iTech Workshop®
Data Integration for Healthcare

expEDIum Medical Billing

v4.3

Release Note

Release Date: March 23, 2019

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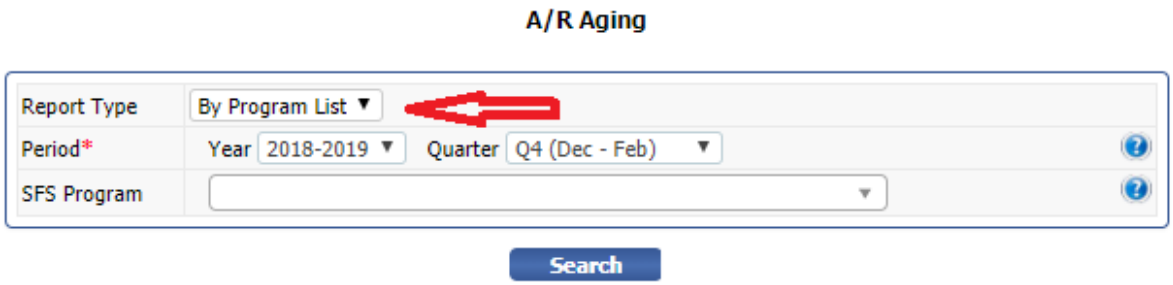
This release note describes tickets that are either enhancements or new features or bug fixes. Some tickets may refer to other tickets from previous releases. These tickets are combination of change requests from any of our partners and that are internally identified at iTech. A summary of tickets is provided in the last page of this release note. On request, we can provide any specific release note for any earlier release. This release note is also available from our website at http://www.itechws.com/releasenote for the last few releases.

1) [Ticket#7523] PH: New Report | A/R Aging Report By Program

As per the client request, a new flavor of A/R Aging Report is introduced which is based on SFS program. The report is available only for Public Health customers and is accessible from **Reports >> Aging >>A/R Aging Report**. A new report type "By Program List" is added to the **Report Type** drop-down. Below is the screenshot.

Option = Report Type

1) Default = Existing A/R Aging Report.
2) By Program List = A/R Aging by SFS Program.



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A/R Aging By SFS Program

2019-2020 Quarter1 (2019-3-01 to 2019-5-31), SFS Program: All

Program Type	Billed Charges	Copay	Ins Pay (Non-Contract)	Ins Pay (Contract)	Patient Pay	Patient Pay (collections)	Write-Off	Ins Adj.	Custom Pay/Credits	Balance Forward Credit	Other Pay/Credits	Debt Set Off	Bad Debt Write Off	SFS Adj.	Account Specific Custom Pay/Credits	Custom Charges/Debits	Balance Forward Debit	Account Specific Custom Charges/Debits
Program Type : AB																		
Mar 2019																		
Unit	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Amount	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Unit	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Amount	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Program Type : BA																		
Mar 2019																		
Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Amount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00
Total Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Total Amount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00

Choose the **Report Type** and click on **Search** button to bring up the report screen. By default, the SFS Program Filter will be shown as empty – This will filter the report result irrespective of the SFS Program. If the reports must be fetched for one or more specific SFS Program(s), choose the program from the dropdown and click Search.

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A/R Aging By SFS Program

2019-2020 Quarter1 (2019-3-01 to 2019-5-31), SFS Program: All

Program Type	Billed Charges	Copay	Ins Pay (Non-Contract)	Ins Pay (Contract)	Patient Pay	Patient Pay (collections)	Write-Off	Ins Adj.	Custom Pay/Credits	Balance Forward Credit	Other Pay/Credits	Debt Set Off	Bad Debt Write Off	SFS Adj.	Account Specific Custom Pay/Credits	Custom Charges/Debits	Balance Forward Debit	Account Specific Custom Charges/Debits
Program Type : AB																		
Mar 2019																		
Unit	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Amount	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Total Unit	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Amount	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00
Program Type : BA																		
Mar 2019																		
Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Amount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00
Total Unit	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0
Total Amount	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00

Note: If transactions are not available for any month for a chosen quarter, then that month will be excluded in the report. As this report is split by SFS Program, this report will not have the functionality of carrying forward A/R from previous quarters.

Below is the detailed explanation of each column in the report:

The report will be grouped by Program, and then by Month

- **Billed Charges**: The count of claims for the time period chosen and their claim charges for the time period chosen are shown as Unit and Amount rows respectively. The dependent secondary claims will not be considered here.

- **Co-pay:** The count of claims for the time period chosen and their copay amount are shown as Unit and Amount respectively. The dependent secondary claims will not be considered here.
- **Ins Pay (Non-Contract):** The count of non-contract claims having postings for the time period chosen and their primary/secondary insurance payment amounts are shown as Unit and Amount respectively.
- **Ins Pay (Contract):** The count of contract claims having payment posted for the time period chosen and their primary/secondary insurance payment amounts are shown as Unit and Amount respectively.
- **Patient Pay:** The count of ledger transactions such as Patient payment (Cash), Patient payment (Check), Patient payment (Credit card), Patient payment (Other) for the time period chosen and the respective transaction amount is shown as Unit and Amount respectively under SFS Program Category.

  Note: The Patient Payment - Debt Set off(Cash), Patient Payment - Debt Set off(Check), Patient Payment - Debt Set Off (Credit Card), Patient Payment - Debt Set off(Other), Debt Set Off does not have SFS Program Dimension and hence the amount will be shown under "No SFS Program" row in this report.
- **Patient Pay (Collections):** The count of the ledger transaction Patient Pay (Collections) for the time period chosen and the respective transaction amount is shown as Unit and Amount respectively.
- **Write Off:** The count of ledger transaction Write Off for the time period chosen and the respective amount is shown as Unit and Amount respectively.
- **Ins Adj:** The counts of claims having postings for the time period chosen and the respective insurance adjustment amount is considered. The insurance adjustments from the posting of dependent secondary claims are not considered and the special logic which is used to fetch and populate the adjustment amount in the original A/R Aging Report is used here as well.

