expEDIum Medical Billing
v4.6

Release Notes

Release Date | Sep 07, 2019

iTech Workshop®
Data Integration for Healthcare

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Data Integration for Healthcare

expEDIum Medical Billing v4.6 Release Notes

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 #1354] PH: Report Enhancement | RA Reports | Post Type Filter| Support for Auto, Manual, All

As per the client request, a new filter "Post Type" is introduced in RA reports in the system for both Public Health and Non-Public Health accounts. The users can now filter the report based on how the payments are posted.

The Post Type filter will have the following options

- Manual – Use this to filter the payments posted manually
- Auto – Use this to filter the payments that are auto posted.
- All – This will be selected by default. Use this to filter the payments irrespective of whether it is manually posted or auto posted.

The following reports are enhanced to have this filter -

For Public Health Accounts

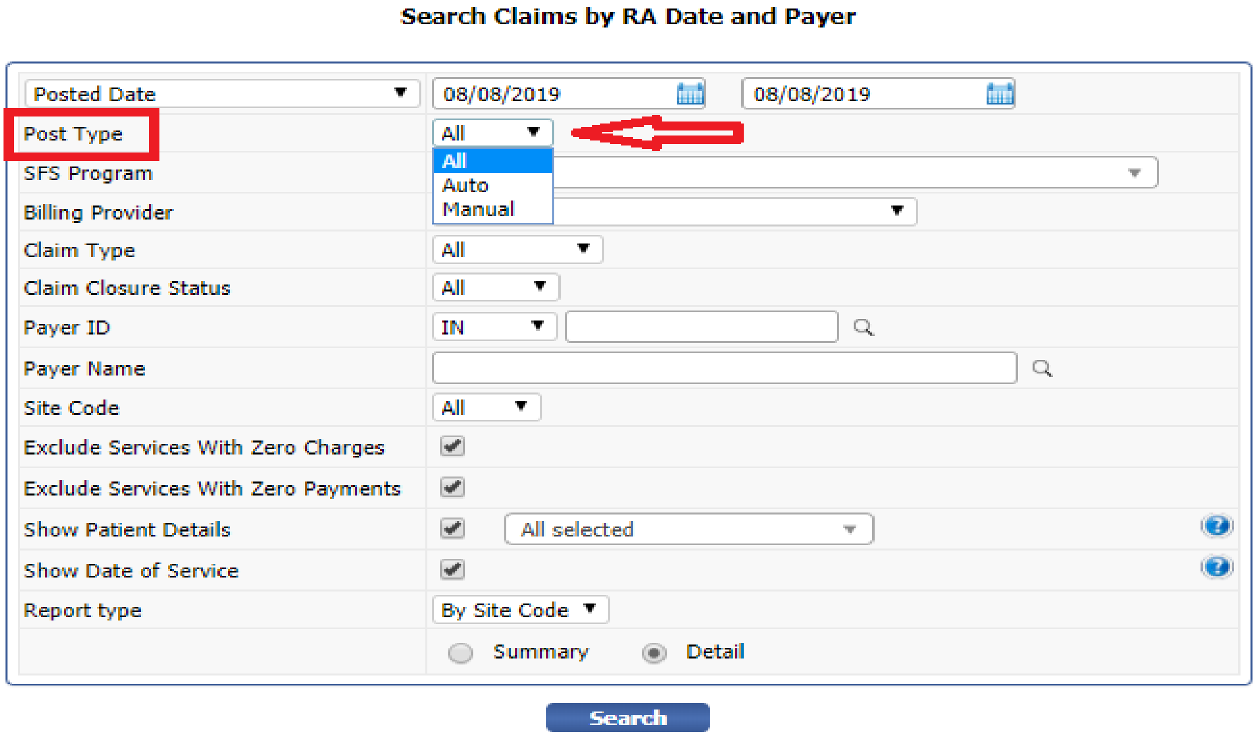
Reports >> Payment Analysis >> Medicaid By RA Date

- Medicaid Claims by RA Date (Summary and Detail)
- Medicaid Claims by RA Date and By Site Code (Summary and Detail)

Reports >> Payment Analysis >> By RA Date and Payer

- Claims by RA Date and By Payer (Summary and Detail)
- Claims by RA Date, By Payer and By Site Code (Summary and Detail)

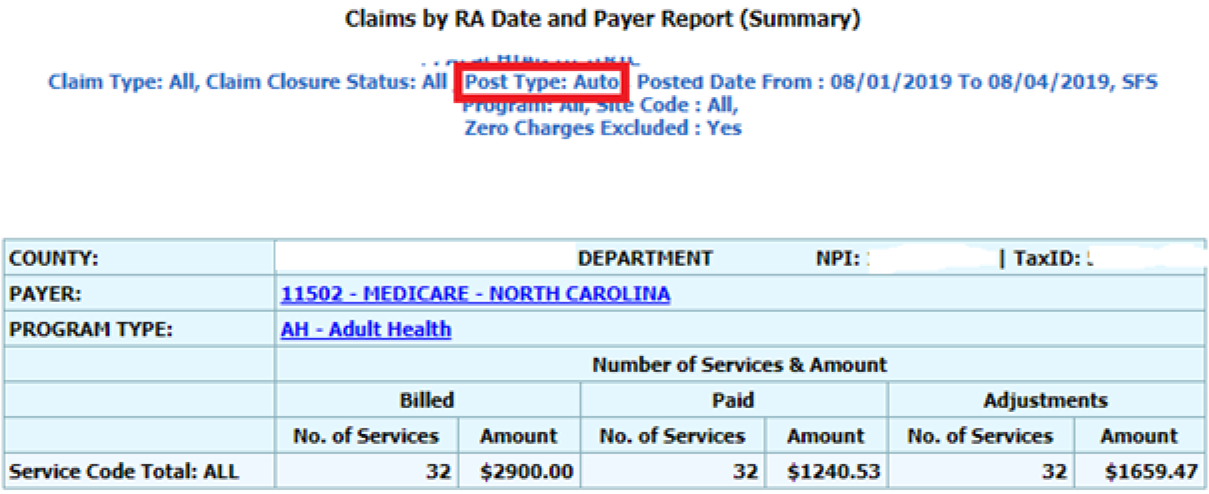
Example | Search Screen | Claims by RA Date and Payer Report



Search Claims by RA Date and Payer

Posted Date	08/08/2019 – 08/08/2019
Post Type	All
SFS Program	
Billing Provider	
Claim Type	All
Claim Closure Status	All
Payer ID	IN
Payer Name	
Site Code	All
Exclude Services With Zero Charges	☑
Exclude Services With Zero Payments	☑
Show Patient Details	☑ All selected
Show Date of Service	☑
Report type	By Site Code
	○ Summary ● Detail

Example | Result Screen | Claims by RA Date and Payer Report



Claims by RA Date and Payer Report (Summary)

Claim Type: All, Claim Closure Status: All, Post Type: Auto, Posted Date From : 08/01/2019 To 08/04/2019, SFS Program: All, Site Code : All,
Zero Charges Excluded : Yes

COUNTY:	DEPARTMENT NPI: | TaxID:					
PAYER:	11502 - MEDICARE - NORTH CAROLINA					
PROGRAM TYPE:	AH - Adult Health					
	Number of Services & Amount					
	Billed		Paid		Adjustments	
	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount
Service Code Total: ALL	32	$2900.00	32	$1240.53	32	$1659.47

Example | Result Screen | Claims by RA Date by Payer and Site Code Report

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Claims by RA Date, by Payer and by Site Code report (Detail)

Post Type: Manual | Claim Closure Status: All, Posted Date From : 08/01/2019 To 08/04/2019
SFS Program: All
Site Code : All
Zero Charges Excluded : Yes ,
Zero Payments Excluded : Yes ,Show Patient Name: Yes, Show Patient Account Number: Yes, Show Patient DOB: Yes, Show Date Of Service: Yes

COUNTY:						NPI:	| TaxID:
PAYER:	PAPER - AYA HEALTHCARE						
SITE CODE:	00301						
PROGRAM TYPE:	IM - Immunization						
	Number of Services & Amount						
	Billed		Paid		Adjustments		
	No. of Services	Amount	No. of Services	Amount	No. of Services	Amount	
Service Code Total: 90471	1	$27.00	1	$27.00	0	$0.00	
Service Code Total: 90707	1	$75.00	1	$75.00	0	$0.00	
Service Code Total:	**2**	**$102.00**	**2**	**$102.00**	**0**	**$0.00**	

