



Product Release V17

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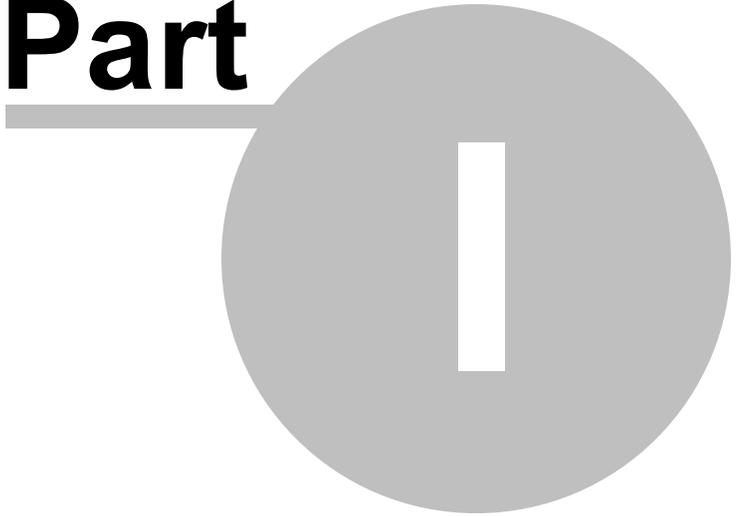
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Part V BUG FIXES

Part



1 PracticeSuite STAGE II - EHR Version 17.0.0

PracticeSuite EHR Version 17.0.0 was certified for Meaningful Use Stage 2 on December 18th 2014.

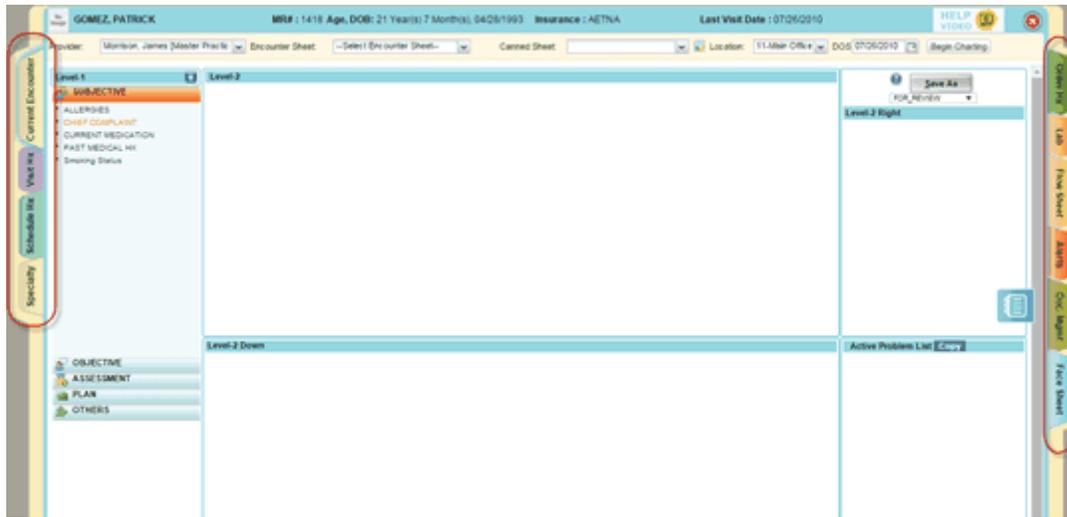
This Complete EHR is 2014 Edition compliant and has been certified by an ONC-ACB in accordance with the applicable certification criteria adopted by the Secretary of Health and Human Services. Please see certification information in the below Table.

Vendor Name:	PracticeSuite, Inc.
Certified EHR Name:	PracticeSuite
Certified EHR Version:	EHR-17.0.0
InfoGard Certification #:	IG-2412-14-0086
Certification Date:	December 18, 2014
Classification:	Complete EHR
Practice Setting:	Ambulatory
Requirements Edition:	2014
Certification Criteria:	§170.314: (a)(1 - 15); (b)(1 - 5, 7); (c)(1 - 3); (d)(1 - 9); (e)(1 - 3); (f)(1 - 3); (g)(2 - 4)
Clinical Quality Measures:	CMS68 v3, CMS69 v2, CMS117 v2, CMS123 v2, CMS127 v2, CMS138 v2, CMS139 v2, CMS147 v2, CMS165 v2, CMS166 v3
Additional SW Required:	N/A

This certification does not represent an endorsement by the U.S. Department of Health and Human Services. Reliability and usability are among the most important components we have focused on this new version of EHR.

The EHR Front-End has been migrated in to the newer HTML5 feature rich framework while maintaining our unique design. We have highlighted some of the notable functional and UI changes below.

1. The tabs have been placed vertically in the new design. The encounter related tabs are placed to the left and the other tabs are placed to the right of the screen. This new design has been implemented to give a look and feel of the conventional paper chart and in addition, to give the users more room for viewing or for charting.



2. A thumbnail of the patient image is placed on the EHR header. Hovering the mouse pointer over the thumbnail displays the full patient image. Click on the patient image to open the picture in an editable mode. The CDSS alerts and other billing alerts appear minimized and placed at the top right hand corner of the screen with an option to navigate to the detailed view of the alerts.



3. The charting save confirmation page now provides added functionality. In addition to the display and print narration options - CDSS Recommendations, Patient Education and INFOBUTTON have been included on the page.

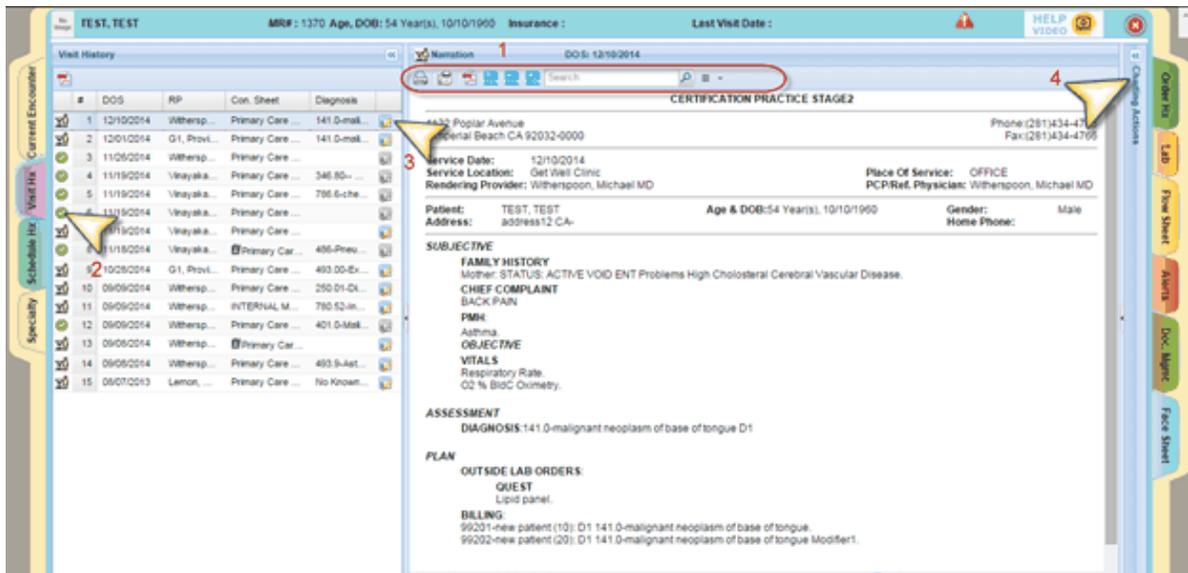
Chart Saved Successfully.

Narration				
CPOE				
Lx(QUEST)				
Clinical Summary (C-CDD)				

(To meet the MU objective #11, please print the Clinical Summary Report and hand a copy to the patient. MU states that EPs perform this for more than 50% of their office visits.)