  Below are the special logic conditions.

  Case 1

  If a claim is having multiple postings,

  For each posting entry,

  - If the Insurance PR is non-zero, and Insurance payment amount is also non-zero, then take the Insurance Adjustment amount for calculation.

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- If the Insurance PR is zero and Insurance payment is non-zero, then take the Insurance Adjustment amount for calculation.
- If the Insurance PR is non-zero, and Insurance payment is zero, then take the Insurance Adjustment amount for calculation.
- If the Insurance PR is zero, and the Insurance payment is also zero, then do not take the Insurance Adjustment amount for calculation.
- Note for (d): In the case where the sum of Insurance PR across all postings is zero, and sum of all Insurance Payments across all postings is zero, then take only the Insurance Adjustment from only one posting (latest posting entry).

Case 2

If a claim has single posting, then the insurance adjustment amount will be directly taken from that posting.

- **Custom Pay/Credits:** The count of ledger transactions such as Custom Payment(Cash), Custom Payment(Check), Custom Payment(Credit Card), Custom Payment(Other) for the time period chosen and the corresponding amount is considered here.
- **Balance Forward Credit:** Balance Forward payment transactions count for the chosen time period and the corresponding amounts are considered.
- **Other Pay/Credits:** The count of manually added transactions Co-Insurance and Deductible for the chosen time period and the corresponding amounts will be considered.
- **Debt Set Off:** Debt set off transactions count for the chosen time period and the corresponding amounts are considered. Now, as there are no SFS Program dimension to Debt Set Off transactions (as balance due is consolidated across all programs), this count/amount will come under No SFS Program group in the report.
- **Bad Debt Write Off:** Bad Debt Write off Transaction count for the chosen time period and the corresponding amounts are considered. Now, as there are no SFS Program dimension to Bad Debt Write-Off transactions (as balance due is consolidated across all programs), this count/amount will come under No SFS Program group in the report. However, the Bad Debt Write Off performed from Bad Debt Write Off By Program Report has SFS dimension, and hence those count/amounts will come under the respective Program group.

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- **SFS Adj:** The count of manually added SFS Adjustment Ledger Transactions for the chosen time period and corresponding amounts are considered.
- **Account Specific Custom Pay/Credits**: The count of account specific user defined payment/credit transactions for the chosen time period and the corresponding amounts are considered.
- **Custom Charges/Debits:** The count of ledger transaction Custom Charge for the time period chosen and the corresponding amount is considered here.
- Balance Forward Debit: Balance Forward charge transactions count for the chosen time period and the corresponding amounts are considered.
- **Account Specific Custom Charges/Debits**: The count of account specific user defined charge/debit transactions for the chosen time period and the corresponding amounts are considered.

2) [Ticket#8409] MDR : Edit Patient Demographics – User Privilege on editing PAN/PCN

A new privilege called **Edit PAN** is added in operator privileges and user roles. For PRACADM user roles, this privilege will be enabled by default. Only for users having this privilege enabled can edit PAN number from Edit Patient Screen. On Edit Patient screen a new toggle button is introduced near Account Number field for such users. By default, this toggle will be turned off and user must turn on to edit the field. If the user saves the patient, leaving the field as empty, as usual the PAN will be autogenerated by the system.

For those users who does not have the privilege to edit PAN, the Account Number field will be disabled and non-editable. The toggle also will not appear near Account Number field. On Add Patient screen, there is no toggle button by default and hence the user can create a PAN of his choice or the system will auto generate the Patient Account Number if left empty, irrespective of the **Edit PAN** privilege

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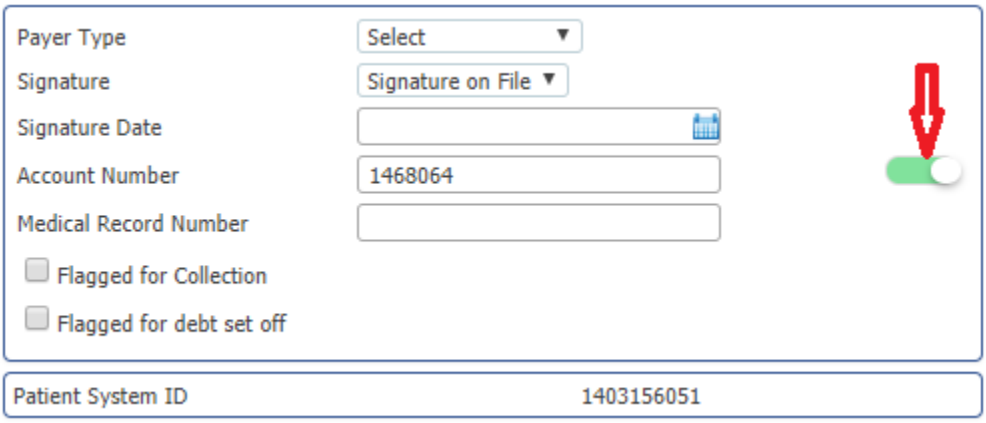
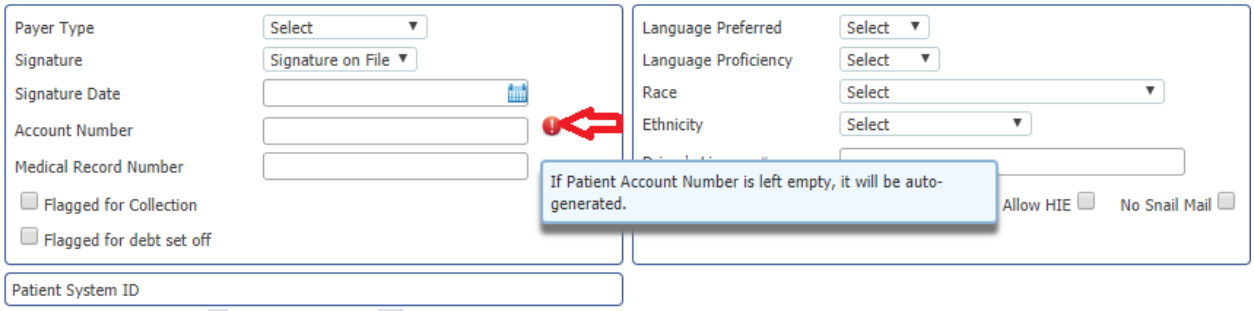


