MEDHOST Enterprise Financials Electronic Billing

User Guide

2019 R1

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Introduction to Manual

In this section

- Introduction to this manual
- Displaying application information

Introduction to This Manual

Overview:

This manual is the primary reference for the Electronic Billing system. The purpose of this manual is to introduce the system to the new user and to provide sufficient detail that as readers progress through the menus, they gain a full understanding of the system.

This manual is based on the Electronic Billing GUI version, rather than the AS/400 green screen version.

The Electronic Billing system is accessed from the Daily Processing Menu in the Patient Accounting system. A menu can be easily accessed directly by typing **GO *menu name*** on a command line. For example, to go directly to the Electronic Billing Maintenance Menu, from any menu type **GO EBMAIN**.

Certain aspects of Electronic Billing may only pertain to a particular state. If an option or process only applies to a certain state, this will be documented in the manual as it is encountered.

In this section

- How this manual is organized
- Finding your way through this manual
- System conventions

How this manual is organized

This manual is organized overall to flow from a general to a specific perspective. The concept is that as users read through this manual, they will be able to develop a conceptual framework as they read. They will add to their understanding as they read more detailed information. The following describes this approach in more detail.

The *Introduction to Menus* section gives an overview of the three menus. It does not attempt to describe every item on every menu. It does however, introduce all the menus and identify their functions. The tabbed sections describe each menu and each activity on the menu. The menu at the front of each section is the index for the section.

The description for each option includes:

- A general overview of the option
- The primary files accessed by an option
- Windows that the option uses and actions for the user to take in those windows
- Buttons, function keys, and field descriptions
- Any other information that would assist a user in performing an option, such as a process that produces a report, processing steps, and examples

The last section contains user comment/request forms and revision cover sheets for manual revisions.

Finding your way through this manual

At the top of each page in this manual is a header to help you locate information and to let you know where you are in the manual. All headers contain the same basic items, as illustrated and explained below. Here's an example of a header for an odd-numbered page (headers on even-numbered pages are mirror images of those on odd-numbered pages):

❶ Electronic Billing

❷ Maintenance Menu
Maintain E/B System Control
❹

❸ EBMAIN
Page 1.3
❺

Header Item	Example
❶ Manual (application) name	Electronic Billing
❷ Menu name	Maintenance Menu
❸ Menu label	EBMAIN
❹ Menu option	*Maintain E/B System Control*
❺ Section page number	Page 1.3 (see note below)

The first digit of the page number corresponds to the menu option number. In the example above, Page 1.3 indicates the third page of the section on Option 1 (Maintain E/B System Control) on the EBMAIN Maintenance Menu.

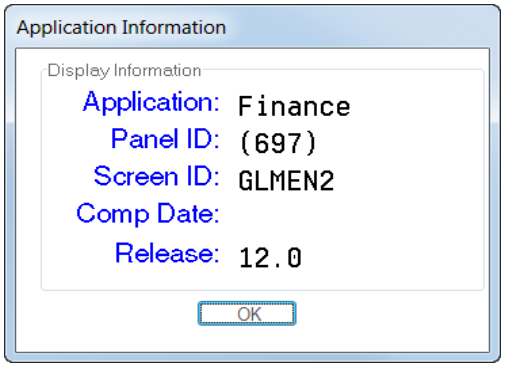
System conventions

Item	Convention
Date	Enter dates in *mmddyy* format unless instructed otherwise on the particular window.
Dollar amount	Enter dollar amounts without decimals. For example, enter $10.00 as **1000**. The system automatically enters decimals and dollar signs where they are appropriate.
Length of field and number of decimals	The system will sometimes display the field length and number of decimals in parentheses next to the field. For example, **10.2** next to a field indicates that the field is 10 digits in length and has two decimal places (automatically entered by the system). In this case, enter $1000.00 as **100000**, then press **Field Exit** or **Field +**. The system will automatically right-justify the entry.

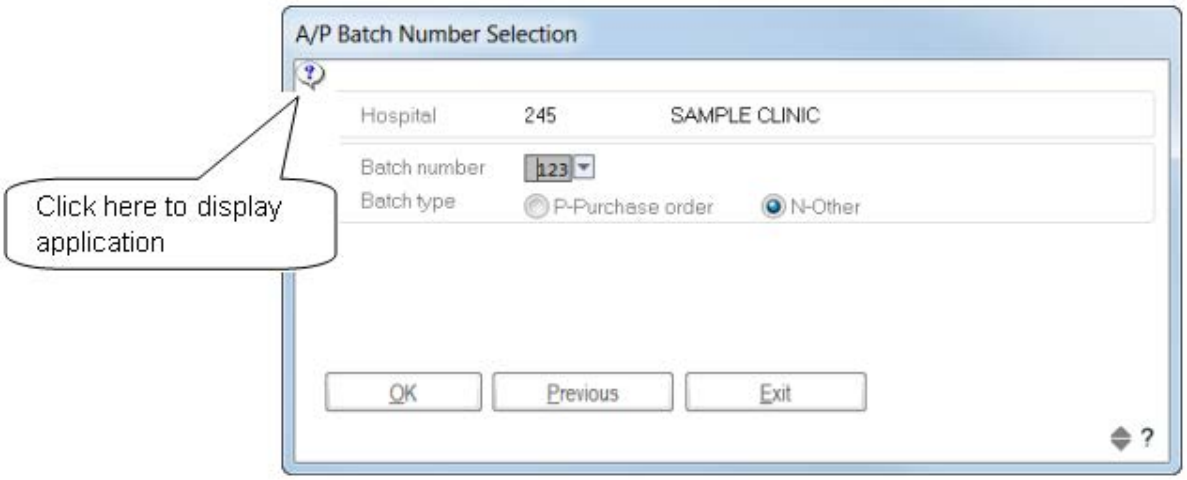
Displaying Application Information

Overview:

From any GUI window, you can display the **Application Information** window, which contains information that can be useful if you have to call Customer Support. The window will appear on top of the GUI window you are working in. To close the **Application Information** window, click **OK**.



To display the window: Click the question mark in the upper left corner.



Introduction to Menus

Overview:

There are currently four primary functional menus in the Electronic Billing system. The main menu (EBMENU Electronic Billing Main Menu) is accessed from the Daily Processing Menu, Option 17 in Patient Accounting.

These menus have been designed to group procedures together for ease in processing. For example, the processing functions are on a separate menu, as are the demand reporting functions.

The following pages briefly describe each of the menus. For detailed explanations of each menu option, see the sections for each menu.

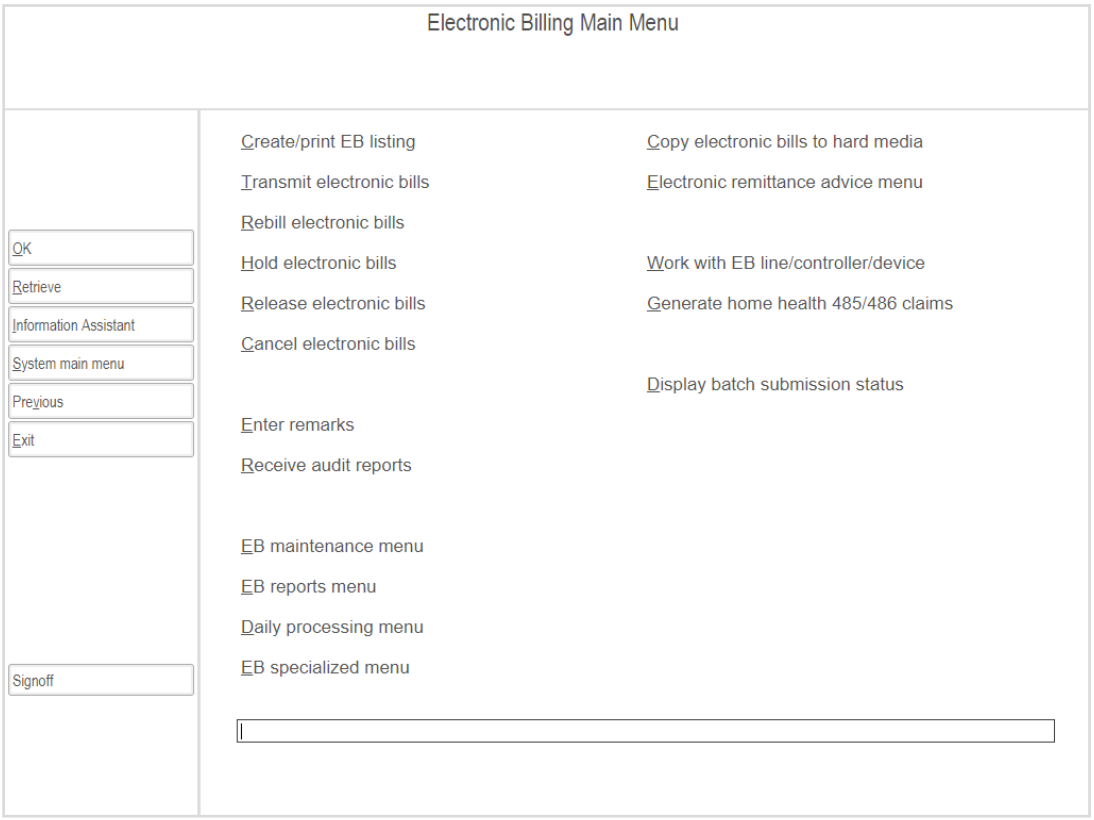
In this section

EBMENU: Electronic Billing Main Menu

Overview: This menu is the main Electronic Billing menu and is accessed from the Daily Processing Menu, Option 17 in Patient Accounting.

For a detailed description of each menu option, refer to the section *Main Menu.*

Action: Select a menu option by clicking on it.

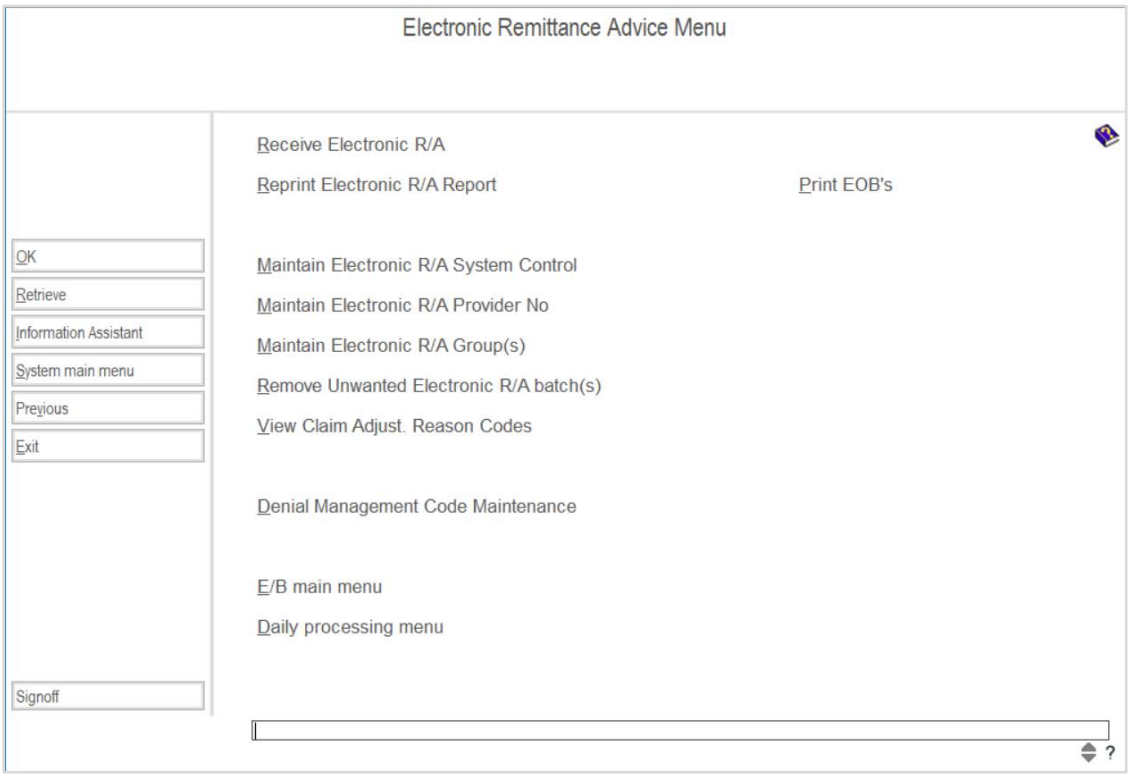


EBMENU Option 11: Electronic Remittance Advice Menu

Overview: This menu is used to process electronic remittance advices.

For a detailed description of each menu option, refer to the section *Electronic Remittance Advice Menu*.

Action: Select a menu option by clicking on it.



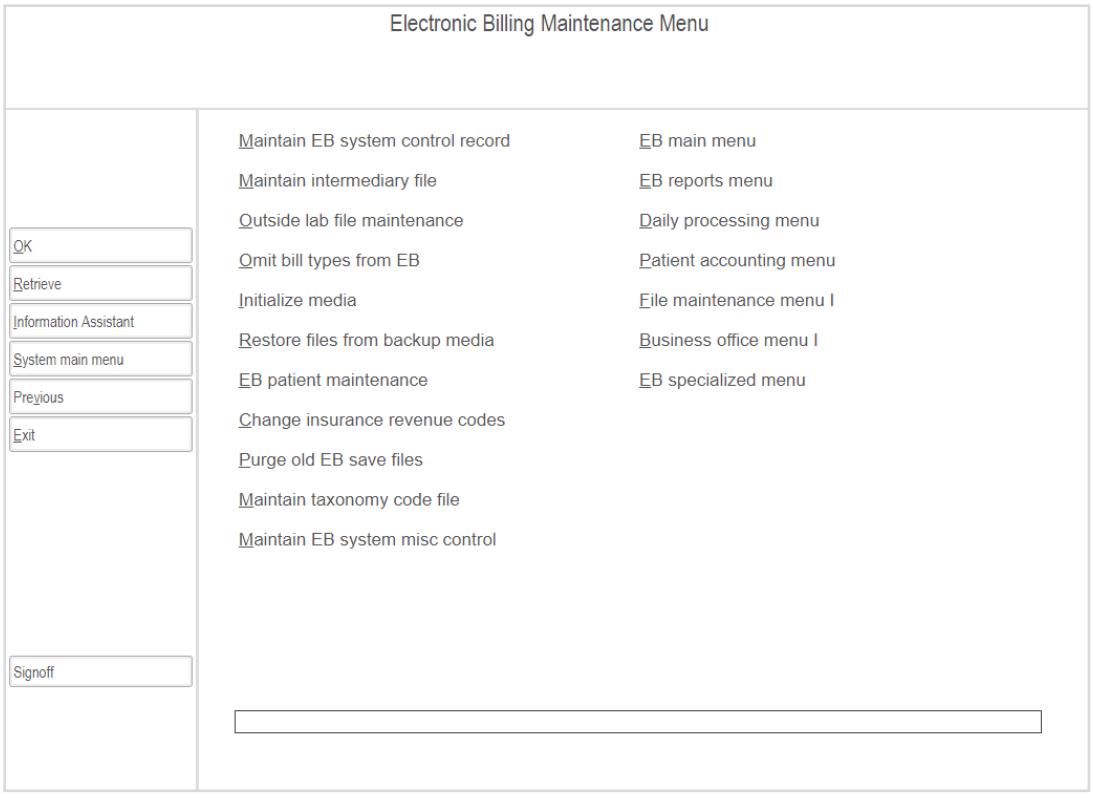
EBMENU Option 20: Electronic Billing Maintenance Menu

Overview: This menu is used to access the Electronic Billing file maintenance options. The system control file, intermediary file, outside lab file, patient benefits maintenance, and taxonomy code file can be maintained from this menu.

Also, from this menu, storage media can be initialized to save and backup the electronic billing files. The backup can be restored from this menu.

For a detailed description of each menu option, refer to the section *Maintenance Menu*.

Action: Select a menu option by clicking on it.

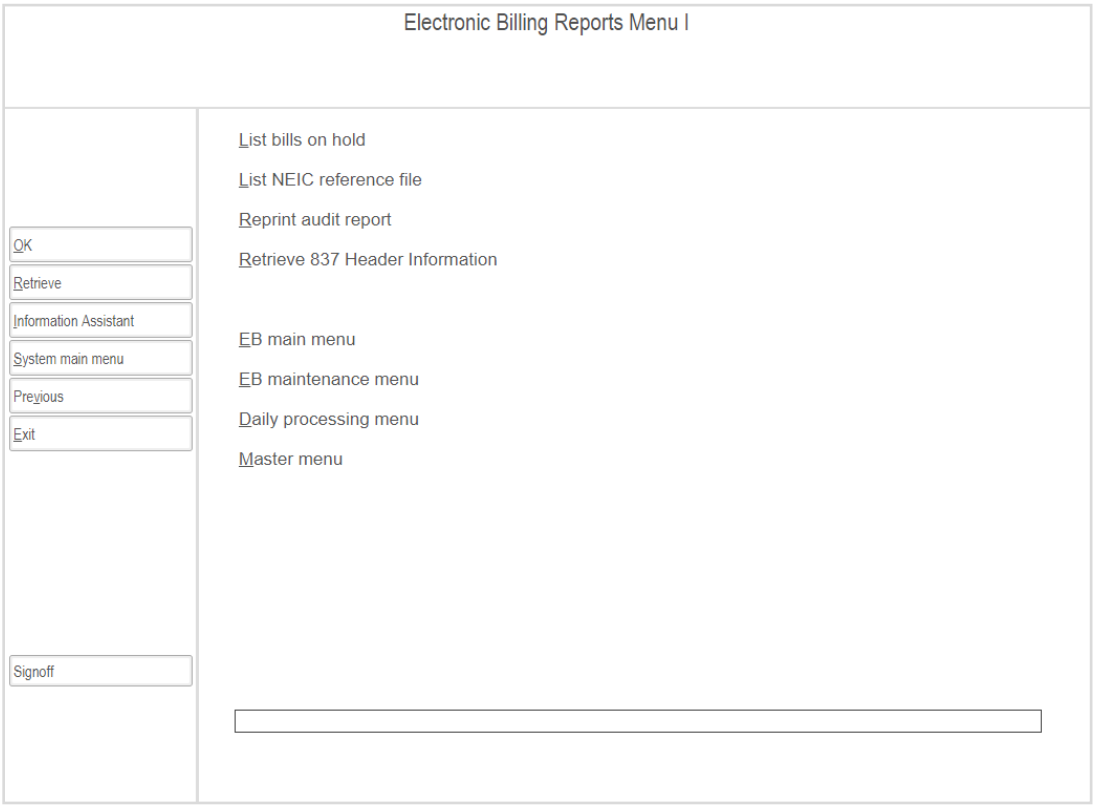


EBMENU Option 21: Electronic Billing Reports Menu I

Overview: This menu is used to run Electronic Billing reports on demand.

For a detailed description of each menu option, refer to the section *Reports Menu I*.

Action: Select a menu option by clicking on it.



EBMENU: Electronic Billing Main Menu

Overview:

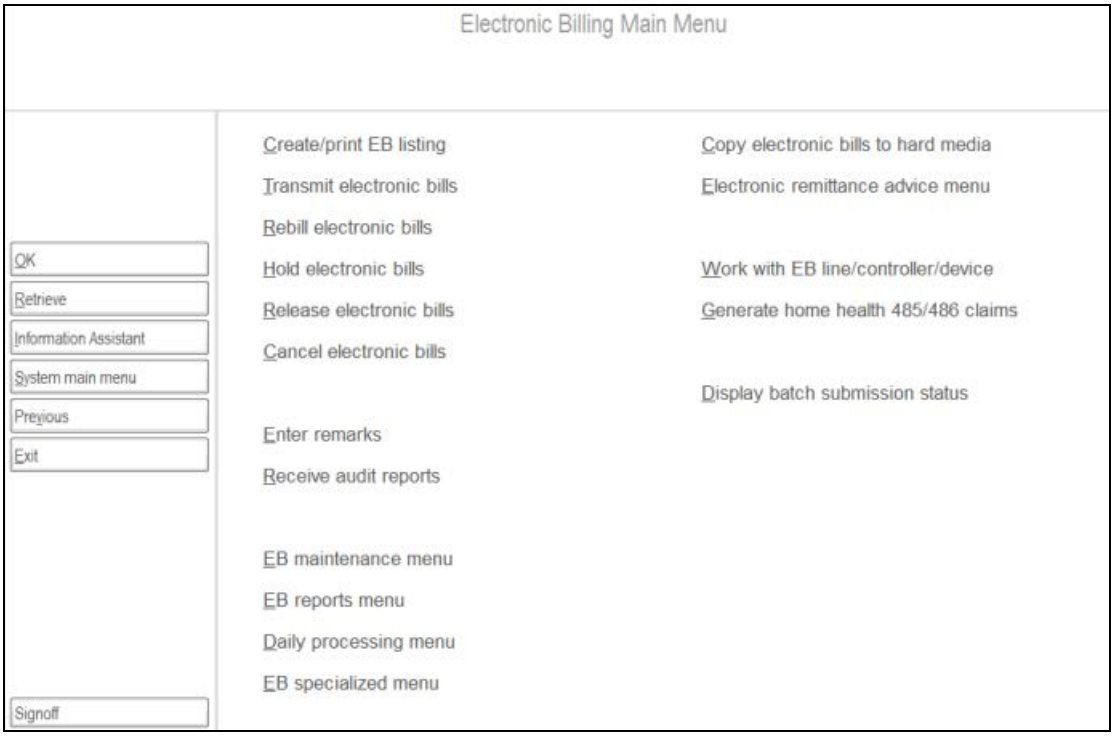
The Electronic Billing Main Menu (EBMENU) (Option 17 on the Daily Processing Menu) is the primary menu in the Electronic Billing system.

The following pages describe each Electronic Billing Main Menu option in sequential order and any main windows that follow each selection. Any reports generated by the system are also described.

Action:

Select a menu option by clicking on it.

Menu option descriptions begin on the next page.



The **Option** column shows the AS/400 green screen menu option number, which you can see in the GUI window by moving the mouse pointer over the menu option and holding it there without clicking.

This table is continued on the next page.

Option Name	Option	Description
Create/print EB listing	1	Print the billing transmission lists, which show the patient records which are to be transmitted to the intermediary for UB and 1500 billing. Before selecting this option, initialize media for backup (if necessary) through Initialize Media, Option 5 on the Maintenance Menu.
Transmit electronic bills	2	Transmit the UB and 1500 electronic bills to the intermediary.
Rebill electronic bills	3	Re-create electronic bills after errors have been corrected. This option is only allowed for patients who have previously been billed.
Hold electronic bills	4	Place on hold electronic bills that are not ready to be transmitted. This option will exclude a patient's claim from the current transmission file. Before selecting this option, make sure you review the Electronic Billing Transmission List produced from Create/Print EB Listing, Option 1 on this menu.
Release electronic bills	5	Release a patient's electronic bill (UB, 1500, or both) that was previously put on hold and should be released to transmit. Before selecting this option, make sure you review the Electronic Bills on Hold Report produced from Hold Electronic Bills, Option 4 on this menu.
Cancel electronic bills	6	Cancel a patient's electronic bill (UB, 1500, or both). Cancelling a bill removes the patient's claim from electronic bills processing. Before selecting this option, make sure you review the Electronic Billing Transmission List produced from Create/Print EB Listing, Option 1 on this menu.
Restore saved file for resend	7	This option has been removed from the *Electronic Billing* menus. Please contact Customer Support if you need assistance restoring a saved file.
Enter remarks	8	Enter remarks that will be printed in the remarks section of UB bills that are printed from the electronic billing claims sent to carriers.
Receive audit reports	9	Sign on and receive the audit report from the intermediary.

Option	Number	Description
Copy electronic bills to hard media	10	Copy electronic bills to tapes or diskettes. You do not need to initialize those media before selecting this option. This option does not apply to some states.
Electronic remittance advice menu	11	Display the Electronic Remittance Advice Menu for processing electronic remittance advices.
Work with EB line/controller/device	13	Run the **WRKCFGSTS** command, which allows you to work with the configuration status functions.
Generate home health 485/486 claims	14	Re-create the home health HCFA-485 and HCFA-486 claims. Use this option if home health and UB claims are being transmitted separately.
Display batch submission status	16	Display the transmission status for the last batch submission for the selected intermediary.
EB maintenance menu	20	Display the Electronic Billing Maintenance Menu for accessing the Electronic Billing file maintenance options. The system control file, intermediary file, outside lab file, and patient benefits maintenance can be maintained from this menu. Also from this menu, storage media can be initialized to save and backup the electronic billing files. The backup can be restored from this menu.
EB reports menu	21	Display Electronic Billing Reports Menu I for running Electronic Billing reports on demand.
Daily processing menu	22	Display the Daily Processing Menu, which is not covered in this manual.
EB specialized menu	23	Display the Electronic Billing Specialized Menu, which is not covered in this manual.

EBMENU Option 1: Create/Print EB Listing

Overview

Create/Print EB Listing (*Option 1* on the *Electronic Billing Main Menu*) is used to print the billing transmission lists and generate a net bill. The lists show the patient records that are to be transmitted to the intermediary for UB and 1500 billing. **Note:** Production of a *Net Bill* is controlled by settings in the *Contract File* (*Contract Management Menu*, *Option 1)*. For more information, refer to the section, *"Net Bill Settings*."

Before selecting this option, initialize media, if necessary, for backup through Option 5 on the Maintenance Menu.

After the electronic billing file is created, an edit program tests the file for errors. If no errors are found during the edit, the billing transmission lists will be printed for Inpatients and Outpatients. An example of the transmission listing is shown below.

However, if errors are found in the electronic billing file, an error list will print instead of the billing transmission lists. If there are errors, the electronic billing file cannot be transmitted until the necessary corrections are made. A sample error list is shown below.

If there are any line items with amount fields that contain negative numbers, a Query report will print listing the items that need to be corrected.

Refer to the "Error Messages" section later in this manual for explanations of each error message.

If there are no errors, a window will appear asking if any other changes need to be made. If changes need to be made, make the changes and rerun this option. Otherwise, the system is ready to back up the files.

If using hard media, you will be prompted to insert the tape/diskette labeled EBSAVE.

Insert the initialized media and press Enter. Make sure enough tapes/diskettes are initialized for the backup.

If you are using save files, the message "BACKUP TO SAVE FILE..." will appear.

When the files are saved, the system returns to the menu and the following message will appear:

"TRANSMISSION LIST COMPLETED. BILLS ARE READY TO BE TRANSMITTED."

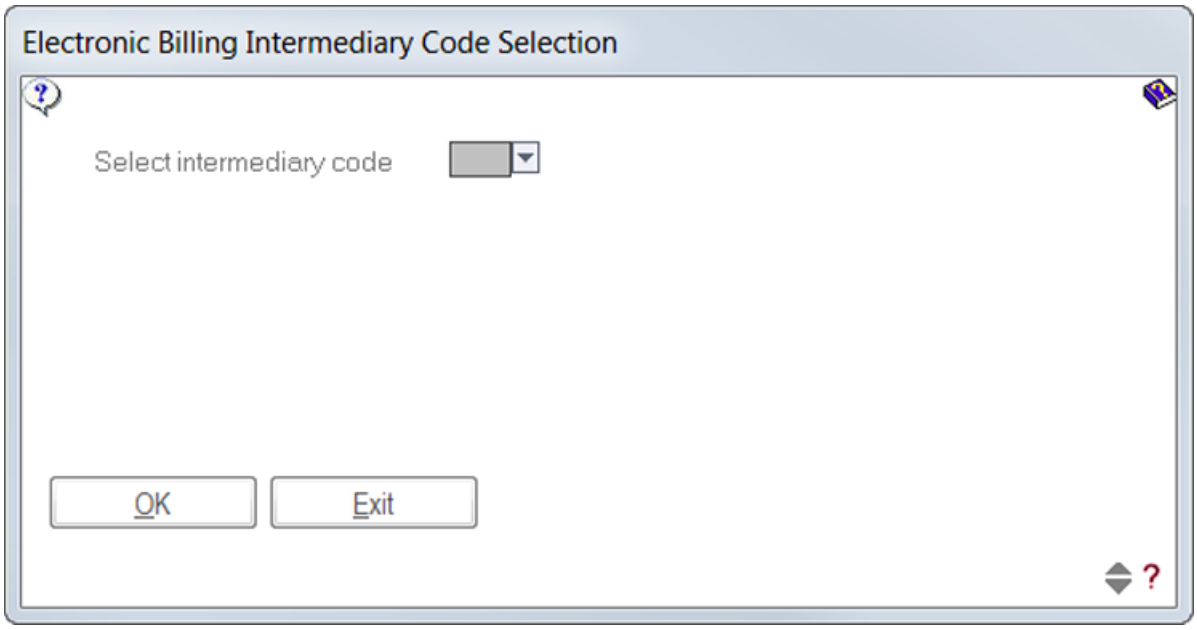
Files

ELECBILL, XNSCODE, XNSUB82

In this section

Intermediary Code Selection window

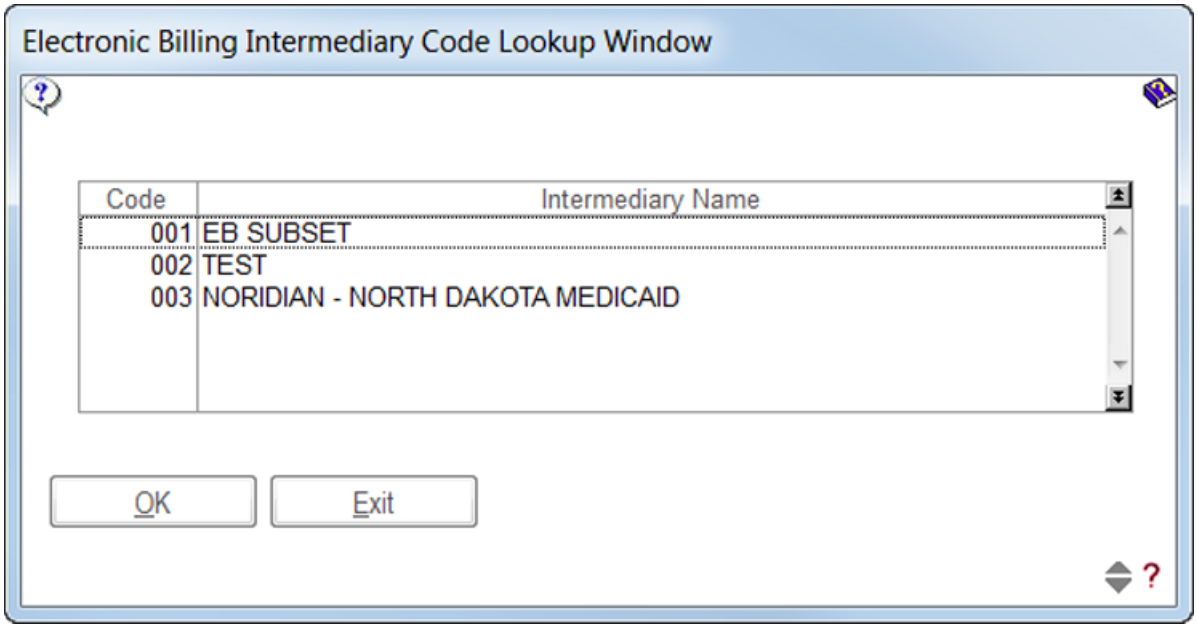
This window appears when you select *Create/Print EB Listing* in the *Electronic Billing Main Menu*.



Action: Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

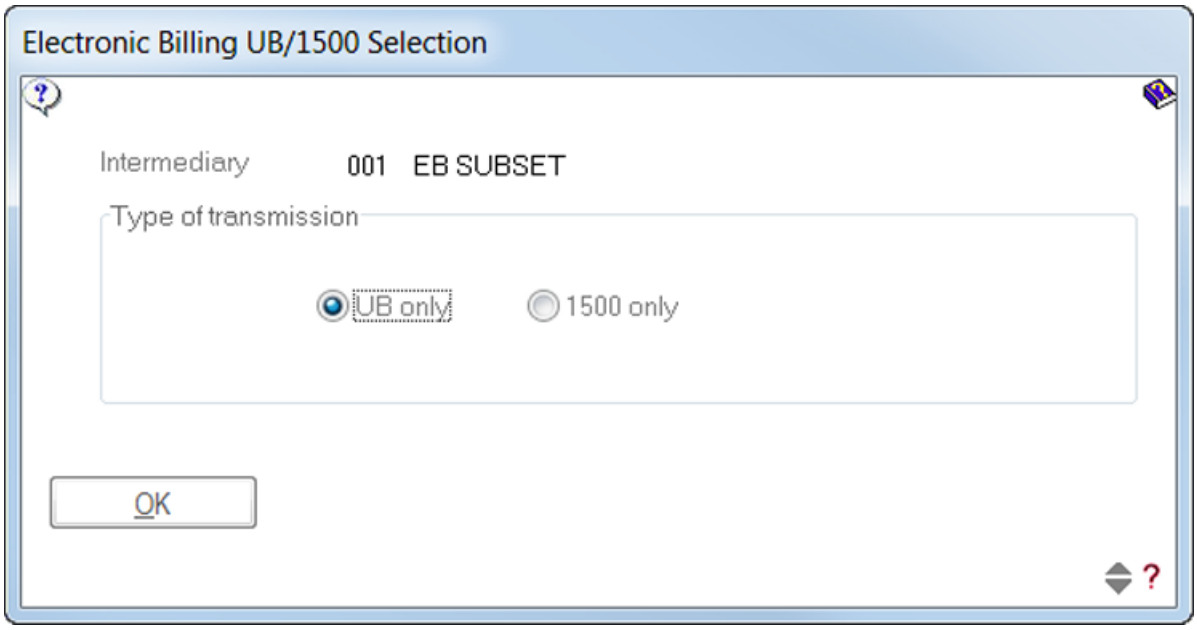
This window appears when you click in the **Intermediary Code Selection** window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

UB/1500 Selection window

This window appears when you click **OK** in the **Intermediary Code Selection** window.



Action: Click the type of transmission you are making, and then click **OK**.

Net Bill Settings

The Net Bill will be produced if **Net Billing** has been turned on in the *Contract File* (*Contract Management Menu, Option 1*) and the *Payor Plan File* (*File Maintenance Menu 1, Option 18*) has a Contract Number and the following settings:

- **Prorate Plan**? field is Yes
- **Auto contractual**? field is Yes
- **Payment Option**? field is 9

Note: A Net Bill is not produced for the following formulas:

Medicare DRG 000

HRG 008

IRF 010

PSYCH DRG 011

RUG 012

DRG 025

Stop Loss Formulas 101, 102, 203, 204, and 205

For more information, refer to the documentation for *Contract Management Menu, Option 1, Contract File* in the *Patient Accounting System Manager's Guide*.

Sample Electronic Billing Transmission List

The last page of the report includes grand totals for the bill amounts and non-covered amounts, as well as the total number of UB claims and total number of combined claims. If any of the information is not contained in the ELECBILL file, `(Not Available)` appears in the report instead.

```
EB0R26                                                                                                                    PAGE        1
RUN DATE:  4/27/07                                                  ELECTRONIC BILLING TRANSMISSION LIST
RUN TIME: 16:57:43                                                              EXAMPLE HOSPITAL
                                                                        TEXAS BLUE CROSS/BLUE SHIELD
INSURANCE: COMMERCIAL INPATIENT
                                                 FROM      THRU      BILL     BILL                   NON-COVERED   BILLING PROV       BILLING PROV       PAY-TO PROV        PAY-TO PROV
PATIENT-CY  PATIENT NAME          POLICY NUMBER  DATE      DATE      DATE     TYPE   BILL AMOUNT     AMOUNT        NPI                NUMBER             NPI                NUMBER
----------  ------------------  -------------------  --------  --------  --------  ----  -------------  ------------  ---------------  ---------------  ---------------  ---------------
0503600-01  MURPHY TRACI        393840321        7/30/05   8/03/05   4/19/07  111       12,199.93          .00  (Not Available)  FEDID00001       1234567890       (Not Available)
                                                              TOTAL AMOUNT:           12,199.93          .00
                                                              TOTAL CLAIMS:                1
EB0R26                                                                                                                    PAGE        2
RUN DATE:  4/27/07                                                  ELECTRONIC BILLING TRANSMISSION LIST
RUN TIME: 16:57:43                                                              EXAMPLE HOSPITAL
                                                                        TEXAS BLUE CROSS/BLUE SHIELD
INSURANCE: COMMERCIAL INPATIENT
                                                 FROM      THRU      BILL     BILL                   NON-COVERED   BILLING PROV       BILLING PROV       PAY-TO PROV        PAY-TO PROV
PATIENT-CY  PATIENT NAME          POLICY NUMBER  DATE      DATE      DATE     TYPE   BILL AMOUNT     AMOUNT        NPI                NUMBER             NPI                NUMBER
----------  ------------------  -------------------  --------  --------  --------  ----  -------------  ------------  ---------------  ---------------  ---------------  ---------------
6000211-01  PATIENT PAYORSETUP  12123123         1/26/07   2/25/07   4/19/07  112           37.30          .00  (Not Available)  FEDID00001       2345678901       (Not Available)
                                                              TOTAL AMOUNT:               37.30          .00
                                                              TOTAL CLAIMS:                1
EB0R26                                                                                                                    PAGE        3
RUN DATE:  4/27/07                                                  ELECTRONIC BILLING TRANSMISSION LIST
RUN TIME: 16:57:43                                                              EXAMPLE HOSPITAL
                                                                        TEXAS BLUE CROSS/BLUE SHIELD
INSURANCE: COMMERCIAL INPATIENT
                                                 FROM      THRU      BILL     BILL                   NON-COVERED   BILLING PROV       BILLING PROV       PAY-TO PROV        PAY-TO PROV
PATIENT-CY  PATIENT NAME          POLICY NUMBER  DATE      DATE      DATE     TYPE   BILL AMOUNT     AMOUNT        NPI                NUMBER             NPI                NUMBER
----------  ------------------  -------------------  --------  --------  --------  ----  -------------  ------------  ---------------  ---------------  ---------------  ---------------
6000197-03  BILL TREATMENTA     1245465          11/01/06  11/15/06  4/19/07  113       19,880.00          .00  (Not Available)  FEDID00001       (Not Available)  (Not Available)
6000198-03  BILL TREATMENTA     125665464        11/01/06  11/15/06  4/19/07  113       19,880.00          .00  (Not Available)  FEDID00001       (Not Available)  (Not Available)
                                                              TOTAL AMOUNT:           39,760.00          .00
                                                              TOTAL CLAIMS:                2
Last page
EB0R26                                                                                                                    PAGE       12
RUN DATE:  4/27/07                                                  ELECTRONIC BILLING TRANSMISSION LIST
RUN TIME: 16:57:43                                                              EXAMPLE HOSPITAL
                                                                        TEXAS BLUE CROSS/BLUE SHIELD
INSURANCE: MEDICAID OUTPATIENT
                                                 FROM      THRU      BILL     BILL                   NON-COVERED   BILLING PROV       BILLING PROV       PAY-TO PROV        PAY-TO PROV
PATIENT-CY  PATIENT NAME          POLICY NUMBER  DATE      DATE      DATE     TYPE   BILL AMOUNT     AMOUNT        NPI                NUMBER             NPI                NUMBER
----------  ------------------  -------------------  --------  --------  --------  ----  -------------  ------------  ---------------  ---------------  ---------------  ---------------
6000014-01  SENKBEIL SHANE      123134654        1/01/06   1/01/06   4/20/07  130        1,340.35          .00  (Not Available)  MCDUB00000002    (Not Available)  (Not Available)
6000220-01  SCHAFER JUNE        391203671D       4/19/07   4/19/07   4/19/07  130             .01          .00  (Not Available)  MCDUB00000001    (Not Available)  (Not Available)
                                                              TOTAL AMOUNT:            1,340.36          .00
                                                              TOTAL CLAIMS:                2
                                                              GRAND TOTALS:          100,604.67          .00
                                                         UB92 TOTAL CLAIMS:               18
                                                     COMBINED TOTAL CLAIMS:               18
```

Sample Electronic Billing Error List

This report includes the insurance type, patient/cycle number, and patient name for non-header records.

```
EB30US                                          EXAMPLE HOSPITAL                                          PAGE   1
RUN DATE:  2/27/08                         ELECTRONIC BILLING ERROR LIST
RUN TIME: 14:20

   REC #/TYPE    INS TYPE   PAT #/CYCLE     PATIENT NAME       * * * * *    E R R O R     M E S S A G E S    * * * *
 -------------  ----------  -----------  --------------------  ------------------------------------------------------------
  1/ISA*                                                     EB-152  REQUIRED INFO MISSING IN ISA SEGMENT  INTER. SENDER ID
                                                             EB-152  REQUIRED INFO MISSING IN ISA SEGMENT  INTER. RECEIVER ID

  2/GS*                                                      EB-153  REQUIRED INFO MISSING IN GS SEGMENT   APPLICATION SNDR CODE
                                                             EB-153  REQUIRED INFO MISSING IN GS SEGMENT   APPLICATION RCR CODE

  6/NM1*41                                                   EB-155  REQUIRED INFO MISSING IN NM1 SEGMENT  NAME LAST/ORGAN. NAME

  6/NM1*41                                                   EB-155  REQUIRED INFO MISSING IN NM1 SEGMENT  IDENTIFICATION CODE

  7/PER*IC                                                   EB-156  REQUIRED INFO MISSING IN PER SEGMENT  SUBMITTER CONTACT NAME

  7/PER*IC                                                   EB-156  REQUIRED INFO MISSING IN PER SEGMENT  COMMUNICATION NUMBER

  8/NM1*40                                                   EB-157  REQUIRED INFO MISSING IN NM1 SEGMENT  NAME LAST/ORGAN. NAME

  8/NM1*40                                                   EB-157  REQUIRED INFO MISSING IN NM1 SEGMENT  IDENTIFICATION CODE

 10/NM1*85   MEDICARE    503569/01   KNUTSON CHARLES L SR  EB-001  FEDERAL TAX I.D. NUMBER IS MISSING

 22/NM1*PR   MEDICARE    503569/01   KNUTSON CHARLES L SR  EB-082  Primary  INSURANCE PAYOR ID IS MISSING    (00400          )

 39/SV2*                                                    EB-058  COVERED DAYS + NONCOVERED DAYS DOES NOT EQUAL TOTAL OF
                                                                    ACCOMMODATION REVENUE CODE(S) UNITS

 96/NM1*85   MEDICARE    503588/01   PETERSON THORA G      EB-001  FEDERAL TAX I.D. NUMBER IS MISSING

108/NM1*PR   MEDICARE    503588/01   PETERSON THORA G      EB-082  Primary  INSURANCE PAYOR ID IS MISSING    (00400          )

125/SV2*                                                    EB-058  COVERED DAYS + NONCOVERED DAYS DOES NOT EQUAL TOTAL OF
                                                                    ACCOMMODATION REVENUE CODE(S) UNITS

182/NM1*85   MEDICARE    503598/01   ZOHA ELSIE M          EB-001  FEDERAL TAX I.D. NUMBER IS MISSING

194/NM1*PR   MEDICARE    503598/01   ZOHA ELSIE M          EB-082  Primary  INSURANCE PAYOR ID IS MISSING    (00400          )

211/SV2*                                                    EB-058  COVERED DAYS + NONCOVERED DAYS DOES NOT EQUAL TOTAL OF
                                                                    ACCOMMODATION REVENUE CODE(S) UNITS
```

EBMENU Option 2: Transmit Electronic Bills

Overview:

Transmit Electronic Bills (Option 2 on the Electronic Billing Main Menu) is used to transmit the UB and 1500 electronic bills to the intermediary.

If the intermediary is set up to submit the transmission to batch, the submission date and time are entered, and then the transmission is submitted to batch processing in the subsystem set up in the Maintain EB system control record for the intermediary. If transmitting in batch, the messages that would appear in the window will be written to the job log. The batch submission status can be viewed in Display Batch Submission Status, Option 16 on the Main Menu.

Basically, this option connects to the intermediary, transmits the file, and then disconnects from the intermediary.

If an error occurs during the transmission, a message window will appear. If the message window is displayed, try the transmit again and if the error occurs again, please call Customer Support immediately.

Messages will appear at the bottom of the window to inform the user of the progress of the transmission.

The messages will vary, based on the intermediary to which the facility is transmitting and the type of communications that is used, either bisynchronous or asynchronous.

If the transmission is successful, a message window will appear.

Depending on the intermediary, a report of the results of the transmission will be transmitted back from the intermediary and will print on the system printer.

For information on using a PC to transmit electronic bills, turn to Appendix A: Transmitting Using a PC.

Files:

ELECBILL

In this section

Transmitting bi-synchronously

These messages will be displayed at the bottom of the window if the facility is transmitting using bisynchronous communications.

Setting Up Lines.
Transmitting.
Transmission Is Complete.

Transmitting asynchronously

These messages will be displayed at the bottom of the window if the facility is transmitting using asynchronous communications. The messages shown are examples from different intermediaries. The messages that your facility receives will depend on the intermediary to which your facility is transmitting.

Mutual of Omaha—Sending UB bills

Attempting to allocate resources...please wait.
Processing dial request.
Initialing modem.
Sending dial instruction. Phone #: 9999999999.
Session established with intermediary.
Sending User ID.
Sending password.
Asking to upload.
Sending file.
Transmitting data with ZMODEM. 99999 bytes of 99999 sent.
Now logging off.
Session with intermediary ended normally.
Hanging up.
Deallocating resources.
The transmission to the intermediary is now complete.
Now clearing the transmission file.

TN Blue Cross Blue Shield—Sending UB bills

Attempting to allocate resources...please wait.
Processing dial request.
Initialing modem.
Sending dial instruction. Phone #: 9999999999.
Session established with intermediary.
Sending User ID.
Sending Password.
Logged on.
Asking to upload.
Sending file name.
Choosing zmodem.
Transmitting data with ZMODEM. 99999 bytes of 99999 sent.
Now logging off.
Session with intermediary ended normally.
Hanging up.
Deallocating resources.
The transmission to the intermediary is now complete.
Now clearing the transmission file.

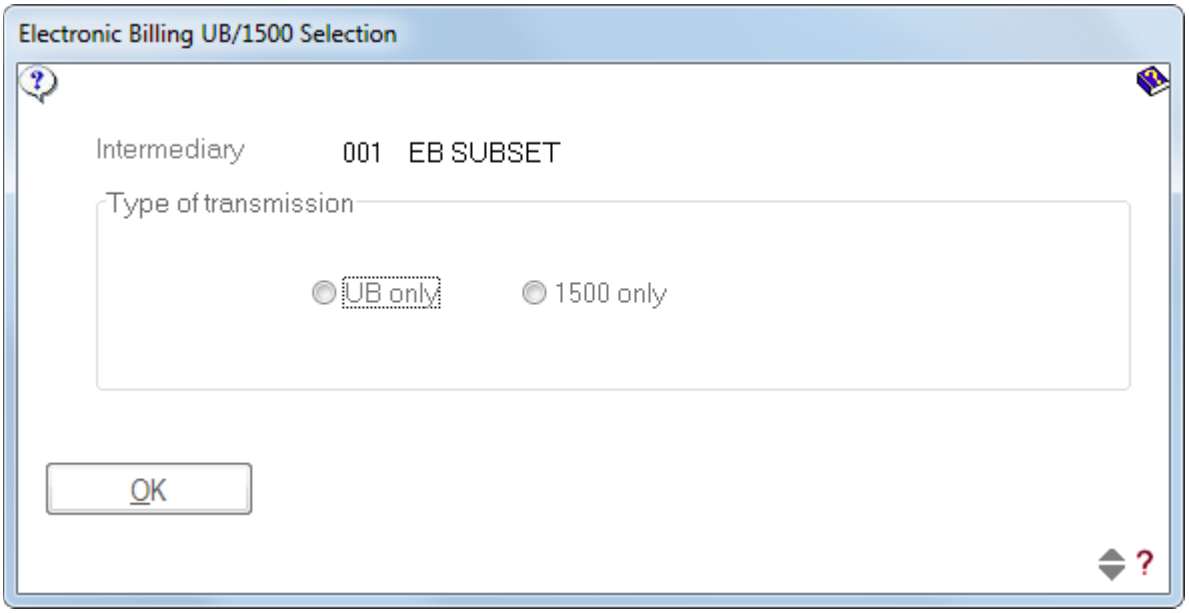
Envoy—Sending 1500 bills

Attempting to allocate resources...please wait.
Processing dial request.
Initialing modem.
Sending dial instruction. Phone #: 9999999999.
Session established with intermediary.
Connected to Intermediary. Verifying Test or Production.
Confirming selection.
Sending logon ID.
Sending password.
Choosing upload option.
Identifying submitter as Submitter/Provider.
Identifying that medical claims are being sent.
Identifying that the file will be zipped.
Identifying that the file will be sent using the ZMODEM protocol.
Begin sending file.
Transmitting data with ZMODEM. 99999 bytes of 99999 sent.
Choosing to retrieve session log.
Retrieving session log.
Signing off.
Hanging up.
Deallocating resources.
The transmission to the intermediary is now complete.
Now clearing the transmission file.

UB/1500 Selection window

This window appears when you select **Transmit Electronic Bills** in the Main Menu.

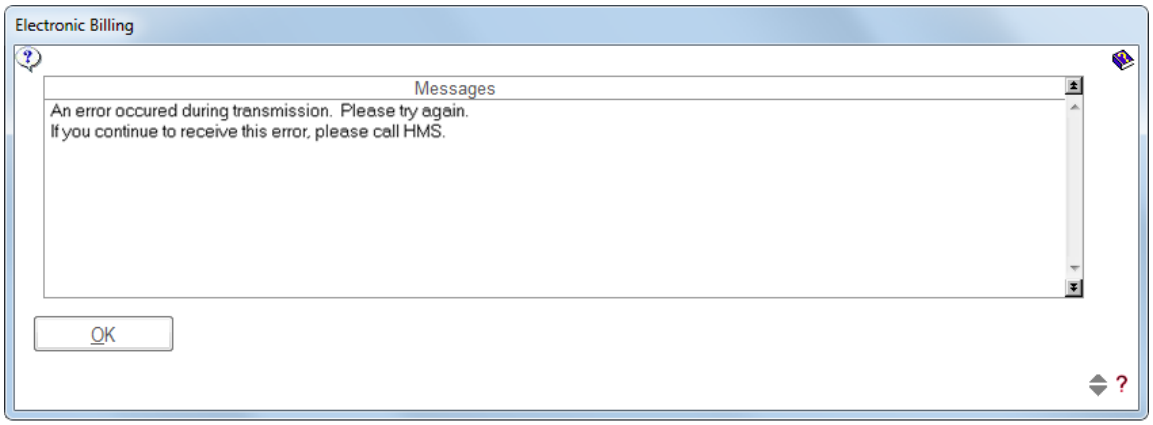
Note: To Transmit Electronic Bills in option 2, a list needs to be created in EBMENU Option 1. If a list is created without errors in any of the accounts then, EBMENU Option 2 will transmit electronic bills.



Action: Select (click on) the code you want and click **OK**.

Error message window

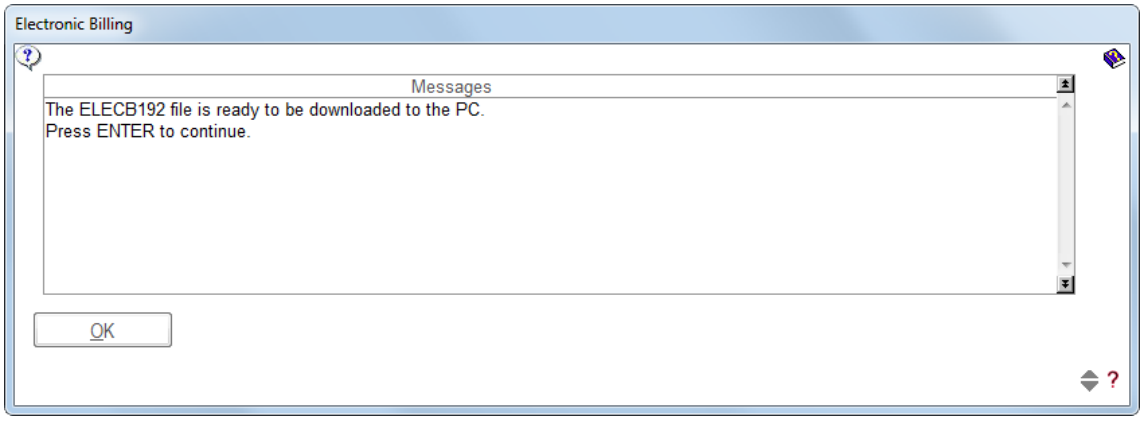
This window appears when an error occurs during transmission.



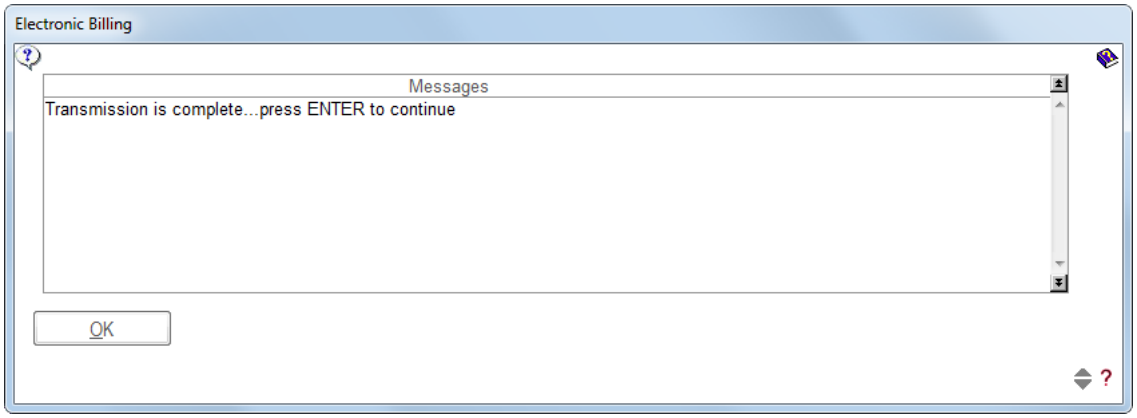
Action: Click **OK** to close the window then, try the transmission again. If the window appears a second time, call Customer Support immediately.

Successful transmission message window

These two windows appear when the file is ready to be downloaded to the PC and the transmission is successful. Depending on the intermediary, a report of the results of the transmission will be transmitted back from the intermediary and will print on the system printer.

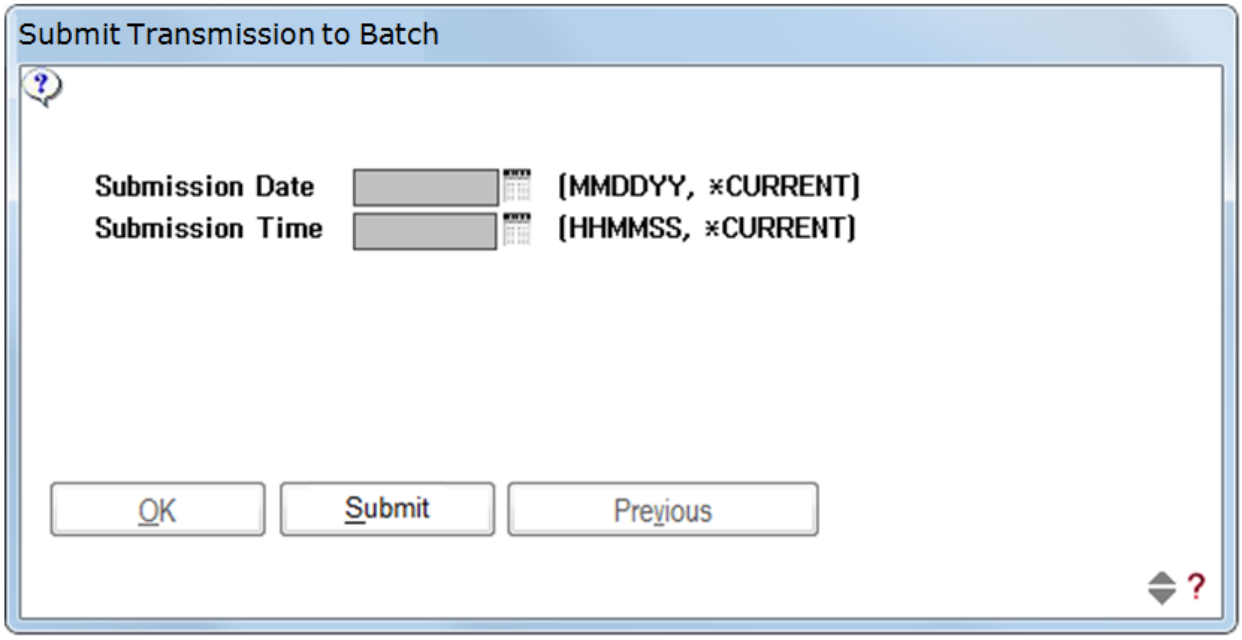


Action: Click **OK**.



Action: Click **OK**.

Submit Transmission to Batch window



This window appears when you select **Transmit Electronic Bills** on the Main Menu, provided that the intermediary is set up to **submit the transmission to batch**. Transmission to batch setup is done through EBMAIN Option 1.

Action:

1. Enter the date and time for the transmission to start.

   Both fields default to ***CURRENT**. If a future date or time is entered, the transmission will wait until the entered date and time before starting.

2. Click **Submit**. (Clicking **Cancel** returns you to the EB Main Menu without submitting the transmission to batch.)

   The transmission is submitted to batch processing in the subsystem set up in the Maintain EB system control record for the intermediary.

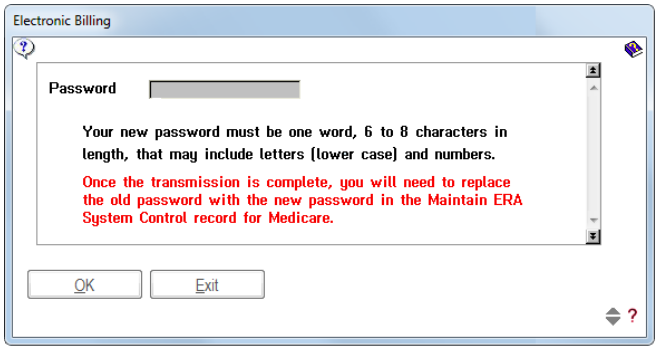
The messages that would appear in the window, if the transmission was not submitted to batch will be written to the job log.

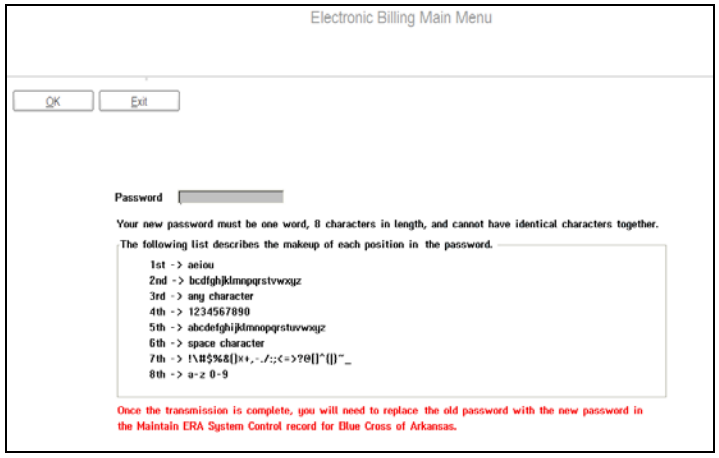
The batch submission status can be viewed in Display Batch Submission Status, Option 16 on the Main Menu.

Password window

This window appears when the password has expired and a new one must be entered.

Two sample windows are shown below, but the precise instructions that appear will vary, depending on the intermediary.





Action: Enter the password according to the instructions in the window, then click **OK**.

Remember to update the following with the new password:

- The EB system control record, Option 1 on the EB Maintenance Menu
- The ERA system control record, through Maintain Electronic R/A System Control, Option 4 on the Electronic Remittance Advice Menu.

EBMENU Option 3: Rebill Electronic Bills

Overview:

Rebill Electronic Bills (Option 3 on the Electronic Billing Main Menu) is used to re-create electronic bills after errors have been corrected. This rebilling is only allowed for patients who have previously been billed.

At the completion of this procedure, the file to retransmit the selected type of bills is created.

The procedures for transmitting electronic bills are applicable to transmitting electronic bills that are being rebilled.

This option does not update any files.

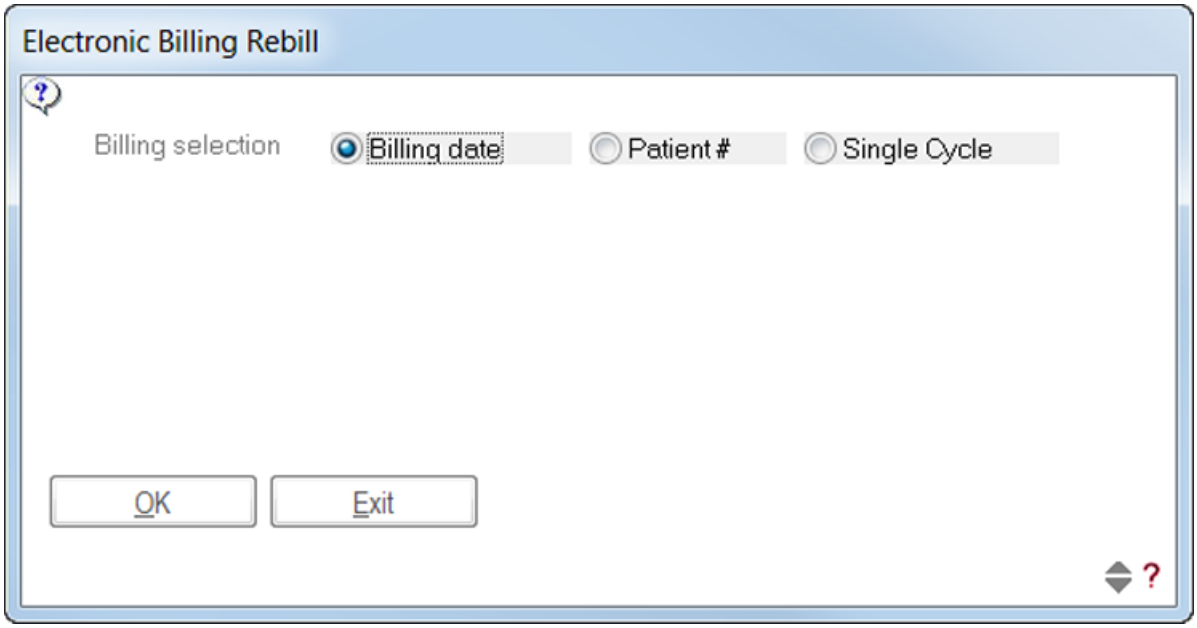
Files:

ELECBILL, XNSUB82, XNSCODE

In this section

Billing selection window

This window appears when you select **Rebill Electronic Bills** on the Main Menu.

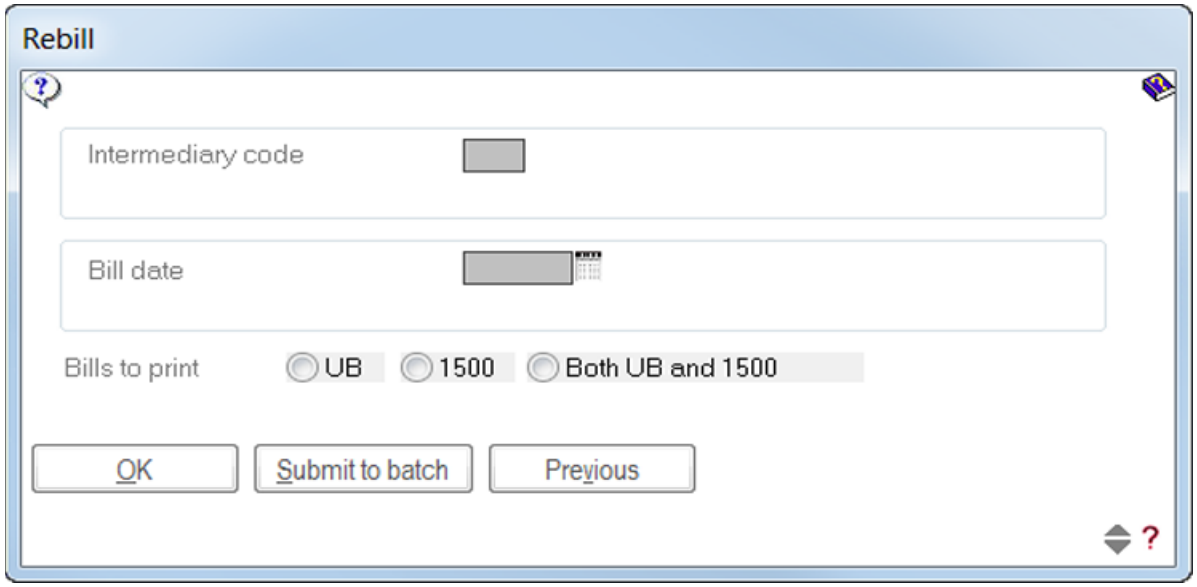


Action: Select (click on) the method (**Billing date**, **Patient #** or **Single Cycle**) for re-creating electronic bills, then click **OK**. The **Single Cycle** option now allows the user to only select a specific cycle for the billing window instead of all cycles as was expected before.

Billing date window

This window appears when you choose to re-create bills by billing date in the billing selection window.

You can re-create more than one set of bills at one time.



Action:

1. Type the intermediary code.
2. Enter the bill date (the date the bills were produced from Patient Accounting).

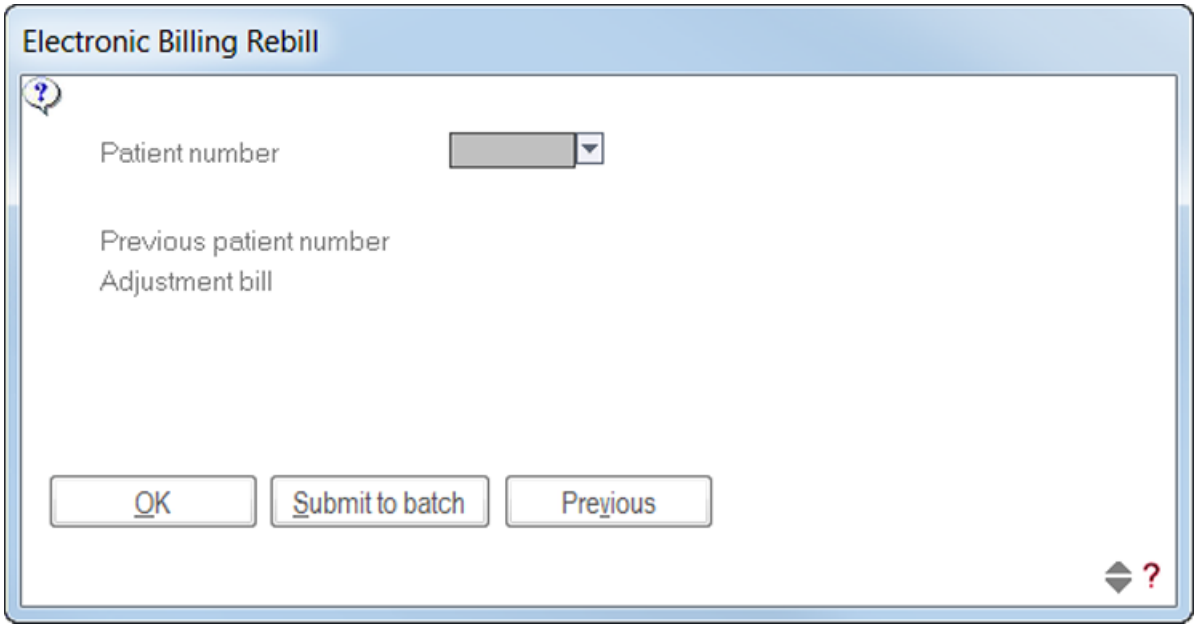
   To enter the date: Either type it in mmddyy format (for example, **072504** for July 25, 2004) or click to select the date.
3. Select (click on) the type of bills to print (re-create).
4. To select another set of bills to re-create, click **OK** and repeat steps 1 to 3. The previously entered code and date appears in the **Previous** fields.

   OR

   If you are through entering dates, go to step 5.
5. When you're ready to re-create the bills, click **Submit to Batch** to submit the rebill process to batch for processing.

Patient number window

This window appears when you choose to re-create bills by patient in the billing selection window (only the **Patient number** field appears). It also reappears at the end of the rebilling process, when it shows the previously selected patient number and whether this is an adjustment bill.

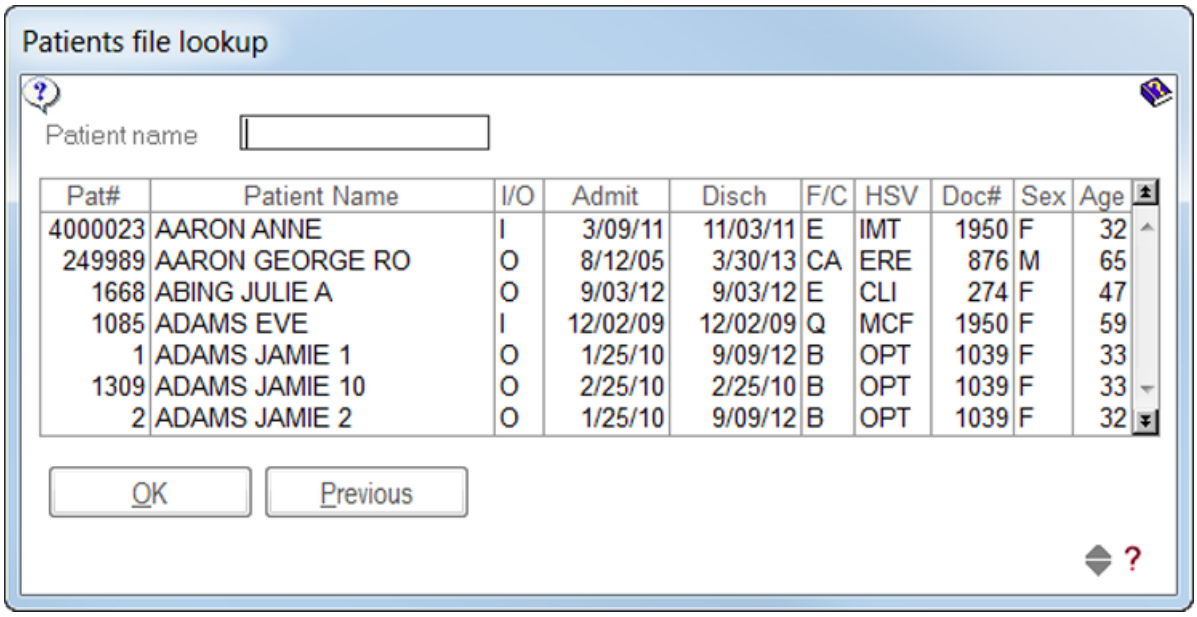


Action: Enter the patient number, and then click **OK**. You can either type the number or click to select it in the **Patients File Lookup** window.

When the window reappears, either enter another patient number or click **Submit to Batch** to submit the rebill process to batch for processing.

Patients File Lookup window

This window appears when you click to enter a patient number.



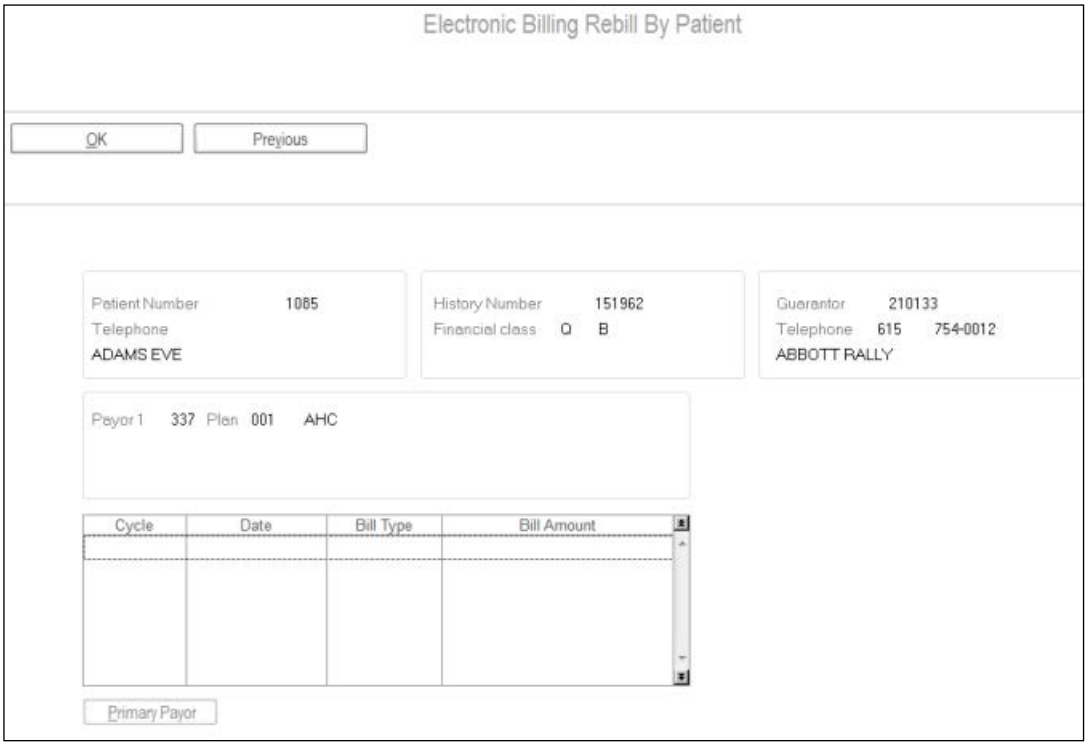
Action:

To find a patient: Type part or all of the patient's last name in the **Patient name** field and click **OK**.

To select a patient: Click on the patient's name and click **OK**. (You can also just double-click on the patient's name.)

Payor/cycle selection window

This window appears when you click **OK** after entering a patient number in the patient number window.



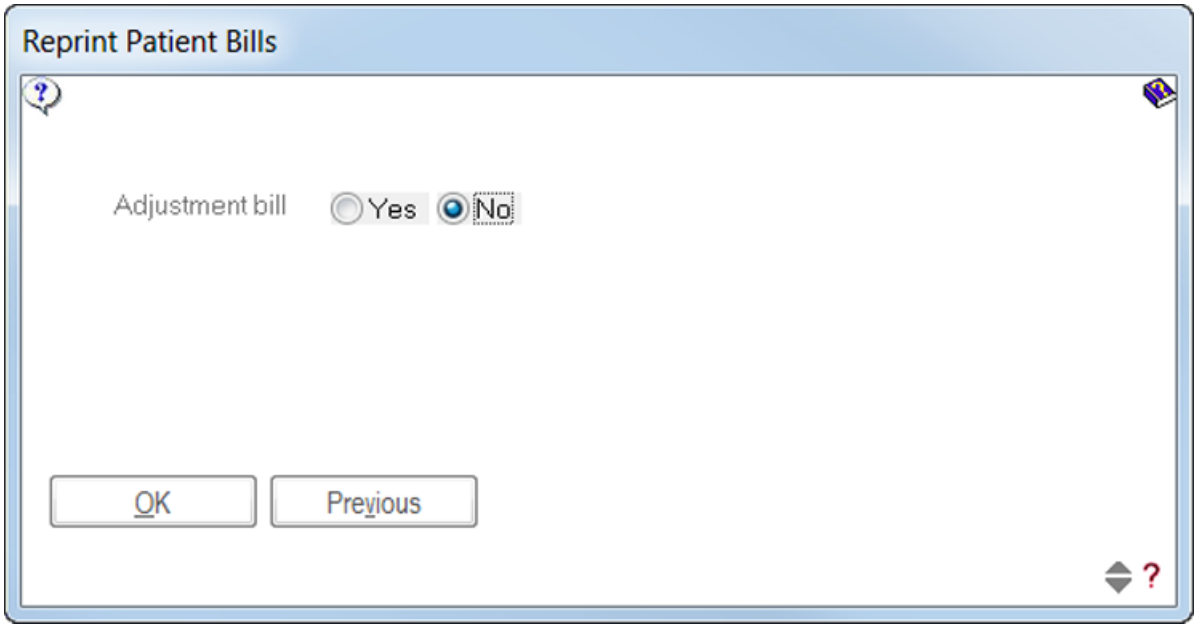
The output queue where the patient bills are printed is determined by settings in Hospital Name/Addr/Id# Record, Option 1 on the System Control File Menu in Patient Accounting, as follows:

- If the **Group bills by HSV output queue** field is set to **Y**, you can specify the output queue where the reprinted patient bills should be directed.
- If the field is set to **N** or if you don't specify an output queue, the reprinted bills will be directed to the default queue specified in the **Output Queue for bills** field.
- If **Patient #** has been selected from the *Billing Selection Window* select **Primary Payor** or **Secondary Payor**, then click **OK**.
- If **Single Cycle** has been selected from the *Billing Selection Window* click on the desired cycle from the Cycle column, then click **Primary** or **Secondary Payor**.

Action: Select (click on) the cycle you want, then click the payor button for the payor you want to bill.

Adjustment bill window

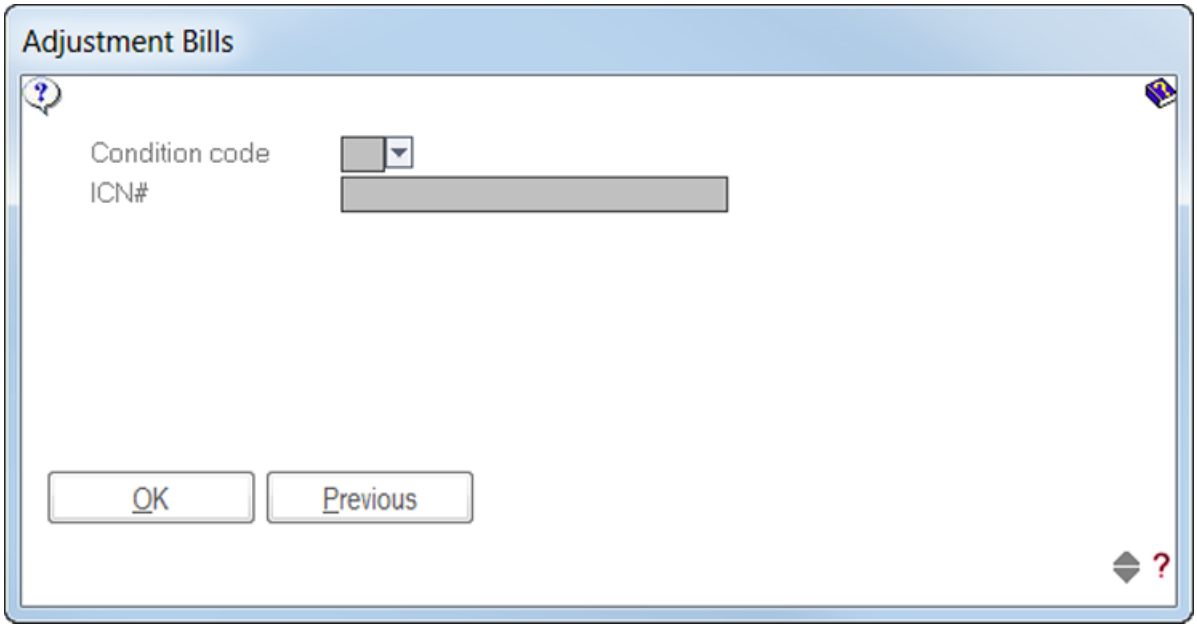
This window appears when you select **Yes** in the adjustment bill window.



Action: If the bill is an adjustment bill, select (click on) **Yes**; if it is not, select **No**. Then click **OK**.

Adjustment Bills window

This window appears when you select **Yes** in the adjustment bill window.



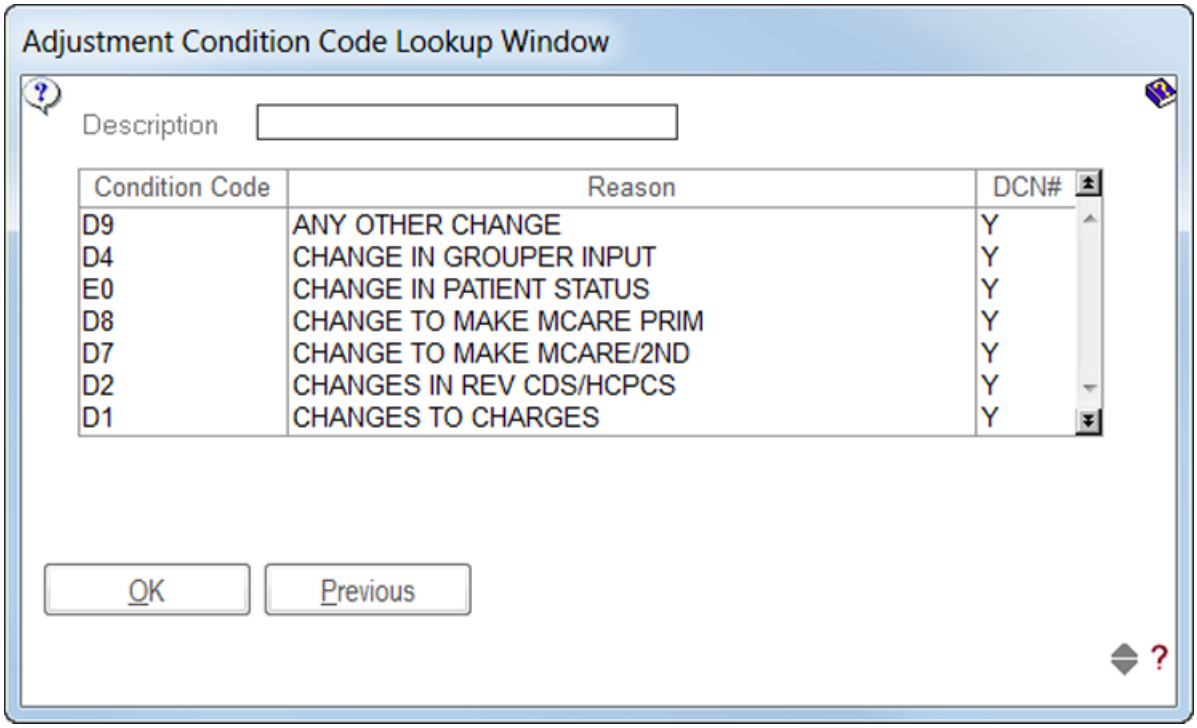
Action: Enter an adjustment condition code and, if required, enter the DCN# (Document Control Number) which will be entered in Locator 37 on the UB bill.

To enter a code: Either type the code or click to select it in the **Adjustment Condition Code Lookup** window. Valid codes are:

Condition Code	Reason	Bill Frequency	DCN# Required	Remarks Required
D0	Changes to service dates	7	Y	N
D1	Changes to charges	7	Y	N
D2	Changes in rev cds/hcpcs	7	Y	N
D3	2nd/subsequent pps bill	7	Y	N
D4	Change in grouper input	7	Y	Y
D5	Correct hicn or prov id	8	N	N
D6	Repay a dup/oig overpay	8	Y	N
D7	Change to make mcare/2nd	7	Y	N
D8	Change to make mcare prim	7	Y	N
D9	Any other Change	7	Y	Y
E0	Change in patient status	7	N	N

Adjustment Condition Code Lookup window

This window appears when you click to enter a condition code in the adjustment bills window.



Action:

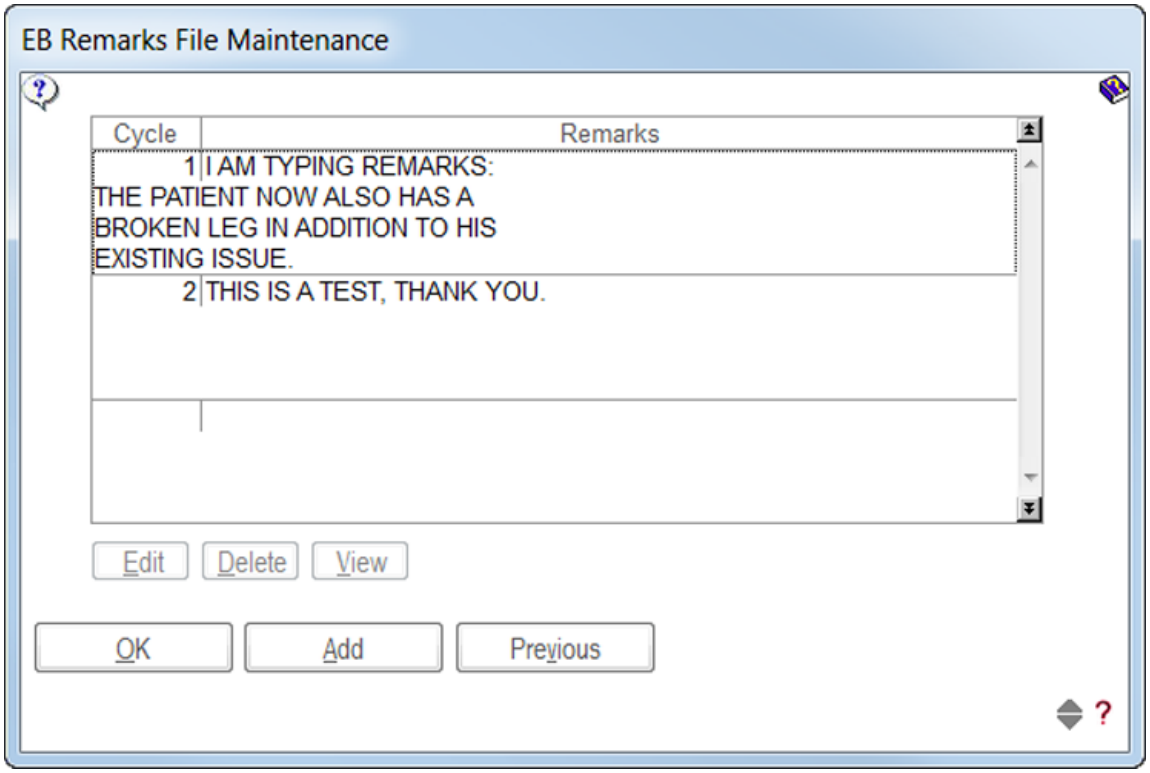
To find a code: Type part or all of the code's description in the **Description** field and click **OK**.

To select a code: Click on the code and click **OK**. (You can also just double-click on the code.)

Remarks selection window

This window appears when you enter a condition code in the adjustment bills window that requires remarks to be entered.

The window lists any remarks that have already been entered. You can add, edit, delete, and view remarks. These remarks will appear in Locator 84 on the UB bill.

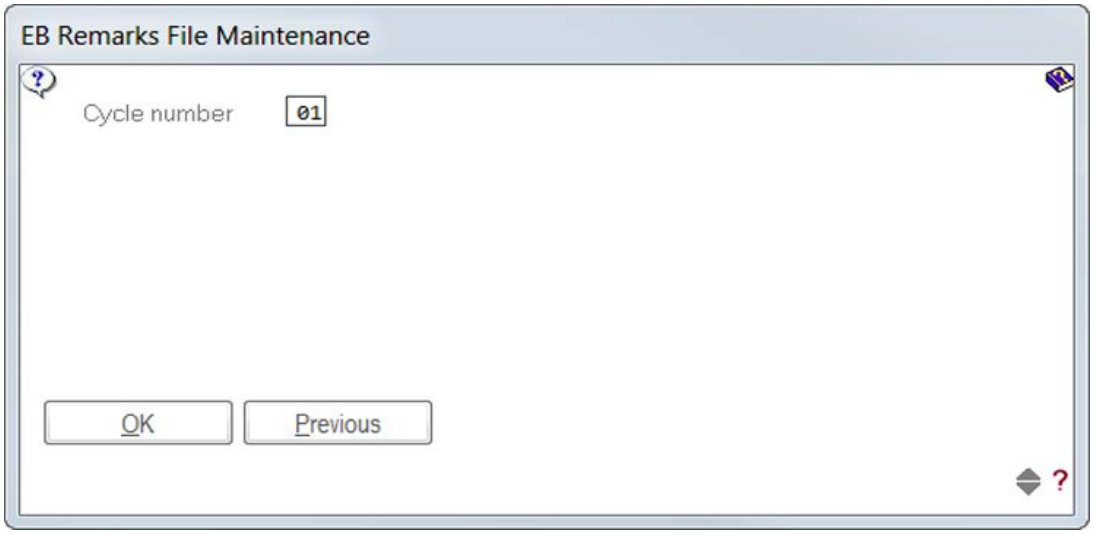


Action:

To enter a remark:	Click **Add**.
To edit, delete, or view a remark:	Select (click on) the remark, then click **Edit**, **Delete**, or **View**. The buttons become active when you select a remark. (To edit, you can also just double-click on the remark.) A window appears for editing, confirming the deletion, or viewing.
When you are through:	Click **OK**.

Cycle number window

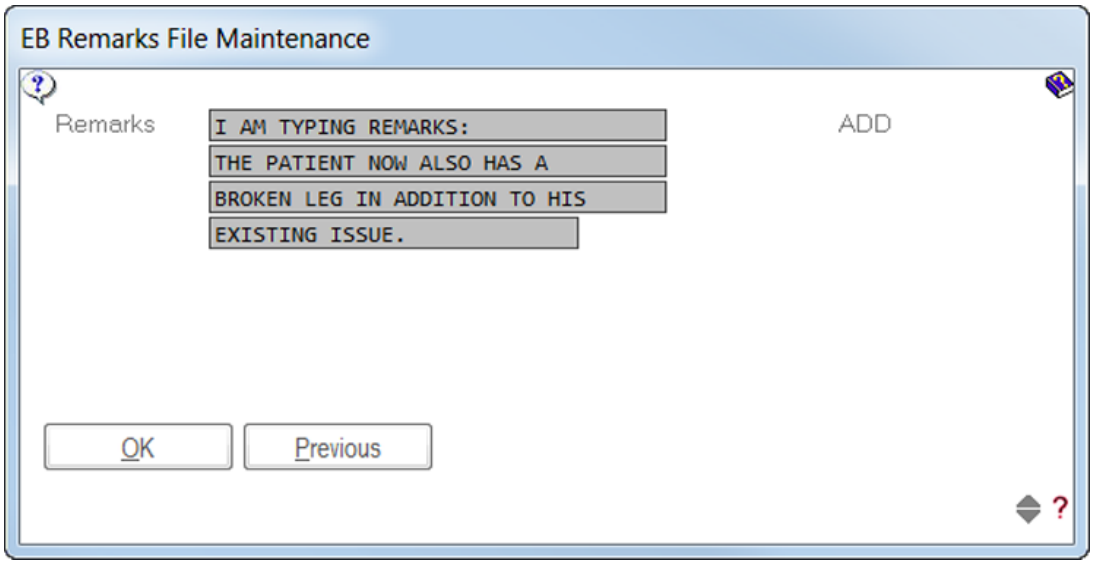
This window appears when you click **Add** in the remarks selection window.



Action: Enter a billing cycle number and click **OK**.

Add remarks window

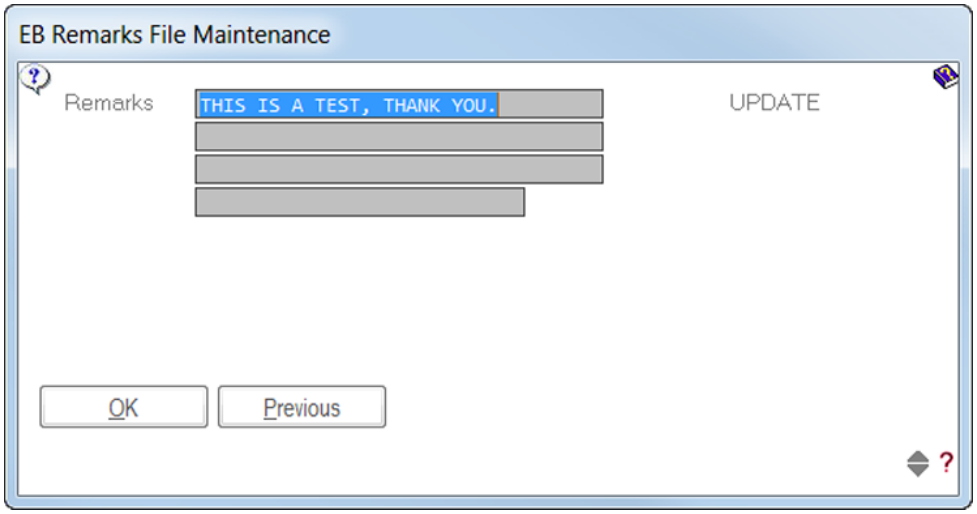
This window appears when you enter a billing cycle number in the cycle number window.



Action: Type your remarks and click **OK**. (Clicking **Previous** returns you to the remarks selection window without saving any remarks you entered.) The remarks will appear in Locator 84 on the UB bill.

Edit remarks window

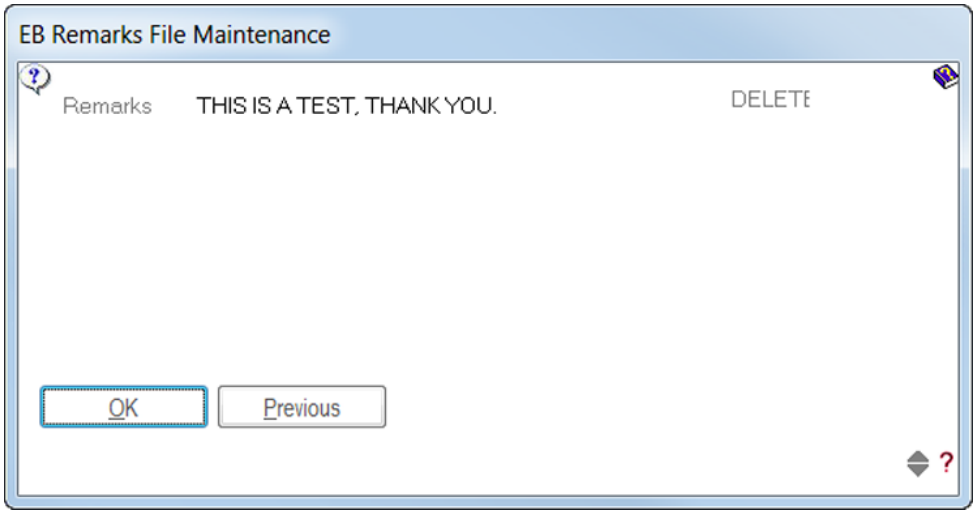
This window appears when you select a remark for editing in the remarks selection window.



Action: Make your changes and click **OK**. (Clicking **Previous** returns you to the remarks selection window without saving any changes you made.) The updated remarks will appear in Locator 84 on the UB bill.

Delete remarks window

This window appears when you select a remark for deletion in the remarks selection window.



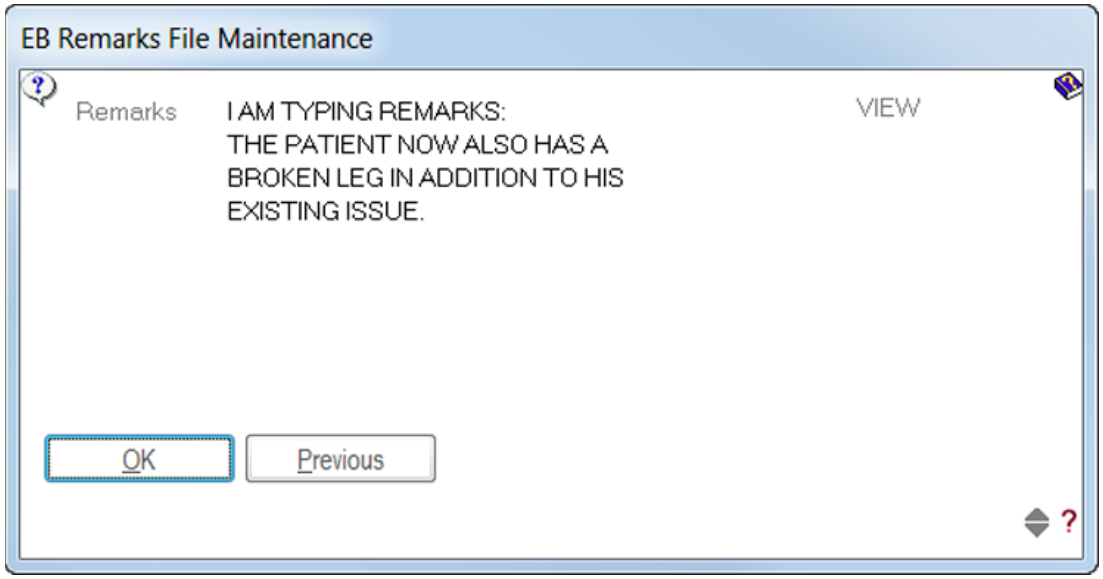
Action: **To delete the remark:** Click **OK**.

To cancel the deletion: Click **Previous**.

View remarks window

This window appears when you select a remark for viewing in the remarks selection window.

You can only view remarks in this window; you cannot edit or delete them.



Action: When you're through viewing, click **Previous**.

EBMENU Option 4: Hold Electronic Bills

Overview:

Hold Electronic Bills (Option 4 on the Electronic Billing Main Menu) is used to place on hold electronic bills that are not ready to be transmitted. This option will exclude a patient's claim from the current transmission file.

Before selecting this option, make sure you review the Electronic Billing Transmission List produced from Create/Print EB Listing, Option 1 on the Electronic Billing Main Menu.

Releasing the bills on hold is controlled by the **Manually release held bills** field in the Maintain EB System Control Record, Option 1 on the Maintenance Menu. If the field is answered **Y**, the bills can be released through Option 5 on the Electronic Billing Main Menu. If the field is answered **N**, the bills placed on hold will automatically be released after each transmission.

When this option is completed, the Electronic Bills On Hold listing will automatically be printed, listing all patients whose bills have been put on hold. An example is shown below.

Electronic bills may be held by patient number and cycle number.

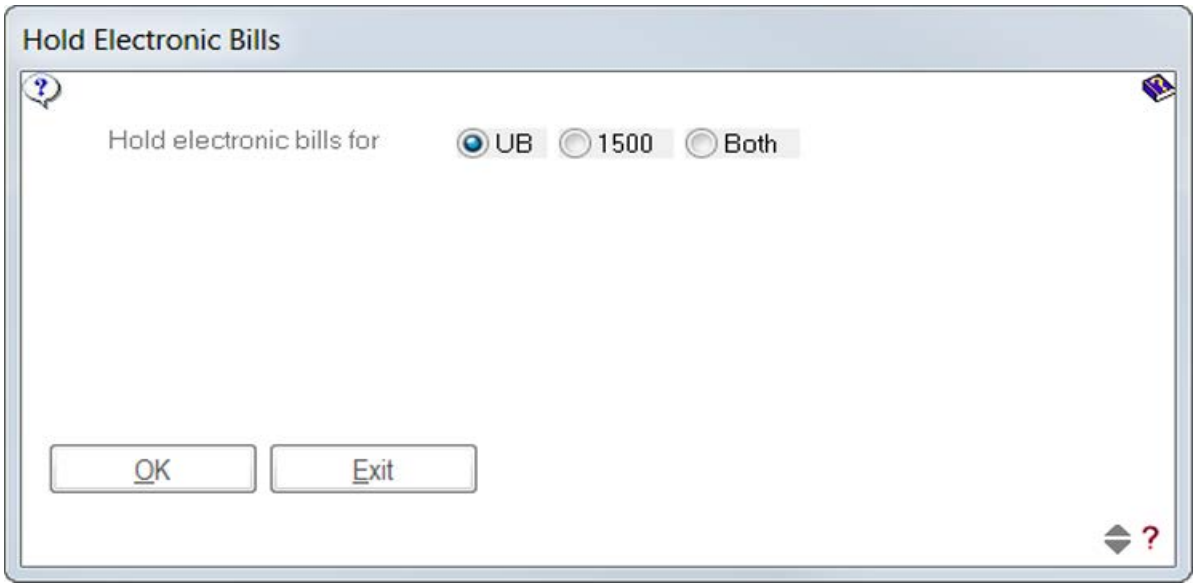
Files:

PATIENTS, XNSUB82, XNSCODE, XNS1500, XNS15LB, XNS15CD

In this section

Bill type selection window

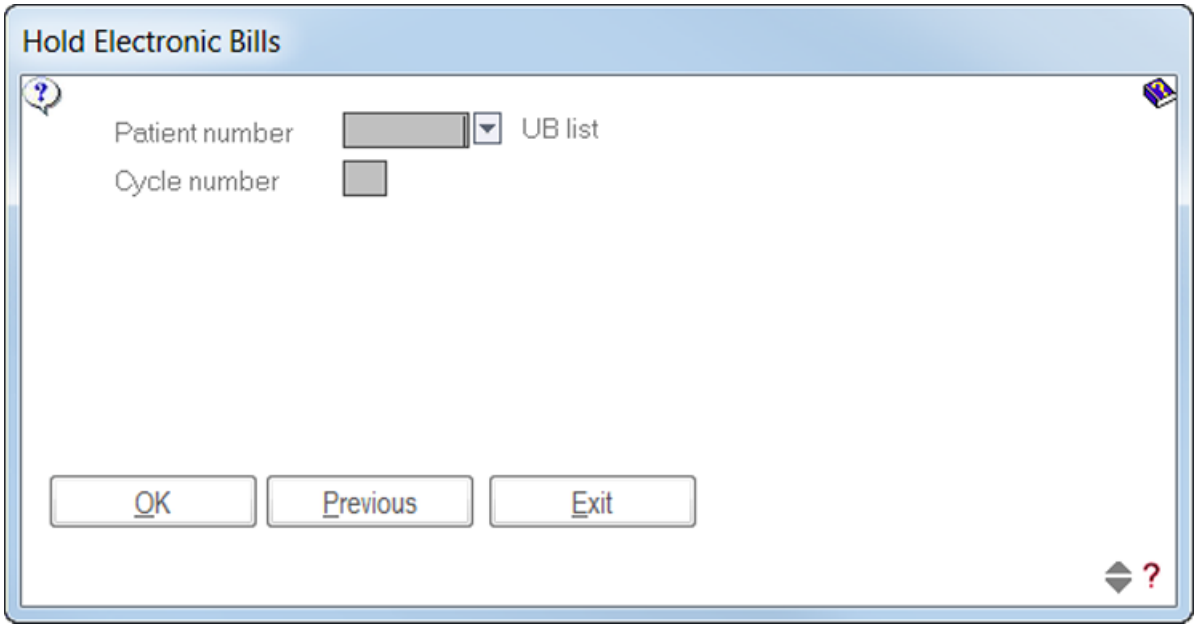
This window appears when you select **Hold Electronic Bills** on the Main Menu.



Action Select (click on) the type of electronic bill (UB, 1500, or both) that you want to put on hold, then click **OK**.

Patient number/cycle number window

This window appears when you select a bill in the bill type selection window.



Action

For each patient whose electronic bills are to be held, enter the patient number and cycle number, and then click **OK**.

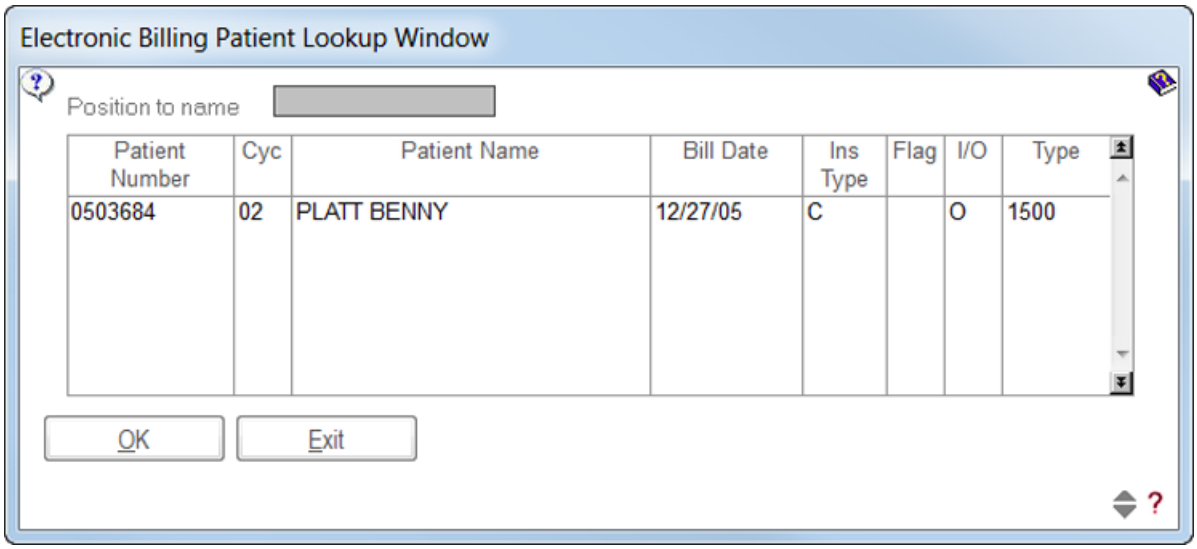
To enter a patient or cycle number: Either type the number or click to search for it and select it.

*The buttons that appear correspond to the selection you made in the bill type selection window. For example, if you selected **Both**, then both buttons appear to allow you to search both the UB and 1500 lists.*

When you have entered all the patient/cycle numbers, click **Exit** to return to the menu. The Electronic Bills On Hold report will be generated.

Electronic Billing Patient Lookup window

This window appears when you click to enter a patient number.



Action

To find a patient: Type part or all of the patient's last name in the **Position to name** field and click **OK**.

To select a patient: Click on the patient's name and click **OK**. (You can also just double-click on the patient's name.)

Sample Electronic Bills on Hold report

EB0R01 EXAMPLE FACILITY PAGE: 1
MONITOR Electronic Bills On Hold DATE: 12/31/04
TIME: 14:40:18

CLAIM TYPE	PATIENT NUMBER	CYCLE NUMBER	PATIENT NAME	PATIENT TYPE	INSURANCE TYPE	BILL TYPE	ADMISSION DATE	DISCHARGE DATE
UB	5702167	01	DAUGHTREY ROBERT M III	I	BLUE CROSS	141	12/01/04	12/02/04
UB	1515733	01	NELSON MAUDIE R	I	MEDICAID	111	12/05/04	12/07/04
UB	1516012	01	DARBY HOUSTON	I	MEDICAID	111	12/10/04	12/13/04
UB	1516145	01	WILLIS DELENE	I	MEDICAID	111	12/15/04	12/20/04

EBMENU Option 5: Release Electronic Bills

Overview:

Release Electronic Bills (Option 5 on the Electronic Billing Main Menu) is used to release a patient's electronic bill (UB, 1500, or both) that was previously put on hold and should be released to transmit.

Before selecting this option, make sure you review the Electronic Bills On Hold report produced from Hold Electronic Bills, Option 4 on the Electronic Billing Main Menu.

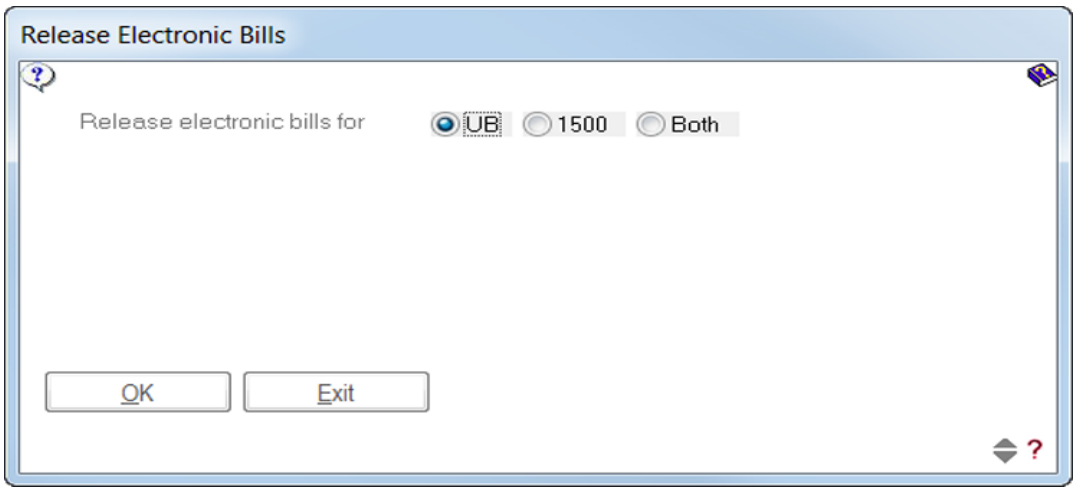
Files:

XNSUB82

In this section

Bill type selection window

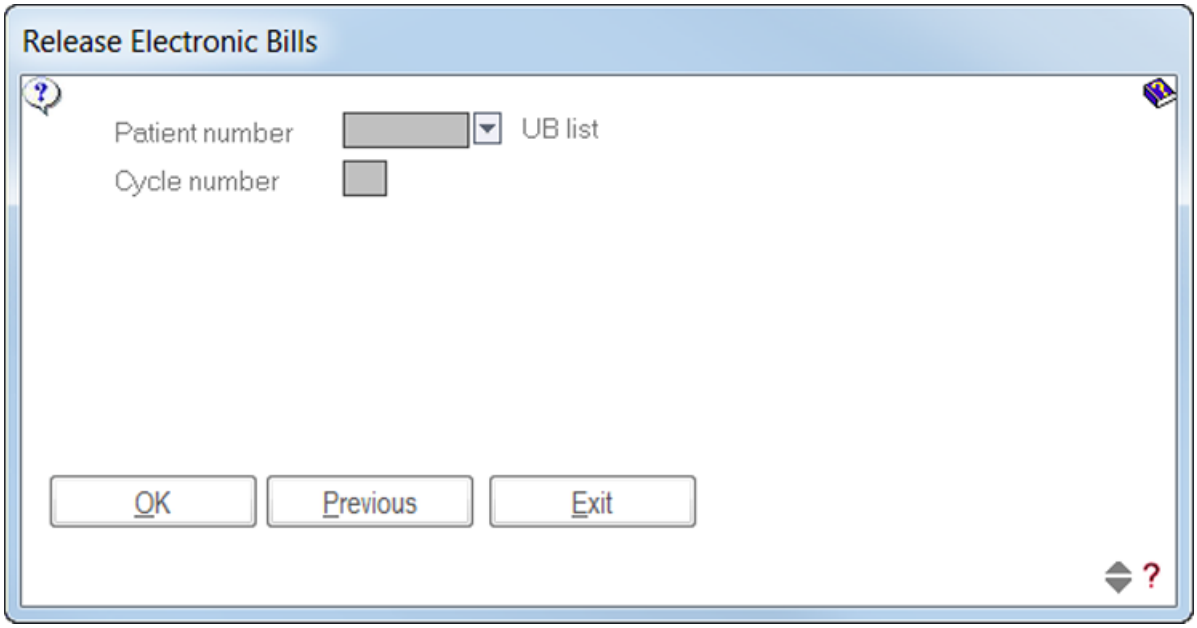
This window appears when you select **Release Electronic Bills** on the Main Menu.



Action Select (click on) the type of electronic bill (UB, 1500, or both) that you want to release, then click **OK**.

Patient number/cycle number window

This window appears when you select a bill in the bill type selection window.



Action

For each patient whose electronic bills are to be released, enter the patient number and cycle number, and then click **OK**.

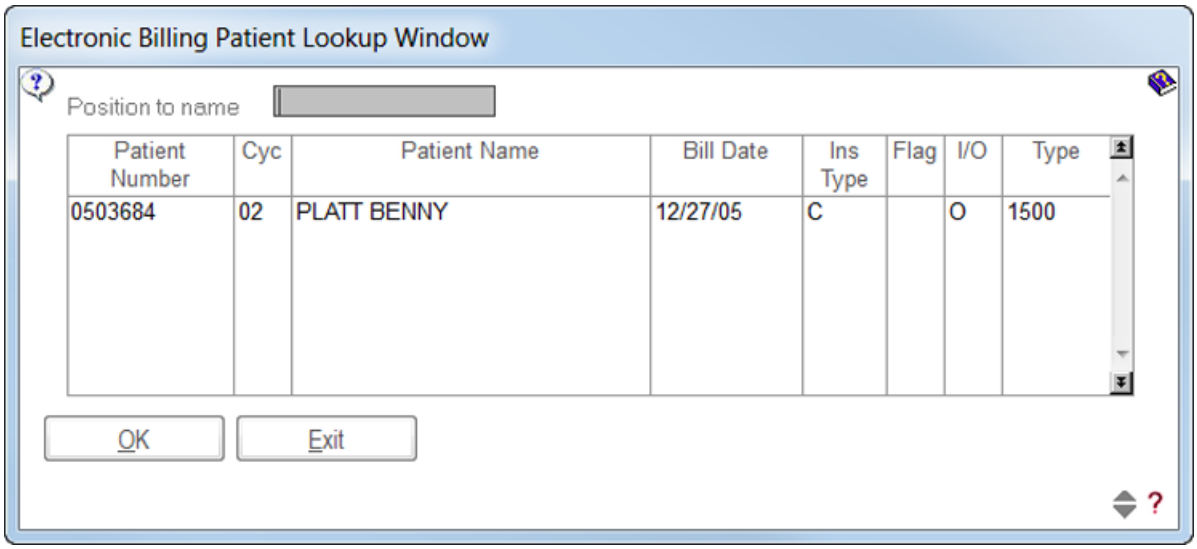
To enter a patient or cycle number: Either type the number or click to search for it and select it.

*The buttons that appear correspond to the selection you made in the bill type selection window. For example, if you selected **Both**, then both buttons appear to allow you to search both the UB and 1500 lists.*

When you have entered all the patient/cycle numbers, click **Exit** to return to the menu.

Electronic Billing Patient Lookup window

This window appears when you click to enter a patient number.



Action

To find a patient: Type part or all of the patient's last name in the **Position to name** field and click **OK**.

To select a patient: Click on the patient's name and click **OK**. (You can also just double-click on the patient's name.)

EBMENU Option 6: Cancel Electronic Bills

Overview:

Cancel Electronic Bills (Option 6 on the Electronic Billing Main Menu) is used to cancel a patient's electronic bill (UB or 1500). Cancelling a bill removes the patient's claim from electronic bills processing.

Before selecting this option, make sure you review the Electronic Billing Transmission List produced from Create/Print EB Listing, Option 1 on the Electronic Billing Main Menu.

This option deletes the patient from the EB transmission file. The patient will have to be rebilled from Rebill Electronic Bills, Option 3 on the Electronic Billing Main Menu.

Files:

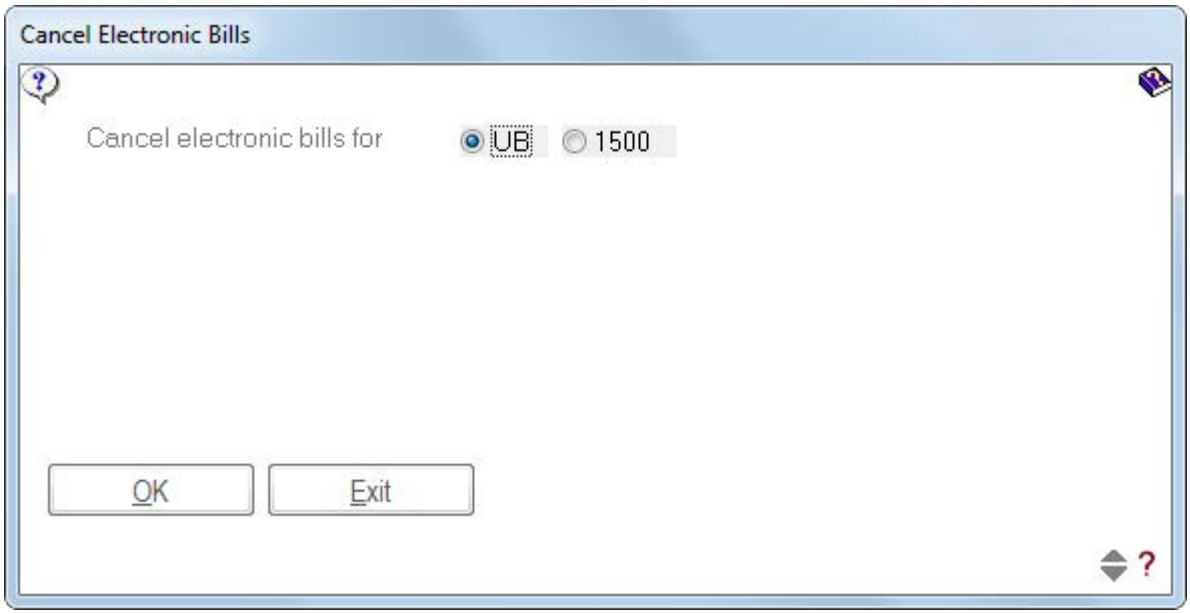
XNSUB82

In this section

Bill type selection window

This window appears when you select **Cancel Electronic Bills** on the Main Menu.

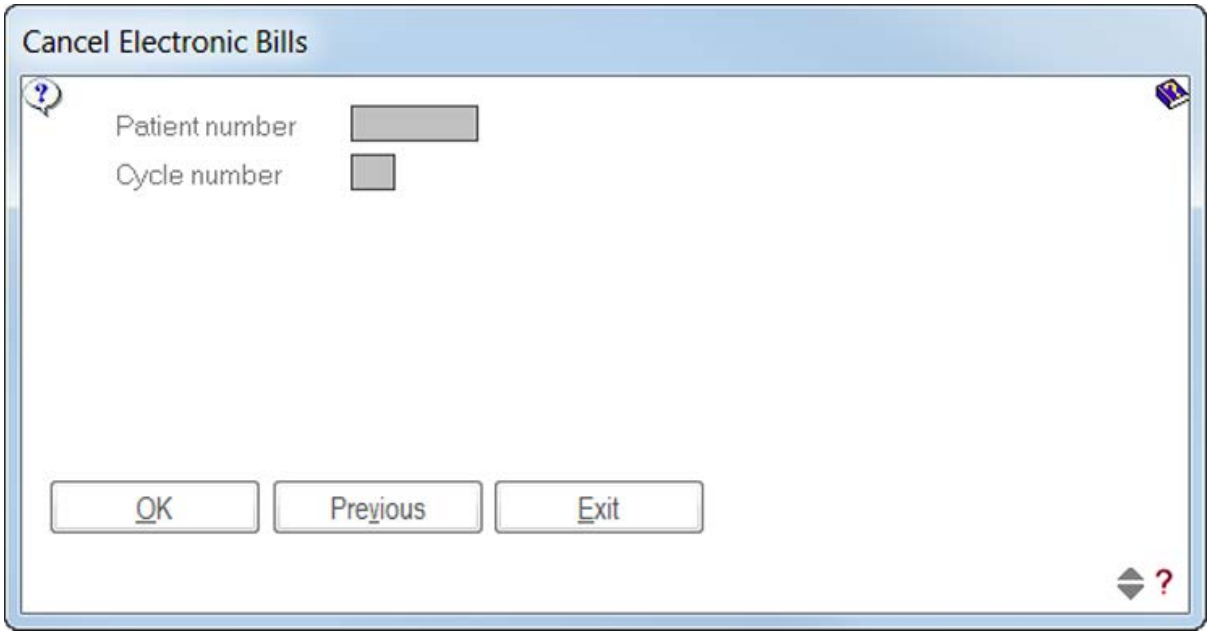
UB has replaced **UB92** in this window.



Action Select (click on) the type of electronic bill (UB or 1500) that you want to cancel, then click **OK**.

Patient number/cycle number window

This window appears when you select a bill in the bill type selection window.



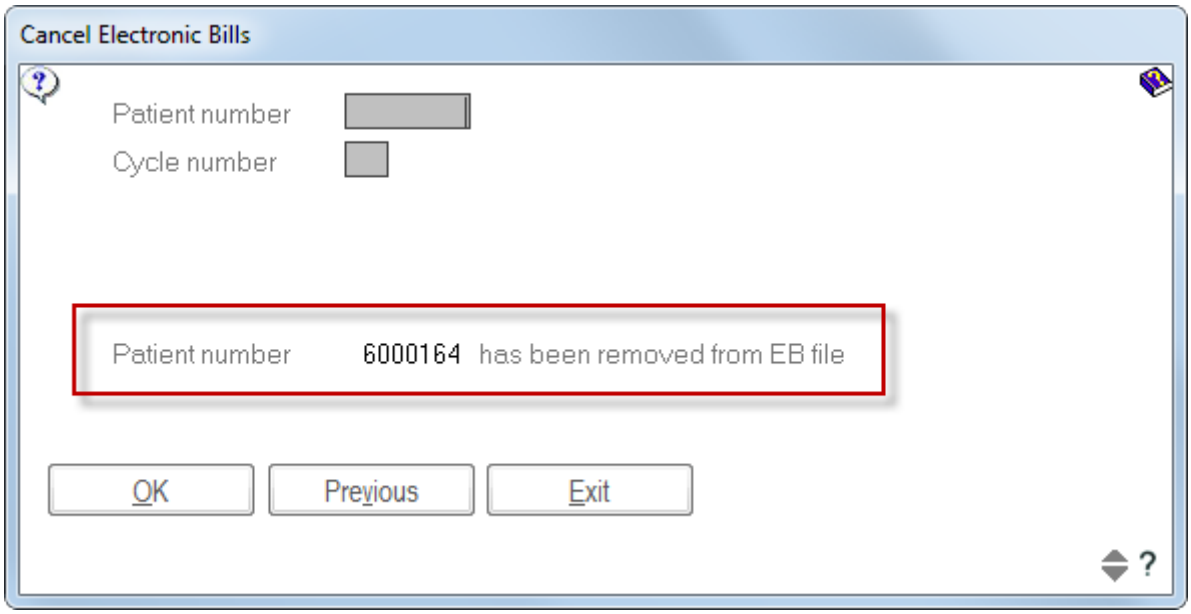
Action

Each patient whose electronic bills are to be cancelled, type the patient number and cycle number, and then click **OK**.

The following message will appear at the bottom of the screen each time you click **OK**:

`Patient number xxxxxxx has been removed from EB file.`

When you have entered all the patient/cycle numbers, click **Exit** to return to the menu.



Patient Number/Cycle Number Window will re-display with a message stating the Patient Number has been removed from EB File. Press **OK** to continue.

EBMENU Option 8: Enter Remarks

This option has been enhanced to allow the use of both 4010 and 5010 formats. You also can enter the Ambulance **Transport Distance** with a decimal.

Overview:

Use this option to enter remarks that will be printed in the remarks section of UB bills that are printed from the electronic billing claims sent to carriers.

There are three versions of the **Remarks** screen. One is used for claims that ***do not*** have a UB revenue code of 0540 = Ambulance Services. The other two are used for claims that ***do*** have a UB revenue code of 0540 = Ambulance Services. One is for version 4010 formats, the other is for version 5010 formats. The two formats and screens are described in separate sections.

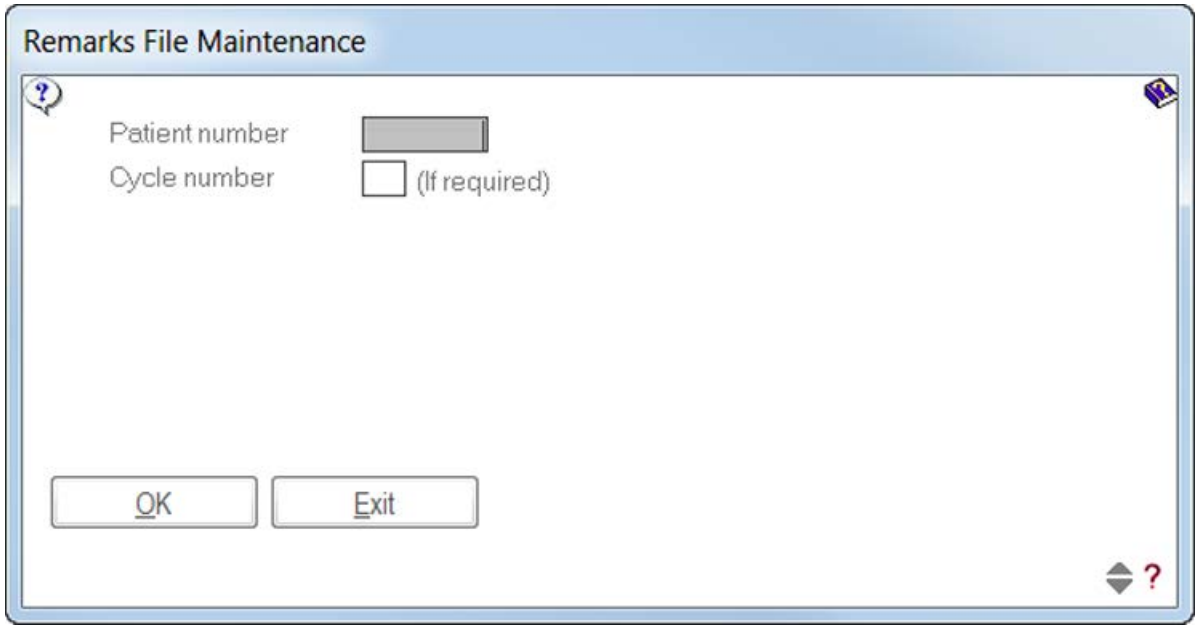
Files:

EBREMARK

Contents

SELECTING A PATIENT

This Patient number / cycle number window appears when you select *Enter Remarks* on the *Electronic Billing Main Menu*.



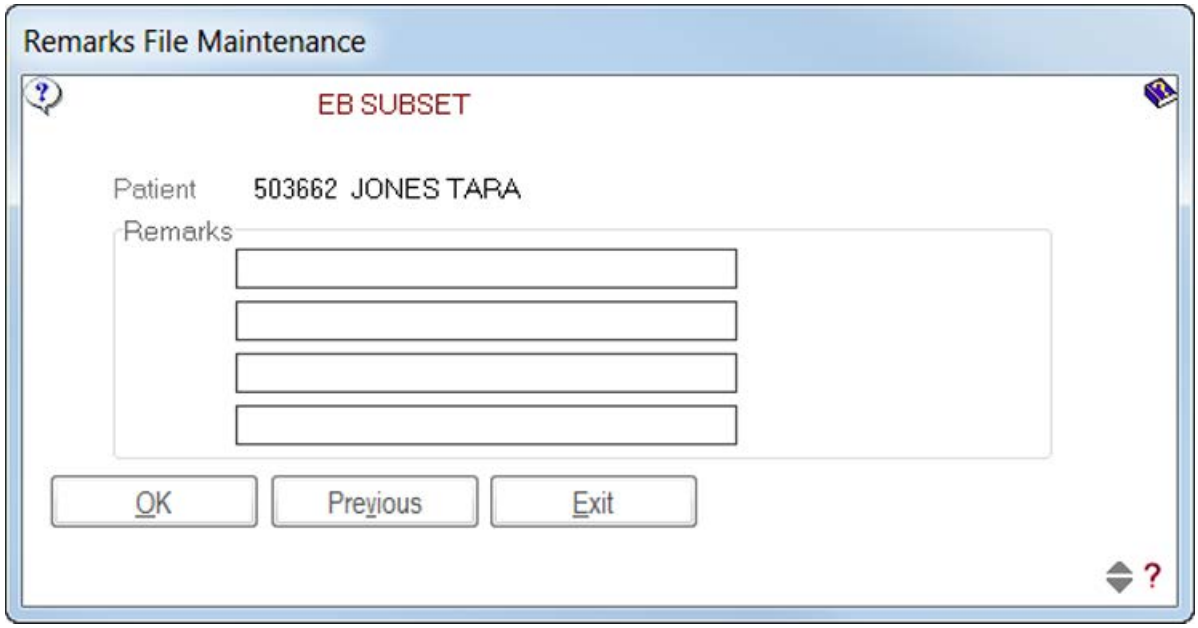
Action Type the patient number and, if required, cycle number for the patient on whose bill you want to enter remarks; then click **OK**. One of two kinds of remarks screens will open next.

ENTERING REMARKS

Claims without Ambulance Services

The Remarks File Maintenance window appears when you click **OK** in the **Patient Number/Cycle Number** window and the claim ***does not*** contain a UB revenue code of 540 = Ambulance services. The same window appears for both transaction formats (4010 and 5010). Use this window to add remarks to the UB bills.

Note: If the claim *does* contain the 0540 code, the **Ambulance Services** window appears instead, as described in the section, "Claims with Ambulance Services."



Action

Type up to four lines of remarks, and then click **OK**.

Clicking **Previous** returns you to the **Patient Number/Cycle Number** window without saving your remarks.

Clicking **Exit** returns you to the **Electronic Billing Main Menu** without saving any changes.

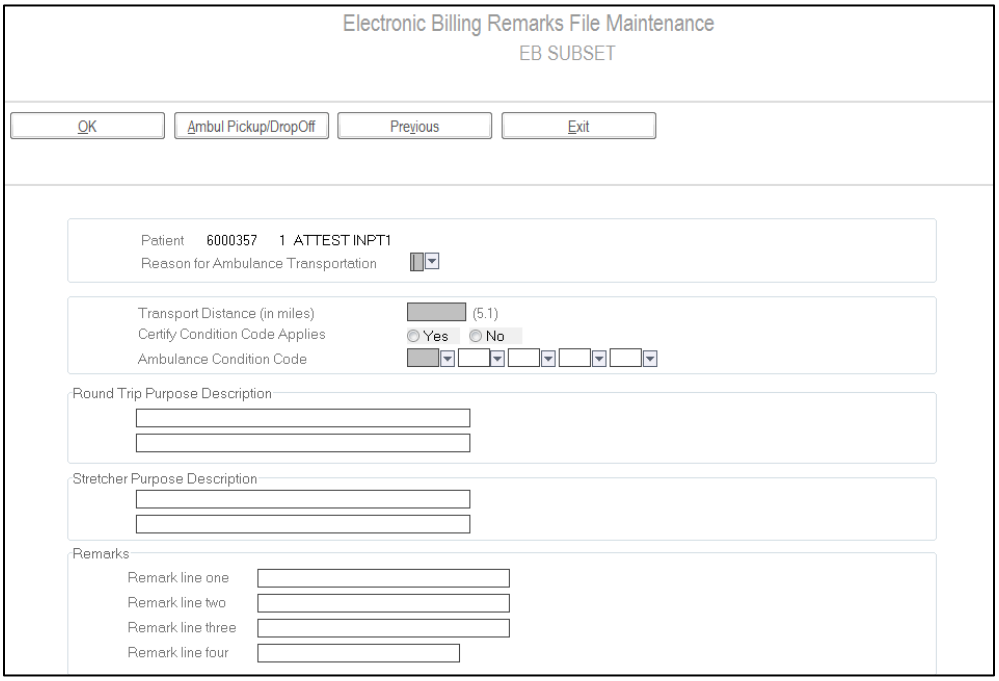
Claims with Ambulance Services

The Ambulance Services–Remarks window appears when you click **OK** in the **Patient Number/Cycle Number** window and the claim ***does*** contain a UB revenue code of 0540 = Ambulance services. Use this window to add information about ambulance use as well as remarks.

Note: If the claim ***does not*** contain the 0540 code, the **Remarks File Maintenance** window appears instead (see the earlier section, "Claims without Ambulance Services.").

Several fields or codes differ for transactions that use the 4010 and 5010 formats, so their screens are shown in separate sections.

4010 Format Ambulance Services Window



The **Transport Distance** field includes a decimal. For example, if the distance is 22.5, enter 225.

Action

Before completing any other information, select **Yes** or **No** in the **Certify Condition Code Applies** field. This is the only required field, but you will not be able to complete the other fields until this field has an entry.

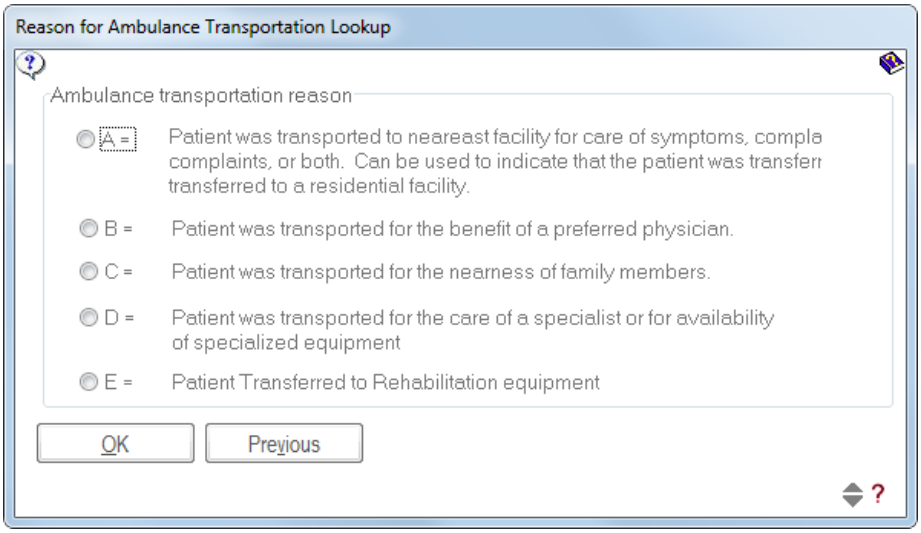
To search for valid codes for the **Reason for Ambulance Transportation**, **Ambulance Transport Code**, and **Ambulance Condition Code** fields, press **F4** in the field or click on the search button . Valid codes are shown on the next pages.

Clicking **Previous** returns you to the **Patient Number/Cycle Number**.