		Patient ID	Patient Name	DOB	Service Date	Service Code	Site Code	Posted Date	Payer Claim ID	eMB Claim ID	Billed Amount	Paid/Reversal Amount	Adjustment Amount
P	P				06/18/2019	90471	00301	08/02/2019			$27.00	$27.00	$0.00
P	P				06/18/2019	90707	00301	08/02/2019			$75.00	$75.00	$0.00

<u>For Non-Public Health Accounts</u>

Reports >> Payment Analysis >> By RA Date and By Provider

- Claims by RA Date and by Provider (Summary and Detail)

<u>Example | Search Screen | Claims by RA Date by Provider Report</u>

Search Claims by RA Date by Provider

Posted Date	08/21/2019 — 08/21/2019
Post Type	All (All / Auto / Manual)
Rendering Provider	
Claim Type	
Claim Closure Status	All
Payer ID	
Payer Name	
Exclude Services With Zero Charges	☑
Exclude Services With Zero Payments	☑
Report type	◉ Summary ○ Detail

Search

<u>Example | Result Screen | Claims by RA Date by Provider</u>

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Claims by RA Date by Provider Report (Summary)

Claim Closure Status: All
Post Type: All
Posted Date From : 08/01/2019 To 08/14/2019
Rendering Provider[s] : All
Zero Charges Excluded : Yes
Zero Payments Excluded : Yes

		Number of Services & Amount					
		Billed		Paid		Adjustments	
		No. of Services	Amount	No. of Services	Amount	No. of Services	Amount
PAYER : 39026 - UMR (FORMERLY UMR WAUSAU)		6	$2550.00	6	$1500.00	6	$1050.00
PROVIDER:	NPI:	6	$2550.00	6	$1500.00	6	$1050.00

		Number of Services & Amount					
		Billed		Paid		Adjustments	
		No. of Services	Amount	No. of Services	Amount	No. of Services	Amount
PAYER : NCXIX - HEALTH CHOICE NC		1	$189.75	1	$189.75	0	$0.00
PROVIDER:	NPI	1	$189.75	1	$189.75	0	$0.00

GRAND TOTAL

PAYER:	ALL PAYERS						
PROVIDER:	ALL PROVIDERS						
		Billed		Paid		Adjustments	
		No. of Services	Amount	No. of Services	Amount	No. of Services	Amount
Service Code Total: ALL	Number of Services & Amount:	7	$2739.75	7	$1689.75	6	$1050.00

2) [Ticket #9468] Print COB2 | Logic Enhancement

The Print COB2 feature was having a logic to fetch the last posting of a secondary claim, and the service line adjudication details of the service lines available in that posting. However, there are cases, especially in split posting/reversal where each service lines might have posted with payment on previous postings of the claim and not necessarily on the last posting always. To handle this, we have implemented an enhanced logic for Print COB2, which we have already implemented in the secondary claim creation recently while pulling the service line payment/adjudication details from primary posting (expEDIum Medical Billing v4.3 – Ticket #9292).

Instead of taking to the last posting of the primary claim, the system will print the last posting of each service line where the service line payment is greater than or equal to zero.
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.

As the adjudication details are fetched separately or each service, the adjudication date of the specific service line posting will be fetched and will be displayed at service line adjudication section and hence

the claim level adjudication date will not be displayed. The adjudication date is fetched using the following logic - Get the Production Date and Check/EFT Date from the respective 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.

Also, the payer paid amount at claim level will be calculated and displayed by adding up the service line payer paid amount.

Note: In this logic, the system looks for service line payments/adjudication details and not claim level posting. Hence, the claim COB adjudication details will not be fetched and shown.

3) [Ticket #9883] MDR: Eligibility Status and history on claim form

There was a request for a new feature enhancement in the HCFA and UB04 claim forms. The clinic requested us to add "Last Eligibility Status" in the claim form for both primary and secondary claim forms. Also, a link is provided on the eligibility status to open the eligibility history window. (This is the same eligibility status which is displayed in patient list screen for each patient with a link to open the eligibility history window).

This feature is implemented on the claim form so that it is helpful for the users to review the eligibility status and history during the claim validation and submission cycle.

This feature is available in the following claim screens –

Primary Professional, Primary Institutional = New Claim (when patient is pulled from patient lookup, or when a primary claim is cloned from another primary claim), Edit Claim, Open Claim is read-only mode

Secondary Professional. Secondary Institutional = New Claim (when patient is pulled from patient lookup, or when a secondary claim is generated from a primary claim from claim search – no pending insurance filter), Edit Claim, Open Claim is read-only mode

Last Eligibility Status - Eligible

Last Eligibility Status – Not Performed

New Claim

Claim Notes

Submit Claim | Cancel | Check Duplicate

Patient System ID	
Last Eligibility Status	Not Performed

Confidential

AMBULANCE

Frequency Code : 1 - Original

Payer ID :	SB810
Payer Name :	Blue Cross Blue Shield of North Carolina
Address1 :	
Address2 :	
City :	State : -- Zip :

1. Select Insurance Program : OTHER

1a. Insured's ID Number : YPPW1687399801

2. Patient's Name (Last, First, MI) :

3. Patient Birth Date : Sex: F

4. Insured's Name (Last, First, MI) :

The "Last Eligibility Status" for a patient will display status such as Eligible/No Eligible/Failed and if eligibility status in not available if eligibility is not yet performed, a status of "Not Performed" will be shown.

The clinic can check the patient "Eligibility History" by clicking on the link provided on the status displayed for the label "Last Eligibility status". For the status "Not Performed", the link will not be available. The eligibility history window which will be displayed is shown below.

PATIENT ELIGIBILITY HISTORY [ ]

Service Type	Proc Code	Mod	Elg/Plan Date	DOS	Created By	Created Date	Status
HEALTH BENEFIT PLAN COVERAGE			09/27/2017		EVANS CINDY	2017-09-26 23:54	Eligible
HEALTH BENEFIT PLAN COVERAGE			05/26/2017		DEBORAH PERRY	2017-05-26 09:22	Eligible

Total Inquiries: 2 | Page 1 | Page 1 of 1

Close

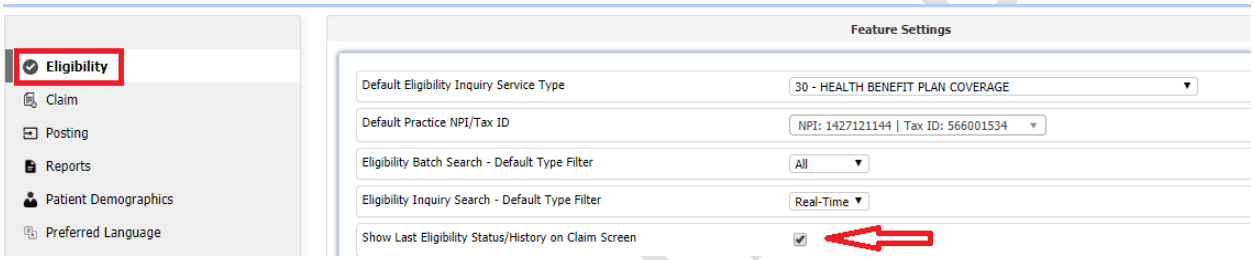
The Last Eligibility Status will be displayed on claim screen only if

1) The practice/hospital account has eligibility feature enabled, AND
2) The user (if the user is an operator) has privilege to use eligibility feature Account has eligibility enabled, AND
3) If Patient identifier in claim is available, AND
   a) Edit/View Claim – if Patient System ID is available in the claim (for edit/view claim screen)
   b) Cloned primary claim - If Patient System ID is present in the original claim from which it is cloned

c) New secondary claim generated from posted primary – If Patient System ID is present in the parent primary posted claim
d) New Primary claim – When Patient Lookup, the patient details including identifier is pulled into the claim and hence this will be always handled
e) New secondary claim - If Patient System ID is present in the original primary claim pulled from Primary Claims Lookup

4) If the account feature settings "Show Last Eligibility Status/History on Claim Screen" enabled.

The account feature setting will have a new configuration "Show Last Eligibility Status/History on Claim Screen". This feature configuration in account settings will be available in administrator login as well as practice/user login. In Practice Login, this configuration will be available only if eligibility feature is enabled for that account. In user/operator login, this configuration will be available only if eligibility feature is enabled for that account and user/operator has privilege to access eligibility feature.