This feature is handled in the following Edit Patient screens

1) Patient DMG - Patient Edit screen
2) Patient Appointments - Patient Lookup - Edit Patient
3) Patient Eligibility - Batch - Patient Lookup - Edit Patient
4) Patient Eligibility - Inquiries - Patient Lookup - Edit Patient



3) [Ticket#8790] PH : Removal Home Health option in Service Facility Filter Drop-Down – Phase 2

A list of search screens was enhanced in ticket #8219 of v4.1.1 release where "Home Health and Home Health without NPI" were replaced with "FACILITY WITHOUT NPI" by default for location filter. Now, the below listed remaining search screens and dashlets are also handled in this release for PHD and Non-PHD accounts.

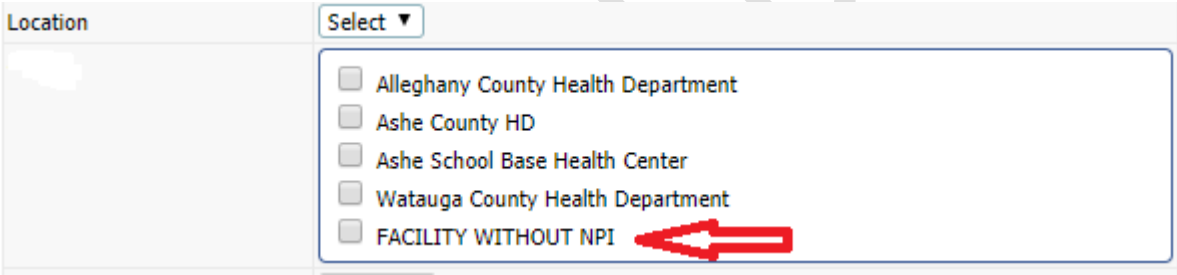
Search Screens:

1) Search Claims

2) Search Denials
3) Search Rejections
4) Search Errors

Dashlets:

1) Denied Claims Summary (Reason Code wise)
2) Denied Claims Summary (Remark Code wise)
3) EDI Claim Summary (Payer wise)
4) Error Claim Summary
5) Procedure Code Summary
6) Procedure Code Summary (Date Wise)
7) Procedure Code Summary (Month Wise)
8) Rejected Claim Summary



4) [Ticket#8884] LNC : Posting Batch Screen Enhancements

The Posting Date Type was always selected as "Received" under the Quick Search option in Posting Module. This is now made configurable i.e. The user can now configure "Posting Date Type" filter under **Maintenance >> Feature Settings >> Posting >> Default Posting Date Type** option. This configuration has four options - Received Date, Production Date, Check/EFT Date, Check Receipt Date. The option selected by the user will be set as default posting date type on the posting screen. Each time the user refreshes posting screen, the date type selected in the feature settings will be set as default type.

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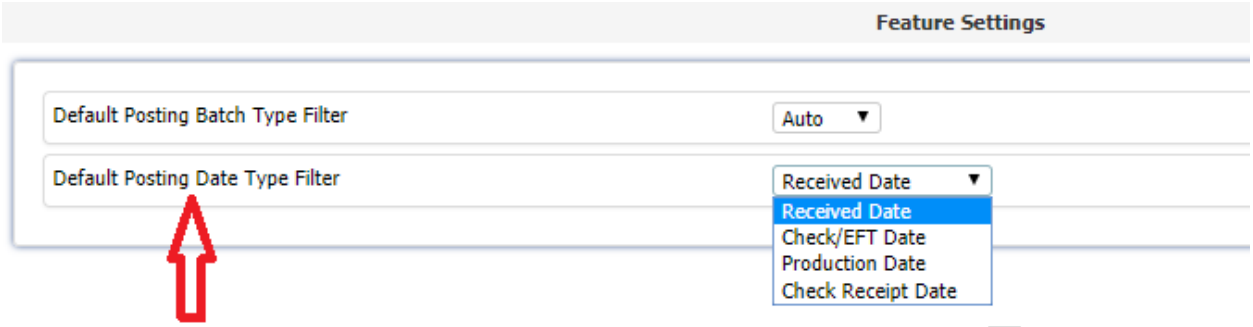
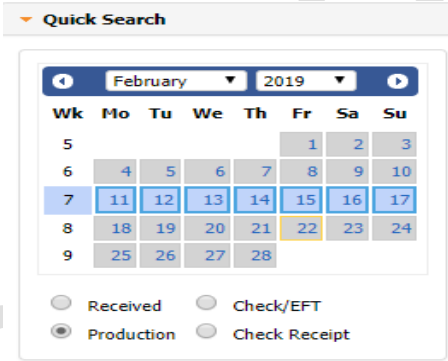


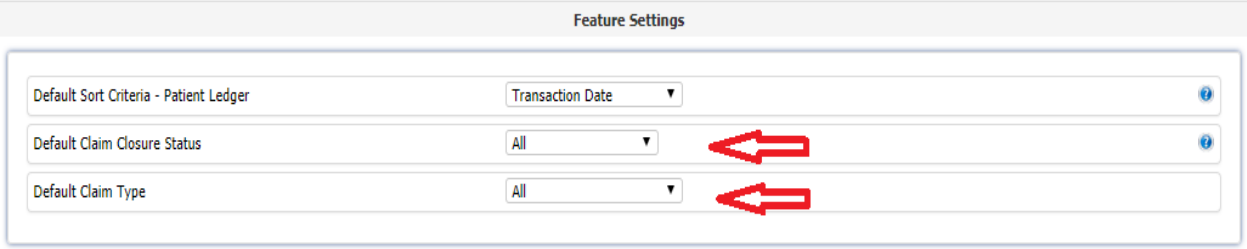
Earlier, the users were able to click only on a day in the calendar. Now we have enhanced this feature in a way where user can select the whole week in the calendar provided under "Quick Search" just by clicking on week number. When user selects the week number, the list of batches for whole week appears in the Posting Quick Search screen.



