RESOURCE AND PATIENT MANAGEMENT SYSTEM

Accounts Receivable

(BAR)

Addendum to User Manual

Version 1.8 Patch 28
June 2018

Office of Information Technology
Division of Information Resource Management

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Preface

The purpose of this addendum is to provide information about the Accounts Receivable (BAR) package. The system is designed to automate the management of accounts receivable in the Resource and Patient Management System (RPMS).

Please review and distribute this addendum to your Accounts Receivable staff ***prior to*** installation of this patch.

Refer to the notes file released with this patch for all other technical documentation.

References to specific commercial products or services do not constitute or imply their endorsement by the Indian Health Service and shall not be used for advertising or product endorsement purposes.

1.0 Introduction

1.1 Summary of Changes

Patch 28 provides enhancements and minor corrections to Version 1.8 of the Accounts Receivable application. These changes include enhancements to editing collection batches, processing electronic remittance advices, and reports.

Change Request 5994 (HEAT 141667, 305486) - Modified the ETDN (Edit Treasury Deposit/IPAC Number) option to allow for editing the A/R Check Number and/or the A/R Account and added audit entries to record changes to these fields. The audit trail can be viewed in FileMan.

Change Request 8345 (HEAT 224215) - Made the following changes to the DAYS IN AR report:

- Added prompt for exporting a delimited file.
- Added prompt for summary or detail, the detail report being a new option.
- Allow a Detail Report to generate for data review.
- Added prompt to export the detail report as an XML document or as an '^' delimited file.
- Made a change to look at the correct LOCATION for 3P Bill data. The report was using the same LOCATION that A/R uses when looking up a bill but if the site said NO to the USE A/R PARENT/SATELLITE SETUP, the LOCATION will not always be the same as A/R.
- Changed some of the date formats so they would all use the same format when comparing dates.
- Removed the check for HOSPITAL LOCATION. The report was trying to use this in place of the VISIT LOCATION, but they are not the same thing

Change Request 8346 (HEAT 275351) – Made a correction Electronic Remittance Advice (ERA) bill matching. When an ERA file contains a payment reversal, the entire file would be matched with a reason Not To Post of 'ERA TOTAL GREATER THAN BATCH/ITEM TOTAL'. Patch 28 will mark an equal number of payments as Not To Post rather than marking the whole file Not To Post.

Change Request 8347 (HEAT 281465) – Made a change for payers who send zero (0) for a bill number in the CLP01 of an ERA file instead of an actual claim number. The ERA claim was getting stuck in a status of 'BUILT' instead of being marked with 'CLAIM UNMATCHED' and a reason Not To Post of 'RA CLAIM NOT FOUND IN RPMS'. This was preventing the entire ERA file from auto-posting.

Change Request 8348 (HEAT 292703) - Added 3P BILL TYPE to the A/R BILL file as a calculated field. The 3P BILL TYPE will reflect the bill type on the 3P Bill at the time the 3P Bill was approved (111 for Inpatient, 131 for Outpatient, etc.).

Change Request 8349 (HEAT 293633) – Created additional fields in the automatic write-off routine. Also made a correction to prevent transactions that are flagged with IGNORE TRANSACTION from being exported to UFMS. Note: this is an OIT option that cannot be accessed from an A/R menu option. Contact OIT if this option is needed.

Change Request 8350 (HEAT 295594) – Made modifications to the UFMS Age Summary Report including:

- Report can now be generated for a range of fiscal years. A fiscal year is calculated in RPMS from 10/1 through 9/30.
- Removed the screen breaks so that the report will scroll across the display screen without the user having to press Enter repeatedly. A message has also been added advising that the report should be exported, or the session should be logged so that the entire report can be viewed.
- Changed the output method so that the report will no longer automatically be tasked. Now the user will have to type **Q** to task it.

Change Request 8351 (HEAT 296731) - Changed the UFMS Age Summary Report to use the 3P APPROVAL DATE rather than the BILLED DATE. Also corrected how the end date is calculated so that the entire last day of the fiscal year is included in the data being reported.

Change Request 8397 (HEAT 155084) - Made changes to the Adjustment & Refund Report including:

- Changed the name of the report to 'Adjustment & Refund Report by Bill Approve Date' and changed the menu mnemonic to ADJA.
- Corrected the report to use the 3P Approval Date rather than the A/R Transaction Date when looking for data to report.
- Corrected the column header name for the Adjustment Category. It was printing 'Adjustment Amount' in error.
- Added a column for the Adjustment Amount.
- Fixed the column named #DAYS (APPR.DT-ADJ.DT); the column header was printing but there was not any data being reported.
- Added a report called 'Adjustment & Refund Report by Transaction Date' (ADJT). This report is identical to the AJDA report except it uses the transaction date for reporting data.

Change Request 8398 (HEAT 301053) - Created a new report in the Accounts Management Reports Menu called the Provider Visit Count Report. This report was designed to be used for MACRA reporting (Medicare Access and CHIP Reauthorization Act). The PVCR report can be run by Date of Service or by Approval Date, by Bill Type of inpatient/outpatient/or both, and for one or more user-specified providers. Based on the criteria selected, the report will provide a list of bills that also have an insurer type of Medicare FI.

Change Request 9277 (HEAT 304002) - A change was made to the A/R Collection Batch/IHS file that requires a user to have programmer mode to be able to delete a collection batch.

Note:	It is strongly discouraged that any collection batch be deleted as deleted information cannot be recovered.

