iTech Workshop®

Data Integration for Healthcare

expEDIum Medical Billing

v3.6.8

Release Notes

Release Date | Saturday, Jun 30, 2018

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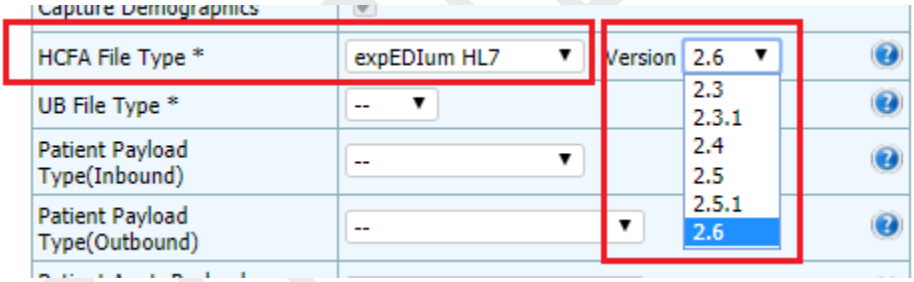
Release Notes

1) [Ticket# 5317] HL7: Support for DFT-P03 (expEDIum Professional Claim Payload) - HL7 v2.3 - v2.6

The claim payloads (professional claims) in HL7 format is supported in the system from this version onwards. The event types supported is **DFT P03** (for patient add/insert) for the versions – v2.3, v2.3.1, v2.4, v2.5, v2.5.1, v2.6.

The claim payload in HL7 format is supported in the system from the below listed features -

The claim payload can be sent from EMR to expEDIum using the SOAP and RESTful Web Services supported in the system and also using the manual upload option from Send Batch menu. The account setup will have the option to configure the HL7 payload as shown below.

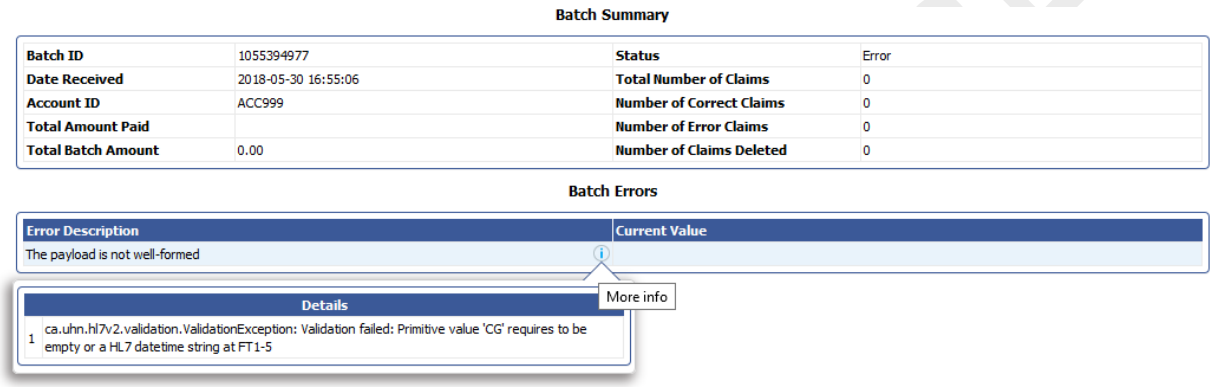


Select "expEDIum HL7" from the drop down provided for the section "HCFA File Type". Select the HL7 version from the adjacent dropdown – by default, the version will be selected as v2.6.

As part of HL7 well-formed-ness check, the system will perform and report the following batch errors

- HL7 payload is not well formed.
- HL7 payload is not compatible with the schema

Note: This is a strict validation on the HL7 syntax (on missing/invalid HL7 parameter values) validation which will fail the payload at a higher level by the HL7 library. This validation will be disabled by default in the application, so that the payload is processed and the user can fix/scrub the claim at claim level). When these errors are reported, the error message in technical terms will be also shown in a tool tip.



Batch Summary

Batch ID	1055394977	**Status**	Error
Date Received	2018-05-30 16:55:06	**Total Number of Claims**	0
Account ID	ACC999	**Number of Correct Claims**	0
Total Amount Paid		**Number of Error Claims**	0
Total Batch Amount	0.00	**Number of Claims Deleted**	0

Batch Errors

Error Description	Current Value
The payload is not well-formed	

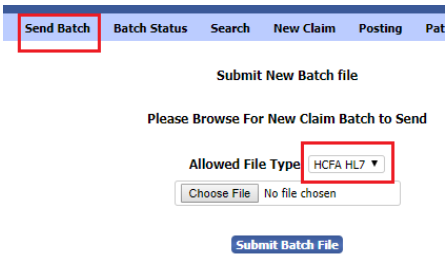
More info

	Details
1	ca.uhn.hl7v2.validation.ValidationException: Validation failed: Primitive value 'CG' requires to be empty or a HL7 datetime string at FT1-5

However, if well-formed and the basic information to parse the HL7 payload is missing, the payload will be still failed at a higher level itself with one of the following batch error messages.

- HL7 Message Type is missing (MSH-9-1)
- Invalid HL7 Message Type (MSH-9-1)
- HL7 Event Type is missing (MSH-9-2)
- Invalid HL7 Event Type (MSH-9-2)
- HL7 Message Structure is missing (MSH-9-3)
- Invalid HL7 Message Structure (MSH-9-3)
- HL7 Version is missing (MSH-12)
- Invalid HL7 Version (MSH-12)

The HL7 claim payload can be manually uploaded from the below option –



In the administrator module, the expEDIum HL7 is added to the file type filter drop down to search for batches/claims of this type. This filter changes are applied on Search Batches, Search Claims, Search Accounts, and Account Report.

Note

The fields not supported in HL7 and supported in expEDIum are handled using custom Z segments. The expEDIum HL7 field mapping and element definition excel document will be provided to the EMR vendors on request.