5) [Ticket#8956] MDR : Feature Configuration | Ledger Claim Closure Status

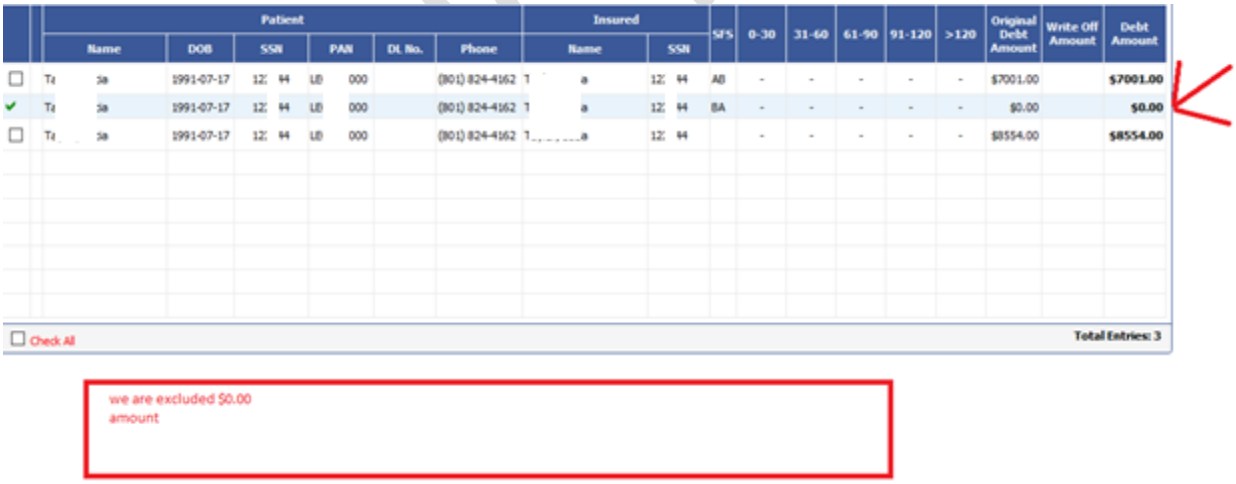
In Patient Ledger screen, the Claim Closure Status Filter was set to "Opened" by default and Claim type was "All" by default. There were client requests asking it to make Claim Closure Status configurable. Under **Maintenance menu >> Feature Settings >> Patient Ledger, two new settings are added -**

- Default Claim Closure Status – All, Opened, Closed. The option "Opened" will be selected by default.
- Default Claim Type – All, Professional, Institutional. The option "All" is selected as default. The practice can change the settings to the option they need. These settings are also available to the administrator to change on behalf of the practice.



6) [Ticket#9069] iTech : Bad Debt Write Off Report - $0.00 SFS Balance should not appear

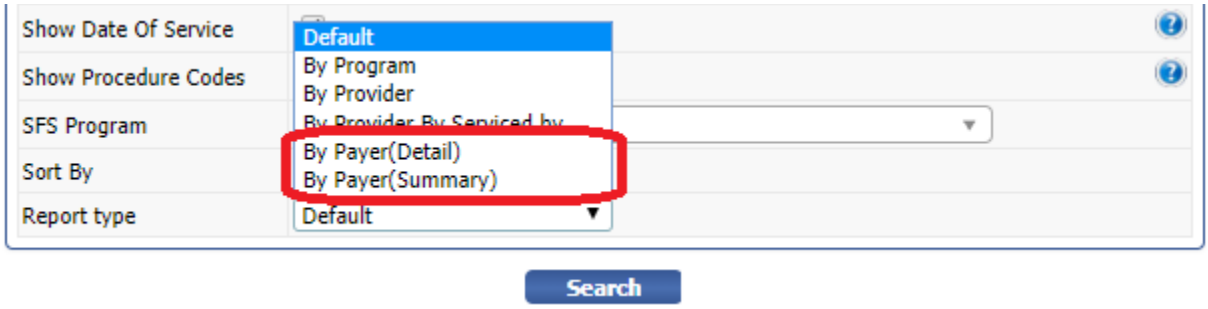
Under the menu, Patients >> Bad Debt Write Off >> Report Type >> By SFS Program, the bad debt write-off report by program was displaying entries with debt of $0.00 when the debt is split by program and displayed. As the zero-dollar debt does not make sense in this report and there is no write off also possible, these zero-dollar debt amounts are now removed from the debt entries screen. Now, it displays only non-zero debt amounts negative or positive values in this new flavor report.as debt.



7) [Ticket#9151] PH : New Report | Insurance Payment Activity By Payer

As per the request from one of the clients, we have added two new flavors/types of Insurance

Payment Activity Report – By Payer (Summary) and By Payer (Detail). This is available under the menu Reports >> Activity Report >> "Insurance Payment Activity Report".



Below shows the sample Insurance Payment Activity Report By Payer (Detail). This report will display primary and secondary claims in separate rows with their respective claim Charge, Co-Pay, Insurance Payment, Insurance PR and Insurance Adjustment amount. The total amount, copay, payment, adjustment and PR amount will be added and will appear as total and grand total. Please note, the claim charges and copay of the primary will be considered in the respective totals if the primary has dependent secondary.

Below shows the sample Insurance Payment Activity Report by Payer (Summary). This report will have only the totals and not the claim details.

