

# Practice Management User's Guide

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# Introduction

Aprima patient relationship manager is a comprehensive and flexible application that allows you to fully replicate the workflow processes used in your office or clinic. It is designed to help you streamline your current processes, while maintaining data and audit trails for all physician-patient interaction and subsequent billing.

Aprima includes two fully integrated components:

- Electronic Health Records (EHR)
- Practice Management System (PM)

The system fully integrates both EHR and PM but, as different users will likely use each component, the two components are considered separately for the purpose of training and documentation.

## Practice Management

The practice management module contains the features and functions that enable you to perform the billing and payment entry tasks of your office, including:

- Posting payments and daily close
- Processing bills and claims
- Balancing and closing
- Managing accounts receivable

## Purpose and Organization of this Guide

This guide is intended as a reference document for billing staff, claims processing staff, and other users of the practice management module of the application. This guide is primarily intended for users who have received training on the application.

Because this guide is intended as a reference document, it is arranged in alphabetical order by topic. Within a major topic, subtopics may be arranged in various ways. Some topics have subtopics that are only loosely related to each other. In these topics, the subtopics are also arranged alphabetically. Other topics have subtopics that are closely related and dependent upon one another. For these topics, the subtopics are arranged logically.

## New and Revised Content

Enhancements and new features are identified in this document using the following conventions.

- *<<New>>*: Identifies new information in the guide. This information may be about a new feature or a new function or workflow for an existing feature.
- *<<Revised>>*: Identifies information in the guide that has been revised as a result of an enhancement or a new feature.

## Other Conventions Used in Documentation

Menu selections are indicated with arrows leading from one item to the next. For example, Tools → List Editor → System → User Group indicates that you should:

1. Select the Tools menu.
2. Choose List Editor from the drop-down list.
3. Select System from the List Editor menu.
4. Select User Group from the System menu.

Field names, menu items, and button names are given in initial upper case, as shown in the steps above. In many instructions, the word 'field' is not included and is instead simply identified by the initial upper case name of the field. For example, the instruction "Enter a Name for the collection status" means "In the Name field, enter a name for the collection status."

Most windows require that you select the OK button to accept your selection or save your entry to the database. Because this is a general requirement of nearly all windows and the procedures in which they are used, this step is not included in most procedures.

# Financial Processing

The application's financial model is based on sound accounting principles and practices, including a double-entry ledger. Therefore, every financial transaction has an equal but opposite entry.

Financial transactions are processed in real-time. This means that charges and payments are posted to a financial date when they are entered, and they are immediately available on all reports for that financial date. The daily process for entering charges and payments, filing claims, and closing a financial date is outlined below.

1. When users log into the application, they select a default batch which will be used for all the charges and payments that they process. A user may change the default at any time, and the user may put a particular transaction into a batch other than the default if desired.

Providers do not have to select a default batch. If a provider has not selected a default batch for the day, a batch will be created the first time the provider creates a superbill from a patient visit note each day and that batch will be the provider's default for that day.

2. Providers and other clinical users will create superbills automatically from their patient visit notes. The charges from these superbills are automatically posted to the providers' default batch.

When a medical assistant or nurse starts the patient visit note to enter vitals or take the history and has a default batch selected, then a superbill will be created in that default batch. When the user does not have default batch selected, then a superbill will not be created. Rather it will be created by the provider and posted to the provider's default batch.

3. If automatic adjustments are used, payment adjustments are determined using the patient's insurance payer and that payer's amount allowed schedule. These adjustments are automatically created, posted to the provider's default batch with the charges, and applied to those charges on the superbill.
4. Front desk staff will enter patient copay payments as patients check in for their appointments. These payments will be posted to the staff member's default batch, and will be automatically allocated to the superbill for the patient visit when that superbill and its charges are created.
5. Billing staff will enter payments received from insurance payers and patients, and will allocate payments and adjustments to specific charges on superbills. Payments and adjustments will be posted to the user's default batch or to the batch selected by the user.
6. Billing staff will search for visits and appointments without superbills, and create any needed superbills. This will automatically create and post the charges and adjustments for those superbills.
7. Billing staff will validate the diagnosis and procedure codes in superbills, and make any coding changes needed. Posted charges and adjustments for modified superbills will be automatically changed to reflect the coding changes. (The optionally purchased clinical claims scrubbing functionality can assist with this step. Clinical claims scrubbing helps reduce the possibility of claim errors by assessing the coding in the superbill with additional patient and insurance information that may not have been available to the provider. However, clinical claims scrubbing is not required for this step in the financial process.)

8. When all the payments, charges, or both have been entered for a batch, the billing staff member responsible for that batch will review it. The Track Superbills and Batch Payments window display details for the charges and payments in a batch. The Deposit Slip, Daily Charges Trial Balance, and Daily Transactions Trial Balance reports can be generated by batch.
9. Batches with correct transactions are then completed. Completing a batch changes the status of the superbills in the batch to either Queued Primary or Pending Patient Payment, depending on the patient's insurance and whether charges are to be claimed.
10. Claims may be processed for batches that are complete or closed. Note that claims are not really in a batch; rather, the charges for the superbill for which the claim is made are in a batch. Therefore, secondary and tertiary claims are associated with the same batch as the primary claim, which is the batch the superbill is in.
11. Once all the batches for a posting date have been completed, a billing administrator or staff member will update the closing date for the financial center or centers associated with the charges and payments in the completed batches. Closing the posting date for a financial center closes all of the associated batches for any posting date up to and including that date. Closing a batch closes all of the charges, payments, and adjustments in that batch.

Updating the closing date may be done as frequently or as infrequently as needed by your practice. The recommended practice is to close daily; this does not mean, however, that you need to close the current date. You may close through a date several days prior to the current date each time you close. Closing regularly is the only way that you can confidently know the dollar amounts of the charges made, payments received, and adjustments made for a posting date, week, month, or year. Closing regularly also means that there is less to process each time you close, and so the process completes quickly.

Update the closing date for a financial center when you are comfortable that the charges and payments through that date are completely and accurately entered. Once a batch is closed, the transactions in that batch are locked down; that is the transactions can be changed only with the appropriate audit trail.

12. After updating the closing date, generate patient statements. Charges, payments, and adjustments appear on patient statements before they have been closed. Therefore, you must ensure that the financial data on the statements given to patients has been reviewed for accuracy and is known to be current.

## Quick Link Icons on the Billing Toolbar

Quick link icons provide shortcuts to frequently used functions. The following table defines the standards icons available on the Billing toolbar. The Billing toolbar displays only when your user setting definition is defined to display to it.

Icon	Description
	Batches
	Track Superbills

<b>Icon</b>	<b>Description</b>
	Track Superbill Procedures
	Track Financials
	Track Payments
	Track Payer Credits
	Track Transactions
	Process Claims
	Filing History
	Superbill Reports
	Update Closing Date
	Track EDI Responses
	Credit Card Settlement
	Credit Card Transactions
	Credit Card Scheduled Payments
	Visits Without Superbill
	Appointments Without Superbill
	Create Statements
	Responsible Party Collections
	Insurance Promises
	Print Collection Letters

## Rounding Dollar Amounts

Mathematical rounding is used to limit the number of decimal places in a number. Rounding replaces a number with another number that is less specific, because it has few decimal places, but is of approximately the same value. Financial processing uses rounding to limit dollar amounts to two decimal places, so that the amount is presented in dollars and cents.

Common rounding simply changes the number up or down based on the midpoint value between 0 and 1. So, if the final digit is between 0 and 4, the number is rounded down. Thus, 1.444 becomes 1.44. If the final digit is 5 or greater, then the number is rounded up. Thus, 1.445 becomes 1.45. This is the simplest form of rounding, but when many numbers are rounded over time, this method results in a significant rounding error.

Therefore, the banker's rounding method is the standard method of rounding for financial and statistical operations. Aprima uses this method for rounding dollar amounts because it is the financial standard.

Like common rounding, the banker's rounding method rounds the number down when the final digit is between 0 and 4 and it rounds the number up when the final digit is between 6 and 9. Banker's rounding differs from common rounding in the way it rounds a number when the final digit is 5. When the final digit is 5, banker's rounding considers the last two digits, not just the final digit. When the digit before the 5 is even, then the number is rounded down. When the digit before the 5 is odd, then number is rounded up.

So, using banker's rounding, 1.435 is rounded up to 1.44. But, 1.445 is rounded down to 1.44. Likewise, 1.455 is rounded up to 1.46, while 1.465 is rounded down to 1.46. In this way, the banker's rounding method reduces the bias found in common rounding, and prevents large amounts of calculations from skewing upward or downward.

## Terms Used in Financial Processing

**Allocate:** To apply money from a payment to a charge on a superbill.

**Allocation:** An amount of money applied from a payment to a charge on a superbill.

**Batch, Financial batch:** A group of financial transactions that are processed together.

**Payer credit:** An amount allocated from a payment to the insurance payer's or the responsible party's account, rather than to a charge on a superbill. A payer credit may be made when the payer overpays, when you have not yet identified the superbill to which it applies, or when a responsible party pays in advance of a service. A payer credit may also be made when you reverse an allocation that was made to a charge on a superbill. Like a payment, a payer credit is an amount of money that can be allocated to charges. However, unlike a payment, a payer credit is money that has been allocated and is associated with billing and rendering providers, a service site, and a financial center. When you create a payer credit from a payment item, you select a single provider as both the billing and rendering providers for the credit. When you create a payer credit from a superbill or when a payer credit is created from reversing an allocation to a charge, the billing and rendering providers on the credit default to the billing and rendering providers associated with the charge.

Payment: A payment item (such as a check, credit card, or cash) that may be allocated to one or more charges in one or more patient accounts.

System closing date: The date through which all financial centers are closed. Dates earlier than system closing date cannot be used as the posting date for any new financial batch.

Transaction: A transaction is set of financial actions made to either a charge on a superbill or a payment item. These actions may include the application of money to charges from a payment or payer credit, adjustments to charges, and transfers of liability from one payer to another (such as from primary insurance payer to secondary, or from insurance payer to responsible party).

## Financial Batches

A financial batch is a group of financial transactions that are processed together. Batching enables you to enter, balance, and close all the charges, payments, and adjustments for providers, service sites, or financial centers together. Batching also enables you to select the posting date used for those transactions, rather than using the system date as the posting date.

The charges on a superbill that is created automatically from a patient visit note are put in the user's default batch. The charges on a superbill that is created from the Patient Demographics or the Appointment windows are put into the creating user's default batch or the batch selected by the user. In either case, the posting date for the batch may not be the same as the date of the actual patient visit. Although all the charges on a superbill are put in the same batch by default, a user may change the batch for individual charges if desired.

Payments and the adjustments associated with them are put into the creating user's default batch or the batch selected by the user. Since payments are not necessarily received and entered on the same day as the charges, payment allocations are frequently in a different batch than the charges to which they apply. Transfers from an insurance payer to the responsible party or another insurance payer are also put into the creating user's default batch or the batch selected by the user.

Charge reversals, voided payments, and similar transactions are put into the creating user's default batch or the batch selected by the user. They are not put into the batch that the original superbill charge or payment allocation was in since that batch will have a different posting date and may have been completed and closed. This means that a superbill may appear in multiple batches.

### Default Batches

All superbill charges, payment allocations, adjustments, and other transactions must be assigned to a batch to be created and processed. To reduce the amount of data entry that must be done when creating and processing transactions, users may want to select a default batch. When a user selects a default batch, then all the charges, payment allocations, and other transactions processed by the user are automatically added to the default batch, as long as that batch is open. The user can, however, override the default by selecting a different batch for a specific superbill or payment.

Users can be prompted to select a default batch when they log into the application. By default, users are not prompted to select a default batch when they log in. If the user is not prompted,

the user must select a default batch if one is desired. If the user does not have a default batch, then the user must select a batch for each superbill and payment created and processed.

There is one exception to this process: superbills created by a provider are automatically assigned to a batch for that provider and the system date when the superbill is created. (Note that the date the superbill is created from a patient visit note may be different from the date on which the patient visit note was initially created or the services were provided to the patient.) When a superbill is created by a provider, the application looks for a batch for the provider and the system date. If an open batch is found, the application adds the new superbill to the batch. If there is no batch for the provider and date, or if the status of the existing batch is completed or closed, then the application creates a new batch and adds the superbill to the new batch. Batches automatically created in this way are given a name that includes the date and the provider's name. When more than one batch is created for a billing provider for a given date, a sequence number is included in the batch name.

If the providers in your practice only create superbills, then they do not necessarily need to be aware that their superbills are assigned to batches. Providers must be aware of and understand batches if they perform any other activity involving transactions, such as entering patient payments or adjustments.

It also important to understand that when a medical assistant or nurse starts the patient visit note to enter vitals or take the history and has a default batch selected, then a superbill will be created in that default batch. When the user does not have default batch selected, then a superbill will not be created. Rather it will be created by the provider and posted to the provider's default batch. If the note is completed without the provider working it, then no superbill will be created. The medical assistant or nurse must close the note, select a default batch, and reopen and complete the note to create the superbill. Or, you can use the Visits without Superbill window to identify the visit note and then create a superbill for it.

The name of a user's currently selected default batch is displayed in the right side of the bottom task bar of most windows.

**Note:** For a superbill to be created from the patient visit note, the provider or medical assistant must have the necessary security access rights to create superbill. If the user does not have the necessary security, no superbill will be created. Use the Visits without Superbill window to identify any visit notes that require superbills and to create superbills for them.

## **Batch Owners**

Every batch has an owner. For most batches, the owner is the user who creates the batch. Batch security defined at the user level determines which other users can add transactions to or remove transactions from an owning user's batch. Some batches are created by the application during an automatic process. For example, the Collections Nightly Processing Job creates a batch for all collection fees. You must define a default owner for system-created batches. Please refer to the Default Owner for System-Created Batches section for instructions.

## Batch Names

The default naming convention for batches includes the owning user's name and the system date. Users can change the batch name when creating a new batch. When a user creates a batch for a posting date that is different from the current system date, the date in the batch name should be changed to the intended posting date.

Practices that prefer to batch transactions by service site, financial center, or other sorting mechanism may want to include that sorting mechanism in the batch name rather than the owning user's name. You can change batch name when you create the batch or at time after the batch is created. Batch names must be unique.

## Financial Batch States

The following table explains the three states that a batch may be in.

State	Description
Open	<p>The posting date for the batch is set when the batch is initially opened, and cannot be modified once set.</p> <p>Superbill charges and payments may be created and associated with the batch, charges may be deleted, and payments and adjustments may be allocated to superbill charges.</p> <p>If a payment is allocated to a charge in an open batch, and that charge is later deleted, the payment amount allocated to that charge reverts to a payer credit amount. The payer credit amount is then available to be allocated to another charge by a user.</p> <p>Transactions may also be moved from one open batch to another.</p> <p>The batch name may be changed, and notes regarding the batch may be added or modified.</p> <p>An open batch may be deleted if there are no transactions associated with it.</p>

State	Description
Complete	<p>Mark a batch as complete to prevent transactions from being added to or removed from the batch. Superbill charges and payments cannot be associated with the completed batch, and payments associated with a completed batch can no longer be allocated to superbill charges. Transactions cannot be moved to or from a complete batch. These restrictions lock the batch, thus enabling you to review the batch and its transactions.</p> <p>Only the notes regarding the batch may be added or modified when a batch is complete. The batch name cannot be changed.</p> <p>A complete, but not yet closed, batch can be unlocked and re-opened by a user with the appropriate security rights.</p>
Closed	<p>A batch is closed when the financial center or financial centers associated with the transactions in the batch are closed through the posting date of the batch.</p> <p>Closed is a permanent unchangeable state. Transactions cannot be added to or removed from a closed batch. The batch name cannot be changed. A closed batch cannot be unlocked and reopened.</p> <p>Notes regarding the batch may be modified by a user with the appropriate security rights. This is the only modification that can be made to a closed batch.</p> <p>An error message will notify users when they attempt to associate superbill charges or payments to closed batches, and will instruct them to select an open batch with a posting date greater than the closed through date for the associated financial center.</p>

## Batch Security

Users who work with financial batches must have the appropriate level of security for the financial batches with which they work and for the tasks which they perform. If you do not have the appropriate level of security, contact your administrative super user.

The following security access levels are available. Users can be given these access levels for the batches that they own and for batches owned by other users.

- New: Create batches.
- Modify: Add, move, change, or delete transactions in an open batch.
- Complete: Lock down all transactions in the batch prior to daily close of the batch's posting date.
- Override: Allows the user re-open a batch that has been marked as 'complete'.

Users who are responsible for entering charges and/or payments need New, Modify, and Complete security access to their own financial batches. Users may also need some or all of these security access levels for financial batches owned by other users. This enables users to process charges and payments across financial batches.

Should a user with this level of security access identify a discrepancy after a financial batch has been completed, then that user must bring the discrepancy to the attention of a user who does have Override security access. That user can then re-open the completed batch. Once the batch has been reopened, any user with Modify access can make the correction. (Any user with Modify access to the reopened, any user with Modify access can make any change to the batch.)

A user who is responsible for the financial close process needs all levels of security access for batches owned by all users who work with transactions in the financial centers for which that user is responsible. If you have different users performing the financial close process for different financial centers, you may also need to have a user who has all security access levels for all users' batches.

## **Batch Basics**

When you log into the application, you should select a default financial batch to be used for all the charges and payments that you process. In some practices, you will be required to select a default batch. If no batch is open, and if you have the necessary security rights, you can open a batch for the posting date.

As you process charges and payments, you may need to view a list of batches and select a batch you need to work with. You may also need to move financial transactions from one batch to another.

### **Select a Default Batch**

This window will automatically display at login if you have selected that option.

1. Tools → Default Batch
2. Use the Find icon to search for and select the desired batch.

### **Viewing and Editing Your Default Batch**

The name of your currently selected default batch is displayed in right side of the bottom task bar of most windows. You can select the batch name on any window to access the Batch window to edit that batch.

## Open a Batch for a Posting Date

At least one batch must be opened for each posting date. More than one batch may be opened for a posting date.

1. Either:
  - Tools → Default Batch → Find icon → New button
  - Billing → Batches → New
2. Enter a Name for the default batch. Batch names must be unique.
3. Select a Posting Date.
4. Select the Make This My Default Batch checkbox if desired.
5. Enter an ID and Notes, if desired.

## Viewing Batches

Use the Batches window to display a list of batches, and to access additional information about a batch.

The Batches window displays the number of payments in a batch, and the total payment amount, and the unallocated payment amount. You can use this information to identify batches that contain payments that must be allocated before the batch is completed and closed.

The Batches window also displays the number of superbills in or referenced by the batch and the total amount of the charges.

If a batch is used only for payments (either from insurance payers or patients), it may show a number of superbills and a zero dollar amount for the superbill charges. This will be a result of transferring an amount due from one entity to another when allocating a payment on a superbill. These superbills and their charges are not actually in the batch; they are only referenced by the batch.

1. Billing → Batches
2. Enter the search criteria for the batches you wish to see.
3. Select the Search button to display a list of all the batches meeting your criteria.
4. You may view additional information about the batch by:
  - Selecting the batch Name link to view the information about the batch itself.
  - Selecting the Payments link to access the Batch Payments window with a list of all the payments in the batch. You will only be able to view payments for financial centers for which you have permissions.
  - Selecting the Superbills link to access the Track Superbills window with a list of all the superbills in the batch. You will only be able to view superbills for financial centers for which you have permissions.

## Entering Payments for a Batch

You may enter payments from the batch they are to be associated with. Use the procedure below to enter payments from the batch. Then allocate the payment to the appropriate superbills in the usual manner.

When all the payments for a batch have been entered, use the Batches window to review the payments entered to the physical payment documents (checks, cash receipts, etc.).

1. Billing → Batches
2. Enter the search criteria for the batches you wish to see.
3. Select the Search button to display a list of all the batches meeting your criteria.
4. Select the Payments link to access the Track Payments window with a list of all the payments in the batch.

**Note:** You will only be able to view payments associated with financial centers to which you have permissions. Therefore, the number of payments displayed on the Track Payments window may not be the same as the number of payments indicated on the Batch window.

5. Select either the New Insurance Payment or New Responsible Party button in the toolbar.
6. Enter the payment information following the instructions in the Entering Payments section of this guide.

## Reassigning Transactions to Another Batch

You may move the transactions from one open batch to another open batch if desired. This enables you to put all the transactions that you want to process together into a single batch. For example, if your practice assigns work to billing staff by provider, then the billing staff may wish to move the transactions from one or more providers' batches into a single batch.

1. Billing → Batches
2. Enter the search criteria for the batches you wish to see.
3. Select the Search button to display a list of all the batches meeting your criteria.
4. To move all the transactions in a batch to another batch:
  - a. Select the checkbox for the batch or batches you wish to move.
  - b. Select the Reassign Batch button.
  - c. Select the batch into which you wish to move the transactions.
5. To move the superbills from one batch to another batch:
  - a. Select the Superbills link for the batch you want to move from.
  - b. In the Track Superbills window, select the checkboxes for the superbills that you want to move.
  - c. Select the Reassign Batch button.
  - d. Select the batch into which you wish to move the superbills.

6. To move payments and adjustments from one batch to another batch:
  - a. Select the Payments link for the batch you want to move from.
  - b. In the Batch Payments window, select the checkboxes for the payments that you want to move. Note that adjustments move with the payment that they are associated with. Automatic adjustments are associated with a \$0.00 payment.
  - b. Select the Reassign Batch button.
  - c. Select the batch into which you wish to move the transactions.

## Reviewing Batches

You will review batches and the financial transactions in them at various times and for various reasons. Before you complete a batch that contains payments, you should review it to make sure that all the payments in the batch have been fully allocated. You should also make sure that the payments in the batch match the actual payment items (checks, credit card charges, etc.) that are entered in the batch. Before completing a batch that contains charges, you should review it to make sure that it contains all the superbills you expect it to contain. You may also want to ensure that the total charge amount for the batch balances with the charges shown on the superbills. You may also review batches when looking for a particular financial transaction or when looking for a discrepancy.

1. Billing → Batches
2. Enter the search criteria for the batches you wish to see.
3. Select the Search button to display a list of all the batches meeting your criteria.
4. If, as is recommended, you are putting payments and charges in separate batches, a batch that includes a number in the Payments column should also have a dollar amount in the payments Amount column and a zero dollar amount in the superbills Amount column. If there is a nonzero amount in the superbills Amount column, you have actual superbills and charges in the batch. You should move these into the appropriate charges batch. (See step 9.)
5. Select the Payments link for a batch to review the payments in it.

This accesses the Batch Payments window, which displays the payments in the selected batch. Note that if the batch contains payments associated with multiple financial centers, this window may not display all the payments in the batch. It will display only the payments associated with the financial centers to which you have access.
6. Review the payments, payment amounts, and adjustment amounts in the batch. If needed, you can create a new payment or reassign payments to a different batch.
7. When you are satisfied that the batch is correct, select the Close button to return to the Batches window.
8. Select the Superbills link for a batch to review the superbills in it.

This accesses the Track Superbills window, which displays all the superbills in or referenced by the selected batch.

9. If the selected batch is used only for payments, it will reference any superbills on which an amount was transferred from one entity to another. You can confirm that the superbills are only referenced by the batch by comparing the batch name in the Batch(s) field for selection criteria to the batch name in the Current Batch Name column. The batch names will be different if the superbill is merely referenced by the payments batch you are reviewing because the actual charges on the superbill are in a different batch.

If the batch names in the Batch(s) field and in the Current Batch Name column are the same, then the superbill contains actual charges. You should move the superbill to the appropriate charges batch. To do this, select the checkbox for the superbill. Then select the Reassign Batch button and select the appropriate batch.

10. If the selected batch is used only for current charges, it will contain current superbills and their charges. Review superbills to make sure they all belong in the batch, and that the batch contains all the superbills expected.
11. When you are satisfied that the batch is correct, select the Close button to return to the Batches window.

### **Completing a Financial Batch**

Completing a financial batch locks it so that transactions cannot be added to or removed from it. This enables you to review the transactions in the batch. It is recommended that you do not complete a provider's financial batch on the same day as the batch date since the provider may still be working in the day's patient visit notes and adding or removing procedures and their charges.

1. Billing → Batches
2. Enter the search criteria for the batches you wish to see.
3. Select the Search button to display a list of all the batches meeting your criteria.
4. Select the batch Name link for the batch or batches that you want to complete.
5. In the Modify Batch window, select the Complete checkbox.

### **Uncompleting a Financial Complete Batch**

If corrections are needed for the payments or charges in a completed batch, the batch may be uncompleted. You must have the necessary security rights to reopen a batch that has been completed.

1. Billing → Batches
2. Enter the search criteria for the batches you wish to see.
3. Select the Search button to display a list of all the batches meeting your criteria.
4. Select the Name link for the desired batch.
5. In the Modify Batch window, deselect the Complete checkbox.

## Billing Rules

Billing rules define how fees are calculated for procedures or services. There are several types of billing rules: fee schedule, time-based, and transportation. Your administrative super user will have defined any billing rules applicable to your practice.

### Fee Schedule Billing Rules

Fee schedule rules are used when a procedure is paid differently under certain circumstances than it is normally. For example, some procedures are paid differently if they are performed in a hospital, rather than in a doctor's office. Some procedures are paid differently depending on the type of provider who performed the procedure.

Fee schedule rules can be somewhat complex because of the conditions, or circumstances, that may apply. These conditions may include:

- Service site
- Service site code
- Provider
- Financial center
- Modifiers

The application searches the fee schedule rules are searched when a procedure code with a rule is entered on a superbill associated with the amount allowed schedule. The application applies a fee schedule rule when the conditions of the rule are met by the conditions on the superbill. The application applies the first rule identified matching the conditions of the superbill.

A rule includes the fee information for the conditions of the rule. The fee may be a flat rate or may be a percentage of the usual fee.

A procedure may have both a fee schedule rule and a time-based billing rule. Time-base billing rules are used to determine the number of units, and are applied when the time is entered in the patient visit note. Fee schedule rules are used to determine the fee per unit, and are applied to the superbill.

### Time-Based Billing

Time-based billing is used for services that are billed based on the time spent. A calculation is used to determine the number of units based on the time spent. The time-based billing functionality can be used for physical therapy, behavioral health, and other services for which a single, simple calculation is used to determine the time to unit.

The time-based billing functionality cannot be used for anesthesia billing or other services in which more complex calculations are need for the first unit and subsequent units for a single procedure code. Time-based billing is not used to determine the appropriate Evaluation and Management (E&M) code when the level of care is based on time rather than documentation.

A time-based billing rule may include the time spent for the first unit, time spent for subsequent units, and rounding used to determine the final unit. The insurance payer or payer and plan

combination determines the time to unit criteria. Time-based billing is determined by the patient's primary insurance payer. If the patient has a secondary insurance payer, the fee charged is determined by the primary insurance payer's rules even if the secondary insurance payer has different rules.

Time-based rules and the transportation rule based on odometer readings are both used to calculate units. If odometer reading information is entered for a procedure that has a time-based billing rule, the odometer reading is used to calculate the units because the mileage rule is the most specific rule.

### **Transportation Billing Rule**

The transportation billing rule is used for routine transportation services. There is only one transportation billing rule, which is that one mile equals one unit of service. The transportation billing rule cannot be used for ambulance services.

Clinical users may enter odometer readings for transportation services if this functionality is enabled for your practice. The odometer readings are used to calculate the number of units for the procedure. One mile equals one unit. Please refer to the Transportation Billing section under Electronic Health Records for instructions on entering the odometer readings.

Odometer readings are entered on a specific procedure in the patient visit note, and are displayed for that procedure on the subsequent superbill. Odometer readings cannot be entered or changed in the superbill.

Time-based rules and the transportation rule based on odometer readings are both used to calculate units. If odometer reading information is entered for a procedure which has a time-based billing rule, the odometer reading is used to calculate the units because the mileage rule is the most specific rule.

### **Identifying the Use of a Billing Rule**

You can identify whether a billing rule has been applied to a procedure charge when reviewing the charges on a superbill. Instructions for identifying and verifying the different types of billing rules are in the Charge Entry section of this document.

## **Claims Mapping Rules**

Claims mapping rules are used when an insurance payer requires that the payer's own code be used on a claim rather than the standard CPT® or HCPCS code. Claims mapping rules are set for an insurance payer. Most insurance payers who require their own codes for certain procedures require their own code for all of their insurance plans. If an insurance payer does require their own code for some insurance plans and not for others, then you will have to create a specific insurance payer record and associate it with the insurance plans that require the payer-specific code.

A claims mapping rule identifies the insurance payer, the procedure code, and the payer-specific override code. Each claims mapping rule, (that is, the combination of these three things) must be unique.

The claims mapping rule is applied when the claim is generated, and when ERA processing applies payments to charges on superbills. Please note that claims mapping rules are not based on the patient's account effective period. If a claims mapping rule is active at the time that a claim is generated or ERA processing is performed, the claims mapping rule is used.

The claims mapping rule that is used when generating a claim or when processing an ERA is based on the insurance payer to which the claim will be submitted or from which the ERA was received. Thus, if a patient has a secondary insurance payer and the primary and secondary payers both have payer-specific codes, the claims mapping override rule will use the primary payer's rule when processing for the primary payer and the secondary payer's rule when processing for the secondary payer.

The payer-specific codes are not used in the patient visit note or superbill, and they do not appear in any reports. However, when reviewing a superbill, you can see whether a claims mapping rule will be applied using the Procedure Detail window.

### **Identifying the Use of a Claims Mapping Rule**

The payer-specific code is not used in the patient visit note or superbill. However, when reviewing the superbill, you can see whether a claims mapping rule will be applied. Instructions for identifying the claims mapping rule are in the Charge Entry section of this document.

## **Charge Entry**

All charges are recorded on a superbill, which pulls together all the information you need to file a claim. If you are using the combined application, the superbill is the link between EHR and PM; the superbill associates patient diagnoses with procedures, and includes patient demographic and insurance information. If you are using the combined application, the superbill is generated automatically from the patient visit note.

If you are using the PM module only, you must create the superbill by entering the data in the required fields. The required fields may vary with your practice, and may also vary depending on the type of superbill you are generating. For example, you may need to add modifiers to a procedure code, or add a hospitalization date if the account is for an inpatient.

### **Superbill Procedure Line Items and Financial Batches**

Each charge on a superbill is associated with a financial batch. The superbill itself is not associated with a financial batch. However, the Superbill window does contain a Batch field, which contains the financial batch that will be used for any action on the superbill that requires a batch. All of the charges on a superbill are associated with the user's default financial batch, if one is selected, when the superbill is created. If the user does not have a default batch selected, then a batch must be selected in order to add a charge to the superbill.

Once the superbill is created with charges on it, you can change the financial batch associated with individual charges. The charges may be in the same financial batch or in different financial batches. Charges on a superbill may be associated with batches that are in different states (open (🔒), completed (🔓), or closed (🔒)). Because each procedure's charge is handled separately, individual charges may be voided and reversed without voiding or reversing the entire superbill.

So, for example, if you have a superbill for a patient for whom a provider is making hospital visits, you add a charge for the visit made each day and associated that charge with a batch with that day's posting date. Each day, you can review and complete the batch for the posting date. The next day, you can add a new charge associated with a different batch for the new posting date. So, a superbill with multiple charges on it could have a charge in an open batch, another charge in a completed batch, and a third charge in a closed batch.

A charge that is in an open batch can be changed or removed from the superbill without affecting other charges on the superbill and without the need to void or reverse the charge. When a charge is in a completed batch, that batch must be unlocked to reopen it before the charge can be changed or removed. When a charge is in closed batch, then an entry reversing the original charge is made into another open batch and, if needed, a new correct charge entry is also made in that same open batch.

When any charge on a superbill is in a closed financial batch, then the Information slider and everything shown on the slider is considered closed. To change the provider, service site, financial center, or patient account, you must unlock the closed batch. This will create an entry in a different, open financial batch that reserves the charge in the closed batch. Once you change the information in the Information slider, then a new charge is created in the open batch with the provider, service site, financial center, and account information you just entered.

### **Synchronizing the Superbill and Patient Visit Note**

When a superbill is created from a patient visit note, the application attempts to keep the superbill synchronized with changes made in the patient note while the financial batches for charges on the superbill are open and while the superbill has a status that allows automatic synchronization. The superbill can be automatically updated by changes on the visit note only when all of the financial batches associated with the superbill are open. If the financial batch for any procedure charge or any financial transaction for any of those procedures is complete or closed, then the application cannot automatically synchronize the superbill with the visit note.

When automatic synchronization can be done, pending charges are generated for any procedures that are added to the visit note and pending charges are deleted for procedures that are deleted from the visit note.

## Charges and Their Payments

Payments may be allocated to both pending and posted charges. Reports may include pending charges, posted charges, or both.

Patient copays that are collected and entered when a patient checks in for an appointment are applied to the patient's account. When the visit note for the appointment is saved, a preliminary superbill is created and charges are generated for any procedure and E&M codes in the visit note. The copay amount in the patient's account is then automatically allocated to the pending charges on the visit superbill.

If a payment has already been allocated to a pending charge, the payment is moved to the patient's account when that charge is deleted.

## Superbills

The superbill pulls together all the information you need to file a claim. If you are using both the electronic health record (EHR) and the practice management (PM) modules, the superbill is the link between them. The superbill associates patient diagnoses with procedures and includes patient demographic and insurance information.

If you are using the combined application, the application generates a superbill automatically from the patient visit note. If you are using only the PM module, you can create the superbill from the appointment. You can also create a superbill from an external patient entry. If there is no visit note or appointment, you can create a superbill directly.

When a superbill is created automatically from a visit note or you create it from an appointment or external patient entry, information from the visit note, appointment, or external patient entry defaults on the superbill. When you create the superbill directly, you must enter the needed information. The required fields for a superbill may vary with your practice, and they may also vary depending on the type of superbill you are generating. For example, you may need to add modifiers to a procedure code or add a hospitalization date if the account is for an inpatient.

The Superbill window includes menus, toolbars, sliders, and tabs. These items are introduced here, and they are explained in more detail in the following sections.

- **Menus:** The Options menu enables individual users to select the sliders and tabs that they want displayed, and to select whether or not they want warning messages to display.
- **Toolbars:** The toolbars contain quick link icons or buttons that access other functions.
- **Sliders:** As with other sliders used in the application, the sliders can be moved to any position and can either float or can be docked in the desired position. When a slider is pinned (docked), it will remember its last location.
  - The Financial Summary slider displays a list of all the transactions on the superbill. Each transaction is summarized, and includes the posting date, the action taken, the general ledger account affected, the financial batch, and the debit, credit, insurance, and total amounts.

- The Information slider contains basic information for the superbill, including provider, service site, financial center, patient, and patient account information. The slider also displays patient case information if a case was associated with the patient visit. Patient case information cannot be changed from the Superbill window. Billing staff may find it convenient to always display the Information slider; clinical users may want to display it only when needed.
- The Payments slider displays the details of all transactions made on the superbill. A transaction is an allocation to or an adjustment on one or more charges on a superbill. From the slider, you can create a new insurance payment, a new responsible party payment, or a new transaction. The slider also displays totals for charges, payments, adjustments, and the balance, patient due, and insurance due amounts. You can create a new payment or transaction from the slider.
- The Dx/SP History slider contains information about the patient's past superbills and the diagnoses and services performed documented in those superbills. This enables you to review the patient's diagnosis and procedure history. It also enables you to select a diagnosis or procedure to add to the current superbill.
- Tabs: There are four system-defined tabs. The Main and Other tabs are always available. The UB and Dental tabs may be displayed or hidden as desired.
  - The Main tab contains general information (service dates, the batch the superbill is in, and the superbill's status), the diagnoses, the fee schedule and amount allowed schedule being used, and procedure information. It also includes the total charge amount, total amount allowed, and total copay amount.
  - The Other tab contains other information frequently, but not always, needed for filing claims.
  - The UB tab is optional. It contains information needed for the uniform bill (UB) claim form used by hospitals, nursing homes, hospice, home health agencies, and other institutional providers and by other providers for professional services covered under Medicare Part A.
  - The Dental tab is optional. It contains information needed for claims for dental services performed by medical practitioners.
  - The Superbill window may include custom-defined tabs created specifically for your practice. Custom-defined tabs enable you to enter any information needed by your practice not otherwise entered in the application.

Superbills may be deleted under certain conditions. Please see the Deleting a Superbill section for more information.

When a superbill is created from the patient visit note, then the application attempts to keep the superbill synchronized with changes made to the patient note. For more information please see the Synchronizing the Patient Visit Note and Superbill section.

## Toolbar Icons and Buttons

The toolbars contains quick link icons or buttons that access other functions. The Patient toolbar contains icons linking to basic patient functions. The Patient toolbar is not explained here since it appears in a number of other windows and always contains the same icons. The Superbill toolbar contains buttons for functions related to superbills and claims. These buttons are explained in the table below.