Change Request 9571 (HEAT 193456) – Standard Adjustment Reason codes have been updated to reflect updates posted by Washington Publishing Company on March 01, 2018. These updates do not affect locally created adjustment codes numbered 1000 and higher.

Change Request 9572 (HEAT 258378) – Corrected the ERA A/R Bill Matching option to allow users to bypass manual bill matching when more than one RPMS bill is found for an ERA claim. Prior to patch 28, if the user did not select anything and pressed return, every claim in the ERA file was marked with a reason Not To Post, which prevented the entire file from auto-posting. In patch 28, if the user selects 'Not Matched' at the manual matching prompt or simply presses Enter, the system will mark only that one claim with a status of 'Claim Unmatched' and a Reason Not To Post of 'USER HAS OVERRIDDEN AUTO REVIEW AND SET STATUS TO 'NOT TO POST'.

Change Request 9580 (HEAT303780) – Added a new report called Patient Payment Summary to the Collection Menu. It will prompt for one or more patients and a Collection Batch start and end date. It will then report all batches found for that patient, a total dollar amount for those batches, how much has and has not been posted, and a detailed list of the batch/items found along with a list of bills that have been posted to, if any.

2.0 Patch 28 Details

2.1 A/R Bill File

A field called 3P Bill Type has been added to the A/R Bill file. This is a calculated field that displays the UB-04 bill type (111 for Inpatient, 131 for Outpatient, etc.) on the 3P claim at the time it was approved in the Third Party Billing application. To view the 3P Bill Type, use the Bill Inquire command from within the Payments and Adjustments (PAY) option or the Post Adjustments (ADJ) option in the Posting Menu.

This field will be used in logic for future reports. Only valid Bill Types should be used on the Third Party Billing side.

```
  POLICY HOLDER (FT): NO CASH,DEMO      POLICY NUMBER (FT): 123456789
  OTHER BILL IDENTIFIER: 402238A-DH-185
  COLLECTIONS STATUS DATE: FEB 09, 2018@10:49:59
  AMOUNT: 216.78                        TYPE: INITIAL BILL
  AMOUNT IN COLLECTIONS(C): 0
  AGE (c): 75                           0-30 (c): 0
  31-60 (c): 0                          61-90 (c): 0
  91-120 (c): 0                         120+ (c): 0
  3P BILL STATUS (c): COMPLETED         PRIMARY DIAGNOSIS (c): E11.8
  ALLOWABLE AMOUNT (c): 173.42          ICD CODE INDICATOR (c): ICD-10-CM
  3P BILL TYPE (c): 131
```

Figure 2-1: 3P BILL TYPE displayed in A/R Bill file

2.2 Collection Batches

2.2.1 Edit Treasury Deposit/IPAC Number

MAN > EDTN

The Edit Treasury Deposit/IPAC Number (EDTN) option has been modified to allow for editing the Check Number and/or the A/R Account on a Collection Batch Item.

This option is located in the Manager menu and the user must have access to view this option.

```
Now editing Collection Batch Items....
------------------------------------------------------------------------------
Item     Check#            A/R ACCOUNT        TDN/IPAC    TYPE       Amount
------------------------------------------------------------------------------
  1  0000504115            NEW MEXICO MEDICA  TDN0504115                500.00
------------------------------------------------------------------------------
Select Collection Batch Item to edit:  1

  1  0000504115            NEW MEXICO MEDICA  TDN0504115                500.00
```

```
Check Number: 0000504115// 00050411560
A/R Account: NEW MEXICO MEDICAID// MEDICARE
```

Figure 2-2: Editing the Check Number and A/R Account in the ETDN option

2.2.2 A/R Collection Batch Auditing

The A/R Collection Batch file was modified to record changes made to the Check Number and/or the A/R Account. The Internal Entry Number (IEN) of the user who made the changes will also be stored along with the date and time the change was made. Changes can be viewed in FileMan by doing an Inquiry on an edited A/R Collection Batch and typing Yes at the 'DISPLAY AUDIT TRAIL' prompt.

```
NUMBER: 908                              NAME: MEDICARE-05/02/2018-1
  COLLECTION ID: MEDICARE                BATCH STATUS: OPEN
  OPENED DATE/TIME: MAY 02, 2018@10:45:52
  OPENED BY USER: CARLTON,GINA           LAST RECEIPT NUMBER: 2
  SITE LOCATION: 2017 DEMO HOSPITAL      A/R SECTION: BUSINESS OFFICE
  TREASURY DEPOSIT NUMBER/IPAC: TDN010203
  BATCH AMOUNT: 5000                     TDN/IPAC/Deposit Date: APR 27, 2018
NUMBER: 1                                ITEM NUMBER: 1
  PAYMENT TYPE: EOB CHECK                DATE/TIME STAMP: MAY 02, 2018@10:46:01
  USER: CARLTON,GINA
  A/R ACCOUNT: MEDICARE
    Changed from "ARIZONA MEDICAID" on May 03, 2018@13:07:26 by User #1936
                                                    (BAR EDIT TDN/IPAC Option)
    Changed from "ARIZONA MEDICAID" on May 02, 2018@10:46:07 by User #1936
                                                    (BAR COL ENTRY Option)
  VISIT LOCATION: 2017 DEMO HOSPITAL
  CHECK NUMBER: 0125632
    Changed from "CHK#0125632" on May 03, 2018@13:07:22 by User #1936
                                                    (BAR EDIT TDN/IPAC Option)
    CREDIT: 2500                           PAYOR: MEDICARE
VISIT LOCATION: 2017 DEMO HOSPITAL       PAID AMOUNT: 2500
  SUFIX (c): DH                          SUB EOB POSTING TOTAL (c): 0
  SUB EOB POSTING BALANCE (c): 2500      SUB EOB UNALLOCATED (c): 0
ITEM CHANGE DATE: MAY 03, 2018@13:07:23
```

Figure 2-3: FileMan Inquiry of an A/R Collection Batch that was edited using the ETDN option

2.3 Electronic Remittance Advice (ERA) Processing

PST > ERA > BLMT/REV

Patch 28 includes several corrections to the ERA bill matching process to address some commonly reported issues. These corrections are detailed below.