2) [Ticket# 6930] PH: Add Patient ID/PAN on Reports

There was a request to add the patient account number in the claim as a column in the billing activity report and aging reports. This enhancement is implemented in the following reports in public health and non-public health accounts–

1) Aging Report – Insurance Claims
2) Aging Report – Self Pay Claims
3) Billing Activity Report

Display of PAN in Billing Activity Report

Billing Activity Report

[Created By: All, Received between : 06/01/2018 to 06/30/2018, Insurance type : Primary, Provider: All, Location: All]

		Claim ID	Batch ID	Patient Name	PAN	DOS	Payer ID	Payer Name	Copay	Charges	Received Date	Submitted Date	Created By
I	P	1778199347	1036189976	s	00	2018-06-21	13162	1199 National Benefit Fund	$0.00	$100.00	2018-06-21 02:10:34		M
P	P	1475163694	0331489688		10818	2018-06-21	13162	1199 National Benefit Fund	$0.00	$100.00	2018-06-21 02:06:43		M
P	P	1815335352	1711782650	IL	11221	2018-06-20	75240	AAG Benefit Plan Administrators, Inc.	$0.00	$55.00	2018-06-20 02:54:12		M
P	P	0375341432	0401302222	IL	11221	2018-04-01	75240	AAG Benefit Plan Administrators, Inc.	$0.00	$55.00	2018-06-12 03:03:42		M
P	P	2027258105	2058422537	IL	11221	2018-06-12	75240	AAG Benefit Plan Administrators, Inc.	$0.00	$55.00	2018-06-12 01:51:05		M
P	P	1147713810	0590362836	IL	11221	2018-02-01	75240	AAG Benefit Plan Administrators, Inc.	$0.00	$55.00	2018-06-11 00:30:24		M
P	P	2126972187	0133156293	IL	11221	2018-02-01	75240	AAG Benefit Plan Administrators, Inc.	$0.00	$110.00	2018-06-08 05:47:24		M

3) [Ticket# 7506] MDR: Anesthesia Logic Enhancement

When the anesthesia claim payloads are received in the system through web services or via claim file upload, the system auto calculates the service line units by the difference between anesthesia start and stop times (if present in the service line), and the original units will be overwritten. These units (anesthesia duration) are then sent to payer with the anesthesia qualifier of MJ (if start and stop are present) in 837P, with a qualifier of UN or DA based on what is explicitly selected in the claim (in the case of institutional claim). In the case of paper claims, together with the units, the start and stop also will be printed.

Some of the EMRs does not always send anesthesia duration in the unit field. They send the time based relative value unit (Base Unit + Time unit) instead. These accounts configure the unit charge in the fee schedule based on this relative value unit. Hence, the auto calculation of start and stop times, overwriting the units with minutes, the service line charge was getting calculated as a higher value, which is incorrect. The manual scrubbing of the claims also has the same logic implemented, and hence the users were not able to put the actual units and recalculate the charges. To resolve this scenario, we have enhanced the anesthesia claim handling in this version by having the following logic changes.

1. The system will not auto-calculate the difference between stop and start and update the units in the services lines. The units in the payload will be saved as it is in the service line. *(change in logic)*

2. In the fee schedule, the system will allow the units to have a value zero or greater. During fee enrichment, the system will take the units in the service line and will be multiplied with the per unit charge in fee schedule to get the charges and the charges in the service line will be overwritten. *(same logic as before)*. If the service line does not carry units, or it is zero, the fee schedule will not be enriched, and the charges in the claim will not be overwritten *(change in logic)*. The claim will fail in validation on units having a value not greater than zero.

3. If units are edited from front end, the user can click on "Populate Fee" to recalculate the fee from fee schedule and the service line charges will be overridden with the recalculates fee, if the fee is configured. *(same logic as before*). The "Calculate" button will not calculate the difference between start and stop time and will not update the units field *(change in logic)*

4. In the case of Outbound 837P, if start and stop is present in the claim – the system will auto-calculate the anesthesia time duration in minutes and populate that as the units with qualifier as MJ for the time-based procedure codes (a list/category of procedure codes) - MJ with 10 units in the case of this service line. For non-time-based procedure codes (a list/category of procedure codes), the units in the claim with qualifier UN will be populated. *(change in logic)*

5. In the case of Outbound 837I, the qualifier MJ is not supported. Even if start and stop is present in the claim – the system will always populate the units in the service line with qualifier specified in the service line (UN or DA) *(change in logic)*

6. For CMS-1500 Print, if start and stop is present in the claim – the system will auto-calculate the anesthesia time duration in minutes and print that as the units in the form for the time-based procedure codes (a list/category of procedure codes) - MJ with 10 units in the case of this service line. For non-time-based procedure codes (a list/category of procedure codes), the units in the claim will be printed. Also, the Start and Stop times (hhmm) format will also be printed in a standard format given by CMS. *(change in logic)*

7. For UB04, the system will always populate the units in the service line with qualifier specified in the service line (UN or DA) *(change in logic)*

Anesthesia Procedure Code Categories

Anesthesia Time/Duration based procedure codes

The procedure codes falling the in the range **00100 – 01999** are the ones for which anesthesia duration (the difference between anesthesia start and stop time in minutes) has to be sent as units to the payer.

Unit based anesthesia procedure codes

The list of procedure codes for which the actual units has to be sent to the payer instead of the anesthesia duration are **99143, 99144, 99145, 99148, 99149, 99150, 99151, 99152, 99153, 99155, 99156, and 99157**.

4) [Ticket# 7655] MDR: Determine Unique Patients using Pt FN, Pt LN, Pt DOB, Pt Sex + Any other patient fields

Some of the clinics wanted to maintain a separate patient record (of the same patient) in EMR for workers compensation claims. These patient records (of the same patient) will be sharing the same details, except the Patient Account Number/Patient Control Number (PAN/PCN). The EMR had the facility to have duplicate patients with same details and different PAN/PCN. However, this was not possible in expEDIum as expEDIum has a default patient matching/duplicate checking using the default fields Patient First Name, Patient Last Name, Patient DOB, Patient Sex.