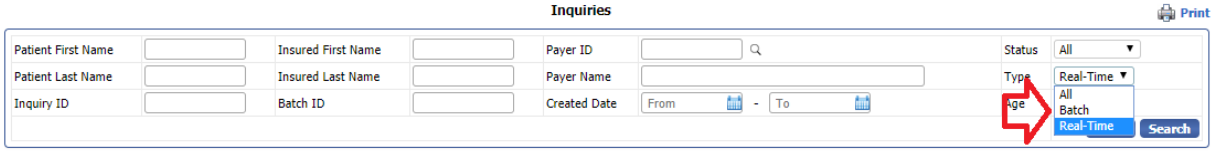


The feature can be turned on or off using the check box provided. By default, the option will be turned off.

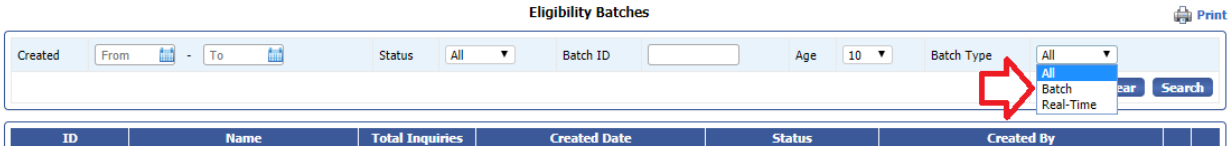
4) [Ticket #9885] MDR: Default eligibility "Type" as "Real time" under inquiries

One of the clients had requested us to default the eligibility type filter (labelled "Type") to "Real Time" instead of "Batch" in Eligibility Inquiry Search/List screen, as most of the users are creating real time eligibility verification than batch.

A new option "All" under this filter is introduced so that users can fetch inquiries irrespective of whether it is real time or batch.

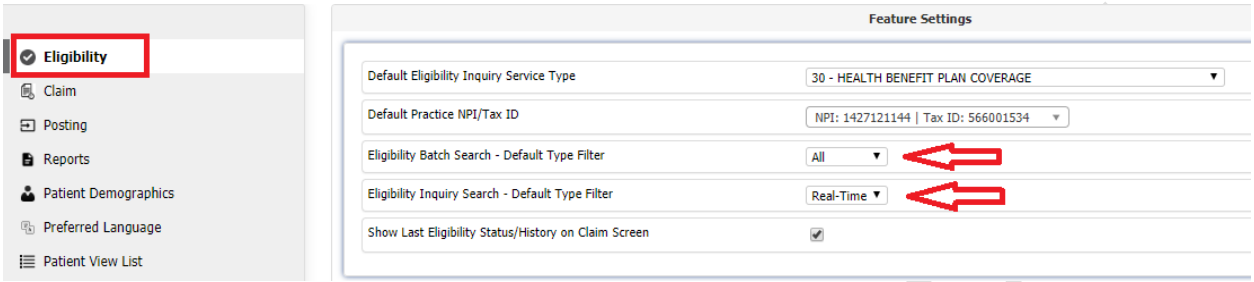


This new option is introduced in Eligibility Batch Search/List Screen as well for the filter "Batch Type".



Also, we have introduced configurations for eligibility type filter under **Maintenance >> Feature Settings > Eligibility > Eligibility Inquiry Search - Default Type Filter**. By default, this configuration will be "Real Time". The clinic can configure the filter type as per their requirement.

The configuration for Eligibility Batch Search/List Screen is available under **Maintenance >> Feature Settings > Eligibility > Eligibility Inquiry Search - Default Type Filter.** By default, this configuration will be "All"



5) [Ticket #9886] PH: Add % to the Aging report columns for Insurance claims and SELF pay claims

As per the client request, we have introduced a new "Percentage" row after each Program Total with the "Grand Total Percentage" at the end of aging report. This percentage row will appear for all Counties and all Programs for age criteria 0-15, 16-30, 31-60, 61-90, 91-120, >120 and Total. This percentage row is added for the following reports.

1) **Aging Report by Program by Payer - Self Pay Claims** = Reports >> Aging >> Self-Pay Claims >> Report Type >> Default /Periodic (Summary and Detail)

2) **Aging Report by Program by Payer – Insurance Claims =** Reports >> Aging >> Insurance Claims >> Report Type >> Default /Periodic (Summary and Detail).

Sample Aging Report by Program by Payer - Self Pay Claims (Default - Detail)

PROGRAM TYPE	TB - Tuberculosis													
027 5		04	11/04/1986	06/18/2019	TB	86580	$0.00	$0.00	$15.00	$0.00	$0.00	$0.00	$15.00
092 5		8	01/18/1993	07/22/2019	TB	86580	$17.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.00
179 6		64	04/10/1998	07/03/2019	TB	86580	$0.00	$0.00	$17.00	$0.00	$0.00	$0.00	$17.00
195 9		18	08/14/1979	07/22/2019	TB	86580	$17.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.00
Program Total							$34.00	$0.00	$32.00	$0.00	$0.00	$0.00	$66.00
Percentage							51.52	0.00	48.48	0.00	0.00	0.00	100.00
COUNTY	HEALTH DEPARTMENT												
PROGRAM TYPE	ALL PROGRAMS												
Total							$4233.20	$5771.60	$11804.00	$0.00	$0.00	$0.00	$21808.80
Percentage							19.41	26.46	54.12	0.00	0.00	0.00	100.00
COUNTY	All COUNTIES												
PROGRAM TYPE	ALL PROGRAMS												
Total							$12590.55	$14955.95	$29686.74	$0.00	$0.00	$0.00	$57233.24
Percentage							22.00	26.13	51.87	0.00	0.00	0.00	100.00

Sample Aging Report by Program by Payer – Insurance Claims (Default - Detail)

PROGRAM TYPE	TB - Tuberculosis													
0		8	01/18/1993	07/22/2019	TB	86580	$17.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.00
1		18	08/14/1979	07/22/2019	TB	86580	$17.00	$0.00	$0.00	$0.00	$0.00	$0.00	$17.00
Program Total							$34.00	$0.00	$0.00	$0.00	$0.00	$0.00	$34.00
Percentage							100.00	0.00	0.00	0.00	0.00	0.00	100.00
COUNTY	HEALTH DEPARTMENT												
PROGRAM TYPE	ALL PROGRAMS												
Total							$4233.20	$5771.60	$0.00	$0.00	$0.00	$0.00	$10004.80
Percentage							42.31	57.69	0.00	0.00	0.00	0.00	100.00
COUNTY	All COUNTIES												
PROGRAM TYPE	ALL PROGRAMS												
Total							$12590.55	$14955.95	$0.00	$0.00	$0.00	$0.00	$27546.50
Percentage							45.71	54.29	0.00	0.00	0.00	0.00	100.00

6) [Ticket #10002] PH: Check/EFT Report by Program List | Add Insurance Program column

One of the clients had requested to add a new column "Insurance Program" in the Check/EFT Report for the report flavor "By Program List – Details" for each claim.

The Insurance Program is feasible only for the report type "By Program List- Details" and hence we have introduced it only this flavor only. This report is available under the menu Posting >> Check/EFT in practice/user login. The report result will also display the "Insurance Program Type" for each claim.

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Check/EFT - By Program List - Details

Type : All, Payer ID : All, SFS Program: All, Payer Name : All, Payment Method : All, Check Number : All, Age : 10 Days

Check/EFT Number	Check/EFT Date	Check Receipt Date	Check/EFT Amount	Post Type	Payment Method	Payer	Payee	Posted Date	Total Claims	Posted Claims	Posted Amount(Claim)	Posted Amount(Service)
	2019-08-16	2019-08-16	326.25	Auto	AUTO			2019-08-16 07:06:14	1	1	500.00	500.00
AH - Adult Health										1	500.00	500.00
Claim ID					Insurance Program				Site Code	Ins Type	Posted Amount(Claim)	Posted Amount(Service)
					COMMERCIAL				10501	P	500.00	500.00
Check/EFT Number	Check/EFT Date	Check Receipt Date	Check/EFT Amount	Post Type	Payment Method	Payer	Payee	Posted Date	Total Claims	Posted Claims	Posted Amount(Claim)	Posted Amount(Service)
	2019-08-16	2019-08-16	326.25	Auto	AUTO			2019-08-16 06:46:59	1	1	500.00	500.00
IM - Immunization										1	500.00	500.00
Claim ID					Insurance Program				Site Code	Ins Type	Posted Amount(Claim)	Posted Amount(Service)
					COMMERCIAL				09501	P	500.00	500.00
Check/EFT Number	Check/EFT Date	Check Receipt Date	Check/EFT Amount	Post Type	Payment Method	Payer	Payee	Posted Date	Total Claims	Posted Claims	Posted Amount(Claim)	Posted Amount(Service)
	2019-08-16	2019-08-16	326.25	Auto	AUTO			2019-08-16 06:30:02	1	1	100.00	100.00
IM - Immunization										1	100.00	100.00
Claim ID					Insurance Program				Site Code	Ins Type	Posted Amount(Claim)	Posted Amount(Service)
									10501	P	100.00	100.00