Occasionally a payer sends a claim number of zero (0) in the CLP01 segment of an ERA file, rather than sending an actual claim number. Prior to patch 28, a claim number of zero (0) caused the claim to get stuck in a status of BUILT and prevented the entire ERA file from auto-posting. In patch 28, when a claim number of zero (0) is received in an ERA file, it will be marked with a status of Claim Unmatched along with a Reason Not to Post of RA CLAIM NOT FOUND IN RPMS. Any other Matched claims that do not have a Reason Not to Post will be allowed to auto-post.

```
BAR Claim Review              May 03, 2018 12:14:10          Page:    1 of    0
HIPAA 835 v5010     File: 1002_ERA_04/30/2018     Chk/EFT#: EFT9987655

#  Claim             Date         Patient           AR Account  Status
1   0                 JAN 12, 2018 PATIENT,DEMO                BUILT

2   123456A           FEB 25, 2018 TEST,PATIENT                MATCHED
    123456A-DH-1234   FEB 25, 2018 TEST,PATIENT    ABC INSURANCE

3   987654A           MAR 2, 2018  DEMO,PATIENT                MATCHED
    987654A-DH-130449 MAR 2, 2018  DEMO,PATIENT    TEST INSURANCE


+         Enter ?? for more actions
1  Edit Status
2  Run Auto Review
3  View Comment
Select Action:Next Screen//
```

Figure 2-4: Prior to patch 28, REV option displays a zero claim number stuck in a status of BUILT

```
BAR Claim Review              May 03, 2018 12:14:10          Page:    1 of    0
HIPAA 835 v5010     File: 1002_ERA_04/30/2018     Chk/EFT#: EFT9987655

#  Claim             Date         Patient           AR Account  Status
1   0                 JAN 12, 2018 PATIENT,DEMO                CLAIM UNMATCHED
                      **********REASONS NOT TO POST********
                            RA CLAIM NOT FOUND IN RPMS

2   123456A           FEB 25, 2018 TEST,PATIENT                MATCHED
    123456AA-DH-1234  FEB 25, 2018 TEST,PATIENT    ABC INSURANCE

3   987654A           MAR 2, 2018  DEMO,PATIENT                MATCHED
    987654A-DH-4567   MAR 2, 2018  DEMO,PATIENT    TEST INSURANCE


+         Enter ?? for more actions
1  Edit Status
2  Run Auto Review
3  View Comment
Select Action:Next Screen//
```

Figure 2-5: Patch 28 sets a zero claim number to CLAIM UNMATCHED with a Reason Not to Post

A correction was made to the ERA bill matching to allow users to bypass manual bill matching, if desired. If more than one RPMS bill is found for an ERA claim, a manual matching screen displays, and several options are displayed to choose from. One of the options is NOT MATCHED. Prior to patch 28, if NOT MATCHED was selected or if the user simply pressed Enter, all of the claims in the ERA file would be marked in error with a Reason Not to Post which prevented the entire file from auto-posting.

Patch 28 allows users to select NOT MATCHED during the manual bill matching or to press Enter without having the entire ERA file marked with a Reason Not to Post. Instead, only those claims that were NOT MATCHED will be marked with a Reason Not to Post of USER HAS OVERRIDEN AUTO-REVIEW AND SET STATUS TO 'NOT TO POST'. Any other Matched claims that do not have a Reason Not to Post will be allowed to auto-post.

```
BILL #             DOS     PATIENT NAME              BILLED AMT    BALANCE
ERA 123456A         03/12/2018 DEMO,GINA A                206.00
 1) 123456A-DH-111   03/12/2018 DEMO,GINA               206.00          206.00
 2) 123456B-DH-111   03/12/2018 DEMO,GINA               206.00          206.00
 3) 123456C-DH-111   03/12/2018 DEMO,GINA               206.00          206.00
Enter (B)ill Inquire,(H)istory,(M)atch to Item,(N)ot Matched,(Q)uit: Not Matched
PROCESSING ENTRY:      5  CLAIM 123456A
```

Figure 2-6: Selecting Not Matched in the A/R Bill Matching option

```
BAR Claim Review              May 11, 2018 11:00:18          Page:    1 of    3
HIPAA 835 v5010     File: 1007_ERA_05/11/2018     Chk/EFT#: EFT908070601

 #  Claim             Date         Patient           AR Account  Status
1   123456A           MAR 12, 2018 DEMO,PATIENT A                  CLAIM UNMATCHED
                     **********REASONS NOT TO POST********
        USER HAS OVERRIDDEN AUTO-REVIEW AND SET STATUS TO 'NOT TO POST'

2   123456B           MAR 12, 2018 DEMO,PATIENT A                  MATCHED
    123456B           MAR 12, 2018 DEMO,PATIENT A     TEST INSURANCE

2   123456C           MAR 12, 2018 DEMO,PATIENT A                  MATCHED
    123456CA-DH-111   MAR 2, 2018  DEMO,PATIENT A    TEST INSURANCE

+         Enter ?? for more actions
1  Edit Status
2  Run Auto Review
3  View Comment
```

Figure 2-7: New Reason Not to Post when NOT MATCHED is selected for manual bill matching

A correction was made to accommodate payment reversals in an ERA file. Prior to patch 28, if an ERA file contained at least one payment reversal, all of the claims in the file would be marked with the following Reason Not to Post and the file would not auto-post without OIT intervention: ERA TOTAL GREATER THAN BATCH/ITEM TOTAL.