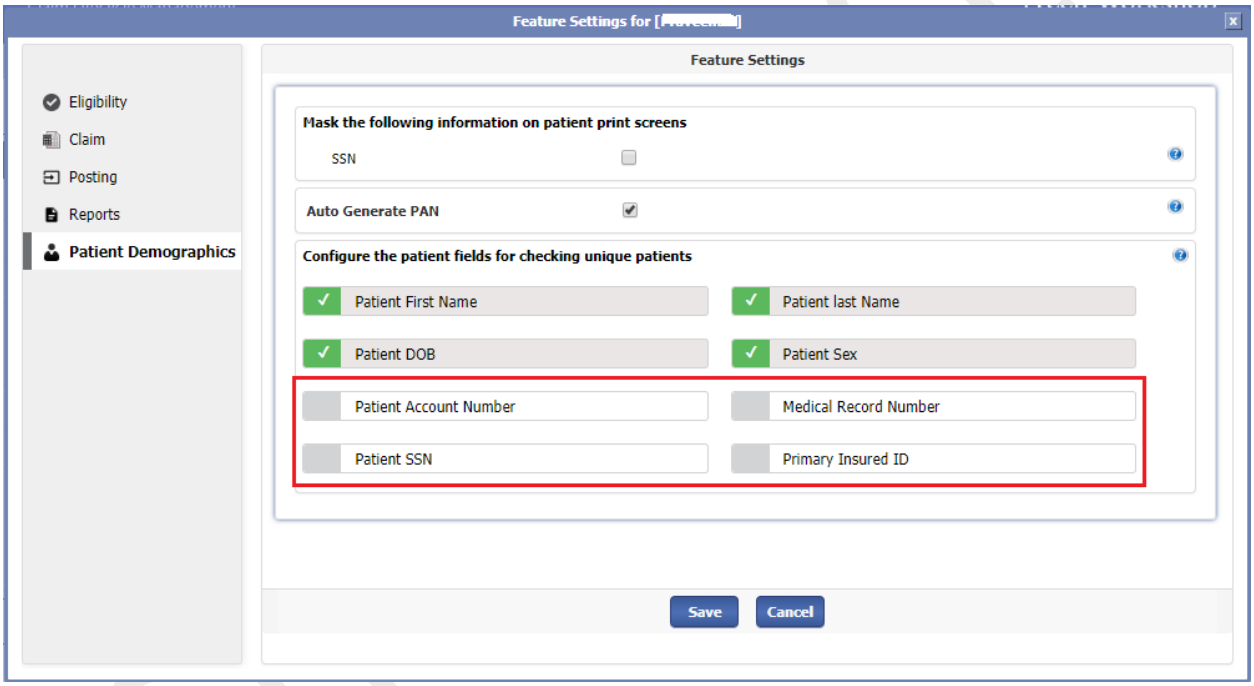
When EMR sends the second record of the patient via web service to expEDIum for adding, as the default fields Patient First Name, Patient Last Name, Patient DOB, Patient Sex are the same, the first record was getting updated instead. To handle this scenario, this patient duplicate check logic is enhanced to have additional fields to be configured for such accounts.

This configuration is available in the administrator module. The clinics who require this feature can request the expEDIum administrator to configure PAN or other supported fields. The default fields will be always Patient First Name, Patient Last Name, Patient DOB, Patient Sex for ensuring backward compatibility, and the system will not allow these fields to be removed from the duplicate patient check.

Configuring the patient fields for uniqueness/duplicate check

This configuration is allowed only from the administrator module.

By default, Patient First Name, Patient Last Name, Patient DOB and Patient Sex will be configured and enabled. These fields cannot be disabled. However, the administrator can enable other fields (one or more) for the accounts based on their request.



The new fields introduced are –

1) Patient Account Number
2) Patient SSN
3) Primary Insured ID
4) Medical Record Number – (Please note, this field will be empty for most of the accounts as it is same as patient account number. This is used in the case of accounts having different patient account number and medical record number).

The modules where the changes will be affected are –

1) The fields configured in the patient unique/duplicate checking are mandatory when a patient is added, or updated (logic as before). That means, if a new field is configured to this list, that field also becomes mandatory in the patient payload/from UI.
   Exception: When a patient was added or updated from front end UI, and if the PAN was left empty, the system will auto generate the PAN. This feature is now externalized as a configuration using the option "Auto Generate PAN". By default, this feature will be turned ON for backward compatibility – in this case PAN will not be considered as a mandatory field from UI as it is going to auto generated by the system if left empty. For accounts, where PAN is configured as one of the duplicate/unique patient check fields and auto generate PAN is turned OFF, the system will force the user to manually enter the PAN. Note, this auto generate PAN is applicable only from UI add/edit patient screens and not from web service modules, by design.
   As new fields are introduced in the patient payload validation, we have introduced
2) Patient Import Module – The duplicate check enhancement is handled for all file types.
3) Patient auto-add from claim submission – when a new claim is processed and validated as pass without errors, the system auto creates the patient (if not already present) in-order to enter the primary/secondary claim submission entry (including auto generated secondary claim from crossover payment) into the ledger for that patient.

There are new error codes introduced in the Soap API and REST API to handle the new on-demand mandatory fields.

SOAP Error Codes

Error Code	Error Description
W1166	Patient Account Number is missing

W1167	Patient MRN is missing
W1168	Patient SSN is missing
W1169	Primary Insured ID is missing

REST Error Codes

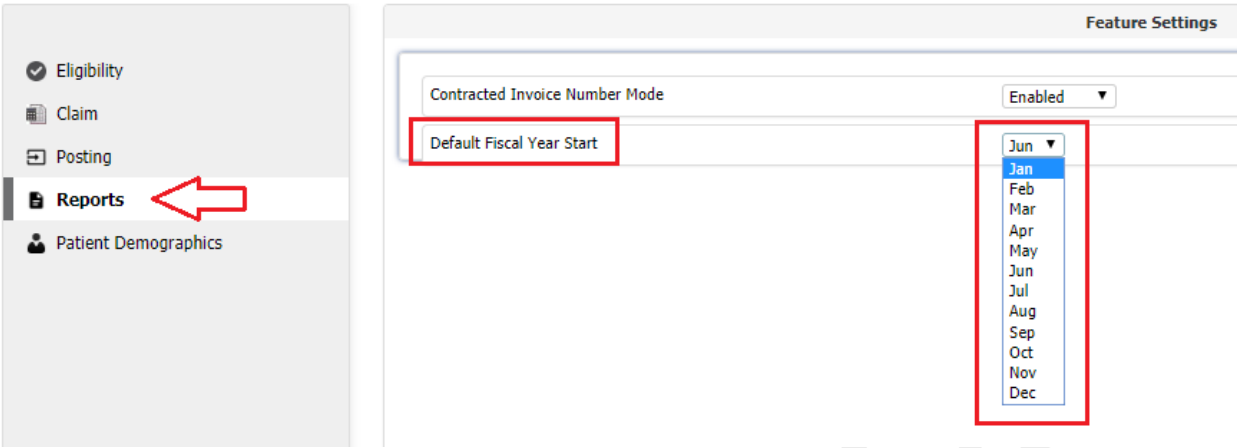
Error Code	Error Description
R0561	Patient Account Number is missing
R0562	Patient MRN is missing
R0563	Patient SSN is missing
R0564	Primary Insured ID is missing

5) [Ticket# 7743] PH: Feature Request for the AR quarter report

There was a request to have the option to configure their own quarter periods instead of the default Jan-Mar, Apr-Jun, Jul-Sep, Oct-Dec on A/R Summary Report.