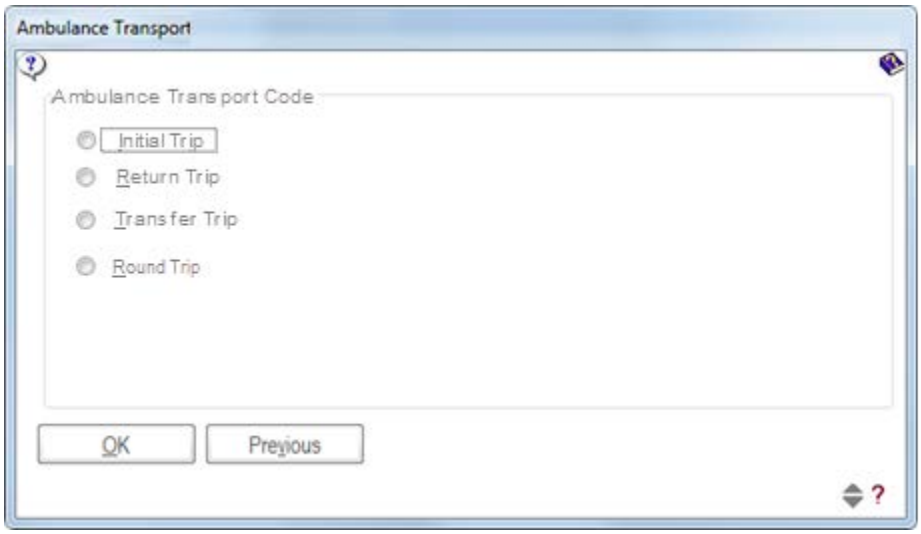
Clicking **Exit** returns you to the **Electronic Billing Main Menu** without saving any changes.

Valid 4010 Ambulance Codes

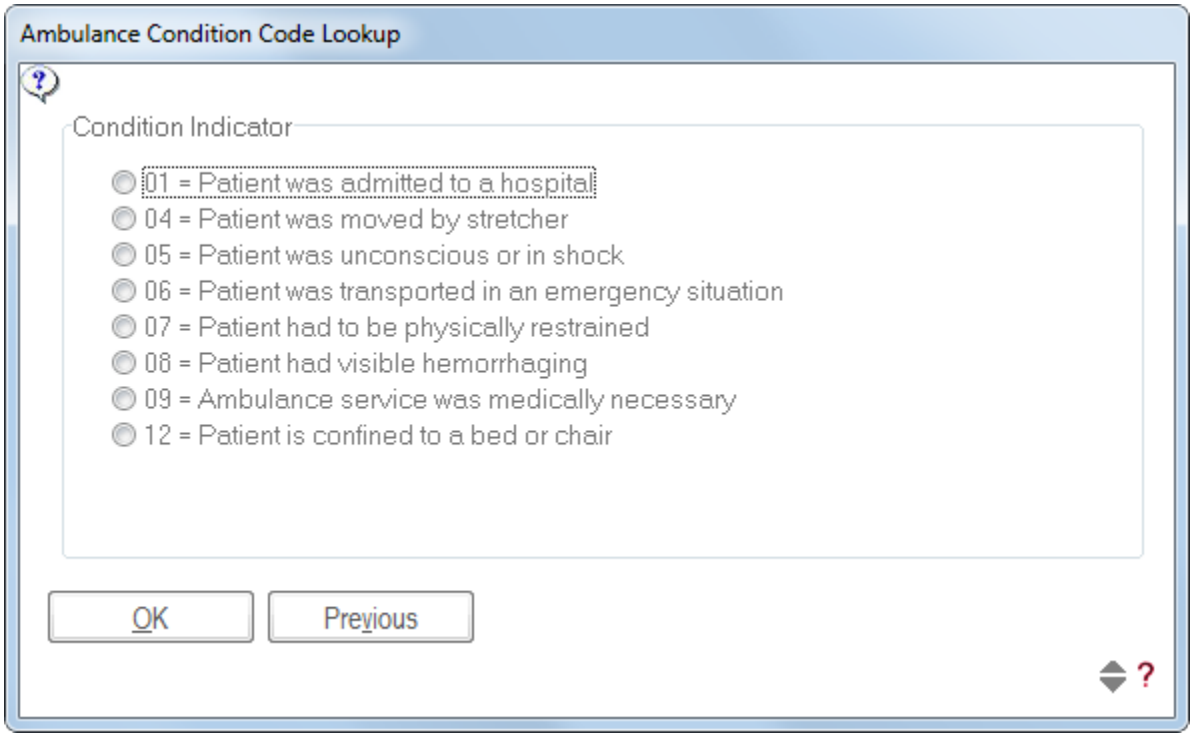
Reason for Ambulance Transportation



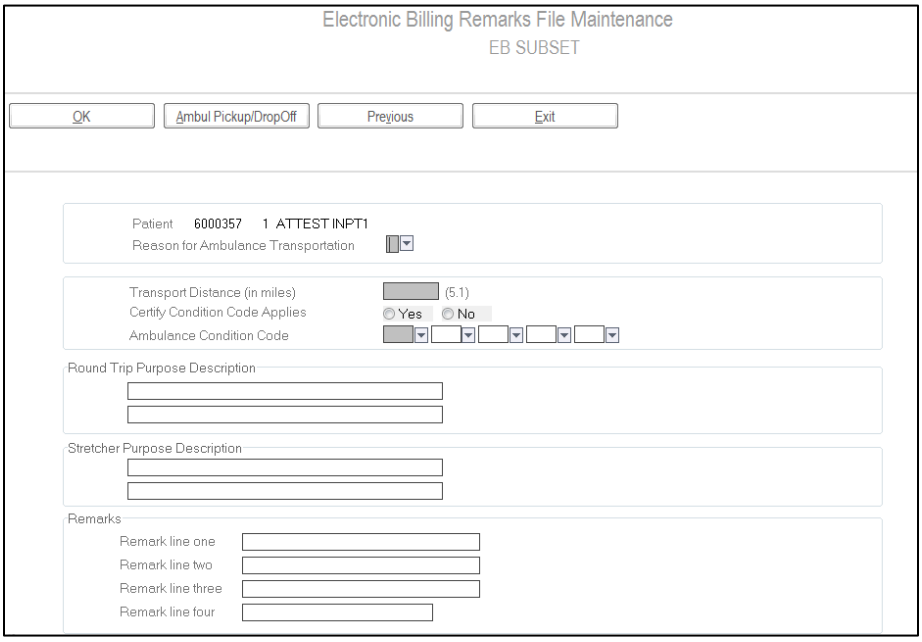
Ambulance Transport Code



Ambulance Condition Indicator



5010 FORMAT AMBULANCE SERVICES WINDOW



The **Transport Distance** field includes a decimal. For example, if the distance is 22.5, enter 225.

Action

Before entering any other information, choose **Yes** or **No** in the **Certify Condition Code Applies** field. This is the only required field, but you will not be able to complete the other fields until this field has an entry.

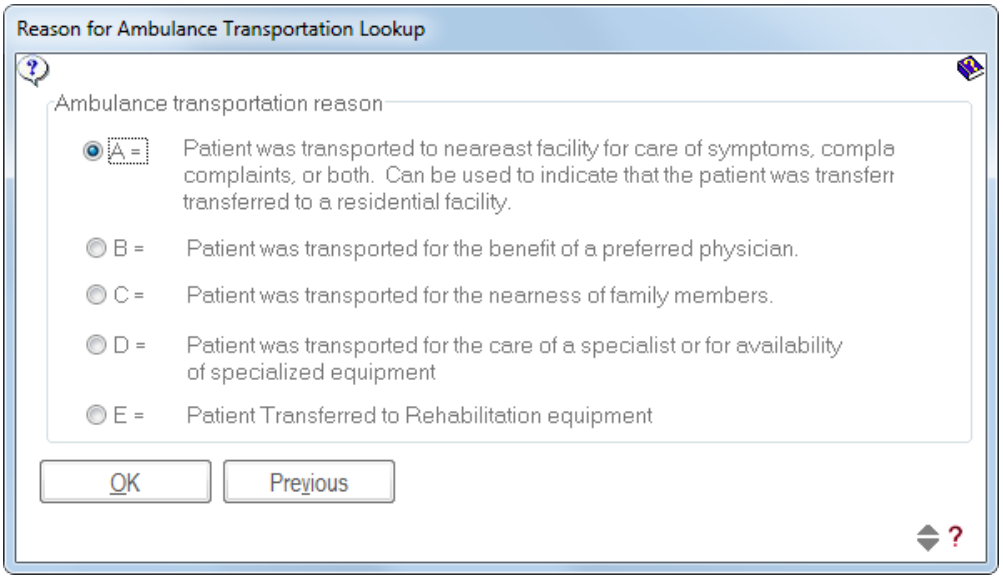
To search for valid codes for the **Reason for Ambulance Transportation** and **Ambulance Condition Code** fields, press **F4** in the field or click on the search button. Valid codes are show on the next pages.

Clicking **Previous** returns you to the **Patient number/cycle number** window without saving any changes.

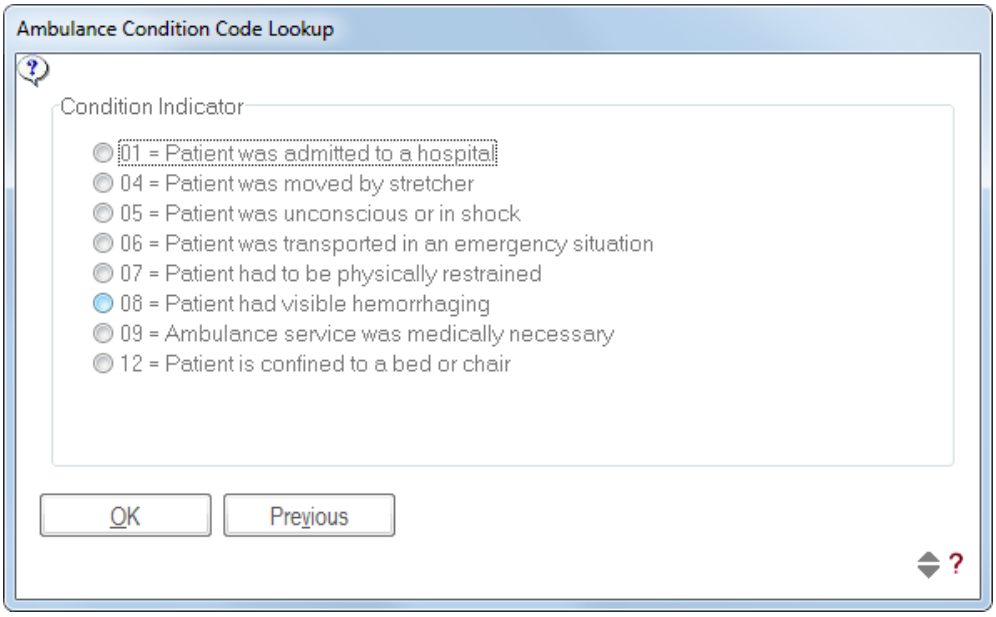
Clicking **Exit** returns you to the **Electronic Billing Main Menu** without saving any changes.

Valid 5010 Ambulance Codes

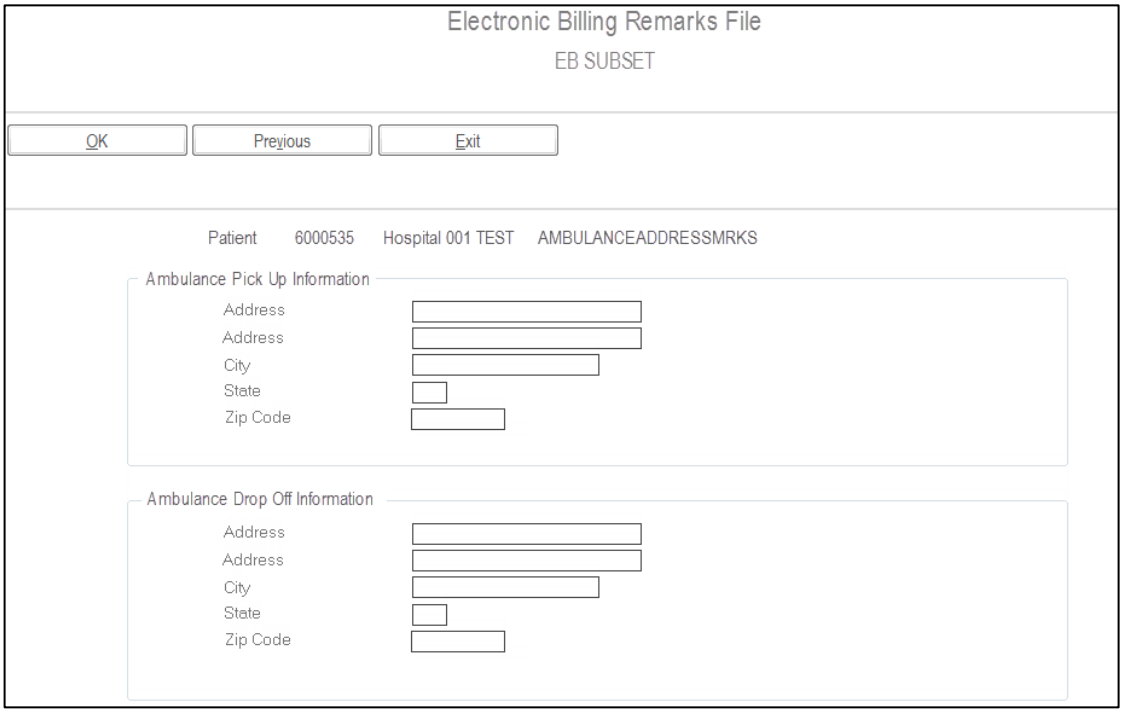
Reason for Ambulance Transportation



Ambulance Condition Indicator



AMBULANCE PICK UP/DROP OFF INFORMATION WINDOW



Action Populate the **Address 1, 2, City, State, and Zip** fields as required according to the patient's information in the **Ambulance Pick Up and Drop Off Information** sections of the screen displayed above.

EBMENU Option 9: Receive Audit Reports

Overview:

Receive Audit Reports (Option 9 on the Electronic Billing Main Menu) is used to sign on and receive the audit report from the intermediary. An example of the Tennessee audit report is shown below.

The following message will appear on the screen:

LINES ARE SET UP, BEGIN TO CHECK SYS OPR MSGS

If a line failure occurs, the system will automatically try again, but you will have to check for system operator messages and redial the number. The following message will appear if a line failure occurs:

COMMUNICATIONS LINE FAILURE ... TRYING CONNECTION AGAIN. YOU WILL NEED TO CHECK SYSTEM OPERATOR MESSAGES AGAIN FOR MANUAL DIAL UP MESSAGE, AND YOU WILL NEED TO RE-DIAL THE NUMBER AT THE APPROPRIATE TIME.

If any other type of error occurs during the transmission, the transmission error window will appear.

When the report is received, the following message will appear:

AUDIT REPORT RECEIVED, PRESS ENTER TO CONTINUE

The Audit report will print on the system printer or will be sent to an output queue.

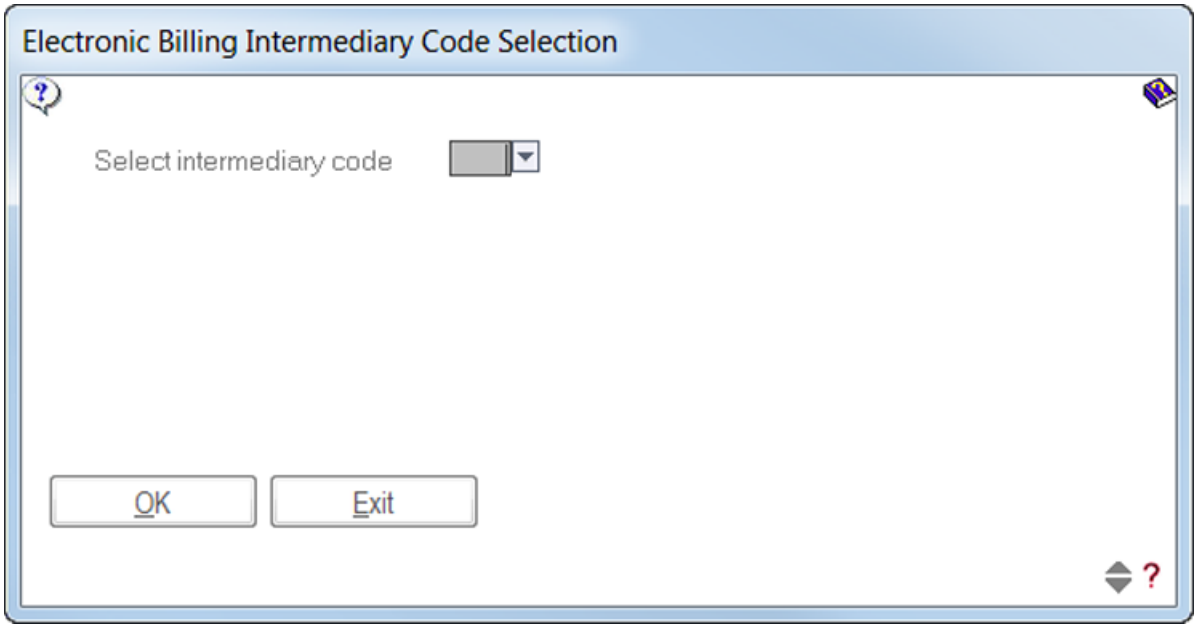
Files:

EBAUDIT

In this section

Intermediary Code Selection window

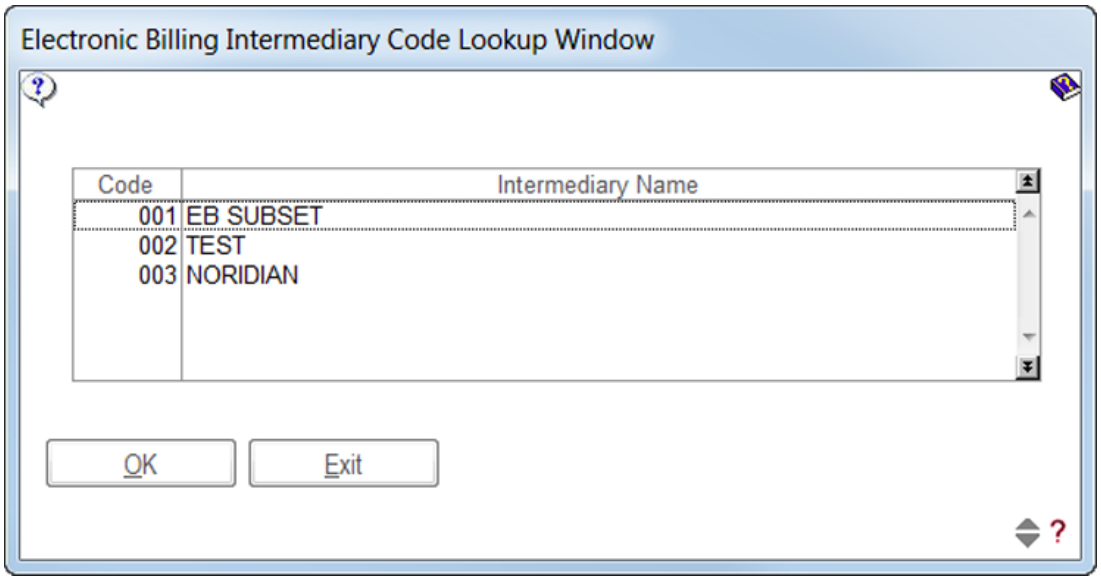
This window appears when you select **Receive Audit Reports** in the Main Menu.



Action: Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

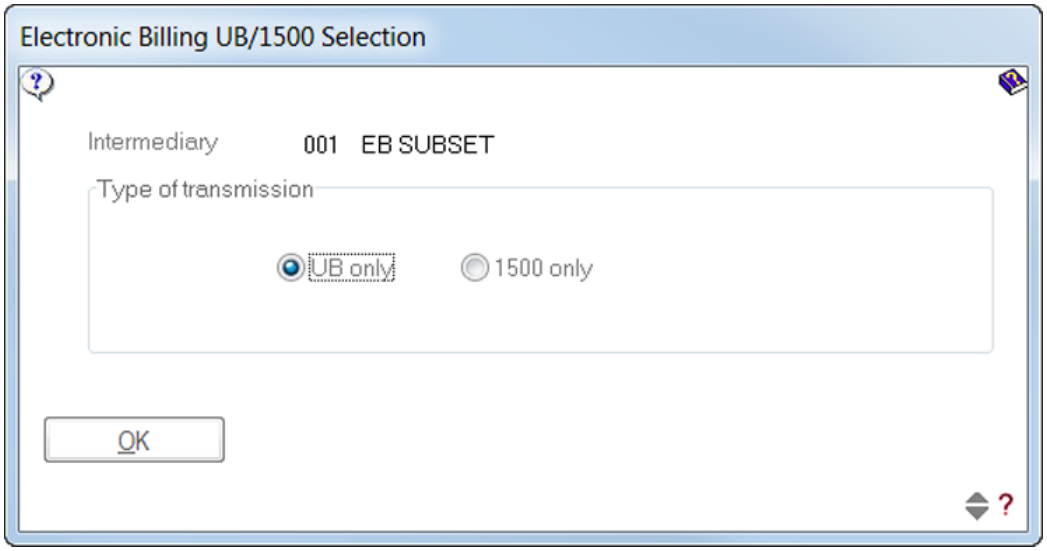
This window appears when you click in the **Intermediary Code Selection** window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

UB/1500 Selection window

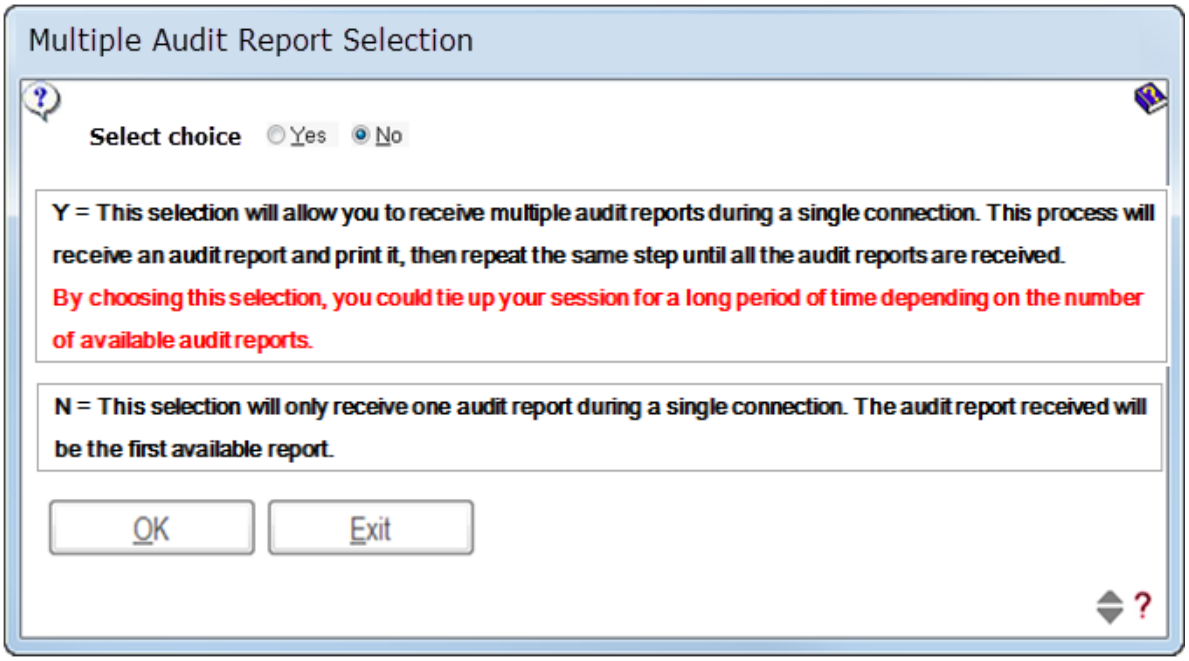
This window appears when you enter an intermediary code in the **Intermediary Code Selection** window and click **OK**.



Action: Select (click on) the code you want and click **OK**.

Multiple Audit Report Selection window

This window appears when the intermediary allows multiple audit reports to be received during a single connection.

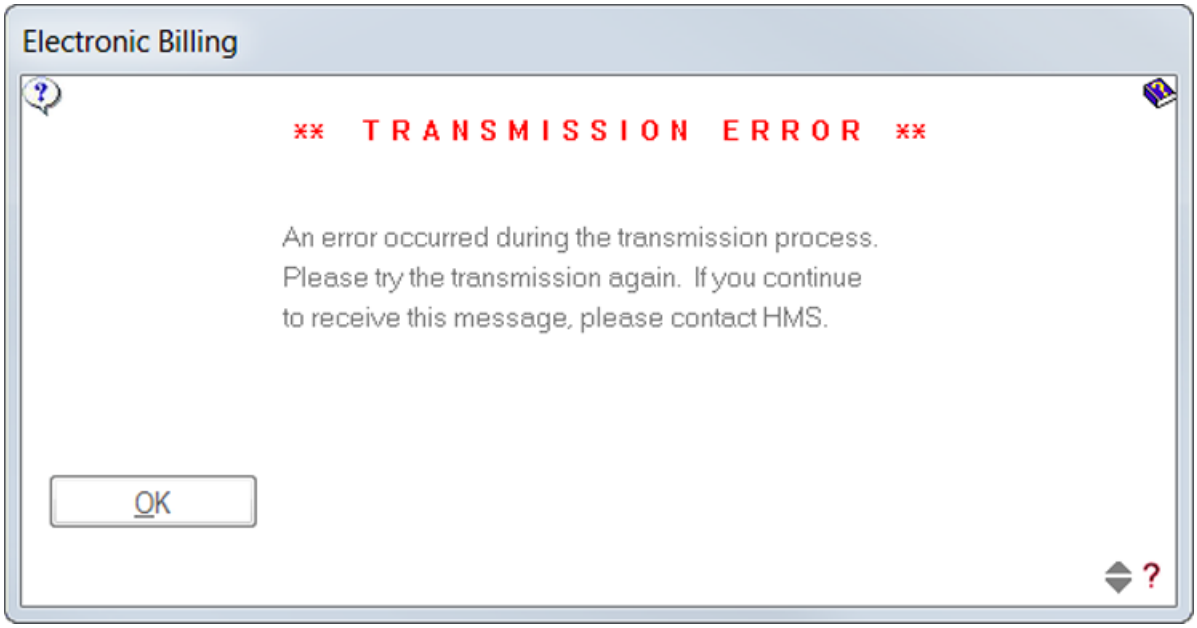


Action Click **Yes** to receive multiple audit reports; click **No** to receive only the first available report. Then click **OK**.

Before making a selection, be sure to read the descriptions in the window, especially for the **Yes** option.

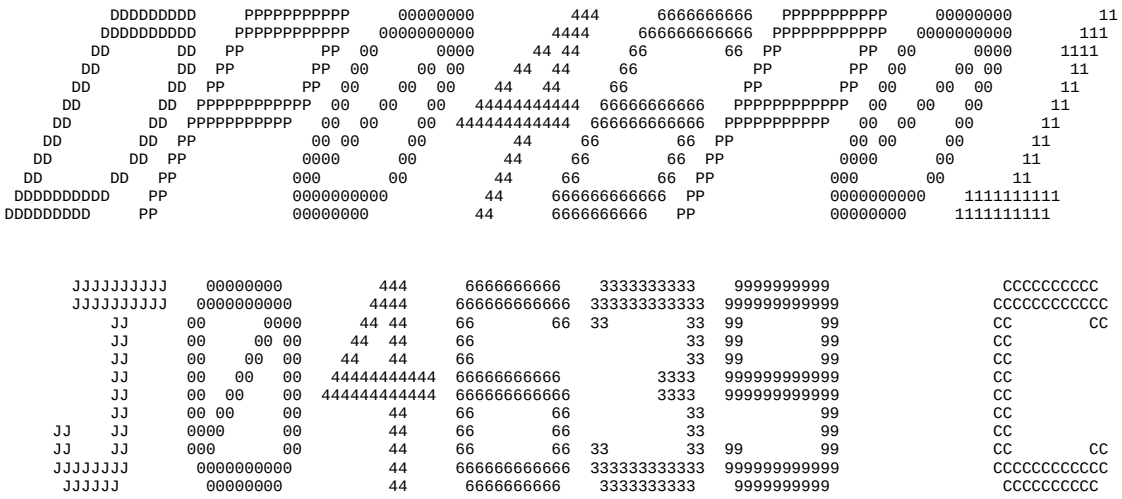
Transmission error window

This window appears when an error occurs during an attempted transmission or reception.

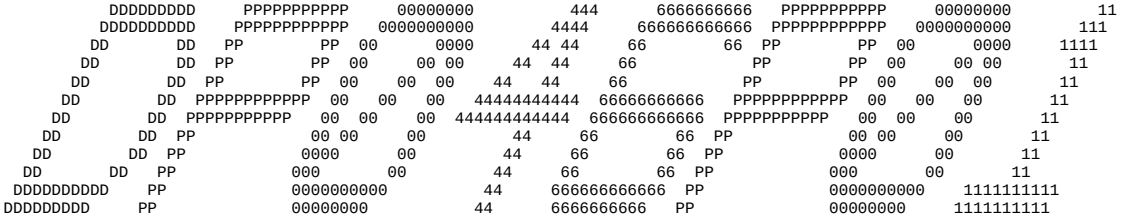


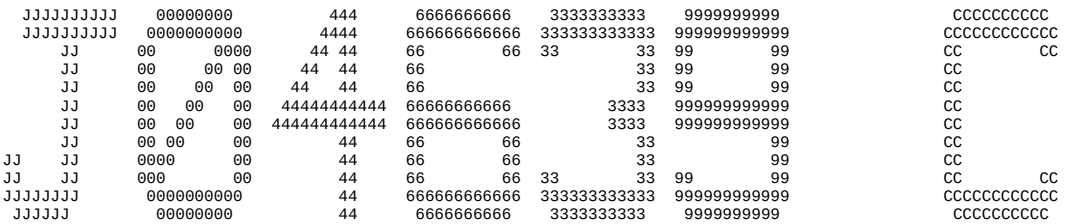
Action Click **OK**, then try transmitting or receiving again. If this window appears again, contact Customer Support.

Sample audit report



```
//DP046P01   JOB ACCT2510,EBS,CLASS=B,MSGCLASS=C,                JOB04639

------ JES2 JOB STATISTICS ------
       1 CARDS READ
       7 SYSOUT PRINT RECORDS
       0 SYSOUT PUNCH RECORDS
       0 SYSOUT SPOOL KBYTES
    0.00 MINUTES EXECUTION TIME
```





```
*C START JOB04639 DP046P01 1       001 001 R22      EBS               ROOM       04:02:55 PM 18 DEC 02 R22.PR1  XA1  START C*
```

EBMENU Option 10: Copy Electronic Bills to Hard Media

Overview:

Copy Electronic Bills to Hard Media (Option 10 on the Electronic Billing Main Menu) is used to copy electronic bills to tapes or diskettes. You do not need to initialize those media before selecting this option.

This option does not apply to some states.

Before the copy is started, a Submission Recap Report will be printed.

When the copy is finished, a completion message is sent.

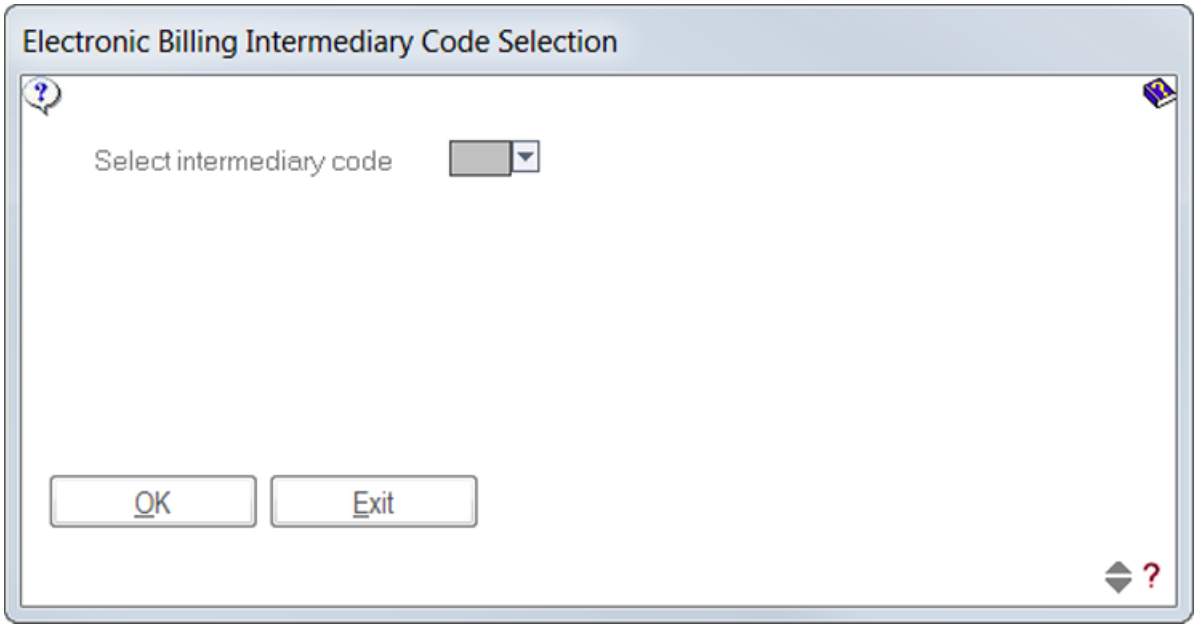
Files:

ELECBILL

In this section

Intermediary Code Selection window

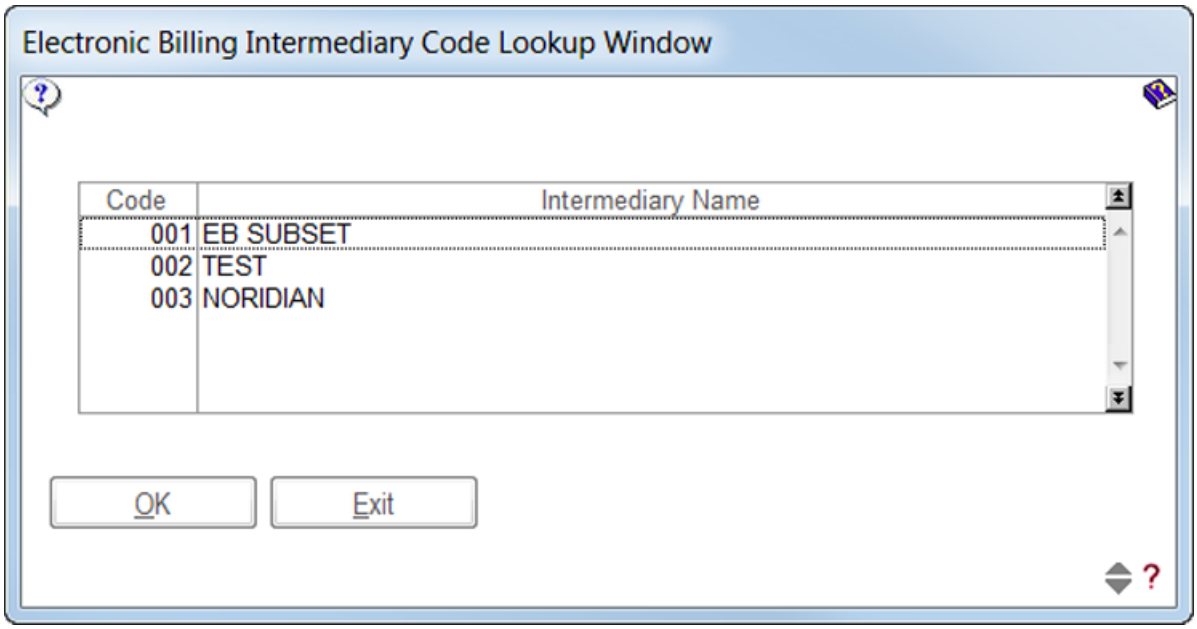
This window appears when you select **Copy Electronic Bills to Hard Media** in the Main Menu.



Action: Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

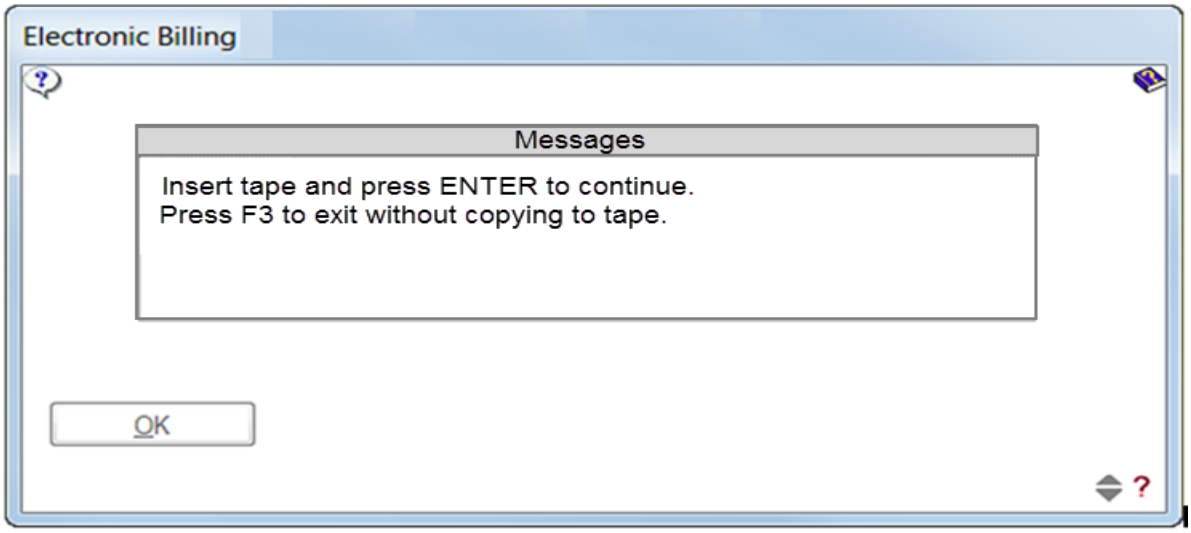
This window appears when you click in the **Intermediary Code Selection** window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

Message Window

This window appears when you select the intermediary whose bills you want to copy.



Action

To copy electronic bills: Insert a tape or diskette, and click **OK**. (Clicking **Exit** returns you to the Main Menu without making any copies.)

To initialize media: Insert the tape or diskette to be initialized, and click **OK**. (This window appears when you enter an intermediary code that is set up in the System Control Record with some form of tape as the backup device.) The system will inform you when the procedure is completed.

Sample Submission Recap Report

SUBMISSION DATE: 4/30/03 PAGE 1

SUBMITTED BY: EXAMPLE FACILITY
3401 WEST END AVE
NASHVILLE TN 37203

INVOICE TYPE HOSPITAL

SUBMITTER ID NUMBER: 1002821

PROVIDER NUMBER	TOTAL INVOICES	TOTAL CLAIMS	SUBMITTED TOTAL	PROVIDER NAME
1002821	8	8	46741.26	EXAMPLE FACILITY
1203886	22	61	10398.75	EXAMPLE FACILITY
GRAND TOTAL	30	69	57140.01	

EBMENU Option 12: Vary Off EB Line/Controller/Device

Overview:

Vary Off EB Line/Controller/Device (Option 12 on the Electronic Billing Main Menu) is used to vary off the communication line, controller, and device used in Electronic Billing.

If the process was successful, the following message will be displayed:

E/B line, controller, and device are varied off.

If a job or process has a lock on the line, controller, or device, the following message will be displayed:

E/B vary off did not complete successfully. Try again.

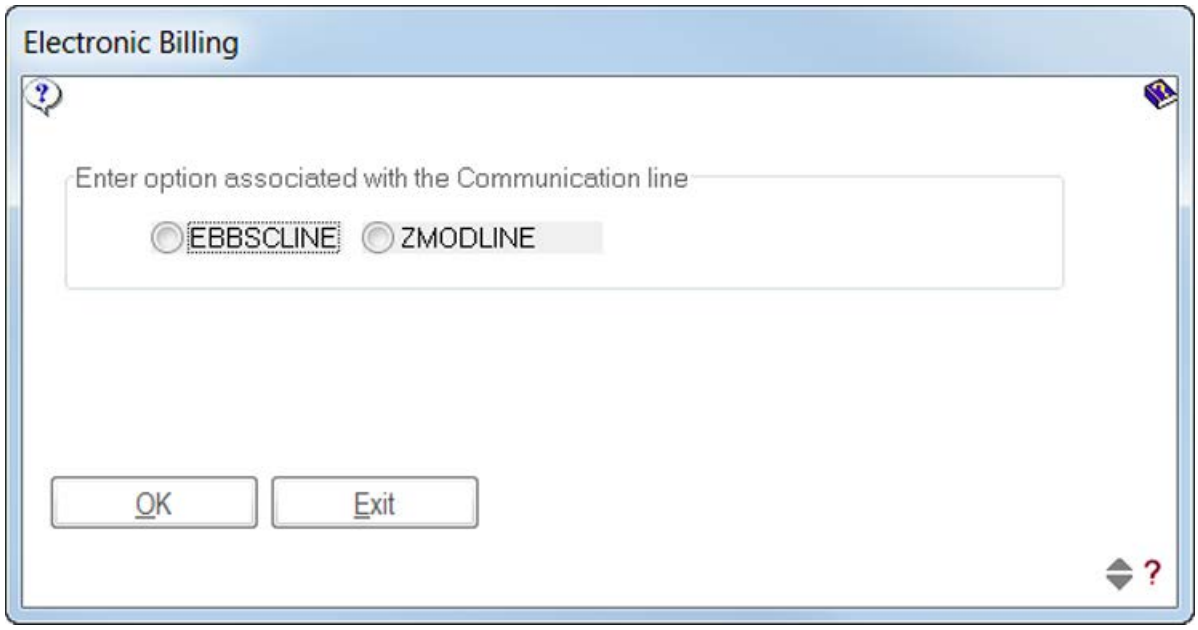
EBMENU Option 13: Work with EB Line/Controller/Device

Overview: **Work with EB Line/Controller/Device** (Option 13 on the Electronic Billing Main Menu) is used to run the **WRKCFGSTS** command, which allows you to work with the configuration status functions.

In this section

Line selection window

This window appears when you select **Work with EB Line/Controller/Device** on the Main Menu.



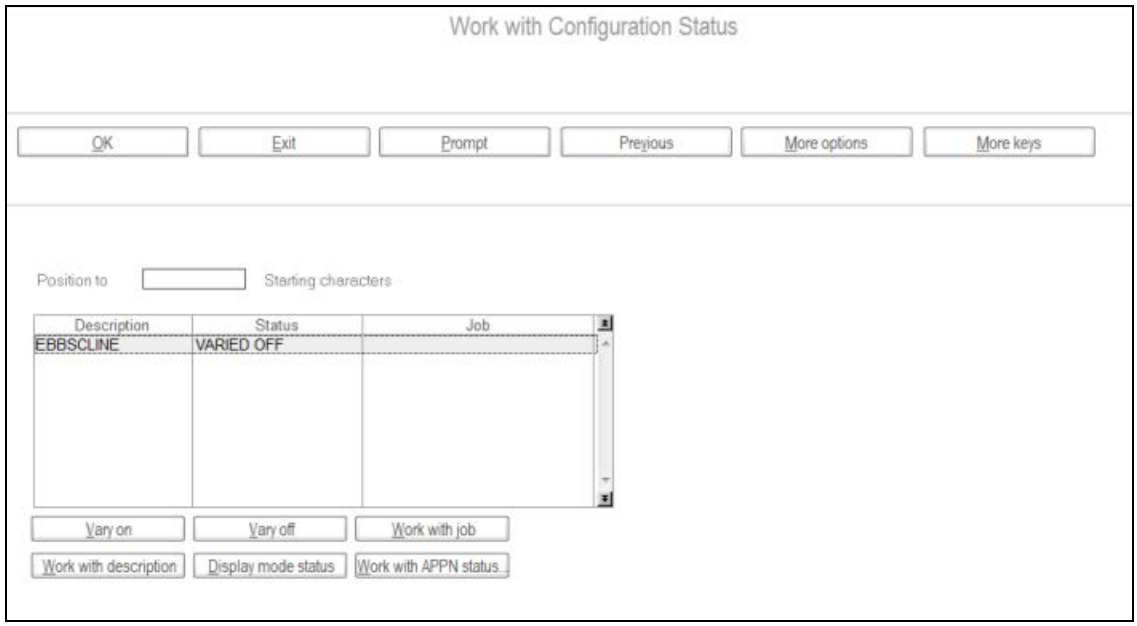
Action Select (click on) the line you want to work with, then click **OK**.

Work with Configuration Status window

In the **Work with Configuration Status** window, the status of the line is displayed first. To see the status of the controller, click **OK**.

The status of the line or controller could be, for example, VARIED OFF, CONNECT PENDING, or ACTIVE.

This window appears when you select a line in the line selection window.



Action To vary the line or controller on or off, select (click on) the line or controller, then click **Vary on** or **Vary off**. When you're through with the window, click **OK** to return to the Electronic Billing Main Menu.

EBMENU Option 14: Generate Home Health 485/486 Claims

Overview:

Generate Home Health 485/486 Claims (Option 14 on the Electronic Billing Main Menu) is used to re-create the home health HCFA-485 and HCFA-486 claims.

This option would primarily be used if home health and UB claims are being transmitted separately. Once UB claims are transmitted, the transmission file is cleared. In order to transmit the home health claims, the file needs to be re-created using this option. When this procedure is finished, the file to retransmit the home health claims is created.

This option does not update any files.

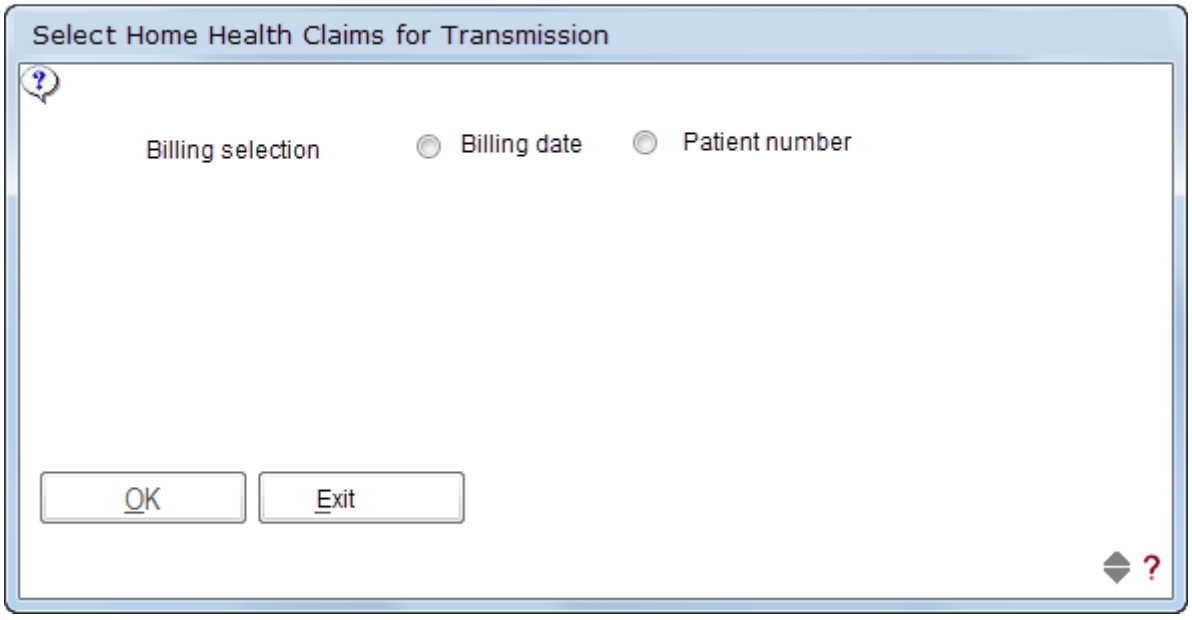
Files:

RBXDATE, ACCUMCHG, HHCERT

In this section

Billing Selection Window

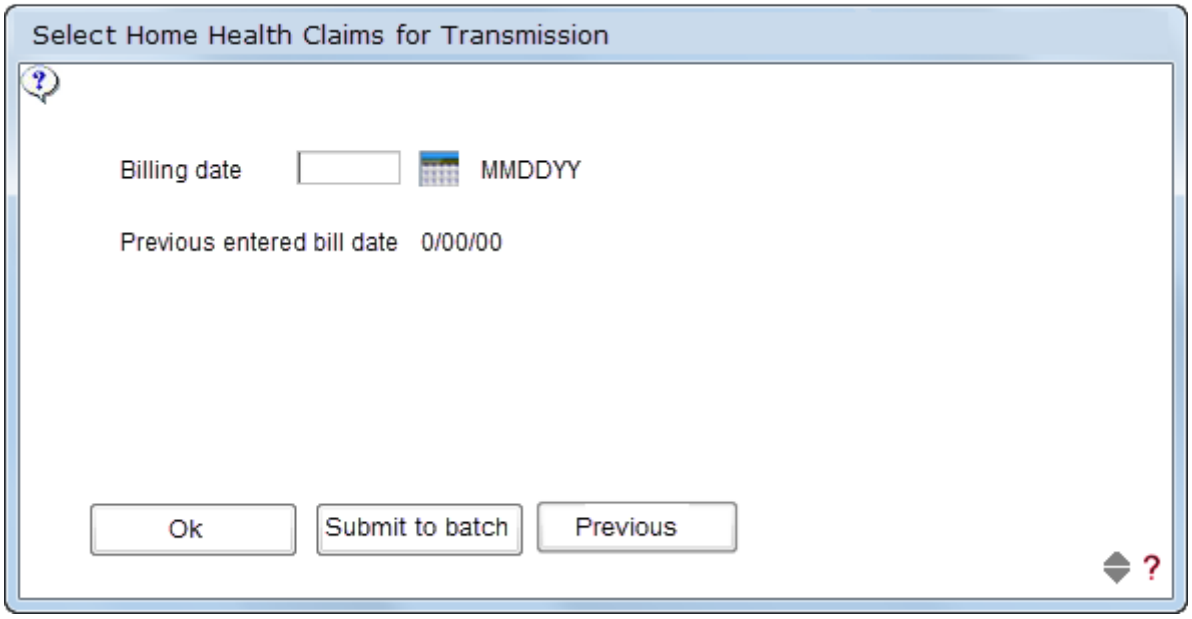
This window appears when you select **Generate Home Health 485/486 Claims** on the Main Menu.



Action Select (click on) the method (billing date or patient) for generating (re-creating) claims, then click **OK**.

Billing Date Window

This window appears when you choose to generate (re-create) claims by billing date in the billing selection window.



You can generate claims for more than one billing date.

When processing has completed, a message will be sent to notify the user to print the billing transmission list (Create/Print EB Listing, Option 1 on the Electronic Billing Main Menu).

Action

1. Enter the billing date (the date the bills were produced from Patient Accounting).

   To enter the date: Either type it in mmddyy format (for example, **072504** for July 25, 2004) or click to select the date.

2. To enter another billing date, click **OK** and repeat step 1. The previously entered code and date appears in the **Previous entered bill date** field.

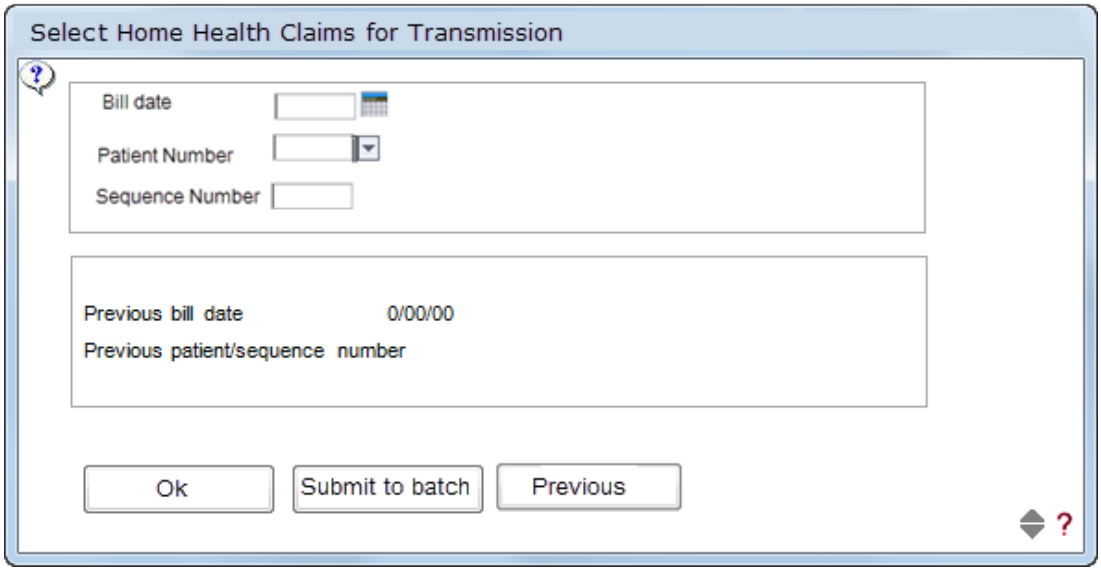
   OR

   If you are through entering dates, go to step 3.

3. When you are ready to generate the claims, click **Submit to Batch** to submit the generation request to batch for processing.

Patient Number Window

This window appears when you choose to generate (re-create) claims by patient in the billing selection window.



You can generate claims for more than one patient.

When processing has completed, a message will be sent to notify the user to print the billing transmission list (Create/Print EB Listing, Option 1 on the Electronic Billing Main Menu).

Action

1. Enter the bill date (the date the bills were produced from Patient Accounting).

   To enter the date: Either type it in mmddyy format (for example, **072504** for July 25, 2004) or click to select the date.

2. Enter the patient number and sequence number.

   To enter the numbers: Either type the numbers or click to select them in the Home Health Patient Lookup window.

3. To enter another patient, click **OK**, then repeat steps 1 and 2. The previously entered information appears in the **Previous** fields.

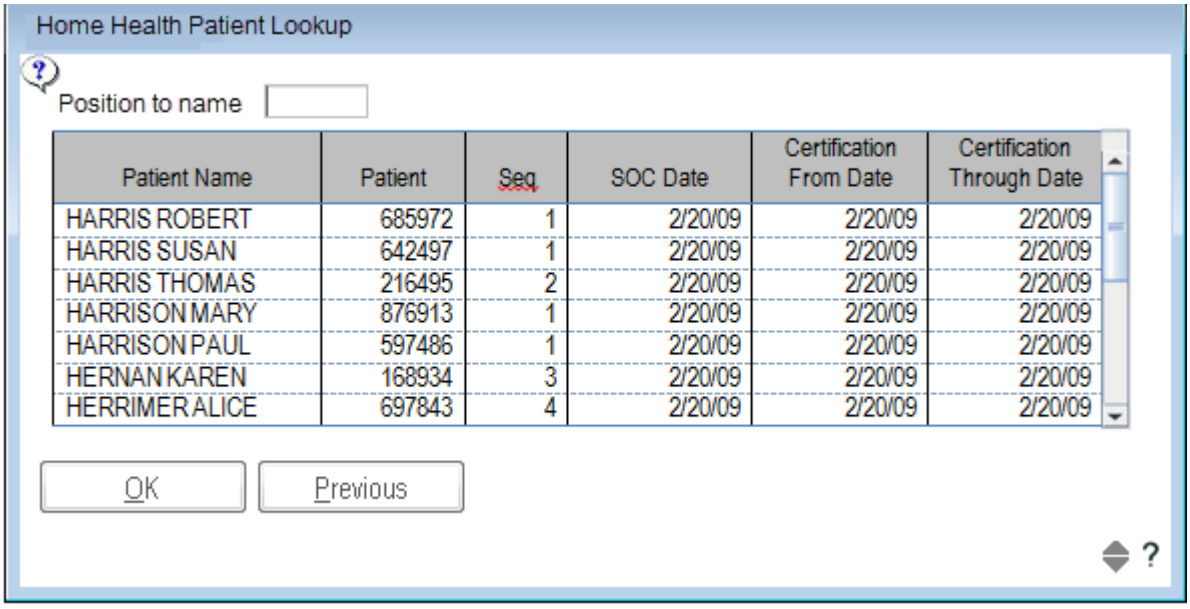
   OR

   If you are through entering patient and sequence numbers, go to step 4.

4. When you are ready to generate the claims, click **Submit to Batch** to submit the generation request to batch for processing.

Home Health Patient Lookup Window

This window appears when you click in the patient number window.



Action

To find a patient: Type part or all of the patient's last name in the **Position to name** field and click **OK**.

To select a patient: Click on the patient's name and click **OK**. (You can also just double-click on the patient's name.)

EBMENU Option 16: Display Batch Submission Status

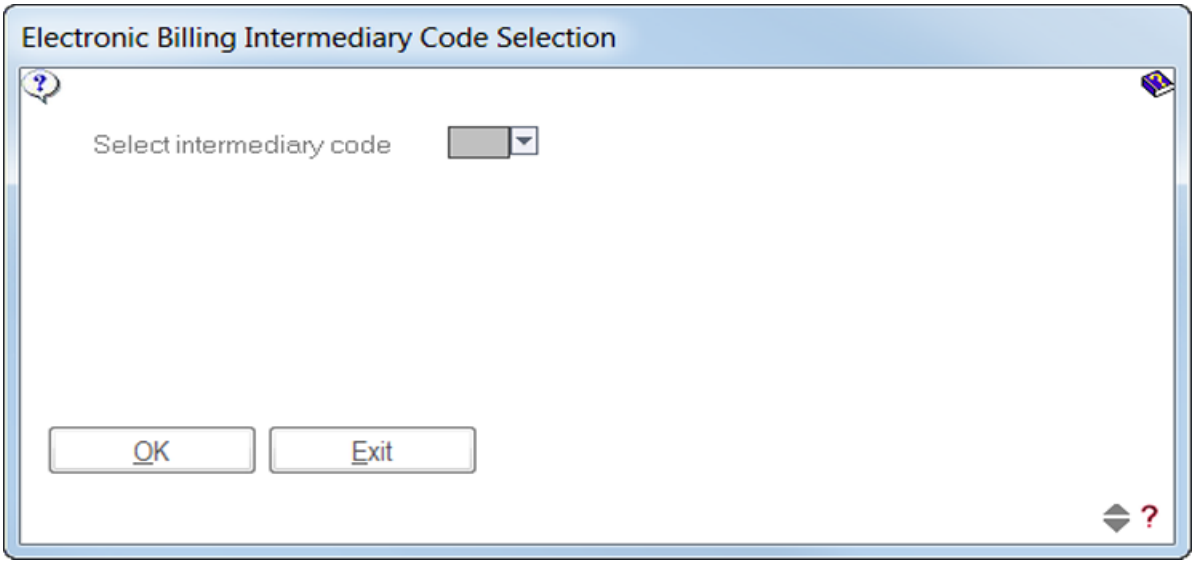
Overview: **Display Batch Submission Status** (Option 16 on the Electronic Billing Main Menu) is used to display the transmission status for the last batch submission for the selected intermediary.

Files: EBINTMED

In this section

Intermediary Code Selection window

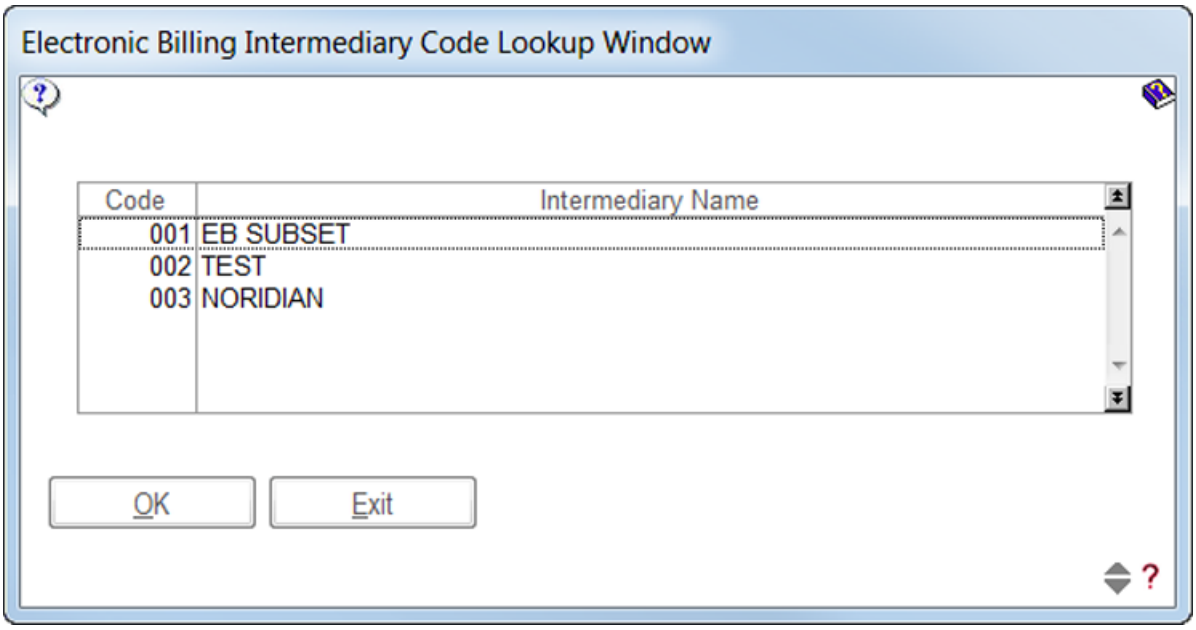
This window appears when you select Display Batch Submission Status in the Electronic Billing Main Menu.



Action: Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

This window appears when you click in the Intermediary Code Selection window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

UB/1500 Selection window

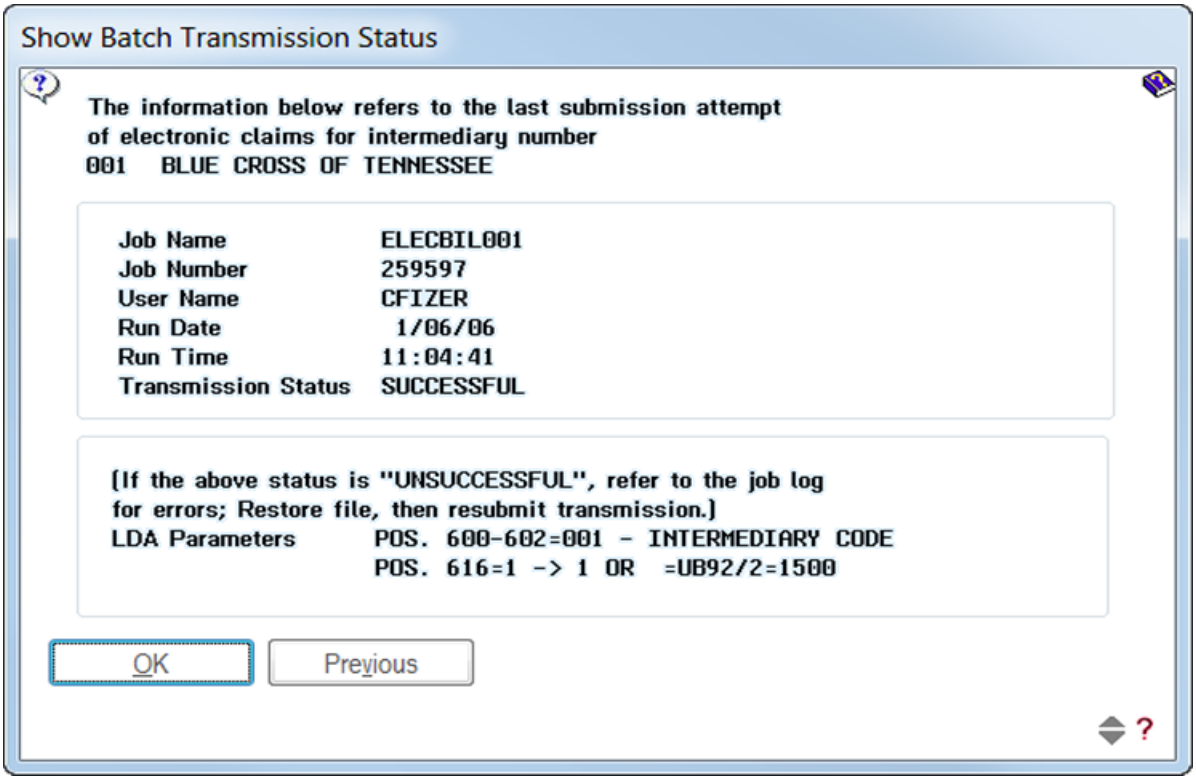
This window appears when you enter an intermediary code in the **Intermediary Code Selection** window and click **OK**.

Action: Select (click on) the code you want and click **OK**.

Show Batch Submission Status Window

This window appears when you enter the intermediary in the Intermediary Code Selection window or, if required, when you select the type of bill in the UB/1500 Selection window.

The window displays the transmission status of the last batch submission.



Action

If the Transmission Status is UNSUCCESSFUL, you will need to check the job log for errors, contact Customer Support to restore the saved file, and then resubmit the transmission (Transmit Electronic Bills, Option 2 on the Electronic Billing Main Menu).

To close the window: Click **Previous**. You will return to the Intermediary Code Selection window, where you can either enter a different intermediary or click **Exit** to return to the Main Menu.

EBMAIN Option 20: Electronic Billing Maintenance Menu

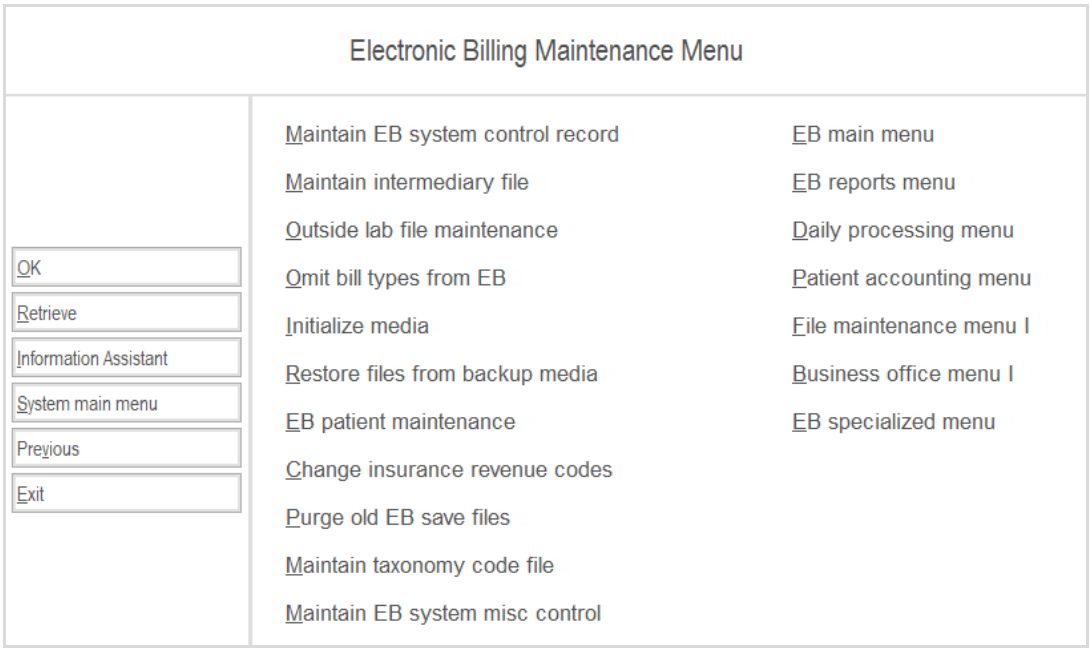
Overview:

The Electronic Billing Maintenance Menu is used to access the Electronic Billing file maintenance options. From the menu, you can:

- Maintain the system control file, intermediary file, outside lab file, patient benefits, and taxonomy code file.
- Initialize storage media to save and back up the electronic billing files.
- Restore the backup.

This menu appears when you select **EB Maintenance Menu** (Option 20) on the Electronic Billing Main Menu.

The following pages describe each Maintenance Menu option in sequential order and any main windows that follow each selection. Any reports generated by the system are also described.



Action:

Select a menu option by clicking on it.

The **Option** column shows the System i (AS/400) green screen menu option number, which you can see in the GUI window by moving the mouse pointer over the menu option and holding it there without clicking.

Option Name	Option	Description
Maintain EB system control record	1	Create and maintain the electronic billing record for your facility. This record must be properly set up before you can transmit electronic bills.
Maintain intermediary file	2	Enter and maintain the intermediary codes. These codes allow multiple intermediaries to be transmitted. This option is also used to specify the type of claims that are being transmitted as live claims and the claims that are being transmitted in test mode.
Outside lab file maintenance	3	Add and maintain information about outside labs.
Omit bill types from EB	4	Select a specific bill type for an intermediary in order to omit that bill type from transmissions.
Initialize media	5	Initialize backup media to be used in saving the electronic billing files.
Restore files from backup media	6	Restore files that have been saved during the transmission of electronic bills through Transmit Electronic Bills, Option 2 on the Electronic Billing Main Menu.
EB patient maintenance	7	Maintain the UB electronic billing file and the 1500 electronic billing file. Almost every field in these files can be maintained. Please use caution.
Change insurance revenue codes	8	Change insurance revenue information in files for all patients. Do not use this option unless instructed to do so by Customer Support.
Purge old EB save files	9	Displays the number of successful and attempted file purges from authorized and non-authorized users.
Maintain taxonomy code file	10	Enter and maintain the taxonomy codes.
Maintain EB system misc control	11	Designate whether to include dates of service on electronic billing transmissions for inpatients with commercial insurance
EB main menu	20	Display the Electronic Billing Main Menu, the primary menu in the Electronic Billing system.

Option Name	Option	Description
EB reports menu	21	Display Electronic Billing Reports Menu I, used to run Electronic Billing reports on demand.
Daily processing menu	22	Display the Daily Processing Menu, which is covered in the Patient Accounting manual.
Patient accounting Menu	23	Display the Patient Accounting Menu, which is covered in the Patient Accounting manual.
File maintenance menu I	24	Display Patient Accounting's File Maintenance Menu I, which is covered in the Patient Accounting System Manager's Guide.
Business office menu I	25	Display Patient Accounting's Business Office Menu I, which is covered in the Patient Accounting manual.
EB specialized menu	26	Display the Electronic Billing Specialized Menu, which is specific to states and/or payors and is not covered in this manual.

EBMAIN Option 1: Maintain EB System Control Record

Overview:

Maintain EB System Control Record (*Option 1* on the *Electronic Billing Maintenance Menu*) is used to create and maintain the electronic billing record(s) for your facility.

Each record must be properly set up before you can transmit electronic bills.

Files:

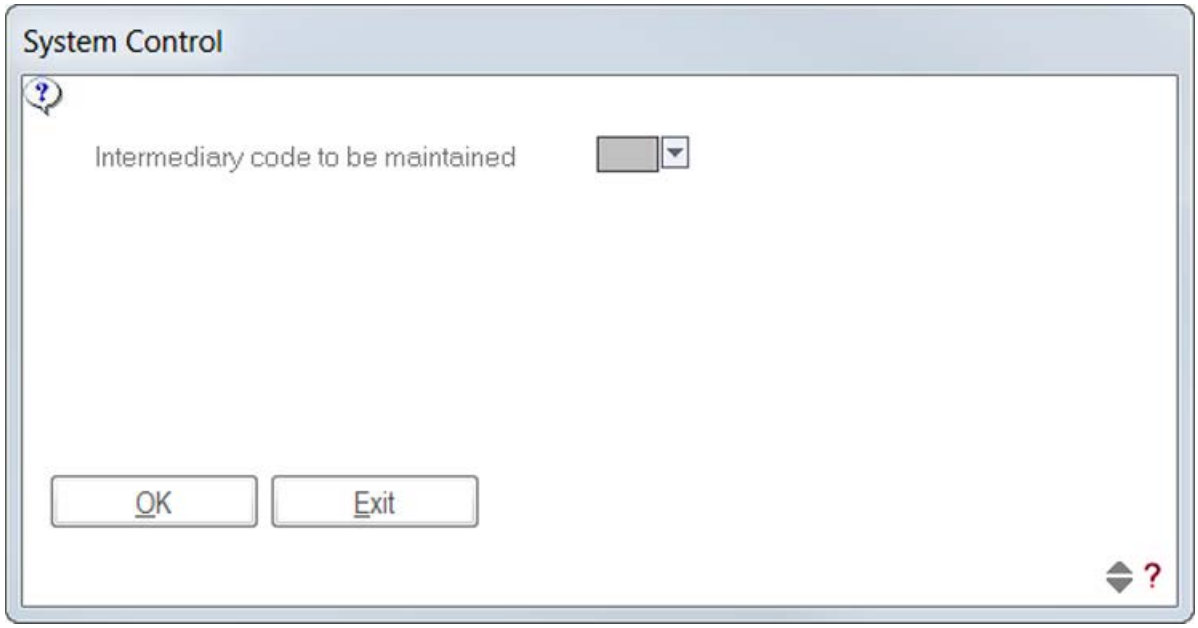
SYSCTL

Contents

SELECTING AN ELECTRONIC BILLING INTERMEDIARY

Intermediary Code Window

This window appears when you select *Maintain EB System Control Record* in the *Electronic Billing Maintenance Menu*.



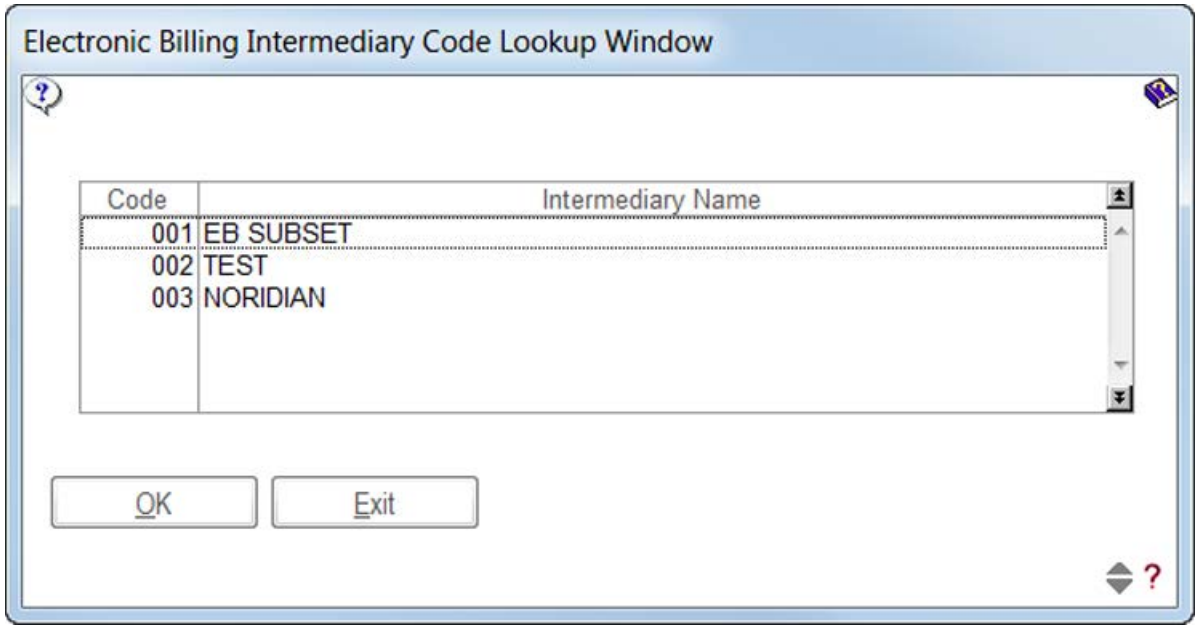
Action

Enter the 3-digit intermediary code you want to maintain, and then click **OK**. You can either type the code or click to search for it in the **Electronic Billing Intermediary Code Lookup** window.

Note: These codes are set up and maintained through *Maintain Intermediary File, Option 2* on the *Maintenance Menu*.

ELECTRONIC BILLING INTERMEDIARY CODE LOOKUP WINDOW

This window appears when you click in the **Intermediary Code** window.



Action To select an intermediary, click on it (to highlight it) and then click **OK**. (You can also just double-click on the intermediary).

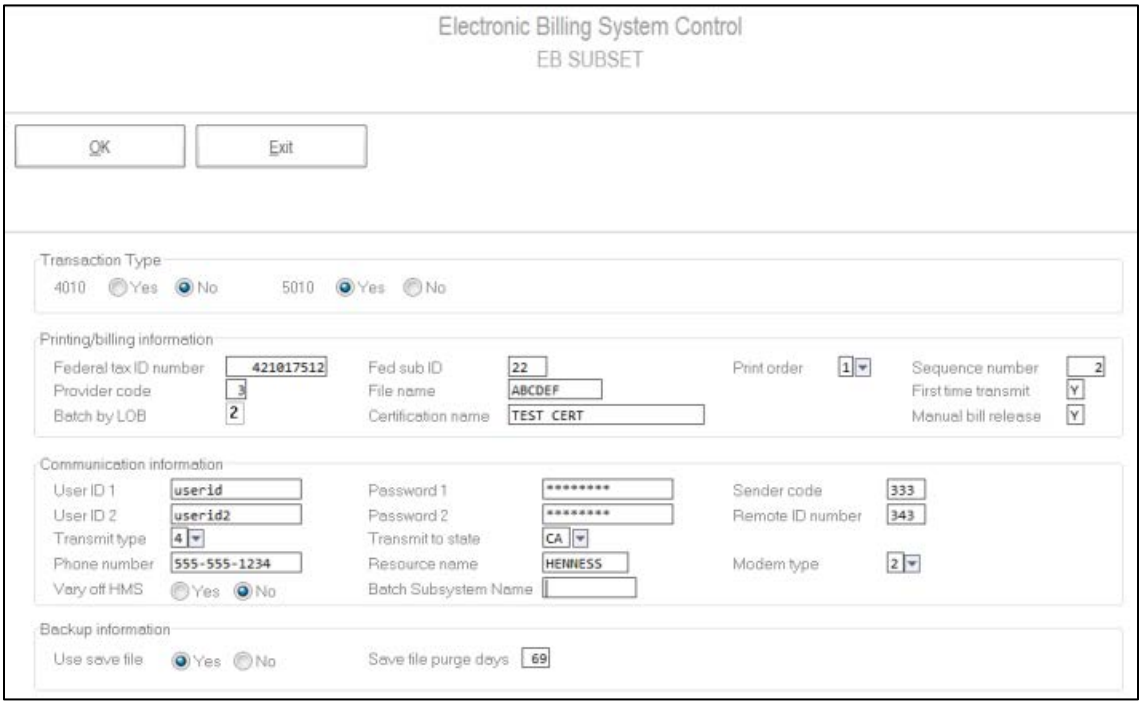
SETTING UP THE ELECTRONIC BILLING RECORD

Electronic Billing Maintenance Window

This window appears when you place an intermediary code in the **Intermediary Code** window.

The Transaction Type fields enable you to set up your records for the older version 4010 format or the newer version 5010 format. If you will be using the 5010 format, remember to also set it in the *Vendor Maintenance* option *(Health Plan Transactions Menu, Option 10)*.

Note: To save changes, you must click **OK** in this window and in the next main window, which is the **Transmission Information** window. In other words, you must page all the way through the main windows and any applicable sub-windows, such as those for the 837 headers.



Action

To maintain the record, make your selections and click **OK**.

To return to the *Electronic Billing Maintenance Menu* without saving any changes, click **Exit**.

FIELD DESCRIPTIONS

Field	Description
Transaction Type	
Transaction Type	Select **Yes** for the desired format (4010 or 5010) and select **No** for the other one. You cannot use both formats at the same time. Transaction Type defaults to the 4010 format.
Printing/Billing Information	
Federal tax ID number	Enter the federal tax ID number assigned to the hospital.
Fed sub ID	Enter the federal sub ID number assigned to the hospital.
Print order	Enter **1** to print the transmission listing in patient number order; enter **2** to print it in patient name order. Or press F4, and then select **Patient number** or **Patient name** in the transmit list order window that appears.
Sequence number	This number is used during the backup of the electronic bills file and as a batch number when transmitting bills. Each transmission should be a different sequence number. The sequence number, which initially should be **001**, will be incremented automatically with each transmission.
Provider code	Enter the provider number assigned by the intermediary.
File name	Enter the name of the file which will be transmitted.
First time transmit	Enter **Y** if this is the first time that bills have been transmitted to the intermediary. Otherwise, enter **N**.
Batch file by lines of business	This field determines if the electronic billing file for the intermediary should create a header and trailer record for each payor. Enter **Y** if the intermediary will accept claims for multiple payors in one transmission and requires a separate header and trailer record for each payor. A header and trailer will be created for each payor. Enter **N** if the intermediary will accept all claims in one transmission, but does not require a header and trailer record for each payor. Only one header and trailer will be created.
Certification name	Enter the name of the contact person (certified personnel) who is responsible for transmitting bills.
Manual bill release	Enter **Y** if bills placed on hold should be released through Release Electronic Bills, Option 5 on the Electronic Billing Main Menu. Otherwise, enter **N**, and the bills placed on hold will automatically be released after each transmission.

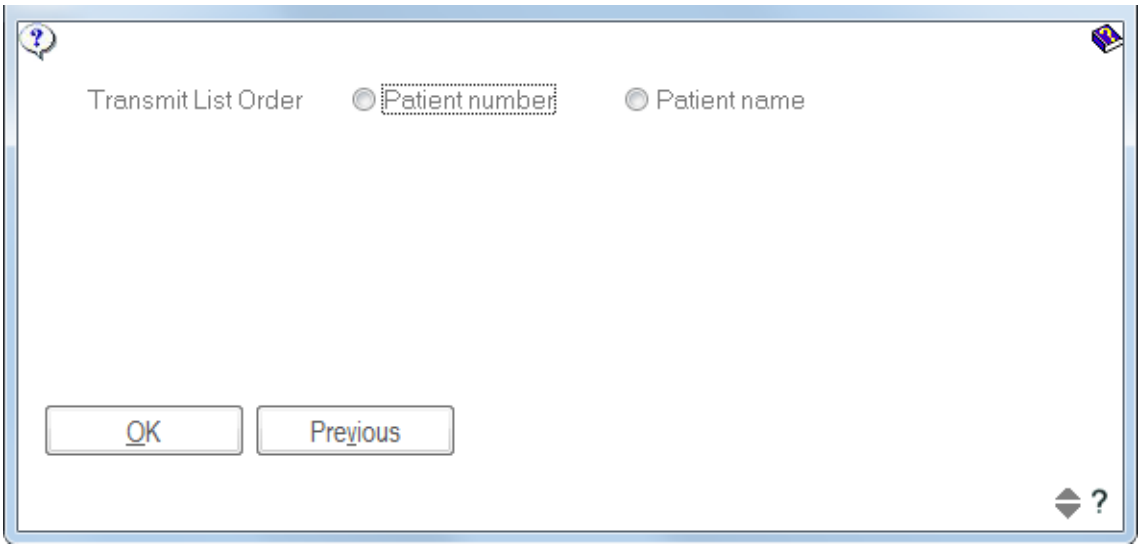
Field	Description
Communication information	
User ID 1	Sender identification provided by the intermediary.
Password 1	The password provided by the intermediary.
Sender code	A sender code assigned by the intermediary.
User ID 2	Receiver identification provided by the intermediary.
Password 2	The password provided by the intermediary.
Remote ID number	This number is assigned by the intermediary.
Transmit type	Enter a number from 1 to 6, or press F4, then select an option in the transmit type selection window that appears. For descriptions of the valid entries, see the "Transmit type selection window" section. **Note:** Certain settings will require the user's Internet Explorer path and the intermediary's Web site address when you set the FTP details.
Transmit to state	Enter the two-character abbreviation for the state to which bills are transmitted for this intermediary. You can either type the code or press F4, and then select the state in the state selection window that appears. Other valid codes you can enter in this field (by either typing or selecting) are: CI Commercial Insurance (NEIC) OM Mutual of Omaha SW SouthWest Regional HH TC ENVOY If you enter **TC**, a prompt window requesting the intermediary state will be displayed when you click OK. TS TriSpan UH United Health Care US ANSI 837 Depending on the state or code entered in this field, a window requesting additional information may be displayed when you click OK. For example, if you enter **TN**, a window will be displayed to allow you to enter signon information.
Phone number	Enter the area code and phone number of the intermediary.
Resource name	Enter the name for the line that is used to transmit (for example, **LIN021** or **LINE01**).

Field	Description
Modem type	Enter **1** if the modem is UDS/Motorola/Bell-compatible; enter **2** if the modem is V.32/IBM7855-compatible. Or press F4, and then select (click on) the type you want in the modem type window that appears. This field is **required** if you entered **1** or **2** in the **Transmit type** field (to indicate that a modem is being used for transmission).
Vary off MEDHOST	Enter **Y** if the communications line is automatically varied off or if the line has to be varied off before transmitting electronic bills. Otherwise, enter **N**.
Batch Subsystem Name	Enter the name of the subsystem to which the batch mode transmit should be directed. This field is **required** if you entered **2** in the **Transmit type** field (to indicate transmission in batch mode).
Backup Information	
Use save file	Click **Yes** to back up EB files to a savefile instead of to hard media (that is, tape or diskette). Otherwise, click **No**.
Save file purge days	Enter the number of days to retain savefiles on the system.

FIELD SUB-WINDOWS

Print Order Field

The Transmit List Order window appears when you press F4 in the Print order field in the **Electronic Billing Maintenance** window.



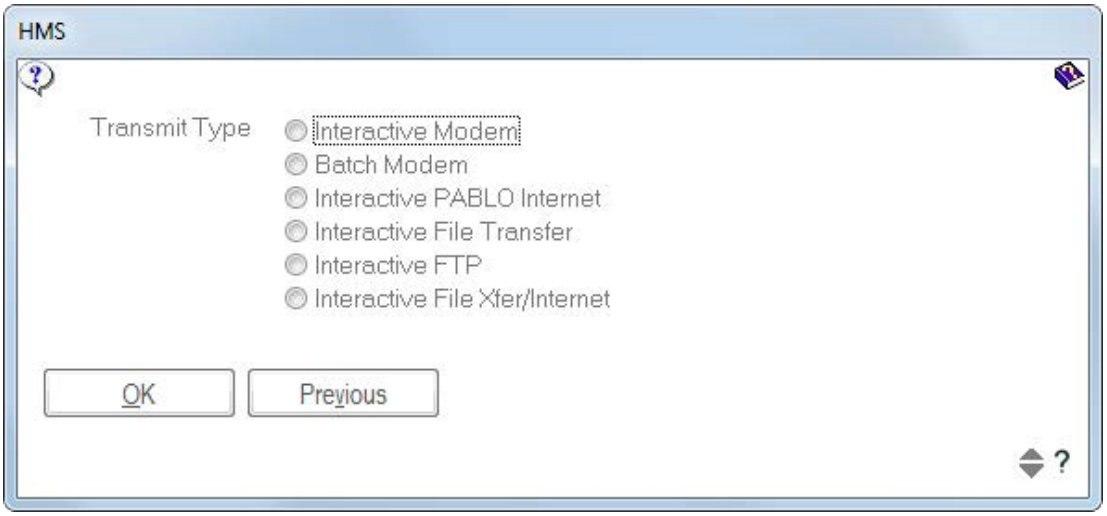
Action Select (click on) Patient number or Patient name as the order in which to print the transmission listing, and then click OK. You will return to the **Electronic Billing Maintenance** window.

Transmit Type Field

The Transmit Type Selection window appears when you press F4 in the Transmit Type field in the **Electronic Billing Maintenance** window.

Note: Certain settings will require the user's Internet Explorer path and the intermediary's Web site address when you set the FTP details.

The most recent version of this window has several changes. The word "Modem" has been added to the first two Transmit Types, and four Interactive types have been added.



Action

Select (click on) an option and then click OK.

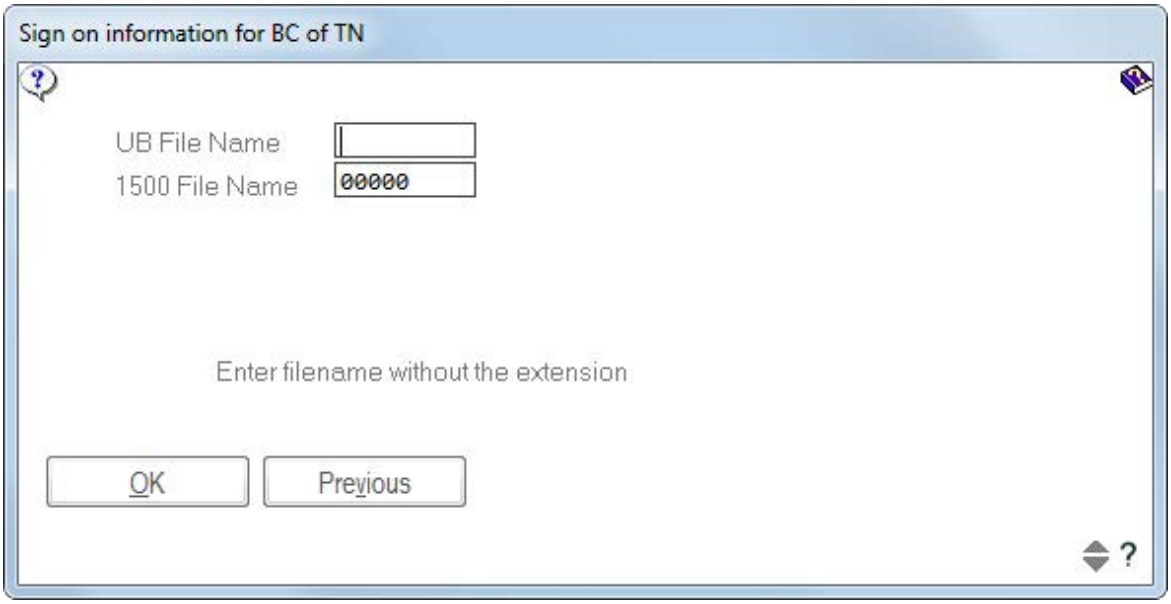
Option	Description
Interactive Modem	Uses a standard modem and allows you to see (at the bottom of the **Electronic Billing Maintenance** window) what exactly is being processed. This option requires an entry in the Modem type field.
Batch Modem	Uses a standard modem and displays a batch window. This option requires an entry in the Modem type field.
Interactive PABLO Internet	Uses the PABLO FTP software. This option requires that you enter FTP detail in the **FTP Claim Submission Maintenance** window.
Interactive File Transfer	Uses the current file transfer process via client access. This is currently the best choice for MEDHOST/SSI clients.
Interactive FTP	Uses standard FTP commands.
Interactive File Xfer/Internet	Uses the file transfer process via the Internet. It is designed for clients who are not able to use the PABLO software. This option requires that you enter FTP detail in the **FTP Claim Submission Maintenance** window.

Transmit to State Field

Depending on the state or code placed in the Transmit to State field, additional windows may open when you press the **OK** button in the **Electronic Billing Maintenance** window. Some of the more common are illustrated.

Sign-On Window

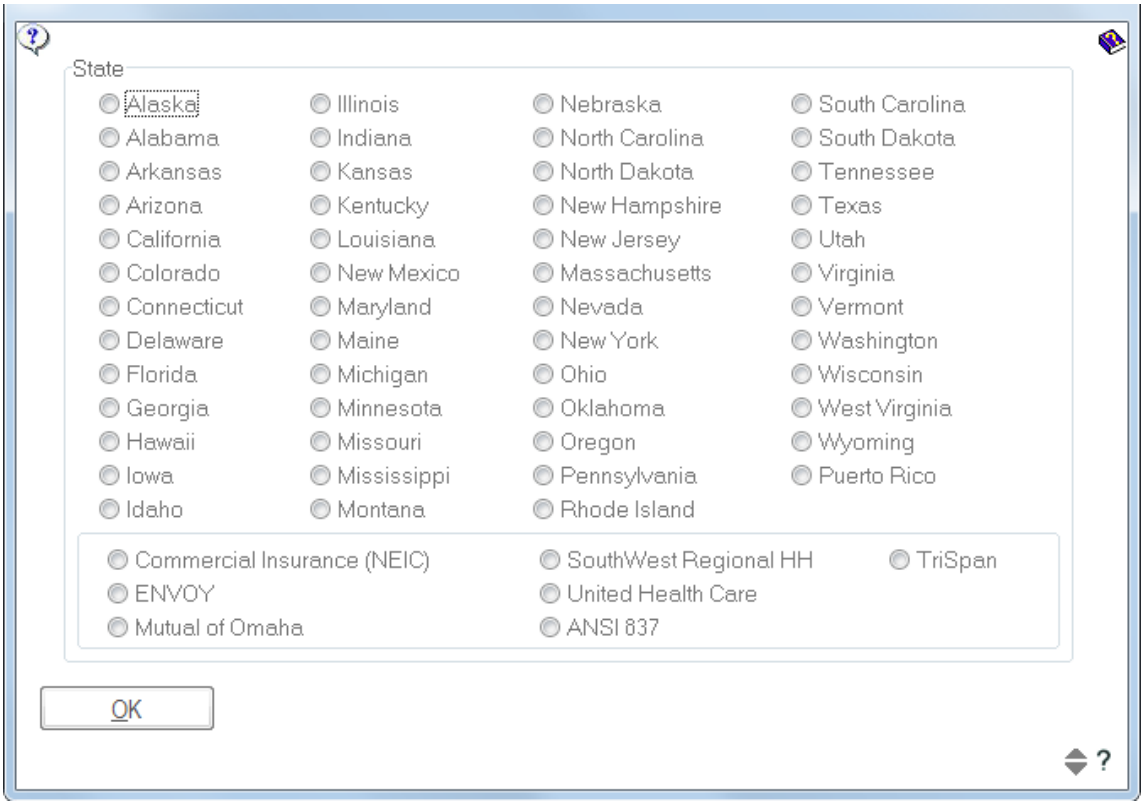
The **Sign On** window appears for some states or codes put in the Transmit to State field.



Action Type the UB and 1500 file names (without extensions), and then click **OK**.

F4 = State Selection Lookup Window

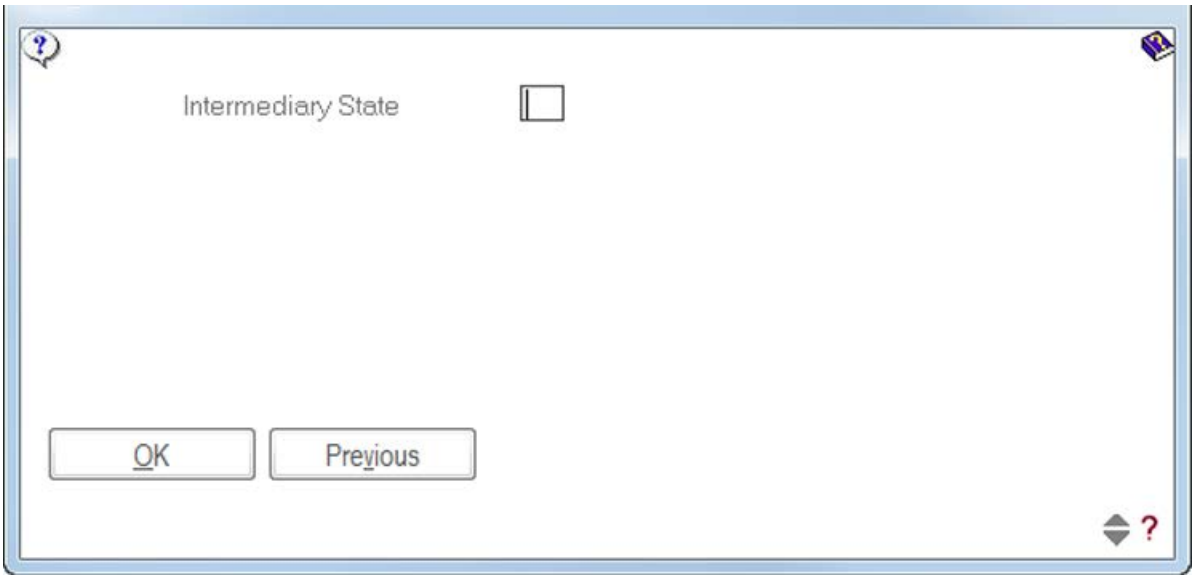
This window appears when you press F4 in the Transmit to State field.



Action Select (click on) the state or code to which bills are transmitted for this intermediary, and then click OK. You will return to the **Electronic Billing Maintenance** window.

Intermediary State Window

The Intermediary State window appears when you press OK and certain states or codes are in the Transmit to State field.

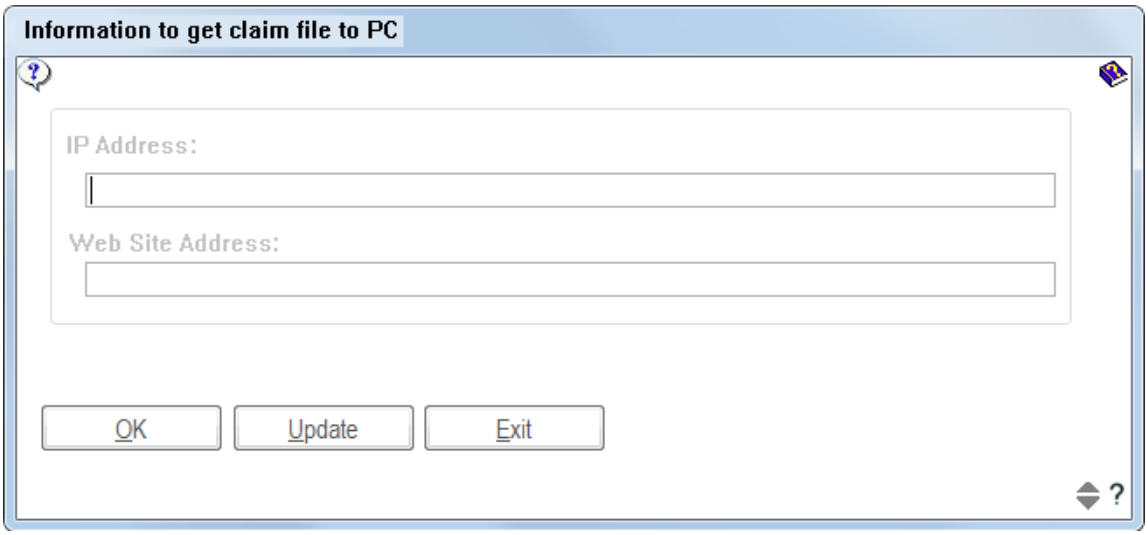


Action Type the two-letter abbreviation for the code or state and click OK.

Note: If you enter TS, and the current date is prior to 09/29/09, the program will submit to TriSpan. If you enter TS, and the current date is 09/29/09 or later, the program will submit to Palmetto.

IP Address Window

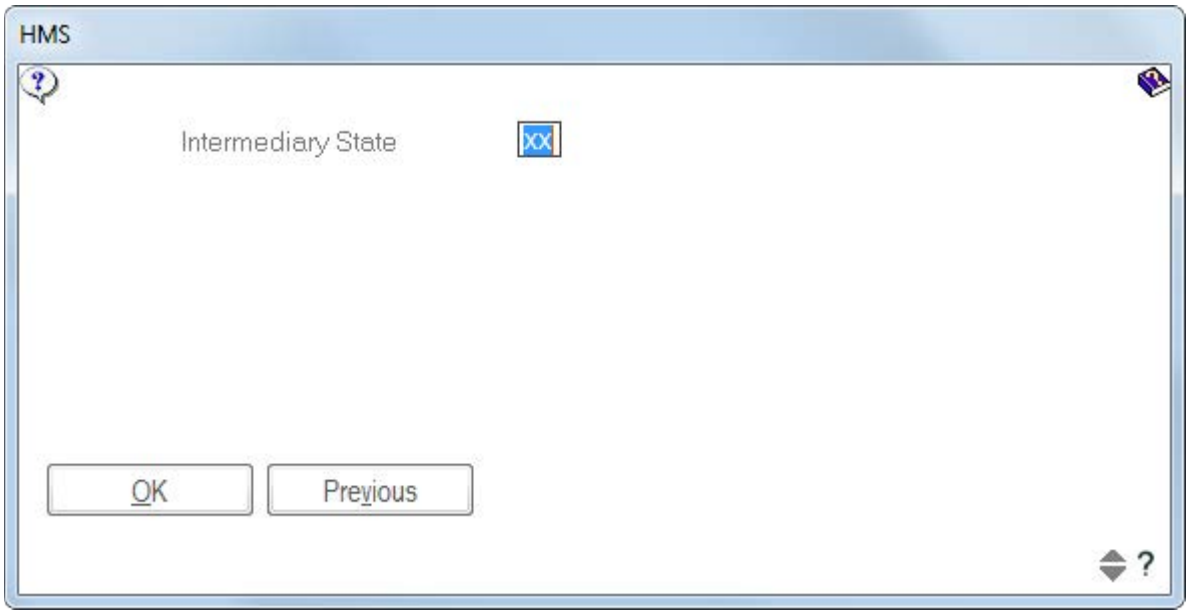
If you enter PR in the Intermediary State window and press OK, the **IP Address** window will appear.



Action Type an IP address and PC path, and then click OK. The **Transmission Information** window will open.

Hospital Name Window

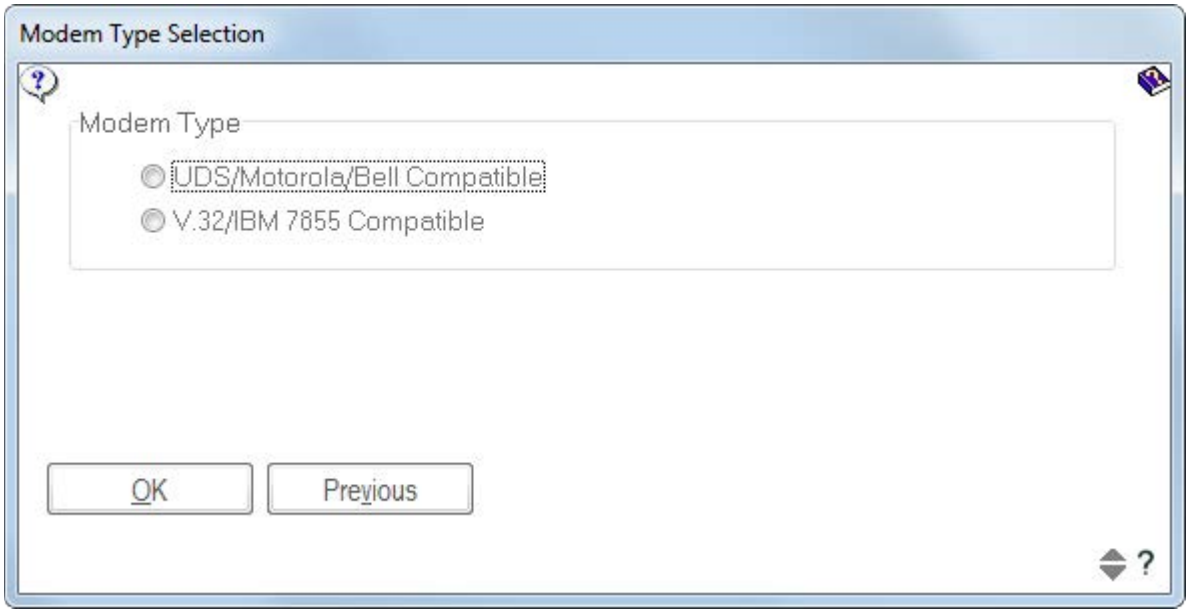
If you enter certain states or codes in the Intermediary State window and press OK, the **Hospital Name** window will appear.



Action Type the first two characters of the hospital's proper name, and then click OK. For example, if the hospital name is St. Joseph, type **JO**, not **ST**.

Modem Type Field

The Modem Type Selection window appears when you press F4 in the Modem Type field in the **Electronic Billing Maintenance** window.



Action Select (click on) UDS/Motorola/Bell Compatible or V.32/IBM 7855 Compatible as the modem type, and then click OK.

Transmission Information Window

This window appears when you click **OK** in the **Electronic Billing Maintenance** window, or sub-windows such as the **Hospital Name** window, **Sign-On Information** window, or **Intermediary State** window.

The **Transmission Information** window is used to maintain the 837I and 837P header information used in transmitting UB and 1500 electronic bills. You can also set up the FTP details.

Note: After you install a new version, you must reset the header records in the *EB System Control Record.* This must be done before the next EB creation. Refer to the section, "Resetting 837 Headers after A Version Change" and the document, ***Appendix D: 5010 Configuration for 270/271 and 837***.

The **FTP Detail** button enables you to set up one FTP entry for each intermediary (rather than just one entry for all intermediaries). This setup function used to be a separate option (#9) on the *Electronic Billing Maintenance Menu*.

Action

To maintain information: Enter information in the window and click **OK** to save it.

To return to the *Electronic Billing Maintenance Menu* without saving any changes: click **Exit**.

To maintain header records: Click the **837I Header File** button or the **837P Header** button.

To set up an FTP entry: Click **FTP Detail**.

FIELD	DESCRIPTION
UB test code	This code is used during testing only. When testing, enter **T**. When entering live claims, this field must be blank.
Other test code	Enter the code for any other test code. When entering live claims, this field must be blank.
1500 sequence number	This number is used during the backup of the electronic bills file and as a batch number when transmitting 1500s. Each transmission should be a different sequence number. This number will be incremented automatically with each transmission. Initially, this number should be **1**.
1500 test code	This code is used during testing only. When testing, enter **T**. When entering live claims, this field must be blank.
1500 submitter #	Enter the Medicare 1500 submitter ID provided by the intermediary.
Xmit 485/486 separately	Enter **Y** if Home Health claims (HCFA-485 and HCFA-486) should be transmitted separately from the UB claims to the intermediary. Enter **N** if the Home Health claims and UB claims should be transmitted together.
1500 IP place of service	Enter the specific inpatient place-of-service code for Blue Cross, Medicare, and/or Medicaid.
1500 OP place of service	Enter the specific outpatient place-of-service code for Blue Cross, Medicare, and/or Medicaid.
1500 type of service	Enter the specific type-of-service code for Blue Cross, Medicare, and/or Medicaid.
Type of claims to xmit	Enter **X** beside the type of claims that can be transmitted to this intermediary. You can transmit UB bills, 1500 bills, home health claims, or any combination of the three.
Secondary/Tertiary xmit	Click **Yes** to transmit secondary and tertiary UB or 1500 claims to the intermediary. Click **No** if you do not want to transmit secondary and tertiary claims.
1500 units or minutes	Select **Units** or **Minutes** for anesthia billing. This will allow the facility to decide if the units from charges or the actual minutes for anesthia will be billed.

837I & 837P HEADERS

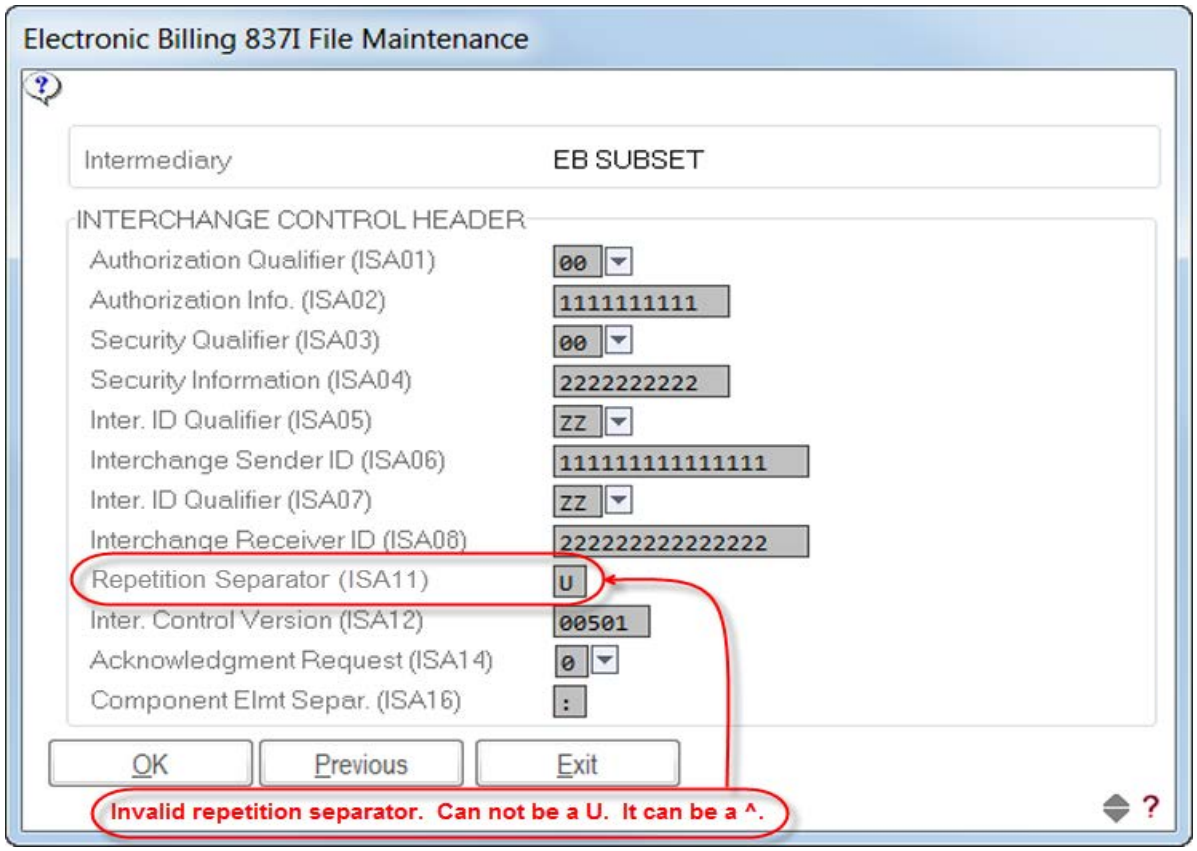
The process for setting up (or re-setting) the 837I and 837P headers is started by pressing the 837I or 837P button.

The settings are grouped into five windows according to their name and identifier, and except for the Functional Group Headers, the same values are used for 837I and 837P.

You move through the windows by pressing the **OK** button until you reach the last window, when you press the **Add/Update** button.

Most values are provided by the intermediary, but certain values are required for the correct transaction format (4010 or 5010). If any of the required values are incorrect, the program will not continue until that setting has been corrected. A message at the bottom of the screen will provide the correct value.

Note: The program will not correct a blank field, so be sure to complete the required (*) fields illustrated in the following sections.



The 837 header windows are listed below in the order they appear when you click on the 837I or 837P button.

WINDOW #	HEADER NAME	SEGMENT SECTION IDENTIFIER
1	Interchange Control	ISA
2*	Functional Group	GS*
2*	Transmission Type	REF*
3	Submitter Name	NM1 (Loop 1000A)
4	Submitter EDI Contact Information	PER
5	Receiver Name	NM1 (Loop 1000B)

*In the 4010 format files, the GS and REF headers appear in the same window. The REF headers are not in the 5010 format files.

Because the windows can vary for version and for bill type, the two formats are described in separate sections.

RESETTING 837 HEADERS

Typically, after a new version is installed you must reset the 837 headers in the *EB System Control Record* before the next EB creation.

The reset must be performed for each intermediary **and** for each file type being used. In other words, if an intermediary uses both UB and 1500 electronic bills, you must perform the header reset twice for that intermediary—once for each bill type. After that, you only need to maintain the headers if you have a new intermediary or the intermediary change a setting.

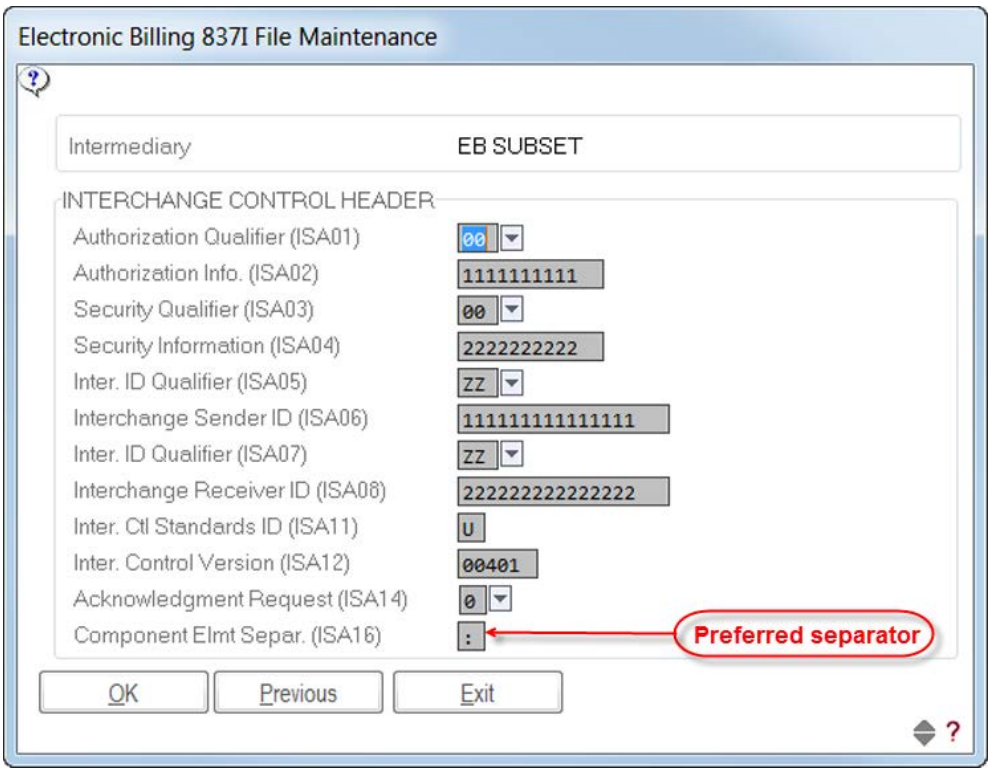
VERSION 5010 FORMAT HEADERS

Interchange Control Header (ISA) Window

This is the first of five 837 5010 format File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

Values with an asterisk (*****) must match those shown on the figure below. The other parameters will be given by the intermediary.

Note: As you press OK at each screen, a message at the bottom of the screen will give the correct value if any of the MEDHOST required fields needs to be changed.



Action

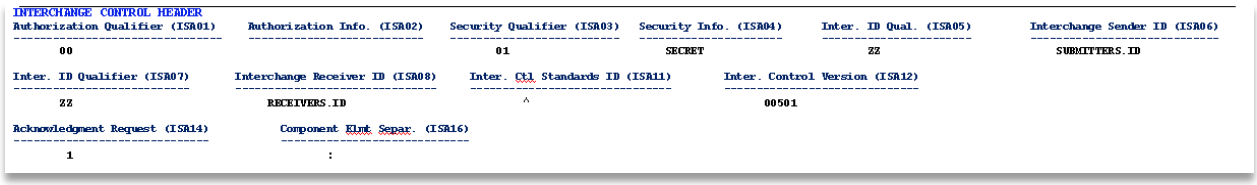
Verify that the contents of your Repetition Separator and Inter. Control Version fields match those in the window shown above. (Unless the intermediary has specified a different Component Elmt Separ. separator, the colon (:) is preferred.) Then click **OK** to save any changes and move to the next screen. The **Functional Group** (GS*) window appears automatically.

Clicking **Previous** or **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Interchange Control Header (ISA) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.


INTERCHANGE CONTROL HEADER

Authorization Qualifier (ISA01)	Authorization Info. (ISA02)	Security Qualifier (ISA03)	Security Info. (ISA04)	Inter. ID Qual. (ISA05)	Interchange Sender ID (ISA06)
00		01	SECRET	ZZ	SUBMITTERS.ID

Inter. ID Qualifier (ISA07)	Interchange Receiver ID (ISA08)	Inter. Ctl Standards ID (ISA11)	Inter. Control Version (ISA12)
ZZ	RECEIVERS.ID	^	00501

Acknowledgment Request (ISA14)	Component Elmt Separ. (ISA16)
1	:

Field	Entry
ISA01	00
ISA02	
ISA03	01
ISA04	SECRET
ISA05	ZZ
ISA06	SUBMITTERS.ID
ISA07	ZZ
ISA08	RECEIVERS.ID
ISA11	**^ ***
ISA12	**00501***
ISA14	1
ISA16	**: (or element provided by intermediary) ***

Functional Group (GS) Window*

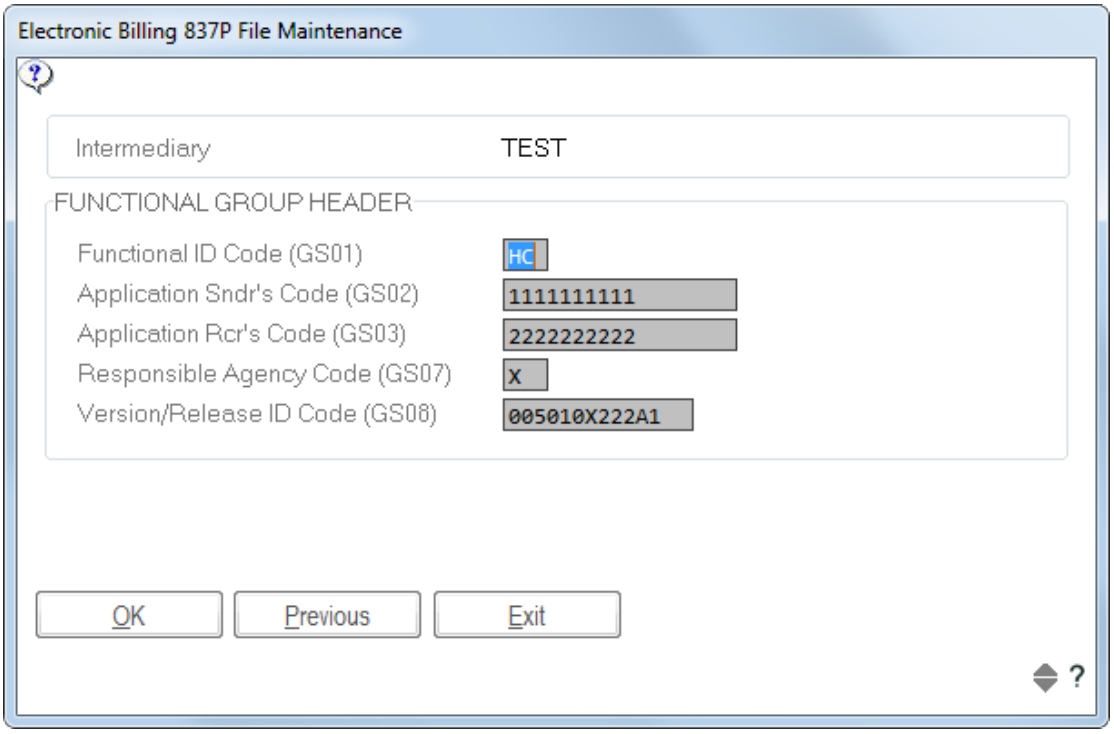
This is the second of five 5010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click OK in the **Interchange Control** (ISA) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.

Note: The Version/Release ID Code (GS08) settings differ for the 837I and 837P headers.

5010 837I



Action

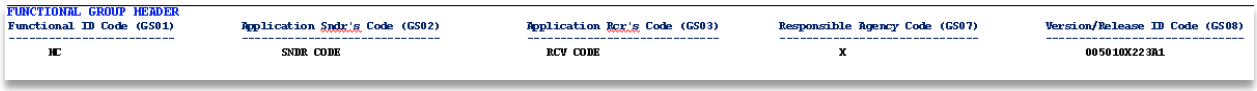
Verify that the contents of your Functional ID Code, Responsible Agency Code, and Version/Release ID Code fields match those in the window shown above. Then click OK to save any changes and move to the next screen. The **Submitter Name** (NM1 Loop 1000A) window appears automatically.

Clicking Previous or Exit returns you to the **Transmission Information** window without saving any changes.

Example

Below are the Functional Group Header (GS) segments of the 837I Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I.

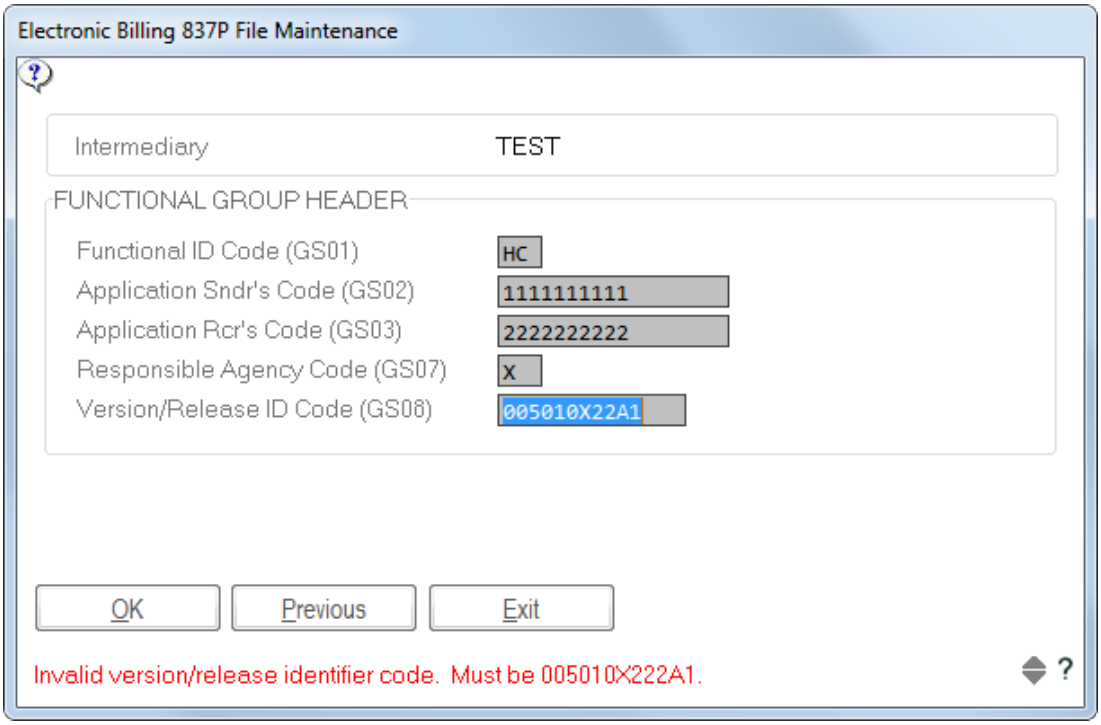


FUNCTIONAL GROUP HEADER

Functional ID Code (GS01)	Application Sndr's Code (GS02)	Application Rcr's Code (GS03)	Responsible Agency Code (GS07)	Version/Release ID Code (GS08)
HC	SNDR CODE	RCV CODE	X	005010X223A1

Field	Entry
GS01	**HC***
GS02	SNDR CODE
GS03	RCV CODE
GS07	**X***
GS08	**005010X223A1***

5010 837P



Action

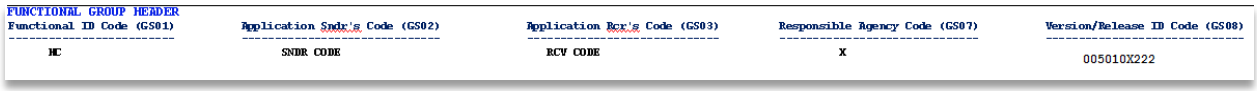
Verify that the contents of your Functional ID Code, Responsible Agency Code, and Version/Release ID Code fields match those in the window shown above. Then click **OK** to save any changes and move to the next screen. The **Submitter Name** (NM1 Loop 1000A) window appears automatically.

Clicking **Previous** or **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below are the Functional Group Header (GS) segments of the 837P Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I.



FUNCTIONAL GROUP HEADER

Functional ID Code (GS01)	Application Sndr's Code (GS02)	Application Rcv's Code (GS03)	Responsible Agency Code (GS07)	Version/Release ID Code (GS08)
HC	SNDR CODE	RCV CODE	X	005010X222

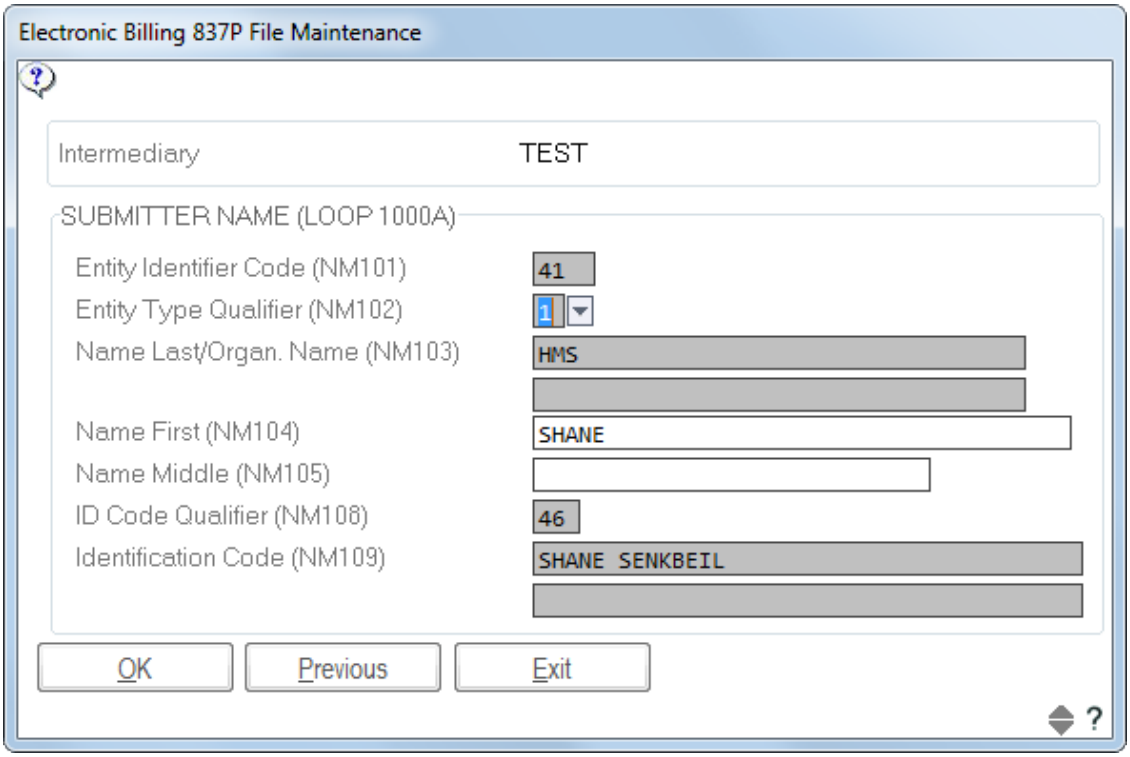
Field	Entry
GS01	**HC***
GS02	SNDR CODE
GS03	RCV CODE
GS07	**X***
GS08	**005010X222***

Submitter Name (NM1 Loop 1000A) Window

This is the third of five 5010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click **OK** in the **Functional Group** (GS*) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.



Action

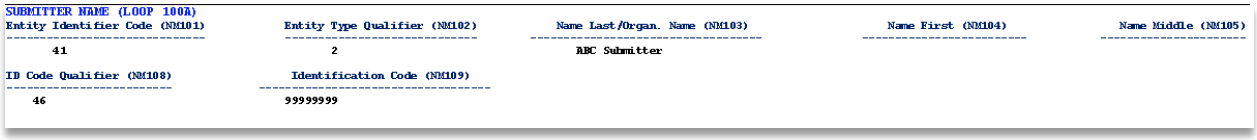
Verify that the contents of your Entity Identifier Code and ID Code Qualifier fields match those in the window shown above. Then click **OK** to save any changes and move to the next screen. The **Submitter EDI Contact Information** (PER) window appears automatically.

Clicking **Previous** or **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Submitter Name (NM1 Loop 1000A) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.



SUBMITTER NAME (LOOP 100A)

Entity Identifier Code (NM101)	Entity Type Qualifier (NM102)	Name Last/Organ. Name (NM103)	Name First (NM104)	Name Middle (NM105)
41	2	ABC Submitter		

ID Code Qualifier (NM108)	Identification Code (NM109)
46	99999999

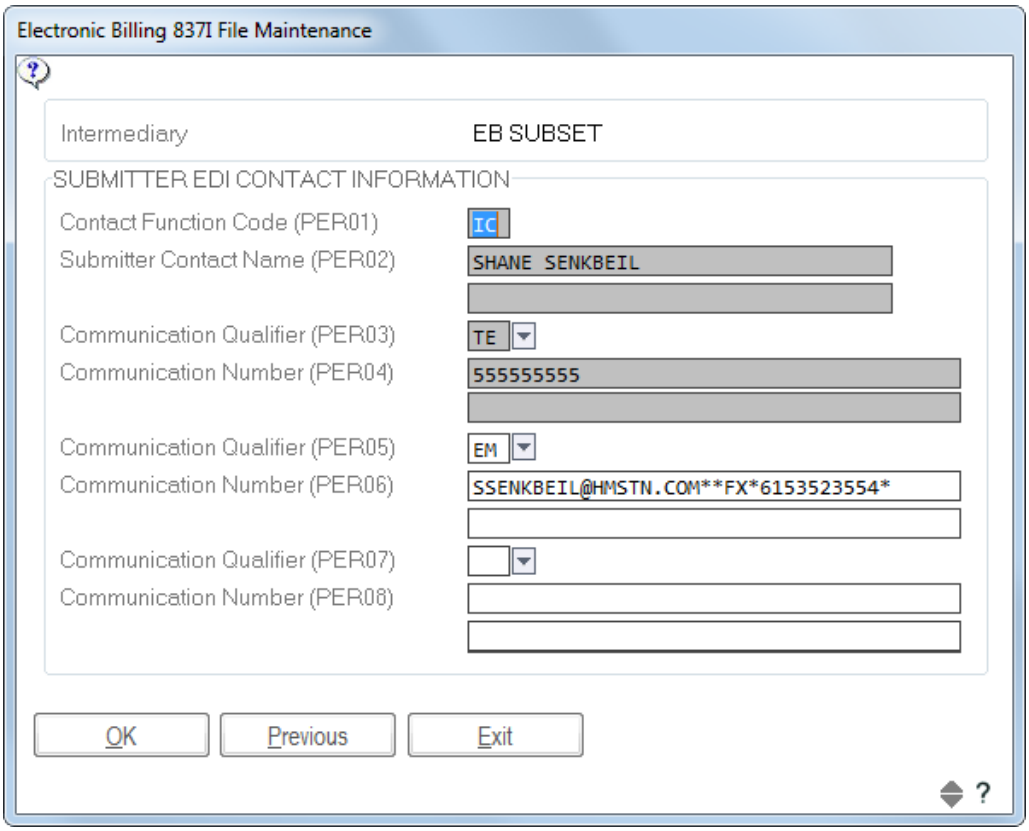
Field	Entry
NM101	**41***
NM102	2
NM103	ABC Submitter
NM104	Bob
NM105	D
NM108	**46***
NM109	99999999

Submitter EDI Contact Information (PER) Window

This is the fourth of five 5010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click **OK** in the **Submitter Name** (Loop 1000A) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.



Action

Verify that your Contact Function Code field matches that in the window shown above. Then click **OK** to save any changes and move to the next screen. The **Receiver Name** (NM1 Loop 1000B) window appears automatically.

To see the list of valid Communication Qualifiers, press the search button .

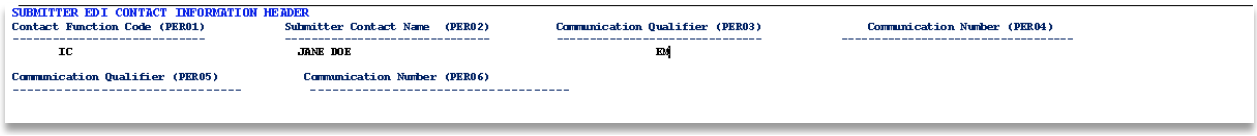
Note: Some of the valid 5010 format communication qualifiers are different than those for the 4010 format, as explained in the "Valid Communication Qualifiers" section.

Clicking **Previous** or **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Submitter EDI Contact Information (PER) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.

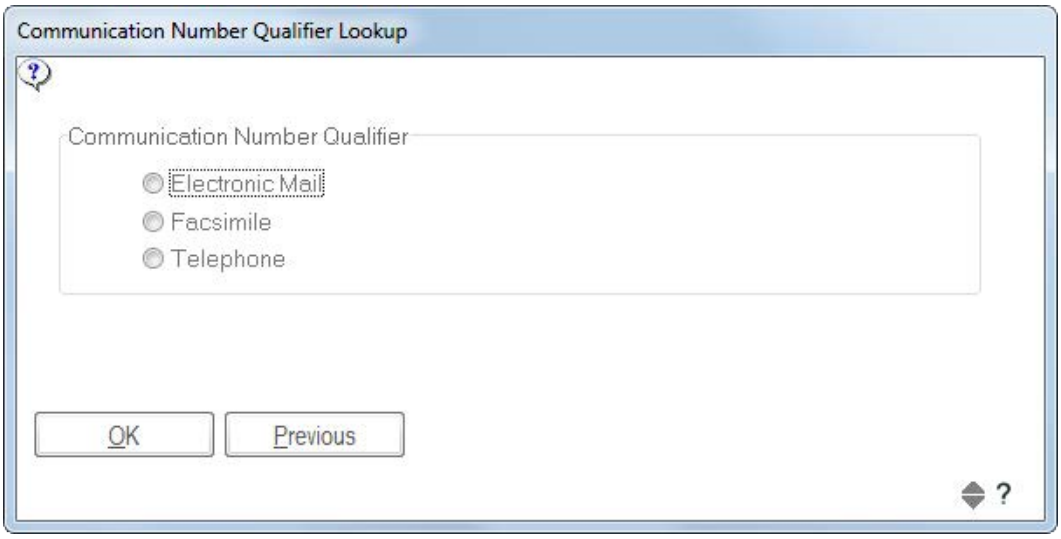


Field	Entry
PER01	**IC***
PER02	JANE DOE
PER03	EM, FX, or TE
PER04	9005555555
PER05 PER07	EM, EX, FX, or TE

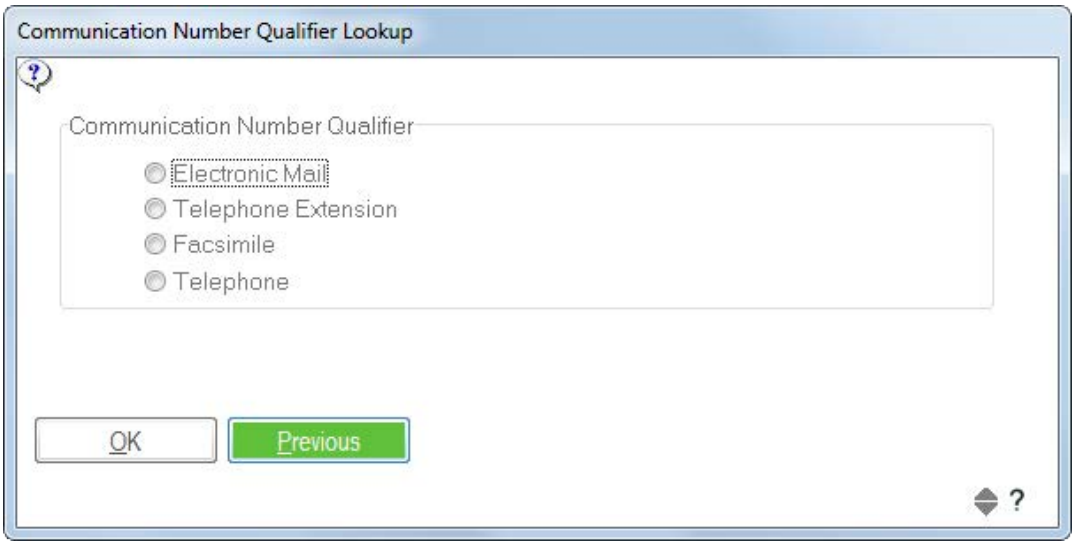
Valid Communication Qualifiers

Some of the valid 5010 format communication qualifiers are different than the ones for the 4010 format. As shown below, the PER03 qualifiers also differ from the PER05 and PER07 qualifiers, which are the same.