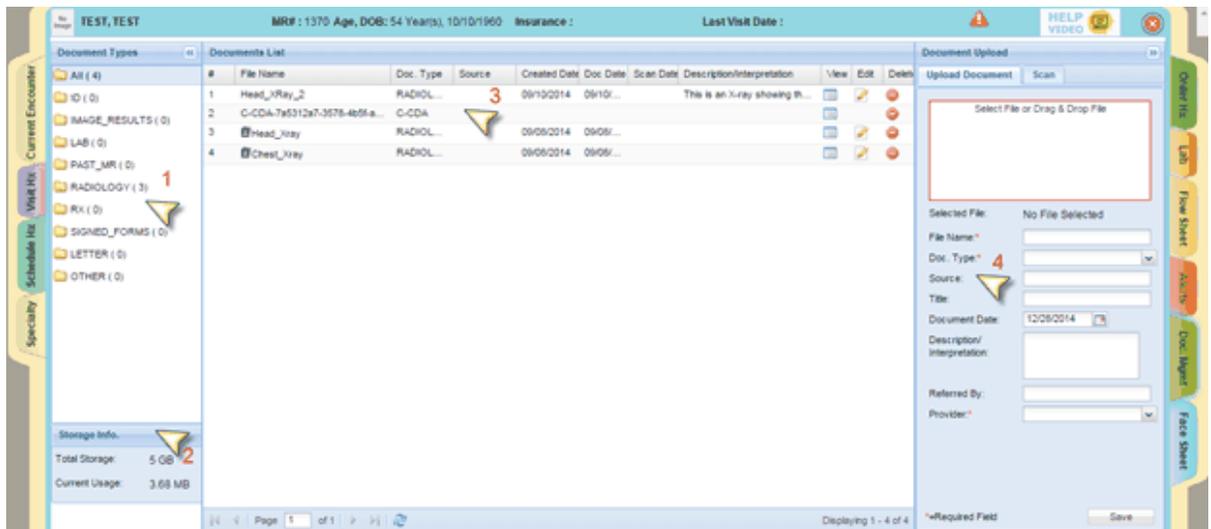
CDSS Recommendations	Description	Action Code	Action Value
CDSS Criteria			
Asthma Assessment - Provider only	Providers are indicated that an asthma assessment must be performed for all patients with a diagnosis of asthma.	LETTER	ASTHMA
Allergy Rule	Consider alternative antibiotics in patients with penicillin and other beta-lactam allergies.	LETTER	Allergy CDSS
But Rule	Counsel overweight and obese patients on weight-loss.	LETTER	Overweight CDSS
Patient Education			
PATIENT EDUCATION MATERIAL FOR HYPERTENSION			
PATIENT EDUCATION MATERIAL FOR INSOMNIA			
PATIENT EDUCATION MATERIAL FOR WARFARIN			
PATIENT EDUCATION MATERIAL FOR ASPIRIN			
INFOBUTTON			
Context-Aware Retrieval Application (infobutton) A service of the U.S. National Library of Medicine From the National Institutes of Health			

4. The “Visit Hx” screen has undergone a major UI improvement. Buttons, Icons and Tabs are organized keeping in mind their usability.



Icons are placed at the top to print, fax and copy the narration. Icons to View, Download and Transmit CCD have also been added to the top part of the screen. Search function added to search specific text in the narration. Options to add Addendum/Update/Amendment are provided through a drop down menu.

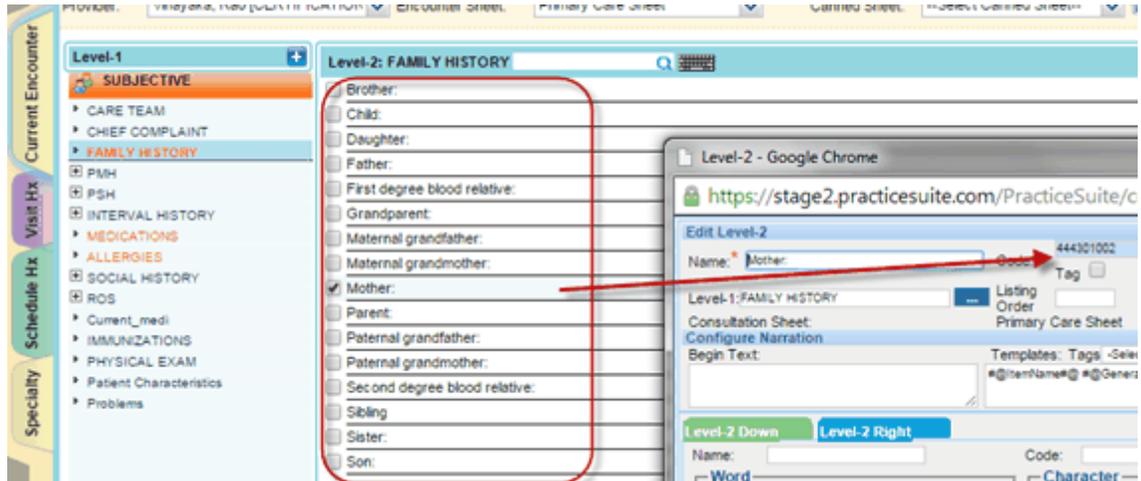
- i. Complete, Pending, Ready for Exam charts are easily identifiable with their icons. You have the ability to collapse the Visit History list by clicking on the << arrow to give more room to view the narration.
 - ii. Incomplete charts can be edited by clicking on the edit option.
 - iii. A notable section in this visit Hx screen is the introduction of a section called “Charting Actions”. Orders, Clinical Summary, CDSS Recommendations, Patient Education materials related to a visit can be accessed from this section. This section is provided with an expandable/collapsible option.
5. Document Management screen has undergone a major overhaul.



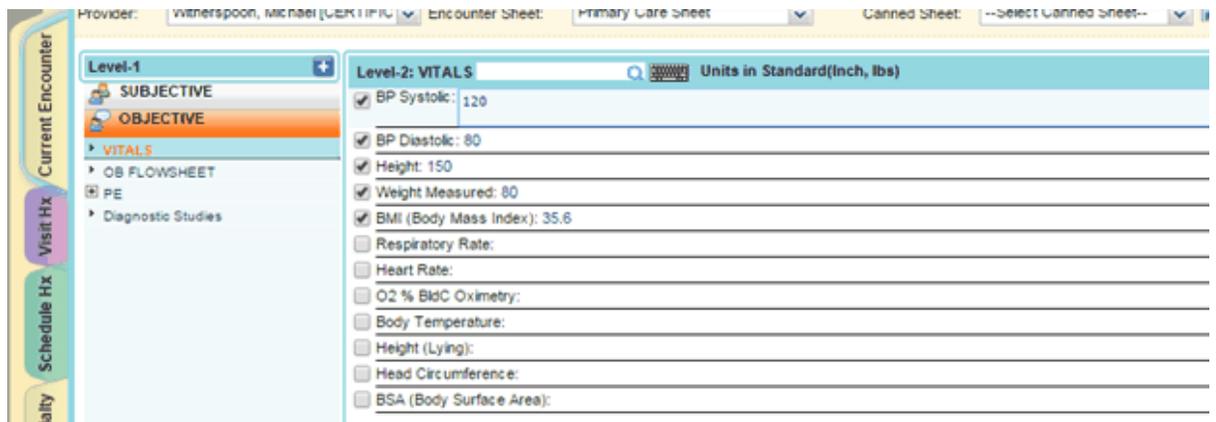
- a) A new grouping section displays the Document Types and the document count for each type. Clicking on the document type will list the documents to the right pane. This helps the users to filter and locate documents easier and faster.
 - b) Storage information such as “Total Storage” and “Current Usage” is now displayed.
 - c) The listing or default ordering of the documents remains unchanged from previous versions.
 - d) The upload section is now a tabbed interface with one for “Upload Document” and a separate tab for “Scan”. A significant technological change in the upload functionality is the replacing of the applet based file upload with the HTML5 technology, thus eliminating the need for any additional plug ins to be installed for the upload feature to function.
6. A new tab called “CDSS Interventions” is added under the “Alert” section which displays the consolidated CDSS Recommendations along with Patient Education and Infobutton.



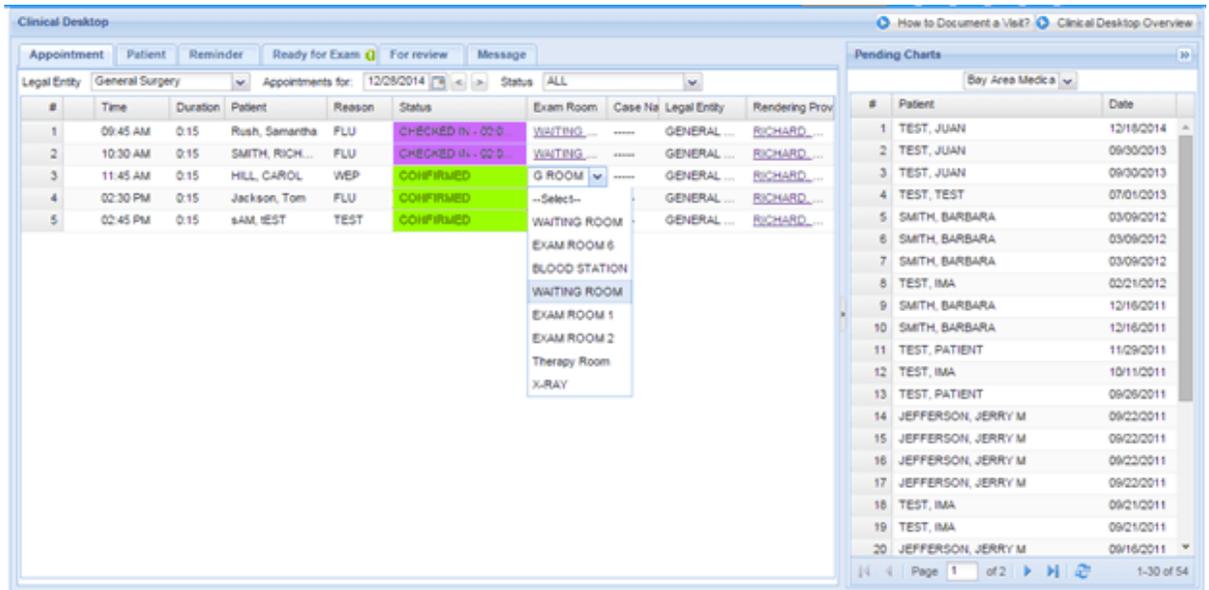
7. As part of requirement of the Stage 2 Meaningful Use we have incorporated the feature for recording information on the patient’s first degree relative and the family history as a structured data. The Level-2 Family History is pre-populated with structured first degree relative information and hence, this ensures the meaningful use related to family history is recorded correctly.