Print

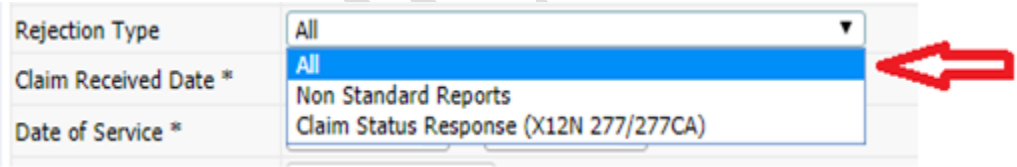
Insurance Payment Activity Report By Payer (Summary)

[Posted between : 02/24/2018 To 03/02/2018, Insurance type : All, Posting type : All, Provider : All, Location : All, Site Code: All , Show Patient Name: Yes , Show Patient Account Number: Yes , Show Patient DOB: Yes , Show Date Of Service: Y , SFS Program : All, Posted Amount : All, Serviced By Provider : All]

Payer ID	Payer Name	Total Claims	Total charge	copay	Total Payment	Total Adjustment	PR	% Paid
	BLUE CROSS BLUE SHIELD OF NORTH CAROLINA	1	$195.00	$0.00	$0.00	$195.00	$0.00	0%
11502	Medicare - North Carolina	31	$3901.00	$0.00	$678.29	$1804.72	$896.99	614%
13306	PHCS Savility Payers	11	$1471.00	$140.00	$0.00	$455.00	$816.00	0%
29076	Medical Mutual of Ohio	1	$160.00	$0.00	$0.00	$46.26	$113.74	0%
37323	Assurant Mini - Med Key Family	1	$100.00	$0.00	$0.00	$100.00	$0.00	0%
39026	UMR- Wausau - UHIS	4	$684.00	$30.00	$249.01	$342.68	$92.31	170%
41124	Meritain Health	2	$601.00	$0.00	$0.00	$35.60	$565.40	0%
44054	GEHA	4	$724.00	$0.00	$0.00	$724.00	$0.00	0%
45289	Fringe Benefit Group Inc.	2	$232.00	$0.00	$164.03	$38.21	$29.76	163%
56162	MedCost, Inc.	3	$340.00	$0.00	$169.53	$150.47	$20.00	167%
60054	Aetna	69	$13474.00	$213.00	$59.48	$3160.75	$10193.58	48%
61101	Humana	3	$496.00	$20.00	$0.00	$258.00	$238.00	0%
62308	CIGNA	7	$1485.00	$0.00	$210.89	$1208.99	$65.12	196%
87726	AARP	1	$240.00	$0.00	$0.00	$70.00	$170.00	0%
87726	United HealthCare	19	$5324.00	$40.00	$250.12	$2045.00	$218.88	237%
CH002	CHAMPUS / TRICARE NORTH (Health Net Federal)	2	$190.00	$0.00	$66.64	$35.97	$87.39	74%
CH002	Humana Military Healthcare Services (TRICARE for South Regio	1	$175.00	$0.00	$56.48	$54.41	$64.11	32%

8) [Ticket#9178] PH : Rejection Search | Support for Report Type All (Non-standard & Standard)

The client had requested to provide "All" option in Search >> Rejection >> Rejection Type. The users had a difficulty in selecting rejection types from the given drop down as it was too technical for them. Hence, we have added a new rejection type option called as "All" to the rejection type drop-down menu which will allow the users to search for the denials reported from both Non-Standard Reports and Claim Status Response (X12N 277/277CA).



The Rejection Search Result for rejection type "All" looks like the screen shot shared below.

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Rejections Search Result
[Insurance Type: Primary, Rejection Type: ALL, Confidential : All, Age: 90 Days, Site Code: All]

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	Code	Description	# of claims	% of claims	
●	A7 - 632	Acknowledgement/Rejected for Invalid Information - The claim/encounter has invalid information as specified in the Status details and has been rejected. Reject Reason Code	1	100.00	☰

Total Rejection Codes: 1
Total Claims: 1

◀ Page 1 ▶ Page 1 of 1

Non Standard Reports | Claim Status Response (X12N 277/277CA)

Back to Search

The black icon indicates that the denial is from "Non-Standard Reports" and green icon indicates that the denial is reported from Claim Status Response (X12N 277/277CA)".

9) [Ticket#9260] PH : Soap API | Issue with Password having apostrophes

The Soap API calls were failing for a newly added practice. The password was changed to temporarily handle this. However, there was an issue in the credential validation due to embedded single quotes/apostrophe in the password. This issue is fixed in this version.

10) [Ticket#9289] iTech : Master Service Line report – Balance Not Rounded Off

There was an issue found in the Master Service Line Report while doing sanity testing on some of the production servers. The Co-pay balance amount in the report was wrongly rounded off to the nearest integer value. This issue is now fixed for all columns in the report, and now the values are rounded off to two decimal places.

Master Service line Report

Print

Provider : All, Referring Provider : All, Location : All, Claim Status : All, Claim Closure Status: All, Claim Received Date From : 01/02/2019 To 01/03/2019, SFS Program: All, Site Code : All

Claim ID	Patient Name	DOS From	DOS To	PAN	DOB	Pri Ins	Proc	Proc Desc	SFS Prg	Claim Status	Claim Closure Status	Units	Unit Chg	Total	Pri Ins Paid	Pri CO-45	Balance	Pri PR-1 Copay	Pri PR-2 Coins	Pri PR-3 Ded	Pri Other Adj	Sec Ins Paid	Sec CO-45	Sec PR-1 Copay	Sec PR-2 Coins	Sec PR-3 Ded	Sec Other Adj
1581	559	2019-01-03	2019-01-03	F	12...	2008-11-09 N.W. Ironworkers Health & Security Trust Fund, Group # F15	G0105	COLORECTAL SCRN; HI RISK IND	CH	Posted	open	1.43	6.99	10.0	5.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grand Total												1.43		$10.00	$5.00	$0.00	$5.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00

11) [Ticket#9292] MDR : Secondary Claims – Primary COB Population Logic Enhancement

When a secondary claim is created by the system, by populating the secondary details from primary claim, the system also populates the primary adjudication details into secondary claim. However, the details were always taken from last posting available on primary claim. In some cases, we have noticed that the last posting is having only the adjudication details of few service lines (Split posting or reversals). In these cases, for manually created secondary claims, the users had to go the primary claim history and look all the posting history, inspect and manually fill the primary COB details for each service line.