PER03 Qualifiers



PER05 & PER07 Qualifiers

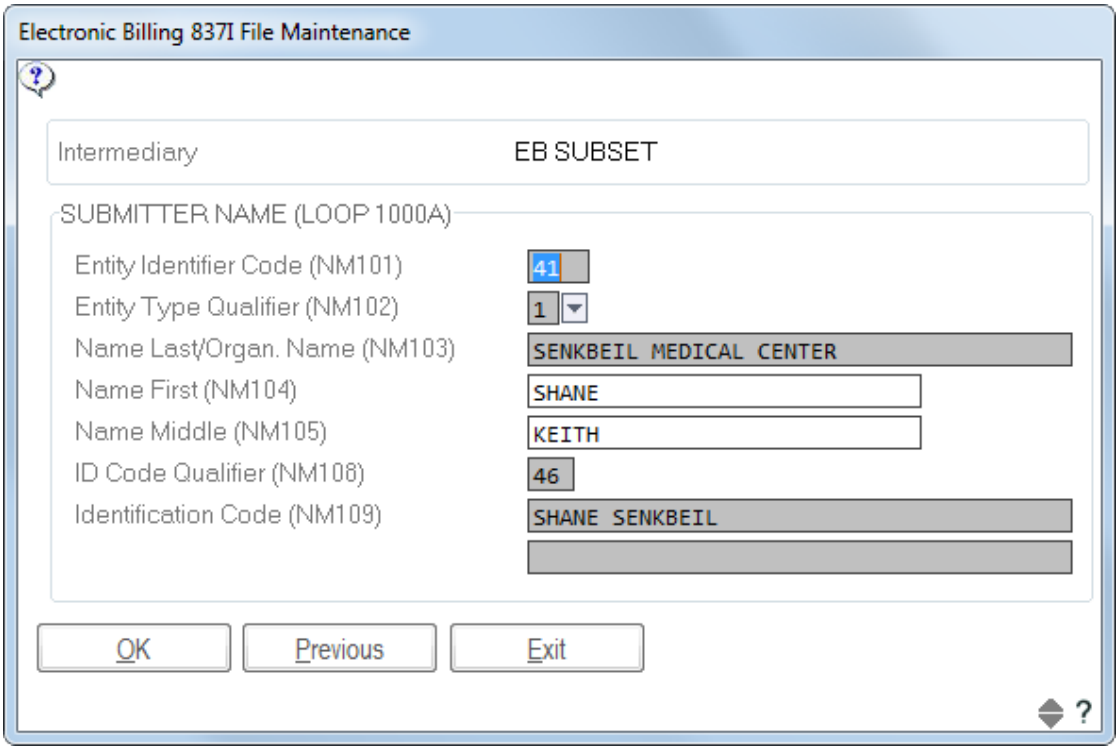


Receiver Name (NM1 Loop 1000B) Window

This is the fifth of five 5010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click **OK** in the **Submitter EDI Contact Information** (PER) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.



Action

Verify that the contents of your Entity Identifier Code, Entity Type Qualifier, and ID Code Qualifier fields match those in the window shown above. Then click **Add/Update** to save it, complete the setup, and return to the **Transmission Information** window.

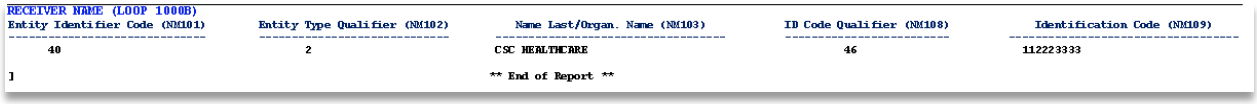
Clicking **Previous** returns you to the **Submitter EDI Contact Information** window.

Clicking **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Receiver Name (NM1, Loop 1000B) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.



RECEIVER NAME (LOOP 1000B)

Entity Identifier Code (NM101)	Entity Type Qualifier (NM102)	Name Last/Organ. Name (NM103)	ID Code Qualifier (NM108)	Identification Code (NM109)
40	2	CSC HEALTHCARE	46	112223333

] ** End of Report **

Field	Entry
NM101	**40***
NM102	**2***
NM103	CSC HEALTHCARE
NM108	**46***
NM109	99999

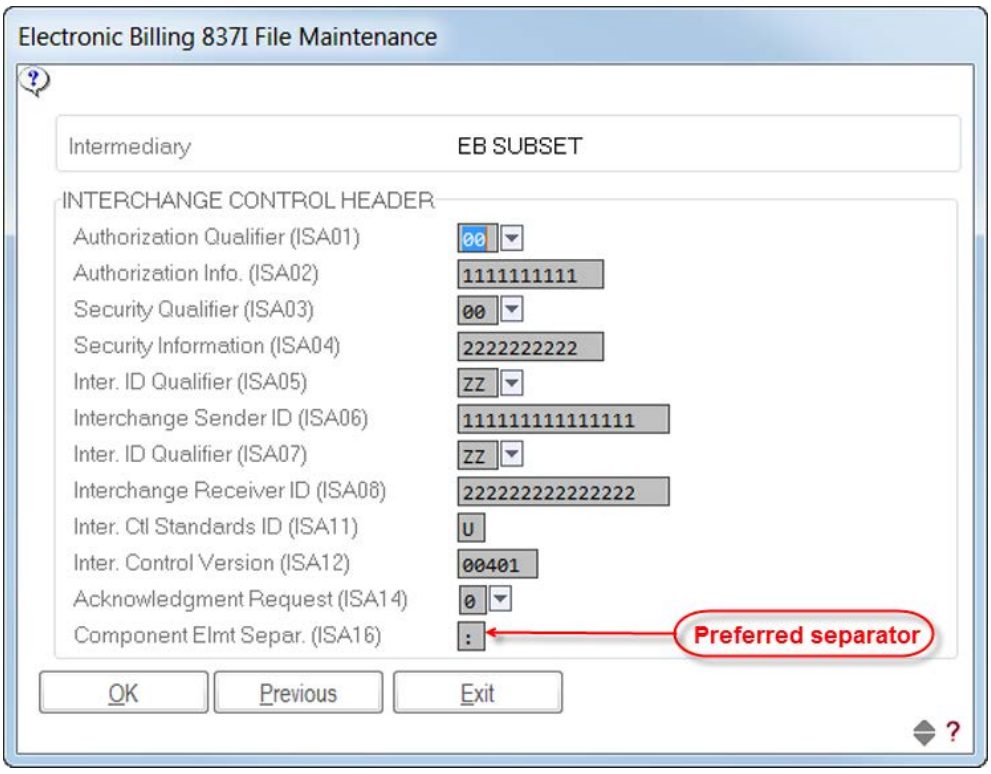
VERSION 4010 FORMAT HEADERS

Interchange Control Header (ISA) Window

This is the first of five 837 4010 format File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

Values with an asterisk (*****) must match those shown on the figure below. The other parameters will be given by the intermediary.

Note: As you press OK at each screen, a message at the bottom of the screen will give the correct value if any of the MEDHOST required fields needs to be changed.



Action

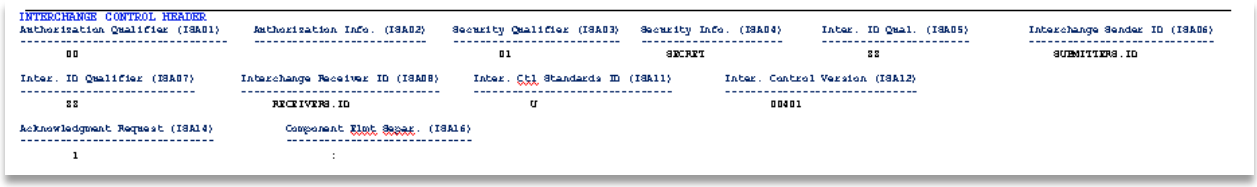
Verify that the contents of your Repetition Separator and Inter. Control Version fields match those in the window shown above. (Unless the intermediary has specified a different Component Elmt Separ., the colon (:) is preferred.) Then click OK to save any changes and move to the next screen. The **Functional Group/Transmission Type** (GS/REF) window appears automatically.

Clicking Previous or Exit returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Interchange Control Header (ISA) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.


INTERCHANGE CONTROL HEADER

Authorization Qualifier (ISA01)	Authorization Info. (ISA02)	Security Qualifier (ISA03)	Security Info. (ISA04)	Inter. ID Qual. (ISA05)	Interchange Sender ID (ISA06)
00		01	SECRET	ZZ	SUBMITTERS.ID

Inter. ID Qualifier (ISA07)	Interchange Receiver ID (ISA08)	Inter. Ctl Standards ID (ISA11)	Inter. Control Version (ISA12)
ZZ	RECEIVERS.ID	U	00401

Acknowledgment Request (ISA14)	Component Elmt Separ. (ISA16)
1	:

Field	Entry
ISA01	00
ISA02	
ISA03	01
ISA04	SECRET
ISA05	ZZ
ISA06	SUBMITTERS.ID
ISA07	ZZ
ISA08	RECEIVERS.ID
ISA11	**U ***
ISA12	**00401***
ISA14	1
ISA16	**: (or element provided by intermediary) ***

Functional Group & Transmission Type (GS & REF*) Window*

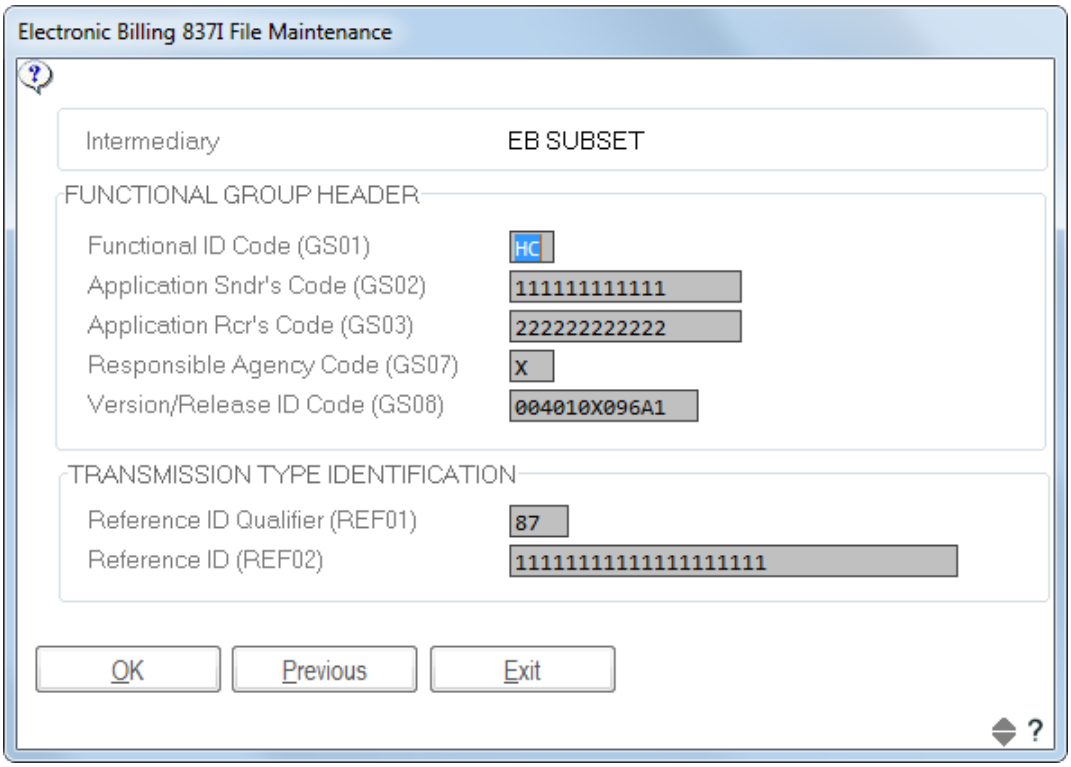
This is the second of five 4010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click OK in the **Interchange Control** (ISA) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.

Note: The Version/Release ID Code (GS08) setting differs for the 837I and 837P headers.

4010 837I



Action

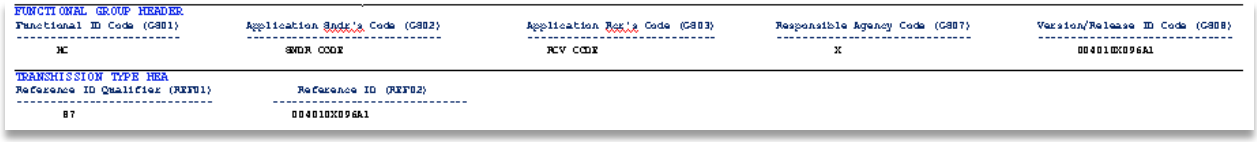
Verify that the contents of your Functional ID Code, Responsible Agency Code, and Version/Release ID Code. fields match those in the window shown above. Then click OK to save any changes and move to the next screen. The **Submitter Name** (NM1 Loop 1000A) window appears automatically.

Clicking Previous or Exit returns you to the **Transmission Information** window without saving any changes.

Example

Below are the Functional Group Header (GS) and Transmission Type Header (REF) segments of the 837I Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I.



FUNCTIONAL GROUP HEADER

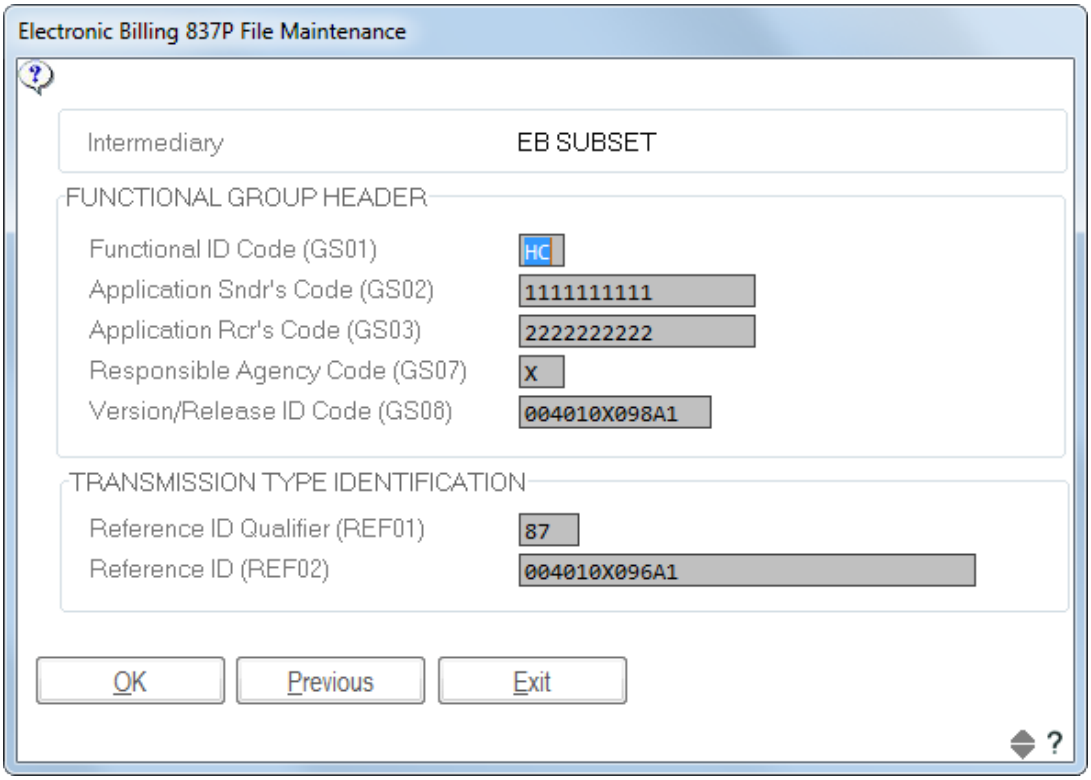
Functional ID Code (GS01)	Application Sndr's Code (GS02)	Application Rcv's Code (GS03)	Responsible Agency Code (GS07)	Version/Release ID Code (GS08)
HC	SNDR CODE	RCV CODE	X	004010X096A1

TRANSMISSION TYPE HEA

Reference ID Qualifier (REF01)	Reference ID (REF02)
87	004010X096A1

Field	Entry
GS01	**HC** *
GS02	SNDR CODE
GS03	RCV CODE
GS07	**X** *
GS08	**004010X096A1***
REF01	**87** *
REF02	004010X096A1

4010 837P



Action

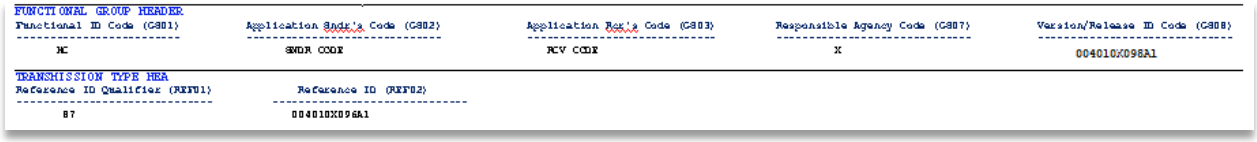
Verify that the contents of your Functional ID Code, Responsible Agency Code, and Version/Release ID Code. fields match those in the window shown above. Then click **OK** to save any changes and move to the next screen. The **Submitter Name** (NM1 Loop 1000A) window appears automatically.

Clicking **Previous** or **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below are the Functional Group Header (GS) and Transmission Type Header (REF) segments of the 837P Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I.



FUNCTIONAL GROUP HEADER

Functional ID Code (GS01)	Application Sndr's Code (GS02)	Application Rcv's Code (GS03)	Responsible Agency Code (GS07)	Version/Release ID Code (GS08)
HC	SNDR CODE	RCV CODE	X	004010X098A1

TRANSMISSION TYPE HEA

Reference ID Qualifier (REF01)	Reference ID (REF02)
87	004010X098A1

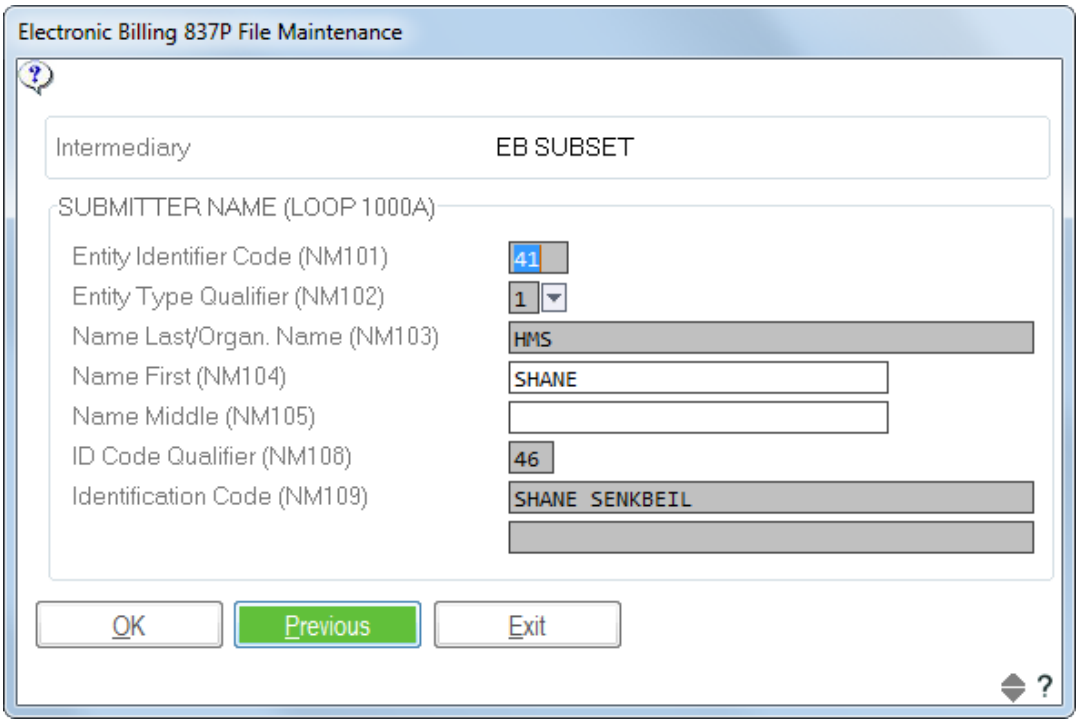
Field	Entry
GS01	**HC** *
GS02	SNDR CODE
GS03	RCV CODE
GS07	**X** *
GS08	**004010X098A1***
REF01	**87** *
REF02	

Submitter Name (NM1 Loop 1000A) Window

This is the third of five 4010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click OK in the **Functional Group & Transmission Type** (GS* & REF*) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.



Action

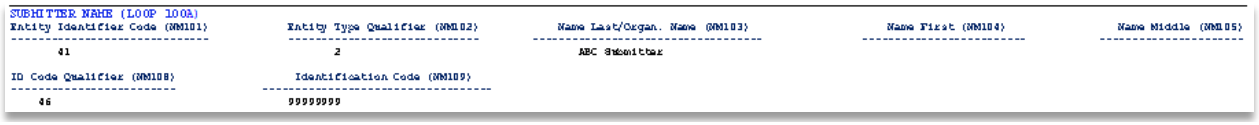
Verify that the contents of your Entity Identifier Code and ID Code Qualifier fields match those in the window shown above. Then click OK to save any changes and move to the next screen. The **Submitter EDI Contact Information** (PER) window appears automatically.

Clicking Previous or Exit returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Submitter Name (NM1, Loop 1000A) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.



SUBMITTER NAME (LOOP 100A)

Entity Identifier Code (NM101)	Entity Type Qualifier (NM102)	Name Last/Organ. Name (NM103)	Name First (NM104)	Name Middle (NM105)
41	2	ABC Submitter		

ID Code Qualifier (NM108)	Identification Code (NM109)
46	99999999

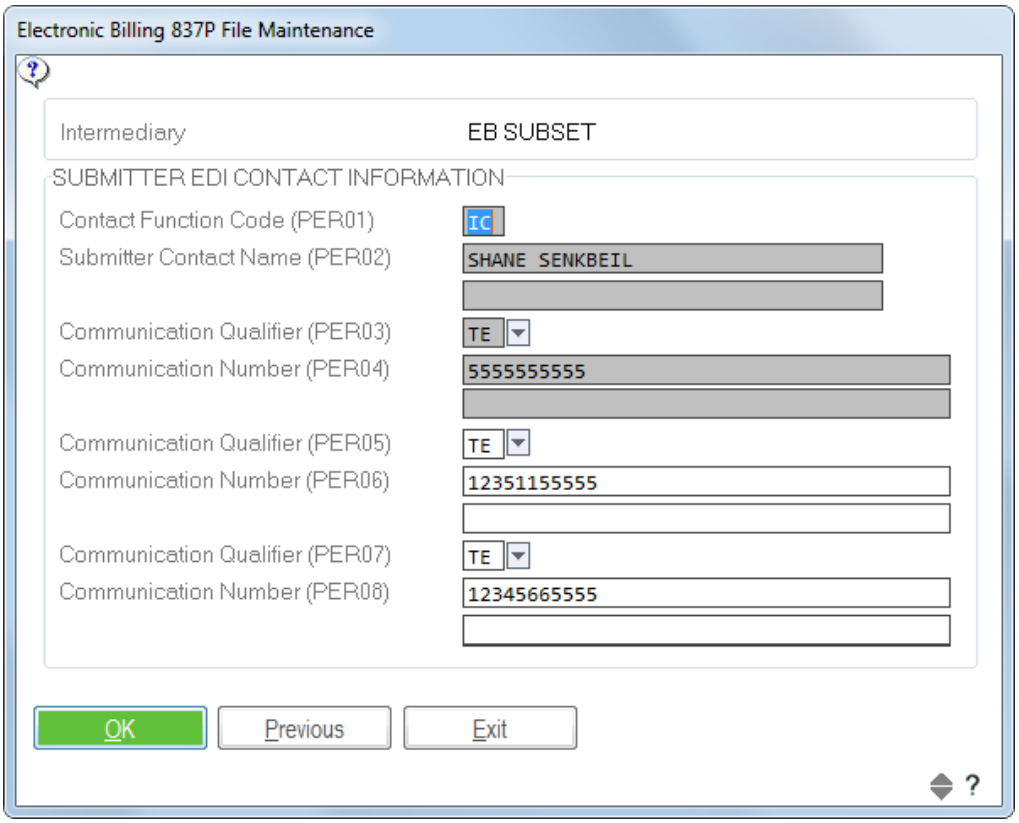
Field	Entry
NM101	**41** *
NM102	2
NM103	ABC Submitter
NM104	Bob
NM105	D
NM108	**46** *
NM109	99999999

Submitter EDI Contact Information (PER) Window

This is the fourth of five 4010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click **OK** in the **Submitter Name** (NM1 Loop 1000A) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.



Action

Verify Contact Function Code field matches that in the window shown above. Then click **OK** to save any changes and move to the next screen. The **Receiver Name** (NM1 Loop 1000B) window appears automatically.

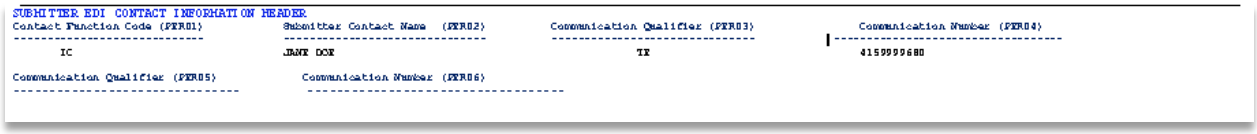
To see the list of valid Communication Qualifiers, press the search button .

Note: Some of the valid 4010 format communication qualifiers are different than those for the 5010 format, as explained in the "Valid Communication Qualifiers" section.

Clicking **Previous** or **Exit** returns you to the **Transmission Information** window without saving any changes.

Example Below is the Submitter EDI Contact Information (PER) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.


SUBMITTER EDI CONTACT INFORMATION HEADER

Contact Function Code (PER01)	Submitter Contact Name (PER02)	Communication Qualifier (PER03)	Communication Number (PER04)
IC	JANE DOE	TE	4159999680

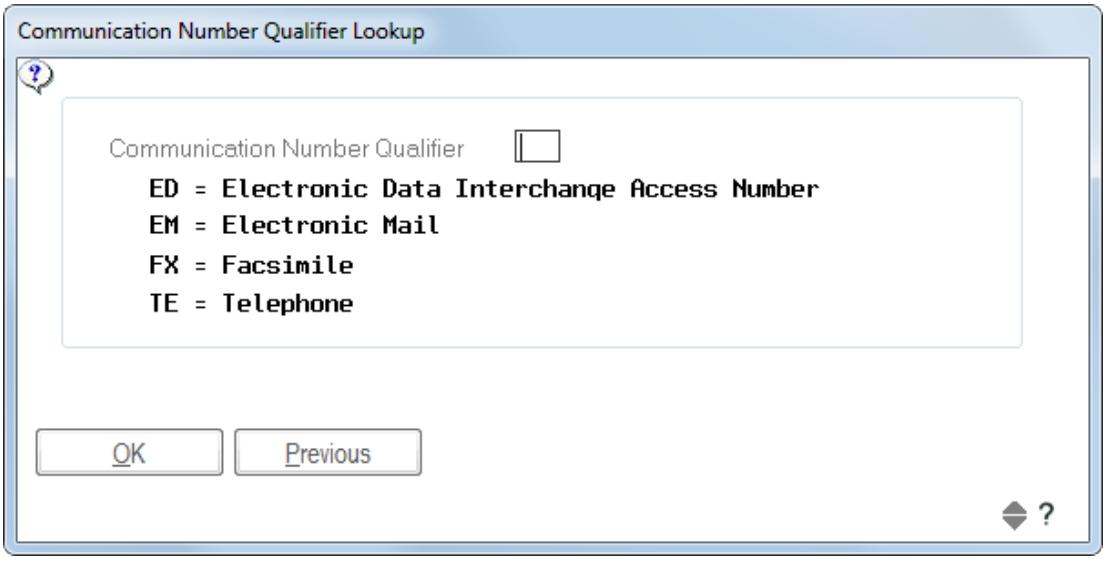
Communication Qualifier (PER05)	Communication Number (PER06)

Field	Entry
PER01	**IC** *
PER02	SHANE SENKBEIL
PER03	ED, EM, FX, or TE
PER04	5555555 7777777777777777777
PER05 PER07	ED, EM, EX, FX, or TE

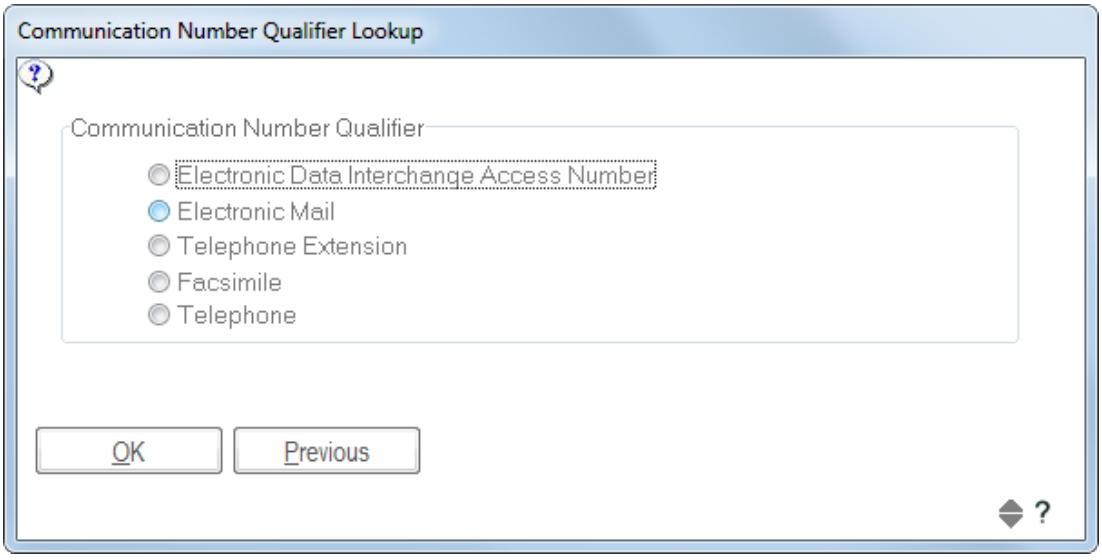
Valid Communication Qualifiers

Some of the valid 4010 format communication qualifiers are different than the ones for the 5010 format. For example, the Electronic Data Interchange Access Number (ED) is no longer in the 5010 format header. As shown below, the PER03 qualifiers also differ from the PER05 and PER07 qualifiers, which are the same.

PER03 Qualifiers



PER05 & PER07 Qualifiers

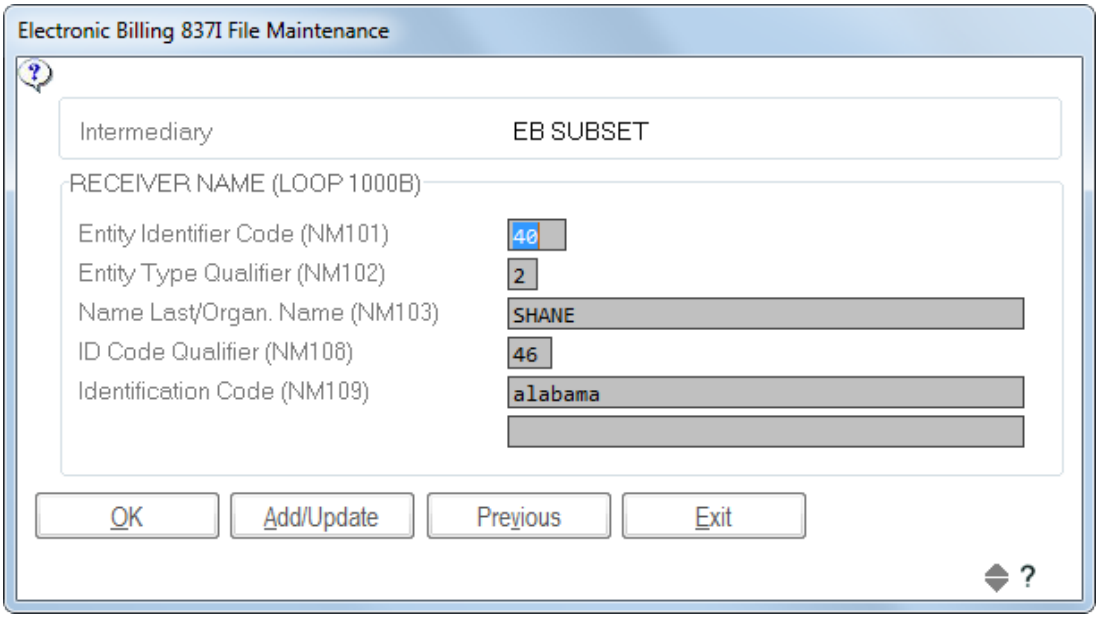


Receiver Name (NM1 Loop 1000B) Window

This is the fifth of five 4010 format 837 File Maintenance windows that appears when you click on one of the 837 buttons in the **Transmission Information** window.

This window appears when you click **OK** in the **Submitter EDI Contact Information** (PER) window.

Values with an asterisk (*) must match those shown on the figure below. The other parameters will be given by the intermediary.



Action

Verify that the contents of your Entity Identifier Code, Entity Type Qualifier, and ID Code Qualifier fields match those in the window shown above. Then click **Add/Update** to save it, complete the setup, and return to the **Transmission Information** window.

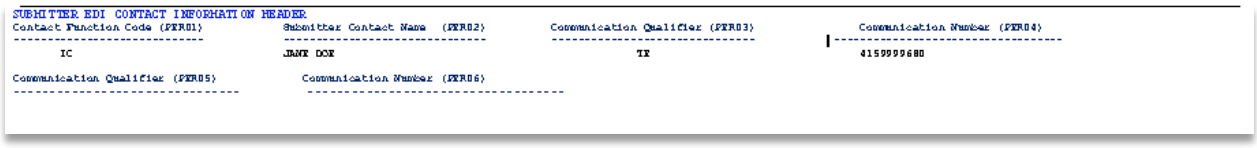
Clicking **Previous** returns you to the **Submitter EDI Contact Information** window.

Clicking **Exit** returns you to the **Transmission Information** window without saving any changes.

Example

Below is the Receiver Name (NM1, Loop 1000B) segment of the 837 Header Information report, followed by a table showing the same information in a different format. (The sample window on the previous page shows information entered in the window.)

For a sample of a complete Header Information Report, go to "EBRPT1 Option 4: Retrieve 837 Header Information" behind the Reports Menu I tab in this manual.


SUBMITTER EDI CONTACT INFORMATION HEADER

Contact Function Code (PER01)	Submitter Contact Name (PER02)	Communication Qualifier (PER03)	Communication Number (PER04)
IC	JANE DOE	TE	4159999680

Communication Qualifier (PER05)	Communication Number (PER06)

Field	Entry
NM101	**40 ***
NM102	**2 ***
NM103	CSC HEALTHCARE
NM108	**46 ***
NM109	99999

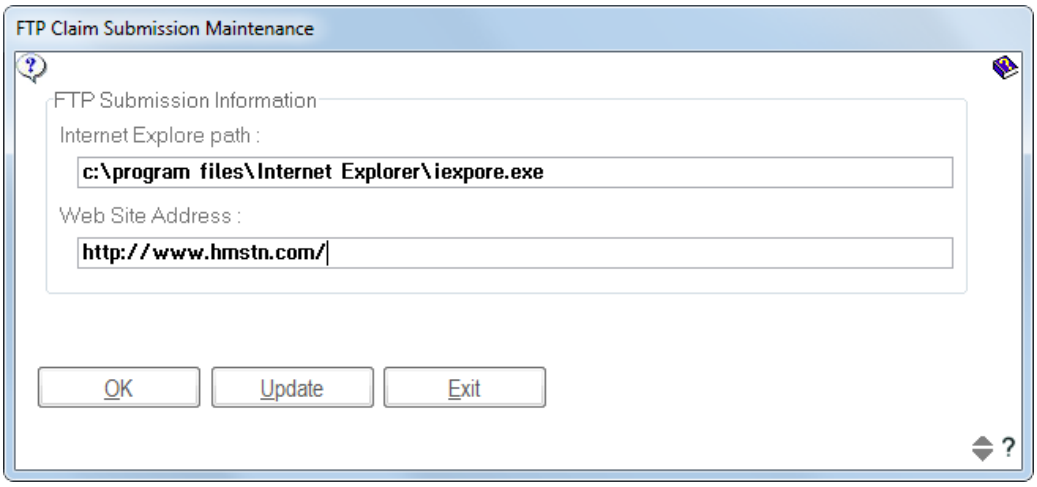
FTP DETAILS WINDOW

This window appears when you click the **FTP Detail** button in the **Transmission Information** window.

This function and window was previously *Electronic Billing Maintenance Menu*, Option 9. You can now use it to set up one FTP entry for each intermediary (instead of just one for all intermediaries).

Use this window to identify the user's Internet Explorer path and the intermediary's Web site address. This information will be used by some states to submit the Electronic Billing file to the intermediary using FTP (File Transfer Protocol).

Note: This information is **required** if the Transmit Type field has been set to Interactive PABLO Internet or Interactive File Xfer/Internet (refer to the **Electronic Billing Maintenance** section).



Action: Type the Internet Explorer path and/or Web site address, then click **Update** to update the information and return to the **Transmission Information** window.

EBMAIN Option 2: Maintain Intermediary File

Overview:

Maintain Intermediary File (Option 2 on the Electronic Billing Maintenance Menu) is used to enter and maintain the intermediary codes. These codes allow multiple intermediaries to be transmitted. The codes set up in this option are assigned to an insurance company/plan through Insurance Company/Plan File, Option 18 on File Maintenance Menu I in Patient Accounting. Every patient with the same company/plan will be transmitted to the intermediary assigned to the company/plan.

Several options in Electronic Billing will display a prompt window to allow an intermediary code to be entered.

This option is also used to specify the type of claims that are being transmitted as live claims and the claims that are being transmitted in test mode. Both live claims and test claims can be transmitted at the same time for an intermediary.

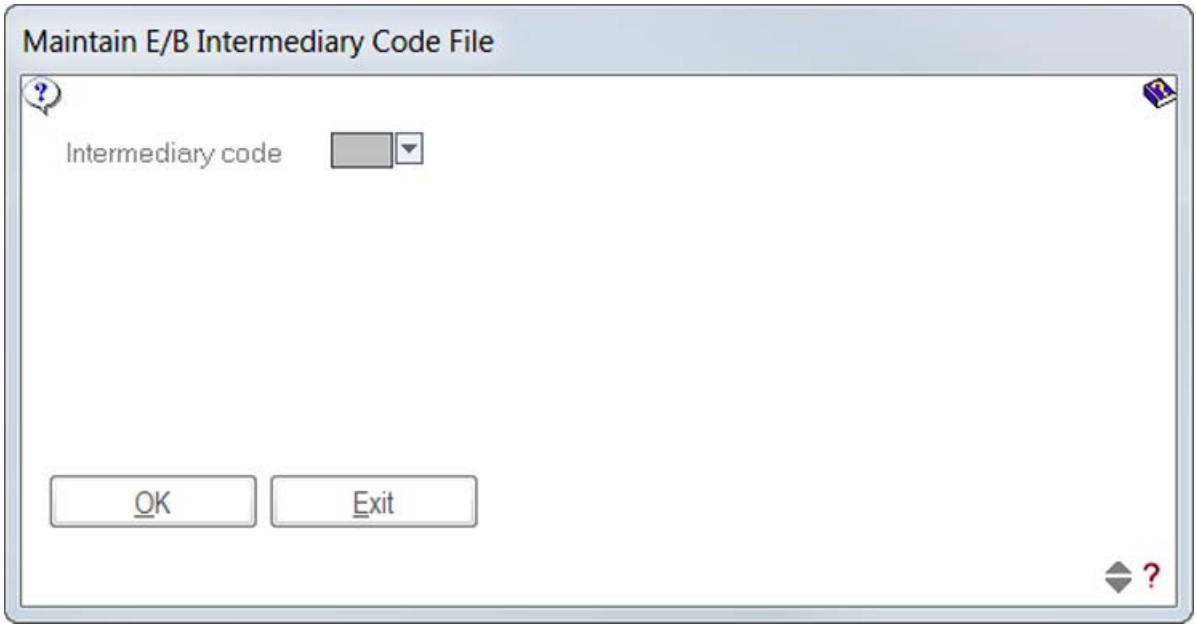
Files:

EBINTMED

In this section

Maintain E/B Intermediary Code File window

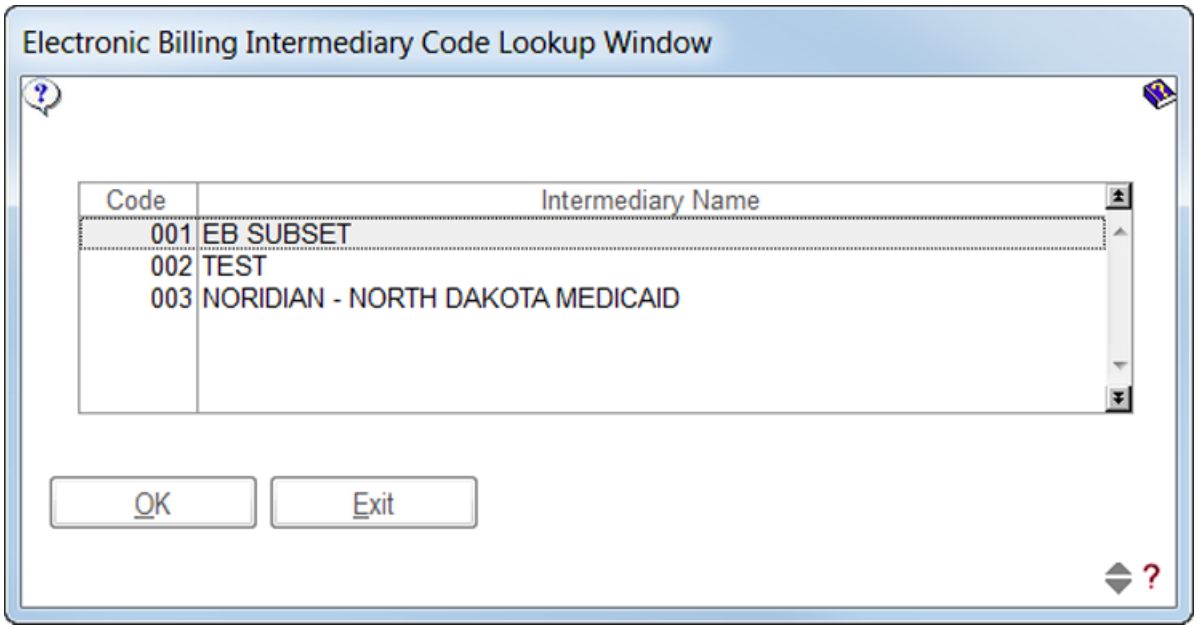
This window appears when you select **Maintain Intermediary File** in the Electronic Billing Maintenance Menu.



Action Enter the 3-digit intermediary code you want to set up or maintain, and then click **OK**. You can either type the code or click to search for it in the **Electronic Billing Intermediary Code Lookup** window.

Electronic Billing Intermediary Code Lookup window

This window appears when you click in the **Maintain E/B Intermediary Code File** window.



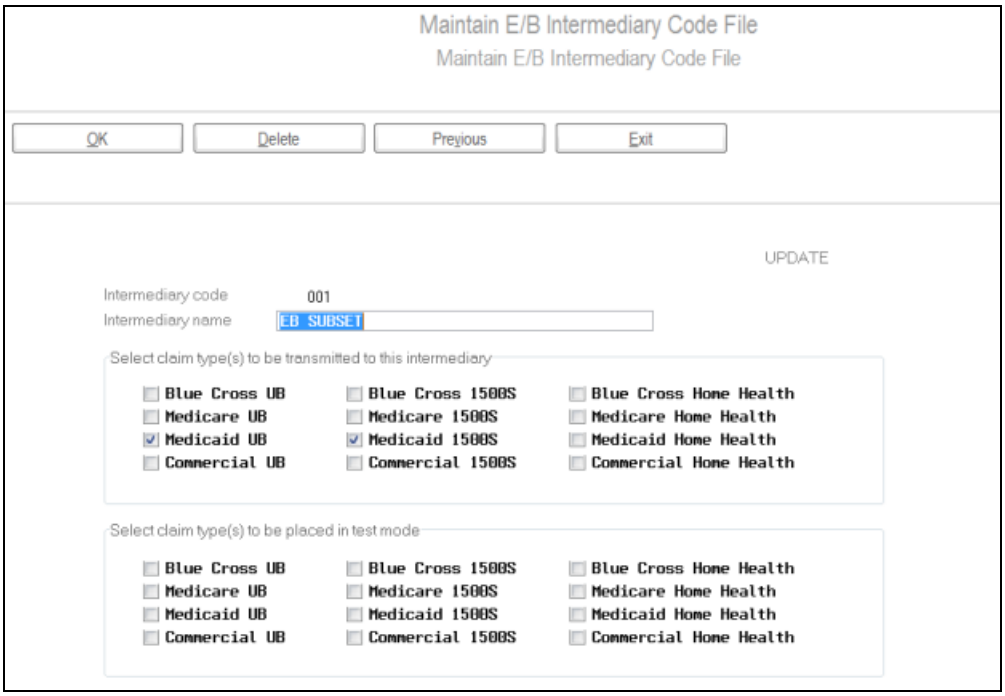
Action Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

Maintenance window

The maintenance window is used to add or update intermediary information.

This window appears when you enter an intermediary code in the **Maintain E/B Intermediary Code File** window.

UB has replaced **UB92** in this window.



Action

To enter or maintain information: Enter information in the window and click **OK** to save it.

(Clicking **Exit** returns you to the Maintenance Menu and clicking **Previous** returns you to the intermediary code window, both without saving any information you entered or changed.)

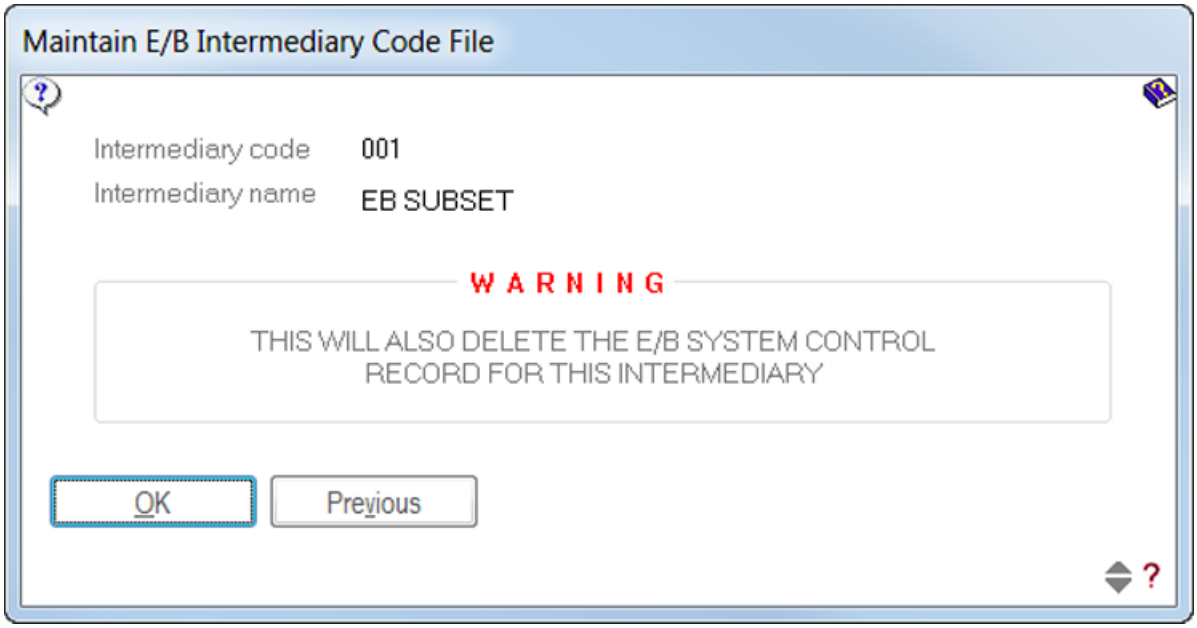
To delete the code from the file: Click **Delete**. You will need to confirm the deletion in the window that appears.

Field	Description
Intermediary code	Three-digit number used to set up or maintain intermediary.
Intermediary name	Enter a description (up to 40 characters) for the

	intermediary. If you are updating, you can change the name that appears in this field, if you wish.
Select claim type(s) to be transmitted to this intermediary	Select (click on) each type of claim (UB, 1500, or home health) that should be transmitted with this intermediary code. Select as many claim types as you wish.
Select claim type(s) to be placed in test mode	Select (click on) each type of claim (UB, 1500, or home health) that should be transmitted in test mode for this intermediary code. Select as many claim types as you wish.

Confirm Deletion window

This window appears when you click **Delete** in the maintenance window.



Action

To delete the intermediary record: Click **OK**.

This will also delete the intermediary's system control record.

To cancel the deletion: Click **Previous**.

EBMAIN Option 3: Outside Lab File Maintenance

Overview: **Outside Lab File Maintenance** (Option 3 on the Electronic Billing Maintenance Menu) is used to add and maintain information about outside labs.

You can create up to ten outside labs, which relate back to the modifiers set up for charges that were performed at an outside lab facility.

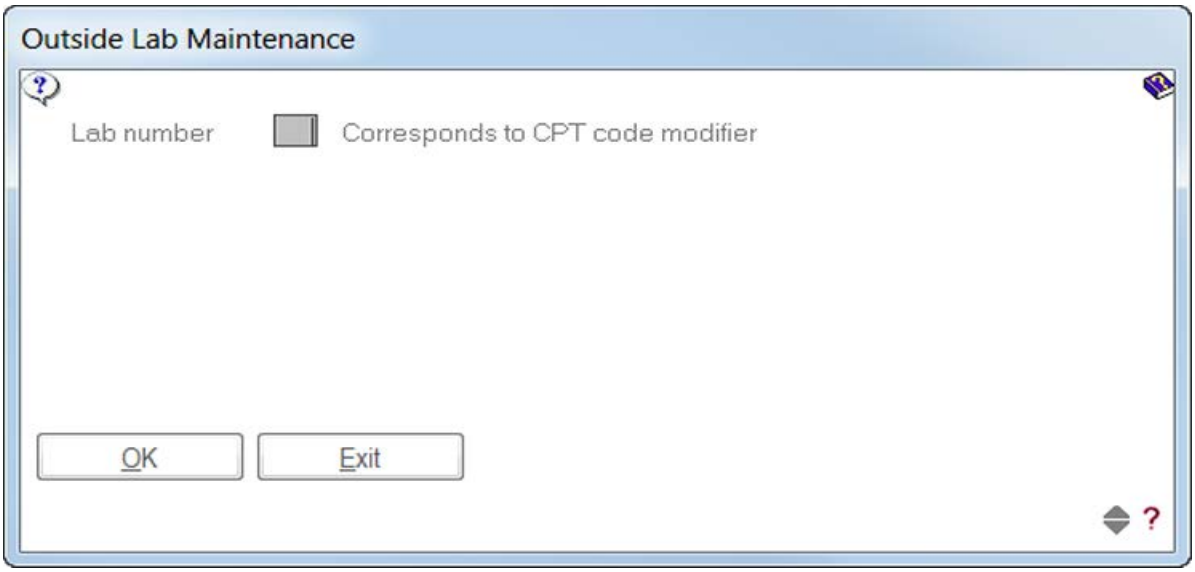
The information entered in this option will print on the HCFA-1500 form.

Files: PASUPP

In this section

Lab number window

This window appears when you select **Outside Lab File Maintenance** in the Electronic Billing Maintenance Menu.

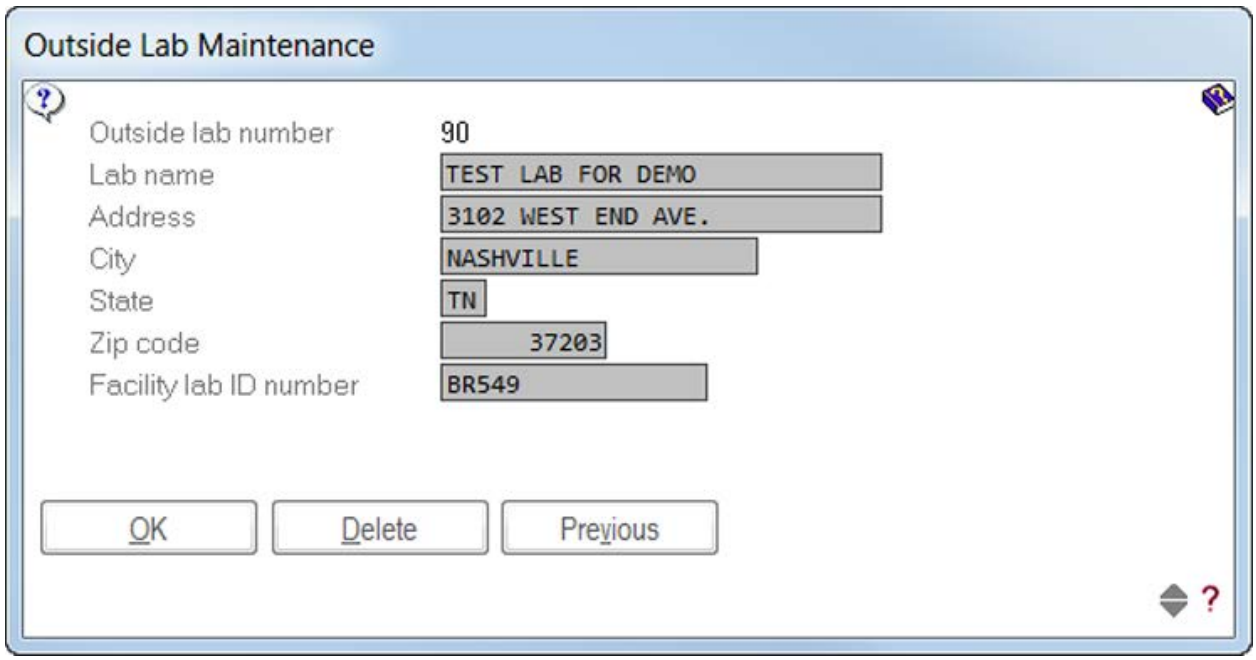


Action Type the lab number you want to set up or maintain, and then click **OK**. The number must be from 90 to 99.

Maintenance window

The maintenance window is used to add or update outside lab information.

This window appears when you enter a lab number in the lab number window.



Action

To enter or maintain information: Enter or update the outside lab's name, address, and/or ID number, and then click **OK** to save it. All information except the ID number is required.

(Clicking **Previous** returns you to the lab number window without saving any information you entered or changed.)

To delete the lab from the file: Click **Delete**.

The lab is deleted immediately (no confirmation window appears), so make sure you really want to delete it.

EBMAIN Option 4: Omit Bill Types from E/B

Overview:

Omit Bill Types from EB (Option 4 on the Electronic Billing Maintenance Menu) is used to select a specific bill type for an intermediary in order to omit that bill type from transmissions. Selecting a type for omission actually adds it to a list of inactive types. Later, if necessary, this option can also be used to remove the bill type from the list and include it once again in transmissions.

You can view the list of inactive bill types in the inactive list window.

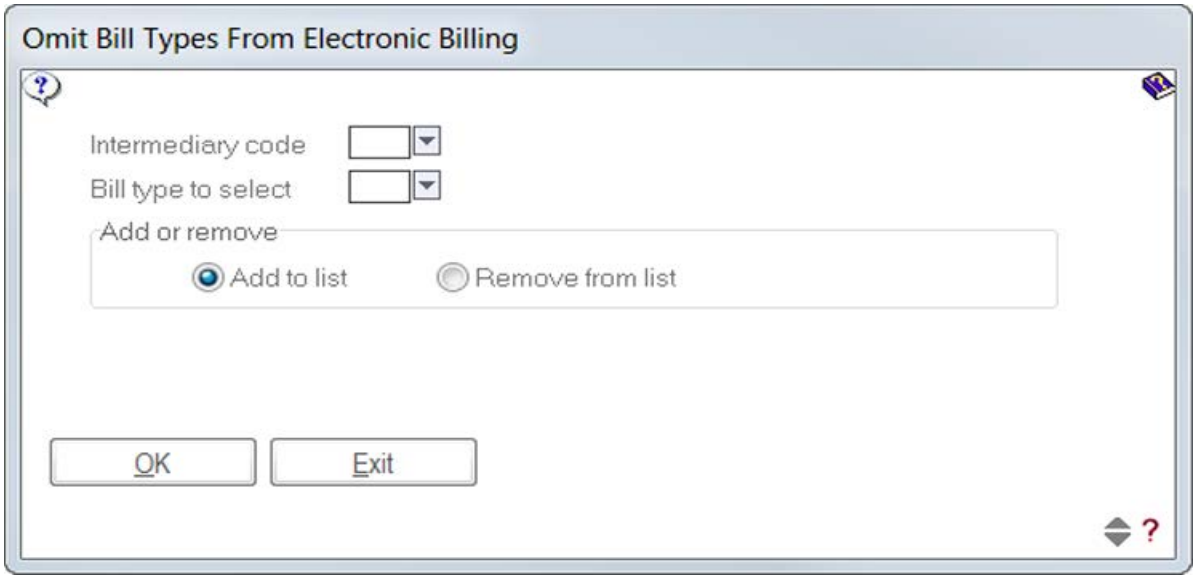
Files:

EBBILTYP, EBINTMED

In this section

Intermediary code/bill type window

This window appears when you select **Omit Bill Types from EB** in the Electronic Billing Maintenance Menu.



Action

To add a bill type to the inactive list: Enter the intermediary code and bill type, select (click on) **Add to list**, and then click **OK**. You can either type the intermediary code or click next to the field to search for it in the **Electronic Billing Intermediary Code Lookup** window. You must type the bill type.

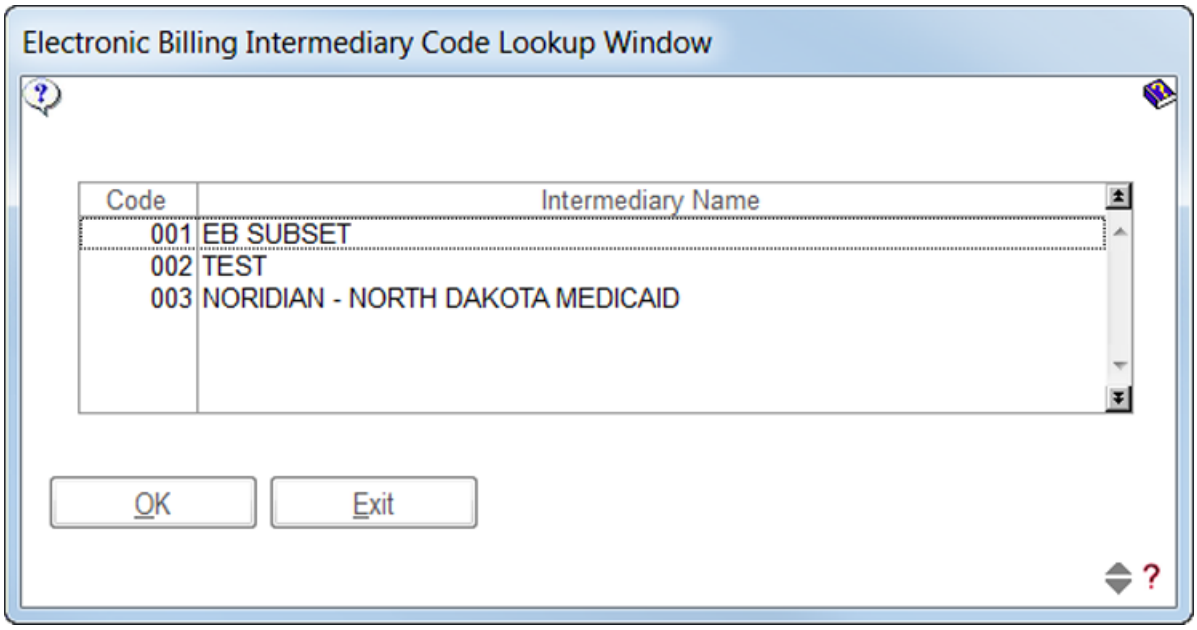
To remove a bill type from the list (and make it active again): Enter the intermediary code and bill type, select (click on) **Remove from list**, and then click **OK**. You can either type the code and bill type, or click next to the **Bill type to select** field to display the inactive list window, then select the intermediary/bill type you want to remove.

When you click **OK** for either action, a message will be displayed in red at the bottom of the window indicating the action taken. For example:

Bill type 111 for intermediary code 005 was removed from list.

Electronic Billing Intermediary Code Lookup window

This window appears when you click in the intermediary code/bill type window.

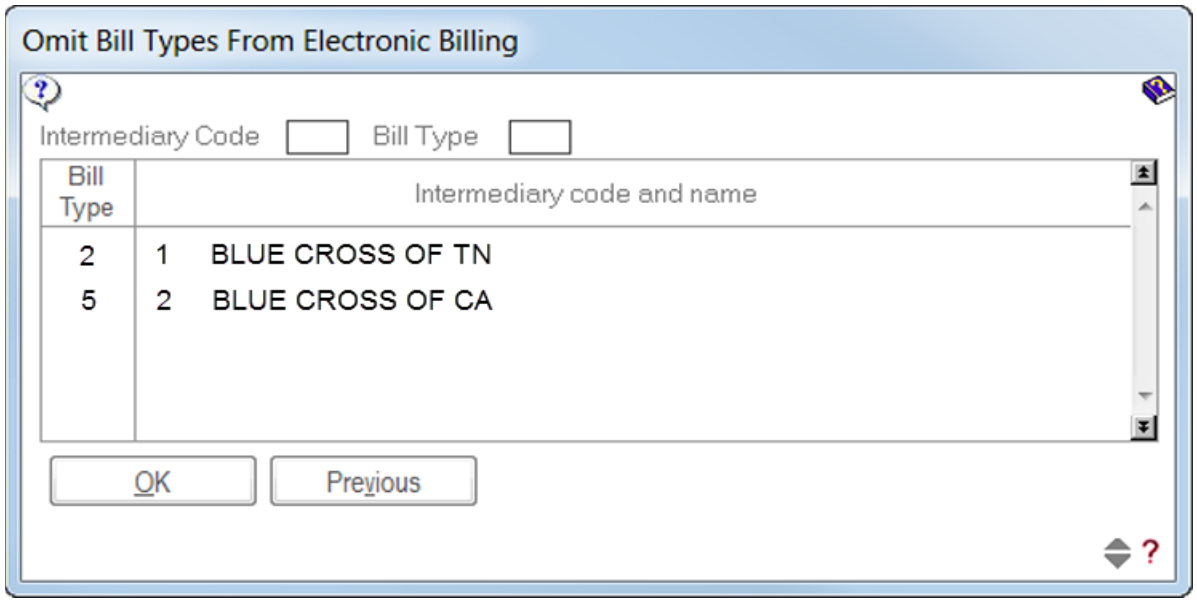


Action Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

Inactive list window

The inactive list window lists all bill types that are currently inactive.

This window appears when you click next to the **Bill type to select** field in the intermediary code/bill type window.



Action

To find an intermediary/bill type: Type the intermediary code and/or bill type in the appropriate fields, and then click **OK**.

To select a bill type: Click on it and then click **OK** (or just double-click on it).

EBMAIN Option 5: Initialize Media

Overview:

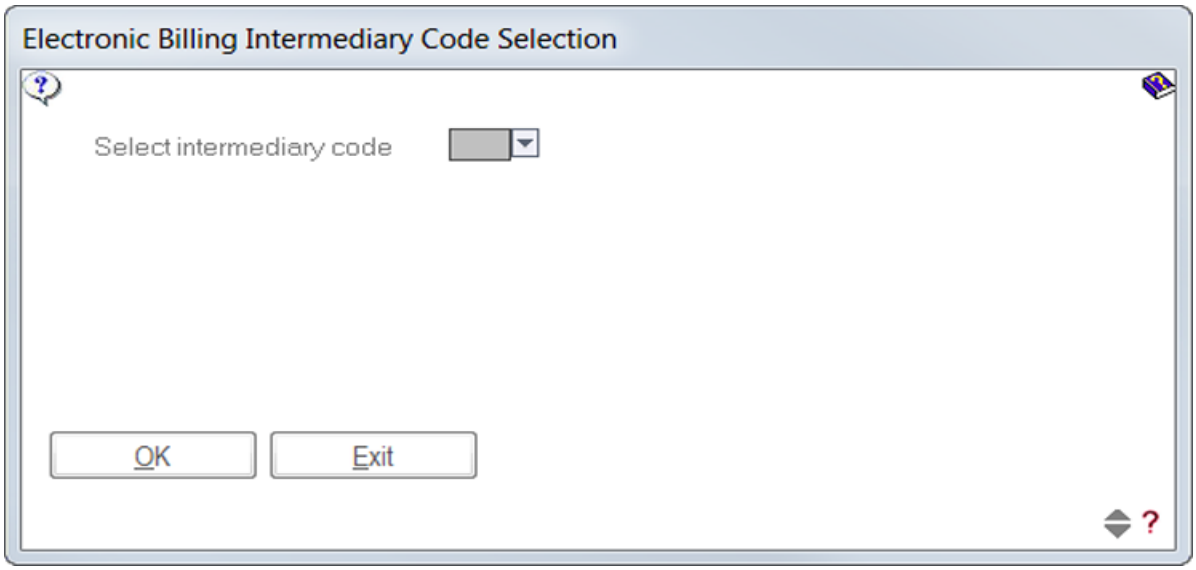
Initialize Media (Option 5 on the Electronic Billing Maintenance Menu) is used to initialize backup media to be used in saving the electronic billing files.

The backup media that are initialized in this option are specified in the installation record (Maintain EB System Control Record, Option 1 on the Electronic Billing Maintenance Menu).

In this section

Intermediary code selection window

This window appears when you select **Initialize Media** in the Maintenance Menu.

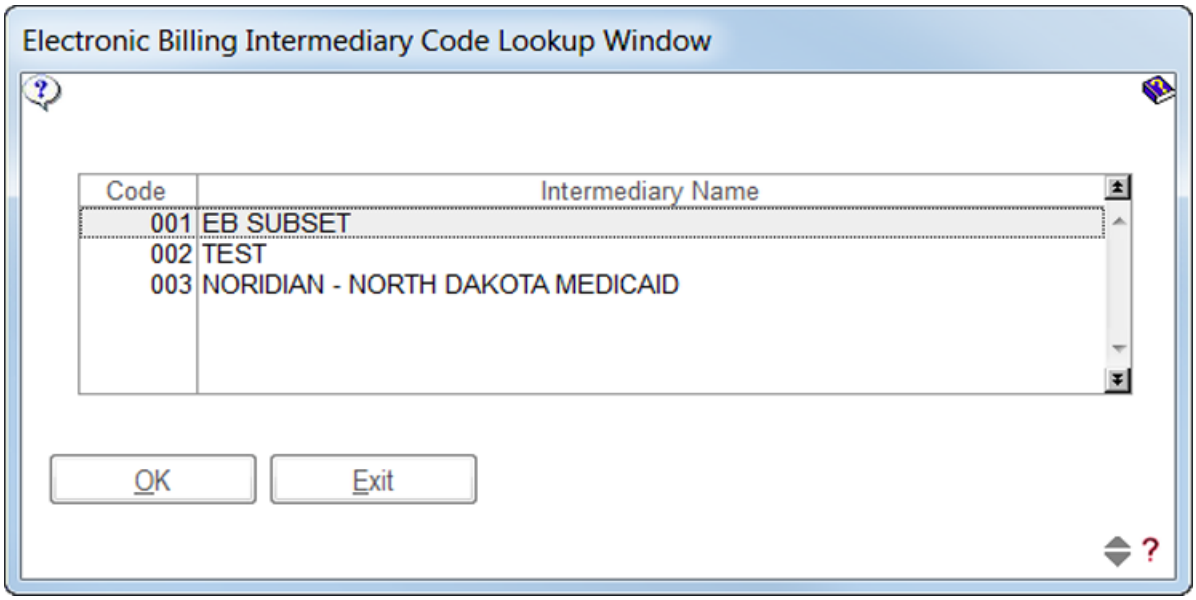


Action:

Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

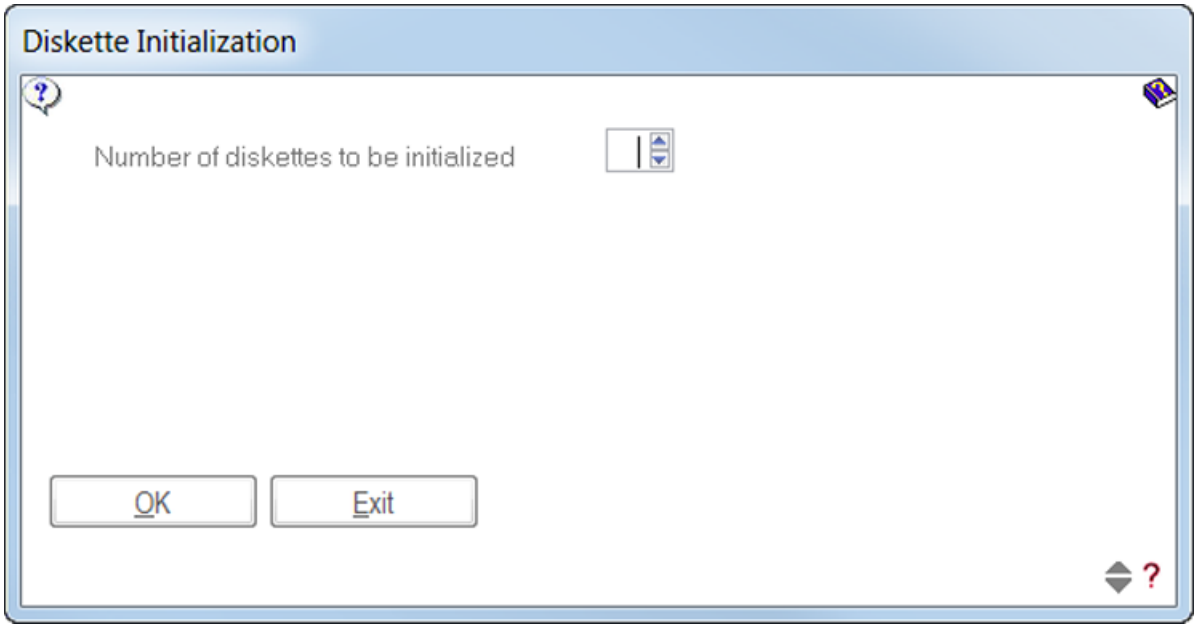
This window appears when you click in the **Intermediary Code Selection** window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

Diskette Initialization window

This window appears when you enter an intermediary code that is set up in the System Control Record with some form of diskette as the backup device.

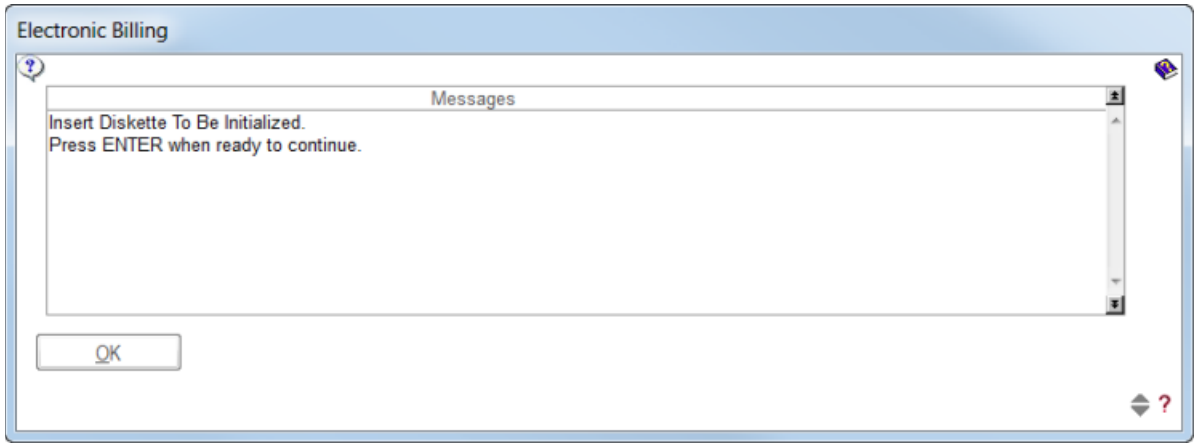


Action Enter the number of diskettes you want to initialize, and then click **OK**. You can either type the number or click to increase or decrease the number.

The system will prompt you in the message window to insert diskettes and inform you when the procedure is completed.

Message window

This window appears when you enter the number of diskettes to be initialized.



Action Insert a diskette and lick **OK**.

EBMAIN Option 6: Restore Files from Backup Media

Overview: **Restore Files from Backup Media** (Option 6 on the Electronic Billing Maintenance Menu) is used to restore files that have been saved during the transmission of electronic bills through Transmit Electronic Bills, Option 2 on the Electronic Billing Main Menu.

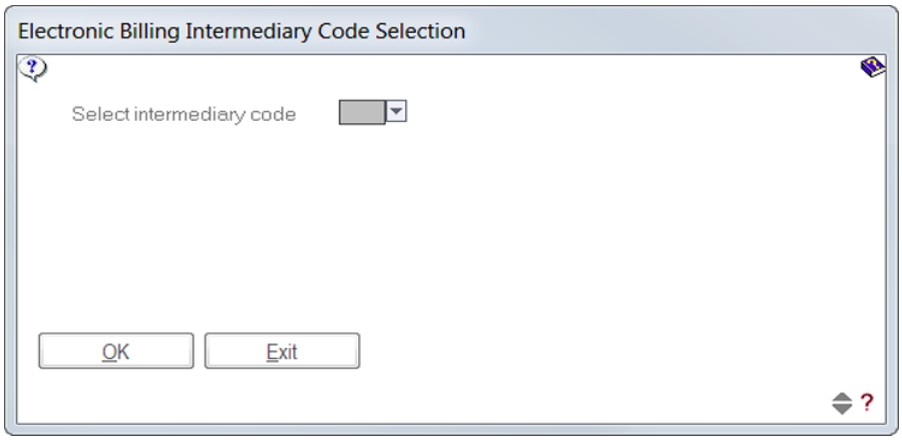
Contact Customer Support before using this option. This option should be used only under MEDHOST supervision, because data in the electronic billing files will be replaced.

Files: XNSUB82, XNSCODE, ELECBILL

In this section

Intermediary code selection window

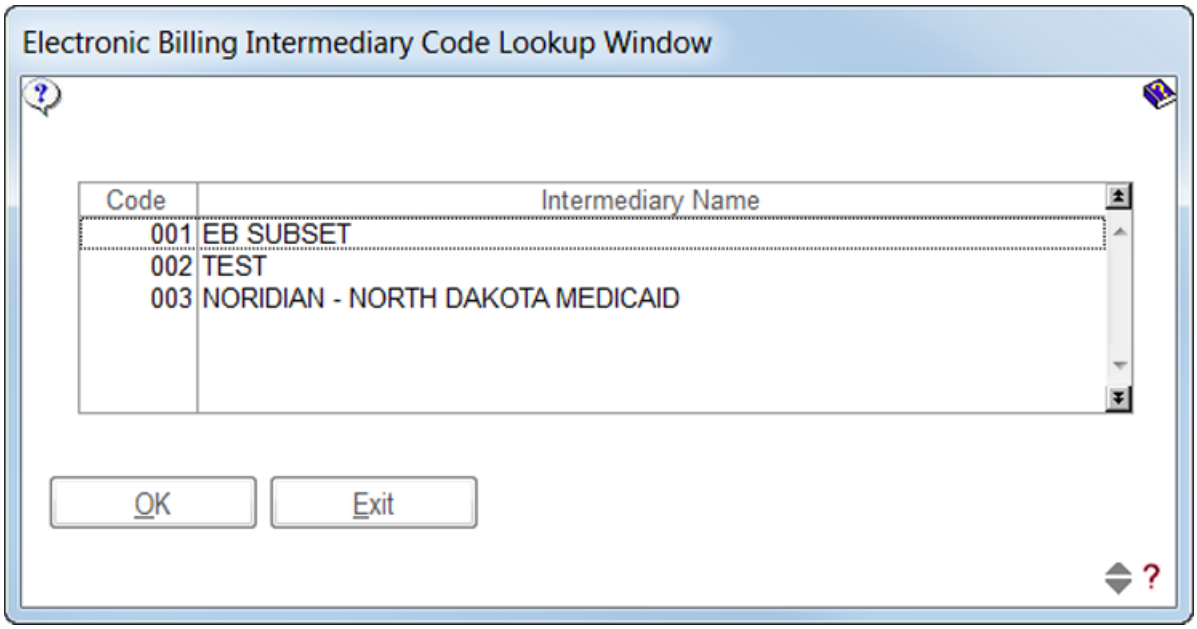
This window appears when you select **Restore Files from Backup Media** in the Maintenance Menu.



Action: Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

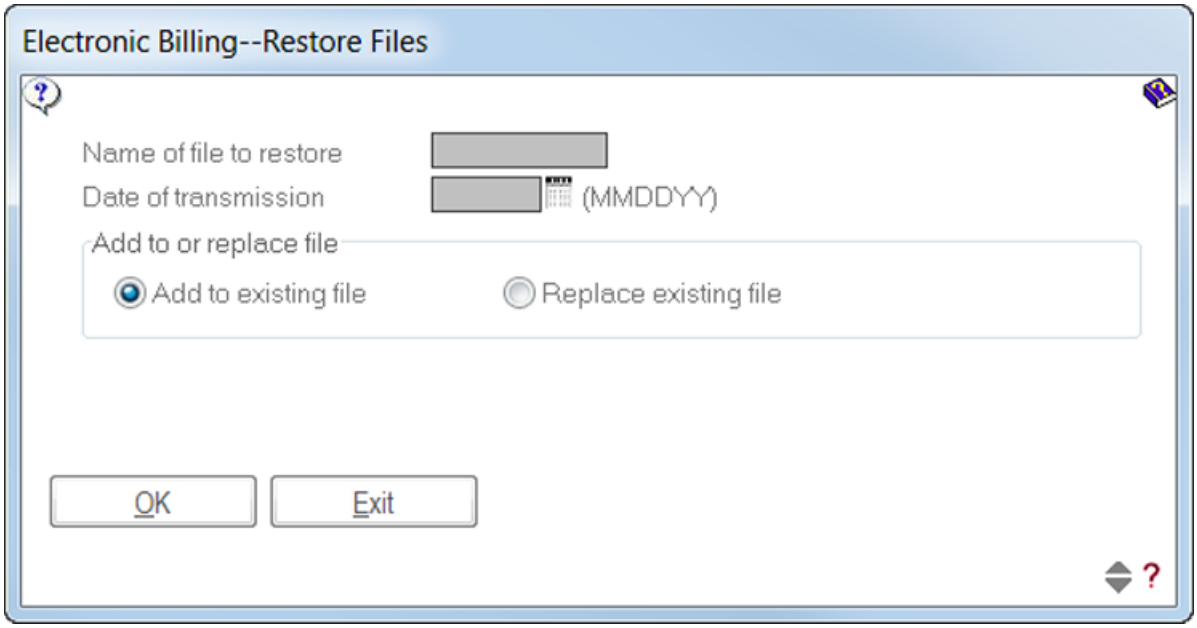
This window appears when you click in the **Intermediary Code Selection** window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

File Restore window

This window appears when you enter an intermediary code in the intermediary code window.



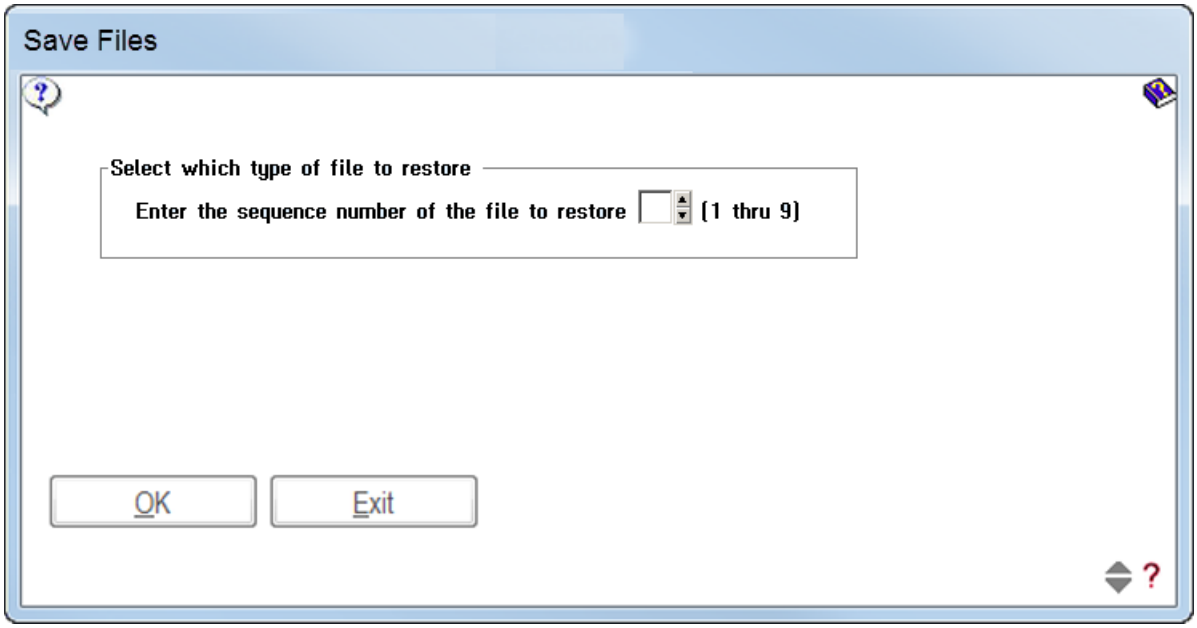
Action

Enter/select information and click **OK**. If more than one file has the name and date you enter, the sequence number window will appear so you can enter the sequence number of the file you want to restore.

Field	Description
Name of file to restore	Type the name of the file you are restoring.
Date of transmission	Enter the date when the file was transmitted. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click to select it.
Add to or replace file	Select (click on) **Add to existing file** to add the restored file to the existing file of the same name; select **Replace existing file** to completely replace the existing file with the restored file.

Sequence number window

This window appears when there is more than one file with the same name and date that you entered in the file restore window. In that case, you must also enter the sequence number of the file you want, in order to distinguish it from the other files.



Action Enter the sequence number (01 through 99) of the file you want to restore, and then click **OK**. You can either type the number or click to increase or decrease the number.

EBMAIN Option 7: EB Patient Maintenance

Overview:

EB Patient Maintenance (*Option 7* on the *Electronic Billing Maintenance Menu*) is used to maintain the UB electronic billing file and the 1500 electronic billing file.

Almost every field in these files can be maintained. Please use caution.

Your facility can use either the 1500 or the 1500-05 form. Which one your facility is using is determined by a setting in the *Patient Accounting 1500 control record, Option 13* on the *System Control Menu*. Maintenance for both is exactly the same.

After updating the electronic billing file through this option, you must run the *Billing Transmission List* to update the transmission file. The list is run through *Create/Print EB Listing, Option 1* on the *Electronic Billing Main Menu*.

This option corrects the current bill only. Corrections must be made through Patient Accounting to avoid any future errors.

TIPS FOR ENTERING INFORMATION

- Grey fields are **required**; white fields are optional.
- In date fields with a calendar icon  next to them, you can either type the date or click  to select it. If you type the date, use mmddyy format (for example, **072504** for July 25, 2004), except for the date of birth, where you should use mmddyyyy format (**07252004** for July 25, 2004).
- In other fields with a search icon  next to them, you can either type the information (e.g., a zip code or CPT code) or click  next to the field, and select the information in the search and selection window that appears.
- In search and selection lists, you can select an item by double-clicking on it or by highlighting it and then clicking **OK**.

Files:

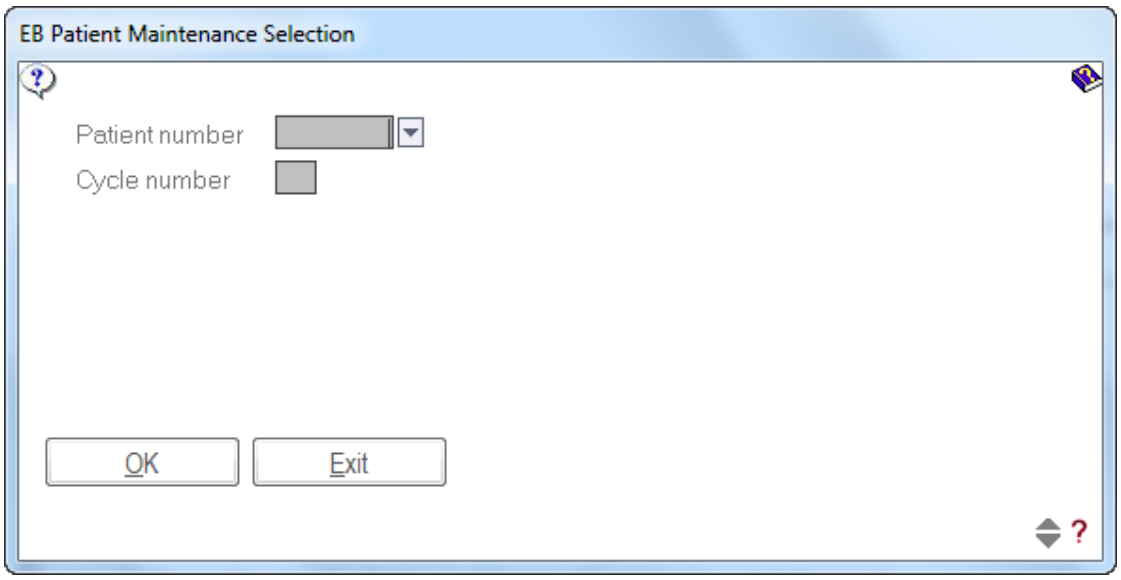
ARMAST, PATIENTS, XNS1500, XNSUB82

IN THIS SECTION

INTRODUCTORY WINDOWS

PATIENT NUMBER/CYCLE NUMBER WINDOW

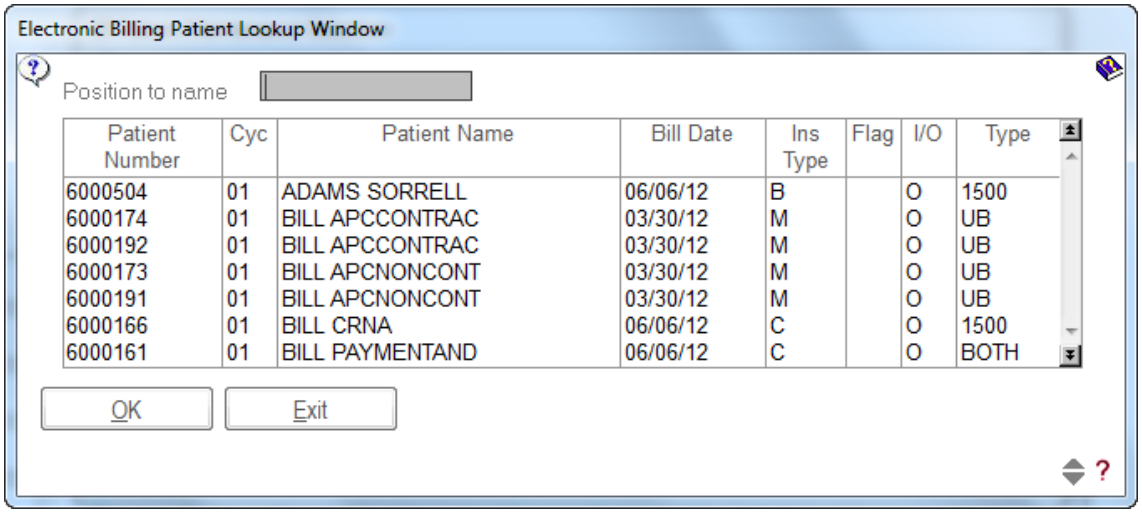
This window appears when you select *EB Patient Maintenance* in the *Electronic Billing Maintenance Menu*.



Action: Enter the patient number and cycle number for the patient you want to maintain, and then click **OK**. You can type both numbers or select them by clicking to display the **Electronic Billing Patient Lookup** window.

ELECTRONIC BILLING PATIENT LOOKUP WINDOW

This window (which has two versions) appears when you click in the **EB Patient Maintenance Selection** window to enter a patient number.



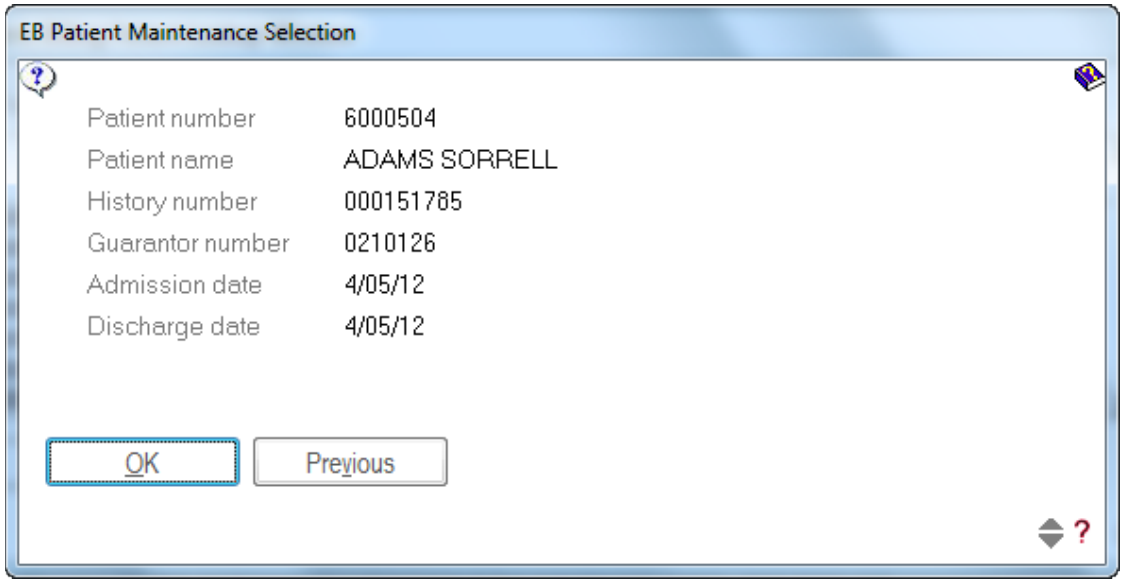
Action:

To find a patient: Type part or all of the patient's last name in the Position to name field and click **OK**.

To select a patient: Click on the patient's name and click **OK**. (You can also just double-click on the patient's name.)

PATIENT VERIFICATION WINDOW

This window appears when you enter a patient number and cycle number in the **EB Patient Maintenance Selection** window or when you select a patient/cycle in the **Electronic Billing Patient Lookup** window.

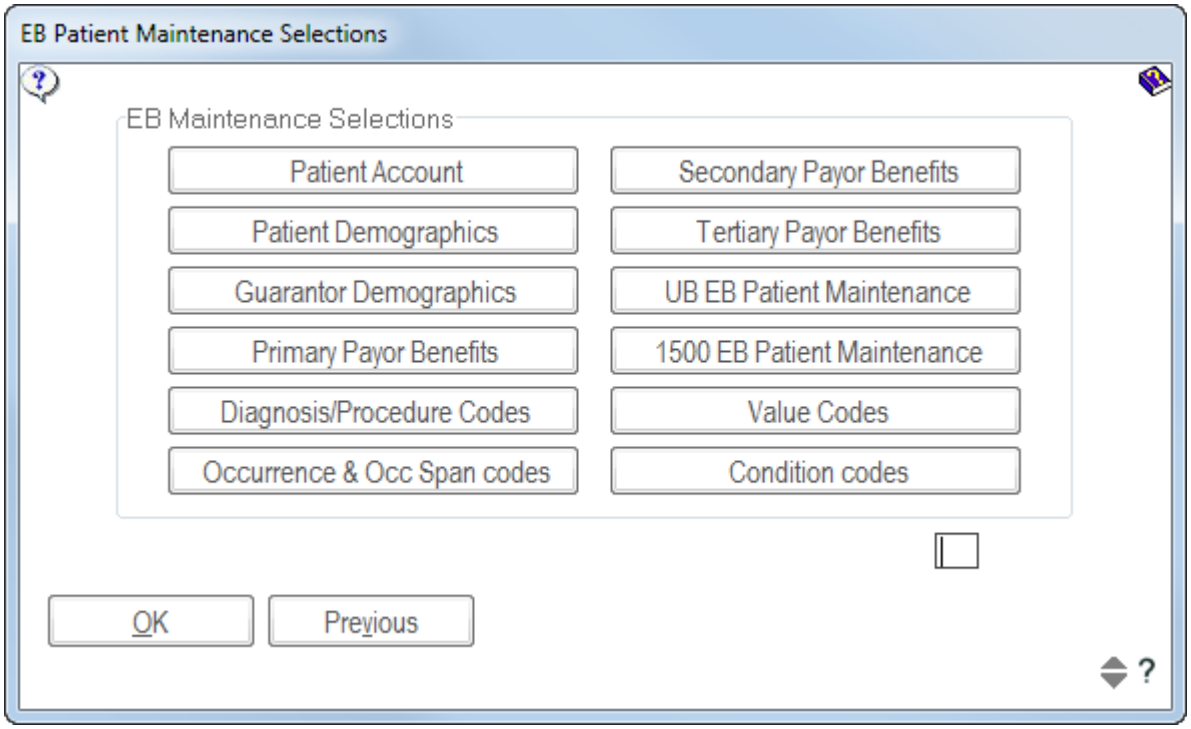


Action Verify that you have the correct patient, then click **OK**. If you do not have the correct patient, click **Previous** so you can enter a different patient/cycle number.

THE MAINTENANCE FUNCTIONS WINDOW

EB PATIENT MAINTENANCE SELECTIONS WINDOW

This window appears when you click **OK** in the **Patient Verification** window.



Action: Click the button for the type of patient information you want to maintain.

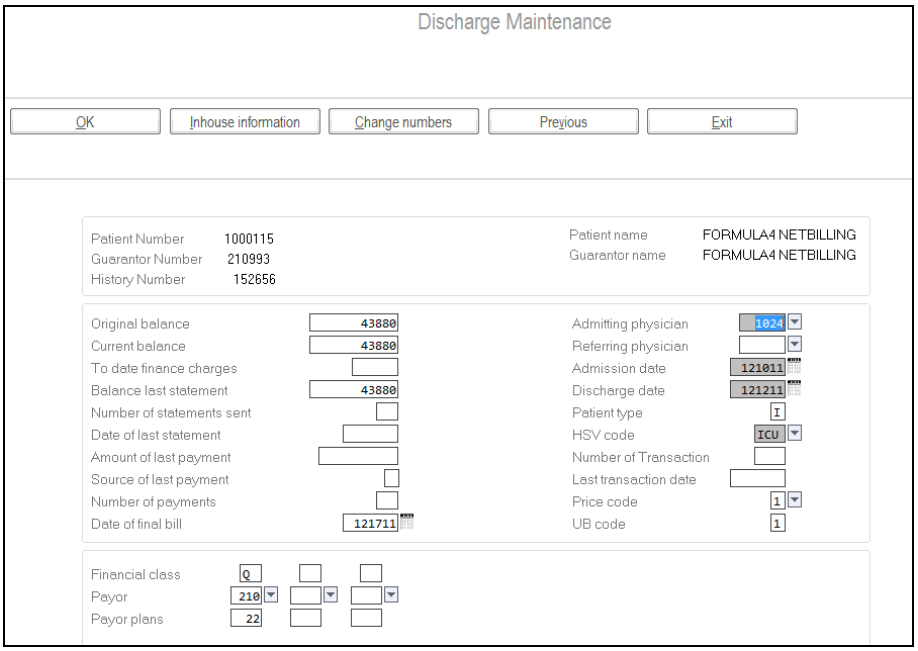
PATIENT ACCOUNT WINDOWS

DISCHARGE MAINTENANCE WINDOW

The **Discharge Maintenance** window lets you maintain information for discharged (final-billed) patients.

This window appears when you select **Patient Account** in the **EB Patient Maintenance Selections** window and the patient has been final billed. Note: If the patient has not been final billed, the **In-House Maintenance** window will open instead of the **Discharge Maintenance** window (refer to the section, "In-House Maintenance Window").

Descriptions of the fields are on the next page.



Action

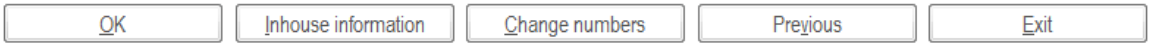
To enter or change discharge information: Make your entries/changes and click **OK**.

To enter or change in-house information: Click **Inhouse information.**

To enter or change history/guarantor number: Click **Change numbers**.

To return to the **EB Patient Maintenance Selections** window without saving any changes, click **Previous** or **Exit.**

Buttons and Function Keys



BUTTON	FUNCTION KEY	DESCRIPTION
OK	Enter	Save and process information in the window and return to the **EB Patient Maintenance Selections** window.
Inhouse Information	F5	View the patient's financial information and maintain some fields.
Change Numbers	F6	View and/or maintain the responses which affect how a patient's information is displayed in the Patient Directory. These responses are initially entered during admission/registration.
Previous	F12	Return to the **EB Patient Maintenance Selections** window without saving or processing any information entered in the window.

Fields

FIELD	DESCRIPTION
General information	**Display only.** The patient's number, name, guarantor number and name, and history number. To change the guarantor or history number, click **Change numbers**.
Account balance information	**Display only.** The patient's account balance information, shown where applicable in dollars and cents (for example, **356350** is $3563.50).
Date of final bill	Enter the date when the patient's final bill was sent. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click to select it.
Admitting physician	**Required.** Enter the admitting physician's number, either by typing it or by clicking next to the field and selecting it in the **Physician Maintenance Lookup** window.

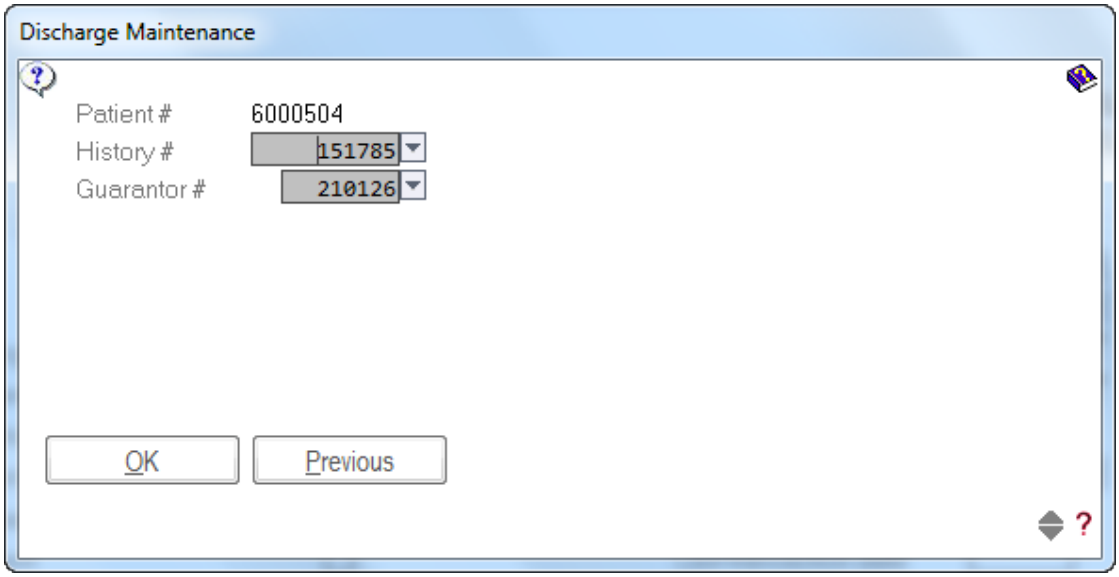
FIELD	DESCRIPTION
Referring physician	Enter the referring physician's number, either by typing it or by clicking next to the field and selecting it in the **Physician Maintenance Lookup** window.
Admission date	**Required.** Enter the date the patient was admitted. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click to select it.
Discharge date	**Required.** Enter the date the patient was discharged. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click to select it.
Patient type	**Display only.** Inpatient (I) or outpatient (O).
HSV code	**Required.** Enter the patient's HSV code, either by typing it or by clicking next to the field and selecting it in the HSV code selection window.
Number of Transaction	Enter the number of transactions that have occurred.
Last transaction date	**Display only.** The date of the last transaction, in mmddyy format (for example, **072504** for July 25, 2004).
Price code	Enter a price code, either by typing it or by clicking next to the field and selecting it in the **Price Code Selection** window.
UB code	Type the UB code.
Payor	For each financial class (E, S, and B), enter the payor code, either by typing it or by clicking next to the field and selecting it in the **Payor Company/Plan Alpha Search** window.
Payor plans	For each financial class (E, S, and B), enter the payor plan number. If you selected (rather than typed) the payor code, this number will be entered automatically.

CHANGE NUMBERS

HISTORY NUMBER/GUARANTOR NUMBER WINDOW #1

The **History # / Guarantor #** window lets you change the patient's history number and/or guarantor number.

This window appears when you click **Change numbers** in the main **Discharge Maintenance** window.



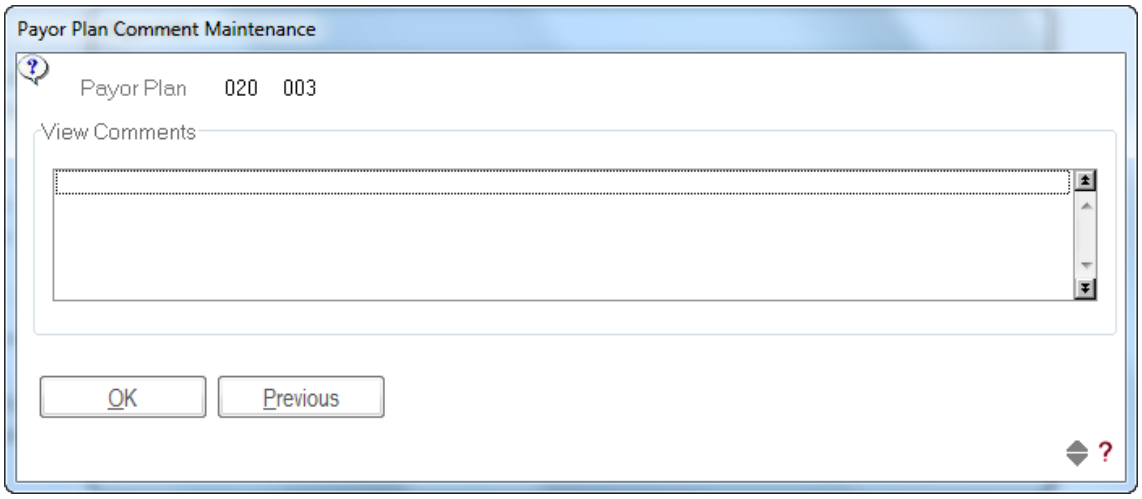
Action

Change one or both numbers, and then click **OK** to save the entries and return to the **EB Patient Maintenance Selections** window.

To return to the main **Discharge Maintenance** window without saving any changes, click **Previous** or **Exit.**

PAYOR PLAN COMMENT MAINTENANCE WINDOW

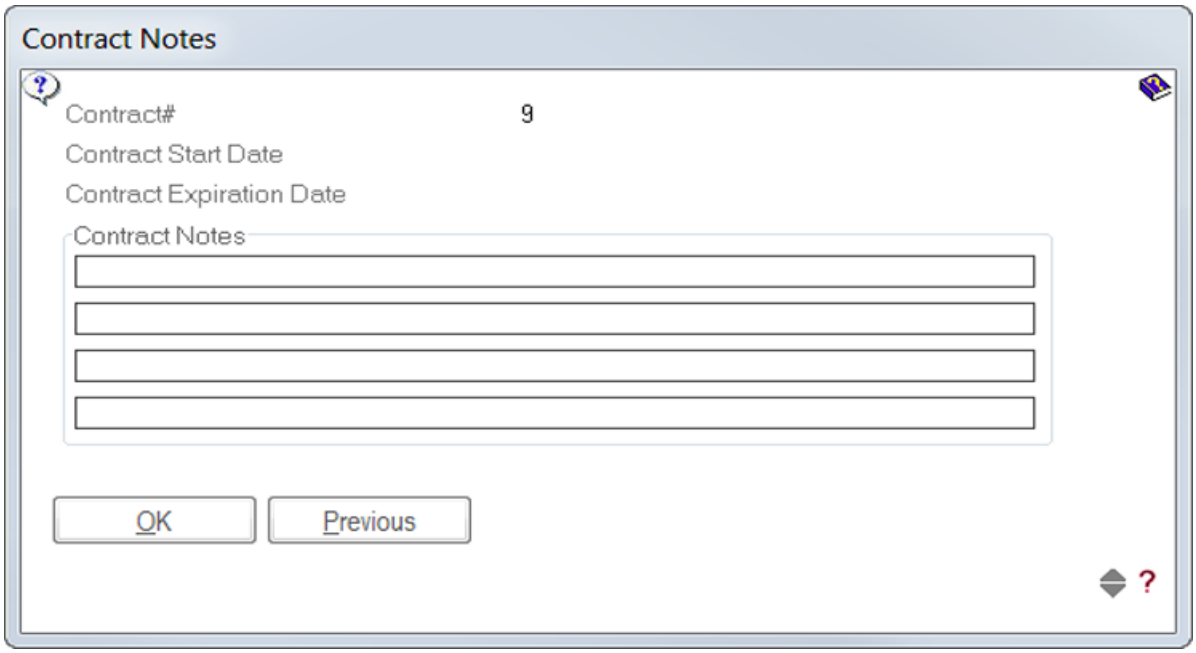
This window appears when you click **Display Comments** in the **Payor Company/Plan Alpha Search** window.



Action When you are through viewing comments, click **OK** or **Previous** to return to the previous window.

CONTRACT NOTES WINDOW

This window appears when you select a contract in the **Contract Selection** window.



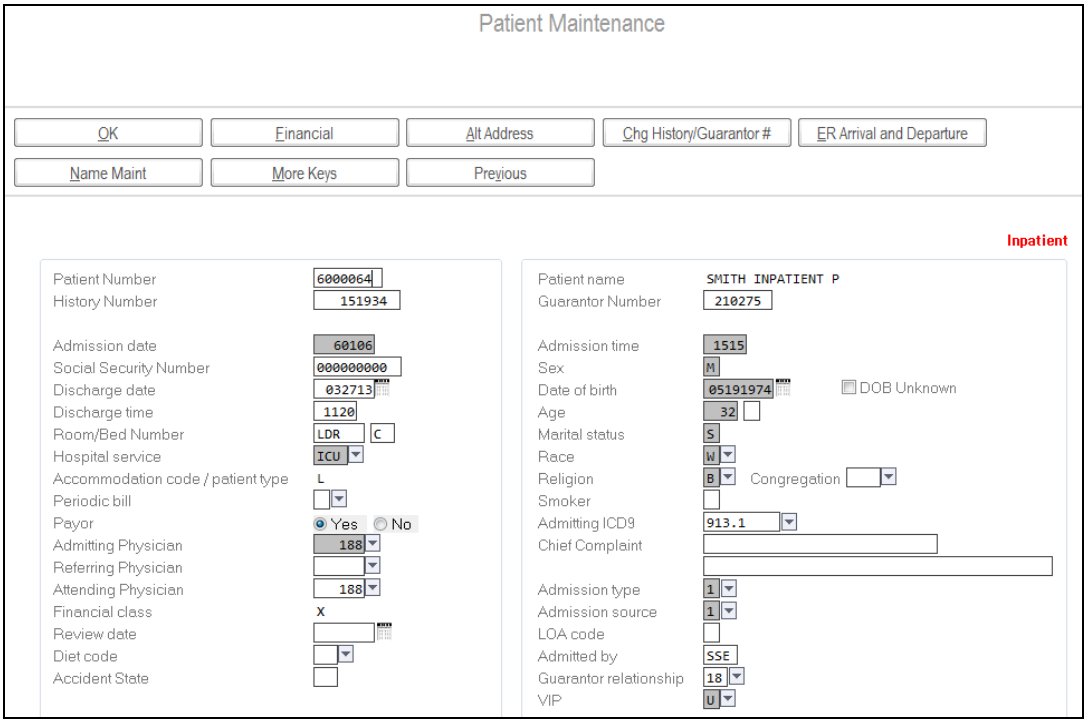
Action When you are through viewing contract notes, click **OK** or **Previous** to return to the **Payor Company/Plan Alpha Search** window.

IN-HOUSE PATIENT MAINTENANCE WINDOW

The "In-House" **Patient Maintenance** window lets you maintain information for current (in-house) patients. You can change admissions information in this window until the patient has been final-billed.

NOTE: If the Patient's History Information supplies a code that has since been deactivated and it is not changed, before allowing the user to move to the next screen a soft warning will appear that the code should be updated if possible. For a new patient, an error message will appear if an invalid code is entered.

This window appears when you click **Patient Account** in the **EB Patient Maintenance Selections** window and the patient has not been final billed. A similar window will open when you click **Inhouse information** in the **Discharge Maintenance** window (refer to the section, "Discharge Maintenance Window").



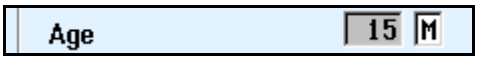
Action Make your entries/changes and click **OK**, or click one of the buttons at the top of the window.

Buttons and Function Keys

BUTTON	FUNCTION KEY	DESCRIPTION
OK	Enter	Save and process information in the window and return to the **EB Patient Maintenance Selections** window.
Financial	F5	View the patient's financial information and maintain some fields.
Directory Responses	F6	View and/or maintain the responses which affect how a patient's information is displayed in the Patient Directory. These responses are initially entered during admission/registration.
Obs Mnt	F7	View and/or maintain the observation admit date/time and discharge date/time. **Note:** This button only appears if the patient has an observation hospital service code.
Alt Address	F8	Enter an alternate patient address.
Chg History / Guarantor #	F11	Change the patient's history number or guarantor number.
ER Arrival and Departure	F13	Allows maintenance of ER Admit Date and Time for inpatients with Admission Type 1 = Emergency. The ER Admit Date/Time information may be used to identify patient records for state reporting (i.e., Florida). **Note:** This button is only present for patients with Admission Type 1 = Emergency.
Name Maint	F16	Displays a window to allow entry / maintenance of patient's full name with Prefix and Suffix.
Previous	F12	Return to the **EB Patient Maintenance Selections** window without saving or processing any information entered in the window.

Field Descriptions

FIELD	DESCRIPTION
Patient Number	**Display only.** The patient's account number for this admission. The account number will be different each time the patient is admitted. The system may be set up to automatically assign this number. UB Locater 3. For more information, see ***System Control Maintenance*** in the ***Patient Accounting System Manager's Guide***.
Patient name	**Required.** Type the patient's name, putting the last name first, with spaces separating the last name, first name, and middle initial. UB Locator 12.
History Number	**Display only.** The patient's history number. The system may be set up to automatically assign this number. For more information, see ***System Control Maintenance*** in the ***Patient Accounting System Manager's Guide***.
Guarantor Number	**Display only.** The guarantor's number. The system may be set up to automatically assign this number. For more information, see ***System Control Maintenance*** in the ***Patient Accounting System Manager's Guide***.
Admission date	**Required.** Type the date the patient was admitted, using mmddyy format (for example, **072504** for July 25, 2004. UB Locator 17.
Admission time	**Required.** Type the time the patient was admitted, using hhmm 24-hour format (for example, **1935** for 7:35 p.m.). UB Locator 18.
Social Security Number	Type the patient's Social Security Number, using digits only, without any slashes or hyphens. For more information about this field, refer to the ***Patient Accounting User's Manual*** and the section on ***Admission Menu, Option 2: Admission***.
Sex	**Required.** Type the patient's sex (**M** for male, **F** for female, or **U** for unknown). UB Locator 15.
Discharge date	Enter the date the patient was discharged. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click  to select it.
Date of birth	**Required.** Enter the date the patient was born. You can either type the date in mmddyyyy format (for example, **07252004** for July 25, 2004) or click  to select it. UB Locator 14.
DOB Unknown	The patient's **Date of Birth** must be entered. However, if this is unknown, select the **DOB Unknown** checkbox.

FIELD	DESCRIPTION
Discharge time	**Required.** Enter the time the patient was discharged, using hhmm 24-hour format (for example, **1935** for 7:35 p.m.).
Age	**Required.** Type the patient's age in years, months, or days; or leave the field blank and let the system calculate the age based on the date of birth. If you typed the patient's age in months or days, also type **M** or **D** in the field to the right of the Age field to indicate that the age is not in years. If you typed the age in years, leave the field blank. For example, this entry indicates an age of 15 *years*:  This entry indicates an age of 15 *months*: 
Room/Bed Number	Enter the room and bed number assigned to the patient. This field is **display only** for in-patients. Rooms and beds are maintained in *Patient Accounting* through *Room/Bed File, Option 13* on *File Maintenance Menu I* (MNTMN1), and can be listed/printed in *Patient Accounting* through *List Room and Bed File, Option 4* on *File Listing Menu I* (MNTMN2).
Marital status	**Required.** Type the code for the patient's marital status. Valid codes are: D Divorced M Married P Life partner S Single U Unknown W Widowed X Legally separated UB Locator 16.
Hospital service	**Required.** Enter the patient's hospital service (HSV) code, either by typing it or by clicking next to the field and selecting it in the **HSV code selection** window. Codes are maintained in *Patient Accounting* through *Hospital Service Code File, Option 19* on *File Maintenance Menu I* (MNTMN1), and can be listed/printed in *Patient Accounting* through *List Table File, Option 13* on *File Listing Menu I* (MNTMN2).

FIELD	DESCRIPTION
Race	**Required.** Enter the patient's race, either by typing the code or by clicking next to the field and selecting it in the **Race Code Selection** window. Up to 6 codes may be selected. Only the 1st race code will be shown. See "Race Code Selection" section for more information. ***NOTE**: Inactive codes are not available for selection or accepted via manual entry.
Accommodation code/patient type	**Display only.** The type of accommodations the patient will have during this admission. This code will be used to determine the room charge for the patient. Codes are maintained in *Patient Accounting* through *Accommodation Codes, Option 1* on the *System Table (Hospital Table File) Menu* (TABMNU), and can be listed/printed in Patient Accounting through *List Table File, Option 13* on *File Listing Menu I* (MNTMN2).
Religion	**Required.** Enter the code for the patient's religion, either by typing the code or by clicking next to the field and selecting it in the **System Table File Lookup** window. You can also leave this field blank and enter the patient's congregation in the Congregation field; the religion will then be entered automatically. Codes are maintained in *Patient Accounting* through *Religion Codes, Option 3* on the *System Table (Hospital Table File) Menu* (TABMNU), and can be listed/printed in *Patient Accounting* through *List Table File, Option 13* on *File Listing Menu I* (MNTMN2).
Congregation	Enter the patient's congregation, either by typing the code or by clicking next to the field and selecting it in the **Congregation Alpha Search** window. The congregation must be associated with the religion. Codes are maintained in *Patient Accounting* through *Congregation Maintenance, Option 17* on the *System Table (Hospital Table File) Menu* (TABMNU), and can be listed/printed in *Patient Accounting* through *List Congregation File, Option 5* on *File Listing Menu II* (MNTMN4).
Periodic bill	If the patient is to be billed regularly, enter the bill period (such as monthly), either by typing the code or by clicking next to the field and selecting it in the **System Table File Lookup** window. Codes are maintained in *Patient Accounting* through *Periodic Billing Codes, Option 11* on the *System Table*

FIELD	DESCRIPTION
	(Hospital Table File) Menu (TABMNU), and can be listed/printed in *Patient Accounting* through *List Table File, Option 13* on *File Listing Menu I (MNTMN2)*.
Smoker	Type **Y** if the patient smokes or **N** if he or she does not.
Payor	**Required.** Click **Yes** if the patient is the payor; click **No** if someone else is the payor.
Admitting ICD10	Enter the ICD10 code that describes the patient's admitting diagnosis, either by typing the code or by clicking next to the field and selecting it in the **ICD10 Diagnosis Code Selection** window. If you type it, make sure you enter the decimal point in the correct position. If you select it, the admitting diagnosis will be entered in its field automatically. UB Locator 67. Codes are maintained in *Patient Accounting* through *ICD10-CM Codes File*, *Option 7* on *File Maintenance Menu I* (MNTMN1), and can be listed/printed in *Patient Accounting* through *ICD10-CM Codes Listing, Option 14* on *File Listing Menu II* (MNTMN4).
Admitting Physician	**Required.** Enter the admitting physician's number, either by typing it or by clicking next to the field and selecting it in the **Physician Maintenance Lookup** window. Numbers are maintained in *Patient Accounting* through *Physician File, Option 16* on *File Maintenance Menu I* (MNTMN1), and can be listed/printed in *Patient Accounting* through *List Doctor Master File, Option 11* on *File Listing Menu I* (MNTMN2).
Admitting diagnosis	Type a description of the admitting diagnosis for the patient. If you leave this field blank and select an admitting ICD10 code, the diagnosis description will be entered here automatically.
Referring Physician	Enter the referring physician's number, either by typing it or by clicking next to the field and selecting it in the **Physician Maintenance Lookup** window. This is any physician, other than the admitting physician, who referred the patient to the hospital. For maintenance, see **Admitting Physician** on the previous page.
Attending Physician	Enter the primary attending physician's number, either by typing it or by clicking next to the field and selecting it in the **Physician Maintenance Lookup** window. For maintenance, see the description for **Admitting Physician** in an earlier cell.

FIELD	DESCRIPTION
Admission source	**Required.** Type the code that identifies the source of the admission. Valid codes are: 1 - Non-healthcare facility 2 - Clinic or Physician's Ofc 3 - Hmo Referral 4 - Transfer from a hospital 5 - Trnfr from a SNF or ICF 6 - Trnfr frm Hlth Care Fclty 7 - Emergency Room 8 - Court/Law Enforcement 9 - Info not available A - Tfr from Critical Acc HSP B - Trnfr from another HHA C - Readmission to same HHA D - Transf frm distinct unit If patient is a Newborn (the answer for the Admission Type is 4), the valid codes for Admission Source are: A - Trnfr from Crtcl Acc Hosp 1 - Normal Delivery 2 - Premature Delivery 3 - Sick Baby 4 - Extramural birth 5 - Born inside this hospital 6 - Born outside this hospital 9 - Unknown UB Locator 20.
Financial class	**Display only.** The code assigned to the patient based on his or her financial status. For example, all Medicare patients are assigned the Medicare financial class. This code will be used to determine billing and collection criteria, as well as to track statistical information. Codes are maintained in *Patient Accounting* through *Financial Class File, Option 14* on *File Maintenance Menu I* (MNTMN1), and can be listed/printed in *Patient Accounting* through *List Financial Class Code File, Option 17* on *File Listing Menu I* (MNTMN2). For more information about this field, refer to the ***Patient Accounting User's Manual*** and the section on ***Admission, Option 2*** on the ***Admission Menu***.

FIELD	DESCRIPTION
Admission type	**Required.** Type the code that identifies the priority of the admission. Valid codes are: 1 - Emergency 2 - Urgent 3 - Elective 4 - Newborn 5 - Trauma center 7/8 - Reserved for national assignment 9 - Information not available (unknown) UB Locator 19.
Review date	Enter the date on which the hospital should review the patient's account. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click to select it.
LOA code	Type the patient's leave-of-absence code for the reason the patient temporarily left the facility (for example, to go home for a visit from a rehab facility or go to another hospital for tests). Codes are maintained in *Patient Accounting* through *Leave of Absence Codes*, *Option 6* on the *System Table (Hospital Table File) Menu* (TABMNU).
Admitted by	Type the initials of the system user who entered the admitting information into the system.
Diet code	Enter the code for any special diet the patient has, either by typing the code or by clicking next to the field and selecting it in the **System Table File Lookup** window. Codes are maintained in *Patient Accounting* through *Diet Codes*, *Option 2* on *System Table* (*Hospital Table File*) *Menu* (TABMNU), and can be listed/printed in *Patient Accounting* through *List Table File, Option 13* on *File Listing Menu I* (MNTMN2).
Guarantor relationship	Enter the code that describes the guarantor's relationship to the patient, either by typing the code or by clicking next to the field and selecting it in the **System Table File Lookup** window. Codes are maintained in *Patient Accounting* through *Relationship Codes*, *Option 14* on *System Table (Hospital Table File) Menu* (TABMNU), and can be listed/printed in *Patient Accounting* through *List Table File*, *Option 13* on *File Listing Menu I* (MNTMN2).
Accident state	If the patient is being admitted because of an accident, type the two-letter abbreviation for the state where the accident occurred (such as CA for California or TN for Tennessee).

FIELD	DESCRIPTION
VIP	**Required.** Enter the VIP (very important person) code, either by typing the code or by clicking next to the field and selecting it in the **VIP Master Lookup** window. These codes specify the patient's VIP status as, for example, a senior citizen or a person who merits special treatment. Codes are maintained in *Patient Accounting* through *VIP Code Maintenance, Option 19* on the *System Table (Hospital Table File) Menu* (TABMNU), and can be listed/printed in *Patient Accounting* through *List VIP Codes, Option 9* on *File Listing Menu II* (MNTMN4).

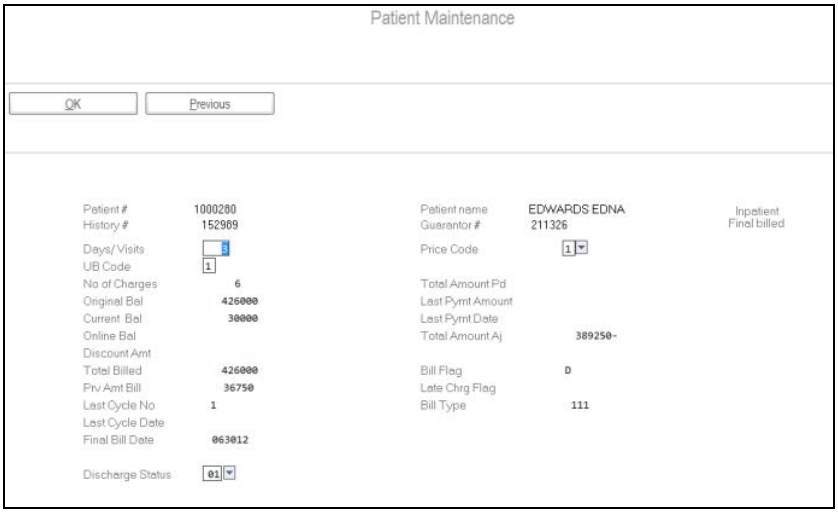
FINANCIAL INFORMATION WINDOW

The **Financial Information** window lets you view the patient's financial information on file in the system. All but four fields are display only (cannot be changed). The four fields you can change are Days/Visits, Price Code, UB Code, and Discharge Status.

The Acuity Level field appears only if both of the following conditions are met:

1. The **Charge by Acuity** field is answered **Y** in the *Billing Control Record, Option 2* on the *System Control Menu* in *Patient Accounting*.
2. AND, either
   a. The patient is an inpatient who has not been final-billed, OR
   b. The patient is an outpatient with a patient type of observation, and a room and bed is assigned.

This window appears when you click **Financial** in the **In-House Maintenance** window.



Action

Make any necessary changes to the fields you can maintain (see above) and click **OK** to save the changes and return to the **EB Patient Maintenance Selections** window.

For the Price Code and Discharge Status fields, you can click next to the field, then select the code or status from the window that appears.

To return to the **In-House Maintenance** window without saving any changes, click **Previous**.

PATIENT DIRECTORY RESPONSES WINDOW

The **Patient Directory Responses** window lets you change the responses which affect how a patient's information is displayed in the Patient Directory. These responses are initially entered during admission/registration.

This window appears when you click the More Keys button on the **In-House Maintenance** window then, the Financial button. **Note:** if Social Security number is missing, the Missing Social Security Code window will display. Select an answer; click **OK** and the Patient Directory Response window displays.

Action

To display the information in the Patient Directory, select **Yes**.

To hide it, select **No**.

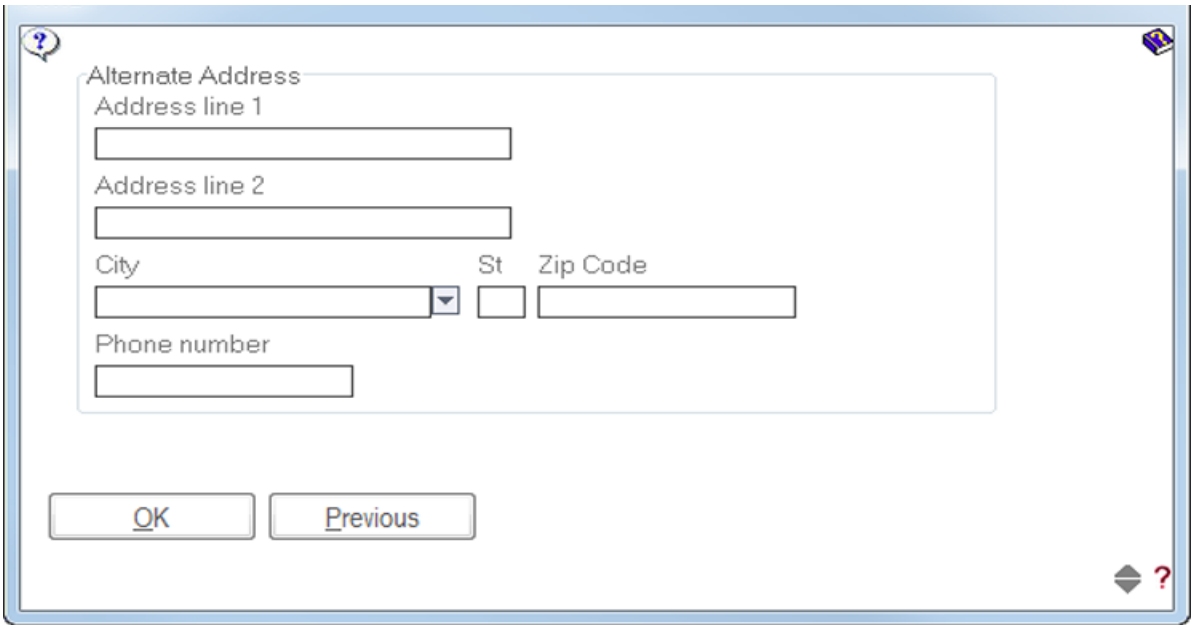
To save the changes and return to the **EB Patient Maintenance Selections** window, click **OK**.

To return to the **In-House Maintenance** window without saving any changes, click **Previous.**

ALTERNATE ADDRESS WINDOW

The alternate address window lets you enter an alternate address for the patient.

This window appears when you click **Alt Address** in the **In-House Maintenance** window.



Action

Enter the address information, and then click **OK** to save the entries and return to the **In-House Maintenance** window.

To return to the previous window without saving any entries, click **Previous**.

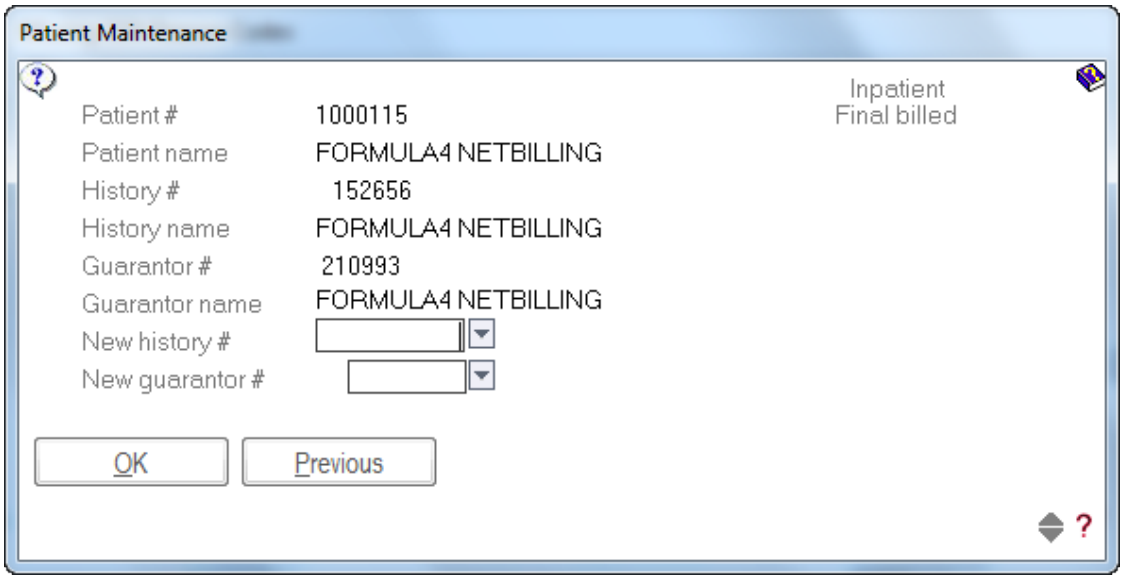
To enter the city, state, and zip code, you can click next to the City field, then select the information in the **Zip Code Selection** window that appears.

CHANGE HISTORY/GUARANTOR

HISTORY NUMBER/GUARANTOR NUMBER WINDOW #2

The **Patient Maintenance–Change Patient Numbers** window lets you change the patient's history number and/or guarantor number.

This window appears when you click **Chg History/Guarantor #** in the **In-House Maintenance** window.

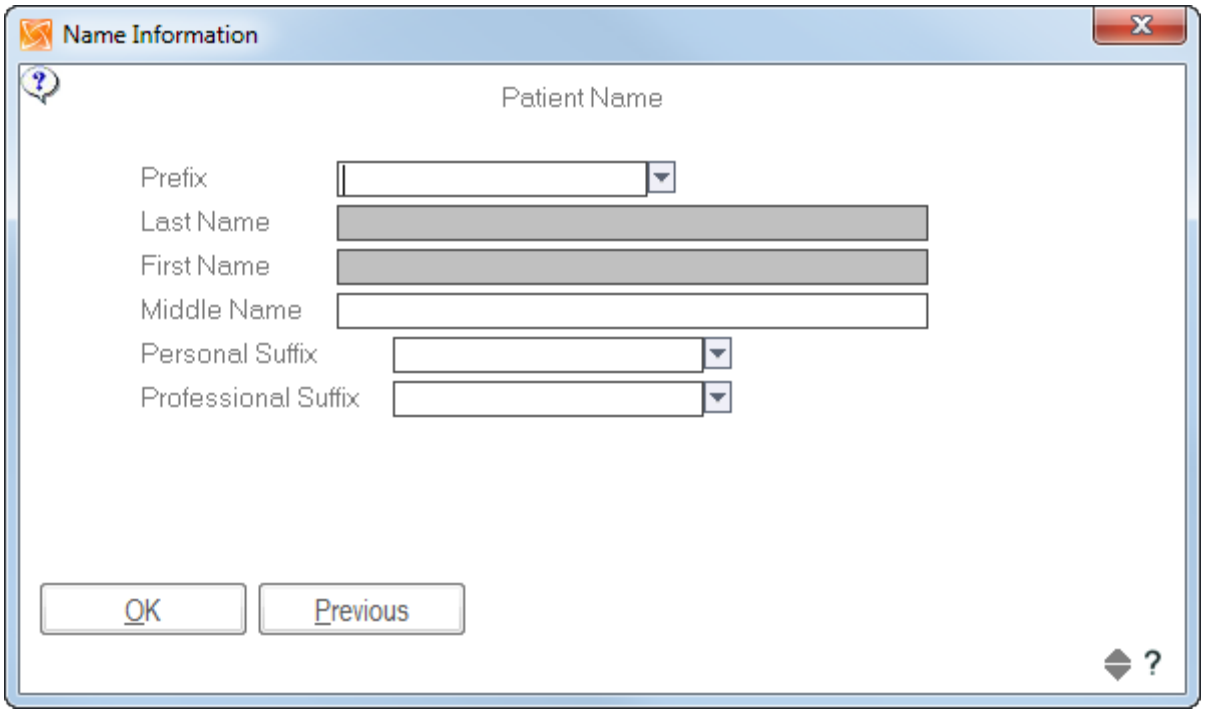


Action

Enter one or both new numbers, and then click **OK** to save the entries and return to the **EB Patient Maintenance Selections** window.

To return to the **In-House Maintenance** window without saving any entries, click **Previous**.

