Insurance User Guide

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by Evident

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Evident™

Insurance User Guide

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications and vendor specifications provided by CMS, ONC and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces the new features and improvements for the **Insurance** application for release Version 22.01. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 22.01 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Work Request (WR) Number and the description. If further information is needed, please contact **Client Services** Support.

Unbilled Insurance Report - New Columns -- FA-13215

DESCRIPTION: When running the Unbilled Insurance Report in CSV format, users may now add the following new columns by selecting them from the Advanced tab:

- Accountants Category Code
- Accountants Category Description
- HIM Coding Status
- HIM Coding Status Datetime
- HIM Coding Status User Name

DOCUMENTATION: See Unbilled Insurance Report - Report Writer 267

Chapter 2 Overview

The TruBridge EHR Insurance System integrates information from Registration, Health Information Management and Account Detail to assist in the creation and the filing of insurance claims. The goal of the Insurance System is to organize and simplify the functions associated with the billing process.

The Insurance Billing process begins in Registration with the collection of insurance coverage information. This process is vital to billing. At the time of Registration, the insurance company, contract number, group name and number and subscriber information are entered into the system. If any of this information is not gathered, the billing process for the specific accounts will not be able to proceed. Therefore, it is vital to stress the importance of gathering all relevant insurance information at the time of Registration.

Coding of a patient's account also plays an important role in insurance billing. Once the diagnoses and procedures are entered by the Health Information Management department, a finish date will be entered. This signals the account has been coded completely, a DRG has been computed and the account is ready to proceed in the billing process.

Two reports indicate the Medical Record status of claims and should be reviewed by both the Health Information Management and Insurance departments. The Approved Waiting for Charges report and the Claims with Missing Information report both contain a column titled "Medical Records Complete?" If answered Y, the account has been coded and contains a finish date.

TruBridge EHR also utilizes Account Detail entered into the system during the billing process. Charges posted to an account are pulled to the claim when it is generated, as well as, patient and subscriber information. There are also several tables which directly affect the generation of claims. Therefore, it can be seen that many aspects of the system and the information entered, directly affect the insurance billing process, which will be explored further in this user guide.

NOTE: *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY or YYMMDD to be used throughout the Insurance application. A TruBridge Representative will need to be contacted in order for the date format to be changed.*

Major Financial Classes

The TruBridge EHR Insurance System uses a Financial Class code to represent Insurance Companies used within the system. These codes may be up to three characters in length. Several codes have been reserved to represent the most common Financial Classifications. They are as follows:

B Blue Cross Carriers
C Commercial Carriers
M Medicare Carriers
P Private Pay Patients
S Tri-Care Carriers
W Workman's Compensation Carriers
X Medicaid Carriers

Inpatient Versus Outpatient Financial Classes

Each character in the Financial Class code is used to identify the type of claim more accurately. This is done by narrowing the description of the claim through the use of specific characters in each of the three positions. The system reads the alpha characters within the code to determine in which insurance company group it belongs. This allows the system to determine how the claim should be treated.

The first position is used to identify the insurance carrier. If this is the only character in the code, it is considered to be an Inpatient claim. Generally, this position will be occupied by one of the Financial Class codes previously identified. Inpatients typically have 1-character Financial Class code but may have a character in the second position.

The second position of this code will tell the system if this claim is for an Outpatient, a patient with physician components, or a specific Inpatient Financial Class. All Outpatient claims have a **B** in the second position. The insurance carrier's Financial Class code will occupy the first position, and a **B** will occupy the second position, indicating an Outpatient claim. Therefore, "MB" will be used to designate a claim as Medicare Outpatient.

Any type of patient may have accompanying physician charges. A **P** in the second position of the Financial Class code indicates a physician claim. "MP" would be the Financial Class code for a Medicare physician claim.

Inpatient Financial Class codes may have a numeric character in the second position to represent a specific insurance company. This would be used when there is a need to separate like Financial Classes. For example, if there are two Blue Cross plans in the area, "B" may be used for the most common Blue Cross plan, while using "B1" for the other Blue Cross plan.

Home Health claims and Swing Bed claims are often broken out under each Financial Class. An **H** in the second position of the Financial Class code is used to indicate a Home Health claim. "MH" would indicate a Medicare Home Health claim.

An **S** occupies the second position of the Financial Class code when this code is used for representing Swing Bed patients. Medicare Swing Bed claims are represented by "MS".

Inpatient claims may also have an alpha character in the second position of the Financial Class code, as long as it is something other than a "B", "H", "S" or "P".

The third position of the Financial Class code may be used in two ways. It may identify a specific group of Outpatients, or it may be used in combination with the second character position to identify a totally different type of claim.

As with the second position, a numeric character can be used to represent a specific group in a Financial Class. For example, if there are two Blue Cross plans that need to be identified, the first may use the code "BB" for Blue Cross Outpatient while the second may use "BB1".

Other Code Uses

The third position allows for additional manipulation of the Financial Class codes to fit the needs of the individual facility. Many times it is to the advantage of the facility to bill Therapy patients, Skilled Nursing Facility patients and non-patients using a unique Financial Class code. TruBridge suggests using the following codes to aid in the billing of these types of claims.

Therapy accounts or recurring Outpatient claims may use the third position to identify these claims by placing an "R" in the third position of the Financial Class code. This, along with other criteria, will allow the claims to be billed by a date range. For more information on monthly billing see Interim Billing Process.

Skilled Nursing Facility patients may be identified by "EC" as the second and third character positions. A Medicare Skilled Nursing Facility patient would have the Financial Class code "MEC".

With HMO's and Managed Care programs on the rise, facilities are interacting with large numbers of commercial carriers. Occasionally, the Financial Class code of "C" does not allow for the segmentation of all commercial carriers due to the volume of commercial insurances. Additional letters may be used to designate commercial insurances and allow further segmentation. The only letters which may not be used for the commercial insurances are the Financial Class codes which have already been designated by TruBridge EHR as major financial classifications.

NOTE: *Facilities outside of the United States may utilize a different address format to display* in select areas of the Insurance application*. The address may display the Province and Postal Code instead of the State and Zip Code when the Country Code field is set to a country code other than "US". A TruBridge Representative should be contacted for the foreign address fields to display.*

Chapter 3 Insurance Screens

3.1 Overview

This section will discuss the Insurance Billing screens. These screens are used to store information needed to print a UB, 1500 or state insurance form.

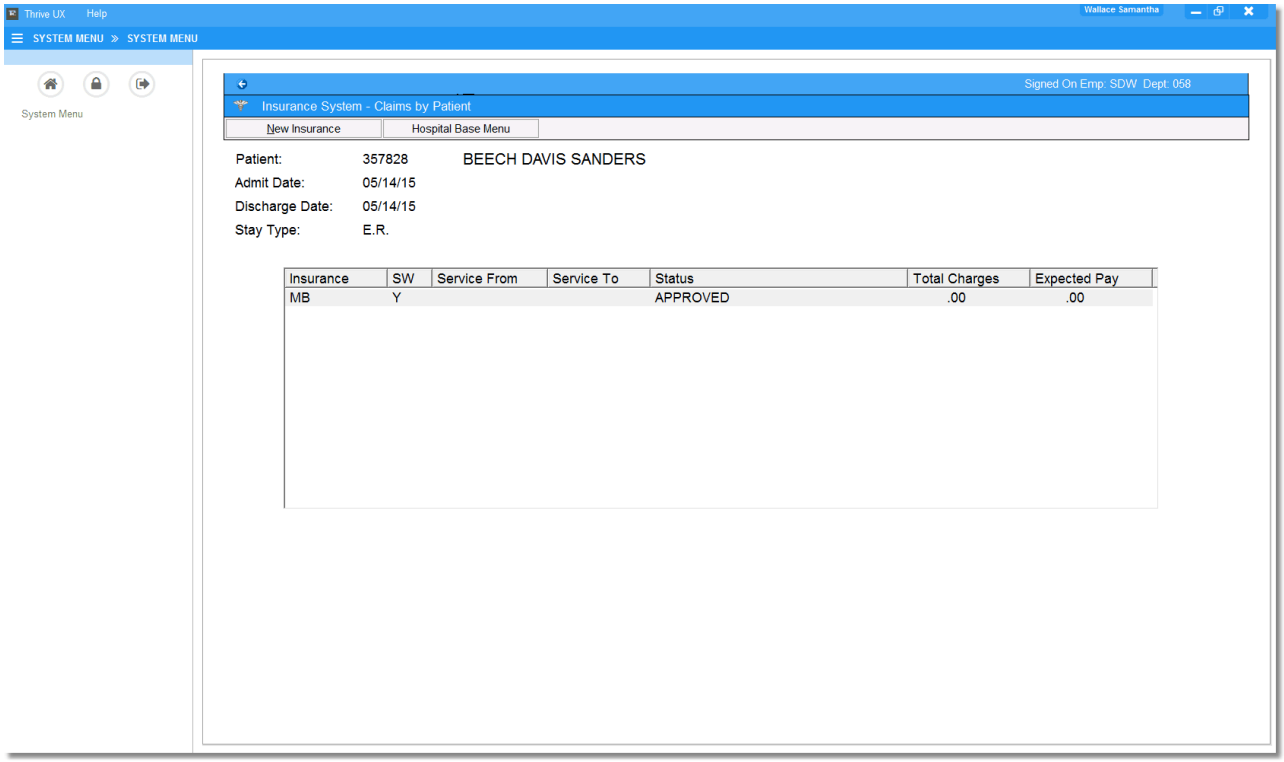
Information pulls to the Insurance screens from Registration, Medical Records and the Account Detail of the patient. Data may also be entered manually by the Insurance Billing department.

Each Financial Class code that is set up in Registration creates a claim within the system. The insurance process begins here. All claims set up for an account are displayed on the Claims by Patient screen.

3.2 Claims By Patient

The Claims by Patient screen displays all insurance claims on the account. The top portion of the screen will display the patient's account number, name, admit date, discharge date and stay type. The following information will display for each claim: financial class code, primary switch, service from and to dates, claim status, total charges and expected pay.

***NOTE**: If the Medical Necessity Control Table has the "ABN Notification" field selected, the message "ABN On File" will display when an Advance Beneficiary Notice (ABN) is signed and the prompt "Did Patient agree to sign the ABN?" is answered **Yes**.*



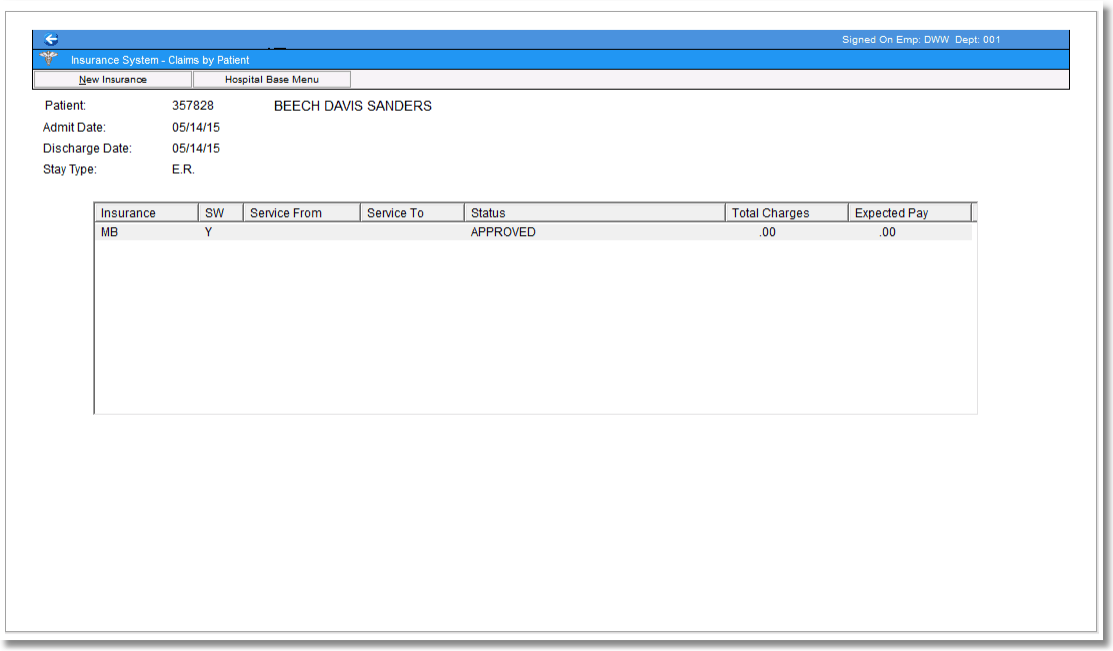
Claims by Patient

New Insurance

This option will be used to add a financial class to patient accounts.

***NOTE**: The New Insurance option will be disabled if Restrict Payer Disclosure 42 is selected on the Guarantor/Ins tab on the Registration and ADT screen.*

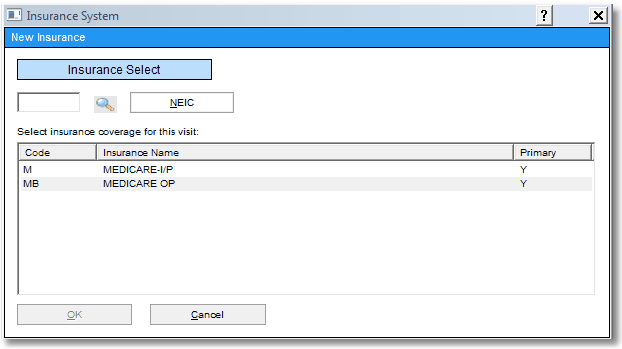
Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance**



Insurance System - Claims By Patient

NOTE: *For financial classes selected from the Person Profile, the insurance company's Name, Address-1, Address-2, City, State and Zip Code will copy from the Person Profile instead of the Insurance Company Table.*

When **New Insurance** is selected the following screen will be displayed.



Insurance System, New Insurance

Select **Lookup** to display a listing of financial classes by description.

- **NEIC:** Select **NEIC** to display a lookup for commercial payers only. This lookup uses the Financial Class description to display the Financial Classes available.

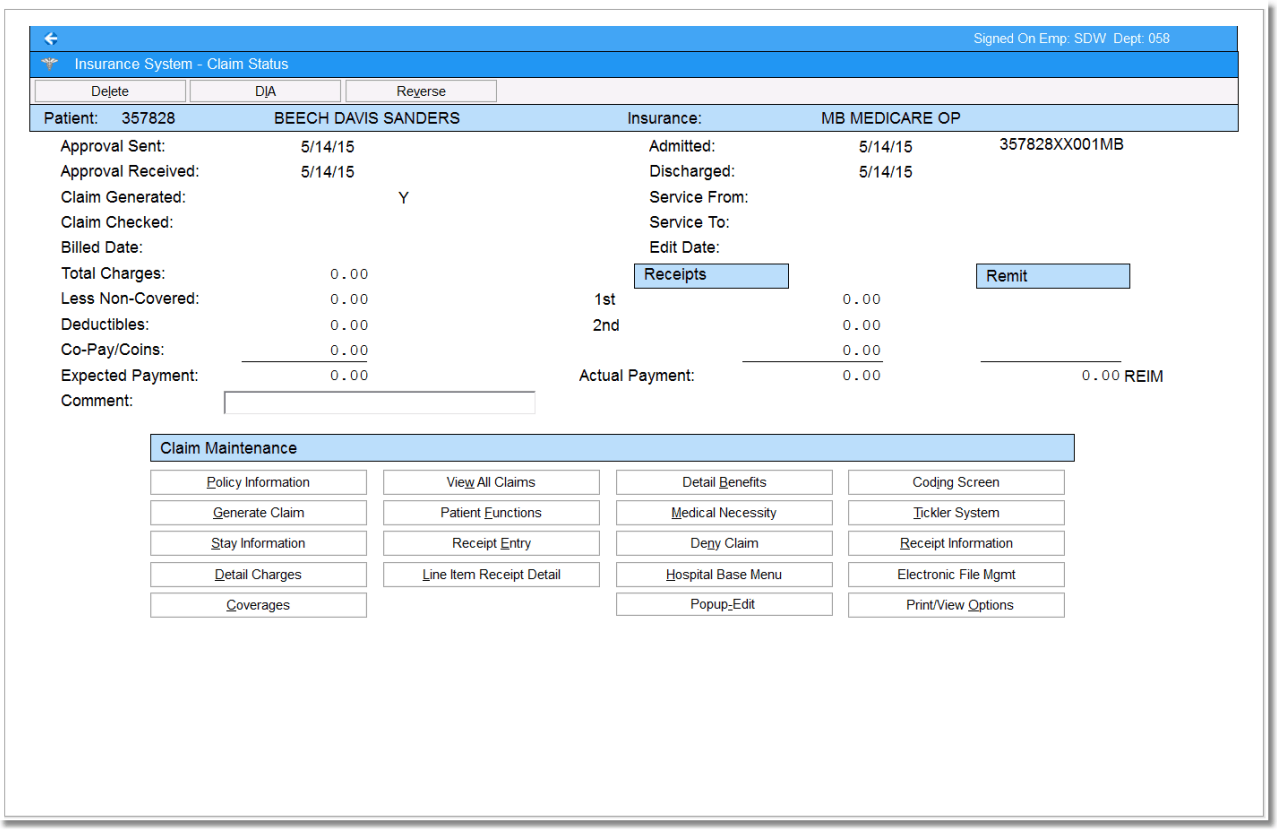
Hospital Base Menu

Selecting this option will return the cursor to the Hospital Base Menu.

3.3 Claim Status

To view a claim, select the desired Financial Class code. The system will then display the Claim Status screen. This screen outlines the overall status of the claim being processed. The lower portion of the screen offers a menu selection of additional insurance screens and the functions associated with the billing process.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim**

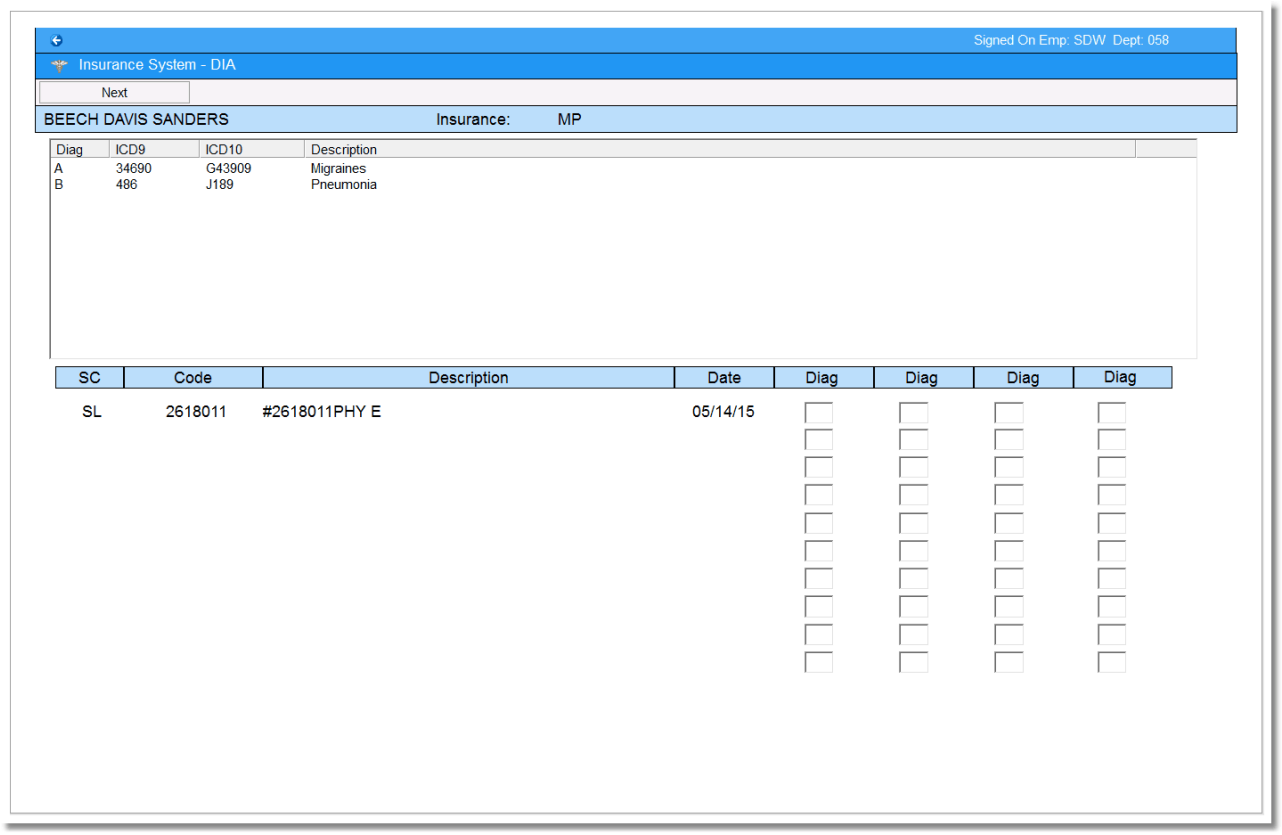


Insurance System - Claim Status

- **Delete:** Selecting this option will delete the claim from the account. It is important to remember if the claim is deleted from this option, it will be deleted from the account entirely. Deleting a claim in error may result in loss of patient information gathered during the registration process.

- **DIA:** The ability to associate a procedure with a diagnosis on a 1500 may be manipulated through the Insurance Claim Status screen by using diagnosis pointers. Select **DIA** to access the diagnosis pointers screen. The top 12 diagnoses from the Medical Records Grouper Screen will display at the top of the screen if the physician claim is generated. The first 10 generated charges will display at the bottom of the screen. To display the next 10 charges, select **Next** at the top of the screen. In the appropriate diagnosis column next to the charge line, enter the corresponding sequence letter of the diagnosis that should pull to locator 24E on the 1500. Up to four codes may be entered per charge line.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance > Claim > DIA**



Insurance System - DIA

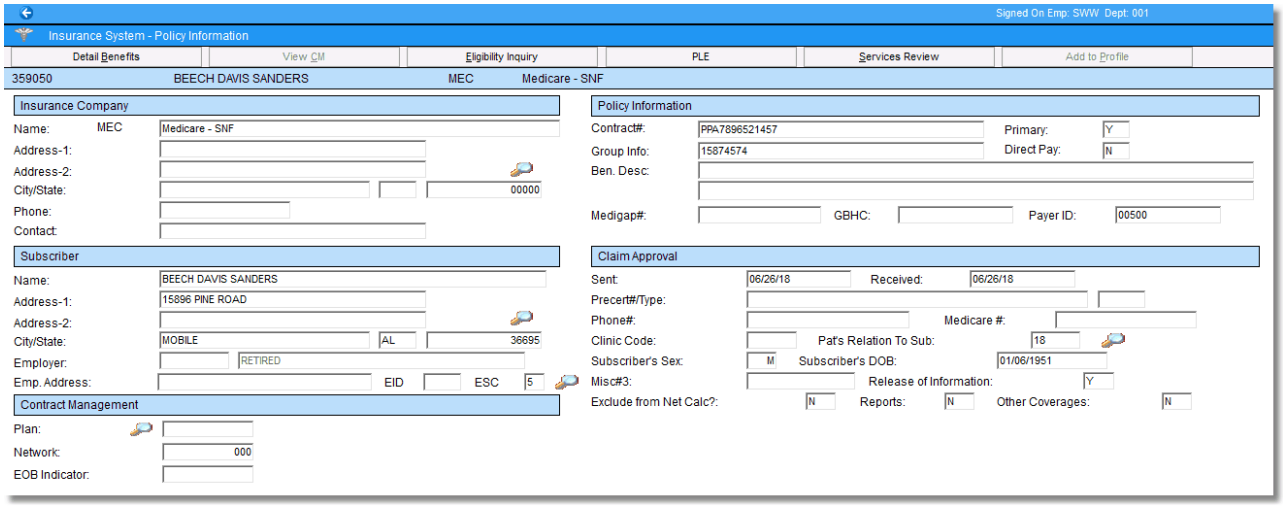
- **Reverse:** This option will reverse a billed claim to the Ready to Bill status. It will also reverse a rejected claim so it may be rebilled; however, the status will remain at Rejected. Refer to System Security for access to this option.

- **Comment:** This line will contain two types of information; either system generated or manually entered comments. If the claim is an APC claim, the system will place a note "(APC CLAIM)" on this line. When a note is entered manually, this is a free-text field. This field will pull to several Insurance reports and is also an available element in the Ad Hoc Reporting System.

3.4 Policy Information

This screen contains information about the insurance policy of the claim being processed. Information pulls from the Registration and ADT screen screens and the Insurance Company table. However, some fields require the information to be entered manually. Below is a description of each field on the Policy Information screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Policy Information**



Insurance System - Policy Information

Insurance Company

- **Name:** The Insurance Company name pulls from the Guarantor/Ins tab on the Registration and ADT screen. Once the Financial Class code is entered in the Insurance Information section, the name associated with the code is displayed. The system allows the name of the Insurance Company to be over-keyed, or if it is correct, select **Enter**. When entered into the Registration and ADT screen, the name pulls to the Policy Information screen. This pulls to locator 38 on the UB.

- **Address:** The Insurance Company address pulls from page 1 of the Insurance Company table. This pulls to locator 38 on the UB.

- **Phone:** The Insurance Company phone number pulls from the Prov Phone field on page 2 of the Insurance Company table.

- **Contact:** This field allows a contact name to be entered and will also pull from Policy Information.

Subscriber

- **Name:** The Subscriber name pulls the patient name from the Patient tab on the Registration and ADT screen for Medicare and Medicaid Financial Classes. For all other insurance types, the Guarantor name, from the Guarantor/Ins tab on the Registration and ADT screen screen will pull. As with the Insurance Company name, the Subscriber name may be over-keyed. This pulls to locator 58 on the UB.

- **Address:** The Subscriber address pulls from the Guarantor/Ins tab in the Guarantor Demographics section.

- **Employer:** The employer name pulls from the Guarantor/Ins tab in the Guarantor Work Information section. This pulls to locator 65 on the UB.

- **Emp Addr:** The employer address field pulls from the Guarantor/Ins tab in the Guarantor Work Information section.

- **EID:** The Employer Information Data (EID) field requires the information to be manually entered.

- **ESC:** The Employment Status Code (ESC) field can be manually entered or if entered in Policy Information, it will pull to this field. However, if this field is blank, a "22", which signifies “Unknown”, will print on the UB.

NOTE: *For financial classes other than Medicare and Medicaid whether the guarantor information, patient information or blank pulls is dependent on the setting in the Copy Guarantor Info to Ins. Subscriber field on page 8 of AHIS.*

Contract Management

The Contract Management fields are used for facilities that have purchased the Contract Management application.

- **Plan:** Information entered in the Guarantor/Ins tab in the Registration and ADT screen, Policy Information, will pull, or the information may be manually entered. There is a lookup option.

- **Network:** Information entered in the Guarantor/Ins tab in the Registration and ADT screen, Policy Information, will pull, or the information may be manually entered.

- **EOB Indicator:** Enter a **Y** if a paper EOB is requested. If no paper EOB is requested, enter an **N**.

Policy Information

- **Contract #:** The Contract Number may be manually entered or if entered in the Guarantor/Ins tab on the Registration and ADT screen, Policy Information, it will pull to this field. This pulls to locator 60 on the UB.

- **Primary:** Answer **Y** to indicate this is the primary claim for the account. Using a **2** or **3** will designate these claims as secondary insurances. The system will then order the claims marked with a **2** as secondary claims and the claims with a **3** as tertiary claims.

- **Group Info:** The Group Information should include a **/** (forward slash) to separate the group name and number. If there is no group name, then the **/** should precede the group number. This information may be manually entered or if entered in the Guarantor/Ins tab on the Registration and ADT screen, Policy Information, will pull to this field. This pulls to locator 61 and 62 on the UB.

- **Direct Pay:** The Direct Pay field requires the information to be entered manually. This is a 1-character field that accepts a **Y** or **N**. If the field is blank or answered **N**, the facility will receive the reimbursement. If the patient should receive the reimbursement, this field should be answered **Y**.

- **Benefit Desc:** The Benefit Description field's use varies from state to state. If necessary, information will be entered manually. This field will hold up to 110 characters of which 108 will transmit electronically. Type **XMIT** in the first four spaces of this field, and type what needs to pull to locator 19 on the 1500 form or to locator 80 on the UB. When using XMIT up to 91 characters will pull to locator 80 on the UB and up to 45 characters will pull to locator 19 on the 1500. To accommodate up to 71 characters on the 1500, type **1500** in the first four spaces of this field and type what need to pull to locator 19 on the 1500.

- **Medigap #:** The Medigap number is used for certain Intermediaries. This number pulls from page 3 of the Insurance Company table.

- **GBHC:** The Georgia Better Health Care (GBHC) is state specific.

- **Payer ID:** The Payer Identification field should remain blank until further notification. Once the HCFA mandate has been completed, this Payer ID will pull to claims in the place of the insurer's name and address. The Payer ID pulls from page 4 of the Insurance Company table.

Claim Approval

- **Sent:** This field is updated with the current date as soon as a claim is set up. There are two ways to set up a claim. The first is by adding the Financial Class code associated with the patient's Insurance Company on the Guarantor/Ins tab of the Registration and ADT screen. The second is by entering **New Insurance** at the top of the Insurance Claims by Patient screen, then keying in the Financial Class code for the intended insurance company or entering the first letters of the financial class description and selecting **Enter**.

- **Received:** This field works differently for each Financial Class code. Once a claim is set up, the system looks at the Require Approval field on page 1 of the Insurance Company table. If this field is answered **Y**, the system requires a received date to be entered manually. If the field is answered **N**, the system will update the received field with the current system date when the claim is created.

- **Precert #/Type:** Enter the intermediary's authorization number in this field. This field will accept 25 characters. The Precert#/Type field will accept a 2-digit Qualifier code. If left blank, the Qualifier code will default to a value of "G1" in the ANSI 837 file. The "G1" code indicates a Prior Authorization number. The Precert# pulls to locator 63 on the UB.

- **Phone#:** The Phone number field pulls from page 4 of the Insurance Company table or it may be entered manually.

- **Medicare #**: Used to record the Medicare Contract Number that was used prior to the issuing of the Medicare Beneficiary Identifier (MBI). This will allow the legacy Medicare Contract # to be recorded for reporting purposes.

- **Clinic Code:** This 2-digit code pulls the clinic address located in the Clinic Table, in the Business Office tables, to locator 2 of the UB, locator 32 of the 1500 and/or locator 33 of the 1500. This information, if entered in the Guarantor/Ins tab on the Registration and ADT screen, Policy Information, will pull to this field.

- **Pat's Relation to Sub:** This code indicates the patient's relationship to the Subscriber. The code pulls to locator 59 on the UB. There is a lookup option.

- **Subscriber's Sex:** Enter the sex of the Subscriber if required by the State, or it will pull from the Guarantor/Ins tab on the Registration and ADT screen, Policy Information.

- **Subscriber's DOB:** Enter the Subscriber's date of birth if required by the State, or it will pull from the Guarantor/Ins tab on the Registration and ADT screen, Policy Information.

- **Misc#3:** This field is state specific.

- **Release of Information:** This field is used for institutional claims. If blank, the system defaults to **Y**. Otherwise, the facility may enter A, I, M, N, O or Y depending on specific requirements. This pulls to locator 52 on the UB.

- **Exclude from Net Calc?:** If this field is set to **Y**, the claim will not pull to the Insurance Adjustments to AR Report. Also, the claim will not pull the Estimated Contractual Amount to the Aged Trial Balance. If blank, the system defaults to **N**.

- **Reports:** If this field is set to **Y**, the claim will not appear on the following reports: Insurance Journals, Insurance Billing Time Analysis, Insurance Reimbursement Analysis and Insurance Receipt List.

- **Other Coverages:** If this field is set to **Y** the claim will not pull to locator 50 on the UB for other claims on the same account.

The following are options at the top of the Policy Information screen:

- **Detail Benefits:** Selecting this option will display the Detail Benefits screen for the claim.

- **View CM:** Selecting this option View CM, Contract Management, is only accessible for claims that will be tracked through Contract Management. This option will display the Selected Account Information screen in Contract Management.

- **Eligibility Inquiry:** Site specific.

Each field on the Policy Information screen, except the patient's name and account number, may be updated manually. Due to state requirements, some fields on this screen may store information differently.

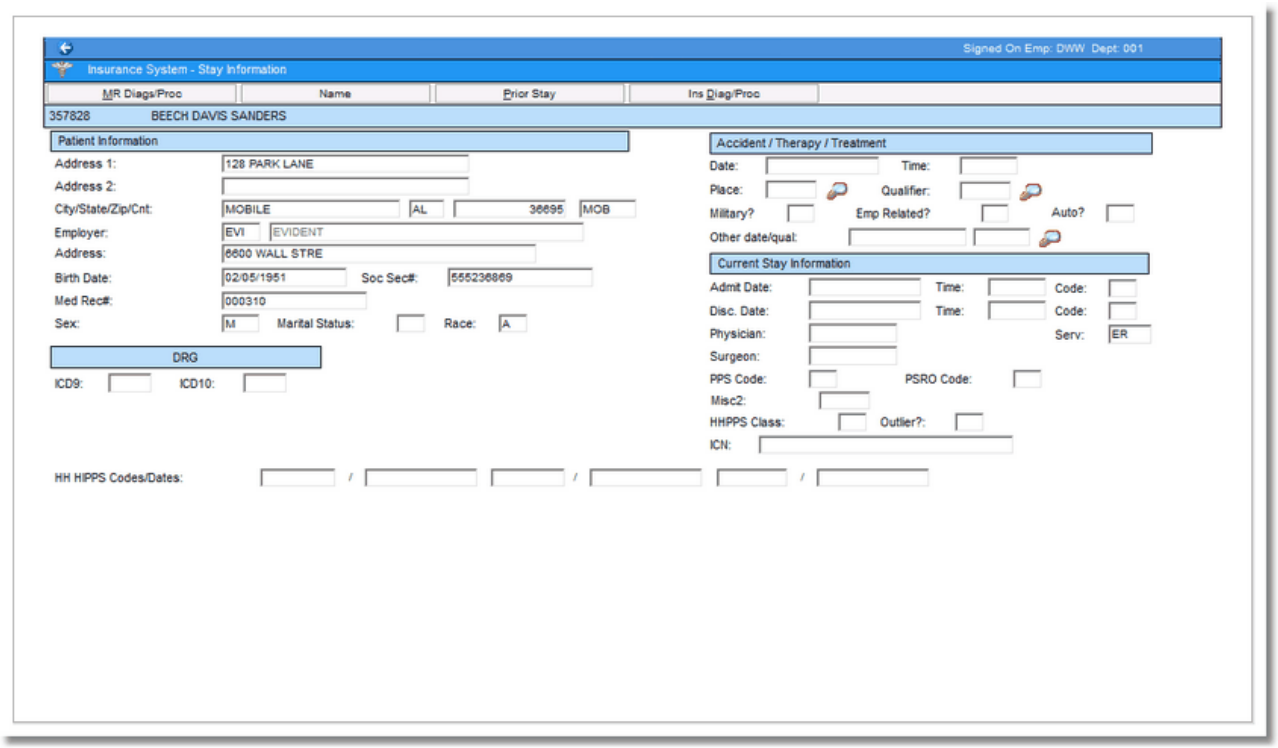
3.5 Generate Claim

When a claim is generated, the charges from the Account Detail screen will be pulled to the Detail Charges screen. Service From and Service To dates will pull admit and discharge dates from the Registration and ADT screen. If there are no admit and discharge dates loaded, dates may be manually entered. The dates entered will pull to locator 6 on the UB.

3.6 Stay Information

This option stores information about the patient's current stay for the claim being processed. Information entered during the Registration process or by the Health Information Department will pull to this screen. Some of this information will pull to the Stay Information screen as soon as the claim is set up. Other information about the account will pull when the claim is generated. Below is a list of the fields on the Stay Information screen and a short description of each.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Insurance claim > Stay Information**



Insurance System - Stay Information

The following are options at the top of the Stay Information screen.

- **Name:** Select this option to change the patient name on the account.
- **Prior Stay**: The occurrence spans for prior stay information should be entered manually.

- **Ins Diag/Proc**: Allows access to the Grouper to review the coding on the account. See Insurance Diagnosis/Procedure 16.

The data that pulls to the Stay Information screen pulls from the Registration and ADT screen and Medical Records. This information may be changed, although the changes will not affect the fields from which it pulled. Therefore, if changes need to be made to a patient's account that should be reflected on all screens, the changes should be made on the screens where the information was originally entered. These changes will be reflected in the Stay Information screen as soon as the claim is generated.

Patient Information

- **Address:** The patient's address pulls from the Patient tab on the Registration and ADT screen. This may be over-keyed at any time before the claim is printed.
- **Employer:** The Employer field stores information from the Patient tab on the Registration and ADT screen.
- **Address:** This Address field pulls the Employer's address from the Guarantor/Ins tab on the Registration and ADT screen.
- **Birth Date:** The patient's Birth Date pulls from the Patient tab on the Registration and ADT screen.
- **Soc Sec#:** The patient's Social Security Number pulls from the Patient tab on the Registration and ADT screen.
- **Med Rec#:** The Medical Records Number may be entered on the Patient tab of the Registration and ADT screen or in the DRG Grouper screen.
- **Sex:** The patient's Sex pulls from the Patient tab on the Registration and ADT screen.
- **Marital Status:** The patient's Marital Status pulls from the Patient tab on the Registration and ADT screen.
- **Race:** The patient's Race pulls from the Patient tab on the Registration and ADT screen.

DRG

- **ICD9: ICD10:** The computed DRG will pull from the Grouper screen.
- **HH HIPPS Codes/Dates:** This field is used with the Home Health Billing system. The 5-digit codes and dates may be manually entered or will pull from the PPS Grouper screens.

Accident/Therapy/Treatment

- **Date: Time:** Once the claim is generated, the accident date and time pull from the Stay tab on the Registration and ADT screen.
- **Place: Qualifier:** Once the claim is generated, the accident place and qualifier pull from the Stay tab on the Registration and ADT screen.

- **Military?: Emp Related?: Auto?:** Information must be manually entered in the Military, Employee Related, and Auto fields.
- **Other Date/Qual:** Once the claim is generated, the other date and qualifier pull from the Stay tab on the Registration and ADT screen.

Current Stay Information

- **Admit Date: Time: Code:** The admission information pulls from the Stay tab on the Registration and ADT screen once the claim is set up.
- **Disc Date: Time: Code:** The discharge information pulls from the Stay tab on the Registration and ADT screen once the claim is set up.
- **Physician:** The Physician number pulls from the Attending field in the Stay tab on the Registration and ADT screen once the claim is set up.
- **Serv:** The Service Code pulls from the Patient tab on the Registration and ADT screen.
- **Surgeon:** The Surgeon's Physician number pulls from page 2 of the DRG Grouper Screen. An "S" will signify the surgeon that performed the procedures.
- **PPS Code: PSRO Code:** The PPS field is not used at this time. This code will pull from the PSRO Code field on page 1 of the Insurance Company table. This pulls to locator 71 on the UB.
- **Misc 2:** This field is a state specific field, information should be entered manually.
- **HHPPS CLASS: OUTLIER:** This field is used with the Home Health Billing system.
- **ICN:** The Internal Control Number should be entered manually. This field is used when re-submitting a claim. This pulls to locator 64 on the UB.

Insurance Diagnosis/Procedure

The Insurance Diagnosis/Procedures (Ins Diag/Proc) option allows access to the Grouper screen so that Medical Record coding may be reviewed. There are two versions of the Grouper screen, the Medical Records Grouper and the Insurance Grouper, below is an explanation of each.

- **Medical Records Grouper**: Displays the coding information entered by Medical Records. Information entered here will automatically copy to the Insurance Grouper.
- **Insurance Grouper**: Displays the diagnosis and procedure information entered by Medical Records. The information displayed here may be edited to change the diagnosis and procedure information that displays on the insurance claim. Changes made on the Insurance Grouper will not copy back to the Medical Records Grouper.

Depending on the user's security, the Grouper screens may be view only, or maintenance may be allowed through this option. Listed below are the combinations of behavior controls that may be used

to assign access to the Grouper for insurance billers. The path to access these behavior controls is: **Special Functions > Identity Management > Logins > select a Login > Behavior Controls**.

- Insurance billers that require view only access to the Insurance Grouper should be given the following behavior controls.
  - **Code by Insurance** set to **Allow**
  - No rule for **Edit Non-HIM Diagnosis and Procedure Information** -or- **Edit Non-HIM Diagnosis and Procedure Information** set to **Deny**

- Insurance billers that require access to view and edit the Insurance Grouper should be given the following behavior controls:
  - **Code by Insurance** set to **Allow**
  - **Edit Non-HIM Diagnosis and Procedure Information** set to **Allow**

- Insurance billers that require access to view and edit the Insurance Grouper AND access to view the Medical Records Grouper should be given the following behavior controls:
  - **Code by Insurance** set to **Allow**
  - **Code by HIM** set to **Allow**
  - **Edit Non-HIM Diagnosis and Procedure Information** set to **Allow**

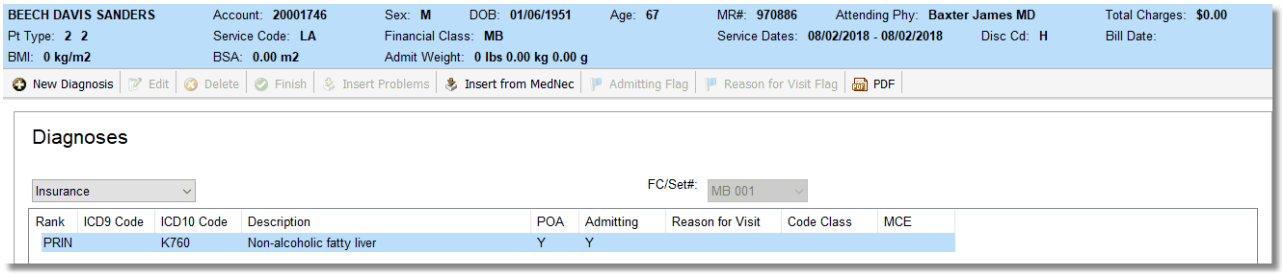
- If the user's login is not assigned to the Health Information Management role, the login must also be given access to the Applications listed below. The path to access the Application rules for a login is: **Special Functions > Identity Management > Logins > select a Login > Applications**.
  - **Coding** set to **Allow**
  - **Health Information Management** set to **Allow**
  - **Table Maintenance** set to **Allow****

NOTE: *Access to the Table Maintenance application will only need to be granted if the user needs the ability to edit the Medical Records or Insurance Grouper.*

Insurance Diagnosis

Selecting **Ins Diag/Proc** will display the Insurance Grouper Diagnoses screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Stay Information > Ins Diag/Proc**



Insurance Diagnoses

The Diagnosis Codes and descriptions will pull from the Medical Records Grouper screen; however, they may be edited for insurance billing purposes by selecting either the **Insurance** or the **Insurance Admitting** option from the drop-down menu. Any changes made using either of these two options will not affect the Medical Records Grouper screen. Any changes that are made will only be reflected on the insurance claim. Below is a description of the drop-down options that are displayed.

- **Insurance:** Selecting the Insurance option will allow the primary and secondary diagnosis information to be edited. The Principle Diagnosis Code pulls to locator 67A on the UB. The Secondary Diagnosis Codes pull to locators 67B-Q, except for codes V00*-Y99* which will pull to locators 72A-C.

- **Insurance Admitting**: Selecting the Insurance Admitting option will allow the Admitting diagnosis that pulls to the insurance claim to be edited. This Admitting Diagnosis Code will pull to locator 69 on the UB.

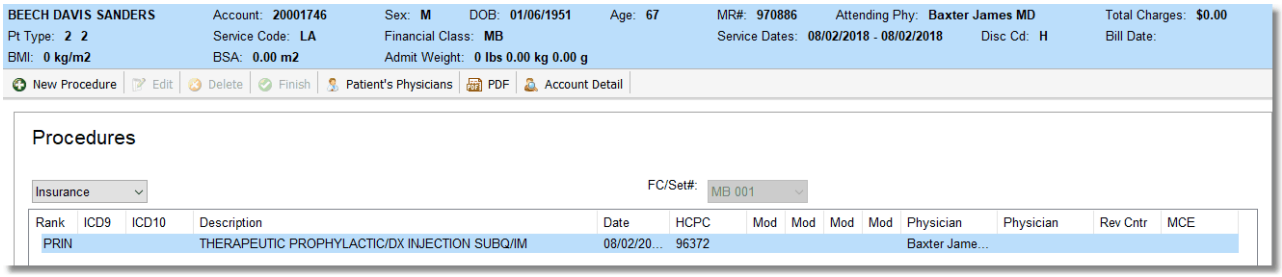
- **FC/Set#**: Displays the Financial Class and Set Number on the claim that was used to access the Insurance Diagnosis/Procedure information screen. This option is view only.

If diagnosis codes have been added to the account, the existing diagnosis codes will display. For more information on updating the Diagnosis screen, please see the Diagnosis section of the Health Information Management documentation.

Insurance Procedures

Select **Procedures** from the navigation bar to view procedure Information.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Stay Information > Ins Diag/Proc > Procedures**



Insurance Procedures

The Procedure Codes and descriptions will pull from the Medical Records Grouper screen; however, they may be edited for insurance billing purposes by selecting **Insurance** from the drop-down menu. Any changes made using this option will not affect the Medical Records Grouper screen. Any changes that are made will only be reflected on the insurance claim. Below is a description of the drop-down options that are displayed.

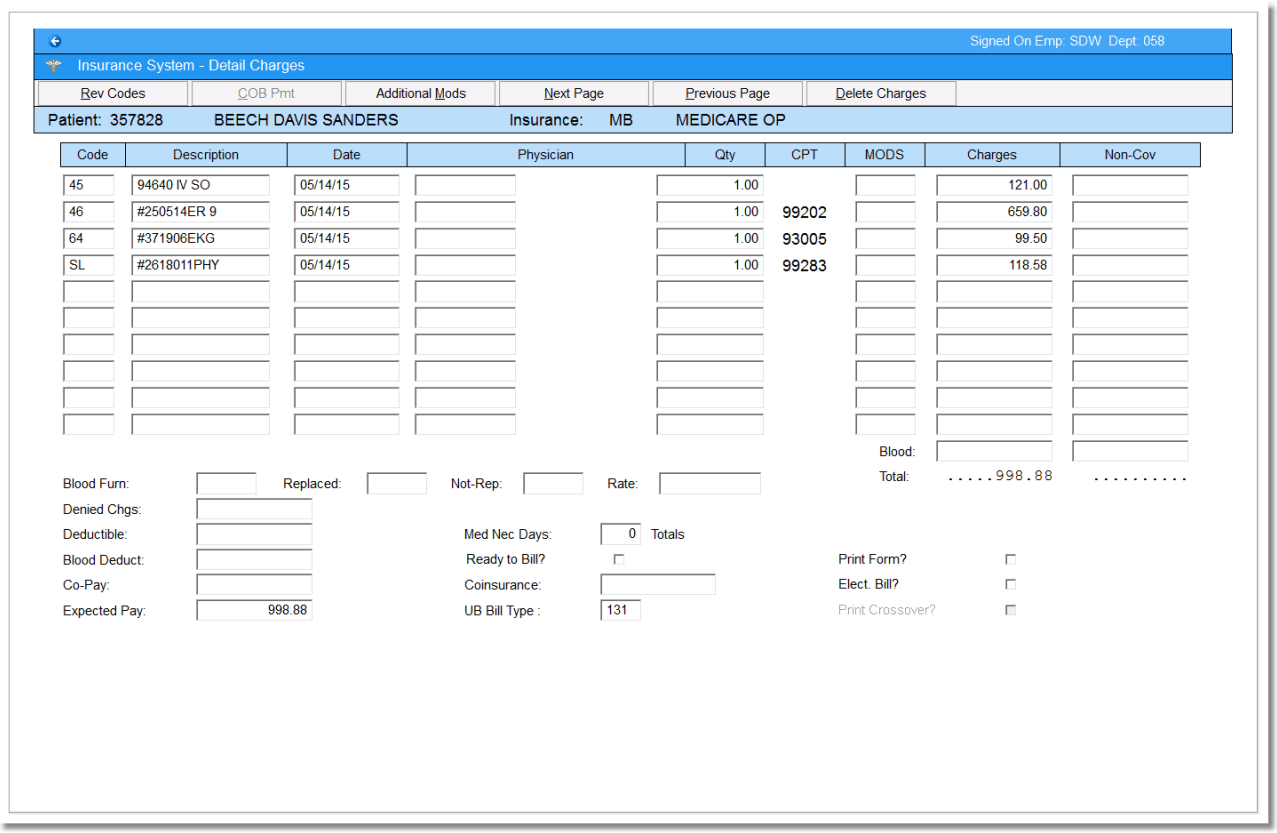
- **Insurance:** The Procedure Codes and date pull from the Medical Records Grouper screen. The Principle Procedure Code pulls to locator 74 on the UB. The first four Secondary Procedure Codes pull to locators 74A-E on the UB.
- **FC/Set#**: Displays the Financial Class and Set Number on the claim that was used to access the Insurance Diagnosis/Procedure information screen. This option is view only.

If procedure codes have been added to the account, the existing procedure codes will display. For more information on updating the Procedures screen, please see the Procedures section of the Health Information Management documentation.

3.7 Detail Charges

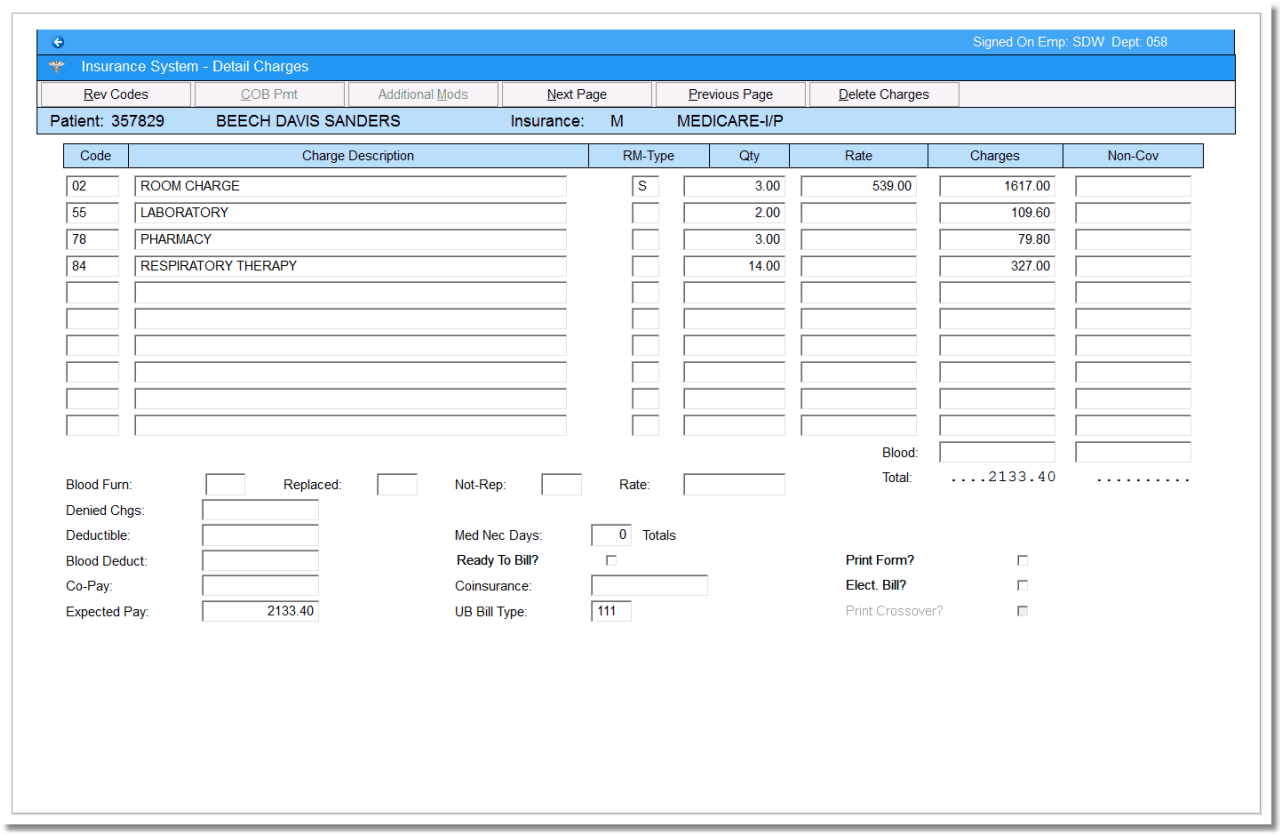
This option contains information from the patient's Account Detail. There are two Detail Charges screens that are used on the system. One is an itemized screen usually used for Outpatient claims. The other is a summarized screen for Inpatient claims.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance > Claim > Itemized Detail Charges**



Insurance System - Detail Charges

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance > Select Claim > Summarized Detail Charges**



Insurance System - Detail Charges

The majority of this screen is used to display the charges that will pull to a claim. Once a claim is generated, the charges within the date range selected will pull to the Detail Charges screen from the Account Detail. Charges may be manipulated on this screen without affecting the patient's Account Detail.

Outpatient claims pull an itemized Detail Charges screen. The Outpatient information pulls the Summary Code from the Item Master. The Charge Description looks to the Item Master at the time the charge is posted to the account to pull the Item Description. If the item has a CPT code loaded on the Item Master Maintenance screen, the description will pull with "#" and the item number preceding the summary code description. If the item does not have a CPT code loaded on the Item Master, the description from the Summary Code table will pull to the Detail Charges screen. The date the charge was incurred also pulls to these fields. The Physician name and number, based on what was entered during charging, pulls to these fields on the itemized Detail Charges screen. The quantity pulls from the Account Detail and is the amount that was entered during charging. The rate is calculated by taking the total charges from the Account Detail and dividing it by the quantity. CPT Modifiers pull from the Item Master Maintenance. The Modifiers are the last four characters in the 9-character CPT code. The covered and non-covered charge amounts are the same for itemized screens and summarized screens.

Inpatient claims pull a summarized Detail Charges screen. Like an Outpatient claim, the charges pull from the Account Detail. The charges pull the 2-character summary code that is associated with the charge in the Item Master. This pulls to the Account Detail at the time the charge is posted. The charge description pulls from the Account Detail that pulled from the description of the summary code at the time the charge was posted. Room Type is only used for room charges and pulls the type of room from the Census charges. The Quantity also pulls from the Account Detail. This is entered during the charging process. The Rate is the dollar amount charged for a single item. The system takes the total amount charged from Account Detail and divides it by the Quantity to get the rate. The Covered Charges are a total amount of charges less the Non-Covered Charges. Non-Covered Charges show on an account if the Room Rate is higher than the amount on the Detail Benefits screen. These Non-Covered Charges also show if the Coverage Percentage is less than 100 on the Detail Benefits screen. Not entering the Full Days on the Detail Benefits screen for Inpatient accounts also results in charges being non-covered.

***NOTE**: If the Contract Billing Report was used to transfer specific charges from a patient's account to a master account, only the charges that are not transferred will be included on the patient's insurance claim.*

The following fields are on the Detail Charges screen for both itemized and summarized claims:

- **Blood:** The blood charges from the patient account will pull to this field.
- **Blood Furn: Replaced: Not Rep: Rate:** These fields require the information to be loaded manually. The Blood Furnished field stores the number of pints of blood furnished for the patient. Replaced is the field that stores the information on the number of pints of blood replaced. The number of pints of blood not replaced is loaded in the Not-Rep field. The Rate field is the average rate of each pint of blood.
- **Denied Chgs:** The Denied Charges field stores the dollar amount of the charges that the insurance company refused to pay. This field is updated manually and will reduce the expected pay for the claim.

- **Deductible:** The Deductible amount pulls the dollar amount that was loaded on the Detail Benefits screen. This field is also updated during the receipting process.

- **Blood Deduct:** The Blood Deductible should be entered manually.

- **Co-Pay:** This field may be updated at any time during the Insurance Billing process. When adjusting this field, the expected pay field will reflect the adjustment.

- **Expected Pay:** The Expected Pay field is calculated each time the claim is generated. The system takes the total charges for the claim less the Non-Covered, Deductible, Co-pay, Coinsurance and Denied Charges to compute the Expected Pay. This pulls to locator 55 on the UB.

- **Med Nec Days:** Medically Necessary Days should be entered manually.

- **Ready to Bill?:** This field defaults to No. When the claim has been through the billing process and is ready to bill, this field should be selected.

- **Coinsurance:** This field may be updated at any time during the Insurance Billing process. When adjusting this field, the expected pay field will reflect the adjustment.

- **UB Bill Type:** This field is computed by the system for Bill Types 111 - 114, 131 - 132, 831 and 851. Other Bill Types needed may be entered on page 1 of the Insurance Company table. This field's information may be over keyed at any time. This pulls to locator 4 on the UB.

- **Print Form?:** The Print Form field should be answered when the claim is Ready to Bill. Selecting this field will allow the claim to print on a form, and leaving the field blank will suppress the claim from printing. Although the claim will not print, the system will still advance the claim status. For more information on this field, see Stages of an Insurance Claim section of this User Guide.

- **Elec Bill?:** This option is allowed on claims that have the Transmit Claim field on page 1 of the Insurance Company table set **Y**. This will allow the claim to pull to the electronic file for this Financial Class. For more information on this field see Insurance Tickler.

- **Print Crossover?:** This field should be answered **Y** if a crossover form will be printed for the claim.

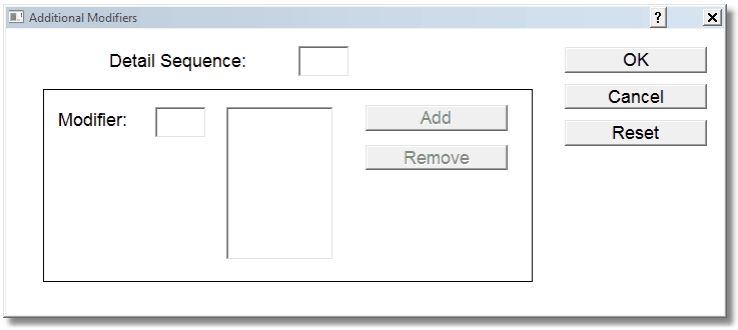
The following options are located at the top of the screen:

- **Rev Codes:** This option will toggle back and forth from the Summary Code display to the Revenue Code display. Selecting **Rev Codes** will display the Revenue Code on the Detail Charges screen. Selecting **Sum Codes** will display the Summary Codes.

- **COB Prnt:** This option is state specific for Michigan.

- **Additional Modifiers:** This option will allow Additional Modifiers to be added to those already listed in the Detail Charges screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Select Claim > Detail Charges > Additional Modifiers**



Insurance System - Additional Modifiers

Selecting the Additional Modifiers option will prompt for the Detail Sequence. Enter the number of the Detail Charge line that corresponds to the line in which the Modifier should be added; (ie. If the Modifier should be added to the third line down in the Detail Charges screen, enter a 3 in the box.) Select **OK** once the sequence number is entered. Enter the Modifier to be added and select Tab on the keyboard to move to the **Add** option. Selecting **Add** will display the Modifier.

Once all information has been entered, select **OK** to complete the addition of the Modifier. The Reset option may be selected if the information entered was incorrect and needs to be cleared. After a Modifier has been added it can be removed by entering the Detail Sequence number of the line, highlighting the incorrect Modifier, then selecting the **Remove** option. Additional Modifiers will pull to locator 44 of the UB and locator 24D of the 1500.

- **Next Page: Previous Page:** Select either option to view more or toggle back to prior charges on the Detail Charges screen.
- **Delete Charges:** This option will delete all charges on the page.
- **Anesthesia:** This view only option will display if there are anesthesia charges that have been generated on the claim. See Anesthesia Charging and Billing in Additional Documentation for more information.

3.8 Coverages

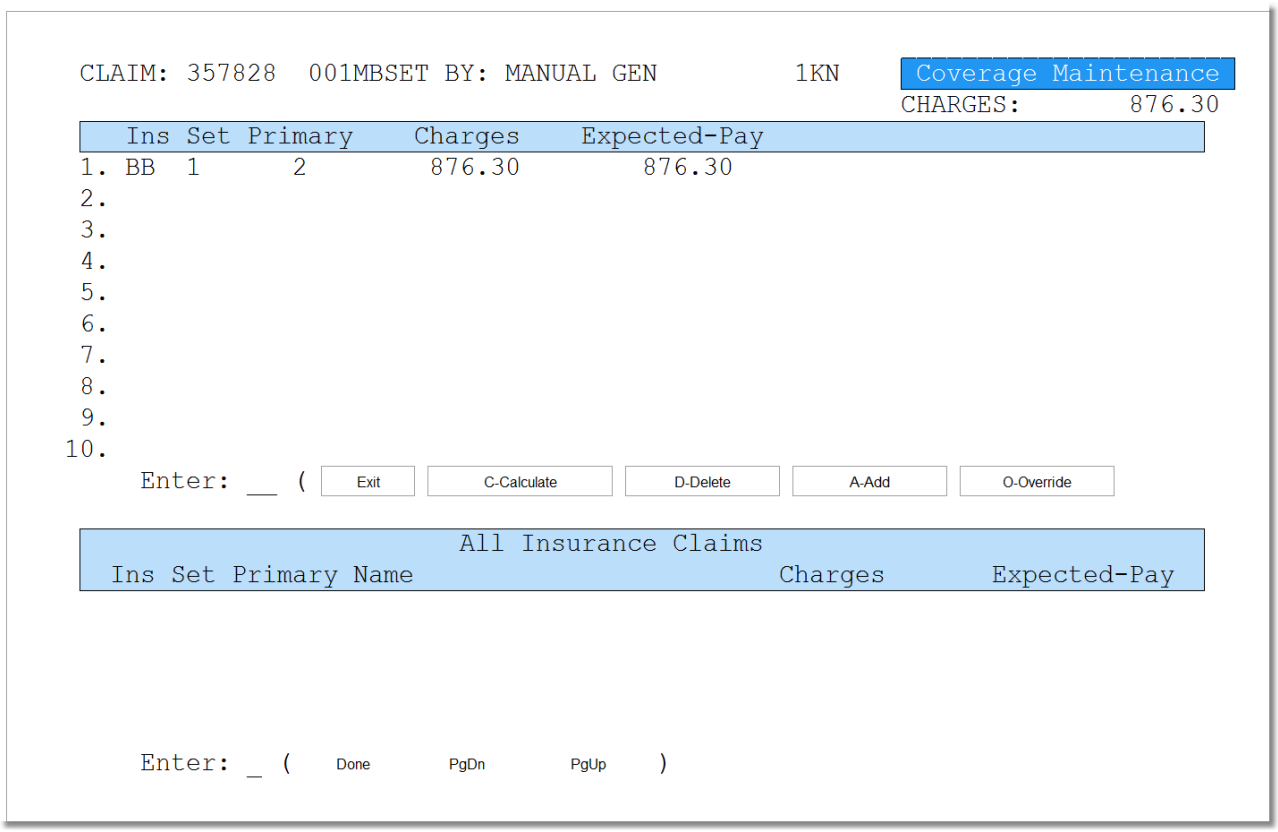
This option identifies other claims on the account that need to be indicated as an additional provider on the UB or on the 1500. Once identified, it links them together. Coverages will calculate on claims at the Unchecked, Ready to Bill or Pending status. If a claim has not been generated, it will not be considered as another coverage for a generated claim. Once a claim is at the Billed status, Coverages may not be manipulated.

Coverages look at the form code, dates of service, primary switch and financial class code to determine what claims should be linked. The system will also take into consideration Insurance Company Table settings such as the Form Code and Bill Physician Charges Separately fields on page 1, the Separate Claims option on page 4 and the Coverage Form Code field on page 6.

If the primary switch, contact number and financial class code are the same, the system will see them as the same Coverage and will not link them. For commercial financial classes, the system will look at the insurance company name rather than the financial class code.

The Exclude from Other Coverages field in Policy Information will exclude the claim from being set as a coverage for any other claim.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Coverages**



Insurance System - Coverages

The Coverages screen will list which claims are linked in the top section of the screen. All other claims that are not linked, will be displayed in the bottom section of the screen. Below, is a listing and description of the different options within the Coverages Maintenance screen:

- **Calculate:** This option should be selected to manually calculate. Selecting calculate will reset all values and any manual changes made to the Coverages screen.

- **Delete:** This option will remove a claim already linked to the selected claim. Selecting Delete will prompt for the sequence number of the claim line that needs to be removed.

- **Add:** This option will add a claim as a linked coverage to the selected claim. Selecting Add will prompt for the sequence number of the claim line at the bottom of the screen that needs to be added.

- **Override:** This option may be used to override Coverage errors. This option should only be used if Coverages causing the error have been thoroughly reviewed and deemed necessary for the current billing scenario.

There will be instances when claims are linked incorrectly causing an error to flag on the account. A listing of Coverage errors an account can get are as follows:

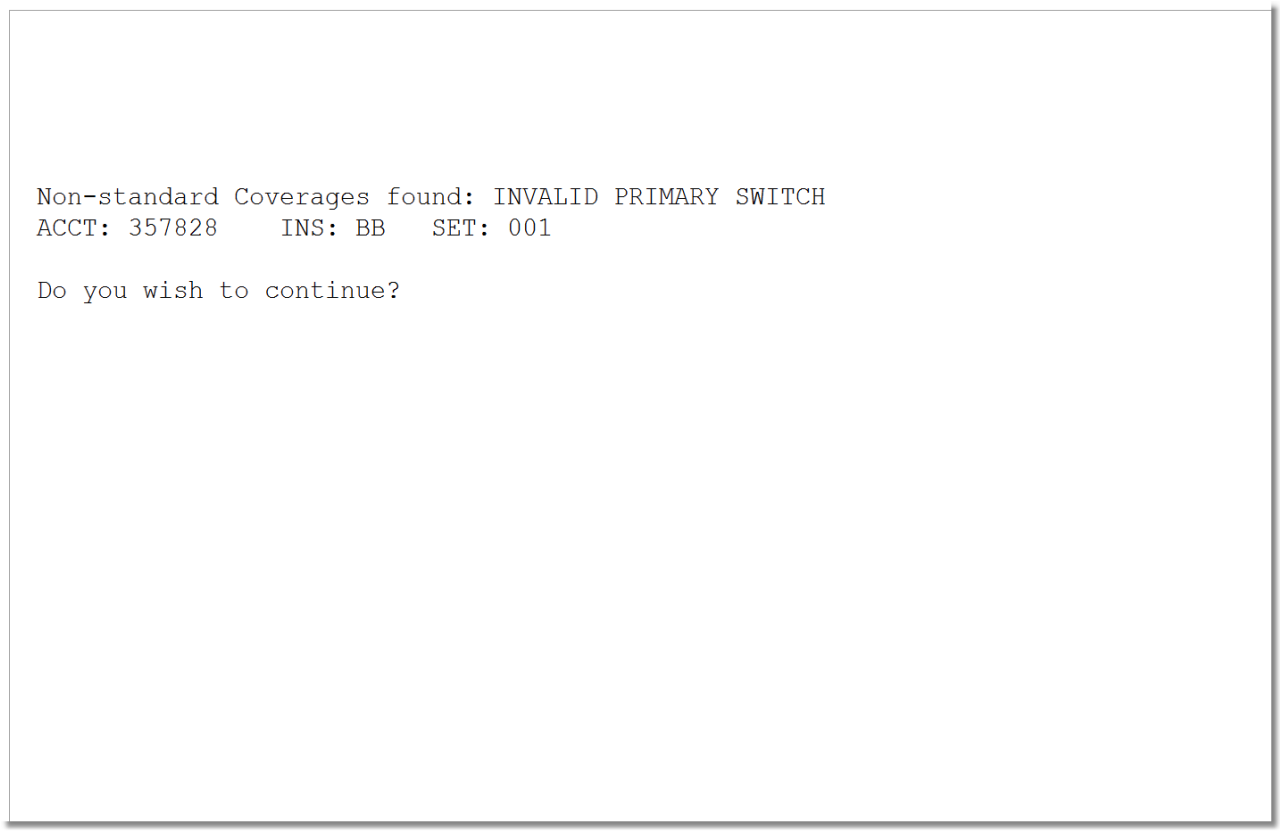
- **Total Coverage Charge Mismatch**: This error occurs if the total charges by primary switch do not match. All charges are totaled by primary switch and compared for a mismatch.

- **Service Date Mismatch**: This error occurs when the service from and to dates are not within the same date range.

- **Invalid Primary Switch**: This error occurs when a coverage claim has a primary switch that is not equal to **Y**, **2** or **3**.

- **Missing Coverage Claim**: This error occurs if one of the coverages on a claim does not exist. This may occur if a claim was deleted and coverages were not recalculated.

- **Multiple Preceding Claims**: This error can occur when calculating COB information for a secondary claim and there is more than one primary coverage claim.

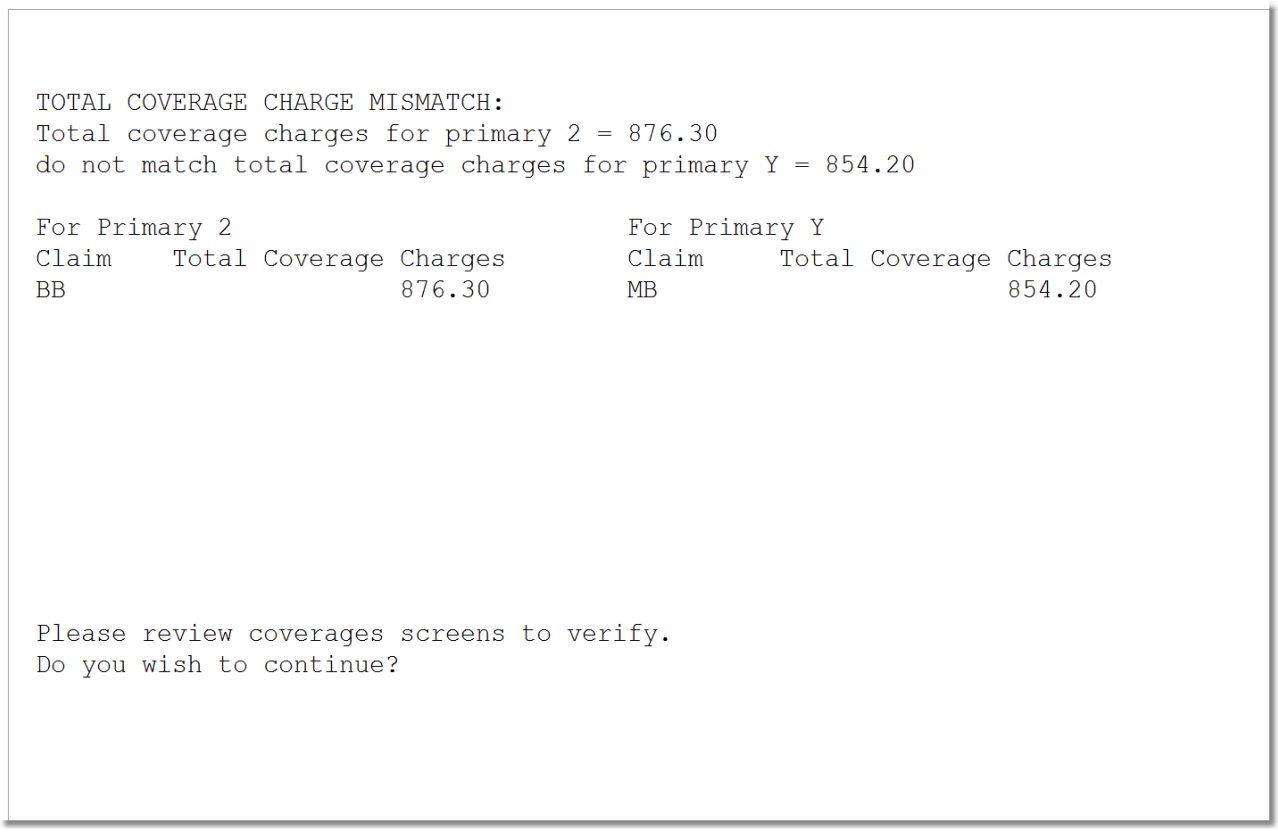


Insurance System - Coverages

When exiting the coverage maintenance screen and an error found, the system will display a warning message, “Non-standard Coverages found: Do you wish to continue?” The message displayed will list a description of the error along with the account number, financial class code and set number. If this prompt is answered **Y**, the system will go back to the claim status screen, and no corrections will be made to the Coverages screen. If this prompt is answered **N**, the system will go to the Coverages screen so that corrections may be made.

Insurance System - Coverages

When leaving the Insurance, Claims by Patient screen, if there is a Coverage error that still exists, the system will display a warning message “Problems were found in claim Coverages. See details below. Do you wish to continue?" If this message is answered **Y**, any claim at Ready to Bill or Pending status listed with Coverage errors will be moved back to the unchecked status. If a claim is moved back to the unchecked status because of Coverage errors, the comment box will add a note saying “COVG ERR.” The system will also capture the login name and CS number of the person who answered the prompt **Y**, and this information will display in the top of the Coverage Maintenance screen. If this prompt is answered **N**, the system will go back into the Insurance screen so that Coverages may be corrected.



Insurance System - Coverages

If the account is getting an error for Total Coverage Charge Mismatch, the above error screen will display. It will give a more detailed error message for the claims that were linked incorrectly. The error will show the total coverage charges for both the primary and the matching secondary claim along with what is setup for both claims as covered. By answering the prompt "Do you wish to continue?" with a **Y**, it will exit out of the Coverage Maintenance. If the prompt is answered with an **N**, it will go back to the Coverage Maintenance screen to correct the error.

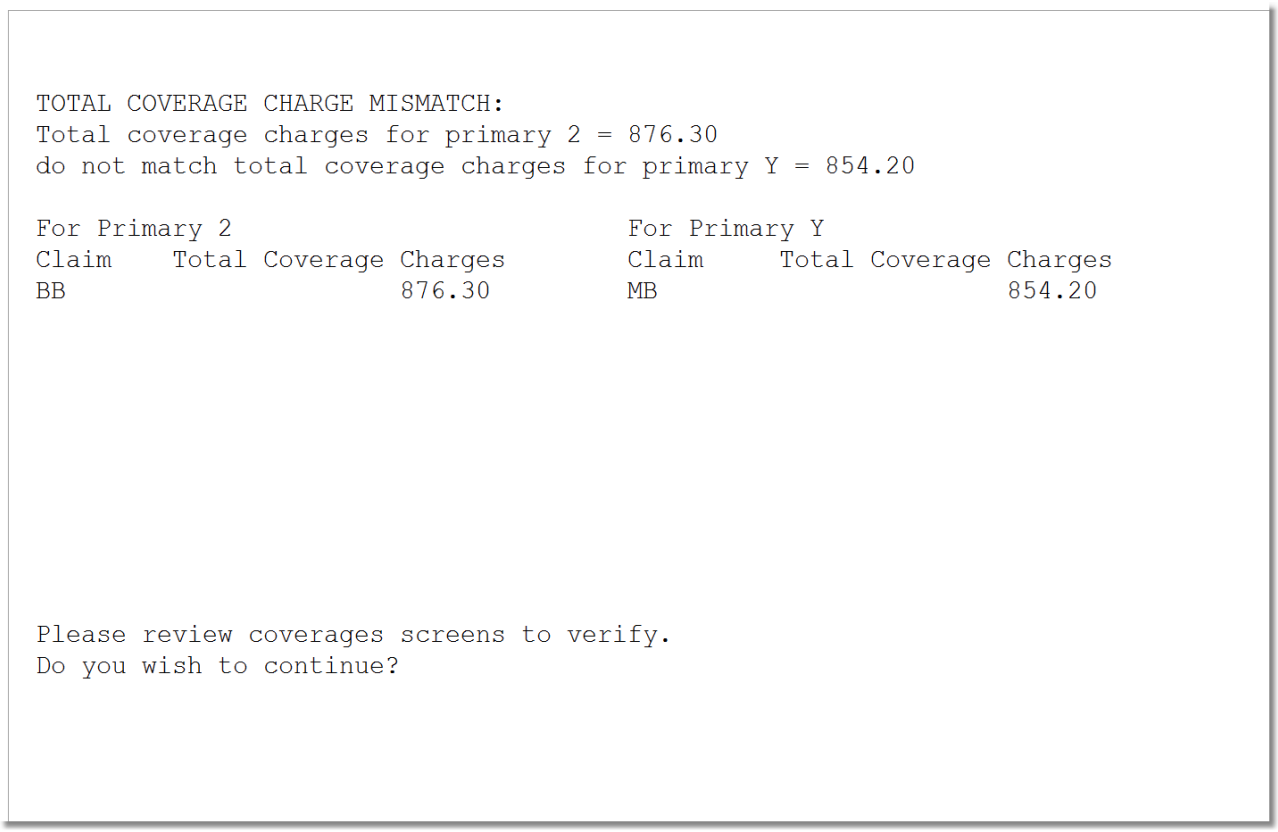
3.9 View All Claims

View All Claims will return to the Claims by Patient Screen.

3.10 Patient Functions

Patient Functions will return the cursor to the Patient Functions screen.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Claim > Patient Functions**

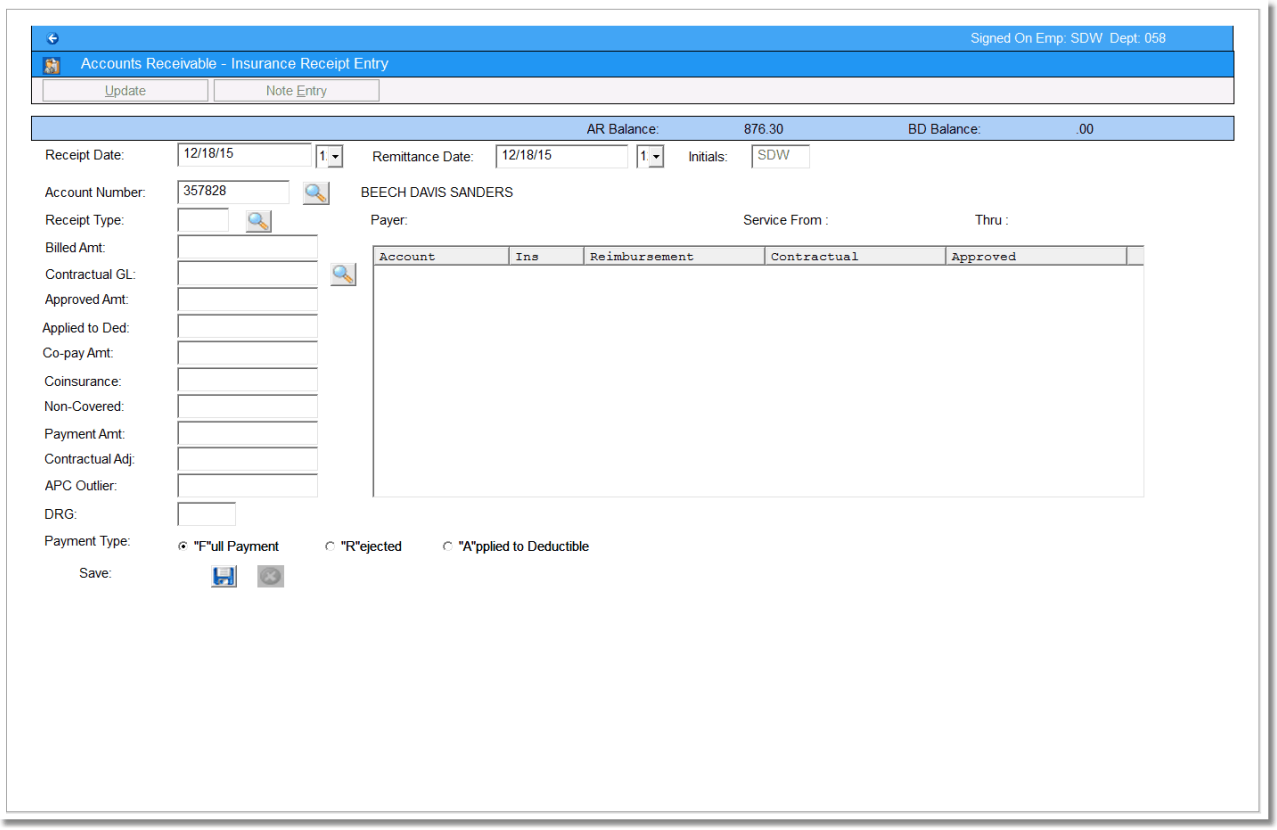


Accounts Receivable - Patient Functions

3.11 Receipt Entry

Receipt Entry allows a receipt to be posted against the claim. TruBridge recommends entering insurance receipts through the Insurance Receipt Entry option in Receipting to capture more detail.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Receipt Entry > Select Billed Claim**

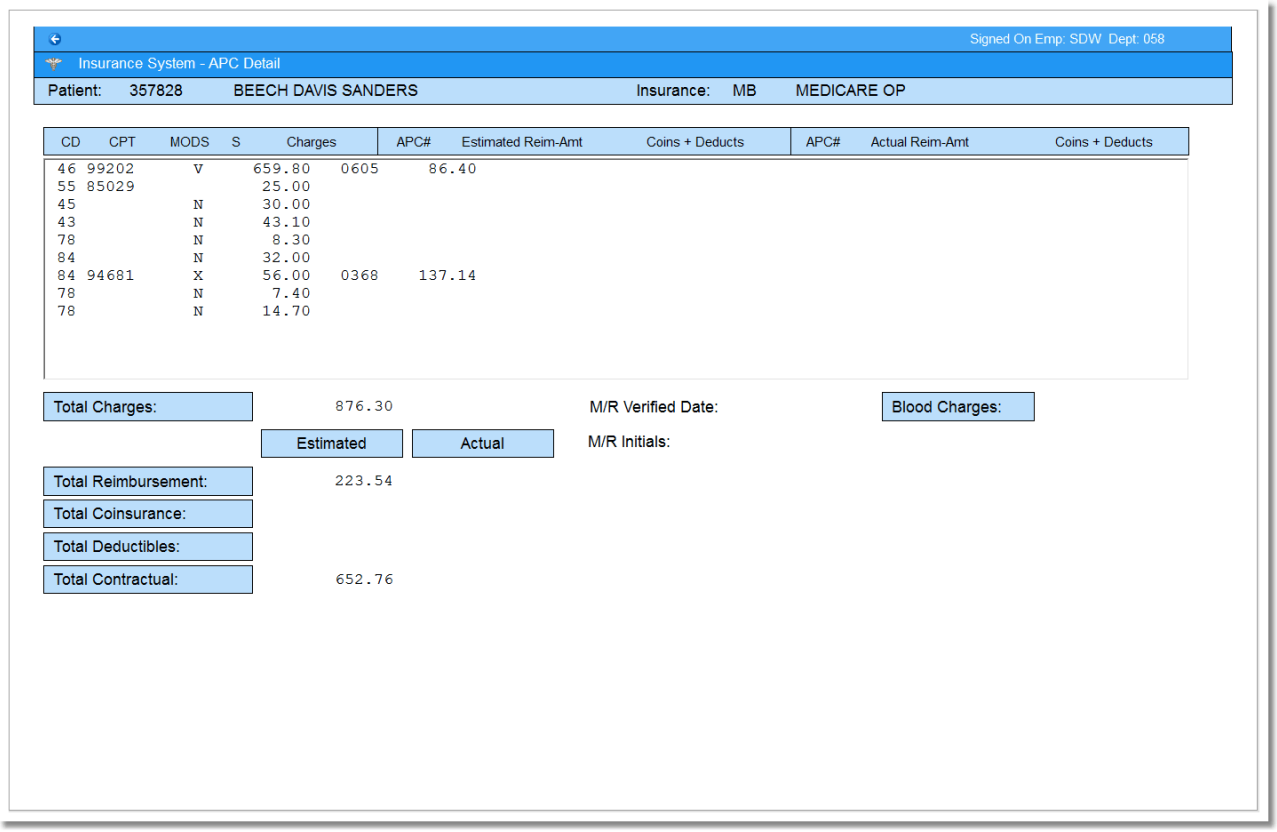


Receipt Entry

3.12 APC Detail

APC Detail shows the estimated and actual APC reimbursement information.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > APC Detail**



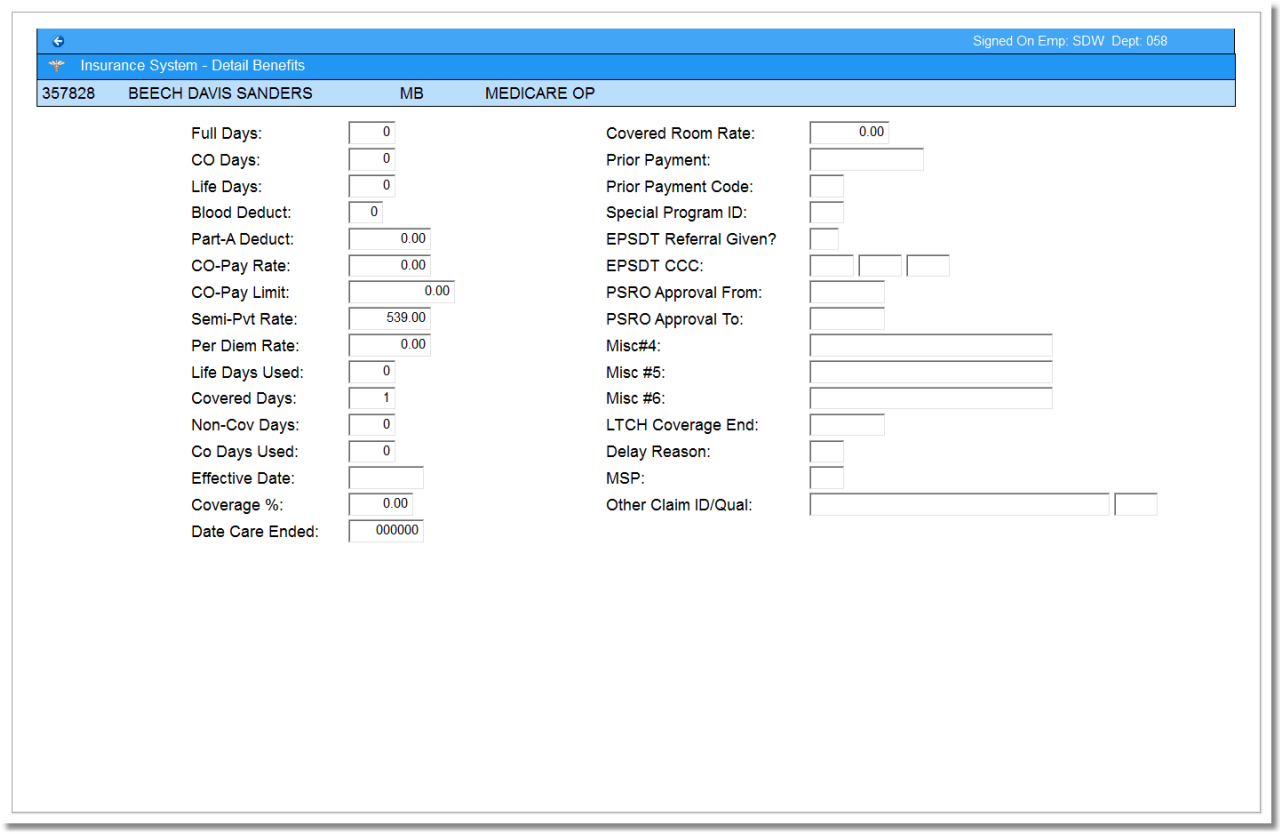
Insurance System - APC Detail

This screen shows each line of detail listed for a claim including any applicable APC's. The Estimated Reimbursement Amount for each APC is reflected as well as any Coinsurance or Deductible. The last two columns will reflect the actual reimbursements entered during Receipting.

3.13 Detail Benefits

Detail Benefits screen is used in the billing process of an insurance claim to store data that describes the terms and conditions of a given insurance policy. Described below are the fields for the Policy Detail Benefits screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Detail Benefits**



Insurance System - Detail Benefits

- **Full Days:** In the Full Days field, the maximum number of days the insurance company has agreed to fully cover should be entered. This is a 3-digit field, therefore, 999 is used to represent an indefinite number.

- **Co Days:** Coinsurance Days are the number of days the insurance company and the patient agree to share a portion of the amount due. Enter the maximum number of days the insurance company has agreed to partially cover. If the number of days is unknown or does not apply to the claim, leave this field blank.

- **Life Days:** Lifetime Reserve Days usually only apply to Medicare claims. Enter the Lifetime Days the patient has for this claim. If this is unknown, leave blank.

  The Full Days, Co Days and Life Days will also populate automatically when the claim is generated if information is loaded on page 6 of the Insurance Company table.