In this version, instead of going to the last posting of the primary claim, the system will fetch the last posting of each service line of that primary claim where the service line payment is greater than or equal to zero and populate the service line COB details in the secondary claim.

For each service line, the preference will go to the postings with payment greater than zero. If there are postings with service line payment greater than zero, the latest posting of greater than zero payment and the respective adjudication details will be taken.

If there are only zero payment postings for a service line, then the latest posting of those zero payments and the respective adjudication details will be taken.

The service line adjudication date is mandatory and should be filled. As the adjudication details are fetched separately or each service, the adjudication date of the specific service line posting will be fetched.

This is done using the logic – Get the Production Date and Check/EFT Date from the Posting Batch/Transaction. If production date is present (will be always present), populate that as adjudication date, or else use Check/EFT date as adjudication date.

The system looks for service line payments/adjudication details when a secondary claim is posted and not claim level COB posting. And, we will not be also populating Claim COB adjudication

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details from Remit, as service line postings can be from multiple remits. In the Claim COB screen, we will add up all the service line payment amounts and populate it as Claim Level Payer Paid Amount. Other fields will be left empty.

As before, the adjudication details will be fetched only if the claim status of the primary claim is "Posted". This is to avoid fetching the details from a claim which is resubmitted and is in a different status now. Even after the secondary claim is created, the primary claim can get posted again – mainly in the case of any resubmissions and split postings. Hence, to pull the latest primary claim adjudication details to secondary claim, a "Reload" icon is provided near the right end of service line table when the claim is opened for revalidation/or for editing. Click this icon to reload the adjudication details from current postings of primary claim into secondary claim. This button will be available on edit professional/institutional claim screen.

This logic where the service line level COB Adjustment details will be pulled is implemented in the following functionalities in the system from which the secondary claims can be generated:

1) **Claim Search**
   Select the Claim Status as Posted and turn on the option "Sec. Pending" for searching claims. This criterion will list the primary claims having current status as "Posted" and are eligible for secondary claim creation (a predefined criteria). The result will have the list of those claims with an additional button to create secondary claim. Click on this button and it will open the new secondary claim screen (Professional or Institutional).

2) **Primary Claims Lookup**
   From New Secondary Claim Screen (Professional and Institutional).

3) **Manual Crossover Posting**
   Posting Batch >> Claim List >> Add Claim (+) button on column header >> Claim Lookup >> Post Type = Secondary. Select a primary claim, which does not have any associated secondary claim and perform cross over posting.

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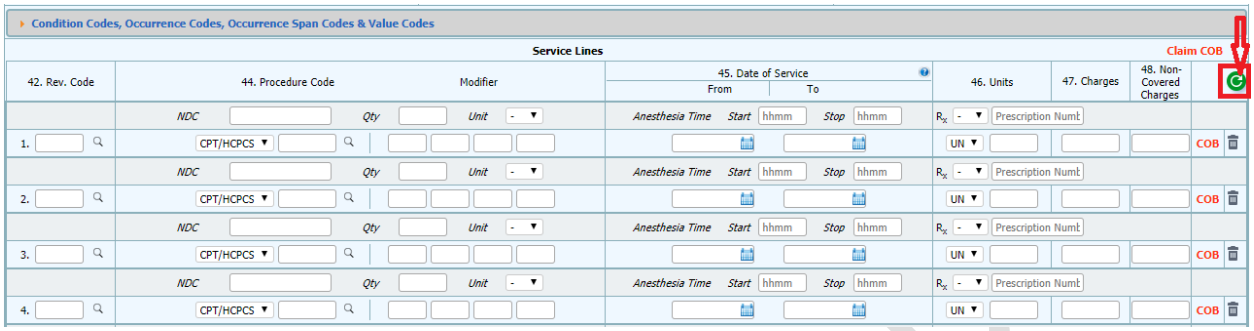
4) **Auto Crossover Posting**

Create cross over ERA for a primary claim with postings which does not have secondary claims. The cross over ERA can have remit status code as 2, 20, 4, 22, 19 for the system to auto generate create secondary claims.



12) [Ticket#9319] PH : (Harford) Patient Statements – "Patient Name Format" enhancement required

One of the clients had requested for a new feature enhancement i.e. in-patient name format on the patient statement. This feature was originally implemented in v4.1.2 (ticket #8769). The client did not want the comma to appear in the patient name on the destination address box and requested to have formats without commas.

To have this request implemented, we are now supporting the following universal formats with an additional check box "Ignore Comma". This option is available under Patient Statements >> Manage>> Settings. The user can choose the required universal format and enable "Ignore Comma" if comma is not required.

1) LastName, FirstName MiddleInitial
2) FirstName LastName MiddleInitial
3) LastName, FirstName
4) FirstName LastName