NAME MAINTENANCE

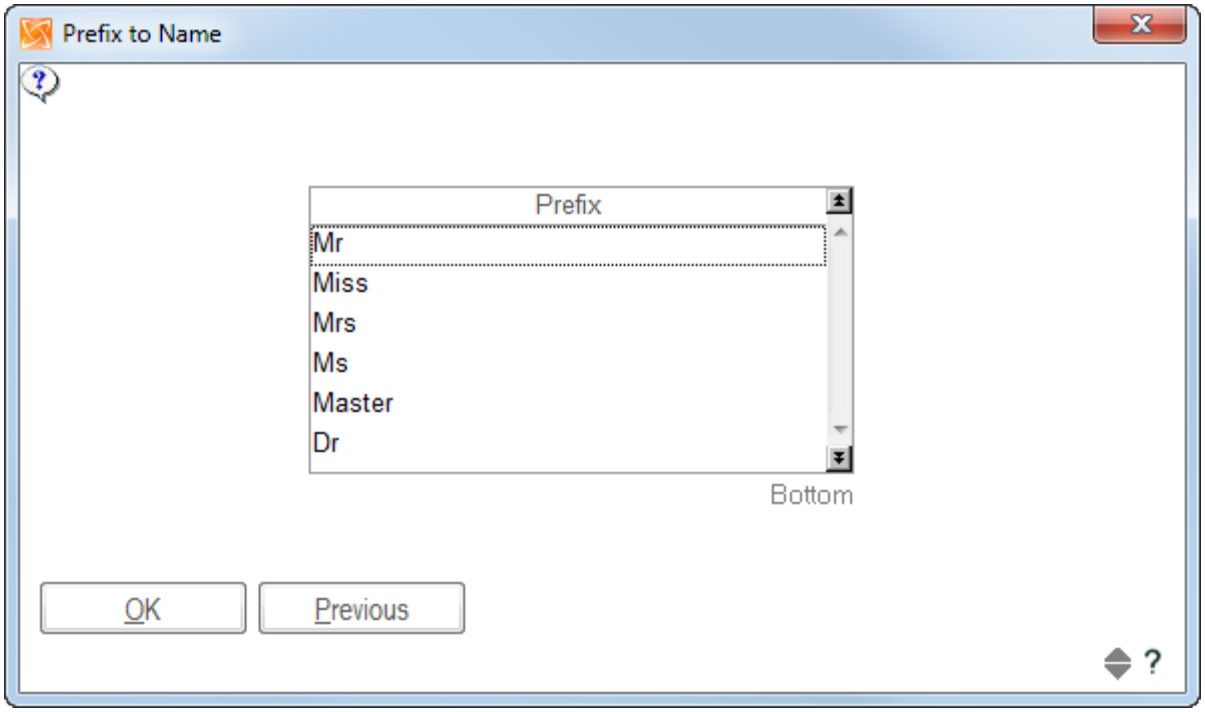


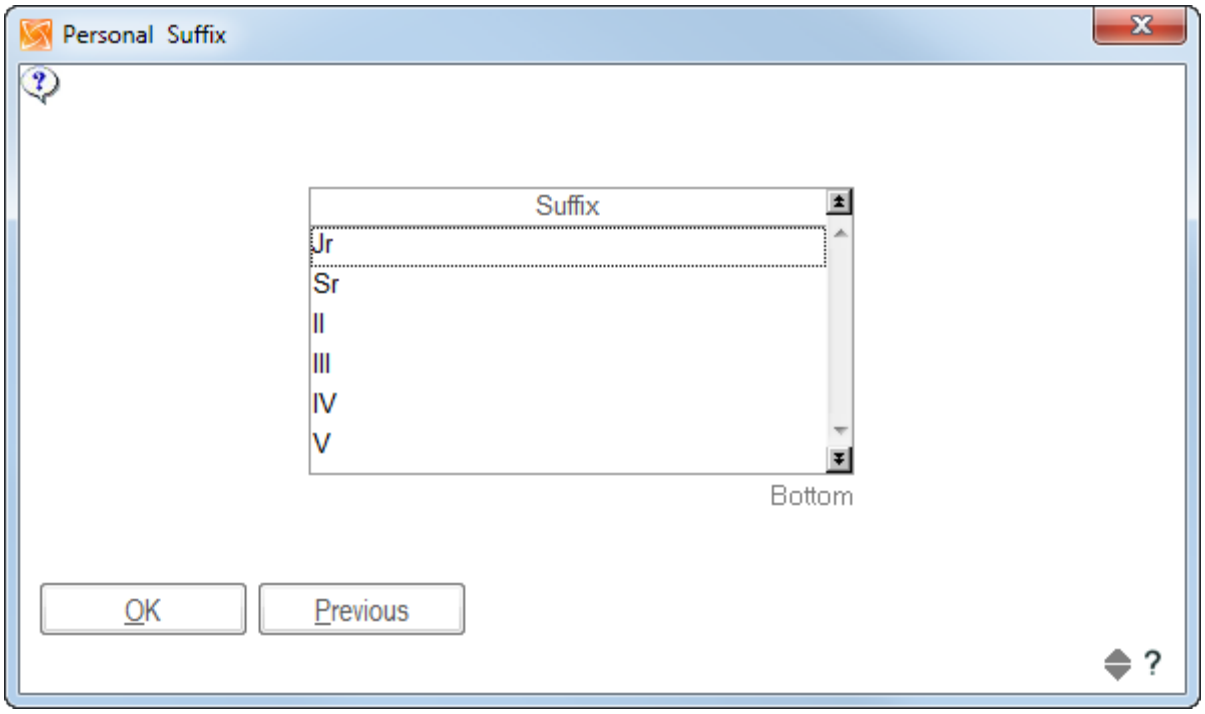
This window displays when **Name Maint** (F16) is clicked from the **Patient Maintenance** window.

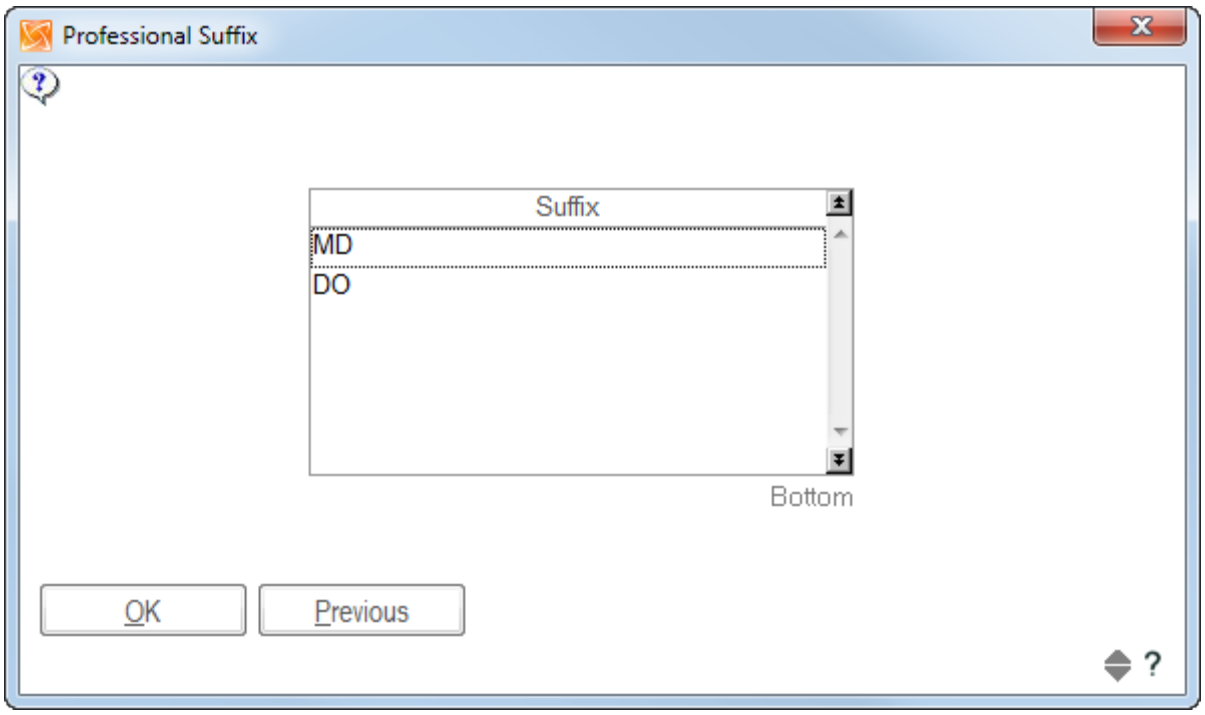
Action

To select a Prefix, Personal Suffix, and/or Profession Suffix, click .
To save and return to the **Patient Maintenance** window, click **OK**.
To return without saving, click **Previous**.

PREFIX, PERSONAL SUFFIX, AND/OR PROFESSION SUFFIX WINDOWS







Action

To select a Prefix, Personal Suffix, and/or Profession Suffix, highlight it and click **OK**. To return, click **Previous**.

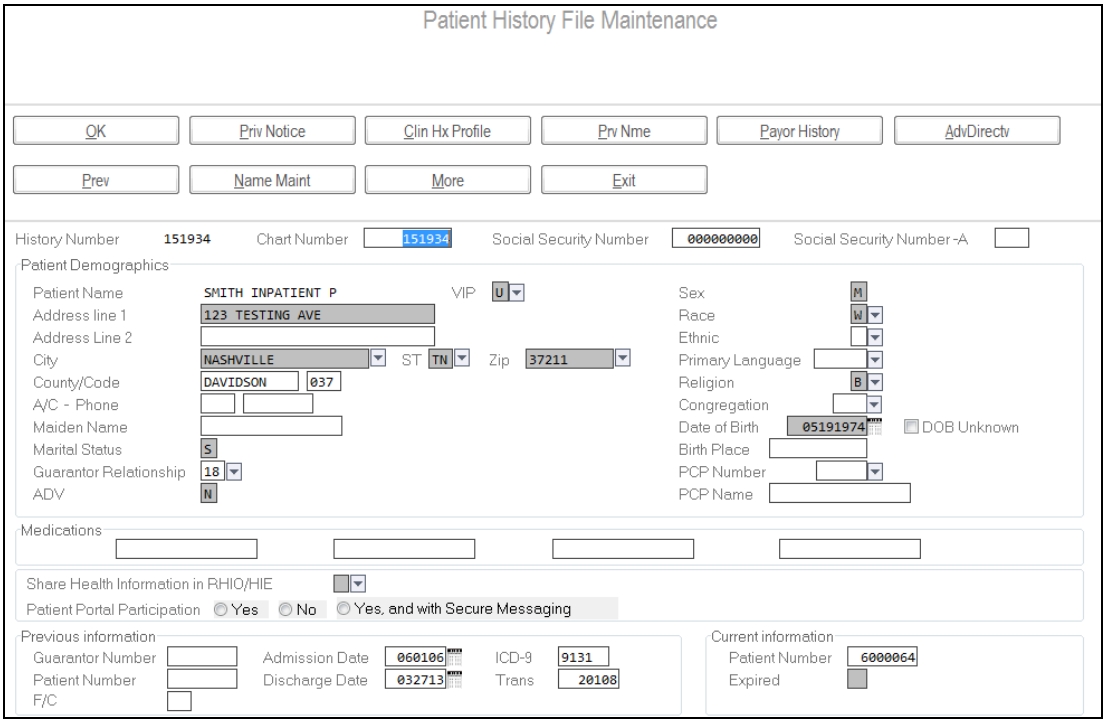
PATIENT DEMOGRAPHICS WINDOWS

PATIENT HISTORY FILE MAINTENANCE WINDOW

The **Patient History File Maintenance** window lets you maintain demographic information for the patient, such as address, marital status, date of birth, allergies, and much more.

NOTE: If the Patient's History Information supplies a code that has since been deactivated and it is not changed, before allowing the user to move to the next screen a soft warning will appear that the code should be updated if possible. For a new patient, an error message will appear if an invalid code is entered.

This window appears when you select **Patient Demographics** in the **EB Patient Maintenance Selections** window.



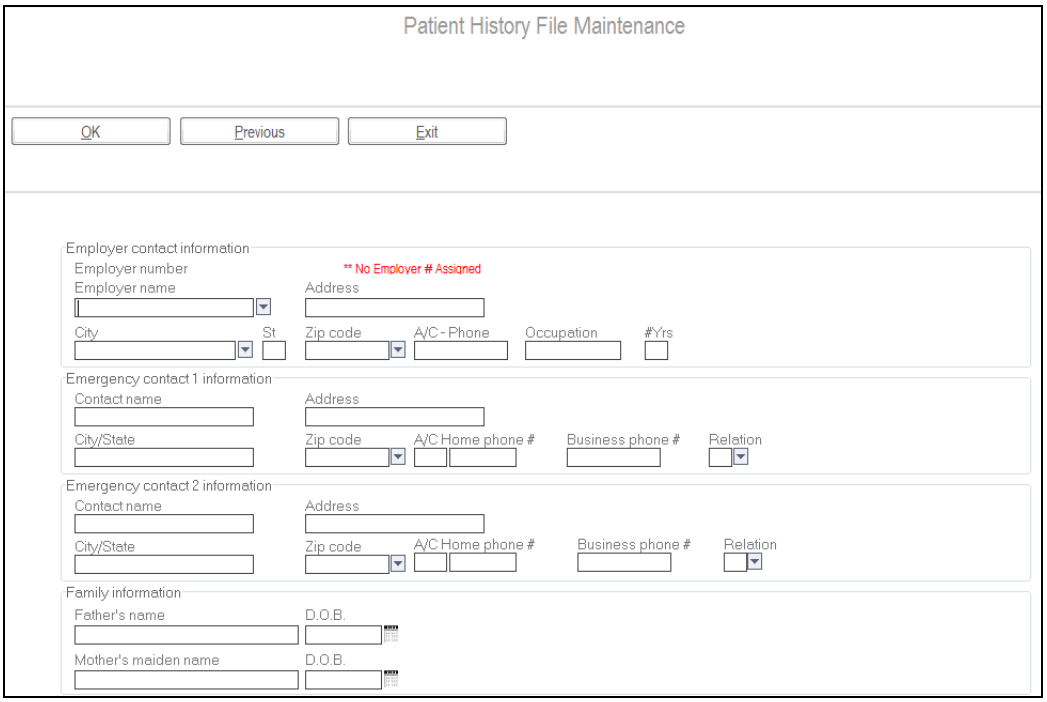
Action Make your entries/changes and click **OK**, or click one of the buttons at the top of the window.

Buttons and Function Keys

BUTTON	FUNCTION KEY	DESCRIPTION
OK	Enter	Save and process information in the window and display the contact information window.
Priv Notice	F5	View and maintain patient privacy notice information.
Clin Hx Profile	F6	View and maintain the patient's clinical history profile, which comprises universal patient data across multiple applications.
Chart#	F7	Add, edit, and delete chart numbers by site location.
Prv Nme	F8	Enter, change, or delete the patient's previous names, such as nicknames, aliases, or maiden names.
Not shown above	F9	Enter travel directions and hazard notes. Directions are to help the clinician find the patient's home; notes are to alert the clinician to anything significant. **Note:** This button only appears for Home Health patients.
Payor Hist	F10	View and maintain the patient's payor history.
AdvDirectv	F11	Assign advance directives to a patient, delete directives from a patient, and/or change the assigned date
Delete	F23	Delete the patient history information. You will need to confirm the deletion in the window that appears.
Previous	F12	Return to the **EB Patient Maintenance Selections** window without saving or processing any information entered in the window.
Name Maint	F16	Displays a window to allow entry / maintenance of patient's full name with Prefix and Suffix.
Exit	F3	Return to the **EB Patient Maintenance Selections** window without saving or processing any information entered in the window.

CONTACT INFORMATION WINDOW

This window appears when you click **OK** in the **Patient History File Maintenance** window.



Action

Make your entries/selections and click **OK** to save them and return to the **EB Patient Maintenance Selections** window.

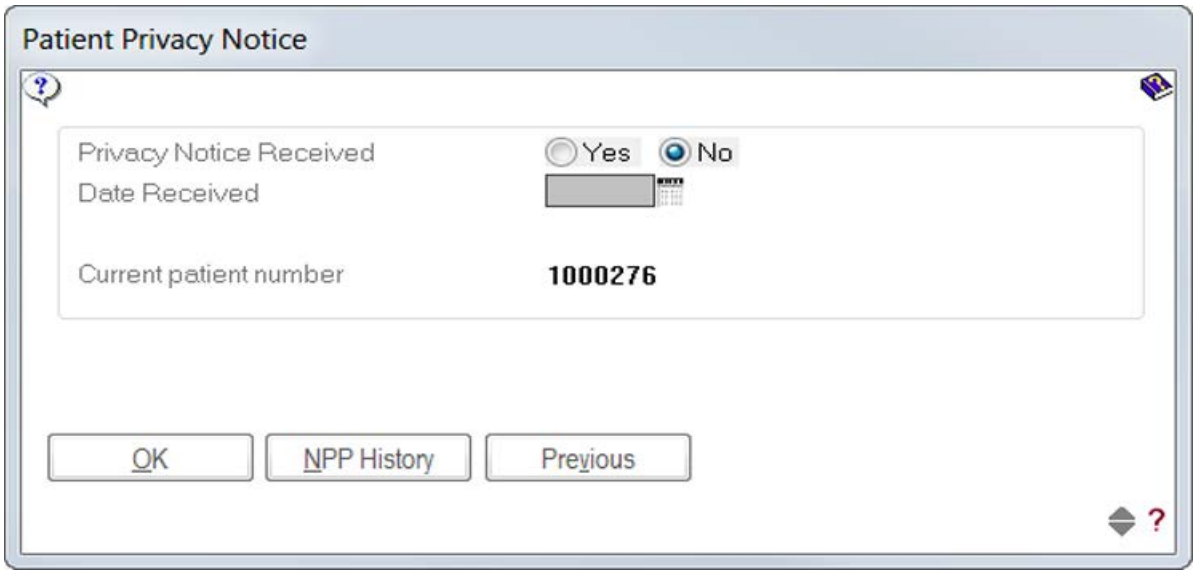
To return to the Patient History File Maintenance window without saving any changes: Click **Previous**.

To return to the **EB Patient Maintenance Selections** window without saving any changes: Click **Exit**.

PATIENT PRIVACY NOTICE WINDOW

This window appears when you click **Priv Notice** in the **Patient History File Maintenance** window.

Both fields are **required**.



Action

Make your entries/selections and click **OK** to save them and return to the **Patient History File Maintenance** window.

To return to the previous window without saving any changes: Click **Previous**.

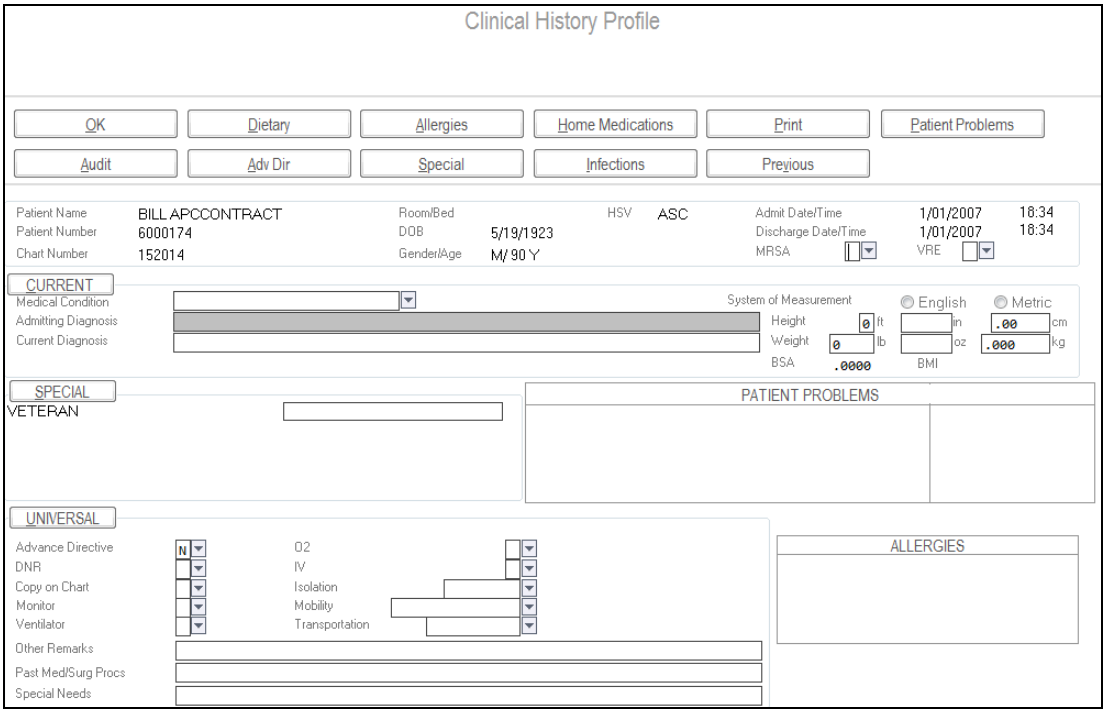
FIELD	DESCRIPTION
Privacy Notice Received	Select (click on) **Yes** if the hospital has received a privacy notice; select **No** if it has not.
Date Received	Enter the date the notice was received. You can either type the date in mmddyy format (for example, **072504** for July 25, 2004) or click to select it.

CLINICAL HISTORY PROFILE WINDOW

The **Clinical History Profile** window lets you maintain universal patient data across multiple applications. For more information, refer to ***Clinical History Profile*** in the ***Patient Care User's Manual***.

This window appears when you click **Clin Hx Profile** in the **Patient Demographics** window.

Button and function key descriptions are on the next page.



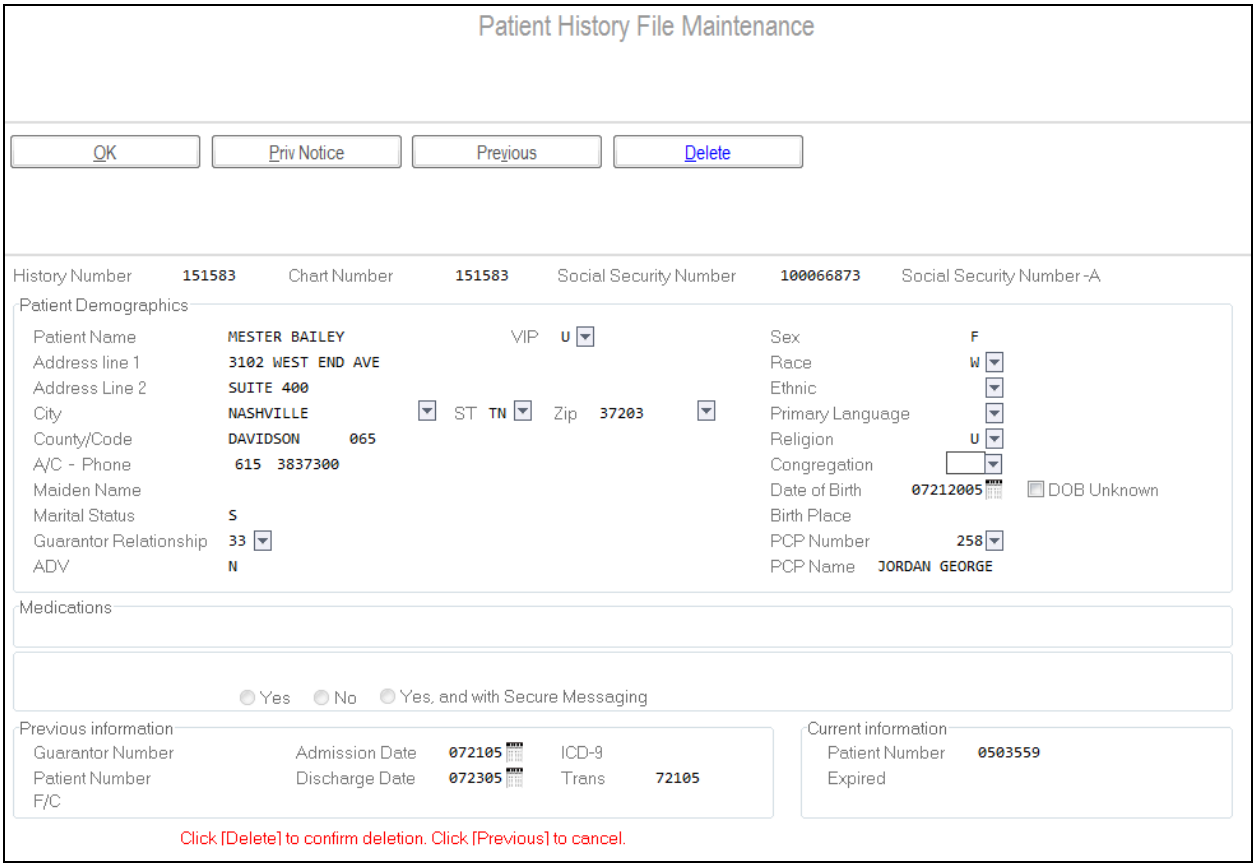
Action Make your entries/changes and click **OK**, or click one of the buttons at the top of the window.

Buttons and Function Keys

BUTTON	FUNCTION KEY	DESCRIPTION
OK	Enter	Save and process information in the window and return to the **Patient Demographics** window.
Allergies	F6	Maintain the patient's allergies.
Advanced Directives	F11	Assign advance directives to a patient, delete directives from a patient, and/or change the assigned date
Previous	F12	Return to the **Patient Demographics** window without saving or processing any information entered in the window.

CONFIRM PATIENT DEMOGRAPHICS DELETION WINDOW

This window appears when you click **Delete** in the **Patient History File Maintenance** window.



Action

To delete the record: Click **Delete**.

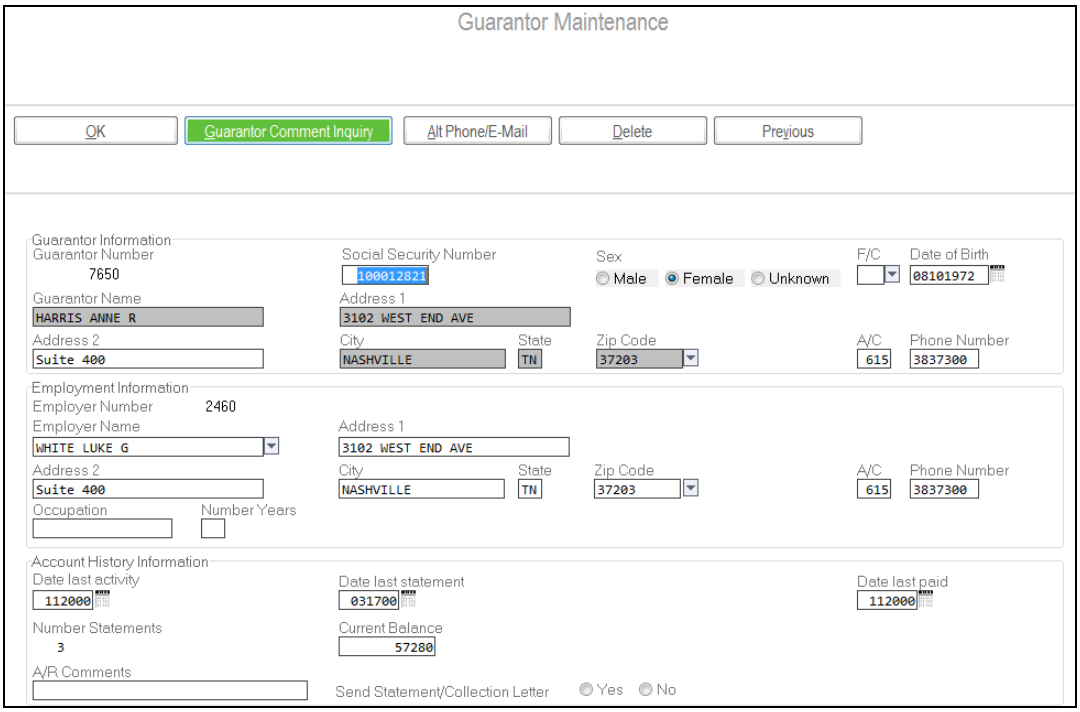
To cancel the deletion: Click **Previous**. Do not click **OK** or **Exit**; that will delete the record.

GUARANTOR DEMOGRAPHICS WINDOW

GUARANTOR MAINTENANCE WINDOW

The **Guarantor Maintenance** window lets you maintain demographic information for the patient's guarantor, such as name, address, date of birth, employment information, account history information, and more.

This window appears when you select **Guarantor Demographics** in the **EB Patient Maintenance Selections** window.



Action

To update information: Make your entries/changes and click **OK**. (Clicking **Previous** returns you to the **EB Patient Maintenance Selections** window without saving any entries/changes.)

To maintain comments: Click **Guarantor Comment Inquiry**.

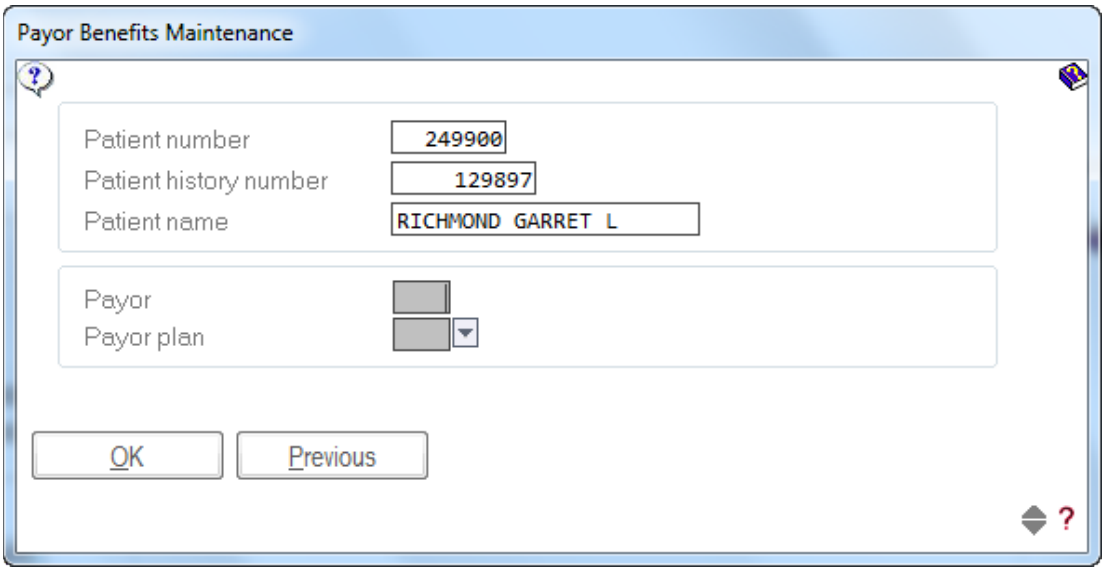
To delete the record: Click **Delete**, then **OK**. **Note:** You cannot delete a guarantor record that is attached to a patient.

PAYOR BENEFITS WINDOW

PAYOR BENEFITS MAINTENANCE WINDOW

The **Payor Benefits Maintenance** window lets you maintain the patient's payor benefits information for primary, secondary, and tertiary payors.

This window appears when you select **Primary Payor Benefits**, **Secondary Payor Benefits**, or **Tertiary Payor Benefits** in the **EB Patient Maintenance Selections** window.



Action

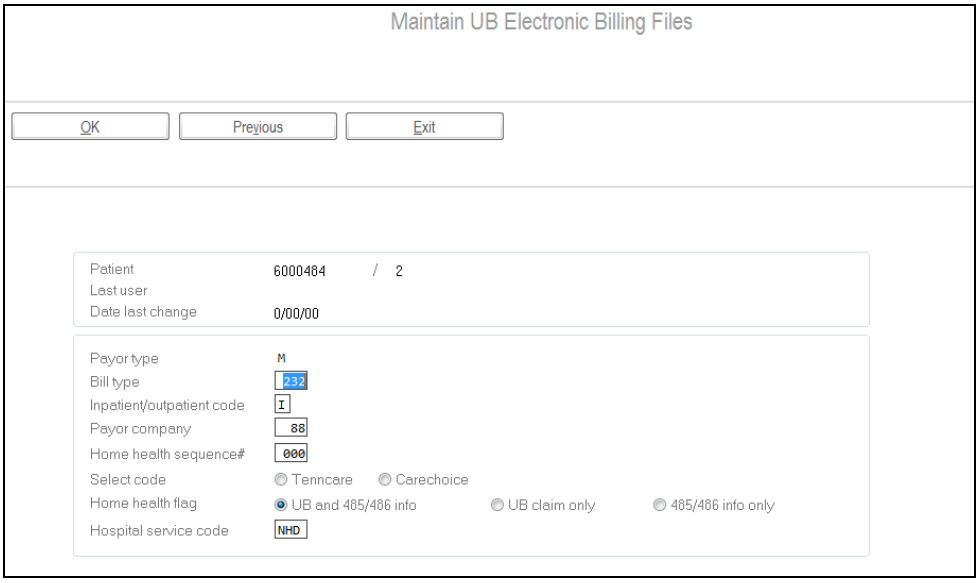
Enter the payor number and plan, and then click **OK**. You can either type the Payor Plan information or click and select the information in the search window that appears.

For more information on the **Payor Benefits Maintenance** window and on maintaining payor benefits, refer to the ***Patient Accounting User's Guide, Business Office Menu I, Option 15: Payor Benefits Maintenance***.

UB EB PATIENT MAINTENANCE WINDOWS

MAINTAIN UB ELECTRONIC BILLING FILES WINDOW

This window appears when you select **UB EB Patient Maintenance** in the **EB Patient Maintenance Selections** window.



Action

To return to a **Maintain UB Electronic Billing Files–Patient Selection** window without saving any changes: Click **Previous**.

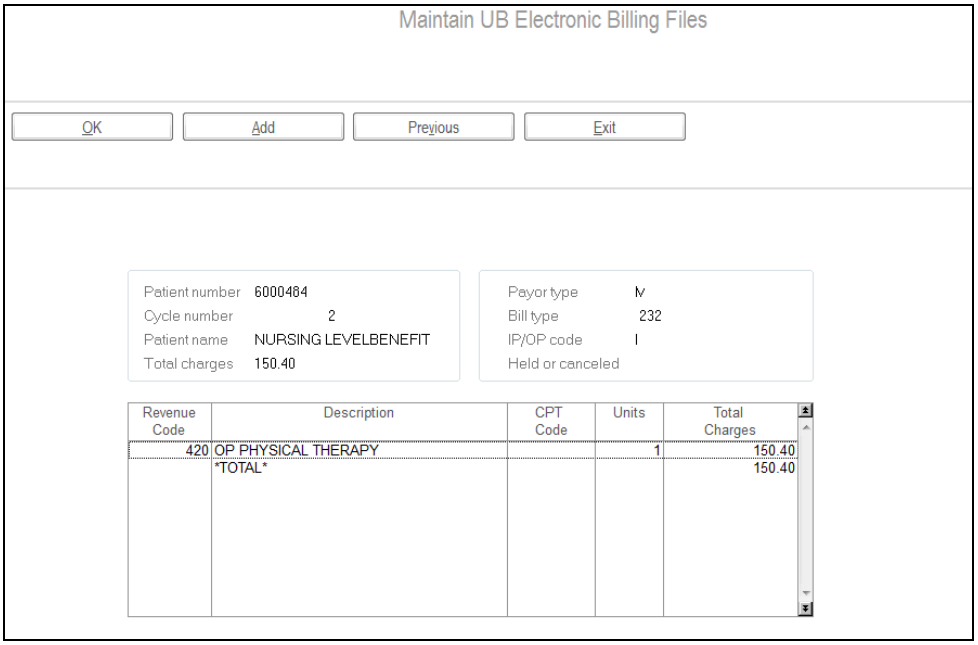
To return to the initial **EB Patient Maintenance Selections** window without saving any changes: Click **Exit**.

Make all necessary changes to the UB information, and then click **OK** to save the changes. Page 2 of the **Maintain UB Electronic Billing Files** window will then open.

MAINTAIN UB ELECTRONIC BILLING FILES WINDOW (PAGE 2)

Page 2 of the **Maintain UB Electronic Billing Files** window lists all UB detail billing records for the patient you are working with. You can add a record, update a listed record, and maintain other billing information such as value, occurrence, occurrence span; procedure, diagnosis, and condition codes.

This window appears when you click **OK** in the initial **Maintain UB Electronic Billing Files** window.



Action

To add a record: Click **Add**.

To update a record: Select the record by clicking on it to highlight it, and then click **OK** (or just double-click on the record).

To maintain other billing information: Click **OK** without selecting a record to display **UB Codes** window #1.

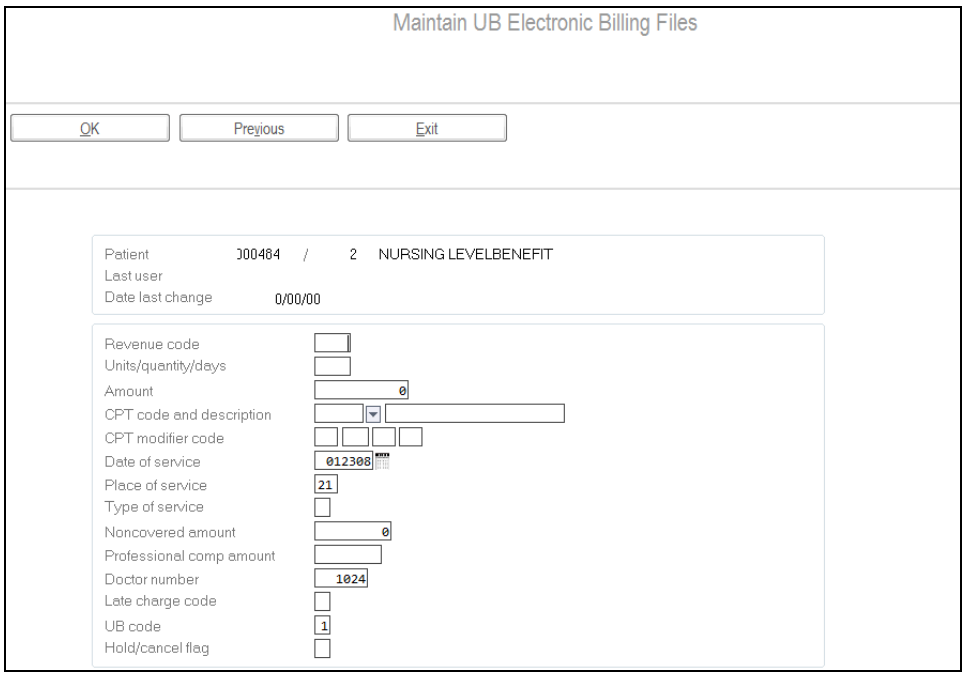
To return to the initial Maintain UB Electronic Billing Files window without saving any changes: Click **Previous**.

To return to the **EB Patient Maintenance Selections** window without saving any changes: Click **Exit**.

MAINTAIN UB ELECTRONIC BILLING FILES WINDOW–ADD

The **Maintain UB Electronic Billing Files–Add** window is used for both adding and updating the patient's UB billing information.

This window appears when you click **Add** or select a detail billing record in the UB detail record window.



Action

To add or maintain the record: Enter or change the UB information, and then click **OK** to save the entries/changes and return to the UB detail record window.

To return to Page 2 of the **Maintain UB Electronic Billing Files** window without saving any changes: Click **Previous**.

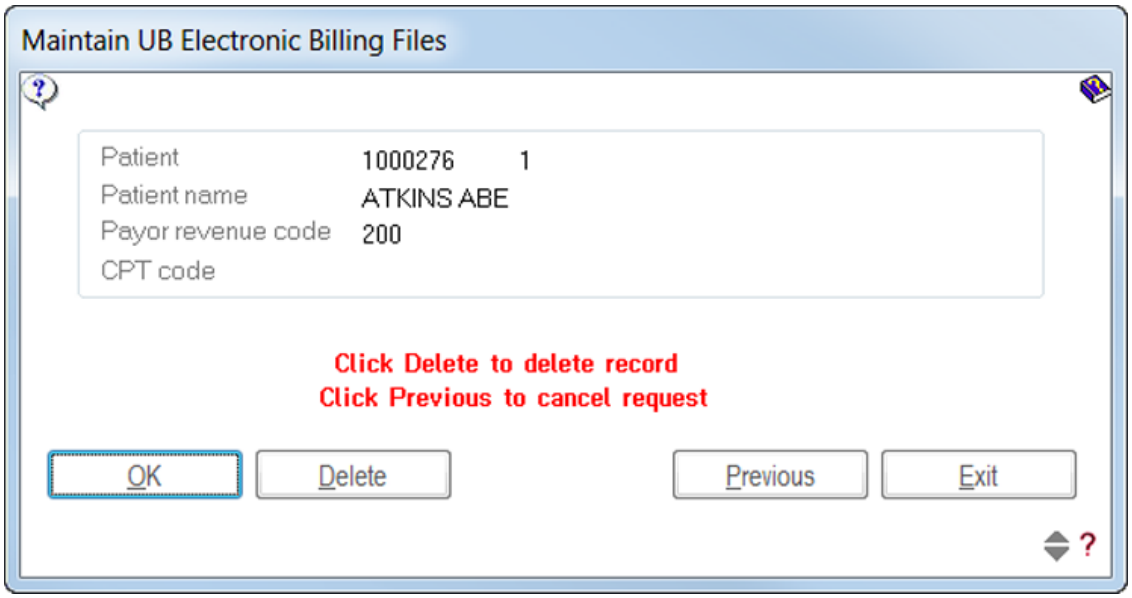
To return to the **EB Patient Maintenance Selections** window without saving any changes: Click **Exit**.

To delete the record: Click **Delete**. You will need to confirm the deletion in the confirmation window that appears.

If you delete the record, you must also adjust the amount in one or more detail records for this patient/cycle so that the total amount remains unchanged. For example, if you delete a record for $41.00, you must modify other charges by an additional $41.00 in order to keep the total unchanged.

CONFIRM UB DELETION WINDOW

This window appears when you click **Delete** in the **Maintain UB Electronic Billing Files–Add** window.



Action

To delete the record: Click **Delete**.

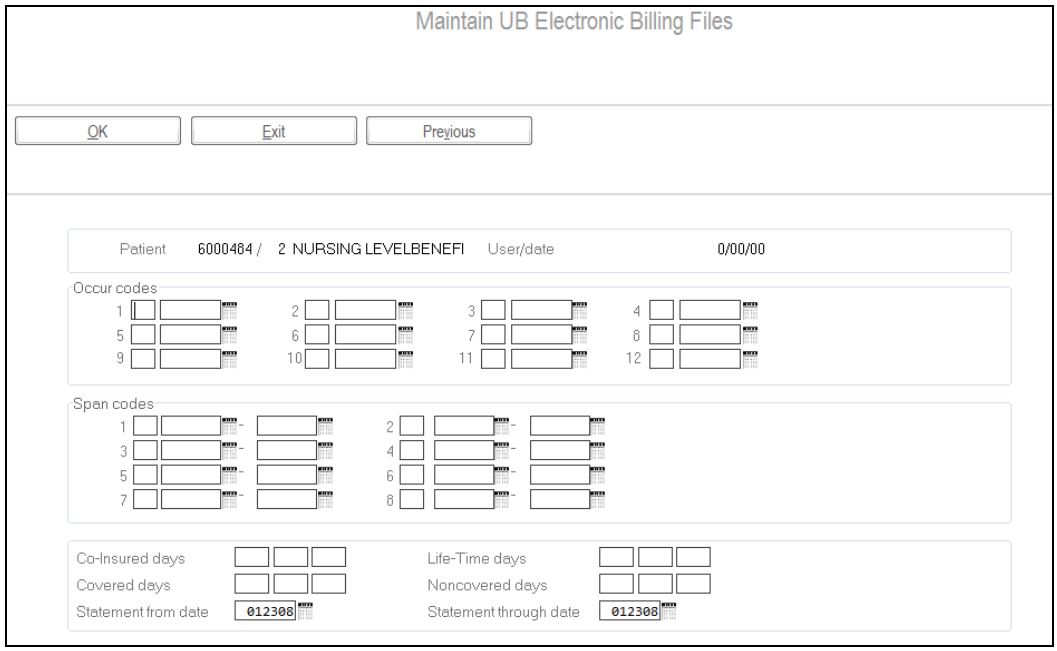
If you delete the record, you must also adjust the amount in one or more detail records for this patient/cycle so that the total amount remains unchanged. For example, if you delete a record for $41.00, you must modify other charges by an additional $41.00 in order to keep the total unchanged.

To cancel the deletion: Click **Previous**, **OK**, or **Exit**.

MAINTAIN UB ELECTRONIC BILLING FILES–OCCUR/SPAN CODES WINDOW

The **Maintain UB Electronic Billing Files–Occur / Span Codes** window lets you maintain occurrence and occurrence span codes, as well as other UB billing information.

This window appears when you click **OK** in Page 2 of the **Maintain UB Electronic Billing Files** window without selecting a record.



Action

To add a record: Enter or select codes and other information, and then click **OK** to save the entries/changes and display UB codes window #2.

To enter the statement from and through dates: Either type the date or click to select it. If you type the date, use mmddyy format (for example, **072504** for July 25, 2004).

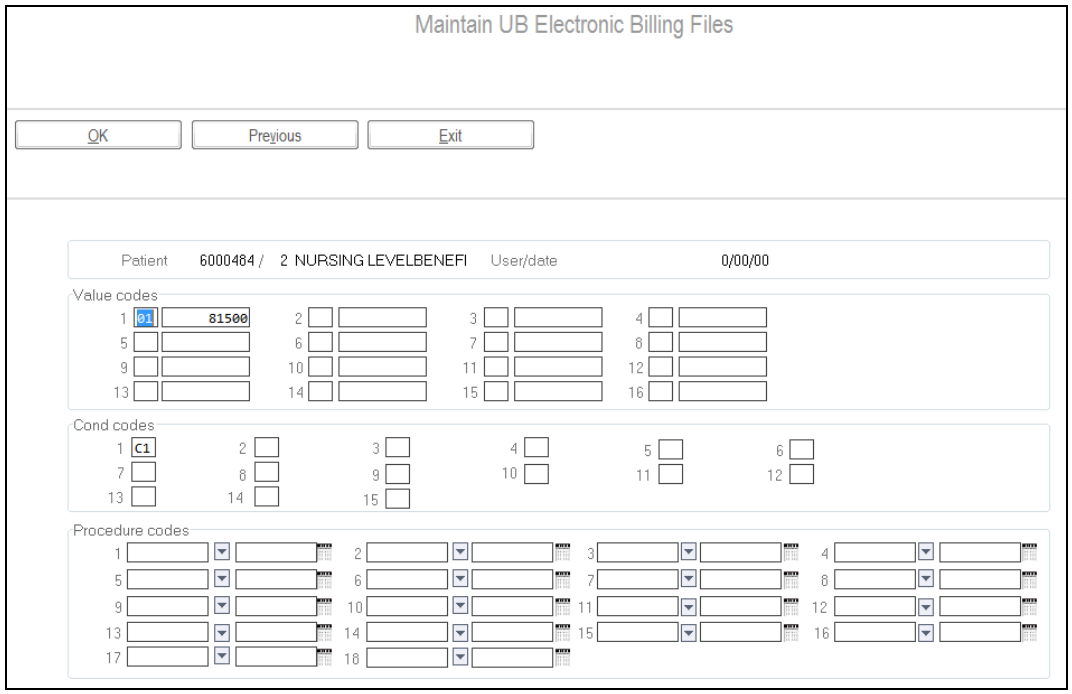
To return to Page 2 of the **Maintain UB Electronic Billing Files** window without saving any changes: Click **Previous**.

To return to the **EB Patient Maintenance Selections** window without saving any changes: Click **Exit**.

MAINTAIN UB ELECTRONIC BILLING FILES–ADDITIONAL CODES WINDOW

The Maintain UB Electronic Billing Files–Additional Codes window lets you maintain value, condition, and procedure codes.

This window appears when you click **OK** in the **Maintain UB Electronic Billing Files–Occur/Span Codes** window.



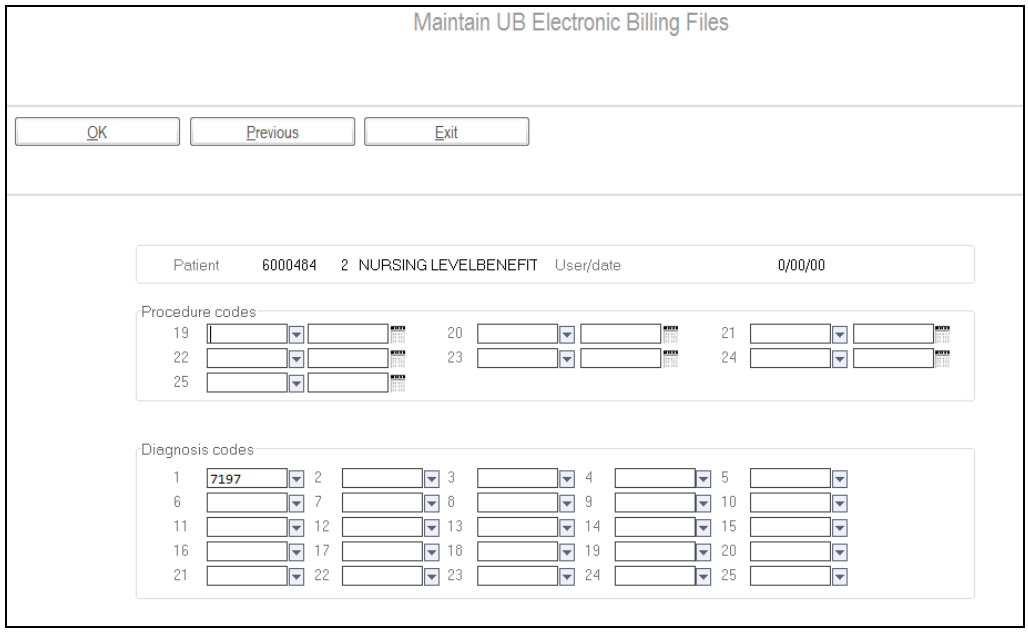
Action

Enter or select codes and other information, and then click **OK** to save the entries/changes and return to the initial **EB Patient Maintenance Selections** window.

To enter procedure codes: Either type the code or click to select the code in the **ICD10 Procedure Codes Display** window that appears.

Procedure codes: There are 18 procedure code fields available on the first window with additional entry fields available on the next window.

The Maintain UB Electronic Billing Files–Additional Codes window lets you maintain additional procedure and diagnosis codes.



Action

Enter or select codes and other information, and then click **OK** to save the entries/changes and return to the initial **EB Patient Maintenance Selections** window.

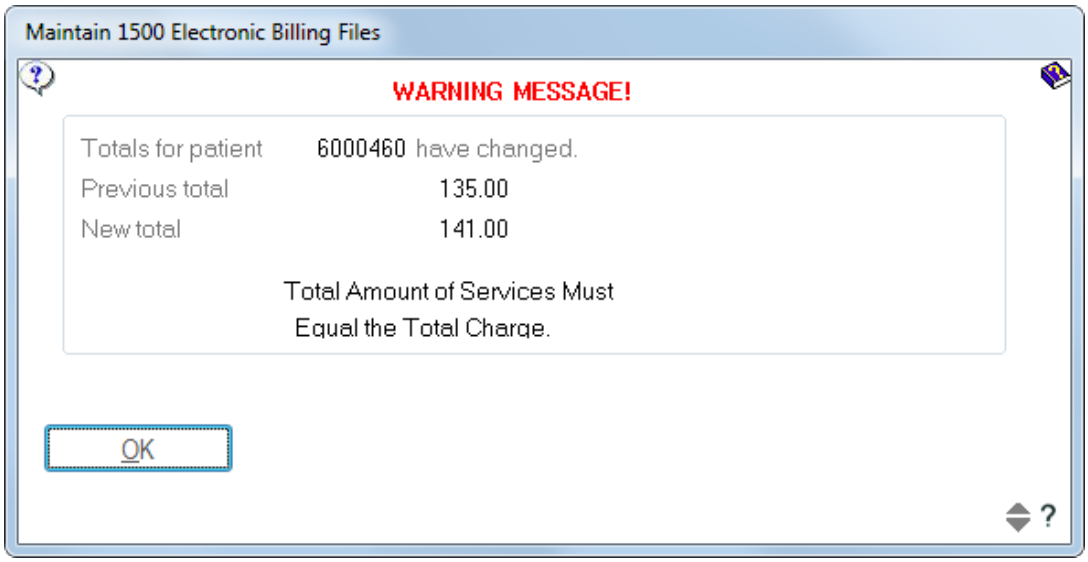
To enter diagnosis codes: Either type the code or click to select the code in the **ICD10 Diagnosis Codes by Description** window that appears.

To return to the **Value/Condition/Procedure Codes** window without saving any changes: Click **Previous**.

To return to the initial **EB Patient Maintenance Selections** window without saving any changes: Click **Exit**.

UB WARNING MESSAGE WINDOW

This window appears when changes are made to amount fields in the UB billing information window and, as a result, total amounts do not agree with the total on file.



Action Click **OK** to return to Page 2 of the **Maintain UB Electronic Billing Files** window, then make the necessary changes to keep the total amount unchanged.

SECONDARY CLAIMS FOR TYPE B (BLUE CROSS), C (COMMERCIAL), AND M (MEDICARE) PAYORS AT CAH FACILITIES

Charges can be edited if all the following conditions exist:

- the Critical Access (CAH) field in the UB Control Record is **Yes**
- the CAH Start date field in the *UB Control Record* is not blank
- the insurance type is B (Blue Cross), C (Commercial), or M (Medicare)
- the claim is the secondary claim

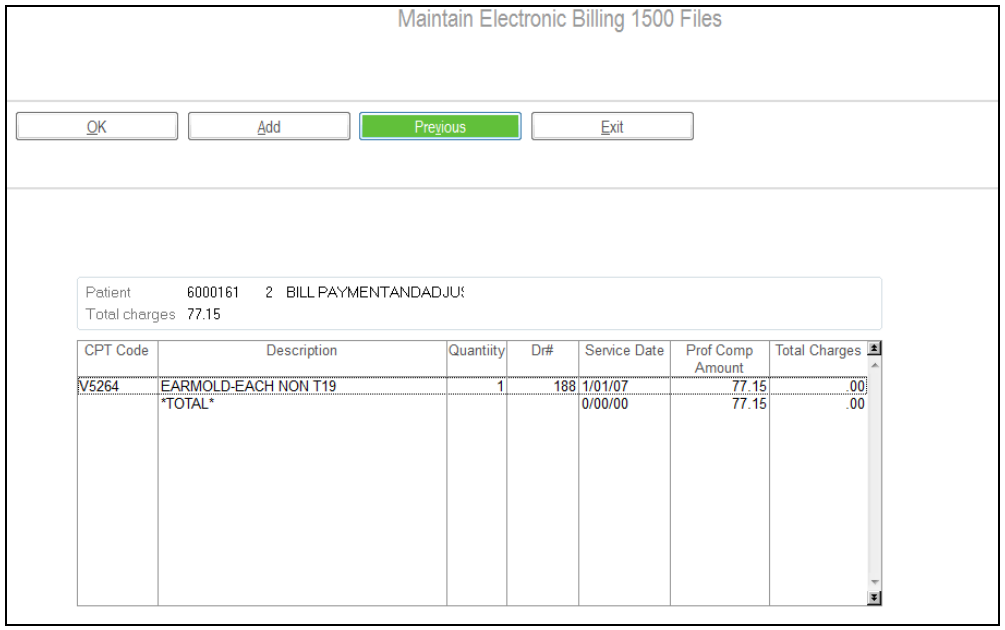
Set the CAH field and CAH Start Date in the *System Control Maintenance Menu*, *Option 4: UB Control Record*.

1500 EB PATIENT MAINTENANCE WINDOWS

MAINTAIN ELECTRONIC BILLING 1500 FILES WINDOW

The **Maintain Electronic Billing 1500 Files** window lists all 1500 detail billing records for the patient you are working with. You can add a record, update a listed record, and maintain other billing information such as the hold/cancel flag, inpatient/outpatient code, and bill type.

This window appears when you select **1500 EB Patient Maintenance** in the **EB Patient Maintenance Selections** window.



Action

To add a record: Click **Add**.

To update a record: Select the record by clicking on it to highlight it, and then click **OK** (or just double-click on the record).

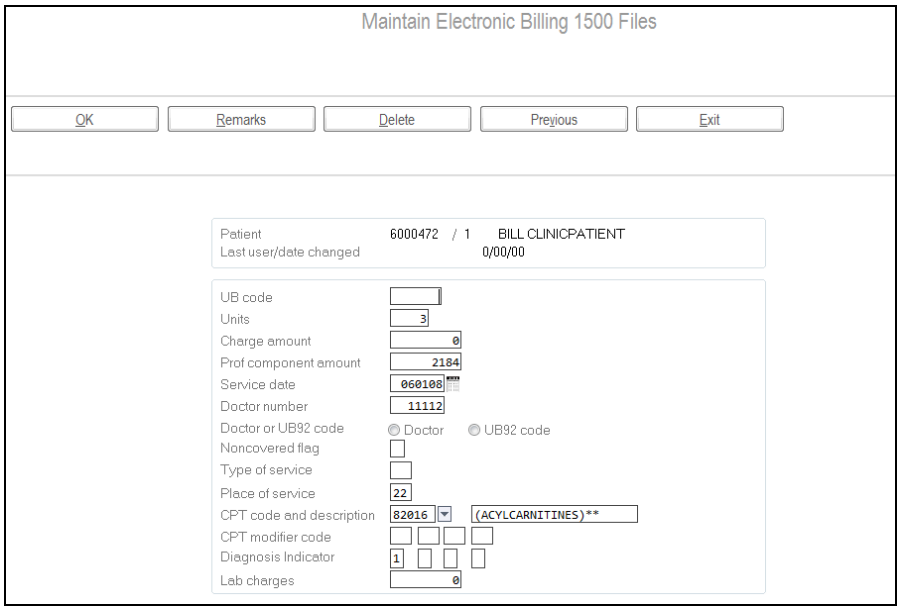
To maintain other billing information: Click **OK** without selecting a record.

To return to the **EB Patient Maintenance Selections** window without saving any changes, click **Exit** or **Previous**.

MAINTAIN ELECTRONIC BILLING 1500 FILES WINDOW (PAGE 2)

Page 2 of the **Maintain Electronic Billing 1500 Files** window is used for both adding and updating the patient's 1500 billing information. You can also enter and maintain remarks and comments related to the billing record.

This window appears when you click **Add** or select a detail billing record in the initial **Maintain Electronic Billing 1500 Files** window.



Action

To add or maintain the record: Enter or change the 1500 information, and then click **OK** to save the entries/changes and display the billing information window.

To enter or maintain remarks or comments: Click **Remarks** to display the remarks window.

To delete the record: Click Delete. You will need to confirm the deletion in the confirmation window that appears.

If you delete the record, you must also adjust the amount in one or more detail records for this patient/cycle so that the total amount remains unchanged. For example, if you delete a record for $41.00, you must modify other charges by an additional $41.00 in order to keep the total unchanged.

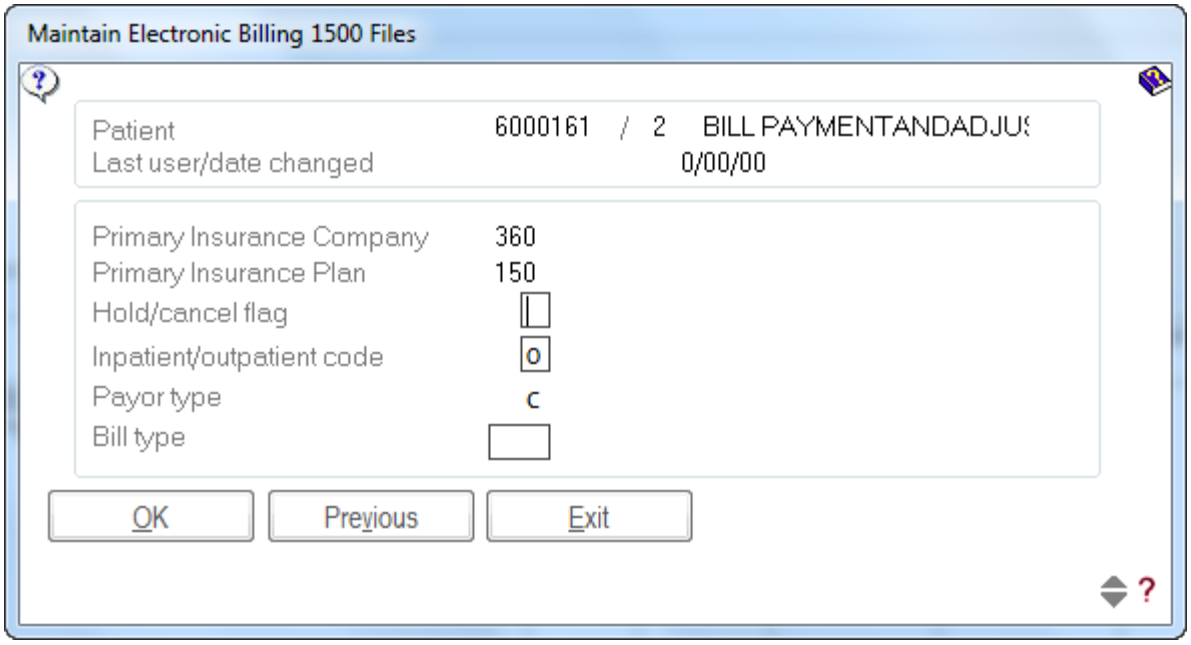
To return to the initial Maintain Electronic Billing 1500 Files window without saving any changes click Previous.

To return to the EB Patient Maintenance Selections window without saving any changes, click **Exit**.

1500 BILLING INFORMATION WINDOW

The **1500 Billing Information** window lets you maintain the patient's hold/cancel flag, inpatient/outpatient code, and bill type.

This window appears when you click **OK** in the initial **Maintain Electronic Billing 1500 Files** window without selecting a record.



Action

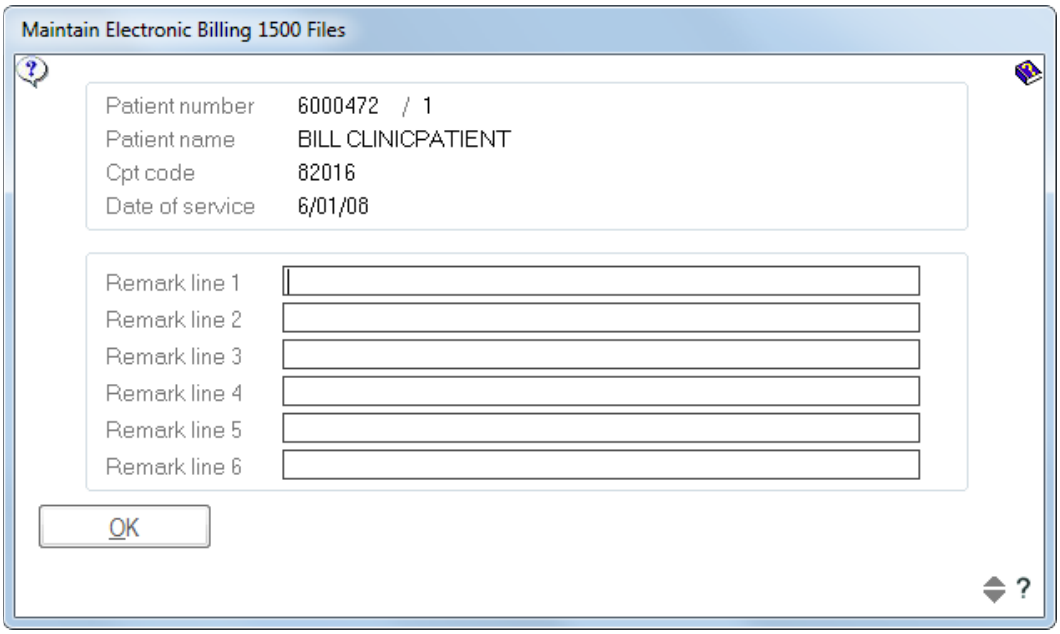
Type the information, and then click **OK** to save your entries and display the **1500 Codes** window.

To return to the patient number window without saving any changes click **Previous.**

To return to the **EB Patient Maintenance Selections** window without saving any changes, click **Exit.**

1500 REMARKS WINDOW

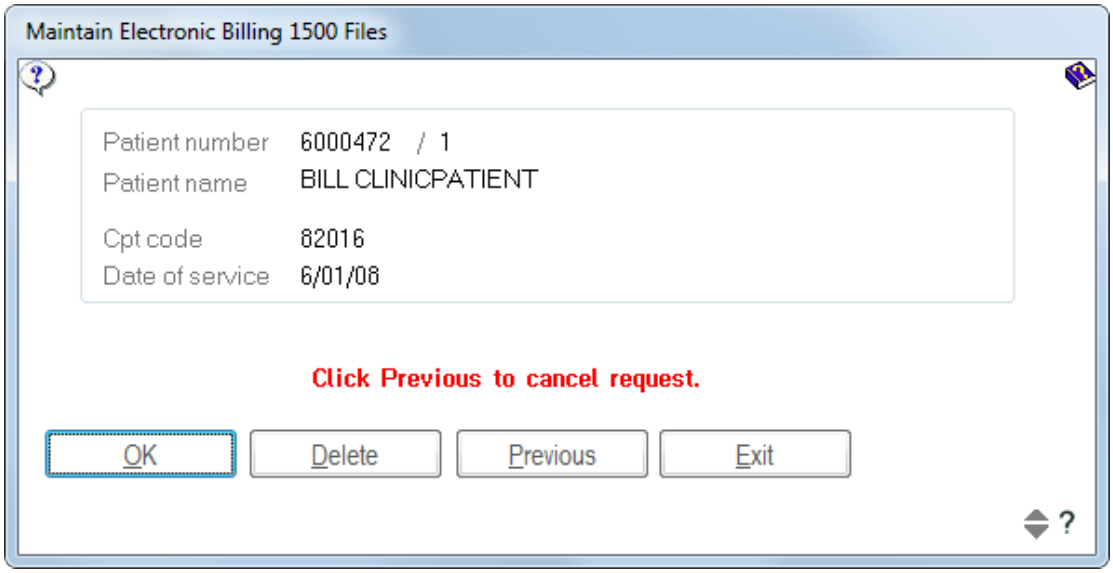
This window appears when you click **Remarks** in Page 2 of the **Maintain Electronic Billing 1500 Files** window.



Action Enter or update remarks, and then click **OK**.

CONFIRM 1500 DELETION WINDOW

This window appears when you click **Delete** in Page 2 of the **Maintain Electronic Billing 1500 Files** window.



Action: **To delete the record:** Click **Delete**.

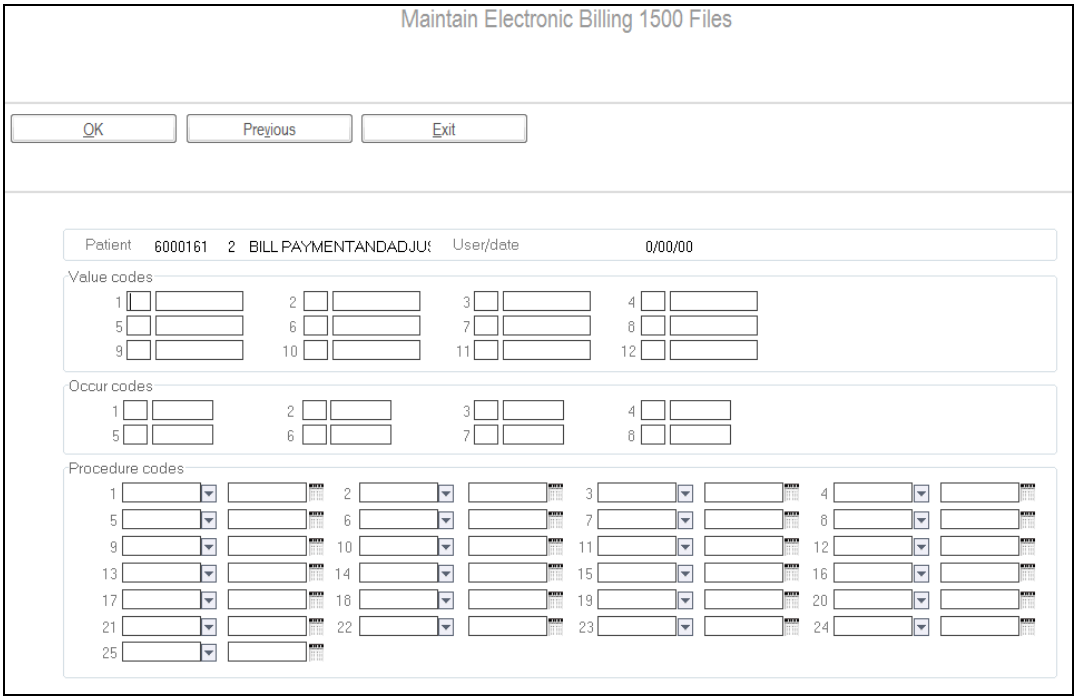
If you delete the record, you must also adjust the amount in one or more detail records for this patient/cycle so that the total amount remains unchanged. For example, if you delete a record for $41.00, you must modify other charges by an additional $41.00 in order to keep the total unchanged.

To cancel the deletion: Click **Previous**, **OK**, or **Exit**.

1500 CODES WINDOW

The **1500 Codes** window lets you maintain value, occurrence, and procedure codes.

This window appears when you click **OK** in the **1500 Billing Information** window.



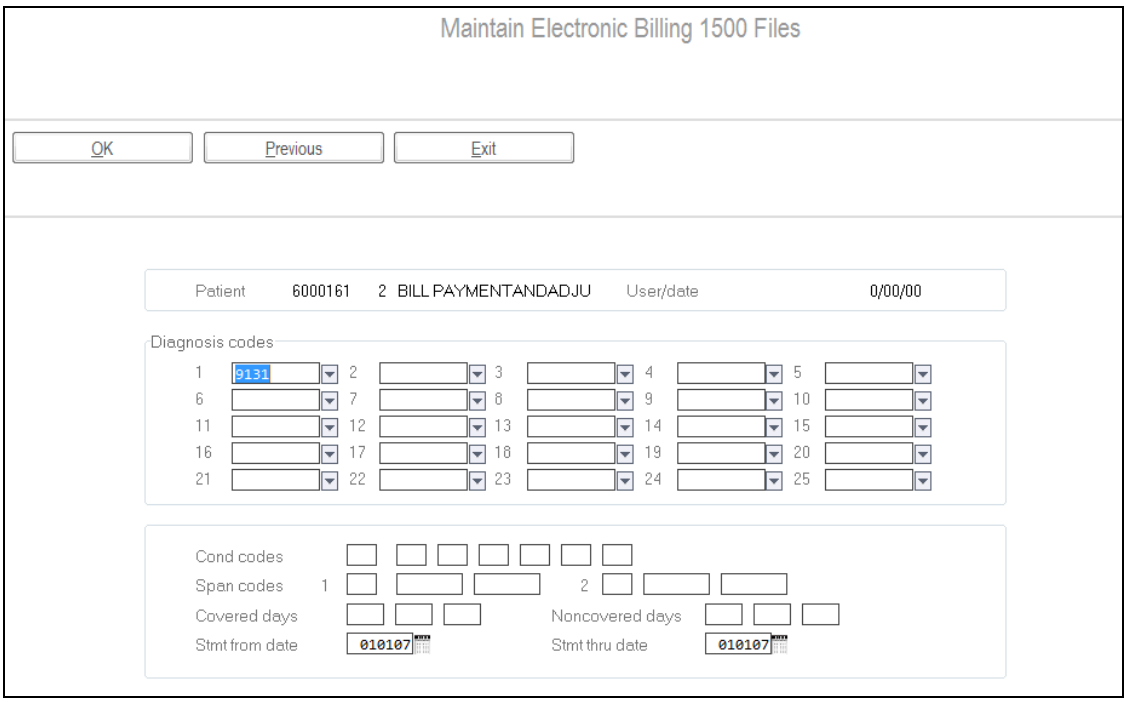
Action

Enter or select codes and other information, and then click **OK** to save the entries/changes and return to the initial **EB Patient Maintenance Selections** window.

To return to the initial **Maintain Electronic Billing 1500 Files** window without saving any changes, click **Previous.**

To return to the **EB Patient Maintenance Selections** window without saving any changes, click **Exit**.

The **1500 Codes** window **– Additional Codes** window lets you maintain diagnosis, condition and span codes as well as other 1500 billing information.



Action

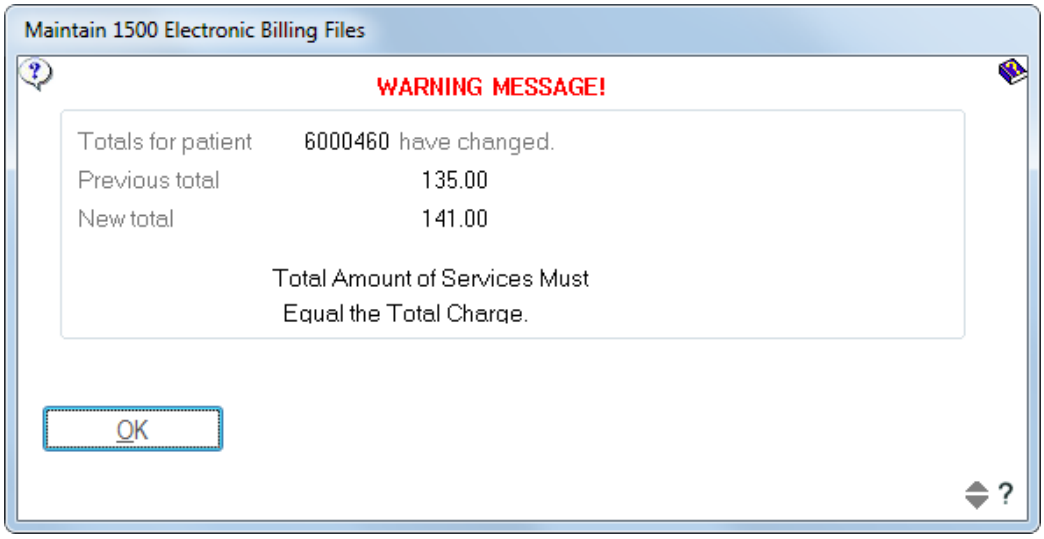
Enter or select codes and other information, and then click **OK** to save the entries/changes and return to the initial **EB Patient Maintenance Selections** window.

To return to the initial **Maintain Electronic Billing 1500 Files** window without saving any changes, click **Previous.**

To return to the **EB Patient Maintenance Selections** window without saving any changes, click **Exit**.

1500 WARNING MESSAGE WINDOW

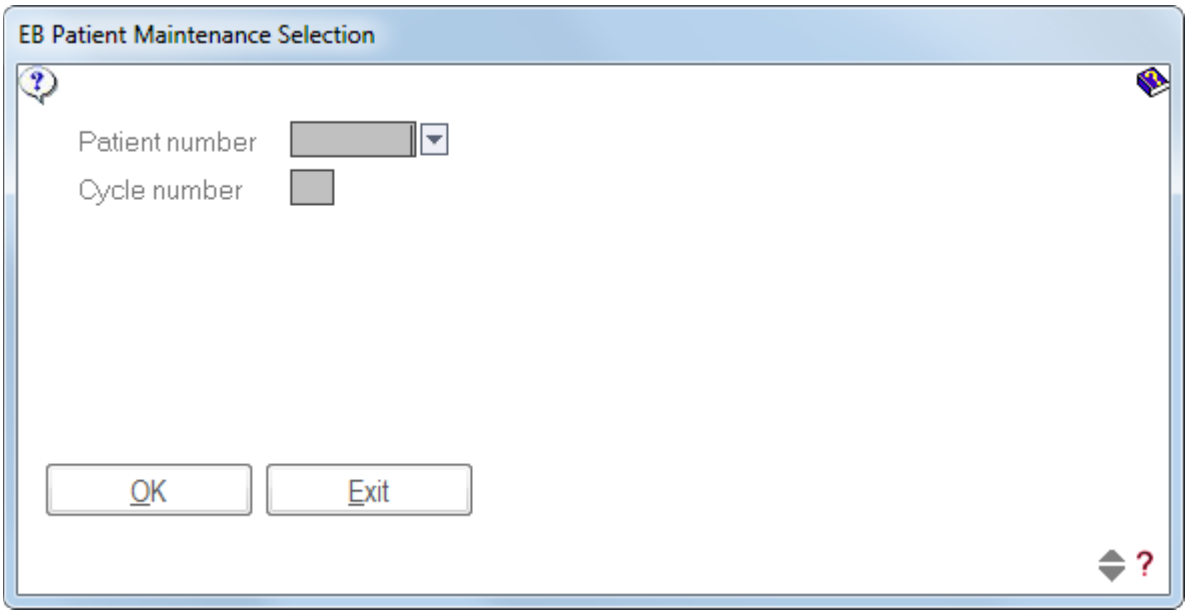
This window appears when changes are made to amount fields in the 1500 maintenance window and, as a result, total amounts do not agree with the total on file.



Action Click **OK** to return to the 1500 detail record window, then make the necessary changes to keep the total amount unchanged.

PATIENT NUMBER WINDOW

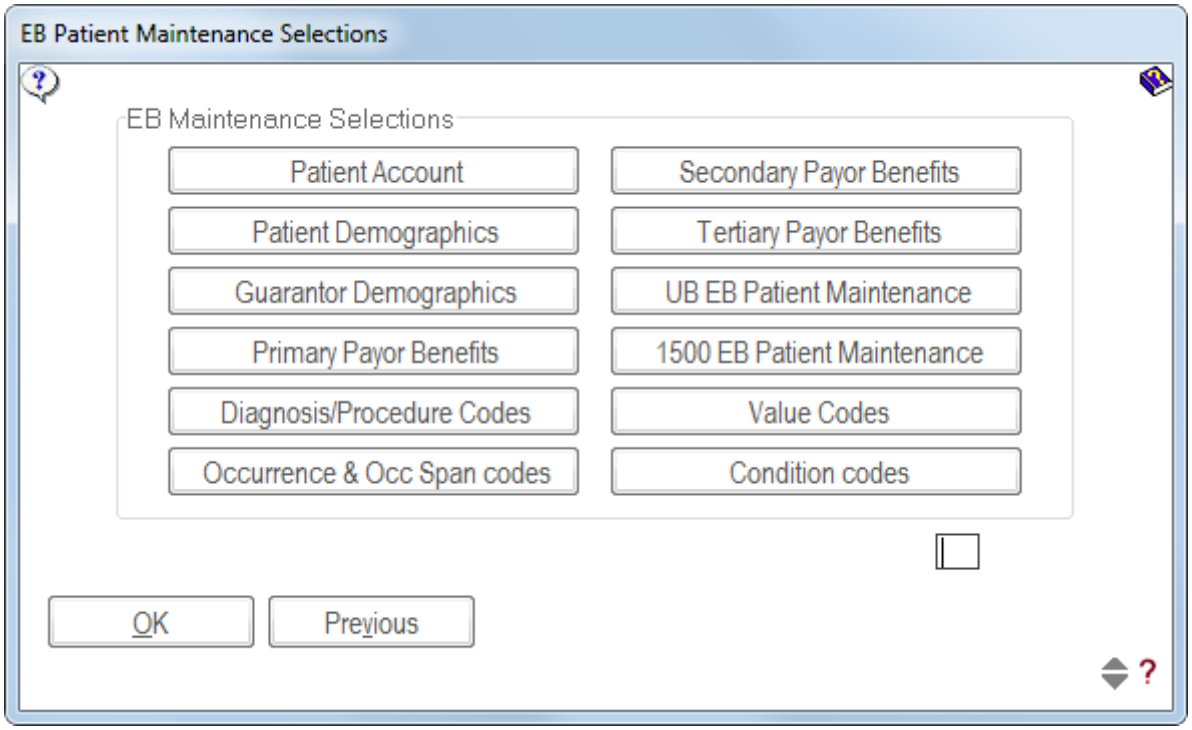
This window appears when you click **Previous** in the **1500 Billing Information** window.



Action Enter the patient number for the patient you want to maintain, and then click **OK**. You can either type the number or select it by clicking to display the **Electronic Billing Patient Lookup** window.

EB PATIENT MAINTENANCE SELECTIONS

This window appears when a Patient/Cycle Number are entered .



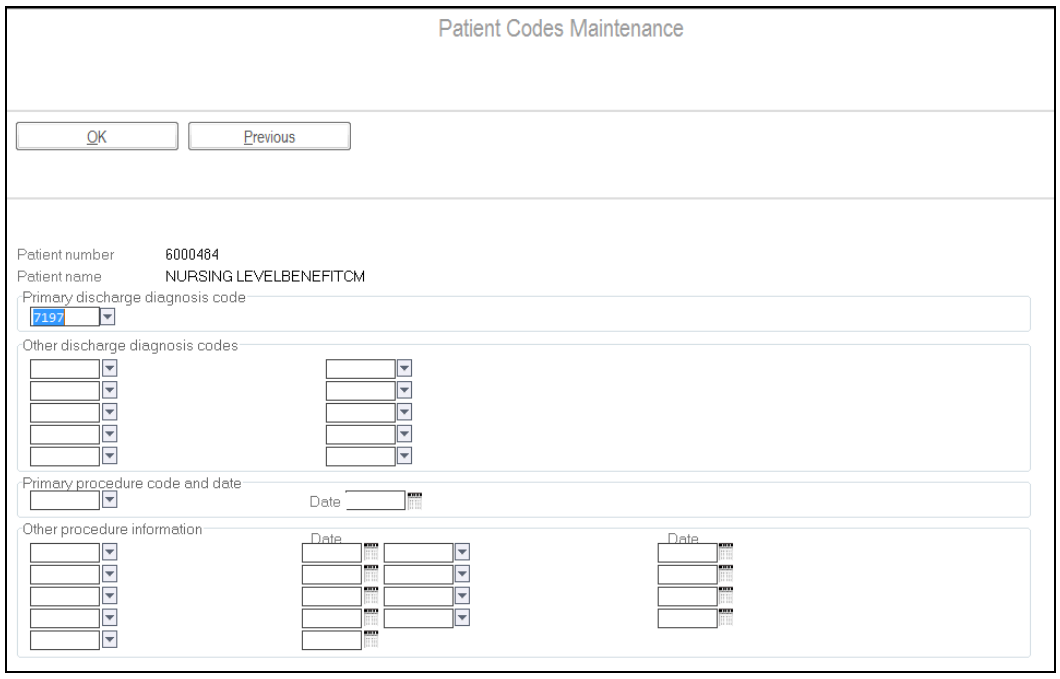
Action

Make a selection to continue.

CODES WINDOWS

DIAGNOSIS/PROCEDURE CODES WINDOW

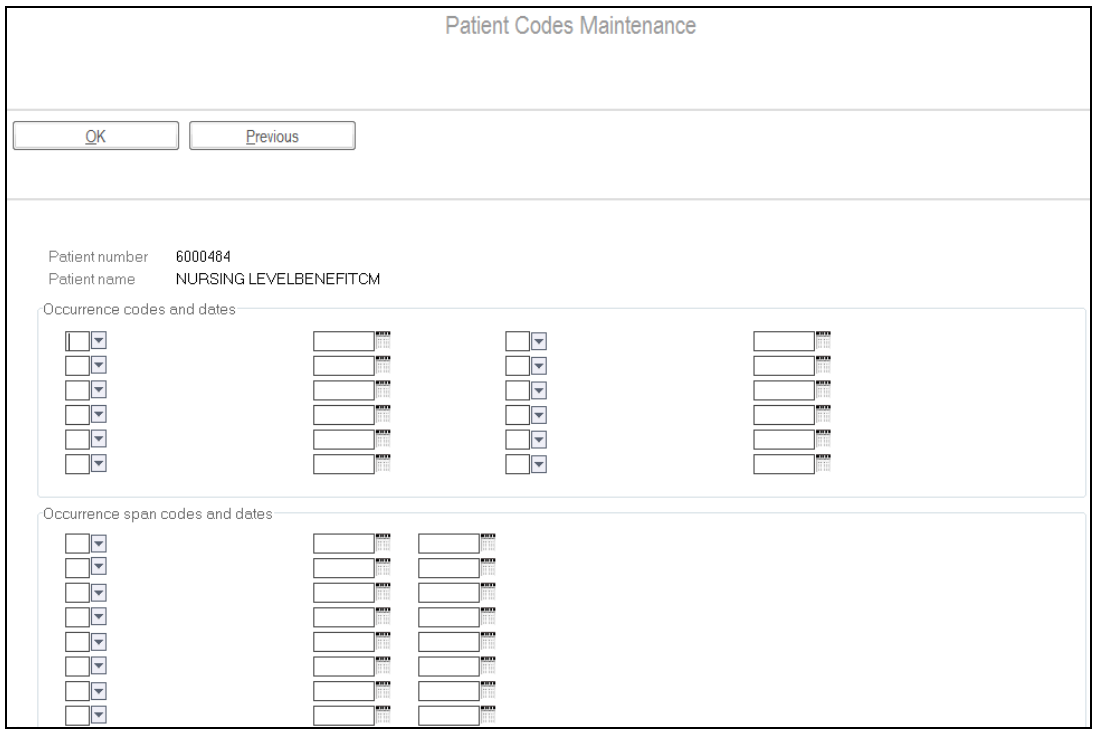
This window appears when you select Diagnosis/Procedure Codes in the initial **EB Patient Maintenance Selections** window.



Action Enter or make any necessary changes to the diagnosis and procedure codes, then click **OK**. The codes will print on the UB bill.

OCCURRENCE/CONDITION CODES WINDOW

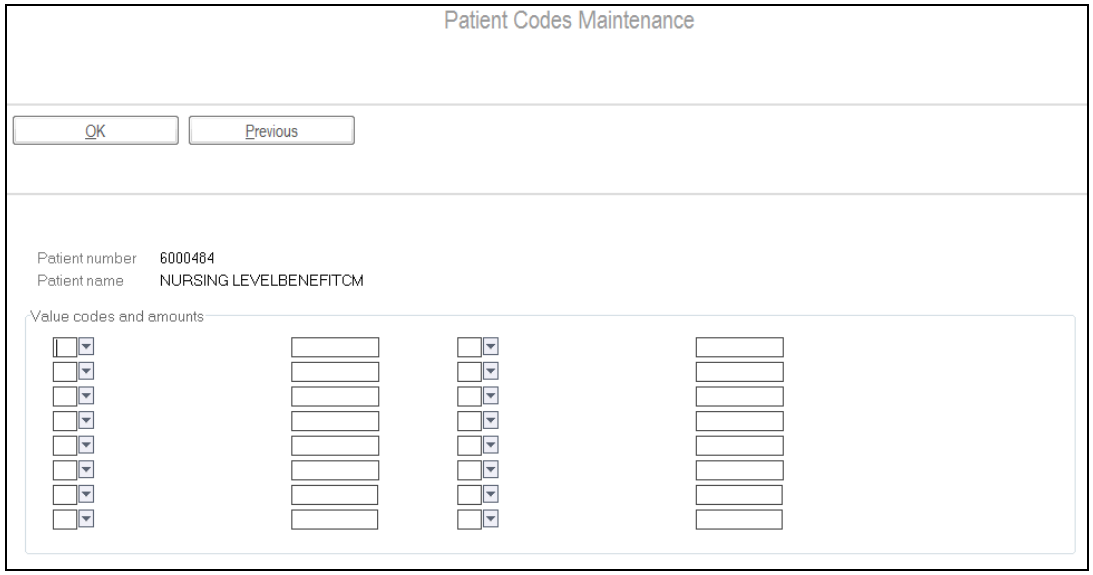
This window appears when you select Occurrence & Occ Span codes in the initial **EB Patient Maintenance Selections** window.



Action Enter or make any necessary changes to the occurrence codes and condition codes, then click **OK**. The codes will print on the UB bill.

VALUE CODES WINDOW

This window appears when you select Value Codes in the initial **EB Patient Maintenance Selections** window.



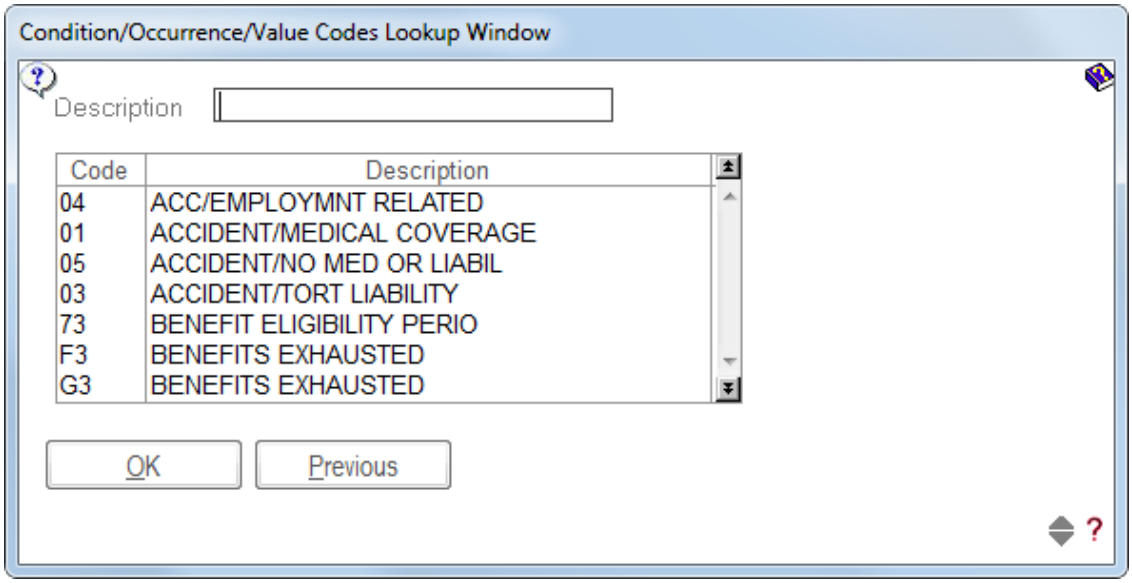
Action Enter or make any necessary changes to the value codes, then click **OK**. The codes will print on the UB bill.

SELECTION/LOOKUP WINDOWS

CONDITION/OCCURRENCE/VALUE CODES LOOKUP WINDOW

The **Condition / Occurrence / Value Codes Lookup** window lists codes that are maintained in *Patient Accounting* through *Condition/Occurrence/Value Codes, Option 3* on *File Maintenance Menu II*.

This window appears when you click next to a code field in the occurrence/condition codes window or the value codes window.



Action

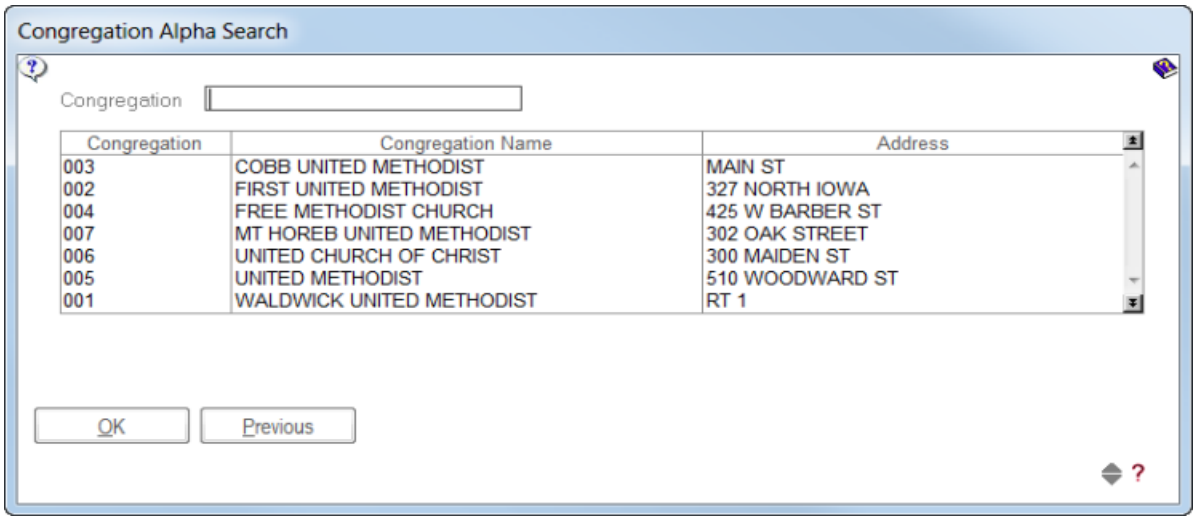
To find a code: Type part or all of the code's description in the Description field and click **OK**.

To select a code: Click on the code to highlight it, and then click **OK** (or just double-click on the code).

CONGREGATION ALPHA SEARCH WINDOW

The **Congregation Alpha Search** window lists religious congregations that are maintained in *Patient Accounting* through *Congregation Maintenance, Option 17* on the *System Table (Hospital Table File) Menu* (TABMNU). The codes can be listed/printed in *Patient Accounting* through *List Congregation File, Option 5* on *File Listing Menu II* (MNTMN4).

This window appears when you click next to the Congregation field in the **In-House Maintenance** window or **Patient Demographics** window.



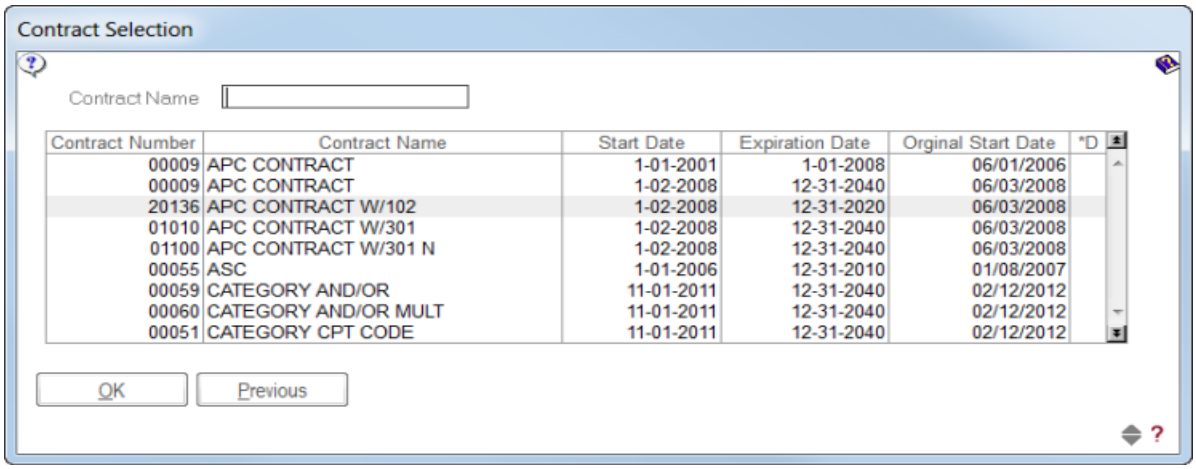
Action

To find a congregation: Type part or all of the congregation's name in the Congregation field, and then click **OK**.

To select a congregation: Click on the congregation to highlight it, and then click **OK** (or just double-click on the congregation). The congregation must be associated with any religion that was entered in the Religion field. If you left the Religion field blank, it will be filled in automatically when you select a congregation.

CONTRACT SELECTION WINDOW

This window appears when you click Display CM Notes in the Payor Company/Plan Alpha Search window.



Action

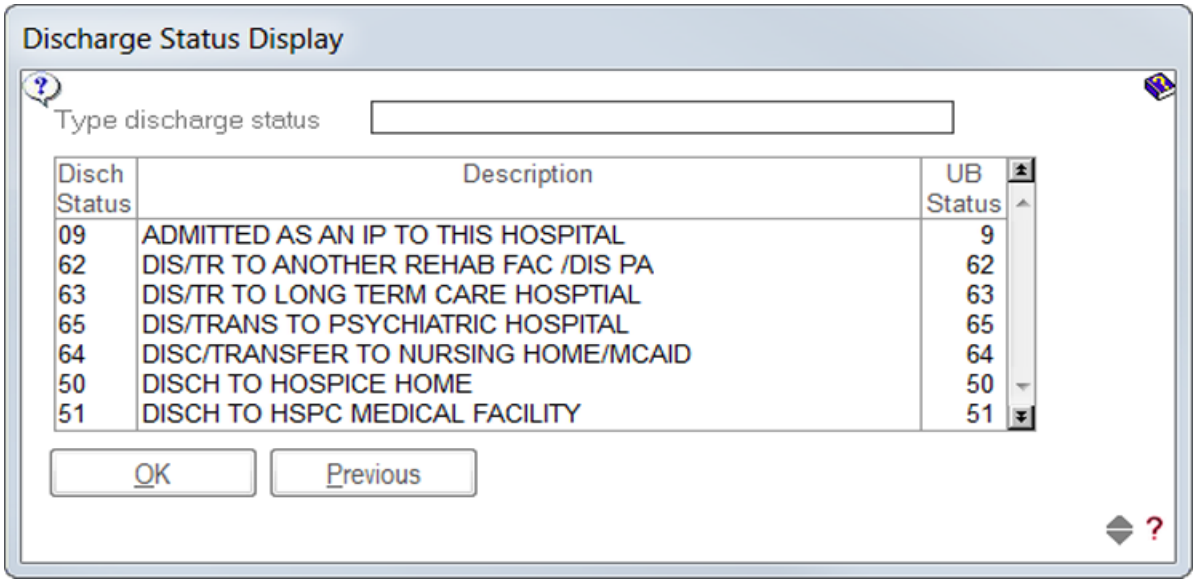
To find a contract: Type part or all of the contract's name in the Contract Name field, and then click **OK**.

To select a contract to view its notes: Click on the contract to highlight it, and then click **OK** (or just double-click on the contract).

DISCHARGE STATUS DISPLAY WINDOW

The Discharge Status Display window lists status codes that are maintained in *Patient Accounting* through Discharge Status Codes, Option 2 on File Maintenance Menu II (MNTMN3). The codes can be listed/printed in *Patient Accounting* through *File Listing Menu II, Option 2: List Discharge Statuses*.

This window appears when you click next to the Discharge Status field in the **Financial Information** window.

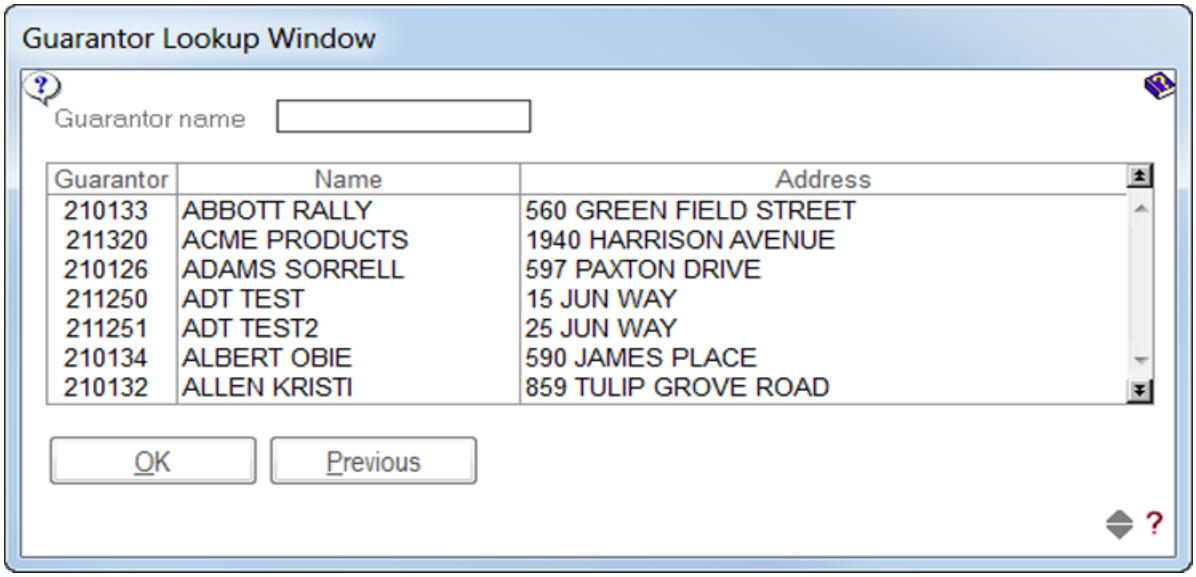


Action

To find a status: Type part or all of the status' description in the Type discharge status field, and then click **OK**. **To select a status:** Click on the status to highlight it, and then click **OK** (or just double-click on the status).

GUARANTOR LOOKUP WINDOW

This window appears when you click next to the Guarantor # field in the discharge maintenance history number/guarantor number window or next to the New guarantor # field in the **In-House Maintenance** history number/guarantor number window.



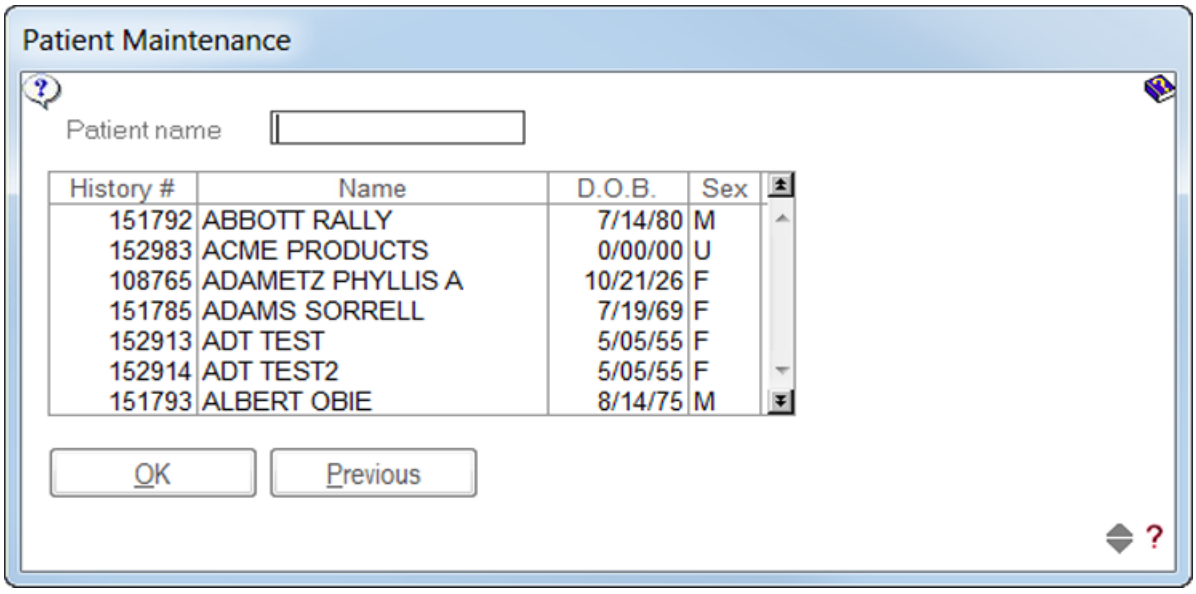
Action

To find a guarantor: Type part or all of the guarantor's name (last name first) in the Guarantor name field, and then click **OK**.

To select a guarantor: Click on the guarantor to highlight it, and then click **OK** (or just double-click on the guarantor).

HISTORY NUMBER SELECTION WINDOW

This window appears when you click next to the History # field in the **History Number/Guarantor Number** window or next to the New history # field in the **In-House Maintenance–History Number/Guarantor Number** window.



Action

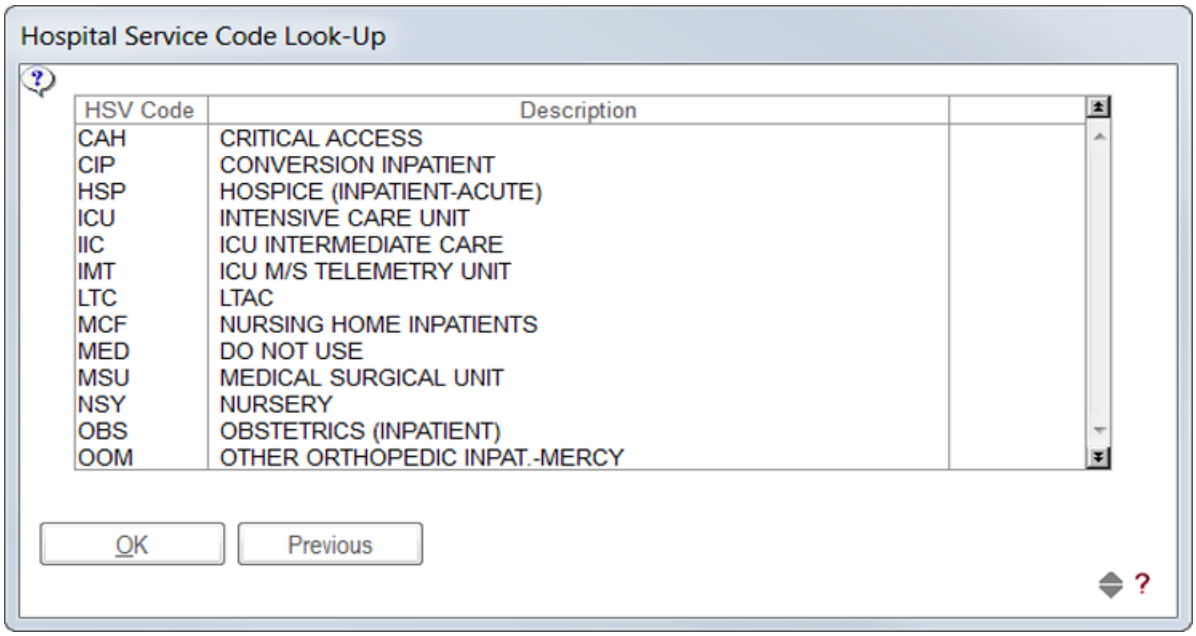
To find a patient: Type part or all of the patient's name (last name first) in the Patient name field, and then click **OK**.

- **To select a history number:** Click on the number to highlight it, and then click **OK** (or just double-click on the number).

HSV CODE SELECTION WINDOW

The **HSV Code Selection** window lists hospital service codes that are maintained in *Patient Accounting* through *Hospital Service Code File, Option 19* on *File Maintenance Menu I* (MNTMN1). The codes can be listed/printed in *Patient Accounting* through *List Table File, Option 13* on *File Listing Menu I* (MNTMN2).

This window appears when you click next to the HSV code field in the **Discharge Maintenance** window or next to the Hospital service field in the **In-House Maintenance** window.

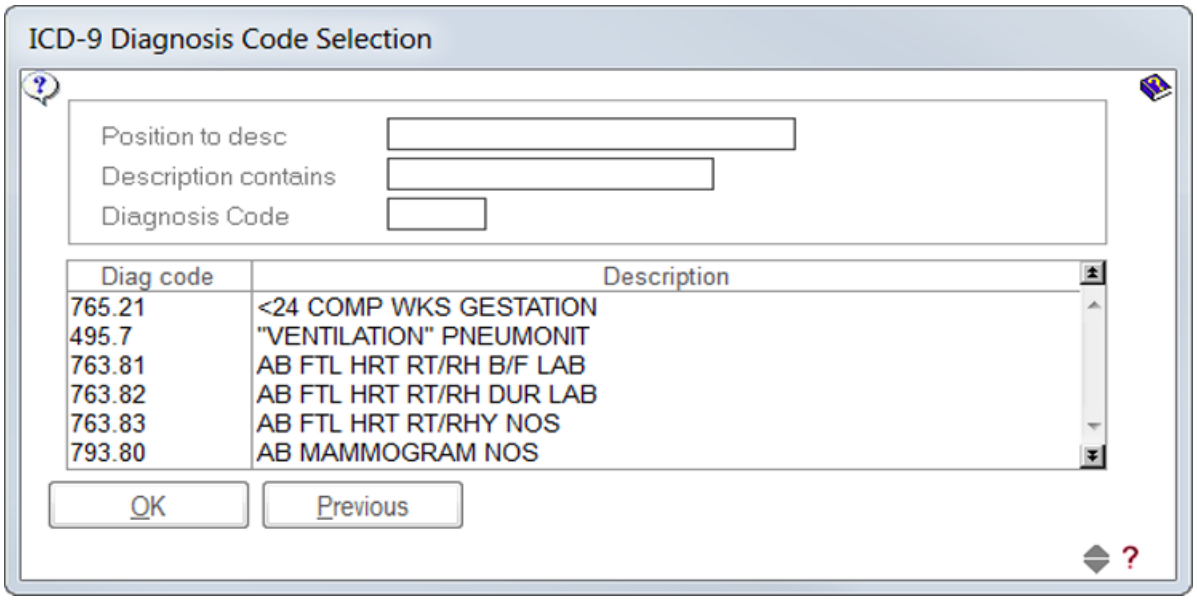


Action Select a code by clicking on it (to highlight it) and then click **OK** (or just double-click on the code).

ICD10 DIAGNOSIS CODE SELECTION WINDOW

The **ICD10 Diagnosis Code Selection** window lists codes that are maintained in *Patient Accounting* through *ICD10-CM Codes File*, *Option 7* on *File Maintenance Menu I* (MNTMN1). The file can be listed/printed in *Patient Accounting* through *ICD10-CM Codes Listing, Option 14* on *File Listing Menu II* (MNTMN4).

This window appears when you click next to the Admitting ICD10 field in the **In-House Maintenance** window or next to a code field in the **Diagnosis/Procedure Codes** window.



Action

To find a code: Type part or all of the code's description in the Description or Description contains field, and then click **OK**. For example:

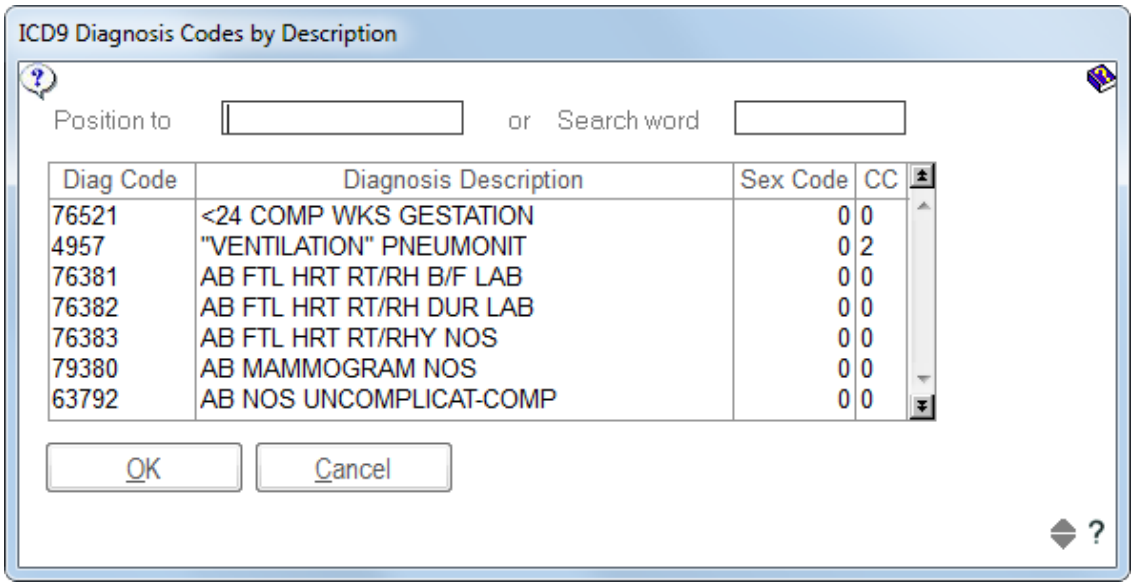
- If you type **acute** (lower- or uppercase) in the Description field, the list will begin with codes whose description begins with ACUTE, such as ACUTE & CHRONIC RESP FAIL and ACUTE BRONCHITIS.
- If you type **bronch** in the Description contains field, the list will be limited to codes whose description contains BRONCH anywhere in the description, such as ACUTE BRONCHITIS and BRONCHITIS NOS.

To select a code: Click on the code to highlight it, and then click **OK** (or just double-click on the code). The code will be entered in the Admitting ICD10 field and the description in the Admitting diagnosis field.

ICD10 DIAGNOSIS CODES BY DESCRIPTION WINDOW

The **ICD10 Diagnosis Codes by Description** window lists codes that are maintained in *Patient Accounting* through *ICD10-CM Codes File, Option 7* on *File Maintenance Menu I* (MNTMN1). The file can be listed/printed in *Patient Accounting* through *ICD10-CM Codes Listing, Option 14* on *File Listing Menu II* (MNTMN4).

This window appears when you click next to a Diagnosis codes field in the **UB Codes** window or **1500 Codes** window.



Action

To find a code: Type part or all of the code's description in the Position to or Search word field, and then click **OK**. For example:

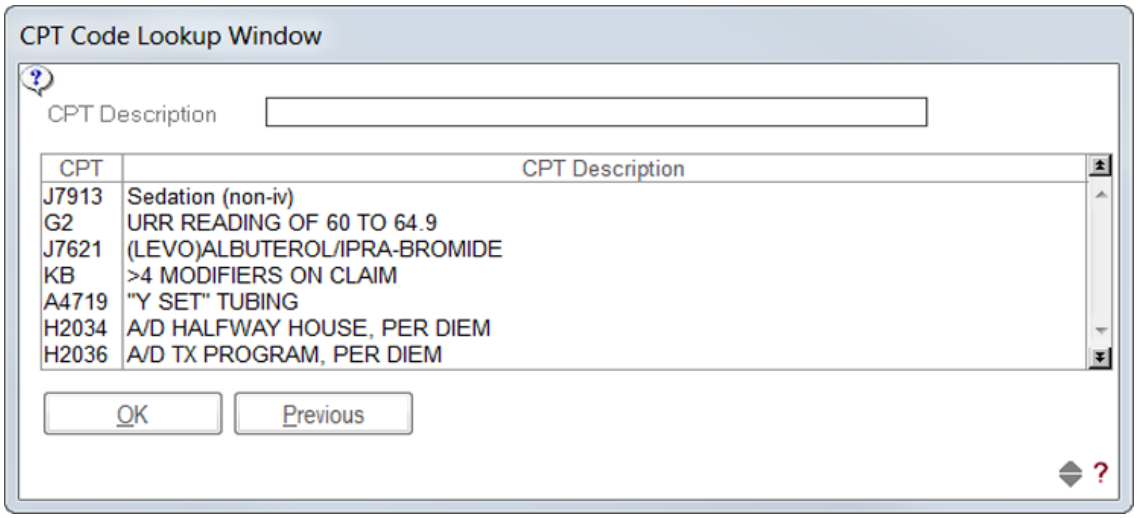
- If you type **acute** (lower- or uppercase) in the Position to field, the list will begin with codes whose description begins with ACUTE, such as ACUTE & CHRONIC RESP FAIL and ACUTE BRONCHITIS.
- If you type **bronch** in the Search word field, the list will be limited to codes whose description contains BRONCH anywhere in the description, such as ACUTE BRONCHITIS and BRONCHITIS NOS.

To select a code: Click on the code to highlight it, and then click **OK** (or just double-click on the code).

ICD10 PROCEDURE CODES DISPLAY WINDOW

The **ICD10 Procedure Codes Display** window lists codes that are maintained in *Patient Accounting* through *ICD10-CM Codes File, Option 7* on *File Maintenance Menu I* (MNTMN1). The file can be listed/printed in *Patient Accounting* through *ICD10-CM Codes Listing, Option 14* on *File Listing Menu II* (MNTMN4).

This window appears when you click next to a Procedure codes field in the **UB Codes** window or **1500 Codes** window, or next to a Code field in the **Diagnosis/Procedure Codes** window.



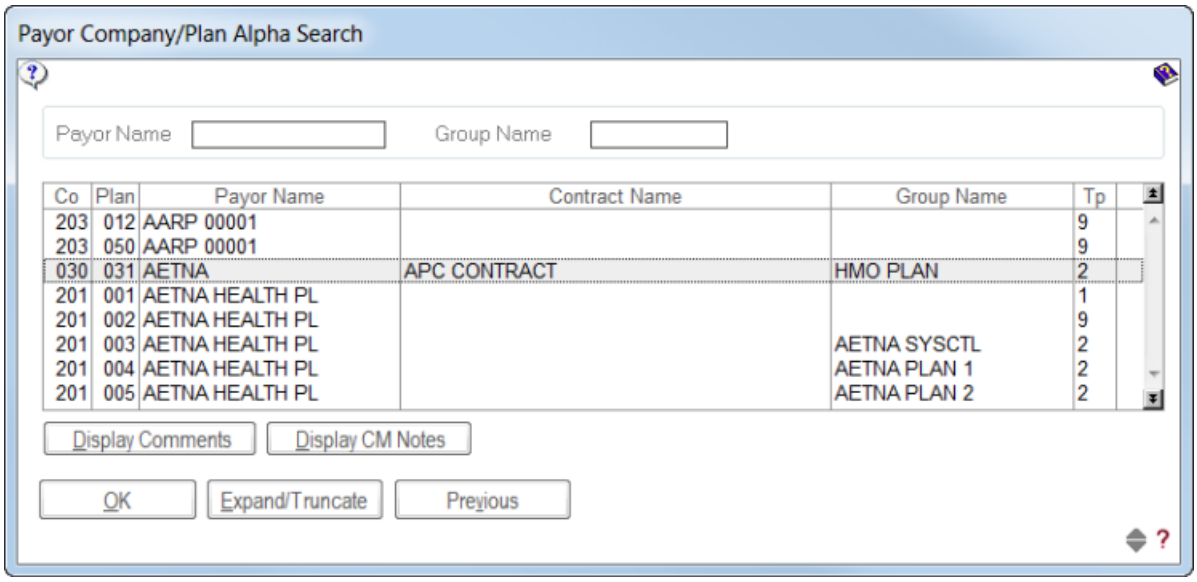
Action

To find a code: Type part or all of the code's description in the Procedure Description field, and then click **OK**.

To select a code: Click on the code to highlight it, and then click **OK** (or just double-click on the code).

PAYOR COMPANY/PLAN ALPHA SEARCH WINDOW

This window appears when you click next to a Payor field in the **Discharge Maintenance** window or when you click **Expand/Truncate** in the second **Payor Company/Plan Alpha Search** window.



Action:

To find a payor: Type part or all of the payor's name or group name in the Payor Name or Group Name fields, and then click **OK**.

To view payors' addresses: Click **Expand/Truncate** to display the second **Payor Company/Plan Alpha Search** window. To hide the addresses (that is, to return to this window), click the button again.

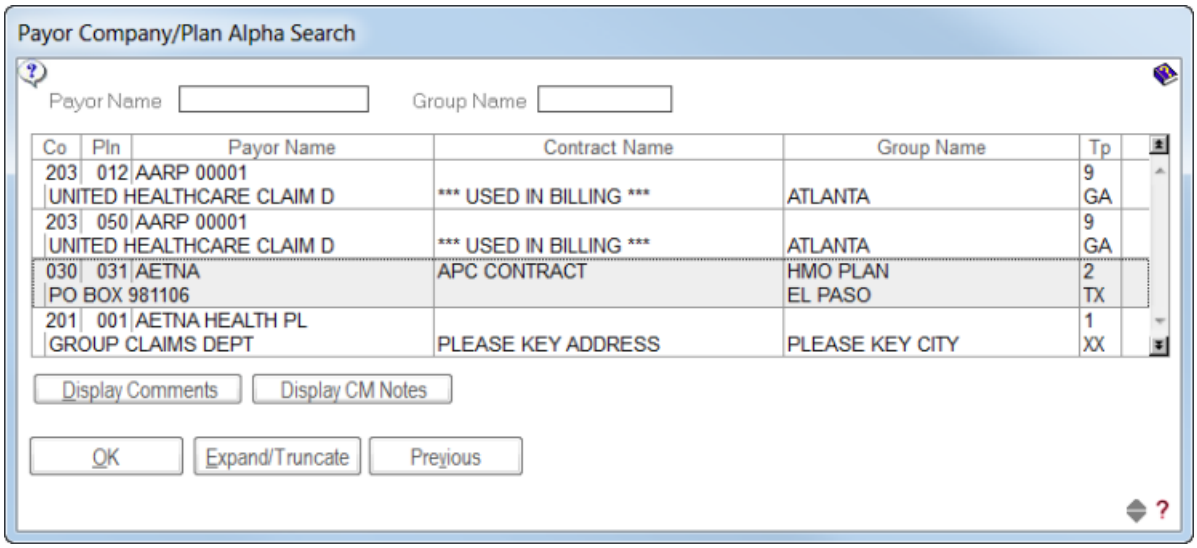
To view comments for a payor: Click on the payor to highlight it, and then click **Display Comments**.

To view contract notes for a payor: Click on the payor's name to highlight it, and then click **Display CM Notes**. In the **Contract Selection** window that appears, select a contract to display the **Contract Notes** window.

To select a payor: Click on the payor to highlight it, and then click **OK** (or just double-click on the payor).

PAYOR COMPANY/PLAN ALPHA SEARCH WINDOW (EXPANDED)

This window appears when you click **Expand/Truncate** in the initial **Payor Company / Plan Alpha Search** window.



Action:

To find a payor: Type part or all of the payor's name or group name in the Payor Name or Group Name fields, and then click **OK**.

To hide payors' addresses: Click **Expand/Truncate** to display the initial **Payor Company / Plan Alpha Search** window. To view the addresses (that is, to return to this window), click the button again.

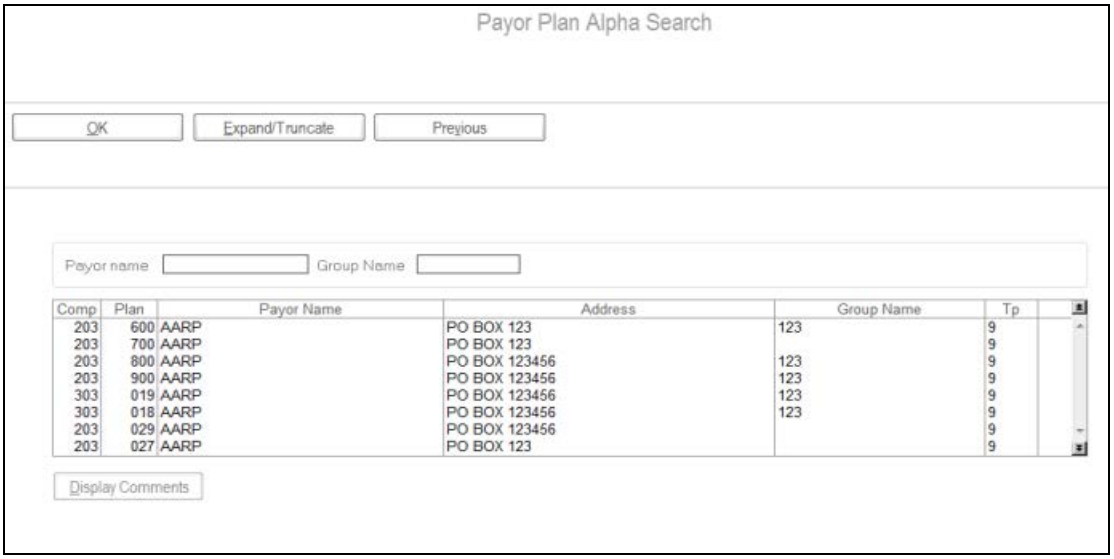
To view comments for a payor: Click on the payor's name to highlight it, and then click **Display Comments**.

To view contract notes for a payor: Click on the payor's name to highlight it, and then click **Display CM Notes**. In the **Contract Selection** window that appears, select a contract to display the **Contract Notes** window.

To select a payor: Click on the payor's name to highlight it, and then click **OK** (or just double-click on the payor).

PAYOR PLAN ALPHA SEARCH WINDOW

This window appears when you click next to a Payor plan field in the **Payor Benefits Maintenance** window or when you click **Expand/Truncate** in the second **Payor Plan Alpha Search** window.



Comp	Plan	Payor Name	Address	Group Name	Tp
203	600	AARP	PO BOX 123	123	9
203	700	AARP	PO BOX 123		9
203	800	AARP	PO BOX 123456	123	9
203	900	AARP	PO BOX 123456	123	9
303	019	AARP	PO BOX 123456	123	9
303	018	AARP	PO BOX 123456	123	9
203	029	AARP	PO BOX 123456		9
203	027	AARP	PO BOX 123		9

Action:

To find a payor: Type part or all of the payor's name or group name in the Payor Name or Group Name fields, and then click **OK**.

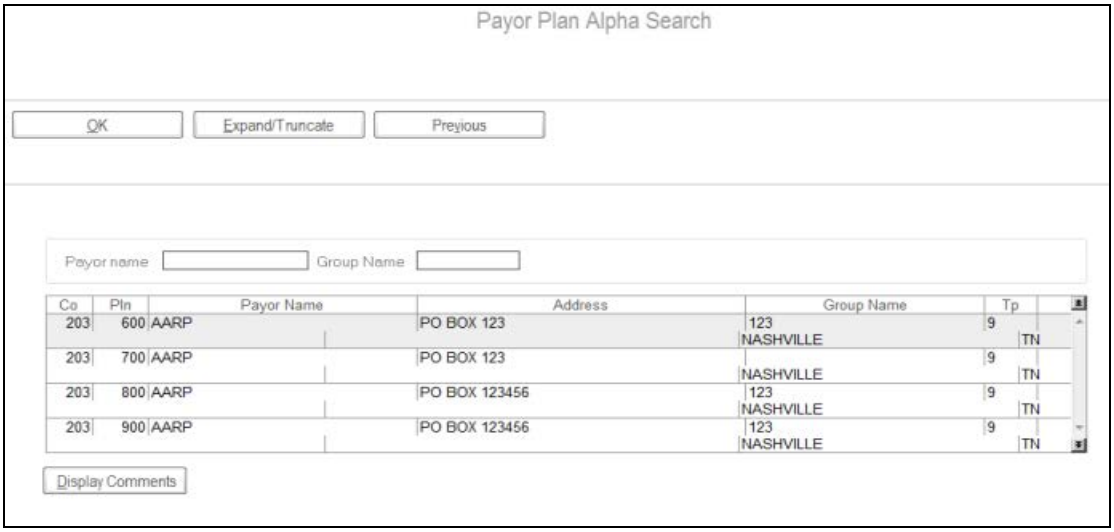
To view payors' addresses: Click **Expand/Truncate** to display the second **Payor Plan Alpha Search** window. To hide the addresses (that is, to return to this window), click the button again.

To view comments for a payor: Click on the payor's name to highlight it, and then click **Display Comments**.

To select a payor: Click on the payor's name to highlight it, and then click **OK** (or just double-click on the payor's name).

PAYOR PLAN ALPHA SEARCH (EXPANDED) WINDOW

This window appears when you click **Expand/Truncate** in the initial **Payor Plan Alpha Search** window.



Action:

To find a payor: Type part or all of the payor's name or group name in the Payor Name or Group Name fields, and then click **OK**.

To hide payors' addresses: Click **Expand/Truncate** to display the initial **Payor Plan Alpha Search** window. To view the addresses (that is, to return to this window), click the button again.

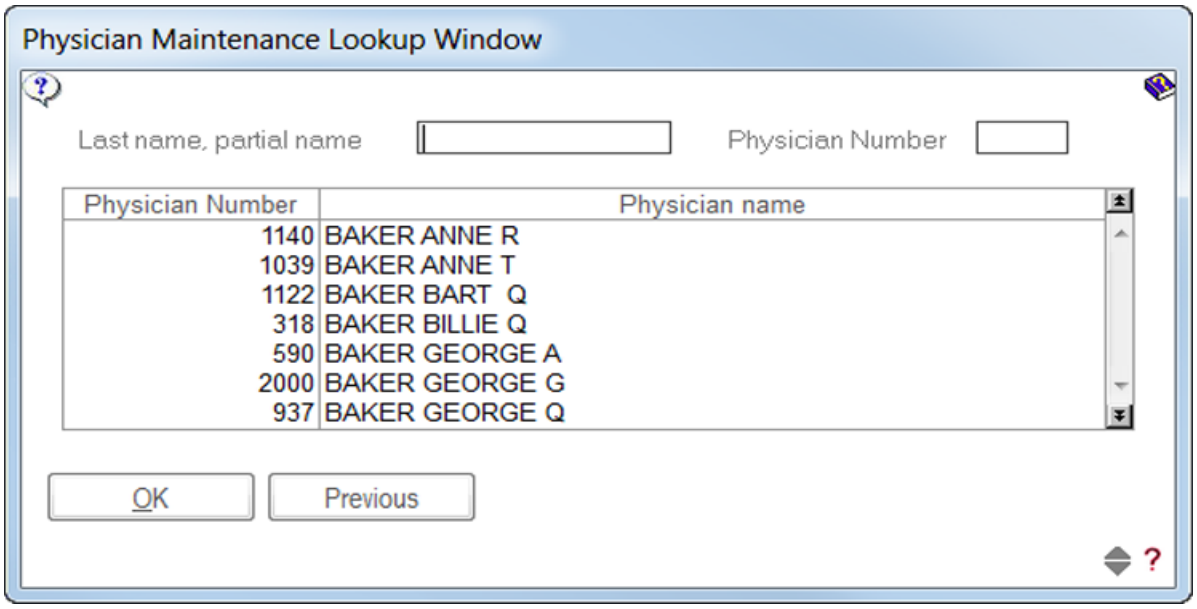
To view comments for a payor: Click on the payor's name to highlight it, and then click **Display Comments**.

To select a payor: Click on the payor's name to highlight it, and then click **OK** (or just double-click on the payor's name).

PHYSICIAN MAINTENANCE LOOKUP WINDOW

The **Physician Maintenance Lookup** window lists physicians that are maintained in *Patient Accounting* through *Physician File, Option 16* on *File Maintenance Menu I* (MNTMN1). The file can be listed/printed in *Patient Accounting* through *List Doctor Master File, Option 11* on *File Listing Menu I* (MNTMN2).

This window appears when you click next to a physician field in the **Discharge Maintenance** window, **In-House Maintenance** window, or **Patient Demographics** window.



Action

To find a physician by name: Type part or all of the physician's last name in the Last name, partial name field, and then click **OK**.

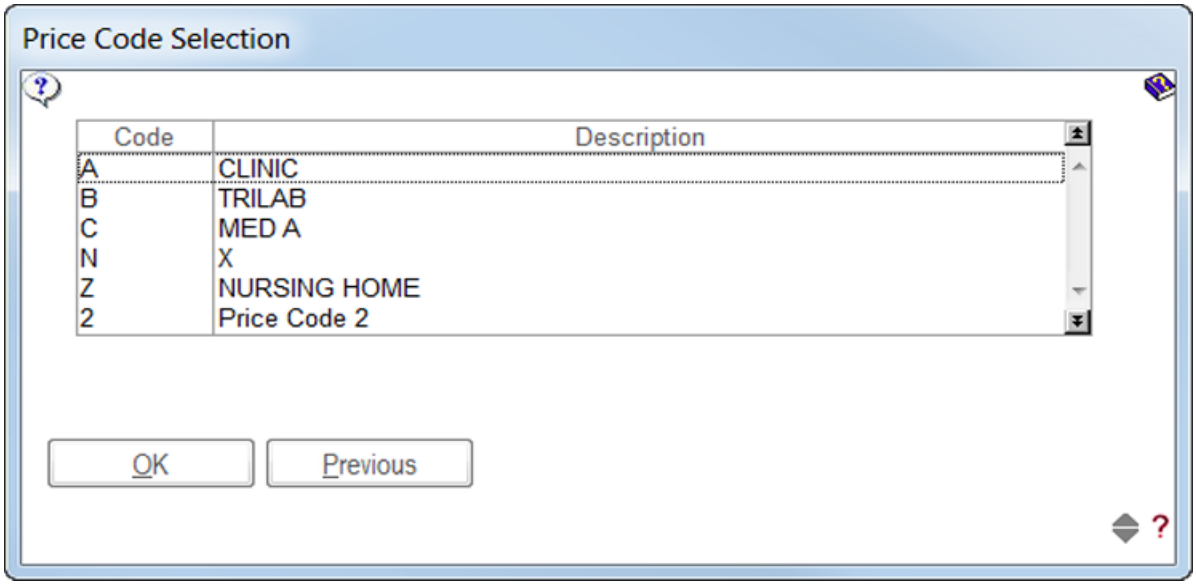
To find a physician by number: Type the physician number in the Physician Number field and click **OK**.

To select a physician: Click on the physician's name to highlight it, and then click **OK** (or just double-click on the physician's name).

PRICE CODE SELECTION WINDOW

The **Price Code Selection** window lists codes that are maintained in *Patient Accounting* through *Alternate Price Code Maintenance, Option 6* on *File Maintenance Menu II* (MNTMN3). The codes can be listed/printed in *Patient Accounting* through *List Alternate Price Codes, Option 4* on *File Listing Menu II* (MNTMN4).

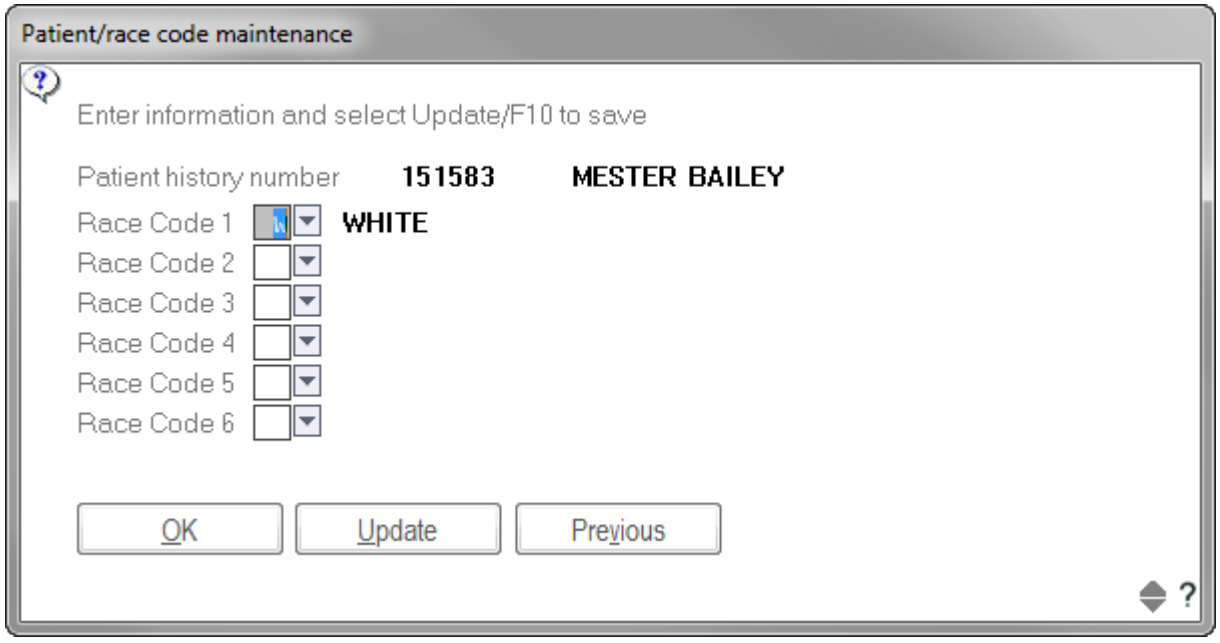
This window appears when you click next to the Price code field in the **Discharge Maintenance** window or the **Financial Information** window.