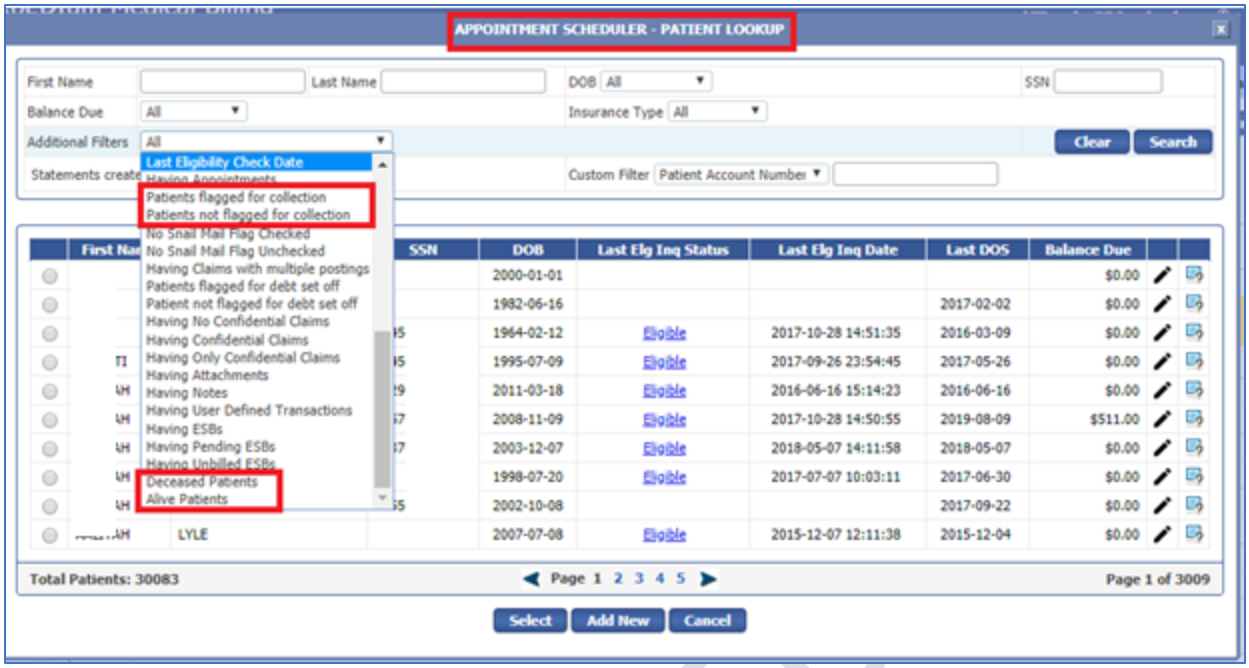
7) [Ticket #10065] iTech : Additional filters to be added in patient lookup (Appointment and Eligibility Inquiry)

In previous v4.5 release, we had introduced four new additional filters in the Patient Demographics lookup such as:

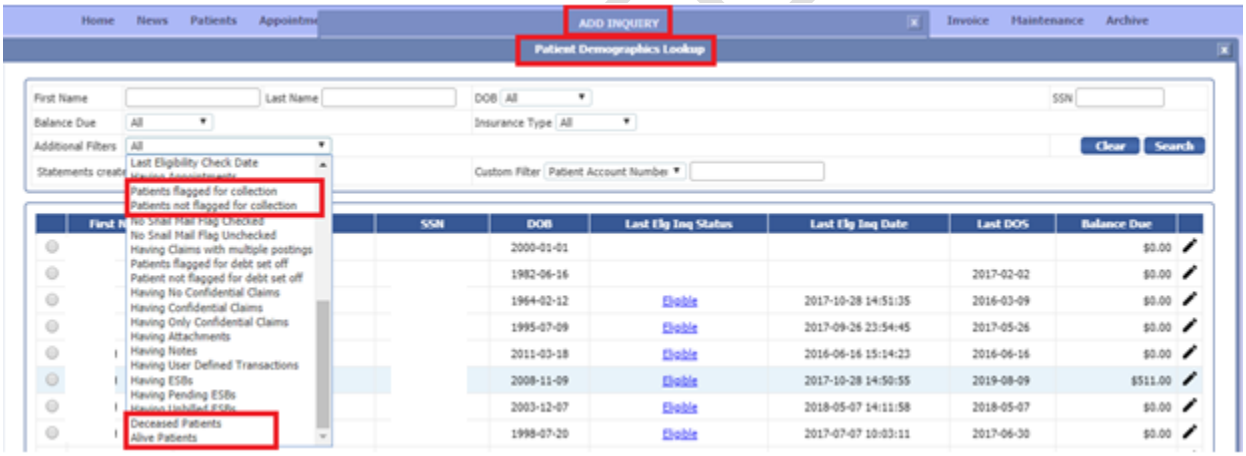
a) Patients flagged for collection
b) Patients not flagged for collection
c) Deceased Patients
d) Alive Patients

In this version, we have introduced the above filters in Eligibility screen and Appointment Lookup.

Below shows the sample screen shot of Appointment lookup.



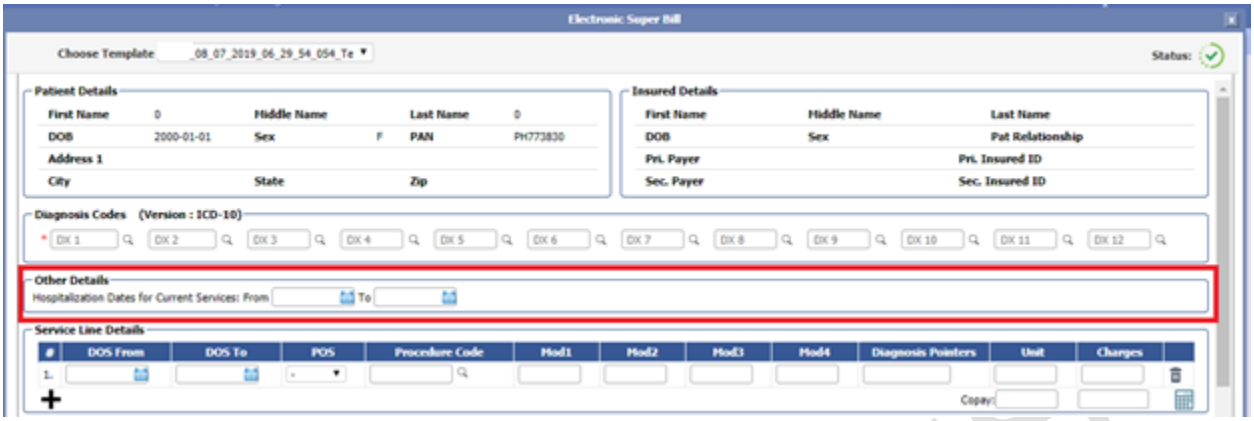
Below shows the sample screenshot in Eligibility lookup.



8) [Ticket #10074] MDR: ESB | Need fields for Hospitalization Date From/To, Serviced By Provider

As per the client request, we have added new fields for Hospitalization Date From/To with date picker/calendar in ESB. This field is mapped with the same field in Box 18 of HCFA 1500 Professional claim form. When a claim is created out of ESB the "Hospitalization Date" will get populated in this claim form/screen.

The "Hospitalization Date" field will appear under "Other Details" section in ESB, as shown below.



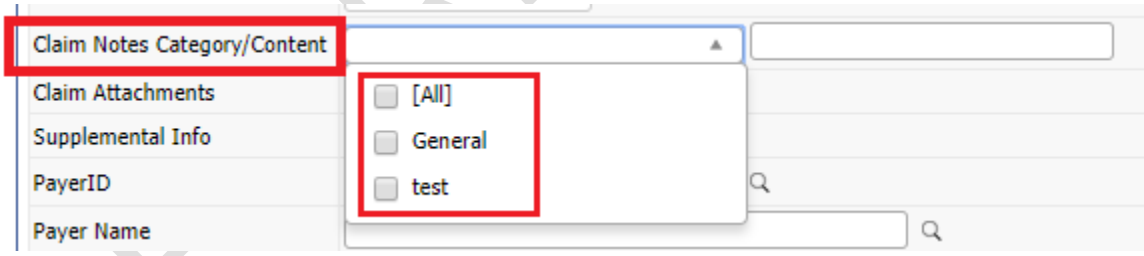
The Hospitalization date will be available only in the new ESB templates. If the clinic/hospital needs this template with Hospitalization Date to be loaded for new ESBs, please contact our support team.