- **Blood Deduct:** This field should have the number of pints of blood to be paid by the patient. If this does not apply to the claim, leave the field blank.
- **Part-A Deduct:** The Part A Deductible may be loaded in this field. Deductibles lower the expected pay amount but do not affect the covered and non-covered dollar amounts. If the claim does not have a deductible, leave the field blank.
- **Co-Pay Rate:** If Coinsurance days are used, enter the rate that is to be paid by the patient. Otherwise, leave the field blank.
- **Co-Pay Limit:** This field is used when the patient is using Coinsurance days, and there is a limit to that rate. If the patient is not using Coinsurance days on this claim, this field should be blank.
- **Semi-Pvt Rate:** The Semi-Private room rate that is loaded on page 1 of AHIS will pull to this field on the Detail Benefits screen unless the Insurance Company table has a room rate loaded on the page 6. The Semi-Private room rate loaded in the Insurance Company table overrides the amount loaded in AHIS for that particular Financial Class.
- **Per Diem Rate:** If the Insurance Company for this claim uses a Per Diem Rate, the daily rate of the allowed reimbursement will pull from the Current P/D Rate field on page 1 of the Insurance Company table. Otherwise, this field should be blank.
- **Life Days Used:** This field is used to store the number of Life Days Used for the insurance claim.
- **Covered Days: Non-Cov Days:** The Covered Days and Non-Covered Days fields are updated by the system. At the time the claim is generated, the system looks at the full days field and determines if the days are covered or non-covered. The number of days is then calculated by the system.
- **Co Days Used:** This field allows the number of Coinsurance Days that the patient has used to be stored on this claim.
- **Effective Date:** The Effective Date field allows the month, date and year to be entered. This is the date the insurance coverage begins. If the coverage began before the admission, it is not necessary to load information in this field.
- **Coverage %:** The Coverage Percent field is used when the insurance company does not cover the claim 100%. If the insurance coverage for this claim is 80%, enter **80** in this field.
- **Date Care Ended:** The Date Care Ended is similar to the effective date. This field allows for the month, date and year the active policy was discontinued.
- **Covered Room Rate:** This is an informational field.
- **Prior Payment:** The Prior Payment field is used to store insurance payments made on this account for the billing period prior to this bill being sent. If utilizing Automated Secondary Billing, the system will automatically update this field of the primary claim with the paid amount for that claim. This pulls to locator 54 on the UB.
- **Prior Payment Code:** This is a state specific field.

- **Special Program ID:** Not used at this time.

- **EPSDT Referral Given?:** Was Early and Periodic Screening, Diagnosis and Treatment referral given to patient? Enter a **Y** or **N** in this field.

- **EPSDT CCC:** Enter up to three Certification Codes for EPSDT from the following:
  - **AV** (available-not used)
  - **NU** (not used)
  - **S2** (under treatment)
  - **ST** (new service requested)

- **PSRO Approval From:** Not used at this time.

- **PSRO Approval To:** Not used at this time.

- **Misc #4, 5 and 6:** These fields are informational fields and must be entered manually.

- **LTCH Coverage End:** If the patient's benefits expire prior to the time of discharge, the date coverage ends can be loaded in this field and the system will calculate a Per Diem reimbursement using the Admit Date as the begin date and this Coverage End date.

- **Delay Reason:** This is a 2-digit reason code placed on the Electronic File. The code represents the reason a claim is being billed late.

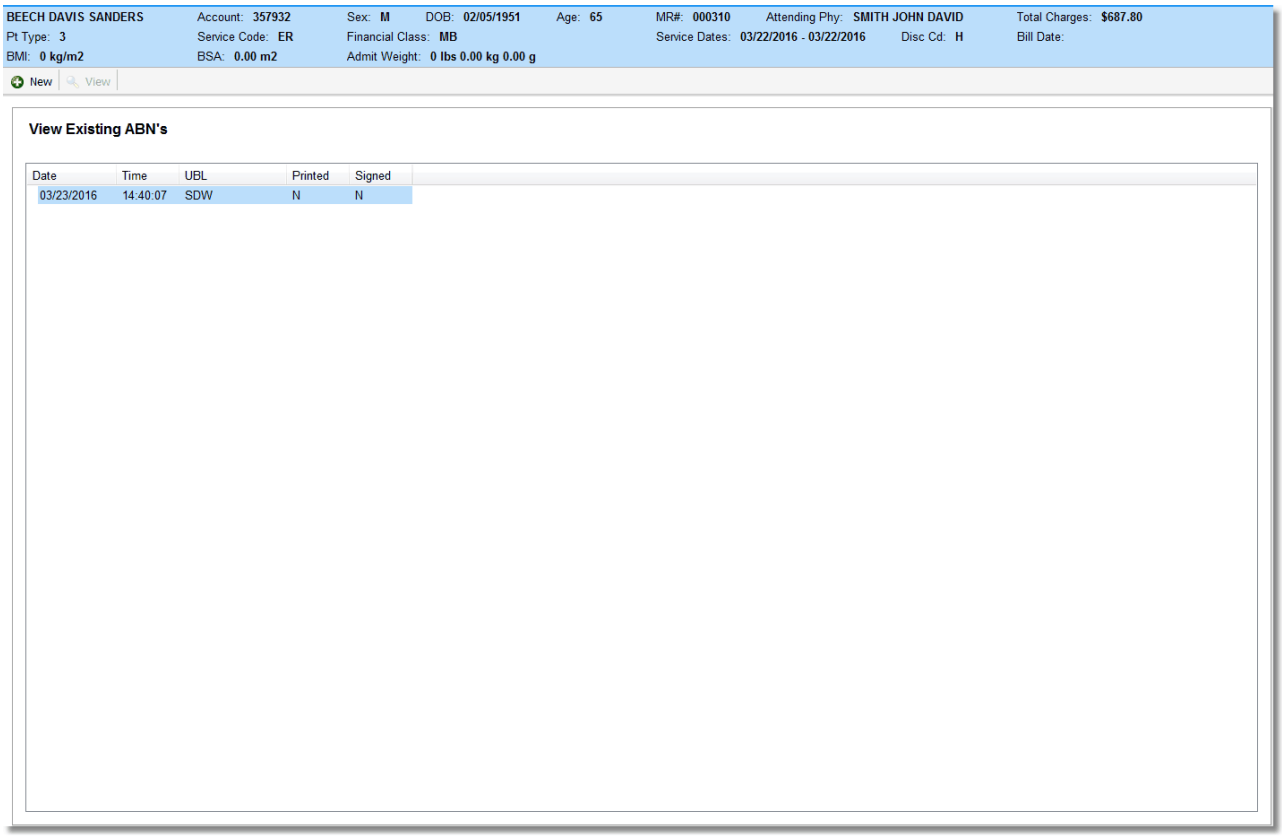
- **MSP:** This field will only pull a code if an account has a Medicare claim that is not primary. If the Medicare Questionnaire is not filled out, a code of 47 will pull to this field. If the Medicare Questionnaire has Part IV, question 9 answered Yes, a 12 should pull to the field. If the Medicare Questionnaire has Part VI, question 1 answered Y, a 13 should pull to this field. This code will pull after an N has been answered to Part I fields 1, 4 and 5, and Part II fields 1, 3 and 7.

- **Other Claim ID/Qual**: Enter the ID number and 2-digit qualifier. This pulls to locator 11b on the 1500.

3.14 Medical Necessity

The Medical Necessity option will allow existing ABN's to be viewed, or new ABN's to be created thru the Medical Necessity Lookup. For more information, please see the Medical Necessity user guide.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Medical Necessity**



Medical Necessity

3.15 Deny Claim

The Deny Claims option should not be used. If a claim needs to be rejected, please use the Insurance Receipt Entry 31 option.

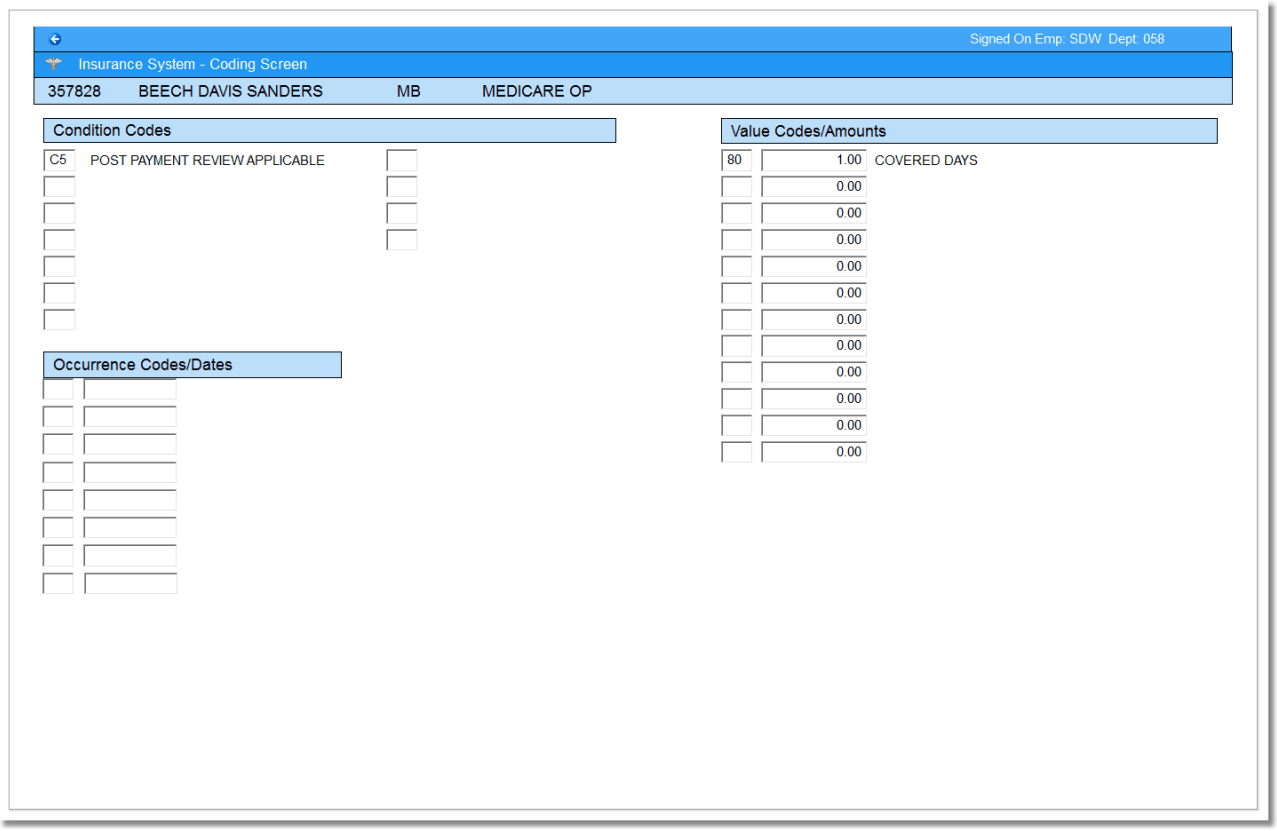
3.16 Hospital Base Menu

This option returns to the Hospital Base Menu.

3.17 Coding Screen

The Coding Screen stores information about Condition Codes, Occurrence Codes and Value Codes necessary for billing the patient's claim. Codes may be loaded as needed to pull to the UB and the1500. Many Intermediaries have specific requirements for these codes to pull and for this reason, may be hardcoded in the system for a particular state and/or a specific Intermediary.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Coding Screen**



Insurance System - Coding Screen

- **Condition Codes:** The Condition Code fields are used to relate this claim with specific conditions of the bill that may affect the payer process. The 2-character code may be entered manually. It may also be loaded in PSRO Code field on page 1 of the Insurance Company table. If a character is loaded in the Insurance Company table, it will pull to the Condition Code field with a "C" preceding it. Condition Codes may be set up in the Business Office tables. This pulls to locators 18-28 on the UB and locator 10d on the 1500.

***NOTE**: When a claim is generated and it has a of J loaded in the Insurance Company Table, page 1 the Form Code field, the Condition Codes section will pull blank.*

- **Occurrence Codes:** The Occurrence Code fields are used to define a significant event related to the billing process. The system will pull the codes loaded in the Stay tab of the Registration and

ADT screen. Additional 2-character codes may be entered manually. Occurrence Codes may be set up in the Business Office tables. This pulls to locators 31-34 on the UB.

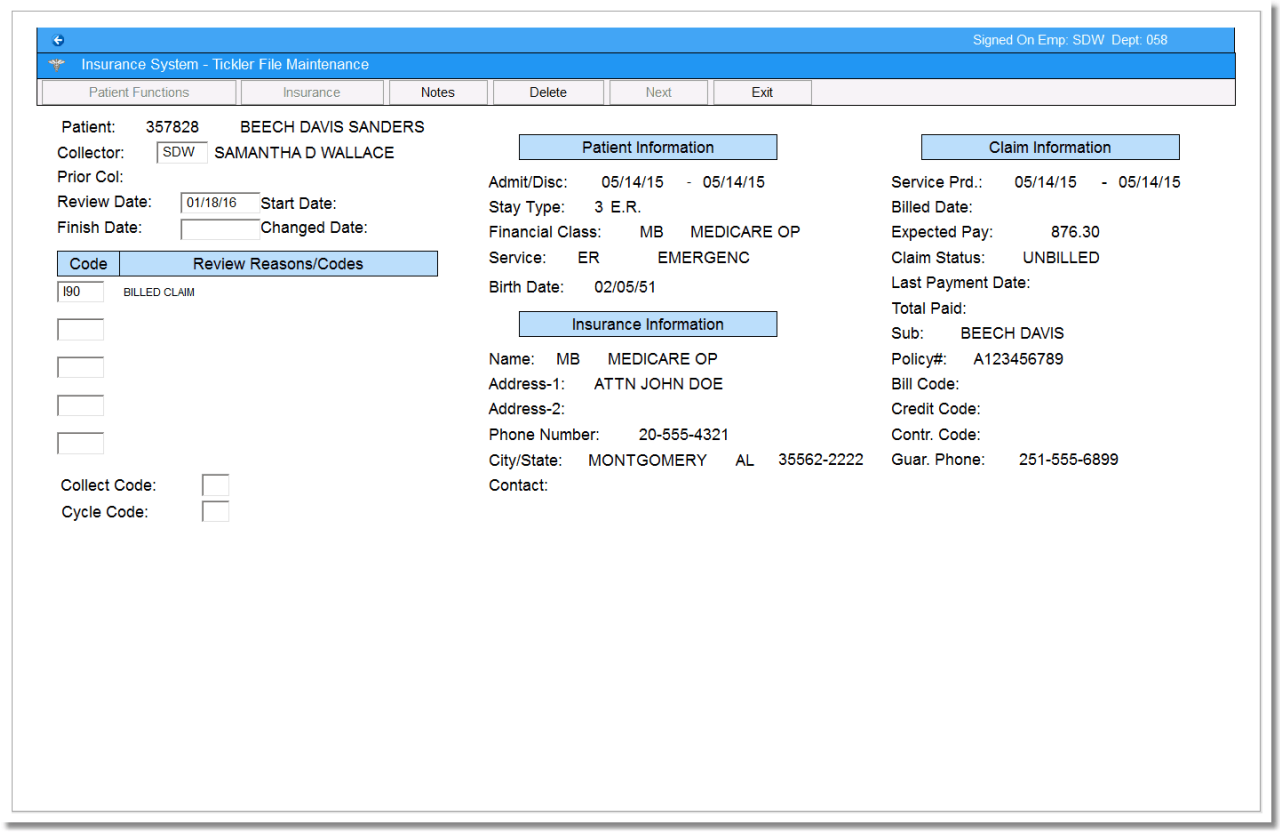
- **Value Codes:** The Value Code fields store the data about specific rates or values associated with the claim. These codes and amounts may be entered manually. Value Codes may be set up in the Business Office tables. Value codes may hold dollar amounts in the millions.

NOTE: *A lookup screen is provided for the Condition, Occurrence and Value Codes by entering a* ***?*** *in the desired field.*

3.18 Tickler System

The Tickler System manually places the claim in the Insurance Tickler System or accesses the existing Tickler account if applicable. For more information see Insurance Tickler 131.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Tickler File Maintenance**

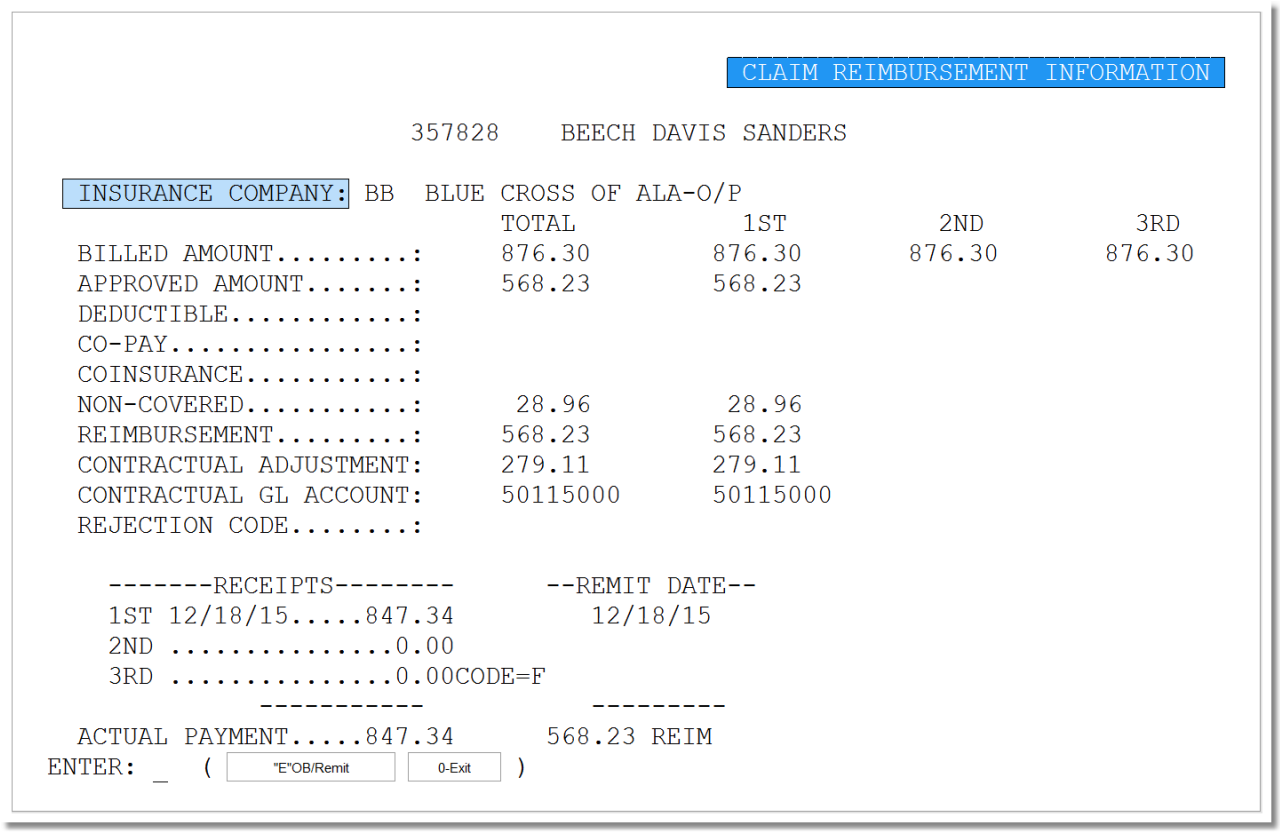


Insurance System - Tickler File Maintenance

3.19 Receipt Information

Receipt Information displays receipt information for the last three receipts. The electronic EOBs may be viewed from this screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Receipt Information**



Claim Reimbursement Information

3.20 Image Store/Retrieve

Image Store/Retrieve allows images of insurance cards or any other patient documentation that have been scanned into the system to be viewed or new images to be stored.

3.21 Print/View Options

When this option is selected, two other options will display. The first option is **Print Form** which will print the UB or 1500. The prompts displayed are the same as printing UB's through the Insurance reports under the Print Reports menu accessed from the Hospital Base Menu. The UB or 1500 may be printed and updated through this option if the claim is at the Ready to Bill status. The second option is **Display Form on Screen** which will display the UB or 1500 claim if it has been generated and will remain available until the claim purges. If the claim is at the Ready to Bill status, it will automatically be displayed without selecting an option.

***NOTE**: When printing UB claims that are itemized (not summarized) the charges will display in ascending order by revenue code and will be subsorted by service date.*

Chapter 4 Registration's Role in Insurance Setup

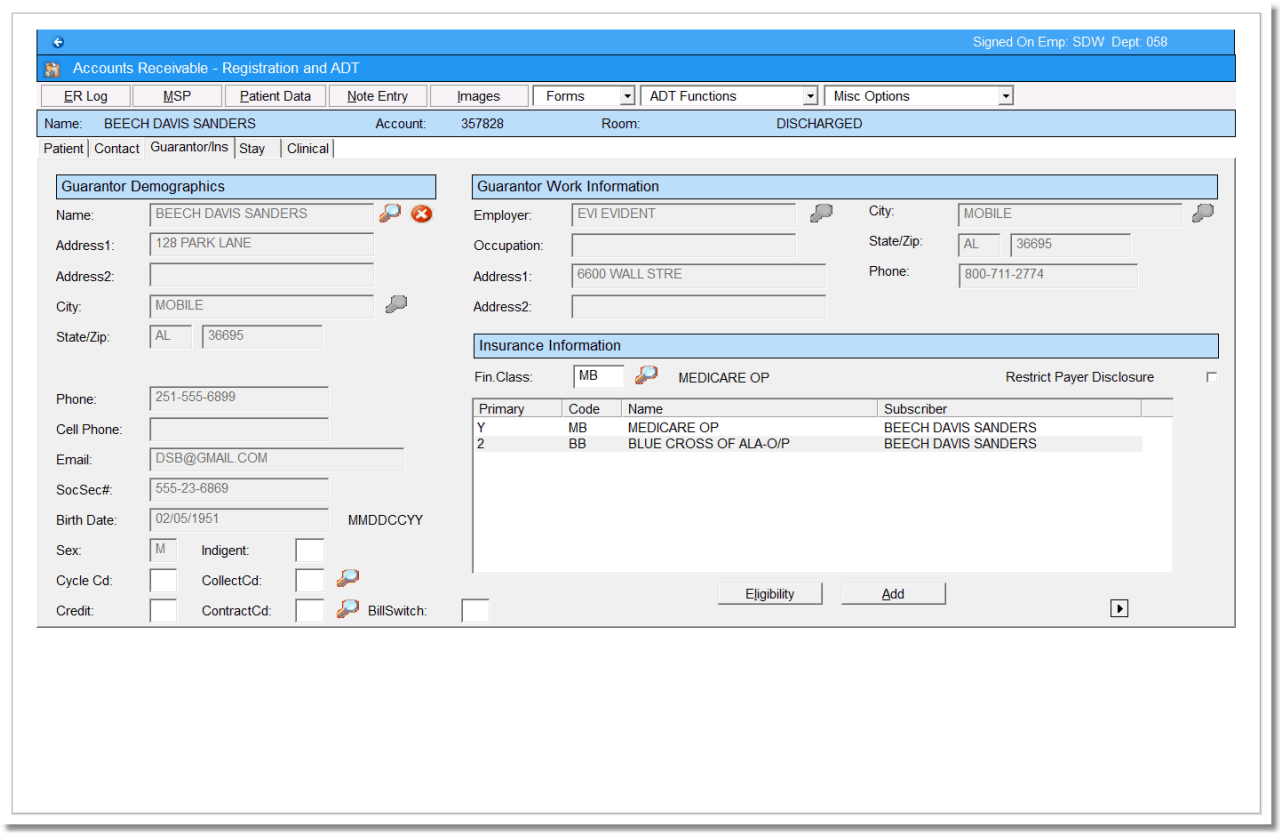
4.1 Overview

Registration plays an important part in the Insurance Billing process. The information that is gathered at this time pulls to the Insurance Billing screens. It is essential that Registration personnel keep accurate information about patient accounts. The Registration and ADT screen screens will store information that is also recorded on the Policy Information, the Stay Information and the Detail Charges screens.

4.2 Insurance Information

The Insurance Information is listed in the Guarantor/Ins tab on the Registration and ADT screen and is used to enter information about each insurance claim associated with the patient's account. Each Financial Class code on this page creates a claim on the Insurance Claim Status screen. The Insurance personnel will bill these claims. Below is a description of each field under the Insurance Information section.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > Guarantor/Ins**



Accounts Receivable - Registration and ADT, Guarantor/Ins

- **Restrict Payer Disclosure:** The Restrict Payer Disclosure field will pull selected, if it was already selected from the Visit information screen; however, the field may be deselected. If the Restrict Payer Disclosure field is selected from the visit, the Fin Class field will auto populate P for Private Pay. The Eligibility and Add options will be disabled.

***NOTE**: Selecting Restrict Payer Disclosure will disable the New Insurance 6 option on the Claims by Patient screen.*

- **Primary:** The Primary Switch field is used to identify the claim as the primary claim when answered **Y**. The system will order the claim marked with a **2** as a secondary claim and the claim with a **3** as the tertiary claim.
- **Code:** The Financial Class code of the claim should be entered in this field. A lookup is provided.
- **Name:** The name of the Insurance Company associated with the Financial Class code will be displayed in this field.
- **Subscriber:** The Subscriber's name associated with this claim will be displayed. For Medicare and Medicaid patients, this field will default to the patient's name. For all other insurance types, it will default to the Guarantor's name or patient name depending on table setup. This field may be over-keyed if necessary.

Through the Insurance Information section, the system will allow the Policy Information screen to be accessed. This will aid in the billing process, so as much information as possible should be gathered at registration.

Once the correct Insurance Company has been selected, and the user exits the Insurance Information box, the Policy Information screen is displayed. This includes Insurance Company Information, Subscriber Information, Contract Number and Group Information.

See the Policy Information 10 and Detail Benefits 33 sections of this User Guide for further information.

4.3 Medicare Questionnaire

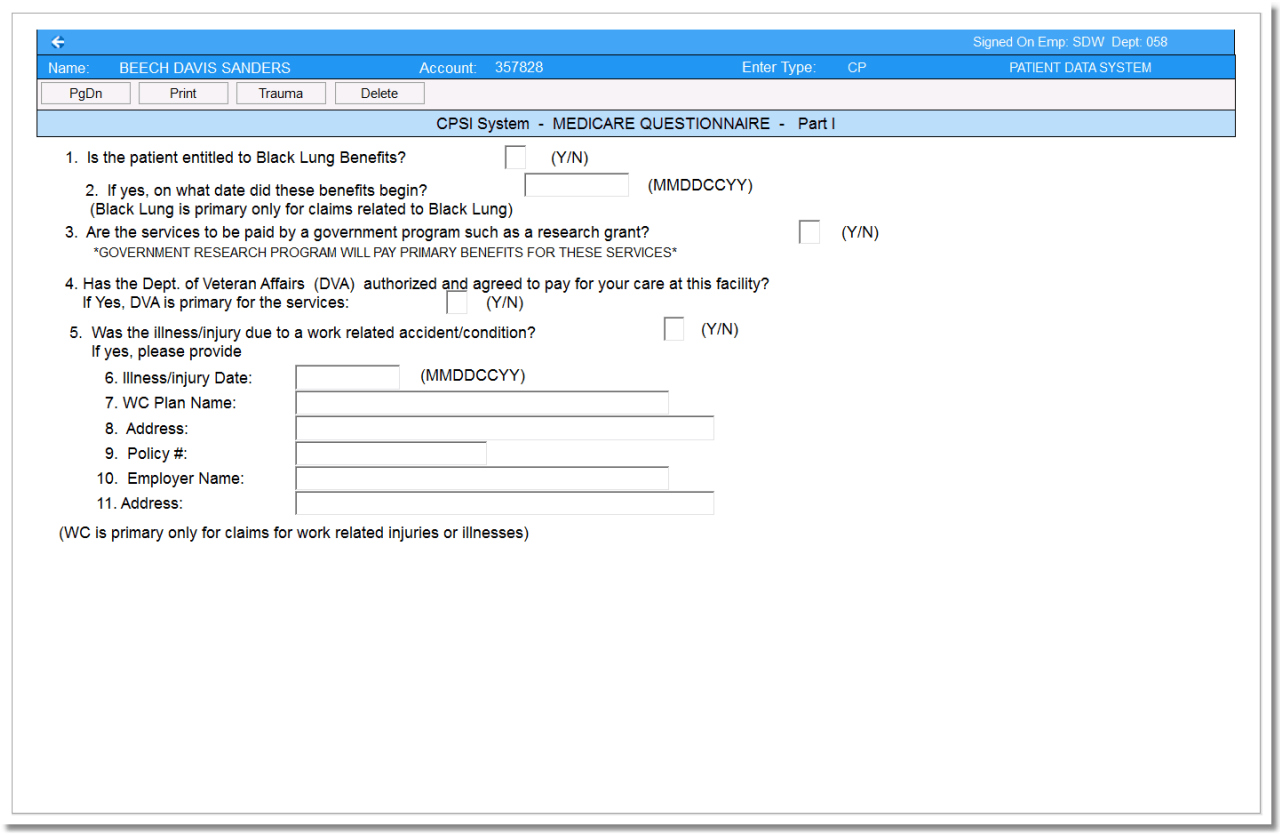
For specific Stay Types, Medicare requires a questionnaire to be filled out for the patient's stay. The system will store information for the Medicare Questionnaire and Medicare Trauma Questionnaire for each account.

To access the Medicare Questionnaire, select the **MSP** button on the Registration and ADT screen.

The Medicare Questionnaire can be set to automatically display at the time of registration. This is controlled in the Insurance Company table, page 4, the Medicare Questionnaire field. The options for this field are discussed in Insurance Company table, Page 4 101.

The following pages illustrate the screens of each questionnaire.

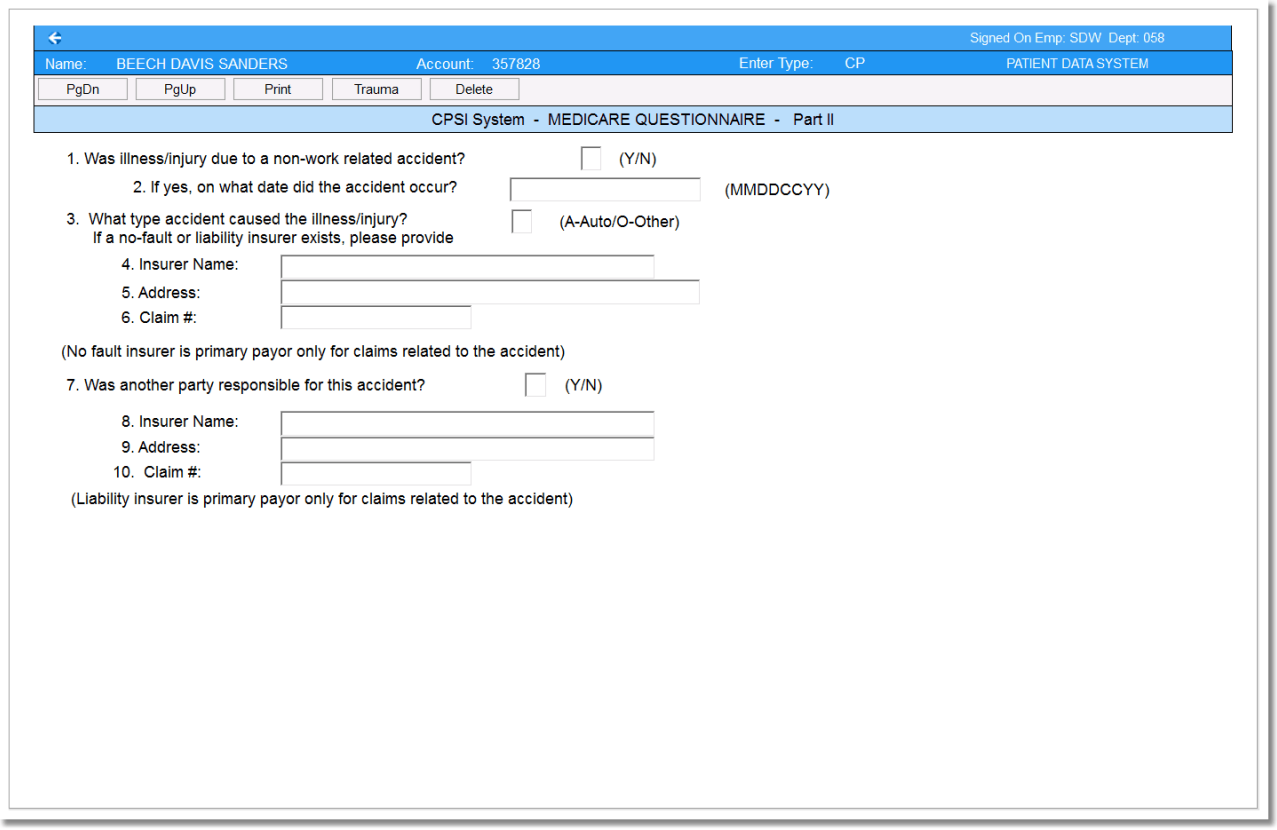
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Part I**



Medicare Questionnaire - Part I

After answering the questions on Part I, select **PgDn** to access Part II of the Medicare Questionnaire.

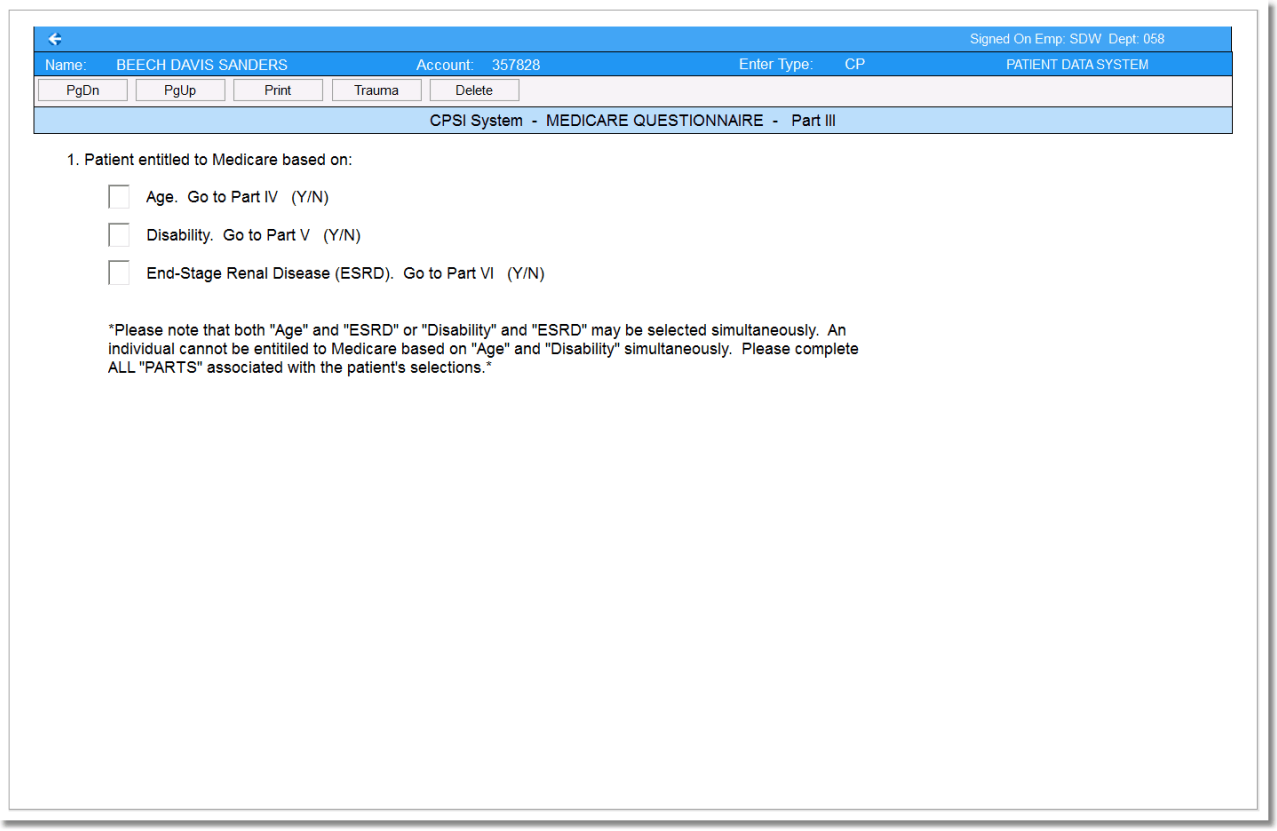
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Part II**



Medicare Questionnaire - Part II

After answering the questions on Part II, select **PgDn** to access Part III of the Medicare Questionnaire.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Part III**

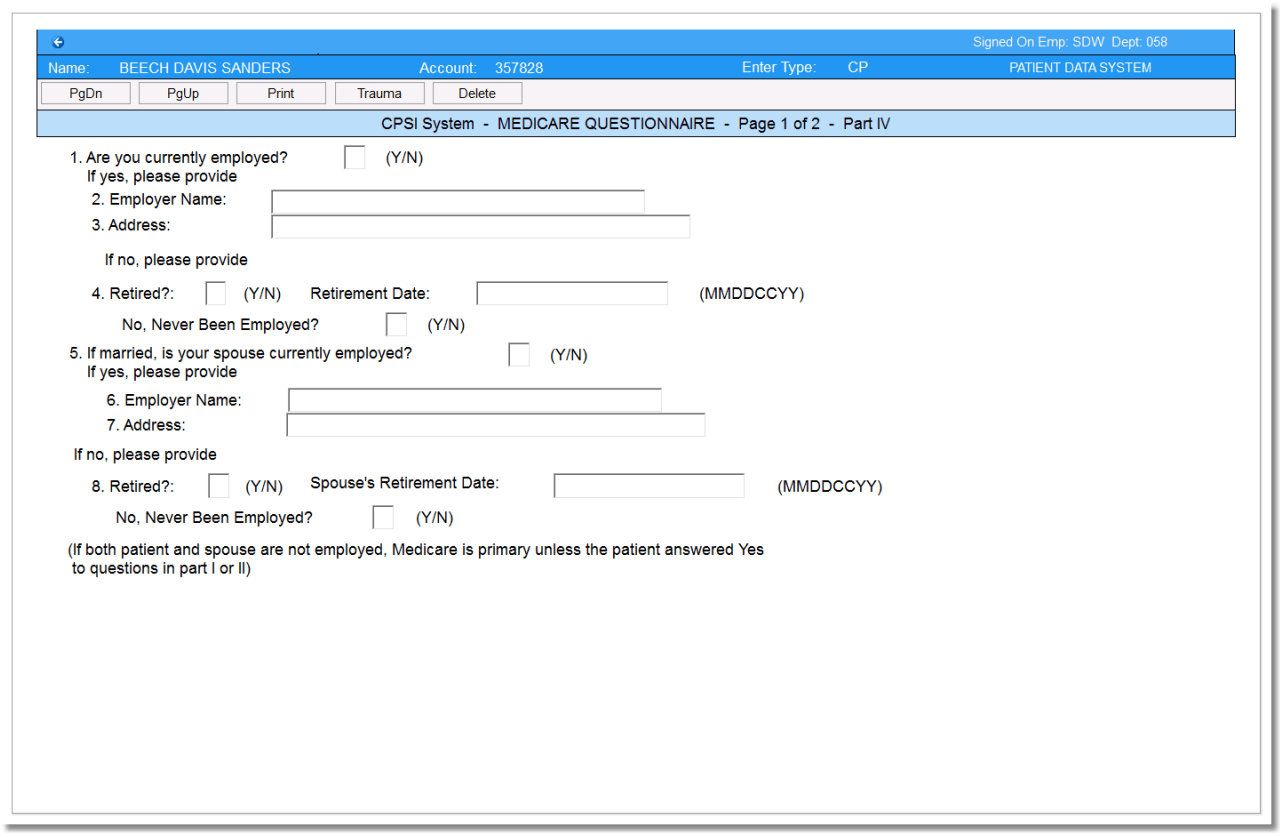


Medicare Questionnaire - Part III

Depending on how the question on Part III is answered, different parts of the Medicare Questionnaire will be accessed. If an **Y** is entered for Age, when selecting **PgDn**, Part IV will be accessed. If a **Y** is entered for Disability, when selecting **PgDn**, Part V will be accessed. If an **Y** is entered for End-Stage Renal Disease, when selecting **PgDn**, Part VI will be accessed. The questions on Part IV, V, and VI will vary.

If Age in Part III is answered **Y**, the following screen will display.

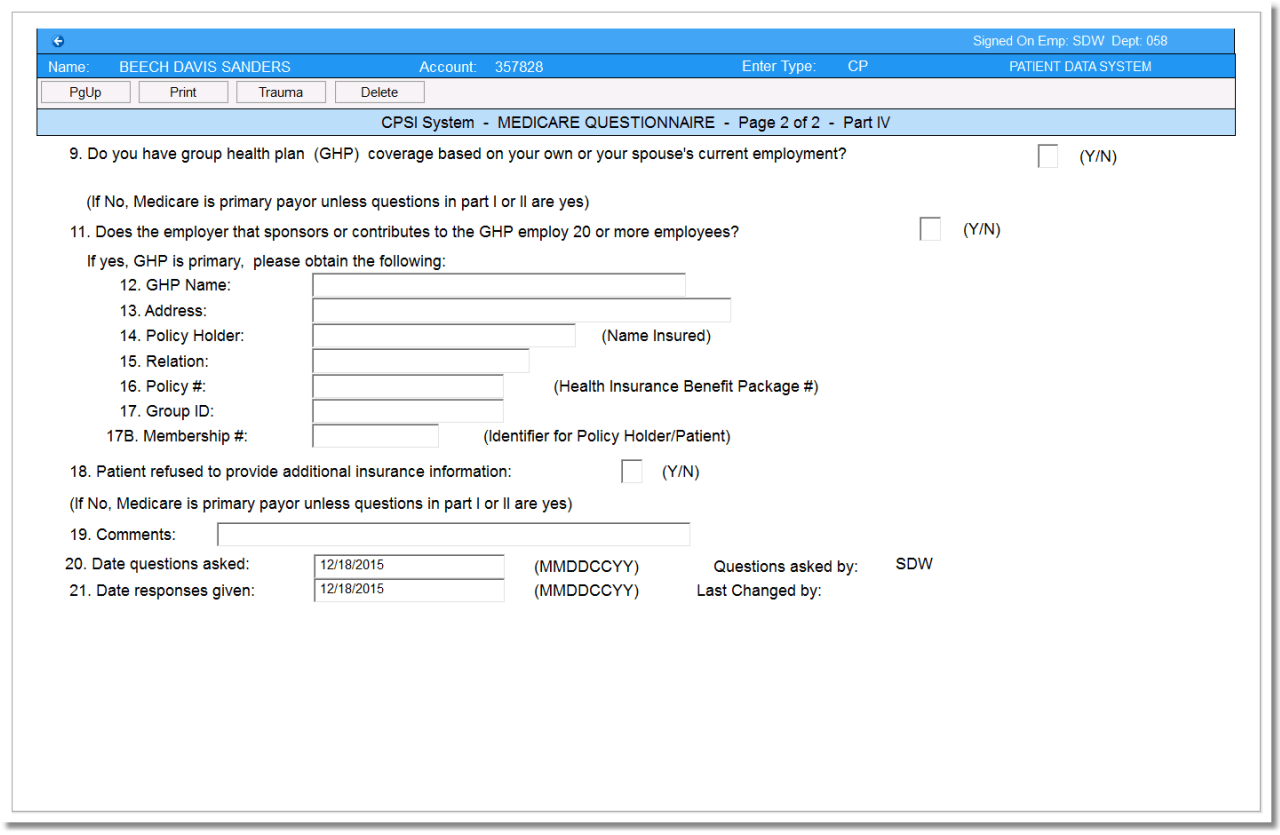
Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Census > MSP > Part IV**



Medicare Questionnaire - Page 1 of 2 - Part IV

Select **PgDn** to access page 2 of Part IV, V or VI.

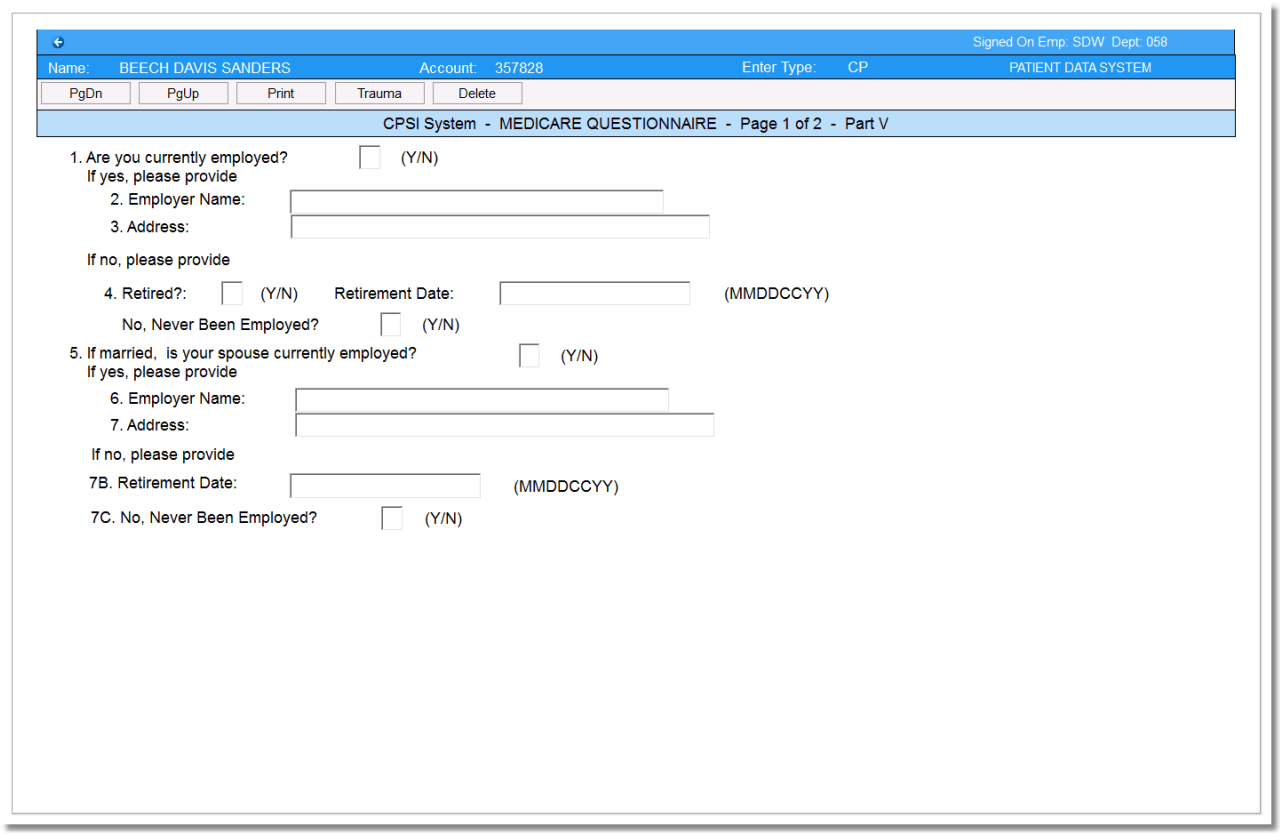
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Page 2 of 2 - Part IV**



Medicare Questionnaire - Page 2 of 2 - Part IV

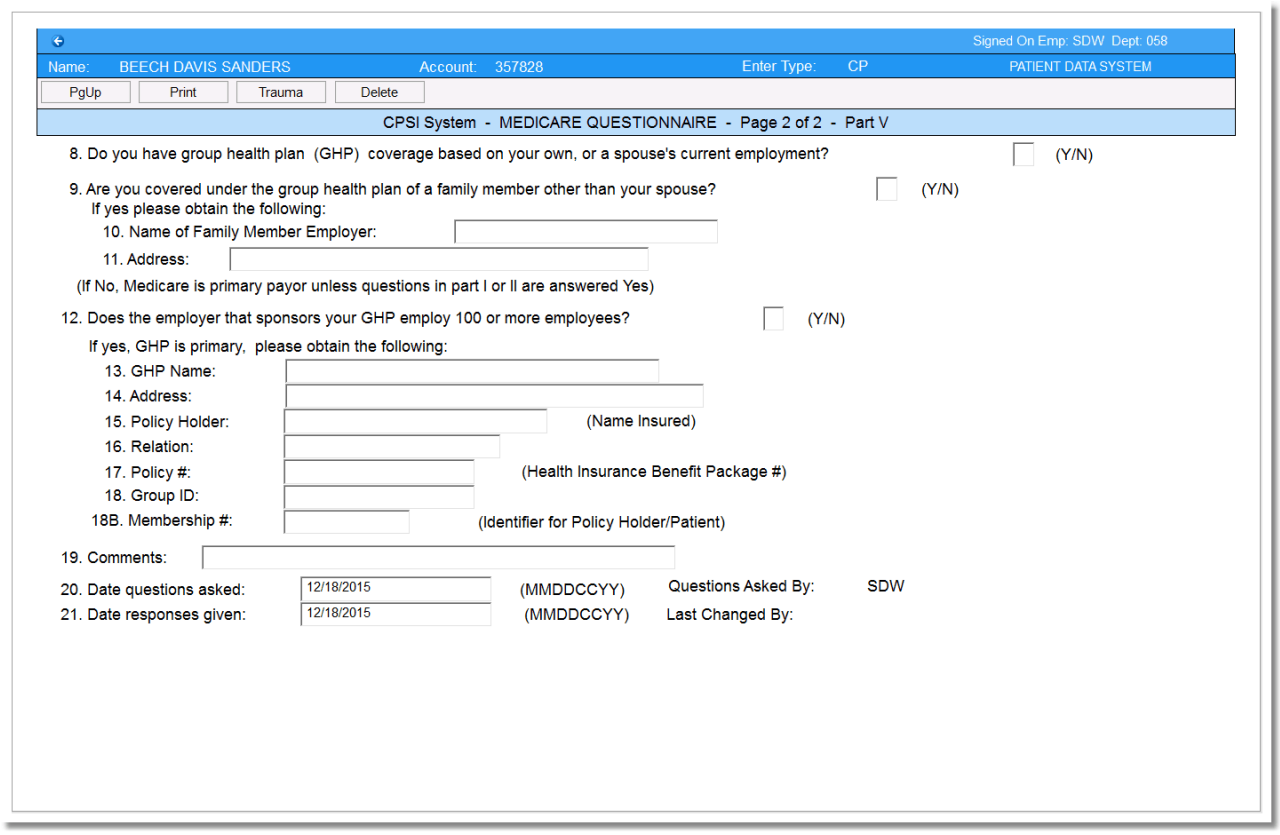
If Disability in Part III is answered **Y**, the following screen will display.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Census > MSP > Part V**



Medicare Questionnaire - Page 1 of 2 - Part V

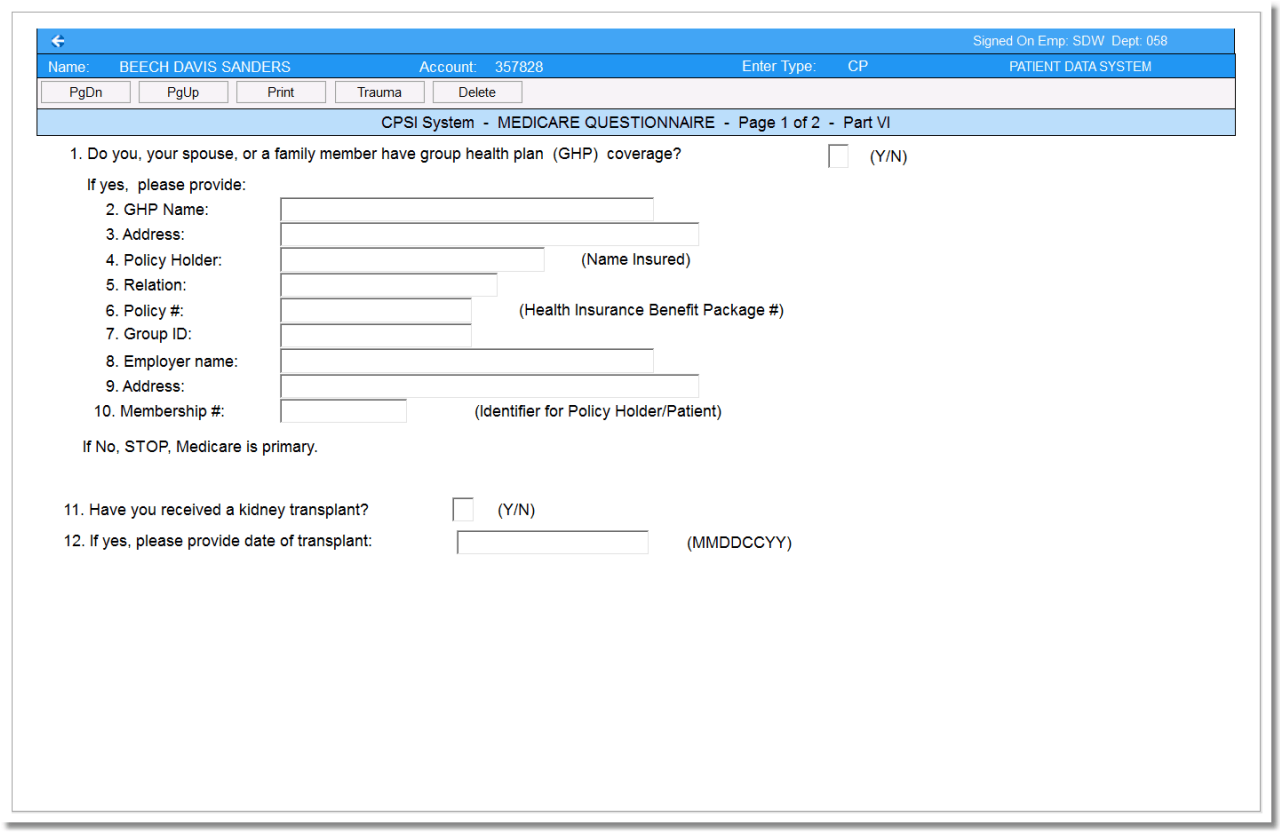
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Page 2 of 2 - Part V**



Medicare Questionnaire - Page 2 of 2 - Part V

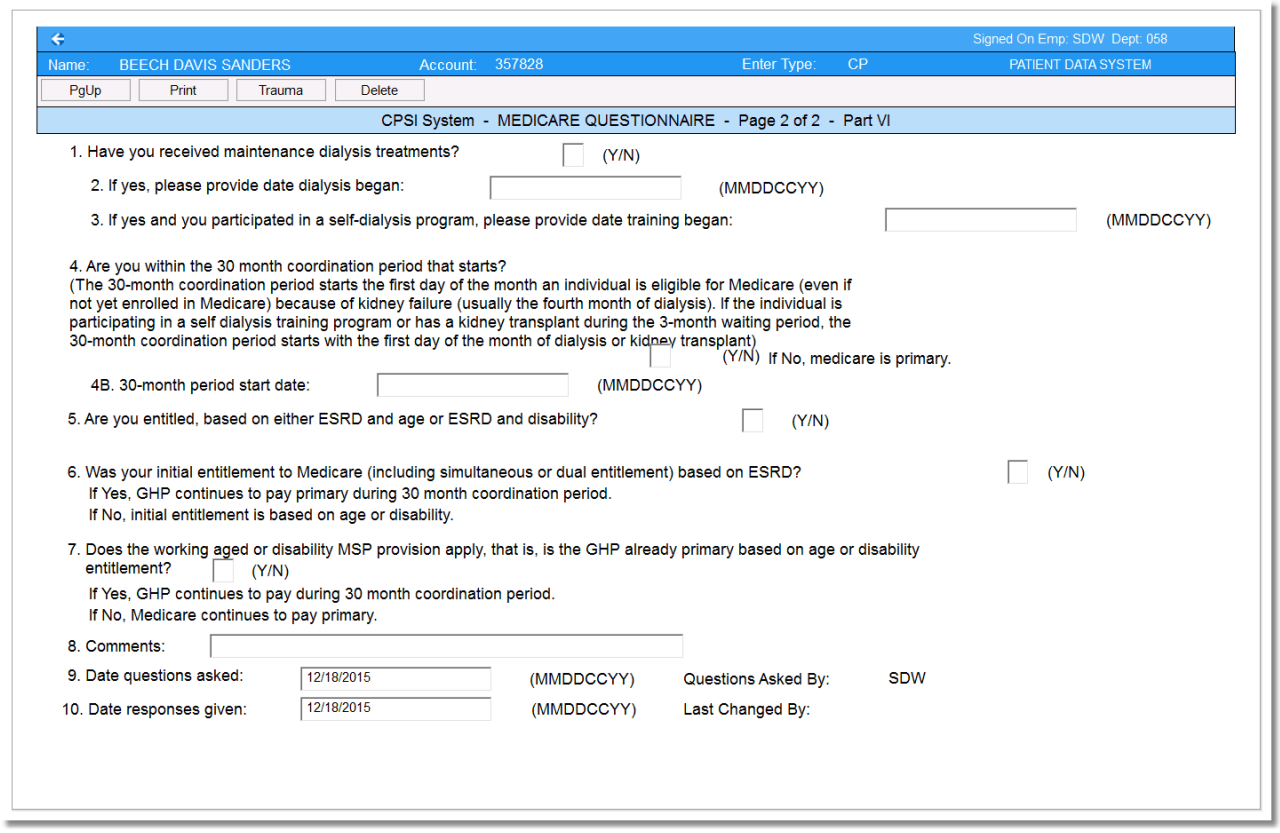
If End-Stage Renal Disease in Part III is answered **Y**, the following screen will display.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Census > MSP > Part VI**



Medicare Questionnaire - Page 1 of 2 - Part VI

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Census > MSP > Page 2 of 2 - Part VI**



Medicare Questionnaire - Page 2 of 2 - Part VI

When all pages have been answered, the Medicare Questionnaire may be printed or the Trauma Questionnaire may be accessed.

At the top of the screen there are several options:

PgUp: The system will return to the previous page of the Medicare Questionnaire.

Print: This option will print the Medicare Questionnaire for the selected patient.

Trauma: This option will access the Trauma Questionnaire for the selected patient.

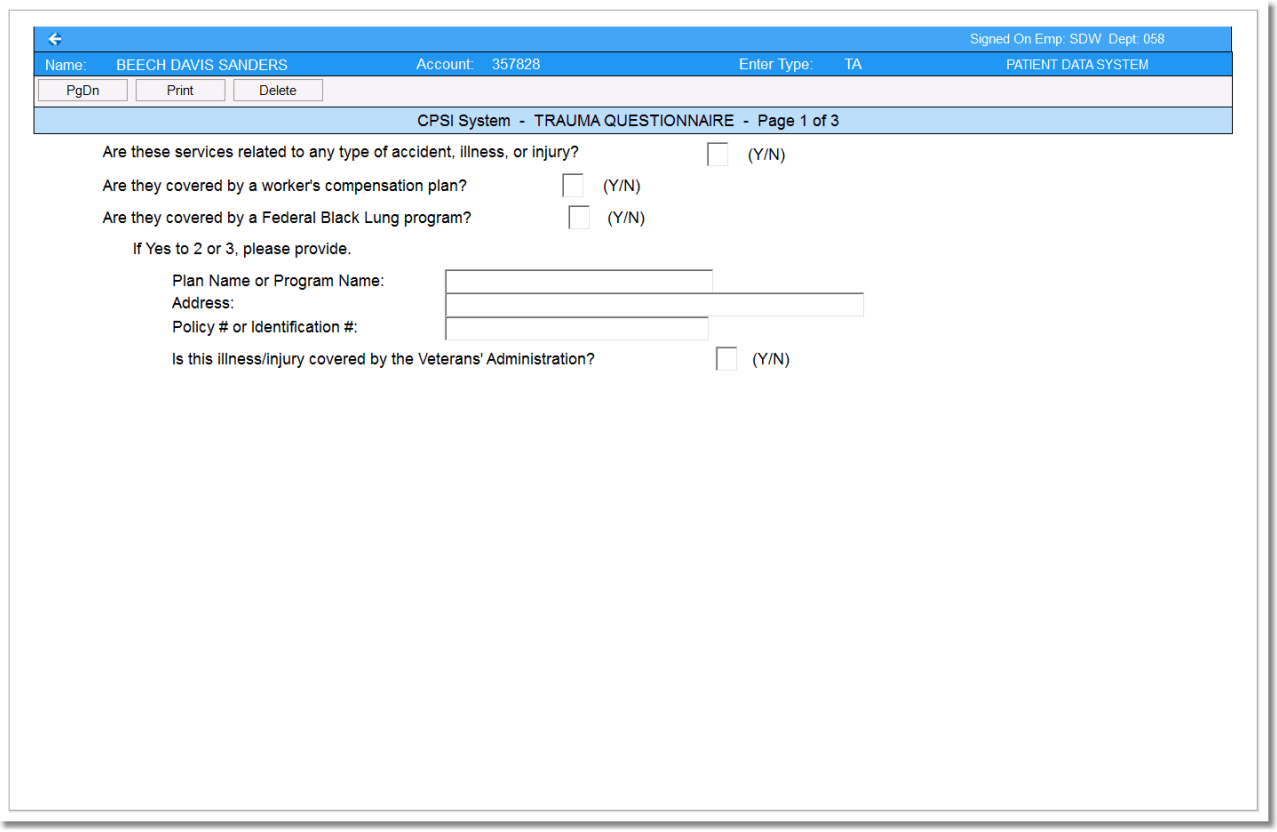
Delete: This option deletes the information entered in the Medicare Questionnaire, and returns to the Registration and ADT screen.

NOTE: *The log name of the person entering the Medicare Questionnaire will pull to the Questions asked by field. The log name of the last person to make any changes will pull to the Last Changed by field.*

4.4 Trauma Questionnaire

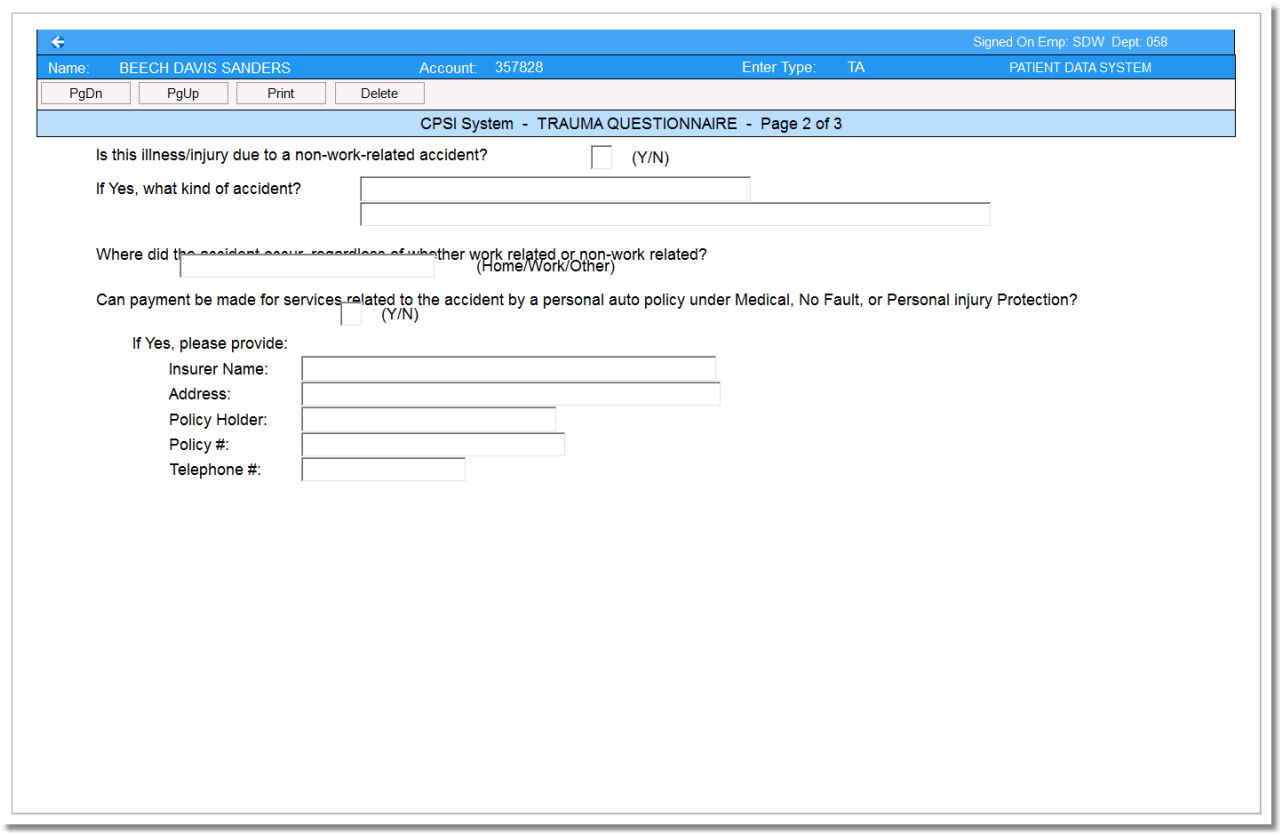
Medicare requires the Medicare Trauma Questionnaire to be answered for trauma patients. To access this questionnaire from the Registration and ADT screen, select the **MSP** button. The Trauma Questionnaire may then be accessed by selecting the **Trama** button.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Census > MSP > Trauma**



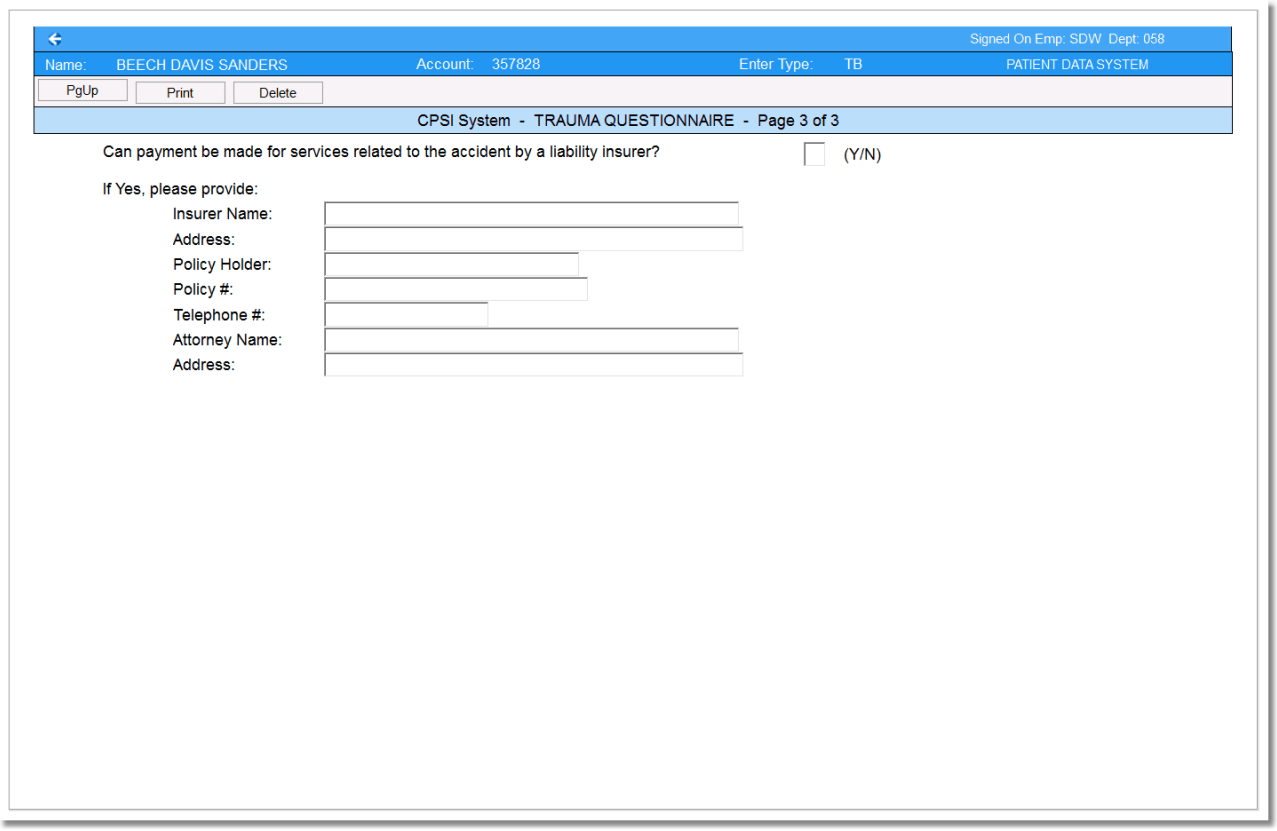
Trauma Questionnaire, Page 1

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Trauma**



Trauma Questionnaire, Page 2

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Census > MSP > Trauma**



Trauma Questionnaire, Page 3

The Trauma Questionnaire can be deleted from the account by selecting **DEL** at the top of the screen.

4.5 Printing Questionnaires

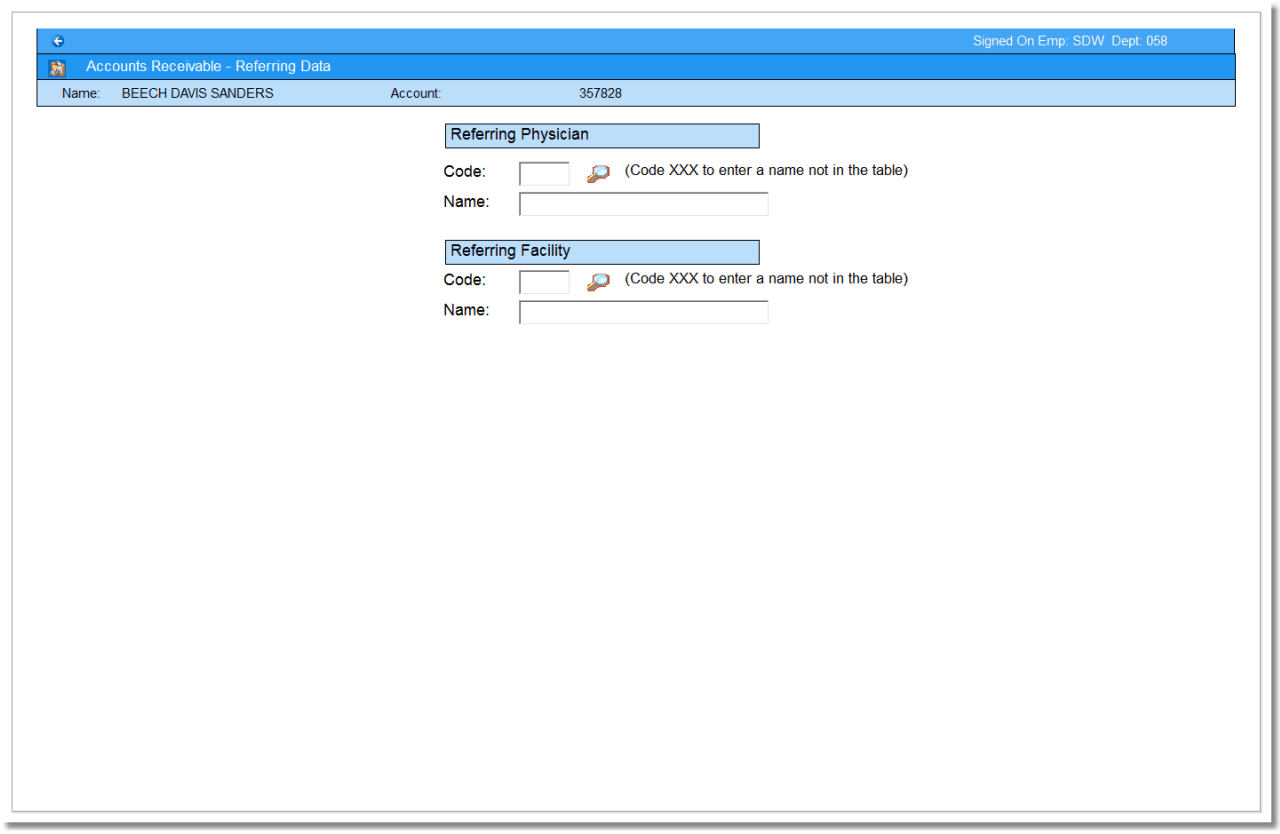
The Medicare Questionnaire and the Trauma Questionnaire may be printed from the Census menu within Print Reports or from a single patient account.

When printing from the report section, select **Print Reports** from the Web Client > System Menu > Hospital Base Menu **>** Census **>** M'care Questionnaire. After selecting to print either the Medicare Questionnaire or the Trauma Questionnaire, the selection can be made for a single account or for a date range by Admit Date.

Another way to print the questionnaire is by entering a patient account number. From the Hospital Base Menu select Patient Account # > Census > MSP then select the **Print** button to print the individual account's Medicare Questionnaire. To print the Trauma Questionnaire, select **Trauma** once in the MSP then select the **Print** button.

4.6 Referring Data

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Referring Data**



Accounts Receivable - Referring Data

Referring Physician

- **Code:** Enter the 3-digit code set up for the desired physician in the Referring Physician table.
- **Name:** The name of the Referring Physician will be populated if the physician is chosen from the lookup. If **XXX** is entered in the code, the physician name will need to be manually entered in this field.

Referring Facility

- **Code:** Enter the 3-digit code for the desired facility in the Referring Facility table.
- **Name:** The name of the Referring Facility will be populated if the facility is chosen from the lookup. If **XXX** is entered in the code, the facility name will need to be manually entered in this field.

If the Referring Physician Code or the Referring Facility Code is not known, a lookup window is provided. Selecting the magnifying glass or entering a question mark (**?**) will display a listing alphabetically by codes.

The information loaded into the Referring Data screen will pull to locator 17a of the 1500 and locator 78 of the UB. This information will pull in place of the attending physician in the Stay tab of the Registration and ADT screen.

Chapter 5 Stages of an Insurance Claim

5.1 Overview

The TruBridge EHR Insurance Billing system is a daily process. To use the system most effectively, claims must be processed through stages. This section will discuss the stages of an Insurance Claim within TruBridge EHR.

5.2 Progression of an Insurance Claim

- **Unapproved Status:** Claims that begin at this status require some form of verification (ex: precertification or data verification). If this type of verification is not required, the claim should not start at this status.

- **Approved Status:** Claims at this status should be automatically generated and require no manual intervention.

- **Unchecked Status:** Claims at this status are here for one or two reasons. First, it may be an APC claim, which will automatically generate to the unchecked status if the Auto Gen Ready-to-Bill field on page 4 of the Insurance Company table is set to **N.** Second, if the claim is not an APC claim, it was most likely manually set back from the Ready to Bill status, and a reason was placed in the Comment field. APC claims will move to the Ready to Bill status once a M/R verified date has been placed on the claim, and the APC Claims to Ready to Bill report has been run. Other claims will have to be manually moved to Ready to Bill.

- **Ready to Bill Status:** Claims at this status will appear on the Insurance UB Edit List and the 1500 Edit List. These edits will print messages indicating any information that may be missing from the claims in this status. After reviewing each edit message and making the necessary corrections to the claim, Print UBs or Print 1500s may be selected. Once the forms are printed, the system gives the option to update claims. Once the claims are updated, the status is advanced to the Billed Status.

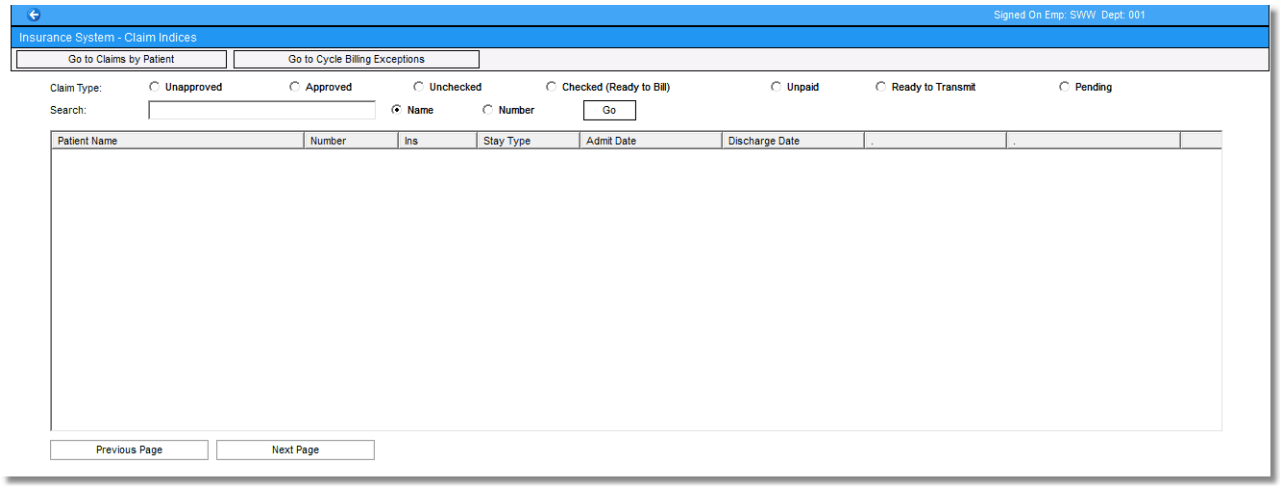
- **Pending Status:** Claims at this status are here for one or two reasons. First, it may be an Electronic Billed claim that has not been picked up by Electronic Billing Services, therefore it does not have an Electronic Billed date. Second, it may be a Secondary claim that has been initially moved to the billed status or fake billed.

- **Billed Status:** When a claim moves to the Billed Status, a note will be placed on the Account Detail stating the Insurance Company's name, Set Number, Billed Date, Service Dates and Expected Pay amount for that claim. Once the claim is at the billed status, the employee initials will pull to the Account Detail. The initials will be displayed in the Code column when the Initials option is selected. If TruBridge moved the claim to billed, the initials will pull as XXX. Claims at this status will appear on the Billed but Unpaid Claims report. The Billed but Unpaid Claims report may be printed by Insurance or by Physician. Once a payment is made for a claim, the Receipting personnel will post the payment information against the appropriate claim. This will advance the claim to the Paid Status. If a claim is rejected, a payment of $0.00 should be posted against the appropriate claim using a payment code of **R**. The system will then reflect this rejection by advancing the claim to the Rejected Status.

Insurance Indices

In the Insurance Indices, all claims at the different statuses may be reviewed.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance**



Insurance System - Claim Indices

There are several options on this page to view the claims of patients.

- **Unapproved Claims:** This will give a listing of all accounts who have claims at the Unapproved status. It will list the Patient Name, Account Number, Insurance code, Stay Type, Admit Date and Discharge Date.

- **Approved Claims:** This will give a listing of all accounts who have claims at the Approved status. It will list the Patient Name, Account Number, Insurance code, Stay Type, Admit Date and Discharge Date.

- **Unchecked Claims:** This will give a listing of all accounts who have claims at the Unchecked status. It will list the Patient Name, Account Number, Insurance code, Stay Type, Service To and Service From.

- **Claims by Patient:** This option will allow an account number to be entered to view the claims for that account.

- **Checked Claims (Ready to Bill):** This will give a listing of all accounts who have claims at the Ready to Bill status. It will list the Patient Name, Account Number, Insurance code, Stay Type, Service To and Service From.

- **Unpaid Claims:** This will give a listing of all accounts who have claims at the Billed Status and have not been Paid or Rejected. It will list the Patient Name, Account Number, Insurance code, Stay Type, Service To, Service From, Total Charges and Expected Payment.

- **Claims Ready to Transmit:** This will give a listing of all accounts who have claims with the Elect Bill switch selected on the Detail Charges screen. It will list the Patient Name, Account Number, Insurance code, Stay Type, Service To, Service From, Total Charges and Expected Payment.

- **Pending Claims:** This will give a listing of all accounts who have claims at the Pending status. It will list the Patient Name, Account Number, Insurance code, Stay Type, Service To, Service From, Total Charges and Expected Payment.

- **Search by Name:** Enter the patient's name and select **Go**.

To view a claim in any of the indices, highlight the line, and the system will display the Claim Status screen for that account. Select any column header for the system to sort the claims based on that heading.

The following options are available at the bottom of the screen:

- **Previous Page:** This will display the previous page.

- **Next:** This will display the next page of accounts.

The following options are available at the top of the screen:

- **Go to Claims by Patient**: Select this option to display the Claims by Patient screen for a specific account. For more information, see Claims by Patient 5.

- **Go to Cycle Billing Exceptions**: Displays a list of claims that were not generated thru Cycle Billing. For more information, see Exceptions Screen 86.

5.3 Reversing Claims

Many times a claim may be advanced prematurely. For this reason, it may become necessary to reverse or change the claims' status back to a previous status.

Claims at the Approved Status may be set back to the Unapproved status by removing the Approval Received Date in the Policy Information screen.

Claims may also be set back from the Ready to Bill Status to the Unchecked Status by deselecting Ready to Bill field on the Detail Charges screen.

Claims that have reached the Billed Status may be reversed to the Ready to Bill Status by selecting **Reverse** at the top of the Insurance Claim Status screen. The original Billed Date is stored to the right of the Billed Date field on the Insurance Claims status screen. The second Billed Date will display on this screen when the claim is billed again. The next time the UB's or the 1500's are printed, a form will print for these claims provided Print Form is answered **Y**.

Claims may be deleted at any stage except the Paid Status. To delete a claim, select **Delete** at the top of the Insurance Claim Status screen. If a claim is at the Billed Status, it must first be reversed before the system will allow the claim to be deleted.

5.4 AutoGen Feature And Requirements

The AutoGen feature allows Non-APC claims to move from the Approved Status to the Ready to Bill status and APC Outpatient claims to move from the Approved Status to the Unchecked Status without manual manipulation by the insurance personnel. The criteria that must be met to allow a claim to drop into the autogen process is as follows:

The claim must be at the Approved Status.

AutoGen I/P? or AutoGen O/P? on page 1 of the Insurance Company table must be answered **Y**, depending on the type of insurance. This allows patient claims for this Financial Class to be eligible for autogeneration.

Lag Days on page 1 of the Insurance Company table is the number of days after the patient's Discharge Date that must be closed in Accounts Receivable to allow the claim to drop into the autogen process.

NOTE: *If utilizing Auto Closing Days/Months in the Business Office Functions, the system is going to look at the Charges Closed thru date to autogen claims.*

Medical Records Complete on page 1 of the Insurance Company table may be answered **Y** or **N**. If this field is answered **Y**, the DRG Grouper screen must have a finished date entered in order for the claims in this Financial Class to be eligible for autogeneration. If this field is answered **N**, a finished date is not required on the DRG Grouper screen for these claims to be automatically generated.

If these requirements are not met, the claim will not drop into the autogen process.

Chapter 6 The Insurance Billing Process

6.1 Overview

TruBridge EHR is a daily billing system. The following procedures are recommended for the daily activities of the insurance billing personnel. To use TruBridge EHR most effectively, claims must be processed on a daily basis.

6.2 Daily Procedures

The printing of these reports will advance the proper claims to the necessary status and provide a listing of claims that requires attention during the Primary Billing process. There are other reports that should be printed and worked after the Primary Billing process has been completed. Primary Billing should be done first thing each morning, and completed prior to moving on to any other billing function.

Print the Insurance Reports:

1. AutoGen Insurance Claims

2. APC Claims to Ready-To-Bill

3. Late Charge/Credit Report: This report is spooled once the day is closed. The first section is the Late Charge/Credit Report, which will show charges that have been posted to an account since discharge. The second portion of this report is the **Unbilled Charges**. Unbilled charges are charges that have been posted to a patient's account that have a billed or generated insurance claim. Billers will need to review this report to see accounts that may need the insurance claims regenned, adjusted or reversed due to late charges.

4. UB Edit List and 1500 Edit List: Correct all errors from the **UB Edit List** and the **1500 Edit List**, and reprint the edits to ensure that all errors have been corrected. This is the first step in making sure a claim is complete prior to the claim being sent.

5. Print UB and Print 1500. This step will advance the claims to the Billed status and allow the claims to be picked up in the Electronic Billing process.

6. Print EBOS Edits (Select Other Applications and Functions > Electronic Billing Outsourcing > Edit with Standard Codes Only or Edit with Payer Specific Codes and Other Applications and Functions > Electronic Billing Outsourcing > Process Commercial EBOS Claims for Commercial) and correct all errors. This is the final step in making sure a claim is complete prior to being sent to the intermediary.

   If utilizing EBOS, please refer to the EBOS User Guide.

Insurance Verification/Pre-Authorization

This section of billing procedures will move claims to the correct status in order to fall into the Primary Billing process for the following day.

7. Unapproved Claims Report: Run this report and work all claims on the report. This report indicates claims that require some form of verification (ex: precertification or data verification). If this type of verification is not required, the claim should not start at this status. If there are additional insurance claims on the account, approve them also. Two asterisks will appear next to claims when the admit date is older than 20 days.

   A. Enter the **Patient Account** # from the Hospital Base Menu or the Master Selection Screen. Next select **Insurance** and the appropriate insurance **claim** from the Insurance Claims by Patient screen. Claims will be displayed in primary order. Work the primary claims first. Verify insurance claim and Stay Type. Create a new claim if necessary.
   B. Select **Policy Information** from the Insurance Claim Status Screen. Enter the Approved date. Verify and add any other pertinent information.
   C. Enter **Detail Benefits**. For primary claims complete the following fields:
      1. Enter Deductible amount.
      2. Enter Coverage % if not filing insurance at 100%. System will default to 100% if field is blank.
   D. For secondary claims, complete steps A and B from above. If the primary insurance is not filed at 100%, you must enter the coverage percent in the Policy Detail Benefits Screen. If the Expected Pay on the secondary claim is the deductible from the primary claim, enter the deductible amount as a negative in the Detail Charges screen of the secondary claim.

Follow-up Procedures

Any claims previously held out of the Primary Billing process will be worked at this time. Claims corrected during this step will fall back into the Primary Billing process for the following day.

8. Claims with Missing Information: Run this report and process claims with a **Y** below M/R complete.

   If a claim appears on this report, it should be for one of three reasons. First, it may be an APC claim, which will automatically generate to the Unchecked status if the Auto Gen Ready-to-Bill field on page 4 of the Insurance Company table is set to **N** and will contain the message "(APC Claim)" in the Comment field. Second, if the claim is <u>not</u> an APC claim, then it was manually set back from the Ready to Bill status and the reason should be placed in the Comment field. The APC claims will move to the Ready to Bill status once a M/R Verified Date has been placed on the claim and APC Claims to Ready to Bill report has been printed. The non-APC claims will not automatically move from the Unchecked status to the Ready to Bill status, and will need to be manually reset to Ready to Bill when ready. Third, if your facility utilizes EBOS, the claim may move back to Unchecked due to fatal ANSI edits. These claims would have “ANSI EDIT” in the Comment field. They must be manually reset to Ready to Bill when ready.
   A. Select **Generate Claim** to pick up any late charges which may have occurred after initial generation.
   B. Select **Stay Information** and verify the information on this screen. Select option **Medical Records Diags/Proc** to view all diagnosis and procedure codes. If changes need to be made to the codes, contact Medical Records. If there are discrepancies, enter these in the Comment field of the Claim Status screen.
   C. Select **Detail Charges** to change the status of the claim to Ready to Bill by selecting the **Ready to Bill** and **Print Form** fields. If this claim is to be transmitted electronically, select the **Elect Bill** field.

D. Repeat steps A and C above for any secondary claims, but do not select the Print Form field. All claims should be at the Ready to Bill status, and the total expected pay of all the claims should be approximately equal to the total charges from the primary claim.

E. Select the **Coding Screen** and verify all Condition, Occurrence and Value codes. All necessary codes must be present in order to print on the UB.

If utilizing EBOS, please refer to the EBOS User Guide.

9. **72 Hour Re-admissions:** Run this report to allow accounts to be reviewed that may need certain charges combined with inpatient accounts to comply with the 72- Hour Rule.

Secondary Billing

10. Process all Secondary claims.

A. If using the Automated Secondary Billing, print the **Secondary Billing Auto Reverse** report. Secondary claims at the Pending status with Primary claims that have been paid in full will be automatically reversed by the system. The Expected Pay will be adjusted to equal the amounts receipted to the Non-covered, Deductible, Co-Pay and Coinsurance of the primary claim, and the claim will be set to Ready to Bill and Print Form, depending upon the setting in the Automated Sec Billing fields on page 4 of the Insurance Company table.
B. To manually process Secondary claims, print the **Secondary Billing Report** to get a listing of paid Primary claims with non-Primary claims at the Pending status. Reverse the Billed date, and enter the correct Expected Pay on the Detail Charges screen.

Adjustment Claims/Rebilling

11. Process all Rejected claims and rebill.

A. If using Rejection Codes, print the **Rejection Code Summary Report**. When in Receipting, select **Update Work Area from Electronic RA File** to locate this report. Rejected claims will be listed along with the Rejection Code Description to assist in easier processing of the claim.
B. If using the Insurance Tickler, the system will update the Insurance Tickler File Maintenance Screen with a review code of I94-Claim Rejected.

6.3 Weekly Procedures

Print the Insurance Reports:

1. Approved Claims: Review claims on this report weekly. Claims that are flagged with two asterisks means the account has been discharged for four days. Claims should move from this report to the Ready to Bill status once the claim meets the criteria for autogenning. Any claim that remains on the report once the account has been coded and lag days have been met should be researched further.

2. Billed But Unpaid & A/R Bal = 0: This report should first be run as an edit to determine which accounts to reject and then as an update to actually reject those selected accounts. This report should be run on a weekly basis to keep the Billed but Unpaid Claims report as clean as possible.

   The edit version is an alpha listing of accounts that have a claim at the billed status with an A/R balance of zero. The update version is an alpha listing of accounts with a billed claim that has been rejected.

3. Billed but Unpaid Claims: This report provides an alpha listing by insurance of all outstanding insurance claims. Financial Classes that do not have any unpaid claims or claims that meet the report's criteria are excluded. The aging columns are Current, 30, 60 and 90 days. The last page of the report lists an aging break down of total dollars for each insurance company over each aging column. This report is helpful in showing which insurance is outstanding and how much payment is expected.

If utilizing EBOS, please refer to the EBOS User Guide.

6.4 Followup Procedures

The majority of an insurance processor's time should be spent following up on outstanding insurance claims and providing the necessary information to the intermediaries that will result in payment of those claims. This section discusses the Daily Insurance Billing procedures, Interim Billing procedures and Secondary Billing procedures. Along with these procedures are Followup procedures.

After claims are billed, it is crucial to the cash flow of the facility to work the claims that have not been paid. The **Insurance Tickler** as well as the **Billed but Unpaid Claims** reports are designed for this purpose.