Action Select a code by clicking on it (to highlight it). Then click **OK** (or just double-click on the code).

RACE CODE SELECTION WINDOW

This window appears when you click next to the Race field in the **In-House Maintenance** window or **Patient Demographics** window.



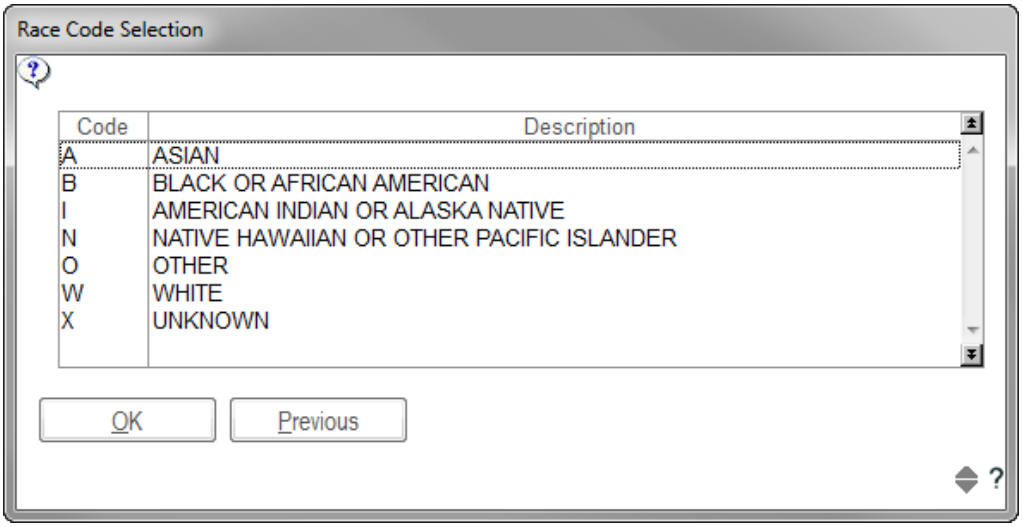
Only the race selected in position 1 will show on the ***Patient Maintenance or Patient History File Maintenance*** window.

NOTE: The same race code may not be selected more than once. If the Patient's History Information supplies a code that has since been deactivated and it is not changed, before allowing the user to move to the next screen a soft warning will appear that the code should be updated if possible. For a new code, an error message will appear if an invalid code is entered. Press **F4** to view available codes.

Action

- To validate the code(s) click **OK**.
- To save the code(s) to the patient's file click **Update**.
- To return without saving any changes click **Previous**.

RACE SELECTION

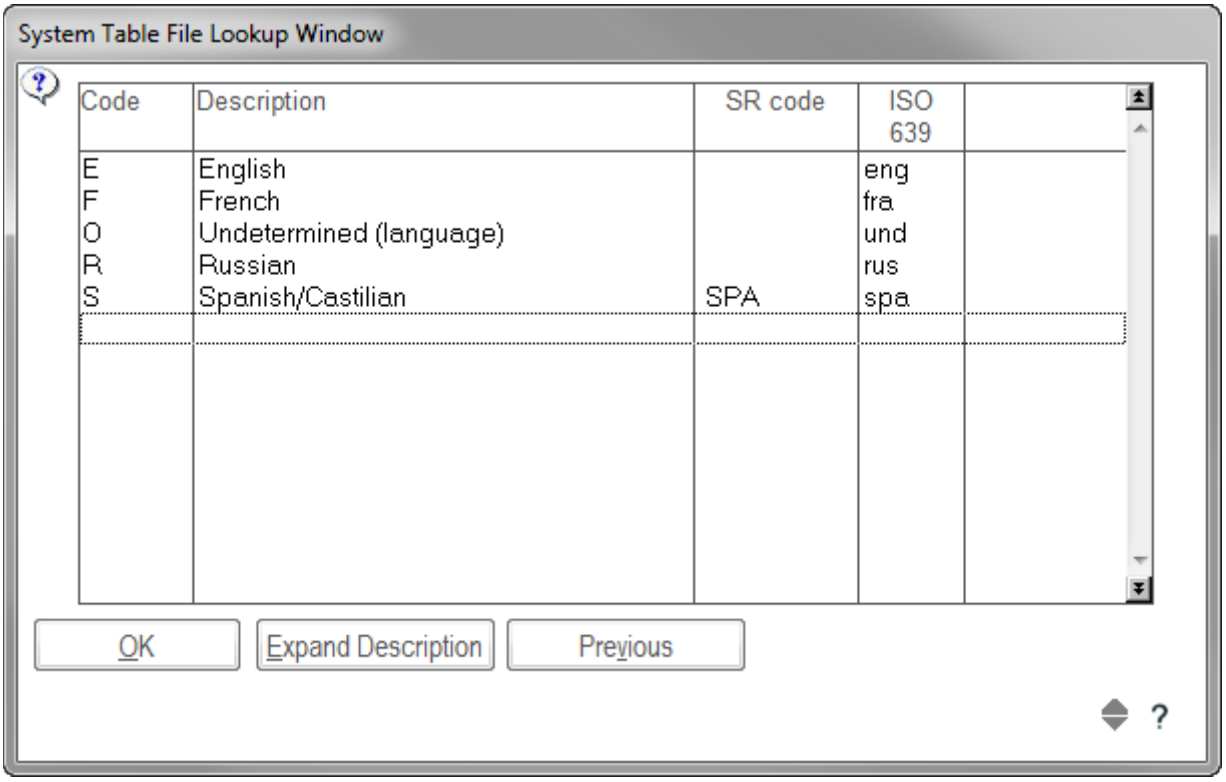


The **Race Code Selection** window lists only active race codes that are maintained in *Patient Accounting* through *Race Cross-Reference Codes, Option 3* on *System Table* (*Hospital Table File*) *Menu II* (TABMN1).

Action

- To select a code highlight it and click **OK**.
- To return without selecting a code click **Previous**.

PRIMARY LANGUAGE



This screen displays from the search prompt next to Primary Language. This screen shows only active codes as set up in ***System Table II Menu, Option 2: Primary Language codes***.

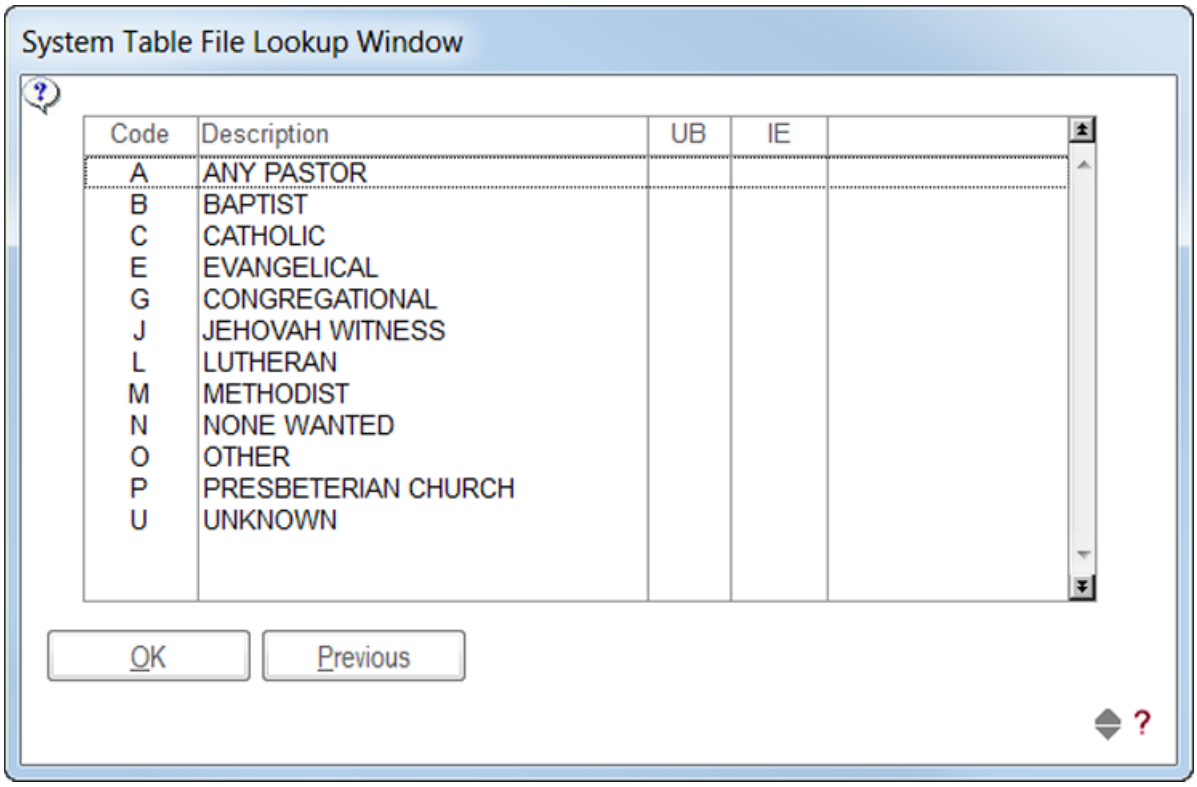
Action

- To select a code highlight it and click **OK**.
- To see a full description click **Expand Description**.
- To return without selecting a code click **Previous**.

SYSTEM TABLE FILE LOOKUP WINDOW

The specific codes listed in this window depend on the field you're using when you display it.

This window appears when you click next to the Periodic bill, Diet code, Religion, or Guarantor relationship fields in the **In-House Maintenance** window or **Patient Demographics** window.

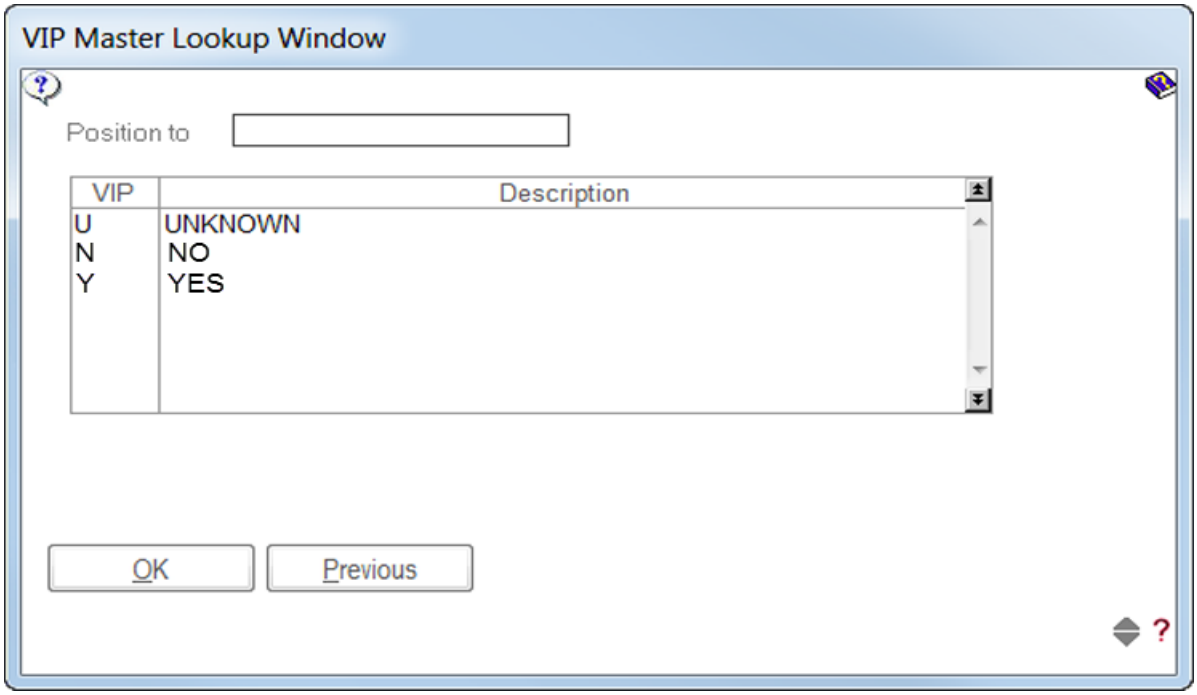


Action Select a code by clicking on it (to highlight it). Then click **OK** (or just double-click on the code).

VIP MASTER LOOKUP WINDOW

The **VIP Master Lookup** window lists VIP codes that are maintained in *Patient Accounting* through *VIP Code Maintenance, Option 19* on the *System Table (Hospital Table File) Menu* (TABMNU). The codes can be listed/printed in *Patient Accounting* through *List VIP Codes, Option 9* on *File Listing Menu II* (MNTMN4). These codes specify the patient's VIP status as, for example, a senior citizen or a person who merits special treatment.

This window appears when you click next to the VIP field in the **In-House Maintenance** window or **Patient Demographics** window.



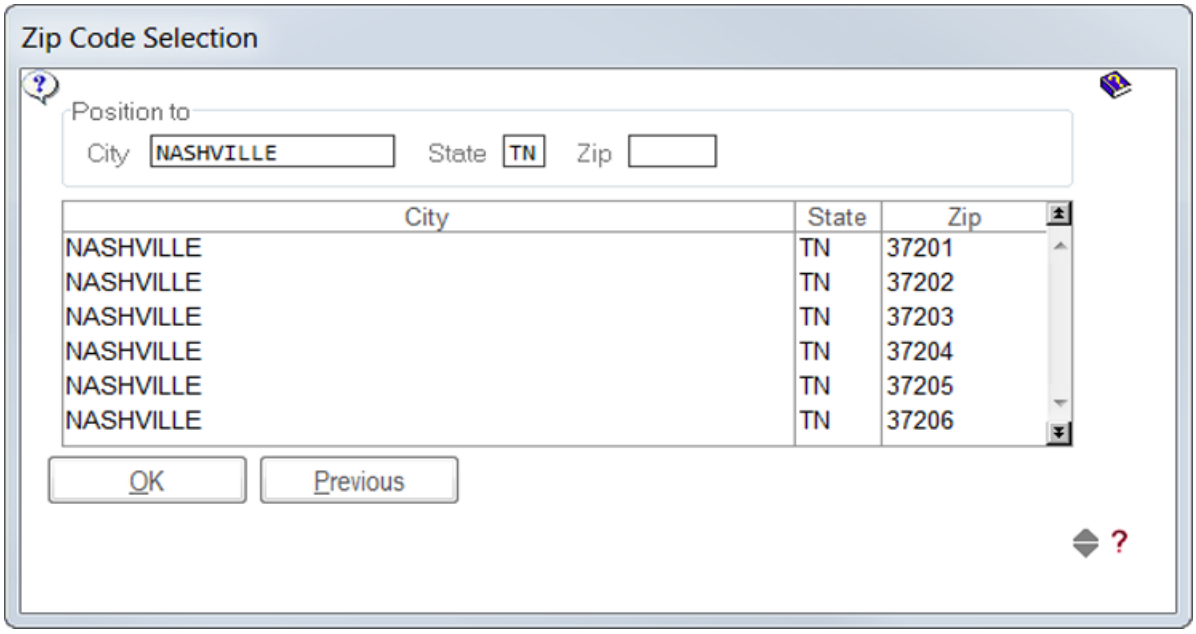
Action

To find a code: Type part or all of the code's description in the Position to field, and then click **OK**.

To select a code: Click on the code to highlight it, and then click **OK** (or just double-click on the code).

ZIP CODE SELECTION WINDOW

This window appears when you click next to the City field in the alternate address window, next to City, ST, or Zip in the **Patient Demographics** window, or next to Zip Code in the **Guarantor Maintenance** window.



Action

To find a city: Type part or all of the city name in the City field, and then click **OK**.

To find a state: Type the state's two-letter postal abbreviation (such as **CA** for California or **TN** for Tennessee) in the State field, and then click **OK**. The state's cities will be listed alphabetically.

To find a zip code: Type part or all of the zip code in the Zip field, and then click **OK**. The state's cities will be listed alphabetically.

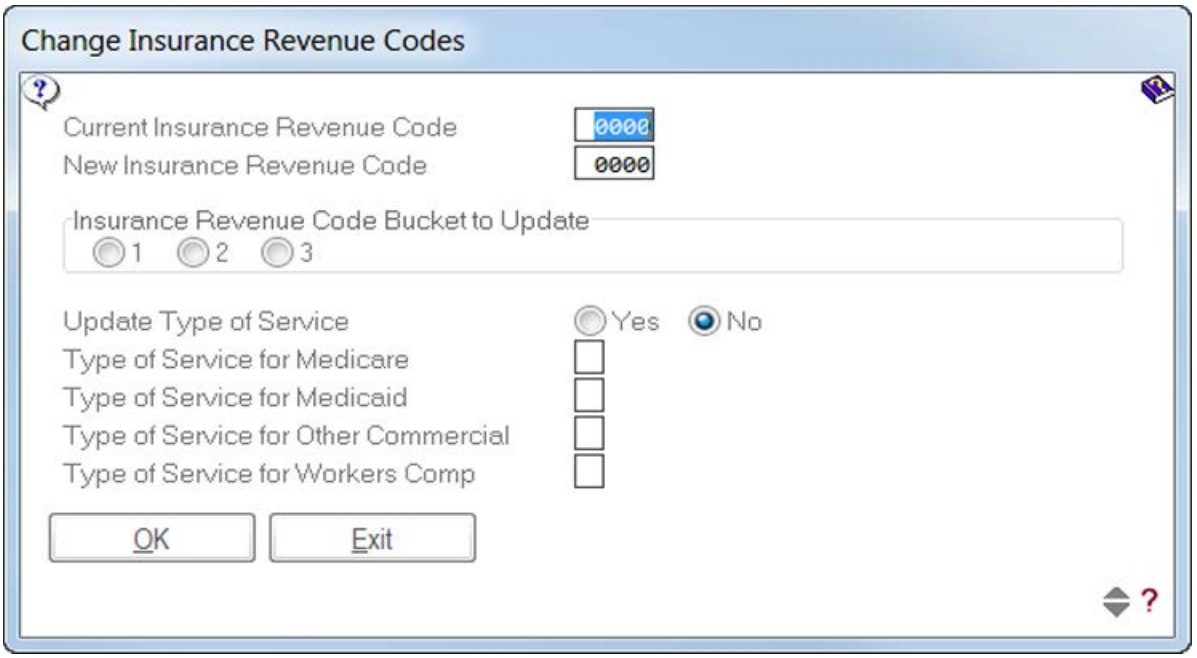
To select a city/state/zip code: Click on the city's name to highlight it, and then click **OK** (or just double-click on the city's name).

EBMAIN Option 8: Change Insurance Revenue Codes

Overview: **Change Insurance Revenue Codes** (Option 8 on the Electronic Billing Maintenance Menu) is used to change insurance revenue information in files for all patients.

Do not use this option unless instructed to do so by Customer Support.

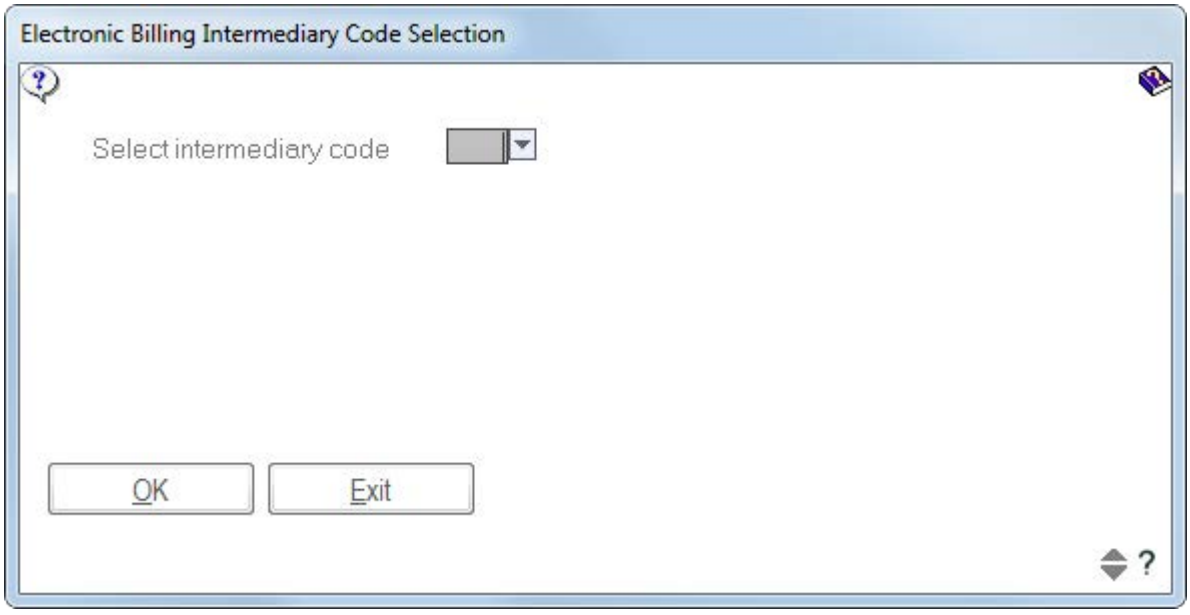
Files: CHRGDESC, INSCDSUM, PACPTCD

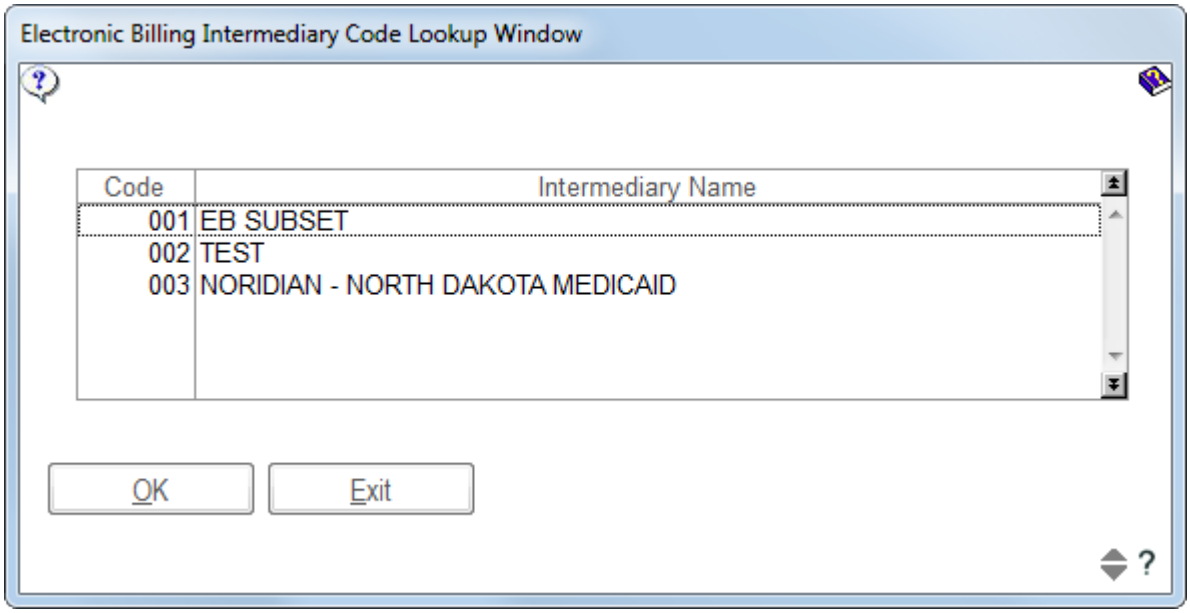


Action: Contact Customer Support and follow the instructions provided.

EBMAIN Option 9: Purge Old EB Save Files

Overview: The **Purge old EB save files option** (Option 9) screen will display how many files were successfully purged and the number of attempted purges by non-authorized users.





Enter or select an intermediary in order to purge save files.

The Save files (EBSAVFXXX where XXX equal the intermediary) will be purged based on the field **Save file purge days** in the Maintain EB system control record, Option 1 on the Maintenance Menu.

The number of save files deleted and the number not deleted due to the user not being authorized to delete will be displayed.

Press OK to return to the menu.

EBMAIN Option 10: Maintain Taxonomy Code File

Overview:

Maintain Taxonomy Code File (Option 10 on the Electronic Billing Maintenance Menu) is used to enter and maintain the taxonomy codes. You can add and delete a code, as well as change a code's information.

The taxonomy code identifies the type of health-care provider involved in furnishing services to beneficiaries. The code identifies the provider type, classification, and specialization. This code is a HIPAA-mandated standard code that is used when conducting certain electronic data interchange health transactions such as electronic billing. Taxonomy codes are maintained by the National Uniform Claim Committee (NUCC).

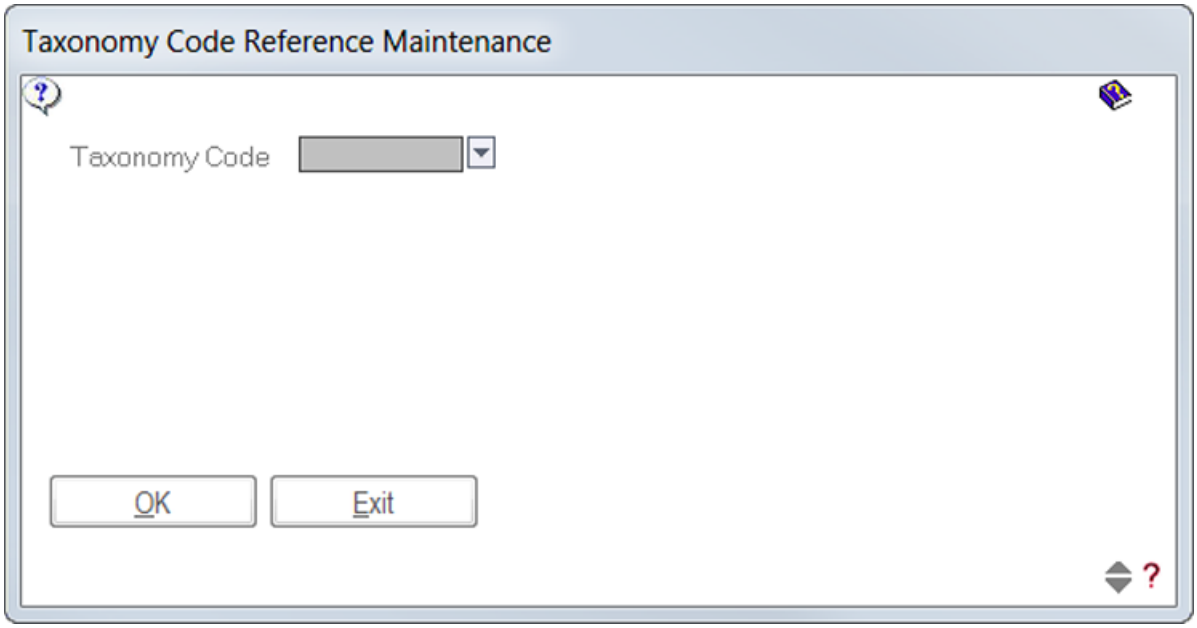
File:

TAXNMYREF

In this section

Taxonomy Code Entry window

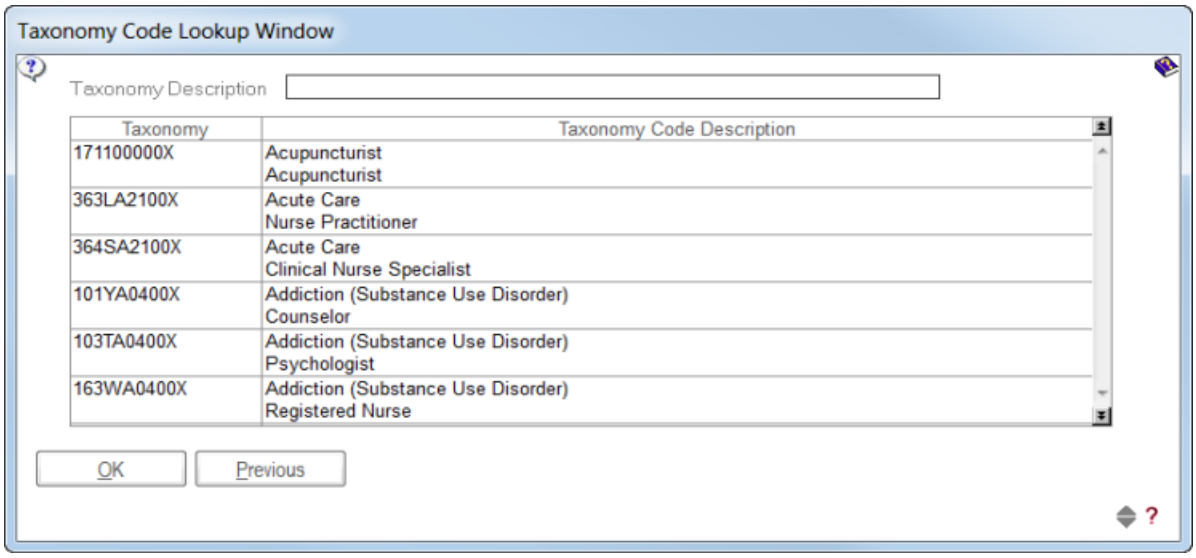
This window appears when you select **Maintain Taxonomy Code File** in the Electronic Billing Maintenance Menu.



Action Enter the taxonomy code you want to set up or maintain, and then click **OK**. You can either type the code or click to search for it in the **Taxonomy Code Lookup** window.

Taxonomy Code Lookup window

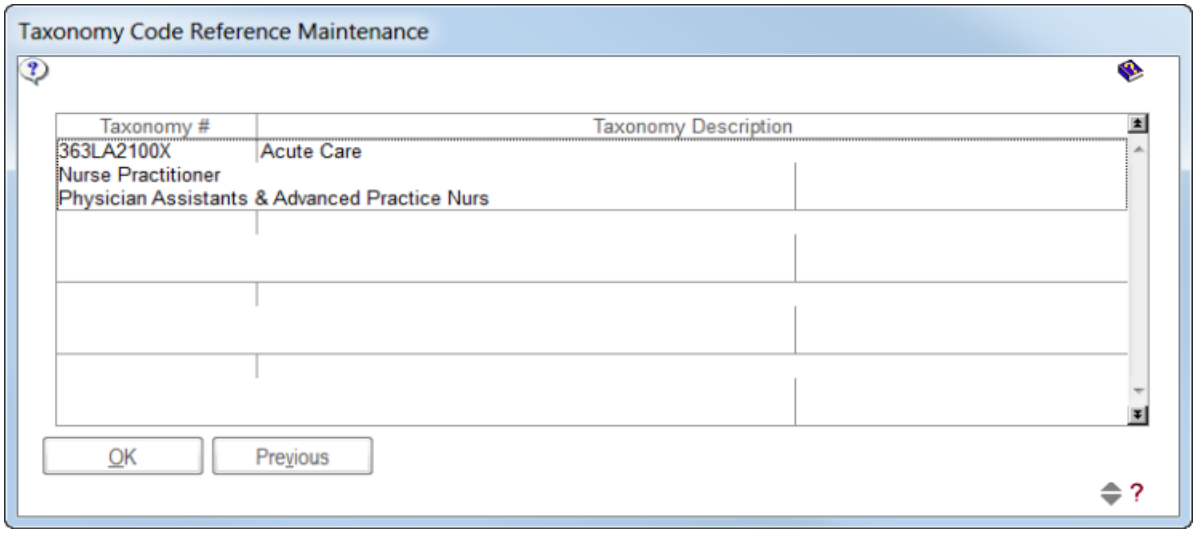
This window appears when you click in the taxonomy code entry window.



Action Select a taxonomy code by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the code).

Taxonomy Code Reference Maintenance window

This window appears when you select a taxonomy code in the **Taxonomy Code Lookup** window.

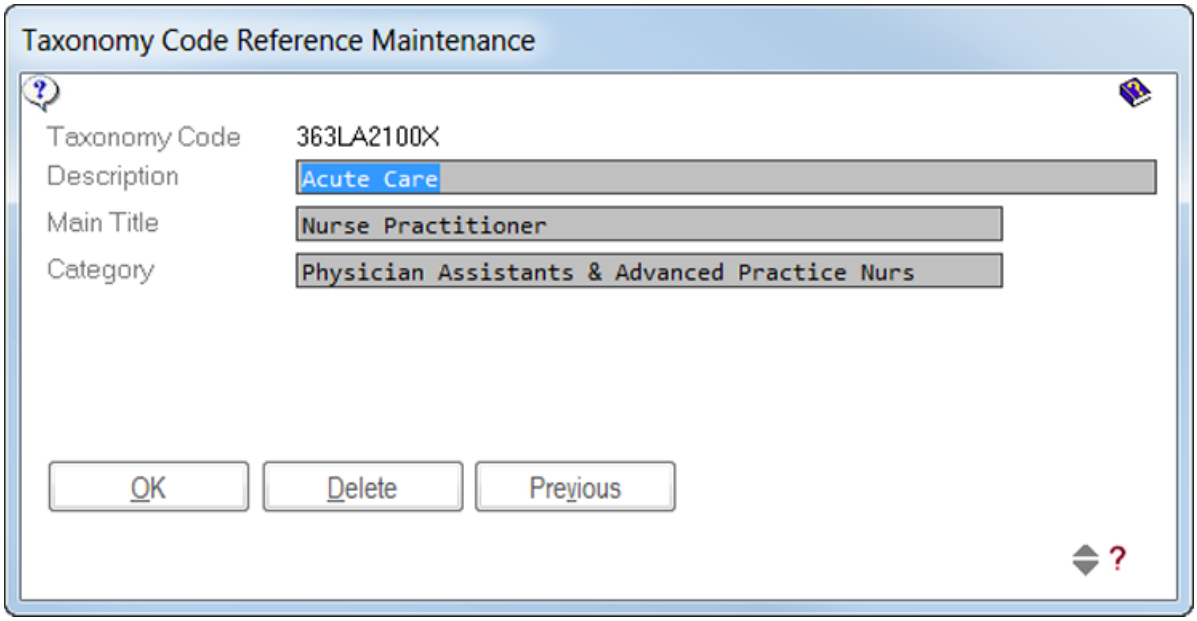


Action Select a taxonomy code by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the code).

Taxonomy Code Information window

The information window is used to add or delete a taxonomy code, or to update a code's information.

This window appears when you select a taxonomy code in the **Taxonomy Code Reference Maintenance** window.



Action

To enter or maintain information: Type the selected code's description, main title, and/or category in the window, and then click **OK** to save your entries.

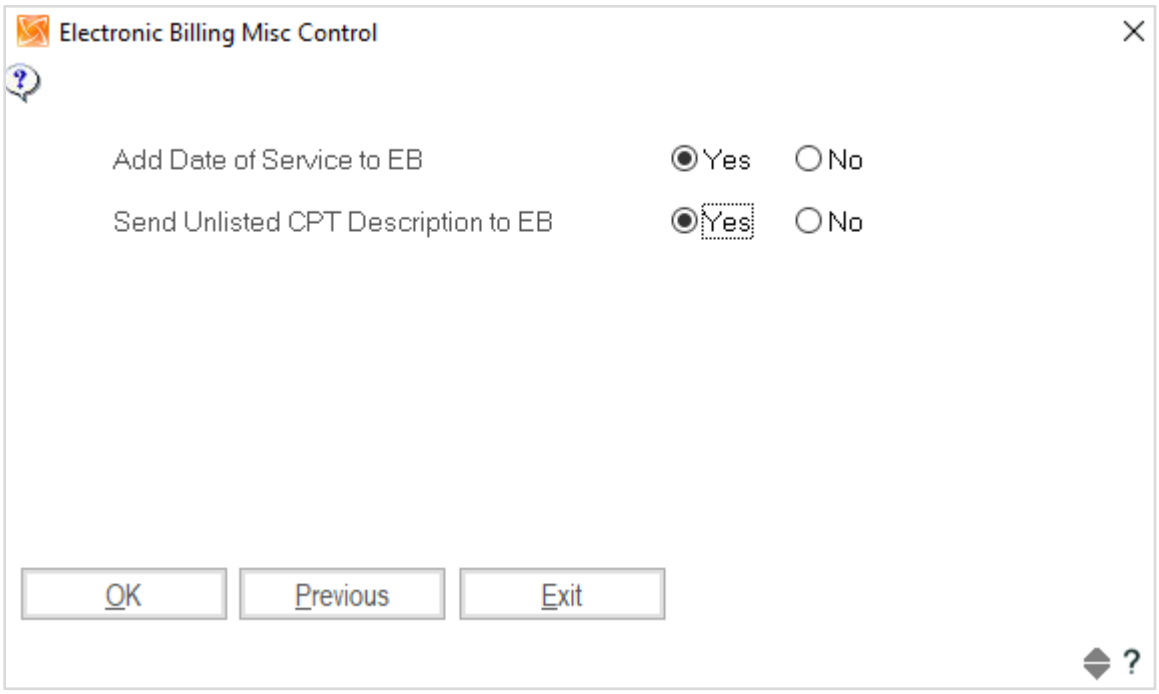
(Clicking **Previous** returns you to the taxonomy code entry window, without saving any information you entered or changed.)

To delete the code from the file: Click **Delete**. Be sure you want to delete the code. There is no confirmation window that appears; as soon as you click **Delete**, the code is deleted from the file.

EBMAIN Option 11: Maintain EB system misc control

Overview: **Maintain EB system misc control** (Option 11 on Electronic Billing Maintenance Menu) controls aspects of the electronic billing process.

File: SYSCONFIG



Action

Select **Yes** or **No** for the fields and click **OK**.

About Add Date of Service to EB

Users can designate whether to include dates of service on electronic billing transmissions for inpatients with commercial insurance. This allows facilities to submit charges as required by payors for residential room and bed charges. For example, charges for revenue code 1002 are electronically transmitted with each date of service on a single line.

This impacts only the electronic billing transmission. UB billing (paper bills) remains unchanged.

These options must be set up for dates of service on individual lines:

- **Payor plan file** (Option 18 on the File Maintenance Menu I)
  Itemize by date of service field must be set to 1 or 2
  1 = Summarize by date of service on UB claim
  2 = Claim for each date of service
- **UB revenue codes file** (Option 5 on the File Maintenance Menu I)
  Print by date of Service for Other field must be set to **Yes** for the payor plan type

About Send Unlisted CPT Description to EB

Users can send the descriptions for unlisted CPT codes for both inpatients and outpatients in the electronic billing file (837). This enhancement meets payor requirements and eliminates rejections due to missing descriptions on inpatient accounts.

> **NOTE**:
> Unlisted CPT codes do not describe a specific procedure or service. If no other CPT code adequately describes a procedure or service, unlisted CPT codes can be used. Listed below are a few examples:
> - CPT G6021 - Unlisted procedure, small intestine
> - CPT 01999 - Unlisted anesthesia procedure
> - CPT 81479 - Unlisted molecular pathology

> **NOTE**:
> If the facility's **State** is **PR** for Puerto Rico in the **Hospital name/addr/id# record**, **Send Unlisted CPT Description to EB** defaults to **Yes**. The field defaults to **No** for all other facilities.

EBRPT1: Electronic Billing Reports Menu I

Overview:

Electronic Billing Reports Menu I is used to run Electronic Billing reports on demand.

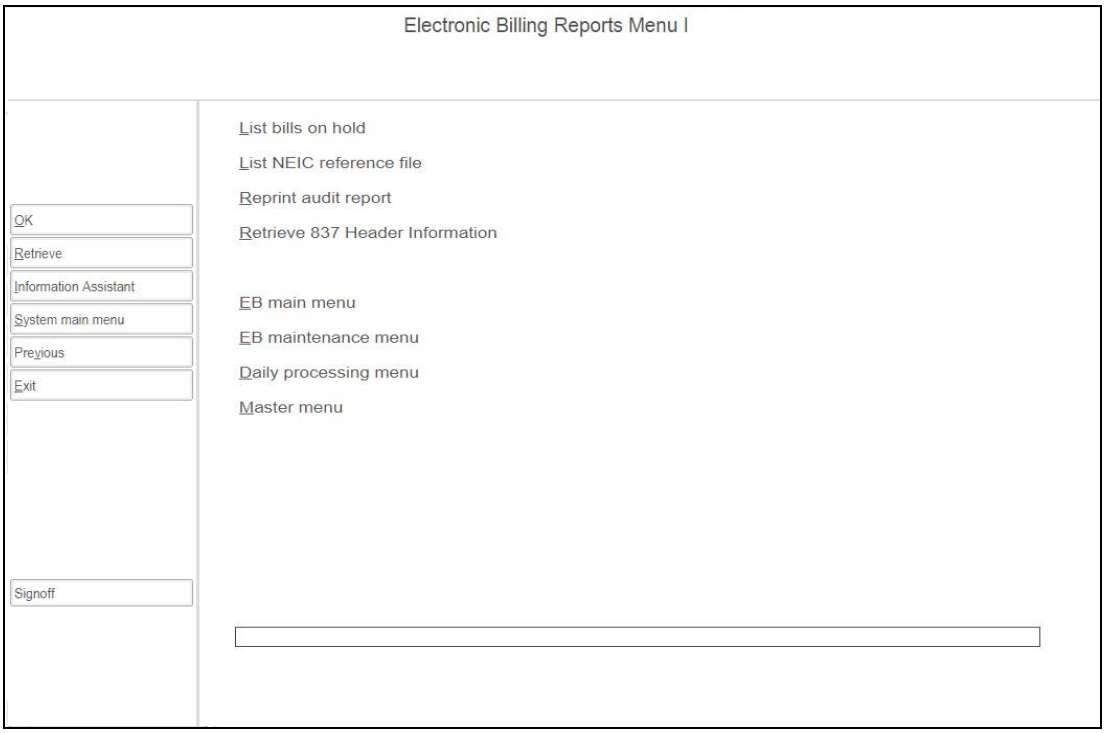
This menu appears when you select **EB Reports Menu** (Option 21) on the Electronic Billing Main Menu.

The following pages describe each Maintenance Menu option in sequential order and any main windows that follow each selection. Any reports generated by the system are also described.

Action:

Select a menu option by clicking on it.

Menu option descriptions begin on the next page.



The **Option** column shows the AS/400 green screen menu option number, which you can see in the GUI window by moving the mouse pointer over the menu option and holding it there without clicking.

Option Name	Option	Description
List bills on hold	1	Create a list of all electronic billing claims placed on hold using Hold Electronic Bills, Option 4 on the Electronic Billing Main Menu.
List NEIC reference file	2	Print a listing of the NEIC (National Electronic Information Corporation) reference master file.
Reprint audit report	3	Reprint a copy of the audit report that was received using Receive Audit Reports, Option 9 on the Electronic Billing Main Menu.
Retrieve 837 Header Information	4	Print 837I and 837P header information for UB and 1500 electronic bills so that the information can be entered in header records through Maintain EB System Control Record, Option 1 on the Electronic Billing Main Menu.
EB main menu	20	Display the Electronic Billing Main Menu, the primary menu in the Electronic Billing system.
EB maintenance menu	21	Display the Electronic Billing Maintenance Menu for accessing the Electronic Billing file maintenance options. The system control file, intermediary file, outside lab file, and patient benefits maintenance can be maintained from this menu. Also, from this menu, storage media can be initialized to save and backup the electronic billing files. The backup can be restored from this menu.
Daily processing menu	22	Display the Daily Processing Menu, which is covered in the Patient Accounting manual.
Master menu	23	Display the Master Menu for your facility.

EBRPT1 Option 1: List Bills on Hold

Overview:

List Bills on Hold (Option 1 on Electronic Billing Reports Menu I) is used to create a list of all electronic billing claims placed on hold using Hold Electronic Bills, Option 4 on the Electronic Billing Main Menu.

The report is also printed automatically at the time the claims are placed on hold.

No prompt window appears when you select this option; the report simply prints to your default output queue.

Program:

EB0R01

Selection:

None

File:

XNSUB82

EB0R01 EXAMPLE FACILITY PAGE: 1
MONITOR Electronic Bills On Hold DATE: 12/31/04
TIME: 14:40:18

CLAIM TYPE	PATIENT NUMBER	CYCLE NUMBER	PATIENT NAME	PATIENT TYPE	INSURANCE TYPE	BILL TYPE	ADMISSION DATE	DISCHARGE DATE
UB	5702167	01	DAUGHTREY ROBERT M III	I	BLUE CROSS	141	12/01/92	12/02/92
UB	1515733	01	NELSON MAUDIE R	I	MEDICAID	111	12/05/92	12/07/92
UB	1516012	01	DARBY HOUSTON	I	MEDICAID	111	12/10/92	12/13/92
UB	1516145	01	WILLIS DELENE	I	MEDICAID	111	12/15/92	12/20/92

EBRPT1 Option 2: List NEIC Reference File

Overview:

List NEIC Reference File (Option 2 on Electronic Billing Reports Menu I) is used to print a listing of the NEIC (National Electronic Information Corporation) reference master file.

The report prints the type of claims accepted, NEIC number, and description.

The NEIC number is entered in the Insurance Master File, Option 6 on File Maintenance Menu I in Patient Accounting. This number is used for electronic transmission of commercial claims.

Program:

NC0R01

Selection:

NEIC payor listing order—Payor name or payor number
Listing for type of claims—UB, 1500, or both

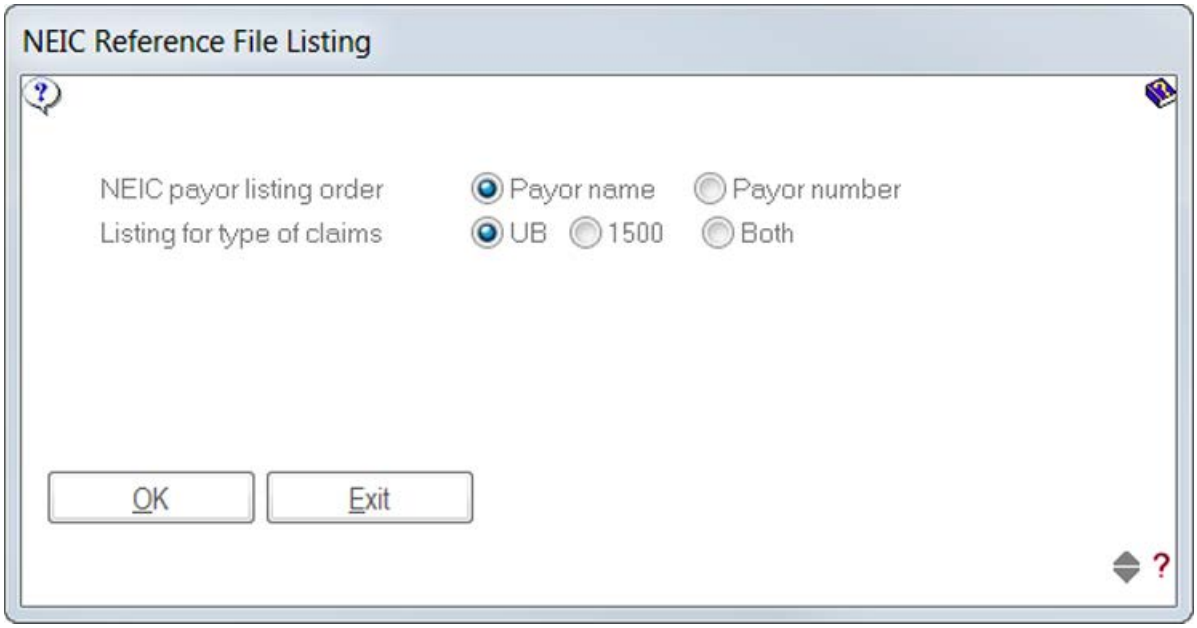
File:

NEICREF

In this section

NEIC Reference File Listing window

This window appears when you select **List NEIC Reference File** on Electronic Billing Reports Menu I.



Action Select (click on) the order in which you want to list information (payor name or number) and select the order type you want to include (UB, 1500, or both), then click **OK**.

Sample NEIC# Reference Master listing

NC0R01 EXAMPLE FACILITY PAGE 1
DATE 4/26/05 NEIC# REFERENCE MASTER 13:54:55

TYPE	NEIC NUMBER	DESCRIPTION
BOTH	01124	GEORGIA POWER COMPANY
1500	04284	TRAVELERS (CGT)
1500	04284	CGT (TRAVELERS)
BOTH	06102	DIVERSIFIED GROUP BROKERAGE (MARLBOROUGH, CT)
BOTH	06105	CONNECTICARE, INC.
1500	06111	OXFORD HEALTH PLAN
BOTH	06131	THIRD PARTY CLAIMS MANAGEMENT
BOTH	13310	SEABURY AND SMITH
BOTH	13310	BENEFIT PLAN ADMINISTRATOR (ST LOUIS, MO)
BOTH	13310	SEABURY & SMITH OFFICE OF ADMIN (WASHINGTON, DC)
UB	13551	GHI (GROUP HEALTH INC)
UB	13551	HIP - NY STATE
1500	14164	WELLCARE OF NEW YORK, INC.
1500	31118	CENTRAL BENEFITS LIFE
1500	31118	CENTRAL BENEFITS MUTUAL
1500	31118	CENTRAL BENEFITS NATIONAL
1500	31417	NATIONWIDE GROUP
1500	31417	NATIONWIDE INSURANCE
1500	31417	NATIONWIDE LIFE AND HEALTH
1500	34097	CENTRAL RESERVE LIFE
1500	34131	SELF-FUNDED PLANS (IL, OH, PA)
UB	35164	SAGMORE HEALTH NETWORK, INC.
BOTH	35175	CHAMPUS
1500	36215	CENTRAL STATES HEALTH & WELFARE FUNDS (SE & SW)
UB	36332	HEALTHSTAR, INC.
BOTH	37124	INTEGRATED BENEFIT SERVICES, IL
BOTH	37602	ALL SAVERS INSURANCE COMPANY
BOTH	37602	ROONEY LIFE INC.
BOTH	37602	GOLDEN RULE INSURANCE COMPANY
1500	38224	HEALTH ALLIANCE PLAN OF MICHIGAN
1500	39026	WAUSAU INSURANCE COMPANIES
BOTH	39151	WEA INSURANCE GROUP
BOTH	41045	NORTHWESTERN NATIONAL LIFE INSURANCE COMPANY
BOTH	41099	JOHN ALDEN LIFE INSURANCE COMPANY
BOTH	41170	HEALTH RISK MANAGEMENT (HRM)

EBRPT1 Option 3: Reprint Audit Report

Overview: **Reprint Audit Report** (Option 2 on Electronic Billing Reports Menu I) is used to reprint a copy of the audit report that was received using Receive Audit Reports, Option 9 on the Electronic Billing Main Menu. (A sample report can be found there.)

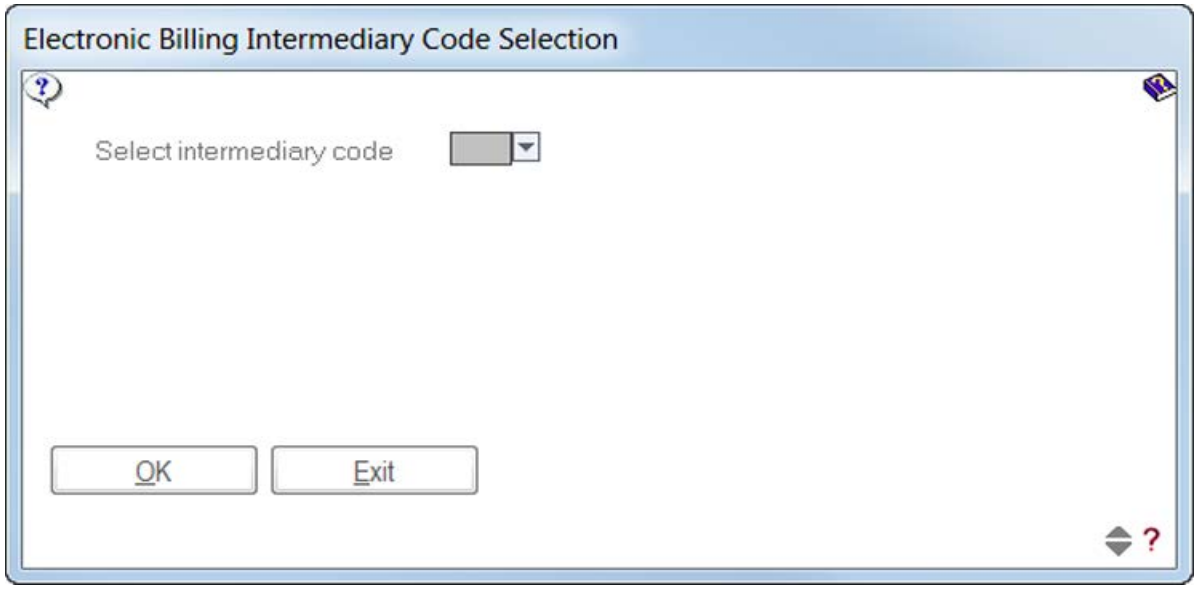
You need to know the intermediary in order to reprint the report.

File: EBAUDIT

In this section

Intermediary Code Selection window

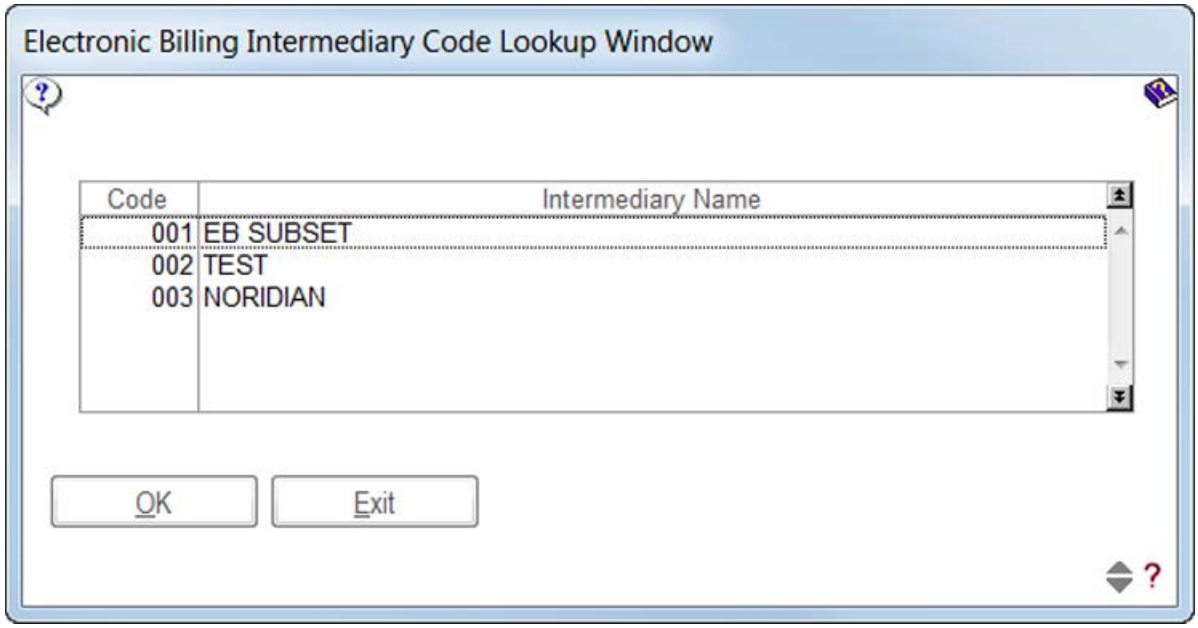
This window appears when you select **Reprint Audit Report** in Electronic Billing Reports Menu I.



Action: Enter the intermediary code by typing it or by clicking to search for it in the **Electronic Billing Intermediary Code Lookup** window; then click **OK**.

Electronic Billing Intermediary Code Lookup window

This window appears when you click in the **Intermediary Code Selection** window.



Action: Select an intermediary by clicking on it (to highlight it) and then clicking **OK**. (You can also just double-click on the intermediary).

EBRPT1 Option 4: Retrieve 837 Header Information

Overview: **Retrieve 837 Header Information** (Option 4 on Electronic Billing Reports Menu I) is used to print header information for the UB or 1500 electronic bill that was most recently restored.

This information can then be entered in the header records through Maintain EB System Control Record, Option 1 on the Electronic Billing Maintenance Menu.

No prompt window appears when you select this option; the report simply prints to your default output queue.

Program: EB0R03

Selection: None

Files: EBINTMED, ELECBILL, SYSCTL

EB0R03 MONITOR 837 Header Information Page No: 1
059 - BLUE CROSS OF TENNESSEE Print Date: 8/31/06
837I Time: 16:30:48

INTERCHANGE CONTROL HEADER

Authorization Qualifier (ISA01)	Authorization Info. (ISA02)	Security Qualifier (ISA03)	Security Info. (ISA04)	Inter. ID Qual. (ISA05)	Interchange Sender ID (ISA06)
00		01	SECRET	ZZ	SUBMITTERS.ID

Inter. ID Qualifier (ISA07)	Interchange Receiver ID (ISA08)	Inter. Ctl Standards ID (ISA11)	Inter. Control Version (ISA12)
ZZ	RECEIVERS.ID	U	00401

Acknowledgment Request (ISA14)	Component Elmt Separ. (ISA16)
1	:

FUNCTIONAL GROUP HEADER

Functional ID Code (GS01)	Application Sndr's Code (GS02)	Application Rcr's Code (GS03)	Responsible Agency Code (GS07)	Version/Release ID Code (GS08)
HC	SNDR CODE	RCV CODE	X	004010X096A1

TRANSMISSION TYPE HEADER

Reference ID Qualifier (REF01)	Reference ID (REF02)
87	004010X096A1

SUBMITTER NAME (LOOP 1000A)

Entity Identifier Code (NM101)	Entity Type Qualifier (NM102)	Name Last/Organ. Name (NM103)	Name First (NM104)	Name Middle (NM105)
41	2	ABC Submitter		

ID Code Qualifier (NM108)	Identification Code (NM109)
46	99999999

SUBMITTER EDI CONTACT INFORMATION HEADER

Contact Function Code (PER01)	Submitter Contact Name (PER02)	Communication Qualifier (PER03)	Communication Number (PER04)
IC	JANE DOE	TE	4159999680

Communication Qualifier (PER05)	Communication Number (PER06)

EB0R03 MONITOR 837 Header Information Page No: 2
059 - BLUE CROSS OF TENNESSEE Print Date: 8/31/06
837I Time: 16:30:48

RECEIVER NAME (LOOP 1000B)

Entity Identifier Code (NM101)	Entity Type Qualifier (NM102)	Name Last/Organ. Name (NM103)	ID Code Qualifier (NM108)	Identification Code (NM109)
40	2	CSC HEALTHCARE	46	112223333

** End of Report **

RMTADV: Electronic Remittance Advice Menu

Overview:

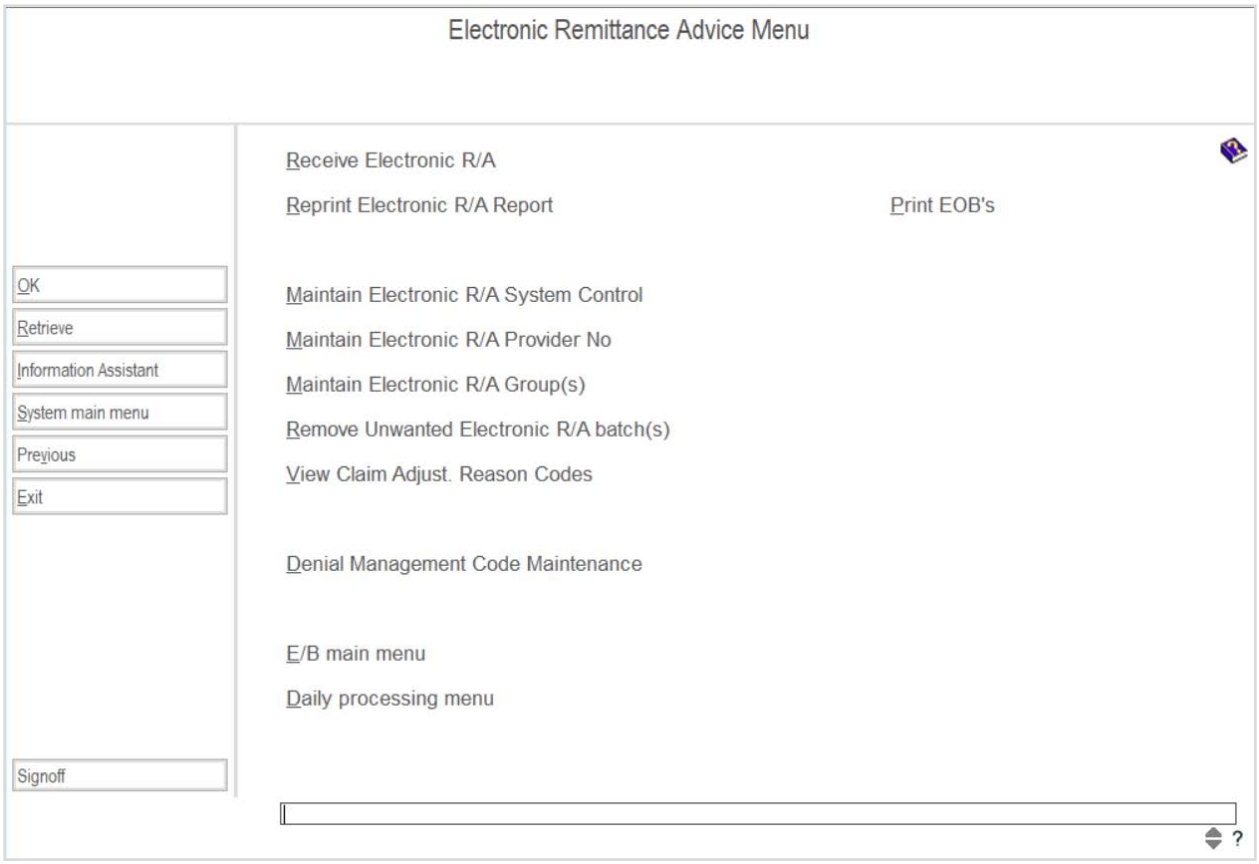
The Electronic Remittance Advice Menu is used to process electronic remittance advices.

This menu appears when you select **Electronic Remittance Advice Menu** (Option 11) on the Electronic Billing Main Menu.

The following pages describe each Electronic Remittance Advice Menu option in sequential order and any main windows that follow each selection. Any reports generated by the system are also described.

Action:

Select a menu option by clicking on it.



Option	Description
Receive Electronic R/A	Receive remittance advices from the intermediary by dialing and connecting to the intermediary, retrieving the remittance advices, and disconnecting from the intermediary. The received file is processed, and two reports will be generated: The Electronic Remittance Advice Listing and the Remittance Advice Error Report Listing.
Reprint Electronic R/A Report	Reprint the Electronic Remittance Advice Listing or the Remittance Advice Error Report Listing that are automatically generated in Option 1, Receive Electronic R/A.
Maintain Electronic R/A System Control	Create and maintain the system control record for the facility. This option can be run in live mode (for processing remittance advices) or in test mode. This option must be completed before attempting to process electronic remittance advices.
Maintain Electronic R/A Provider No	Maintain the hospital provider information to be used in electronic remittance advice processing. The information maintained in this option will override the information in Patient Accounting. Do not use this option unless instructed to do so by MEDHOST.
Maintain Electronic R/A Group(s)	Maintain ERA groups and the intermediary codes assigned within. When an ERA file is processed for one code, it will be processed for each of the other intermediary codes within the same group.
Remove Unwanted Electronic R/A batch(s)	Delete batches received in Option 1, Receive Electronic R/A. This option can only be run if the Electronic Remittance Advice system is running in the test mode, which is set up in Option 4, Maintain Electronic R/A System Control.
View Claim Adjust. Reason Codes	View and maintain the claim adjustment reason codes received by the intermediary.
Denial Management Code Maintenance	Maintain Denial Management Codes
Print EOB's	Print an explanation of benefits (EOB) for all patients who have a secondary insurance and have a record in Remittance Advice Entry, Option 6 on the Daily Processing Menu in Patient Accounting.
E/B main menu	Display the Electronic Billing Main Menu, the primary menu in the Electronic Billing system.
Daily processing menu	Display the Daily Processing Menu, which is not covered in this manual. Refer to the Patient Accounting User's Manual.

RMTADV Option 1: Receive Electronic R/A

Overview:

Receive Electronic R/A is used to receive remittance advices from the intermediary by several different methods, one method is dialing and connecting to the intermediary, retrieving the remittance advices, and disconnecting from the intermediary; the second method is by an automated SFTP process to pull the ERAs straight to Enter Remittance Advice, these clients use the Receive ERA option just once to start (or restart) the auto job; and then, the third method is clients sign on to their vendor's website and pull the file back to a drive on their PC then move it to the IFS and then they run the Receive ERA option to pull the data from the IFS to MEDHOST.

NOTE: No electronic R/A processes can be run during Day End, Month End, and/or Backup (PBBACKUP).

A batch header and detail records are created which contain the received information. Batch numbers 970 to 979 are reserved for electronic remittance advices. The batch can be maintained through Enter Remittance Advice, Option 6 on the Daily Processing Menu in Patient Accounting. It is suggested that users confirm that the ERA totals match the batch totals in the Enter Remittance Advice option.

Informational messages display while remittance advice data is being received. When the data has been received and the job has been submitted to batch for processing, the Electronic Remittance Advice Menu appears again, with the following message:
Job has been submitted to batch for completion.

The received file is processed and reports generated:

The **Electronic Remittance Advice Listing** generates and shows the remittance advice information received. It contains data for all claims including those with errors. Patients whose claim was not denied appear on this report. If a patient only had a line-item rejection (error), he or she will still appear on this report.

If *all* the conditions listed below are met, the contractual adjustment amount will *not* post and the report will include the following message wherever it is applicable:
**** Cont. Adj. Amount(s) will not post for a claim status code of 2 ****

The required conditions are:

- The insurance type is Blue Cross.
- The claims data are not in error.
- The claims status code is 2 (Processed as Secondary).
- The system ID matches S15550.

In this section

Receiving Bisynchronous

These messages will be displayed at the bottom of the screen if the facility is receiving using bisynchronous communications.

Setting Up Lines.
Receiving.

Receiving Asynchronously

These messages will be displayed at the bottom of the screen if the facility is receiving using asynchronous communications. The messages shown are examples from different intermediaries. The messages that your facility receives will depend on the intermediary from which your facility is receiving.

Mutual of Omaha—Receiving electronic R/A

Attempting to allocate resources...please wait.
Processing dial request.
Initialing modem.
Sending dial instruction. Phone #: 9999999999.
Session established with intermediary.
Sending User ID.
Sending password.
Asking to upload.
Receiving file.
Now logging off.
Hanging up.
Deallocating resources.
Session with Mutual of Omaha ended normally.

TN Blue Cross Blue Shield— Receiving electronic R/A

Attempting to allocate resources...please wait.
Processing dial request.
Initialing modem.
Sending dial instruction. Phone #: 9999999999.
Session established with intermediary.
Sending User ID.
Sending Password.
Logged on.
Making receive files from BCBSTN selection...
Selecting Reports / Remittance Advice option...
Choosing the select a library option...
Choosing the library.
Choosing the DOS file listing option...
Identifying available files.
Processing last screen of available files...
Selecting to download now...
Choosing zmodem protocol.
Sending a carriage return.
Choosing to exit...

Choosing the Exit File Libraries option...
Choosing to exit...
Now logging off.
Hanging up.
Deallocating resources.
Session with BCBS Tennessee ended normally.

File names and descriptions

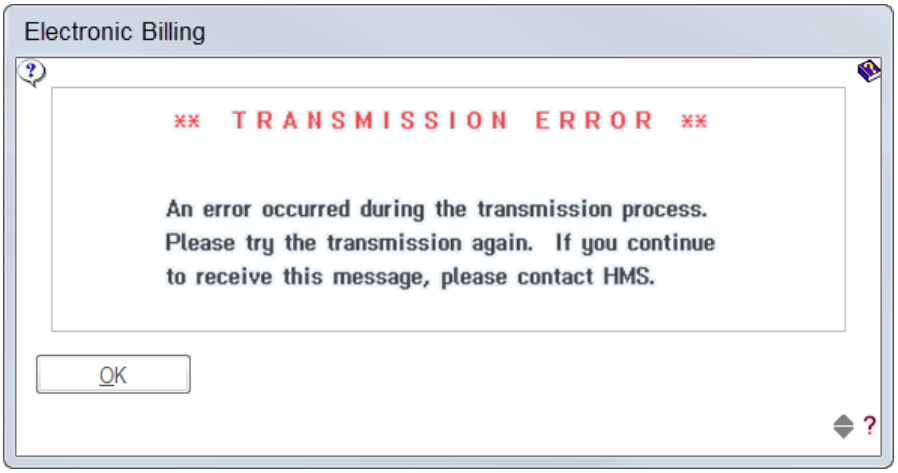
Listed below are the files that are used in the remittance advice system. These files can be used in Query to create a report containing information needed by the facility.

File	Description
EREDAT	835 Monetary Amounts
EREDATH	835 Monetary Amounts
EREDATHL1	835 Monetary Amounts
EREDATL1	835 Monetary Amounts
EREDCL	835 Claim Level Data
EREDCLH	835 Claim Level Data
EREDCLHL1	835 Claim Level Data
EREDCLHL2	835 Claim Level Data
EREDCLHL3	835 Claim Level Data
EREDCLL1	835 Claim Level Data
EREDCLL2	835 Claim Level Data
EREDCLL3	835 Claim Level Data
EREDCS	835 Claim Level Adjustments (CAS)
EREDCSH	835 Claim Level Adjustments (CAS)
EREDCSHL1	835 Claim Level Adjustments (CAS)
EREDCSL1	835 Claim Level Adjustments (CAS)
EREDFH	835 File Header
EREDFHH	835 File Header
EREDLQ	835 Industry Code
EREDLQH	835 Industry Code
EREDPA	835 Provider Adjustment
EREDPAH	835 Provider Adjustment
EREDQY	835 Provider Subtotal Data
EREDQYH	835 Provider Subtotal Data
EREDQYHL1	835 Provider Subtotal Data
EREDQYL1	832 Provider Subtotal Data
EREDRF	835 Reference Numbers
EREDRFH	835 Reference Numbers
EREDSV	835 Service Information
EREDSVH	835 Service Information
EREDSVHL1	835 Service Information
EREDSVL1	835 Service Information
EREDTS	835 Transaction Statistics
EREDTSH	835 Transaction Statistics

The Physical Files with **H** at the end of the file name (and listed in bold above), as in EREDATH, will hold the processed Electronic Remittance Advice information. The **H** at the end of the file name indicates that the file contains history information.

Transmission error window

This window appears when an error occurs during an attempted transmission or reception.

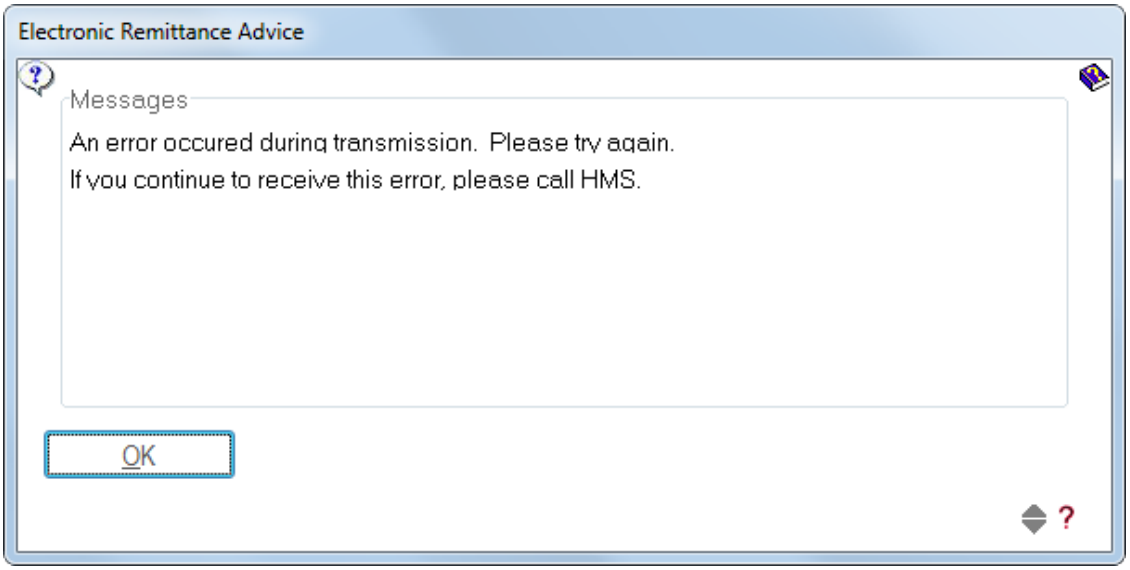


Action Click **OK**, then try transmitting or receiving again. If this window appears again, contact MEDHOST Support.

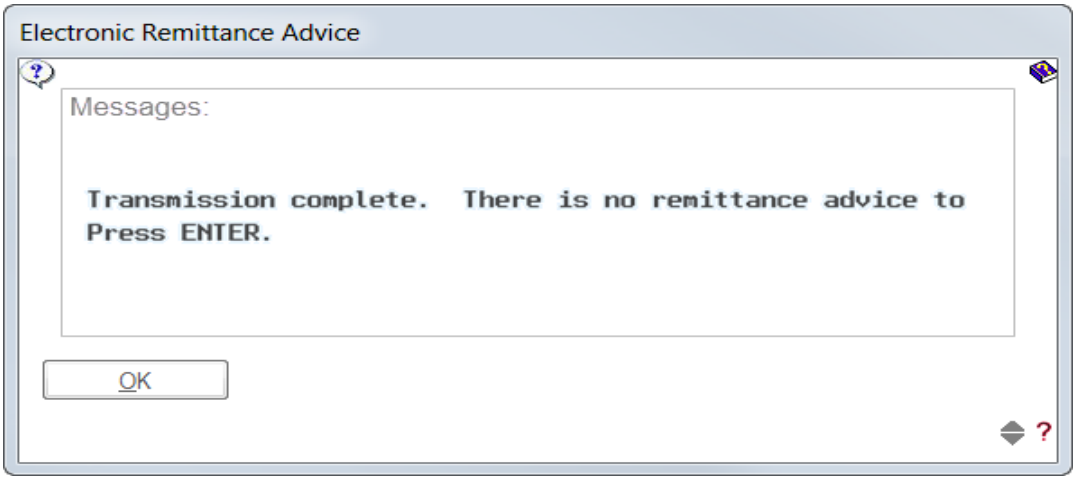
Message windows

Action Click **OK**, then follow any instructions the window gives.

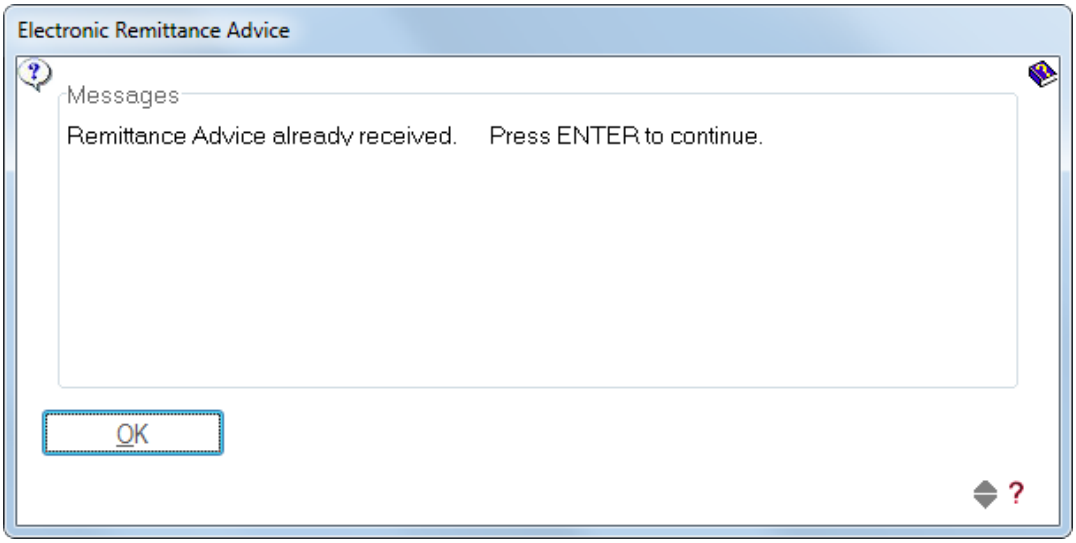
The window below appears when an error occurs while you are attempting to transmit or receive data. After clicking **OK**, try again. If the window appears a second time, call MEDHOST Support.



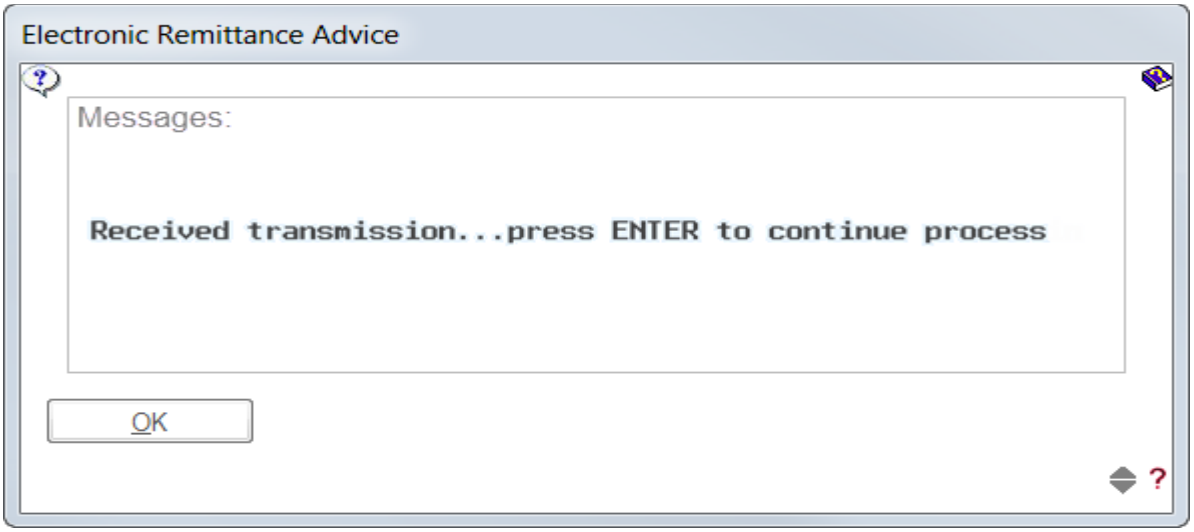
The window below appears when the remittance file you are attempting to receive is empty.



The window below appears when the file you are attempting to receive has already been received from the intermediary from a previous dial-up, but has not yet been processed.



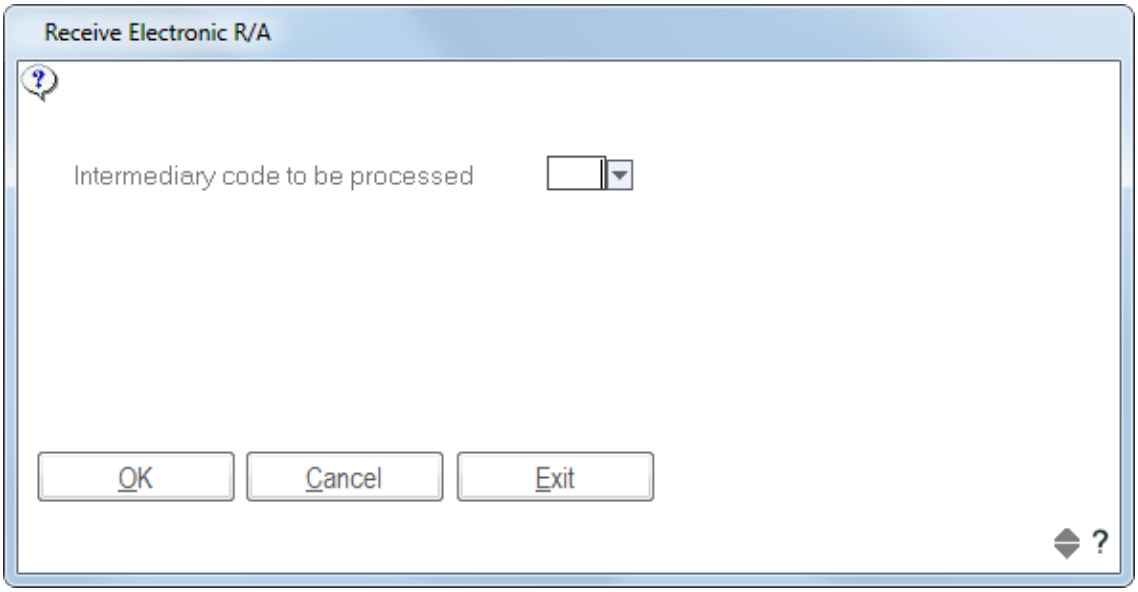
The window below appears when you have successfully received electronic remittance advice.



Intermediary code selection window

This window appears when you select **Receive Electronic R/A** from the Electronic Remittance Advice Menu. This option may need to be run multiple times per day if the client uses multiple intermediaries

Note: No electronic R/A processes should be run during Day End, Month End, and/or Backup (PBBACKUP).



Action

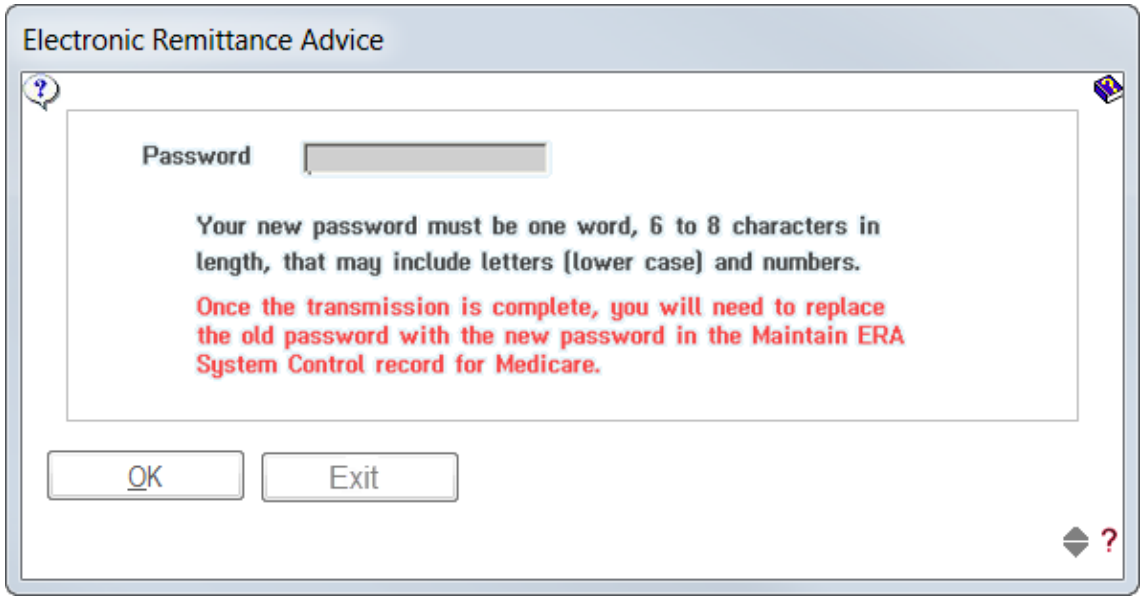
Enter the 3-digit intermediary code you want to use, and then click **OK**. You can either type the code or click to search for it in the **Electronic R/A Intermediary Code Lookup** window.

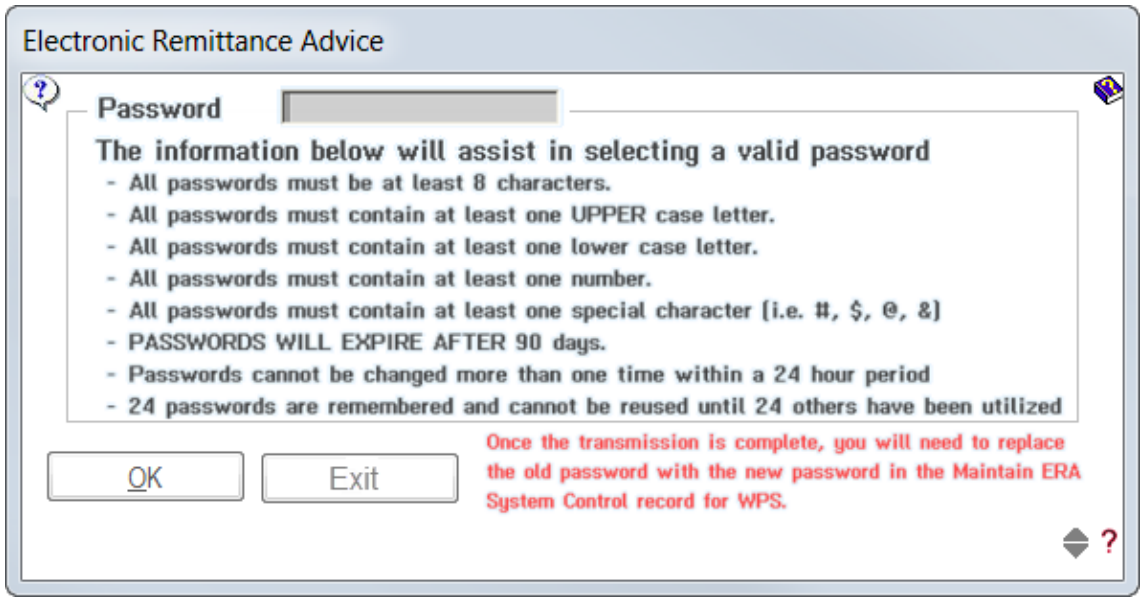
These codes are set up and maintained through Maintain Intermediary File, Option 2 on the Maintenance Menu.

Password window

This window appears when the password has expired and a new one must be entered.

Two sample windows are shown below, but the precise instructions that appear will vary, depending on the intermediary.





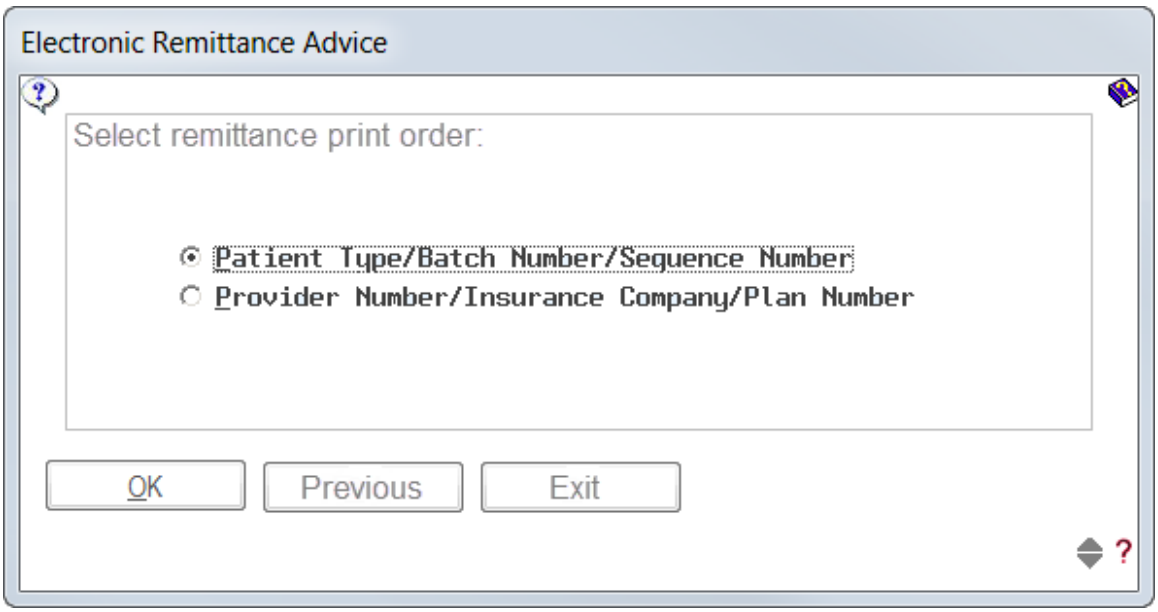
Action: Enter the password according to the instructions in the window, then click **OK**.

Remember to update the following with the new password:

- The EB system control record, Option 1 on the EB Maintenance Menu
- The ERA system control record, through Maintain Electronic R/A System Control, Option 4 on the Electronic Remittance Advice Menu.

Print order selection window

This window appears when you have successfully received electronic remittance advice.



Action

Select (click on) the print order you want for the Electronic Remittance Advice Listing or (if reprinting) the Error Report, and then click **OK**.

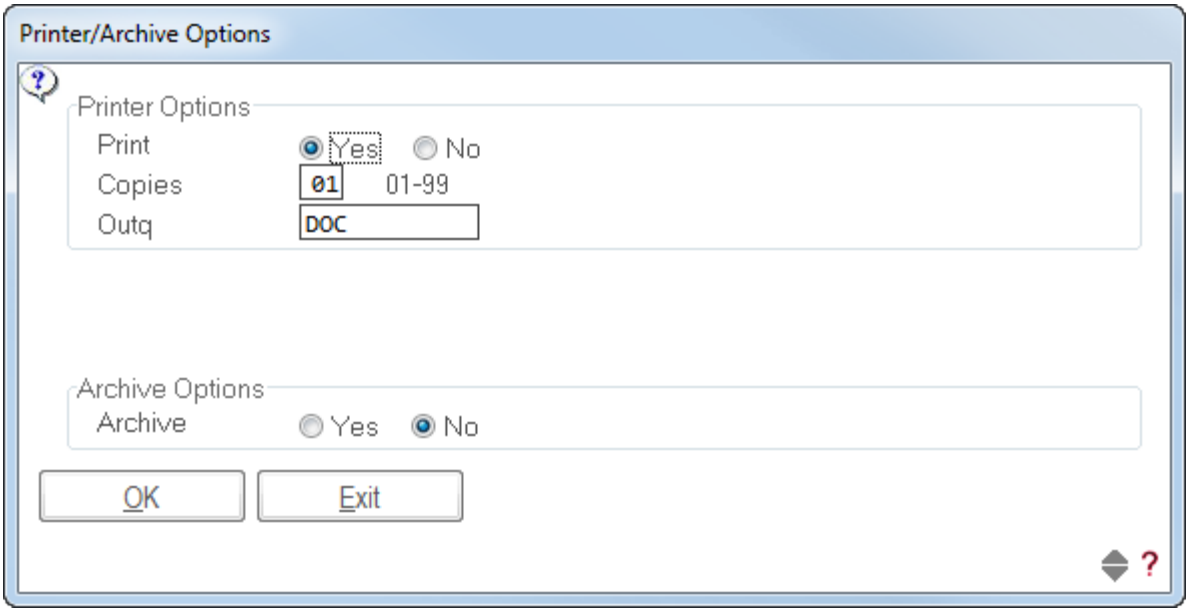
The print order you select determines the totals that print on the report, as follows:

- If you select **Patient Type/Batch Number/Sequence Number**, the totals will be for patient type and batch number.
- If you select **Provider Number/Insurance Company/Plan Number**, the totals will be for the provider and then the insurance company/plan.

The Error Report generated by reprinting uses the same format as the Electronic Remittance Advice Listing, but has Error Report in the report title.

Printer Options

This window appears when you select a print order.

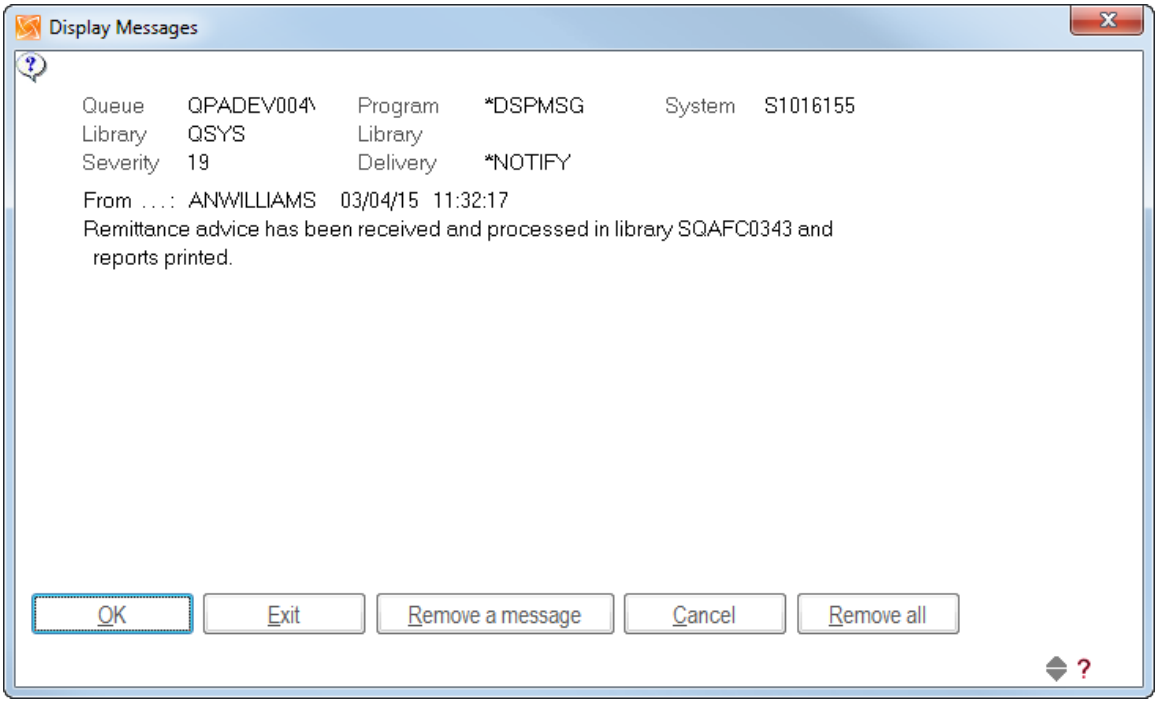


Action Enter the print options and output queue

Select whether to archive the report generated

Display Messages window

This window appears when the batch job has finished processing.



At this point, the remittance advice batch has been created and the reports have been sent to the output queue.

If the batch contains errors, the Remittance Advice Error Report Listing will be generated, listing the errors for each patient.

Action Click **Exit** or remove the message.

Medicare Sequestration

Sequestration is a payment reduction by Medicare mandated by Congress because they could not adopt a budget by last April. Instead of reducing the formulas that Medicare uses to calculate expected payment, they just put in a 2% reduction to the net Medicare payment generated to the hospital (after subtracting patient liability amounts). It results in two issues that customers must manually handle:

1. The expected payment will not be correct (sequestration amounts cannot be added to our formula), causing a contract monitoring variance
2. If a customer writes off contract allowances at billing (charges – expected payment), MEDHOST currently does not post contractual allowances from remittances. If we did, this would duplicate the allowance written off at billing. Therefore, the account balance will not be correct until the customer posts the sequestration penalty amount to each account manually.

The #2 issue above is the reason we created this functionality. If the customer turns on auto-contractual (where allowances are written off at billing), we will now automatically post these sequestration penalty amounts from ERA's as a contractual allowance amount. The account will then be in balance and the customer will not have to identify and post these manually.

Message currently printing on the report states: Cont Adj amt will not post because Auto Cont is turned on, except for the monies associated with Mcare Sequestration. Reason cde 253.

Sample Electronic Remittance Advice Listing (in Patient Type/Batch Number/Sequence Number Order)

Print Date: 12/03/13
Remit Date: 3/25/13
Bill Type: Inpatient

Electronic Remittance Advice

Document Control Number: 000011314
Version #: 005010X221A

Patient Name / Admit Date / Dschg Date / Sequence No.	Patient Nbr / HIC Nbr / Claim Nbr	TOB / Patient Stat / Claim Status	Cov Days / NonCov Days / Cost Days / Total Chgs	DRG / DRG Weight / DRG Amt / Covered Chgs	Cap Outlier / NonCov Chgs	Cost Outlier / Day Outlier / Disp Share / Denied	PPS Capital / Lab Charged / Lab Paid / Blood Deduct	ESRD / MSP Prim Pay / Pro Fees / Deductible	Adj to Bal / IME Adj / Med Ed / Coinsurance	Cap DSH / Cap FSP / Cap HSP / Contract Adj	Per Diem / Reim Rate / Interest / Payment	Remark	Remark
KLAUCK VIOLET R	6000174 -01	721	0	000	.00	.00	.00	.00	.00	.00	.00		
2007-01-01	MEBFCQYQ		0			.00	.00	.00	.00	.00	.000		
2007-01-01	130318E140470000	1	0	.00		.00	.00	.00	.00	.00	.00		
1		Reason	164.00	164.00	.00	.00	.00	.00	.00	59.34	104.66		

ServDate	PT	Proc	Mods	Rev	APC	Code	Units									
Cont Adj amt will not post because Auto Cont is turned on, except for the monies associated with Mcare Sequestration. Reason cde 253																
2013-03-11	HC	99214			00000	45	1.000	140.00	101.57	.00	.00	.00	.00	.00	38.43	101.57	N6
2013-03-11	HC	81003			48368	253	1.000	24.00	3.09	.00	.00	.00	.00	.00	20.91	3.09	N6

Sample Electronic Remittance Advice Listing (in Provider Number/Insurance Company/Plan Number Order)

```
Provider No.: 1902132988                                                        QA MEDICAL CENTER - BILLING MASTER LIB                                                          Page No:    1
Ins. Co/Plan:  18/  4                                                              Electronic Remittance Advice                                                 Document Control Number: 000011314
  Print Date: 10/20/13                                                                                                                                                            Version #: 005010X221A1
  Remit Date:  3/25/13


Patient Name      Patient Nbr         TOB               Cov Days     DRG            Cap Outlier    Cost Outlier  PPS Capital   ESRD          Adj to Bal   Cap DSH              Per Diem  Remark  Remark
Admit Date        HIC Nbr             Patient Stat      NonCov Days  DRG Weight                    Day Outlier   Lab Charged   MSP Prim Pay  IME Adj      Cap FSP             Reim Rate  Remark  Remark
Dschg Date        Claim Nbr           Claim Status      Cost Days    DRG Amt                       Disp Share    Lab Paid      Pro Fees      Med Ed       Cap HSP              Interest  Remark  Remark
Batch No.         Sequence No.                          Total Chgs   Covered Chgs   NonCov Chgs    Denied        Blood Deduct  Deductible    Coinsurance  Contract Adj          Payment  Remark  Remark
============      ===========         ============      ==========   ============   ===========    ============  ============  ============  ===========  ============   ==============  ======  ======
KLAUCK VIOLET R   6000174 -01                  721                0            000            .00            .00           .00           .00         .00            .00             .00
2007-01-01        MEBFCQYQ                                        0                                           .00           .00           .00         .00            .00            .000
2007-01-01        130318E140470000           1                    0            .00                            .00           .00           .00         .00            .00             .00
970                 1                 Reason               164.00         164.00            .00            .00           .00           .00         .00            .00          104.66
ServDate   PT Proc  Mods  Rev    APC      Code    Units ----------   ------------   -----------    ------------  ------------  ------------  -----------  ------------       ---------
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09

KLAUCK VIOLET R   6000174 -01                  721                0            000            .00            .00           .00           .00         .00            .00             .00
2007-01-01        MEBFCQYQ                                        0                                           .00           .00           .00         .00            .00            .000
2007-01-01        130318E140470000           1                    0            .00                            .00           .00           .00         .00            .00             .00
970                 1                 Reason               164.00         164.00            .00            .00           .00           .00         .00            .00          104.66
ServDate   PT Proc  Mods  Rev    APC      Code    Units ----------   ------------   -----------    ------------  ------------  ------------  -----------  ------------       ---------
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09

KLAUCK VIOLET R   6000174 -01                  721                0            000            .00            .00           .00           .00         .00            .00             .00
2007-01-01        MEBFCQYQ                                        0                                           .00           .00           .00         .00            .00            .000
2007-01-01        130318E140470000           1                    0            .00                            .00           .00           .00         .00            .00             .00
970                 1                 Reason               164.00         164.00            .00            .00           .00           .00         .00            .00          104.66
ServDate   PT Proc  Mods  Rev    APC      Code    Units ----------   ------------   -----------    ------------  ------------  ------------  -----------  ------------       ---------
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 99214              00000             1.000     140.00         101.57            .00            .00           .00           .00         .00            .00          101.57 N6
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09
2013-03-11 HC 81003              48368             1.000      24.00           3.09            .00            .00           .00           .00         .00            .00            3.09

KLAUCK VIOLET R   6000174 -01                  721                0            000            .00            .00           .00           .00         .00            .00             .00
2007-01-01        MEBFCQYQ                                        0                                           .00           .00           .00         .00            .00            .000
2007-01-01        130318E140470000           1                    0            .00                            .00           .00           .00         .00            .00             .00
970                 1                 Reason               164.00         164.00            .00            .00           .00           .00         .00            .00          104.66
ServDate   PT Proc  Mods  Rev    APC      Code    Units ----------   ------------   -----------    ------------  ------------  ------------  -----------  ------------       ---------
```

Error Report

Warning! Transaction date in next month

When ERA's come in live (RMTADV option 1) or are reprinted (RMTADV option 2), the batch entry date will be checked against the current system date. If the batch entry date is in a future month, the reports will print this alert "Warning! Transaction date in next month." This informs the client so they can suspend the batch in case they do not want these to go to Accounts Receivable.

Batch Number:
Print Date: 2/17/14
Remit Date: 3/27/14 Warning! Transaction date in next month
Bill Type: Inpatient

QA MEDICAL CENTER - ELEVEN DOT ONE
Electronic Remittance Advice
Error Report

Page No: 1
Document Control Number: 000011314
Version #:

Patient Name / Admit Date / Dschg Date / Sequence No.	Patient Nbr / HIC Nbr / Claim Nbr	TOB / Patient Stat / Claim Status	Cov Days / NonCov Days / Cost Days / Total Chgs	DRG / DRG Weight / DRG Amt / Covered Chgs	Cap Outlier / NonCov Chgs	Cost Outlier / Day Outlier / Disp Share / Denied	PPS Capital / Lab Charged / Lab Paid / Blood Deduct	ESRD / MSP Prim Pay / Pro Fees / Deductible	Adj to Bal / IME Adj / Med Ed / Coinsurance	Cap DSH / Cap FSP / Cap HSP / Contract Adj	Per Diem / Reim Rate / Interest / Payment	Remark	Remark
CLEARMAN WESLEY	0000289 -61	721	0	000	.00	.00	.00	.00	.00	.00	.00		
	MEBF4MQQ		0			.00	.00	.00	.00	.00	.000		
	130319E427990000	1	0	.00		.00	.00	.00	.00	.00	.00		
		Reason	140.00	140.00	.00	81.74	.00	.00	50.00	.00	74.13		
ServDate PT Proc Mods Rev	APC	Code	Units										
2012-12-20 HC 99214	00000	45 3	1.000	140.00	99.13	.00	81.74	.00	.00	50.00	.00	74.13	N59
		45 3											
2012-12-20 HC 99214	00000	45 3	1.000	140.00	99.13	.00	81.74	.00	.00	50.00	.00	74.13	N59
		45 3											

Remit Reconciliation Overview

Remit reconciliation helps billers balance accounts that use auto contractual. During billing, the system calculates the expected payment from the insurance company based on contractual agreements. Once the payment is received via Electronic Remittance Advice, if the calculated adjustment amount is not the same as the actual adjustment amount from the remit, remit reconciliation (**Reverse Auto Cont for ERA**) reverses the auto contractual amount and posts the contractual adjustment amount from the remit to the account.

ERA report messages related to remit reconciliation:

- This message displays when the auto contractual amount was reversed and the contractual adjustment posts:

  ERA contractual amounts will post and auto contractuals will be reversed when Reverse Auto Contractual for ERA = Yes

- This message displays when the auto contractual amount matches the remit contractual amount:

  Cont Adj will not post due to the amount matching the Remit Cont amount and Reverse Auto Cont flag = Yes

ERA Reports Example

The following examples include remit reconciliation messages in the ERA Report.

This message displays when the auto contractual amount was reversed and the contractual adjustment posts:

ERA contractual amounts will post and auto contractuals will be reversed when Reverse Auto Contractual for ERA = Yes

```
Batch Number: 970                                          QA MEDICAL CENTER - BILLING MASTER LIB                                          Page No:    1
  Print Date:  8/07/15                                         Electronic Remittance Advice                                  Document Control Number: 415400155
  Remit Date:  6/04/14                                                                                                     Medhost ERA ID Number: 152190933
   Bill Type: Outpatient                                                                                                          Version #: 005010X221A1

Patient Name      Patient Nbr        TOB              Cov Days     DRG            Cap Outlier   Cost Outlier  PPS Capital   ESRD          Adj to Bal   Cap DSH           Per Diem  Remark  Remark
Admit Date        HIC Nbr            Patient Stat     NonCov Days  DRG Weight     Sequestratn   Day Outlier   Lab Charged   MSP Prim Pay  IME Adj      Cap FSP           Reim Rate Remark  Remark
Dschg Date        Claim Nbr          Claim Status     Cost Days    DRG Amt                      Disp Share    Lab Paid      Pro Fees      Med Ed       Cap HSP           Interest  Remark  Remark
Sequence No.                                          Total Chgs   Covered Chgs   NonCov Chgs   Denied        Blood Deduct  Deductible    Coinsurance  Contract Adj      Payment   Remark  Remark
============      ===========        ============     ==========   ============   ===========   ============  ============  ============  ===========  ============  ========  ======  ======
PIF83083 MDSICD9  6000269 -01                 851             0            000           .00           .00           .00           .00          .00           .58
2007-09-15        123456                                       0                          .00           .00        220.90           .00          .00          .000
2007-09-18        21414103738707WIA            19             0            .00                         .00        125.57           .00          .00           .00  MA18
  1                                    Reason              741.10         741.10           .00           .00           .00        104.04       317.76        319.30
ServDate   PT Proc  Mods  Rev   APC     Code    Units   ----------   ------------   -----------   ------------  ------------  ------------  -----------  ------------  ---------
ERA contractual amounts will post and auto contractuals will be reversed when Reverse Auto Contractual for ERA = Yes.
2014-05-05 HC 36415        0300       97  253    1.000        21.70          12.34           .00           .00           .00           .00          .00          9.36         12.34
2014-05-05 HC 80061        0301       97  253    1.000       120.55          68.52           .00           .00           .00           .00          .00         52.03         68.52
2014-05-05 HC 84450        0301       97  253    1.000        39.95          22.71           .00           .00           .00           .00          .00         17.24         22.71
2014-05-05 HC 84460        0301       97  253    1.000        38.70          22.00           .00           .00           .00           .00          .00         16.70         22.00
2014-05-05 HC 76536        0402       97  253    1.000       520.20         193.73           .00           .00           .00           .00       104.04        222.43        193.73
                                      2
```

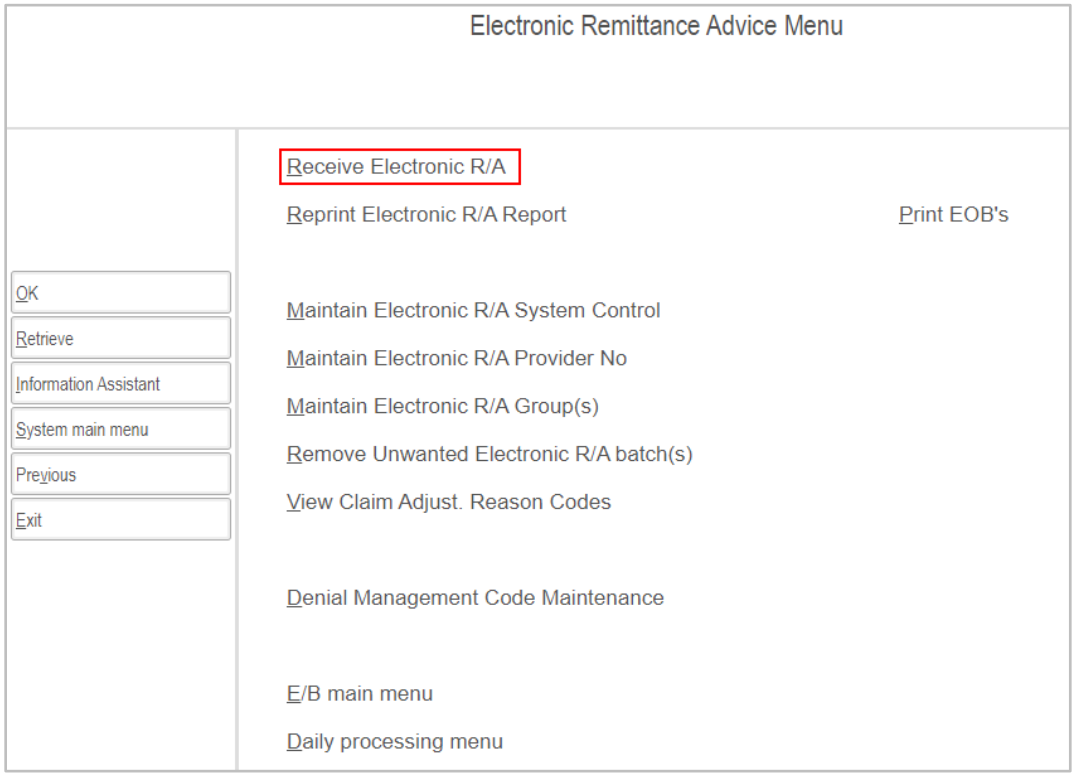
This message displays when the auto contractual amount matches the remit contractual amount:

Cont Adj will not post due to the amount matching the Remit Cont amount and Reverse Auto Cont flag = Yes

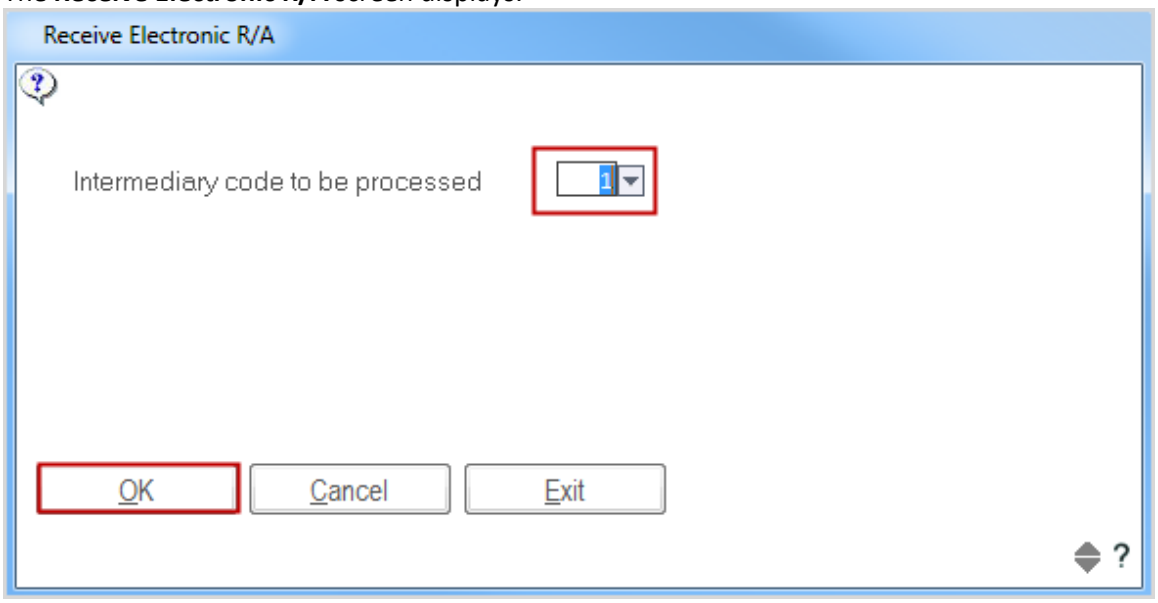
```
Batch Number: 970                                  QA MEDICAL CENTER - BILLING MASTER LIB                    Page No:    1
  Print Date:  8/07/15                                 Electronic Remittance Advice                  Document Control Number: 415400155
  Remit Date:  6/04/14                                                                             Medhost ERA ID Number: 152191235
   Bill Type: Outpatient                                                                                    Version #: 005010X221A1

Patient Name      Patient Nbr        TOB              Cov Days    DRG             Cap Outlier   Cost Outlier  PPS Capital  ESRD          Adj to Bal   Cap DSH          Per Diem  Remark  Remark
Admit Date        HIC Nbr            Patient Stat     NonCov Days DRG Weight      Sequestratn   Day Outlier   Lab Charged  MSP Prim Pay  IME Adj      Cap FSP          Reim Rate Remark  Remark
Dschg Date        Claim Nbr          Claim Status     Cost Days   DRG Amt                       Disp Share    Lab Paid     Pro Fees      Med Ed       Cap HSP          Interest  Remark  Remark
Sequence No.                                          Total Chgs  Covered Chgs  NonCov Chgs   Denied        Blood Deduct Deductible    Coinsurance  Contract Adj     Payment   Remark  Remark
============      ===========        ============     ==========  ============  ===========   ============  ===========  ============  ===========  ============  ========  ======  ======
PIP83083 MDSICD9  6000269 -01                 851            0           000          .00           .00          .00          .00          .00          .00       .58
2007-09-15        123456                                      0                        .00           .00     4,175.57          .00          .00          .00      .000
2007-09-18        21414103738707WIA            19            0           .00                        .00       125.57          .00          .00          .00      .00  MA18
  1                                    Reason            741.10        741.10          .00           .00          .00          .00       104.04     4,260.00   319.30
ServDate   PT Proc  Mods  Rev   APC     Code    Units  ----------  ------------  -----------   ------------  -----------  ------------  -----------  ------------  ---------
Cont Adj will not post due to the amount matching the Remit Cont amount and Reverse Auto Cont flag = Yes.
2014-05-05 HC 36415        0300        97  253   1.000    1,032.34         12.34          .00           .00          .00          .00          .00     1,020.00     12.34
2014-05-05 HC 80061        0301        97  253   1.000    1,078.52         68.52          .00           .00          .00          .00          .00     1,010.00     68.52
2014-05-05 HC 84450        0301        97  253   1.000    1,032.71         22.71          .00           .00          .00          .00          .00     1,010.00     22.71
2014-05-05 HC 84460        0301        97  253   1.000    1,032.00         22.00          .00           .00          .00          .00          .00     1,010.00     22.00
2014-05-05 HC 76536        0402        97  253   1.000      508.13        193.73          .00           .00          .00          .00       104.04       210.00    193.73
                                       2
```

To view contractual adjustment and claim status messages on reports

1. From the **Electronic Remittance Advice Menu**, select **Receive Electronic R/A** (Option 1)



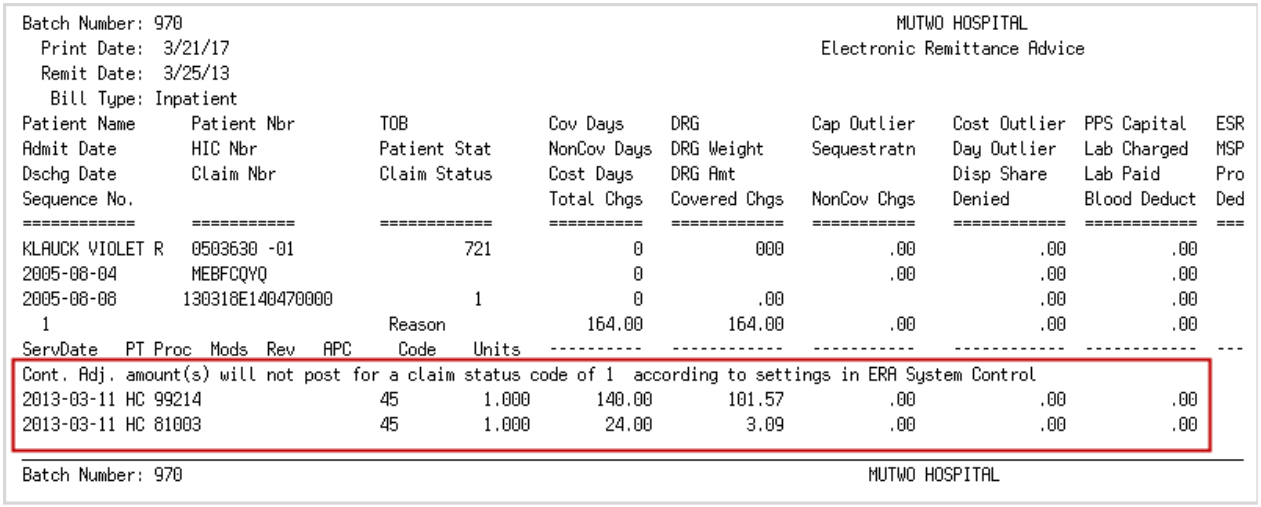
The **Receive Electronic R/A** screen displays.



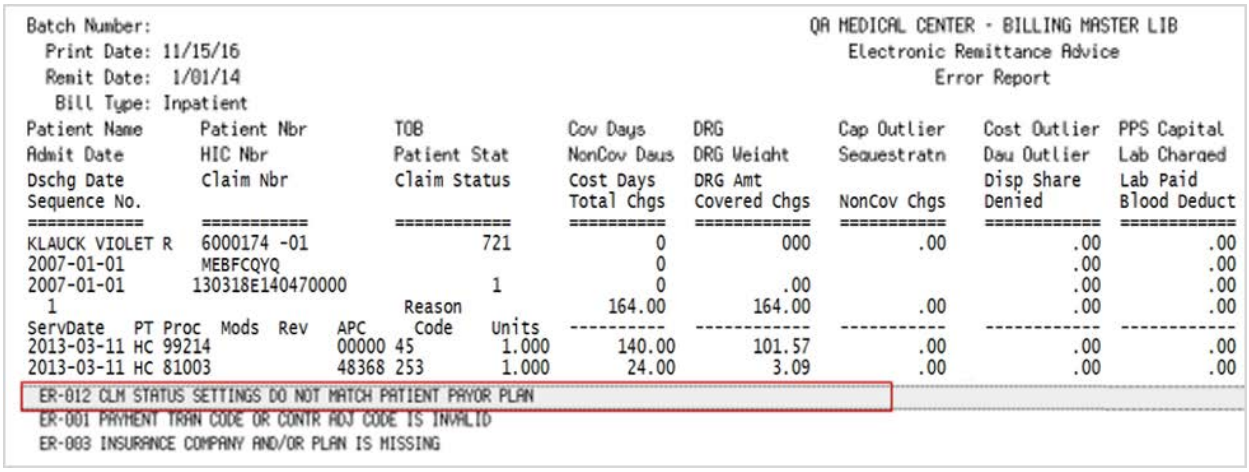
2. Select the **Intermediary code to be processed**

3. Click **OK**

The report generates. A message displays on the report when a contractual adjustment flag is set to **Yes** but no claim status code is selected in the ERA system control file.



```
Batch Number: 970                                                    MUTWO HOSPITAL
  Print Date:  3/21/17                                          Electronic Remittance Advice
  Remit Date:  3/25/13
   Bill Type: Inpatient
Patient Name      Patient Nbr        TOB             Cov Days     DRG           Cap Outlier   Cost Outlier  PPS Capital   ESR
Admit Date        HIC Nbr            Patient Stat    NonCov Days  DRG Weight    Sequestratn   Day Outlier   Lab Charged   MSP
Dschg Date        Claim Nbr          Claim Status    Cost Days    DRG Amt                     Disp Share    Lab Paid      Pro
Sequence No.                                         Total Chgs   Covered Chgs  NonCov Chgs   Denied        Blood Deduct  Ded
============      ==========         ============    ==========   ============  ===========   ============  ============  ===
KLAUCK VIOLET R   0503630 -01                721            0           000          .00           .00           .00
2005-08-04        MEBFCQYQ                                 0                        .00           .00           .00
2005-08-08       130318E140470000              1           0           .00                        .00           .00
  1                                  Reason          164.00        164.00          .00           .00           .00
ServDate   PT Proc  Mods  Rev   APC     Code    Units  ----------   ------------  -----------   ------------  ------------  ---
Cont. Adj. amount(s) will not post for a claim status code of 1  according to settings in ERA System Control
2013-03-11 HC 99214                  45         1.000       140.00        101.57          .00           .00           .00
2013-03-11 HC 81003                  45         1.000        24.00          3.09          .00           .00           .00

Batch Number: 970                                                                    MUTWO HOSPITAL
```



```
Batch Number:                                              QA MEDICAL CENTER - BILLING MASTER LIB
  Print Date: 11/15/16                                          Electronic Remittance Advice
  Remit Date:  1/01/14                                               Error Report
   Bill Type: Inpatient
Patient Name      Patient Nbr          TOB              Cov Days     DRG           Cap Outlier    Cost Outlier  PPS Capital
Admit Date        HIC Nbr              Patient Stat     NonCov Daus  DRG Weight    Sequestratn    Dau Outlier   Lab Charged
Dschg Date        Claim Nbr            Claim Status     Cost Days    DRG Amt                      Disp Share    Lab Paid
Sequence No.                                            Total Chgs   Covered Chgs  NonCov Chgs    Denied        Blood Deduct
============      ==========           ============     ==========   ============  ===========    ============  ============
KLAUCK VIOLET R   6000174 -01                   721           0          000          .00            .00           .00
2007-01-01        MEBFCQYQ                                    0                                      .00           .00
2007-01-01        130318E140470000               1           0          .00                         .00           .00
  1                                    Reason              164.00       164.00         .00            .00           .00
ServDate   PT Proc  Mods  Rev   APC     Code    Units  ----------   ------------  -----------    ------------  ------------
2013-03-11 HC 99214              00000 45          1.000      140.00       101.57         .00            .00           .00
2013-03-11 HC 81003              48368 253         1.000       24.00         3.09         .00            .00           .00
  ER-012 CLM STATUS SETTINGS DO NOT MATCH PATIENT PAYOR PLAN
  ER-001 PAYMENT TRAN CODE OR CONTR ADJ CODE IS INVALID
  ER-003 INSURANCE COMPANY AND/OR PLAN IS MISSING
```

Error Message Details

ER-012 CLM STATUS SETTINGS DO NOT MATCH PATIENT PAYOR PLAN

The insurance type on the received ERA does not match the patient's payor plan.

Here is an example scenario that would produce this error message.
The Electronic Remittance Advice System Control (Remittance Advice Menu, Option 4) has the following settings:

Allow Secondary C/A by Claim Status = Y
Claim Status Codes = 2 (Processed as Secondary)

An ERA comes in for an account that shows secondary with a claim status of 2, but the insurance on the ERA is not the same insurance type as the actual secondary insurance listed on the account.

RMTADV Option 2: Reprint Electronic R/A Report

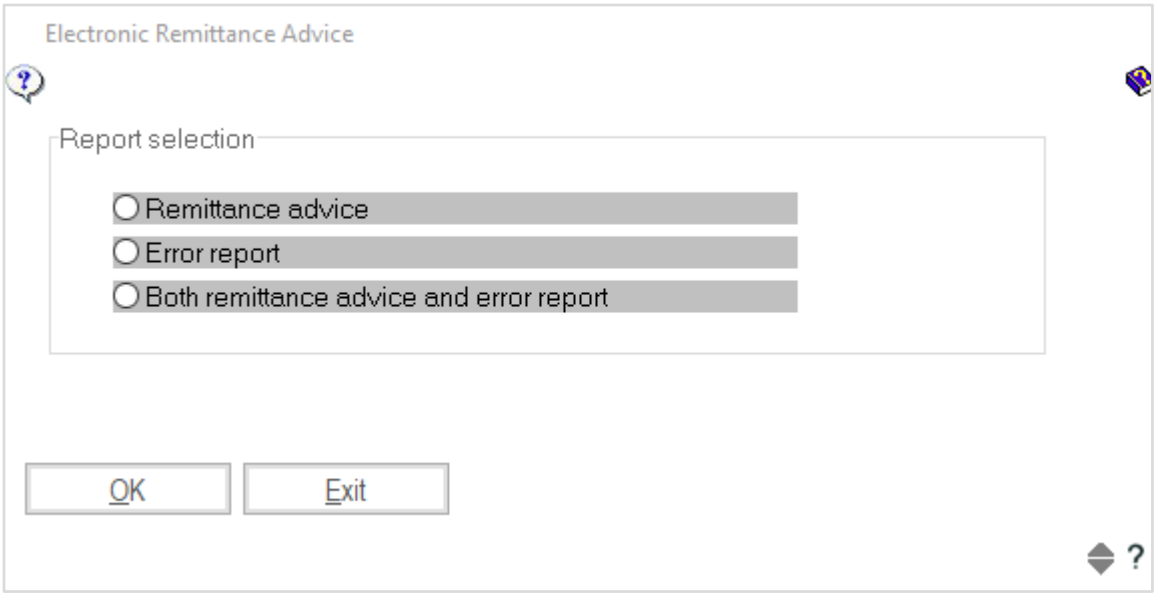
Overview:

Reprint Electronic R/A Report (Option 2 on the Electronic Remittance Advice Menu) is used to reprint the Electronic Remittance Advice Listing or the Remittance Advice Error Report Listing that are automatically generated in Option 1, Receive Electronic R/A.

- The **Electronic Remittance Advice Listing** shows the remittance advice information received from the intermediary.
- The **Electronic Remittance Advice Error Report** shows entire claims that have been denied and lists all the patients that have an error. The error code descriptions will print at the end of the report.

In this section

Report Selection



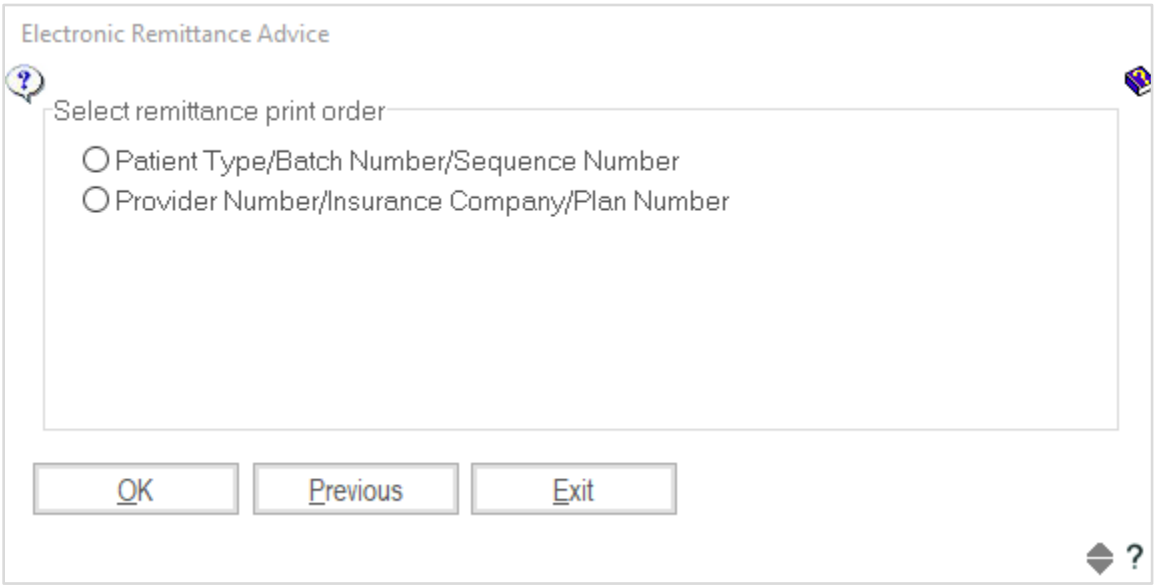
Action

Select **Remittance advice**, **Error report**, or **Both remittance advice and error report**.

The Error Report generated uses the same format as the Electronic Remittance Advice Listing but has **Error Report** in the report title.

Click **OK** and the **Select remittance print order** window displays.

Print order selection



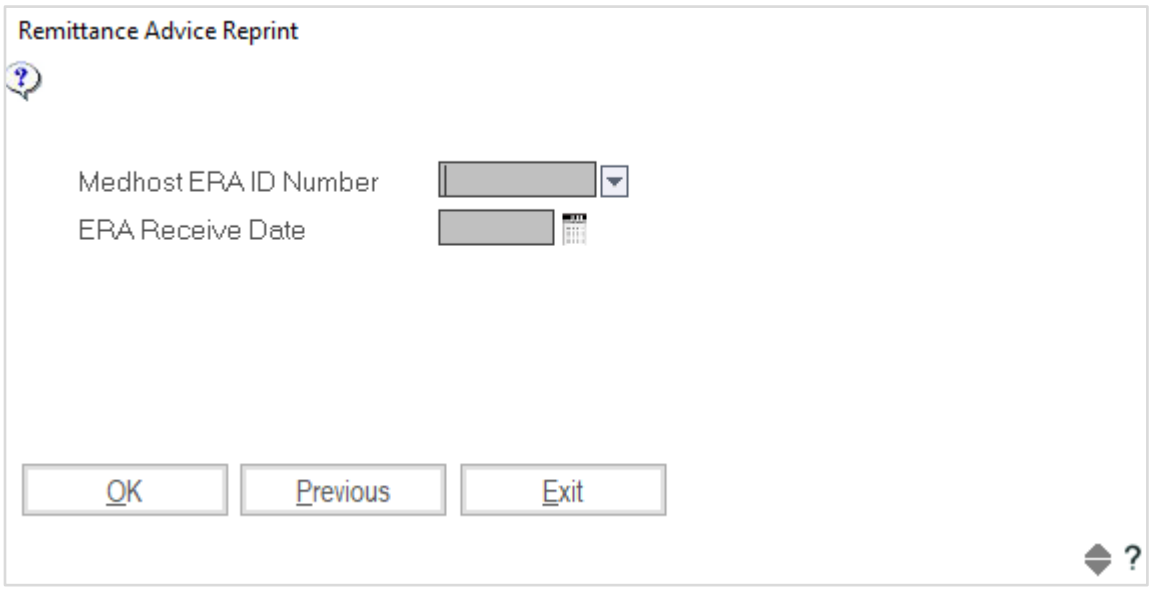
Action

Select the remittance print order and click **OK**.

- **Patient Type / Batch number / Sequence Number**
  Payor/plan and Payor name print for each account.
  Report totals print for patient type and batch number.

- **Provider Number / Insurance Company / Plan Number**
  The Payor/plan name prints in the report heading.
  Report totals print for the provider and then the insurance company/plan.

Medhost ERA ID Number/ERA Receive Date



This screen displays when a selection is made on the print order screen.

Action

Refer to the following report selection options:

- Leave both fields blank then use the **Medhost ERA ID Number** drop-down to display a list of available remits.
- Enter the **Medhost ERA ID Number**, if known, or use the drop-down to select an ERA which automatically populates the **ERA Receive Date**. If there is no specific remit for the entered ERA, the window displays beginning with the entered ERA in descending order.
- Enter the **ERA Receive Date** then use the **Medhost ERA ID Number** drop-down to select the ERA to reprint. If there is no specific remit for the entered date, the window shows beginning with the entered date in descending date order.

About the Medhost ERA ID Number

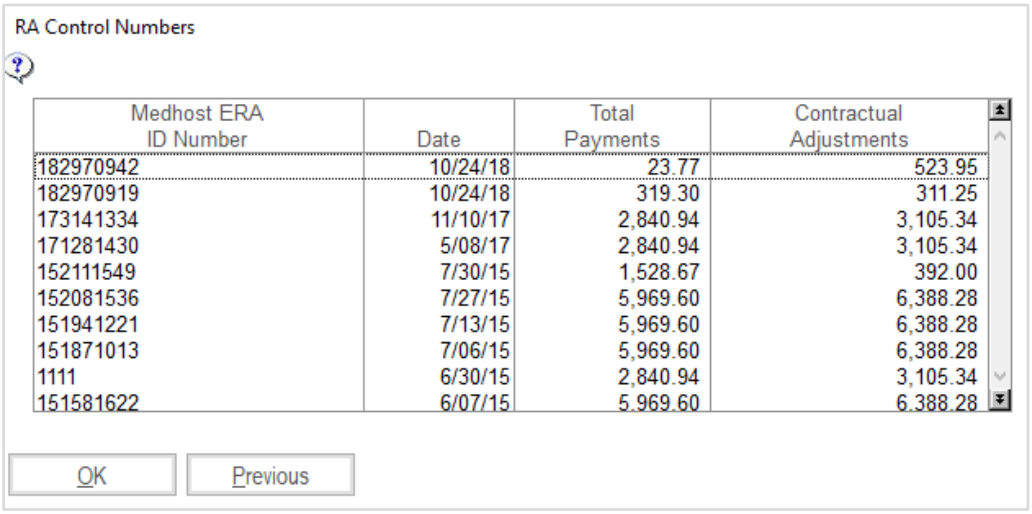
Please note the following:

- If a Medhost ERA ID Number is received from the intermediary, it will be a 9-digit number.
- If an Medhost ERA ID Number (Document Control Number) is entered by the user when entering a Remittance Advice batch in Enter Remittance Advice, Option 6 on the Daily Processing Menu in Patient Accounting, it can be user-defined as the remit date or even as text to identify the batch.
- The same Medhost ERA ID Number will be used for both the Electronic Remittance Advice Listing and the Error Report.

To determine the Medhost ERA ID Number for a report that has been received since the last Day End Processing, do the following:

1. Go to Enter Remittance Advice, Option 6 on the Daily Processing Menu in Patient Accounting.
2. Click  to search for a batch in the range of 970 to 979 with the appropriate date.
3. Select the batch, and the R/A document control number displays on the Batch Control screen.

Medhost ERA ID Number selection



Action

Select a Medhost ERA ID Number (RA Document Control Number).

To select the number, double-click a line or click it once to highlight, and then click **OK**.

The selected reports generate. See examples below.