9) [Ticket #10075] MDR: Claim search based on the "Notes Category"

One of the clients had requested us to add "Notes Category" filter in Search claims screen.

The system already had a feature to filter claims "with claim notes" and "without claim notes", and if "with claim notes" option is chosen, the user can specify part of the claim notes and further filter the claims.

The claim notes are added by user under the default category "General" or other user defined categories. But there was no option for the user to search for claims with claim notes under specific category. A new filter is added in claim search screen as shown below –



This filter will come up when the option "With Claim Notes" is chosen under Claim Notes filter. By default, no categories will be selected, and hence it filters claims irrespective of what the note category is. Select one or more categories to filter claims having notes added under those categories. The existing claim notes text filter is now moved to the right side of the category dropdown.

10) [Ticket #10076] MDR: ESB | ESB Feature – Default Service facility/ billing provider/ rendering provider/ referring provider per template

One of the clients had requested us to configure default Rendering Provider, Referring Provider, Service Facility/Location and Billing Provider in ESB template for specific accounts. As current ESB

templates does not support this functionality - we have enhanced the ESB Module to handle this request in this version. Now, if the template is configured with default providers/facility, they will be selected as the default in the respective dropdowns when the new ESB screen is opened using that template.

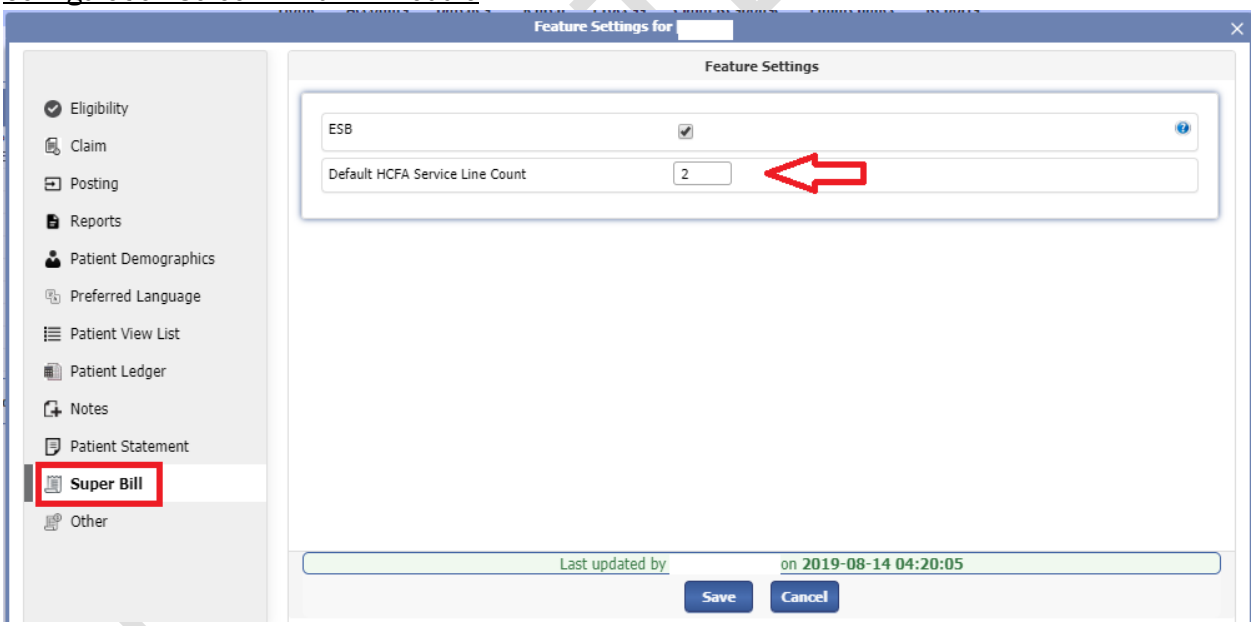
The clinics who need specific defaults on the above fields, can contact our support team to create new templates and upload it.

11) [Ticket #10078] MDR: ESB | Service line to be defaulted to 4 instead of 1

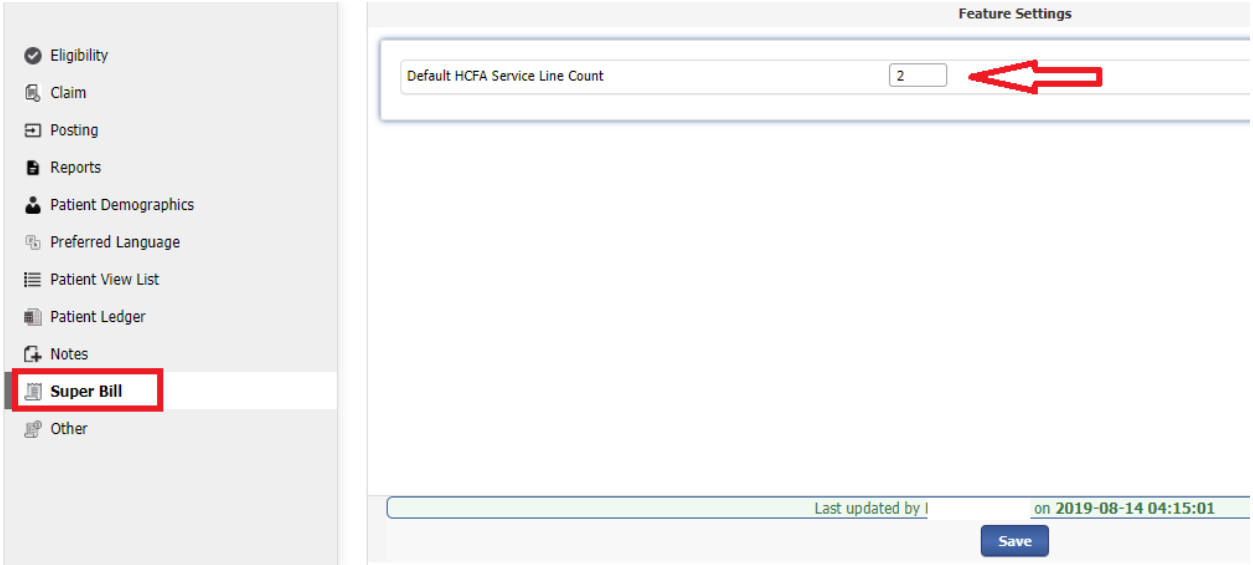
In the previous releases, when a new ESB screen is opened, the initial number of service lines displayed on the screen by default was 1, and user is expected to add more service lines using the + icon provided. Some of the clinics wanted more than one service lines displayed by default on ESB screen.

A new configuration **Default HCFA Service Line Count** is added in the account settings for administrator and also the users to configure the number of service lines the clinic wants to see in new ESB screen, as shown below. This is available under the section "Super Bill". The default value is 1 for this configuration.

Configuration Screen in Admin Module



Configuration Screen in Practice/User Module



12) [Ticket #10079] PH: Go To page | Other Search screens | Phase 1

As per the request from one of our clients, we had added a new feature "Go to Page" feature in Claim Search Results screen in v4.4 of our product. In this version, we have implemented this in other search screens as well in three separate phases. In the phase 1, we have added this in the following screens. We have completed the implementation of other two phases too (Phase 2 and Phase 3) in this version itself – Ticket #10081, Ticket #10084.

In Admin Module

1) Posting >> Check/EFT

In User Module

1) Posting >> Manage >> Batch list, claims for batch
2) Batch Status
3) Patient view list
4) Posting >> Check/EFT
5) Patient Statements >> Manage >> Task View, File View, Patient View

In Manager Module

1) Patient View List

13) [Ticket #10080] PH: Insured Name on Debt Set Off letter for minors

Previously, our system was designed to display patient name instead of insured name in the debt set off letter when the patient is minor. Now, while creating the "Debt Set Off letter" system will check the following, and populate insured name for minor patients

1) If the patient is minor (less than 18 years of age) AND
2) If the patient relationship to insured is marked as "Child" in the primary insured tab in patient demographics AND
3) If Insured First Name and Last Name is available in the primary insured tab in patient demographics

If these conditions do no match, the patient name itself will be populated for minors.