The Insurance Tickler System is designed to simplify inhouse collection efforts on insurance accounts. Accounts may be moved into the Insurance Tickler File automatically or manually, depending on Business Office Table settings. Once assigned to the Insurance Tickler, accounts may be distributed for review based on either financial class or balance. Accounts dropped into the Insurance Tickler become eligible for review through the Insurance Tickler File Functions screen. For more information on the Insurance Tickler see the Collections User Guide.

If the Insurance Tickler is not being utilized, on a weekly basis the Billed but Unpaid & AR = 0 report should be printed. This report allows claims that have a zero Accounts Receivable balance and an outstanding insurance claim, to be reviewed. This report will display these claims on the screen and give the option to reject them. Once all claims have been displayed and the options to reject have been answered, a report will be printed. The claims that were rejected will be flagged with the word **Rejected**. Upon completion, the claims will be considered rejected in all insurance screens and an appropriate message will be entered on the Account Detail.

After printing and working the Billed but Unpaid Claims & AR = 0 report, the Billed but Unpaid Claims report should be printed. This report may be printed by Physician or by Insurance Company. The report that is most convenient for the Insurance personnel to work with should be printed and divided among the department. The information listed will age claims according to the billed date. The oldest claims should be worked first. Working a claim consists of researching the unpaid claim to determine why it has not been paid and contacting the intermediary with the information needed to have the claim processed.

In addition to working the Billed but Unpaid Claims reports, the daily reports should be viewed for discrepancies such as Financial Class information not matching the Stay Type. An Outpatient Stay Type should have an Outpatient Financial Class. The claims that should be addressed are claims that have mistakes. Claims that have not advanced from the daily reports should also be researched to determine why they are not being advanced.

If utilizing EBOS, please refer to the EBOS User Guide.

6.5 Secondary Billing Procedures

Secondary Billing of insurance claims is done on a daily basis as the primary claim on the account is paid or rejected by the insurance company. As seen in the section on Daily Procedures, the secondary claims on an account are worked and kept at the same status as the primary claim. There are two different methods for Secondary Billing. The following is a series of steps that allow for the most efficient and effective method to secondary bill.

If using the **Automated Secondary Billing**, the Automated Sec Billing field on page 4 of the Insurance Company table should be set to **Y**. The **Secondary Billing Auto Reverse** report should be printed. When printing the report, the system searches through all paid claims with a payment type of **F**, Paid in Full or **A**, Applied to Deductible, in the selected date range. If the account has a secondary claim, the secondary claim will be reversed to the Ready to Bill status with an expected pay equal to the sum of the Non-covered, Deductible, Co-pay and Coinsurance amounts from the claim that was paid. The Print Form will be selected or left blank, depending on how the Print Form field on page 4 of the Insurance Company table is set. The Elect Bill will be selected or blank depending on how the Elect Bill field on page 4 of the Insurance Company table is set.

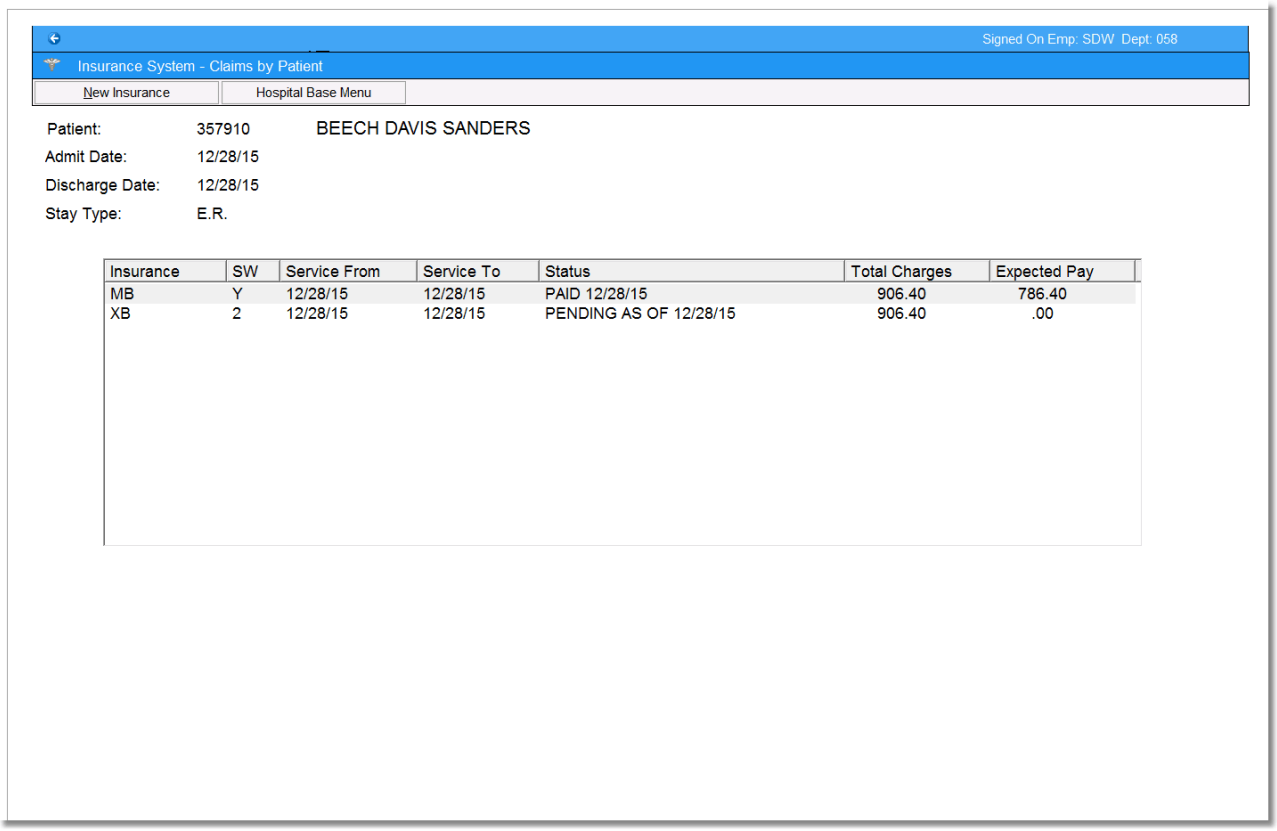
NOTE: *Non-Primary claims should be reviewed to ensure that the amounts are appropriately reflected on the claims.*

If using the manual Secondary Billing method, and the intermediary requires a copy of the primary remit along with the secondary form during the receipting process, receipting personnel should highlight claims on the remittance being paid or rejected that have a secondary claim. The remittance is then given to the Insurance personnel in charge of secondary billing. This allows the Insurance personnel to determine which claims need to have a secondary claim worked. The **Secondary Billing Report** should also be printed. This report lists the claims that have been paid or rejected within the date range of the report that have other claims on the account. The remittance and the Secondary Billing report are the first steps in the process of manually billing secondary claims.

When the remittance is received, the highlighted accounts should be accessed by entering the patient number on the Hospital Base Menu and selecting Insurance from the Patient Functions screen. All claims for this account will be listed on the Insurance Claims by Patient screen.

If electronically billing these secondary claims via EBOS, please refer to the EBOS User Guide.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claims By Patient**

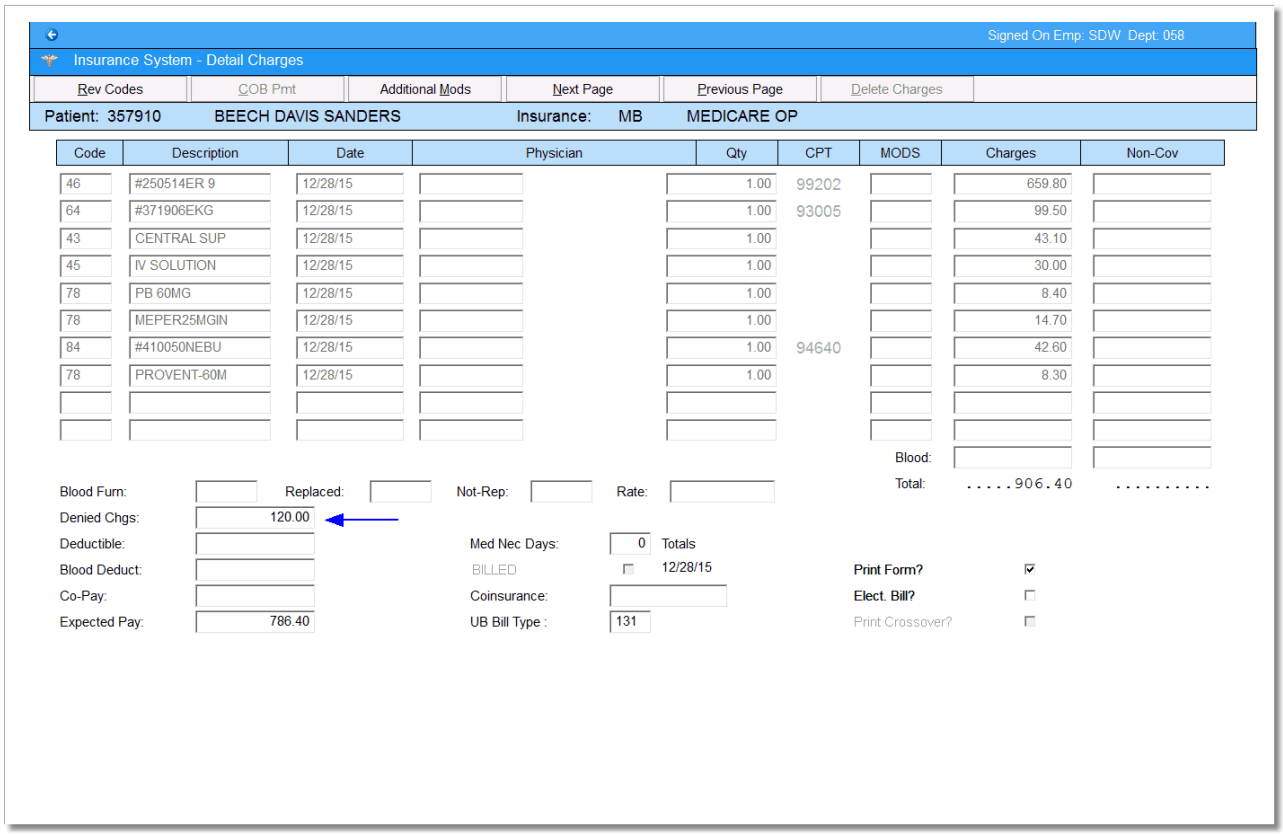


Claims By Patient

Select the primary claim. Once the primary claim is chosen, select **Detail Charges**.

On the Detail Charges screen, verify the Expected Pay amount. It should reflect the Non-covered, Deductible, Co-pay and Coinsurance amounts entered during receipting. It may be necessary to adjust the Denied Charges, Deductible, Blood Deductible, Co-pay or Coinsurance fields.

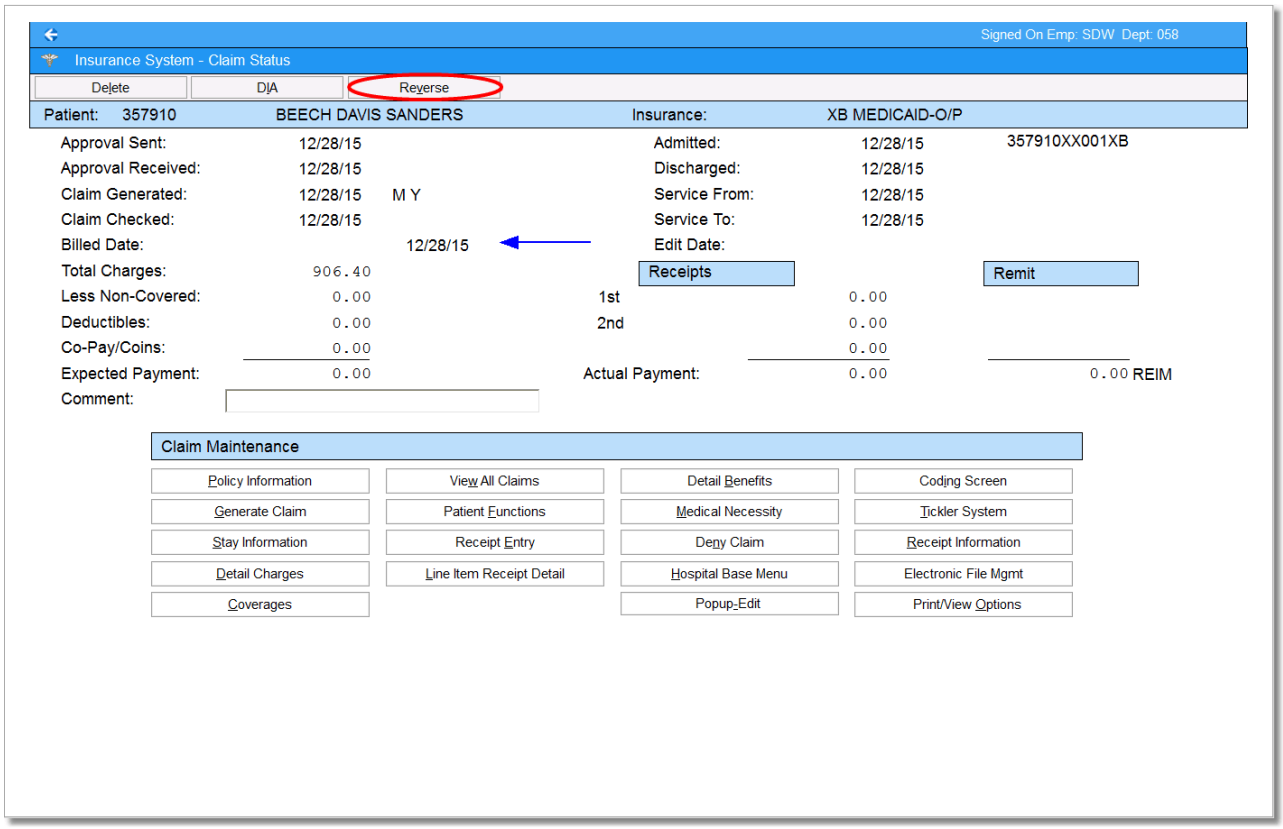
Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance > Detail Charges**



Insurance System - Detail Charges

Exit the primary claim. On the secondary claim, the Billed Date should be reversed. This is done by locking onto the secondary claim selecting **Reverse** at the top of the screen. Reversing the Billed Date will cause the secondary insurance to age properly on the Billed but Unpaid report and the Expected Pay will be correct. As seen below, after selecting Reverse, the Billed Date will be removed but will display the original date directly to the right.

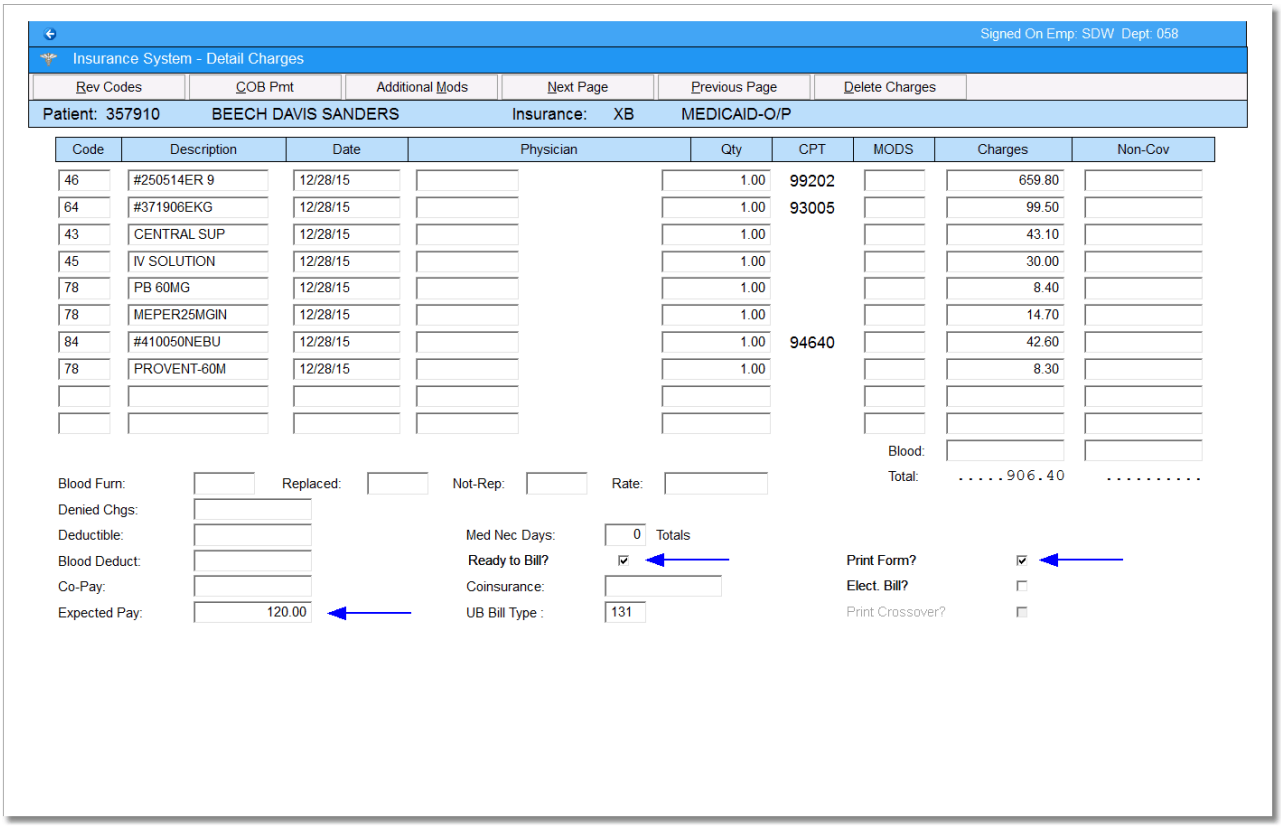
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim**



Insurance System - Claim Status

Select **Detail Charges** then **Expected Pay**. Enter the difference between the total charges and the actual payment of the primary claim. The claim should be set to the Ready to Bill status. From the Detail Charges screen, the **Ready to Bill** option should be selected, and **Print Form** option should also be selected. Selecting Ready to Bill will allow the claim to advance to the Billed status the next time UB's are updated. Selecting the Print Form field will allow a UB to print. If the secondary claims are not sent in the electronic file, Elect Bill should not be selected.

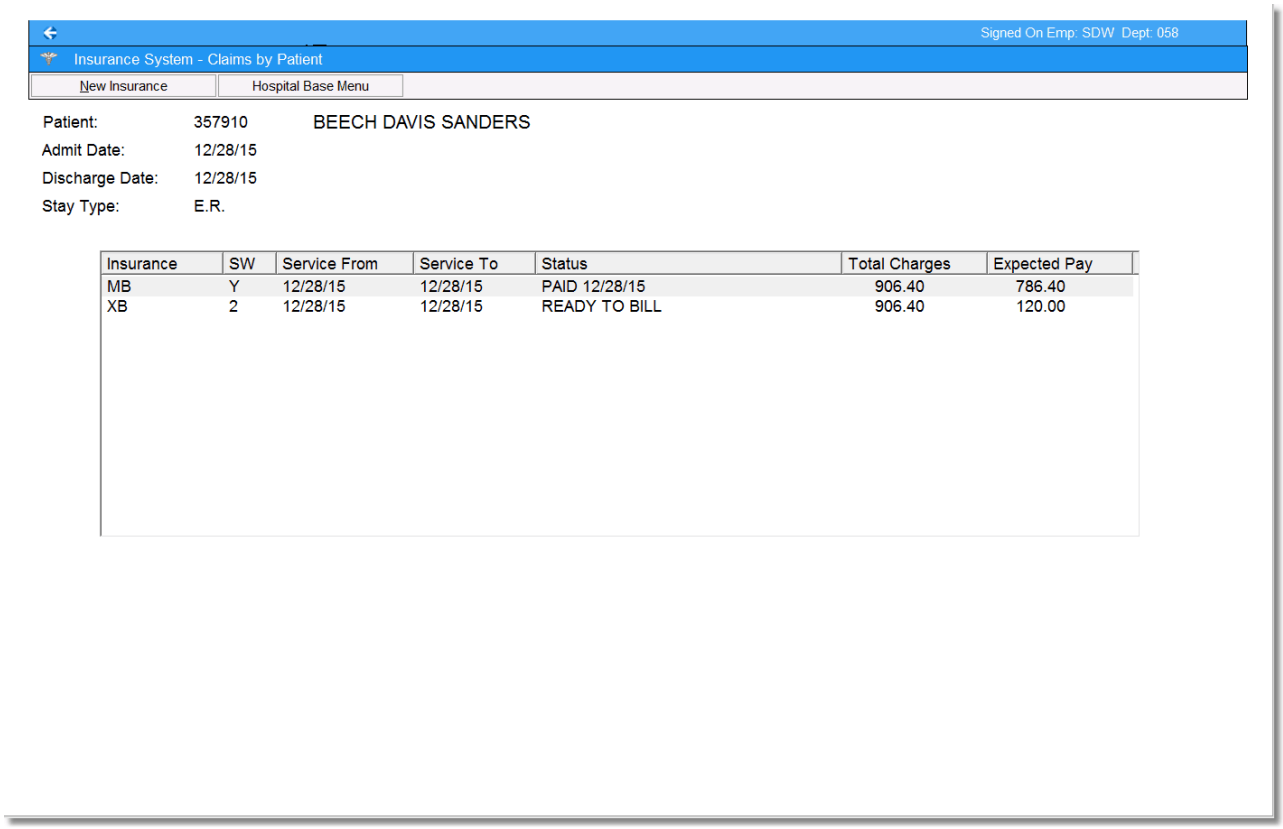
Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Detail Charges**



Insurance System - Detail Charges

The Expected Pay column on the Claims by Patient screen should now reflect the amount the claims expect to receive from the Insurance companies. The sum of the Expected Pay column should be equal to the total charges. An example of this is shown below.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance**



Insurance System - Claims By Patient

Staying current with the billing of secondary claims is important in the management of patient accounts. Once the primary claim is paid or rejected, the secondary claim should be billed as soon as possible to allow the flow of the billing cycle to continue. Once all claims are satisfied, the system will allow the remainder of the amount due to become the patient's responsibility, in accordance with billing policies and procedures.

6.6 Interim Billing Procedures

Insurance Billing procedures for Outpatient and Inpatient claims are done on a daily basis. Billing for Long Term and Recurring accounts should be done using the **Create Claims by Charge Period** program. This program is a generation program that moves claims from the Approved status to the Ready to Bill status for a chosen date range. TruBridge recommends that claims meet the following criteria when utilizing the Create Claims by Charge Period program:

- The patient Stay Type entered in the Patient tab on the Registration and ADT screen should be 2, 3, 4 or 5.
- The account should be assigned a cycle code of 5 or 6 in the Guarantor/Ins tab on the Registration and ADT screen.

- The account should not have a discharge date in the Stay tab on the Registration and ADT screen.

- The Financial Class should have a "B" in the second position to represent an Outpatient claim. TruBridge suggests the Financial Class code be three characters ending with "R", to represent a Recurring Financial Class, for example MBR, CBR, BBR.

***NOTE**: The above criteria will not determine if a claim falls into the Create Claims by Charge Period program.*

In addition to the recommended settings, the following criteria must be met in order for claims to fall into the Create Claims by Charge Period program:

- The account must have charges for the date range selected. The charge period is determined by the Service Date or the AR Date on the Account Detail. If the CCBCP Gen by SVS Dates field on page 1 of AHIS is set to **N**, the system will generate the insurance claim based on AR Date instead of Service Date. Please contact a TruBridge Software Representative before changing this option.

- Charges within the date range chosen will not pull to these claims if the charge is not covered by insurance. This is controlled in the Summary Code table.

- If a date is loaded in Date Care Ended, on the Detail Benefits screen, the Create Claims by Charge Period program will not create a claim for the account after that date.

The Insurance Company table for the Financial Classes that will be used for the Create Claims by Charge Period program should have the following fields answered:

- **Form Code:** This field should be set to **U** so the system will print a UB.

- **Bill Phy Chg Separate:** This field should be set to **Y** to set up a Physician claim for accounts that have physician components. If answered **Y**, a Financial Class code representing a Physician claim must be entered. This is the code assigned when a Physician claim is created.

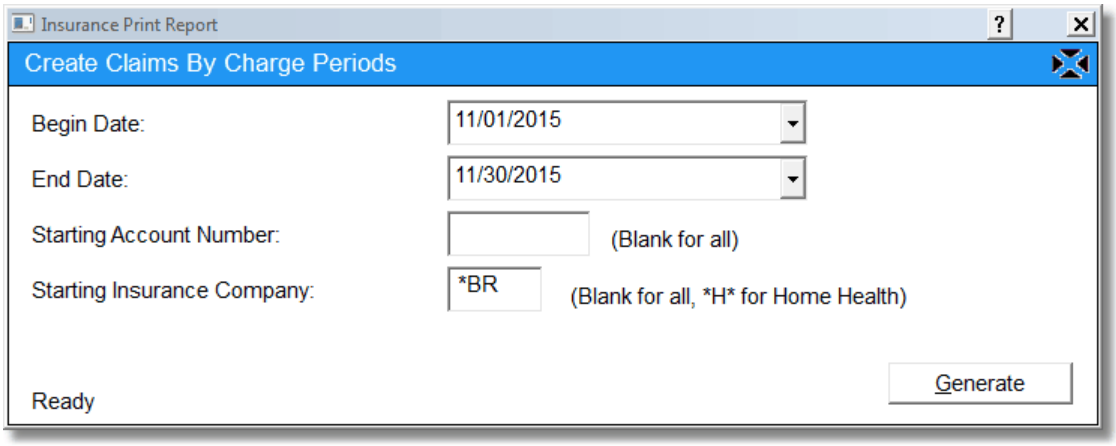
- **Require Approval:** This field should be set to **N**.

- **Auto Gen I/P?: Auto Gen O/P?:** Both fields should be answered **N**.

- **M/R Complete:** If this field is answered **Y**, the Medical Records coding screen must have a Finish Date to allow the claim to drop into the Create Claims by Charge Period program. If the Financial Class requires Medical Records coding to be complete before a claim is generated, the DRG Grouper screen must be updated with a Finish Date greater than the last Billed Date for each date range the Create Claims by Charge Period program is run. If this field is answered **N**, the Finish Date on the DRG Grouper screen will not be considered when the program is creating the claims for the charge period.

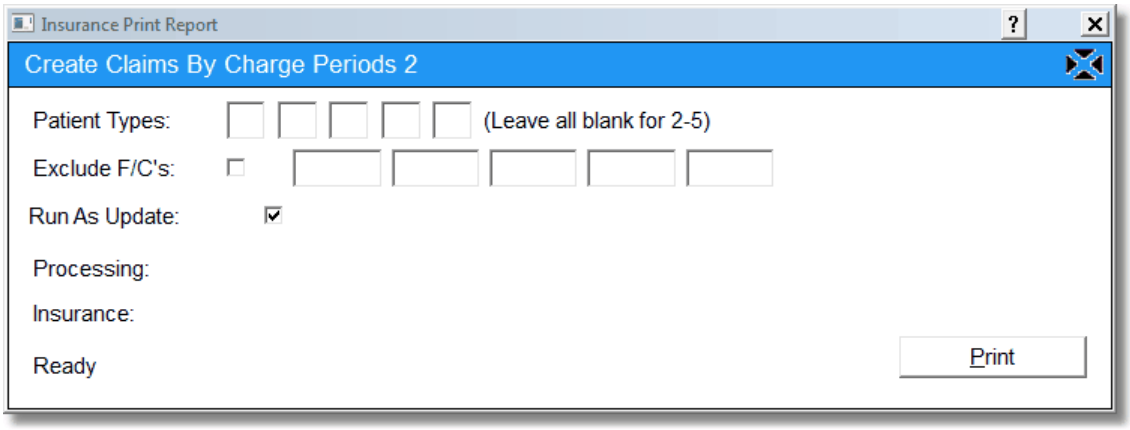
***NOTE:** See Tables Affecting Insurance for a complete list of the Insurance Company table fields.*

Select **Web Client > System Menu > Hospital Base Menu > Print Reports > Insurance > Create Claims By Charge Periods**



Create Claims By Charge Periods

The desired stay type should be entered, and the system will prompt to exclude any Financial Classes. Once the claims have been generated, the **Create Claims by Charge Period Exception Report** will print. This report will list any accounts which should have had a claim created but did not meet the criteria of a Medical Records Finish Date. This report is described in further detail in the Printed Reports section of this user guide.



Create Claims By Charge Periods 2

6.7 Cycle Billing Procedures

The Cycle Billing application provides a way to customize the length of interim billing cycles based on financial class and patient type. ~~Cycle Billing is only available in TruBridge EHR UX~~. A TruBridge Client Services Representative will need to be contacted to turn on the Cycle Billing application prior to use. After the application is active, the Cycle Billing table will need to be set up. The Cycle Billing table determines the frequency of each cycle based on financial class and patient type. For more information, please see the Cycle Billing Table 76 section.

Once the Cycle Billing table is set up, an entry will need to be made in the Pay Source table on the accounts that will use Cycle Billing. For more information, please see the Pay Source Table 81 section.

The initial entry in the Pay Source table should be made after the Insurance has been added on the Guarantor/Ins tab during the registration process. Subsequent entries will be automatically generated and placed in the Pay Source table as the Cycle Billing claim generation program runs. The Cycle Billing claim generation program will run automatically on a daily basis via CRON. The program will generate claims based on the following criteria:

- Autogen I/P? Autogen O/P on page 1 of the Insurance Company table should be blank (set to **N**). The Cycle Billing claim generation program ignores these fields when generating claims; however, TruBridge recommends that Autogen be turned off for financial classes that will use Cycle Billing.

- Medical Records Complete on page 1 of the Insurance Company table may be selected (set to **Y**) or blank (set to **N**). If this field is selected (set to **Y**), the Medical Records Grouper screen must be updated with a Finish Date that is greater than the last Billed Date for each billing cycle that is run. If this field is blank (set to **N**), the Finish Date on the Grouper screen will not be considered when the program is creating the claims for the cycle.

- Lag Days on page 1 of the Insurance Company are the number of Charge Days after the patient's Next Cycle Date that must be closed to allow the claim to generate via Cycle Billing. For example, if the Next Cycle End Date is 06/11/18 and Lag Days are set to 3, then the Charge Days will need to be closed thru 6/14/18 before the account meets the Lag Days criteria. The Charges Closed Thru Date is found in Business Office Functions.

- There must be a Coverage From Date but no Coverage To Date in the Pay Source Table. If the Coverage From Date is a Future Date, then a claim will not be generated. A future date is used to accommodate a coverage that is changing in the future.

- The Next Cycle End Date in the Pay Source table must be prior to the present date.

- If there is a Discharge Date prior to the present date on the account, but there is still a line without a Coverage To Date in the Pay Source table, then a claim will generate.

***NOTE**: The Cycle Billing claim generation program looks to the primary insurance claim when determining if a claim meets the criteria to generate. If there are entries in the Pay Source table for secondary and tertiary claims, they will generate when the primary claim meets the criteria to generate. If there is no primary claim entered, no other claims will be generated.*

If the above criteria are met, TruBridge EHR will move the claim from the Approved Status to the Ready to Bill Status and create the next entry in the Pay Source table. The next entry will have a Coverage From Date that is equal to the present date plus 1. The Next Cycle End Date will also be updated to reflect the ending date for the next billing cycle.

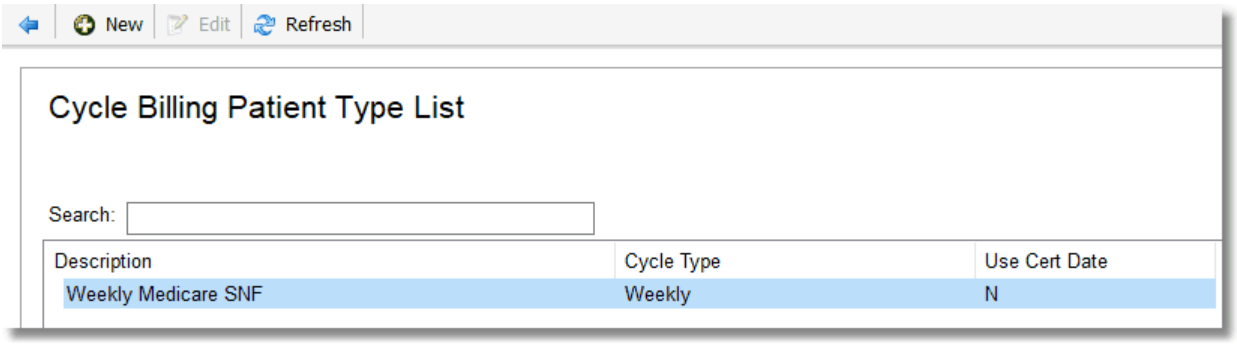
If a claim cannot be generated, or if the Next Cycle End date cannot be computed, the account will pull to the Exceptions List to be reviewed. This list should be worked daily if using Cycle Billing. Please see the Exceptions List 86 section for more information.

Cycle Billing Table

Each Financial Class that will use Cycle Billing must have an entry in the Cycle Billing table. The Cycle Billing Table determines the frequency of each cycle based on patient type. Cycles may be defined using Financial Class, Stay Type, Sub Type and Service Code. Cycles containing the same combination of Financial Class, Stay Type, Sub Type and Service Code may not be made within the table.

To begin select **Cycle Billing** from the Patient Intake tables screen.

Select **Web Client** > **Tables** > **Patient Intake** > **Cycle Billing**



Cycle Billing Patient Type List

The Cycle Billing Patient Type List will display. The following information displays for each existing cycle:

- **Description**: The name of the billing cycle.
- **Cycle Type**: The frequency of the cycle. This field will display either End of Month, Number of Days, Weekly, or None depending on the Cycle Type that was chosen for this cycle.
- **Use Cert Date**: This field will display a **Y** if Use Cert (Certification) Date was selected when the cycle was created. An **N** will display if this field was left blank.

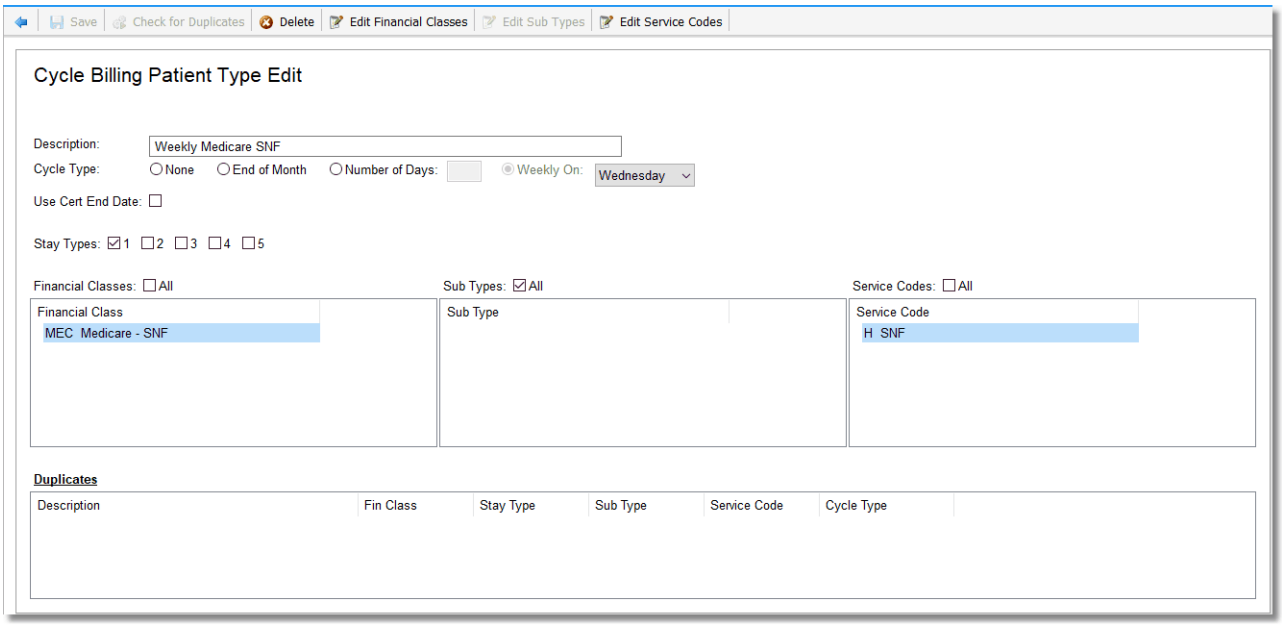
The following options are available on the action bar:

- **Back Arrow**: Select this option to return to the Patient Intake table screen.
- **New**: Select this option to create a new billing cycle.

- **Edit**: Select an existing billing cycle from the list, then select Edit to update an existing billing cycle.
- **Refresh**: Select this option to update the Cycle Billing Patient Type List with recent changes.

Select **New** to create a new billing cycle.

Select **Web Client** > **Tables** > **Patient Intake** > **Cycle Billing** > **New**



Cycle Billing Patient Type Edit

- **Description**: Enter a name for the billing cycle. A name is required for each billing cycle.
- **Cycle Type**: Select how often claims should be generated for this cycle.
  - **None**: Select for billing cycles that will not use the other cycle types. For example, if a cycle should be run based on Pre-Certification dates and not based on End of Month, Number of Days, or Weekly cycle types.
  - **End of Month**: Select for billing cycles that should generate claims on the last day of the month.
  - **Number of Days**: Select for billing cycles that should generate claims for a specified number of days. If selected, the length (in days) of the cycle will need to be entered.
  - **Weekly**: Select for billing cycles that should generate claims weekly. If selected, the day that the cycle should end should be selected from the drop-down.
- **Use Cert End Date**: Select this option when the cycle should be based on the Pre-Certification End Date that is entered in the Pay Source table. This option may be used along with other cycle types. If no other cycle types will be used, then None should be selected as the Cycle Type.
  - **Example1**: If Use Cert End Date is selected and Cycle Type is set to None, then the cycle will be generated using the Pre-certification From and To Dates. For example, if the Pre-Certification From date is 06/01/18 and the Pre-Certification To date is 06/15/18 the billing cycle would begin on 6/1 and end on 6/15; one claim would be generated for the Pre-Certification period.

***NOTE**: Billing cycles that have Use Cert End Date selected, and Cycle Type set to None, may have multiple entries in the Pay Source table. This will allow entries for different Pre-Certification periods to be entered at one time. For these types of billing cycles, the Pre-Certification From and To dates entered on the Pay Source table should not overlap. It is also important to note that when there is more than one entry in the Pay Source table, all entries will generate as soon as they meet the claim generation criteria - regardless of what Next Cycle End Date has been calculated.*

- **Example 2**: If Use Cert End Date is selected and another Cycle Type is selected, then claims will generate based on the frequency designated by the Cycle Type, but claims will stop generating when the Pre-Certification To date is less than or equal to the Next Cycle End Date. For example, if the Pre-Certification To date is 06/10/18 and the Next Cycle End Date is 06/13/18, then a claim would not be generated because the Pre-Certification has expired for the billing period.

- **Stay Types**: Select the Stay Types that will use this billing cycle.

- **Financial Class**: This box identifies which financial classes will use this billing cycle. Select the **All** checkbox if all Financial classes will use this billing cycle or select **Edit Financial Classes** from the action bar to select specific financial classes. See below for details.

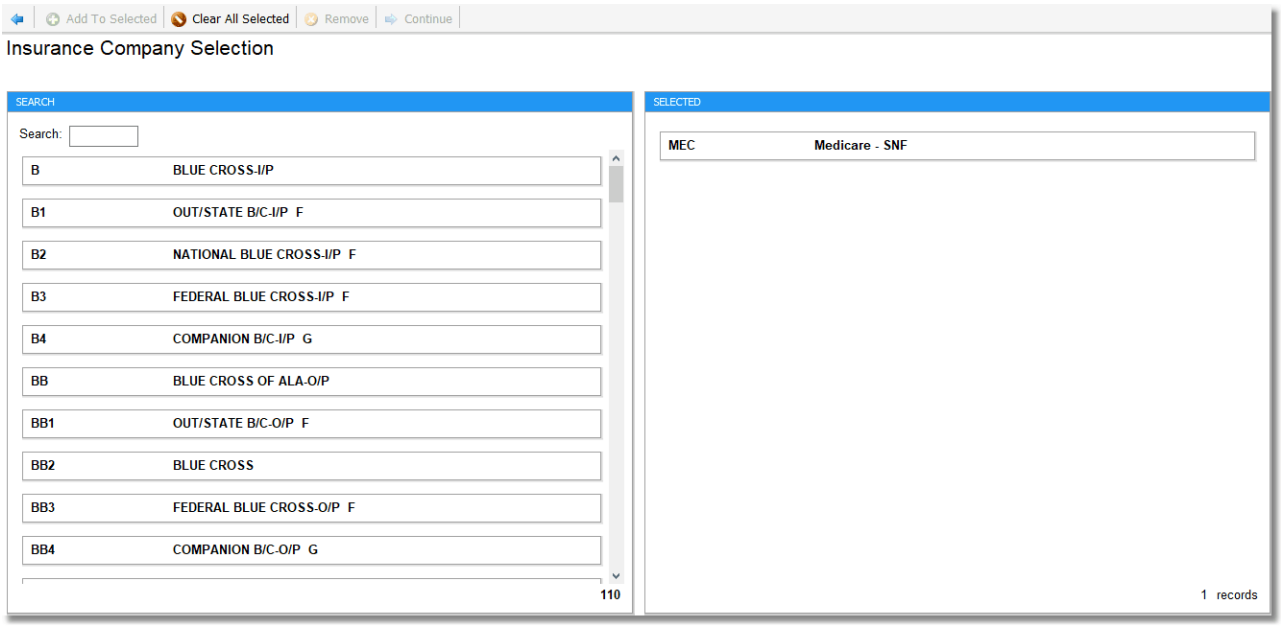
- **Sub Type**: This box identifies which Sub Types will use this billing cycle. Select the **All** checkbox if all Sub Types will use this billing cycle or select **Edit Sub Types** from the action bar to select specific Sub Types. See below for details.

- **Service Code**: This box identifies which Service Codes will use this billing cycle. Select the **All** checkbox if all Service Codes will use this billing cycle or select **Edit Service Codes** from the action bar to select specific Service Codes. See below for details.

***NOTE**: The Financial Class, Sub Type and Service Code fields must be answered; either the All box should be checked or the Edit options should be used to select specific codes. If these fields are not addressed, the **Check for Duplicates** option will not become active and the billing cycle cannot not be saved.*

To add specific Financial Classes, Sub Types or Service Codes to the billing cycle, select **Edit Financial Classes**, **Edit Sub Types** or **Edit Service Codes** to display the selection screen. This screen allows codes to be searched and added to the billing cycle.

Select **Web Client** > **Tables** > **Patient Intake** > **Cycle Billing** > **New** > **Edit Financial Classes**



Insurance Company Selection

The following options are available on the action bar:

- **Back Arrow**: Select this option to return to the Cycle Billing Patient Type Edit screen.
- **Add to Selected**: After selecting a code from the Search list, select this option to add the code to the Selected list.
- **Clear All Selected**: Select his option to remove all codes from the Selected list.
- **Remove**: After selecting a code from the Selected list, select this option to remove the code from the Selected list.
- **Continue**: Select this option once all codes have been added to the Selected list.

Once the Cycle Billing Patient Type Edit screen is completed, select **Check for Duplicates**. This will populate the Duplicates box at the bottom of the screen. If duplicate entries exist they will display here. If no duplicates exist it will say "No Duplicates Found."

No billing cycle may have the same combination of Financial Class, Stay Type, Sub Type and Service Code. For example, if Billing Cycle 1 has Stay Type **1**, Financial Class **M**, Sub Type **01**, and Service Code **P** and Billing Cycle 2 has Stay Type **1**, Financial Class **M**, Sub Type **01** and Service Code **ALL** - then a duplicate entry would exist because the Service Code **P** is included in both billing cycles.

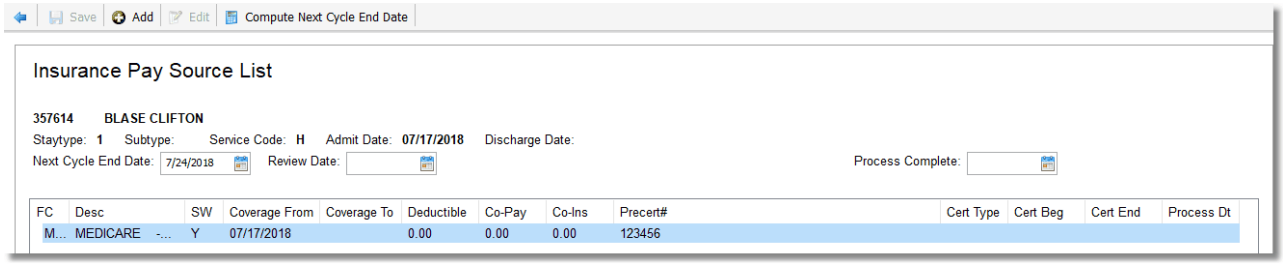
Check for Duplicates must be selected before the Save option will become active. If duplicates entries exist, the Cycle Billing table will need to be modified before the billing cycle can be saved. If there are no duplicate entries, select **Save** to add the billing cycle to the Cycle Billing table. The **Delete** option will allow the billing cycle to be removed from the Cycle Billing table. Select the **Back Arrow** to return to the Cycle Billing Patient Type List screen.

Pay Source Table

The initial entry in the Pay Source table should be made after the Insurance has been added and the account has been admitted during the registration process. Subsequent entries will be automatically generated and placed in the Pay Source table as the Cycle Billing generation program runs.

The Pay Source table may be accessed on the Guarantor/Ins tab in the Census screen or from the Insurance screen. To begin, select **Pay Source**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Account Number** > **Census** > **Guarantor/Ins Tab** > **Pay Source**
or **Web Client** > **System Menu** > **Hospital Base Menu** > **Account Number** > **Insurance** > **Pay Source**



Insurance Pay Source List

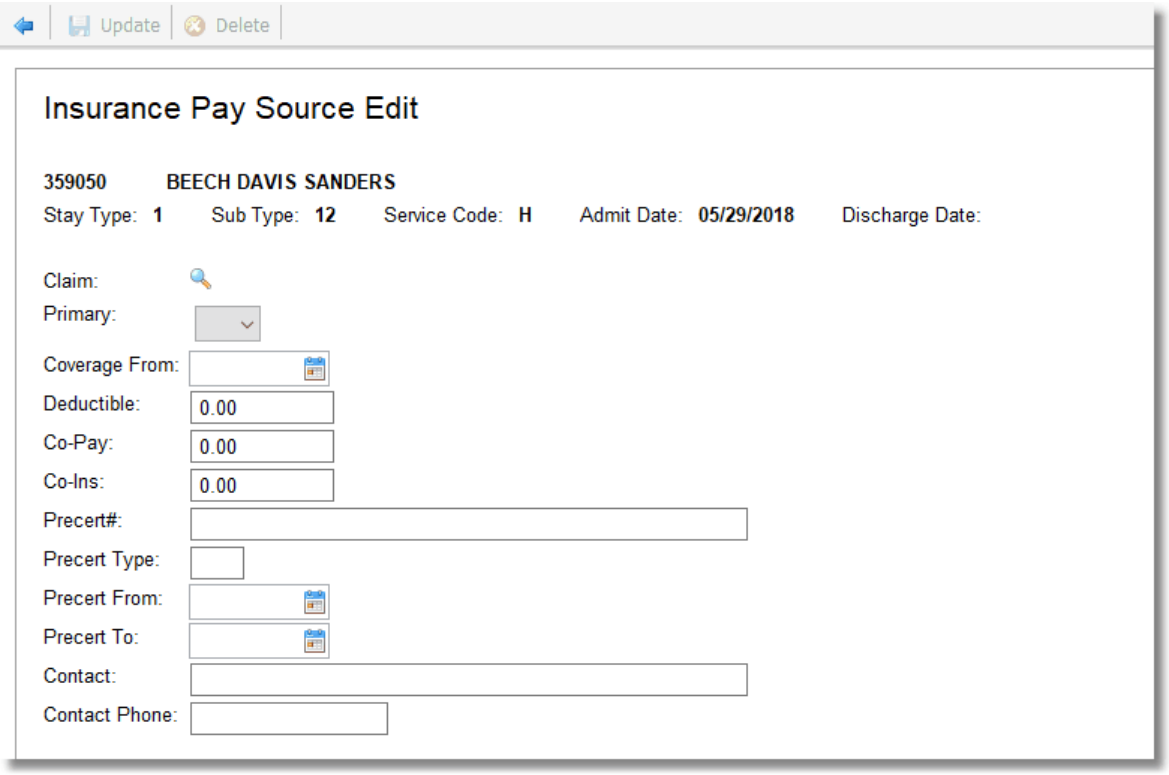
The Insurance Pay Source List will display. The following information will display at the top of the screen: Account Number, Patient Name, Stay Type, Sub Type, Service Code, Admit Date and Discharge Date. The following information displays for each existing claim:

- **FC (Financial Class)**: The Financial Class Code for the insurance claim.
- **Desc (Description)**: The description of the Financial Class Code from the Insurance Company Table.
- **SW (Primary Switch)**: Set to **Y** for Primary claims, **2** for Secondary claims, and **3** for Tertiary claims.
- **Coverage From**: The beginning coverage date that was entered on the Insurance Pay Source Edit screen.
- **Coverage To**: The ending coverage date that was entered on the Insurance Pay Source Edit screen.
- **Deductible**: The deductible that was entered on the Insurance Pay Source Edit screen.
- **Co-Pay**: The co-pay that was entered on the Insurance Pay Source Edit screen.

- **Co-Insurance**: The co-insurance that was entered on the Insurance Pay Source Edit screen.
- **Precert# (Pre-Certification Number)**: The Pre-Certification number that was entered on the Insurance Pay Source Edit screen.
- **Cert Type (Pre-Certification Type)**: The Pre-Certification type that was entered on the Insurance Pay Source Edit screen.
- **Cert Beg (Pre-Certification Begin Date)**:The Pre-Certification From Date that was entered on the Insurance Pay Source Edit screen.
- **Cert End (Pre-Certification End Date)**: The Pre-Certification To Date that was entered on the Insurance Pay Source Edit screen.
- **Process Dt (Process Date)**: The day the claim was processed thru the Cycle Billing claim generation program.

Choose an entry, then select **Edit** to update an existing entry or select **Add** to create a new entry.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Account Number** > **Census** > **Guarantor/Ins Tab** > **Pay Source** > **Add**
or **Web Client** > **System Menu** > **Hospital Base Menu** > **Account Number** > **Insurance** > **Pay Source** > **Add**



Insurance Pay Source Edit

The following fields may be addressed on the Insurance Pay Source Edit screen.

- **Claim**: Use the magnifying glass to display a list of claims that have been added to the account. Select the claim that will be generated using cycle billing. Private Pay will always be an option on the claim look up. A Claim must be selected to update the Pay Source table.

- **Primary**: Select the primary switch for the claim. Select **Y** for Primary, **2** for Secondary and **3** for Tertiary. The primary switch identifies which claim will be billed first. A Primary switch must be selected to update the Pay Source table.

- **Coverage From**: Select the date that coverage should begin for this claim. A Coverage From date must be selected to update the Pay Source table.

***NOTE**: The Claim and Coverage From date may not be edited after the entry is saved. If changes need to be made, the entry will need to be deleted and a new entry will need to be added.*

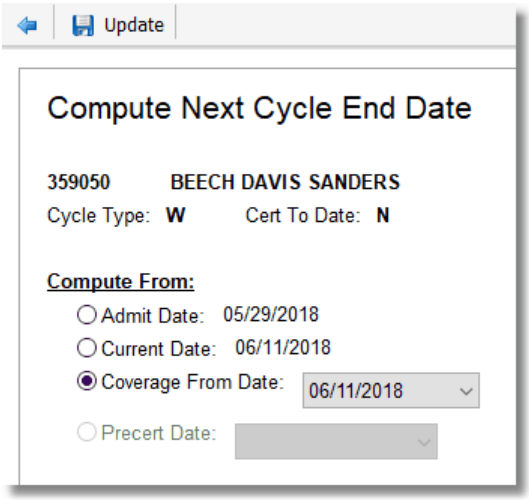
- **Deductible**: Enter the deductible amount for this claim. This will impact the Expected Pay on the claim once the claim is generated.

- **Co-Pay**: Enter the co-pay amount for this claim. This will impact the Expected Pay on the claim once the claim is generated.

- **Co-Insurance**: Enter the co-insurance amount for this claim.
- **Precert# (Pre-Certification Number)**: This will pull the pre-certification number that was entered on the Policy Information screen.
- **Precert Type (Pre-Certification Type)**: The pre-certification type that was entered on Policy Information screen.
- **Precert From(Pre-Certification From Date)**: The date the pre-certification period begins for this pre-certification number. A warning will display if the Precert From date is greater than the Coverage From date.
- **Precert To (Pre-Certification To Date)**: The date the pre-certification period ends for this pre-certification number.
- **Contact**: Enter the name of the contact for the pre-certification.
- **Contact Phone**: Enter the pre-certification phone number. This may automatically populate with the pre-certification phone number entered on the Policy Information screen.

Once all information has been entered, select **Update**. **Delete** will remove this entry from the pay source table. Select the **Back Arrow** to return to the Insurance Pay Source List screen. After the initial entry has been made in the pay source table, the Next Cycle End Date needs to be calculated. This may be done manually or by selecting **Calculate Next Cycle Date**.

Select **Web Client** > **System Menu** > **Hospital Base Menu** > **Account Number** > **Census** > **Guarantor/Ins Tab** > **Pay Source** > **Calculate Next Cycle Date**
or **Web Client** > **System Menu** > **Hospital Base Menu** > **Account Number** > **Insurance** > **Pay Source** > **Calculate Next Cycle Date**



Compute Next Cycle End Date

The following options are available for calculating the Next Cycle End Date.

- **Admit Date**: Select this option to have TruBridge EHR use the Admit Date as the cycle begin date. TruBridge EHR will look to the cycle begin date and the setup in the Cycle Billing table to calculate the Next Cycle End Date.

- **Current Date**: Select this option to have TruBridge EHR use the Current Date as the cycle begin date. TruBridge EHR will look to the cycle begin date and the setup in the Cycle Billing table to calculate the Next Cycle End Date.

- **Coverage From Date**: Select this option to have TruBridge EHR use the Coverage From Date as the cycle begin date. A drop-down menu is available to select the appropriate Coverage From Date that is loaded on the Insurance Pay Source Edit screen. TruBridge EHR will look to the cycle begin date and the setup in the Cycle Billing table to calculate the Next Cycle End Date.

- **Percert Date (Pre-Certification Date**): Select this option to have TruBridge EHR use the Precert Dates as the cycle beginning and ending dates. A drop-down menu is available to select the appropriate Precert From date that is loaded on the Insurance Pay Source Edit screen. If selected, TruBridge EHR will use the Pre-Certification To Date as the Next Cycle End Date, even if the Billing Cycle has an additional Cycle Type (Monthly, Weekly, Number of Days) selected.

Once a Compute From method has been selected, select **Update**. The Insurance Pay Source List screen will display again with the Next Cycle End Date populated. After Next Cycle End Date has been added, it may not be removed and it may only be updated. Below is a description of additional options that are available on this screen.

- **Review Date**: This field is used to pull accounts to the Cycle Billing Review Due 266 report. The review date should be entered here so that the account will display on the report when it is up for review. For example, a review date could be entered prior to the expiration of a Pre-Certification number, so that a new pre-certification number may be acquired prior to the next billing cycle.

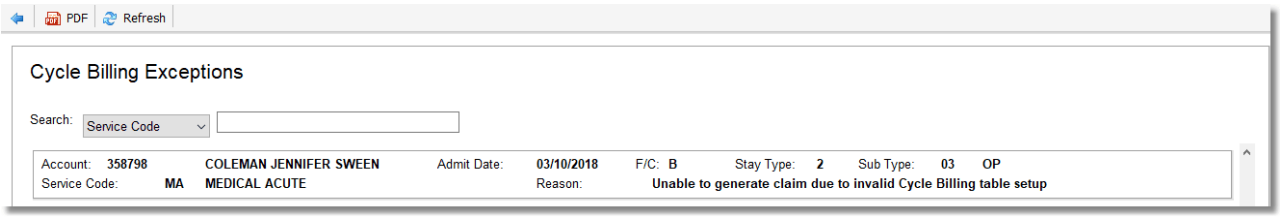
- **Process Complete**: The Process Complete date will be automatically added to the Pay Source table after the account has been discharged and the last claim has been generated. A Process Complete date may also be manually added. A warning will display if there are unprocessed entries in the Pay Source table and a Process Date is added. Claims will not be generated on accounts that have a Process Complete date and the Add option will be inactive so no new entries may be added to the Pay Source table.

Select **Save** to keep any changes made to the Review Date and the Process Complete date. Select **Back Arrow** to exit the Pay Source table.

Exceptions List

The Exceptions List displays accounts that did not have a claim generated, or accounts where the Next Cycle End date could not be computed when the Cycle Billing claim generation program was run. This list should be worked daily if using Cycle Billing. The Exception List may be accessed from the Insurance System - Claim Indices screen by selecting **Go to Cycle Billing Exceptions**.

Select **Web Client** > **System Menu > Master Selection** > **Insurance** > **Go to Cycle Billing Exceptions**



Cycle Billing Exceptions

A search feature is available to search for exceptions by Account Number, Admit Date, Patient Name, Reason, Service Code, Stay Type, or Sub Type. If searching by Reason, a drop-down menu is available to select a specific reason. An account will pull to the Exceptions List for one of the following reasons:

- **Unable to generate claim due to invalid Cycle Billing table setup**: This exception occurs when the Stay Type, Sub Type, Service Code or Financial Class are changed either on the account or within the Cycle Billing table after the entry in the Pay Source table was made. For example, if a valid entry is made in the Pay Source table on an account, but later the Stay Type on the account is changed, and that Stay Type does not match what is set up on the Cycle Billing table then the entry would now be considered invalid.

- **Unable to update Next Cycle End date due to lack of current precert dates**: This exception may occur when the billing cycle uses the Pre-Certification End Date with or without other Cycle Types (ex. Monthly, Weekly, Number of Days). For those billing cycles that ONLY use the Pre-Certification End Date, it identifies accounts where the Pre-Certification Dates are missing. For billing cycles that use the Pre-Certification End Date AND another Cycle Type, it identifies accounts where the Pre-Certification To date is less than or equal to the Next Cycle End Date. For example, if the Pre-Certification To date is 06/10/18 and the Next Cycle End Date is 06/13/18, then a claim would not be generated because the Pre-Certification has expired for the billing period.

- **Lab multi-channel overflow**: This exception is not used.

- **Unable to generate claim due to missing Next Cycle End date**: This exception occurs when the Next Cycle End date was not calculated or manually entered in the Pay Source table on the account. For example, an entry was made in the Pay Source table, but the user exited the screen prior to calculating or entering the Next Cycle End date.

- **Unable to generate claim due to missing MR Finish date**: This exception occurs when Insurance Company Table, Page 1 has MR Complete selected (set to **Y**) and the account either does not have a Medical Records Finish Date in the Grouper or the Finish Date is not greater than the last billed date on the account. For example, if the last claim was billed on 06/13/18, but the MR Finish Date is 05/29/18, the claim would not generate because the Finish Date hasn't been updated since the last claim was billed.

- **Unable to generate claim due to invalid financial class**: This exception occurs when the Financial Class does not exist in the Insurance Company Table. For example, an entry is made in the Pay Source table on the account, but the financial class on the claim is later deleted from the Insurance Company Table.

- **Unable to generate claim, no primary insurance in Pay Source**: This exception occurs when there is not an entry in the Pay Source table with a Primary Switch of **Y**. The Cycle Billing claim generation program looks to the primary insurance claim when determining if a claim meets the criteria to generate. If there are entries in the Pay Source table for secondary and tertiary claims, they will generate when the primary claim meets the criteria to generate. If there is no primary claim entered, no other claims will be generated.

The following options are available on the action bar.

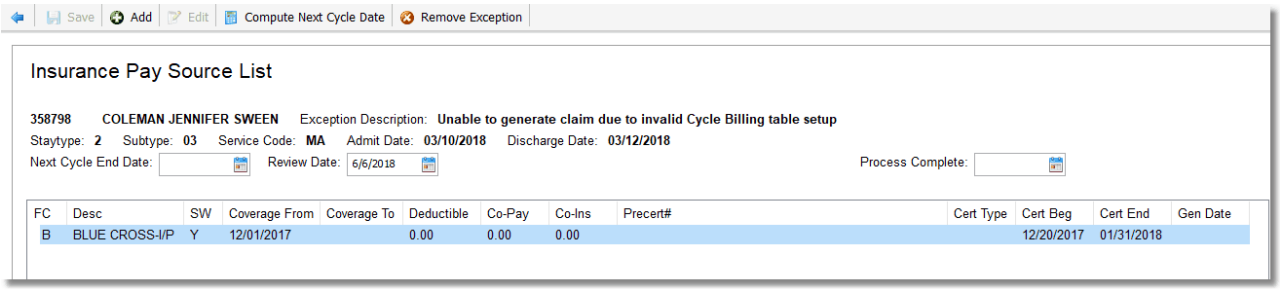
- **PDF**: Display the information on the Exceptions List in a report format.

- **Refresh**: Updates the information displayed on the Exceptions List.

- **Back Arrow**: Returns the user to the Insurance System - Claim Indices screen.

The Pay Source Table may be accessed from the Exceptions List by selecting the account. This will allow the Cycle Billing information to be displayed and/or updated.

Select **Web Client** > **System Menu > Master Selection** > **Insurance** > **Go to Cycle Billing Exceptions** > **Select an Account**



Insurance Pay Source List

Additional resources are available in the Pay Source Table for accounts that are on the Exception List.

- **Exception Description**: Displays the reason the account pulled to the Exception List.

- **Remove Exception**: Once the exception has been resolved, the account may be removed from the Exception List by selecting Remove Exception. If the exception is resolved and Remove Exception is not selected, the account will not be removed from the Exception List until the Cycle Billing claim generation program runs again. The **Save** option will need to be selected after Remove Exception is chosen.

For more details on the Pay Source Table, please see the Pay Source Table 81 section.

6.8 RHC Billing Procedures for Preventative Health Services

Rural Healthcare Clinics are required to bill detailed claims and no longer bundle their charges. TruBridge EHR has created the RHC Qualifying Visit Codes table to determine how charge amounts should total within the system for billing purposes, dependent upon specific billing scenarios. This tables includes three types of HCPC's/CPT's: Medical Services, Preventative Health Services and Mental Health Services. The RHC Qualifying Visit Codes table will be controlled by the facility to determine which codes fall within each type. For more information about the RHC Qualifying Visit Codes table, please refer to the Table Maintenance - Business Office documentation.

Additionally, It is also imperative that the following table maintenance be performed.

- Insurance Companies Table
  - Page 1
    - UB Type of Bill field needs to be to 711
    - Summarize O/P Insurance field needs to be set to N.
    - Detail Charges field needs to be set to Y.
  - Pages 6 & 7
    - Combine Summary Codes fields need to be left blank and any existing codes should be removed.
  - Page 9
    - Bundle to Procedure field needs to be selected.
    - List Procedures needs to be set to "7".
    - Modifier field need to have "CG" loaded.

- Summary Code Table
  - Summarize OP needs to equal N.

Below are different scenarios to understand how TruBridge EHR determines which charge amounts should total.

Medical Services Visit

If a claim has a Medical Services HCPC Code with revenue code 052*, then that HCPC code will pull to the first line of the claim with the total charge amount for the entire visit and a modifier of CG. All other charges encountered during the visit will then be reported with the appropriate HCPC, revenue code and price.

Account Detail:

Revenue Cd	CPT	Price
521	99213	$100.00
300	36415	$29.00
Total Charges:		$129.00

UB Detail Display:

Revenue Cd	CPT	Price	Modifier
521	99213	$129.00	CG
300	36415	$29.00	
Total Charges:		$158.00	

Medical Services Visit and Preventative Health Service

If a claim has a Medical Services HCPC code with revenue code 052* and has a Preventative Health Service HCPC code with revenue code 052*, then the Medical Services HCPC code will pull to the first line of the claim with the total charge amount of the entire visit with a CG modifier, minus the Preventative Health Service charge amount. The Preventative Health Service HCPC code will pull to its own line with its charged amount. All other charges encountered during the visit will then be reported on the subsequent lines with the appropriate HCPC, revenue code and price.

Account Detail:

Revenue Cd	CPT	Price
521	99213	$100.00
300	36415	$29.00
521	G0101	$50.00
Total Charges:		$179.00

UB Detail Display:

Revenue Cd	CPT	Price	Modifier
521	99213	$129.00	CG
521	G0101	$50.00	
300	36415	$29.00	
Total Charges:		$208.00	

Mental Health Service

If a claim has a Mental Health HCPC code with revenue code 0900, then that HCPC code will pull to the first line of the claim with the total charge amount for the entire visit with a modifier of CG. All other charges encountered during the visit will then be reported with the appropriate HCPC, revenue code and price.

Account Detail:

Revenue Cd	CPT	Price
900	90834	$85.21
900	90063	$25.42
Total Charges:		$110.63

UB Detail Display:

Revenue Cd	CPT	Price	Modifier
900	90834	$110.63	CG
900	90063	$25.42	
Total Charges:		$136.05	

Mental Health and Medical Services Visit

If a claim has a Mental Health HCPC code with revenue code 0900 and a Medical Services HCPC code with revenue code 052*, then the Medical Services HCPC will pull to the first line of the claim with the total charge amount for the entire visit with a modifier of CG, minus any Mental Health charge amounts with a 0900 revenue code. The Mental Health HCPC will pull to its own line with the total charges of all other 0900 revenue charges. All other charges encountered during the visit will then be reported on the subsequent lines with the appropriate HCPC, revenue code and price.

Account Detail:

Revenue Cd	CPT	Price
900	90834	$85.21
521	99213	$100.00
900	90863	$25.42
Total Charges:		$210.63

UB Detail Display:

Revenue Cd	CPT	Price	Modifier
521	99213	$100.00	CG
900	90834	$110.63	
900	90863	$25.42	
Total Charges:		$236.05	

NOTE: *Please contact a TruBridge Client Services Representative for additional setup that needs to be done in TruBridge EHR.*

6.9 RUG-III Billing

Skilled Nursing facilities that will be reimbursed on the Skilled Nursing Prospective Payment System may use the Create Claims by Charge Period program or manually generate claims for RUG-III billing. Before billing claims, table maintenance must be performed:

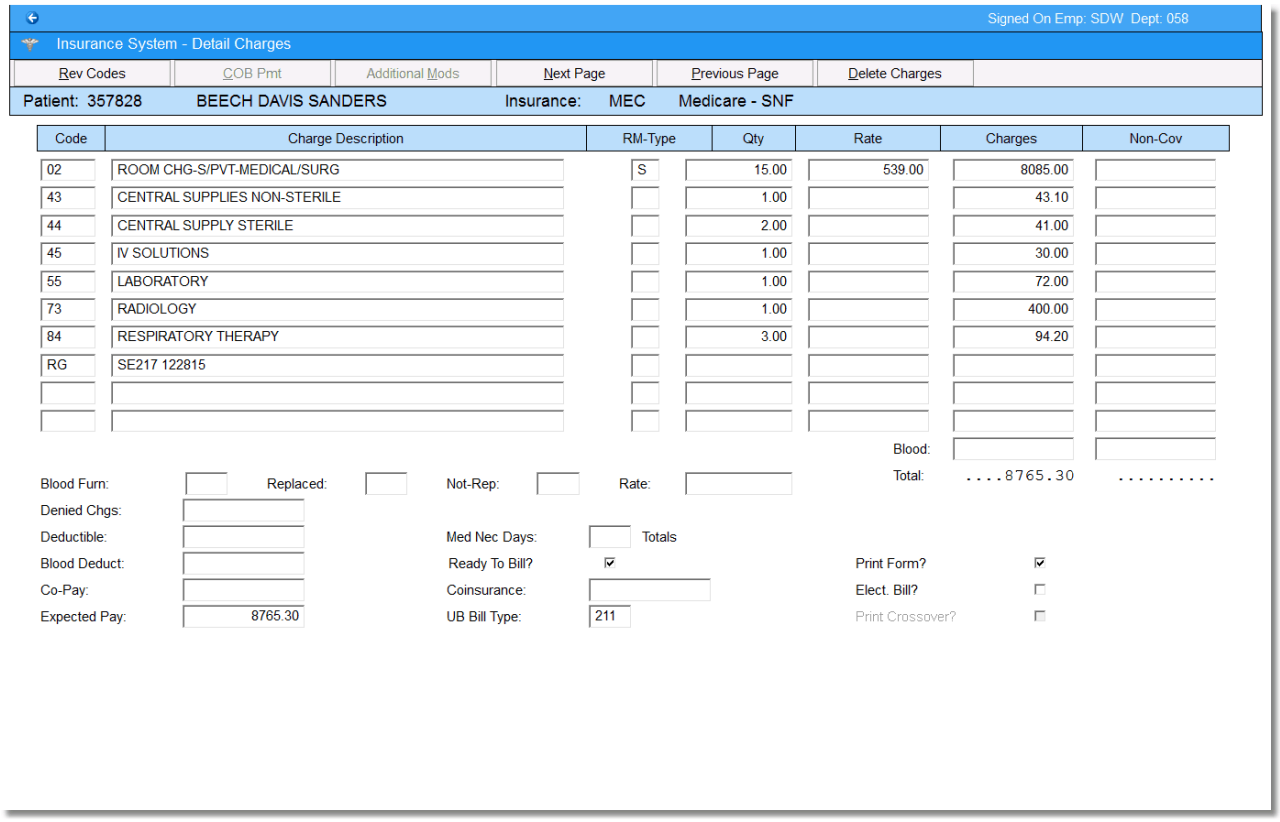
- Set up a new Summary Code in the Charge Summary Code table and load Revenue Code 0022 in the UB Revenue Code field. This may be any available Summary Code other than a Summary Code beginning with "W".
- The Insurance Company table page 4, Skilled Nursing Prospective Payment field, should be answered **Y** for all insurance companies which reimburse based on the RUG-III category. Once the switch is set to **Y**, the new Summary Code should be loaded in the second portion of this field.
- The Insurance Company table page 4 Max Chg. Lines on Claim field, must have a setting greater than 25 for correct claims generation. The maximum number of lines allowed by a facility's intermediary should be loaded.

Billing procedures differ depending if a facility has the TruBridge Resident Assessment Instrument (RAI) software.

Facilities with TruBridge Resident Assessment Instrument (RAI) software

When claims are generated through Create Claims by Charge Period or manually, the system will pull the RUG-III categories and modifiers to the Detail Charges screen from the MDS that cover days for the billing period. Only MDS that have been locked will pull when claims are generated. The Locked/Unlocked MDS Records report will help identify unlocked MDS. Listed below is an example of the Detail Charges screen.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance > Detail Charges**

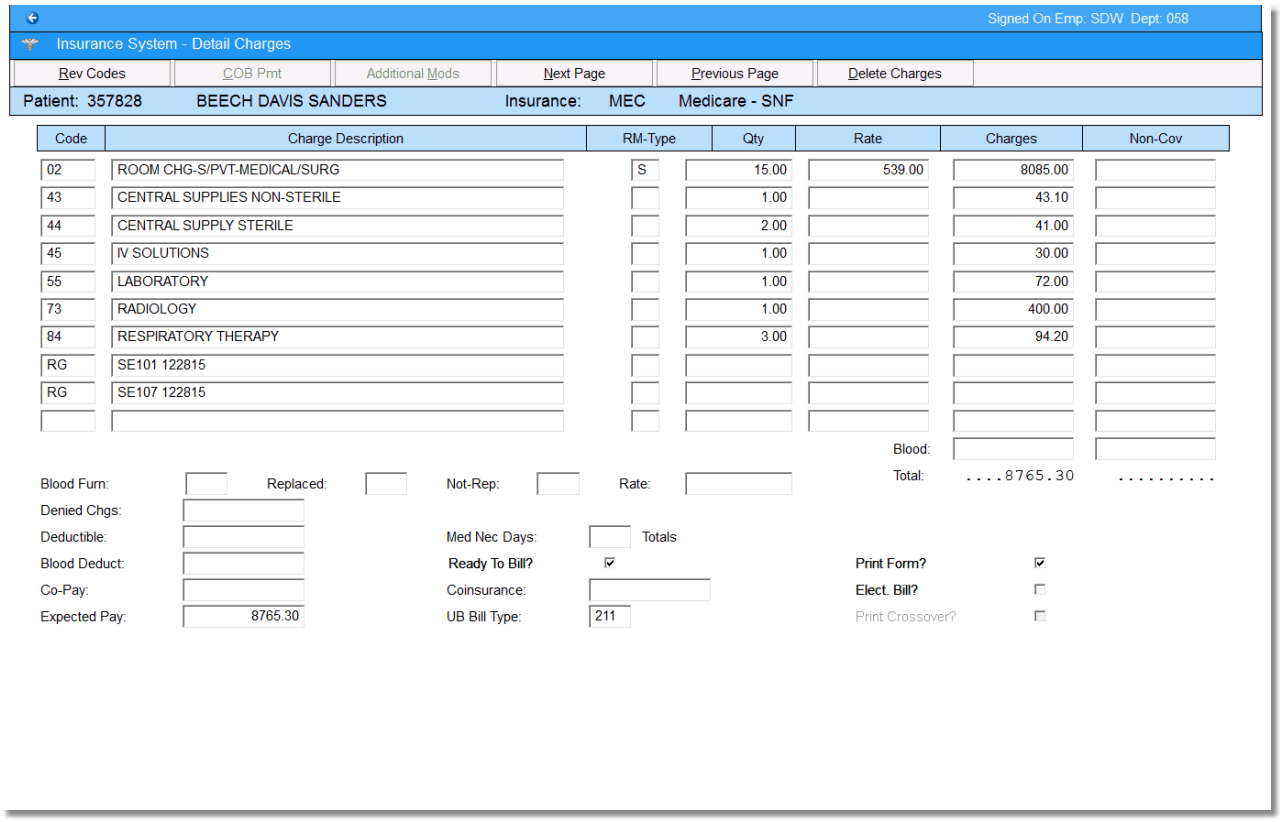


Insurance System - Detail Charges

Facilities without TruBridge Resident Assessment Instrument (RAI) software

Claims should be generated using the Create Claims by Charge Period option or manually. When locked on the claim, the Detail Charges screen may be accessed. The new Summary Code may be entered on the first available line. There must be a different line for each RUG-III category if applicable. In the description column, enter the RUG-III category and modifier, enter one space, and then enter the date of the assessment. Listed below is an example of the Detail Charges screen.

Select **Web Client > System Menu >** **Hospital Base Menu > Patient Account # > Insurance > Detail Charges**



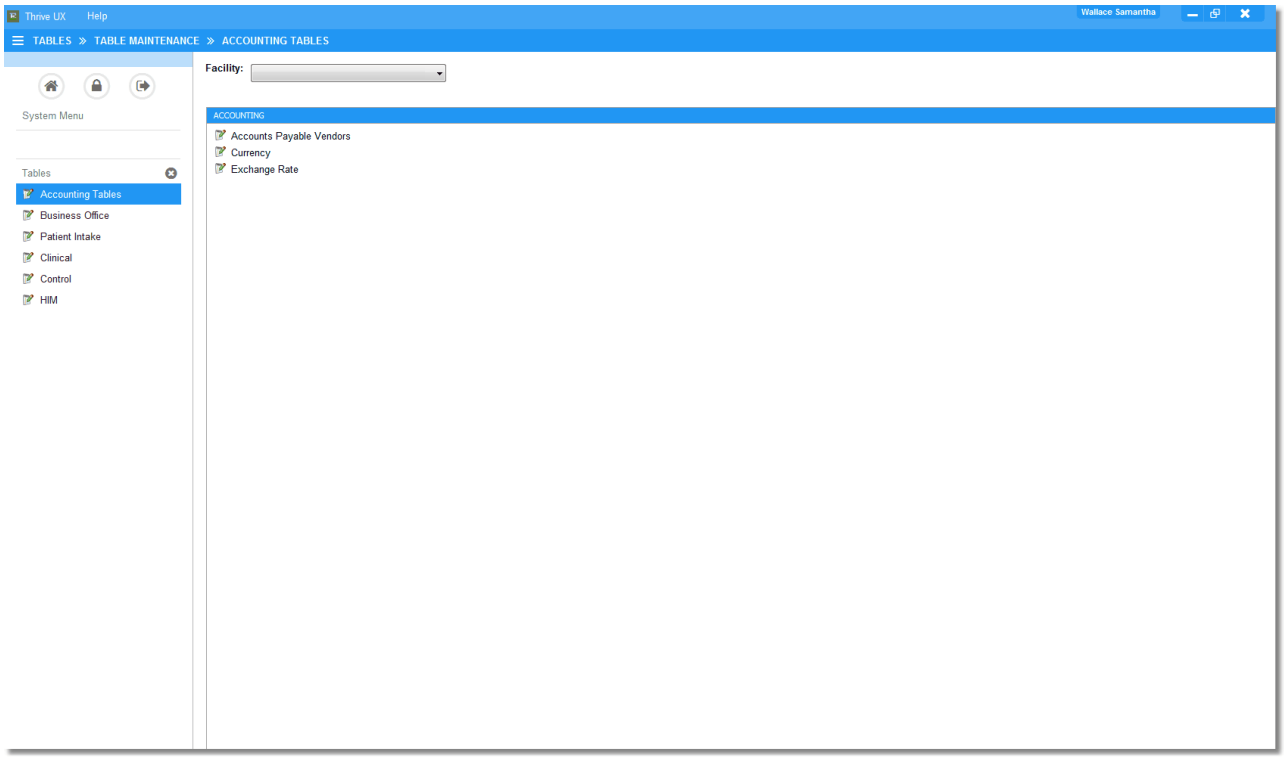
Insurance System - Detail Charges

Chapter 7 Tables Affecting Insurance

7.1 Overview

Information that affects the insurance billing process pulls from all areas of the Accounts Receivable application. Table maintenance is an important part of the billing process. This section discusses the tables that have an impact in this process. Most of the tables used for insurance billing are found in Table Maintenance.

Select **Web Client** > **Tables**



Tables Maintenance

7.2 Business Office

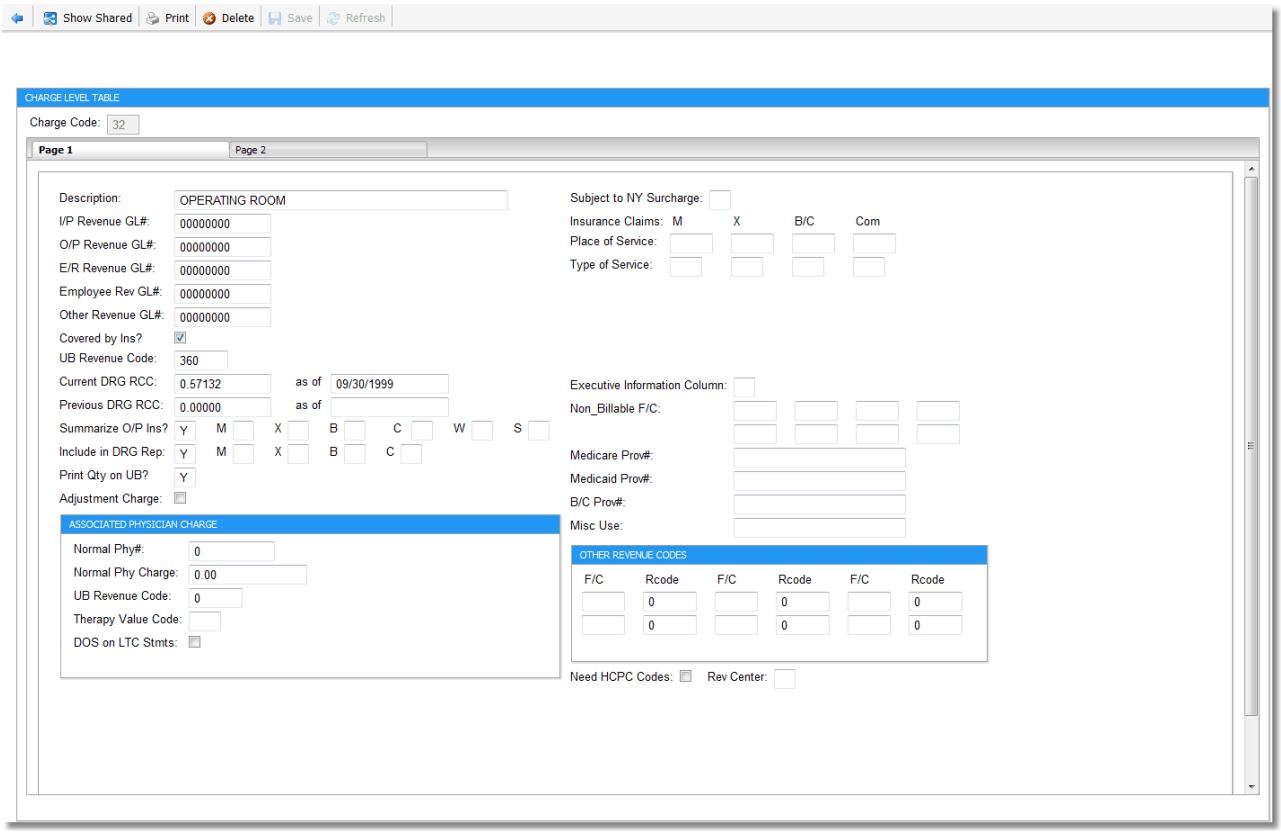
Charge Summary Codes

The Charge Summary Code table is used to store information about different categories of chargeable items. A Summary Code is a 2-character code used to represent these groups of chargeable items. For example, there are several thousand unique chargeable items within a given department, such as Pharmacy. These items must be summarized into one or two categories for printing on an insurance form. The Summary Codes used to represent Pharmacy items are 45 for IV Therapy and 78 for Pharmaceuticals. All items that should be grouped together on insurance forms should use the appropriate Summary Charge Code. The typical range of Summary Charge Codes that are used on the system are listed below along with a description of the fields relevant to the insurance billing process.

Typical Ranges for Summary Charge Codes:

00-25	Room Charges
45, 78	Pharmacy
79	Pharmacy Injection
55-60	Lab
71-76	X-Ray
84	Respiratory Therapy
85	Physical Therapy
W*	Bad Debt Adjustments

Select **Web Client** > **Tables** > **Business Office** > **Charge Summary Codes** > **Select Code** > **Page 1**



Charge Summary Codes, Page 1

- **Description:** The description of the Summary Code should be loaded in this field.

- **Covered by Ins?:** **Non-Billable F/C:** This field is used for the Create Claims by Charge Period program. When a claim is generated by the Create Claims by Charge Period program, and this field is left blank or answered **Y**, the items associated with the specific Summary Code will print on the insurance forms. All Summary Codes except adjustment Summary Codes should have this field answered **Y**. Adjustments should not appear on insurance forms; therefore, those Summary Codes should be answered **N**.

  The "Non-Billable F/C" portion allows eight spaces for entering non-billable financial classes. Wildcarding may be used. For any financial class entered in this field, the summary code will not pull to the Insurance Detail Charges screen. This applies to claims that are manually generated, auto generated or billed through Claims Created by Charge Period.

- **UB Revenue Code:** The Revenue Code used for billing the group of items associated with the Summary Code should be loaded in this field. This will pull to the UB for charges associated with the specific Summary Code.

- **Summarize O/P Ins?:** This field will allow the items within this Summary Code for Outpatient Financial Classes to be summarized, detailed or summarized by date. To summarize an Outpatient's charges for specific Summary Codes, a **Y** should be placed after the corresponding letter of the Financial Class. To have the items print in detail, an **N** should be placed after the letter representing the specific Financial Class. If it is necessary to have the items associated with this Summary Code to summarize by the service date the item was charged, a **D** should be entered into this field. To have all Financial Classes react the same, a **Y**, **N** or **D** may be entered into the first position of this field.

- **Print Qty on UB:** This field should be answered **Y** or **N**. Answering this field **Y** will allow the quantity charged to be printed on the UB form.

- **UB Revenue Code:** If the Revenue Code for the physician components is different than the hospital revenue code, it may be loaded in this field.

- **Therapy Value Code:** If a specific Therapy Value Code needs to print on the UB for Medicare Outpatient claims, it may be loaded in this field. The Value Code will pull for Medicare Outpatient claims when an item is charged to the patient's account, and it is an interim billing account.

- **Subject to NY Surcharge:** If answered **Y**, the Summary Code will be subject to NY Surcharge.

- **Place of Service:** The Place of Service listed for the Financial Class category will pull to locator 24B of the 1500 form. Page two of the Summary Charge Code table allows the Place of Service to be designated for specific Financial Classes.

- **Type of Service:** The Type of Service listed for the Financial Class category will pull to locator 24B of the 1500 form. Page two of the Summary Charge Code table allows the Type of Service to be designated for specific Financial Classes.

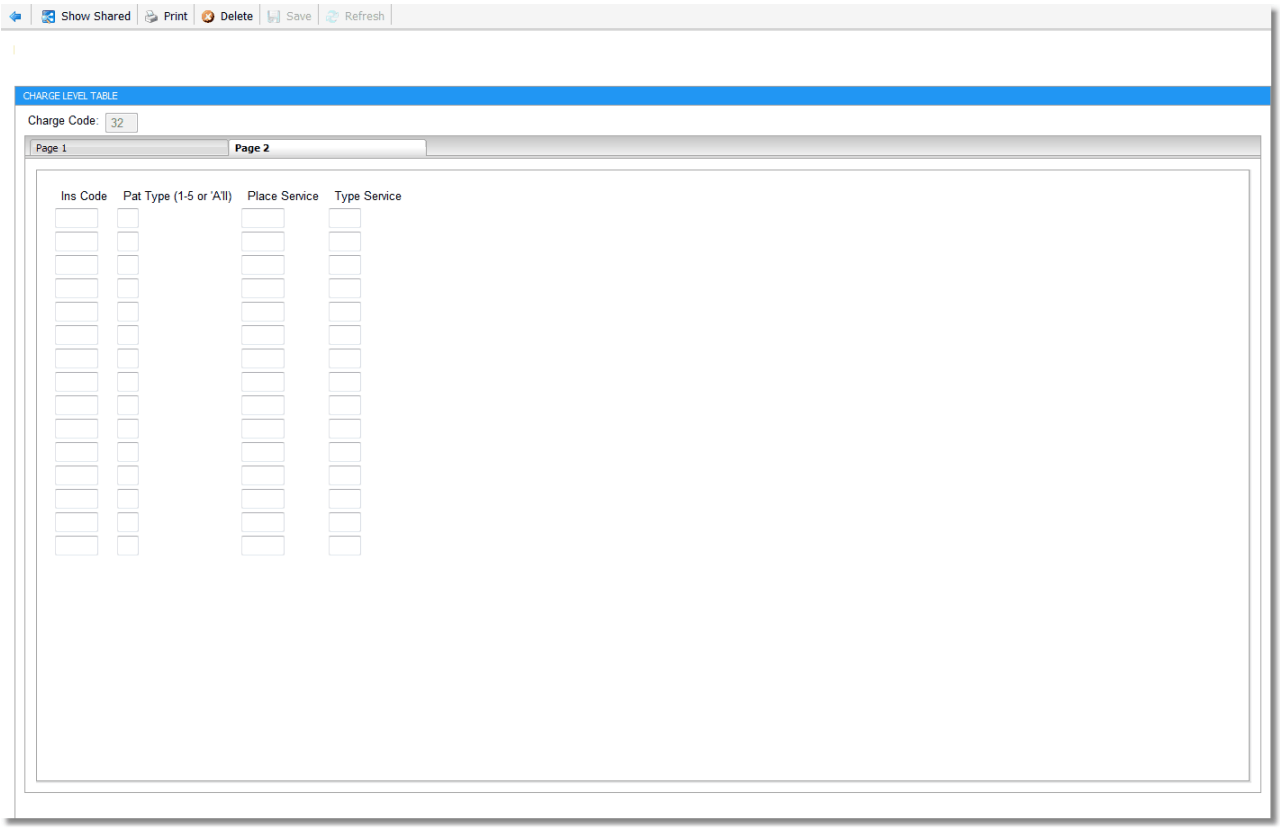
- **Medicare Prov# Medicaid Prov# B/C Prov#:** For states “NH” and “VT”, these provider numbers will pull to locator 33 of the 1500 claim for Medicare, Medicaid and Blue Cross.

- **Misc Use:** This field is used for state-specific miscellaneous uses.

- **Other Revenue Codes:** This field will allow up to six different Revenue Codes to be designated for specific Financial Class codes. Wild-carding is accepted. If entered, this will override the UB Revenue Code field for the specified Financial Class code.

- **Need HCPC Codes: Rev Center:** Enter a **Y** to allow the HCPC codes loaded on the DRG Grouper screen to pull to the UB, with a quantity of one, when the Combine O/R E/R field from the Insurance Company table page 2 is answered **Y**. Enter an **N** to allow the CPT codes from the Item Master to pull to the UB. Enter an **S** to allow the HCPC codes loaded on the DRG Grouper screen to pull to the UB, with the true quantity from the account detail, when the Combine O/R E/R field from the Insurance Company table page 2 is answered **Y**. Rev Center will allow any summary code to be assigned a specific revenue center.

Select **Web Client** > **Tables** > **Business Office** > **Charge Summary Codes** > **Select a Code** > **Page 2**



Summary Code Table, Page 2

The second page of the Summary Charge Code table allows for certain Place of Service and Type of Service codes to print on the 1500 Physician Claims in locators 24B and 24C, respectively.