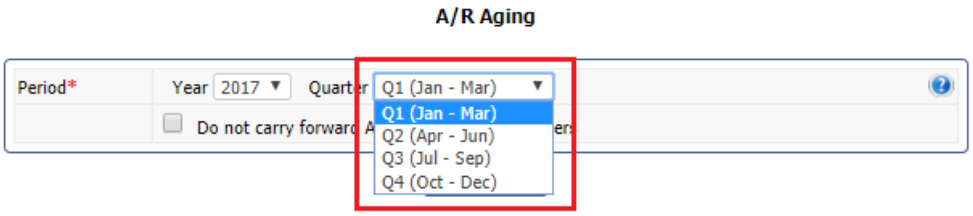
From this version onwards, users can configure the start month of their Fiscal Year for A/R Summary Report. By default, Jan will be the default start month of the Fiscal Year. This can be changed from the menu "Maintenance >> Feature Settings" under the option "Reports >> Default Fiscal Year Start".

This option is also available from the administrator login for administrators to configure.



The report search screen and the report result screen for two different fiscal years are shown below.

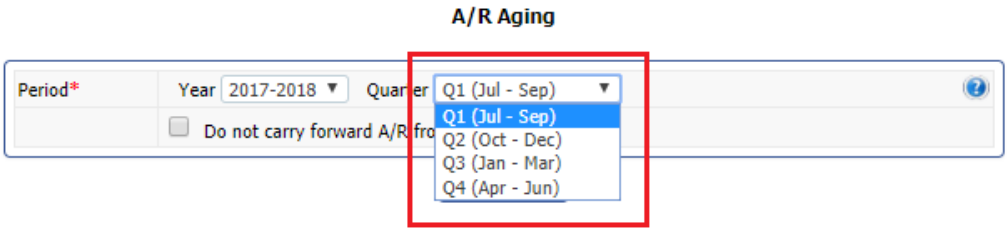
Example 1 (The default Jan as the Start Month of the Fiscal Year)



ACCDEMO

2017 Quarter1 (2017-1-01 to 2017-3-31)								
	Jan 2017		Feb 2017		Mar 2017		Total	
	Units	Amount	Units	Amount	Units	Amount	Units	Amount
BILLED CHARGES	0	$0.00	0	$0.00	0	$0.00	0	$0.00

Example 2 (Jul as the Start Month of the Fiscal Year)

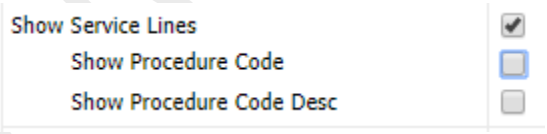


2017-2018 Quarter1 (2017-7-01 to 2017-9-30)								
	Jul 2017		Aug 2017		Sep 2017		Total	
	Units	Amount	Units	Amount	Units	Amount	Units	Amount
BILLED CHARGES	0	$0.00	0	$0.00	0	$0.00	0	$0.00

PH: Patient Statement Creation Issue - Error on parameter 120 (character varying) / parameter 120 (text)

6) [Ticket# 7817] PH: Patient Statement Creation Issue - Error on parameter 120 (character varying) / parameter 120 (text)

There was an issue when patient statement is created for some accounts where the statement creations gets stuck in between. The application gives an error "ERROR: type of parameter 120 (character varying) does not match that when preparing the plan (text)". It was found that this issue (SQL Error) happens when the system runs the patient statement task creation of the account when the option "Show Service Lines" is enabled and the sub options "Show Procedure Code" and "Show Procedure Code Desc." options are unchecked.

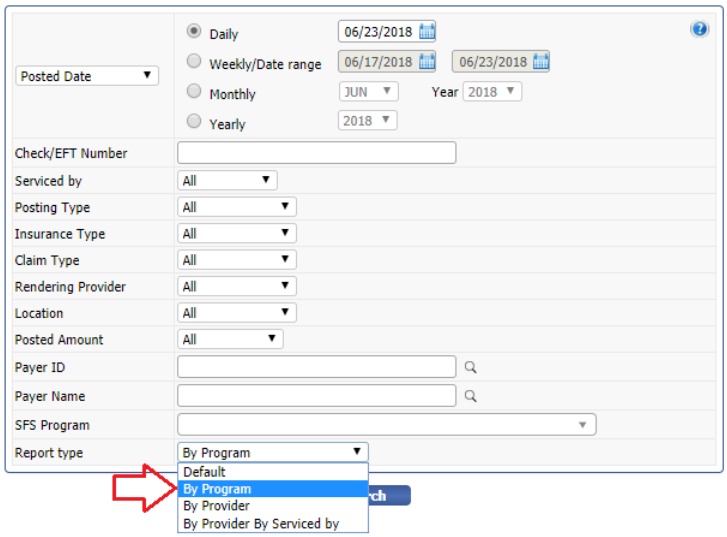


This is issue is resolved in this version.

7) [Ticket# 7822] PH: Insurance payment Activity group by program

The insurance payment activity report is enhanced to have "by Program" flavor for Public Health accounts. The Report Type option is converted to a drop down with the additional option "By Program".

Insurance Payment Activity Report



The report will be grouped by SFS Program with group totals on Claim Charges and Insurance Payments, and also a grand total at the bottom of the report

AH (Adult Health)

		Claim ID	Patient Name	DOS	Payer ID	Payer Name	Claim Charge	Ins. Payment	Type	Posted Date	Check Number	Check/EFT Date	Check Receipt Date	RA Date
P	P	2027361068	P IL	2018-06-03	13162	1199 National Benefit Fund	$150.00	$0.00	Manual	2018-06-21 06:58:07.518	12	2018-06-03	2018-06-03	2018-06-21
P	S	1242397714	P IL	2018-06-03	13162	1199 National Benefit Fund	$150.00	$0.00	Manual	2018-06-21 07:19:22.65	1331	2018-06-21	2018-06-21	2018-06-21
P	P	0828294840	P IL	2018-06-21	13162	1199 National Benefit Fund	$150.00	$10.00	Manual	2018-06-21 07:23:14.31	1331	2018-06-21	2018-06-21	2018-06-21
P	P	1369197286	P IL	2018-06-22	13162	1199 National Benefit Fund	$150.00	$0.00	Manual	2018-06-22 00:06:18.517	wqeqwe	2018-06-22	2018-06-22	2018-06-22
P	S	2146307426	P IL	2018-06-22	13162	1199 National Benefit Fund	$150.00	$0.00	Manual	2018-06-22 00:12:05.625	wqeqwe	2018-06-22	2018-06-22	2018-06-22
P	P	1838571449	P IL	2018-06-22	13162	1199 National Benefit Fund	$1.00	$0.00	Manual	2018-06-22 02:50:42.809	sdffd	2018-06-02	2018-06-02	2018-06-22
P	P	0411398797	P IL	2018-06-22	13162	1199 National Benefit Fund	$1.00	$0.00	Manual	2018-06-22 00:53:28.322	wqeqwe	2018-06-22	2018-06-22	2018-06-22
P	S	0603805646	P IL	2018-06-22	13162	1199 National Benefit Fund	$1.00	$0.00	Manual	2018-06-22 00:56:33.605	wqeqwe	2018-06-22	2018-06-22	2018-06-22
Total		**8**					**$753.00**	**$10.00**						