Patch 28 will match up payment reversals with an equal or greater dollar amount of payments and will mark only those payment reversals and payments with the following Reason Not to Post: PAYMENT REVERSAL FOUND -- MUST DO MANUAL POSTING. The highest payment amount will be used first to reduce the number of payments that must be posted manually. Any other Matched claims that do not have a Reason Not to Post will be allowed to auto-post.

```
Now will look for PLBs, Payment Reversals, and Negative Payments...

Looking for PLB Segment... No PLB Segments found

Looking for Payment Reversals... PAYMENT REVERSAL FOUND
   Bills will be marked Not To Post to accommodate
      E-Bill#             E-Pymt      E-Claim Status Code
1     456789A             -200.00     22 | Reversal of Previous
      987654A              325.00      1 | Processed as Primary


Looking for Negative Payments... No Negative Payments found
<CR> - Continue:
```

Figure 2-8: BLMT option will match up payment reversals with an equal or greater amount of payments

```
BAR Claim Review              May 03, 2018 12:14:10          Page:    1 of    0
HIPAA 835 v5010     File: 1004_ERA_04/30/2018     Chk/EFT#: EFT9987655

#  Claim             Date         Patient           AR Account  Status
1   456789A          APR 5, 2018  DEMO,PATIENT                   MATCHED
                     **********REASONS NOT TO POST********
                PAYMENT REVERSAL FOUND -- MUST DO MANUAL POSTING
    456789A-DH-3333  APR 05, 2018 DEMO,PATIENT      TRAVELERS INDEM

2   987654A           APR 20, 2018 PATIENT,TEST                   MATCHED
                     **********REASONS NOT TO POST********
                PAYMENT REVERSAL FOUND -- MUST DO MANUAL POSTING
    987654A-DH-2222  APR 20, 2018 PATIENT,TEST      TRAVELERS INDEM

3   112233A           APR 20, 2018 TEST,DEMO A                    MATCHED
    112233A-DH-4444   APR 20, 2018 TEST,DEMO A      TRAVELERS INS

+         Enter ?? for more actions
1  Edit Status
2  Run Auto Review
3  View Comment
Select Action:Next Screen//
```

Figure 2-9: REV option shows payment reversals and the payments that were matched up and marked as Not to Post

2.4 Reports

2.4.1 Patient Payment Summary

COL > PPS

A new report titled Patient Payment Summary has been added to the Account Management Reports Menu and contains the payment information posted to bills for batches created during a certain time frame. It will prompt for one or more patients and a Collection Batch start and end date. The header of the report for each patient will contain the Total Amount Batched, the Amount Posted, the remaining amount available To Be Posted, and the number of payments posted so far (Num of Pymts Posted). If no data is found for the selected patient and date range, the fields in the report header will display zeros.

Within the body of the report, the information listed below will be displayed. If no batches are found for the patient selected and the date range used, the report will display *** NO DATA TO PRINT ***.

- Collection Batch: displays a list of A/R Collection Batches found that contain batched payments for the selected patient
  - Comment: displays Collection Batch Item comments that were made during collection batch creation, if any
- Item Receipt#: displays the receipt number that was generated in the Prepayment Collections option, if the Prepayment Collections option was used to record the patient payment
- Type: displays the method of payment selected during collection batch creation (CA for Cash, CC for Credit Card, or CK for Personal Check)
- Batched Amount: displays the dollar amount that was batched for the Collection Batch Item shown
- Bill Number: displays the bill number that a payment has been posted to from within the Collection Batch Item that’s displayed, if any
- Posted Amount: displays the dollar amount posted to bills displayed in the Bill Number field, if applicable

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |        ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28          |
            +                Patient Payment Summary                  +
            |                   2017 DEMO HOSPITAL                    |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: PINTO-YAZZIE,ANGELA     BUSINESS OFFICE     25-MAY-2018 10:43 AM
Select A/R Account: NO CASH,DEMO  NO CASH,DEMO
Select Another A/R Account:

 ============ Entry of A/R Collection Batch Range =============
```

```
Enter A/R Collection Batch STARTING DATE for the Report:  040118

Enter ENDING DATE for the Report:  043018

Print Collection Batch Comments (if Present)? No// YES
Enter DEVICE: HOME//   VT
```

Figure 2-10: Report parameters for Patient Payment Summary

```
                          Patient Payment Summary
                             2017 DEMO HOSPITAL
MAY 18,2018@12:26                                                      Page 1
------------------------------------------------------------------------------
   Patient Name: NO CASH,DEMO                    HRN: 185963