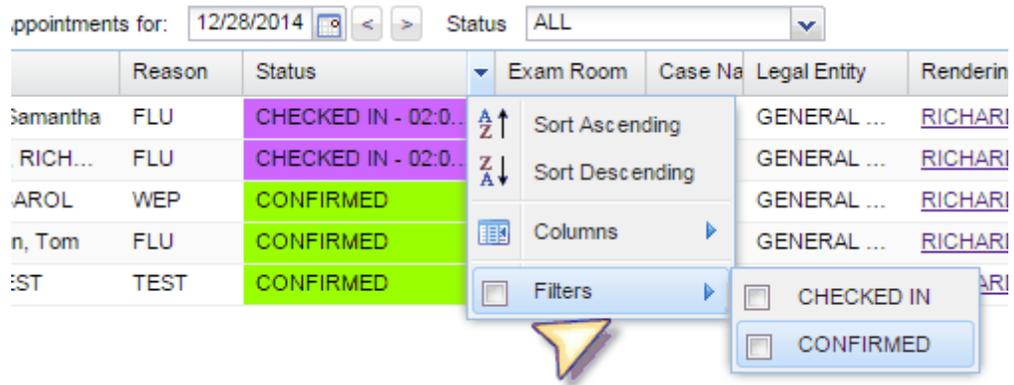
8. Vitals data is restricted to numeric value entries only. Units displayed at the top.



9. The enhanced Clinical Desktop main screen provides flexibility in performing certain functions that previously were complicated or had to be accomplished from a different screen. Users can now perform some important functions without navigating to a different screen. For example, the users can now change the “Exam Room” and “Rendering Provider” from the Clinical Desktop main screen by clicking on the cell and selecting the new value from the drop down. Also, the pending charts count is now displayed at the bottom of the table.



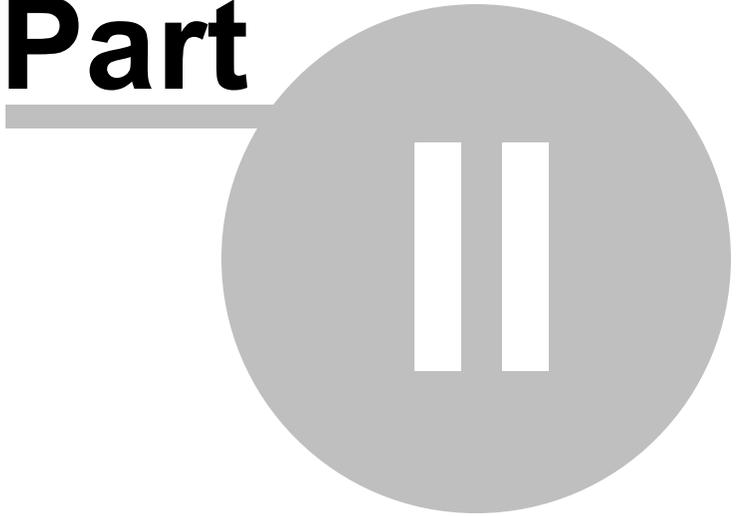
Each column in the table has an additional filter element that can be used for filtering of the columns based on the values in the table.



10. The meaningful use report:

Some objective in the menu set in Stage 1 have been moved to the core set for Stage 2 and are now required for all providers. There are also some new Stage 2 core and menu objectives. The listing order of the objectives has been modified according to the new requirement. Users can not only view the numerator and denominator count but they can also pull the list of patients that falls under each objective's numerator and denominator.

Part



2 NEW FEATURES

2.1 Payment Type

Users have the ability to add Custom Payment Type and define the Payment Type for the new look up as - Insurance, Co insurance, Co pay or Deductible.

This can be done by Navigating towards CLAIM LOOK UPS under Billing Setup. Click on Claim Look ups and search claim look ups screen will open up as shown below.



Click on the + icon to add a new Look up value.



Select the Look up Type as "Payment Type". Next, select one of the system defined Payment Types for the new added user defined type. Type & enter all the required fields. Selecting the existing payment type will make the new added type behave the same as the selected payment type.



2.2 UB04 Form

Custom printer alignment facility is now available for UB-04 forms.

The screenshot shows the 'Print/Re-Bill' interface with several tabs: 'Batch Claims', 'Batch Summary', 'Print / Re-Bill', 'Claim Log', and 'Clearing House'. Below the tabs are various search and filter parameters including Claim Batch Type, Patient LN, Claim Date, DOS, Acct. Date, Amount, Claim Status, Patient FN, Legal Entity, Provider, Calculate Date As, Ins. Level, Claims Receiver, Insurance / Payer ID, Place Of Service, CPT, Batch #, and Claim #. A table lists claims with columns for Claim #, Batch #, Claim Date, DOS Start, Amount, Insurance, Billing Method (Primary/Secondary), Level, Patient Name, and Activity. At the bottom, there are buttons for 'Printer Align', 'Generate Claim', 'Re-Bill', and form selection options for 'UB04 Form' and 'UB04 Blank Form'. The 'Printer Align' button is circled in red.

Click on the Printer Align Button to open the claim form alignment setup screen. Enter the values as required in the fields & hit Save option to align the printer for accurate printing of UB04 claim forms.

The 'Printer Alignment' dialog box contains the following information:

- Information:**
 - Enter the left and top offsets to adjust printer alignment
 - To shift to the right and down, please enter a number greater than 0
- Printer Type:*** (Dropdown menu: --Select--)
- Printer Name:** (Dropdown menu: --Select--)
- Left Offset:** (Text input field)
- Top Offset:** (Text input field)
- * = REQUIRED FIELD**
- Buttons:** Save, Close

2.3 Scheduler

'Entered by' and 'Last Processed by' user information is displayed on the Appointment screen.

Patient Information

New Appt (Click to create another appointment on this time slot)

Name & Other Informations

Select Existing Patient Click to Add New Patient

MR# 1490

Last Name: * TEST First Name: * JUAN Middle: Patient Alert(s) X
1) Clinical Alert/Recall

DOB: 06/05/1945 Age: 69 Gender: * Male Phone#: * (305)444-4444

PC Ref# Account Type: * INSURANCE Last seen Date

Scheduling Options

Provider: * Richard, Joetta C [General Surgery] Case: 1490-4120 Confirmation Method: PHONE

Date of Appt. * 12/19/2014 Time * 08:45 AM Appt. Duration * Hr 00 Mins 15 Priority 1

Schedule Status * CONFIRMED Schedule Type * APPOINTMENT Exam Room * WAITING ROOM Schedule Source: PHONE

Canceled By: PATIENT Demographic Sheet Report

Appt. Reason: * test SuperBill Demographic Sheet Report

Billing Information

Primary Secondary Tertiary Patient 0.00 On-Account(\$191.00) Total 15.17 Payment Entry Hide

AETNA 15.17
Total 15.17

Last Statement Date Statement Mailed 0 Times

Notes

Last Processed By: admin_admin(admin) on 12/19/2014 4:15 AM Entered By: admin_admin(admin) on 12/19/2014 12:40 AM

* = REQUIRED FIELD

2.4 Patient Financial Summary Report

Financial Summary Report generation option is included in the Patient Information screen.