Button	Description
Delete	Deletes the superbill. A superbill may be deleted only when all the charges on the superbill are in open financial batches.
Copy	You can copy a superbill to make a new superbill containing the same patient, diagnosis, and procedure information. This is useful when you have two providers who will bill for the same services performed for the patient, such as for a primary and assistant surgeon. When you select the Copy button, the Superbill window opens with a new superbill that contains all the information from the original superbill. The new superbill is given a new superbill ID.
 Print	Accesses a drop-down menu that enables you to print the superbill or generate a claim for it.
History	Accesses the Superbill History window, which lists all actions that have applied to the superbill, including errors, status changes, reversal events, and notes.
Create Insurance Promise	Accesses the Insurance Payer Promise window to create a promise for this superbill.
Create Payer Credit	Accesses the Create Payer Credit window to create a payer credit from this superbill. This is useful when reviewing overpaid superbills.
Recompute Financials	Recomputes the financial information for the superbill based on changes to the patient account, provider, or other information associated with the superbill.
 Diagnosis Association	Accesses the Procedure Diagnosis Mapping window. This window enables you to review or enter associations between the diagnoses and procedures on the superbill.
Show All	Displays reversed charges, which are hidden by default. The button is active only when there reversed charges on the superbill.
Batch State	The batch state icon indicates the state of the financial batch that is currently available for use. This may be open (  ) , complete (  ) , or closed (  ) .
Clear Dx	Selecting this button removes all the diagnosis pointers in the Diag Ptr column. You must then enter the diagnosis pointers needed.

<b>Button</b>	<b>Description</b>
View Note	Accesses the Visit Note window, which displays the visit information from the Visit Text tab of the patient visit note associated with the superbill. This enables you to quickly review diagnosis and procedure codes and other information in the visit note.
Review Audit	Accesses the Review Superbill window, which displays audit entries for any changes made to the superbill from the superbill, visit note, or billing message. Please note that this window only displays entries for changes made since the implementation of the 2015 version of the application.

## **Information Slider**

The Information slider contains general information about the provider or providers, the patient, and the patient's account. Much of the patient and patient account information is read-only, and is pulled from the Patient Demographics window.

### *Provider/Site Information*

The default settings in this section are taken from information that was provided when the appointment was scheduled or from the Visit Information slider if the settings were updated in Full Note Composer or Superbill Composer. If information was not provided, these fields are blank. You can enter or edit all information in this section.

- The Billing and Rendering Providers may be the same person or different people. For example, a physician may be both the billing provider who bills for the service and the rendering provider who performed the service. Or a physician may be the billing provider who bills for the service, but the rendering provider is a nurse practitioner who performed the service, but who cannot bill. (Remember that the provider identified as the billing provider on the patient visit note and superbill is identified as the rendering provider on insurance claims. The provider identified as the rendering provider on a patient visit note and superbill does not appear on the subsequent claim.)
- Operating Provider applies to institutional claims only.
- Service Site is the location at which services were provided.
- Correctly entering or not entering a Referring Provider is very important to ensuring that insurance claims are correct. When a primary care physician refers a patient to a specialist, the specialist must include the referring primary care physician's name on the insurance claim. If this is not included, the insurance payer may refuse the claim or delay payment while they request the information from you. Therefore, it is important to enter the referring provider in the superbill so that it is included in the claim. However, if there is referring provider information in the claim when there should not be, the insurance payer may refuse the claim or delay payment while they request clarification. This could happen, for example, if a provider in your practice refers a patient to another provider for consultation, and incorrectly enters the consulting provider's name in the referring provider field in the patient visit note.

When the referring provider is entered in the patient visit note, either through the Appointment window or through the Visit Information slider in Full Note Composer, or Superbill Composer, the referring provider is automatically populated.

- Supervising Provider must be identified when the rendering provider requires supervision, such as nurse practitioner.
- Financial Center is associated with the billing provider.
- Enter the Referring Date if required. When the referring provider is entered in the patient visit note, either through the Appointment window or through the Visit Information slider in Full Note Composer, or other clinical note type window, the referring date is automatically populated.
- Attending Provider applies to institutional claims only.
- Ordering Provider is not yet used to populate claims. It will be used to populate the revised 1500 paper claim once adopted by CMS.

### *Account Information*

By default, the patient's insurance Account is set to the main account that is defined on the Account tab of the Patient Demographics window. Change this if required by selecting from the patient's alternative accounts.

By default, the Use Insured's Authorize Assignment checkbox is selected, and the default values from the patient's account are shown selected but inactive. Deselect the Use Insured's Authorize Assignment checkbox to override the defaults for this superbill (for example, if a patient requests that this particular superbill be treated as self-pay, with a courtesy claim sent on the patient's behalf).

Select the Allow Only Paper Claims checkbox if you wish to force the superbill to be filed as a paper claim. This may be a requirement for some types of accounts (such as some worker's compensation accounts), or it may be used if you need to send extra documentation with the claim or if you have received errors from sending the claim electronically.

The Box 17 Provider field enables you to select the qualifier for the role of the provider (ordering, referring, or supervising) to populate in Box 17 of the revised 1500 claim form. The Box 17 Provider field is not used on the current paper claim form. However, if you make a selection in this field, then it will be used to determine the provider included in Box 17 on the claim. It will be used to populate the revised 1500 paper claim once adopted by CMS.

The Use Primary Payer's Accept Assignment checkbox is selected by default. This indicates that the accept assignments are defaulted to those of the insurance payer. You can override these settings by deselecting the Accept Assignment checkbox and selecting from:

- Accept Assignment
- Accept Assignment Lab Only
- Do Not Accept Assignment

Other fields in this section are taken directly from the patient account information. They are not editable, but if you select a different patient account, the information is changed to reflect the new account.

## *Patient Information*

Patient Name, Gender, Birth Date, SSN, and Release Signed are taken from the Patient Demographics and are not editable.

You may associate the superbill with a Patient Case if desired. This will be populated if the patient visit note was associated with a patient case.

## **Financial Summary Slider**

The Financial Summary slider displays a list of all the transactions on the superbill. Each transaction is summarized, and includes the posting date, the action taken, the general ledger account affected, the financial batch, and the debit, credit, insurance, and total amounts. The transaction summary also includes the insurance payer and plan in the IPLN column and the liability owner in the IPAY column.

## **Payments Slider**

The Payments slider in the Superbill window displays the details of all transactions made on the superbill. A transaction is an allocation to one or more charges on a superbill. The slider also displays totals for charges, payments, adjustments, and the balance, patient due, and insurance due amounts. You can create a new payment or transaction from the slider.

Select the Date hyperlink to access the Allocate Payment window to review the payment allocations and adjustments for a particular payment. Select the Reference hyperlink to access Track Payments window.

From the slider, you can create a new insurance payment, a new responsible party payment, or a new transaction. Please see the Payment Entry section for information on payments and payment allocation.

**IMPORTANT:** You can enter a payment for a superbill from the Payments slider even when the superbill is opened as read-only. A superbill will open as read-only if another user has the same the superbill or the associated patient visit note open.

## **Dx/SP History Slider**

The Dx/SP History slider that contains information about the patient's past superbills and the diagnoses and services performed documented in those superbills. This enables you to review the patient's diagnosis and procedure history. It also enables you to select a diagnosis or procedure to add to the current superbill.

1. Highlight the Service Date entry that you wish to review.
2. To add a diagnosis or procedure from that service date to the current superbill, select the checkbox for the desired diagnosis or procedure.

## **Main Tab**

### *General Information*

The External ID is a mandatory field for superbills, and must be unique. You may enter your own alphanumeric ID, or the application will generate a unique, numeric ID. You will not be able to save a superbill if you use an ID that has already been used.

The Service Start Date and Service End Date initially default to the day of the patient visit. If you enter different dates for procedures, the start date will default to the date of the first procedure, and the end date will default to the latest procedure end date. You can edit these if necessary.

If your practice uses time-based billing rules, then Service Start Time and Service End Time fields are also available. Service start and end times cannot be entered or edited in the superbill. They are entered in the patient visit note, and are simply displayed in the superbill.

Batch is the financial batch that will be used for any action requiring a batch, such as adding another procedure to the superbill. This batch is not associated with the superbill itself; it is merely used for charges and transactions requiring a batch. This will be your default batch if one is selected.

The marketing Referral Source identifies a marketing campaign whereby a new patient learned of your practice. This may be your practice website, an advertisement you placed in a particular publication, or something similar. A referral source is not a referral from another physician. The marketing referral source associated with the patient visit note is associated with and displayed on the superbill created from that visit note. You can also enter the marketing referral source directly on a superbill if needed.

Status is used to track the superbill through the claims process. When initially generated, the superbill has a status of Preliminary. You must update the status manually to Ready to Post, but after that the status is updated automatically as the charges are balanced and closed, the claim file, and payments received and posted. The application also includes a number of other statuses that you can assign manually to indicate a problem or particular state and to remove the superbill from automated claim processing temporarily or permanently. Please see the online help topic 'Superbill Status Definitions' for an explanation of each pre-defined status, and its place in the claim processing workflow. For more information on the automatic updating of statuses, please see the online help topic 'Superbill Status Changes'.

Your practice may have added your own status values, if desired. When you track superbills, you can search on any one or more status values, including any user-defined values.

### *Diagnoses, Procedures, and Charges*

The Diagnoses, Procedures, and Charges section contains information that may be pulled from the patient visit note or entered directly into the Superbill window.

The Superbill window can include up to 24 diagnosis codes. The Superbill window displays a read-only list of diagnoses. You may select the Diagnoses hyperlink to access the Superbill Diagnoses window, where you can enter, delete, and change the order of the diagnoses. Please note that although the Superbill window allows 24 diagnosis codes, claims cannot yet accept this number of diagnosis codes.

The Fee Schedule and the Allowed Schedule are determined by the patient's insurance payer and plan or the provider. If you have the necessary security permissions, you can select the Set Fee/Allowed Schedule Manually checkbox. Then you can select another fee schedule if needed. Changing the fee schedule and/or amount allowed schedule may change the charge amount, allowed amount, and copay amount for the procedures.

The Procedures section enables you enter the details for each procedure performed. When you add a procedure, another procedure line will appear. From any field in the procedure line, you can press the F5 key or use the More  icon to access the Procedure Detail window, which enables you to enter additional information about the procedure. Additional information includes contract type, fee and charge information, NDC information, medication measurement information, and service line notes.

The Service Start date, Procedure, and Modifiers come from the patient visit note, or may be entered when creating a superbill directly. If procedures have not been associated with diagnoses, enter the diagnosis association in the Diagnosis Pointer (Diag Ptr) field. Enter this as a value; for example, if the procedure is linked to diagnosis number 1, enter 1 in the diagnosis pointer field. To link a procedure to more than one diagnosis, enter the associated numbers with no spaces or punctuation; for example, 234 for association with diagnoses 2, 3, and 4. Note that 5010 claim requirements allow only four diagnoses per procedure.

The Units, Charge amount, Total Allowed amount, and Total Copay amount are determined by the fee schedule and amount allowed schedule. By default, only the highest copay for all procedures on the superbill is included. If you have the necessary security permissions, you can override the charge amount, the amount allowed for a procedure, and the copay for a procedure. You must access the Procedure Detail window to make these changes.

If you don't wish to file a claim for one or more procedures (for example, because the procedure is not covered), check the Do Not Claim checkbox. If this is checked before the superbill is processed through Balance & Close Charges, it ensures that the charges are billable to the patient or defined responsible party. If the checkbox is checked after the charges have been posted via Balance & Close Charges, it does not alter the liability, but does affect whether the procedure is included in the claim. You may wish to use this option if you have already filed a superbill and you need to re-file individual items.

You can use the up and down arrow icons to rearrange the order of the procedures.

Use the delete icon to delete a procedure line. This deletes all the information associated with the procedure. If a payment, adjustment, or transfer has been applied to the procedure, and that payment, adjustment, or transfer is in an open financial batch, then the payment, adjustment, or transfer is simply rolled back as unallocated and available for distribution to other remaining balances due. If the payment, adjustment, or transfer is in a complete financial batch, then the delete button for the procedure will be disabled and you will not be able to delete it from the superbill. If the payment or transfer is in a closed financial posting date, you will be able to delete the procedure and any associated payment amount will become an account credit, available for refund or re-allocation to any other remaining balance due.

When a procedure required an ABN, and the completion of that ABN was indicated in the patient visit note, the ABN Completed checkbox will be selected. This notifies you that the proper paperwork was obtained for the procedure. You can then edit the superbill to include

the appropriate modifier on the procedure or procedures that may not be covered. The modifier will be included when you process the claim.

The Total Charges amount, Total Allowed amount, Total Coinsurance amount, and Total Copay amount are displayed at the bottom of the tab. Note that the total coinsurance amount is calculated from the amounts allowed, not the fee amounts.

## Other Tab

The Other tab contains other information frequently, but not always, needed for filing claims. Some of the information is mandatory in certain situations. For example, if the superbill is for an inpatient, you must complete onset hospitalization dates.

- Condition Related To identifies the related cause of the condition for which the patient was treated, such as Auto Accident. The list associated with your practice will display when you select the search field.
- The State in which the accident took place, if the claim is related to an accident.
- Enter dates for Onset of Current and First Episodes, Unable to Work From/To, and Hospitalized From/To if these are applicable to the visit.
  - If you enter any of these dates, it is only necessary to enter the onset date for unable to work and hospitalization. The end date is optional.
  - The Qualifier field for the Onset First Episode identifies which date is submitted, such as the initial treatment date, the accident date, etc. It is not yet used to populate claims. It will be used to populate the revised 1500 paper claim once adopted by CMS.
- Prior Authorization Codes for up to three insurance payers.
- Type of service indicators for EPSDT, family planning, and emergency.
  - If either the EPSDT or Family Planning checkboxes are selected, it will populate the CMS-1500 form, Box 24H.
  - If the Emergency checkbox is selected, this populates CMS-1500, Box 24I.
- COB, the coordination of benefits indicator, is used to populate CMS-1500, Box 24J.

**Note:** The COB field is not included in the new CMS-1500 (08/05) paper claim form, and there are no government mandates for the use of the field. Should you need to accommodate any unique requirements of local insurance payers who elect to maintain the old CMS-1500 (12/90) paper claim form, you may now use the COB field on the superbill for that purpose. The COB field on the superbill will now accept up to three characters.
- Box 10d is used to populate CMS-1500, Box 10d. This is a General Note text field, so that you can create saved notes for re-use.
- Enter pregnancy-related information if needed.
- Enter EPSDT referral codes if needed.
- Enter an Emergency indicator code if needed.
- Enter claim information, such as delay reason and claim notes.
- In the Paperwork area, enter information for any additional supporting paperwork that you are submitting separately.

- a. Select the paperwork Type. The paperwork type indicates the title or contents of the document, report, or supporting item.
  - b. Select the paperwork report transmission Code. The paperwork report transmission code defines the timing, transmission method, or transmission format by which the paperwork is to be sent.
  - c. Enter the Control No. The control number may be up to 50 characters.
- The Last Seen by Supervising Provider date is needed for a few billing scenarios in which an insurance payer will cover a procedure for a specialist only when a primary care physician or other specialist has given the patient a specific diagnosis and is providing care for that diagnosis. For example, routine foot care services may be covered only if the patient has been diagnosed with diabetes. Under these conditions, you must include the supervising provider's name, the diagnosis, and the date the supervising provider last saw the patient.
  - Initial Treatment date, if entered, populates Loop 2300, DTP\*454\*D8\* in the electronic claim.
  - Claim Note/Box 19 is used for both paper and electronic claims. For paper CMS-1500 claims, it populates Box 19. This is a General Note text field, so that you can create saved notes for re-use.

### **UB Tab**

The UB tab contains information needed for the uniform bill (UB) claim form used by hospitals, nursing homes, hospice, home health agencies, and other institutional providers and by other providers for professional services covered under Medicare Part A. It includes:

- Value codes
- Condition codes
- Occurrence codes and timespans
- Admission and discharge information
- Procedures and dates
- Treatment authorizations
- Cover period timespan
- Care dates
- Other related information

### **Dental Tab**

The Dental tab is optional. It contains information needed for claims for dental services performed by medical practitioners. It includes:

- Series start date
- Type of service indicators
- Prosthesis replacement reason
- Unusual service remarks

## <<Revised>> Custom Tabs

Your administrative super user may configure additional tabs for specific uses. These tabs may be custom tabs or may be a system-defined optional tab.

The system-defined form layout Supplemental Claim Information can be used in the Superbill window to enable entering information for chiropractic spinal manipulation, a homebound indicator, and an additional claim information date, if needed. This information populates in loop 2300 of electronic claims.

## Create or Review a Superbill

When a superbill is created automatically from the patient visit note, the service dates, account, provider, service site, diagnosis, and procedure information default to the information entered in the patient visit note. When a patient case, referring provider, or authorization code is associated with the visit, that information also defaults to the superbill. You can change any of the defaulted information as needed.

When you create a superbill from an appointment, the service dates, account, provider, and service site information default to the information entered for the appointment. When a patient case, referring provider, or authorization code is associated with the appointment, that information also defaults to the superbill. You can change any of the defaulted information as needed.

You can also create a superbill for an external patient treatment event displayed on the Desktop. Information from the external patient entry will default to the visit note or superbill.

When you create a superbill from the Track Superbills window or Patient Demographics window, you must enter the service dates, account, provider, and service site information in the superbill.

A superbill must be associated with a financial batch. A new superbill is associated with your default financial batch if you have one selected. If you do not have a default financial batch selected, the application will prompt you for a batch when you enter any financial information (such as provider, service site, procedure, etc.).

Patient information in the superbill is displayed only. Any changes needed to this information must be made in the Patient Demographics window.

A service line note for a particular procedure may be entered in the superbill. Service line notes may up to 80 characters. Service line notes are then included on the subsequent insurance claim, whether filed electronically or on paper. In the electronic claim, the service line note appears in the NTE segment of the 2400 SVC loop. On the paper claim, it appears beneath the procedure code. The note will also be sent back in electronic remittance advice (ERA) if received.

When an NDC number is included in the patient visit note for an administered drug, then the subsequent superbill contains information about the NDC number. The information is included in the service line note for the procedure with which the NDC number is associated. The note includes the procedure modifier for NDC numbers, the NDC number, and the units of measure. If desired, you can edit the note to include the number of units administered.

A superbill (and subsequent claim) for durable medical equipment can only contain charges for that durable medical equipment. It cannot contain any other procedures. DMERC insurance payers will deny claims that contain any other procedures.

1. Access the Superbill window by either:
  - Appointment → Visit Note & Superbill tab → New Superbill button
  - Appointment → Visit Note & Superbill tab → Superbill link
  - Patient Demographics → New → Superbill
  - Billing → Track Superbills → ID link
2. Access the Information slider.
  - a. Verify or select the Provider information. Correctly entering the various providers is extremely important to ensuring that provider productivity is correctly recorded and that insurance claims are correct.
    - The Billing Provider is the provider for whom the insurance claim will be made. (This person will be identified as the rendering provider on the claim itself.)
    - The Rendering Provider is the provider who actually performed the services. By default, the rendering provider is the same as billing provider. Select another provider if needed. This information is not used for the insurance claim.
    - The Referring Provider is the physician who referred the patient to you for services. Specialists must include the referring physician's name on the insurance claim. If this is not included, the insurance payer may refuse the claim or delay payment while they request the information from you. Therefore, it is important to enter the referring provider in the superbill so that it is included in the claim.
  - b. Verify or select the Service Site at which the services were performed. The service site is used on the insurance claim; be sure this is correctly recorded for hospital, nursing home, or other external site visits.
  - c. Verify or enter the Financial Center.

Financial centers are used to separate financial information for different service sites or providers. If your practice is using financial centers, they will have been set up by your administrative super user. If you are not using financial centers, all your services sites and providers will be associated with the default Main financial center.
  - d. Verify or enter the Referring Date if applicable. This is the date the patient was referred to your practice.
  - e. Verify or select the Account. Changing the account may change the insurance payer and plan information and the insurance assignment information displayed.
  - f. Verify or select the appropriate Assignment checkbox or checkboxes.

By default, the Use Insured's Authorize Assignment checkbox and Primary Payer's Accept Assignment checkbox are selected and the default values from the selected patient account are shown as selected but inactive. You can change these if needed; for example, if the superbill is to be treated as self-pay.

- g. Select the Allow Only Paper Claims checkbox if you wish to force the superbill to be filed as a paper claim. This may be a requirement for some types of accounts (such as some worker's compensation accounts), or it may be used if you need to send extra documentation with the claim or if you have received errors from sending the claim electronically.
  - h. The Box 17 Provider field enables you to select the qualifier for the role of the provider (ordering, referring, or supervising) to populate in Box 17 of the revised 1500 claim form. The Box 17 Provider field is not used on the current paper claim form. However, if you make a selection in this field, then it will be used to determine the provider included in Box 17 on the claim. It is used to populate the revised 1500 paper claim form adopted by CMS.
  - i. Associate a Patient Case, if desired. This field will be populated if the patient visit note was associated with a patient case.
  - j. Enter any Notes for the superbill, if desired. Notes entered here appear in the Track Superbills window, but are not included in the Superbill History.
3. Select the Main tab, and then verify or enter the General Information.
    - a. Verify or enter the Service Start and End Dates.
    - b. Verify or a select the financial Batch.
    - c. Select a marketing Referral Source, if desired. This information is for internal reporting only; it is not used on the insurance claim.
    - d. Verify or select the superbill Status.
  4. In the Diagnoses area, review the list of diagnoses.
    - a. To change the diagnoses, select the Diagnoses hyperlink.
    - b. In the Superbill Diagnoses window, search for and select up to 24 diagnosis codes.
    - c. Use the Up and Down arrow icons to change the order of the diagnoses.
    - d. Select the OK button to save the diagnoses and return to the Superbill window.
  5. Verify or enter the Fee Schedule and amount Allowed Schedule.
 

To enter or change the fee schedule or amount allowed schedule, you must select the Set Fee/Allowed Schedule Manually checkbox. This checkbox will be enabled only if you have the necessary security permissions.
  6. Verify or enter one or more Procedures performed. For each procedure, you may enter:
    - Service Start. The service start and end dates are necessary for hospital or other external site visits. For visits performed in your office, the service dates entered in step 3 are sufficient.
    - Procedure. This is required.
    - Modifiers. Select one or more as appropriate.
    - Diag Ptr (diagnosis pointer). Associate the procedure to a diagnosis by entering the numeric value of the diagnosis. You may either select from the entries or you may type in your selections. When typing, you must also type a separator between selections. For example, you must enter '1.2.3' or 1;2;3.' with periods or semicolons between numbers so that your selections are identified. Using periods enables you to quickly enter your selections using your 10-key pad.

- Units. Enter the number of units used or provided. This may default for the selected procedure.
  - Charge. The charge will be automatically populated for the procedure if charges have been defined in the fee schedule. Otherwise, you must enter the charge amount.
  - Tot Charge: This is the total charge for the procedure. This is determined by the fee schedule. This amount will be greater than the Charge amount and the Total Allowed amount when tax is applied to the procedure. You cannot change this amount on this window. To change the amount, you must access the Procedure Detail window.
  - Tot Allowed: This is the total allowed amount for the procedure. This is determined by the fee and amount allowed schedules. You cannot change this amount on this window. To change the amount, you must access the Procedure Detail window.
  - Tot Copay: This is the total copay amount. This is determined by the fee and amount allowed schedules and the copay information for the insurance payer and plan associated with the patient account. You cannot change this amount on this window. To change the amount, you must access the Procedure Detail window.
  - Don't Claim. Select this checkbox for any procedure that is not to be included in the insurance claim. Charges for procedures that are not claimed are posted to the patient's liability.
  - More. Select the note icon (📝) to access the Procedure Detail window. This window enables you to view enter all the procedure information displayed on the Main tab of the Superbill window and additional information. Please see Entering Procedure Details for more information.
  - Use the Delete icon (✖) to delete a procedure and its information.
  - Use the Up and Down arrow icons to change the order of the procedures on the superbill (and subsequent claim).
7. The ABN Complete checkbox will be selected if it was selected in the patient visit note from which the superbill was created. When selected, you must include the appropriate modifier on the procedure or procedures that may not be covered. The modifier will be included when you process the claim.
  8. The Total Charge, Total Allowed, Total Coinsurance, and Total Copay fields display the calculated totals for all procedures on the superbill. The Total Tax field will display if you are using the tax functionality. It will contain an amount if any procedures include a tax amount.
  9. Select the Other tab and verify or enter additional information as appropriate.
    - Condition Related To. Use this field to indicate on the claim that the services are related to or result from a specific circumstance, such as an auto accident or employment. This is related to Box 10 a, b and c on the CMS-1500 paper claim form.
    - State. Use this field to indicate the state in which an auto accident occurred. This is related to Box 10b Place on the CMS-1500 paper claim form.
    - Onset Current Episode. Enter the date of onset for the current episode. This is related to Box 14 on the CMS-1500 paper claim form.
    - Onset First Episode. Enter the date of onset for the first episode. This is related to Box 15 on the CMS-1500 paper claim form.
    - Unable To Work From. If the patient is unable to work, enter the first date the patient was unable to work. This is related to Box 16 on the CMS-1500 paper claim form.

- Unable To Work To. If the patient is unable to work, enter the date the patient is expected to be able to return to work. This is related to Box 16 on the CMS-1500 paper claim form.
  - Hospitalized From. If the superbill is for a hospital visit, enter the date the patient was admitted to the hospital. This is a required field for inpatient hospital services. This is related to Box 18 on the CMS-1500 paper claim form.
  - Hospitalized To. If the superbill is for a hospital visit and the patient has been discharged, enter the date the patient left the hospital. This is related to Box 18 on the CMS-1500 paper claim form.
  - Prior Authorization Codes. Use the Carrier 1, 2, and 3 fields to enter prior authorization codes from insurance payers as needed.
  - EPSDT. Select this checkbox when Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program services are being billed on the claim to Medicaid. This is related to Box 24 H on the CMS-1500 paper claim form.
  - Family Planning. Select this checkbox when family planning services are being billed on the claim to Medicaid. This is related to Box 24 H on the CMS-1500 paper claim form.
  - Emergency. Select this checkbox if the services were provided on an emergency basis. This field does not populate on the insurance claim.
  - COB. Coordination of Benefits does not populate on the claim.
  - Box 10d. Use this free text field to enter any information you want to appear in Box 10d on the CMS-1500 paper claim form.
  - LMP Date and Estimated Date of Birth. Use these fields for pregnancy related claims, as needed.
  - EPSDT Referral. Select the appropriate referral codes as needed for EPSDT claims.
  - Resubmission Code. Use this field to enter a resubmission code provided by an insurance payer.
  - Emergency Indicator. Select the appropriate emergency services indicator, if appropriate.
  - Claim Header Note Type.
  - Delay Reason. When appropriate select the code indicating the reason for a delay in filing the claim.
  - Claim Note. Use this field to enter any notes regarding the claim.
  - Box 19. Use this free text field to enter any information you want to appear in Box 19 on the CMS-1500 paper claim form.
10. Select the UB tab, and enter any information needed for an institutional claim.
  11. Select the Dental tab, and enter any information needed for claims for dental services performed by medical practitioners.
  12. When all information is complete and correct, select Ready to Post as the superbill status.

### **Using ICD-10 Diagnosis Codes**

Your user setting definition must be configured to enable the use of ICD-10 diagnosis codes in order to search for and select from the ICD-10 code set when creating superbills.

The Find Diagnosis Code 10 window enables you to search for and view ICD-10 diagnosis codes. You may search for a code by ICD-10 code, ICD-9 code, or term. When searching by term, you may enter all or part of the code name.

You may also search for a range of ICD-9 or ICD-10 codes. In the Range field, type the first code in the range, then a hyphen (-), and then the last code in the range. For example, J67-J68. To search for more than one range, type the first range, then a semicolon (;), and then the second range. For example, J67-J68;537-538.

Please remember that there are many more ICD-10 codes than ICD-9 codes, and the code names can be very specific. Because there are so many codes, searching by term will be slow if you only enter a word or two. However, being too specific can also cause the search to be slow or to fail. When searching by term, try to search by the most important, most identifying three to five words. Then adjust your search if needed.

- By default, the maximum number of search results for ICD-10 codes is limited to 100. The application will display a warning if your search resulted in the maximum number of items. Refine your search criteria to display a more reasonable number of results.
- An error may occur if your search term contains a word or words with a very large number of matches. An error may also occur if your search term contains so many words that the application has difficulty finding and matching all possible combinations. If an error occurs, reduce the number of words in your search criteria.

So for example, 'fracture fibula' will return more results than the window will display, and the results shown may not include the diagnosis for which you are looking. But, 'displaced oblique fracture shaft left fibula subsequent encounter delayed healing' may be too specific to process, and result an error. Better search results are obtained by using something in the middle, such as 'oblique fracture left fibula' or 'oblique fracture left fibula delayed'.

The list displays the ICD-10 code, the corresponding ICD-9 code, the description, the associated SNOMED code, whether or not the code is billable, and the risk assessment factor (RAF). Please note that the RAF is the RAF score is currently for the corresponding ICD-9 code, when available. The Centers for Medicare and Medicaid have not defined RAF scores for ICD-10 codes.

While most ICD-10 codes correspond with an ICD-9 code, there are some codes in each code set that do not have a corresponding code in the other code set. If you are coding with ICD-10 and the insurance payer requires an ICD-9 code, then you must select an ICD-10 code that does have a corresponding ICD-9 code. The Find Diagnosis Code 10 window displays an IMO placeholder code when a diagnosis code does not have a corresponding code in the other code set. The placeholder codes are IMO0001 and IMO0002. The placeholder codes may appear in either the ICD-10 or the ICD-9 column of the Find Diagnosis Code 10 window.

Selecting an ICD-10 code actually selects both the ICD-10 code and its corresponding ICD-9 code. The Diagnosis area of the superbill displays the selected ICD-10 and ICD-9 code pair. The application determines whether to include the ICD-10 code or the ICD-9 code on claims based on the ICD-10 start date identified for the insurance payer.

## *Searching for a Code*

1. Billing menu → Track Superbills
2. Select the New Superbill button. This opens the Superbill window.
3. On the Main tab, the entered diagnoses are listed in the Diagnoses area of the window.
4. To add a diagnosis, use the Tab key to move to the Diagnoses link, and press the Enter key. This opens the Diagnosis window.
5. In the Diagnosis window, select the Find () icon to open the Find Diagnosis Code 10 window.
6. In the Find Diagnosis Code 10 window, you may search by ICD-10 code, ICD-9 code, or term.
7. Highlight the desired code. This displays the available modifiers in the bottom pane of the Find window.
8. Select the appropriate modifiers/qualifiers.
  - Modifiers/qualifiers in blue text are associated with the selected term.
  - Selected modifiers/qualifiers determine the final specific code selected.
9. Select the OK button to return to the Diagnosis window.
10. In the Diagnosis window, select the OK button to select the diagnosis code and return to the Superbill window.
11. The Superbill window then displays the selected diagnosis with both the ICD-10 code and the corresponding ICD-9 code.

## *Modifiers*

The ICD-10 code that you select as the diagnosis is a combination of a base code, and one or more modifiers or qualifiers. The base code is identified by three alphanumeric characters followed by a decimal point. For example, M48. or S32. Modifiers and qualifiers are identified by alphanumeric characters following the decimal point.

Each modifier and/or qualifier increases the specificity of the code, and restricts the additional modifiers and qualifiers that may be selected. For example, M48.4 is less specific than M48.45, which is less specific than M48.45X, which is less specific than M48.45XA. Each time you select a modifier option for a modifier/qualifier type, you determine the options available for the modifier/qualifier type is the next level of specificity.

The options available any modifier/qualifier type are determined by the options you have selected for other modifier/qualifier types. A given selection may expand or narrow the options available for another modifier/qualifier type.

If your selections result in a code that is too specific or that does not have the desired modifier options for modifier/qualifier type, then you can go back to the next higher level, which is less specific. If needed, you can continue working back through the levels until you reach the base code.

### *Billable and Specific*

Each ICD-10 code may be either billable or non-billable, and specific or non-specific. The BillSpec column identifies these characteristics with the following icons.

<b>Icon</b>	<b>Description</b>
	Billable
	Non-Billable
	Specific
	Non-Specific

### *Additional Information for Codes*

The Notes column in the Diagnosis Code 10 window displays additional information about the diagnosis code. This information can include that an additional diagnosis may be required, that the diagnosis has exclusions or inclusions, and other information about the code.

Types of information are identified by the following prefix letters.

- A: Use Additional Code
- E: Excludes
- F: Code First
- I: Includes
- U: Use Additional Code

To view the full note, hover the mouse cursor over the Notes field.

### *Entering an ICD-10 Code that Corresponds to Multiple ICD-9 Codes*

There are instances in which a single ICD-10 code corresponds to multiple ICD-9 codes. For example, the ICD-10 code Z23, for Encounter for Immunization, corresponds with a large number of ICD-9 codes for individual vaccinations. During this transition period before ICD-10 codes become effective, it is necessary to be able to enter multiple ICD-9 codes in a patient visit note or superbill even though those ICD-9 codes all correspond to the same ICD-10 code. However, the application prevents you from entering a particular diagnosis into a visit note or superbill more than one time since duplicate diagnosis codes will cause the subsequent claim to fail.

Therefore, when you are using the ICD-10 functionality, the application checks both the ICD-10 code and its corresponding ICD-9 code to identify a diagnosis. So if the ICD-10 code and corresponding ICD-9 both match a diagnosis that is already entered, the application will prevent you from adding that ICD-10/ICD-9 combination again. If the ICD-10 code matches a diagnosis already entered but the ICD-9 code does not, the application will allow you to enter that ICD-10/ICD-9 combination.

Once ICD-10 codes become effective, it will be very important to review the diagnoses on a superbill based on the insurance payer or payers to which the claim will be submitted. While an insurance payer is accepting ICD-9 codes, then it is important that all applicable ICD-9 codes appear on the superbill, even if all of those ICD-9 codes correspond to a single ICD-10 code. But, once a payer is identified as ready to accept ICD-10 codes, then it will be necessary to ensure that a particular ICD-10 code only appears on a superbill one time.

## **Procedure Details**

Use the Procedure Details window to enter additional information for a procedure on a superbill. Much of the data in this window will be prepopulated from the superbill, and may be pulled from the patient visit note. Fee, allowed, and copay amounts are from the fee schedule and amount allowed schedule. Total charge and total allowed amounts are calculated based on the fee schedule, amount allowed schedule, and units.

If you have the necessary security permissions, you can override the fee, allowed, and copay amounts on this window. By default, the application only includes a single copay amount, and it uses the highest copay amount for all the procedures on the superbill. If you need to charge copay amounts for multiple procedures on the superbill, you can enter those amounts here.

### *Verify the Billing Rule*

If you use complex billing rules and the amount allowed for a superbill procedure is not as expected, then you can use the Show Rule Detail button to verify how the rule is computing the amount allowed from the Procedure Detail window. This accesses the Fee Rule Feedback window which displays a basic evaluation of the rule and how it is applied. The window displays only what is evaluated. Thus, if the rule fails on the first compare, the remaining compares are not displayed. And, if a rule matches, then the remaining rules do not need to be evaluated and are not displayed.

### *Review the Application of Time-Based and Transportation Rules*

If your practice is using time-based billing rules or transportation rules, then you may view a procedure's start and stop times or odometer readings in the Procedure Details window. You can only review this information. You cannot enter or modify start and stop times or odometer readings. This information can only be entered and modified from the patient visit note.

### *Verify Purchased Services*

Purchased services are services provided to a patient by another entity, such as a laboratory or imaging center, which bills your practice for the service. You then bill the patient and the patient's insurance payer for the service. The Purchased Service/Outside Lab area of the Procedure Details window displays information for these services. This will be populated from information defined on the procedure code. You may change it if needed.

The purchased services information is included in electronic claims in the loop 2310C: (Purchased Service Provider) with QB qualifier in NM101 and the provider information. The purchased services information also adds the PS1 segment to the claim.

### *Verify the Claims Mapping Rule*

Claims mapping rules are used when an insurance payer requires that the payer's own code be used on a claim rather than the standard CPT or HCPCS code. The payer-specific code is not used in the patient visit note or superbill. However, when reviewing the superbill, you can see whether a claims mapping rule will be applied using the Procedure Detail window.

### *Custom Tabs*

The Procedure Detail window may include custom-defined tabs created specifically for your practice. Custom-defined tabs enable you to enter any information needed by your practice not otherwise entered in the application.