Total Amount Batched:     2,175.00               Num of Pymts Posted: 1
       Amount Posted:       120.78
        To Be Posted:     2,054.22
------------------------------------------------------------------------------
                                                 Batched   Bill        Posted
Collection Batch         Item Receipt#    Type     Amount   Number      Amount
------------------------------------------------------------------------------

PT PYMT-04/10/2018-2       1               CK    1,500.00 402238A-DH    120.78

PT PYMT-04/10/2018-2       2               CA      250.00
  Comment:
    THIS IS A COLLECTION BATCH COMMENT.
PT PYMT-04/10/2018-2       3               CC      250.00

                                                 _________             _________
                                                  2,175.00               120.78


REPORT COMPLETE FOR NO CASH,JOHNNY
```

Figure 2-11: Patient Payment Summary

2.4.2 Provider Visit Count Report

RPT > AMRM > PVCR

A new report titled Provider Visit Count Report (PVCR) has been added to the Account Management Reports Menu. This report was designed to assist with MACRA (Medicare Access and CHIP Reauthorization Act) reporting. It will prompt for Approval Date or Visit Date, a date range, the desired bill type (inpatient, outpatient, or both), and one or more user-specified providers or all providers. The report will list the number of bills, amount billed, and amount paid for bills that have an insurer type of 'Medicare FI' and meet the selection parameters chosen.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
           |        ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28          |
           +              Provider Visit Count Report                +
           |                   2017 DEMO HOSPITAL                    |
           +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: PINTO-YAZZIE,ANGELA     BUSINESS OFFICE     25-MAY-2018 10:45 AM
```

```
NOTE:  This report will contain data for all Visit Locations where a provider
       saw Medicare patients.  There will be a summary line for each provider
       under each Visit Location, with detail lines underneath that breaks down
       the data further by bill type and visit type.

     Select one of the following:

          1         Approval Date
          2         Visit Date

Select TYPE of DATE Desired: 1  Approval Date

 ============ Entry of APPROVAL DATE Range =============

Select Beginning Date: 010117  (JAN 01, 2017)
Select Ending Date: 123117  (DEC 31, 2017)

     Select one of the following:

          1         Inpatient
          2         Outpatient
          3         Both Inpatient and Outpatient

Select ENCOUNTER TYPE Desired: 3  Both Inpatient and Outpatient

Select PROVIDER: DOCTOR,MARY
Enter DEVICE: HOME//   VT
```

Figure 2-12: Report parameters for Provider Visit Count Report

```
================================================================================
Provider Visit Count Report                        APR 26,2018@13:39   Page 1
For Medicare
at ALL Visit Locations under 2017 DEMO H Billing Location
with VISIT DATES from 01/01/2017 to 12/31/2017
for ALL BILL TYPES
================================================================================
Provider                                Bill Count    Amount Billed  Amount Paid
================================================================================

DOCTOR,MARY                             69            24,145.13      718.99
   Bill Type: 999
     Visit Type: 131 OUTPATIENT              3            1,097.13          0.00
     Visit Type: 501 UNBILLABLE              1            1,104.00          0.00
     Visit Type: 999 PROFESSIONAL COM       65           21,944.00        718.99



REPORT COMPLETE
```

Figure 2-13: Provider Visit Count Report run for one provider

To run the report for all providers, press Enter at the ‘Select PROVIDER’ prompt, but keep in mind that the report could be lengthy depending on how many providers are set up in your database as each provider’s name will be listed even if there is no data to report.

```
Select PROVIDER: ALL

Enter DEVICE: HOME//   VT

================================================================================
Provider Visit Count Report                        JUN 1,2018@14:40   Page 1
For Medicare
at ALL Visit Locations under 2017 DEMO H Billing Location
with VISIT DATES from 05/01/2018 to 06/01/2018
for ALL BILL TYPES
================================================================================
Provider                                 Bill Count    Amount Billed  Amount Paid
================================================================================

No data for Provider DOCTOR-A,CHARLENE F


No data for Provider DOCTOR-B,JOSEPH JR


No data for Provider DOCTOR-C,DEBBIE L


No data for Provider DOCTOR-D,STEVEN C


No data for Provider DOCTOR-E,KEITH L
```

Figure 2-14: Provider Visit Count Report run for all providers with no data to report

2.4.3 UFMS Age Summary Report

RPT > ARM > USM

Several changes were made to the UFMS Age Summary Report (USM) to provide for easier and more accurate reporting. The report was modified so that it can now be generated for a range of fiscal years, if desired. A correction was also made to how the end date is calculated so that the entire last day of a fiscal year is included in the data being reported, and the report will now use the 3P APPROVAL DATE for calculating aged bills, rather than using the BILLED DATE.

Prior to patch 28, the report contained screen breaks that required users to repeatedly press Enter to get to the end of the report. These screen breaks were removed, and a message was added advising that the report should be exported, or the user's session logged so that the entire report can be viewed.

Finally, the output method was corrected so that the report will no longer be automatically tasked. Now, in order to the task the report, the user will have to type **Q** at the 'Device' prompt. This is in line with other reports in RPMS.