The screenshot displays the PracticeSuite patient profile interface. The main form is divided into several sections:

- Patient Information:** MR# 765565775, PC Ref#, Last: test, First: demo, Addr1: 1234 anywhere st, Zip: 90210, City: San Jose, State: CA, Country: USA, Active:
- Contact Information:** Home, Cell, Work, Ext, E-mail
- Status/Acc. Type:** Employment: UNKNOWN, Student: UNKNOWN, Acc. Type: INSURANCE
- Additional Information:** DOB: 02/12/1979, Age: 35, Gender: Male, SSN, Race: Declined, Native Hawaiian or Other Pacific Islander, Marital: SINGLE, Ethnicity: Unknown, Pref. Language: English
- Provider/PCP Information:** Rendering Provider, PCP/Ref Physician
- Insurance Information Table:**

Coverage	Active	Payer	INS. #	Group #	Co pay
Primary	Y	MEDICAID - 1234	42371	.	0.00

On the right side, there is a sidebar with a "No Image" placeholder and a list of tabs: Financial Summary (highlighted), Authorization, Case, Schedule History, Ledger, Recalls, Enter Payment, Statement History, Generate Statement, Eligibility, Notes, Document Mgmt, Guarantor, Portal Access, and Other Attributes.

At the bottom, there is a legend for required fields, a "Run Patient Validation" checkbox, and "Save" and "Close" buttons.

Patient Financial Summary delivers only the key healthcare-specific metrics you need for a more complete picture of patients insurance benefits and financial summary. This synthesized financial report can help you improve increasing the collection right at the point of service.

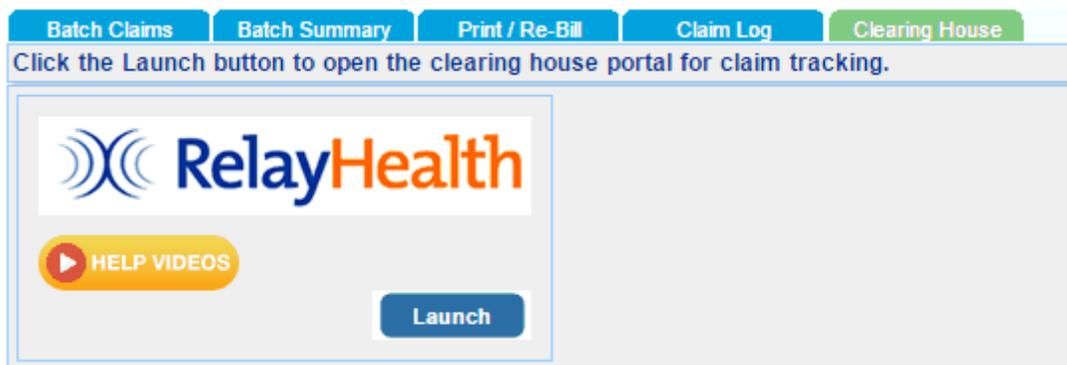
Key elements of the patient's insurance benefits are provided so you can collect co-pay and deductible amounts upfront.

Patient Financial Summary	
Patient:	test, testing MR#: 1450
DOB:	07/06/1972 Subscriber#: 34534534
Eligibility	
Verified: <input type="checkbox"/>	Last Checked On: By:
Last Verified Insurance Name:	
Insurance Valid	
Primary <input checked="" type="checkbox"/> AETNA Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/>	
Collect from Patient Today	
Co-Pay for Today	0.00
Co-Insurance Amount	0.00
Because of Deductible	0.00
Previous Balance	0.00
Credit On-Account	161.00
Total Due	-161.00
Comments	
Additional Financial Information	
Insurance	Aging
Last Payment Amount	0.00
Last Payment Date	NO RECORDS FOUND
Last Visit Date	10/04/2011
Unpaid Balance	0.00
Last Claim Submission Date	
Last Follow-up Date	
Patient	Aging
Patient Ledger	Schedule Hx
Last Payment Amount	10.00
Last Payment Date	01/20/2010
On-Account(Credit Balance)	161.00
Unpaid Balance	0.00
In Collection	<input type="checkbox"/>
In Collection Date	
Balance in Collections	0.00
Last Statement Date	
Last Missed/Cancelled Appt.	11/03/2011
Last Visit Date	10/04/2011
Close	

2.5 Relay Health

PracticeSuite is now integrated with Relay Health Clearinghouse for Claim Submissions, Eligibility verification & for receiving ERA Files.

Relay Health's Support & Audit Tool is a comprehensive easy use system which offers several business advantages. It provides the transparent use of processing & delivering transmission files, claims, remittance files and reports. There is a help video in the Clearinghouse tab which provides tutorial on claims tracking and other functions within Relay Health.



2.6 Claim validation

PracticeSuite provides a Claims validation engine to validate all the necessary data elements on a claim for ensuring a clean claim submission to the Clearinghouse/Payer. PracticeSuite system internally validates the claim(s) against a set of pre-defined rules based on Clearing House / Plan specific requirements. Claims not meeting the requirements are reported with a validation message for correction before the batch is generated. This powerful feature reduces any chance of data entry errors. The rules engine flags messages based on the error level as - errors, warnings, alerts & simple validation messages.

Claim validations are triggered in the following modules within the system

- a.) Claim work Bench /submit claims
- b.) Charge Entry
- c.) Charge Master
- d.) Patient Master

Users can also configure the modules where the validation engine needs to run to check for errors. This can be setup from the Claims Validations Rules Setup section on the Practice Options screen. Any module that does not require a validation check can be left unchecked in the check box next to the module name.



i. Running Claim Validation in Claim work Bench

On the “Batch Claims” screen a new check box named – ‘Run Claims Validation’ is added to trigger the validation while the claims are being generated. This check box is always checked by default.

The screenshot shows the 'Batch Claims' interface with several tabs: 'Batch Claims', 'Batch Summary', 'Print / Re-Run', 'Claim Log', and 'Clearing House'. Below the tabs is a 'Parameters' section with fields for 'DOS From', 'Acct. Date From', 'Insurance / Payer ID', 'To:', 'To:', 'Claims Receiver', 'Legal Entity', and 'Provider'. A red box highlights the 'Run Claims Validation' checkbox, which is checked. To the right of the checkbox are buttons for 'Generate Batch(es)' and 'Close'.

Click on Generate Batches and Validation screen will open up after validating all the claim specific requirements and will acknowledge with errors, warning, alerts & validation messages if any. If there are no claim errors, the validation screen will display the ‘No Records Found’ message and you can continue with the normal claims generation process.

The screenshot shows the 'Claim Validation Rules' screen with the status '(0) Errors, (0) Warnings, (0) Alerts, (0) Messages'. A red circle highlights the text 'NO RECORDS FOUND'. Below this text are three buttons: 'Re-Validate', 'Proceed With Claim Generation', and 'Close'.

If there are any validation errors - the system will display the message/ warning on the screen.

The screenshot shows the 'Claim Validation Rules' screen with the status '(8) Errors, (0) Warnings, (0) Alerts, (36) Messages'. Below this is a table with columns: '# DOS', 'Rendering Provider', 'MRN', 'DOB', 'Line# CPT', 'Message Type', and 'Message'. The table contains four rows of data, each with a 'CM' icon in the right margin.

# DOS	Rendering Provider	MRN	DOB	Line# CPT	Message Type	Message
1 Patient: sam, tjara		1391	07/04/1990			
1 10/04/2014	Alvarado, Nichole R			1 99211	MESSAGE	Service line rendering provider NPI must be valid
2 10/04/2014	Alvarado, Nichole R				MESSAGE	Supervising provider NPI is required when supervising provider present
3 10/04/2014	Alvarado, Nichole R				MESSAGE	Rendering Provider NPI must be entered
4 10/04/2014	Alvarado, Nichole R				MESSAGE	Service Location NPI is Blank or Invalid

At the bottom of the screen are buttons for 'Re-Validate', 'Proceed With Claim Generation', and 'Close'.

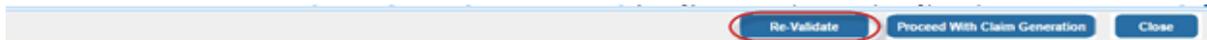
The errors flagged on the validation screen can be corrected by going into the relevant screen. A shortcut is placed next to the error and clicking on it directs the user to the relevant screen to make the necessary corrections.

The screenshot shows the 'Claim Validation Rules' screen with the status '(0) Errors, (0) Warnings, (0) Alerts, (36) Messages'. Below this is a table with columns: '# DOS', 'Rendering Provider', 'MRN', 'DOB', 'Line# CPT', 'Message Type', and 'Message'. The table contains four rows of data, each with a 'CM' icon in the right margin.

