```

Figure 9-20: Posing Unallocated Cash

9.6 Post Refunds (REF)

Use this Posting Menu option to post refunds. The AR package allows for you to post this category as a tracking step but you must follow your local procedures for sending the supporting documentation to the Finance Office so the refund can be issued.

Refunds may become necessary for the following reasons:

- A patient or insurance company may overpay by mistake.
- A duplicate payment may have been received because of an error.
- An insurance company may have sent a payment to the wrong place.

To post a refund, follow these steps:

1. Type REF at the “Select Posting Menu Option” prompt. The system displays the “Roll-Over as You Post?” prompt.
2. Type Y to rollover to Third Party Billing as you post or press the Return key to accept the default response of *No*. The system displays the “Enter Your Signature :” prompt.

3. Type the bill number or ?? to select from a list (it can be very long). If you do not know the bill number, press the Return key and continue to Step 4. If you entered or selected a bill number, go to Step 6.

```
Select Posting Menu Option: REF Post Refunds

Enter your Current Signature Code: SIGNATURE VERIFIED

Roll-over as you post? NO// Y YES

Select A/R BILL/IHS BILL NUMBER: 1 249A-ASU-4919
```

Figure 9-21: Posting a refund (steps 1-3)

4. Type the Patient Name or ?? to select from a list (it can be very long). (See section 9.1.3.) If you do not know the patient name, press the Return key and continue to Step 5. If you entered or selected a patient name, type a beginning date and an ending date, then go to Step 6.
5. Type the DOS. (See section 9.1.4.) The system displays the account and prompts you to choose a line. Go to Step 6.
6. Type the line number. The system displays the "Select Command:" prompt.
7. Type R (Refund). The system displays the "Refund Amount:" prompt.
8. Type the amount of the refund. The system displays the "Adjustment Type:" prompt.
9. Type the type of adjustment or ?? to select from a list of adjustment types. The system displays the account with the refund amount displayed under "Current Payments" and the "Select Command (Line#2)" prompt.
10. Type Q to Quit. The system displays the "Line #" prompt.
11. Type a caret (^). The system displays the "Select Action (P,M,C):" prompt.
12. Type P for Post to A/R. This completes the process.

Claims for TESTPATIENT,JAMIE M from 11/01/1999 to 11/01/1999							Page: 1
Line #	DOS	Claim #	Billed Amount	Current Payments	Current Adjust.	Current Balance	
1	11/01/1999	249A-ASU-0000	172.00	0.00	0.00	0.00	
Line #: 1							
Select Command (Line # 1) : R							
Refund Amount: 10							
Adjustment Type: 109 OVER PAYMENT							
Claims for TESTPATIENT,JAMIE M from 11/01/1999 to 11/01/1999							Page: 1

Line #	DOS	Claim #	Billed Amount	Current Payments	Current Adjust.	Current Balance
1	11/01/1999	249A-ASU-0000	172.00	-109.00	0.00	109.00

Select Command (Line # 1) : Q

Select Action (P/M/C): P POST TO A/R

Please wait... Posting Transactions..

Figure 9-22: Posting a Refund (steps 4-12)

9.7 Post Remark Codes (RMK)

The posting option called Post Remark Codes allow you to manually post remark codes, if desired. See Appendix C: Remittance Advice Remark Codes for a complete listing of remark codes.

To manually post codes, follow these steps:

1. Type RMK at the “Select Posting Menu Option:” prompt located in the Posting menu.
2. Type your signature code at the “Enter Your Current Signature Code:” prompt.
3. Type the name or number of a batch at the “Select Batch:” prompt, and then type the name of a batch item at the “Select Batch Item:” prompt.

If you type an invalid batch or batch item, the system displays the following warning:

A valid collection batch and item was not entered. Continue?.

If you respond by typing Y, type the bill number at the “Select A/R Bill/IHS Bill Number:” prompt.

If you respond by typing N, you are returned to the Posting menu.

If you do not know the bill number, press the Return key at a blank “Select A/R Bill/IHS Bill Number:” prompt and enter a patient name at the “Select Patient Name:” prompt, or press the Return key again at a blank “Select Patient Name:” prompt to enter a bill DOS at the “Select Bill DOS:” prompt.

4. Type a remark code at the “Select Remark Code:” prompt.
5. Type any additional remark codes at the “Select Additional Remark Code:” prompt. If you are done entering remark codes, press the Return key at a blank “Select Additional Remark Code:” prompt.

Select Posting Menu Option: RMK Post Remark Codes

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Post Remark Codes                               +
|           LITTLE BUILDING HEALTH CENTER                   |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,DEMO           BUSINESS OFFICE           4-MAR-2004 10:09 AM

Enter your Current Signature Code: ***** SIGNATURE VERIFIED

Select Batch: [RET]
A valid collection batch and item was not entered. Continue? N// Y YES

Select A/R BILL/IHS BILL NUMBER:           113510-AA-2

Select Remark Code: N54           Claim information is inconsistent with pre-
certified/authorized services.

Select Additional Remark Code: [RET]
    
```

Figure 9-23: Using the RMK option (steps 1-5)

6. A summary of the bill and remark code(s) displays (Figure 9-24).

Note: Only if the patient was an inpatient will the “To:” field display, indicating a range of days for the date of service where the “DOS:” field is the first day of service and the “To:” field is the last day of service.

- 7. Type Y at the “Post these remark codes to this bill?” prompt, if you want to post the codes, otherwise type N to return to step 1.
- 8. A message indicating the codes are posting displays.
- 9. Press the Return key at the “Enter Return to Continue:” prompt.
- 10. You can enter another bill number, patient name, or DOS if you want to continue. If you want to exit, press the Return key at the remaining prompts.

```

BILL #: 113510-96-2           DATE BILLED: MAR 10, 1996
PATIENT: PATIENT,DEMO           AGE OF BILL: 59598 DAYS
CHART: 101772           BILL STATUS: PENDING

DOS: MAR 06, 1996           A/R ACCT: AETNA HLTHCARE ASR PROG OF WI
TO: MAR 07, 1996

*****
N54
Claim information is inconsistent with pre-certified/authorized services.
*****
Post these remark codes to this bill? Y// Y YES

Posting Remark Code N54

Enter RETURN to continue: [RET]
    
```

```
Select A/R BILL/IHS BILL NUMBER: [RET]
Select PATIENT NAME: [RET]
Select Bill DOS: [RET]
```

Figure 9-24: Using the RML option (steps 6-10)

9.8 Post NCPDP Reject/Payment Codes (RX)

The AR package includes the addition of HIPAA compliant NCPDP Reject/Payment Codes. The NCPDP Reject/Payment Code table is distributed with the Pharmacy POS software.

Important:

If Pharmacy POS is not installed on your system, you will not be able to post manually and NCPDP reject codes on the ERA will come up as "Not Matched."

If applicable, these NCPDP codes are automatically posted to A/R during the ERA Post Claims process. The new codes will be posted as a new transaction type called "NCPDP Rej/Pay." A new option has been added to accommodate the NCPDP codes: Post NCPDP Reject/Payment Codes (RX). Please refer to Appendix D: NCPDP Rej/Pay Codes for a full list of NCPDP Reject/Payment codes. The new NCPDP Rej/Pay codes will be posted as a new transaction type called "NCPDP Rej/Pay." When running a Bill Posted summary, the NCPDP codes will display in Transaction Type column.

The new posting option called Post NCPDP Reject/Payment Codes allows you to manually post NCPDP Reject/Payment codes, if desired.

To manually post these codes, follow these steps:

1. Type RX at the "Select Posting Menu Option:" prompt located in the Posting menu.
2. Type your signature code at the "Enter Your Current Signature Code:" prompt.

Type the name or number of a batch at the "Select Batch:" prompt, and then type the name of a batch item at the "Select Batch Item:" prompt. If you do not type a valid batch or batch item, the system displays a warning: A valid collection batch and item was not entered. Continue?. If you respond by typing Y, you will be allowed to type bill number at the "Select A/R Bill/IHS Bill Number:" prompt. If you respond by typing N, you will be returned to the Posting menu. If you do not know the bill number, you can press the Return key at a blank "Select A/R Bill/IHS Bill Number:" prompt to enter a patient name at the "Select Patient Name:" prompt, or press the Return key again at a blank "Select Patient Name:" prompt to enter a bill DOS at the "Select Bill DOS:" prompt.

3. Type a remark code at the “Select NCPDP Reject Payment Code:” prompt.
4. Type any NCPDP codes at the “Select Additional Remark Code:” prompt. If you are done entering remark codes, press the Return key at a blank “NCPDP Reject Payment Code:” prompt.

```

Select Posting Menu Option: RX Post NCPDP Reject/Payment Codes

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +-----+
      |          Post NCPDP Reject/Payment Codes                |
      |          LITTLE BUILDING HEALTH CENTER                  |
      +-----+
User:  USER,DEMO          BUSINESS OFFICE          4-MAR-2004 10:12 AM

Enter your Current Signature Code: ***** SIGNATURE VERIFIED

Select Batch: DEMO HEALTH CENTER-02/26/2004-1 DEMO HEALTH CENTER
-02/26/200          LITTLE BUILDING HEAL
===> Total Posted: $ 0.00          ===> Remaining Balance: $ 54326.54

Select Batch Item: 1
===> Item Total Posted: $ 0.00          ===> Item Remaining Balance: $ 54326.54

Select Visit Location: LITTLE BUILDING HEALTH CENTER 54326.54
===> Sub-Item Total Posted: $ 0.00 ==> Sub-Item Remaining Balance: $ 54326.54

Select A/R BILL/IHS BILL NUMBER: 113510-96-2

Select NCPDP Reject Payment Code: 21 M/I Patient Gender Code

Select Additional NCPDP Reject Payment Code: 65 Patient Is Not Covered

Select Additional NCPDP Reject Payment Code: 12 M/I Patient Location

Select Additional NCPDP Reject Payment Code: [RET]

```

Figure 9-25: Using the RX option (steps 1-5)

5. A summary of the bill and NCPDP code(s) displays (Figure 9-26).

Note: Only if the patient was an inpatient will the “To:” field display, indicating a range of days for the date of service where the “DOS:” field is the first day of service and the “To:” field is the last day of service.

6. Type *Y* at the “Post these NCPDP Reject/Payment codes to this bill?” prompt, if you want to post the codes, otherwise type *N* to return to step 1.
7. A message indicating the codes are posting displays.
8. Press the Return key at the “Enter Return to Continue:” prompt.

9. You can enter another bill number, patient name, or DOS if you want to continue.
If you want to exit, press the Return key at the remaining prompts.

```

BILL #: 113510-96-2          DATE BILLED: FEB 2, 1996
PATIENT: PATIENT, DEMO      AGE OF BILL: 59598 DAYS
CHART: 101772              BILL STATUS:

      DOS: MAR 06, 1996      A/R ACCT: AETNA HLTHCARE ASR PROG OF WI
      TO: MAR 07, 1996

*****
10
M/I Patient Gender Code

12
M/I Patient Location

65
Patient Is Not Covered
*****
Post these NCPDP Reject/Payment codes to this bill? Y// Y YES

Posting NCPDP Reject/Payment Code 10
Posting NCPDP Reject/Payment Code 12
Posting NCPDP Reject/Payment Code 65

Enter RETURN to continue: [RET]

Select A/R BILL/IHS BILL NUMBER: [RET]
Select PATIENT NAME: [RET]
Select Bill DOS: [RET]

```

Figure 9-26: Using the RX option (steps 6-7)

9.9 Bill Posting Summary (BPS)

This Posting Menu option displays a bill-posting summary:

New Remark Code Transaction Type on Bill Posted Summary

The new A/R EDI Remark Codes will be posted as a new transaction type called “Remark Code.” When running a Bill Posted summary, the remark codes will display in the transaction type column.

The new NCPDP Rej/Pay codes will be posted as a new transaction type called “NCPDP Rej/Pay.” When running a Bill Posted summary, the NCPDP codes will display in transaction type column.

To display the Bill Posting Summary, follow these steps:

1. Type BPS at the “Select Posting Menu Option:” prompt. The system displays the “Select A/R Bill/IHS Bill Number:” prompt.

2. Type the bill number or ?? to select from a list. The system prompts you to select print or browse the output onscreen.
3. Type P or B. The 2-page Bill Posting Summary display is generated.

```

Select A/R BILL/IHS BILL NUMBER: 1 249A-ASU-4919

Select one of the following:

P          PRINT Output
B          BROWSE Output on Screen

Do you wish to : P// P RINT Output
DEVICE: HOME// [RET]   Right Margin: 80//[RET]

List of Transactions for Bill 113510-96-2

Patient: PATIENT,DEMO           Beg DOS : MAR 06, 1996
Address: ROUTE 1 BOX 1A         End DOS : MAR 07, 1996
ANYWHERE, MINNESOTA 56591      LST STMT:

Phone #: 555-555-5832          Insurer: AETNA HLTHCARE ASR PROG OF WI
                                Balance: 1200.00

Trans Dt   By   Trans Type           Amount      Balance
          A/R Account           Batch        Item
-----
03/04/2004 LL  REMARK CODE           N54          0.00      1,200.00
                AETNA HLTHCARE ASR PROG OF WI NO BATCH
                Claim information is inconsistent with p
                re-certified/authorized services.

Enter RETURN to continue: [RET]
                >> SUMMARY <<

BILL      113510-96-2  >PAYMENTS<           >ADJUSTMENTS<
BILLED    1200.00     3-P CRD             0.00      NON-PAY           0.00
PAY TOT   0.00       PAYMENTS            0.00      DED               0.00
ADJ TOT   0.00       PAY CRD             0.00      CO-PAY           0.00
                                WR OFFS           0.00      PENALTY          0.00
                                GROUPER           0.00      TOTAL ADJ*       0.00
                                REFUND           0.00
ROLLOVER  1200.00     TOTAL PAY*          0.00

Pat:      FRENKBARG,GRACE J
P: AETNA HLTHCARE ASR PROG OF WI
S:
T:
    
```

Remark Code will display in the Transaction Type column. The code itself will display in the Batch column, and the short description will display.

Figure 9-26: Bill posting summary

9.10 New Adjustment Categories and Types (PRT)

Use this option to run a list that contains the names of adjustment categories and types that are part of the A/R package. It has been included as a learning aid for new users.

To print a list of all adjustment categories and types, follow these steps:

1. Type PST at the “Select A/R Master Menu Option:” prompt.
2. Type PRT at the “Select Posting Menu Option:” prompt.
3. Press the Return key at the “Start With Name:” prompt to accept the default answer.
4. Type the name of the device where you want the report to print at the “Device:” prompt.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Adjustment Categories & Types                  +
|          DEMO HOSPITAL                                  |
+-----+
User: DEMO,USER          BUSINESS OFFICE          7-OCT-2002 10:15 AM ??
START WITH NAME: FIRST// [RET]
DEVICE: HOME

A/R Posting Categories & Elements          OCT  7,2002  10:15          PAGE 1
NAME
      IEN      IEN  NAME
-----
WRITE OFF
      3      146  99 MEDICARE ADJ
GROUPER ALLOWANCE
      16      94   APG
WRITE OFF
      3      501  AUTO WRITE-OFF 2000
      3      502  AUTO WRITE-OFF 2001
      3      173  BAD DEBT/COLLECTION AGENCY
      3      150  BCBS WRITE OFF
NON PAYMENT
      4      134  BEYOND FILING LIMIT
PAYMENT CREDIT
      20     113  BILLED IN ERROR
WRITE OFF
      3      135  BILLED IN ERROR
      3     1002  CAP PAYMENT
      3      500  CLEAN UP 2000
CO-PAY
      14      27   CO-PAYMENT
NON PAYMENT
      4      174  CODING ERROR
      4      18   COSMETIC / ELECTIVE
PAYMENT CREDIT
      20     149  CREDIT ADJUSTMENT--SEE MEMOS
      20     139  CREDIT FROM OTHER BILL
    
```

20	138	CREDIT TO OTHER BILL
----	-----	----------------------

Figure 9-27: Sample listing of adjustment categories and types (excerpt)

9.11 Standard Adjustment Reason Inquiry (IADJ)

The AR package has an option called the Standard Adjustment Reason Code Inquiry (IADJ) that allows you to run an inquiry on any of the HIPAA Standard Adjustment codes.

To run a Standard Adjustment Reason inquiry, follow these steps:

1. Type IADJ at the “Select Posting Menu Option:” prompt.
2. A note displays, indicating where you can obtain a hard copy of the Standard Adjustment Reason Codes file. This display will change depending on what version/patch of A/R your site is currently running.
3. Type the code that you want to view at the “Standard Adjustment Reason Code:” prompt.
4. Type the name of an output device at the “Output Device:” prompt.
5. A listing of the code displays, showing both the short and full description of the code (Figure 9-29).

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Standard Adjustment Reason Inquiry          +
|          LITTLE BUILDING HEALTH CENTER                |
+-----+
User: USER,DEMO          BUSINESS OFFICE          27-FEB-2004 9:22 AM

NOTE:  For a complete hardcopy listing of Standard Adjustment Reason Codes,
       please refer to the User Manual for A/R v1.8.

Standard Adjustment Reason Code: 17

Output DEVICE: HOME// [RET]

=====
Standard Adjustment Reason Code Inquiry          FEB 27,2004@09:22   Page 1
=====

STANDARD          SHORT Payment adjusted-requested info not
  CODE: 17          DESC: provided or insufficient/incomplete

  RPMS 4          RPMS 617
CATEGORY: NON PAYMENT          REASON: Pymt Adj Info Incomplete

FULL STANDARD CODE DESCRIPTION:
    
```

Payment adjusted because requested information was not provided or was insufficient/incomplete. Additional information is supplied using the remittance advice remarks codes whenever appropriate.

Figure 9-28: Using the IADJ option (step 5)

9.12 Remittance Advice Remark Code Inquiry (IRMK)

The AR package includes a new posting option called Remittance Advice Remark Code Inquiry (IRMK) allowing the user to inquire about individual remark codes and see full descriptions of each of the codes. This option only allows you to view one Remark Code at a time or you cannot run a list of multiple codes. To see a complete listing of codes, refer to Appendix C: Remittance Advice Remark Codes.

To run a remittance advice remark code inquiry, follow these steps:

1. Type IRMK at the “Select Posting Menu Option:” prompt located in the Posting menu.
2. A note displays, indicating where you can obtain a hard copy of the Remark Codes file. This display will change depending on what version/patch of A/R your site is currently running.
3. Type the code that you want to view at the “Remittance Advice Remark Code:” prompt.
4. Type the name of an output device at the “Output Device:” prompt.
5. A listing of the code displays, showing both the short and long description of the code (Figure 9-30).

```
Select Posting Menu Option: IRMK  Remittance Advice Remark Code Inquiry

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +-----+-----+-----+-----+-----+-----+-----+-----+
      |          Remittance Advice Remark Code Inquiry          |
      |          LITTLE BUILDING HEALTH CENTER                  |
      +-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,DEMO          BUSINESS OFFICE          27-FEB-2004 9:22 AM

NOTE:  To obtain a complete hardcopy listing of Remittance Advice Remark
Codes, please refer to the User Manual for A/R v1.8.

Remittance Advice Remark Code: M26

Output DEVICE: HOME//  [RET]

=====
Standard Remittance Advice Remark Code Inquiry          FEB 27,2004@09:22  Page 1
=====

CODE:          M26
```

SHORT DESC: Pymt adjusted, info not substantiate level of srvc, refund pat
w/in 30 days

LONG DESC:

Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(1) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.

Figure 9-29: Viewing the IRMK option

9.13 Auto Post Beneficiary (BEN)

This option is used to write off any open balances on A/R Accounts you select that include the words *Benefic* and *Patient*. The system searches for bills with an open balance and write them off to A/R Category Write Off (3), A/R Type Indian Ben (136).

To auto-post a beneficiary, follow these steps:

1. Type BEN at the “Select Posting Menu Option:” prompt.

The screen shown in Figure 9-31 is displayed.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Auto Post Beneficiary                         +
|           NOT-A-REAL FACILITY                           |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,NAME                                           4-OCT-2005 11:51 AM

Select Beneficiary Account to be Auto-Posted:

```

Figure 9-30: Auto post beneficiary (step 1-2)

2. Type the name of the beneficiary account you want at the “Select Beneficiary Account to be Auto-Posted:” prompt.
3. Type Y or N at the “Is this the proper account?” prompt. A message is displayed indicating the system is proceeding with auto-posting the selected account.
4. Type P for Patient or B for Bill at the “Select Report Sort By: (Patient/Bill): (P/B):” prompt.
5. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - type the name of the printer to print this report
 - press the Return key to view this report on your monitor

Figure 9-32 shows an example of this report.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Auto Post Beneficiary                         +
|           UNSPECIFIED SERVICE UNIT                     |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,NAME           BUSINESS OFFICE           20-MAY-2004 10:35 AM

Select Beneficiary Account to be Auto-Posted: 125 1813;AUTNINS(
Account selected is BENEFICIARY PATIENT (INDIAN)
Is this the proper account? Y YES
Proceeding with Auto-Posting of: BENEFICIARY PATIENT (INDIAN)
Select Report Sorting By:(Patient/Bill) : (P/B): B// B
Output DEVICE: HOME// [RET]

WARNING: Confidential Patient Information, Privacy Act Applies

```

```

=====
Auto Post Beneficiary                                MAY 20,2004@10:35   Page 1
For AR Account: BENEFICIARY PATIENT (INDIAN)
By Bill
=====
BILL          PATIENT          DOS          AMOUNT
=====
506A-AH-109561  BECKMAN,DANDY DAYE  OCT 15, 1999          40.00
                                     =====
TOTAL BILLS: 1          TOTAL AMOUNT          40.00
=====

```

Figure 9-31: Auto post beneficiary (selections and sample report)

This completes the procedure for creating the auto-post beneficiary report.

9.14 ERA Posting (ERA)

This Posting Menu option, when selected, displays the Electronic Remittance Advice (ERA) Posting Menu illustrated below. It is through this menu that you load an electronic ERA import from a remote host file and post the claim amounts it contains to the A/R bills they match. Posting of the ERA has been modified due to an issue identified with Medicare Part B 835 testing. The system will now review the 835 file received for Claim Date of Service. If it is not received, it will look for the Line Item Date of Service to post. The modification will apply to all Payers. Refer to section 17.2 for the procedures to prepare to download ERAs and to download and process those ERAs.

Type ERA at the “Select Posting Menu Option:” prompt to display the ERA Posting menu. Use the procedures that follow in the sections below to work with the ERA.

The typical sequence for working with an import file is as follows:

1. Load the import from the remote host directory and give it a local filename (section 9.14.1).
2. View the import header information to investigate the reason(s) for the non-postable claims (section 9.14.2).
3. Review the postable claims, then post them (section 9.14.3).
4. Generate and view a report(s) on the posting process, including claim status (section 9.14.5).

9.14.1 Load New Import (NEW)

Use this menu option to load the new EDI transport file to RPMS from the remote host file. When using the HIPAA 835 v4010 option, the system will verify if the file you entered is in the correct HIPAA 835 format. If the file is not compliant, you will see an error message and the file will not be loaded. If the file is not HIPAA compliant, you must notify the Payer to see if they can provide you a HIPAA compliant 835 file.

```

Enter your Current Signature Code:      SIGNATURE VERIFIED
Select A/R EDI TRANSPORT NAME: ??

Choose from:
  ACHHHS 835 MODIFIED
  AHCCCS
  HIPAA 835 v4010
  MEDICARE 835 3041.4A
  MEDICARE 835 3041.4B

Select A/R EDI TRANSPORT NAME:

```

Figure 9-32: A/R EDI transport name screen

During the load process, if the bill found on the ERA file is cancelled in RPMS 3P, the bill will not be matched and cannot be posted electronically. Also during the loading process, the system attempts to match the claim numbers in the import to account receivable bill numbers.

To load the new EDI transport file, follow these steps:

1. Type NEW at the “Select ERA Posting Option:” prompt. The system displays a choice of transport file names, including AHCCCS, and the “Select A/R EDI Transport Name:” prompt.
2. Type the name of the transport file or type ?? to select from a list of transport files. You are prompted to indicate the directory path to the transport file.
3. Press the Return key to accept the default path (/usr/spool/uucppublic) or, at the “Replace:” prompt, type the full path. You are now prompted for the filename you want to give to the imported file.
4. Type the filename for the imported file and press the Return key. The system displays the filename, directory path, and EDI transport name. Then it prompts if you want to proceed with the import.
5. If you want to stop here, press the Return key to accept the default response of *No*. If you want to continue, type Y and press the Return key. If you answer *No*, you are returned to the ERA Posting menu. If you answer *Yes*, the import is completed and a line count is displayed.

```
Select ERA Posting Option: NEW Load New Import
```

```

+++++-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+              Load New Import                          +
|              DEMO HOSPITAL                             |
+++++-----+
User: USER, DEMO                BUSINESS OFFICE          20-FEB-2003 12:07 PM

Enter your Current Signature Code:    SIGNATURE VERIFIED
Select A/R EDI TRANSPORT NAME: MEDICARE 835 3041.4A
Enter the directory path for the transport file: /usr/spool/uucppublic/
  Replace [RET]
File Name : NEW FILE NAME

File          Directory          Transport
NEW FILE NAME /usr/spool/uucppublic/  MEDICARE 835 3041.4A

Do you want to proceed? N// YES

```

Figure 9-33: Using the NEW option

9.14.2 View Import Header (VIEW)

This menu option is used to view the identification information contained in the header of an import file. The file header contains information about the electronic import including, for instance, the number of claims in it, payment amount and check number, payee and provider information, control numbers, and provider-level corrections. The information in this header file can help you determine what is in the import file and the reason(s) that a claim was not matched.

To access import header information, follow these steps:

1. Type VIEW at the “Select ERA Posting Option:” prompt.
2. Type your signature code at the “Enter your Current Signature Code:” prompt.
3. Type an A/R EDI import name, or the date/time of the import, or the host file name, or a check number that corresponds to an import at the “Select File:” prompt. You can also type ?? to select from a list of host files. The header information is displayed.

```

+++++-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+              View Import Header                        +
|              NOT-A-REAL FACILITY                     |
+++++-----+
User: USER, DEMO                BUSINESS OFFICE          27-OCT-2005 3:29 PM

Select file:    1007_ERA_04/13/2005bcbsaz pharm dt0401.txtCHK/EFT #:
000043348

OUTPUT BROWSER          Oct 27, 2005 15:30:37          Page:    1 of    6
VIEW IMPORT: 1007_ERA_04/13/2005

```



```

*ISA      0-010-ISA
Authorization Info Qualif 00 | No Authorization Info Present
Authorization Information 043000096
Security Information Qual 00 | No Security Info Present
Security Information      043000096
Interchange ID Qualifier ZZ | Mutually Defined
Interchange Sender ID    043000096835
Interchange ID Qualifier ZZ | Mutually Defined
Interchange Receiver ID  IHSPARK-PBCBSAZ
Interchange Date         APR 01, 2005
Interchange Time         T 1015
Control Standards Identif U | US EDI Community ASC X12, TDCC, and UCS
Control Version Number   00401 | Draft Standards for Trial Use
Interchange Control Numbe 000000001
Acknowledgment Requested 0 | No Acknowledgement Requested
Usage Indicator         P | Production Data
+           Enter ?? for more actions
>>>
+   NEXT SCREEN          -   PREVIOUS SCREEN      Q   QUIT
Select Action: +//

```

Figure 9-34: Viewing the import header

9.14.3 Review Postable Claims (REV)

This option displays the claims in an import batch for your review and indicates for each claim whether or not it matches an A/R bill number. If a claim number could not be matched to a bill number, it will not be posted. This option allows for more than one check number to be displayed per remittance advice. Also, the system matches the EFT Check/Trace number(s) from the ERA to the collection batch/item(s) and displays a message notifying you that there are no matches, a match, or several matches. Once the bills for a Check/EFT Trace number have been reviewed, the check is removed from the selection list.

To review claims in an indicated transport file and edit their status, follow these steps:

1. Type REV at the “Select ERA Posting Option:” prompt.
2. Type your signature code at the “Enter your Current Signature Code:” prompt. The “Select File:” prompt is displayed.
3. Type an A/R EDI import name, or the date/time of the import, or the host file name or a check number that corresponds to an import. You can also type ?? to select from a list of recently imported files. The Claim Review screen as illustrated above is displayed for the indicated file.
4. To edit the status of a claim:
 - a. Move through the display until the claim you want to edit is displayed.

- b. Type 1 (for Edit Status) at the “Select Action:” prompt and press the Return key.
- c. At the “Select(s)” prompt, type the number of the claim you want to edit and press the Return key.
- d. When prompted if you want to change the status of the indicated claim, type Y and press the Return key. You can press the Return key to accept the default answer of *No* to leave the status as it is.
- e. After you complete this process for one claim, the new status displays, and you are in position to either move to another screen of the display or to edit another claim status.

```

+---+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+          Review Postable Claims          +
|          NOT-A-REAL FACILITY          |
+---+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,DEMO          BUSINESS OFFICE          27-OCT-2005 3:33 PM

Select file: 1006_ERA_04/13/2005   bcbsaz pharm dt0401.txtCHK/EFT #:
000043348

There are 1 chk/EFT #(s) for file 1006_ERA_04/13/2005

Now matching Check/EFT Trace #'s on ERA to Check # of Collection
Batch/Item...

Chk/EFT # 000043348 does not match any existing batch/items.

Done matching Check/EFT Trace # of ERA to Check # of Collection Batch/Item.

Enter RETURN to continue:

1) CHECK #: 000043348          BATCH: ** no RPMS match **          ITEM:
   A/R ACCOUNT:          BATCHED AMT:          0.00  BALANCE:
0.00

Please enter the LINE # of the check you wish to REVIEW: 1// 1

```

Figure 9-35: Reviewing claims in an indicated file

9.14.4 Post ERA Claims (PST)

This option posts the payment amounts in an imported and loaded file to the matching A/R bills and displays the information shown on the next page that is relevant to the batch and its posting results. The batch name is displayed when listing batches to choose from at the Collection Batch prompt. This option only displays checks that have been reviewed using the REV option. Also, if posting the ERA bill will result in a negative balance on RPMS, a warning message will prompt you if the bill should be posted. If you choose not to post the bill, the system does not post the bill and you are prompted to continue the posting process.

Note: A new site parameter dependent prompt has been added, prompting you immediately after posting of the Check/EFT Trace is complete. You are asked if rollback should occur at this time. If Yes, bills are rolled back to 3P. If No, the bills are flagged and you must use the ROL option to rollback.

Figure 9-37 displays one or more payments in the total amount of \$10,210.00 that have been posted previously to the import batch named MEDICARE-08/05/1999-1, leaving a balance of \$5,659.34 against which no payment amounts have yet been posted.

```

Transport: MEDICARE 835 3041.4A
Created from ERN00018.ERN on MAY 17, 2000@14:27:07

Select Batch: MEDICARE-08/06/1999-1      1546
      ==> Total Posted: $ 10210.00      ==> Remaining Balance: $
5659.34

Select Batch Item: ??

Choose from:
   1      1      12356      486.48 MEDICARE      EO
   2      2      12588      164.91 MEDICARE      EO
   3      3      48999      201.40 MEDICARE      EO
   4      4      58889      4662.40 MEDICARE      EO
   5      5      488777      354.15 MEDICARE      EO
   6      6      1530      10000.00 MEDICARE      EO

Select Batch Item:
Do you want to select a different batch? N//

The above information details the transport and batch that
has been selected to post matched claims to the A/R database.
DO YOU WANT TO POST CLAIMS NOW.? N//
    
```

Figure 9-36: Post ERA claims screen

The 6 items making up that un-posted balance are listed in the following format. (Figure 9-38)

Sequence #	Check #	Amount	Payor
1	1	12356	486.48 MEDICARE

Figure 9-37: ERA un-posted balance

To post a payment batch, follow these steps:

1. Type PST at the “Select ERA Posting Option:” prompt.
2. Type your signature code at the “Enter your Current Signature Code:” prompt.

3. Type an A/R EDI import name, or the date/time of the import, or the host file name, or a check number that corresponds to an import at the "Select File:" prompt. You can also type ?? to select from a list of host files.
4. Type the name of the batch you want to post or type ?? to select it from the list of batches at the "Select Batch:" prompt. You will be prompted for the batch item.
5. Type the name of the batch item or type ?? to select it from the list of batch items. You will be prompted to post the matched claims now.
6. To post the claims in the indicated batch, type Y and press the Return key. After you complete this process for one claim, you are returned to the ERA Posting menu.

9.14.5 Report ERA Claims (RPT)

This option displays a claim report for a selected file and allows you to select the claims to be included in the report by category. The report can be generated for one or more categories including unmatched claims, unmatched reasons, unmatched claims and reasons, claims not to post, matched claims, and posted claims.