### *View the Procedure Details*

1. Superbill → Main tab
2. From a procedure line either press the F5 key or select the More () icon. This accesses the Procedure Detail window.
3. The Procedure code is prepopulated and cannot be changed.
4. Verify or enter the number of Units for the procedure.
5. Select the Multiply Units checkbox if the fee for the procedure should be multiplied by the number of units performed.
6. Verify or enter the Service Dates.
7. The Contract Type field is not used at this time.
8. If you are using time-based billing rules, select the Billable Time hyperlink to view the start and stop times entered for the procedure. You cannot enter this information. If the start and stop time were not entered in the visit note, then you must enter the number of units in the superbill.
9. If you are using transportation rules, select the Odometer Readings hyperlink to view the odometer readings. You cannot enter this information. If the odometer readings were not entered in the visit note, then you must enter the number of units in the superbill.
10. Select the Manually Set the Fee/Allowed checkbox if you want to override the fee amount and amount allowed determined by the fee schedule and amount allowed schedule. You must have the necessary security access rights to select this checkbox.
11. Verify or enter the Fee, Allowed, Coinsurance, and Copay amounts. Note that the coinsurance amount is based on the allowed amount, not the fee amount.
12. The Subtotal Fee, Allowed, and Copay amounts are calculated based on the fee and allowed amounts, and the number of units.
13. The Tax amount field will display if you are using the tax functionality. It will contain the tax amount if the procedure is taxed.
14. The Total Charge, Total Allowed, and Total Coinsurance amounts will recalculate as needed.
15. The Insurance Percent field displays the insurance percentage from the amount allowed schedule.
16. Select the financial Batch for the charge.

17. The Charge Detail area displays transaction details for the charge.

The Override column displays payer-specific code information if a claims mapping rule applies.

18. The data in the NDC Information section is prepopulated from the procedure code record. You may modify this information if needed.

When an NDC number is included in the patient visit note for an administered drug, then the subsequent superbill contains information about the NDC number. The information is included in the service line note for the procedure with which the NDC number is associated. The note includes the procedure modifier for NDC numbers, the NDC number, and the units of measure. If desired, you can edit the note to include the number of units administered.

19. Enter the Medication Measurement information as appropriate. This enables you to enter additional information about the need for a medication, such as Procrit. This information is included in loop 24 record MEA of electronic claims. (You must enter this information in the Box 19 field on the Other tab of the Superbill window for paper claims.)

a. Select the appropriate Reference radio button. When NA is selected, no other entries will be included on the claim. Select Starting Dosage or Test Results when additional information must be included for a medication.

b. Select the appropriate Qualifier.

c. Enter the Value.

20. Enter any Notes, if desired. Service line notes may be up to 80 characters. Service line notes are then included on the subsequent insurance claim, whether filed electronically or on paper. In the electronic claim, the service line note appears in the NTE segment of the 2400 SVC loop. On the paper claim, it appears beneath the procedure code. The note will also be sent back in electronic remittance advice (ERA) if received. The note icon background color changes to yellow when text has been entered.

21. In the Fund/Eligibility Type area, enter or modify information needed for federal or state funded programs. The fund type and eligibility fund from a patient's account period will default to the procedures on superbills. You may enter this information on a particular procedure if it is not entered in the patient's account, and you can override the patient's default information if needed.

a. Verify or enter the Fund Type. If you change the information defaulted from the patient's account period, then "(Overridden)" is added to the field name.

b. Verify or enter the Eligibility Fund. If you change the information defaulted from the patient's account period, then "(Overridden)" is added to the field name.

22. In the Paperwork area, enter information for any additional supporting paperwork that you are submitting separately.

a. Select the paperwork Type. The paperwork type indicates the title or contents of the document, report, or supporting item.

b. Select the paperwork report transmission Code. The paperwork report transmission code defines the timing, transmission method, or transmission format by which the paperwork is to be sent.

c. Enter the Control No. The control number may be up to 50 characters.

23. The Purchased Service/Outside Lab area displays information for services that you purchase from another medical provider and then bill to the patient and insurance payer. This will be populated from information defined on the procedure code. You may change it if needed.
  - a. The Charge field is the amount the medical services provider charges you for the procedure.
  - b. The Provider is the medical services provider that actually performs the procedure and bills you for the service.

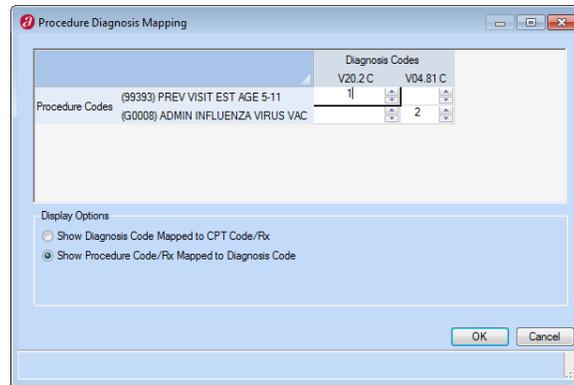
### **Verify the Billing Rule**

If you use complex billing rules and the amount allowed for a superbill procedure is not as expected, then you can verify how the rule is computing the amount allowed. The billing rule can be verified from the Superbill once the rule has been applied. So, you can verify a rule when a billing user questions the amount allowed for a procedure in a superbill. Or, you can create a superbill that contains the procedure code and is associated with the amount allowed schedule that includes the billing rule for that procedure code.

1. Superbill window
2. Verify that the superbill is associated with the amount allowed schedule that contains the billing rule you want to verify.
3. Select the More () icon for the procedure code that has the billing rule.
4. In the Procedure Detail window, select the Show Rule Detail button. This button will be active only when a rule is applied to the procedure.
5. The Fee Rule Feedback window displays a basic evaluation of the rule and how it is applied. The window displays only what is evaluated. Thus, if the rule fails on the first compare, the remaining compares are not displayed. And, if a rule matches, then the remaining rules do not need to be evaluated and are not displayed.

## Diagnosis Association

You may select the Dx Association () icon to associate diagnoses with procedures in the Procedure Diagnosis Mapping window. The Procedure Diagnosis Mapping window displays a table of the procedures and diagnoses on the superbill. You choose to display the table with diagnoses as rows and procedures as columns, or with procedures as rows and diagnoses as columns. In either display, you enter the diagnosis pointer number in the field that intersects a diagnosis and a procedure.



Once you have entered the diagnoses to be linked to a procedure, you may select the Expand () icon in the Procedure field on the Superbill window. Diagnoses are listed in the order in which you selected or typed them. You may change the order by selecting a diagnosis, and then using the Up () and Down () arrows to move it where desired. You may delete a diagnosis by selecting the Delete () icon.

## Copy a Superbill

You can copy a superbill to make a new superbill containing the same patient, diagnosis, and procedure information. This is useful when you have two providers who will bill for the same services performed for the patient, such as for a primary and assistant surgeon.

1. Either:
  - Appointment → Visit Note & Superbill tab → Superbill link or New Superbill button
  - Patient Demographics → New → Superbill
  - Billing → Track Superbills → Superbill ID link
2. Select the Copy button.

The Superbill window opens with a new superbill that contains all the information from the original superbill. The new superbill is given a new superbill ID.

3. Make any needed changes to the new superbill.

## Superbills for Alternate Insurance Payers

Medicare and some Medicaid and other insurance payers contract with separate insurance payers to cover certain charges, such as durable medical equipment (DME). Claims for the charges covered by the alternate insurance payer must be sent to that alternate payer, not to the patient's actual insurance payer.

If you work with an insurance payer who uses an alternate insurance payer and plan, your administrative super user may have set up the insurance payer and the amount allowed schedule associated with the insurance payer in such a way that a separate superbill is created for any charges covered by an alternate payer.

Thus, if you have a Medicare patient for whom a provider applied a wrist brace, then two superbills will be automatically created from the patient visit note. One superbill, which will be claimed to Medicare, will include the charge for the office visit and any other services performed. A second superbill, which will be claimed to the alternate insurance payer, will include the charge for the wrist brace.

All superbills are given a numeric superbill identifier when they are created. When a superbill is split as a result of an alternate insurance payer, the primary superbill is given a numeric superbill identifier and the second superbill that is automatically created for the alternate payer is given the same superbill identifier with an alphabetic suffix. So for example, if the primary superbill's identifier is 123, the identifier for the alternate payer superbill will be 123A.

## Using Procedure Sets

A procedure set is a special type of custom procedure code that enables you to group multiple procedures that are frequently performed together. You can then use the procedure set to easily enter all of the procedures in the set in a superbill. You select a procedure set just as you would any other procedure. But instead of populating the procedure set code and description on the superbill, the application populates the superbill with all the individual procedure codes in the set. Thus, the superbill and subsequent claim contain all the information needed for billing. The procedure set code and description do not appear in the superbill, claim, or financial reports; the individual procedure codes in the set do.

Procedure sets can also be used by a provider when charting a patient visit note. When the provider selects a procedure set, only the procedure set code and description appear in the patient visit. The superbill created from that visit note does not contain the procedure set; it includes the individual procedures in the set.

All procedure sets are user-defined. Please check with your administrative super user to determine whether any procedure sets have been defined for your practice.

## Using Service Site Specific Procedures

There are some circumstances that require that a specific procedure be credited to a particular service site. For example, you may have two office locations, but only one of them does lab work and so lab procedures need to be credited to that service site. If this type of circumstance applies to your practice, your administrative super user may have defined the service site on one or more specific procedure codes.

When a procedure code that has a defined service site is included on a visit note that is associated with a different service site, a separate superbill will be created for the procedure that is site specific. If the service site on the visit note is the same as the service site for the procedure, then only one superbill will be created. When you create a superbill directly (rather than automatically from a visit note), if the service site identified on the superbill is different from the service site on a procedure added to that superbill, then the application will automatically create a new superbill for that procedure when you save and close the superbill you are creating.

All superbills are given a numeric superbill identifier when they are created. When a superbill is split as a result of a site-specific procedure, the primary superbill is given a numeric superbill identifier and the second superbill that is automatically created for the site specific procedure is given the same superbill identifier with an alphabetic suffix. So, for example, if the primary superbill's identifier is 123, the identifier for the site-specific superbill will be 123A. If the original visit note or superbill included two procedures that are specific to two different sites, then three superbills will be created, and they will be identified as 123, 123A, and 123B.

If the original patient visit note has a service site identified and the only procedure on that visit note is site specific to a different service site, then two superbills will be created. One superbill will have the service site identified on the visit note and will have no procedures. The second superbill will have the service site specified by the procedure and will include the procedure. The reason for creating two superbills is that the visit note may not be complete at the time the superbills are created, and additional procedures may be added to the note and thus to the primary superbill. It is important to remember that a superbill that does not contain any procedures will prevent the closing of the financial center for that date. If there are no procedures needed on that superbill, then superbill is not needed and should be deleted.

The application will split a superbill for a site-specific procedure only if the superbill is in an open financial batch. So, if you or your administrative super user modifies a procedure to make it site specific, then any superbill that includes that procedure and that is in an open financial batch will be split if the superbill or the visit note is opened and edited. Superbills that include the procedure and that are in open financial batches but that are not opened and edited will not be split. Superbills that are in closed financial batches will not be split, even if they are opened and edited.

## Synchronizing the Patient Visit Note and Superbill

When a superbill is created from a patient visit note, the application attempts to keep the superbill synchronized with changes made in the patient note while the financial batches for charges on the superbill are open and while the superbill has a status that allows synchronization. When synchronization can be done, it may include all the information that comes from the visit note or it may include all the information except the coding.

When there is only one active superbill associated with a patient visit note, then all visit information from the patient visit note is applied to that superbill when changes are made in the note. When there are two or more active superbills associated with the same patient visit note, then the diagnosis and procedure codes in the patient visit note may be split among the superbills. As a result, any coding changes made in the patient visit note cannot be applied to the superbills. All other visit information, such as the ABN Completed flag or service site, is applied to all the superbills associated to the patient visit note.

When a superbill is created, its status is set to the level indicated by the provider in the patient visit note. If the status is changed in the patient visit note, the status is also updated in the superbill, with one exception. The superbill status is not changed when the status of the superbill is past the selection in the visit note. For example, if superbill status is Preliminary and the visit note changes the status to Ready to Review, then the superbill status is changed to Ready to Review. But, if the superbill status is Ready to Submit and the visit note changes the status to Ready to Review, then superbill status is not changed.

## Combining Services from Multiple Superbills

The combining services functionality is part of the optional, licensed behavioral health module.

Certain types of time-based services may be provided to a patient by more than one provider on the same day. However, insurance payers will not pay multiple providers for the same service provided on the same day. Therefore, you must submit a single claim that combines the units of the service.

If your practice provides this type of service, then you can enable functionality that enables billing users to combine two or more superbills for the same patient with the same procedure code and the same service site into a single superbill. You may also set this up so that superbills are combined by a system job that runs on a regular basis.

The single combined claim may be filed under a specific provider's name or under the practice name. If the combined claims are filed under the practice name, then you must create a provider record (using the Provider window) for the practice. The provider record for the practice must have an application license as a billing provider. Please see the *Administrative User's Guide* or the Online Help for more information.

Please note that the combine services functionality is most effective when your practice uses both the EHR and PM modules of the application. The functionality can, however, be used if you are using only the PM module.

## How the Application Combines Services

The combine services functionality enables you or the job to select one or more superbills for the same patient on the same day with the same procedure code and same service site, and roll up the time-based units for the procedure code onto a new superbill.

When you or the job combine services, the application takes the following actions. When you combine services on superbills, then the following actions are taken for the procedure codes that you have selected. When the job combines services, then the actions are taken for all the procedure codes on the superbills.

- The application identifies the superbills with the same patient account, service date, financial center, service site, procedure code, and procedure code modifiers.
- When the patient account, service date, financial center, service site, procedure code, and modifiers match, the application creates a new superbill with the following characteristics.
  - The combined services superbill uses the procedure code, service date, and service site from the original superbills.
  - It uses the provider that is configured for combined services superbills.
  - It includes all the diagnosis codes associated with the procedure from any of the original superbills, and all the diagnosis codes are associated with the procedure.
  - The units associated with the procedure on the combined services superbill are the sum of the units for the procedure on all the source superbills.
  - The combined services superbill has a status of Preliminary.
  - The combined services superbill is not associated with a visit or appointment.
  - A superbill note identifies the original superbills from which the combined superbill was created.
- When the procedure is combined into the new combined services superbill, then the application makes the following to the original superbills.
  - The application zeros the charge for the procedure code on the original superbills, if possible.
    - If the procedure is in an open financial batch, then the charge amount is simply changed to \$0.00.
    - If the procedure is in a closed financial batch, then the application does not change the charge amount on the original superbill. Since the original charge is not zeroed out and the units are included in the new combined superbill, this results in duplicate charges which you must reconcile appropriately.
  - The application marks the procedure code as 'Do Not Claim' on the original superbills.
    - If the procedure is in a closed financial batch, then the procedure is not marked as 'Do Not Claim' on the original superbill since the procedure still has a charge amount.

- The application updates the superbill status on the original superbills when appropriate.
  - When the charges are combined onto another superbill, the superbill status of the original superbill is changed to the success status identified in the combined services configuration.
  - If the procedure is in a closed financial batch, then the superbill status is not changed on the original superbill.
- The application creates a superbill note which identifies that ID of the combined services superbill.
- When a superbill is rejected for combination, the application makes the following changes to the superbill. A superbill is rejected if it meets the criteria for combining with other superbills which have already been combined.
  - The superbill status is changed to the exception status identified in the combined services configuration.
  - A superbill note is created which identifies the ID of the combined services superbill for which this superbill qualifies.

It is recommended that you combine services after the visit notes associated with the original superbills are complete. This helps avoid problems that may result from changes to procedure codes, time, or units once the services are combined. If changes are made to any of the original superbills or their associated patient visit notes after combining services, then you must manually make any needed change to the combined services superbill.

It is also recommended that you review superbills daily, or at least frequently, to identify those superbills with services that need to be combined. You may want to change the status of identified superbills to a hold status if the associated visit notes are not yet complete. Then you can easily identify the superbills and combine the services once the visit notes are completed.

Combining services is done from the Track Superbill Procedures window. The items that you search for and the data you need to review when combining services is specific to this purpose. Therefore, you may want to define a specific filter including search criteria and column settings to use for identifying and monitoring superbills for the purpose of combining services.

Please note that it is possible to combine the services from superbills more than once. Each time you combine the services, a new superbill will be created. However, since the charges on the original superbills were changed to \$0.00 the first time the superbills were combined, combining them again will generate a new superbill with \$0.00 charges.

### **Combined Superbills and Recomputing Financials Due to Account Changes**

Please note that superbills which have been processed through the combined services functionality may not be eligible for recomputing financials when a change is made to the patient's account. This is because the charges on these superbills are changed to \$0.00 by the combined services process. If all the charges on the superbill were combined, and so now are \$0.00, then it is not appropriate to update these superbills with a new charge amount. If there are any procedures on the superbill that were not combined, then those procedures will still have charges and thus are eligible for recomputing financials.

## Combine Services from Superbills

Use this process to identify superbills and combine services. The combine services functionality is available only if it has been enabled and configured.

1. Either:
  - Billing menu → Track Superbills
  - Billing menu → Track Superbill Procedures
2. Search for superbill procedures that may need to be combined. You may want to search by:
  - Procedure code
  - Service date
  - Service site
3. Select the Patient column header to sort the procedure entries by patient. This enables you to easily see all the entries for a patient.
4. Review the superbills to determine those that need to be combined.
5. Select the checkboxes for the superbills and procedures for which you want to combine services.
6. Select the Combine Services button.
7. The Combined Services Confirmation window appears. The window displays the target combined services superbills to be created and the source superbills from which information is taken.

Services are combined based on the following items. A combined superbill will be created for each set of these items that all match.

- Patient account
  - Procedure code
  - Modifiers
  - Service date
  - Financial center
  - Service site
8. Select the OK button to create the combined superbill, update the source superbills, and return to the Track Superbill Procedures window.

## Master Claims

Medicare Part A and some other institutional billing scenarios require that you file a single claim per month for all the services performed for the patient during that month. The master claim functionality enables you to identify and select superbills for individual patient visits, and move the procedures from those superbills to a single superbill which may then be filed as the monthly master claim. The superbills selected for a patient must all have the same account in order for the application to move the procedures to a new master claim superbill.

The master claim superbill that is created includes all services performed with their service dates and charges. It is not, however, associated with a visit since it contains procedures from multiple visits.

The master claim will be filed under an entity's name since it is an institutional claim. However, you must create a provider record (using the Provider window) for the practice or entity that will be used for filing these claims. The provider record for the practice or other entity must have an application license as a billing provider. Please see the *Administrative User's Guide* or the Online Help for more information.

It is recommended that you create the master claim after the visit notes associated with the original superbills are complete. This helps avoid problems that may result from changes to procedure codes, time, or units once the services are moved to the master claim. If changes are made to any of the original superbills or their associated patient visit notes after creating the master claim, then you must manually make any needed change to the master claim superbill.

It is also recommended that you create superbill statuses specifically for master claim processing. You need a status, such as Master Claim Hold, to be assigned to the superbills that are generated for individual patient visits during a given month. The special status helps to ensure that individual claims are not filed for these superbills during regular claims processing. You also need a status, such as Master Claim for Review, to be assigned to the master claims when they are created. This special status enables you to review and process the master claim superbills separately from regular superbills. Please see the *Administrative User's Guide* or the Online Help for more information on creating a superbill status.

Please note that the master claim functionality is most effective when your practice uses both the EHR and PM modules of the application. The functionality can, however, be used if you are using only the PM module.

Users must be granted specific security rights in order to use the master claim functionality.

### Master Claim Workflow

Superbills are created for a patient throughout the month, either automatically from patient visit notes or by users creating superbills. As you review superbills throughout the month, you must assign a status to the superbills that precludes them from normal claim processing.

At the beginning of the next month, you review all the superbills created for the patient during the previous month, and then select the superbills with charges that need to be included on a master claim for the month.

To create the master claim, you must select the billing provider, the service site, and the financial center for the master claim superbill. You must also select the status to be assigned to the new superbill.

When you invoke the master claim functionality, the application performs the following for each patient.

- Determines whether the superbills for the patient have the same account. If so, the process proceeds for the patient. If not, the patient is skipped.
- Creates a new superbill in your default financial batch with the selected provider, service site, and financial center.
- Copies the diagnoses codes from the original superbills to the new superbill.
- Removes the procedures and charges from the original superbills, and adds them to the new superbill.
- Reverses any charges from original superbills that were in closed financial batches. The reversals are made in your default batch.
- Moves existing payments for charges (such as copay payments) to the new master claim superbill.
- Lists procedures and charges on the new master claim superbill by service date, in chronological order.
- Associates procedures on the new master claim superbill with the diagnosis code with which they associated on the original superbills.
- Assigns the new master claim superbill the status you specified.
- Assigns the original superbills the status of Complete.
- Writes superbill notes to the new master claim superbill identifying all the original superbills from which procedures were moved.
- Writes superbill notes to the original superbills identifying the master claim superbill to which the procedures were moved.
- Recomputes financials as appropriate.

After the application creates the new master claim superbills, you must review them and process claims for them in the usual manner.

Under certain circumstances, it may be possible for a patient to have an account period change in the middle of the month. As a result, the service dates on the master claim would span the old and the new account periods. You must file separate claims for the two account periods. Therefore, you must split the master claim superbill into two superbills, each with service dates that correspond to the start and end dates of the account periods.

## Create Master Claims

Please note that you must have a default batch selected prior to performing this process.

1. Billing menu → Track Superbill
2. Search for superbills for which a master claim superbill is needed. You may want to search by:
  - Superbill status
  - Service date
3. Select the Patient column header to sort the procedure entries by patient. This enables you to easily see all the entries for a patient.
4. Review the superbills to determine those with charges that need to be moved to a master claim.
5. Select the checkboxes for the superbills need to be moved to a master claim.
6. Select the Master Claim button.
7. The Create Master Claim window appears.
  - a. Select the Superbill Status for the master claim superbills to be created.
  - b. Select the Service Site.
  - c. Select the Financial Center.
  - d. Select the Billing Provider.
  - e. Select the Rendering Provider.
  - f. Select the OK button.
8. When processing is complete, the Master Claim window is displayed.
  - To review the superbills processed, select the Expand tree (⊕) icon.
  - When a master claim is created for a patient, a list of superbills used to create the master claim appears beneath the patient name.
  - When the superbills for a patient have more than one account, the patient is skipped. The message "Skipping Patient: *name*. Multiple Accounts Found" is displayed.
9. Select the Close button to return to the Track Superbill Procedures window.

## Automatically Generated Superbills for Administrative Fees

If your practice is using the automatic appointment cancellation fee functionality or the automated accounts receivable functionality, then the application may automatically create superbills for these administrative fees. You review and process these superbills just as superbills for clinical charges.

When the application generates superbills for appointment cancellation fees or collection fees, it also creates a financial batch for the fees. Your administrative super user will have defined the owner of these system-created batches in the practice settings.

Superbills for appointment cancellation fees are created with the status 'Ready to Review'. Superbills for collection fees are created with the status 'Preliminary'.

## Charge Tracking

### Reviewing Appointments without Superbills

Use the Appointments Without Superbills window to search for appointments that do not have an associated superbill, and generate the superbill where required. Superbills are generated with a status of Preliminary. Once a superbill has been created for an appointment, that appointment will no longer be listed on this window. You should check this window daily to be sure that superbills are generated for all patient appointments.

1. Billing → Appointments Without Superbills
2. Select the desired search criteria.

The default search criteria searches for appointments from the last two weeks with a status of Discharged. You may change the criteria as needed.

3. Select Search to list the appointments that meet your criteria.
4. If desired, select the Date/Time link of an item to access the appointment.
5. Select the checkbox of each item for which you want to generate a superbill. Select all items by checking the checkbox at the top of the window.
6. Select the Generate Superbills button.

Once the superbills are generated for the selected items, they are removed from the display. Use the Track Superbills window to access the new superbills.

## Reviewing Visits Without Superbill

Use the Visits Without Superbill window to search for patient visits that do not have an associated superbill, and generate the superbill where required. You should check this window daily to be sure that superbills are generated for all patient visits.

Some types of visit notes, such as prescription refill visits and lab order visits, are unlikely to require a superbill. You may filter out visit notes with these visit types.

The Visits Without Superbill window displays a locked icon () when a visit is in use by another user. This enables you to easily identify visits that you cannot open and for which you cannot create a superbill at this time.

1. Billing → Visits Without Superbills
2. Select the desired search criteria.  
The default search criteria searches for visits from the last two weeks with a status of Completed and visit type of Standard or Private. You may change the criteria as needed.
3. Select Search to list the appointments that meet your criteria.
4. If desired, select the Date/Time link of an item to access the appointment.
5. Select the checkbox of each item for which you want to generate a superbill. Select all items by checking the checkbox at the top of the window.
6. Select the Generate Superbills button.

Once the superbills are generated for the selected items, they are removed from the display. Use the Track Superbills window to access the new superbills.

## Reviewing Superbills to Prepare for Claims

Use the Track Superbills window to identify the superbills that need to be reviewed and prepared for submitting as claims. You can access each superbill to verify its contents. Then you can change the status of the reviewed superbills to Ready to Submit.

Users who have security access rights to recompute financial information may also change the service site, financial center, or billing or rendering provider. When you make changes to any of these items, the application will recompute the financials for the selected superbills.

The Track Superbills window lists all superbills with the search criteria you specify. However, regardless of the search criteria entered, the window will only display superbills for financial centers for which you have permissions.

When searching for superbills by posting date, it is important to remember that each procedure on the superbill is associated with a financial batch, and each batch has a posting date. Therefore, a single superbill may appear in the search results for more than one posting date.

A superbill is locked and cannot be opened when it or its associated visit note is being used by another user. This prevents multiple users from making changes to one superbill at the same time.

The Track Superbills window displays a locked icon () when a superbill or its associated visit note is in use by another user. This enables you to easily identify superbills that you cannot open.

You may want to define a search filter or filters for reviewing superbills to prepare for claims. Your filter can include both the search criteria and the column selection and order that you prefer when performing this task.

1. Billing → Track Superbills
2. Enter the desired filtering criteria, and then select the Search button. This displays a list of superbills matching your criteria.
3. Select the superbill ID hyperlink to access the Superbill window.
  - a. Verify, correct, and complete the information in the superbill as needed.
  - b. Select the OK button to return to the Track Superbills window.
4. Repeat step 3 for each superbill.
5. Change the status on the superbills that are now ready for submitting as claims.
  - a. Select the checkboxes for the superbills that you have reviewed.
  - b. Select the Update Superbills button.
  - c. In the Update Superbills window, select the Ready to Submit status.
  - d. Select the OK button to change the status for the selected superbills.

## **Validating Superbills**

Once you have reviewed and prepared the superbills, use the Track Superbills window to validate the superbills you believe are ready to be claimed. Validation includes the application's standard claim scrubbing, which enables you to identify problems and make corrections before you complete the financial batch or batches containing the superbills.

The application's standard claim scrubbing verifies that the data fields required by all insurance payers do contain data. Some fields are scrubbed for every claim, and other fields are scrubbed under certain conditions. Your administrative super user may have defined additional claim scrub profiles for specific payers.

When you validate a superbill, its superbill status is changed as follows.

- **Failed Validation:** Assigned when there are errors from code validation or claim scrubbing. You must correct these errors before submitting the superbill as a claim.
- **Queued:** Assigned when there are no errors, and an insurance payer is identified for the superbill.
- **Pending Patient Payment:** Assigned when there are no errors, and there is no insurance payer identified for the superbill.
- **Complete:** Assigned when there are no errors, there are no charge amounts, and there is no insurance payer identified.

It is recommended that you regularly check for superbills with the Failed Validation status. You must correct the errors on these superbills, and then validate them again so that claims may be submitted for them.

You may want to define a search filter or filters for validating superbills. Your filter can include both the search criteria and the column selection and order that you prefer when performing this task.

1. Billing → Track Superbills
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the superbill or superbills on which you want to perform claim scrubbing.
4. Select the Validate button.
5. When validation is complete, search for the superbills that failed validation. In the Superbill Status field, select Failed Code Validation and select the Search button.
6. Review and correct each superbill.
  - a. Select the Errors link in the Code Validation column. This accesses the Superbill Report window for the selected superbill.
  - b. The Notes column contains the validation message.
  - c. Select the Superbill link to access the Superbill window where you can make any necessary changes to the diagnosis and procedure coding. Both the Superbill and Superbill History windows may be open at the same time.
  - d. Change the superbill Status to Coding Valid, and then select OK to save and close the superbill.
  - e. In the Superbill Report window, select the Select All checkbox () to select all the error messages.
  - f. Select the Mark Viewed checkbox, and then select the Update button to mark all the selected errors as having been reviewed.
  - g. Select the Close button to close the Superbill History window and return to Track Superbills.
7. Repeat step 6 for each superbill that failed validation.

## Reviewing Superbills without Insurance

Use the Track Superbills window to identify superbills for patients who do not have insurance. Then review the superbills to prepare them for billing. You can access each superbill to verify its contents. Then you can change the status of the reviewed superbills to Pending Patient Payment.

When there is no insurance payer associated with the superbill, you may change the service site, financial center, or billing or rendering provider without needing to recompute the financials.

The Track Superbills window lists all superbills with the search criteria you specify. However, regardless of the search criteria entered, the window will only display superbills for financial centers for which you have permissions.

When searching for superbills by posting date, it is important to remember that each procedure on the superbill is associated with a financial batch, and each batch has a posting date. Therefore, a single superbill may appear in the search results for more than one posting date.

A superbill is locked and cannot be opened when it or its associated visit note is being used by another user. This prevents multiple users from making changes to one superbill at the same time. The Track Superbills window displays a locked icon () when a superbill or its associated visit note is in use by another user. This enables you to easily identify superbills that you cannot open.

You may want to define a search filter or filters for reviewing superbills without insurance. Your filter can include both the search criteria and the column selection and order that you prefer when performing this task.

1. Billing → Track Superbills
2. Select the Enable Expanded Filter Criteria checkbox.
3. Select the None checkbox to the right of the Current Insurance Plan field. This disables the Current Insurance Plan field, and searches only for superbills that are not associated with an insurance payer.
4. Enter any other desired filtering criteria, and then select the Search button. This displays a list of superbills matching your criteria.
5. Select the superbill ID hyperlink to access the Superbill window.
  - a. Verify, correct, and complete the information in the superbill as needed.
  - b. Select the OK button to return to the Track Superbills window.
6. Repeat step 5 for each superbill.
7. Change the status on the superbills that are now ready for billing.
  - a. Select the checkboxes for the superbills that you have reviewed.
  - b. Select the Update Superbills button.
  - c. In the Update Superbills window, select the Pending Patient Payment status.
  - d. Select the OK button to change the status for the selected superbills.

## Reassigning a Superbill to Another Financial Batch

You can reassign superbills from one open financial batch to another open financial batch from the Track Superbills window. You must remember that when you do this, you are actually reassigning the charges in the superbills from one batch to another. A superbill may have charges that are assigned to one or more financial batches, and those batches may be in different states (that is open, completed, closed).

Charges that are assigned to open financial batches will be reassigned to the target financial batch. If any charges in the selected superbill are in a completed or closed financial batch, those charges will not be reassigned. So, after you reassign a superbill to another financial batch, that superbill may be assigned to both the original batch and the target batch.

It is possible for charges that are assigned to an open financial batch to not be reassigned to the target batch. Reassignment will not be made if the superbill's financial center is closed through the posting date of the target batch. For example, take a superbill that is associated with financial center A, which is closed through September 30. You would like to reassign the superbill from batch 1, which is open and has a posting date of October 3, to batch 2, which is open and has a posting date of September 30. In this case, the superbill charges in batch 1 cannot be reassigned because the associated financial center is closed through the posting date of batch 2.

1. Billing → Track Superbills
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the superbill or superbills you want to reassign from their current financial batch.
4. Select the Reassign Batch button.
5. In the Reassign Batch popup window, select the financial batch to which you want to assign the selected superbills' charges.
6. Select the OK button to reassign the superbill charges. A popup message will display the results of the reassignment.
7. Select the OK button to close the message, and return to the Track Superbill window.

## Superbill History

The Superbill History window lists actions that have been taken on a superbill. Actions include such things as claim processing errors, payments, reversal events, and notes.

Some actions on a superbill are identified as follow-up actions. A follow-up action on a superbill is an action that moves a superbill through the claim and payment lifecycle toward completion. You can use the date of the last follow-up action to track and monitor superbills to help you ensure that you are processing them in a timely manner.

Follow-up actions include activities such as claim scrubbing and receiving electronic responses from the insurance payer. You can enter notes into the superbill history as you work on processing it through its lifecycle. When you enter a note into the superbill history, you may choose whether to mark the note as a follow-up action.

The application adds notes the superbill history from ERA process for actions related to ERA, procedure, transaction, and service amount. When the action type is ERA, the note is added to all superbills (claims) in the ERA file.

1. Superbill → History button
2. Enter the desired filtering criteria, and then select the Search button.
3. If desired, select the New Superbill Note button to add a note.
  - a. In the Superbill Notes window, type the content of the note or select a saved note that you want to use.
  - b. If appropriate, select the Include as Follow-Up Action checkbox.
  - c. Select the OK button to save the note and return to the Superbill History window.
4. If desired, select the Description hyperlink to access the EDI response text associated with the action.
5. If desired, select the hyperlink text in the Notes column to display the full text of the note.
6. If desired, select the Print button to print the list of all actions that have been applied to the superbill.

## Track Superbill Procedures

The Track Superbill Procedures window enables you to review the procedure and charge information on superbills. The window displays the superbill ID, procedure code, the number ordered, the charge amount and other charge information, modifiers, and diagnosis association. The window also displays much of the superbill information displayed on the Track Superbills window. Filtering criteria for the Track Superbill Procedures window is very similar to the filtering criteria for the Track Superbills window. The Track Superbill Procedures window also includes filtering criteria for procedure, diagnosis, and modifier.

You can access the Superbill window by selecting the ID hyperlink.

If you have security access rights to superbills, then you may change the superbill status on one or more selected superbills. If you have security access rights to recompute financial information,

you may also change the service site, financial center, or billing or rendering provider. When you make changes to any of these items, the application will recompute the financials for the selected superbills.

1. Billing → Track Superbill Procedures
2. Select the desired search criteria. You must define at least one search parameter.  
By default, the Preliminary and Ready to Review superbill statuses are selected. You can modify this as desired.
3. If desired, Select the Enable Expanded Filtering Criteria checkbox and select from the expanded filtering criteria. Using the expanding filtering may increase the amount of time it takes for the application to search for and display results.
4. Select Search to list all superbills that meet your criteria.
5. Select the Superbill ID link to open the superbill.
6. Verify the content of the superbill, and enter or correct data as needed. (Please see Create or Review a Superbill for more information.)
7. When all information is complete and correct, select Ready to Post as the superbill status.  
Depending on your search criteria, items may be removed from the Track Superbill display as you change them to Ready to Post.

### **Move Procedures and Charges to Another Financial Batch**

You can reassign procedures and their charges to another financial batch from this window.

1. Billing → Track Superbill Procedures
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the procedure or procedures that you want to reassign from their current financial batch.
4. Select the Reassign Batch button.
5. In the Reassign Batch popup window, select the financial batch to which you want to assign the selected superbills' charges.
6. Select the OK button to reassign the superbill charges. A popup message will display the results of the reassignment.
7. Select the OK button to close the message, and then return to the Track Superbill Procedure window.

## Reviewing Superbills when Patient Account Information Changes

Changes to the insurance payer, insurance plan, or the insured party on a patient's account may affect existing superbills and charges, even those that have been completely paid. For example, if the insurance payer or plan is changed, then all superbills for the account period are updated with the new insurance information. Fee amounts, amounts allowed, and copay amounts are also updated. This may mean that the insurance payer or responsible party still owes money on a superbill or that a superbill is overpaid. Such changes affect your financials. Therefore, when you make changes to an account that may affect superbills, the application will display a popup message telling you how many superbills are possibly affected, and asking if you want to review those superbills.

It is recommended that superbills are reviewed at the time changes are made to the account, if at all possible. If another user, such as front desk staff, makes an account change but cannot review the superbills, then it is recommended that they notify billing staff of the change. Then you must review the patient's superbills for the account and account period that has changed. You may need to send a claim to the newly identified insurance payer, resubmit a corrected claim, bill the responsible party for an amount due, create a payer credit from an overpayment, or take some other appropriate action.

Use the following procedure to identify and review the superbills which may be affected by a change to a patient's account.

1. Patient Demographics → Accounts tab
2. Select the hyperlink for the account name. This accesses the Account window.
3. In the Account Periods table, highlight the account period which has been changed. This displays information for that account period.
4. In the Account Insurance area, select the Superbills hyperlink. This displays the Track Superbills window with a list of the superbills from the selected account period.
5. From the Track Superbills window, you can review the superbills and determine what action is needed.

## Correcting a Charge

A charge that is in a completed or closed batch may be corrected if needed. The manner in which the correction is made depends on whether the batch containing the charge is completed or closed.

When the batch containing the charge is completed, you can unlock the batch so that you can make the correction. Unlocking the batch changes the state of the batch from completed to open. Once the batch is open, you can change any charge in that batch. You must have security permissions to uncomplete a batch in order to correct a charge in a completed batch.