# DOS	Rendering Provider	MRN	DOB	Line# CPT	Message Type	Message
1 Patient: sam, tjara		1391	07/04/1990			
1 10/04/2014	Alvarado, Nichole R			1 99211	MESSAGE	Service line rendering provider NPI must be valid
2 10/04/2014	Alvarado, Nichole R				MESSAGE	Service Location NPI is Blank or Invalid
3 10/04/2014	Alvarado, Nichole R				MESSAGE	Supervising provider NPI is required when supervising provider present
4 10/04/2014	Alvarado, Nichole R				MESSAGE	Rendering Provider NPI must be entered

At the bottom of the screen are buttons for 'Re-Validate', 'Proceed With Claim Generation', and 'Close'.

After making corrections, the claim(s) can be re-validated by clicking on the Re-Validate button.



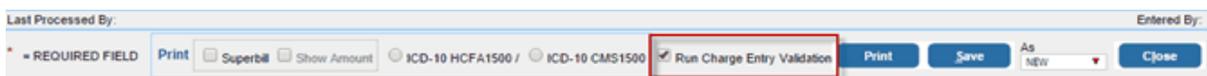
Once all the errors are resolved, it is recommended to re-validate again to ensure zero errors. No Records Found message indicates that the claims have passed all necessary validations and are good for submission.



Continue with the normal claim generation/submission processes.

i. Running Claim Validation in Charge Entry

'Run Charge Entry Validation' check box is added at the bottom of the Charge Entry screen to validate claims at the time of claims entry.



Once you have entered all the charge information and hit **Save**, the claims validation engine will be triggered and check for any errors on the claim before the charge is saved. If any errors are detected by the validation engine, the relevant error/warning message(s) is displayed on the Charge Entry screen. The charge gets saved, if no errors are found.

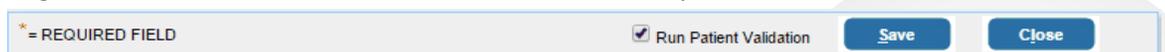
i. Running Claim validation in Charge Master

"Run Claim Validation" is added to the bottom of the Charge Master/Edit Charges screen to validate the claim information being saved from the screen. The system will acknowledge with errors, warning, alerts & validation messages if any and save if there are no errors.



ii. Running Claim validation in Patient Master

Patient information required for a successful claims processing is also validated at the Patient Information screen. The 'Run Patient Validation' option can be used for this purpose and saves the patient if the required information is entered for the patient or flags validation errors and does not save if there are any validation errors.

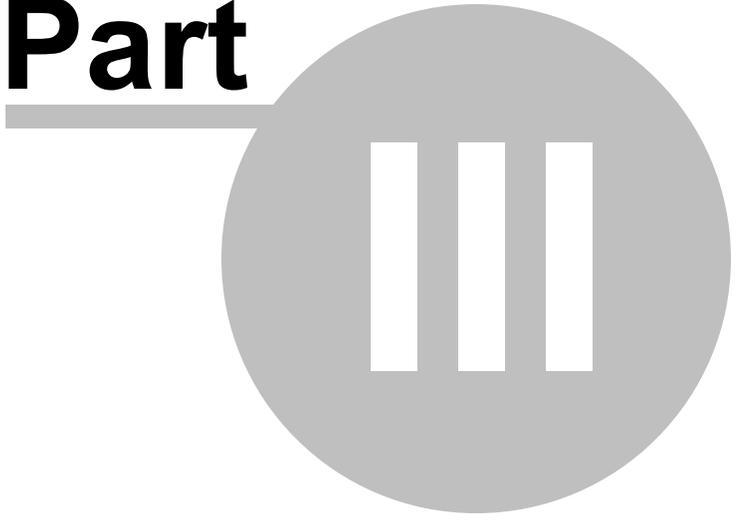


2.7 Default Service Location

Users can now set the default service location and POS code form the billing options. When a charge is created from Charge Entry or Charge master the system will default the service location and POS code specified in the billing option screen.

The screenshot displays the 'Billing Options' configuration interface. The 'Default Place Of Service' field is highlighted with a red box. It contains a radio button labeled 'C' and a dropdown menu labeled 'Service Location' with a '--Select--' option. Other fields include Claim #, Claim Batch #, Batch grouping Rule, Claim Grouping Rule, Claim Batch Name, Claim Creation Frequency, Payment #, Patient Statement #, and Default Claim Response Limit. The interface includes 'Save' and 'Close' buttons at the bottom right.

Part



3 ENHANCEMENTS

3.1 Patient Ledger

Different AR Classifications in the Ledger is shown in different color. A Legends is included that signify the category.

To show the AR classifications with respect to the Legends, Select the check box for Show Legends and click on Search.

Below are the classifications,

- Claim denied for untimely filing / Late appeal
- Insurance /Patient paid
- Claims older than 30 days. Claim Submitted, Waiting for payments
- HOLD
- Patient seen within 30 days. Claim Submitted, waiting for payments
- IN_COLLECTION
- Insurance paid, patient balance outstanding.

Detailed - Patient Aging Report

Parameters: Patient: [Patient Name] Legal Entity: ALL Provider: ALL Case: [Case ID]

DOS From: [Date] To: [Date] Calculate Date As: --Select--

Acct. Date From: [Date] To: [Date] Calculate Date As: --Select--

Show Denial Information: Show Legends:

Search Close

Name: [Patient Name] MR#: 1422 DOB: [DOB]

Legal Entity#: ALL Provider: ALL

Last Claim		Total Amount
Sent	12/19/2014	48,064.57
Sent To	Uni Plus Plan	220.00
Statement sent	12/29/2014	1,444.00
Payment Received:	12/17/2014	4,553.95
		0.00

Outstanding Claims: 204 Nos. **Total Balance Due: 41,846.62**

Total Visits: 215 **On-Account (\$5,013.00)**

Last Appt: 12/29/2014 09:00 AM Next Appt:

Legend:

- Claim denied for Untimely Filing/Late Appeal
- Insurance/patient paid.
- Claims older than 30 days. Claim Submitted, Waiting for payments
- HOLD
- Patient seen within 30 days. Claim Submitted, waiting for payments
- IN_COLLECTION
- Insurance paid, patient balance outstanding.

Also Included "Show Denial Information" check box to show line sub status and payer remarks.

3.2 Collection Manager

New search filter "Case Type" & "Accident Related Claims Only" are added in the Collection Manager Screen.

New parameters – 'Case Type' and 'Accident Related Claims Only' are added on the Collections Manager search filter options for listing claims for specific Case Type or to list Accident claims

Collection Manager

Denial Category: [Dropdown] C

LE: ALL

Rendering Provider: ALL

Patient: [Patient Name] C

Case Type: ALL

Filter by: Denials Claims over Payer Response Limit Threshold

Aged Over: DOS: 0, LCD: 0, LFD: 0

Accident Related Claims Only

Due From: Insurance

Collector Name: ALL

Collection Status: New

Collection Sub Status: ALL

Payer: [Dropdown] C

Show Reminders:

Search Close

3.3 Box #17a

A new field - State License # added in Referring Provider setup screen. Box 17A in HCFA/CMS is mapped to this new field on Referring Provider..

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	
DN	000000 P 000000 MD	17b.	NPI 0123456789

INSTRUCTIONS 17a: The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The **NUCC** defines the following qualifiers used in **5010A1**:

0B State License Number

1G Provider UPIN Number

G2 Provider Commercial Number

LU Location Number (This qualifier is used for Supervising Provider only.)

DESCRIPTION: The non-NPI ID number of the referring, ordering, or supervising provider is the unique identifier of the professional or provider designated taxonomy code.

FIELD SPECIFICATION: This field allows for the entry of 2 characters in the qualifier field and 17 characters in the Other ID# field.

3.4 Medicaid Re-Submission Code

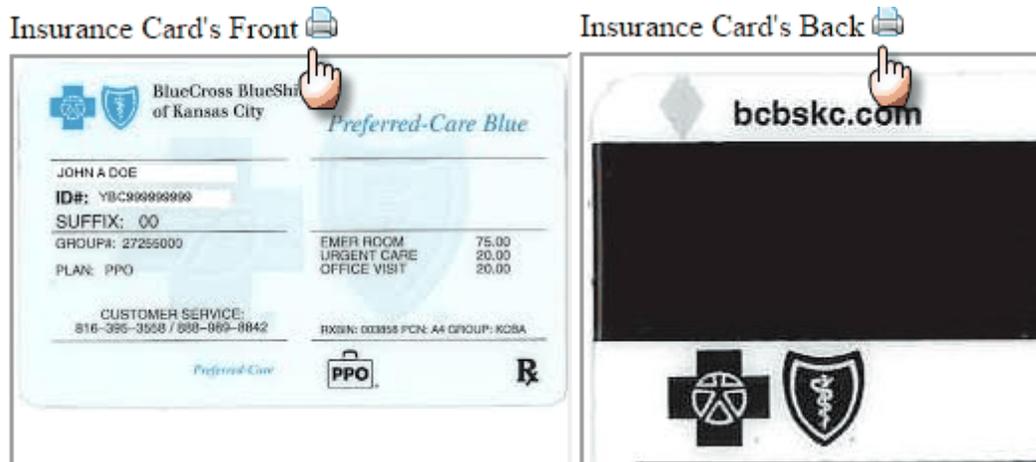
Changed the label "Medicaid Resub. Code" to "Resubmisson Code" and "Medicaid orig. ref. Code:" to "Original Ref. #:" on the Encounter tab in Charge Master/Edit Charges.