Example Report

- **Print order = Patient Type / Batch number / Sequence Number**

```
Batch Number: 970                                          EXAMPLE MEDICAL CENTER                                    Page No:    1
   Print Date:  1/07/21                                    Electronic Remittance Advice                  Document Control Number: 199492873
   Remit Date:  7/19/17                                                                                   Medhost ERA ID Number: 182970942
    Bill Type: Outpatient                                                                                                 Version #: 005010X221A1

 Patient Name     Patient Nbr       TOB              Cov Days    DRG           Cap Outlier   Cost Outlier  PPS Capital   ESRD          Adj to Bal   Cap DSH          Per Diem  Remark  Remark
 Admit Date       HIC Nbr           Patient Stat     NonCov Days DRG Weight    Sequestratn   Day Outlier   Lab Charged   MSP Prim Pay  IME Adj      Cap FSP          Reim Rate  Remark  Remark
 Dschg Date       Claim Nbr         Claim Status     Cost Days   DRG Amt                     Disp Share    Lab Paid      Pro Fees      Med Ed       Cap HSP          Interest   Remark  Remark
 Sequence No.     Payr/Pln/Name                      Total Chgs  Covered Chgs  NonCov Chgs   Denied        Blood Deduct  Deductible    Coinsurance  Contract Adj     Payment    Remark  Remark
 ============     =============     ============     ==========  ============  ===========   ============  ============  ============  ===========  ============     ========   ======  ======
 SMART SALLY       2000249 -01              131              0           000          .00           .00           .00           .00          .00              .00
 2011-07-16        9999                                      0                        .00           .00      1,000.65           .00          .00              .00      .000
 2011-07-17       17166G999999               3              0           .00                        .00         23.77           .00          .00              .00      .00
   1              18/  2 MEDICARE 002                1,000.65         23.77          .00           .00           .00           .00          .00           523.95    23.77
 ServDate   PT Proc  Mods  Rev   APC    Rsn Cd  Units   ----------  ------------  -----------   ------------  ------------  ---------- -----------  ------------        ---------
 2017-06-08 HC 36415         0300        24        1.000    109.20          .00          .00           .00           .00           .00          .00          109.20          .00  N381
 2017-06-08 HC 80053         0301       131        1.000    339.15        13.11          .00           .00           .00           .00          .00            .00         13.11  N381
 2017-06-08 HC 85025         0305       131        1.000    137.55        10.66          .00           .00           .00           .00          .00            .00         10.66  N381
 2017-06-08 HC 84153         0309        24        1.000    414.75          .00          .00           .00           .00           .00          .00          414.75          .00  N381
 ____________________________________________________________________________________________________________________________________________________________________________________

Batch Number: 970                                          EXAMPLE MEDICAL CENTER                                    Page No:    1
  Print Date:  1/07/21                                     Electronic Remittance Advice                  Document Control Number: 199492873
  Remit Date:  7/19/17                                                                                   Medhost ERA ID Number: 182970942
                                                                                                                        Version #: 005010X221A1
          CLAIMS DATA                                PASS THRU AMOUNTS                                  PROVIDER PAYMENT RECAP

                Covered Days:              0                        Capital:            .00
             NonCovered Days:              0                 Return on Equity:          .00                PAYMENTS
                   Cost Days:              0          Direct Medical Education:         .00                   Drg Out Amt:            .00
           Submitted Charges:      1,000.65                  Kidney Acquisition:       .00                      Interest:            .00
            Accepted Charges:      1,000.65                            Bad Debt:       .00                   Proc Cd Amt:            .00
              Error Charges:           .00          Non Physician Anesthetists:       .00                Net Reimbursement:       23.77
            Covered Charges:         23.77                    Total Pass Thru:        .00                   Total Pass Thru:         .00
         NonCovered Charges:           .00                                                                    PIP Payments:         .00
            Denied Charges:           .00                        PIP Payment:        .00                   Settlement Pymts:         .00
                Deductible:           .00                 Settlement Payments:       .00             Accelerated Payments:         .00
              CoInsurance:            .00                 Accelerated Payments:      .00                      Refunds:         .00
                  Payment:         23.77                             Refunds:        .00                   Penalty Release:         .00
        MSP Prim. Pay Amount:          .00                      Penalty Release:      .00                   Trans Outp Pymt:         .00
          Day Outlier Amount:          .00                      Trans Outp Pymt:      .00                   Hemophilia Add-on:       .00
          CAP Outlier Amount:          .00                     Hemophilia Add-on:     .00                     New Tech Add-on:       .00
         Cost Outlier Amount:          .00                       New Tech Add-on:     .00                     Void / Resissue:       .00
                         DSH:          .00                        Void / Reissue:     .00                      935 Payments:         .00
                         IME:          .00                      935 Payments:         .00                   Balance Forward:         .00
                    Interest:          .00          WITHHOLD FROM PAYMENTS:                                       Withhold:         .00
                Contractual Adj:    523.95             Claims Accounts Receivable:    .00                Adjustment to Balance:         .00
              Sequestration Amount:     .00                    Accelerated Payments:    .00
                      DRG Amount:       .00                                                                 Net Provider Payment:    23.77
                                                                          Penalty:        .00                (Payments minus Withhold)
                                                                       Settlement:        .00
                                                          Affiliated Withholding:         .00
                 Submitted OP Claims:         1                    935 Withholding:      .00
                  Accepted OP Claims:         1                 Federal Payment Levy:    .00
                     Error OP Claims:         0                          Non_Tax FPLP:    .00
                                                                    Total Withhold:        .00
```

Example Report

- **Print order = Provider Number / Insurance Company / Plan Number**

```
Provider No.: 6                                          EXAMPLE MEDICAL CENTER                                    Page No:    1
Ins. Co/Plan:  18/  2  MEDICARE 001                     Electronic Remittance Advice                  Document Control Number: 199492873
   Print Date:  1/07/21                                                                               Medhost ERA ID Number: 182970942
   Remit Date:  7/19/17                                                                                        Version #: 005010X221A1

 Patient Name    Patient Nbr       TOB              Cov Days    DRG           Cap Outlier   Cost Outlier  PPS Capital   ESRD          Adj to Bal   Cap DSH          Per Diem  Remark  Remark
 Admit Date      HIC Nbr           Patient Stat     NonCov Days DRG Weight    Sequestratn   Day Outlier   Lab Charged   MSP Prim Pay  IME Adj      Cap FSP          Reim Rate  Remark  Remark
 Dschg Date      Claim Nbr         Claim Status     Cost Days   DRG Amt                     Disp Share    Lab Paid      Pro Fees      Med Ed       Cap HSP          Interest   Remark  Remark
 Sequence No.    Sequence No.                       Total Chgs  Covered Chgs  NonCov Chgs   Denied        Blood Deduct  Deductible    Coinsurance  Contract Adj     Payment    Remark  Remark
 ============    ============      ============     ==========  ============  ===========   ============  ============  ============  ===========  ============     ========== ======  ======
 SMART SALLY     2000249 -01              131              0           000          .00           .00           .00           .00          .00              .00
 2011-07-16      9999                                      0                        .00           .00      1,000.65           .00          .00              .000
 2011-07-17      17166G999999               3              0           .00                        .00         23.77           .00          .00              .00
 970               1                    Reason         1,000.65        23.77          .00           .00           .00           .00          .00           523.95          23.77
 ServDate   PT Proc  Mods  Rev   APC  Code  Units    ----------  ------------  -----------   ------------  ------------  --------  -----------  ------------     ---------
 2017-06-08 HC 36415        0300       24       1.000    109.20          .00          .00           .00           .00          .00          .00          .00          109.20           .00  N381
 2017-06-08 HC 80053        0301       131      1.000    339.15        13.11          .00           .00           .00          .00          .00          .00            .00          13.11  N381
 2017-06-08 HC 85025        0305       131      1.000    137.55        10.66          .00           .00           .00          .00          .00          .00            .00          10.66  N381
 2017-06-08 HC 84153        0309       24       1.000    414.75          .00          .00           .00           .00          .00          .00          .00          414.75           .00  N381
```

```
Provider No.: 6                                          EXAMPLE MEDICAL CENTER                                    Page No:    1
Ins. Co/Plan:  18/  2  MEDICARE 001                     Electronic Remittance Advice                  Document Control Number: 199492873
   Print Date:  1/07/21                                                                               Medhost ERA ID Number: 182970942
   Remit Date:  7/19/17                                                                                        Version #: 005010X221A1

          CLAIMS DATA                                    PASS THRU AMOUNTS                                 PROVIDER PAYMENT RECAP

                Covered Days:              0                                  Capital:            .00                 PAYMENTS
             NonCovered Days:              0                       Return on Equity:            .00                    Drg Out Amt:            .00
                   Cost Days:              0            Direct Medical Education:               .00                        Interest:            .00
            Submitted Charges:       1,000.65                   Kidney Acquisition:            .00                     Proc Cd Amt:            .00
              Accepted Charges:      1,000.65                          Bad Debt:               .00                  Net Reimbursement:          23.77
                 Error Charges:           .00          Non Physician Anesthetists:            .00                    Total Pass Thru:            .00
               Covered Charges:         23.77                    Total Pass Thru:            .00                        PIP Payments:            .00
            NonCovered Charges:           .00                                                                      Settlement Pymts:            .00
                Denied Charges:           .00                        PIP Payment:            .00                 Accelerated Payments:            .00
                   Deductible:            .00                  Settlement Payments:          .00                           Refunds:            .00
                  CoInsurance:            .00                 Accelerated Payments:          .00                    Penalty Release:            .00
                      Payment:          23.77                           Refunds:              .00                    Trans Outp Pymt:            .00
        MSP Prim. Pay Amount:             .00                    Penalty Release:            .00                    Hemophilia Add-on:          .00
          Day Outlier Amount:             .00                    Trans Outp Pymt:            .00                      New Tech Add-on:          .00
          CAP Outlier Amount:             .00                   Hemophilia Add-on:           .00                      Void / Resissue:          .00
         Cost Outlier Amount:             .00                     New Tech Add-on:           .00                       935 Payments:            .00
                         DSH:             .00                      Void / Reissue:           .00                    Balance Forward:            .00
                         IME:             .00                        935 Payments:           .00                           Withhold:            .00
                    Interest:             .00          WITHHOLD FROM PAYMENTS:                                 Adjustment to Balance:          .00
              Contractual Adj:          523.95             Claims Accounts Receivable:       .00
           Sequestration Amount:            .00                 Accelerated Payments:       .00
                    DRG Amount:             .00                                                                 Net Provider Payment:       23.77
                                                                          Penalty:            .00                (Payments minus Withhold)
                                                                       Settlement:            .00
                                                             Affiliated Withholding:          .00
                 Submitted OP Claims:            1                  935 Withholding:          .00
                   Accepted OP Claims:           1                Federal Payment Levy:       .00
                      Error OP Claims:           0                          Non_Tax FPLP:       .00
                                                                     Total Withhold:            .00
```

Medicare Sequestration

Sequestration is a "payment reduction" by Medicare mandated by Congress because they could not adopt a budget by last April. Instead of reducing the formulas that Medicare uses to calculate expected payment, they just put in a 2% reduction to the net Medicare payment generated to the hospital (after subtracting patient liability amounts). It results in two issues that customers must manually handle:

1. The expected payment will not be correct (sequestration amounts cannot be added to our formula), causing a contract monitoring variance
2. If a customer writes off contract allowances at billing (charges – expected payment), MEDHOST currently does not post contractual allowances from remittances. If we did, this would duplicate the allowance written off at billing. Therefore, the account balance will not be correct until the customer posts the sequestration penalty amount to each account manually.

The #2 issue (above) is the reason we created this functionality. If the customer turns on auto contractual (where allowances are written off at billing), we will automatically post these sequestration penalty amounts from ERA's as a contractual allowance amount. The account will then be in balance and the customer will not have to identify and post these manually.

Message currently printing on the report states: Cont Adj amt will not post because Auto Cont is turned on, except for the monies associated with Mcare Sequestration. Reason cde 253.

About sequestration transaction codes

Transaction codes separate sequestration amounts reported in the ERA (electronic remittance advice). The reason code type SEQ identifies reason code 253 as a sequestration adjustment in the Remit Advice Codes Maintenance. Having the sequestration amounts displayed in separate fields helps the Business Office Director when reviewing the revenue and general ledger accounts.

Sequestration transaction codes display on Remittance Advice Entry screens and reports.

About sequestration percentages

For Medicare inpatients with contracted coverage, sequestration amounts display on Remittance Advice Entry screens and reports so that the sequestration dollars are easily identifiable.

The estimated sequestration amount will not automatically post to patient accounts; this amount is displayed for review and information purposes only. The sequestration percentage amounts are set in the payor plan maintenance file.

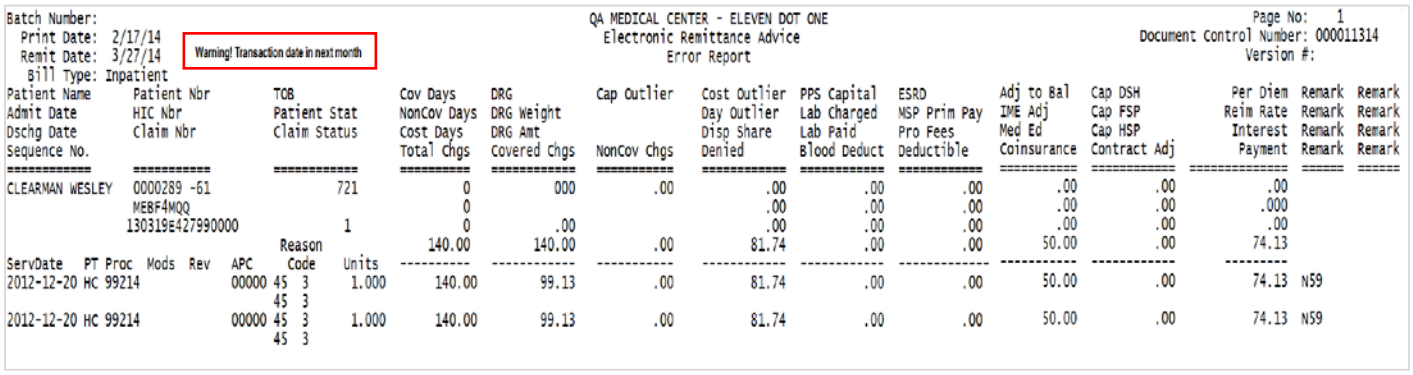
Error Message - Medicare Sequestration Example

Conj Adj amt will not post because Auto Cont is turned on, except for the monies associated with Mcare Sequestration, Reason Code 253

```
Batch Number: 970                                                    EXAMPLE MEDICAL CENTER                                                    Page No:    1
   Print Date: 12/03/20                                              Electronic Remittance Advice                                  Document Control Number: 00011314
   Remit Date:  5/25/20                                                                                                          Medhost ERA ID Number: 182970942
    Bill Type: Inpatient                                                                                                                    Version #: 005010X221A1

 Patient Name     Patient Nbr       TOB              Cov Days    DRG           Cap Outlier   Cost Outlier  PPS Capital   ESRD          Adj to Bal   Cap DSH          Per Diem  Remark  Remark
 Admit Date       HIC Nbr           Patient Stat     NonCov Days DRG Weight    Sequestratn   Day Outlier   Lab Charged   MSP Prim Pay  IME Adj      Cap FSP          Reim Rate  Remark  Remark
 Dschg Date       Claim Nbr         Claim Status     Cost Days   DRG Amt                   Disp Share    Lab Paid      Pro Fees      Med Ed       Cap HSP          Interest  Remark  Remark
 Sequence No.     Payr/Pln/Name                      Total Chgs  Covered Chgs  NonCov Chgs   Denied        Blood Deduct  Deductible    Coinsurance  Contract Adj     Payment  Remark  Remark
 ============     =============     ============     =========  ============  ===========   ============  ============  ============  ===========  ============  ========== ======  ======
 BAKER JOAN R     6000174 -01               721              0           000          .00           .00           .00           .00          .00           .00          .00
 2020-04-16       MEBFCQYQ                                   0                        .00           .00           .00           .00          .00           .00         .000
 2020-04-25       17166G999999                1              0           .00                        .00           .00           .00          .00           .00          .00
   1              18/  1 MEDICARE 001          164.00         164.00          .00           .00           .00           .00          .00         59.34         104.66
 ServDate   PT Proc  Mods  Rev   APC   Rsn Cd  Units    ----------  ----------  ----------  ------------  ------------  ------------  -----------  ------------        ---------
 Cont Adj amt will not post because Auto Cont is turned on, except for the monies associated with Mcare Sequestration, Reason cde 253
 2020-04-16 HC 99214            00000 45        1.000     140.00        101.57          .00           .00           .00           .00          .00          38.43         101.57  N6
 2020-04-25 HC 81003            48368 253       1.000      24.00          3.09          .00           .00           .00           .00          .00          20.91           3.09  N6
```

Error Report - Warning! Transaction date in next month

When ERAs are received (RMTADV option 1) or are reprinted (RMTADV option 2), the batch entry date will be checked against the current system date. If the batch entry date is in a future month, the reports will print this alert: Warning! Transaction date in next month. This informs the client so they can suspend the batch in case they do not want these to go to Accounts Receivable.



Batch Number:
Print Date: 2/17/14
Remit Date: 3/27/14
Bill Type: Inpatient

Warning! Transaction date in next month

QA MEDICAL CENTER - ELEVEN DOT ONE
Electronic Remittance Advice
Error Report

Page No: 1
Document Control Number: 000011314
Version #:

Patient Name / Admit Date / Dschg Date / Sequence No.	Patient Nbr / HIC Nbr / Claim Nbr	TOB / Patient Stat / Claim Status	Cov Days / NonCov Days / Cost Days / Total Chgs	DRG / DRG Weight / DRG Amt / Covered Chgs	Cap Outlier / NonCov Chgs	Cost Outlier / Day Outlier / Disp Share / Denied	PPS Capital / Lab Charged / Lab Paid / Blood Deduct	ESRD / NSP Prim Pay / Pro Fees / Deductible	Adj to Bal / IME Adj / Med Ed / Coinsurance	Cap DSH / Cap FSP / Cap HSP / Contract Adj	Per Diem / Reim Rate / Interest / Payment	Remark	Remark
CLEARMAN WESLEY	0000289 -61	721	0	000	.00	.00	.00	.00	.00	.00	.00		
	MEBF4MQQ		0			.00	.00	.00	.00	.00	.000		
	130319E427990000	1	0	.00		.00	.00	.00	.00	.00	.00		
		Reason	140.00	140.00	.00	81.74	.00	.00	50.00	.00	74.13		
ServDate PT Proc Mods Rev	APC	Code	Units										
2012-12-20 HC 99214	00000	45 3	1.000	140.00	99.13	.00	81.74	.00	.00	50.00	.00	74.13	N59
		45 3											
2012-12-20 HC 99214	00000	45 3	1.000	140.00	99.13	.00	81.74	.00	.00	50.00	.00	74.13	N59
		45 3											

Error Report - Claim Status Settings

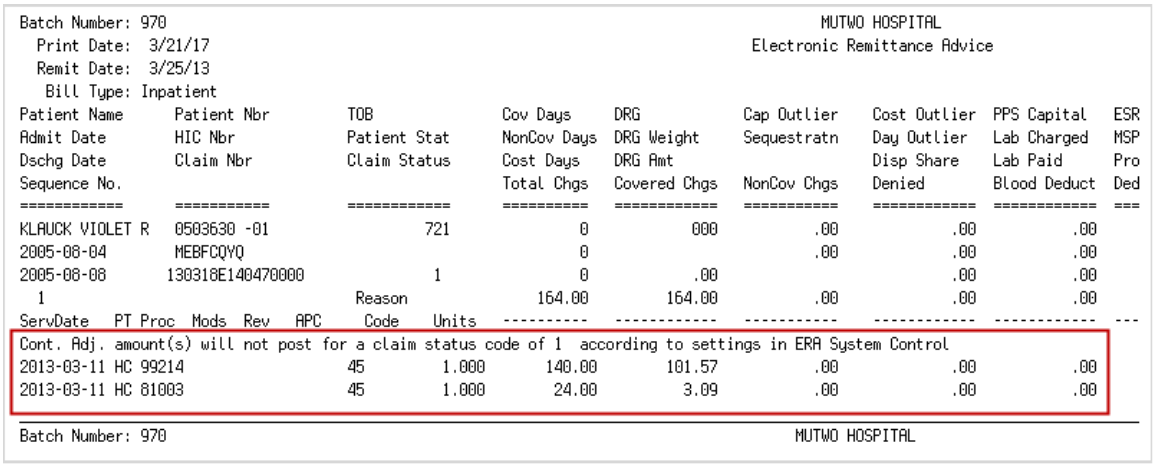
ER-012 CLM STATUS SETTINGS DO NOT MATCH PATIENT PAYOR PLAN

The insurance type on the received ERA does not match the patient's payor plan.

Here is an example scenario that would produce this error message.
The Electronic Remittance Advice System Control (Remittance Advice Menu, Option 4) has the following settings:

Allow Secondary C/A by Claim Status = Y
Claim Status Codes = 2 (Processed as Secondary)

An ERA comes in for an account that shows secondary with a claim status of 2, but the insurance on the ERA is not the same insurance type as the actual secondary insurance listed on the account.

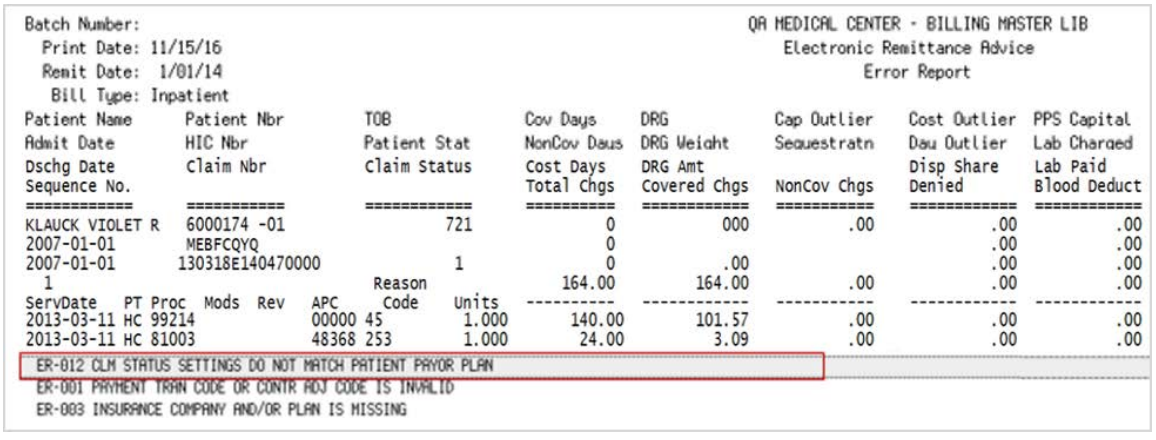


Batch Number: 970 — MUTWO HOSPITAL
Print Date: 3/21/17 — Electronic Remittance Advice
Remit Date: 3/25/13
Bill Type: Inpatient

Patient Name / Admit Date / Dschg Date / Sequence No.	Patient Nbr / HIC Nbr / Claim Nbr	TOB / Patient Stat / Claim Status	Cov Days / NonCov Days / Cost Days / Total Chgs	DRG / DRG Weight / DRG Amt / Covered Chgs	Cap Outlier / Sequestratn / NonCov Chgs	Cost Outlier / Day Outlier / Disp Share / Denied	PPS Capital / Lab Charged / Lab Paid / Blood Deduct	ESR / MSP / Pro / Ded
KLAUCK VIOLET R	0503630 -01	721	0	000	.00	.00	.00	
2005-08-04	MEBFCQYQ		0		.00	.00	.00	
2005-08-08	130318E140470000	1	0	.00		.00	.00	
1		Reason	164.00	164.00	.00	.00	.00	

ServDate	PT	Proc	Mods	Rev	APC	Code	Units					
Cont. Adj. amount(s) will not post for a claim status code of 1 according to settings in ERA System Control												
2013-03-11	HC	99214				45	1.000	140.00	101.57	.00	.00	.00
2013-03-11	HC	81003				45	1.000	24.00	3.09	.00	.00	.00

Batch Number: 970 — MUTWO HOSPITAL



Batch Number:
Print Date: 11/15/16 — QA MEDICAL CENTER - BILLING MASTER LIB
Remit Date: 1/01/14 — Electronic Remittance Advice
Bill Type: Inpatient — Error Report

Patient Name / Admit Date / Dschg Date / Sequence No.	Patient Nbr / HIC Nbr / Claim Nbr	TOB / Patient Stat / Claim Status	Cov Days / NonCov Daus / Cost Days / Total Chgs	DRG / DRG Weight / DRG Amt / Covered Chgs	Cap Outlier / Sequestratn / NonCov Chgs	Cost Outlier / Dau Outlier / Disp Share / Denied	PPS Capital / Lab Charged / Lab Paid / Blood Deduct
KLAUCK VIOLET R	6000174 -01	721	0	000	.00	.00	.00
2007-01-01	MEBFCQYQ		0			.00	.00
2007-01-01	130318E140470000	1	0	.00		.00	.00
1		Reason	164.00	164.00	.00	.00	.00

ServDate	PT	Proc	Mods	Rev	APC	Code	Units					
2013-03-11	HC	99214			00000	45	1.000	140.00	101.57	.00	.00	.00
2013-03-11	HC	81003			48368	253	1.000	24.00	3.09	.00	.00	.00

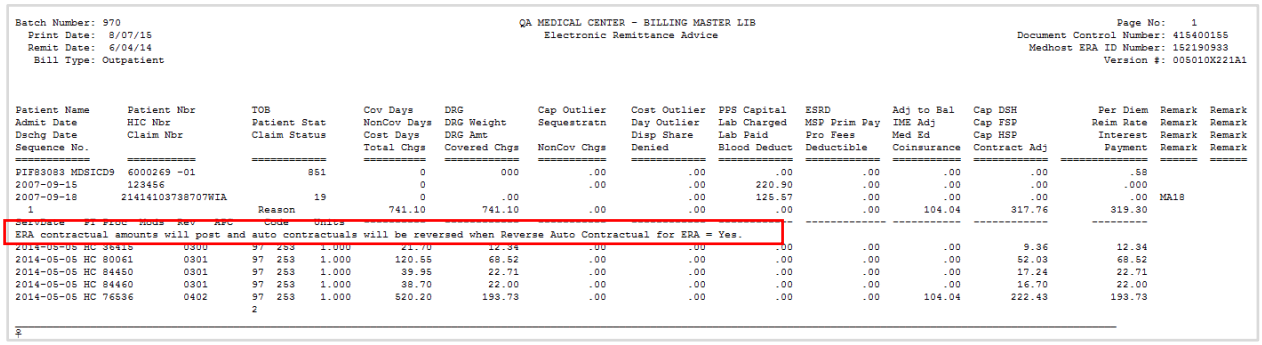
ER-012 CLM STATUS SETTINGS DO NOT MATCH PATIENT PAYOR PLAN
ER-001 PAYMENT TRAN CODE OR CONTR ADJ CODE IS INVALID
ER-003 INSURANCE COMPANY AND/OR PLAN IS MISSING

Remit Reconciliation Overview

Remit reconciliation helps billers balance accounts that use auto contractual. During billing, the system calculates the expected payment from the insurance company based on contractual agreements. Once the payment is received via Electronic Remittance Advice, if the calculated adjustment amount is not the same as the actual adjustment amount from the remit, remit reconciliation (**Reverse Auto Cont for ERA**) reverses the auto contractual amount and posts the contractual adjustment amount from the remit to the account.

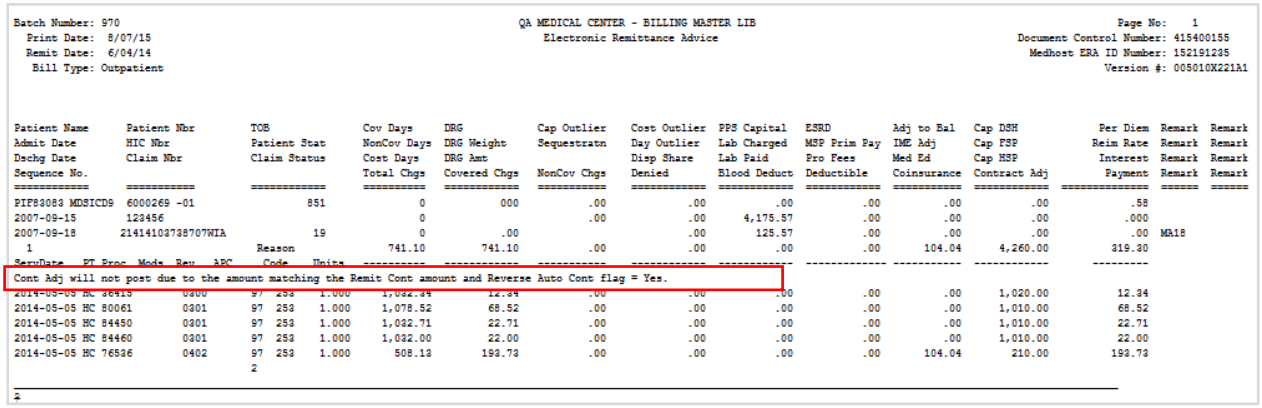
ERA report messages related to remit reconciliation:

- This message displays when the auto contractual amount was reversed and the contractual adjustment posts: **ERA contractual amounts will post and auto contractuals will be reversed when Reverse Auto Contractual for ERA = Yes**



```
Batch Number: 970                                   QA MEDICAL CENTER - BILLING MASTER LIB                          Page No:    1
  Print Date:  8/07/15                                  Electronic Remittance Advice                  Document Control Number: 415400155
  Remit Date:  6/04/14                                                                              Medhost ERA ID Number: 152190933
   Bill Type: Outpatient                                                                                        Version #: 005010X221A1

Patient Name      Patient Nbr        TOB              Cov Days    DRG           Cap Outlier   Cost Outlier  PPS Capital  ESRD          Adj to Bal   Cap DSH          Per Diem  Remark  Remark
Admit Date        HIC Nbr            Patient Stat     NonCov Days DRG Weight    Sequestratn   Day Outlier   Lab Charged  MSP Prim Pay  IME Adj      Cap FSP          Reim Rate Remark  Remark
Dschg Date        Claim Nbr          Claim Status     Cost Days   DRG Amt       Disp Share    Lab Paid      Pro Fees     Deductible    Med Ed       Cap HSP          Interest  Remark  Remark
Sequence No.                                          Total Chgs  Covered Chgs  NonCov Chgs   Denied        Blood Deduct Coinsurance   Contract Adj     Payment   Remark  Remark
============      ==========         ============     ==========  ============  ===========   ============  ============ ============ ===========  ============== ========  ======
PIF83083 MDSICD9  6000269 -01                 851             0           000           .00           .00          .00          .00          .00           .58
2007-09-15        123456                                       0                         .00           .00       220.90          .00          .00          .000
2007-09-18        21414103738707WIA           19             0           .00                         .00       125.57          .00          .00           .00  MA18
  1                                    Reason          741.10        741.10           .00           .00          .00          .00       104.04       317.76        319.30
ServDate    PT Proc  Mods  Rev   APC     Code     Units  ---------- ------------ ----------- ------------ ------------ ------------ ------------ ---------- ---------
ERA contractual amounts will post and auto contractuals will be reversed when Reverse Auto Contractual for ERA = Yes.
2014-05-05 HC 36415        0300          97  253    1.000       21.70        12.34           .00           .00          .00          .00          .00         9.36        12.34
2014-05-05 HC 80061        0301          97  253    1.000      120.55        68.52           .00           .00          .00          .00          .00        52.03        68.52
2014-05-05 HC 84450        0301          97  253    1.000       39.95        22.71           .00           .00          .00          .00          .00        17.24        22.71
2014-05-05 HC 84460        0301          97  253    1.000       38.70        22.00           .00           .00          .00          .00          .00        16.70        22.00
2014-05-05 HC 76536        0402          97  253    1.000      520.20       193.73           .00           .00          .00          .00       104.04       222.43       193.73
                                         2
```

- This message displays when the auto contractual amount matches the remit contractual amount: **Cont Adj will not post due to the amount matching the Remit Cont amount and Reverse Auto Cont flag = Yes**



```
Batch Number: 970                                   QA MEDICAL CENTER - BILLING MASTER LIB                          Page No:    1
  Print Date:  8/07/15                                  Electronic Remittance Advice                  Document Control Number: 415400155
  Remit Date:  6/04/14                                                                              Medhost ERA ID Number: 152191235
   Bill Type: Outpatient                                                                                        Version #: 005010X221A1

Patient Name      Patient Nbr        TOB              Cov Days    DRG           Cap Outlier   Cost Outlier  PPS Capital  ESRD          Adj to Bal   Cap DSH          Per Diem  Remark  Remark
Admit Date        HIC Nbr            Patient Stat     NonCov Days DRG Weight    Sequestratn   Day Outlier   Lab Charged  MSP Prim Pay  IME Adj      Cap FSP          Reim Rate Remark  Remark
Dschg Date        Claim Nbr          Claim Status     Cost Days   DRG Amt       Disp Share    Lab Paid      Pro Fees     Deductible    Med Ed       Cap HSP          Interest  Remark  Remark
Sequence No.                                          Total Chgs  Covered Chgs  NonCov Chgs   Denied        Blood Deduct Coinsurance   Contract Adj     Payment   Remark  Remark
============      ==========         ============     ==========  ============  ===========   ============  ============ ============ ===========  ============== ========  ======
PIF83083 MDSICD9  6000269 -01                 851             0           000           .00           .00          .00          .00          .00           .58
2007-09-15        123456                                       0                         .00           .00     4,175.57          .00          .00          .000
2007-09-18        21414103738707WIA           19             0           .00                         .00       125.57          .00          .00           .00  MA18
  1                                    Reason          741.10        741.10           .00           .00          .00          .00       104.04     4,260.00        319.30
ServDate    PT Proc  Mods  Rev   APC     Code     Units  ---------- ------------ ----------- ------------ ------------ ------------ ------------ ---------- ---------
Cont Adj will not post due to the amount matching the Remit Cont amount and Reverse Auto Cont flag = Yes.
2014-05-05 HC 36415        0300          97  253    1.000    1,032.34        12.34           .00           .00          .00          .00          .00     1,020.00        12.34
2014-05-05 HC 80061        0301          97  253    1.000    1,078.52        68.52           .00           .00          .00          .00          .00     1,010.00        68.52
2014-05-05 HC 84450        0301          97  253    1.000    1,032.71        22.71           .00           .00          .00          .00          .00     1,010.00        22.71
2014-05-05 HC 84460        0301          97  253    1.000    1,032.00        22.00           .00           .00          .00          .00          .00     1,010.00        22.00
2014-05-05 HC 76536        0402          97  253    1.000      508.13       193.73           .00           .00          .00          .00       104.04       210.00       193.73
                                         2
```

RMTADV Option 4: Maintain Electronic R/A System Control

Overview:

Maintain Electronic R/A System Control (*Option 4* on the *Electronic Remittance Advice Menu*) is used to create and maintain the ERA System Control Record for a facility.

MEDHOST must set up the ERA System Control Record before processing electronic remittance advices.

For example, facilities in Pennsylvania, New Jersey, Maryland, Delaware, and the District of Columbia recently changed ERA intermediaries, from WPS to Highmark. Because settings for WPS and Highmark are different, the facilities' ERA System Control Records required adjustment.

The *Maintain Electronic R/A System Control* option has two independent sets of interface screens. These are based on the Electronic Remittance State Code that MEDHOST has set up for your facility, as follows.

This document describes how to set up the ERA System Control Record for facilities with either type of Electronic Remittance State Code. If you think your Electronic Remittance State Code might need to be changed (e.g., if your intermediary changes), please contact Customer Support for assistance.

This option can be run in live mode (for processing remittance advices) or in test mode. For details, see the Testing Mode descriptions in the section relevant to your facility.

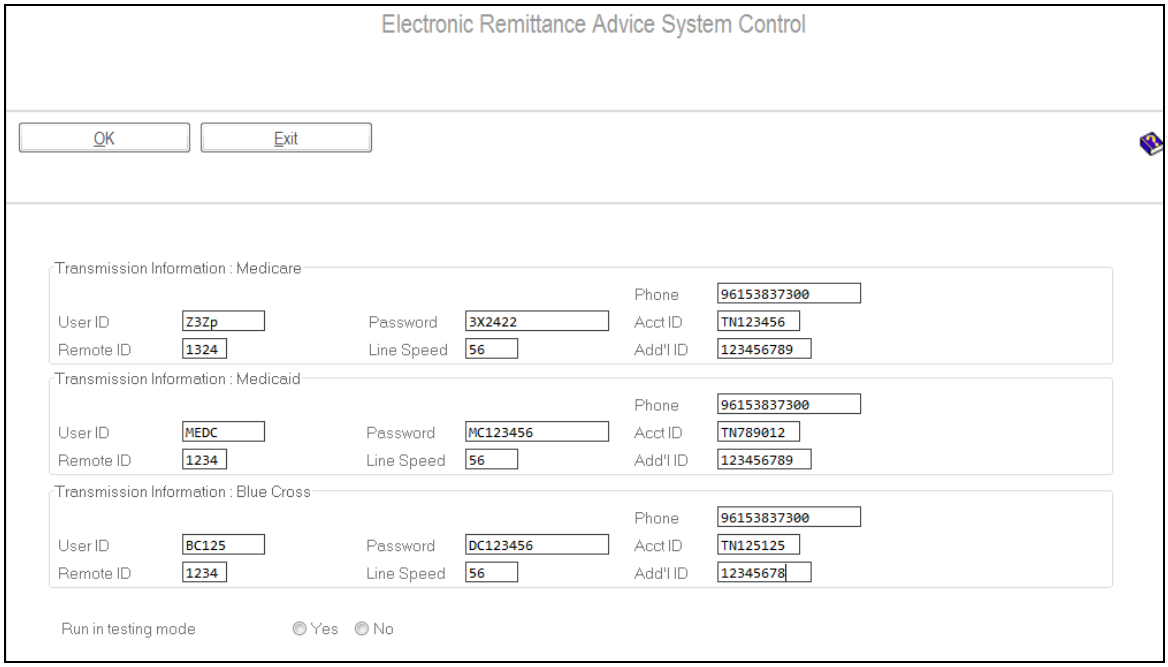
Files:

MUUSRH, SYSCTL

Contents

Interface for a Specific State Code

Add/Maintain a Record for a State Intermediary



The Electronic Remittance Advice (ERA) System Control window for a State intermediary appears when you select the *Maintain Electronic R/A System Control* link from the *Electronic Remittance Advice Menu* and your facility's Electronic Remittance State Code corresponds to your state.

Note: If your screen has different fields, go to the section, "Interface for the US Code."

You can enter and maintain separate sets of information for Medicare, Medicaid, and Blue Cross. The fields are described on the next page.

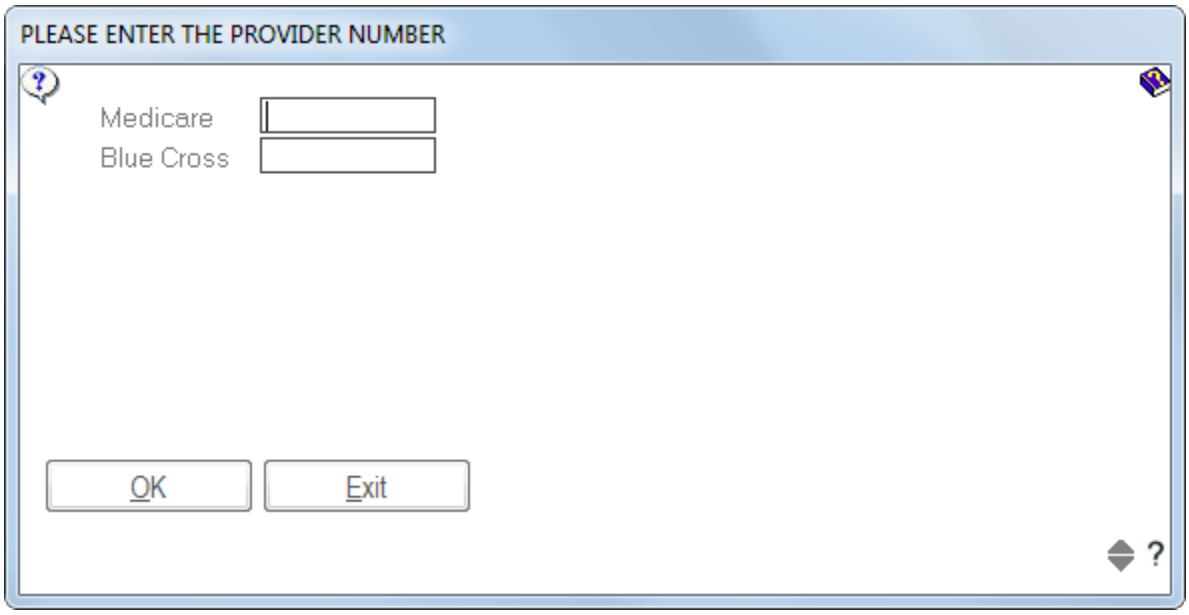
Action

Enter or maintain the system control information for the electronic remittance advice. Then click **OK** to save the information. For some Electronic Remittance State Codes, such as TN, a **Provider Number** window will open next (see the section, "Example Provider Number Window"). Otherwise, the intermediary's ERA System Control Record is complete, and you will return to the **Electronic Remittance Advice** menu.

To return to the *Electronic Remittance Advice Menu* without saving any entries or changes, click **Exit**.

Field	Description
Phone	Enter the phone number of the intermediary.
User ID	Enter the sender identification provided by the intermediary.
Password	Enter the password provided by the intermediary.
Acct ID	Enter the account number assigned by the intermediary.
Add'l ID	Enter any additional ID supplied by the intermediary, if applicable.
Remote ID	Enter the remote ID assigned by the intermediary.
Line Speed	Enter the speed of the modem that is being used (for example, **2400**, **4800**, or **9600**).
Run in testing mode	Click **Yes** if running in test mode. When testing is complete, click **No**. When processing live remittance advices, this field must be **No**.

Example Provider Number Window



The Provider Number window appears when you click **OK** in the state **ERA System Control** window and have been given certain Electronic Remittance State Codes. The example window below appears when the Electronic Remittance State Code is TN (for Tennessee). The window will vary according to the providers you set up in the state **ERA System Control** window.

The provider number will allow the remittance advices, in this case Medicare and/or Blue Cross, to be received through *Receive Electronic R/A*, *Option 1* on the *Electronic Remittance Advice Menu*.

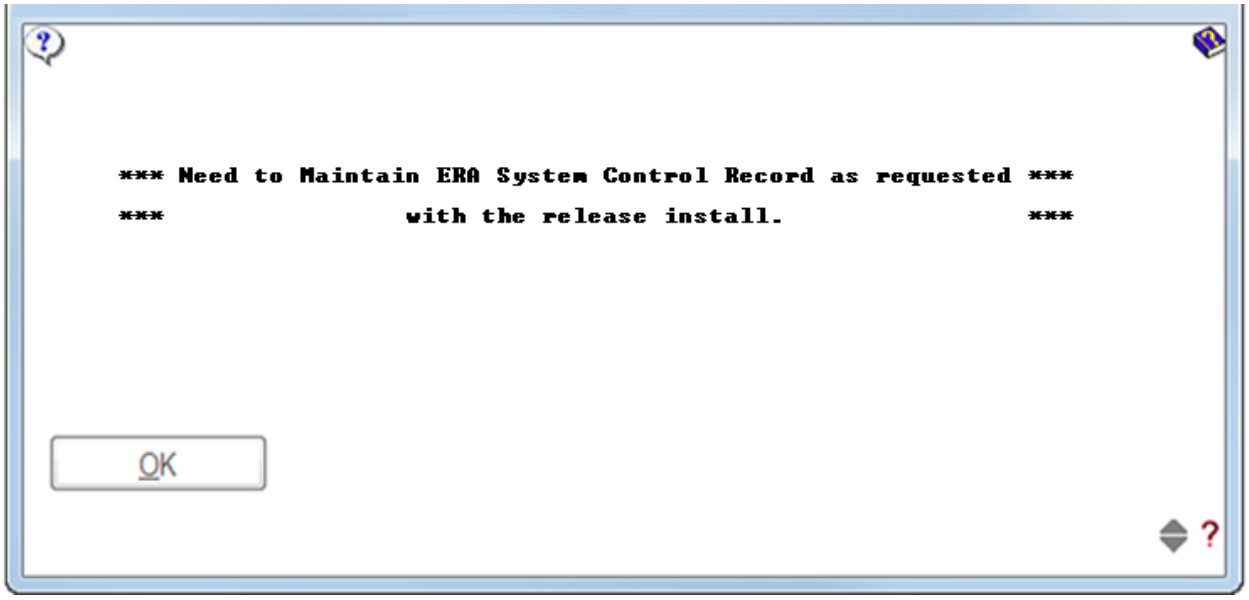
When you select the *Receive Electronic R/A* option, you can then choose to receive either Medicare or Blue Cross remittance advices.

Action

Enter the provider numbers and then click **OK**. This completes the setup for the state version of the ERA System Control Record, and you will return to the **Electronic Remittance Advice** menu.

Interface for the US Code

Warning Message Window

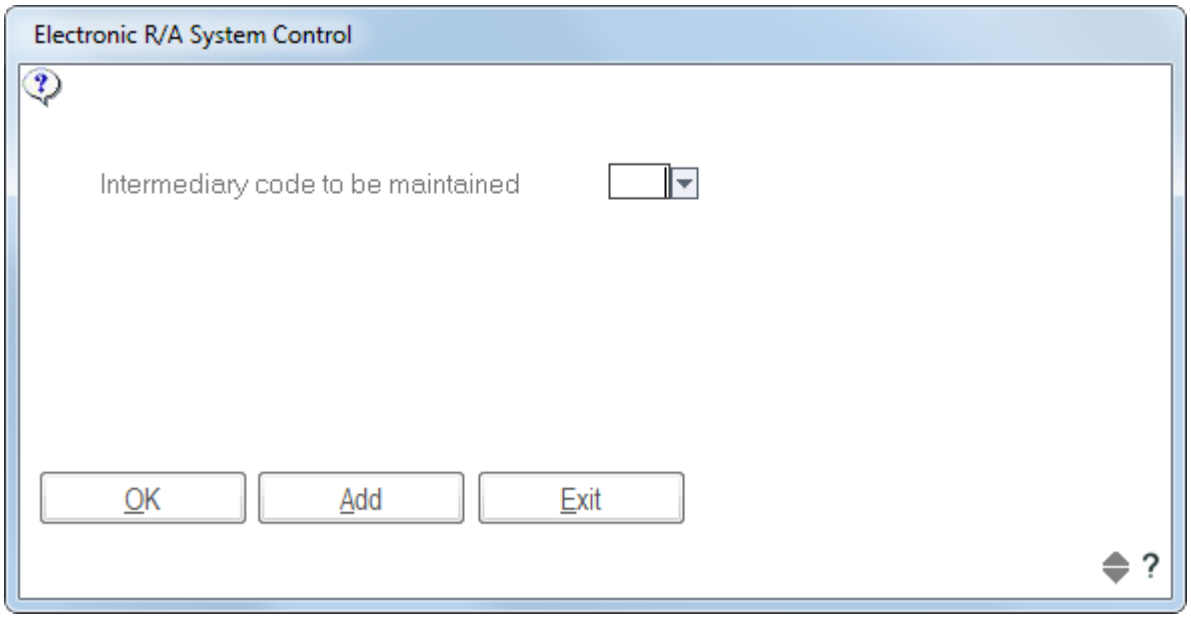


This Warning window appears when the Electronic Remittance State Code is US and you attempt to receive electronic remits without having properly set up the intermediary in the Electronic Admittance System Control File.

Action

Click **OK** to close the window. Then set up the intermediary's record in the Electronic Admittance System Control File according to the instructions in this section ("Interface for the US Code").

Select/Add a US Intermediary



The Electronic R/A System Control window for a US intermediary appears when you select the *Maintain Electronic R/A System Control* link from the *Electronic Remittance Advice Menu* and your facility's Electronic Remittance State Code is US.

You can use this window to start a record for an intermediary or to access and maintain an existing intermediary record.

Note:

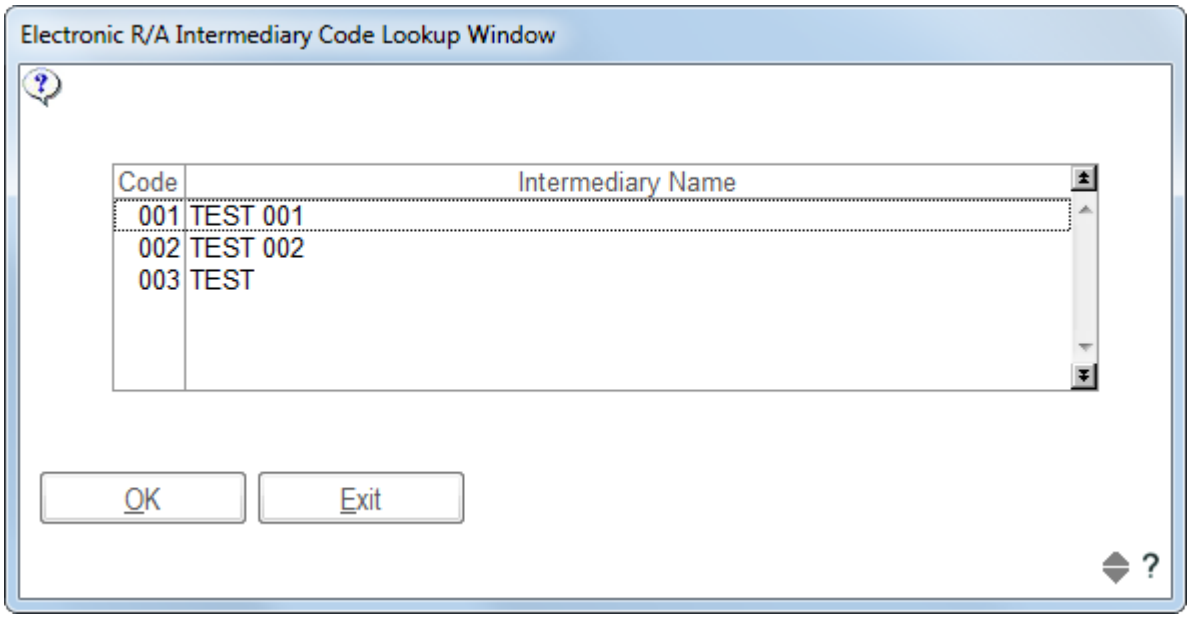
- If your window looks different, go to the section, "Interface for a Specific State Code."
- Intermediary codes are set up and maintained through *Maintain Intermediary File*, *Option 2* on the *Electronic Billing Maintenance Menu*. These intermediary codes are completely different from the "State" or "US" Electronic Remittance State Codes that MEDHOST sets up.

Action

To add an intermediary record: Enter a new intermediary code or leave the entry field blank and click **Add**. The **Electronic Remittance Advice (ERA) System Control** window for a US intermediary will open (refer to the section, "Add/Maintain a Record for a US Intermediary").

To access an existing intermediary record: Type the code or search for it by clicking the search button (refer to the next page). Then click the **OK** button. The **Electronic Remittance Advice (ERA) System Control** window for a US intermediary will open (refer to the section, "Add/Maintain a Record for a US Intermediary").

Electronic R/A Intermediary Code Lookup Window

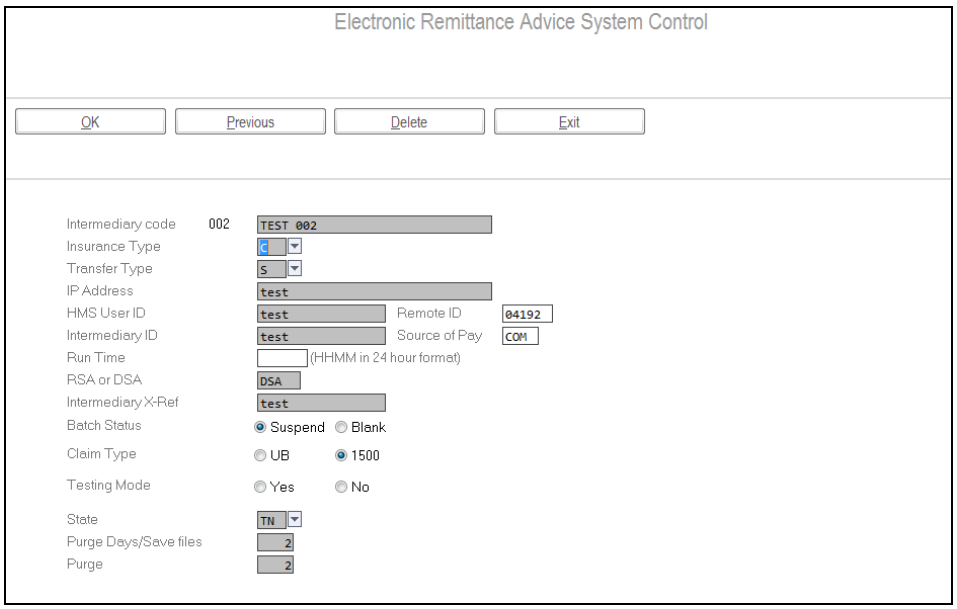


The Electronic R/A Intermediary Code Lookup window appears when you click in the **Electronic R/A System Control** window for a US intermediary. The list contains the intermediaries with completed ERA System Control Records.

Action

Select an intermediary by double-clicking on it, or by clicking on it (to highlight it) and then clicking **OK**. The **Electronic Remittance Advice (ERA) System Control** window for a US intermediary will open.

Add/Maintain a Record for a US Intermediary



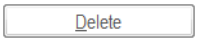
The Electronic Remittance Advice (ERA) System Control window for a US intermediary appears when you click **OK** in the **Electronic R/A System Control** window for a US intermediary.

The window for a new intermediary record will be slightly different than one that you are maintaining.

- If you are adding an intermediary record, all entry fields are blank and there are no fields in the middle of the window (see below). This is because the middle fields reflect the code you enter in the Transfer Type field. These fields are described in the section, "Fields Specific to Transfer Type."
- If you are maintaining an existing intermediary record, the fields contain current information, and the fields in the middle of the window reflect the Transfer Type code. For example, there will be no additional fields for Transfer Type, **C** = Client Access.

Action

To add or maintain the record, complete the fields according to your requirements, then click **OK**. For descriptions of the fields, refer to the following sections. After you complete the fields in this screen, the intermediary's ERA System Control Record will be complete, and you will return to the **Electronic Remittance Advice** menu.

If you are maintaining the record, a 

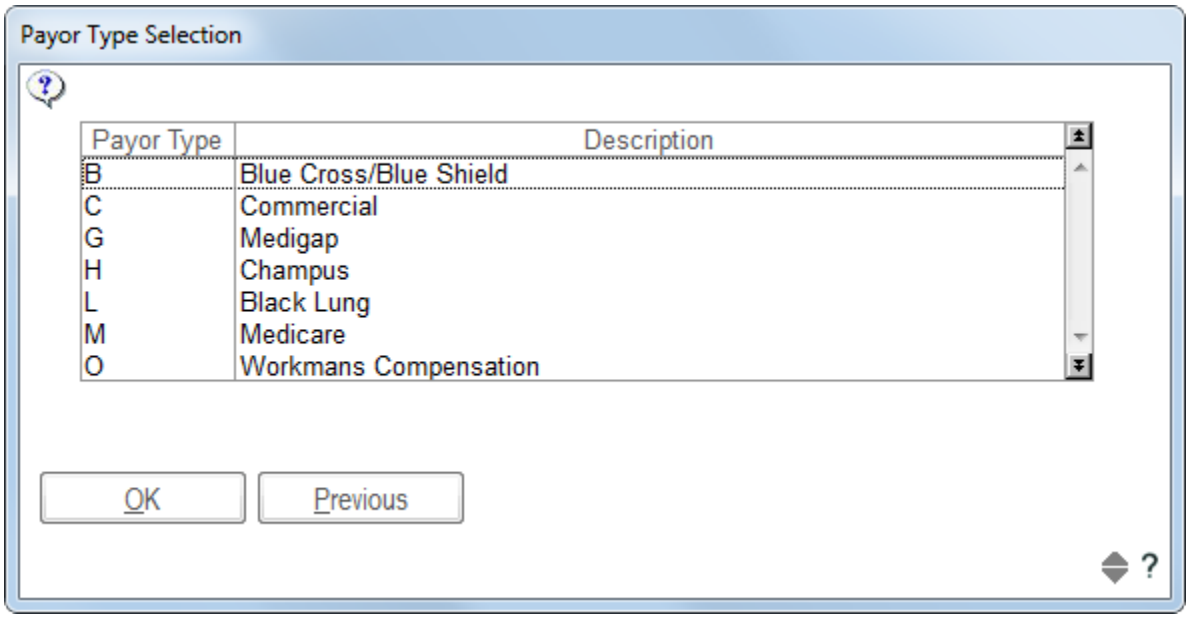
button will be present (refer to the section, "Deleting a Record").

Fields for All Transfer Types

For information about the fields that depend on Transfer Type, see the section, "Fields Specific to Transfer Types."

Field	Description
Intermediary Code	Type a description for the intermediary (maximum 30 characters; for example, **MEDICARE UB**).
Insurance Type	Enter the intermediary's insurance type code (one character). You can either type the code or click to search for and select it.
Transfer Type	Enter or search for the intermediary's one-character Transfer Type code (see the section, "Transfer Type Selection Window"). The Transfer Type code determines fields that appear in the middle of the window. Valid codes are **C**, **D**, **M,** or **S**. Type **F** is for future use.
Claim Type	Select **UB** or **1500** for the claim type to be associated with the intermediary.
State	Enter or search for the intermediary's two-letter state code (see the section, "State Code Selection Window"). **Note:** This is ***not*** the same code as the Electronic Remittance State Code; the ER State Code is set using a different application.
Testing Mode	Select **Yes** if the intermediary is being tested; otherwise, select **No**. When you are processing live remittance advices, this field must be **No**.
Purge Days/Save Files	Type the number of days (up to 999) for which the intermediary's Electronic Remittance *daily* files will be saved. After this number of days, the files will be purged automatically.
Purge Days/History Files	Type the number of days (up to 999) for which the intermediary's Electronic Remittance *history* files will be saved. After this number of days, the files will be purged automatically.

Insurance Type – Payor Type Selection

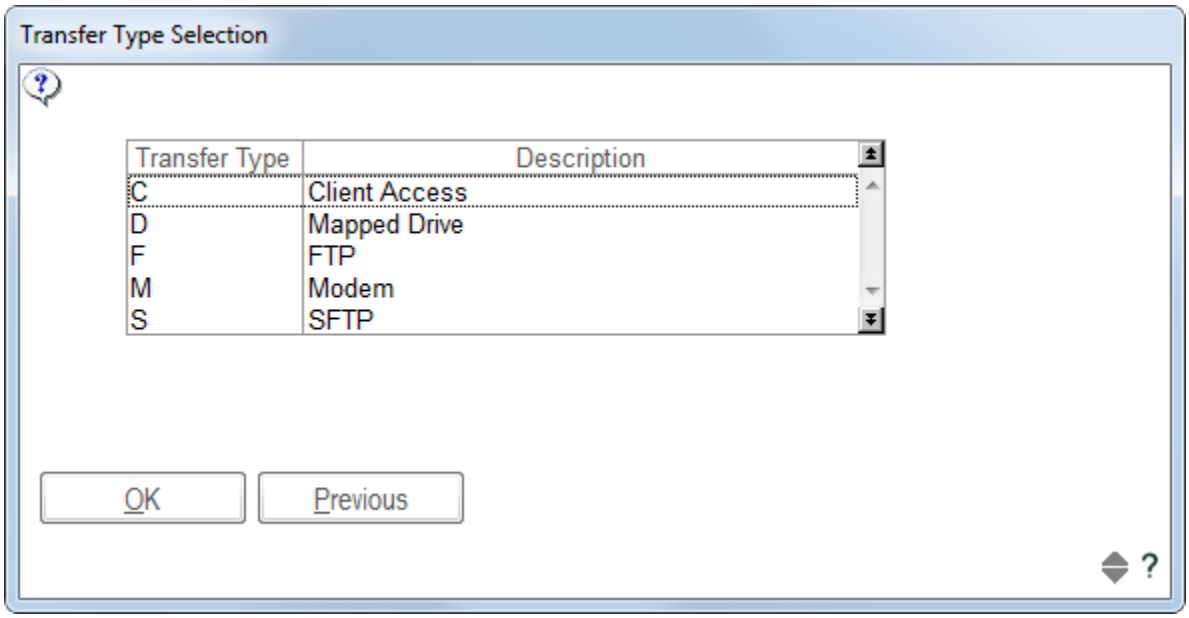


The Insurance Type – Payor Type Selection window displays when the Insurance Type down arrow is clicked on the Electronic Remittance Advice System Control screen.

Action

Select a Payor Type and click **OK** to continue or **Previous** to return to the previous screen without making changes.

Transfer Type Selection Window



This window appears when you click next to the Transfer Type field in the **ERA System Control** window for a US intermediary.

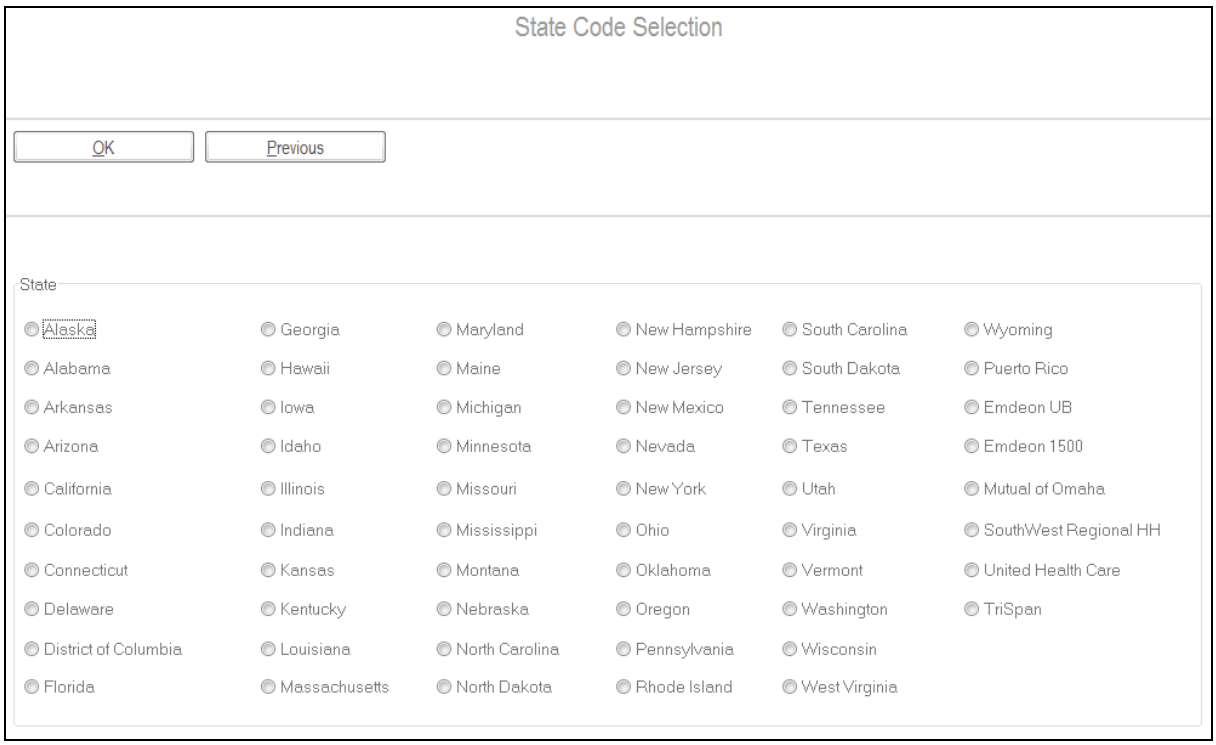
The Transfer Type you select determines which fields appear in the middle part of the **ERA System Control** window for a US intermediary.

Action

Select a transfer type by double-clicking on it, or by clicking on it (to highlight it) and then clicking **OK**.

Select only **C**, **D**, **M**, or **S**. Type **F** is for future use.

State Code Selection Window



This window appears when you click next to the State field in the **ERA System Control** window for a US intermediary.

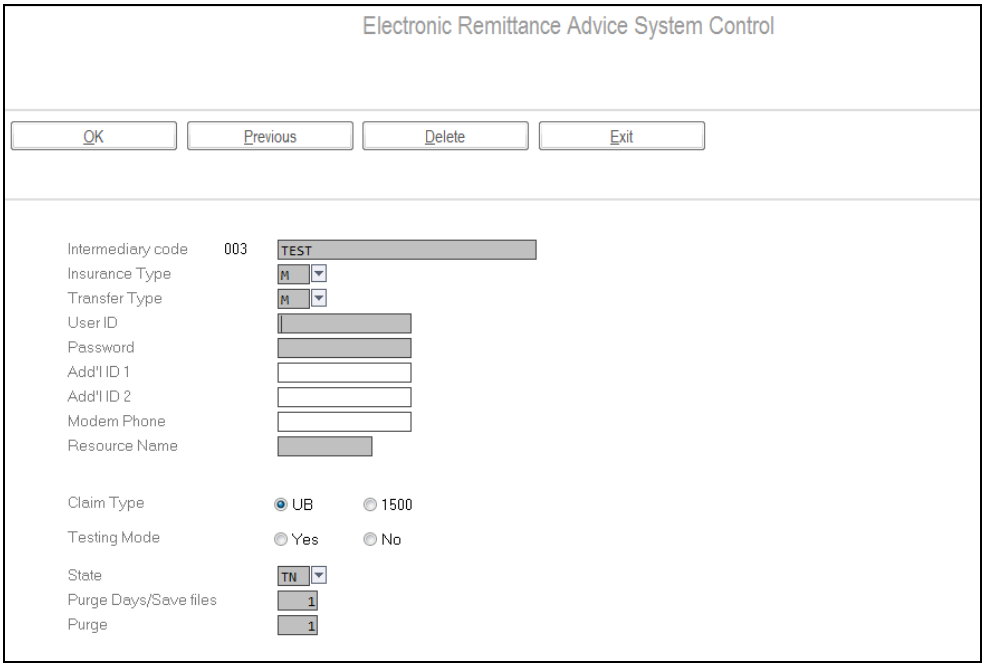
Note: You can now select the District of Columbia from the **State Code Selection** screen.

Action

Select a state or other item (in the far right column) by clicking on it and then clicking **OK**. You will return to the **ERA System Control** window.

Fields Specific to Transfer Types

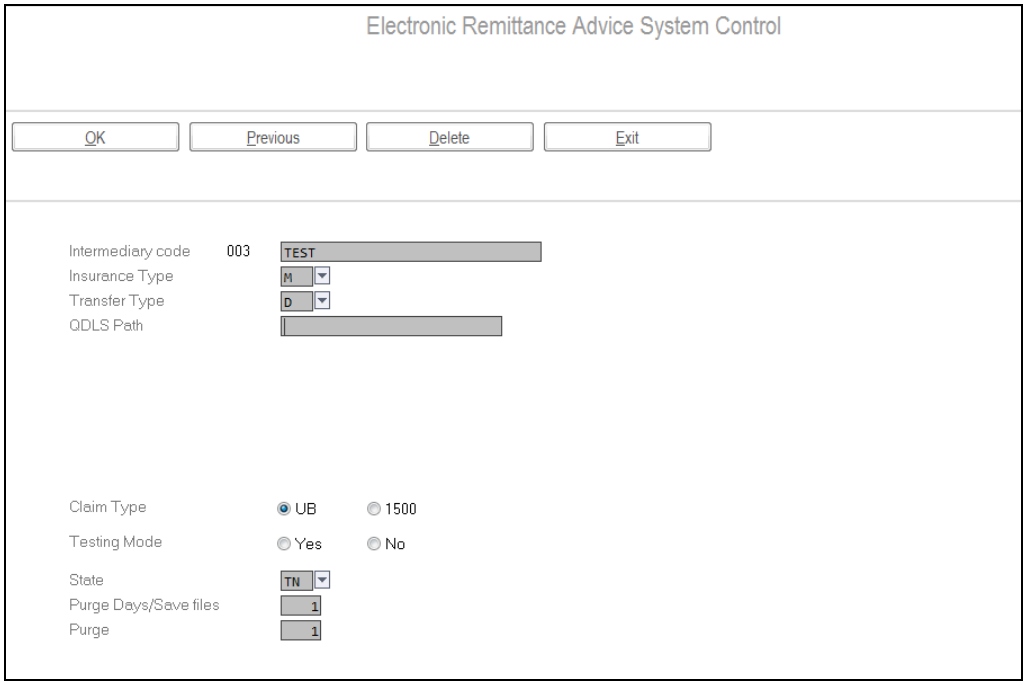
Transfer Type M (Modem)



The other fields are described in the section, "Fields for All Transfer Types."

Field	Description
User ID and **Password**	Type the user ID and password required for retrieving electronic remits from the intermediary (maximum 14 characters each).
Add'l ID 1 and **2**	Type any additional user IDs if other identification is needed to communicate with the intermediary (maximum 14 characters each).
Modem Phone	Type the modem phone number, including an area code that connects you to the intermediary (maximum 14 characters). Type only the digits without any punctuation (for example, **6155551111**).
Resource Name	Type the communication line used to dial direct to the intermediary (maximum 9 characters; for example, ***FIRST**).

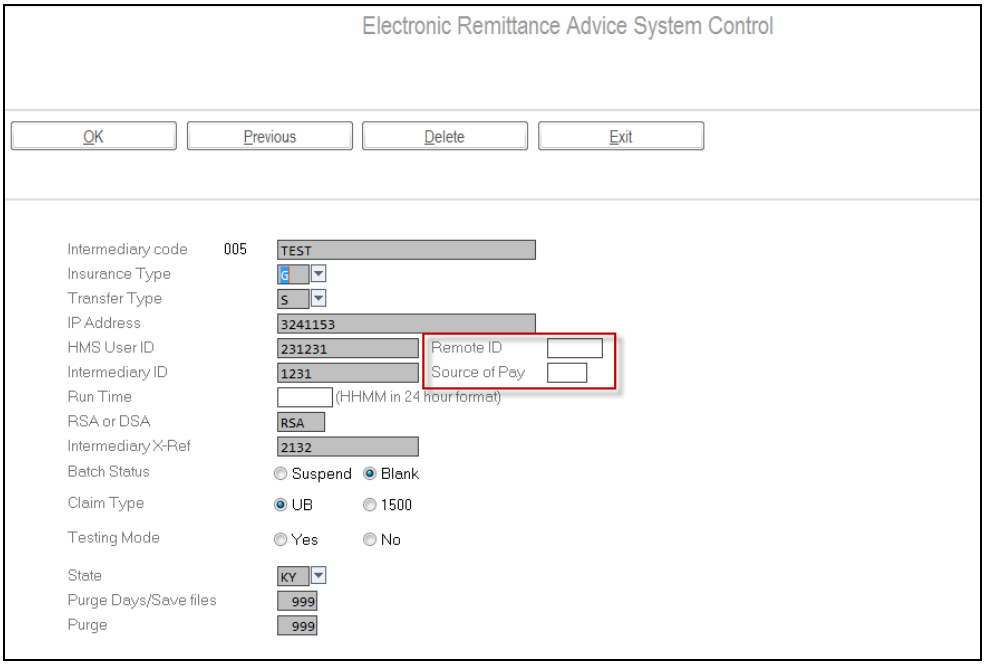
Transfer Type D (Mapped Drive)



The other fields are described in the section, "Fields for All Transfer Types."

Field	Description
QDLS Path	Type the location and name of the 835 file in the QDLS folder (maximum 25 characters; for example, **/QDLS/ERA/835.TXT**).

Transfer Type S (SFTP)



The setup in this window allows for the automation of the electronic remittance advice file transfer/posting process when 834 remits are received by SSI or other outside vendors.

Note:

Remote I.D. and Source of Pay (Overrides)

The Insurance type and Remote Payor ID determines which file to pull for an intermediary at SSI.

- The S is used for Auto ERA only. The fields only display when the communication type is S (SFTP).
- If the type is “C” (commercial), the Automated ERA process will look for a file with “COM” in certain positions of the file name at SSI. If the remote payor is set up with SSI as a commercial payor, SSI puts their remits in a file with “COM” in the name.
- If a remote payor sends a non-commercial payment (such as Medicaid), the Automated ERA process to look for a file with “CAD” in the name and there will be no file association so, the file will not process correctly.
- When a payor is not following the standards (for example set up as a commercial payor at SSI but sending Medicaid), the new Remote I.D. and Source of Pay overrides can be employed to get their ERA’s and process them correctly into the system. To do this, set up a new intermediary for the single payor and enter their Remote I.D.
- If a Remote I.D. and Source of Pay is entered for an intermediary, this will override the standard association of insurance type to SSI file name and allow the file to be pulled in and processed correctly. **Note**: The Remote I.D. and

Source of Pay are mutually inclusive - if one is entered the other one must also be entered also. In addition, a unique Remote I.D. and Source of Pay combination can be assigned to one intermediary and claim type combination only. These overrides are only needed in the scenario described above and normally these fields will be blank.

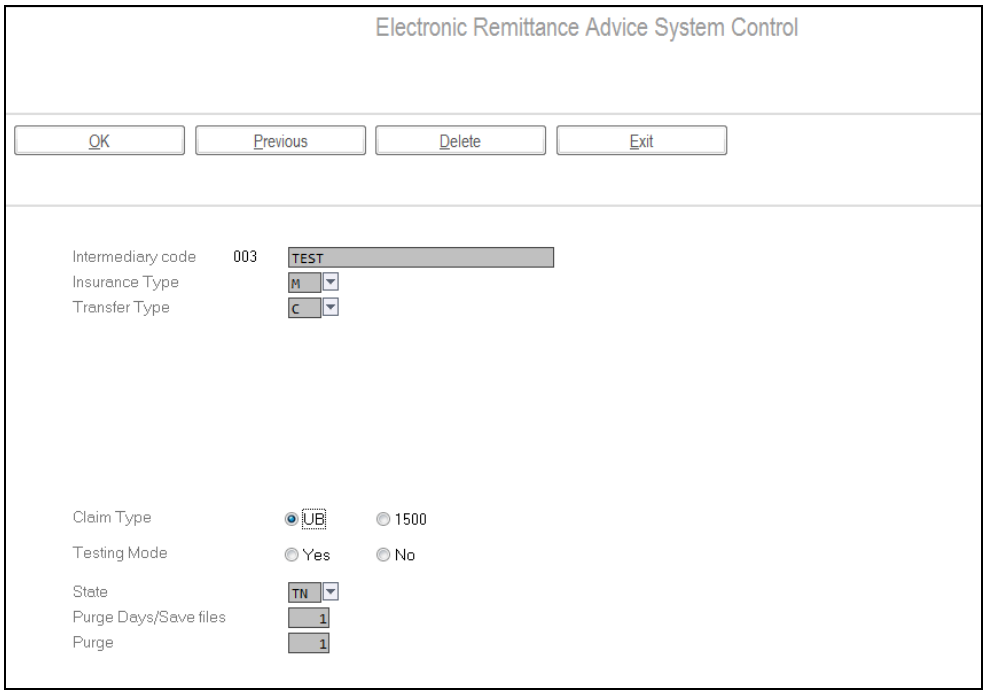
Batch Status

The batch status flag can be “S” or blank. If an “S” is entered, all automated ERA’s that come in for this intermediary will be suspended to allow them to be reviewed before posting. Leaving the batch status blank will allow them to come in and post automatically as normal.

The other fields are described in the section, “Fields for All Transfer Types.”

Field	Description
IP Address	(Required field) This is the SSI IP address that the facility will connect to. Enter a valid IP address for your facility (maximum 30 characters).
MEDHOST User ID	(Required field) This option is the user profile that runs the receive program (MEDHOST). This is created by the set up program.
Intermediary ID	(Required field) This option reflects the user profile assigned by the intermediary. This is created by SSI and will be provided to the client when the public/private keys are provided
Run Time	(Required field) This option designates the frequency the system will look for new remittances. Valid entries are actual time of day, i.e., 0100=1:00 a.m.
RSA or DSA	(Required field) Choose the type of encryption used for private/public key. Valid entries are RSA or DSA.
Intermediary X-Ref	(Required field) This is created by SSI and will be provided to the client when the public/private keys are provided. This is used on the SSI side on their systems.

Transfer Type C (Client Access)



There are no extra settings/fields for Transfer Type **C** (Client Access).

Transfer Type F (FTP)

Do not use this code; it is reserved for future use.

Contractual Adjustments

About Contractual Adjustments by Claim Status

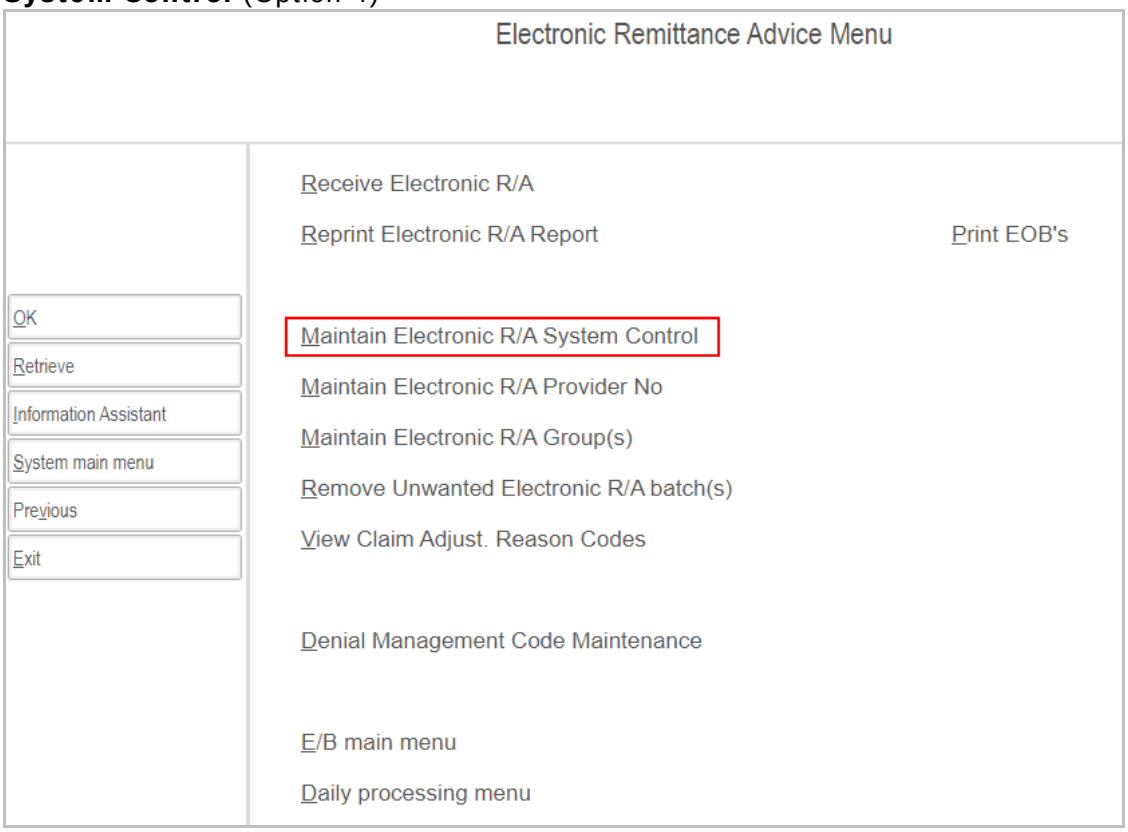
When an ERA is processed, billers control the following:

- Whether the primary, secondary, and tertiary contractual adjustment amounts are automatically written off
- When a contractual adjustment posts to a patient account per intermediary, payor position, and claim status

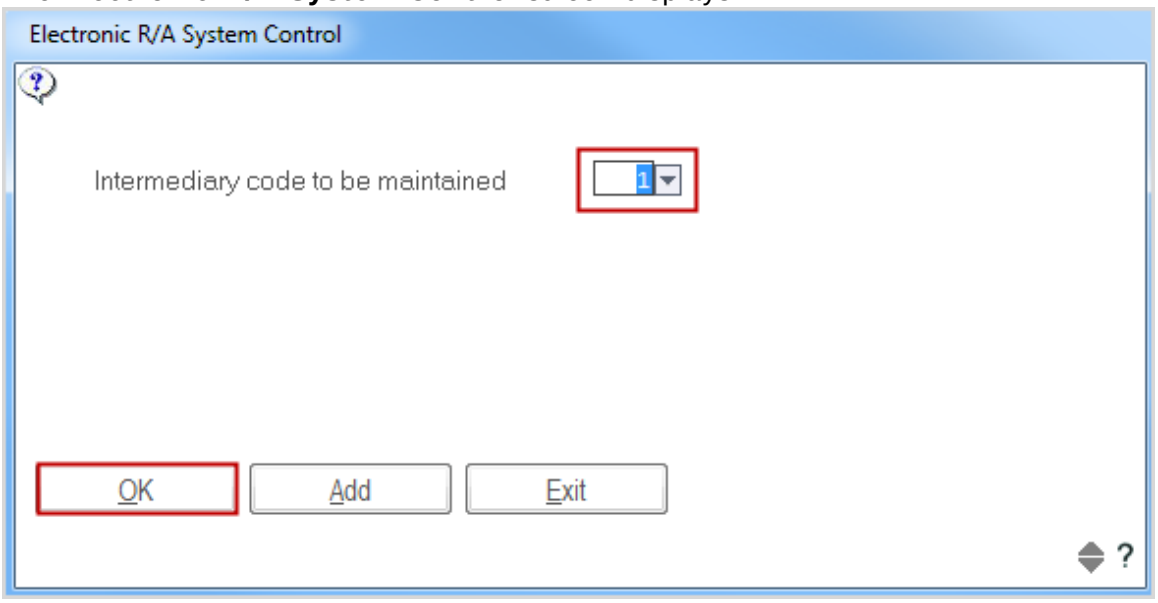
These controls provide an accurate account balance.

To set up contractual adjustments by claim status

1. From the **Electronic Remittance Advice Menu**, select **Maintain Electronic R/A System Control** (Option 4)

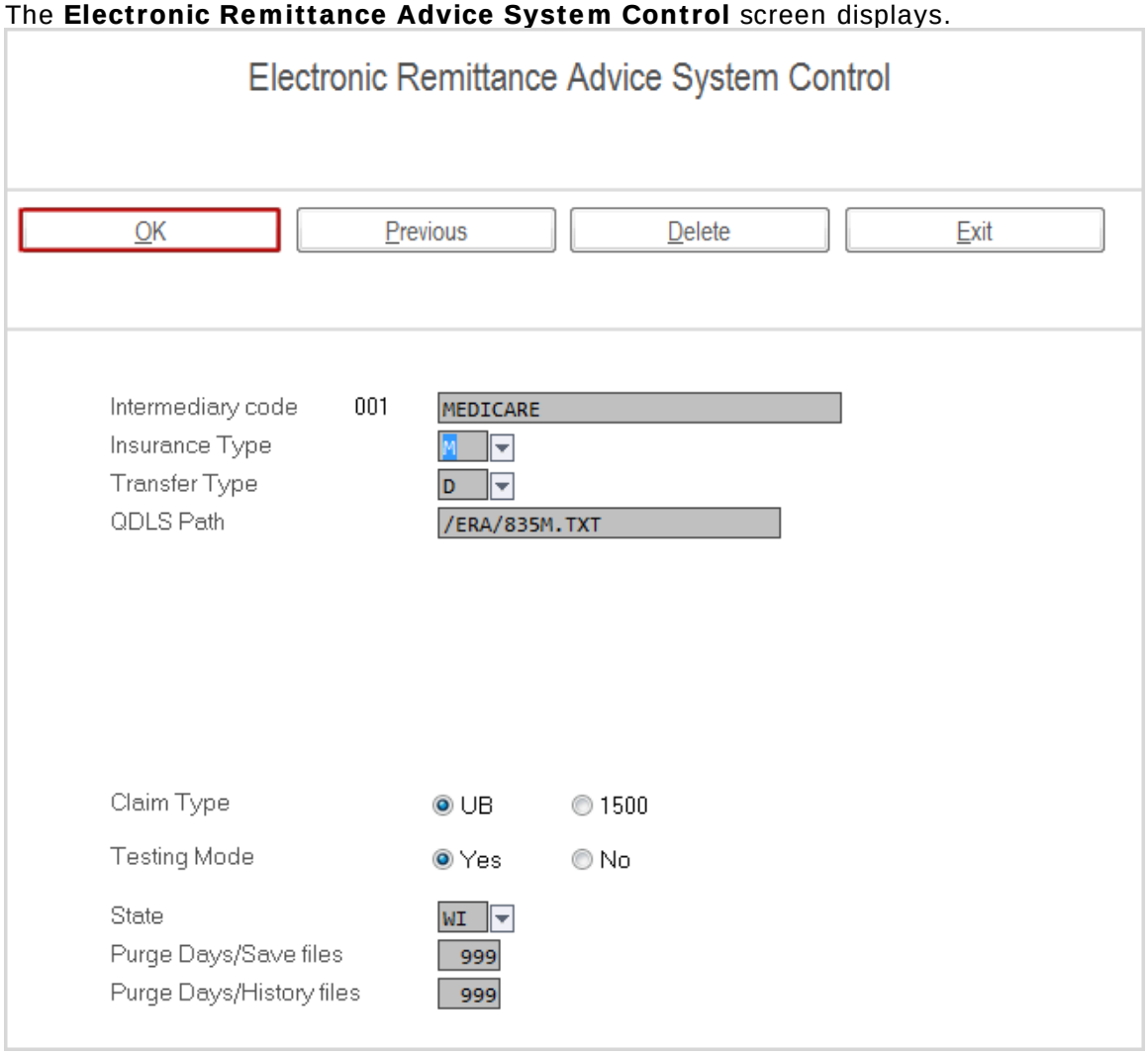


The **Electronic R/A System Control** screen displays.



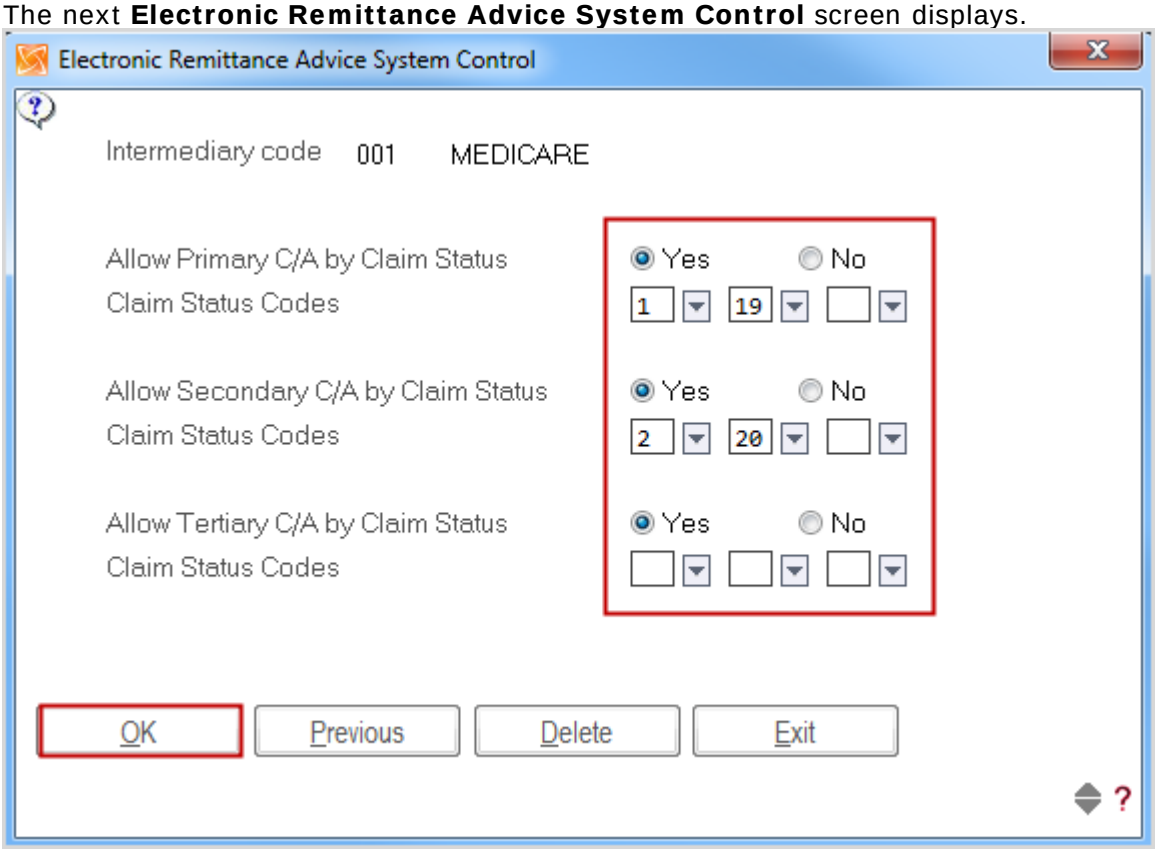
2. Enter an **Intermediary code** or select one using the drop-down
3. Click **OK**

The **Electronic Remittance Advice System Control** screen displays.



4. Click **OK**

The next **Electronic Remittance Advice System Control** screen displays.



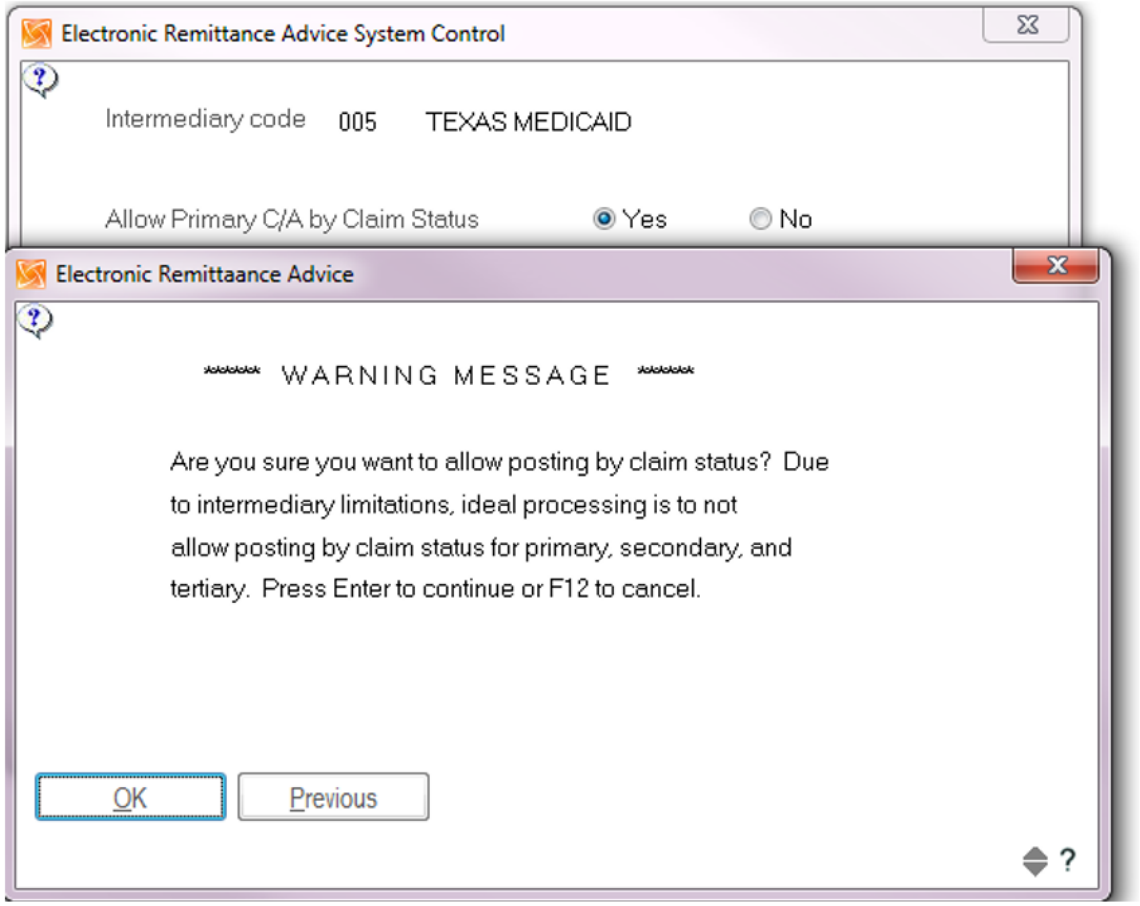
5. Select **Yes** to allow **Primary**, **Secondary**, or **Tertiary** contract adjustment by claim status

6. Select **Claim Status Codes**

NOTE:
If you select **Yes**, and leave the **Claim Status Codes** blank, no contract adjustments post. If you select **Yes**, and select specific **Claim Status Codes,** only contract adjustments for the corresponding codes post.

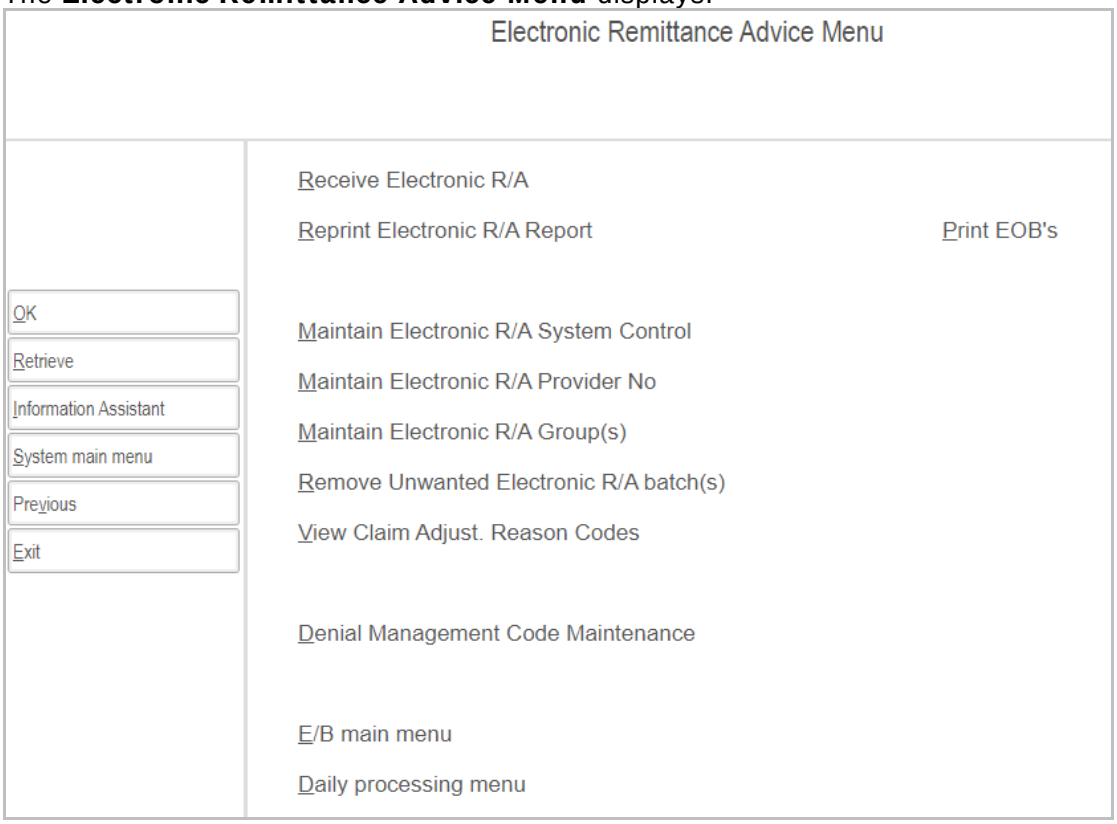
All flags default to **No** as a best practice when you use Texas Medicaid. Texas

Medicaid always displays a warning when you attempt to select **Yes**.

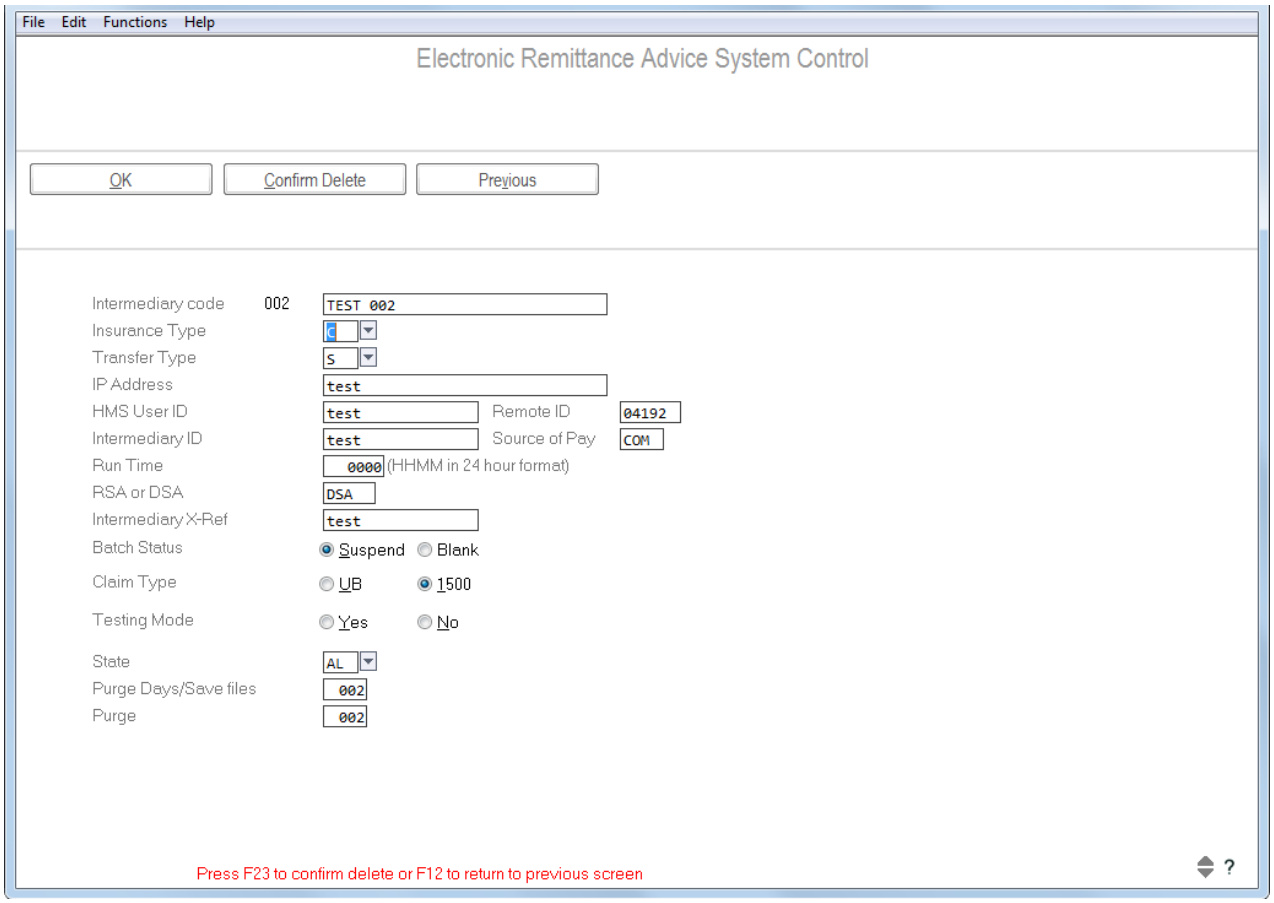


7. Click **OK** through the reminder of the screens

The **Electronic Remittance Advice Menu** displays.



Deleting a Record



This window appears when you click Delete on the **ERA System Control** window for a US intermediary. This button will delete this record from the ERA System Control File.

Note: The Delete button only appears when you are maintaining a record. It is not in the window for a new record.

Action

To delete the record: Click the Confirm Delete button or pre F23. The record will be removed from the ERA System Control File, and the **Electronic R/A System Control** window will open so that you can select the record for another intermediary.

To return to the previous window without deleting: Click the Previous button.

RMTADV Option 5: Maintain Electronic R/A Provider No.

Overview:

Maintain Electronic R/A Provider No. (Option 5 on the Electronic Remittance Advice Menu) is used to maintain the hospital provider information to be used in electronic remittance advice processing. The information maintained in this option will override the information in Patient Accounting.

Do not use this option unless instructed to do so by Customer Support.

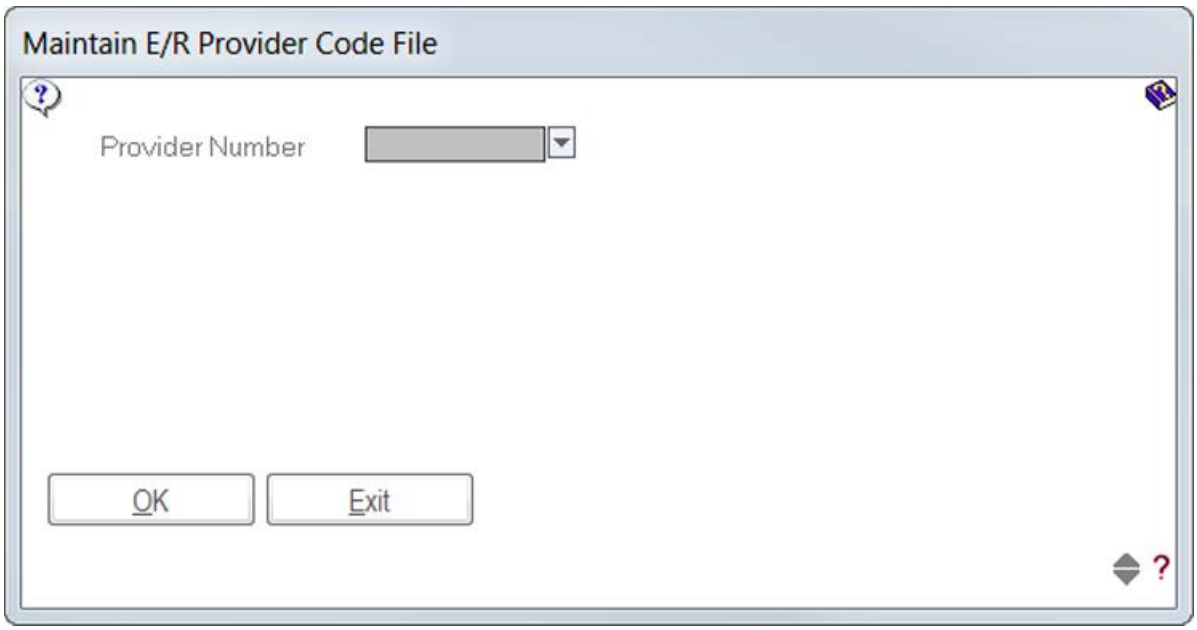
Files:

ERPRVNUM

In this section

Provider number window

This window appears when you select **Maintain Electronic R/A Provider No.** from the Electronic Remittance Advice Menu.

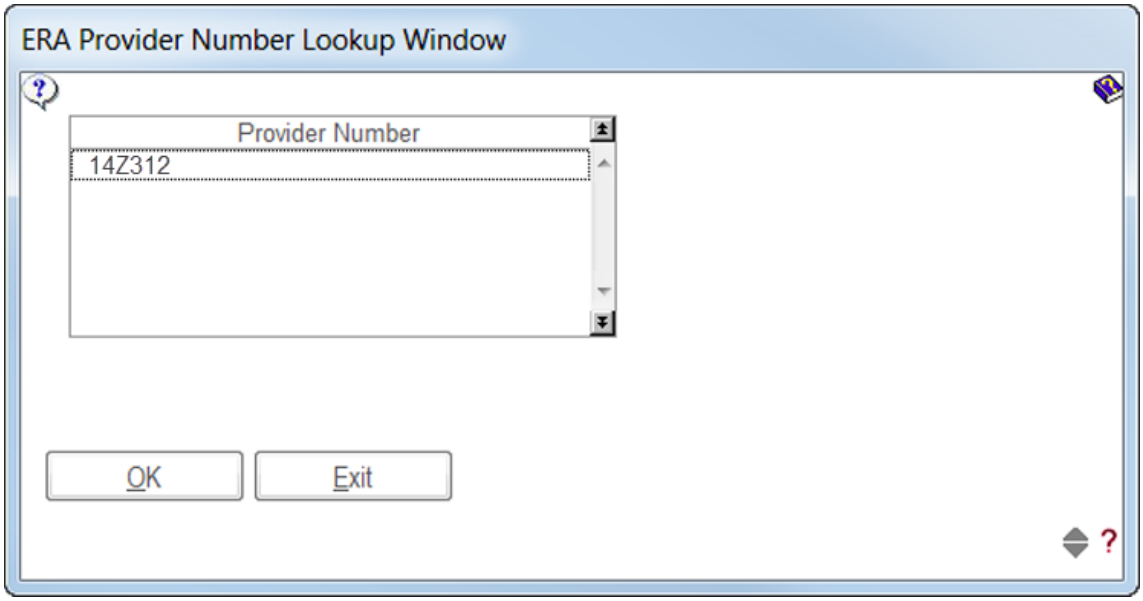


Action Enter the provider number you want to maintain, and then click **OK**.

To enter the number: Either type it or click to search for it and select it in the **ERA Provider Number Lookup** window.

ERA Provider Number Lookup Window

This window appears when you click in the provider number window.

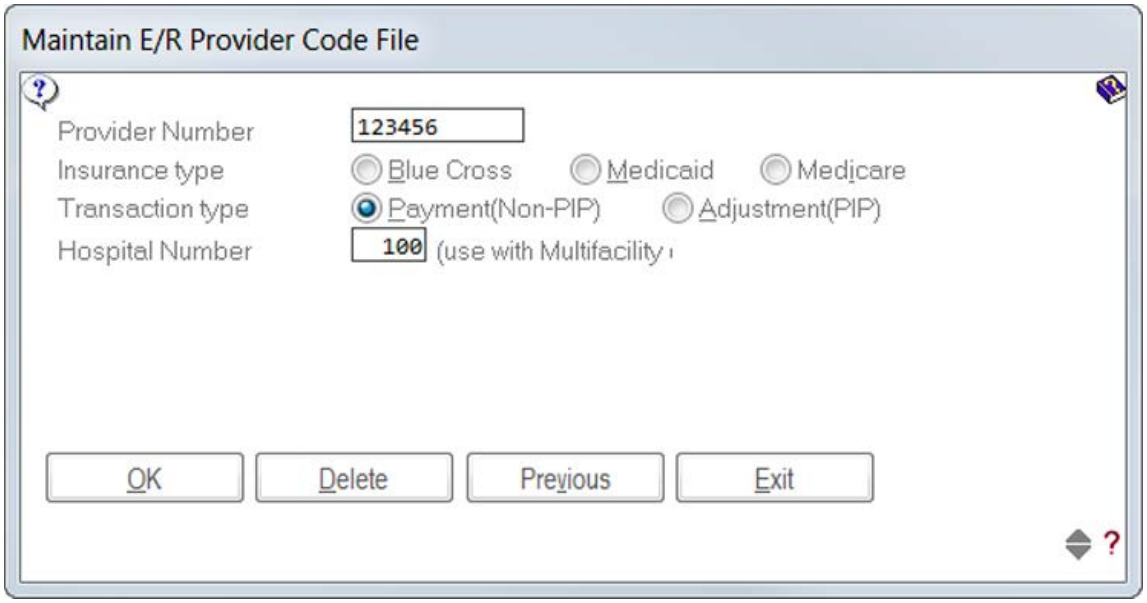


Action Select the provider number you want.

To select the number: Either (1) double-click on it or (2) click on it once to highlight it, and then click **OK**.

Provider number information window

This window appears when you click **OK** after entering a provider number in the provider number window.



The A/R Transaction Codes will be retrieved from the Payor Master, Option 6 on File Maintenance Menu I in Patient Accounting.

This information will override the information in Patient Accounting.

Action

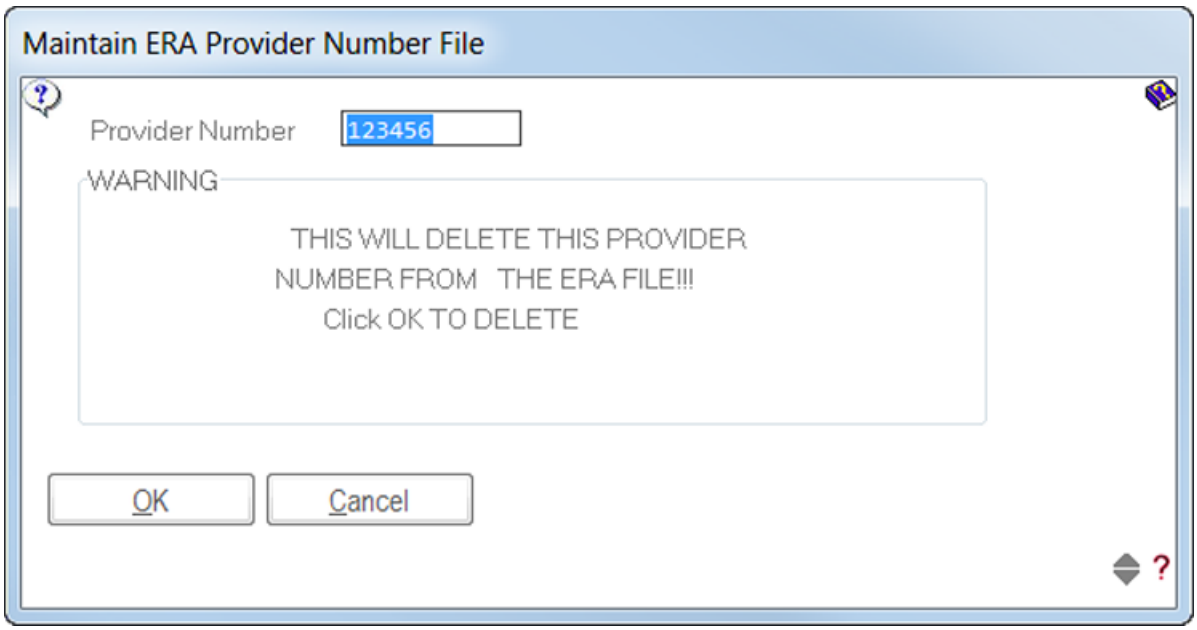
To enter or maintain information: Enter or select information, and then click **OK**. (Clicking **Exit** or **Previous** returns you to the Electronic Remittance Advice Menu or the provider number window without saving any information you entered or changed.)

To delete the provider record: Click **Delete**, then click **OK** in the confirmation window that appears (or click **Cancel** if you decide not to delete the record).

Field	Description
Provider Number	The provider number you entered earlier. You can change it if you wish.
Insurance Type	Select (click on) the type you want.
Transaction Type	Select (click on) the type you want.
Hospital Number	If your facility is part of a multi-facility environment, enter the facility number. Otherwise, leave the field blank.

Delete Confirmation Window

This window appears when you click **Delete** in the provider number information window.



Action

To delete the provider record: Click **OK**.

To cancel the deletion: Click **Cancel**.

RMTADV Option 6: Maintain Electronic R/A Group(s)

Electronic Remittance Advice Group Maintenance Overview

Business office users can now create and maintain ERA groups, assigning multiple intermediary codes to a group. Now when SSI sends an ERA file with a mix of accounts, such as regular Medicare and Medicare Advantage plans serviced by commercial payors, both Medicare and commercial intermediary codes can be attached to the group. This prevents the error caused when the insurance type of the intermediary does not match the insurance type of the plan. This prevents the business office from having to receive an ERA multiple times, using different intermediary codes each time.

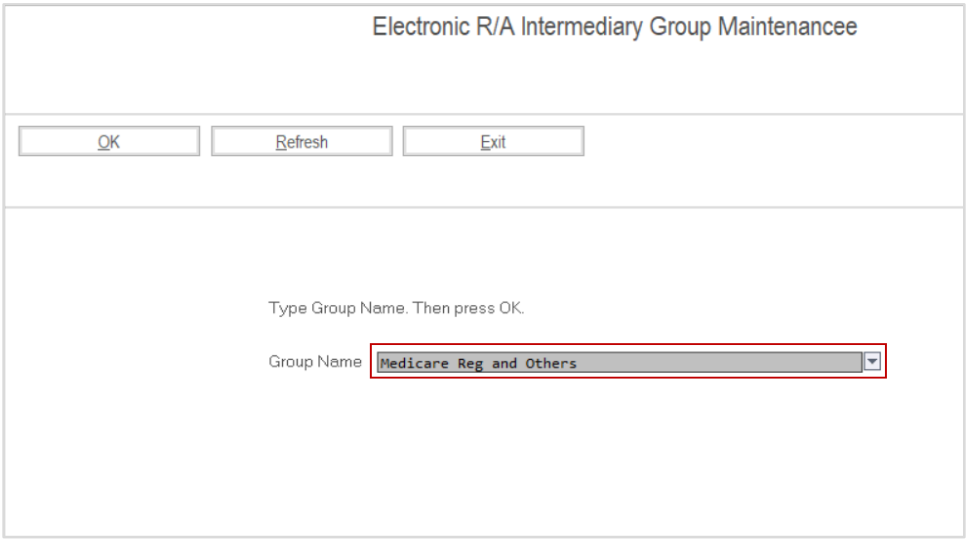
In this article, you will learn:

About Electronic Remittance Advice Groups

Electronic Remittance Advice groups allow users to receive ERA files using one intermediary code and have the file process for additional intermediary codes connected to it in a group. The receiving of the file is the same process, but the processing of the file applies to all the intermediary codes within a group. For example, a group is set up with both commercial and Medicare intermediary codes. A user receives the ERA using the commercial intermediary code. The file received has both commercial and Medicare claims. The file is processed, and the commercial claims are posted. Then the file is reprocessed, and the Medicare claims are posted.

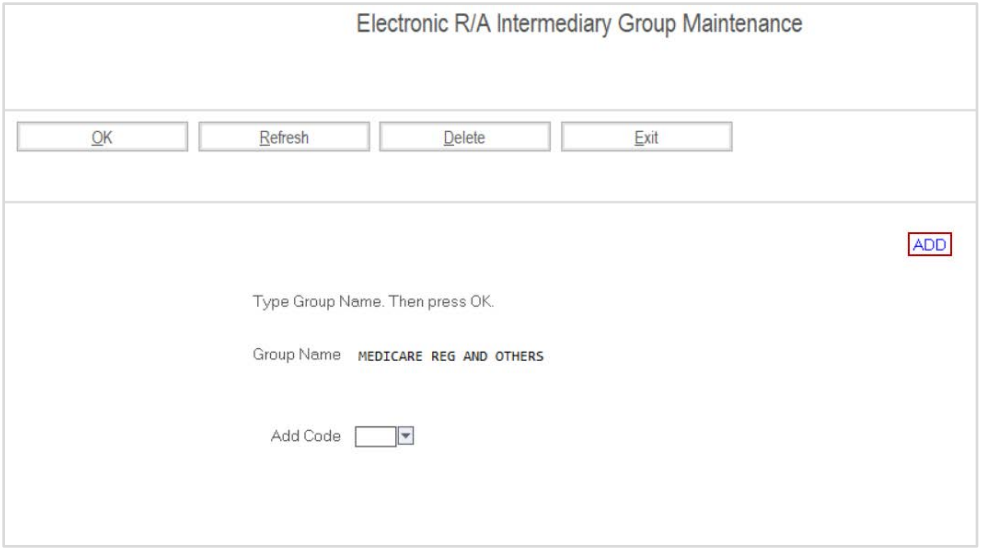
To add an electronic remittance advice group

1. Enter a new **Group Name**

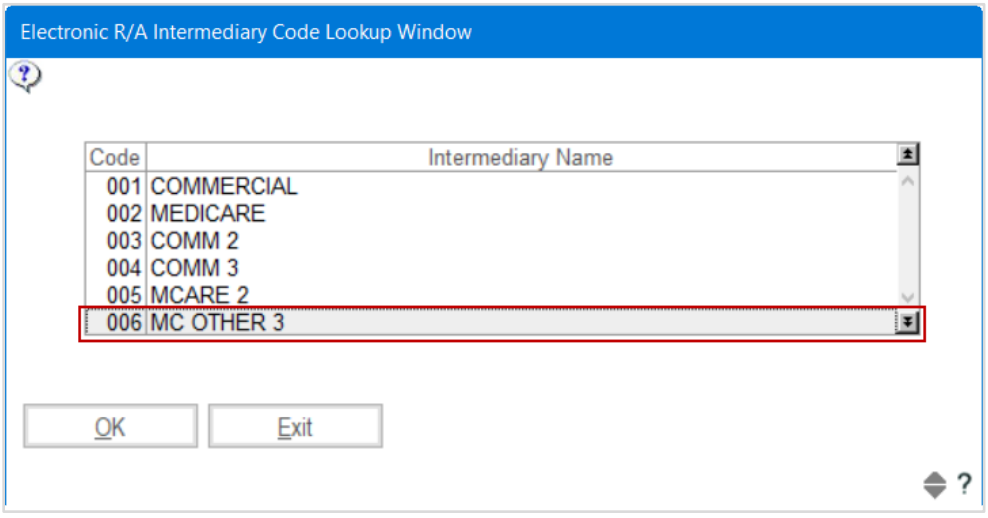


2. Click **OK** or press Enter

   The **Electronic R/A Intermediary Group Maintenance** window opens in **ADD** mode.

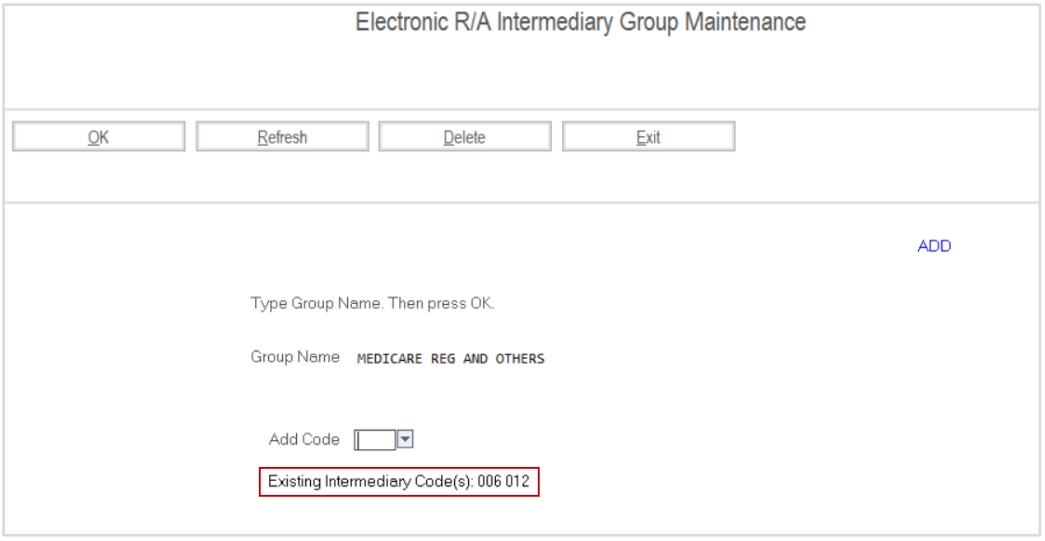


3. Enter the code or click the drop-down arrow to pull up the **Electronic R/A Intermediary Code Lookup Window**

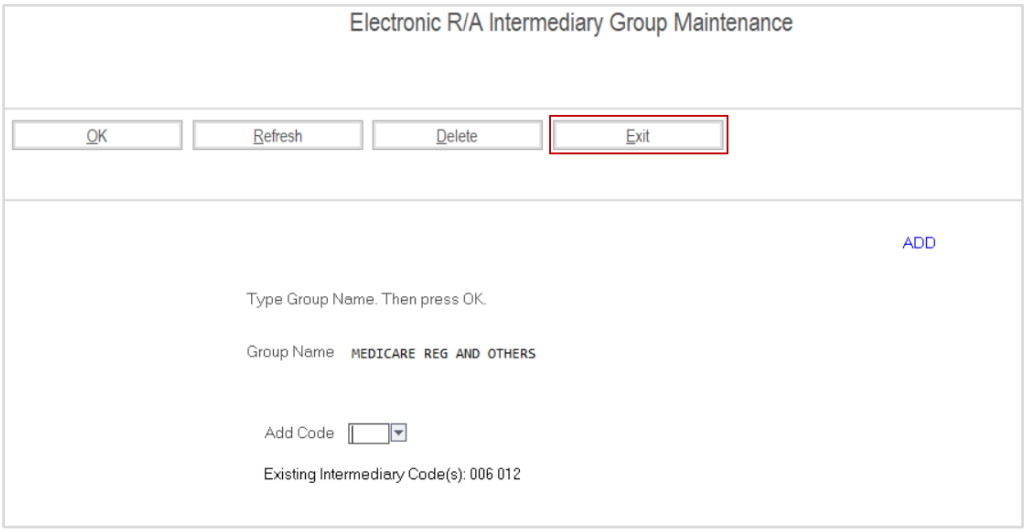


4. Click **OK** or press Enter

5. Continue adding intermediary codes until all appropriate intermediary codes are attached to the group

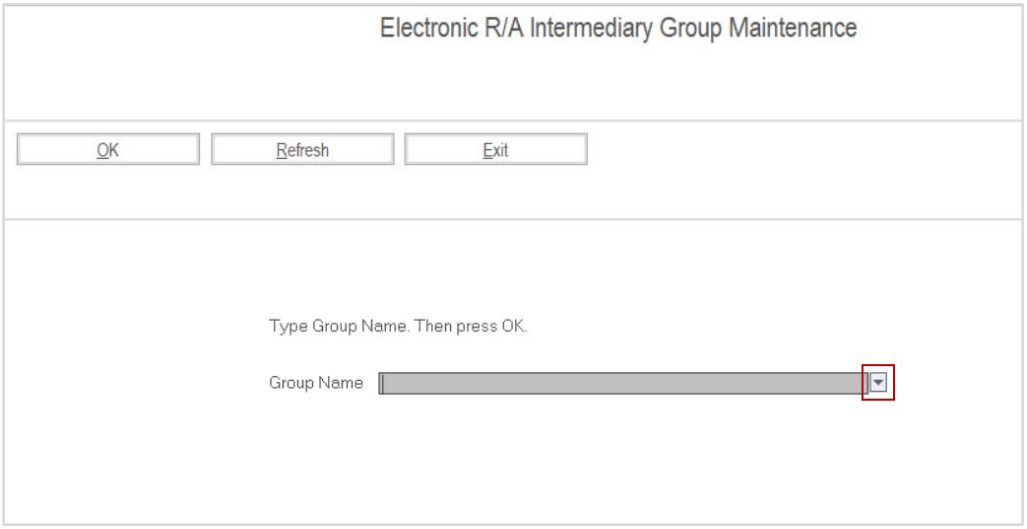


6. Click **Exit** when complete

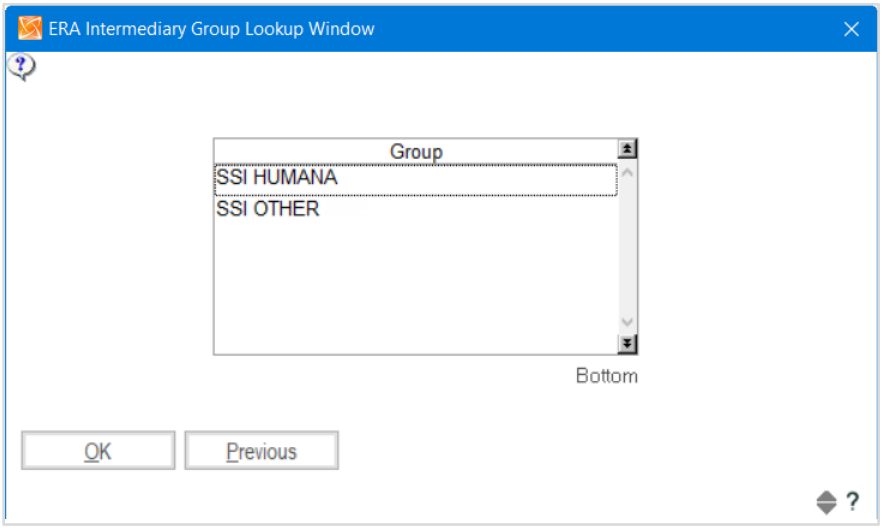


To remove an intermediary code from an electronic remittance advice group

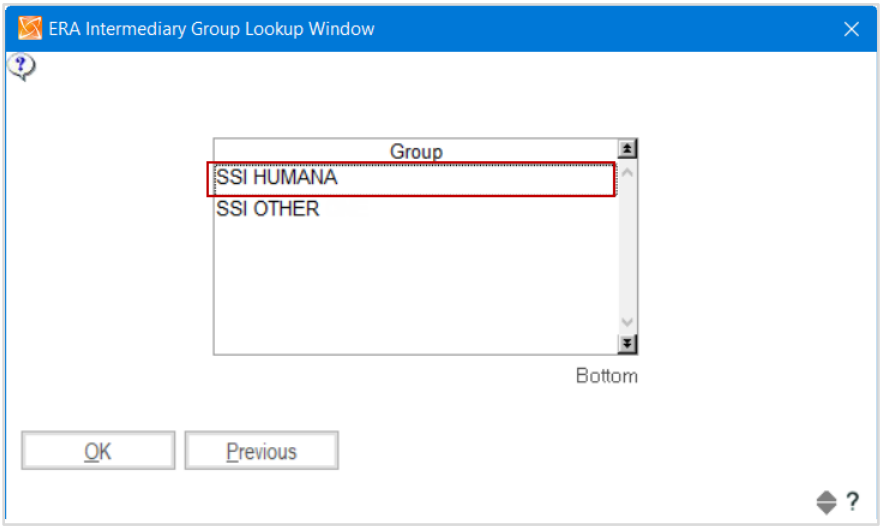
1. Use the drop-down to pull up the **ERA Intermediary Group Lookup Window**



The **ERA Intermediary Group Lookup Window** displays.

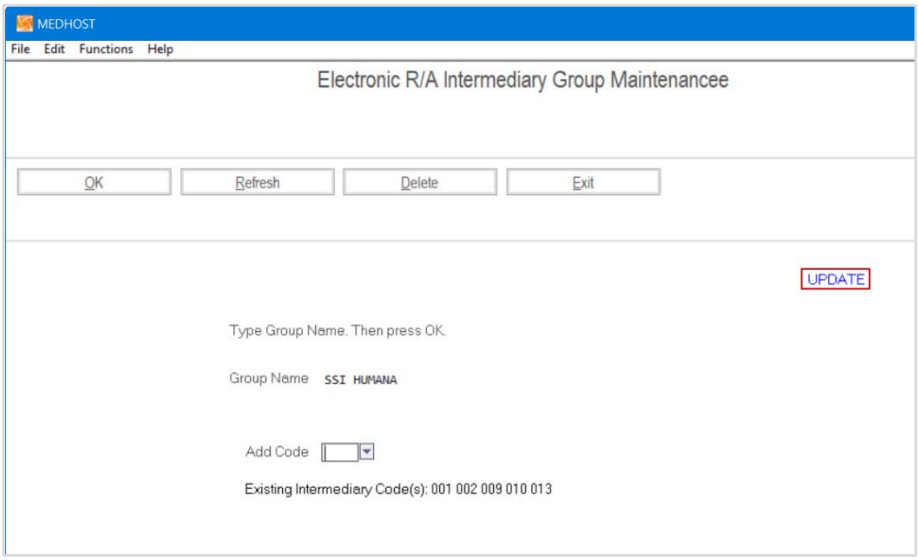


2. Select a group

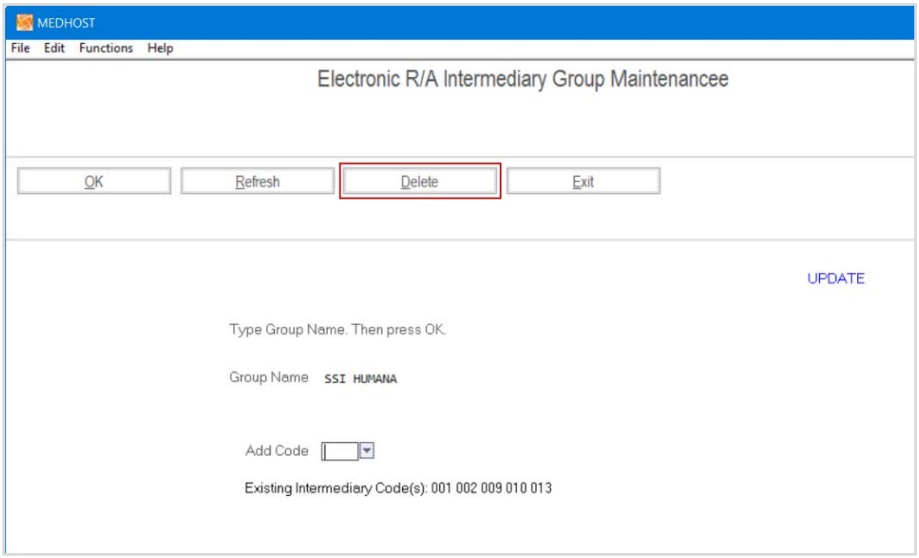


3. Click **OK** or press Enter

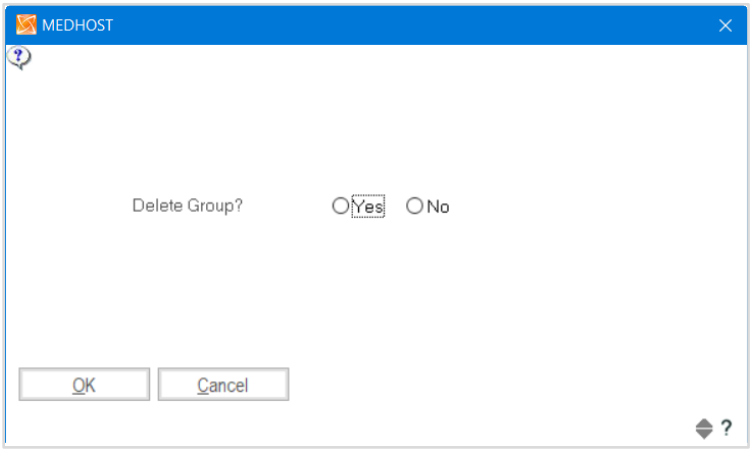
4. The display opens in **UPDATE** status



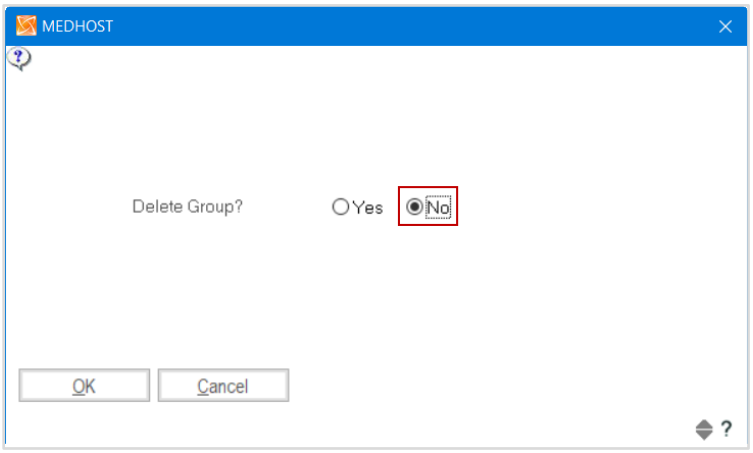
5. Click **Delete**



A window asking if you want to delete the group appears.

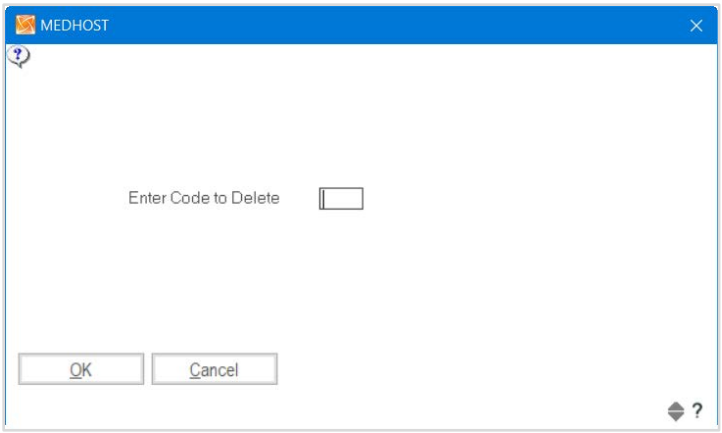


6. Select **No**

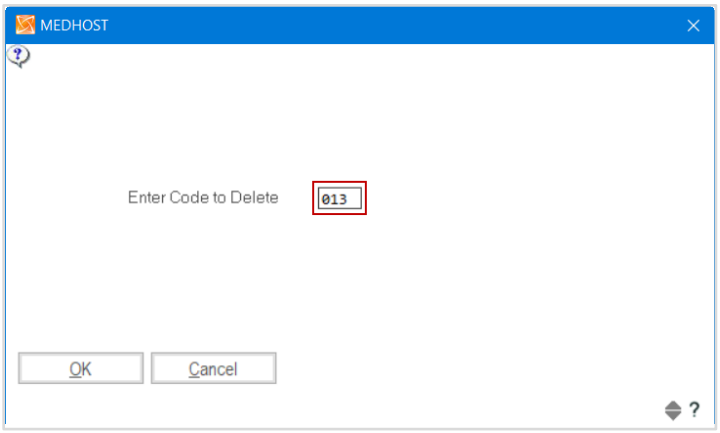


7. Click **OK**

A window displays for the deletion of intermediary codes.