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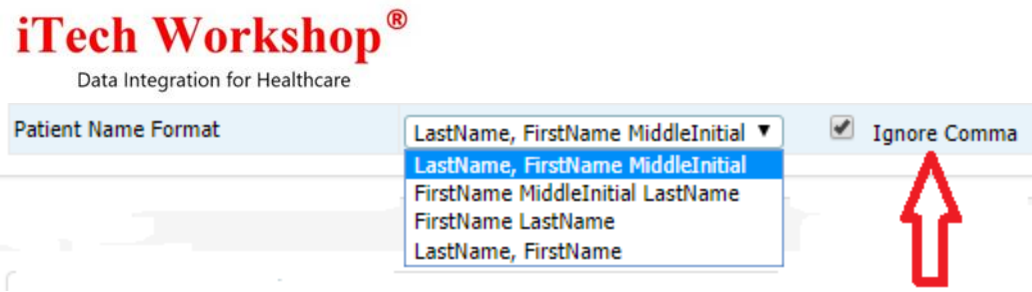
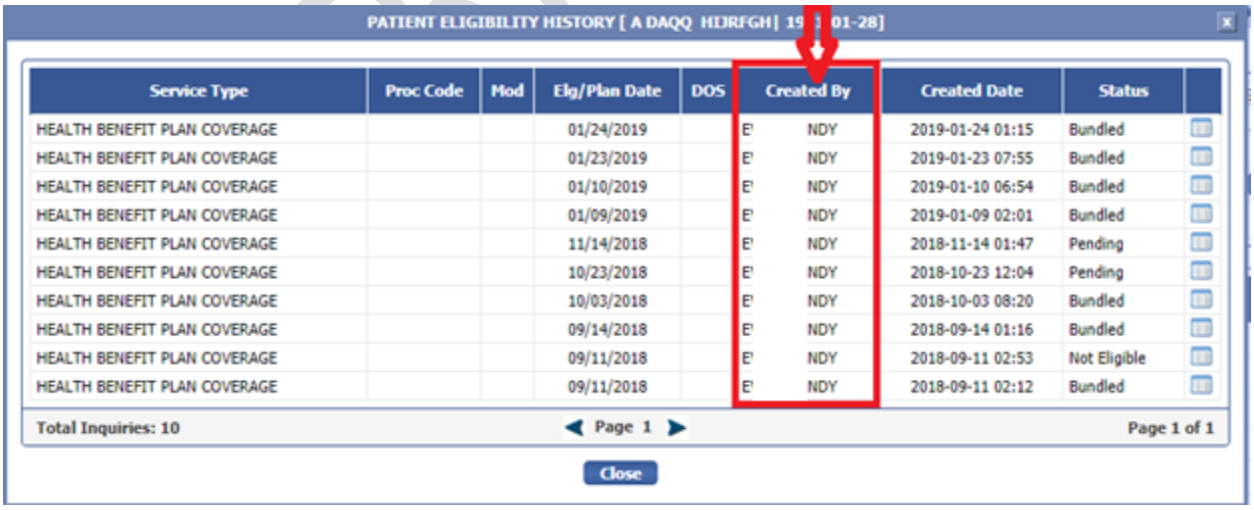


The patient name format together with Ignore Comma option will be saved as search criteria and can be viewed under the Task Details Section in the "More Information" window, which is available from Task View, File View and Patient View.

13) [Ticket#9320] PH : This "Created By" column under "patient eligibility history" window

One of the clients requested to add "Created By" column under "Patient Eligibility History" window. We already have a "Created By" column under Patient >> Eligibility >> Inquiries where, clinic can see who (operator) ran the Insurance Eligibility Verification for the patient. Now, we have added "Created By" column under "Patient Eligibility History" window as it will be helpful and easy for them to identify who created the inquiry. Note, this "Created By" column in Patient Eligibility History screen will display the name of the user and not the expEDIum Operator ID.



14) [Ticket#9356] PH : Public Health | Exclude Confidential Claims from Pt Statement Amount Due and Aging Calculation

The confidential claims transaction details are already hidden from patient statement body. The confidential claims are now excluded from the statement amount due calculation and the corresponding aging amount calculation.

A hot patch (v3.6.8_421) is applied on one of the production servers and v4.2.1 on one of the demo servers - on Tuesday, March 5, 2019. The remaining production and demo servers will have this patch as part of v3.6.8_43 and v4.3 release.

15) [Ticket#9357] MDR : Not able to update Block time in Appointment module

There was an issue in editing the first block time configuration in appointment scheduler module under Provider Settings. The system was not allowing to update block time configuration and the drop downs for appointment type was not listing the types. This issue was happening only in WildFly version. These are fixed in this version and the provider can edit block time configuration and the dropdown is listing the Appointment Types

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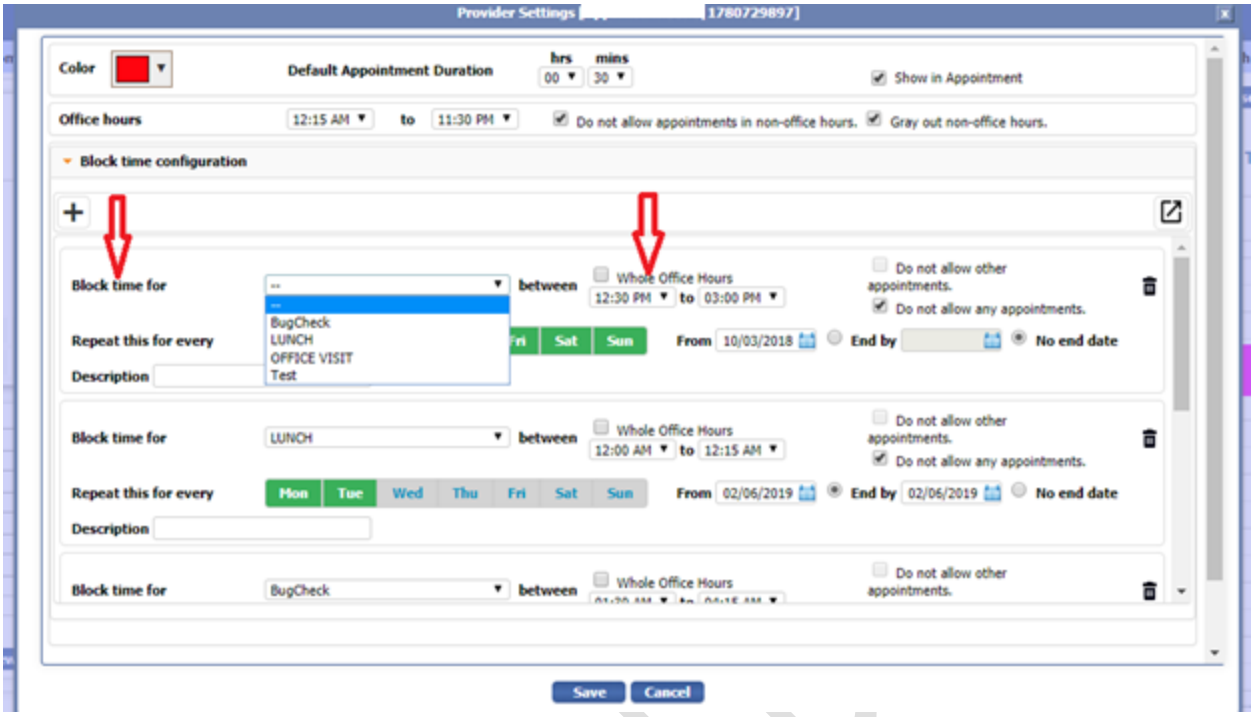

16) [Ticket#9384] PH : 837P Outbound EDI Edit | Allow Billing Provider Taxonomy Code for Medicaid Missouri (MCDMO)

expEDIum does not send billing provider taxonomy code by default on all claims. As most of the payers expect only rendering provider taxonomy code, we do send only rendering provider taxonomy code in the outbound EDI. However, we have an edit to send both– that is, Rendering Provider Taxonomy code and Billing Provider taxonomy code for a list of payers.

