Thrive Provider EHR Financial

Thrive Provider
EHR Financial

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by Evident

PATIENT CENTERED.
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Evident™

Thrive Provider EHR Financial

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Version : 19

Published : October 2017

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Chapter 1 Introduction

1.1 Attestation Disclaimer

Meaningful Use attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. Evident and TruBridge Meaningful Use certified products, recommended processes and supporting documentation are based on Evident's interpretation of the Meaningful Use 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, Evident and TruBridge bear no responsibility for attestation information submitted by the client.

1.2 What's New

This section introduces the new features and improvements for the **Thrive Provider EHR Financial** for release Version 19. An asterisk (*) preceding the WR description denotes this WR was added to the documentation after the initial release. A brief summary of each enhancement is given referencing its particular location if applicable.

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

Additional Demographics -- WR 1301091339

DESCRIPTION: Additional Demographic information can now be captured via this enhancement. The information it will hold is for Alternate name, address, Prefix, Suffix and professional suffix as well as additional phone numbers and contact information.

DOCUMENTATION: See Demographics 12

Ability to Decline Clinical Summary -- 1303250929

DESCRIPTION: The Patient visit Screen now has a field that will allow Patients to Decline a copy of the Patient Summary.

DOCUMENTATION: See New Clinic Visit 28

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Foreign Date Format -- WR 1511201547

DESCRIPTION: Facilities outside of the United States have the ability to choose a date format of MMDDYY, DDMMYY or YYMMDD to be used throughout the Charging application. Currently, the date format excludes reports in the Report Writer format. An Evident Representative will need to be contacted in order for the date format to be changed.

DOCUMENTATION: See Charging Overview.

MU2 Clinical CQMs - Tobacco Table Update -- WR 1307300919

DESCRIPTION: The Tobacco field on the Demographics tab of the Person Profile screen has been changed to Smokeless Tobacco. The field is now table driven. Next to the Smokeless Tobacco field is a look up with a list of responses that may be selected. The list is maintained and supported by Evident. This was created for the purpose of meeting Meaningful Use Objectives.

DOCUMENTATION: See Demographics 12

1.3 Online Presentations

This section contains a list of available online presentations that are applicable for this user guide. They are not intended to replace the detail of the user guide but are to be used in conjunction with the user guides to enhance the process and/or procedures related to this application. To browse all presentations currently available online, sign in to evident.com and select Presentations or click on one of the following links:

Click here to view all Online Presentations
Click here to view all QuickCaps

Auto Closing Day and Months
Charging and Item Master
MP-EHR Appointment Scheduling
Person Profile and Registration

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Chapter 2 Overview

The first section of this user guide will cover the processes of registering patients, incorporating the use of a Person File, as well as charge/coding and appointment scheduling.

The Person File houses all demographic information for a patient and their contacts. This allows for accurate patient records and consistency throughout the registration areas. The charge/coding method is unique to the clinic, and the appointment scheduling is also something that has been redesigned.

The following sections will discuss these unique functions, as well as covering suggested reports and billing processes. However, we also suggest review of additional user guides for:

- Ad Hoc Reporting
- AR Reports
- Auto Closing Days and Months
- Business Office Tables
- Collections
- Medical Records (for transcription & reports)
- Receipting
- System Security

The second section of this user guide will discuss the Thrive Provider EHR Clinical software and how it works in conjunction with the Thrive Provider EHR Financial Software. It provides a complete ambulatory charting system for the management of modern provider offices or large medical clinics. Capabilities of the system include patient charting, prescription entry and retrieval, image storage, ancillary order entry and review, electronic superbill with it automatically being updated based on the charting, as well as many other clinical functions. It allows for multiple users to access and view the same patient record without interrupting work flow. Thrive Provider EHR Clinical is a table and template driven system. It provides the capability for multiple users to enter documentation on the same patient while the system maintains the integrity of the individual entry.

The Ambulatory Clinical Documentation manual will review the system functions and table setup.

Notes on Starting and Using the Software

To start the software, login to ClientWare with the respective clinic login. Logins are specific to the clinic and Evident initially creates 10 logins for each clinic. If needed, more logins may be set up by a Thrive Provider EHR Support Representative. After the login is entered, return through the password, unless the facility has pass worded individual logins with the support of Evident's technical department. The next screen will display as follows:

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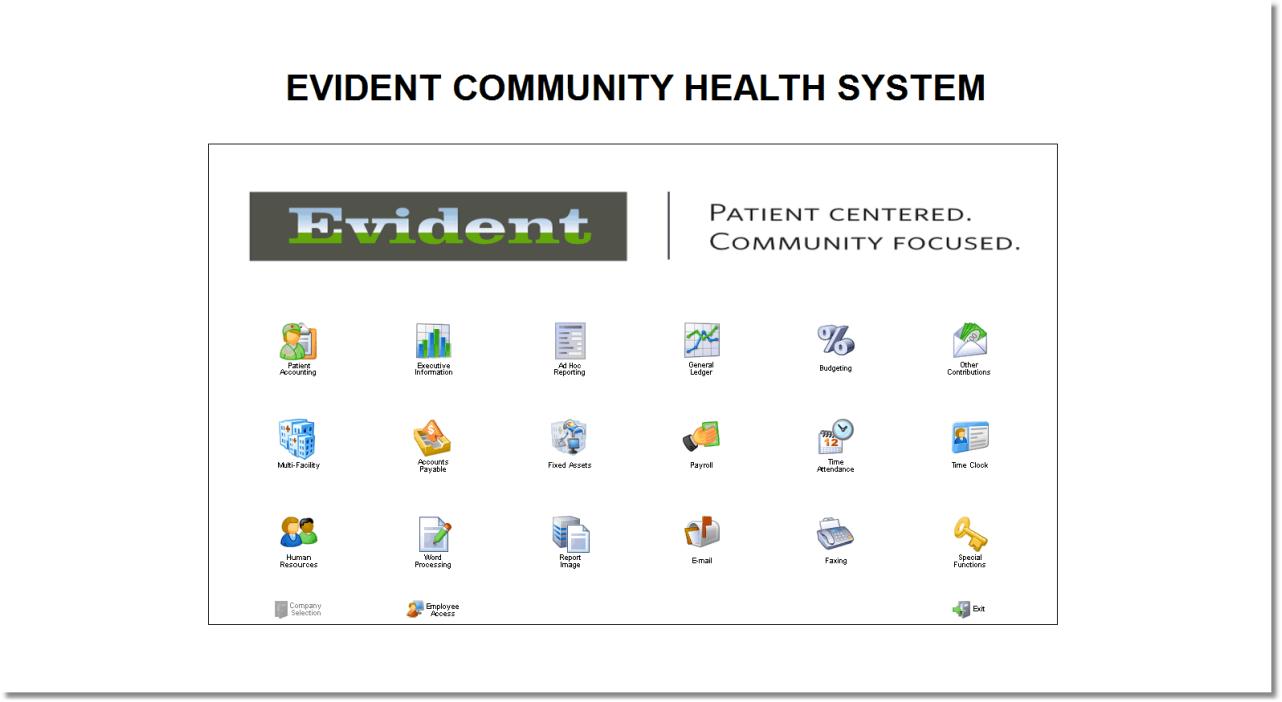
Select **Medical Practice EMR Menu**



Evident System Selection Screen

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The Evident System Selection screen displays the selections that have been purchased. The following applications listed below may be utilized to access the patient accounts:

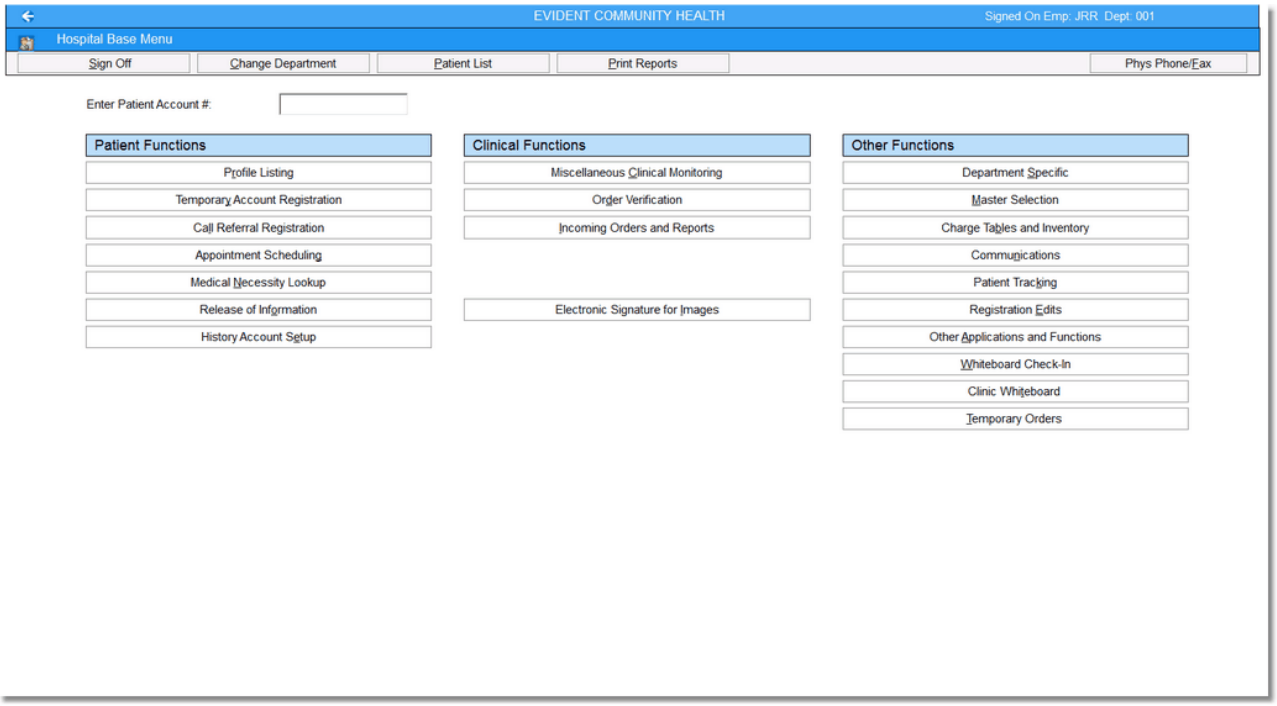
AR – provider AR
DB – Ad Hoc Reporting
WP – Word Processing
SF – Special Functions
RI – Report Image
PW Employee Access

The other applications listed below may be utilized by the practice if purchased. A Evident Marketing Representative must be contacted if these other applications listed are needed by the facility.

AP Accounts Payable
GL General Ledger
FA Fixed Assets
PR Payroll
TA Time Attendance
TC Time Clock

AR should be selected to access the charting module. When selected, the following screen will display and all patient documentation will start from this screen and be discussed throughout this User Guide.

Select **Clinic Base Menu**



Clinic Base Menu

Patient Selection

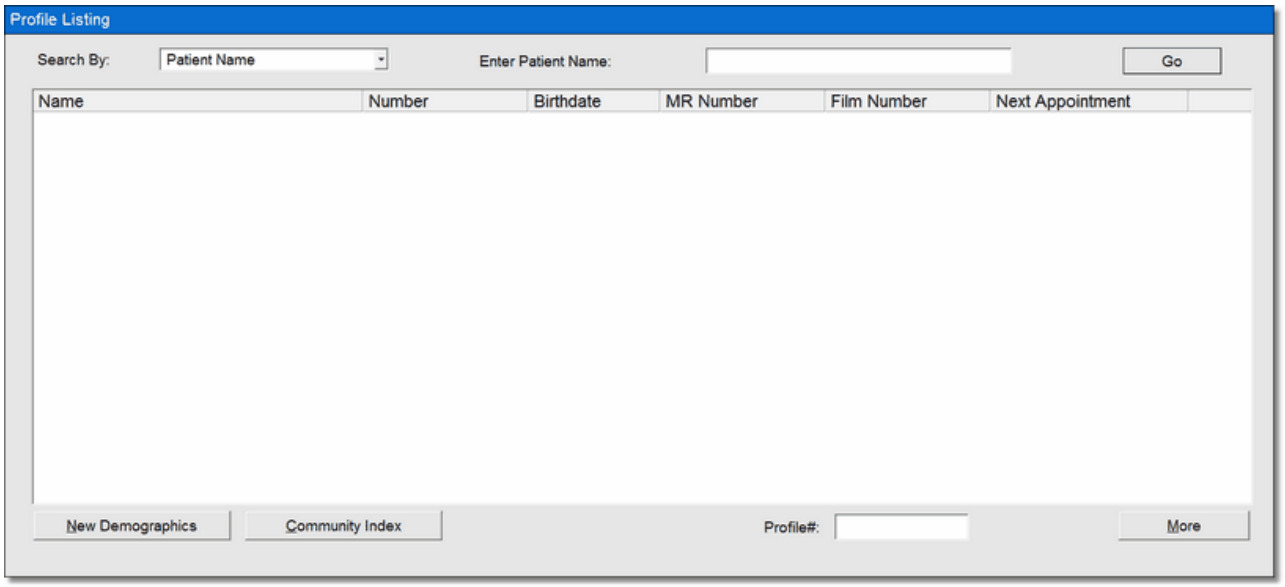
The patient's data may be accessed from the whiteboard as well as from the Clinic Base Menu. From the base menu, utilize one of multiple indexes to search for the patient.

1. From the Clinic Base Menu, select **Profile Listing**.

2. Search for patient by either **Patient Name** or **Guarantor Name**.

3. Visit screen, select **Patient Charting**. There are five options within Patient Charting: Narrative, Electronic Forms, Vital Signs, Patient Image and Print Reports.

Select **Clinic Base Menu** > **Profile Listing** > **Search By: Patient Name**



Profile Listing

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Chapter 3 Registration through Person Profile

3.1 Introduction

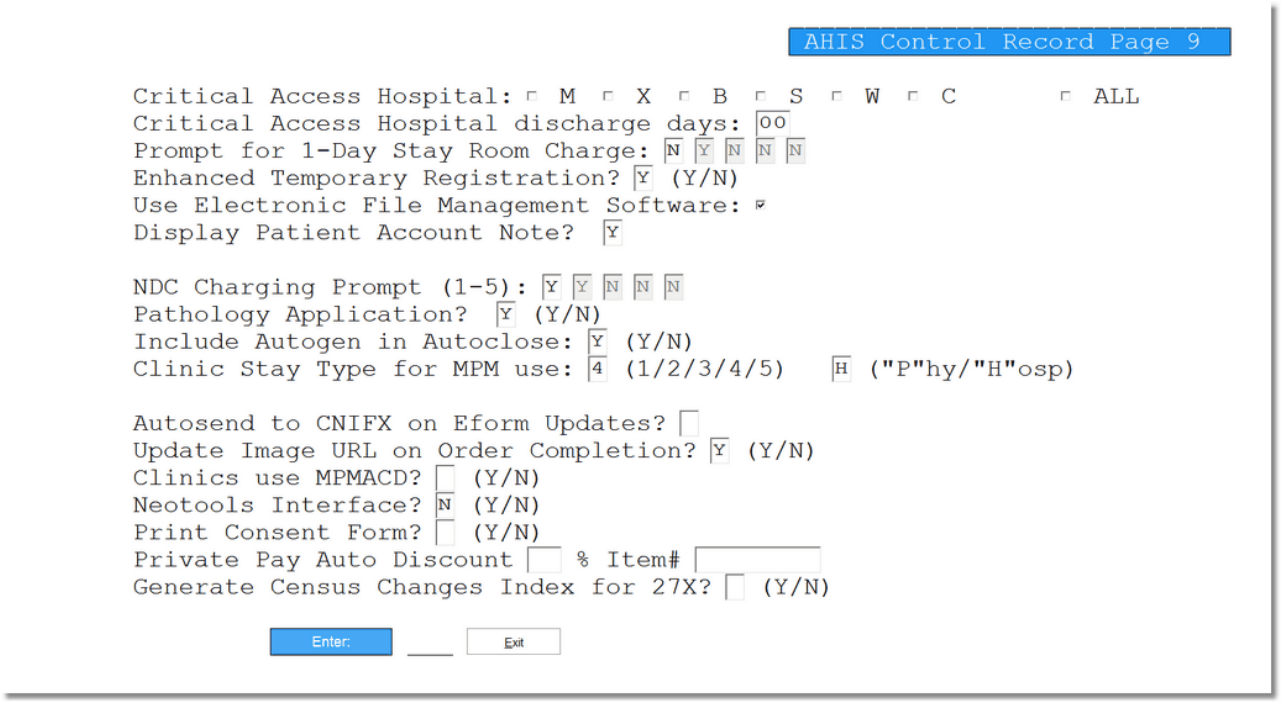
This section will discuss the registration and patient lookup options using the Person Profile. Table set up that is necessary for this to function correctly will also be covered.

3.2 Table Setup

This section will discuss the table maintenance necessary prior to utilizing Registration through the Person File and the new clinic screens.

AHIS

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance Menu** > **AHIS** >**Page 9**



AHIS Control Record, Page 9

- **Clinic Stay Type for MPM use:**
  - The first field represents the Clinic Stay Type. This Stay Type will determine the registration screen selection when **Create Visit** is selected.
  - There are two options for the second field:
    - **H** represents the clinic utilizing the Thrive Provider EHR software as a department of a hospital where the clinics and hospital share the same AR and company.

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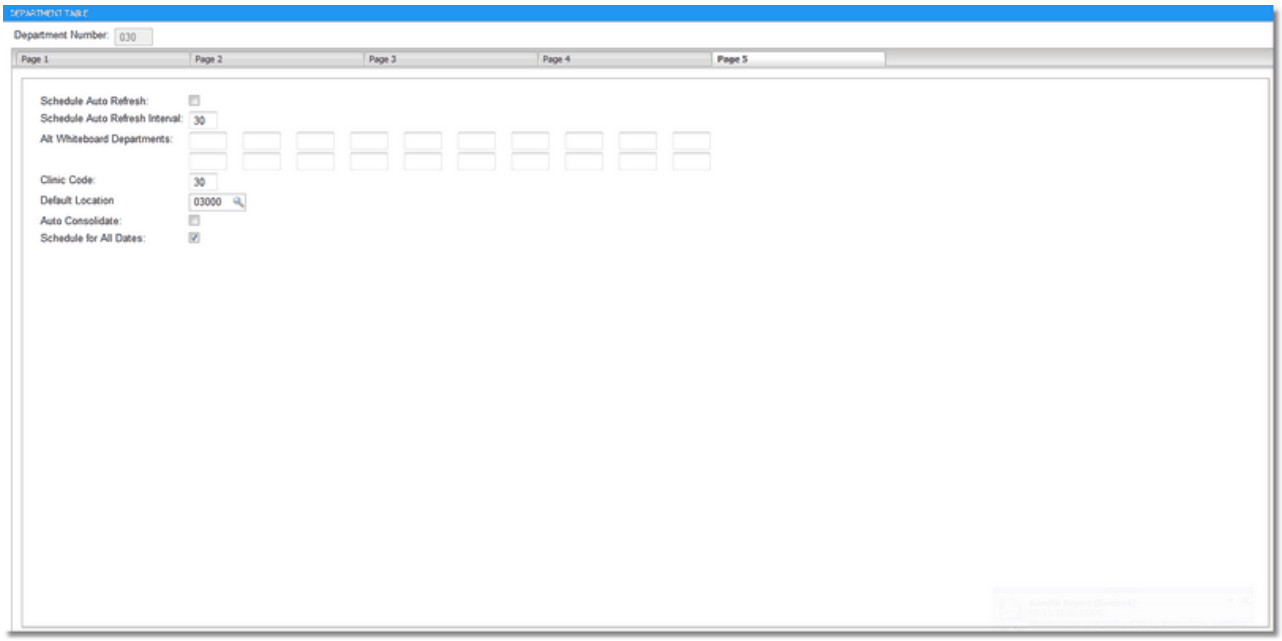
- **P** represents a clinic utilizing the Thrive Provider EHR software as a separate AR and company.

Please contact Evident Client Services Support to adjust this field.

Department Table

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Table Maintenance** > **Control** > **Department Table** > **Page 5**



Department Maintenance, Page 5

- **Clinic Code:** This 2-digit code is set up in the Clinic Code table. A code entered here will pull the place of service associated with this Clinic Code to the 1500 billing form when charging from this department. Each clinic will also need to be set up as a department with the corresponding Clinic Code loaded in this field. A department and clinic code will also need to be set up for each place of service, example nursing home.

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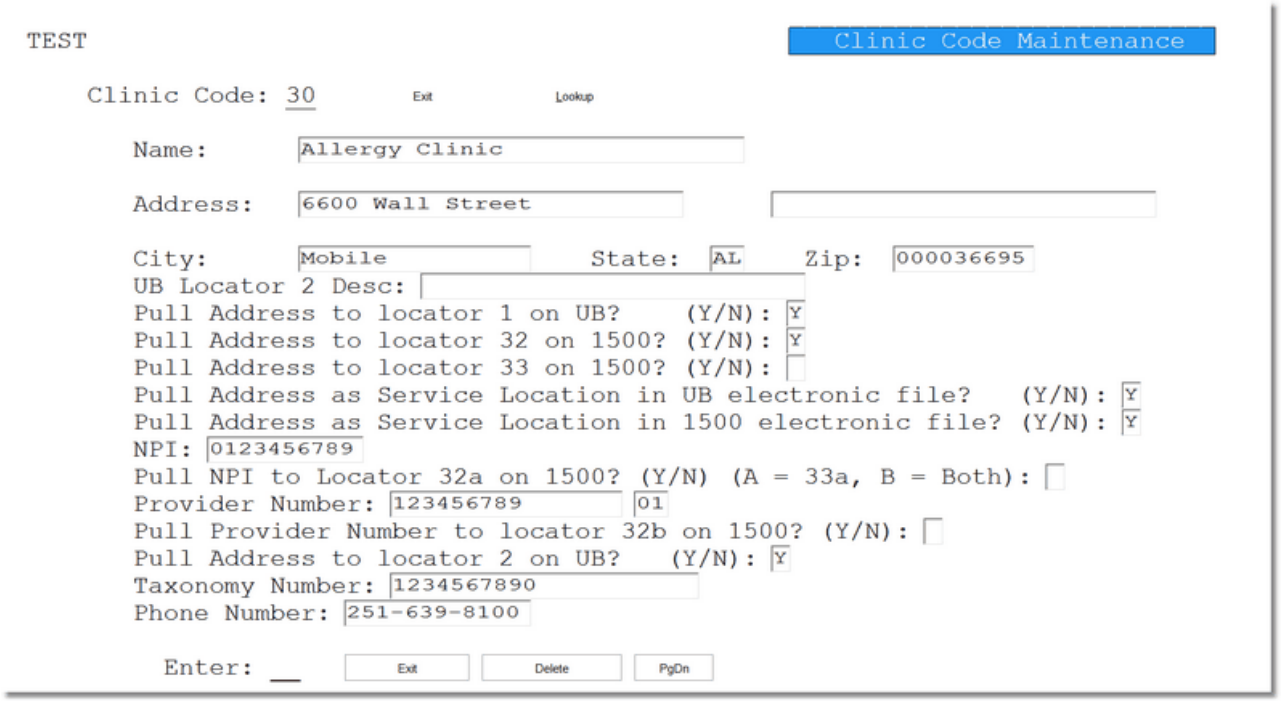
Clinic Code Table

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance** > **Clinic Table**



Clinic Code Maintenance

- **Clinic Code:** Enter 2-digit alpha or numeric code for the clinic.
- **Name:** Enter the clinic name.
- **Address:** Enter the mailing address for the clinic.
- **City, State and Zip:** Enter the City, State and Zip Code for the clinic.
- **Phone Number:** Enter the phone number for the clinic.

NOTE: *This information will pull to the 1500.*

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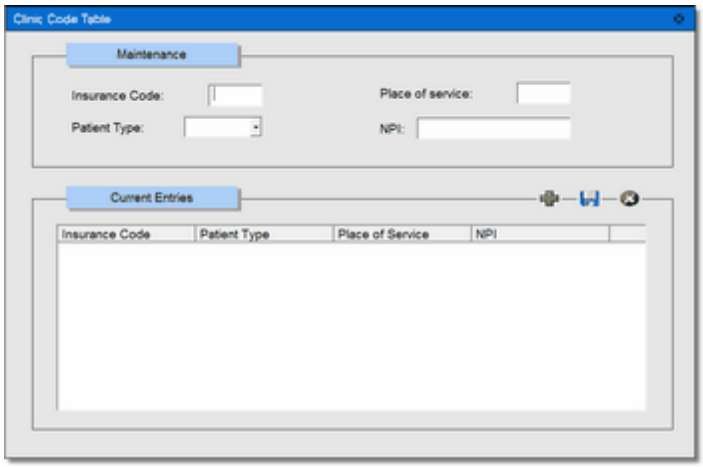
Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance** > **Clinic Table** >**PgDn**



Clinic Code Maintenance, Page 2

The second page of the Clinic Code Table allows the Place of Service and NPI number to be identified for different Financial Classes.

- **Insurance Code:** The specific Financial Class code is loaded in this field. Wild-carding may be used by entering asterisks.
- **Patient Type:** A stay type must be selected to have claim read the Place of Service and NPI. MP-EMR clinic visits default to stay type 2, so entering a **2** or **ALL** will allow information to pull to the claim.
- **Place of Service:** Enter the appropriate Place of Service that is needed for the claim.
- **NPI:** Enter the appropriate NPI number that is needed for the claim. If field is blank, the NPI from page one of the clinic code table will be used.

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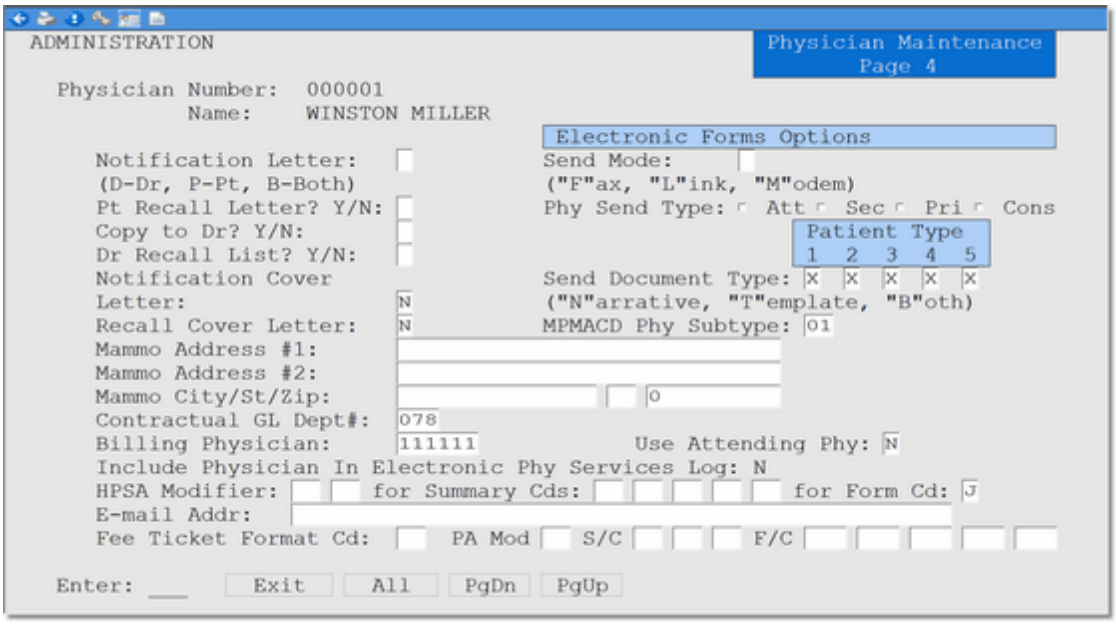
Physicians Table

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance** > **Physicians** > **Page 4**



Physician Maintenance, Page 4

- **Contractual GL Dept #:** If the physician does not float to any other clinic location then the clinic department may be loaded in this field to allow the 8-digit contractual general ledger number for insurance receipting to be completed with the physician's clinic department.

- **Billing Physician:** If an alternate physician number is loaded in this field, the alternate physician's information will show on the 1500 instead of this table's physician (when loaded as the Admitting Physician).

- **MPMACD Phy Subtype:** The Sub Type associated with the physician may be loaded in this field.

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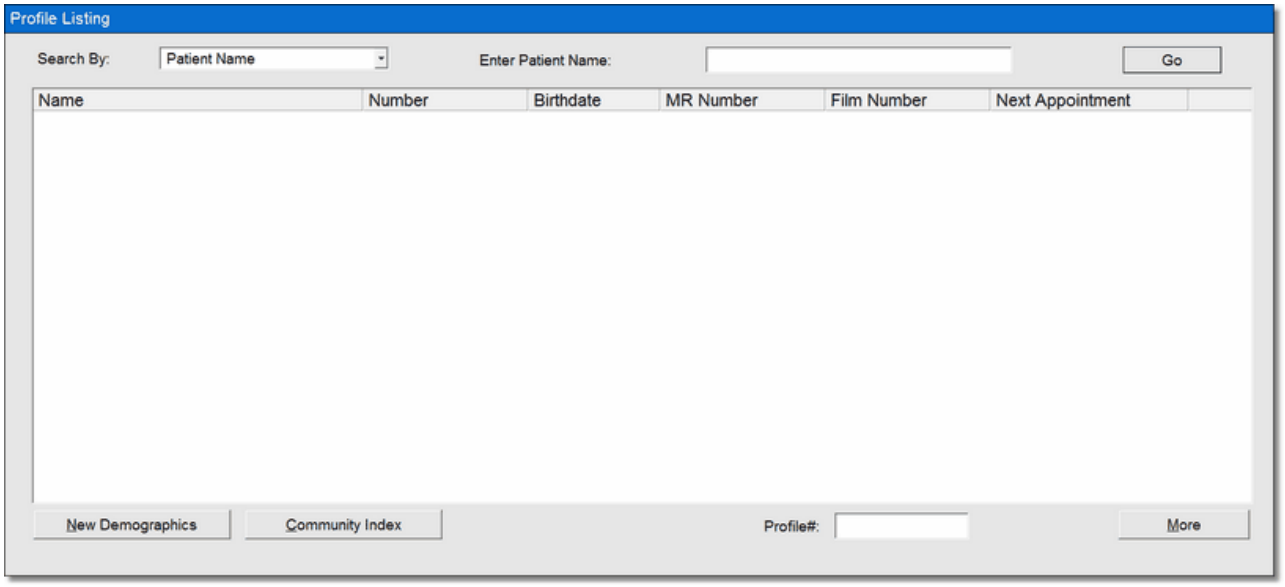
3.3 Profile Listing

All patients and contacts will be listed in the system as a Person File. The Community Listing houses basic demographic and insurance coverage information. Prior to registering a visit, a Person File must be created. The community listing is accessed by selecting the **Profile Listing** (or **Main Patient Registration** in a Combined hospital/clinic A/R) option.

Select **Clinic Base Menu** > **Profile Listing**



Profile Listing

If the person has been previously seen at the facility, search the listing and select the patient's Person File. You may search for the patient by Patient Name, Birth Date, Film #, Medical Record # and SSN/Profile #. Verify all information and make any necessary changes to the file. Even if the person is a new patient to the facility, verify that they are not in the Person File as a guarantor or other contact.

You may also search by guarantor by accessing the Search By option and using the drop-down menu. Select **Guarantor Name**. Enter in the name in the Enter Guarantor Name field. Select **Go**. This will pull the guarantor with each associated guarantee listed beneath and slightly indented.

Demographics

If the patient is not in the system, select **New Demographics**. If a family member of the patient has already been seen at the facility you may access that person and select the **Misc Options** drop-down and then select the "Just-like family member" feature. This will copy the basic demographics, guarantor and insurance information from the current account that was accessed into the new profile once the Social Security Number has been assigned.

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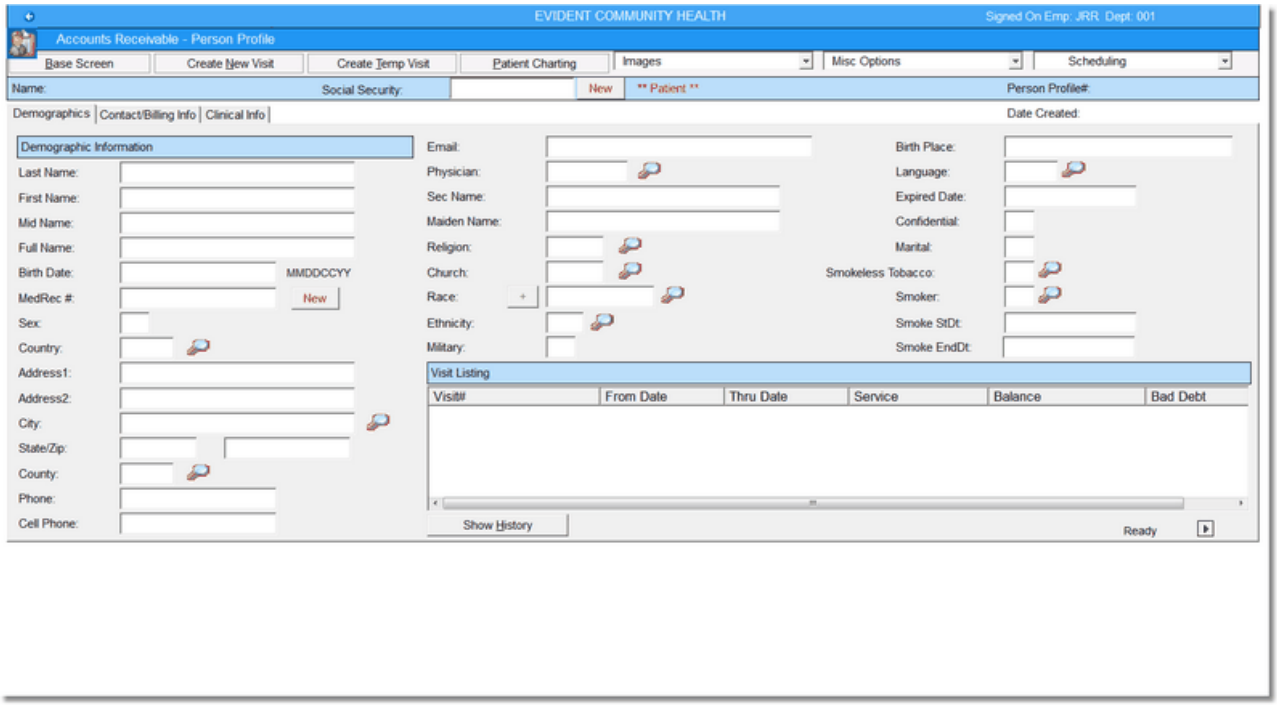
Select **Clinic Base Menu** > **Profile Listing** > **New Demographics**



Accounts Receivable - Person Profile, Demographics

- **Social Security:** Enter the patient's Social Security number or if unknown, select **New**. New will populate the field with a generic number. Once the social security number is determined, it will need to be updated using the **Change SSN** option at top of the Person File.

- **Last Name:** Enter the patient's last name in uppercase letters. Do not use any punctuation.

- **First Name:** Enter the patient's first name in uppercase letters. Do not use any punctuation.

- **Mid Name:** Enter the patient's middle name and any titles, such as "JR" or "MD", the patient may have in uppercase letters. Do not use any punctuation.

- **Full Name:** This field will populate once the last name, first name and middle name are entered.

- **Birth Date:** Enter the patient's Birth Date in MMDDYYYY format. For example, March 18, 1973, should be entered as 03181973. Once the date is entered, the age will calculate and appear to the right.

- **MedRec#:** Enter a Medical Record number. For Medical Record numbers that are assigned automatically by the system, select the **NEW** button or enter a question mark (**?**). A message will appear that states "About to assign a new Med Rec Number. Do you wish to continue?" If **Yes** is selected, the system will assign the next available medical record number loaded in AHIS page 5, Automatic MR#. If **No** is selected, the cursor will remain in the medical record number field.

- **Sex:** Enter **M** for male, **F** for female or **U** for unknown.

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- **Country:** Enter the patient's two or 3-digit country code. A lookup window is available. Select the magnifying glass or enter a question mark (**?**) to see the listing. Entering a code other than **US** will allow alpha characters to be entered in the Zip code field.

- **Address-1:** Enter the patient's street address or Post Office Box number.

- **Address2:** Enter the patient's apartment name and/or number.

NOTE: *If the patient has a physical and mailing address that differ, enter the physical address in the Address1 field and the mailing address in the Address2 field.*

- **City:** Enter the city in which the patient resides. A lookup window is available. Select the magnifying glass or enter a question mark (**?**) to see the listing. Select the correct city.

- **State/Zip:** Enter the state and the five or 9-digit Zip code. Do not separate numbers with punctuation. If utilizing the Auto Zip feature, the state will automatically be entered once the zip code is entered.

- **County:** Enter the County code for the county in which the patient lives. A lookup window is available. Select the magnifying glass or key in a question mark (**?**) to see the listing. Select the correct county.

- **Phone:** Enter the area code and phone number. Do not separate numbers with dashes.

- **Cell Phone:** Enter the area code and cell phone number. Do not separate numbers with dashes.

- **Email:** Enter the patient's email address. Punctuation may be used in this field.

- **Physician:** Enter the primary physician for the patient if appropriate. This will pull to new clinic visits or accounts for the hospital as the physician or admitting physician. This field may be skipped and the physician entered on the visit.

- **Sec Name:** Enter the patient's nickname or "aka" name. This will pull to certain letters or other patient communications if requested.

- **Maiden Name:** Enter the patient's maiden name.

- **Religion:** Enter the Religion code that describes the patient's religion. A lookup window is available. Select the magnify glass or enter a question mark (**?**) to see the available options. Select the correct religion.

- **Church:** Enter the Church code that represents the patient's church. A lookup window is available. Select the magnify glass or enter a question mark (**?**) to see the listing. Select the correct church.

- **Race:** Enter the patient's race. This field will accept up to 10 alpha/numeric characters that are facility-defined. Select the magnify glass or enter a question mark (**?**) to see the listing. Select the correct race.

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- **Ethnicity:** Enter the patient's ethnicity. This field will accept up to 20 alpha/numeric characters that are facility-defined. For reporting purposes, it is important to be consistent with the ethnicity codes used.

- **Birth Place:** Enter the patient's city and state of birth. This is a free text field with no lookup window.

- **Language:** Enter the patient's language. This field will accept up to 20 alpha/numeric characters that are facility-defined. For reporting purposes, it is important to be consistent with the language codes used.

- **Expired Date:** If the patient has expired, enter the date in this field. This date is attached to the patient's medical record number and will pull to the Master Patient Index.

- **Confidential:** If the patient is to be considered confidential, enter a **Y** in this field. Enter **N** if the patient is not confidential. Making a patient confidential will allow them to be omitted from several Census reports and eliminate them from the patient index for employees that do not have access.

- **Smokeless Tobacco:** Enter the code that represents the patients current tobacco usage. A look up window is available. Select the **magnifying glass icon,** or enter a question mark **(?)** to see the listing. Select the correct current tobacco usage. These categories are hard coded.

1 Does not use moist powdered tobacco
2 Never used moist powdered tobacco
3 Ex-user of moist powdered tobacco
4 Never chewed tobacco
5 Snuff user
6 User of moist powdered tobacco
7 Chews tobacco
9 Tobacco consumption unknown

- **Marital:** Enter one of the following hard-coded marital status codes for the patient:

S	Single	**X**	Separated	**W**	Widowed
M	Married	**U**	Unknown		
D	Divorced	**P**	Life-Time Partner		

- **Smoker:** Enter **Y** if the patient smokes or **N** if the patient does not smoke.

- **Military:** Enter a **Y** if the patient is receiving Military benefits such as Tricare. Enter an **N** if the patient is not receiving military benefits.

Visit Listings

Steps to create a New Visit will be discussed in detail later in this document.

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Misc Options

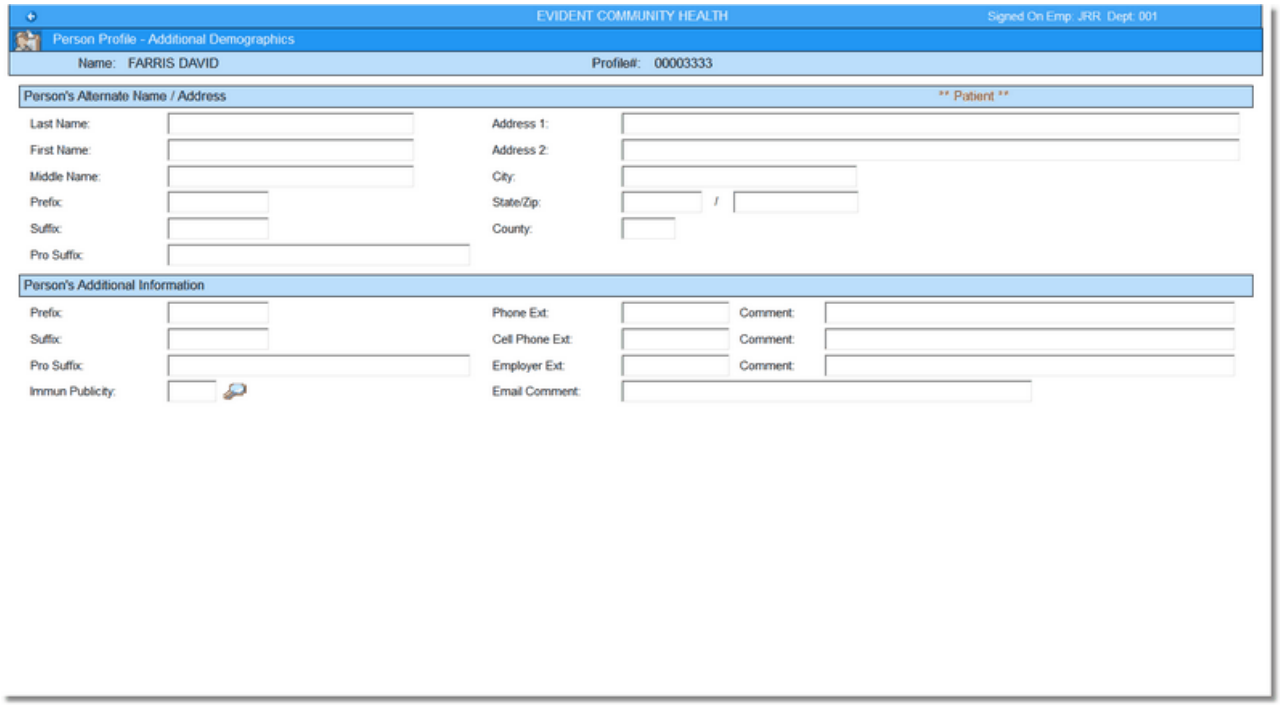
Miscellaneous Options allow access to other functions on the patient's profile in the Thrive System.

Additional Demographics

the information entered on the Additional Demographic screens does not copy to any other part of the system. The information entered is informational only.

This option will allow the capture of additional demographic information. If information is entered on this screen from the Person Profile, that information will pull to the Additional Demographic screen on the visit. Misc Options > Additional Demographics when a new visit is created through the Create New Visit option. However, changes made to the Additional Demographic screen from the Person Profile will not copy to existing visits.

Select **Clinic Base Menu** > **Profile Listing** > **Search Patient** > **Misc Options** > **Additional Demographics**



Miscellaneous Options

NOTE: The Additional Demographics screen may also be accessed on the Emergency Contact profile and the visit.

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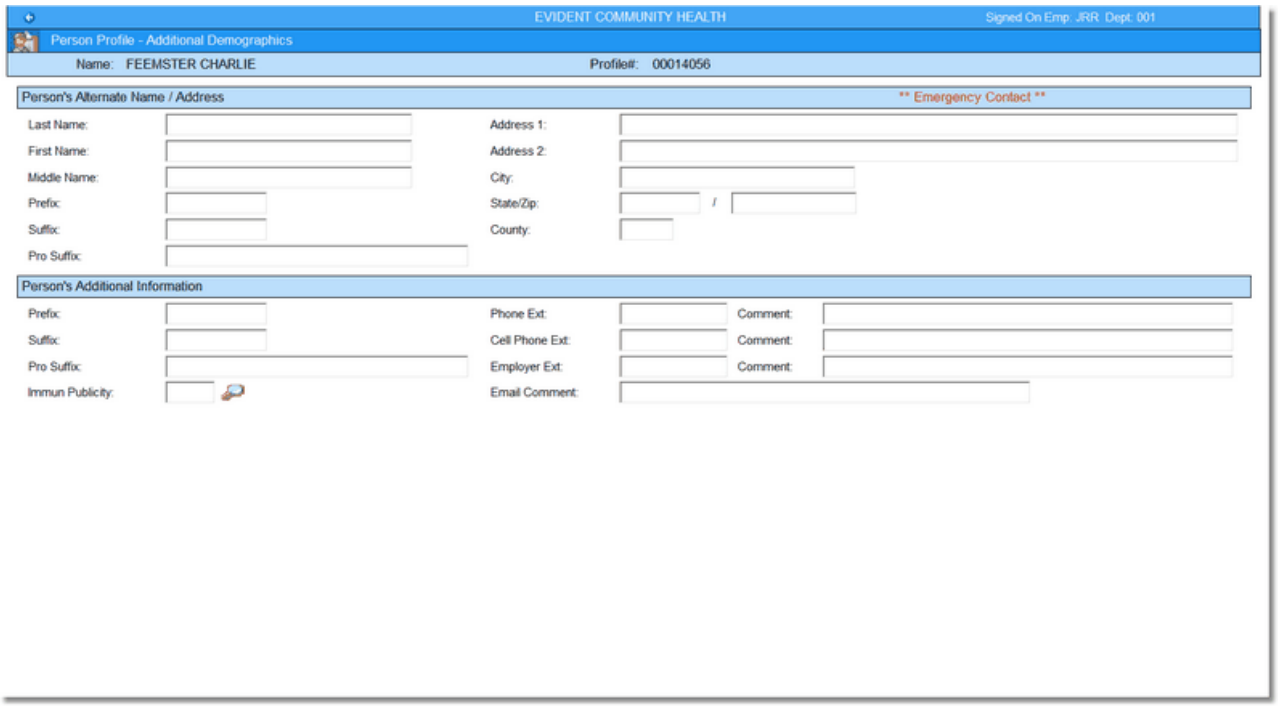
Select **Clinic Base Menu > Profile Listing > Search Patient > Contact/Billing Info > Notify > Misc Options > Additional Demographics**



Person Profile - Additional Demographics, Emergency Contact

NOTE: The Immun Publicity (Immunization Publicity) field has been added to the Patient Profile and Emergency Contact profile Additional Demographics screens. this field will be used for the immunization administrations. Select the magnifying glass icon to search the Immunization Publicity Code Table for the appropriate code.

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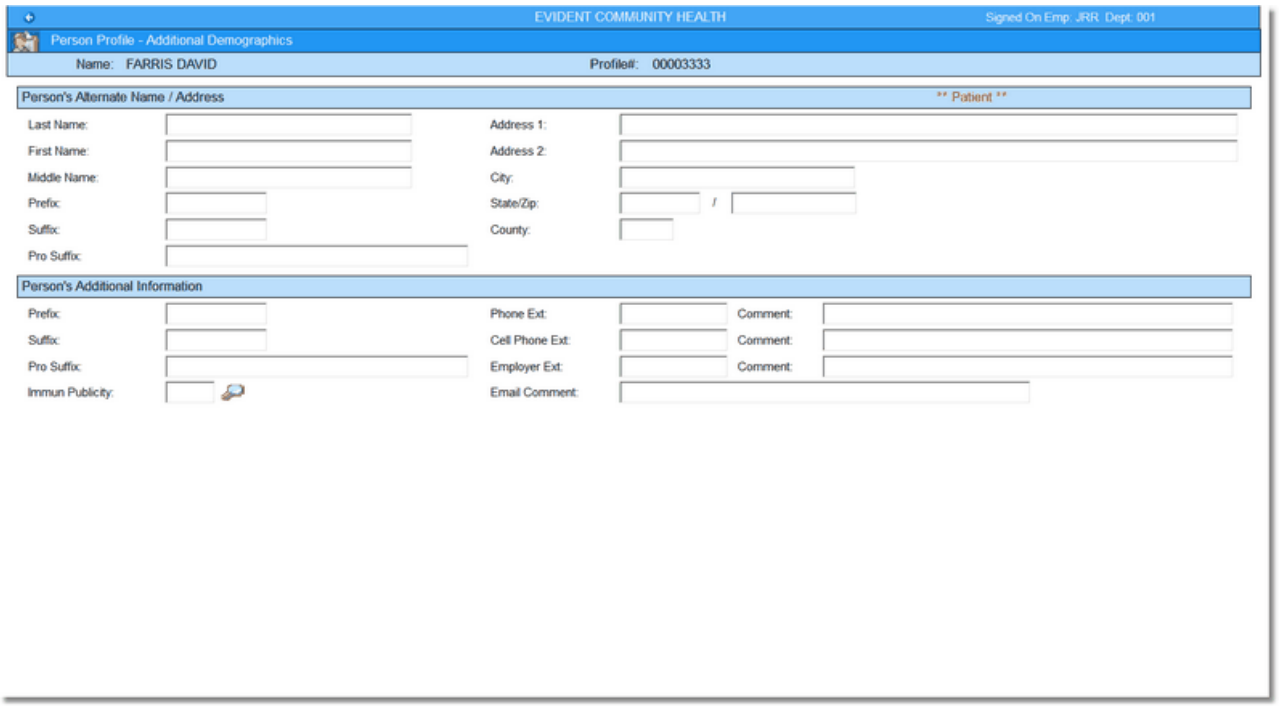
Select **Clinic Base Menu** > **Patient Account #** > **MP-EMR Visit** > **Misc Options** > **Additional Demographics**



Visit Additional Demographics

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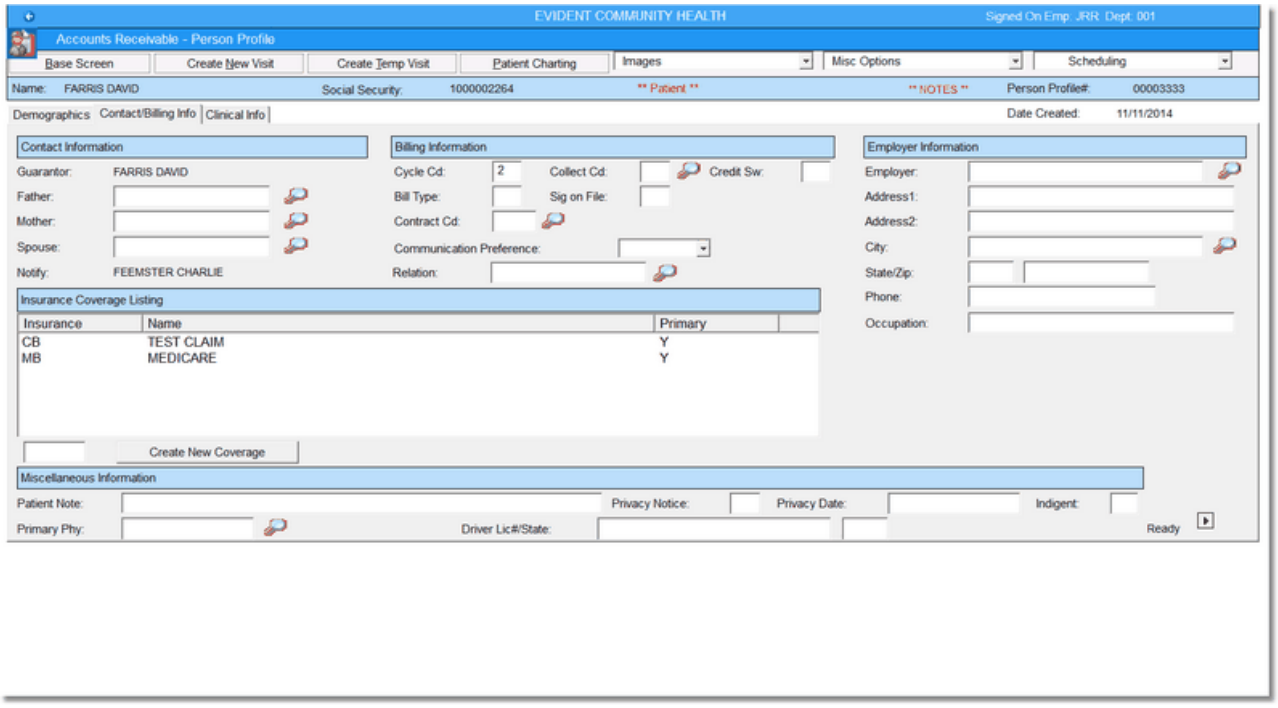
Contact/Billing Info

Select **Clinic Base Menu** > **Profile Listing** > **Person File** > **Contact/Billing Info**



Accounts Receivable - Person Profile, Contact/Billing Info

Contact Information

For contacts attached to the account, a Person File must exist. If the contact is not listed in the facility's Profile Listing, a new demographic will need to be added. To add the contact, use the magnifying glass to access the Profile Listing and select the correct person. Be sure to verify the information listed for contact. If the contact is not in the listing, select New Demographic to add.

- **Guarantor:** Select the guarantor for the account. A lookup window is available. Select the magnifying glass to see the listing. This is important for the billing process. Entering a "S" and enter in this field will attach the patient as the guarantor.
- **Father:** Select the patient's father. A lookup window is available. Select the magnifying glass to see the listing.
- **Mother:** Select the patient's mother. A lookup window is available. Select the magnifying glass to see the listing.
- **Spouse:** If the patient is married, select the spouse. A lookup window is available. Select the magnifying glass to see the listing.
- **Notify:** Select the patient's notify in case of emergency contact. A lookup window is available. Select the magnifying glass to see the listing.

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NOTE: *To change a contact listed or update information, use the mouse to right-click the person. Select either* ***Edit*** *or* ***Remove*** *and select* ***OK****.*

Billing Information

- **Cycle Cd:** System assigned during the statement process. Denotes the billing cycle in which patient will receive a statement.
- **Collect Cd:** Do not populate this field at the time of registration. The system automatically assigns this code during the statement process.
- **Credit Sw:** This field is not required to be used. Site's may utilize this field as needed for informational purposes.
- **Bill Type:** If necessary, enter one of the following Bill Switches to prevent a statement from printing for this patient:

  I Insurance Only
  X Medicaid Patient
  A Address Incorrect (remove this as soon as address is corrected)
  D Need Detailed Statement (manually requested)

- **Sig on File:** If the person's signature is on file, this field should be marked as **Y**. This relates to locators 12 and 13 on the 1500 form.
- **Contract Cd:** This field should not be populated on the Profile unless this patient will never be seen for purposes other than a contracted account.

Employer Information

- **Employer:** Enter the patient's employer name. A lookup window is available. Select the magnifying glass or enter a question mark (?) to see the listing. Select the correct employer.
- **Address1:** Enter the street address or Post Office Box number of the employer's location. When the lookup is used, this will pull from the Employer Table.
- **Address2:** Enter the suite name and/or number.
- **City:** Enter the city. A lookup window is available. Select the magnifying glass or enter a question mark (?) to see the listing. Select the correct city.
- **State/Zip:** Enter the state and the five or 9-digit zip code.
- **Phone:** Enter the area code and phone number of employer. Do not use punctuation marks.
- **Occupation:** Enter the occupation of the patient.

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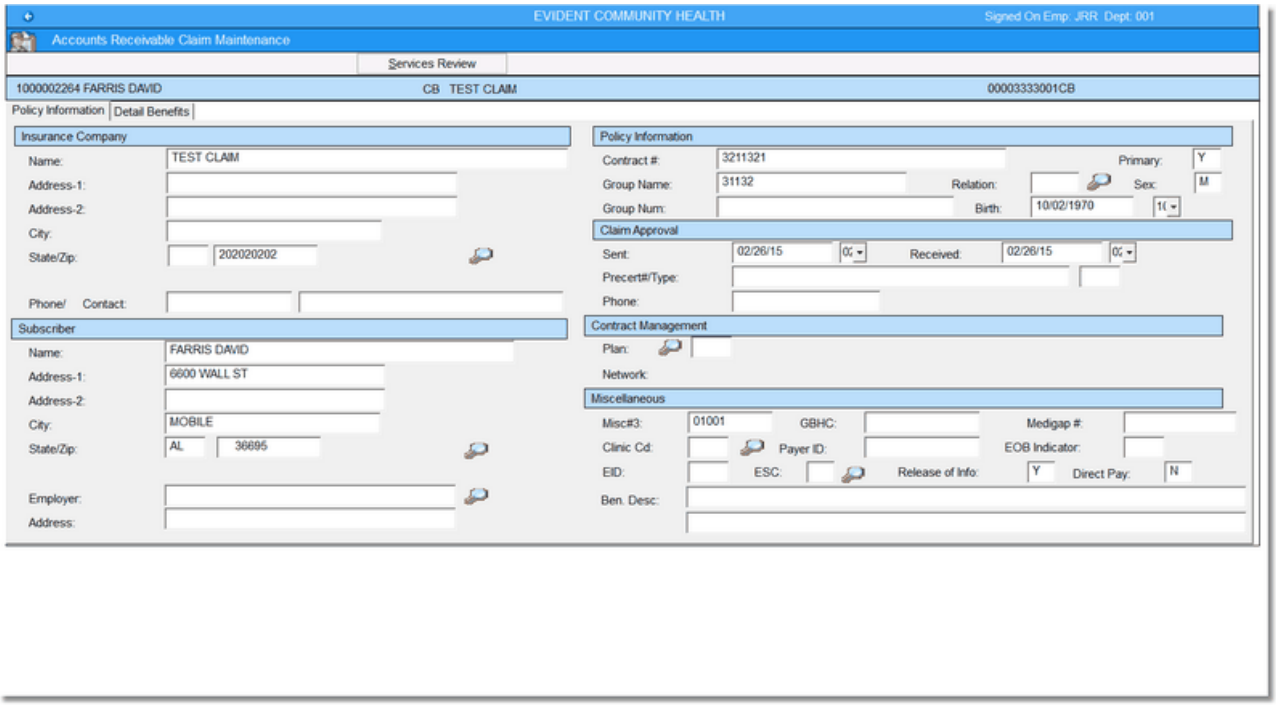
Insurance Coverage Listing

This will list the patient's current Insurance financial class information. This will list all active coverage for the patient for all of patient visits/accounts. Select **Create New Coverage**, and using the lookup select the correct Insurance financial classes.

Select **Clinic Base Menu** > **Profile Listing** > **Person File** > **Contact/Billing Info** > **Create New Coverage**



Policy Information for Account

Insurance Company

- **Name:** The name of the Insurance Company that was entered on the Contact/Billing Info tab will pull.
- **Address-1:** Enter the street address or Post Office Box number of the Insurance Company.
- **Address-2:** Enter additional address information if necessary.
- **City/State:** Enter the City and the 2-character State code and Zip code.
- **Phone:** Enter the area code and phone number of Insurance Company
- **Contact:** Enter the name of the person who should be contacted to verify insurance information.

NOTE: *When the Insurance Company's Name, Address1, Address2, City, State and Zip Code are loaded in the Insurance Company table, the information will automatically pull to the above fields.*

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Subscriber

- **Name:** The name of the guarantor entered will pull to the subscriber section for all insurance types except for Medicare and Medicaid, which will pull the patient name.

NOTE: *The Copy Guarantor Info to Ins. Subscriber field on page 8 of AHIS will allow the guarantor information to pull the subscriber fields. If this field is set to* ***P****, the patient information will pull to the subscriber fields. An* ***N*** *will allow these fields to remain blank.*

- **Address-1:** Pulls the guarantor's street address or Post Office Box number.

- **Address-2:** Pulls the guarantor's apartment name and/or number.

- **City/State:** Pulls the guarantor's city in the first field, the state in the second, and the zip code in the last field.

- **Employer:** Pulls the guarantor's employer. Select the magnifying glass or enter a question mark (**?**) to access the employer lookup. If the employer is not listed, enter 999 as the employer code and the field will become free form.

- **Emp. Address:** Pulls the guarantor's employer's street address.

- **EID:** The Employment Information Data should be entered here.

- **ESC:** Employment Status Code (ESC) is updated manually. There is not a lookup for this field.The following codes apply:
  - **1**-Full Time
  - **2**-Part Time
  - **3**-Unemployed
  - **4**-Self Employed
  - **5**-Retired
  - **9**-Unknown

Policy Information

- **Contract #:** Enter the Contract number of the insurance.

- **Primary:** This field should be answered **Y** for the primary insurance and **2** or **3** for all other insurances.

  Setting the secondary and tertiary insurances primary switch to a 2 or 3 helps insurance billers identify which secondary insurance to bill after the primary insurance company has paid.

- **Group:** Enter applicable group information.

- **Direct Pay:** If set to **N** the hospital receives the reimbursement. If set to **Y** the patient receives the reimbursement. This will default to **N**.

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- **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 then type what needs to pull to locator 19 on the 1500 form or to locator 80 on the UB04.

- **Medigap#:** The Medigap number is used for certain intermediaries. It may be entered manually or pull from the Medigap field on page 8 in the Insurance Company table.

- **GBHC:** The Georgia Better HealthCare number should be entered here.

- **Payer ID:** The Payer ID for electronic billing may be manually loaded here or may pull from the Payor ID field on page 4 in the Insurance Company table.

Claim Approval

- **Sent:** This field is updated with the current dates as soon as a financial class code is entered on the account.

- **Received:** The Received field works based on the financial class. 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**, once approval is received (pre-authorization) a received date will need to be manually entered. To enter the current date a period may be entered (**.**). If the field is set to **N**, the system will update the received date when the claim is created.

- **Precert #/Type:** Enter the intermediaries' Pre-certification Authorization number and Qualifier Code Type obtained. A 25-digit precert number may be entered. The Qualifier Code designates the type of Pre-certification Authorization Number. If a Qualifier Code is not entered, the system defaults to **G1**.

- **Phone #:** The Pre-certification Phone Number pulls from page 4 of the Insurance Company table.

- **Clinic Code:** Do not enter information in this field. The clinic code will be updated at the time of charge entry for the clinic.

- **Pat's Relation to Sub:** This code indicates the patient's relationship to the subscriber. This code pulls to locator 59 on the UB04 and locator 6 on the 1500. Some codes that may apply include:
  - **18**-Self
  - **01**-Spouse
  - **19**-Natural Child/Insured Financial Responsibility
  - **43**-Natural Child/Insured does not have Financial Responsibility
  - **17**-Step Child
  - **10**-Foster Child
  - **15**-Ward of the Court
  - **20**-Employee

- **Subscriber's Sex:** Enter the sex of the subscriber.

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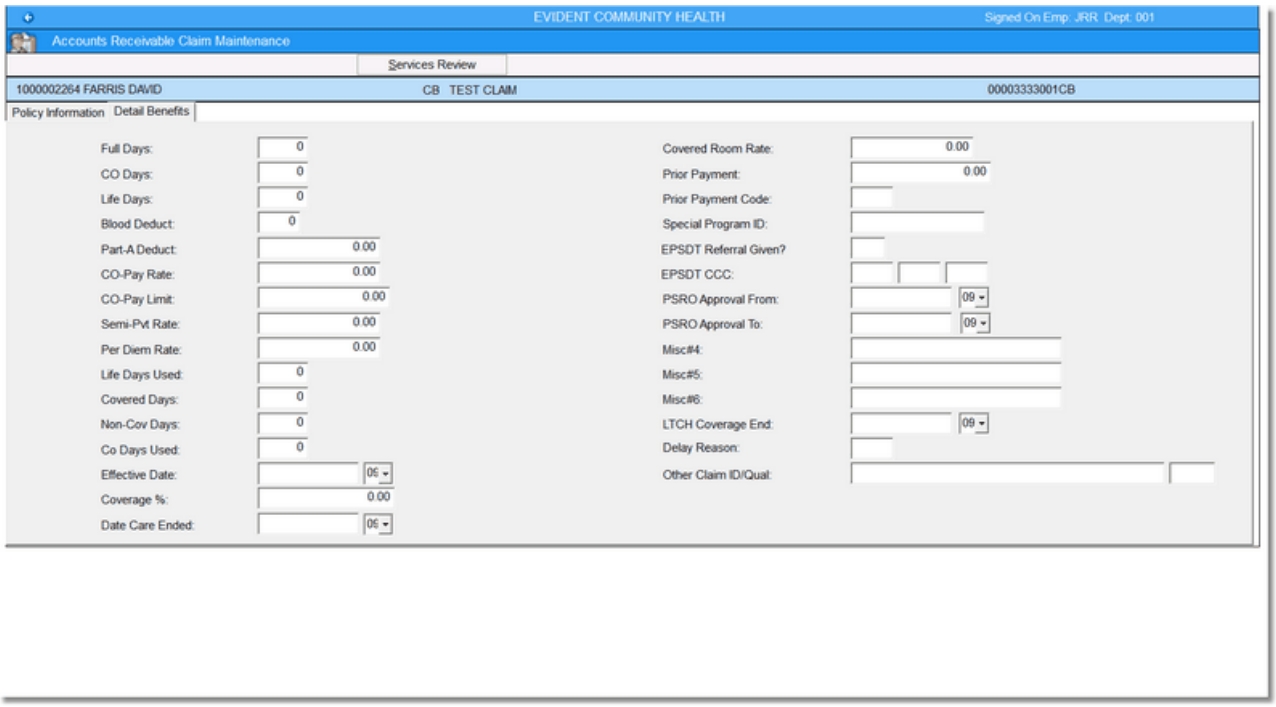
- **Subscriber's DOB:** Pulls the guarantor's date of birth in the format of MMDDYYYY.
- **Misc#3:** This field is for state specific use. This miscellaneous field requires information to be entered manually.
- **Release of Information:** This field is used for institutional claims. If blank, the system 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 UB04.

Contract Management

- **Plan:** Updated manually by facilities using the Contract Management application or may be pulled automatically from the Insurance Company Table.
- **Network:** Updated automatically by the system when using the Contract Management application.
- **EOB Indicator:** Entering **Y**, will indicate if the secondary payer needs a hardcopy EOB from the primary attached to the claim.

Detail Benefits

Select **Clinic Base Menu** > **Profile Listing** > **Person File** > **Contact/Billing Info** > **Create New Coverage** > **PgDn**



Insurance System - Detail Benefits

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- **Full Days:** Enter the maximum number of days the Insurance Company plans to cover the patient.
- **Co Days:** Enter the maximum number of days the Insurance Company will partially cover the patient's bill amount.
- **Life Days:** Life Days normally only apply to Medicare claims. If life days apply to this patient's insurance, enter the number of days in this field.
- **Blood Deduct:** Enter the number of pints of blood the patient is responsible for paying for.
- **Part A Deduct:** Deductible amounts lower the expected pay amount but do not affect the covered and non-covered dollar amounts. If there is a deductible amount, enter it in this field.
- **Co-Pay Rate:** Enter the rate the patient is responsible for if co-insurance days are used.
- **Co-Pay Limit:** If those patients using co-insurance days have a limit on the co-pay rate, enter the limit amount in this field.
- **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:** The daily Per Diem rate loaded in the Insurance Company table for a particular Financial Class will pull to this field.
- **Life Days Used:** Enter the number of life days used for the Insurance claim.
- **Covered Days** and **Non-Cov Days:** The covered and non-covered days are updated by the system. When the claim is generated, the system looks at the full days field and determines if the days are covered or non-covered.
- **Co Days Used:** Load the number of co-days a patient has used for a particular financial class.
- **Effective Date:** Enter the date the insurance coverage began. The date should be entered in MMDDYY format.
- **Coverage %:** If the Insurance Company is not covering a claim at 100%, enter the percentage amount in this field.
- **Date Care Ended:** Enter the date the Insurance Policy ended. Enter the date in MMDDYY format.
- **Covered Room Rate:** Enter the covered room rate amount. This field is used for informational purposes.
- **Prior Payment:** If an insurance payment was made on the account for a billing period prior to the period the claim is being generated, enter the payment amount in this field.

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- **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? **Y** or **N**
- **EPSDT CCC:** Certification Code for EPSDT: **AV**(available-not used), **NU** (not used), **S2**(under treatment) or **ST** (new service requested)
- **PSRO Approval From:** Not used at this time.
- **PSRO Approval To:** Not used at this time.
- **Misc#4:** This field is informational and must be entered manually.
- **Misc#5:** This field is informational and must be entered manually.
- **Misc#6:** This field is informational and must be entered manually.
- **LTCH Coverage End:** If the patient's benefits expire prior to the time of discharge, the date coverage ends may 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.

NOTE: *If there is a required field on Policy Information or Detailed Benefits, that information must be filled out before exiting this screen. The required field will highlight in red indicating this information must be entered. This is defined by the Policy Information Controls in the Insurance Company table by entering an* ***R*** *in the required fields.*

Miscellaneous Information

- **Patient Note:** This is a free text note about the patient.
- **Privacy Notice:** Indicates if the patient has signed a Privacy Notice.
- **Privacy Date:** Enter the date the person received the privacy notice. To have the current date pull, type a period (**.**) then tab to next field.
- **Indigent:** Enter a **Y** if this is a Medicare patient and has been deemed indigent. Leave this field blank if this patient is not indigent. For financial classes other than Medicare, this field may remain blank. This information will pull to the Medicare Bad Debt report.
- **Family Phy:** Enter the family physician number. There is a lookup available by selecting the magnifying glass. This will pull to all hospital accounts, Stay tab.