To generate an ERA Claim Report, follow these steps:

1. Type RPT at the "Select ERA Posting Option:" prompt.
2. Type an A/R EDI import name, or the date/time of the import, or the host file name or a check number that corresponds to an import at the "Select file:" prompt. You can also type ?? to select from a list of recently imported files. The system displays a list of lines that you can choose to report on.
3. Type the line number for which you would like a report at the "Please enter the Line # of the check you wish to Report:" prompt.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
|                Report ERA Claims                                    |
|                NOT-A-REAL FACILITY                                  |
+-----+
User: USER, DEMO                BUSINESS OFFICE                27-OCT-2005 3:36 PM

Select file:    1006_ERA_04/13/2005bcbsaz pharm dt0401.txtCHK/EFT #:
000043348

1) CHECK #: 000043348                BATCH: ** no RPMS match **                ITEM:
   A/R ACCOUNT:                BATCHED AMT:                0.00 BALANCE:                0.00

Please enter the LINE # of the check you wish to REPORT: 1// 1

Reports for :                1006_ERA_04/13/2005
    
```

bcbsaz pharm dt0401.txt	CHK/EFT #: 000043348
-------------------------	----------------------

Figure 9-38: Using the RPT option (steps 1-3)

4. At the “Enter Response:” prompt, type one or more categories you want included in the report by the one-letter code indicated for each as shown in the example (CRXN).
5. Type D (Detailed), B (Brief - one line), or S (Summary - totals only) at the “Select the type of report:” prompt.
6. Type P (Print) or B (Browse) at the “Do you wish to:” prompt.
7. Type the name of a print device at the “Output Device:” prompt.

```

Enter the list of Claim Status(s) you desire to print,
and in the sequence to be printed out.

C - Claim Unmatched      R - Reason Unmatched      N - Not to Post
M - Matched              P - Posted                X - Claim & Reason
Unmatched
A - All Categories
  Example:  CRXN

Enter response: A

Select the type of report: : (D/B/S): Brief - One Line

      Select one of the following:

          P          PRINT Output
          B          BROWSE Output on Screen

Do you wish to : P// RINT Output

Output DEVICE: HOME//  VIRTUAL
    
```

Figure 9-39: Using the RPT option (steps 4-7)

8. The report is displayed as illustrated in Figure 9-41.

```

=====
WARNING: Confidential Patient Information, Privacy Act Applies
=====
ELECTRONIC CLAIM REPORT - Brief                OCT 27,2005@15:36   Page 1
FOR FILE NAME: bcbsaz pharm dt0401.txt        CHECK/EFT TRACE: 000043348
FOR RPMS FILE: 1006_ERA_04/13/2005 FOR COLORADO RIVER IHS PHARMACY
-----
BATCH: ** No RPMS match **                      ITEM #
-----
BLUE CROSS BLUE SHIELD OF AZ                   CUSTOMER SERVICE
2444 W LAS PALMARITAS DRIVE                    bhumbert@phx1.bcbsaz.com
PHOENIX, AZ 85021- 488
=====
    
```

```
===== CLAIM UNMATCHED =====  
0746042          BOGUS,CAMILLA          OCT 27, 2004 - 85009086801  
  ** BILL NOT MATCHED TO RPMS - RA CLAIM NOT FOUND IN RPMS **  
0750013          USER,JUANA            OCT 22, 2004 - 85009101401  
  ** BILL NOT MATCHED TO RPMS - RA CLAIM NOT FOUND IN RPMS **  
0769969          CHARLES,DEMO          OCT 29, 2004 - 85009871301  
  
Enter RETURN to continue or '^' to exit:
```

Figure 9-40: Sample RPT report

10.0 Rollback Bills to a Third Party (ROL)

This Master Menu option rolls back updates to the Third Party Billing package for all posted accounts whose balances are now zero (0). With this rollback information on accounts, the Third Party Billing software looks for secondary payment sources.

You can also perform this rollback process when using the Posting Menu. As you begin to use the options that actually post to accounts (i.e., PAY, ADJ, PUC, and REF), you are first prompted if you want to rollback to Third Party Billing as you post. Thus, you can either perform the rollback as you post to accounts or by using this option separately.

This option will roll back fifty (50) bills at a time. If your facility does not roll back payments on a timely basis, the older paid bills will be rolled back first. Note the date the rollback occurs is the date reflected as the paid date in the Third Party Billing package.

To rollback bills to a third party, follow these steps:

1. Type ROL at the "Select A/R Master Menu Option:" prompt. The system displays the bill review figure on the previous page.
2. Press the Return key. The system indicates that it is checking for unbilled sources and lists any it finds. Then it displays the "Re-Open Claim for Further Billing? (Y/N)?" prompt.
3. Type Y to open a new claim for the unbilled sources or N and press the Return key. This completes the process.
4. If there are more bills that need to be rolled back into Third Party Billing, the system prompts you with the message, 50 Bills have been processed for Rollover. Press the Return key to continue or the caret (^) to exit. To restart the Rollback process, press the Return key.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
+-----+-----+-----+-----+-----+-----+-----+-----+
|                Rollback Bills to 3-Party                            |
|                DEMO HOSPITAL                                        |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER, DEMO                BUSINESS OFFICE                10-FEB-2003 12:44 PM

Reviewing Bill 9A-JSU-39659                                           4871
BILL          9A-JSU-39659  >PAYMENTS<                               >ADJUSTMENTS<
BILLED        4.90         3-P CRD                                0.00         NON-PAY          0.00
PAY TOT       4.90         PAYMENTS                       4.90         DED              0.00
ADJ TOT       0.00         PAY CRD                                0.00         CO-PAY          0.00
                                     WR OFFS                                0.00         PENALTY         0.00
                                     GROUPER                                0.00         TOTAL ADJ*      0.00
                                     REFUND                                 0.00
    
```

ROLLOVER	0.00	TOTAL PAY*	4.90
Pat: PATIENT, DEMO			
P: NEW MEXICO BC/BS INC			
S:			
T:			
CHECKING FOR UNBILLED SOURCES.			
NONE			
50 Bills have been processed for Rollover			
Enter RETURN to continue or '^' to exit:			

Figure 10-1: A/R master menu with rollback bills to 3-party option, steps 2-4

11.0 Report Menu (RPT)

Reports Menu

The existing reports menu allows separation of reports by data output as well as allowing for future reports to be easier managed.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+-----+
|          Report Menu          |
|          UNSPECIFIED SERVICE UNIT          |
+-----+-----+
User:  USER,GRETA          BUSINESS OFFICE          21-JUL-2004 10:47 AM

AMRM  Account Management Reports Menu ...
ARM   Aging Reports Menu ...
BRM   Batch Reports Menu ...
FRM   Financial Reports Menu ...
MRM   Maintenance Reports Menu ...
RRM   Rollback Reports Menu ...

Select Report Menu Option:

```

Figure 11-1: Reports menu

Report items are sorted under each of the following categories:

- Account Management Reports Menu
 - BLS Bills Listing Report
 - LBL Large Balance List
 - NEG Bill Negative Balance List
 - SBL Small Balance List
- Aging Reports Menu
 - AGE Age Report
 - ADT Age Detail Report
 - ASM Age Summary Report
 - AOI Age Open Items Report
 - ADL Age Day Letter & List
- Batch Reports Menu
 - BSL Batch Statistical Report
 - BPP Batch Posted Payments
- Financial Reports Menu
 - ADA Advise of Allowance RPT
 - IPDR Inpatient Primary Diagnosis Report

- PRP Payment Summary Report by Collection Batch
- PSR Period Summary Report
- STA A/R Statistical Report
- TAR Transaction Report
- Maintenance Reports Menu
 - ATS A/R Bill and Transaction Synchronization Report
 - EOB EOB Training Model
 - IEN 3P Missing Bill List
 - MM A/R & 3P Bill Mis-Match List
 - RR Bill Re-Roll List
- Rollback Reports Menu
 - ROD Rollback Detail (Daily)
 - ROS Rollback Summary

11.1 Reporting Basics

Most of the reports in the A/R Package that are printed are based on a set of criteria you choose called inclusion parameters. Not all reports use all the available parameters and only the parameters that apply to a specific report will display when you are setting up the report. A list of the inclusion parameters, including a brief description, used in the AR package are provided in section 11.1.1. Please refer back to this list when generating reports. A parameter can be removed by reselecting it and making a null entry by returning at the prompt with no entry typed in.

Similar to the reports that use inclusion parameters, the AR package also runs pre-built reports that you can sort by certain fields. The fields that you can sort the reports by include some of the same fields that are used as inclusion parameters. The fields by which you can sort are also listed with the inclusion parameters in section 11.1.1.

Other reports have already been built and are generated when you enter a date range for which to pull the data. These reports do not require any additional inclusion parameters; you only need to follow the prompts.

11.1.1 Sorting and Inclusion Parameters

Allowance Category

Type the number 1, 2, 3, 4, or 5 at the “Select type of Allowance Category to Display:” prompt. Once selected, the Allowance Category is added to the list of inclusion parameters that are in effect. Note you cannot have both a Billing Entity and Allowance Category.

A/R Entry Clerk

Type the NEW PERSON NAME, or INITIAL, or SSN, or VERIFY CODE, or NICK NAME, or SERVICE/SECTION, or DEA#, or VA#, or CODE, or IHS LOCAL CODE, or IHS ADC INDEX, or ALIAS. Your selection is added to the inclusion parameters that are in effect.

A/R Account

Type an A/R account number at the “Select A/R Account:” prompt. You can type another A/R account number at the “Select Another A/R Account:” prompt. If you want to select all A/R accounts, press the Return key at a blank “Select A/R Account:” prompt. You may also type ?? to see a list of available options.

Billing Entity

The system displays a list of billing entities for your selection. Type the number of the desired one at the “Select Type of Billing Entity to Display:” prompt.

Clinic Type

Type a clinic name at the “Select Clinic:” prompt. You can type another clinic name at the “Select Another Clinic:” prompt. If you want to select all clinics, press the Return key to accept the default of All. You may also type ?? to see a list of available options.

Collection Point

Type the Accounts Receivable collection point name at the “Select A/R COLLECTION POINT/IHS NAME:” prompt. This is the billing or visit location and is available from the Payment Summary Report by Collection Batch (PRP) option of the Financial Reports Menu (FRM).

Collection Batch

Type the Accounts Receivable collection batch name, or the date or time opened, or the check number at the “Select A/R Collection Batch/IHS Name:” prompt. It is available from the Batch Reports Menu (BRM) option of the Reports Menu (RPT).

Collection Batch Item

Type the Accounts Receivable collection batch name, or the date or time opened, or the check number at the “Select Collection Batch:” prompt. You will then be provided a choice in which you can type in the specific batch item you are searching for.

Date Range

The system gives you a choice among the date the batch was created. Type the number of the date you want to use, then, as prompted, type the beginning and ending dates of the range you want the report to include.

Diagnosis

Select the primary diagnosis code range for the report. When selecting ICD Codes, you can type ?? for a complete listing of all available codes.

Note: You can also type the first few numbers of a code, such as 250, and the system will begin listing all codes that begin with 250 in groups of five from which to choose.

1. Type the beginning diagnosis code for the range at the “Low ICD Code:” prompt. Type Y at the “OK?” prompt to confirm choice or type N to enter a new beginning diagnosis code for the range.
2. Type the ending diagnosis code for the range at the “High ICD Code:” prompt. Type Y at the “OK?” prompt to confirm choice or type N to enter a new ending diagnosis code for the range. Once selected the ICD Code range displays in the existing report parameters list.

Discharge Service

Type a discharge service at the “Select Discharge Service:” prompt. You can type another discharge service at the “Select Another Discharge Service:” prompt. If you want to select all discharge services, press the Return key at a blank “Select Discharge Service:” prompt. You may also type ?? to see a list of available options.

Insurer Type

Select from the list of insurer types and type the number of insurer type at the “Select Insurer Type to Display:” prompt. If you want to select all categories, press the Return key at a blank “Select Insurer Type to Display:” prompt.

Large Balance

If you select 4 (Large Balance), type the new large balance amount at the “Large Balance:” prompt. You can also keep the default setting of \$5000 by pressing the Return key. The Large Balance amount has always been listed with the inclusion parameters that are in effect; but will change with any modification.

Location

When you are prompted for a specific location, type the location name or type ?? to choose from a list of locations. The system prompts for another inclusion parameter.

Provider

The system prompts for the provider’s name. You can either type it in or type ?? to select it from a list.

Report Type

The system prompts for whether you want a Detailed or Summary report or a report with both detail and summary information.

Small Balance

Type the new small balance amount at the “Small Balance:” prompt. You can also keep the default setting of \$5 by pressing the Return key at the “Small Balance:” prompt. The Small Balance amount has always been listed with the inclusion parameters that are in effect; but will change with any modification.

Transaction Date Range

Type the beginning and ending dates of the range you want the report to include.

Visit Type

Type a visit type at the “Select Visit Type:” prompt. You can type another visit type at the “Select Another Visit Type:” prompt. If you want to select all visit types, press the Return key to select the default of ALL. You may also type ?? to see a list of available options.

11.2 Account Management Reports Menu (AMRM)

Use this option to access the Bills List report (BLS), Bill Negative report (NEG), and Small Balance List (SBL).

To access the Account Management Reports menu, type AMRM at the “Select Report Menu Option:” prompt at the Report menu. Sections 11.2.1 through 11.2.4 explain how to use each option listed.

11.2.1 Bills Listing Report (BLS)

This report provides detailed information on bills uploaded from the Third Party Billing package. This report may be sorted by Date Range, Clinic/Visit Type, Billing Entity, and Provider.

To display the BLS report, follow these steps:

1. Type BLS at the “Select Account Management Reports Menu Option:” prompt. The system prompts for selection(s) from among the following Inclusion Parameters by which the report is to be restricted.
2. Type the number of the first parameter with which you want to restrict the report. Note that, after each selection, your choices are listed and you are presented with the inclusion list again.

3. Continue in this way until you have identified all the inclusion parameters you want by which to restrict your report, and then press the Return key at the blank field to continue.
4. When prompted for the way you want to sort the report, type C for Clinic or press the Return key to accept the default Visit Type, then make your selection of either detailed or summary, depending on how you chose to sort the report. Note that you can press the Return key to accept all clinics or visit types.
5. Type the name of the printer or press the Return key to accept the default Home to display the report on your screen at the "Device:" prompt. The system prints or displays the report.

```

WARNING: Confidential Patient Information, Privacy Act Applies
=====
DETAIL Bills Listing Report                                FEB 20,2003   Page 1
for ALL BILLING SOURCE(S)
at DEMO HOSPITAL Visit locaton under DEMO HOSPITAL Billing Location
=====
Patient              Bill Number          DOS           Amount Billed   Balance
=====
      Visit Location: DEMO HOSPITAL
      Clinic: HOME CARE
      A/R Account: ARIZONA MEDICAID

PATIENT,DEMO        261A-AH              SEP 01, 1999      880.70         880.70
PATIENT,DEMO        261B-AH-1122         SEP 01, 1999      150.00         150.00
-----
A/R Account          Count:      2          Total:          1,030.70       1,030.70
-----
Clinic Type          Count:      2          Total:          1,030.70       1,030.70
-----
      Clinic: IMMUNIZATION
      A/R Account: ARIZONA MEDICAID

PATIENT2,DEMO       355B-ASU-6484        MAY 03, 2000       50.00          50.00

Enter RETURN to continue or '^' to exit:
    
```

Figure 11-2: Running a bills listing report

11.2.2 Large Balance List (LBL)

This report can be used by managers to list all bills with open accounts that have a large balance based on the balances selected in the sort parameters. The AR staff can use this report to follow up on accounts that have large balances before the bills with smaller balances are worked.

This report contains data for Visit location(s) regardless of billing location. The report can be restricted to include one or more parameters (LOCATION, BILLING ENTITY, ALLOWANCE, CATEGORY, and LARGE BALANCE). This report pulls data from the A/R Bill/IHS file (only those with an open balance) first. Then, bills with a balance smaller than the default (or the amount you enter) are ignored. The default large balance is \$5000. The minimum balance is \$50.00; the maximum is \$10,000,000.

To print the Large Balance List, follow these steps:

1. Type LBL at the “Select Account Management Reports Menu Option:” prompt.

The screen shown in Figure 11-3 is displayed.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+-----+
|          Large Balance List                             |
|          NOT-A-REAL FACILITY                           |
+-----+-----+
User: YOUR, NAME                                     23-SEP-2005 14:54 PM

NOTE:  This report will contain data for VISIT location(s) regardless of
       BILLING location.

INCLUSION PARAMETERS in Effect for Large Balance List:
=====
- Large Balance.....: $5,000.00

Select one of the following:

      1      LOCATION
      2      BILLING ENTITY
      3      ALLOWANCE CATEGORY
      4      LARGE BALANCE

Select ONE or MORE of the above INCLUSION PARAMETERS:
    
```

Figure 11-3: Large balance parameters (steps 1 and 2)

2. Type the number of a parameter you want to add to your report in response to the “Select ONE or MORE of the above INCLUSION PARAMETERS:” prompt then press the Return key.

Note: After each selection, the “Select ONE or MORE of the above INCLUSION PARAMETERS:” prompt is displayed again. If you need to delete a previously selected parameter, type its number again and press the Return key.

3. Repeat step 2, as needed, until you have selected all parameters you want to add to your report then go to step 4.

If you select 2 BILLING ENTITY, the prompt shown in Figure 11-4 appears.

```
Select one of the following:
```

```

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE
4          NON-BENEFICIARY PATIENTS
5          BENEFICIARY PATIENTS
6          SPECIFIC A/R ACCOUNT
7          SPECIFIC PATIENT
8          WORKMEN'S COMP
9          PRIVATE + WORKMEN'S COMP
10         CHIP

Select TYPE of BILLING ENTITY to Display: ??

```

Figure 11-4: Billing Entity prompt step2 and 3)

If you select 3 ALLOWANCE CATEGORY, the prompt shown in Figure 11-5 is displayed.

```

Select one of the following:

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE (INS TYPES P H F M)
4          CHIP
5          OTHER              (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display:

```

Figure 11-5: Allowance Category prompt step 2 and 3)

If you select 4 LARGE BALANCE, type an amount between \$50 and \$10,000,000 and press the Return key. The default is \$5,000.

4. Press the Return key at the blank field to quit selecting parameters.

The prompts shown in Figure 11-6 are displayed.

```

INCLUDE CLINIC OR VISIT TYPE? ? N// Y

Sort Report by [V]isit Type or [C]linic: V// V or C
Select Visit Type: ALL// [RET]

```

Figure 11-6: Large balance list (inclusion parameters – step 5)

5. Type Y or N at the “INCLUDE CLINIC OR VISIT TYPE?” prompt.
 - If you typed N, go to step 6.
 - If you typed Y, do the following:
 - Type V or C at the “Sort Report by [V]isit Type or [C]linic:” prompt and press the Return key.

- Enter the code for the visit type or clinic in response to either the “Select Visit Type: ALL” or Select Clinic: ALL” prompt and press the Return key. To view the list of visit types or clinics, type?? at either prompt or go to either Table 2-1 or Table 2-2 in this document for visit types or clinic codes, respectively. You can also press the Return key to include all visit types or all clinics (depending on which selection you chose) in your report.

6. Run the report by responding to the “Output DEVICE:” prompt as follows:

- type the name of the printer to print this report
- press the Return key to view this report on your monitor

Figure 11-7 shows an example of this report.

WARNING: Confidential Patient Information, Privacy Act Applies							
=====							
Large Balance List over \$50.00				SEP 23,2005@15:15 Page 1			
for ALL BILLING SOURCE(S) at ALL Visit location regardless of Billing Location							
=====							
BILL NUMBER	DOS	DATE BILLED	DTB	BILLED AMT	BALANCE	AGE	
=====							
VISIT LOCATION: NOT-A-REAL FACILITY							
A/R ACCOUNT: AETNA HLTHCARE ASR PROG OF WI							
113510-96-2	03/06/1996	99/99/2699	3488	1,200.00	1,200.00		
60166							
AR Account Subtotal (\$) and Average (#):			3488	1,200.00	1,200.00		
60166							
A/R ACCOUNT: ARIZONA MEDICAID							
3145A-WE-43587	01/13/2005	01/13/2005	253	91.00	91.00	253	
3152A-WE-43587	01/21/2005	01/31/2005	245	66.00	66.00	235	
AR Account Subtotal (\$) and Average (#):			249	157.00	157.00	244	
A/R ACCOUNT: BLUE CROSS/BLUE SHIELD OF MN							
WARNING: Confidential Patient Information, Privacy Act Applies							
=====							
Large Balance List over \$50.00				SEP 23,2005@15:15 Page 2			
for ALL BILLING SOURCE(S) at ALL Visit location regardless of Billing Location							
=====							
BILL NUMBER	DOS	DATE BILLED	DTB	BILLED AMT	BALANCE	AGE	
=====							
1686A-WE-6938	09/18/1991	03/05/1992	5119	87.18	87.18	2640	
1958A-WE-4736	10/01/1991	03/05/1992	5106	92.20	92.20	2640	
2198A-WE-4548	10/15/1991	03/05/1992	5092	116.98	116.98	2640	
311A-WE-4548	07/09/1991	03/05/1992	5190	59.58	59.58	2640	
963A-WE-4548	08/13/1991	03/05/1992	5155	103.98	103.98	2640	

1162A-WE-6115	08/22/1991	03/06/1992	5146	62.06	62.06	2640
3057A-WE-10553	12/03/1991	03/06/1992	5043	54.30	54.30	2640
956A-WE-6115	08/12/1991	03/06/1992	5156	66.84	66.84	2640
995A-WE-10553	08/14/1991	03/06/1992	5154	79.00	79.00	2640
113510-1999-3	03/25/1999	03/26/1999	2374	445.00	445.00	2373
AR Account Subtotal (\$ and Average (#):			4854	1,167.12	1,167.12	2613
A/R ACCOUNT: KIDSCARE (AZ)						
* * E N D O F R E P O R T * *						

Figure11-7: Large balance list (sample report)

This completes the procedure for creating the large balance report.

11.2.3 Bill Negative Balance List (NEG)

This option lists all A/R Bills with a Current Balance less than zero. This report is useful to identify inaccuracies in posting of amounts by the AR staff. These negative amounts negatively affect the ASM and PSR reports.

Note that you must run the Bill File Error Scan option first before running this report (section 7.17).

To print the Negative Balance report, follow these steps:

1. Type NEG at the “Select Report Menu Option:” prompt. The system will identify all bills that have negative balances in your database. The bills will remain on the report until corrected.
2. Run the report by responding to the “DEVICE:” prompt as follows:
 - type the name of the printer to print this report
 - press the Return key to view this report on your monitor

Figure 11-8 provides an example of this report.

20-FEB-2003		NEGATIVE BALANCE				Page: 1
=====						
IEN	BILL#	PATIENT	DOS	BILLED TO	BALANCE	

AR	10167 583	PATIENT, HENRIETTA	04/25/2001	MEDICARE	-1.000	
AR	10175 604A	TEST, JOSEPH	07/24/2001	AARP	-5,869.340	
AR	10280 727A	PATIENT, HENRIETTA	09/24/2001	MEDICARE	-1.000	
AR	10281 734A	PATIENT, HENRIETTA	11/18/2001	MEDICARE	-1.000	
AR	10285 744A	PATIENT, DEMO	12/01/2001	DELTA DENT	-124.000	
AR	10325 795	PATIENT, HENRIETTA	01/22/2002	NEW MEXICO	-509.500	
E N D O F R E P O R T						

```
Enter RETURN to continue:
```

Figure 11-7: Negative balance (sample report)

11.2.4 Small Balance List (SBL)

This report lists A/R bills with a balance between \$0.00 and \$99.00. This report is printed by management to identify bills with low balances. The site may decide to adjust these bills to zero balances because the site may not want to expend resources to pursue these payments.

The default balance is \$5.00. You can change the default balance amount when you select the inclusion parameters each time you run the report. Note that you must run the Bill File Error Scan option first (see section 7.17).

To print the Small Balance List, follow these steps:

1. Type SBL at the “Select Account Management Reports Menu Option:” prompt.

The screen shown in Figure 11-9 is displayed.

```

      +-----+-----+-----+-----+-----+-----+-----+-----+-----+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      |                Small Balance List                                  +
      |                NOT-A-REAL FACILITY                                |
      +-----+-----+-----+-----+-----+-----+-----+-----+
User:  USER, NAME                24-SEP-2005 15:23 PM
BUS

NOTE:  This report will contain data for VISIT location(s) regardless of
       BILLING location.

INCLUSION PARAMETERS in Effect for Small Balance List:
=====
- Small Balance.....: $5.00

Select one of the following:

      1          LOCATION
      2          BILLING ENTITY
      3          ALLOWANCE CATEGORY
      4          SMALL BALANCE

Select ONE or MORE of the above INCLUSION PARAMETERS:
    
```

Figure 11-8: Small balance list parameters (steps 1 and 2)

2. Type the number of a parameter you want to add to your report in response to the “Select ONE or MORE of the above INCLUSION PARAMETERS:” prompt then press the Return key.

Note: After each selection, the “Select ONE or MORE of the above INCLUSION PARAMETERS:” prompt is displayed again. To delete a previously selected parameter, type its number again and press the Return key.

3. Repeat step 2, as needed, until you have selected all parameters you want to add to your report then go to step 4.

If you select 2 BILLING ENTITY, the prompt shown in Figure 11-4 appears.

```

Select one of the following:

      1      MEDICARE
      2      MEDICAID
      3      PRIVATE INSURANCE
      4      NON-BENEFICIARY PATIENTS
      5      BENEFICIARY PATIENTS
      6      SPECIFIC A/R ACCOUNT
      7      SPECIFIC PATIENT
      8      WORKMEN'S COMP
      9      PRIVATE + WORKMEN'S COMP
     10      CHIP

Select TYPE of BILLING ENTITY to Display: ??

```

Figure 11-10: Billing Entity prompt steps 2 and 3)

If you select 3 ALLOWANCE CATEGORY, the prompt shown in Figure 11-5 is displayed.

```

Select one of the following:

      1      MEDICARE
      2      MEDICAID
      3      PRIVATE INSURANCE (INS TYPES P H F M)
      4      CHIP
      5      OTHER              (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display:

```

Figure 11-9: Allowance Category prompt steps 2 and 3)

If you select 4 SMALL BALANCE, type an amount between \$0.00 and \$99.00 and press the Return key. The default is \$5.00.

4. Press the Return key at the blank field to quit selecting parameters.

The prompts shown in Figure 11-6 are displayed.

```

INCLUDE CLINIC OR VISIT TYPE? ? N// Y

Sort Report by [V]isit Type or [C]linic: V// V or C

```

Select Visit Type: ALL// [RET]

Figure 11-10: Large balance list (inclusion parameters – step 5)

5. Type Y or N at the “INCLUDE CLINIC OR VISIT TYPE?” prompt and press the Return key.
 - If you typed N, go to step 6.
 - If you typed Y, do the following:
 - Type V or C at the “Sort Report by [V]isit Type or [C]linic:” prompt and press the Return key.
 - Enter the code for the visit type or clinic in response to either the “Select Visit Type: ALL” or Select Clinic: ALL” prompt and press the Return key.

To view the complete list of visit types or clinics, type?? at either prompt or go to either Table 2-1 or Table 2-2 in this document for visit types or clinic codes, respectively. You can also press the Return key to include all visit types or all clinics (depending on which selection you chose) in your report.
6. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report.
 - Press the Return key to view this report on your monitor.

Figure 11-7 shows an example of this report.

WARNING: Confidential Patient Information, Privacy Act Applies					
=====					
Small Balance List under \$8.00		MAY 17,2004@14:23		Page 1	
for PRIVATE INSURANCE ALLOWANCE CATEGORY(S)					
at UNSPECIFIED SERVICE UNIT Visit location regardless of Billing Location					
=====					
BILL NUMBER	DOS	DATE BILLED	BILLED AMT	BALANCE	AGE
=====					
VISIT LOCATION: UNSPECIFIED SERVICE UNIT					
A/R ACCOUNT: BC/BS OF MARYLAND INC					
935B-AH-1072	08/10/2002	10/21/2002	5.80	5.80	574
1651A-AH-43566	04/02/2004	04/14/2004	0.99	0.99	33
AR Account Subtotal (\$) and Average (#):			6.79	6.79	304
A/R ACCOUNT: BC/BS UNITED OF WI					
1382-AH-109775	09/04/2003	11/14/2003	5.43	5.43	185
AR Account Subtotal (\$) and Average (#):			5.43	5.43	185
A/R ACCOUNT: BLUE CROSS/BLUE SHIELD OF NM					

615-AH-9518	07/21/2001	07/25/2001	1.00	1.00	1027
AR Account Subtotal (\$) and Average (#):			1.00	1.00	1027
A/R ACCOUNT: MAIL HANDLERS BENEFIT PLAN					
581-AH	01/31/2001	04/02/2001	1.00	1.00	1141
581-AH-3644	01/31/2001	04/02/2001	1.00	1.00	1141
AR Account Subtotal (\$) and Average (#):			2.00	2.00	1141
A/R ACCOUNT: UNITED HEALTH OF WI INS CO INC					
1381-AH-109757	09/04/2003	11/14/2003	5.43	5.43	185
AR Account Subtotal (\$) and Average (#):			5.43	5.43	185
Visit Loc Subtotal (\$) and Average (#):			20.65	20.65	612
Report Total (\$) and Average (#):			20.65	20.65	612
Enter RETURN to continue or '^' to exit:					

Figure 11-11: Small balance list (Sample Report)

This completes the procedure for creating and printing the small balance report.

11.3 Aging Reports Menu (ARM)

Use this option to access the Age Day Letter and List, Age Detail report, Age report, Age Open Items report, and Age Summary report. Bills will age by approval date regardless of export date.

To access the Aging Reports menu, type ARM at the “Select Report Menu Option:” prompt at the Report menu. Sections 11.3.1 through 11.3.5 explain how to use each option.

11.3.1 Age Day Letter & List (ADL)

- The Age Day Letter and List Report will provide a summary that includes the payer name and the total dollar amount that is owed for the open accounts.

This option automatically prints a follow up form letter to third party payers requesting payment. The List Report serves as an attachment to the form letter and provides detailed information to the payer.

The List Report contains the following information:

- Policy holder’s name and number
- Patient name

- Billed amount and Balance due
- Date of Service
- Claim number
- Comment line for the payer to document any notes for the response

Note: The Age Day Letter and List report contain bills with values greater than \$0.01 plus values that carry a credit balance. Be aware that this may “inflate” the amount billed field and lower your outstanding balance field. It is also important to note that the Site needs to edit the form letter to include specific information on the facility name, address, and contact information. To edit this letter, go into the Site Parameter menu. See 7.8, Insurer Age Cover Letter Edit (LET)....

Summary of bills/accounts over 1 days	04/14/2003	PAGE: 1
NEW MEXICO BC/BS INC	367.47	
NEW MEXICO MEDICAID	54,515.12	
BCBS OF NEW MEXICO (FEP)	18,474.82	
MAIL HANDLERS BENEFIT PLAN	306.50	
GOV EMPLOYEES HOSPITAL ASSOC	828.90	
PRESBYTERIAN HEALTH PLAN	2,077.26	
AETNA LIFE AND CASUALTY	1,004.63	
LIFE COURSE	391.68	
DELTA DENTAL OF NEW MEXICO INC	2,017.37	
MEDICAID PRESBYTERIAN	4,586.87	
MEDICAID LOVELACE	4,128.52	
MEDICAID CIMARRON	7,120.04	
LOVELACE HEALTH PLAN	3,402.46	
AETNA LIFE INSURANCE	199.00	
E N D O F R E P O R T		
Enter RETURN to continue or '^' to exit:		

Figure 11-12: Age day sample report

Department of Health and Human Services
 Indian Health Service
 Albq IHS Area Office
 Finance Office

DATE: 14 APR 2003

TO: NEW MEXICO BC/BS INC
 P.O. BOX 27630
 ALBUQUERQUE
 NEW MEXICO

```

87125-7630
(800)344-7343
PRIVATE INSURANCE

FROM: BUSINESS OFFICE address for payments
1234 HOMESTEAD ROAD NE
ALBUQUERQUE
NEW MEXICO
87110

Regarding Past due bills over 1 days totaling $ 367.47

The above past due has been calculated as of this date. A detailed listing
of claims is attached for your reference and information. Please review
and advise us as to the status of the past due claims.

If you have questions or concerns, please call the Business Office at
505-759-3291. We appreciate your cooperation.

Sincerely

MR. MANAGER
Business Office Manager
    
```

Figure 11-13: Sample age day letter

NEW MEXICO BC/BS INC	over 1 days	04/14/2003	PAGE: 3		
Policy Holder	Policy #	Claim #	DOS	Amt Bld	Balance
HOLDER, MAY Pat: PATIENT,OMARR	YIA000201234	3A-JSU-1	09/09/1994	45.34	45.34
HOLDER, POLY Pat: PATIENT,MIGUEL	R99906529	8A-JSU-3	09/13/1994	86.87	86.87
HOLDER, LAWRENCE Pat: PATIENT,MARLON	YIA000223333	2A-JSU-1	09/13/1994	16.50	16.50
HOLDER, SHARON Pat: PATIENT,JAMES	YIA000334444	5A-JSU-7	09/13/1994	51.66	51.66
HOLDER, CEE Pat: PATIENT,JUDY	YIA000446987	6A-JSU-1	09/13/1994	45.04	45.04
HOLDER, JEN Pat: PATIENT,HEATHER	YIA000123456	1A-JSU-1	09/13/1994	46.85	46.85

Figure 11-14: Sample report (the attachment)

To print the Age Day Letter and List, follow these steps:

1. Type ADL at the "Select Aging Reports Menu Option:" prompt.
2. Type the aging date (number of days past the bill approval date) you want at the "Enter a Number:" prompt.