- **Ins Code:** The Financial Class code that needs a Place and/or Type of Service code to pull to the 1500 form for a Summary Code should be loaded in the first column. The system will allow an ***** to be entered for wildcarding purposes. If all Medicare Financial Classes should pull a specific Place or Type of Service for a specific Summary Code a "M**" may be entered. This will allow all Financial Class codes beginning with a "M" to pull the Place and Type of Service.

- **Pat Type:** The table will allow a Stay Type to be entered that will only pull the information to the 1500 for the specific Stay Type. If the change should take place for all patient Stay Types, an **A** should be entered.

- **Place Service:** The Place of Service Code should be entered. This will be the code that prints on the 1500 form.

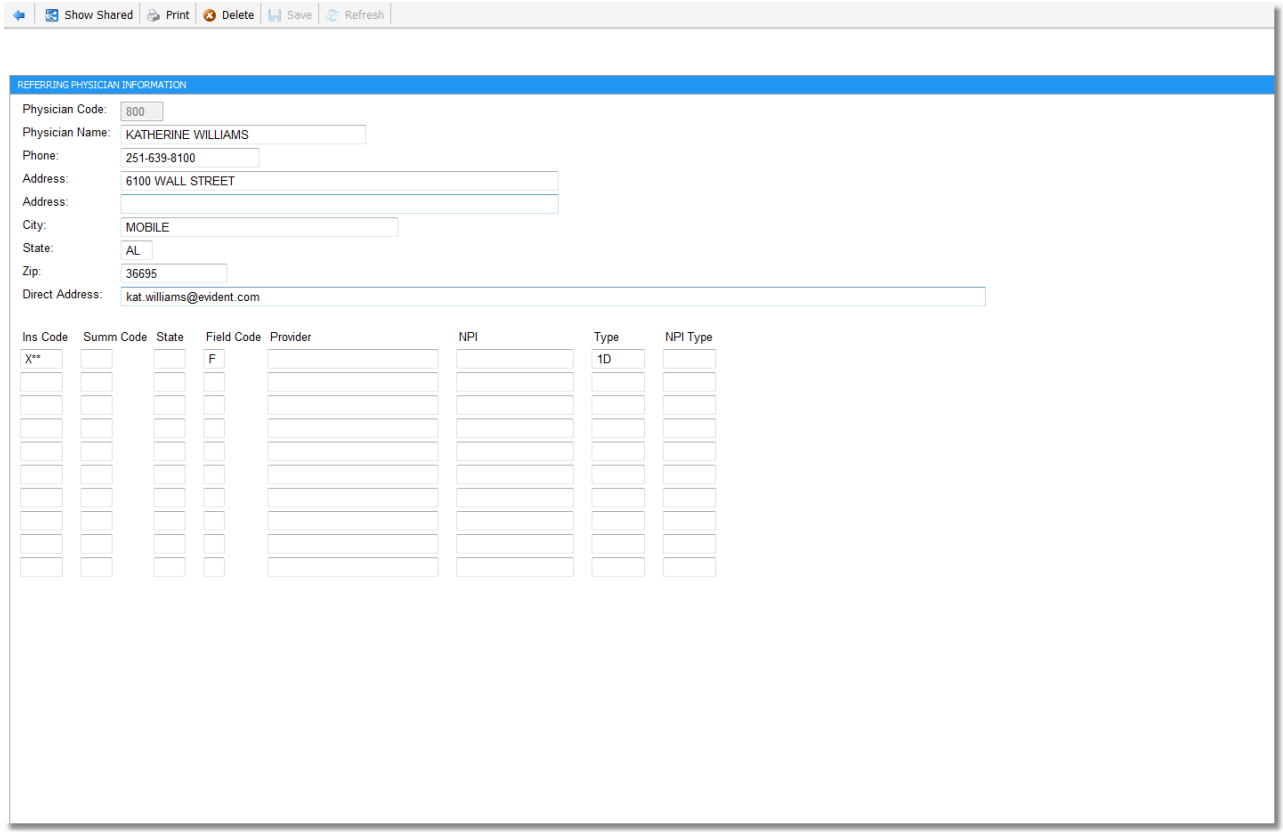
- **Type Service:** The code that represents the Type of Service needed to print on the 1500 form should be loaded.

Referring Facilities

See the Referring Facilities section of the Table Maintenance - Business Office User Guide.

Referring Physicians

Select **Web Client** > **Tables** > **Business Office** > **Referring Physician** > **Select a Physician**



Referring Physician Maintenance

- **Physician Code:** Enter a 3-character code to represent the Referring Physician.
- **Physician Name:** Enter the Referring Physician's name using up to 22 characters.

The lower section of the Referring Physician table allows for the set up of Insurance Codes, Summary Codes, Provider numbers and NPI numbers to manipulate the printing of 1500s and UBs. This table has specific codes the system recognizes that will determine where the Provider Numbers pull on 1500's and UB's.

- **Insurance Code:** The Financial Class Code for the particular insurance company that requires the number loaded in the Provider Number column to pull to the 1500 or UB. Wildcarding is allowed.

- **Summary Code:**
  The 2-character Summary Charge Code should be entered in this column. The system will look at the Financial Class Code then the Summary Code to determine the lines of detail for the claims that should be affected.

- **State:** Enter the 2-character state code for the claims that require the number loaded in the Provider Number column to pull to the 1500 or UB.

- **Field Code:** The Field Code is a 1-character code that corresponds to a particular locator on the 1500 (Field Code 1 for locator 17a) or the UB form (Field Code U for locator 78) to which the Provider Number will be printed.

- **Provider:** This column stores the number that will print on the 1500 or the UB in the locator designated by the fourth column.

- **NPI:** This column stores the National Provider Identification that will print on the 1500 or the UB in the locator designated by the fourth column.

- **Type:** Enter the 4-character Physician Type that will pull to the electronic ANSI file for UBs and 1500s.

- **NPI Type:** Enter the qualifier that will pull to locator 78 and/or 79 on the UB.

Clinic Table

See the Clinic Table section of the Table Maintenance - Business Office User Guide.

Insurance

Companies

The Insurance Company table is the most important table related to insurance billing. A table is set up for each Financial Class code used in the system to store specific information relating to the different insurance companies. Below is an explanation of each field.

Insurance Company table, Page 1

See the Insurance Companies, Page 1 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 2

See the Insurance Companies, Page 2 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 3

See the Insurance Companies, Page 3 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 4

See the Insurance Companies, Page 4 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 5

See the Insurance Companies, Page 5 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 6

See the Insurance Companies, Page 6 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 7

See the Insurance Companies, Page 7 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 8

See the Insurance Companies, Page 8 section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 9

See the Insurance Companies, Page 9 section of the Table Maintenance - Business Office User Guide.

Insurance Companies, Policy Information

See the Insurance Companies, Policy Information section of the Table Maintenance - Business Office User Guide.

Insurance Companies, Detail Benefits

See the Insurance Companies, Detail Benefits section of the Table Maintenance - Business Office User Guide.

Insurance Companies, Separate Claims

See the Insurance Companies, Separate Claims section of the Table Maintenance - Business Office User Guide.

Insurance Companies, Room Type Coverage

See the Insurance Companies, Room Type Coverage section of the Table Maintenance - Business Office User Guide.

Condition Codes

Please see the Condition Codes section in the Table Maintenance - Business Office User Guide.

Occurence Codes

See the Occurrence Codes section of the Table Maintenance - Business Office User Guide.

Value Codes

See the Value Codes section of the Table Maintenance - Business Office User Guide.

Rejection Codes

See the Rejection Codes section of the Table Maintenance - Business Office User Guide.

EB/CCI Edit Codes

See the EB/CCI Edit Codes Table section of the Business Office Table User Guide.

Treatment Qualifier Codes

See the Treatment Qualifier Codes section of the Table Maintenance - Business Office User Guide.

7.3 Patient Intake

Accident Places table

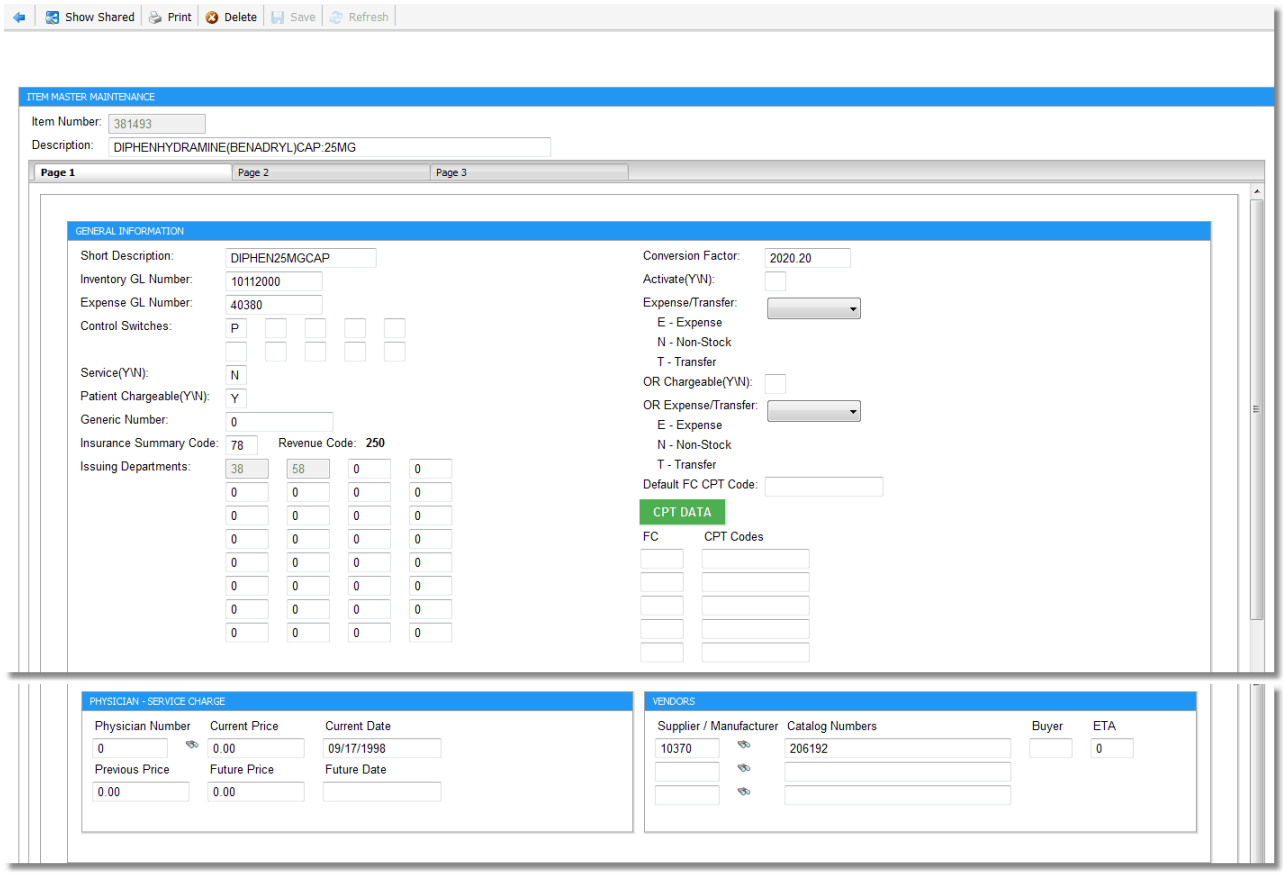
See the Accident Places Codes section of the Table Maintenance - Patient Intake User Guide.

7.4 Control

Item Master

Each item that is used in the system should be set up in the Item Master. This table stores information relating to that item. Below is a list of the fields that affect insurance claims.

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Page 1**



Item Master Maintenance, Page 1

- **Insurance Summary Code:** The Summary Charge Code used to group this item with like charge item numbers should be loaded in this field. Once the summary code is entered, the revenue code associated with this summary code will display. Only a valid Summary Codes that is set up in the Charge Summary Code 95 table will be accepted in this field.

- **Physician Number:** The Physician number should be loaded for items that are physician components.

- **Physician Service Charge:** The dollar amount of the physician charge should be loaded in the Current Price field. This dollar amount is the portion of the item's price that is the physician's component.

NOTE: *The Physician Number and Physician Service Charge fields are only necessary for items that have physician components. If the physician number is not constant, 999999 maybe entered. This will allow the physician number to be entered during charging. If nothing is entered in the Physician Number field, yet there is a current amount entered, the system will stop on this field during charging requiring a physician number to be entered. The Current Price field may have 99999.99 entered in the item master where the physician component is different each time it is charged. This will pull the charge dollar amount as the amount of the physician component. If the Current Price field is blank the system does not consider the item to have a physician component.*

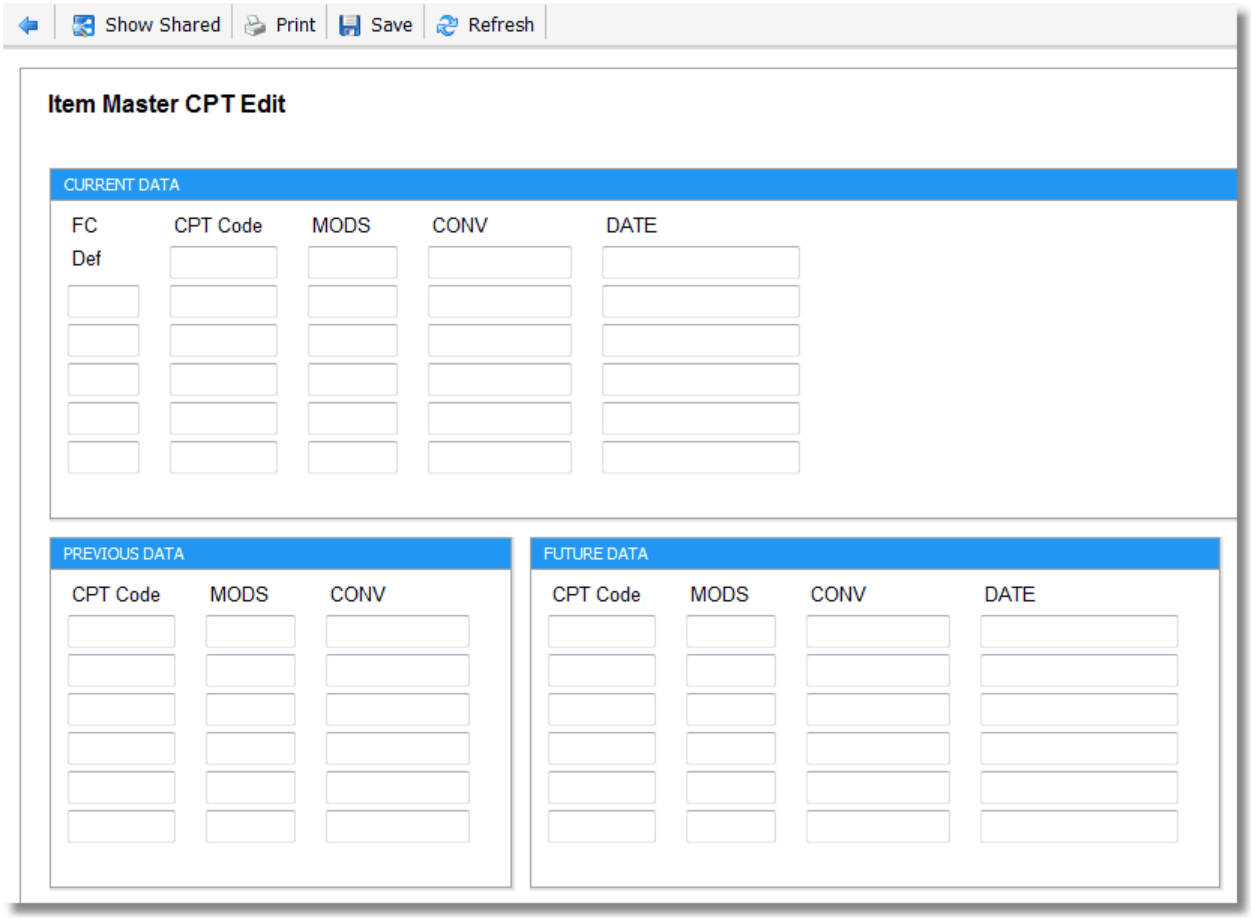
- **Conversion Factor:** The APC Conversion Unit should be loaded in this field if applicable. This field will allow Pharmacy to charge the actual number of primary units dispensed to the patient. The system will apply the conversion unit to the CPT code to determine the correct number of CPT codes to charge.

- **Default FC CPT Code:** CPT Codes are 5-digit numbers that are significant for insurance billing. Not all items have CPT codes, such as Central Supply items. For those that do, the code should be entered in this field. Up to two 2-digit modifiers may be attached to the CPT code to pull to the insurance billing forms.

- **FC: CPT Code:** The default CPT code that is associated with this item should be loaded in the Insurance Summary Code field. If the item does not need a CPT code to print when it is charged, this field should be blank. These fields should be used for up to five specific Financial Class codes along with the CPT code that should pull to the claim when this item is charged for the specific Financial Class. Wildcarding may be used for these fields.

- **CPT Data:** When selected, this option will display the Item Master Financial Class CPT & MOD Maintenance screen. This screen allows Current, Future and Previous data to be stored for CPTs, Modifiers and APC-Conversion. This is used for the default and five financial class specific CPT Codes associated with the item. Any changes to a CPT code should be updated in these fields.

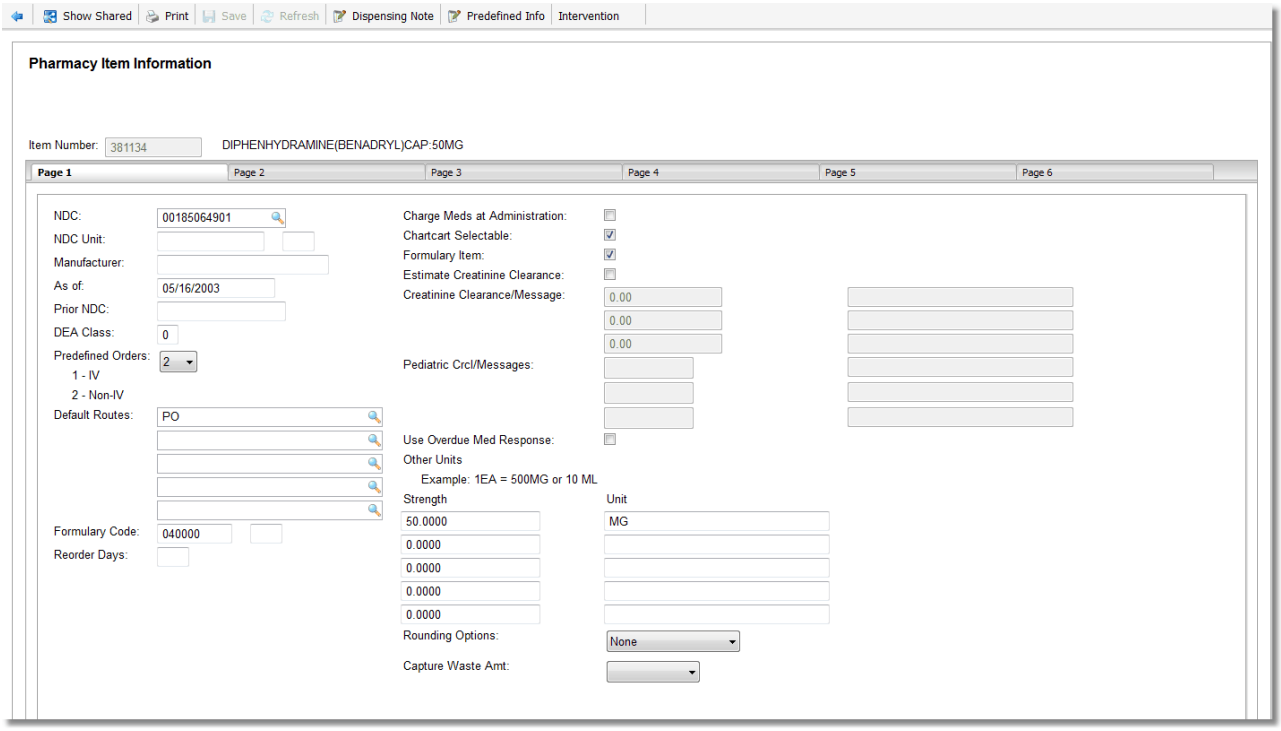
Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an Item** > **CPT Data**



CPT Data

Pharmacy Information

Select **Web Client** > **Tables** > **Control** > **Item Master** > **Select an item** > **Pharmacy Information** > **Page 1**



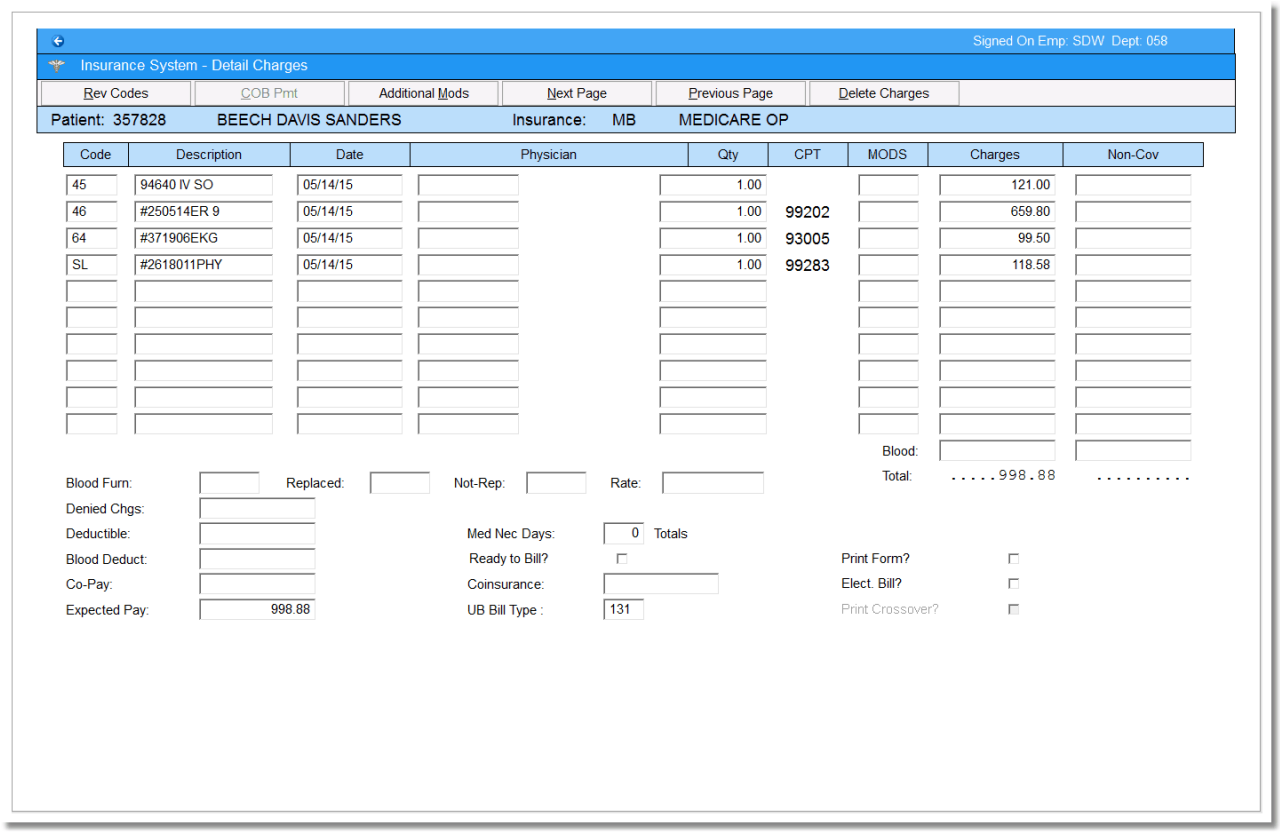
Pharmacy Information, Page 1

- **NDC:** Enter the NDC code or select the magnifying glass to see a listing of codes.

Detail Charges

Charges will be displayed on the Detail Charges screen for a claim after the claim is generated. The 2-digit Summary Code that relates to the 3-digit Revenue Code appears in the first column under Code. In order to view the Revenue Code select **Rev Code** at the top of the screen. The lines of detail that pull to this screen will have a pound sign ("#") preceding the item number and description when a CPT code is going to print to the insurance form. The CPT codes and modifiers will also show on the Detail Charges screen.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Detail Charges**

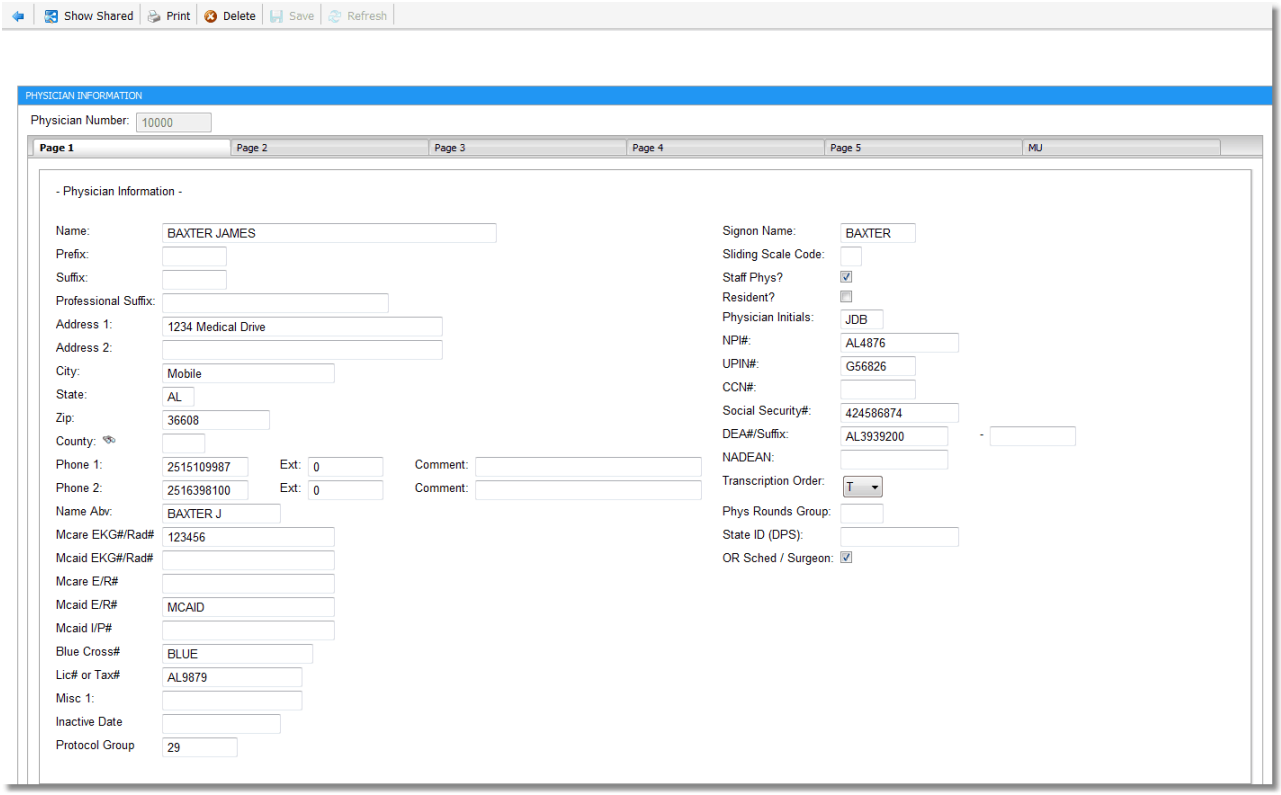


Insurance System - Detail Charges

Physicians

The Physicians table stores information about individual physicians working in the hospital. A majority of the data in this table will affect insurance billing. Some of the information that is stored in this table will pull to UB's, 1500's and state-specific forms. The fields that affect insurance on this table are listed below.

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 1**



Physician Maintenance, Page 1

- **Physcian Number**: The 6-digit numeric code that represents the physician.
- **Name:** The physician's name should be loaded in this field. The last name should be loaded, followed by the first name and middle initial.
- **Address 1 & 2**: Enter the address that will pull to statements and/or collection letters for this physician.
- **City:** Enter the city that will pull to statements and/or collection letters for this physician.
- **State:** Enter the state that will pull to statements and/or collection letters for this physician.
- **Zip Code:** Enter the zip code that will pull to statements and/or collection letters for this physician.

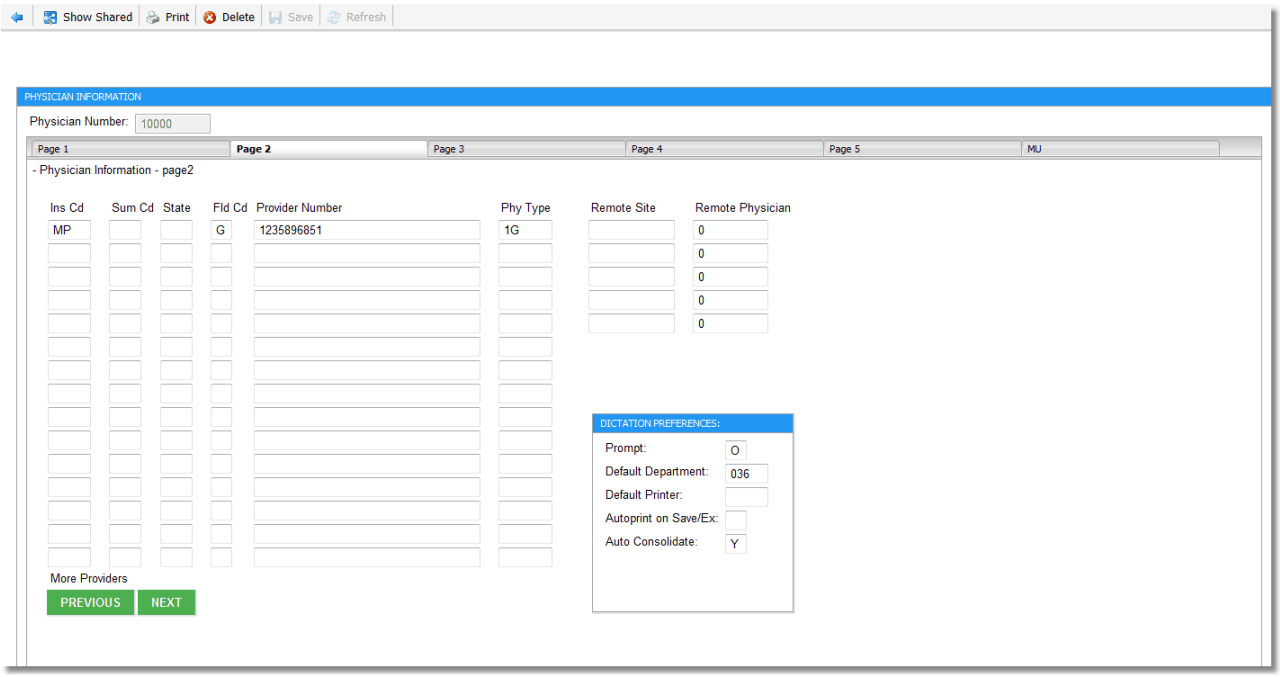
- **County**: Enter the county associated with this Physician.
- **Phone 1: Phone 2:** The phone numbers of the physician should be loaded in these fields.
- **Name Abbv:** The abbreviation of the physician's name should be loaded in this field. This will pull during registration and on the UB, 1500 and state specific forms.
- **Mcare EKG# /Rad#:** The physician's Medicare EKG or radiology number should be loaded in this field.
- **Mcaid EKG# /Rad#:** The EKG or radiology Medicaid number for this physician should be loaded in this field.
- **Mcare E/R#:** The physician's Medicare E/R number may be loaded in this field.
- **Mcaid E/R#:** The physician's Medicaid Emergency Room number may be loaded in this field.
- **Mcaid I/P#:** The physician's Medicaid Inpatient number may be loaded in this field.
- **Blue Cross#:** The Blue Cross physician number should be loaded in this field.

***NOTE**: The above six provider number fields may be left blank if the provider numbers are the same as the provider numbers used for the facility. If the numbers are different for specific physicians, they should be loaded on the individual physician's maintenance screen.*

- **Lic# or Tax#:** The physician's License or Tax Identification Number should be loaded in this field. This pulls to locator 25 on the 1500.
- **Staff Physician?: Resident:** If this is a Staff Physician, this field should be selected. The switch will determine how the physician number is listed on screen displays. Select the box for Resident the physician is a Resident.
- **NPI#:** The physician's NPI number may be loaded in this field. This pulls to locator 76 on the UB.
- **UPIN #:** The physician's UPIN number may be loaded in this field. This pulls to locators 2 and 76 on the UB.
- **Social Security #:** This physician's Social Security Number may be loaded in this field.
- **DEA #:** The physician's Drug Enforcement Agency number should be loaded in this field.

The second page of the Physicians table allows for the setup of Insurance Codes, Summary Codes and Provider Numbers to manipulate the printing of 1500s and UBs. This table has specific codes the system recognizes that will determine where the physician numbers pull on 1500s and UBs.

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 2**



Physician Maintenance, Page 2

- **Ins Code:** The Financial Class code for the particular Insurance Company to be affected should be entered into this column.

- **Summ Code:** The 2-character Summary Charge Code should be entered in this column. The system will look at the Financial Class code then the Summary Code to determine the lines of detail for the claims that should be affected.

- **St:** Enter the 2-character state code for the claims that the change needs to effect.

- **Fld Code:** The Field Code is a 1-digit code that corresponds to a particular field on the 1500 or the UB form in which the physician number will be printed.

  - **1500 Field Codes:**
    - **1 -** Pulls the number loaded in column 5 - Provider Number to locator 17a on the 1500. If the claim is a North Carolina or Kentucky Medicaid claim, the physician table for the referring physician will override anything loaded on this page. ***NOTE:*** *When the system is searching for a code, the following hierarchy will be followed:*
      1. *Referring Physician table - Field Code 1*
      2. *Charging Physician table - Field Code 1*
      3. *Billing Physician table - Page 4, Billing Physician*
      4. *Attending Physician table - Field Code 1*
      5. *Attending Physician table - Page 1, UPIN#*

- **3 -** Pulls the number loaded in column 5 to the shaded portion of locator 24J on the 1500. ***NOTE:*** *When the system is searching for a code to pull to the shaded portion of locator 24J for all states except KY and NM, the following hierarchy will be followed:*
    1. *Charging Physician table - Field Code 3*
    2. *Charging Physician table - Page 1, Lic# or Tax# (Commercial) Mcare EKG#/Rad# - Blue Cross# fields Provider # (All other Financial Classes)*
    3. *Stay Info Physician table - Field Code 3*
    4. *Stay Info Physician table - Page 1, Lic# or Tax# (Commercial) Provider # (All other Financial Classes)*
- ***3 (Continued) :*** *For states of KY and NM, the following hierarchy will be followed:*
    1. *Charging Physician table - Field Code T*
    2. *Charging Physician table - Field Code 3*
    3. *Charging Physician table - Page 1,Lic# or Tax# (Commercial) Provider # (All other Financial Classes)*
    4. *Stay Info Physician table - Field Code T*
    5. *Stay Info Physician table - Field Code 3*
    6. *Stay Info Physician table - Page 1, Lic# or Tax# (Commercial) Provider # (All other Financial Classes)*
- **4 -** Pulls the number loaded in column 5 to the unshaded portion of locator 24J on the 1500. ***NOTE:*** *When the system is searching for a code to pull to the unshaded portion of locator 24J, the following hierarchy will be followed:*
    1. *Charging Physician table - Field Code 4*
    2. *Charging Physician table - Page 1, NPI*
    3. *Stay Info Physician table - Field Code 4*
    4. *Stay Info Physician table - Page 1, NPI*
    5. *Physician 999999 table - Page 1, NPI*
- **5 -** Pulls the number loaded in column 5 to locator 33b on the 1500.
- **6 -** Pulls the number loaded in column 5 to locator 33b on the 1500, if nothing is loaded for Field Code 5. ***NOTE:*** *When the system is searching for a taxonomy code to pull to locator 33b on the 1500, the following hierarchy will be followed:*
    1. *Charging Physician table - Field Code 5*
    2. *Charging Physician table - Field Code 6*
    3. *Attending Physician table - Field Code 5*
    4. *Attending Physician table - Field Code 6*
    5. *Physician 999999 table - Field Code 5*
    6. *Physician 999999 table - Field Code 6*
    7. *Insurance Company table - Page 1 Provider Number*
- **N -** Pulls the number loaded in column 5 to locator 17b and 24J on the 1500. ***NOTE:*** *When the system is searching for a code to pull to locator 24J, the following hierarchy will be followed:*
    1. *Charging Physician table - Field Code 4*
    2. *Charging Physician table - Field Code N*
    3. *Charging Physician table - Page 1, NPI*
    4. *Stay Info Physician table - Field Code 4*
    5. *Stay Info Physician table - Field Code N*
    6. *Stay Info Physician table - Page 1, NPI*
    7. *Physician 999999 table - Page 1, NPI*
- **T -** Pulls the number loaded in column 5 to the locator 24J if state code loaded in physician table page 1 is "KY" or "NM".

- **n -** Pulls the number loaded in column 5 to locator 33a on the 1500. ***NOTE:*** *When the system is searching for a code to pull to locator 33a, the following hierarchy will be followed:*
    1. *Charging Physician table - Field Code n*
    2. *Attending Physician table - Field Code n*
    3. *Physician 999999 table - Field Code N*
    4. *Physician 999999 table - Page 1, NPI*
- **E -** Pulls the number loaded in column 5 to locator 25 on the 1500.

- **UB Field Codes:**
    - **1 -** Pulls the number loaded in column 5 to locator 79 on the UB if state code loaded in physician table page 1 is "KY".
    - **T -** If the claim is Kentucky Medicaid, the number loaded in column 5 will pull to locator 81a, if attending physician, or 81b, if operating physician.
    - **N -** Pulls the number loaded in column 5 to locator 78 and/or 79.
    - **U -** Pulls the number loaded in column 5 to locator 76 QUAL on the UB. If the claim is an Iowa Medicaid claim, the number loaded in column 5 will pull to locator 79 on the UB.
    - **When** *determining which physician's information to display in locators 78 and 79, TruBridge EHR will use the hierarchy listed below*.

Locator 78:

1. Referring Physician loaded in Referring Data

2. Primary Procedure's Secondary Physician in the Grouper (Physician Type must be Surgeon or Assisting Surgeon)

3. Secondary Procedure's Primary Physician in the Grouper (Physician Type must be Surgeon or Assisting Surgeon. This Physician will not pull if this is the same Physician as the Operating Physician in Locator 77)

4. Secondary Procedure's Secondary Physician (Physician Type must be Surgeon or Assisting Surgeon)

The Physician's information will pull from the following tables.

- *Referring Physician table - NPI*
- *Referring Physician table - Provider Number*
- *Physician table - Field Code N (NPI)*
- *If there is not a Field Code N loaded, ZZ will pull to the box in front of the NPI field.*
- *Physician table - Field Code U (QUAL)*
- *Physician table - Page 1, NPI*
- *Physician table - Page 1, Lic# or Tax# (QUAL)*
- *Physician table - Page 1, UPIN (QUAL)*
- *Blank field if Insurance Company table - Page 6, NPI Only is selected.*

Locator 79:

1. If Locator 78 is displaying a Referring Physician, the Primary Procedure's Secondary Physician in the Grouper (Physician Type must be Surgeon or Assisting Surgeon. This Physician will not pull if this is the same Physician as the Operating Physician in Locator 77)

2. If Locator 78 is NOT displaying a Referring Physician, TruBridge EHR looks to the additional procedures in ranking order to find a Primary or Secondary Physician that is not listed as the Operating Physician in Locator 77 or the Other Physician in Locator 78 (Physician Type must be Surgeon or Assisting Surgeon)

The Physician's information will pull from the following tables.

- *Physician table - Field Code N (NPI); If there is not a Field Code N loaded, ZZ will pull to the box in front of the NPI field.*
- *Physician table - Field Code U (QUAL)*
- *Physician table - Page 1, NPI*
- *Physician table - Page 1, Lic# or Tax# (QUAL)*
- *Physician table - Page 1, UPIN (QUAL)*
- *Blank field if Insurance Company table - Page 6, NPI Only is selected.*

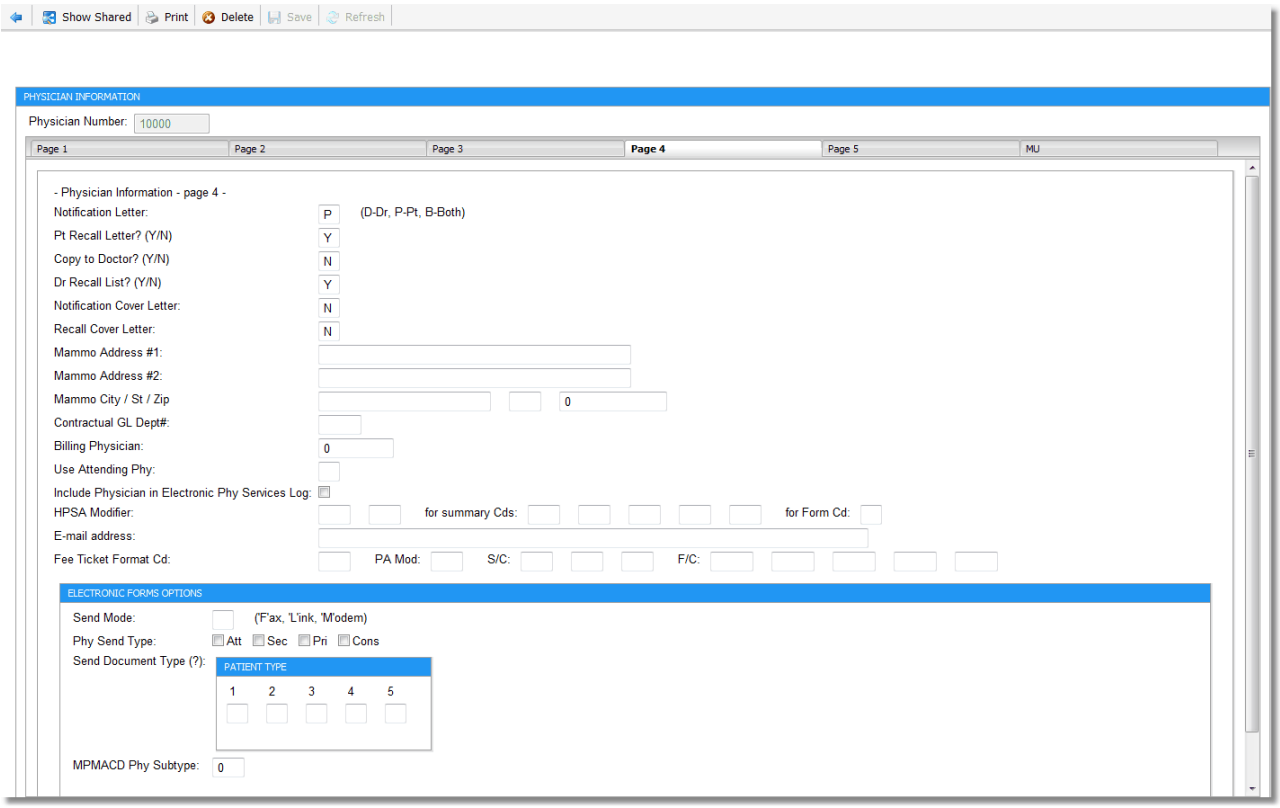
- **Provider Number:** This column stores a number, up to 15 digits long, that will print on the 1500 or the UB in the field designated by the fourth column.

- **Phy Type:** Enter the 4-character Physician Type that will pull to the electronic ANSI file for UB's and 1500's.

NOTE: *To set up more Provider Numbers, choose **Next** beneath the More Providers option.*

Page 4 of the Physicians table allows the setup for billing physicians and the ability to have billing information pull to the Physician Electronic Log.

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Select a Physician** > **Page 4**



Physician Maintenance, Page 4

- **Billing Physician:** If an alternate physician number is loaded in this field, the alternate physician's UPIN number will pull to locator 76 of the UB04 instead of this table's physician (when loaded as the Admitting Physician).

- **Use Attending Phy:** Setting this field to **N** allows the billing physician's information to pull to the 1500 form. If set to **Y,** the attending physician pulls from the Attending field in the Stay tab on the Registration and ADT screen.

- **Include Physician In Electronic Phy Services Log:** If selected, the **Services Log By Dictating Physician** for this physician will be generated through cron and placed in a file on the hospitals NT server to be accessed by the physician's billing service. If not selected, the billing physician's information will only print on the Physician's Services Log.

- **HPSA Modifier: for Summary Cds: for Form Cd:** This field contains three parts. The first part allows up to two valid modifiers to pull automatically to a Medicare physician claim with the subsequent Charge Summary Code loaded. The second part is the summary codes that the modifiers need to pull. This field works in conjunction with the Medicare Part B Health Professional Shortage Area Program. The third part allows a **J** to be entered to pull modifiers to a 1500 or a **U** to pull the modifiers to a UB (if using Method II billing for Critical Access.)

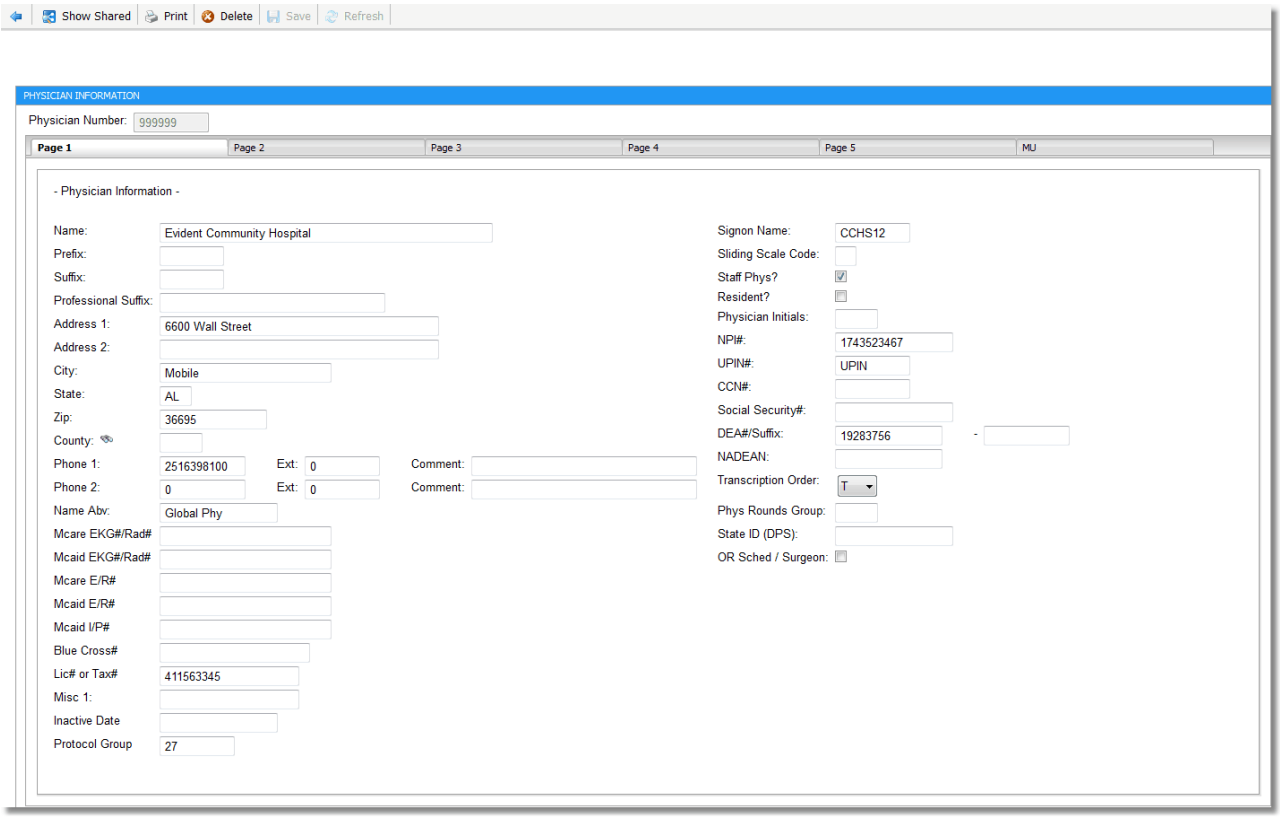
- **PA Mod S/C F/C:** This field contains three parts. The first part allows a valid modifier for a pro fee charge to pull automatically to the claim. The second part allows up to three Summary Codes to be entered. If this field is left blank, the system will look at all Summary Codes. The third part allows up to five Financial Class codes to be entered. Wildcarding is allowed in this field.

NOTE: *The modifier will pull to the Detail Charges screen for the listed Summary Code. If there are modifiers pulling from the Item Master, the modifiers listed above will pull to the Additional Modifiers screen.*

Physicians 999999 Maintenance

Physician number 999999 in the Physicians table is used to represent the facility. The information that is the same for all physicians at the facility may be entered in this table. Any information that is specific for a physician should be loaded in the individual table. This information will override the Physician 999999 table.

Select **Web Client** > **Tables** > **Control** > **Physicians** > **Physician 999999** > **Page 1**



Physician Maintenance, Page 1

- **Name:** The name of the hospital should be loaded in this field.
- **Address 1: Address 2:** The hospital's address is loaded in these fields.
- **City/St/Zip:** The hospital's City, State, and Zip Code is loaded in this field. The state code that is loaded in this field allows the system to react to programs that are designed to read the hospital's state.
- **Phone 1: Phone 2:** The phone numbers of the hospital should be loaded in these fields.
- **Mcare EKG# /Rad#:** The hospital's Medicare EKG or radiology number is loaded in this field.
- **Mcaid EKG# /Rad#:** The hospital's EKG or radiology Medicaid number is loaded in this field.
- **Mcare E/R#:** The hospital's Medicare E/R number is loaded in this field.
- **Mcaid E/R#:** The hospital's Medicaid Emergency Room number is loaded in this field.
- **Mcaid I/P#:** The hospital's Medicaid Inpatient number is loaded in this field.
- **Blue Cross#:** The hospital's Blue Cross number is loaded in this field.
- **Lic# or Tax #:** The hospital's Tax Identification number is loaded in this field. This pulls to locator 5 on the UB.

- **NPI#**: Enter the Hospital's National Provider Identification number. This pulls to locator 56 on the UB.

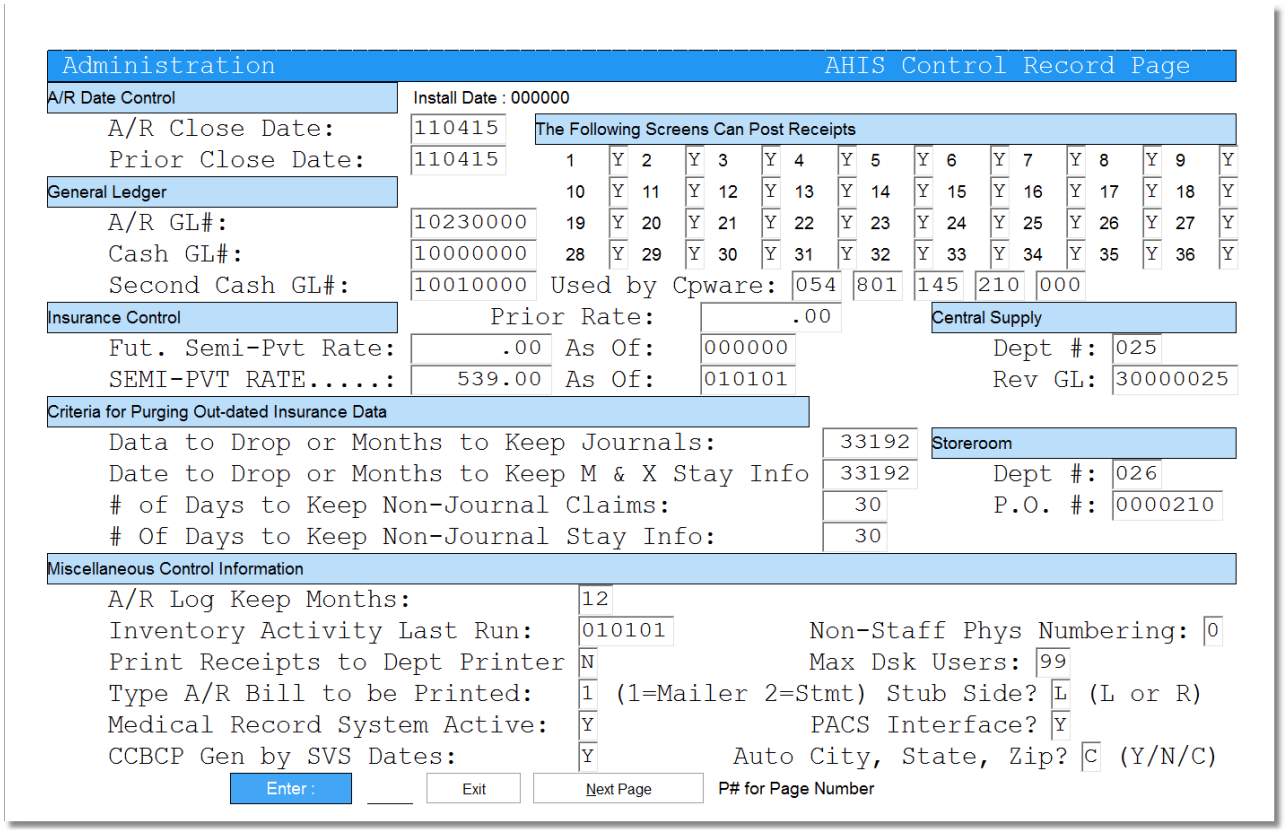
NOTE: *The name and address in the Physician 999999 table will pull to locator 1 of the UB.*

7.5 Business Office Table Maintenance

AHIS

The AHIS Control Record is a table that contains information about various areas of TruBridge EHR. The insurance billing programs read several fields in this table to pull information to specific areas in the billing system and to react to this information. The fields that affect insurance billing are listed below.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 1**



AHIS Control Record Page

- **Prior Rate:** This is the semi-private room rate used to determine the calculation of non-covered room charges for patients with a service date prior to the As Of date of the current Semi-Pvt Rate.
- **Fut. Semi-Pvt Rate: As Of:** Enter the facility's future semi-private room rate. This allows for upcoming room rate changes to be put in place in advance. Enter the date the new semi private rate will go into effect in the As Of field.

- **Semi-Pvt Rate: As Of:** This field is the current semi-private room rate and the date this rate took effect. The difference between a private room rate and the amount in this field will pull as non-covered on a UB for private room charges with a service date since this As Of date.

- **Date to Drop or Months to Keep Journals:** Enter a date to purge or the number of months to keep journal insurance claims. The TruBridge recommended setting is 24 months.

- **Date to Drop or Months to Keep M & X Stay Info:** Enter a date to purge or the number of months to keep Medicare and Medicaid claim stay information. The TruBridge recommended setting is 24 months.

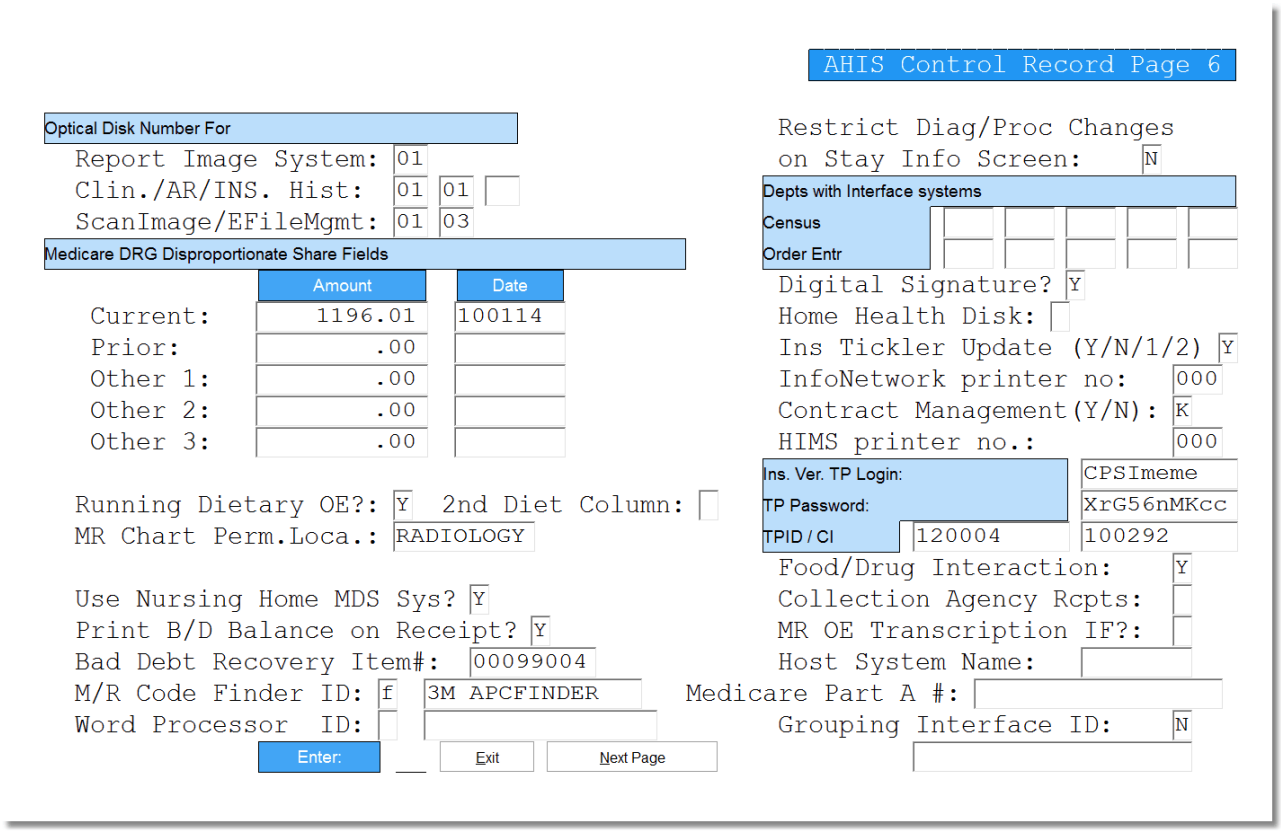
- **# of Days to Keep Non-Journal Claims:** Enter the number of days to keep non-journal claim detail. The TruBridge recommended setting is 180 days.

- **# of Days to Keep Non-Journal Stay Info:** Enter the number of days to keep non-journal stay information. The TruBridge recommended setting is 180 days.

  NOTE: *The Insurance Purge is an automatic weekly function. The purge program reads these fields to determine when the journal, M & X stay information detail, non-journal claims and non-journal stay information is purged. The months or days entered in the Criteria For Purging Out-Dated Insurance Data fields are calculated from the date the claims are paid or rejected. The purge program will only purge claims that have been receipted as "F"ull, "R"ejected, or "A"pplied to Deductible during receipt entry.*

- **CCBCP Gen by Svs Dates:** If answered **Y,** when Create Claims by Charge Period is performed, claims will generate based on Service Date. If answered **N**, claims will generate based on AR Date. The default will be Service Date. When accessing this field, the system will prompt for an override password. TruBridge Financial Support must be contacted.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 6**

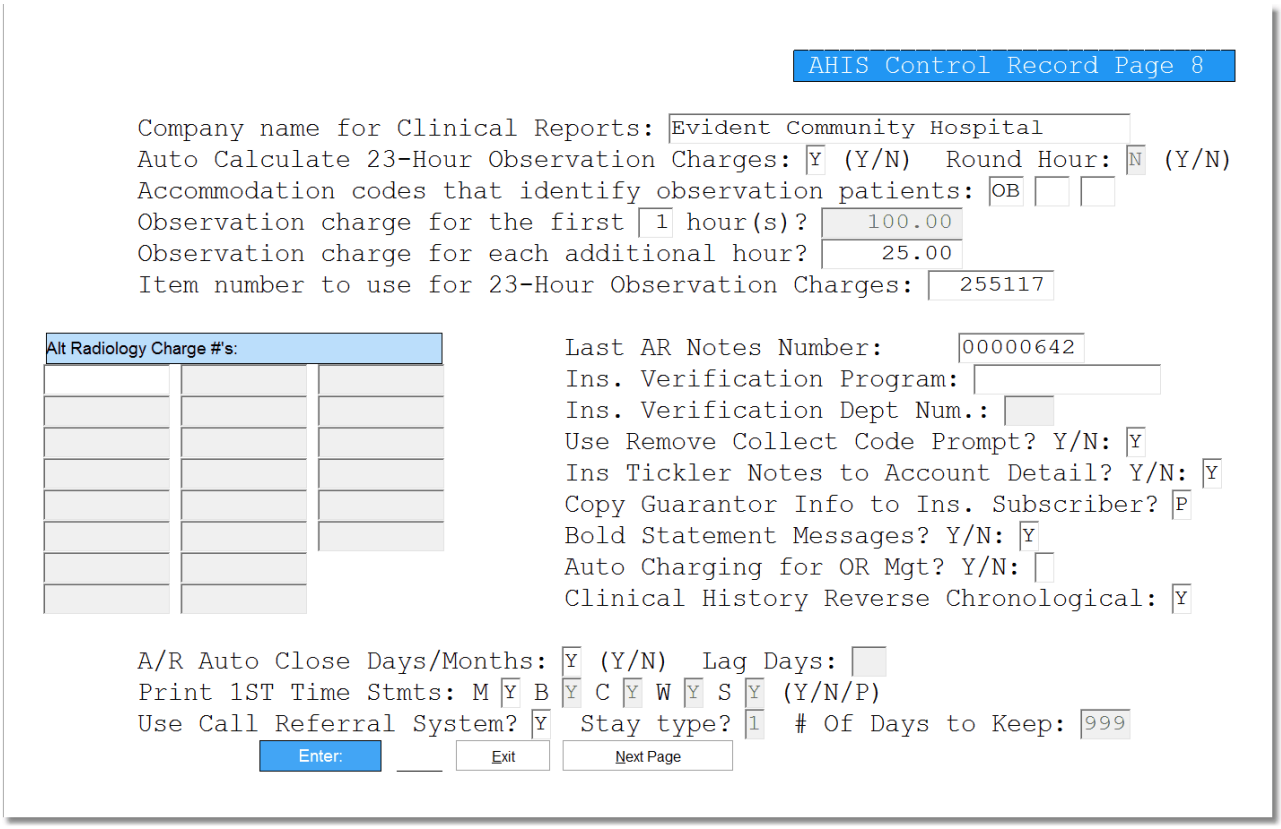


AHIS Control Record, Page 6

- **Restrict Diag/Proc Changes On Stay Info Screen:** This field may be answered **Y** or **N**. If this field is answered **Y**, it will force the Medical Records information entered on the Stay Information screen to be view only. An **N** will allow the diagnosis and procedure codes to be manipulated when accessed from the Stay Information screen in the Insurance Billing screens. Changes made on the Stay Information screen to Medical Records codes will not affect the DRG Grouper screen.

- **Ins. Ver. TPLogin: TPPassword:** These fields are used in conjunction with the purchased interface to the Passport insurance verification system. For further information, contact a TruBridge Marketing Representative.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 8**

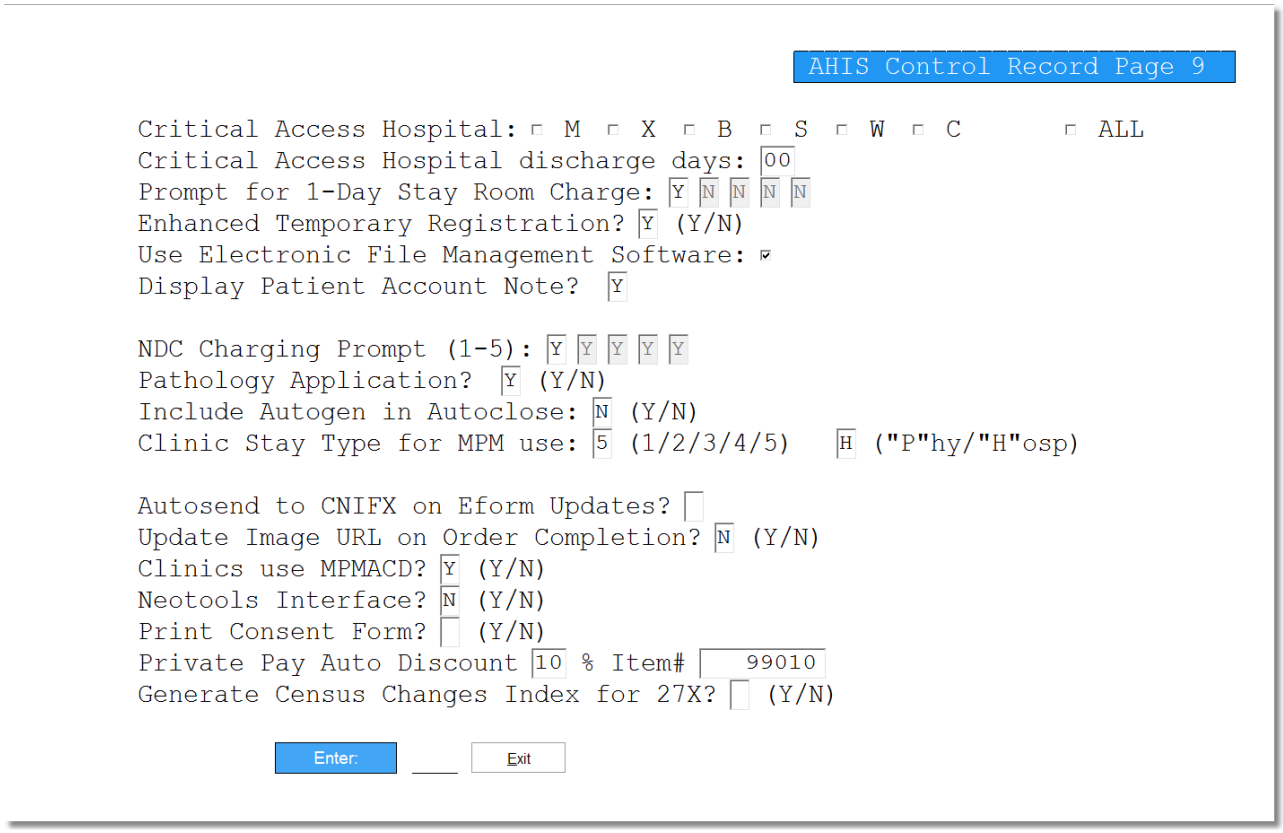


AHIS Control Record, Page 8

- **Ins. Verification Program: Ins Verification Dept. Num.:** These fields are used in conjunction with the purchased interface to the WebMD insurance verification system.

- **Copy Guarantor Info to Ins. Subscriber?:** Enter **Y,** and the system will automatically pull guarantor information to the insurance subscriber information fields when adding insurance during registration. Enter **N,** and the system will not copy any information to the subscriber fields. Enter **P**, and the system will automatically pull the patient information to the insurance subscriber information fields.The default will be **Y**. This does not affect Medicare and Medicaid financial classes.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 9**

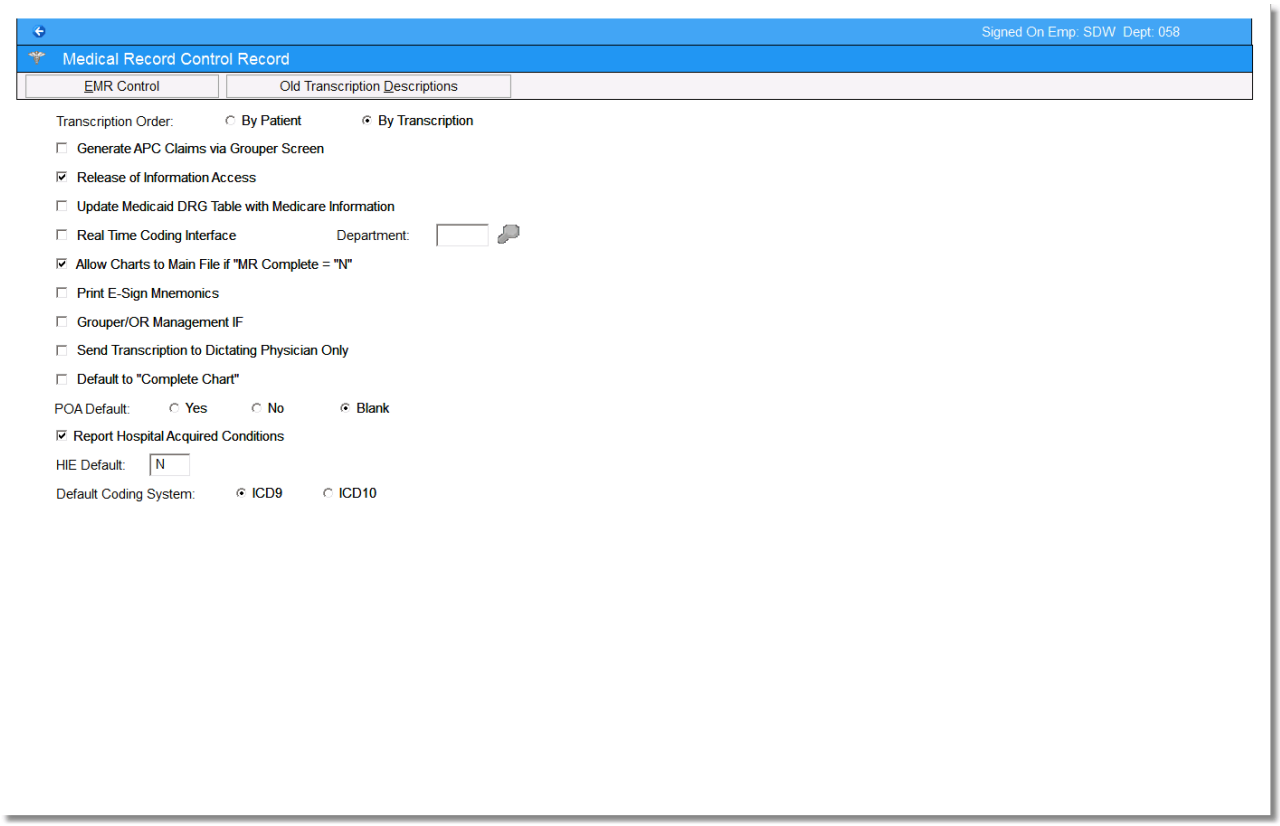


AHIS Control Record, Page 9

- **Include Autogen in Autoclose:** When this is set to **Y**, "Autogen" and "APC Claims to Ready to Bill" will run automatically when the **Charges Closed thru** date meets the lag days criteria set in the Insurance Company table. This will move the appropriate claims to the Ready to Bill or Billed status depending on how the Auto Gen Ready-to-Bill field on page 4 of the Insurance Company table is set and whether or not the facility has purchased Electronic Billing Outsourcing. APC claims will also move to the Billed status if claims have a verified date.

Medical Records

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > Medical Records**



Medical Record Control Record

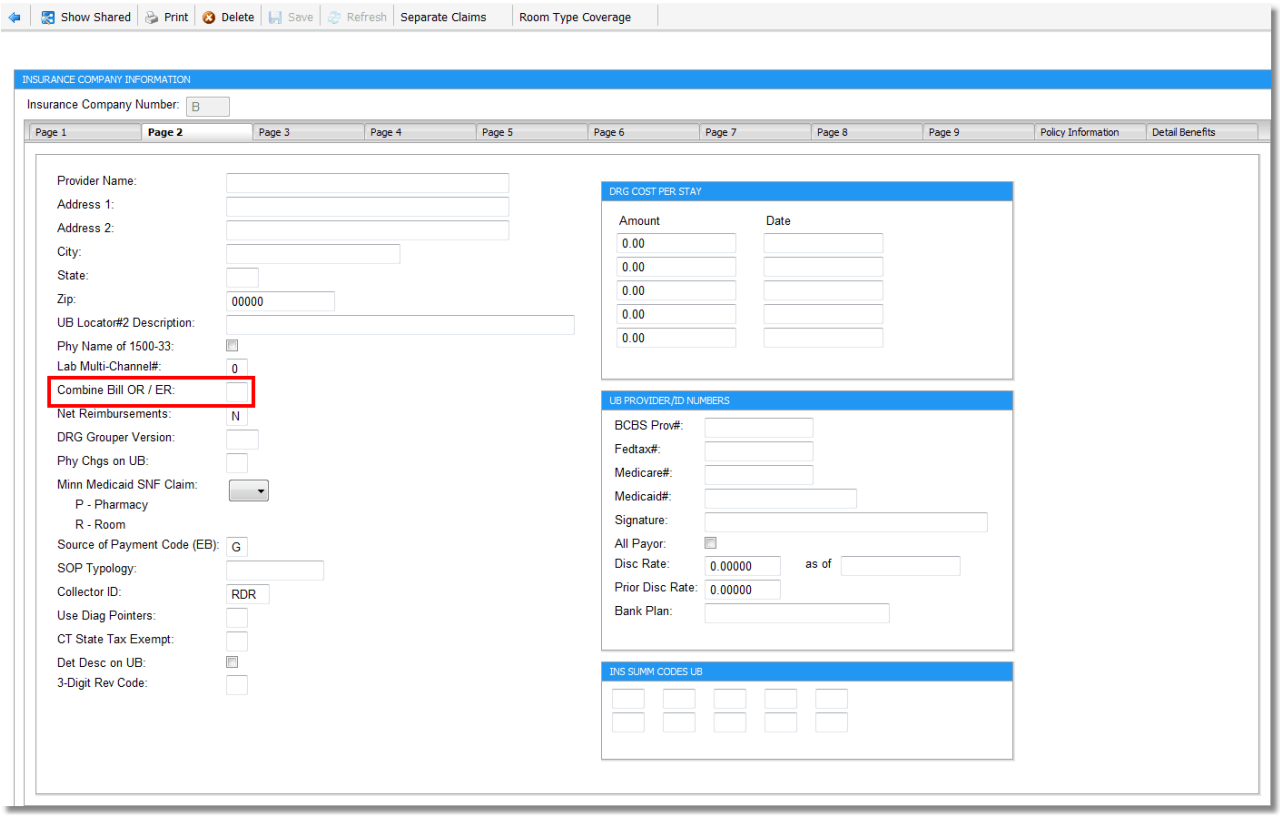
- **Generate APC Claims via Grouper Screen:** If this field is selected**,** and the account meets the regular criteria to autogen the claim, an APC claim will generate once the Finish Date is entered in the Grouper screen.

7.6 Summarizing Revenue Centers

To enable the system to report procedures in the Revenue Center in which the procedure was performed and have a HCPC code pull from the Medical Records DRG Grouper screen, several tables must be manipulated. Below is a description of the fields for each table that must be manipulated.

Insurance Company table

Select **Web Client** > **Tables** > **Business Office** > **Insurance Companies** > **Page 2**

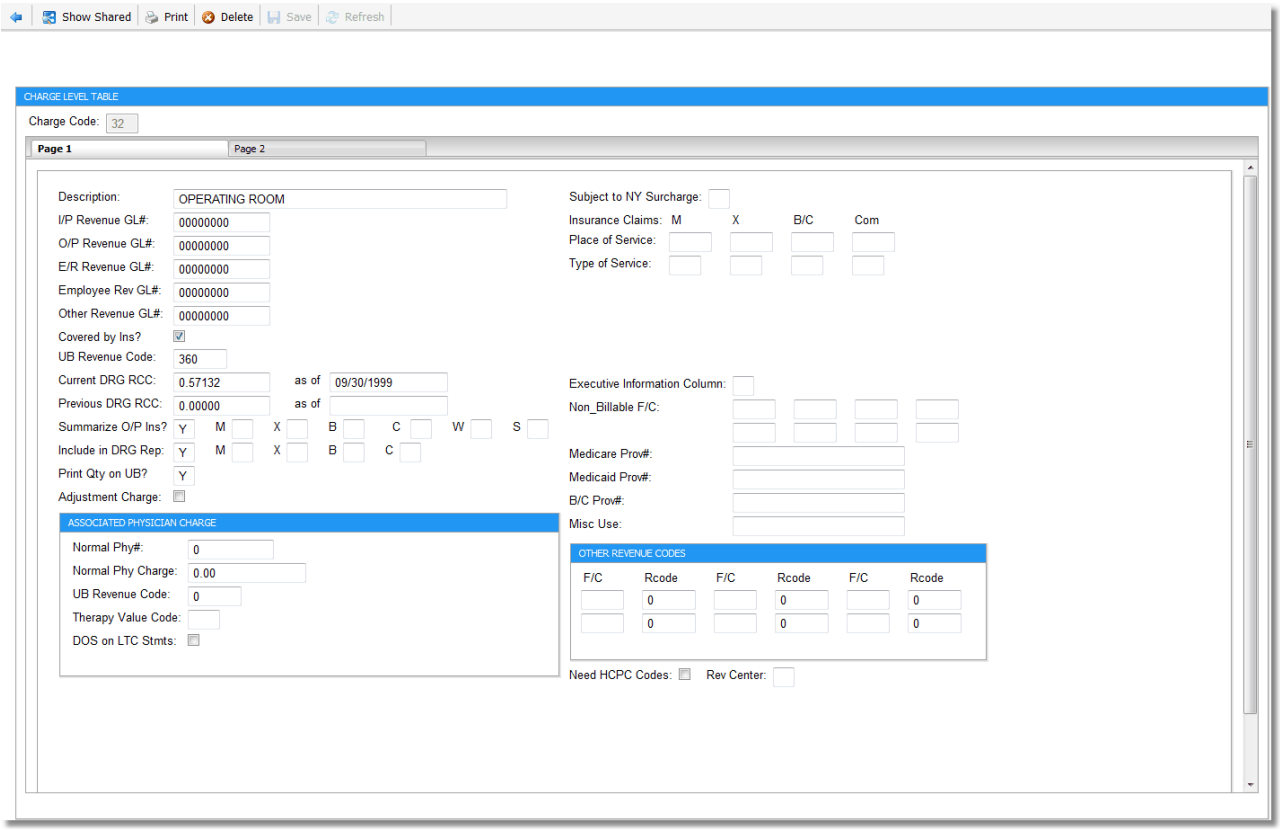


Insurance Company Maint., Page 2

- **Combine Bill OR & ER:** This field should be answered with a **Y** for all Financial Classes that require OR and ER charges to be combined or that require Revenue Centers to be summarized.

Summary Code table

Select **Web Client** > **Tables** > **Business Office** > **Chg Summary Cds** > **Page 1**

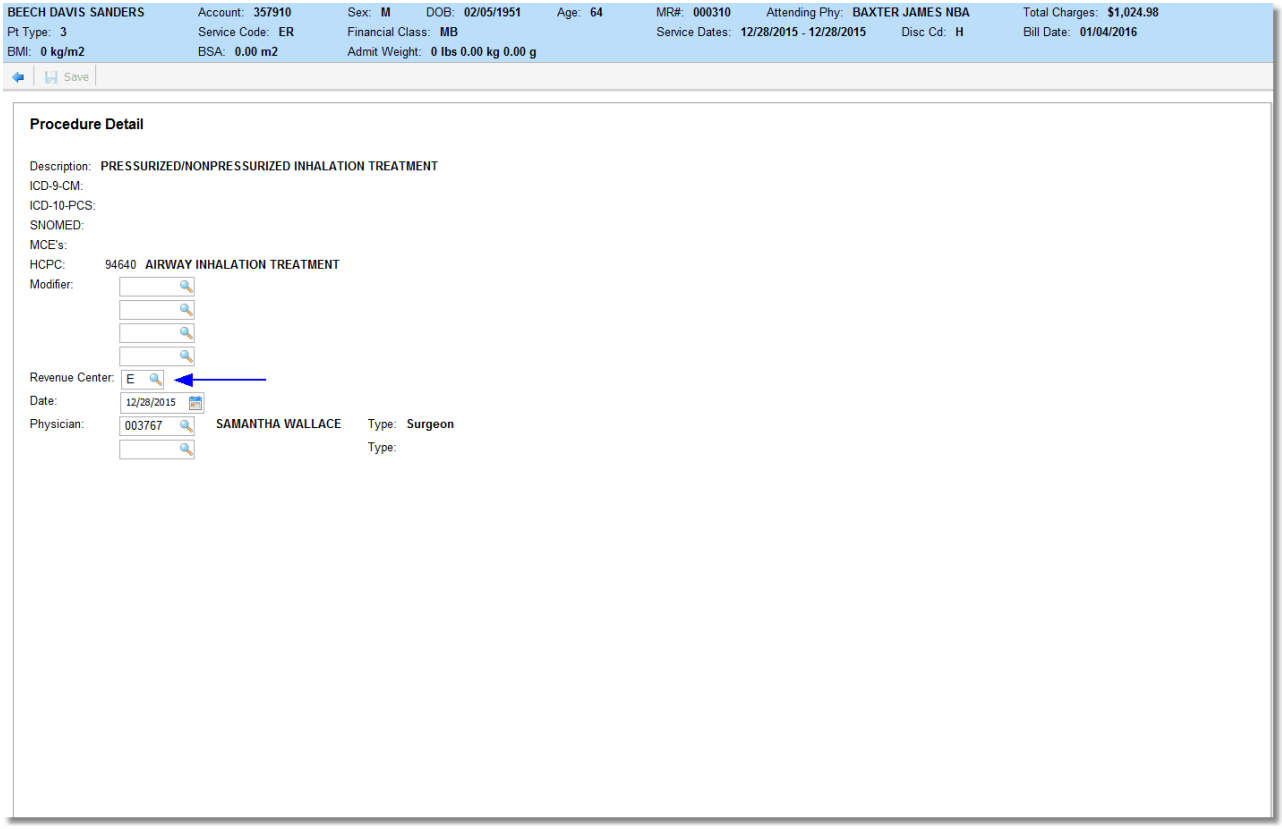


Charge Summary Codes, Page 1

- **Need HCPC Codes: Rev Center:** Enter a **Y** to allow the HCPC's loaded on the DRG Grouper screen to pull to the UB when the Combine O/R E/R field on page 2 of the Insurance Company table is answered **Y**. Enter an **N** to pull the CPT code assiciated with an item in the Item Master but not pull any HCPC's entered in the DRG Grouper screen. Enter an **S** to allow charge items without CPT code(s) loaded to pull to a separate line of detail on the UB and not combine with any other summary code even when the Need HCPC Codes field is marked **Y**. Rev Center will allow any summary code to be assigned a revenue center.

Grouper Screen

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Medical Records > Grouper > Procedures > double-click a Procedure**



Grouper - Procedures

The Revenue Center field is used to designate the place of service the procedure was performed. An alpha revenue center code from A-Z can be assigned to each summary code loaded in the Charge Summary Code table, page 1. HCPCs that are associated with a revenue center will be broken out on a separate detailed line on the Detail Charges screen. If there are no Revenue Center codes loaded on the Grouper Screen, the system will look at all charges on the patient's Account Detail until the system reaches the first item charged that has a summary code with the Need HCPC field marked **Y**es. The system will then use the summary code and combine the charges into one line of detail on the Detail Charges screen. If there are several HCPC codes loaded, the system will produce multiple lines on the UB with the same summary code.

7.7 Waste Capture for Pharmacy Items

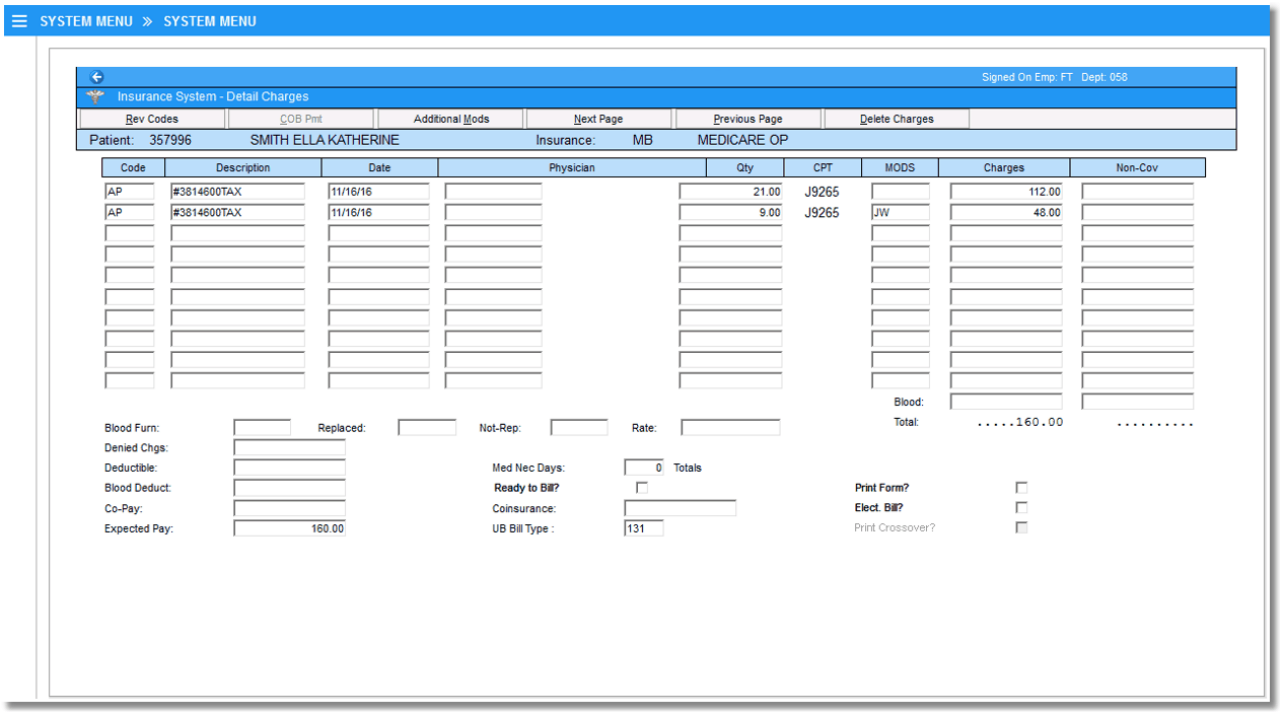
The Medication Waste feature will allow medication waste that is captured during charging to display on the insurance claim.

The following set up must be completed for the Waste Modifier to be display on the claim.

- Insurance Company Table, Page 9 must have a Waste Modifier loaded (JW)
- Insurance Company Table, Page 4 APC Reimburse must be selected (or set to Y) -OR- Insurance Company Table, Page 7 must have Conversion Factor for Pharmacy Charges selected (or set to Y)
- Item Master - Pharmacy Information, Page 1 must have Capture Waste set to Y or P

If the above table set up is complete and the quantity administered/wasted is captured during charging, then when the claim is generated the charge will be broken into two lines. The first line will pull the quantity administered and the charge amount for the administered portion. The second line will pull the quantity wasted, the charge amount for the wasted portion, and the modifier that is listed in the Waste Modifier field.

If the amount wasted is less than one, then the first line will pull the quantity administered along with a modifier of JZ. The JZ modifier is hard coded to pull for charges with waste amounts less than one when there is a Waste Modifier loaded on Page 9 of the Insurance Company Table.



Detail Charges

When the Item has a Conversion Factor loaded on Page 1 of the Item Master, TruBridge EHR will use the following calculations to determine the quantity and charge amount. Each calculation will be done once for the Administered amount and once for the Wasted amount.

Quantity

Quantity Administered or Wasted

÷ Pharmacy Strength (Item Master - Pharmacy Information, Page 1)

= True Quantity Administered or Wasted

X Conversion Factor (Item Master, Page 1)

= Administered or Wasted Quantity on Detail Charges

The Administered and Wasted quantities will be rounded using the following guidelines.

- If the Administered quantity computes to a value that is not a whole number, TruBridge EHR will round the units up to the next whole number. For example, if the Administered quantity computes as 7.2 mg, then 8 mg will display on the claim.
- If the Wasted quantity computes to a value that is greater than 1.0 but not a whole number, TruBridge EHR will round the units down to the next lower whole number. For example, if the Wasted quantity computes as 2.8 mg, then 2 mg will display on the claim.
- If the administered units compute to a value less than 1, the claim will display only one charge line for the quantity of 1 with the full charge amount; there will be no second line for the wasted quantity.

Charge Amount

Quantity Administered or Wasted

÷ Pharmacy Strength (Item Master - Pharmacy Information, Page 1)

= True Quantity Administered or Wasted

X Item Price (Item Master, Page 3)

= Administered or Wasted Charge Amount on Detail Charges

The Administered and Wasted charge amounts will be rounded using the following guidelines.

- If the Administered amount computes with a digit in the thousandths place, TruBridge EHR will round up to the next highest hundredth. For example, if the Administered charge amount computes as $2185.075, then $2185.08 will display the claim.

- If the Wasted amount computes with a digit in the thousandths place, TruBridge EHR will round down to the next lowest hundredth. For example, if the Wasted charge amount computes as $437.015, then $437.01 will display on the claim.

***NOTE**: The Item Price will be displayed on Page 3 in the traditional Item Master (Hospital Base Menu > Charge Tables and Inventory > Enter Item Number > Item Master > Page 3). In the updated Item Master, the Item Price is located under the Item Pricing Information option (Tables > Control > Item Master > Select Item > Item Pricing Information).*

Chapter 8 Insurance Tickler

8.1 Overview

The Insurance Tickler System is designed to simplify inhouse collection efforts on insurance accounts. Accounts may be moved into the Insurance Tickler File automatically or manually, depending on Business Office Table settings. Accounts dropped into the Insurance Tickler become eligible for review through the Insurance Tickler File Functions screen.

The system will automatically assign accounts to the Insurance Tickler based on criteria set up in AHIS, page 6. They may be set to update the tickler when a claim is moved to the Billed status and/or Paid status. Once assigned to the Insurance Tickler, accounts may be distributed for review based on either financial class, collector or balance.