When the batch containing the charge is closed, then you can unlock the charge. This allows you to select an open batch that will be used to creating an entry reversing the original charge and a new entry for the correct charge. When you unlock the charge and select an open batch, you can then change any charge in any closed batch on the superbill.

1. Billing → Track Superbills → Superbill ID link
2. In the Superbill window, identify the charge which needs to be corrected.
3. Select the Complete Batch () or Closed Batch icon () icon for the desired charge.
4. Either:
  - If the batch is completed, a confirmation message about reopening the batch will appear. Select the Yes button.
  - If the batch is closed, a popup window will ask you to select an open batch.
5. Correct the charge as needed.
6. Select the OK button to save the new information and close the Superbill window.
  - If the charge was in a completed batch, that batch was opened, your correction to the charge was made in that batch, and the batch was then completed again.
  - If the charge was in a closed batch, the original charge is still in that batch. A reversing charge is now in the open batch you selected, and a new correct charge is also in that batch.

## Deleting a Superbill

A superbill may only be deleted under specific circumstances. A superbill may be deleted when all of the following conditions are met:

- It has never been filed as a claim.
- It has never been included on a statement.
- All the procedures on the superbill are in open batches.
- Any payments on the superbill are in open batches.

When a superbill is deleted, any payments applied to the superbill will be removed and applied to a payer credit. You must re-allocate the payer credit.

If the superbill cannot be deleted because it does not meet all of the conditions stated above, then the individual charges on the superbill must be reversed. The superbill itself cannot be reversed; only the charges on the superbill.

## Automatic Write-Offs

The automatic write-off functionality is optional. If your practice is using this functionality, your administrative user will have set up fee schedules, amount allowed schedules, and insurance payers and plans as appropriate.

Generally, there is a difference in the amount you charge for a procedure and the amount allowed for that procedure by the patient's insurance payer. As a result, the total payment amount that you receive from the patient's insurance payer or payers and the patient do not equal the charge amount. In order to balance your charges and payments, you must enter a write-off adjustment for the difference.

When the necessary set up for automatic write-offs has been done, the application will enter automatic write-off adjustments as superbills are created and payments allocated.

The adjustment amount entered on the insurance liability is the difference between the full charge for the procedure and its amount allowed. If that difference is greater than the remaining insurance liability, then adjustment amount is the remaining liability amount. Like the real-time charges, the write-off cannot occur once a superbill's batch is closed or locked since no transactions can be written to a closed or locked batch.

All automatic write-off adjustments include an adjustment note identifying them as an automatic write-off. This note identifies the superbill and procedure for which the adjustment was entered.

## Payment Entry

When you receive payments, either from patients or insurance payers, these payments must be allocated to the corresponding charges. The bulk of payment entry is done through the Track Payments and Allocate Payment windows, but payments and payment allocations can also be made through the Appointment, Checkout, Batch Payments, and Superbill windows.

Note that patient copay amounts are allocated to the corresponding superbill charges when entered. Other patient payments entered through the patient check in or check out process do not automatically allocate. That process creates the deposit — or payment item — for the payment, but it does not allocate the payment amount to any charges.

All payments and payment allocations must be in a financial batch. When copay payments are entered during check in or check out, they are put in your default batch if you have one selected. If you do not have a default batch, you must select a batch for the payment when you enter it. When patient or insurance payer payments are entered through the Track Payments window, they are put in your default batch, if available, or you must select a batch when making the entry. When you enter payments from the Batch Payments window, the payments are put in the selected batch.

## Copay Log

The Copay Log lists patient copay payments made for patient visits. You can use it to balance the copay payments received each day verifying that all copays have been entered into the system.

You may select the Ref Number hyperlink to access the Payment window.

1. Desktop → Copay Log
2. Enter the desired selection criteria.
3. Select the Search button to display the copays matching your selection criteria.

## Entering Payments on Appointments

The Account tab on the Appointment window displays the visit copay amount and the account balance. Account balance information includes the name of the patient's responsible party, the responsible party's balance, the patient's balance, and the account balance. Use the Account tab to enter the copay or account payments.

When you enter a payment that is applied to the patient's account, rather than the current copay amount, the payment is automatically allocated to the account. Payments are allocated to the oldest outstanding charges first.

A payment is written to the database when you either select the Print Payment Receipt button or the OK button.

You can delete the payment from the Appointment window. As with other payment deletions, this action is recorded in the Audit Trail.

### **Processing Copay Payments for Uninsured Patients**

Many practices will collect full payment upfront from patients who do not have insurance. The payment is generally entered as if it were a copay on the Appointment window. The application handles these payments differently than copay payments from insured patients during the period when the provider is charting the patient visit note.

The application creates a superbill for the visit when the provider or other clinical user saves the patient visit note. The superbill is created with a status of preliminary. Copay payments and payments from uninsured patients are applied to the charges on the superbill as the provider or other clinical user works with the visit note, adding or changing procedures, and saving the visit note.

When the provider concludes the patient visit, the provider sets a status for the superbill. The status may be preliminary, if the provider is not yet finished with the patient visit note, or ready to review or ready to submit, if the provider is finished with the visit or expects any further work in the visit note to not affect the charges. Usually, the provider will leave the visit note status as incomplete when setting the superbill status as preliminary. The provider may leave the visit note status as incomplete or change it to complete when setting the superbill status to ready for review or ready to submit.

When the patient has insurance, you will review these superbills and process claims for them in your usual manner. If the provider makes changes to patient visit note that may affect the superbill or you make changes to the superbill that may affect the visit note, then the application attempts to synchronize these changes. Please see the Synchronizing the Superbill and Patient Visit Note section under Charge Entry for more information on synchronization.

When the patient does not have insurance, the application handles the payment and the superbill status in the same manner as for patients with insurance as long as the patient visit note is incomplete. Once the provider marks the visit note as complete and sets the superbill status as either ready to review or ready to submit, then the application processes the superbill.

- When all the charges on the superbill are completely paid, then the application changes the superbill status to complete. You do not need to do anything further with the superbill or the payment.
- If there is a balance due, the superbill stays in the status set by the provider. You will review these superbills in your usual manner.
- If there is a remaining balance paid, the superbill stays in the status set by the provider. You will review these superbills in your usual manner.

### **Enter a Payment on an Appointment**

1. Either:
  - Schedule → New → New Appointment
  - Desktop → New → New Appointment
  - Patient Demographics → New → New Appointment
2. Select the Account tab.
3. Select the Account to which payment will be applied.

This field defaults to either the main account associated with the patient in Patient Demographics or to the account associated with the patient case selected on the appointment.
4. The Copay Amounts displayed are the amounts entered in the patient's account. 'N/A' indicates no amount was entered; \$0.00 indicates the copay amount is zero.
5. Enter details of the Visit or the Account Payment:
  - a. Enter the Amount being paid.
  - b. Select the Method of payment: cash, check, credit card, debit card. (If you are using Easy Pay for credit card payments and select a type of credit card, you will be able to scan the card to create the payment. Please see Processing a Credit Card Payment for a Copay or Processing a Credit Card Payment for an Account Balance for more information.)
  - c. Enter a Reference to identify the payment. You may choose to use the check number, patient name, last four digits of a credit/debit card, or some combination of information.
  - d. <<New>> Select a Financial Center, if desired. This field is displayed only if your database is configured to designate financial centers on payments.
  - e. Select the Date of the payment.
  - f. Select the financial Batch. This will be your default financial batch if you have one selected.
  - g. Enter a Billing Note to identify what the payment is for, if desired.
6. You can print a receipt for the payment by selecting the Print Payment Receipt button.

## Entering Payments

There are generally three types of payments: a payment you receive from an insurance payer, a payment you receive from a responsible party, and a refund payment you make to a responsible party. There can be a variation to these basic types of payments. For example, you may receive a payment from someone on the behalf of a responsible party. Variations on the basic types of payments are entered in the same manner as the basic payment.

The Insurance Payment and Responsible Party Payment windows are very similar in their look and functionality, but there are some differences. The differences in the functionality of the windows are discussed below in the procedures for entering payments. Both windows contain the following sliders.

- **Attachments:** This slider enables you to add and view attachments, such as a scanned copy of the EOB or check, or a letter or other document related to the payment item.
- **Financial Summary:** This slider displays a list of the transactions within the payment. A transaction is an allocation to one or more charges on a superbill.
- **Transaction Details:** This slider displays allocations made from the payment item, and it enables you to select a superbill to which you want to make an allocation. It is recommended that this slider be opened and pinned in bottom of the window to make allocating payments to superbills easier.
- **Payer Account Credit:** Enables you to allocate money from the payment to a payer credit, rather than to a charge on a superbill.

When you create a payment item, whether from an insurance payer or a responsible party, you can print a receipt for the payment.

The title bar of the payment window displays information about the payment once it is entered. The title bar displays the payment reference number, the payer, and the payment amount.

### Payment Entry Hotkeys

The following hotkeys may be used when entering payments and transactions.

Hotkey	Function
Alt+A	Apply
Alt+B	Batch
Alt+C	Cancel
Alt+D	Deposit Date
Alt+E	Comment
Alt+I	Scan Credit Card
Alt+L	Allocate to Superbills

<b>Hotkey</b>	<b>Function</b>
Alt+M	Amount Paid
Alt+N	Reference Number
Alt+O	OK
Alt+P	Payer
Alt+R	Print Receipt
Alt+S	Superbill
Alt+T	Payment Type
Alt+U	Use Responsible Party Information

### **Saving Payment Information**

As you are working in either payment window, you can save your work by selecting the Apply button. This applies your entries to the database, but leaves the window open and active so that you can continue working. The OK button saves your entries and closes the window.

### **Enter an Insurance Payment**

An insurance payer generally will send a single payment for several patients and superbills. When you enter the payment in the database, you will create a single payment item for the entire amount of the payment. Then you will allocate money from that payment to the various patients and superbills.

1. Billing → Track Payments
2. Select the New Insurance Payment button.
3. Select the Payment Type.
4. Select the desired financial Batch. This will be your default batch if you have selected one.
5. <<New>> Select a Financial Center, if desired. This field is displayed only if your database is configured to designate financial centers on payments.
6. Enter a Reference Number to identify the payment. You may choose to use the check number, insurance payer name, or other meaningful information.
7. Select the Payer from whom the payment is received. Only insurance payers can be selected from the Insurance Payment window.
8. Enter the Amount Paid. This is the total amount of the payment item.

9. The Unallocated field displays the portion of the payment that has not yet been allocated to a superbill.

The Unallocated amount is initially the same as the Amount Paid. As you allocate amounts from the payment, the Unallocated amount will be reduced. When the Unallocated amount is \$0, the payment has been fully allocated.

10. Select the Deposit Date. This defaults to today's date, but you may select another date if needed.

11. Enter any Comments, if desired.

12. Either:

- Select the New button to save the payment item, and then enter the next payment.
- Select the Apply button to save the payment item, and then continue working with the payment.
- Select the Transaction Details slider to begin allocating money from the payment item to superbills. See the Allocate Money from a Payment to a Superbill section below for instructions.
- Select the OK button to save the payment item and close the window.

### **View EOB**

Select the EOB button on the New Insurance Payment to view the Electronic Remittance Advice report associated with the payment. This button will only be active for insurance payments created through ERA processing.

### **View ERA Rejection Details**

Select the ERA Rejections button to generate the ERA Rejection Detail report for the payment. This button will only be active for insurance payments created through ERA processing.

### **Enter a Responsible Party Payment**

A payment from a responsible party may be for a single superbill for a single patient, for multiple superbills for a single patient, or for multiple superbills for more than one patient. Most responsible party payments are received from the responsible party. However, you may at times receive a payment from someone else on behalf of a responsible party. These payments are entered in the same way as a payment received from the responsible party.

1. Billing → Track Payments
2. Select the New Responsible Party Payment button.
3. Select the Payment Type.
4. Select the desired financial Batch. This will be your default batch if you have selected one.
5. <<New>> Select a Financial Center, if desired. This field is displayed only if your database is configured to designate financial centers on payments.
6. Enter a Reference Number to identify the payment. You may choose to use the check number, patient name, last four digits of a credit/debit card, or other meaningful information.

7. Select the Payer from whom the payment is received. Only responsible parties can be selected from the Responsible Party Payment window.

If the payment was received from someone other than the responsible party, you may select the responsible party since the payment is made on the behalf of the responsible party and if desired, use the Reference Number field or the Notes field to identify the entity who actually made the payment. Of, if you need to report on or otherwise keep track of payments made by an someone other than the responsible party, then you must create a responsible party record (List Editor >> Demographics >> Responsible Party) for that person or corporation even though that record will not be associated with a patient record.

8. Enter the Amount Paid. This is the total amount of the payment item.
9. The Unallocated field displays the portion of the payment that has not yet been allocated to a superbill.

The Unallocated amount is initially the same as the Amount Paid. As you allocate amounts from the payment, the Unallocated amount will be reduced. When the Unallocated amount is \$0, the payment has been fully allocated.

10. Select the Deposit Date. This defaults to today's date, but you may select another date if needed.

11. Enter any Comments, if desired.

12. *<<Revised>>* If you want to automatically allocate the payment to the oldest charges, select the Allocate to Superbills checkbox.

When a financial center has been designated, then automatic allocations are only made to charges for that financial center.

13. Either:

- Select the New button to save the payment item, and then enter the next payment.
- Select the Apply button to save the payment item, and then continue working with the payment.
- Select the Transaction Details slider to begin allocating money from the payment item to superbills. See the Allocate Money from a Payment to a Superbill section below for instructions.
- Select the OK button to save the payment item and close the window.

## Reassigning a Payment to Another Financial Batch

You can reassign a payment item from one open financial batch to another open financial batch. You cannot reassign payment items from or to completed or closed financial batches.

When you reassign a payment from one financial batch to another, all of the transactions that were made from the payment and that are still in the same batch as the payment will also be reassigned to the target financial batch. Any transaction made from the payment which is assigned to a different financial batch than the payment will not be reassigned to the target batch.

1. Billing → Track Payments
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the payment or payments you want to reassign from their current financial batch.
4. Select the Reassign Batch button.
5. In the Reassign Batch popup window, select the financial batch to which you want to assign the selected payments.
6. Select the OK button to reassign the payments. A popup message will display the results of the reassignment.
7. Select the OK button to close the message, and return to the Track Payments window.

## Print Receipts

After you have entered responsible party payments, you may print any receipts that are needed.

The application will not print a receipt for insurance payments. If an insurance payment is selected, it will automatically be unselected when you print.

1. Billing → Track Payments
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the payments that need receipts.
4. Select the Print Receipt button.
5. In the Print Preview window, review each of the receipts generated.
6. Either:
  - If all the receipts are correct, select the Print icon to access the Print window and print the receipts.
  - If any receipt is incorrect, close the window. Then deselect the checkbox for any payments that you do not want to include. Repeat the process from step 4.

## Removing Page Numbers and Footers from Receipts

The functionality for printing multiple receipts uses your internet browser. Therefore, the receipts may contain a header with the page number and a footer with a URL (i.e., "http//..."). The page numbers may be confusing to responsible parties since the print functionality treats all the selected receipts as a single document. Thus, a single page receipt may have a page number of something like "Page 10 of 50".

You may change your individual print configuration to remove the page number header and the footer. This must be done by each user on each PC used to print receipts.

1. Billing → Track Payments
2. Select the checkbox for any payment, and then select the Print Receipt button.
3. In the Print Preview window, select the Page Setup () icon.
4. In the Page Setup window, change all the Header and Footer selections to '-Empty-'.
5. Select the OK button to save the changes, and close the Page Setup window.
6. Close the Print Preview window.

## Allocating Payments to Superbill Charges

Once a payment has been entered, you may allocate the money in the payment to charges on superbills. A payment may be allocated to a single charge on a superbill, to multiple charges on a superbill, or to charges on multiple superbills for one or more patients. Payment allocations are made in the Transaction window.

### Function Buttons

The table below describes the function of the buttons on the Transaction window.

Button	Description
Ledger	Accesses the Patient Ledger report. This enables you to quickly generate an up-to-date ledger for a responsible party when you apply a payment to a superbill.
New Message	Creates a new task message.
Superbill History	Accesses the Superbill History window, which lists all actions that have been applied to the superbill, including errors, status changes, reversal events, and notes.
EOB	Accesses the Electronic Remittance Advice report. Note that from this window, the report only displays the section of the report associated with selected superbill.

## Sliders

The sliders on the Transaction enable additional functionality.

- Procedure Level Detail: Displays the details of all financial actions taken on the procedures. Each action (charge, payment, transfer, etc.) taken on each charge is listed. Each entry also includes the financial batch of the transaction, and the state of that batch. Use this slider to enter additional payment allocations and adjustments to a charge item.

Payment entry notes are accessible from the Procedure Level Detail slider. When you are posting payment allocations and a default payment entry note is populated as a result of your selection of a reason code, you can remove or modify the default note text or enter additional text to it. When a default payment entry note is populated as part of ERA processing, then you can enter additional note text if desired.

- Claim Level Detail: Enables you to enter and view the claim level adjustments and information required for secondary or tertiary claims. You may also want to enter this information for tracking or reporting purposes. This information is required when there will be a subsequent secondary or tertiary claim. You may also want to enter this information for tracking or reporting purposes. The information in this section will be automatically populated by ERA processing of payments.

## Transaction Detail Lines and Totals

The center section of the window contains the transaction detail lines, or charge lines. Totals are shown beneath the transaction detail lines. You may want to adjust the size of the window so that the totals line is close to the last transaction detail line. This may make it easier to identify each total amount.

The following table explains the items of information in each transaction detail line.

Column	Description
	Line number.
DOS	Date of service. This is the date of service on the superbill. This should match the EOB or statement from which the payment is made.
Code	Procedure code from the superbill. This should match the EOB when allocating an insurance payment.
Mod	Modifiers for the procedure code.
Charge	The fee charged for the procedure code.
Balance	These columns show the liability for money due. This will change as you allocate payments.
Insurance	The balance for which the insurance payer is liable.
Patient	The balance for which the patient or patient's responsible party is liable.

<b>Column</b>	<b>Description</b>
Total	The total of the insurance and patient liable amounts.
Allowed	Amount allowed by the insurance payer and plan for the procedure. These fields are used in financial reports.
Estimated	The estimated amount allowed is pulled from the amount allowed schedule associated with the patient's insurance payer and plan.
Actual	The actual amount allowed is identified on the ERA or EOB from the insurance payer. When you enter the actual amount allowed, the contractual adjustment is calculated and entered.
Payment	Enter the payment allocation in these fields. If you need to enter an additional payment allocation, use the Procedure Level Detail slider.
Amount	Enter the amount paid.
Type	Select the appropriate payment credit type.
	Select the Notes icon to enter any additional information about the payment if desired.
Contract	These fields are used for the insurance payer contractual adjustment. If an additional adjustment is needed, enter it in the Adjustment columns, to the right in the window and explained below.
Adj	The contractual adjustment amount is calculated when you enter the actual allowed amount. You can change this amount if desired.
Type	The adjustment credit type defaults to Contractual for the calculated contractual adjustment. You can change this if desired.
	Select the Notes icon to enter any additional information about the contractual adjustment if desired.
Transfer To	Use these columns to transfer liability for the balance to the patient.
Patient	Enter the balance amount to be transferred to the patient's liability.
Type	The default credit type is Transfer. You can change this if desired.
	Select the Notes icon to enter any additional information about the transfer if desired.
Adjustment	Use these columns to enter an additional insurance adjustment on the charge. If you need to enter more than one additional adjustment on the charge, use the Procedure Level Detail slider.
Amount	Enter the adjustment amount.

<b>Column</b>	<b>Description</b>
Type	Select the appropriate adjustment credit type.
	Select the Notes icon to enter any additional information about the adjustment if desired.
Transfer To	Use these columns to transfer liability for the balance from the patient back to the insurance payer.
Insurance	Enter the balance amount to be transferred to the insurance payer's liability.
Type	The default credit type is Transfer. You can change this if desired.
	Select the Notes icon to enter any additional information about the transfer if desired.
Patient Adjustment	Use these columns to enter a patient adjustment on the charge. If you need to enter more than one adjustment for a charge, use the Procedure Level Detail slider.
Amount	Enter the adjustment amount.
Type	Select the appropriate adjustment credit type.
	Select the Notes icon to enter any additional information about the adjustment if desired.
Total	These columns display the charge totals.
Paid	The total amount paid by the insurance payer or payers and the patient.
Adjusted	The total of all adjustments.
Split	Select this checkbox if you want to move the charge onto a new superbill so that the selected charges can be processed separately.

### **Superbill Status Display and Setting**

The Transaction window displays the current status of the selected superbill, and prompts a new status based on the actions you take in the window. You may choose to change the status of the superbill when allocating a payment or to leave status as it is. If you choose to change the superbill's status, you may use the status suggested by the application or you may choose another system-defined or user-defined status.

When you access the Transaction window for the first time for a superbill and allocate money to a charge or charges, the application assumes that a change in the superbill's status is appropriate. Therefore, the Update Superbill status checkbox is selected by default. You do not, however, have to change the superbill status. If you do not want to change the status, then

deselect the Update Superbill status checkbox. If you want to change the status, but do not want the status suggested by the application, then select the desired status.

When you access the Transaction window a subsequent time for a superbill, the application will suggest a new status if appropriate based on the actions you take. The application does not assume that the change in status is necessary, so the Update Superbill status checkbox is not selected. If you want to change the status of the superbill, you must select the Update Superbill status checkbox. You may accept the status suggested by the application, or you may select the desired status.

You may select any system-defined status that is valid for the conditions of the superbill or any user-defined status. The Transaction window will not allow you to change the superbill to a system-defined status that is invalid for the current conditions. For example, you cannot change a superbill's status to Complete when there is a balance for either the insurance payer or the responsible party.

If you select the status Pending Patient Payment and there is any outstanding balance for the insurance payer, then the application will transfer that balance from the insurance payer to the responsible party. This is because a superbill can have the Pending Patient Payment status only when there is no insurance payer balance. Transferring the remaining insurance payer balance to the responsible party ensures that the superbill is not placed in an invalid status.

## **Status Bar**

The status bar at the bottom of the window may display messages related to the payment or to the superbill to which the payment is being applied. For example, a message will appear in the status bar when the batch is closed or when you do not have permission to the financial center.

## **Transferring Liability from One Payer to Another Payer**

Once an insurance payer makes a payment for the charges on a superbill – or notifies you that they are not making a payment for charges—then the liability for any remaining balance is transferred from that insurance payer to either another insurance payer, if the patient has a secondary or tertiary insurance, or to the patient.

The application automatically transfers the remaining balance on all charges when you change the superbill's status. The remaining balances are transferred to another insurance payer when the superbill's status is changed to Queued and the secondary or tertiary insurance payer is selected. The remaining balances are transferred to the patient when the superbill's status is changed to Pending Patient Payment.

The transfer is made when you select the OK button, so you will not see the transfer when you select the new status for the superbill. You will see that the balances for the charges have been transferred when you next view the superbill in the Transaction window.

Liability for the entire remaining balance for each charge is transferred to the next payer. It is not possible to transfer a portion of a remaining balance. It is also not possible to transfer the remaining balance for some charges but not for others. You can, however, split one or more charges onto a new superbill so that you can process them separately. Please see the Splitting the Charges onto a New Superbill section for more information.

## Searching for Unallocated Payments

You should search for unallocated payments daily, and then allocate those payments to charges or payer credits. Payment items that are entered but not allocated to charges do not reduce patient or insurance payer balances. A financial batch that contains a payment that has not been fully allocated to charges, payer credits, or both cannot be completed or closed.

1. Billing → Track Payments
2. Select the Show Only Unapplied Payments checkbox and select the Search button. This lists all payments that have been entered, but have not yet been allocated.
3. Use the appropriate allocating procedure below to allocate the payments to charges or payer credits.

## Allocating Money from a Payment to a Superbill

Money is allocated from a payment to charges on a superbill on the Transaction window. The columns displayed in this window depend on the type of a payment item from which the allocation is being made. You may allocate money from an insurance payment, a responsible party payment, or both.

You may also enter adjustments and transfers that are not associated with any payment. Please see the Creating a Transaction section for instructions.

1. Billing → Track Payments
2. Either:
  - Select the reference number for an existing payment item.
  - Select the New Insurance Payment button to enter a new payment item. Complete the payment entry process described above.
  - Select the New Responsible Party button to enter a new payment item. Complete the payment entry process described above.
3. Select the Transaction Details slider.
4. In the slider, select the desired Superbill. This opens the Transaction window.
5. Accept the automatically generated Transaction number, or enter a number of your own.
6. Select the desired Batch. This will be your default batch if one is selected.
7. The Insurance fields will be populated if you are allocating from an insurance payment. You may select a payment if there is not one selected.
  - a. Payment: The insurance payment from which you are allocating money to charges.
  - b. Insurance: The insurance payer from which the payment was received.
  - c. Amount: The amount of the payment. The payment amount cannot be changed from this window.
  - d. Unallocated: The amount of money from the payment that has not yet been allocated to a charge. This amount will change as you allocate money to charges. When the Unallocated amount is 0.00, then the payment is fully allocated.

- e. Payer Credit: If the insurance payer has a payer credit that is associated with the same provider, service site, and financial center as the superbill, that payer credit amount will be displayed. To view all the payer credits for the insurance payer, select the Find icon. The Find icon with a red checkmark () indicates that there are one or more payer credits.
8. The Responsible Party fields will be populated if you are allocating from a responsible party payment. You may select a payment if there is not one selected.
- a. Payment: The responsible party payment from which you are allocating money to charges.
  - b. Amount: The amount of the payment. The payment amount cannot be changed from this window.
  - c. Unallocated: The amount of money from the payment that has not yet been allocated to a charge. This amount will change as you allocate money to charges.
  - d. Payer Credit: If the responsible party has a payer credit that is associated with the same provider, service site, and financial center as the superbill, that payer credit amount will be displayed. To view all the payer credits for the responsible party, select the Find icon. The Find icon with a red checkmark () indicates that there are one or more payer credits.
9. Enter actions on a charge. The actions you take will depend on the type of payment you are processing.
- a. In the Allowed Actual field, enter the actual amount allowed by the insurance payer if you are entering an insurance payment.
  - b. In the Payment Amount field, enter the amount paid by the insurance payer for this charge.
  - c. In the Contract Adj field, enter the contractual adjustment amount for the charge. This is the difference between the charge amount and the actual amount allowed.
  - d. In the Transfer To Patient field, enter any amount you want to transfer from insurance liability to responsible party liability.
  - e. In the Adjustment field, enter any additional adjustment amount.
  - f. In the Patient Payment Amount field, enter the amount paid by the responsible party for this charge.
  - g. In the Transfer To Insurance field, enter any amount you want to transfer from responsible party liability to insurance liability.
  - h. In the Patient Adjustment Amount field, enter the amount of any adjustment you are making the patient-liable portion of the charge.
  - i. Review the Total Paid and Total Adjusted amounts. If these are not correct, make any changes needed using substeps a through h.
  - j. Repeat substeps a through i for all charges on the superbill.
10. If appropriate, select the Update Superbill Status checkbox, and then select the appropriate status for the superbill.

11. Either:

- Select the Apply button to save your entries in the database and continue working in this window.
- Select the OK button to save your entries and close the window.

### **Allocating Money from a Payer Credit to a Superbill Charge**

When a responsible party or an insurance payer has a payer credit, you can allocate money from that payer credit to charges on a superbill. The Payer Credit window is very similar in appearance and functionality to the Responsible Party Payment window and Insurance Payment window. You allocate payment amounts to charges from a payer credit in the same way as you allocate payment amounts to charges from either of the Payment windows.

Please refer to the Allocating a Payment to a Payer Credit section below for information on how a payer credit is created.

1. Billing → Track Payer Credits
2. Enter the desired search criteria, and then select the Search button to display a list of payer credits matching your search criteria.

The Available Balance column displays the amount of the payer credit available to be allocated to charges.

3. Select the Payer Credit hyperlink for the payer credit you want to allocate.
4. In the Payer Credit window, select the Transaction Details slider.
5. In the slider, select the desired Superbill. This opens the Transaction window.
6. Accept the automatically generated Transaction number, or enter a number of your own.
7. Select the desired Batch. This will be your default batch if one is selected.
8. The Insurance fields will be populated if you are allocating from an insurance payment. You may select a payment if there is not one selected.
  - a. Payment: The insurance payment from which you are allocating money to charges.
  - b. Insurance: The insurance payer from which the payment was received.
  - c. Amount: The amount of the payment. The payment amount cannot be changed from this window.
  - d. Unallocated: The amount of money from the payment that has not yet been allocated to a charge. This amount will change as you allocate money to charges. When the Unallocated amount is 0.00, then the payment is fully allocated.
  - e. Payer Credit: If the insurance payer has a payer credit that is associated with the same provider, service site, and financial center as the superbill, that payer credit amount will be displayed. To view all the payer credits for the insurance payer, select the Find icon. The Find icon with a red checkmark () indicates that there are one or more payer credits.

9. The Responsible Party fields will be populated if you are allocating from a responsible party payment. You may select a payment if there is not one selected.
  - a. Payment: The responsible party payment from which you are allocating money to charges.
  - b. Amount: The amount of the payment. The payment amount cannot be changed from this window.
  - c. Unallocated: The amount of money from the payment that has not yet been allocated to a charge. This amount will change as you allocate money to charges.
  - d. Payer Credit: If the responsible party has a payer credit that is associated with the same provider, service site, and financial center as the superbill, that payer credit amount will be displayed. To view all the payer credits for the responsible party, select the Find icon. The Find icon with a red checkmark () indicates that there are one or more payer credits.
10. Enter actions on a charge. The actions you take will depend on the type of payment you are processing.
  - a. In the Allowed Actual field, enter the actual amount allowed by the insurance payer if you are entering an insurance payment.
  - b. In the Payment Amount field, enter the amount paid by the insurance payer for this charge.
  - c. In the Contract Adj field, enter the contractual adjustment amount for the charge. This is the difference between the charge amount and the actual amount allowed.
  - d. In the Transfer To Patient field, enter any amount you want to transfer from insurance liability to responsible party liability.
  - e. In the Adjustment field, enter any additional adjust amount.
  - f. In the Patient Payment Amount field, enter the amount paid by the responsible party for this charge.
  - g. In the Transfer To Insurance field, enter any amount you want to transfer from responsible party liability to insurance liability.
  - h. In the Patient Adjustment Amount field, enter the amount of any adjustment you are making the patient-liable portion of the charge.
  - i. Review the Total Paid and Total Adjusted amounts. If these are not correct, make any changes needed using substeps a through h.
  - j. Repeat substeps a through i for all charges on the superbill.
11. If appropriate, select the Update Superbill Status checkbox, and then select the appropriate status for the superbill.
12. Either:
  - Select the Apply button to save your entries in the database and continue working in this window.
  - Select the OK button to save your entries and close the window.

## Entering Multiple Transfers on a Superbill Charge

There are circumstances that require multiple transfers for a charge; for example, when the patient's deductible is paid by the health savings account. Use the following procedure to enter multiple transfers on a charge.

1. Billing → Track Payments
2. Either:
  - Select the reference number for an existing payment item.
  - Select the New Insurance Payment button to enter a new payment item. Complete the payment entry process described above.
  - Select the New Responsible Party button to enter a new payment item. Complete the payment entry process described above.
3. Select the Transaction Details slider.
4. In the slider, select the desired Superbill. This opens the Transaction window.
5. Accept the automatically generated Transaction number, or enter a number of your own.
6. Select the desired Batch. This will be your default batch if one is selected.
7. The Insurance fields will be populated if you are allocating from an insurance payment. You may select a payment if there is not one selected.
8. The Responsible Party fields will be populated if you are allocating from a responsible party payment. You may select a payment if there is not one selected.
9. Highlight the desired charge, and then select the Procedure Level Detail slider.
10. Enter the transfer information for the procedure charge.
  - a. In the Code field, select the procedure code for which you are making the transfer entry.
  - b. In the Amount field, enter the amount of the transfer.
  - c. In the Type field, select the desired payment type for the transfer.
  - d. Enter any additional information needed.
11. Continue making payment allocations as appropriate.
12. Either:
  - Select the Apply button to save your entries in the database and continue working in this window.
  - Select the OK button to save your entries and close the window.

## Viewing the Procedure Level Detail

Use the Procedure Level Detail slider in the Transaction window to view the details of all financial actions taken on the procedures. Each action (charge, payment, transfer, etc.) taken on each charge is listed. Each entry also includes the financial batch of the transaction, and the state of that batch.

1. Transaction → Procedure Level Detail slider
2. From the Options menu, select View, then select the types of actions you displayed.
3. Review the actions and make any changes needed.
4. If desired, enter a new action in the blank line at the bottom of the list of actions.
5. If needed, select the Delete icon (  ) to delete a transaction.

## Viewing the Claim Level Detail

Use the Claim Level Detail slider in the Transaction window to enter and view the claim level adjustments and information required for secondary or tertiary claims. You may also want to enter this information for tracking or reporting purposes.

This information is required when there will be a subsequent secondary or tertiary claim. You may also want to enter this information for tracking or reporting purposes. The information in this section will be automatically populated by ERA processing of payments.

1. Transaction → Claim Level Detail slider
2. In the ICN field, enter the internal control number assigned by the insurance payer to identify the claim. This is needed to resubmit the claim to the payer and to submit a secondary or tertiary claim.  
  
Please note that the ICN is not entered by ERA processing. You must enter this number when it is needed for subsequent claims processing.
3. In the Adjudication Date field, enter the date the claim was processed by the insurance payer. (The adjudication date is not necessarily the same as the payment date.) This is required if there will be a secondary claim.
4. In the Claim Level Adjustments section, enter any adjustments or remarks made at the claim level. It is important to note that the data entered in this section does not affect the payment allocation to the superbill. Because it does not affect the payment allocation, this data is not subject to the batch closing rules, and so it can be entered or changed at any time.
  - Group Code: Identify the general category of the payment adjustment.
  - Reason Code: Identify reasons for certain actions taken by insurance payers when processing claims. They are used in statement of benefits and electronic remittance advice to explain what was paid or not paid by the insurance payer. May be system or user defined.
  - Amount: The amount does not affect the payments or adjustments on the superbill.
  - Quantity

5. In the Medicare Outpatient Adjudication section, enter the following information as needed.
  - Reimbursement Rate
  - HCPCS Amount
  - Remark Codes. Remittance advice remark codes are used by insurance payers to explain how they handled a payment for a claim or why they handled it the way they did. Include the remark code when entering a payment from a primary insurance payer if the patient has a secondary insurance payer. Secondary and tertiary payers require this information when they process claims.
  - ESRD Amount
  - Professional Amount
  - Discount Amount
  - Per Day Limit Amount
  - Patient Responsibility Amount

### **Balancing Transactions for the Coordination of Benefits**

When a patient has more than one insurance payer, the payments, adjustments, and remarks for each procedure on a superbill must equal the total charge for the procedure for the secondary insurance payer to accept the claim. A yellow warning message will appear at the top of the window when any procedure on the superbill does not balance and the patient has more than one insurance payer.

You can then use the Coordination of Benefits (COB) Calculator to balance the payment data from the primary insurance payer in such a way that the claim will be accepted by the secondary insurance payer. The COB Calculator is on the Claim Level Detail slider in the Transaction window.

The COB Calculator lists each procedure on the superbill. For each procedure, it shows the liability owner (such as Secondary insurance payer), the charge amount, paid amount, adjusted amount, remark amount, and remaining amount. The remaining amount for each procedure must be \$0.00 before you can submit a claim to a secondary or tertiary insurance payer. The COB Calculator also contains columns for group code and reason code so that you can enter a remark to balance the procedure.

Patient payments are not considered by the COB Calculator. You must create a remark explaining a patient payment, such as a copay amount you collected at the time of the visit.

1. Transaction → Claim Level Detail slider
2. Distribute the payment from the primary insurance payer to the procedures on the superbill.
3. Enter any adjustments for the procedures.
4. Use the COB Calculator to create a remark for the remaining amount on a procedure.
  - a. Select the Group Code that identifies the general category of the remark, such as patient responsibility.
  - b. Select the Reason Code that more specifically identifies the reason for remarking the amount, such as copay.

- c. The Remaining Amount changes to \$0.00, and the Remark Amount changes to the amount that had been remaining.
5. Repeat steps 2 through 4 for each procedure on the superbill.

### **Allocating a Payment to a Payer Credit**

When you receive a payment that you do not want to allocate to a superbill, either in full or in part, you can allocate the money to the payer's account as a payer credit. This generally happens when a responsible party overpays for services already rendered or pays in advance for services that will be rendered in the future.

You may also decide to allocate a payment to a payer credit when you cannot identify the superbill to which the payment should be allocated or because you need to complete the financial batch associated with the payment but do not have time to fully allocate the payment to the appropriate superbills and charges.