As per the client request, we have added Medicaid Missouri also to this EDI edit. Now the claims for Medicaid Missouri will carry both billing provider and rendering provider taxonomy code in the outbound EDI. This edit is applicable to all professional 837P 5010 outbound claims for Medicaid Missouri (Office Ally Payer ID = MCDMO).

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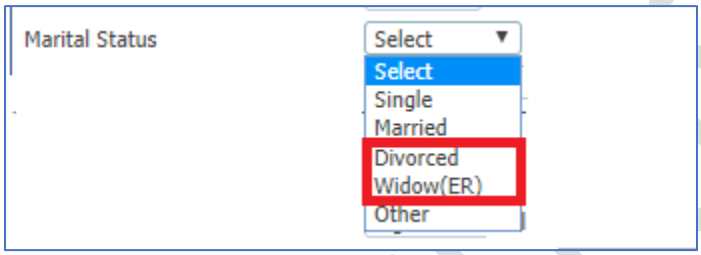
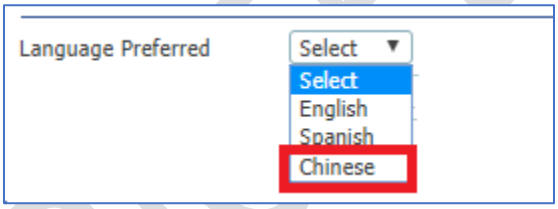
17) [Ticket#9412] MDR : Additional options in "Marital Status" and "Language Preferred" in Patient Demographics

One of the clients wanted an additional option for the fields Marital Status and Language Preferred in the patient demographic. They suggested to add two new options **Divorced** and **Widow(er)** under **Marital Status** and **Chinese** under **Preferred Language.**





We have added the above-mentioned options to Marital Status and Language Preferred drop down in Add/Edit Patient screen, Marital Status for Patient, Primary Insured, Secondary Insured and Tertiary Insured. Language Preferred for Patient. Also, this enhancement is added in other modules too -

1) Import Patient-XML
2) Import Patient-CSV
3) Import/Export CSV map (system default and currently used by accounts)
4) Patient Summary Print – Patient Module, Appointments
5) Export Patient-XML
6) Export Patient-CSV
7) New Professional Claim Screen – When Patient is pulled using Patient Lookup, the patient marital status Divorced and Widow(er) will be populated as Other in claim

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8) Edit Professional Claim Screen (Error Claim) – When Patient Refresh windows is used to reload patient details, the patient marital status Divorced and Widow(er) will be populated as Other in claim, if chose to reload.
9) Marital status of Divorced and Widow(er) will be populated as Other when thin claim is enriched with demographics details using system ID.

18) [Ticket#9448] PH : P/S Creation from ledger – Download issue from Manage screen

There was an issue reported, when downloading the patient statement PDF file (single patient statement created from Ledger) from Patient Statement Task View on demo server. The user was getting a 0 byte PDF file when they clicked on "1" in no of files column under Task View. This was happening only on WildFly version. This issue is fixed in this version. A hot patch (v4.2.1.20190307) is applied on that demo server.

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Bugzilla List of tickets

#	ID	Client	Ext. Ticket #	Summary	Version
1	7523	Patagonia	23006	PH: New Report | A/R Aging Report By Program	V4.3
2	8409	MDR	-	MDR: Edit Patient Demographics – User Privilege on editing PAN/PCN	V4.3
3	8790	Patagonia	29673	PH: Removal Home Health option in Service Facility Drop-down – Phase 2	V4.3
4	8884	LNC	-	LNC: Posting Batch Screen Enhancements	V4.3
5	8956	MDR	78283	MDR: Feature Configuration | Ledger Claim Closure Status	V4.3
6	9069	Internal	Internal	iTech: Bad Debt Write Off Report - $0.00 SFS Balance should not appear	V4.3
7	9151	Patagonia	30838	PH: New Report | Insurance Payment Activity By Payer	V4.3
8	9178	Patagonia	31539	PH: Rejection Search | Support for Report Type All (Non-Standard & Standard)	V4.3
9	9260	Patagonia	Via email	PH: Soap API | Issue with password having apostrophes	V4.3
10	9289	Internal	Internal	iTech: Master Service line Report – Balance Not Rounded Off	V4.3
11	9292	MDR	79072	MDR: Secondary Claims – Primary COB Population Logic Enhancement	V4.3
12	9319	Patagonia	33586	PH: (Harford) Patient Statements – "Patient Name Format" enhancement required	V4.3
13	9320	Patagonia	33563	PH: This "Created By" column under "patient eligibility history" window	V4.3
14	9356	Patagonia	33923	PH: Public Health | Exclude Confidential Claims from Pt Statement Amount Due and Aging Calculation	V4.3
15	9357	MDR	Via email	MDR: Not able to update Block time in appointment module	V4.3
16	9384	Patagonia	Via email	PH: 837P Outbound EDI Edit | Allow Billing Provider Taxonomy Code for Medicaid Missouri (MCDMO)	V4.3
17	9412	MDR	Via email	MDR: Additional options in "Marital Status" and "Language Preferred in Patient Demographics	V4.3
18	9448	Patagonia	Via email	PH: P/S Creation from ledger – Download issue from Manage screen	V4.3

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