3. Type an individual account, type ?? to select from a list, or press the Return key to include all accounts at the “Select A/R Accounts/IHS:” prompt.
4. The system displays the account name and prompts for entry of another account. Press the Return key at a blank “Select A/R Accounts/IHS:” prompt.
5. Press the Return key to accept the account(s) at the “Selected Account(s) Correct?” prompt.
6. Press the Return key to include more than just the summary at the “Summary Only?” prompt.

The system prompts you to define the fields that on how you want the report sorted. The following options are provided:

- 1 Policy Holder
 - 2 Policy Number
 - 3 Patient
 - 4 Date of Service
7. Type 1, 2, or 3 at the “Within Account Sort By:” prompt.
 8. Type the name of the printer or press the Return key to accept the default Home to display the report on your screen at the “Device:” prompt. The system prints or displays the report.

```

Select Aging Reports Menu Option: ADL Age Day Letter & List

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +          Age Day Letter & List                          +
      |          DEMO HOSPITAL                                  |
      +-----+
User: USER, DEMO          BUSINESS OFFICE          20-FEB-2003 4:33 PM

Enter the minimum age (in days) of bills to be itemized.
Enter a number (0-9000): 360
Select individual A/R accounts or hit RETURN for ALL accounts.
Select A/R ACCOUNTS/IHS: ??

Choose from:
105          ADAM, ADAM
106          DEMO, ELEANOR P
107          TESTPATIENT, DORENE A
108          HOME
109          UN-ALLOCATED

Select A/R ACCOUNTS/IHS: 105 1;VA(200,
Select A/R ACCOUNTS/IHS:
ADAM, ADAM
    
```

```

Selected Account(s) Correct? YES// [RET]
Summary Only? NO//[RET]

      Select one of the following:

          1          POLICY HOLDER
          2          POLICY NUMBER
          3          PATIENT
          4          DATE OF SERVICE

Within Account Sort By: 1// [RET]  POLICY HOLDER
Print to Device: HOME//[RET]
    
```

Figure 11-15: Printing the age day letter and list

11.3.2 Age Detail Report (ADT)

This report provides detailed information on bills, including billed amount and unpaid balance on open bills. This report may be sorted by: Clinic/Visit Type, Billing Entity and Provider.

To generate an Age Detail Report, follow these steps:

1. Type ADT at the “Select Aging Reports Menu Option:” prompt.
2. Type the number of the first parameter with which you want to restrict the report. Note that, after each selection, your choices are listed and you are presented with the inclusion list again.
3. Continue in this way until you have identified all the inclusion parameters you want by which to restrict your report, and then press the Return key at the blank field to continue.
4. Type V or C at the “Sort Report by [V]isit Type or [C]linic:” prompt. If you choose V, you will be prompted to select a visit type. If you choose C, you will be prompted to choose a clinic. Make the appropriate choices for your selections. To select your choice from a list, type ?? at either prompt.
5. Select the device and line length.

Note: The Age Detail report contains bills with values that are greater than \$.01 plus values that carry a credit balance. You will need to be aware that this may “inflate” the amount billed field and lower your outstanding balance field.

```

=====
WARNING: Confidential Patient Information, Privacy Act Applies
=====
Detail Age Detail Report for ALL BILLING SOURCE(S) FEB 20,2003@16:41  Page 1
at DEMO HOSPITAL Visit locaton under DEMO HOSPITAL Billing Location
=====
Patient          Bill Number          DOS          Amount Billed          Balance
=====
    
```

Visit Location: DEMO HOSPITAL					
Visit Type: INPATIENT					
A/R Account: ARIZONA MEDICAID					
PATIENT, HENRIETTA	406B-AH-1072	MAY 01, 2000	768.00	768.00	
PATIENT, HENRIETTA	381B-ASU-1072	MAY 15, 2000	1,058.00	1,058.00	
DEMO, RENEE	405A-ASU-6484	MAY 01, 2000	14,910.00	14,030.96	
DEMO, RENEE	487B-ASU-6484	JUL 15, 2000	5,325.00	5,325.00	
DEMO, RENEE	563A-AH-6484	JUL 15, 1999	5,325.00	5,325.00	
DEMO2, DONALD M	69B-ASU-44362	APR 22, 1997	111.00	111.00	
DEMO3, JENNIFER	764A-AH-50061	DEC 05, 2001	3,918.00	3,918.00	
DEMO4, GRETCHEN	952A-AH-49585	JUL 18, 2002	9,042.00	9,042.00	

Enter RETURN to continue or '^' to exit:

Figure 11-16: Printing an age detail report

11.3.3 Age Report (AGE)

The Age Report provides the following information:

- Patient Name
- Subscriber ID (Usually The Patient's SSN)
- Bill Number
- Date Of Service (DOS) and Date Of Last Payment (DOL)
- Amount Of Original Bill
- Current Category Of Bill In Age (30 To 120+ Days)
- Current Balance

You may sort this report by Facility, Insurer, Clinic, or Patient. The Age Report provides detailed information on all outstanding bills. This report contains information taken from the A/R bill file. It is 165 characters wide and needs a printer set at 16 characters per inch, landscaped.

Note: The Age report will contain bills with values that are greater than \$.01 plus values that carry a credit balance. You will need to be aware that this may “inflate” the amount billed field and lower your outstanding balance field.

To display the Age Report, follow these steps:

6. Type AGE at the “Select Aging Reports Menu Option:” prompt.
7. Type F, I, C, or P at the “Facility, Insurer, Clinic, or Patient:” prompt.

8. Type the name of the facility, insurer, clinic, or patient, or type ?? to select from a list, or press the Return key to include all at the "Select <entry> or Press <Return> for All <such entries>:" prompt.
9. Type the name of the printer or H (Home) if you want the information displayed on screen at the "Device:" prompt. Then press the Return key at the "Right Margin:" prompt. The system displays or prints the report.

CONFIDENTIAL PATIENT INFORMATION									
DATE:		DETAILED AGING REPORT BY CLINIC BASED ON DATE BILLED					PAGE 1		
06/15/2000		DEMO HOSPITAL							
SELECTION: ALL									
BILL #	DOS	DOL PAYMENT	Billed	Current	31-60	61-90	91-120	120+	BALANCE
=====									
CLINIC TYPE: HOME CARE									
PATIENT: PATIENT, HENRIETTA									
280A-ASU	01/10/2000		155.00					155.00	155.00
PATIENT: DEMO2, SYLVIA									
261A-ASU-11	09/01/1999		880.70		880.70				880.70
261B-ASU-11	09/01/1999		150.00		150.00				150.00
SUBTOTAL			1340.70	0.00	1030.70	0.00	0.00	310.00	1185.70
CLINIC TYPE: IMMUNIZATION									
PATIENT: DEMO, RENEE									
355A-ASU-64	05/03/2000		150.00		150.00				150.00
SUBTOTAL			150.00	0.00	150.00	0.00	0.00	0.00	150.00
CLINIC TYPE: LABORATORY SERVICES									
PATIENT: DEMO3, CYNTHIA									
169A-ASU-66	09/14/1999		155.00					155.00	155.00
169B-ASU-66	09/14/1999		155.00					155.00	155.00
169C-ASU-66	09/14/1999		155.00					155.00	155.00
SUBTOTAL			465.00	0.00	0.00	0.00	0.00	465.00	465.00
CLINIC TYPE: MENTAL HEALTH									
PATIENT: DEMO4, JOE									
370A-ASU-12	05/05/2000		172.00		172.00				172.00
PATIENT: PATIENT4, HANK									
361A-ASU-80	05/02/2000		172.00		172.00				172.00
SUBTOTAL			344.00	0.00	344.00	0.00	0.00	0.00	344.00
CLINIC TYPE: OBSTETRICS									
PATIENT: PATIENT, PATRICIA									
327A-ASU-78	05/02/2000		450.00		450.00				450.00
SUBTOTAL			450.00	0.00	450.00	0.00	0.00	0.00	450.00
CLINIC TYPE: PEDIATRIC									
PATIENT: PATIENT, JOHN									
351A-ASU-20	05/05/2000		172.00		172.00				172.00
SUBTOTAL			344.00	0.00	344.00	0.00	0.00	0.00	172.00
CLINIC TYPE: PHARMACY									
PATIENT: DEMO2, LUCINDA									
202101-2000	05/01/2000		27.00					27.00	27.00
SUBTOTAL			27.00	0.00	0.00	0.00	0.00	27.00	27.00

CLINIC TYPE: SURGICAL							
PATIENT: DEMO, HENRIETTA							
277A-ASU-10	12/15/1999	155.00				155.00	155.00

SUBTOTAL		155.00	0.00	0.00	0.00	0.00	155.00

TOTAL		42271.75	15968.00	15232.75	0.00	28.27	2201.00

						33268.02	

Figure 11-17: Age report

11.3.4 Aged Open Items Report (AOI)

The Age Open Items Report (AOI) can be sorted by one or all Patients or Insurers and shows outstanding bills between 0 and 120 days old as shown in Figure 11-20.

PATIENT	BILL #	DOS	0-30	31-60	61-90

PATIENT, JOHN	123A	5/2/95		12.34	

Figure 11-18: Aged open items report (fields sample)

The fields on this report include:

- Patient or Insurer Name
- Bill #: Number of bill in A/R
- DOS Beginning Date Of Service for A/R bill
- (0-30)-(120+): Category of Days bill(s) are outstanding

This report displays credit balances to the ASM and AOI reports to balance. In version 1.7, you created this report using FileMan, which does not properly recognize sort elements containing commas. In version 1.8, the report uses M code, which does not have the same issue with commas in sort elements. There are no significant changes to content or format expected.

Note: The AOI report contains bills with values that are greater than \$0.00 plus values that carry a credit balance. Be aware that this may “inflate” the amount billed field and lower your outstanding balance field.

To run the Age Open Items Report, follow these steps:

1. Type AOI at the “Select Aging Reports Menu Option:” prompt.

The screen shown in Figure 11-21 is displayed.

+-----+	
	ACCOUNTS RECEIVABLE SYSTEM - VER 1.8
+	Aged Open Items Report
	NOT-A-REAL FACILITY
+-----+	
User: USER NAME	4-OCT-2005 8:43 AM

```

BUS

NOTE:  This report will contain data for VISIT location(s) regardless of
        BILLING location.

Select Visit LOCATION:

        Select one of the following:

            1          0-30
            2          31-60
            3          61-90
            4          91-120
            5          120+

Select aging range for bills:

```

Figure 11-19: Aged open items parameters (steps 1-3)

2. Type the location at the “Select Visit Location:” prompt and press the Return key.

To view a complete list of locations, type two questions marks (??) then select a location and press the Return key or press the Return key to accept the default location.

3. Type the appropriate number at the “Select aging range for bills:” prompt.

Your choices are:

1	0-30
2	31-60
3	61-90
4	91-120
5	120+

4. Type I (Insurers) or P (Patients) at the “Should the report contain data for Insurer or Patient (I/P):” prompt, press the Return key and respond to the following prompt as appropriate:
 - If you chose Insurer, type the name of the insurer or press the Return key for all insurers at the “Select Insurer or press <Return> for all Insurers:” prompt.
 - If you chose Patient, type the patient’s name at the “Select Patient:” prompt or type two questions marks (??) for a list of patients then type the patient’s name at the “Select Patient:” prompt.
5. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report
 - Press the Return key to view this report on your monitor

Figure 11-22 shows an example of this report.

```

=====
WARNING: Confidential Patient Information, Privacy Act Applies
=====
Aged Open Items Report                                OCT 4,2005@09:26   Page 1
for Bills OVER 120 days old
at ALL Visit location(s) regardless of Billing Location
=====
PATIENT NAME                BILL NUMBER                DOS                OVER 120
=====
VISIT Location:  NOT-A-REAL FACILITY
A/R Account:    KIDSCARE (AZ)

NAIL,RUSTY                3136A-WE-75625            08/19/2004            859.00
* KIDSCARE (AZ) TOTAL                                -----            859.00
** NOT-A-REAL FACILITY TOTAL                          -----            859.00
*** REPORT TOTAL                                      =====            859.00

Enter RETURN to continue or '^' to exit:
    
```

Figure 11-20: Aged open items report (report)

This completes the procedure for creating the aged open items report.

11.3.5 Age Summary Report (ASM)

This report is one of the main reports that managers should use to monitor their accounts receivable. It will provide data by Allowance Category, payer, aging ranges and dollar amounts. Managers should print this report at each month end reconciliation process to identify which payers are not reimbursing for bills submitted.

This report also allows the sorting by Discharge Service. Also, bill level detail is given, allowing better tools for reconciliation.

Note: Insurer type abbreviations are listed below:

- H HMO
- M Medicare suppl
- D Medicaid FI
- R Medicare FI
- P Private insurance
- W Workmen's comp
- C CHAMPUS
- F Fraternal organization
- N Non-beneficiary (non-Indian)
- I Indian patient

K CHIP (Kidscare)

To run the ASM report, follow these steps:

1. Type ASM at the “Select Aging Reports Menu Option:” prompt in the Aging Reports menu located in the A/R reports menu.

The screen shown in Figure 11-23 is displayed

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+
|          Age Summary Report                            |
|          NOT-A-REAL FACILITY                            |
+-----+
User:  USER,NAME                                     4-OCT-2005 2:23 PM
BUS
NOTE:  This report will contain data for VISIT location(s) regardless of
       BILLING location.
Select Visit LOCATION:
    
```

Figure 11-21: Age summary report (steps 1 and 2)

2. Type the name of a location at the “Select Visit Location:” prompt or press the Return key to select all locations.

Note: If you type the name of a single location, your report will include information for that location only.

3. Type the number of one of the following options shown in Figure 11-24 at the “Select criteria for sorting:” prompt and press the Return key.

```

Select one of the following:

1          A/R ACCOUNT
2          CLINIC TYPE
3          VISIT TYPE
4          DISCHARGE SERVICE
5          ALLOWANCE CATEGORY
6          BILLING ENTITY
7          INSURER TYPE
    
```

Figure 11-22: ASM report sort criteria (step 3)

Note: For the following bulleted items, you can type ?? to view the complete list of codes after you type one of the numbers shown in Figure 11-24. You can only select one of the listed items per report.

- If you type 1 A/R ACCOUNT, chose the payer by typing in the number of the payer as shown in Figure 11-25 at the “Select A/R Account:” prompt or press the Return key to include all accounts.


```

Choose from:
1      AETNA HLTHCARE ASR PROG OF WI
2      BLUE CROSS/BLUE SHIELD OF MN
3      IBAA GROUP INSURANCE SERVICE
4      NEW MEXICO BC/BS INC
5      KIDSCARE (AZ)
6      UNITED DENTAL CARE INC
7      ARIZONA MEDICAID
8      MEDICARE
9      BC/BS OF ARIZONA INC

```

Figure 11-23: ASM report A/R account selection (step 3)

- If you type 2 CLINIC TYPE, type the code for the clinic shown in Table 2-1 at the “Select A/R Account:” prompt or press the Return key to include all clinic types.
 - If you type 3 VISIT TYPE, type the code for the visit shown in Table 2-2 at the “Select A/R Account:” prompt or press the Return key to include all visit types.
 - If you type 4 DISCHARGE SERVICE, type the code for the visit shown in Table 2-2 at the “Select A/R Account:” prompt or press the Return key to include all discharge services.
 - If you type 5 ALLOWANCE CATEGORY, type the number of a category shown in Figure 11-26 at the “Select TYPE of ALLOWANCE CATEGORY to Display:” prompt or press the Return key to include all allowance categories.
4. Type the number that corresponds to the report summary you want at the “Select REPORT TYPE:” prompt.

Figure 11-26 shows your choices. If you do not want a detailed listing of all of the bills that are unpaid by Payer, you may want to print a summary report. Below is a listing of choices in which you can print the summary reports.

```

Select one of the following:
      1      Summarize by ALLOW CAT/BILL ENTITY/INS TYPE
      2      Summarize by PAYER w/in ALLOW CAT/BILL ENTITY/INS TYPE
      3      Summarize by BILL w/in PAYER w/in ALLOW CAT/BILL
ENTITY/INS
TYPE
Select REPORT TYPE:

```

Figure 11-24: ASM report summary selection (step 4)

5. Run the report by responding to the “Output DEVICE:” prompt as follows:
- type the name of the printer to print this report
 - press the Return key to view this report on your monitor

Figure 11-27 shows an example of this report.

```

=====
WARNING: Confidential Patient Information, Privacy Act Applies
=====
Age Summary Report for ALL BILLING SOURCE(S)      JUN 4,2003@12:19   Page 1
at ALL Visit location(s) under UNSPECIFIED HEALTH CENTER Billing Location
=====
BILLING ENTITY      CURRENT      31-60      61-90      91-120      120+      BALANCE
=====
MEDICAID
MEDICAID CIMARRON      0.00      0.00      0.00      0.00      6828.56      6828.56
MEDICAID LOVELACE      0.00      0.00      0.00      0.00      4128.52      4128.52
MEDICAID PRESBYTER      0.00      0.00      0.00      0.00      4408.03      4408.03
MONTANA MEDICAID      0.00      0.00      0.00      0.00      172.00      172.00
NEW MEXICO MEDICAI      0.00      378.00      0.00      0.00      53199.12      53577.12
-----
BILL ENTITY TOTAL      0.00      378.00      0.00      0.00      68736.23      69114.23

MEDICARE
MEDICARE      0.00      0.00      0.00      0.00      12901.73      12901.73
-----
BILL ENTITY TOTAL      0.00      0.00      0.00      0.00      12901.73      12901.73

NON-BENEFICIARY PAT

=====
WARNING: Confidential Patient Information, Privacy Act Applies
=====
Age Summary Report for ALL BILLING SOURCE(S)      JUN 4,2003@12:20   Page 4
at ALL Visit location(s) under UNSPECIFIED HEALTH CENTER Billing Location
=====
BILLING ENTITY      CURRENT      31-60      61-90      91-120      120+      BALANCE
=====
PREBYTERIAN HEALT      0.00      0.00      0.00      0.00      2077.26      2077.26
UNITED HEALTH CARE      0.00      0.00      0.00      0.00      442.19      442.19
WEA INSURANCE      0.00      0.00      0.00      0.00      371.64      371.64
-----
BILL ENTITY TOTAL      0.00      0.00      0.00      0.00      54258.64      54258.64

WORKMEN'S COMP
WORKMEN'S COMP      0.00      0.00      0.00      0.00      114.20      114.20
-----
BILL ENTITY TOTAL      0.00      0.00      0.00      0.00      114.20      114.20
=====
0.00      378.00      0.00      0.00      136617.09      136995.09
=====

```

Figure 11-25: Using the new ASM report (step 7)

This completes the procedure for creating the age summary report.

11.4 Batch Reports Menu (BRM)

Use this option to run either the Batch Posted Payments or the Batch Statistical reports.

To access the Batched Reports menu, type BRM at the “Select Report Menu Option:” prompt at the Report menu. Sections 11.4.1 and 11.4.2 explain how to use each option.

11.4.1 Batch Statistical Report (BSL)

The Batch Statistical Report displays each collection point and displays how much has been posted. It also shows outstanding amounts that need to be posted from each batch. The amount shown under the Collections Processed column indicates the amount posted and under the Balance column is the amount still to be posted. Other information displayed in this report includes dates, batch names, and batch totals.

To display or print the Batch Statistical Report, follow these steps:

1. Type BSL at the “Select Batch Reports Menu Option:” prompt.
2. Type the beginning date of date range at the “Enter Beginning Date:” prompt.
3. Type the ending date of date range at the “Enter Ending Date:” prompt.
4. Type H (Home) to display on your screen or type the name of your printer at the “Device:” prompt. Then press the Return key at the “Right Margin:” prompt. The system prints or displays the report.

DATE :		BATCH STATISTICS FOR					PAGE 1
02/20/03		DEMO HOSPITAL					
		20-FEB-2002 TO 20-FEB-2003					
BATCH DATE	BATCH	COLLECTIONS	UNALLOCATED	REFUNDED			
-SEQ-BS	TOTAL	PROCESSED	TRUE	TOTAL	FROM BATCH		
BALANCE							
=====							
COLLECTION ID: AAOBO							
03/21/2002-1- P	5869.34	0.00	0.00	0.00	0.00	5869.34	

SUBTOTAL	5869.34	0.00	0.00	0.00	0.00	5869.34	
COLLECTION ID: GUEST02							
03/14/2002-1- P	5869.34	0.00	0.00	0.00	0.00	5869.34	
03/21/2002-1- P	5525.19	0.00	0.00	0.00	0.00	5525.19	

SUBTOTAL	11394.53	0.00	0.00	0.00	0.00	11394.53	

Figure 11-26: Batch statistical report

11.4.2 Batch Posted Payments (BPP)

The Batch Posted Payments Report provides detailed posting information by batch. This report is used to match up payments in the Collections Register to those posted in batch. The report prompts for a specific batch and only shows Payments to that batch.

Note: It is important to remember to request batches by specific name and date.

Terms used in this report are defined as follows:

- DEMO-05/28/1999-1: Batch Name
- IT: Item within the Batch
- Bill (A/R) (delete #): Number of bill in A/R
- PMT: Amount of Payment Posted
- DT: Date payment was posted to bill
- BILLED TO: Payer the bill was sent to
- PATIENT: Patient name on bill

To print or display the Batch Posted Payments Report, follow these steps:

1. Type BPP at the “Select Batch Reports Menu Option:” prompt.
2. Type the account or ?? to select from a list at the “Select A/R Collection Batch/IHS Name:” prompt.
3. Type P to print the report or B to view the report on your monitor at the “Do you wish to:” prompt.
4. Type H (Home) to display on your screen or type the name of your printer for a hard copy at the “Device:” prompt. Then press the Return key at the “Right Margin:” prompt. The system prints or displays the report.

DEMO -05/28/1999-1POSTINGS ***CONFIDENTIAL PATIENT INFORMATION***						
APR 14, 2003 09:53 PAGE 1						
IT	BILL (A/R)	PMT	DT	BILLED TO	PATIENT	

A/R ACCOUNT: MEDICARE						
1	00000A-JSU	110.40	06/07/1999	MEDICARE	PATIENT1, CHERYL	
	00000A-JSU	110.40	06/07/1999	MEDICARE	PATIENT2, JO	
	00000A-JSU	30.40	06/07/1999	MEDICARE	PATIENT3, TIA	
	00000A-JSU	110.40	06/07/1999	MEDICARE	PATIENT4, RUDLEY	
	00000A-JSU	110.40	06/07/1999	MEDICARE	PATIENT4, RUDLEY	
	00000A-JSU	110.40	06/07/1999	MEDICARE	PATIENT6, TROY F	
	00000A-JSU	110.40	06/07/1999	MEDICARE	PATIENT7, RUEBEN K	
SUBTOTAL		692.80	-----			
TOTAL		692.80	-----			

Figure 11-27: Batch posted payments report

11.5 Financial Reports Menu (FRM)

Use this option access the Advise of Allowance, Period Summary, A/R Statistical, and Transaction reports.

To access the Financial Reports menu, type FRM at the “Select Report Menu Option:” prompt at the Report menu. Sections 11.5.1 through 11.5.6 explain how to use each of the options.

11.5.1 Advise of Allowance Report (ADA)

These reports are useful especially for those situations where a parent facility has to report to its satellites on how much money they will be receiving. Both reports are generated by entering a date range (Beginning and Ending Dates).

The Detailed Advice of Allowance Report provides information on how much has been collected for each satellite facility on a daily basis. The information given on the detailed report includes the following: date logged, claim identification, A/R account and the amount collected.

The Summary Advice of Allowance Report is used to show how much money will be given to each satellite facility for a given date range, for example, July 1 through July 31. There is a total given for each satellite facility.

To generate an Advise of Allowance Report, follow these steps:

1. Type ADA at the “Select Financial Reports Menu Option:” prompt. The system displays the “Select One: (Detail/Summary)” prompt.
2. Type D (Detailed) or S (Summary).
3. The system displays the “Enter Beginning Date:” prompt. Type the date on which the report should begin.
4. The system displays the “Enter Ending Date:” prompt. Type the date on which the report should end.
5. The system displays the “Device:” prompt. Type H (Home) to display the report on your screen or type the name of your printer for a hard copy. Then press the Return key at the “Right Margin:” prompt.
6. The system prints or displays the report.

DATE:	ADVICE OF ALLOWANCE FOR THE PERIOD		PAGE 1
04/14/2003	14-APR-2002 TO 14-APR-2003		
DEMO HEALTH CENTER			
DATE	CLAIM		
LOGGED	ID	A/R ACCOUNT	COLLECTIONS
=====			

DEMO HEALTH CENTER			
11/26/2002	14152A-JSU-34111	MEDICAID CIMARRON	152.00
01/17/2003	9A-JSU-39659	BCBS OF NEW MEXICO	4.90
01/17/2003	20781B-JSU-56	BCBS OF NEW MEXICO	12.00
01/17/2003	20781A-JSU-56	BCBS OF NEW MEXICO	36.00
01/17/2003	20531A-JSU	BCBS OF NEW MEXICO	25.00
01/17/2003	20781B-JSU-56	BCBS OF NEW MEXICO	50.00
SUBTOTAL			279.90
TOTAL			279.90

Figure 11-28: Advice of allowance report (detailed)

DATE	ADVICE OF ALLOWANCE SUMMARY FOR THE PERIOD	PAGE
04/14/2003	14-APR-2002 TO 14-APR-2003	1
COLLECTIONS		
=====		
=====		
DEMO HEALTH CENTER		
SUBTOTAL		279.90
TOTAL		279.90

Figure 11-29: Advice of allowance report (summary)

11.5.2 Inpatient Primary Diagnosis Report (IPDR)

The Inpatient Primary Diagnosis Report is available in the AR package to allow the managers to print a report for Inpatient bills to provide statistics on revenue generated amounts by Discharge Service.

To run the Inpatient Primary Diagnosis report, follow these steps:

1. Type IPDR at the “Select Financial Reports Menu Option:” prompt.

The screen shown in Figure 11-29 is displayed.

```

+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           Inpatient Primary Diagnosis Report             +
|           NOT-A-REAL FACILITY                             |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER, NAME                                           28-SEP-2005 2:20 PM

NOTE:  This report will contain data for VISIT location(s) regardless of
        BILLING location.

INCLUSION PARAMETERS in Effect for Inpatient Primary Diagnosis Report:
=====

Select one of the following:

      1      LOCATION
      2      BILLING ENTITY
      3      ALLOWANCE CATEGORY
    
```

4	DATE RANGE
5	PROVIDER
6	DIAGNOSIS
7	DISCHARGE SERVICE

Select ONE or MORE of the above INCLUSION PARAMETERS:

Figure 11-30: Inpatient Primary Diagnosis Report (steps 1 and 2)

2. Type the number of the first parameter that you want to use to restrict your report.

Note: After each selection, your choices are listed and you are presented with the inclusion list again.

If you select 2 BILLING ENTITY, the prompt shown in Figure 11-30 appears.

Select one of the following:

1	MEDICARE
2	MEDICAID
3	PRIVATE INSURANCE
4	NON-BENEFICIARY PATIENTS
5	BENEFICIARY PATIENTS
6	SPECIFIC A/R ACCOUNT
7	SPECIFIC PATIENT
8	WORKMEN'S COMP
9	PRIVATE + WORKMEN'S COMP
10	CHIP

Select TYPE of BILLING ENTITY to Display: ??

Figure 11-31: Billing Entity prompt (steps 2 and 3)

If you select 3 ALLOWANCE CATEGORY, the prompt shown in Figure 11-31 is displayed.

Select one of the following:

1	MEDICARE
2	MEDICAID
3	PRIVATE INSURANCE (INS TYPES P H F M)
4	CHIP
5	OTHER (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display:

Figure 11-32: Allowance Category prompt (steps 2 and 3)

If you select 4 Date Range, type 1 for the Approval Date or 2 for the Admission Date at the “Select TYPE of DATE Desired:” prompt, then enter the starting and ending dates at the appropriate prompts.

Figure 11-32 provides as an example of these prompts and responses.

```

Select one of the following:

      1      Approval Date
      2      Admission Date

Select TYPE of DATE Desired: 1 Approval Date

===== Entry of APPROVAL DATE Range =====

Enter STARTING APPROVAL DATE for the Report: ^

      Select one of the following:

            1      Approval Date
            2      Admission Date

Select TYPE of DATE Desired: 2 Admission Date

===== Entry of ADMISSION DATE Range =====

Enter STARTING ADMISSION DATE for the Report: 1/1/1952

Enter ENDING DATE for the Report: 12/31/2004

```

Figure 11-33: Approval and Admission date range prompts (steps 2 and 3)

If you select 5 Provider, type the NEW PERSON NAME, or INITIAL, or SSN, or VERIFY CODE, or NICK NAME, or SERVICE/SECTION, or DEA#, or VA#, or CODE, or IHS LOCAL CODE, or IHS ADC INDEX, or ALIAS” or at the “Select NEW PERSON NAME:” prompt. To view the entire list, type ??.

If you select 6 DIAGNOSIS, type the beginning ICD DIAGNOSIS CODE NUMBER, or DESCRIPTION at the “LOW ICD Code:” prompt then type the ending ICD DIAGNOSIS CODE NUMBER, or DESCRIPTION at the “HIGH ICD code prompt. To view the entire list, type ??.

If you select 7 DISCHARGE SERVICE, type the name of the discharge service or type ?? to display the entire list.

3. Repeat step 2, as needed, until you have selected all parameters you want to add to your report then go to step 4 when you finish.
4. Press the Return key at the blank field to quit selecting parameters.
5. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report.
 - Press the Return key to view this report on your monitor.

Figure 11-33 shows an example of this report.

WARNING: Confidential Information, Privacy Act Applies


```

=====
INPATIENT PRIMARY DIAGNOSIS REPORT                                DEC 14, 2001    PAGE:    1
FOR APPROVAL DATES <DATE> TO <DATE>
FOR ALL BILLING ENTITIES, FOR ALL DISCHARGE SERVICES
FOR PRIMARY DIAGNOSIS  <???'> TO <???'>
=====
DIAGOSIS          BILLS          COVERED          AMOUNT          AMOUNT          CO-PAYS/
                   DAYS          BILLED          PAID          DEDUCTIBLES    ADJUSTMENTS
=====
VISIT LOCATION:                ALBUQUERQUE HOSPITAL
BILLING ENTITY:  CHAMPUS
DISCHARGE SERVICE:  SURGERY

 244.9            2            56            2163.00         3140.00         100.00         -1077.00
-----
DSCH SVC TOT    2            56            2163.00         3140.00         100.00         -1077.00
-----
BILL ENT TOT    2            56            2163.00         3140.00         100.00         -1077.00

BILLING ENTITY:  MEDICAID
DISCHARGE SERVICE:  GENERAL MEDICINE

 413.9            4            12            15672.00         4852.00          0.00           0.00
 650.             5            14            18284.00         16025.00         0.00           0.00
 784.0            2            32            41972.00         36840.00         0.00          2842.00
 V27.0            12           24            31344.00          860.00          0.00           972.00
 V71.2            1             2             2612.00           0.00          0.00          2612.00
-----
DSCH SVC TOT   24            84           109884.00         58577.00          0.00          6426.00

DISCHARGE SERVICE:  INTERNAL MEDICINE

 531.01           3             9            11754.00          6600.00          0.00           0.00
 723.1            1             2             2612.00          3444.00          0.00           0.00
 862.22           5            15            19590.00         16992.00          0.00           0.00
 925.2            3             7             9142.00          2650.00          0.00          2600.00
 250.00           3             9            11754.00          3544.00          0.00           0.00
 303.90           8            25            32650.00          1344.00          0.00           0.00
 784.0            1             2             2612.00          1723.00          0.00           0.00
 V22.1            4            12            15672.00         14910.00          0.00           0.00
 V69.8            3            12            15672.00          6584.00          0.00           0.00
-----
DSCH SVC TOT   31            93           121458.00         57791.00          0.00          2600.00
-----
BILL ENT TOT   55            177           231342.00         116368.00          0.00          9026.00
-----
VIS LOC TOT    57            233           233505.00         119508.00         100.00          7949.00
=====
TOTAL          57            233           233505.00         119508.00         100.00          7949.00
=====

```

Figure 11-34: Inpatient Primary Diagnosis Report (sample report)

This completes the procedure for creating the inpatient primary diagnosis report.

11.5.3 Payment Summary Report by Collection Batch (PRP)

This report provides the Manager information on payments by any Collection batch, Collection Point or Insurer Type selected. It will also contain the Billing location information. Selecting a Visit Location allows you to run the report for a specific Visit location under this Billing location.

To run the Payment Summary Report by Collection Batch, follow these steps:

1. Type PRP at the “Select Financial Reports Menu Option:” prompt.

The screen shown in Figure 11-34 is displayed

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+      Payment Summary Report by Collection Batch      +
|          NOT-A-REAL FACILITY                          |
+-----+
User: USER, NAME                                     29-SEP-2005 1:15 PM
BUS
NOTE: This report will contain data for the BILLING location you are logged
      into. Selecting a Visit Location will allow you to run the report for
      a specific VISIT location under this BILLING location.

INCLUSION PARAMETERS in Effect for Payment Summary Report by Collection
Batch:
=====

      Select one of the following:

          1      LOCATION
          2      COLLECTION POINT
          3      INSURER TYPE

Select ONE or MORE of the above INCLUSION PARAMETERS:
    
```

Figure 11-35: Inpatient Primary Diagnosis Report (sample report)

2. Type the number of a parameter you want to add to your report in response to the “Select ONE or MORE of the above INCLUSION PARAMETERS:” prompt then press the Return key.