Because a payer credit is allocated from a payment, you must associate it with a provider, service site, and financial center. This enables you to track the money and ensures that your financial reports are correct.

When you allocate money from the payer credit to a superbill charge, you may change the provider, service site, and/or financial center if needed. So for example, if a responsible party pays in advance for a surgical procedure, you will want to allocate the payer credit to the provider who will perform the surgery, the service site where the surgery will be performed, and the financial center that is appropriate. If however, the surgery is actually performed by another provider, when you allocate the payer credit amount to the surgery charges, the allocation is made to the provider related to the charge. This will move the amount from the provider who was expected to perform the surgery to the provider who actually performed it.

1. Billing → Track Payments
2. Either:
  - Select the reference number for an existing payment item.
  - Select the New Insurance Payment button to enter a new payment item. Complete the payment entry process described above.
  - Select the New Responsible Party button to enter a new payment item. Complete the payment entry process described above.
3. If desired, allocate money from the payment to superbill charges.
4. Select the Payer Credit slider.
5. In the slider, create the payer credit for the unallocated amount remaining from the payment. This may be all or part of the payment amount.
  - a. Select the checkbox for 'Allocate Remaining as Payer Credit'.
  - b. Select the Billing Provider to be associated with the payer credit amount.
  - c. Select the Service Site.
  - d. Select the Financial Center.

- e. Information entered in the Notes field is used as the name of the payer credit transaction.

You will be able to search for the payer credit using these notes. If you do not enter a note, one will be automatically created to aid searching. The format for automatic notes is shown below. It is recommended that you begin a note in this format when you want to include additional information about the payer credit.

- Responsible party name – Payment reference number
- Insurance payer name – Payment reference number

6. Select the OK button in the Payment window to create the payer credit.

### **Splitting the Charges onto a New Superbill**

Sometimes when you are allocating a payment to a superbill or entering other transactions, you would like to be able to move some of the charges on the superbill to another superbill so that they can be processed separately. For example, an insurance payer may pay for two of three charges on a superbill. You would like to be able to split the undisputed charges from the superbill and put them on another superbill. Then you can continue the normal processing of the charges that have been paid, while you investigate why the third charge was not paid.

You can select one or more paid procedures to be moved from the original superbill to a new superbill. The new superbill is a copy of the original superbill in all ways, except that it only contains the selected charges. All the payment and adjustment transactions on the paid procedures move to the new superbill with the procedures. The original superbill is unchanged except that the selected charges are removed from it.

All superbills are given a numeric superbill identifier when they are created. When a superbill is split, the new superbill that is created is given the same superbill identifier as the original superbill but with an alphabetic suffix. So for example, if the original superbill's identifier is 123, the identifier for the new superbill will be 123A.

1. Billing → Track Payments
2. Either:
  - Select the reference number for an existing payment item.
  - Select the New Insurance Payment button to enter a new payment item. Complete the payment entry process described above.
  - Select the New Responsible Party button to enter a new payment item. Complete the payment entry process described above.
3. Select the Transaction Details slider.
4. In the slider, select the desired Superbill. This opens the Transaction window.
5. Accept the automatically generated Transaction number, or enter a number of your own.
6. Select the desired Batch. This will be your default batch if one is selected.
7. Enter the appropriate payments and adjustments on the charges that can be processed.

8. For the paid charge or charges you want to move to a new superbill, select the Split checkbox in the far right column and press the Tab key.

At the bottom of the window, a second Update Superbill line appears. The top line is for the original superbill (superbill xx) and the second line is for the new superbill (superbill xxA).

9. Update the status of the original superbill. This superbill contains the charges that were not split.
  - a. Select the Update Superbill checkbox for the original superbill.
  - b. Select the appropriate superbill status for the original superbill.
  - c. Select the payer (secondary insurance, patient) to which the remaining liability is to be transferred.
10. Update the status of the new superbill. This superbill contains the charges that were split.
  - a. Select the Update Superbill checkbox for the new superbill.
  - b. Accept the default status of Insurance Action, or select another status if desired.
  - c. The current payer remains the liability owner.
11. Select the OK button to create the new superbill, move the charges, and update the superbills' statuses.

### **Changing a Superbill while Allocating Payments**

Often while entering and allocating payments, you will identify a change that needs to be made to the superbill. The recommended workflow for changing a superbill during the payment entry process is to select the Superbill ID hyperlink from the Insurance Payment or Responsible Party Payment window. To prevent conflicts between data entered in the payment transaction and data entered in the superbill, the application prevents you from opening a superbill from the Transaction window.

It is recommended that you do not open a superbill from the Track Superbills window at the same time that you have the Transaction window open to allocate monies to the superbill. Doing so can result in conflicts between the data entered in the payment transaction and changes made in the superbill.

## Allocating Payments Automatically and Quick Allocation Entry

There are a number of ways in which the application can help you reduce the data entry needed to allocate money from payments and payer credits to charges. You can automatically allocate responsible party payments and payer credits to charges on superbills. Automatic allocation always allocates money to the oldest unpaid charges for which the responsible party is liable.

The application also has hotkeys that enable you to quickly enter the expected payment allocations, transfers, and adjustments with the minimal number of key strokes. Quick entry using the hotkeys is available for both insurance and responsible party payments. When using quick entry, you only have to manually enter those allocations that are an exception, and let the application make all the entries for allocations that are as expected. When allocating a payment to a superbill, you can enter the exceptions first, and then use the hotkeys to make the remaining entries. Or, you can use the hotkeys first to make all entries, and then change any entries that are exceptions. This allows you to decide the quickest and easiest way to make the entries based on the characteristics of the particular payment deposit item and superbills.

### **Automatically Allocating Money from a Payment to Charges**

A payment from a responsible party may be automatically allocated to the oldest unpaid charges for which the responsible party is liable.

1. Billing → Track Payments
2. Either:
  - Select the reference number for an existing payment item.
  - Select the New Responsible Party button to enter a new payment item. Enter the payment information as described above.
3. Select the Allocate to Superbills checkbox.
4. Either:
  - Select the Apply button to save the payment item, and enter the next payment.
  - Select the OK button to save the payment item and close the window.

## **Automatically Allocating Money from Multiple Payments to Charges**

You can select multiple responsible party payments to automatically allocate to charges. Money is allocated to the oldest unpaid charges for which the responsible party is liable.

You cannot use this process to allocate from insurance payments. If an insurance payment is selected, it will automatically be unselected when you allocate.

1. Billing → Track Payments
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the payments that need receipts.
4. Select the Allocate button.
5. A message is displayed telling you how payments you have selected. Either:
  - Select the Yes button to allocate the payments.
  - Select the No button to cancel the action.

## **Automatically Allocating Money from a Payer Credit to Charges**

A responsible party payer credit may be automatically allocated to the oldest unpaid charges for which the responsible party is liable. In order for the payer credit to be auto allocated to a charge, the charge must be associated with the same provider, service site, and financial center as the payer credit. To allocate from the payer credit to charges associated with a different provider, service site, or financial center, than you must allocate to the charges using the Allocating Money from a Payer Credit to a Superbill Charge procedure described above.

1. Billing → Track Payer Credits
2. Enter the desired search criteria, and then select the Search button.
3. Select the Payer Credit hyperlink for the payer credit you want to allocate.
4. In the Payer Credit window, select the Allocate to Superbills checkbox.
5. Either:
  - Select the Apply button to save the payment item, and then enter the next payment.
  - Select the OK button to save the payment item and close the window.

## Quick Entry of Balance Due Amounts Using the Slash Hotkey

You can enter all payment, transfer, or adjustments for a payer based on the balance due from that payer by using the slash (/) key in the top right of the numerical keypad on a standard keyboard. The behavior of the slash key entries is based on the column in which it is used.

**Note:** This feature does not work with the Question Mark/Slash key on the main keyboard. To use this feature, you must have a keyboard with a numerical keypad or an external numerical keypad.



When using the slash key to enter payment allocations, the application considers the source of the payer (insurance or responsible party), and determines the current balance due from that payer for each charge. It enters each charge's balance due as the payment allocation for that charge.

When using the slash key to enter contractual insurance adjustments, the application considers the remaining balance due from the insurance payer, and enters that as the adjustment amount. This updates the actual allowed amount in the same manner as manual entry or ERA processing. It also enters the default adjustment type, again as with regular entry.

When using the slash key to enter in the second insurance adjustment column, the application makes entries in the same as it does for contractual adjustments. The only difference is that these adjustments do not change the actual allowed amount.

You can use the slash key in the Transfer column to transfer the remaining balance to the patient. You would do this when you are not going to change the superbill status to Pending Patient Payment. For example, when you are using a status for disputes or rebilling. When you are going to save the superbill with the status of Pending Patient Payment, then there is no need for you to the slash key in the Transfer because the application makes these transfers automatically when save the superbill.

You can make a transfer from the patient balance back to the insurance liability by using the slash key in the transfer to insurance column. You may do this, for example, when you have allocated a co-insurance payment amount from the patient, but the insurance actually paid the full amount allowed.

When allocating from an insurance payment, you can use the slash key in the Patient Adjustment column to adjust off any amount remaining in the patient balance.

When entering patient payments, transfers, and allocations, using the slash key works the same way as it does for insurance payments. The only difference is that it uses the patient balance as the basis for the entries.

The application will not enter any amount for an individual charge item that is greater than the amount due from the payer for that item. The application will also not enter payment amounts greater than the unallocated amount available on the payment deposit item. If there is not enough unallocated money in the payment deposit, then payment allocations will not be entered on all charges.

1. Transaction window
2. Select a payment Deposit. The selected payment deposit must have an unallocated amount available.
3. In the desired Payment, Adjustment, or Transfer column, select the cell for the first charge.
4. Press the Slash (/) key. Notice that amounts are entered in the selected column for this charge and for other charges with an amount due from the payer. The amount allocated to any individual charge is either the remaining balance for that charge, or if entering payments, the remaining amount of the deposit.

### **Quick Entry of a Single Balance Due Amount Using the Asterisk Hotkey**

You can enter a single amount based on the balance due from the payer using the asterisk (\*) key in the top right of the numerical keypad on a standard keyboard.

**Note:** This does not work with the 8 key in the numbers row of the main keyboard or with the Num Lock key on laptop or a tablet that does not have a separate numerical keypad. To use this feature, you must have a keyboard with a numerical keypad or an external numerical keypad.



You can use the asterisk hotkey to enter the payment amount for a procedure charge when the payment amount received is exactly the balance owed by the payer. This enables you enter the correct dollar and cents amount with a single key stroke. You can then use the arrow keys to move to the next item. This enables you enter amounts with a minimal number of key strokes and without lifting your hand from the key board.

You can also use the asterisk hotkey to enter adjustment or transfer amounts when the amount you want to enter is exactly the balance owed.

The asterisk hotkey is particularly helpful when allocating payment amounts for insurance payments. It is helpful for entering both insurance payer and responsible party payer payment adjustment and transfer amounts.

The asterisk hotkey does not work in an entry field in which there is already an entry.

1. Transaction window
2. Select an insurance payment Deposit. The selected payment deposit must have an unallocated amount available.
3. Select the cell in which you want to enter an amount, such as the insurance Payment Amount.
4. Press the \* key. Notice that the exact balance due amount for the payer is entered in the cell.
5. Press the Down Arrow key to access the next procedure line.
6. Press the \* key to enter the amount. Again, notice that the exact balance due amount for the payer is entered in the cell.
7. Repeat as needed. When you have finished all of the entries in a column, you can use the Right Arrow and Up Arrow keys to move to the next column, and continue making entries.

## Processing Credit Card Payments

You may choose to enroll with Easy Pay to enable the processing of credit card payments within the application. The Easy Pay software is specifically designed for medical practices. Easy Pay Solutions, Inc. is a registered ISO/MSP for HSBC Bank USA, National Association, Buffalo, NY. Easy Pay processes all major credit cards (Visa, MasterCard, American Express, and Diners Club). You must complete the proper merchant application for each of the credit card brands you want to accept. To enroll, please contact Support.

**Note:** This section only includes information for processing credit card payments using Easy Pay. If you are processing credit card payments through ClearGage® as part of the payment management services, then please refer to the Payment Management Services section of this guide for information.

Easy Pay uses a card swipe device that attaches to your computer through a USB port. To enter a payment, you can swipe a credit card or you can type the information, for example, when a payment is made by phone. When you swipe a card or enter the card holder information, Easy Pay obtains authorization for the payment amount from the credit card company or bank using the Internet. This eliminates the need for a credit card terminal.

As with a credit card terminal, the money for a credit card payment is not transferred from the credit card company to you until you perform the settlement process. You can perform the settlement process from the application at any time. If you would like settlement to be performed automatically, you may set up automatic settlement with Easy Pay.

Once the settlement process has run, you can review the settlement history for the settlement batch. You can view the settlement details for individual payment transactions at any time, both prior to settlement and following settlement.

Incorrect credit card payments may be deleted prior to settlement since they have not been processed by the credit card company and no money has been issued for them. Once the settlement has been performed for a payment, that payment must be reversed if it is incorrect in any way; it cannot be deleted.

Credit card information stored in the application for use by Easy Pay is very secure. Easy Pay has been certified to meet the industry standard Payment Acceptance Best Practices (PABP) security requirements. This is the standard required by Visa, MasterCard, American Express, and Discover. All the credit card data stored in the application is encrypted so that the credit card data is protected. Card numbers in application windows, on receipts, and in reports are masked so that only the four digits of the number are visible. Card expiration dates are not printed in order to prevent fraud.

Before you can process card payments, your administrative super user must have configured your practice settings to use the Easy Pay credit card processing functionality.

## **Payment Receipts**

Receipts for credit card payments must meet Easy Pay's and the credit card industry's requirements. The receipt must include the address of the physical location at which the transaction occurred. Therefore, the receipt includes the practice name and the service site address.

Your database may be configured to enable electronic signatures using a signature pad.

## **Annual Consent Agreements**

An annual consent agreement enables you to save credit card information so that you can process payments on that card in the future. Though called an annual agreement, the agreement is actually for any time period up to a year. The consent agreement also defines the maximum amount of any single payment that may be made from the agreement and the total dollar amount of all payments that may be made from the agreement. The agreement expires when either the time period end date is reached or the total dollar amount has been charged.

You can use annual consent agreements to improve your cash flow. For example, at the time of a patient visit, you may want to establish a consent agreement with the responsible party for the anticipated patient liability after their insurance has paid. In this instance, you may want to make the consent agreement for a time period that allows you to process the claim and to receive and process the insurance payment. You may also want to make the anticipated patient liability amount be both the maximum single payment amount and the total dollar amount of all payments for the consent agreement. Such an agreement enables you to process payment for the responsible party as soon as they become liable. It also enables the responsibility party to know when to expect the charge and how much to expect it to be.

As another example, a responsible party may want to establish an annual consent agreement so that visit copay and co-insurance payments may be processed for patient visits when the responsible party is not present or does not have the card available. If you make such an agreement when scheduling an appointment, then the time period may be just long enough to cover the date of the appointment or a few days after. You may want to make both the maximum single payment and the total dollar amount of all payments be the amount you anticipate for the visit's copay and co-insurance amounts.

If you make an agreement with the responsible party for a longer period of time that may include more than one appointment, then you may want to make the maximum single payment amount large enough to cover the copay amount and some portion of any visit's co-insurance

amount. For such an agreement, the total dollar amount of all payments that made from the agreement may be larger than the maximum single payment amount.

The application will never allow you to make a payment that exceeds the maximum amount of a single payment defined in the consent agreement. It also will not allow you to make a payment that exceeds the total dollar amount defined in the consent agreement. But the application does not know when a payment from a consent agreement is appropriate or not. You must establish policies and practices that help you ensure that any payments generated from a consent agreement, whether manually entered or automatically generated, are aligned with the terms of your agreements with your responsible parties.

### **Recurring Consent Agreements**

A recurring consent agreement enables you to save credit card information for scheduled payments, such as for a payment plan. A recurring consent agreement is for a specific number of payments of a defined amount. The agreement expires when charge transactions have been made for all the payments.

Easy Pay processes the charge to the credit card on the scheduled date. The application obtains the charge information from Easy Pay, and automatically processes the payment items (deposits) for those recurring consent agreements. You then use the Track Payments window to identify these payments and allocate the money to superbill charges.

The application creates a financial batch for the payment items created for recurring consent agreements. The naming standard for these batches is "YYYYMMDD Scheduled Payments".

### **Payments from the Patient Portal**

Your Patient Portal may be configured to enable patients and responsible parties to make credit card payments from their Portal accounts. A patient may make a payment by entering their credit card information and the payment information.

If you have an annual consent agreement set up with the patient, then the patient may make payment using that agreement. In this case, the patient does not need to enter the credit card information. The patient only needs to enter the payment amount. The payment amount is limited to the maximum payment amount established in the consent agreement.

Use the Track Payments window to identify these payments and allocate the money to superbill charges.

### **Refunds**

Refunds cannot be processed as a credit card transaction. To process a credit card refund, please contact Easy Pay to process the actual credit card transaction. Then enter the negative payment in the application without using the Scan Credit Card button.

## Citrix Compatibility

The Easy Pay card swipe device is not compatible with Citrix. If you are using Citrix and want to use Easy Pay, you will have to enter all credit card payments manually rather than by swiping the card.

## Processing a Copay Payment

Use the following procedure to process an appointment copay payment using a credit card and Easy Pay processing.

1. Desktop or Schedule → More Options (  ) icon → Update Appointment
2. Select the Account tab.
3. In the Visit Payment area, enter the payment Amount.
4. Select the Method of payment. This will be the type of credit card being used. (You can select any payment type indicated as True in the Allow Scanner column.)
5. Enter or select the payment processing Batch.
6. Enter a Billing Note to identify what the payment is for, if desired.
7. Select the Scan Credit Card button.

The message “You have cards on file appears next to button if the responsible party has a consent agreement on file. When an agreement exists, the Payment Method window is displayed.

- To make payment from the agreement, please refer to the Processing a Payment from a Consent Agreement section for instructions.
  - To make a payment from the credit card, select the Use Different Card button. Then proceed with the next step.
8. This opens a Browser window that connects to the Easy Pay payment web application. You may scan the card to populate the following fields or you may enter this information if needed.
    - Cardholder Name
    - Cardholder Address
    - Account Number
    - Expires date
  9. Enter the CVV/CVD security number from the card.
  10. The Responsible Party Name is populated from the appointment information.
  11. Enter a Service Description if desired.
  12. Select the Submit button to process the card transaction.

Please note that you cannot close the window until the charge has completely processed. Processing is complete when the window closes and the Print window appears or the Denial, or Failure message appears at the top of the window.

13. The Print window appears. Select OK to print the receipt. Printing defaults to two copies of the receipt: one for the credit card holder and one for your records.

14. This returns to the Appointment window where the Reference field now includes the credit card transaction number.

### **Processing an Account Balance Payment**

Use the following procedure to process a credit card payment on the patient's account balance at the time of an appointment.

1. Desktop or Schedule → More Options (  ) icon → Update Appointment
2. Select the Account tab.
3. In the Account Payment area, enter the payment Amount.
4. Select the Method of payment. This will be the type of credit card being used. (You can select any payment type indicated as True in the Allow Scanner column.)
5. Enter or select the payment processing Batch.
6. Enter a Billing Note to identify what the payment is for, if desired.
7. Select the Scan Credit Card button.

The message "You have cards on file" appears next to button if the responsible party has a consent agreement on file. When an agreement exists, the Payment Method window is displayed.

- To make payment from the agreement, please refer to the Processing a Payment from a Consent Agreement section for instructions.
  - To make a payment from the credit card, select the Use Different Card button. Then proceed with the next step.
8. This opens a Browser window that connects to the Easy Pay payment web application. You may scan the card to populate the following fields or you may enter this information if needed.
    - Cardholder Name
    - Cardholder Address
    - Account Number
    - Expires date
  9. Enter the CVV/CVD security number from the card.
  10. The Responsible Party Name is populated from the appointment information.
  11. Enter a Service Description if desired.
  12. Select the Submit button to process the card transaction.

Please note that you cannot close the window until the charge has completely processed. Processing is complete when the window closes and the Print window appears or the Denial, or Failure message appears at the top of the window.
  13. The Print window appears. Select OK to print the receipt. Printing defaults to two copies of the receipt: one for the credit card holder and one for your records.
  14. This returns to the Appointment window where the Reference field now includes the credit card transaction number.

## Processing a Credit Card Payment Received by Mail or Phone

Use the following procedure to process a credit card payment when you do not have the credit card to swipe. This is most likely when you receive authorization over the phone or in the mail.

Transactions that are entered manually are charged at a different, higher rate than the fully-qualified rate of swiped card transactions. If you enter the ZIP code for the credit card holder's billing address, then the transaction is charged at the mid-qualified rate. If you do not enter the ZIP code, then the transaction is charged the non-qualified rate, the highest transaction rate.

1. Billing → Track Payments
2. Select the New Responsible Party Payment button.
3. Select the Payment Type. This will be the type of credit card being used. (You can select any payment type indicated as True in the Allow Scanner column.)
4. Select the desired financial Batch. This will be your default batch if you have selected one.
5. Select the Payer from whom the payment is received. This does not have to be the same person to whom the credit card is issued.
6. Enter the Amount Paid.
7. Select the Scan Credit Card button.

The message "You have cards on file" appears next to button if the responsible party has a consent agreement on file. When an agreement exists, the Payment Method window is displayed.

- To make payment from the agreement, please refer to the Processing a Payment from a Consent Agreement section for instructions.
  - To make a payment from the credit card, select the Use Different Card button. Then proceed with the next step.
8. This opens a Browser window that connects to the Easy Pay payment web application. You may scan the card to populate the following fields or you may enter this information if needed.
    - Cardholder Name
    - Cardholder Address
    - Account Number
    - Expires date
  9. Enter the CVV/CVD security number from the card.
  10. The Responsible Party Name is populated from the appointment information.
  11. Enter a Service Description if desired.
  12. Select the Submit button to process the card transaction.

Please note that you cannot close the window until the charge has completely processed. Processing is complete when the window closes and the Print window appears or the Denial, or Failure message appears at the top of the window.
  13. The Print window appears. Select OK to print the receipt. Printing defaults to two copies of the receipt: one for the credit card holder and one for your records.

14. This returns to the Responsible Party Payment window where the Reference field now includes the credit card transaction number.
15. Enter any Comments, if desired.
16. If you want to automatically allocate the payment to the oldest charges, select the Allocate checkbox.
17. Either:
  - Select the New button to save the payment item, and enter the next payment.
  - Select the Apply button to save the payment item, and continue working with the payment.
  - Select the Transaction Details slider to begin allocating money from the payment item to superbills. See the Allocate Money from a Payment to a Superbill section below for instructions.
  - Select the OK button to save the payment item and close the window.

### **Processing a Payment from a Consent Agreement**

You can process a payment from an annual consent agreement from the Appointment window and from the Responsible Party payment window. When an agreement exists for the responsible party, the message "You have cards on file" appears next to Scan Credit Card button.

1. Either:
  - Desktop or Schedule → More Options (  ) icon → Update Appointment → Account tab
  - Billing menu → Track Payments → New Responsible Party Payment button
2. Enter the following payment information:
  - Payment amount
  - Batch
  - Notes or comments
3. Select the Scan Credit Card button. When an agreement exists, the Payment Method window is displayed.
4. In the Payment Method window, select the Select hyperlink for the agreement you want to use for the payment.
5. The Select Annual Consent popup displays information about the consent agreement, including the amount remaining in the agreement and the per charge limit.
6. Select the OK button to make the payment.
7. In the Print Receipt window, select either:
  - The Provider and Patient Receipt button to print two copies of the receipt.
  - The Patient Receipt Only button to print one copy of the receipt.
8. In the Print window, select the Print button to print the receipt.

## Obtaining Voice Authorization for a Payment

Occasionally, when you swipe a card or enter the card details manually, a message will appear notifying you that voice authorization is required for the payment. Use the following procedure to obtain authorization and process the payment.

1. When the Voice Authorize This Transaction message appears, call the phone number shown in the Auth. Phone No. field in the message.
2. Give the authorization representative the requested details as shown on the message.
3. Enter the Authorization Code provided by the authorization representative.
4. Select the OK button to process the message. The following message will appear.
5. When you receive the Response message, select the OK button.
6. Continue the payment entry process in the usual manner.

## Payment Error Messages

There are a number of error messages that may be received when attempting to process a credit card payment. Messages are displayed in the Comment field of the New Payment window. Error messages and possible resolutions are listed in the table below. The table does not include all possible error messages.

Error Message	Possible Resolution
"Amount is either: equal to 0, has no decimal, has decimal in wrong place,	Correct the payment amount, and then swipe the card again.
Account #/mag stripe is invalid.	Try swiping the card again or enter the card details manually.
Amount requested exceeds credit limit.	Enter a lower amount or refuse the credit card.
Card has been reported lost or stolen.	Refuse the credit card.
Cardholder's bank did not approve transaction.	Refuse the credit card.
Expiration date is either incorrect format or prior to today.	Try swiping the card again or enter the card details manually.
Fatal communications error.	The application is unable to connect to the card service. Check your Internet connection.
Invalid American Banking Association number.	Refuse the credit card.
Invalid International Control Account number.	Refuse the credit card.
The Bank Merchant ID is incorrect.	This is a setup error. Contact Support for assistance in correcting your setup.

<b>Error Message</b>	<b>Possible Resolution</b>
The merchant ID is not valid or active.	This is a setup error. Contact Support for assistance in correcting your setup.
The transaction format isn't valid, typically invalid SIC code	This is a setup error. Contact Support for assistance in correcting your setup.
Transaction is not valid for this authorizer.	This is a setup error. Contact Support for assistance in correcting your setup.
Unknown error code	Try swiping the card again or enter the card details manually. If this reoccurs, contact Support.

### **Creating an Annual Consent**

1. Patient Demographics → Account Tab
2. Select the hyperlink for the Responsible Party field. This accesses the Responsible Party window.
3. In the Responsible Party window, select the Credit Card tab.
4. Select the Annual Consent Setup button.
5. This opens a Browser window that connects to the Easy Pay payment web application. You may scan the card to populate the following fields or you may enter this information if needed.
  - Cardholder Name
  - Cardholder Address
  - Account Number
  - Expires date
6. Enter the CVV/CVD security number from the card.
7. The Responsible Party Name is prepopulated.
8. Enter a Service Description if desired.
9. Enter the Consent Information.
  - a. Select the Effectively Immediately checkbox if the consent agreement begins today. Otherwise, deselect this checkbox.
  - b. Enter the Start Date of the consent agreement.
  - c. In the Num Days field, enter the number of days the consent agreement is valid. This defaults to 365, but you may enter a different number. The agreement cannot be for more than a year.
  - d. You may enter the End Date, which will calculate the number of days. Or the End Date may be calculated from the number entered in the Num Days field.
  - e. In the Limit field, enter the dollar limit for individual payments made under this agreement.

- f. In the Lifetime field, enter the total dollar limit for the consent agreement. This is the maximum total amount that may be charged for all payments under this agreement.
  - g. Enter the cardholder's Email address if desired. If entered, Easy Pay will email a receipt to this address when a payment is made from the consent agreement.
10. Select the Submit button to process the card transaction.

Please note that you cannot close the window until the charge has completely processed. Processing is complete when the window closes and the Print window appears or the Denial, or Failure message appears at the top of the window.

11. A Receipt Options popup will ask if you would like to use an electronic signature.
- Select Yes if you have a signature pad. The Generate Document window will open, and you may have the cardholder enter the signature for the agreement.
  - Select No to print the agreement for the cardholder to sign.

### **Creating a Recurring Consent**

Use this process to create a recurring consent for scheduled credit card payments.

1. Patient Demographics → Account Tab
2. Select the hyperlink for the Responsible Party field. This accesses the Responsible Party window.
3. In the Responsible Party window, select the Credit Card tab.
4. Select the Recurring Consent Setup button.
5. This opens a Browser window that connects to the Easy Pay payment web application. You may scan the card to populate the following fields or you may enter this information if needed.
  - Cardholder Name
  - Cardholder Address
  - Account Number
  - Expires date
6. Enter the CVV/CVD security number from the card.
7. The Responsible Party Name is prepopulated.
8. Enter a Service Description if desired.
9. Enter the Recurring Information.
  - a. Enter the Total amount for all payments to be made under this agreement.
  - b. In the Payments field, enter the amount of each individual payment to be made under this agreement.
  - c. Enter the First Payment Date. This defaults to today's date, but you may enter a future date.
  - d. In the Num Payments field, enter the number of payments in this agreement.
  - e. Select the Period for the recurring payments. This may be, for example, weekly, monthly, twice monthly, etc.

- f. Select the Adjust Last Payment checkbox, if appropriate.
  - g. Enter the amount of the Last Payment.
10. Select the Submit button to process the card transaction.
- Please note that you cannot close the window until the charge has completely processed. Processing is complete when the window closes and the Print window appears or the Denial, or Failure message appears at the top of the window.
11. A Receipt Options popup will ask if you would like to use an electronic signature.
- Select Yes if you have a signature pad. The Generate Document window will open, and you may have the cardholder enter the signature for the agreement.
  - Select No to print the agreement for the cardholder to sign.

### **View a Responsible Party's Consents**

Consent information is not stored in your database. The application accesses the Easy Pay client portal to display information. Therefore, there may be a slight delay before the results are displayed.

1. Patient Demographics → Account Tab
2. Select the hyperlink for the Responsible Party field. This accesses the Responsible Party window.
3. In the Responsible Party window, select the Credit Card tab.
4. Consents are displayed at the top of the tab. By default, only active consents are displayed.
  - Select the Update hyperlink to make changes to a consent agreement. You may only change the card expiration date, card holder's ZIP code and email address, and any notes on the agreement.
  - Select the Print hyperlink to print the agreement document.
  - Select the View hyperlink to view the consent agreement and a list of the scheduled payments. This hyperlink only works for recurring agreements.
  - Select the Cancel hyperlink to cancel an agreement.
5. Select the Display Cancelled Consents to include consents that have been cancelled.
6. Select the Display Expired Consents checkbox to include consents that have expired.
7. Select the Search button to refresh the display of the consents.

### **Update Information for a Consent Agreement**

1. Patient Demographics → Account Tab
2. Select the hyperlink for the Responsible Party field. This accesses the Responsible Party window.
3. In the Responsible Party window, select the Credit Card tab.
4. Consents are displayed at the top of the tab.

5. Select the Update hyperlink to make changes to a consent agreement. You may only change the:
  - Card expiration date
  - Card holder's ZIP code
  - Email address
  - Notes
6. Select the Save Changes button to save the changes to the consent agreement.

### **Viewing Credit Card Scheduled Payments**

You may view all the scheduled payments that you have set up. You should check this window regularly to determine whether any scheduled payments failed. The Credit Card Scheduled Payments window accesses the Easy Pay client portal to display information. Therefore, there may be a slight delay before the results are displayed.

1. Billing → Credit Card Scheduled Payments
2. Enter the desired filtering criteria, and then select the Search button.
3. Scheduled payments matching your criteria are displayed.

### **Deleted and Reversed Payments**

Please note that if you delete or reverse a payment that was created using the Easy Pay credit card processing application, then the credit card transaction will be automatically reversed.

### **Viewing the Credit Card Payment Settlement History and Details**

The settlement process is performed by the credit card settlement job, which should be run nightly and which may also be run on demand. When the job runs, it attempts to settle all of the credit card payments entered since the last time the job ran. This includes all payments from recurring consent agreements and payments made on the Patient Portal.

You should review the settlement history daily, or at least regularly, to verify that the settlement is complete. No funds change hands until settlement is run.

Settlement history and details are provided for all payment transactions, including failed transactions and payments that have not yet been settled. The settlement details are stored in the Easy Pay client portal; they are not in the application database. The Settlement History and the Settlement History Detail windows access the Easy Pay client portal to display information. Therefore, there may be a slight delay before the results are displayed.

Easy Pay allows up to 100 transactions to be displayed at a time. This means that if more than 100 transactions match your date range, only 100 will be displayed and you will not know whether there are other transactions in that date range. If you are searching for a specific transaction or transactions, you should make your date range as narrow as possible.

1. Billing → Credit Card Settlements
2. Enter the From and To Dates, and then select the Search button.

3. A list of settlement records matching your criteria will display.
  - Batch Number: This is the reference number for the settlement batch.
  - Amount: This is the total amount of all transactions in the settlement batch.
  - Num of Trans: The number of transactions in the settlement batch.
  - Created On: The date the settlement batch was created.
  - Status: The status of the settlement.
4. To view the transactions in a settlement batch, select the Batch Number hyperlink. Select this hyperlink to access the Settlement History Detail window.
  - Deposit Ref Num: This is the reference number for the payment in the application database. You may select this number to access the Responsible Party Payment window.
  - Tx ID: Transaction ID: This is Easy Pay's transaction number, and it is not used by the application.
  - Submitting App:
  - Tx Status: The status of the transaction.
    - Error: Indicates that an error occurred in the processing of the payment transaction.
    - Failed: Indicates that the payment transaction failed to process
    - Open: Indicates a payment transaction that has been processed, but not yet settled.
    - Refund: Indicates a payment refund that has been processed and settled.
    - Refunded: Indicates a payment refund that has been processed, but not yet settled.
    - Reversed: Indicates a payment transaction that was processed and then voided. This status is only used by credit card companies that process an actual reversal transaction in order to remove the 'hold to buy' amount of the original payment transaction.
    - Settled: Indicates a payment transaction that has been settled.
    - Void: Indicates a payment transaction that was processed and then voided.
  - Is Locked:
  - Responsible Party Name: This is the responsible party for the account. This may not be the cardholder of the card used to make the payment.
  - Acct Name: This is the name of the cardholder of the card used to make the payment.
  - Acct Number: The credit card number. For security purposes, this number is masked so that only the first four digits and the last four digits of the number display. All other digits in the number are represented by Xs.
  - Amount: The payment amount charged or debited.
  - Date: The date and time the payment was entered.
  - Card Name: The abbreviation for the credit card company which issued the card, such as MasterCard, Visa, or American Express.
5. Select the Close button in the Settlement History Detail window to return to the Settlement History window.

6. Select the Close button in the Settlement History window when you have finished viewing the settlement information.

### **Performing an On-Demand Settlement of Credit Card Transactions**

The settlement process transfers money from the credit card company to you for each payment settled. Your administrative super user will have configured an automatic settlement to be performed once a day after normal business hours. You may also perform an on-demand settlement if desired.

The Easy Pay client portal allows up to 100 transactions to be viewed in the Credit Card Transaction History window. However, when you run the settlement process, all the payments that have not yet been settled are processed even if not all of those payments are displayed. If you want to review the payments before you settle them, you should review payments frequently to ensure that all unsettled payments may be displayed.

Transactions list in red cannot be accessed through the application. If you need information on these transactions, you must access them through Easy Pay.

1. Billing → Credit Card Transactions
2. Enter the desired search criteria, and then select the Search button.
3. A list of credit card transactions matching your criteria will display.
4. For each transaction that you want to settle, select the checkbox in the Include In Batch column. Please note that this column is on the far right of the window.
5. Select the Create Settlement button.
6. When settlement is complete, the Settlement Created popup will appear. It will include the batch number, the number of transactions settled, and the total dollar amount.

### **Automatic Payments from Credit Card Consent Agreements**

You can select responsible parties with a current credit card consent agreements on file and automatically generate and allocate payments from those consent agreements. This can help improve your cash flow by enabling you to process payments as soon as the responsible party becomes liable for an amount. You can perform this process at any time and as frequently as appropriate. It is good practice to perform this process before generating statements so that you reduce the number of statements that must be sent.

Automated generation of payments determines the amount of a responsible party's liability and the amount of the consent agreement. Then, it processes a credit card payment for the lowest of those amounts. Automatic allocation to superbills is always done from oldest to most recent charge.

The application will not generate a payment that exceeds the maximum amount of a single payment defined in the consent agreement. It also will not generate a payment that exceeds the total dollar amount defined in the consent agreement.

The application does not, however, limit the number of payments that may be generated in a given amount of time. So, you perform this process with a degree of care. It is possible that

multiple payments will be processed for a responsible party if the responsible party's balance due is greater than the maximum single payment amount but less than the total dollar amount defined in their consent agreement. Therefore, you must establish policies and practices that help you ensure you are making charges that are appropriate to the terms of your agreements with your responsible parties.

Automatic payments are generated and allocated using batch processing. Once you start the process, then you may continue with other work while the application performs the processing. It is recommended that you review the payments and allocations after processing completes so that you know what was actually done. It is possible that a credit card company will deny a charge or will issue a charge amount for less than you expected.

Automatic payments from credit card consents can only be used to generate responsible party payments. It cannot be used for insurance payments.