AB (Behavioral Health Physician in Adult Health)

		Claim ID	Patient Name	DOS	Payer ID	Payer Name	Claim Charge	Ins. Payment	Type	Posted Date	Check Number	Check/EFT Date	Check Receipt Date	RA Date
I	S	1823790071	F	2018-06-22	13162	1199 National Benefit Fund	$1.00	$0.00	Manual	2018-06-22 00:58:41.222	wqeqwe	2018-06-22	2018-06-22	2018-06-22
I	P	1506040531	F	2018-06-22	13162	1199 National Benefit Fund	$1.00	$0.00	Manual	2018-06-22 01:22:43.332	wqeqwe	2018-06-22	2018-06-22	2018-06-22
I	P	0704270126	F	2018-06-22	13162	1199 National Benefit Fund	$10000.00	$0.00	Manual	2018-06-22 02:11:20.536	dfsdfsda	2018-06-01	2018-06-01	2018-06-22
I	P	1381216515	F	2018-06-22	13162	1199 National Benefit Fund	$10000.00	$0.00	Manual	2018-06-22 08:27:30.195	dfsdfsda	2018-06-01	2018-06-01	2018-06-22
I	P	1381216515	F	2018-06-22	13162	1199 National Benefit Fund	$10000.00	$0.00	Manual	2018-06-22 08:21:27.681	sdffd	2018-06-02	2018-06-02	2018-06-22
I	P	0704270126	F	2018-06-22	13162	1199 National Benefit Fund	$10000.00	$0.00	Manual	2018-06-22 02:50:12.433	sdffd	2018-06-02	2018-06-02	2018-06-22
P	P	2072795463	F	2018-06-17	13162	1199 National Benefit Fund	$150.00	$50.00	Manual	2018-06-20 01:40:52.285	2072795463	2018-06-14	2018-06-14	2018-06-20
I	P	1381216515	F	2018-06-22	13162	1199 National Benefit Fund	$10000.00	$0.00	Manual	2018-06-22 08:22:31.169	sdffd	2018-06-02	2018-06-02	2018-06-22
P	S	0312020709	F	2018-06-17	13162	1199 National Benefit Fund	$150.00	$100.00	Manual	2018-06-20 01:56:11.34	2072795463	2018-06-14	2018-06-14	2018-06-20
P	P	1250555933	F	2018-06-17	13162	1199 National Benefit Fund	$150.00	$100.00	Manual	2018-06-20 01:45:11.055	2072795463	2018-06-14	2018-06-14	2018-06-20
I	P	1451833229	F	2018-06-03	13162	1199 National Benefit Fund	$500.00	$0.00	Manual	2018-06-21 07:02:20.815	12	2018-06-03	2018-06-03	2018-06-21
I	P	1451833229	F	2018-06-03	13162	1199 National Benefit Fund	$500.00	$0.00	Manual	2018-06-21 07:15:51.498	1331	2018-06-21	2018-06-21	2018-06-21
I	S	1509881755	F	2018-06-03	13162	1199 NATIONAL BENEFIT FUNDD	$500.00	$0.00	Manual	2018-06-21 07:24:43.619	1331	2018-06-21	2018-06-21	2018-06-21
I	P	0287022806	F	2018-06-22	13162	1199 National Benefit Fund	$500.00	$0.00	Manual	2018-06-22 00:08:38.507	wqeqwe	2018-06-22	2018-06-22	2018-06-22
I	S	1762481995	F	2018-06-22	13162	1199 NATIONAL BENEFIT FUNDD	$500.00	$0.00	Manual	2018-06-22 00:17:11.109	wqeqwe	2018-06-22	2018-06-22	2018-06-22
Total		**15**					**$52952.00**	**$250.00**						

Grand Total: 23 **$53705.00** **$260.00**

8) [Ticket# 7829] PH: Medicaid patient Volume Report output criteria enhancement

In this report, even though the user selects Include/Exclude as the options in the Payer ID and Payer Name filters, the SQL Clauses such as IN/NOT IN and LIKE/NOT LIKE were displayed as the filter criteria on the report screen.

Medicaid Patient Volume Report

CLEVELAND COUNTY HEALTH DEPARTMENT

[Service Date From : 4/9/2018 To 05/08/2018 Payer ID : IN (NCXIX) , Payer Name : LIKE (HEALTH CHOICE NC)]

Total Encounters	1555
Total Medicaid Encounters	18
Paid Medicaid Encounters	10
Zero Paid Medicaid Encounters	8
% Medicaid Patient Volume *	1.16%

This issue is now fixed and will show Include/Exclude for both Payer ID and Payer Name as the filter criteria on the report screen.

Medicaid Patient Volume Report

[Service Date From : 3/26/2018 To 06/23/2018 Payer ID : Include (NCXIX) , Payer Name : Include (Medicaid - North Carolina)]

Total Encounters	74

9) [Ticket# 7837] MB-Shoolin: secondary PR in master claim detailed report is populating repeated values whereas the total of Secondary PR shows incorrect value.

There was a glitch in the query used in the report where some claims were repeated with wrong amount in secondary adjudication details, even though the claim is not having secondary submission. This is fixed in this version.

10) [Ticket# 7855] MDR: Activity Summary by Provider, Insurance Payment Activity - Split by Serviced by Provider

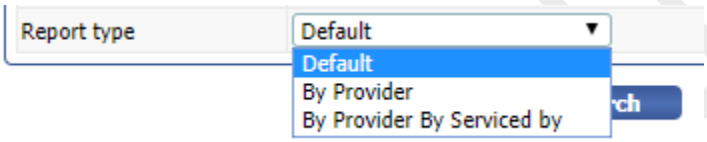
New report type "By Serviced by Provider" is added in Insurance Payment Activity Report. The Report Type option is converted to a dropdown and the following flavors

1) By Provider

   This option when chosen will split the report by Rendering Provider

2) By Provider by Serviced By

   The report will be split by the combination of Rendering Provider & Serviced by Provider.