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
          |        ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28          |
          +                UFMS Age Summary Report                  +
          |                   2017 DEMO HOSPITAL                    |
```

```
          +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
     User: PINTO-YAZZIE,ANGELA     BUSINESS OFFICE     25-MAY-2018 10:59 AM


BULK for Billed Date prior to 10/1/2008 will run automatically.
Enter FYnn-FYnn for a range of Fiscal Years e.g. FY09-FY12

Enter FISCAL YEAR for the Report: FY08-FY18// FY16-FY18

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

Select Visit LOCATION: ALL

     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              (INS TYPES R MD MH MC MMC)
          2         MEDICAID              (INS TYPES D K FPL)
          3         PRIVATE INSURANCE     (INS TYPES P H F M)
          4         VETERANS              (INS TYPES V)
          5         OTHER                 (INS TYPES W C N I G T SEP TSI)

Select TYPE of ALLOWANCE CATEGORY to Display: ALL

     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: 1//   Summarize by ALLOW CAT/BILL ENTITY/INS TYPE

This report is designed to be session logged or sent to a
host file server device with no pauses between reports or full
screens of information so please take appropriate steps to
allow viewing of the entire report.


Enter RETURN to continue or '^' to exit:
DEVICE: HOME//   VT    Right Margin: 80//
```

Figure 2-15: UFMS Age Summary Report changes to Fiscal Year prompt and new message being displayed

2.4.4 Days in AR

RPT > FRM > DAYS

The Days in AR (DAYS) report has been modified to report more accurate data, to provide detailed data, and to allow for exporting the report as either a delimited report or as a spreadsheet xml formatted report.

After a Date Range has been selected along with any of the other desired parameters, a new prompt will be displayed that allows for selecting a Summary report or a Detail report. The Summary report is the pre-patch 28 report and is simply a summary of data based on the selected parameters. The Summary report can be exported as a Delimited file, with a caret '^' being the delimiter, or it can be exported as a report that does not require formatting and can be viewed using a text editor like Notepad.

Note: When exporting the report, type **HFS** at the 'Device' prompt. At the 'HOST FILE NAME' prompt, type the name of your directory path (where you want the report exported to) and give the report a name. The directory path at your facility will most likely be different than the directory path shown in the examples below.

```
     Select one of the following:

          S         SUMMARY
          D         DETAIL

SUMMARY OR DETAIL REPORT: SUMMARY//
DELIMITED? NO// YES
DEVICE: HOME// HFS  HOST FILE SERVER
HOST FILE NAME: C:\TEMP\//C:\PUB\DAYS SUMMARY  ADDRESS/PARAMETERS: "WNS"//
```

Figure 2-16: Exporting the DAYS Summary report as a delimited file

The Detail report is new in patch 28. When run for the same parameters as the Summary report, the Detail report will provide information on each bill that was used to calculate the numbers on the Summary report. This detailed information can be used to validate the data on the Summary report. It can also be used to identify individual visits, claims, or bills that got delayed in the revenue generation process at some point.

The Detail report also allows for exporting a delimited report or an XML report. The XML report will be automatically formatted for use in Excel 2013 or higher when the report is retrieved from your server. When using the XML option, it is important to use XML as the extension name of the exported report.

```
Select one of the following:

          S         SUMMARY
```

```
          D         DETAIL

SUMMARY OR DETAIL REPORT: SUMMARY// DETAIL

     Select one of the following:

          D         DELIMITED
          X         XML

Please select DELIMITED file or a spreadsheet XML file: DELIMITED// XML

NOTE: the DETAIL should be written to a HFS host file.
The report is in spreadsheet XML format so please use an xml
suffix on the file name.
i.e. 'c:\temp\daysreport.xml'

DEVICE: HOME// HFS  HOST FILE SERVER
HOST FILE NAME: C:\TEMP\//C:\PUB\DAYS DETAILED.XML  ADDRESS/PARAMETERS: "WNS"//
```

Figure 2-17: Exporting the DAYS Detail report as an XML delimited file

```
Select one of the following:

          S         SUMMARY
          D         DETAIL

SUMMARY OR DETAIL REPORT: SUMMARY// DETAIL

     Select one of the following:

          D         DELIMITED
          X         XML

Please select DELIMITED file or a spreadsheet XML file: DELIMITED//

NOTE: the DETAIL should be written to a HFS host file.

DEVICE: HOME// HFS  HOST FILE SERVER
HOST FILE NAME: C:\TEMP\//C:\PUB\DAYSDETAILED  ADDRESS/PARAMETERS: "WNS"//
```

Figure 2-18: Exporting the DAYS Detail report as a delimited file

The Summary report provides the following data:

- Number of visits
- Number of visits that resulted in bills being approved
- Total number of bills
- Total billed amount
- Average visits checked in
- Average days to create PCC
- Average days to review
- Average days to approve bill

- Average days to export bill
- Average days to receipt of payment
- Average days to post first payment
- Average days to post last payment
- Total dollar amount of payments posted

The Detail report provides the following data:

- Visit Internal Entry Number (IEN)
- Month and year that the service was rendered
- Visit Location
- Visit Admit Date (Date of Service)
- Date Patient Care Component (PCC) visit was created
- Number of days it took for PCC visit to be created
- The date when PCC visit was reviewed
- Number of days it took for PCC visit to be reviewed
- Bill Number
- Date the bill was approved in Third Party Billing
- Number of days it took for claim to be approved in Third Party Billing
- Date the bill was exported to the payer
- Number of days it took for bill to be exported
- Date the collection batch was finalized
- Number of days it took to finalize the collection batch
- Date the first transaction was posted to the bill
- Number of days it took to post the first transaction
- Date the last transaction was posted to the bill
- Number of days it took to post the last transaction
- Provider name
- Billed Amount
- If more than one bill was created for a PCC visit, that bill will be listed in the next column (BILL NUM 2) followed by all of the other columns listed above.

2.4.5 Adjustment & Refund Reports

RPT > FRM > ADJA/ADJT

Several changes have been made to the existing Adjustment & Refund Report to provide accurate data and also to allow for running a report by bill approve date or by transaction date. The name of the Adjustment & Refund Report has been changed to Adjustment & Refund Report by Bill Approval Date (ADJA), and a new report named Adjustment & Refund Report by Transaction Date (ADJT) has been added.

The ADJA report will now use the 3P APPROVAL DATE rather than the A/R transaction date when searching for data to report. Prior to patch 28, the column that reported the adjustment category was incorrectly named Adjustment Amount. This column is now named Adjustment Category and an additional column was added to report the Adjustment Amount. A correction was also made to the #DAYS column so that it reports data. Prior to patch 28, this column was not being populated.

The ADJT report is identical to the ADJA report, except the ADJT report will provide information based on a bill's transaction date, or the date a transaction was posted.

Because of the amount of data provided on these reports, they are best viewed when exported to a Host File Server and imported into a spreadsheet application like Excel.