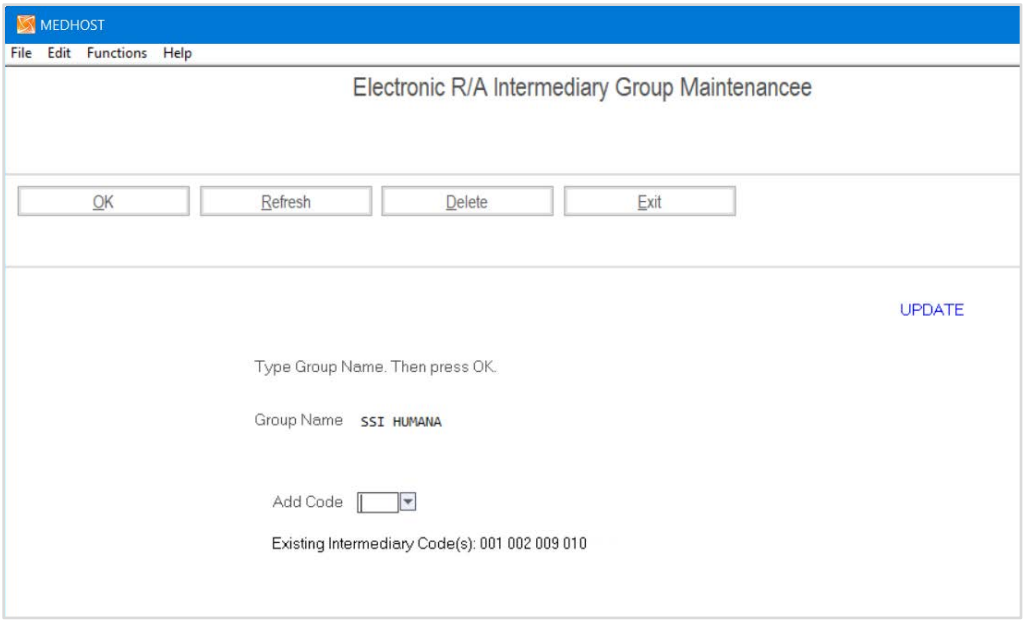


8. Enter code to delete



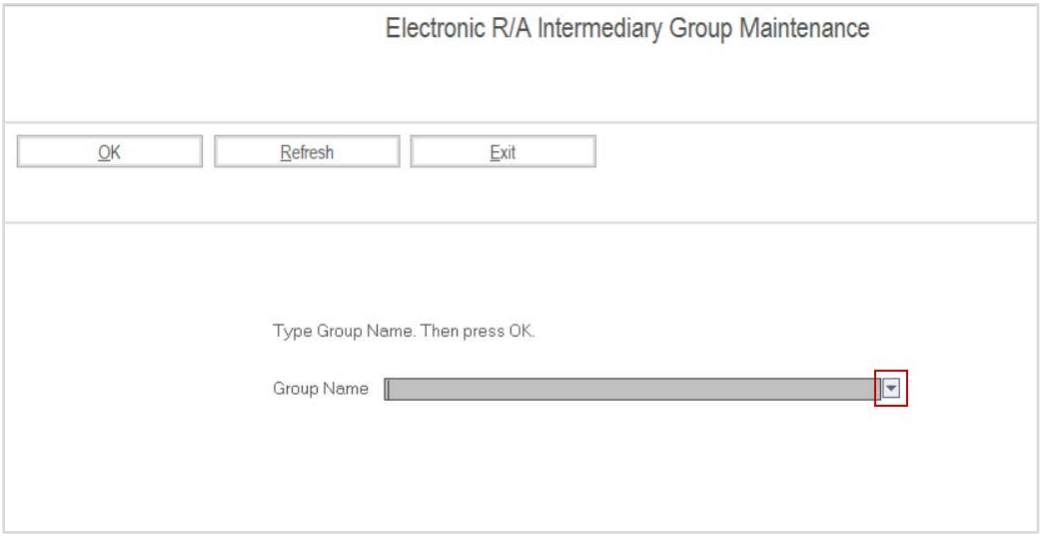
9. Click **OK** or press Enter

The code is no longer associated with the group.

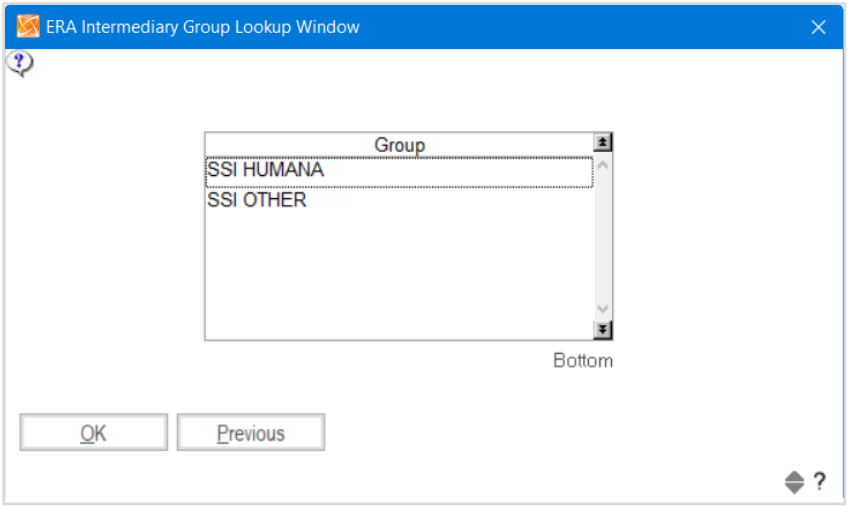


To delete an electronic remittance advice group

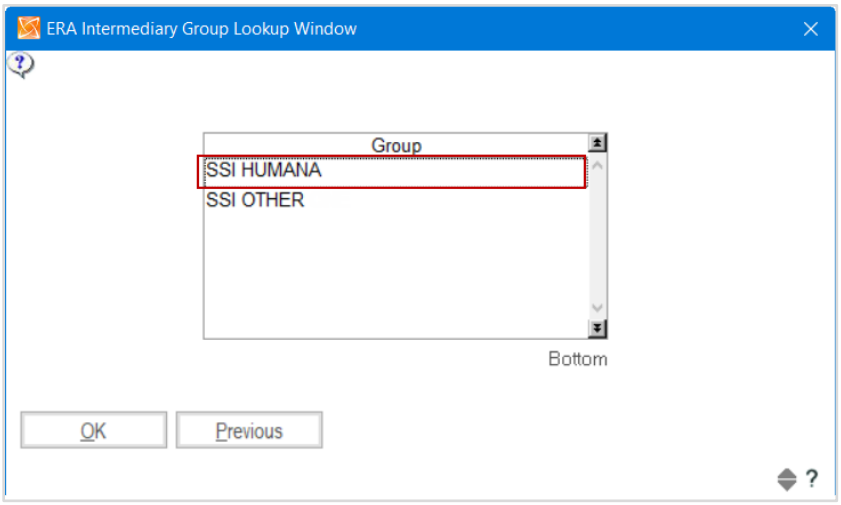
1. Use the drop-down to pull up the **ERA Intermediary Group Lookup Window**



The **ERA Intermediary Group Lookup Window** displays.

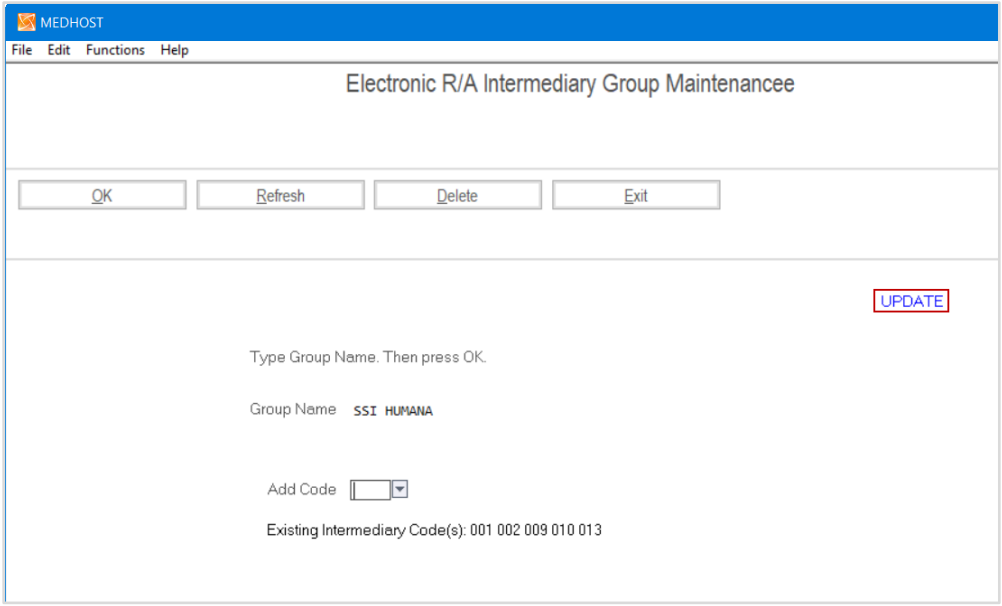


2. Select a group

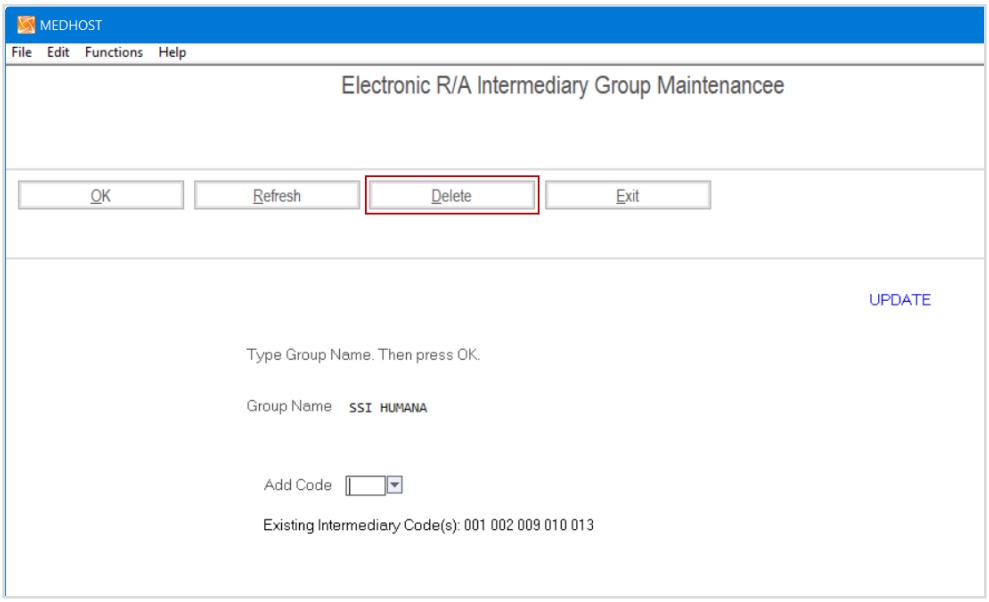


3. Click **OK** or press Enter

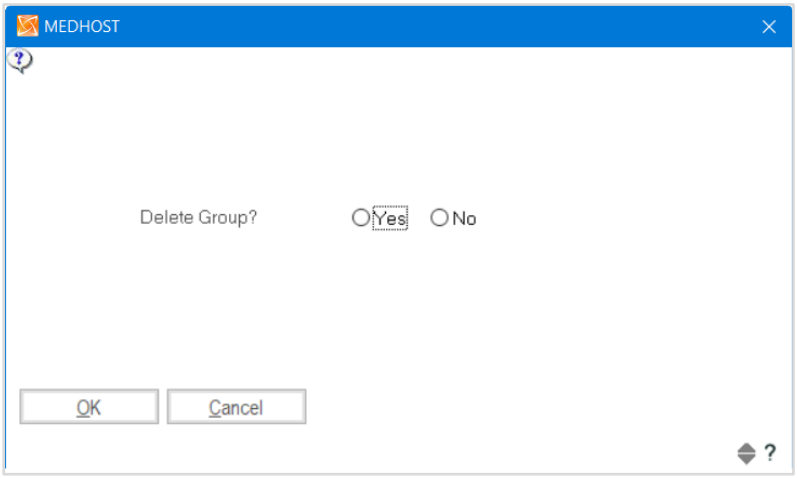
4. The display opens in **UPDATE** status



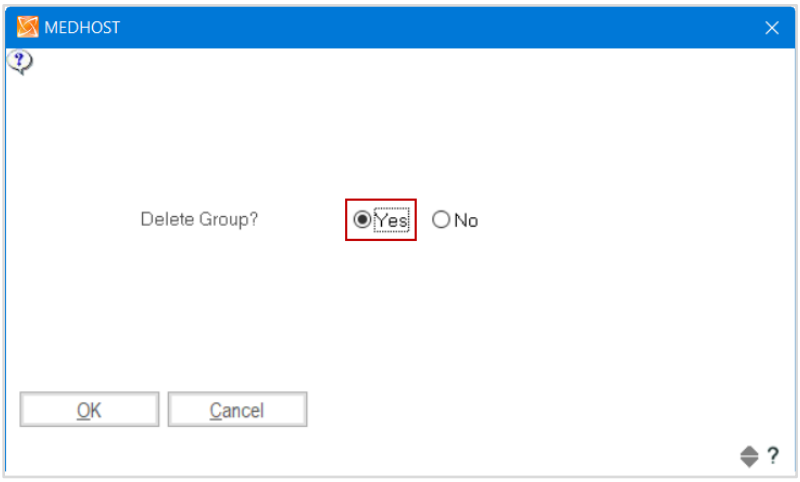
5. Click **Delete**



A window asking if you want to delete the group appears.

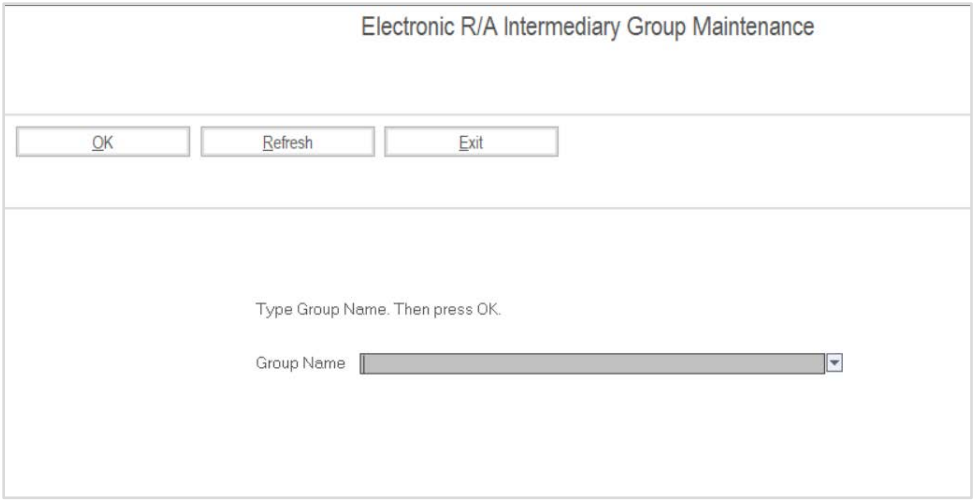


6. Select **Yes**



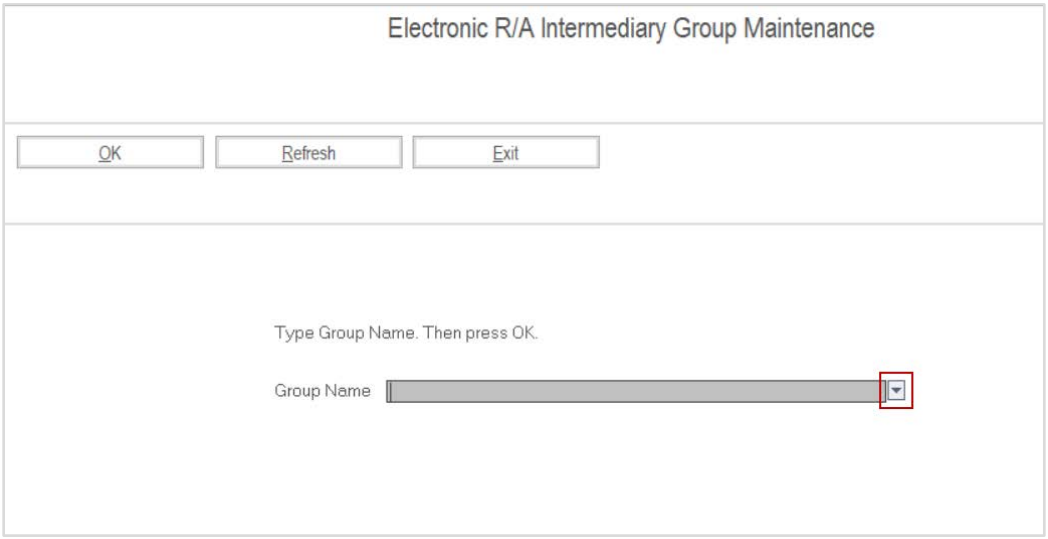
7. Click **OK** or hit Enter

The group has been deleted and the **Electronic R/A Intermediary Group Maintenance** selection screen displays.

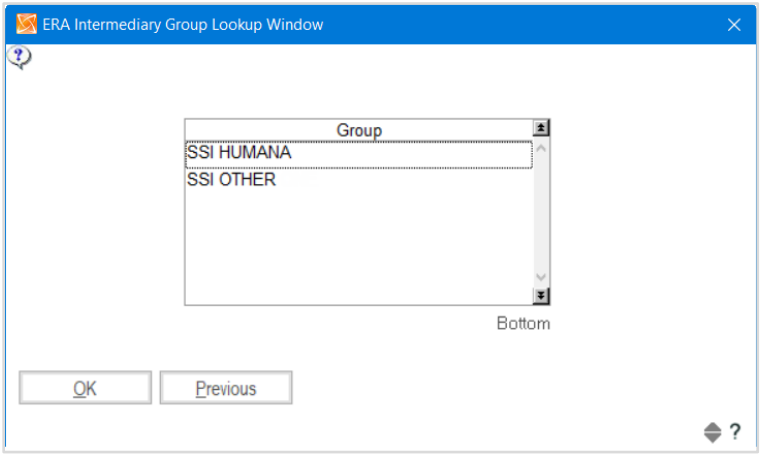


To add an intermediary code to an electronic remittance advice group

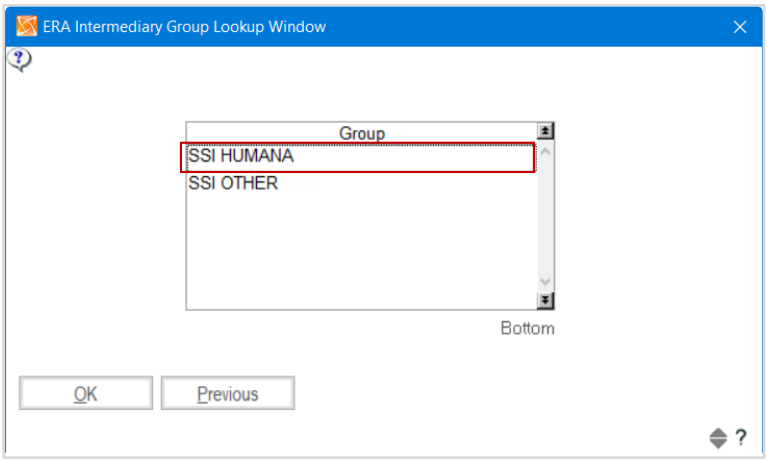
1. Use the drop-down to pull up the **ERA Intermediary Group Lookup Window**



The **ERA Intermediary Group Lookup Window** displays.

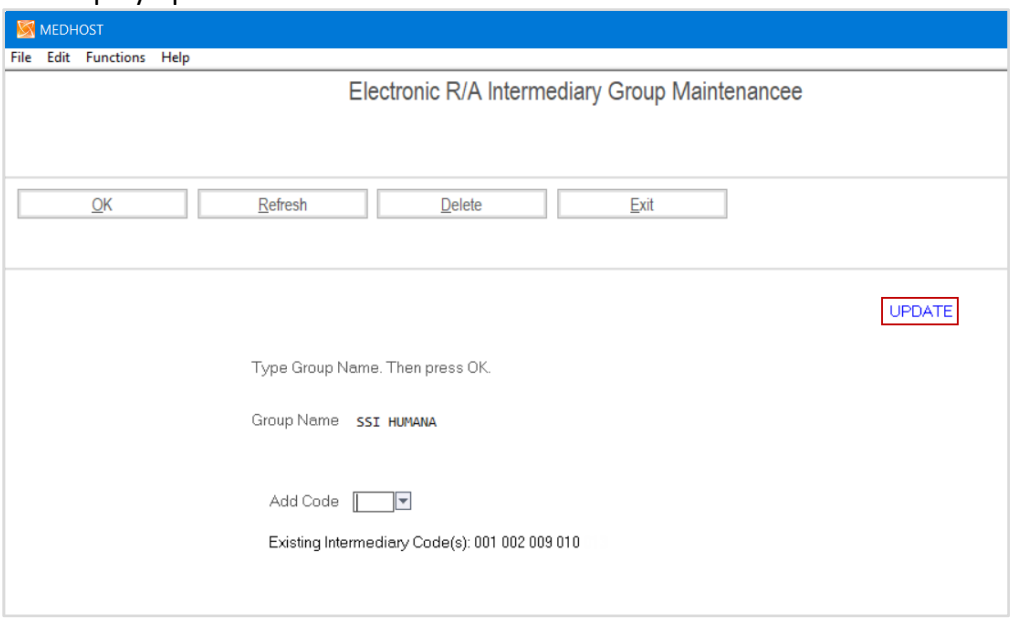


2. Select a group

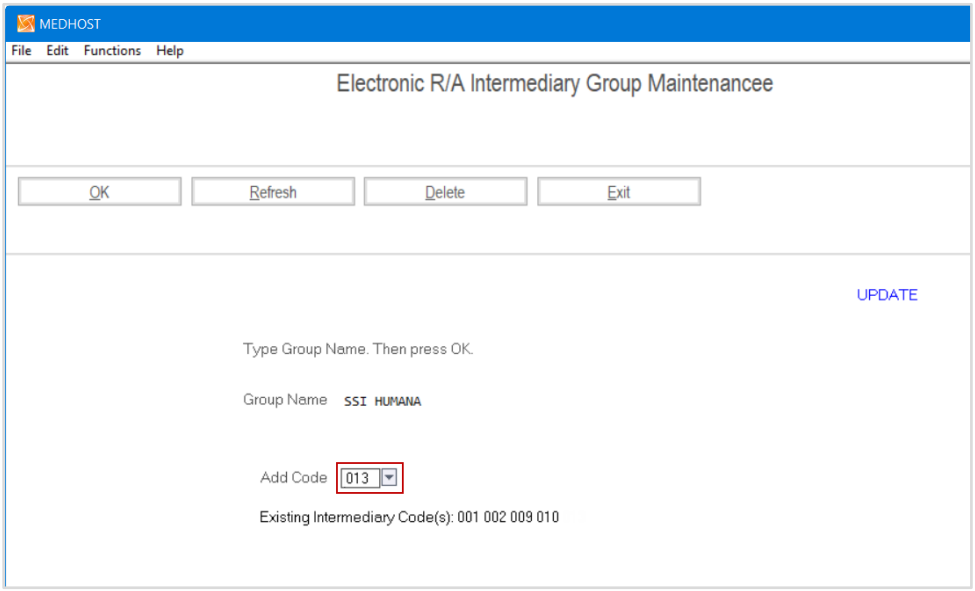


3. Click **OK** or press Enter

The display opens in **UPDATE** status.

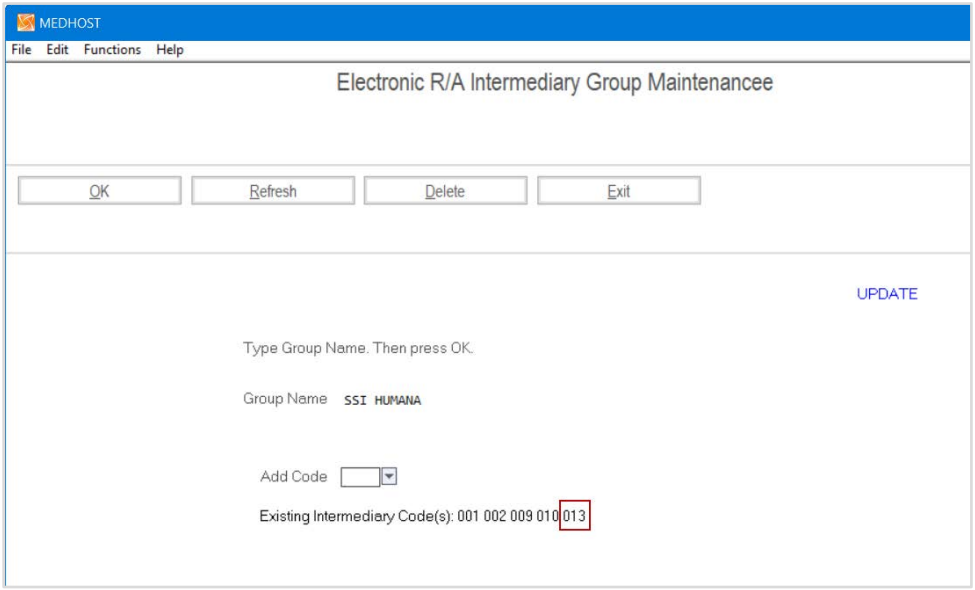


4. Enter the code or click the drop-down arrow to pull up the **Electronic R/A Intermediary Code Lookup Window**



5. Click **OK** or hit Enter

   The code now appears with the **Existing Intermediary Code(s)**.



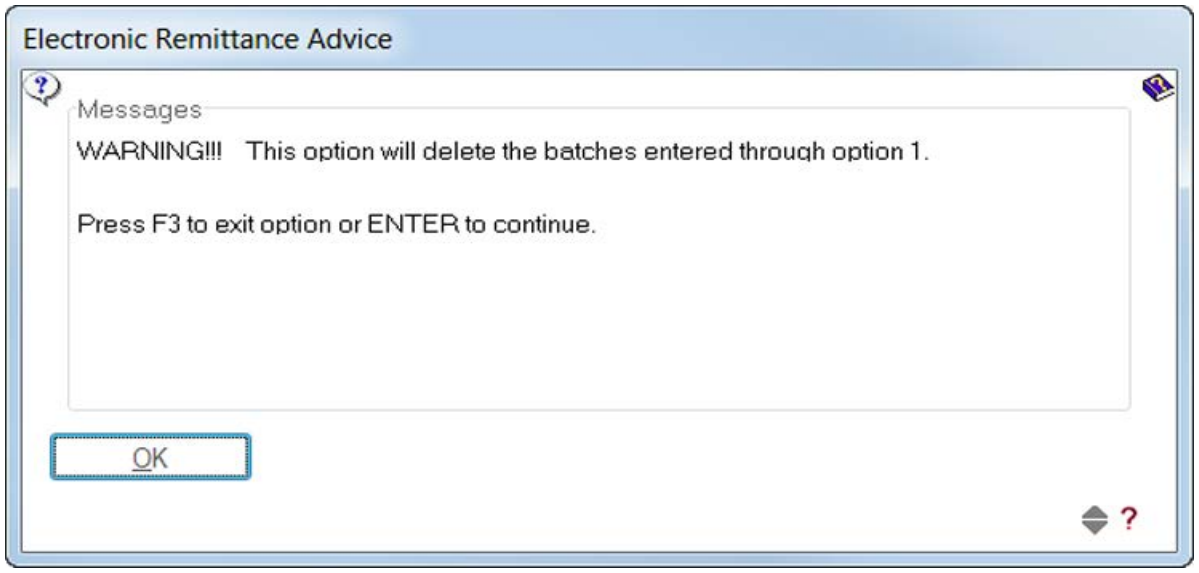
RMTADV Option 7: Remove Unwanted Electronic R/A Batch(s)

Overview:

Remove Unwanted Electronic R/A Batch(s) (Option 7 on the Electronic Remittance Advice Menu) is used to delete the most recent RA batch received in Option 1, Receive Electronic R/A. It deletes the RA batch out of Daily Processing Menu and Enter Remittance Advice option but does not delete the RA data from ERA history.

This option can only be run if the Electronic Remittance Advice system is running in the test and live mode which is set up in Maintain Electronic R/A System Control, Option 4.

This window appears when you select **Remove Unwanted Electronic R/A Batch(s)** in the Electronic Remittance Advice Menu.



Action

To delete the batches: Click **OK**.

To cancel the deletion: Press **F3**.

RMTADV Option 8: View Claim Adjust. Reason Codes

Overview:

View Claim Adjust. Reason Codes (*Option 8* on the *Electronic Remittance Advice Menu*) is used to view and maintain the claim-adjustment reason codes received by the intermediary. These codes could appear on the *Electronic Remittance Advice Listing* or *Remittance Advice Error Report Listing*. Both reports are automatically generated by *Option 1*, *Receive Electronic R/A*.

MEDHOST provides the client with a "starter" list of codes and updates them via our regulatory releases when CMS has a related update. The client is apprised of these updates via the quarterly release information. CMS defines the reason code and reason group so those are the fields that MEDHOST populates/updates. The client needs to add/update the reason type for each reason code that applies to their facility. The type determines into which field in the log the money will go - deductible, copay, denial, contractual, etc. If an account on an ERA is assigned a reason code and the client has not assigned that code a reason type, any money associated with the reason code will not affect the account balance and the transaction will not be reported on the ERA Listing.

Codes can sorted, added, and changed but use caution when doing so in this option.

The codes are the claim-adjustment reason codes that could identify an error. These codes will indicate why a service was not covered or why a service was denied. The complete list of current codes is available at the Washington Publishing Company website:

http://www.wpc-edi.com/codes

The codes in this option will be checked automatically when the remittance advice file is received. If the condition is found in the file, the code will print on the reports.

The electronic remittance advice programs will read these claim-adjustment reason codes to determine how to identify a particular amount as a deductible, co-insurance, denial, contractual adjustment, and so on.

Note: Denial Management software purchase and installation is required prior to use in order to use/see certain functions/screens.

Without Software installation the following will not display:		**Pages**
Fields	Payor, Denial Category and Denial Type	8.4, 8.7, 8.15, 8.16
Screens	Payor Master Lookup	8.10
	DM Category Maintenance	8.13
	DM Type Code Maintenance	8.14

File: ERAXREF

CONTENTS

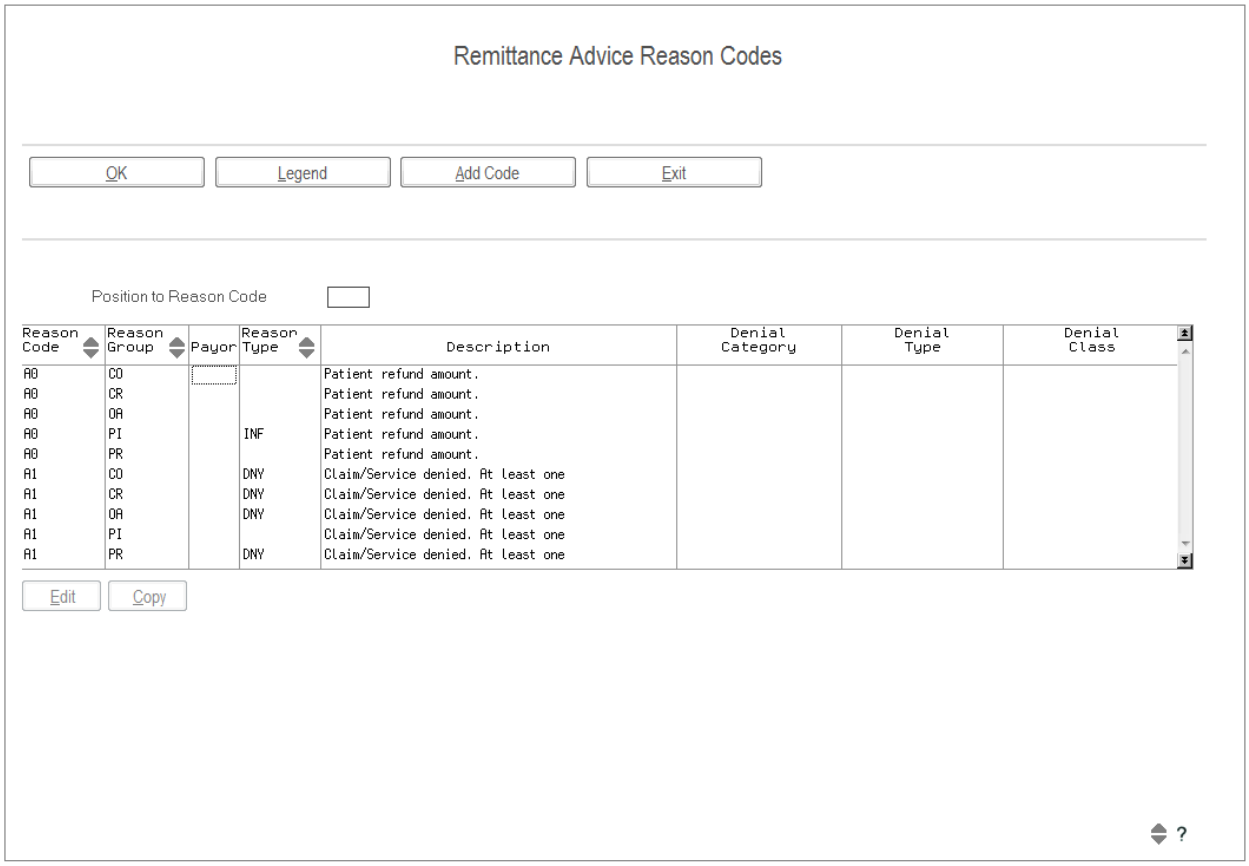
ACCESSING REMITTANCE ADVICE REASON CODES

The Remittance Advice Reason Codes window appears when you select the *View Claim Adjust. Reason Codes* link from the *Electronic Remittance Advice Menu*. The **Remittance Advice Reason Codes** window lists all claim-adjustment reason codes that have been set up, in alphanumeric order by code.

You will use the window to add or maintain codes and their Groups, Types, and Descriptions.

You can use the sort buttons (and) at the top of the Code, Type, and Group columns to order the list, in either ascending or descending order. In ascending order any blanks will be at the top, so you can easily identify the codes that do not have Types or Groups set up.

The definitions of fields and buttons are on the next page.



Note: MEDHOST updates the Claim Adjustment Reason Codes on a quarterly basis. The updates include new codes and their descriptions as well as any existing codes and descriptions that have changed. The Claim Adjustment Reason Codes also require Type and Group codes if they are to be included on reports. The section, “Working with Reason Codes,” describes how to add Type and Group codes.

Action

To:	Do this:
Sort the list	Click to sort the list in ascending or descending order.
Find a code	Type part or all of the code in the **Position to Reason Code** field and click OK. The code you typed will appear at the top of the list.
Add a code	Click Add Code.
Edit a code	Highlight the code you want by selecting (clicking on) it, then click Edit.

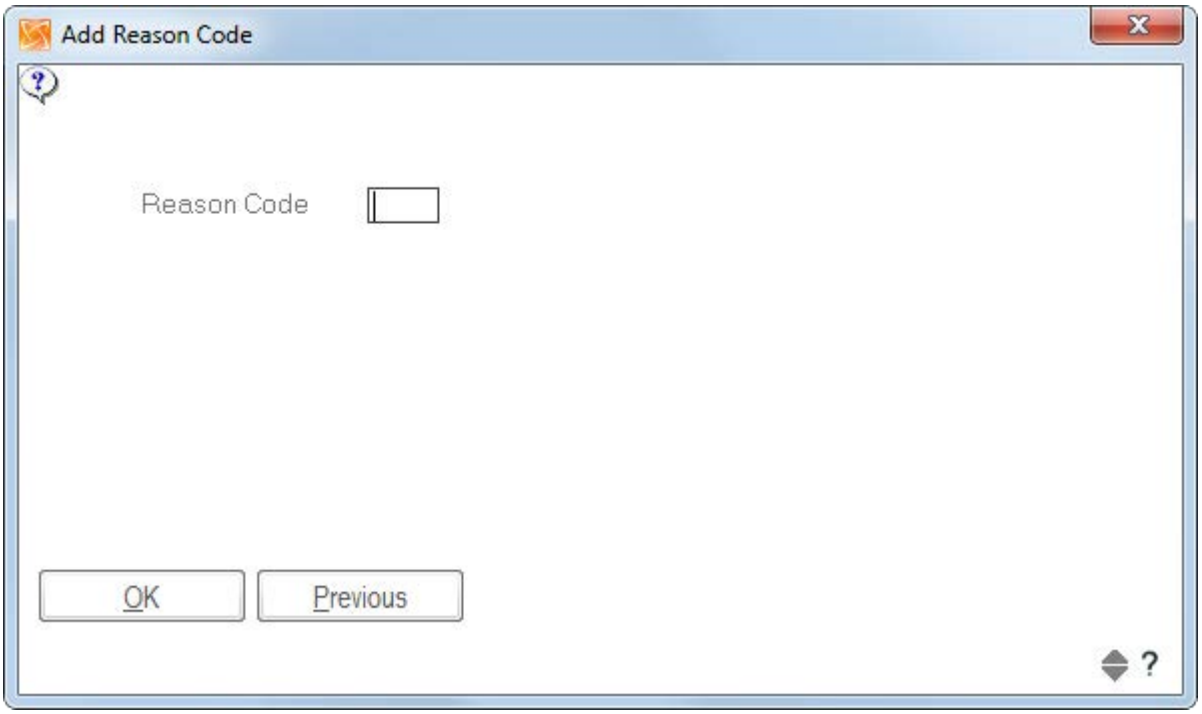
Buttons and Function Keys

Button	Function Key	Description
OK	Enter	Position the list of codes to what you entered in the Position to Reason Code field.
Add Code	F6	Add a code to the list.
Exit	F3	Return to the *Electronic Remittance Advice Menu*.

Button	Option	Description
Edit Type/Group/ Description	2	Change the Reason Group, Reason Type, and/or Description of the selected code.

ADDING A REASON CODE

The Add Reason Code window appears when the **Add Code** in the **Remittance Advice Reason Codes** window is clicked.



Action

Type a new Reason Code selected from the national standard Claim-Adjustment Reason Code list then, click **OK**. The **Reason Code Description** window will open.

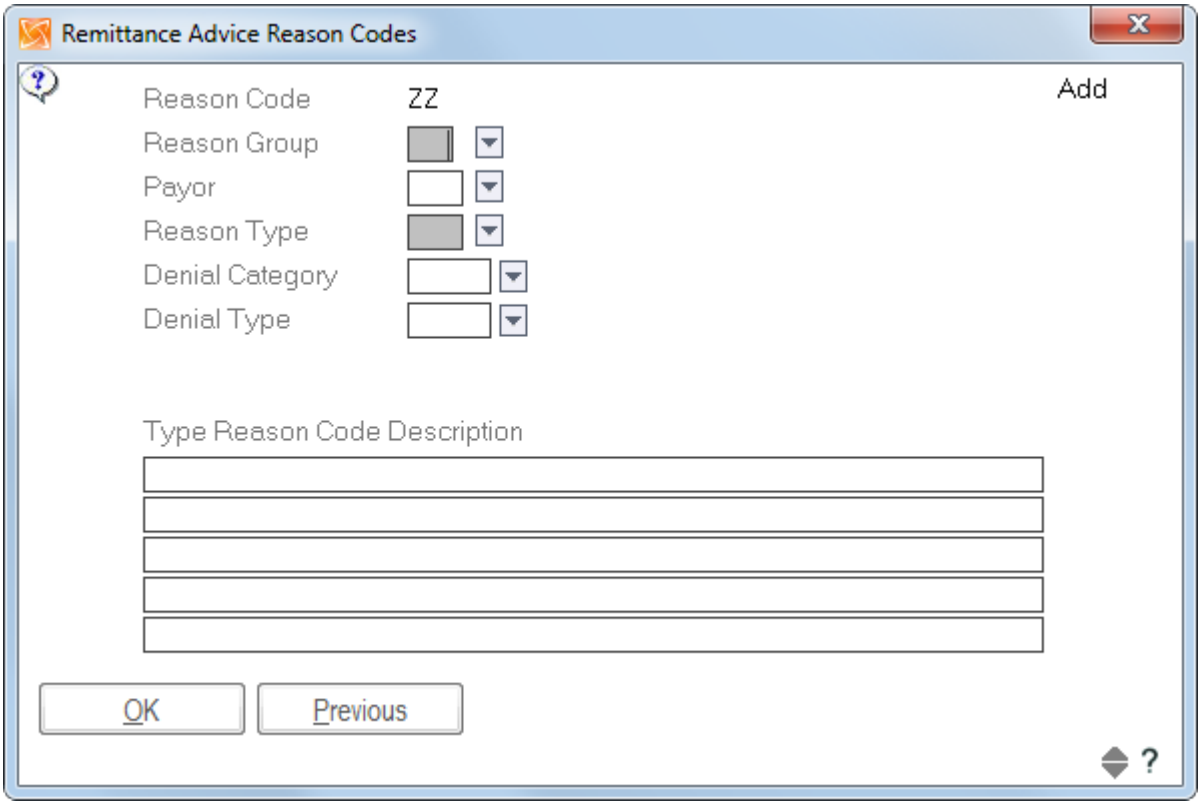
You can use the link below to access the current code lists** from the **Reference** page at the Washington Publishing Company's website. Code lists include the claim-adjustment reason codes, at the link below.

http://www.wpc-edi.com/reference/

** These lists are maintained by the Centers for Medicare and Medicaid Services (CMS), The National Uniform Claim Committee (NUCC), and committees that meet during trimester X12 meetings.

WORKING WITH REASON CODES - ADD

The Reason Code Description window appears after you type a new code in the **Add Reason Code** window and click **OK** .



Action

Fields in gray and description are required.

Type or search for ( ) the Reason Group, Reason Type, and/or Description, and then click **OK** to save your entries and return to a previous window. If you are adding a new code, enter all three codes.

Click Previous to return to a previous window without saving any entries.

See the table on the next page for descriptions of the fields.

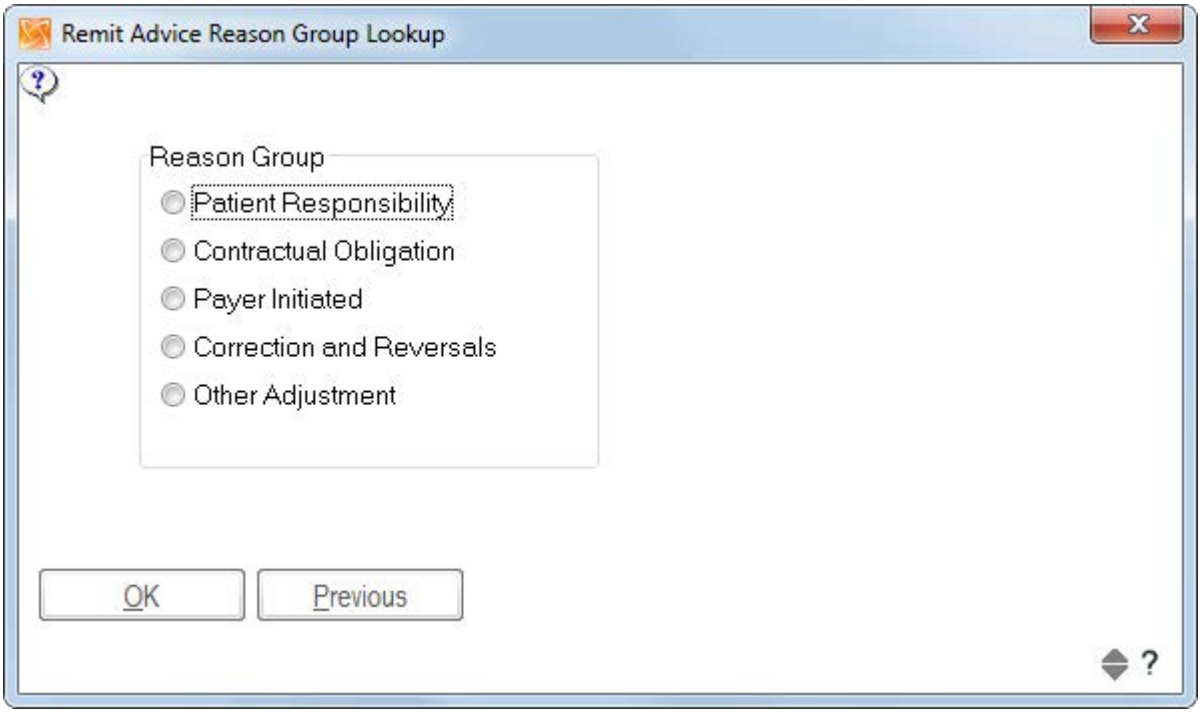
Field Descriptions

Field	Description
Reason Code	**Display only.** Reason codes are the national standard claim-adjustment reason codes. The complete list of the current codes is available at the Washington Publishing Company's website: http://www.wpc-edi.com/codes
Reason Group	Enter or change the Reason Group. You can either type the group code, or click next to the field and then select the group you want in the **Remittance Advice Reason Group** window that appears. These are the 835-specified Reason Groups. The valid reason groups are: PR = Patient Responsibility CO = Contractual Obligation PI = Payer Initiated CR = Correction and Reversals OA = Other Adjustment Items given the CO (Contractual Obligation) Reason Group code are no longer automatically placed in the Contract Adj column of the *Electronic Remittance Advice* report. For this reason, you must maintain your ERA Reason Codes, especially those that are set up for CO Reason Type 23 or any adjustments that would not be posted as a contractual.
Reason Type	Enter or change Reason Type. You can either type the code, or click next to the field and then select the group you want in the **Remittance Advice Reason Type Lookup** window that appears. The Reason Types determine where a remittance advice amount will print on the *Electronic Remittance Advice Listing*. For valid Reason Types and the columns in which the amount will be printed, see the section, "Reason Types." There is now an MSP Reason Type code for MSP Primary Payer Amount. It places the amount in the MSP Primary Pay Amount field on the *Electronic Remittance Advice* report.
Description	Enter or change the reason code's Description. If you are changing it, you can provide more details or add information.

Reason Groups

This window appears when the next to the Reason Group field in the **Reason Code Description** window is clicked.

You now control where the money for the CO (Contractual Obligation) Reason Group code appears, because it is no longer automatically placed in the Contract Adj column of the *Electronic Remittance Advice* report. Instead, it will be placed in the column indicated by the Reason Type. For this reason, you must maintain your ERA Reason Codes, especially those that are set up for CO Reason Type 23 or any adjustments that would not be posted as a contractual.



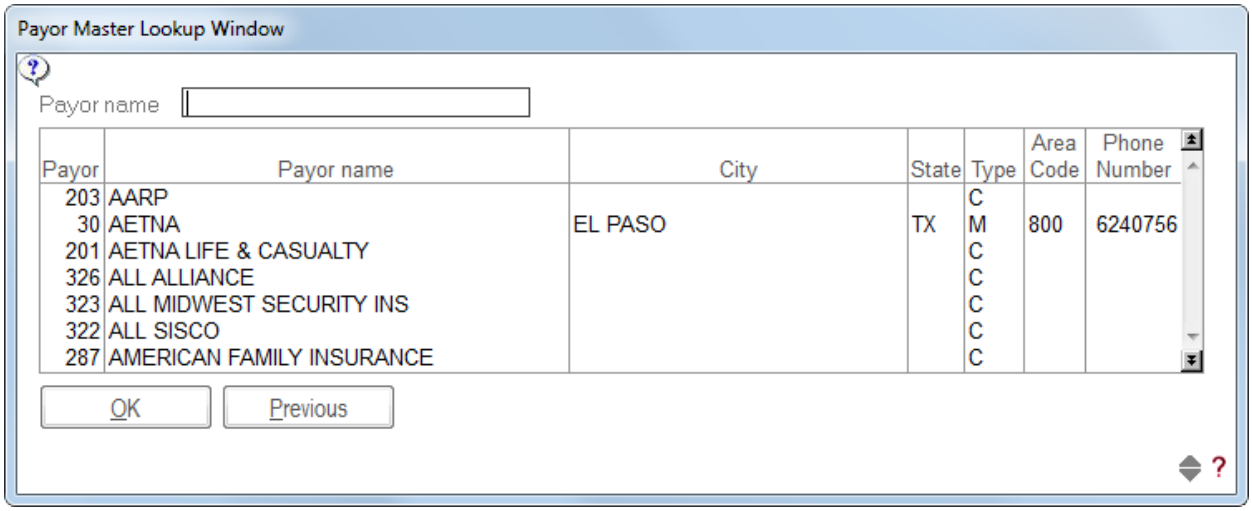
Action

Select a Reason Group then, click **OK**.

Click **Previous** to return to the previous window without entering a code.

Payor Master Lookup Window

The Payor Master Lookup Window displays when the Denial Category down arrow is clicked while on the Add, Copy or Edit screens.



Action

Select a Reason Group then, click **OK**.

Click **Previous** to return to the previous window without entering a code.

Reason Types

This window appears when the next to the Reason Type field in the **Reason Code Description** window is clicked.

Two reason types have been added:

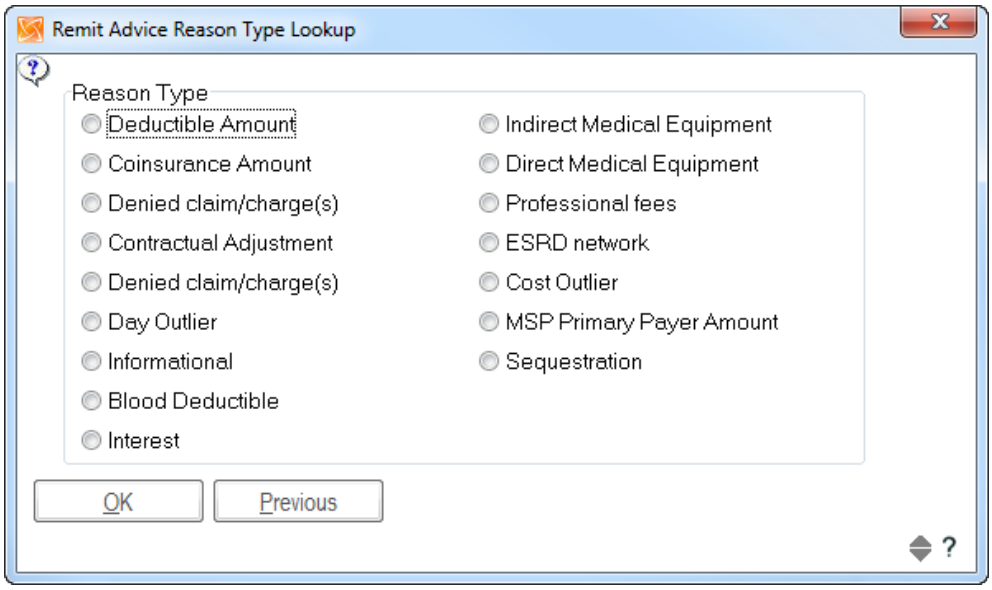
The **MSP Primary Payer Amount** reason type is used to populate the MSP Primary Pay Amount field on the *Electronic Remittance Advice* report. (In the past, all remittance advice records with a Reason Group of CO = Contractual Obligation would be placed in the Contract Adj column, regardless of the Reason Type.)

The **Sequestration** reason type (SEQ) is used to link specific transaction codes to Medicare Sequestration dollars received in the ERA.

About sequestration transaction codes

Transaction codes separate sequestration amounts reported in the ERA (electronic remittance advice). The reason code type SEQ identifies reason code 253 as a sequestration adjustment in the Remit Advice Codes Maintenance. Having the sequestration amounts displayed in separate fields helps the Business Office Director when reviewing the revenue and general ledger accounts.

Sequestration transaction codes display on Remittance Advice Entry screens and reports.



Action Select a Reason Type then, click **OK** .

Click **Previous** to return to the previous window without entering a code.

VALID REASON TYPES

Listed below are the valid Reason Types and the columns in which the amount will be printed.

Items with the CO (Contractual Obligation) Reason Group code are no longer automatically placed in the Contract Adj column, so you can use the Reason Type Code to specify where they will be placed.

Reason Type Code	Description	Remittance Advice Listing Column
MSP	MSP Primary Payor	MSP Primary Pay Amount
DDA	Deductible amount	Deductible
CIA	Co-insurance amount	Coinsurance
NCC	Non-covered charges	NonCov Chgs
CAD	Contract adjustment	Contract Adj
DNY	Denied claim/charges	Denied
DYO	Day outlier	Day Outlier
INT	Interest	Interest
BDD	Blood deductible	Blood Deduct
INF	Informational	Not Printed
IME	Indirect medical equipment	IME Adj
DME	Direct medical equipment	Med Ed
PRF	Professional fees	Pro Fees
ERD	ESRD	ESRD
CTO	Cost outlier	Cost Outlier
SEQ	Sequestration	Sequestration amount

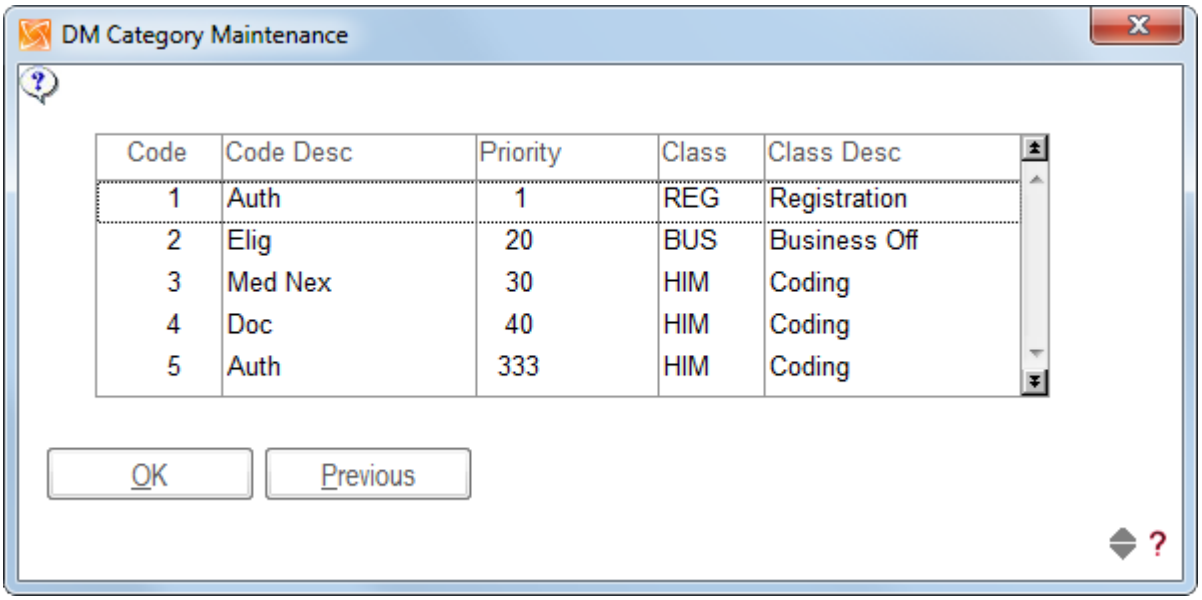
EXAMPLES

Here are a few examples of codes and the output column where an amount will be printed.

Reason Code	Reason Group	Reason Type	Remittance Advice Listing Column
1	PR	DDA	Deductible
18	CO	CAD	Contract Adj
18	PR	DNY	Denied
23	OA	MSP	MSP Primary Pay
B8	PR	NCC	NonCov Chgs

DENIAL CATEGORY SELECTION SCREEN

The Denial Category Selection Window displays when the Denial Category down arrow is clicked while on the Add, Copy or Edit screens.

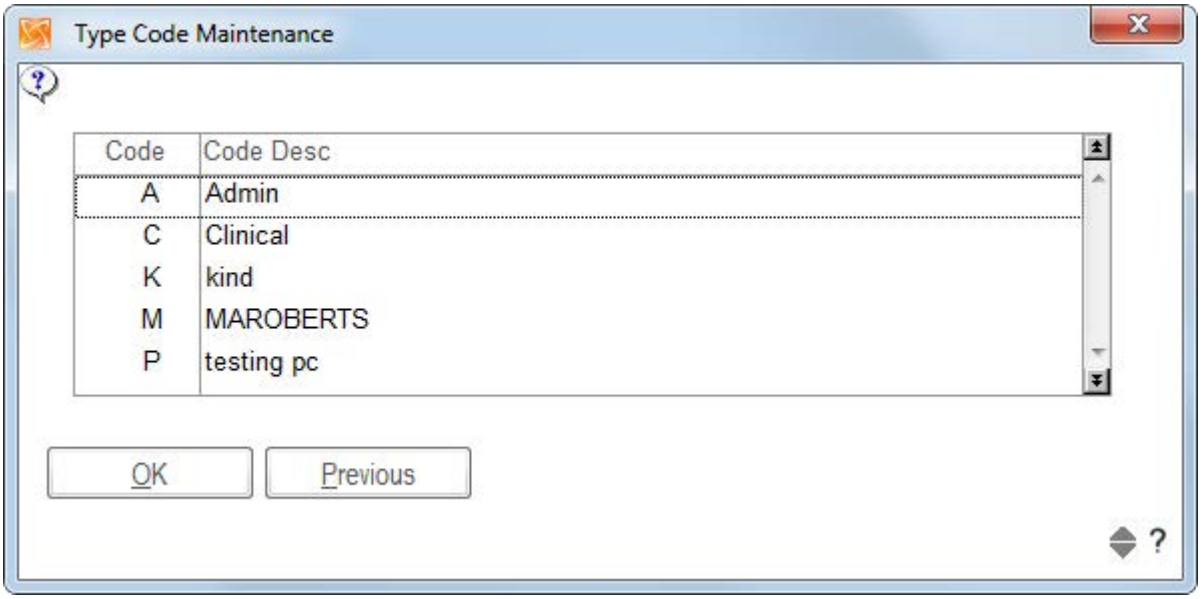


Action

Select a code then, press **OK** to continue or **Previous** to return to the previous screen.

DENIAL TYPE SELECTION SCREEN

The Denial Type Selection Window displays when the Denial Type down arrow is clicked while on the Add, Copy or Edit screens.

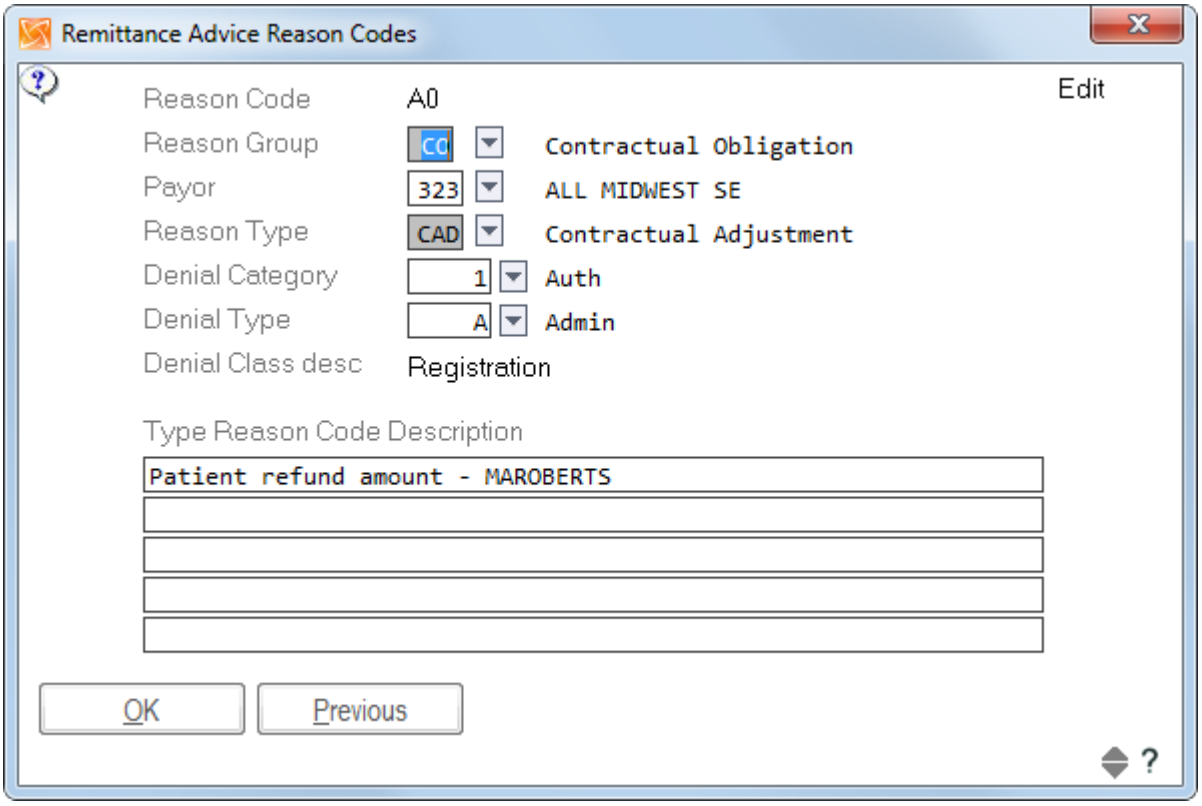


Action

Select a code then, press **OK** to continue or **Previous** to return to the previous screen.

UPDATE Reason Code description – EDIT

The Update Reason Code Description window displays when a Reason Code line item is selected and the Edit button [Edit] is clicked.



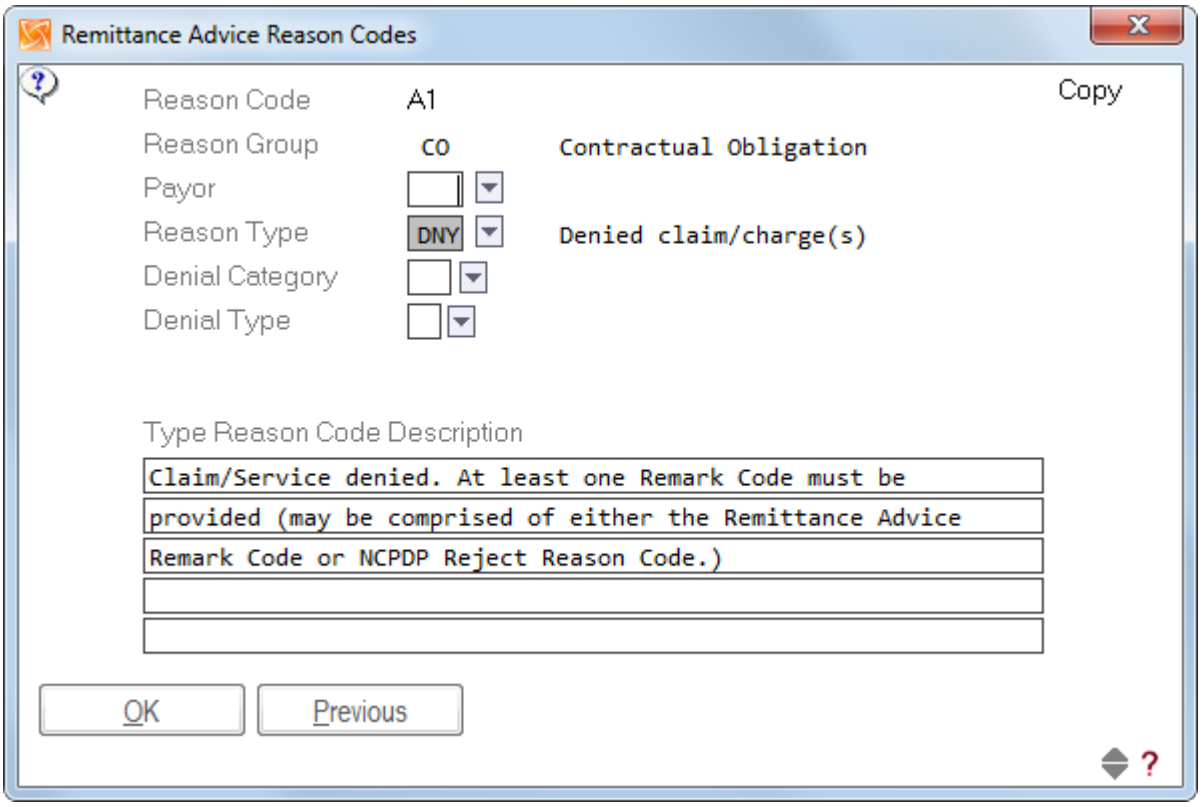
Action

If Denial Category is blank, the Denial Class Description label and description will not display. If a Denial Category is selected, the Denial Class Description label and description will display.

Make necessary changes then, press **OK** to continue or **Previous** to return to the previous screen.

Add Reason Type – Copy

The Add Reason Type window displays when a Reason Code line item is selected and the Copy button [Copy] is clicked.

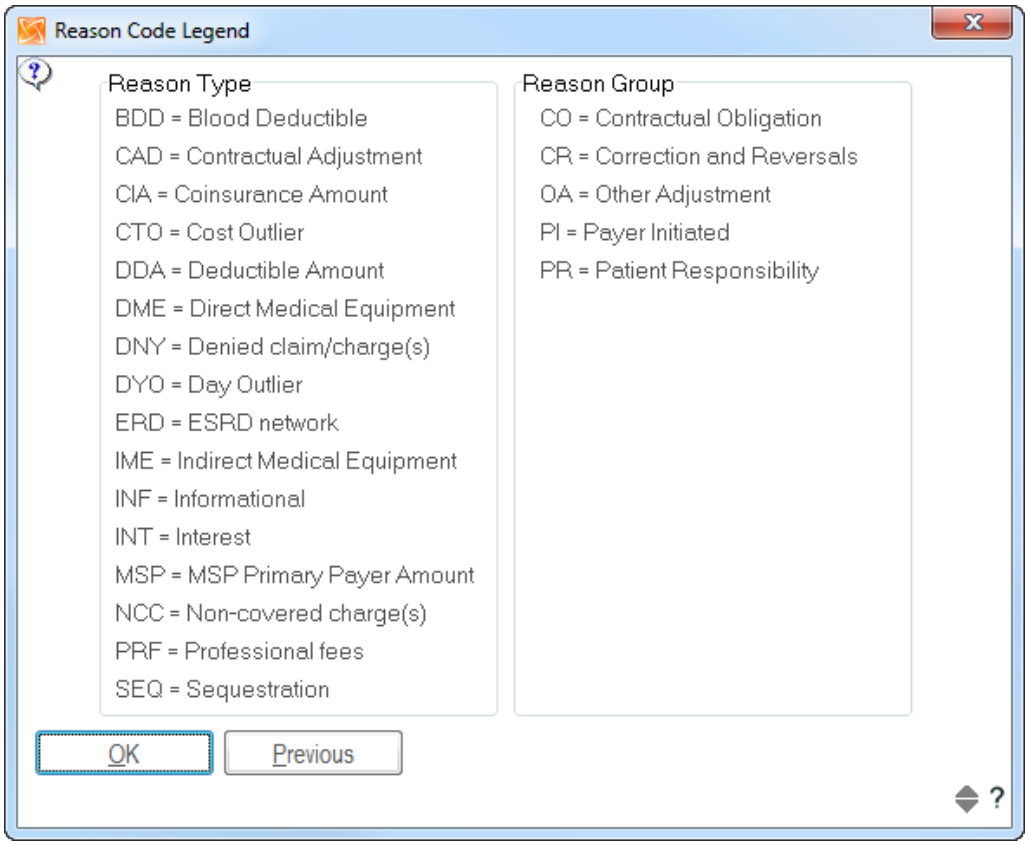


Action

Make necessary changes to the copied version then, press **OK** to continue or **Previous** to return to the previous screen.

F1 – REASON CODE LEGEND

The Patient Logic Denial Management – Legend window displays when **F1** is pressed or the Legend button Legend is clicked on the Admittance Advice Reason Code window.



Action

Press **OK** to continue or **Previous** to return to the previous screen.

RMTADV Option 9: Denial Management Code Maintenance

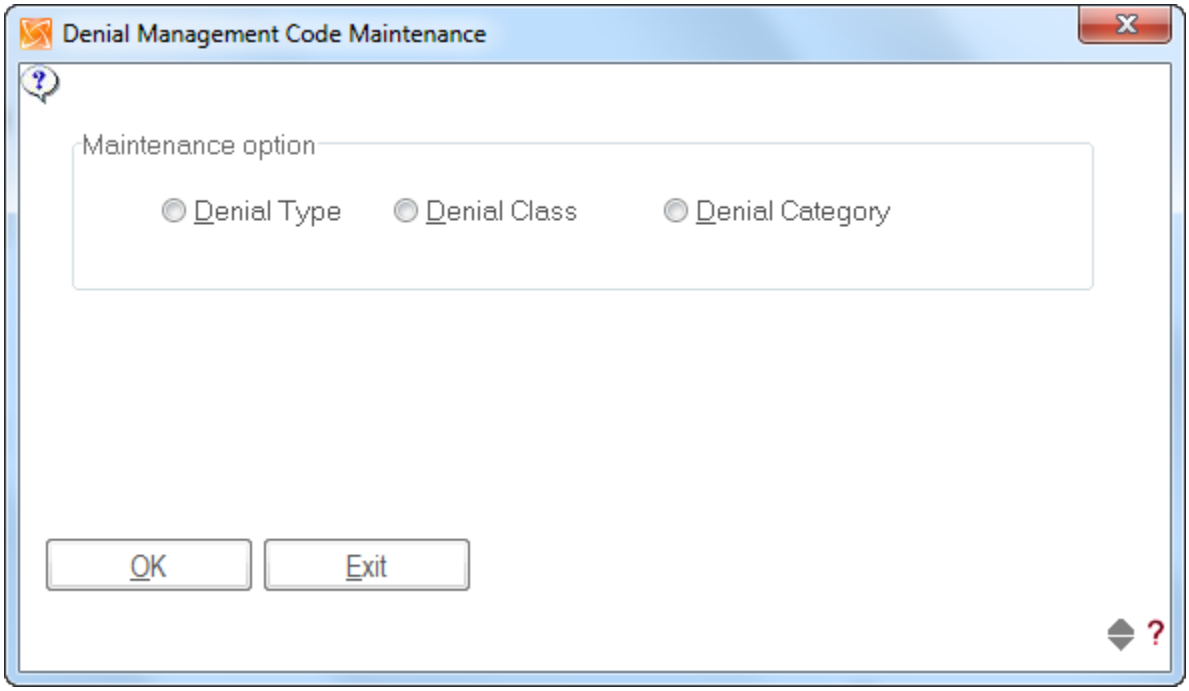
Overview: Use this option to create and maintain Denial Type, Category and Class Management Codes.

Note: This option is not functional until the new Denial Management software is installed.

File: SYSTABFL, PLDMCDEC, PLDMCDEV1

Table of Contents

DENIAL MANAGEMENT CODE MAINTENANCE

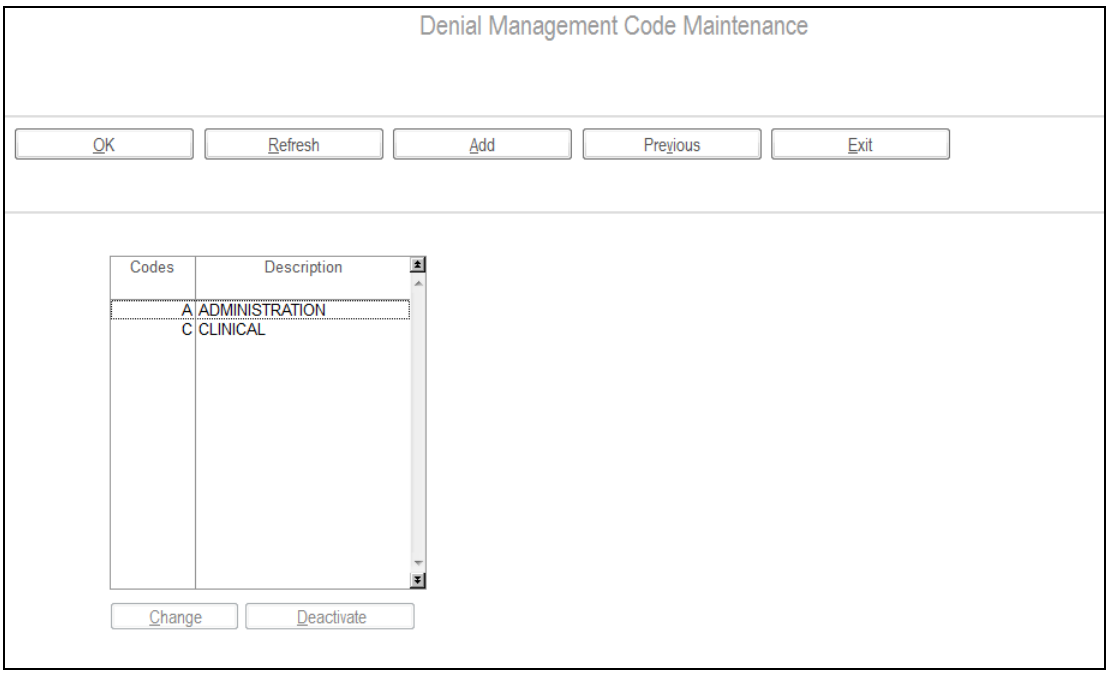


The Denial Management Code Maintenance window displays when **Option 9 (Denial Management Code Maintenance)** is selected from the **Remittance Advice** menu.

Action

Maintenance Option: Select **Denial Type**, **Denial Class** or **Denial Category** and click **OK** to continue, **Previous** to return to the previous screen, or **Exit** to quit.

DENIAL MANAGEMENT CODE MAINTENANCE – DENIAL TYPE



The **Denial Management Code Maintenance – Denial Type** window displays when Denial Type is selected from the **Denial Management Code Maintenance** window.

Action

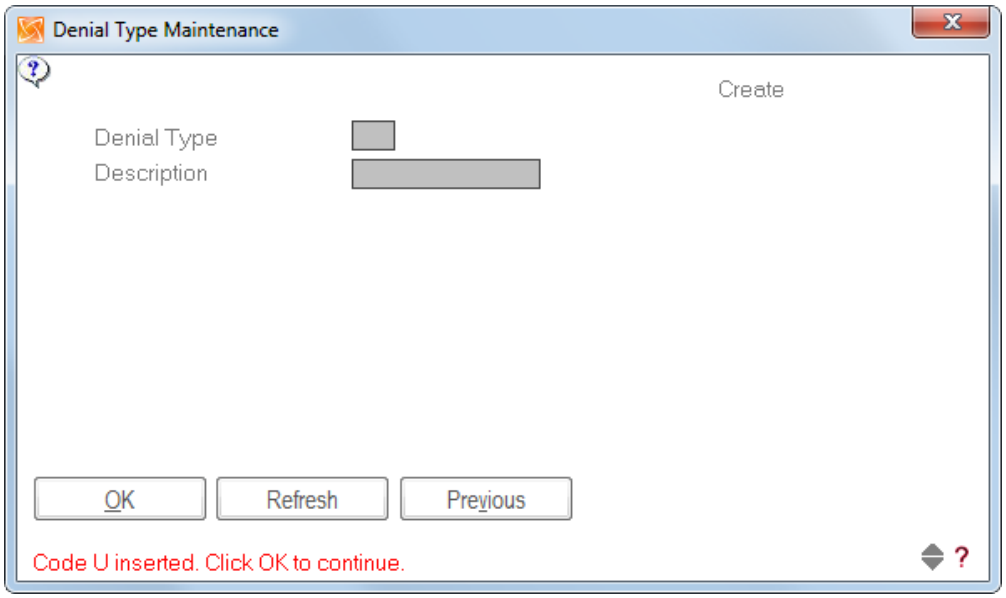
Select a Denial Type Code line item to update and click **Change** and the **DM Type Code Maintenance Update** window displays.

Select a Denial Type code and click **Deactivate** to deactivate the code and description.

Note: If a DM code is attached to a reason code, a message will display, “Code attached to category or reason. Deactivate not allowed.”

Click **OK** to update, **Previous** to return to the previous screen, or **Exit** to quit.

Denial Type Maintenance – Add



The **DM Type Code Maintenance – Create** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Type** window and **F6** is pressed or **Add** is clicked.

Note: The Description display on the **Remittance Advice Reason Codes** window **(RMTADV) – Option 8**.

Action

Gray fields are required.

Denial Type: Enter a Type Code. When a new code is added and **OK** is clicked, a message will display at the bottom of the window. **Example:** "**Code E inserted. Click OK to continue**."

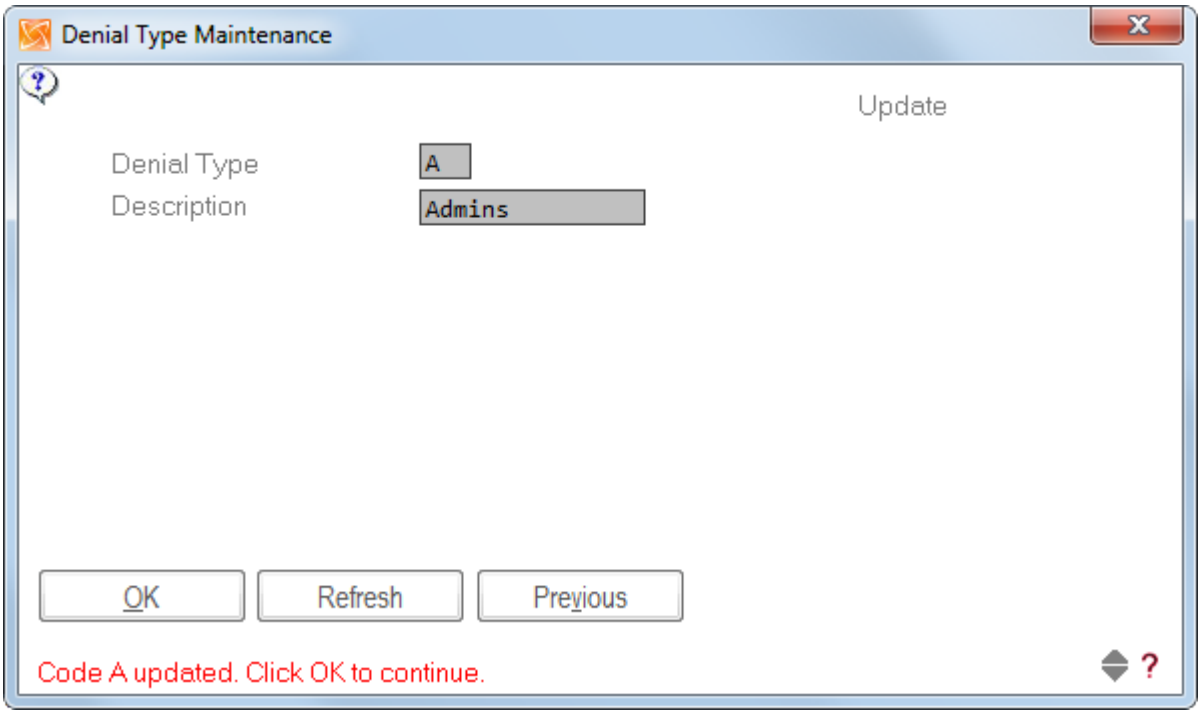
Once a code and description are entered and OK is clicked, they are checked for duplication, neither of which is case sensitive. If an upper case "E" is entered then, a lower case "e", it will display as a duplicate. The same is true for a description. So, if a code is entered that already exists, a note will display stating: "**Duplicate code value not allowed. Please rekey**."

Multiple entries are allowed after initial entry and message displays stating code has been added. Fields will display blank allowing another code to be added.

Description: Enter a description. If the description field is left blank, a warning message will display. Example: "**Description is blank or not valid. Please rekey**."

Click **OK**, to accept added code and the fields clear; more codes can be keyed once fields clear or click **OK** twice will take user back to Codes Maintenance screen. Click **Previous** to return to the previous screen or **Refresh** to refresh window content.

Denial Type Maintenance – Update



The **DM Type Code Maintenance – Update** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Type** window and change is clicked.

Note:

- When a code is updated and **OK** is clicked, a message will display at the bottom of the window. **Example:** "Code O updated. Click OK to continue."
- If the Description field is left blank, a message will display at the left bottom of the screen "Description is blank or not valid. Please rekey."

Action

Gray fields are required.

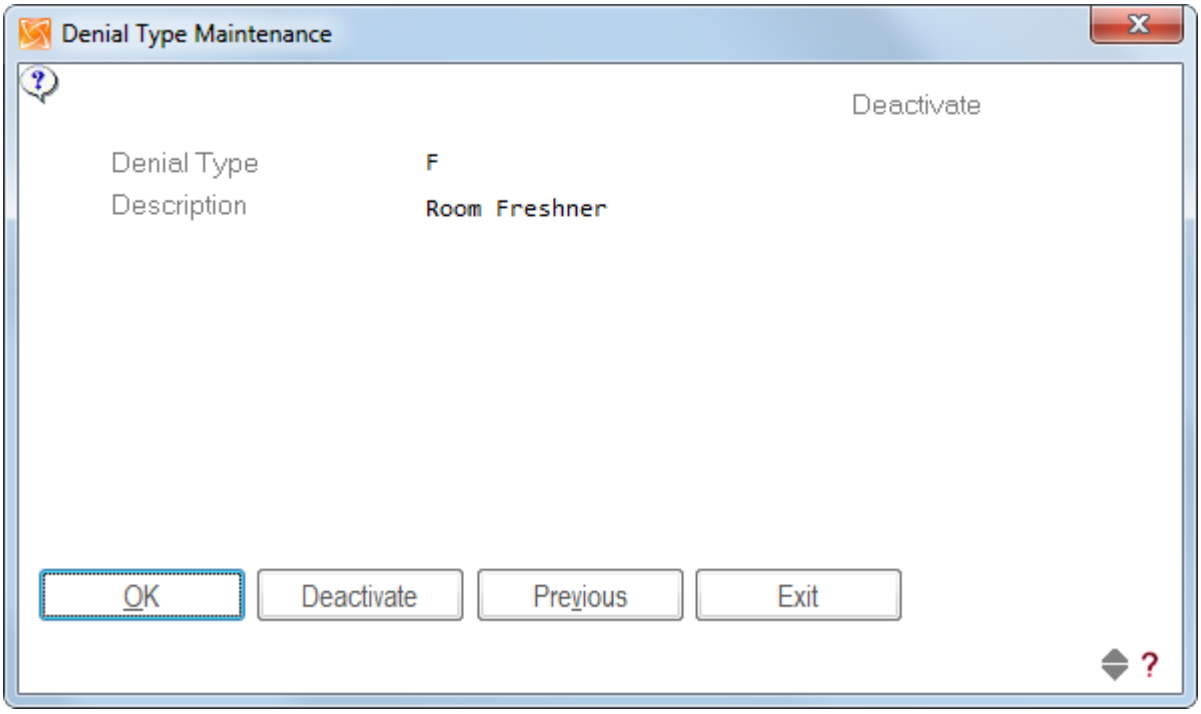
Make changes to either of the two fields:

Denial Type: Enter a Class Code.

Description: Enter a description.

Click **OK** twice to accept changes and return to code maintenance screen or Click **Previous** to return to the previous screen or **Refresh** to refresh window content.

Denial Type Maintenance – Deactivate



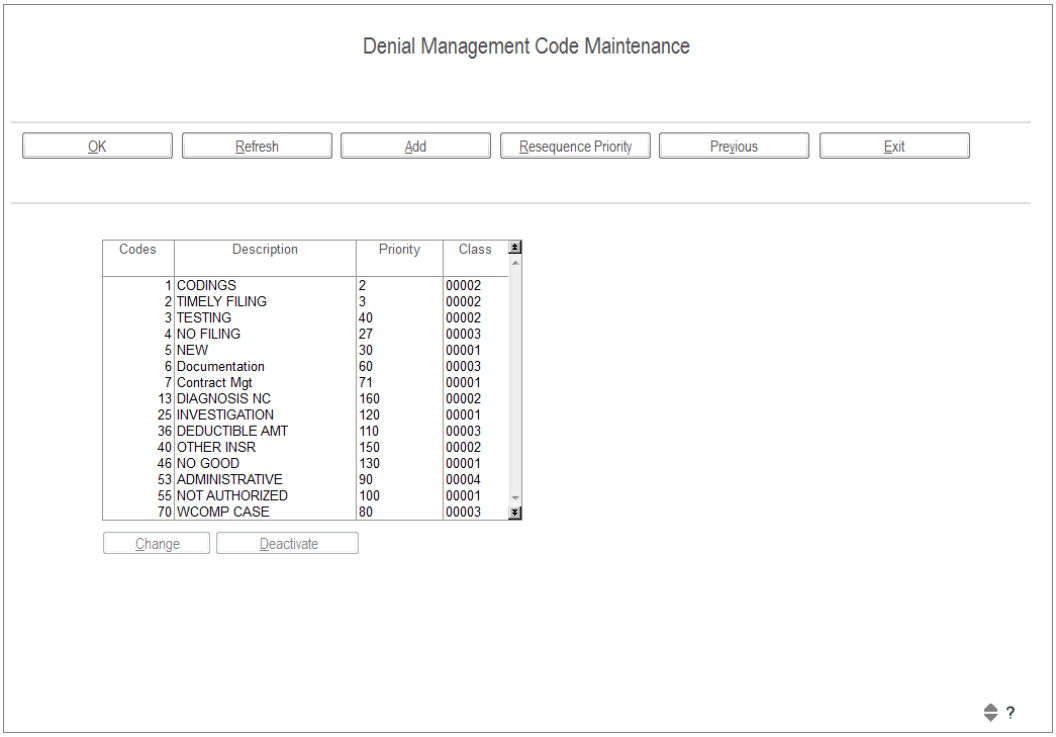
The **DM Class Code Maintenance – Deactivate** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Type** window and Deactivate is clicked.

Action

Deactivate: To confirm deactivation, press **F23** or click **Deactivate**.

Click **OK** to accept changes and continue, **Previous** to return to the previous screen, or **Exit** to quit.

DENIAL MANAGEMENT CODE MAINTENANCE – DENIAL CATEGORY



The **Denial Management Code Maintenance – Denial Category** window displays when Denial Type is selected from the **Denial Management Code Maintenance** window.

Note:

A Category cannot be set up using Class until the Denial Class is set up.

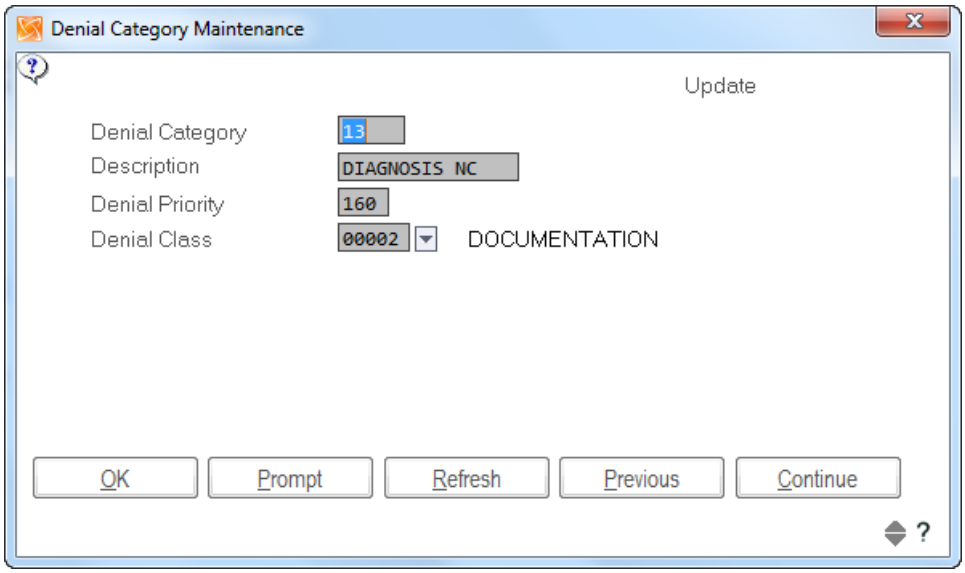
Action

Select a Denial Category Code line item to update and click **Change** and the **DM Category Code Maintenance Update** window displays.

Select a Denial Category code and click **Deactivate** to deactivate the code and description. **Note:** If a DM code is attached to a reason code, a message will display, “Code attached to category or reason. Deactivate not allowed.”

Click **OK** to update, **Previous** to return to the previous screen, or **Exit** to quit.

Denial Category Category Maintenance – Add



The **DM Category Maintenance – Create** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Category** window and **F6** is pressed or **Add** is clicked.

Note: The **Description** displays on the **Remittance Advice Reason Codes** window **(RMTADV) – Option 8**.

Action

Gray fields are required.

Denial Category: Enter a Category Code. When a new code is added and **OK** is clicked, a message will display at the bottom of the window. **Example:** "**Code 12 inserted. Click OK to continue**."

Once a code and description are entered and OK is clicked, they are checked for duplication, neither of which is case sensitive. If an existing code is entered, a note will display stating: "**Duplicate code value not allowed. Please rekey**."
Multiple entries are allowed after initial entry and message displays stating code has been added. Fields will display blank allowing another code to be added.

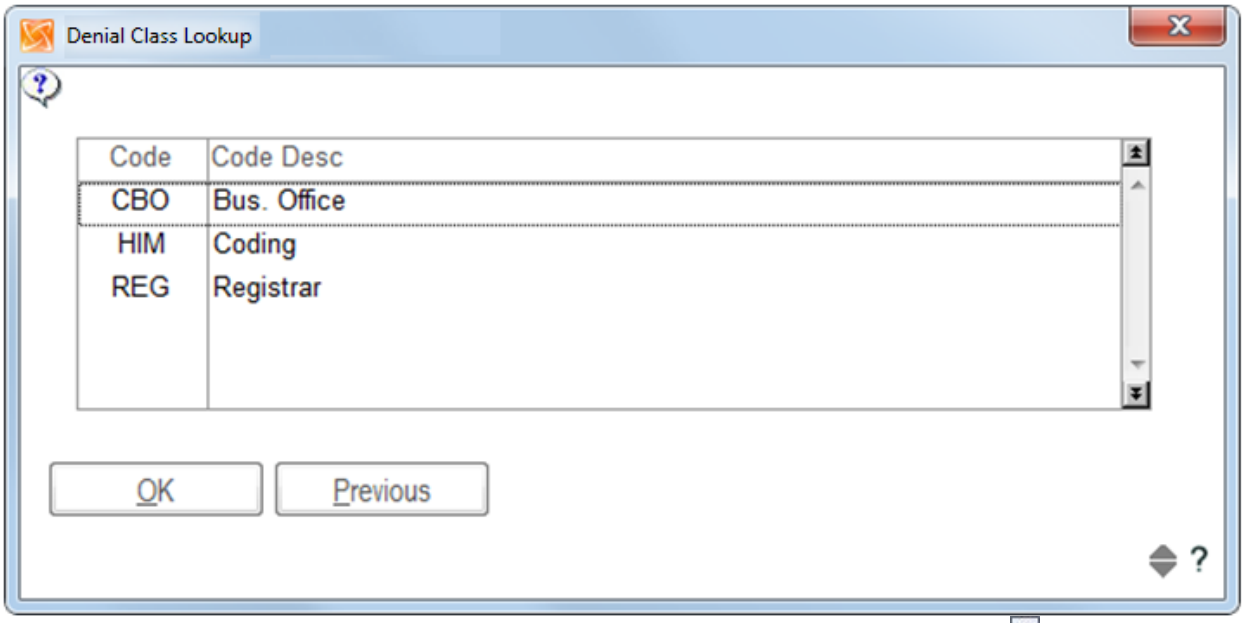
Description: Enter a description. If the description field is left blank, a warning message will display. Example: "**Description is blank or not valid. Please rekey**."

Denial Priority: Enter a unique weight factor.

Denial Class: Enter or select a Class Code.

Click **OK**, to accept and the fields clear; more codes can be keyed once fields clear or click **OK** twice will take user back to Codes Maintenance screen. Click **Previous** to return to the previous screen or **Refresh** to refresh window content.

Denial Class Lookup

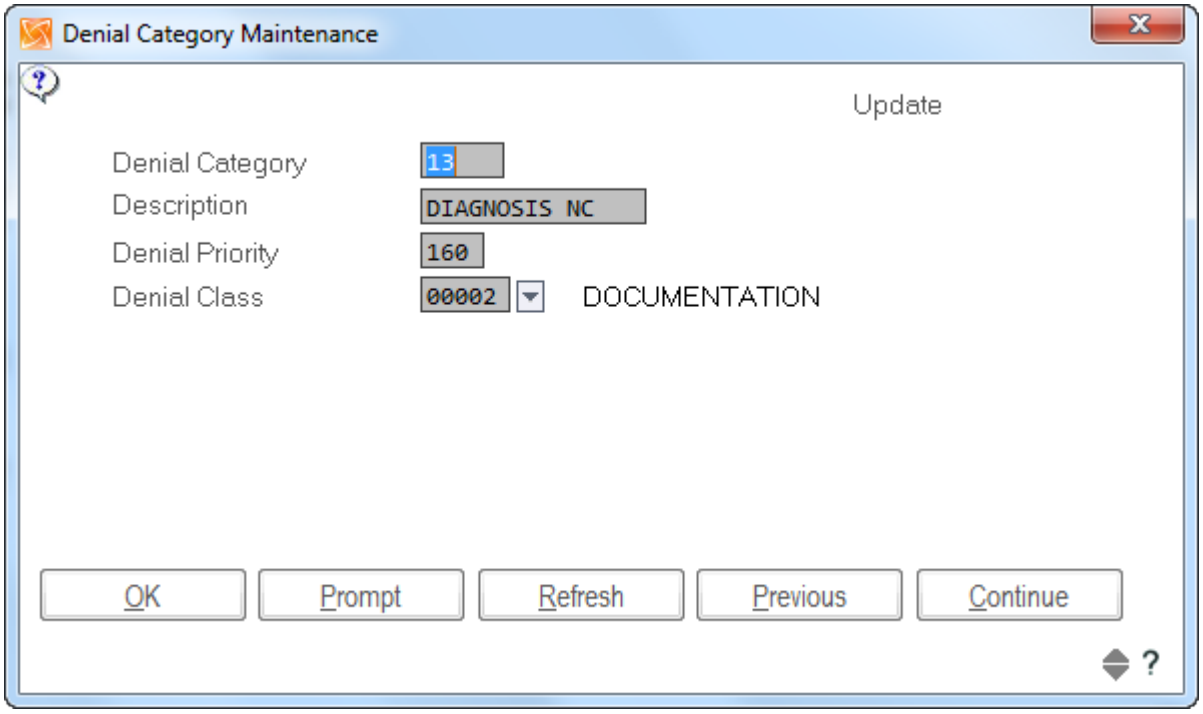


The **DM Class Code Maintenance** window displays when the Class Code down arrow is clicked on the **DM Category Maintenance – Create** window.

Action

Select a Code then, click **OK** to continue or **Previous** to return to the previous screen.

Denial Category Maintenance – Update



The **DM Category Maintenance – Update** window displays when a line item is selected from the **Denial Management Category Maintenance – Denial Category** window and change is clicked.

Note:

- When a code is updated and **OK** is clicked, a message will display at the bottom of the window. **Example:** "Code 11 updated. Click OK to continue."
- If the Description field is left blank, a message will display at the left bottom of the screen, "Description is blank or not valid. Please rekey."

Action

Make Changes to any of the following fields:

Denial Category: Enter a Class Code.

Description: Enter a description.

Denial Priority: Enter a numeric up to three-digit number.

Denial Class: Enter or select a Class Code.

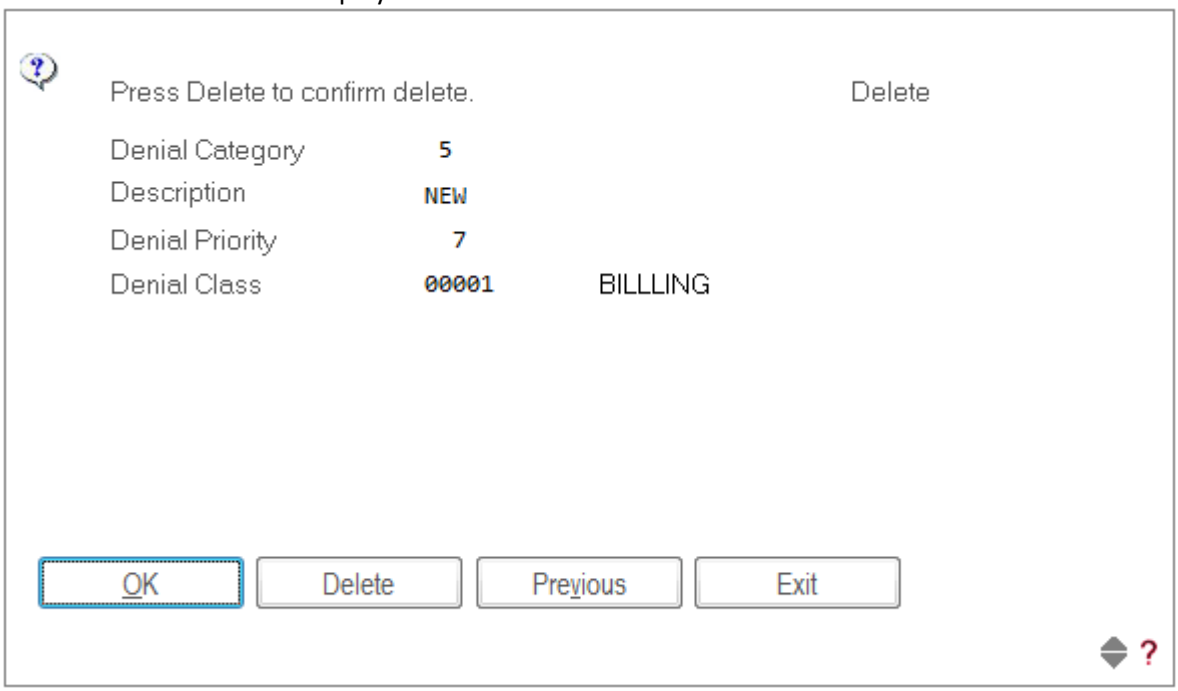
Click **OK** twice to accept changes and return to code maintenance screen or Click **Previous** to return to the previous screen or **Refresh** to refresh window content.

Denial Category Maintenance – Delete

To Delete a Denial Category Code

1. Select a line item from the **Denial Management Code Maintenance Denial Category** view
2. Click Delete

The **Confirm Delete** view displays.



3. Click **Delete** to confirm delete

Note:
A code attached to a reason code cannot be deleted and a message displays on the **Denial Management Code Maintenance Denial Category** view stating: "Cannot delete. Code attached to a reason code. Use F9 to display links."

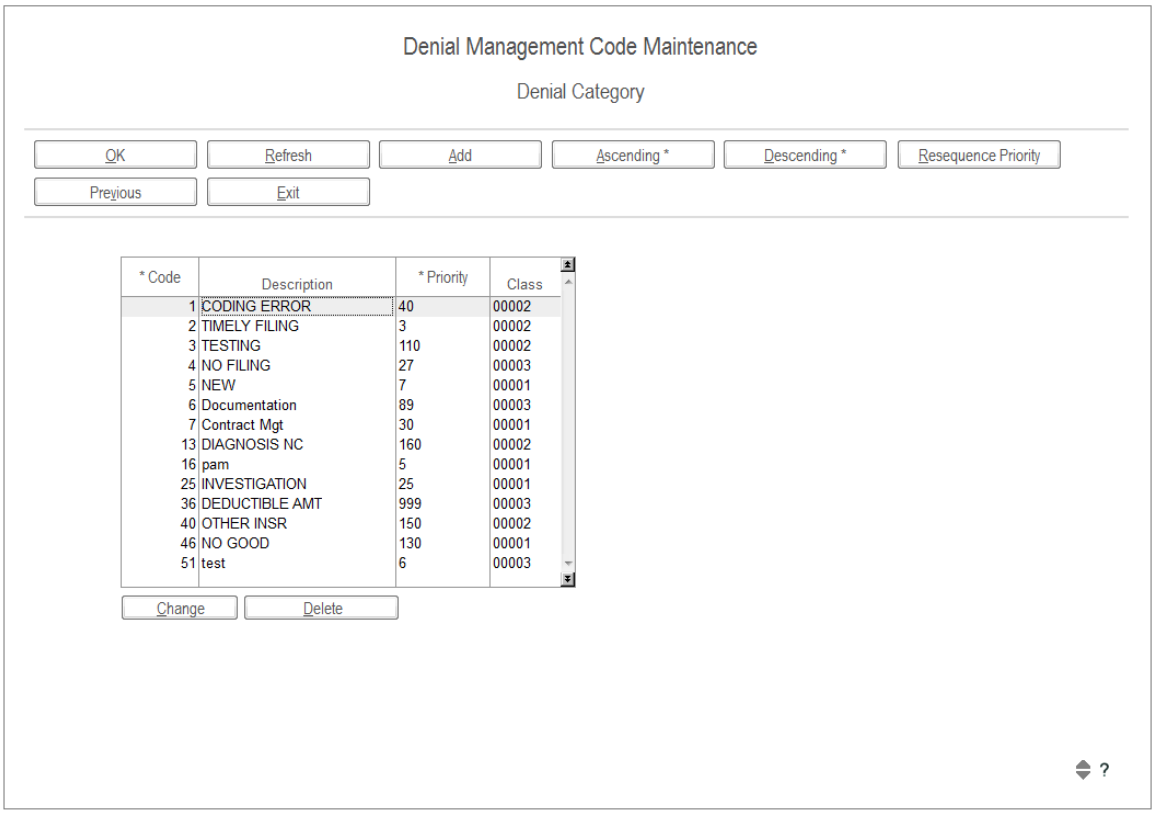
Denial Category Maintenance – Resequence Prority (F10)

To re-sequence priority

Note:
When there are multiple denials, the one with the highest priority shows up as being the reason the claim was denied on the work list.

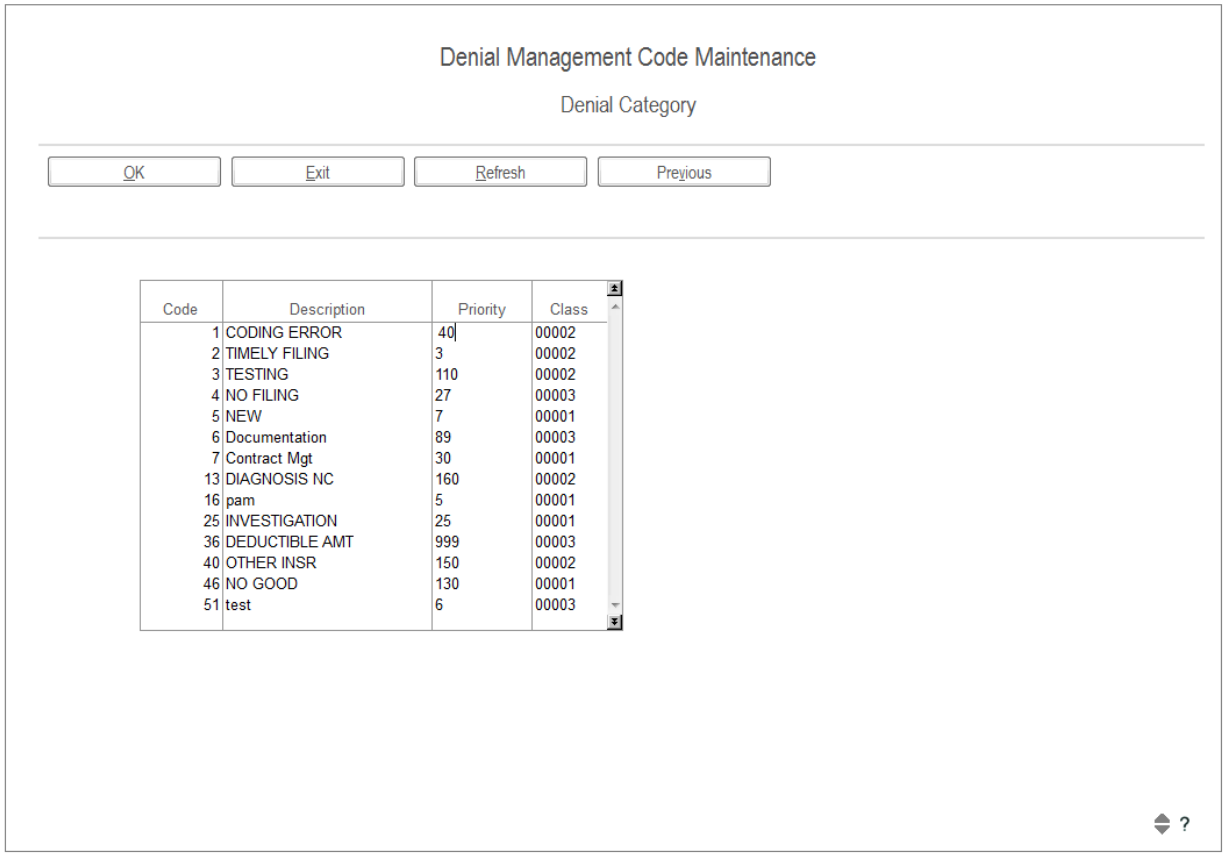
1. Select **Denial Category** from the **Denial Management Code Maintenance** view

   The **Denial Management Code Maintenance** view displays.



2. Click **Resequence Priority**

The **Denial Management Code Maintenance** view displays.

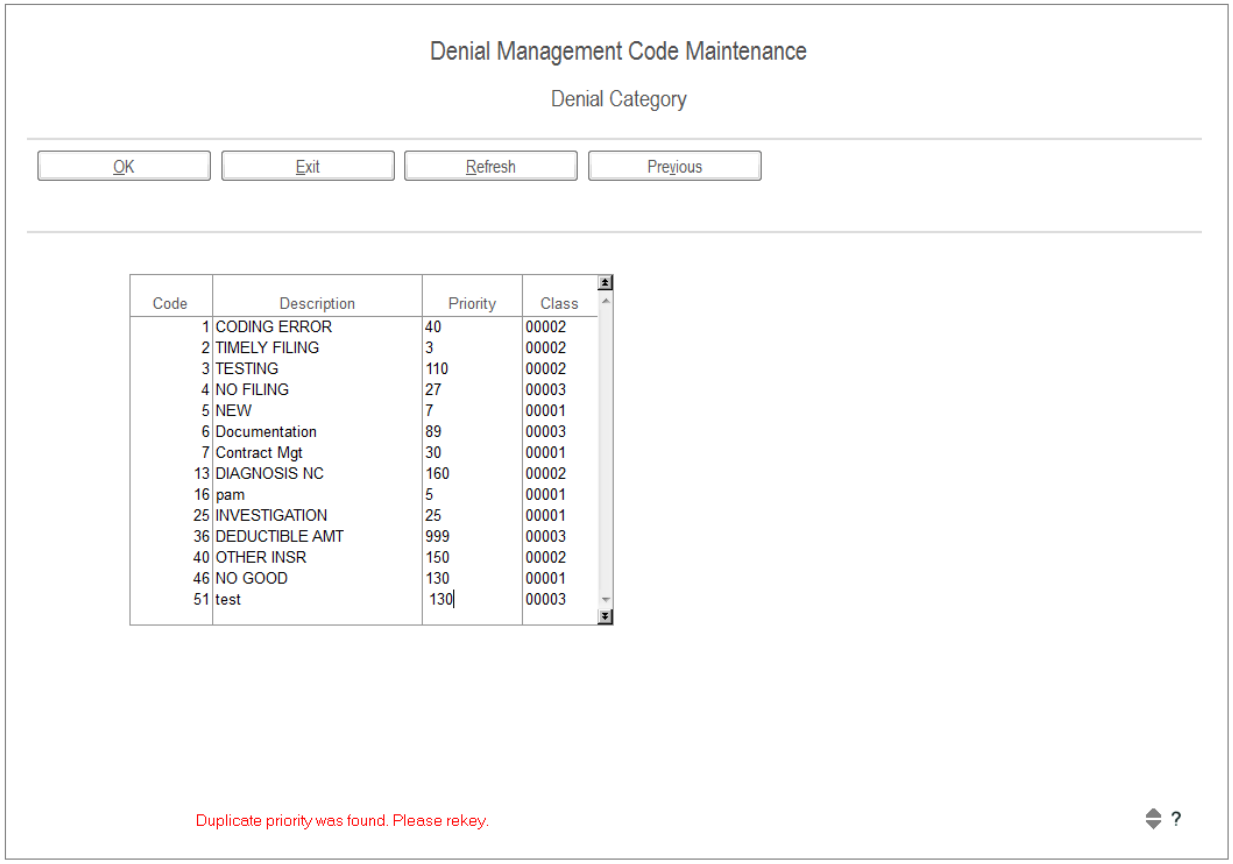


Note:

The Denial Management Code Maintenance view changes only displaying **OK, Exit, Refresh,** and **Previous** as options.

3. Position cursor in the **Priority** column to the right of the line item to change
4. Enter a new **Priority Code**
5. Click **OK**

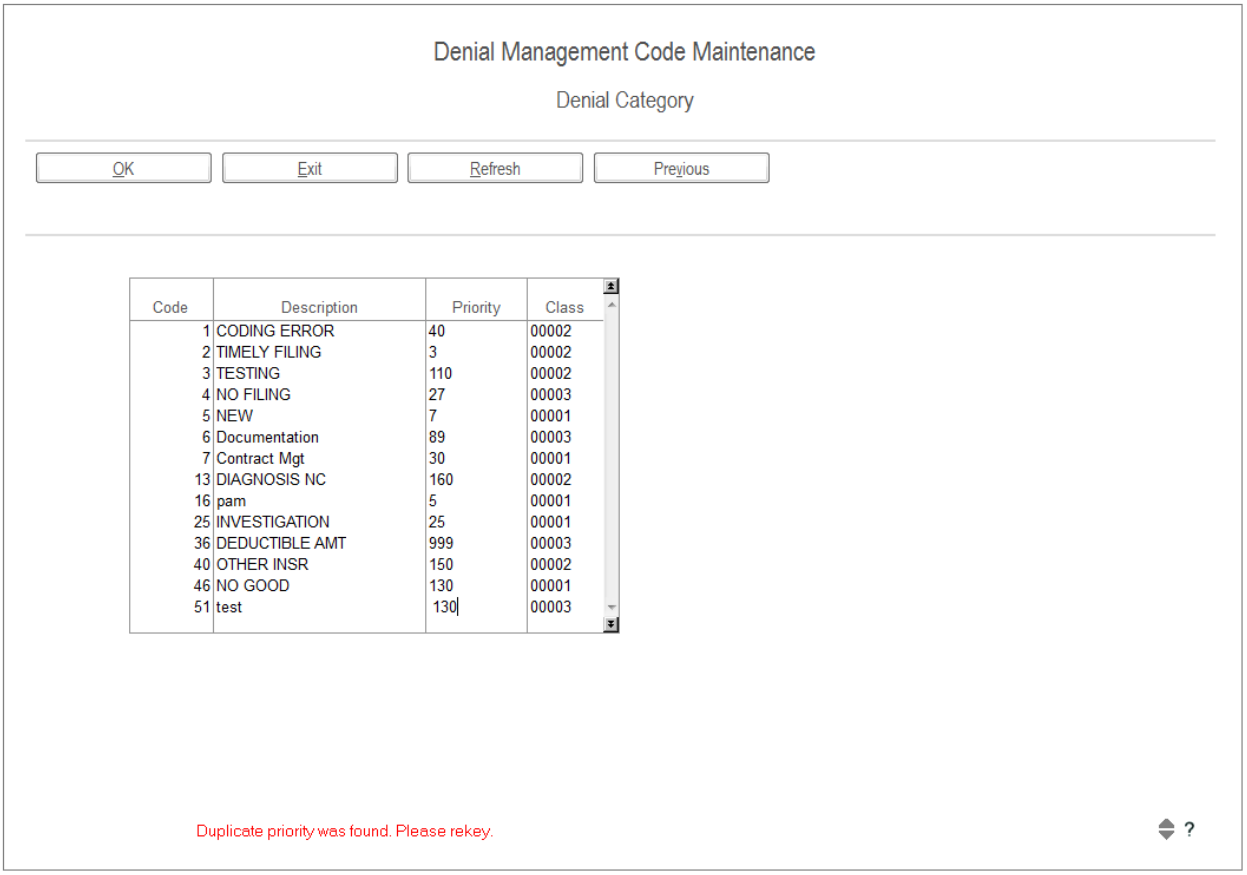
The **Denial Management Code Maintenance** view displays with duplicate priority message.



Note:

When a Priority number is duplicated, a message displays stating, "**Duplicate priority was found. Please rekey**." Duplicate priority Code displays in red.

The **Denial Management Code Maintenance** duplicate priority message view.

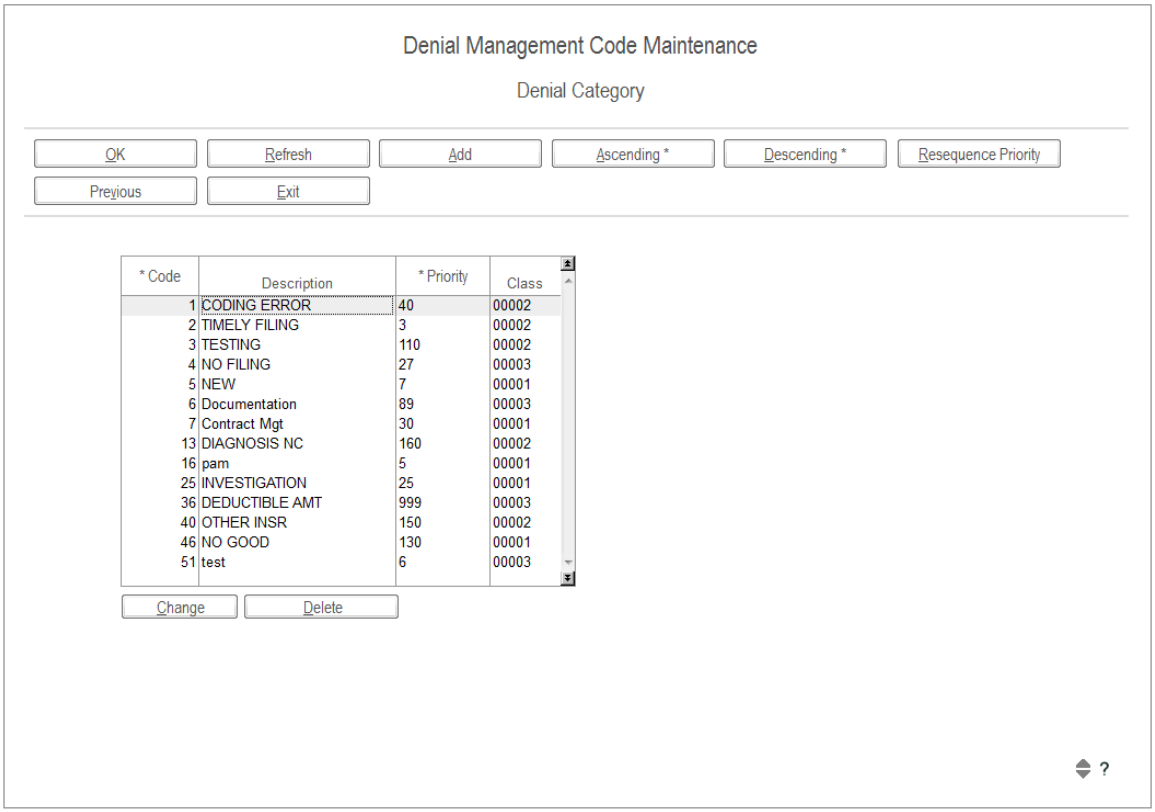


Denial Category Maintenance – Sort on Code and Priority

To Sort on Code and Priority of Denial Categories

1. Select **Denial Category** from the **Denial Management Code Maintenance** view

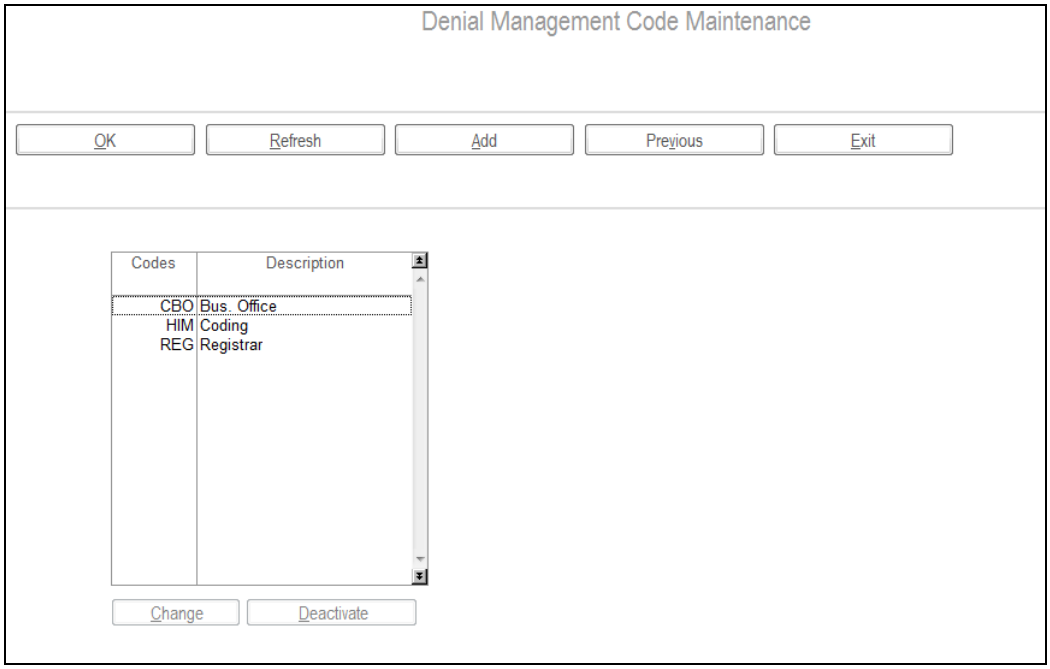
The **Denial Category** view displays.



2. Click in either the **Code** or **Priority** column
3. Click **Ascending** or **Descending** to sort data

Data sorts in ascending or descending order in the column the cursor is positioned.

DENIAL MANAGEMENT CODE MAINTENANCE – DENIAL CLASS



The **Denial Management Code Maintenance – Denial Class** window displays when Denial Type is selected from the **Denial Management Code Maintenance** window.

Action

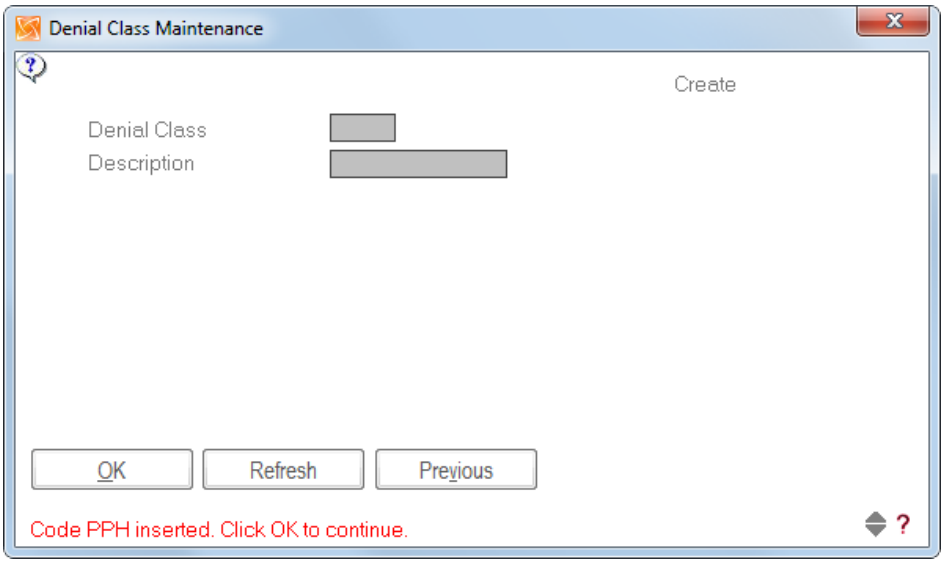
Select a Denial Class Code line item to update and click **Change** and the **DM Class Code Maintenance Update** window displays.

Select a Class Category code and click **Deactivate** to deactivate the code and description.

Note: If a DM code is attached to a reason code, a message will display stating, “Code attached to category or reason. Deactivate not allowed.”

Click **OK** to update, **Previous** to return to the previous screen, or **Exit** to quit.

Denial Class Maintenance – Add



The **DM Class Code Maintenance – Create** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Class** window and **F6** is pressed or **Add** is clicked.

Note: The Description will display on the **Remittance Advice Reason Codes** window **(RMTADV) – Option 8**.

Action

Gray fields are required.

Denial Class: Enter a Class Code. When a new code is added and **OK** is clicked, a message will display at the bottom of the window. **Example:** "**Code EEE inserted. Click OK to continue**."

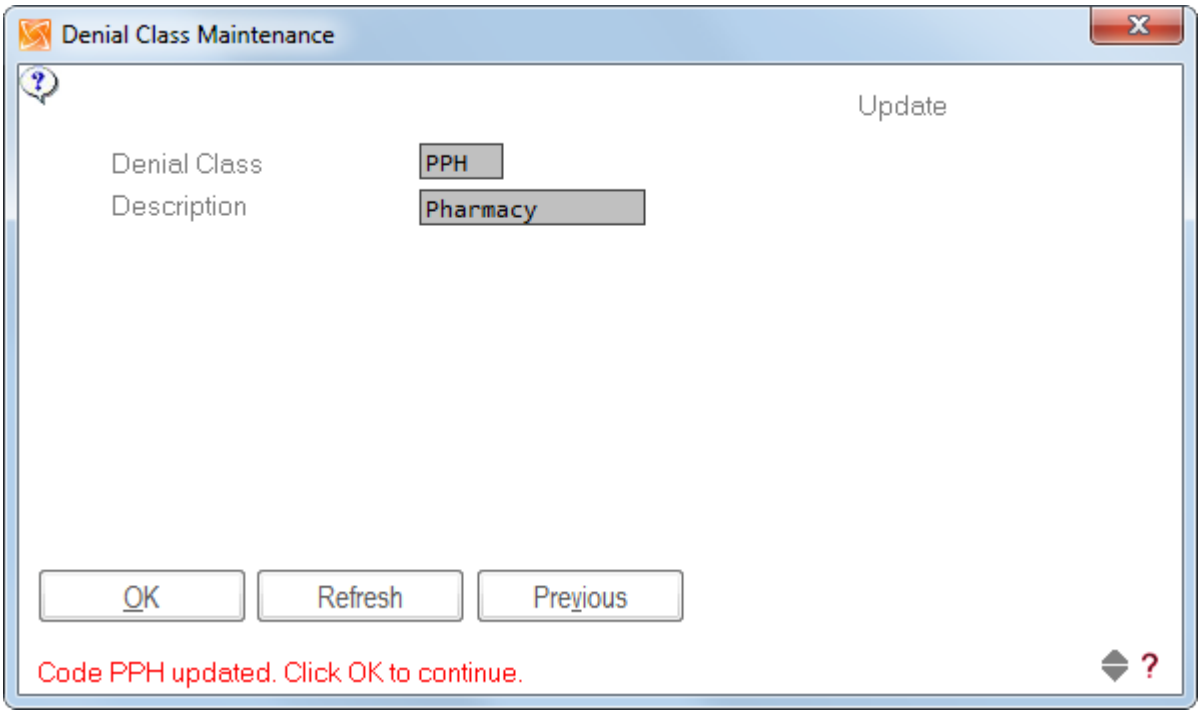
Once a code and description are entered and OK is clicked, they are checked for duplication, neither of which is case sensitive. If an upper case "E" is entered then, a lower case "e", it will display as a duplicate. The same is true for a description. So, if a code is entered that already exists, a note will display stating: "**Duplicate code value not allowed. Please rekey**."

Multiple entries are allowed after initial entry and message displays stating code has been added. Fields will display blank allowing another code to be added.

Description: Enter a description. If the description field is left blank, a warning message will display. Example: "**Description is blank or not valid. Please rekey**."

*Click **OK**, to accept and the fields clear; more codes can be keyed once fields clear or click **OK** twice will take user back to Codes Maintenance screen. Click **Previous** to return to the previous screen or **Refresh** to refresh window content.*

Denial Class Maintenance – Update



The **DM Class Code Maintenance – Update** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Class** window and change is clicked.

Note:

- When a code is updated and **OK** is clicked, a message will display at the bottom of the window. **Example:** "Code MAR updated. Click OK to continue."
- If the Description field is left blank, a message will display at the left bottom of the screen, "Description is blank or not valid. Please rekey."

Action

Gray fields are required.

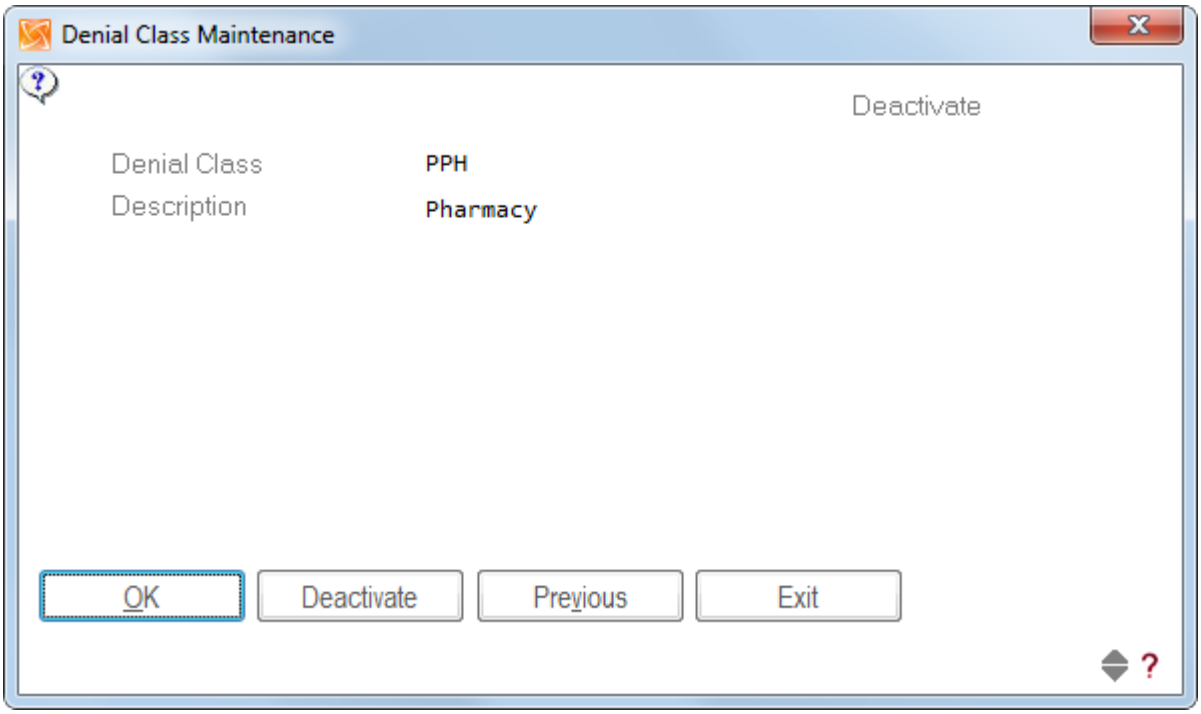
Make Changes to either field:

Denial Class: Enter a Class Code.

Description: Enter a description.

Click **OK** twice to accept changes and return to code maintenance screen or Click **Previous** to return to the previous screen or **Refresh** to refresh window content.

Denial Class Maintenance – Deactivate



The **DM Class Code Maintenance – Deactivate** window displays when a line item is selected from the **Denial Management Code Maintenance – Denial Class** window and Deactivate is clicked.

Action

Deactivate: To confirm deactivation, press F23 or click **Deactivate**.

Click **OK** to accept changes and continue, **Previous** to return to the previous screen, or **Exit** to quit.

RMTADV Option 11: Print EOB's

The Explanation of Benefits has been enhanced to provide more information.

Overview:

Print EOB's (*Electronic Remittance Advice Menu*, *Option 11*) is used to print an Explanation of Benefits (EOB) for all patients who have a secondary insurance and have a record in *Remittance Advice Entry* (*Daily Processing Menu, Option 6)* in Patient Accounting.

The EOB prints claim information such as Submitted Charges, Contractual Adjustment Amount, Co-Insurance/Deductible Amount, and Payment Amount, Check/EFT Number, Adjustment Reason Codes, and Remarks.

EOBs can be printed from this option as long as the required data has not been purged. Purge days are set up in the ERA System Control File. EOBs may be printed by document control number or by patient number, with the option to choose to include or omit detail charges. You can also sort the EOBs by patient number or name. Examples of detailed and summary versions of an EOB are shown in the final section, "Sample EOBs."

Medhost will auto-assigned a unique Ctl# as the control number in all ERED* tables. The original number given by the intermediary will go in a new column at the end of table EREDFH/EREDFHH. The original number is still accessible on the screens/reports in case contact with the intermediary is necessary to troubleshoot claims.

Program:

ER0R04: Detail and Summary

Selection:

Select EOB by - Document Control Number or Patient Number

Select EOB by Document Control Number

Sort EOB reports by - **Patient Number** or **Patient Name**

Include detail charges - **Yes** or **No**

Select EOB by Patient Number

Select a **Patient**

Select a **Claim**

Include detail charges - **Yes** or **No**

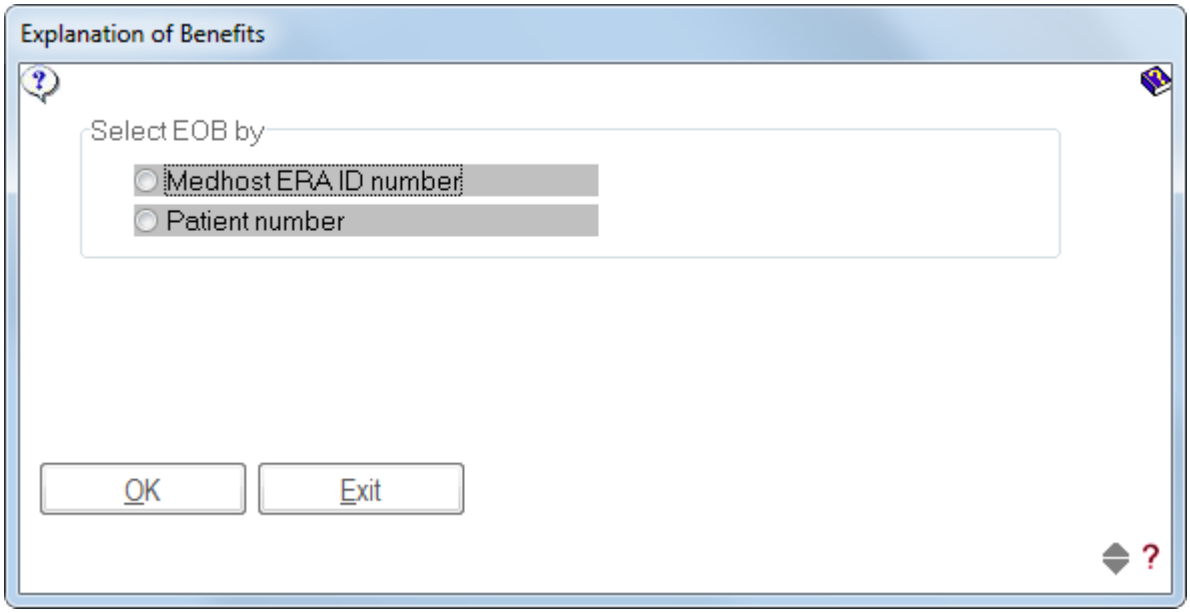
Files:

ARRATDTL, ARSUMMRY, BENEFITS, EREDATHL1, EREDCLH, EREDCSH, EREDCSHL1, EREDFHH, EREDQYHL1, EREDSVHL1, INSPLAN, PATHIST, PATIENTS, SYSCTL

CONTENTS

SELECTING THE EOB PRINTING METHOD

The Explanation of Benefits–Select EOB window opens after you select the *Print EOB's* link from the *Electronic Remittance Advice Menu*.



Action

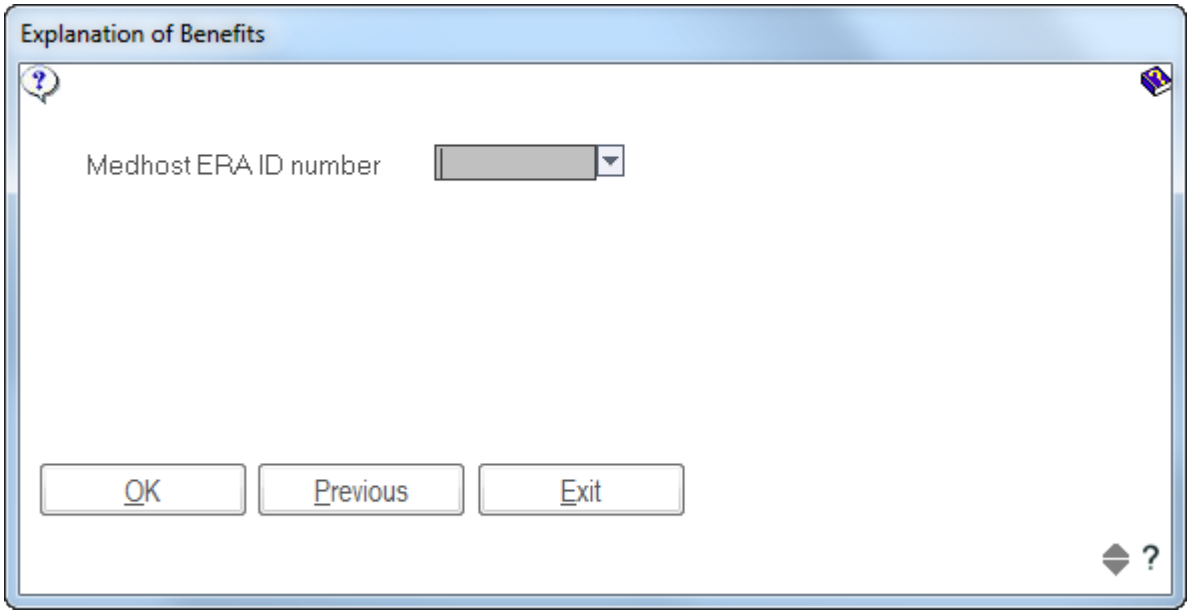
Select (click on) the method for printing the EOBs (by Document Control Number or Patient Number), and then click the **OK** button.

The next window will depend on your selection. Refer to the appropriate window for your method: "Printing by Document Control Number" or "Printing by Patient Number."

Note: The Medhost ERA ID number is a Medhost unique identifier number that prevents intermediaries that do not use unique ICN#s from affecting EOB retrieval.

Printing by Document Control Number

The Explanation of Benefits–Document Control Number window appears after you select Document Control Number in the **Select EOB** window.