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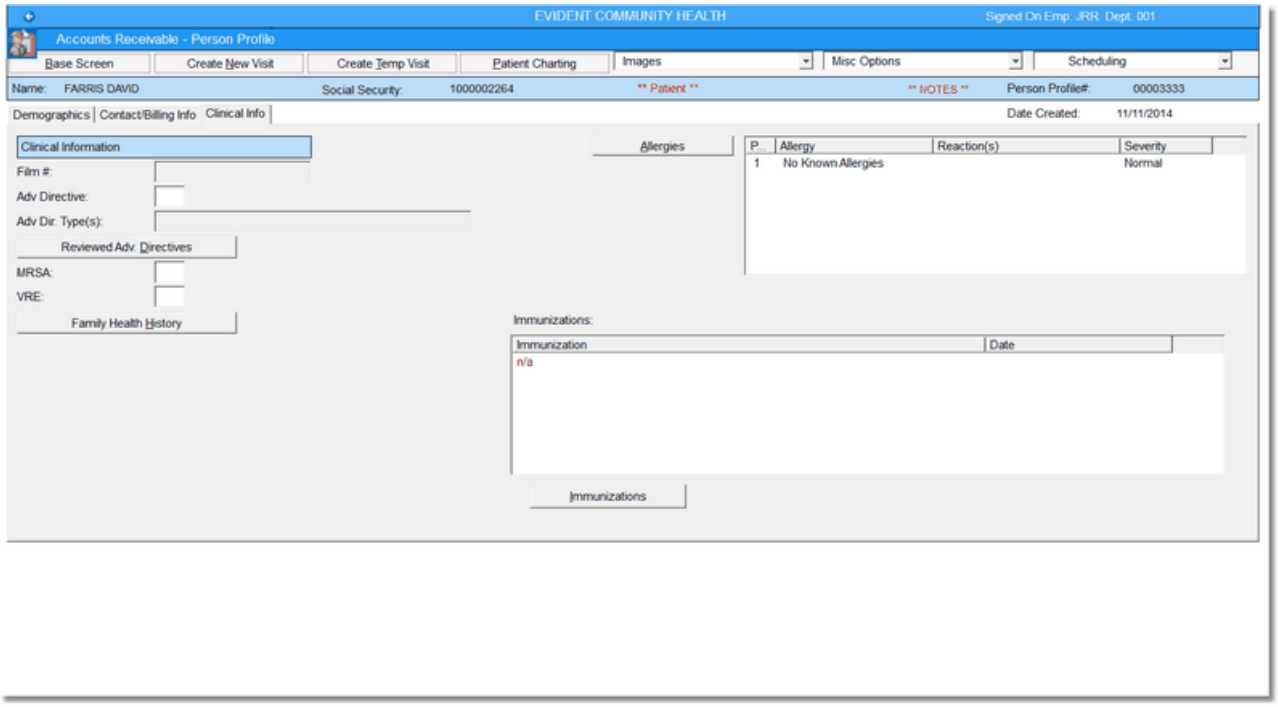
Clinical Info

This section will contain information that will be used by clinical areas and personnel. This section will contain the patient's allergy and immunization information as well as Isolation and Advance Directive information.

Select **Clinic Base Menu** > **Profile Listing**> **Person File** > **Clinical Info**



Accounts Receivable - Person Profile, Clinical Info

- **Film #:** This will be used by the hospital radiology department.
- **Adv Directive:** Enter **Y** if the patient has an Advanced Directive (such as a living will), **N** if the patient does not have an Advanced Directive, **U** if Unknown or **A** if Not Applicable.
- **Adv. Dir. Type(s):** This is a free text field that will be used for informational purposes.
- **Reviewed Adv. Directives:** Selecting this button will populate the date and time to indicated that Adv. Directive was reviewed. The user's initials will populate with the date and time.
- **MRSA:** This field will not by utilized by the clinic at this time.
- **VRE:** This field will not by utilized by the clinic at this time.

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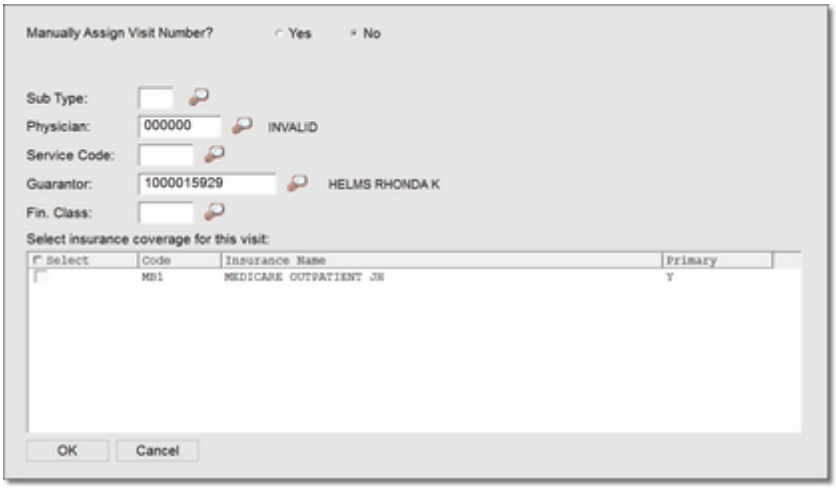
- **Allergies:** Select this option to obtain a listing of allergies to add to the patient's account. An allergy may be selected from the list, **No Known Allergies**, **No Known Drug Allergies**, **No Know Env. Allergies** or **No Known Food Allergies** may be selected or **Other** may be selected to enter free text. Select **Save Changes** before exiting this screen.

- **Immunizations:** Select this option to obtain a listing of immunizations to add to the patient's account. An immunization may be selected from the list or select **Create New Immunization** to add one. Enter a date in the Date Received field, and select **Add**. Select **Save Changes** before exiting this screen.

New Clinic Visit

To create a New Clinic Visit, from the Demographics tab of the Person File, select the option **Create New Visit** at the top of the screen. If the clinic is using Sub Types an additional Sub Type prompt will appear, the use of Sub Types will be discussed with Evident staff prior to use.

Select **Clinic Base Menu** > **Profile Listing** > **Select Patient** > **Create New Visit**



Visit Information

- **Manually Assign Visit Number?** A visit number may be manually assigned by selecting the Yes radio button.

- **Stay Type:** Select the visit Stay Type by using the drop-down menu.

- **Sub Type:** If using Sub Types this option will be available. Enter in the Sub Type for this visit. A lookup is provided.

NOTE: *The Stay Type field is only available for the hospital setting.*

- **Physician:** The physician will default from the Person Profile, if loaded there, otherwise this should be entered or over-keyed to reflect the provider the patient will be seeing for this visit.

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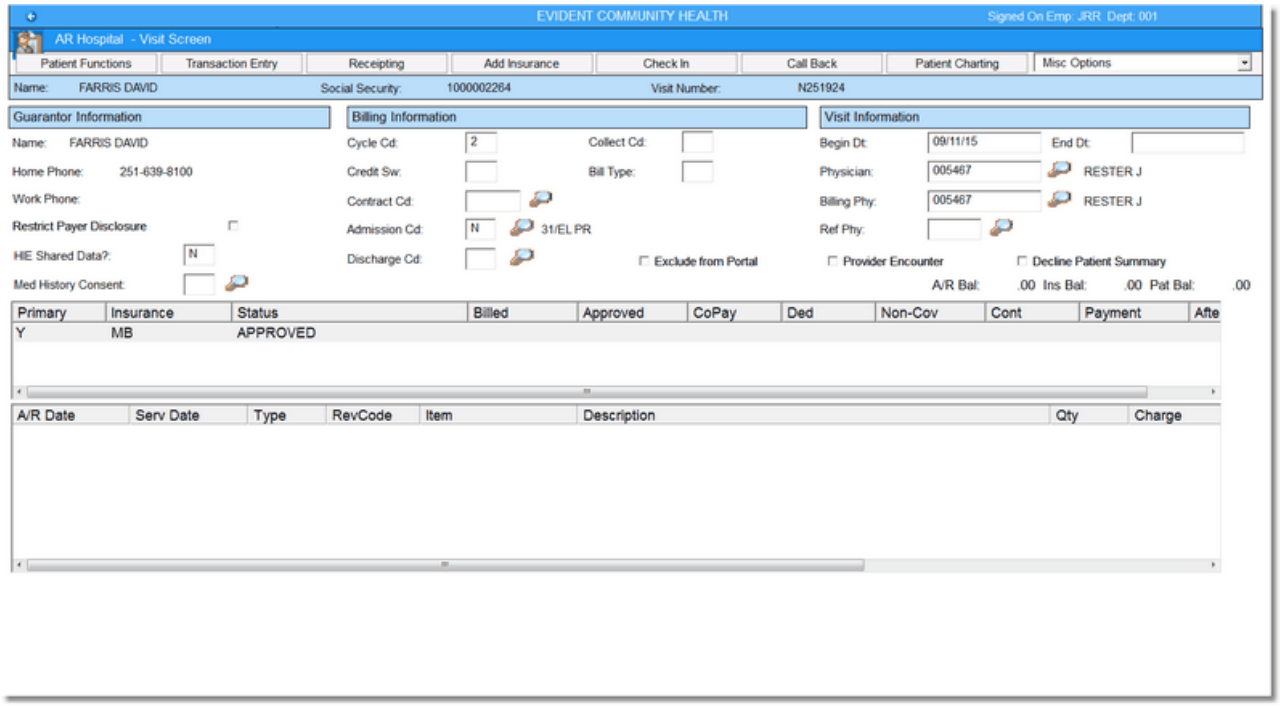
- **Service Code:** Enter the service code that best describes the patient's visit. To display a listing of service codes select the magnifying glass or enter a question mark (**?**) to see the listing. Select the correct service code. This is an optional field for the clinic.

- **Guarantor:** This information will default from the Person Profile but may be over-keyed if there is a unique guarantor for this one visit.

- **Fin Class:** The code for the insurance which is considered primary for this visit.

- **Select insurance coverage for this visit:** Select each insurance that will apply to this visit.

Select **Clinic Base Menu** > **Profile Listing** > **Select Patient** > **Create New Visit** > **Clinic Stay Type**



AR Hospital - Visit Screen

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

- **Patient Function:** Select this option to access the Patient Functions screen of the patient.

- **Transaction Entry:** This option allows Diagnosis coding and patient charging.

- **Receipting:** This option allows entry of over the counter receipts.

- **Add Insurance:** This allows additional insurance coverage to be added for this visit only.

- **Check In:** This option will place the patient on the clinic whiteboard, if the facility is utilizing the ACD portion of the software.

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- **Call Back:** This option will update the nurse's call back listing, if the facility is utilizing the ACD portion of the software.

- **Patient Charting:** This option will take authorized users to the clinic electronic record, if the facility is utilizing the ACD portion of the software.

- **Misc Options:** This area provides a drop-down option for access to fee tickets and other state or clinic type forms.

The bottom portion of this screen will reflect the insurance claims and their status as well as the detail of the account.

Guarantor Info

The Guarantor Information will pull from the Person File contact information. The insurance information will also pull in from the Person File. This information may be over-keyed to indicate a unique guarantor for this visit.

- **HIE Shared Date?:** This field show if the patient will allow the sharing of their health information. Three responses are allowed: **Y** if the information can be shared. **N**, if the information is not to be shared. Or the field can be completed with an **E.** Populating the wield with an E would signify the information can only be share in the event of an emergency

- **Med History Consent:** This field is used to determine if the provider is allowed to retrieve medication history from Surescript, and the eligibility of the patient coverages. Must have E-scribe turned on for this to be accessible. When a visit is created, the system will send a 270 to Surescripts for all of the patient's coverage's and their consent levels will be sent. Surescripts will return a 271 to display the provider prescription eligibility.

  Appropriate responses to the field are:

  Y = Consent Given
  N = no Consent
  P = Prescriber
  X = Parental/Guardian consent on behalf of minor for prescriber to receive the medication history from prescriber
  Z = Parental/Guardian consent on behalf of minor for prescriber to only receive the medication history the prescriber prescribed.

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Billing Info

This is normally not completed at the time of registration.

- **Cycle Cd:** System assigned during the statement process or brought forward from the person profile. Denotes the billing cycle in which the patient will receive a statement.
- **Collect Cd:** The system automatically assigns this code during the statement process.
- **Credit Sw:** This field is not used by Thrive at this time. This field may be utilized as needed for informational purposes.
- **Bill Type:** If necessary, enter one of the following Bill Switches to prevent a statement from printing for this patient: If entered on the profile this will copy forward to each of the subsequent visits but maybe over-keyed. If entered on the visit screen this will apply to this visit only.

  I: Insurance Only
  X: Medicaid Patient
  A: Address Incorrect (remove this as soon as address is corrected.)
  D: Need Detailed Statement (manually requested.)

- **Contract Cd:** Enter the Contract Billing Code that represents the company that has a contract with the hospital. A lookup window is available. Select the magnifying glass or enter a question mark (**?**) to see the listing. Select the correct contract code. When entered on the visit screen it will apply to this visit only.

Visit Info

- **Begin Dt and End Dt:** These dates will default to the current date, however, the dates may be over-keyed if needed.
- **Physician:** This is the primary provider of the visit. This will default to the provider entered on the Create Visit screen but may be over-keyed. A non-staff physician can be added via look-up by using the "New" option.
- **Billing Phy:** If the primary provider is not the billing physician, load the billing physician for the claim. This field may be automatically populated if there is a Billing Physician loaded in the primary provider's table entry. There is a lookup available. A non-staff physician can be added via look-up by using the "New" option.
- **Ref Phy:** List the referring physician for the visit. If there is not one, the system will default the primary physician to the claim. A lookup is available. A non-staff physician can be added via look-up by using the "New" option.
- **Provider Encounter:** Provider encounter box should be checked when physician is seen. This box should also be checked for the visit to be included in Meaningful Use Statistic calculations.

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- **Decline Patient Summary:** With the adoption of Meaningful Use, there is the objective to provide each patient with a copy of their Clinical Summary for each visit. With Stage II, CMS is taking into consideration that many patients do not want a copy of their clinical information. This field allows for the clinic to keep up with this information.

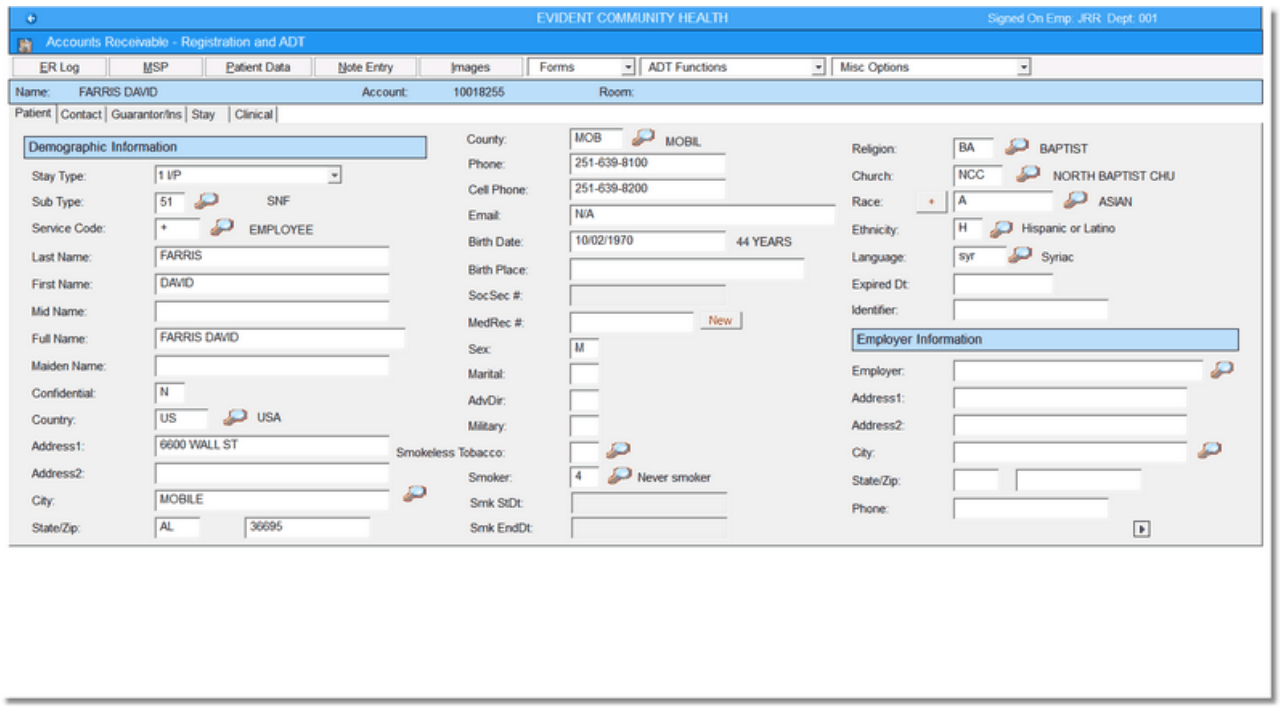
New Hospital Account

If the facility using the Person Profile does so for Inpatient as well as Outpatient types the table settings may be configured to accommodate these patients. For Stay Types other than the clinic, the following screen options will be available.

From the Person Profile screen, select the option **Create New Visit.** The option will appear to select the Stay Type and Sub Type. Use the drop-down menu to select the correct Stay Type and/ or Sub Type.

Once a hospital Stay Type is selected and the appropriate financial class/insurance information is completed, the Census screens will appear. Most of the information will already pull directly from the Person File. Verify information and be sure to complete the Stay tab with the correct admit and discharge information as these do not automatically populate.

Select **Hospital Base Menu** > **Main Patient Registration** > **Person File** > **Create New Visit** > **Hospital Stay Type**



Accounts Receivable - Registration and ADT, Patient

Additional documentation on the Census screens may be found in the Registration User Guide.

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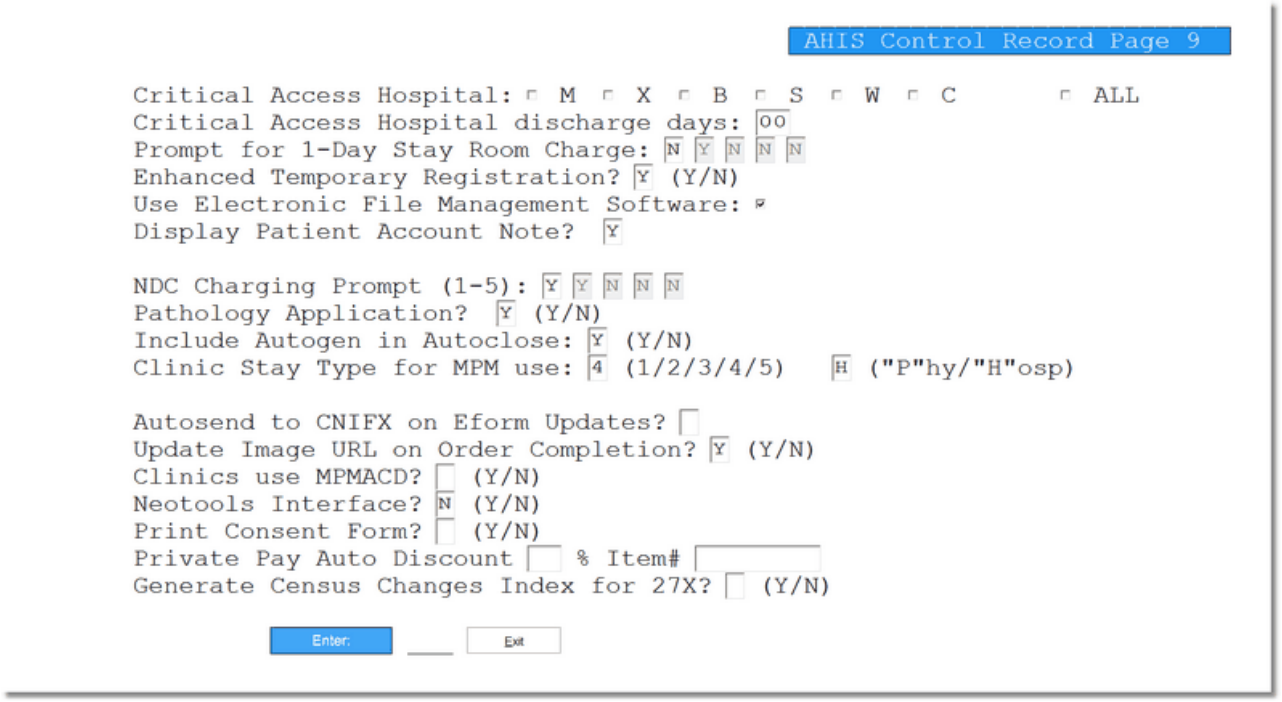
Chapter 4 Clinic Charging and Coding

For clinics that use the Patient Accounting module to perform all of the Accounts Receivable functions, there is a separate option that will allow a clinic to enter the necessary charges and codes for patients. In order to utilize this function, some table setup is necessary.

4.1 Tables

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Business Office Table Maintenance** > **AHIS** >**Page 9**



AHIS Control Record, Page 9

- **Clinic Stay Type for MPM use:**
  - The first field indicates the Clinic Stay Type. This Stay Type will determine the registration screen selection when **Create Visit** is selected.
  - There are two options for the second field:
    - o An **H** will indicate if the hospital is utilizing the profile or if the clinics and hospital share the same AR and company.
    - o A **P** will indicate if the clinics are utilizing the Profile software.

Evident will maintain this field.

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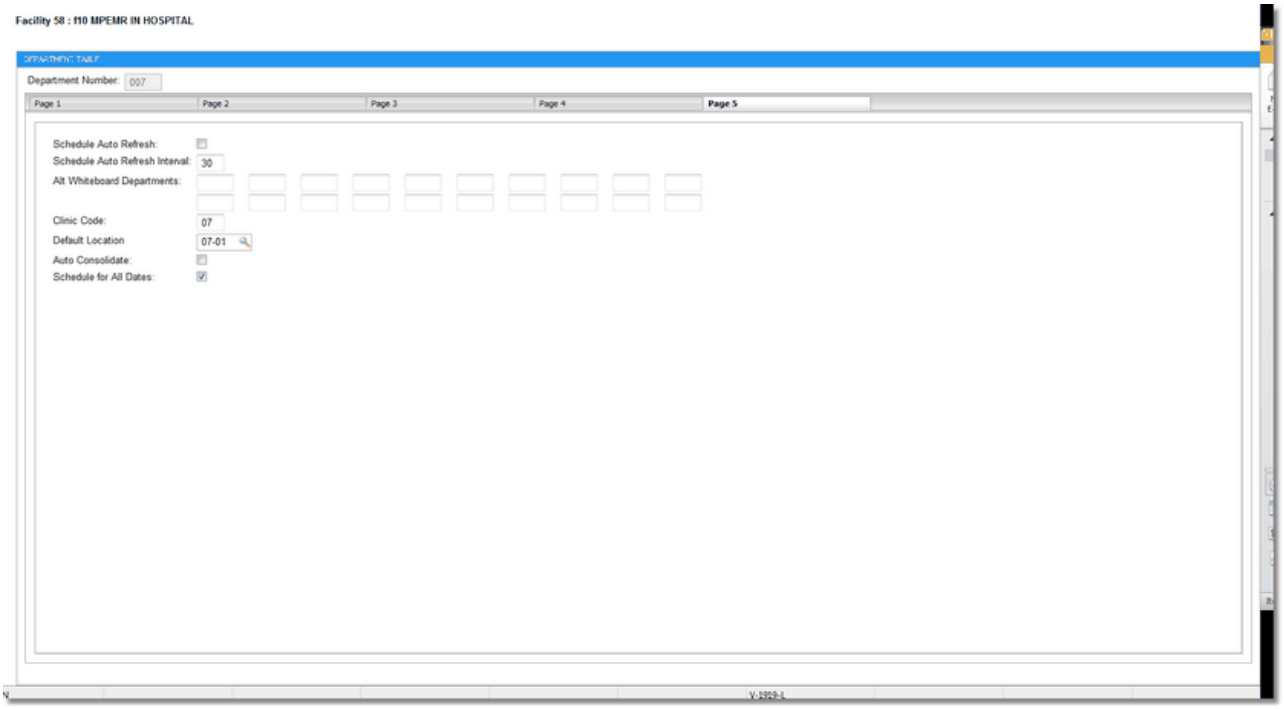
Department Table

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance Menu** > **Control** > **Department Table** > **Page 5**



Department Maintenance, Page 5

- **Clinic Code:** This 2-digit code is set up in the Clinic Code table. A code entered here will pull the place of service associated with this Clinic Code to the 1500 billing form when charging from this department. Each clinic will also need to be set up as a department with the corresponding Clinic Code loaded in this field. A department and clinic code will also need to be set up for each place of service, example nursing home.

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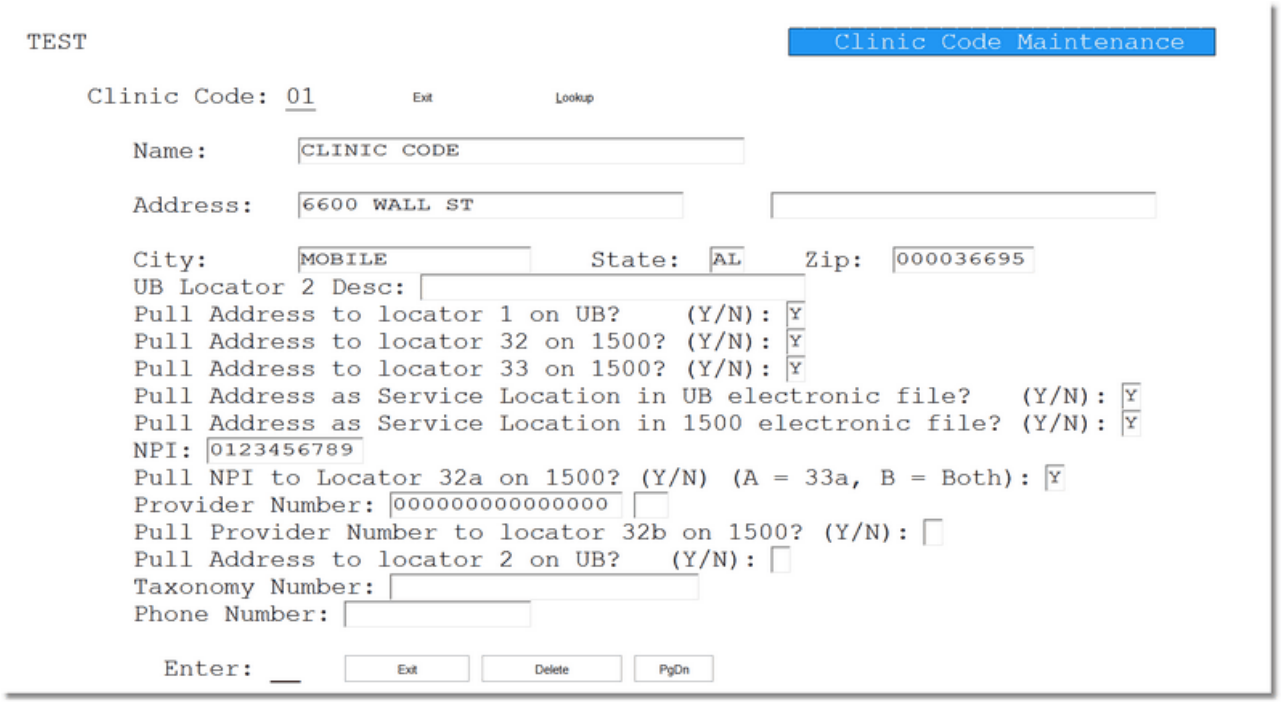
Clinic Table

Select **Clinic Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance Menu > Clinic Table > Page 1**



Clinic Code Maintenance

- **Clinic Code:** Enter 2-digit alpha or numeric code for the clinic or location.
- **Name:** Enter the clinic or location name.
- **Address:** Enter the mailing address for the clinic or location.
- **Address 2:** Enter the second line of the mailing address for the clinic or location.
- **City, State and Zip:** Enter the City, State and Zip Code for the clinic or location.
- **Phone Number:** Enter the phone number for the clinic

NOTE: *This information will pull to the 1500.*

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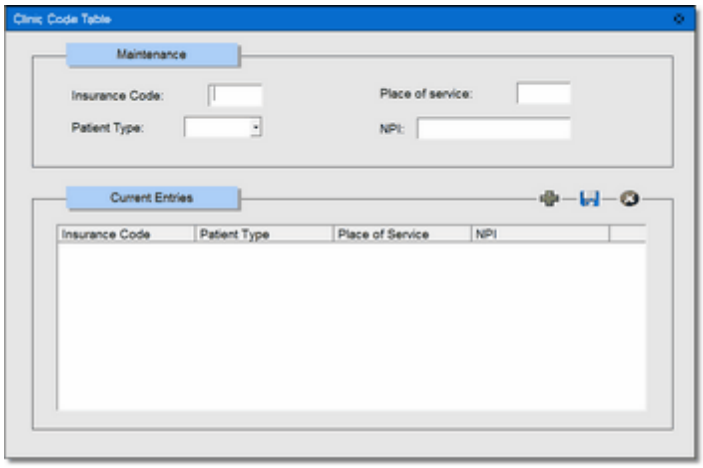
Select **Clinic Base Menu > Master Selection > Business Office Tables > Business Office Table Maintenance Menu > Clinic Table > Page 2**



Clinic Code Table, Page 2

The second page of the Clinic Code Table allows the Place of Service to be identified for different Financial Classes and Stay Types. If a Clinic Code is loaded in the Policy Information on the patient's account it will override the information entered during charging. The system will look to the Summary Code table instead of this table.

- **Ins Code:** The specific Financial Class code should be loaded in this field. Wild-carding may be used by entering asterisks ******. For example, **MB*** will indicate all Financial Class codes that begin with MB.

- **Pat Type 1-5 or A-All:** The table will allow a Stay Type to be entered that will only pull the information to the 1500 for the specific Stay Type. Entering **A** will pull the information for all Stay Types.

- **Place Service:** Enter the Place of Service code that should pull to the 1500.

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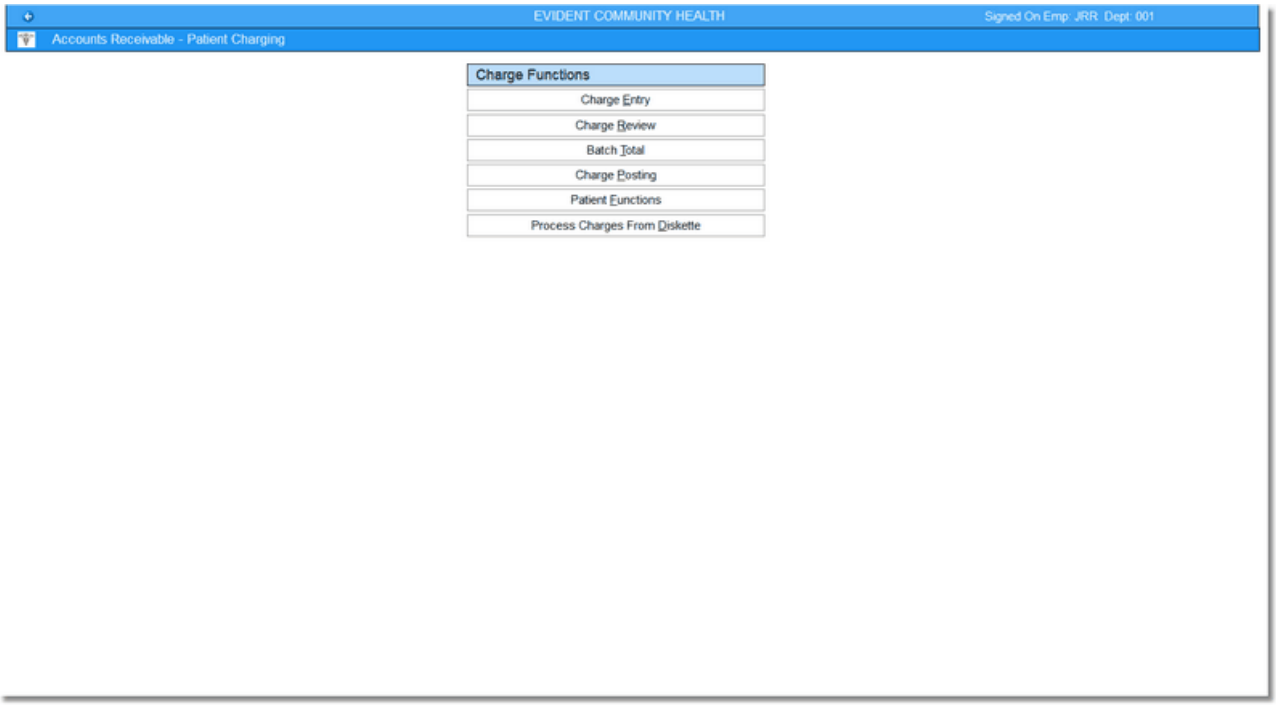
4.2 Accessing the Charge/Coding screen

The clinic Charge/Coding screen may be accessed from different places in the software. The first is from the General charging screens.

Select **Clinic Base Menu** > **Patient Visit #** > **Patient Charging - General**



Accounts Receivable - Patient Charging

The second is from the visit screen.

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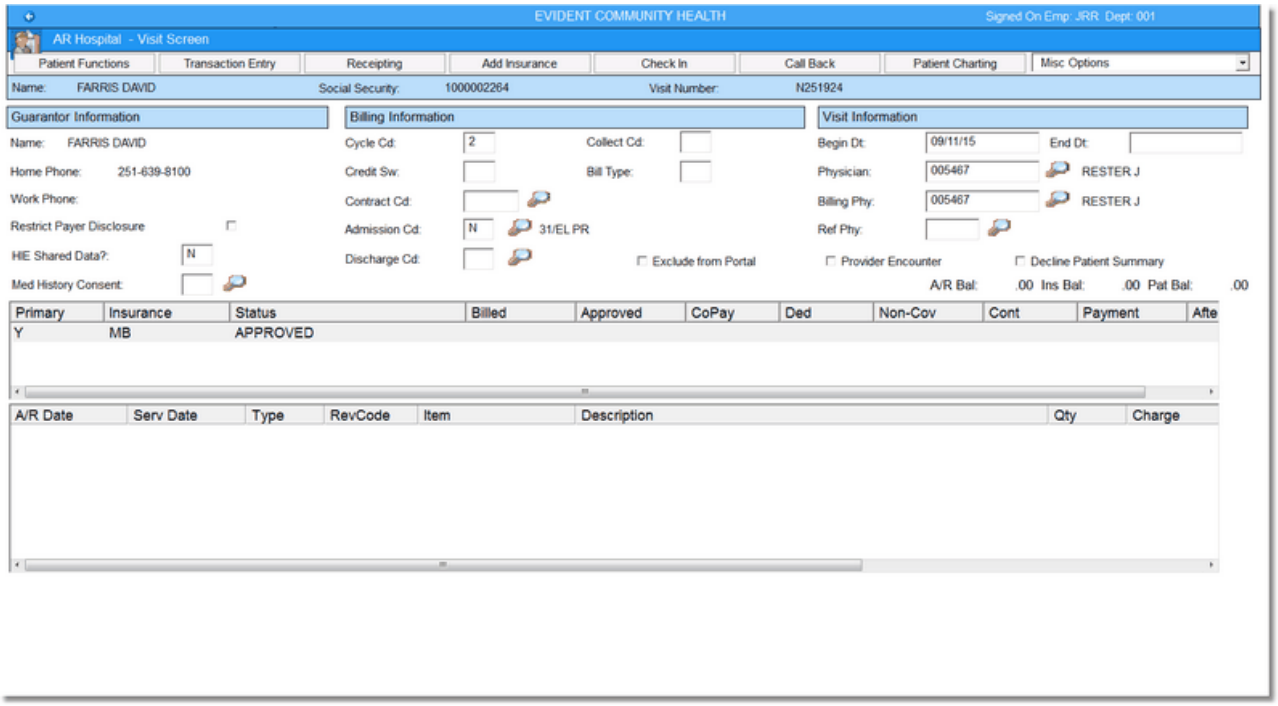
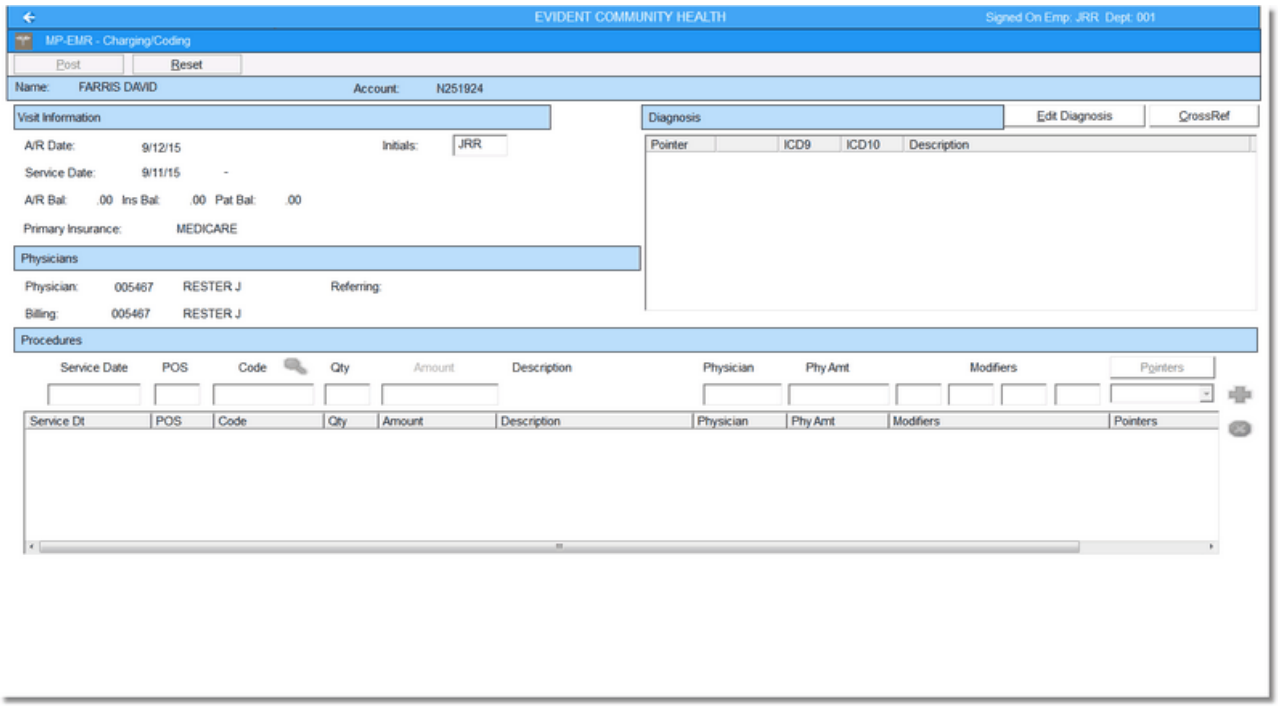
Select **Clinic Base Menu > Patient Visit # > MP-EMR Visit > Transaction Entry**



AR Hospital - Visit Screen

Select **Clinic Base Menu > Patient Account # > Patient Charging - General > Clinic Charging/ Coding**



MP-EMR - Charging/Coding

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Visit Information

- **AR Date:** This defaults to either the service date or the current open date, whichever is greater.
- **Service Date:** The service date pulls from the dates entered on the visit screen.
- **A/R Bal:** The total current outstanding balance for the visit.
- **Ins Bal:** The outstanding balance due from insurance.
- **Pat Bal:** The current amount due from the patient.
- **Primary Insurance:** This will display the primary insurance selected for this visit
- **Initials:** The initials of the employee keying the charges must be entered. When utilizing Employee Sign On, this field will automatically be populated. These initials pull to such reports as the Charge Edit List and the Daily Edit, which will also recap the number and dollar amount of charges posted by initials. This offers a means of tracking productivity as well as the validity of charges.

Physicians

- **Physician:** This will be the provider of the service that will copy forward from the visit screen.
- **Billing:** This will be the provider that will be used for insurance billing purposed that will copy forward from the visit screen.
- **Referring:** This will be the referring physician if applicable that will copy forward from the visit screen.

Diagnosis

- Select **Edit Diagnosis** to enter diagnosis codes on the patient account

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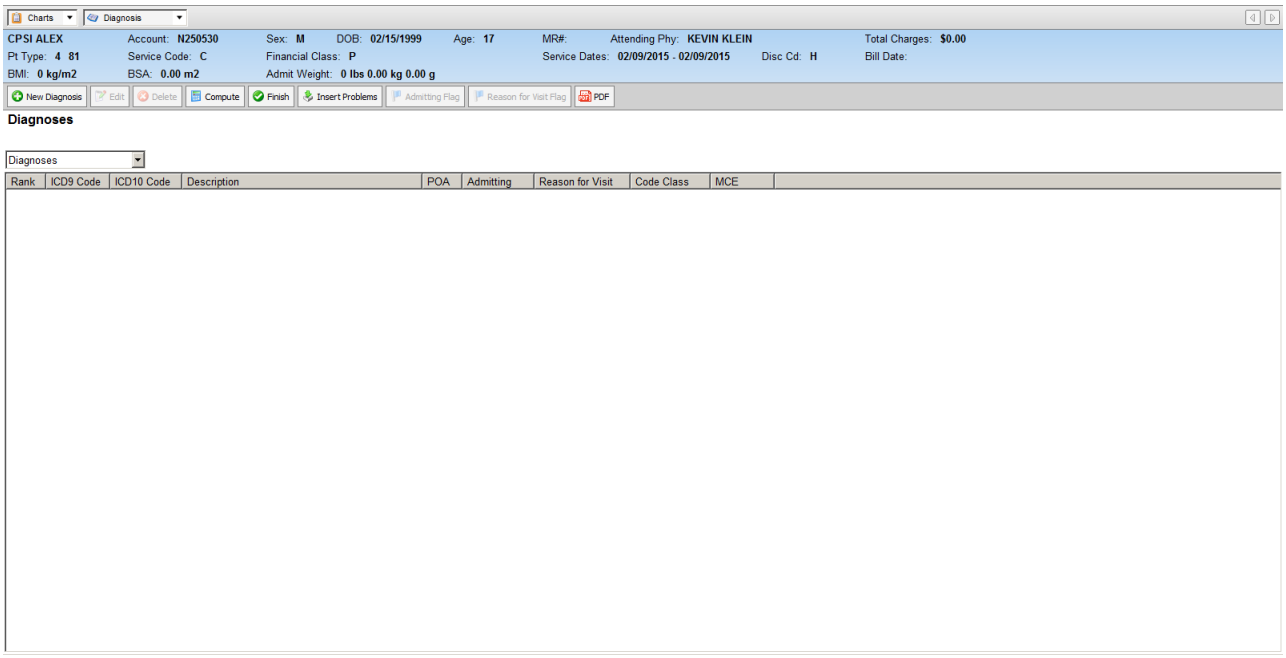
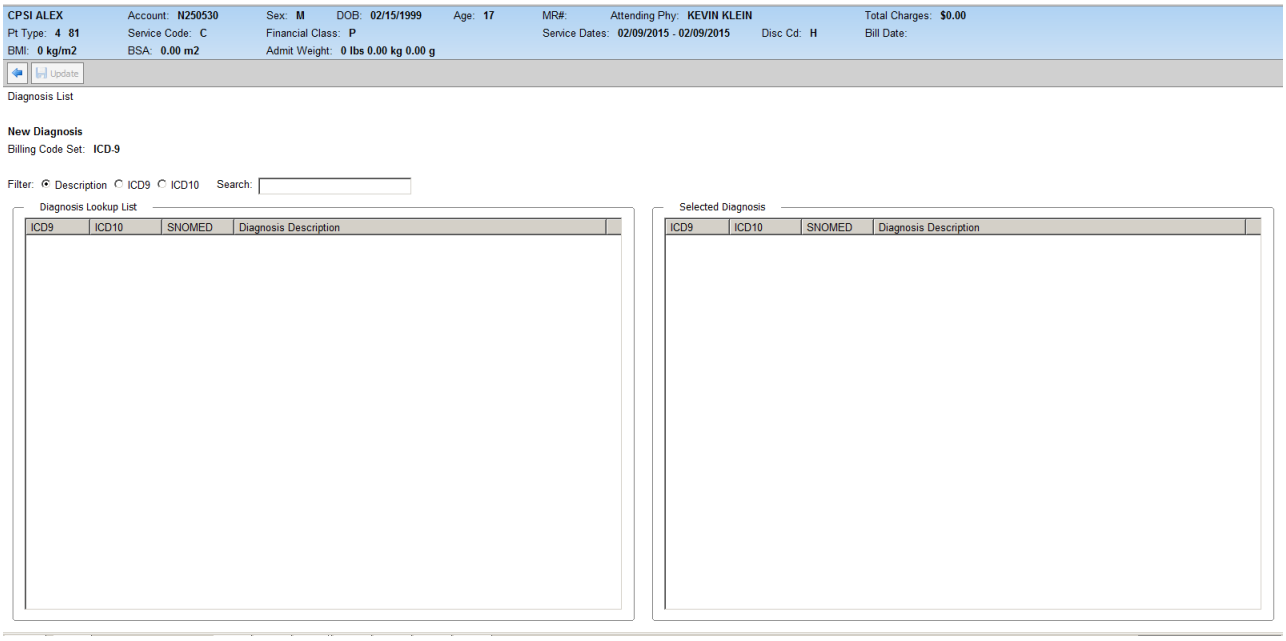
Select **Clinic Base Menu** > **Patient Account #** > **MPEMR Visit** > **Transaction Entry** > **Edit Diagnosis**



MP-EMR - Charging/Coding

- To add a new diagnosis code, select **New Diagnosis** on the action bar.

Select **Clinic Base Menu** > **Patient Account #** > **MPEMR Visit** > **Transaction Entry** > **Edit Diagnosis** > **New Diagnosis**



MP-EMR - Charging/Coding

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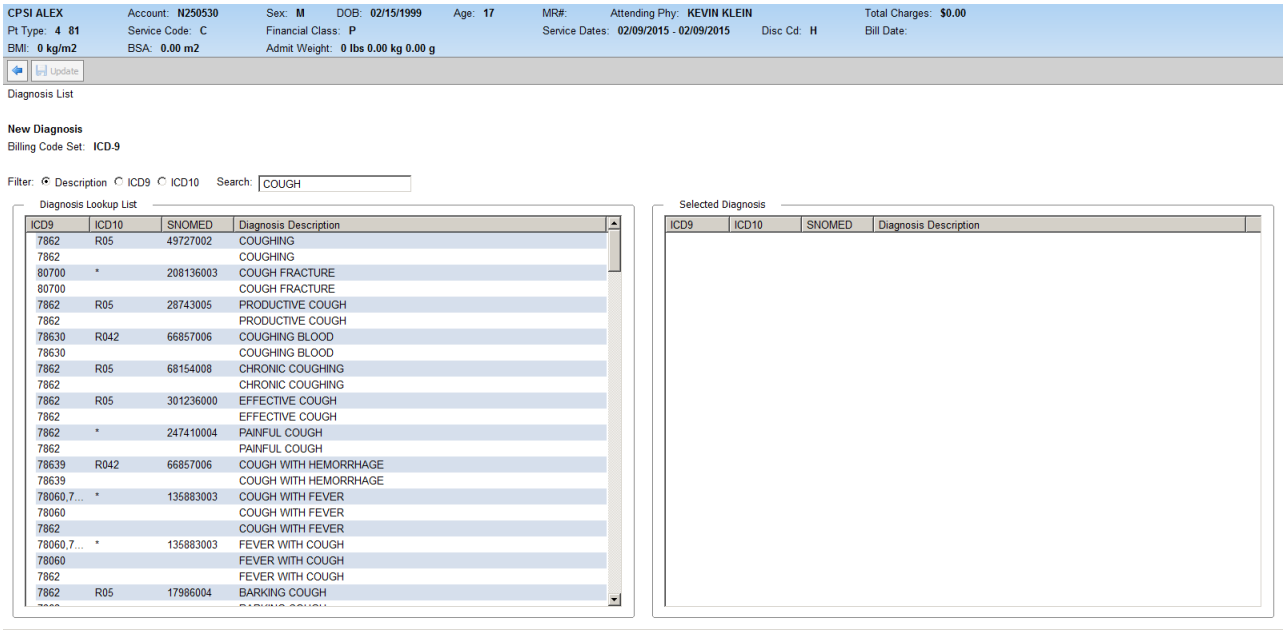
- The **Diagnosis List** screen will display. The Filter gives the ability to search for the diagnosis code by Description, ICD-9 or ICD-10. Once the search criteria is entered in the **Search** field, the search results will display the ICD-9, ICD-10, Snomed and Diagnosis Description.



MP-EMR - Charging/Coding

- **Description:** Displays the diagnosis code description selected from the Diagnosis List screen
- **ICD-9-CM:** Displays the ICD-9-CM code selected from the Diagnosis List screen
- **ICD-10-CM:** Displays the ICD-10-CM code selected from the Diagnosis List screen
- **SNOMED:** Displays the SNOMED code selected from the Diagnosis List screen
- Double-click the diagnosis code to move the the diagnosis from the **Diagnosis Lookup List** to **Selected Diagnosis**.
- Continue using the **Diagnosis Lookup List** until all diagnosis have been moved to **Selected Diagnosis**. Select **Update** when complete.

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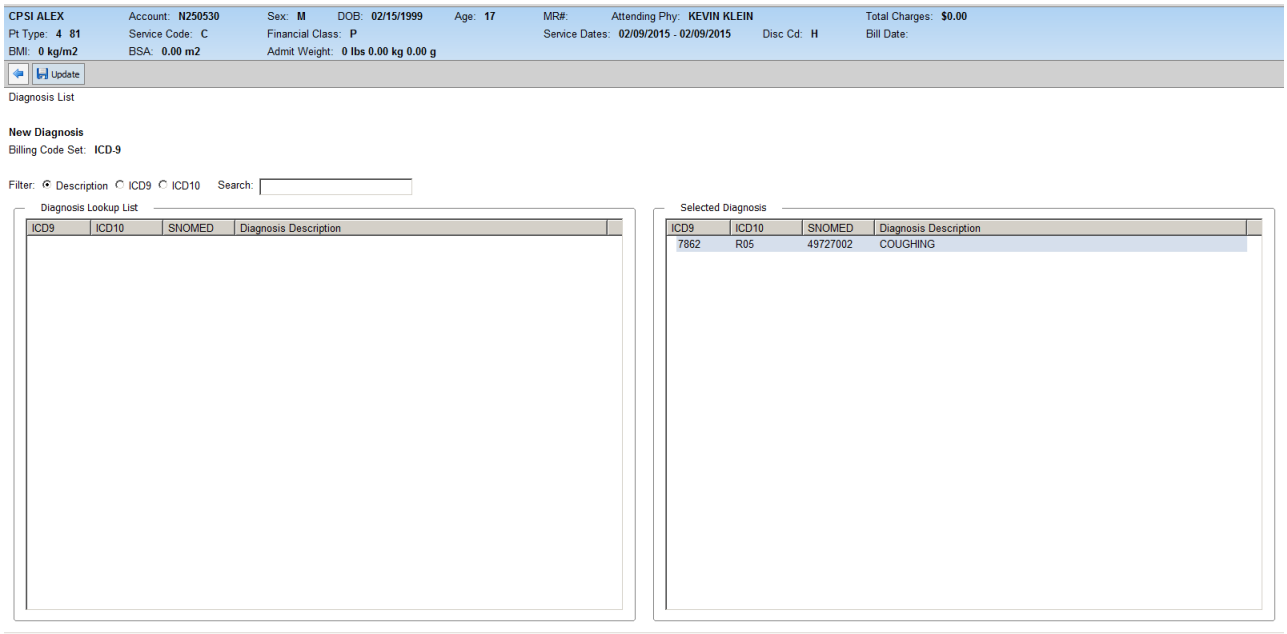
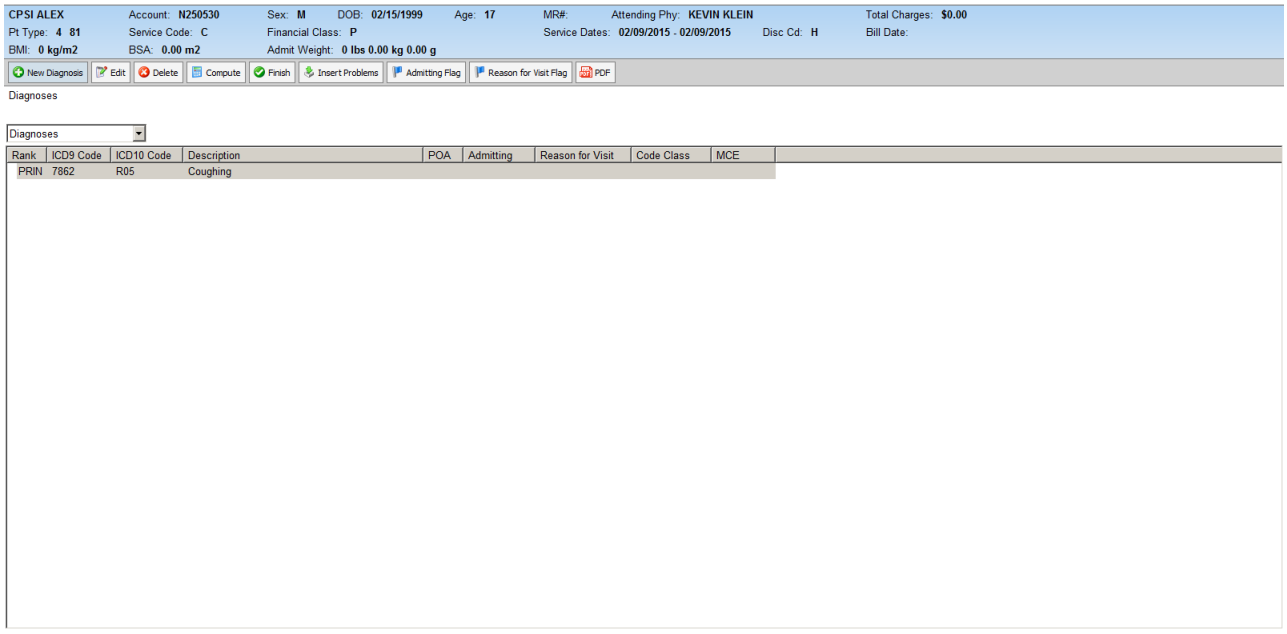


MP-EMR - Charging/Coding

- Duplicate Diagnosis may not be entered. The system will display a warning of “Duplicate Diagnosis”.
- The selected diagnosis codes will list in the assigned ranking order on the Diagnoses screen



MP-EMR - Charging/Coding

- **Rank:** Displays the ranking assigned to the diagnosis code on the Diagnosis Detail screen
- **ICD9 Code:** Displays the ICD-9 code selected on the Diagnosis List screen

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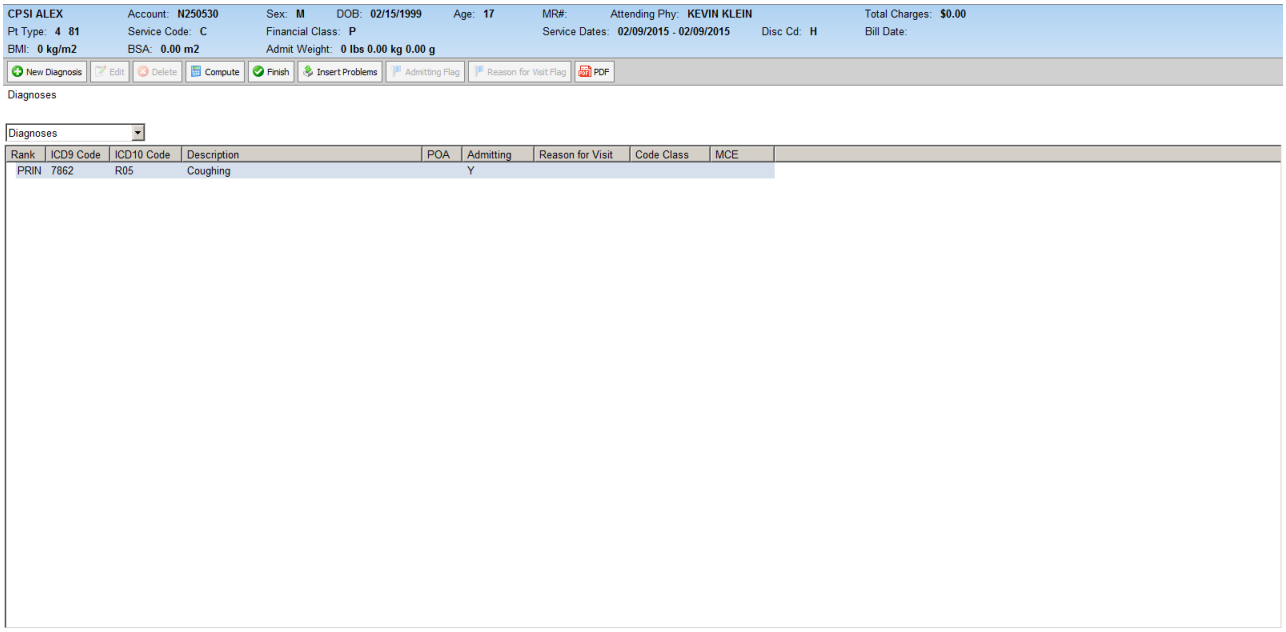
- **ICD10 Code:** Displays the ICD-10 code selected on the Diagnosis List screen
- **Description:** Displays the diagnosis code description selected on the Diagnosis List screen
- **Admitting:** Flags the diagnosis as the Admitting Diagnosis
- **Reason for Visit:** Flags the diagnosis as the Reason for Visit
- **POA:** Displays the POA code selected on the Diagnosis Detail screen
- **Code Class:** Displays applicable indicators of **C** for CC, **H** for HAC, and **M** for MCC
- **MCE's:** Displays any applicable Medicare Code Edit.
- To flag a diagnosis as the admitting diagnosis, highlight the diagnosis then select **Admitting Flag** radio button. A "Y" will then appear under **Admitting**.



MP-EMR - Charging/Coding

- To flag a diagnosis as the reason for visit, highlight the diagnosis then select the **Reason for Visit** radio button. A "Y" will then appear under **Reason for Visit.**

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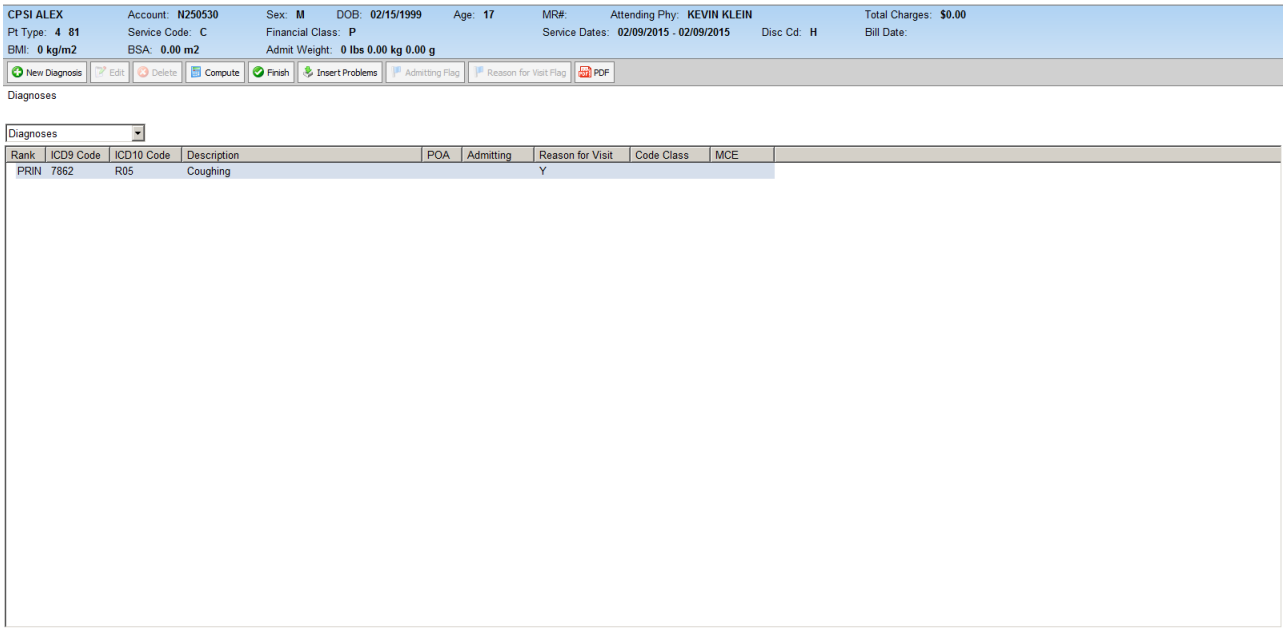

MP-EMR - Charging/Coding

- To edit an existing diagnosis code, highlight the code and select **Edit** on the action bar or double-click the diagnosis code. Once all changes have been made, select **Save** on the action bar.
- To remove a diagnosis code, highlight the code and select **Delete** on the action bar.
- To exit back to the Clinic - Charging/Coding screen, select the "X" at the top right hand corner of the screen

Inserting Problems from the Problem List

- Diagnosis codes from the Problem List may be inserted into the Diagnoses screen.
- To begin, select **Insert Problems** on the action bar.
- Once Insert Problems is selected, the Problem List will display. The Display options are "All" to show all problems or "Active Only". The defaulted display is Active Only. Select **Check All** to insert all of the displayed problems or select the desired problems individually from the list. Once the problems have been selected, select **Insert** on the action bar.
- The selected diagnosis codes will display on the Diagnoses screen.
- Once the problems are inserted, the **Rank** and **POA** may be edited if necessary**.** To do this, select each problem then select **Edit** to access the Diagnosis Detail screen.
- When all information has been entered for the diagnosis code, select **Save** on the action bar. Select the **back arrow** to return to the Diagnoses screen.

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- This process should be repeated until all diagnoses have been addressed.

Procedures

- **Service Date:** The Service Date will default to the begin date. However, in the case of late charges, the Service Date should always be over-keyed to reflect the actual date of service. The system will only allow dates that are within the begin and end date fields on the visit screen.

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

- **POS:** Enter the 3-digit number of the place of service/department that is tied to the location for this charge. If the place of service/department entered is not loaded in the Item Master on field 13 - Issuing Department, a message “NOT FOR DEPT” will display.

- **Code:** Enter the appropriate Procedure code. There are currently two ways to access the Procedure code lookup window. The first is by entering a question mark (**?**) upon reaching this field. This will pull the items associated with the POS selected. The second method of accessing the item lookup window is to enter the first few characters of the Procedure's name in the Code field. The system searches for the first Procedure that is associated with the POS beginning with these letters and displays them in the Charge Entry Item Lookup menu.

- **Qty:** Enter the quantity of the item to be charged.

- **Amount:** The dollar amount of the item pulls directly from the Item Master, page 3.

- **Description:** This field pulls from the description field in the item master.

- **Physician:** If the facility is using "Split Billing" and a professional component is applicable, the physician’s number should be entered. If a physician number is loaded in the Item Master, it will automatically pull.

- **Phy Amt:** The Physician Charge Amount will pull from page 1 of the Item Master. This will be a portion of the charge amount and not an addition to it. For example, if the charge price is $75.00 and the Physician Charge Amount is $25.00, the total amount posted to the patient’s account will be $75.00.

- **Modifiers:** Up to four modifiers may be entered.

- **Pointers:** Select the drop-down menu to select the correct diagnosis code to associate with the procedure. Or, select the to have the procedure point to all of the entered diagnosis.

If Diagnosis Codes are addressed via the problem list and charges are done via Order Entry once the Provider posts the entries they are finalized/posted for Transaction entry.If the modifiers or pointers are not correct they can now be corrected in Transaction Entry screen.

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Chapter 5 Appointment Scheduling

5.1 Overview

The MP EMR Physician Appointment functions are completely interactive and in real time. Once data is entered into the system and the appointment screen is exited, the appointment information may be accessed by everyone utilizing the system. Before using the appointment functions, the practice must set up information in the tables.

This section will cover the following functions:

- Appointment Table Maintenance
  - Practice Information
  - Appointment Codes
- Appointment Options
  - Appointments by Patient
  - Appointments by Date
  - Setting up a New Appointment
  - Appointment Maintenance
- Appointment Schedule Displays
- Appointment Reports

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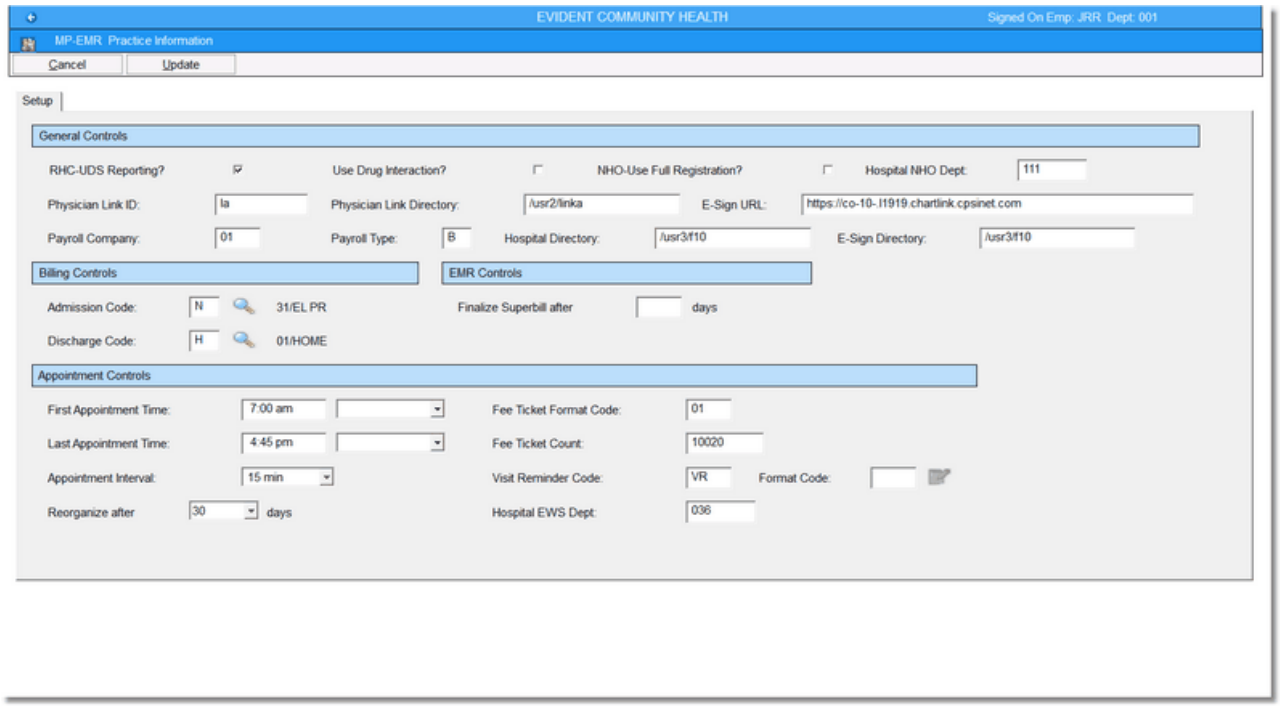
5.2 Table Maintenance

There is table maintenance that must be performed for Appointment Scheduling.

Practice Information

Select **Clinic Base Menu > Master Selection > Business Office Table Maintenance > MP-EMR Menu > Practice Information**



MP-EMR Practice Information

Appointment Control

Practice Information Appointment Control should be set before using the appointment functions. These fields are used to establish appointment begin and end times for the clinic and the display intervals for the appointments. Establish the first and last appointment time of the practice, and set the default appointment interval.

- **First Appointment Time:** Enter the earliest possible appointment time for the entire clinic. Enter the time using military time or select from the drop-down box.
- **Last Appointment Time:** Enter the latest possible appointment time for the entire clinic. Enter the time using military time or select from the drop-down box.
- **Appointment Interval:** Enter the increment period to use for displays and reports. This is not the duration of your appointments. Enter the amount in multiples of 5 or use the drop-down box.

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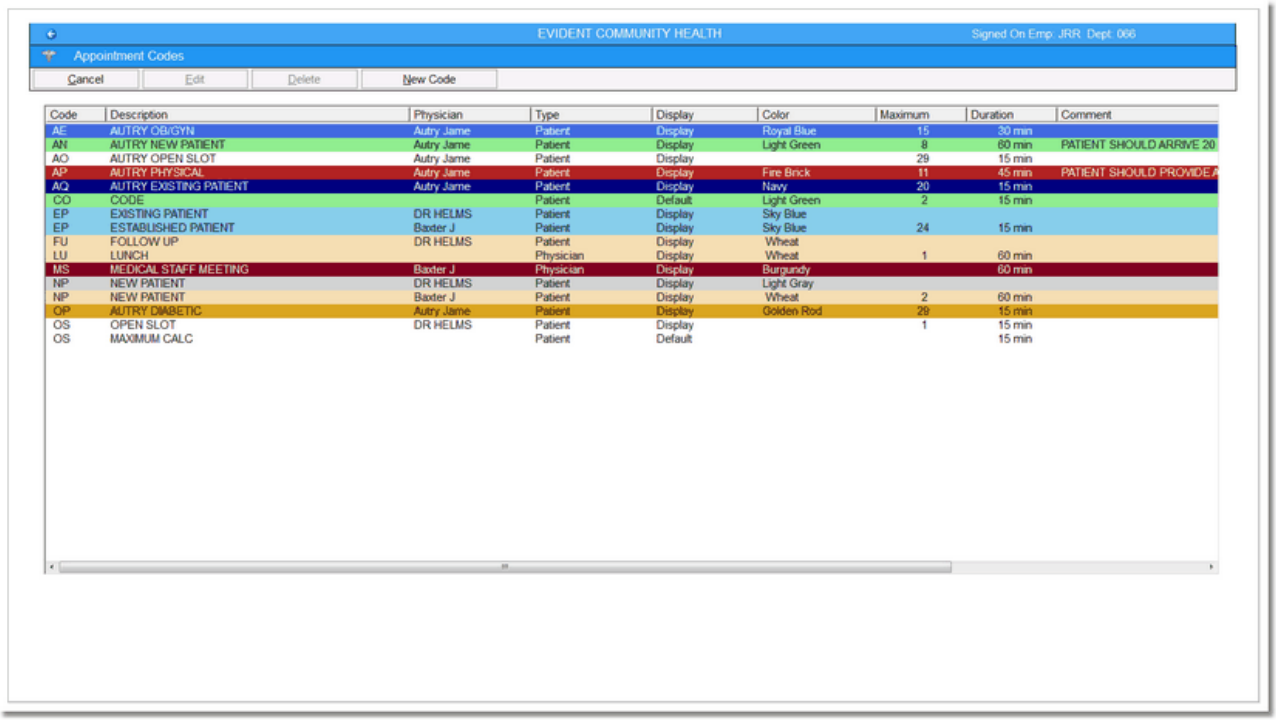
- **Reorganize after:** Set this field for the maximum number of days to maintain the detail of the appointment scheduler AFTER that date has past. The past appointment detail will remain accessible on the patient's account display regardless of the reorganize date.
- **Fee Ticket Format Code:** Evident personnel will load the appropriate code for the default fee ticket program.
- **Fee Ticket Count:** Evident personnel will load the beginning fee ticket number if being used by the custom fee ticket program.
- **Visit Reminder Code:** If the practice is using visit reminders the appropriate code will be entered here.
- **Format Code:** This allows the visit reminder letter to be accessed and edited from this screen. The code is also to be loaded for the letter to print.
- **Hospital EWS Dept.:** If using Enterprise Wide Scheduler, the department that represents the clinic within the hospital tables will need to be loaded here. If this application is being used the remaining table set up will not be necessary

After changes are made to this screen you must select **Update** for the changes to take place.