AALAM AHMED(NPI: 2357373730), JOHN SMITH (NPI:1234567890)

		Claim ID	Patient Name	DOS	Payer ID	Payer Name	Claim Charge	Ins. Payment	Type	Posted Date	Check Number	Check/EFT Date	Check Receipt Date	RA Date
P	P	1815335352	[illegible]CIL	2018-06-20	75240	AAG Benefit Plan Administrators, Inc.	$55.00	$0.00	Manual	2018-06-20 09:33:19.466	0000000000	2018-06-20	2018-06-20	2018-06-20
P	P	2027258105	F[illegible]CIL	2018-06-12	75240	AAG Benefit Plan Administrators, Inc.	$55.00	$0.00	Manual	2018-06-20 09:33:19.654	0000000000	2018-06-20	2018-06-20	2018-06-20
P	P	1103443811	F[illegible]CIL	2018-06-08	95378	UnitedHealthcare Community Plan / TN	$110.00	$0.00	Manual	2018-06-20 09:33:19.923	0000000000	2018-06-20	2018-06-20	2018-06-20
I	P	1778199347	V[illegible]ris	2018-06-21	13162	1199 National Benefit Fund	$100.00	$30.00	Manual	2018-06-21 03:11:34.715	14[illegible]9	2018-06-21	2018-06-21	2018-06-21
P	P	1475163694	E[illegible]	2018-06-21	13162	1199 National Benefit Fund	$100.00	$20.00	Manual	2018-06-21 03:11:34.84	14[illegible]9	2018-06-21	2018-06-21	2018-06-21
P	S	1244703848	E[illegible]	2018-06-21	MCRIL	Medicare	$100.00	$15.00	Manual	2018-06-21 03:26:05.458	14[illegible]9	2018-06-21	2018-06-21	2018-06-21
I	S	0899212074	V[illegible]ris	2018-06-21	13162	1199 National Benefit Fund	$100.00	$14.00	Manual	2018-06-21 03:26:05.317	14[illegible]9	2018-06-21	2018-06-21	2018-06-21
P	P	2145276401	F[illegible]CIL	2018-06-08	75240	AAG Benefit Plan Administrators, Inc.	$110.00	$20.00	Manual	2018-06-21 05:23:22.524	14[illegible]9	2018-06-21	2018-06-21	2018-06-21
I	P	1273859234	V[illegible]ris	2018-06-08	75240	American Administrative Group	$100.00	$138.98	Auto	2018-06-21 06:27:05.31	18[illegible]6	2018-04-24	2018-04-24	2018-06-21
P	P	0106234109	F[illegible]CIL	2018-06-02	13162	1199 NATIONAL BENEFIT FUNDD	$110.00	$187.27	Auto	2018-06-21 06:27:05.904	18[illegible]6	2018-04-24	2018-04-24	2018-06-21
P	P	1709009081	E[illegible]	2018-05-28	13162	1199 National Benefit Fund	$80.00	$10.00	Manual	2018-06-07 02:44:18.414	0[illegible]02	2018-05-29	2018-05-29	2018-05-29
P	S	0733727601	E[illegible]	2018-05-28	MCRIL	Medicare	$80.00	$20.00	Manual	2018-06-07 02:45:39.307	0[illegible]02	2018-05-29	2018-05-29	2018-05-29
Total		12					$1100.00	$455.25						
Grand Total: 12							$1100.00	$455.25						

The Activity Summary by Provider report is already by default grouped/split by Rendering Provider + Serviced By combination, and hence no change is made on that report.

11) [Ticket# 7880] iTech: HL7 - Diagnosis code FT1-19 segment overwrite issue

There was a glitch in parsing the diagnosis codes from the FT1-19 segment (in the claim payload in expEDIum HL7 DFT P03 format), if there are multiple occurrences of them. This is fixed in this version. The diagnosis pointer construction which is dependent on the diagnosis code parsing logic was also corrected.

Note: The support for claim payload in DFT-P03 format is supported from this version. Please refer Ticket 5317 above.

12) [Ticket# 7906] PH: Insurance Analysis by Procedure Report issue

The Insurance Analysis by Procedure Report was having a glitch

1) Some of the procedure codes were repeating with the payment amount added up, when the result is grouped by procedure. This is fixed in this version.
2) The average amount was calculated based on number of service lines and not number of procedures/number of units. This is also fixed.

The fixes are applied on Practice Analysis by Procedure report too.

13) [Ticket# 7933] PH: Charge amount in the insurance Payment Activity Report

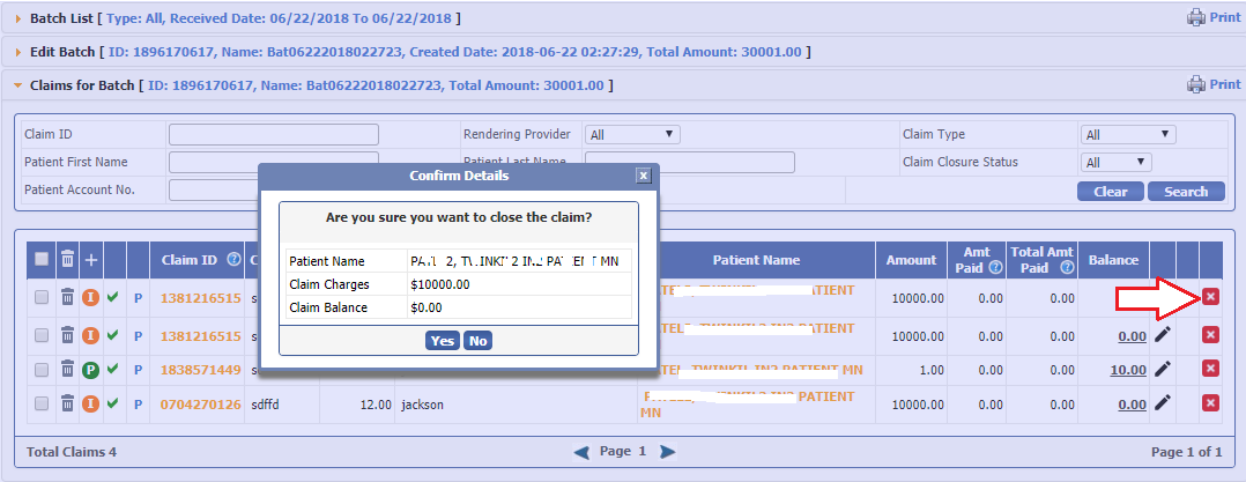
Claim Charges were not available in the Insurance Payment Activity Report. This is now introduced in this version for all flavors of this report – Default, By Provider, By Provider by Serviced By and also on the By Program on Public Health accounts.