14) [Ticket #10081] PH: Go To page | Other Search screens | Phase 2

As mentioned in Ticket #10079, the modules where the Go To Page option is implemented as Phase 2 is listed below -

In Admin Module

1) Search >> Errors
2) Search >> Batches
3) Search >> Denials
4) Search >> Rejections
5) Search >> Deleted Claims

In User Module

1) Search >> Errors
2) Search >> Batches
3) Search >> Denials
4) Search >> Rejections
5) Search >> Deleted Claims
6) Eligibility >> Batches
7) Eligibility >> Inquiries
8) Patient >> History >> Import/Export

In Manager Module

1) Search >> Errors
2) Search >> Batches
3) Search >> Denials
4) Search >> Rejections
5) Eligibility >> Batches
6) Eligibility >> Inquiries

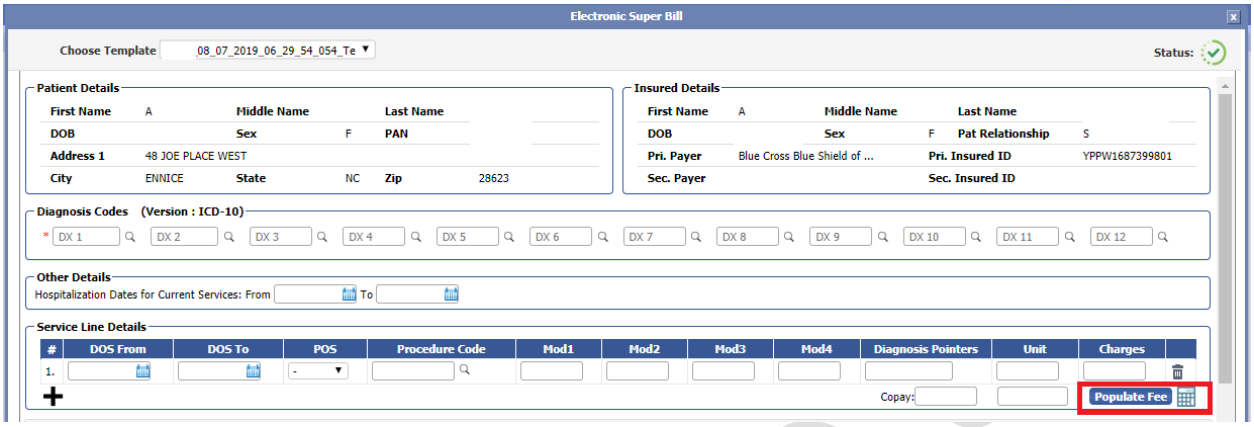
15) [Ticket #10083] MDR: ESB | Populate Fee button as in claim form

One of the clients had requested us for a new feature enhancement in the ESB screen. The clinic had requested us to add a "Populate Fee" button in the ESB form. The ESB templates are now enhanced to include Populate Fee button. The button will be visible only on the new templates configured with this option and uploaded to the respective accounts. Also, even if the button is configured in the template, it will be visible only if Fee Schedule feature is enabled for the account. Please contact our support team if any of the clinics requires this feature configured in new templates.

A new button "Populate Fee" button is added in ESB template now. This button will populate service line details with the fee details in a claim when an ESB is submitted as a claim.

The Populate Fee button works the same way it works in the claim screen. This requires at least the payer ID to be present in the ESB screen carried forward from patient demographics to pull the fees to service line. For ambiguous payers (CONTRACT, PAPER), payer name is also required. This is the existing behavior in claim screen as well. If Payer ID does not exist in ESB, then system will display a pop-up window with an alert message to specify or configure the payer details in Patient Demographics.

Previously, payer name was displayed on a tool tip for primary payer in the Insured Details tab. Now we are displaying Payer name and Payer ID in the Insured Details tab.



16) [Ticket #10084] PH: Go To page | Other Search screens | Phase 3

As mentioned in Ticket #10079, the modules where the Go To Page option is implemented as Phase 3 is listed below -

In User Module

1) Maintenance >> Operators
2) Maintenance >> Contracted Payers
3) Maintenance >> Claim Print >> Claims List
4) Maintenance >> Fee schedule >> List
5) Archive >> Claim Closure

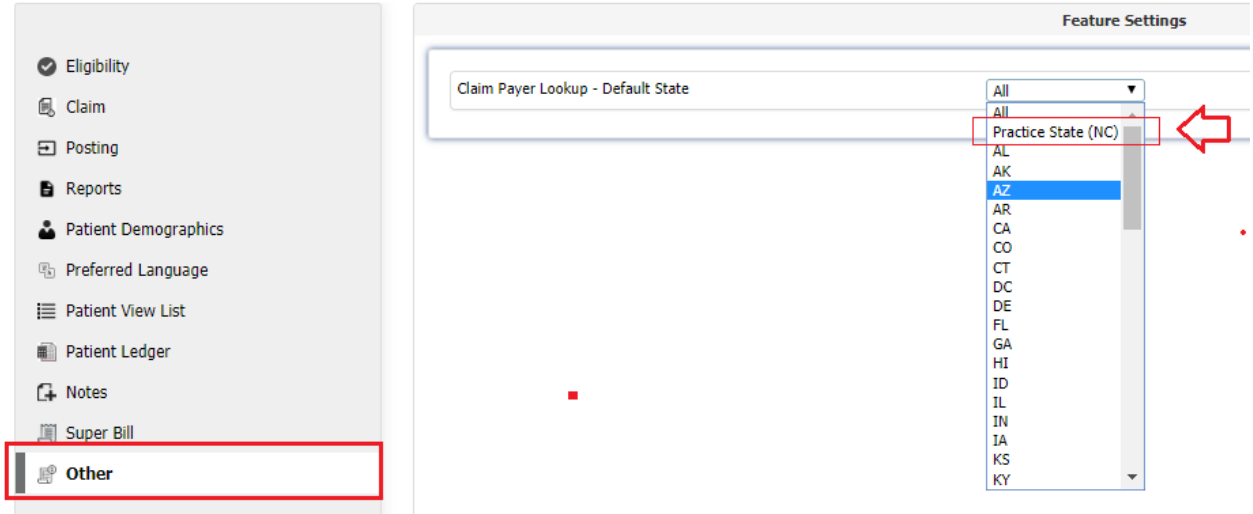
17) [Ticket #10085] MDR: Payer Lookup | Configure Default State

As per the request from one of the clients, they need the state code to be automatically populated in the payer filter panel in payer lookup window, so that when they search for payers, they see only the payers in that state only.

The clinic can configure default state of their choice from account feature settings screen and save them. By default, "All" will be displayed for backward compatibility and payer lookup will work as before. The user can configure it with the entry "Practice State (<state-code>)" or configure a custom state code from the list. This configuration is available under **Maintenance >> Feature settings > Other > Claim Payer Look up – Default State**

The global payer list is expected to have the state codes available (for electronic and paper payers) for successfully filtering the payers based on state code. From claim screen (new/edit), if an electronic payer (which does not require address details) is pulled into the claim using payer lookup, the payer ID, payer name and state code alone will get populated on payer section. We have implemented logic where, payer address1, address2, city, state, zip will be populated in the claim only if city, state and zip are present. This will ensure that payer lookup pull address details only for payers

where address details are populated in global payer list. And for electronic payers with only payer ID, name and partial address is present, the payer lookup will pull only payer id and payer name to claim.



18) [Ticket #10120] MDR: Appointment ID and Patient DOB columns on the Appointment Detail Report

As per the client request, we have introduced "Appointment ID" as a new column in the Appointment Detail report. The clinic can show or hide Appointment ID in the report by enabling the "Show Appointment ID" from the search screen. Also, we have changed few column names in the Appointment Detail report - the Claim Charge Amount will be displayed as Claim Charge, Primary Paid Amount as Primary Paid, Secondary Paid Amount as Secondary Paid and Total Paid Amount as Total Paid to decrease the width of the report.