Appointment Codes

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Menu** > **Appointment Codes**



Appointment Codes

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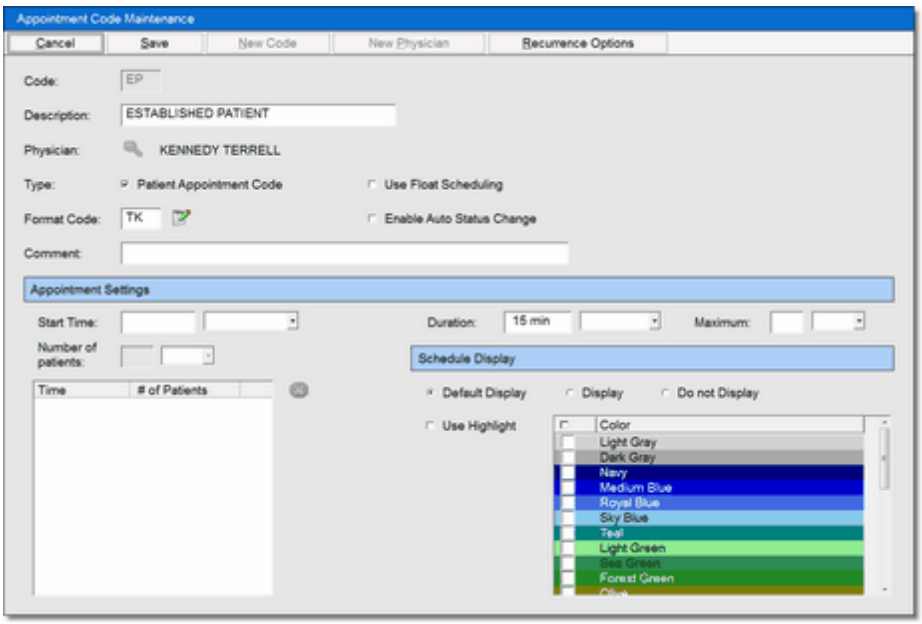
Before using the appointment functions, the practice must set up the Appointment Codes. This screen will display existing appointment codes per physician. To establish individual provider schedules by code you may double click on an existing code or select **New Code**.

- **Code:** This is the 2-digit facility-defined appointment code.
- **Description:** This is the facility-defined description for this appointment code.
- **Physician:** This is the provider for which this code was created.
- **Type:** This indicates if this is a patient appointment type.
- **Display:** Indicates if this appointment type will display on the schedule.
- **Color:** Displays the highlight color being used for this appointment type, if any.
- **Maximum:** Displays the maximum number of this type of patient the provider prefers to see in a day.
- **Duration:** Displays the common duration for this appointment type.
- **Comment:** Displays any comments entered for this appointment code.

NOTE: *A sort may be done by any of the column titles by double clicking on the title name.*

To enter a new code, select **New Code** at the top of the screen. Adjustments may be made to an existing code by double clicking on that code.

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Menu** > **Appointment Codes** > **New Code**



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- **Code:** Codes are facility-defined and are a 2-digit alpha/numeric. They may be repeated for different providers.
- **Description:** Enter the description for the appointment type. This field is facility-defined.
- **Just Like Appointment Code:** An existing appointment code may be copied in and adjustments may be made.
- **Physician:** Select the magnifying glass icon to select the provider. Enter the 6-digit physician number or use the lookup.
- **Type:** Select this field if this is a patient appointment type. Non-patient type appointments such as staff meetings may also set up .
- **Format Code:** There is the ability to select specific appointment reminders that may be linked to particular appointment codes. This will allow for the physician practice to remind patients of circumstances unique to their visit.
- **Comment:** Entering a comment will appear on certain lookup screens. This field is used for comments or communications to the staff about the appointment type, such as to remind patient to present 15 minutes prior to appointment.

Appointment Settings

- **Start time:** Enter the preferred time for this visit type. Enter the time using military time or the drop-down. Then a prompt will appear to enter the number of patients to be seen at this particular time. Continue to enter all times the provider is available for this appointment type.
- **Number of Patients:** Enter the number of patients to be seen at this "Start time."
- **Duration:** Enter the duration of this appointment type.
- **Maximum:** Displays the maximum number of this type of patient the physician prefers to see in a day.
- **Schedule Display:** Select whether this patient type should display or not display. Default display should be selected for all patient appointment types. Display or Do Not Display may be selected for non-patient type appointments.
- **Use Highlight:** A color code may be selected for this appointment type.

Once the appointment type and times have been set, select **Recurrence Options** at the top of the screen to set the repeats of this schedule.

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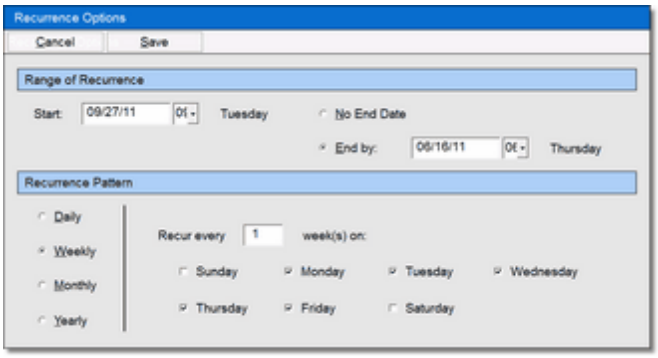
Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Menu** > **Appointment Codes** > **New Code** > **Appointment Code Maintenance** > **Recurrence Options**



Recurrence Options

Range of Recurrence

- **Start:** Enter the first date to repeat this appointment type by selecting the drop-down calendar.
- **No End Date:** Select this option to have no end date for this appointment type.
- **End by:** Select a date to stop the repeat of the appointment type.

Recurrence Pattern

- **Daily:** This option will allow a repeat for a specific number of days or to select for every weekday.
- **Weekly:** This option will allow a repeat for a specific number of weeks or to select specific days during the week to repeat this visit.
- **Monthly:** This option will allow a repeat for a specific date for a certain number of months or to select a specific day for a certain number of months.
- **Yearly:** This option will allow a repeat for a specific date for a certain number of years or to select a specific day for a certain number of years.

Once the recurrence has been set, select **Save**.

5.3 Appointment Options

Within the Thrive Provider EHR system, there are several different ways to setup appointments as well as search the system for existing appointment.

Appointments by Patient

Once the appropriate tables are set up, the practice may begin using the appointment functions.

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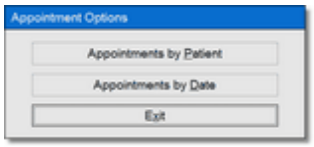
Select **Clinic Base Menu** > **Appointment Scheduling**



Appointment Options

- **Appointments by Patient:** List all patients with an appointment or select the magnifying glass to enter a single patient's name. The profile listing itself will display the patient's next appointment or double click on the patient's name to display all related appointments. To begin a search date select the drop-down calendar.

- **Appointments by Date:** This is the recommended area for scheduling new appointments, viewing availability and previously scheduled appointments. This option provides a variety of scheduling functions.
  - **Date:** Enter the date for the appointment. It will default to the current date.
  - **Physician:** The system will default to all providers. Select the magnifying glass to search and select a single physician or double click on multiple physicians.
  - **Type:** The system will default to ALL. Select the drop-down to search for a particular appointment type.
  - **Display:** This option defaults to available or unscheduled appointment times. Select the drop-down to search for All or scheduled appointments as well.
  - **Go:** This starts the search.

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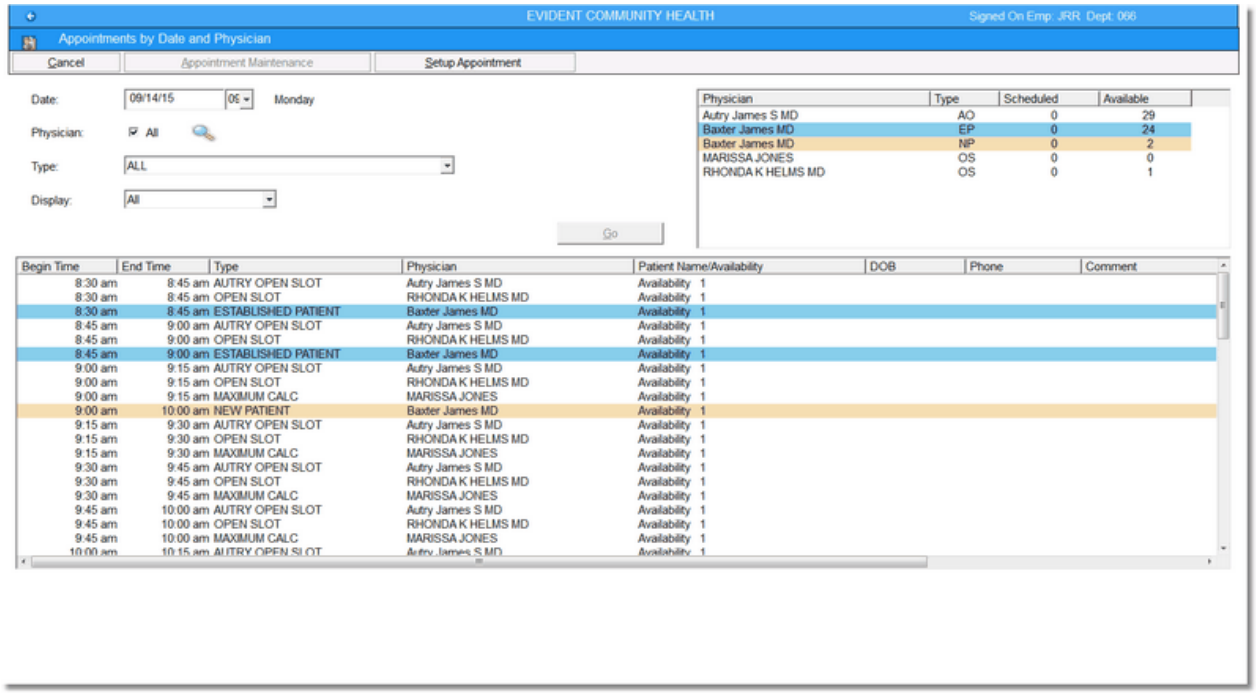
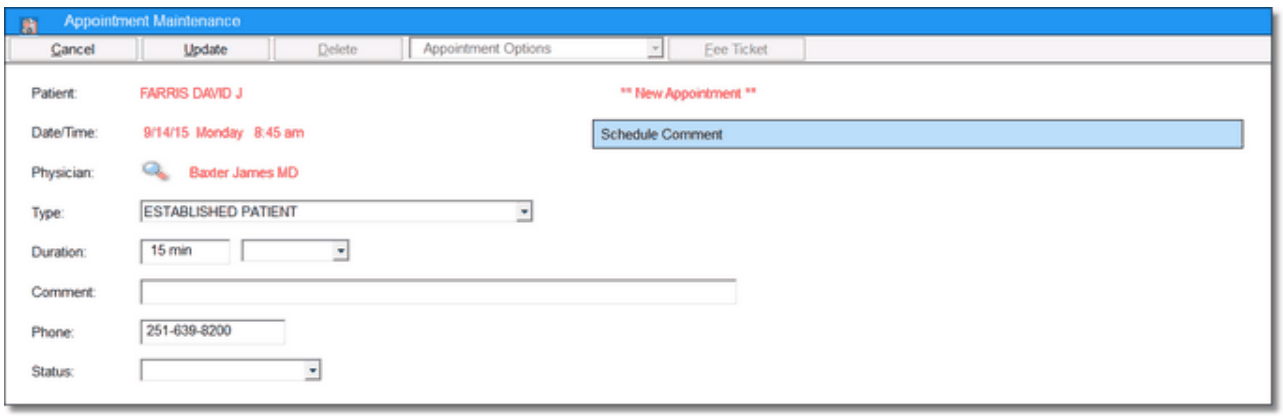
Select **Clinic Base Menu** > **Appointment Scheduling** > **Appointments by Date**



Appointments by Date and Physician

To schedule, select the appropriate time slot. This provides a profile listing to look up the patient. The patient must have a person profile to be scheduled. Select the patient from the listing.

Select **Clinic Base Menu** > **Appointment Scheduling** > **Appointments by Date** > **select time slot**



Appointment Maintenance

- **Patient:** Pulls from the Person Profile.
- **Date/Time:** Pulls from the selected appointment time slot.

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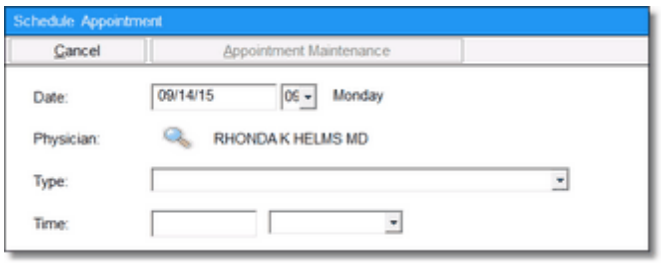
- **Physician:** Pulls from the selected appointment time slot. Select the magnifying glass to change the physician.
- **Type:** Pulls from the selected appointment time slot. Select the drop-down to change the appointment type.
- **Duration:** Pulls from the table setting for the duration of the selected appointment type. Select the drop-down to change the appointment duration.
- **Comment:** This comment will pull to the appointment reports and lookups and will also update the Thrive Provider EHR physician whiteboard.
- **Phone:** Pulls from the patient's profile home phone field but may be over-keyed with any phone number.
- **Status:** This field defaults to blank and should remain blank for normal appointment functions. However, after the appointment time has passed the drop-down box may be used to indicate completed, rescheduled, canceled or no-show appointments.

Once everything on the appointment maintenance screen has been confirmed select **Update** to schedule the appointment.

Setup Appointment

Another option under the Appointment by Date is the **Setup Appointment**. Select this option to insert an appointment type where there may not be an availability listed on the schedule. Select the option then choose the appropriate date, physician, type and time.

Select **Clinic Base Menu** > **Appointment Scheduling** > **Appointments by Date** > **Setup Appointment**



Schedule Appointment

Select **Appointment Maintenance** to choose the patient and complete the appointment maintenance.

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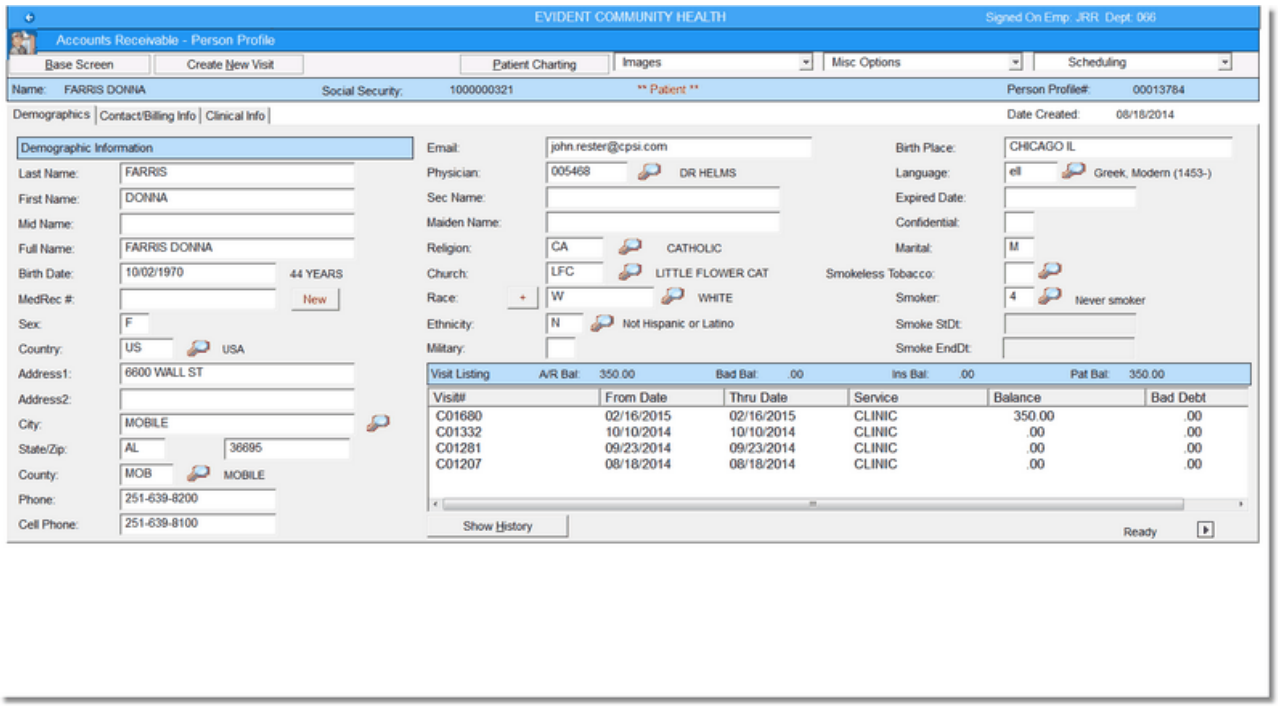
5.4 Schedule from Person Profile

Appointment scheduling may also be accessed from the patient's profile. When scheduling from this method Thrive Provider EHR Clinical sites may receive a message indicating whether or not the provider has requested a follow-up visit for this patient.

Select **Base Menu** > **Main Patient Registration** > **select Patient** > **Person Profile** > **Scheduling**



Accounts Receivable - Person Profile

- **Schedule Appointment:** This allows the date, physician and appointment type to be selected. Once a specific appointment type has been selected a new option for "First Available" will display.

- **Appointments by Patient:** Select this option to view all the patient's existing appointments.

- **Patients Next Appointment:** Select this option to view the patient's next appointment.

- **Visit Reminders:** This allows the user to create a manual visit reminder for the patient

Selecting an existing appointment for a patient will display an option to re-schedule that appointment. This may be done as follows:

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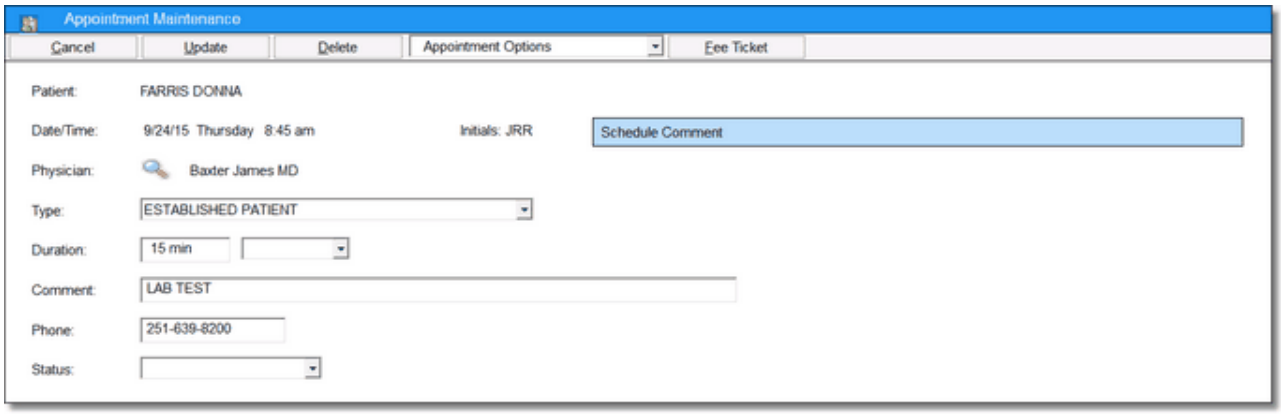
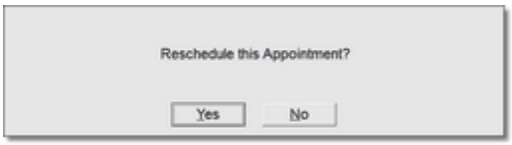
Select **Clinic Base Menu** > **Main Patient Registration** > **Choose Patient** > **Person Profile** > **Scheduling** > **Patient's Next Appointment** > **Appointment Maintenance**



Appointment Maintenance

Select **Medical Practice EMR - Base Menu** > **Main Patient Registration** > **Choose Patient** > **Person Profile** > **Scheduling** > **Patient's Next Appointment** > **Appointment Maintenance** > **Reschedule**



Warning

Selecting **Yes** will allow the appointment to be rescheduled by choosing a new date. Select the **Appointment by Date** to choose a new appointment time.

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Chapter 6 Thrive Provider EHR Insurance Procedures

6.1 Introduction

The Evident 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 Evident billing system recommends using daily and weekly procedures to assist personnel in the billing activities. Within the billing procedures are UB04 and 1500 claim edits. These edits help the Business Office to determine what additional information should be included on the insurance claims prior to billing. After determining the billing process for the claims, follow-up should be done by using the Insurance Tickler.

6.2 Insurance Procedures

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

6.3 Daily Procedures

Daily procedures will vary based on claims being billed from the facility or billed through Evident Electronic Billing Outsourcing.

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. Late Charge/Credit Report: This report is spooled once the day is closed. This report will show all unbilled charges for accounts that have insurance claims that have been generated or billed at the time of charge. Billers will need to review this report to see accounts that may need the insurance claims adjusted or reversed due to late charges.

3. UB04 Edit List and 1500 Edit List: Correct all errors from the **UB04 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.

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

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.

5. 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 was manually set back from the Ready to Bill status and the reason should be in the comment field. It 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 **UB Coding** and verify all Condition, Occurrence and Value codes. All necessary codes must be present in order to print on the UB04.

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

Secondary Procedures

6. Process all Secondary claims.

   A. If using the Automated Secondary Billing, print the **Secondary Billing Auto Reverse** report. Secondary claims at the Billed 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 Billed status. Reverse the Billed date, and enter the correct Expected Pay on the Detail Charges screen.

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Adjustment Claims/Re-Billing

7. 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.

6.4 Weekly Procedures

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: The 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 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: The 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.

6.5 EBOS Procedures

Primary Billing should be done first thing each morning and completed prior to moving on to any other billing function.

1. Print EBS 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 EBS 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 EBS, please refer to the EBS User Guide.

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Primary Billing

2. The Late Charge/Credit Report is spooled once the day is closed. This report will show all unbilled charges for accounts that have insurance claims that have been generated or billed at the time of charge. Billers will need to review this report to see accounts that may need the insurance claims adjusted or reversed due to late charges.

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.

3. Claims with Missing Information: Run this report to process claims.

If a claim appears on this report, it should be for one of two reasons. First, it was manually set back from the Ready to Bill status, and the reason should be placed in the comment field. It must be manually reset to Ready to Bill. Second, 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 **UB Coding** and verify all Condition, Occurrence and Value codes. All necessary codes must be present in order to print on the UB04.

Please refer to the EBS User Guide.

Secondary Billing

Process all Secondary claims.

A. If using the Automated Secondary Billing, print the **Secondary Billing Auto Reverse** report. Secondary claims at the Billed 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.

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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 Billed status. Reverse the Billed date, and enter the correct Expected Pay on the Detail Charges screen.

Adjustment Claims/Re-Billing

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.

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: The 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 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: The 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.

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6.6 Form Locators

Form Locators are used to show where billing information is located on the UB04 and 1500. Evient determines where information pulls from the system to these locators. The following information will show the description of the locator and where the information is pulled from in the system.

1500 Locators

LOC	DESCRIPTION	PULLED FROM/DETERMINED BY CPSI SYSTEM
1	FINANCIAL CLASS	REGISTRATION - GUARANTOR/INS TAB; POLICY INFORMATION
1a	INSURED'S I.D. NUMBER	POLICY INFORMATION - CONTRACT #
2	PATIENT'S NAME	REGISTRATION - PATIENT TAB - FULL NAME field
3	PATIENT'S BIRTHDAY and SEX	REGISTRATION - PATIENT TAB - BIRTH DATE and SEX field; STAY INFORMATION
4	INSURED'S NAME	POLICY INFORMATION - SUBSCRIBER NAME
5	PATIENT'S ADDRESS	STAY INFORMATION - PATIENT'S ADDRESS
6	PAT REL TO INSURED	POLICY INFORMATION - REL field
7	INSURED'S ADDRESS	REGISTRATION - GUARANTOR/INS TAB; POLICY INFORMATION - SUBSCRIBER ADDRESS
8	PATIENT STATUS	STAY INFORMATION - MARITAL STATUS ESC CODE
9	OTHER INSURED'S NAME	POLICY INFORMATION (Additional insurance claim)
9a	OTHER INSURED'S POLICY OR GROUP NUMBER	POLICY INFORMATION (Additional insurance claim)
9b	OTHER INSURED'S DATE OF BIRTH and SEX	POLICY INFORMATION (Additional insurance claim)
9c	EMPLOYER'S NAME	POLICY INFORMATION (Additional insurance claim)
9d	INSURANCE PLAN	POLICY INFORMATION (Additional insurance claim)
10	IS PATIENT'S CONDITION RELATED TO:	REGISTRATION - STAY TAB - ACCIDENT/THERAPY SECTION; STAY INFORMATION
10a	EMPLOYMENT? (Current or Previous)	REGISTRATION - STAY TAB - ACCIDENT/THERAPY SECTION; STAY INFORMATION
10b	AUTO ACCIDENT? PLACE (State)	REGISTRATION - STAY TAB - ACCIDENT/THERAPY SECTION; STAY INFORMATION (Occurance Code 02 and State Code loaded = YES)

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10c	OTHER ACCIDENT?	REGISTRATION - STAY TAB - ACCIDENT/THERAPY SECTION; STAY INFORMATION (Occurance Code 02 and no State Code loaded = YES)
10d	RESERVED FOR LOCAL USE	RESERVED FOR LOCAL USE
11	INSURED'S POLICY	POLICY INFORMATION - GROUP
11a	INSURED'S BIRTHDAY & SEX	POLICY INFORMATION
11b	EMPLOYER'S NAME	POLICY INFORMATION
11c	INSURANCE PLAN NAME	POLICY INFORMATION
11d	ANOTHER CLAIM?	HARD CODED (if "Y", system will complete 9-9d)
12	SIGNATURE	HARD CODED to pull "SIGNATURE ON FILE" and Admit Date
13	SIGNATURE	HARD CODED to pull “SIGNATURE ON FILE”
14	DATE OF CURRENT ILLNESS	STAY INFORMATION - ACCIDENT INFORMATION DATE field
15	DATE OF SAME ILLNESS	NOT CURRENTLY USED
16	DATES UNABLE TO WORK	NOT CURRENTLY USED
17	REFERRING PHYSICIAN	REFERRING DATA - PHYSICIAN or STAY INFORMATION - ADMITTING PHYSICIAN
17a	OTHER ID# AND QUALIFIER	REFERRING PHYSICIAN TABLE - field code 1 CHARGING PHYSICIAN TABLE - field code 1 BILLING PHYSICIAN TABLE - page 4 Billing Physician field ADMITTING PHYSICIAN TABLE - field code 1 ADMITTING PHYSICIAN TABLE - page 1 UPIN# field
17b	NPI	REFERRING PHYSICIAN TABLE - NPI populated with field code 1, or PHYSICIAN TABLE - page 1 NPI# field
18	HOSPITALIZATION DATES	STAY INFORMATION (for I/P’s only)
19	RESERVED FOR LOCAL USE	STATE SPECIFIC
20	OUTSIDE LAB	NOT CURRENTLY USED
21	DIAGNOSIS	STAY INFORMATION, DRG GROUPER SCREEN
22	MEDIC AID RESUBMISSION	NOT CURRENTLY USED
23	PRIOR AUTHORIZATION NUM	CLIA NUMBER - page 5 of Order Entry Information POLICY INFORMATION - PERCERT #

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24A	DATES OF SERVICE	DETAIL CHARGES SCREEN
24B	PLACE OF SERVICE	SUMMARY CODE TABLE - Place of Service field or specified on page 2 or CLINIC CODE TABLE - page 2
24C	EMG	EMERGENCY VISIT
24D	PROCEDURES and SERVICES	ITEM MASTER or DRG GROUPER SCREEN
24E	DIAGNOSIS POINTER	INSURANCE STATUS SCREEN - DIA
24F	CHARGES	DETAIL CHARGES SCREEN
24G	DAYS or UNITS	DETAIL CHARGES SCREEN
24H	EPSDT FAMILY PLAN	HARD CODED
24I	ID QUAL	HARD CODED
24J	RENDERING PROVIDER ID. #	(shaded portion) All states except KY and NM CHARGING PHYSICIAN TABLE - field code 3 CHARGING PHYSICIAN TABLE - page 1, Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes)fields STAY INFO PHYSICIAN TABLE - field code 3 STAY INFO PHYSICIAN TABLE - page 1, Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes)fields (shaded portion) for states KY and NM CHARGING PHYSICIAN TABLE - field code T CHARGING PHYSICIAN TABLE - field code 3 CHARGING PHYSICIAN TABLE - page 1 Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes)fields STAY INFO PHYSICIAN TABLE - field code T STAY INFO PHYSICIAN TABLE - field code 3 STAY INFO PHYSICIAN TABLE - page 1 page 1 Lic# or Tax# (Commercial) field, Provider # (All other Financial Classes)fields (unshaded portion) CHARGING PHYSICIAN TABLE - field code 4 CHARGING PHYSICIAN TABLE - field code N CHARGING PHYSICIAN TABLE - page 1 NPI# field STAY INFO PHYSICIAN TABLE - field code 4 STAY INFO PHYSICIAN TABLE - field code N STAY INFO PHYSICIAN TABLE - page 1 NPI# field PHYSICIAN 999999 TABLE - page 1 NPI# field
25	FEDERAL TAX ID NUMBER	INSURANCE COMPANY TABLE - page 2 Fedtax# field; PHYSICIAN TABLE #999999 - page 1 Lic# or Tax# field; if blank will pull from PHYSICIAN TABLE - page 1 Social

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		Security# field
26	PATIENTS ACCOUNT NO	PATIENT FUNCTIONS SCREEN
27	ACCEPT ASSIGNMENT	NOT CURRENTLY USED
28	TOTAL CHARGES	DETAIL CHARGES SCREEN
29	AMOUNT PAID	DETAIL BENEFITS - PRIOR PAYMENT
30	BALANCE DUE	TOTAL CHARGES - PRIOR PAYMENT = EXPECT PAY
31	SIGNATURE OF PHY	HARD CODED to pull BILLED date, INSURANCE COMPANY TABLE - page 4 Phy Signature 1500 ... 31 field
32	SERVICE FACILITY LOCATION INFO	PHYSICIAN TABLE #999999 - Physician Group Information fields or CLINIC CODE TABLE
32a	NPI NUMBER	CLINIC CODE TABLE - NPI & Pull NPI to Locator 32a on 1500 = Y CLINIC CODE TABLE - NPI & Pull NPI to Locator 32a on 1500 = N - pull NPI from Physician Table #999999 PHYSICIAN TABLE #999999 - page 1 NPI field
32b	OTHER ID NUMBER	INSURANCE COMPANY TABLE - page 6 NPI Only field, this locator will pull blank CLINIC CODE TABLE - Provider Number & Pull Provider Number to locator 32b on 1500 = Y CLINIC CODE TABLE - Provider Number & Pull Provider Number to locator 32b on 1500 = N - pull from Physician Table #999999 PHYSICIAN TABLE #999999 - page 1 Mcare EKG#/ Rad# - Blue Cross# fields
33	PHYSICIAN NAME and ADDRESS	CLINIC CODE TABLE; PHYSICIAN TABLE and/or INSURANCE COMPANY TABLE - page 2
33a	NPI NUMBER	CHARGING PHYSICIAN TABLE - field code n ADMITTING PHYSICIAN TABLE - field code n PHYSICIAN TABLE #999999 - field code N PHYSICIAN TABLE #999999 - page 1 NPI field
33b	OTHER ID NUMBER	CHARGING PHYSICIAN TABLE - field code 5 CHARGING PHYSICIAN TABLE - field code 6 ADMITTING PHYSICIAN TABLE - field code 5 ADMITTING PHYSICIAN TABLE - field code 6 PHYSICIAN 999999 TABLE - field code 5 PHYSICIAN 999999 TABLE - field code 6 INSURANCE COMPANY TABLE - page 1 Provider Number field

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6.7 UB04 Insurance Claim Edits

Within the billing procedures are UB04 claim edits. These edits help the Business Office to determine what additional information should be included on the insurance claims prior to billing.

UB04 Locators

LOC	DESCRIPTION	PULLED FROM/DETERMINED BY CPSI SYSTEM
1	PROVIDER NAME, ADDRESS, TELEPHONE, FAX & COUNTY CODE	CLINIC CODE TABLE PHYSICIAN TABLE #999999 - Physician Group Information
2	PAY-TO NAME, ADDRESS	CLINIC TABLE - Name and address fields & Pull Address to locator 2 on UB04 field INSURANCE CO. TABLE - page 2
3a	PATIENT CONTROL NUMBER	PATIENT ACCOUNT NUMBER
3b	MEDICAL RECORD NUMBER	STAY INFORMATION – MED REC# field
4	TYPE OF BILL	DETAIL CHARGES SCREEN – UB BILL TYPE; may be affected by INSURANCE CO. TABLE - page 1 UB Type Bill field
5	FED TAX NUMBER	INSURANCE COMPANY TABLE - page 2 Fedtax# field PHYSICIAN TABLE #999999 - page 1 Lic# or Tax# field
6	STMT COVERS PERIOD	INSURANCE CLAIMS STATUS SCREEN Service From/ To Dates
7	UNLABELED	STATE SPECIFIC (COVERED DAYS)
8a	PATIENT NAME ID	FOR FUTURE USE
8b	PATIENT NAME	REGISTRATION - PATIENT TAB - FULL NAME field
9a	PATIENT ADDRESS – STREET	REGISTRATION - PATIENT TAB - ADDRESS 1 & 2 fields
9b	PATIENT ADDRESS – CITY	REGISTRATION - PATIENT TAB - CITY field
9c	PATIENT ADDRESS – STATE	REGISTRATION - PATIENT TAB - STATE field
9d	PATIENT ADDRESS – ZIP	REGISTRATION - PATIENT TAB - ZIP field
9e	PATIENT ADDRESS – COUNTY CODE	REGISTRATION - PATIENT TAB - COUNTY CODE field

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10	PATIENT BIRTHDAY	REGISTRATION - PATIENT TAB - BIRTH DATE field
11	PATIENT SEX	REGISTRATION - PATIENT TAB - SEX field
12	ADMISSION DATE	REGISTRATION - STAY TAB - ADMISSION DATE/TIME field
13	ADMISSION HOUR	REGISTRATION - STAY TAB - ADMISSION DATE/TIME field
14	TYPE OF ADMISSION/VISIT	REGISTRATION - STAY TAB - ADMISSION CODE field (FIRST NUMBER)
15	SOURCE OF ADMISSION	REGISTRATION - STAY TAB - ADMISSION CODE field (SECOND NUMBER)
16	DISCHARGE HOUR	REGISTRATION - STAY TAB - DISCHARGE HOUR field
17	PATIENT/STATUS DISCHARGE CODE	REGISTRATION - STAY TAB - DISCHARGE CODE field
18-28	CONDITION CODES	UB CODING
29	ACCIDENT STATE	REGISTRATION - STAY TAB - ACCIDENT/THERAPY STATE field
30	UNLABELED	
31-34	OCCURRENCE CODE/DATE	UB CODING
35-36	OCCURRENCE SPAN CODE	PRIOR STAY INFORMATION
37	UNLABELED	
38	RESPONSIBLE PARTY - NAME/ADDRESS	INSURANCE ADDRESS - If INSURANCE COMPANY TABLE - page 4 Print Ins Addr Loc 38 field is set to Y GUARANTOR ADDRESS - If INSURANCE COMPANY TABLE - page 4 Print Ins Addr Loc 38 field is set to N
39-41	VALUE CODE/AMOUNT	UB CODING
42	REVENUE CODE	SUMMARY CODE TABLE - UB92 Revenue Code; DETAIL CHARGES
43	REVENUE CODE DESCRIPTION	SUMM CD TABLE - Description field; ITEM MASTER - Description field; DETAIL CHARGES
43-44	PAGE OF PAGE; CREATION DATE	NUMBER OF PAGES OF UB04; DATE CLAIM WAS PRINTED
44	HCPCS/RATES/HIPPS RATE CODES	ITEM MASTER - (CPTS), DRG GROUPER SCREEN (HCPCS), DETAIL CHARGES (RATES), ROOM RATE(for Revenue Codes 1001 and 1002)

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45	SERVICE DATE	DETAIL CHARGES
46	UNITS OF SERVICE	DETAIL CHARGES
47	TOTAL CHARGES	DETAIL CHARGES
48	NON-COVERED CHARGES	DETAIL CHARGES
49	UNLABELED	
50	PAYER – PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - INSURANCE COMPANY field; INSURANCE COMPANY TABLE - page 1 Name field
51	HEALTH PLAN ID	FOR FUTURE USE
52	RELEASE OF INFO - PRIMARY, SECONDARY & TERTIARY	Defaults to "Y"; POLICY INFORMATION - RELEASE OF INFORMATION
53	ASSIGNMENT OF BENEFITS - PRIMARY, SECONDARY & TERTIARY	STATE SPECIFIC
54	PRIOR PAYMENTS - PRIMARY, SECONDARY & TERTIARY	DETAIL BENEFITS - PRIOR PAYMENT field
55	EST. AMOUNT DUE - PRIMARY, SECONDARY & TERTIARY	DETAIL CHARGES - EXPECTED PAY
56	NPI	CLINIC CODE TABLE - NPI field if a clinic code is associated with the claim; otherwise, will pull from PHYSICIAN TABLE #999999 - page 1 NPI field or page 2, field code = N
57	OTHER PROVIDER - PRIMARY, SECONDARY & TERTIARY	INSURANCE COMPANY TABLE - page 1 Provider Number field
58	INSURED'S NAME- PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - SUBSCRIBER NAME
59	PAT.'S RELATION TO SUBSC - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - PAT'S RELATION TO SUB
60	INSURED'S UNIQUE ID - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - CONTRACT#

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61	GROUP NAME - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - GROUP INFO (GROUP NAME)
62	INSURANCE GROUP NO. - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - GROUP INFO (GROUP NUMBER)
63	TREATMENT AUTH. CDS - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - PRECERT#
64	DOCUMENT CONTROL NO	STAY INFORMATION - ICN
65	EMPLOYER NAME - PRIMARY, SECONDARY & TERTIARY	POLICY INFORMATION - EMPLOYER
66	DIAG VERSION QUALIFIER	QUALIFIER 9 REQUIRED Shaded area - Pulls a Y if ICT p7 f21 is set to Y.
67A-Q	PRIN. DIAG. CD. and PRESENT AT ADMISSION	STAY INFORMATION and DRG GROUPER SCREEN; the eighth digit (Present at Admission) pulls from the DRG GROUPER SCREEN @ ADM column
68	UNLABELED	
69	ADMITTING DIAG. CODE	DRG GROUPER SCREEN and STAY INFORMATION
70a-c	PATIENT'S REASON FOR VISIT	DRG GROUPER SCREEN - page 1 DRG field
71	PPS CODES	STAY INFORMATION - PPS field
72	ECI (EXTERNAL CAUSE OF INJURY CD)	PULLS ECODES FROM DIAG LIST ON GROUPER if ICT page 7 POA field is set to Yes
73	UNLABELED	
74	PRINCIPAL PROCEDURE CODE/DATE	STAY INFORMATION; DRG GROUPER SCREEN
74a-e	OTHER PROCEDURE CODE/DATE	STAY INFORMATION; DRG GROUPER SCREEN
75	UNLABELED	

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76	ATTENDING – NPI/QUAL/ID & LAST/FIRST	PHYSICIAN TABLE, page 1 NPI field, QUAL/ID - page 1 Lic# or Tax# & UPIN fields, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL
77	OPERATING – NPI/QUAL/ID & LAST/FIRST	PHYSICIAN TABLE, page 1 NPI field QUAL/ID - page 1 Lic# or Tax# & UPIN fields, QUAL may be overwritten from page 2 fld code U with phy type as the QUAL
78-79	OTHER – NPI/QUAL/ID & LAST/FIRST	Locator 78: REFERRING PHYSICIAN TABLE - NPI REFERRING PHYSICIAN TABLE - Provider Number PHYSICIAN TABLE - page 2, field code N (NPI) NOTE: If there is not a field code N loaded, ZZ will pull to the box in front of the NPI field. PHYSICIAN TABLE - page 2, field code U (QUAL) PHYSICIAN TABLE - NPI PHYSICIAN TABLE - Lic# or Tax# (QUAL) PHYSICIAN TABLE - UPIN (QUAL) Blank field if INSURANCE COMPANY TABLE - page 6 NPI field is selected. Locator 79: PHYSICIAN TABLE - page 2, field code N (NPI) NOTE: If there is not a field code N loaded, ZZ will pull to the box in front of the NPI field. PHYSICIAN TABLE - page 2, field code U (QUAL) PHYSICIAN TABLE - NPI PHYSICIAN TABLE - Lic# or Tax# (QUAL) PHYSICIAN TABLE - UPIN (QUAL) Blank field if INSURANCE COMPANY TABLE - page 6 NPI field is selected. QUAL: REFERRING PHYSICIAN TABLE - NPI Type
80	REMARKS	POLICY INFORMATION - BENEFIT DESC, INS COMPANY TABLE - page 4 Print Ins Addr Loc 80 field
81CC a-d	CODE - CODE - QUAL/ CODE/VALUE	TAXONOMY CODE 208D00000X pulls unless a different code is loaded in the PHYSICIAN #999999 TABLE - page 2 using a field code T; OVERFLOW pulls from UB CODING

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Edits 1-100

EDIT 1 - TWO OUTPATIENT CLAIMS W/ THE SAME SERVICE DATES

Scenario: The above edit appears if a patient has two claims on the Insurance screen with the same F/C, Service Dates, and the Bill Type is 131.
To Correct: All charges on the two claims will need to be manually generated onto one claim and billed on hard copy.

EDIT 2, 3 and 4 - PROVIDER INFORMATION BLANK

EDIT 2 - PROVIDER NAME BLANK
EDIT 3 - PROVIDER ADDRESS BLANK
EDIT 4 - PROVIDER PHONE NUMBER BLANK

Locator: 1 - Provider Name/Address/Phone
Scenario: The above edits appear if a claim does not have a Provider Name, Address, or Phone number printing on the UB in locator 1.
To Correct: Verify which of the above is missing. Load the missing information in the Physician Group Information fields of the Physician 999999 table.

EDIT 5 - TYPE OF BILL BLANK

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim does not have a Bill Type on the claim's Detail Charges screen.
To Correct: Verify the correct Bill Type and load in Detail Charges screen of the Claim. The claim does not have to be regenerated.

EDIT 6 - TYPE OF BILL INVALID

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim does not have a valid Bill Type. The Bill Type must meet the following criteria:
1st Digit is Type of Facility: 1, 2, 3, 7 or 8 only.
2nd Digit is Bill Classification: If 1st digit = 1 - 1, 2, 3, 4 or 8 only.
If 1st digit = 2 - 1, 2, 3 or 4 only.
If 1st digit = 7 - 1, 2, 4 or 5 only.
If 1st digit = 8 - 3 or 5 only.
3rd Digit is Frequency: 0, 1, 2, 3, 4, 5, 7, 8 or 9 only.
To Correct: Verify the correct Bill Type and load it in Detail Charges screen of the claim. The claim does not have to be regenerated.

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EDIT 7 - TYPE OF BILL INVALID

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 54X and the Bill Type is 11X.
To Correct: Verify the Bill Type is correct. If not, change Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify the account has the correct charges. If charges with the above Revenue Code are incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 8 - TYPE OF BILL INVALID - REV CODE 84X

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 84X and the Bill Type is 11X.
To Correct: Verify Bill Type is correct. If not, change Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify account has the correct charges. If charges with the above Revenue Code is incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 9 - TYPE OF BILL INVALID - REV CODE 23X

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 23X and the Bill Type is 11X.
To Correct: Verify Bill Type is correct. If not, change the Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify the account has the correct charges. If charges with the above Revenue Codes are incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 10 - TYPE OF BILL INVALID - REV CODE 322 OR 323

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a charge with Revenue Code 322 or 323 and the Bill Type is 11X, 12X or 13X.
To Correct: Verify Bill Type is correct. If not, change Bill Type on the claim's Detail Charges screen. If Bill Type is correct, verify the account has the correct charges. If charges with the above Revenue Codes are incorrect, have Data Processing back the charges off the account and regenerate the claim.

EDIT 11 - BILL TYPE NOT X1X OR X8X; OCC-CD 20,21,22,23, OR 26

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Code of 20, 21, 22, 23 or 26, and the Bill Type is not X1X or X8X.
To Correct: Verify Occurrence Codes are correct. If incorrect, change codes in the UB Coding screen of the claim. If the Occurrence Codes are correct, change Bill Type on the claim's Detail Charges screen. There is no need to regenerate the claim.

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EDIT 12 - BILL TYPE NOT X3X OR X8X; OCC-CD 40 OR 41

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Code of 40 or 41 and the Bill Type is not X3X or X8X.
To Correct: Verify Occurrence Codes are correct. If incorrect, change codes on the UB coding screen of the claim. If the Occurrence Codes are correct, change the Bill Type on the claim's Detail Charges screen. There is no need to regenerate the claim.

EDIT 13 - BILL TYPE INVALID; OCC-SPAN-CD = 70

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 70 and the Bill Type is not 11X, 18X or 21X.
To Correct: Verify the Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 14 - BILL TYPE INVALID; OCC-SPAN-CD = 71

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 71 and the Bill Type is not 11X or 21X.
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 15 - BILL TYPE INVALID; OCC-SPAN-CD = 72

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 72 and the Bill Type is not 13X, 14X, 71X, 74X or 75X.
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 16 - BILL TYPE NOT 11X; OCC-SPAN-CD = 75

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has an Occurrence Span Code of 75 and the Bill Type is not 11X.
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

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EDIT 17 - NEED COND CODE C3 WITH OCCUR SPAN OF MO

Locator: 24-30 Condition Codes
Scenario: The above edit appears if a Medicare, Blue Cross or Medicaid claim has an Occurrence Span Code = "MO," but does not have a Condition Code of "C3."
To Correct: Verify Occurrence Span Code is correct. If incorrect, change on the Stay Information screen of the claim. If correct, enter a Condition Code of C3 in the UB Coding screen of the claim. There is no need to regenerate the claim.

EDIT 18 - CANNOT HAVE OCCUR SPAN THRU DATE OF 999999

Locator: 36 - Occurrence Span
Scenario: The above edit appears if a Champus claim for a patient whose age is greater than 10 years old and the patient's relation to subscriber is not 03, 04, 05 or 10 or new relation codes 19, 43, 17 or 22 & has an Occurrence Span Thru date = 999999.
To Correct: Verify Patient relation to subscriber. If incorrect, change on the Policy Information screen of the claim. If correct, verify the Occurrence Span Thru date and correct on the Stay Information screen. There is no need to regenerate the claim.

EDIT 19 - VALUE CD = 15; BILL TYPE INVALID

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a Value Code = 15 and the Bill Type is not equal to 11X, 12X, 13X, 14X, 18X, 21X or 83X.
To Correct: Verify Value Code is correct. If incorrect, change on the UB Coding screen. If correct, enter the correct Bill Type on the claim's Detail Charges screen. There is no need to regenerate the claim.

EDIT 20 - BILL TYPE INVALID WITH COND CODE

Locator: 4 - Type of Bill
Scenario: The above edit appears if a claim has a Condition Code of D0, D1, D2, D3, D4, D7, D8, D9 or E0 and the Bill Type is not XX7. This same edit appears if a claim has a Condition Code of D5 or D6 and the Bill Type is not XX8.
To Correct: Verify the Condition Code is correct. If incorrect, make corrections on the UB Coding screen of the claim. If correct, change the Bill Type on the claim's Detail Charges screen. The claim does not have to be regenerated.

EDIT 21 - FEDERAL TAX NUMBER FROM INS TABLE IS NOT NUMERIC

Locator: 5 - Federal Tax Number
Scenario: The above edit appears if a claim has a Federal Tax number loaded in the Insurance Company table, page 2, that is not numeric or is blank.
To Correct: Verify the Federal Tax Number is correct and load it in the Insurance Company table, page 2. There is no need to regenerate the claim.

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EDIT 22 - FEDERAL TAX NUMBER IS NOT NUMERIC

Locator: 5 - Federal Tax Number
Scenario: The above edit appears if a claim has a physician loaded on the Stay Information screen with a tax number from the Physician table that is not numeric or is blank.
To Correct: Verify the Federal Tax number and load it in the Lic# or Tax# field in the Physician table for the particular physician. There is no need to regenerate the claim.

EDIT 23 - STMT 'FROM' DATE = 000000

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim does not have a date in the Service From field of the Insurance Claim Status screen.
To Correct: Verify the Admit date is correct. If not, have admitting correct the admit date through Census. If correct, regenerate the insurance claim and key in the correct service FROM date.

EDIT 24 - STMT 'THROUGH' DATE = 000000

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim does not have a date in the Service To field of the Insurance Claim Status screen.
To Correct: Verify the Discharge date is correct. If not, have admitting correct the discharge date through Census. If correct, regenerate the insurance claim and key in the correct “Service To” date.

EDIT 25 - STMT 'FROM' DATE > STMT 'THROUGH' DATE

Locator: 6 – Statement Covers Period
Scenario: The above edit appears if a claim has a “Service From” date after the claim's “Service To” date. Example: From date = 08/15/05 and To date = 08/12/05.
To Correct: Verify Admit and Discharge dates are correct. If incorrect, have admitting correct through Census. If dates are correct, regenerate insurance claim and key in the correct service From and To dates.

EDIT 26 - STMT "THROUGH" DATE > CURRENT DATE

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim has a “Service To” date > than the current date. Example: Current date is 8/1/05 and To date is 8/2/05.
To Correct: Verify Discharge date is correct. If incorrect, have admitting make corrections through Census. If date is correct, then regenerate the insurance claim and key in the correct "To" date. If correct, change the Bill Type on the Claims Detail Charges screen. The claim does not have to be regenerated.

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EDIT 27 - STMT 'FROM' YEAR NOT = STMT 'THROUGH' YEAR

Locator: 6 - Statement Covers Period
Scenario: The above edit appears if a claim has a Service From date in a different year than the Service To date and the Bill Type is 12X, 13X, 14X, 18X, 21X, 72X or 83X.
To Correct: Verify the admit and discharge dates are correct. If incorrect, have admitting change through Census Functions. If correct, then verify the Bill Type. The Bill Type can't be those listed above. If the Bill Type is correct then two claims will need to be setup; one from the admit date to the end of the year and the other from the beginning of the year until the discharge date.

EDIT 28 - COV DAYS + NONCOV NOT = STMT PERIOD DAYS

Locator: 7 - Covered days
Scenario: The above edit appears if a claim has Covered days + Non-Covered days not equal to the total period days and the Bill Type is 11X, 18X or 21X.
To Correct: Verify admit and discharge dates are correct. If incorrect, have admitting change through Census. If correct, verify Covered days and Non-Covered days and enter them on the Insurance Claim's Detail Benefits screen.

EDIT 29 - COV DAYS > 100; BILL TYPE 21X

Locator: 7 - Covered days
Scenario: The above edit appears if a claim has Covered days greater than 100 and the Bill Type is 21X.
To Correct: Verify that the Bill Type is correct. If incorrect, change on the claim's Detail Charges screen. If correct, then the Covered days cannot exceed 100.

EDIT 30 - COV DAYS > 150; BILL TYPE = 11X

Locator: 7 - Covered days
Scenario: The above edit appears if a claim has Covered days greater than 150 and the Bill Type is 11X.
To Correct: Verify that the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If correct, then the Covered days cannot exceed 150.

EDIT 31 - MEDICARE; COND CD = 40; CHECK COV DAYS

Scenario: The above edit appears if a Medicare claim has a Condition Code of 40 and the Covered days do not equal zero and Non-Covered days equals 1.
To Correct: Verify Condition Code is correct. If incorrect, delete the Condition Code on the UB Coding screen of the insurance claim. If the Condition Code is correct, the Covered days must be zero and the Non-Covered days must be one.

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EDIT 32 - COINS DAYS > COVERED DAYS

Scenario: The above edit appears if a Medicare claim has Co-Insurance Days Used (Co Days Used on the claim's Detail Benefits screen) greater than the Covered days.
To Correct: Verify claim has the correct amount of Co-Insurance days used on the Detail Benefits screen and it is not greater then the Covered days. The claim does not have to be regenerated.

EDIT 33 - CO-INS DAYS > 0; NEED VALUE CD 09 OR 11

Scenario: The above edit appears if a Medicare claim has Co-Insurance Days Used loaded in the claim's Detail Benefits screen which are greater than 0 and does not have Value Code 09 or 11 loaded on the UB Coding screen.
To Correct: Verify that the amount of Co-Insurance days used is the correct amount. If correct, then load Value Code 09 or 11 on the UB Coding screen of the claim. There is no need to regenerate the claim.

EDIT 34 - LIFE DAYS > 60

Locator: 10 - Life Reserve Days
Scenario: The above edit appears if a Medicare claim has Life Days Used loaded on the Detail Benefits screen of the claim and life days used is greater than 60.
To Correct: Verify the correct amount of Life Days Used is loaded and it's less than 60 days. The claim will need to be regenerated.

EDIT 35 - LIFE DAYS > COVERED DAYS

Scenario: The above edit appears if a Medicare claim has Life Days Used in the claim's Detail Benefits screen which are greater than the Covered days.
To Correct: Verify the claim has the correct amount of Life Days Used in the Detail Benefits screen and that they are not greater than the Covered days. The claim does not have to be regenerated.

EDIT 36 - COVERED DAYS > 365 ON CHAMPUS CLAIM

Scenario: The above edit appears if a Champus claim has Covered days greater than 365.
To Correct: Verify that the Financial Class is correct. If incorrect, enter the correct insurance on the Insurance screen of the patient. If correct, the Covered days cannot exceed 365 days.

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EDIT 37 - LIFE DAYS > 0; NEED VALUE CD 08 OR 10

Scenario: The above edit appears if a Medicare claim has Life Days Used in the Detail Benefits screen and does not have Value Code 08 or 10 on the UB coding screen.
To Correct: Verify the correct amount of Life Days Used. If incorrect, change in the Detail Benefits screen of the claim. If correct, load Value Code 08 or 10 on the UB Coding screen of the insurance claim. If the Life Days Used are changed, the claim will need to be regenerated. If the Value Code is entered, there is no need to regenerate the claim.

EDIT 38 - PATIENT'S NAME NOT ENTERED

Locator: 8b - Patient Name
Scenario: The above edit appears if a claim does not have a patient's name.
To Correct: Verify the patient's name and load it in the Patient tab on the Registration and ADT screen. The claim will have to be regenerated.

EDIT 39 - PATIENT NAME MUST INCLUDE LAST NAME AND FIRST INIT

Locator: 8b - Patient Name
Scenario: The above edit appears if a claim has only the last name of a patient loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the patient's name. The name must include at a minimum, the last name and first initial. The claim will need to be regenerated.

EDIT 40 - PATIENT'S STREET NOT ENTERED

Locator: 9a - Patient Address
Scenario: The above edit appears if a claim does not have a patient street address loaded in the Patient tab on the Registration and ADT screen - "Address1."
To Correct: Verify the correct street and load in the Patient tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 41 - PATIENT'S CITY NOT ENTERED

Locator: 9b - Patient Address
Scenario: The above edit appears if a claim does not have a patient's city loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the city is correct and load it in the Patient tab on the Registration and ADT screen and then regenerate the insurance claim.

EDIT 42 - PATIENT'S STATE NOT ENTERED

Locator: 9c - Patient Address
Scenario: The above edit appears if a claim does not have the patient's state loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the state is correct and load it in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

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EDIT 43 - PATIENT'S ZIP CODE NOT ENTERED

Locator: 9d - Patient Address
Scenario: The above edit appears if a claim does not have the patient's zip code loaded in the Patient tab on the Registration and ADT screen.
To Correct: Verify the zip code is correct and load it in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 44 - PATIENT'S ZIP IS INVALID FOR PATIENT STATE

Locator: 9d - Patient Address
Scenario: The above edit appears if a claim has a zip code loaded that is invalid for the state code loaded. The edit verifies this based on a range of zip codes obtained by the Post Office for each state.
To Correct: Verify the zip code is correct for the state loaded. Change either the state code or zip code, whichever is incorrect, in the Patient tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 45 - PATIENT'S BIRTHDATE IS MISSING

Locator: 10 - Birthdate
Scenario: The above edit appears if a claim does not have a date of birth loaded for the patient.
To Correct: Verify the patient's date of birth and load in the Patient tab on the Registration and ADT screen. Regenerate the claim.

EDIT 46 - BIRTH CENTURY INVALID

Locator: 10 - Birthdate
Scenario: The above edit appears if a claim has a birthdate loaded in the Patient tab on the Registration and ADT screen that is less than 1800 or greater than 2000.
To Correct: Verify the birthdate is correct and load in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 47 - AGE MUST BE > 65; VALUE CODE 12 LISTED

Locator: 10 - Birthdate
Scenario: The above edit appears if any claim except Medicare that has a Value Code of 12 listed on the UB Coding screen and the age is not greater than 65.
To Correct: Verify the Value Code is correct. If incorrect, delete the code from the UB Coding screen of the claim. If correct, verify the birthdate is correct and load in the Patient tab on the Registration and ADT screen. If the Value Code is corrected, there is no need to regenerate the claim. If the birthdate is corrected, the claim will need to be regenerated.

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EDIT 48 - AGE MUST BE < 65; VALUE CODE 43 LISTED

Locator: 10 - Birthdate
Scenario: The above edit appears if any claim except Commercial has a Value Code of 43 listed on the UB Coding screen and the age is not less than 65.
To Correct: Verify the Value Code is correct. If incorrect, delete the code from the UB Coding screen of the claim. If correct, verify the birthdate is correct and load in the Patient tab on the Registration and ADT screen. If the Value Code is corrected, there is no need to regenerate the claim. If the birthdate is corrected, the claim will need to be regenerated.

EDIT 49 - BIRTHDATE > ADMISSION DATE

Locator: 10 - Birthdate
Scenario: The above edit appears if any claim except Medicare, Blue Cross or Medicaid shows the date of birth is greater than the admission date.
To Correct: Verify the birth and admission dates are correct. If the date of birth is incorrect, enter the correct date in the Patient tab on the Registration and ADT screen. If admission date is incorrect, then have admissions correct through Census. The claim will need to be regenerated.

EDIT 50 - INVALID PATIENT SEX

Locator: 11 - Sex
Scenario: The above edit appears if a claim has a patient's sex that is not "M" - Male or "F" - Female.
To Correct: Verify the sex of the patient is correct and load it in the Patient tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 51 - INVALID MARITAL STATUS

Scenario: The above edit appears if a claim does not have any of the following marital status codes in the Patient tab on the Registration and ADT screen: "S" - Single, "M" - Married, "D" - Divorced, "X" - Separated, "W" - Widowed, "U" - Unknown or "P" - Life Time Partner.
To Correct: Check the marital status and load it in the Patient tab on the Registration and ADT screen. Regenerate the insurance claim.

EDIT 52 - MUST ENTER ADMIT DATE FOR THIS BILL TYPE

Locator: 12 - Admission Date
Scenario: The above edit appears if a claim has a Bill Type of 11X, 18X, 21X or 82X and there is no admit date.
To Correct: Verify the Bill Type. If incorrect, change on the claim's Detail Charges screen. If the Bill Type is correct, have admissions enter the correct admit date through Census. The claim will need to be regenerated.

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EDIT 53 - ADMIT DATE > STMT 'FROM' DATE

Locator: 12 - Admission Date
Scenario: The above edit appears if a claim has an admit date after the service "From" date on the claim.
To Correct: Verify the admit date is correct. If incorrect, have admissions correct the date through the Stay tab on the Registration and ADT screen. If admit date is correct, regen the insurance claim and enter the correct "From" date.

EDIT 54 - ADMISSION DATE > CURRENT DATE

Locator: 12 - Admission Date
Scenario: The above edit appears if a claim has an admit date greater than the current date.
To Correct: Verify the admit date and have admissions change the date through the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 55 - INVALID ADMIT HOUR

Locator: 13 - Admission Hour
Scenario: The above edit appears if a claim has an admit hour other than 00 - 23 or 99.
To Correct: Verify the admission hour falls within the 24 hour time period and is valid. If it needs to be changed, correct on the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 56 - ADMIT HOUR NOT ENTERED

Locator: 13 - Admission Hour
Scenario: The above edit appears if a claim other than Blue Cross, Medicare or Medicaid does not have an admit hour loaded in the Stay tab on the Registration and ADT screen.
To Correct: Verify the admit hour is correct and load in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 57 - ADMIT TYPE MISSING

Locator: 14 - Admission Type
Scenario: The above edit appears if a claim has a Bill Type of 11X, 18X or 21X and does not have an admission code.
To Correct: Verify the Bill Type. If incorrect, change on the claim's Detail Charges screen. If correct, verify the admission code and enter it on the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

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EDIT 58 - ADMIT TYPE INVALID

Locator: 14 - Admission Type
Scenario: The above edit appears if a claim has an admission type other than a 1, 2, 3, 4, 5 or 9.
To Correct: Verify the admission type in the Stay tab on the Registration and ADT screen. The first number of the admission code in the Stay tab on the Registration and ADT screen must be a 1, 2, 3 or 9. The claim will need to be regenerated.

EDIT 59 - ADMISSION TYPE BLANK

Locator: 14 - Admission Type
Scenario: The above edit appears if a claim does not have an admission type loaded.
To Correct: Verify the correct admission type and load the code in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 60 - ADMIT SOURCE MISSING

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim does not have an admission source loaded on the Stay tab on the Registration and ADT screen. The last number of the admission code is the admission source.
To Correct: Verify the correct admission source is loaded and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 61 - ADMIT SOURCE INVALID

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim has an admission source that is not a 1-9 and A.
To Correct: Verify the admission source is correct and enter it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 62 - ADMIT SOURCE OF 9 INVALID FOR BILL TYPE

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim has an admit source of 9 and the Bill Type is 13X or 83X.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If Bill Type is correct, the admission source cannot be a 9. The admission source will need to be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

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EDIT 63 - ADMIT SOURCE BLANK

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim does not have an admission source loaded in the Stay tab on the Registration and ADT screen.
To Correct: Verify the admission source is correct and load it in Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 64 - ADM SOURCE NOT VALID WITH ADMIT TYPE

Locator: 15 - Admission Source
Scenario: The above edits appear if a Champus claim has an admit type of 1 and does not have an admit source of 4 - 7.
To Correct: Verify the admission type is correct. If incorrect, change on the Stay tab on the Registration and ADT screen. If admission type is correct, the source may only be 4 - 7. The claim will need to be regenerated.

EDIT 65 - ADM TYPE = 4; ADM SOURCE UNACCEPTABLE

Locator: 15 - Admission Source
Scenario: The above edit appears if a claim is not Blue Cross, Medicare or Medicaid, the admission type is 4, and the admission source is not 1-4 or 9.
To Correct: Verify the admission type is correct. If incorrect, then change on the Stay tab on the Registration and ADT screen. If correct, then the admit source must be 1-4 or 9. The claim will need to be regenerated.

EDIT 66 - INVALID DISCHARGE HOUR

Locator: 16 - Discharge Hour
Scenario: The above edit appears if a claim has a discharge hour that is not 00 - 23 or 99.
To Correct: Verify the discharge time is correct in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 67 - DISCHARGE HOUR NOT ENTERED

Locator: 16 - Discharge Hour
Scenario: The above edit appears if a claim is not Medicare, Blue Cross or Medicaid and does not have a discharge hour loaded.
To Correct: Verify the discharge hour is correct and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

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EDIT 68 - DISCHARGE STATUS MISSING

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim has a Bill Type of 11X, 13X, 18X, 21X or 83X and does not have a discharge status loaded.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If the Bill Type is correct, verify the discharge status and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 69 - INVALID DISCHARGE STATUS

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim has a discharge status not equal to 01 - 09, 20, 30, 40 – 43, 50, 51, 61 – 66 or 70.
To Correct: Verify the discharge status is correct and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 70 - DISCHARGE STATUS BLANK

Locator: 17 - Discharge Status
Scenario: The above edits appear if a Champus claim does not have a discharge status code loaded.
To Correct: Verify the discharge status and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 71 - CANNOT HAVE DISC STATUS = 30 WITH THIS BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edits appear if a claim for a Stay Type 1 patient has a Bill Type with the third digit as a 1 or 4 and the discharge status code equals 30.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If Bill Type is correct, the discharge status code cannot be a 30. The status may be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 72 - INVALID DISC STAT FOR LISTED BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edit appears if there is a claim for a Stay Type 1 patient with the third digit of the Bill Type being a 1 or 4 and the discharge status does not equal to 01-07, 20, 40-43, 50, 61-63, 65 or 70.
To Correct: Verify the Bill Type is correct. If incorrect, change the Bill Type on the claim's Detail Charges screen. If the Bill Type is correct, the discharge status code has to be a 01-07, 40-42 or 20. The status may be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

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EDIT 73 - CANNOT HAVE LISTED DISC STAT WITH THIS BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim for a Stay Type 1 patient has the third digit of the Bill Type as a 2 or 3 and the discharge code is a 01-08.
To Correct: Verify the Bill Type is correct. If incorrect, change the Bill Type in the claim's Detail Charges screen. If the Bill Type is correct, then the discharge status code cannot be a 01-08. The status may be changed in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 74 – DISCHARGE STATUS 09 NOT VALID FOR BILL TYPE

Locator: 17 - Discharge Status
Scenario: The above edit appears if a claim does not have a Bill Type of 13X, 14X, 83X or 85X and has a discharge status of 09 loaded.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If the Bill Type is correct, verify the discharge status is correct and load it in the Stay tab on the Registration and ADT screen. The claim will need to be regenerated.

EDIT 75 - INVALID CONDITION CODE ON ACCOUNT

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code that is not equal to 01-11, 18-24, 26-29, 31-34 or 36-41 on the UB Coding screen.
To Correct: Check to see if the claim needs a Condition Code and load the correct code in the UB Coding screen. If the claim does not need a Condition Code, delete the Condition Code. The claim does not need to be regenerated.

EDIT 76 - NEED COND CD = 02 FOR VALUE CD = 14 OR 41

Locator: 18 - 28 Condition Codes
Scenario: The above edits appear if a claim has Value Code 15 or 41 in the UB Coding screen and does not have a Condition Code 02.
To Correct: Verify Value Code. If incorrect, change the code on the UB Coding screen. If correct, the claim must have an 02 Condition Code loaded on the UB Coding screen. The claim does not need to be regenerated.

EDIT 77 - ESC = 1 OR 2; MISSING COND CD, OCC CD OR VALUE CD

Locator: 18 - 28 Condition Codes
Scenario: A claim has an Employment Status Code (ESC) of 1 or 2 and does not have at least one of the following: a Condition Code 10 or 11, an Occurrence Code 24 or Value Code of 12, 13 or 43 in the UB Coding screen.
To Correct: Verify the Employment Status Code on the Policy Information screen. If incorrect, enter the correct code. If the ESC is correct, the claim must have one of the codes listed above. The claim does not need to be regenerated.

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EDIT 78 - BILL TYPE = XX7; NEED CHANGE REQUEST CODE

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type of XX7 and does not have a Condition Code of D0, D1, D2, D3, D4, D7, D8, D9 or E0 in the UB Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If the Bill Type is correct, then the Condition Code must be a D0, D1, D2, D3, D4, D7, D8, D9 or E0 in the UB Coding screen. The claim does not need to be regenerated.

EDIT 79 - BILL TYPE = XX7; SHOULD HAVE ONLY ONE ADJUST CODE

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type of XX7 and has at least two or more of the following Condition Codes: D0, D1, D2, D3, D4, D7, D8, D9 or E0 on the UB Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If the Bill Type is correct, then the claim may only have one of the Condition Codes. The claim does not need to be regenerated.

EDIT 80 - MEDICARE CLAIM - NEEDS COND CODE C1 - C7

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a Medicare Stay Type 1 claim does not have a Condition Code of C1 - C7 in the UB Coding screen.
To Correct: Verify the correct Condition Code and load in the UB Coding screen of the claim. The claim does not need to be regenerated.

EDIT 81 - BILL TYPE = XX8; NEED CHANGE REQUEST CODE D5 OR D6

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type XX8 and does not have a Condition Code D5 or D6 in the UB Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If correct, the claim must have a Condition Code of D5 or D6 on the UB Coding screen. The claim does not need to be regenerated.

EDIT 82 - BILL TYPE = XX8; SHOULD HAVE ONLY ONE ADJUST CODE

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Bill Type of XX8 and has both Condition Codes D5 and D6 on the UB Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If correct, the claim may only have one of the Condition Codes. Verify which code is correct and delete the incorrect one from the UB Coding screen. The claim does not need to be regenerated.

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EDIT 83 - NEEDS A6 CONDITION CODE; PRIN DIAG = V0481

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim with service dates after 10/01/03 has a diagnosis "V0481" and does not have a Condition Code of "A6" in the UB Coding screen.
To Correct: Verify the Diagnosis is correct. If not, have Medical Records change the Diagnosis on the Grouper screen. If the diagnosis is correct, load Condition Code A6 on the UB Coding screen. If the Diagnosis Code is corrected, the claim will need to be regenerated. If the Condition Code is entered, the claim does not have to be regenerated.

EDIT 84 - NEEDS A6 CONDITION CODE; HAS REV CDS 636 AND 771

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim, with service dates after 10/01/94, has charges with Revenue Codes 636 and 771, and does not have a Condition Code of "A6" in the UB Coding screen.
To Correct: Verify charges are correct. If incorrect, have Data Processing correct through Charge Entry. If charges are correct, load a Condition Code of A6 in the UB Coding screen. If the charges are corrected, the claim will need to be regenerated. If Condition Code is entered, the claim does not have to be regenerated.