Although the Insurance Tickler File is designed for automatically assigning accounts, manual assignment may be done. By selecting the **Insurance Tickler System** when locked onto an Patient Account in Patient Functions, the system will display all claims for that account. By selecting the sequence number of a claim not already in the Tickler File, the system will place this claim into the file.

If the claim is not given a reason code once it has been manually entered into the Tickler File, the system will list this claim as “Invalid”, when it is accessed by selecting Process Accounts by Date and Display Accounts by Date on the Insurance Tickler File Functions screen.

Another way to enter a claim into the Tickler File is by selecting Tickler System from the Insurance Claim Status screen. This claim will also be listed as “Invalid” if no reason code is assigned.

If table settings are set up properly, there should be no reason to enter claims into the Insurance Tickler manually, and all “Invalid” claims should be deleted from the Tickler File.

Each collector begins processing the Insurance Tickler by selecting Collector Signon, using a code previously set up and defined in the Collector ID's table. The Insurance Tickler File Functions screen is displayed, listing the following options: Claim Maintenance, Transfer Claims, Process by Date, Display by Date and Display Calendar.

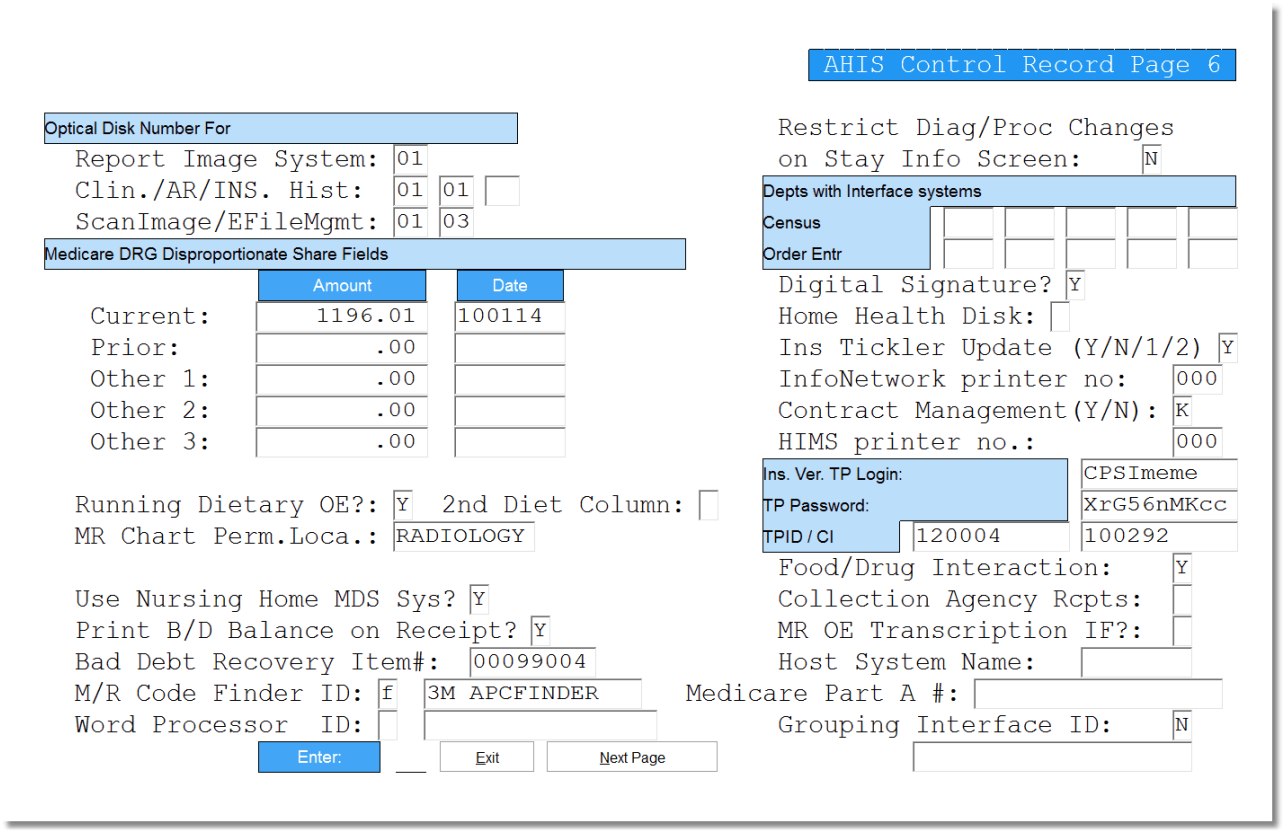
Before any Insurance Tickler functions may be performed, table maintenance must be performed in AHIS, the Collector ID's table, the Insurance Company tables and Review Codes table.

8.2 Table Maintenance

Prior to using the Insurance Tickler system, table maintenance must be performed.

AHIS, Page 6

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 6**

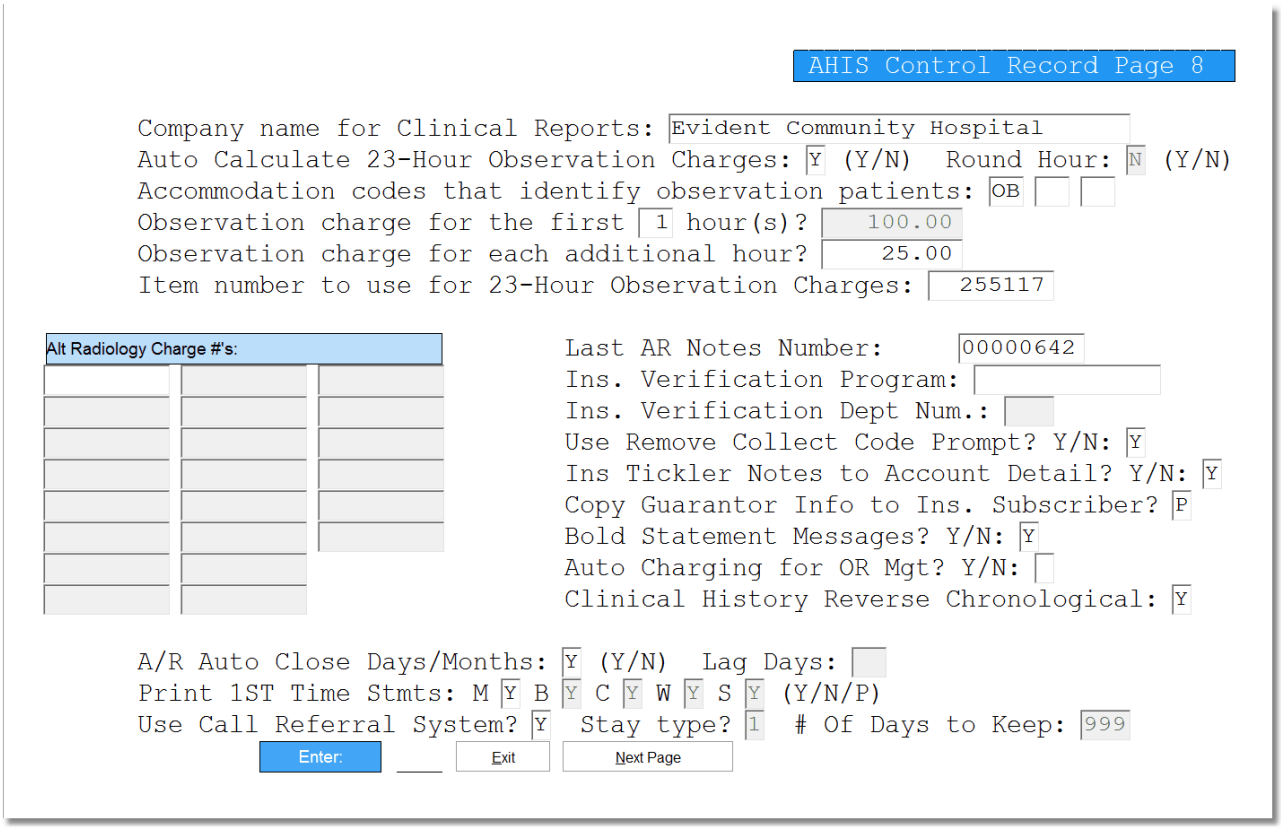


AHIS Control Record, Page 6

- **Ins Tickler Update (Y/N/1/2):** Entering a **Y** will cause the Tickler to be auto-updated when a claim is moved to the Billed status and when the claim is Paid. Entering an **N** will not move any information into the Insurance Tickler. Entering a **1** will update the Tickler only when a claim is moved to the Billed status, and entering a **2** will update the Tickler only when an existing claim within the Tickler is Paid.

AHIS, Page 8

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 8**



AHIS Control Record, Page 8

- **Insurance Tickler Notes to Account Detail? Y/N:** Entering a **Y** will allow any notes entered on a claim through the Tickler File Maintenance screen to be included on the Patient Account Detail. Entering an **N** will keep the notes in the Notes area of the Tickler system.

Collector ID's

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > Collector ID's** or
Web Client > Tables > Business Office Tables > Collector ID's

A/R Collector ID's

The Collector ID's are set up in the Collector ID's table. Generally, the collector's three initials are entered as the code.

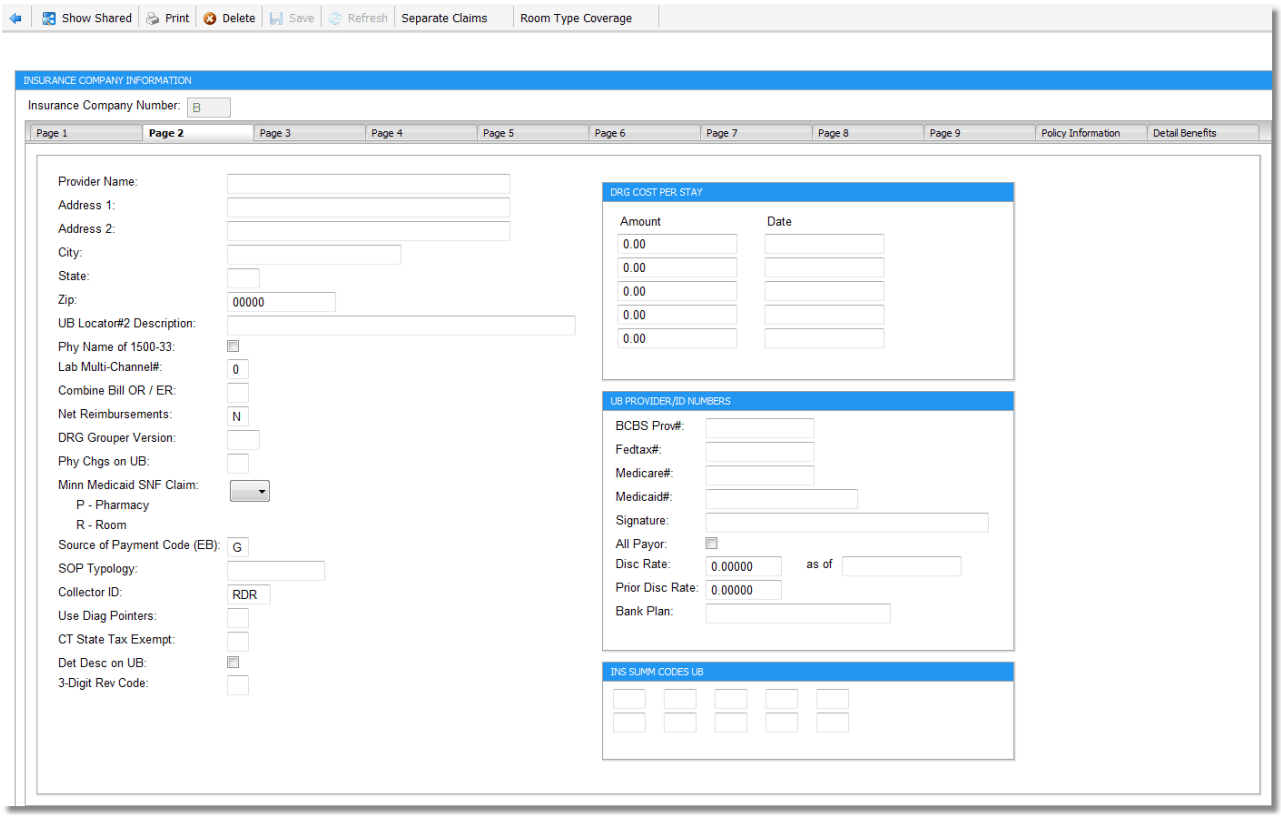
If a code was entered in error, or one is no longer valid, type **DEL** in the Name field to remove it from the Collector ID's table.

Review Codes

Please see the Review Codes section of the Table Maintenance - Business Office User Guide.

Insurance Company table, Page 2

Select **Web Client** > **Tables** > **Business Office** > **Insurance Companies** > **Page 2**



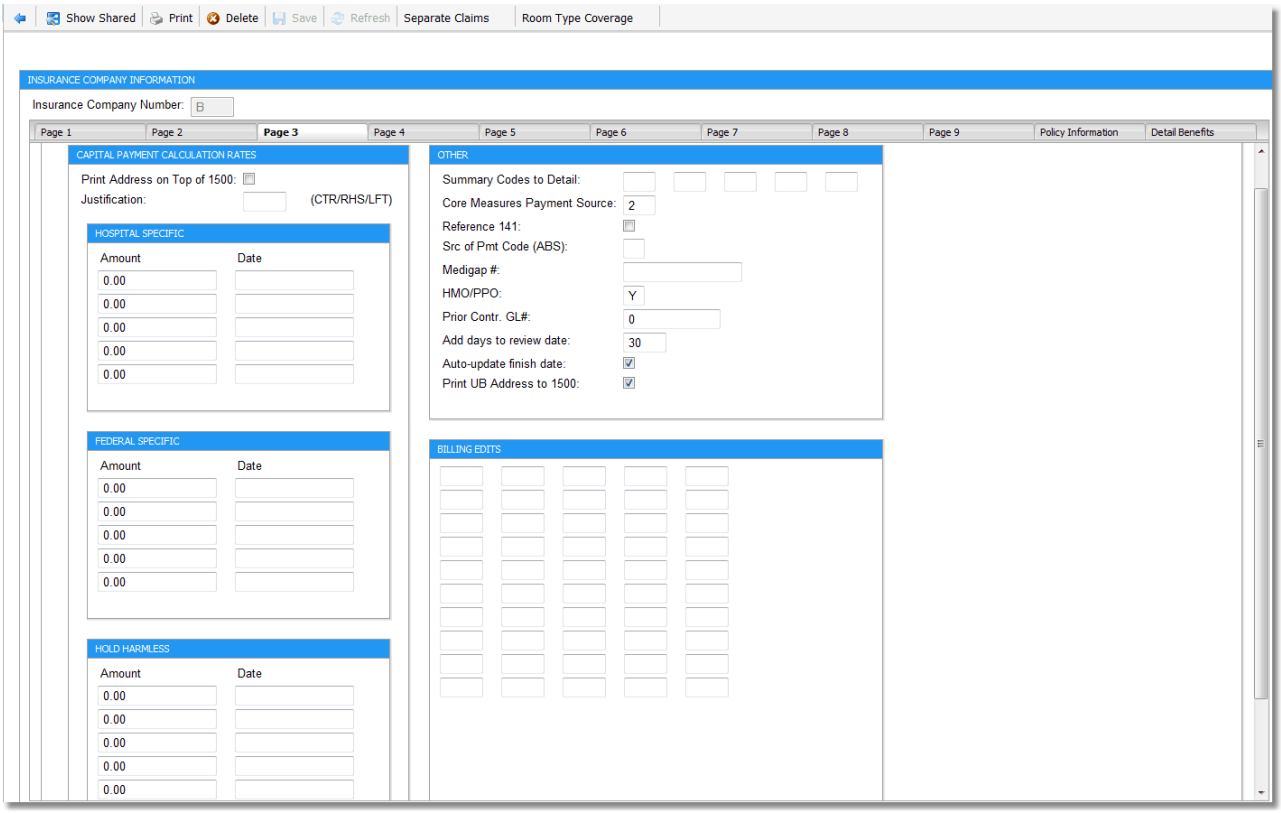
Insurance Company Maint., Page 2

- **Collector ID:** Enter the code for the Collector who works insurance collections for this company. The code is not valid unless it is first set up in the Collector ID's table. When a claim is Billed and automatically placed into the Tickler File, it will be assigned by the system to the Collector ID listed in this field.
  - Entering **NA** in this field will exclude this insurance company's claims from moving into the Tickler File.
  - If this field is left blank, the Collector ID will default to the insurance company code. For example, Medicare O/P claims will be assigned to Collector MB. If this method is chosen, the Insurance Company Code IDs must also be set up in the Collector ID table. This will allow the ability to transfer files from one Collector to another. If the IDs are not set up, the system will consider the Collector ID invalid.

NOTE: *This field is only used when assigning accounts to collector's based on the patient's financial class.*

Insurance Company table, Page 3

Select **Web Client** > **Tables** > **Business Office** > **Insurance Companies** > **Page 3**



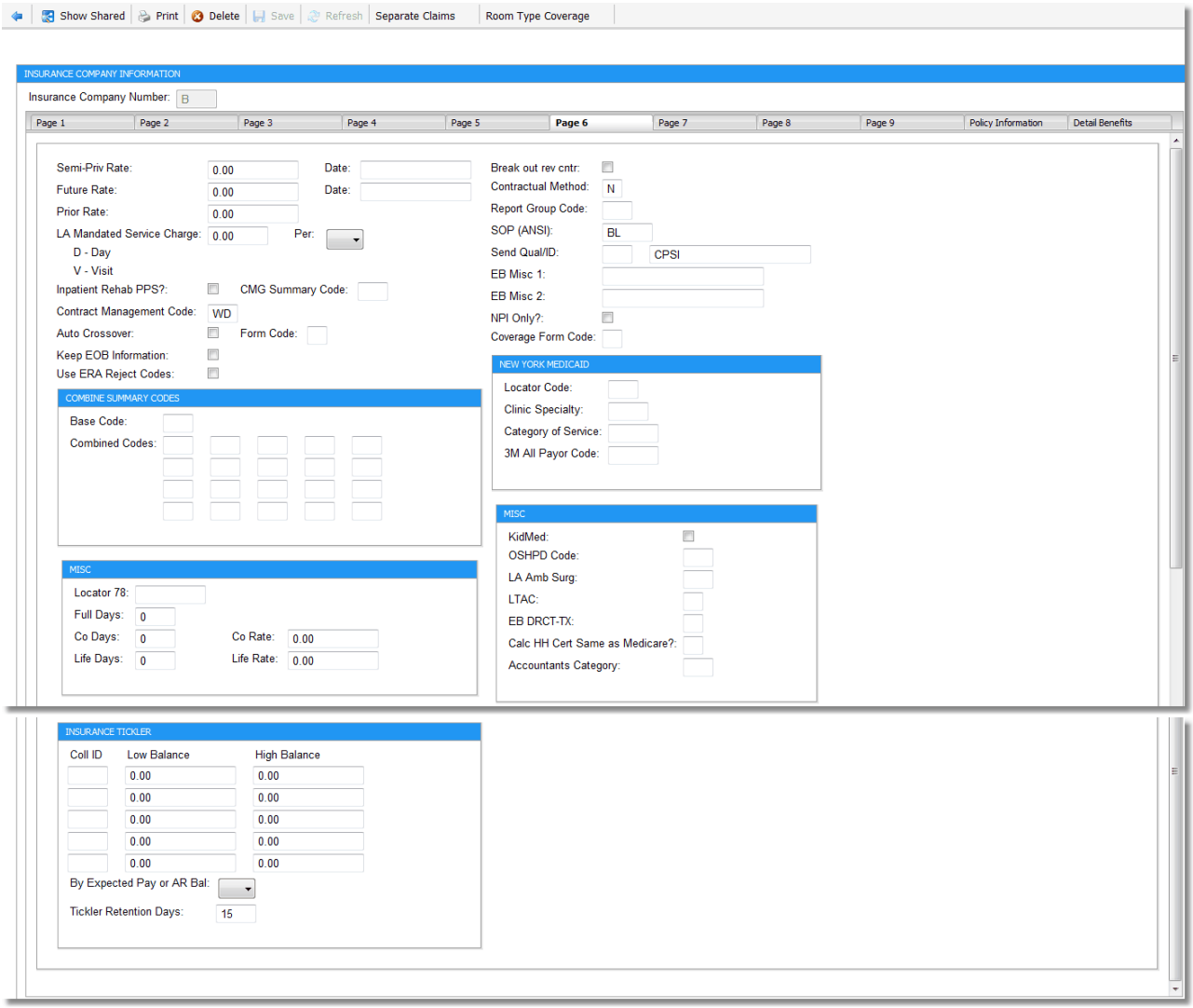
Insurance Company Maint., Page 3

- **Add Days to Review Date:** The number of days entered here will be added to the claim's Billed date and become the Review Date. If left blank, the Review Date will be one day past the Billed Date.

- **Auto Update Finish Date:** If selected, when a claim has a full payment posted against it, the system will place the receipt date in the Finish Date field of the Insurance Tickler file when the Daily Receipts List is printed.

Insurance Company table, Page 6

Select **Web Client** > **Tables** > **Business Office** > **Insurance Companies** > **Page 6**



Insurance Company Maint., Page 6

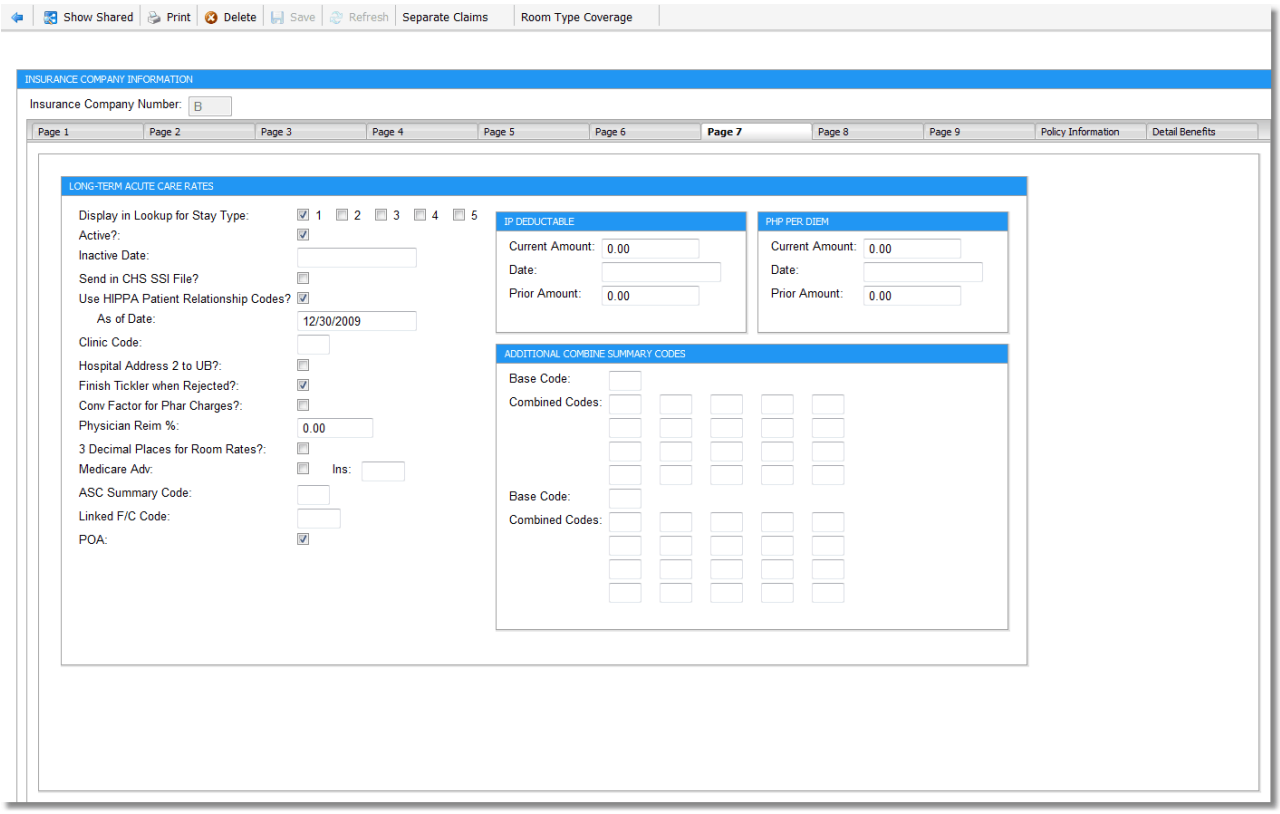
- **Insurance Tickler:** This is a 4-part question that requires establishing the parameters that should be met in order to have the system distribute claims based on account balance.
  - **Coll Id:** The first prompt is for Collector Id. The collector identification code previously set up in the Collector ID's table should be entered in this field. Typically this will be the collector's three initials.
  - **Low Bal/Hi Bal:** These fields establish the low and high account balances to be distributed to the specified collector.
  - **By Expected Pay or AR Bal:** This field determines which balance the system should read for collector account assignment. To have the system assign accounts based on the Expected Pay amount, enter an **E** in this field. To have the system assign accounts based on the full AR Balance, enter an **A** in this field.

NOTE: *This field is only used when assigning accounts to collector's based on the patient's balance. This field overrides the Collector ID loaded on page 2.*

- **Tickler Retention Days:** The number of days entered in this field represents the number of days past the finish date the claim will remain in the system before being automatically purged. The default for this is 31 days; (i.e., if the field is left blank or 0, the system retains the claim in the tickler for 31 days past the finish date.)

Insurance Company table, Page 7

Select **Web Client** > **Tables** > **Business Office** > **Insurance Companies** > **Page 7**



Insurance Company Maint., Page 7

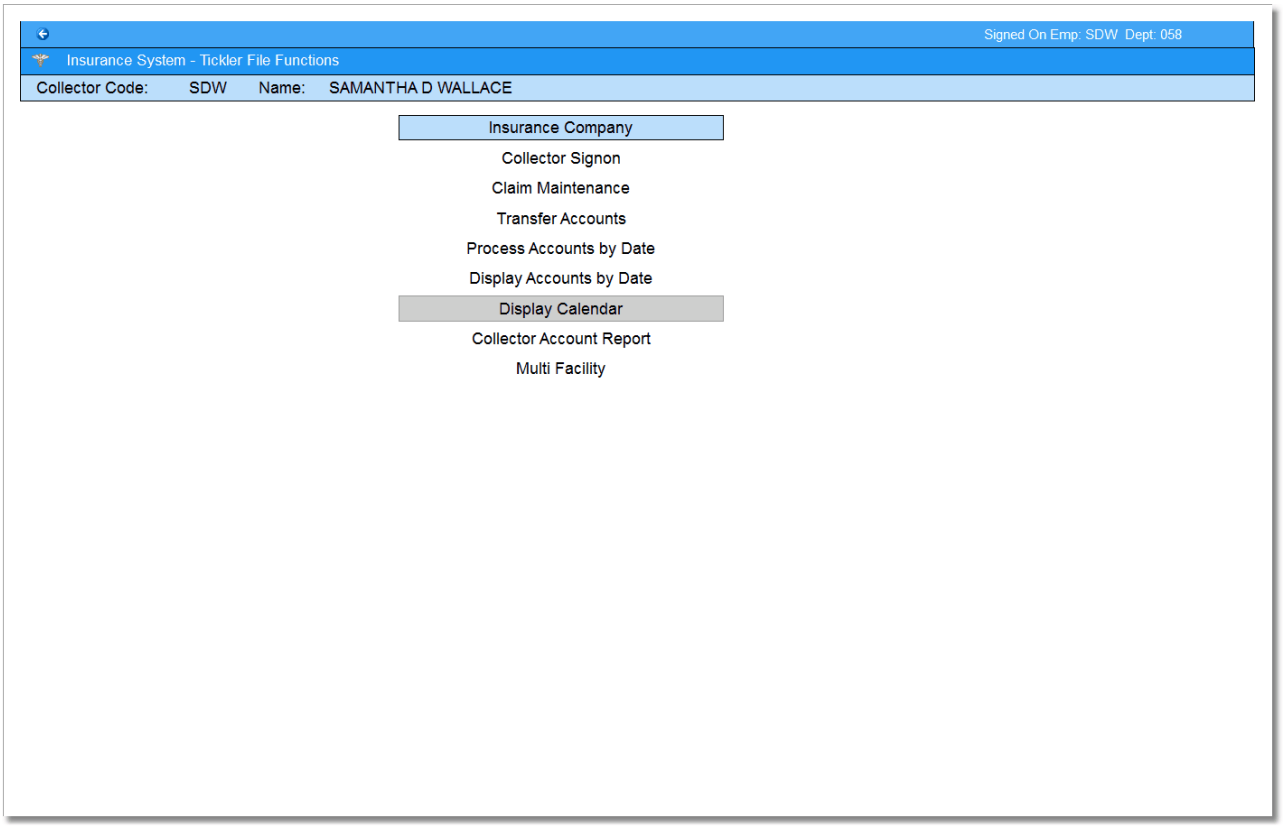
- **Finish Tickler when Rejected?:** If this field is blank, the system will not put a finish date so the claim will be in the tickler and can be reviewed to determine if the rejection is valid.

NOTE: *If this field is set to Yes, the system will put a finish date if the claim is rejected through Receipting, the Billed But Unpaid & A/R Bal=0 report or the Deny Claim option in the Claim Status screen.*

8.3 Using The Insurance Tickler

Once the Insurance Company table, the Collector ID's table, the Review Code table, and AHIS are set up, the Tickler System is ready for utilization. Once in the Insurance Tickler System, the following menu will display:

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System**



Insurance System - Tickler File Functions

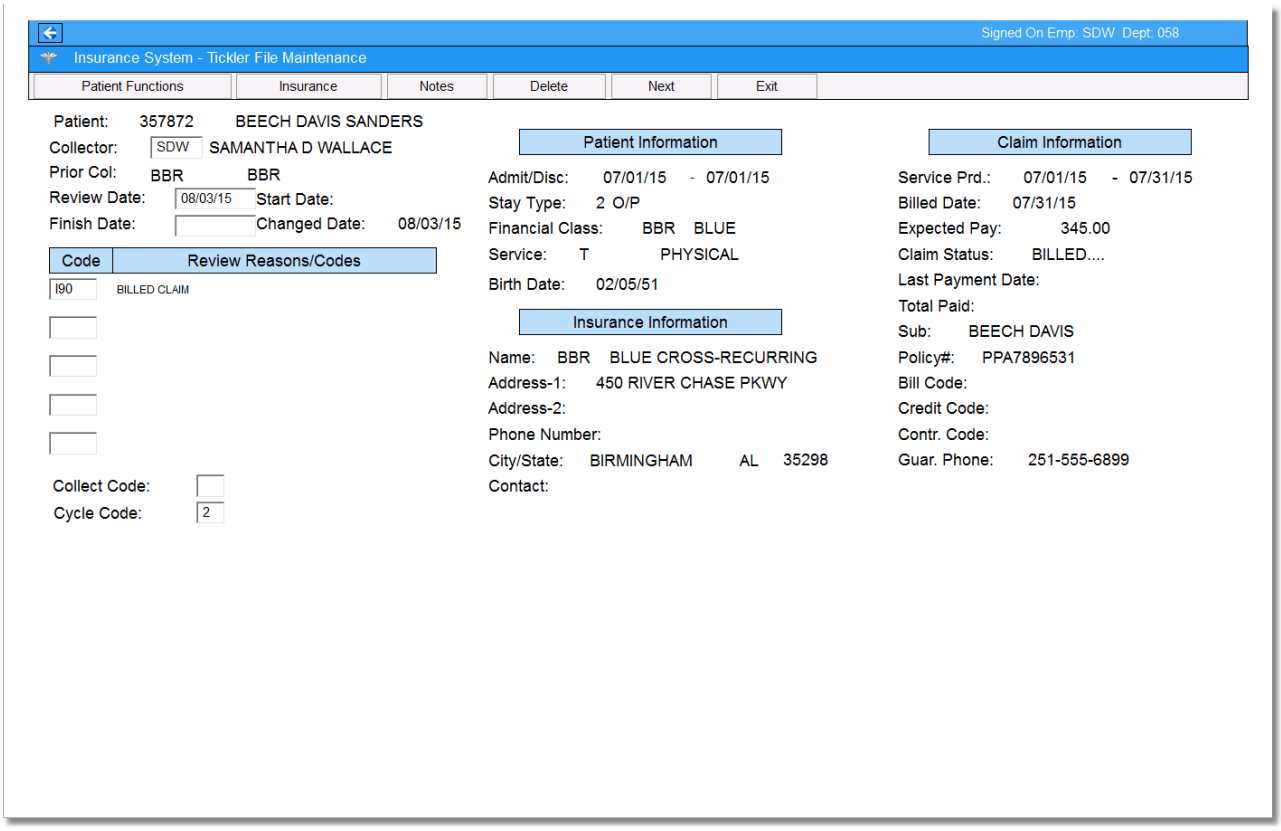
- **Collector Signon:** Selecting this option will prompt for a Collector ID code. The system will verify the code with the Collector ID's table. The benefit of using this option is the timesaving aspect of insurance personnel processing only those accounts that are assigned to their code.

- **Claim Maintenance:** Selecting this option allows access to the Insurance Tickler File Maintenance Screen by entering a specific account number. All claims on this account will list on the screen. After selecting one of the claims, the system will go directly into the Tickler File. If there is no previous tickler entry for that claim, the system will create one.

- **Transfer Accounts:** The Transfer Accounts option allows transferring of accounts from one insurance clerk to another. This feature will only recognize collector ID's that have been set up in the Collector ID's table in the Business Office Tables. This feature gives the Business Office Manager a quick and easy way to ensure an absent Collector's accounts will be reviewed. It will move all file entries from a specified date range from one collector to another.

- **Process Accounts By Date:** This option allows the signed on insurance clerk to access and perform maintenance to the accounts assigned to that clerk by date. Upon selecting this option, the system will first prompt for a starting date. The next prompt allows the collector to include claims with finish dates. If selected, the system will include accounts set with the review date selected that have finish dates entered. It will then display the Insurance Tickler File Maintenance screen for the account that appears first in that day's index.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System > Process Accounts By Date**



Insurance System - Tickler File Maintenance

Once all the necessary tasks have been completed for the account, the collector should select the next button at the top of the screen. This will display the next account's Tickler File Maintenance screen. This routine will continue until all claims for the selected date and clerk have been processed or until the process is exited by pressing exit at the top of the screen.

After all of the files for the selected dates have been worked, the system will prompt that the end of the file for that date has been reached. If there are no subsequent days to work, the system will prompt, “Hit Return To Continue.” If there are more claims with review dates after the completed date, the system will prompt, “Do You Want the Next Day?” Answering with a **Y** will allow the collector to continue on to the next day’s followups. Answering with an **N** will take the collector back to the Insurance Tickler base screen. While working claims for a selected date, entering exit at the bottom of the claim’s Tickler File Maintenance Screen will allow the collector to exit from processing claims.

- **Display Accounts by Date:** Selecting this option will display all claims assigned to a particular collector.

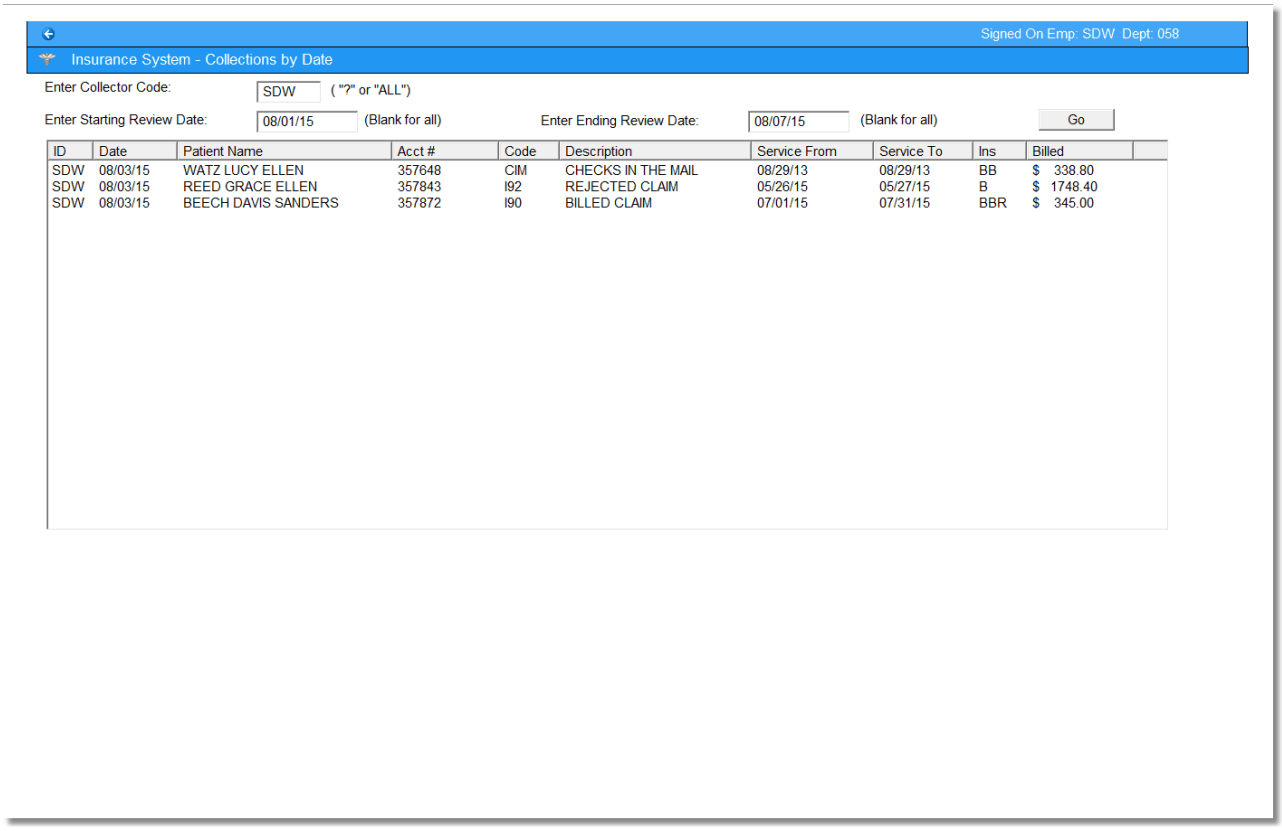
  The signed-on collector will display in the Enter Collector Code field. To view claims for another collector, enter in the Collector ID. If the Collector ID is unknown, enter a **?** in the Enter Collector Code field and select **Go,** to display a listing of all Collector ID's along with the quantity of claims assigned to each one. To view all claims that need to be reviewed, enter **ALL**.

  A review starting and ending date range may be entered or may be left blank to view all claims that need to be reviewed. Select **Go** to view claims.

  The columns will display the Collector ID, Review Date, Patient Name, Account Number, Review Code, Review Code Description, Service From and To Dates, Financial Class and Billed Amount. The columns may be sorted, ascending or descending, by selecting the column headings. The order of the columns may also be changed by selecting the column heading and dragging it to the desired location.

  To enter a specific Tickler File, select the claim from the listing.

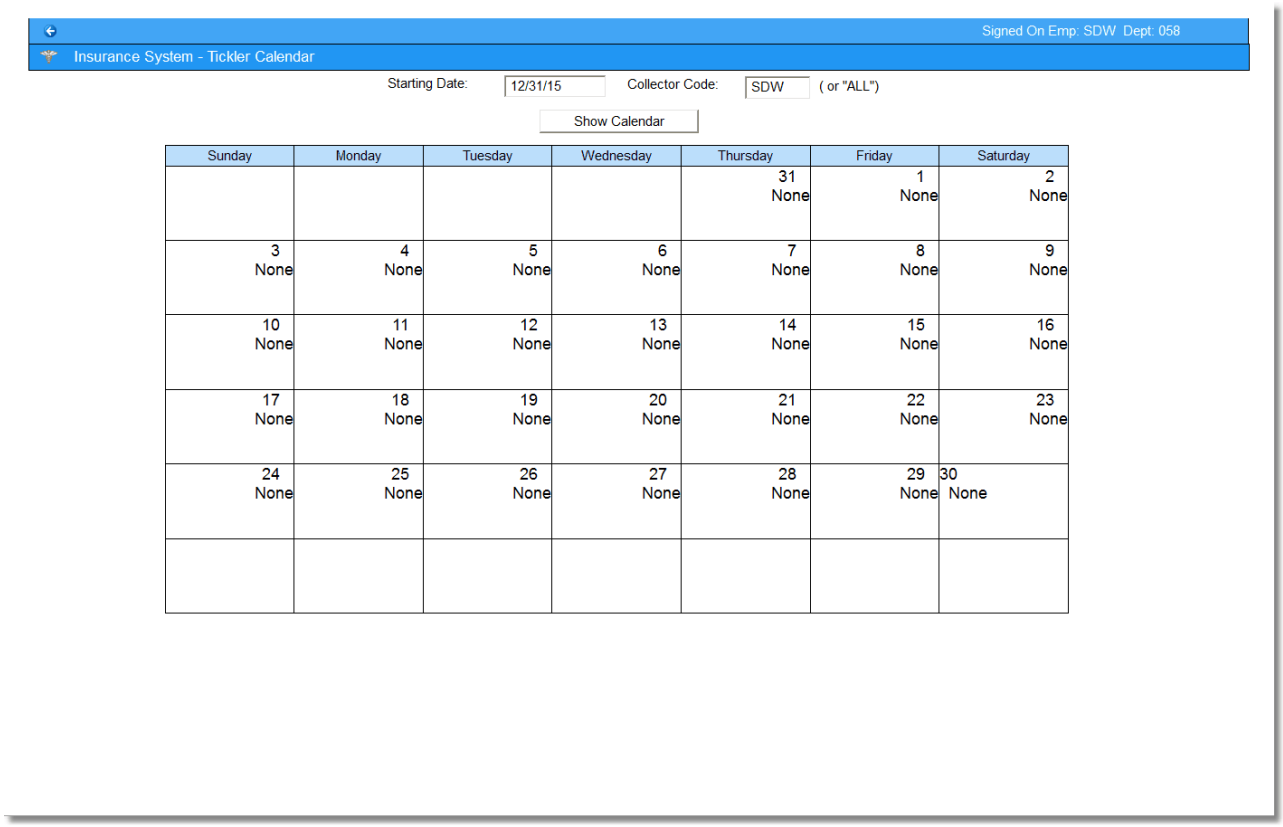
Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System > Display Accounts By Date**



Insurance System - Collections By Date

- **Display Calendar:** This option displays the Insurance Tickler File Schedule. The schedule display is a date grid containing daily totals of accounts to be reviewed over a selected time period. The system defaults to the current date and calculates the end date, but these dates may be over-keyed. A specific Collector ID may also be selected, or enter **All** for all Collector IDs.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System > Display Calendar**



Insurance System - Tickler Calendar

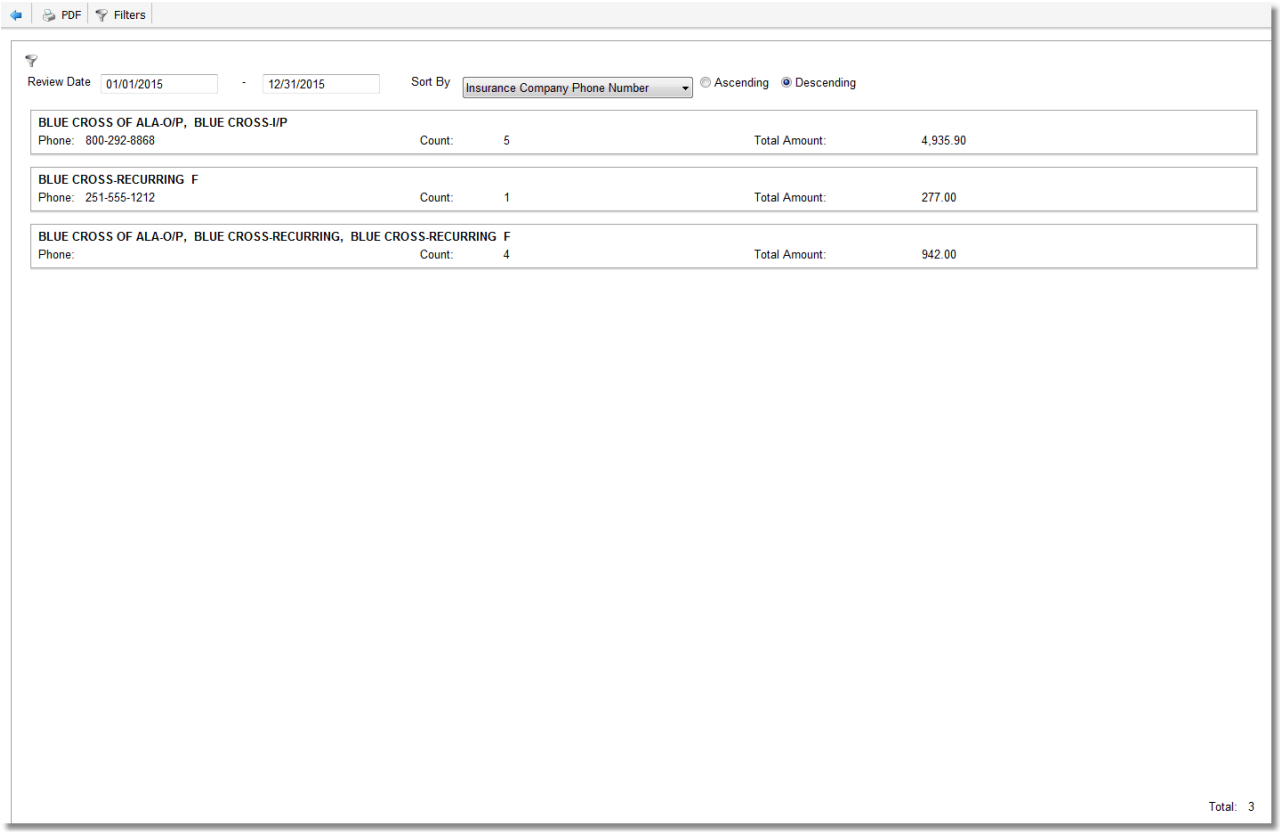
- **Collector Account Report**: The Collector Account Report will provide a listing of claims that need to be reviewed in the Insurance Tickler File. Please see the Collector Account Report 152 section for more information.

- **Multi Facility:** This option will allow insurance claims across multiple facilities to be worked from one location in the Insurance Tickler. Please see the Multi Facility 145 section for details on the functionality of this option.

8.4 Multi Facility

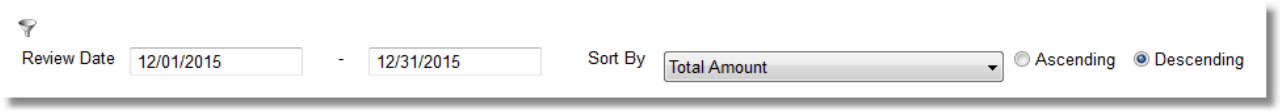
The Multi Facility option will allow insurance claims across multiple facilities to be worked from one location in the Insurance Tickler.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System > Multi Facility**



Multi Facility Insurance Tickler

Once the Multi Facility option is selected, a list of claims will be displayed. Options for pulling and sorting claims in the listing are available at the top of the screen.



Sorting Options

- **Review Date**: A review starting and ending date range may be entered to view all claims that need to be reviewed.
- **Sort By**: Claims pulling to the listing may be sorted by the following options.

  Total Amount
  Record Count
  Insurance Company Phone Number

- **Ascending/Descending**: Select Ascending or Descending to view the results by the Sort option selected.

-  **(Filters)**:The filters will only display if they have been set up by the signed-in user. Not every user will see the same filters at the top of the screen. For more information on how to set up filters, see the Filters section.

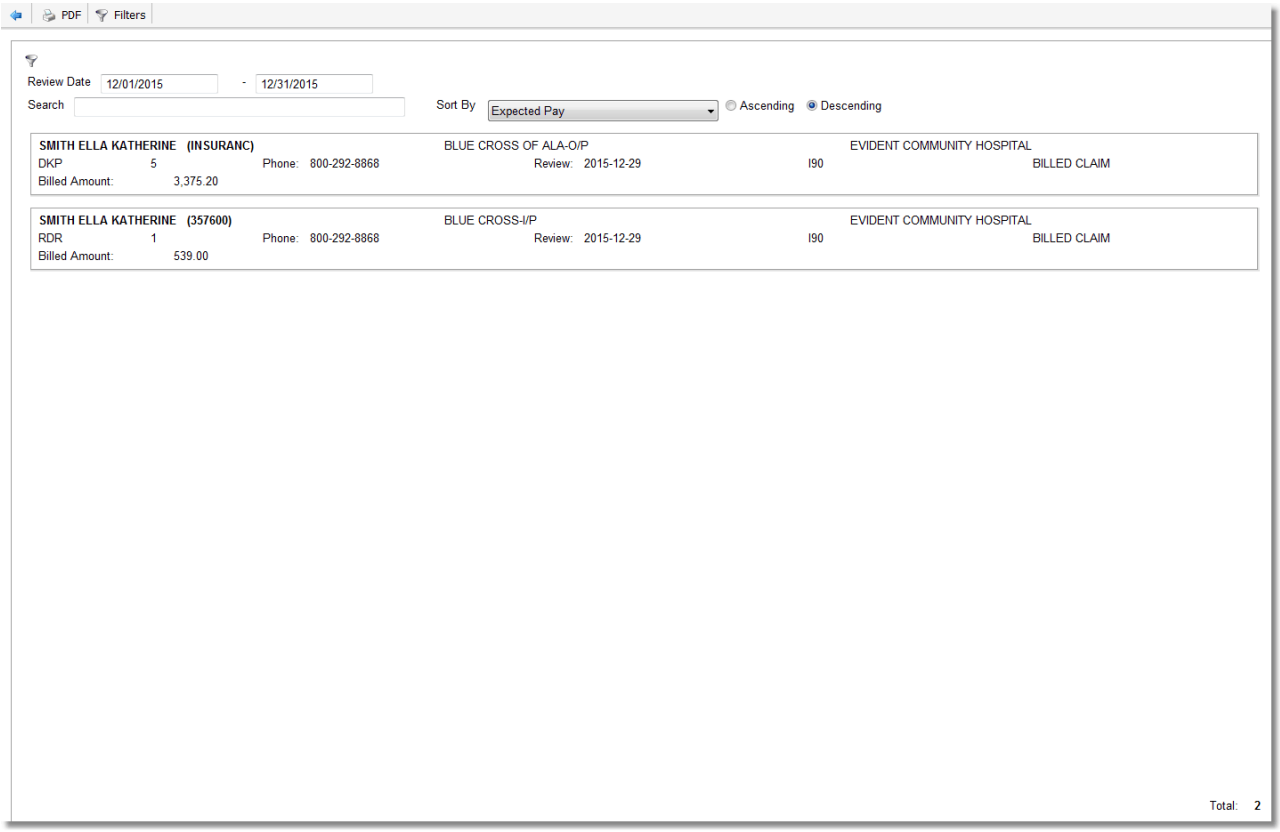
Once the sorting option has been selected, claims will pull to the listing based on the criteria chosen. Claims will be grouped together by insurance company telephone number and the following information will display.

Claim Group

- **Insurance Company Name**:This is the name of the insurance company. Multiple insurance company names will pull to this line if more than one insurance company has the same phone number.
- **Phone**: This is the phone number of the insurance company for the claims in this group.
- **Count**: This is the number of claims with this phone number in this group.
- **Total Amount**: This is the sum of all the billed dollar amounts for all the claims in this group.

Select the claim group to view all the claims in that grouping.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System > Multi Facility > Select Claim Group**



Claim Grouping

Options for pulling and sorting claims in the listing are available at the top of the screen. Once the sorting option has been selected, claims within this group will pull to the listing based on the criteria chosen. There is also a search. The following information will be displayed for each claim:

Claim Listing

- **Patient Name**: This is the name of the patient on the account.
- **Patient Account Number**: This is the account number of the patient associated with the claim.
- **Insurance Company Name**: This is the insurance company name that is loaded in Policy Information.
- **Facility Name**: This is the name of the facility where the claim originated.
- **Collector ID**: This is the Collector ID that is assigned to the claim.

- **Financial Class Set Number**:This field represents the sequence number of a particular financial class on a patient account. If there are multiple claims with the same financial class on the account, the system will assign a set number of 1, 2, etc.
- **Phone**: This is the insurance company phone number that is loaded in Policy Information.
- **Review**: This is the date the account is scheduled for review.
- **Review Code**: This is the last Review Code that was assigned to the account in the Insurance Tickler.
- **Review Description**: This is the description of the Review Code listed for the claim.
- **Billed Amount**: This is the billed amount on the insurance claim.

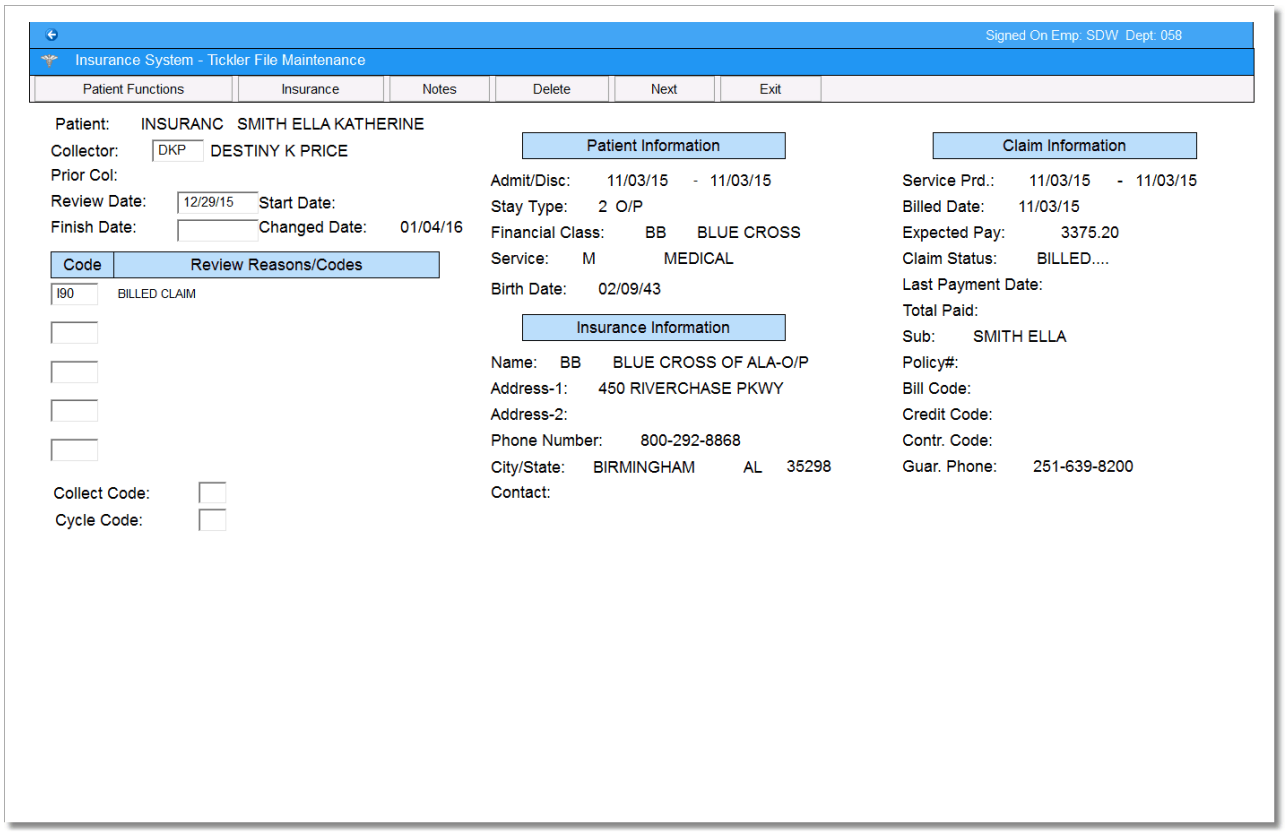
The following options are available on the action bar at the bottom of the screen:

- **PDF**: Display the information in the claim listing in a report format.
- **Filters**: Allows Filters to be created and added. Please see the additional documentation on Filters for more information.

Select **Back Arrow** to return to the previous screen.

Select the claim to access the Insurance Tickler File Maintenance screen and work the insurance claim.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler System > Multi Facility > Select Claim Group > Select Claim**



Multi Facility - Insurance Tickler File Maintenance

Please see the Insurance Tickler File Maintenance 157 section of this user guide for more information on this screen.

Select the **Back Arrow** or the **Next** button to return to the list of claims that need to be worked.

8.5 Collector Account Report - Report Writer

The Collector Account Report will provide a listing of claims that need to be reviewed in the Insurance Tickler File.

How to Print

1. Select **Report Dashboard** from the Application Drawer.

2. Select **Collector Account Report**.

3. Select a print option.

System prompts, "Facility:"

5. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

System prompts, "Collector Code:"

6. Enter in a Collector ID to print claims assigned to a specific Collector ID, or leave blank to include all Collector ID's.

System prompts, "Insurance:"

7. Enter in an Insurance Financial Class code to print claims for a specific insurance, or leave blank to include all Insurance Financial Classes.

System prompts, "Review Date Range:"

8. Enter in the desired review date range, the information is for. A date range is required in order to pull information to the report.

System prompts, "Status:"

9. Select one of the following tickler status'. A status is required in order to pull the information to the report:
Unfinished
Finished
All

System prompts, "Changed Status:"

10. Select one of the following options to see claims that have been assigned to different collectors. A Changed Status is required in order to pull the information to the report:
All
Changed Only

System prompts, "Change Date Range:"

11. Enter in a date range for claims that have a changed status.

System prompts, "Sections to Exclude:"

12. Select one or more of the following desired sections to exclude, or leave blank to print all:
Exclude Collector Totals
Exclude Grand Totals

System prompts, "Level of Detail:"

13. Use the drop-down box to select one of the following options:
Detail
Summary
Report Summary Only

System prompts, "Include Cover Sheet:"

14. Select this option to include a Cover Sheet with the report.

System prompts, "Output Format:"

15. Use the drop-down box to select one of the following report Format options:
HTML
PDF
XML
CSV

System prompts, "Run Report"

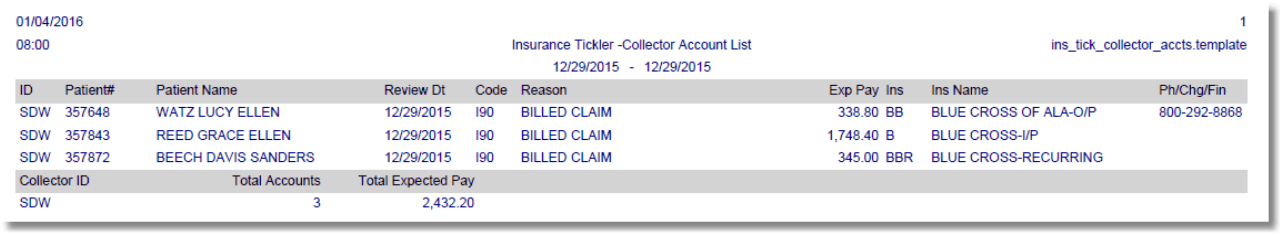
16. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Collector Account Report may be printed for specific collectors or for all collectors. The report will produce a recap page listing each Collector ID code and the number of accounts being worked. Patient Number, Name, Review Date, Review Reason and Expected Pay will be shown on this report.

The Report Writer application allows the user to filter, sort and manipulate this report to customize the data extracted out of the system. See the additional documentation on Report Writer for more information on these options.

Collector Account Report - Report Writer



01/04/2016 1
08:00 Insurance Tickler -Collector Account List ins_tick_collector_accts.template
12/29/2015 - 12/29/2015

ID	Patient#	Patient Name	Review Dt	Code	Reason	Exp Pay	Ins	Ins Name	Ph/Chg/Fin
SDW	357648	WATZ LUCY ELLEN	12/29/2015	I90	BILLED CLAIM	338.80	BB	BLUE CROSS OF ALA-O/P	800-292-8868
SDW	357843	REED GRACE ELLEN	12/29/2015	I90	BILLED CLAIM	1,748.40	B	BLUE CROSS-I/P	
SDW	357872	BEECH DAVIS SANDERS	12/29/2015	I90	BILLED CLAIM	345.00	BBR	BLUE CROSS-RECURRING	

Collector ID	Total Accounts	Total Expected Pay
SDW	3	2,432.20

Listed below is an explanation of each column.

- **ID:** Collector ID on the claim in the Insurance Tickler File.
- **Patient #:** Patient's account number pulls from Account field on the Registration and ADT screen.
- **Patient Name:** Patient's name pulls from the Full Name field on the Patient tab in the Registration and ADT screen.
- **Review Dt:** Review date pulls from the Insurance Tickler File.
- **Code:** Review code pulls from the Insurance Tickler File. The last code entered in the tickler will pull to the report.
- **Reason:** Description of the reason associated with the associated review code.
- **Expect Pay:** Expected pay amount pulls from the Detail Charges screen.
- **Ins:** Insurance Company Code pulls from the Policy Information screen.
- **Ins Name:** Insurance Company Name pulls from the Policy Information screen.
- **Phone/Change/Finish Date:** Depending on the options selected during the file build of this report, either the Insurance Company phone number (Policy Information Screen), the Changed Date (in the Insurance Tickler File), or the Finish Date (in the Insurance Tickler File) will pull to this column.
- **Totals:** Total amount of claims to be reviewed and the total expected pay for the date range selected.

8.6 Insurance Tickler Report

The Insurance Tickler Report will assist in the monitoring of accounts within the Insurance Tickler File.

How to Print

1. Select **Report Dashboard** from the Application Drawer.

2. Select **Insurance Tickler Report**

System prompts, "Facility:"

6. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

System prompts, "Collector ID:"

7. Enter in a Collector ID to print claims assigned to a specific Collector ID, or leave blank to include all Collector ID's.

System prompts, "Insurance Code:"

8. Enter the desired financial class. Use ***** to wildcard insurance companies or leave blank to print for all financial classes.

System prompts, "Review Date Range:"

9. Enter in the desired review date range.

NOTE: *If an account in the tickler has a finish date, it will still be included on this report until it is either deleted or purged from the tickler.*

System prompts, "Include Cover Sheet"

10.Select this option to include a Cover Sheet with the report.

System prompts, "Safe Mode:"

11. Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a **?**. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.

System prompts, “Output Format:"

12. Use the drop-down box to select one of the following report Format options:
    HTML
    PDF
    XML
    CSV
    MAPLIST

System prompts, “Run Report"

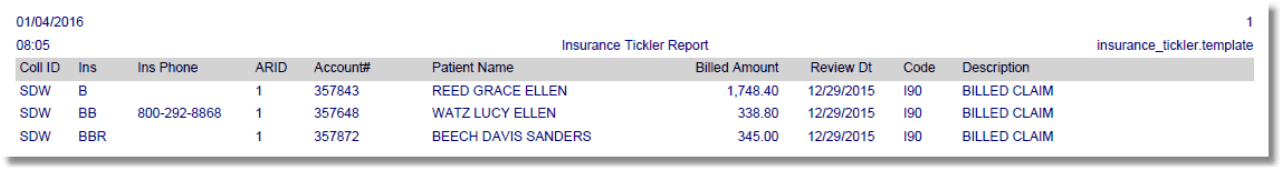
13. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Insurance Tickler Report will assist in the monitoring of accounts within the Insurance Tickler File.This report may be printed for specific collectors or for all collectors. It groups the claims first by collector ID and then by insurance code and phone number.

The Report Writer application allows the user to filter, sort and manipulate this report to customize the data extracted out of the system. See the additional documentation on Report Writer for more information on these options.

Insurance Tickler Report - Report Writer



01/04/2016 1
08:05 Insurance Tickler Report insurance_tickler.template

Coll ID	Ins	Ins Phone	ARID	Account#	Patient Name	Billed Amount	Review Dt	Code	Description
SDW	B		1	357843	REED GRACE ELLEN	1,748.40	12/29/2015	I90	BILLED CLAIM
SDW	BB	800-292-8868	1	357648	WATZ LUCY ELLEN	338.80	12/29/2015	I90	BILLED CLAIM
SDW	BBR		1	357872	BEECH DAVIS SANDERS	345.00	12/29/2015	I90	BILLED CLAIM

Listed below is an explanation of each column.

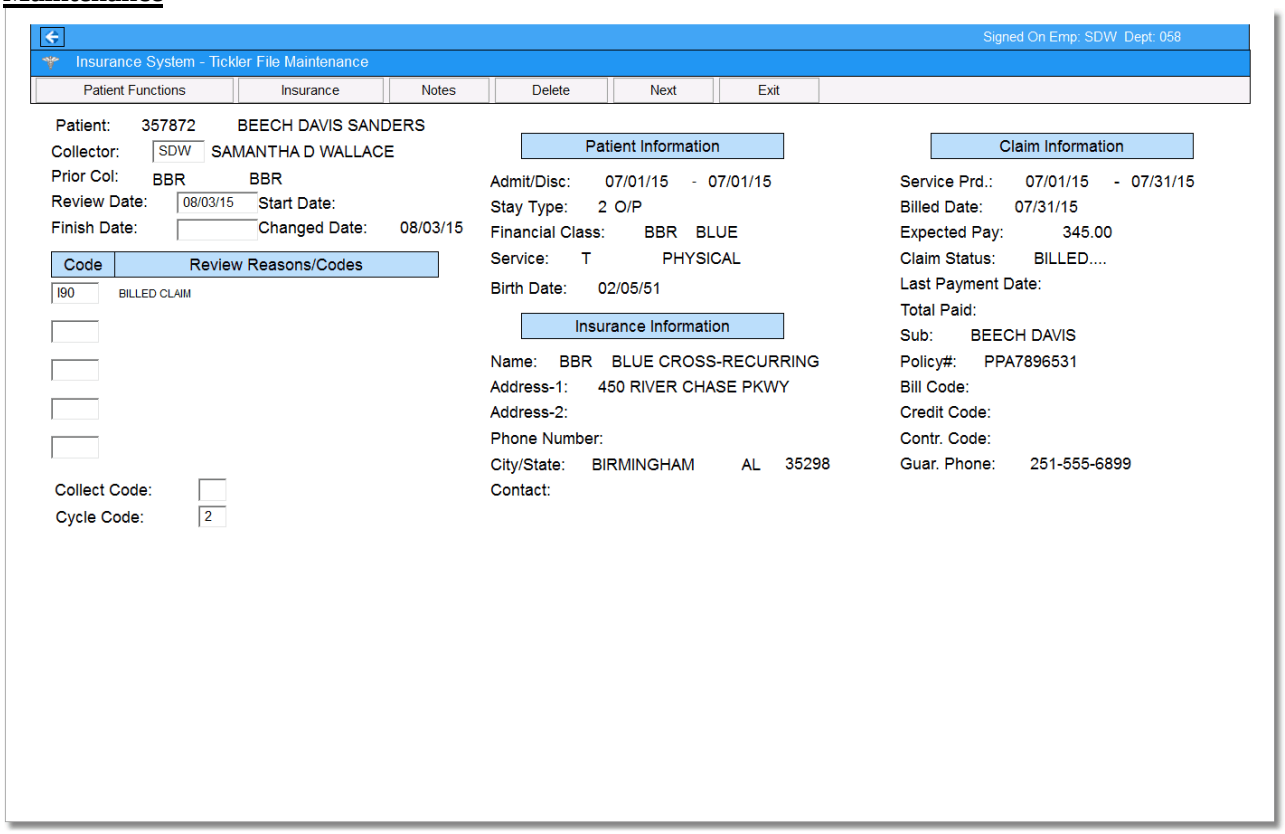
- **Coll ID:** Collector ID on the claim in the Insurance Tickler File
- **Ins**: Insurance company code pulls from the Policy Information screen
- **Ins Phone**: Insurance company phone number pulls from the Policy Information screen
- **ARID**: Pulls the id number of the facility the report is being run
- **Account#:** Patient’s account number pulls from Account field on the Registration and ADT screen
- **Patient Name:** Pulls from the Full Name field on the Patient tab in the Registration and ADT screen
- **Billed Amount**: Pulls from the Expected Pay field on the Detail Charges screen
- **Review Dt:** Review Date pulls from the Insurance Tickler File
- **Code:** Review code pulls from the Insurance Tickler File

- **Description:** Description of the reason associated with the associated review code

8.7 Insurance Tickler File Maintenance

The following is an example of the Insurance Tickler File Maintenance screen.

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Insurance Tickler File Maintenance**



Insurance System - Tickler File Maintenance

This screen may be accessed from the Patient Functions screen or the Insurance Claim Status screen by selecting Tickler System. If the claim is not already set up in the tickler, the system will place this claim into the file. It may also be accessed by selecting one of the options in the Tickler File Functions screen. This screen provides information pertaining to the patient's account and claim and displays the Admit and Discharge Dates, the Stay Type, the patient's primary Financial Class, the Service Code, etc. If this information is changed on the Registration and ADT screen, it will be reflected here. A description of the various options follows.

- **Collector:** This field lists the Collector ID that is assigned to the claim. The name associated with the ID code will display. The Collector ID may be changed by keying in a different Collector ID.
  - **Prior Col:** This field is not accessible. This field will display the last Insurance Collector assigned to this account if it has been changed.

- **Review Date:** This field will contain the date the account is scheduled for review. This date is used for the assigning of accounts worked, by day, for the Collector. This field will be completed by the system automatically when a claim is Billed and placed into the Tickler by the system. The Review Date is based on the number of days loaded in the Add Days to Review Date field on page 3 of the Insurance Company table.

  For example, if this field had 15 days loaded, and the UB was printed and updated to the Billed status on 11/1/13, the claim will be set up in the Insurance Tickler with a Review Date of 11/16/13. If this field is blank, the system will automatically assign a Review Date for the day after the claim's Billed date. If the review date is changed, the system will update the Chngd Date field with the current date.

- **Start Date:** This field will contain the date this claim was placed in the Tickler.

- **Finish Date:** This field is used by the Collector to signal to the system that all Collection efforts have been exhausted. It also signals the system that the account can be dropped from the Tickler File. Once a month, the system will automatically run a purge and delete all claims from the Tickler that have a Finish Date older than 31 days.

  If the Auto Update Finish Date field on page 3 of the Insurance Company table is set to **Y**, and the claim has a full payment posted against it, the system will place the receipt date in this field.

  If a Finish Date is manually entered in this field, the system will update the Changed Date field with the current date.

- **Changed Date:** This field will update automatically whenever the Review Date or Finish Date is changed. A report may be run based on the Change Date and can be used for collector productivity.

- **Review Reasons/Codes:** When entering Review/Reason Codes, a lookup help screen may be accessed by entering a **?** in this field. The system will automatically update the file entry with one of the listed codes. If a claim is manually entered into the tickler, a reason code must be entered or the system will list the claim as Invalid.

  I90 Claim Billed
  I91 Claim E/B
  I92 Claim Paid In Full
  I93 Claim Partial Payment
  I94 Claim Rejected
  I95 Claim Payment Other

  The above codes, as well as any user-defined codes, will need to be set up in the Review Codes table prior to using the Insurance Tickler System.

- **Collect Code:** The Collect Code pulls from the Guarantor/Ins tab on the Registration and ADT screen. Any change in this field will be automatically updated in the Registration and ADT screen.

- **Cycle Code:** The Cycle Code pulls from the Guarantor/Ins tab on the Registration and ADT screen. Any change in this field will be automatically updated in the Registration and ADT screen.

NOTE: *If the collect or cycle codes are manually changed on the Tickler File Maintenance screen, a note will be placed on the Account Detail. The note will include the AR date of the change, the initials of the employee who made the change, the time the change was made and the old and new collect or cycle codes.*

- **Patient Information:** The Patient's Admit/Discharge dates, Stay Type, Financial Class, Service Code and Birth Date will pull to this section.

- **Insurance Information:** The Insurance Tickler will pull information directly from the claim's Policy Information screen. This will include the Financial Class name, Address, Phone Number, City, State, Zip and Contact.

- **Claim Information:** This will pull the insurance claim's information.

- **Patient Functions:** Select this option to access the Patient Functions screen. Any option may be chosen from this screen. Select Insurance Tickler System to return to the Insurance Tickler.

- **Insurance:** Select this option to access the Insurance Claim Status screen on the insurance claim. From this screen, the Tickler File may be re-entered by selecting Tickler System.

- **Notes:** Select this option to display the Insurance Tickler Note Maintenance screen. Notes may be entered and will be retained within this screen unless the field labeled "Insurance Tickler Notes to Acct Detail" is set to Y in the AHIS table, page eight. If this field is set, the notes entered here will pull to the Account Detail.

- **Delete:** Select this option to manually delete the claim from the Insurance Tickler System. Once a month the system will automatically run a purge and delete all claims from the Tickler that have a Finish Date older than 31 days. Therefore, it is important to remember to enter a Finish Date when all collection efforts on that claim have been completed or exhausted. Refer to the System Security User Guide for more information on manually deleting a claim from the tickler.

- **Next:** Select this option to return to the Hospital Base Menu.

- **Exit:** Select this option to return to the Tickler File Functions screen.

In addition to using the Insurance Tickler, there are several reports that may be helpful in facilitating the research of insurance claims.

The Billed But Unpaid Claims report is an aging report for insurance claims. It is used to ensure that unpaid claims do not go unnoticed for an unlimited amount of time. It should be printed on a regular basis for research purposes, to determine if unpaid claims should be re-billed or rejected. It is an alpha listing by insurance company of all outstanding insurance claims. Also, it is helpful in monitoring the expected pay due from each insurance company.

The Billed but Unpaid & A/R Bal = 0 is used by the Business Office to reduce the number of claims with a zero balance on the Billed But Unpaid report. It should first be run as an edit to determine which accounts to reject and then as an update to actually reject those selected accounts. This report should be run on a weekly basis to keep the Billed but Unpaid report as clean as possible. The edit version is an alpha listing of accounts that have a claim at the Billed status with an A/R balance of zero. The update version displays the word “Rejected” to the right of the claim’s Expected Pay. The report lists the patient’s account number, patient’s name, insurance, whether the claim is primary or secondary, the Billed date and the Expected Pay amount.

The Insurance Billing Time Analysis should be printed and reviewed on a regular basis for the purpose of analyzing the turn-around-time between insurance submittal and payment. Also, it will greatly aid in the identification of problem areas and help in eliminating unnecessary delays in submission. It also provides the number of days between the Admission date and the date the approval was sent, the Approval Sent date and the Approval Received date, the Discharge date and date the claim was generated, the generation date and the date the claim was billed, the Billed date and the date payment was received, and the Discharge date and the Payment Received date.

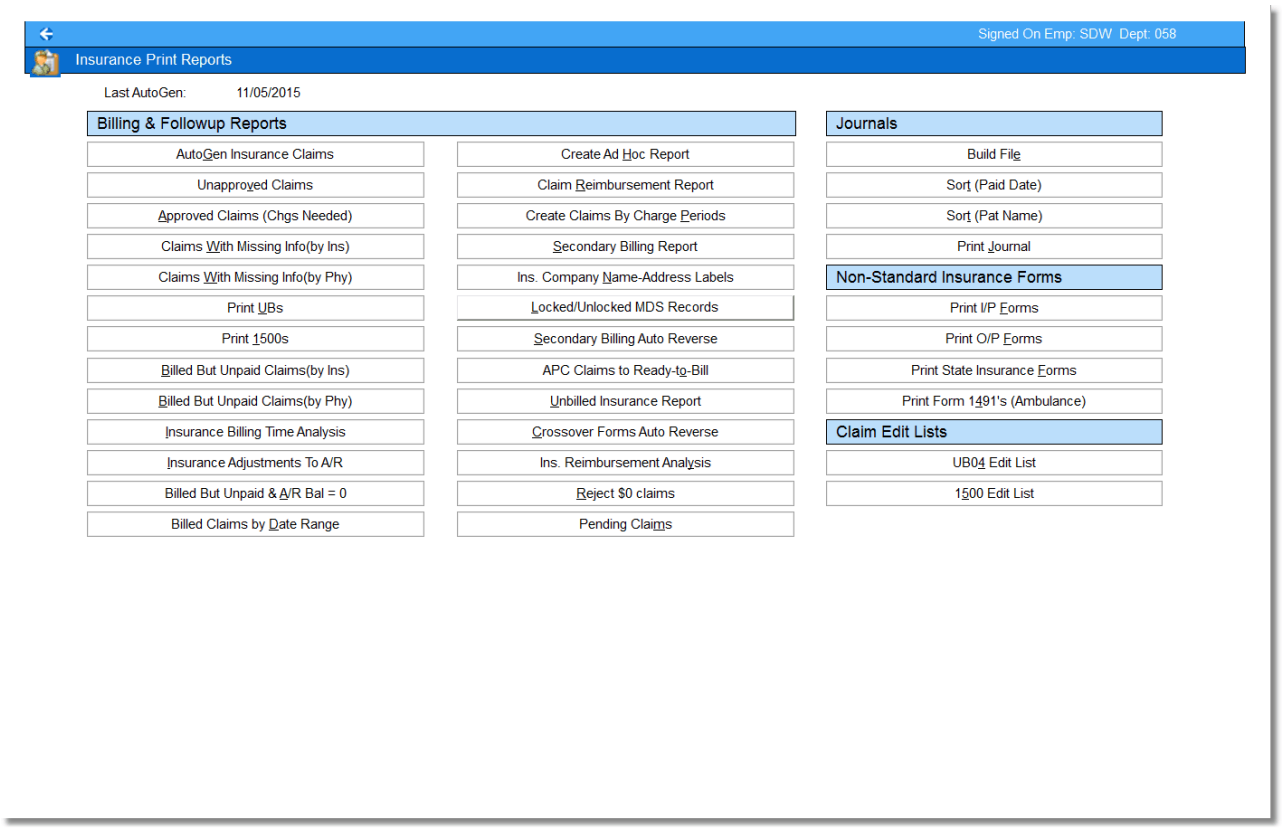
The Secondary Billing Report is used by the Business Office to list accounts that have a secondary claim, and the primary has been paid within the date range selected. It is a list of accounts that had a claim paid during the date range entered with another claim on the insurance screen. The report is a numeric listing of the secondary accounts, which page breaks by the primary Financial Class. The last page of the report gives recap by insurance company, with the total number of claims and the total billed amount for each. The Secondary billing Report may be printed and worked every time a remittance is entered and posted during receipting. Secondary Billing may also be automated. For further information, see Tables Affecting Insurance.

Chapter 9 Insurance Journals

9.1 Overview

Insurance Journals may be kept on any Financial Class desired. Journals are used to store information about specific Financial Class claims for audit and internal survey purposes. The options for building, sorting and printing journals are found in the Insurance Print Reports menu shown below.

Select **Web Client > System Menu > Hospital Base Menu > Print Reports > Insurance**



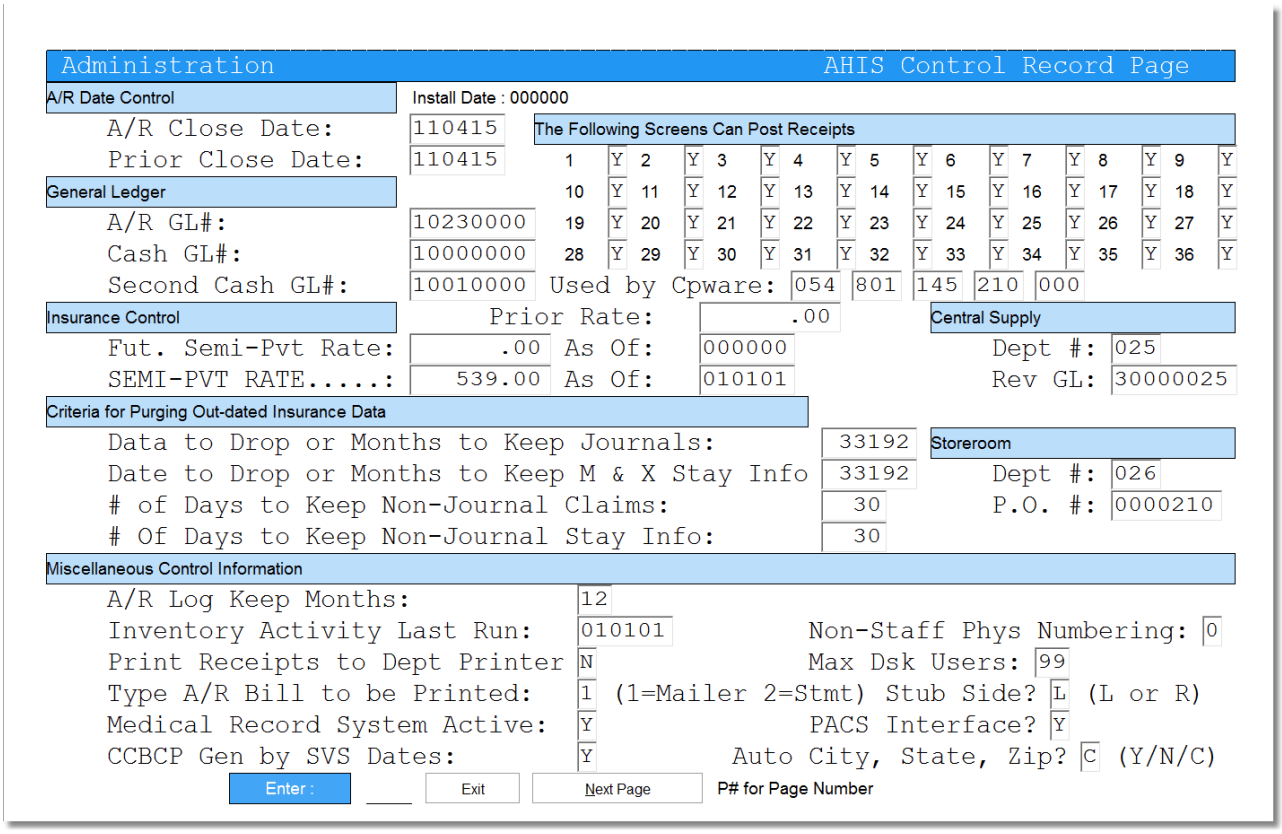
Insurance Print Reports

9.2 Table Maintenance Affecting Journals

Specific fields in the AHIS Control Record and the Insurance Company table must be set up in order for information from specific claims to be retained on the system in the Insurance Journal files. The purging criteria for insurance data is loaded in AHIS. The next few pages list descriptions of each field the system reads before purging information.

AHIS Control Record

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 1**



AHIS Control Record Page

- **Date to Drop or Months to Keep Journals:** The detail kept on the system for journaled insurances will eventually purge. A date or a number of months may be loaded in this field. If a date is loaded, the system will purge the journal data based on this date. Dates should be loaded in the MMDDYY format. Entering a number of months will allow the system to retain the journal information data for the requested number of months in this field. The system will only purge claims that have been paid or rejected through the receipting functions.

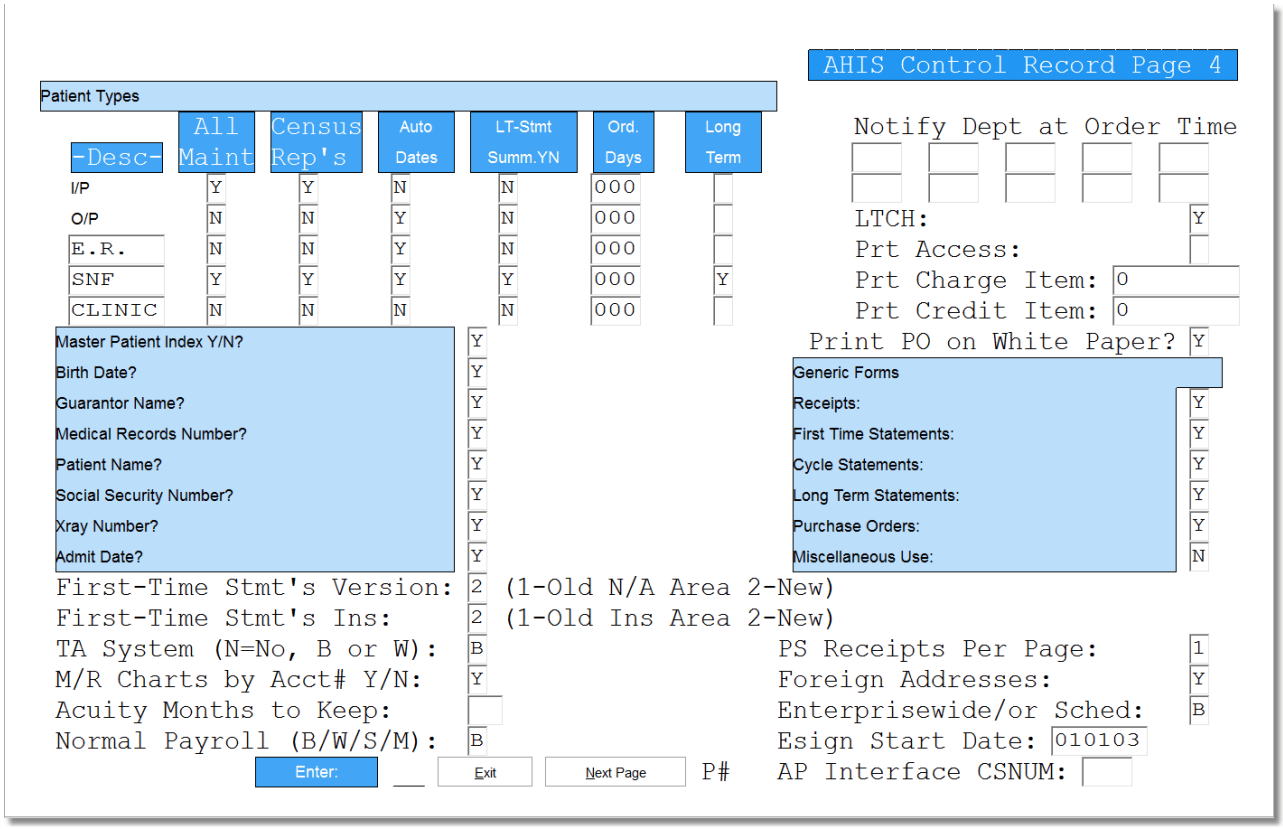
- **Date to Drop or Months to Keep M & X Stay Info:** The Stay Information detail kept on the system for journaled insurances will be purged. The system will allow a date or a number of months based on claims' service dates to purge this data. Dates should be loaded in the MMDDYY format. Entering a number of months will allow the system to retain Stay Information data for the requested number of months in this field.

- **# Of Days To Keep Non-Journal Claims:** The number of days the system will retain non-journal claim information should be loaded in this field. Only claims that have been paid or rejected will qualify for purging.

- **# Of Days To Keep Non-Journal Stay Info:** The number of days the system will retain non-journaled insurance Stay Information data should be loaded in this field. This is based on the service date of the insurance claim.

NOTE: *The insurance purge is a weekly function. The purge program will read these fields to determine when detail information and stay information data on insurance claims should be purged.*

Select **Web Client > System Menu > Hospital Base Menu > Master Selection > Business Office Tables > Business Office Tables Maintenance > AHIS > Page 4**



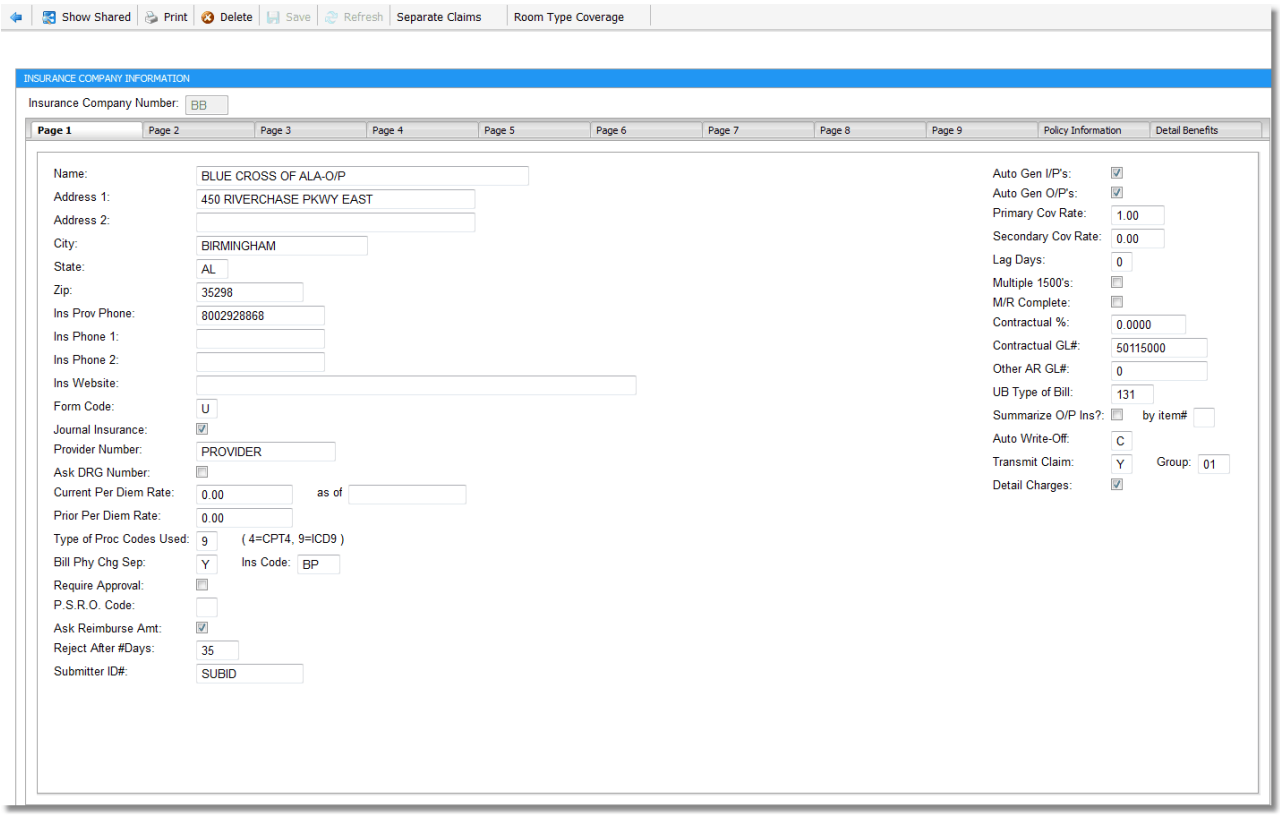
AHIS Control Record, Page 4

- **Patient Types:** When building and printing journal files, the system will look to the Long Term column for each Stay Type to determine if the file should include information for long term patient accounts. If this column is answered **Y** for a specific stay type, the system will allow accounts with no discharge date to pull to journals that are built for incurred claims.