Resubmission Code	Original Claim ▼	Original Ref. #:	<input type="text"/>
-------------------	------------------	------------------	----------------------

Enter the appropriate code to indicate whether a re-submission of a denied claim, an adjustment of a paid claim, or a void of a paid claim. Enter the Claim Reference Number (CRN) of the denied claim being resubmitted or the paid claim being adjusted or voided in the field labeled "Original Ref #."

3.5 Printing Insurance Card

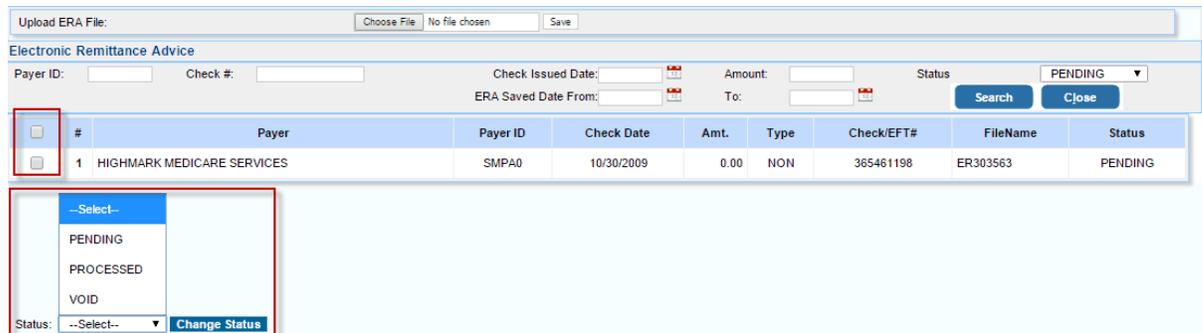
Print option added to Patient Insurance Screen to print the patient's insurance card.



3.6 ERA

Change status of multiple ERA's at one go

Users now have the ability to change the status of multiple ERA's in one step. Select the ERA's and choose the appropriate status from the drop down combo box and hit on Change status button to change the status of all or the selected ERA's.



A new DOS filter is added so that users can now filter claims in an ERA based on Date of Service.

Electronic Remittance Advice VersionControl#1

Sender Code: 133052274	Receiver Code: 800210350	Creation Date & Time: 10/29/2009	End Date: -
------------------------	--------------------------	----------------------------------	-------------

Financial Information: [Notification Only]

Check#: 365489188	Date: 10/30/2009	ERA Amt.: 0.00
Payment#: 5-4852	Payment Amt.: 0.0	Actual Check Amt.: 0.0
Adj. Reason Code: ADJ SFS	Acct. Date: 01/24/2011	Payment Date: 01/24/2011
Comment:	Matched Amt.: 0.00	Unmatched Amt.: 0.00

Payee Information:

Payee: HIGHMARK MEDICARE SERVICES
Address: PO BOX 890413, null, CAMP HILL, PA 17089
Payee ID: SMPA0 Match
ID Code: INTERNAL MEDICINE CLU
Legend: <input checked="" type="checkbox"/> Matched Claim <input type="checkbox"/> Unmatched Claim <input type="checkbox"/> Unmatched Line
Provider: --All--

DOS From: [] To: [] Include Closed Lines Include Previously Posted Exclude Prior PR Payments and Adjustments Claim Status: --All-- Search Close

#1: Provider Summary Information:

Total Claims:	Total Claim Charge Amt.	Total Covered Charge Amt.	Non Covered Amt.	Total Denied Amt.	Total Provider Payment Amt.
0.00	0.00	0.00	0.00	0.00	0.00

1: FANELLA, BURMAN MRN 283249354 Claim Status Code: 4 - (Denied) ICNF: 9993297738

Code	M1	M2	M3	M4	Date	Billed	Allowed	Amt. Paid	Units Adj. Amt.	Pat. Responsibility	Remark Code	Line Status
95310					10/01/2008	1,300.00	0	0.00	0 [C 0-B7]	1,300.00		Match

Process Print Proceed to Post Close

3.7 Mass Posting

Filter the payments for mass postings based on legal entity.

A new "Legal Entity" filter is added to the Mass Posting screen for users to list claims for the selected Legal Entity.

Mass Posting

Acct. Date From: [] To: [] Calculate Date As: --Select--

Pymt. Date From: [] To: [] Calculate Date As: --Select--

Patient: [] Include Insurance Lines Include payments made on the DOS

Legal Entity: ALL Search Close

3.8 x-SuperBill

A new check box "Exclude error claims" added to the X-Superbill screen to hide claims with error(s). Selecting the filter will list only claims without any errors.

x SuperBill

Parameters

Acct. Date From: [] To: [] Calculate Date As: --Select--

DOS From: [] To: [] Calculate Date As: --Select--

Legal Entity: ALL

Provider: ALL Exclude error claims

Charge Entry Charge Master/UB04

Set Line Status To: BILL_TO_PR Acct. Date: 12/28/2014 Process Search Close

Select All	DOS From	DOS TO	CPT	Rev. Code	Rev. Code Description	Diagnosis	M1	M2	M3	M4	Units UOM	Charge	Total Charges	Rem. Amt.	Line Status
1	Name	DOB	MR#: 1442	PC Ref#:	PR. INS.	SE. INS.									
<input type="checkbox"/>	Case#			Case Type	Provider	SE. INS. Plan									
<input type="checkbox"/>	99201				346.80,346.10						1 UN	90.45	90.45		NEW
<input type="checkbox"/>	99212				346.80,346.10						1 xx	93.33	93.33		NEW
<input type="checkbox"/>	99213				346.80,346.10						1 UN	149.50	149.50		NEW
Patient Total												333.28	333.28	333.28	

Line Count : 3

3.9 Case Switch

Case Switch function now includes an option to re-bill the selected claims from the same screen.

Payment: New Search

Payment# Pmt. Date From: To: --Select--

Legal Entity: Podiatry Provider: ALLEN, D WADN [Podiatry] Status: PARTIAL APPLIED PSTS#:

Acct. Date: 12/16/2014 Entry Date: 12/17/2014 Pmt. Date: 12/17/2014 Collected by: BILLING OFFICE

Pmt. Type: CLAIM Payor: INSURANCE Code: Name: AETNA

Method: CASH Default Adj. Code: ADJ 5F5

Payment#: 96-6139
Total Amt.: 150.00
Applied Amt.: 150.00
On Account Amt.: 30.00

Search Encounter Lines

Patient: Jefferson, Jerry Account(S5013.00) Claim #: DOS From: To: LE: ALL Process Secondary: INS First Show Closed Lines: Show All Lines:

3.12 UB04

Guarantor field added to the UB04 Case screen

Main UB04 Case Switch

Type Of Bill: Admission Date: Admission HR: Admission Type:

Admission SRC: Admission DHR: Treatment Auth. Code: Guarantor:

Rendering Prov. ---Select--- Attending Physician

Operating Physician ---Select--- Other Physician

Condition Codes Patient Reason DX Admit DX

Occurrence Occurrence Span

Code	Date	Code	Date	Code	From	Through	Code	From	Through

Principal & Other Diagnosis Code Value Codes

Code	Amount	Code	Amount	Code	Amount	Code	Amount

* = REQUIRED FIELD

3.13 Email Updation

Users with invalid or incomplete email address will receive a prompt to update their Email address on successful login. Updating the correct email address will be helpful to users to self reset their user password. The users can utilize the Forgot Password option to have the system trigger a new temporary password to the email.