EDIT 85 - ADJ COND CD; BILL TYPE SHOULD END IN 7 OR 8

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code of any one of the following: D0, D1, D2, D3, D4, D5, D6, D7, D8, D9 or E0, and the Bill Type does not end in a 7 or 8.
To Correct: Verify Condition Code is correct. If incorrect, delete code from the UB Coding screen of the claim. If correct, the Bill Type must end in a 7 or 8. Correct the Bill Type in the claim's Detail Charges screen. The claim will not need to be regenerated.

EDIT 86 - CAN'T USE COND CD 70,71,73,74, OR 76 W/PRIN DIAG

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code of 70, 71, 73, 74 or 76 and the Principal Diagnosis is not 585.
To Correct: Verify the Condition Code is correct. If incorrect, delete code from the UB Coding screen of the claim. If correct, the Principal Diagnosis Code must be 585. Have Medical records verify and correct on the Medical Records Grouper screen. The claim will need to be regenerated.

EDIT 87 - NEED COND CD 70,71,73,74, OR 76 W/PRIN DIAG

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Principal Diagnosis of 585 and does not have a Condition Code of 70, 71, 73, 74 or 76 on the UB Coding screen of the claim.
To Correct: Verify Principal Diagnosis Code. If incorrect, have Medical Records correct on the Medical Records Grouper screen. If diagnosis is correct, load one of the Condition Codes in the UB Coding screen of the claim. If diagnosis is corrected, the claim will need to be regenerated. If the Condition Code is added, there is no need to regenerate the claim.

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EDIT 88 - CAN'T USE COND CD 81 - 86 WITH BILL TYPE LISTED

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has a Condition Code of 81 - 86 and the Bill Type is X3X (except 73X or 83X).
To Correct: Verify the Condition Code. If incorrect, delete code from the UB Coding screen of the claim. If correct, the Bill Type cannot be X3X except 73X or 83X. The Bill Type may be changed on the claim's Detail Charges screen. The claim does not need to be regenerated.

EDIT 89 - NEED COND CD 02 WITH OCC CD 04

Locator: 18 - 28 Condition Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 04 and is missing a Condition Code of 02.
To Correct: Verify Occurrence Code is correct. If incorrect, delete code from the UB Coding screen of the claim. If correct, the claim needs a Condition Code of 02 loaded in the UB Coding screen. The claim does not need to be regenerated.

EDIT 90 - INVALID OCCURRENCE CODE ON ACCOUNT

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code on the UB Coding screen and it is not one of the following: 01-06, 09-12, 17-22, 24-46, A1-A3, B1-B3 or C1-C3.
To Correct: Verify the claim needs a Condition Code. Correct the code in the UB Coding screen. The claim does not need to be regenerated.

EDIT 91 - NEED TO ENTER OCCURRENCE DATE FOR OCCURRENCE CODE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code in the UB Coding screen and is missing an Occurrence Date.
To Correct: If Occurrence Code is not needed, delete from the UB Coding screen. If Occurrence Code is correct, then verify the date and load in the UB Coding screen. The claim does not need to be regenerated.

EDIT 92 - NEED TO ENTER OCCURRENCE CODE FOR OCCURRENCE DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Date in the UB Coding screen and is missing an Occurrence Code.
To Correct: Verify the Occurrence Code is needed. If Occurrence Code is not needed, delete date from the UB Coding screen. If Occurrence Code is correct, verify the code and load in the UB Coding screen. The claim does not need to be regenerated.

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EDIT 93 - OCCURRENCE DATE > CURRENT DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Date in the UB9 Coding screen that is greater than the current date.
To Correct: Verify the Occurrence Date and change in the UB Coding screen. The Occurrence Date cannot be a future date. The claim does not need to be regenerated.

EDIT 94 - TRAUMA DIAGNOSIS - NEED OCCURRENCE CODE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a trauma Diagnosis Code of 80000-99899 and does not have an Occurrence Code of 01 - 05 in the UB Coding screen of the claim.
To Correct: Verify the diagnosis is correct. If incorrect, have Medical Records change in the Grouper screen and the claim will need to be regenerated. If diagnosis is correct, the claim must have an Occurrence Code of 01 - 05. The claim does not need to be regenerated.

EDIT 95 - VALUE CODE = 15; NEED OCCUR CD = 04

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Value Code of 15 in the UB Coding screen and does not have an Occurrence Code of 04.
To Correct: Verify the Value Code is correct. If incorrect, delete code from UB Coding screen. If correct, the claim must have an Occurrence Code of 04 in the UB Coding screen. The claim will not need to be regenerated.

EDIT 96 - DIAGNOSIS REQUIRES OCCUR CD OF 05 OR 24

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Diagnosis Code of 500 - 506 or 508 and does not have an Occurrence Code of 05 or 24 in the UB Coding screen.
To Correct: Verify the Diagnosis Code is correct. If incorrect, have Medical Records change on the Grouper screen. The claim will need to be regenerated. If Diagnosis Code is correct, the claim must have either an 05 or 24 Occurrence Code in the UB Coding screen. The claim will not need to be regenerated.

EDIT 97 - OCCUR DT > STMT "FROM" DATE; OCC CD 01-06 OR 11

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Date greater than the statement "From" date and the Occurrence Code is 01-06 or 11.
To Correct: Verify the correct Occurrence Date and that it is prior to the statement "From" date. Enter the correct date in the UB Coding screen. The claim will not need to be regenerated.

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EDIT 98 - OCCUR CD = 10; CHECK OCCURRENCE DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim that is not Medicare, Medicaid, Blue Cross or Champus has an Occurrence Code of 10 and an Occurrence Date that is less than one year prior to the statement "From" date.
To Correct: Verify correct Occurrence Date and that it is not less than one year prior to statement "From" date. Enter the correct Occurrence Code and date in the UB Coding screen. The claim will not need to be regenerated.

EDIT 99 - OCCUR CD 42 NOT CONSISTENT WITH BILL TYPE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 42 and the third character of the Bill Type is not equal to 1, 4 or 7.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If correct, the claim cannot have an Occurrence Code of 42. Delete the Occurrence Code from the UB Coding screen. The claim will not need to be regenerated.

EDIT 100 - OCCUR CD 42 DATE NOT = STMT "TO" DATE

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 42, the third character of the Bill Type is equal to 1, 4 or 7, and the Occurrence Date in the UB Coding screen is not equal to the statement "To" date.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If correct, the claim's Occurrence Date must equal the statement "To" date. Change Occurrence Date in the UB Coding screen. The claim will not need to be regenerated.

Edits 101-200

EDIT 101 - NEED OCCUR CODE 01 - 06 OR 11

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an admission type of 1 or 2, the Diagnosis Code is not 630-67699 or V22-V24, and does not have an Occurrence Code of 01-06 or 11 in the UB Coding screen. This edit will pull for M**, B**, X**, S** and C** claims.
To Correct: Verify which Occurrence Code is needed and load in the UB Coding screen. The claim will not need to be regenerated.

EDIT 102 - NEED OCCUR CODE 01 - 06

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Value Code of 45 and does not have at least one Occurrence Code of 01 - 06 in the UB Coding screen.

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To Correct: Verify the Value Code is correct. If incorrect, delete the code from the UB Coding screen. If correct, the claim must have at least one Occurrence Code of 01 - 06. Verify which Occurrence Code is correct and enter the code in the UB Coding screen. The claim will not need to be regenerated.

EDIT 103 - NEED OCCUR CD 11 & 35; HAS REV CD 42X

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 42X, and does not have both Occurrence Codes of 11 & 35 on the UB Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If Bill Type and the Revenue Code are correct, the claim must have both Occurrence Codes of 11 and 35 in the UB Coding screen. The claim will not need to be regenerated.

EDIT 104 - NEED OCCUR CD 11,17 & 44; HAS REV CD 43X

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 43X, and does not have all three Occurrence Codes 11, 17 & 44 in the UB Coding screen.
To Correct: Verify that the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If the Bill Type and Revenue Code are correct, the claim must have Occurrence Codes 11, 17 and 44 in the UB Coding screen. The claim will not need to be regenerated.

EDIT 105 - NEED OCCUR CD 11 & 45; HAS REV CD 44X

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 44X, and does not have both Occurrence Codes of 11 & 45 in the UB Coding screen.
To Correct: Verify that the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If the Bill Type and Revenue Code are correct, the claim must have both Occurrence Codes 11 and 34 in the UB Coding screen. The claim will not need to be regenerated.

EDIT 106 - NEED OCCUR CD 11 & 46; HAS REV CD 943

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 943, and does not have both Occurrence Codes 11 and 46 in the UB Coding screen.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If the Bill Type and the Revenue Code is correct, the claim must have both Occurrence Codes 11 and 46 in the UB Coding screen. The claim will not need to be regenerated.

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EDIT 107 - NEED OCCUR CD 18 OR 19; ESC = 5

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has an Employment Status Code of 5, does not have a Value Code of 12-16, 41 or 43 in the UB Coding screen, and does not have an Occurrence Code of 18 or 19.
To Correct: Verify that the ESC code and Value Codes are correct. If correct, the claim must have an Occurrence Code of 18 or 19 in the UB Coding screen. The claim will not need to be regenerated.

EDIT 108 - NEED OCCUR CD 33; HAS COND CD = 06

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Condition Code of 06 and does not have an Occurrence Code of 33 in the UB Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, it may be changed in the UB Coding screen. If Condition Code is correct, enter an Occurrence Code of 33 in the UB Coding screen. The claim will not need to be regenerated.

EDIT 109 - NEED OCCUR CD 33; HAS VALUE CD = 13

Locator: 31 - 34 Occurrence Codes
Scenario: The above edit appears if a claim has a Value Code of 13 in the UB Coding screen and does not have an Occurrence Code of 33.
To Correct: Verify that the Value Code is correct. If incorrect, it may be changed in the UB Coding screen. If Value Code is correct, the claim must have an Occurrence Code of 33. The claim will not need to be regenerated.

EDIT 110 - INVALID OCCURRENCE SPAN CODE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span Code on the claim's Stay Information screen and it is not 70 - 78 or MO. When M0, and “O” being alpha, the edit will pull. When M0, and “0” is numeric the edit will not pull.
To Correct: Verify the correct Occurrence Span Code and load in the Stay Information screen of the claim. The claim will not need to be regenerated.

EDIT 111 - OCC SPAN "MO" HAS BEGIN DATE PRIOR TO ADMISSION

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span Code of "MO" and the begin date is prior to the admission date in the claim's Stay Information screen.
To Correct: Verify the correct Occurrence Span Code begin date and load in the Stay Information screen of the claim. The claim will not need to be regenerated.

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EDIT 112 - NEED OCCUR SPAN CODE OF "MO" WITH COND "C3"

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a Commercial, Champus, or Workman's Comp claim has a Condition Code of C3 and does not have an Occurrence Span Code of "MO" in the claim's Stay Information screen.
To Correct: Verify the Condition Code is correct. If incorrect, change in the UB Coding screen. If correct, enter Occurrence Span Code of "MO" in the Stay Information screen. The claim will not need to be regenerated.

EDIT 113 - NEED OCCUR SPAN CODE OF 70-78 WITH COND "C3"

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a Medicare claim has a Condition Code of "C3" and does not have an Occurrence Span Code of 70-78 in the claim's Stay Information screen.
To Correct: Verify the Condition Code is correct. If incorrect, change in the UB Coding screen. If correct, enter Occurrence Span Code of 70-78 in the Stay Information screen. The claim will not need to be regenerated.

EDIT 114 - OCCUR SPAN "THRU" DATE LESS THAN "FROM" DATE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span "Thru" date prior to the span "From" date on the claim's Stay Information screen - Prior Stay.
To Correct: Verify the "From" and "Thru" dates. Enter the correct dates in the Stay Information screen - Prior Stay for the claim. The claim will not need to be regenerated.

EDIT 115 - MISSING DATE FOR OCCURRENCE SPAN

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span Code in the Stay Information screen - Prior Stay and is missing a date.
To Correct: Verify the dates are correct and load in the Stay Information screen for the claim. If the Occurrence Span Code is not needed, delete from the Stay Information screen - Prior Stay. The claim will not need to be regenerated.

EDIT 116 - SPAN "THROUGH" DATE LESS THAN SPAN "FROM" DATE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a claim has an Occurrence Span "Thru" date prior to the Occurrence Span "From" date on the claim's Stay Information screen - Prior Stay.
To Correct: Verify the correct Occurrence Span dates and correct on the Stay Information screen - Prior Stay for the claim. The claim will not need to be regenerated.

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EDIT 117 - OCCUR SPAN "FROM" DATE > ADMIT DATE

Locator: 35 - 36 - Occurrence Span Codes
Scenario: The above edit appears if a Champus claim has an Occurrence Span "From" date on the claim's Stay Information screen - Prior Stay prior to the admission date of the patient.
To Correct: Verify the correct "From" date and enter in the Stay Information screen - Prior Stay. The claim will not need to be regenerated.

EDIT 118 - MISSING ICN # FOR MEDICARE CLAIM

Locator: 37
Scenario: The above edit appears if a Medicare claim has a Bill Type of XX7 or XX8 and is missing an ICN# in the Stay Information screen for the claim.
To Correct: Verify the Bill Type is correct. If incorrect, change on the claim's Detail Charges screen. If correct, enter the Internal Control Number on the Stay Information screen. The claim will not need to be regenerated.

EDIT 119 - MISSING RESPONSIBLE PARTY NAME

Locator: 38 - Responsible Party Name
Scenario: The above edit appears if a claim is missing the subscriber's name and address on the Policy Information screen for the claim.
To Correct: Verify the correct subscriber's name and address and enter in the Policy Information screen of the claim. The claim will not need to be regenerated.

EDIT 120 - INVALID VALUE CODE ON ACCOUNT

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim that is not Commercial and has a Value Code that is not one of the following: 01, 02, 04-06, 08-16, 21-24, 30, 31, 37-53, 56-60, 68, A1-A3, B1-B3, C1-C3 or D3 on the UB Coding screen of the claim.
To Correct: Verify a Value Code is needed. If the code is not needed, delete code from the UB Coding screen of the claim. If code is required, then it must be one of the valid Value Codes listed above. The claim will not need to be regenerated.

EDIT 121 - VALUE CODE HAS NO VALUE AMOUNT

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code loaded on the UB Coding screen and has no amount loaded.
To Correct: Verify the Value Code is needed. If not needed, remove the code from UB Coding screen of the claim. If the Value Code is required, the amount must be entered. The claim will not need to be regenerated.

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EDIT 122 - VALUE AMOUNT HAS NO VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a value amount loaded in the UB Coding screen and has no code loaded.
To Correct: Verify the Value Code is needed. If not needed, remove the amount from UB Coding screen of the claim. If the Value Code is required, it must be entered with the amount. The claim will not need to be regenerated.

EDIT 123 - HAS MORE THAN ONE OF VALUE CODES A1, B1, C1

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare Inpatient claim has more than one of the following Value Codes: A1, B1 or C1 in the UB Coding screen of the claim.
To Correct: Verify the correct Value Code and delete the codes that are not needed from the UB Coding screen. The claim will not need to be regenerated.

EDIT 124 - NEED VALUE CD 23 FOR MEDICAID SECONDARY CLAIM

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicaid Secondary claim is missing Value Code 23 from the UB Coding screen.
To Correct: Verify the Value Code amount. Enter Value Code 23 and the amount in the UB Coding screen. The claim will not need to be regenerated.

EDIT 125 - NEED VALUE CODE 05 DUE TO REVENUE CODES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Revenue Codes 96X (except 964), 97X, or 98X, and does not have a Value Code of 05 and value amount in the UB Coding screen.
To Correct: Verify the correct value amount and load Value Code 05 and the amount in the UB Coding screen for the claim. The claim will not need to be regenerated.

EDIT 126 - VALUE CD 05 AMT NOT = SUM OF 96X, 97X, 98X

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Revenue Codes 96X, 97X (except 978) or 98X and the Value Code 05 amount is not equal to the sum of the listed Revenue Codes.
To Correct: Verify the correct value amount and load the amount with Value Code 05 in the UB Coding screen of the claim. The claim will not need to be regenerated.

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EDIT 127 - MEDICARE SECONDARY OR TERTIARY- NEED VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare secondary or tertiary claim does not have one of the following Value Codes loaded in the UB Coding screen: 12, 13, 14, 15, 16, 41, 42 or 43.
To Correct: Verify which Value Code is needed and enter in the UB Coding screen for the Medicare secondary or tertiary claim. The claim will not need to be regenerated.

EDIT 128 - OCCUR CD 01,02,03, OR 04 LISTED; NEED VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has an Occurrence Code of 01, 02, 03 or 04 and does not have one of the following Value Codes in the UB coding screen: 12, 13, 14, 15, 16, 41, 42 or 43.
To Correct: Verify which Value Code is needed and enter in the UB Coding screen for the Medicare secondary or tertiary claim. The claim does not need to be regenerated.

EDIT 129 - COND CD = 10; CANNOT HAVE VALUE CD = 12,13, OR 43

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of 10 in the UB Coding screen and has Value Codes 12, 13 or 43.
To Correct: Verify the Condition Code is correct. If incorrect, delete the code from the UB Coding screen. If Condition Code is correct, delete the Value Code 12, 13 or 43 from the Coding screen. The claim does not need to be regenerated.

EDIT 130 - COND CD = 09; CANNOT HAVE VALUE CD = 12,15,41 OR 43

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of 09 in the UB Coding screen and has Value Codes 12, 15, 41 or 43.
To Correct: Verify the Condition Code is correct. If incorrect, delete the code from the UB Coding screen. If the Condition Code is correct, delete the Value Code 12, 15, 41 or 43 from the Coding screen. The claim does not need to be regenerated.

EDIT 131 - MISSING VALUE CODE; HAS REV CD = 380, 381, OR 382

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Revenue Codes 380, 381 or 382 and does not have both Value Codes 37 and 38 in the UB Coding screen.
To Correct: Verify the value amount. Load Value Code 37 and 38 and the value amount in the UB Coding screen. The claim does not need to be regenerated.

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EDIT 132 - HAS VALUE CD = 06; NEEDS VALUE CD 37, 38, OR 39

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 06 and does not have a Value Code of 37, 38 or 39 in the UB Coding screen.
To Correct: Verify Value Code 06 is required. If it's not required, delete code from the UB Coding screen. If Value Code 06 is required, Value Codes 37, 38 or 39 should be entered.

EDIT 133 - VALUE CODE 38 AMOUNT > (VALUE CODE 39 AMT LESS 3)

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare claim has an amount for Value Code 38 greater than the Value Code 39 amount minus 3 in the UB Coding screen.
To Correct: Verify the correct value amount for Value Codes 38 and 39. Enter the correct amount in the UB Coding screen for the claim. The claim does not need to be regenerated.

EDIT 134 - VALUE CODE 38 AMOUNT > VALUE CODE 37 AMOUNT

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim that is not Medicare, Blue Cross or Medicaid has a Value Code 38 amount greater than Value Code 37 amount on the UB Coding screen.
To Correct: Verify the correct value amount for Value Codes 38 and 37. Enter the correct amounts in the UB Coding screen. The claim does not need to be regenerated.

EDIT 135 - VAL CD 08 OR 10 ENTERED; LIFE DAYS NOT > 0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 08 or 10 in the UB Coding screen and does not have Life Reserve Days greater than zero in the claim's Detail Benefits screen.
To Correct: Verify the correct amount of Life Reserve days and load in the Detail Benefits screen of the claim. The claim will need to be regenerated.

EDIT 136 - VAL CD 09 OR 11 ENTERED; COINS DAYS NOT >0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 09 or 11 in the UB Coding screen and does not have Co-Insurance days greater than zero in the claim's Detail Benefits screen.
To Correct: Verify the correct amount of Co-Insurance days and load in the Detail Benefits screen for the claim. The claim will need to be regenerated.

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EDIT 137 - VALUE CODE 50 INVALID FOR BILL TYPE 18X

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has Value Code of 50 in the UB Coding screen and has a Bill Type of 18X.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If Bill Type is correct, the Value Code of 50 needs to be deleted from the UB Coding screen. The claim does not need to be regenerated.

EDIT 138 - MISSING VALUE CODE 06, 37 OR 38 FOR BLOOD CHARGES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare or Medicaid claim has charges with Revenue Code 38X and does not have a Value Code of 06, 37, or 38 in the UB Coding screen.
To Correct: Verify the correct Value Code and amount and enter in the UB Coding screen. The claim does not need to be regenerated.

EDIT 139 - MISSING VALUE CODE 37 or 38 FOR BLOOD CHARGES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Medicare or Medicaid claim has charges with Revenue Code 380, 381 or 382 and does not have a Value Code of 37 or 38 in the UB Coding screen.
To Correct: Verify the correct Value Code and amount and enter in the UB Coding screen. The claim does not need to be regenerated.

EDIT 140 - CANNOT HAVE VALUE CD 43 WITH COND CD 11

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 43 and Condition Code of 11 in the UB Coding screen.
To Correct: Verify which Value Code is required (either 43 or 11). Delete the Value Code that is not needed in the UB Coding screen. The claim will not need to be regenerated.

EDIT 141 - MISSING VALUE CODE 68

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has charges for Revenue Codes 634 or 635, the Bill Type is 11X, 13X or 72X, and is missing Value Code 68 in the UB Coding screen.
To Correct: Verify that Value Code 68 is entered in the UB Coding screen. The claim will not need to be regenerated.

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EDIT 142 - MISSING VALUE CODE 48 OR 49

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has charges for Revenue Codes 634 or 635, the Bill Type is 11X, 13X or 72X, and is missing Value Codes 48 or 49 in the UB Coding screen.
To Correct: Verify the Value Code is correct and enter in the UB Coding screen. The claim will not need to be regenerated.

EDIT 143 - MISSING VAL CD 50 OR VALUE AMOUNT TOO SMALL

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 42X, is missing a Value Code of 50, or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 42X.
To Correct: If Value Code 50 is entered, verify the amount is greater than or equal to the sum of the charges for Revenue Code 42X. The claim will need to be regenerated.

EDIT 144 - MISSING VAL CD 51 OR VALUE AMOUNT TOO SMALL

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, has charges with Revenue Code 43X, is missing Value Code 51, or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 43X.
To Correct: If Value Code 51 is entered, verify the amount is greater than or equal to the sum of the charges for Revenue Code 43X. The claim will need to be regenerated.

EDIT 145 - MISSING VAL CD 52 OR VALUE AMOUNT TOO SMALL

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, charges for Revenue Code 44X and is either missing Value Code of 52 or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 44X.
To Correct: If Value Code 52 is entered, verify the amount is greater than or equal to the sum of the charges for Revenue Code 44X. The claim will need to be regenerated.

EDIT 146 - MISSING VAL CD 53 OR VALUE AMOUNT TOO SMALL

Locators: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 74X, 75X or 83X, charges for Revenue Code 943 and is either missing Value Code of 53, or the Value Code amount is not greater than or equal to the sum of the charges for Revenue Code 943.
To Correct: Verify Value Code 53 is entered and the amount is greater than or equal to the sum of the charges for Revenue Code 943. The claim will need to be regenerated.

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EDIT 147 - VALUE AMOUNT GREATER THAN TOTAL CHARGES

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of any of the following: 05, 12, 13, 14, 15, 16, 41, 42 or 43 and the value amount is greater than the total charges.
To Correct: Verify the Value Code is required. If the code is required, enter the amount of the Value Code. Verify the value amount is not greater than the total charges. The claim will not need to be regenerated.

EDIT 148 - VALUE CD = 37,38,39,50,51,52,53, OR 68; CENTS > 0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 37 - 39, 50 - 53 or 68 and the cents portion of the value amount is greater than zero.
To Correct: Verify the Value Code is required. If the code is required, enter the amount of the Value Code. Verify the code is not greater than zero. The claim will not need to be regenerated.

EDIT 149 - COND CD = D7; NEED VALUE CODE

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of D7 and does not have one of the following Value Codes: 12, 13, 14, 15, 16, 41, 42, 43 or 47 in the UB Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, then delete Condition Code from the UB Coding screen of the claim. If Condition Code is correct, then one of the Value Codes listed needs to be entered in the UB Coding screen. The claim will not need to be regenerated.

EDIT 150 - COND CD = D7; VALUE CODE HAS AMOUNT = 0

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of D7 and has value amount equal to zero for the following Value Codes: 12, 13, 14, 15, 16, 41, 42, 43 or 47 in the UB Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, delete the Condition Code from the UB Coding screen. If correct, the value amount for the listed Value Codes has to be greater than zero. The claim will not need to be regenerated.

EDIT 151 - COND CD = D8; BAD VALUE CODE LISTED

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Condition Code of D8 and also has a Value Code of 12, 13, 14, 15, 16, 41, 42, 43 or 47 in the UB Coding screen.
To Correct: Verify the Condition Code is correct. If incorrect, delete code from the UB Coding screen. If code is correct, the Value Code listed is invalid with this Condition Code. Delete Value Code from UB Coding screen. The claim will not need to be regenerated.

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EDIT 152 - HAVE VALUE CODE 37,38, OR 39; NEED VALUE CODE 06

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a claim has a Value Code of 37, 38 or 39 and does not have a Value Code of 06 in the UB Coding screen.
To Correct: Verify the Value Code amount. Enter Value Code 06 and the amount in the UB Coding screen. The claim will not need to be regenerated.

EDIT 153 - HAS VALUE CODES 01 AND 02

Locator: 39 - 41 Value Codes
Scenario: The above edit appears if a Commercial or Workman's Compensation claim has a Value Code of 01 and 02 in the UB Coding screen.
To Correct: Verify which Value Code is the correct code (01 or 02.) Delete the invalid code from the UB Coding screen. The claim will not need to be regenerated.

EDIT 154 - COND CD OR PRIN DIAG FOR REV CDS 636 AND 771

Locator: 42 - Revenue Code
Scenario: The above edit appears if the following criteria is not met: Condition Code "A6" is entered in the UB Coding screen for a claim, the Principal Diagnosis "V0481" must be present in the Grouper screen, and a charge with Revenue Code 636 or 771 must be entered. Also, the "From" date in statement covers period must be 10/01/03 or After.
To Correct: Verify which of the above is missing. Then load in Stay Information, claim's Detail Charges screen or UB Coding screen.

EDIT 155 - PRIN DIAG NOT = 585; CAN'T HAVE LISTED REV CD

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has charges with Revenue Codes 820 - 825, 829-835, 839-846, 849-856, 859, 880, 881 or 889 and the Principal Diagnosis Code is not equal to 585.
To Correct: Verify that the charges are correct. If incorrect, have Data Processing back off charges and then regenerate the claim. If charges are correct, the Principal Diagnosis must be 585. Have Medical Records change Principal Diagnosis Code in the Grouper screen and regenerate the claim.

EDIT 157 - NEED ROOM CHARGE SUMMARY CODE WITH THIS BILL TYPE

Locator: 42 - Revenue Code
Scenario: The above edit appears if the following criteria is not met: A claim has a Bill Type of 11X, 18X, or 21X and does not have any of the following Revenue Codes: 10X, 11X, 12X, 13X, 14X, 15X, 16X, 17X, 18X, 20X or 21X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify Account has Room Charges. If not, have Data Processing enter Charges and then regenerate claim.

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EDIT 158 - PRIN DIAG = 585; REV CD LISTED IS NOT ALLOWED

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Medicare claim has a Principal Diagnosis Code of 585 and Revenue Codes other than the following: 250-259, 634, 635, 636, 820-825, 829-835, 839-846, 849-856, 859, 880, 881 or 889. Also the Bill Type is 72X.
To Correct: Verify that the Principal Diagnosis is correct. If correct, then the only valid Revenue Codes are those listed. If Revenue Codes or Principal Diagnosis Code is changed, the claim will need to be regenerated.

EDIT 159 - INVALID REVENUE CODE FOR BILL TYPE 12X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has a Bill Type of 12X and does not have one of the following Revenue Codes: 272, 274, 275, 30X, 31X, 32X, 33X, 34X, 35X, 401, 402, 42X, 43X, 44X, 460, 461, 48X, 610, 612, 619, 73X, 74X, 80X or 921.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify Account has at least one charge with the above Revenue Codes. If not, have Data Processing enter Charges and then regenerate the claim.

EDIT 160 - INVALID REVENUE CODE FOR BILL TYPE 14X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has Bill Type of 14X and does not have charges for Revenue Code 254, 255, 30X, 31X, 32X, 241, 35X, 40X or 46X.
To Correct: Verify the Bill Type is correct. If incorrect, it may be changed in the claim's Detail Charges screen. If the Bill Type is correct, the only valid Revenue Codes that the claim may have are the ones listed. Have Data Processing correct the charges and regenerate the claim.

EDIT 161 - HAS REV CD = 38X; VALUE AMTS FOR 37 AND 39 EQUAL

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has Value Codes 37 and 39, the amounts for each code are equal, and there are charges with Revenue Code 38X.
To Correct: Verify Value Codes and amounts are correct. If not, change codes and amounts in the UB Coding screen. If they are correct, then the charges with Revenue Code 38X have to be backed off the account detail and the claim must be regenerated.

EDIT 162 - ROOM REV CODE INCONSISTENT WITH VALUE CODE 02

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Champus claim has a Value Code 02 and charges for Revenue Codes 120-139 or 150-159.
To Correct: Verify Value Code in the UB Coding screen is correct. If incorrect, delete from the Coding screen. If correct, the room charges on the claim cannot be Revenue Codes 120-139 or 150-159. Have Data Processing correct the charges and regenerate the claim.

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EDIT 163 - VALUE CD 05; NEED REV CD 96X, 97X, OR 98X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Champus claim has Value Code 05 and does not have charges with Revenue Codes 96X, 97X or 98X.
To Correct: Verify Value Code is correct. If incorrect, delete code from the UB Coding screen. If code is correct, the charges on the claim must be for Revenue Codes 96X, 97X or 98X. Have Data Processing enter charges and regenerate the claim.

EDIT 164 - REVENUE CODE 762 INVALID FOR CHAMPUS CLAIMS

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Champus claim has charges with Revenue Code 762.
To Correct: Verify the correct charges and have Data Processing correct through patient Charging. The claim will need to be regenerated.

EDIT 165 - VALUE CD 38 LISTED BUT NO CHARGES FOR REV CD 38X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has Value Code 38 entered in the UB Coding screen and no charges with Revenue Code 38X.
To Correct: Verify Value Code is correct. If not, delete the Value Code in the UB Coding screen. If Value Code is correct and the Charge is missing, have Data Processing enter the correct charge. The claim needs to be regenerated.

EDIT 166 - PHARMACY CANNOT BE THE ONLY SERVICE BILLED

Locator: 42 - Revenue Code
Scenario: The above edit appears if a Blue Cross claim has only charges with Revenue Code 25X.
To Correct: Verify other charges that are needed. Revenue Code 25X cannot be the only charges on the claim. Have Data Processing correct charges through patient Charging. Then regenerate the claim.

EDIT 167 - HAS REV CD 99X; TYPEBILL = 12X, 13X, 14X, or 83X

Locator: 42 - Revenue Code
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 14X or 83X and has any 99X Revenue Codes (excluding 996 and 997).
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify what charge had the Invalid Revenue Code. Either back off the incorrect item or change Revenue Code in the Summary Code table for that item. Regenerate the claim.

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EDIT 168 - HCPC CODE NEEDS A MODIFIER

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Medicaid or Blue Cross claim has charges for Revenue Code 360 and the items are missing modifiers associated with the CPT codes.
To Correct: Verify which items are for Revenue Code 360 and load the modifiers in the Item Master directly after the CPT code. The claim will need to be regenerated.

EDIT 169 - NEED HCPC CODE WITH LISTED REV CDS AND BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 23X, 74X, 75X or 83X and has any one of the following Revenue Codes: 45X, 46X, 48X, 490, 51X, 73X, 74X, 75X or 92X and the items do not have CPT codes in the Item Master.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above Revenue Codes and the items have CPT codes in the Item Master. If the items are missing CPT codes, load the CPT code in the Item Master and regenerated the claim.

EDIT 170 - BILL TYPE SHOULD BE 13X, 14X, OR 83X W/REV & HCPC

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has charges with Revenue Codes: 471, 481, 482, 730, 732, 921, 922, 32X-35X, 40X, 46X, 61X, 74X or 75X and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the charges are correct. If incorrect, have Data Processing correct through patient Charging and regenerate the claim. If correct, then the Bill Type needs to be changed on the Detail Charges screen of the claim to 13X, 14X or 83X. The claim will not need to be regenerated.

EDIT 171 - NEED HCPC CODE WITH REVENUE CD = 274

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 22X, 23X, 74X, 75X or 83X, charged with Revenue Code 274, and does not have a CPT code.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has a charge with Revenue Code 274. Verify that the item has a CPT code loaded in Item Master. If it is missing, load the CPT in the Item Master and regenerate the claim.

EDIT 172 - NEED HCPC CODE WITH REVENUE CD = 277

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X and an item is charged with Revenue Code 277 without a CPT code loaded in the Item Master.
To Correct: Verify Bill Type is Correct. If not, change Bill Type in the Detail Charges screen. If Value Code is correct, and the Charge is missing, have Data Processing enter the correct charge. The claim needs to be regenerated.

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EDIT 173 - NEED VALID LAB HCPC CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X, 72X or 83X and has Revenue Codes 30x or 31X, and does not have a valid CPT code in the Item Master. A valid CPT code is 80002 – 89399, 99195 or any of the following: P2038, P3000, P3001, P7001, P9604, G0001 or G0103.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify what charge had valid Revenue Code with invalid CPT code. Load the valid CPT code in the Item Master and then regenerate the claim.

EDIT 174 - NEED VALID RADIOLOGY HCPC CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X, has any one of the following Revenue Codes: 32X, 333, 340, 341, 342, 344, 345, 346, 347, 348, 349, 35X, 40X or 61X, and does not have a CPT code of 70000-79999 in the item master.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above Revenue Codes and the items have valid CPT codes in the Item Master. If the items are missing CPT codes, load the CPT code in the Item Master and regenerate the Claim.

EDIT 175 - NEED ASC HCPC CD OR ICD9 V641 - V642 W/REV CD = 36X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X, is charged with Revenue Code 36X, and does not have either a valid CPT code or ICD9 Diagnosis Code V641 - V643.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has a charge with Revenue Code 36X, a valid CPT code in the Item Master, or one of the ICD9 Diagnosis Codes. If the item is missing a CPT code, load it in the Item Master and regenerate the claim. If the ICD9 code is missing, have Medical Records correct it in the Grouper screen. Regenerate the claim.

EDIT 176 - NEED ASC HCPC - O/P SURGICAL PROCEDURE CD LISTED

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X and one of the following procedure codes are listed in the Medical Records Grouper screen: 132, 133, 586, 863, 0391, 0392, 0443, 1259, 1319, 1341, 1359, 1361, 1364, 1366, 1369, 1371, 1372, 1424, 1434, 1699, 2103, 3322, 3324, 3491, 3899, 4131, 4292, 4413, 4414, 4513, 4523-4525, 4541, 4823, 5302, 5732, 5794, 5795, 6011, 6909, 7902, 8512, 8521, 8611, 8622 or 8659, and a valid ASC Revenue Code without a valid ASC CPT code is in the Item Master.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has a procedure code listed above. If so then verify that the valid ASC Revenue Code has a valid ASC CPT code loaded in Item Master. If any information is missing, load in appropriate tables and regenerate the claim.

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EDIT 177 - HAS REV CD = 636; BILL TYPE = 72X; NEED HCPC CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if the following criteria are not met: A claim has a Bill Type of 72X and a charge with Revenue Code 636. The claim must have one of the CPT codes in the Item Master listed in Appendix A (attached.)
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has the correct charges with Revenue Code 636. If charges are correct, verify those items have one of the CPT codes listed in Appendix A is in the Item Master. If any information is missing, load in appropriate tables. Regenerate the insurance claim.

EDIT 178 - NEED CPT CD P9010 WITH REV CD 382

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X and a Revenue Code of 382 and does not have a CPT code in the Item Master of P9010.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9010 loaded in the Item Master. If CPT is missing, load in Item master and regenerate the claim.

EDIT 179 - NEED CPT CD P9012 WITH REV CD 387

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X and a Revenue Code of 387 and does not have a CPT code in the Item Master of P9012.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter the charge. If charge is on account detail, verify the item has a CPT of P9012 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 180 - NEED CPT CD P9013 WITH REV CD 386

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, Revenue Code of 386, and does not have a CPT code in the Item Master of P9013.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9013 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

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EDIT 181 - NEED CPT CD P9017 OR P9018 WITH REV CD 383

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 383, and does not have a CPT code in the Item Master of P9017 or P9018.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9010 or P9018 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 182 - NEED CPT CD P9019 WITH REV CD 384

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 384, and does not have a CPT code in the Item Master of P9019.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify Account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9019 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 183 - NEED CPT CD P9021 WITH REV CD 381

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 381, and does not have a CPT code in the Item Master of P9021.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9010 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 184 - NEED CPT CD P9022 WITH REV CD 380

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 72X, a Revenue Code of 380, and does not have a CPT code in the Item Master of P9022.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim Detail Charges screen. If Bill Type is correct, verify account has at least one charge item with the above Revenue Code. If not, have Data Processing enter charge. If charge is on account detail, verify the item has a CPT of P9022 loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

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EDIT 185 - NEED SPECIAL CPT CD WITH REV CD 390

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if the following criteria is not met: A claim has a Bill Type of 72X, a Revenue Code of 390, and it does not have at least one of the following CPT codes loaded in the Item Master for charges entered:
86021, 86022, 86023, 86038, 86060, 86063, 86140, 86155, 86171, 86185, 86287, 86289, 86290, 86291, 86293, 86295, 86296, 86299, 86311, 86353, 86382, 86403, 86590, 86592, 86593, 86687, 86689 or 86800.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify what charge was for the Revenue Code 390 and verify that there is one of the above listed CPT codes in the Item Master. If item is missing a CPT code, load in Item Master and regenerate the claim.

EDIT 186 - CPT 66983 - 66986 ALLOWED WITH REV CD 276 ONLY

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X, has a CPT code of 66983 - 66986 loaded in the Item Master, and does not have Revenue Code 276.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above CPT codes and the Revenue Code associated with those items is 276. If charge is on account detail, verify the item has correct CPT loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 187 - CPT 66983 - 66986 W/BILL TYPE 13X, 83X ONLY

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with CPT codes 66983 - 66986 and the Bill Type is not 13X or 83X.
To Correct: Verify CPT codes are correct for the items charged. If incorrect, then delete from Item Master and regenerate the claim. If CPT codes are correct, then change the Bill Type in the Detail Charges screen for the claim. The claim does not have to be regenerated.

EDIT 188 - CPT ONLY ALLOWED WITH REVENUE CODE 46X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X, or 83X, has a Revenue Code of 46X, and is not charged with an item with any of the following CPT codes:
94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762 or 94770.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above CPT code in the Item Master. Verify the Revenue Code associated with those items is 46X. Load missing information in appropriate tables and regenerate the claim.

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EDIT 189 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with Revenue Code 46X and any of the following CPT codes:
94010, 94060, 94070, 94150, 94160, 94200, 94240, 94250, 94260, 94350, 94360, 94370, 94375, 94400, 94450, 94620, 94680, 94681, 94690, 94720, 94725, 94750, 94760, 94761, 94762 or 94770 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, then the above CPT codes are not allowed with a Bill Type other than 13X, 14X or 83X. Delete CPT codes from the items and regenerate the claim.

EDIT 190 - CPT ONLY ALLOWED WITH REVENUE CODE 471

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 92541 - 92547, 92552, 92553, 92555 - 92557, 92561 - 92565, 92567 - 92569, 92571 - 92578, 92580, 92582 - 92585, 92589 or 92596, and the Revenue Code associated with those items is not 471.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 471. If any information is missing, load in appropriate tables and regenerate claim.

EDIT 191 - CPT ONLY ALLOWED WITH REVENUE CODE 75X.

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 91000, 91010, 91011, 91012, 91030, 91032, 91033, 91052, 91055, 91060, 91065 or 91122, and the Revenue Code is not 75X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with Revenue Code 75X and those items have the above listed CPT codes in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 192 - CPT ONLY ALLOWED WITH REVENUE 730

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT code 93005, 93024, 93041, 93202, 93208, 93210 and 93221, and the Revenue Code associated with those items is not 730.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above CPT codes and the Revenue Code associated with those items is 730. Verify which information is missing and load in appropriate tables and regenerate the claim.

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EDIT 193 - CPT 9301/93014 ONLY ALLOWED WITH REV CODE 732

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, an item with a CPT 93012 or 93014, and the Revenue Code is not 732.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 732. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 194 - CPT 93012/93014 NOT ALLOWED WITH BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has charges with CPT code 93012 or 93014 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, the items charged cannot have CPT codes 93012 or 93014. Delete the CPT code from the items and regenerate the claim.

EDIT 195 - CPT 93017/93015 ONLY ALLOWED WITH REV CODE 482

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has an item with a CPT of 93017 or 93015, and the Revenue Code is not 482.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 482. If any information is missing, load in appropriate tables and regenerate claim.

EDIT 196 - CPT 93017/93015 NOT ALLOWED WITH BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with CPT code 93017 or 93015 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, the items charged cannot have CPT codes 93017 or 93015 on the claim. Delete the CPT codes from the item master and regenerate the claim.

EDIT 197 - CPT ONLY ALLOWED WITH REVENUE CODES 480 & 481

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has a CPT code of 93501, 92505, 93510, 93511, 93514, 93524, 93526, 93527, 93528, 93529, 93555, 93556, 93561, 93562 or Q0035, and the Revenue Code is not 480 or 481.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with above listed CPT codes. Verify the Revenue Codes are 480 or 481. Verify any missing information and load in appropriate tables. Regenerate the claim.

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EDIT 198 - CPT ONLY ALLOWED WITH REVENUE CODE 731

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 93225, 93226, 93231, 93232 or 93236, and the Revenue Code associated with those items is not 731.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above CPT codes and the Revenue Code associated with those items is 731. Verify which information is missing and load in appropriate tables and regenerate the claim.

EDIT 199 - CPT ONLY ALLOWED WITH REV CODE 480

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has CPT codes 93307, 93308, 93312, 93314, 93320, 93321, 93325, 93350, 93600, 93602, 93603, 93607, 93609, 93610, 93612, 93615, 93616, 93618, 93619, 93620, 93624, 93631, 93640, 93641 or 93642, and the Revenue Code is not 480.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 480. If any information is missing, load in appropriate tables and regenerate the claim.

EDIT 200 - CPT ONLY ALLOWED WITH REV CODE 921

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X, 83X, or 85X and has any of the following CPT codes: 54240, 93721, 93731, 93732 - 93738, 93740, 93770, 93875, 93880, 93882, 93886, 93888, 93922 - 93926, 93930, 93931, 93965, 93970, 93971, 93975, 93976, 93978, 93979, 93980 or 93981, and the Revenue Code associated with any of these items is not 921.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 921. If any information is missing, load in the appropriate tables and regenerate the claim.

Edits 201-300

EDIT 201 - CPT ONLY ALLOWED WITH REVENUE CODE 73X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any charge item with a CPT code of 93255, 93268 or 93278, and the Revenue Code is not 73X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with above listed CPT codes. Verify the Revenue Code is 73X. Any missing information should be loaded in appropriate tables the claim should be regenerated.

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EDIT 202 - CPT ONLY ALLOWED WITH REV CODE 74X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, is with an item with any of the following CPT codes:
95816, 95817, 95819, 95821 - 95824, 95826, 95827, 95829, 95920, 95933, 95950, 95951, 95953 - 95956, 95958, 95961 or 95962, and the Revenue Code is not 74X.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 74X. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 203 - CPT ONLY ALLOWED WITH REV CODE 922

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, is charged with an item with any of the following CPT codes:
95842, 95858, 95860, 95861, 95863, 95864, 95867, 95868, 95869, 95872, 95875, 95900, 95904, 95925, 95935 or 95937, and the Revenue Code is not 922.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 922. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 204 - CPT ONLY ALLOWED WITH REV CODES 74X AND 920

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, charged with an item that has a CPT code of 95805, 95807, 95808 or 95810, and the Revenue Code is not 74X or 920.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 74X or 920. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 205 - CPT ONLY ALLOWED WITH REVENUE CODE 920

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any charge item with one of the following CPT codes:
51736, 51741, 51792, 51795, 51797, 54250, 59020, 59025, 92060, 92065, 92081, 92082, 92083, 92235, 92250, 92265, 92270, 92275, 92280, 92283, 92284, 92285 or 92286, and the Revenue Code is not 920.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with above listed CPT codes and Revenue Code of 920. Verify any missing information and load in appropriate tables. Regenerate the claim.

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EDIT 206 - CPT ONLY ALLOWED WITH REV CODE 924

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 13X, 14X or 83X, has any item with any of the following CPT codes: 95004, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071 or 95078, and the Revenue Code is not 924.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with the above listed CPT codes and the Revenue Code is 924. If any information is missing, load in the appropriate tables and regenerate the claim.

EDIT 220 - NEED HCPC CODE WITH REV CD 636 FOR BILL TYPE 11X

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a Bill Type of 11X, the item was charged with Revenue Code 636, and does not have a CPT code.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has an item charged with Revenue Code 636 and a CPT code loaded in the Item Master. If CPT is missing, load in Item Master and regenerate the claim.

EDIT 221 - INVALID CPT WITH BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim with service dates after 10/16/91 has items charged with any of the following CPT codes:
90100-90170, 90300-90370, 90400-90470, 90590, 90699, 90750-90778,
90781, 90935-90999, 93000, 93010, 93014, 93015, 93018, 93040, 93042, 93201,
93204, 93205, 93209, 93220, 93222, 93227, 93230, 93233, 93235, 93224, 93237,
96400-96549, 97010-97799, 988900-98922, 99000-99152, 99160-99162, 99171-99174,
99190-99192 or 99199 and the Bill Type is 13X, 14X or 83X.
To Correct: Verify Bill Type is correct. If incorrect, it may be changed on the claim's Detail Charges screen. If correct, the items charged cannot have any of the listed CPT codes if the service from date is greater than 10/16/91. Delete the CPT codes from those items and regenerate the claim.

EDIT 222 - NEED CPT 90655, 90657, 90658 & 90660 WITH REV CD 636

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim with service dates after 10/01/03 has a Condition Code of "A6" or a diagnosis "V0481," a charge item with Revenue Code 636, and does not have a CPT Code of 90655, 90657-58 & 90660 in the Item Master.
To Correct: Verify the Condition Code or Diagnosis is correct. If not, have Medical Records change Diagnosis in the Grouper screen. If Condition Code is incorrect, change on the UB Coding screen on the claim. If both are correct, verify the item charged with 636 Revenue Code has a CPT Code of 90655, 90657-58 & 90660 in the Item Master. If the CPT is missing, load in Item Master and regenerate the claim.

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EDIT 223 - NEED CPT G0008 WITH REV CD 771

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim with service dates after 10/01/03
has a Condition Code of "A6" or a diagnosis "V0481," a charge item with Revenue Code 771, and does not have a CPT Code of G0008 in the Item Master.
To Correct: Verify the Condition Code or Diagnosis is correct. If not, have Medical Records change Diagnosis in the Grouper screen. If Condition Code is incorrect, change in the UB Coding screen in the claim. If both are correct, verify the item charged with 771 Revenue Code has a CPT Code of G0008 in the Item Master. If the CPT is missing, load in Item Master.

EDIT 224 - SERVICE DATE ON CHARGE NOT WITHIN STATEMENT DATES

Locator: 45 - Service Date
Scenario: The above edit appears if a claim has a charge with a service date that does not fall within the "from" and "to" dates.
To Correct: Verify "from" and "to" dates are correct. If those dates are correct, then change the service date in the Detail Charges screen for the insurance claim. There is no need to regenerate the claim.

EDIT 225 - TOTAL CHARGES FOR REV CD 180 SHOULD BE 0

Locator: 47 - Total Charges
Scenario: The above edit appears if a claim has total charges for Revenue Code 180 greater than zero.
To Correct: Verify the total charges for Revenue Code 180 is equal to zero. Enter in the Detail Charges screen on the line with the summary code for Revenue Code 180, 0 total charges. The claim does not have to be regenerated.

EDIT 226 - NEED NONCOVERED CHARGE WITH REV CDS 18X, 99X

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has charges with Revenue Code 18X or 99X and does not have Non-Covered charges associated with those Revenue Codes.
To Correct: Verify the correct amount of Non-Covered charges for the Revenue Codes listed and enter the amount on the claim's Detail Charges screen. The claim will not need to be regenerated.

EDIT 227 - NEEDS UNITS OF SERVICE FOR SOME REV CODES

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a charge with no quantity for the following Revenue Codes:
10X, 11X, 12X, 13X, 14X, 15X, 16X, 18X, 20X, 21X, 380, 360, 381, 382, 54X, 55X, 63X, 80X, 82X, 83X, 84X, 85X or 91X.
To Correct: Verify quantity for those Revenue Codes. If charges need to be added or backed off the account, inform Data Processing. Then regenerate the claim. If charges are correct and the quantity is correct, change in the Detail Charges screen of the claim. The claim will not have to be regenerated.

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EDIT 228 - NEED RATES WITH SOME REVENUE CODES

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has charges with Revenue Codes: 100-169, 200-219 or 550-599 (except 561) and the rates equal zero.
To Correct: Verify the correct rates for the above listed Revenue Codes and load in the Detail Charges screen. The claim will not need to be regenerated.

EDIT 229 - ACCOMMODATION REV CD > $999.99

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Blue Cross claim has charges for Revenue Codes 100-219 and an amount greater than $999.99.
To Correct: Verify the correct rate for listed Revenue Codes and enter in the Detail Charges screen. Ensure the amount is less than $999.99. The claim will not need to be regenerated.

EDIT 230 - ACCOMMODATION REV CD > $9999.99

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Commercial or Workman's Comp claim has charges for Revenue Codes 100-219 and an amount greater than $9999.99.
To Correct: Verify the correct rate for listed Revenue Codes and enter in the Detail Charges screen of the claim. Ensure the amount is less than $9999.99. The claim will not need to be regenerated.

EDIT 231 - ROOM CHARGE QUANTITIES NOT = COVERED DAYS

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type X1X, X2X or X8X, has Revenue Codes 10X, 11X, 12X, 13X, 14X, 15X, 16X, 20X or 21X and the quantity of room charges does not equal the Covered days.
To Correct: Verify quantity for those Revenue Codes is the correct amount. If charges need to be added or backed off the account, inform Data Processing. Then regenerate the claim.

EDIT 232 - COND CD 40 ENTERED; COVERED DAYS NOT = 0

Locator: 46 - Service Units
Scenario: The above edit appears if the following criteria is not met: A claim has a Bill Type X1X, X2X or X8X and has Revenue Codes 10X, 11X, 12X, 13X, 14X, 15X, 16X, 20X or 21X. If there is a Condition Code of 40 in the UB Coding screen, (which means Same Day Transfer) then the quantity of those charges must equal zero.
To Correct: Verify quantity for those Revenue Codes is the correct amount. If charges need to be added or backed off the account, inform Data Processing. Verify the Condition Code. If it is incorrect, then delete code from the UB Coding screen. Regenerate the claim.

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EDIT 233 - NEED UNITS OF SERVICE FOR REV CDS 30X, 31X

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type 13X, 14X or 83X, has Revenue Codes 30X or 31X, and the quantity of charges equals zero.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has charges for those Revenue Codes with quantity in the claim's Detail Charges screen.

EDIT 234 - NEED UNITS OF SERVICE FOR SOME REVENUE CDS

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type 13X or 83X, has any of the following Revenue Codes:
255, 291, 293, 32X - 34X, 40X - 48X, 51X - 53X, 61X, 64X, 73X - 75X,
88X, 92X or 94X, and the quantity of charges equals zero.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has charges for those Revenue Codes with quantity on the claim's Detail Charges screen.

EDIT 235 - NEED UNITS OF SERVICE FOR REVENUE CODE 274

Locator: 46 - Service Units
Scenario: The above edit appears if a claim has a Bill Type 12X, 13X, 22X, 23X, 74X, 75X or 83X, has Revenue Code 274, and the quantity of charges equals zero.
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has charges for Revenue Code 274 with quantity on the claim's Detail Charges screen.

EDIT 236 - TOTAL CHARGES NOT GREATER THAN ZERO

Locator: 47 - Total Charges
Scenario: The above edit appears if a claim has Total Charges of Zero.
To Correct: Verify Claim is setup correctly and has charges on the Account Detail. If charges are entered, then regenerate the claim. If charges are missing, set claim back to the "UNCHECKED" status and have Data Processing enter charges, then regenerate the claim.

EDIT 237 - NONCOVERED CHARGES EXCEED TOTAL CHARGES

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has Non-Covered Charges that exceed Total charges.
To Correct: Verify claim is setup correctly and has charges greater than Non Covered charges on the claim's Detail Charges screen. Choose the sequence number that has more Non-Covered and enter correct amount. There is no need to regenerate the claim.

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EDIT 238 - TOTAL CHARGES > $999,999.99

Locator: 47 - Total Charges
Scenario: The above edit appears if a Blue Cross claim has total charges greater than $999,999.99.
To Correct: Verify the correct amount of charges and have Data Processing correct through patient Charging. The claim will need to be regenerated.

EDIT 239 - NONCOVERED CHARGES GREATER THAN ZERO

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has a Bill Type of 12X, 13X, 14X, 83X or 851, and there are Non-Covered Charges greater than zero.
To Correct: Verify Bill Type is correct. If Bill Type is incorrect, then change on the claim's Detail Charges screen. If Bill Type is correct, then select the sequence number in the claim's Detail Charges screen and delete the Non-Covered charges. There is no need to regenerate the claim.

EDIT 240 - CHARGES FOR REV CD 99X SHOULD BE NONCOVERED CHARGES

Locator: 48 - Non-Covered Charges
Scenario: The above edit appears if a claim has charges for Revenue Code 99X (excluding 996 and 997) and Total charges equal Non-Covered Charges.
To Correct: Verify charges are correct. If correct, then on the claim's Detail Charges screen select the sequence number for Revenue Code 99X and enter total charges in Non-Covered column. There is no need to regenerate the claim.

EDIT 241 - MISSING PAYER NAME IN FIELD 50A
MISSING PAYER NAME IN FIELD 50B
MISSING PAYER NAME IN FIELD 50C

Locator: 50 - Payer Name
Scenario: The above edit appears if the name of the particular Insurance is not loaded in the Policy Information screen for the claim. The first edit for locator 50A represents the primary insurance. The other two edits appear for the secondary claims.
To Correct: Verify the Insurance Company Name is loaded in the Business Office Tables. If the name is loaded in the table, check the Policy Information screen and verify the name is loaded. There is no need to regenerate the claim.

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EDIT 242 - MISSING PAYER NAME IN FIELD 50 - OCC CD = B1, B2 OR B3
EDIT 243 - MISSING PAYER NAME IN FIELD 50 - OCC CD = C1, C2 OR C3

Locator: 50 - Payer Name
Scenario: The above edit appears if the name of the particular Insurance is not loaded on the Policy Information screen of the secondary claims. If there is an Occurrence Code on the Primary claim of B1, B2 or B3 edit 242 appears. If there is an Occurrence Code of C1, C2 or C3, edit 243 appears.
To Correct: Verify Occurrence Codes are correct. If not, delete codes from UB Coding screen. If Occurrence Codes are correct, verify Insurance Company Name is loaded in the Business Office Tables. If name is loaded in the table, check Policy Information screen and verify name is loaded. There is no need to regenerate the claim.

EDIT 244 - MISSING PAYER NAME IN FIELD 50B - VAL CD = B1, B2 OR B3
EDIT 245 - MISSING PAYER NAME IN FIELD 50C - VAL CD = C1, C2 OR C3

Locator: 50 - Payer Name
Scenario: The above edit appears if the name of the particular Insurance is not loaded in the Policy Information screen of the secondary claims. If there is a Value Code on the Primary claim of B1, B2 or B3, edit 244 appears. If there is a Value Code of C1, C2 or C3, edit 245 appears.
To Correct: Verify Value Codes are correct. If not, delete codes from UB Coding screen. If Value Codes are correct, verify Insurance Company Name is loaded in the Business Office Tables. If name is loaded in the table, check Policy Information screen and verify name is loaded. There is no need to regenerate the claim.

EDIT 246 - MEDICARE CANNOT BE PRIMARY WITH LISTED VALUE CODE

Locator: 50 - Payer Name
Scenario: The above edit appears if a Medicare claim is primary with a Value Code of 12 - 16 or 41 – 43.
To Correct: Verify Value Codes are correct. If Value Code is not correct, delete from UB Coding screen. If Value Codes are correct, verify the primary Y/N switch in the Policy Information screen is set to N. There is no need to regenerate the claim.

EDIT 247 - MEDICARE CANNOT BE PRIMARY WITH LISTED OCCUR CD

Locator: 50 - Payer Name
Scenario: The above edit appears if a Medicare claim is primary with an Occurrence Code 01 – 04.
To Correct: Verify Occurrence Codes are correct. If Occurrence Code is not correct, delete from UB Coding screen. If Occurrence Code is correct, verify primary Y/N switch in the Policy Information screen is set to N. There is no need to regenerate the claim.

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EDIT 248 - MEDICARE CANNOT BE PRIMARY WITH LISTED COND CD

Locator: 50 - Payer Name
Scenario: The above edit appears if a Medicare claim is primary with a Condition Code of 02 or 06.

To Correct: Verify Condition Code is correct. If Condition Code is not correct, delete from UB Coding screen. If Condition Code is correct, verify primary Y/N switch in the Policy Information screen is set to N. There is no need to regenerate the claim.

EDIT 249 - MEDICARE SECONDARY - NEED VALUE CD 12-16 OR 41-43

Locator: 50 – Payer Name
Scenario: The above edit appears if a patient has a Medicare Secondary Insurance, but does not have Value Code 12-16 or 41-43.
To Correct: Verify Insurance is setup correctly. If setup correctly, load Value Code 12 - 16 or 41-43 in the UB Coding screen. There is no need to regenerate the claim.

EDIT 250 - MISSING PROVIDER NUMBER IN FIELD 51

Locator: 51 - Provider Number
Scenario: The above edit appears if a claim is not a Commercial Insurance and is missing the Provider Number in the Insurance Company table.
To Correct: Verify Insurance is correct. If Insurance is correct, load the valid Provider Number in the Insurance Company table. The claim does not have to be regenerated.

EDIT 251 - PRIOR PAYMENTS EXCEED TOTAL CHARGES

Locator: 54 - Prior Payments
Scenario: The above edit appears if a claim has Prior Payments that are greater than Total charges.
To Correct: Verify total charges and prior payments. Correct Prior Payments in the Detail Benefits screen of the claim. There is no need to regenerate the claim.

EDIT 252 - PRIOR PAYMENTS = 0: VAL CD = 12-16 OR 41-43

Locator: 54 - Prior Payments
Scenario: The above edit appears if a claim has Value Code 12-16 or 41-43 and there is not a Prior Payment on the Detail Benefits screen of the Insurance Claim.
To Correct: Verify Value Code is correct. If Value Code, is incorrect, delete from the UB Coding screen of the claim. If Value Code is correct, load a prior payment in the Detail Benefits screen of the claim. There is no need to regenerate the claim.

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EDIT 253 - MISSING INSURED'S NAME IN FIELD 58

Locator: 58 - Insured’s Name
Scenario: The above edit appears if the subscriber's name is missing in the Policy Information screen of the claim.
To Correct: Verify Subscriber's Information in the Policy Information screen. If missing, load insured's name. There is no need to regenerate the claim. Also, load information in the Guarantor/ Ins tab on the Registration and ADT screen for future claims/just like accounts.

EDIT 254 - VALUE CD 12-16; NEED INSURED'S NAME IN 58

Locator: 58 - Insured’s Name
Scenario: The above edit appears if a claim has Value Codes of 12-16 and does not have insured's name in the Policy Information screen of the claim.
To Correct: Verify Value Codes are correct. If correct, load missing subscriber's name in Policy Information screen of the claim. There is no need to regenerate.

EDIT 255 - MISSING PATIENT REL TO SUBSCRIBER IN 59

Locator: 59 - Patient’s Relation to Subscriber
Scenario: The above edit appears if a claim does not have a code to specify what the patient's relationship to the subscriber is.
To Correct: Verify the relationship and load appropriate 2-digit code in the Policy Information screen. There is no need to regenerate the claim.

EDIT 256 - INVALID PATIENT REL TO SUBSCRIBER IN 59

Locator: 59 - Patient’s Relation to Subscriber
Scenario: The above edit appears if a claim has a Patient's Relation to Subscriber not equal to 01 – 19. If using new codes they are 18, 01, 19, 43, 17, 10, 15, 20, 22, 39, 40, 05, 07, 41, 23, 24 and 04.
To Correct: Verify the relationship and load appropriate 2-digit code in the Policy Information screen. There is no need to regenerate the claim.

EDIT 257 - FIELD 59 MUST BE 01 OR 02 BASED ON VALUE CODES

Locator: 59 - Patient’s Relation to Subscriber
Scenario: The above edit appears if a claim has Value Codes 14, 15, 16, 41 or 42 in the UB Coding screen of the claim and the patient's relation to subscriber is not a 01 or 02. If using new relation codes they are 18 and 01.
To Correct: Verify the relationship and load appropriate 2-digit code in the Policy Information screen. There is no need to regenerate the claim.

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EDIT 258 - CHAMPUS PAT REL SHOULD BE 01-05, 07, 10 OR 16

Locator: 59 - Patient's Relation to Subscriber
Scenario: The above edit appears if a Champus claim does not have a Patient's Relation to Subscriber of 01-05, 07, 10 or 16. If using new relationship codes they are 18, 01, 19, 43, 17, 15, 22 or 23.
To Correct: Verify that the Insurance is correct. If correct, then verify Patient's Relationship to subscriber is one of the above. There is no need to regenerate the claim.

EDIT 259 - FIELD 59 MUST BE 01-06 OR 18 BASED ON VALUE CODES

Locator: 59 - Patient's Relation to Subscriber
Scenario: The above edit appears if a secondary claim has a Value Code of 43, does not have Value Codes 14, 15, 16, 41 or 42, and the patient's Relation to Subscriber is not 01 - 06 or 18 or if using new relationship codes 18, 01, 19, 43, 17, 10, 15, 20, 22, 39, 40, 05, 07, 41, 23 or 24.
To Correct: Verify the Value Code. If correct, then verify the Patient's Relationship to Subscriber is 01 - 06 or 18 or new relationship codes mentioned above and load in the Policy Information screen. There is no need to regenerate the claim.

EDIT 260 - CONTRACT/CERTIFICATE NUMBER BLANK

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Workman's Compensation claim is missing a Contract/ Certificate number in the Policy Information screen.
To Correct: Verify the correct Contract/Certificate number and load in the Policy Information screen of the claim. The claim will not need to be regenerated.

Edit 261 - POSITION 8 OF CONTRACT NUMBER NOT BLANK

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if an Oklahoma Medicaid claim has a Contract Number greater than 8 characters.
To Correct: Verify the correct Contract Number and load in the Policy Information screen of the claim. The claim will not need to be regenerated.

EDIT 262 - CONTRACT NBR IS BLANK OR ALL ZEROS

Locator: 60 – Insured's Unique ID
Scenario: The above edit appears if a claim is missing a Contract Number or the Contract Number is all zeros.
To Correct: Verify the correct Contract Number and load in the Policy Information screen of the claim. The claim will not need to be regenerated.

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EDIT 264 - FIRST 3 DIGITS OF MEDICARE CERTIFICATE INVALID

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if the first three digits of the Medicare claim certificate number are not alpha.
To Correct: Verify the correct certificate number and that it begins with three alpha characters. Enter it on the Policy Information screen of the claim. The claim will not need to be regenerated.

Edit 265 - MEDICARE SUFFIX IS MISSING OR INVALID

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Medicare claim has a Contract Number in which the tenth digit, which is the Medicare suffix, is not an A, B, C, D, E, F, H, J, K, M, T or W.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 266 - MEDICARE SUFFIX OF H MUST BE FOLLOWED BY A,B,OR C

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Medicare claim has a suffix (tenth digit of Contract Number) of H and the next digit is not an A, B or C.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 267 - CONTRACT # HAS EMBEDDED SPACES/SPECIAL CHARACTERS

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Medicare, Blue Cross or Medicaid claim has a Contract Number with special characters, (i.e., &, *, # or spaces). The number must be alpha or numeric characters.
To Correct: Verify Contract Number and load in Policy Information, insuring that all characters are alpha or numeric. There is no need to regenerate the claim.

EDIT 268 - MISSING CONTRACT NUMBER IN FIELD 60

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if an Insurance Claim does not have a Contract Number in the Policy Information screen.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

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Edit 269 - CHAMPUS CONTRACT NUMBER NOT NUMERIC

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Champus Claim has a Contract Number in the Policy Information screen that is not numeric.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 270 - COMMERCIAL CONTRACT NUMBER NOT NUMERIC

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Commercial Claim has a Contract Number in the Policy Information screen that is not numeric.
To Correct: Verify Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 271 - MISSING GROUP NAME IN FIELD 61

Locator: 61 - Group Name
Scenario: The above edit appears if a Claim has a Value Code of 12, 13 or 43 and does not have a Group Name in the Policy Information screen.
To Correct: Verify Value Codes are correct. If Value Codes are correct, verify Group Name and load in Policy Information screen. There is no need to regenerate the claim.

EDIT 272 - COMMERCIAL GROUP NUMBER IS BLANK

Locator: 62 – Insurance Group No.
Scenario: The above edit appears if a Commercial Claim does not have a Group Number in the Policy Information screen.
To Correct: Verify Group Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 273 - GROUP NUMBER SHOULD BE 999999

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has the 9th digit of the Contract Number as an M or U and does not have a Group Number equal to 999999 in the Policy Information screen.
To Correct: Verify Group Number and load in Policy Information for the appropriate claim. The claim will need to be regenerated.

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Edit 274 - COMMERCIAL CONTRACT # = GROUP

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a Contract Number that is the same as the Group Number.
To Correct: Verify the correct Contract Number or Group Number and load in the Policy Information screen of the claim. There is no need to regenerate the claim.

EDIT 275 - COMMERCIAL CONTRACT # = EMPLOYER NAME

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a Contract Number equal to the employer name on the Policy Information screen.
To Correct: Verify Group Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 276 - INVALID CONTRACT NUMBER FOR COMMERCIAL CLAIM

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Commercial Claim has a Contract Number in the Policy Information screen of "Individual", "Unknown", "Self", "None" or "1234567890".
To Correct: Verify the correct Contract Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

EDIT 277 - INVALID GROUP NUMBER FOR COMMERCIAL CLAIM

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a Group Number in the Policy Information screen of "Individual", "Unknown", "Self", "None" or "1234567890."
To Correct: Verify the correct Group Number and load in Policy Information for the appropriate claim. There is no need to regenerate the claim.

Edit 278 - INVALID CHARACTER IN COMMERCIAL GROUP NAME

Locator: 61 - Group Name
Scenario: The above edit appears if a Commercial Claim has a character in the Group Name that is not alpha or numeric.
To Correct: Verify Commercial Group Name. Enter correct name in the Policy Information screen. There is no need to regenerate the claim.

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EDIT 279 - INVALID CHARACTER IN COMMERCIAL GROUP NUMBER

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a Commercial Claim has a character in the Group Number that is not alpha or numeric.
To Correct: Verify commercial Group Number. Enter correct number in the Policy Information screen. There is no need to regenerate the claim.

EDIT 280 - GROUP NAME SHOULD NOT BE LISTED IN 61 - COND CD

Locator: 61 - Group Name
Scenario: The above edit appears if a claim has a Group Name in the Policy Information screen and has a Condition Code of 09 or 11.
To Correct: Verify Condition Code is correct. If code is correct, delete the Group Name for the particular insurance. There is no need to regenerate the claim.

EDIT 281 - MISSING GROUP NUMBER IN FIELD 62

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a claim has a Value Code of 12, 13 or 43 and does not have a Group Number in the Policy Information screen.
To Correct: Verify Value Codes are correct. If Value Codes are correct, verify Group Number and load in Policy Information screen. There is no need to regenerate the claim.

EDIT 282 - GROUP NUMBER SHOULD NOT BE LISTED IN 62 - COND CD

Locator: 62 - Insurance Group No.
Scenario: The above edit appears if a claim has a Group Number in the Policy Information screen and has a Condition Code of 09 or 11.
To Correct: Verify Condition Code is correct. If code is correct, delete the Group Number for the particular insurance. There is no need to regenerate the claim.

EDIT 283 - MEDICAID SNF PATIENT - NEED TREAT AUTH IN 63

Locator: 63 - Treatment Authorization Codes
Scenario: The above edit appears if a Medicaid Claim has a Bill Type of 2XX and does not have a Treatment Authorization Code.
To Correct: Verify Bill Type is correct. If not, change in claim's Detail Charges screen. If Bill Type is correct, enter Treatment Authorization Code in Stay Information screen for the claim in the HHPPS Class field. There is no need to regenerate the claim.

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EDIT 284 - INVALID ESC CODE IN FIELD 64

Locator: 64 - Document Control Number
Scenario: The above edit appears if a claim has an Employment Status Code (ESC) that is not 1 - 9.
To Correct: Verify ESC code is correct. If not, change in Policy Information screen. There is no need to regenerate the claim.

EDIT 285 - MEDICAID SECONDARY - NEED ESC CODE

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Medicaid secondary claim does not have an Employment Status Code in the Policy Information screen.
To Correct: Verify the ESC code and load it in Policy Information screen. There is no need to regenerate the claim.

EDIT 286 - COMMERCIAL CLAIM - NEED ESC CODE

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Commercial Claim does not have an Employment Status Code in the Policy Information screen.
To Correct: Verify ESC code and enter in Policy Information screen. The claim will need to be regenerated.

EDIT 287 - FOR MEDICARE, ESC COMPLETE; NEED EMP NAME

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Medicare Claim has an Employment Status Code and does not have an Employer Name.
To Correct: Verify ESC code is correct. If not, delete code from Policy Information screen. If code is correct, verify claim has an Employer name loaded in the Policy Information screen. There is no need to regenerate the claim.

EDIT 288 - ESC CODE SHOULD BE BLANK - COND CD 09 LISTED

Locator: 64 - Document Control Number
Scenario: The above edit appears if a Claim has a Condition Code of 09 and has an Employment Status Code.
To Correct: Verify Condition Code. If incorrect, delete from the UB Coding screen. If correct, delete ESC code in Policy Information screen. There is no need to regenerate the claim.