Note: After each selection, the “Select ONE or MORE of the above INCLUSION PARAMETERS:” prompt is displayed again. If you need to delete a previously selected parameter, type its number again and press the Return key.

If you select 2 COLLECTION POINT, type the name of the collection point at the “Select A.R COLLECTION POINT” prompt.

If you select 3 Insurer Type, the prompt shown in Figure 11-35 is displayed.

```

Select ONE or MORE of the above INCLUSION PARAMETERS: 3  INSURER TYPE

  Select one of the following:

      H          HMO
      M          MEDICARE SUPPL.
      D          MEDICAID FI
      R          MEDICARE FI
      P          PRIVATE INSURANCE
      W          WORKMEN'S COMP
      C          CHAMPUS
      F          FRATERNAL ORGANIZATION
      N          NON-BENEFICIARY (NON-INDIAN)
      I          INDIAN PATIENT
      K          CHIP (KIDSCARE)

Select INSURER TYPE to Display:

```

Figure 11-36: Insurer Type prompt (steps 2 and 3)

3. Repeat step 2, as needed, until you have selected all parameter you want to add to your report then go to step 4 when you finish.

4. Press the Return key at the blank field to quit selecting parameters.

The “Entry of COLLECTION BATCH OPEN DATE Range” prompt appears.

5. Type the beginning open batch date at the “Select Beginning Date:” prompt.

6. Type the ending open batch date at the “Select Ending Date:” prompt.

Note: The date range must not exceed 31 days, maximum.

7. Type Y or N at the “INCLUDE CLINIC OR VISIT TYPE?” prompt.

- If you typed N, go to step 8.
- If you typed Y, do the following:
 - Type V or C at the “Sort Report by [V]isit Type or [C]linic:” prompt and press the Return key.
 - Enter the code for the visit type or clinic in response to either the “Select Visit Type: ALL” or Select Clinic: ALL” prompt and press the Return key.

To view the list of visit types or clinics, type?? at either prompt or go to either Table 2-1 or Table 2-2 in this document for visit types or clinic codes, respectively. You can also press the Return key to include all visit types or all clinics (depending on which selection you chose) in your report.

8. Run the report by responding to the “Output DEVICE:” prompt as follows:

- Type the name of the printer to print this report.

- Press the Return key to view this report on your monitor.

Figure 11-36 shows an example of this report. Your actual report may vary based on the inclusion parameters you choose.

WARNING: Confidential Information, Privacy Act Applies			
=====			
PAYMENT SUMMARY REPORT		DEC 14, 2001	PAGE: 1
FOR BATCH DATES OF SEP 01 2000 TO SEP 30 2000			
FOR COLLECTION POINT: MCR			
BATCHED AMOUNT: \$ 85,943.55			
=====			
MONTH	# OF BILLS	BILLED AMOUNT	PAYMENTS
=====			
VISIT LOCATION: ALBUQUERQUE HOSPITAL			
VISIT TYPE: INPATIENT			
MAY 2000	50	17,056.65	13,562.00
JUNE 2000	12	16,652.89	8,000.00
JULY 2000	9	7,546.88	5,664.00
AUGUST 2000	1	5,185.00	2,795.00
	----	-----	-----
VISIT TYPE TOTAL	72	46,441.42	30,021.00
VISIT TYPE: OUTPATIENT			
APRIL 2000	32	39,502.98	23,330.12
MAY 2000	11	8,416.28	4,384.91
JUNE 2000	4	1,291.22	833.09
JULY 2000	7	2,394.09	586.81
	----	-----	-----
VISIT TYPE TOTAL	54	51,607.57	29,134.93
	----	-----	-----
LOCATION TOTAL	126	98,048.99	59,155.93
VISIT LOCATION: ISLETA HEALTH CENTER			
VISIT TYPE: OUTPATIENT			
MAY 2000	24	1,209.08	958.26
JUNE 2000	7	961.48	582.56
AUGUST 2000	18	8,459.00	3,287.09
	----	-----	-----
VISIT TYPE TOTAL	49	10,629.56	4,827.91
VISIT TYPE: DENTAL			
JUNE 2000	12	7,825.83	6,562.22
	----	-----	-----
VISIT TYPE TOTAL	12	7,825.83	6,562.22
	----	-----	-----
LOCATION TOTAL	61	18,455.39	11,390.13
	====	=====	=====
TOTAL	187	116,504.38	70,546.06

COLLECTION BATCHES		BATCHED AMOUNTS	UNPOSTED BALANCE

Medicare IP-09/15/2000-1	26,461.00	2,943.04
PI OPV-09/17/2000-1	14,482.54	3,495.00
PI OPV-09/23/2000-4	32,456.02	5,231.99
MEDICAID OPV-09/23/2000-7	12,543.99	1,394.00

TOTALS	85,943.55	13064.03
***** R E P O R T C O M P L E T E *****		

Figure 11-37: Payment summary report (sample report)

This completes the procedure for creating the payment summary report.

11.5.4 Period Summary Report (PSR)

The PSR report is one of the main AR reports that is used during the facility’s month end process. This report provides a summary of all bills that were posted or had an AR transaction activity. It can be sorted for all billing sources for a specified date range, including total billed, payment, and adjustment amounts.

This report has been rewritten to use the AR transaction file. The transaction file allows for more detail that is displayed on the report which provides for more information for the month end reconciliation process. More detailed parameters have been added which assists the manager with printing customized reports. The report can be run using the same parameters as the AGE summary report. Additional sorting criteria selections include the following: Discharge and Insurer Type. When the Allowance Category, Billing Entity or Insurer Type is selected as the sorting criteria, you can also sort by Bill w/in Payer w/in Allowance Category, Billing Entity or Insurer Type.

Note: This report contains data for Visit location(s) regardless of billing location.

To run the Period Summary Report, follow these steps:

1. Type PSR at the “Select Financial Reports Menu Option:” prompt in the Financial Reports menu located in the A/R Reports menu.

The screen shown in Figure 11-38 is displayed

```

+-----+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|           Period Summary Report                           |
|           NOT-A-REAL FACILITY                             |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User:  USER,NAME                                           4-OCT-2005 1:58 PM
NOTE:  This report will contain data for VISIT location(s) regardless of
    
```

BILLING location.

Select Visit LOCATION:

Figure 11-38: Period summary report (steps 1-2)

2. Type the name of a location at the “Select Location:” prompt or press the Return key at the blank “Select Location:” prompt to select ALL locations.

Note: If you enter a location name, your report will only include information about that location.

3. Type the number that corresponds to the way you want to sort your report at the “Select criteria for sorting;” prompt.

Note You can only select one sort method.

Your choices are:

- 1 A/R ACCOUNT
 - 2 CLINIC TYPE
 - 3 VISIT TYPE
 - 4 DISCHARGE SERVICE
 - 5 ALLOWANCE CATEGORY
 - 6 BILLING ENTITY
 - 7 INSURER TYPE
4. Type the start date for your report at the “Select Beginning Date:” prompt.
 5. Type the end date for your report at the “Select Ending Date:” prompt.
 6. Run the report by responding to the “Output DEVICE:” prompt as follows:
 - Type the name of the printer to print this report.
 - Press the Return key to view this report on your monitor.

Figure 11-39 shows an example of this report. Your actual report will vary based on the parameters you choose.

```

WARNING: Confidential Patient Information, Privacy Act Applies
=====
Period Summary Report for ALL INSURER TYPE(S)      JUN 4,2003@11:14   Page 1
Sorted by PAYER with TRANSACTION DATES from 06/04/2002 to 06/04/2003
at ALL Visit location(s) regardless of Billing Location
=====
INSURER TYPE           Billed Amt           Payment           Adjustment           Refund
=====
    
```

```

*** VISIT Location: UNSPECIFIED HEALTH CENTER

MEDICAID FI
MEDICAID PRESBY          0.00          0.00          39.00          0.00
NEW MEXICO MEDI         344.00        1,184.00          0.00          378.00
-----
** Ins Type Total          344.00        1,184.00          39.00          378.00
PRIVATE INSURANCE
BCBS OF NEW MEX          0.00          25.00          1.49          0.00
LOVELACE HEALTH         106.00          0.00          0.00          0.00
NEW MEXICO BC/B         372.37          4.90          0.00          0.00
PRESBYTERIAN HE          96.00          98.00          11.96          0.00
-----
**Ins Type Total          574.37          127.90          13.45          0.00
-----
***VISIT Loc Total          918.37        1,311.90          52.45          378.00
=====
***** REPORT Total          918.37        1,311.90          52.45          378.00
    
```

Figure 11-39:Period summary report (sample report)

This completes the procedure for creating the period summary report.

11.5.5 AR Statistical Report (STA)

The AR Statistical Report (STA) is very similar to the Statistical Report in the Third Party Billing package but the data is not the same. The AR Statistical Report should be used to identify accurate collection amounts. The report in the Third Party Billing package does not provide this accuracy. This report shows what services have been billed, paid, and collected based on the approval date, the visit date, or the export date. This report may be sorted by clinic or visit type.

To generate the AR Statistical Report, follow these steps:

1. Type STA at the “Select Financial Reports Menu Option:” prompt.
2. Type the number of the first parameter with which you want to restrict the report. Note that, after each selection, your choices are listed and you are presented with the inclusion list.
3. Continue in this way until you have identified all the inclusion parameters you want by which to restrict your report, then press the return key at a blank “Select One or More of the above Inclusion Parameters:” prompt to continue.
4. Type Y or N at the “Include Clinic or Visit Type?” prompt. If you type N, skip to step 5. If you type Y, you will be prompted to enter additional parameters.
 - a. Type V or C at the “Sort Report by [V]isit Type or [C]linic:” prompt.

- b. If you choose V, you will be prompted to select a visit type. If you choose C, you will be prompted to choose a clinic. Make the appropriate choices for your selections. To select your choice from a list, type ?? at either prompt.
5. Type Y or N at the “Do you wish to include Cancelled bills?” prompt.
6. Type the name of a print device at the “Device:” prompt.

```

=====
AR STATISTICAL REPORT for ALL BILLING SOURCES                DEC 6,2001   Page 1
at DEMO HEALTH CENTER with VISIT DATES from 12/06/2000 to 12/06/2001
=====

```

VISIT TYPE	NUMBER VISITS	UNDUP PATIENTS	BILLED AMOUNT	PAID AMOUNT	ADJ AMOUNT	UNPAID AMOUNT

DEMO HEALTH CENTER						
ZERO-PAY CLA	1	1	185.00	0.00	0.00	185.00
INPATIENT	3	3	10,234.29	13,267.00	-4,044.00	1,011.29
OUTPATIENT	24	5	4,448.14	308.00	110.00	4,030.14
CROSSOVER (I	1	1	776.00	0.00	0.00	776.00
EMERGENCY RO	2	1	221.41	100.00	50.00	71.41
PHARMACY	1	1	0.00	0.00	0.00	0.00
DENTAL	4	3	169.00	27.00	63.00	79.00
PROFESSIONAL	8	7	4,514.76	260.00	0.00	4,254.76
	44	13	20,548.60	13,962.00	-3,821.00	10,408.60

TOTAL COVERED INPATIENT DAYS			12			
END OF REPORT						

Figure 11-40: Printing an AR statistical report

This completes the process for printing the AR Statistical Report.

11.5.6 Transaction Report (TAR)

This report presents a listing of transactions for all billing sources. This report may be sorted by Clinic/Visit Type, Transaction Date Range, Collection Batch, Collection Batch Item, A/R Entry Clerk and Provider.

To Print the Transaction Report, follow these steps:

1. Type TAR at the “Select Financial Reports Menu Option:” prompt.
2. Type the number of the first parameter with which you want to restrict the report. Note that, after each selection, your choices are listed and you are presented with the inclusion list again.
3. Continue in this way until you have identified all the inclusion parameters you want by which to restrict your report, then press the return key at a blank “Select One or More of the above Inclusion Parameters:” prompt to continue.

4. Type Y or N at the “Include Clinic or Visit Type?” prompt.
5. Type V (Visit) or C (Clinic) at the “Sort Report by [V]isit Type or [C]linic:” prompt.
6. Type the visit type or press the Return key for all at the “Select Visit Type:” prompt.
7. Type the name of a print device at the “Device:” prompt.

```

DETAIL Transaction Report for ALL BILLING SOURCES      NOV 9,2000      Page 1
=====
Bill Number      PAY-AMT      PRV-CRD      REFUND      PAYMENT      BILL AMT      ADJUSTMENT
=====
      Visit Location.....: DEMO HOSPITAL
      Collection Batch.....: AAOBO-09/08/1999-1
      Collection Batch Item: 1
      Visit Type.....: OUTPATIENT
      A/R Account.....: MEDICARE
44155A-ASU-667  110.00      0.00      0.00      110.00      138.00      28.00
-----
A/R Acct Tot:   110.00      0.00      0.00      110.00      138.00      28.00
  Visit Tot     110.00      0.00      0.00      110.00      138.00      28.00
  Item Tot      110.00      0.00      0.00      110.00      138.00      28.00
  Batch Tot     110.00      0.00      0.00      110.00      138.00      28.00

      Collection Batch.....: AAOBO-10/08/1999-1
      Collection Batch Item: 1
      Visit Type.....: OUTPATIENT
      A/R Account.....: MEDICARE
44155A-ASU-667  40.00      0.00      0.00      40.00      138.00      140.00
Enter RETURN to continue or '^' to exit:
    
```

Figure 11-41: Running a Transaction Report

11.6 Maintenance Reports Menu (MRM)

Use this option to access the A/R Bill and Transaction Synchronization report, the EOB Training model, 3P Missing Bill list, A/R and 3P Bill Mis-match list, and the Bill Re-roll list.

To access the Maintenance Reports menu, type MRM at the “Select Report Menu Option:” prompt at the Report menu. Sections 11.6.1 through 11.6.5 explain how to use each of the options listed in Figure 11-43.

```

+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
|          Maintenance Reports Menu                       |
|          DEMO HOSPITAL                                  |
+-----+
User: USER, DEMO          BUSINESS OFFICE          10-FEB-2003 3:42 PM
    
```

```

ATS      A/R Bill and Transaction Synchronization Report
EOB      EOB Training Model
IEN      3P Missing Bill List
MM       A/R & 3P Bill Mis-Match List
RR       Bill Re-Roll List

Select Maintenance Reports Menu Option:
    
```

Figure 11-42: Accessing the Maintenance report menu

11.6.1 A/R Bill and Transaction Synchronization Report (ATS)

The A/R Bill and Transaction Synchronization Report (ATS) allows users to see which bills are not in sync with the transaction history. The users are expected to work these accounts. They will NOT automatically receive a transaction to make them balance.

To print an A/R Bill and Transaction Synchronization report, follow these steps:

1. To print an A/R Bill and Transaction Synchronization Report, type ATS at the “Select Maintenance Reports Menu Option:” prompt.
2. Type a location at the “Select Visit Location:” prompt. Press the Return key at a blank “Select Visit:” prompt for all locations.
3. Type 1 (Detail) or 2 (Summary) at the “Select Type of Report desired:” prompt. The summary report will display the A/R Bill Balance, the transaction history balance and the difference. The detail report will include the data from the Summary report and include the actually transaction history for the bill. An example of each report is displayed below.
4. Type the name of an output device at the “Output Device:” prompt.

```

WARNING: Confidential Patient Information, Privacy Act Applies
=====
SUMMARY A/R Bill and Transaction Synchronization Report  JUL 16,2002  Page 1
at ALL Visit location(s) regardless of Billing Location
=====
A/R BILL      DOS      A/R ACCOUNT      BILL      TRANSACTION
                BALANCE  HISTORY BAL  DIFFERENCE
=====
Visit Location: DEMO  HEALTH CENTER
17147B-JSU    11/23/1998  BCBS OF NEW MEX      36.56      73.12      -36.56
** Visit Location Total (Bill cnt: 1)      36.56      73.12      -36.56
*** REPORT TOTAL      (Bill cnt: 1)      36.56      73.12      -36.56
    
```

Figure 11-43: New A/R bill and transaction synchronization report (summary)

```

=====
WARNING: Confidential Patient Information, Privacy Act Applies
=====
DETAIL A/R Bill and Transaction Synchronization Report   JUL 16,2002   Page 1
at DEMO HEALTH CENTER Visit location(s) regardless of Billing Location
=====
A/R BILL          DOS          A/R ACCOUNT          BILL          TRANSACTION
                                     BALANCE          HISTORY BAL  DIFFERENCE
=====
Visit Location: DEMO HEALTH CENTER
17147B-JSU      11/23/1998  BCBS OF NEW MEX      36.56          73.12          -36.56

TR DATE          TR TYPE          A/R ACCOUNT          TR AMOUNT          TR BALANCE
-----
03/23/1999  BILL NEW          BCBS OF NEW ME          36.56          36.56
09/10/2001  ADJUST ACCOUNT  BCBS OF NEW ME          -36.56          36.56
10/10/2001  ADJUST ACCOUNT  BCBS OF NEW ME          36.56          73.12
10/10/2001  ADJUST ACCOUNT  BCBS OF NEW ME          -36.56          36.56
06/10/2002  AUTO IN SYNC     BCBS OF NEW ME          36.56          73.12

** Visit Location Total (Bill cnt: 1)    36.56          73.12          -36.56
*** REPORT TOTAL (Bill cnt: 1)    36.56          73.12          -36.56
=====
    
```

Figure 11-44: New A/R bill and transaction synchronization report (detail)

11.6.2 EOB Training Model (EOB)

This option allows users to display a sample EOB for training purposes. The display provides information on what has been billed and how much has been collected. The EOB shows the A/R account, the date of service, bill number, and patients' names. There is a sub-totaled amount displayed for each insurance company. This report was included in the A/R Package ONLY as a training tool. It is a model EOB that is used solely for training new users.

To display a Model EOB, follow these steps:

1. Type EOB at the “Select Maintenance Reports Menu Option:” prompt.
2. Type the date on which the report should begin at the “Start with 3P Approve Date: (First)” prompt.
3. Type the date on which the report should end at the “Go to 3P Approve Date: (LAST)” prompt.
4. Type H (Home) to display on your screen at the “Device:” prompt. The system displays the sample EOB.

A/R BILL/IHS LIST	APR 14, 2003 09:59	PAGE 1
	AMOUNT	

PATIENT	DOS BEGIN	BILL NUMBER	BILLED	PAID

3P APPROVE DATE: SEP 13,1994				
A/R ACCOUNT: NEW MEXICO BC/BS INC				
PATIENT, HEATHER	SEP 13,1994	1A-JSU-17389	46.85	32.80
PATIENT, MARLON	SEP 13,1994	2A-JSU-17279	16.50	11.55
PATIENT, OMARR J	SEP 9,1994	3A-JSU-17269	45.34	31.74
			-----	-----
SUBTOTAL			108.69	76.08
			-----	-----
SUBTOTAL			108.69	76.08

Figure 11-45: Running the EOB training model

11.6.3 3P Missing Bill List Report (IEN)

This option lists A/R Bills where the 3P IEN field is incorrect. Note that you must run the Bill File Error Scan option first (see the Bill File Error Scan section of the Manager Menu).

To print the 3P Missing Bill List Report, follow these steps:

1. Type IEN at the “Select Report Menu Option:” prompt.
2. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. The system prints/displays the report.

```

Select Maintenance Reports Menu Option: IEN 3P Missing Bill List

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      +-----+
      |          3P Missing Bill List                          |
      |          DEMO HOSPITAL                                |
      +-----+
User:  USER, DEMO          BUSINESS OFFICE          21-FEB-2003 11:17 AM

DEVICE: HOME// [RET]

3-MAR-1999          A/R MISSING 3P BILL          Page: 1
=====
IENBILL#          PATIENT          DOS          BILLED TO          AMT BILLED
-----
E N D   O F   R E P O R T
    
```

Figure 11-46: Printing the 3P missing bill list report

11.6.4 A/R & 3P Bill Mismatch List (MM)

This option lists every A/R bill where the 3P bill name, DOS, Patient Name, billed amount, or insurer are not equal. Note that you must run the Bill File Error Scan option first (see the Bill File Error Scan section of the Manager Menu).

To print the A/R & 3P Bill Mismatch Report, follow these steps:

1. Type MM at the “Select Maintenance Reports Menu Option:” prompt.
2. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. The system prints/displays the report.

```

Select Maintenance Reports Menu Option: MM  A/R & 3P Bill Mis-Match List

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      |          A/R & 3P Bill Mis-Match List                  |
      |          DEMO HOSPITAL                                  |
      +-----+
User:  USER, DEMO                BUSINESS OFFICE        21-FEB-2003 11:38 AM

DEVICE: HOME// [RET]

3-MAR-1999          3P - A/R MISMATCH      Page: 1
=====
      IEN      BILL#  PATIENT                DOS          BILLED TO      AMT BILLED
-----
AR  150      00000A DEMO,JOHN                01/23/1999     NEW MEXICO      57.00
3P  155      00000A DEMO,JOHN                01/23/1999     NEW MEXICO     172.00

AR  154      00001A CAT,BLACKIE                01/21/1999     MEDICARE        13.00
3P  159      00001A CAT,BLACKIE                01/21/1999     MEDICARE         5.00

AR  170      00002D DOG,SPOTTED                02/02/1999     MAIL HANDL      60.00
3P  175      00002D DOG,SPOTTED                02/02/1999     MEDICARE     475.00

AR  233      00003A PATIENT,KENNETH                02/11/1999     CHAMPUS         3.00
3P  237      00003A PATIENT,KENNETH                02/11/1999     MEDICARE     475.00

E N D   O F   R E P O R T
    
```

Figure 11-47: Printing the A/R & 3P Bill Mismatch List

11.6.5 Bill Re-Roll List (RR)

This report lists A/R bills where the 3P IEN field has been corrected and that are ready for re-roll to 3P. Note that you must run the Bill File Error Scan option first (see the Bill File Error Scan section of the Manager Menu).

To print the Bill Re-Roll List, follow these steps:

1. Type RR at the “Select Maintenance Reports Menu Option:” prompt.
2. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. The system prints/displays the report.

```

Select Maintenance Reports Menu Option: RR  Bill Re-Roll List

      +-----+
      |          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
      |          Bill Re-Roll List                              |
      |          DEMO HOSPITAL                                  |
      +-----+
    
```

```

+-----+
User: USER, DEMO                BUSINESS OFFICE                21-FEB-2003 11:43 AM
DEVICE: HOME// [RET]

21-FEB-2003                RE-ROLL                Page: 1
=====
 IEN    BILL#    PATIENT                DOS                BILLED TO                AMT BILLED
-----
AR  10064  153A    PATIENT,CYNTHIA        08/01/1999  NEW MEXICO                88.00
AR  10205  632A    PATIENT2,DONNA         07/14/2001  PRESBYTERI                147.00
AR  10206  633A    SUMMERS,DONNA          06/15/2001  PRESBYTERI                182.00
AR  10389  916A    DEMO3,RENEE            06/24/2002  UNITED HEA                23.26
AR  10406  1025A   PATIENT3,HENRIETTA     12/15/2002  MEDICARE                  160.00

E N D    O F    R E P O R T
    
```

Figure 11-48: Printing the Re-roll List Layout

11.7 Rollback Reports Menu (RRM)

Use this option to access the Rollback Detail and Rollback Summary reports.

To access the Rollback Reports menu, type RRM at the “Select Report Menu Option:” prompt at the Report menu. Sections 11.7.1 through 11.7.2 explain how to use each of the options listed in Figure 11-50.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
+                Rollback Reports Menu                +
|                DEMO HOSPITAL                |
+-----+
User: USER, DEMO                BUSINESS OFFICE                21-FEB-2003 11:46 AM

ROD    Rollback Detail (Daily)
ROS    Rollback Summary

Select Rollback Reports Menu Option:
    
```

Figure 11-49: Accessing the Rollback reports menu

11.7.1 Rollback Summary (ROS)

This report option allows users to display or print a Summary Rollback report on all rollback transactions that have been made during a given date range. It provides the total dollar amount of all rollbacks and the total number of rollback transactions that have been made over the specified date range.

To print a Rollback Summary Report, follow these steps:

1. Type ROS at the “Select Report Menu Option:” prompt.

2. Type the date on which the report should being at the “Select Beginning Date:” prompt.
3. Type the date on which the report should end at the “Select Ending Date:” prompt.
4. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. The system prints/displays the report.

21 FEB 2003		ROLLOVER SUMMARY REPORT		Page: 1
DATE	ROLLOVER AMOUNT	BILL COUNT		
03/08/2002	185.00	1		
03/14/2002	142.35	4		
03/21/2002	25.00	4		
04/18/2002	39.40	2		
05/07/2002	0.00	1		
06/03/2002	15.00	1		
06/06/2002	10.00	1		
07/18/2002	15.00	1		
08/08/2002	48.00	1		
09/17/2002	812.00	6		
10/03/2002	0.00	2		
10/16/2002	10.70	1		
12/23/2002	0.00	1		
01/31/2003	207.00	2		
02/19/2003	20.00	3		

Enter RETURN to continue or '^' to exit:

Figure 11-50: Printing a rollover summary

11.7.2 Rollback Detail (Daily) (ROD)

This report option allows users to display or print a detailed Report on all rollback transactions that have been made during the posting process. It provides the total dollar amount of all rollbacks and the total number of rollback transactions. In addition it shows a Primary payer and a Secondary payer. This makes it easy for the staff to rollback a bill so that the secondary payer will be sent a bill.

To print the Rollback Detail Report, follow these steps:

1. Type ROD at the “Select Report Menu Option:” prompt.
2. Type the date on which the report is to begin at “Select Beginning Date:” prompt.
3. Type the ending date of date range at the “Select Ending Date:” prompt.
4. Type the name of your printer or H (Home) to display on your screen at the “Device:” prompt. Then press the Return key at the “Right Margin: 80//” prompt. The system prints/displays the report.

21 FEB 2003		ROLLOVER DETAIL REPORT			Page: 1
DATE	ROLLOVER AMOUNT	A/R BILL	3P BILL STATUS	3P CLAIM STATUS	
03/08/2002	185.00	783A-AH-7319	COMPLETED	Claim Completed	
03/14/2002	19.50	607B-AH-1072	COMPLETED	In EDIT Mode	
03/14/2002	0.00	607A-AH-1072	CANCELLED	In EDIT Mode	
03/14/2002	62.85	377A-ASU-6675	COMPLETED		
03/14/2002	60.00	379A-ASU-64002	COMPLETED	In EDIT Mode	
03/21/2002	0.00	810A-AH	CANCELLED	In EDIT Mode	
03/21/2002	15.00	240A-ASU-3644	COMPLETED	Claim Completed	
03/21/2002	0.00	165A-AH-532543	COMPLETED	Claim Completed	
03/21/2002	10.00	571A-AH-1072	COMPLETED	In EDIT Mode	
04/18/2002	27.60	296A-ASU-64001	COMPLETED	Uneditable	
04/18/2002	11.80	735A-AH-1072	COMPLETED	In EDIT Mode	
05/07/2002	0.00	71A-AH-153507	COMPLETED	Claim Completed	
06/03/2002	15.00	850A-AH-4919	COMPLETED	Uneditable	

Enter RETURN to continue or '^' to exit:

Figure 11-51: Running the rollover detail report

12.0 Switch Service/ Section (SVC)

This Master Menu option, step 3 of Setup, is available to users who may have to function as both a "business office person" and a "fiscal office person." Users who fit into this category may use this option to switch back and forth. This enables those users to access both business office and fiscal management files. Normally, users are assigned only one service section, either business or fiscal. This option functions as a toggle between the Business Office (97) service and the Fiscal Service (98).

When accessing A/R, the user's service/section will be set to Business Office if it is not already Business Office or Fiscal Service. On the screen below, the display shows the Business Office. If you want to switch back to your former service/section designation, you can use the SVC prompt. The system returns you to the A/R Master Menu after you have made the switch.

To switch service/section between Business Office and Fiscal Services, follow these steps:

1. Type SVC at the "Select A/R Master Menu:" option.
2. Type 97 (Business Office) or 98 (Fiscal Service) at the "Select A/R Table Entry/IHS Name:" prompt. The system returns you to the A/R Master Menu.

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
+-----+-----+-----+-----+-----+-----+-----+-----+
|                A/R MASTER MENU                                     |
+-----+-----+-----+-----+-----+-----+-----+-----+
|                UNSPECIFIED SERVICE UNIT                           |
+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,GRETA                BUSINESS OFFICE                21-JUL-2004 2:00 PM

ACM    Account Management Menu ...
COL    Collection Menu ...
DCM    Debt Collection Menu ...
MAN    Manager ...
PAS    Patient Account Statement Menu ...
PST    Posting Menu ...
ROL    Rollback Bills to 3-Party
RPT    Report Menu ...
SVC    Switch Service/Section
UA     User Assistance
UPL    Upload from Third Party Bill File

Select A/R MASTER MENU Option: SVC  Switch Service/Section

Select A/R TABLE ENTRY/IHS NAME: ??
Choose from:
   97                BUSINESS OFFICE
   98                FISCAL SERVICE

Select A/R TABLE ENTRY/IHS NAME:

```

Figure 12.1: A/R master menu, switch service/section option

13.0 User Assistance (UA)

This Master Menu option provides online help for using ScreenMan, the Full Screen Editor, your electronic signature, and the A/R Glossary. It also provides information on new A/R features as they become available.

To access the User Assistance menu, type UA at the “Select A/R Master Menu Option:” prompt.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           A/R MASTER MENU                               +
|           UNSPECIFIED SERVICE UNIT                       |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,GRETA                BUSINESS OFFICE          21-JUL-2004 2:00 PM

ACM   Account Management Menu ...
COL   Collection Menu ...
DCM   Debt Collection Menu ...
MAN   Manager ...
PAS   Patient Account Statement Menu ...
PST   Posting Menu ...
ROL   Rollback Bills to 3-Party
RPT   Report Menu ...
SVC   Switch Service/Section
UA    User Assistance
UPL   Upload from Third Party Bill File

Select A/R MASTER MENU Option:

```

Figure 13-1: Accessing the User Assistance Option

Type at least the first letter of the main highlighted word in an option (shown in Figure 13-2 in boldface) at the “Select Help System Action:” prompt. Each of the options is described below.