```
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
            |        ACCOUNTS RECEIVABLE SYSTEM - VER 1.8p28          |
            +                 Financial Reports Menu                  +
            |                   2017 DEMO HOSPITAL                    |
            +-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+-+
      User: PINTO-YAZZIE,ANGELA     BUSINESS OFFICE     18-MAY-2018 2:49 PM


    ADA    Advise of Allowance RPT
    IPDR   Inpatient Primary Diagnosis Report
    PRP    Payment Summary Report by Collection Batch
    PSR    Period Summary Report
    TDN    Payment Summary Report by TDN
    STA    A/R Statistical Report
    TAR    Transaction Report
    TSR    Transaction Statistical Report
    DAYS   Days in AR
    ADJA   Adjustment & Refund Report by Bill Approve Date
    ADJT   Adjustment & Refund Report by Transaction Date
    AWOR   Automatic Write-Off Report
    PAY    Top Payer Report
    NBR    Non-Ben Payment Report
```

Figure 2-19: Financial Reports Menu now provides two Adjustment & Refund Reports

2.5 Updates to Standard Adjustment Reason Codes

Patch 28 contains the most recent updates to Standard Adjustment Reason (SAR) codes as published by the Washington Publishing Company (WPC) on 3/1/2018 and will be added to the A/R EDI STND CLAIM ADJ REASONS file automatically when patch 28 is installed. These updates include 28 new codes as well as numerous changes to some of the existing code descriptions. SAR codes are used by the Electronic Remittance Advice posting option and can also be utilized via the manual posting options (PAY,ADJ, etc.). It is important to note that adjustment codes numbered 1000 and higher are local codes that are specific to each facility and will not be affected by this patch.

The following is a list of new SAR codes that have been added to A/R with the installation of patch 28. To export a complete list of SAR codes from RPMS, use the 'Create Report Std Adjustment Reason Codes' option in the A/R Posting menu (PST – RADJ). To view a complete list of SAR codes as released by the Washington Publishing Company, visit their website at http://www.x12.org/codes/claim-adjustment-reason-codes/.

Table 2-1: New SAR Codes Added to RPMS

SAR Code # from WPC	RPMS FULL STANDARD CODE DESCRIPTION To view complete SAR code descriptions, go to the Washington Publishing Company website at www.wpc-edi.com	RPMS Adjustment Category Code	RPMS Adjustment Category	RPMS Adjustment Reason Code	RPMS Adjustment Reason
259	Additional payment for Dental/Vision service utilization.	22	General Information	309	Addl Pmt dntal/vision Svc Util
260	Processed under Medicaid ACA Enhanced Fee Schedule	22	General Information	310	Prcsd undr McdACA enhncd f/sch
261	The procedure or service is inconsistent with the patient's history.	4	Non Payment	311	Proc/Srv incnsistnt w/PtHistry
262	Adjustment for delivery cost. Usage: To be used for pharmaceuticals only.	4	Non Payment	312	Adj for delivery cost(RX only)
263	Adjustment for shipping cost. Usage: To be used for pharmaceuticals only.	4	Non Payment	313	Adj for shipping cost(RX only)
264	Adjustment for postage cost. Usage: To be used for pharmaceuticals only.	4	Non Payment	314	Adj for postage cost (RX only)
265	Adjustment for administrative cost. Usage: To be used for pharmaceuticals only.	4	Non Payment	315	Adj for admin cost (RX only)
266	Adjustment for compound preparation cost. Usage: To be used for pharmaceuticals only.	4	Non Payment	316	Adj, compnd prep cost(RX only)
267	Claim/service spans multiple months. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.)	4	Non Payment	317	Rebill sep clm/sv for month sv

SAR Code # from WPC	RPMS FULL STANDARD CODE DESCRIPTION To view complete SAR code descriptions, go to the Washington Publishing Company website at www.wpc-edi.com	RPMS Adjustment Category Code	RPMS Adjustment Category	RPMS Adjustment Reason Code	RPMS Adjustment Reason
268	The Claim spans two calendar years. Please resubmit one claim per calendar year.	4	Non Payment	318	Resub one clm per cal year
269	Anesthesia not covered for this service/procedure. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4	Non Payment	319	Anesthesia not cov for proc
270	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's dental plan for further consideration.	4	Non Payment	320	Ben not avail-Submit to dental plan
271	Prior contractual reductions related to a current periodic payment as part of a contractual payment schedule when deferred amounts have been previously reported. (Use only with Group Code OA)	4	Non Payment	321	Prior contractual reductions
272	Coverage/program guidelines were not met.	4	Non Payment	322	Cvg/program guidelines not met
273	Coverage/program guidelines were exceeded.	4	Non Payment	323	Cvg/progrm guidelines exceeded
274	Fee/Service not payable per patient Care Coordination arrangement.	4	Non Payment	324	Not payable-PtCareCoord arngmt