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EDIT 289 - ESC CODE MISSING - COND CD 10 LISTED

Locator: 64 - Document Control Number
Scenario: The above edit appears if a claim has a Condition Code of 10 and does not have an Employment Status Code.
To Correct: Verify Condition Code is correct. If not, delete code from UB Coding screen. If code is correct, verify ESC code and load in the Policy Information screen. There is no need to regenerate the claim.

EDIT 290 - EMPLOYER NAME MUST BE ENTERED IN 65 - COND CD 10

Locator: 65 - Employer Name
Scenario: The above edit appears if a claim has a Condition Code of 10 and does not have an Employer Name loaded in the Policy Information screen.
To Correct: Verify Condition Code is correct. If not, delete code from UB Coding screen. If Code is correct, verify Employer Name and load in the Policy Information screen.

EDIT 291 - EMP ADDRESS MUST BE ENTERED IN 66 - COND CD 10

Scenario: The above edit appears if a claim has a Condition Code of 10 and does not have an Employer Address loaded in the Policy Information screen.
To Correct: Verify Condition Code is correct. If not, delete code from UB Coding screen. If code is correct, verify Employer Address and load in the Policy Information screen.

EDIT 292 - MISSING DIAGNOSIS CODE IN FIELD 67

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim that has a Bill Type other than 14X, has Revenue Codes 30X or 31X, and does not have a Principal Diagnosis Code in locator 67.
To Correct: Verify Bill Type. If Bill Type is incorrect, change in Detail Charges screen of the claim. If Bill Type on the claim is correct, verify that Medical Records has completed the coding on this account. Once Medical Records enters the Primary Diagnosis in the Medical Records Grouper screen the claim must be regenerated.

EDIT 293 - INVALID DIAGNOSIS CODE IN FIELD 67, PRIN DIAG

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim has an invalid ICD9 Diagnosis Code in field 67.
To Correct: Verify Diagnosis Code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Diagnosis Code and it is not in the Thrive table, call Evident Software Support in order to correct the table.

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EDIT 294 - PRINCIPAL DIAGNOSIS SHOULD BE V0481

Locator: 67 – Prin Diag Cd
Scenario: The above edit appears if a claim has a Condition Code of A6 or has a Revenue Code of 636 or 771, but does not have a Principal Diagnosis of V0481, V0482 or V0489.
To Correct: Verify Condition Code is correct. If not, delete code from UB Coding screen. If code is correct, verify Revenue Codes are correct. If not, have Data Processing correct the charges. If Revenue Codes are correct, have Medical Records enter V048 as the Principal Diagnosis Code in the Medical Records Grouper screen. The claim will need to be regenerated.

EDIT 295 - BASED ON PRIN DIAG, NEED OCCUR CD/SPAN CD 01-06

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a Blue Cross, Medicare, Medicaid or Champus Claim has a Principal Diagnosis Code greater than 800 and less than 9999 and does not have an Occurrence Code/Span Code of 01 - 06.
To Correct: Verify Principal Diagnosis is correct. If not, have Medical Records correct in the Grouper screen. If correct, load Occurrence Code/Span code of 01 - 06 in the UB Coding screen. If diagnosis has to be corrected, then the claim will need to be regenerated. If Codes are loaded on the claim there is no need to regenerate the claim.

EDIT 296 - INVALID PRINCIPAL DIAGNOSIS; E-CODE

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim has a Principal Diagnosis Code that begins with an "E."
To Correct: Verify Principal Diagnosis. If an E-code diagnosis is principal, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 297 - INVALID PRINCIPAL DIAGNOSIS; MANIFESTATION CODE

Locator: 67 - Prin Diag Cd
Scenario: The above edit appears if a claim has a Diagnosis Code in Appendix B (attached) listed as the Principal Diagnosis.
To Correct: Verify Principal Diagnosis. If it is one of the codes in Appendix B, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 298 - INVALID DIAGNOSIS CODE IN OTHER DIAG FIELD

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has an invalid ICD9 Diagnosis Code in fields 68 - 75.
To Correct: Verify Diagnosis Code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Diagnosis Code and it is not in the Thrive table, call Evident Software Support in order to correct the table.

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EDIT 299 - DIAGNOSIS CODE LISTED TWICE

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has duplicated Diagnosis Codes in locators 68 - 75.
To Correct: Verify which Other Diagnosis Codes are duplicated. Then have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 300 - E-CODES INVALID FOR CHAMPUS CLAIMS

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a Champus claim has Diagnosis Codes that begin with an "E" in locators 68 - 75.
To Correct: Verify Diagnosis Codes are correct. Then have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

Edits 301-400

EDIT 301 - BLANK LOCATOR BETWEEN OTHER DIAGNOSIS CODES

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has any blank locators in between Diagnosis Codes in locators 68 - 75. For example, locator 68 should not be blank if there is a Diagnosis Code in locator 69.
To Correct: Verify Other Diagnosis is correct. If not, have Medical Records correct in the Grouper screen. Ensure that there are no blank fields in the Grouper screen for other diagnoses. Verify that the other Diagnosis Codes fill up fields 22 - 30 in order. Claim will need to be regenerated if changes are made.

EDIT 302 - NEED DIAGNOSIS CODE OF 2860, 2861, OR 2864

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has a Bill Type of 11X, a Revenue Code of 636, and it does not have a Diagnosis Code of 2860, 2861 or 2864.
To Correct: Verify Bill Type is correct. If not, change in the Detail Charges screen in the claim. If Bill Type is correct, verify Revenue Code is correct. If correct, have Medical Records enter the appropriate diagnosis in the Grouper screen. The claim will then need to be regenerated.

EDIT 303 - NEED SECONDARY DIAG WITH THIS PRINCIPAL DIAG

Locator: 67A-Q - Other Diagnosis Codes
Scenario: The above edit appears if a claim has a Bill Type of 1XX or 2XX, a Principal Diagnosis of V571, V572, V573, V579 or V5789, and there is not a secondary diagnosis present.
To Correct: Verify Principal Diagnosis. If correct, have Medical Records enter a secondary diagnosis. The claim will need to be regenerated.

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EDIT 304 - ADMITTING DIAGNOSIS MUST BE ENTERED IN FIELD 76
ADMITTING DIAGNOSIS IS NOT A VALID ICD9 CODE

Locator: 69 - Admitting Diagnosis Code
Scenario: The above edit appears if a claim has a Bill Type of 11X and there is not an Admitting Diagnosis Code in locator 69. The second edit appears if there is an invalid Admitting Diagnosis Code entered.
To Correct: Verify Bill Type is correct. If correct, have Medical Records verify and load an Admitting Diagnosis Code in the Medical Records Grouper screen. Verify that the admitting diagnosis is correct. If not, have Medical Records correct in the Grouper screen. If the diagnosis is valid and it is not in the Thrive table, call Evident Software Support in order to correct the table. The claim will need to be regenerated.

EDIT 305 - ADMIT DIAG E-CODE ARE INVALID FOR CHAMPUS CLAIMS

Locator: 69 – Admitting Diagnosis Code
Scenario: The above edit appears if a Champus Claim has an Admitting Diagnosis Code in locator 69 that begins with an "E".
To Correct: Verify Diagnosis Codes are correct. Then have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 306 - MISSING PRINCIPAL PROCEDURE DATE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has a Principal Procedure Code and is missing a date.
To Correct: Verify Principal Procedure Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify when the procedure was performed and load date in the Grouper screen. The claim will then need to be regenerated.

EDIT 307 - PRINCIPAL PROCEDURE IS NOT A VALID ICD9 CODE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has an invalid Principal Procedure Code loaded in locator 74.
To Correct: Verify Procedure code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Procedure code and it is not in the Thrive table, call Evident Software Support in order to correct the table.

EDIT 308 - HAVE PRIN PROC DATE; MISSING PRIN PROC CODE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has a Principal Procedure Date but not a Principal Procedure Code.
To Correct: Verify Principal Procedure Date is correct. If incorrect, have Medical Records correct in the Grouper screen. If date is correct, have Medical Records verify what procedure was performed and load code in the Grouper screen. The claim will then need to be regenerated.

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EDIT 309 - PRINCIPAL PROCEDURE DATE > STMT 'THROUGH' DATE
EDIT 310 - PRINCIPAL PROCEDURE DATE < STMT 'FROM' DATE

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edits appear if a claim has a Principal Procedure date loaded in locator 74 and it does not fall in the date range of the Service "From" and "To" date.
To Correct: Verify Procedure date falls within the Service "From" and "To" Date. If incorrect, have Medical Records correct in the Grouper screen. Then the claim will need to be regenerated.

EDIT 311 - DIAG = MATERNITY COMPLIC; PRIN PROC INCONSISTENT

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a Champus Claim has a Diagnosis Code of 630 – 6689 but does not have a Principal Procedure Code of 650 - 7599.
To Correct: Verify Diagnosis Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify Principal Procedure and load in the Grouper screen. The claim will then need to be regenerated.

EDIT 312 - DIAG = MATERNITY COMPLIC; OTHER PROC INCONSISTENT

Locator: 74a-e - Other Procedure Code/Date
Scenario: The above edit appears if a Champus Claim has a Diagnosis Code of 630 – 6689, but does not have an Other Procedure Code of 650 - 7599.
To Correct: Verify Diagnosis Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify Other Procedure and load in the Grouper screen. The claim will then need to be regenerated.

EDIT 313 - PROC = CAESAREAN; DIAG CODES INCONSISTENT

Locator: 67A-Q - Diagnosis Codes
Scenario: The above edit appears if a Champus Claim has a Principal Procedure Code of 740 - 749, but does not have a Diagnosis Code of 630 - 6769.
To Correct: Verify Diagnosis Code is correct. If incorrect, have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify what procedure was performed and load in the Grouper screen. The claim will then need to be regenerated.

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EDIT 314 - MISSING PRINCIPAL PROCEDURE CODE

Locator: 74 - Principal Procedure Code/Date
Scenario: There are two different scenarios that will cause this edit to pull. The first is if a claim has a Bill Type of 11X, a Revenue Code of 36X, and a Diagnosis Code other than V641 - V643, but does not have a Procedure Code. The second is if a Champus claim has a charge with Revenue Code 36X or 49X but does not have a Principal Procedure Code.
To Correct: For the first scenario, verify Bill Type is correct. If incorrect, change in the Detail Charges screen of the claim. If correct, verify charges are correct. If incorrect, have Data Processing correct. If correct, verify Diagnosis is correct. If incorrect have Medical Records correct in the Grouper screen. If code is correct, have Medical Records verify what Procedure was done and load in the Grouper screen. The claim will then need to be regenerated. For the second scenario, verify Revenue Code is correct. If incorrect, have Data Processing correct. If charge is correct, have Medical Records verify what principal procedure was done and load in the Grouper screen. The claim will need to be regenerated.

EDIT 315 - 1171, 2095, 375, 5051 NOT VALID AS PRINCIPAL PROC

Locator: 74 - Principal Procedure Code/Date
Scenario: The above edit appears if a claim has a Principal Procedure Code of 1171, 2095, 375 or 5051.
To Correct: Verify Principal Procedure Code and have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 316 - MISSING PROCEDURE DATE ON A SECONDARY PROCEDURE
EDIT 317 - HAVE SECONDARY PROC DATE; MISSING SEC PROC CODE

Locator: 74a-e - Other Procedure Code/Date
Scenario: Edit 316 appears if a claim has a Secondary Procedure Code and no Secondary Procedure date. Edit 371 appears if there is a Secondary Procedure Date and no Secondary Procedure Code.
To Correct: Verify which information is missing and have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 318 - SECONDARY PROCEDURE IS NOT A VALID ICD9 CODE

Locator: 74a-e - Other Procedure Code/Date
Scenario: The above edit appears if a claim has an invalid Secondary Procedure Code loaded in locator 81.
To Correct: Verify Procedure code is correct. If not, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated. If code is a correct ICD9 Procedure code and it is not in the Thrive table, call Evident Software Support in order to correct the table.

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EDIT 319 - SECONDARY PROCEDURE DATE > STMT 'THROUGH' DATE
EDIT 320 - SECONDARY PROCEDURE DATE < STMT 'FROM' DATE

Locator: 74a-e - Other Procedure Code/Date
Scenario: The above edits appear if a claim has a Secondary Procedure date loaded in locators 74a-e that does not fall in the date range of the Service "From" and "To" date of the claim.
To Correct: Verify Procedure date falls within the Service "From" and "To" date. If incorrect, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 321 - OCCUR CD = 24; MISSING REMARKS IN LOC 84

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has an Occurrence Code of 24 in the UB Coding screen but no remarks in locator 80.
To Correct: Verify Occurrence Code is correct. If incorrect, delete code from the UB Coding screen of the Insurance Claim. If code is correct, load remarks in the Policy Information screen in the Ben. Desc field. The remarks must be preceded with the phrase "XMIT." There is no need to regenerate the claim.

EDIT 322 - CHARACTER IN REMARK LINE 1 NOT ALPHA/NUMERIC

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has special characters (e.g., $, #, @, etc) in the first line of remarks in locator 80. The remarks should only be alpha or numeric.
To Correct: Verify remarks should be entered. If not, delete remarks from the Policy Information screen in the Ben Desc field. If remarks are required, verify that they do not contain special characters. There is no need to regenerate the claim.

EDIT 323 - CHARACTER IN REMARK LINE 2 NOT ALPHA/NUMERIC

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has special characters (e.g., $, #, @, etc) in the second line of remarks in locator 80. The remarks should only be alpha or numeric.
To Correct: Verify remarks should be entered. If not, delete remarks from the Policy Information screen in the Ben. Desc field. If remarks are required, verify that they do not contain special characters. There is no need to regenerate the claim.

EDIT 324 - CHARACTER IN REMARK LINE 3 NOT ALPHA/NUMERIC

Locator: 80 - Remarks
Scenario: The above edit appears if a claim has special characters (e.g., $, #, @, etc) in the third line of remarks in locator 80. The remarks should only be alpha or numeric.
To Correct: Verify remarks should be entered. If not, delete remarks from the Policy Information screen in the Ben. Desc field. If remarks are required, verify that they do not contain special characters. There is no need to regenerate the claim.

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EDIT 325 - LOCATOR 82 IS BLANK

Locator: 76 - Attending Physician ID
Scenario: The above edit appears if a claim does not have an Attending Physician number loaded in the Stay Information screen.
To Correct: Determine the correct Attending Physician and load that number into the Stay Information screen. If the physician is not loaded in the Stay tab on the Registration and ADT screen, then notify the appropriate department.

EDIT 326 - MISSING SURGEON

Locator: 77 - Other Physician ID
Scenario: The above edit appears if a claim has a Principal Procedure Code in the Grouper screen and does not have a Surgeon in Stay Information.
To Correct: Verify with Medical Records that the Procedure Code loaded is correct. If so, they will need to add a Surgeon in the Grouper screen. The Physician number should then be loaded in Stay Information. The claim will not need to be regenerated.

EDIT 327 - MISSING SURGEON'S UPIN NBR

Locator: 77 - Other Physician ID
Scenario: The above edit appears if a claim has a Surgeon loaded in the Stay Information screen with UPIN# field blank in the Physician table.
To Correct: Verify Physician is correct. Verify the UPIN of the surgeon and load in the Business Office Tables (Select Hospital Base Menu > Master Selection > Business Office Tables> Maintenance Menu > Physicians) in the UPIN# field. There is no need to regenerate the claim.

EDIT 328 - CLAIM CONTAINS INVALID REVENUE CODE

Locator: 42 - Revenue Codes
Scenario: The above edit appears if an Alabama Medicaid claim has a Bill Type of 3XX and contains Revenue Codes other than 55X or 57X.
To Correct: Verify Bill Type is correct. If incorrect, it may be changed in the Detail Charges screen of the claim. If Bill Type is correct, then the only valid Revenue Codes that may be billed is 55X or 57X. Have Data Processing correct charges through patient Charging and regenerate the claim.

EDIT 329 - DUP REV CODE AND CPT CODE

Locator: 42 - Revenue Codes
Scenario: The above edit appears if an Outpatient claim has duplicate Revenue Codes and CPT codes from the Item Master.
To Correct: Verify the type claim and Revenue Codes that need to be detailed and pull CPT codes or summarized and not pull CPT codes. If Revenue Codes need to be summarized, then set the Summarize O/P Ins field in the Summary Code table to summarize for the financial class. The claim will need to be regenerated.

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EDIT 330 - EXP PAY NOT = SUM OF DETAIL LINES

Locator: 55 - Est. Amount Due
Scenario: The above edit appears if a claim has a sum total of amounts on the Detail Charges screen that does not equal the Expected Pay.
To Correct: Verify which line in the Detail Charges screen of the claim is incorrect, (i.e., Non-covered, Deductible, Co-pay etc.). Correct the line that is wrong. The claim does not have to be regenerated.

EDIT 331 - EXP PAY NOT GREATER THAN ZERO

Locator: 55 - Est. Amount Due
Scenario: The above edit appears if a claim has an Expected Pay that is not greater than zero.
To Correct: Verify the correct amount that is expected to be received from the Insurance Company. If charges need to be generated on the Detail Charges screen, verify they are posted to the patients account detail. If on account detail, regenerate the claim. If charges are missing, have Data Processing correct through patient Charging and regenerate the claim.

EDIT 332 - OUTPATIENT CHARGE AMOUNT IS LESS THAN 0

Locator: 47 - Total Charges
Scenario: The above edit appears if an Outpatient claim has total charges that are less than 0.
To Correct: Verify the correct charges are on the account detail. If any charges are missing, have Data Processing correct through patient Charging. The claim will need to be regenerated.

EDIT 333 - ROOM CHARGE AMOUNT IS LESS THAN 0

Locator: 42 - Revenue Codes
Scenario: The above edit appears if a claim has charges for a Revenue Code between 100 - 219 and it is less than zero.
To Correct: Verify that room charges are on the account detail. If not, have Data Processing post through transaction entry. The claim will need to be regenerated.

EDIT 334 - PATIENT NAME MUST INCLUDE LAST NAME AND FIRST INIT

Locator: 8b - Patient Name
Scenario: The above edit appears if a claim only includes the patient's last name.
To Correct: Verify the patient's name in the Patient tab on the Registration and ADT screen. The claim must have, at a minimum, a last name and first initial. The claim will need to be regenerated.

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EDIT 335 - ATTENDING PHYSICIAN'S UPIN NBR MISSING

Locator: 76 - Attending Physician ID
Scenario: The above edit appears if a claim has an Attending Physician loaded in the Stay Information screen with the UPIN# field blank in the Physician table.
To Correct: Verify Physician is correct. Verify the UPIN of the attending physician and load in the Business Office Tables (Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Physician). There is no need to regenerate the claim.

EDIT 336 - MISSING SURGERY PROC CODE FOR REV CODE 71X

Locator: 74 - Procedure Codes
Scenario: The above edit appears if a claim has charges for Revenue Code 71X and is missing a procedure code in the Stay Information screen.
To Correct: Verify charges are correct. If incorrect, have Data Processing correct through patient Charging. If charges are correct, have Medical Records enter a procedure code in the Medical Records Grouper screen. The claim will need to be regenerated.

EDIT 337 - REVENUE CODE 405 NEEDS PRECERTIFICATION

Locator: 42 - Revenue Codes
Scenario: The above edit appears if a claim has charges for Revenue Code 405 and does not have a pre-certification number loaded in the Stay Information screen.
To Correct: Verify the pre-certification number and load in the Stay Information screen. The claim will not need to be regenerated.

EDIT 338 - MISSING CPT CODE FOR REVENUE CODE 300 TO 369

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a Medicare claim has charges for Revenue Codes 300 - 369 and is missing CPT codes.
To Correct: Verify the correct CPT that is required and load in the Item Master for items in Revenue Codes 300 - 369. Regenerate the claim.

EDIT 339 - ACCIDENT HOUR BUT NO ACCIDENT DIAGNOSIS

Locator: 67A - Q - Diagnosis Codes
Scenario: The above edit appears if a claim has an accident hour in the Stay Information screen but does not have an accident diagnosis.
To Correct: Verify the accident hour is correct. If incorrect, then delete from the Stay tab on the Registration and ADT screen. If correct, then the patient has to have an accident diagnosis. Have Medical Records enter diagnosis in Grouper screen and regenerate the claim.

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EDIT 340 - MEDICAID WITHOUT 13 DIGIT POLICY NUMBER

Locator: 60 - Insured's Unique ID
Scenario: The above edit appears if a Louisiana Medicaid claim does not have a 13-digit policy number.
To Correct: Verify the correct policy number and load in the Policy Information screen for the claim. The claim will not need to be regenerated.

EDIT 341 - AMBULANCE CLAIM - NO REMARKS

Locator: 80 - Remarks
Scenario: The above edit appears if a claim for the state of Georgia has charges for Revenue Code 54X and has no remarks in the Policy Information screen.
To Correct: Verify the remarks that are needed and load in the Policy Information screen in the Ben. Desc field, preceded with "XMIT". The claim will not need to be regenerated.

EDIT 342 - PHYSICIAN NUMBER 888888 NOT ON FILE

Locator: 76 - Attending Physician ID
Scenario: The above edit appears if a claim has an Attending Physician in the Stay Information screen with the number 888888, which is an unknown physician.
To Correct: Verify the correct physician and load the number in the Stay Information screen of the claim. The claim will not need to be regenerated.

EDIT 343 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes:
92504, 92511, 925411-92548, 92551-92553, 32555-92557, 92561-92569, 92571-92578, 92580-92585, 92589 or 92596 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges may not have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 344 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes:
91000, 91010-91012, 91020, 91030, 91032, 91033, 91052, 91055, 91060,
91065 or 91122 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges may not have the listed CPT codes on the UB. Verify the Summarize O/P ins field in the Summary Code table for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

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EDIT 345 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93000, 93005, 93024, 93040, 93041, 93201, 93202, 93205, 93208, 93210, 93220, 93221, Q0019, Q0023, Q0027 or Q0030 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table for the particular Financial Class is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 346 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93501, 93505, 93510, 93511, 93514, 93524, 93526-93529, 93555, 93556, 93561, 93562 or Q0035 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table for the particular Financial Class is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 347 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93225, 93226, 93231, 93232 or 93236 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 348 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 93300, 93305, 93307-93309, 93312, 93314, 93320, 93321, 93325, 93350, 93600, 93602, 93603, 93607, 93609, 93610, 93612, 93603, 93607, 93610, 93612, 93615, 93616, 93618-93620, 93624, 93631 or 93640-93641 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

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EDIT 349 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 54240, 93720, 93721, 93731-93738, 93740, 93770, 93875-93882, 93886, 93888, 93920-93931, 93965-93971, 93975, 93976 or 93978-93981 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarizer; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 350 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with CPT codes 93255, 93268 or 93278 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 351 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 95816, 95817, 95819, 95821-95824, 95826, 95827, 95829, 95920, 95933, 95950, 95951, 95953-95956, 95958, 95961 or 95962 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 352 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 95842, 95858, 95860, 95861, 95863, 95864, 95867-95869, 95872, 95875, 95900, 95904, 95925, 95935 or 95937 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

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EDIT 353 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 958052, 95807, 95808 or 95810, and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 354 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 51736, 51741, 51792, 51795, 51797, 54250, 59020, 59025, 93060, 92065, 92081-92083, 92235, 92250, 92265, 92270, 92275, 92280 or 92283-92286 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 355 - CPT NOT ALLOWED WITH LISTED BILL TYPE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has items charged with the following CPT codes: 95004, 95024, 95027, 95028, 95044, 95052, 95056, 95060, 95065, 95070, 95071 or 95078 and the Bill Type is not 13X, 14X or 83X.
To Correct: Verify the Bill Type is correct. If correct, the charges cannot have the listed CPT codes on the UB. Verify the Summarize O/P Ins field in the Summary Code table, for the particular Financial Class, is set to summarize; therefore, the CPT will not pull. The claim will need to be regenerated. If Bill Type is incorrect, change in the Detail Charges screen of the claim to a 13X, 14X or 83X. The claim does not have to be regenerated.

EDIT 356 - GA BETTER HEALTHCARE AUTHORIZATION # MISSING

Locator: 78 - Other Physician ID
Scenario: This edit will appear if the Georgia Better Health Care number is not loaded in Policy Information in the GBHC# field or on the second page of the Physician table.
To Correct: Verify that the number is missing in Policy Information and load in the GBHC# field. Once this has been done, there is no need to regenerate the claim.

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EDIT 357 - GROUP NAME/NUMBER CONTAINS EXTRA DASH

Locator: 61-62 Group Name/Insurance Group No.
Scenario: The above edit will appear if there is more than one slash "/" in the Group Info field of Policy Information. There should only be one slash.
To Correct: Verify that there is more than one slash and correct in the Group Info field of Policy Information. The claim does not need to be regenerated.

EDIT 358 - INVALID EMPLOYER NAME

Locator: 65 - Employer Name
Scenario: This edit will appear if the Employer Name field in the Patient tab on the Registration and ADT screen Maintenance contains the words "Unemployed", "Disabled", "None", or "Retired."
To Correct: Verify that the above Employer name is loaded in the Patient tab on the Registration and ADT screen and correct it accordingly. If the above person is not employed, then leave the field blank. The claim will then have to be regenerated.

EDIT 359 - VERIFY DIAGNOSIS CD; CPT = XXXXX

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if the claim contains the following CPT codes: 82728, 86316, 84153 or 93005.
To Correct: Verify that the Diagnosis Code and the CPT are pulling correctly. If not, the diagnosis or the CPT will need to be corrected. The CPT may be corrected on the Detail Charges screen and on the actual item in the Item Master. The Diagnosis Code may be corrected on the Stay Information screen or through Medical Records.

EDIT 360 - EXP PAY NOT = SUM OF DETAIL LINES

Locator: 55 - Est. Amount Due
Scenario: This edit will appear if the Expected Pay does not equal the Detail Charges total.
To Correct: Verify that the totals do not match, then research. The Detail Charges screen will only print 7 digits of a dollar figure. If the dollar amount is over $99,999.99, the edit will appear because the dollar amount will not match total charges in the Insurance screen. The Total Charges field may print up to 8 digits.

EDIT 361 - REV CODE 54X NEEDS A MODIFIER

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if a Medicare claim exists with a Revenue Code of 54X that does not have a modifier.
To Correct: Verify that the above criteria applies. Then, load the modifier in the Item Master. Once loaded, regenerate the claim.

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EDIT 362 - ATTENDING PHYSICIAN LICENSE NBR MISSING

Locator: 76 - 78 - Attending/Other Physician IDs
Scenario: This edit will appear for Alabama Medicaid claims when the License/Tax number is missing from the Physician's table.
To Correct: Verify that the field is blank. Load the number in the Lic# or Tax# field in the Physician's table field. The claim will not need to be regenerated.

EDIT 363 - KENTUCKY BLUE CROSS LAB CHARGES ON FILE-REVIEW

Scenario: The above edit appears if Kentucky Blue Cross lab charges are present.
To Correct: Verify that the above criteria has been met. Make sure charges are pulling to a physician claim.

EDIT 364 - CLAIM CONTAINS REV CODE 253

Locator: 42 - Revenue Code
Scenario: This edit will appear for Texas Medicaid claims with a Revenue Code of 253.
To Correct: Verify that the charges are "take home drugs". If so, they must be billed as non-covered. Detail Charges will need to be manipulated if charges are not pulling as non-covered. For future claims, the Summary Charge code may be loaded in the Non-Covered Sum-CD field on page 4 of the Insurance Company tables to force those charges to pull as non-covered.

EDIT 365 - ADMIT TYPE=1; CHECK FOR ER CERT.

Locator: 14 - Admission Type
Scenario: This edit will appear if the claim is an Alabama Medicaid claim with an emergency visit admit type of "1".
To Correct: Verify the above criteria. Once this is done, check to see if "Certified Emergency" or "E" is pulling to the UB04 in the correct locator.

EDIT 366 - ADMIT YR AND DISCHARGE YR MUST BE THE SAME

Locator: 12 - Admit Date
Scenario: This edit will appear if the admit and discharge year are not the same on a Medicare claim.
To Correct: Verify that the dates fall in different years. If so, those charges must be billed separately. Create another claim and manipulate the Detail Charges screen.

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EDIT 367 - BILL TYPE 13X, 14X, OR 83X-ADMT DT NOT=DIS D

Locator: 4 - Type of Bill
Scenario: This edit will appear for Alabama Medicaid claims with a Bill Type of 13X, 14X or 83X and the admit/discharge dates are different.
To Correct: Verify the Bill Types and admit/discharge dates. If dates differ, then the charges must be billed separately for each service date. A new claim will need to be created and Detail Charges manipulated.

EDIT 368 - MISSING INSURED'S NAME IN FIELD 58

Locator: 58 - Insured's Name
Scenario: This edit will appear when a claim exists with the Patient Relation to Subscriber as "01" or "18" if using new relationship codes and the patient and subscriber names do not match.
To Correct: Verify the names of the patient and subscriber. If they do not match, either the relationship or subscriber name needs to be corrected. Enter the correct information in Policy Information. Do not regenerate the claim.

EDIT 369 - BILL TYPE 14X WITH REV CD 25X, 27X, OR 450

Locator: 42 - Revenue Code
Scenario: This edit will appear when a Revenue Code of 25X, 27X or 450 is present with a Bill Type of 14X. The Bill Type should be 13X.
To Correct: Verify Bill Type and Revenue Codes. Change Bill Type to 13X on the Detail Charges screen. Do not regenerate the claim.

EDIT 370 - E-CODE WITH NO ACCIDENT DATE

Locator: 31-36 Occurrence Codes
Scenario: This edit will appear when an E-Code is present without an accident date.
To Correct: Verify that the accident date is missing and that the E-Code is correct. Enter the accident date in Stay Information, Accident Information date or re-code in the Medical Records Grouper screen, depending on which is correct. Do not regenerate the claim.

EDIT 371 - MISSING KENPAC PHY

Locator: 77 - Other Physician ID
Scenario: This edit will appear when a referring physician is not loaded in Referring Data from the Patient Functions screen for a Kentucky Medicaid patient.
To Correct: Verify that the physician is not loaded in Referring Data on the Patient Functions screen and then load the correct physician. Regenerate the claim.

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EDIT 372 - DIAGNOSIS 520.0 - 529.9 ON MCARE CLAIM

Locator: 67A - Q - Diagnosis Codes
Scenario: This edit will appear when Diagnosis Codes of 5200 to 5299 are placed on a Medicare account. These are invalid Diagnosis Codes for Medicare and should not be billed.
To Correct: Verify that the Diagnosis Code or codes are present and remove the codes from the Medical Records Grouper screen. Also, remove the codes from the Stay Information screen. Do not regenerate the claim.

EDIT 373 - REVENUE CODE OF 54X PRESENT

Locator: 42 - Revenue Code
Scenario: This edit will appear if a Revenue Code of 54X is present.
To Correct: This is simply a notice for the presence of the 54X Revenue Codes. If the 54X Revenue Codes are present then the claim should be an ambulance claim.

EDIT 374 - REV CODE 253 ON MEDICAID UB92

Locator: 42 - Revenue Code
Scenario: This edit will appear when a Revenue Code of 253 is present on an Iowa Medicaid UB04.
To Correct: Verify that the Revenue Code is present. If so, check the Detail Charges screen for the item that is pulling the above Revenue Code and correct it. Also, check the appropriate Summary Code and remove the Revenue Code. Do not regenerate the claim.

EDIT 375 - TYPE OF BILL INVALID – REV CODE 450

Locator: 42 - Revenue Code
Scenario: This edit will appear if a Revenue Code of 450 exists on a claim with a Bill Type of 111.
To Correct: Verify that the Revenue Code of 450 and the 111 Bill Type are present. If so, then either the Revenue Code or the Bill Type are incorrect. To change the Bill Type, access the Detail Charges screen and change the UB Bill Type field. If the Revenue Code is incorrect, then a summary code may need to be changed on the Detail Charges screen. Do not regenerate the claim.

EDIT 376 - MISSING PCP CODE

Locator: 31
Scenario: This edit will appear when there is a referring physician loaded for Indiana Medicaid claims with a missing 2-digit Precert#. This number should be loaded in the Percer#/Type field of Policy Information and pull to locator 31 of the UB04.
To Correct: Verify that the 2-digit code is missing and load it in Policy Information. Do not regenerate the claim.

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EDIT 377 - INPATIENT CHARGE AMOUNT IS LESS THAN 0

Locator: 47 - Total Charges
Scenario: This edit will appear when an I/P claim contains a negative revenue amount even if the claim has a positive balance.
To Correct: Verify that the negative charge is present and remove it from the Detail Charges screen. Do not regenerate the claim.

EDIT 378 - MISSING VALUE CODE 81 OR COND CODE 80

Locator: 18 - 28 Condition Codes, 39-41 Value Codes
Scenario: This edit will appear if a Value Code of 81 and/or a Condition Code of 80 are missing for Georgia Medicaid Outpatient claims.
To Correct: Verify that the code is missing and load it in the UB Coding screen. Do not regenerate the claim.

EDIT 379 - NEEDS A1, X2, OR X3 CONDITION CODE

Locator: 18 - 28 Condition Codes
Scenario: This edit will appear if a 1, 2, 3 or 4 is not loaded in the Misc#3 field of Policy Information for Alabama Medicaid 1500 claims.
To Correct: Verify that the above numbers are not loaded. Load the correct number in the Misc#3 field. Do not regenerate the claim.

EDIT 380 - OR PROCEDURE WITHOUT HCPC

Locator: 74 - Procedure Codes, 44 – HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when a HCPC is not present on a Medicare claim containing an OR procedure.
To Correct: Verify that the HCPC is not present, then load the HCPC on the Detail Charges screen. Do not regenerate the claim.

EDIT 381 - ADMITTING DIAGNOSIS IS NOT VALID ICD9 CODE

Locator: 69 - Admitting Diagnosis
Scenario: This edit will appear when there is an invalid Admitting Diagnosis Code on the claim.
To Correct: Verify that the invalid code is present and correct the code on the Stay Information screen and in the Medical Records Grouper screen. Also, if needed, load the code in the Diagnosis table. Do not regenerate the claim.

EDIT 382 - PENDING CPT NOT COVERED

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when a CPT code is present that is not going to be covered. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT code is present and remove it from the Detail Charges screen. Also, the Medical Necessity table may need to be updated. Do not regenerate the claim.

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EDIT 383 - SCREENING CPT NOT COVERED

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when a screening CPT is present that will not be covered. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT is present and remove it from the Detail Charges screen. The Medical Necessity table may need to be updated. Do not regenerate the claim.

EDIT 384 - CPT NOT SUPPORTED BY DIAGNOSIS

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if there is a CPT code that does not have a supporting diagnosis loaded in the Medical Necessity table. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT code does not have a supporting diagnosis and correct. Load the diagnosis in the Medical Necessity table or remove the CPT from the table and the Detail Charges screen. Do not regenerate the claim.

EDIT 385 - HOME HEALTH BILL TYPE REQUIRES MSA NUMBER

Locator: 4 - Type of Bill
Scenario: This edit will appear when a Home Health Bill Type is present without an MSA number. The MSA number is a 4-digit number that signifies the area of the agency.
To Correct: Verify that the Bill Type is for Home Health. Also, verify that the MSA number is missing and load it in the appropriate field. The MSA number must pull with a Value Code of 61. The dollar amount must end with a period and 2 zeroes. If the Value Code and the correct dollar amount are not pulling, load them in the UB Coding screen. Do not regenerate the claim.

EDIT 386 - DIAGNOSIS CODE EXPIRED

Locator: 67A - Q - Diagnosis Codes
Scenario: This edit will appear when a Diagnosis Code is present that has expired.
To Correct: Verify that the Diagnosis Code has expired by checking the Diagnosis Code table in the Business Office Tables. If so, decide whether the Diagnosis Code should be expired and correct. If it should be expired, then use another Diagnosis Code. Load the correct code in Stay Information. If it should not be expired, remove the date and call Evident to verify this. Do not regenerate the claim.

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EDIT 387 - EXPIRED CPT CODE

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear when one or more of the following problems exist: if an invalid CPT code is loaded in the Item Master, if the CPT code in the Item Master has expired, if a CPT on the Detail Charges screen is invalid, and/or if a CPT code on the Detail Charges screen has expired.
To Correct: Verify the location of the CPT code problem and correct it appropriately. If the problem exists in the Item Master, enter a valid CPT or remove the problem CPT code. Or, if the CPT on the Detail Charges screen is the problem, then remove it or enter a valid one. Do not regenerate the claim.

EDIT 388 - INS. SPECIFIC NON-COVERED CHARGE ON CLAIM

Locator: 48 - Non-Covered Charges
Scenario: This edit will pull if a Summary Charge Code has been entered in the Non-Covered Sum CD field on page 4 of the Insurance Company table to cause those charges to pull to the Non-Covered column and they are instead pulling as Covered.
To Correct: Access the Detail Charges screen of the claim and enter the charges into the Non-Covered column for the appropriate Summary Charge Code. The claim will not need to be regenerated.

EDIT 389 - DUP CPT CODE – SAME DAY

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will pull if a CPT code is pulling multiple times for the same Service Date on a claim.
To Correct: Verify that the item with the CPT code was posted duplicate times to the patient's Account Detail. If they were posted in error, have Data Processing remove the charges and regenerate the claim. If a single CPT code was entered into multiple Item Masters incorrectly, then replace with the correct CPT code and regenerate the claim.

EDIT 390 - E OR M DIAGNOSIS CODES PRESENT

Locator: 67A - Q - Diagnosis Codes
Scenario: This edit will print if the state is Louisiana, the Financial Class of the claim is Medicaid, and the claim has any Diagnosis Codes that begin with "E" or "M".
To Correct: The Diagnosis Code should be removed so that it will not print to the claim. The claim will not need to be regenerated.

EDIT 391 - REFUND CHARGE PRESENT

Scenario: The above edit will pull if a Refund Charge (Summary Charge Code "RF") exists on the claim.
To Correct: Verify the reason the charge was posted to the patient's account. If posted in error, have Data Processing back the charge off the patient's account and regenerate the claim.

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EDIT 392 - **OBSERVATION REV CODE 762 QUANTITY > 48**

Locator: 42 - Revenue Code, 46 - Units of Service
Scenario: This edit will pull if a Medicare claim has a Revenue Code of 762 with a quantity greater than 48.
To Correct: Verify if the charge was placed in error on the patient's account. If so, have Data Processing reverse and enter the correct charge. The claim will then need to be regenerated. If the charge was not posted in error, then the Detail Charges screen will need to be manipulated so that the quantity of the Observation Charge is not greater than 48. The claim will not need to be regenerated.

EDIT 393 - **NO PRIMARY CLAIM WITH SECONDARY CLAIM PRESENT**

Scenario: This edit will pull to a secondary claim if there is no primary claim present on the account.
To Correct: Research should be conducted to determine why no primary claim exists on the account. Create the primary claim and move it to the same status as the secondary claim.

EDIT 395 - CPT FREQUENCY LIMIT PRESENT FOR CPT XXXXX

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: If a Frequency Interval has been loaded in the Medical Necessity table (Path: Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Med-Nec > "U"pdate Medical Necessity File > Select seq# > Frequency of Test) for the CPT specified (if supported by a Diagnosis), then this edit will appear. It indicates that a frequency limit exists for this CPT.
To Correct: Steps should be taken to determine if this test has been ordered more frequently than the limit specified for the time frame (Month, Day, Year) indicated in the Medical Necessity table, which may cause the test to be denied if billed.

EDIT 397 - **REVENUE CODES 250, 270 & 483 ALL PRESENT**

Locator: 42 - Revenue Code
Scenario: This edit will appear if a Medicaid claim for the state of Michigan with a Bill Type of 13X contains all three Revenue Codes and has HCPC codes of 92XXX and 93XXX.
To Correct: The edit will be removed once the claim no longer contains all three Revenue Codes 250, 270 and 483.

EDIT 398 - **QUANTITY >1 FOR TOB 711 AND REV CODE 521**

Locator: 46 - Service Units
Scenario: This edit will appear if a claim with a Bill Type of 711 and contains a Revenue Code 521 with a quantity greater than 1.
To Correct: The edit will no longer appear if the quantity of the Revenue Code 521 is 1 or removed.

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EDIT 399 - **CONDITION CODE 20 OR 21 NEEDED FOR PROCEDURE**

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if an MB* claim contains a CPT with a Status Indicator of "A" but no Condition Code 20 or 21 are present.
To Correct: This edit will no longer appear once a Condition Code of 20 or 21 is present on the claim.

EDIT 400 - **CONDITION CODE G0 NEEDED FOR PROCEDURE**

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if multiple CPT's with Status Indicator "V" are present for the same date of service without a Condition Code of G0.
To Correct: This edit will no longer appear once a Condition Code of G0 is present on the claim.

Edits 401-500

EDIT 401 - MODIFIER 25 NEEDED FOR PROC AND DATE COMBO

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if a CPT with Status Indicator "V" is present along with CPT's with Status Indicators "S" or "T" on the same date of service with no Modifier 25 on the "V" CPT.
To Correct: The edit will no longer appear once a Modifier 25 has been added to the "V" CPT.

EDIT 402 - MODIFIER 73 OR 74 WITH UNITS > 1

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if a CPT/HCPC has a Modifier of 73 or 74 and the units of service are greater than 1.
To Correct: This edit will no longer appear once the units of service are 1 or removed.

EDIT 403 - ONLY INCIDENTAL SVCS – REIMB MAY BE $0.00

Locator: 44 – HCPCS/Rates/HIPPS Code
Scenario: This edit will appear on an MB* claim if a CPT with Status Indicator "N" is present on the claim, indicating an Incidental Procedure and reimbursement may be $0.00.
To Correct: This edit will no longer appear once an "N" CPT no longer exists on the claim.

EDIT 404 - INPATIENT PROCEDURE PRESENT ON CLAIM

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: This edit will appear if an MB* claim contains a CPT code with a Status Indicator of "C", indicating an Inpatient Procedure.
To Correct: This edit will no longer appear once the Inpatient Procedure has been removed from the claim.

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EDIT 405 - MISSOURI MEDICAID: ADDITIONAL INFORMATION REQUIRED

Scenario: Missouri Medicaid has several surgical procedures that require additional information to be submitted with the claim. This edit will appear if a Missouri X** claim has one of the following CPT codes:
28290, 28292, 28293, 28296, 28297, 28306, 28308, 47600, 47605, 47610, 47612, 47620, 49495, 49500, 49500-50, 49505, 49505-50, 49520, 49525, 49550, 49550-50, 49555, 49560, 49565, 49570, 49580, 49585, 56308, 56316, 56317, 56340, 56341, 56342, 57240, 57250, 57260, 57265, 58120, 58150, 58152, 58180, 58200, 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58285, 59525, 63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63020-50, 63030, 63030-50, 63035, 63040, 63042, 63045, 63046, 63047, 63048, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63086, 63088, 63090, 63091, 63180, 63182, 63185, 63190, 63191, 63194, 63195, 63196, 63197, 63198, 63199, 66840, 66850, 66852, 66920, 66983, 66984, 55250, 55250W1, 56301, 56302, 58600, 58605, 58611, 58615.
To Correct: This is a notice for the presence of one of the CPT codes listed. Additional Information is required and the claim must also be filed paper.

EDIT 406 - ABN SIGNATURE ON FILE; ABN REQUIRES SIGNATURE

Scenario: This edit will pull a message depending upon whether the patient's Advanced Beneficiary Notice has been signed.

EDIT 407 - PATIENT STATUS CODE 30 INVALID FOR BILL TYPE 131

Scenario: This edit will pull for the state of Kansas if the Bill Type is 131 and a Discharge Code of 30 is present.
To Correct: Once the Discharge Code of 30 has been changed, the edit will no longer pull.

EDIT 408 - CPT (82985 OR 83036) NOT SUPPORTED BY DIAGNOSIS

Scenario: This edit will pull if CPT Codes 82985 or 83036 are present but are not linked to any of the following Diagnosis Codes: 25000–25093, 3548–3549, 3558-3559, 3582, 36201-36229, 34800–64804, 7902, 7906, 9623, V122 and V5869.
To Correct: The edit will no longer pull once CPT Code 82985 or 83036 are supported by one of the Diagnosis Codes listed above.

EDIT 410 - MISSING OR INVALID OASIS MATCHING KEY

Scenario: This edit will pull if there is no Precert# for claims with Financial Class MH* and Bill Types 322, 332, 329 and 339.
To Correct: The edit will no longer pull once there is a Precert# loaded in Policy Information.

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EDIT 411 - INVALID HIPPS CODE

Scenario: This edit will pull if there is an invalid HIPPS code on claims with Financial Class MH* and Bill Types 322, 332, 329 and 339.
To Correct: The edit will no longer pull once there is a valid HIPPS Code loaded in Stay Information, HH HIPPS Codes/Dates field. The code should have 4 Alpha characters followed by a 1 only.

EDIT 412 - TX MEDICAID O/P MUST HAVE HCPC-CPT CODE

Scenario: For the state of Texas, this edit will pull if a Medicaid O/P claim does not have an associated CPT code loaded.
To Correct: The edit will no longer pull once a CPT code is loaded in the item master and the claim is regenerated.

EDIT 413 - CHARGE LINE AMOUNT MUST BE > 0

Scenario: For the state of Arkansas, this edit will pull if a Blue Cross claim has a line in the Detail Charges screen with a zero dollar amount.
To Correct: The edit will no longer pull once the zero dollar charge line has been removed.

EDIT 414 - CONTRACT NUMBER IN WRONG FORMAT

Locator: 60 - Insured's Unique ID
Scenario: For the state of Washington, this edit will pull if a Medicaid claim has a Contract number that is not in the following format: AANNNNNNAAAAAX, where A = Alpha, N = Numeric and X=Alpha or Numeric.
To Correct: The edit will no longer pull once the Contract number meets the above requirement.

EDIT 415 - TOO MANY LINES OF DETAIL (>20)

Scenario: For the state of Texas, this edit will pull if a Blue Cross claim has more than 20 lines of detail.
To Correct: The edit will no longer pull once there are 20 lines or less of detail in the Detail Charges screen.

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EDIT 416 - CLAIM MUST BE BILLED THRU BHO

Scenario: For the state of Tennessee, this edit will pull if a Medicaid claim with one of the following diagnoses is billed through Tenncare (X**):
290.0-290.4, 290.8-290.13, 290.20-290.21, 290.40-290.43, 291-291.9, 292.0-292.1, 292.8-292.9, 292.11-292.12, 292.81-292.84, 292.89, 292.0-293.1, 293.8-293.9, 293.81-293.84, 293.89, 294.0-294.1, 294.8-294.11, 295.0-295.9, 296.0- 296.9, 296.80-296.82, 296.89-296.90, 296.99 297, 297.0-297.3, 297.8-297.9, 298, 298.0-298.4, 298.8-298.9, 299-299.91, 300, 300.00-300.02, 300.7-300.9, 300.09-300.16, 300.19-300.23, 300.29, 300.81-300.82, 300.89, 301.0-301.5, 301.6-301.9, 301.10-301.13, 301.20-301.22, 301.50-301.51, 301.81-301.84, 301.89, 302, 302.0-302.9, 302.50-302.53, 302.70-302.76, 302.79, 302.81-302.85, 302.89, 303.00-303.93, 304.0-304.9, 305, 305.0, 305.2-305.9, 306-306.99, 307-307.9, 307.20-307.23, 307.40-307.49, 307.50-307.54, 307.59, 307.80, 308, 308.1-308.4, 308.9, 309.0-309.4, 309.8, 309.9, 309.21-309.24, 309.28, 309.81-309.83, 309.89, 310.0-310.1, 310.9, 311, 312, 312.0-312.4, 312.8-312.9, 312.39, 312.81-312.82, 312.89, 312.30-312.35, 313.00-313.99, 314.0-314.2, 314.8-314.9, 314.00-314.01, 316.
To Correct: The edit will no longer pull once the claim is changed to bill through "BHO" instead of Tenncare (X**).

EDIT 417 - CLAIM SPANS MORE THAN ONE MONTH

Scenario: For the state of Alabama, this edit will pull if a Medicaid claim has service dates that are in two different months.
To Correct: The Medicaid claim may need to be split billed.

EDIT 418 - INPATIENT REHAB PPS

Scenario: This edit will pull for claims whose Insurance Company table has "Inpatient Rehab PPS?" answered "Y" and there is a 2 digit CMG Summary Code on the Detail Charges screen.

EDIT 420 - LINES OF DETAIL >MAX IN INS CO TABLE

Scenario: This edit will pull for Blue Cross claims (except APC claims) when "??" or "ZZ" summary code appears on the Detail Charges screen of the claim. When either of these pull to UB04, the claim has exceeded the number of detailed lines specified in the Max chg Lines on Claim field on page 4 of the Insurance Company table.
To Correct: Edit will no longer pull when the correct numbers of lines pull to the UB04.

EDIT 421 - ER OR OP STAY WITH ROOM CHARGES (REV CD 10X-21X)

Scenario: Edit will appear if there are room charges on an outpatient or ER account, stay type 2 or 3. The revenue codes for room charges would fall in the 10X to 21X range.
To Correct: Room charges should be taken off account through Review and Delete screen.

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EDIT 422 - MEDICARE OBSERVATION (GO244)

Scenario: Edit appears if a Medicare Outpatient claim has a revenue category 762 and one of the following diagnosis codes: 4110, 4111, 41181, 41189, 4130, 4131, 4139, 78605, 78650, 78651, 78652, 78659, 49301, 49302, 49311, 49312, 49321, 49322, 49391, 49392, 3918, 39891, 40201, 40211, 40291, 40401, 40403, 40411, 40413, 40491, 40493, 4280, 4281, 4289, 42820-42823, 42830-42833 or 42840-42843.
To Correct: Determine if the HCPC code GO244 may be used to bill the claim. This edit is a warning, it will continue printing as long as the claim meets the criteria.

EDIT 423 - NEED VALUE CODE A0 FOR AMBULANCE CLAIMS

Scenario: Edit will appear if a *BA or *CA claim for ambulance charges does not have Value Code A0 in front of the 5 digit zip code in the UB Coding screen. (I.e., A0XXXXX where A0= the Value Code and X = zip code.
To Correct: Value code and zip code (A0XXXXX) need to be on UB Coding screen.

EDIT 424 - REVENUE CODES 250 & 637 PRESENT

Scenario: This edit pulls for Medicare Outpatient claims that have revenue codes of 250 and 637.
To Correct: The revenue codes should be combined on the Detail Charges screen if the drug (637) that is administered is considered part of the procedure.

EDIT 426 - ACCIDENT OCCURANCE CODE – VAL CD 45 MISSING

Scenario: This edit pulls for New York Blue Cross claims when occurrence codes 01-06 & 11 appear in the UB Coding screen, but no "45" value code is present.
To Correct: Accident date and time should be loaded in the Stay tab on the Registration and ADT screen.

EDIT 427 - CLAIM GENERATION DATE >90 DAYS FOR X CLAIM – NO REASON CODE**

Scenario: This edit pulls if New York sites submit a claim to NY Medicaid 90 days after discharge. If so, they are required to supply a reason code on Form A or B.
To Correct: Reason code must be loaded in the Medigap # field in Policy Information.

EDIT 436 - MISSING TPL CODE

Scenario: This edit pulls if the claim has Medicaid as a secondary insurance to an insurance other than Medicare. A 6-digit TPL code is required.
To Correct: Verify that a TPL code is loaded. This pulls from Policy Information, Group Info field (before the /) for a UB04 and the same location for a 1500. The TPL is the "group name". If unavailable the billers should consult the manual with TPL codes provided by Medicaid.

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EDIT 441 - DIAGNOSIS CODES DOESN'T SUPPORT MEDICAL NECESSITY

Scenario: This edit will appear if the claim reflects one of the following blood count CPT codes: 85007, 85008, 85013, 85014, 85018, 85025, 85027 or 85048
and reflects only one of the following diagnosis codes which do not support Medical Necessity for a blood count on a Medicare outpatient. The diagnosis codes that do not support Medical Necessity are as follows: 07810-07819, 2100-2109, 2140, 2160-2169, 217, 2220-2229, 2240, 2300, 2320-2329, 2240, 2300, 2320-2329, 30000-30009, 3010-3019, 3020-3029, 3070, 30720-30723, 3073, 30780-89, 31200-3129, 3130-39, 31400-3149, 36330-36335, 36340-43, 36350-57, 36370-3639,
36600-3669, 3670-3679, 37100-3719, 37300-3739, 37500-3759, 37100-3719, 37300-3739, 37500-3759, 37621-3769, 37710-37716, 37721-37724, 38420-25, 38481-82, 83500-3859, 3870-79, 38800-3885, 38900-3899, 440-4401, 44381-4439, 4481, 4570, 470, 4710-19, 4780, 4784, 5200-5209,52100-5219, 52400-5249, 5250-5263, 5276-79,
5756, 6000-6009, 6030, 6038-39, 605, 6060-61, 6081, 6083, 6100-6109, 6111-16,
6119, 6162, 6180-6189, 6200-03, 6216-17, 6272-79, 6280-89, 67600-67694, 6910-18,
6920-29, 700, 7010-19, 7020-28, 7039, 7060-69, 70900-7094, 71500-71598, 71600-71699, 71800-71899, 7260 -72691, 72700-7279, 72810-72885, 7320-7329, 73300-73309, 734, 7350-7359, 73600-7369, 7370-7379, 7380-89, 7390-99, 8300-8399, 8400-8489, 9050-9099, 9100-9199, 9300-932, 9550-9579, V030-V069, V110-V119, V140-V148, V160, V163, V210-V219, V2501-V259, V260-V269, V400-V409, V410-V419, V430-V431, V440-V449, V450-V4589, V480-V489, V490-V499,V51, V520-V529, V5301-V5309, V531, V5331-V5339, V534-V539, V540-49, V550-59, V570-V579, V585, V5901-V599, V610-V619, V622-29, V652-53, V6540-49, V655, V658-59, V660-69, V673-74, V693, V7101-09, V720-22, V724-27, V729, V7610-19 and V762.
To Correct: Verify that the correct diagnosis is on the claim.

EDIT 442 - NCD Denied Diagnosis Codes

Scenario: This edit will appear if there is a CPT code that has a "denied" ICD-9-CM diagnosis code as the reason the test is being performed. This edit has been added to assist in compliance with the National Coverage Decisions. The list of CPT codes are 87086, 87088,87539, 86689, 86701, 86702, 86703, 87390, 87391, 87534, 87535, 87537, 87538, 85007, 85008, 85013, 85014, 85018, 85025, 85027, 85048, 85730, 85610, 82728, 83540, 83550, 84466, 82523, 82947, 82948, 82962, 82985, 83036, 84436, 84439, 84443, 84479, 80061, 82465, 83715, 83716, 83718, 83721, 84478, 80162, 82105, 82378, 84702, 86304, 86300, 86301, 84153, 82977, 80074 and 82270. The denied ICD-9 codes are 7980-7989, V161-V162, V1640, V1651-V1659, V166, V167, V168, V169, V170-V178, V180-V188, V190-V198, V200-V202, V280-V289, V500-V509, V532, V600-V609, V620, V621, V650, V651, V680-V689, V700-V709, V730-V7399, V700-V709, V730-V7399, V740-V749, V750-V759, V760, V763, V642-V769, V770-V779, V790-V789, V790-V799, V800-V803, V810-V816, V820-V829.
To Correct: Verify that the CPT code does not have a supporting diagnosis. If the patient has requested that this noncovered/denied service be billed to Medicare the GZ modifier must be added to the CPT prior to submission of the UB04.

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EDIT 443 - MISSING SUBSCRIBER DOB

Scenario: This edit pulls if EBS claims are lacking the subscriber date of Birth.
To Correct: Verify that subscriber DOB is loaded in policy information.

EDIT 444 - MISSING AUTHORIZATION PHY

Scenario: This edit flags all X** claims when the state code is "ME" in the physician 999999 table and there is no physician loaded in the Referring Data screen on the patient's account.
To Correct: Verify that referring physician is loaded on account.

EDIT 445 - MISSING REFERRING AUTH NUMBER

Scenario: This edit flags all X** claims when the state code is "ME" in the physician 999999 and there is a referring physician setup on the claim but no referring physician authorization number loaded in the Referring Physician table (Hospital Base Menu > Master Selection > Business Office tables > Maintenance Menu > Referring Physician).
To Correct: Verify that referring physician authorization number is loaded in Referring Physician table.

EDIT 446 - MISSING REFERRAL NUMBER

Scenario: This edit pulls if a referring physician is loaded on the claim for State code "LA" and no provider number is loaded.
To Correct: Verify that referring physician is loaded on the claim, if so make sure provider number is loaded. If not, one should be loaded.

EDIT 447 - REVENUE CODE 490 REQUIRES CHARGES BILLED UNDER ONE LINE

Scenario: This edit pulls when an O/P hospital claim includes an ICD-9 procedure in which the first two digits fall within the range of 01-86.
To correct: Verify that the ICD-9 procedure is correct. The claim must be built under one line using revenue code 490.

EDIT 448 - INCIDENTAL CHARGES BILLED ALONE

Scenario: This edit flags claims that only have incidental charges on them or one of the following revenue codes; 250, 251, 252, 253, 254, 255, 256, 271, 272 or 278.
To Correct: Verify charges are correct. Some charges may need to be placed on a separate claim. Incidental charges cannot be billed alone.

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EDIT 451 - REV CODE 360 HAS ZERO CHARGE

Scenario: This edit appears if Rev Code 360 is present on an account multiple times as well as a line(s) with $0.00 charge amount.
To Correct: Verify charges on account.

EDIT 452 - MISSING OCCURRENCE CODE 11 FOR ONSET OF ILLNESS

Scenario: This edit appears on all commercial claims that do not have an 11
Occurrence code for onset of illness.
To Correct: Verify onset of illness and load occurrence code 11 in UB Coding screen.

EDIT 453 - POSSIBLE 3rd PARTY LIAB – PROVIDE DOCUMENTATION

Scenario: This edit appears when any accident diagnosis code is present on an account. These accident diagnosis codes will begin with either an "E", "8" or "9".
To Correct: Supplemental documentation is needed for accident patients. Documentation will vary per financial class and each individual situation.

EDIT 454 - MISSING REFERRING PHYSICIAN

Scenario: This edit appears on Medicaid claims in the State of Louisiana
when a referring physician is not loaded on the patient's account. A referring physician is required on the claim.
To Correct: Lock on the patients account, select Referring Data and load the referring physician. The claim has to be regenned.

EDIT 456 - REPETITIVE AND NONREPETITIVE SERVICES EXIST

Scenario: This edit appears on Medicare claims when a non repetitive revenue code appears on a claim with a repetitive revenue code. A repetitive revenue code would consist of the following: 290-299, 333, 410-419, 420-429, 430-439, 440-449, 550-559, 820-859, 482, 943, 900-901 and 911-919.This only applies to claims that have a bill type of 13x.
To Correct: Verify the revenue codes. If repetitive and non repetitive revenue codes exist on the account they should be separated. This may be accomplished through the Separate Claims For fields on page 4 of the Insurance Company table.

EDIT 457 - NEED OCC CODE 74 - ADDITIONAL MEDICARE CLAIM

Scenario: This edit appears on Medicare claims when the dates of service for a repetitive service and non repetitive service are billed on the same day.
To Correct: Occurrence code 74 should be added to the recurring Medicare claim in the UB Coding screen. This will allow Medicare to identify that it is not duplicated billing.

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EDIT 459 - MISSING DEVICE CODE FOR CPT/HCPC 92995 OR 92996
C-Code: C1721

Scenario: This edit appears on MB* claims that have the APC Reimburse field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper.

EDIT 460 - MISSING DEVICE CODE FOR CPT/HCPC G0298 OR G0300
C-Code: C1721

Scenario: This edit appears on MB* claims that have the APC Reimburse field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 461 - MISSING DEVICE CODE FOR CPT/HCPC G0297 OR G0299
C-Code: C1722

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 462 - MISSING DEVICE CODE FOR CPT/HCPC 35458, 35459, 35460, 35470, 35471, 35472-35476, 92997-92998, 92282 OR 92984.
C-Code: C1725, C1885

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 463 - MISSING DEVICE CODE FOR CPT/HCPC 93600, 93602, 93603, 93609, 93610, 93612, 93615, 93616, 93618, 93623 OR 93631.
C-Code: C1730, C1731, C1732, C1733, C2629, C2630

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

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EDIT 464 - MISSING DEVICE CODE FOR CPT/HCPC 36557, 36558, 36570, 36571, 36581 36585 OR 36640
C-Code: C1751

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 465 - MISSING DEVICE CODE FOR CPT/HCPC 36557, 36558 or 36581
C-Code: C1750, C1752

Scenario: This edit appears on MB* claims that have the Insurance Company table, page 4, APC REIMBURSE? is set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 466 - MISSING DEVICE CODE FOR CPT/HCPC 61885, 63685, 64590 OR 61886
C-Code: C1767, C1820

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 467 - MISSING DEVICE CODE FOR CPT/HCPC 36260, 36563 OR 36583
C-Code: C1772, C1891

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 468 - MISSING DEVICE CODE FOR CPT/HCPC 33211, 33216 OR 33217
C-Code: C1779, C1898

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

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EDIT 469 - MISSING DEVICE CODE FOR CPT/HCPC 33212
C-Code: C1786, C2620

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 470 - MISSING DEVICE CODE FOR CPT/HCPC 36570, 36571 or 36585
C-Code: C1788

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 471 - MISSING DEVICE CODE FOR CPT/HCPC 43256, 44370, 44379, 44383, 44397 45327, 45345 OR 45387
C-Code: C1874, C1875, C1876, C1877

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 472 - MISSING DEVICE CODE FOR CPT/HCPC G0297, G0298, G0299 OR G0300
C-Code: C1882

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 473 - MISSING DEVICE CODE FOR CPT/HCPC 61626
C-Code: C1887, C2628

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

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EDIT 474 - MISSING DEVICE CODE FOR CPT/HCPC 93600, 93602, 93603, 93610, 93612, 93615, 93616, 93618, 93623 OR 93631 C-Code: C1766, C1892, C1893, C1894

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 476 - MISSING DEVICE CODE FOR CPT/HCPC 33224 OR 33225
C-Code: C1900

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 477 - MISSING DEVICE CODE FOR CPT/HCPC 43256, 44370, 44379, 44383, 44397 45327 45345 or 45387
C-Code: C2617

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 478 - MISSING DEVICE CODE FOR CPT/HCPC 55873
C-Code: C2618

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

EDIT 479 - MISSING DEVICE CODE FOR CPT/HCPC 43256, 44370, 44379, 44383, 44397, 45327, 45345, 45387, 36260, 36563 OR 36583
C-Code: C2625

Scenario: This edit appears on MB* claims that have the APC Reimbursement field on page 4 of the Insurance Company table set to Yes. If the CPT/HCPC above appears on the Detail Charges screen the corresponding C-Code also needs to be on the Detail Charges screen.
To Correct: Verify that C-Code is loaded in the Item Master or DRG Grouper screen.

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Edit 487 - REVENUE CODE 0343 NEEDS A VALID RADIOLOGY HCPC

Scenario: The above edit appears if a claim has a Bill Type of 13X or 83X and a Revenue Code of 343.The claim must have one of the CPT codes in the Item Master listed in Appendix A (attached).
To Correct: Verify Bill Type is correct. If not, change Bill Type in the claim's Detail Charges screen. If Bill Type is correct, verify account has items with the above Revenue Codes and the items have valid CPT codes in the Item Master. If the items are missing CPT codes, load the CPT code in the Item Master and regenerate the Claim.

Edit 488 - CLAIM REQUIRES MODIFIER 25

Scenario: The above edit appears anytime a Medicare patient (M**) has a revenue code of 450 and CPT of 99281-99285, without a modifier of 25, and any other 450 revenue code is present.
To Correct: Verify the insurance is correct. If the account has a revenue code of 450 with a CPT of 99281-99285 and any other lines of detail with a revenue code of 450 and CPT of 99281-99285, the CPT must have a modifier of 25. The modifier may be added in the Detail Charges screen.

EDIT 490 - NEW YORK BLUE CROSS CLAIM NEEDS BIRTHWEIGHT

Scenario: The above edit appears if financial class B** has state code of NY in the Insurance Company table and the claim does not show the birth weight for a patient less than 29 days old with a bill type of 11X.
To Correct: Verify the insurance and date of birth for the patient. If this is correct, add the weight in the patient's account in the Clinical tab on the Registration and ADT screen.

EDIT 491 - CPT/HCPC CODES THAT SUPPORT MEDICAL NECESSITY

Scenario: The above edit appears for M**claims if CPT/HCPC codes J0882 or J0886 are present in the Detail Charges screen, and ICD9s 28521 and 5856 are not loaded in the Grouper screen (pulling to Stay Information screen).
To Correct: Verify the Insurance company. If CPT/HCPC codes J0882 or J0886 are pulling to the Detail Charges screen, verify if ICD9 28521 and 5856 should be coded on the Grouper screen. The claim will need to be regenerated if any codes are changed.

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EDIT 493 - PREAUTHORIZATION REQUIRED FOR RADIOLOGY PROCEDURES

Scenario: The above edit appears for BB* claims with IA as the state code on page 1 of the Insurance Company table. A pre authorization number must be entered in the Policy Information screen or in the Guarantor/Ins tab on the Registration and ADT screen for accounts with non-emergency radiology procedures.
To Correct: Verify the insurance company code. If the account has one of the following CPT codes, a pre certification number must be entered in the Policy Information screen. CPT's: 74150, 74160, 74170, 71250, 71260, 71270, 73200-73202, 73700-7302, 70450, 70460, 70470, 70480-70482, 70486-70488, 70490-70492, 72192-72194, 72125-72133, 74175, 75635, 71275, 73206, 70496, 70498, 72191, 74181-74186, 76400, 76093, 76094, 71550-71552, 75552-75556, 73218-73223, 73718-73723, 70336, 70540, 70542, 70543, 70551-70553, 72195-72197, 72141, 72142, 72156, 72146, 72147, 72157, 72148, 72149, 72158, 74185, 71555, 73225, 73725, 70544-70549, 72198, 72159, 76390, 78460, 78461, 78464, 78465, 78466, 78468, 78469, 78472, 78473, 78481, 78483, 78494, 78608, 78609, 78491, 78492, 78811-78816

EDIT 494 - ICD9 NEEDED FOR ANEMIA AND INDICATION

Scenario: The above edit appears for M** claims with CPT/HCPC codes J0885 or J0881 in Detail Charges screen (loaded on item or in the MR grouper screen), but do not have an ICD-9 code from the following two list. Each claim needs at least one from each category.
Each claim must contain an ICD-9 from the following anemia list:
2850, 28521, 28522, 28529.
Each claim must also contain an ICD-9 code from the appropriate indication as follows:
1400-20891, 2300-2399, 40311, 40391, 40413, 40491, 40493, 5853, 5854, 5855, E9317, V078, V5811.
To Correct: Verify the Insurance. If the account has a CPT/HCPC code of J0885 or J0881, it must have one of the following ICD9 codes from the anemia list: 2850, 28521, 28522, 28529 and also one of the following ICD9 codes from the appropriate indication list: 1400-20891, 2300-2399, 40311, 40391, 40413, 40491, 40493, 5853, 5854, 5855, E9317, V078, V5811. The claim will need to be regenerated to pull any additional codes that have been added.

EDIT 496 - HALTER MONITOR NEEDS DIAGNOSIS CODE

Scenario: The above edit appears if a claim is M**, has one of the following CPT/HCPC codes on the detail charges screen: 93224 93225 93226 93227 93230 93231 93232 93233 or 93235 and does not have an appropriate principle diagnosis.
To Correct: Verify the CPT/HCPC is correct. If correct add a principle diagnosis code of 41000-41092, 4110-4118, 41100-41189, 412, 4130, 4131, 4139, 4148, 4240, 4241, 4254, 4260, 42610, 42612, 42613, 4262, 4263, 4264, 42651, 42652, 42653, 4266, 4267, 42681, 42682, 42689, 4269, 4270, 4271, 4272, 42731, 42732, 42742, 42760, 42761, 42769, 42781, 42789, 4279, 4280-4289, 4358, 4359, 78002, 7802, 7804, 7850, 7851, 78602, 78609, 78650, 78651, 78659, 99601, V4500, V4501, V5863, V5864, V5865, V5869, V5883, or V6751 on page 1 of the MR Grouper screen.

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EDIT 497 - VACCINE CHARGE ON INPATIENT

Scenario: This edit will appear if the account is an Inpatient, with a 771 revenue code present and the Type of Bill does not equal 12X .
To Correct: Check the bill type on the account. If incorrect, change the bill type on the Detail Charges screen.

EDIT 499 - BLOOD PRODUCT CHARGE BUT NO BLOOD ADMINISTRATION CHARGE

Scenario: This edit will appear if there is a blood product charge with a 038X
or 0390 revenue code, but no 0391 revenue code is present.
To Correct : Verify charges and revenue codes on the account. If a charge needs to be added, contact data processing.

EDIT 500 - DUPLICATE BLOOD ADMINISTRATION CHARGES ON THE SAME DAY

Scenario: This edit will appear if CPT Code range 36430 through 36460 is duplicated on the same day.
To Correct: Verify charges and CPT codes on the account. If a charge needs to be added or credited on the account, contact data processing.

Edits 501-507

EDIT 501 - Need CPT PANEL CODE 80050

Locator: 44 - HCPCS/Rates/HIPPS Code
Scenario: The above edit appears if a claim has a F/C of XB*, state code of MO (Insurance Company table, p1) and CPT codes 84443, 85025 and 80053 appear on the claim with the same service dates. The edit will also appear if a claim has a F/C of XB*, state code of MO (Insurance Company table, p1) and CPT codes 80053, 84443 and 85027 appear on the claim with the same service dates.
To Correct: Claims with the CPT codes listed above with the same service dates need to bill under CPT code 80050.

EDIT 503 - CPT REQUIRES NDC CPT#

Scenario: The above edit appears if a claim has a F/C of X**, Bill Type 13x or 85X, a Revenue Code of 636, and there is not a NDC number attached to the item.
To Correct: An NDC number will need to be entered in the item.