### **Generate and Allocate Payments from Consent Agreements**

1. Billing menu → Track Superbills ()
2. In the Track Superbills window, select the checkbox for Current CC Consent Only.
3. Select the checkbox for Enable Expanded Filter Criteria.
4. In the Patient Liability Between area, enter 0.01 in the first field and leave the second field blank.
5. In the Responsible Party Liability Between area, enter 0.01 in the first field and leave the second field blank.
6. Enter any other selection criteria desired.
7. Select the Search button to display a list of superbills matching your criteria.

The CC Consent column displays the credit card consent amount available for the responsible party and a two-character code that indicates the extent to which the consent can be used for the patient's liability on the superbill.

- The first character of the code identifies the liability holder.
  - I — Insurance Payer
  - P — Patient
  - N — None
- The second character of the code identifies the extent to which the consent agreement can cover the balance due.
  - F — Full payment
  - P — Partial payment
  - N — No payment

8. Review the superbills, and then select the checkbox for each superbill for which you want to generate a payment.
9. Select the Auto Apply Consents button.

10. A popup message will identify the number of payments you are about to generate.
  - Select the Yes button to generate the payments and payment allocations.
  - Select the No button to cancel.

### **Review the Credit Card Consent Payment Batch**

Automatic payments are generated and allocated using batch processing. Processing time depends on the number of payments and allocations to be made, and on any other processing being done on your network at the time. You may review the batch while it is processing to monitor its progress if you desire, but this is not necessary.

Once the batch completes, you should review it so that you know the payments and allocations that were actually made. It is possible that a credit card company will deny a charge or will issue a charge amount for less than you expected.

1. Tools menu → Batch Process Management
2. In the Batch Process window, select Credit Card Consents in the Batch Process Type field.
3. In the Created Date, select Today or other timespan appropriate to your processing.
4. Select the Search button to display the batches meeting your filtering criteria.
5. Review the batch information displayed.
  - Name: The name of the batch. The name will be 'CC Consents XXX', where XXX is a randomly generated three-digit number identifying the specific batch.
  - Batch Type: This will be Credit Card Consents for the batches for these payments.
  - Status: Identifies whether the data in the batch is available.
    - Detail: Detailed batch data is available.
    - Not Started: The job has not yet started creating the batch.
    - Error: The batch could not generate due to errors.
  - Run Mode: Indicates whether the batch is Running or Not Running.
  - Run Start: This will be blank for credit card consent batches.
  - Run Completed: The number of responsible parties in the batch for which payment generation completed.
  - Run Generated: The number of responsible parties in the batch.
  - Run Errors: The number of responsible parties with payment generation errors in the batch.
  - Run Total: The total number of responsible parties in the batch. This is the total of the responsible parties with payments generated and the responsible parties with payment generation errors.
  - Created: The date and time the credit card consent batch was created.
6. Select the batch Name hyperlink to access the Batch Process Summary window. This window displays summary information for the batch, including the status, the total number of responsible parties in the batch, the number of completed payments in the batch, the total of the payments, and other information.

7. In the Batch Process Summary window, select the View Batch Detail hyperlink. This accesses the Credit Card Consent Detail window.
8. The Credit Card Consent Detail window lists each responsible party in the batch. It also gives the payment amount and the payment reference ID. The bottom of the window displays the total amount of all payments made.
9. If needed, select a Reference ID hyperlink to access the Responsible Party Payment window. This enables you to review the payment and access the Transaction Details to review the allocations made from the payment.
10. If needed, select the Generated hyperlink to access details about the superbills, service dates, and transactions in the payment.

### **Review the Payments in a Credit Card Consent Payment Batch**

You can review the payments in a credit card consent payment batch from the Payments window. The financial batch for credit card consent payments are named with the date, followed by the credit card consent batch name. That name is 'CC Consents *XXX*', where *XXX* is a randomly generated three-digit number identifying the specific batch.

1. Billing menu → Track Payments
2. In the Payments window, select the desired filtering criteria. This may include the Batch name or the Deposit Date for the credit card consent payments.
3. Select the Search button to display a list of the payments matching your criteria.
4. Review the payments as needed.

## **Correcting Payments and Payment Allocations**

When you change a payment item or a payment allocation to a charge on a superbill, the application determines how to handle the change based on the state of the financial batch containing the payment item or payment allocation.

### **Open Batch**

When the payment item or payment allocation to be changed is in an open batch, the payment item or payment allocation is changed. If the payment has been allocated to charges on a superbill, then those allocations are removed from the charges on the superbill. Transfers from the insurance payer to the patient will also be removed.

However, transfers from one insurance payer to another insurance payer (primary to secondary) will not be removed. You will need to enter a new transaction to transfer the money back to the original insurance payer if this is needed.

## **Completed Batch**

You must have security permissions to uncomplete financial batches in order to change a payment in a completed batch.

When the payment item or payment allocation to be changed is in a completed financial batch, the application uncompletes the batch so that it is open. Then the payment item or payment allocation is changed in the now open batch. Payment allocations and transfers associated with the changed payment are handled in the same way as when changing a payment from an open batch.

After you change the payment item or payment allocation, you must complete the batch you just re-opened.

## **Closed Batch**

When the payment item or payment allocation to be changed is in a closed batch, a reversing entry for the original payment item or payment allocation must be made and a new, corrected payment item or payment allocation must be made. Both these entries are made automatically by the application in an open financial batch. When you have a default batch selected, the application uses your default batch for the two new entries. When you do not have a default batch selected, the application prompts you to select an open batch to be used for the new entries.

## **Determining the Batch Used for Changes**

The following rules are used to determine the financial batch used for changes to payments and payment allocations. The rules are applied in order.

1. When the user selects a batch, the user-selected batch is used. This selection overrides all other rules.
2. When an insurance deposit is entered and the payment is in an open batch, then the insurance deposit batch is used.
3. When an account responsible party payment is entered and the payment is in an open batch, then the account responsible party payment batch is used.
4. When a default batch for the current user is available, then the user's default batch is used.

## **Changing a Payment**

1. Billing → Track Payments
2. Search for and select the reference number for the desired payment item.
3. In the Payment window, make the needed corrections.
4. Select OK to change the payment.

## **Changing an Allocation to a Superbill Charge**

1. Billing → Track Payments
2. Select the reference number for the payment item from which the allocation was made.
3. Select the Transaction Details slider.
4. In the slider, select the Name link for the transaction you want to change. This opens the Transaction window.
5. Make the necessary changes to the allocation.
6. Select the OK button to save the change and close the Transaction window.

## **Deleting Payments or Payment Allocations**

When you delete a payment item or payment allocation, the application determines how to handle the deletion based on the state of the financial batch containing the payment item or payment allocation.

Please note that if you delete or reverse a payment that was created using the Easy Pay credit card processing application, then the credit card transaction will be automatically reversed.

### **Open Batch**

When the payment item or payment allocation to be deleted is in an open batch, the payment item or payment allocation is deleted. If the payment has been allocated to charges on a superbill, then those allocations are removed from the charges on the superbill. Transfers from the insurance payer to the patient will also be removed.

However, transfers from one insurance payer to another insurance payer (primary to secondary) will not be removed. You will need to enter a new transaction to transfer the money back to the original insurance payer if this is needed.

### **Completed Batch**

You must have security permissions to uncomplete financial batches in order to delete a payment item or payment allocation from a completed batch.

When the payment item or payment allocation to be deleted is in a completed financial batch, the application uncompletes the batch so that it is open. Then the payment item or payment allocation is deleted from the now open batch. Payment allocations and transfers associated with the deleted payment are handled in the same way as when deleting a payment from an open batch.

After you delete the payment item or payment allocation, you must complete the batch you just re-opened.

## **Closed Batch**

When the payment item or payment allocation to be deleted is in a closed batch, a reversing entry for the original payment item or payment allocation must be made and a new, corrected payment item or payment allocation must be made. Both these entries are made automatically by the application in an open financial batch. When you have a default batch selected, the application uses your default batch for the two new entries. When you do not have a default batch selected, the application prompts you to select an open batch to be used for the new entries.

### **Deleting a Payment**

1. Billing → Track Payments
2. Search for the desired payment item.
3. Select the Delete icon for desired payment item.
4. A confirmation popup window appears.
  - Select OK to delete the payment.
  - Select Cancel to cancel the deletion.

### **Deleting an Allocation to a Superbill Charge**

1. Billing → Track Payments
2. Search for the desired payment item.
3. Select the reference number for the payment item from which the allocation was made.
4. Select the Transaction Details slider.
5. In the slider, select the Delete icon for the transaction you want to delete.
6. A prompt will ask you to confirm the deletion.
  - Select the Yes button to delete the payment.
  - Select the No button to cancel the deletion.
7. Select the OK button to save the change and close the Payment window.

## **Allocating Patient Visit Payments**

Patient payments for the copay amount usually automatically allocate to the superbill. However, there are times when payments do not automatically allocate, and you must allocate them manually. You should look for unallocated visit payments regularly.

1. Billing → Track Payments
2. Select the Show Only Unapplied Payments checkbox, and then select the Search button.
3. Select the Reference hyperlink for a responsible party payment with an unallocated amount.
4. In the Payments window, display the Transaction slider.
5. In the Superbill field, search for and select the superbill for the visit payment.

6. In the Transaction window, allocate the copay amount to the appropriate charge.
7. Verify the superbill status or select the desired status.

## Allocating Interest Paid by Insurance Payer

When an interest payment is received at the same time as an insurance payment, they can both be allocated at the same time.

Generally, interest is paid on individual procedure charges, and you enter the interest on individual charge items. Occasionally, interest is paid on a claim as a whole. When this happens, you can enter the interest on a single charge item or across all charge items. If you prefer to see that the interest was paid on the claim, not individual items, you will need to define a procedure code for interest payments. Then when an interest payment is received, you must add the interest payment procedure code to the superbill before entering the payment.

1. Billing → Track Payments
2. Search for the desired payment, and then select its Reference hyperlink.
3. In the Payments window, display the Transaction slider.
4. In the Superbill field, search for and select the superbill for which the interest payment was received.
5. In the Transaction window, enter the regular insurance payment and adjustment first.
6. Select the Procedure Level Details slider.
7. In the slider, enter adjustments to raise the balance on each charge for which interest has been paid.
  - a. In the Code column, select the procedure code for the charge item.
  - b. In the Amount column, enter the interest amount as a negative amount.
  - c. In the Type column, select the adjustment type appropriate for the interest payment. You may want to define a specific adjustment type for interest payments.
  - d. Repeat for each charge.
8. In the slider, enter the interest payments on the charges.
  - a. In the Code column, select the procedure code for the charge item.
  - b. In the Amount column, enter the interest amount as a positive amount.
  - c. In the Type column, select the payment type appropriate for the interest payment. You may want to define a specific payment type for interest payments.
  - d. Repeat for each charge.

## Balance Write Off Processing

The application includes functionality that helps you manage superbill balances and write them off when appropriate. It is important to understand that when using this functionality, the application writes off balances on individual procedures on a superbill. When performing this process, you must review superbills to determine if any changes are needed and if a write off is appropriate.

To use the balance write off functionality, you must have the needed security access.

### <<Revised>> Use Track Superbills to Identify and Write Off Balances

Use the Track Superbills window to identify superbills that meet your practice's requirements for writing off the balance. You may want to define a search filter for processing write-offs. Your filter can include the order of the columns in the window. Your filter enables you to quickly search for superbills and review their balances.

1. Billing menu → Track Superbills
2. Select the Advanced button to display the filtering criteria.
3. Select the Enable Expanded Filter Criteria checkbox.
4. Enter the search criteria appropriate for your practice's write off requirements. This may include:
  - Superbill Status to identify superbills for which claims have been processed.
  - Date range to identify balances older than a certain date. You may search by Service Date, Last Filed Date, or Visit Date. The Custom Dates timespan may be used to identify items older than a date by leaving the From date empty and entering only an Ending date.
  - Patient Liability Between to identify patient balances within your defined balance range. This will generally be balances between 0.01 and your balance threshold.
  - Responsible Party Liability Between to identify responsible parties who may have individual superbills that meet your write off criteria, but whose total balance is greater than your write-off amount or responsible parties to whom you would need to send a statement anyway.
  - Insurance Liability Between to identify insurance balances within your defined balance range. This will generally be balances between 0.01 and your balance threshold.

Remember that searches use all the criteria selected. If you enter a patient liability range and an insurance liability range, then only superbills matching both will be displayed in the search results. Search for these separately if you are only interested in one payer's balance.
5. Select the Search button to display a list of all superbills matching your selection criteria.
6. If needed, select the Advanced button to hide the filtering criteria and maximize the list of superbills.

7. Review the superbills to identify any which have a balance you want to write off. You may want to review:
  - Status: If the status indicates a potential problem, such as Hold, Dispute, or other status used by your practice, then you may want to further investigate the superbill before writing off the balance.
  - Total Liability, Patient Liability, Insurance Liability, and Responsible Party Liability: Verify that the liability amounts meet your threshold for a write-off, and that the liability of the various parties is as expected.
8. Select the checkboxes for the superbills which have balances that you want to write off.
9. Select the Writeoff Balance button.
10. In the Select Writeoff Details window:
  - a. Select the Insurance checkbox to write off the insurance payers balances.
  - b. Select the Adjustment Type to use for the insurance payer write off adjustments.
  - c. Select the Patient checkbox to write off the patient balances.
  - d. Select the Adjustment Type to use for the patient write off adjustments.
  - e. Select the financial Batch for the adjustments.
  - f. If desired, enter a Remark. The remark information is the same as in the Patient Remark window. You may enter:
    - Remark text
    - The application areas in which the popup remark will display
    - Effective and expiration dates for the remark
  - g. Select a Patient Status to assign to the patient, if desired.
  - h. <<New>>Select a Superbill Status to assign to the superbills, if desired.
  - i. Select the 'Include Follow Up Action' checkbox if you want the write off to be identified as a follow up action on the superbills.
  - j. Enter any appropriate notes in the Superbill Notes field.
  - k. Select the OK button to process the write off adjustments and return to the Track Superbills window.

### **Use the AR Active Writeoff Report to Identify and Write Off Balances**

You may also use the AR Active Writeoff report to identify superbills that meet your practice's requirements for writing off the balance. This report generates an Excel file that enables you to sort and filter the data as needed.

When you generate the report, the application also opens the Select Writeoff Details window. After reviewing the data in the report, you can use the Select Writeoff Details window to write off the balances if appropriate. You may write-off up to 5,000 superbills at one time.

It is important to understand that when writing off balances from this report, you are writing off every balance listed. If the report includes balances that you do not want to write off, then you must change your filtering criteria and generate the report again. Removing a balance item

from the report file does not change what will be written off if you complete that action. The balances are marked in the database when the report is generated. The report file is simply so that you can view them.

You may want to define and save a filter or filters for the report. This will enable you to search quickly for the superbills when reviewing their balances.

If you do not have security rights to the balance write off functionality, then generating the report will open the Excel file, but the Select Writeoff Details window will not open.

1. Reports () icon
2. In the Excel folder, select the AR Active Writeoff report.
3. Enter the filtering criteria appropriate for your practice's write off requirements.
4. Select the View button to generate the report. This opens Excel to display the report data, and it opens the Select Writeoff Details window.
5. Review the report to determine whether you want to write off all the balances listed.
  - If the report includes balances that you do not want to write off, then you must change your filtering criteria and generate the report again.
  - Removing a balance item from the report does not change what will be written off if you complete that action. The balances are marked in the database when the report is generated. The file is simply so that you can view them.
6. If you want to write off all the balances, proceed to step 7. Otherwise, simply close the Select Writeoff Details window.
7. In the Select Writeoff Details window:
  - a. Select the Insurance checkbox to write off the insurance payers balances.
  - b. Select the Adjustment Type to use for the insurance payer write off adjustments.
  - c. Select the Patient checkbox to write off the patient balances.
  - d. Select the Adjustment Type to use for the patient write off adjustments.
  - e. Select the financial Batch for the adjustments.
  - f. If desired, enter a Remark. The remark information is the same as in the Patient Remark window. You may enter:
    - Remark text
    - The application areas in which the popup remark will display
    - Effective and expiration dates for the remark
  - g. Select a Patient Status to assign to the patient if desired.
  - h. Select the OK button to process the write off adjustments and return to the Track Superbills window.

## Entering Refunds

The application includes functionality that helps to automate the refund process.

A refund may be made for a single amount on a single procedure on a single superbill. Or, it may be several small amounts on multiple procedure charge items on a superbill. It may even be multiple procedure charge items on multiple superbills.

There are several ways in which refunds can be entered and processed. The recommended method is to process a refund from a payer credit. This handles the refund as an over payment. Please review the Refund Processing Workflow section below for more information.

You can also enter a refund as a negative payment. This is a good method because the negative payment takes money out in the same manner in which it was put in.

The third refund method is entering a negative adjustment. This method is not recommended because a negative adjustment takes the money out by reducing the amount charged, which is not a true reflection of the transaction.

To most effectively use the refund process, your administrative super user must have performed the following set up tasks.

- Modify your payment types so that the refund method is identified.
- Assign the appropriate security rights to users who will approve refunds and/or who can issue refunds without an approval.
- Identify the recipients of refund approval messages for each user who processes refunds.

### **Security for Processing Refunds**

You must have security rights to process refunds. Your administrative super user may have set up users' security rights in a variety of ways to fit the needs of your practice.

Users who have security rights for payment entry have the ability to create and review payer credits and to request a refund from a payer credit. Additional security rights must be granted to users who will approve those refund requests and to users who may process refund payments for approved requests.

If your practice does not use an approval process for refunds, users may be given security rights to process refund payments without an approval. This security level may also be appropriate for the billing manager or another staff member even if your practice does have a refund approval process.

If you are using the check printing functionality, then security rights must be granted to the user or users who will print the refund checks.

Please note that if you process refunds by entering negative payments or negative adjustments, then no additional security rights are needed. Negative payments and negative adjustments can be entered by any user who has security rights for payment entry.

## **Refund Payment Types**

You may want to create patient refund and insurance refund payment types so that you can easily identify and report on refunds. (Payment Types are defined in List Editor → Payment Entry → Payment Types.)

## **Refund Payment Method**

Many practices issue checks for all refunds, regardless of how the original payment was received. Some practices, however, prefer to issue a refund as a credit card transaction when the original payment was made by credit card. You can identify your preferred refund method for each payment type.

The refund method is the payment type that you prefer to use when the refund payment is made. It is recommended that you define a specific payment type or payment types for refunds. For example, if you issue refund checks, define a Refund Check payment type. If you also issue refunds by credit card, define a Refund Credit Card payment type. The refund payment types will make it easy for users to identify payments and refunds on financial reports, statements, and patient ledgers.

When refunds are processed, the application sums all of the payer credits for a particular responsible party or insurance payer so that a single refund can be issued for the full amount. The user has the option of selecting any payment type when processing refund payments. But, if you have identified different refund methods for different payment types, then the user can use the refund method to determine how to select payer credits for refund processing.

So, for example, Jane Doe has a total payer credit amount of \$50 dollars. Of that total amount, \$20 dollars was paid by credit card. If you have identified a refund method of credit card for your credit card payment types, then the user can decide to process the payer credits together for a single refund. Or the user can process two refunds so that the \$20 originally paid by credit card is refunded by credit card.

### *Refund Checks*

You may print refund checks from the application if desired. Checks print on the standard three-part preprinted business check form, with the check on the bottom portion of the form.

An audit trail entry is created every time checks are printed.

### *Credit Card Refunds*

Please note that refunds cannot be processed as a credit card transaction. To process a credit card refund, please contact Easy Pay to process the actual credit card transaction. Then enter the negative payment in the application without using the Scan Credit Card button.

## Refund Processing Workflow

The application includes functionality that helps to automate the refund process. The general refund workflow is:

1. Identify overpaid superbills.
2. Create a payer credit for the amount of the overpayment on a superbill.
3. Identify responsible parties and insurance payers who have payer credits and who also do not have any amount owed.
4. Create a refund approval request message, and send it for approval.

This step and the following approval step are optional. If your business practices do not, then your administrative super user will have granted you the security rights to process refunds without approval.

5. Review and approve refunds.
6. Process the refund payments.

## Refund Status

The refund status is a property of the payer credit that identifies the payer credit's position in the refund process. The application includes the following refund statuses.

- **Open:** This status is given to the payer credit when it is created. The Open status indicates that a refund has not been requested.
- **Pending:** This status is given to the payer credit when you create a refund request for the payer credit.
- **Approved:** This status is given to the payer credit when you or another user approves the refund request for the payer credit.
- **Rejected:** This status is given to the payer credit when you or another user rejects the refund request for the payer credit.
- **Closed:** This status is given to the payer credit when a refund payment is created from the payer credit. You cannot create another refund for the payer credit once the status is Closed.

## Identify Overpaid Superbills

Use the Track Superbills window to identify superbills that have been overpaid. You may want to define a search filter for overpaid superbills. This will enable you to search quickly for the superbills.

It is recommended that you search for overpaid superbills on a regular basis. This may be monthly, weekly, or daily, depending on the characteristics of your practice and your business policies regarding payments and refunds.

1. Billing menu → Track Superbills
2. Select the Advanced button to display the filtering criteria.
3. In the Superbill Status field, select Overpaid.

4. In the Maximum Items Returned field, enter -1 so that all overpaid items will be displayed.
5. Leave all other filtering criteria blank.
6. Select the Search button to display a list of all overpaid superbills.
7. Select the Advanced button to hide the filtering criteria and maximize the list of superbills.
8. Select the superbill ID hyperlink to access a superbill to review the payments. Refer to the Review an Overpaid Superbill and Create a Payer Credit section for instructions on the second task in the refund workflow.
9. Repeat step 8 for all overpaid superbills.

### **Review Overpaid Superbills and Create Payer Credits**

Use this process to review overpaid superbills, and create payer credits for the overpayment amounts. You can also change the status of the superbill to Complete when you create the payer credit.

It is recommended that you review overpaid superbills and create payer credits for the overpayment amounts on a regular basis. This ensures that your superbills are completed in a timely manner. It also ensures that all overpayments are promptly identified, and payer credits created.

You can create a payer credit for all or part of the payment amount received from the payer. You cannot create a payer credit for more than the payment amount. This ensures that you do not refund more money than you received.

When you create the payer credit, you can transfer an amount from one payer, such as the insurance payer, to the payer, such as the responsible party, for whom the payer credit will be created. This will be the case, for example, when insurance payer pays more than anticipated so you need to refund the responsible party's copay or coinsurance payment.

1. Billing menu → Track Superbills
2. Search for overpaid superbills using the criteria described in the Identify Overpaid Superbills section above or a filter you have defined for overpaid superbills.
3. Select the superbill ID hyperlink to access a superbill.
4. In the Superbill window, select the Payments slider to review the payment allocations.
5. If the payment allocations are correct and the superbill is overpaid, then select the Create Payer Credit button.

**Note:** If the payment allocations are not correct, then you must correct them in the Transaction window in the usual manner. You cannot correct payment allocations using the refund processing functionality.

6. In the Create Payer Credit window, select the Payer To Credit for the refund.
7. If desired, select the Expand (⊕) icon for a payer to display the individual charges.
8. To transfer money to the payer credit, select the Transfer checkbox for the payer to be credited.

9. If needed, transfer money from another payer to the payer to be credited by selecting the Transfer checkbox for the payer from which the money will transferred.
10. When you have indicated all the necessary transfers, the application will populate the Transfer Amount and Adjusted Balance amount fields for all the payers.
11. The application will also populate the Amount To Credit field. The payer credit will be created for this amount.
12. Select the Complete Superbill checkbox if you want to change the superbill's status to Complete when the payer credit is created.
13. Select the OK button to transfer money from one payer to the other, create the payer credit, and return to the Superbill window.  
  
When you do this, the application will add a comment to the original payment item (also called deposit) identifying the superbill from which the payer credit was made.
14. In the Superbill window, select the OK button to update the superbill and return to the Track Superbills window.
15. Repeat steps 3 through 14 for all overpaid superbills.

### **Review Payer Credits and Request Refunds**

Use this process to review the payer credits, and when appropriate, to request a refund for payer credits.

You may want to define a specific filter for the Payer Credits window to use when reviewing credits for possible refunds. Your filter may include both filtering criteria and column settings to make reviewing the credits easier. You may want to include the following filtering criteria:

- Select a Refund Status of Open.
- Select the 'Include Items in Open Batches' checkbox.
- Select the 'Include Items in Complete Batches' checkbox.
- Select the 'Include Items in Closed Batches' checkbox.
- Select the 'Show Only Unapplied Payer Credits' checkbox.
- Select the 'Show Only With Inactive Superbills' checkbox.
- Select the 'Responsible Party' checkbox.

Refunds to insurance payers are usually made under specific circumstances for a specific payment. Generally, you will not be searching for insurance payers when reviewing payer credits for refunds.

1. Billing menu → Track Payer Credits
2. Enter the desired filtering criteria for payer credits, and then select the Search button.
3. Review the payer credits to determine if a refund is appropriate. You may want to review:
  - Payer Balance: If the payer has a balance due, you may want to apply the payer credit to the charges due instead of issuing a refund.

- Has Active Superbills: If the payer has active superbills (any status other than 'complete'), then you may want to wait. Once the superbills have been processed and claimed, and the insurance payer pays, then the responsible party may owe for charges on these superbills.
  - Next Appointment: If any of the patients associated with the responsible party have an appointment scheduled, then you may want to hold the credit to apply to charges from the upcoming visit.
4. Select the checkboxes for all the payer credits for which you want to request refund approval.
  5. Select the Create Refund Approval Message button.
  6. The New Message window opens, and displays a list of the responsible parties for whom a refund is requested.
    - a. Enter a recipient in the Assign To field. This may be prepopulated based on default message settings.
    - b. Select a Due Date if desired.
    - c. Select the OK button to send the message and close the Message window.
  7. The application changes the refund status for the selected payer credits from Open to Pending.

### **Review and Process Refund Requests**

Use this process to review the refund request messages, and to approve or reject the refund requests.

1. Either:
  - Desktop → Message Time Stamp or More Options () icon
  - Message Center → Created date
2. In the Message window, the Refund tab displays a list of the payer credits for which a refund has been requested.

The display on the Refund tab is the same as the display in the Payer Credits window. You may want to review:

- Payer Balance: If the payer has a balance due, you may want to apply the payer credit to the charges due instead of issuing a refund.
  - Has Active Superbills: If the payer has active superbills (any status other than 'complete'), then you may want to wait. Once the superbills have been processed and claimed, and the insurance payer pays, then the responsible party may owe for charges on these superbills.
  - Next Appointment: If any of the patients associated with the responsible party have an appointment scheduled, then you may want to hold the credit to apply to charges from the upcoming visit.
3. To enter a comment:
    - a. Select the checkbox for the desired payer credit or credits.
    - b. Select the Comment button.

- c. In the Refunds Notes window, enter the comment and select the OK button to return to the Message window.
4. To reject a refund request:
  - a. Select the checkbox for the desired payer credit or credits.
  - b. Select the Reject button.
  - c. In the Refunds Notes window, enter the comment and select the OK button to return to the Message window.
  - d. The Refund Status changes to 'Rejected' and the checkbox column is displayed in red.
5. To approve a refund requests:
  - a. Select the checkbox for the desired payer credit or credits.
  - b. Select the Approve button.
  - c. The Refund Status changes to 'Approved' and the checkbox column is displayed in green.
6. When you have acted upon all the refund requests, select the Complete button.

### **Generate the Refunds**

Use the following process to generate the refund payments for approved refund requests. If you have the necessary security rights, you can generate the refund payments for requests that have not been approved or for which no approval was requested.

When you generate the refund payments within the application, you may also print checks for the refunds or generate a payment file which may import into a financial system, such as Intuit QuickBooks, from which you can print checks.

If you are issuing refunds by credit card, the refund payment can be entered in the application, but the credit card transaction cannot. You must process the credit card transaction for the refund with your credit process processor, such as Easy Pay.

You may want to define a specific filter for the Payer Credits window to use when generating refunds. Your filter may include both filtering criteria and column settings to make reviewing the credits easier. Depending on your refund policies and procedures, you may want to search for payer credits with a refund status of 'Approved', with an approval date within a specific timespan, and in all batch states. You may also want to filter for only payers with inactive superbills, since a superbill and charges may have been created in the time since the refund was approved.

1. Billing menu → Track Payer Credits
2. Enter the desired filtering criteria for payer credits, and then select the Search button.
3. Review the payer credits to determine which refunds to process. You may, for example, want to process refunds to be issued by check separately from refunds to be issued by credit card.
4. Select the checkboxes for the payer credits for which you want to generate refund payments.
5. Select the Refund button.

6. In the Refund window, select the Refund Payment Type.
  - The Refund Payment Type will default to the payment type that is the refund method if all the payer credits have the same refund method. You can override the default selection if desired.
  - A yellow warning message will appear at the top of the window when the selected payer credits do not all have the same refund method. You may then choose to refund all the selected payer credits with a single payment type, or you may unselect the payer credits that you do not wish to process.

Select the Expand () icon for a payer to see all of the payer credits and their refund methods.
7. In the Reference # section, select the radio button for the manner in which you want the payment reference numbers to be created.
  - Starting Reference #: Use when you will be printing checks. Enter the check number from the first check form. Payments will be automatically numbered starting with this number. The numbers appear in the Refund Ref # column for each refund listed.
  - Original Deposit Reference #: Use if you want the refund payment's reference number to include the reference number of the original payment. The numbers appear in the Refund Ref # column for each refund listed.
  - Manually Enter Reference #: Use if you want to enter a specific reference number for an individual item. This may be needed, for example, if a single check did not print correctly and must be reprinted. When selected, you must enter the desired reference number in the Refund Ref # column.
8. If desired enter a comment for one or all of the refund payments.
  - Select the Notes () icon to enter a comment for a specific refund payment.
  - Select the Comment All button to enter a comment for all the refund payments listed.
9. To print checks:
  - a. Select the Print Checks button.
  - b. If all the checks printed correctly, go to the next step. If any checks did not print correctly, use step 7 to enter a new check number and repeat the process until all checks are correctly printed.
10. To create a CSV file of the refund payments for import into a financial application:
  - a. Select the Save To Excel button.
  - b. Browse to the location in which you want to save the file.
  - c. Enter the File Name for the file.
  - d. Select the Open button to save the file.
11. To print the check register, select the Register Report button. It is recommended that you review the report before continuing to the next step to generate the refunds.

12. Select the OK button to create the refund payments, and close the Refund window.

**Note:** If you are printing checks, do not select the OK button to create the refund payments until all of the checks are correctly printed.

When you create the refund payments, the application also updates the payer credit balance to \$0.00 and changes the refund status of the payer credit to 'Closed'.

### **Refunding a Payer Credit**

When processing refunds manually, you can easily enter a refund payment while reviewing your payer credits. If you typically create payer credits from overpayments on superbills, then you can process all refunds from the Payer Credits window.

When you have more than one payer credit from a responsible party, you can create a single refund payment for the entire credit by processing all of the payer credits at one time. If you want to show an individual refund for each payer credit for the responsible party, then process the payer credits one at a time.

When you create a refund payment from one or more payer credits, you can refund the entire credit amount or only a portion of the credit amount.

The reference number for the refund payment is based on the reference number for the original payment from which the payer credit was created.

1. Billing → Track Payer Credits
2. Select the Show Only Unapplied Payer Credits checkbox.
3. Enter any additional search criteria if desired.
4. Select the Search button to display a list of all payer credits matching your criteria.
5. Select the checkboxes for the payer credits that you want to refund.
  - If you select credits for multiple payers, a refund payment will be created for each payer.
  - If you select multiple credits for a single payer, one refund payment will be created for that payer. The refund payment amount will be for the sum of all the credits. You can change the amount if desired.
6. Select the Refund button.
7. The Refund window opens displaying an entry for each refund payment to be created.
8. If desired, you may change the payment Amount to anything less than the full payer credit amount.
9. If desired, enter Comments for the refund payment.
10. Select the OK button to process the payments.

## Entering a Refund as a Negative Payment

When processing refunds manually, you can enter a refund as a negative payment. This is a good method because the negative payment takes money out in the same manner in which it was put in.

1. Billing → Track Payments
2. Either:
  - Select the New Insurance Payment button if the refund is to an insurance payer.
  - Select the New Responsible Party Payment button if the refund is to a responsible party.
3. In the New Payment window, enter the refund information.
  - a. In Payment Type, select the appropriate payment type for the refund.
  - b. Select the desired Batch.
  - c. Enter your refund check number in the Reference Number field.
  - d. In the Payer field, select the insurance payer or responsible party to whom the refund is being issued.
  - e. In the Amount Paid field, enter the refund amount as a negative.
  - f. In the Deposit Date field, enter the date of the refund.
4. Search for and select the Superbill for which the refund is being issued.
5. In the Transaction window, enter a negative payment for the amount of the refund.
6. Use the statement note to explain the purpose for the refund.
7. Repeat steps 5 and 6 for each charge item on the superbill for which a refund is being made.
8. If needed, repeat steps 4 through 7 to refund amounts for another superbill.

## Posting a Refund as a Negative Adjustment

When processing refunds manual, you can enter a refund as a negative adjustment. This method is not recommended because a negative adjustment takes the money out by reducing the amount charged, which is not a true reflection of the transaction.

1. Billing → Track Payments
2. Either:
  - Select the New Insurance Payment button if the refund is to an insurance payer.
  - Select the New Responsible Party Payment button if the refund is to a responsible party.
3. In the New Payment window, enter the refund information.
  - a. In Payment Type, select the appropriate payment type for the refund.
  - b. Select the desired Batch.
  - c. Enter your refund check number in the Reference Number field.

- d. In the Payer field, select the insurance payer or responsible party to whom the refund is being issued.
  - e. In the Amount Paid field, enter 0.00 as the refund amount.
  - f. In the Deposit Date field, enter the date of the refund.
4. Search for and select the Superbill for which the refund is being issued.
  5. In the Transaction window, enter a negative adjustment for the amount of the refund.
  6. Use the statement note to explain the purpose for the refund.
  7. Repeat steps 5 and 6 for each charge item on the superbill for which a refund is being made.
  8. If needed, repeat steps 4 through 7 to refund amounts for another superbill.

## Attachments for Payment Items

You can attach a scanned document or other file to a deposit (that is, a payment item such as a check from a patient or insurance payer or a deposit created by ERA processing). This enables you to scan the actual check, a paper EOB, a letter from the patient, or other item, and attach it to the deposit to help document the payment. To perform this procedure the document or image file must already exist in a folder on your machine or on the server, and the deposit must already exist in the application database.

You can attach a document or file to a deposit item from the Document Linking window or from the Attachment slider on the Deposit window.

Attachments for deposits do not require approval. An attachment can be removed from the deposit if needed. Attachments can be made to deposits in open, complete, and closed batches.

### Document Linking

1. Desktop → Document Linking (  ) icon
2. Select the Manually Integrate From Folder radio button.
3. Select the From Folder checkbox.
4. Enter the path to the file or select the Browse button, and browse to the desired folder.
5. Select the desired Document Integration Option.
  - Copied from the source: the file will be copied from the source. The original copy will remain in the source folder.
  - Linked to the source: the file will not be embedded in the deposit record. It will remain in the source folder and will be linked to the deposit record. (Note that linking does not put the document in the database. Instead, it simply establishes a link to the document in its present location. If the document is later moved, deleted, renamed, or overwritten, the link to the attachment will no longer work.)
  - Moved from the source: the file will be moved from the source to the deposit record. The original file will be deleted.

6. Select the Deposit Reference radio button, and search for and select the desired deposit. The payment amount and the payer will appear beneath this field.
7. Select OK, and continue the process on the Documents Are Being Copied (or Linked or Moved) screen.
8. Select the document or documents to be linked. Select multiple documents only if they are to be attached to same deposit.
  - Select individual documents for linking: select the checkbox located on the top-left corner of the document icon you want to link.
  - Select all documents for linking: select the checkbox link located at the bottom of the Open documents field.
  - De-select all open documents from linking: select the Empty checkbox link located at the bottom of the Open documents field.
9. Select the "Attach Selected Files" button. This moves the selected files to the Document Pages field on the right side of the screen.
10. In the Deposit field, search for and select the desired deposit item if it is not already identified.
11. The Type field will default to Deposit.
12. In the Doc. Name field, enter a name for the document group if desired, or accept the default. This simply names the group of files that you are attaching together.

The document group name is used in this screen to categorize files, and also appears in the Attachment slider.

### **Deposit Attachment Slider**

1. Billing → Payment Entry
2. In the Reference Number field, search for and select the desired deposit item.
3. Select the Modify button.
4. Select the Attachment slider.

This displays a list of all files attached to the deposit.
5. Select the New button.
6. In the Attachment window, select the Import button.
7. Select the Import Files option.
8. Browse to and select the file you want to attach.
9. In the Attachments window, enter a Name for the attachment.
10. Enter any Notes if desired.