```

                                A/R USER ASSISTANCE

USER ASSISTANCE IS AVAILABLE FOR:

      1.  Glossary
      2.  ScreenMan
      3.  Full Screen Editor
      4.  Electronic Signature
      5.  NEW FEATURES

Select HELP SYSTEM action or <return>:

```

Figure 13-2: Using the A/R User Assistance menu

13.1 Glossary

This Master Menu option provides an electronic version of the glossary provided in section 19.0 of this manual. Refer to that section for the glossary.

13.2 ScreenMan

13.2.1 Editing Keys (while using ScreenMan)

- Insert/Replace toggle: <PF3>
- Move right one character: <Cursor Right>
- Move left one character: <Cursor Left>
- Move to right of window: <PF1><Cursor Right>
- Move to left of window: <PF1><Cursor Left>
- Move to end of field: <PF1><PF1><Cursor Right>
- Move to beginning of field: <PF1><PF1><Cursor Left>
- Move to next space: <PF1><SpaceBar>
- Delete character under cursor: <PF2>
- Delete character left of cursor:
- Delete field/Restore default: <PF1>D or <CTRL-U> /Restore edits toggle
- Delete from cursor to end of field: <PF1><PF2>
- Help (this screen): <PF1>H

13.2.2 Navigational Keys

- Field below: <Cursor Down>
- Next page: <PF1><Cursor Down>
- Field above: <Cursor Up>
- Previous page: <PF1><Cursor Up>
- Field to right: <TAB>
- Next block: <PF1><PF4>
- Field to left: <PF1><TAB>
- Jump to a field: ^caption Pre-defined order <Return>
- Go to Command Line: ^
- Go into a multiple or WP field: <Return>

13.2.3 Command Line Options

- EXIT: Exit the form.
- CLOSE: Close the window and return to the previous level.
- SAVE: Save all changes made during the editing session.
- NEXT PAGE: Go to the next page.
- REFRESH: Repaint the screen.

13.3 Full Screen Editor

Use the following commands for Editor: (Press the F1 key then type H to access this same information when you are in *editing mode* while making for free-text entries under Comments, Item Descriptions, etc.)

1. Use cursor arrow keys to move around on screen.
2. Press PF keys as following:
 - PF1: command key; (see below)
 - PF2: turn word-wrap (at end of line) on or off
 - PF3: switch between 'insert' and 'replace' for text
3. Press the PF1 key followed by any of the following letter keys for the indicated action:

e	Exit editor and save text
q	Quit editor and do not save changes
a	Exit screen editor, switch to (a)lternate editor
d	Delete the line that the cursor is on
r	Reformat paragraph (join lines from cursor to next blank line)
?	Turn ruler pointer (^) on/off
h	Help screen (you're reading it!)
b or t	Move to the (b)ottom or (t)op of entire text
cursor up/down	Move to top/bottom of screen or to previous/next screen
cursor left/right	Move to left or right of current line
j	Join this line of text to next line
<Tab>	Set/clear tab stop at cursor location
m	Set left (m)argin
<space>	Move to the next <space> to right of cursor (similar to <tab> key action , but using spaces of current line)

4. Press the Tab key to move right on the current line to the next tab setting as indicated by 't' on the ruler line at the bottom. Press PF1-Tab to set and clear tabs.

Note: The Tab key is NOT inserted into text. The Tab key only moves the cursor.

13.4 Electronic Signature

The electronic signature feature is a requirement for AR users so that an auditing trail can be used to ensure accounting practices can be monitored. Each AR package User will have to set up their individual electronic signature as this is a main feature of A/R.

Your Electronic Signature allows your entry to and use of several options within RPMS.

To add or edit your Electronic Signature, follow these steps:

1. Log into the system as usual, but type TBOX (for TOOLBOX) at the “Select IHS Kernel Option:” prompt.
2. Type Electronic Signature Code Edit at the “Select User's Toolbox Option:” prompt. The system indicates that the option is designed to permit you to enter or change your initials, phone number, and Elec. Signature Code.

```

CORE   IHS Core ...
DEV    Device Management ...
FM     VA FileMan ...
MAN    Manage Mailman ...
MM     Menu Management ...
PROG   Programmer Options ...
SM     Operations Management ...
SPL    Spool Management ...
TM     Taskman Management ...
UE     User Management ...
SS     System Security ...
       Application Utilities ...

Select IHS Kernel Option: TBOX  User's Toolbox

      Display User Characteristics
      Edit User Characteristics
      Electronic Signature code Edit
      Menu Templates ...
      Spooler Menu ...
      Switch UCI
      TaskMan User
      User Help

Select User's Toolbox Option: ELECTRONIC SIGNATURE CODE EDIT

```

Figure 13-3: Using the electronic signature edit option (steps 1-2)

3. Type your initials or press the Return key to accept you initials if they are already displayed by the system at the "Initial:" prompt.
4. Type your full name at the "Signature Block Printed Name:" prompt. If your name is already displayed, press the Return key.
5. Type your title at the "Signature Block Title:" prompt. Press the Return key to move on if your title is already displayed.
6. Type your work phone number at the "Office Phone:" prompt. Press the Return key to move on if your correct phone number is already displayed
7. Type your voice pager number at the "Voice Pager:" prompt. Press the Return key to move on if your correct phone number is already displayed
8. Type your voice pager number at the "Digital Pager:" prompt. Press the Return key to move on if your correct phone number is already displayed.
9. If you are typing your signature code for the first time, type a new 7-digit code at the "Enter Your Signature Code:" prompt. The system prompts you to re-type the same number to make sure it is what you want. Re-type the same 7-digit number. If you re-entered the number correctly, the system lets you know that you have successfully entered your new signature code. The system displays DONE.
10. If you already possess a signature code, type it in after the signature code prompt. The system then informs you that it has verified your signature. The system displays the "Enter New Signature Code:" prompt.
11. Edit your existing signature code by entering a new 7-digit number. The system displays the "Re-Enter Signature Code for Verification:" prompt.
12. Type your new "edited" signature code. The system signals you that you have successfully edited your existing signature code by displaying DONE.

```
INITIAL: AA// [RET]
SIGNATURE BLOCK PRINTED NAME: ADAMS,ADA<// [RET]
SIGNATURE BLOCK TITLE: PHYSICAN [RET]
OFFICE PHONE: [RET]
VOICE PAGER: [RET]
DIGITAL PAGER: [RET]

Your typing will not show.
ENTER NEW SIGNATURE CODE:
RE-ENTER SIGNATURE CODE FOR VERIFICATION:
DONE
```

Figure 13-4: Using the electronic signature edit option (steps 2-11)

13.5 Posting Using the 835 ERA Features

This version includes automated payment posting by processing ANSI 835 explanation of benefits or remittance advice files.

ERA Posting

A menu option allowing the user to post an electronic remittance advice from Medicare or other payers who provide the 835 format. This is a main menu that contains the following submenus:

Load New Import

A new menu option used to import the electronic remittance advice sent from Medicare into the RPMS system. Medicare and other payers provide the ANSI 835 3051.4a format.

View Import Header

A new menu option allowing the user to view the identification information in the file sent by Medicare or other payers.

Review Postable Claims

This new menu option allows the user to review postable claims found within the Medicare or payer file and how they match to bills found in A/R.

Post ERA Claims

Executing this menu option will post payments and adjustments to those bills that matched in the Medicare or other payer file.

Report ERA Claims

This option reports all bills from the Medicare or other payer file and their status. Status may be unmatched claims, unmatched reasons, unmatched claims and reasons, claims not to post, matched claims, posted claims.

ERA Import Delete

A manager menu option used to delete the Medicare or other payer file after it has been imported to RPMS. Do not use this option unless instructed by the Manager.

14.0 Upload from Third Party Bill File (UPL)

This Master Menu option allows you to automatically pull in existing bills from Third Party Billing. You may pull up (upload) bills in any of the following ways:

- Individually
- By approval dates (see the Upload 3P Bills by Approval Date(s) section of the Manager menu.)

To access the UPL option, type UPL at the “Select A/R Master Menu Option:” prompt.

```

+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
|           ACCOUNTS RECEIVABLE SYSTEM - VER 1.8           |
+           A/R MASTER MENU                               +
|           UNSPECIFIED SERVICE UNIT                       |
+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+---+
User: USER,GRETA           BUSINESS OFFICE           21-JUL-2004 2:00 PM

ACM   Account Management Menu ...
COL   Collection Menu ...
DCM   Debt Collection Menu ...
MAN   Manager ...
PAS   Patient Account Statement Menu ...
PST   Posting Menu ...
ROL   Rollback Bills to 3-Party
RPT   Report Menu ...
SVC   Switch Service/Section
UA    User Assistance
UPL   Upload from Third Party Bill File

Select A/R MASTER MENU Option: UPL  Upload from Third Party Bill File
    
```

Figure 14-1: Accessing the UPL option

To upload Third Party Bills individually, follow these steps:

1. Type your assigned Signature Code at the “Enter Your Current Signature Code:” prompt. The system displays the message Signature Verified.
2. Type the location or ?? to select it from a list at the “Select A/R Parent/Satellite/IHS Location:” prompt.
3. Type the bill number or ?? to select it from a list at the “Select 3P Bill:” prompt.

```

Enter your Current Signature Code:     SIGNATURE VERIFIED

Please pick the satellite you wish to load

Select A/R PARENT/SATELLITE/IHS LOCATION: DEMO HOSPITAL           999
DEMO           DEMO           01
    
```


Select 3P Bill:

Figure 14-2: Using the UPL option (steps 1-3)

4. The system displays the selected bill and the “OK? Yes//” prompt is displayed.
5. Press the Return key to accept the displayed bill. The system displays the full selected bill number for confirmation again and prompts, “Correct? YES//”.
6. Press the Return key to accept the displayed bill number. The system displays the message, Uploading 43510B-ASU-223344 ...Done, then prompts for another 3P Bill Number to upload.
7. Type the caret (^) and press the Return key to quit. This completes the process.

15.0 EISS Capability

The Executive Information Support System (EISS) is a web-based system that allows authorized users to access specific information regarding financial data that is retrieved from the AR package. This feature will allow information from the ASM and PSR reports to pass to EISS when the reports are run under certain criteria. The system deletes EISS files from local drive after successful submission to the central location.

15.1 Site Parameters

In order for the EISS functionality to operate correctly, you must set up four new site parameters through the Site Parameters Edit (SPE) option. The first three items will be automatically populated with data when the Site manager installs the patch. On the EISS (local) path, you will have to find out what path name your local Site manager defined during the installation of this patch. It is recommended that you do not use a public drive to store these files. Once this is defined, follow the instructions in this field.

EISS System: Type the IP address used for sending PSR and ASM Summary data to the Web.

EISS Username: Type the user name needed to access the remote system receiving the ASM and PSR data.

EISS Password: Type the password needed to access the remote system receiving the ASM and PSR data.

EISS (local) path: Type the directory (path name) on the local system that will hold the ASM and PSR summary data. Since this file holds financial data Do Not use a public drive to store this file.

To access the Site Parameters option, follow these steps:

1. Type SPE at the “Select Manager Option:” prompt that is located in the Manager menu.
2. Type the name of your site at the “Select A/R Site Parameter/IHS RPMS Site:” prompt.
3. Type Y or N at the “OK?” prompt to confirm or replace your selection.
4. Follow the prompts as they appear on your screen. Type new parameters at each of the prompts or press the Return key to accept the default response.

```
Select Manager Option: SPE Site Parameter Edit
```

```

+-----+
|                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
+-----+
```

```

+                               Site Parameter Edit                               +
|                               UNSPECIFIED SERVICE UNIT                          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,DEMO                BUSINESS OFFICE                20-AUG-2003 11:20 AM

Select A/R SITE PARAMETER/IHS RPMS SITE: UNSPECIFIED SERVICE UNIT
NM
...OK? Yes// [RET] (Yes)

MULTIPLE 3P EOB LOCATIONS: YES// [RET]
MULTIPLE FISCAL EOB LOCATIONS: YES//[RET]
USABLE: USABLE//[RET]
ACCEPT 3P BILLS: ACCEPT//[RET]
ROLL OVER DURING POSTING: ASK//[RET]
SMALL BALANCE: 5.00//[RET]
Location Type For Reports: BILLING//[RET]
Default Path: /usrx/xxd/duser///[RET]
EISS System: xxx.xxx.xx.x
EISS Username: xxxxxx
EISS Password: xxxxxx
EISS (local) path: /usrx/xxd/duser
Select EDI PAYER: [RET]

Select A/R SITE PARAMETER/IHS RPMS SITE:
    
```

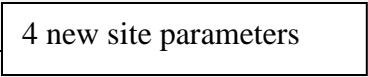


Figure 15-1: Setting the EISS parameters

15.2 PSR for the EISS

To pass PSR information to the EISS, you must run the report as described in the following procedure which uses

- Allowance Category/ALL
- Summarize by Allow Cat/Bill Entity/Ins Type
- First and last days of the month

To run the PSR for the EISS, follow these steps:

1. Type PSR at the “Select Financial Reports Menu Option:” prompt that is located in the Reports menu under Financial Reports.
2. Type the name of your location at the “Select Visit Location:” prompt.

```

Select Financial Reports Menu Option: PSR  Period Summary Report

+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          ACCOUNTS RECEIVABLE SYSTEM - VER 1.8          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
|          Period Summary Report          |
|          UNSPECIFIED SERVICE UNIT          |
+-----+-----+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,DEMO                BUSINESS OFFICE                21-AUG-2003 9:23 AM

NOTE:  This report will contain data for VISIT location(s) regardless of
        BILLING location.
    
```

```
Select Visit LOCATION: UNSPECIFIED SERVICE UNIT                                NM
```

Figure 15-2: Running the PSR for the EISS (steps 1 & 2)

3. Type 5 (Allowance Category) at the “Select Criteria for Sorting:” prompt.
4. Press the Return key at the blank “Select Type of Allowance Category to Display:” prompt to select ALL categories.
5. Type 1 (Summarize by Allow Cat/Bill Entity/Ins Type) at the “Select Report Type:” prompt.
6. Type the first day of the month at the “Select Beginning Date:” prompt.
7. Type the last day of the month at the “Select Ending Date:” prompt.
8. Run the report by responding to the “Output Device:” prompt as follows:
 - Type the name of the printer to print this report.
 - Press the Return key to view this report on your monitor.

While the system is creating the report, the following messages appear:

```
DOS File Being Created'
Please Standby - Copying Data to DOS File
c:\inetpub\ftproot\pub\BARPSR113510200
411012004120120050830143644_000002.TXT

File was sent successfully
```

Figure 15-3 provides an example of this report.

```
Select one of the following:

1          A/R ACCOUNT
2          CLINIC TYPE
3          VISIT TYPE
4          DISCHARGE SERVICE
5          ALLOWANCE CATEGORY
6          BILLING ENTITY
7          INSURER TYPE

Select criteria for sorting: 5  ALLOWANCE CATEGORY

Select one of the following:

1          MEDICARE
2          MEDICAID
3          PRIVATE INSURANCE (INS TYPES P H F M)
4          CHIP
5          OTHER                (INS TYPES W C N I)

Select TYPE of ALLOWANCE CATEGORY to Display: [RET] ALL

Select one of the following:
```


To run the ASM for the EISS, follow these steps:

1. Type ASM at the “Select Aging Reports Menu Option:” prompt that is located in the Reports menu under Aging reports.
2. Type the name of your location at the “Select Visit Location:” prompt.

```

Select Aging Reports Menu Option: ASM Age Summary Report

      +---+-----+-----+-----+-----+-----+-----+-----+-----+
      |                ACCOUNTS RECEIVABLE SYSTEM - VER 1.8                |
      +                Age Summary Report                +
      |                UNSPECIFIED SERVICE UNIT                |
      +---+-----+-----+-----+-----+-----+-----+-----+-----+
User: USER,DEMO                BUSINESS OFFICE                21-AUG-2003 9:47 AM

NOTE: This report will contain data for the BILLING location you are logged
into. Selecting a Visit Location will allow you to run the report for
a specific VISIT location under this BILLING location.

Select Visit LOCATION: UNSPECIFIED SERVICE UNIT                NM
    
```

Figure 15-5: Running the ASM for the EISS (steps 1 & 2)

3. Type 5 (Allowance Category) at the “Select Criteria for Sorting:” prompt.
4. Press the Return key at the blank “Select Type of Allowance Category to Display:” prompt to select ALL categories.
5. Type 1 (Summarize by Allow Cat/Bill Entity/Ins Type) at the “Select Report Type:” prompt.
6. Run the report by responding to the “Output Device:” prompt as follows:
 - Type the name of the printer to print this report.
 - Press the Return key to view this report on your monitor.

While the system is creating the report, the following messages appear:

```

DOS File Being Created'
Please Standby - Copying Data to DOS File
c:\inetpub\ftproot\pub\BARPSR113510200
411012004120120050830143644_000002.TXT

File was sent successfully
    
```

Figure 15-6 provides an example of this report.

```

Select one of the following:

1          A/R ACCOUNT
2          CLINIC TYPE
3          VISIT TYPE
4          DISCHARGE SERVICE
5          ALLOWANCE CATEGORY
6          BILLING ENTITY
    
```


BARPSRXXXXXX2003070120030731200308210928_000005.TXT

Position	Description
1-6	Namespace_rpt
7-12	ASUFAC (if null send "xxxxxx")
13-20	Begin Date of Data (yyyymmdd)
21-28	End Date of Data (yyyymmdd)
29-42	Run Date (yyyymmddhhmmss)
43	Spacer (_)
44-49	Record Count, Right Justify, 0 fill
50-53	File Extension (.TXT)

Table 15-1: EISS file naming convention

16.0 Glossary

The following list of terms and their definitions can also be accessed online by selecting the User Assistance option from the A/R Master Menu.

Term	Definition
A/R Account	The name of a patient, employee, vendor, or insurance company that will be or has been billed for services rendered.
A/R Account Entry	The process of entering an Accounts Receivable transaction into the system database.
Account Menu	The menu that contains the options for entering accounts and manipulating account data.
Accounts Receivable	Money that is owed. This is usually the result of items or services that have been billed but not paid. Accounts Receivable can also refer to managing these unpaid bills to ensure payment is received and properly credited.
Beneficiary	A person who is entitled to received services from the IHS because they fall within the IHS guidelines of eligibility.
Bill Menu	The menu that lists the options to let you generate bills, add/edit items and provide explanations for all charges.
Bill ID	The identification number of the bill. The system will automatically generate a new bill number for each new bill entered on to the system. This number may also represent the bill number that is generated and transferred from the Third Party Billing Package when a new claim is approved.
Bill Entry Location	The location/service section of the person who is creating the bill.
Billing Service	Location of Service. Place (clinic) where service being billed took place. i.e., pharmaceutical, surgical, etc.
Brief Description	A brief description used to further define a service, charge, adjustment, etc. These are entered by the user in free text format using the A/R System's word processing component.
Business Office Section	Allows access to the Business Office files only. Each user is entered to the A/R System as a Business Office or Fiscal Services person or both. This is identified in the Kernel set up in your computer system.
Cancel	Choosing this option undoes the process you have just completed. The system will then allow repeat of the process. This command does not affect prior transactions.
Claim Number	The number assigned to the bill you are sending to a billable entity.
Claim	A set of codes and fees which you have grouped together in order to bill the responsible party for services rendered.
Clinic	Where the services being billed occurred. Examples: Surgical, optometry, pharmacy.
Collection Report Exceptions	A report that generates a list of deletions or modifications made to individual items on a specific collection register.
Collection Batch	A collection of checks, EOBs, or credit card or cash receipts that indicate payment from individuals or entities on a given date.
Collection Point	The place where money is collected, i.e., cashier's office, business office, pharmacy window, etc.

Term	Definition
Collection Point Edit	The process of changing the parameters of a collection point. You may customize each collection point so that the system prompts only specific questions during collections entry.
Collections Entry	The process of entering collection information (amount, payor, facility of service, identifying number, etc.) into the collection register for further processing.
Collections Report	A report that is generated after all adjustments and final reviews have taken place, verifying all information contained on the Collection Register is correct. This report is given to finance to be used in the deposit process.
Collections Report Detailed	A report that is generated while the collection batch has not been moved into the review status. This report shows a detailed listing of all collections entered for a given day at a given collection point.
Command	The instructions you give the computer to record a certain transaction. For example, selecting "Payment" or "P" at the command prompt tells the computer you are applying a payment to a chosen bill.
Current Balance	The amount that remains unpaid on a bill.
Deductible	Usually calculated on an annual basis, the patient must pay this amount "out-of-pocket" before insurance reimbursement starts. The amount varies for different policies with different insurance companies.
Default Response	Many of the prompts in the A/R program contain responses that can be activated simply by pressing RETURN. For example: "Do you really want to quit? No//." Pressing RETURN tells the system you do not want to quit. "No//" is considered the default response.
Delete Item	The process used to either back out an item in a manual bill just entered or delete an item from the Check Register before the batch is put in Review status.
Device	The name of the printer you want the system to use when printing information. "Home" means the computer screen.
Distribution	The process of assigning payments to the facility where services were provided so that the correct facility is credited for the receipt of funds.
DOS	Date Of Service
Edit	The process of changing information that has already been entered on the system. If data has not been entered, you may enter new data using the "Edit" function.
Entry User	The name of the person who is entering data to the system. In most cases, your name appears on the top of the screen to indicate that you have accessed the system. The system always documents who is making entries.
EOB	Explanation Of Benefits. The report from a third party payer that explains the coverage and reimbursement determination for a claim or group of claims.
Fiscal Services Section	A designation for personnel who are working with general ledger accounts.
GL	General Ledger
Guarantor	The party who is financially responsible for payment for services rendered.
Help	On-line help means accessing Help frames and descriptions of each

Term	Definition
	option to see what it allows the user to do. Type up to three question marks '???' at a prompt when you are unsure how to respond. This activates Help.
Insurer Demographics	Data about the insurance company such as name, address, telephone, contact person, etc.
Item	Collection: A particular entry on the Collection Register that is retrieved when posting takes place.
Item	Manual Bills: An individual charge in which you are billing for reimbursement.
Item Code	A description of an billable services/items identified by the National Standard Code for that item. Such as, HCPCS, CPT, ICD, NDF, etc. It can be a model number, serial number, etc.
Item Date	The date the item/service was provided.
Item Related Service	An additional miscellaneous item for which you are charging. Examples: Dispensing fee for pharmacy.
Item Related Service Cost	The total amount billed for all Item Related Services.
Itemized Charges	A comprehensive list of all charges.
Items Edit	The process used to change any portion of an item, description, or cost.
Line #	While posting, you may ask the computer to bring up more than one claim to chose from. Each claim represents a line #.
Manager	The manager is the person responsible for maintaining the A/R system at a given site. That person sets the system, site parameters, parent facilities, and grants access to others who will be using the system.
Message	A note attached to provide others with information to lessen any confusion when communicating on a bill, patient or third party payor (account).
More	A prompt, usually at the end of bill entry sequence, that prompts if you want to answer questions that were originally flagged with "No - Don't ask these particular questions during normal entry".
New Bill	Any new bill entered into the system manually, not resulting from the Third Party Billing Package upload.
Non-Beneficiary	A person who is not eligible to receive services at IHS and tribal facilities due to regulations, policies and procedures.
Non-Covered	Refers to person/services/procedures/items for which an insurance company will not pay usually due to limitations of a specific policy.
Non-Pay	The denial of reimbursement for services rendered.
Option	An executable item under a menu. Example: A/R Account Entry (ACE) is an option under the A/R Manager's Menu.
Parent Facility	A central facility that does the collections, posting and follow up for its satellite facilities.
Parent Facility Addition	This option lets users set up a master file for parent facilities and its satellite facilities.
Parent Facility Kill	FOR TESTING ONLY: An option under the manager's menu that can be used to delete a parent facility from the A/R System. Use this ONLY when you want to completely delete all records for the parent facility and its satellites. CAUTION: This option can destroy years of

Term	Definition
	data.
Parent Facility Selection	The process of viewing and selecting the central facility that does the posting and follow up for its satellite facilities. By selecting and accessing a parent facility, you gain access to files that also belong to its satellite facilities. The selections that are available are set up in the Kernel file at the facility.
Parent/Satellite Edit	An option that lets the user establish or change the parent and satellite facility relationship for facilities.
Patient Demographics	Confidential information about the patient (age, sex, address, telephone number, etc.)
Payment Type	An indication of how the payment is made: by check, credit card, cash or EOB check.
Penalty	Non payment or reduction of payment due to failure to comply with a particular Third Party Resource's requirements. Example: Filing a claim after the allotted time, or lack of pre-certification.
Posting Adjustments	Posting a non-payment transaction to a bill. Example: Deductible, Write-Off, etc. OR you may need to correct a payment after you have originally posted.
Posting Payments	The action of reconciling payments with existing bills to create an audit of all payments receipted.
Quit	To indicate that you have finished working on a specific transaction and you would like to exit that particular option of the package and proceed to another function or menu.
Required Response	A response that must be entered before the system will release you from a prompt and allow you to move on.
Review Status	A Collection Register is moved into review status before it is finalized to be forwarded to finance. This allows for any final editing and correcting to be performed. Once a batch moves into the final stage, editing is limited.
Rollback	The process of sending a bill to a secondary third party resource. Once an initial bill is sent and payment is received from the primary resource, a new bill can be generated through the Third Party Billing Package to be submitted for additional payment on the balance due for the service performed.
Satellite Facility	A health facility that is affiliated with another facility (parent) and does not do its own collection process, posting, or follow up. Therefore, a relationship must be established in the system between these facilities to allow the parent facility to account for collections and posting transactions.
Search Unsuccessful	A message from the A/R System that it was unable to locate a specific item with the information provided.
Select	To choose one option from a list of options.
Signature Code	Your unique, individually-assigned signature number that only the computer recognizes. The number takes the place of a regular signature when you have to approve a transaction or when you are about to enter a restricted domain of the A/R Software.
Site Manager	The person in charge of setting up and maintaining the RPMS System at the facility or area level.
Site Parameter Edit	A menu option that allows for certain parameters set to be site specific. Example: One facility may want to identify

Term	Definition
	Inpatient/Outpatient criteria on all checks whereas another facility may not want to.
Standard Table Edits	Enables a user to add to and edit standard tables above and beyond the hard coded tables. This allows for site specific tables to be set up and utilized by facilities.

17.0 Appendix A

17.1 Procedure for Establishing the Capability to Download ERAs

Using the following information, fill in the Medicare Part A Electronic Remittance Advice Request Form (provided after these instructions) and submit it to Jana White at the address on the form.

- ERA Transmission: GPNET rEDI-link Blue
- ANSI X12 835 Version: 3051.4A01
- Will you be using TX-ACE for ERA: No
- Will you be using the PC-Print for the ERA: Yes

It will take 5-7 days to process your request. Jana will give the Contact Person listed on the form a login and password to gain access to the system.

Once you have been set up as an Electronic Provider, your remittance advices will be set up on the bulletin board.

You will use the same transmission software that you currently use for transmitting your claims electronically to BC/BS of South Carolina (Medicare).

- ProComm Plus
- Modem Line

You will receive a hardcopy of the Remittance Advice (or two) if you currently do so. It usually takes up to 6 months/year for the hardcopies to stop coming. You will receive a letter from Medicare, informing you that you will receive hardcopies for another 30 days.

Suggestion: Keep a manual log of this process until you are comfortable that all steps have been completed. See an example of a Log Sheet following these instructions.

Your Collection process remains the same. Checks MUST be entered into the Accounts Receivable Collection Point, establishing a Collection Batch and Item #. You will tie this remittance advice to a Collection Batch. Log this information.

Adjustment Tables have been set up, matching Medicare Reason Codes with A/R Adjustment Codes.

17.2 Procedure to Download and Process your ERAs

Step 1: Download Files onto your PC (Area or Service Unit)

1. Dial into Trailblazers EDI System Bulletin Board. Use the same method you use to send your claims electronically. The phone number is the same -- (803)788-9860.
2. Type your Login and Password. (Not the same as when you are sending files.)
3. Select the LIST option.
4. Review the list of files to be downloaded. Make sure you stay in sequential order. If you are missing one, contact Jana White via email.
5. Select the DOWNLOAD option.
6. Select the Z MODEM.
7. At the "Do you wish to download all the files in the mailbox? (Y/N)" question, answer Yes. Files are downloaded one at a time. They are named "ERN00001.ERN, ERN00002.ERN, etc. "Transfer COMPLETED SUCCESSFULLY."
8. Exit Trailblazers (hang up).
9. Check to make sure the files reside on your PC. Check the same place you check for Confirmation of Electronic File Submission (Prowin, Download Folder).

Step 2: Download file into the Public Directory of the Service Unit

1. Using File Transfer Protocol (FTP), bring up the location you want to send the file to.
2. Transfer the File from your PC (C: Drive, Prowin, Download Folder) to the Location (left to right). Set the File Structure to ASCII (not binary) and file it in the location's public directory.
3. Make sure the name of the file remains in Capital Letters (including the .extension). (For some reason, it is changing on my machine). If it has changed in the public directory of the location, rename the file to ERN0000#.ERN.
4. Exit FTP.

Note: Electronic signatures are required throughout all functions of the era process.

Step 3: Download ERN File to the RPMS Accounts Receivable System

1. Go in A/R, PST (Posting Menu), ERA (ERA Posting)

2. Menu options will be:
 - Load New Import
 - View Import Header
 - Review Postable Claims
 - Post ERA Claims
 - Report ERA Claims
3. Select ERA Posting Option: NEW Load New Import. This allows you to load the file you have received from Medicare into the proper format for the A/R to read it.
4. Select A/R EDI Transport Name: ? Medicare 835 3041.4A
5. Type the directory path for the transport file: /usr/spool/uucppublic (If it's correct, do not change it.) This directory path references where are you pulling the file from/ where you stored it when you transferred the file from your PC. The system will default to the public directory as listed above.
6. File Name: ERN* or ERN0000#.ERN if you know the file name. (By typing ERN*, you get a list of all Electronic Remittance Advice files you have in the public directory).
7. Review the File Name and make sure it is correct.
8. Do you want to proceed N// Yes.
9. The system renames the file for reference purposes. Format: 1001 ERA 07/04/00. You can access the file using either name. Files are renamed in numerical order depending on when you load them into A/R.
10. The system now loads the file into the A/R system.
 - a. Stage 1: Extracting data from transport to segments. Splitting Image into Segments.
 - b. Stage 2: Parse segments into elements and values. Processing Segments into Values.
 - c. Stage 3: Build Postable Claims. Processing Record Values into Postable Claims.
 - d. Stage 4: Matching E-Claims to A/R Bills and Reason Codes.
 - B (M) = Matched
 - X = Claim & Reason Unmatched
 - C = Claim Unmatched (cannot find a claim in A/R to match the claim in E File)

- R = Reason Unmatched (reason code from Medicare is not listed in established tables)

11. All 4 stages have completed processing.

Step 4: View Import Header

This step allows you to track specifics about the Electronic Remittance Advice. Some of the information may not be useful immediately, but it is important to know where to look for important data.

1. Select ERA Posting Option: **VIEW** View Import Header
2. See Attachment for the important fields.

Use this information to verify that you have received everything that you should have.

Step 5: Review Postable Claims

Use this step to review all the claims before you actually post them to the A/R Accounts. Remember, what you are viewing, are only those claims that had a claim and reason code match within the A/R System.

1. Select ERA Posting Option: **REV** Review Postable Claims
2. Select File: **1001** ERA 07/04/2000 ERN00001 CHK: 003241952
3. Matched claims are listed in the following format:

#	Claim	Date	Patient	AR Account Status
1	205512A-CR-9999	DEC. 07, 1999	DEMO, CYNTHIA A.	MATCHED
	205512A-CR-9999	DEC. 07, 1999	DEMO, CYNTHIA A.	MEDICARE
2	207217A-CR-1111	JAN 24, 2000	PATIENT, HELEN	MATCHED
	207217A-CR-1111	JAN 24, 2000	PATIENT, HELEN	MEDICARE

Figure 17-1: Matched claims format

This *first* line is the data from the *ERA File*. The *second* line is the data found in *A/R*.

4. Quickly review all of the claims and make sure you want to **POST** them to *A/R*.
5. If for some reason, you chose not to post certain claims, you can flag them as **N = Not To Post**. This removes them from the “Postable” status, and you can research and post them manually.
 - Select Action: 1 Edit Status.
 - Select Line # of Claim: 2
 - Change the Matched Status to “Not to Post”. Claim will have to be posted manually.

Step 6: Report ERA Claims

In this step, you look at all of the ERA Claims and their statuses before posting. If any Claims are Unmatched, you are able to print a report, research the information, and then manually post these claims.

1. Select ERA Posting Option: **RPT** Report ERA Claims
2. Select File: **1001** ERA 07/04/2000 ERN00001.ERN CHK: 0032419542
3. Enter the list of Claim Status(s) you desire to print: **A**. (You can print more than one status by putting them in the order you wish to see them printed. Example: CMNRX)
 - C =Claims Unmatched
 - M =Matched
 - A =All Categories
 - R =Reason Unmatched
 - P =Posted
 - N =Not to Post
 - X =Claim & Reason Unmatched.
4. Select the type of Report: **D**.
 - D =Detailed – Show both ERA and A/R Bill Files. Detailed information including payment, deductibles, co-pays, reason codes, outstanding balance, billed amount, etc.
 - B =Brief – Shows only the payment amount and bill information from the ERA file.
 - S =Summary – Totals Only.

Detail reports show you the balances on you A/R Claims allowing you to see if there are any duplicate payments.

Step 7: Post ERA Claims

Step 8: Roll Back to Third Party Billing

This *MUST* be done using the ROL method of Rolling Back after the completion of the Posting.

Step 9: Delete ERA Import

In this step you delete an import ERN File from A/R so it does not have to be viewed after the Posting is completed. If you delete a file by mistake, you can import it again if you have NOT deleted it from your Public Directory.

1. Go to you A/R Main Menu: MAN Manager...
2. Select: ERAD ERA Import Delete.

MEDICARE PART A ELECTRONIC REMITTANCE ADVICE REQUEST FORM

Provider Name:

Provider Address:

Contact Person:

Telephone Number:

Provider/Vendor ERA Receiver ID number (if available):

ERA Transmission:

Advantis: UserID Account number

 GPNET rEDI-link Blue

ANSI X12 835 Version:

_____ 3030.2A _____ 3051.3A _____ 3051.4A01

Will you be using TX-ACE for ERA?

_____ Yes _____ No

Will you be using the PC-Print for the ERA?

_____ Yes _____ NO

*Provider number(s):

Provider Signature:

*List all Medicare provider numbers that should be included on this Remittance file. Providers must sign signifying his approval if remittance is to be provided to a vendor.

You may return this form by faxing to: 469/372-1555 Attention: Jana White, or mail to:

TrailBlazer Health Enterprises, LLC

8330 LBJ Freeway

Executive Center III

Dallas, TX 75243

Attention: Jana White, 09-1905

Medicare - Electronic Remittance Advice

SAMPLE

ERN#	RENAME	(1)	(2)	(3)	(4)			(5)	(6)	(7)	(8)	(9)	(10)			
		Reload	Imported	FTP'd	Loaded	View Import Header			Coll.			Item	Review	Review	Deleted	Deleted
		Rename	from BC/BS	to Crow	For Posting	Check #	RA #	\$ Amount	Batch	#	Postables	Reports	Posted	Rollback	in A/R	Pub Dir.
ERN00001	1001		X	X	X	32419542	643	18117.27	4/6/00	1	X	X	X			
ERN00002	1004	1006	X	X	X	Remit00644	644	0			X	X	X			
ERN00003	1006		X	X	X	32420448	645	60.8	#####	5	X	X	X			

18.0 Appendix B

18.1 Summary of Flat Rate Posting (FRP) Process

The FRP allows you to post *like* payments and adjustments in a more efficient and timesaving manner. This tool can be used especially for Medicare, Medicaid, and Beneficiary Medical Program Posting. This will allow you to enter one payment amount and one adjustment amount (or multiple if deductible and co-payments exist), and apply those transactions to various bills, posting them all at once. Saving time, money, and hands from Carpel tunnel Syndrome.

From the PST- Posting Menu in A/R, you can access two options to use for Flat Rate Posting:

- **FRP: Flat Rate Posting:** Allows you to post transactions to the individual A/R bills.
- **FBL: View Flat Rate Bills:** Allows you to review any flat rate batches that have already been posted to the individual accounts.

Note: Your collection process remains the same. You need to enter your checks into a collection batch/item as you currently do.

Here are the steps in posting transactions via Flat Rate Posting. (Notice that your electronic signature is necessary throughout the process.)

1. Establish the connection
2. Set up transactions
3. Create the FRP batch
4. Review your work
5. Post to the accounts

Step 1: Establish a Connection to a Collection Batch/Item

1. Select FRP – Flat Rate Posting from the Posting Menu.
2. Select previously opened FRP batch.

FRP Batch = This is a batch of bills that have been entered for posting, usually grouped by Collection Batch/Item. If you type a question mark, the system will display those batches that you have currently started to enter but did not finish posting for some reason. This allows you to continue with that particular batch or “Create a New Entry.” If you do not want to finish an existing FRP Batch, press <Return> at the FRP Batch prompt.

3. Create New Entry? Yes// YES

This will allow you to select a Collection Batch and Item number to tie the posting transactions. You can post “Zero Pay” batches as well. Press <Return> at the Select Batch prompt and the system will allow you to enter Adjustments Only.