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EDIT 504 - CONDITION CODE AN REQUIRED

Scenario: This edit is only for Medicaid of Ohio. The above edit appears if any of the following codes are NOT on the account and Condition Code "AN" is NOT on the account.
ICD-9:
765, 8029, 8019, 8026, 8102, 8103, 5123, 5124, 5421, 8051, 8108, 3950, 3929, 3601, 8021, 8151, 8154, 6021, 6029, 683, 684, 6851, 6859,
CPT/HCPC:
21010, 21050, 21060, 21070, 21240-21243, 29800, 29804, 29870, 29871, 29874-29877, 29879-29889, 22840, 63075, 63076, 47562-47564, 49320-49323, 49329, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22842, 22843, 22844, 22851, 63030, 63035, 63042, 63044, 63047, 35470, 35476, 33619, 34520, 35516, 35518, 35521, 35533, 35551, 35556, 35558, 35566, 35571, 35583, 35585, 35587, 35616, 35621, 35623, 35650, 35654, 35656, 35661, 35666, 35671, 92982, 92984, 92995, 92996, 29826, 29805, 29819, 27130, 27132, 27437, 27438, 27445, 27446, 27447, 52601, 52612, 52614, 52620, 52630, 52647, 52648, 51925, 58150, 58152,
58180, 58200, 58260, 58262, 58263, 58267, 58270, 58275, 58280, 58550, 58552,
58951.
To Correct: This edit will no longer appear if one of the above codes are added to the account or if Condition Code "AN" is added to the UB Coding screen. The claim will need to be regenerated if any changes are made.

EDIT 505 - MISSING OR INVALID ATTENDING PHYSICIAN'S NPI

Scenario: The above edit appears if a claim has an Attending Physician loaded in the Stay Information screen with the NPI field blank or is not 10 characters in the Physician table.
To Correct: Verify Physician is correct. Verify the NPI of the attending physician and load in the Business Office Tables (Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Physician). There is no need to regenerate the claim.

EDIT 506 - MISSING OR INVALID SURGEON'S NPI

Scenario: The above edit appears if a claim has a Surgeon loaded in the Stay Information screen with the NPI field blank or is not 10 characters in the Physician table.
To Correct: Verify Physician is correct. Verify the NPI of the surgeon and load in the Business Office Tables (Hospital Base Menu > Master Selection > Business Office Tables > Maintenance Menu > Physician). There is no need to regenerate the claim.

EDIT 507 - BLUE CROSS OF NORTH DAKOTA REQUIRES 86X BILLTYPE

Scenario: The above edit appears if a claim has a F/C of B**, the Insurance Company table has a state code of ND and the UB Bill Type is not 86X.
To Correct: Verify the UB Bill Type in the Detail Charges screen. There is no need to regenerate the claim if the Bill Type is changed.

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Appendix A

Valid CPT for Edit Number 177

J0290
J0340
J0380
J0510
J0530
J0610
J0630
J0635
J0690
J0694
J0695
J0696
J0697
J0698
J0700
J0710
J0743
J0745
J0780
J0895
J0970
J1050
J1070
J1080
J1160
J1165
J1170
J1200
J1240
J1380
J1390
J1410
J1580
J1630
J1631
J1720
J1760
J1780
J1790
J1840
J1885
J1890
J1940
J2060
J2175
J2270
J2320

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J2321
J2322
J2540
J2550
J2560
J2680
J2700
J2720
J2765
J2920
J2930
J2970
J3010
J3070
J3120
J3130
J3230
J3250
J3260
J3280
J3301
J3364
J3365
J3370
J3410
J3420
J3430
Z9930
Z9935
Z9939
Z9941
Z9943
Z9944
Z9945
Z9949
Z9955
Z9959
Z9963
Z9969
Z9970
Z9971
Z9972
Z9974
Z9975
Z9976
Z9977
Z9996
Z9997
Z9998
90724
90731

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90732

Valid CPT for Edit Number 487

70000-79999
A4641
A4642
A9500
A9502
A9503
A9505
A9507
A9508
A9510
A9511
A9512
A9513
A9514
A9515
A9516
A9519
A9520
A9521
A9524
A9526
A9528
A9529
A9531
A9600
C1079
C1080
C1081
C1082
C1091
C1092
C1093
C1122
C1200
C1201
C1775
C9013
C9102
C9103
C9400
C9401
C9403
C9404
Q3000
Q3002
Q3003

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Q3004
Q3005
Q3006
Q3007
Q3008
Q3009
Q3010
Q3011
Q3012

Appendix B

Edit 297 appears if a claim has a Diagnosis Code listed in this section as the Principal Diagnosis.

Principal Diagnosis Codes; Manifestation Code Edit Number 297

3207
3210
3211
3212
3213
3214
3218
3230
3231
3232
3234
3236
3237
3302
3303
3317
3344
3362
3363
3371
3571
3572
3573
3574
3581
3595
3596
36201
36202
36271
36272
36411
36541

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36542
36543
36544
36641
36642
36643
36644
37044
37105
37215
37231
37233
3734
3735
3736
37451
37613
37621
37622
38013
38015
38202
4200
4211
4220
42491
4257
4258
44381
45620
45621
4841
4843
4845
4846
4847
4848
5161
5171
5172
5178
5670
5731
5732
58081
58181
58281
58381
59081
5954
59801

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6014
60491
60881
61611
61651
6281
7130
7131
7132
7133
7134
7135
7136
7137
7138
72081
72701
7311
7318
73740
73741
73742
73743
7740
77431
7745

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6.8 1500 Insurance Claim Edits

Within the billing procedures are 1500 claim edits. These edits help the Business Office to determine what additional information should be included on the insurance claims prior to billing.

EDIT 1 - PATIENT NAME IS BLANK

Locator: 2 - Patient's Name
Scenario: The patient's name is missing from the Patient tab on the Registration and ADT screen.
To Correct: Load the patient name in the Patient tab on the Registration and ADT screen.

EDIT 2 - NAME 'BABY' IS INVALID

Locator: 2 - Patient's Name
Scenario: The patient's name is "BABY"
To Correct: Change the patient name from "BABY" to the appropriate name.

EDIT 3 - INVALID PATIENT SEX

Locator: 3 - Patient's Birth Date/Sex
Scenario: The patient's sex is not loaded in the Patient tab on the Registration and ADT screen.
To Correct: Load this information in the Patient tab on the Registration and ADT screen.

EDIT 4 - PATIENT BIRTHDAY INVALID

Locator: 3 - Patient's Birth Date/Sex
Scenario: The patient's birth date is missing.
To Correct: Load the information in the Patient tab on the Registration and ADT screen.

EDIT 5 - PATIENT ADDRESS IS BLANK

Locator: 5 - Address/Phone
Scenario: The patient's address is missing.
To Correct: Load the information in the Patient tab on the Registration and ADT screen.

EDIT 6 - PATIENT ADDRESS1 CONTAINS SPECIAL CHARACTERS

Locator: 5 - Address/Phone
Scenario: Unusual characters appear in address field.
To Correct: Load the correct information in the Patient tab on the Registration and ADT screen.

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EDIT 7 - PATIENT ADDRESS2 CONTAINS SPECIAL CHARACTERS

Locator: 5 - Address/Phone
Scenario: Unusual characters appear in address field.
To Correct: Load the correct information in the Patient tab on the Registration and ADT screen.

EDIT 8 - PATIENT CITY IS NOT ALPHABETIC

Locator: 5 - Address/Phone
Scenario: For the state of Texas, this edit occurs if non-alpha characters appear in the city field.
To Correct: Load the correct city in the Patient tab on the Registration and ADT screen.

EDIT 9 - PATIENT STATE IS NOT ALPHABETIC

Locator: 5 - Address/Phone
Scenario: For the state of Texas, this edit occurs if non-alpha characters appear in the state field.
To Correct: Load the correct state in the Patient tab on the Registration and ADT screen.

EDIT 10 - PATIENT ZIP CODE IS MISSING

Locator: 5 - Address/Phone
Scenario: The patient Zip code is missing.
To Correct: Load the information in the Patient tab on the Registration and ADT screen.

EDIT 11 - ADMISSION DATE IS INVALID

Locator: 18 - Hospitalization Dates Related to Current Services
Scenario: Admission date is missing.
To Correct: Load the correct Admission Date in the Stay Information screen.

EDIT 12 - PATIENT AGE > 65 & THIS CLAIM IS NOT MEDICARE

Scenario: Patient is over the age of 65, and does not have the Financial Class of Medicare. This edit will pull for Blue Cross claims in the state of Texas that meet this scenario.
To Correct: If the Patient does have Medicare, set up a Medicare claim.

EDIT 13 - BLUE CROSS WITHOUT BANK PLAN NUMBER

Scenario: If the Financial class is Blue Cross and the Provider state is North Carolina, and the Bank Plan Number is missing, then this edit will appear.
To Correct: Go to the Bank Plan field on page 2 of the Insurance Company table and load the information.

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EDIT 14 - PATIENT AND SUBSCRIBER NAME MUST BE DIFFERENT

Locators: 2 - Patient's Name and 4 - Insured's Name
Scenario: If relation code in Policy Information screen is a number other than 1, then patient name and subscriber name must be different.
To Correct: Either change the relation code, or correct the Subscriber in the Guarantor/Ins tab on the Registration and ADT screen.

EDIT 15 - PATIENT AND SUBSCRIBER NAME MUST MATCH

Locators: 2 - Patient's Name and 4 - Insured's Name
Scenario: If relation code in Registration Policy Information screen of registration is 1, then patient name and subscriber name must be the same.
To Correct: Either change the relation code, or correct the Subscriber in the Guarantor/Ins tab on the Registration and ADT screen.

EDIT 16 - CONTRACT/CERTIFICATE NUMBER BLANK

Locator: 11 - Insured's Policy Group or FECA Number
Scenario: The contract and group number is blank in the patient's Insurance Policy Information screen.
To Correct: Load the information in the Guarantor/Ins tab on the Registration and ADT screen.

EDIT 17 - CONTRACT NUMBER IS BLANK OR ALL ZEROS

Locator: 1a - Insured's I.D. Number
Scenario: Contract Number field is blank.
To Correct: Load the Contract Number in the Policy information screen.

EDIT 18 - FIRST CHARACTER OF CONTRACT NUMBER NOT NUMERIC

Locator: 1a - Insured's I.D. Number
Scenario: For Medicare claims in the state of New Hampshire, if the Contract number begins with a character other than numeric, this edit will appear.
To Correct: Enter the correct number in the Policy information screen.

EDIT 19 - MEDICARE CERTIFICATE NOT NUMERIC

Locator: 1a - Insured's I.D. Number
Scenario: This edit will pull if the numeric portion of the certificate number is not numeric.
To Correct: Correct the number in the Policy Information screen.
Example: Certificate number would be XXA422058081A.

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EDIT 20 - FIRST 3 DIGITS OF MEDICARE CERTIFICATE INVALID

Locator: 1a - Insured's I.D. Number
Scenario: This edit will pull if the first three characters are not XXA.
To Correct: Correct the number in the Policy Information screen.
Example: Certificate number would be XXA422058081A.

EDIT 21 - MEDICARE SUFFIX IS MISSING OR INVALID

Locator: 1a - Insured's I.D. Number
Scenario: This edit pulls if the fourteenth character of the Certificate number is not A, B, C, D, E, G or H.
To Correct: Correct the number in the Policy Information screen.
Example: Certificate number would be XXA422058081A.

EDIT 22 - MEDICARE SUFFIX OF H MUST BE FOLLOWED BY A, B OR C

Locator: 1a - Insured's I.D. Number
Scenario: This edit checks the fourteenth character of the Certificate number. When a suffix of "H" follows the certificate number, the system also checks to ensure another suffix code of A, B or C follows to further explain the plan the patient has.
To Correct: Correct the number in the Policy Information screen.

EDIT 23 - CONTRACT NUMBER HAS EMBEDDED SPACES/SPECIAL CHARACTERS

Locator: 1a - Insured's I.D. Number
Scenario: This edit checks the Policy Information screen to see if any character other then alpha or numeric exist.
To Correct: Remove spaces and/or punctuation from the contract number in the Policy Information screen from this field.

EDIT 24 - SUBSCRIBER IS BLANK

Locator: 4 - Insured's Name
Scenario: Subscribers name is missing from the Policy Information screen.
To Correct: Enter the guarantor name in the Policy Information screen.

EDIT 25 - SUBSCRIBER ADDRESS OR CITY IS BLANK

Locator: 7 - Insured's Address
Scenario: Subscribers address is missing from the Policy Information screen.
To Correct: Enter the Guarantors address in the Policy Information screen.

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EDIT 26 - INSURED ADDRESS1 CONTAINS SPECIAL CHARACTERS

Locator: 7 - Insured's Address
Scenario: Non-alpha and/or non-numeric characters appear in the Subscribers address.
To Correct: Correct the address and remove any punctuation in the Policy Information screen.

EDIT 27 - INSURED ADDRESS2 CONTAINS SPECIAL CHARACTERS

Locator: 7 - Insured's Address
Scenario: Non-alpha and/or non-numeric characters appear in the Subscribers address.
To Correct: Correct the address and remove any punctuation in the Policy Information screens.

EDIT 28 - SUBSCRIBER STATE BLANK

Locator: 7 - Insured's Address
Scenario: The state is not loaded in the Policy Information screen for the address.
To Correct: Enter the Guarantors address state in the Policy Information screen.

EDIT 29 - SUBSCRIBER ZIP CODE MISSING

Locator: 7 - Insured's Address
Scenario: The Zip Code is not loaded in the Policy Information screen.
To Correct: Enter the Guarantors Zip Code in the Policy Information screen.

EDIT 30 - PRE-CERT NUMBER IS BLANK

Locator: 23 - Prior Authorization Number
Scenario: The pre certification number is missing from the Policy Information screen.
To Correct: Enter the precert number in the Policy Information screen.

EDIT 31 - INCORRECT CLAIM TYPE – NOT OUTPATIENT

Scenario: This edit will appear after a claim is generated then the form code is changed in the Insurance Company table.
To Correct: Check the patient type and also verify the form code in the Insurance Company table.

EDIT 32 - DETAIL CHARGE DATE INVALID

Locator: 24A - Date(s) of service
Scenario: For the state of Arkansas, this edit pulls if the Service date is missing.
To Correct: Verify dates of charges via patient account detail.

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EDIT 33 - DETAIL CHARGE DATE INVALID

Locator: 24A - Date(s) of service
Scenario: This will occur if the charges on the patient account are not within the admit and discharge dates.
To Correct: Verify dates of charges via patient account detail.

EDIT 34 - OUTPATIENT CHARGE IS LESS THAN 0

Locator: 24F - $ Charges
Scenario: No charges appear on the patient account detail.
To Correct: Verify charges have been entered and posted to the patient account detail.

EDIT 35 - MORE THAN 5 DETAIL CHARGE ITEMS

Scenario: For Medicaid claims in the state of Georgia, this edit will pull if the patient claim has more then five lines of detail.
To Correct: Manually create another claim for this patient account.

EDIT 36 - TOO MANY SUMMARY CHARGE CODES

Scenario: When the detail has exceeded the number of lines allowed, it displays a Charge Summary code of "??"
To Correct: Increase the Max chg Lines on Claim on page 4 of the Insurance Company table.

EDIT 37 - CLAIM CONTAINS MORE THAN 6 DETAIL LINES

Scenario: For "MP" and "BP" claims in the state of Kansas, this edit pulls if more then 6 lines of detail appear on the claim.
To Correct: Manually create another claim for this patient account.

EDIT 38 - CLAIM CONTAINS MORE THAN 6 DETAIL LINES

Scenario: For "BP" claims in the state of Vermont, this edit pulls if more then 6 lines of detail appear on the claim.
To Correct: Manually create another claim for this patient account.

EDIT 39 - MULTIPLE REV CODE 960-969 FOR SAME STAY

Scenario: For "MP" claims in the state of South Carolina, this edit pulls if there is more then one charge for Anesthesia.
To Correct: This edit is strictly a flag to warn of this occurrence. In this instance, verify the validity of multiple revenues codes for anesthesia.

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EDIT 40 - CLAIM CONTAINS MORE THAN 12 DETAIL LINES

Scenario: For "XP" claims in the state of Mississippi, the above edit appears if the claim has more than 12 lines of detail on the account.
To Correct: Create another claim for this patient account.

EDIT 41 - CRNA CHARGES MUST NOT BE BILLED ON PAPER CLAIMS

Scenario: For the state of Alabama, the system looks for CPT codes between 00100 and 01999.
To Correct: If the above CPT codes appear on the claim, it cannot be billed electronically. A paper 1500 must be submitted.

EDIT 42 - BLUE CROSS ANESTHESIA CLAIM MINUTES MUST BE ENTERED

Scenario: For Blue Cross claims in the state of Idaho, if Revenue codes 963, 964 or 370 appear on the claim, this edit will appear, regardless of whether minutes are loaded or not. This is strictly a flag for the Insurance Biller.
To Correct: Verify the Anesthesia minutes are on the patient account.

EDIT 43 - REPEAT PROCEDURE BY SAME PHYSICIAN

Scenario: This edit will pull if there is a duplicate procedure listed for the same physician.
To Correct: Verify the Medical Records coding for this patient account.

EDIT 44 - REPEAT PROCEDURE BE ANOTHER PHYSICIAN

Scenario: This edit will pull if there is a duplicate procedure listed for another physician.
To Correct: Verify the Medical Records coding for this patient.

EDIT 45 - MISSING CPT CODE

Scenario: This edit will pull if there is not a CPT code on the claim.
To Correct: All charges on a 1500 should have a CPT code. Verify the coding is appropriate as well as charges.

EDIT 46 - TOTAL CHARGES EXCEED $99,999.99

Scenario: This edit will pull if the total charges exceed $99,999.99.
To Correct: Verify the charges to appear on the claim. This is done via the Detail Charges screen. If necessary, manually create another claim.

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EDIT 47 - NO DIAGNOSIS CODE PRESENT

Locator: 21 - Diagnosis Code
Scenario: This edit will pull if the Diagnosis Code is missing.
To Correct: Verify the information is loaded in the Medical Records coding screen.

EDIT 48 - CLAIM CONTAINS AN E-CODE

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: This edit will pull for Medicare claims for the state of Kansas if an E-CODE is listed as a diagnosis code.
To Correct: Confirm the diagnosis in the Medical Records Grouper screens.

EDIT 49 - E-CODE DIAGNOSIS INVALID

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: For Blue Cross claims, this edit will pull if an E-Code is listed as a diagnosis.
To Correct: Medical Records will have to verify the coding for this claim.

EDIT 50 - ADMITTING DIAGNOSIS BLANK

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: For Medicare claims in the states of Arkansas, Louisiana, New Hampshire and Vermont, this edit will pull if the Admitting diagnosis is missing.
To Correct: Medical Records will need to correct this or the information may be entered into the Stay Information screen.

EDIT 51 - SURGERY DATE MISSING

Scenario: This edit will pull if the Surgery date is missing.
To Correct: Enter the procedure date in the first column on page 2 of the Medical Records screen.

EDIT 52 - SURGERY PROCEDURE CODE MISSING

Scenario: If surgical procedure code is missing the system will flag for this error.
To Correct: Enter the procedure codes in the second column on page 2 of the Medical Records Grouper screen.

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EDIT 53 - NO VALID DIAGNOSIS CODE PRESENT FOR EKG

Scenario: If an account has a CPT of 93010 and does not have one of the following Diagnosis codes or fall within the given ranges, then this edit will appear.
The diagnosis codes are as follows:

V7281	4140 – 4149	7804
0930 – 0934	4150 – 4151	7807
1640 – 1649	4160 – 4169	7820
2127	4170 – 4179	7823
3062	4200 – 42099	7825
391	4210 – 4219	7850 - 7859
393	4220 – 42299	78600 - 78609
3940 – 3949	4230 – 4239	778650 - 8659
3950 – 3959	4240 – 42499	7870
3960 – 3969	4250 – 4259	7871
3970 – 3979	4260 - 4269	7890
3980 – 39899	270 – 4279	7891
4010 – 4019	4280 – 4289	7932
40291 – 40300	4290 – 4299	79430 - 79431
40300 – 40391	4410 – 4419	99600 - 99609
4040 – 4049	4440 - 44489	7991
40500 – 40599	4460 - 4467	V450
41000 – 41092	4580 - 4589	V472
4110 – 41189	7800	V717
412	7802	
4130 – 4139	7803	

To Correct: Load the correct diagnosis on the patient Medical Records Grouper screen.

EDIT 54 - ACCIDENT HOUR BUT NO ACCIDENT DIAGNOSIS

Scenario: Accident hour is loaded in the Stay tab on the Registration and ADT screen., but no Accident diagnosis is present (except for Occurrence Code 11 – ILLNESS).
To Correct: Verify the Medical Records coding to ensure this was truly an accident.

EDIT 55 - ACCIDENT DATE BUT NO ACCIDENT DIAGNOSIS

Scenario: Accident date is loaded in the Stay tab on the Registration and ADT screen., but no Accident diagnosis is present (except for Occurrence Code 11 – ILLNESS).
To Correct: Verify the Medical Records coding to ensure this was truly an accident.

EDIT 56 - ACCIDENT DIAGNOSIS BUT NO ACCIDENT TIME

Scenario: There is an accident diagnosis but there is not an accident time.
To Correct: Verify this was the result of an accident; load the accident time in the Stay Information screen.

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EDIT 57 - ACCIDENT DIAGNOSIS BUT NO ACCIDENT DATE

Scenario: There is an accident diagnosis but there is not an accident time.
To Correct: Verify this was the result of an accident; load the accident date in the Stay Information screen.

EDIT 58 - EXPIRED DIAGNOSIS CODE

Locator: 21 - Diagnosis or Nature of Illness or Injury
Scenario: This edit pulls if an expired diagnosis code appears on a patient claim. The system reads the expiration date loaded in the Diagnosis table.
To Correct: Verify the diagnosis code is valid, and expiration date on the Diagnosis Code table.

EDIT 59 - MISSING TIMES OF ANESTHESIA

Scenario: For the state of Arizona and for Medicaid claims in the state of Arkansas, this edit pulls if a CPT for Anesthesia (00100-01999) appears on the patient claim and no value code of "BA". For the state of Iowa, this edit pulls for Blue Cross claims if a CPT for Anesthesia appears on the patient claim and no value code of "AT".
To Correct: Need to verify the Anesthesia times are on the patient account.

EDIT 60 - PHYSICIAN PROVIDER NUMBER MISSING

Locator: 33 - Billing Provider Info & Ph #
Scenario: For the state of Arizona, this edit pulls if the physician provider number is missing from the physician table.
To Correct: Physician table or Insurance Company table.

EDIT 61 - POLICY INFORMATION – FIELD 25 NO 1, 3 OR 4

Scenario: For Medicaid claims for the state of Alabama, this edit pulls if the Subscriber's DOB in the Policy Information screen is blank.
To Correct: The Subscriber's DOB in the Policy Information screen should have a 1, 3 or 4.

EDIT 62 - ATTENDING PHYSICIAN NAME MISSING

Scenario: This edit pulls if the Attending Physician is not entered.
To Correct: In the Medical Records screen the Attending Physician needs to be loaded.

EDIT 63 - PHYSICIAN NUMBER 888888 - NOT ON FILE

Scenario: This edit will pull if this physician number pulls to the claim. This Physician is sometimes set up for additional information to pull to the electronic file for billing.
To Correct: Remove this physician from the patient Medical Records screen.

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EDIT 64 - SURGEON NUMBER MISSING OR INVALID

Scenario: Surgeon is not listed in Medical Records coding for the patient.
To Correct: Enter the Surgeon for the procedure associated with this claim.

EDIT 65 - SURGEON NUMBER, PRINCIPLE PROCEDURE CODE OR PROCEDURE DATE MISSING

Scenario: A surgeon is listed, but no surgical procedure appears on the Medical Records Coding screen.
To Correct: Verify the Medical Records Coding for the patient account, and add the necessary codes.

EDIT 66 - CLAIM TOTAL IS NOT GREATER THAN ZERO

Locator: 28 - Total Charge
Scenario: This edit pulls if the total charges on the claim are not greater than zero dollars.
To Correct: Verify the account charges via Account Detail.

EDIT 67 - EXPECTED PAY IS NOT GREATER THAN ZERO

Locator: 30 - Balance Due
Scenario: This edit pulls if the expected pay on the claim is not greater than zero.
To Correct: Verify the charges on the Account Detail screen.

EDIT 68 - BENEFIT DESCRIPTION MUST BE COMPLETED!!

Scenario: For Medicare claims for the states of Massachusetts, Maine, New Hampshire or Vermont, this edit will appear if the Benefit Description is not completed.
To Correct: Go to the Policy Information screen and populate the field with then necessary information.

EDIT 69 - **NO PRIOR PAYMENT INFO ON CLAIM**

Scenario: For the state of Michigan, if a Medicaid secondary claim does not have prior payment information in the Prior Payment and Prior Payment Code fields in the Detail Benefits screen, this edit will pull.
To Correct: Enter prior payment information in both fields in the Detail Benefits screen. This information will pull to locators 24K and 24J, respectively, of the 1500.

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EDIT 70 - CLAIM SPANS MORE THAN ONE CALENDAR MONTH

Scenario: For the state of Alabama, this edit will pull if a Medicaid claim has service dates that are in two different months.
To Correct: The Medicaid claim may need to be split billed.

EDIT 71 - INVALID PRINCIPAL DIAGNOSIS; E-CODE

Scenario: This edit will pull for Medicaid claims in the state of Louisiana if the Principal Diagnosis Code begins with an "E".
To Correct: If the Principal Diagnosis is an E-code, have Medical Records correct in the Grouper screen. The claim will then need to be regenerated.

EDIT 75 - CPT NOT SUPPORTED BY DIAGNOSIS

Locator: 24D - Procedures, Services, or Supplies
Scenario: This edit will appear if there is a CPT code that does not have a supporting diagnosis loaded in the Medical Necessity table. This edit was added to help with Medical Necessity.
To Correct: Verify that the CPT code does not have a supporting diagnosis and correct. Load the diagnosis in the Medical Necessity table or remove the CPT from the table and the Detail Charges screen. Do not regenerate the claim.

EDIT 78 - MISSING AUTHORIZATION PHY

Locator: 17 - Referring Physician
Scenario: This edit flags all X** claims when the state code is "ME" in the physician table 999999 and there is no physician loaded in the Referring Data screen on the patient's account.
To Correct: Verify that referring physician is loaded on the account.

EDIT 79 - MISSING REFERRING AUTH NUMBER

Locator: 17a - ID Number of Referring Physician
Scenario: This edit flags all X** claims when the state code is "ME" in the physician table 999999 and there is a referring physician setup on the claim but no referring physician authorization loaded in the referring physician table.
To Correct: Verify that referring physician authorization number is loaded in
Referring Physician table.

EDIT 81 - POSSIBLE 3rd PARTY LIAB – PROVIDE DOCUMENTATION

Scenario: This edit appears when any accident diagnosis code is present on an account. These accident diagnosis codes will begin with either an "E", "8", or "9".
To Correct: Supplemental documentation is needed for accident patients. Documentation will vary per financial class and each individual situation.

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EDIT 82 - EXPIRED CPT CODE

Scenario: This edit appears if a CPT code in the Detail Charges screen is either invalid or has expired.
To Correct: Verify and update the Detail Charges screen with the correct or current CPT code. Update the CPT code in the Item Master of the charge item to prevent this edit from pulling on future claims.

EDIT 85 - CPT REQUIRES NDC CPT#
Scenario: The above edit appears if a claim has a F/C of X**, Bill Type 13x or 85X, a Revenue Code of 636 and there is not a NDC number attached to the item.
To Correct: An NDC number will need to be entered in the item.

6.9 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 chapter 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. Automated Secondary Billing consists of running a report, reviewing UB and 1500 edits on the secondary claims that have been set to Ready to Bill and moving these claims. Manual Secondary Billing is more time consuming and involves a series of steps. Both methods are discussed in this chapter.

Secondary Billing

Secondary billing has been automated to speed up the process and has proven to be more accurate. When 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 in the past two days 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.

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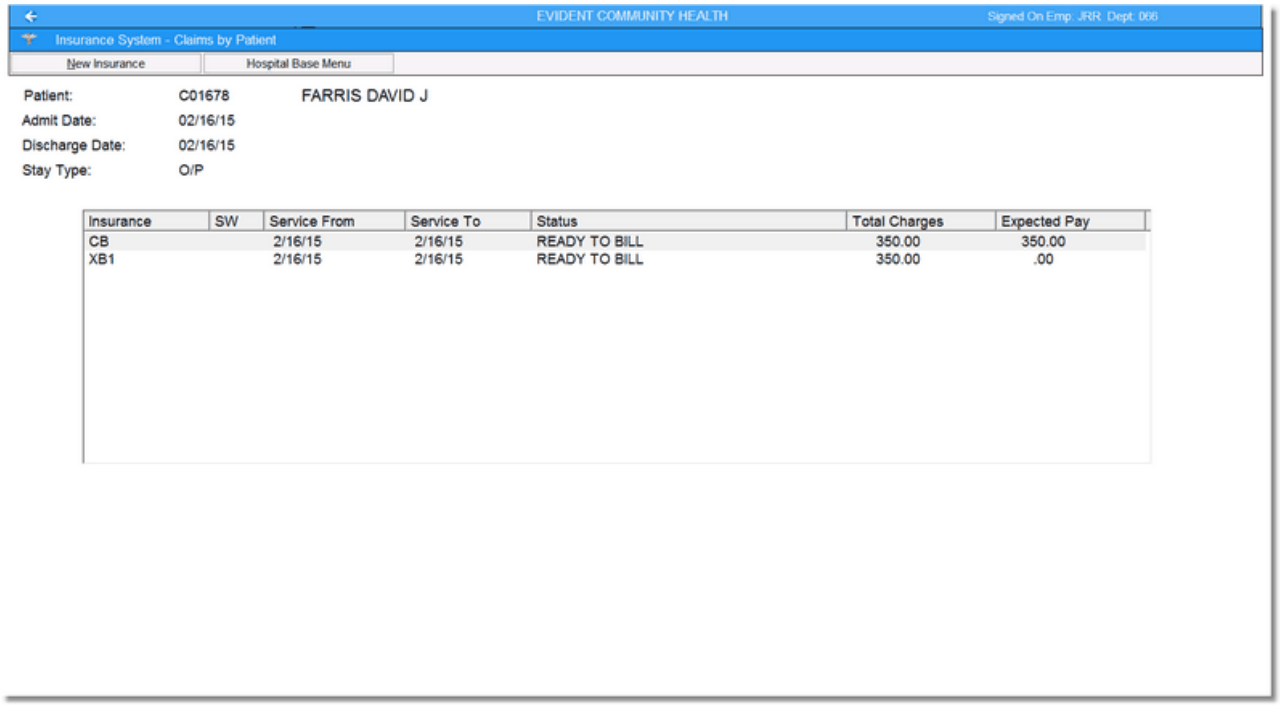
When the remittance is received, the highlighted accounts should be accessed by entering the patient number on the Hospital Base Menu and selecting Insurance from the Patient Functions screen. All claims for this account will be listed on the Insurance Claims by Patient screen.

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

Select **Clinic Base Menu** > **Patient Account #** > **Insurance** > **Claims By Patient**



Insurance System - Claims By Patient

Select the sequence number associated with 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.

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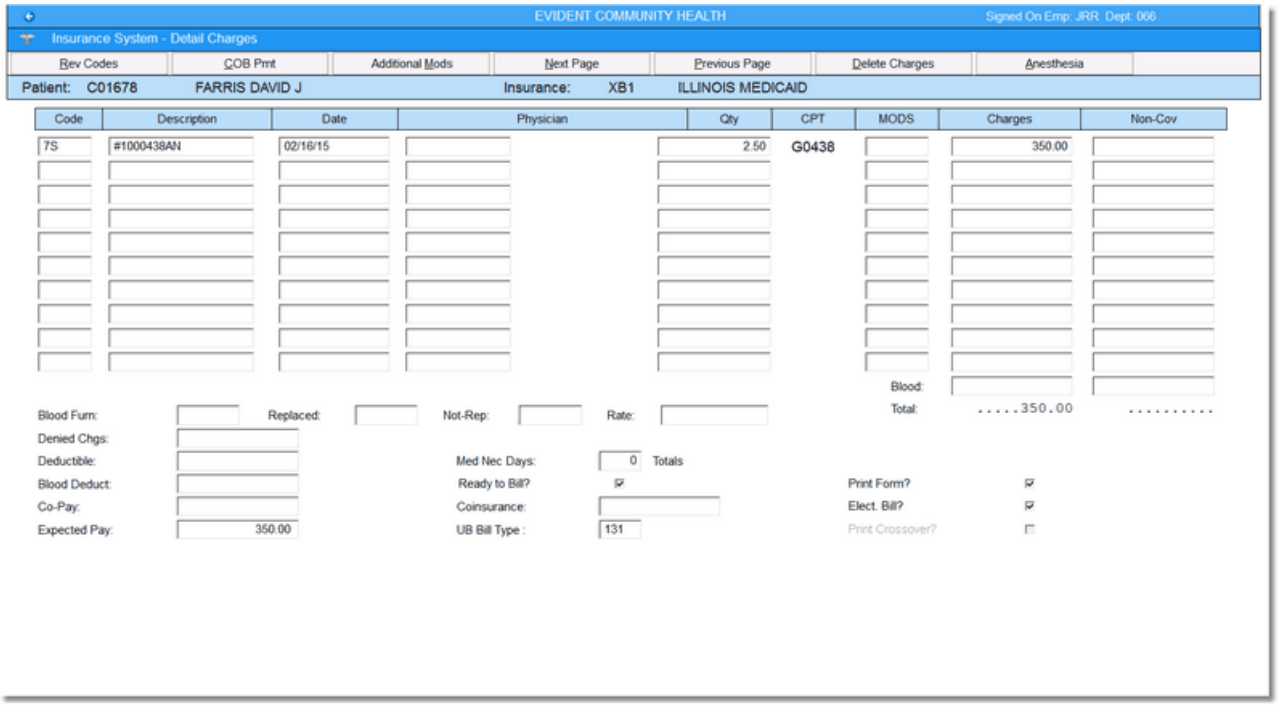
Select **Clinic Base Menu** > **Patient Account #** > **Insurance** > **Detail Charges**



Insurance System - Detail Charges

Exit the primary claim. The Expected Pay should reflect the amount receipted against the claim as shown below.

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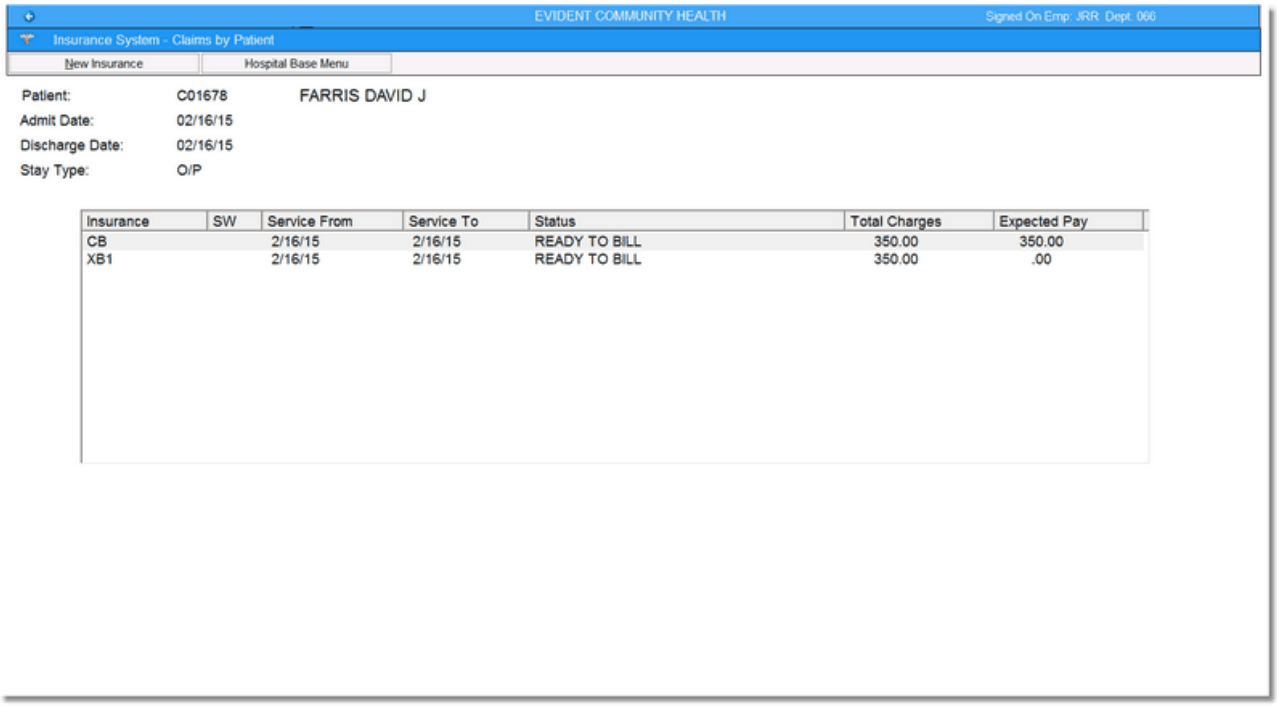
Select **Clinic Base Menu** > **Patient Account #** > **Insurance** > **Claims By Patient**



Insurance System - Claims By Patient

On the secondary claim, the Billed Date should be reversed. This is done by locking onto the secondary claim and 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. After selecting **Reverse**, the Billed Date will be removed but will display the original date directly to the right.

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 the **Print Form** option should also be selected. Selecting Ready to Bill will allow the claim to advance to the Billed status the next time UB04s are updated. Selecting Print Form will allow a UB04 to print. If the secondary claims are not sent in the electronic file **Elect Bill** should not be selected.

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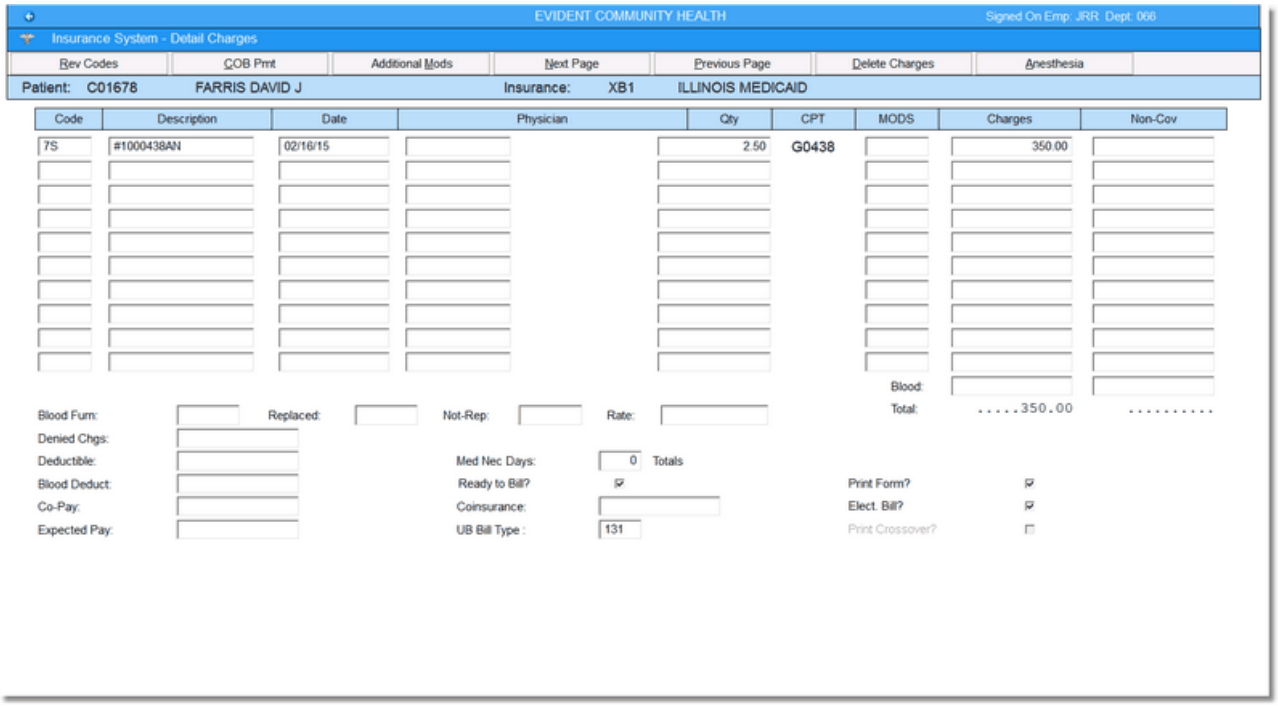
Select **Clinic Base Menu** > **Patient Account #** > **Insurance** > **Detail Charges**



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.

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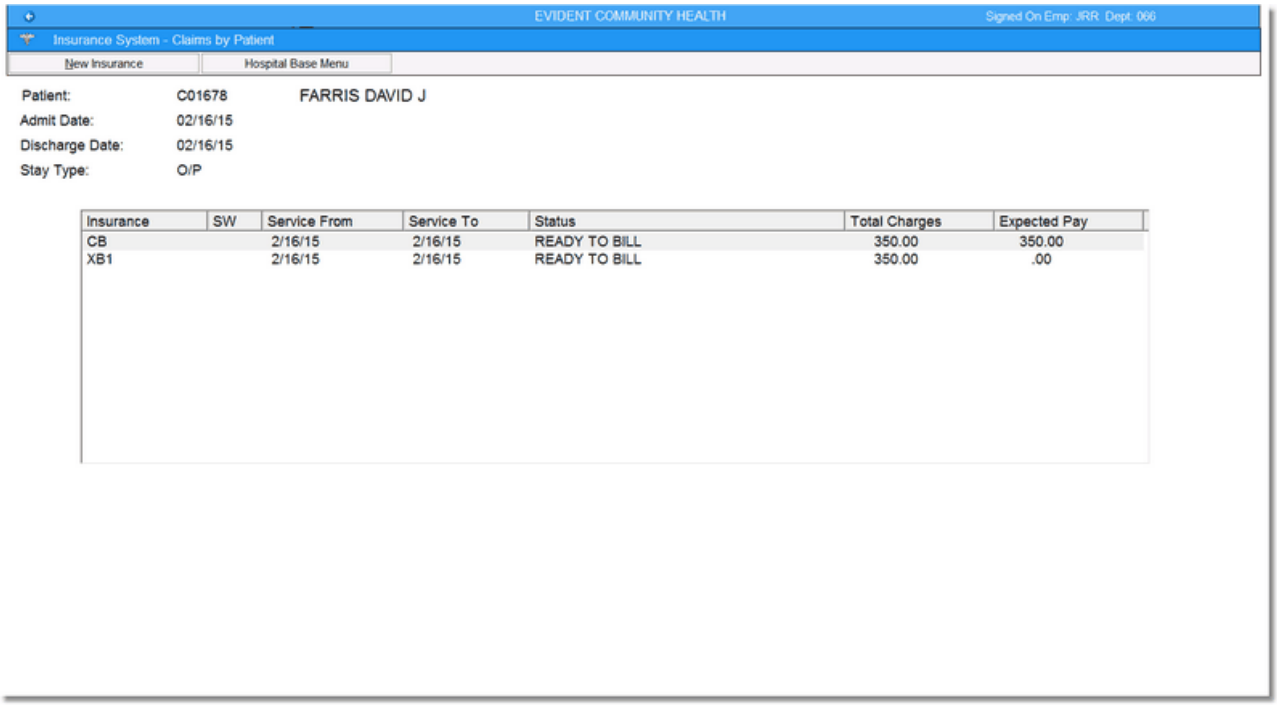
Select **Clinic Base Menu** > **Patient Account #** > **Insurance** > **Claims by Patient**



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.

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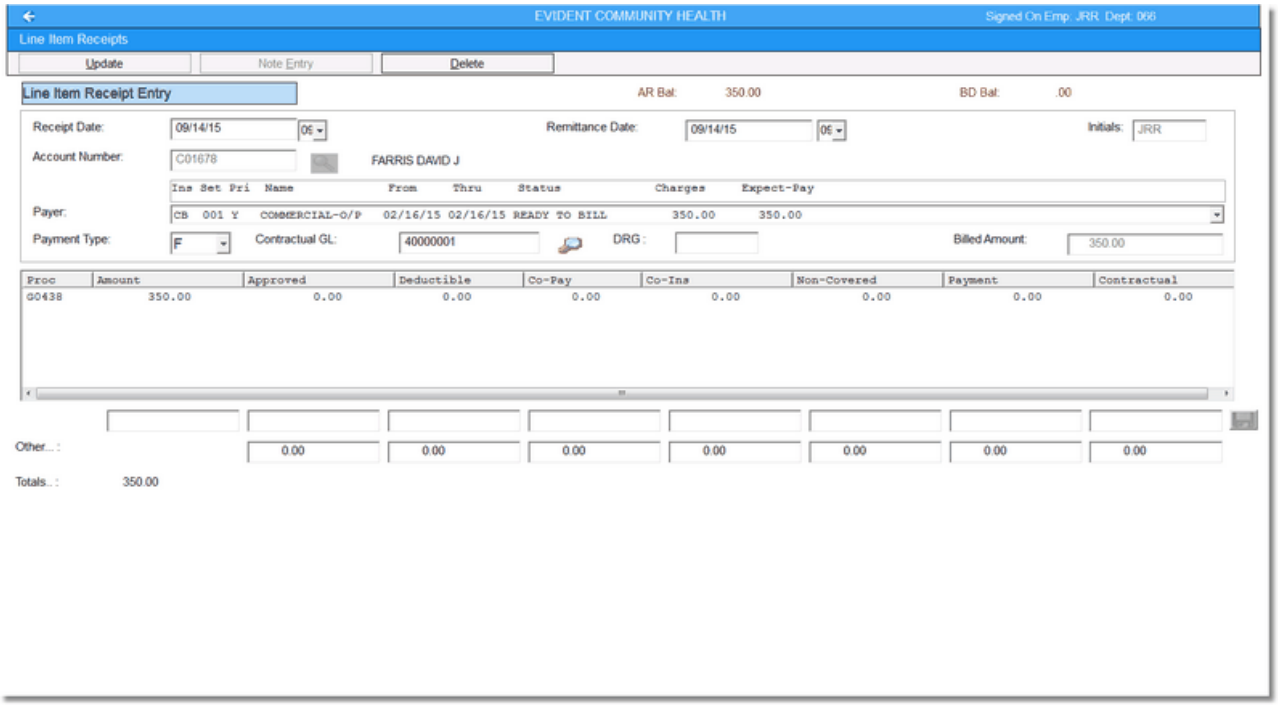
Chapter 7 Line Item Receipting

The Thrive system allows the user to enter insurance receipts via line item. This gives the user the ability to enter each line of the receipted claim.

Select **Clinic Base Menu** > **Master Selection** > **Receipts** > **Line Item Receipts**



Line Item Receipts

- **Receipt Date:** The system defaults to the current date for receipt entry. If a date other than the current date is needed, over-key the current date using MMDDYY format or by selecting a date from drop-down menu.

- **Remittance Date:** Enter the date the remittance was received. The system defaults to the current date. If a date other than the current date is needed, over-key the current date using MMDDYY format or by selecting a date from drop-down menu.

- **Initials:** The clerk entering the receipt will be required to enter his/her initials. When Employee Sign On is utilized, the system will automatically insert the initials of the employee posting the receipts and will not allow the initials to be changed.

- **Account Number:** Enter the patient's account number to which the insurance payment will be applied. Once the account number is entered, the patient's name will display to the right of the account number. If the A/R number is unknown, a lookup is available.

- **Payer:** Select the insurance claim to receipt from the drop-down menu. The following information will display for each claim:
  - **Ins:** The financial class associated with that insurance claim.

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- **Set:** This aids in selecting the correct claim when there are multiple claims for the same financial class.
- **Pri:** Denotes primary, secondary or tertiary status of a claim.
- **Name:** The name of the insurance company associated with the financial class.
- **From Thru:** The service dates charges were incurred for this claim.
- **Status:** The claim status (i.e., Billed, Paid) and the date the claim was billed, paid or rejected.
- **Charges:** Displays the total charges for this claim.
- **Expect-Pay:** Displays the expected pay amount for this claim.

- **Payment Type:** Select **F** for Full Payment, **R** for Rejected or **A** for Applied to Deductible. If Rejected is selected, and the Insurance Company table, Ask for Rejection Code field is set to **Y**, the system will prompt for a code. Only codes loaded in the Rejection Code Table will be accepted. Once the receipt is posted, the Reject Code and description will display in the Account Detail along with the other receipting information.

  NOTE: *Rejected insurance claims should be receipted with zero dollar amounts before selecting* ***R*** *for Rejected.*

- **Contractual GL:** Enter the 8-digit General Ledger number to which the received insurance payment will be receipted. If the Contractual GL# field in the Insurance Company table has an account number loaded, this number will automatically pull. If the General Ledger Number needs to be changed, over-key or select from the drop-down menu.

- **DRG:** If the Insurance Company table, Ask DRG Number field is set to **Y**, the receipted DRG will have to be entered. If set to **P**, the DRG will be required for primary claims only.

- **Billed Amount:** The amount billed will pull from the insurance claim.

When ready to remit, highlight the appropriate procedure line and it will copy to the entry line beneath the list. The following will be displayed for each line of detail on the claim.

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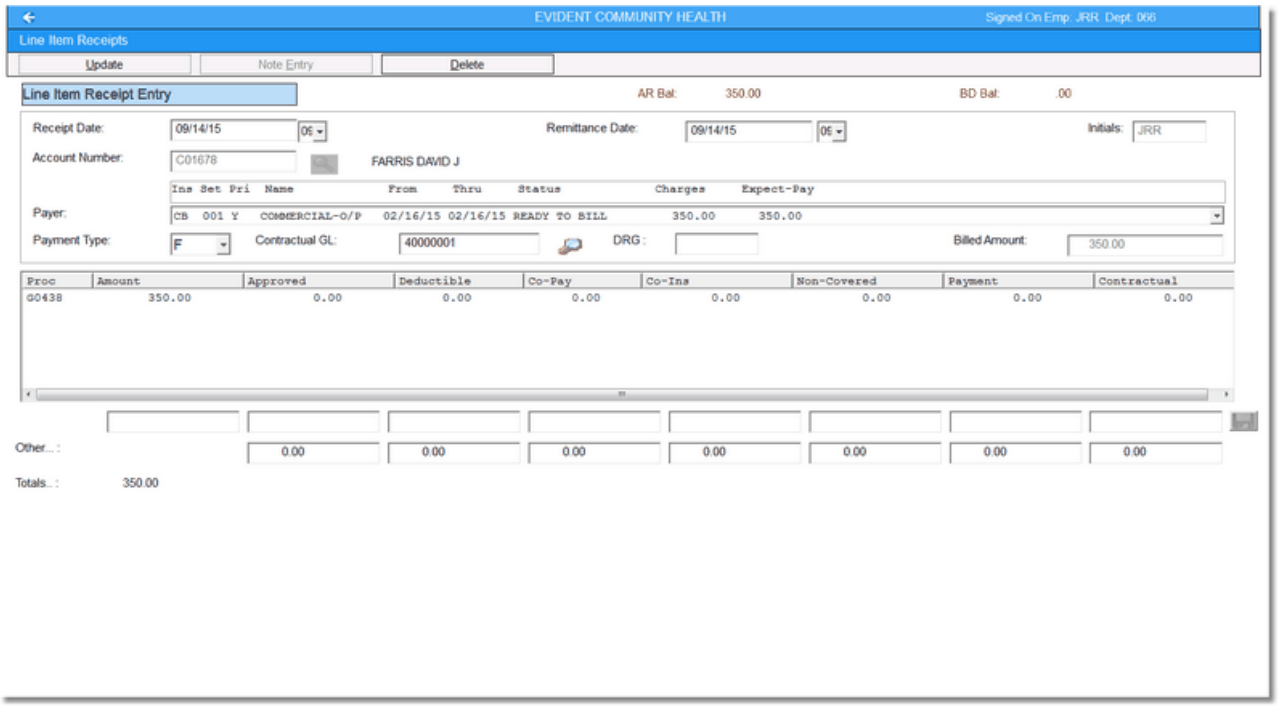
Select **Hospital Base Menu** > **Master Selection** > **Receipts** > **Line Item Receipts** > **Enter account** > **select claim**



Line Item Receipts

- **Approved:** Enter the amount of Approved Charges for the claim. If the Insurance Company table, Auto-Write Off field is set to **A**, the Approved Amount will need to be entered, and the system will calculate the Contractual Adjustment.
- **Deductible:** Enter the amount applied to the deductible for the claim.
- **Co-Pay:** Enter the Co-Pay amount of the claim.
- **Co-Ins:** Enter the Co-Insurance amount of the claim.
- **Non-Covered:** Enter the Non-Covered amount of the claim.
- **Payment:** Enter the dollar amount of the Insurance Payment.
- **Contractual:** If the Insurance Company table, Auto-Write Off field is set to **C,** the Contractual Adjustment amount will need to be entered, and the system will calculate the Approved amount.

Select 💾 to save this receipt and move it to the review area allowing additional receipts to be entered.

The following selections are available at the top of the Line Item Receipts screen.

Update: Once all insurance receipts have been entered, select **Update** to move all receipts to the Review Work Area/Post and Print screen.

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Note Entry: This allows notes to be entered on the selected patient's account. These notes will appear on the Account Detail.

Delete: If selected, this option will delete the insurance receipt information before it is posted.

The AR balance and/or the Bad Debt balance for the account being receipted will display at the top of the screen. If the account has a Bad Debt balance, it will display in red.

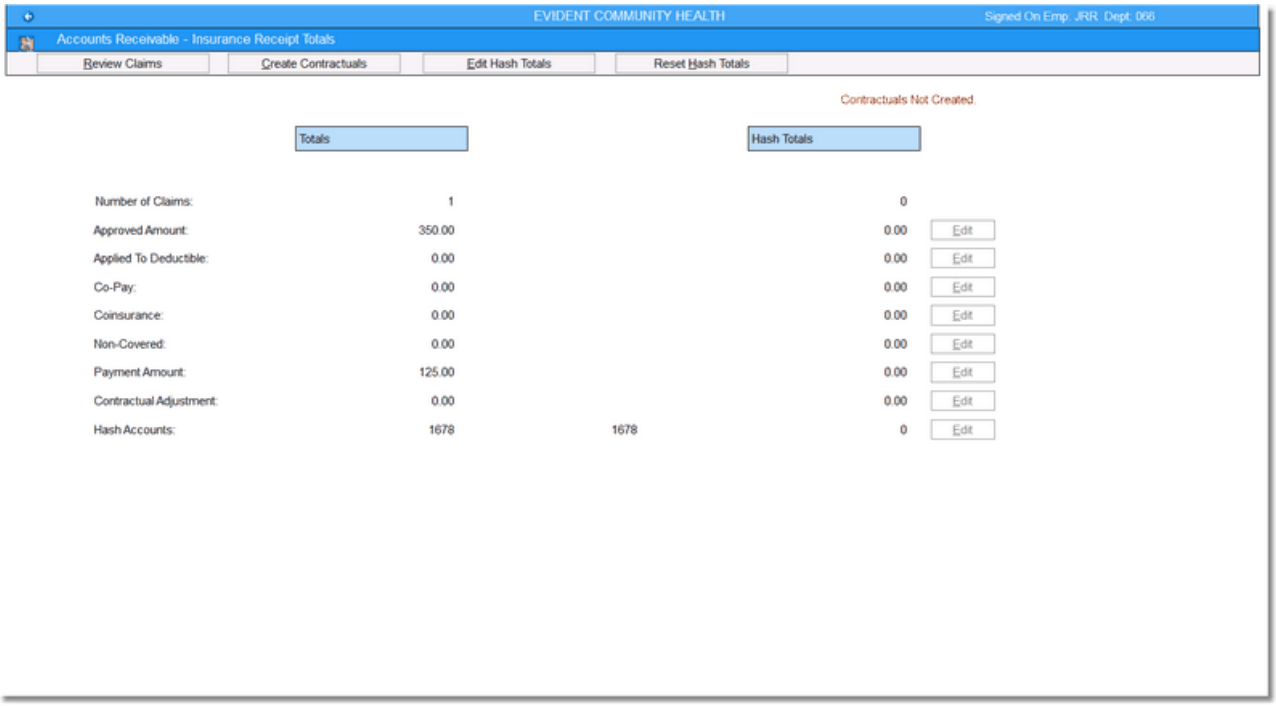
The Receipting application will not calculate an approved amount or contractual adjustment for any insurance claim that has the primary switch set to **2** or **3**. All fields must be manually keyed when receipting against a secondary claim.

The Receipting application pulls the total charges as the Billed Amount for primary claims in the Insurance Receipts Entry screen; however, the Billed Amount must be manually over-keyed for the secondary claim. This is because in most cases, the secondary claim is not billed for the full amount of the total charges.

The Insurance Receipts Totals screen allows receipt totals to be viewed after claims are receipted and to create contractual adjustment entries. The system will create contractual adjustment entries to the General Ledger account numbers that appear in the Insurance Receipts Entry screen.

From the Receipts screen, select Insurance Receipts Totals. The system will display totals for all insurance claims that were receipted through Insurance Receipts Entry.

Select **Hospital Base Menu** > **Master Selection** > **Receipts** > **Insurance Receipts Totals**



Accounts Receivable - Insurance Receipt Totals

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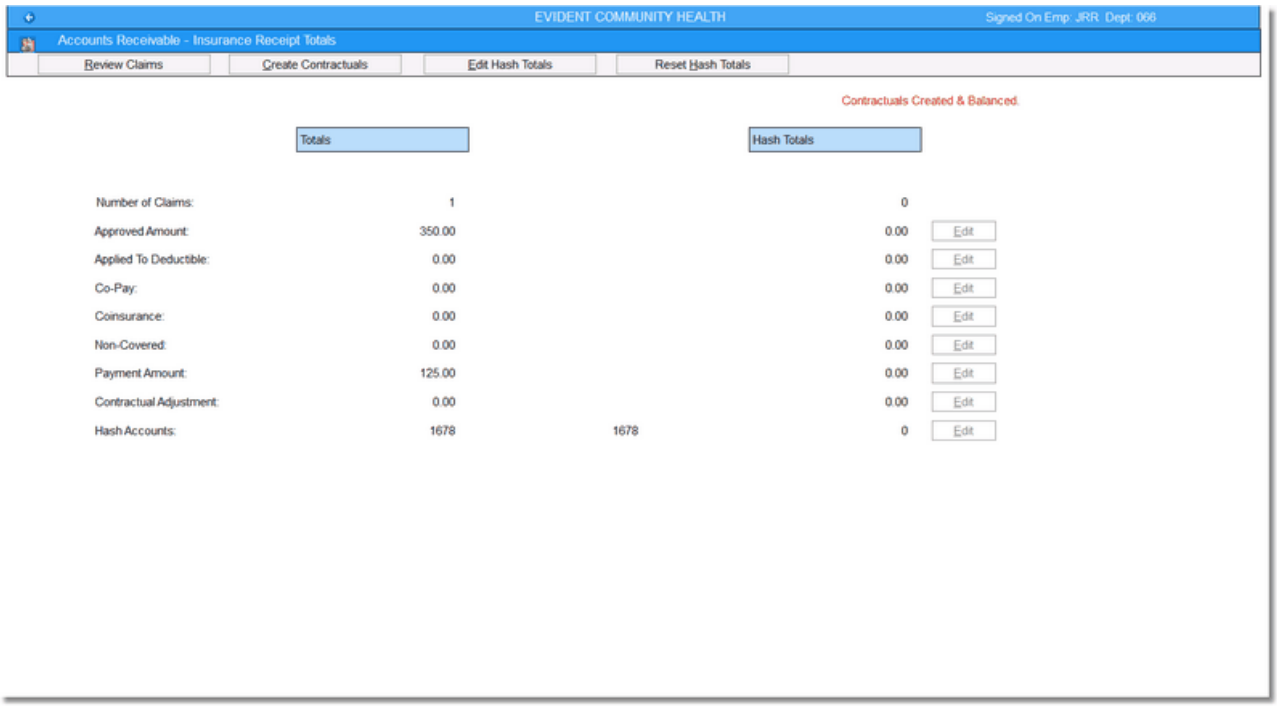
- **Review Claims:** Select this option to review each claim that was receipted against. When **Review Claims** is selected, the Review Work Area/Post and Print screen will be displayed. Selecting a receipt will display the receipt in the Insurance Receipt Entry screen where corrections may be made. The back arrow or **Esc** key will exit the Insurance Receipt Entry screen and return to the Insurance Receipt Totals screen.

- **Create Contractuals:** Once the receipt totals have been balanced, **Create Contractuals** should be selected from the top of the Insurance Receipt Totals screen. This will automatically create contractual entries in the Review Work Area to the General Ledger account numbers that were entered in the Insurance Receipts Entry screen. The following screen shows the message that will appear after **Create Contractuals** is selected.

Select **Hospital Base Menu** > **Master Selection** > **Receipts** > **Insurance Receipt Totals** > **Create Contractuals**



Accounts Receivable - Insurance Receipt Totals

The contractual entries will display in the **Review Work Area/Post and Print** after being created. Once the entries are reviewed from the Insurance Receipt Totals screen as well the Review Work Area and no errors are detected, select **Post** at the top of the Review Work Area.

- **Edit Hash Totals:** The system provides totals for each column of receipt information entered in the Totals section. Select this option to enter or change the Hash Totals.

- **Reset Hash Totals:** This option will reset all Hash Totals to zero.

When all insurance receipts have been posted, receipt information may be viewed for each claim that was receipted against.

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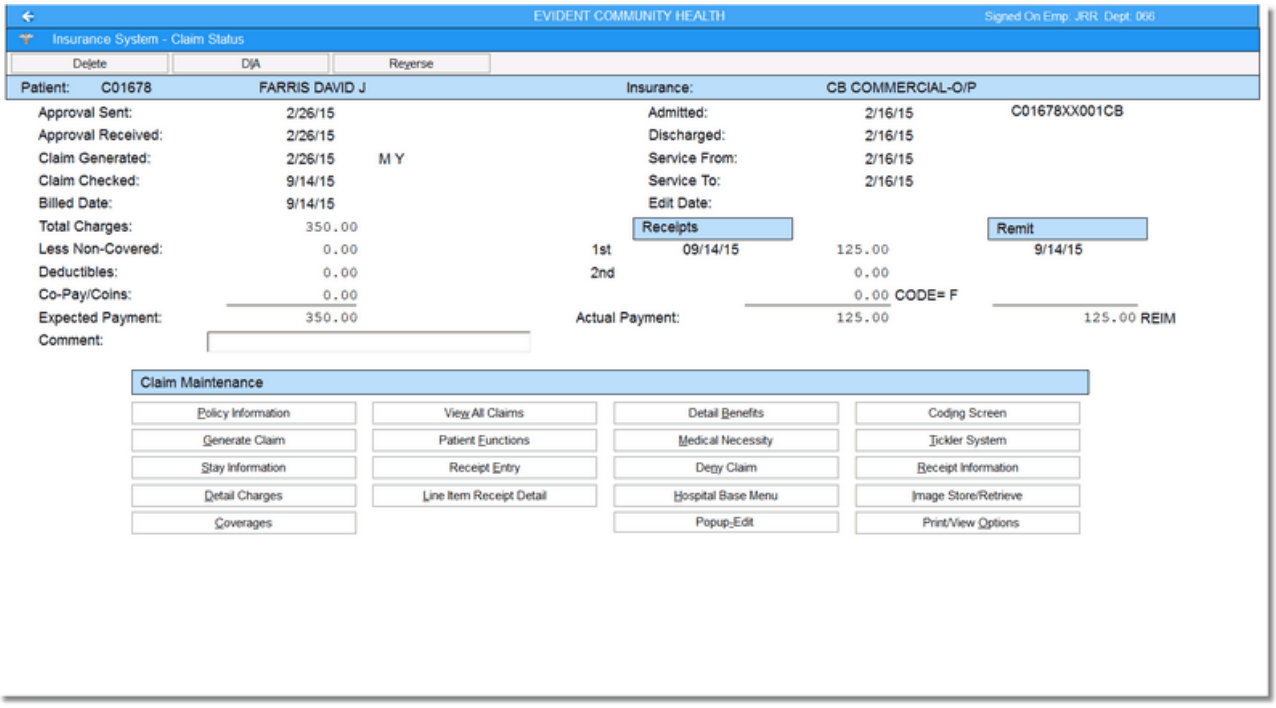
The Insurance Claim Status screen will reflect the receipted amounts. When insurance receipts are posted, the total charges, non-covered, deductible, co-pay and co insurance amounts will pull to the status screen for each claim. The Expected Payment is also updated. The Expected Pay amount will not have to be manually changed in order to reflect the actual payment made because the system changes the Expected Payment amount.

Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **Claim**



Insurance System - Claim Status

There is an option **Line Item Receipt Detail** that will show the payment information per line as entered via the line item receipting screen.

The Detail Charges screen is also updated with receipt information for individual claims. The Expected Payment is updated in order to reflect the non-covered, deductible, co-pay and coinsurance amounts entered during receipting. The Expected Pay will change when the deductible, co-pay and coinsurance amounts pull to the Detail Charges screen. Although there is not a non-covered amount field in the Detail Charges screen, the amount is stored within the insurance record and will be reflected in the Expected Payment amount, as shown in the following example.

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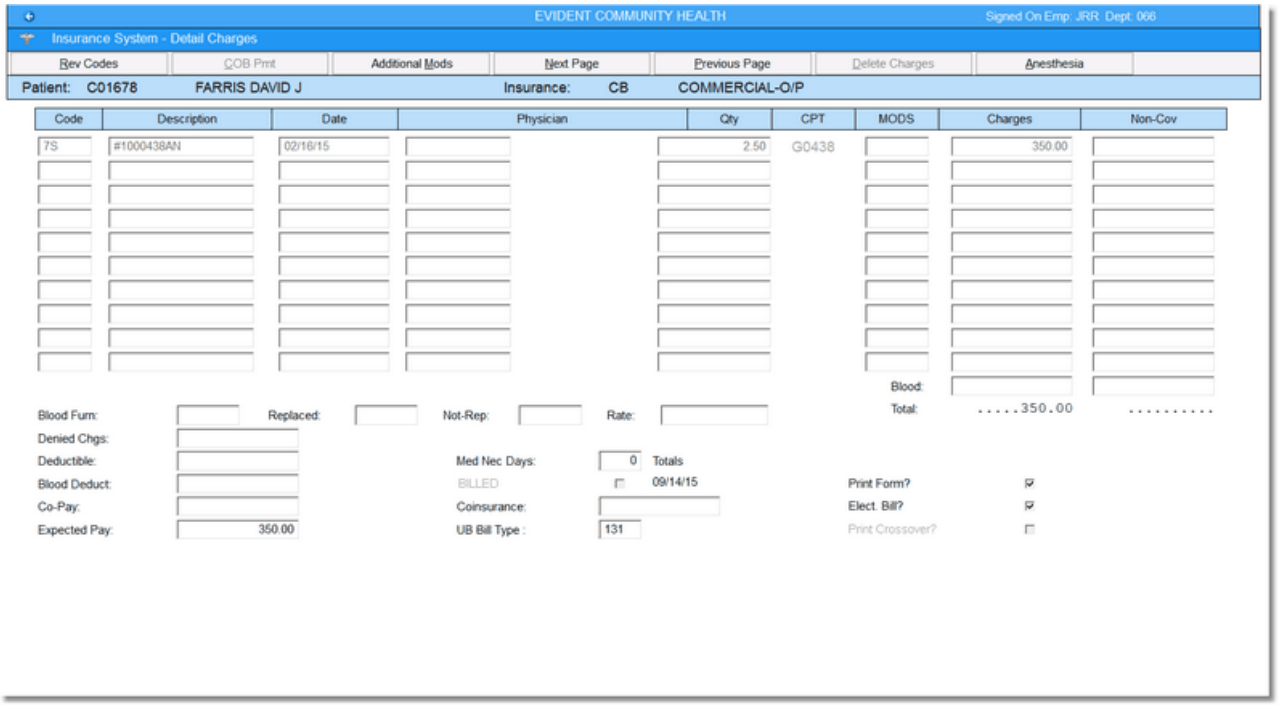
Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **Claim** > **Detail Charges**



Insurance System - Detail Charges

Net Reimbursements on the second page of the Insurance Company Table should be answered **Y** so the true reimbursement amounts are reflected in Receipt Information.

The system displays the claim reimbursement totals for a claim in the Receipt Information option in the Claims Status screen. If more than one payment is made on a claim, and Net Reimbursements in the Insurance Company Table is set to **N**, the system will only display the last payment amount as the reimbursement amount. However, if more than one payment is made on a claim and Net Reimbursements is answered with a **Y**, the system will combine the totals of each payment made on the claim and display it as the reimbursement amount, as shown below.

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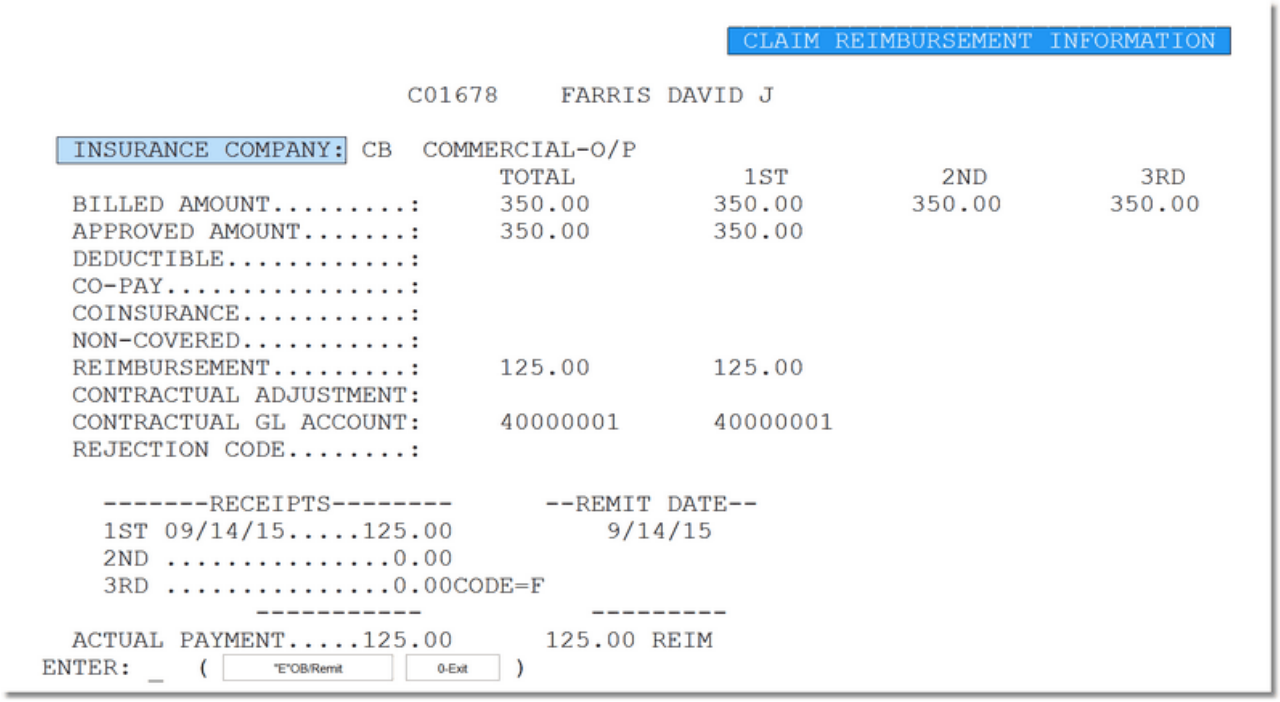
Select **Hospital Base Menu** > **Patient Account #** > **Insurance** > **Claim** > **Receipt Information**



Claim Reimbursement Information

- **EOB:** This option gives the ability to view an electronic version of the Explanation of Benefits. It may be viewed if the facility utilizes Electronic Remittance.