## Reviewing Payer Credits

The Payer Credit window enables you to display a list of payer credits. It is recommended that you review payer credits at least once a week. This will help you ensure that payer credits are allocated to charges in a timely manner. When a responsible party or an insurance payer has a payer credit, you can allocate money from that payer credit to charges on a superbill. You allocate payment amounts to charges from a payer credit in the same way as you allocate payment amounts to charges from either of the Payment windows.

The Payer Credit window displays the payment reference number for the payment item from which the payer credit was created, and the responsible party or insurance payer to whom the amount is credited. It also displays the billing provider, service site, and financial center to which the credit balance is currently allocated. The Amount column displays the full amount of the payer credit. The Available Balance column displays the amount available to be allocated to charges.

Select the Payer Credit hyperlink to access the Payer Credit window. Select the Deposit Reference hyperlink to access the Payment window for the payment from which the payer credit was created.

From the Transaction Details slider, you can select a superbill to which you want to allocate money from the payer credit. For responsible party payer credits, you may auto allocate to superbill charges with the same billing provider, service site, and financial center as the payer credit.

1. Billing → Track Payer Credits
2. Select the Show Only Unapplied Payer Credits checkbox.
3. Enter any additional search criteria if desired.
3. Select the Search button to display a list of all payer credits matching your criteria.

### Viewing a Responsible Party's Payer Credits

You may also view a responsible party's payer credits while reviewing a patient's account information.

1. Patient Demographics → Accounts tab
2. The Payer Credit Balance field displays the total amount applied to the responsible party.
3. Select the Payer Credit Balance amount hyperlink to access the Payer Credits window.
4. The Payer Credits window displays a list of all payer credits that have been applied to the responsible party.
  - The Receipt column displays the amount of the payer credit.
  - The Receipt Balance column displays the amount available to be applied to charges.

## Tracking Financial Transactions

A transaction is set of financial actions made to the charges on a superbill. These actions are basically line items in a ledger, and may include the application of money to charges from a payment, adjustments to charges, and transfers of liability from one payer to another (such as from primary insurance payer to secondary, or from insurance payer to responsible party). Transactions make it easier for you to review and follow all of the financial actions made on a superbill.

Transactions are most often associated with payment items, but they do not have to be. A transaction can contain adjustments or transfers of liability when no payment has been made. A transaction can also contain allocations to charges from a payer credit.

Each financial action in a transaction is associated with a financial batch. When the transaction is created, all of actions taken in that transaction are in the financial batch assigned to the transaction. However, you may later reassign individual actions in a transaction to another financial batch. The batch for the transaction does not have to be the same as the batch for the payment item or for any of the charges on the superbill.

Each transaction is automatically assigned a transaction number when the transaction is created. The transaction number is the payment reference number-superbill ID when the transaction is associated with a payment item. When adjustments or transfers are made that are not associated with a payment item, the transaction number is TRAN-superbill ID. You can change the transaction number if desired.

From the Transaction window, you can view detailed financial actions taken on the superbill and its subsequent claim or on individual procedures on the superbill. These are viewed from the Claim Level Detail slider and the Procedure Level Detail slider.

### Tracking Transactions

The Track Transactions window lists transactions that match your selection criteria. The window displays the transaction number and information about the transaction.

From this window, you can:

- Search for and review transactions.
- Select the appropriate hyperlink to access the transaction, superbill, patient, deposit, or financial batch.
- Select the Delete icon (  ) to delete a transaction.
- Select the New button to create a new transaction. This accesses the Transaction window.

## Creating a Transaction

You can create a transaction that is not associated with a payment. This enables you to make adjustments or transfers directly to the superbill.

1. Billing → Track Transactions
2. Select the New button to access the Transaction window.
3. Select the desired Superbill.
4. Accept the automatically generated Transaction number, or enter a number of your own.
5. Select the desired Batch. This will be your default batch if one is selected.
6. Since the transaction is not associated with a payment, the fields in the Insurance and Responsible Party sections of the window will be empty.
7. Enter actions on a charge:
  - a. In the Allowed Actual field, enter the actual amount allowed by the insurance payer if you are entering an insurance payment.
  - b. In the Payment Amount field, enter the amount paid by the insurance payer for this charge.
  - c. In the Contract Adj field, enter the contractual adjustment amount for the charge. This is the difference between the charge amount and the actual amount allowed.
  - d. In the Transfer To Patient field, enter any amount you want to transfer from insurance liability to responsible party liability.
  - e. In the Adjustment field, enter any additional adjust amount.
  - f. In the Patient Payment Amount field, enter the amount paid by the responsible party for this charge.
  - g. In the Transfer To Insurance field, enter any amount you want to transfer from responsible party liability to insurance liability.
  - h. In the Patient Adjustment Amount field, enter the amount of any adjustment you are making the patient-liable portion of the charge.
  - i. Review the Total Paid and Total Adjusted amounts. If these are not correct, make any changes needed using substeps a through h.
  - j. Repeat substeps a through i for all charges on the superbill.
8. If appropriate, select the Update Superbill Status checkbox, and then select the appropriate status for the superbill.
9. Either:
  - Select the Apply button to save your entries in the database and continue working in this window.
  - Select the OK button to save your entries and close the window.

## Payment Management Services

Payment management is an optional service offered through ClearGage®. Payment management services include accounts receivable management, credit card processing, and payment plan financing that help you manage your patient and responsible party payments. ClearGage is Payment Card Industry (PCI) Level 1 certified. They comply with the 'Truth in Lending Act' and all applicable state and federal lending regulations.

When you enroll with ClearGage, you may establish a prompt-payment discount and payment plan options you want to offer patients. ClearGage then manages patient notification when a superbill balance is due from the patient, accepts and processes patient payments through their payment portal, and establishes payment plans and financing with patients and their responsible parties. ClearGage also generates and sends all responsible part statements for you.

### **Patient Consent**

ClearGage is a HIPAA-compliant payment processor. Therefore, you do not need to obtain patient consent or to identify patient consent within the application prior to sending superbill balance due information to ClearGage. When a responsible party has a balance due on a superbill, ClearGage contacts them to obtain their consent to receive phone calls, text messages, and/or emails regarding payments, payment plans, and other payment services.

### **Patient Balance and Payment Information Sent to ClearGage**

The application sends superbill balance information to ClearGage once a day. Balance information is only sent once the patient becomes liable for the balance on a superbill. The balance on a superbill will continue to be sent to ClearGage daily until the remaining superbill balance is \$0.00.

Because superbill balance information is sent once a day, the account information available to a responsible party on the ClearGage payment portal may not reflect payments recently entered into your database.

### **Payment Due Notification Messages**

ClearGage notifies responsible parties when they become liable for a balance due on a superbill. The notification includes a link to the ClearGage payment portal, where the responsible party may enter a payment.

Please note that the Payment notification messages link to the ClearGage payment portal, not to your Aprima Patient Portal.

### **Payment Information Received from ClearGage**

ClearGage sends responsible party payment information to your database once a day. When the application receives the ClearGage payment information file, it processes the information to create payment entries in your database. Therefore, it may take one or two days for a payment made on the ClearGage portal to appear in your database.

Payments created from the ClearGage payment information file are in a financial batch named 'MM/DD/YYYY ClearGage Transaction', where MM/DD/YYYY is the date the payment file was received. Payments received from ClearGage identify the superbill or superbills to which the payment is to be applied. The application automatically allocates the payment amount to charges on the superbill in the usual manner.

If a patient was given a prompt-payment discount, then the payment information received from ClearGage will also create a zero dollar payment with a patient payment adjustment for the discount amount. This appears in the ClearGage Transaction financial batch as a separate payment item. Adjustments cannot be automatically allocated by the application.

You must review ClearGage financial batches in the usual manner to allocate remaining payment amounts, adjustment amounts, or negative payments for credit card reversals.

### **Payment Plans**

Responsible parties who meet your practice's criteria for a payment plan may establish a plan agreement from the ClearGage portal site. Once the payment plan is established, ClearGage automatically processes the payments on the scheduled payment date, using the credit card or bank information provided by the responsible party.

The responsible party may make additional payments toward the balance due. The responsible party may also increase the amount of the remaining scheduled payments in the payment plan. The responsible party cannot decrease the amount of the scheduled payments once the payment plan has been established.

Information about payments made for payment plans is sent to your database once a day in the payment information file. Then the application creates the payment entries in a financial batch named 'MM/DD/YYYY ClearGage Transaction' and applies the payments to charges on superbills.

### **Processing Credit Card Payments**

As part of the payment management services, you may choose to process credit card payments through ClearGage. Credit card transactions are entered in the ClearGage payment portal, which you may access through Aprima.

Although the ClearGage payment portal appears within an Aprima window, all the information displayed and entered is in the ClearGage portal. Therefore, credit card payments entered in this way are not payments entered in your Aprima database. Just like payments entered by responsible parties in the ClearGage payment portal, ClearGage then sends information about the credit card payments you enter to your database once a day.

Then, when the application receives the ClearGage payment information file, it processes the information to create payment entries in your database. Then the application creates the payment entries in a financial batch named 'MM/DD/YYYY ClearGage Transaction'. Once payments are created in your database, you can review and process the payments to apply money to charges on superbills. So, it may take a day or two for the payment to show up in your database.

### *Enter a Credit Card Payment*

Use the following process to enter a credit card payment using payment management services.

1. Open the Patient Demographics window for the patient for whom you want to enter the credit card transaction.
2. Select the Payment Management button on the toolbar.
3. From the dropdown menu, select the Payment Dashboard entry. This accesses the ClearGage payment portal.
4. In the Payment Dashboard, select the Make Payment button.
5. This opens a Payment Information window on the ClearGage payment portal. Patient information displayed on this window is from the ClearGage patient account.
6. Enter the payment Amount.
7. Select the Payment Method. This may be a credit or debit card or it may be a checking or savings bank account.
8. Enter the required credit card or bank account information. If using a credit or debit card, you may scan the card to populate this information.
9. Enter any other information needed for the payment, such as the date of service or notes.
10. Select the Continue button to review the payment information entered.
11. If all the information is correct, select the Submit button to process the card transaction.

Remember, the payment is not entered in your Aprima database. It will be entered when you receive the payment information file from ClearGage.

### **Account on File**

Payment management services enables you to establish an account-on-file agreement with a patient or a patient's responsible party. The agreement enables you to save credit card or bank account information for the responsible party so that you can process payments in the future. You must obtain written consent from the patient or responsible party prior to establishing the agreement.

The account-on-file agreement establishes:

- The credit or debit card or the checking or savings bank account from which a payment may be made,
- The time period during which the agreement is active,
- The maximum number of payments which may be made, and
- The maximum dollar amount of any single payment.

Account-on-file agreements can help you improve your cash flow. For example, at the time of a patient visit, you may want to establish an agreement with the responsible party for the anticipated patient liability after their insurance has paid. In this instance, you may want to make the consent agreement for a time period that allows you to process the claim and to receive and process the insurance payment. In this case, the agreement may be for a single payment with the maximum payment amount the anticipated patient liability amount. Such an

agreement enables you to process payment for the responsible party as soon as they become liable. It also enables the responsible party to know when to expect the charge and how much to expect it to be.

As another example, a responsible party may want to establish an account-on-file agreement so that visit copay and co-insurance payments may be processed for patient visits when the responsible party is not present or does not have the card available. If you make such an agreement when scheduling an appointment, then the time period may be just long enough to cover the date of the appointment, file the claim, and receive the insurance payment. You may want to make the maximum payment amount to be the amount you anticipate for the visit's copay and co-insurance amounts.

You may also make an account-on-file agreement for a longer period of time that will cover multiple appointments. For example, you may establish an agreement for period that will cover a course of treatment or for a general time period, such as six months or a year.

All of the account-on-file agreement information is stored in the ClearGage payment portal. Once the agreement is established, you may enter payments in the payment portal using the account information. Payments can only be made during the time period established in the agreement. The ClearGage payment portal will never allow you to make a payment that exceeds the maximum amount of a single payment defined in the consent agreement. It also will not allow you to make more payments than the maximum agreed number of payments in the agreements. But, the ClearGage payment portal does not know when a payment from an account-on-file agreement is appropriate or not. You must establish policies and practices that help you ensure that any payments generated from an agreement are aligned with the terms of your agreements with your responsible parties.

Once the account-on-file has been created, you may use it to create a payment in the ClearGage portal just as you would enter a credit card payment. As with credit card payments, the payment is not entered in to your Aprima database.

As part of the payment management services, you may choose to process credit card payments through ClearGage. Credit card transactions are entered in the ClearGage payment portal, which you may access through Aprima. Just like payments entered by responsible parties in the ClearGage payment portal, ClearGage then sends information about the credit card payments you enter to your database once a day.

Then, when the application receives the ClearGage payment information file, it processes the information to create payment entries in your database. Then the application creates the payment entries in a financial batch named 'MM/DD/YYYY ClearGage Transaction'. Once payments are created in your database, you can review and process the payments to apply money to charges on superbills. So, it may take a day or two for the payment to show up in your database.

### *Create an Account-On-File Agreement*

Use the following process to create an account-on-file agreement for a patient. Please note that the patient must have a consent agreement with ClearGage in order for you to create the account-on-file.

1. Open the Patient Demographics window for the patient for whom you want to enter the agreement.
2. Select the Account On File link on the Patient Details pane.
3. In the Account Authorization Status field, selecting Pending.
4. Enter the Maximum Preauthorized Amount Per Payment Event. This the maximum amount that any single payment may be.
5. Enter the Maximum Number of Preauthorized Payment Events. This is the maximum number of payments that may be made from this agreement.
6. Enter the Authorized Duration of the Agreement.
7. Select the Payment Method. Then in the Payment Method popup window:
  - a. Enter the information needed for the credit/debit card or the bank account.
  - b. Select Save button to save the information.
8. Enter a secondary payment method if desired.
9. Select the Print Agreement button. This prints the agreements for the patient/responsible party to sign.
10. If the patient/responsible party signs the agreement, then change the Account Authorization Status to Active. If the patient/responsible party wants to review the agreement and sign it later, leave the status as Pending.
11. Select the Save Changes button.

### **Statements**

When you are using payment management services, you will not generate and mail statements for patients and their responsible parties. Rather than sending statements once a month, patients are notified by phone, text, or email as soon as they become responsible for a superbill balance. The notification includes a hyperlink to the ClearGage payment portal, thus encouraging the patient or responsible party to pay immediately.

If a patient or responsible party does not agree to receive notifications from ClearGage, then a statement must be sent. ClearGage may also determine that a statement must be sent to a patient if the patient has received multiple notifications but has not made a payment. ClearGage sends statement requests for specific responsible parties to your database as needed, When the application receives the statement request, it generates the requested statements and transmits them to ClearGage, who then mails the statements.

Statements generated for ClearGage appear in statement batches, which you may review if needed. Statements are also attached to responsible party records in the usual manner.

# Electronic Remittance Advice (ERA)

Files containing electronic remittance advice (ERA) information from claim clearinghouses can be received and processed, and the payments applied to patient accounts and superbills. ERA processing is optional functionality. If your practice is using ERA functionality, your administrative user will have set up the rules engine, the insurance payers from which you will receive ERA files, and the jobs and job schedules for processing the files.

The ERA is an electronic response from the insurance payer explaining what they did and did not pay for a submitted claim and why. Thus, it is an electronic form of the explanation of benefits (EOB). The ERA also includes information about payments, either paper or electronic, sent separately to the clinic.

Insurance payers send the ERA to the clearinghouse, which then sends the ERA to the application. When the ERA is received, the application uses a set of ERA rules to update the accounts receivable module with the payment information. ERA rules enable you to configure the application by payer to enter new insurance check payments, enter new transactions (payments and adjustments on individual superbill charges), send messages to users to look in detail at some items, change statuses, forward liabilities, and so on based on the amounts and reason codes in the ERA message. When processing cannot be done automatically based on the configured rules, you can view the ERA message in the window, much like a paper EOB, and manually make the entries.

## Import and Process EDI Responses

EDI stands for electronic data interchange. EDI responses include both electronic remittance advice (ERA) files and claim response reports. The Track EDI Responses window enables you to list, sort, and work with all the files that you receive from your claim clearinghouse.

You can use the Track EDI Responses window to download and process ERA files and claim response reports. You can also import, analyze, and process ERA files that have already been downloaded.

The window also enables you to archive ERA files and claim response reports so that they no longer appear in the window when you are processing your current files. You can archive processed files and files that have not been processed. By archiving a file that you are not going to process for some reason, you remove it from the list and ensure that it is not processed accidentally. You can search for archived files so that you can review the file again if needed. **(Note:** Archiving a claim response report does not complete or otherwise affect the message in which that report was received.)

You must import and process EDI response files on a regular basis. If you do not, you may have difficulty importing the files. Processing may be done automatically by the processing job, or you may initiate the import and processing functions on demand.

You must also check the processed response files to ensure that they completely and correctly processed, and to identify, investigate, and complete any item that was not processed. This may include superbills which could not be processed, superbills for which no payment was received, and superbills for which all or part of the payment was not allocated.

## Amount Allowed

Electronic remittance advice (ERA) processing will update the amount allowed for a charge when creating the payment if the amount allowed identified by the payer is different from the amount allowed indicated on the superbill and claim. Previously, the amount allowed was set only from the B6 value in the ERA file. The process is now based on the procedure, transaction and service amount.

- Procedure
  - When an AMT segment with a B6 amount qualifier code exits, then that monetary amount is used as the amount allowed.
- Transaction
  - When an AMT segment with a B6 amount qualifier code exits, then that monetary amount is used as the amount allowed.
  - When the B6 is not found, then the amount allowed is calculated. (The amount allowed is the billed amount minus the adjusted amount for this transaction.)  
**Note:** This would normally be put on the CO-45 and/or the CO-42 transactions.
- Service Amount
  - When an AMT segment with a B6 amount qualifier code exits, then that monetary amount is used as the amount allowed.

## Superbill Notes

Notes are added to the superbill history from ERA process for actions related to ERA, procedure, transaction, and service amount as well as for superbill. When the action type is ERA, the note is added to all superbills (claims) in the ERA file.

## Superbills Locked During Processing

Under certain circumstances, a superbill will become locked during ERA processing. As a result, the payment cannot be allocated to the superbill. When ERA processing could not allocate payments for one or superbills, you must either reprocess the ERA file or enter the payment allocations manually.

The Notes/Errors column will display the following message when the payment allocation could not be made for a superbill:

ERA Claim processing was locked for superbill xyz. Please try re-processing at a later time.

## Processing Buttons

Button	Description
Download	Runs the interface message listener which downloads and imports remittance files. This job looks at the HL7® partners, in particular, the ERA Partner that can be set up to download ERA remittance files from a directory or FTP.

Button	Description
Import ERA	Imports a selected ERA remittance file into the database, and analyzes any ERA remittance files in the database that have not been parsed. The analysis reads the ERA file, creates ERA records, and matches those records with existing items such as a superbill or procedure. This is basically a pre-processor. This runs the ERA Message Processor job. The analyze step will create a row in the display with a status of unprocessed.
Process ERA	Applies an ERA rule group to those remittance records that have been analyzed. This runs the ERA job. This step will change the state of the transaction to either Processed or Error.
Change Status	Change the status of selected files from Hold to Unprocessed. Files with a status of Unprocessed are processed by the ERA processing job during its scheduled run. Files with a status of Hold are not processed by the ERA processing job during its scheduled run.
Archive	Archives ERA files and claim response reports so that they no longer appear in the window when you are processing your current files. You can archive processed files and files that have not been processed. By archiving a file that you are not going to process for some reason, you remove it from the list and ensure that it is not processed accidentally. You can search for archived files so that you can review the file again if needed. (Note: Archiving a claim response report does not complete or otherwise affect the message in which that report was received.)

### Unprocessed and Hold Status

Your administrative super user can configure whether imported files are given a status of Unprocessed or Hold. Files with a status of Unprocessed are processed by the ERA processing job during its scheduled run. Files with a status of Hold are not processed by the ERA processing job during its scheduled run.

The Hold status enables you to review a file, and determine whether or not you want it processed. Once you have determined that a file should be processed, you can either initiate the processing or you can change the status to Unprocessed so that it will be processed the next time the ERA processing job runs. If you determine that a file should not be processed, you can archive it unprocessed.

### View EDI Response Files

1. Billing → Track EDI Responses

2. Enter the desired search criteria.

**Note:** If you wish to save the search filter, enter a name in the View Options field and select the Save As button.

3. Select the Search button.

## Download Files

Downloading runs the interface message listener which downloads and imports remittance files. This job looks at the HL7 partners, in particular, the ERA Partner that can be set up to download EDI response files from a directory or FTP.

When you download files, the application actually performs two downloads. It first downloads ERA files, and then it downloads claim response reports.

1. Billing → Track EDI Responses
2. Select the desired Clearinghouse.  
You must specify a clearinghouse to download ERA files.
3. Select the Download button.

## Import and Process EDI/ERA Files

Use this process to import a selected ERA remittance file into the database. This also analyzes ERA remittance files in the database that have not been parsed. This functionality reads the ERA file, creates ERA records, and matches those records with existing items such as a superbill or procedure. This is basically a pre-processor. This runs the ERA Message Processor job. The analyze step will create a row in the display with a status of unprocessed.

1. Billing → Track EDI Responses
2. Select the desired Clearinghouse.
3. Select the Import ERA button.
4. In the Import ERA File popup window,
  - a. Select the Browse () icon to browse to and select the file you want to import.
  - b. Select the OK button to import the file.
5. Select the Search button to display the file you just imported.  
The Status column displays the status as Hold.
6. Review the file as needed.
  - Select the Reference ID hyperlink to view the report of the file.
  - Select the Status hyperlink to view the raw data file.
7. Either:
  - To process the file immediately, select the checkbox for the file, and then select the Process ERA button.
  - To have the file processed by the ERA processing job, select the checkbox for the file, and then select the Change Status button to change the file status to Unprocessed.
  - To archive the job unprocessed, select the checkbox for the file, and then select the Archive button.

## **Process ERA Messages**

Processing applies an ERA rule group to those remittance records that have been analyzed. This runs the ERA job. This step will change the state of the transaction to either Processed or Error.

1. Billing → Track EDI Responses
2. Select the checkbox for the file or files you want to process.
3. Select the Process button in the toolbar.

## **View the ERA Report**

1. Billing → Track EDI Responses
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the Reference ID link for the desired file.
4. The report is displayed in the Report window.

## **View the Claim Response Report Message**

1. Billing → Track EDI Responses
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the Reference ID link for the desired file.
4. The raw text is displayed in the View window.

## **View the Raw File**

You may view the text of a raw ERA or claim response report file. Use CTRL-F to search for a text string in the raw text. You may also select text and copy it by accessing right-click editing menu.

1. Billing → Track EDI Responses
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the Status link for the desired file.
4. The raw text is displayed in the View window.

## **View the Notes or Errors**

1. Billing → Track EDI Responses
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the Notes/Errors link for the desired file.
4. The Track ERA Errors window displays a list of all errors associated with the ERA file.
5. Select the Reference ID link to view the ERA report.

## **Archive a File**

1. Billing → Track EDI Responses
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the file or files that you want to archive.
4. Select the Archive button.

## **Searching for Archived Files**

1. Billing → Track EDI Responses
2. Select the Include Archived checkbox.
3. Enter the any other desired filtering criteria, and then select the Search button.
4. If desired, unarchive file:
  - a. Select the checkbox for the desired file.
  - b. Select the Archive button to unarchive the previously archived file.

## **ERA Report**

An Electronic Remittance Advice report is generated for each imported and processed ERA file. The report is similar to the Medicare Remit Easy Print (MREP) report. The report lists each patient for which a claim was processed, and the following information about that claim:

- Superbill/claim number
- Payer claim contract number
- Rendering provider's ID
- Procedure
- Billed amount for the procedure
- Amount allowed for the procedure
- Deductible amount for the procedure
- Coinsurance amount for the procedure
- Group and reason codes applied to the procedure
- Adjustment amount for the group and reason codes
- Amount paid for the procedure
- Interest amount
- Late filing charge amount
- Net amount
- Processing status

The report also contains a totals section at the end, which includes the total number of claims; the total billed, allowed, deductible, coinsurance, and adjustment amounts; and the total

check amount. This section of the report also lists any provider adjustment codes and adjustment amounts that are not to any specific claim or service.

The final section of the report is a glossary of the group and reason codes that are included in the report.

### **Accessing the ERA Report**

You may access the Electronic Remittance Advice report in several ways:

- From the Track EDI Responses window, select the Reference ID link.
- From the Track Payments window, select the EOB button.
- From the Allocate Payment window, select the EOB button. Note that from this window, the report only displays the section of the report associated with selected superbill.

### **Accessing Additional Information**

Select the patient name link to access the Patient Demographics window.

Select the superbill ID (SBID) link to access the Superbill window.

Select the status link to access the Track EDI Responses window where you can view the errors.

### **Claim Statuses**

The table below gives the claim statuses and their meaning.

<b>Status</b>	<b>Meaning</b>
Unprocessed	Superbill/claim has never been processed.
Error	Superbill/claim processing has failed due to errors. Please review the errors, and manually process as appropriate.
Processed	Superbill/claim has successfully processed and completed.
Locked	Superbill/claim was locked during processing because an exception occurred due to database deadlock or load problems. As a result, the allocation was not made. This superbill/claim will be reprocessed if the ERA is set to reprocess.
(unknown)	Indicates a problem in the ERA processing. Please contact Support.

# Billing and Claims

Billing includes the overall process of generating and tracking superbills, balancing and closing charges, entering payments, and posting claims.

Much of the information used, such as insurance payers, insurance plans, fees, copays and parameters that relate specifically to your practice, is defined by the practice administrative super user. Users then associate insurance information with patient procedures and file claims either electronically or via paper forms.

Electronic claims are filed through a clearinghouse. You must register with the clearinghouse before you can file claims electronically.

## Claim Format and Claim Format Value Types Overview

Claim formats and claim format value types are needed for processing claims. These items will have been established by your administrative super user. This section gives an overview of these items so that you understand what they are and how they used in processing claims. If you have the necessary security access, you may be able to view or to add and modify these items. Please refer to the *Administrative User's Guide* for instructions on viewing, adding, or modifying claim formats and claim format value types.

A claim format defines the identifying numbers used in fixed fields on either electronic or paper based claims, and whether the claims are generated as group claims or individual provider claims. Claim formats are used in conjunction with claim format value types, which specify the actual values used for particular individuals and entities. For example, the claim format value type for DEA numbers will specify each provider's DEA number. Together, the claim format value type and the claim format will be used to populate the provider's DEA number on a claim form.

You will have separate claim formats for electronic and paper claims. You may also have a claim format for UB-04 institutional claims.

**Note:** A new claim type has been defined for the revised CMS 1500 claim form. It is named Paper CMS-1500 5010. The claim type is available now, but you should not use it until you have an insurance payer that accepts the revised claim form.

A claim format, with its associated claim format value types, can be used for multiple insurance payers as long as those insurance payers have the same information requirements and needs. For example, you may have one electronic claim format that you use for most or all of your commercial insurance payers. However, you may need a specific claim format for a particular payer to address requirements that are specific to that payer.

For example, Medicare requires that claims for lab test procedures identify the provider who ordered the test be identified on the claim as the referring provider for the lab procedure. So, you may have an electronic claim format specifically for Medicare that is defined to identify the billing provider as the referring provider when there is no referring provider identified.

You may also have a claim format specifically for Medicare durable medical equipment regional carriers (DMERCs). Durable medical equipment can only be claimed with a DMERC insurance payer. The claim format associated with the DMERC insurance payer must indicate that the claims may be used for durable medical equipment.

In some rare, but very specific circumstances, the NPI number reported on insurance claims needs to follow different rules than the standard. This is often, but not exclusively, needed for institutional billing. If you need to use a different rule for identifying the NPI used for an insurance payer's claims, you can override the NPI rules on the claim format.

## Reviewing Insurance Payer and Plan Setup

Insurance payers and insurance plans will have been set up by your administrative super user. However, you may need to review how payers and plans are set up, and depending on your security permissions, you may add or modify insurance payers and plans in the future. Please refer to the *Administrative User's Guide* for instructions.

## Electronic Claims Clearinghouse

If you will be processing claims electronically, your administrative user will have set up your chosen claims clearinghouse, the insurance payers and plans for which you will process electronic claims, and the jobs and job schedules used to submit claims and receive messages and reports. Should you need to review or modify any of these items, please refer to the online help or the *Administrative User's Guide* for instructions. You must have the necessary security access to review or modify these items.

Claim reports received from the claims clearinghouse and insurance payers are received as file attachments to the claim report messages. There is no size limit on the reports. You can save the report file to your hard drive if desired, and can then use the file as needed.

### Aprima EDI Solutions Reports

Aprima EDI Solutions, which uses the Practice Insights clearinghouse, provides the following reports.

- ANSI 270 (Eligibility and Benefit Request) and the ANSI 271 (Eligibility and Benefit Response)
- 997 Functional Acknowledgement. This report is generated as ANSI compliance errors are detected (e.g., missing mandatory fields). A 997 is expected within 24 hours of origin. This report is a batch-level report only.
- ANSI 276 (Claim Status Request) and the ANSI 277 (Claim Status Response)
- ANSI 837 (Request for Payment). This is the file format used for electronic billing of professional services (CMS-1500 billing). ANSI 837 is shorthand for the ASC X12N 837 (004010X098A1) file format.
- ANSI 835 (Claim Payment and Remittance Advice). The ANSI 835 will contain claims that are a mixture of claim-level and line-level payments.

## Clinical Claims Scrubbing

The optionally purchased clinical claims scrubbing add-in functionality interfaces with the Practice Insight clearinghouse and the Alpha II claim scrubbing engine. Clinical claim scrubbing enables you to identify proper diagnosis and procedure code combinations and to validate coverage policies. It is important to recognize that this validation is against a specific set of insurance rules; it is not a general validation of the completeness or correctness of your coding.

Clinical claim scrubbing verifies both professional and institutional claims from the payer's perspective. In addition to Medicare's local coverage determination (LCD) and national coverage determination (NCD) rules, the claim scrubbing engine also uses an additional proprietary clinical medical necessity database, which covers virtually all possible diagnosis/procedure code combinations. Clinical claim scrubbing performs the following edits:

- Diagnosis code validity
- Procedure code validity
- Correct Coding Initiative (CCI) bundling
- RVU sequencing
- Modifier usage
- Outpatient prospective payment system (OPPS) validity
- Medical necessity

To use clinical claim scrubbing, your administrative super user must have enabled this functionality in your practice settings.

Prior to processing a claim, the clinical claim scrubbing interface available from Track Superbills so that you can validate the coding when processing superbills. Pre-claim scrubbing gives you information and warning messages for any potential issues identified. You can then decide what, if any, changes to make to the coding. These messages are only informational; even warning and error messages only provide information about possible problems. The warning and error designations only indicate the severity of the possible problem. The messages — whether informational, warning, or error — do not prevent you from submitting the claim with the current coding if you determined it to be appropriate. Pre-claim scrubbing serves a valuable purpose, but it is limited because it uses only the data that is available in a superbill.

When processing claims, clinical claim scrubbing enables a far more robust validation because it uses all the data that is available in the claim and the full set of code validation edits available in the claim scrubbing engine. It also enables you to create and use your own custom edits for specific payers or circumstances.

### **Clinical Claim Scrubbing from Track Superbills**

You can validate the diagnosis and procedure coding in one or more superbills from the Track Superbills window. When you validate a superbill, its superbill status is changed as follows:

- Failed Validation: Assigned when there are errors from code validation or claim scrubbing.
- Queued: Assigned when there are no errors, and an insurance payer is identified for the superbill.

- Pending Patient Payment: Assigned when there are no errors, and there is no insurance payer identified for the superbill.
- Complete: Assigned when there are no errors, there are no charge amounts, and there is no insurance payer identified.

1. Billing → Track Superbills
2. Enter the desired search criteria, and then select Search to list all superbills that meet your criteria.
3. Select the checkbox for each superbill that you want to validate.
3. Select the checkbox for the superbill or superbills on which you want to perform code validation and claim scrubbing.
4. Select the Validate button.
5. When validation is complete, search for the superbills that failed validation. In the Superbill Status field, select Failed Code Validation and select the Search button.
6. Review and correct each superbill.
  - a. Select the Errors link in the Code Validation column. This accesses the Superbill Report window for the selected superbill.
  - b. The Notes column contains the validation message.
  - c. Select the Superbill link to access the Superbill window where you can make any necessary changes to the diagnosis and procedure coding. Both the Superbill and Superbill History windows may be open at the same time.
  - d. Change the superbill Status to Coding Valid, and then select OK to save and close the superbill.
  - e. In the Superbill Report window, select the Select All checkbox () to select all the error messages.
  - f. Select the Mark Viewed checkbox, and then select the Update button to mark all the selected errors as having been reviewed.
  - g. Select the Close button to close the Superbill History window and return to Track Superbills.
7. Repeat step 6 for each superbill that failed validation.

## Processing Claims

The Process Claims window enables you to select superbills within specified categories, and to transmit electronic claims or print paper claims.

When you process claims, the application scrubs the superbills to ensure they contain data in all the fields required for a claim submission to the specified insurance payer. The application generates claims for all superbills containing sufficient information, and it logs errors for any superbills that do not contain sufficient information. You may view the errors logged against superbills on the Process Claims and Superbill Reports windows.

If your practice uses the optional clinical claims scrubbing functionality, then claim information is transmitted to Practice Insight and then to Alpha II for claims scrubbing. Code validation errors logged against superbills are displayed on the on the Process Claims and Superbill Reports windows with the other scrubbing errors.

It is recommended that you review the superbills that are ready to be filed as claims daily. Filing claims daily will help you ensure that claims are filed in a timely manner.

Superbills must have a status of Queued or Queued Rejected to appear in the Process Claims window. The default filtering criteria for processing claims is electronic 837 claim format, the primary insurance, your claims clearinghouse, and service dates within the last 30 days. As with other tracking windows, you may create and save filters for superbills that you process regularly, such as paper claims, secondary insurance, or the provider or providers for whose claims you are responsible.

## **Electronic Claims**

Electronic claims are transmitted to the clearinghouse for clearing, and submission to the insurance payer. Use the EDI Claim Files report to list all the claim files created or transmitted on a specific date or for a range of dates for a claims clearinghouse. (Please see the *Reports Guide* for more information.)

Keep in the mind the following points when processing electronic claims.

- If there are multiple billing providers, each with their own electronic submitter ID, then the number of claim files generated will equal the number of billing providers. All the claim files will be encapsulated in a single zip file.
- If there are multiple billing providers and the Export to File checkbox is selected, then the File window box will pop up once for each billing provider in the selected superbills.
- If a claim is successfully processed, the superbill status will be updated to Filed.
- If a claim is not batched because of an error on the superbill, the superbill status will be updated to Queued Rejected.
- Currently, electronic claims may only include diagnosis pointers for the first 8 diagnosis codes on the superbill. If a superbill has 9 or more diagnosis codes, then you must either point all procedures on the superbill to only the first 8 diagnosis codes, or you must split the diagnoses and procedures onto two superbills. If a claim contains a diagnosis pointer of 9 or greater, the claim will fail with the error message "Must point to a valid ICD-9 value."
- If the batched file is successfully transmitted, the superbill will remain in a status of Filed until clearinghouse and/or payer reports are processed against the claim. Further changes to the superbill status will be based upon these response files.
- If the processed batch file fails to transmit for any reason, the following actions will occur.
  - An error message will appear on the claims window. This message includes the actual error message from the clearinghouse.
  - The clearinghouse error message will also be logged in the error log so that the support team can use them in troubleshooting chronic transmission failures.
  - The superbills for the claims that failed transmission will remain in a status of Queued.

- The claim file that failed the transmission attempt will be deleted from the database. Only successfully transmitted files will be retained in the database. This eliminates any false perception that a failed batch has actually been transmitted.
- The wait time for receiving the response file for electronically submitted claims may be from 30 seconds to 2 minutes. The difference in the wait time is dependent on the number of claims submitted and the time it takes the clearinghouse to prepare the response file for those claims.

### **Revised CMS 1500 5010 Claim Layout**

The Centers for Medicare and Medicaid Services (CMS) adopted the revised CMS-1500 claim form in January 2014. Revisions to the form were primarily to address the implementation of ICD-10 diagnosis codes. Other changes include expanding the number of possible diagnosis codes and adding qualifiers to identify ordering, referring, and supervising provider roles. The revised form may include up to 12 diagnosis codes. The claim format type for the revised form is named Paper CMS-1500 5010.

### **Medicaid EPSDT CMS 1500 Claim Layout**

In the Medicaid EPSDT CMS 1500 paper claim layout, the Box 24C and Box 24J fields are populated in a slightly different manner than the standard CMS 1500 paper claim layout.

In this format, Box24C is populated with the EPSDT referral condition indicator ID. The two-digit EPSDT referral condition indicator ID is entered on the Superbill window's Other tab in the EPSDT Referral Condition field. Up to four referral conditions may entered on the superbill, but only the first referral condition is included in the claim. All procedure rows on the printed claim form will populate Box 24C with that EPSDT referral code.