AALAM AHMED(NPI: 2357373730), JOHN SMITH (NPI:1234567890)

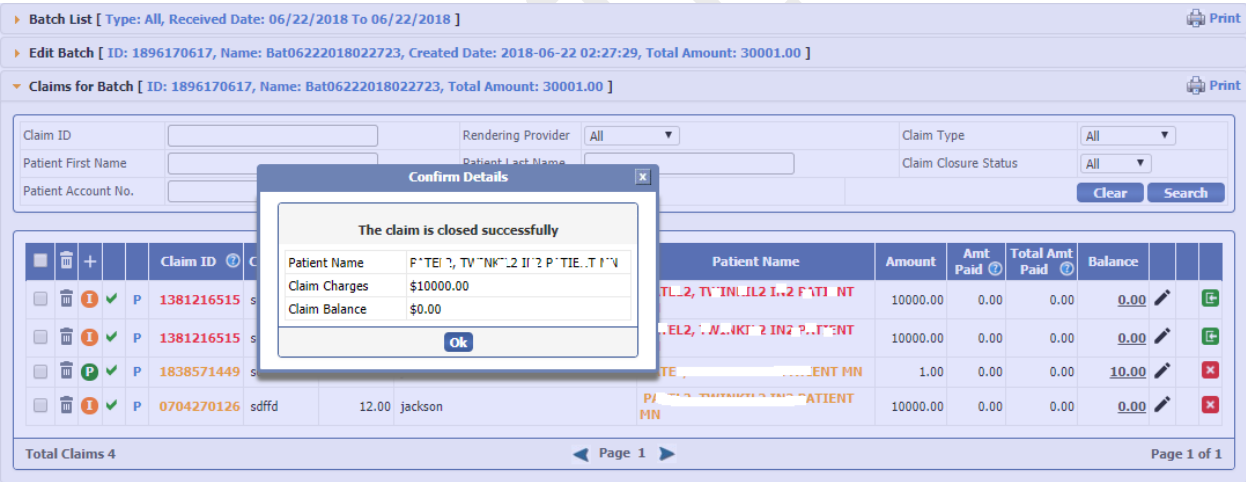
		Claim ID	Patient Name	DOS	Payer ID	Payer Name	Claim Charge	Ins. Payment	Type	Posted Date	Check Number	Check/EFT Date	Check Receipt Date	RA Date
P	P	1815335352	F CIL	2018-06-20	75240	AAG Benefit Plan Administrators, Inc.	$55.00	$0.00	Manual	2018-06-20 09:33:19.466	0000000000	2018-06-20	2018-06-20	2018-06-20
P	P	2027258105	F CIL	2018-06-12	75240	AAG Benefit Plan Administrators, Inc.	$55.00	$0.00	Manual	2018-06-20 09:33:19.654	0000000000	2018-06-20	2018-06-20	2018-06-20
P	P	1103443811	F CIL	2018-06-08	95378	UnitedHealthcare Community Plan / TN	$110.00	$0.00	Manual	2018-06-20 09:33:19.923	0000000000	2018-06-20	2018-06-20	2018-06-20
I	P	1778199347	V ris	2018-06-21	13162	1199 National Benefit Fund	$100.00	$30.00	Manual	2018-06-21 03:11:34.715	14 9	2018-06-21	2018-06-21	2018-06-21
P	P	1475163694	E	2018-06-21	13162	1199 National Benefit Fund	$100.00	$20.00	Manual	2018-06-21 03:11:34.84	14 9	2018-06-21	2018-06-21	2018-06-21
P	S	1244703848	E	2018-06-21	MCRIL	Medicare	$100.00	$15.00	Manual	2018-06-21 03:26:05.458	14 9	2018-06-21	2018-06-21	2018-06-21
I	S	0899212074	V ris	2018-06-21	13162	1199 National Benefit Fund	$100.00	$14.00	Manual	2018-06-21 03:26:05.317	14 9	2018-06-21	2018-06-21	2018-06-21
P	P	2145276401	F CIL	2018-06-08	75240	AAG Benefit Plan Administrators, Inc.	$110.00	$20.00	Manual	2018-06-21 05:23:22.524	14 9	2018-06-21	2018-06-21	2018-06-21
I	P	1273859234	V ris	2018-06-08	75240	American Administrative Group	$100.00	$138.98	Auto	2018-06-21 06:27:05.31	18 6	2018-04-24	2018-04-24	2018-06-21
P	P	0106234109	F CIL	2018-06-02	13162	1199 NATIONAL BENEFIT FUNDD	$110.00	$187.27	Auto	2018-06-21 06:27:05.904	18 6	2018-04-24	2018-04-24	2018-06-21
P	P	1709009081	E	2018-05-28	13162	1199 National Benefit Fund	$80.00	$10.00	Manual	2018-06-07 02:44:18.414	0 2	2018-05-29	2018-05-29	2018-05-29
P	S	0733727601	E	2018-05-28	MCRIL	Medicare	$80.00	$20.00	Manual	2018-06-07 02:45:39.307	0 2	2018-05-29	2018-05-29	2018-05-29
Total		12					$1100.00	$455.25						
Grand Total: 12							$1100.00	$455.25						

14) [Ticket# 7939] PH: Feature request for use the enter key in "the claim is closed successfully" OK box also.

On Posting >> Manage – Claim List screen, when user closes (or opens) a claim, a confirmation window pops up asking "Are you sure you want to close the claim?" with Yes/No option.



Once the "Yes" is clicked, a message box pop up saying it is successfully closed/opened with an Ok button, which has to be clicked to come back to the parent claim list screen.



The user expects the "Yes" button to be clicked when they press the "Enter/Carriage Return" key on the keyboard and also the same behavior on the Ok button on the second message box.

This feature was not available in this module and it is now implemented. The user can now click "Enter" key on both the confirmation and message boxes to close them and come back to the parent claim list screen.

This feature is also implemented in Claim Closure Module (Menu: Archive >> Claim Closure)

15) [Ticket# 7961] Hot Patch (v3.6.7.1) | MB: System not able to generate "Practice Analysis by Procedure" report

In the previous version, the option to display Medicare Allowed Amount was introduced in the Practice Analysis Report. However, few issues were found.

Allowed amount was coming as zero always for some of the claims.

1) There was a glitch were CMS MC Allowed Amount Chart was based on 5-digit zip code and the report was not truncating the practice's 9-digit zip code to 5-digit zip code to fetch the Allowed Amount – this is fixed.