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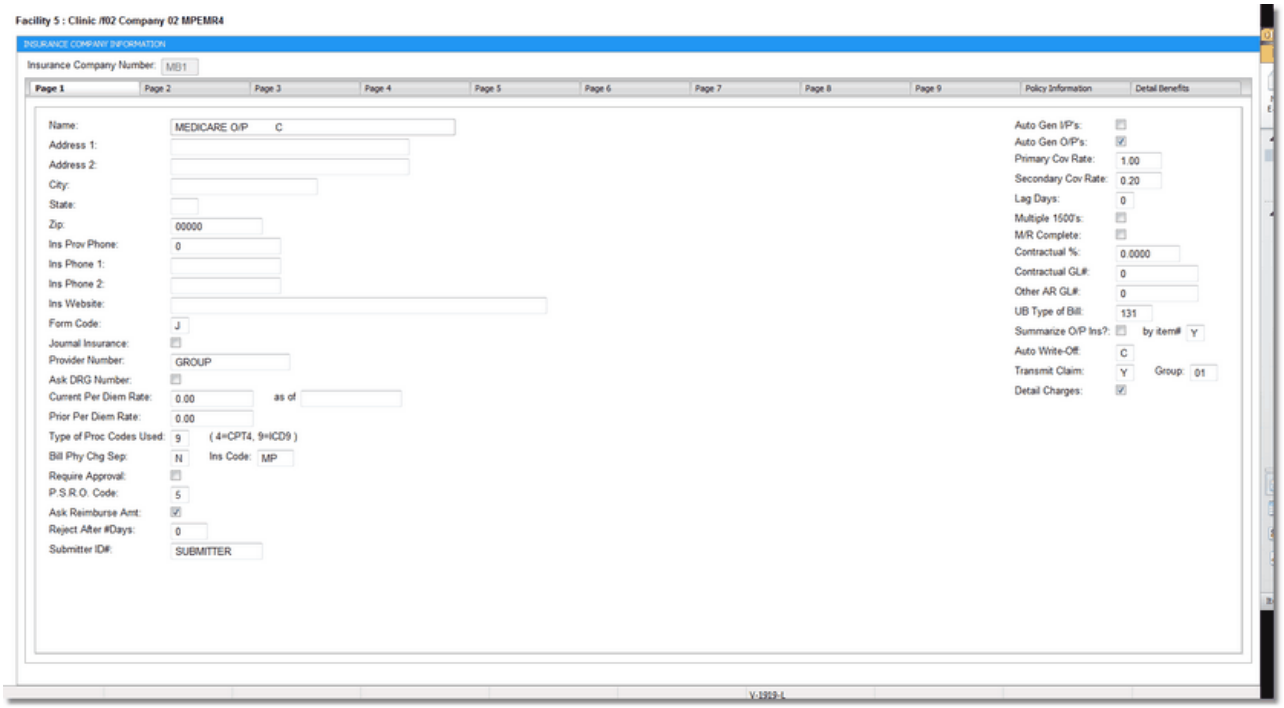
Chapter 8 Ability to set Contractual Writeoffs per physician or Place of service/dept

The Evident system allows Contractual Writeoffs to be entered per Physician or Place of Service/ Department. The following set up is required for this to function properly.

Select **Clinic Base Menu > Master Selection > Business Office Tables > Table Maintenance Menu > B.O. > Insurance**



Insurance Company Record Maint. pg 1

Contractual GL#: The full 8-digit General Ledger number ot the first 5 digits of the General Ledger number may be enered in the contractual GL# on page 1 of the insurance Company Table. If only the 5-digit number is loaded, the 3-digit Contractual GL Dept# will be pulled from page 4 of the Physician table.

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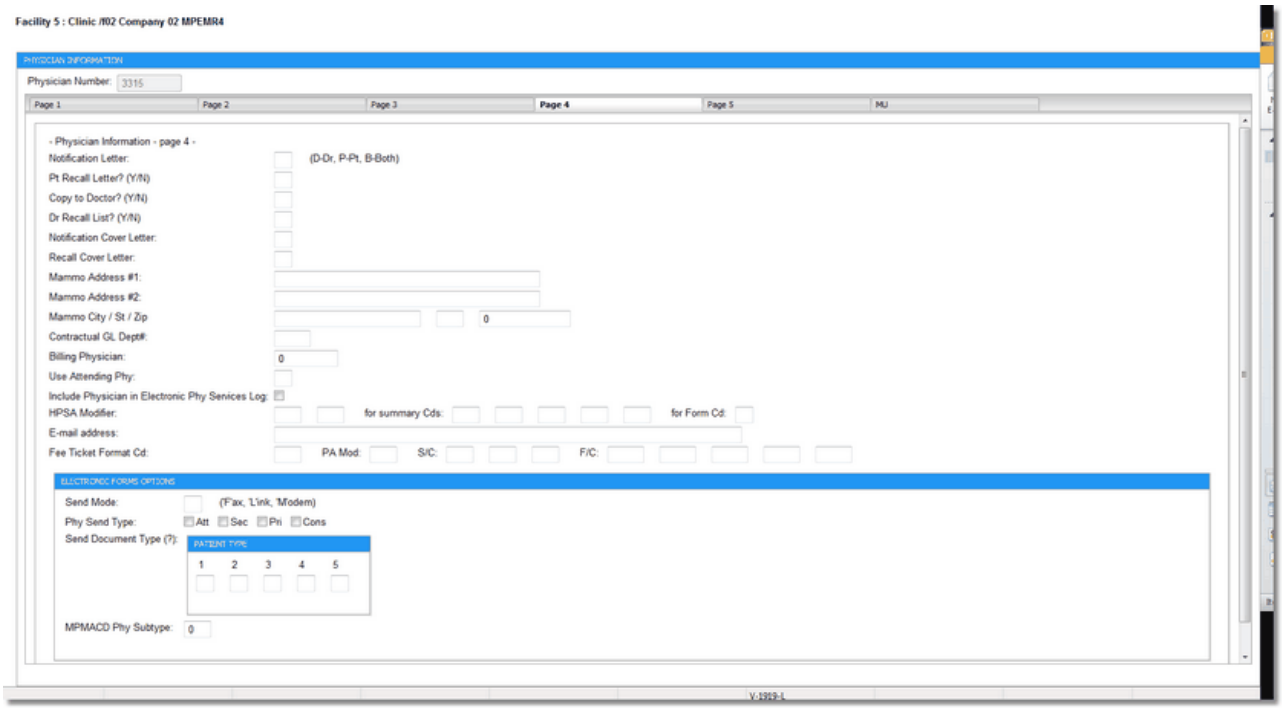
Select **Clinic Base Menu > Master Selection > Business Office Tables > Table Maintenance Menu > Control > Physicians**



Physician Maintenance page 4

Contractual GL Dept#: The 3-digit Contractual L dept # may be entered on page 4 of the physician table. This will be used as the last three digits of the GL number for the contractual during receipting.

While receipting either by insurance Receipt entry, Line item receipting, or Insurance Conversion receipt entr, the system will pull the contractual General Ledger number based on the following hierarchy:

If the Insurance Company Table page 1 has an 8-digit valid number loaded, this number will pull to the receipting screen.
If the Insurance Company Table page 1 has a 5-digit number loaded, the system will pull these number as the first 5 digits of the General Ledger number and will look to the Physician Table page 4 to pull the last 3 digits of the General Ledger number. The system will system will look to the Detail Charges screen for a charging physician and if blank then to the attending physician on the Stay informatin screen to pull the last 3-digits of the General Ledger number from the Contractual GL Dept# field.
If the Insurance Company Table has a 5-digit number loaded, and both the Physician from the Detail Charges and the Attending Physician have a blank or invalid Contractual GL Dept loaded, the system will look to the Charging screen 3-digit Department to pull the last 3-digits of the General Ledger number.

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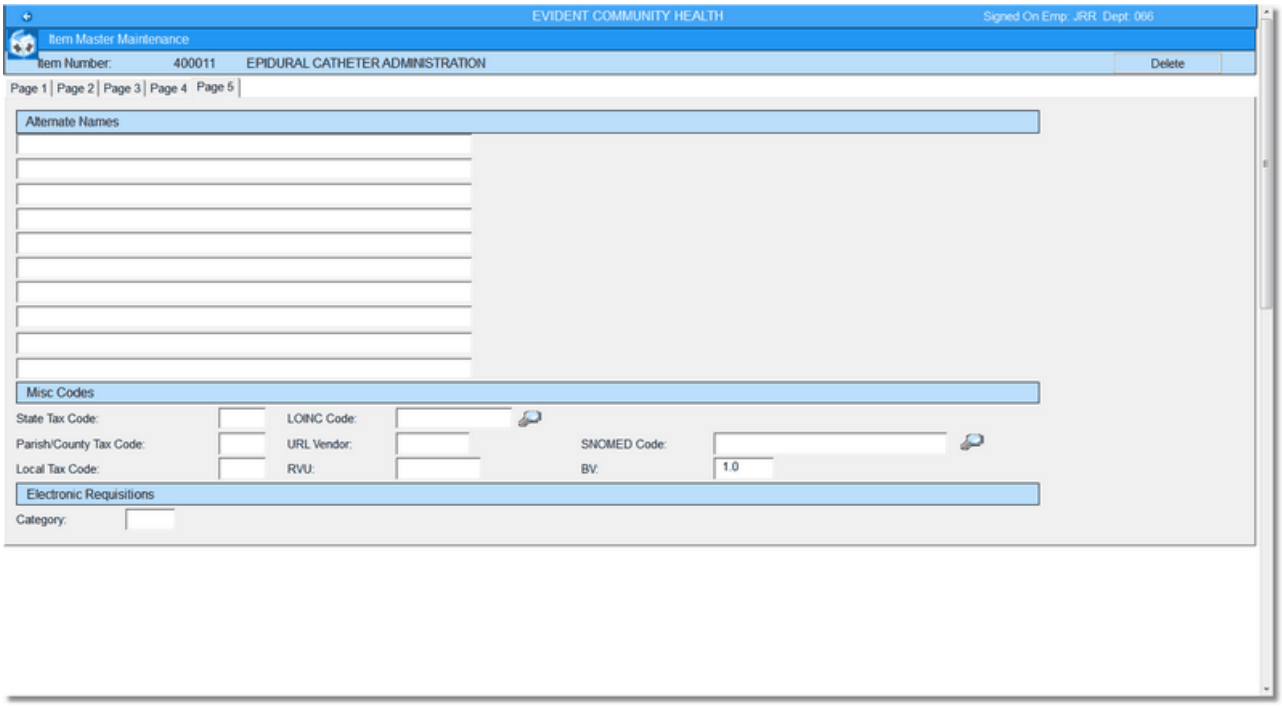
Chapter 9 Anesthesia Charge/Billing

The Thrive system now allows the user the ability to enter Anesthesia times and basic values.

Select **Clinic Base Menu** > **Charge Tables and Inventory** > **Item number** > **Item Master** > **Page 5**



Item Master Maintenance page 5

BV: This field is for the basic values.

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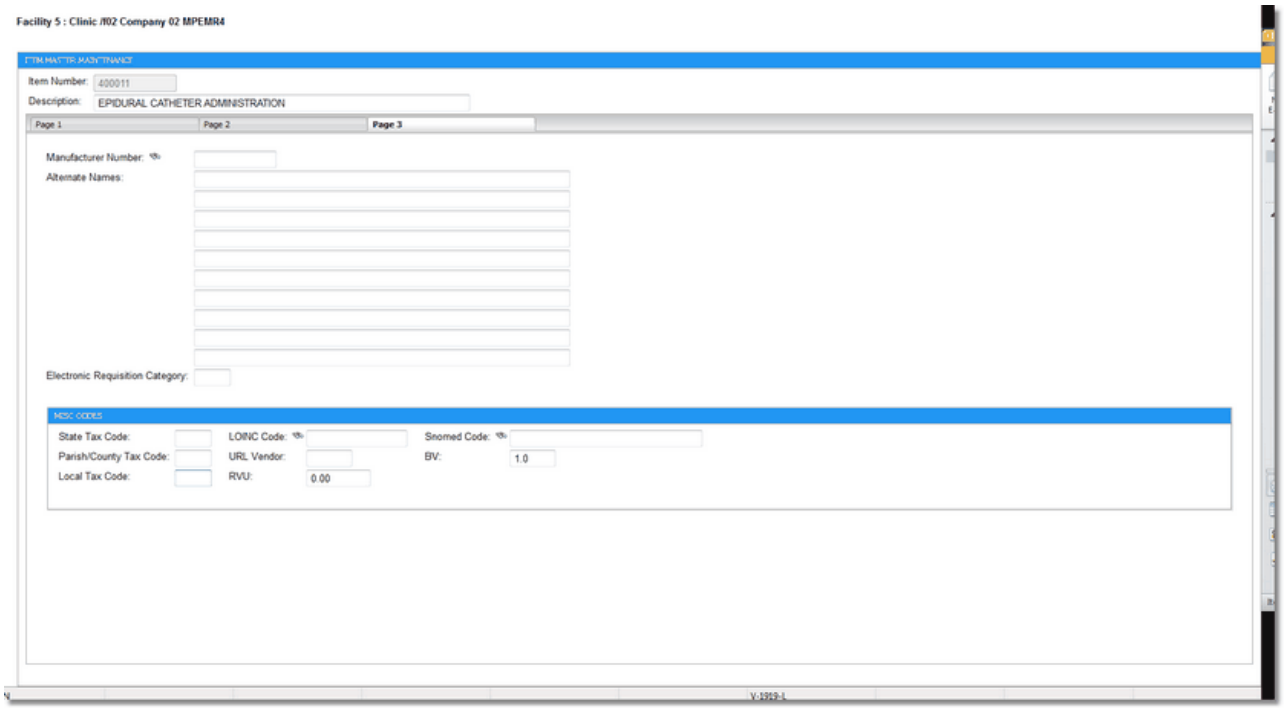
Select **Clinic Base Menu > Master Selection > Business Office Tables > Table Maintenance > Control > Item Master > Page 3**



Item Master Maintenance page 3

BV: This field is for the basic values.

With the table maintenance done, you will now need to enter the charge on the patient account for the billing information to pull to the UB.

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Select **Clinic Base Menu > Account number > Patient Charging > Charge Entry > Enter Item number with Basic Value > Anesthesia Entry**

or

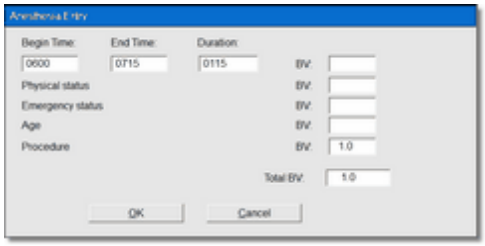
Select **Clinic Base Menu > Account number > MPEMR Visit > Transaction Entry > Enter Item with Basic Value > Anesthesia Entry**

or

Select **Clinic Base Menu > Account number > Medical Records > Anesthesia Entry**

or

Select **Clinic Base Menu > Account number > Insurance > Select Insurance > Detail Charges > Anesthesia**



Anesthesia Entry

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Chapter 10 Reports

10.1 Introduction

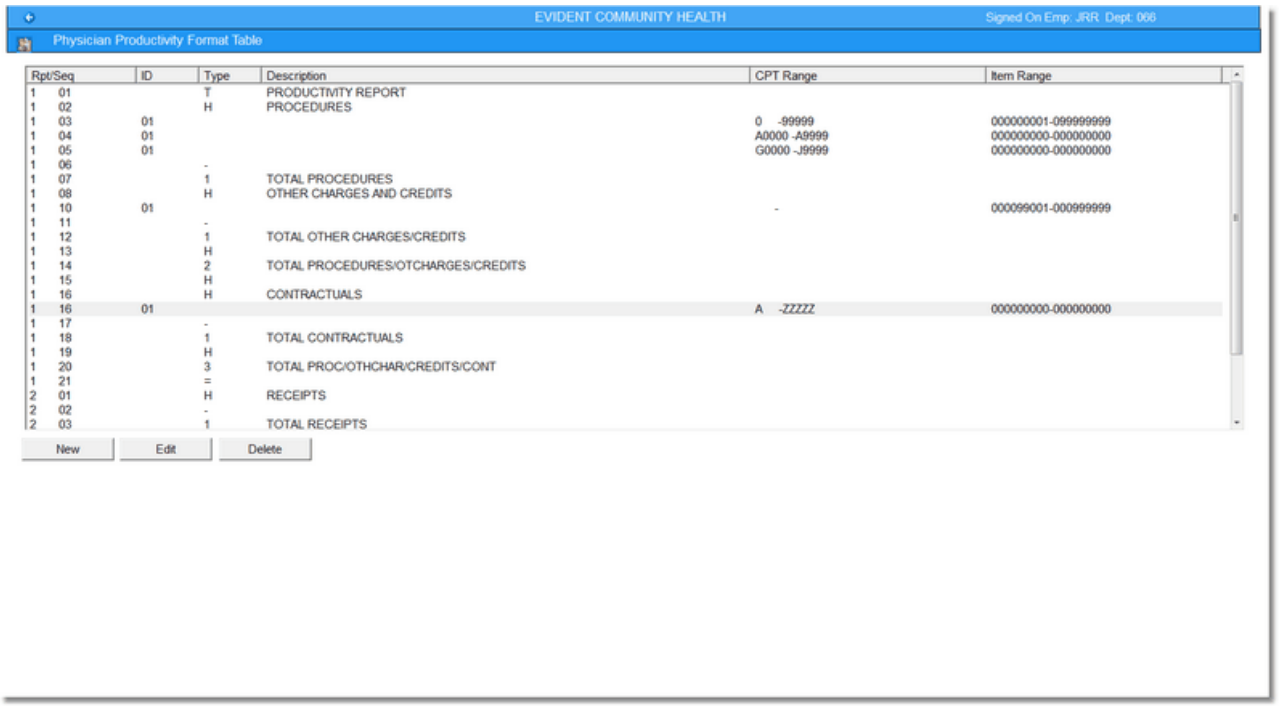
This section will cover specific reports for clinic use. General reports are described in the Accounts Receivable, Medical Records and Collections User Guides.

10.2 Physician Statistic Reports

Table Maintenance

The Statistical Format table allows the practice to customize a monthly statistics report to provide the breakdown of monthly activity within the practice. The report, based on the setup, will give balances for all physicians and is used in the end of month procedures to verify the accounts receivable balance. The following screen displays an example of the report setup.

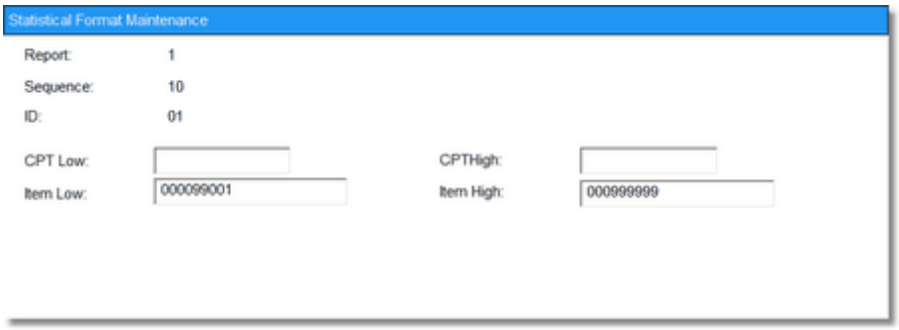
Select **Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Tables** > **Statistical Format**



Physician Productivity Format Table

Understanding and maintaining the Statistical Format table is necessary to maintain correct totals. Evident will have a standard format in place at the time of the initial install and it will only be necessary to make minor additions or maintenance to satisfy the needs of the practice. If procedures are added to the system, it is necessary to make sure they are added or already included in the range of procedures within the report format. Each line has its own maintenance record. The following screens will be used to explain the setup of the format that will best suit the practice.

Select **Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Tables** > **Statistical Format** > **New or Edit**



Statistical Format Maintenance

- **Enter Report:** Enter a number 1-9 to identify the report.
- **Sequence:** The sequence number is the order in which the line will print on the report. This should be in sequential order starting with 01 and not to exceed 99.
- **ID:** An entry here is only needed if this line is to indicate a range of procedures, which the system will scan and accumulate totals to print for this line. This field must be numeric and start with 01 through 99. The number loaded here will total to other lines with a type record of 1-5. If an ID number is loaded, the system will not allow the entry of a type record or description, but will allow the entry of a range of procedures. The above screen is an example of a line with an ID number.
- **CPT Low and CPT High:** Enter the range of CPTs to pull to the statistic report.
- **Item Low and Item High:** Enter the range of item numbers to pull to the statistic report.

In order to set up additional reports and sequences to pull to the statistic report, the type record and the description must be completed for each report and sequence.

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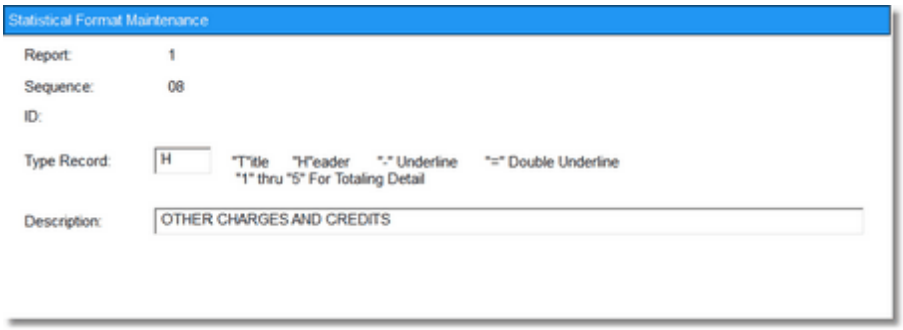
Select **Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Tables** > **Statistical Format** > **New or Edit**



Statistical Format Maintenance

- **Type Record:** For lines that do not have an "ID" number assigned, the following Type Record lines are available:
  - **Title:** Enter **T** at the beginning of the report format to display the Title on the report. A description should be entered.
  - **Header:** Enter **H** to give a header description for a section of the report. A Header line if used as a header for a section of the report will have a description loaded. A Header line may be used to skip a line, which means that no description should be entered.
  - **-:** A minus sign may be used to underline a section of the report. If a "-" is used, a description should not be loaded.
  - **=:** An equal sign may be used to double underline a section of the report. If an equal sign is used, a description should not be loaded.
  - **1** thru **5:** When a totaling of lines is necessary, entering a line type of 1-5 will give a total of all preceding lines. For example, if a 1 is entered as the type line, the system will add up all totals of "ID" lines back until it reaches another line labeled as a type 1. So, a type 1 line may be used numerous times to give subtotals. A type 2 line will add up all previous lines until it reaches another type 2 line. Same for type lines 3-5. A description of the data totaled should be keyed into the description field of the line.

- **Description:** Enter the description of the line if needed.

After completing the setup of each individual line, data input may be accessed and changed by entering the Report, Sequence and ID or Type characters for that line. Any entry may be changed by typing over that field. The line may be deleted by selecting **Delete** at the bottom of the line maintenance table.

The statistical report format automatically displays by following this path:

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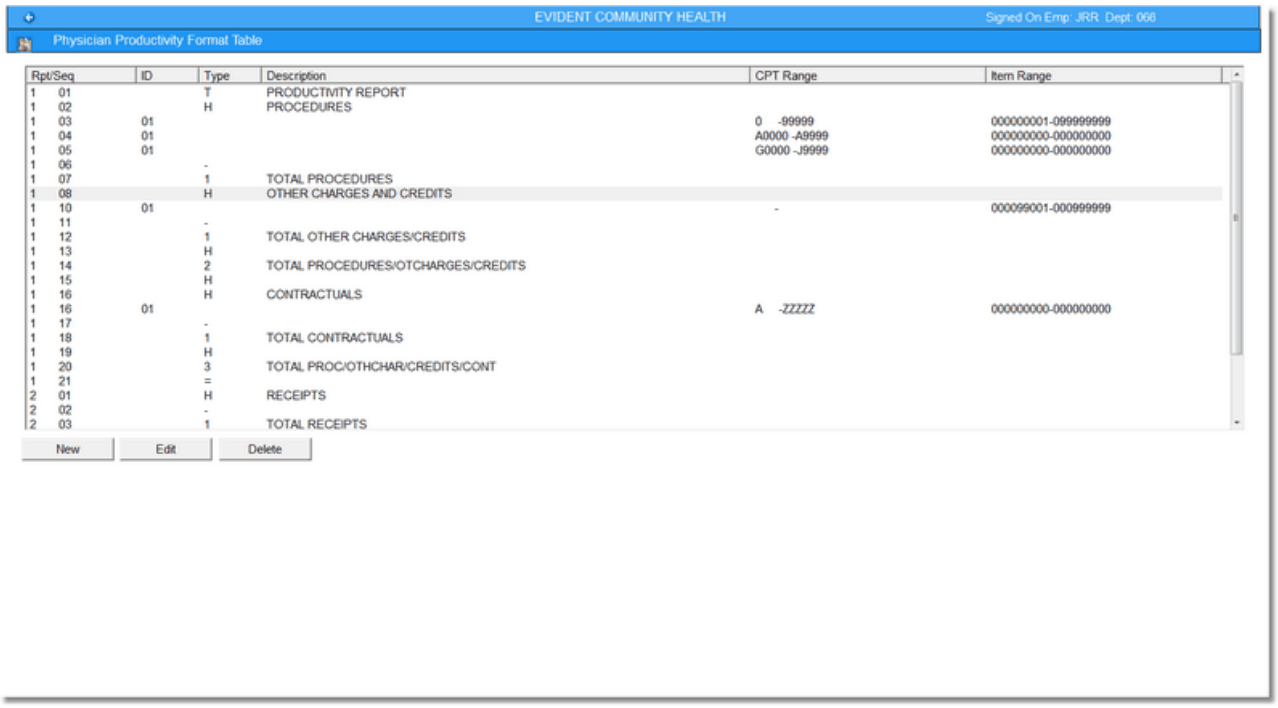
Select **Base Menu > Master Selection > Business Office Tables > MP-EMR Tables > Statistical Format**



Physician Productivity Format Table

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Physician Statistics

How to Print

1. Select **Print Reports** from the Base Menu.
2. Select **Accounts Receivable**.
3. Select **Receipts**.
4. Select **Physician Statistics**.
5. Select a print option.

   The system prompts for the Begin and Ending dates.

6. Enter the dates in MMDDYY format.

   System prompts, “By Service Date”:

7. Enter **Y** if the report should print by date of service. Enter **N** if the report should print by A/R date.
8. Enter **Y** if the report should print by place of service. Enter **N** if the report should not print by place of service.
9. Enter **Y** if the report should summarize by physician. Enter **N** if report should not summarize by physician.

   System prompts, "Okay To Start?"

10. Enter **Y** to print the report. Enter **N** to reenter the information.

Description and Usage

The report produces a detail list of all procedures, other charges and credits and receipts for the date range specified. The purpose of the report is to give the practice an exact record of the source and types of revenue generated by each provider in the practice.

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Physician Statistics

RUN DATE: 12/07/31 PAGE 1
TIME: 09:35 PRODUCTIVITY REPORT ARPHYSTXP
FOR SERVICE-DATE RANGE 06/01/12-06/30/12
POS= 01

	-CODE-	CPT	CURRENT RATE	CURRENT RATE	COUNT	%	AMOUNT	%	RVU
PROCEDURES									
ACE BANDAGE YO R&D	000005700	36557	1.50	1.50	10	10.9	15.00	.0	0.00
ELECTROLYTE PANEL	004245317	80051	25.00	25.00	1	1.1	25.00	.0	0.00
URINALYSIS	010081002	81002	85.03	85.03	20	21.7	1700.60	.1	0.00
DEPO PROVERA	007090471	90471	70.00	285589.00	1	1.1	285589.00	13.9	0.00
7 TEST VISIT	010090611	90661		500.00	1	1.1	500.00	.0	0.00
EKG	010093010	93010		17.00	1	1.1	17.00	.0	0.00
ANESTHESIA	010000100	96150	500.00	500.00	4	4.3	2000.00	.1	0.00
OFFICE VISIT IV - NEW	010099204	99204		75.00	1	1.1	75.00	.0	0.00
CPT 99211	000099211	99211	36.00	36.00	2	2.2	72.00	.0	0.00
OFFICE VISIT LIMITED - ESTAB	010099212	99212	420.00	388.50	10	10.9	3885.00	.2	0.00
LEO TEST ITEM	008002769	99213	200.00	521475.33	3	3.3	1564426.00	76.0	0.00
OFFICE VISIT LEVEL II - ESTAB	010099213	99213	75.00	75.00	10	10.9	750.00	.0	9999.90
CPT 99212	000099212	99214	42.00	42.00	3	3.3	126.00	.0	0.00
CPT 99215	000099215	99215	99.21	66732.81	3	3.3	200198.42	9.7	0.00
INITIAL HOSPITAL CARE	010099221	99221	123.00	123.00	1	1.1	123.00	.0	0.00
6 TESTING VISIT	001009223	99233	89.00	10.00	3	3.3	30.00	.0	0.00
6 TESTING VISIT	010099233	99233	89.00	30.00	1	1.1	30.00	.0	0.00
CPT 99336	000099336	99336	99.33	99.33	4	4.3	397.32	.0	0.00
CPT 99406	000099406	99406	99.40	99.40	1	1.1	99.40	.0	0.00*
INJECTION	010000120	J0120	20.00	20.00	1	1.1	20.00	.0	0.00
DEPO PROVERA	010001055	J1055	20.00	20.00	1	1.1	20.00	.0	0.00
TOTAL PROCEDURES				25123.16	82		2060098.74		9999.90
FLUVIRIN INJECTION NDC TEST	010002037	Q2037		100.00	1	1.1	100.00	.0	0.00
OTHER CHARGES AND CREDITS									
BAD DEBT	000099001			-94.00	1	1.1	-94.00	.0	0.00
BAD DEBT RECOVERY	000099004			47.00	2	2.2	94.00	.0	0.00
CPT 99213	000099213		100.00	100.00	1	1.1	100.00	.0	0.00
TOTAL OTHER CHARGES/CREDITS				40.00	5		200.00		0.00
TOTAL PROC/OTHER CHGS/CREDITS				23681.59	87		2060298.74		0.00
CONTRACTUALS									
TOTAL CONTRACTUALS							.00		0.00
TOTAL PROC/OTH CHGS/CREDITS/CONTRAC				23681.59	87		2060298.74		0.00

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Listed below is an explanation of each column.

- **Procedures:** Listing of the description of each procedure code used in the selected date range.
- **Code:** The item number of the description that is listed.
- **Current CPT:** The procedure code of the description that is listed.
- **Current Rate:** The price of each procedure at the time of printing.
- **Current Monthly-Rate:** The average rate for the selected date range.
- **Current Count:** The number of times this procedure code was entered during the selected date range.
- **Current Percentage:** The percentage of the overall total that the procedure code was charged during the selected date range.
- **Current Amount:** The total amount of the procedure code that was charged for the selected date range.
- **RVU:** The Relative Value Unit of the procedure code that was charged for the selected date range.
- **Total Procedures:** The total of each procedure column.
- **Other Charges and Credits:** Gives a detail description of each adjustment, contractual code used for the month printing in columns as the procedure codes.
- **Total Other Charges and Credits:** Gives a total of each column.
- **Total Procedures and Other Charges and Credits:** Gives a total of the two sections.
- **Receipts:** Gives a detail description of each receipt code used during the month, printing them in columns as the procedure codes.

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Physician Receipts by Date

The Physician Receipts by Date report will show the receipts broken out by provider.

How to Print

1. Select **Print Reports** from the Medical Practice EMR - Base Menu.
2. Select **Accounts Receivable**.
3. Select **Receipts**.
4. Select **Physician Receipt by Date**.
5. Select a print option.

   System prompts, “Receipts by Service Date?”

6. Enter **Y** if a receipt list is needed based on the date of service entry or **N** if receipts for A/R entry dates within the date range selected is required.
7. Enter Period Begin and Period End dates for the report in MMDDYY format.

   System prompts, "Totals Only?"

8. Enter **N** to print a detail report or **Y** for receipt totals only.

   System prompts, “Okay To Start?”

9. Answer **Y** if report settings are correct or **N** to change.

Description and Usage

This report will total all receipts for a selected date range by physician and financial class. If “Totals Only” is answered **N**, the report produces a detail list of receipts and the physician who the receipts were allocated. The total page shows the revenue by physician name and number. A second total page pulls totals by physician name and number and by Financial Class. Any receipts not posted to a physician will be listed as unapplied.

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Receipts Allocation

RUN DATE: 07/31/12 (PAGE 1
TIME: 13:28 ALLOCATION OF RECEIPTS FROM 06/01/12 TO 06/15/12 ARRCPTS
BASED ON RECEIPT PHYSICIAN NBR

PATIENT NUMBER	NAME	PHYSICIAN	ALLOCATED RECEIPTS	PATIENT TOTAL
612288	FARRIS DONNA	130000 MYERS KATE MD	.00	
			2020202.02-	2020202.02-
612390	BRAND SPANKING NEW	000002 ANDREWS KYLE	334.00	334.00
612590	BAXTER LEO F	111666 ANDERSON SHANNON	.00	
612890	KENNEDY RICHARD T JR	UNAPPLIED	70.00	70.00
613008	RAYS CPSI TEST	033110 PROULX ROCCO	.00	
613836	PARDUE HOLLY BIRD BOO	UNAPPLIED	1.25	1.25
613878	KENNEDY RICHARD	004330 KENNEDY TERRELL	.00	
613896	RAYS CPSI TEST	033110 PROULX ROCCO	.00	
614259	KENNEDY RICHARD	004330 KENNEDY TERRELL	.00	
614454	KENNEDY RICHARD	004330 KENNEDY TERRELL	15.00-	15.00-
614474	CPSI BONNIE	111666 ANDERSON SHANNON	.00	
614479	KENNEDY RICHARD	004330 KENNEDY TERRELL	160.00	160.00

RUN DATE: 07/31/12 (PAGE 4
TIME: 13:28 ALLOCATION OF RECEIPTS FROM 06/01/12 TO 06/15/12 ARRCPTS
BASED ON RECEIPT PHYSICIAN NBR

PHYSICIAN	MEDICARE	MEDICAID	BLUE CROSS	WORKMAN'S COMP	COMMERCIAL	PRIVATE	TOTAL
000002 ANDREWS KYLE	.00	.00	.00	.00	.00	334.00	334.00
004330 KENNEDY TERRELL	.00	.00	160.00	.00	.00	15.00-	145.00
004336 POWE MEGAN	.00	.00	.00	40.00-	.00	2049896.57	2049856.57
004360 Cheryl Lawrence	.00	.00	.00	.00	.00	60.00	60.00
UNAPPLIED	.00	.00	70.00	.00	.00	1.25	71.25
	.00	.00	230.00	40.00-	.00	2050276.82	2050466.82

*** SUMMARY BY RECEIPT CODE ***

	INS RECEIPTS	.00
CA	PAYMENT-CASH	2049931.57
CK	PAYMENT-CHECK	346.50
IN	PAYMENT-INSURANCE	260.00

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Listed below is an explanation of each column.

- **Patient Number:** Patient's assigned account number.
- **Name:** Patient's name from the Patient demographics screen.
- **Physician:** Physician names and number entered during receipting or assigned during receipting insurance claims.
- **Allocated Receipts**: How the receipt was distributed to the physicians.
- **Patient Total:** The total amount of the receipt.

Physician Total Page

- **Physician:** Physician names and number.
- **Receipts:** The total amount of receipts allocated to the physician.

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Financial Class Totals

- **Physician:** Physician names and number.
- **Insurance Columns:** The different Financial Classes, Medicare, Medicaid, Blue Cross, Workers Comp, Commercial and Private Pay.
- **Total:** The total of Financial Classes.
- **Summary By Receipt Code:** This prints a list of revenue by receipt code.

Receipt Allocation (by Service Date)

RUN DATE: 07/31/12 PAGE 2
TIME: 13:36 ALLOCATION OF RECEIPTS FROM 06/01/12 TO 06/15/12 ARRCPTS
BASED ON RECEIPT PHYSICIAN NBR BY SERVICE DATE

PATIENT NUMBER	NAME	PHYSICIAN SERVICE	A/R	TOTAL CHARGES	RECEIPT AMOUNT	ALLOCATED RECEIPTS	PATIENT TOTAL	ADJUST -MENTS	BALANCE
615139	BOLES GABRIEL	005468 HELMS RHONDA K		125.00		.00		.00	125.00
615140	BOLES GABRIEL	005468 HELMS RHONDA K		125.00		.00		.00	125.00

RUN DATE: 07/31/12 PAGE 4
TIME: 13:36 ALLOCATION OF RECEIPTS FROM 06/01/12 TO 06/15/12 ARRCPTS
BASED ON RECEIPT PHYSICIAN NBR BY SERVICE DATE

PHYSICIAN	MEDICARE	MEDICAID	BLUE CROSS	WORKMAN'S COMP	COMMERCIAL	PRIVATE	TOTAL
004330 KENNEDY TERRELL	.00	.00	.00	.00	.00	15.00-	15.00-
004336 POWE MEGAN	.00	.00	.00	40.00-	.00	2050096.57	2050056.57
004360 Cheryl Lawrence	.00	.00	.00	.00	.00	60.00	60.00
111666 ANDERSON SHANNON	.00	.00	.00	.00	.00	10.00	10.00
	.00	.00	.00	40.00-	.00	2050151.57	2050111.57

*** SUMMARY BY RECEIPT CODE ***

	INS RECEIPTS	.00
CA	PAYMENT-CASH	2049931.57
CK	PAYMENT-CHECK	220.00
IN	PAYMENT-INSURANCE	40.00-

Listed below is an explanation of each column.

- **Patient Number:** Patient's assigned account number.

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- **Name:** Patient's name from the Patient demographics screen.
- **Physician:** Physician names and number entered during receipting or assigned during receipting insurance claims.
- **Service:** The service date entered during receipting or assigned during receipting insurance claims.
- **A/R:** The A/R date entered during receipting or assigned during receipting insurance claims.
- **Total Charges:** The total amount of charges entered on the patient's account detail for the selected date range.
- **Receipt Amount:** The total amount of the receipt.
- **Allocated Receipts:** How the receipt was distributed to the physicians.
- **Patient Total:** The total amount of receipts applied to the patient's account. This amount is the total of patient receipts as well as insurance receipts.
- **Adjustments:** The total amount of adjustments or write-offs applied to the patient's account.
- **Balance:** The balance on the patient's account for the specified date of service.

Physician Total Page

- **Physician:** Physician names and number.
- **Charges:** The total charge amount allocated to the physician.
- **Receipts:** The total receipt amount allocated to the physician.
- **Adjustment:** The total adjustment amount allocated to the physician.
- **Balance:** The total balance of the charges, receipts and adjustments to the physician.

Financial Class Totals

- **Physician:** Physician names and number.
- **Insurance Columns:** The different Financial Classes, Medicare, Medicaid, Blue Cross, Workers Comp, Commercial and Private Pay.
- **Total:** The total of Financial Classes.
- **Summary by Receipt Code:** This prints a list of revenue by receipt code.

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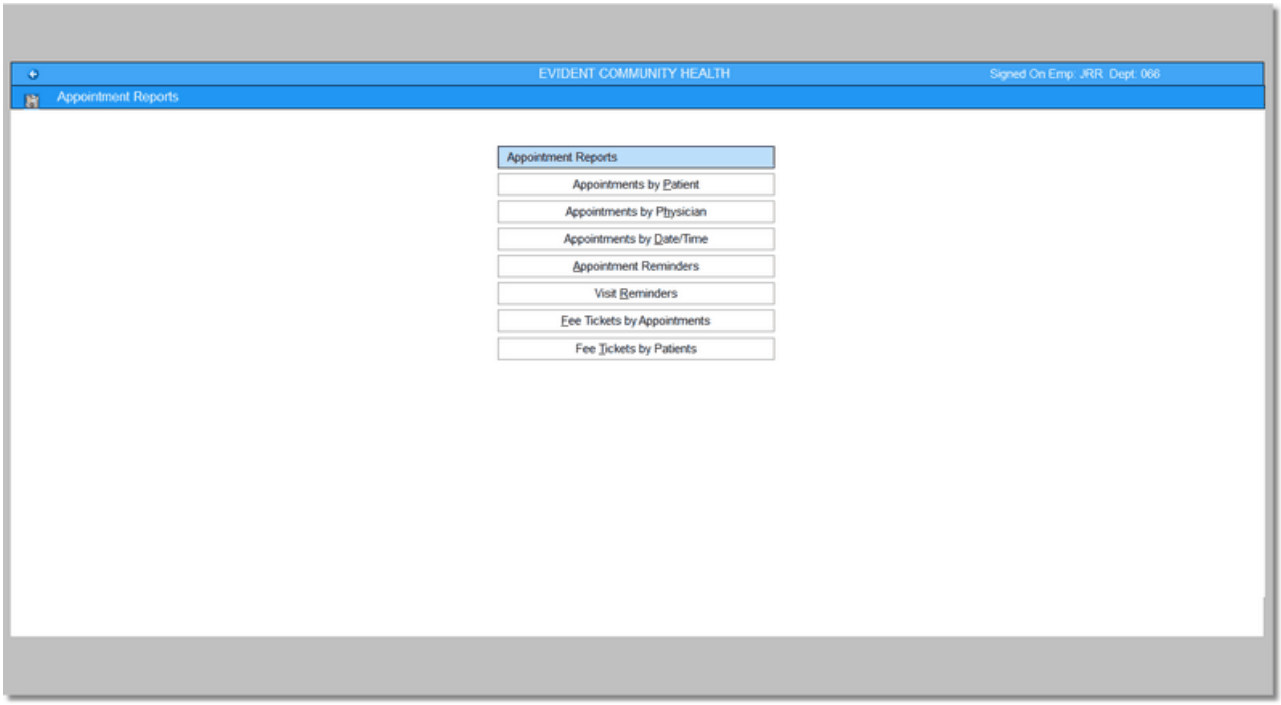
10.3 Appointment Reports

The system provides for a number of reports that list appointments. Appointments may be listed by patient name, physician number or by patient number. In addition, fee tickets may be printed by physician number and appointment date/time.

Select **Base Menu** > **Print Reports** > **Appointment Reports**



Appointment Reports

- **Appointments By Patient:** Prints a list of appointments for the selected date range by provider or for all providers. It will also print for a selected status and may auto-update appointments for no-shows.
- **Appointments By Physician:** Prints appointments for selected physicians by date. This report lists all existing appointments by the time that the appointment is scheduled.
- **Appointments By Date/Time:** Not used at this time.
- **Appointment Reminders:** Prints appointment reminders for the selected date range.
- **Visit Reminders:** Prints visit reminders created manually or via the preventative tab in ACD. It will print in either a list or letter format.
- **Fee Tickets By Appointment:** Prints a fee ticket for each patient with a scheduled appointment by specific date and physician.

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- **Fee Tickets By Patient:** Prints fee tickets for selected patients.

10.4 Line Item Receipts Report

The Line Item Receipts report provides a method for tracking receipts by procedure.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.
2. Select **Accounts Receivable**.
3. Select **Receipts**.
4. Select **Line Item Receipts**.
5. Select a print option.

   System prompts, "Starting Date:" and "Ending Date:"
6. Enter the beginning and ending date range or select dates from the drop-down menus. The format is MMDDYY. The system will default to the current system date.

   System prompts, "A/R Date (Change Date):" and "Receipt Date:"
7. Selecting A/R Date will lists receipts that have procedures charged in the given date range. Selecting Receipt Date will lists receipts that were posted in the given date range.

   System prompts, "Physician Number (Return for ALL):"
8. Enter specific physician number to list only receipts for that physician. All physicians will print to the report if left blank.

   System prompts, "Financial Class (Return for ALL):"
9. Enter specific financial class to list only receipts for that financial class. All financial classes will print to report if left blank.

   System prompts, "Procedure Range (Maximum of 10):"
10. Enter specific procedure code or procedure code range to limit report to certain procedures. Once procedure code or range is entered, select the save disk to add range. Leave the procedure range box unchecked to list all procedures on the report.

    System prompts, "Totals Only:"
11. Placing a check in the box will give the total receipt numbers. Leave the box unchecked to list receipt amounts by procedure.

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Description and Usage

The Line Item Receipt report provides a method to track receipts posted through Line Item Receipting.

Line Item Receipt Report (Listing by Procedure)

RUN DATE: 07/31/12 PAGE 1
TIME: 15:31 LINE ITEM RECEIPTS BY PROCEDURE RCLITEMRPT
AND INSURANCE COMPANY
DATE RANGE BY: AR DATE
FROM: 06/01/12 TO: 07/31/12

PHYSICIAN: ALL
INSURANCE: ALL

PROC	NAME	RATE	COUNT	DEDUCT	CO-INS	NON-COV	PAYMENT	CONTRACTUAL	TOTAL
99212	OFFICE/OUTPATIENT VISIT EST	420.00	1	.00	.00	.00	400.00	20.00	420.00
	****** TOTALS ******	420.00	1	.00	.00	.00	400.00	20.00	420.00

Line Item Receipt Report (Listing by Insurance)

RUN DATE: 07/31/12 PAGE 2
TIME: 15:31 LINE ITEM RECEIPTS BY PROCEDURE RCLITEMRPT
AND INSURANCE COMPANY
DATE RANGE BY: AR DATE
FROM: 06/01/12 TO: 07/31/12

PHYSICIAN: ALL
INSURANCE: ALL

INS	NAME	RATE	DEDUCT	CO-INS	NON-COV	PAYMENT	CONTRACTUAL	TOTAL
MB1	MEDICARE OUTPATIENT JH	420.00	.00	.00	.00	400.00	20.00	420.00
	****** TOTALS ******	420.00	.00	.00	.00	400.00	20.00	420.00

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Line Item Receipt Report (Totals Only)

RUN DATE: 07/31/12 PAGE 1
TIME: 15:40 LINE ITEM RECEIPTS BY PROCEDURE RCLITEMRPT
AND INSURANCE COMPANY
DATE RANGE BY: AR DATE
FROM: 06/01/12 TO: 07/31/12

PHYSICIAN: ALL
INSURANCE: ALL

PROC	NAME	RATE	COUNT	DEDUCT	CO-INS	NON-COV	PAYMENT	CONTRACTUAL	TOTAL
	****** TOTALS ******	420.00	1	.00	.00	.00	400.00	20.00	420.00

Listed below is an explanation of each column.

- **Physician:** The physician number followed by the physician name will appear when generating for a specific physician. The word ALL will appear when generating for all physicians.
- **Insurance:** The financial class code will appear when generating for a specific financial class. The word ALL will appear when generating for all financial classes.
- **Proc (Procedure):** The procedure code receipted will appear.
- **Name:** The name of the procedure.
- **Rate:** Pulls the total amount charged for that procedure.
- **Count:** Pulls the quantity charged for the procedure. This amount is multiplied by the procedure price to calculate the amount that appears in the rate column.
- **Deduct (Deductible):** Deductible amount entered during receipting.
- **Co-Ins (Co-Insurance):** Co-Insurance and Co-Pay amounts entered during receipting.
- **Non-Cov (Non-Covered):** Non-Covered amount entered during receipting.
- **Payment:** Paid amount entered during receipting.
- **Contractual:** Contractual Adjustment entered during receipting.
- **Total:** Total amount receipted to the procedure. This amount includes the payment amount and contractual adjustment.
- **Ins (Insurance):** Lists the financial class with totals receipted for that financial class.
- **Name:** The name of the financial class.

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NOTE: *This report will only pull receipts entered through Line Item Receipting.*

10.5 Person Profile Maintenance

The Thrive system has three utilities to correct visits and profiles. These utilities are the Unapplied Visits Report, Add Visit to Profile and Data Mismatch Report.

Unapplied Visits Report

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection Screen.

2. Select **Medical Records.**

3. Select **Admin.**

4. Select **Person Profile Maintenance.**

5. Select **Unapplied Visits Report.**

6. Select a print option. Evident recommends **Spool to File**.

Description and Usage

The Unapplied Visits report has two sections. The Unapplied Visits Corrected section automatically attaches visits that are not associated with a profile to a profile. The system looks to the Name, Social Security Number and Date of Birth. If the Name, Social Security Number and Date of Birth do not match a profile, a new profile will be created. The second part of the report, Unapplied Visits, will identify all visits without a profile.

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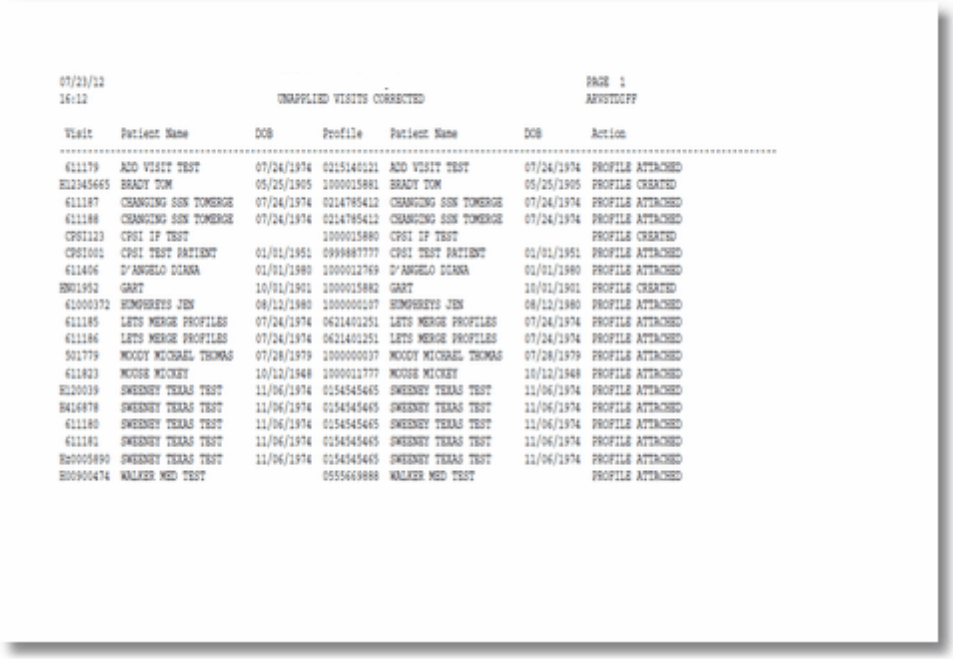
Unapplied Visits Corrected



07/23/12 PAGE 1
16:12 UNAPPLIED VISITS CORRECTED ARVSTDCFF

Visit	Patient Name	DOB	Profile	Patient Name	DOB	Action
611179	ADD VISIT TEST	07/24/1974	0215140121	ADD VISIT TEST	07/24/1974	PROFILE ATTACHED
EL2345665	BRADY TOM	05/25/1905	1000015881	BRADY TOM	05/25/1905	PROFILE CREATED
611187	CHANGING SSN TOMERGE	07/24/1974	0214785412	CHANGING SSN TOMERGE	07/24/1974	PROFILE ATTACHED
611188	CHANGING SSN TOMERGE	07/24/1974	0214785412	CHANGING SSN TOMERGE	07/24/1974	PROFILE ATTACHED
CPS1123	CPSI IP TEST		1000015880	CPSI IP TEST		PROFILE CREATED
CPS1001	CPSI TEST PATIENT	01/01/1951	0998887777	CPSI TEST PATIENT	01/01/1951	PROFILE ATTACHED
611406	D'ANGELO DIANA	01/01/1980	1000012769	D'ANGELO DIANA	01/01/1980	PROFILE ATTACHED
HN01952	GART	10/01/1901	1000015882	GART	10/01/1901	PROFILE CREATED
61000372	HUMPHREYS JEN	08/12/1980	1000000107	HUMPHREYS JEN	08/12/1980	PROFILE ATTACHED
611185	LETS MERGE PROFILES	07/24/1974	0621401251	LETS MERGE PROFILES	07/24/1974	PROFILE ATTACHED
611186	LETS MERGE PROFILES	07/24/1974	0621401251	LETS MERGE PROFILES	07/24/1974	PROFILE ATTACHED
501779	MOODY MICHAEL THOMAS	07/28/1979	1000000037	MOODY MICHAEL THOMAS	07/28/1979	PROFILE ATTACHED
611823	MOOSE MICKEY	10/12/1948	1000011777	MOOSE MICKEY	10/12/1948	PROFILE ATTACHED
EL20039	SWEENEY TEXAS TEST	11/06/1974	0154545465	SWEENEY TEXAS TEST	11/06/1974	PROFILE ATTACHED
B416878	SWEENEY TEXAS TEST	11/06/1974	0154545465	SWEENEY TEXAS TEST	11/06/1974	PROFILE ATTACHED
611180	SWEENEY TEXAS TEST	11/06/1974	0154545465	SWEENEY TEXAS TEST	11/06/1974	PROFILE ATTACHED
611181	SWEENEY TEXAS TEST	11/06/1974	0154545465	SWEENEY TEXAS TEST	11/06/1974	PROFILE ATTACHED
Hz0005890	SWEENEY TEXAS TEST	11/06/1974	0154545465	SWEENEY TEXAS TEST	11/06/1974	PROFILE ATTACHED
EH00900474	WALKER MED TEST		0555669888	WALKER MED TEST		PROFILE ATTACHED

Listed below is an explanation of each column.

- **Visit:** The Visit number associated with the patient.
- **Patient Name:** The Patient Name on the visit.
- **DOB:** The Date of Birth of the patient.
- **Profile:** The Profile number created by the system. This is also the Social Security Number if the number begins with a zero.
- **Patient Name:** The Patient Name on the profile.
- **DOB:** The Date of Birth of the patient as listed on the profile.
- **Action:**
  - **Profile Created:** This indicates a profile was created for this patient.
  - **Profile Attached:** This indicates a visit was attached to a profile.

Unapplied Visits

Listed below is an explanation of each column.

- **Visit:** The Visit number associated with the patient.
- **Patient Name:** The Patient Name on the visit.

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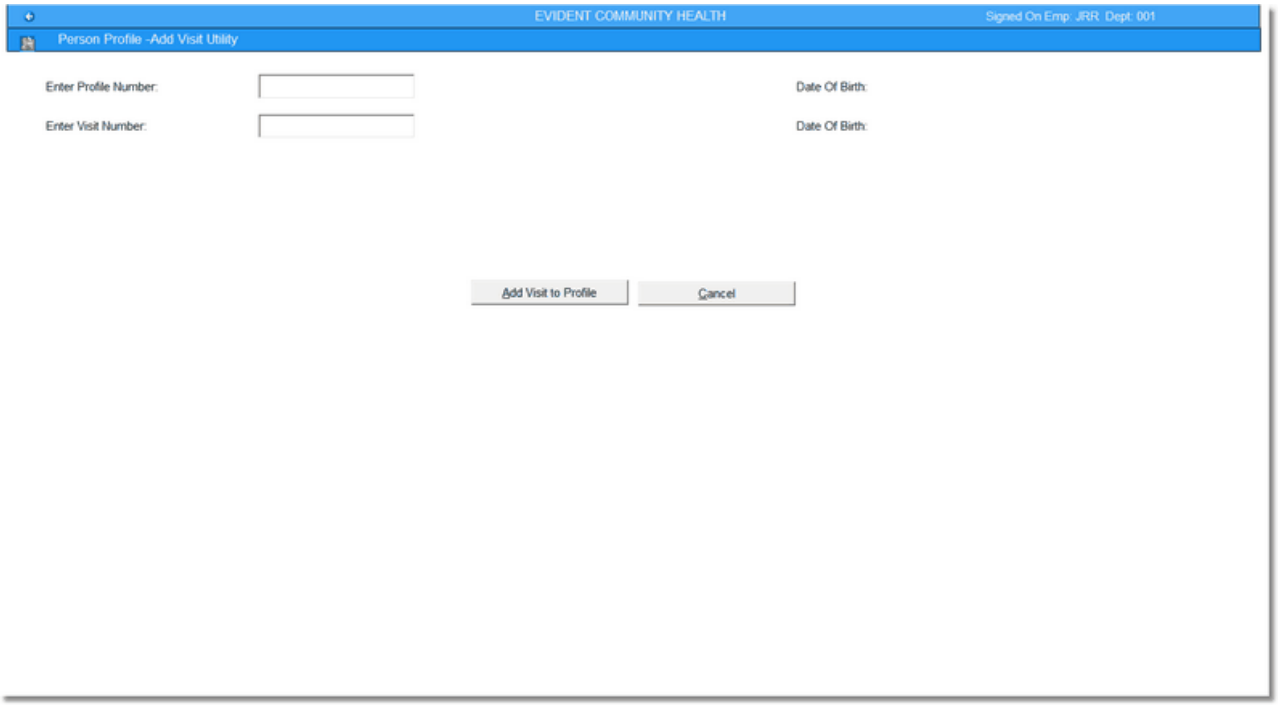
- **DOB:** The Date of Birth of the patient.
- **Profile:** The Profile number created by the system. This is also the Social Security Number if the number begins with a zero.
- **Patient Name:** The Patient Name on the profile.
- **DOB:** The Date of Birth of the patient as listed on the profile.
- **Action:**
  - **DOB:** This indicates that the Dates of Birth do not match.
  - **Duplicate Social:** This indicates the Names and Social Security Numbers do not match.

Add Visit to Profile

Select **Clinic Base Menu** > **Print Reports** > **Medical Records** > **Admin** > **Person Profile Maintenance** > **Add Visit to Profile**



Person Profile - Add Visit Utility

- **Enter Profile Number:** Enter the profile number assigned to the profile. If a true Social Security Number is the profile number, enter a leading zero so that number is 10 digits.
- **Enter Visit Number:** Enter the visit number that will be attached to the profile.
- **Add Visit to Profile:** Selecting this option will attach the visit to the profile.

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- **Cancel:** Exits screen without attaching visit to profile.

NOTE: *Verify that the names and dates of birth match prior to adding the visit to the profile.*

Data Mismatch Report

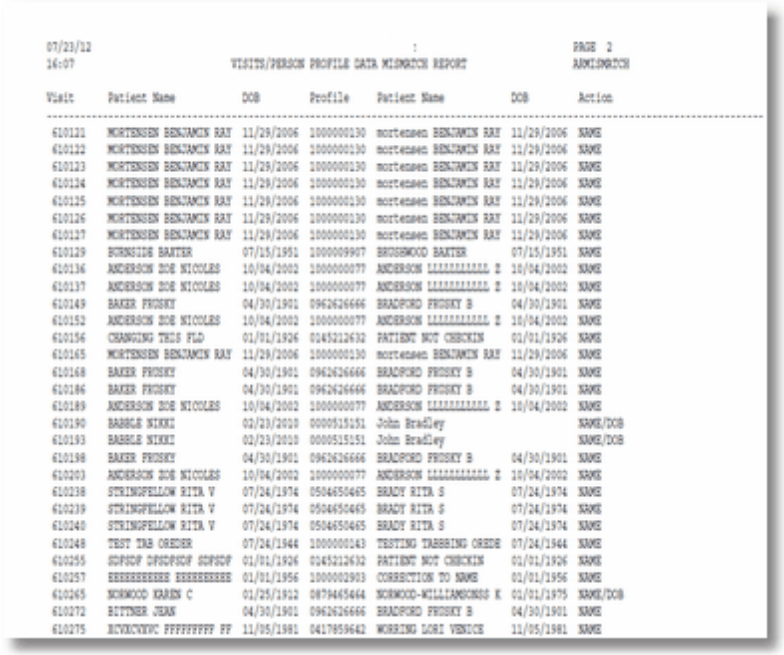
How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection Screen.
2. Select **Medical Records.**
3. Select **Admin.**
4. Select **Person Profile Maintenance.**
5. Select **Data Mismatch Report.**
6. Select a print option.

Description and Usage

The Data Mismatch Report will list all visits/accounts that are attached to a profile but the profile data is different from the visit/account data.

Visits/Person Profile Data Mismatch Report



07/23/12 : PAGE 2
16:07 VISITS/PERSON PROFILE DATA MISMATCH REPORT ARMISMATCH

Visit	Patient Name	DOB	Profile	Patient Name	DOB	Action
610121	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610122	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610123	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610124	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610125	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610126	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610127	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610129	BURNSIDE BARTER	07/15/1951	1000009907	BRUSHWOOD BARTER	07/15/1951	NAME
610136	ANDERSON DOE NICOLES	10/04/2002	1000000077	ANDERSON LLLLLLLLLL Z	10/04/2002	NAME
610137	ANDERSON DOE NICOLES	10/04/2002	1000000077	ANDERSON LLLLLLLLLL Z	10/04/2002	NAME
610149	BAKER FROSKY	04/30/1901	0962626666	BRADFORD FROSKY B	04/30/1901	NAME
610152	ANDERSON DOE NICOLES	10/04/2002	1000000077	ANDERSON LLLLLLLLLL Z	10/04/2002	NAME
610156	CHANGING THIS FLD	01/01/1926	0145212632	PATIENT NOT CHECKIN	01/01/1926	NAME
610165	MORTENSEN BENJAMIN RAY	11/29/2006	1000000130	mortensen BENJAMIN RAY	11/29/2006	NAME
610168	BAKER FROSKY	04/30/1901	0962626666	BRADFORD FROSKY B	04/30/1901	NAME
610186	BAKER FROSKY	04/30/1901	0962626666	BRADFORD FROSKY B	04/30/1901	NAME
610189	ANDERSON DOE NICOLES	10/04/2002	1000000077	ANDERSON LLLLLLLLLL Z	10/04/2002	NAME
610190	BABBLE NIKKI	02/23/2010	0000515151	John Bradley		NAME/DOB
610193	BABBLE NIKKI	02/23/2010	0000515151	John Bradley		NAME/DOB
610198	BAKER FROSKY	04/30/1901	0962626666	BRADFORD FROSKY B	04/30/1901	NAME
610203	ANDERSON DOE NICOLES	10/04/2002	1000000077	ANDERSON LLLLLLLLLL Z	10/04/2002	NAME
610238	STRINGFELLOW RITA V	07/24/1974	0504650465	BRADY RITA S	07/24/1974	NAME
610239	STRINGFELLOW RITA V	07/24/1974	0504650465	BRADY RITA S	07/24/1974	NAME
610240	STRINGFELLOW RITA V	07/24/1974	0504650465	BRADY RITA S	07/24/1974	NAME
610248	TEST TAB ORDER	07/24/1944	1000000143	TESTING TABBING ORDE	07/24/1944	NAME
610255	SDFSDF DFSDFSDF SDFSDF	01/01/1926	0145212632	PATIENT NOT CHECKIN	01/01/1926	NAME
610257	EEEEEEEEEE EEEEEEEEE	01/01/1956	1000002903	CORRECTION TO NAME	01/01/1956	NAME
610265	NORWOOD KAREN C	01/25/1912	0879465464	NORWOOD-WILLIAMSONSS K	01/01/1975	NAME/DOB
610272	BITTNER JEAN	04/30/1901	0962626666	BRADFORD FROSKY B	04/30/1901	NAME
610275	HCVXCVXVC FFFFFFFFF FF	11/05/1981	0417859642	WORRING LORI VENICE	11/05/1981	NAME

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Listed below is an explanation of each column.

- **Visit:** The Visit number associated with the patient.
- **Patient Name:** The Patient Name on the visit.
- **DOB:** The Date of Birth of the patient.
- **Profile:** The Profile number created by the system. This is also the Social Security Number if the number begins with a zero.
- **Patient Name:** The Patient Name on the profile.
- **DOB:** The Date of Birth of the patient as listed on the profile.
- **Action:**
  - **DOB:** This indicates that the Date of Birth does not match on a visit to the Date of Birth on a profile.
  - **Name/DOB:** This indicates that the Name and/or Date of Birth does not match on a visit to the Name and/or Date of Birth on a profile.

10.6 RHC Encounter Report

The RHC Encounter report list all patient encounters by physician by service date for RHC reporting purposes.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection Screen.
2. Select **Medical Records**.
3. Select **Page 2**.
4. Select **RHC Encounters Report**.
5. Select a print option.

   System prompts, "Begin Date:" and End Date:" This is based on Service Date.
6. Enter the beginning and ending date range or select dates from the drop-down menus. The format is MMDDYY. The system will default to the current system date.

   System prompts, "Begin Code:" and "End Code:"

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7. Enter the Insurance code or codes desired. The system defaults to ALL, but specific insurance codes or a range may be entered. The magnifying glass will open the insurance search box. Wild-carding may be used. Once codes are selected, select if Primary, Secondary or Both insurance claims need to pull.

   System prompts, "Begin Code:" and "End Code:"

8. Enter the Procedure code or codes needed. The system defaults to ALL, but specific procedure codes or procedure range may be entered. The magnifying glass will open the CPT search box.

   System prompts, "Begin Code:" and "End Code:"

9. Enter the Diagnosis code or codes needed. The system defaults to ALL, but specific diagnosis codes or diagnosis ranges may be entered. The magnifying glass will open the diagnosis search box.

10. Select **Generate** to generate the report. **Clear All** will reset parameters.

    System prompts, "Print Detail"

11. Check box if detail information is needed.

12. Enter the physician number or leave box checked for all physicians.

13. Enter the department number or leave box checked for all departments.

Description and Usage

This report gives a total number of patient encounters (visits) by physician and place of service. This report is used for statistical information required by some insurance companies. If a detail report is requested, it will print patient name and account number per physician and place of service.

Encounter Report

09/16/2015 f10 MPEMR IN HOSPITAL 1
13:53 RHC Encounter Report rhc_encounters.template
08/01/2015 - 08/31/2015

Place of Service: 1 TEST

Physician#	Phys Name	M**	B**	C**	X**	P	Total Encounters
5467	RESTER JOHN TEST	1		1			2
40868	BUSCHMANN MARK J	1	2				3
345678	ALICIA MILLWOOD		4				4
999999	FACILITY TEST PHY	2	2	1	1	1	7
Department Totals:		4	8	2	1	1	16

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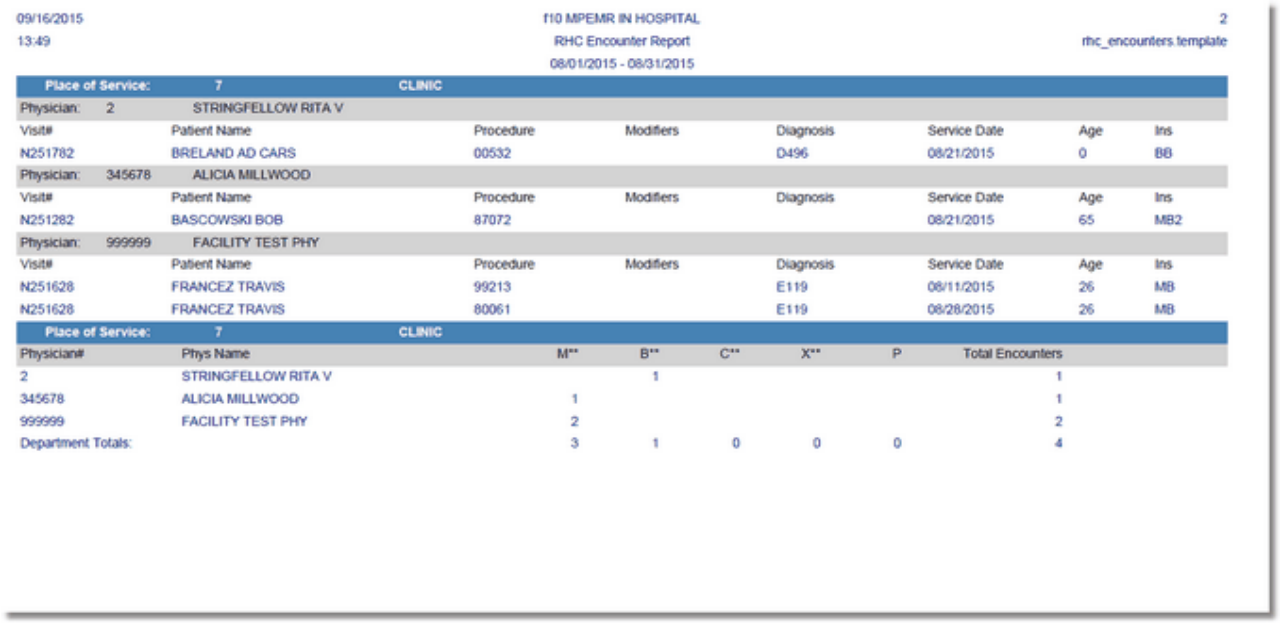
Encounter Report (by Detail)



09/16/2015 f10 MPEMR IN HOSPITAL 2
13:49 RHC Encounter Report rhc_encounters.template
08/01/2015 - 08/31/2015

Place of Service:	7	CLINIC					
Physician:	2	STRINGFELLOW RITA V					
Visit#	Patient Name	Procedure	Modifiers	Diagnosis	Service Date	Age	Ins
N251782	BRELAND AD CARS	00532		D496	08/21/2015	0	BB
Physician:	345678	ALICIA MILLWOOD					
Visit#	Patient Name	Procedure	Modifiers	Diagnosis	Service Date	Age	Ins
N251282	BASCOWSKI BOB	87072			08/21/2015	65	MB2
Physician:	999999	FACILITY TEST PHY					
Visit#	Patient Name	Procedure	Modifiers	Diagnosis	Service Date	Age	Ins
N251628	FRANCEZ TRAVIS	99213		E119	08/11/2015	26	MB
N251628	FRANCEZ TRAVIS	80061		E119	08/28/2015	26	MB

Place of Service:	7	CLINIC					
Physician#	Phys Name	M**	B**	C**	X**	P	Total Encounters
2	STRINGFELLOW RITA V		1				1
345678	ALICIA MILLWOOD	1					1
999999	FACILITY TEST PHY	2					2
Department Totals:		3	1	0	0	0	4

Listed below is an explanation of each column.