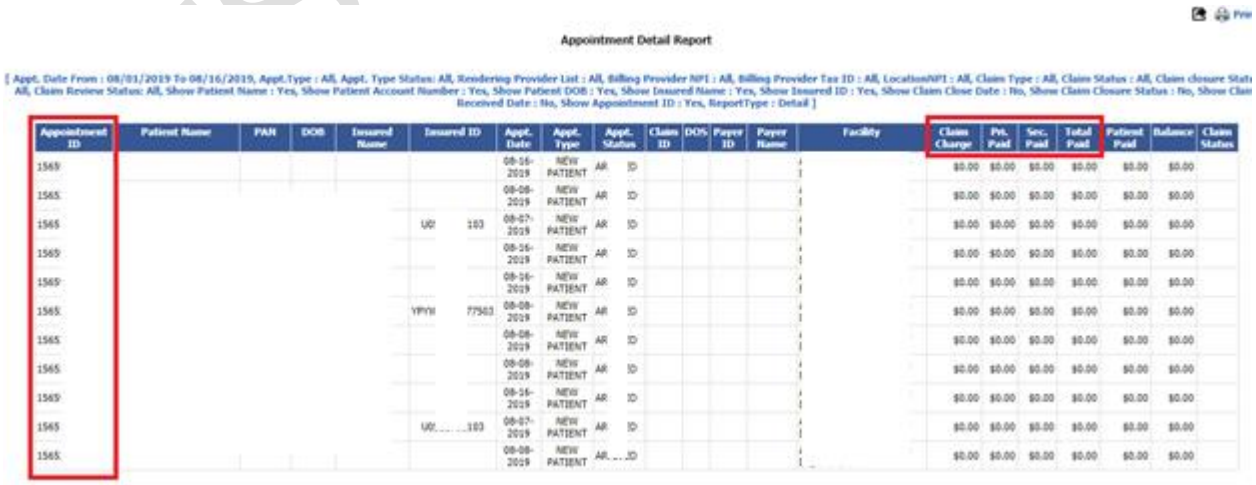
The Patient DOB column was already supported in the report.

Search Appointment Detail Report

Appointment Date	Current Month	Month AUG, Year 2019, Date Range 08/01/2019 – 08/16/2019
Appointment Type	All selected	
Appointment Status	All selected	
Rendering Provider	All selected	
Billing Provider	All	
Referring Provider		
Location	All selected	
Claim Status	All	
Claim Type	All	
Claim Closure Status	All	
Patient Account Number		
Payer ID		
Payer Name		
Show Appointment ID	☑	
Show Patient Details	☑	All selected
Show Insured Details	☑	Insured Name, Insured ID
Show Claim Received Date	☐	
Show Claim Close Date	☐	
Show Claim Closure Status	☐	
Report Type	Detail	

Search

Below shows the sample "Appointment Detail Report" with Appointment ID and Columns Names.



19) [Ticket #10197] PH: Patient Statement Offset Changes | Tuning for Single Window Envelope 9, Envelope 10 (Single and Double Window)

There was an issue with patient statement envelope, the clinic was unable to fit the patient statement address for single window envelope 9, single window envelope 10 and double window envelope 10. Hence, the "Send To" box was shifted from 639 to 671 in y-axis and "Billing Period" box is shifted from 690 to 702 towards y-axis. Now, the patient statement address fits in all 3 envelopes.

20) [Ticket #10216] PH: Claim Ledger Summary | Amount Round off Issue in Receipt

There was a round off issue while generating the receipt for a patient transaction from Claim Ledger Screen. This issue was not occurring when the receipt is generated from Patient Ledger Screen. For example, the amount "199.79" was displayed as "199.78999999999". This issue is now fixed, by rounding off the amount value.

21) [Ticket #10221] MDR: Do not replace with demographic provider when appointment is being created in Unit View/Timeline View

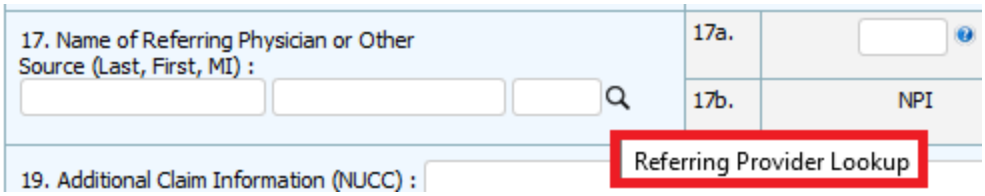
This is a feature change in the appointment module, while creating an appointment in unit view and timeline view for a specific provider. In unit view and timeline view, we have separate columns for each configured rendering providers. If an appointment creation is initiated from these two views by clicking on the specific provider column, the respective provider will be auto-populated in the new appointment. Now, when a patient having another provider configured in patient demographics is used in the appointment using patient lookup (auto/manual lookup), that provider in demographics was replacing the provider in the appointment screen. The client had requested to not replace the provider when the appointment is created from unit view and timeline view for specific providers. This provider replacement logic from patient demographics is now removed from Unit View and Timeline View.

22) [Ticket #10233] iTech: Edit Removal | Referring Provider ID Length Validation in Prof/Inst Claim (Front-end and Back-end)

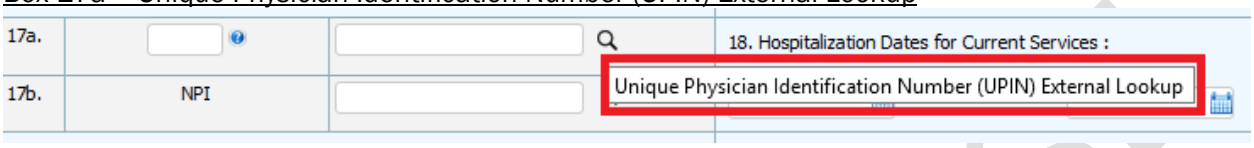
There was an issue in edit claim form while validating the Referring Provider ID, the system was throwing an error if the length of Legacy ID is not equal to 6 digits. As the legacy ID can be 6-digit UPIN or other IDs which are not 6 digits, we have decided to remove this validation from front end claim screen (professional and institutional) and also from back end.

Also, new tool tips are introduced in the following fields for both Professional and Institutional claim forms.

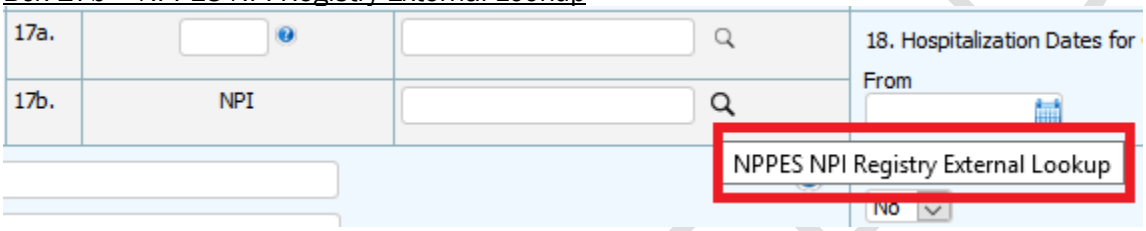
Box 17 = Referring Provider Lookup



Box 17a = Unique Physician Identification Number (UPIN) External Lookup



Box 17b = NPPES NPI Registry External Lookup



23) [Ticket #10246] PH: Revenue Board Report | Summary and Detail | Fix for Pending Amount

There was an issue reported by the clinic for self-pay claims in Revenue Board report for report type summary and detail for PHD accounts. the pending amount column of self-pay claims where patient payments were not available was showing an amount which is the sum of SFS PR Amount and SFS Adjustment Amount. This was a glitch and was resolved by changing the logic to display only SFS PR Amount as Pending Amount for such cases.

24) [Ticket #10267] PH: {Hot Patch=v4.5.0.1) Optimized Stored Procedure for the on-the-fly P/S Amount Due calculation for Bulk P/S Filter

The patient statement enhancement to support filtering patients based on Statement Amount Due instead of Current Balance Due was introduced in v4.5. However, the query to calculate the statement amount due and filtering patients was slow and some of the patient statement tasks took hours to complete. We optimized the stored procedure to improve the speed of amount due calculation and a hot patch was deployed on Aug 05, 2018 only on one of the servers as v4.5.0.1 on top of v4.5..