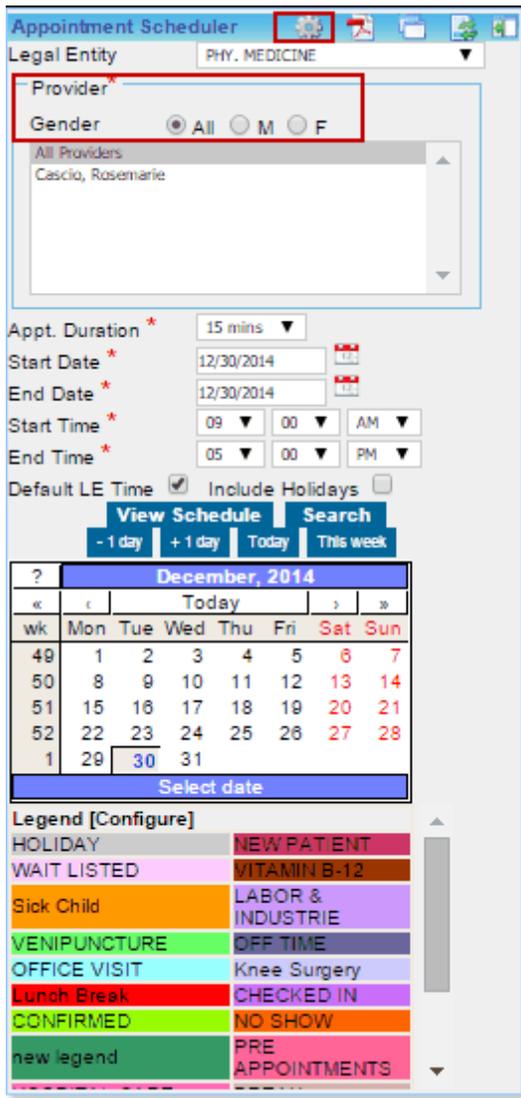
3.14 Charge Master- Line Activity

The Line activities in the Charge Master are displayed in the Descending order. For better Visibility the denials are shown in light red color, Payments are shown in green and follow-up/resubmission charges are in yellow color.

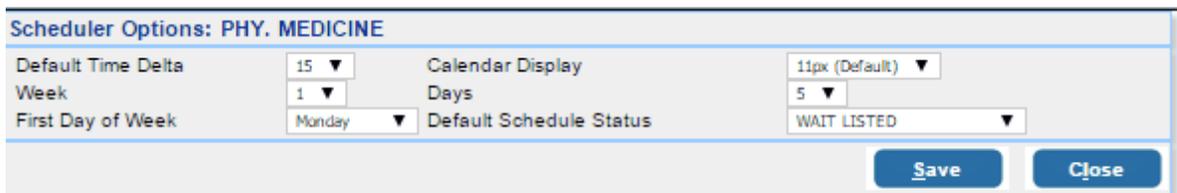
Date & Time	Activity	Entered By
12/29/2014 12:32 AM	Line # set to Bill to PT Payment# 7-0143 Check# - PSTSW - Receipt Date: 12/18/2014 Payor:AMERIGROUP	Business (Manually Posted)
12/29/2014 12:32 AM	Line Status Changed From CLAIM_REBILLED_TO_PR To BILL_TO_PT	Business (Charge Master)
12/29/2014 12:29 AM	Submitted to paper in AJ-2945	Business (Charge Master)
12/29/2014 12:28 AM	Line Status Changed From CLAIM_SENT_TO_PR To RE_BILL_TO_PR	Business (Charge Master)
12/29/2014 12:29 AM	Claim Grouping Override Changed To SCESEPARATE CLAIM EXCLUSION	Business (Charge Master)
12/29/2014 12:29 AM	EDI Claim Generated. Claim# AJ-2945	Business (Charge Master)
12/29/2014 12:29 AM	Line Status Changed From RE_BILL_TO_PR To CLAIM_REBILLED_TO_PR Amount applied \$10	Business (Charge Master)
12/29/2014 12:27 AM	Payment# 7-0143 Check# - PSTSW - Receipt Date: 12/18/2014 Payor:AMERIGROUP	Business (Manually Posted)
12/29/2014 12:28 AM	Submitted to paper in AJ-2944	Business (Charge Master)
12/29/2014 12:28 AM	Line Status Changed From NEW To BILL TO PR	Business (Charge Master)

3.15 Scheduler

In Appointment Scheduler window, now providers can be filtered based on Gender. Even the scheduler option screen can now be accessed from the Left Panel itself by clicking on the settings icon.



A new option to adjust Calendar font size and cell height is also provided.



Appointment Time is included in the scheduler bubble which will help the users to identify the appointment start time easily.

testoe, joe[MR#: 2070][DOB:]
Primary INS.:
Exam Room: WAITING ROOM
Req. Reason: -
Appt. Time: 8:30 AM
Duration: 0:30 hrs
Appt. Type: APPOINTMENT

Notes

[EV](#) | [Check In](#) | [Payment](#) | [Ledger](#) | [Schedule Hx](#) | [Recalls](#) | [Follow Up](#) | [Label1](#) | [Label2](#) | [Superbill](#) | [Financial Summary](#) | [Notes](#)
[Cancel Appt.](#)



Part

IV

4 REPORT UPDATES

4.1 New Reports

4.1.1 Appointments- Charges Reconciliation Report (B6)

A new report named Appointments-Charges Reconciliation report added to B. Super Bill Section on the Report Central. This report gives the status of the charges created from Charge Entry/ Charge Master (Edit Charges)/ an external system against each appointment and providing their billed status.

4.1.2 Referring Provider Wise Encounter Details Report (E5)

The report provides the Referring Provider selected on the Claim Encounter and the Claim Line information.

Referring Provider Wise Encounter Details Report

Parameters
 DOS From: 12/28/2014 To: 12/30/2014 Calculate Date As: --Select--

* REQUIRED FIELD

#	Referring Provider	Patient	DOS From	DOS To	CPT	Diagnosis	Primary Insurance	Primary Insurance	First Claim Date	Total Charge	Primary Insurance	Adj. Amt	ReasonLine	Status	Closed Date			
	FromCodeName	NotesUPIN	First NameLast NameMR#	PC Ref#	StateDOB		Name	Subscriber#		Allowed	Paid							
1	SP AJ	258741	2837	CA	10/28/1987	12/29/2014	12/29/2014	99245 250.03	AMERIGROUP	A147856	12/29/2014	570.00	0.00	10.00	0.00	DENIAL	BILL_TO_PT	12/29/2014

4.1.3 Service Location Wise A/R Aging Report (D13)

A new report for A/R aging based on Service Location is added to Report Central. The report has filters for Legal Entity and Provider for report generation.

Service Location Wise A/R Aging Report

Parameters
 Legal Entity: ALL Provider: ALL Service Location: ALL

Search Close

4.2 Report Enhancements

4.2.1 Summary - Insurance Balance and Aging by Patient (D4)

A new column "Patient Last Payment Date" added to the Summary-Insurance Balance and Aging by Patient Report. The field shows the last patient payment posted date for the patients on the report.

4.2.2 Monthly Activity Analysis Report (J7)

The Charges, Payments and Adjustments are displayed on the report in a different color for better visibility.

Monthly Activity Analysis Report														Unapplied Payments												
Generated by Irdc, Support on 12/19/2014																										
DOS Range : 12/30/2013 - 11/30/2014																										
Date Of Service																										
Acct. Date	Nov - 2014	Oct - 2014	Sep - 2014	Aug - 2014	Jul - 2014	Jun - 2014	May - 2014	Apr - 2014	Mar - 2014	Feb - 2014	Jan - 2014	Dec - 2013	Totals	Acct. Date	Unapplied Payments											
Nov Chg.	88048	364896	297483	11713	1	1	672	1475						764289	100%											
2014 Pmt.	6728	37442	31667	17778	740	2877	6737	197		608		294		104867	14%											
Adj.	19072	157276	163827	81677	1358	10964	21390	705		792		956		458018	60%											
Oct Chg.		82352	70620	92287									245259	100%												
2014 Pmt.		6676	19141	48767	4886	10388	1363	475		219			91914	37%												
Adj.		16541	73610	273144	38047	62865	17387	5431		3671		7084	507099	207%												
Sep Chg.		84377	623229	16303			2000						725909	100%												
2014 Pmt.		6148	19141	20472	24976	373	4704	2031		614		40	59358	8%												
Adj.		13517	79578	100500	29%	633	18742	4267		12529		19931	253597	35%												
Aug Chg.				96473	241474								336947	100%												
2014 Pmt.				620	42589	48071	16880	775	11330	4463	619	584	125832	37%												
Adj.				190689	55%	211183	55%	4059	34846	8679	1327	5416	514704	153%												
Jul Chg.					279897	369409	167769	300	300				817675	100%												
2014 Pmt.					8905	16866	24790	13933	4817	528	199	759	87917	8%												
Adj.					18488	94827	109154	34285	5859	520	276	5736	269146	33%												
Jun Chg.						125821	121736	216871					464428	100%												
2014 Pmt.						1222	12802	23305	43533	981	1608		83490	18%												
Adj.						1562	45144	131661	135678	5319	7191	700	327256	70%												
May Chg.							87714	945	199589				288248	100%												
2014 Pmt.							686	18422	12580	27512	4110	236	63585	22%												
Adj.								55525	50064	91770	28617	2212	228187	79%												
Apr Chg.								95582	151388	68002	1600	1500	318272	100%												
2014 Pmt.								2908	22587	18068	7462	9	74498	23%												
Adj.								4323	89762	52316	39036	57055	241522	76%												
Mar Chg.									150096	311561	3391	2841	467889	100%												
2014 Pmt.									2268	42636	41868	4089	96039	19%												
Adj.									8448	173379	117450	11354	307630	66%												
Feb Chg.										99174	273574	20727	393475	100%												
2014 Pmt.										3518	19444	41761	64722	16%												
Adj.										8062	81794	144121	233978	59%												
Jan Chg.											93736	241940	335676	100%												
2014 Pmt.											3774	16315	20088	6%												
Adj.											5477	84304	89781	27%												
Dec Chg.												147119	147119	100%												
2013 Pmt.												908	934	1%												
Adj.												3443	3443	2%												
Tot. Chg.	88048	447248	453480	822702	537675	497602	379693	313698	501373	478737	372501	414127	5305184													
Tot. Pmt.	6728	44118	56966	87637	60962	79481	67962	61696	97620	88530	79121	88334	848246													
Tot. Adj.	19072	173817	250953	434198	349082	382234	270283	240297	340103	364639	287253	322427	3434360													
Tot. Coll.	25003	217935	307949	521835	429144	461715	338245	301993	437624	463170	366374	410821	426206													
Balance	62248	711	229313	511	144531	32%	300867	37%	108531	20%	96187	7%	40448	11%	11705	4%	63749	13%	15667	3%	6127	2%	3306	1%	1022578	