- **Place of Service:** The encounter place of service. The place of service number and description reads from the department table.
- **Physician:** The physician name and number associated with the encounter.
- **Insurance:** The insurance attached to the encounter. The summary version of the report groups by the first character of the financial class. Any financial class that begins with a character not listed will be included in the C** totals.
- **Total Encounters:** The total number of encounters for the specific physician.

Encounter Report by Detail

- **Visit Number:** The number associated with the patient's specific date of service.
- **Patient Name:** Patient's name as listed on the account.
- **Procedure:** Procedure code associated with the encounter.
- **Diagnosis:** Diagnosis code associated with the encounter.
- **Service Date:** Date of the encounter.
- **Age:** The age of the patient at the time of the encounter.

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- **Insurance Code:** The financial class attached to the patient's account.

10.7 RHC-UDS Reporting

RHC-UDS stands for Rural Health Clinic - Uniform Data System. The Bureau of Primary Health Care requires statistical data to be reported when a facility receives grants. This section will cover the reporting capabilities and maintenance required. The statistical data gathered by the system is for Rural Health Clinics to report information to the government as required, but the reporting capabilities may be used by any facility.

The statistics that may be gathered by utilizing the RHC-UDS reporting includes:

Users by Age/Gender/Ethnicity
Perinatal Profile
Managed Care Enrollment and Revenue
Selected Diagnosis and Services Rendered

A detailed description of maintenance required and information that pulls to the reports will be covered in this section.

Table Maintenance

There are several tables that need to be set for the RHC-UDS Reporting.

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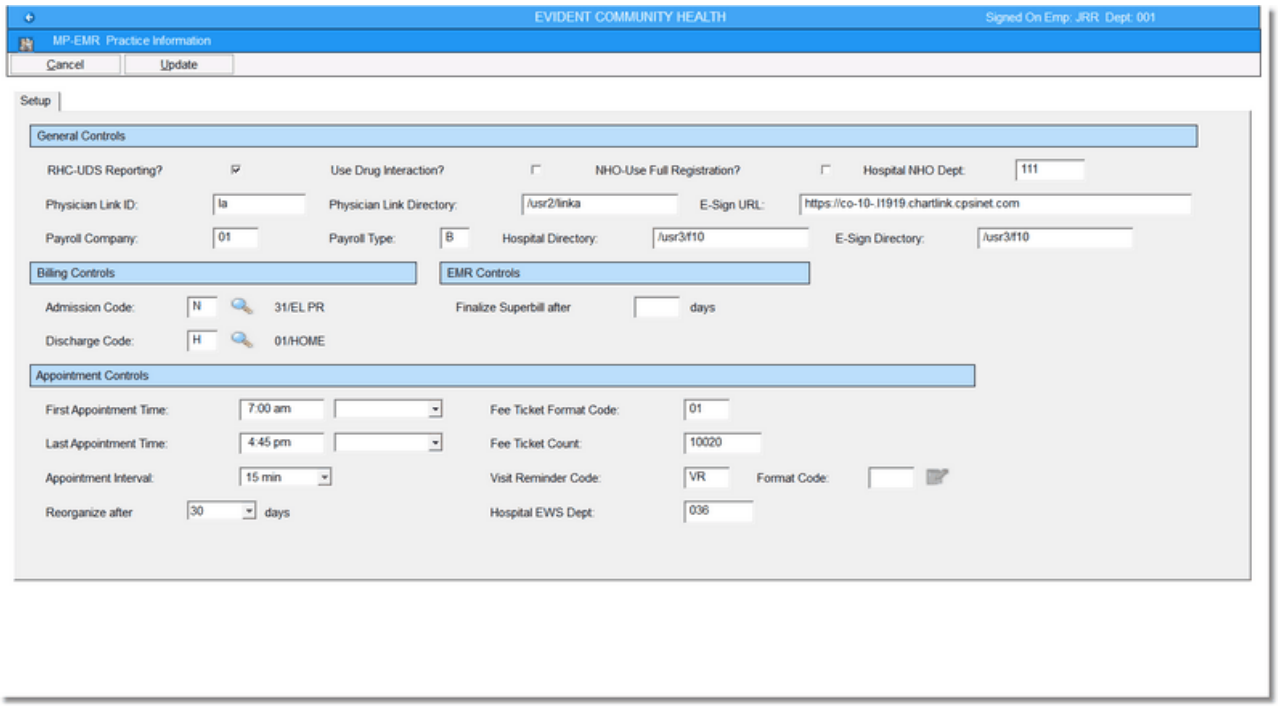
Practice Information

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Menu** > **Practice Information**



MP-EMR Practice Information

- **RHC-UDS Reporting:** Activate this field to use RHC-UDS reporting. Once this field is active, the RHC-UDS Table will be available in the MP-EMR Menu. An active field will also add an option for RHC-UDS Reports on the Print Report Menu and add RHC-UDS fields to both the diagnosis and CPT code tables.

RHC UDS Table

The RHC-UDS Table contains three sections. The first section contains the Category Codes. The second section contains the Subcategory Codes. The final section contains the Income Levels. These sections control the information that pulls to the RHC-UDS reports.

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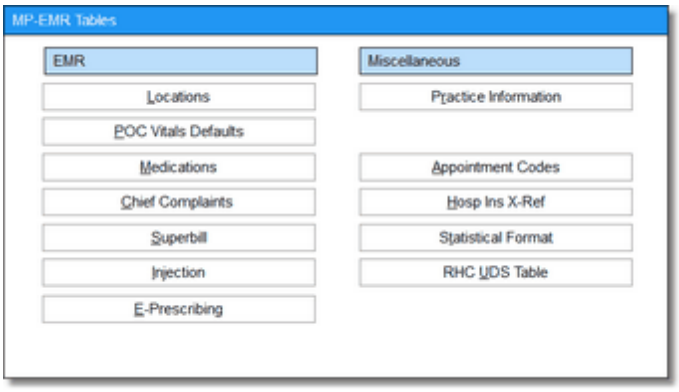
Select **Clinic Base Menu > Master Selection > Business Office Tables > MP-EMR Menu > RHC UDS Table**

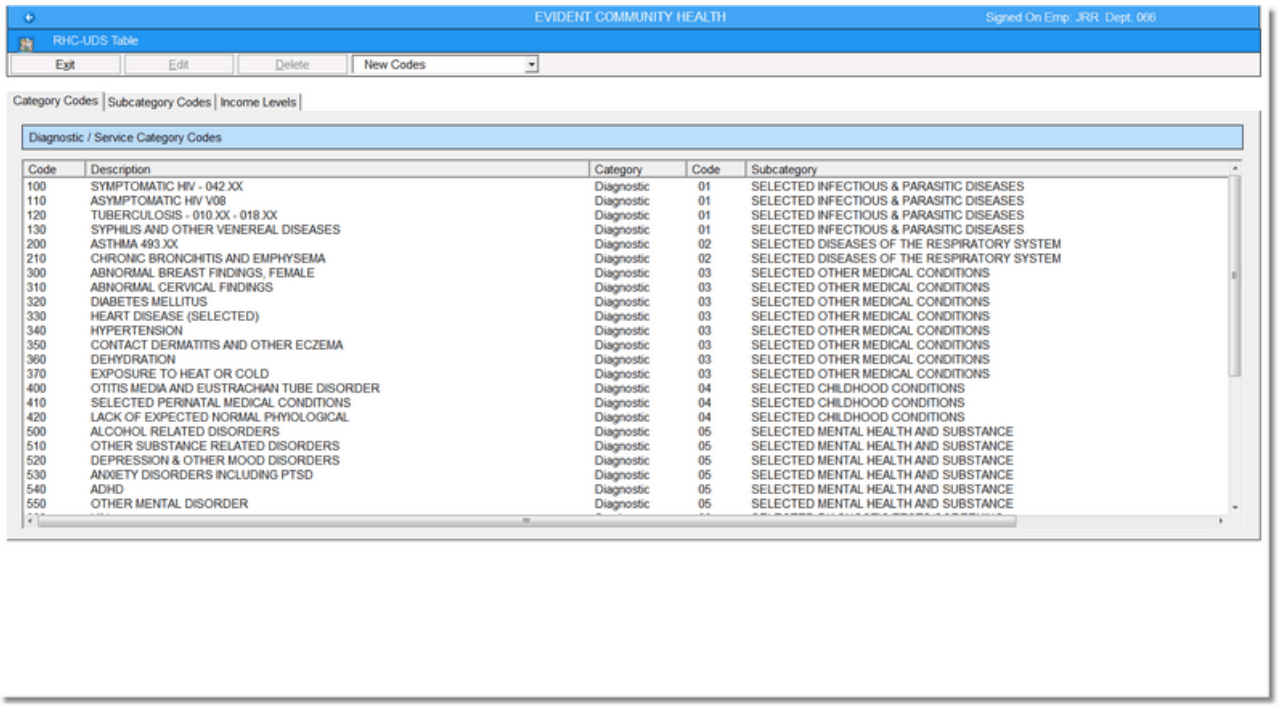


RHC-UDS Table

Category Code

Diagnostic/Service Category Codes are codes that define the information that appears on the "Selected Diagnosis/Service Rendered" report.

Select **Clinic Base Menu > Master Selection > Business Office Tables > MP-EMR Menu > RHC UDS Table > New Category Code**



Category Codes

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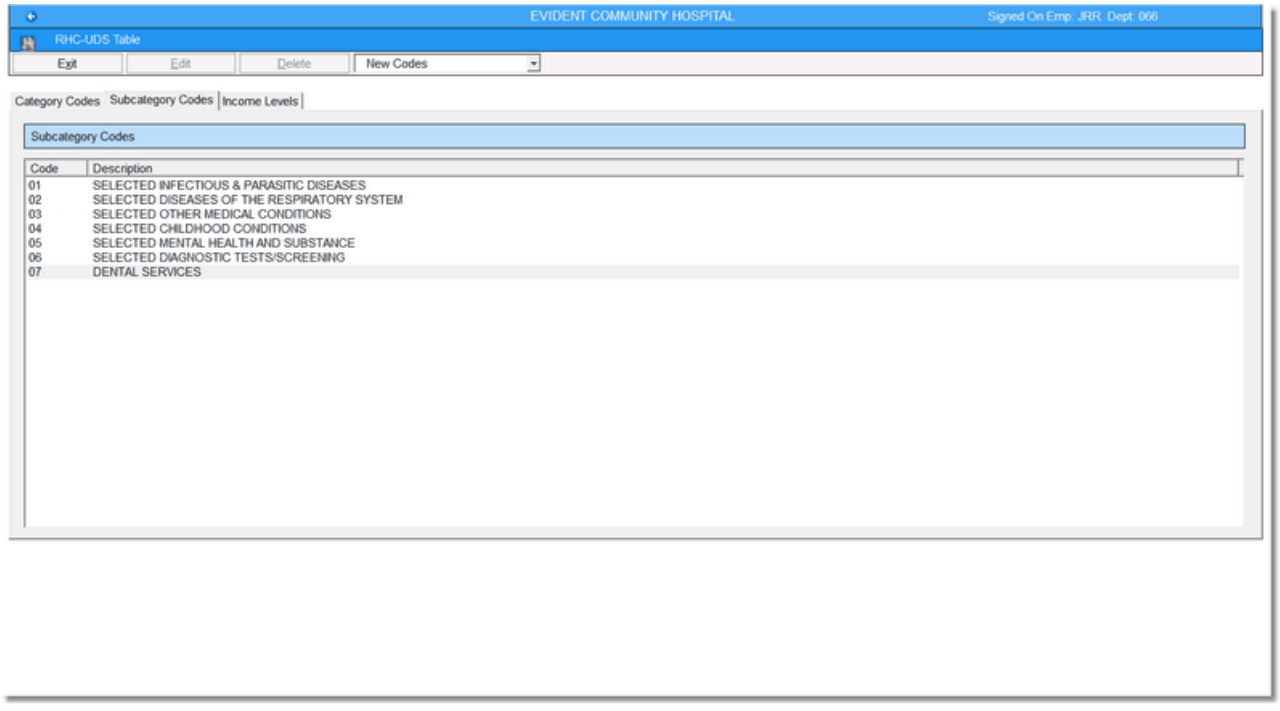
- **Code:** Three digit code that identifies the category on the "Selected Diagnosis/Services Rendered" report. The report prints in numeric order, therefore, this field should only contain a numeric value.
- **Description:** Enter up to 80 characters to describe the Category.
- **Category:** Select Diagnostic or Service. Diagnostic category is primarily used with diagnosis codes. Service category is primarily used with procedure codes.
- **Subcategory:** Use the drop down to select a Subcategory.
- **Cancel:** Exits screen without saving changes.
- **Save:** Saves changes made.
- **New Code:** Allows creation of a new code.

Subcategory Codes

Subcategories attach to the category codes and provide sub-headings on the "Selected Diagnosis/ Services Rendered" report.

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Menu** > **RHC UDS Table** > **New Subcategory Code**



Subcategory Codes

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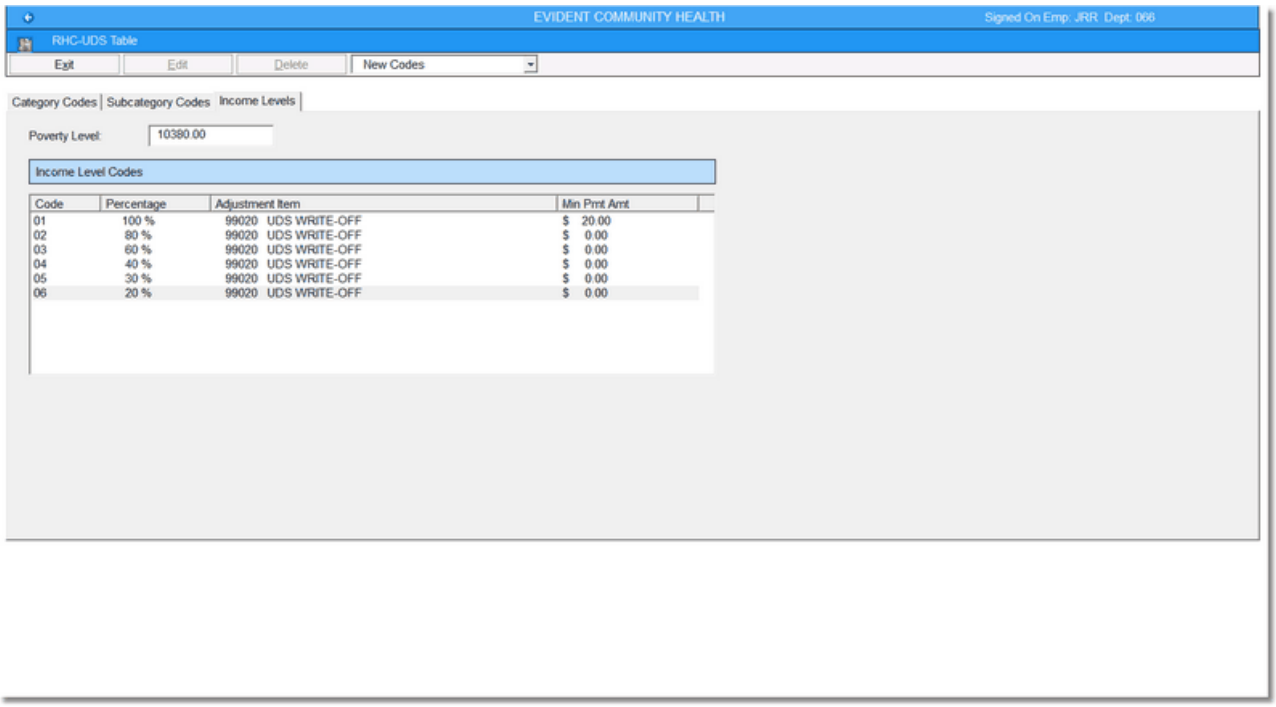
- **Code:** Two digit code that identifies the subcategory. Codes will list in numeric order under the corresponding category codes on the "Selected Diagnosis/Services Rendered" report.
- **Description:** Enter up to 80 characters to describe Subcategory.
- **Cancel:** Exits the screen without saving changes.
- **Save:** Saves changes made.
- **New Code:** Allows creation of new code.

Income Levels

This section includes the Poverty Level and allows entry of Income Levels. The Poverty Level is utilized by the "Socioeconomic Characteristics" report to define the number of users by "Income as a Percent of Poverty Level". The Income Levels allow system to adjust visit balance by a sliding fee. The sliding fee will adjust a percentage of the balance. The percentage is determined by the number of family members of the patient and the patient's yearly income.

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **MP-EMR Menu** > **RHC UDS Table** > **New Income Level**



Income Levels

- **Code:** Two character code used to identify the Income Level. Coded is also referred to as the UDS code.

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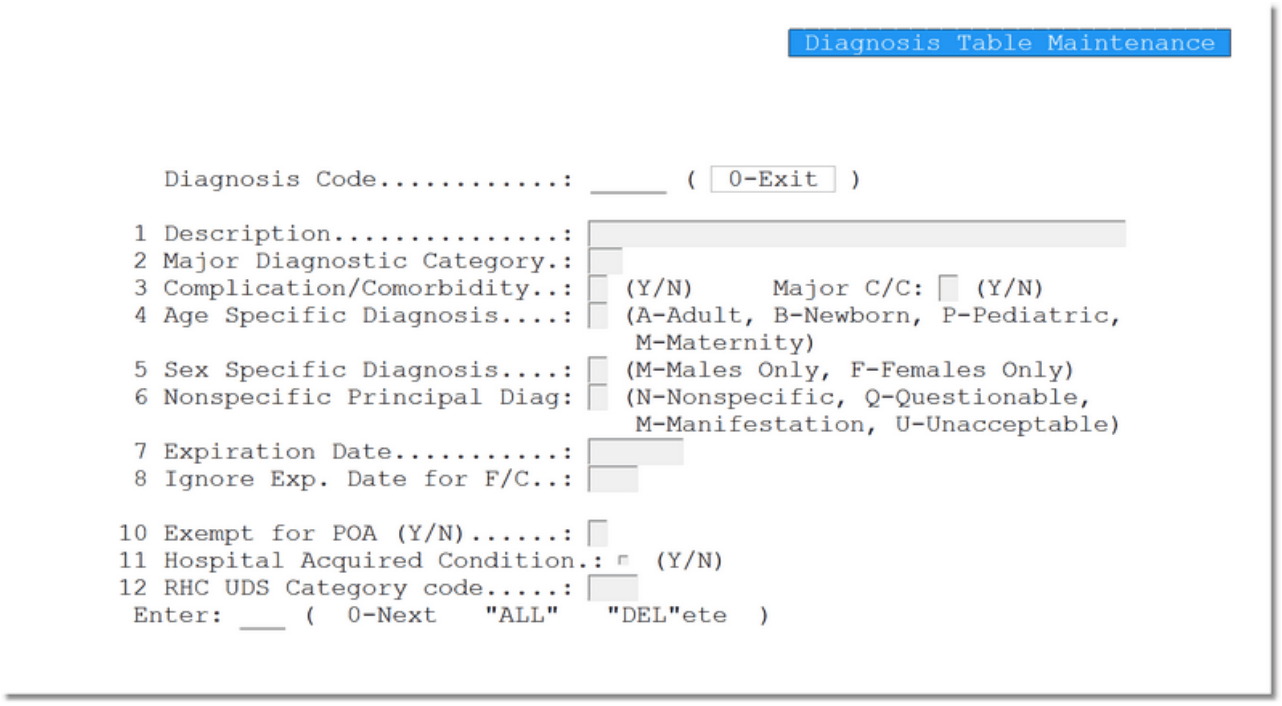
- **Sliding Fee:** Percentage amount of the adjustment. The system will first read the yearly income and number of family members of the patient to determine which sliding fee percentage is used.
- **Family Member(s):** Enter the number of family member(s). Up to 20 family members may be entered per code. The Family Member field is directly associated with the Income Max field.
- **Income Max:** Enter the maximum income associated with the sliding fee percentage. The amount is specifically associated with the number loaded in the Family Member(s) field. Once income is entered, the amount populates in the table on the right. Entries may be deleted from the table.
- **Adjustment Item:** The Item used to apply sliding fee adjustment. One item may be used per code.
- **Cancel:** Exits screen without saving changes.
- **Save:** Saves changes made.

The Income Level codes are created for a specific sliding fee percentage. This allows entry of income ranges for the number of family members (example: if code 01 has maximum income of $10,000 for a family of one and code 02 has maximum income of $15,000 for a family member of one, a patient that has yearly income of $12,000 would fall under code 02).

Diagnosis Table

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance Menu** > **Diagnosis Codes** > **Diagnosis Table Maintenance**

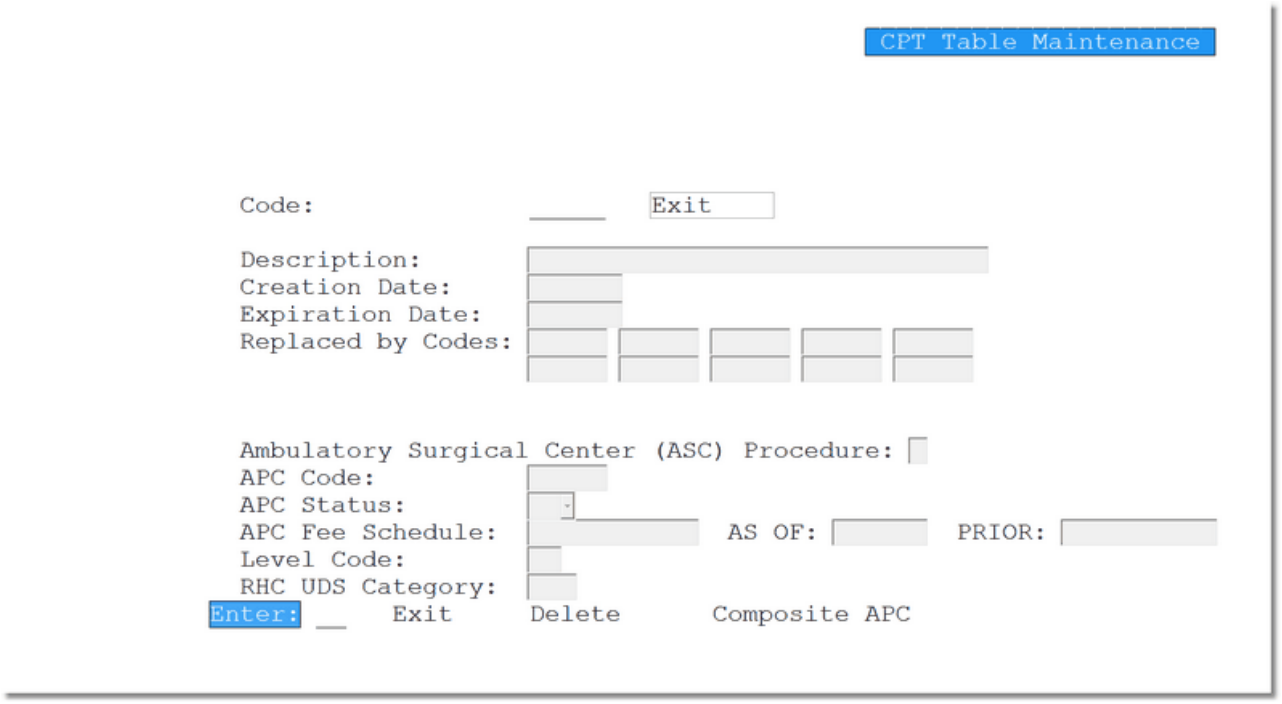


Diagnosis Table Maintenance

- **RHC UDS Category Code:** Load the RHC-UDS Category code that applies to this diagnosis.

CPT Code Table

Select **Clinic Base Menu** > **Master Selection** > **Business Office Tables** > **Maintenance Menu** > **Diagnosis Codes** > **CPT Table Maintenance**



CPT Table Maintenance

- **RHC UDS Category Code:** Load the RHC-UDS Category code that applies to this procedure.

Using the RHC-UDS Screen

When "RHC-UDS Reporting" is activated in Practice Information, there will be an option under Misc Options to access the RHC-UDS screen. Each field on the RHC-UDS screen dictates how the information appears in the RHC-UDS reports.

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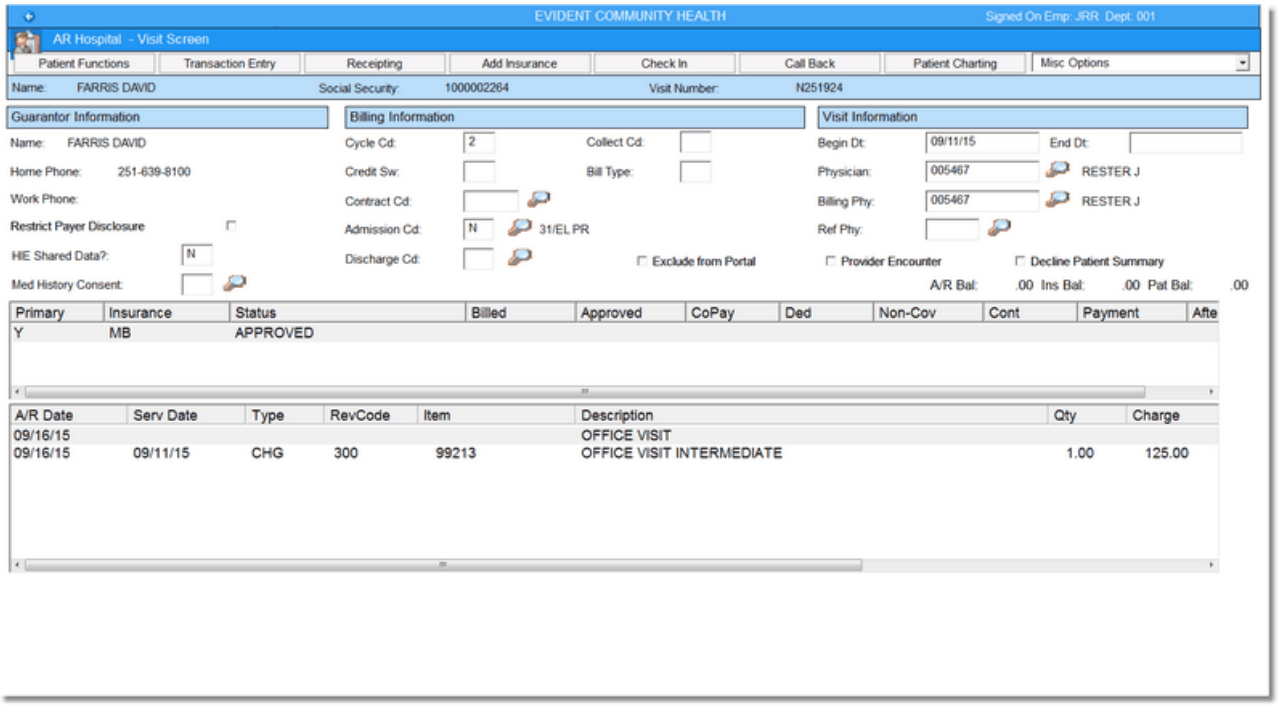
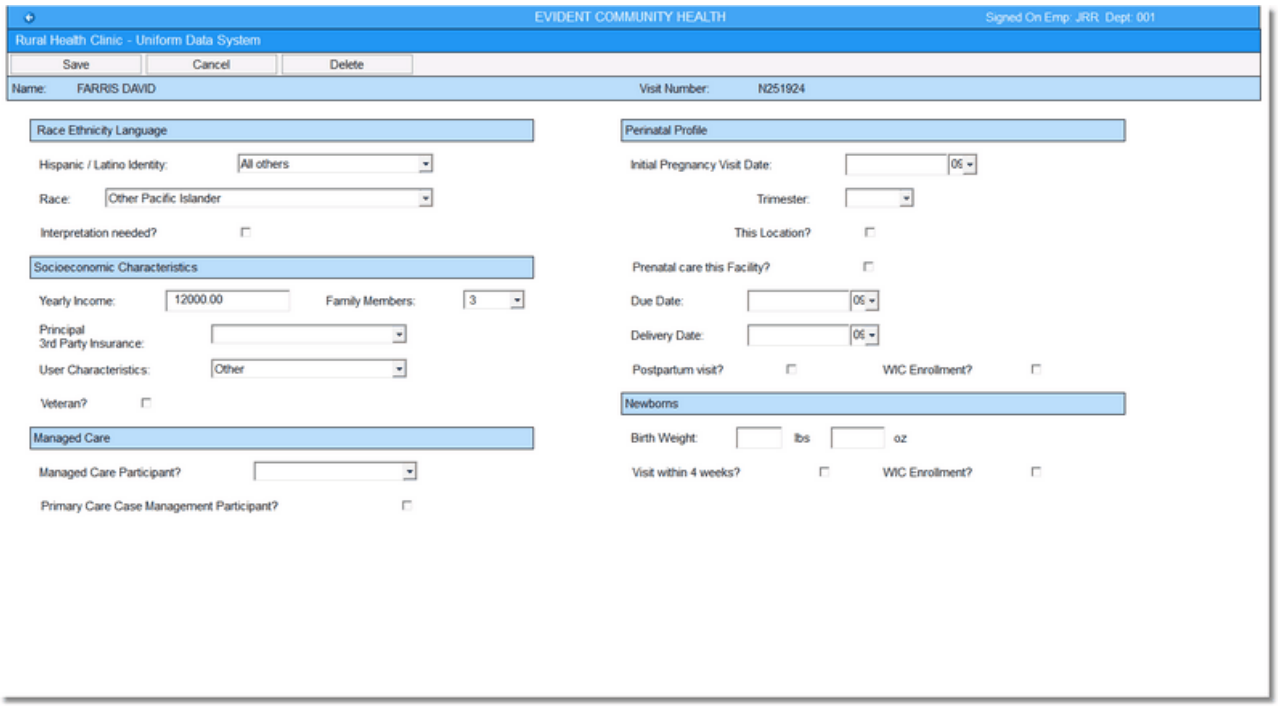
Select **Clinic Base Menu > Patient Visit # > MP-EMR Visit**



Visit Screen

Select **Clinic Base Menu > Patient Visit # > MP-EMR Visit > RHC UDS**



Rural Health Clinic - Uniform Data System

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Race/Ethnicity/Language

- **Hispanic/Latino Identity:** Use the drop-down menu to populate the appropriate response.
- **Race:** Use the drop-down menu to select the patient's race.
- **Interpretation Needed?:** If the patient needs an interpreter, check the box. If an interpreter is not needed, leave box unchecked.

Socioeconomic Characteristics

- **Yearly Income:** Enter the patient's yearly income.
- **Family Members:** Use the drop-down menu to select the number of family members for the patient. The number selected should include the patient.
- **Principal 3rd Party Insurance:** Use the drop-down menu to select the appropriate insurance classification for the patient.
- **User Characteristics:** Use the drop-down menu to select the appropriate characteristic code for the patient.
- **Veteran?:** If the patient is a veteran of the military, check box. If patient is not a veteran, leave box unchecked.

Managed Care

- **Managed Care Participant?:** Use the drop-down menu to populate the appropriate response.
- **Primary Care Case Management Participant?:** If the patient is a primary care case participant, check box. If patient is not a primary care case participant, leave box unchecked.

Perinatal Profile

- **Initial Pregnancy Visit Date:** Enter the initial pregnancy visit date or use the calendar option to select date. The format MMDDYY.
- **Trimester:** Enter the trimester of the pregnancy when the initial visit took place.
- **This Location?:** If the initial visit took place at this facility, check box. If initial visit took place at a different facility, leave box unchecked.
- **Prenatal Care This Facility?:** If patient received or is to receive prenatal care at this facility, check box. If the patient will not receive prenatal care at this facility, leave box unchecked.
- **Due Date:** Enter the due date or use the calendar option to select date. The format MMDDYY.

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- **Delivery Date:** Enter the date the baby was born or use the calendar option to select date. The format MMDDYY.
- **Postpartum Visit?:** If visit is a postpartum visit, check box. The field will be used to record the time from delivery to the postpartum visit.
- **WIC Enrollment?:** If the mother is enrolled in WIC, check box. If the mother is not enrolled in WIC, leave box unchecked.

Newborns

- **Birth Weight:** Enter the birth weight of the baby.
- **Visit Within 4 Weeks?:** If the child visits the facility within four weeks of delivery, check box. If child does not visit the office within four weeks of delivery, leave box unchecked.
- **WIC Enrollment?:** If the child is enrolled in WIC, check box. If the child is not enrolled in WIC, leave box unchecked.

NOTE: *The newborn portion should only be completed on the child's visit.*

- **Save:** Saves changes made.
- **Cancel:** Exits screen without retaining changes.
- **Delete:** Deletes the RHC-UDS screen from the visit. Deleting the screen will remove the UDS code from the visit and prevent visit from affecting RHC-UDS reporting.

Once RHC-UDS screen is saved to the visit, the UDS code appears on the visit screen. The system determines the code by the numbers loaded in the yearly income and family member fields.

Sliding Fee Adjustments

The Sliding Fee Adjustments may be applied to both Private Pay patients and patients with insurance. Adjustments to Private Pay patients are applied when charges are posted to the visit. Adjustments to patients with insurance are applied by the Sliding Fee Report. The report creates the adjustment after all claims are paid or rejected on the visit.

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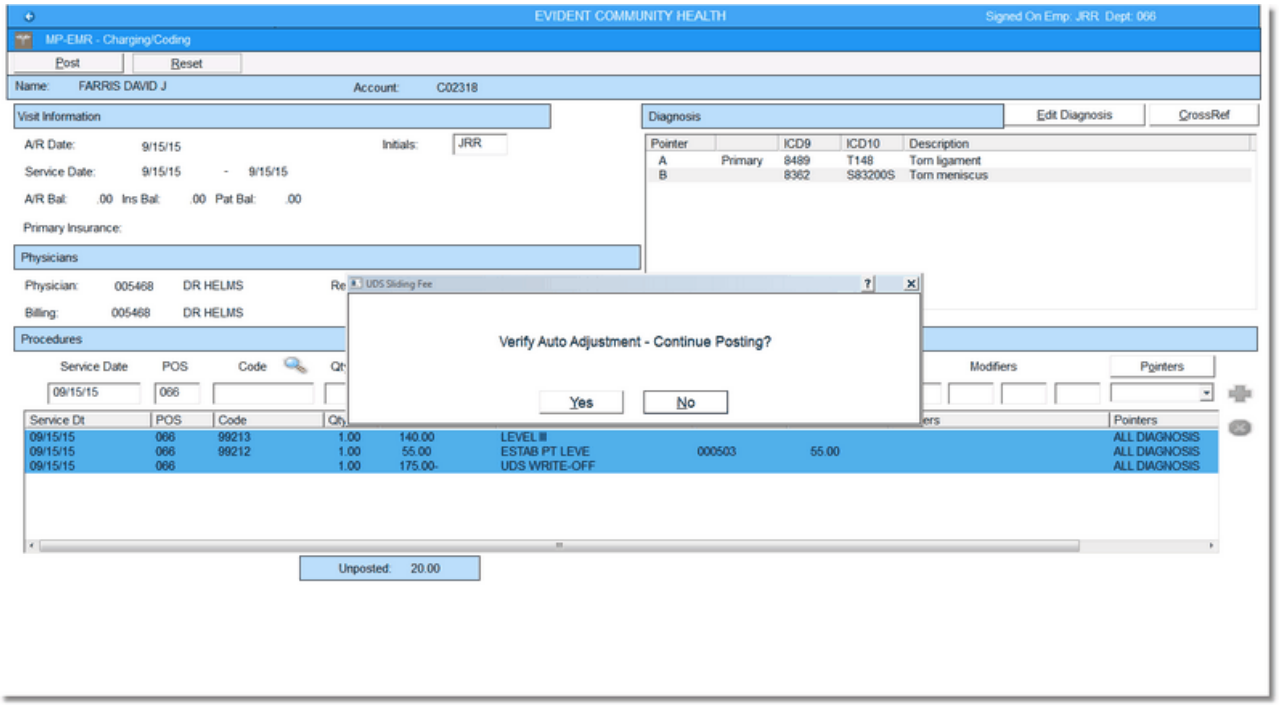
Select **Clinic Base Menu > Patient Visit # > MP-EMR Visit > Transaction Entry > Post**



UDS Sliding Fee

The "UDS Sliding Fee" box appears on Private Pay patients at the time of posting charges via transaction entry. For patients with insurance, the Sliding Fee report will create the adjustment in the transaction entry screen. The charge must then be posted. Once posted, the adjustment appears on both the transaction entry screen and the account detail. The Sliding Fee report will be covered later in this chapter.

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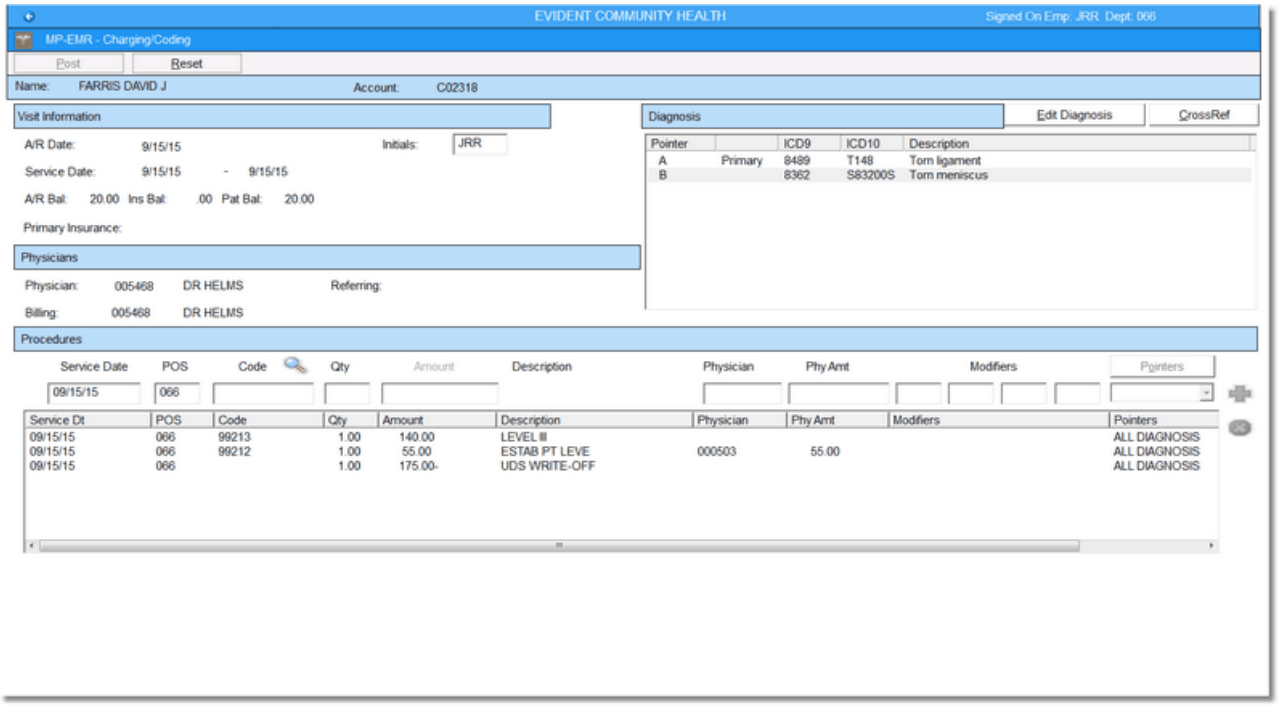
Select **Clinic Base Menu** > **Patient Visit #** > **MP-EMR Visit** > **Transaction Entry**



MP-EMR - Charging/Coding

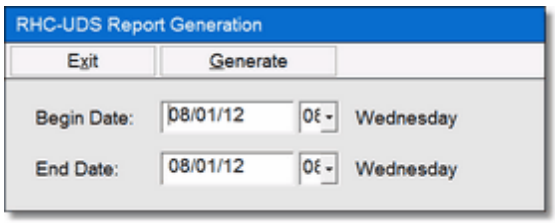
Generate UDS File

Prior to printing any of the RHC-UDS reports, a file must be generated.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.
2. Select **RHC-UDS Reports**.
3. Select **Generate UDS File**.

Select **Clinic Base Menu** > **Print Reports** > **RHC-UDS Reports** > **Generate UDS File**



RHC-UDS Report Generation

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4. Enter the desired date range for the file build or use the calendar option. The format is MMDDYY.

5. Select **Generate** to start file generation.

Description and Usage

The file generation will build a file to store all information for RHC-UDS reports. Once file is generated, the date range will appear on the RHC-UDS Reports screen.

Sliding Fee Report

The Sliding Fee Report provides ability to apply sliding fee adjustments to patients with receipted insurance claims.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.

2. Select **RHC-UDS Reports.**

3. Select **Sliding Fee Report**.

4. Select a print option.

   System prompts, "Receipt Date Range:"

5. Enter the beginning and ending date range or select dates from the drop-down menus. The format is MMDDYY. The system will default to the current system date.

6. Select **Generate**.

Description and Usage

The Sliding Fee Report will list patients that have receipted insurance claims in the given date range. The report will only list accounts that are marked as UDS accounts and only when the final claim of the account is paid/rejected. The report will also create the adjustment in the transaction entry screen. The adjustment must be posted from the transaction entry screen to affect the patient account.

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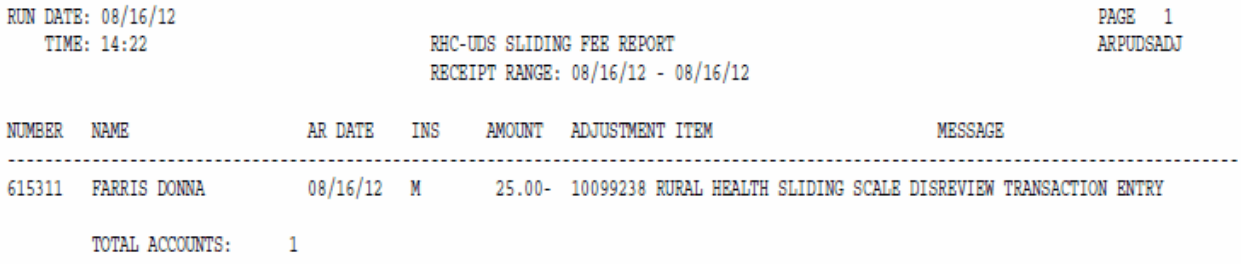
Sliding Fee Report



RUN DATE: 08/16/12 PAGE 1
TIME: 14:22 RHC-UDS SLIDING FEE REPORT ARPUDSADJ
RECEIPT RANGE: 08/16/12 - 08/16/12

NUMBER	NAME	AR DATE	INS	AMOUNT	ADJUSTMENT ITEM	MESSAGE
615311	FARRIS DONNA	08/16/12	M	25.00-	10099238 RURAL HEALTH SLIDING SCALE DISREVIEW	TRANSACTION ENTRY

TOTAL ACCOUNTS: 1

Listed below is an explanation of each column.

- **Number:** The account/visit number of the patient.
- **Name:** The name of the patient.
- **A/R Date:** The A/R date of creation of the adjustment charge.
- **Ins (Insurance):** The financial class that was receipted on the patient account.
- **Amount:** Dollar amount charged through the adjustment.
- **Adjustment Item:** The item number and description of the adjustment charged.
- **Message:** Field will populate, "Review Transaction Entry" if adjustment was created. Other messages will appear if adjustment could not be created.

NOTE: *Report creates adjustment charges that must be posted on the visit via the transaction entry screen.*

Users by Age/Gender/Ethnicity

This report gives the total number of patients for the specified date range by age and sex. Race/ ethnicity percentages will be included, along with, the percentage of patients that required language interpreters.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.
2. Select **RHC-UDS Reports.**
3. Select **Users by Age/Gender/Ethnicity**.

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System prompts, "Select Migrants:"

4. Select **All**, **Exclude** or **Include** and select **Continue**.

5. Select a print option.

Description and Usage

This report will record each patient's information with a visit during the date range of the UDS File Generation. The patient must have the Race/Ethnicity/Language section of the RHC-UDS screen completed.

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Users by Age/Gender/Ethnicity

```
RUN DATE: 08/02/12                                                    ARPDUDSAGI
    TIME: 13:01       USERS BY AGE/GENDER/RACE/LANGUAGE               PAGE    1
                             08/01/12 TO 08/02/12

NUMBER OF USERS
-------------------------------------------------------

AGE GROUPS                   MALE USERS    FEMALE USERS
==========================   ==========    ============
  AGES <1
  AGE   1
  AGE   2
  AGE   3
  AGE   4
  AGE   5
  AGE   6
  AGE   7
  AGE   8
  AGE   9
  AGE  10
  AGE  11
  AGE  12
  AGE  13
  AGE  14
  AGE  15
  AGE  16
  AGE  17
  AGE  18
  AGE  19
  AGE  20
  AGE  21
  AGE  22
  AGE  23
  AGE  24
  AGES 25-29
  AGES 30-34                                          1
  AGES 35-39
  AGES 40-44                                          1
  AGES 45-49
  AGES 50-54
  AGES 55-59
  AGES 60-64
  AGES 65-69
  AGES 70-74
  AGES 75-79
  AGES 80-84
  AGES 85 AND OVER
                             ----------    ----------
TOTAL USERS  100%                                     2
                             ==========    ==========
```

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Users by Age/Gender/Ethnicity (Proportion of Users)

```
RUN DATE: 08/02/12                                                    ARPDUDSAGE
    TIME: 13:01       USERS BY AGE/GENDER/RACE/LANGUAGE               PAGE    2
                            08/01/12 TO 08/02/12

PROPORTION OF USERS
-----------------------------------------------------

HISPANIC/LATINO IDENTITY              PERCENT    NUMBER
==================================    =======    ======
  HISPANIC OR LATINO
  ALL OTHERS INCLUDING UNREPORTED       100%          2
                                      -------    -------
TOTAL USERS                             100%          2
                                      =======    =======


RACE/ETHNICITY                        PERCENT    NUMBER
==================================    =======    ======
    NATIVE HAWAIIAN
    OTHER PACIFIC ISLANDER
                                      =======    =======
  TOTAL HAWAIIAN/PACIFIC ISLANDER

  ASIAN
  BLACK/AFRICAN AMERICAN
  AMERICAN INDIAN/ALASKA NATIVE
  WHITE                                  50%          1
  MORE THAN ONE RACE
  UNREPORTED/REFUSED TO REPORT           50%          1
                                      -------    -------
TOTAL USERS                             100%          2
                                      =======    =======


LANGUAGE                              PERCENT    NUMBER
==================================    =======    ======
INTERPRETATION NEEDED
                                      =======    =======


ZIP CODES                             PERCENT    NUMBER
==================================    =======    ======
36695                                   100%          2
                                      -------    -------
TOTAL USERS                             100%          2
                                      =======    =======
```

Listed below is an explanation of each column.

- **Age Groups:** This is a breakdown of ages.
- **Male Users:** The number of male patients will appear in this column. Each age category will list the number of male patients.
- **Female Users:** The number of female patients will appear in this column. Each age category will list the number of female patients.

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- **Hispanic/Latino Identity:** Lists all available responses to Hispanic/Latino identity field on the RHC-UDS screen. This system will also list the number of patients identified in the category and calculate the percentage of patients in each category.

- **Race/Ethnicity:** Lists all available responses to the Race field on the RHC-UDS screen. This system will also list the number of patients identified in the category and calculate the percentage of patients in each category.

- **Language:** This will give the number and percentage of patients that have the "Interpretation Needed?" box check on the RHC-UDS screen.

- **Zip Code:** Lists the zip codes of patients with populated RHC-UDS screens. This system will also list the number of patients identified in the category and calculate the percentage of patients in each category.

Socioeconomic Characteristics

This report will list the number of patients by their income as a percent of the poverty level. The yearly income on the RHC-UDS screen of the patient must be populated for information to appear on report.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.

2. Select **RHC-UDS Reports.**

3. Select **Socioeconomic Characteristics**.

   System prompts, "Select Migrants:"

4. Select **All**, **Exclude** or **Include** and select **Continue**.

5. Select a print option.

Description and Usage

The report will record each patient's information that has a visit during the date range of the UDS File Generation. The patient must have the Socioeconomic Characteristics section of the RHC-UDS screen completed.

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Socioeconomic Characteristics

```
RUN DATE: 08/02/12                                                    ARPDUDSSOC
    TIME: 13:32          SOCIOECONOMIC CHARACTERISTICS                PAGE   1
                              08/01/12 TO 08/02/12

CHARACTERISTIC                                    NUMBER OF USERS
====================================   ========================
INCOME AS A PERCENT OF POVERTY LEVEL
-------------------------------------------------------------------
  100% AND BELOW                                                 2
  101 - 150%
  151 - 200%
  OVER 200%
  UNKNOWN
                                                         ---------
TOTAL                                                            2
                                                        =========

PRINCIPAL THIRD PARTY INSURANCE SOURCE       0-19      20 & OVER
-------------------------------------------------------------------
  NONE/UNINSURED                                                 2

    REGULAR MEDICAID
    CHIP MEDICAID
                                          ---------     ---------
  TOTAL MEDICAID

  MEDICARE

    OTHER PUBLIC INSURANCE NON-CHIP
    OTHER PUBLIC INSURANCE CHIP
                                          ---------     ---------
  TOTAL PUBLIC INSURANCE

  PRIVATE INSURANCE
                                          ---------     ---------
TOTAL                                                            2
                                         =========     =========

SELECTED USER CHARACTERISTICS
-------------------------------------------------------------------
  MIGRANT
  SEASONAL
                                                         ---------
TOTAL MIGRANT/SEASONAL WORKER OR DEPENDENT
                                                        =========

  HOMELESS SHELTER
  TRANSITIONAL
  DOUBLING UP
  STREET
  OTHER
  UNKNOWN                                                        2
                                                         ---------
TOTAL HOMELESS                                                   2
                                                        =========

TOTAL VETERANS
                                                        =========
```

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RUN DATE: 08/02/12 ARPDUDSSOC
TIME: 13:32 SOCIOECONOMIC CHARACTERISTICS PAGE 1
08/01/12 TO 08/02/12

CHARACTERISTIC	NUMBER OF USERS
INCOME AS A PERCENT OF POVERTY LEVEL	
100% AND BELOW	2
101 - 150%	
151 - 200%	
OVER 200%	
UNKNOWN	
TOTAL	2

PRINCIPAL THIRD PARTY INSURANCE SOURCE	0-19	20 & OVER
NONE/UNINSURED		2
REGULAR MEDICAID		
CHIP MEDICAID		
TOTAL MEDICAID		
MEDICARE		
OTHER PUBLIC INSURANCE NON-CHIP		
OTHER PUBLIC INSURANCE CHIP		
TOTAL PUBLIC INSURANCE		
PRIVATE INSURANCE		
TOTAL		2

SELECTED USER CHARACTERISTICS	
MIGRANT	
SEASONAL	
TOTAL MIGRANT/SEASONAL WORKER OR DEPENDENT	
HOMELESS SHELTER	
TRANSITIONAL	
DOUBLING UP	
STREET	
OTHER	
UNKNOWN	2
TOTAL HOMELESS	2
TOTAL VETERANS	

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Listed below is an explanation of each column.

- **Income as a Percent of Poverty:** Records the number of patients that apply to each percentage of the poverty level.
- **Principal Third Party Insurance Source:** Lists all available responses to the Principal Third Party Insurance field on the RHC-UDS screen. The report separates patients by age ranges 0-19 and 20 & over.
- **Select User Characteristics:** Lists the number of patients associated with each characteristic. This reads from the User Characteristics field on the RHC-UDS screen.
- **Total Veterans:** The total number of veterans as indicated by the Veteran field on the RHC-UDS screen.

Perinatal Profile

The Perinatal Profile will display accounts that are listed in the Perinatal Profile or the Newborn section of the RHC-UDS screens.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.
2. Select **RHC-UDS Reports.**
3. Select **Perinatal Profile**.

   System prompts, "Select Migrants:"
4. Select **All**, **Exclude** or **Include** and select **Continue**.
5. Select a print option.

Description and Usage

This report will record information for each patient that had a visit entered during the date range of the UDS File Generation. The Perinatal Profile and Newborns section of the RHC-UDS screen will need to be populated to pull to this report.

The report will give the following information:

- Total patients known to be pregnant.
- Total patients known to be pregnant with HIV.
- Number of prenatal care patients by age.

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- A percentage breakdown of prenatal care patients by race.
- Number of users that had their first pregnancy visit at this facility or another facility, and which trimester the patient was in at the time of the first visit.
- Prenatal care patients that delivered during the year.
- Number of births by weight.
- Prenatal care patients who received postpartum care within 8 weeks of delivery.
- Infants delivered that received a newborn visit within 4 weeks of birth.
- Enrollment of prenatal care patients and infants in WIC.

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Perinatal Profile

```
RUN DATE: 08/02/12                                                ARPDUDSPNAT
    TIME: 15:21              PERINATAL PROFILE                    PAGE   1
                           07/01/12 TO 08/02/12

CHARACTERISTIC                                          NUMBER OF USERS
================================================   ==========================

GRANTEES WHO PROVIDE PRENATAL CARE
--------------------------------------------------------------------------------
DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE USERS

AGE
  LESS THAN 15 YEARS
  AGES 15-19
  AGES 20-24
  AGES 25-44                                                              1
  AGES 45 AND OVER
                                                                      ---------
TOTAL USERS  100%                                                         1
                                                                     =========

HISPANIC/LATINO IDENTITY
--------------------------------------------------------------------------------
  HISPANIC OR LATINO
  ALL OTHERS INCLUDING UNREPORTED                          100%           1
                                                                      ---------
TOTAL USERS                                                100%           1
                                                                     =========



RACE/ETHNICITY
--------------------------------------------------------------------------------
    NATIVE HAWAIIAN
    OTHER PACIFIC ISLANDER                                 100%           1
                                                                      ---------
  TOTAL HAWAIIAN/PACIFIC ISLANDER                          100%           1

  ASIAN
  BLACK/AFRICAN AMERICAN
  AMERICAN INDIAN/ALASKA NATIVE
  WHITE
  MORE THAN ONE RACE
  UNREPORTED/REFUSED TO REPORT
                                                                      ---------
TOTAL USERS                                                100%           1
                                                                     =========
```

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RUN DATE: 08/02/12 ARPDUDSPNAT
TIME: 15:21 PERINATAL PROFILE PAGE 1
07/01/12 TO 08/02/12

CHARACTERISTIC		NUMBER OF USERS
GRANTEES WHO PROVIDE PRENATAL CARE		
DEMOGRAPHIC CHARACTERISTICS OF PRENATAL CARE USERS		
AGE		
LESS THAN 15 YEARS		
AGES 15-19		
AGES 20-24		
AGES 25-44		1
AGES 45 AND OVER		
TOTAL USERS 100%		1
HISPANIC/LATINO IDENTITY		
HISPANIC OR LATINO		
ALL OTHERS INCLUDING UNREPORTED	100%	1
TOTAL USERS	100%	1
RACE/ETHNICITY		
NATIVE HAWAIIAN		
OTHER PACIFIC ISLANDER	100%	1
TOTAL HAWAIIAN/PACIFIC ISLANDER	100%	1
ASIAN		
BLACK/AFRICAN AMERICAN		
AMERICAN INDIAN/ALASKA NATIVE		
WHITE		
MORE THAN ONE RACE		
UNREPORTED/REFUSED TO REPORT		
TOTAL USERS	100%	1

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Perinatal Profile (continued)

```
RUN DATE: 08/02/12                                                    ARPDUDSPNAT
    TIME: 15:21              PERINATAL PROFILE                        PAGE   2
                          07/01/12 TO 08/02/12

CHARACTERISTIC                                          NUMBER OF USERS
================================================   ==========================

TRIMESTER OF ENTRY INTO PRENATAL CARE

TRIMESTER OF FIRST KNOWN VISIT                     GRANTEE SITE  ANOTHER SITE
-------------------------------------------------------------------------------
FIRST TRIMESTER                                           1
SECOND TRIMESTER
THIRD TRIMESTER


DELIVERY, POSTPARUM AND INFANT UTILIZATION DURING THE CALENDAR YEAR
-------------------------------------------------------------------------------
            HAWAIIAN PACIFIC  ASIAN  BLACK AMERICAN WHITE UNKNOWN LATINO TOTAL
                     ISLANDER             INDIAN
PRENATAL
 DELIVERED

8WK
 POSTPARTUM

INFANT BIRTH
< 1500 GRAMS

< 2500 GRAMS

> 2500 GRAMS

VISIT WITHIN
 4 WEEKS


ENROLLMENT OF PRENATAL CARE USERS AND THEIR INFANTS IN WIC
-------------------------------------------------------------------------------
PRENATAL CARE USERS
INFANTS
POSTPARTUM CARE USERS
```

Listed below is an explanation of each column.

- **Age:** Total number of patients, by age, known to be pregnant. There is a breakdown of patients by age ranges.
- **Race/Ethnicity:** The breakdown of pregnant patients by race/ethnicity. The system also provides a percentage of patients by race/ethnicity.
- **Trimester of First Known Visit:** Number of patients that had their first visit at this facility or another facility and by trimester of the initial visit.

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- **Prenatal Users Delivered:** Number of prenatal care patients, by race/ethnicity, who delivered during the UDS file build range, according to delivery date loaded in the RHC-UDS screen.

- **8WK Postpartum:** Number of patients, by race/ethnicity, who delivered during the UDS file build range and have "Postpartum visit?" checked on the RHC-UDS screen.

Infant Births

- **< 1500 Grams:** Total number of infants, by race/ethnicity, that have a birth weight less than 1500 grams. The weight is loaded under the Newborns section of the RHC-UDS screen.

- **< 2500 Grams:** Total number of infants, by race/ethnicity, that have a birth weight between 1501 and 2500 grams. The weight is loaded under the Newborns section of the RHC-UDS screen.

- **> 2500 Grams:** Total number of infants, by race/ethnicity, that have a birth weight more than 2500 grams. The weight is loaded under the Newborns section of the RHC-UDS screen.

- **Visit Within 4 Weeks:** Total number of infants, by race/ethnicity, that have the "Visit within 4 weeks?" box checked and the delivery date is in the UDS file date range.

- **Enrollment of Prenatal Care Users and Their Infants in WIC:** Number of patients that have the "WIC Enrollment?" field checked on the RHC-UDS screen.

Managed Care Enrollment/Revenue

This report will record information for each patient that had a visit during the date range of the UDS File Generation.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.

2. Select **RHC-UDS Reports.**

3. Select **Managed Care Enrollment/Revenue**.

   System prompts, "Select Migrants:"

4. Select **All**, **Exclude** or **Include** and select **Continue**.

5. Select a print option.

Description and Usage

The report will record information for each patient that had a visit during the date range of the UDS File Generation. The report will read the Managed Care section of the RHC-UDS screen.

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This report will list the following information:

- Member months for managed care (capitated/fee-for-service)
- Managed care encounters (capitated/fee-for-service)
- Enrollees in managed care plans (capitated/fee-for-service)
- Enrollees in primary care case management programs
- Total managed care revenue (capitated/fee-for-service)
- Revenue for non-managed care and managed care participants by insurance

Managed Care Enrollment/Revenue

RUN DATE: 08/02/12 ARPDUDSMCRV
TIME: 15:35 MANAGED CARE ENROLLMENT/REVENUE PAGE 1
07/01/12 TO 08/02/12

MANAGED CARE ENROLLMENT/UTILIZATION

PAYOR CATEGORY	MEDICAID	MEDICARE	CHIP-MEDICAID OTHER CHIP	UNINSURED PRIVATE	TOTAL
UTILIZATION DATA					
Member months for Managed Care(capitated)	0	0	0	0	0
Member months for Managed Care(fee-for-service)	0	0	0	0	0
Total Member months for Managed Care	0	0	0	0	0
Managed Care Encounters(capitated)	0	0	0	0	0
Managed Care Encounters(fee-for-service)	0	0	0	0	0
Total Managed Care Encounters	0	0	0	0	0
Enrollees in Managed Care Plans(capitated)	0	0	0	0	0
Enrollees in Managed Care Plans(fee-for-service)	0	0	0	0	0
Total Enrollees in Managed Care Plans	0	0	0	0	0
Enrollees in Primary Care Case Management Programs	0	0	0	0	0

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Managed Care Enrollment/Revenue (continued)

RUN DATE: 08/02/12 ARPDUDSMCRV
TIME: 15:35 MANAGED CARE ENROLLMENT/REVENUE PAGE 2
07/01/12 TO 08/02/12

MANAGED CARE REVENUE

PAYOR CATEGORY	MEDICAID	MEDICARE	CHIP-MEDICAID OTHER CHIP	UNINSURED PRIVATE	TOTAL
REVENUE					
Capitation Revenue for services	0.00	0.00	0.00	0.00	0.00
Fee-for-service Revenue for services	0.00	0.00	0.00	0.00	0.00
Total Revenue for services	0.00	0.00	0.00	0.00	0.00

PATIENT RELATED REVENUE

	CHARGES	RECEIPTS
Medicaid Non-Managed Care	1,223.60	0.00
Medicaid Managed Care(capitated)	0.00	0.00
Medicaid Managed Care(fee-for-service)	0.00	0.00
Total Medicaid	1,223.60	0.00
Medicare Non-Managed Care	0.00	0.00
Medicare Managed Care(capitated)	0.00	0.00
Medicare Managed Care(fee-for-service)	0.00	0.00
Total Medicare	0.00	0.00
CHIP-Medicaid/Other-CHIP Non-Managed Care	0.00	0.00
CHIP-Medicaid/Other-CHIP Managed Care(capitated)	0.00	0.00
CHIP-Medicaid/Other-CHIP Managed Care(fee-for-service)	0.00	0.00
Total CHIP-Medicaid/Other-CHIP	0.00	0.00
Private Non-Managed Care	0.00	0.00
Private Managed Care(capitated)	0.00	0.00
Private Managed Care(fee-for-service)	0.00	0.00
Total Private	0.00	0.00
Uninsured Non-Managed Care	220.00	-20.00
Uninsured Managed Care(capitated)	0.00	0.00
Uninsured Managed Care(fee-for-service)	0.00	0.00
Total Uninsured	220.00	-20.00

Listed below is an explanation of each column.

- **Member Months for Managed Care (Capitated):** Total number of months with any patients that have Capitation selected for "Managed Care Participant?" on the RHC-UDS screen.

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- **Member Months for Managed Care (Fee-For-Service):** Total number of months with any patients that have Fee-for-service selected for "Managed Care Participant?" on the RHC-UDS screen.

- **Managed Care Encounters (Capitated):** Total number of actual encounters for patients that have Capitation selected for "Managed Care Participant?" on the RHC-UDS screen.

- **Managed Care Encounters (Fee-For-Service):** Total number of actual encounters for patients that have Fee-for-service selected for "Managed Care Participant?" on the RHC-UDS screen.

- **Enrollees In Managed Care Plans (Capitated):** Total number of patients that have Capitation selected for "Managed Care Participant?" on the RHC-UDS screen.

- **Enrollees In Managed Care Plans (Fee-For-Service):** Total number of patients that have Fee-for-service selected for "Managed Care Participant?" on the RHC-UDS screen.

- **Enrollees In Primary Care Case Management Programs:** Total number of patients with "Primary Care Case Management Participant?" selected on the RHC-UDS screen.

The following fields will give information based on the Managed Care Revenue. The revenue will break by principal third party insurance data entered on the RHC-UDS screen.

- **Capitation Revenue for Services:** The revenue for the patients that have Capitation selected as "Managed Care Participant?" on the RHC-UDS screen. Revenue will list by principal third party insurance.

- **Fee-For-Service Revenue for Services:** The revenue for the patients that have Fee-For-Service selected as "Managed Care Participant?" on the RHC-UDS screen. Revenue will list by principal third party insurance.

The following fields will give information based on the total Patient Related Revenue. The patients must have the RHC-UDS screen populated to appear in this section.

- **Medicaid Non-Managed Care:** Total revenue for patients that have third party insurance selected as Medicaid and "Managed Care Participant?" answered as No.

- **Medicaid Managed Care (Capitated):** Total revenue for patients that have third party insurance selected as Medicaid and "Managed Care Participant?" answered as Capitation.

- **Medicaid Managed Care (Fee-For-Service):** Total revenue for patients that have third party insurance selected as Medicaid and "Managed Care Participant?" answered as Fee-for-service.

- **Medicare Non-Managed Care:** Total revenue for patients that have third party insurance selected as Medicare and "Managed Care Participant?" answered as No.

- **Medicare Managed Care (Capitated):** Total revenue for patients that have third party insurance selected as Medicare and "Managed Care Participant?" answered as Capitation.

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- **Medicare Managed Care (Fee-For-Service):** Total revenue for patients that have third party insurance selected as Medicare and "Managed Care Participant?" answered as Fee-for-service.

- **Chip-Medicaid/Other-Chip Non-Managed Care:** Total revenue for patients that have third party insurance selected as CHIP Medicaid or Other CHIP and "Managed Care Participant?" answered as No.

- **Chip-Medicaid/Other-Chip Managed Care (Capitated):** Total revenue for patients that have third party insurance selected as CHIP Medicaid or Other CHIP and "Managed Care Participant?" answered as Capitation.

- **Chip-Medicaid/Other-Chip Managed Care (Fee-For-Service):** Total revenue for patients that have third party insurance selected as CHIP Medicaid or Other CHIP and "Managed Care Participant?" answered as Fee-for-service.

- **Private Non-Managed Care:** Total revenue for patients that have third party insurance selected as Other Non-CHIP or Private and "Managed Care Participant?" answered as No.

- **Private Managed Care (Capitated):** Total revenue for patients that have third party insurance selected as Other Non-CHIP or Private and "Managed Care Participant?" answered as Capitation.

- **Private Managed Care (Fee-For-Service):** Total revenue for patients that have third party insurance selected as Other Non-CHIP or Private and "Managed Care Participant?" answered as Fee-for-service.

- **Uninsured Non-Managed Care:** Total revenue for patients that have third party insurance selected as None/Uninsured and "Managed Care Participant?" answered as No.

- **Managed Care (Capitated):** Total revenue for patients that have third party insurance selected as None/Uninsured and "Managed Care Participant?" answered as Capitation.

- **Managed Care (Fee-For-Service):** Total revenue for patients that have third party insurance selected as None/Uninsured and "Managed Care Participant?" answered as Fee-for-service.

Selected Diagnosis/Services Rendered

The report will print the codes that are classified as Diagnostic Category and Service Category and lists the number of encounters and patients.

How to Print

1. Select **Print Reports** from the Clinic Base Menu or the Master Selection screen.

2. Select **RHC-UDS Reports.**

3. Select **Selected Diagnosis/Services Rendered.**

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System prompts, "Begin Date:" and "End Date:"

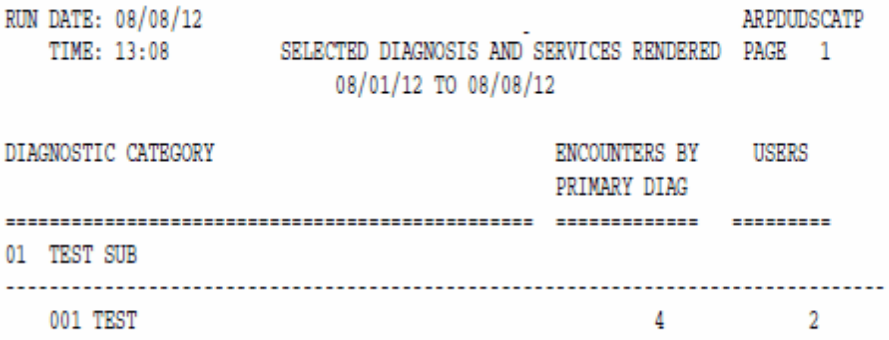
4. Enter the date range desired or use the calendar option and select **Generate**. The format is MMDDYY.

5. Select a print option.

Description and Usage

The report will print based on the codes created in the RHC-UDS Table. This report may be designed by the facility to record the number of encounters by a primary diagnosis or procedure code range and allow the total number of patients to be counted. This report will print the codes that are classified as "Diagnostic Category", then list the total number of encounters by the primary diagnosis, and list the total number of patients. The next section of the report will list the codes that are classified as "Service Category" and list the number of encounters and patients.

Selected Diagnosis and Services Rendered



```
RUN DATE: 08/08/12                                                ARPDUDSCATP
    TIME: 13:08          SELECTED DIAGNOSIS AND SERVICES RENDERED  PAGE   1
                              08/01/12 TO 08/08/12

DIAGNOSTIC CATEGORY                              ENCOUNTERS BY     USERS
                                                 PRIMARY DIAG
================================================ =============   =========
01  TEST SUB
--------------------------------------------------------------------------------
    001 TEST                                                4            2
```

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Selected Diagnosis and Services Rendered (continued)

```
RUN DATE: 08/08/12                                              ARPDUDSCATP
    TIME: 13:26          SELECTED DIAGNOSIS AND SERVICES RENDERED  PAGE   2
                              08/01/12 TO 08/08/12

SERVICE CATEGORY                                    ENCOUNTERS      USERS
==================================================  ============   =========
01  TEST SUB
--------------------------------------------------------------------------------
    002 Service                                              1           1
```

Listed below is an explanation of each column.

- **Diagnostic Category:** All codes that were created in the RHC-UDS Category table that have Diagnosis selected as the category will print in this section of the report. The report will list the Subcategory heading that the category code falls under and will list each diagnostic category line.
- **Encounters by Primary Diagnosis:** The total number of encounters will list for each diagnosis category line.
- **Users:** The total number of patients that have the selected category of diagnosis/procedures charged to their account.
- **Service Category:** All codes that were created in the RHC-UDS Category table that have Service selected as the category will print in this section of the report. The report will list first the Subcategory heading that the category code falls under and will list each service category line.
- **Encounters:** Total number of encounters will list for each category line.
- **Users:** The total number of patients that have the selected category of diagnosis/procedures charged to their account.

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