```
Select Batch: 062700
  Partial match to: Jun 27, 2000!13:54:46 Medicare FY00-06/27/2000-1
Total Posted: $1128.80 Remaining Balance: $69561.99
Select Item: 1
Item Total Posted: $0.00      Item Remaining Balance: $21303.19
```

Step 2. Establish the Payment/Adjustment Amounts You Want to Post to Every Bill Entered

1. Select Command (P/A/Q): P

P = Payment Amount

A = Adjustment Amount

Q = Quit (Entering Payment and Adjustment Amounts). Q will also allow you to review what you have entered for Payment and Adjustment Amounts.

2. Payment Amount: **110.40**

3. Select Command (P/A/Q): **A**

4. Adjustment Amount: **27.60**

5. Adjustment Category: **14 Co-Pay**

6. Repeat “P” or “A” Command until all of your transactions are entered.

7. Select Command (P?A?Q): **Q**

Q will allow you to review what you have entered for transactions. It will show the Transaction Type, Dollar Amount, Adjustment Category, and Adjustment Reason.

Payment: 110.40

Adjustments: 27.60 Co-Pay Co-Payment

Step 3: Create a “Flat Rate Posting Batch” That Will Be Posted

1. The system will display the:
 - **Amount to Post:** Payment amount you have identified as getting ready to POST to individual accounts.
 - **Remaining Balance:** The dollar amount you have left to account for, for this particular Collection Batch/Item. The system automatically keeps track of all the entries into the FRP Batch and keeps the balances on screen so you know if you made an error. If you try to enter too many bills, the system will give you a warning.
2. Select A/R Bill/HIS Bill Number: **98369**
 - Bill Look Ups can be done with patient Name and Date of Service as well as Bill Number. If you use this option, the Bill number will not be displayed at this time, but can be seen during the Review Process.
 - The Bill must exist in the A/R System.
 - The system automatically checks to see if this bill has been posted before, and also checks to see if the Billed Insurer is in fact the same as the Payer Insurer. For example, if the Payer on this Batch/Item is listed as Medicare, and the Bill entered was billed to GEHA, you will get the message: "The Payer (GEHA) on this bill does not match the Payer (Medicare) on the item. Continue? No//."
 - The system automatically checks to see if a particular bill was already entered in this FRP Batch. For example, if you try to enter the same bill twice, you will get the message "98369-HA has already been entered" and the system will force you to enter another bill.
 - The system will automatically check for Negative Balances on the FRP Batch (won't let you post more than the item amount) and checks for Negative Balances on an A/R Bill that has been entered.
3. Continue to Enter Bills until the Amount to Post equals the amount of the Item AND the Remaining Balance = \$0.
4. If you make a mistake, you can REVIEW by pressing <Return> at the A/R Bill Prompt.

Step 4: Review/Edit Your Work Before Final Posting

1. Reviewing the Batch will allow you to visualize the specifics of the FRP Batch before posting. You can review the: Batch Name, Item Number, Check Number, Payer, payment amount, Adjustment amount(s) (Category and Reason), Starting Balance, Ending Balance, # of Bills to Post, and the Bills Numbers and Specifics. You MUST review before you can post. If you make ANY changes to the FRP Batch, you have to REVIEW again before you can continue.

2. Select Command (P/R/E/C/Q): R
 - **P** Post (Post Transactions to individual accounts)
 - **R** Review the FRP Transactions
 - **E** Edit (Delete or Add to the FRP Batch prior to Posting)
 - **C** Cancel (Everything that has been entered into the A/R Flat Rate Posting file will be deleted. Used if you want to start over before posting.
 - **Q** Quit (Quit the current process of entering transactions, but the transactions will remain in the Flat Rate Posting File, but not Posted).
3. If you see a Bill that should not be a part of the Batch, you can Edit/Delete the Bill.
 - a. Select Command (P/R/E/C/Q): E
 - b. Select Flat Rate Post Bill: 98369 (This is the Bill that you want to remove, not a new bill that has not been entered.)
4. If you don't see a bill that should be part of the Batch, you can Add the Bill.
 - a. Select Command (P/R/E/C/Q): **E**
 - b. Select Flat Rate Post Bill: Press <Return>
 - c. Select A/R Bill/IHS Bill Number: Enter New Bill Number 99845
 - d. System will utilize the same edits as before, displaying the Amount to Post and Remaining Balance to Post.
5. If you want to Cancel the Entire Flat Rate Posting File,
 - Select Command (P/R/E/C/Q): **C**

Remember: If you make any changes (Edits/Deletes/Additions) to a flat rate posting batch, you must review the file before you can post.

Step 5: Post Your Transactions to the Individual A/R Accounts

Select Command (P/R/E/C/Q): **P**

The system will take some time posting to the individual accounts, but the user may minimize the screen and move on to something else if a large amount of transactions have been entered. The system will also display the number of Bills that Payments and Adjustments were made to.

Step 6: Delete Flat Rate Posting Batch (Optional)

This will allow you to delete the Flat Rate Posting Batches from the system. Once this is done, the batches will no longer be displayed in the FBL option.

- a. Main A/R Menu, Select: **MAN Manager...**
- b. Select: **FRD** Delete Flat Rate Posting Batch
- c. Enter: Batch Name or ?? for a list of Batches

19.0 Appendix C

19.1 Remittance Advice Remark Codes

Indian Health Service Remittance Advice Remark Codes A/R v1.8 (Includes February 2004 Code List Updates)

Code	Short Description	Long Description
M1	X-ray not taken within the past 12 months or near enough to start of treatment	X-ray not taken within the past 12 months or near enough to the start of treatment.
M2	Not paid separately when the patient is an inpatient.	Not paid separately when the patient is an inpatient.
M3	Equipment is the same or similar to equipment already being used.	Equipment is the same or similar to equipment already being used.
M4	This is the last monthly installment payment for this durable medical equipment.	This is the last monthly installment payment for this durable medical equipment.
M5	Mo rental pymt can't til earlier: 15th of 1st mo or mo equipmnt not needed	Month rental payments can continue until the earlier of the 15th month from the first rental month, or the month when the equipment is no longer needed.
M6	You furnish & srvc item til pt doesnt need it, we pay mntnce/srvc evry 6 mo per.	You must furnish and service this item for as long as the patient continues to need it. We can pay for maintenance and/or servicing fore very 6 month period after the end of the 15th paid rental month or the end of the warranty period.
M7	No rental pymt after item purchased or after total rental pymt = purchase price	No rental payments after the item is purchased, or after the total of issued rental payments equals the purchase price.
M8	We don't take bloodgas tst res when tst condcted by medsupl'r or while pat on Oxy	We do not accept blood gas tests results when the test was conducted by a medical supplier or taken while the patient is on oxygen.
M9	10th rental must, offer patient choice to purchase	This is the tenth rental month. You must offer the patient the choice of changing the rental to a purchase agreement.
M10	Equipment purchases limited to 1st or 10th month of medical necessity	Equipment purchases are limited to the first or the tenth month of medical necessity.
M11	DME, orthotics & prosthetics must be billed to DME who srvc pat's zip code	DME, orthotics and prosthetics must be billed to the DME carrier who

Code	Short Description	Long Description
M12	Diagnostic tests by phys must indicate if purchased svrc included on claim	services the patient's zip code. Diagnostic tests performed by a physician must indicate whether purchased services are included on the claim.
M13	Only one initial visit is covered per specialty per medical group.	Only one initial visit is covered per specialty per medical group.
M14	No separat pymt for injectn admin drng off vst, nopymt for off vst ifonly injectn	No separate payment for an injection administered during an office visit, and no payment for a full office visit if the patient only received an injection.
M15	Separately billd svrc/tst bundled components same prcdr. Separate pymt not allwd	Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
M16	Please see the letter or bulletin of (date) for further information.	Please see the letter or bulletin of (date) for further information.
M17	Payment approved as you didn't/couldn't know not normally covered for patient	Payment approved as you did not know, and could not reasonably have been expected to know, that this would not normally have been covered for this patient. In the future, you will be liable for charges for the same service(s) under the same or similar conditions.
M18	Certain svcs approved home use, Hosp and SNF are not considered patient's home	Certain services may be approved for home use. Neither a hospital nor a Skilled Nursing Facility (SNF) is considered to be a patient's home.
M19	Missing/incomplete/invalid oxygen certification/re-certification.	Missing/incomplete/invalid oxygen certification/re-certification.
M20	Missing/incomplete/invalid HCPCS.	Missing/incomplete/invalid HCPCS.
M21	Missing/incomplete/invalid place of residence for svrc/item provided in a home	Missing/incomplete/invalid place of residence for this service/item provided in a home.
M22	Missing/incomplete/invalid number of miles traveled.	Missing/incomplete/invalid number of miles traveled.
M23	Invoice needed for the cost of the material or contrast agent.	Invoice needed for the cost of the material or contrast agent.
M24	Missing/incomplete/invalid number of doses per vial.	Missing/incomplete/invalid number of doses per vial.
M25	Payment adjusted, info furnished does not substantiate this level of service	Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you believe the service should have been fully covered as billed, or if you did not know and could not reasonably have been expected to know that we would not pay for this level of service, or if you notified the patient in writing in advance that we

Code	Short Description	Long Description
M26	Pymt adjusted, info not substantiate level of srvc, refund pat w/in 30 days	<p>would not pay for this level of service and he/she agreed in writing to pay, ask us to review your claim within 120 days of the date of this notice. If you do not request a review, we will, upon application from the patient, reimburse him/her for the amount you have collected from him/her in excess of any deductible and coinsurance amounts. We will recover the reimbursement from you as an overpayment.</p> <p>Payment has been adjusted because the information furnished does not substantiate the need for this level of service. If you have collected any amount from the patient for this level of service /any amount that exceeds the limiting charge for the less extensive service, the law requires you to refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to the refund requirement in two cases: - If you did not know, and could not have reasonably been expected to know, that we would not pay for this service; or - If you notified the patient in writing before providing the service that you believed that we were likely to deny the service, and the patient signed a statement agreeing to pay for the service. If you come within either exception, or if you believe the carrier was wrong in its determination that we do not pay for this service, you should request review of this determination within 30 days of the date of this notice. Your request for review should include any additional information necessary to support your position. If you request review within 30 days of receiving this notice, you may delay refunding the amount to the patient until you receive the results of the review. If the review decision is favorable to you, you do not need to make any refund. If, however, the review is unfavorable, the law specifies that you must make the refund within 15 days of receiving the unfavorable review decision. The law also permits you to request review at any time within 120 days of the date of this</p>

Code	Short Description	Long Description
M27	Pat relieved of liability of pymt. Provider liable for charges including coins.	<p>notice. However, a review request that is received more than 30 days after the date of this notice, does not permit you to delay making the refund.</p> <p>Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. he patient has received a separate notice of this denial decision. The notice advises that he/she may be entitled to a refund of any amounts paid, if you should have known that we would not pay and did not tell him/her. It also instructs the patient to contact your office if he/she does not hear anything about a refund within 30 days. The requirements for refund are in 1842(l) of the Social Security Act and 42CFR411.408. The section specifies that physicians who knowingly and willfully fail to make appropriate refunds may be subject to civil monetary penalties and/or exclusion from the program. Please contact this office if you have any questions about this notice.</p> <p>The patient has been relieved of liability of payment of these items and services under the limitation of liability provision of the law. You, the provider, are ultimately liable for the patient's waived charges, including any charges for coinsurance, since the items or services were not reasonable and necessary or constituted custodial care, and you knew or could reasonably have been expected to know, that they were not covered. You may appeal this determination provided that the patient does not exercise his/her appeal rights. If the beneficiary appeals the initial determination, you are automatically made a party to the appeals determination. If, however, the patient or his/her representative has stated in writing that he/she does not intend to request a reconsideration, or the patient's liability was entirely waived in the initial determination, you may initiate an appeal. You may ask for a reconsideration for hospital insurance</p>

Code	Short Description	Long Description
		(or a review for medical insurance) regarding both the coverage determination and the issue of whether you exercised due care. The request for reconsideration must be filed within 120 days of the date of this notice (or, for a medical insurance review, within 120 days of the date of this notice). You may make the request through any Social Security office or through this office.
M28	Not qualify for pymt under Part B when Part A coverage exhausted/not available	This does not qualify for payment under Part B when Part A coverage is exhausted or not otherwise available.
M29	Missing/incomplete/invalid operative report.	Missing/incomplete/invalid operative report.
M30	Missing/incomplete/invalid pathology report.	Missing/incomplete/invalid pathology report.
M31	Missing/incomplete/invalid radiology report.	Missing/incomplete/invalid radiology report.
M32	Conditional payment pending decision on this service by patient's primary payer	This is a conditional payment made pending a decision on this service by the patient's primary payer. This payment may be subject to refund upon your receipt of any additional payment for this service from another payer. You must contact this office immediately upon receipt of an additional payment for this service.
M33	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.	Missing/incomplete/invalid UPIN for the ordering/referring/performing provider.
M34	Claim lacks the CLIA certification number.	Claim lacks the CLIA certification number.
M35	Missing/incomplete/invalid pre-operative photos or visual field results.	Missing/incomplete/invalid pre-operative photos or visual field results.
M36	11th rental mo, we can't pay until you indicate patient offered purchase option	This is the 11th rental month. We cannot pay for this until you indicate that the patient has been given the option of changing the rental to a purchase.
M37	Service not covered when the patient is under age 35.	Service not covered when the patient is under age 35.
M38	Pt liable chrgs, informd in writing prior srvc provided we wouldn't pay, pt agrd	The patient is liable for the charges for this service as you informed the patient in writing before the service was furnished that we would not pay for it, and the patient agreed to pay.
M39	Pat not liable pymt, noncoverage notice provided pat not comply program requirmnt	The patient is not liable for payment for this service as the advance notice of non-coverage you provided the patient

Code	Short Description	Long Description
		did not comply with program requirements.
M40	Claim must be assigned and must be filed by the practitioner's employer.	Claim must be assigned and must be filed by the practitioner's employer.
M41	We do not pay for this as the patient has no legal obligation to pay for this.	We do not pay for this as the patient has no legal obligation to pay for this.
M42	The medical necessity form must be personally signed by the attending physician.	The medical necessity form must be personally signed by the attending physician.
M43	Pymt for srvc previously made to you/another prvdr by diff carrier/intermediary	Payment for this service previously issued to you or another provider by another carrier/intermediary.
M44	Missing/incomplete/invalid condition code.	Missing/incomplete/invalid condition code.
M45	Missing/incomplete/invalid occurrence codes or dates.	Missing/incomplete/invalid occurrence codes or dates.
M46	Missing/incomplete/invalid occurrence span code or dates.	Missing/incomplete/invalid occurrence span code or dates.
M47	Missing/incomplete/invalid internal or document control number.	Missing/incomplete/invalid internal or document control number.
M48	Pymt for srvc rendered to hosp inpat made to hosp, req pymt from hosp, not pat	Payment for services furnished to hospital inpatients (other than professional services of physicians) can only be made to the hospital. You must request payment from the hospital rather than the patient for this service.
M49	Missing/incomplete/invalid value code(s) or amount(s).	Missing/incomplete/invalid value code(s) or amount(s).
M50	Missing/incomplete/invalid revenue code(s).	Missing/incomplete/invalid revenue code(s).
M51	Missing/incomplete/invalid procedure code(s) and/or dates.	Missing/incomplete/invalid procedure code(s) and/or dates.
M52	Missing/incomplete/invalid "from" date(s) of service.	Missing/incomplete/invalid "from" date(s) of service.
M53	Missing/incomplete/invalid days or units of service.	Missing/incomplete/invalid days or units of service.
M54	Missing/incomplete/invalid total charges.	Missing/incomplete/invalid total charges.
M55	Not pay self-admin anti-emetic drugs not admin w/covered oral anti-cancer drug	We do not pay for self-administered anti-emetic drugs that are not administered with a covered oral anti-cancer drug.
M56	Missing/incomplete/invalid payer identifier.	Missing/incomplete/invalid payer identifier.
M57	Missing/incomplete/invalid provider identifier.	Missing/incomplete/invalid provider identifier.
M58	Missing/incomplete/invalid claim information. Resubmit claim after corrections.	Missing/incomplete/invalid claim information. Resubmit claim after corrections.

Code	Short Description	Long Description
M59	Missing/incomplete/invalid "to" date(s) of service.	Missing/incomplete/invalid "to" date(s) of service.
M60	Missing/incomplete/invalid Certificate of Medical Necessity.	Missing/incomplete/invalid Certificate of Medical Necessity.
M61	We can't pay for this, approval period for FDA clinical trial has expired	We cannot pay for this as the approval period for the FDA clinical trial has expired.
M62	Missing/incomplete/invalid treatment authorization code.	Missing/incomplete/invalid treatment authorization code.
M63	We do not pay for more than one of these on the same day.	We do not pay for more than one of these on the same day.
M64	Missing/incomplete/invalid other diagnosis.	Missing/incomplete/invalid other diagnosis.
M65	1 interpreting phys chrg per claim allowed when purch diagnostic test indicated	One interpreting physician charge can be submitted per claim when a purchased diagnostic test is indicated. Please submit a separate claim for each interpreting physician.
M66	recrds show diagnostic tst subjct price limits billed&proc submt incld prof comp	Our records indicate that you billed diagnostic tests subject to price limitations and the procedure code submitted includes a professional component. Only the technical component is subject to price limitations. Please submit the technical and professional components of this service as separate line items.
M67	Missing/incomplete/invalid other procedure code(s) and/or date(s).	Missing/incomplete/invalid other procedure code(s) and/or date(s).
M68	Missing/incomplete/invalid atnd/order/render/supvsr/refer phys id.	Missing/incomplete/invalid attending, attending, ordering, rendering, supervising or referring physician identification.
M69	Paid at reg rate, you didn't submit justifying documentation for mod proc code	Paid at the regular rate as you did not submit documentation to justify the modified procedure code.
M70	NDC code submitted was translated to HCPCS for processing, cont sumbitting NDC	NDC code submitted for this service was translated to a HCPCS code for processing, but please continue to submit the NDC on future claims for this item.
M71	Total payment reduced due to overlap of tests billed.	Total payment reduced due to overlap of tests billed.
M72	Did not enter full 8-digit date (MM/DD/CCYY).	Did not enter full 8-digit date (MM/DD/CCYY).
M73	HPSA bonus only paid on prof comp of srvc. Rebill as separate prof and tech comp	The HPSA bonus can only be paid on the professional component of this service. Rebill as separate professional and technical components. Use the HPSA modifier on the professional component only.

Code	Short Description	Long Description
M74	This service does not qualify for a HPSA bonus payment.	This service does not qualify for a HPSA bonus payment.
M75	Allwd amt adj. Mult automated multichannel tst perfrmd sameday combined for pymt	Allowed amount adjusted. Multiple automated multichannel tests performed on the same day combined for payment.
M76	Missing/incomplete/invalid diagnosis or condition.	Missing/incomplete/invalid diagnosis or condition.
M77	Missing/incomplete/invalid place of service.	Missing/incomplete/invalid place of service.
M78	Missing/incomplete/invalid HCPCS modifier.	Missing/incomplete/invalid HCPCS modifier.
M79	Missing/incomplete/invalid charge.	Missing/incomplete/invalid charge.
M80	Not covr'd when performed during same sess'n/date as prev processed srvc for pat	Not covered when performed during the same session/date as a previously processed service for the patient.
M81	You are required to code to the highest level of specificity	You are required to code to the highest level of specificity.
M82	Service is not covered when patient is under age 50.	Service is not covered when patient is under age 50.
M83	Service is not covered unless the patient is classified as at high risk.	Service is not covered unless the patient is classified as at high risk.
M84	Medical code sets used must be the codes in effect at the time of service	Medical code sets used must be the codes in effect at the time of service.
M85	Subjected to review of physician evaluation and management services.	Subjected to review of physician evaluation and management services.
M86	Service denied, payment already for same/similar procedure w/in set time frame	Service denied because payment already made for same/similar procedure within set time frame.
M87	Claim/service(s) subjected to CFO-CAP prepayment review.	Claim/service(s) subjected to CFO-CAP prepayment review.
M88	We cannot pay for lab tests unless billed by the lab that did the work.	We cannot pay for laboratory tests unless billed by the laboratory that did the work.
M89	Not covered more than once under age 40.	Not covered more than once under age 40.
M90	Not covered more than once in a 12 month period.	Not covered more than once in a 12 month period.
M91	Lab procedures w/different CLIA cert numbers must be billed on separate claims.	Lab procedures with different CLIA certification numbers must be billed on separate claims.
M92	Services subjected to review under the Home Health Medical Review Initiative.	Services subjected to review under the Home Health Medical Review Initiative.
M93	Info suppld supprts break in therapy. New capped rentl per w/delivery of equip	Information supplied supports a break in therapy. A new capped rental period began with delivery of this equipment.
M94	Info suppld doesn't supprt break in therapy. New capped rentl period won't begin	Information supplied does not support a break in therapy. A new capped rental period will not begin.

Code	Short Description	Long Description
M95	Services subjected to Home Health Initiative medical review/cost report audit.	Services subjected to Home Health Initiative medical review/cost report audit.
M96	Tech comp of service furnished to inpatient may only be billed by that inpat fac	The technical component of a service furnished to an inpatient may only be billed by that inpatient facility. You must contact the inpatient facility for technical component reimbursement. If not already billed, you should bill us for the professional component only.
M97	Not pd to practitioner when provided to pat in POS.Pymt incl in reimburse to fac	Not paid to practitioner when provided to patient in this place of service. Payment included in the reimbursement issued the facility.
M98	Begin using Universal Product Number, soon payment denied if no/wrong UPN	Begin to report the Universal Product Number on claims for items of this type. We will soon begin to deny payment for items of this type if billed without the correct UPN.
M99	Missing/incomplete/invalid Universal Product Number/Serial Number.	Missing/incomplete/invalid Universal Product Number/Serial Number.
M100	We don't pay oral anti-emetic not admin immed w/in 48 hrs of admin covrd chemo	We do not pay for an oral anti-emetic drug that is not administered for use immediately before, at, or within 48 hours of administration of a covered chemotherapy drug.
M101	Begin using G1-G5 mod w/this HCPCS. Soon deny payment if billed w/out G1-G5 mod	Begin to report a G1-G5 modifier with this HCPCS. We will soon begin to deny payment for this service if billed without a G1-G5 modifier.
M102	Service not performed on equipment approved by the FDA for this purpose.	Service not performed on equipment approved by the FDA for this purpose.
M103	Info supprt brk in ther/info on rec not supprt need/pmt reduc/new capd rent per	Information supplied supports a break in therapy. However, the medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a new capped rental period will begin with the delivery of this equipment.
M104	Info suppld supports break in therapy. New capped rentl period w/deliv of equip	Information supplied supports a break in therapy. A new capped rental period will begin with delivery of the equipment. This is the maximum approved under the fee schedule for this item or service.
M105	Info not suprt brk in ther/infoonrec not suprt need/pmt rdc/nonew capd rent per	Information supplied does not support a break in therapy. The medical information we have for this patient does not support the need for this item as billed. We have approved payment for this item at a reduced level, and a

Code	Short Description	Long Description
M106	Info suppld not support break in therapy/New capped rental period will not begin	new capped rental period will not begin. Information supplied does not support a break in therapy. A new capped rental period will not begin. This is the maximum approved under the fee schedule for this item or service.
M107	Pymt reduced as 90-day rolling average hematocrit for ESRD patient exceeds 36.5%	Payment reduced as 90-day rolling average hematocrit for ESRD patient exceeded 36.5%.
M108	Missing/incomplete/invalid prov ident for prov who interpreted diagnostic test	Missing/incomplete/invalid provider identifier for the provider who interpreted the diagnostic test.
M109	We provide bundled pymt for teleconsultation. Send 25% pymt to refer practitioner	We have provided you with a bundled payment for a teleconsultation. You must send 25 percent of the teleconsultation payment to the referring practitioner.
M110	Missing/incomplete/invalid prov ident for prov interpret srvc purchased from	Missing/incomplete/invalid provider identifier for the provider from whom you purchased interpretation services.
M111	We don't pay chiropractic manipulative treatment when patient refuses x-ray taken	We do not pay for chiropractic manipulative treatment when the patient refuses to have an x-ray taken.
M112	Apprvd amt based on max allowance for item under DMEPOS Competitive Bidding Demo	The approved amount is based on the maximum allowance for this item under the DMEPOS Competitive Bidding Demonstration.
M113	Pat use srvc prior curnt rnd DMEPOS Competitive Bid Demo/aprvd amt allw prior rnd	Our records indicate that this patient began using this service(s) prior to the current round of the DMEPOS Competitive Bidding Demonstration. Therefore, the approved amount is based on the allowance in effect prior to this round of bidding for this item.
M114	Srvc processed accordance rules & guidelines under Competitive Bid Demo Project	This service was processed in accordance with rules and guidelines under the Competitive Bidding Demonstration Project. If you would like more information regarding this project, you may phone 1-888-289-0710.
M115	This item denied when provided to this patient by a non-demonstration supplier	This item is denied when provided to this patient by a non-demonstration supplier.
M116	Paid under Competitive Bid Demo. Proj ending, future srvc may not be paid	Paid under the Competitive Bidding Demonstration project. Project is ending, and future services may not be paid under this project.
M117	Not covered unless submitted via electronic claim.	Not covered unless submitted via electronic claim.

Code	Short Description	Long Description
M118	Letter to follow containing further information.	Letter to follow containing further information.
M119	Missing/incomplete/invalid National Drug Code (NDC).	Missing/incomplete/invalid National Drug Code (NDC).
M120	Miss/incmplt/invlid provid subst phys srvc reciprocal billing/locum tenens arngmt	Missing/incomplete/invalid provider identifier for the substituting physician who furnished the service(s) under a reciprocal billing orlocum tenens arrangement.
M121	We pay for this service only when performed with a covered cryosurgical ablation	We pay for this service only when performed with a covered cryosurgical ablation.
M122	Missing/incomplete/invalid level of subluxation.	Missing/incomplete/invalid level of subluxation.
M123	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.	Missing/incomplete/invalid name, strength, or dosage of the drug furnished.
M124	Missing/incomplete/invalid indication whether patient owns equip req part/supply	Missing/incomplete/invalid indication of whether the patient owns the equipment that requires the part or supply.
M125	Missing/incomplete/invalid info on period time service/supply/equipment needed	Missing/incomplete/invalid information on the period of time for which the service/supply/equipment will be needed.
M126	Missing/incomplete/invalid individual lab codes included in the test.	Missing/incomplete/invalid individual lab codes included in the test.
M127	Missing/incomplete/invalid patient medical record for this service.	Missing/incomplete/invalid patient medical record for this service.
M128	Missing/incomplete/invalid date of the patient's last physician visit.	Missing/incomplete/invalid date of the patient's last physician visit.
M129	Missing/incomplete/invalid indicator of x-ray availability for review.	Missing/incomplete/invalid indicator of x-ray availability for review.
M130	Missing/incomplete/invalid invoice/stmnt cert cost lens, less disc/type lens use	Missing/incomplete/invalid invoice or statement certifying the actual cost of the lens, less discounts, and/or the type of intraocular lens used.
M131	Missing/incomplete/invalid physician financial relationship form.	Missing/incomplete/invalid physician financial relationship form.
M132	Missing/incomplete/invalid pacemaker registration form.	Missing/incomplete/invalid pacemaker registration form.
M133	Claim not identify who performed purchased diagnostic test or amount charged	Claim did not identify who performed the purchased diagnostic test or the amount you were charged for the test.
M134	Performed by a facility/supplier in which the provider has a financial interest.	Performed by a facility/supplier in which the provider has a financial interest.
M135	Missing/incomplete/invalid plan of treatment.	Missing/incomplete/invalid plan of treatment.
M136	Missing/incomplete/invalid indication service	Missing/incomplete/invalid indication

Code	Short Description	Long Description
	supervised/valuated by physician	that the service was supervised or evaluated by a physician.
M137	Part B coinsurance under a demonstration project.	Part B coinsurance under a demonstration project.
M138	Pat id demo partcpnt/not enrld demo time srvc render. Cvrgr limit demo partcpnts	Patient identified as a demonstration participant but the patient was not enrolled in the demonstration at the time services were rendered. Coverage is limited to demonstration participants.
M139	Denied services exceed the coverage limit for the demonstration.	Denied services exceed the coverage limit for the demonstration.
M140	Srvc not cvrd til after pat 50 birthday, ie, no cvrg prior day after 50 birthday	Service not covered until after the patient's 50th birthday, i.e., no coverage prior to the day after the 50th birthday
M141	Missing/incomplete/invalid physician certified plan of care.	Missing/incomplete/invalid physician certified plan of care.
M142	Miss/incomplete/invalid American Diabetes Association Certificate of Recognition	Missing/incomplete/invalid American Diabetes Association Certificate of Recognition.
M143	We have no record you are licensed to dispensed drugs in the State where located	We have no record that you are licensed to dispensed drugs in the State where located.
M144	Pre-/post-operative care payment included in allowance for the surgery/procedure	Pre-/post-operative care payment is included in the allowance for the surgery/procedure.
MA01	If not agree aprvd srvc, appeal. One who not do 1st clm rev. Write w/in 120 day	If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the review. However, in order to be eligible for a review, you must write to us within 120 days of the date of this notice, unless you have a good reason for being late. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF recertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act, and the patient chooses not to appeal. If your carrier

Code	Short Description	Long Description
MA02	If not agree detrmnation,right to appeal.Write w/in 120 dy.Dec by QIO w/in 60 dy	<p>issues telephone review decisions, a professional provider should phone the carrier's office for a telephone review if the criteria for a telephone review are met.</p> <p>If you do not agree with this determination, you have the right to appeal. You must file a written request for a reconsideration within 120 days of the date of this notice. Decisions made by a Quality Improvement Organization (QIO) must be appealed to that QIO within 60 days.</p> <p>An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF non-certified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial because the patient was not terminally ill, and either the patient or the provider is liable under Section N1879 of the Social Security Act, and the patient chooses not to appeal.</p>
MA03	If not agree w/approved amt & \$100 or more in dispute, ask hearing w/in 6 months	<p>If you do not agree with the approved amounts and \$100 or more is in dispute (less deductible and coinsurance), you may ask for a hearing. You must request a hearing within six months of the date of this notice. To meet the \$100, you may combine amounts on other claims that have been denied. This includes reopened reviews if you received a revised decision. You must appeal each claim on time. At the hearing, you may present any new evidence which could affect our decision. An institutional provider, e.g., hospital, Skilled Nursing Facility (SNF), Home Health Agency (HHA) or a hospice may appeal only if the claim involves a reasonable and necessary denial, a SNF noncertified bed denial, or a home health denial because the patient was not homebound or was not in need of intermittent skilled nursing services, or a hospice care denial</p>

Code	Short Description	Long Description
MA04	2ndry pymt not consdrd w/out id/pymt info from primry. Info not report/illegible	because the patient was not terminally ill, and either the patient or the provider is liable under Section 1879 of the Social Security Act , and the patient chooses not to appeal. Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