Insurance Company table

The Insurance Company table stores the fields the system reads to denote which Financial Classes should retain journal information and the information that is kept. Below is a list of these fields.

Select **Web Client** > **Tables** > **Business Office** > **Companies**



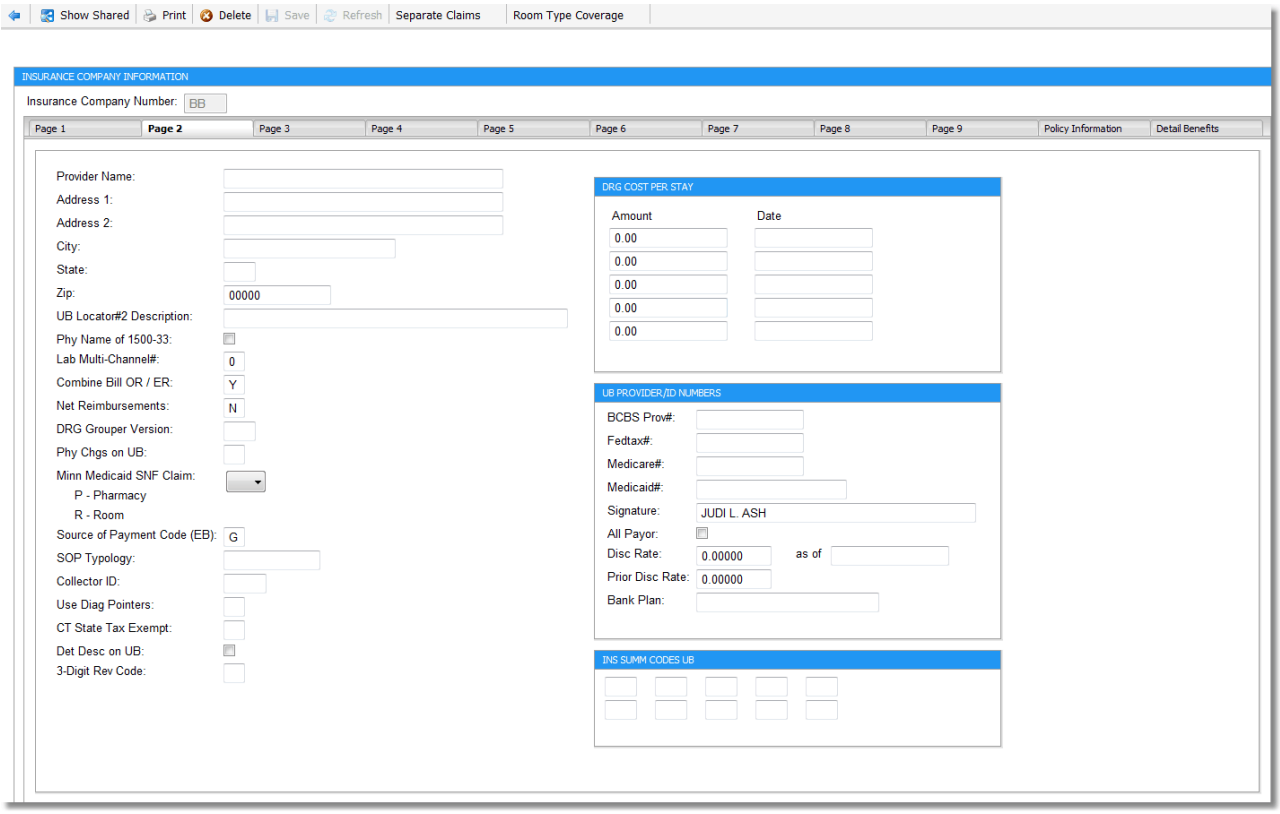
Insurance Company Record Maint., Page 1

- **Journal Insurance:** This field should be answered **Y**, **N** or **C**. If journals are kept for this Financial Class, this field should be answered with a **Y**. If no journal information is required for this Financial Class, this field should be answered with an **N**. If this Financial Class does not require journal information to be kept, this field could be answered with a **C**. Loading a **C** will give the ability to enter a Deductible and Co-pay during the receipting process for an insurance with no contractual adjustment.

- **Ask DRG Number:** This field affects the receipting of insurance claims. If this Financial Class does not require a DRG to be entered and stored in journals, this field should be answered **N**. Answering **Y** will allow a DRG to be entered at the time the claim is receipted, and the information will be stored in the insurance journal for this Financial Class code. The DRG will only need to be entered for primary claims if a **P** is entered.

- **Current Per Diem Rate:** The current Per Diem rate should be used for Financial Classes that use a Per Diem for reimbursement rather than a DRG. If a Per Diem rate is loaded when journals are printed, the reimbursement will be computed using this rate. Otherwise, the system will calculate a reimbursement based off the rate computed on the DRG Grouper screen.

Select **Web Client** > **Tables** > **Business Office** > **Companies** > **Page 2**



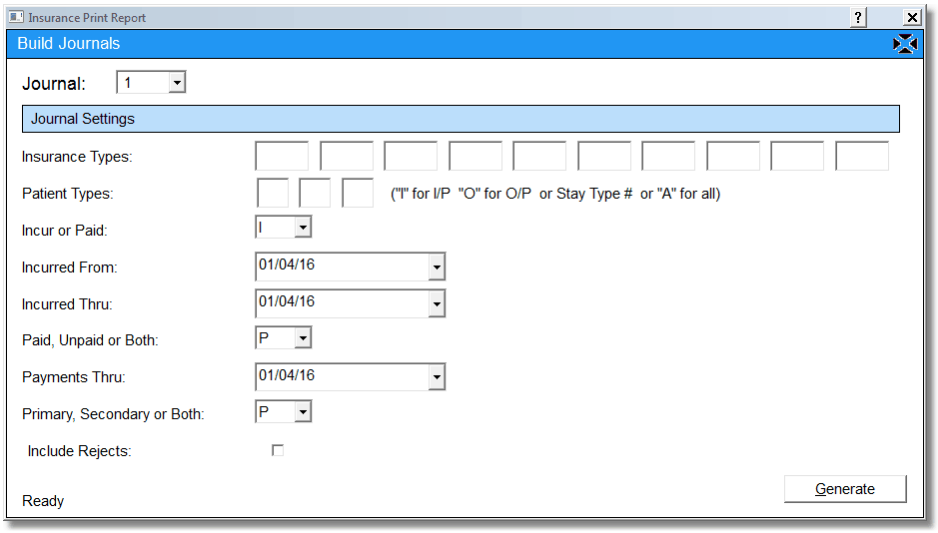
Insurance Company Maint., Page 2

- **Net Reimbursements:** The Net Reimbursement field will default to **Y** and will add multiple receipts made to the same claim. When the receipt amount is displayed on the Insurance Claim Status screen, the total amount of the reimbursements made to this claim will be added together. To display only the amount of the last payment reimbursement, answer this field **N**. The information that is displayed on the Insurance Claim Status screen is the data that is stored in the journal files for this Financial Class.

9.3 Building And Sorting Journals

The system will allow up to 10 journals to be built at one time. The ability to wildcard journals is permitted using **. To build a journal, choose **Build File** from the Journals section of the Insurance Reports menu. Specific information must be answered about the journal that is desired. Below is a list of the fields that must be answered when building a journal.

Select **Web Client > System Menu > Hospital Base Menu > Print Reports > Insurance > Build File**



Insurance Print Report

- **Journal:** Select a number to assign the journal being created.
- **Insurance Types:** This allows specific Financial Class codes to be entered that will pull to the printed report. Wildcarding is allowed in this field. If wildcarding is not used, up to 10 financial classes may be entered which will comprise one journal.
- **Patient Types:** The Patient Type must be entered. The system will pull information about specific claims based on one of the following: Enter an **I** for Inpatients (Stay Type 1), **O** for Outpatients (Stay Types 2-5), the number (1-5) for Specific Stay Types or **A** for All Stay Types.
- **Incurred or Paid:** This will allow the journal to be printed for claims with service dates that fall in the date range of the from and thru dates specified by entering an **I** for incurred. To pull claims that were paid during the chosen date range, a **P** should be entered. Generally, journals that are built to balance to remittances use the paid option.
- **Paid From - Paid Thru:** The time frame of the period of claims that will print in the journal must be entered in this field. If the Incur or Paid option has Incurred claims, this journal will pull information about claims using the Service From and Service To dates on the claim to determine if it should fall into this journal. If the Service From date on the claim falls into the date range chosen for the file build of incurred claims, this claim will drop into the file. This is true for all Financial Classes except Medicare. When building an incurred Medicare journal, the system will look at the Service To date of the claim. This is the date that must be in the chosen file date range to allow Medicare claims to drop into the journal file build. Answering column 3 to pull paid claims will allow the system to pull claims that were receipted as paid during the date range of the journal file build.
- **Paid, Unpaid or Both:** Incurred journals may be built for claims that are paid, unpaid or both. The system will allow this field to be answered with a **P**, **U** or **B** when building a file for an incurred journal. When building a journal file for paid claims, the system will bypass this column assuming this file is for paid claims only.

- **Payments Thru:** The date that is entered will capture the information pulling to the journal as of this day. This field may be entered for incurred journals. The system assumes the Payment Thru date is the same as the Thru date entered in the fourth column for a paid claim's journal.

- **Primary, Secondary or Both:** This prompt will allow the file build to pull primary claims only by choosing option **P**. To pull only non-primary claims a **S** should be chosen. To build a file for claims regardless of the claim being primary or secondary **B** should be entered. Once the field is answered the code entered will pull next to the sequence number of the journal being built.

- **Include Rejects Y/N?:** If the journal should include rejected claims, this prompt should be selected.

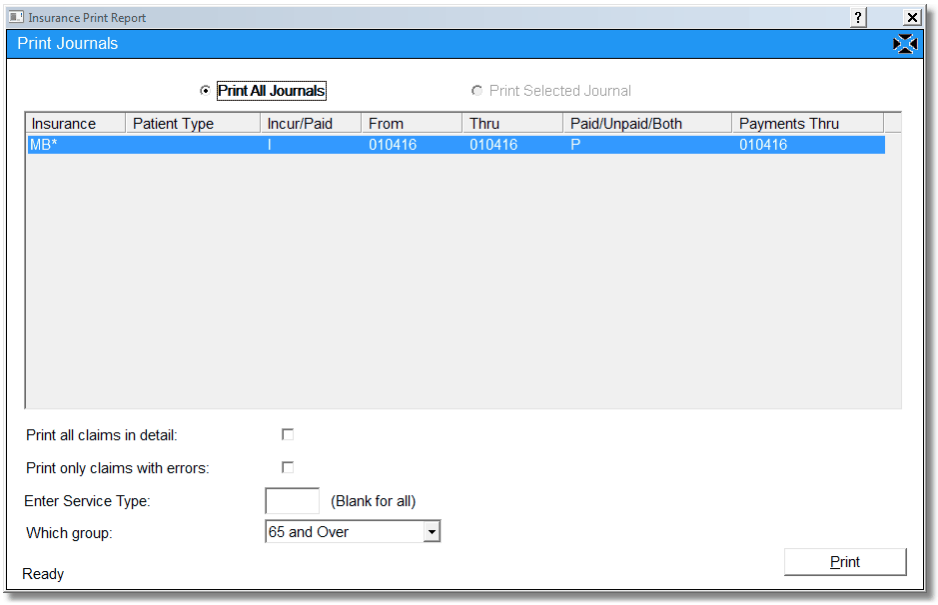
- **Generate:** After answering all the prompts, select this option to build the journal.

There are three options for sorting claims. The first is option **Paid Date** from the Insurance Reports menu. This option allows the journal that was just built to be sorted by the paid date. The other sorting option is **Patient Name** from the Insurance Reports menu. This will sort the journal by the patient's name. If neither of these options is chosen, the system will sort the journal by the patient's account number. The file build for a journal will remain on the system until another file is built for a journal.

9.4 Printing Journals

To print a specific journal or all journals that were built, choose **Print Journal** from the Insurance Reports menu. After choosing this option, the prompt "Did You Sort by Paid Date?" will be displayed. If the journal file was not sorted by paid date select **No**. If the journal file that was built was sorted by the paid date select **Yes**. This will display the prompt "Enter Fiscal Year Begin Date". The screen will now display the journals that were built. Below is an example of this screen.

Select **Web Client > System Menu > Hospital Base Menu > Print Reports > Insurance > Print Journal**

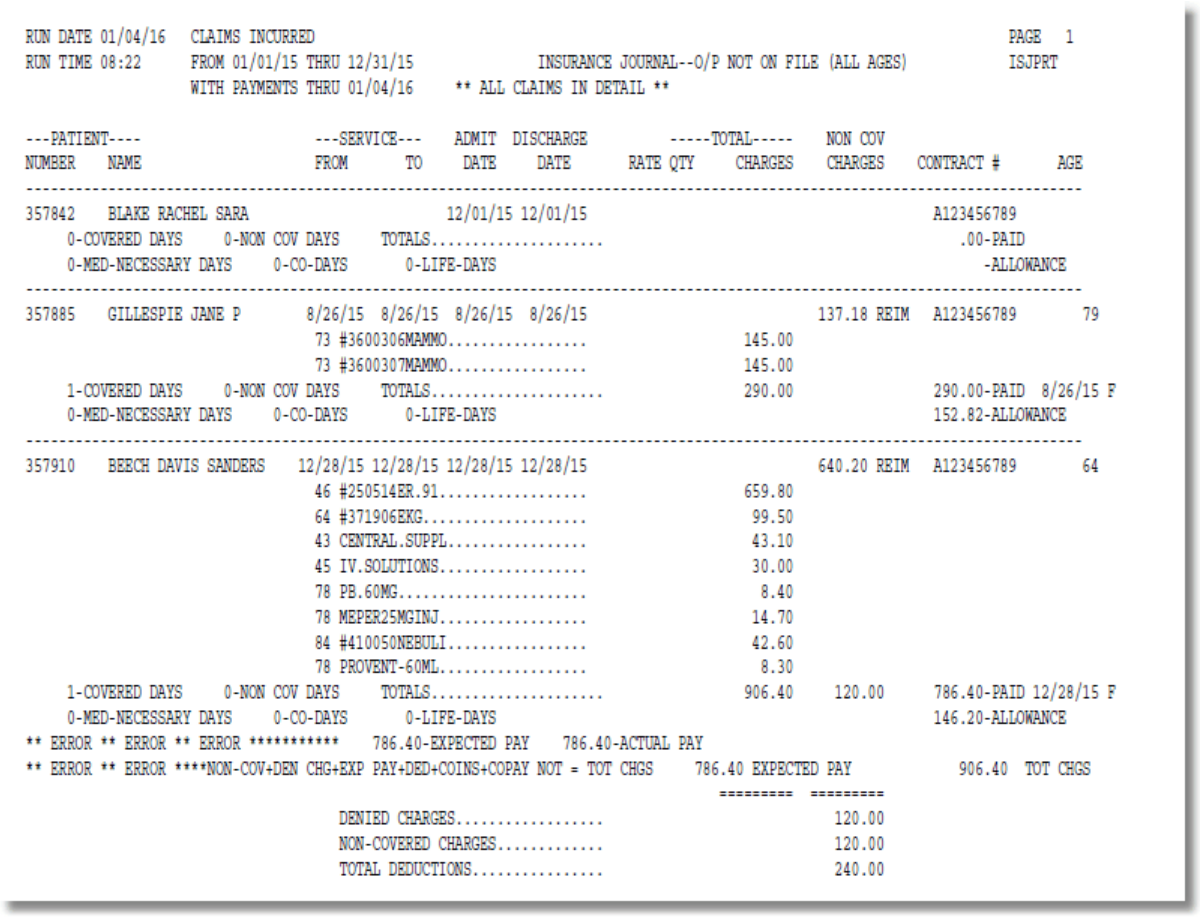


Insurance Print Report

Several prompts are given after the journals are listed. These questions must be answered to direct the system on printing the journal.

- **Print All Journals:** Select this prompt to print all journals currently built.
- **Print Selected Journal:** Select this option to only print a portion of the journals currently built. Select the desired journals highlighting the ones to be printed.
- **Print All Claims In Detail?:** Select this option to print journal(s) by account number.
- **Print Only Claims With Errors?:** Select this option to print only the journals with errors.
- **Enter Service Type: (Blank for all)** If a journal is to print for a specific Service Type, enter the service code. Claims with the selected service code from the Registration and ADT screen screen under the Patient tab will print. If this field is blank, all the claims will print to the journal regardless of the service code.
- **Which Group?: Select 65 & Over, Under 65 or Both:** Journal files built for Medicare claims will receive this prompt. These journals may be printed for specific age groups.

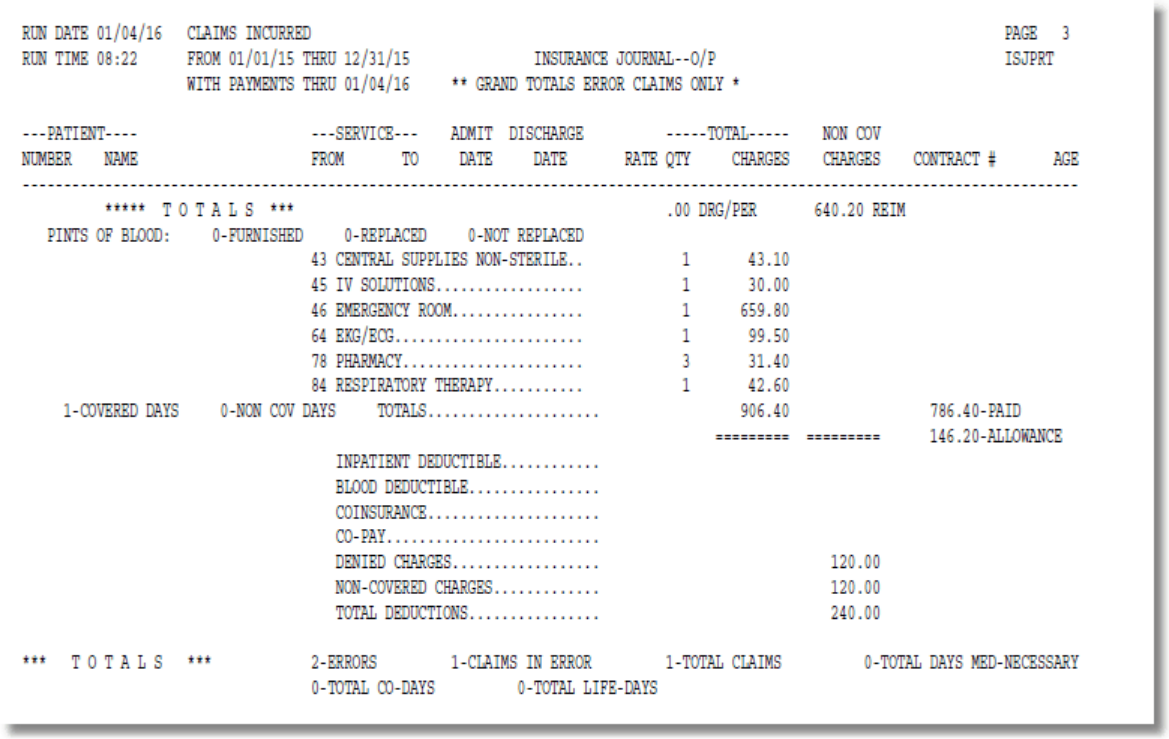
9.5 Insurance Journals



```
RUN DATE 01/04/16   CLAIMS INCURRED                                                                    PAGE   1
RUN TIME 08:22      FROM 01/01/15 THRU 12/31/15          INSURANCE JOURNAL--O/P NOT ON FILE (ALL AGES)  ISJPRT
                    WITH PAYMENTS THRU 01/04/16    ** ALL CLAIMS IN DETAIL **

---PATIENT----                    ---SERVICE---   ADMIT  DISCHARGE        -----TOTAL-----   NON COV
NUMBER    NAME                    FROM      TO    DATE     DATE      RATE QTY    CHARGES   CHARGES   CONTRACT #      AGE
-------------------------------------------------------------------------------------------------------------------------
357842    BLAKE RACHEL SARA                     12/01/15 12/01/15                                      A123456789
     0-COVERED DAYS     0-NON COV DAYS     TOTALS.....                                                  .00-PAID
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                -ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------
357885    GILLESPIE JANE P        8/26/15  8/26/15  8/26/15  8/26/15                    137.18 REIM   A123456789       79
                                  73 #3600306MAMMO.....                 145.00
                                  73 #3600307MAMMO.....                 145.00
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....                 290.00                      290.00-PAID  8/26/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                           152.82-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------
357910    BEECH DAVIS SANDERS    12/28/15 12/28/15 12/28/15 12/28/15                    640.20 REIM   A123456789       64
                                  46 #250514ER.91.....                  659.80
                                  64 #371906EKG.....                     99.50
                                  43 CENTRAL.SUPPL.....                  43.10
                                  45 IV.SOLUTIONS.....                   30.00
                                  78 PB.60MG.....                         8.40
                                  78 MEPER25MGINJ.....                   14.70
                                  84 #410050NEBULI.....                  42.60
                                  78 PROVENT-60ML.....                    8.30
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....                 906.40     120.00      786.40-PAID 12/28/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                           146.20-ALLOWANCE
** ERROR ** ERROR ** ERROR **********    786.40-EXPECTED PAY    786.40-ACTUAL PAY
** ERROR ** ERROR ****NON-COV+DEN CHG+EXP PAY+DED+COINS+COPAY NOT = TOT CHGS     786.40 EXPECTED PAY           906.40  TOT CHGS
                                                                                 =========  =========
                                     DENIED CHARGES.....                            120.00
                                     NON-COVERED CHARGES.....                       120.00
                                     TOTAL DEDUCTIONS.....                          240.00
```

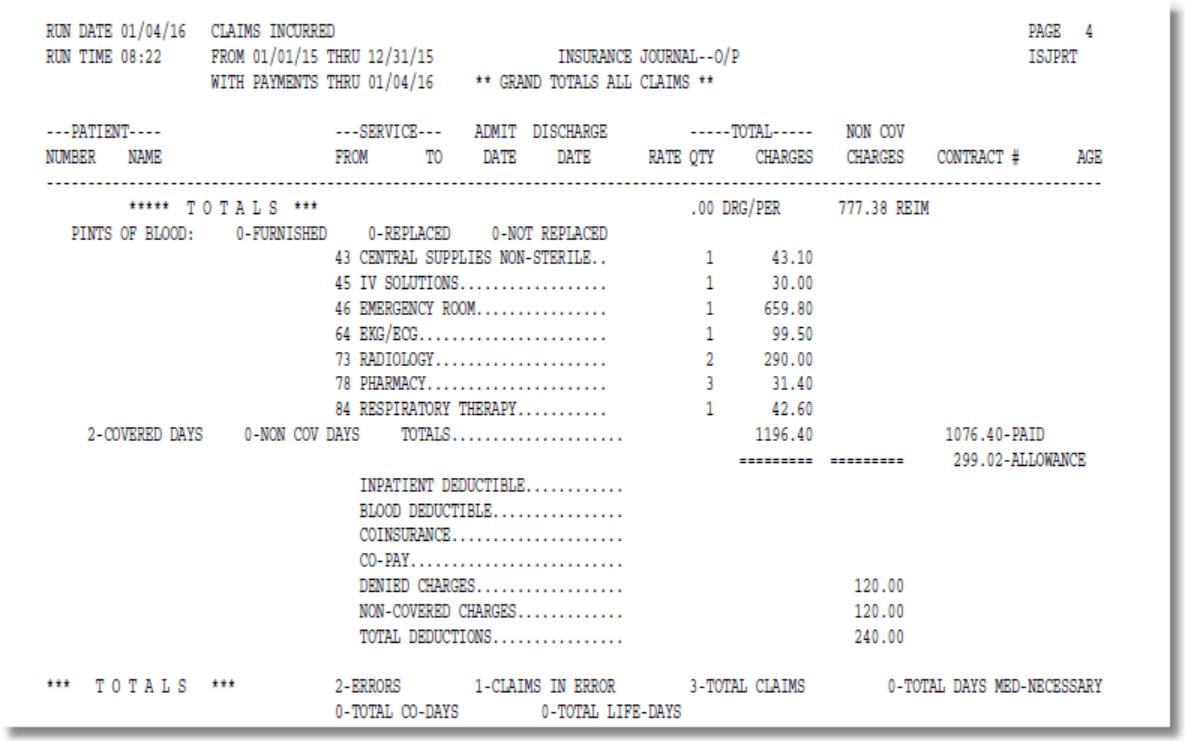
Insurance Journals (Totals)



```
RUN DATE 01/04/16   CLAIMS INCURRED                                                                    PAGE   3
RUN TIME 08:22      FROM 01/01/15 THRU 12/31/15          INSURANCE JOURNAL--O/P                        ISJPRT
                    WITH PAYMENTS THRU 01/04/16    ** GRAND TOTALS ERROR CLAIMS ONLY *

---PATIENT----                  ---SERVICE---   ADMIT  DISCHARGE        -----TOTAL-----   NON COV
NUMBER    NAME                  FROM      TO    DATE     DATE      RATE QTY    CHARGES    CHARGES    CONTRACT #      AGE
-------------------------------------------------------------------------------------------------------------------------
        *****  T O T A L S  ***                                        .00 DRG/PER      640.20 REIM
  PINTS OF BLOOD:     0-FURNISHED     0-REPLACED     0-NOT REPLACED
                           43 CENTRAL SUPPLIES NON-STERILE..          1      43.10
                           45 IV SOLUTIONS.................           1      30.00
                           46 EMERGENCY ROOM...............           1     659.80
                           64 EKG/ECG......................           1      99.50
                           78 PHARMACY.....................           3      31.40
                           84 RESPIRATORY THERAPY..........           1      42.60
    1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................        906.40              786.40-PAID
                                                                        =========  =========     146.20-ALLOWANCE
                                INPATIENT DEDUCTIBLE.....
                                BLOOD DEDUCTIBLE.........
                                COINSURANCE..............
                                CO-PAY...................
                                DENIED CHARGES...........                          120.00
                                NON-COVERED CHARGES......                          120.00
                                TOTAL DEDUCTIONS.........                          240.00

***   T O T A L S   ***         2-ERRORS        1-CLAIMS IN ERROR        1-TOTAL CLAIMS         0-TOTAL DAYS MED-NECESSARY
                                0-TOTAL CO-DAYS         0-TOTAL LIFE-DAYS
```



```
RUN DATE 01/04/16   CLAIMS INCURRED                                                                    PAGE   4
RUN TIME 08:22      FROM 01/01/15 THRU 12/31/15          INSURANCE JOURNAL--O/P                        ISJPRT
                    WITH PAYMENTS THRU 01/04/16    ** GRAND TOTALS ALL CLAIMS **

---PATIENT----                  ---SERVICE---   ADMIT  DISCHARGE        -----TOTAL-----   NON COV
NUMBER    NAME                  FROM      TO    DATE     DATE      RATE QTY    CHARGES    CHARGES    CONTRACT #      AGE
-------------------------------------------------------------------------------------------------------------------------
        *****  T O T A L S  ***                                        .00 DRG/PER      777.38 REIM
  PINTS OF BLOOD:     0-FURNISHED     0-REPLACED     0-NOT REPLACED
                           43 CENTRAL SUPPLIES NON-STERILE..          1      43.10
                           45 IV SOLUTIONS.................           1      30.00
                           46 EMERGENCY ROOM...............           1     659.80
                           64 EKG/ECG......................           1      99.50
                           73 RADIOLOGY....................           2     290.00
                           78 PHARMACY.....................           3      31.40
                           84 RESPIRATORY THERAPY..........           1      42.60
    2-COVERED DAYS     0-NON COV DAYS     TOTALS.....................       1196.40             1076.40-PAID
                                                                        =========  =========     299.02-ALLOWANCE
                                INPATIENT DEDUCTIBLE.....
                                BLOOD DEDUCTIBLE.........
                                COINSURANCE..............
                                CO-PAY...................
                                DENIED CHARGES...........                          120.00
                                NON-COVERED CHARGES......                          120.00
                                TOTAL DEDUCTIONS.........                          240.00

***   T O T A L S   ***         2-ERRORS        1-CLAIMS IN ERROR        3-TOTAL CLAIMS         0-TOTAL DAYS MED-NECESSARY
                                0-TOTAL CO-DAYS         0-TOTAL LIFE-DAYS
```

Listed below is an explanation of each column.

- **Patient Number/Name:** Patient account number and name from the Patient tab on the Registration and ADT screen.
- **Service From/To:** Specifies the start and stop date the claim was generated, from the insurance Claim Status screen.
- **Admit/Discharge Date:** Patient admit and discharge date from the Stay tab on the Registration and ADT screen.
- **Total Rate/Qty/Charges:** Rate, Quantity and Total of charged item from Detail Charges screen.
- **Non Cov Charges:** Charges not covered by insurance from the Detail Charges screen.
- **Contract #:** Insurance contract number from Policy Information.
- **Age:** Patient's age from the Patient tab on the Registration and ADT screen.
- **Per Diem/DRG:** This column will either pull the per diem rate loaded on page 1 of the Insurance Company table or the DRG and reimbursement calculated in the Medical Records Grouper screen on the account.

***NOTE**: If an ICD-10 DRG is present on the account, TruBridge EHR will use the ICD-10 DRG and reimbursement information. If an ICD-10 DRG is not present on the account, TruBridge EHR will use the ICD-9 DRG and reimbursement from the Medical Records Grouper screen.*

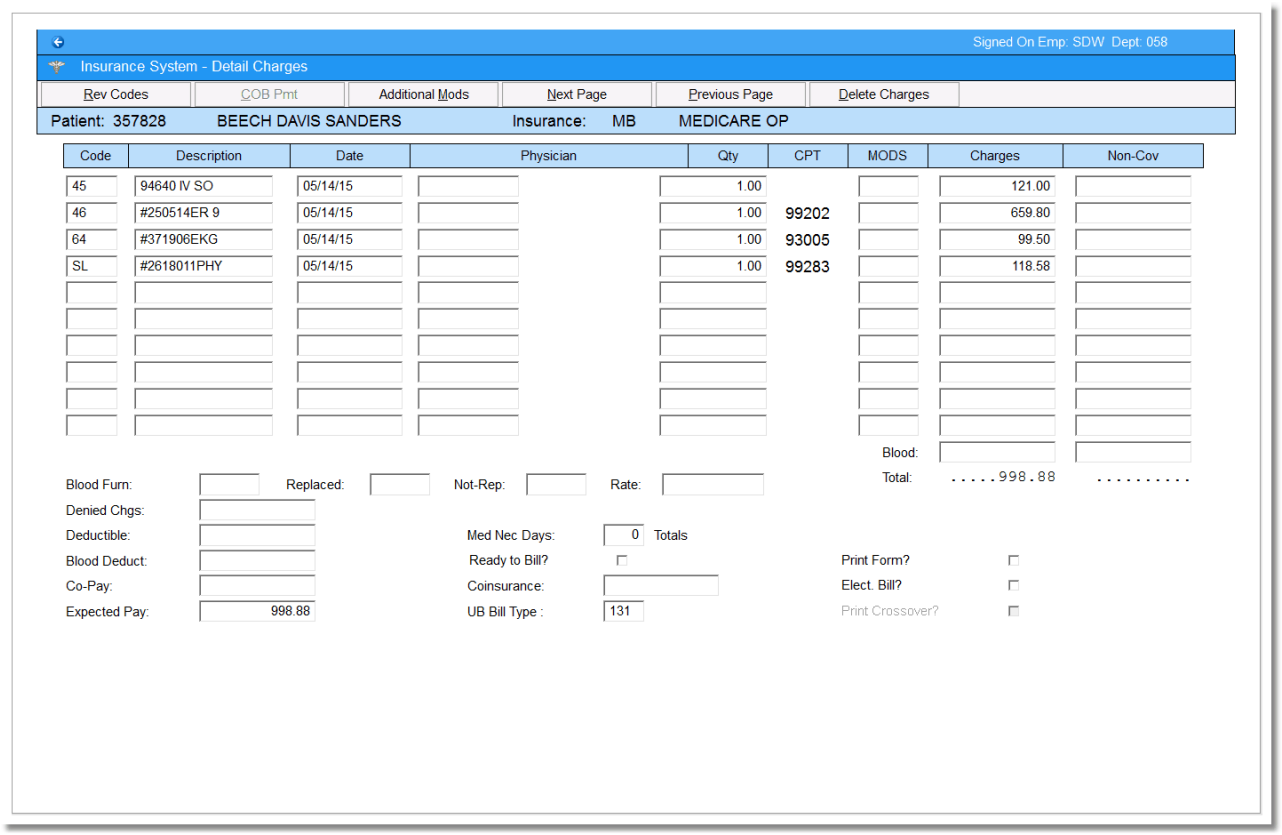
- **Reim (Reimbursement):** The reimbursement amount entered during receipting.
- **Summary Code:** Charge item summary code from the Detail Charges screen.
- **Paid/Allowance:** The amount that has been receipted to this claim and the total charges less the DRG reimbursement. The Allowance is the contractual amount.
- **Errors:** The total amount of errors on all claims.
- **Claims in Error:** The total number of claims found with errors.

9.6 Correcting Journal Errors

Claims in the journal program may appear with an error message when the number of room charges on a claim and the number of days stayed do not match. The print program will also look at the expected pay amount on the claim. If this amount does not equal the actual payment, the system will consider this an error.

To correct errors on a claim, the Detail Charges screen must be adjusted.

Select **Web Client > System Menu > Hospital Base Menu > Patient Account # > Insurance > Claim > Detail Charges**



Insurance System - Detail Charges

The receipting functions update claims with the deductible, denied charges and co-pay dollar amounts from the remittance the insurance company sends with the claims payment. The dollar amounts will be displayed on the journal. If the deductible, denied charges or the co-pay was not entered during receipting, the journals will reflect this error. The correction must be made on the Detail Charges screen. Once the correct amounts are entered into these fields, the expected payment will be adjusted.

Claims with a different number of room charges than the length of stay will display an error message. This is to indicate that there was an error at the time the claim was billed. Before printing an insurance form an edit is run. This edit will list the room charge error and it should be corrected before the claim is billed. If it is not corrected at the time the claim is billed, it should not be adjusted for printing journals.

Chapter 10 Printed Reports

10.1 Overview

The TruBridge EHR Printed Reports system will provide information concerning Insurance activity. It is important to understand each of the following reports and how to print them. This section contains examples and explanations for all Printed Reports.

10.2 AutoGen Insurance Claims

The AutoGen Insurance Claims is used by the Business Office to move Non-APC Outpatient claims from the Approved status to the Ready to Bill status and APC Outpatient claims from Approved status to the Unchecked status.

NOTE: *The APC claims will advance to the Unchecked status depending on how the Auto Gen Ready-to-Bill field on page 4 of the Insurance Company table is set.*

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **AutoGen Insurance Claims**.

   System prompts, "Are You Sure You Want To Auto Gen Insurance Claims?"

4. If the above information is correct, select **Yes** to continue. Select **No** to exit without AutoGenning.

Description and Usage

The AutoGen Insurance Claims option moves Non-APC Outpatient claims from the Approved status to the Ready to Bill status automatically. The Insurance Company table directly affects this option, and the following fields should be manipulated:

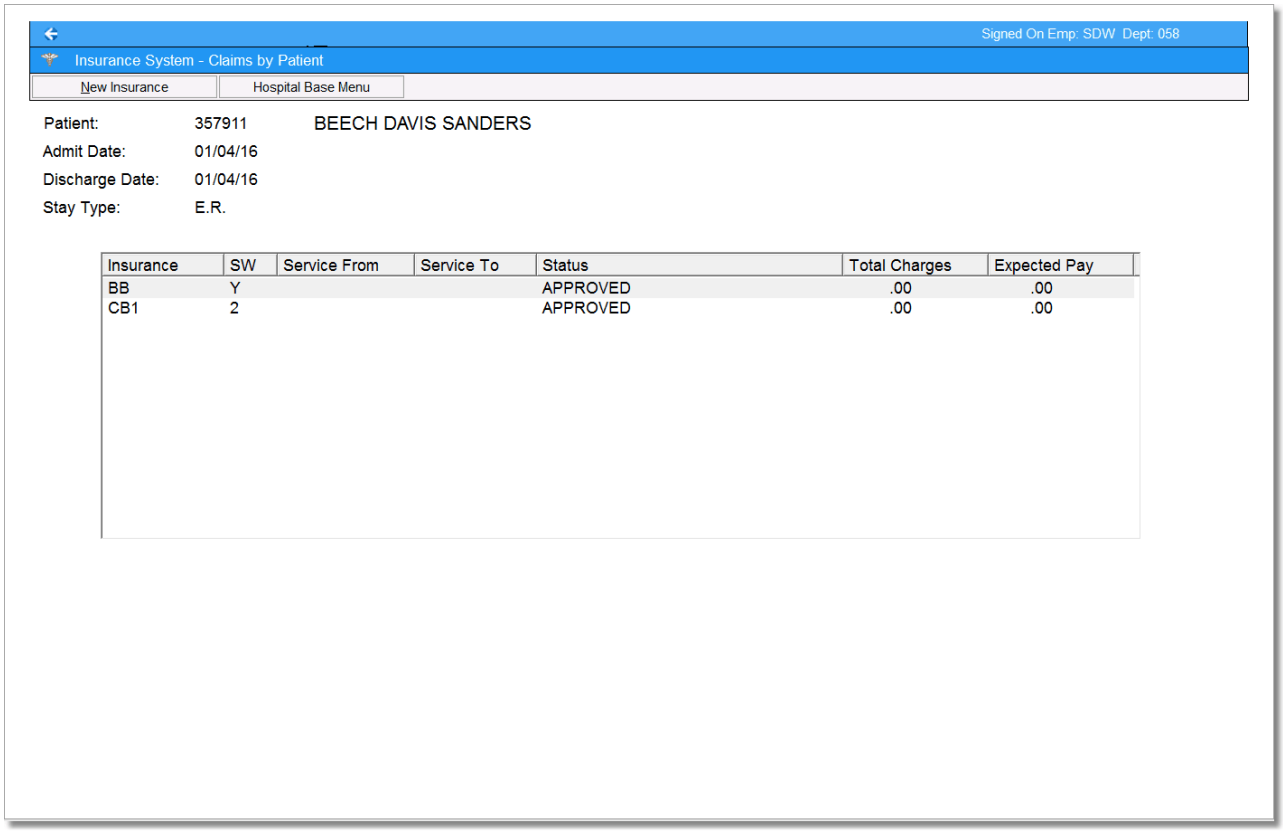
Auto Gen I/P's: **Y** (Y OR N)
Auto Gen O/P's: **Y** (Y OR N)
Lag Day:
M/R Complete: **Y** (Y OR N)
Summarize O/P Ins? By Item #:

When the AutoGen option is selected, the system will determine if the above criteria are met, based on these fields. For a claim to be automatically generated, at least three days must have been closed since the Discharge Date (Lag Days). Also, if M/R Complete? is set to **Y**, then there must be a date in the Finished Date of the Medical Records Grouper screen for the claim to generate. This indicates that the Medical Records department has completed coding.

The AutoGen feature will also summarize or detail the charges, depending upon the setting of the Summarize O/P Ins field. On the following page is an example of a claim at the Approved status, which is automatically set up at the time of registration. A claim that has been automatically generated and moved to the Ready to Bill status is also displayed.

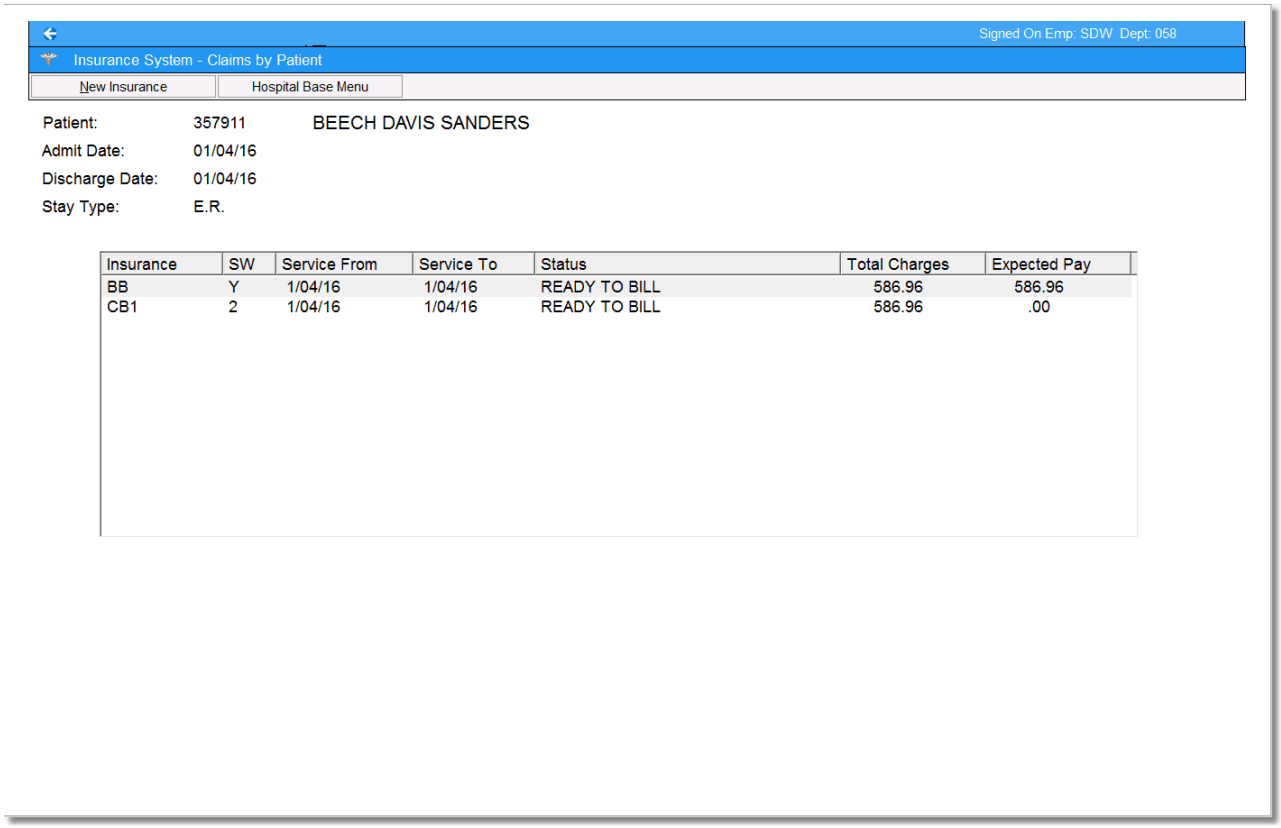
NOTE: *The date the Autogen was last run will display at the top of the Insurance Print Reports screen (Print Reports > Insurance).*

Below is an example of a claim created at the Approved status at the time of registration.



Insurance System - Claims By Patient

Choose AutoGen Insurance Claims and claims that meet certain criteria will move from the Approved to the Ready to Bill status.



Insurance System - Claims By Patient

Notice that Physician claims will also generate if there are charges present with physician components.

10.3 Unapproved Claims

The Unapproved Claims report lists all claims at the Unapproved status. All claims should be worked to move them to the Approved status.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Unapproved Claims**.
4. Select a print option.

   System prompts, “Sort By:”

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**d**	Serv Cd-Ins-Alpha
b	Alpha-Ins-Serv Cd	**e**	Ins-Alpha-ServCd
c	Serv Cd-Alpha-Ins	**f**	Ins-Serv Cd-Alpha

   System prompts, “Service Codes or All:"

6. Enter up to 10 desired Service Codes or select **ALL** to pull all Service Codes.

   System prompts, “Print:"

7. Select **Print** to begin the printing process.

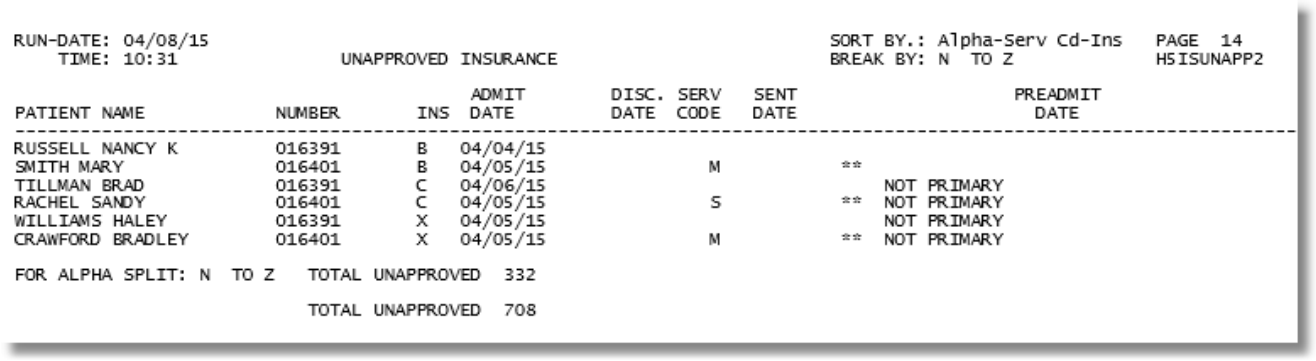
Description and Usage

The Unapproved Claims report should be printed and worked daily. This report page breaks and subtotals by Financial Class, with a grand total number of Unapproved claims printing at the end of the report.

The report indicates claims that require some form of verification (ex: pre-certification or data verification). If this type of verification is not required then the claim should start at the Approved status rather than the Unapproved status. If there are additional insurance claims at the Unapproved status on the account then approve them also. Two asterisks will appear next to claims when the admit date is older than 20 days.

For primary Inpatient claims, it will be necessary to enter the Full Days**,** Co Days and Life Days fields in Detail Benefits for Medicare claims and the Full Days for all other Financial Classes. These fields will automatically populate once the claim is generated when setup in the Insurance Company table, page 6.

Unapproved Claims



```
RUN-DATE: 04/08/15                                          SORT BY.: Alpha-Serv Cd-Ins   PAGE  14
    TIME: 10:31              UNAPPROVED INSURANCE           BREAK BY: N  TO Z             H5ISUNAPP2

                                    ADMIT       DISC. SERV   SENT                    PREADMIT
PATIENT NAME            NUMBER      INS  DATE       DATE  CODE   DATE                  DATE
-------------------------------------------------------------------------------------------------
RUSSELL NANCY K         016391      B    04/04/15
SMITH MARY              016401      B    04/05/15            M          **
TILLMAN BRAD            016391      C    04/06/15                          NOT PRIMARY
RACHEL SANDY            016401      C    04/05/15            S          **  NOT PRIMARY
WILLIAMS HALEY          016391      X    04/05/15                          NOT PRIMARY
CRAWFORD BRADLEY        016401      X    04/05/15            M          **  NOT PRIMARY

FOR ALPHA SPLIT: N  TO Z    TOTAL UNAPPROVED  332

                            TOTAL UNAPPROVED  708
```

Listed below is an explanation of each column.

- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen. If the account is a repeat admission within 72 hours, the flag “72H” will print after the Account Number.
- **Ins (Insurance Code):** Pulls from the Insurance Claims by Patient screen.
- **Admit Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Disc Date (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Serv Code (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Sent Date:** Pulls from the Policy Information screen, Sent Date.
- **Pre admit Date:** If there is no Admit Date, the pre-Admit Date pulls from the Stay tab on the Registration and ADT screen.

10.4 Approved Claims (Chgs Needed)

The Approved Claims (Chgs Needed) report lists claims at the Approved status. Claims at this status should be automatically generated and require no manual intervention.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Approved Claims (Chgs Needed).**
4. Select a print option.

   System prompts, “Sort By:”

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**d**	Serv Cd-Ins-Alpha
b	Alpha-Ins-Serv Cd	**e**	Ins-Alpha-ServCd
c	Serv Cd-Alpha-Ins	**f**	Ins-Serv Cd-Alpha

   System prompts, “Service Codes or All:"

6. Enter up to 10 desired Service Codes or select **ALL** to pull all Service Codes.

   System prompts, “Include Secondary Claims:”

7. Select this option to include secondary claims or leave blank to exclude secondary claims from the report.

   System prompts “Print Medical Records Complete:"

8. Select **Yes** if the report should only print the accounts that have Medical Records complete, or select **No** if the report should only print the accounts that do not have Medical Records complete. Select **Both** and the report will print all accounts that have both Medical Records complete and not complete.

   System prompts, “Exclude Patients with a Discharge Date:"

9. Select this option to exclude claims with no Discharge date or leave blank to include all claims.

   System prompts, “Print:"

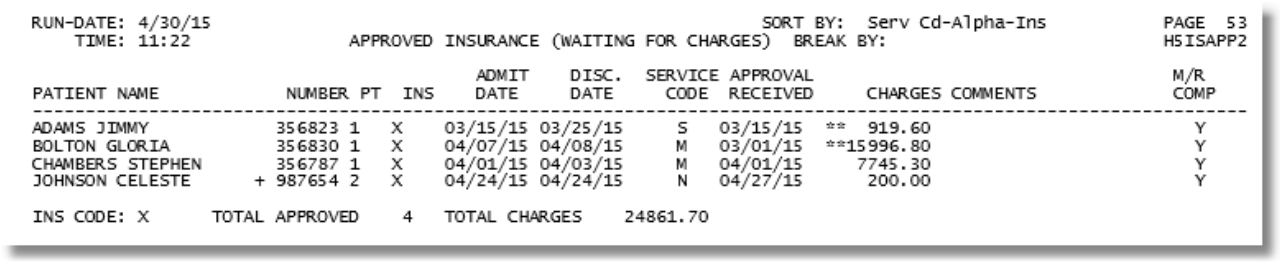
10. Select **Print** to begin the printing process.

Description and Usage

The Approved Claims Report should be printed and reviewed weekly. This report page breaks and subtotals by Financial Class, with a grand total number of Approved claims printing at the end of the report. The two asterisks appear 4 days after the discharge date.

Claims should move from this report to the Ready to Bill status once the claim meets the criteria for autogenning. Any claim that remains on the report once the account has been coded and lag days have been met should be researched further.

Approved Claims (Chgs Needed)



RUN-DATE: 4/30/15 SORT BY: Serv Cd-Alpha-Ins PAGE 53
TIME: 11:22 APPROVED INSURANCE (WAITING FOR CHARGES) BREAK BY: H5ISAPP2

PATIENT NAME	NUMBER	PT	INS	ADMIT DATE	DISC. DATE	SERVICE CODE	APPROVAL RECEIVED	CHARGES	COMMENTS	M/R COMP
ADAMS JIMMY	356823	1	X	03/15/15	03/25/15	S	03/15/15	** 919.60		Y
BOLTON GLORIA	356830	1	X	04/07/15	04/08/15	M	03/01/15	**15996.80		Y
CHAMBERS STEPHEN	356787	1	X	04/01/15	04/03/15	M	04/01/15	7745.30		Y
JOHNSON CELESTE	+ 987654	2	X	04/24/15	04/24/15	N	04/27/15	200.00		Y

INS CODE: X TOTAL APPROVED 4 TOTAL CHARGES 24861.70

Listed below is an explanation of each column.

- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Pt (Stay type):** Pulls from the Patient tab on the Registration and ADT screen.
- **Ins (Insurance Code):** The insurance code pulls from the Insurance Claims by Patient screen.
- **Admit Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Disc Date (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Service Code:** Pulls from the Patient tab on the Registration and ADT screen.
- **Approval Received:** Pulls from the Policy Information screen.
- **Charges:** The total amount of charges pulls from Account Detail.
- **Comments:** The Comments pull from Comments on the Insurance Claims Status screen.
- **M/R Comp (Medical Records Complete):** A **Y** indicates Medical Records coding is complete and the Finish Date has been added to the grouper screen. An **N** indicates that coding is not complete.

10.5 Claims With Missing Information (By Ins)

The Claims with Missing Information (By Ins) report lists all claims at the Unchecked status. This report should be printed and worked daily as part of the Followup Procedures once Primary Billing is complete.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Claims With Missing Information (By Ins)**.
4. Select a print option.

   System prompts, “Sort By:”

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**d**	Serv Cd-Ins-Alpha
b	Alpha-Ins-Serv Cd	**e**	Ins-Alpha-ServCd
c	Serv Cd-Alpha-Ins	**f**	Ins-Serv Cd-Alpha

   System prompts, "Include Secondary Claims:"

6. Select this option to include secondary claims on the report. If left blank the secondary claims will not print to the report.

   System prompts, “Print:"

7. Select **Print** to start the generation process.

   System prompts, "Enter as of Date:"

8. Enter the date the report will be run through and select "Ok."

   If the Sort By option is by Service Code, the system will prompt, "Service Codes: Or Select All:"

9. Enter the desired Service Code. If all Service Codes are to print, select **Ok**.

   System prompts, "Would you like to pull coder initials?"

10. If this prompt is answered **Yes**, the coders initials will replace the "Current, 30, 60, 90 days" columns.

    The report will print once this prompt is answered

Description and Usage

The Claims With Missing Information report should be printed and worked daily. This report page breaks and subtotals by insurance company. The last page of the report ages the expected payment under the columns Current, Over 30, Over 60 and Over 90. The last page also gives the total number of claims for each insurance company. There is a grand total that gives the totals of each aging column for all insurance companies and a grand total of the number of claims at the Unchecked status.

If a claim appears on this report, then it should be for one of two reasons. First, it may be an APC claim, which will autogen to the Unchecked status if the Auto Gen to Ready-to-Bill field on page 4 of the Insurance Company table is set to **N** and will contain the message “APC Claim” in the Comment field. Second, if the claim is <u>not</u> an APC claim, then it was most likely manually set back from the Ready To Bill status and the reason should be placed in the comment field. The APC claims will move to the Ready To Bill status once a M/R Verified Date has been placed on the claim and the APC Claims to Ready to Bill report has been run. The non-APC will not automatically move from the Unchecked status to the Ready To Bill status and will need to be manually reset to Ready To Bill when ready.

NOTE: *The advancement of APC claims depend on how the Insurance Company table is set.*

Claims With Missing Information (By Insurance)

RUN DATE: 06/03/15 TIME: 11:53 — CLAIMS WITH MISSING INFORMATION (BY INSURANCE) AS OF 05/25/15 — PAGE 36 H5ISUNCKP

INSURANCE NUMBER		PATIENT NAME	DISC DATE	AMOUNT TO BE BILLED	CUR	30	60	90	PHYSICIAN	REASON FOR NOT BILLING	M/R COMP	SERV CD
CB1 AETNA-O/P												
PRI. 413862		SMITH JOHN	05/01/15	100.00		X			BEVER	MISSING DIAG CODE	N	B
SEC. 416216		ABBEY CAROLINE	04/18/15	54.50		X			SWEENEY	MISSING MODIFIER	Y	O
PRI. 416815	72H	CRAWFORD BRADLEY	03/28/15	3754.96			X		SWEENEY	MISSING MODIFIER	Y	E
SEC. 700000		SMITH JUSTIN	04/25/15	500.00		X			ADAMS	MISSING DIAG CODE	N	A
		* * * T O T A L S * * *		4409.46		TOTAL CLAIMS			4			

Claims With Missing Information (By Insurance Totals)

RUN DATE: 06/03/15 TIME: 11:53 — CLAIMS WITH MISSING INFORMATION (BY INSURANCE) AS OF 05/25/15 — PAGE 93 H5ISUNCKP

NUMBER	NAME	CURRENT	OVER-30	OVER-60	OVER-90	BALANCE	CLAIMS
B	BLUE CROSS I/P	101.40	421.18	87.25	424.16	78.99	67
BP	BC/BS - PHYSICIAN	167.00	52.83	40.90		560.73	22
M	MEDICARE I/P	60.58	45.94	499.32	482.62	88.46	154
MB	MEDICARE-O/P	83.13	350.57	997.94	68.56	95.20	290
MBR	MEDICARE RECURRING		571.78			571.78	7
X	MEDICAID INSURANCE DESCRIPTION		58.72	1182.00	19.75	340.72	14
XB	MEDICAID-O/P	190.25	983.81	57.75		115.06	69
	* * * T O T A L S * * *	547.36	2484.83	2865.16	995.09	1847.94	593

Listed below is an explanation of each column.

- **Ins (Insurance code):** The Insurance code pulls from the Insurance Claims by Patient screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen. If this account is a repeat admission within 72 hours, the flag “72H” will pull after the Account Number.
- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Disc Date (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Amount to be Billed:** The expected pay amount pulls from the detail charges screen.
- **Current:** An “X” pulls to this column if the Discharge Date is less than 30 days old.
- **30:** An “X” pulls to this column if the Discharge Date is over 30 but less than 60 days old.
- **60:** An “X” pulls to this column if the Discharge Date is over 60 but less than 90 days old.
- **90:** An “X” pulls to this column if the Discharge Date is over 90 days old.
- **Physician:** The attending physician pulls from the Patient tab on the Registration and ADT screen.
- **Reason for Not Billing:** The comments pull from the Comment field of the Insurance Claims Status screen.
- **M/R Comp (Medical Record Complete):** A **Y** indicates Medical Records coding is complete and the Finish Date has been added to the grouper screen. A **N** indicates that coding is not complete.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.

10.6 Claims With Missing Information (By Phy)

The Claims with Missing Information (By Phy) is used by the Business Office to advance Inpatient claims to the Ready to Bill status and by Medical Records to review which patient accounts need to be coded.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Claims With Missing Information (By Phys)**.
4. Select a print option.

   System prompts, "Include Secondary Claims? Yes/No:"

5. Select **Yes** to include secondary claims or **No** to exclude secondary claims from the report.

   System prompts, "Would you like to pull coder initials?"

6. If answered **Yes**, the coders initials will replace the "Current, 30, 60, 90 days" columns.

   System prompts, As of date for insurance aging:"

7. Enter the date the report will be run through.

   System prompts, “Print medical record number?:"

8. Select this option to print the patient medical record number to report or leave blank to omit the Medical Record Number from the report.

   System prompts, “Print:"

9. Select **Print** to begin the printing process.

Description and Usage

The Claims with Missing Information (By Phy) report should be printed and worked on a daily basis. The report page breaks and subtotals by physician. The last page of the report ages the expected pay under the columns Current, Over 30, Over 60 and Over 90. The last page also gives the total number of claims for each physician.

Medical Records may use this report to see what needs to be coded. If they are waiting on the doctor to assign a diagnosis, this report may be used to determine which physicians are holding up the billing.

To advance the claim to the Ready to Bill status, the patient's Account Number should be locked onto, and **Insurance** should be selected. Verify the Stay Information and all Condition, Occurrence and Value codes in the Coding Screen. After all of this is completed, Detail Charges should be selected. The Ready to Bill and Print Form fields should be selected for all primary claims. Ready to Bill should be selected and Print Form blank for all secondary claims.

If a Non-APC Outpatient claim appears on this report, a reason should be noted in the Comment field of the Insurance Claim Status screen. These claims automatically generate from the Approved status to the Ready to Bill status. Any Non-APC Outpatient claims that appear on this report will need to be manually set to Ready to Bill.

For an APC claim, the system will advance the claim to the Unchecked status and place "APC Claim" in the Comment field once the claim is autogenned. Once the Medical Records Verification Date has been placed on the account, and APC Claims to Ready-to-Bill report has been run, the claim will move to the Ready to Bill status.

NOTE: *The advancement of APC claims depend on how the Insurance Company table is set.*

Claims With Missing Information (By Physician)

```
RUN DATE: 16/01/04                                                    MEDICAL RECORDS     PAGE   1
    TIME: 09:25                                CLAIMS WITH MISSING INFORMATION (BY PHYSICIAN)     ISPHYP
                                               AS OF 01/04/16

    INSURANCE--------------------------------- DISC   AMOUNT TO                  #DAYS CHART      #DAYS                        SRV  M/R
     NUMBER     NAME------------------          DATE   BE BILLED  CUR  30  60  90  DISC. LOCATION   LOCA.   INSURANCE          CD  COMP

       NOT ON FILE

PRI. 348069       CHAPMAN COREY            12/20/15     561.20  X                 15                   CIGNA                  M    N
                                  REASON FOR NOT BILLING ABOVE CLAIM:                      ANSI EDIT
PRI. 356942       ARTHUR BART              12/22/15     216.56  X                 12                   BLUE CROSS-O/P         ER   N
                                  REASON FOR NOT BILLING ABOVE CLAIM:                      ANSI EDIT
PRI. 523558       ALEXANDER BETTY L        12/02/15     215.00      X             32                   MEDICARE-O/P           ER   N
                                  REASON FOR NOT BILLING ABOVE CLAIM: (APC CLAIM)          ANSI EDIT

                * * * T O T A L S * * *              992.73       TOTAL CLAIMS        3
```

Claims With Missing Information (By Physician Totals)

```
    TIME: 09:25                                CLAIMS WITH MISSING INFORMATION (BY PHYSICIAN)     ISPHYP
                                               AS OF 01/04/16

NUMBER  NAME                                CURRENT     OVER-30     OVER-60     OVER-90     BALANCE      CLAIMS

  4100 LOWERY J                                                                   200.00       200.00          1
 10000 BAXTER J                                         16236.45                16729.26     32965.71         14
 30000 CRABTREE J                                                                   63.20        63.20          1
 68000 BIXLER S                                                                    142.28       142.28          3
100000 BROWN A                                                                    1229.30      1229.30          5
110000 MAYSON H                                                                  28694.30     28694.30          2
705000 TAYLOR J                                                                  45215.10     45215.10          3
805000 DEXTER R                                                                    299.40       299.40          1
859000 DIXON J                                                                    1294.25      1294.25          3
860000 KENNEDY I                                                                  2365.90      2365.90          1
900000 WILLIAMS J                                                                 1780.80      1780.80          3
997000 BAYLOR A                                                                   7921.95     28072.40          6
999999 Global Phy                                                                 1978.60      1978.60          6

       * * * T O T A L S * * *                          16236.45                107914.31    124150.76         49

TOTAL NUMBER OF ACCOUNTS CURRENT      0
TOTAL NUMBER OF ACCOUNTS OVER-30      1
TOTAL NUMBER OF ACCOUNTS OVER-60      0
TOTAL NUMBER OF ACCOUNTS OVER-90     48

TOTAL NUMBER OF ACCOUNTS             49
```

Listed below is an explanation of each column.

- **Ins (Insurance Code):** Pulls from the Insurance Claims by Patient screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen. If this account is a repeat admission within 72 hours, the flag “72H” will print after the Account Number.
- **Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Med. Rec.# (Medical Record Number):** Pulls from the Patient tab on the Registration and ADT screen.,if the prompt “Print Medical Record Number” is answered **Y**.
- **Disc Date (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Amount to be Billed:** The expected pay amount pulls from the detail charges screen.
- **Current:** An “X” pulls to this column if the Discharge Date is less than 30 days old.

- **30:** An "X" pulls to this column if the Discharge Date is over 30 but less than 60 days old.
- **60:** An "X" pulls to this column if the Discharge Date is over 60 but less than 90 days old.
- **90:** An "X" pulls to this column if the Discharge Date is over 90 days old.
- **# Days Disc:** The number of days since discharge.
- **Chart Location:** The location of the patient's medical record chart pulls from Medical Records.
- **# Days Loca:** The number of days that the Medical Record chart has been in its current location.
- **Ins (Insurance Code):** Pulls from the Insurance Claims by Patient screen.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **M/R Comp (Medical Record Complete):** A **Y** indicates that Medical Records coding is complete and the Finish Date has been added to the grouper screen. A **N** indicates that coding is not complete. The report is divided into two sections. The first section are accounts that have not been coded, therefore do not have a finish date. The second section are accounts that have been coded, therefore have a finish date.

Totals Section

- **Totals:** The total amounts for each physician.
- **Total Number of Accounts:** The number of accounts Current, Over-30, Over-60 and Over-90 past discharge.

10.7 Print UBs

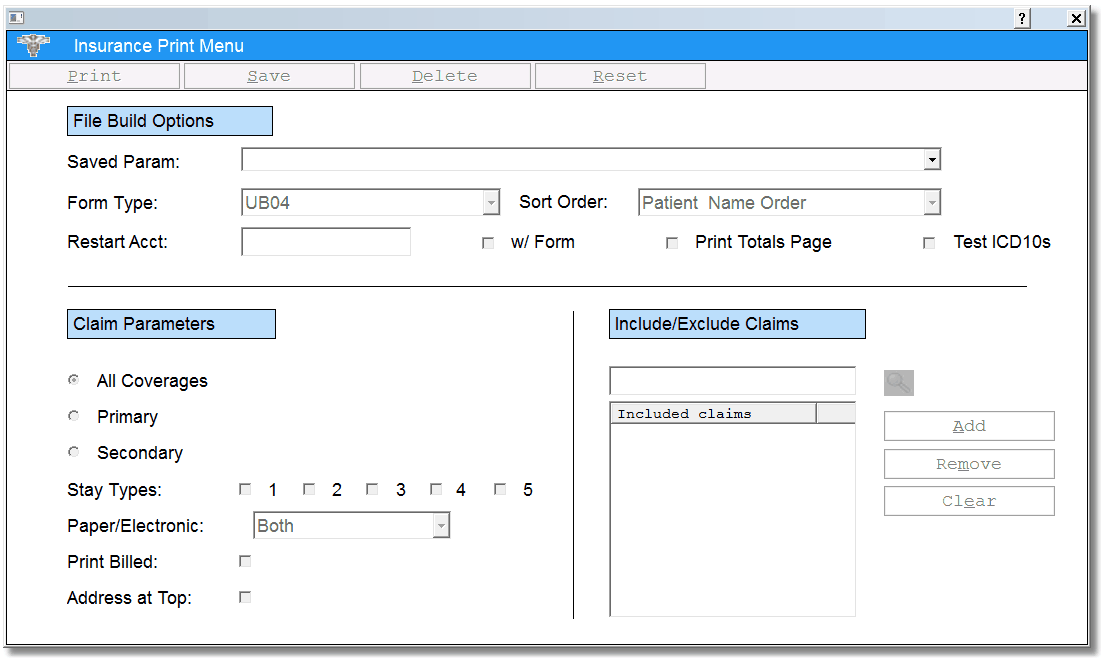
The UB billing forms may be printed as necessary by the facility.

How to Print

1. Select **Print Reports** from the **Hospital** Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print UBs**.

After selecting UB the user may print on the new form by including or excluding certain claims based on the parameters described below.

4. Select a print option.



Print UBs Insurance Print Menu

File Build Options

- **Saved Parameters:** Prior to printing the UB, it will be necessary to determine how to separate the claims billed on the new forms from the claims printed on the old forms. This option contains a drop-down menu with the following selections in addition to some user-defined selections, which are explained below:

Print All	**By Intermediary**
By Account	**By Stay**
By Insurance	**By Restart**

Select the option that will be used to determine which claims will be billed on the UB form. The option selected in this field will adjust remaining prompts. For example if **By Insurance** is selected, the option to select financial classes will be available. If **By Restart** is selected, an account number may be entered to begin the printing process with that account number.

User-defined selections within the Saved Parameters drop-down menu are also available. Once all fields on this Insurance Print Menu have been selected, the user may save these parameters eliminating the need to complete all fields every time certain types of claims are printed. Printing the same type of claims in the future will be as easy as selecting the desired user-defined saved parameter from the drop-down menu. The **Save** option is explained under Other Options within this document.

- **Form Type:** UB will display.
- **Sort Order:** This option will print the claims in order by either **Account Number** or **Financial Class**.
- **w/Form:** Selecting this option will generate the UBs on a laser form. Do not select this option if printing to a preprinted UB.
- **Restart Acct:** If **By Restart** is selected in Saved Parameters, an account number may be entered in this field as the account number to begin printing the UB forms. This option will gather information from the last file build created.
- **Test ICD10s**: This option allows the ability to create ICD-10 test print files. See ICD-10 Test Print Files 198 for more information.

Claim Parameters

- **All Coverages:** Selecting this option will print all UB claims at the Ready to Bill status.
- **Primary:** Selecting this option will only print primary UB claims at the Ready to Bill status.
- **Secondary:** Selecting this option will only print secondary UB claims at the Ready to Bill status.
- **Stay Types:** Select the desired stay types to print the new UB forms. Any combination or all stay types may be selected. This selection is available if the Saved Parameter **By Stay** is chosen.
- **Paper/Electronic:** This option will allow the UB claims to be produced in paper form, electronically or both.
- **Print Billed:** This option will allow the user to print UB claims at the Billed status.
- **Address on Top:** This option will print the address loaded on page 1 of the Insurance Company table to the top of the UB.

Include/Exclude Claims

Include/Exclude Claims will allow the addition or removal of claims by account number, financial class or intermediary. Depending on what is selected in Save Parameters, the options in this section will differ.

- **Account Numbers:** If **By Account** is selected from the Save Parameters drop-down menu, a list of all the accounts that will print claims on a new UB form will display. The user may add or remove claims from the existing list. A lookup may be accessed by selecting the magnifying glass. The Patient List will display to assist in adding accounts. Accounts may also be added by keying the account number in the field at the top of the displayed list and selecting **Add** (Alt-A). To remove an account, highlight the account and select **Remove** (Alt-m). To remove all accounts in the list, select **Clear** (Alt-e).

- **Financial Classes:** If **By Insurance** is selected in Save Parameters, a list of financial classes that will print claims on a new UB form will display. The user may add or remove financial classes from the existing list. A lookup may be accessed by selecting the magnifying glass this will display all financial class codes to select. Financial classes may also be added by keying the financial class code in the field at the top of the displayed list and selecting **Add** (Alt-A**)**. Wildcarding may be used for financial classes. To remove an insurance code, highlight the code and select **Remove** (Alt-m). To remove all financial class codes in the list, select **Clear** (Alt-e).

- **Intermediary:** If **By Intermediary** is selected in Save Parameters, a list of intermediary groups that will print claims on a new UB form will display. The user may add or remove intermediaries from the existing list. A lookup may be accessed by selecting the magnifying glass. This will display all intermediaries available for selection. Intermediaries that are not linked to a specific financial class will not be allowed for selection. Intermediaries may also be added by keying the intermediary code in the field to the left of the magnifying glass and selecting **Add** (Alt-A). To remove an intermediary, highlight the code and select **Remove** (Alt-m). To remove all intermediaries in the list, select **Clear** (Alt-e).

NOTE: *If* ***Print All*** *is selected in Save Parameters, a list of all accounts that will print claims on a new UB form will display yet may not be manipulated*

After all prompts have been answered, the following options located at the top of the screen are available:

- **Print:** This will print the UB forms to the print option selected.

- **Save:** Select Save (Alt-S) to save a set of user-defined parameters, which will prevent having to answer all prompts each time UB claims are printed. The system will prompt, “Create a name for the saved parameters.” Enter a description under which the current selections will be stored. The description entered will be displayed in the Saved Parameters drop-down menu and may be selected for the future printing of UB claims. After entering the description select **OK** (Alt-O).

- **Delete:** Select **Delete** (Alt-D) to remove any entry from the Saved Parameters drop-down that will no longer be needed.

- **Reset:** Select **Reset** (Alt-R) to set the screen back to the original information before choosing any option after Saved Parameters.

System prompts, "Printing Options:"

System prompts, "Did It Print Correctly?:"

5. Select **No** to reprint the first UB again. Select **Yes** to continue to the next prompt.

   System prompts, “Insurance Update is next, Do You Wish To Update?:"

6. Select **Yes** to move the claims to the Billed status or **No** to leave the claims at the Ready to Bill status.

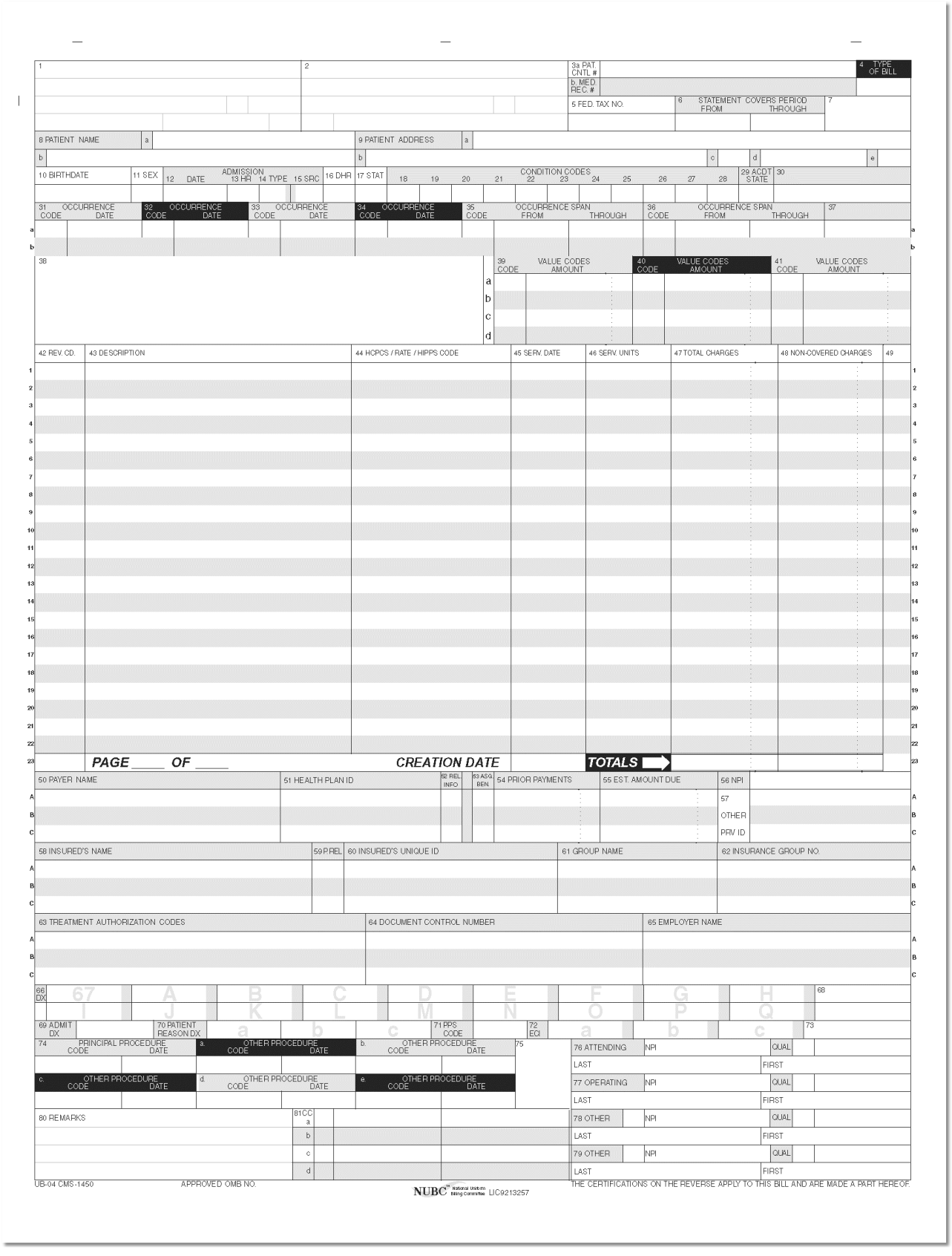
Description and Usage

The UB provides the information charged to a patient’s account in a format that is accepted by Insurance Providers.

When printed as an update, the system advances claims from Ready to Bill to the Billed status. Once printed, the biller should verify that all necessary information has printed on the form. If changes need to be made to the claim, select “Reverse” and make the necessary changes. A corrected UB will generate the next time bills are printed.

An explanation of each locator on the UB may be found in the Insurance Procedures and Edits User Guide.

Print UBs



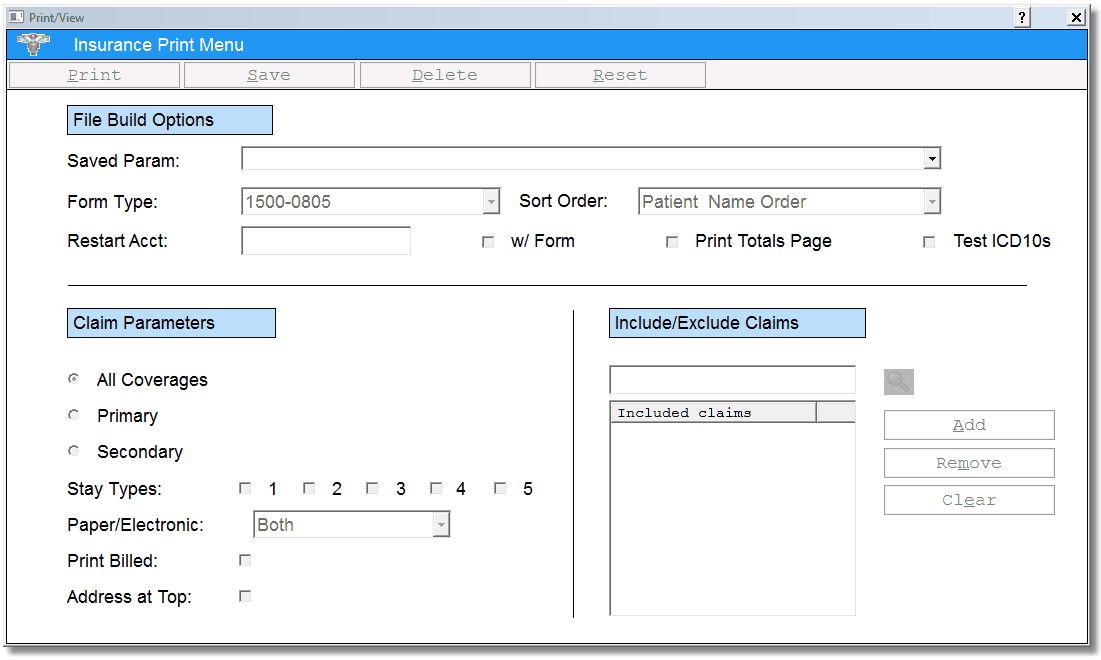
10.8 Print 1500s

The 1500 billing forms may be printed as necessary by the facility

How to Print

1. Select **Print Reports** from the Hospital Base screen or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print 1500s**.
4. Select a print option.

To print the old 1500 form, select **1500 (08-05).** To print the new 1500 form, select **1500 (02-12)**. After selecting 1500 (02-12) the user may print 1500s on the new form by including or excluding certain claims based on the parameters described below.



Print 1500 Insurance Print Menu

File Build options

- **Saved Parameters:** Prior to printing the new 1500, it will be necessary to determine how to separate the claims billed on the new forms from the claims printed on the old forms. This option contains a drop-down menu with the following selections in addition to some user-defined selections, which are explained below:

Print All	**By Intermediary**
By Account	**By Stay**
By Insurance	**By Restart**

  Select the option that will be used to determine which claims will be billed on the new 1500 form. The option selected in this field will adjust remaining prompts. For example if **By Insurance** is selected, the option to select financial classes will be available. If **By Restart** is selected, an account number may be entered to begin the printing process with that account number.

  User-defined selections within the Saved Parameters drop-down menu are also available. Once all fields on this Insurance Print Menu have been selected, the user may save these parameters eliminating the need to complete all fields every time certain types of claims are printed. Printing the same type of claims in the future will be as easy as selecting the desired user-defined saved parameter from the drop-down menu. The **Save** option is explained under Other Options within this document.

- **Form Type:** 1500-0212 will display.

- **Sort Order:** This option will print the claims in order by either **Account Number** or **Financial Class**.

- **w/Form:** Selecting this option will generate the 1500s on a laser form. Do not select this option if printing to a preprinted 1500.

- **Restart Acct:** If **By Restart** is selected in Saved Parameters, an account number may be entered in this field as the account number to begin printing the 1500 forms. This option will gather information from the last file build created.

- **Test ICD10s**: This option allows the ability to create ICD-10 test print files. See ICD-10 Test Print File 198 for more information.

Claim Parameters

- **All Coverages:** Selecting this option will print all 1500 claims at the Ready to Bill status.

- **Primary:** Selecting this option will only print primary 1500 claims at the Ready to Bill status.

- **Secondary:** Selecting this option will only print secondary 1500 claims at the Ready to Bill status.

- **Stay Types:** Select the desired stay types to print the new 1500 forms. Any combination or all stay types may be selected. This selection is available if the Saved Parameter **By Stay** is chosen.

- **Paper/Electronic:** This option will allow the 1500 claims to be produced in paper form, electronically or both.

- **Print Billed:** This option will allow the user to print 1500 claims at the Billed status.

- **Address on Top:** This option will print the address loaded on page 1 of the Insurance Company table to the top of the 1500 form if the Print Addr on top of 1500 field on page 3 of the Insurance Company table is set to **Y**.

Include/Exclude Parameters

Include/Exclude Claims will allow the addition or removal of claims by account number, financial class or intermediary. Depending on what is selected in Save Parameters, the options in this section will differ.

- **Account Numbers:** If **By Account** is selected from the Save Parameters drop-down menu, a list of all the accounts that will print claims on a new 1500 form will display. The user may add or remove claims from the existing list. A lookup may be accessed by selecting the magnifying glass. The Patient List will display to assist in adding accounts. Accounts may also be added by keying the account number in the field at the top of the displayed list and selecting **Add** (Alt-A**)**. To remove an account, highlight the account and select **Remove** (Alt-m). To remove all accounts in the list, select **Clear** (Alt-e).

- **Financial Classes:** If **By Insurance** is selected in Save Parameters, a list of financial classes that will print claims on a new 1500 form will display. The user may add or remove financial classes from the existing list. A lookup may be accessed by selecting the magnifying glass, which will display all financial class codes to select. Financial classes may also be added by keying the financial class code in the field at the top of the displayed list and selecting **Add** (Alt-A**)**. Wildcarding may be used for financial classes. To remove an insurance code, highlight the code and select **Remove** (Alt-m). To remove all financial class codes in the list, select **Clear** (Alt-e).

- **Intermediary:** If **By Intermediary** is selected in Save Parameters, a list of intermediary groups that will print claims on a new 1500 form will display. The user may add or remove intermediaries from the existing list. A lookup may be accessed by selecting the magnifying glass which will display all intermediaries available for selection. Intermediaries that are not linked to a specific financial class will not be allowed for selection. Intermediaries may also be added by keying the intermediary code in the field to the left of the magnifying glass and selecting **Add** (Alt-A). To remove an intermediary, highlight the code and select **Remove** (Alt-m). To remove all intermediaries in the list, select **Clear** (Alt-e).

NOTE: *If* ***Print All*** *is selected in Save Parameters, a list of all accounts that will print claims on a new 1500 form will display yet may not be manipulated.*

Other Options

After all prompts have been answered, the following options located at the top of the screen are available.

- **Print:** This will print the 1500 forms to the print option selected prior to entering the print report.
- **Save:** Select Save (Alt-S) to save a set of user-defined parameters, which will prevent having to answer all prompts each time 1500 claims are printed. The system will prompt, “Create a name for the saved parameters.” Enter a description under which the current selections will be stored. The description entered will be displayed in the Saved Parameters drop-down menu and may be selected for the future printing of 1500 claims. After entering the description, select **OK** (Alt-O).
- **Delete:** Select **Delete** (Alt-D) to remove any entry from the Saved Parameters drop-down that will no longer be needed.
- **Reset:** Select **Reset** (Alt-R) to set the screen back to the original settings before choosing any option after Saved Parameters.

NOTE: *If there is a revenue code in the range 100-219, the claim is flagged as a UB and nothing will print.*

If printing to a laser printer the system will prompt, "You are printing to a multitray printer Print from tray (1,2,3):"

5. Enter the tray number.

   System prompts “Insurance Update is next, Do You Wish To Update?:"

6. **Yes** will move the claims to the Billed status, and **No** will leave the claims at the Ready to Bill status.

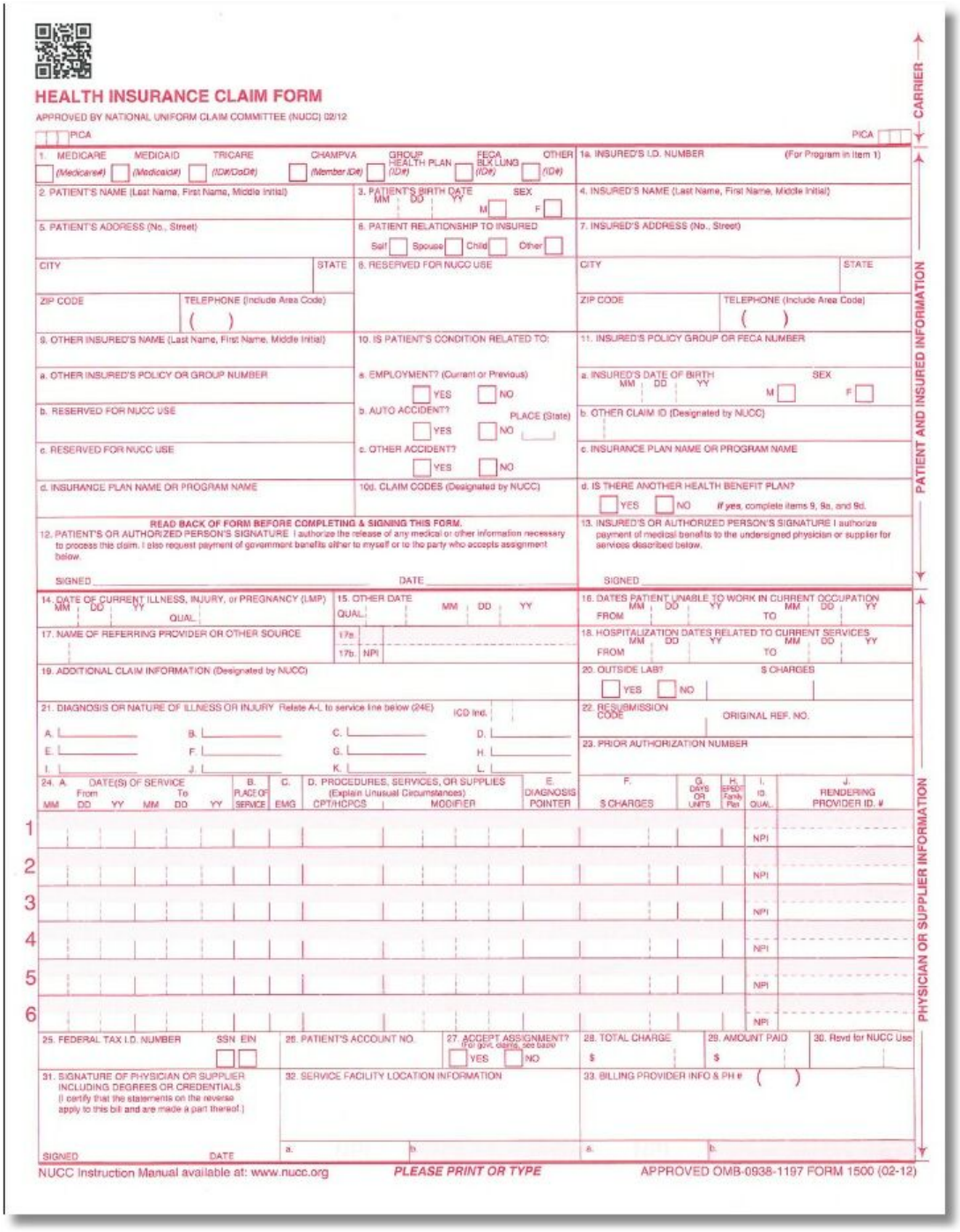
Description and Usage

The 1500 form provides the physician charges in a format that is accepted by Insurance Providers.

When printed as an update, the system advances claims from Ready to Bill to the Billed status. Once printed, the biller should verify that all necessary information has printed on the form. If changes need to be made to the claim, select “Reverse” and make the necessary changes. A corrected 1500 form will generate the next time bills are printed.

An explanation of each locator on the 1500 may be found in the Insurance Procedures and Edits User Guide.

Print 1500's



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code)

ZIP CODE TELEPHONE (Include Area Code)

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? PLACE (State) YES NO

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL

15. OTHER DATE QUAL MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. b.

33. BILLING PROVIDER INFO & PH # ( )

a. b.

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

10.9 ICD-10 Test Print File

TruBridge has developed functionality to create ICD-10 Test Print Files for internal testing needs. This functionality may be found in the Print UBs 188 and Print 1500s 193 options on the Insurance Print Reports Menu. This section will detail the steps required to build an ICD-10 test file. Facilities who submit files directly to a payer or another clearinghouse (i.e. hardcopy) will be responsible for performing all applicable testing for their facility.

The following criteria must be met in order to use the ICD-10 Test Print File option:

- The facility must have version 1906 of ClientWare installed.
- The new Medical Record Grouper screens must be used.
- The existing ICD-9 codes must be linked to the applicable ICD-10 codes.

Please contact TruBridge's Financial Software Support for information regarding these requirements.

How to Print

1. Select **Print Reports** from the **Hospital** Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print UBs** or **Print 1500s**
4. Select a Print Option

System prompts, "Test ICD10s:"

5. If this option is selected, claims may be printed with ICD-10 codes.

***NOTE**: The user may include or exclude certain claims based on the parameters described in the Print UBs 188 and Print 1500s 193 section.*

After all prompts have been answered and the user selects **Print**:

System prompts, "Insurance Update is next, Do You Wish To Update?:"

6. Select **No** to leave the claims at the Ready to Bill status when printing the ICD-10 Test Print File. If **Yes** is selected claims will move to the Billed status.