Action

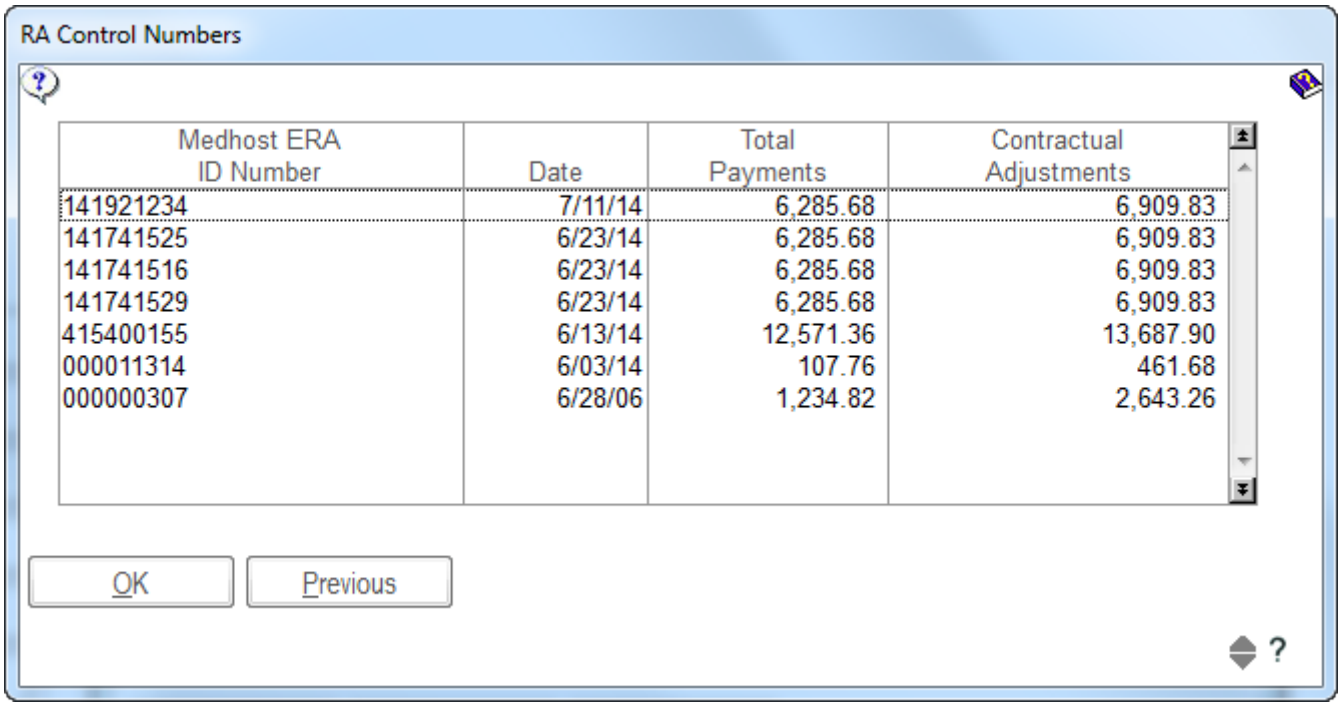
Enter the Document Control Number for which you want to print the EOBs, and then click **OK**.

- Type the number and press (click on) the **OK** button. The **Explanation of Benefits–Sort** window will open (see the section, "Selecting the Sort Method").
- Press (click on) the search icon to select the number from a list and the **RA Control Numbers** window will open (see the section, "Searching for the Document Control Number").

(Clicking **Previous** returns you to the **Select EOB** window; clicking **Exit** returns you to the *Electronic Remittance Advice Menu*.)

SEARCHING FOR THE DOCUMENT CONTROL NUMBER

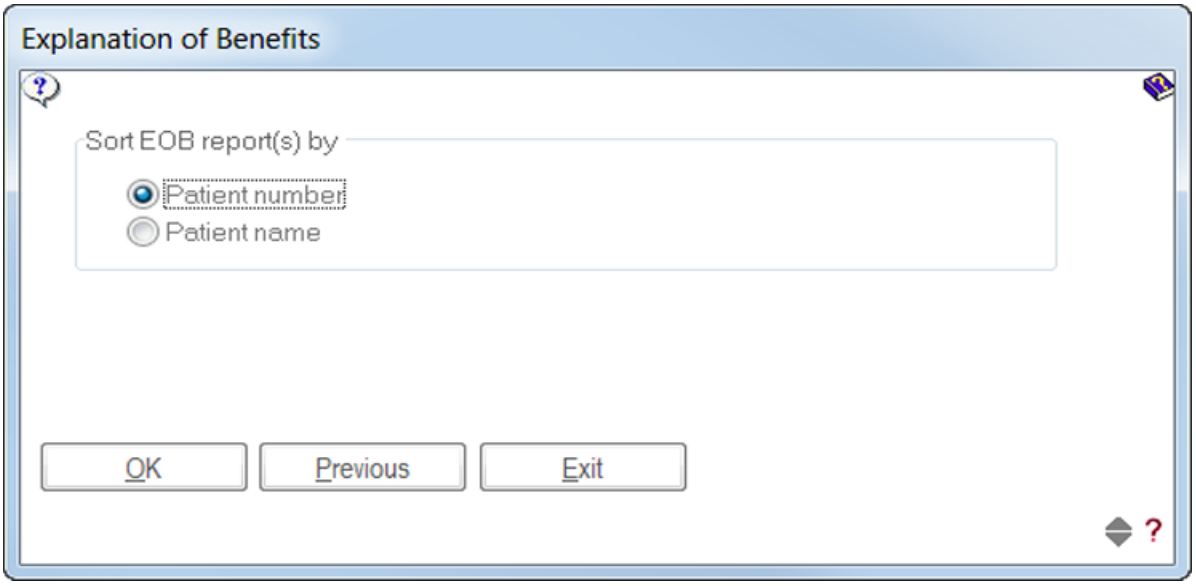
The RA Control Numbers window appears when you click the search icon in the **Document Control Number** window.



Action Highlight the **RA (Remittance Advice) Number** you need and press (click on) the **OK** button. The **Explanation of Benefits–Sort** window will open (see the section, "Selecting the Sort Method").

SELECTING THE SORTING METHOD

The Explanation of Benefits–Sort EOB Reports window appears after you enter or select a Document Control Number.



Action

Select (click on) the sort method for printing the EOBs (by Patient Number or Patient Name), and then click **OK**. The **Explanation of Benefits–Include Detail** window will open (refer to the section, "Specifying the Report Detail").

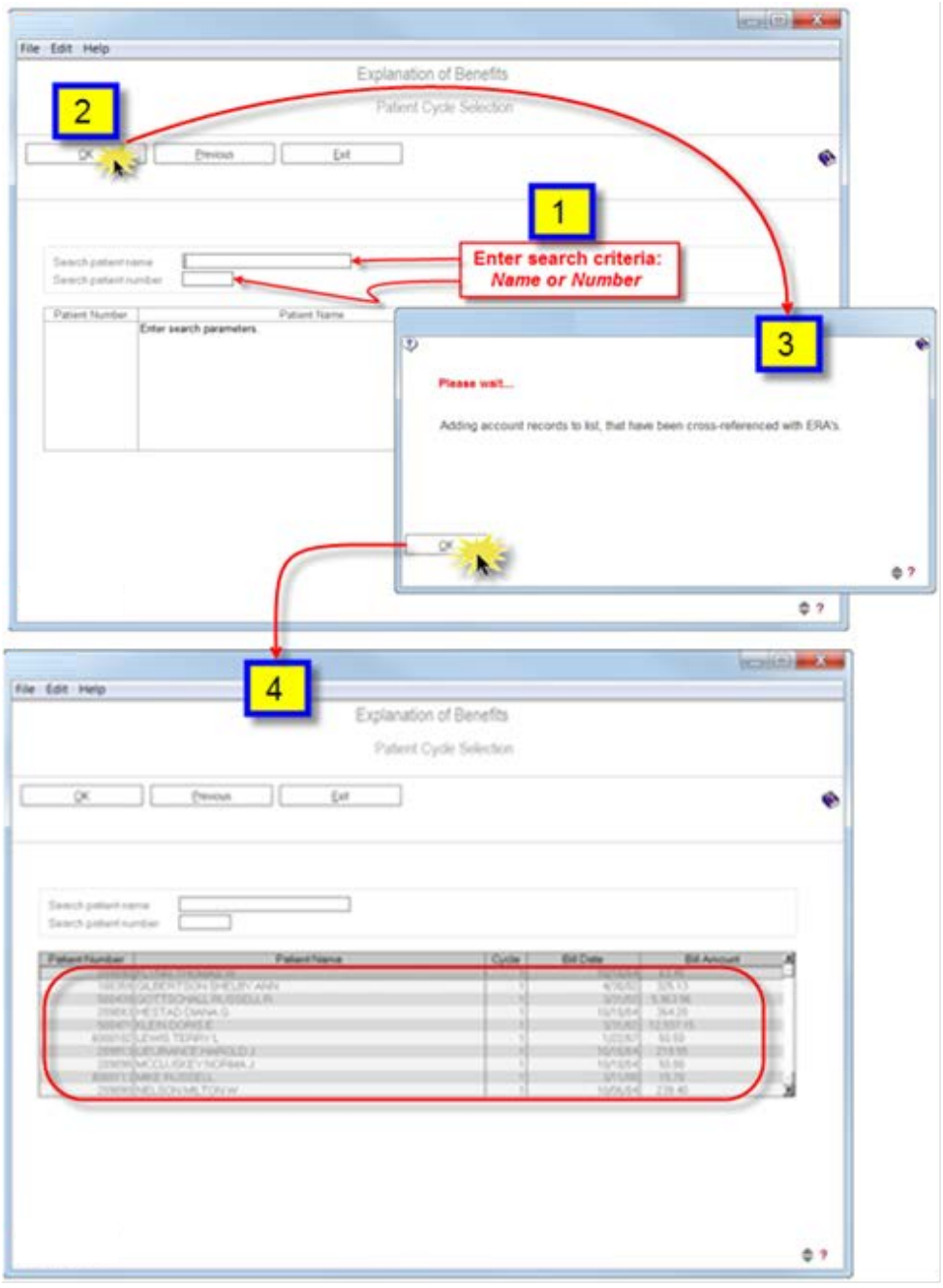
(Clicking **Previous** returns you to the document control number window; clicking **Exit** displays the **Include Detail Charges** window.)

PRINTING BY PATIENT NUMBER

ACCESSING PATIENTS' CLAIMS

The Explanation of Benefits–Patient Cycle Selection window appears after you select Patient Number in the **Select EOB** window.

Use this window to generate a list of patients' claims or one patient's claims.



Action

Enter a patient's name or number and press (click on) the **OK** button.

- To display a list of all patients' claims, type part or all of a patient's name (last name first) in the Search Patient Name field and click **OK**.
- To display a list of a specific patients' claims, type the entire patient number in the Search Patient Number field and click **OK**.

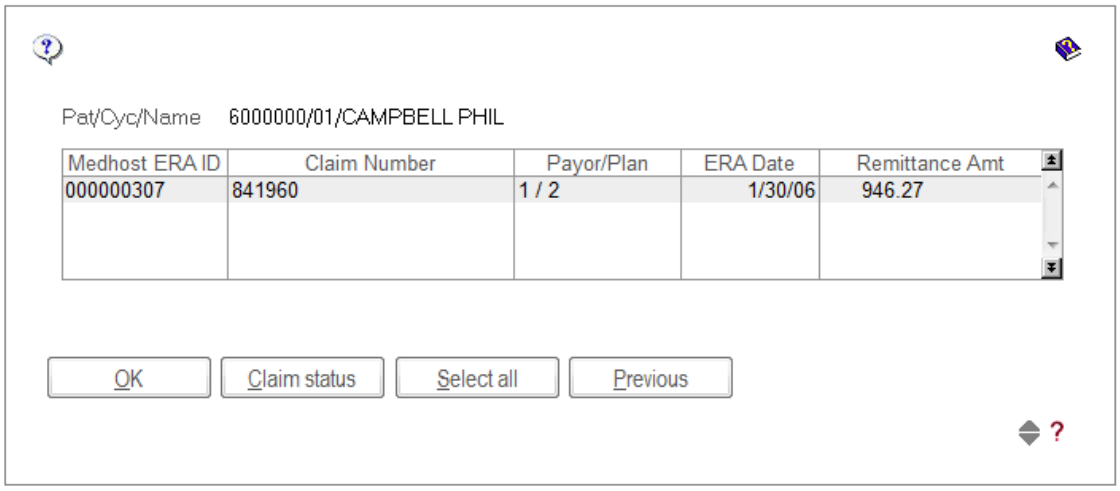
In both cases, a status window may appear briefly (#3 in the example on the previous page).

When the **Patient Cycle Selection** window reappears, select the patient's record and press (click on) the **OK** button. The **Claim Selection** window will open.

(Clicking **Previous** returns you to the initial **Select EOB** window without selecting a patient. Clicking **Exit** returns you to the *Electronic Remittance Advice Menu* without selecting a patient.)

SELECTING A PATIENT'S CLAIM

The **Explanation of Benefits–Patient/Cycle/Name** window opens after you select the patient's record from the **Patient Cycle Selection** window. This window lists all the selected patient's claims and lets you view the status of the claims and/or select the ones you want to print.



Action

To view the claims' status, click the **Claim Status** button. Status codes and their descriptions will be shown under each one (refer to the section, "Viewing the Claims' Status").

To hide the claims' status, click the **Claim Status** button again.

To print the EOBs for one claim, select it and then press (click on) the **OK** button. The **Include Detail Charges** window will open (see the section, "Specifying the EOB's Detail").

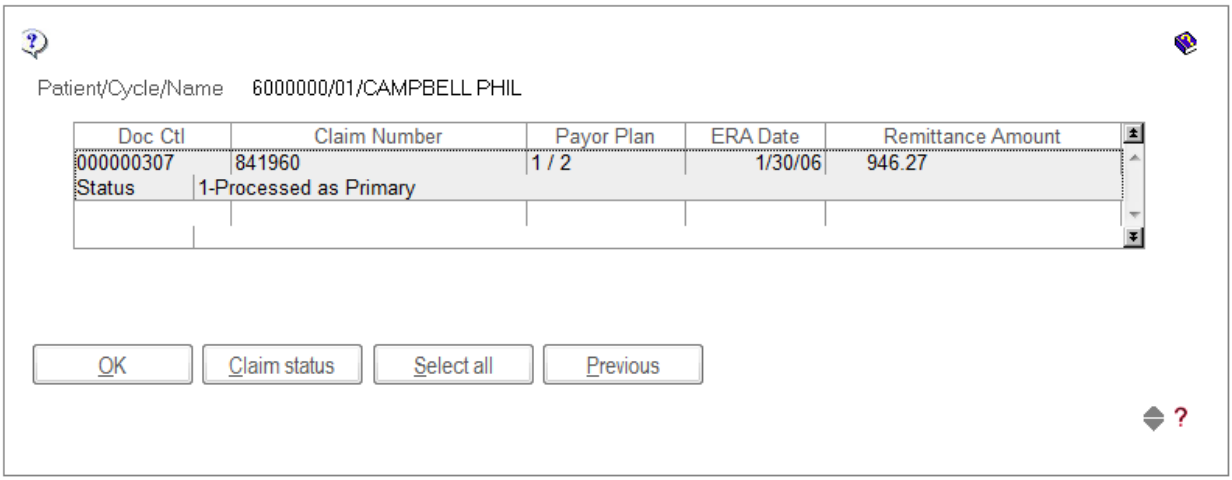
To print EOBs for all the claims, click the **Select All** button. The **Include Detail Charges** window will open (see the section, "Specifying the EOB's Detail").

VIEWING CLAIM STATUS

The claims list expands when you click the **Claim Status** button in the **Patient/Cycle/Name** window. The window lists all the patient's claims with each one's status shown on the line below it.

You can print while the status is displayed.

The status codes are described in the table on the next page.



Action

To hide the claims' status, click the **Claim Status** button.

To print the EOBs for one claim, select it and then press (click on) the **OK** button. The **Include Detail Charges** window will open (see the section, "Specifying the EOB's Detail").

To print EOBs for all the claims, click the **Select All** button. The **Include Detail Charges** window will open (see the section, "Specifying the EOB's Detail").

CLAIM STATUS CODES

STATUS	DESCRIPTION
1	Processed as Primary
2	Processed as Secondary
3	Processed as Tertiary
4	Denied
5	Pended
10	Received, but not in process
13	Suspended
15	Suspended - investigation with field
16	Suspended - return with material
17	Suspended - review pending
19	Processed as Primary, Forwarded to Additional Payer(s)
20	Processed as Secondary, Forwarded to Additional Payer(s)
21	Processed as Tertiary, Forwarded to Additional Payer(s)
22	Reversal of Previous Payment
23	Not Our Claim, Forwarded to Additional Payer(s)
25	Predetermination Pricing Only - No Payment
27	Reviewed

SPECIFYING THE EOB DETAIL

The Explanation of Benefits–Include Detail window appears after you select a sort method in the **Sort** window (if printing EOBs by Document Control Number) or when you select one or more claims in the **Patient Claim** window (if printing by Patient Number).

Action

To include individual (detail) charges on the EOBs, click **Yes**. Then click **OK**.

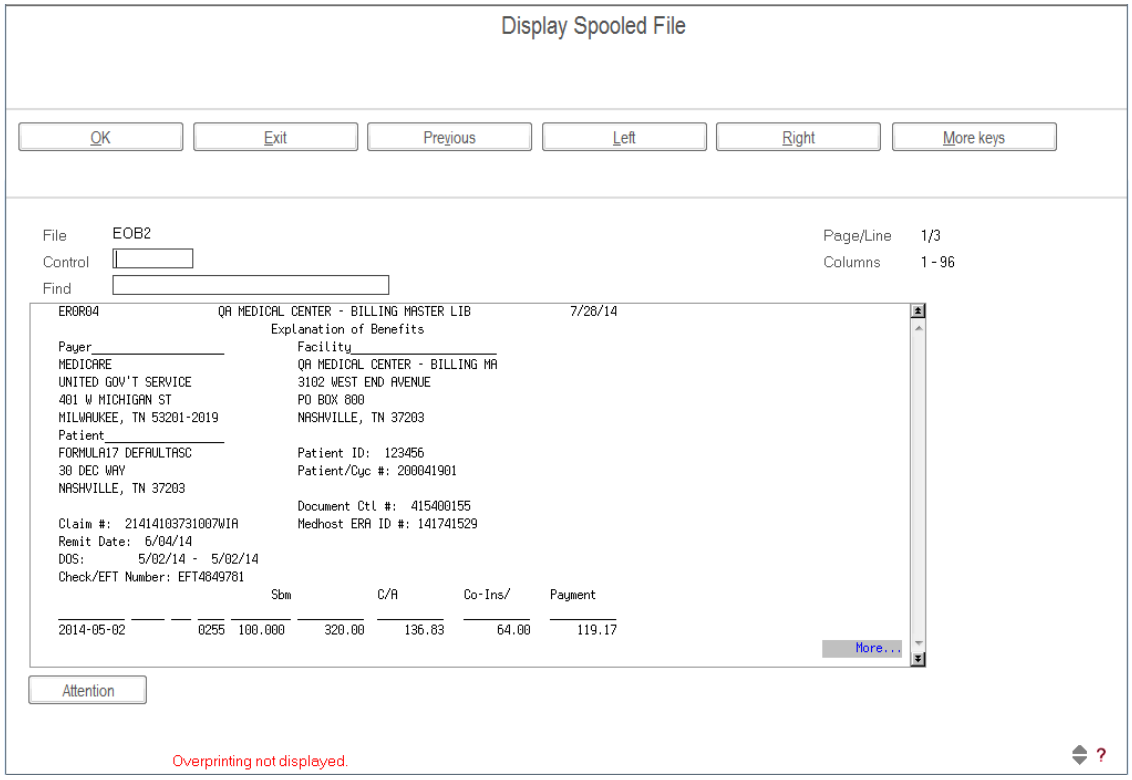
To include only totals for Submitted Charges, Contractual Adjustment Amount, Co-Insurance/Deductible Amount, and Payment Amount, click **No**. Then click **OK**.

The EOBs will first be displayed on-screen in the **Display Spooled File** window (refer to the section, "Reviewing the EOB before Printing"). Then you can send them to a printer if you wish.

(Clicking **Previous** returns you to the initial **Document Control Number** window; clicking **Exit** returns you to the *Electronic Remittance Advice Menu*.)

REVIEWING THE EOB BEFORE PRINTING

The Display Spooled File window appears when you select the level of detail and click **OK** in the **Include Detail Charges** window.



This window shows you the specified EOBs on-screen so you can decide whether to print them.

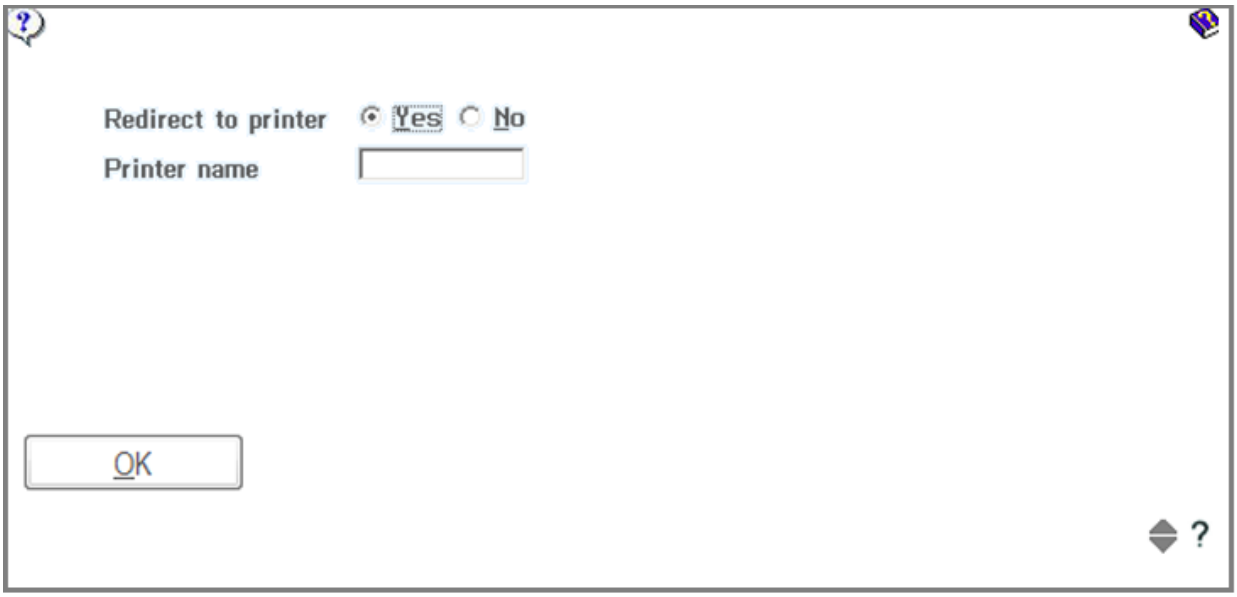
Action

To print the EOB, press **OK**. The **Redirect Print Output** window will open (refer to the section, "Printing the Explanation of Benefits").

To exit the program, press **Exit**. The **Redirect Print Output** window will open (refer to the section, "Printing the Explanation of Benefits").

PRINTING THE EXPLANATION OF BENEFITS

This window appears when you click **OK**, **Exit**, or **Previous** in the **Display Spooled File** window.



Action

To print the EOBs: Select **Yes** for Redirect to Printer, complete the Printer Name field, and then press (click on) the **OK** button.

To not print the EOBs: Select **No** for Redirect to Printer, leave the Printer Name field blank, and then press (click on) the **OK** button.
In both cases, you will return to the *Electronic Remittance Advice Menu*.

SAMPLE EOBS

With Detail charges

ER0R04 QA MEDICAL CENTER - BILLING MASTER LIB 7/28/14
Explanation of Benefits

Payer
MEDICARE - APC - CONTRACT
UNITED GOV'T SERVICE
401 W MICHIGAN ST
MILWAUKEE, WI 53201-2019
Patient
PIF89008 APRIL
28 JULY WAY
NASHVILLE, TN 37203

Facility
QA MEDICAL CENTER - BILLING MA
3102 WEST END AVENUE
PO BOX 800
NASHVILLE, TN 37203

Patient ID: 123456
Patient/Cyc #: 200058901

Document Ctl #:
Medhost ERA ID #: 415400155

Claim #: 21414303325607WIA
Remit Date: 6/04/14
DOS: 5/06/14 - 5/06/14
Check/EFT Number: EFT4849781

				Sbm		C/A	Co-Ins/	Payment
2014-05-06	96374		0260	0.000	234.60	0.00	0.00	0.00
2014-05-06	96374		0260	0.000	234.60	0.00	0.00	0.00
2014-05-06	36415		0300	0.000	21.70	0.00	0.00	0.00
2014-05-06	36415		0300	0.000	21.70	0.00	0.00	0.00
2014-05-06	80048		0301	0.000	64.50	0.00	0.00	0.00
2014-05-06	80048		0301	0.000	64.50	0.00	0.00	0.00
2014-05-06	83880		0301	0.000	152.30	0.00	0.00	0.00
2014-05-06	83880		0301	0.000	152.30	0.00	0.00	0.00
2014-05-06	84484		0301	0.000	102.35	0.00	0.00	0.00
2014-05-06	84484		0301	0.000	102.35	0.00	0.00	0.00
2014-05-06	85027		0305	0.000	48.90	0.00	0.00	0.00
2014-05-06	85027		0305	0.000	48.90	0.00	0.00	0.00
2014-05-06	71020		0324	0.000	182.05	0.00	0.00	0.00
2014-05-06	71020		0324	0.000	182.05	0.00	0.00	0.00
2014-05-06	99285		0450	0.000	870.15	0.00	0.00	0.00
2014-05-06	99285		0450	0.000	870.15	0.00	0.00	0.00
2014-05-06	J1940		0636	0.000	19.00	0.00	0.00	0.00
2014-05-06	J1940		0636	0.000	19.00	0.00	0.00	0.00
2014-05-06	93005		0730	0.000	65.20	0.00	0.00	0.00
2014-05-06	93005		0730	0.000	65.20	0.00	0.00	0.00
2014-05-06	99285		0981	0.000	436.95	0.00	0.00	0.00
2014-05-06	99285		0981	0.000	436.95	0.00	0.00	0.00
2014-05-06	93010	59	0985	0.000	76.15	0.00	0.00	0.00
2014-05-06	93010	59	0985	0.000	76.15	0.00	0.00	0.00
				Claim Totals:	2273.85	0.00	0.00	0.00

TOB : 850
Patient Stat : -
HIC Nbr : 330284966A
NonCov Days : 0
DRG : -
DRG Amt : 0.00
Cost Outlier : 0.00
Disp Share : 0.00
NonCov Chgs : 0.00
Cap FSP : 0.00
Denied : 0.00
Lab Paid : 0.00
ESRD : 0.00
MSP Prim Pay : 0.00
Pro Fees : 0.00
Med Ed : 0.00
Reim Rate : 0.000
Adj. Reason Codes : B9
Remarks: N211

Claim Status : 4
Claim Nbr : 21414303325607WI
Cov Days : 0
Cost Days : -
DRG Weight : -
Cap Outlier : 0.00
Day Outlier : 0.00
PPS Capital : 0.00
Cap DSH : 0.00
Cap HSP : 0.00
Lab Charged : 779.50
Blood Deduct : 0.00
Deductible : 0.00
Coinsurance : 0.00
IME Adj : 0.00
Per Diem : 0.58
Interest : 0.00

SAMPLE EOBS

Without Detail charges

```
ER0R04                  QA MEDICAL CENTER - BILLING MASTER LIB          7/28/14
                              Explanation of Benefits
Payer_____________________      Facility_____________________________
MEDICARE - APC - CONTRACT       QA MEDICAL CENTER - BILLING MA
UNITED GOV'T SERVICE            3102 WEST END AVENUE
401 W MICHIGAN ST               PO BOX 800
MILWAUKEE, WI 53201-2019        NASHVILLE, TN 37203
Patient___________________
PIF89008 APRIL                  Patient ID:  123456
28 JULY WAY                     Patient/Cyc #: 200058901
NASHVILLE, TN 37203
                                Document Ctl #:
Claim #:  21414303325607WIA     Medhost ERA ID #: 415400155
Remit Date:  6/04/14
DOS:        5/06/14 -  5/06/14
Check/EFT Number: EFT4849781
                        Sbm         C/A         Co-Ins      Deductible  Payment
                     __________  __________  __________  __________  __________
          Claim Totals:   2273.85        0.00        0.00        0.00        0.00
TOB          : 850              Claim Status : 4
Patient Stat : -                Claim Nbr    : 21414303325607WI
HIC Nbr      : 330284966A       Cov Days     : 0
NonCov Days  : 0                Cost Days    : -
DRG          : -                DRG Weight   : -
DRG Amt      : 0.00             Cap Outlier  : 0.00
Cost Outlier : 0.00             Day Outlier  : 0.00
Disp Share   : 0.00             PPS Capital  : 0.00
NonCov Chgs  : 0.00             Cap DSH      : 0.00
Cap FSP      : 0.00             Cap HSP      : 0.00
Denied       : 0.00             Lab Charged  : 0.00
Lab Paid     : 0.00             Blood Deduct : 0.00
ESRD         : 0.00             Deductible   : 0.00
MSP Prim Pay : 0.00             Coinsurance  : 0.00
Pro Fees     : 0.00             IME Adj      : 0.00
Med Ed       : 0.00             Per Diem     : 0.58
Reim Rate    : 0.000            Interest     : 0.00
Adj. Reason Codes  : B9
Remarks: N211
```

Error Messages

Overview:

When the electronic billing file is created in Create/Print EB Listing, Option 1 on the EB Main Menu, the file is tested for errors. If errors are found, an Electronic Billing Error List will print, listing the error messages. The electronic billing file cannot be transmitted until the necessary corrections are made.

This section lists those error messages in numerical order (they all begin with EB) and describes a cause for the error and an action that will correct the error. Error messages are shown in generic form. The message that actually prints might contain more specific information such as a patient number, revenue code, diagnosis code, etc.

Some duplicate message numbers with different message descriptions are listed. In other cases, similar or identical messages have different numbers, and are listed under each number.

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-001 **FEDERAL TAX I.D. NUMBER IS ZERO**

CAUSE: The federal tax ID number was not entered in the electronic billing record.

ACTION: Enter the federal tax ID number in Maintain EB System Control Record (Option 1, EB Maintenance Menu).

EB-001 **_____ TAX I.D. NUMBER IS MISSING**

CAUSE: The federal tax ID number was not entered in the electronic billing record.

ACTION: Enter the federal tax ID number in Maintain EB System Control Record (Option 1, EB Maintenance Menu).

EB-002 **PROVIDER NUMBER IS MISSING OR INVALID**

CAUSE: The provider number indicated was not entered in the system control file.

ACTION: Enter the provider number in Patient Accounting using Provider Type Code File (Option 10, File Maintenance Menu I).

EB-002 **_____ NUMBER IS MISSING**

CAUSE: The number indicated was not entered in the system control file.

ACTION: Enter the number in Patient Accounting using Provider Type Code File (Option 10, File Maintenance Menu I).

EB-002A **PROVIDER TAXONOMY CODE IS MISSING**

CAUSE: The provider taxonomy code is blank in the Provider Type Code file.

ACTION: Enter the provider taxonomy code in Patient Accounting using Provider Type Code File (Option 10, File Maintenance Menu I).

EB-002B **N.P.I. NUMBER IS MISSING**

CAUSE: The NPI number is blank in the Provider Type Code file.

ACTION: Enter the number in Patient Accounting using Provider Type Code File (Option 10, File Maintenance Menu I).

EB-003 **TYPE OF BILL IS ZERO OR INVALID**

CAUSE: Possible program error or entering error.

ACTION: Change the bill type through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-003 **TYPE OF BILL FREQUENCY MUST BE A 1,6,7 OR 8 ONLY**

CAUSE: Possible program error or entering error.

ACTION: Change the bill type through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-004 **SENDER CODE, PASSWORD, OR USER ID IS MISSING**

CAUSE: Sender code, password, or user ID is blank.

ACTION: Correct through Maintain EB System Control Record (Option 1, EB Maintenance Menu).

EB-004A **SUBMITTER'S CONTACT NAME IS MISSING**

CAUSE: The Cert name (certified personnel) is blank in the EB System Control Record. This is the contact person who is responsible for transmitting the bills.

ACTION: Correct through Maintain EB System Control Record (Option 1, EB Maintenance Menu).

EB-005 **PROVIDER NAME IS MISSING**

CAUSE: Hospital name was not entered in the system control file.

ACTION: Enter the hospital name in Patient Accounting using Hospital Name/Addr/ID# Record (Option 1, System Control Menu).

EB-006 **PROVIDER ADDRESS, CITY, STATE, OR ZIP CODE IS MISSING**

CAUSE: Hospital address, city, state, or zip code was not entered in the system control file.

ACTION: Enter the hospital address, city, state, or zip code in Patient Accounting using Hospital Name/Addr/ID# Record (Option 1, System Control Menu).

EB-007 PATIENT FIRST NAME OR LAST NAME IS MISSING
CAUSE: Patient's name does not appear in the patient history file. Possible program error.
ACTION: Contact Customer Support.

EB-008 PATIENT ADDRESS, CITY, STATE, OR ZIP CODE IS MISSING
CAUSE: Patient's address, city, state, or zip code does not appear in the patient history file. Possible program error.
ACTION: Contact Customer Support.

EB-009 STATEMENT COVERS PERIOD - FROM DATE IS ZEROS
CAUSE: Possible electronic billing program error.
ACTION: Contact Customer Support.

EB-010 STATEMENT COVERS PERIOD - THRU DATE IS ZEROS
CAUSE: Possible electronic billing program error.
ACTION: Contact Customer Support.

EB-011 FROM DATE NOT LESS THAN THRU DATE _____
CAUSE: Possible electronic billing program error.
ACTION: Contact Customer Support.

EB-012 PATIENT'S HISTORY NUMBER IS MISSING
CAUSE: Patient's history number is missing from the patient file.
ACTION: Contact Customer Support.

EB-013 _____ INSURANCE POLICY NUMBER IS MISSING OR INVALID
CAUSE: Policy number is missing or incorrect in the patient benefits file (BENEFITS).
ACTION: Enter or correct the policy number in Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-014 INSURANCE ELECTRONIC BILLING PLAN CODE IS MISSING
CAUSE: E/B plan code is missing from the Payor Plan file (INSPLAN).
ACTION: Enter the E/B plan code in Payor Plan File in Patient Accounting (Option 18, File Maintenance Menu I).

EB-015 _____ INSURANCE COMPANY NAME IS MISSING OR SHOULD BE
CAUSE: Insurance payor name is missing from the patient benefits file (BENEFITS) or the payor name code is missing from the Payor Plan file (INSPLAN).
ACTION: Enter the payor name code in Payor Plan File in Patient Accounting (Option 18, File Maintenance Menu I).

EB-016 _____INSURED'S FIRST OR LAST NAME IS MISSING/INVALID FORMAT
CAUSE: The insured's name was not found in the patient benefits file (BENEFITS).
ACTION: Enter the insured's name in Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-017 **INSURED'S SEX MUST BE "F" OR "M"**

CAUSE: The insured's sex code is invalid in the patient benefits file (BENEFITS).

ACTION: Enter the appropriate sex code for the insured in Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-018 **ACCOMODATION CODES ARE MISSING OR ZEROS**

CAUSE: An accommodation code was not found in the UB file for this patient. Possible billing program error.

ACTION: Enter an accommodation code through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-019 **ACCOMODATION RATES ARE MISSING OR ZEROS**

CAUSE: An accommodation rate was not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-020 **ANCILLARY CODES ARE MISSING OR ZEROS**

CAUSE: An ancillary code was not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-021 **ANCILLARY DATES ARE MISSING**

CAUSE: The charge dates were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-022 **ANCILLARY UNITS ARE MISSING**

CAUSE: The number of units were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-023 **ANCILLARY CHARGES ARE MISSING OR ZEROS**

CAUSE: Ancillary charges were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-024 **OUTPATIENT REVENUE CODES ARE MISSING OR ZEROS**

CAUSE: Outpatient revenue codes were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-025 **OUTPATIENT UNITS OF SERVICE ARE MISSING**

CAUSE: Outpatient units were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-026 OUTPATIENT DATES OF SERVICE ARE MISSING

CAUSE: Outpatient dates of service were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-027 ____ OUTPATIENT CHARGES ARE MISSING OR ZEROS

CAUSE: Outpatient charges were not found in the UB file for this patient. Possible billing program error.

ACTION: Contact Customer Support.

EB-028 PRINCIPLE PROCEDURE CODE IS MISSING

CAUSE: Principle procedure code was not found in the PATIENTS file.

ACTION: Enter the code in Patient Accounting using Enter Diagnosis (Option 12, Business Office Menu I) and enter the code in EB using EB Patient Maintenance (Option 7, Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-029 ATTENDING OR RENDERING PHYSICIAN'S TAXONOMY CODE IS MISSING

CAUSE: Attending or rendering physician's taxonomy code is not found in the physician's file.

ACTION: Enter the physician's taxonomy code in the Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-029 ATTENDING OR RENDERING PHYSICIAN'S N.P.I. OR TAX ID IS MISSING OR INVALID

CAUSE: Attending or rendering physician's NPI or federal tax ID number is not found in the physician's file.

ACTION: Enter the physician's NPI or taxonomy code in the Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-030 ATTENDING OR RENDERING PHYSICIAN'S FIRST NAME OR LAST NAME IS MISSING

CAUSE: Attending or rendering physician name is not in physician's record.

ACTION: Enter the physician's name in the Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-031 ATTENDING, PCP, ADMITTING, ORDERING, OR REFERRING/ OPERATING PHYSICIAN'S _____ #IS MISSING OR INVALID

CAUSE: Specified physician's UPIN number or license number is not found in the physician's file.

ACTION: Enter the physician's license/UPIN number in Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-031 ATTENDING, PCP, ADMITTING, ORDERING, OR REFERRING/ OPERATING PHYSICIAN'S N.P.I. IS MISSING OR INVALID

CAUSE: Specified physician's NPI number is not found in the physician's file.

ACTION: Enter the physician's NPI number in Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-031 **ATTENDING, PCP, ADMITTING, ORDERING, OR REFERRING PHYSICIAN'S TAX ID IS MISSING OR INVALID**

CAUSE: Specified physician's tax ID is not found in the physician's file.

ACTION: Enter the physician's tax ID in Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-031 **ATTENDING, PCP, ADMITTING, ORDERING, OR REFERRING PHYSICIAN'S TAXONOMY CODE IS MISSING**

CAUSE: Specified physician's taxonomy code is not found in the physician's file.

ACTION: Enter the physician's taxonomy code in the Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-032 **ADMITTING, ORDERING, ATTENDING, PCP, OR REFERRING/ OPERATING PHYSICIAN FIRST NAME OR LAST NAME IS MISSING**

CAUSE: Specified physician's first name or last name is not in physician's file.

ACTION: Enter the physician's name in Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-033 **PRO APPROVAL INDICATOR IS MISSING OR INVALID (CONDITION CODE "C1" – "C7")**

CAUSE: PRO approval indicator is blank or not a valid number.

ACTION: Enter a valid PRO approval indicator in Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-034 **____ REVENUE CODE REQUIRES A HCPCS/CPT OR CONDITION CODE**

CAUSE: The indicated revenue code requires a CPT or condition code.

ACTION: Enter a CPT code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-034 **MEDICARE OUTPATIENT SURGERY CHARGE REQUIRES A CPT CODE**

CAUSE: The indicated charge (revenue code) requires a CPT code.

ACTION: Enter a condition code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-035 **__ X _ REVENUE CODE NON-COVERED AMT IS GREATER THAN TOTAL CHARGE**

CAUSE: A revenue code contains a non-covered amount greater than the charge amount. Possible billing program error.

ACTION: Contact Customer Support.

EB-036 PRIMARY DIAGNOSIS CODE CANNOT BEGIN WITH AN "E"

CAUSE: The primary diagnosis code is a trauma code. Medicare does not accept trauma codes as the primary diagnosis.

ACTION: The should be corrected by the Medical Records department. To correct for this bill, change the code in EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-036 ADMITTING DIAGNOSIS BLANK OR INVALID

CAUSE: The admitting diagnosis code is missing or is invalid.

ACTION: The code should be corrected by the Medical Records department. To correct for this bill, change the code in EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-036 PRINCIPAL PROCEDURE CODE CANNOT BE BLANK

CAUSE: The principal procedure code is missing.

ACTION: The code should be corrected by the Medical Records department. To correct for this bill, change the code in EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-037 RECEIVER TYPE CODE IS MISSING OR INVALID

CAUSE: Receiver type code in header record of EB file is invalid.

ACTION: Contact Customer Support.

EB-038 EMPLOYER INFORMATION IS MISSING

CAUSE: Employer name, address, city, state or zip is missing.

ACTION: Correct through Patient Accounting using Patient Maintenance (Option 1, Business Office Menu I).

EB-039 _____ INSURANCE GROUP NUMBER AND/OR NAME IS MISSING OR INVALID

CAUSE: Group number or name is blank or invalid in the payor record.

ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-040 OCCURRENCE SPAN CODES AND/OR DATES ARE MISSING OR INVALID

CAUSE: Occurrence span codes/dates are not valid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-040 **BILL TYPE 21X OR 18X REQUIRES OCC. SPAN CODE 70 AND DATES**

CAUSE: Occurrence span codes/dates are not valid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-040 **OCCURRENCE CODE 21, 31, AND/OR 32 REQUIRES OCCURRENCE SPAN CODE 76**

CAUSE: Occurrence span codes/dates are not valid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-041 **REVENUE CODE IS INVALID FOR ELECTRONIC BILLING**

CAUSE: A revenue code exists in the EB file that is invalid for electronic bills processing.

ACTION: Cancel claim from electronic billing.

EB-041 **REVENUE CODE '54X' PRESENT FOR O/P DO NOT TRANSMIT**

CAUSE: A revenue code exists in the EB file that is invalid for electronic bills processing.

ACTION: Cancel claim from electronic billing.

EB-042 **_____ PROC CODE DATE ISN'T WITHIN STATEMENT DATES**

CAUSE: A procedure code date is not valid.

ACTION: Enter a valid date through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-043 **A REQUIRED OCCURRENCE CODE AND DATE IS MISSING OR INVALID**

CAUSE: An occurrence code and/or date is missing or invalid which is required.

ACTION: Enter a valid occurrence code and date through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-043 **IF DIAGNOSIS CODE 800-999, OCC CODE 01-06 OR 11 IS REQUIRED**

CAUSE: An occurrence code of 01-06 or 11 is required if the primary diagnosis code is 800-999.

ACTION: Enter a valid occurrence code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-043 **PHY THERAPY REQ OCC CODES 11 & 35 AND VAL CODE 50**

CAUSE: An occurrence code and value code are missing or invalid.

ACTION: Enter a valid occurrence code and value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-043 **IF NON-COVERED DAYS PRESENT, OCCURENCE CODE MUST BE PRESENT**

CAUSE: An occurrence code is missing or invalid.

ACTION: Enter a valid occurrence code and value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-043 **OCCURRENCE CODE __ DATE IS GREATER THAN STATEMENT FROM DATE**

CAUSE: An occurrence code is missing or invalid.

ACTION: Enter a valid occurrence code and value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-044 **REVENUE CODE CONTAINS INVALID CPT CODE**

CAUSE: The revenue code's CPT code is invalid.

ACTION: Enter a valid CPT code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-045 **EMPLOYMENT STATUS CODE IS MISSING OR INVALID**

CAUSE: The employment status code is invalid.

ACTION: Enter a valid code through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-046 **REVENUE CODE 38X REQUIRES BLOOD VALUE CODES (37 AND 38 OR 39)**

CAUSE: The indicated revenue code requires blood pints furnished.

ACTION: Enter the appropriate value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-046 **VALUE CODES 37-39 AMT MUST BE GREATER THAN OR EQUAL TO 1.00**

CAUSE: A required value code amount is missing or invalid.

ACTION: Enter the value code amount through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-047 **VALUE CODE OR VALUE AMOUNT IS MISSING OR INVALID**

CAUSE: A required value code and amount is missing or invalid.

ACTION: Enter the value code and amount through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-047 **___ REV CODE HAS MISSING VALUE CODE**

CAUSE: A required value code and amount is missing or invalid.

ACTION: Enter the value code and amount through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-048 **A REQUIRED VALUE CODE IS MISSING OR INVALID**

CAUSE: A value code is required and is missing or invalid.

ACTION: Enter the correct value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-048 **OCCURRENCE CODE __ REQUIRES VALUE CODE __**

CAUSE: A value code is required and is missing or invalid.

ACTION: Enter the correct value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-048 **__ VALUE CODE IS REQUIRED FOR REV CODE ___X & BILL TYPE __X**

CAUSE: A value code is required and is missing or invalid.

ACTION: Enter the correct value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-048 **VALUE CODE 24 IS MISSING**

CAUSE: A value code is required and is missing or invalid.

ACTION: Enter the correct value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-048 **OCCURRENCE CODE 01 REQUIRES OCCURRENCE CODE24, CONDITION CODE 08, OR VALUE CODE 12-16 OR 41-43.**

CAUSE: An occurrence code is required and is missing or invalid.

ACTION: Enter the correct occurrence code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-049 **__ CONDITION CODE IS INVALID**

CAUSE: A condition code is required and is missing or invalid.

ACTION: Enter the correct condition code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-049 **__X BILL TYPE REQUIRES A CONDITION CODE OF C1, C3, C4 OR C5**

CAUSE: A condition code is required and is missing or invalid.

ACTION: Enter the correct condition code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-049 **FOR BILL TYPE XX7 & XX8 A CLAIM CHANGE REASON CODE IS REQUIRED**

CAUSE: A claim change reason condition code is required and is missing or invalid.

ACTION: Enter the correct condition code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-050 **__ REVENUE CODE MUST BE NON-COVERED CHARGES**

CAUSE: The indicated revenue code requires non-covered charges.

ACTION: Enter the non-covered charges through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-051 **REVENUE CODE REQUIRES MOTHER AND BABY TO BE FILED TOGETHER**

CAUSE: The indicated revenue code requires that a mother and baby be filed together as one claim.

ACTION: Correct this error through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-052 VALUE CODE AMOUNT GREATER THAN OR EQUAL TO TOTAL CHARGES

CAUSE: The value code for the transaction has an amount the same or greater than the total charge.

ACTION: Correct this error through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-053 REFERRAL NUMBER FOR PCP IS MISSING

CAUSE: Patient's referral number for PCP is missing.

ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-054 PATIENT'S DATE OF BIRTH IS MISSING OR INVALID

CAUSE: Patient's birth date was not found in the PATIENTS file.

ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-055 PATIENT'S SEX CODE IS INVALID OR PATIENT'S SEX MUST BE "F", "M', OR "U"

CAUSE: Patient's sex code is missing or invalid.

ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-056 PATIENT'S DISCHARGE HOUR IS MISSING OR INVALID

CAUSE: Patient's discharge hour is missing or invalid in the PATIENTS file.

ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-057 PATIENT DISCHARGE STATUS IS MISSING OR INVALID

CAUSE: Patient's discharge status is missing or invalid in the PATIENTS file. Possible program error.

ACTION: Contact Customer Support.

EB-058 COVERED DAYS IS ZERO

CAUSE: Covered days were not found in the UB file.

ACTION: Enter covered days through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-058 **COVERED DAYS + NONCOVERED DAYS + COINSUR DAYS + LIFETIME DAYS DOES NOT EQUAL STATEMENT COVER PERIOD (THRU DATE – FROM DATE)**

CAUSE: Covered days amount is incorrect in the UB file.
ACTION: Enter covered days through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-058 **COVERED DAYS + NONCOVERED DAYS + COINSUR DAYS + LIFETIME DAYS DOES NOT EQUAL TOTAL OF ACCOMODATION REVENUE CODE(S) UNITS**

CAUSE: Covered days amount is incorrect in the UB file.
ACTION: Enter covered days through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-058 **COINSURANCE DAYS CANNOT BE GREATER THAN COVERED DAYS**

CAUSE: Covered days amount is incorrect in the UB file.
ACTION: Enter covered days through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-058 **VALUE CODE 09 OR 11 IS REQUIRED IF COINSURANCE DAYS ARE > 0**

CAUSE: Covered days amount is incorrect in the UB file.
ACTION: Enter covered days through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-059 **REVENUE CODE IS MISSING**

CAUSE: Revenue code was not found in UB file.
ACTION: Enter the revenue code through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-060 **TOTAL CHARGES ARE MISSING FOR REVENUE CODE**

CAUSE: Total charges were not found in the UB file.
ACTION: Contact Customer Support.

EB-060 **HCPCS CODE CHARGES ARE MISSING**

CAUSE: HCPCS code charges were not found in the UB file.
ACTION: Contact Customer Support.

EB-061 **RELEASE OF INFORMATION REQUIRED FOR MEDICARE**
CAUSE: Payor release of information is missing or invalid.
ACTION: Enter a valid release of information indicator through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-062 **ASSIGNMENT OF BENEFITS INDICATOR IS MISSING OR INVALID**
CAUSE: The assignment of benefits indicator is missing or invalid.
ACTION: Correct this error through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-063 **PRIMARY DIAGNOSIS CODE IS MISSING**
CAUSE: Primary diagnosis code was not found.
ACTION: Enter a primary diagnosis code in EB File Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-064 **PATIENT MARITAL STATUS IS MISSING OR INVALID**
CAUSE: The patient's marital status is not valid.
ACTION: Enter a valid code through Patient Maintenance (Option 1, Business Office Menu I).

EB-066 **REMARKS ARE REQUIRED**
CAUSE: The indicated patient requires remarks to be entered.
ACTION: Correct through Enter Remarks (Option 8, EB Main Menu).

EB-067 **PROCEDURE CODE ENTERED BUT NO SURGICAL PHYSICIAN**
CAUSE: Procedure code does not have an associated operating physician name, license, or UPIN number.
ACTION: Correct through Physician File (Option 16, File Maintenance Menu I).

EB-068 **SURGICAL PHYSICIAN ENTERED BUT NO PROCEDURE CODE**
CAUSE: Operating physician is not associated with a procedure code.
ACTION: Enter a procedure code through EB File Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-069 **TYPE OF ADMISSION IS INVALID**
CAUSE: Type of admission is missing or not valid.
ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-070 **SOURCE OF ADMISSION IS INVALID**
CAUSE: Source of admission is missing or invalid.
ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-071 **CLAIM MUST BE FILED ON PAPER**

CAUSE: This claim is invalid for electronic billing processing.

ACTION: Cancel claim through Cancel Electronic Bills (Option 6, EB Main Menu).

EB-072 **REVENUE CODE IS INVALID**

CAUSE: An invalid revenue code was entered.

ACTION: Enter a valid revenue code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-073 **___ IS A REVENUE CODE THAT REQUIRES UNITS**

CAUSE: Units are missing for a revenue code that requires units.

ACTION: Enter units through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-074 **___ IS AN INVALID CPT4/HCPCS CODE FOR RADIOLOGY CODE ___ OR REVENUE CODE ___**

CAUSE: A required HCPCS/CPT code is missing or invalid.

ACTION: Enter a valid CPT code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-074 **CPT CODE INVALID. CANNOT BE 99001 FOR LAB.**

CAUSE: A required HCPCS/CPT code is missing or invalid.

ACTION: Enter a valid CPT code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-074 **HCPCS CODE FOR CHARGE IS MISSING OR INVALID**

CAUSE: A required HCPCS/CPT code is missing or invalid.

ACTION: Enter a valid CPT code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-075 **_____ IS AN INVALID THRU/DISCHARGE DATE**
CAUSE: Discharge or final bill date is invalid. Possible program error.
ACTION: Contact Customer Support.

EB-075 **DISCHARGE DATE IS ZERO OR INVALID**
CAUSE: Discharge or final bill date is invalid. Possible program error.
ACTION: Contact Customer Support.

EB-076 **PROCEDURE CODE ENTERED BUT NO DATE**
CAUSE: Procedure code date is zeros.
ACTION: Enter the procedure code date through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-077 **PROCEDURE CODE DATE BUT NO PROCEDURE CODE**
CAUSE: Procedure code is missing.
ACTION: Enter the procedure code through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-078 **ADMITTING DIAGNOSIS CODE IS MISSING**
CAUSE: Admitting diagnosis code was not found.
ACTION: Correct through Enter Diagnosis in Patient Accounting (Option 12, Business Office Menu I).

EB-079 **OCCURRENCE CODE BUT NO OCCURRENCE DATE**
CAUSE: Occurrence code does not have a corresponding date.
ACTION: Enter the date through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-080 **OCCURRENCE DATE BUT NO OCCURRENCE CODE**
CAUSE: Occurrence date does not have a corresponding code.
ACTION: Correct error through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-081 **ACCOMMODATION RECORD IS MISSING**
CAUSE: Inpatient does not have an accommodation (room) record/revenue code. Possible program error.
ACTION: Contact Customer Support.

EB-082 PAYOR ID IS MISSING OR INVALID
CAUSE: Payor code is missing or not found.
ACTION: Enter the 5-digit payor code in Patient Accounting using Payor Master (Option 6 on the File Maintenance Menu I).

EB-083 PROVIDER TELEPHONE NUMBER IS MISSING
CAUSE: Hospital's telephone number is missing.
ACTION: Enter phone number in Patient Accounting using Hospital Name/Addr/ID# Record (Option 1, System Control Menu).

EB-084 COORDINATION OF BENEFITS IS MISSING
CAUSE: Coordination of benefits was not found in the patient benefits file (BENEFITS).
ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-085 REVENUE CODE MUST BE FILED ON PAPER
CAUSE: Revenue code not valid for electronic billing.
ACTION: Contact Customer Support.

EB-086 VALUE CODES OUT OF ORDER
CAUSE: Value codes must be in alpha/numerical order. Possible program error.
ACTION: Contact Customer Support.

EB-087 CONDITION CODES ARE OUT OF ORDER
CAUSE: Condition codes must be in alpha/numerical order. Possible program error.
ACTION: Contact Customer Support.

EB-088 OCCURRENCE CODES ARE OUT OF ORDER
CAUSE: Occurrence codes must be in alpha/numerical order. Possible program error.
ACTION: Contact Customer Support.

EB-089 GUARANTOR ADDRESS, CITY, STATE, OR ZIP CODE IS MISSING
CAUSE: Guarantor information was not found in the guarantor file.
ACTION: Correct through Patient Maintenance (Option 1, Business Office Menu I).

EB-090 GUARANTOR FIRST AND/OR LAST NAME IS MISSING
CAUSE: Guarantor name was not found.
ACTION: Correct through Patient Maintenance (Option 1, Business Office Menu I).

EB-091 **DIAGNOSIS DESCRIPTION IS REQUIRED FOR INPATIENTS**
CAUSE: Possible invalid diagnosis code.
ACTION: Enter a valid diagnosis code through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-092 **PHYSICAL RECORD COUNT(S) ARE INVALID**
CAUSE: The count of actual physical records are invalid.
ACTION: Contact Customer Support.

EB-093 **MORE THAN ONE SOURCE OF PAYMENT IS MEDICARE FOR THIS PATIENT**
CAUSE: Medicare cannot have more than one source of payment.
ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-094 **MSP PAYOR CODE IS INVALID**
CAUSE: A valid value code for payor primary to Medicare is missing.
ACTION: Enter a valid value code through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-095 **TYPE OF SERVICE IS MISSING OR INVALID**
CAUSE: Type of service code is missing or invalid.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-096 **PATIENT RELATIONSHIP IS NOT VALID**
CAUSE: Patient's relationship code is either missing or invalid.
ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-097 **INVALID TYPE OF BATCH**
CAUSE: Inpatient/outpatient flag is neither "I" nor "O".
ACTION: Contact Customer Support.

EB-098 **STATEMENT FROM AND THROUGH DATES ARE INVALID**
CAUSE: The date range is invalid.
ACTION: Contact Customer Support.

EB-099 **DESCRIPTION OF SERVICE IS MISSING**

CAUSE: Description of service is blank.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-100 **_____ PATIENT RELATIONSHIP CODE IS MISSING OR INVALID**

CAUSE: Patient's relationship code is either missing or invalid.

ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-100 **_____ PATIENT RELATIONSHIP CODE MUST BE SELF (PATIENT INSURED)**

CAUSE: Patient's relationship code is either missing or invalid.

ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-101 **ADMIT DATE IS ZERO OR INVALID**

CAUSE: Patient admission date is zero or invalid.

ACTION: Correct through Patient Maintenance (Option 1, Business Office Menu I) and (if patient is not a cycle bill) in EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-102 **ADMIT DATE IS GREATER THAN STATEMENT FROM DATE**

CAUSE: Admit date cannot be greater than statement from date.

ACTION: Contact Customer Support.

EB-103 **ACCIDENT HOUR IS MISSING OR INVALID**

CAUSE: Accident hour is required and is missing or invalid.

ACTION: Correct using Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-104 **REVENUE CODE REQUIRES A PROCEDURE CODE**

CAUSE: The indicated revenue code requires a procedure code.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-105 **BILL TYPE CANNOT BE TRANSMITTED**

CAUSE: Bill type is invalid for electronic billing.

ACTION: Cancel bill through Cancel Electronic Bills (Option 6, EB Main Menu).

EB-106 **UNITS MUST BE ZERO**
CAUSE: Units/quantity for this revenue code must equal zero.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-107 **TOTAL AMOUNT BILLED IS ZERO**
CAUSE: Total charges is zero. Possible program error.
ACTION: Contact Customer Support.

EB-108 **SERVICE FROM AND/OR THROUGH DATE IS MISSING**
CAUSE: Date of service was not found.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-108 **___ REV CODE SERVICE DATE IS NOT WITHIN STATEMENT DATES**
CAUSE: Date of service was not found.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-108 **HCPCS CODE SERVICE DATE IS MISSING OR GREATER THAN CURRENT DATE**
CAUSE: Date of service was not found or is invalid.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-109 **INVALID DIAGNOSIS CODE ___**
CAUSE: The indicated diagnosis code is invalid.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-109 **BILL TYPE 831 REQUIRES AN ICD-9-CM CODE**
CAUSE: The indicated diagnosis code is invalid.
ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).
Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-110 **___ PROCEDURE CODE INVALID**

CAUSE: The indicated procedure code is invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-110 **___ PROCEDURE CODE MUST NOT BE USED ON AN OUTPATIENT CLAIM**

CAUSE: The indicated procedure code is invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-110 **BILL TYPE 831 REQUIRES A SURGICAL PHYSICIAN CODE**

CAUSE: The indicated procedure code is invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-111 **ADMIT HOUR IS INVALID**

CAUSE: Patient admit hour is not valid.

ACTION: Correct through Patient Maintenance in Patient Accounting (Option 1, Business Office Menu I).

EB-112 **PLACE OF SERVICE CODE IS MISSING OR INVALID**

CAUSE: Place of service code is missing or invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-112 **HCPCS CODE PLACE OF SERVICE CODE IS MISSING OR INVALID**

CAUSE: Place of service code is missing or invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-113 **PROVIDER TYPE CODE IS MISSING**

CAUSE: Provider type code was not found in EB System Control record.

ACTION: Enter the provider code in EB System Control (Option 1, EB Maintenance Menu).

EB-114 **MEDICARE GROUP NAME CANNOT BE BLANK**

CAUSE: Group name is blank in the payor record.

ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-115 **NO INSURANCE FOUND FOR PATIENT - ENTER INSURANCE INFO OR CANCEL CLAIM**

CAUSE: Patient does not have any insurance information.

ACTION: Enter the insurance information in EB Patient Maintenance (Option 7, EB Maintenance Menu) or cancel the claim (Option 6, EB Main Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-115 **FOR BILL TYPE XX7, A REASON CODE MUST BE ENTERED IN REMARKS**

CAUSE: The indicated bill type requires a reason code to be entered as a remark.

ACTION: Correct through Enter remarks (Option 8, EB Main Menu).

EB-115 **FOR BILL TYPE 13X & 83X & REV CODE 54X REMARKS MUST BE ENTERED**

CAUSE: The indicated bill type and revenue code requires a remark.

ACTION: Correct through Enter Remarks (Option 8, EB Main Menu).

EB-115 **CPT CODE MODIFIER MUST BE "SH" OR "OC" FOR PHARMACY**

CAUSE: CPT code modifier is invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-116 **_____ INSURED DATE OF BIRTH IS MISSING OR INVALID**

CAUSE: The insured person's date of birth is missing or invalid for the primary, secondary, or tertiary payor (the word PRIMARY, SECONDARY, or TERTIARY will appear in the blank at the beginning of the message).

ACTION: Correct through Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-118 **INSURED'S ADDRESS, CITY, STATE, OR ZIP CODE IS MISSING**

CAUSE: Insured's name, address, city, state or zip is missing or entered incorrectly. For example, if the zip code is not left-justified, this error will be received.

ACTION: Correct through Patient Accounting using Patient Maintenance (Option 1, Business Office Menu I).

EB-119 OTHER PROCEDURE DATE BEFORE ADMIT DATE

CAUSE: Other procedure date is prior to the admit date.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-120 PRINCIPAL DIAGNOSIS HAS INCORRECT OCCURRENCE CODE

CAUSE: The principal diagnosis has a missing or invalid occurrence code.

ACTION: Enter a valid occurrence code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-121 GROUP NUMBER MISSING WHEN PLAN ROUTE CODE IS ZGA

CAUSE: Group number is blank or invalid.

ACTION: Correct through Patient Accounting using Payor Benefits Maintenance (Option 15, Business Office Menu I).

EB-122 ADMITTING PHYSICIAN'S LICENSE OR UPIN NUMBER IS MISSING

CAUSE: Admitting physician's license number or UPIN number is not found in the physician's file.

ACTION: Enter the physician's license number or UPIN number in the Physician file in Patient Accounting (Option 16, File Maintenance Menu I).

EB-123 EMERG PROC CODE REQ FOR TYPE OF BILL

CAUSE: The type of bill requires an emergency procedure code.

ACTION: Enter the procedure code through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-125 XX OCCURRENCE SPAN CODE IS INVALID

CAUSE: The Occurrence span codes is invalid.

ACTION: Correct through EB Patient Maintenance (Option 7, EB Maintenance Menu).

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

EB-128 RENDERING PHYSICIAN'S _____ # SHOULD BE USED

CAUSE: An incorrect physician's provider number is being used.

ACTION: The correct physician's provider number should be used for the payor plan in Locator 24K on the 1500.

EB-129 ATTENDING PHYSICIAN'S _____ # SHOULD BE USED
CAUSE: An incorrect physician's provider number is being used.
ACTION: The correct physician's provider number should be used for the payor plan in Locator 82 on the UB.

EB-130 LOCATION CODE IS MISSING
CAUSE: The location code is missing.
ACTION: Enter the Location Code in the Provider Type Code file. The Location Code field is specific to New York facilities.

EB-131 OPERATING PHYSICIANS' _____ # SHOULD BE USED
CAUSE: An incorrect physician's provider number is being used.
ACTION: The correct physician's provider number should be used for Locator 83 on the UB.

EB-133 AMBULANCE TRANSPORTATION CODE IS MISSING
CAUSE: A patient's claim has a revenue code of 054X for Ambulance Services and the Ambulance Transport Code has not been entered.
ACTION: Enter the code in Enter Remarks, Option 8 on the Electronic Billing Main Menu.

EB-134 AMBULANCE TRANSPORTATION REASON CODE IS MISSING
CAUSE: A patient's claim has a revenue code of 054X for Ambulance Services and the Reason for Ambulance Transportation has not been entered.
ACTION: Enter the code in Enter Remarks, Option 8 on the Electronic Billing Main Menu.

EB-135 AMBULANCE TRANSPORTATION DISTANCE IS ZERO
CAUSE: A patient's claim has a revenue code of 054X for Ambulance Services and the Transport Distance (in miles) has not been entered.
ACTION: Enter the distance in Enter Remarks, Option 8 on the Electronic Billing Main Menu.

EB-136 AMBULANCE CONDITION CODE IS MISSING
CAUSE: A patient's claim has a revenue code of 054X for Ambulance Services and an Ambulance Condition Code has not been entered.
ACTION: Enter the code(s) in Enter Remarks, Option 8 on the Electronic Billing Main Menu.

EB-138 INSURANCE TYPE INVALID FOR PAYOR
CAUSE: A patient's claim has an insurance type (in the payor plan) that is invalid for that claim.
ACTION: Contact Customer Support.

EB-150 LABORTORY/FACILITY NAME, ADDRESS, CITY, STATE, ZIP, ID IS MISSING
CAUSE: If a CPT modifier 90 through 99 is present, the outside lab information must be entered.
ACTION: Enter the information in the Outside Labs file in Patient Accounting (Option 22, System Control Menu).

EB-151 DOCTORS TAX ID NUMBER IS MISSING
CAUSE: The federal tax ID number was not entered in the electronic billing record.
ACTION: Enter the federal tax ID number in Maintain EB System Control Record (Option 1, EB Maintenance Menu).

EB-152 REQUIRED INFO INVALID IN ISA SEGMENT
CAUSE: Required information is invalid in the 837 ISA segment.
ACTION: Enter valid information through Maintain EB System Control Record (Option 1, Electronic Billing Maintenance Menu).

EB-153 REQUIRED INFO INVALID IN GS SEGMENT
CAUSE: Required information is invalid in the 837 GS segment.
ACTION: Enter valid information through Maintain EB System Control Record (Option 1, Electronic Billing Maintenance Menu).

EB-154 REQUIRED INFO MISSING IN REF SEGMENT
CAUSE: Required information is missing in the 837 REF segment.
ACTION: Enter the information through Maintain EB System Control Record (Option 1, Electronic Billing Maintenance Menu).

EB-155 REQUIRED INFO MISSING IN NM1 SEGMENT
CAUSE: Required information is missing in the 837 NM1 segment.
ACTION: Enter the information through Maintain EB System Control Record (Option 1, Electronic Billing Maintenance Menu).

EB-156 REQUIRED INFO MISSING IN PER SEGMENT
CAUSE: Required information is missing in the 837 PER segment.
ACTION: Enter the information through Maintain EB System Control Record (Option 1, Electronic Billing Maintenance Menu).

EB-157 REQUIRED INFO INVALID IN NM1 SEGMENT
CAUSE: Required information is invalid in the 837 NM1 segment.
ACTION: Enter valid information through Maintain EB System Control Record (Option 1, Electronic Billing Maintenance Menu).

EB-201 HOME HEALTH START OF CARE DATE IS MISSING
CAUSE: Start of care date was not found.
ACTION: Enter date in Maintain 485 Information (Option 5, Home Health Menu).

EB-202 HOME HEALTH CERTIFICATION FROM DATE IS MISSING
CAUSE: Certification from date was not found.
ACTION: Enter date in Maintain 485 Information (Option 5, Home Health Menu).

EB-203 HOME HEALTH CERTIFICATION THRU DATE IS MISSING
CAUSE: Certification through date was no found.
ACTION: Enter date in Maintain 485 Information (Option 5, Home Health Menu).

EB-204 HOME HEALTH PRIMARY DIAGNOSIS DATE IS MISSING
CAUSE: Primary diagnosis date was not found.
ACTION: Enter date in Maintain 485 Information (Option 5, Home Health Menu).

EB-205 HOME HEALTH SECONDARY DIAGNOSIS DATE IS MISSING
CAUSE: Secondary diagnosis date was not found.
ACTION: Enter date in Maintain 485 Information (Option 5, Home Health Menu).

EB-206 AT LEAST ONE FUNCTIONAL LIMITATION IS REQUIRED FOR HOME HEALTH
CAUSE: A functional limitation was not found.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-207 AT LEAST ONE ACTIVITIES PERMITTED IS REQUIRED IS HOME HEALTH
CAUSE: An activities permitted was not found.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-208 AT LEAST ONE MENTAL STATUS CODE IS REQUIRED FOR HOME HEALTH
CAUSE: A mental status was not found.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-209 HOME HEALTH PROGNOSIS IS REQUIRED
CAUSE: Prognosis was not found.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-210 PHYSICIAN FIRST OR LAST NAME IS MISSING FOR HOME HEALTH RECORD
CAUSE: Physician first and/or last name was not found.
ACTION: Correct through Physician maintenance (Option 16, File Maintenance Menu).

EB-211 PHYSICIAN ZIP CODE IS MISSING FOR HOME HEALTH RECORD
CAUSE: Physician zip code was not found.
ACTION: Correct through Physician maintenance (Option 16, File Maintenance Menu).

EB-212 HOME HEALTH MEDICARE COVERED MUST BE EITHER "Y" OR "N"
CAUSE: Medicare covered field is invalid.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-213 HOME HEALTH CERTIFICATION IS INVALID
CAUSE: Certification is invalid.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-214 HOME HEALTH SURGICAL PROCEDURE CODE WITHOUT DATE
CAUSE: Procedure code was entered without the date.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-215 HOME HEALTH SURGICAL PROCEDURE DATE WITHOUT CODE
CAUSE: Procedure date was entered without the code.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-216 HOME HEALTH DISCIPLINE IS REQUIRED
CAUSE: Discipline was not found.
ACTION: Correct through specific services/terms in Maintain 486 Information (Option 6, Home Health Menu).

EB-217 AT LEAST ONE FREQUENCY AND DURATION IS REQUIRED FOR HOME HEALTH
CAUSE: A frequency and duration was not found.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-218 AT LEAST ONE TREATMENT CODE IS REQUIRED FOR HOME HEALTH
CAUSE: A treatment code was not found.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-219 HOME HEALTH TOTAL VISITS PROJECTED CANNOT BE ZERO
CAUSE: Total visits projected equals zero.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-220 HOME HEALTH FORM 485 MEDICATIONS, NUTRITIONAL REQUIREMNTS, ORDERS FOR DISCIPLINES, OR GOALS/ REHABILITATION ELEMENT IS MISSING
CAUSE: The specified data element is required and is missing.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-221 HOME HEALTH FORM 485 DATA MISSING FOR
CAUSE: The specified element does not contain any data.
ACTION: Correct through Maintain 485 Information (Option 5, Home Health Menu).

EB-222 HOME HEALTH FREQUENCY NUMBER OR PERIOD IS INVALID
CAUSE: Frequency and duration contains an invalid number or period.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-223 HOME HEALTH TREATMENT CODE IS INVALID
CAUSE: The treatment code entered is invalid.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-224 HOME HEALTH DISCIPLINE INFORMATION IS MISSING
CAUSE: No discipline/frequency and duration/treatment codes have been entered.
ACTION: Correct through specific services/terms in Maintain 486 Information (Option 6, Home Health Menu).

EB-225 HOME HEALTH FORM 486 UPDATED INFORMATION, FUNCTIONAL LIMITATIONS, OR PATIENT LEAVES HOME ELEMENT IS MISSING
CAUSE: The specified data element is required and is missing.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-226 HOME HEALTH FORM 486 DATA MISSING FOR
CAUSE: The specified element does not contain any data.
ACTION: Correct through Maintain 486 Information (Option 6, Home Health Menu).

EB-227 PAYOR ORGANIZATION CODE IS MISSING
CAUSE: The NAIC number for the payor is blank or invalid.
ACTION: Enter or correct the NAIC number in Patient Accounting in the Payor master file (Option 6, File Maintenance Menu I).

EB-228 HOME HEALTH SKILLED NURSING FACILITY MUST BE "N", "Y", OR "U'
CAUSE: The skilled nursing facility code is missing.
ACTION: Enter through Maintain 486 Information (Option 6, Home Health Menu).

EB-229 HOME HEALTH FACILITY TYPE CODE IS MISSING OR INVALID
CAUSE: The facility code is missing.
ACTION: Enter through Maintain 486 Information (Option 6, Home Health Menu).

Electronic Remittance Advice Error Messages

Overview:

When the electronic remittance advice (ERA) is received in Received Electronic R/A, Option 1 on the Electronic Remittance Advice Menu, the file is tested for errors. If errors are found, an Error Report generates.

This section lists those error messages in numerical order (they all begin with ER) and describes a cause for the error and an action that will correct the error. Error messages are shown in generic form. The message that prints might contain more specific information.

Some duplicate message numbers with different message descriptions are listed. In other cases, similar or identical messages have different numbers, and are listed under each number. Read the message carefully.

Any corrections made using EB Patient Maintenance only corrects the claim for electronic processing. Corrections should also be made through Patient Accounting to avoid future errors.

ER-001 PAYMENT TRAN CODE OR CONTR ADJ CODE IS INVALID

CAUSE: The transaction code received is not a valid code in the A/R Transaction Codes file (ARDESC).

ACTION: Verify the transaction codes on the patient's account with the codes in the A/R Transaction Codes file, Option 3 on the File Maintenance Menu I.

ER-002 CLAIM WILL BE OR IS A BAD DEBT WRITE OFF

CAUSE: The account and cycle from the received ERA file was found in the ARTRNDTL file (Cash Receipts Transaction Detail file) with a transaction type of B=Bad Debt write off. This would also happen if a payment or adjustments hits an account the same day that the account is written off to bad debt but has not been posted yet.

ACTION: Contact MEDHOST Customer Support.

ER-003 INSURANCE COMPANY AND/OR PLAN IS MISSING

CAUSE: Account is missing an insurance company or plan. This could happen if the payor is sending the ERA file with accounts that are not MEDHOST accounts.

This error would also be generated if the Insurance type of the ERA file being processed did not match the insurance type associated with the account's payor plan(s).

ACTION: Contact MEDHOST Customer Support.

ER-004 PATIENT/CYCLE NUMBER IS ZERO OR NOT FOUND.

ER-004 PATIENT/CYCLE NUMBER IS NOT VALID.

CAUSE: The patient and cycle number are not found in our files. The ERA file has patient and cycle number that is not matching a patient and cycle number in MEDHOST accounts.

ACTION: Contact MEDHOST Customer Support.

ER-005 CLAIM STATUS=4 (THE ENTIRE CLAIM WAS DENIED.)

CAUSE: The claim status code is 4 which indicates the entire claim is denied.

ACTION: Review claim remarks for resolution.

ER-006 INSUR CO/PLAN NOT (INS. TYPE NOT " ")

CAUSE: The insurance type (payor) of the ERA Intermediary code being processed does not match the insurance type of the account's payor plan.

ACTION: Confirm the ERA file was processed under the correct ERA intermediary code.

ER-007 PATIENT# WAS NOT FOUND IN PATIENTS OR ARMAST FILES

CAUSE: The patient number are not found in our files. The ERA file has patient number that is not matching a patient number in MEDHOST accounts.

ACTION: Contact MEDHOST Customer Support.

ER-008 CLAIM STATUS=13 (THE ENTIRE CLAIM WAS PENDED)

CAUSE: The claim status code is 13 which indicates the entire claim is pending.

ACTION: Contact MEDHOST Customer Support.

ER-009 CLAIM STATUS=10 (CLAIM RECEIVED, BUT NOT IN PROCESS)

CAUSE: The claim status code is 10 which indicates the claim was received in the ERA file but has not yet been processed.

ACTION: Contact MEDHOST Customer Support.

ER-010 PROV#/NPI INS. TYPE MISSING (PLEASE CONTACT HMS)

CAUSE: The patient's account is missing an insurance type for the provider number/NPI retrieved from the ERA file.

Intermediaries have changed the Medicare 835 ERA file to NPI only. This has caused ERA's to be processed with a zero transaction code.

ACTION: Contact MEDHOST Customer Support.

ER-011 AR TRANSACTION CODE IS INACTIVE

CAUSE: The transaction code received is not a valid code in the A/R Transaction Codes file (ARDESC).

ACTION: Verify the transaction codes on the patient's account with the codes in the A/R Transaction Codes file, Option 3 on the File Maintenance Menu I in Patient Accounting.

ER-012 CLM STATUS SETTINGS DO NOT MATCH PATIENT PAYOR PLAN.

CAUSE: The insurance type on the received ERA does not match the patient's payor plan.

Here is an example scenario that would produce this error message.

The Electronic Remittance Advice System Control (Remittance Advice Menu, Option 4) has the following settings:

Allow Secondary C/A by Claim Status = Y
Claim Status Codes = 2 (Processed as Secondary)

An ERA comes in for an account that shows secondary with a claim status of 2, but the insurance on the ERA is not the same insurance type as the actual secondary insurance listed on the account.

ACTION: Verify the patient's payor plan. Be sure the correct payor plan with the appropriate insurance type is assigned to the patient.

Appendix A: Transmitting Using a PC

Overview:

This process is used by facilities which use a PC in transmitting their electronic bills.

These facilities must purchase Procomm Plus and send MEDHOST the registration card for license verification. MEDHOST will change the Procomm Plus program to automate the process and send the program to the client. These facilities must also have PC Support installed.

Below is a summary of steps for transmitting electronic bills using a PC.

Process	System
1. Create/print listing (Option 1, EB Main Menu).	MEDHOST
2. Correct any errors on the report to get the file ready to transmit.	MEDHOST
3. Download the file EBXMIT2 using PCS(TRANSFER DATA – HOST TO PC).	PC Support
4. Access Procomm Plus from the menu or type **PCPLUS** from the PCPLUS directory.	Procomm Plus
5. Transmit Electronic Bills to EDS (Option 1, Procomm Plus Menu). This option will dial the intermediary, connect, transmit the file, and disconnect from the intermediary.	Procomm Plus
6. Wait 15 to 30 minutes.	
7. Receive Audit Report EDS (Option 2, Procomm Plus Menu). This option will dial the intermediary, connect, receive the file, and disconnect from the intermediary.	Procomm Plus
8. After reports have been received, upload the reports to the AS/400 using PCS(TRANSFER DATA – PC TO HOST).	PC Support
9. Receive audit reports (Option 9, EB Main Menu).	MEDHOST

Appendix B: 837P Billing/Pay-To Loops by PA1500 Setup

Overview:

Appendix B contains examples of how the 837P Loop 2010AA (Billing Provider) and/or Loop 2010AB (Pay-To Provider) segments will look, based on the information provided in Locators 33 and 33A. The information supplied in the REF segments depends on the particular number/entry selected for 33 and/or 33A.

Each example includes a window image (screen shot) of the setup, followed by the segments that result from that setup.

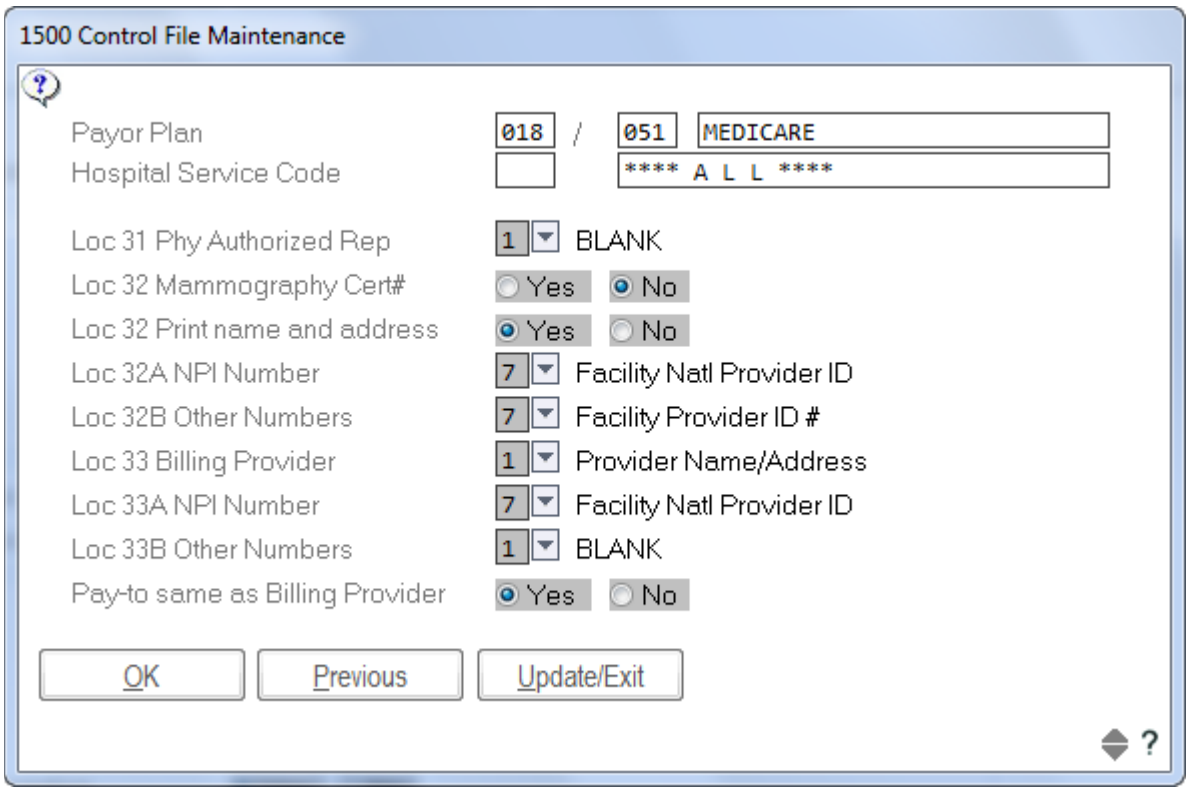
The table below shows which Locator entries are used in each example.

All examples use the same information in the following fields:

Payor Plan	Medicare
Hospital Service Code	All
Loc 31 Phy Authorized Rep	Blank
Loc 32 Mammography Cert#	No
Loc 32 Print name and address	Yes

Example	Locator 33 Billing Provider	Locator 33A NPI Number	Pay-to same as Billing Provider
Example 1	Provider name and address	Facility/ National Provider ID	Yes
Example 2	Provider name and address	Facility/ National Provider ID	No **Pay-to Provider** – Performing Physician Address **Pay-to Number** – Performing Physician National Provider ID
Example 3	Performing Physician Address	Performing Physician National Provider ID	Yes
Example 4	Performing Physician Address	Performing Physician National Provider ID	**Pay-to Provider** – Provider Name/Address **Pay-to Number** – Performing Physician National Provider ID No

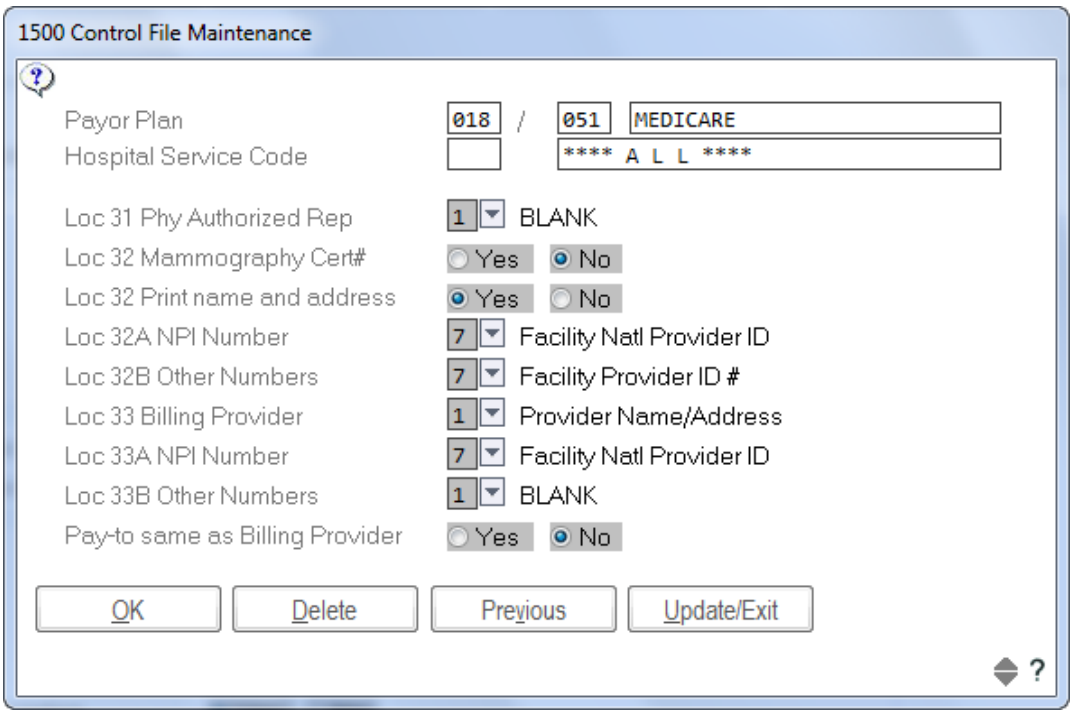
Example 1

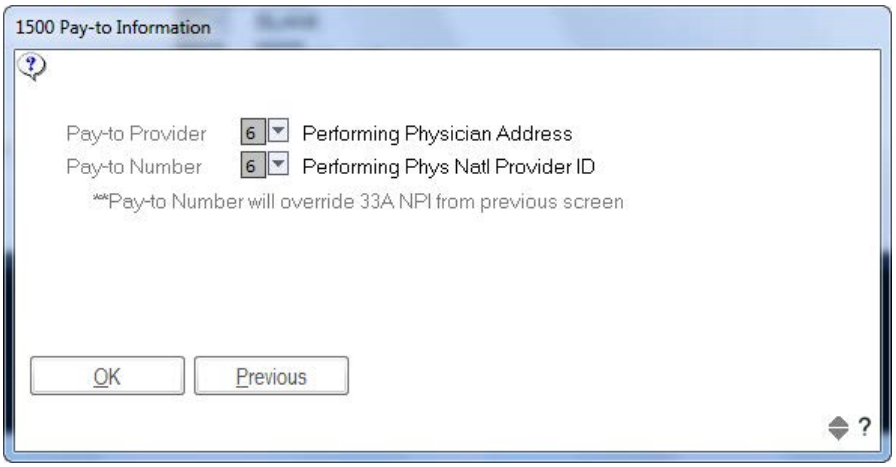


5010 format

HL*5**20*1~
NM1*85*2*SENKBEILS MEDICAL CENTER*****XX*NPIPROV001~
N3*14 WEST ENDOFTHERAINBOW A~
N4*NASHVILLE*TN*372111111~
REF*EI*FEDID00001~

Example 2

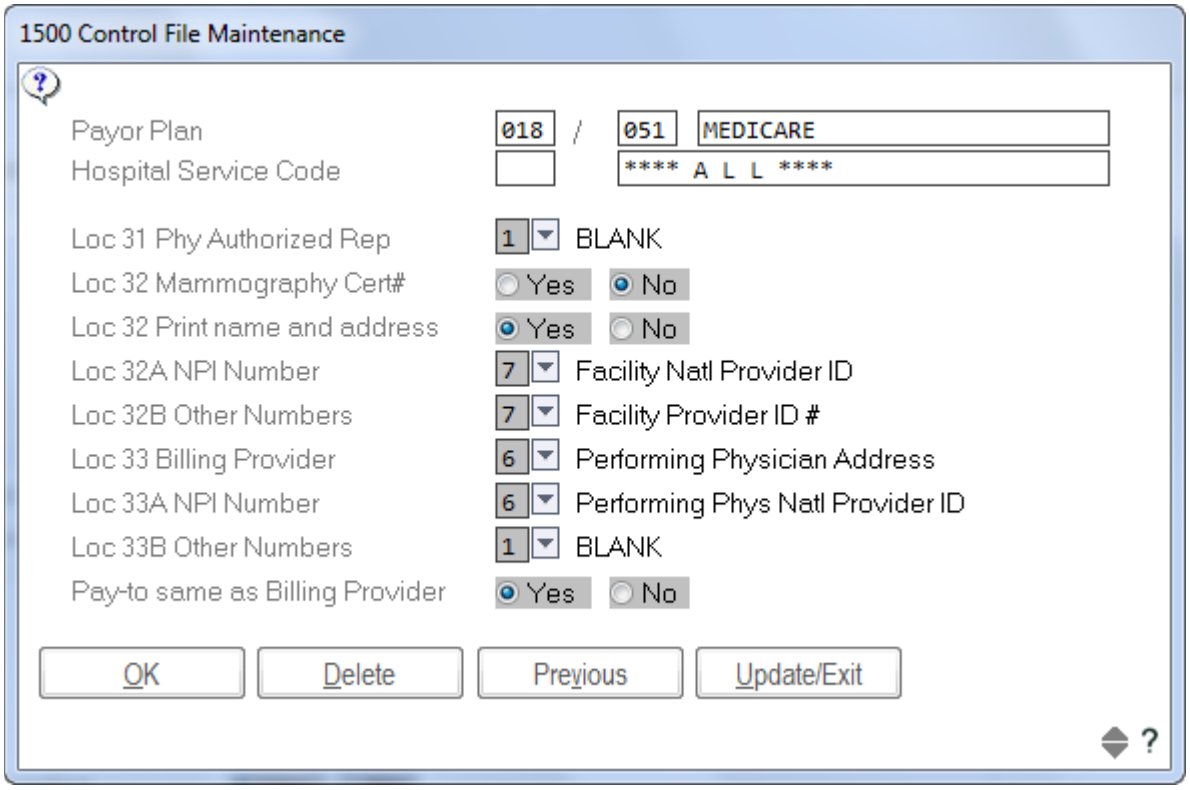




5010 format

HL*5**20*1~
NM1*85*2*SENKBEILS MEDICAL CENTER*****XX*NPIPROV001~
N3*14 WEST ENDOFTHERAINBOW A~
N4*NASHVILLE*TN*372111111~
REF*EI*FEDID00001~
NM1*87*1~
N3*3102 JANE ROGERS ADDRESS~
N4*NASHVILLE*TN*37203~

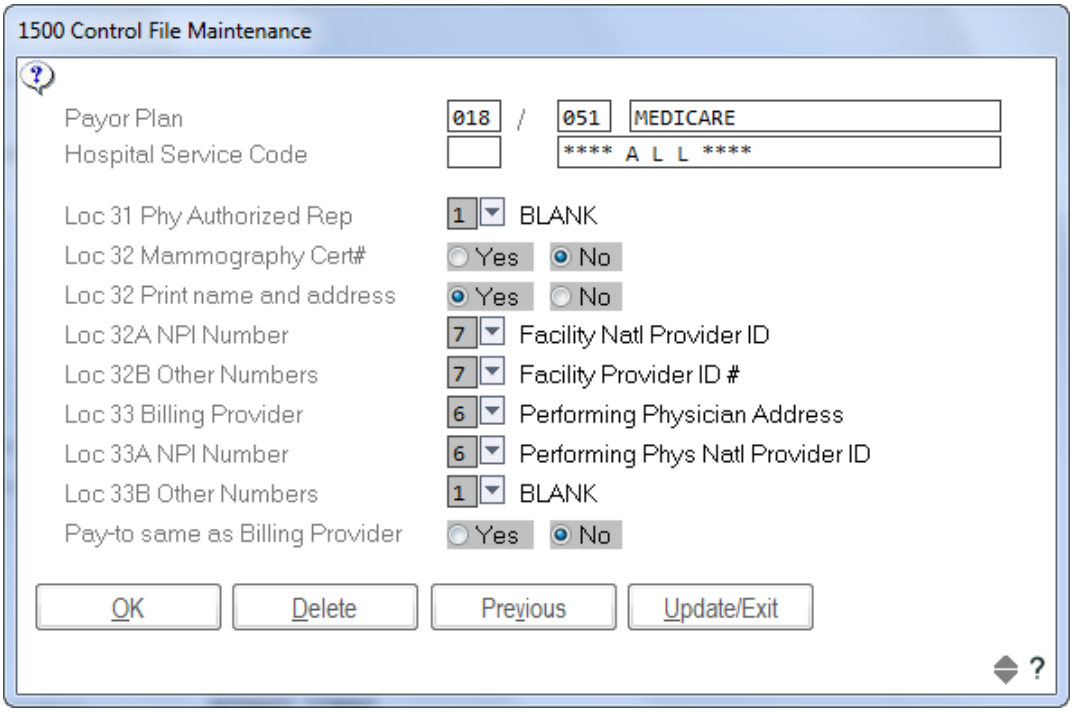
Example 3

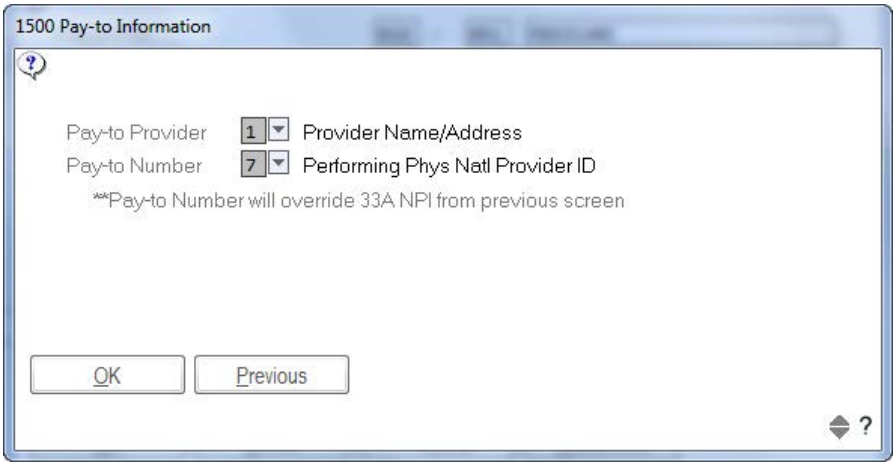


5010 format

HL*5**20*1~
PRV*BI*PXC*2084P0804X~
NM1*85*1*ROGERSLASTNA*JANEFIRSTNAM****XX*NPI0001024~
N3*3102 JANE ROGERS ADDRESS~
N4*NASHVILLE*TN*37203~
REF*EI*FEDID00001~

Example 4





5010 format

HL*5**20*1~
PRV*BI*PXC*2084P0804X~
NM1*85*1*ROGERSLASTNA*JANEFIRSTNAM****XX*NPI0001024~
N3*3102 JANE ROGERS ADDRESS~
N4*NASHVILLE*TN*37203~
REF*EI*FEDID00001~
NM1*87*2~
N3*14 WEST ENDOFTHERAINBOW A~
N4*NASHVILLE*TN*372111111~

Appendix C: MEDHOST-Supported EB Intermediaries

This appendix contains the current list of Electronic Billing intermediaries that are supported by MEDHOST.

MEDHOST-Supported Electronic Billing Intermediaries October 24, 2012

Intermediary	BlueCross UB	Medicare UB	Medicaid UB	Commercial UB	BlueCross 1500	Medicare 1500	Medicaid 1500	Commercial 1500
EB 837 SUBSET	X	X	X	X	X	X	X	X

Appendix D: 5010 Configuration for 270/271 and 837

Overview:

This appendix explains how to configure the Version 5010 format for insurance eligibility (270/271) and 837 subset and how to test the Version 5010 format.

Configuration requires updating one or more settings in the *Vendor Maintenance* option (*Health Plan Transactions Menu, Option 10*) and the *Maintain EB System Control Record* option (*Electronic Billing Maintenance Menu, Option 1*). The process is described in the section *Version 5010 Configuration.*

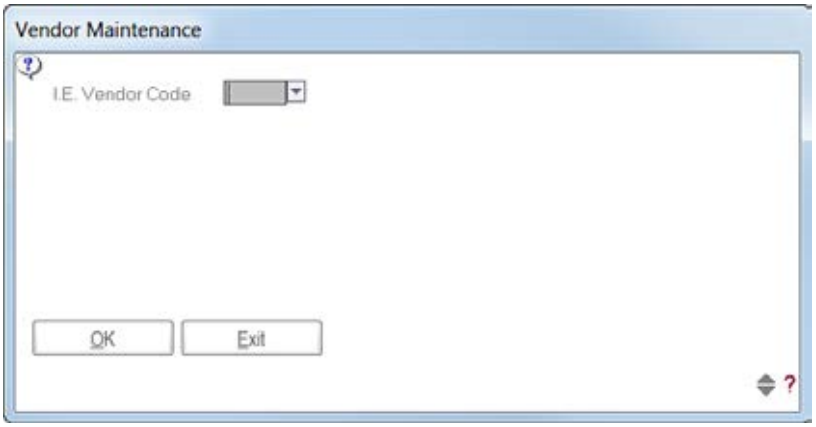
Testing the format is done at any time after you have finished electronic billing for the day, as explained in the section *Testing the 5010 Format.*

Note: MEDHOST recommends that you perform the 5010 format testing in a training library.

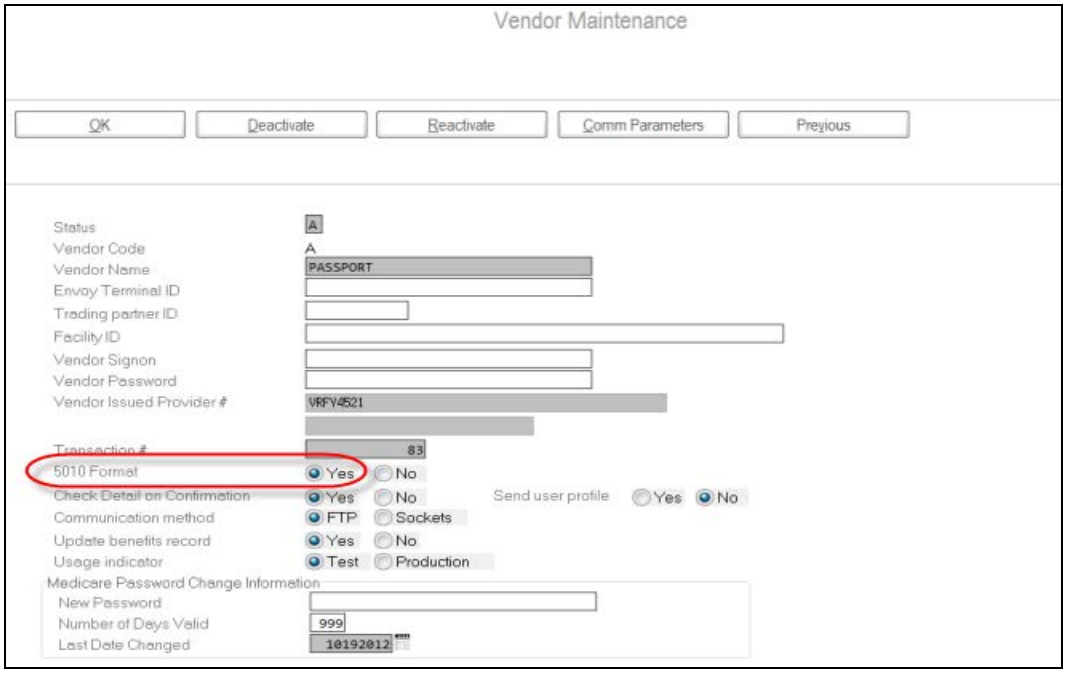
VERSION 5010 CONFIGURATION

Insurance Eligibility

1. Select the *Vendor Maintenance* option (see *Health Plan Transactions Menu, Option 10*) so you can set the format to Version 5010. The **Intermediary Code** search dialog will open.



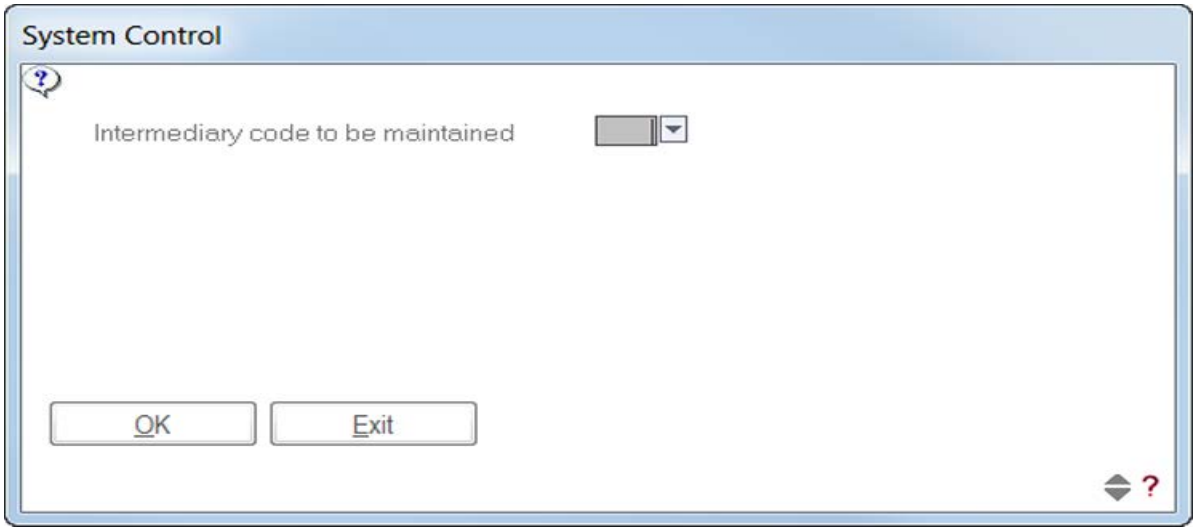
2. Select or search for the appropriate code and press the **OK** button. The **Vendor Maintenance** screen will open.



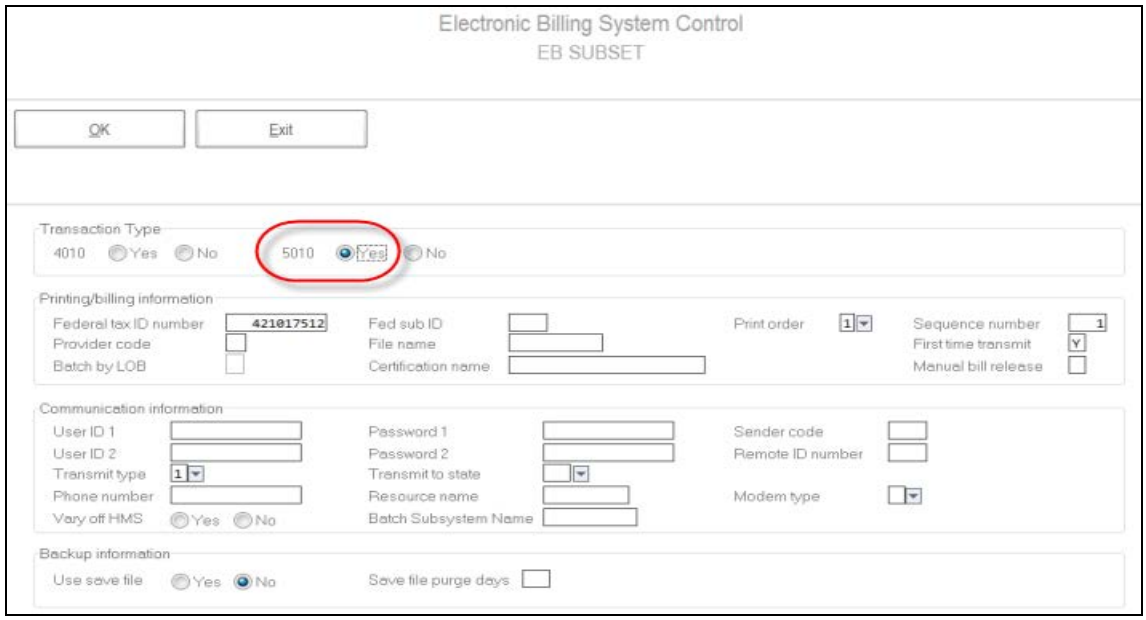
3. Select **Yes** for the 5010 Format item and press **OK** to exit.

Electronic Billing

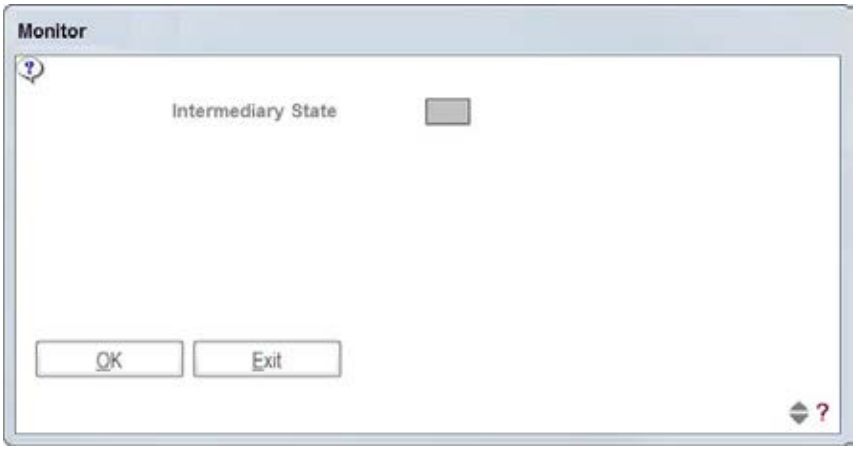
1. Select the *Maintain EB System Control Record* option (see *Electronic Billing Maintenance Menu, Option 1*) so you can update the transaction type and 837 subset headers for Version 5010.



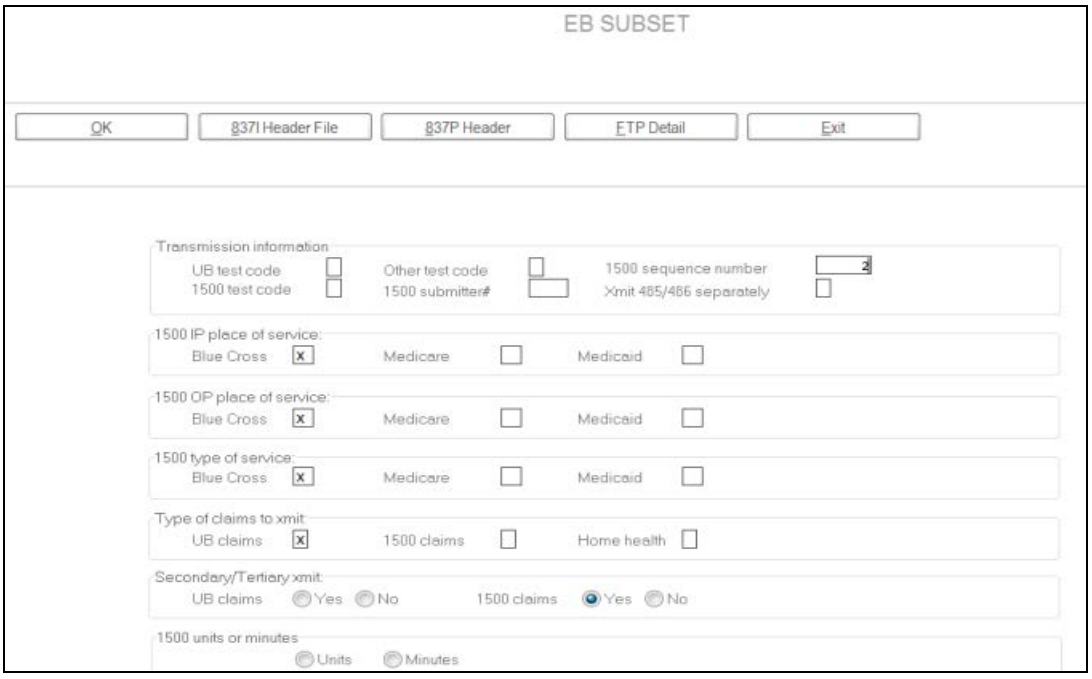
2. When the **Intermediary Code** search dialog opens, select your intermediary code and press the **OK** button.



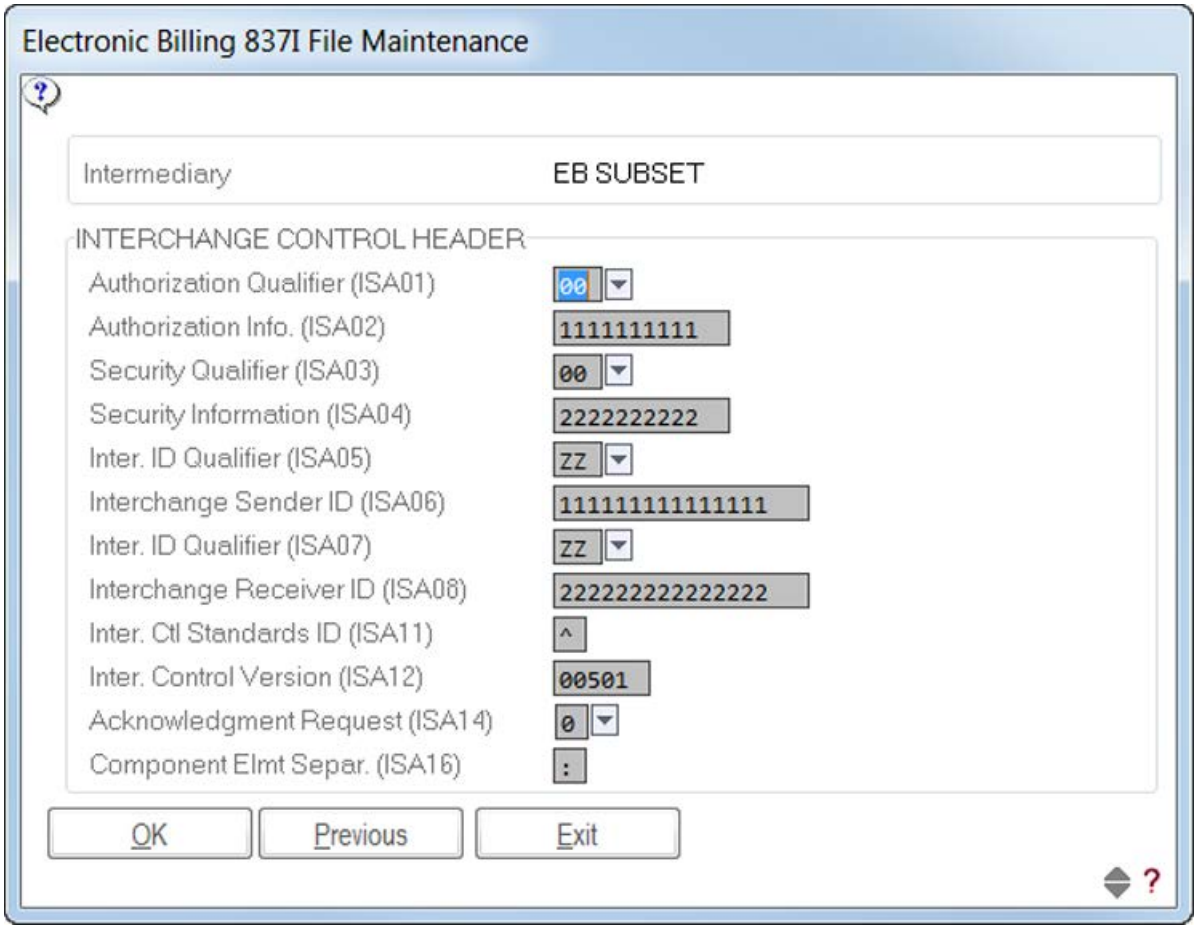
3. In the Transaction Type section, select **No** for 4010 and **Yes** for 5010. Then press the **OK** button. The **Intermediary State** search box will open.



4. Press the **OK** button (if necessary, enter your Intermediary State first). The **EB 837 Subset–Transmission Information** screen will open with buttons for the 837I Header File and the 837P Header.



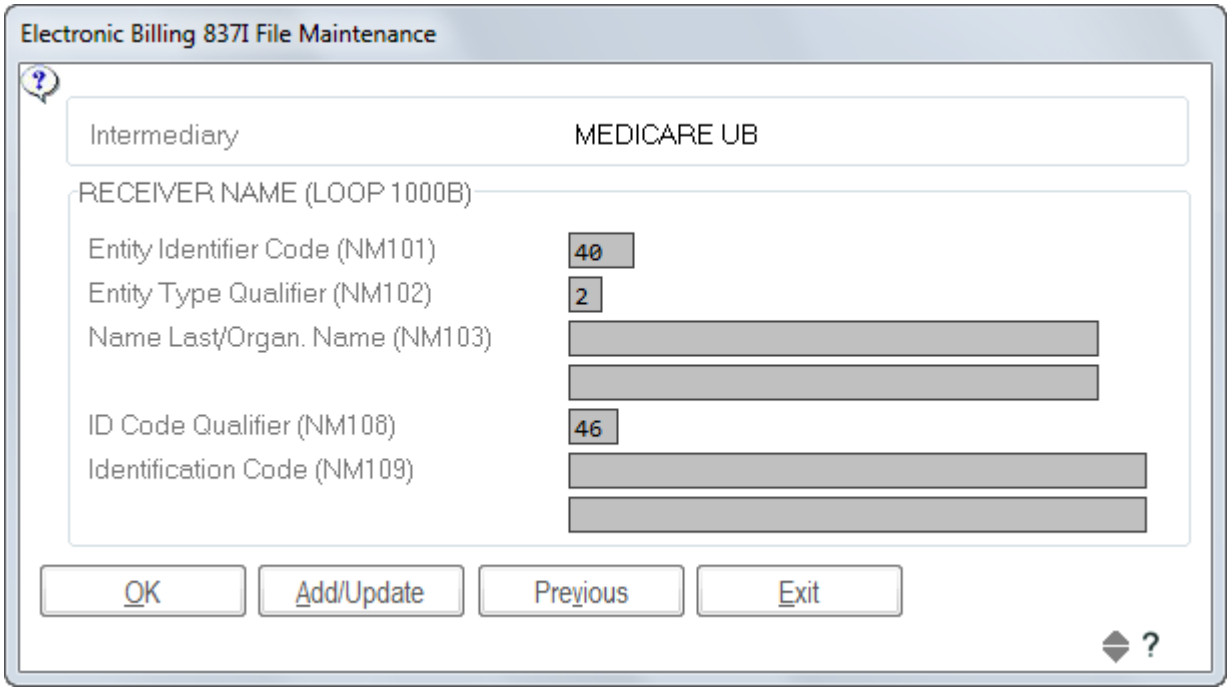
5. Press the **837I Header File** button. The **Interchange Control Header** screen opens. This is the first of five header screens.



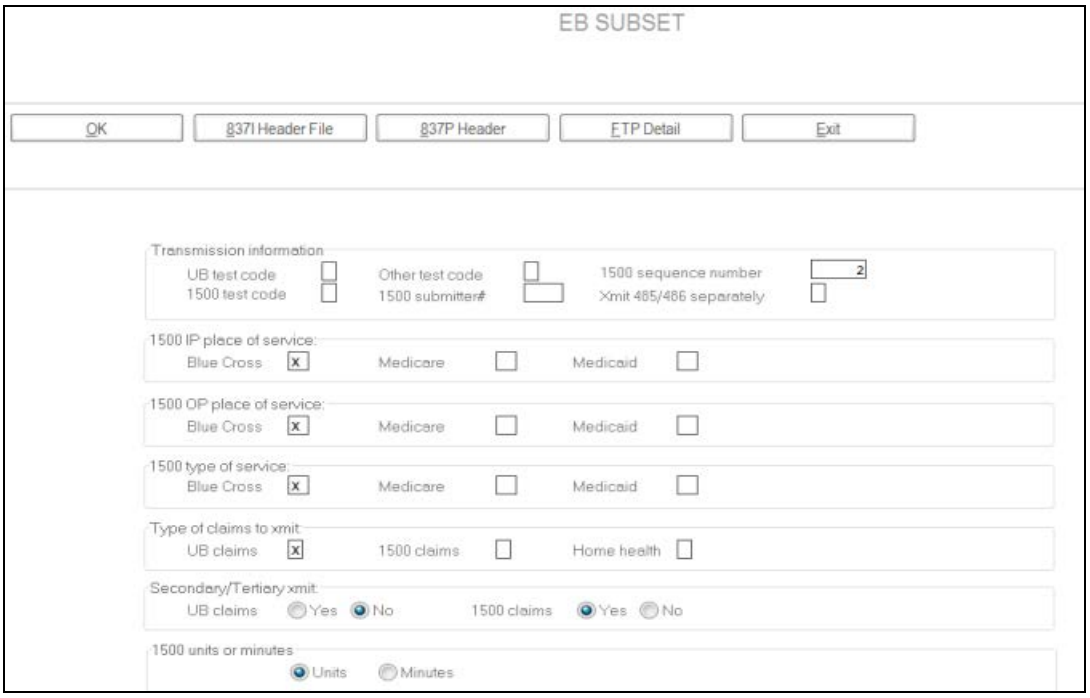
6. Verify that the screen values are the same as the ones shown above. Then press the **OK** button. A message will appear at the bottom of the screen if any settings need to be changed.

7. To save any changes to the settings, page through the header screens by pressing **OK** for each one, until you reach the **RECEIVER NAME** screen.

   Note: As you press **OK** at each screen, a message at the bottom of the screen will give you the correct values if a setting needs to be changed.



8. At the **RECEIVER NAME** screen, press on the **Add/Update** button. You will return to the **EB 837 Subset–Transmission Information** screen, which has the buttons for the 837I and 837P headers.



9. Press the **837P Header** button and repeat the process used to update the 837I Header.

10. When you return to this screen, press **Exit** to return to the **Electronic Billing Maintenance Menu**. Now you have finished the configuration for Version 5010 and the 837 subsets.

TESTING THE 5010 FORMAT

Before beginning the test:

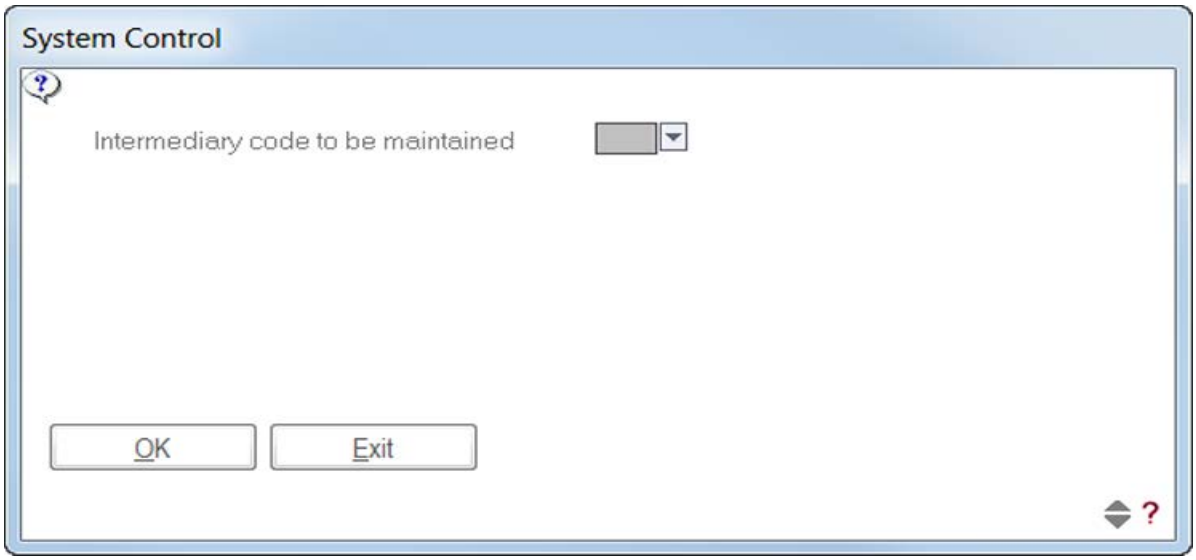
- **Contact your Intermediary to notify them of your 5010 format testing.**
- **MEDHOST recommends that you perform the 5010 format testing in a training library.**
- **Record your current settings in each of the screens (e.g., using screen captures or notes). You will use these records to return to your original settings when the test is over.**
- **Wait to test the changes for the 837 subset until after daily electronic billing has been completed.**

There are three parts to the test:

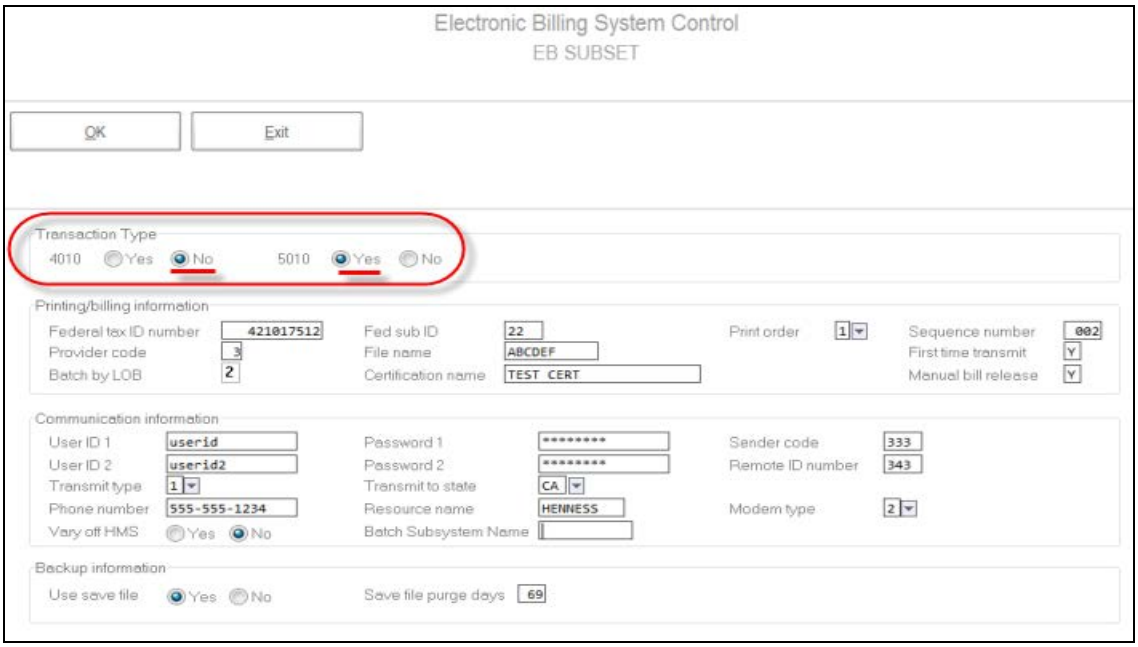
- Set up the Test Values
- Rebill and Generate an 837 File
- Revert to the Original Settings

Set Up the Test Values

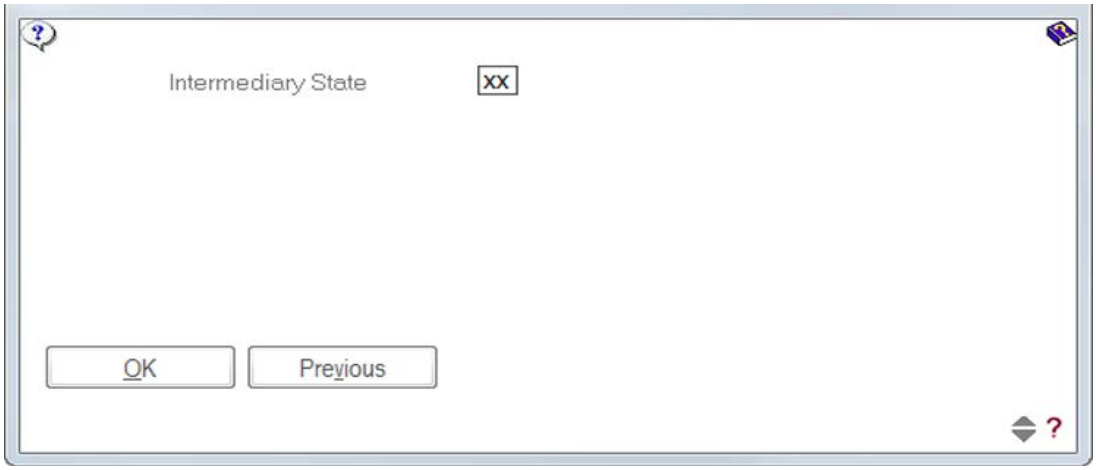
1. Select the *Maintain EB System Control Record* option (see *Electronic Billing Maintenance Menu, Option 1*). The **Intermediary Code** search dialog will open.



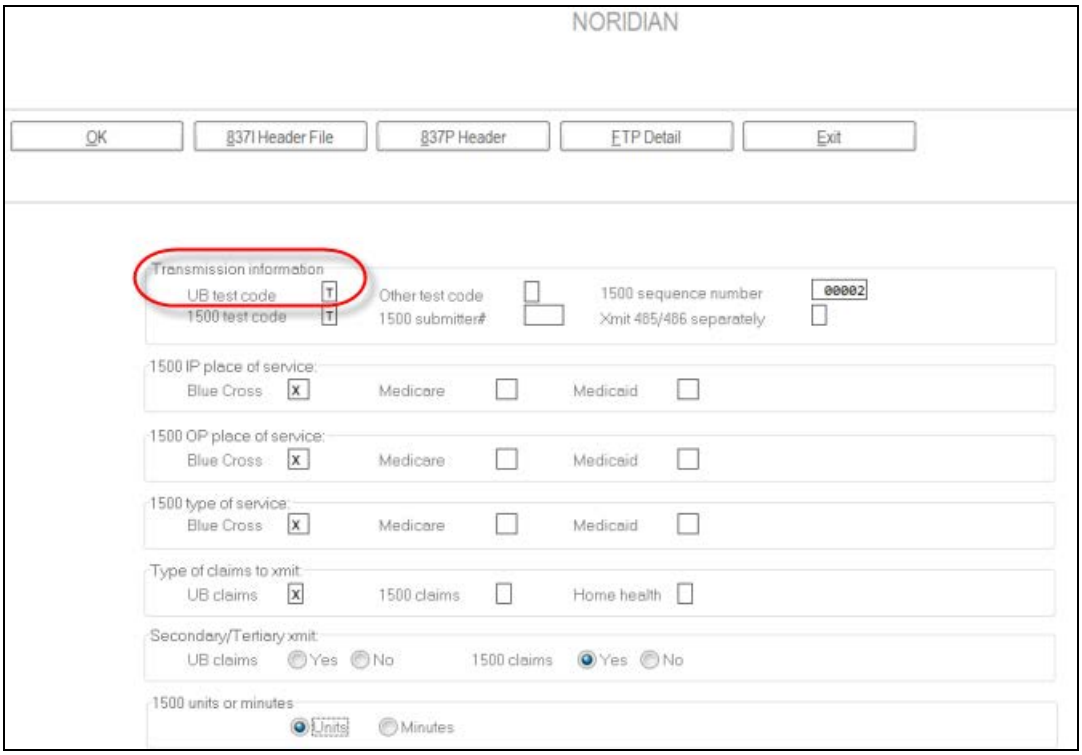
2. Select or search for your intermediary code and press the OK button. The **EB 837 Subset–Transaction Type** screen will open.



3. Verify that the Transaction Type is **No** for 4010 and **Yes** for 5010. Press the **OK** button. The **Intermediary State** search box will open.

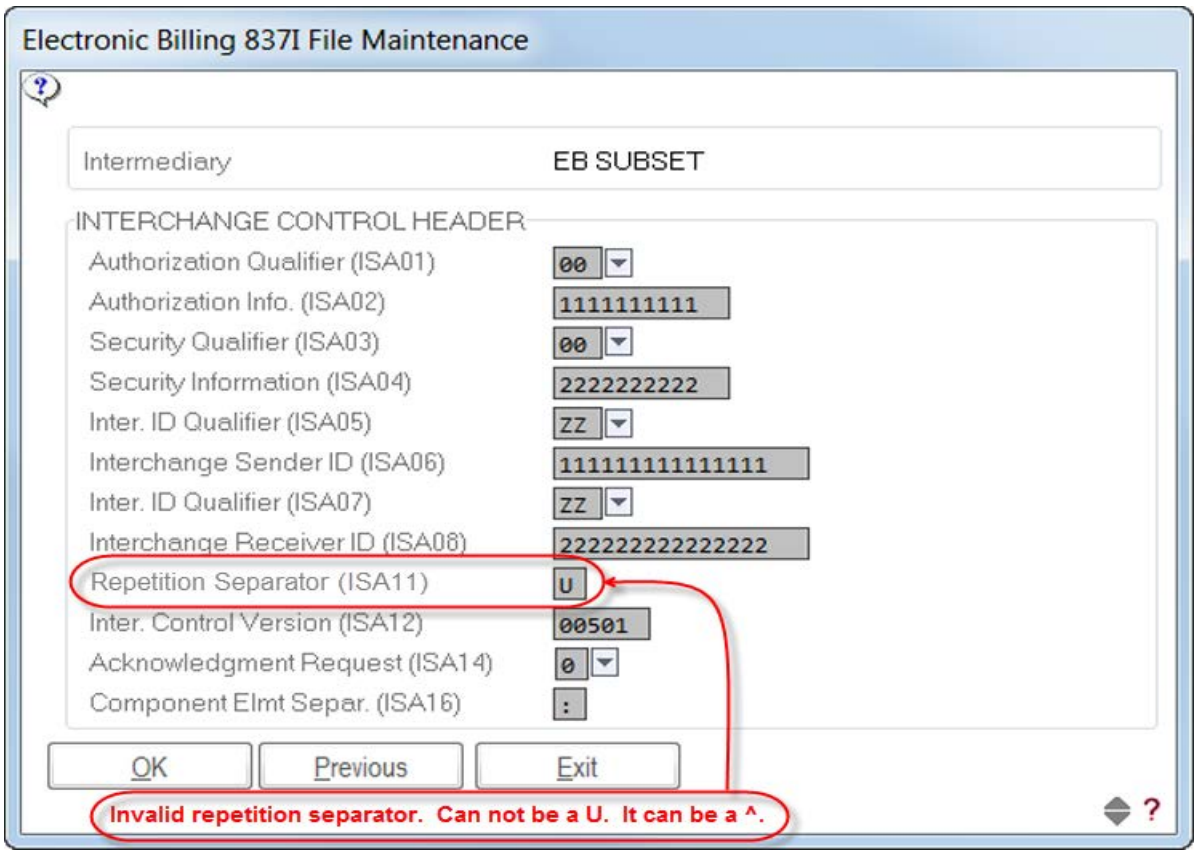


4. Press the **OK** button (if necessary, enter your Intermediary State first). The **EB 837 Subset–Transmission Information** screen will open with buttons for the 837I Header File and the 837P Header.

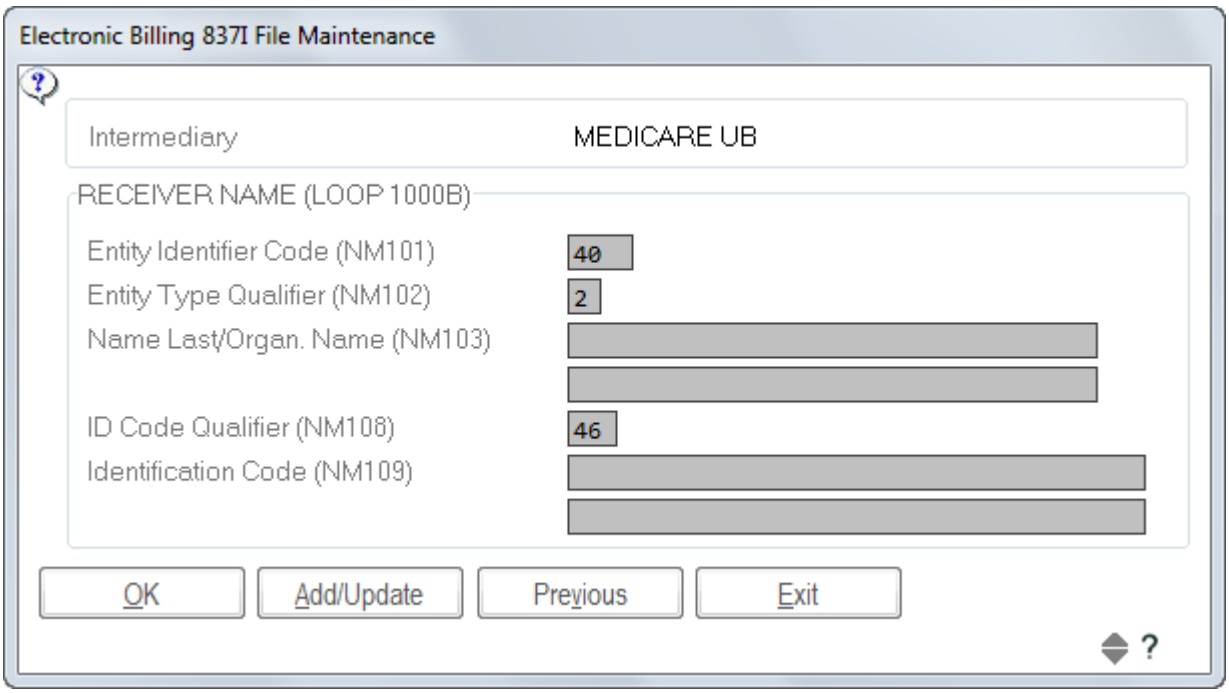


5. According to the type of code you want to test—UB code, 1500 code, or both—place a "T" in the UB Test code field and/or 1500 test code field.

6. Press the **837I Header File** button. The **Electronic Billing 837I File Maintenance–Interchange Control Header** screen will open. This is the first of five header setting screens.



7. Page through the header screens by pressing the **OK** button until you reach the **RECEIVER NAME** screen. This process helps verify that the settings are correct, because a message at the bottom of the screen will give you the correct value if a setting needs to be changed.



8. At the **RECEIVER NAME** screen, press on the **Add/Update** button. You will return to the **EB 837 Subset–Transmission Information** screen, which contains the 837I and 837P Header buttons.

9. Press the **837P Header** button and page through the five **Electronic Billing 837P File Maintenance** header screens to check their values.

10. When you return to the **EB 837 Subset–Transmission Information** screen, press the **OK** button to return to the main *Electronic Billing Maintenance Menu*.

Rebill & Generate an 837 File

Perform a rebill on previous claims using Bill Date or Patient Number (see *Electronic Billing Main Menu, Option 4: Rebill Electronic Bills*).

When the system notifies you that the rebilling process has finished, generate the bill (see *Electronic Billing Main Menu, Option 1: Create/Print EB Listing*).

Revert to the Original Settings

The reversion process differs for those who will continue to use the Version 5010 format and those who are still using the Version 4010 format.

Using the Version 5010 Format

Remove the T from the UB Test Code and/or 1500 Test Code items in the **EB 837 Subset–Transmission Information** screen.

Using the Version 4010 Format

1. Select **No** for the **5010 Format** field in the **Vendor Maintenance** screen (*Health Plan Transactions Menu, Option 10*), shown on page D.2 of this document.
2. Change the Transaction Type format **from** Version 5010 **to** Version 4010 in the **EB 837 Subset–Transaction Type** screen (*Electronic Billing Maintenance Menu, Option 1, Maintain EB System Control Record*).
3. Remove the T from the UB Test Code and/or 1500 Test Code items in the **EB 837 Subset–Transmission Information** screen (*Electronic Billing Maintenance Menu, Option 1, Maintain EB System Control Record*).
4. Page through the 837I and 837P header screens to reset the values so they are consistent with Version 4010. Refer to the section, *"Set Up the Test Values"* for examples of the process.
5. Press **OK** to save your changes and exit.

Index

Listed in alphabetical order below and on the next page are all the Electronic Billing menu options and topics described in this manual, along with their tabbed section and, where applicable, menu option number.