25) [Ticket #10268] MDR: Insurance Payment Activity Report - Rendering provider filter issue

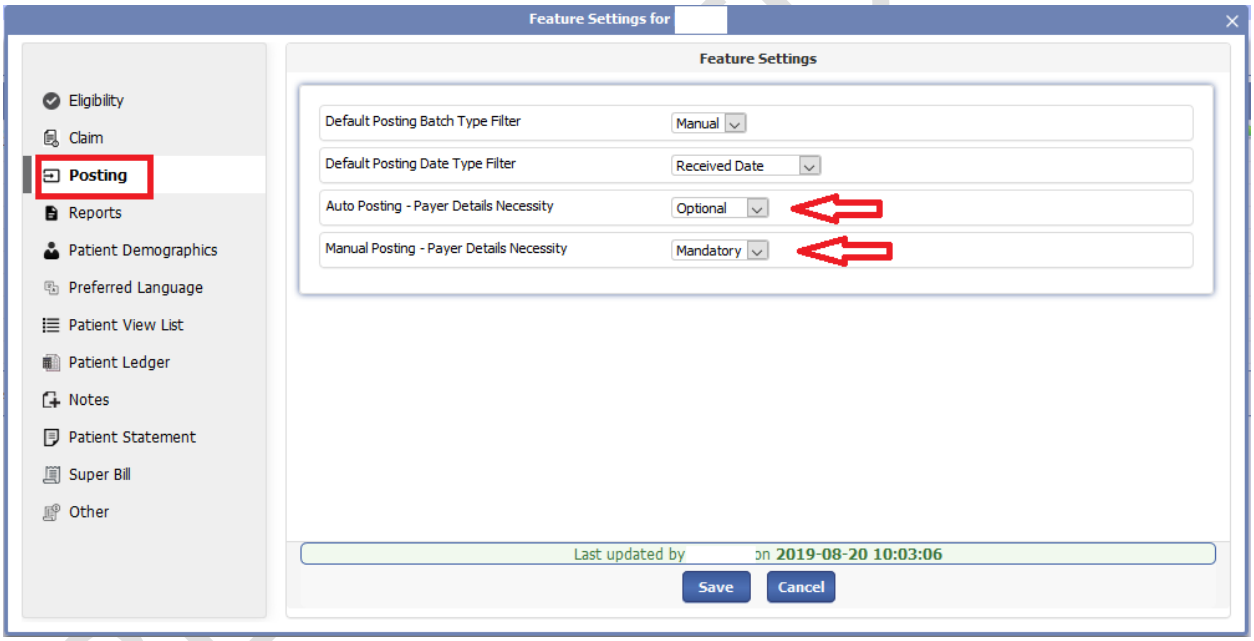
One of the clinics had reported an issue with the Rendering Provider filter in the Insurance Payment Activity report. The rendering Provider filter has two drop down options “All” and also to select multiple providers. But both the options were fetching the result set for “All”. There was a minor glitch and it is fixed in this version.

26) [Ticket #10269] MDR: Payer Details Mandatory Check on Posting Batches | With Account Settings

One of the clients had requested us to make payer details such as Payer Name and Payer ID as mandatory in Posting >> Manage >> Edit Batch for both Auto and Manual posted batches and also in New Batch for Manual Posted Batches.

In the admin module, a new account feature setting is introduced to make Payer Name and Payer ID as mandatory or optional. This is available under Accounts >> Search >> Account List >> Feature Settings >> Posting >> "Auto Posting – Payer Details Necessity" and "Manual Posting- Payer Details Necessity" with two drop down options such as "Optional" and "Mandatory". For the accounts which need this feature, the administrator can choose either of the option from feature settings to make payer details as Mandatory or Optional for the relevant accounts. By default, the payer name and payer ID will be optional on Add/Edit Posting Batch.

Note, for auto posted batches, there will be multiple checks and hence this validation if enabled will be applicable on all check/transaction screens.



27) [Ticket #10279] Insurance Payment Activity Report | Total Claim Count displaying wrongly

One of the clients had reported an issue where wrong total claim count is displayed in the report result screen of Insurance Payment Activity Report for report types By Provider, By Program, By Provider by Serviced by and By Program by Payer (Summary). This issue is now fixed in this version.

28) [Ticket #10342] PH: {Hot Patch=v4.5.0.2) Optimized Stored Procedure for the on-the-fly P/S Amount Due calculation for Bulk P/S Filter

The patient statement enhancement to support filtering patients based on Statement Amount Due instead of Current Balance Due was introduced in v4.5. We have also applied an optimization patch (v4.5.0.1 – Ticket #10267). Now, the feature is further optimized in two places - by using a new statement due calculation logic (taken from statement body creation module) for patient filtering using statement due, and also reused this statement amount due for certain cases in statement body creation instead of calculating it again. A hot patch was deployed on Aug 26, 2018 only on one of the servers as v4.5.0.2 on top of v4.5.0.1

29) [Ticket #10377] PH: Claim Bill | Enhancements to fit Envelope 9/10

The **Send To** and **Remit To** boxes in the claim bill were not fitting correctly when folded and put in #9 Envelope and #10 Single and Double Window Envelope. The address content in these boxed are now shifted to right (+X axis) to fit the above said envelopes. Also, when Address 2 is present in **Send To**, the address lines were pushed down. This was adjusted by changing **Date of Service** Box to single rectangle to reduce height, and the **Send To** box and content is now shifted up (+Y axis) to that available space.

Bugzilla List of tickets

#	ID	Client	Ext. Ticket #	Summary	Version
1	1354	PH	4517	PH: Report Enhancement | RA Reports | Post Type Filter | Support for Auto, Manual, All	V4.6
2	9468	iTech	Internal	Print COB2 | Logic Enhancement	V4.6
3	9883	MDR	Via Email	MDR: Eligibility status and history on claim form	V4.6
4	9885	MDR	Via Call	MDR: Default eligibility "Type" as "Real time" under inquiries	V4.6
5	9886	PH	36121	PH: Add % to the Aging report columns for Insurance claims and SELF Pay claims	V4.6
6	10002	PH	36120	PH: Check/EFT Report By Program List | Add Insurance Program Column	V4.6
7	10065	iTech	Internal	iTech: Additional Filters to be added in Patient Lookup (Appt. and Eligibility Inquiry)	V4.6
8	10074	MDR	Via Email	MDR: ESB | Need fields for Hospitalization Date From/To, Serviced By Provider	V4.6
9	10075	MDR	Via Call	MDR: Claim search based on the "Notes Category"	V4.6
10	10076	MDR	Via Email	MDR: ESB | ESB Feature - Default service facility/billing provider/rend. provider/referring provider per template	V4.6
11	10078	MDR	Via Email	MDR: ESB| Service line to be defaulted to 4 instead of 1	V4.6
12	10079	PH	27826	PH: Go To Page | Other Search Screens | Phase 1	V4.6
13	10080	PH	184244	PH: Insured Name on Debt Set Off Letter for minors	V4.6
14	10081	PH	27826	PH: Go To Page | Other Search Screens | Phase 2	V4.6
15	10083	MDR	Via Email	MDR: ESB | Populate fee button as in claim form	V4.6
16	10084	PH	27826	PH: Go To Page | Other Search Screens | Phase 3	V4.6
17	10085	MDR	Via Email	MDR: Payer Lookup | Configure Default State	V4.6
18	10120	MDR	Internal	MDR: Appointment ID and Patient DOB columns on the Appointment Detail Report	V4.6
19	10197	PH	35513	PH: Patient Statement Offset Changes | Tuning for Single Window Envelope 9, Envelope 10 (Single and Double Window)	V4.6
20	10216	PH	404031	PH: Claim Ledger Summary | Amount Round off Issue in Receipt	V4.6
21	10221	MDR	Via Email	MDR: Do not replace with demographic provider when appointment is being created in Unit View/Timeline View	V4.6
22	10233	iTech	Internal	iTech: Edit Removal | Referring Provider ID Length Validation in Prof/Inst Claim (Front-end and Back-end)	V4.6
23	10246	PH	404106	PH: Revenue Board Report | Summary and Detail | Fix for Pending Amount	V4.6
24	10267	PH	Via Email	PH: {Hot Patch=v4.5.0.1) Optimized Stored Procedure for the on-the-fly P/S Amount Due calculation for Bulk P/S Filter	V4.5.0.1

25	10268	MDR	Via Email	MDR: Insurance Payment Activity Report - Rendering provider filter issue	V4.6
26	10269	MDR	Via Call	MDR: Payer Details Mandatory Check on Posting Batches | With Account Settings	V4.6
27	10279	iTech	Internal	Insurance Payment Activity Report | Total Claim Count displaying wrongly	V4.6
28	10342	iTech	Internal	PH: {Hot Patch=v4.5.0.2) Optimized Stored Procedure for the on-the-fly P/S Amount Due calculation for Bulk P/S Filter	v4.5.0.2
29	10377	PH	551419	PH: Claim Bill | Enhancements to fit Envelope 9/10	V4.6

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