Description and Usage

The ICD-10 Test Print File option will give users the ability to preview what a UB04 or 1500 will look like using ICD-10 codes. This is a temporary measure that may be used until ICD-10's are fully implemented.

The following locators will be affected on the UB04:

- Locator 66: will pull a 0 instead of a 9
- Locators 67, 69, 70, 72, 74: will pull ICD-10 codes

The following locator will be affected on the 1500:

- Locator 21: will pull ICD-10 codes

10.10 Billed But Unpaid Claims (By Ins)

The Billed but Unpaid Claims (by Ins) is used by the Business Office to do follow-up work on claims that have been billed but payment has not been made against the claim.

NOTE: *This report is also available in the Report Writer format on the Report Dashboard. Please refer to the* *Billed But Unpaid Claims (By Ins) - Report Writer* 262 *topic in the Report Dashboard section of this user guide.*

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen.
2. Select **Insurance**.
3. Select **Billed but Unpaid Claims (by Ins)**.
4. Select a print option.

   System prompts, “Sort By:"

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**d**	Serv Cd-Ins-Alpha
b	Alpha-Ins-Serv Cd	**e**	Ins-Alpha-ServCd
c	Serv Cd-Alpha-Ins	**f**	Ins-Serv Cd-Alpha

   System prompts, "Enter Insurance Companies, * to wildcard, (Blank for all):"

6. Up to 10 financial classes may be entered. Use “*****” to wildcard insurance companies or leave blank to print for all financials classes.

   System prompts, “Sort By Balance:"

7. Select this option to sort report by account balance.

   System prompts, "Generate:"

8. Select this option to begin the printing process.

   System prompts, "As of date for Insurance aging:"

9. Enter the date the report will be run through.

   System prompts, "Include Claims:"

10. Select **Primary** to print only Primary claims. Select **Secondary** to print only secondary claims. Select **Both** to print both Primary and Secondary claims.

    System prompts “Expected Pay Low: High:"

11. Enter the range of dollar amounts for the expected pay the report will print or return for all claims with an expected pay to print to the report.

    System prompts, “Which Claims:"

12. Use the drop-down box to select one of the following options:
    For Claims in Current
    For Claims in Over-30 Day
    For Claims in Over-60 Day
    For Claims in Over-90 Day
    For All Claims

    System prompts, “Sort by balance:"

13. Select this option to sort the report by balance.

    System prompts, “Service Codes to pull (Blank for all):"

14. Enter up to 10 desired Service Codes or leave blank to pull all Service Codes.

    System prompts, “Print:"

15. Select **Print** to begin the printing process.

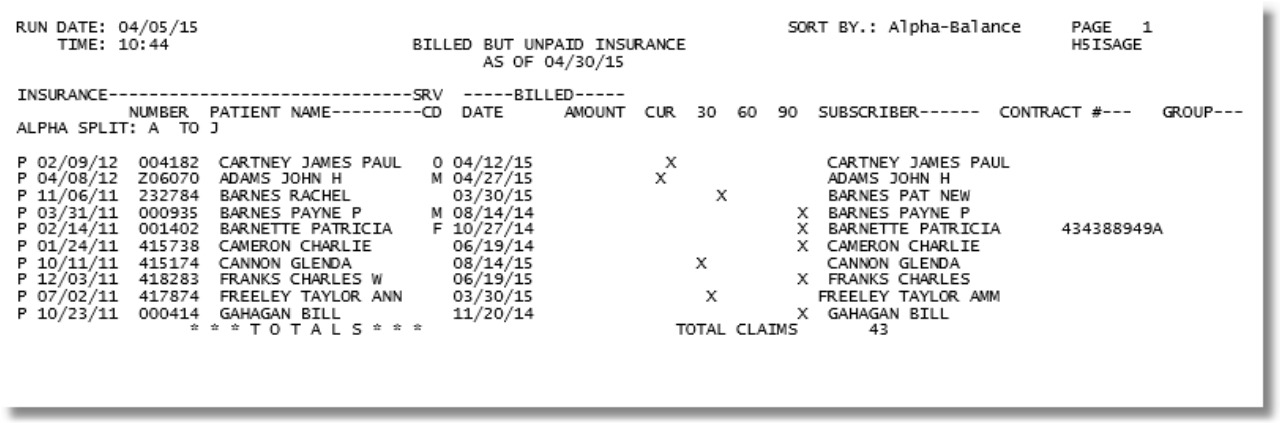
Description and Usage

The Billed but Unpaid Claims (by Ins) report provides an alpha listing by insurance of all outstanding insurance claims. Financial Classes that do not have any unpaid claims or claims that meet the report’s criteria are excluded. The report lists insurance, patient account number, patient name, billed date, billed amount, aging columns, subscriber name, contract number and group information.

The aging columns are Current, 30, 60 and 90 days. The last page of the report lists an aging breakdown of total dollars for each insurance company in each aging column.

The Billed but Unpaid Claims (By Ins) report should be printed and worked on a weekly basis. This report is helpful in showing which insurance is outstanding and how much payment is expected.

Billed But Unpaid Claims (By Insurance)

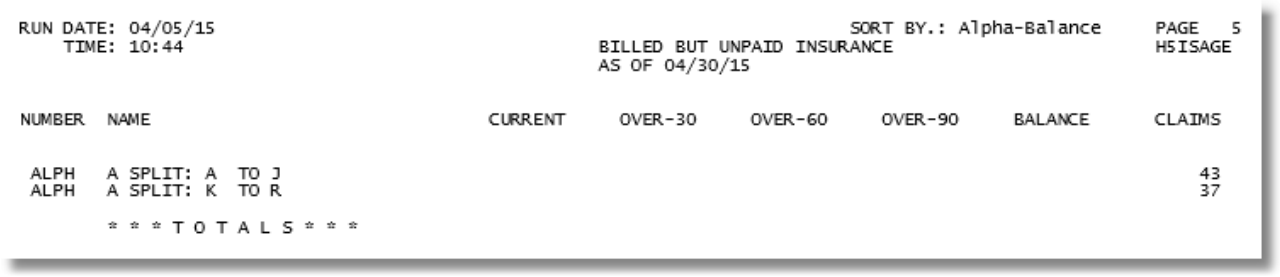


```
RUN DATE: 04/05/15                                                    SORT BY.: Alpha-Balance     PAGE   1
    TIME: 10:44                          BILLED BUT UNPAID INSURANCE                            H5ISAGE
                                               AS OF 04/30/15

INSURANCE--------------------------------SRV  -----BILLED-----
         NUMBER  PATIENT NAME---------CD  DATE      AMOUNT  CUR  30  60  90  SUBSCRIBER------  CONTRACT #---   GROUP---
ALPHA SPLIT: A  TO J

P 02/09/12  004182  CARTNEY JAMES PAUL   0 04/12/15             X              CARTNEY JAMES PAUL
P 04/08/12  Z06070  ADAMS JOHN H        M 04/27/15            X               ADAMS JOHN H
P 11/06/11  232784  BARNES RACHEL        03/30/15                  X          BARNES PAT NEW
P 03/31/11  000935  BARNES PAYNE P      M 08/14/14                        X   BARNES PAYNE P
P 02/14/11  001402  BARNETTE PATRICIA   F 10/27/14                        X   BARNETTE PATRICIA      434388949A
P 01/24/11  415738  CAMERON CHARLIE       06/19/14                        X   CAMERON CHARLIE
P 10/11/11  415174  CANNON GLENDA         08/14/15                  X         CANNON GLENDA
P 12/03/11  418283  FRANKS CHARLES W      06/19/15                        X   FRANKS CHARLES
P 07/02/11  417874  FREELEY TAYLOR ANN    03/30/15                    X       FREELEY TAYLOR AMM
P 10/23/11  000414  GAHAGAN BILL          11/20/14                        X   GAHAGAN BILL
            * * * T O T A L S * * *                          TOTAL CLAIMS      43
```

Billed But Unpaid Claims (By Insurance Totals by Alpha Split)



```
RUN DATE: 04/05/15                                                    SORT BY.: Alpha-Balance     PAGE   5
    TIME: 10:44                          BILLED BUT UNPAID INSURANCE                            H5ISAGE
                                               AS OF 04/30/15

NUMBER  NAME                                CURRENT     OVER-30     OVER-60     OVER-90     BALANCE     CLAIMS

 ALPH   A SPLIT: A  TO J                                                                          43
 ALPH   A SPLIT: K  TO R                                                                          37

        * * * T O T A L S * * *
```

Listed below is an explanation of each column.

- **Insurance:** Pulls from Policy Information. This indicates whether the insurance is primary or secondary.
- **Date:** Pulls the ending service date of the claim.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Billed Date and Amount:** The billed date and expected pay amount pulls from the Detail Charges screen.
- **Current:** An "X" pulls to this column if the billed date is less than 30 days old.
- **30:** An "X" pulls to this column if the billed date is over 30 but less than 60 days old.

- **60:** An “X” pulls to this column if the billed date is over 60 but less than 90 days old.
- **90:** An “X” pulls to this column if the billed date is over 90 days old.
- **Subscriber:** Pulls from Policy Information.
- **Contract #:** Pulls from Policy Information.
- **Group:** The group information pulls from Policy Information.

10.11 Billed But Unpaid Claims (By Phy)

The Billed but Unpaid Claims (by Phy) is used by the Business Office to perform follow-up work on claims that have been billed but payment has not been made against the claim.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Billed but Unpaid Claims (by Phy)**.
4. Select a print option.

   System prompts, "Include Secondary Claims?:"

5. Select **Yes** to include secondary claims or **No** to exclude secondary claims from the report.

   System prompts, "As of Date for Insurance Aging:"

6. Enter the date the report will be run through.

   System prompts, “Print:"

7. Select **Print** to begin the printing process.

Description and Usage

The Billed but Unpaid Claims (by Phy) report provides an alpha listing by physician of all outstanding insurance claims. The report should be printed to determine the dollar amount that has been billed based on the admitting physician.

The report indicates whether the insurance is primary or secondary, then lists the patient number, patient name, billed date, billed amount, aging columns and insurance name. The aging columns are Current, 30, 60 and 90 days. The last page of the report gives an aging break down of total dollars for each physician.

Billed But Unpaid Claims (By Physician)

RUN DATE: 03/03/16
TIME: 08:55

UNPAID INSURANCE CLAIMS (BY PHYSICIAN)
AS OF 03/26/16

PAGE 9
H5ISPHYP2

INSURANCE	NUMBER	PATIENT NAME	SRV CD	BILLED DATE	AMOUNT BILLED	CUR	30	60	90	INSURANCE
PRI.	416907	JOHNSON DANIEL	M	03/29/15					X	BLUE CROSS I/P
PRI.	415790	JONES KENNY	A	07/08/15	16908.75				X	SOUTHWEST REHAB HOSPITAL
PRI.	414444	LONGHORN STEVE	E	01/17/15					X	BLUE CROSS
PRI.	414703	HODGE PREE	K	05/30/15					X	MCAID/MCARE CROSSOVER
PRI.	416911	POWELL JEREMY	M	08/06/15	720.00				X	MEDICARE OUTPATIENT
PRI.	416911	SANDSON JASON	M	10/09/15	40.00				X	MEDICARE OUTPATIENT
SEC.	416175	ZARON BRENDA	M	08/07/15	728.50				X	BLUE CROSS O/P
SEC.	415825	ROSEN MARY	M	07/26/15	122.00				X	BLUE CROSS I/P
PRI.	415791	RUSSELL JAY	M	07/26/15	12.00				X	BLUE CROSS O/P

Billed But Unpaid Claims (By Physician Totals)

RUN DATE: 03/03/16
TIME: 11:44

UNPAID INSURANCE CLAIMS (BY PHYSICIAN)
AS OF 03/26/15

PAGE 40
H5ISPHYP2

NUMBER	NAME	CURRENT	OVER-30	OVER-60	OVER-90	
333341	LOWERY J	930.00				930.00
331000	HENDERSONT	68.54	3344.55	1201.80	141.30	4756.19
332000	HOLLINGER S					
322077	ALBY		1288.60			1288.60
322105	WEISS LEE					
333000	DAWDY	885.00		723.00	100.00	1708.00
334000	DOUGLASS J	933.25				933.25
334231	NOVAK					
100000	PORTERHOUS			1861.00	2137.80	3998.80
110000	MAYSON H	703.20			44.80	748.00
111111	BULLOCK	309.05	140.00	20.00		469.05
123001	SMITH D	350.00				350.00
123654	CRED DOC	1410.00				1410.00
333421	SCHRINER J					
444569	NEWBARRY	614.73				614.73
555555	PAIDAPATY	75.00				75.00
705000	THRASH J	92.25			680.50	772.75
777636	MCGUIRE M	2514.50			283.50	2798.00
802000	BROWNING J				594.35	594.35
805000	DEXTER				291.30	291.30
900900	ANDERSON M		8489.69		774.55	9264.24
	* * * T O T A L S * * *	9399231.49	15894.30	4175.00	81538.11	9500838.90

Listed below is an explanation of each column.

- **Insurance:** This field indicates if the insurance claim is primary or secondary.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Serv Cd (Service Code:** Pulls from the Patient tab on the Registration and ADT screen.
- **Billed Date:** Pulls from the Detail Charges screen.
- **Amount Billed:** The expected pay amount pulls from the Detail Charges screen.

- **Current:** An “X” pulls to this column if the billed date is less than 30 days old.
- **30:** An “X” pulls to this column if the billed date is over 30 but less than 60 days old.
- **60:** An “X” pulls to this column if the billed date is over 60 but less than 90 days old.
- **90:** An “X” pulls to this column if the billed date is over 90 days old.
- **Insurance:** Pulls from Policy Information.
- **Physician:** The attending physician pulls from the Stay tab on the Registration and ADT screen.

10.12 Insurance Billing Time Analysis

The Insurance Billing Time Analysis should be printed and reviewed on a regular basis for the purpose of analyzing the turn around time between insurance submittal and payment. Also, it will greatly aid in the identification of problem areas and help in eliminating unnecessary delays in submission.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen.
2. Select **Insurance**.
3. Select **Insurance Billing Time Analysis**.
4. Select a print option.

   System prompts, “Sort by:"

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**d**	Serv Cd-Ins-Alpha
b	Alpha-Ins-Serv Cd	**e**	Ins-Alpha-ServCd
c	Serv Cd-Alpha-Ins	**f**	Ins-Serv Cd-Alpha

   System prompts, “Service Codes (Blank for all):"

6. Enter up to 10 desired Service Codes or leave blank to pull all Service Codes.

   System prompts, "Insurance Codes (Blank for all):"

7. Enter up to 10 desired Financial class codes or leave blank to pull all Financial classes. The wildcard option (*) may be used.

   System prompts, "Starting Payment date:" and "Ending Payment date:"

8. Enter the date range of payments to pull to report.

System prompts, "Claim Types:"

9. Use the drop-down box to select from the following options. Select **Primary** to print only Primary claims. Select **Secondary** to print only Secondary claims. Select **Both** to print both Primary and Secondary claims.

   System prompts, "Totals Only:"

10. If this field is selected the report will print only the Total lines from each report section. If unchecked it will print in Detail with the addition of a Totals page.

    System prompts, “Print:"

11. Select **Print** to begin the printing process.

Description and Usage

The Insurance Billing Time Analysis report provides the number of days between the Discharge date and the Medical Record finish date, the Admission date and the date the approval was sent, the Approval Sent date and the Approval Received date, the Discharge date and the date the claim was generated, the generation date and the date the claim was billed, the Billed date and the date payment was received, and the Discharge date and Payment Received date. The report will sub-total by financial class code, and give averages for each column.

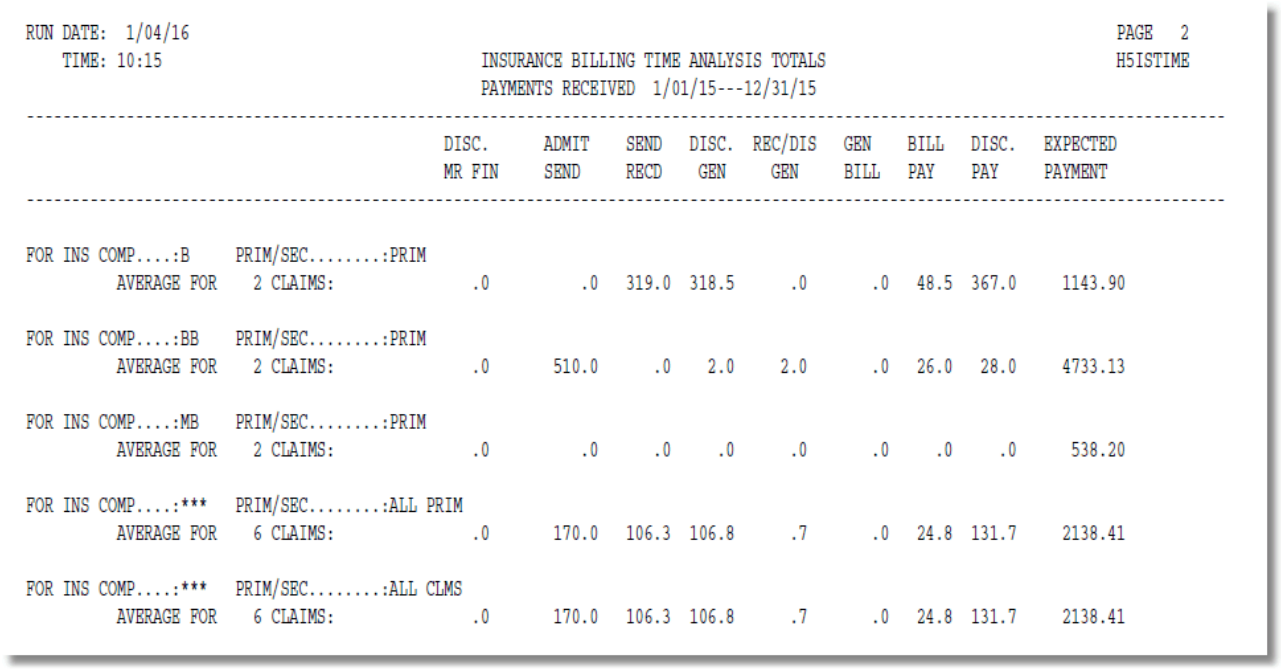
Insurance Billing Time Analysis

RUN DATE: 1/04/16 SORT-STR: Alpha-Ins-Serv Cd PAGE 1
TIME: 10:15 INSURANCE BILLING TIME ANALYSIS H5ISTIME
PAYMENTS RECEIVED 1/01/15---12/31/15

FOR ALPHA SPLIT: A TO Z PRIM/SEC: PRIMARY

PATIENT	NUMBER	SRV	CONTRACT#	DISC. MR FIN	ADMIT SEND	SEND RECD	DISC. GEN	REC/DIS GEN	GEN BILL	BILL PAY	DISC. PAY	EXPECTED PAYMENT
BEECH DAVIS SAND	357910 001MB	ER	A123456789	0	0	0	0	0	0	0	0	786.40
GILLESPIE JANE P	357885 001MB	R	A123456789	0	0	0	0	0	0	0	0	290.00
REED GRACE ELLEN	357843 001B	M	PPA12345648674	0	0	1	0	0	0	96	96	1748.40
SMITH ELLA KATHE	357351 001BB	M	PPL5454518744	0	1020	0	4	4	0	0	4	9127.47
WATZ LUCY ELLEN	357648 001BB	R	123456789	0	0	0	0	0	0	52	52	338.80
WILSON MARTIN E	357677 001B	M	123456789	0	0	637	637	0	0	1	638	539.40
AVERAGE FOR 6 CLAIMS:				.0	170.0	106.3	106.8	.7	.0	24.8	131.7	2138.41

Insurance Billing Time Analysis (Totals)



RUN DATE: 1/04/16 PAGE 2
TIME: 10:15 INSURANCE BILLING TIME ANALYSIS TOTALS H5ISTIME
PAYMENTS RECEIVED 1/01/15---12/31/15

	DISC. MR FIN	ADMIT SEND	SEND RECD	DISC. GEN	REC/DIS GEN	GEN BILL	BILL PAY	DISC. PAY	EXPECTED PAYMENT
FOR INS COMP....:B PRIM/SEC.....:PRIM									
AVERAGE FOR 2 CLAIMS:	.0	.0	319.0	318.5	.0	.0	48.5	367.0	1143.90
FOR INS COMP....:BB PRIM/SEC.....:PRIM									
AVERAGE FOR 2 CLAIMS:	.0	510.0	.0	2.0	2.0	.0	26.0	28.0	4733.13
FOR INS COMP....:MB PRIM/SEC.....:PRIM									
AVERAGE FOR 2 CLAIMS:	.0	.0	.0	.0	.0	.0	.0	.0	538.20
FOR INS COMP....:*** PRIM/SEC.....:ALL PRIM									
AVERAGE FOR 6 CLAIMS:	.0	170.0	106.3	106.8	.7	.0	24.8	131.7	2138.41
FOR INS COMP....:*** PRIM/SEC.....:ALL CLMS									
AVERAGE FOR 6 CLAIMS:	.0	170.0	106.3	106.8	.7	.0	24.8	131.7	2138.41

Listed below is an explanation of each column.

- **Insurance:** Pulls from Policy Information.
- **Patient:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Number:** Pulls the Patient Control Number from the Claims Status screen.
- **Subscriber:** Pulls the Subscriber Name from the Policy Information screen.
- **Srv (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Contract #:** Pulls from Policy Information.
- **Disc MR Fin:** This column is the number of days between the Discharge date and the Medical Record finish date.
- **Admit Sent:** This column is the number of days between the Admission Date and the date the approval was sent.
- **Send Recd:** This column is the number of days between the Approval Sent date and the Approval Received date.
- **Disc Gen:** This column is the number of days between the Discharge Date and date the claim was generated.

- **Rec/Dis Gen:** If the Approval has not been received before the Discharge date, then it is the number of days between the Approval Received date and the date of Generation. If Approval has been received then it is the number of days between the Discharge date and the date of generation.
- **Gen Bill:** This column is the number of days between the Generation date and the date the claim was billed.
- **Bill Pay:** This column is the number of days between the Billed date and Payment Received date.
- **Disc Pay:** This column is the number of days between the Discharge date and Payment Received date.
- **Expected Payment:** The expected pay amount pulls from the Detail Charges screen.

10.13 Insurance Adjustments To A/R

The Insurance Adjustments to A/R report offers the ability to make G/L entries to the Accounts Receivable and Contractual Adjustment accounts in order to reflect a more realistic A/R balance on financials. The report estimates the Contractual Adjustment for claims in the Billed but Unpaid status and may include claims in the Ready to Bill status. The Contractual Adjustment may be estimated in several ways depending on how the Contractual Method field on page 6 of the Insurance Company table and the Current P/D Rate, Contractual %, Contractual GL and Other AR GL# fields on page1 of the Insurance Company table are set.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Insurance Adjustments to A/R**.
4. Select a print option.

   System prompts, "Include claims that are at the ready to bill stage:"

5. Select this option to have the report include claims at the Ready to Bill status. Leave blank to omit claims at the Ready to Bill status from the report.

   System prompts, "Enter Insurance Companies (Blank for All):"

6. Enter up to 10 Financial class codes to print to the report. Enter **ALL** to run report for all financial classes.

   System prompts, "As of date:"

7. Select an "As of date." G/L Transactions may only be created if the last day of the month is used. This report will allow the system to be back-dated up to 31 days. It will also allow a future date to be entered up to seven days. This report will pull claims with a Billed date that is less than the as of date or a Paid date that is greater than the as of date.

   System prompts, “Generate:"

8. Select generate to start the process.

   System prompts, “Summarize by Discharge Month?:"

9. If this field is selected, the detail under each financial class will be sub-sorted by discharge date with a subtotal for every month with activity.

   System prompts, "Include inhouse accounts:"

10. If this field is selected, the system will include any accounts not yet discharged.

    System prompts, “Print:"

11. Select **Print** to begin the printing process.

    System prompts, "Do you want to generate G/L Entries?:"

12. If **Yes** is selected, the system creates journal entries for the A/R account and the Contractual Adjustment account on the last day of the month and creates reversing entries on the first day of the following month.

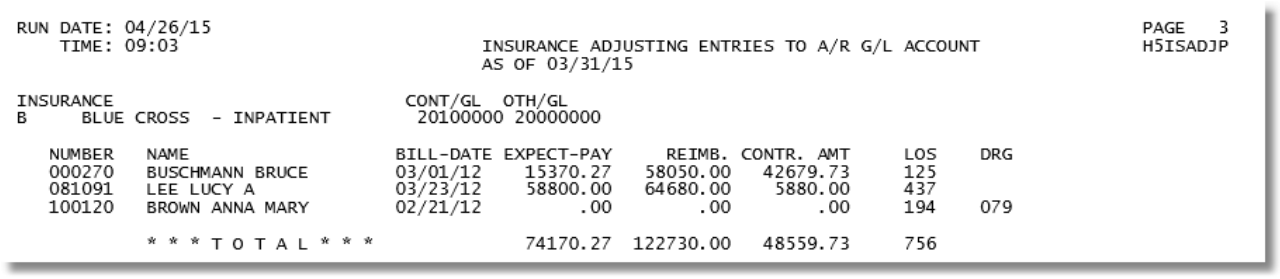
After creating the entries, it will be necessary to enter the GL system and post the transactions to permanent file. The edit list must be run from the same terminal that created the entries.

Description and Usage

The Insurance Adjustments to A/R report provides an alpha list by insurance company of all claims at the Billed and Ready to Bill (if included) status.

The report also gives the Contractual G/L and Other G/L numbers based on what is loaded on page 1 of the Insurance Company table. The Expected Pay, Reimbursement, Contractual amount, Length of Stay and DRG are reported, and the last page of the report gives a summarized break down by G/L number.

Insurance Adjustments To A/R



RUN DATE: 04/26/15
TIME: 09:03

INSURANCE ADJUSTING ENTRIES TO A/R G/L ACCOUNT
AS OF 03/31/15

PAGE 3
H5ISADJP

INSURANCE CONT/GL OTH/GL
B BLUE CROSS - INPATIENT 20100000 20000000

NUMBER	NAME	BILL-DATE	EXPECT-PAY	REIMB.	CONTR. AMT	LOS	DRG
000270	BUSCHMANN BRUCE	03/01/12	15370.27	58050.00	42679.73	125	
081091	LEE LUCY A	03/23/12	58800.00	64680.00	5880.00	437	
100120	BROWN ANNA MARY	02/21/12	.00	.00	.00	194	079
	* * * T O T A L * * *		74170.27	122730.00	48559.73	756	

Listed below is an explanation of each column.

- **Insurance:** Pulls from Policy Information.
- **Cont/GL (Contractual GL Number):** Pulls from the Contractual GL# field on page 1 of the Insurance Company table.
- **Oth/GL (Other GL Number):** Pulls from the Other AR GL# field on page 1 of the Insurance Company table.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Bill-Date:** Pulls from Insurance Claim Status screen. If the claim is at a Ready to Bill status the bill date will be the claim generation date.
- **Expect-Pay:** Pulls from the Detail Charges screen.
- **Reim (Reimbursement):** To determine the Reimbursement for this report, the system will look to the Contractual Method field on page 6 of the Insurance Company table. Enter **D** for Per Diem to have the Current P/D Rate field on page 1 of the Insurance Company table to be used to determine Reimbursement. Enter **P** for Percent Discount to use the Contractual % field on page 1 of the Insurance Company table. Enter **M** to use the Managed Care Plan table. For APC claims, Reimbursement and Contractual amounts will pull from the APC Detail screen of the claim. This field will default to **N**, which will use the following hierarchy:
  1. Current per diem (Insurance Company table, page 1, Current P/D Rate field).
  2. Contractual % (Insurance Company table, page 1 Contractual % field)-The Hospital will need to estimate the percentage it collects (not what is written off) from a particular insurance company. This percentage figure is entered in the Contractual % field on page 1 of the Insurance Company table and is multiplied by the Expected Pay to determine the Reimbursement.
  3. Computed DRG (Medical Records Grouper Screen)
  4. Claim's Expected Pay (Insurance Claim Status Screen)
- **Contr Amt (Contractual Adjustment Amount):** The difference between the Expected Pay and the Reimbursement will be the Contractual Adjustment.
- **LOS (Length of Stay):** This column shows the actual length of stay.
- **DRG:** The computed DRG pulls from the Medical Records Grouper screen.

The last page of this report will give a break down of what will be posted to the General Ledger. The system will list the General Ledger account number and description along with the amount to be debited or credited. The system will also provide a Total line. The Debit and Credit amount in this line should match.

10.14 Billed But Unpaid & A/R Balance = 0

The Billed but Unpaid & A/R Balance = 0 report is used by the Business Office to reduce the number of claims with a zero balance on the Billed but Unpaid report.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Billed But Unpaid & A/R Balance = 0**.
4. Select a print option.

   System prompts, "Update run"

5. If blank the system will print an edit report with all insurance claims with a zero A/R balance. Select this option for the system to stop on every claim with a zero A/R balance and prompt “Reject”.

   System prompts, "Exclude financial classes:"

6. Enter the financial classes to exclude from this report.
7. Select **Continue**.

   If the Update option is selected, the system will stop on every claim with a zero A/R balance. The system will prompt, "Yes, No or Reject All".

8. Selecting **Yes** will reject the current claim. **No** will not reject the claim. **Reject All** will reject the current claim and the remainder of claims to the end of the file.

Description and Usage

The Billed but Unpaid & A/R Balance = 0 report should first be run as an edit to determine which accounts to reject and then as an update to actually reject those selected accounts. This report should be run on a weekly basis prior to working the Billed but Unpaid report in order to keep that report as clean as possible.

The edit version is an alpha listing of accounts that have a claim at the pending or billed status with an A/R balance of zero. The update version is an alpha listing of accounts with a pending or billed claim that has been rejected. The report lists the patient account number, patient name, insurance, whether the claim is primary or secondary, the billed date and the expected pay amount.

Billed But Unpaid & A/R Balance = 0

RUN DATE 10/31/15 *UPDATE* PAGE 1
TIME 13:59 BILLED BUT UNPAID INSURANCE WITH ZERO A/R BALANCE H5ISUNPDZ

NUMBER	NAME	INS	PRIM	SRV	BILLED	EXPECTED PAY	
357227	BASS EARNEST T	CB	Y	O	8/06/15	80.00	REJECTED
356841	BLACKWELL CHARLES	BB	N	L	2/29/15	75.63	REJECTED
356866	BOURNE STEVE	MB	Y	E	2/29/15	163.00	REJECTED
356882	BOURNE STEVE	MB	Y	O	2/29/15	3005.00	
356874	BROWN JONATHON	BB	Y	O	2/29/15	200.51	REJECTED
357104	BRYARS CARLEEN	M	Y	M	7/09/15	191.00	
357168	EDMOND JACKIE	BB	Y	O	5/10/15	454.25	REJECTED
352221	GREEN JOE	B	Y	M	4/17/15	8263.00	
300328	GREEN BOB	BB	N	M	9/07/15	284.36	REJECTED
300940	GREEN MAXINE	B	3	S	4/16/15	7896.25	
313504	HAS ROSA M	MB	N	O	4/04/15	741.00	
357087	MILFORD FELICIA	BB	Y	E	9/07/15	25.00	REJECTED
357130	NICHOLAS SPARKS	BB	Y	E	1/24/15	82.36	
480164	OLSON LORAINE	BB	2	E	1/12/15	741.36	
480164	OLSON LORAINE	MB	Y	O	1/12/15	1236.52	
356867	ROBERTSON TOMMIE	BB	Y	O	2/29/15	635.00	
357002	REID THOMAS	MB	Y	O	8/06/15	852.25	
356881	ROGERS CHARLIE C	BB	Y	E	2/29/15	1452.63	

Listed below is an explanation of each column.

- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Ins (Insurance Code):** Pulls from Policy Information.
- **Prim (Primary Switch):** Pulls from Policy Information.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Billed:** Pulls from the Detail Charges screen.
- **Expected Pay:** Pulls from the Detail Charges screen.

10.15 Billed Claims By Date Range

The Billed Claims By Date Range report will pull claims with a billed date that is within the date range entered.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen.
2. Select **Insurance**.
3. Select **Billed Claims By Date Range**.
4. Select a print option.

   System prompts, "Enter beginning billed date:" and "Enter ending billed date:"

5. Enter the billing date range for the report.

   System prompts, "Include specific financial classes: (Blank for All)"

6. Enter up to 20 financial class codes or leave blank for the report to run for all financial classes. This field may be wildcarded.

   System prompts, "Exclude specific financial classes: (Blank for None)"

7. Enter up to 20 financial class codes to exclude from this report. This field may be wildcarded.

   System prompts, "Select claim type:"

8. Use the drop-down box to select **All**, **Electronic Claims**, **Paper** or **Unprinted**. If All is selected the report will page break by section with subtotals and a grand total at the end of the report.

   System prompts, "Select primary switch:"

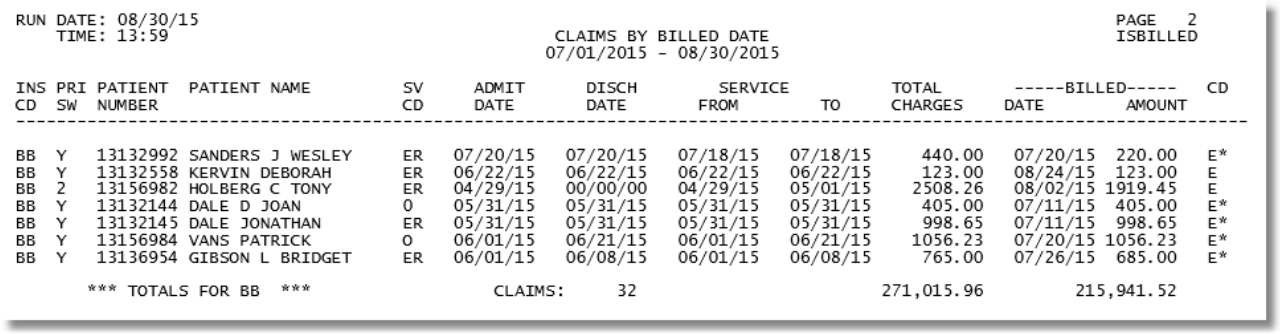
9. Use the drop-down box to select **Primary** to report only Primary claims, **Secondary** to report only Secondary claims, or **All** to report Primary and Secondary claims.

   System prompts, "Exclude Bill Types: (Blank for None)"

10. Enter up to 20 Bill Types to exclude from this report. This field may be wildcarded.
11. Select **Print**.

Description and Usage

Billed Claims By Date Range



RUN DATE: 08/30/15 TIME: 13:59 — PAGE 2 — ISBILLED

CLAIMS BY BILLED DATE
07/01/2015 - 08/30/2015

INS CD	PRI SW	PATIENT NUMBER	PATIENT NAME	SV CD	ADMIT DATE	DISCH DATE	SERVICE FROM	SERVICE TO	TOTAL CHARGES	BILLED DATE	BILLED AMOUNT	CD
BB	Y	13132992	SANDERS J WESLEY	ER	07/20/15	07/20/15	07/18/15	07/18/15	440.00	07/20/15	220.00	E*
BB	Y	13132558	KERVIN DEBORAH	ER	06/22/15	06/22/15	06/22/15	06/22/15	123.00	08/24/15	123.00	E
BB	2	13156982	HOLBERG C TONY	ER	04/29/15	00/00/00	04/29/15	05/01/15	2508.26	08/02/15	1919.45	E
BB	Y	13132144	DALE D JOAN	O	05/31/15	05/31/15	05/31/15	05/31/15	405.00	07/11/15	405.00	E*
BB	Y	13132145	DALE JONATHAN	ER	05/31/15	05/31/15	05/31/15	05/31/15	998.65	07/11/15	998.65	E*
BB	Y	13156984	VANS PATRICK	O	06/01/15	06/21/15	06/01/15	06/21/15	1056.23	07/20/15	1056.23	E*
BB	Y	13136954	GIBSON L BRIDGET	ER	06/01/15	06/08/15	06/01/15	06/08/15	765.00	07/26/15	685.00	E*
*** TOTALS FOR BB ***				CLAIMS: 32					271,015.96		215,941.52	

Listed below is an explanation of each column.

- **Ins Cd:** Pulls from Policy Information. This indicates whether the insurance is primary or secondary.
- **Pri Sw (Primary Switch):** Pulls a **Y** for Primary, **2** for Secondary or **3** for Tertiary.
- **Patient Number:** Pulls from the Registration and ADT screen.
- **Patient Name:** Pulls from the Patient tab on the Registration and ADT screen.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Admit Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Disc Date (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Service From/To:** Specifies the start and stop date the claim was generated, from the insurance claim status screen.
- **Tot-Charges:** This column lists the Total Charges on the Account Detail.
- **Billed Date:** The billed date of the claim.
- **Billed Amount:** For Billed claims, the Expected Pay amount pulls. For Paid or Rejected claims, the Total Charges amount pulls from the Detail Charges screen.
- **CD:**
  - This column should be an **E** if the Ready to Bill field on the Detail Charges screen is set to **Yes** or **No** and Elec. Bill is set to **Yes**. An asterisk (*****) will pull next to the E if there is an Electronic Billed Date.
  - A **P** indicates that the Ready to Bill field on the Detail Charges Screen is set to **Yes** and Elec. Bill is set to **No**.
  - A **U** if the Ready to Bill field on the Detail Charges Screen and Elec. Bill is set to **No**.

10.16 Claim Reimbursement Report

The Claim Reimbursement Report will give an estimated expected reimbursement by using totals from unbilled and/or unpaid claims. This report will break by financial class listing all accounts and totals for each.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen.
2. Select **Insurance**.
3. Select **Claim Reimbursement Report**.

   System prompts, "Claim Types:"

4. Select **Unbilled**, **Unpaid** or **Both**.

   System prompts, "Claim delimiter:"

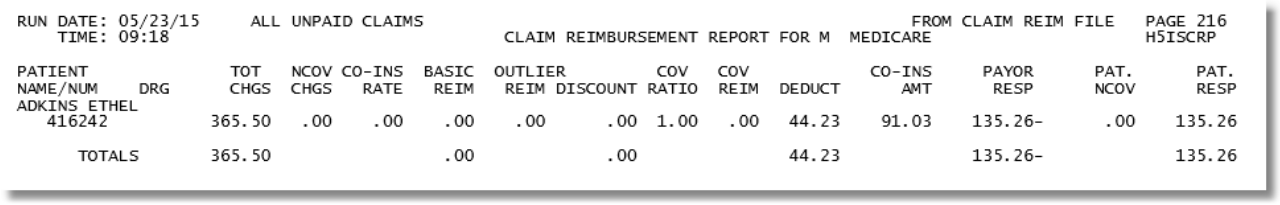
5. Select **All Payors**, **Selected Insurances** or **All Claims**.

   If the above prompt is answered **Selected Insurances**, the system will prompt, "Enter Insurance Companies, (Blank for All):"

6. Enter the desired financial class codes.
7. Select **Generate**.

Description and Usage

Claim Reimbursement Report



RUN DATE: 05/23/15 ALL UNPAID CLAIMS FROM CLAIM REIM FILE PAGE 216
TIME: 09:18 CLAIM REIMBURSEMENT REPORT FOR M MEDICARE H5ISCRP

PATIENT NAME/NUM	DRG	TOT CHGS	NCOV CHGS	CO-INS RATE	BASIC REIM	OUTLIER REIM	DISCOUNT	COV RATIO	COV REIM	DEDUCT	CO-INS AMT	PAYOR RESP	PAT. NCOV	PAT. RESP
ADKINS ETHEL 416242		365.50	.00	.00	.00	.00	.00	1.00	.00	44.23	91.03	135.26-	.00	135.26
TOTALS		365.50			.00		.00			44.23		135.26-		135.26

Listed below is an explanation of each column.

- **Patient Name/Num:** The patient's name pulls from the Patient tab on the Registration and ADT screen.
- **DRG:** The DRG pulls from Medical Records Grouper screen.
- **Tot Chgs (Total Charges):** This column lists the Total Charges on the insurance claim.
- **Ncov Chgs (Total Charges):** The non-covered charges pull from the Detail Charges screen.
- **Co-Ins Rate (Co-Insurance Rate):** Pulls from Detail Benefits screen.
- **Basic Reim (Basic Reimbursement):** This is the Payment Amount entered in receipting.
- **Outlier Reim Discount (Outlier Reimbursement Discount):** Pulls from AHIS page 5.
- **Cov Ratio (Covered Ratio):** This is the Covered Days in Detail Benefits.
- **Cov Reim (Covered Reimbursement:** This is the Payment Amount entered in receipting.
- **Deduct (Deductible):** The deductible amount pulls from the Detail Charges screen.
- **Co-Ins Amt (Co-Insurance Amount):** The copay amount pulls from the Detail Charges screen.
- **Payor Resp (Payor Responsibility):** This is the Payment Amount entered in receipting.
- **Pat. Ncov (Patient Non-Covered):** Pulls from the Detail Benefits screen.
- **Pat. Resp(Patient Responsibility):** Amount due from patient.

10.17 Create Claims By Charge Period

Create Claims by Charge Period is used by the Business Office to generate interim bills.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Create Claims by Charge Period**.
4. Select a print option.

   System prompts, "Begin Date:" and "End Date:"

5. Enter the date range for the report. If CCBCP Gen by Svs Dates field on page 1 of AHIS is set to **N** system will look at AR Date range instead of Service Date range.

   System prompts, "Starting Account Number (Blank for all):"

6. Enter a starting account number and the report will begin printing. Leave blank to have the report print for all accounts.

   System prompts, “Starting Insurance Company (Blank for all) (*H* for All Home Health):"

7. Enter a financial class code for which the report will run. Leave blank if report will run for all financial classes.

   System prompts, "Generate:"

8. Select this option to begin the printing process.

   System prompts, "Patient Types (Leave all blank for 2-5):"

9. Enter the stay types for which the report will run. Leave blank to pull stay types 2-5 to the report.

   System prompts, “Exclude F/C’s:"

10. If this prompt is selected, enter up to 5 F/C’S to exclude.

    System prompts, "Run As Update:"

11. Selecting this prompt will generate the claims to the Ready To Bill Status. If this box is not selected, an edit report will print with the claims that meet the criteria to generate to the Ready To Bill Status.

    System prompts, “Print:"

12. Select **Print** to begin the printing process.

    System prompts, "Do you wish to identify duplicate dates of service?:"

13. If this prompt is selected **Yes** the system will identify patients with the same Social Security Number during the same billing cycle.

Description and Usage

Create Claims by Charge Period is used for the interim claims for long term and/or recurring patients. This will generate claims for accounts without a discharge date and advance it to the Ready to Bill status, based on the above prompts.

TruBridge recommends that claims meet the following criteria when utilizing the Create Claims by Charge Period program:

- The patient Stay Type entered in the Patient tab on the Registration and ADT screen should be 2, 3, 4 or 5.
- The account should be assigned a cycle code of 5 or 6 in the Guarantor/Ins tab on the Registration and ADT screen.
- The account should not have a discharge date in the Stay tab on the Registration and ADT screen.
- The Financial Class should have a "B" in the second position to represent an Outpatient claim. TruBridge suggests the Financial Class code be three characters ending with "R", to represent a Recurring Financial Class, for example MBR, CBR, BBR.

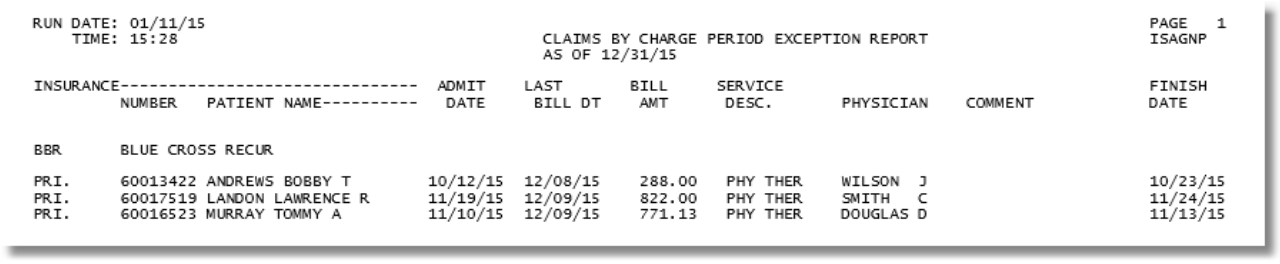
NOTE*: The above criteria will not determine if a claim falls into the Create Claims by Charge Period program.*

In addition to the recommended settings, the following criteria must be met in order for claims to fall into the Create Claims by Charge Period program:

- The account must have charges for the date range selected. The charge period is determined by the Service Date or the AR Date on the Account Detail. If the CCBCP Gen by SVS Dates field on page 1 of AHIS is set to **N**, the system will generate the insurance claim based on AR Date instead of Service Date. Please contact a TruBridge Software Representative before changing this option.
- Charges within the date range chosen will not pull to these claims if the charge is not covered by insurance. This is controlled in the Summary Code table.
- If a date is loaded in Date Care Ended, on the Detail Benefits screen, the Create Claims by Charge Period program will not create a claim for the account after that date.

The Exception Report follows the creating of claims and provides a list of patients that meet the above criteria but either the Medical Records Finish Date is not present on the account or the Medical Records Finish Date is not greater than the billed date of last months claim which causes no claim to be created. The report is numeric and page breaks by insurance company.

Exception Report



RUN DATE: 01/11/15
TIME: 15:28

CLAIMS BY CHARGE PERIOD EXCEPTION REPORT
AS OF 12/31/15

PAGE 1
ISAGNP

INSURANCE	NUMBER	PATIENT NAME	ADMIT DATE	LAST BILL DT	BILL AMT	SERVICE DESC.	PHYSICIAN	COMMENT	FINISH DATE
BBR		BLUE CROSS RECUR							
PRI.	60013422	ANDREWS BOBBY T	10/12/15	12/08/15	288.00	PHY THER	WILSON J		10/23/15
PRI.	60017519	LANDON LAWRENCE R	11/19/15	12/09/15	822.00	PHY THER	SMITH C		11/24/15
PRI.	60016523	MURRAY TOMMY A	11/10/15	12/09/15	771.13	PHY THER	DOUGLAS D		11/13/15

Listed below is an explanation of each column.

- **Ins (Insurance):** The insurance pulls from Policy Information. This indicates whether the insurance is primary or secondary.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Admit Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Last Bill Date:** Pulls from the Claims by Patient screen.
- **Bill Amt (Billed Amount):** The expected pay amount pulls from the Detail Charges screen.
- **Service Desc (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Physician:** The attending physician pulls from the Stay tab on the Registration and ADT screen.
- **Comment:** Pulls from the Claim Status screen.
- **Finish Date:** Pulls from the Medical Records Grouper screen.

10.18 Secondary Billing Report

The Secondary Billing Report is used by the Business Office to list accounts that have a secondary claim when the primary has been paid within the date range selected.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Secondary Billing Report**.
4. Select a print option.

System prompts, "Beginning Receipt Date:" and “Ending Receipt Date:"

5. Enter the receipt date range for the report.

   System prompts, “Print Paying Insurance Code?:"

6. If selected, the report will print the last paid insurance in the date range selected and print billed claims below. The report will print UB and 1500 claims on separate pages. If not selected, the report will print in the original format.

7. Select **Generate** to begin the printing process.

Description and Usage

The Secondary Billing Report is a list of accounts that had a claim paid during the date range entered with another claim on the insurance screen. The additional claim must have an expected pay amount equal to zero. The report is a numeric listing of the secondary accounts, which page breaks by the primary Financial Class. The last page of the report gives a recap by insurance company with the total number of claims and the total billed amount for each.

The Secondary Billing Report should be printed and worked daily. Secondary Billing may also be automated. For further information on this, see Tables Affecting Insurance.

Secondary Billing Report

RUN DATE: 03/29/15 PAGE 5
TIME: 08:58 INSURANCE SECONDARY BILLING REPORT ISSECBILP
CLAIMS PAID FROM: 03/01/15 THRU: 03/01/15

FINANCIAL CLASS: MB - MEDICARE OUTPATIENT

NUMBER	NAME	SRV	PRIM	INS	BILLED DATE	AMOUNT	CUR	30	60	90	SUBSCRIBER	CONTRACT#	AR BALANCE
400108	APPON JOHN	U	Y	MB		10.00					APPON JOHN	417424258A	10.00
401712	ACOFF VIVIAN	U	2	CB	110115	1102.00				X	ACOFF VIVIAN		1102.00
412702	MILLER EVAN	J	2	XB1	031315	290.00	X				MILLER GEORGE		954.00
400089	WILSON JANSON	E	Y	MB	031115	25.00	X				WILSON JANSON		100.00
414297	ATKINS JENNY S	E	2	XB		1761.61					ATKINS JENNY		1751.56
400509	CROSS FRANCIS	A	2	CB2	031815	20.00	X				CROSS FRANCIS		330.00
412599	SMITH JASON L	V	Y	BP	032515	96.50-	X				TETTON JAMES	1111122111	297.97
TOTALS	7												4545.53

RUN DATE: 03/29/15 EVIDENT COMMUNITY HOSPITAL PAGE 11
TIME: 08:58 INSURANCE SECONDARY BILLING REPORT ISSECBILP
CLAIMS PAID FROM: 03/01/15 THRU: 03/01/15

F/C	CLAIMS	A/R BALANCE
B	1	230.00
BB	13	7970.17
CBA	3	2953.75
DB1	1	1323.00
MB	9	205433.53
MBR	2	55.00
X	1	.00
X1	1	22.00
XB2	1	270.00
XTA	2	15.00
TOTAL	34	218272.45

Listed below is an explanation of each column.

- **Number (Account number):** Pulls from the Registration and ADT screen.
- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Primary (Primary Switch):** Pulls from Policy Information.
- **Ins (Insurance code):** Pulls from Policy Information.
- **Billed Date and Amount:** Pulls from of the Detail Charges screen.
- **Cur 30 60 90:** This column ages the claim from the billed date.
- **Subscriber:** Pulls from Policy Information.
- **Contract (Contract Number):** Pulls from Policy Information.
- **A/R Balance (Account Balance):** Pulls from the patient's Account Detail.

10.19 Insurance Company Name-Address Labels For Last Printed Claims

The Insurance Company Name/Address Labels For Last Printed Claims option prints labels to be used when mailing claims.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Insurance Company Name-Address Labels**.
4. Select a form version.
5. Select a print option.

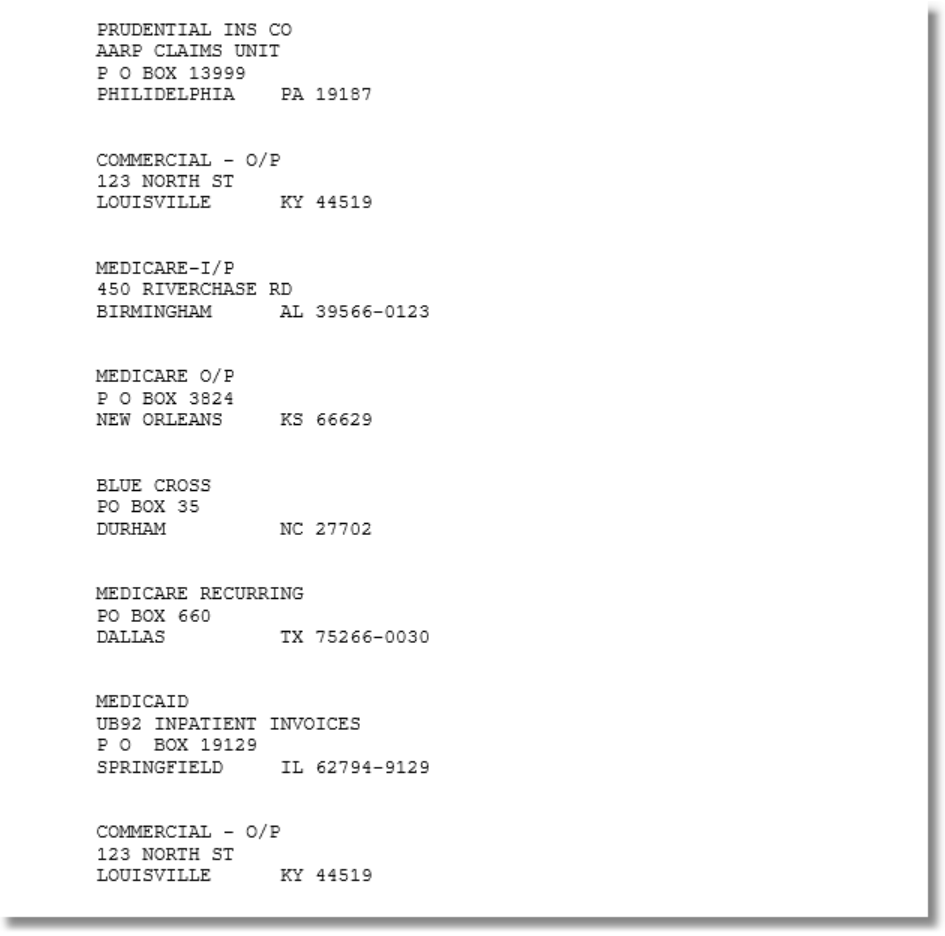
   System prompts, "Print Labels For Secondary Claims?"

6. Select this option to print labels for secondary claims. Leave blank if no labels are needed for secondary claims.
7. Select **Print** to begin the printing process.

Description and Usage

The Insurance Company Name/Address Labels For Last Printed Claims option prints labels to be used when mailing claims. The labels may be printed with the insurance company's name and address for claims that printed an insurance form in the last run printed. The address information pulls from the Insurance Company section of the claims' Policy Information screen.

Insurance Company Name/Address Labels



```
PRUDENTIAL INS CO
AARP CLAIMS UNIT
P O BOX 13999
PHILIDELPHIA    PA 19187


COMMERCIAL - O/P
123 NORTH ST
LOUISVILLE      KY 44519


MEDICARE-I/P
450 RIVERCHASE RD
BIRMINGHAM      AL 39566-0123


MEDICARE O/P
P O BOX 3824
NEW ORLEANS     KS 66629


BLUE CROSS
PO BOX 35
DURHAM          NC 27702


MEDICARE RECURRING
PO BOX 660
DALLAS          TX 75266-0030


MEDICAID
UB92 INPATIENT INVOICES
P O  BOX 19129
SPRINGFIELD     IL 62794-9129


COMMERCIAL - O/P
123 NORTH ST
LOUISVILLE      KY 44519
```

10.20 Locked/Unlocked MDS Records

The Locked/Unlocked MDS Records report looks at the RAI (Resident Assessment Instrument) application and determines if the MDS (Minimum Data Set) is locked or unlocked.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Locked/Unlocked MDS Records**.
4. Select a print option.

   System prompts, "Beginning Date:" and “Ending Date:"

5. Enter the date range for the report.

   System prompts, “Print."

6. Select **Print** to begin the printing process.

Description and Usage

The Locked/Unlocked MDS Records report is similar to the Claims with Missing Information report, only showing if the account is locked or unlocked.

The RAI application drives the reimbursement process, but the software application files the claims for reimbursement. This report allows the two departments to communicate effectively to facilitate accurate and timely submittal of data to the separate reporting entities.

Locked/Unlocked MDS Records

RUN DATE: 04/11/15
TIME: 15:41

ALL MDS RECORDS
FROM 09/01/15 TO 11/03/15

PAGE 1
H5ISLUMDS

NUMBER	PATIENT NAME----------	ADMIT DATE	DISC DATE	PHYSICIAN	MDS DATE	ASSESS REF DATE	MDS LOCK DATE	RUG CODE	TYPE OF ASSESSMENT
706254	HARMONY MARY	10/21/15	10/21/11	STONE	10/24/11	10/26/11		PA152	MEDICARE 30 DAY ASSESSMENT
700166	BAXTER CARLEEN	10/22/11	10/22/11	KENNEDY	10/25/11	10/27/11			
700450	STEVE EDWARDS	10/01/11	10/02/15		10/10/15	10/12/15			
700450	WILMINGTON KIMBERLY	10/01/15	10/02/15	DEX	10/10/15	10/12/15			
700460	JOHNSON CONNIE	10/19/15	10/20/15	SMITH	10/12/15	10/12/15			
700461	HAYES BILLY	10/22/15	10/22/15		11/03/15	11/05/15			
700516	PETER JENNIGNGS	11/01/15	11/03/15	JACKSON	11/18/15	11/18/15		RHB01	Medicare 5 day assessment

Listed below is an explanation of each column.

- **Number (Account Number):** Pulls from the Registration and ADT screen.

- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Admit Date:** Pulls from the Stay tab on the Registration and ADT screen.
- **Disc Date (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Physician:** The attending physician pulls from the Stay tab on the Registration and ADT screen.
- **MDS Date (Minimum Data Set):** Pulls from the RAI application.
- **Assess Ref Date (Assessment Reference Date):** Pulls from the RAI application.
- **MDS (Minimum Date Set):** The MDS Lock Date is the date this account was locked. This pulls from the RAI application.
- **Rug Code (Resource Utilization Groups):** The code that is calculated for the MDS and pulls from the RAI application. This code is used when billing insurance.
- **Type of Assessment:** Pulls from the RAI application.

10.21 Secondary Billing Auto Reverse

The Secondary Billing Auto Reverse is used to automatically reverse the secondary claim once a payment has been made on the primary claim.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance Reports**.
3. Select **Secondary Billing Auto Reverse**.
4. Select a print option.

   System prompts, "Beginning Receipt Date:" and “Ending Receipt Date:"

5. Enter the receipt date range for the report.
6. Select **Print** to begin the printing process.

   System prompts, “Print EOB’s?:"

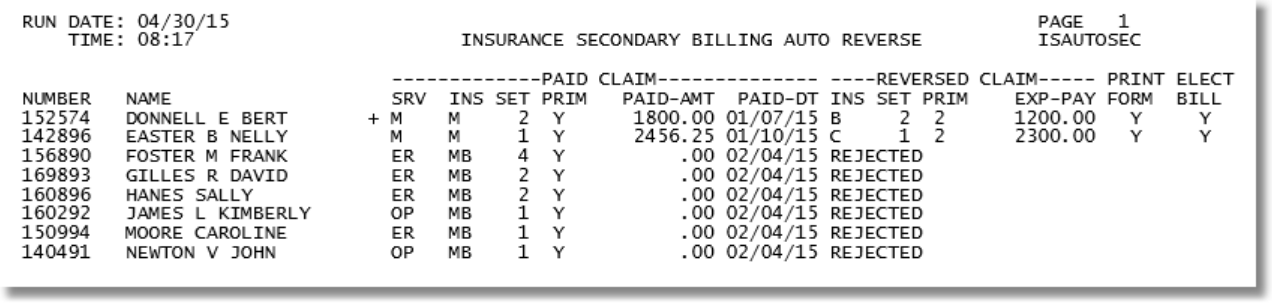
7. Select **Yes** to have the system print all EOB’s posted during the date range entered in the same order that UB’s print (Insurance Company table, page 6, Keep EOB information field must be set to **Y**).

Description and Usage

The Secondary Billing Auto Reverse report provides an automated means of billing secondary claims when the primary insurance has paid. When printing the report, the system searches through all paid claims with a payment type of “F” Paid in Full or “A” Apply to Deductible in the selected date range. The secondary claim will be reversed to the Ready to Bill status with an expected pay equal to the sum of the deductible, co-pay, coinsurance and non-covered amounts from the claim that was paid. The report will also denote if the reversed claim is marked as electronically billed. This will need to be set up for auto reversal in the Insurance Company table.

This report will also print an Exceptions Report of claims that did not auto reverse. The first section will provide a list of accounts that have claims that have not been reversed because the secondary claim's new calculated expected pay would equal zero. This would be in the case of a recurring account where the primary insurance paid for that date of service in full. The second section will provide a list of accounts that have claims that were not auto reversed for any other reason other than a calculated zero expect pay. This report should be reviewed to make sure that secondary claims are billed for the correct expected pay or manually rejected.

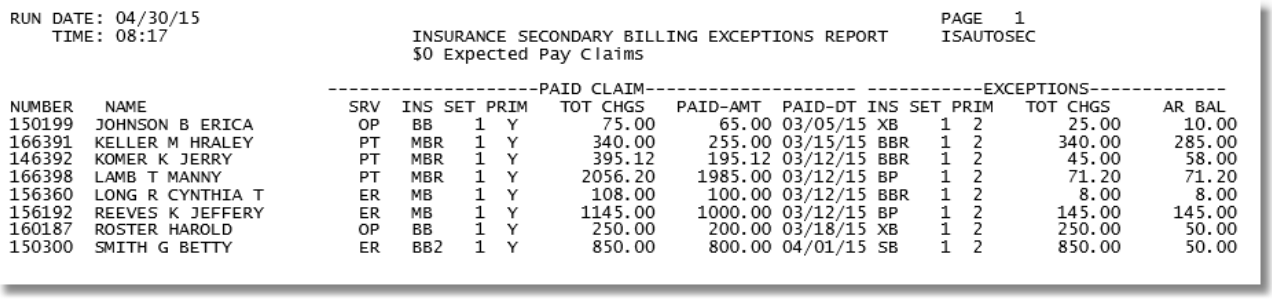
Secondary Billing Auto Reverse



RUN DATE: 04/30/15 TIME: 08:17 — INSURANCE SECONDARY BILLING AUTO REVERSE — PAGE 1 ISAUTOSEC

NUMBER	NAME		PAID CLAIM SRV	INS	SET	PRIM	PAID-AMT	PAID-DT	REVERSED CLAIM INS	SET	PRIM	EXP-PAY	PRINT FORM	ELECT BILL
152574	DONNELL E BERT	+	M	M	2	Y	1800.00	01/07/15	B	2	2	1200.00	Y	Y
142896	EASTER B NELLY		M	M	1	Y	2456.25	01/10/15	C	1	2	2300.00	Y	Y
156890	FOSTER M FRANK		ER	MB	4	Y	.00	02/04/15	REJECTED					
169893	GILLES R DAVID		ER	MB	2	Y	.00	02/04/15	REJECTED					
160896	HANES SALLY		ER	MB	2	Y	.00	02/04/15	REJECTED					
160292	JAMES L KIMBERLY		OP	MB	1	Y	.00	02/04/15	REJECTED					
150994	MOORE CAROLINE		ER	MB	1	Y	.00	02/04/15	REJECTED					
140491	NEWTON V JOHN		OP	MB	1	Y	.00	02/04/15	REJECTED					

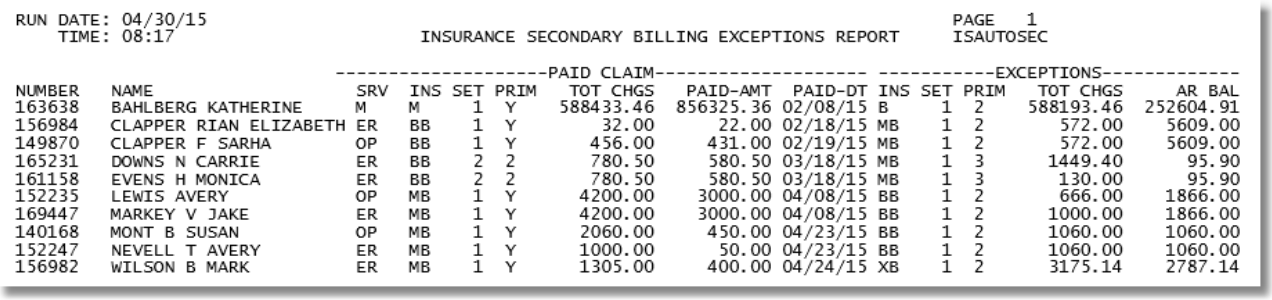
Secondary Billing Auto Reverse (Zero Expect Pay)



RUN DATE: 04/30/15 TIME: 08:17 — INSURANCE SECONDARY BILLING EXCEPTIONS REPORT — $0 Expected Pay Claims — PAGE 1 ISAUTOSEC

NUMBER	NAME	PAID CLAIM SRV	INS	SET	PRIM	TOT CHGS	PAID-AMT	PAID-DT	EXCEPTIONS INS	SET	PRIM	TOT CHGS	AR BAL
150199	JOHNSON B ERICA	OP	BB	1	Y	75.00	65.00	03/05/15	XB	1	2	25.00	10.00
166391	KELLER M HRALEY	PT	MBR	1	Y	340.00	255.00	03/15/15	BBR	1	2	340.00	285.00
146392	KOMER K JERRY	PT	MBR	1	Y	395.12	195.12	03/12/15	BBR	1	2	45.00	58.00
166398	LAMB T MANNY	PT	MBR	1	Y	2056.20	1985.00	03/12/15	BP	1	2	71.20	71.20
156360	LONG R CYNTHIA T	ER	MB	1	Y	108.00	100.00	03/12/15	BBR	1	2	8.00	8.00
156192	REEVES K JEFFERY	ER	MB	1	Y	1145.00	1000.00	03/12/15	BP	1	2	145.00	145.00
160187	ROSTER HAROLD	OP	BB	1	Y	250.00	200.00	03/18/15	XB	1	2	250.00	50.00
150300	SMITH G BETTY	ER	BB2	1	Y	850.00	800.00	04/01/15	SB	1	2	850.00	50.00

Secondary Billing Auto Reverse (Exceptions)



RUN DATE: 04/30/15 TIME: 08:17 — INSURANCE SECONDARY BILLING EXCEPTIONS REPORT — PAGE 1 ISAUTOSEC

NUMBER	NAME	PAID CLAIM SRV	INS	SET	PRIM	TOT CHGS	PAID-AMT	PAID-DT	EXCEPTIONS INS	SET	PRIM	TOT CHGS	AR BAL
163638	BAHLBERG KATHERINE	M	M	1	Y	588433.46	856325.36	02/08/15	B	1	2	588193.46	252604.91
156984	CLAPPER RIAN ELIZABETH	ER	BB	1	Y	32.00	22.00	02/18/15	MB	1	2	572.00	5609.00
149870	CLAPPER F SARHA	OP	BB	1	Y	456.00	431.00	02/19/15	MB	1	2	572.00	5609.00
165231	DOWNS N CARRIE	ER	BB	2	2	780.50	580.50	03/18/15	MB	1	3	1449.40	95.90
161158	EVENS H MONICA	ER	BB	2	2	780.50	580.50	03/18/15	MB	1	3	130.00	95.90
152235	LEWIS AVERY	OP	MB	1	Y	4200.00	3000.00	04/08/15	BB	1	2	666.00	1866.00
169447	MARKEY V JAKE	ER	MB	1	Y	4200.00	3000.00	04/08/15	BB	1	2	1000.00	1866.00
140168	MONT B SUSAN	OP	MB	1	Y	2060.00	450.00	04/23/15	BB	1	2	1060.00	1060.00
152247	NEVELL T AVERY	ER	MB	1	Y	1000.00	50.00	04/23/15	BB	1	2	1060.00	1060.00
156982	WILSON B MARK	ER	MB	1	Y	1305.00	400.00	04/24/15	XB	1	2	3175.14	2787.14

Listed below is an explanation of each column.

- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Ins (Insurance Code):** Pulls from Policy Information.

- **Set:** Refers to which claim has been paid. The system assigns a set number for each primary claim on the account. If there are more than one insurance claims with the same Financial Class code, the system will assign a set number of 1, 2, etc.
- **Prim (Primary Switch):** Pulls from the Policy Information screen on the paid claim.
- **Paid Amt (Paid Amount):** The actual payment of the claim. This includes the Reimbursement and the Contractual amount of the claim.
- **Paid Dt (Paid Date):** The date the claim was paid.
- **Ins (Insurance Code):** This column lists the insurance code of the claim that is reversed for secondary billing.
- **Set:** Refers to which claim has been reversed. The system assigns a set number for each secondary claim on the account. If there are more than one insurance claims with the same Financial Class code, the system will assign a set number of 1, 2, etc.
- **Prim (Primary Switch):** The primary switch of the reversed claim pulls from the Policy Information screen.
- **Exp-Pay (Expected Pay):** The sum of the deductible, co-pay, coinsurance, and non-covered amounts from the claim that was receipted. This is the new expected pay of the secondary claim.
- **Print Form:** The print form field of the reversed claim pulls from the Detail Charges screen. Depending on how Automated Sec Billing field of the Insurance Company table is set, the system will either select the Print Form field or leave it blank when the claim is reversed.
- **Elect Bill:** The Elect. Bill field of the reversed claims pulls from the Detail Charges screen. Depending on how Automated Sec Billing field of the Insurance Company table is set, the system will either select the Elect. Bill field or leave it blank when the claim is reversed.

10.22 APC Claims To Ready to Bill

The APC Claims to Ready-to-Bill report should be run daily as part of the Insurance daily procedures. This option moves APC claims with a Medical Record Verified Date at the Unchecked Status to the Ready to Bill Status.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **APC Claims to Ready-to-Bill**.

Description and Usage

The APC Claims to Ready-To-Bill report moves APC claims with a Medical Record Verified Date at the Unchecked Status to the Ready to Bill Status. This report should be run daily and will list each APC claim that was moved to the Ready to Bill Status.

APC Claims To Ready-To-Bill

RUN DATE: 11/22/15 PAGE 1
TIME: 10:25 Insurance -- Move APC Claims to Ready-To-Bill ISAPCRTB

INS	NAME	NUMBER	FROM	THRU	VERIFIED	TOT-CHARGES	EXPECT-PAY
MB	ARDOYNO SALLY	701668	11/11/15	11/11/15	11/22/15	269.75	269.75
MB	ARNOLD BRENT	701071	10/18/15	10/18/15	11/22/15	419.26	419.26
MB	BASSINGER TINA	701230	11/06/15	11/06/15	11/21/15	125.05	125.05
MB	CASEY RHONDA	701640	11/18/15	11/18/15	11/21/15	62.50	62.50
MB	GARDNER FRANCIS	701216	11/17/15	11/18/15	11/21/15	4278.75	4278.75
MB	HANCOCK CHANDLER R	701468	11/02/15	11/02/15	11/22/15	568.02	568.02
MB	MARINO JASON	701251	11/03/15	11/03/15	11/21/15	92.75	92.75
MB	SANFORD MARTIN M	701291	11/18/15	11/18/15	11/21/15	62.50	62.50
MB	SHAPIRO JESSICA M	701746	11/15/15	11/15/15	11/22/15	110.00	110.00
MB	TAYLOR MARIA S	701238	11/18/15	11/18/15	11/21/15	623.02	623.02
MB	TRAVIS CYNTHIA	701402	11/20/15	11/20/15	11/22/15	87.23	87.23
MB	UNDERWOOD DALE W	701611	11/16/15	11/16/15	11/22/15	1201.01	1201.01
MB	VICKERS TERESA A	701213	11/07/15	11/07/15	11/21/15	824.78	824.78
MB	WALKER TONYA	701260	11/19/15	11/19/15	11/22/15	3208.56	3208.56
MB	WILLIAMS BRENDA N	701281	11/14/15	11/14/15	11/21/15	77.00	77.00
MB	WILLIAMS RONALD JR	701327	11/16/15	11/16/15	11/22/15	231.50	231.50
	TOTAL CLAIMS 16					12241.68	12241.68

Listed below is an explanation of each column.

- **Ins (Insurance Code):** This column lists the Financial Class code of the APC claim.
- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen.

- **From:** The Service From date is the beginning date of service for the claim and pulls from the Insurance Claim Status screen.
- **Thru:** The Service Thru date is the end date of service for the claim and pulls from the Insurance Claim Status screen.
- **Verified:** The Medical Records Verified Date pulls from the Medical Records Insurance Modifier Maintenance screen.
- **Tot-Charges:** This column lists the Total Charges on the insurance claim.
- **Expect-Pay:** This column lists the Expected Pay on the insurance claim.

10.23 Unbilled Insurance Report

The Unbilled Insurance report provides a complete listing of all insurance claims that have not been billed.

NOTE: *This report is also available in the Report Writer format on the Report Dashboard. Please refer to the* *Unbilled Insurance Report - Report Writer* 267 *topic in the Report Dashboard section of this user guide.*

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Unbilled Insurance Report**.
4. Select a print option.

   System prompts "Sort By:"

5. Select a sort option. The options include:

a Alpha-Serv Cd-Ins	**e** Ins-Alpha-ServCd
b Alpha-Ins-Serv Cd	**f** Ins-Serv Cd-Alpha
c Serv Cd-Alpha-Ins	**g** Status-Alpha-Serv Cd
d Serv Cd-Ins-Alpha	**h** Reason Cd-Alpha-Ins

   System prompts, “Enter stay types (Blank for ALL):"

6. Up to five Stay Types may be entered or all Stay Types may be reported by leaving this option blank.

   System prompts, “Enter service codes (Blank for ALL):"

7. Up to ten service codes may be entered or all may be reported by leaving this option blank.

   System prompts, “Include blank codes?:"

8. If selected, accounts without service codes will pull to the report. If blank, accounts without service codes will not print on the report.

   System prompts, “Primary, Secondary or Both:"

9. Use the drop-down box to select **P** to report only Primary claims, **S** to report only Secondary claims or **B** to report Primary and Secondary claims.

   System prompts, “Report Type:"

10. Use the drop-down box to select **Details** or **Totals**. If Totals is selected, a 1-page summary of the number of accounts, total charges, total balances and expected pay for the specified accounts will print. If Details is selected, detailed information will print for each patient number followed by a Grand Totals page.

11. Select **Generate** to begin the printing process.

Description and Usage

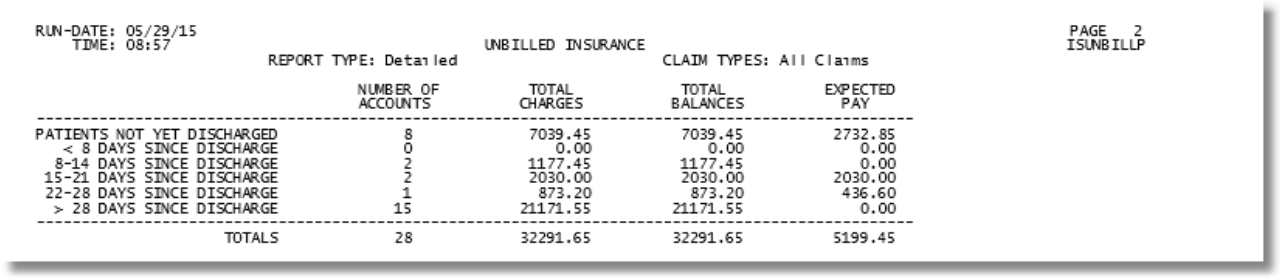
The Unbilled Insurance report provides a listing of all insurance claims that have not been billed. It will pull a reason code for not being billed as well as the comment listed on the Insurance Claim Status screen.

Unbilled Insurance Report

RUN-DATE: 05/29/15 PAGE 1
TIME: 08:57 UNBILLED INSURANCE ISUNBILLP
REPORT TYPE: Detailed CLAIM TYPES: All Claims

PATIENT NAME	ACCT #	ADMIT DT	DISCH DT	TOTAL CHGS	ACCT BAL	INS	EXPECT PAY	CLAIM STATUS	STAY	LOS	SVC	REASON
ADAMS RANDY	414391	05/14/15	CURR ACC	900.40	900.40	B	0.00	UNAPPROVED	1	15		D
ALLEN PATRICK K	357987	05/18/15	05/18/15	303.35	303.35	MB	303.35	UNCHECKED	2	1	M	U
COMMENTS:(APC CLAIM)		(APC)										
BARNES HEATHER	414090	04/10/15	04/10/15	814.55	814.55	MB	739.55	UNCHECKED	2	1		U
COMMENTS:(APC CLAIM)												
BAUGHMAN GREGORY F	322373	03/27/15	03/27/15	280.50	280.50	BB	280.50	UNCHECKED	3	1	M	U
EDLUND MELVIN	413989	03/01/15	03/01/15	344.60	344.60	MB	166.45	UNCHECKED	2	1		U
COMMENTS:(APC CLAIM)												
FLANDERS OLAN	123123	05/01/15	CURR ACC	39.00	39.00	M	0.00	UNAPPROVED	1	28		D
FRANKLIN RONALD M	414138	05/03/15	CURR ACC	9863.75	9863.75	M	0.00	UNAPPROVED	1	26		D
FREEMAN NICHOLAS R	463022	04/04/15	04/04/15	831.00	831.00	XB	831.00	UNCHECKED	2	1		U
HALLMAN MICHAEL	414107	05/10/15	05/10/15	1015.00	1015.00	MB1	1015.00	READY TO BILL	3	1	7	R
COMMENTS:(APC CLAIM)												
HALLMAN STEPHEN	414115	05/10/15	05/10/15	1015.00	1015.00	MB2	1015.00	READY TO BILL	3	1	7	R
COMMENTS:(APC CLAIM)												
HALLMAN TERRY	414108	03/31/15	04/01/15	411.00	411.00	MB1	220.00	UNCHECKED	3	1	7	U
COMMENTS:(APC CLAIM)												
JONES JIM	414457	05/22/15	CURR ACC	230.00	230.00	S	0.00	UNAPPROVED	1	7		D
MAURIN CATHERINE M	414048	03/28/15	03/30/15	8.25	8.25	B	0.00	UNAPPROVED	1	2		I
PARKER GARRY	413854	02/19/15	02/19/15	30.00	30.00	BB	30.00	UNCHECKED	2	1		U
PHILLIPS CAMMIE	654987	05/03/15	CURR ACC	4953.00	4953.00	B	0.00	UNAPPROVED	1	26		D
RAHWAY LYDIA	414087	04/11/15	04/11/15	162.00	162.00	MB	162.00	UNCHECKED	2	1		U
COMMENTS:(APC CLAIM)												
RUSTAND FELECIA	413906	02/28/15	CURR ACC	764.00	764.00	B	0.00	UNAPPROVED	1	90		D
SMILEY RICKY	414454	05/21/15	CURR ACC	39.00	39.00	C8	0.00	UNAPPROVED	1	8		D
SMITH JOHN	413806	02/10/15	02/11/15	1055.00	1055.00	B	0.00	UNAPPROVED	1	1		I
SMITH JOHN	413806	02/10/15	02/11/15	1055.00	1055.00	C6	0.00	APPROVED	1	1		M
SMITH MARY	357709	01/12/15	01/16/15	809.60	809.60	C	0.00	UNAPPROVED	1	4		I
SMITH MARY	357709	01/12/15	01/16/15	809.60	809.60	W	0.00	UNAPPROVED	1	4		I
SMITH PATRICIA	414229	04/26/15	05/04/15	1177.45	1177.45	M	0.00	UNAPPROVED	1	8		I
SMITH ROBERT	413752	04/19/15	04/19/15	125.00	125.00	CB3	0.00	APPROVED	2	1		M
THOMAS ELIZABETH M	357950	05/21/15	05/21/15	436.60	436.60	BB	416.60	READY TO BILL	2	1	E	R
THOMAS ELIZABETH M	357950	05/21/15	05/21/15	436.60	436.60	BP	20.00	READY TO BILL	2	1	E	R
WILLOWS CATHERINE M	413896	05/03/15	CURR ACC	4382.40	4382.40	C1	0.00	UNAPPROVED	1	26		D

Unbilled Insurance Report (Totals)



RUN-DATE: 05/29/15 TIME: 08:57 — UNBILLED INSURANCE — PAGE 2 ISUNBILLP

REPORT TYPE: Detailed — CLAIM TYPES: All Claims

	NUMBER OF ACCOUNTS	TOTAL CHARGES	TOTAL BALANCES	EXPECTED PAY
PATIENTS NOT YET DISCHARGED	8	7039.45	7039.45	2732.85
< 8 DAYS SINCE DISCHARGE	0	0.00	0.00	0.00
8-14 DAYS SINCE DISCHARGE	2	1177.45	1177.45	0.00
15-21 DAYS SINCE DISCHARGE	2	2030.00	2030.00	2030.00
22-28 DAYS SINCE DISCHARGE	1	873.20	873.20	436.60
> 28 DAYS SINCE DISCHARGE	15	21171.55	21171.55	0.00
TOTALS	28	32291.65	32291.65	5199.45

Listed below is an explanation of each column.

- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Admit Dt (Admit Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Disch Dt (Discharge Date):** Pulls from the Stay tab on the Registration and ADT screen.
- **Total Chgs (Total Charges):** The total amount charged to the patient account.
- **Acct Bal (Account Balance):** Pulls from the Patient Account Detail screen.
- **Ins (Insurance Code):** This column lists the Insurance code of the claim that is set up in the Insurance Claims by Patient screen but is not at a Billed, Paid or Rejected status.
- **Expect Pay (Expected Pay):** Pulls from the Detail Charge screen for that claim.
- **Claim Status:** Pulls from the Insurance Claims by Patient screen.
- **Stay (Patient Stay Type):** Pulls from the Patient tab on the Registration and ADT screen.
- **LOS (Length of Stay):** Is calculated as Discharge Date minus Admit Date. If the patient has not been discharged, it is calculated as Run-Date minus Admit Date.
- **Serv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Reason:** The Reason Code is determined by the system. The codes are as follows:
  - **A** Patient has not been admitted
  - **D** Patient has not been discharged
  - **G** Insurance has not been generated
  - **I** Insurance has not been verified (Policy Information “Received” is blank
  - **M** Medical Records has not coded or verified the account
  - **R** Claim is Ready to Bill
  - **U** Claim is Unchecked
  - **P** Claim is Pending
- **Comments:** Comments pull from the Insurance Claim Status screen.

- **Totals:** Totals are based on the number of days between discharge date and the date of the report.
- **Number of Accounts:** The total number of accounts reported.
- **Total Charges:** The total amount of the Total Charges column.
- **Total Balances:** The total amount of the Account Balance column.
- **Expected Pay:** The total amount of the Expected Pay column.

10.24 Crossover Forms Auto Reverse

For states that must submit state-specific forms for Medicaid claims that are crossing over from Medicare this report will be utilized.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Crossover Forms Auto Reverse Report**.
4. Select a print option.

   System prompts, “Beginning Receipt Date:"

5. Enter the receipt date to begin printing the report.

   System prompts, “Minimum days since receipt: will include payments before MMDDYY:"

6. A number of days can be entered or return will pull zero days. The date payments will be included before will display.

   System prompts, “Receipted insurance code: Blank for all, wildcarding Ok:"

7. Leave blank for all financial classes or up to 5 financial classes may be entered, using wildcarding if necessary.

   System prompts, “Crossover insurance code: Blank for all, wildcarding Ok:"

8. Leave blank for all financial classes or up to 5 financial classes may be entered, using wildcarding if necessary.

   System prompts, “Run type:"

9. Use the drop-down box to select “Print only” or “Update”. “Print only” will print a list of paid claims, the claims that will be reversed, and if the crossover form will print. Entering “Update” will reverse the claims.

System prompts, “Print:"

10. Select **Print** to begin the printing process.

Description and Usage

This report will print a list of receipted primary claims in the range specified and will check all other claims on the accounts to see if one or more has Auto Crossover selected with a Billed Date older than the minimum days. If the report is run as an “Update”, the secondary crossover claims will be reversed, set to Ready to Bill, the Expected Pay updated and the Print Crossover field in Detail Charges selected. Only financial classes with Auto Crossover = **Y** on page 6 of the Insurance Company table set will actually be reversed, even when wildcarding is used.

Once the report has been run as an update, the claims are ready to be moved to the Billed status by printing the state-specific crossover forms through the Custom Reports Menu.

This report should be run daily to ensure the billing is current.

Crossover Forms Auto Reverse

TIME: 15:29 INSURANCE CROSSOVER FORM AUTO REVERSE RUN TYPE: PRINT ONLY ISAUTOX

NUMBER	NAME	INS	SET	PRIM	PAID-AMT	PAID-DT	INS	SET	PRIM	EXP-PAY	FORM
		----------PAID CLAIM----------					----REVERSED CLAIM------				PRINT
329868	HODGE LILLIE J	MB	1	Y	.00	01/02/15	REJECTED				
329610	RESTER HAROLD M	MB	1	Y	.00	01/10/15	REJECTED				
300167	O'CAIN SHANELL	MB	1	Y	.00	01/15/15	REJECTED				
331562	PARKER DON G	MB	1	Y	.00	01/15/15	REJECTED				
300071	BRYAN JATAVIOUS	MB	1	Y	.00	01/15/15	REJECTED				
332379	PHILLIPS KEITH	MB	1	Y	.00	01/18/15	REJECTED				
331581	BURTON ROBERT	MB	1	Y	.00	01/21/15	REJECTED				
330718	COOPER CRESSIE D	MB	1	Y	.00	01/22/15	REJECTED				
330916	TIMMS STEPHEN M	MB	1	Y	.00	01/22/15	REJECTED				
330901	SPIVEY VONDA	MB	1	Y	.00	01/22/15	REJECTED				
330750	RUSTAND HANNAH L	MB	1	Y	.00	01/22/15	REJECTED				
331189	MATHER ROSANNA	MB	2	Y	.00	01/24/15	REJECTED				
300182	THARNISH ADAM	MB	1	Y	.00	01/24/15	REJECTED				
332360	DOMNING BRENDA	MB	1	Y	.00	01/25/15	REJECTED				
332400	DOMNING BRENDA	MB	1	Y	.00	01/25/15	REJECTED				
330784	BEDFORD FRANCES A	MB	1	Y	.00	01/28/15	REJECTED				
300037	SUMMERLIN THERESA	MB	1	Y	.00	01/29/15	REJECTED				
330862	SUMMERLIN THERESA	MB	1	Y	.00	01/29/15	REJECTED				
330666	CORBETT JEFFERSON G	MB	1	Y	.00	01/30/15	REJECTED				
331603	COPELAND LORI	MB	1	Y	.00	01/30/15	REJECTED				
331655	ADAMS WAUTINE	MB	1	Y	.00	02/05/15	REJECTED				
300158	WILLIAMNS SAMUEL T	MB	1	Y	.00	02/06/15	REJECTED				
331150	BAGWELL JESSICA R	MB	1	Y	.00	02/06/15	REJECTED				
332378	LAMB JOEY	MB	1	Y	.00	02/06/15	REJECTED				
331319	BRINKMAN JOHN G	MB	1	Y	.00	02/11/15	REJECTED				
330566	STORER JOHN	MB	1	Y	.00	02/13/15	REJECTED				
330535	BRADLEY CAROLYN N	MB	1	Y	.00	02/13/15	REJECTED				
332008	MARKS JESSICA	MB	1	Y	.00	02/14/15	REJECTED				
331710	BRINSON DIANE W	MB	1	Y	.00	02/14/15	REJECTED				
330976	FRANKS SHIRLEY	MB	1	Y	.00	02/14/15	REJECTED				
331853	GIBSON PATRICIA	MB	1	Y	.00	02/18/15	REJECTED				
328939	MALONE BESSIE R	MB	1	Y	.00	02/19/15	REJECTED				
331251	MALONE BESSIE R	MB	1	Y	.00	02/19/15	REJECTED				
331590	STEPP WILLIAM	MB	1	Y	.00	02/22/15	REJECTED				
U32415	STEPP WILLIAM	MB	1	Y	.00	02/22/15	REJECTED				
300374	O'LEARY LILLIE A	MB	1	Y	.00	02/26/15	REJECTED				
331601	BARNES SHARON F	MB	1	Y	.00	02/26/15	REJECTED				
331809	RICHARDSON DIANE B	MB	1	Y	.00	02/27/15	REJECTED				
332014	RICHARDSON DIANE B	MB	1	Y	.00	02/27/15	REJECTED				
332168	RICHARDSON DIANE B	MB	1	Y	.00	02/27/15	REJECTED				
332240	COREY JANICE	MB	1	Y	.00	02/27/15	REJECTED				
331728	SIMMONS KEVIN	MB	1	Y	.00	02/27/15	REJECTED				
330260	NELSON LANA	MB	1	Y	.00	02/28/15	REJECTED				
U32443	FRANSEN JOEY	MB	1	Y	.00	03/01/15	REJECTED				
U32314	RIKARD LLOYD	MB	1	Y	.00	03/05/15	REJECTED				
M40016	COLE DENISE	MB	1	Y	.00	03/05/15	REJECTED				
331585	WILSON BARBARA	MB	1	Y	.00	03/08/15	REJECTED				
332115	DUKES CALVIN	MB	1	Y	.00	03/08/15	REJECTED				
U32435	ELLIOT JOEY	MB	1	Y	.00	03/11/15	REJECTED				
332050	MOCK ELIA	MB	1	Y	.00	03/11/15	REJECTED				

Listed below is an explanation of each column.

- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Ins (Insurance Code):** The Financial Class code of the claim that was paid.
- **Set:** This field represents the sequence number of a particular financial class on a patient account. If there are multiple claims with the same financial class on the account, then the set number will indicate which of these claims was paid on.
- **Primary:** Pulls from the Policy Information screen.
- **Paid Amount/Date:** These fields pull from the Claim Reimbursement Information screen.

- **Ins (Insurance Code):** The Financial Class code of the claim that was auto reversed.
- **Set:** This field represents the sequence number of a particular financial class on a patient account. If there are multiple claims with the same financial class on the account, then the set number will indicate which of these claims was reversed.
- **Primary:** This field pulls from the Policy Information screen.
- **Expected Pay:** This field pulls from the Detail Charges screen.
- **Print Form:** This field pulls from the Detail Charges screen.

NOTE: *The "Run Type" is reflected in the upper right of the header of the report.*

10.25 Insurance Reimbursement Analysis

The Insurance Reimbursement Analysis Report is an optional report developed to provide reimbursement information on claims setup on patient accounts. This report will retain data for up to 365 days. If this report is used routinely, it is recommended that it be Spooled on a monthly basis and moved to ADR (permanent storage) in the Report Image System.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen.