MA05	Incorrect admission date patient status or type of bill entry on claim.	Incorrect admission date patient status or type of bill entry on claim.
MA06	Missing/incomplete/invalid beginning and/or ending date(s).	Missing/incomplete/invalid beginning and/or ending date(s).
MA07	The claim information has also been forwarded to Medicaid for review.	The claim information has also been forwarded to Medicaid for review.
MA08	Also sbmt clm pat oth ins poss pmt supl ben.We not fwd/supl cvrg not Medigap/MCR	You should also submit this claim to the patient's other insurer for potential payment of supplemental benefits. We did not forward the claim information as the supplemental coverage is not with a Medigap plan, or you do not participate in Medicare.
MA09	Claim submitted unassgn but processed assgn. You agrd accept assignmt all claims	Claim submitted as unassigned but processed as assigned. You agreed to accept assignment for all claims.
MA10	Patient's payment in excess amount owed. You must refund overpayment to patient	The patient's payment was in excess of the amount owed. You must refund the overpayment to the patient.
MA11	Pmt conditional.If no-fault/liability/WorkComp/VA/grp plan cvrg, rfnd may due us	Payment is being issued on a conditional basis. If no-fault insurance, liability insurance, Workers' Compensation, Department of Veterans Affairs, or a group health plan for employees and dependents also covers this claim, a refund may be due us. Please contact us if the patient is covered by any of these sources.
MA12	Not estblsh right under the law to bill srvc furnish by person furnish this srvc	You have not established that you have the right under the law to bill for services furnished by the person(s) that furnished this (these) service(s).
MA13	May be subject penalties if bill patient amounts not reported w/PR group code.	You may be subject to penalties if you bill the patient for amounts not reported with the PR (patient responsibility) group code.
MA14	Pat mbr emplyr-sponsrd hlthpln.Srvc outside pln not cvrd.Pmt this clm not notifd	Patient is a member of an employer-sponsored prepaid health plan. Services from outside that health plan are not covered. However, as you were not previously notified of this, we

Code	Short Description	Long Description
MA15	Claim separated expedite handling. Receive separate notice for oth srvc report	are paying this time. In the future, we will not pay you for non-plan services. Your claim has been separated to expedite handling. You will receive a separate notice for the other services reported.
MA16	The patient is covered by the Black Lung Program. Send this claim to them	The patient is covered by the Black Lung Program. Send this claim to the Department of Labor, Federal Black Lung Program, P.O. Box 828, Lanham-Seabrook MD 20703.
MA17	Prim pyr&pd prim rate. Contct pat oth ins to rfd excess pd due erroneous prim pmt	We are the primary payer and have paid at the primary rate. You must contact the patient's other insurer to refund any excess it may have paid due to its erroneous primary payment.
MA18	Claim info fwd pat suppl ins. Send any ques regarding supplemental ben to them	The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
MA19	Inf notsent Medigap. Incrrct/invld info sbmt on ins. Vfy inf sbmt 2ndry clm direct	Information was not sent to the Medigap insurer due to incorrect/invalid information you submitted concerning that insurer. Please verify your information and submit your secondary claim directly to that insurer.
MA20	SNF not cvrd care primary urethral catheter for convenience/control incontinence	Skilled Nursing Facility (SNF) stay not covered when care is primarily related to the use of an urethral catheter for convenience or the control of incontinence.
MA21	SSA records indicate mismatch with name and sex.	SSA records indicate mismatch with name and sex.
MA22	Payment of less than \$1.00 suppressed.	Payment of less than \$1.00 suppressed.
MA23	Demand bill approved as result of medical review.	Demand bill approved as result of medical review.
MA24	ChristianScienceSanitarium/SkilledNursingFacility (SNF) bill same benefit period	Christian Science Sanitarium/ Skilled Nursing Facility (SNF) bill in the same benefit period.
MA25	Patient may not elect change hospice provider more than once in a benefit period	A patient may not elect to change a hospice provider more than once in a benefit period.
MA26	Our records indicate that you were previously informed of this rule.	Our records indicate that you were previously informed of this rule.
MA27	Missing/incomplete/invalid entitlement number or name shown on the claim.	Missing/incomplete/invalid entitlement number or name shown on the claim.
MA28	Rcpt notice by phys/suplr not acct assgn is info only & they not party determin	Receipt of this notice by a physician or supplier who did not accept

Code	Short Description	Long Description
MA29	Missing/incomplete/invalid provider name, city, state, or zip code.	assignment is for information only and does not make the physician or supplier a party to the determination. No additional rights to appeal this decision, above those rights already provided for by regulation/instruction, are conferred by receipt of this notice. Missing/incomplete/invalid provider name, city, state, or zip code.
MA30	Missing/incomplete/invalid type of bill.	Missing/incomplete/invalid type of bill.
MA31	Missing/incomplete/invalid beginning and ending dates of the period billed.	Missing/incomplete/invalid beginning and ending dates of the period billed.
MA32	Missing/incomplete/invalid number of covered days during the billing period.	Missing/incomplete/invalid number of covered days during the billing period.
MA33	Missing/incomplete/invalid noncovered days during the billing period.	Missing/incomplete/invalid noncovered days during the billing period.
MA34	Missing/incomplete/invalid number of coinsurance days during the billing period.	Missing/incomplete/invalid number of coinsurance days during the billing period.
MA35	Missing/incomplete/invalid number of lifetime reserve days.	Missing/incomplete/invalid number of lifetime reserve days.
MA36	Missing/incomplete/invalid patient name.	Missing/incomplete/invalid patient name.
MA37	Missing/incomplete/invalid patient's address.	Missing/incomplete/invalid patient's address.
MA38	Missing/incomplete/invalid birth date.	Missing/incomplete/invalid birth date.
MA39	Missing/incomplete/invalid gender.	Missing/incomplete/invalid gender.
MA40	Missing/incomplete/invalid admission date.	Missing/incomplete/invalid admission date.
MA41	Missing/incomplete/invalid admission type.	Missing/incomplete/invalid admission type.
MA42	Missing/incomplete/invalid admission source.	Missing/incomplete/invalid admission source.
MA43	Missing/incomplete/invalid patient status.	Missing/incomplete/invalid patient status.
MA44	No appeal rights. Adjudicative decision based on law.	No appeal rights. Adjudicative decision based on law.
MA45	As previously advised, portion/all of payment is being held in a special account	As previously advised, a portion or all of your payment is being held in a special account.
MA46	New info considered/addtnl pmt can't issd. Please review info listed for expln	The new information was considered, however, additional payment cannot be issued. Please review the information listed for the explanation.
MA47	Records show opted out MCR, agree w/patient not bill MCR. We can't pay. Pat resp	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment.

Code	Short Description	Long Description
MA48	Missing/incomplete/invalid name or address of responsible party or primary payer	Missing/incomplete/invalid name or address of responsible party or primary payer.
MA49	Miss/incmplt/invid prov id home hlth agcy/hosp phys perf care pln ovrsght srvc	Missing/incomplete/invalid six-digit provider identifier for home health agency or hospice for physician(s) performing care plan oversight services.
MA50	Miss/incmplt/invid Investigational Device Exemption # FDA-apprvd clin trial srvc	Missing/incomplete/invalid Investigational Device Exemption number for FDA-approved clinical trial services.
MA51	Missing/incomplete/invalid CLIA cert # for lab service billed by phys office lab	Missing/incomplete/invalid CLIA certification number for laboratory services billed by physician office laboratory.
MA52	Missing/incomplete/invalid date.	Missing/incomplete/invalid date.
MA53	Missing/incomplete/invalid Competitive Bidding Demonstration Project Id	Missing/incomplete/invalid Competitive Bidding Demonstration Project identification.
MA54	Physician certification or election consent for hospice care not received timely	Physician certification or election consent for hospice care not received timely.
MA55	Not cvrd pat recd med hlth care svc,auto revoke rcv relig non-med hlth care svc	Not covered as patient received medical health care services, automatically revoking his/her election to receive religious non-medical health care services.
MA56	Opted out MCR, agree w/pat not bill MCR. Can't pay. Pat resp limiting chrg amt	Our records show you have opted out of Medicare, agreeing with the patient not to bill Medicare for services/tests/supplies furnished. As result, we cannot pay this claim. The patient is responsible for payment, but under Federal law, you cannot charge the patient more than the limiting charge amount.
MA57	Pat submitd written request revoke election religious non-med health care srvc	Patient submitted written request to revoke his/her election for religious non-medical health care services.
MA58	Missing/incomplete/invalid release of information indicator.	Missing/incomplete/invalid release of information indicator.
MA59	Pat ovrrpd. Rfnd pat w/in 30 days the diff between pymnt and pat responsibility	The patient overpaid you for these services. You must issue the patient a refund within 30 days for the difference between his/he rpayment and the total amount shown as patient responsibility on this notice.
MA60	Missing/incomplete/invalid patient relationship to insured.	Missing/incomplete/invalid patient relationship to insured.
MA61	Missing/incomplete/invalid social security # or	Missing/incomplete/invalid social

Code	Short Description	Long Description
	health insurance claim number	security number or health insurance claim number.
MA62	Telephone review decision.	Telephone review decision.
MA63	Missing/incomplete/invalid principal diagnosis.	Missing/incomplete/invalid principal diagnosis.
MA64	We should be 3rd payer. Can't process til recvd pymt info from 1st & 2nd payers	Our records indicate that we should be the third payer for this claim. We cannot process this claim until we have received payment information from the primary and secondary payers.
MA65	Missing/incomplete/invalid admitting diagnosis.	Missing/incomplete/invalid admitting diagnosis.
MA66	Missing/incomplete/invalid principal procedure code or date.	Missing/incomplete/invalid principal procedure code or date.
MA67	Correction to a prior claim.	Correction to a prior claim.
MA68	Not x-over claim, 2nd ins info incomplete. Supply complt info/use PLANID of ins	We did not crossover this claim because the secondary insurance information on the claim was incomplete. Please supply complete information or use the PLANID of the insurer to assure correct and timely routing of the claim.
MA69	Missing/incomplete/invalid remarks.	Missing/incomplete/invalid remarks.
MA70	Missing/incomplete/invalid provider representative signature.	Missing/incomplete/invalid provider representative signature.
MA71	Missing/incomplete/invalid provider representative signature date.	Missing/incomplete/invalid provider representative signature date.
MA72	Pat ovrpd assigned srvcs. Rfnd pat w/in 30 days the diff between pymt & pat resp	The patient overpaid you for these assigned services. You must issue the patient a refund within 30 days for the difference between his/her payment to you and the total of the amount shown as patient responsibility and as paid to the patient on this notice.
MA73	Info remit assoc w/MCR demo. No pmt issd fee-for-srvc MCR pat elect managed care	Informational remittance associated with a Medicare demonstration. No payment issued under fee-for-service Medicare as patient has elected managed care.
MA74	Payment replaces earlier payment that was either lost, damaged or returned	This payment replaces an earlier payment for this claim that was either lost, damaged or returned.
MA75	Missing/incomplete/invalid patient or authorized representative signature.	Missing/incomplete/invalid patient or authorized representative signature.
MA76	Missing/incomplete/invalid prov id HHA/hospice phys perform care pln oversight srvcs	Missing/incomplete/invalid provider identifier for home health agency or hospice when physician is performing care plan oversight services.
MA77	Pat ovrpd. Rfnd pat w/in 30 days diff betwn pat	The patient overpaid you. You must issue the patient a refund within 30

Code	Short Description	Long Description
	pmt less prev pyr pmt & pat resp	days for the difference between the patient's payment less the total of our and other payer payments and the amount shown as patient responsibility on this notice.
MA78	Patient overpaid. Refund patient w/in 30 days diff between allowed amt & pat pmt	The patient overpaid you. You must issue the patient a refund within 30 days for the difference between our allowed amount total and the amount paid by the patient.
MA79	Billed in excess of interim rate.	Billed in excess of interim rate.
MA80	Info notice. Pmt issd hosp by intermediary for svc this encnter under demo proj	Informational notice. No payment issued for this claim with this notice. Payment issued to the hospital by its intermediary for all services for this encounter under a demonstration project.
MA81	Missing/incomplete/invalid provider/supplier signature.	Missing/incomplete/invalid provider/supplier signature.
MA82	Miss/incmplt/invalid prov/suplr billing #/id or billing nam,addr,city,st,zip,ph #	Missing/incomplete/invalid provider/supplier billing number/identifier or billing name, address, city, state, zip code, or phone number.
MA83	Not indicate whether 1st or 2nd pyr. Refer item 11 of HCFA-1500 instr for assist	Did not indicate whether we are the primary or secondary payer. Refer to Item 11 in the HCFA-1500 instructions for assistance.
MA84	Pat id participant Nat'l Emphysema Treatment Trial but pat not participant/apprvd	Patient identified as participating in the National Emphysema Treatment Trial but our records indicate that this patient is either not a participant, or has not yet been approved for this phase of the study. Contact Johns Hopkins University, the study coordinator, to resolve if there was a discrepancy.
MA85	Oth primry pyr; you not complete/enter accurate ins plan/grp/program name or id #	Our records indicate that a primary payer exists (other than ourselves); however, you did not complete or enter accurately the insurance plan/group/program name or identification number. Enter the PlanID when effective.
MA86	Missing/incomplete/invalid group or policy # of insured for the primary coverage	Missing/incomplete/invalid group or policy number of the insured for the primary coverage.
MA87	Missing/incomplete/invalid insured's name for the primary payer.	Missing/incomplete/invalid insured's name for the primary payer.
MA88	Missing/incomplete/invalid insured's address and/or phone # for primary payer	Missing/incomplete/invalid insured's address and/or telephone number for

Code	Short Description	Long Description
MA89	Missing/incomplete/invalid patient's relationship to insured for primary payer	the primary payer. Missing/incomplete/invalid patient's relationship to the insured for the primary payer.
MA90	Missing/incomplete/invalid employment status code for the primary insured.	Missing/incomplete/invalid employment status code for the primary insured.
MA91	This determination is the result of the appeal you filed.	This determination is the result of the appeal you filed.
MA92	Missing/incomplete/invalid plan information for other insurance.	Missing/incomplete/invalid plan information for other insurance.
MA93	Non-PIP (Periodic Interim Payment) claim.	Non-PIP (Periodic Interim Payment) claim.
MA94	"Attending phys not hospice employee" not on clm cert render phys not emply hosp	Did not enter the statement "Attending physician not hospice employee" on the claim to certify that the rendering physician is not an employee of the hospice. Refer to item 19 on the HCFA-1500.
MA95	De-activate and refer to M51.	De-activate and refer to M51.
MA96	Claim rejected. Coded MCR Managed Care Demo but pat not enrld MCR mangd care pln	Claim rejected. Coded as a Medicare Managed Care Demonstration but patient is not enrolled in a Medicare managed care plan.
MA97	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.	Missing/incomplete/invalid Medicare Managed Care Demonstration contract number.
MA98	Claim Rejectd. Not correct MCR Managed Care Demo contract # for this beneficiary	Claim Rejected. Does not contain the correct Medicare Managed Care Demonstration contract number for this beneficiary.
MA99	Missing/incomplete/invalid Medigap information.	Missing/incomplete/invalid Medigap information.
MA100	Missing/incomplete/invalid date of current illness, injury or pregnancy.	Missing/incomplete/invalid date of current illness, injury or pregnancy.
MA101	A SNF responsible payment of outside prov who furnish srvcs/supls to residents	A Skilled Nursing Facility (SNF) is responsible for payment of outside providers who furnish these services/supplies to residents.
MA102	Missng/incmplt/invld name/prov id rendering/referring/ordering/supervising prov	Missing/incomplete/invalid name or provider identifier for the rendering/referring/ordering/supervising provider.
MA103	Hemophilia Add On.	Hemophilia Add On.
MA104	Missing/incomplete/invalid date pat last seen or provider id of attending phys	Missing/incomplete/invalid date the patient was last seen or the provider identifier of the attending physician.
MA105	Missing/incomplete/invalid provider number for this place of service.	Missing/incomplete/invalid provider number for this place of service.
MA106	PIP (Periodic Interim Payment) claim.	PIP (Periodic Interim Payment) claim.

Code	Short Description	Long Description
MA107	Paper claim contains more than three separate data items in field 19.	Paper claim contains more than three separate data items in field 19.
MA108	Paper claim contains more than one data item in field 23.	Paper claim contains more than one data item in field 23.
MA109	Claim processed in accordance with ambulatory surgical guidelines.	Claim processed in accordance with ambulatory surgical guidelines.
MA110	Miss/incmplt/invld info if diagnostic performed outside entity/no purchasd tests	Missing/incomplete/invalid information on whether the diagnostic test(s) were performed by an outside entity or if no purchased tests are included on the claim.
MA111	Missing/incomplete/invalid purchase price of test/performing lab's name & addr	Missing/incomplete/invalid purchase price of the test(s) and/or the performing laboratory's name and address.
MA112	Missing/incomplete/invalid group practice information.	Missing/incomplete/invalid group practice information.
MA113	Incmlpt/invld TIN submtd per IRS.Not process.May not bill pat pnding corrct TIN	Incomplete/invalid taxpayer identification number (TIN) submitted by you per the Internal Revenue Service. Your claims cannot be processed without your correct TIN, and you may not bill the patient pending correction of your TIN. There are no appeal rights for unprocessable claims, but you may resubmit this claim after you have notified this office of your correct TIN.
MA114	Missing/incomplete/invalid information on where the services were furnished.	Missing/incomplete/invalid information on where the services were furnished.
MA115	Missing/incomplete/invalid physical location where services rendered in a HPSA	Missing/incomplete/invalid physical location (name and address, or PIN) where the service(s) were rendered in a Health Professional Shortage Area (HPSA).
MA116	Stmnt "Homebound" not on claim validate lab svcs performed at home/in institutn	Did not complete the statement "Homebound" on the claim to validate whether laboratory services were performed at home or in an institution.
MA117	This claim has been assessed a \$1.00 user fee.	This claim has been assessed a \$1.00 user fee.
MA118	Coins/deduct amts apply for svcs/suppls furn MCR-elig vet thru VA. No MCR pmt	Coinsurance and/or deductible amounts apply to a claim for services or supplies furnished to a Medicare-eligible veteran through a facility of the Department of Veterans Affairs. No Medicare payment issued.
MA119	Provider level adjustment for late claim filing applies to this claim.	Provider level adjustment for late claim filing applies to this claim.
MA120	Missing/incomplete/invalid CLIA certification number.	Missing/incomplete/invalid CLIA certification number.

Code	Short Description	Long Description
MA121	Missing/incomplete/invalid date the x-ray was performed.	Missing/incomplete/invalid date the x-ray was performed.
MA122	Missing/incomplete/invalid initial date actual treatment occurred.	Missing/incomplete/invalid initial date actual treatment occurred.
MA123	Center not selected participate in study, therefore, we cannot pay for services	Your center was not selected to participate in this study, therefore, we cannot pay for these services.
MA124	Processed for IME only.	Processed for IME only.
MA125	Per legislation governing this program, payment constitutes payment in full.	Per legislation governing this program, payment constitutes payment in full.
MA126	Pancreas transplant not covered unless kidney transplant performed.	Pancreas transplant not covered unless kidney transplant performed.
MA127	Reserved for future use.	Reserved for future use.
MA128	Missing/incomplete/invalid six-digit FDA approved, identification number.	Missing/incomplete/invalid six-digit FDA approved, identification number.
MA129	This provider was not certified for this procedure on this date of service.	This provider was not certified for this procedure on this date of service.
MA130	Incmlpt/invld info,no appeal rights afforded.Submt new clm w/ complt/corct info	Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.
MA131	Phys already paid in conjunction w/demo clm. Have phys withdraw clm & rfnd pmt	Physician already paid for services in conjunction with this demonstration claim. You must have the physician withdraw that claim and refund the payment before we can process your claim.
MA132	Adjustment to the pre-demonstration rate.	Adjustment to the pre-demonstration rate.
MA133	Claim overlaps inpatient stay. Rebill only services rendered outside inpat stay	Claim overlaps inpatient stay. Rebill only those services rendered outside the inpatient stay.
MA134	Missing/incomplete/invalid provider number of facility where patient resides	Missing/incomplete/invalid provider number of the facility where the patient resides.
N1	May appeal this decision in writing. Instruction incld contract/plan benefit doc	You may appeal this decision in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N2	allowance made accordance most appropriate course of treatment provision of plan	This allowance has been made in accordance with the most appropriate course of treatment provision of the plan.
N3	Missing/incomplete/invalid consent form.	Missing/incomplete/invalid consent form.
N4	Missing/incomplete/invalid prior insurance carrier EOB.	Missing/incomplete/invalid prior insurance carrier EOB.

Code	Short Description	Long Description
N5	EOB received from previous payer. Claim not on file.	EOB received from previous payer. Claim not on file.
N6	FEHB law(U.S.C. 8904(b)),can't pay more for cvrd care than MCR allwd if A/B cvrg	Under FEHB law (U.S.C. 8904(b)), we cannot pay more for covered care than the amount Medicare would have allowed if the patient were enrolled in Medicare Part A and/or Medicare Part B.
N7	Processing claim/service included consideration under Major Medical provisions	Processing of this claim/service has included consideration under Major Medical provisions.
N8	X-over clm deny by prev pyr&complt dat not fwd.Resubmt to pyr to provd adjud dat	Crossover claim denied by previous payer and complete claim data not forwarded. Resubmit this claim to this payer to provide adequate data for adjudication.
N9	Adjustment represents the estimated amount the primary payer may have paid.	Adjustment represents the estimated amount the primary payer may have paid.
N10	Clm/svc adj on findings rev org/prof conslt/manual adjudicatn/med or dentl advsr	Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.
N11	Denial reversed because of medical review.	Denial reversed because of medical review.
N12	Pol prov cvrg suppl MCR. Mbr not MCR B,mbr resp pmt of chrg would be cvrd by MCR	Policy provides coverage supplemental to Medicare. As member does not appear to be enrolled in Medicare Part B, the member is responsible for payment of the portion of the charge that would have been covered by Medicare.
N13	Payment based on professional/technical component modifier(s).	Payment based on professional/technical component modifier(s).
N14	Payment based on contractual amt or agreemet, fee schedule, or max allowable amt	Payment based on a contractual amount or agreement, fee schedule, or maximum allowable amount.
N15	Services for a newborn must be billed separately.	Services for a newborn must be billed separately.
N16	Family/member Out-of-Pocket maximum met. Payment based on a higher percentage.	Family/member Out-of-Pocket maximum has been met. Payment based on a higher percentage.
N17	Per admission deductible.	Per admission deductible.
N18	Payment based on the Medicare allowed amount.	Payment based on the Medicare allowed amount.
N19	Procedure code incidental to primary procedure.	Procedure code incidental to primary procedure.
N20	Service not payable with other service rendered on the same date.	Service not payable with other service rendered on the same date.

Code	Short Description	Long Description
N21	Range of dates separated onto single lines.	Range of dates separated onto single lines.
N22	Procedure code added/changed as it more accurately describes services rendered	This procedure code was added/changed because it more accurately describes the services rendered.
N23	Pat liability maybe affectd due coord of ben w/oth carriers/max benefit provision	Patient liability may be affected due to coordination of benefits with other carriers and/or maximum benefit provisions.
N24	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.	Missing/incomplete/invalid Electronic Funds Transfer (EFT) banking information.
N25	Co contractd by ben plan prov admin clm pmt svc only,not assume finan risk/oblig	This company has been contracted by your benefit plan to provide administrative claims payment services only. This company does not assume financial risk or obligation with respect to claims processed on behalf of your benefit plan.
N26	Missing/incomplete/invalid itemized bill.	Missing/incomplete/invalid itemized bill.
N27	Missing/incomplete/invalid treatment number.	Missing/incomplete/invalid treatment number.
N28	Consent form requirements not fulfilled.	Consent form requirements not fulfilled.
N29	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.	Missing/incomplete/invalid documentation/orders/notes/summary/report/invoice.
N30	Patient ineligible for this service.	Patient ineligible for this service.
N31	Missing/incomplete/invalid prescribing/referring/attending provider license num	Missing/incomplete/invalid prescribing/referring/attending provider license number.
N32	Claim must be submitted by the provider who rendered the service.	Claim must be submitted by the provider who rendered the service.
N33	No record of health check prior to initiation of treatment.	No record of health check prior to initiation of treatment.
N34	Incorrect claim form for this service.	Incorrect claim form for this service.
N35	Program integrity/utilization review decision.	Program integrity/utilization review decision.
N36	Claim must meet primary payer processing requirements before we considr payment	Claim must meet primary payer's processing requirements before we can consider payment.
N37	Missing/incomplete/invalid tooth number/letter.	Missing/incomplete/invalid tooth number/letter.
N38	Missing/incomplete/invalid place of service.	Missing/incomplete/invalid place of service.
N39	Procedure code is not compatible with tooth number/letter.	Procedure code is not compatible with tooth number/letter.
N40	Missing/incomplete/invalid x-ray.	Missing/incomplete/invalid x-ray.

Code	Short Description	Long Description
N41	Authorization request denied.	Authorization request denied.
N42	No record of mental health assessment.	No record of mental health assessment.
N43	Bed hold or leave days exceeded	Bed hold or leave days exceeded.
N44	Pyr share reg surchrg/assessmnts/allwncs/hlth care-relatd tx pd directly reg auth	Payer's share of regulatory surcharges, assessments, allowances or health care-related taxes paid directly to the regulatory authority.
N45	Payment based on authorized amount.	Payment based on authorized amount.
N46	Missing/incomplete/invalid admission hour.	Missing/incomplete/invalid admission hour.
N47	Claim conflicts with another inpatient stay.	Claim conflicts with another inpatient stay.
N48	Claim information not agree with information received from oth insurance carrier	Claim information does not agree with information received from other insurance carrier.
N49	Court ordered coverage information needs validation.	Court ordered coverage information needs validation.
N50	Missing/incomplete/invalid discharge information.	Missing/incomplete/invalid discharge information.
N51	Electronic interchange agreement not on file for provider/submitter.	Electronic interchange agreement not on file for provider/submitter.
N52	Patient not enrolled in billing provider's managed care plan on date of service	Patient not enrolled in the billing provider's managed care plan on the date of service.
N53	Missing/incomplete/invalid point of pick-up address.	Missing/incomplete/invalid point of pick-up address.
N54	Claim information is inconsistent with pre-certified/authorized services.	Claim information is inconsistent with pre-certified/authorized services.
N55	Procedures for billing group/referring/performing providers were not followed	Procedures for billing with group/referring/performing providers were not followed.
N56	Procedure code billd not correct/valid for services billd/date of service billd	Procedure code billed is not correct/valid for the services billed or the date of service billed.
N57	Missing/incomplete/invalid prescribing/dispensed date.	Missing/incomplete/invalid prescribing/dispensed date.
N58	Missing/incomplete/invalid patient liability amount.	Missing/incomplete/invalid patient liability amount.
N59	Please refer to provider manual for additional program and provider information	Please refer to your provider manual for additional program and provider information.
N60	A valid NDC is required for payment of drug claims effective October 02.	A valid NDC is required for payment of drug claims effective October 02.
N61	Rebill services on separate claims.	Rebill services on separate claims.
N62	Inpatient admission spans multiple rate periods. Resubmit separate claims.	Inpatient admission spans multiple rate periods. Resubmit separate claims.
N63	Rebill services on separate claim lines.	Rebill services on separate claim lines.
N64	The "from" and "to" dates must be different.	The "from" and "to" dates must be

Code	Short Description	Long Description
N65	Procedure code/rate count not determined/on file, for date of service/provider	different. Procedure code or procedure rate count cannot be determined, or was not on file, for the date of service/provider.
N66	Missing/incomplete/invalid documentation.	Missing/incomplete/invalid documentation.
N67	Prof provider svcs not paid separately. Included in fac pmt under demo project	Professional provider services not paid separately. Included in facility payment under a demonstration project. Apply to that facility for payment, or resubmit your claim if: the facility notifies you the patient was excluded from this demonstration; or if you furnished these services in another location on the date of the patient's admission or discharge from a demonstration hospital. If services were furnished in a facility not involved in the demonstration on the same date the patient was discharged from or admitted to a demonstration facility, you must report the provider ID number for the non-demonstration facility on the new claim.
N68	Prior payment cancelled, subsequently notified patient covered by a demo project	Prior payment being cancelled as we were subsequently notified this patient was covered by a demonstration project in this site of service. Professional services were included in the payment made to the facility. You must contact the facility for your payment. Prior payment made to you by the patient or another insurer for this claim must be refunded to the payer within 30 days.
N69	PPS code changed by claims processing system. Insufficient visits or therapies.	PPS (Prospective Payment System) code changed by claims processing system. Insufficient visits or therapies.
N70	Home health consolidated billing and payment applies.	Home health consolidated billing and payment applies.
N71	unassigned claim drug/bio/clin diagnostic lab/ambulance svcs processed assigned	Your unassigned claim for a drug or biological, clinical diagnostic laboratory services or ambulance service was processed as an assigned claim. You are required by law to accept assignment for these types of claims.
N72	PPS code changed by medical reviewers. Not supported by clinical records	PPS (Prospective Payment System) code changed by medical reviewers. Not supported by clinical records.
N73	A SNF resp pmt outside prov who furnish svcs/supls under arrangemnt to resident	A Skilled Nursing Facility is responsible for payment of outside

Code	Short Description	Long Description
		providers who furnish these services/supplies under arrangement to its residents.
N74	Resubmt w/multiple claims, each claim cvrg srvcs provided only 1 calendar month	Resubmit with multiple claims, each claim covering services provided in only one calendar month.
N75	Missing/incomplete/invalid tooth surface information.	Missing/incomplete/invalid tooth surface information.
N76	Missing/incomplete/invalid number of riders.	Missing/incomplete/invalid number of riders.
N77	Missing/incomplete/invalid designated provider number.	Missing/incomplete/invalid designated provider number.
N78	Necessary components of child and teen checkup (EPSDT) were not completed.	The necessary components of the child and teen checkup (EPSDT) were not completed.
N79	Service billed is not compatible with patient location information.	Service billed is not compatible with patient location information.
N80	Missing/incomplete/invalid prenatal screening information.	Missing/incomplete/invalid prenatal screening information.
N81	Procedure billed is not compatible with tooth surface code.	Procedure billed is not compatible with tooth surface code.
N82	Prov must acctpt ins pmt as pmt in full 3rd party pyr contrct says full reimburse	Provider must accept insurance payment as payment in full when a third party payer contract specifies full reimbursement.
N83	No appeal right. Adjudicative decision based provisions of demonstration project	No appeal rights. Adjudicative decision based on the provisions of a demonstration project.
N84	Further installment payments forthcoming.	Further installment payments forthcoming.
N85	Final installment payment.	Final installment payment.
N86	Fail trial pelvic muscle exer traing req biofdbck traing trt urinary incnt cvrd	A failed trial of pelvic muscle exercise training is required in order for biofeedback training for the treatment of urinary incontinence to be covered.
N87	Home use of biofeedback therapy is not covered.	Home use of biofeedback therapy is not covered.
N88	Payment conditional. An HHA episode care notice has been filed for this patient	This payment is being made conditionally. An HHA episode of care notice has been filed for this patient. When a patient is treated under a HHA episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the HHA's payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under a HHA episode of care.
N89	Payment info forwarded more one other payer,	Payment information for this claim has been forwarded to more than one

Code	Short Description	Long Description
	but only one identified on remit	other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
N90	Covered only when performed by the attending physician.	Covered only when performed by the attending physician.
N91	Services not included in the appeal review.	Services not included in the appeal review.
N92	This facility is not certified for digital mammography.	This facility is not certified for digital mammography.
N93	Sep claim required each place of service. Srvc multiple site not billd same clm	A separate claim must be submitted for each place of service. Services furnished at multiple sites may not be billed in the same claim.