2) If the allowed amount of a procedure code is updated in multiple quarters, and both entries were present in the Allowed Amount store, the report was failing to fetch the allowed amount from the appropriate quarter and was returning as $0.00 – this is fixed

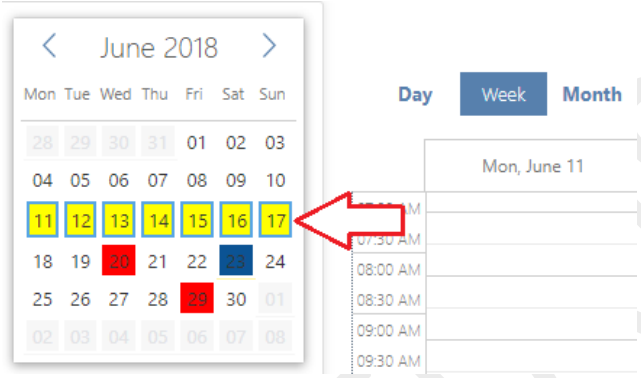
Both the fixes are applied as a hot patch on June 12, 2018 as v3.6.7.1 on all production and demo servers.

16) [Ticket# 7963] MDR: Selected date with a different color regardless of whether the day has appointment or not

When a date is clicked and selected on the calendar on the left panel of the appointment window, the selected date was colored with a yellow, or other colors (if appointments are present for the day). The user requested whether they can give a bracket around the date or any other mechanism to give a clear indicator on the "selected date"

A square shaped blue border is introduced and it now appears around the date on the month wise calendar, when it is clicked. This behavior is available in Day, Week, Unit and Timeline View.

A screenshot from the Week View is shown below -



17) [Ticket# 8011] PH: Billing Provider Taxonomy code in EDI (95378 - UnitedHealthcare Community Plan / TN)

The following payer also requires billing provider taxonomy code to be populated in 2000A PRV Segment.

Payer ID = **95378**

Payer Name = **UNITEDHEALTHCARE COMMUNITY PLAN / TN**

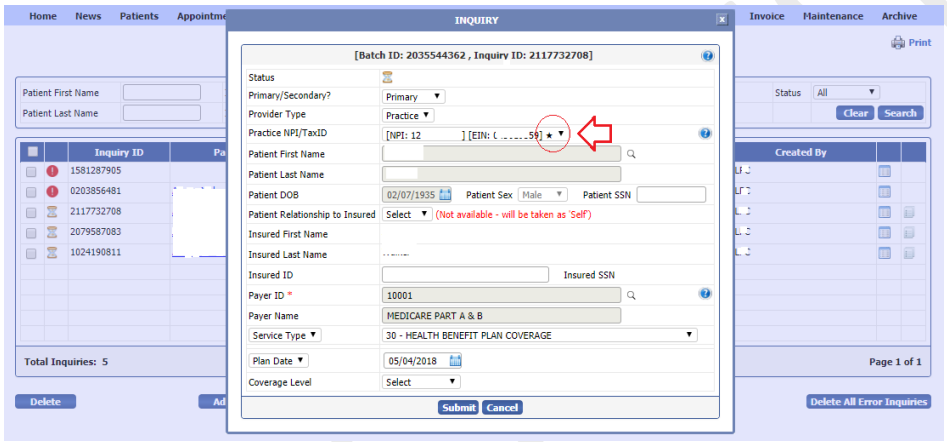
Please note, this is EDI edit is available only for the professional claims (837P 5010).

18) [Ticket# 8090] MDR: Issue in Appointment Patient Summary PDF Export

An issue was found when patient summary window is exported to PDF where a blank page was displayed on print preview screen. There was a minor glitch where this happens when there are empty tables in the patient summary preview. This is fixed in this version.

19) [Ticket# 8156] MDR: Eligibility NPI/Tax ID Issue in Eligibility Inquiry

The inquires in an eligibility batch can viewed in read-only mode using the option "View Inquiry". This pop up a window which shows the details of the inquiry submitted. In this screen, erroneously the Practice NPI/Tax ID configured in the account setup as default was displayed in the "Practice NPI/Tax ID" field instead of the Practice NPI/Tax ID chosen by the user (from a multiple Tax ID/NPI drop down) in the original inquiry.



This display issue is fixed in this version.

Bugzilla List of tickets available in this release

#	iTech Ticket#	Client	Client Ticket #	Summary	Version
1	5317	iTech	-	HL7: Support for DFT-P03 (expEDIum Professional Claim Payload) - HL7 v2.3 - v2.6	v3.6.8
2	6930	Patagonia	25641	PH: Add Patient ID/PAN on Reports	v3.6.8
3	7506	MDReports	Email	MDR: Anesthesia Logic Enhancement	v3.6.8
4	7655	MDReports	Email	MDR: Determine Unique Patients using Pt FN, Pt LN, Pt DOB, Pt Sex + Any other patient fields	v3.6.8
5	7743	Patagonia	27892	PH: Feature Request for the AR quarter report	v3.6.8
6	7817	Patagonia	27851	PH: Patient Statement Creation Issue - Error on parameter 120 (character varying) / parameter 120 (text)	v3.6.8
7	7822	Patagonia	26830, 28474	PH: Insurance payment Activity group by program	v3.6.8
8	7829	Patagonia	27870	PH: Medicaid patient Volume Report output criteria enhancement	v3.6.8
9	7837	Shoolin	Email	MB-Shoolin: secondary PR in master claim detailed report is populating repeated values whereas the total of Secondary PR shows incorrect value.	v3.6.8
10	7855	MDReports	Email	MDR: Activity Summary by Provider, Insurance Payment Activity - Split by Serviced by Provider	v3.6.8
11	7880	iTech		iTech: HL7 - Diagnosis code FT1-19 segment overwrite issue	v3.6.8
12	7906	Patagonia	28068	PH: Insurance Analysis by Procedure Report issue	v3.6.8
13	7933	Patagonia	28059	PH: Charge amount in the insurance Payment Activity Report	v3.6.8
14	7939	Patagonia	28780	PH: Feature request for use the enter key in "the claim is closed successfully" OK box also.	v3.6.8
15	7961	iTech	-	Hot Patch (v3.6.7.1) | MB: System not able to generate "Practice Analysis by Procedure" report	v3.6.7.1
16	7963	MDReports	Email	MDR: Selected date with a different color regardless of whether the day has appointment or not	v3.6.8
17	8011	Patagonia	-	PH: Billing Provider Taxonomy code in EDI (95378 - UnitedHealthcare Community Plan / TN)	v3.6.8
18	8090	MDReports	Email	MDR: Issue in Appointment Patient Summary PDF Export	v3.6.8
19	8156	MDReports	Email	MDR: Eligibility NPI/Tax ID Issue in Eligibility Inquiry	v3.6.8

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