% Apply to DOS only (Vertical / Y-Axis)
 CCP - Cannot calculate Percentage. Numbers may not reflect all activities for this Period.

4.2.3 Payments by Month by Provider Report (I20)

A new search filter - 'Case Type' added to the Payments by Month by Provider Report.

Payments By Month By Provider Detailed Report

Parameters

Acct. Date From: To: Calculate Date As: --Select--

Legal Entity: ALL

Provider: ALL

Case Type: ALL

* = REQUIRED FIELD

Search Close

The report results are also grouped by Case Type.

#	Acct. Date	Provider	Case Type	Patient	MR#	Case#	Legal Entity	Insurance			DOS From	DOS To	CPT
								Primary	Secondary	Tertiary			
1	12/2014		PRIVATE/GROUP HEALTH INSURANCE PLAN										
2	12/2014		PRIVATE/GROUP HEALTH INSURANCE PLAN										
3	12/2014		PRIVATE/GROUP HEALTH INSURANCE PLAN										

Case Type: PRIVATE/GROUP HEALTH INSURANCE PLAN

4.2.4 Denial Report (G2)

Two new columns added to the Denial report - "Previous Claim Date & Previous Claim#" The fields provide the previous claim batched date and the previous submitted claim #.

Denial Report

Parameters

Posting/Denial Entry Date From: 12/01/2014 To: 12/23/2014 Calculate Date As: --Select--

DOS From: To: Calculate Date As: --Select--

Denial Code: Sort: Denial Code

Insurance Company: User: ALL

Exclude PAID_CLOSE Exclude WO_CLOSE Exclude HOLD

Search Close

# Patient	Legal Entity	DOS	CPT	INS.	Claim #	Claim Date	Denial Code	Payor Remark	User	Member#	Number of Times Denied	Billed Amt.	Payments Applied			AVG. Age	Current Line Status	Previous Claims		
													Patient	INS.	Write Off			DOS/LCD	Claim Date	Claim#
1	Ortho, William Michael	12/02/2014	9020	AMERIGROUP	AG-2872	12/11/2014	C001		Bushara	414755	1	570.00	0.00	0.00	0.00	15	13	CLAIM_REBILLED_TO_FF	12/15/2014	AG-2881

4.2.5 Patient Statement (C2)

- "Last Visit date" field added in the CSV format of the statement output file.

AU	AV	AW	AX	AY	AZ
61-90	91-120	>=121	Co-Insura	Last Visit Date	PC Ref#
0	0	177.58	0		
0	0	30	0		
0	0	0	0	12/17/2014	

- "PC Ref#" has been added in the CSV format of patient Statements.

AU	AV	AW	AX	AY	AZ
61-90	91-120	>=121	Co-Insura	Last Visit Date	PC Ref#
0	0	177.58	0		
0	0	30	0		
0	0	0	0	12/17/2014	

- Patient Statements are now sorted by Date of Service.

4.2.6 Generate Patients In Collections List (C10)

SSN# & the Secondary Insurance Name added in the CSV format of the report.

4.2.7 Generate Patient Pre-Collection Letter (C4)

The following additional tags have been made available for the Patient Pre-Collections Letter.

- Patient Total Due
- Patient Last Name
- Guarantor Name
- Guarantor Address.

4.2.8 Financial Summary By Type of Service Report (I17)

Renamed the report - "Financial Summary By TOS" to "Financial Summary By Type of Service Report"

4.2.9 Posting Detail Report (I6)

A new search filter "Line Sub status" added to the Posting Details Report to filter claims using the Line Sub Status.

A check box – 'Show Over payment Only' is added to the report filters for displaying claims that have over payments posted for a selected date range.

The screenshot displays the 'Posting Detail Report' filter window. It contains several input fields and dropdown menus for filtering data. The 'Line Sub Status' dropdown is highlighted with a red box and set to 'ALL'. The 'Show Over Payment Only' checkbox is also highlighted with a red box and is currently unchecked. Other visible fields include Patient Name, Payment #, Acct. Date From, DOS From, Posting Date From, PSTS#, Legal Entity (set to ALL), Provider (with a list of providers), Source (set to --Select--), User (set to ALL), To (with date pickers), Check #, CPT, and Payor Type (set to ALL). A 'Clear' button is located at the top right of the filter section. At the bottom right, there are 'Search' and 'Close' buttons.

4.2.10 Appointment Worksheet Report (A2)

PC Ref # field added to the Appointment Worksheet Report results.

Appointment Worksheet Report

Parameters

Appt. Date From: 12/29/2014 To: 12/29/2014 Calculate Date As: --Select--

Legal Entity: ALL

Provider Name: ALL

Appt. Source: ALL Appt. Type: ALL

Appt. Status: ALL Sort By: Date

Include Cancelled Include Hospital Care

* = REQUIRED FIELD

Search Close

Patient	PC Ref#	Appointment Date	Appointment Time	Legal Entity	Rendering Provider	Appointment Status
	158269	12/29/2014	12 : 00 AM	Dermatology	Salgado, James B	CHECKED IN
	158269	12/29/2014	07 : 30 AM	Bay Area Medical Group	Allen, Steven W	CHECKED IN

4.2.11 Patient By Insurance Co. Report (E2)

A new column named "Group #" added to the report results.

Patients By Insurance Co. Report

Parameters

Creation Date From: 12/01/2014 To: 12/29/2014 Calculate Date As: --Select--

Insurance Co.: Patient Name

Sort Results By: Include Inactive Patients Include End Dated Pat. INS.

Search Close

#	Patient Name	MR#	DOB	Patient Address	Phone(Home)	Phone(Cell)	Insured #	Group #	INS. Level	Creation Date
1	INS. Co.: AETNA PayorID: 60054 Payor Address: PO BOX 31450, TAMPA, FL- 32423-4234									
1	Jenkins, Susan	765565825	8/29/1953	123 house			25368874	-	P	12/14/2014
2	Nana, Phad	765565829	12/8/1976	Top Central square			4562222	23655888	P	12/14/2014
3	Nashif, Vaidya	765565831	9/19/1985	44201	(852)741-2333		785440588	1254788	S	12/16/2014
4	Thomas, Susan	765565826	8/29/1976	PO BOX 27287			4627265	1225693	P	12/14/2014

4.2.12 Patient Charges / Payments History Report (C7)

Created a summary report of this report. Provided radio buttons to switch between detailed and summary report types.

Patient Charges / Payments History Report

Parameters

Patient: Case #:

DOS From: To: Calculate Date As: --Select--

Detail Summary/UB04

* = REQUIRED FIELD

Search Close

Part

V

5 BUG FIXES

- The order of the CPTs in Summary Encounter Line Activity Report is made consistent with that in Charge Master.
- The comments entered in the Payment were not displaying on the Payment Receipt. This is resolved.
- Unable to open the Guarantor and Other Attributes screens using the latest version of Chrome browser. This is now resolved.
- When a case is created by Auto Case functionality, previously only professional claims were set by default. This is corrected and now the system will check the default case type specified in the practice option.