2. Select **Insurance**.

3. Select **Ins. Reimbursement Analysis**.

4. Select a print option.

   System prompts, “Discharge Date Range:"

5. Enter the desired range of patient discharge dates.

   System prompts, “Print Payor Detail:"

6. If selected, the report will detail each patient’s reimbursement information, as well as sub-totaling each financial class and grand totaling all financial classes. If this prompt is left blank, the report will print in a summarized format listing totals by financial class and the number of claims that contributed to that total. The report will give grand totals.

   System prompts, “Payor: (Wildcard = *)"

7. Enter the desired financial class to pull to the report. Note the wildcard option (*) may be used. The system defaults to blank, which will pull reimbursement information for all financial classes during the date range selected.

   System prompts, “Include Secondaries:"

8. Selecting this option includes secondary financial classes on the report only if “Read AR for Charges” is answered “N”.

   System prompts, “Include Pd/UnPd/Both:"

9. Use the drop-down box to select “Paid”, “Unpaid” or “Both”. The system defaults to pull both paid and unpaid claims. To include only paid claims, select “Paid”. To include only unpaid claims, respond “Unpaid."

   System prompts, “Include Rejected:"

10. Selecting this option includes rejected claims on the report. Leaving it blank will omit rejected claims from the report.

    System prompts, “Read AR for Charges? Include Adj:"

11. If this field is selected the Total Charges figure that prints on the report will pull from the patient's Account Detail. If this field is blank, the Total Charges figure will pull from field Expected Pay of the patient's Detail Charges screen for that claim. If secondary claims are included on the report, this prompt should be blank. If "Include Adj." is selected, adjustment charges will pull to the total charges figure that prints on the report.

    System prompts "Read AR for Receipts:"

12. Selecting this option indicates the Insurance Receipts, Contractual, Reimbursement, Co-Pay, Coinsurance and Deductible figures will pull from the patient's Account Detail. If this field is blank, those figures will pull from Receipt Information from the Insurance Claim Status screen. The Receipt Information screen can retain receipt information of up to 3 payments per claim. Therefore, if a site frequently receives more than 3 payments per claim for certain financial classes, then this field should be selected so it will read all receipt information from the Account Detail.

    System Prompts, "Print:"

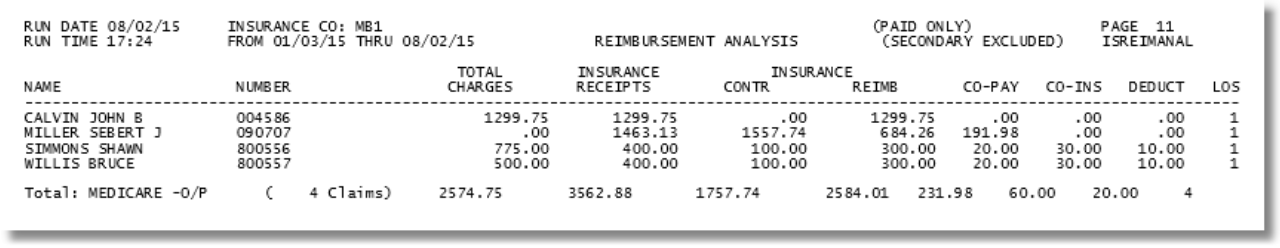
13. Select **Print** to begin the printing process.

Description and Usage

The Insurance Reimbursement Analysis Report shows patient name and account number, total charges, insurance receipts and contractual adjustments, as well as co-pay, co-insurance and deductible information. The report breaks by financial class.

This report may be utilized by the Business Office to compare estimated vs. actual reimbursement for the selected payor. Thus it is a "true-cash" report illustrating what actual dollar amount affected A/R.

Insurance Reimbursement Analysis



RUN DATE 08/02/15 INSURANCE CO: MB1 (PAID ONLY) PAGE 11
RUN TIME 17:24 FROM 01/03/15 THRU 08/02/15 REIMBURSEMENT ANALYSIS (SECONDARY EXCLUDED) ISREIMANAL

NAME	NUMBER	TOTAL CHARGES	INSURANCE RECEIPTS	INSURANCE CONTR	INSURANCE REIMB	CO-PAY	CO-INS	DEDUCT	LOS
CALVIN JOHN B	004586	1299.75	1299.75	.00	1299.75	.00	.00	.00	1
MILLER SEBERT J	090707	.00	1463.13	1557.74	684.26	191.98	.00	.00	1
SIMMONS SHAWN	800556	775.00	400.00	100.00	300.00	20.00	30.00	10.00	1
WILLIS BRUCE	800557	500.00	400.00	100.00	300.00	20.00	30.00	10.00	1
Total: MEDICARE -O/P	(4 Claims)	2574.75	3562.88	1757.74	2584.01	231.98	60.00	20.00	4

Listed below is an explanation of each column.

- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen.

- **Total Charges:** If "Read AR for Charges" was selected when building the report, the Total Charges figure pulls from the patient's Account Detail. If that field was left blank, then the Total Charges figure pulls from "Expected Pay" of the patient's Detail Charges screen.

- **Insurance Receipts:** If "Read AR for Receipts" was selected when building the report, then the Insurance Receipts figure pulls from the patient's Account Detail. If that field was left blank, then the Insurance Receipts figure pulls from Receipt Information from the Insurance Claim Status screen.

- **Insurance Contr/Reimb:** If "Read AR for Receipts" was selected when building the report, then the Insurance Contractual and Reimbursement figures pull from the patient's Account Detail. If that field was left blank, then the Insurance Contractual and Reimbursement figures pull from Receipt Information from the Insurance Claim Status screen.

NOTE: *If Net Reimbursement is set to* ***N*** *(ICT p2), the report will pull the last reimbursement amount of payment. If the field is set to* ***Y*** *(as is the default), the report will pull all reimbursement amounts to the INSURANCE REIMB column.*

- **Co-Pay:** If "Read AR for Receipts" was selected when building the report, then the Co-Pay figure pulls from the patient's Account Detail. If that field was left blank, then the Co-Pay figure pulls from Receipt Information from the Insurance Claim Status screen.

- **Co-Ins:** If "Read AR for Receipts" was selected when building the report, then the Co-Pay figure pulls from the patient's Account Detail. If that field was left blank, then the Co-Pay figure pulls from Receipt Information from the Insurance Claim Status screen.

- **Deduct:** If "Read AR for Receipts" was selected when building the report, then the Deductible figure pulls from the patient's Account Detail. If that field was left blank, then the Deductible figure pulls from Receipt Information from the Insurance Claim Status screen.

- **Los:** Patient's length of stay reported in days.

10.26 Reject $0 claims

The Reject $0 claims report is used to reduce the number of claims with a zero dollar charge amount, eliminating unnecessary claims in the billing process.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen.

2. Select **Insurance**.

3. Select **Reject $0 Claims**.

4. Select a print option.

   System prompts, "Update run"

5. If blank the system will print an edit report with all insurance claims with a zero dollar charge amount.

6. Select **Continue**.

7. If the Update option is selected, the system will stop on every claim with a zero dollar charge amount. The system will prompt, "Yes, No or Reject All $0 Claims".

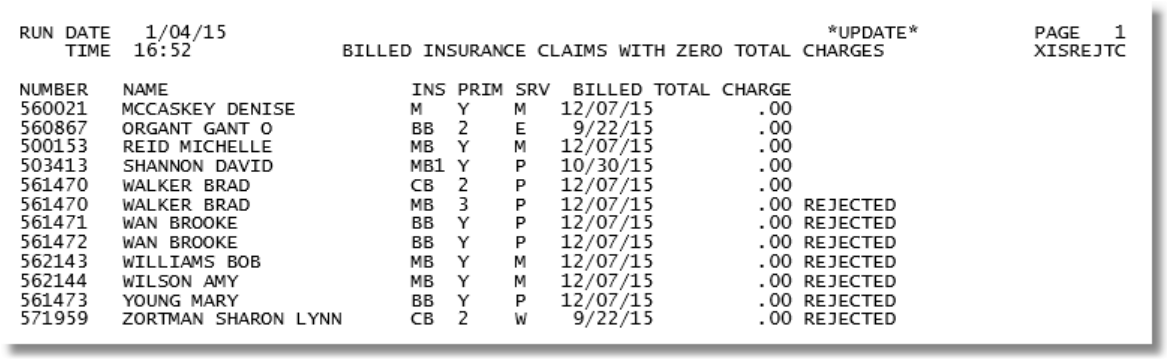
8. Selecting **Yes** will reject the current claim. **No** will not reject the claim. **Reject All $0 Claims** will reject the current claim and the remainder of claims to the end of the file.

Description and Usage

The Reject $0 claims report should first be run as an edit to determine which claims to reject then as an update to actually reject those selected claims. This report should be run as often as needed to clean up unnecessary claims.

The edit version is an alpha listing of accounts that have a claim at the billed status with a a zero dollar charge amount. The update version is an alpha listing of accounts with a billed claim that has been rejected or is still outstanding, dependent upon how prompts were answered. The report lists the patient account number, patient name, insurance, whether the claim is primary or secondary, service code, the billed date and the total charge amount.

Reject $0 claims



RUN DATE 1/04/15 *UPDATE* PAGE 1
TIME 16:52 BILLED INSURANCE CLAIMS WITH ZERO TOTAL CHARGES XISREJTC

NUMBER	NAME	INS	PRIM	SRV	BILLED	TOTAL CHARGE	
560021	MCCASKEY DENISE	M	Y	M	12/07/15	.00	
560867	ORGANT GANT O	BB	2	E	9/22/15	.00	
500153	REID MICHELLE	MB	Y	M	12/07/15	.00	
503413	SHANNON DAVID	MB1	Y	P	10/30/15	.00	
561470	WALKER BRAD	CB	2	P	12/07/15	.00	
561470	WALKER BRAD	MB	3	P	12/07/15	.00	REJECTED
561471	WAN BROOKE	BB	Y	P	12/07/15	.00	REJECTED
561472	WAN BROOKE	BB	Y	P	12/07/15	.00	REJECTED
562143	WILLIAMS BOB	MB	Y	M	12/07/15	.00	REJECTED
562144	WILSON AMY	MB	Y	M	12/07/15	.00	REJECTED
561473	YOUNG MARY	BB	Y	P	12/07/15	.00	REJECTED
571959	ZORTMAN SHARON LYNN	CB	2	W	9/22/15	.00	REJECTED

Listed below is an explanation of each column.

- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Name (Patient Name):** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Ins (Insurance Code):** Pulls from Policy Information.
- **Prim (Primary Switch):** Pulls from Policy Information.
- **Srv (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Billed:** Pulls from the Detail Charges screen.
- **Total Charges:** Pulls from the Detail Charges screen.

10.27 Pending Claims

The Pending Claims report lists all Insurance claims at the Pending status.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection Screen

2. Select **Insurance**

3. Select **Pending Claims**

System prompts, “Facility:"

4. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

System prompts, "As of Date:"

5. Use the drop-down box to select a date, or choose Manual Selection to enter a date manually. This date is used to determine the aging of the insurance claim.

System prompts, “Primary Switch:"

6. Select **Primary** to print only Primary claims. Select **Secondary** to print only Secondary claims. Leave blank or select **Both** to print the Primary and Secondary claims.

System prompts, "Expected Pay Range:"

7. Enter the range of dollar amounts for the Expected Pay the report will print or leave blank for all claims with an Expected Pay to print to the report.

System prompts, "Insurance Code:"

8. Enter the desired financial class. Use ***** to wildcard insurance companies or leave blank to print for all financial classes.

System prompts, "Service:"

9. Enter the desired Service Code. Leave blank to print all Service Codes.

System prompts, "Claim Type:"

10. Select **Electronic** to print claims at the Pending status that have the Elect box selected in the Detail Charges screen. Select **Unprinted** to print claims at the Pending status that have both the Elect and Print box unselected in Detail Charges screen. Select **All** to print both Electronic and Unprinted claims.

System prompts “Aging Selection:"

11. Use the drop-down box to select one of the following options or leave blank to print all aging selections:
    Current
    Over 30
    Over 60
    Over 90

    System prompts, “Sections to Exclude"

12. Select one or more of the following desired sections to exclude or leave blank to print all:
    Exclude Insurance Summary
    Exclude Grand Totals

    System prompts, “Level of Detail:"

13. Use the drop-down box to select one of the following options:
    Detail
    Summary
    Report Summary Only

    System prompts, "Include Cover Sheet"

14. Select this option to include a Cover Sheet with the report.

    System prompts, "Safe Mode:"

15. Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a **?**. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.

    System prompts, “Output Format:"

16. Use the drop-down box to select one of the following report Format options:
    HTML
    PDF
    XML
    CSV
    MAPLIST

    System prompts, “Run Report"

17. Select **Run Report** to display the report in the selected output format.

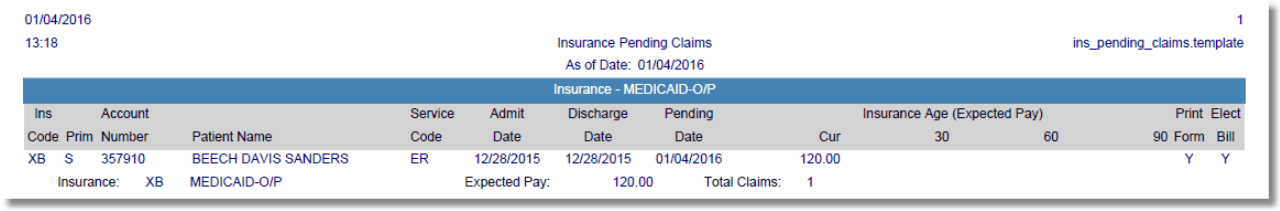
Description and Usage

The Pending Claims report provides a listing by insurance of all Pending insurance claims. Financial Classes that do not have any pending claims or claims that do not meet the report's criteria are excluded. The report lists insurance code, primary switch, patient account number, patient name, service code, admit date, discharge date, pending date, aging selections, print form and elect bill.

The aging selections are Current, Over 30, Over 60 and Over 90 days. The last page of the report lists the Insurance Summary with an aging breakdown of total dollars for each insurance company in each aging column followed by a breakdown of total expected pay for each insurance company.

The Report Writer application allows the user to filter, sort and manipulate this report to customize the data extracted out of the system. See the additional documentation on Report Writer for more information on these options.

Pending Claims



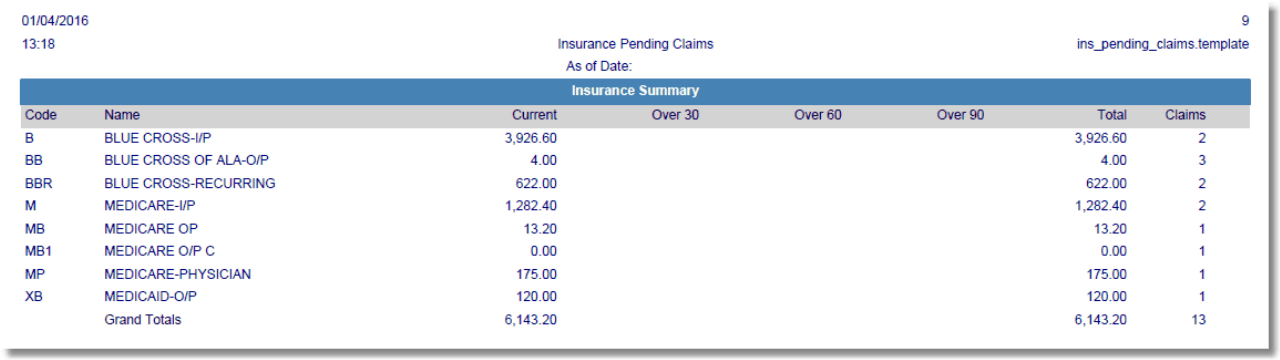
01/04/2016 1
13:18 Insurance Pending Claims ins_pending_claims.template
As of Date: 01/04/2016

Insurance - MEDICAID-O/P

Ins Code	Prim	Account Number	Patient Name	Service Code	Admit Date	Discharge Date	Pending Date	Insurance Age (Expected Pay) Cur	30	60	90	Print Form	Elect Bill
XB	S	357910	BEECH DAVIS SANDERS	ER	12/28/2015	12/28/2015	01/04/2016	120.00				Y	Y

Insurance: XB MEDICAID-O/P Expected Pay: 120.00 Total Claims: 1

Pending Claims (Grand Totals)



01/04/2016 9
13:18 Insurance Pending Claims ins_pending_claims.template
As of Date:

Insurance Summary

Code	Name	Current	Over 30	Over 60	Over 90	Total	Claims
B	BLUE CROSS-I/P	3,926.60				3,926.60	2
BB	BLUE CROSS OF ALA-O/P	4.00				4.00	3
BBR	BLUE CROSS-RECURRING	622.00				622.00	2
M	MEDICARE-I/P	1,282.40				1,282.40	2
MB	MEDICARE OP	13.20				13.20	1
MB1	MEDICARE O/P C	0.00				0.00	1
MP	MEDICARE-PHYSICIAN	175.00				175.00	1
XB	MEDICAID-O/P	120.00				120.00	1
	Grand Totals	6,143.20				6,143.20	13

- **Ins Code (Insurance Code)**: Pulls financial class code of the claim in Pending status from Policy Information screen
- **Prim (Primary Switch)**: Indicates whether this is the Primary or Secondary claim, pulls from Policy Information screen
- **Account Number**: Pulls the patient's account number from the Registration and ADT screen

- **Patient Name**: Pulls the patient's name from the Full Name field in the Patient tab on the Registration and ADT screen
- **Service Code**: Pulls the patient's service code from the Patient tab on the Registration and ADT screen
- **Admit Date**: Pulls the patient's admit date from the Stay tab on the Registration and ADT screen
- **Discharge Date**: Pulls the patient's discharge date from the Stay tab on the Registration and ADT screen
- **Pending Date**: Date the claim was moved to Pending status, pulls from Detail Charges screen
- **Cur (Current)**: The Expected Pay pulls to this column if the pending date is less than 30 days old.
- **30**: The Expected Pay pulls to this column if the pending date is over 30 but less than 60 days old.
- **60**: The Expected Pay pulls to this column if the pending date is over 60 but less than 90 days old.
- **90**:The Expected Pay pulls to this column if the pending date is over 90 days old.
- **Print Form**: A **Y** pulls to this column if the Print Form box is selected in the Detail Charges screen.
- **Elect Bill**: A **Y** pulls to this column if the Elect Bill box is selected in the Detail Charges screen.

10.28 Journals

A file build will need to be performed prior to printing journals. Once the file build has been completed select how the journal will be sorted. The journals may be sorted by paid date, patient name or if neither is selected the journal will sort by patient account number. Refer to Insurance Journals 161 for more information.

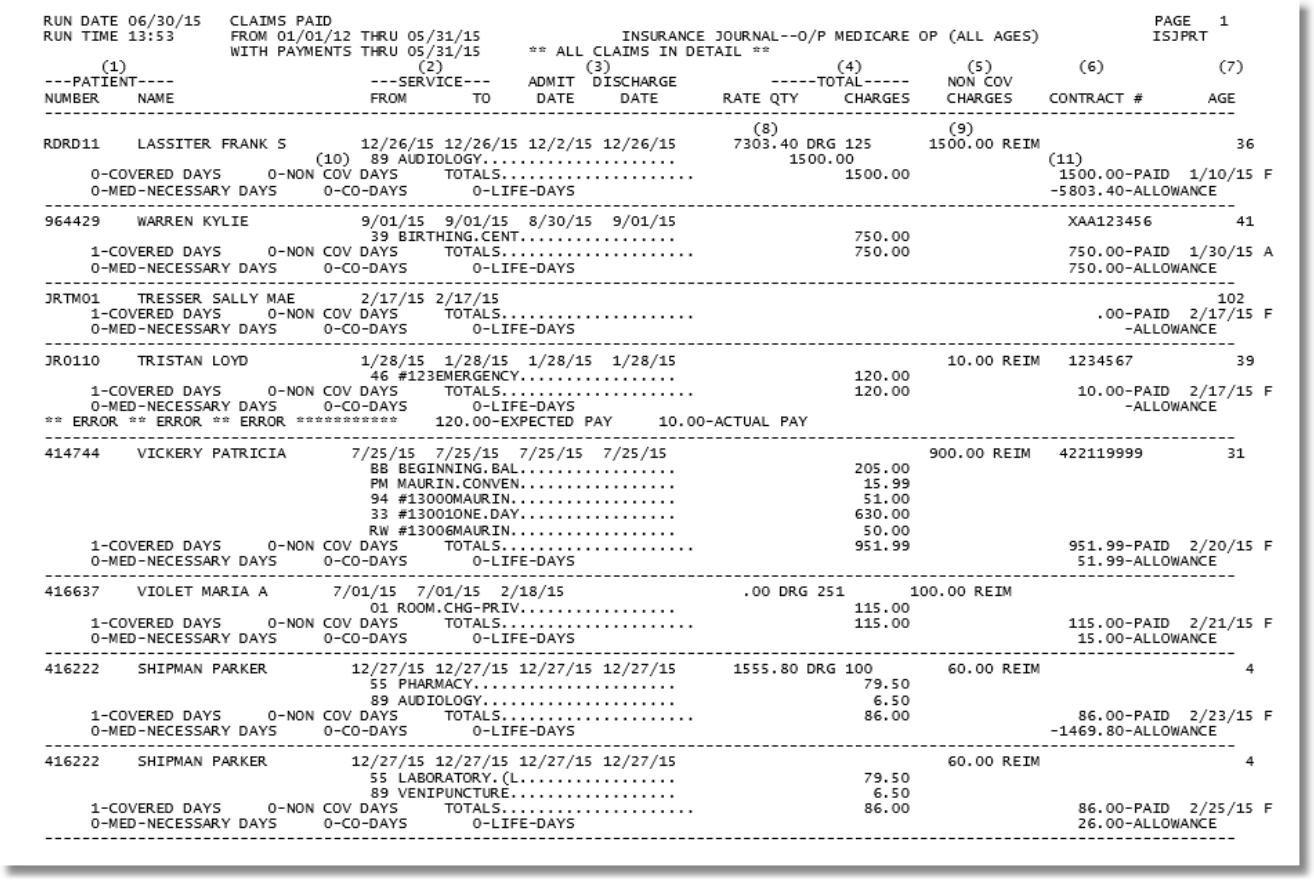
How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print Journal**.

Description and Usage

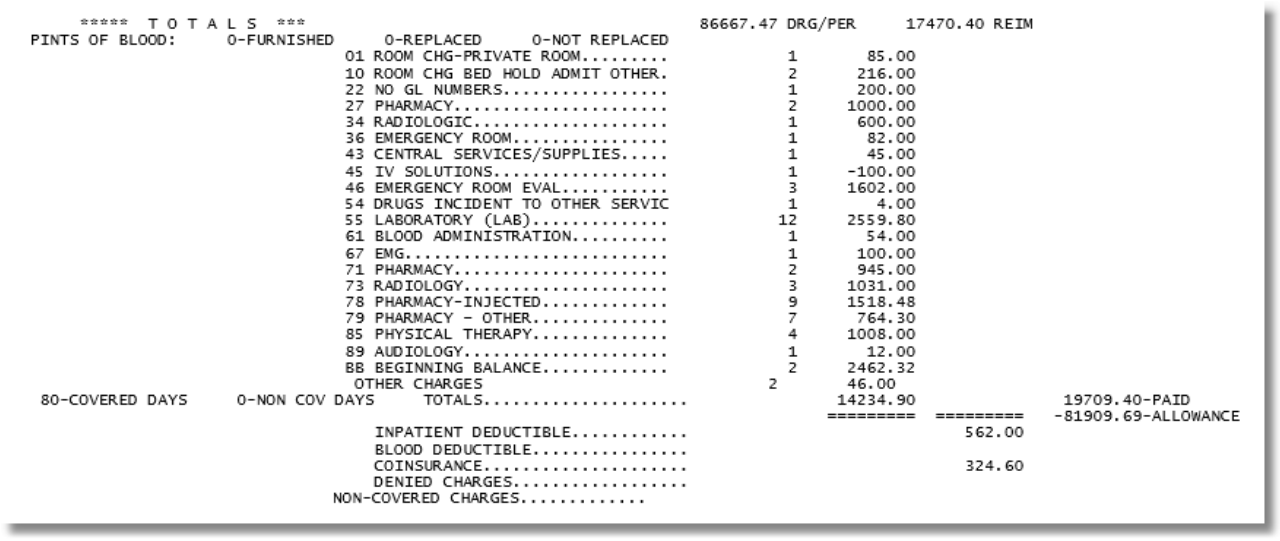
Insurance Journals may be kept on any Financial Class desired. These journals are used to store information about specific Financial Class claims for audit and internal survey purposes. A more detailed description of the journals may be found in Printed Reports.

Journals



```
RUN DATE 06/30/15   CLAIMS PAID                                                                                    PAGE   1
RUN TIME 13:53      FROM 01/01/12 THRU 05/31/15          INSURANCE JOURNAL--O/P MEDICARE OP (ALL AGES)             ISJPRT
                    WITH PAYMENTS THRU 05/31/15    ** ALL CLAIMS IN DETAIL **
      (1)                          (2)                (3)                    (4)          (5)          (6)          (7)
---PATIENT----                      ---SERVICE---    ADMIT  DISCHARGE          -----TOTAL-----    NON COV
NUMBER    NAME                      FROM       TO    DATE     DATE       RATE QTY     CHARGES    CHARGES    CONTRACT #       AGE
-------------------------------------------------------------------------------------------------------------------------------
                                                                                (8)                (9)
RDRD11    LASSITER FRANK S        12/26/15 12/26/15 12/2/15 12/26/15      7303.40 DRG 125      1500.00 REIM                    36
                        (10)  89 AUDIOLOGY.....................          1500.00                          (11)
     0-COVERED DAYS     0-NON COV DAYS     TOTALS.....................          1500.00                1500.00-PAID  1/10/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                              -5803.40-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
964429    WARREN KYLIE            9/01/15  9/01/15  8/30/15  9/01/15                                        XAA123456         41
                                   39 BIRTHING.CENT.................                  750.00
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                  750.00                750.00-PAID  1/30/15 A
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                    750.00-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
JRTM01    TRESSER SALLY MAE       2/17/15 2/17/15                                                                          102
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                                          .00-PAID  2/17/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                      -ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
JR0110    TRISTAN LOYD            1/28/15  1/28/15  1/28/15  1/28/15                          10.00 REIM   1234567           39
                                   46 #123EMERGENCY.................                  120.00
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                  120.00                 10.00-PAID  2/17/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                        -ALLOWANCE
** ERROR ** ERROR ** ERROR **********    120.00-EXPECTED PAY     10.00-ACTUAL PAY
-------------------------------------------------------------------------------------------------------------------------------
414744    VICKERY PATRICIA       7/25/15  7/25/15  7/25/15  7/25/15                          900.00 REIM   422119999         31
                                   BB BEGINNING.BAL.................                  205.00
                                   PM MAURIN.CONVEN.................                   15.99
                                   94 #13000MAURIN..................                   51.00
                                   33 #13001ONE.DAY.................                  630.00
                                   RW #13006MAURIN..................                   50.00
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                  951.99                 951.99-PAID  2/20/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                      51.99-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
416637    VIOLET MARIA A          7/01/15  7/01/15  2/18/15                .00 DRG 251       100.00 REIM
                                   01 ROOM.CHG-PRIV.................                  115.00
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                  115.00                 115.00-PAID  2/21/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                      15.00-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
416222    SHIPMAN PARKER         12/27/15 12/27/15 12/27/15 12/27/15      1555.80 DRG 100        60.00 REIM                     4
                                   55 PHARMACY......................                   79.50
                                   89 AUDIOLOGY.....................                    6.50
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                   86.00                  86.00-PAID  2/23/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                   -1469.80-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
416222    SHIPMAN PARKER         12/27/15 12/27/15 12/27/15 12/27/15                          60.00 REIM                     4
                                   55 LABORATORY.(L.................                   79.50
                                   89 VENIPUNCTURE..................                    6.50
     1-COVERED DAYS     0-NON COV DAYS     TOTALS.....................                   86.00                  86.00-PAID  2/25/15 F
     0-MED-NECESSARY DAYS     0-CO-DAYS       0-LIFE-DAYS                                                      26.00-ALLOWANCE
-------------------------------------------------------------------------------------------------------------------------------
```

Journals (Totals)



```
     *****  T O T A L S  ***                                  86667.47 DRG/PER     17470.40 REIM
PINTS OF BLOOD:     0-FURNISHED     0-REPLACED     0-NOT REPLACED
                                01 ROOM CHG-PRIVATE ROOM.........          1       85.00
                                10 ROOM CHG BED HOLD ADMIT OTHER.          2      216.00
                                22 NO GL NUMBERS.................          1      200.00
                                27 PHARMACY......................          2     1000.00
                                34 RADIOLOGIC....................          1      600.00
                                36 EMERGENCY ROOM................          1       82.00
                                43 CENTRAL SERVICES/SUPPLIES.....          1       45.00
                                45 IV SOLUTIONS..................          1     -100.00
                                46 EMERGENCY ROOM EVAL...........          3     1602.00
                                54 DRUGS INCIDENT TO OTHER SERVIC          1        4.00
                                55 LABORATORY (LAB)..............         12     2559.80
                                61 BLOOD ADMINISTRATION..........          1       54.00
                                67 EMG...........................          1      100.00
                                71 PHARMACY......................          2      945.00
                                73 RADIOLOGY.....................          3     1031.00
                                78 PHARMACY-INJECTED.............          9     1518.48
                                79 PHARMACY - OTHER..............          7      764.30
                                85 PHYSICAL THERAPY..............          4     1008.00
                                89 AUDIOLOGY.....................          1       12.00
                                BB BEGINNING BALANCE.............          2     2462.32
                                 OTHER CHARGES                      2       46.00
 80-COVERED DAYS     0-NON COV DAYS      TOTALS.....................       14234.90             19709.40-PAID
                                                                      =========  =========   -81909.69-ALLOWANCE
                                   INPATIENT DEDUCTIBLE............                 562.00
                                   BLOOD DEDUCTIBLE................
                                   COINSURANCE.....................                 324.60
                                   DENIED CHARGES..................
                                NON-COVERED CHARGES.............
```

Listed below is an explanation of each column.

- **Patient Number/Name:** Pulls from the Patient tab on the Registration and ADT screen.
- **Service From/To:** Specifies the start and stop date the claim was generated, from the insurance claim status screen.
- **Admit / Discharge Date:** Patient admit and discharge date from the Stay tab on the Registration and ADT screen.
- **Total Rate/Qty/Charges:** Rate, Quantity and Total of charged item from Detail Charges screen
- **Non Cov Charges:** Charges not covered by insurance from the Detail Charges screen.
- **Contract #:** Insurance contract number from Policy Information.
- **Age:** Patient's age from the Patient tab on the Registration and ADT screen.
- **Per Diem/DRG:** The per diem rate used to calculate the reimbursement or the DRG calculated on a claim from the Insurance Company table, page 1 or DRG Grouper screen.
- **Reim (Reimbursement):** The reimbursement amount entered during receipting.
- **Summary Code:** Charge item summary code from the Detail Charges screen.
- **Paid/Allowance:** The amount that has been receipted to this claim and the total charges less the DRG reimbursement.

10.29 Print I/P Forms

This print option is for state specific forms.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print I/P Forms**.

Description and Usage

This print option is for state specific forms. A hospital would choose this option if their state requires an insurance form other than the UB and the 1500 forms.

10.30 Print O/P Forms

This print option is for state specific forms.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print O/P Forms**.

Description and Usage

This print option is for state specific forms. A hospital would choose this option if their state requires an insurance form other than the UB and the 1500 forms.

10.31 Print State Insurance Forms

This print option is for state specific forms.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print State Insurance Forms**.

Description and Usage

This print option is for state specific forms. A hospital would choose this option if their state requires an insurance form other than the UB and the 1500 forms.

10.32 Print Form 1491's (Ambulance)

This print option is for Ambulance forms.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **Print Form 1491's (Ambulance)**.

Description and Usage

This print option is for states that require Ambulance charges be billed on a Form 1491.

10.33 UB04 Edit List

The UB Edit List is used by the Business Office to determine what additional information should be included on the insurance claims prior to billing.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **UB Edit List**.
4. Select a print option.

   System prompts, “Sort By:”

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**e**	Ins-Alpha-ServCd
b	Alpha-Ins-Serv Cd	**f**	Ins-Serv Cd-Alpha
c	Serv Cd-Alpha-Ins	**g**	Dept Flag-Ins-Alpha
d	Serv Cd-Ins-Alpha		

System prompts, "Enter account numbers:"

6. If selected patient account numbers will need to be entered and edits will be printed only for the claims on the accounts. The system brings up every claim for the given account number and prompts “Include this Claim” or “Exclude this Claim”.

System prompts, “Type of Claim to be edited (U-Unbilled, T-To be xmitted):"

7. Enter **U** to print edits for claims that are not billed and **T** to print edits for claims that are ready to be transmitted to the intermediary.

System prompts, "Specific companies (Blank for all):"

8. If selected enter up to six company codes.

System prompts, "Intermediary Codes (M, B, X, C or All):"

9. **ALL** will print the report for all financial classes, or enter the desired Financial Class codes for which the report will run.

System prompts, "Include Secondaries:"

10. **Select** this option to include secondary claims or leave blank to exclude secondary claims from the report.

11. Select **Generate** to begin the printing process.

If sort option g-Dept Flag-Ins-Alpha is selected the following prompt will appear:

System prompts, “Print for dept (Blank for all):"

12. Enter **I** for Insurance, **M** for Medical Records, or **R** for Registration to receive edits for the specified department. If left blank all edits will print.

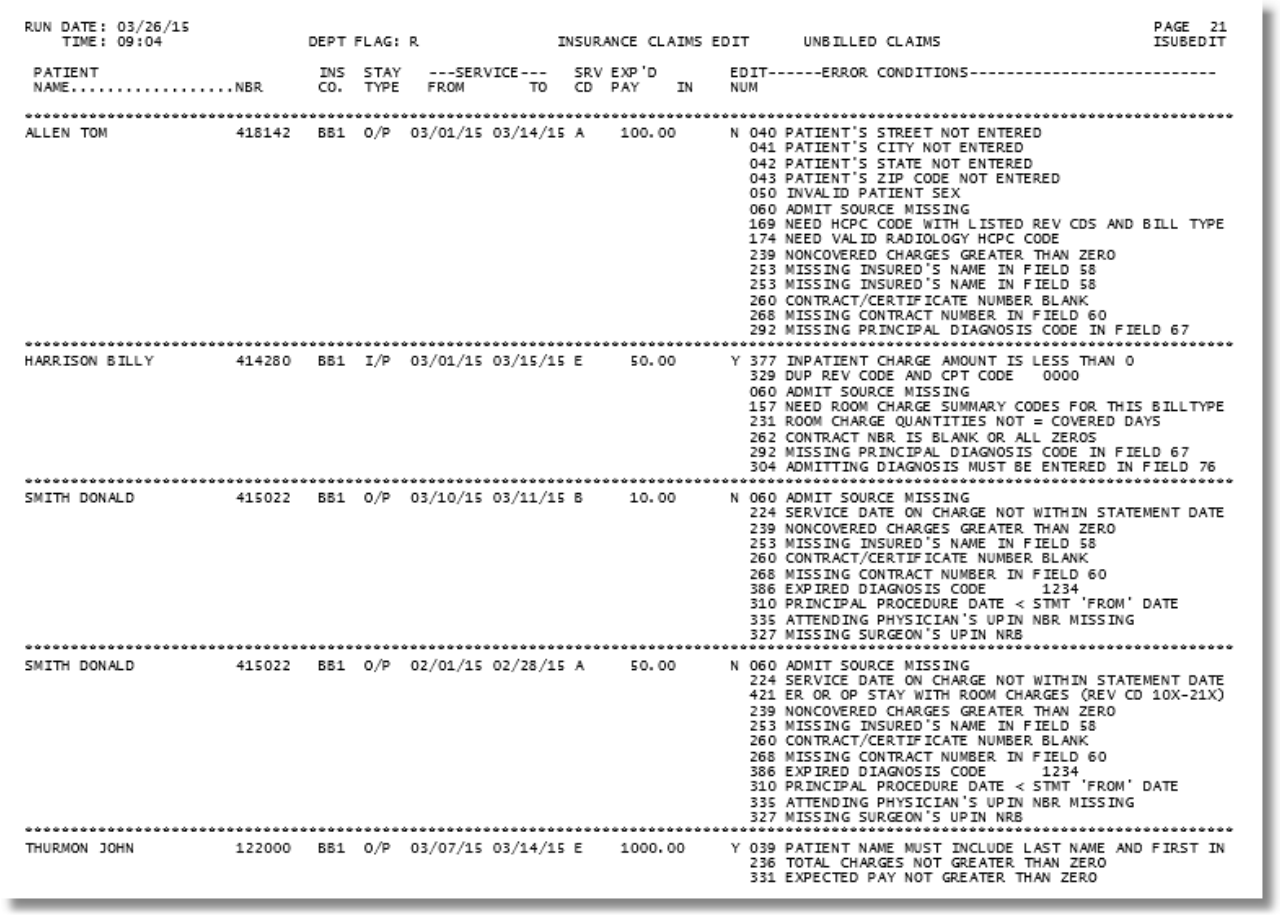
Description and Usage

The UB Edit List should be printed and worked on a daily basis.

The report prints a list of all insurance claims with problems that may cause the claim to be rejected. The report should be worked, reprinted and worked again until no errors exist.

If there are edits that should be suppressed for a specific Financial Class, this can be done in the Billing Edits field on page 3 of the Insurance Company table. A maximum of 50 edit numbers may be entered for each insurance company, preventing these edits from appearing on the report.

UB Edit List



```
RUN DATE: 03/26/15                                                                                    PAGE  21
    TIME: 09:04              DEPT FLAG: R              INSURANCE CLAIMS EDIT     UNBILLED CLAIMS      ISUBEDIT

 PATIENT                      INS  STAY   ---SERVICE---   SRV EXP'D       EDIT------ERROR CONDITIONS----------------------------
 NAME.................NBR      CO.  TYPE   FROM       TO   CD  PAY    IN    NUM
*************************************************************************************************************************************
ALLEN TOM             418142   BB1  O/P  03/01/15 03/14/15 A    100.00      N 040 PATIENT'S STREET NOT ENTERED
                                                                              041 PATIENT'S CITY NOT ENTERED
                                                                              042 PATIENT'S STATE NOT ENTERED
                                                                              043 PATIENT'S ZIP CODE NOT ENTERED
                                                                              050 INVALID PATIENT SEX
                                                                              060 ADMIT SOURCE MISSING
                                                                              169 NEED HCPC CODE WITH LISTED REV CDS AND BILL TYPE
                                                                              174 NEED VALID RADIOLOGY HCPC CODE
                                                                              239 NONCOVERED CHARGES GREATER THAN ZERO
                                                                              253 MISSING INSURED'S NAME IN FIELD 58
                                                                              253 MISSING INSURED'S NAME IN FIELD 58
                                                                              260 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                              268 MISSING CONTRACT NUMBER IN FIELD 60
                                                                              292 MISSING PRINCIPAL DIAGNOSIS CODE IN FIELD 67
*************************************************************************************************************************************
HARRISON BILLY        414280   BB1  I/P  03/01/15 03/15/15 E     50.00      Y 377 INPATIENT CHARGE AMOUNT IS LESS THAN 0
                                                                              329 DUP REV CODE AND CPT CODE   0000
                                                                              060 ADMIT SOURCE MISSING
                                                                              157 NEED ROOM CHARGE SUMMARY CODES FOR THIS BILLTYPE
                                                                              231 ROOM CHARGE QUANTITIES NOT = COVERED DAYS
                                                                              262 CONTRACT NBR IS BLANK OR ALL ZEROS
                                                                              292 MISSING PRINCIPAL DIAGNOSIS CODE IN FIELD 67
                                                                              304 ADMITTING DIAGNOSIS MUST BE ENTERED IN FIELD 76
*************************************************************************************************************************************
SMITH DONALD          415022   BB1  O/P  03/10/15 03/11/15 B     10.00      N 060 ADMIT SOURCE MISSING
                                                                              224 SERVICE DATE ON CHARGE NOT WITHIN STATEMENT DATE
                                                                              239 NONCOVERED CHARGES GREATER THAN ZERO
                                                                              253 MISSING INSURED'S NAME IN FIELD 58
                                                                              260 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                              268 MISSING CONTRACT NUMBER IN FIELD 60
                                                                              386 EXPIRED DIAGNOSIS CODE      1234
                                                                              310 PRINCIPAL PROCEDURE DATE < STMT 'FROM' DATE
                                                                              335 ATTENDING PHYSICIAN'S UPIN NBR MISSING
                                                                              327 MISSING SURGEON'S UPIN NRB
*************************************************************************************************************************************
SMITH DONALD          415022   BB1  O/P  02/01/15 02/28/15 A     50.00      N 060 ADMIT SOURCE MISSING
                                                                              224 SERVICE DATE ON CHARGE NOT WITHIN STATEMENT DATE
                                                                              421 ER OR OP STAY WITH ROOM CHARGES (REV CD 10X-21X)
                                                                              239 NONCOVERED CHARGES GREATER THAN ZERO
                                                                              253 MISSING INSURED'S NAME IN FIELD 58
                                                                              260 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                              268 MISSING CONTRACT NUMBER IN FIELD 60
                                                                              386 EXPIRED DIAGNOSIS CODE      1234
                                                                              310 PRINCIPAL PROCEDURE DATE < STMT 'FROM' DATE
                                                                              335 ATTENDING PHYSICIAN'S UPIN NBR MISSING
                                                                              327 MISSING SURGEON'S UPIN NRB
*************************************************************************************************************************************
THURMON JOHN          122000   BB1  O/P  03/07/15 03/14/15 E    1000.00      Y 039 PATIENT NAME MUST INCLUDE LAST NAME AND FIRST IN
                                                                              236 TOTAL CHARGES NOT GREATER THAN ZERO
                                                                              331 EXPECTED PAY NOT GREATER THAN ZERO
```

Listed below is an explanation of each column.

- **Patient Name:** Pulls from the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Ins (Insurance Code):** Pulls from Policy Information.
- **Stay Type:** Pulls from the Registration and ADT screen, page 1.
- **Service From and To:** The service dates pull from the Insurance Claims Status screen. This will usually be the admit and discharge dates except for recurring patients.
- **Srv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Exp'd Pay (Expected Pay):** Pulls from the Detail Charges screen.

- The next column pulls from the Detail Charges screen. This indicates if this claim is going to be billed electronically.
- **Edit Num (Edit Number):** The number that corresponds to the error that may cause this claim to reject.
- **Error Conditions:** The reason claim may be rejected.

10.34 1500 Edit List

The 1500 Edit List is used by the Business Office to determine what additional information should be included on the form prior to billing.

How to Print

1. Select **Print Reports** from the Hospital Base Menu or the Master Selection screen.
2. Select **Insurance**.
3. Select **1500 Edit List**.
4. Select a print option.

   System prompts, “Sort By:”

5. Select a sort option. The options include:

a	Alpha-Serv Cd-Ins	**e**	Ins-Alpha-ServCd
b	Alpha-Ins-Serv Cd	**f**	Ins-Serv Cd-Alpha
c	Serv Cd-Alpha-Ins	**g**	Dept Flag-Ins-Alpha
d	Serv Cd-Ins-Alpha		

   System prompts, "Enter account numbers:"

6. If selected patient account numbers will need to be entered and edits will be printed only for the claims on the accounts. The system brings up every claim for the given account number and prompts “Include this Claim” or “Exclude this Claim."

   System prompts, “Type of Claim to be edited (U-Unbilled, T-To be xmitted):"

7. Enter **U** to print edits for claims that are not billed and **T** to print edits for claims that are ready to be transmitted to the intermediary.

   System prompts, "Specific companies (Blank for all):"

8. If selected enter up to 6 company codes.

   System prompts, "Intermediary Codes (M, B, X, C or All):"

9. **ALL** will print the report for all financial classes or enter the desired Financial Class codes for which the report will run.

System prompts, "Include Secondaries:"

10. Select this option to include secondary claims or leave blank to exclude secondary claims from the report.

11. Select **Generate** to begin the printing process.

If sort option g-Dept Flag-Ins-Alpha is selected the following prompt will appear:

System prompts, “Print for dept (Blank for all):"

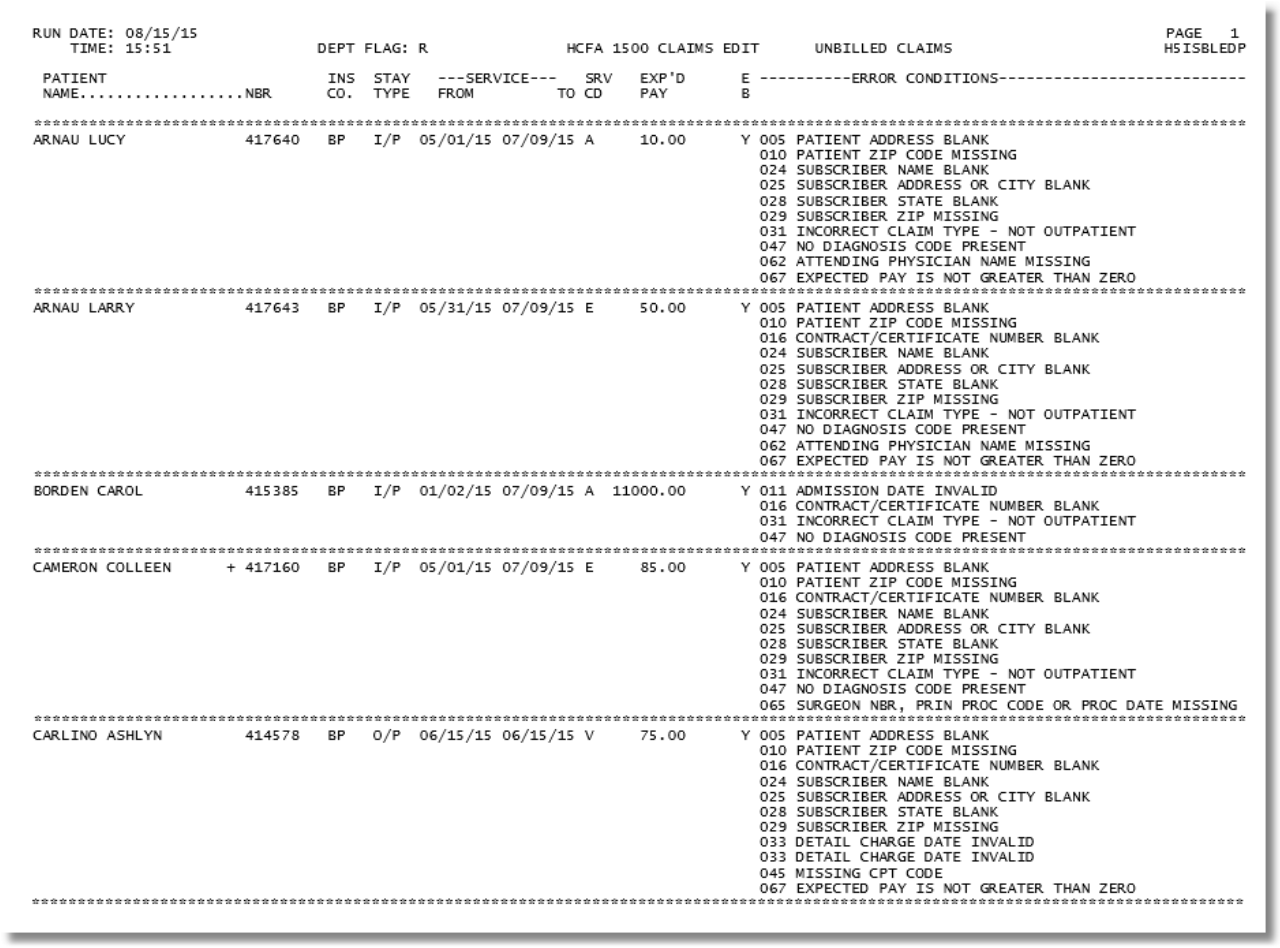
12. Enter **I** for Insurance, **M** for Medical Records, or **R** for Registration to receive edits for the specified department. If left blank all edits will print.

Description and Usage

The 1500 Edit List should be printed and worked on a daily basis. The report gives a list of all Physician claims with problems that may cause the claim to be rejected. The report should be worked, reprinted and worked again until no errors exist.

If there are edits that should be suppressed for a specific Financial Class, this can be done in the Billing Edits field on page 3 of the Insurance Company table. A maximum of 50 edit numbers may be entered for each insurance company, preventing these edits from appearing on the report.

1500 Edit List



```
RUN DATE: 08/15/15                                                                                                    PAGE   1
    TIME: 15:51                DEPT FLAG: R              HCFA 1500 CLAIMS EDIT      UNBILLED CLAIMS                  H5ISBLEDP

 PATIENT                        INS  STAY   ---SERVICE---    SRV   EXP'D      E ----------ERROR CONDITIONS----------------------------
 NAME.................NBR       CO.  TYPE   FROM          TO CD    PAY        B

*************************************************************************************************************************************************
ARNAU LUCY             417640   BP   I/P  05/01/15 07/09/15 A     10.00      Y 005 PATIENT ADDRESS BLANK
                                                                                 010 PATIENT ZIP CODE MISSING
                                                                                 024 SUBSCRIBER NAME BLANK
                                                                                 025 SUBSCRIBER ADDRESS OR CITY BLANK
                                                                                 028 SUBSCRIBER STATE BLANK
                                                                                 029 SUBSCRIBER ZIP MISSING
                                                                                 031 INCORRECT CLAIM TYPE - NOT OUTPATIENT
                                                                                 047 NO DIAGNOSIS CODE PRESENT
                                                                                 062 ATTENDING PHYSICIAN NAME MISSING
                                                                                 067 EXPECTED PAY IS NOT GREATER THAN ZERO
*************************************************************************************************************************************************
ARNAU LARRY            417643   BP   I/P  05/31/15 07/09/15 E     50.00      Y 005 PATIENT ADDRESS BLANK
                                                                                 010 PATIENT ZIP CODE MISSING
                                                                                 016 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                                 024 SUBSCRIBER NAME BLANK
                                                                                 025 SUBSCRIBER ADDRESS OR CITY BLANK
                                                                                 028 SUBSCRIBER STATE BLANK
                                                                                 029 SUBSCRIBER ZIP MISSING
                                                                                 031 INCORRECT CLAIM TYPE - NOT OUTPATIENT
                                                                                 047 NO DIAGNOSIS CODE PRESENT
                                                                                 062 ATTENDING PHYSICIAN NAME MISSING
                                                                                 067 EXPECTED PAY IS NOT GREATER THAN ZERO
*************************************************************************************************************************************************
BORDEN CAROL           415385   BP   I/P  01/02/15 07/09/15 A  11000.00      Y 011 ADMISSION DATE INVALID
                                                                                 016 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                                 031 INCORRECT CLAIM TYPE - NOT OUTPATIENT
                                                                                 047 NO DIAGNOSIS CODE PRESENT
*************************************************************************************************************************************************
CAMERON COLLEEN      + 417160   BP   I/P  05/01/15 07/09/15 E     85.00      Y 005 PATIENT ADDRESS BLANK
                                                                                 010 PATIENT ZIP CODE MISSING
                                                                                 016 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                                 024 SUBSCRIBER NAME BLANK
                                                                                 025 SUBSCRIBER ADDRESS OR CITY BLANK
                                                                                 028 SUBSCRIBER STATE BLANK
                                                                                 029 SUBSCRIBER ZIP MISSING
                                                                                 031 INCORRECT CLAIM TYPE - NOT OUTPATIENT
                                                                                 047 NO DIAGNOSIS CODE PRESENT
                                                                                 065 SURGEON NBR, PRIN PROC CODE OR PROC DATE MISSING
*************************************************************************************************************************************************
CARLINO ASHLYN         414578   BP   O/P  06/15/15 06/15/15 V     75.00      Y 005 PATIENT ADDRESS BLANK
                                                                                 010 PATIENT ZIP CODE MISSING
                                                                                 016 CONTRACT/CERTIFICATE NUMBER BLANK
                                                                                 024 SUBSCRIBER NAME BLANK
                                                                                 025 SUBSCRIBER ADDRESS OR CITY BLANK
                                                                                 028 SUBSCRIBER STATE BLANK
                                                                                 029 SUBSCRIBER ZIP MISSING
                                                                                 033 DETAIL CHARGE DATE INVALID
                                                                                 033 DETAIL CHARGE DATE INVALID
                                                                                 045 MISSING CPT CODE
                                                                                 067 EXPECTED PAY IS NOT GREATER THAN ZERO
*************************************************************************************************************************************************
```

Listed below is an explanation of each column.

- **Patient Name:** Pulls from the Patient tab on the Registration and ADT screen.
- **Number (Account Number):** Pulls from the Registration and ADT screen.
- **Ins (Insurance Code):** Pulls from Policy Information.
- **Stay Type:** Pulls from the Patient tab of the Registration and ADT screen.
- **Service From and To:** The service dates pull from the Insurance Claim Status screen. This will default to the admit and discharge dates, except for recurring patients.
- **Srv Cd (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Exp'd Pay (Expected Pay):** Pulls from the Detail Charges screen.
- **E B (Electronic Bill Switch):** Pulls from the Detail Charges screen. This indicates if this claim is going to be billed electronically.

- **Edit Num (Edit Number):** The number that corresponds to the error that may cause this claim to reject.

- **Error Conditions:** The reason for which this claim may be rejected.

10.35 Diagnosis Variance Report

The Diagnosis Variance Report will list billed insurance claims where diagnosis information differs between Insurance and Medical Records.

How to Print

1. Select **Report Dashboard** from the Application Drawer.

2. Select **Diagnosis Variance Report**

System prompts, "Facility:"

3. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

System prompts, "Billed Date Range"

4. Enter the desired billed date range or leave blank for all billed claims.

System prompts, "Financial Class:"

5. Enter the desired financial class. Use ***** to wildcard insurance companies or leave blank to print for all financial classes.

System prompts, "Account Number:"

6. Enter in the desired account number or leave blank for all account numbers.

System prompts, "Include Cover Sheet"

7. Select this option to include a Cover Sheet with the report.

System prompts, "Safe Mode:"

8. Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a **?**. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.

System prompts, “Output Format:"

9. Use the drop-down box to select one of the following report Format options:
   - **HTML**
   - **PDF**
   - **XML**
   - **CSV**
   - **MAPLIST**
   - **TXT**

System prompts, "Page Orientation"

10. Select the desired page orientation.

System prompts, “Run Report"

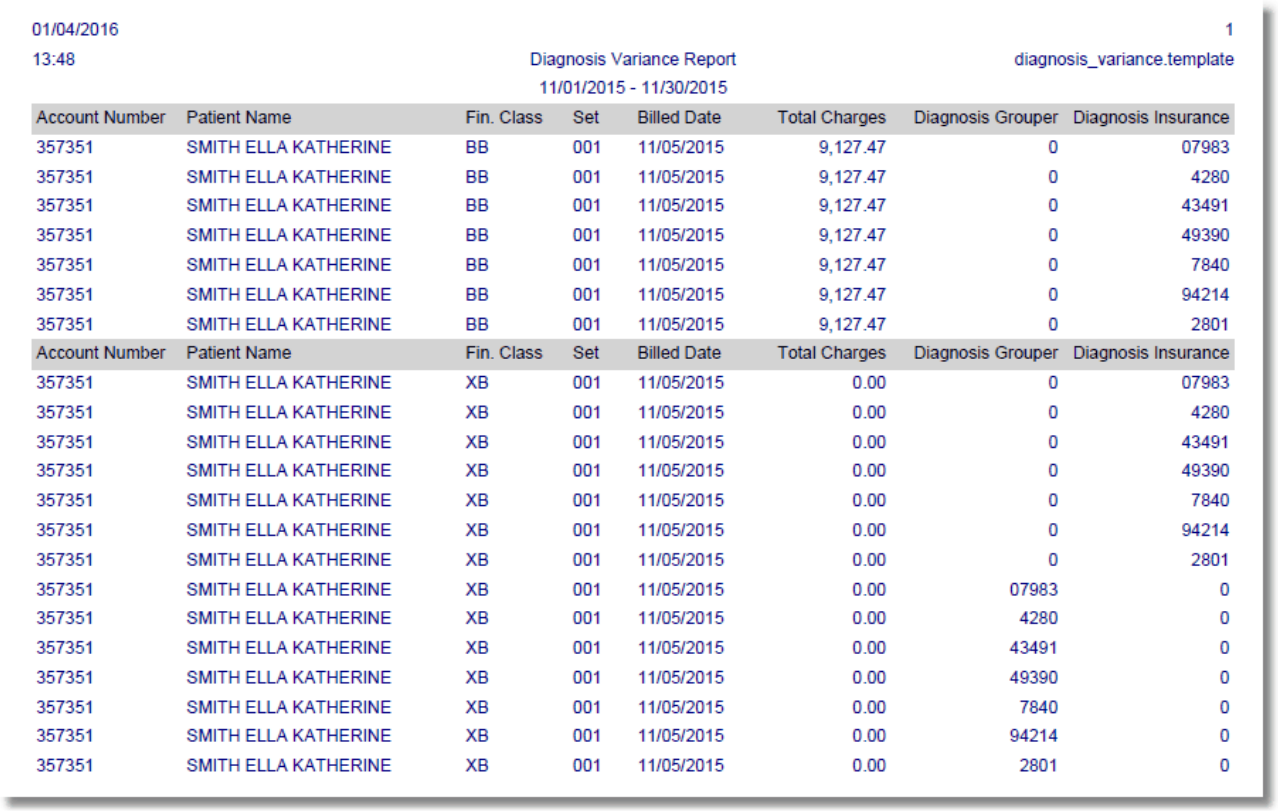
11. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Diagnosis Variance Report will list billed insurance claims where diagnosis information differs between Insurance and Medical Records. Insurance diagnosis information pulls from within the Ins Diag/Proc option or the Grouper when the Insurance and Insurance Admitting radio buttons are selected. Medical Records diagnosis information pulls from within the Ins Diag/Proc option or the Grouper when the Diagnosis and Admitting Diagnosis radio buttons are selected. If the admitting and other diagnoses loaded on the account differ in these two areas the account will pull to the report.

See Insurance Diagnoses 17 for more information.

Diagnosis Variance Report



01/04/2016 1

13:48 Diagnosis Variance Report diagnosis_variance.template

11/01/2015 - 11/30/2015

Account Number	Patient Name	Fin. Class	Set	Billed Date	Total Charges	Diagnosis Grouper	Diagnosis Insurance
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	07983
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	4280
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	43491
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	49390
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	7840
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	94214
357351	SMITH ELLA KATHERINE	BB	001	11/05/2015	9,127.47	0	2801
Account Number	Patient Name	Fin. Class	Set	Billed Date	Total Charges	Diagnosis Grouper	Diagnosis Insurance
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	07983
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	4280
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	43491
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	49390
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	7840
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	94214
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	0	2801
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	07983	0
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	4280	0
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	43491	0
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	49390	0
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	7840	0
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	94214	0
357351	SMITH ELLA KATHERINE	XB	001	11/05/2015	0.00	2801	0

Listed below is an explanation of each column.

- **Account Number**: Pulls from the Registration and ADT screen
- **Patient Name**:Pulls from the Patient tab on the Registration and ADT screen
- **Fin. Class (Financial Class)**: Pulls from Policy Information
- **Set**:This field represents the sequence number of a particular financial class on a patient account. If there are multiple claims with the same financial class on the account, the system will assign a set number of 001, 002, etc.
- **Billed Date**: Pulls the billed date of the claim
- **Total Charges**: The total amount of charges pulls from Account Detail
- **Diagnosis Grouper**: Pulls diagnosis codes that are listed when the Diagnosis and Admitting Diagnosis radio buttons are selected from within the Ins Diag/Proc option or the Grouper
- **Diagnosis Insurance**: Pulls diagnosis codes that are listed when the Insurance and Insurance Admitting radio buttons are selected from within the Ins Diag/Proc option or the Grouper

10.36 Procedures Variance Report

The Procedures Variance Report will list billed insurance claims where procedure information differs between Insurance and Medical Records.

How to Print

1. Select **Report Dashboard** from the Application Drawer.

2. Select **Procedure Variance Report**

System prompts, "Facility:"

3. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

System prompts, "Billed Date Range"

4. Enter the desired billed date range or leave blank for all billed claims.

System prompts, "Financial Class:"

5. Enter the desired financial class. Use ***** to wildcard insurance companies or leave blank to print for all financial classes.

System prompts, "Account Number:"

6. Enter in the desired account number or leave blank for all account numbers.

System prompts, "Include Cover Sheet"

7. Select this option to include a Cover Sheet with the report.

System prompts, "Safe Mode:"

8. Select this option if the report would not build due to bad data being in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode will replace all of the bad characters with a **?**. This will allow the intended report to generate. The bad data may then be seen and can be corrected from the account level.

System prompts, “Output Format:"

9. Use the drop-down box to select one of the following report Format options:
   - **HTML**
   - **PDF**
   - **XML**
   - **CSV**
   - **MAPLIST**
   - **TXT**

System prompts, "Page Orientation"

10. Select the desired page orientation.

System prompts, “Run Report"

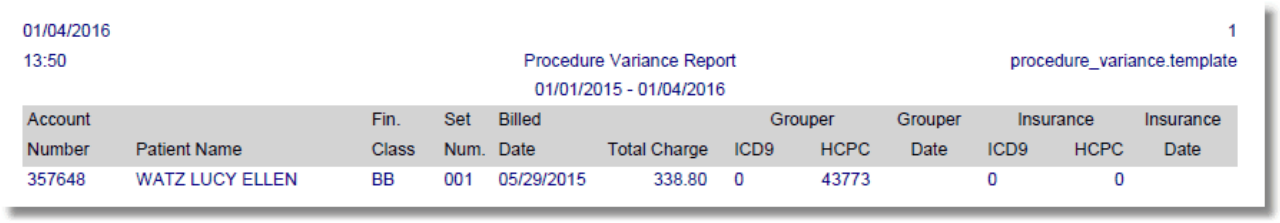
11. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Procedure Variance Report will list billed insurance claims where procedure information differs between Insurance and Medical Records. Insurance procedure information pulls from within the Ins Diag/Proc option or the Grouper when the Insurance radio button is selected. Medical Records procedure information pulls from within the Ins Diag/Proc option or the Grouper when the Procedure radio button is selected. If the ICD-9, HCPC or procedure date loaded on the account differ in these two areas the account will pull to the report.

See Insurance Procedures 19 for more information.

Procedure Variance Report



01/04/2016 1
13:50 Procedure Variance Report procedure_variance.template
01/01/2015 - 01/04/2016

Account Number	Patient Name	Fin. Class	Set Num.	Billed Date	Total Charge	Grouper ICD9	Grouper HCPC	Grouper Date	Insurance ICD9	Insurance HCPC	Insurance Date
357648	WATZ LUCY ELLEN	BB	001	05/29/2015	338.80	0	43773		0	0	

Listed below is an explanation of each column.

- **Account Number**: Pulls from the Registration and ADT screen
- **Patient Name**: Pulls from the Patient tab on the Registration and ADT screen
- **Fin. Class (Financial Class)**: Pulls from Policy Information
- **Set**:This field represents the sequence number of a particular financial class on a patient account. If there are multiple claims with the same financial class on the account, the system will assign a set number of 001, 002, etc.
- **Billed Date**: Pulls the billed date of the claim

- **Total Charges**: Total amount of charges pulls from Account Detail
- **Grouper ICD9/HCPC**: Pulls the ICD-9 and HCPC codes listed when the Procedure radio button is selected from within the Ins Diag/Proc option or the Grouper
- **Grouper Date**: Pulls the procedure date listed when the Procedure radio button is selected from within the Ins Diag/Proc option or the Grouper
- **Insurance ICD9/HCPC**: Pulls the ICD-9 and HCPC codes listed when the Insurance radio button is selected from within the Ins Diag/Proc option or the Grouper
- **Insurance Date**: Pulls the procedure date listed when the Insurance radio button is selected from within the Ins Diag/Proc option or the Grouper

Chapter 11 Report Dashboard

11.1 Billed But Unpaid Claims (By Ins) - Report Writer

The Billed but Unpaid Claims (by Ins) report is used by the Business Office to do follow-up work on outstanding claims. This report can now be open within the Report Writer application for enhanced reporting capabilities.

How to Print

1. Select **Report Dashboard** from the Application Drawer.

2. Select **Billed but Unpaid Claims (by Ins)**.

3. Select a print option.

System prompts, “Facility:"

4. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

System prompts, "As of Date:"

5. Use the drop-down box to select a date, or choose Manual Selection to enter a date manually.

System prompts, “Primary Switch:"

6. Select **Primary** to print only Primary claims. Select **Secondary** to print only Secondary claims. Leave blank to print both Primary and Secondary claims.

System prompts, "Expected Pay Range:"

7. Enter the range of dollar amounts for the Expected Pay the report will print or leave blank for all claims with an Expected Pay to print to the report.

System prompts, "Insurance Code:"

8. Enter the desired financial class. Use ***** to wildcard insurance companies or leave blank to print for all financial classes.

System prompts, "Service:"

9. Enter the desired Service Code. Leave blank to print all Service Codes.

System prompts “Aging Selection:"

10. Use the drop-down box to select one of the following options or leave blank to print all aging selections:
    Current
    Over 30
    Over 60
    Over 90

    System prompts, “Sections to Exclude"

11. Select one or more of the following desired sections to exclude or leave blank to print all:
    Exclude Insurance Summary
    Exclude Grand Totals
    Exclude Summary Totals

    System prompts, “Level of Detail:"

12. Use the drop-down box to select one of the following options:
    Detail
    Summary
    Report Summary Only

    System prompts, "Include Cover Sheet"

13. Select this option to include a Cover Sheet with the report.

    System prompts, “Output Format:"

14. Use the drop-down box to select one of the following report Format options:
    HTML
    PDF
    XML
    CSV

NOTE: *When using the CSV option, additional fields may be included in the report that are not available in PDF format. Examples include: Accountants Category Code, GL Revenue Reclassification, Accommodation Code Data Base Code. To include these fields or view the full list of additional fields, from the parameters screen, select* ***Advanced*** *and then choose* ***Columns****.*

    System prompts, “Run Report"

15. Select Run Report to display the report in the selected output format.

Description and Usage

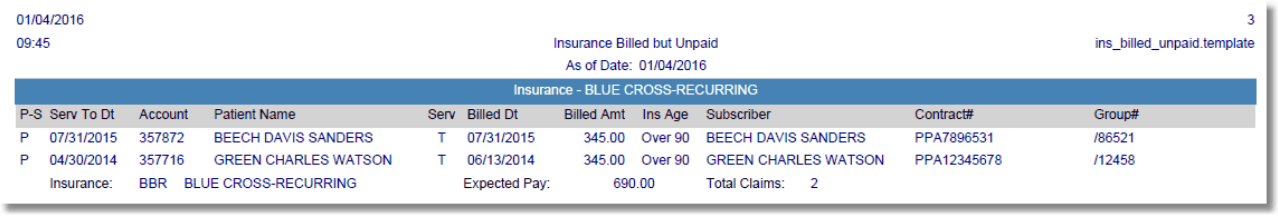
The Billed but Unpaid Claims (by Ins) report within the Report Writer application provides a listing by insurance of all outstanding insurance claims. Financial Classes that do not have any unpaid claims or claims that meet the report's criteria are excluded. The report lists insurance, patient account number, patient name, billed date, billed amount, aging, subscriber name, contract number and group information.

The aging selections are Current, Over 30, Over 60 and Over 90 days. The last page of the report lists the Insurance Summary with an aging breakdown of total dollars for each insurance company in each aging column followed by a breakdown of total expected pay for each insurance company.

The Billed but Unpaid Claims (By Ins) report should be printed and worked on a weekly basis. This report is helpful in showing which insurance is outstanding and how much payment is expected.

The Report Writer application allows the user to filter, sort and manipulate this report so that he may customize the data extracted out of the system. See the additional documentation on Report Writer for more information on these options.

Billed but Unpaid Claims (by Insurance) - Report Writer

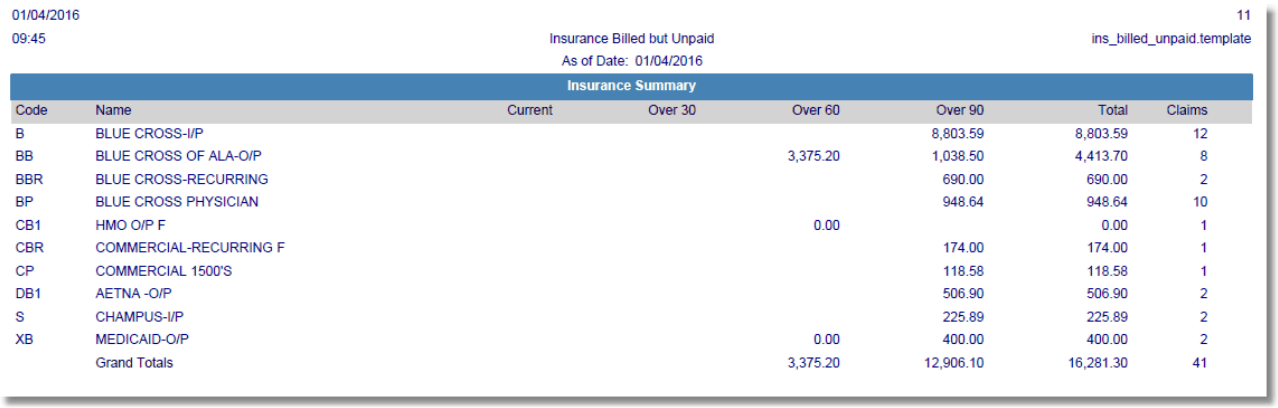


01/04/2016 3
09:45 Insurance Billed but Unpaid ins_billed_unpaid.template
As of Date: 01/04/2016

Insurance - BLUE CROSS-RECURRING

P-S	Serv To Dt	Account	Patient Name	Serv	Billed Dt	Billed Amt	Ins Age	Subscriber	Contract#	Group#
P	07/31/2015	357872	BEECH DAVIS SANDERS	T	07/31/2015	345.00	Over 90	BEECH DAVIS SANDERS	PPA7896531	/86521
P	04/30/2014	357716	GREEN CHARLES WATSON	T	06/13/2014	345.00	Over 90	GREEN CHARLES WATSON	PPA12345678	/12458
	Insurance:	BBR	BLUE CROSS-RECURRING		Expected Pay:	690.00		Total Claims: 2		

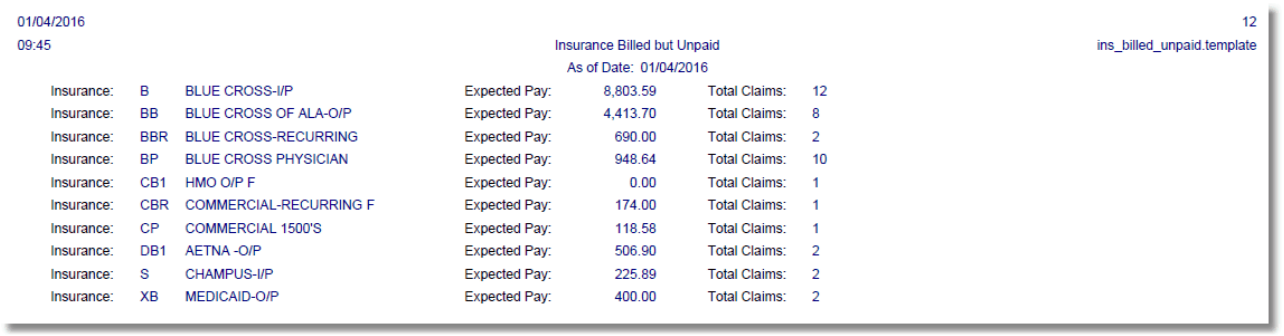
Billed but Unpaid Claims (by Insurance) - Insurance Summary - Report Writer



01/04/2016 11
09:45 Insurance Billed but Unpaid ins_billed_unpaid.template
As of Date: 01/04/2016

Insurance Summary

Code	Name	Current	Over 30	Over 60	Over 90	Total	Claims
B	BLUE CROSS-I/P				8,803.59	8,803.59	12
BB	BLUE CROSS OF ALA-O/P			3,375.20	1,038.50	4,413.70	8
BBR	BLUE CROSS-RECURRING				690.00	690.00	2
BP	BLUE CROSS PHYSICIAN				948.64	948.64	10
CB1	HMO O/P F			0.00		0.00	1
CBR	COMMERCIAL-RECURRING F				174.00	174.00	1
CP	COMMERCIAL 1500'S				118.58	118.58	1
DB1	AETNA -O/P				506.90	506.90	2
S	CHAMPUS-I/P				225.89	225.89	2
XB	MEDICAID-O/P			0.00	400.00	400.00	2
	Grand Totals			3,375.20	12,906.10	16,281.30	41



01/04/2016 12
09:45 Insurance Billed but Unpaid ins_billed_unpaid.template
As of Date: 01/04/2016

Insurance:	B	BLUE CROSS-I/P	Expected Pay:	8,803.59	Total Claims:	12
Insurance:	BB	BLUE CROSS OF ALA-O/P	Expected Pay:	4,413.70	Total Claims:	8
Insurance:	BBR	BLUE CROSS-RECURRING	Expected Pay:	690.00	Total Claims:	2
Insurance:	BP	BLUE CROSS PHYSICIAN	Expected Pay:	948.64	Total Claims:	10
Insurance:	CB1	HMO O/P F	Expected Pay:	0.00	Total Claims:	1
Insurance:	CBR	COMMERCIAL-RECURRING F	Expected Pay:	174.00	Total Claims:	1
Insurance:	CP	COMMERCIAL 1500'S	Expected Pay:	118.58	Total Claims:	1
Insurance:	DB1	AETNA -O/P	Expected Pay:	506.90	Total Claims:	2
Insurance:	S	CHAMPUS-I/P	Expected Pay:	225.89	Total Claims:	2
Insurance:	XB	MEDICAID-O/P	Expected Pay:	400.00	Total Claims:	2

Listed below is an explanation of each column.

- **P-S (Primary-Secondary):** Indicates whether this is the Primary or Secondary claim. Pulls from Policy Information.
- **Serv To Dt:** Pulls the ending service date of the claim.
- **Account (Number):** Pulls from the Registration and ADT Screen.
- **Patient Name:** Pulls from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Serv (Service Code):** Pulls from the Patient tab on the Registration and ADT screen.
- **Billed Dt:** Pulls from the Detail Charges screen.
- **Billed Amt:** Pulls from the Detail Charges screen.
- **Ins Age:** Pulls as **Current** if the billed date is less than 30 days old. Pulls as **Over 30** if the billed date is over 30 but less than 60 days old. Pulls as **Over 60** if the billed date is over 60 but less than 90 days old. Pulls as **Over 90** if the over 90 days old.
- **Subscriber:** Pulls from the Policy Information.
- **Contract #(Number):** Pulls from the Policy Information.
- **Group #(Number):** Pulls from the Policy Information.

11.2 Cycle Billing Review Due

The Cycle Billing Review Due report will display accounts that have a Review Date in the Pay Source Table for a selected date range.

How to Print

1. Select **Report Dashboard** from the Application Drawer.

2. Select **Cycle Billing Review Due**

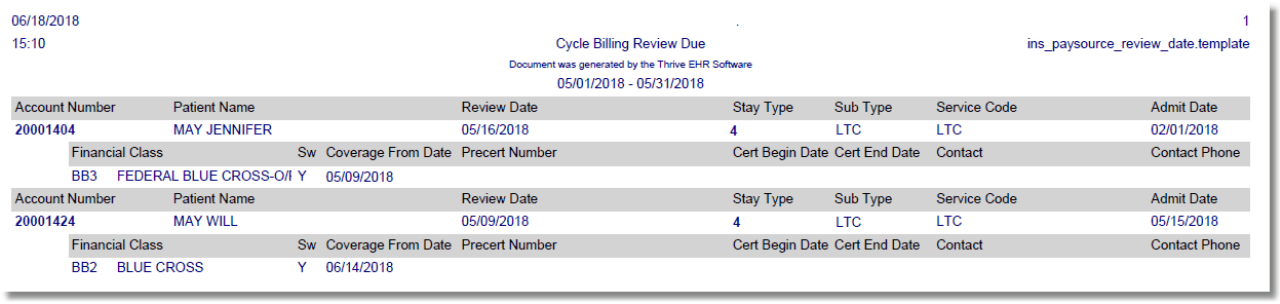
3. Select report parameters:
   - **Facility**: Select the desired Facility from which to pull information. (Only Facilities selected for access under that User Based Login will be available for selection.)
   - **Review Date Range**: Select a Date Range option from the drop down. Or select Manual Selection to enter dates manually.
   - **Financial Class**: Enter the desired financial class or leave blank for all financial classes.
   - **Stay Type**: Enter the desired Stay Type or leave blank for all stay types.
   - **Sub Type**: Enter the desired Sub Type or leave blank for all sub types.
   - **Service Code**: Enter the desired Service Code or leave blank for all service codes.
   - **Include Cover Sheet**: Select this option to include a Cover Sheet with the report.
   - **Safe Mode**: Select this option to print report in safe mode.
   - **Output Format**: Use the drop-down box to select one of the following report Format options:
     - **PDF**
     - **XML**
     - **CSV**
     - **HTML**
     - **MAPLIST**
     - **TXT**

4. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Cycle Billing Review Due report is used to identify accounts that need their Pay Source Table entries reviewed prior to billing. This report will display accounts that have Review Date in the Pay Source Table for the selected date range. For example, a Review Date could be entered prior to the expiration of a Pre-Certification number, so that a new pre-certification number may be acquired prior to the next billing cycle. These accounts will then pull to the report based on their Review Date so that they may be addressed. In order to pull to the report, there cannot be a Complete Date or a Coverage To date in the Pay Source Table.

Cycle Billing Review Due



06/18/2018 1
15:10 Cycle Billing Review Due ins_paysource_review_date.template
Document was generated by the Thrive EHR Software
05/01/2018 - 05/31/2018

Account Number	Patient Name	Review Date	Stay Type	Sub Type	Service Code	Admit Date
20001404	MAY JENNIFER	05/16/2018	4	LTC	LTC	02/01/2018

Financial Class		Sw	Coverage From Date	Precert Number	Cert Begin Date	Cert End Date	Contact	Contact Phone
BB3	FEDERAL BLUE CROSS-O/I	Y	05/09/2018					

Account Number	Patient Name	Review Date	Stay Type	Sub Type	Service Code	Admit Date
20001424	MAY WILL	05/09/2018	4	LTC	LTC	05/15/2018

Financial Class		Sw	Coverage From Date	Precert Number	Cert Begin Date	Cert End Date	Contact	Contact Phone
BB2	BLUE CROSS	Y	06/14/2018					

Listed below is an explanation of each column.

- **Account Number**: Pulls from the Registration and ADT screen.
- **Patient Name**: Pulls from the Registration and ADT screen.
- **Review Date**: Pulls from the Pay Source table.
- **Stay Type**: Pulls from the Registration and ADT screen.
- **Sub Type**: Pulls from the Registration and ADT screen.
- **Service Code**: Pulls from the Registration and ADT screen.
- **Admit Date**: Pulls from the Registration and ADT screen.
- **Financial Class**: Pulls the Claim from the Pay Source table.
- **Sw (Primary Switch)**: Pulls the Primary Switch from the Pay Source table.
- **Coverage From Date**: Pulls the Coverage From Date from the Pay Source table.
- **Precet Number (Pre-Certification Number)**: Pulls the Pre-Certification Number from the Pay Source table.
- **Cert Begin Date**: Pulls the Pre-Certification From Date from the Pay Source table.
- **Cert End Date**: Pulls the Pre-Certification To Date from the Pay Source table.
- **Contact**: Pulls the Pre-Certification contact from the Pay Source table.
- **Contact Phone**: Pulls the Pre-Certification contact phone number from the Pay Source table.

11.3 Unbilled Insurance Report - Report Writer

The Unbilled Insurance Report provides a complete listing of all insurance claims that have not been billed.

How to Print

1. Select **Report Dashboard** from the Application Drawer.
2. Select **Unbilled Insurance Report**.
3. Select a print option.

   System prompts, "Facility:"

4. Select the desired Facility. (Only Facilities selected for access under that User Based Login will be available for selection.)

   System prompts, "Stay Type:"

5. Select a stay type, or leave blank to print all.

   System prompts, "Service Code:"

6. Enter a Service Code, or leave blank to print all.

   System prompts, "Insurance Code:"

7. Enter an Insurance Financial Class code, or leave blank to print all.

   System prompts, "Primary Switch:"

8. Select one of the following or leave blank to print all:
   Primary Only
   Secondary Only

   System prompts, "Sections to Exclude:"

9. Select one or more of the following desired sections to exclude, or leave blank to print all:
   Exclude Grand Totals
   Exclude Reason Code Descriptions

   System prompts, "Level of Detail:"

10. Use the drop-down box to select one of the following options:
    Detail
    Summary
    Report Summary Only

    System prompts, "Include Cover Sheet:"

11. Select this option to include a Cover Sheet with the report.

    System prompts, "Output Format:"

12. Use the drop-down box to select one of the following report Format options:
    HTML
    PDF
    XML
    CSV

NOTE: *When using the CSV option, additional columns may be included in the report that are not available in PDF format. Examples include: Accountants Category, Accountants Category Description, GL Revenue Reclassification, Accommodation Code Data Base Code, HIM Coding Status, HIM Coding Status Date/Time, and HIM Coding Status User Name. To include these columns or view the full list of additional columns available, from the parameters screen, select* ***Advanced*** *and then select* ***Columns****.*

   System prompts, "Run Report"

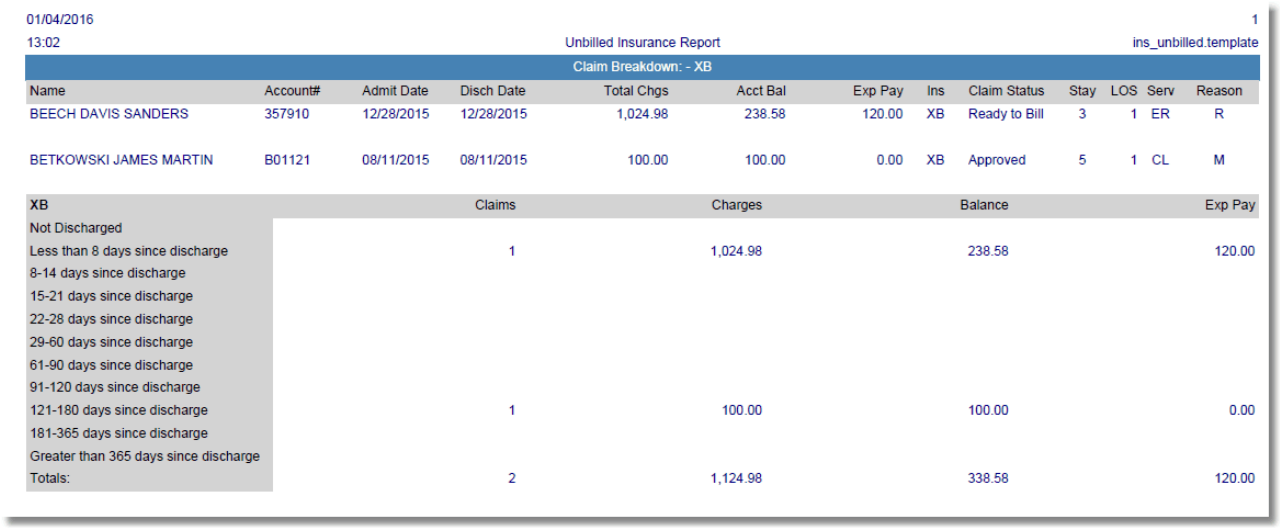
13. Select **Run Report** to display the report in the selected output format.

Description and Usage

The Unbilled Insurance report provides a listing of all insurance claims that have not been billed. It will pull a reason code for not being billed as well as the comment listed on the Insurance Claim Status screen.

The Report Writer application allows the user to filter, sort and manipulate this report so that they may customize the data extracted out of the system. See the additional documentation on Report Writer for more information on these options.

Unbilled Insurance Report - Report Writer



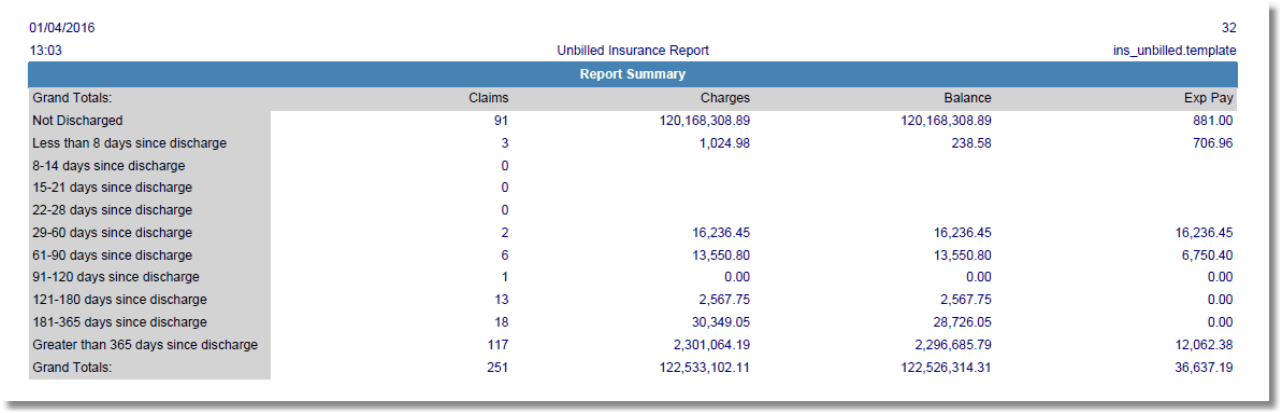
01/04/2016 1
13:02 Unbilled Insurance Report ins_unbilled.template

Claim Breakdown: - XB

Name	Account#	Admit Date	Disch Date	Total Chgs	Acct Bal	Exp Pay	Ins	Claim Status	Stay	LOS	Serv	Reason
BEECH DAVIS SANDERS	357910	12/28/2015	12/28/2015	1,024.98	238.58	120.00	XB	Ready to Bill	3	1	ER	R
BETKOWSKI JAMES MARTIN	B01121	08/11/2015	08/11/2015	100.00	100.00	0.00	XB	Approved	5	1	CL	M

XB	Claims	Charges	Balance	Exp Pay
Not Discharged				
Less than 8 days since discharge	1	1,024.98	238.58	120.00
8-14 days since discharge				
15-21 days since discharge				
22-28 days since discharge				
29-60 days since discharge				
61-90 days since discharge				
91-120 days since discharge				
121-180 days since discharge	1	100.00	100.00	0.00
181-365 days since discharge				
Greater than 365 days since discharge				
Totals:	2	1,124.98	338.58	120.00

Unbilled Insurance Report (Grand Totals) - Report Writer



01/04/2016 32
13:03 Unbilled Insurance Report ins_unbilled.template

Report Summary

Grand Totals:	Claims	Charges	Balance	Exp Pay
Not Discharged	91	120,168,308.89	120,168,308.89	881.00
Less than 8 days since discharge	3	1,024.98	238.58	706.96
8-14 days since discharge	0			
15-21 days since discharge	0			
22-28 days since discharge	0			
29-60 days since discharge	2	16,236.45	16,236.45	16,236.45
61-90 days since discharge	6	13,550.80	13,550.80	6,750.40
91-120 days since discharge	1	0.00	0.00	0.00
121-180 days since discharge	13	2,567.75	2,567.75	0.00
181-365 days since discharge	18	30,349.05	28,726.05	0.00
Greater than 365 days since discharge	117	2,301,064.19	2,296,685.79	12,062.38
Grand Totals:	251	122,533,102.11	122,526,314.31	36,637.19

Listed below is an explanation of each column.

- **Name:** Pulls the patient's name from the Full Name field in the Patient tab on the Registration and ADT screen.
- **Account #:** Pulls the patient's account number from the Registration and ADT screen.
- **Admit Date:** Pulls the patient's admit date from the Stay tab on the Registration and ADT screen.
- **Disch Date:** Pulls the patient's discharge date from the Stay tab on the Registration and ADT screen.
- **Total Chgs:** The total amount charged to the patient account.
- **Acct Bal:** Pulls from the Patient Account Detail screen.
- **Exp Pay:** Pulls from the Detail Charge screen for that claim.

- **Ins:** This column lists the Insurance code of the claim that is set up in the Insurance Claims by Patient screen but is not at a Billed, Paid or Rejected status.
- **Claim Status:** Pulls from the Insurance Claims by Patient screen.
- **Stay:** Pulls the patient's stay type from the Patient tab on the Registration and ADT screen.
- **LOS:** Pulls the patient's Length of Stay and is calculated as Discharge Date minus Admit Date. If the patient has not been discharged, it is calculated as Run-Date minus Admit Date.
- **Serv:** Pulls the patient's service code from the Patient tab on the Registration and ADT screen.
- **Reason:** The Reason Code is determined by the system. The codes are as follows:
  - **A** Patient has not been admitted
  - **D** Patient has not been discharged
  - **G** Insurance has not been generated
  - **I** Insurance has not been verified (Policy Information “Received” is blank
  - **M** Medical Records has not coded or verified the account
  - **R** Claim is Ready to Bill
  - **U** Claim is Unchecked
  - **P** Claim is Pending
- **Comments:** Comments pull from the Insurance Claim Status screen.
- **Ins Totals:** Totals are based on the number of days between discharge date and the date of the report.
- **Claims:** The total number of accounts reported.
- **Charges:** The total amount of the Total Charges column.
- **Balance:** The total amount of the Account Balance column.
- **Exp Pay:** The total amount of the Expected Pay column.