275	Prior payer's (or payers') patient responsibility (deductible, coinsurance, co-payment) not covered. (Use only with Group Code PR)	4	Non Payment	325	Prior payer pt resp not coverd

SAR Code # from WPC	RPMS FULL STANDARD CODE DESCRIPTION To view complete SAR code descriptions, go to the Washington Publishing Company website at www.wpc-edi.com	RPMS Adjustment Category Code	RPMS Adjustment Category	RPMS Adjustment Reason Code	RPMS Adjustment Reason
276	Services denied by the prior payer(s) are not covered by this payer.	4	Non Payment	326	Svc denied by prior payer
277	The disposition of the claim is undetermined during the premium payment grace period per Health Insurance SHOP Exchange requirements.	22	General Information	327	Undetermined-prem grace period
278	Performance program proficiency requirements not met. (Use only with Group Codes CO or PI)	4	Non Payment	328	Performance prgm req not met
279	Services not provided by Preferred network providers. Usage: Use this code when there are member network limitations. For example, using contracted providers not in the member's 'narrow' network.	4	Non Payment	329	Svc not prov by network prov
280	Claim received by the medical plan, but benefits not available under this plan. Submit these services to the patient's Pharmacy plan for further consideration.	4	Non Payment	330	Submit to RX plan
281	Deductible waived per contractual agreement. Use only with Group Code CO.	4	Non Payment	331	Ded waived-contract agreement
282	The procedure/revenue code is inconsistent with the type of bill. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	4	Non Payment	332	Proc/Rev code inconst w/TOB

SAR Code # from WPC	RPMS FULL STANDARD CODE DESCRIPTION To view complete SAR code descriptions, go to the Washington Publishing Company website at www.wpc-edi.com	RPMS Adjustment Category Code	RPMS Adjustment Category	RPMS Adjustment Reason Code	RPMS Adjustment Reason
283	Attending provider is not eligible to provide direction of care.	4	Non Payment	333	Prov not elig to prov dir care
284	Precertification/authorization/notification/ pre-treatment number may be valid but does not apply to the billed services.	4	Non Payment	334	Precert does not apply to srv
285	Appeal procedures not followed	4	Non Payment	335	Appeal proc not followed
286	Appeal time limits not met	4	Non Payment	336	Appeal time limits not met
287	Referral exceeded	4	Non Payment	337	Referral exceeded
288	Referral absent	4	Non Payment	338	Referral absent
289	Services considered under the dental and medical plans, benefits not available. Notes: Also see CARCs 254, 270 and 280.	4	Non Payment	339	Svc cvrd by med/dent, no bnfts
290	Claim received by the dental plan, but benefits not available under this plan. Claim has been forwarded to the patient's medical plan for further consideration.	4	Non Payment	340	No bnfts-Forward to med plan
291	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's dental plan for further consideration.	4	Non Payment	341	No bnfts-Forward to dentl plan
292	Claim received by the medical plan, but benefits not available under this plan. Claim has been forwarded to the patient's pharmacy plan for further consideration.	4	Non Payment	342	No bnfts-Forward to pharm plan

SAR Code # from WPC	RPMS FULL STANDARD CODE DESCRIPTION To view complete SAR code descriptions, go to the Washington Publishing Company website at www.wpc-edi.com	RPMS Adjustment Category Code	RPMS Adjustment Category	RPMS Adjustment Reason Code	RPMS Adjustment Reason
293	Payment made to employer.	4	Non Payment	343	Payment made to employer
294	Payment made to attorney.	4	Non Payment	344	Payment made to attorney
295	Pharmacy Direct/Indirect Remuneration (DIR)	4	Non Payment	345	RX Direct/IndirectRemuneration
P24	Payment adjusted based on Preferred Provider Organization (PPO).	4	Non Payment	424	Pmt Adj-PPO
P25	Payment adjusted based on Medical Provider Network (MPN).	4	Non Payment	425	Pmt Adj-MPN
P26	Payment adjusted based on Voluntary Provider network (VPN).	4	Non Payment	426	Pmt Adj-VPN
P27	Payment denied based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies.	4	Non Payment	427	Pmt Den-Liab Coverage Benefts
P28	Payment adjusted based on the Liability Coverage Benefits jurisdictional regulations and/or payment policies.	4	Non Payment	428	Pmt Adj-Liab Coverage Benefts
P29	Liability Benefits jurisdictional fee schedule adjustment.	4	Non Payment	429	Liab Bnfts fee sched adjust

Acronym List

Acronym	Term Meaning
3P	Third Party
A/R	Accounts Receivable
ABM	Third Party Billing
ADJ	Post Adjustments
ERA	Electronic Remittance Advice
ETC	Et cetera
MACRA	Medicare Access and CHIP Reauthorization Act
OIT	Office of Information Technology
XML	eXtensible Markup Language
PAY	Post Payments and Adjustments
PCC	Patient Care Component
RPMS	Resource and Patient Management System
SAR	Standard Adjustment Reason
UFMS	United Financial Management System
WPC	Washington Publishing Company

Contact Information

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