N94	Claim/Service denied more specific taxonomy code required for adjudication	Claim/Service denied because a more specific taxonomy code is required for adjudication.
N95	This provider type/provider specialty may not bill this service.	This provider type/provider specialty may not bill this service.
N96	Pat refractory conven'l ther & approp surg candidate implantation w/anesth occur	Patient must be refractory to conventional therapy (documented behavioral, pharmacologic and/or surgical corrective therapy) and bean appropriate surgical candidate such that implantation with anesthesia can occur.
N97	Strss incnt/urnry obstr/spec neuro dis assoc w/2ndry manif above 3 indicatn excl	Patients with stress incontinence, urinary obstruction, and specific neurologic diseases (e.g., diabetes with peripheral nerve involvement)which are associated with secondary manifestations of the above three indications are excluded.
N98	Patient must have successful test stimulation to support subsequent implantation	Patient must have had a successful test stimulation in order to support subsequent implantation. Before a patient is eligible for permanent implantation, he/she must demonstrate a 50 percent or greater improvement through test stimulation. Improvement is measured through voiding diaries.
N99	Pat must demo adeq abilty void diary data clin reslt implant proc properly eval	Patient must be able to demonstrate adequate ability to record voiding diary data such that clinical results of the implant procedure can be properly evaluated.
N100	PPS (Prospect Payment System) code corrected during adjudication.	PPS (Prospect Payment System) code corrected during adjudication.
N101	Add'l info need to process claim. Please resubmit w/id # provider where service	Additional information is needed in order to process this claim. Please resubmit the claim with the

Code	Short Description	Long Description
N102	Denied w/out reviewing med rec, requested rec not received or received timely	identification number of the provider where this service took place. The Medicare number of the site of service provider should be preceded with the letters "HSP" and entered into item #32 on the claim form. You may bill only one site of service provider number per claim. This claim has been denied without reviewing the medical record because the requested records were not received or were not received timely.
N103	Social Security rec say pat prisoner at time of svc. Pat liable hlth care cost	Social Security records indicate that this patient was a prisoner when the service was rendered. This payer does not cover items and services furnished to an individual while they are in State or local custody under a penal authority, unless under State or local law, the individual is personally liable for the cost of his or her health care while incarcerated and the State or local government pursues such debt in the same way and with the same vigor as any other debt.
N104	Not payable under claims jurisdiction area. Id correct MCR contractor thru CMS	This claim/service is not payable under our claims jurisdiction area. You can identify the correct Medicare contractor to process this claim/service through the CMS website at www.cms.hhs.gov .
N105	This is a misdirected claim/service for an RRB beneficiary.	This is a misdirected claim/service for an RRB beneficiary. Submit paper claims to the RRB carrier: Palmetto GBA, P.O. Box 10066, Augusta, GA 30999. Call 866-749-4301 for RRB EDI information for electronic claims processing.
N106	Payment for services to SNF inpatients can only be made to the SNF.	Payment for services furnished to Skilled Nursing Facility (SNF) inpatients (except for excluded services) can only be made to the SNF. You must request payment from the SNF rather than the patient for this service.
N107	Services to SNF inpatient must be inpat claim. Can't bill separately as outpatient	Services furnished to Skilled Nursing Facility (SNF) inpatients must be billed on the inpatient claim. They cannot be billed separately as outpatient services.
N108	Missing/incomplete/invalid upgrade information.	This claim was chosen for complex review and was denied after reviewing the medical records.
N109	This claim chosen for complex review & denied after reviewing medical records.	

Code	Short Description	Long Description
N110	This facility is not certified for film mammography.	This facility is not certified for film mammography.
N111	No appeal right except duplicate claim/service issue.	No appeal right except duplicate claim/service issue. This service was included in a claim that has been previously billed and adjudicated.
N112	This claim is excluded from your electronic remittance advice.	This claim is excluded from your electronic remittance advice.
N113	Only one initial visit is covered per physician, group practice or provider.	Only one initial visit is covered per physician, group practice or provider.
N114	Dur transition Ambulance Fee Schedule, pmt basd lessr of blended amt/submt chrg	During the transition to the Ambulance Fee Schedule, payment is based on the lesser of a blended amount calculated using a percentage of the reasonable charge/cost and fee schedule amounts, or the submitted charge for the service. You will be notified yearly what the percentages for the blended payment calculation will be.
N115	This decision was based on a local medical review policy (LMRP).	This decision was based on a local medical review policy (LMRP). An LMRP provides a guide to assist in determining whether a particular item or service is covered. A copy of this policy is available at http://www.cms.hhs.gov/mcd , or if you do not have web access, you may contact the contractor to request a copy of the LMRP.
N116	Pmt conditional, srvc provided in home, possible pat undr home hlth episode care	This payment is being made conditionally because the service was provided in the home, and it is possible that the patient is under a home health episode of care. When a patient is treated under a home health episode of care, consolidated billing requires that certain therapy services and supplies, such as this, be included in the home health agency's (HHA's) payment. This payment will need to be recouped from you if we establish that the patient is concurrently receiving treatment under an HHA episode of care.
N117	This service is paid only once in a patient's lifetime.	This service is paid only once in a patient's lifetime.
N118	This service is not paid if billed more than once every 28 days.	This service is not paid if billed more than once every 28 days.
N119	Svc not pd if billd once evry 28 days, & pat 5/more consec days in any inpat/SNF	This service is not paid if billed once every 28 days, and the patient has spent 5 or more consecutive days in

Code	Short Description	Long Description
N120	Payment subject home health prospective pymt sys partial episode pymt adjustment	any inpatient or Skilled/nursing Facility (SNF) within those 28 days. Payment is subject to home health prospective payment system partial episode payment adjustment. Patient was transferred/discharged/readmitted during payment episode.
N121	No cvrg itms/srvcs provided this type practitioner for pat in covered SNF stay	No coverage for items or services provided by this type of practitioner for patients in a covered Skilled Nursing Facility (SNF) stay.
N122	Mammography add-on code cannot be billed by itself.	Mammography add-on code cannot be billed by itself.
N123	This split service & represents portion of units from originally submitted srvc	This is a split service and represents a portion of the units from the originally submitted service.
N124	Pmt denied. Info not substantiate need for this more extensive service/item	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. The patient is liable for the charges for this service/item as you informed the patient in writing before the service/item was furnished that we would not pay for it, and the patient agreed to pay.
N125	Payment denied, information not substantiate need for more extensive service/itm	Payment has been denied for the/made only for a less extensive service/item because the information furnished does not substantiate the need for the (more extensive) service/item. If you have collected any amount from the patient, you must refund that amount to the patient within 30 days of receiving this notice. The law permits exceptions to this refund requirement in two cases: -If you did not know, and could not have reasonably been expected to know, that Medicare would not pay for this service/item; or -If you notified the beneficiary in writing before providing it that Medicare likely would deny the service/item, and the beneficiary signed a statement agreeing to pay. If an exception applies to you, or you believe the carrier was wrong in denying payment, you should request review of this determination by the carrier within 30 days of receiving this notice. Your request for review should

Code	Short Description	Long Description
N126	Social Security Records indicate that this individual has been deported.	<p>include any additional information necessary to support your position. If you request review within 30-days, you may delay refunding to the beneficiary until you receive the results of the review. If the review determination is favorable to you, you do not have to make any refund. If the review is unfavorable, you must make the refund within 15 days of receiving the unfavorable review decision. You may request review of the determination at any time within 120 days of receiving this notice. A review requested after the 30-day period does not permit you to delay making the refund. Regardless of when a review is requested, the patient will be notified that you have requested one, and will receive a copy of the determination. The patient has received a separate notice of this denial decision. The notice advises that he or she maybe entitled to a refund of any amounts paid, if you should have known that Medicare would not pay and did not tell him or her. It also instructs the patient to contact your office if he or she does not hear anything about a refund within 30 days. The requirements for refund are in §1834(a)(18) of the Social Security Act (and in §§1834(j)(4) and 1879(h) by cross-reference to §1834(a)(18)). Section 1834(a)(18)(B) specifies that suppliers which knowingly and willfully fail to make appropriate refunds may be subject to civil money penalties and/or exclusion from the Medicare program. If you have any questions about this notice, please contact this office.</p>
N127	This is misdirected claim/service for United Mine Workers of America beneficiary	<p>Social Security Records indicate that this individual has been deported. This payer does not cover items and services furnished to individuals who have been deported.</p> <p>This is a misdirected claim/service for a United Mine Workers of America beneficiary. Submit paper claims to: UMWA Health and Retirement Funds, PO Box 389, Ephraim, UT 84627-0361. Call Envoy at 1-800-215-4730 for</p>

Code	Short Description	Long Description
		information on electronic claims submission.
N128	This amount represents the prior to coverage portion of the allowance.	This amount represents the prior to coverage portion of the allowance.
N129	This amount represents the dollar amount not eligible due to the patient's age.	This amount represents the dollar amount not eligible due to the patient's age.
N130	Consult plan benefit documents for information about restrictions this service.	Consult plan benefit documents for information about restrictions for this service.
N131	Total payments under multiple contracts cannot exceed allowance for this service	Total payments under multiple contracts cannot exceed the allowance for this service.
N132	Pmt will cease for srvc's this US Gov't debarred/excl'd prov after 30 day grace per	Payments will cease for services rendered by this US Government debarred or excluded provider after the 30 day grace period as previously notified.
N133	Services for predetermination & services requesting payment processed separately	Services for predetermination and services requesting payment are being processed separately.
N134	Represents scheduled pymt for service. If treatment discont'd, contact Cust Srvc	This represents your scheduled payment for this service. If treatment has been discontinued, please contact Customer Service.
N135	Record fees are patient's responsibility and limited to the specified co-payment	Record fees are the patient's responsibility and limited to the specified co-payment.
N136	To obtain info on process to file appeal in AZ, call Depart's Consumr Assist Off	To obtain information on the process to file an appeal in Arizona, call the Department's Consumer Assistance Office at (602) 912-8444 or (800) 325-2548.
N137	You may file appeal w/our Company/file complaint w/Commissioner in Maryland	You, the provider, acting on the Member's behalf, may file an appeal with our Company. You, the provider, on the Member's behalf, may file a complaint with the Commissioner in the state of Maryland without first filing an appeal, if the coverage decision involves an urgent condition for which care has not been rendered. The Commissioner's address: Commissioner Steven B. Larsen, Maryland Insurance Administration, 525 St. Paul Place, Baltimore, MD 21202 - (410) 468-2000.
N138	If disagree Dentl Advisor opinion&add'l info relative, submt radiographs 2nd rev	In the event you disagree with the Dental Advisor's opinion and have additional information relative to the case, you may submit radiographs to

Code	Short Description	Long Description
N139	Code of Fed Reg, Ch 32, Sect 199.13 non-particpat prov not approp appealing prty	<p>the Dental Advisor Unit at the subscriber's dental insurance carrier for a second Independent Dental Advisor Review.</p> <p>Under the Code of Federal Regulations, Chapter 32, Section 199.13 anon-participating provider is not an appropriate appealing party. Therefore, if you disagree with the Dental Advisor's opinion, you may appeal the determination if appointed in writing, by the beneficiary, to act as his/her representative. Should you be appointed as a representative, submit a copy of this letter, a signed statement explaining the matter in which you disagree, and any radiographs and relevant information to the subscriber's Dental insurance carrier within 90 days from the date of this letter.</p>
N140	Not authorized OCONUS provider, not considered an appropriate appealing party.	<p>You have not been designated as an authorized OCONUS provider therefore are not considered an appropriate appealing party. If the beneficiary has appointed you, in writing, to act as his/her representative and you disagree with the Dental Advisor's opinion, you may appeal by submitting a copy of this letter, a signed statement explaining the matter in which you disagree, and any relevant information to the subscriber's Dental insurance carrier within 90days from the date of this letter.</p>
N141	Patient not reside long-term care facility during all/part service dates billed	<p>The patient was not residing in a long-term care facility during all or part of the service dates billed.</p>
N142	The original claim was denied. Resubmit a new claim, not a replacement claim.	<p>The original claim was denied. Resubmit a new claim, not a replacement claim.</p>
N143	The patient not in hospice program during all or part of service dates billed	<p>The patient was not in a hospice program during all or part of the service dates billed.</p>
N144	The rate changed during the dates of service billed.	<p>The rate changed during the dates of service billed.</p>
N145	Missing/incomplete/invalid provider identifier for this place of service.	<p>Missing/incomplete/invalid provider identifier for this place of service.</p>
N146	Missing/incomplete/invalid/not approved screening document.	<p>Missing/incomplete/invalid/not approved screening document.</p>
N147	Long term care case mix/per diem rate not determined,pat ID # miss/incmplt/invld	<p>Long term care case mix or per diem rate cannot be determined because</p>

Code	Short Description	Long Description
		the patient ID number is missing, incomplete, or invalid on the assignment request.
N148	Missing/incomplete/invalid date of last menstrual period.	Missing/incomplete/invalid date of last menstrual period.
N149	Rebill all applicable services on a single claim.	Rebill all applicable services on a single claim.
N150	Missing/incomplete/invalid model number.	Missing/incomplete/invalid model number.
N151	phone contact services not paid til face-to-face contact requirement met	Telephone contact services will not be paid until the face-to-face contact requirement has been met.
N152	Missing/incomplete/invalid replacement claim information.	Missing/incomplete/invalid replacement claim information.
N153	Missing/incomplete/invalid room and board rate.	Missing/incomplete/invalid room and board rate.
N154	This payment was delayed for correction of provider's mailing address.	This payment was delayed for correction of provider's mailing address.
N155	Our records not indicate oth ins on file. submit oth ins info for our records	Our records do not indicate that other insurance is on file. Please submit other insurance information for our records.
N156	Patient responsible difference between approved treatment & elective treatment	The patient is responsible for the difference between the approved treatment and the elective treatment.
N157	Transportation to/from this destination is not covered.	Transportation to/from this destination is not covered.
N158	Transportation in a vehicle other than an ambulance is not covered.	Transportation in a vehicle other than an ambulance is not covered.
N159	Payment denied/reduced, mileage not covered when patient not in the ambulance	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N160	Patient choose option before pymt made for procedure/equipment/supply/service	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.
N161	This drug/service/supply is covered only when the associated service is covered	This drug/service/supply is covered only when the associated service is covered.
N162	Alert. Claim paid, but billed test/specialty not included Lab Certification	This is an alert. Although your claim was paid, you have billed for a test/specialty not included in your Laboratory Certification. Your failure to correct the laboratory certification information wil result in a denial of payment in the near future.
N163	Medical record does not support code billed per the code definition.	Medical record does not support code billed per the code definition.
N164	Transportation to/from this destination is not covered.	Transportation to/from this destination is not covered.

Code	Short Description	Long Description
N165	Transportation in a vehicle other than an ambulance is not covered.	Transportation in a vehicle other than an ambulance is not covered.
N166	Payment denied/reduced, mileage not covered when patient not in the ambulance	Payment denied/reduced because mileage is not covered when the patient is not in the ambulance.
N167	Charges exceed the post-transplant coverage limit.	Charges exceed the post-transplant coverage limit.
N168	Patient choose option before payment for procedure/equipment/supply/service.	The patient must choose an option before a payment can be made for this procedure/equipment/supply/service.
N169	This drug/service/supply is covered only when the associated service is covered.	This drug/service/supply is covered only when the associated service is covered.
N170	A new/revised/renewed certificate of medical necessity is needed.	A new/revised/renewed certificate of medical necessity is needed.
N171	Payment for repair/replacement is not covered or has exceeded the purchase price	Payment for repair or replacement is not covered or has exceeded the purchase price.
N172	Patient not liable denied/adjusted charge for receiving any updated service/item	The patient is not liable for the denied/adjusted charge(s) for receiving any updated service/item.
N173	No qualifying hospital stay dates were provided for this episode of care.	No qualifying hospital stay dates were provided for this episode of care.
N174	Not cvrd srvc/proc/equip/bed, pat liability limited amts in adj under group "PR"	This is not a covered service/procedure/ equipment/bed, however patient liability is limited to amounts shown in the adjustments under group "PR".
N175	Missing/incomplete/invalid Review Organization Approval.	Missing/incomplete/invalid Review Organization Approval.
N176	Srvcs provided aboard ship cvrd only when United States registry & in US waters	Services provided aboard a ship are covered only when the ship is of United States registry and is in United States waters. In addition, a doctor licensed to practice in the United States must provide the service.
N177	Not sent to patient's other insurer. They indicated no add'l payment can be made	We did not send this claim to patient's other insurer. They have indicated no additional payment can be made.
N178	Missing/invalid/incomplete pre-operative photos or visual field results.	Missing/invalid/incomplete pre-operative photos or visual field results.
N179	Add'l information requested from member. Charges be reconsidered upon receipt	Additional information has been requested from the member. The charges will be reconsidered upon receipt of that information.
N180	This item/service not meet criteria for the category under which it was billed	This item or service does not meet the criteria for the category under which it was billed.
N181	Add'l info req another prov involved in care. Chrsgs be reconsidered upon receipt	Additional information has been requested from another provider involved in the care of this member.

Code	Short Description	Long Description
		The charges will be reconsidered upon receipt of that information.
N182	This claim/service must be billed according to the schedule for this plan.	This claim/service must be billed according to the schedule for this plan.
N183	Predetermination advisory msg, when service submitted, add'l documents required	This is a predetermination advisory message, when this service is submitted for payment additional documentation as specified in plan documents will be required to process benefits.
N184	Rebill technical and professional components separately.	Rebill technical and professional components separately.
N185	Do not resubmit this claim/service.	Do not resubmit this claim/service.
N186	NAS required for this service. Contact the nearest MTF for assistance.	Non-Availability Statement (NAS) required for this service. Contact the nearest Military Treatment Facility (MTF) for assistance.
N187	May request review follow receipt notice, follow instr contract/plan benefit doc	You may request a review in writing within the required time limits following receipt of this notice by following the instructions included in your contract or plan benefit documents.
N188	The approved level of care does not match the procedure code submitted.	The approved level of care does not match the procedure code submitted.
N189	Service has been paid as a one-time exception to the plan's benefit restrictions	This service has been paid as a one-time exception to the plan's benefit restrictions.
N190	Missing/incomplete/invalid contract indicator.	Missing/incomplete/invalid contract indicator.
N191	The provider must update insurance information directly with payer.	The provider must update insurance information directly with payer.
N192	Patient is a Medicaid/Qualified Medicare Beneficiary.	Patient is a Medicaid/Qualified Medicare Beneficiary.
N193	Specific federal/state/local program may cover service through another payer	Specific federal/state/local program may cover this service through another payer.
N194	Technical component not paid if provider does not own the equipment used.	Technical component not paid if provider does not own the equipment used.
N195	The technical component must be billed separately.	The technical component must be billed separately.
N196	Patient eligible to apply for other coverage which may be primary.	Patient eligible to apply for other coverage which may be primary.
N197	The subscriber must update insurance information directly with payer.	The subscriber must update insurance information directly with payer.
N198	Rendering provider must be affiliated with the pay-to provider.	Rendering provider must be affiliated with the pay-to provider.
N199	Additional payment approved based on payer-initiated review/audit.	Additional payment approved based on payer-initiated review/audit.
N200	The professional component must be billed	The professional component must be

Code	Short Description	Long Description
N201	separately. Mental hlth fac resp pmt of outside providers of services/supplies to residents	billed separately. A mental health facility is responsible for payment of outside providers who furnish these services/supplies to residents.
N202	Additional information/explanation will be sent separately	Additional information/explanation will be sent separately
N203	Missing/incomplete/invalid anesthesia time/units	Missing/incomplete/invalid anesthesia time/units
N204	Srvcs under review possible pre-existing condition. Send med rec for prior 12 mo	Services under review for possible pre-existing condition. Send medical records for prior 12 months
N205	Information provided was illegible	Information provided was illegible
N206	The supporting documentation does not match the claim	The supporting documentation does not match the claim
N207	Missing/incomplete/invalid birth weight	Missing/incomplete/invalid birth weight
N208	Missing/incomplete/invalid DRG code	Missing/incomplete/invalid DRG code
N209	Missing/invalid/incomplete taxpayer identification number (TIN)	Missing/invalid/incomplete taxpayer identification number (TIN)
N210	You may appeal this decision	You may appeal this decision
N211	You may not appeal this decision	You may not appeal this decision
N212	Charges processed under a Point of Service benefit	Charges processed under a Point of Service benefit

20.0 Appendix D

20.1 NCPDP Rej/Pay Codes

Indian Health Service

NCPDP Reject/Payment Codes (from Pharmacy POS)

24-Feb-04

Code	Description
1	M/I Bin
2	M/I Version Number
3	M/I Transaction Code
4	M/I Processor Control Number
5	M/I Pharmacy Number
6	M/I Group Number
7	M/I Cardholder ID Number
8	M/I Person Code
9	M/I Birth Date
10	M/I Patient Gender Code
11	M/I Patient Relationship Code
12	M/I Patient Location
13	M/I Other Coverage Code
14	M/I Eligibility Clarification Code
15	M/I Date of Service
16	M/I Prescription/Service Reference Number
17	M/I Fill Number
18	M/I METRIC QUANTITY
19	M/I Days Supply
20	M/I Compound Code
21	M/I Product/Service ID
22	M/I Dispense As Written(DAW)/Product Selection Code
23	M/I Ingredient Cost Submitted
24	M/I SALES TAX
25	M/I Prescriber ID
26	M/I Unit of Measure
27	(FUTURE USE)
28	M/I Date Prescription Written
29	M/I Number Refills Authorized
30	M/I P.A./M.C. CODE AND NUMBER
31	(FUTURE USE)
32	M/I Level of Service
33	M/I Prescription Origin Code

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
34	M/I Submission Clarification Code
35	M/I Primary Care Provider ID
36	M/I CLINIC ID
37	(FUTURE USE)
38	M/I Basis of Cost
39	M/I Diagnosis Code
40	Pharmacy Not Contracted With Plan on Date of Service
41	Submit Bill To Other Processor Or Primary Payer
42	(FUTURE USE)
43	(FUTURE USE)
44	(FUTURE USE)
45	(FUTURE USE)
46	(FUTURE USE)
47	(FUTURE USE)
48	(FUTURE USE)
49	(FUTURE USE)
50	Non-Matched Pharmacy Number
51	Non-Matched Group ID
52	Non-Matched Cardholder ID
53	Non-Matched Person Code
54	Non-Matched Product/Service ID Number
55	Non-Matched Product Package Size
56	Non-Matched Prescriber ID
57	NON-MATCHED P.A./M.C. NUMBER
58	Non-Matched Primary Prescriber
59	NON-MATCHED CLINIC ID
60	Product/Service Not Covered For Patient Age
61	Product/Service Not Covered For Patient Gender
62	Patient/Card Holder ID Name Mismatch
63	Institutionalized Patient Product/Service ID Not Covered
64	Claim Submitted Does Not Match Prior Authorization
65	Patient Is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Product/Service Not Covered
71	Prescriber Is Not Covered
72	Primary Prescriber Is Not Covered
73	Refills Are Not Covered

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
74	Other Carrier Payment Meets Or Exceeds Payable
75	Prior Authorization Required
76	Plan Limitations Exceeded
77	Discontinued Product/Service ID Number
78	Cost Exceeds Maximum
79	Refill Too Soon
80	Drug-Diagnosis Mismatch
81	Claim Too Old
82	Claim Is Post-Dated
83	Duplicate Paid/Captured Claim
84	Claim Has Not Been Paid/Captured
85	Claim Not Processed
86	Submit Manual Reversal
87	Reversal Not Processed
88	DUR Reject Error
89	Rejected Claim Fees Paid
90	Host Hung Up
91	Host Response Error
92	System Unavailable/Host Unavailable
93	PLANNED UNAVAILABLE
94	INVALID MESSAGE
95	Time Out
96	Scheduled Downtime
97	Payor Unavailable
98	Connection To Payer Is Down
99	Host Processing Error
CA	M/I Patient First Name
CB	M/I Patient Last Name
CC	M/I Cardholder First Name
CD	M/I Cardholder Last Name
CE	M/I Home Plan
CF	M/I Employer Name
CG	M/I Employer Street Address
CH	M/I Employer City Address
CI	M/I Employer State/Province Address
CJ	M/I Employer Zip Postal Zone
CK	M/I Employer Phone Number
CL	M/I Employer Contact Name
CM	M/I Patient Street Address
CN	M/I Patient City Address

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
CO	M/I Patient State/Province Address
CP	M/I Patient Zip/Postal Zone
CQ	M/I Patient Phone Number
CR	M/I Carrier ID
CT	PATIENT SOCIAL SECURITY NUMBER
DP	M/I DRUG TYPE OVERRIDE
DR	M/I Prescriber Last Name
DQ	M/I Usual and Customary Charge
DS	M/I POSTAGE AMOUNT CLAIMED
DT	M/I Unit Dost Indicator
DU	M/I Gross Amount Due
DV	M/I Other Payer Amount Paid
DW	M/I BASIS OF DAYS SUPPLY DETERMINATION
DX	M/I Patient Paid Amount Submitted
DY	M/I Date of Injury
DZ	M/I Claim/Reference ID
E1	M/I Product/Service ID Qualifier
E2	ALTERNATE PRODUCT CODE
E3	M/I Incentive Amount Submitted
E4	M/I Reason For Service Code
E5	M/I Professional Service Code
E6	M/I Result of Service Code
E7	M/I Quantity Dispensed
E8	M/I Other Payer Date
M1	Patient Not Covered In This Aid Category
M2	Recipient Locked In
M3	Host PA/MC Error
M4	Prescription/Service Reference Number/Time Limit Exceeded
M5	Requires Manual Claim
M6	Host Eligibility Error
M7	Host Drug File Error
M8	Host Provider File Error
MZ	Error Overflow
1C	M/I Smoker/Non-Smoker Code
1E	M/I Prescriber Location Code
2C	M/I Pregnancy Indicator
2E	M/I Primary Care Provider ID Qualifier
3A	M/I Request Type
3B	M/I Request Period Date-Begin
3C	M/I Request Period Date-End

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
3D	M/I Basis of Request
3E	M/I Authorized Representative First Name
3F	M/I Authorized Representative Last Name
3G	M/I Authorized Representative Street Address
3H	M/I Authorized Representative City Address
3J	M/I Authorized Representative State/Province Address
3K	M/I Authorized Representative Zip/Postal Zone
3M	M/I Prescriber Phone Number
3N	M/I Prior Authorized Number Assigned
3P	M/I Authorization Number
3R	Prior Authorization Not Required
3S	M/I Prior Authorization Supporting Documentation
3T	Active Prior Auth Exists Resubmit At Expiration of Prior Auth
3W	Prior Authorization in Process
3X	Authorization Number Not Found
3Y	Prior Authorization Denied
4C	M/I Coordination of Benefits/Other Payments Count
4E	M/I Primary Care Provider Last Name
5C	M/I Other Payer Coverage Type
5E	M/I Other Payer Reject Count
6C	M/I Other Payer ID Qualifier
6E	M/I Other Payer Reject Code
7C	M/I Other Payer ID
7E	M/I DUR/PPS Code Counter
8C	M/I Facility ID
8E	M/I DUR/PPS Level of Effort
AA	Patient Spenddown Not Met
AB	Date Written Is After Date Filled
AC	Product Not Covered Non-Participating Manufacturer
AD	Billing Provider Not Eligible To Bill This Claim Type
AE	QMB (Qualified Medicare Beneficiary)-Bill Medicare
AF	Patient Enrolled Under Managed Care
AG	Days Supply Limitation For Product/Service
AH	Unit Dose Packaging Only Payable For Nursing Home Recipients
AJ	Generic Drug Required
AK	M/I Software Vendor/Certification ID
AM	M/I Segment Identification
A9	M/I Transaction Count
BE	M/I Professional Service Fee Submitted
B2	M/I Service Provider ID Qualifier

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
CW	M/I Alternate ID
CX	M/I Patient ID Qualifier
CY	M/I Patient ID
CZ	M/I Employer ID
DC	M/I Dispensing Fee Submitted
DN	M/I Basis of Cost Determination
EA	M/I Originally Prescribed Product/Service Code
EB	M/I Originally Prescribed Quantity
EC	M/I Compound Ingredient Component Count
ED	M/I Compound Ingredient Quantity
EE	M/I Compound Ingredient Drug Cost
EF	M/I Compound Dosage Form Description Code
EG	M/I Compound Dispensing Unit Form Indicator
EH	M/I Compound Route of Administration
EJ	M/I Originally Prescribed Product/Service ID Qualifier
EK	M/I Scheduled Prescription ID Number
EM	M/I Prescription/Service Reference Number Qualifier
EN	M/I Associated Prescription/Service REference Number
Ep	M/I Associated Prescription/Service Date
ER	M/I Procedure Modifier Code
ET	M/I Quantity Prescribed
EU	M/I Prior Authorization Type Code
EV	M/I Prior Authorization Number Submitted
EW	M/I Intermediary Authorization Type ID
EX	M/I Intermediary Authorization ID
EY	M/I Provider ID Qualifier
EZ	M/I Prescriber ID Qualifier
E9	M/I Provider ID
FO	M/I Plan ID
GE	M/I Percentage Sales Tax Amount Submitted
HA	M/I Flat Sales Tax Amount Submitted
HB	M/I Other Payer Amount Paid Count
HC	M/I Other Payer Amount Paid Qualifier
HD	M/I Dispensing Status
HE	M/I Percentage Sales Tax Rate Submitted
HF	M/I Quantity Intended To Be Dispensed
HG	M/I Days Supply Intended To Be Dispensed
H1	M/I Measurement Time
H2	M/I Measurement Dimension
H3	M/I Measurement Unit

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
H4	M/I Measurement Value
H5	M/I Primary Care Provider Location Code
H6	M/I DUR Co-Agent Id
H7	M/I Other Amount Claimed Submitted Count
H8	M/I Other Amount Claimed Submitted Qualifier
H9	M/I Other Amount Claimed Submitted
JE	M/I Percentage Sales Tax Basis Submitted
J9	M/I DUR Co-Agent ID Qualifier
KE	M/I Coupon Type
ME	M/I Coupon Number
NE	M/I Coupon Value Amount
NN	Transaction Rejected At Switch Or Intermediary
PA	PA Exhausted/Not Renewable
PB	Invalid Transaction Count For This Transaction Code
PC	M/I Claim Segment
PD	M/I Clinical Segment
PE	M/I COB/Other Payments Segment
PF	M/I Compound Segment
PG	M/I Coupon Segment
PH	M/I DUR/PPS Segment
PJ	M/I Insurance Segment
PK	M/I Patient Segment
PM	M/I Pharmacy Provider Segment
PN	M/I Prescriber Segment
PP	M/I Pricing Segment
PR	M/I Prior Authorization Segment
PS	M/I Transaction Header Segment
PT	M/I Workers' Compensation Segment
PV	Non-Matched Associated Prescription/Service Date
PW	Non-Matched Employer ID
PX	Non-Matched Other Payer ID
PY	Non-Matched Unit Form/Route of Administration
PZ	Non-Matched Unit Of Measure To Product/Service ID
P1	Associated Prescription/Service Reference Number Not Found
P2	Clinical Information Counter Out Of Sequence
P3	Compound Ingrid Component Count Does Not Match Number of Repetitions
P4	COB/Other Payments Count Does Not Match Number of Repetitions
P5	Coupon Expired
P6	Date of Service Prior To Date Of Birth
P7	Diagnosis Code Count Does Not Match Number Of Repetitions

Indian Health Service
NCPDP Reject/Payment Codes (from Pharmacy POS)
24-Feb-04

Code	Description
P8	DUR/PPS Code Counter Out of Sequence
P9	Field Is Non-Repeatable
RA	PA Reversal Out Of Order
RB	Multiple Partials Not Allowed
RC	Different Drug Entity Between Partial & Completion
RD	Mismatched Cardholder/Group ID-Partial To Completion
RE	M/I Compound Product ID Qualifier
RF	Improper Order of 'Dispensing Status' Code on Partial Fill Transaction
RG	M/I Associated Prescription/Service Ref Num on Completion Transaction
RH	M/I Associated Prescription/Service Date on Completion Transaction
RJ	Associated Partial Fill Transaction Not on File
RK	Partial Fill Transaction Not Supported
RM	Completion Trans Not Permitted W/ Same 'Date of Service' Partl Trans
RN	Plan Limits Exceeded On Intended Partial Fill Values
RP	Out Of Sequence 'P' Reversal on Partial Fill Transaction
RS	M/I Associated Prescription/Service Date on Partial Transaction
RT	M/I Associated Prescription/Service Ref Number on Partial Trans
RU	Mandatory Elements Must Occur Befr Optional Data Elements In Segment
R1	Other Amount Claimed Submitted Count Does Not Match # of Repetitions
R2	Other Payer Reject Count Does Not Match Number Of Repetitions
R3	Procedure Modifier Code Count Does Match Number Of Repetitions
R4	Procedure Modifier Code Invalid For Product/Service ID
R5	Product/Service ID Must Be Zero When Product/Service ID Qual Equals 06
R6	Product/Service Not Appropriate For This Location
R7	Repeating Segment Not Allowed In Same Transaction
R8	Syntax Error
R9	Value In Gross Amount Due Does Not Follow Pricing Formulae
SE	M/I Procedure Modifier Code Count
TE	M/I Compound Product ID
UE	M/I Compound Ingredient Basis Of Cost Determination
VE	M/I Diagnosis Code Count
WE	M/I Diagnosis Code Qualifier
XE	M/I Clinical Information Counter
ZE	M/I Measurement Date

21.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the ITSC Help Desk by:

Phone: (505) 248-4371 or (888) 830-7280

Fax: (505) 248-4363

Web: <http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm>

E-mail: support@ihs.gov