When the superbill includes an EPSDT referral condition indicator ID, then Box 24J on this claim format is blank, whether filing as an individual or as a group. When the superbill does not contain an EPSDT referral condition indicator ID, then Box 24J on this claim format is populated using the same logic as the regular CMS 1500 NPI claim layout.

### **Processing Claims Using a Non-Standard Paper Claim Layout**

Occasionally, an insurance payer will require a non-standard layout for payer claims. A non-standard layout populates certain boxes on the paper claim form with different information than normal. Some state-specific Medicaid payers require non-standard paper claim layouts, and other, commercial payers may also.

If the insurance payer requires the non-standard claim layout be used for all primary and secondary claims, then your administrative super user can associate the non-standard claim layout with the insurance payer. This enables you to process the claims for this insurance payer with your standard paper claims. The application identifies the non-standard layout and process the claims for the payer appropriately.

If the insurance payer requires the non-standard claim layout be used for some claims, such as secondary claims, but not for all claims, then you cannot have the non-standard claim layout associated with the insurance payer. You must process the claims that require the non-standard layout separately and select the layout needed during processing.

## **Secondary Claims**

Paper secondary claims are generated using the Medicare Secondary claim form layout for the CMS 1500 NPI paper claim form. This claim format always leaves the following boxes empty on the claim form: 9.a, 9.b, 9.c, 9.d, 11.a, 11.b, 11.c, and 11.d.

Before processing an electronic secondary claim, you must ensure that the original fee for a procedure balances with the payments received from the primary insurance payer, the adjustments from the primary insurance payer, and the remaining balance that the primary payer considers to be the patient's responsibility. It is important to understand that the balance that the primary insurance payer considers to be the patient's responsibility may not be the same as the current patient balance. The amount the primary insurance payer considers to be the patient's responsibility may include a copay amount and/or a coinsurance amount, and these amounts may have already been paid by the patient.

You can review the payments and adjustments made by the primary insurance payer and the patient as you prepare to file the secondary claim.

## **Insurance Default Processing Options for Electronic or Paper Claims**

The application enables you to identify an insurance payer's or an insurance plan's requirements for electronic and paper claim creation. An insurance payer may, for example, accept electronic claims when they are the primary payer, but accept only paper claims when they are the secondary (or other non-primary) payer. The default option enables you to generate claims in the proper format without opening individual superbills to set the paper claim option. If you have an insurance payer or plan that requires payer claims, then your administrative super user will set the appropriate default.

## **Diligently Monitoring Claim Status**

Aprima recommends that you diligently monitor the status of your claims and your claims aging.

When you process electronic claims, superbills which are submitted to the claims clearinghouse are given a status of Filed. The Filed status is a temporary status that may last up to 24 hours. Once the claim has been received by the claims clearinghouse, the status changes to Succeeded or Rejected. Please note, however, that you may need to have made another claims submission in order to have received status information back from the claims clearinghouse. You must reprocess the claim for any superbill which has had the Filed status for more than 24 hours if you have processed claims for other superbills during that time.

It is important to remember that the superbill status Succeeded only indicates that the last entity (either clearinghouse or insurance payer) to receive the claim has acknowledged receiving it. The Succeeded status does not indicate whether or not the payer will pay the claim.

Monitor your claims based on the typical amount of time it takes to receive payment from an insurance payer. For example, if a particular payer typically sends payment 10 to 15 days after receiving the claim, then you should review any claim that has had the status of Succeeded for more than 20 days. Then call the insurance payer regarding the claim.

## Processing Electronic Primary Claims

1. Billing → Process Claims
2. In the Claim Format Type field, select Electronic 837.
3. In the Claim Insurance field, select Primary.
4. Enter additional search criteria, as desired to select claims for processing.
  - Some criteria are multi-select, so you can search on more than one rendering and/or billing provider, service site, payer, or patient.
  - You may use only the standard filtering criteria, or you may also use the expanded filtering criteria. Using the expanding filtering may increase the amount of time it takes for the application to search for and display results.
5. Select Search, and superbills that meet your criteria are listed.

Only superbills meeting your criteria and in financial centers that you have access to will be displayed. Superbills in financial centers that you do not have access to will not be displayed.
6. Select the checkbox for the superbills for which you want to file claims. Select all superbills by selecting the checkbox at the top of the window.
7. Select the Process button.

The Processing window appears while the claims are processed and sent to the clearinghouse. The application also receives reports from the clearinghouse for previously submitted claims. Processing may take a few seconds to a few minutes depending on the number of claims.
8. Once the claims have processed, only superbills with errors that could not be processed will display. You can work the errors here, by selecting the hyperlink in the Errors/Warnings column, or you can work the errors from the Superbill Reports window.

## Processing Electronic Secondary Claims

Use this procedure to process electronic claims for secondary insurance payers. Before processing a secondary claim, you must ensure that the original fee for a procedure balances with the payments received from the primary insurance payer, the adjustments from the primary insurance payer, and the remaining balance that the primary payer considers to be the patient's responsibility. It is important to understand that the balance that the primary insurance payer considers to be the patient's responsibility may not be the same as the current patient balance. The amount the primary insurance payer considers to be the patient's responsibility may include a copay amount and/or a coinsurance amount, and these amounts may have already been paid by the patient.

You can review the payments and adjustments made by the primary insurance payer and the patient as you prepare to file the secondary claim.

1. Billing → Process Claims
2. In the Claim Format Type field, select either Electronic 837 or Electronic Institutional 837.
3. In the Claim Insurance field, select Secondary.
4. The Clearinghouse fields defaults to your claims clearinghouse.
5. Enter any additional search criteria as desired.
6. Select the Search button to display all superbills meeting your search criteria.
7. Select the Superbill link to access the superbill you want to review.
  - a. In the Superbill window, open the Payments slider to review the payments made on the superbill.
  - b. Select the Transaction hyperlink to access the Transaction window.
  - c. Either:
    - All the procedures on the superbill are balanced if there is no message at the top of the Transaction window. No action is needed. Go to substep d.
    - If any of the procedures on the superbill do not balance, a yellow error message will appear at the top of the Transaction window. The message states that the COB items for the superbill do not balance. You must enter the remarks or adjustments needed to balance the procedures. See the Balancing Transactions for the Coordination of Benefits section for instructions. When complete, continue with substep d.
  - d. Close the Transaction and Superbill windows to return to the Process Claims window.
  - e. Repeat step 7 for all superbills that need to be reviewed.
8. In the Process Claims window, select the checkboxes for the superbills for which you want to file secondary claims.
9. Select the Process button to process the claims.
10. Once the claims have processed, only superbills with errors which could not be processed will be displayed. You can work the errors here, by selecting the hyperlink in the Errors/Warnings column or you can work the errors from the Superbill Reports window.

## Processing Paper Claims

1. Billing → Process Claims
2. In the Claim Format Type field, select Paper CMS-1500.
3. In the Claim Insurance field, select Primary, Secondary, or Tertiary as appropriate. (Select Tertiary to process the claim for the third insurance payer and for any additional insurance payers. When there are more than three insurance payers, the application identifies the insurance payer that currently has liability.).
4. Enter additional search criteria, as desired to select claims for processing.
  - Some criteria are multi-select, so you can search on more than one rendering and/or billing provider, service site, payer, or patient.
  - You may use only the standard filtering criteria, or you may also use the expanded filtering criteria. Using the expanding filtering may increase the amount of time it takes for the application to search for and display results.
5. Select Search, and superbills that meet your criteria are listed.

Only superbills meeting your criteria and in financial centers that you have access to will be displayed. Superbills in financial centers that you do not have access to will not be displayed.
6. Select the checkbox for the superbills for which you want to file claims. Select all superbills by selecting the checkbox at the top of the window.
7. Either:
  - Select the Print button to print the claims using the CMS-1500-NPI claim layout.
  - Select the Claim Layout button to select another claim layout.
8. Once the claims have process, only superbills with errors which could not be processed will be display. You can work the errors here, by selecting the hyperlink in the Errors/Warnings column or you can work the errors from the Superbill Reports window.

## Identifying Claims with no Claim Format

When neither the insurance payer nor the insurance plan identified on a superbill has a claim format defined, then the claim for the superbill cannot be processed. In most cases, this will be caught by claim scrubbing when processing claims. However, there are circumstances in which the missing claim format will result in superbill never being selected for claims processing. Also, the Process Claims window now excludes superbills which are not associated with a claim format unless you specifically choose to include them in the search.

Therefore, it is recommended that you periodically search for claims with no claim format. You should do this frequently enough to ensure that you are processing all claims within your insurance payers' timely filing requirements, which can be anywhere between 30 days and 12 months.

Use the following procedure to identify superbills that are not associated with a claim format. Then your administrative super user — or you, if you have the necessary security access rights — must define the claim format for the insurance payer or insurance plan.

1. Billing menu → Process Claims
2. Select the Include Claims Lacking a Claim Format checkbox.
3. Select the Enable Expanded Filter Criteria checkbox. This also expands the columns displayed in the window.
4. Select any additional filtering criteria, and then select the Search button.
5. Review the contents of the Filing Method column. The Filing Method column displays the claim format defined for the insurance payer/plan identified on the superbill.
  - When the Filing Method column is populated, the superbill has a claim format.
  - When the Filing Method column is empty, then the superbill does not have a claim format.
    - a. Note the insurance payer and plan.
    - b. Your administrative super user or you must define the claim format for the insurance payer or insurance plan.
      - List Editor → Demographics → Insurance Payer
      - List Editor → Demographics → Insurance Plan

### **Reprocessing Rejected Claims**

Use the following process to reprocessing claims that have been rejected by the scrub process or by the insurance payer.

1. Identify the claims that have been rejected.
  - a. Billing → Superbill Reports
  - b. Search for superbills with the Report Type of 'Error' or 'Warning'.
 

Superbills that have been rejected by the scrub process have the status 'Queued Rejected'. Superbills that have been rejected by the insurance payer have the status 'Rejected Primary', 'Rejected Secondary', or 'Rejected Tertiary'.

Basic information about the errors appears in the Notes column.
2. Select the Superbill column to sort the results by superbill ID number. This enables you to see all the errors for a superbill together.
3. Review the information in the Notes column to identify the problem, such as missing information in the superbill or missing patient information.
4. View and correct the errors on an individual superbill and its claim.
  - a. Select the Superbill number link to access an individual superbill.
  - b. In the Superbill window, select the History button to access the Superbill History.
  - c. In the Superbill History window, review the information in the Notes column for any errors to identify the problem.
  - d. Correct the errors in the superbill, and update the status of the corrected superbill.
  - e. Select the OK button to return to the Superbill reports window.

5. View and correct errors in patient or responsible party information.
  - a. Select the Patient link to access the Patient Demographics window.
  - b. Go to the appropriate window to make the necessary corrections. You may need to make corrections in Patient or patient Account windows.
  - c. Make the needed corrections, and then select the OK button to return to the Superbill reports window.
6. Mark the items that you have reviewed:
  - a. Select the checkbox for superbill that you have resolved and want to mark as reviewed. You can check all items by selecting the checkbox at the top of the window, or select individual items by checking the checkbox at the left of the entry.
  - b. Select the Mark Reviewed button and the errors are removed from the Superbill Reports window. The superbills will then redisplay on the Process Claims window.
7. To change the status of one or more superbills:
  - a. Select the checkboxes for the desired superbills.
  - b. Select the Update Superbills button.
  - c. In the Update Superbills window, select the desired status.
  - d. Select the OK button to save the change and close the window.
8. Reprocess the claims.
  - a. Billing → Process Claims
  - b. Process the claims in the usual manner. Corrected superbills with a 'Queued' status will be included in the processing.

### **Resubmitting as a Corrected Claim**

To resubmit a superbill as a corrected claim, you must enter a resubmit code and the original claim's internal control number (ICN) on the superbill. The resubmit code for a replacement (corrected) claim is 7. The resubmit code for to void (or cancel) a claim is 8. The ICN is assigned by the insurance payer to identify the claim, and is included on the EOB.

When resubmitting a superbill as a corrected claim, all the original procedures, both paid and unpaid, remain on the claim. The resubmit code and ICN are included in the claim generated from the superbill, whether electronic or paper.

1. Billing → Track Superbills → Superbill ID link
2. Select the Other tab.
3. In the Resubmit field, enter 'x:yyyy', where x is the resubmit code and yyy is the ICN for the original claim. The semicolon (;) is used to separate the two codes.
4. Process the claim for the original superbill in the usual manner.

## Process a Claim from a Superbill

You can print a claim for a specific superbill while working with that superbill. This is helpful, for example, when you are correcting a superbill to reprocess a rejected claim.

1. Billing → Track Superbills → Superbill ID link
2. Verify the content of the superbill: make sure account information is correct, diagnosis pointers link to the correct procedures, etc. Select the checkboxes if any procedures should not be claimed.
3. Change the status of the superbill to Ready to Submit.
4. Select Print button, and then select Claim.  
This accesses the Process Claim window with the selected superbill listed.
5. In the Process Claim window, the Claim Format Type and Claim Insurance fields will be populated for the superbill and the checkbox for the superbill will be selected.
6. Select the Print button to print the paper claim.
7. In the Printer window, select the OK button.
8. Close the Process Claim button to return to the Superbill window.

## Superbill Reports

The Superbill Report window is used for claim error handling. It lists any claim errors generated by either the validation on the superbill performed by the application for missing information, or received electronically from the claim clearinghouse or the payer. It also lists other communications, such as acknowledgement reports, received from the claims clearinghouse.

It is recommended that you review the Superbill Report window daily, and deal with all errors and other communications from the clearinghouse. Once you have reviewed and dealt with an item, you can mark it as reviewed. Reviewed items do not appear in the list unless you specifically search for them.

When you receive errors, you should first check the mapping of the information, as most errors are generated because information is not mapped correctly. You should check information such as:

- The correct claim format is associated with the insurance payer (for example, a paper claim format instead of an electronic claim format).
- The content of the associated claim format is correct.

If notes have been added to superbills, these are listed in the notes column on the window. If a superbill includes more than one note, a separate line entry will be included for each note. Individual errors are also notified via messaging.

While reviewing and correcting errors, you may change the status of one or more superbills from the Superbill Reports window. It is important to remember, however, that this window displays the current status of the superbill, but it does not display or enable you to select the current payer (such as the secondary insurance payer, or the responsible party). Therefore, you should only

change a superbill's status from this window when you selecting a status that does not require a payer, such as Complete or Hold.

### **Reviewing Acknowledgement and Other Information Reports**

The claims clearinghouse will send acknowledgment and other information reports for processed claims. You should review these regularly.

1. Billing → Superbill Reports
2. In the Report Type field, select Information.
3. Select the Search button to display all the informational reports.  
The number of items found is displayed in the lower left of the window's status bar. The window displays 100 items by default. You can change the Maximum Items Returned or work the displayed items and then repeat your search.
4. Select the Superbill column to sort the results by superbill ID number. This enables you to see all the reports for a superbill together.
5. Review the information in the Notes column.
6. Select the checkbox for the item that you want to mark as reviewed. You can check all items by selecting the checkbox at the top of the window, or select individual items by checking the checkbox at the left of the entry.
7. Select the Mark Reviewed button to remove the selected items from the Superbill Reports window.

### **Reviewing and Correcting Errors**

Use this process to review and correct errors with superbills. Once you have corrected the errors, use the Process Claims window to resubmit the claims for these superbills.

1. Billing → Superbill Reports
2. In the Report Type field, select Error and Warning.
3. Select the Search button to display all the errors and warnings.  
The number of items found is displayed in the lower left of the window's status bar. The window displays 100 items by default. You can change the Maximum Items Returned or work the displayed items and then repeat your search.
4. Select the Superbill column to sort the results by superbill ID number. This enables you to see all the errors for a superbill together.
5. Review the information in the Notes column to identify the problem, such as missing information in the superbill or missing patient information.
6. Select the Superbill ID link to open the superbill to which the error relates.
7. Correct the errors in the superbill, update the status, and close the superbill.
8. If there are problems with patient or responsible party information, select the Patient link to access the Patient Demographics window.

9. Correct the errors in the patient, account, or responsible party information. Then close the Patient Demographics window and return to the Superbill Reports window.
10. Mark the items that you have reviewed:
  - a. Select the checkbox for superbill that you have resolved and want to mark as reviewed. You can check all items by selecting the checkbox at the top of the window, or select individual items by checking the checkbox at the left of the entry.
  - b. Select the Mark Reviewed button and the errors are removed from the Superbill Reports window. The superbills will then redisplay on the Process Claims window.
11. To change the status of one or more superbills:
  - a. Select the checkboxes for the desired superbills.
  - b. Select the Change Status button.
  - c. Select the desired status.
  - d. Select the OK button to save the change, and close the window.

## Filing History

The Filing History window lists all filed claims, paper or electronic, accepted or rejected. It provides a means of searching for previous claims batches, review filing history or resubmit a batch of claims where necessary.

1. Billing → Filing History
2. Select Claim Format Type: Electronic or Paper.
3. Select the claim insurance: Primary, Secondary.
4. You can specify a date range. By default, the dates define the previous month, ending today. Change these as necessary.
5. Narrow the search by selecting additional search criteria.
  - Superbill Status, Claim Batch, Claim Creator, Claim Payer, Billing Provider, Service Site, and Patient are multi-select, so you can search on more than one entry for each criterion.
  - Most searches will return results very quickly. However, if your search criteria are broad (for example, searching for a full year) and your database is large, then the search may take a few minutes.
  - You may use only the standard filtering criteria, or you may also use the expanded filtering criteria. Using the expanding filtering may increase the amount of time it takes for the application to search for and display results.
  - You can print the search results by selecting Print from the File menu.
6. View individual superbills by selecting the superbill ID.
7. Review and make any changes to the superbill, if needed. For example, you can select the Don't Claim checkbox against any procedures that have already been claimed and do not need refiling. Close the superbill.

8. Select the corresponding button to reprocess any of the superbills.
  - Process Electronic 837 Batch for electronic claims
  - Print Paper CMS-1500 Batch for paper claims

## Track Superbills

The Track Superbills window lists all superbills with the search criteria you specify. However, regardless of the search criteria entered, the window will only display superbills for financial centers for which you have permissions.

When searching for superbills by posting date, it is important to remember that each procedure on the superbill is associated with a financial batch, and each batch has a posting date. Therefore, a single superbill may appear in the search results for more than one posting date.

Once you display the list of superbills, you can perform a number of tasks.

- Review superbills and prepare them for submitting as claims.
- Print the search results by selecting Print from the File menu.
- Export the search results to an Excel file by selecting Export to Excel from the File menu.
- Validate the diagnosis and procedure coding in one or more superbills by selecting the Validate button.
- Assign superbills to a different financial batch by selecting the Reassign Batch button.
- Create an insurance promise for one or more superbills by selecting the Create Insurance Promise button.
- Create a new superbill by selecting the New Superbill button.
- Identify superbills which meet your practice's requirements for writing off the balance, and when appropriate, process the write-off adjustment by selecting the Writeoff Balance button.
- Recompute the financials for one or more superbills by selecting the Recompute Financials button.
- Change the status, service site, financial center, or provider on one or more superbills by selecting the Update Superbills button.
- Identify overpaid superbills.
- Combine services from two or more superbills for the same patient on the same day with the same procedure code and same service site. Combining services rolls up the time-based units for the procedure code onto a new superbill.
- Create a master claim superbill that includes all the services performed for a patient during a month, with the service dates and charges for each service.

As with all tracking windows, you can create and save filters for frequent use. Creating filters to search for the superbills you need to perform frequent tasks can save you time. The default filtering criterion for this window is superbill statuses of Preliminary and Ready to Review.

## **Identifying When the Superbill or Visit Note is in Use**

A superbill is locked and cannot be opened when it or its associated visit note is being used by another user. This prevents multiple users from making changes to one superbill at the same time. The Track Superbills window displays a locked icon () when a superbill or its associated visit note is in use by another user. This enables you to easily identify superbills which you cannot open.

## **Identifying When the Visit Note is Complete**

The Track Superbills window includes a Visit Status column which indicates whether the patient visit note associated with the superbill has a status of Complete. When the status of the associated patient visit note is Complete, then a C is displayed in the Visit Status column. The Visit Status column is empty if the superbill is not associated with a patient visit note or if the status of the associated patient visit note is Incomplete. The visit status is helpful, for example, in determining when a superbill is ready to review for claims processing.

## **Identifying the Last Follow-Up Date**

Some actions on a superbill are identified as follow-up actions. A follow-up action on a superbill is an action that moves a superbill through the claim and payment lifecycle toward completion. Follow-up actions include activities such as claim scrubbing and receiving electronic responses from the insurance payer. Notes entered by users into the superbill history may also have been marked as a follow-up action.

You can use the date of the last follow-up action to track and monitor superbills to help you ensure that you are processing them in a timely manner. For example, you can filter the Track Superbills window to identify superbills where the last follow-up action date is older than 30 days. You can then review the individual superbills, and take appropriate action as needed.

## **Identifying Overpaid Superbills**

Use the Track Superbills window to identify superbills that have been overpaid. You may want to define a search filter for overpaid superbills. This will enable you to search quickly for the superbills.

It is recommended that you search for overpaid superbills on a regular basis. This may be monthly, weekly, or daily, depending on the characteristics of your practice and your business policies regarding payments and refunds.

## **Review Superbills to Prepare for Claims**

Use the Track Superbills window to identify the superbills that need to be reviewed and prepared for submitting as claims. You can access each superbill to verify its contents. Then you can change the status of the reviewed superbills to Ready to Submit.

The Track Superbills window lists all superbills with the search criteria you specify. However, regardless of the search criteria entered, the window will only display superbills for financial centers for which you have permissions.

When searching for superbills by posting date, it is important to remember that each procedure on the superbill is associated with a financial batch, and each batch has a posting date. Therefore, a single superbill may appear in the search results for more than one posting date.

You may want to define a search filter or filters for reviewing superbills to prepare for claims. Your filter can include both the search criteria and the column selection and order that you prefer when performing this task.

1. Billing → Track Superbills
2. Enter search criteria.
  - There must be at least one search parameter defined. By default, the Preliminary and Ready to Review superbill statuses are selected. You can modify this as desired.
  - If you have a default filter, the criteria will be defined as specified in the filter.
  - You may use only the standard filtering criteria, or you may also use the expanded filtering criteria. Using the expanding filtering may increase the amount of time it takes for the application to search for and display results.
3. Select Search to list all superbills that meet your criteria.

**Note:** You can print the search results by selecting Print from the File menu.
4. Access additional information by selecting a hyperlink.
  - Select a superbill ID to open the superbill.
  - Select a visit date to open the patient visit note.
  - Select a patient name to open Patient Demographics.

## Validating Superbills

Once you have reviewed and prepared the superbills, use the Track Superbills window to validate the superbills you believe are ready to be claimed. Validation includes the application's standard claim scrubbing, which enables you to identify problems and make corrections before you complete the financial batch or batches containing the superbills.

The application's standard claim scrubbing verifies that the data fields required by all insurance payers do contain data. Some fields are scrubbed for every claim, and other fields are scrubbed under certain conditions. Your administrative super user may have defined additional claim scrub profiles for specific payers.

When you validate a superbill, its superbill status is changed as follows.

- **Failed Validation:** Assigned when there are errors from code validation or claim scrubbing. You must correct these errors before submitting the superbill as a claim.
- **Queued:** Assigned when there are no errors, and an insurance payer is identified for the superbill.
- **Pending Patient Payment:** Assigned when there are no errors, and there is no insurance payer identified for the superbill.
- **Complete:** Assigned when there are no errors, there are no charge amounts, and there is no insurance payer identified.

It is recommended that you regularly check for superbills with the Failed Validation status. You must correct the errors on these superbills, and then validate them again so that claims may be submitted for them.

You may want to define a search filter or filters for validating superbills. Your filter can include both the search criteria and the column selection and order that you prefer when performing this task.

1. Billing → Track Superbills
2. Enter the desired filtering criteria, and then select the Search button.
3. Select the checkbox for the superbill or superbills on which you want to perform claim scrubbing.
4. Select the Validate button.
5. When validation is complete, search for the superbills that failed validation. In the Superbill Status field, select Failed Code Validation and select the Search button.
6. Review and correct each superbill.
  - a. Select the Errors link in the Code Validation column. This accesses the Superbill Report window for the selected superbill.
  - b. The Notes column contains the validation message.
  - c. Select the Superbill link to access the Superbill window where you can make any necessary changes to the diagnosis and procedure coding. Both the Superbill and Superbill History windows may be open at the same time.
  - d. Change the superbill Status to Coding Valid, and then select OK to save and close the superbill.
  - e. In the Superbill Report window, select the Select All checkbox to select all the error messages.
  - f. Select the Mark Viewed checkbox, and then select the Update button to mark all the selected errors as having been reviewed.
  - g. Select the Close button to close the Superbill History window and return to Track Superbills.
7. Repeat step 6 for each superbill that failed validation.

### **Change Superbill Status and Other Basic Information**

If you have security access rights to superbills, then you may change the superbill status for one or more superbills from the Track Superbills window.

If you have security access rights to recompute financial information, you may also change the service site, financial center, or billing or rendering provider on superbills. When you make changes to any of these items, the application will recompute the financials for the selected superbills.

1. Billing → Track Superbills
2. Enter the desired search criteria, and then select the Search button.

3. Select the checkboxes for the superbills that you want to change.
4. Select the Update Superbills button. This access the Update Superbills window.
5. To change the status of the superbills, select the desired Superbill Status.
6. To change the financial information on the superbills:
  - a. Select the desired Service Site.
  - b. Select the desired Financial Center.
  - c. Select the desired Billing Provider.
  - d. Select the desired Rendering Provider.
  - e. The Recompute Financials checkbox will be selected if the changes may affect the financials.
7. To enter a note on the superbills:
  - a. Select the Include Follow-Up Action checkbox if you want to identify the changes and your note as a follow-up action in the superbills' history.
  - b. Enter the text of the Superbill Note.
8. Select the OK button to save the changes to the superbills.

### **Display ABN Information**

1. Billing → Track Superbills
2. Select the "Enable Expanded Filter Criteria" checkbox, and then select the Search button.
3. The ABN Complete column indicates whether the ABN Complete checkbox on the superbill is selected.

### **Reassign Superbills to Another Batch**

You can reassign superbills from one open financial batch to another open financial batch from the Track Superbills window. You must remember that when you do this, you are actually reassigning the charges in the superbills from one batch to another. A superbill may have charges that are assigned to one or more financial batches, and those batches may be in different states (that is open, completed, closed).

Charges that are assigned to open financial batches will be reassigned to the target financial batch. If any charges in the selected superbill are in a completed or closed financial batch, those charges will not be reassigned. So, after you reassign a superbill to another financial batch, that superbill may be assigned to both the original batch and the target batch.

It is possible for charges that are assigned to an open financial batch to not be reassigned to the target batch. Reassignment will not be made if the superbill's financial center is closed through the posting date of the target batch. For example, take a superbill that is associated with financial center A, which is closed through September 30. You would like to reassign the superbill from batch 1, which is open and has a posting date of October 3, to batch 2, which is open and has a posting date of September 30. In this case, the superbill charges in batch 1 cannot be reassigned because the associated financial center is closed through the posting date of batch 2.

Because some or all of the charges on a superbill may not be reassigned, the application displays a popup window that lists all the superbills reassigned, each procedure for which there is a charge on the superbill, and the result of the reassignment.

1. Select the checkboxes for the superbills that you want to move.
2. Select the Reassign Batch button.
3. Select the batch into which you wish to move the superbills.

### **Create an Insurance Promise**

You can create an insurance promise for one or more superbills.

1. Select the checkboxes for the superbills that you want to associate with the insurance payer promise.
2. Select the Create Insurance Promise button.
3. Enter the necessary data for the Insurance Payer Promise.

### **Create a New Superbill**

Select the New Superbill button. This accesses the Superbill window.

## **Correcting and Re-filing an Insurance Claim**

If a superbill is filed to an incorrect insurance company, change the insurance company on the patient's account and re-file the claim.

1. Desktop → Find Patient
2. Search for patient.
3. From the patient's demographic window, select the Account Tab.
4. Select the account to be corrected and select New Account Period.
5. Enter the effective date of the new insurance, if you do not know the effective date make sure to enter a date that is prior to the DOS you are trying to refile.

**Note:** Do not remove or replace an Insurance Payer/Plan if a claim has been filed to it. It is always best to begin a New Account Period to preserve the congruity of the product.

6. Select Add Insurance.
  - a. Enter the New Insurance Payer/Plan.
  - b. Enter the New Member ID and Group ID.
  - c. Enter the Insurance Copay Amounts.
7. Check the Account page to make sure the Account Period is correct and begins prior to the DOS you are refiling.
8. Select Superbills from the Patient Menu.
9. Select the superbill ID.

10. Verify the insurance company is correct.
11. Change the superbill status to Queued Primary.
12. Select the History Tab.
13. Select Add Superbill Note to document the change to the superbill.
14. Billing → Process Claims
15. Filter on the Patient Name and Search for the superbill.
16. Check the checkbox to process.

## Aligning Claims to Print on the CMS-1500 Form

The CMS-1500-NPI claim form report is designed to print on the standard CMS-1500-NPI claim form. You must adjust the report to align properly with the claim form in the printer being used. You may have to adjust this alignment from time to time (for example, as a result of changing printers, upgrading the application, or even getting a new supply of claim forms).

Printers that are attached directly to a desktop PC, rather than to the network, can usually be aligned by setting the offsets in the print set that includes the CMS-1500-NPI claim form report. Printers that are attached to the network may need to be adjusted using the HCFA Alignment Tool window. Whether the printer is attached to a desktop PC or to the network, you must make sure that the CMS-1500-NPI claim report is included in a print set, and that the print set is selected by all users who print claims.

### Process for Aligning a Printer Attached to a Desktop PC

1. Ensure that the print set containing the CMS-1500-NPI claim report is selected.
2. Modify the print set to adjust the printer offsets for the CMS-1500-NPI claim report.
3. Print a claim to determine if the text alignment is correct.
4. If not, repeat steps 2 through 4 until the alignment is correct.

### Process for Aligning a Printer Attached to the Network

1. Ensure that the print set containing the CMS-1500-NPI claim report is selected.
2. Modify the print set to adjust the printer offsets for the CMS-1500-NPI claim report.
3. Print a claim to determine if the text alignment is correct.
4. If not, adjust the print alignment in the HCFA Alignment Tool window.
5. Print a claim to determine if the text alignment is correct.
6. If not, repeat steps 5 through 7 until the alignment is correct.

**Note:** Most alignment issues are simple in that all the text of the claim is misaligned with the form in the same way and by the same amount. These issues can usually be resolved quickly by following the procedures presented here. However, some alignment issues are more complex, and different sections of the claim text are misaligned with the form in different ways and amounts. You must call Support for assistance in addressing these alignment issues.

## Select the Print Set

1. Tools → Print Set
2. Select the print set you modified for the claim forms. This places a checkmark next to the print set.

## Modify the Print Set

1. List Editor (  ) → System → Print Sets
2. Search for and select the print set that includes the CMS-1500-NPI claim form. (This may be named CMS-Claims.)
3. Select the Modify button.
4. Locate the CMS-1500-NPI entry in the Print Sets window.
5. Verify that the Printer Settings field identifies the printer used for claim forms.
6. In the Offsets fields, make the following entries.
  - Top: 0.146
  - Left: 0.112
7. Select the OK button to save the new offsets.
8. Print a claim.
9. If the alignment is not correct, either:
  - If the printer is connected to a desktop, adjust the top and left offsets as appropriate until the alignment is correct.
    - To move the text up, enter a larger number as the Top offset.
    - To move the text down, enter a smaller number as the Top offset.
    - To move the text to the left, enter a larger number as the Left offset.
    - To move the text to the right, enter a smaller number as the Left offset.
  - If the printer is connected to the network, adjust the alignment with the HCFA Alignment Tool Window.

## Align Text with the HCFA Alignment Tool Window

When you open the HCFA Alignment Tool window, the claim text appears correctly aligned with the claim form. You will move the text until it appears to be misaligned in the same way and degree as the text when you print a claim. This aligns the actual printed text on a form.

1. Tools → Align HCF Tool
2. In the Print Set field, search for and select the print set that includes the CMS-1500-NPI claim report.
3. Click anywhere on the text, and hold the left mouse button down.

4. Drag the text until it appears to be misaligned in the same way as your printed claim.  
For example, if the text on your printed claim is slightly low and to the right, then drag the text down and to the right.
5. If needed, use the Left, Right, Up, and Down arrows at the top of the window to make fine adjustments to the location of the text.
6. When the text in the window matches the text on your printed claim, select the OK button. This saves the new top and left offsets to the selected print set.
7. Print a claim.
8. If the alignment is not correct, repeat this procedure making minor adjustments to the offsets. The old offsets and the new offsets appear at the bottom of the window.
9. If necessary, select the Reset Position button at the top of the window to return to the last saved offsets.

## Balancing and Closing

### Overview

Closing a posting date is essentially the same process that you or your accountant uses to close your financial books each month or that you use to reconcile your bank account statement. Like closing the financials for a month or reconciling a monthly bank statement, closing the posting date locks the financial transactions for that posting date. This is a sound accounting practice that enables you to generate valid financial reports that you can use for financial balancing.

Updating the closing date for a financial center permanently closes all the financial batches associated with that financial center through the selected close date. Once a financial batch is closed, no changes can be made to the transactions in that batch. Therefore, the application will not allow you to close a financial center if an associated batch contains a payment transaction that has not been fully allocated to either charges on superbills or to a payer credit.

The phrase “closed through date” means that this is the last locked down financial date for a particular financial center or for the system. A financial center cannot have an open posting date prior to its closed-through date, and no financial center can have an open posting date prior to the system’s closed-through date.

Once a date is closed for a financial center, you will not be able to apply charges, payments, or adjustments to that date for that financial center. This does not mean, however, that corrections cannot be made if errors are found later. Instead, it means that those corrections are clearly identified and are documented with an auditable trail. This ensures the integrity of your financial transactions. Closing regularly is the only way that you can confidently know the dollar amounts of the charges made, payments received, and adjustments made for a posting date, week, month, or year.

If you do not close regularly, you cannot be sure of your financial position. It is better to close frequently and make documented corrections when needed, than to leave a posting date open for a long time ‘just in case’ something needs to be changed. Leaving a posting date open for a long time and making changes can lead to compounded errors that are much harder to identify and correct.

It is highly recommended that you close a posting date every day. It is also highly recommended that you do not close for the current calendar date. You should close for a posting date that is one day to two weeks prior to today. This allows enough time for surgeries and other postings in arrears, and still provides you with an accurate, current financial position.

For example, some practices will regularly close Monday's posting date on Tuesday, while other practices will regularly close Monday's posting date on the following Monday. Closing daily, or at least frequently, means that there is less to process each time you close. This makes it easier for you to review the transactions prior to closing, and it means that the update closing date process within the application completes quickly.

You may close through a given posting date for one or more financial centers at a time. When you close through a posting date, all of the financial batches containing financial transactions associated with the selected financial center or centers are closed. Batches that are empty and batches that contain only unallocated payments will not be closed because they are not associated with a financial center.

Remember that the transactions that are in a financial batch are not necessarily all associated with the same financial center. When a batch contains transactions that are associated with more than one financial center, all the financial centers must be closed through the posting date of that batch at the same time. So, you will not be able to update the closing date for financial center A if a batch contains transactions for both financial center A and financial center B, and financial center B cannot be closed because other batches contain transactions for financial center B that have not yet been processed and balanced. You have two options in this situation. You may wait to update the closing date for both financial center A and B until all the batches containing transactions for both financial centers have been processed and balanced. Or you may move the transactions related to the financial center B to another batch with a posting date that will not be closed, and then update the closing date for financial center A.

All system processes that create batches, such as ERA processing and automated accounts receivable processing, should be scheduled to run overnight after midnight. This ensures that the processes do not attempt to create a batch for a financial center that has been closed through the previous day's date.

### **Performing the Balancing and Closing Processes**

The balancing and closing activities may be performed by one or several people. In a small practice, one person may be responsible for all financial transactions and for balancing and closing. In a larger practice, one person may be responsible for charges and another for payments, or one person may be responsible for provider A's financial transactions while another person is responsible for provider B's financial transactions. In this situation, a supervisor or manager may be responsible for updating the closing date after the staff have reviewed their transactions and completed their financial batches.

### **Closing Open and Completed Batches**

Before you close through a posting date for a financial center, you can complete the batches associated with that financial center through the desired date. This enables you verify that all financial transactions have been fully processed (for example, all payments have been fully allocated). Then you can confidently close the financial centers through that date.

Please note that the application will allow you to close through a date that includes open financial batches (that is, batches not marked as complete). Therefore, it is possible to close a batch that has not been reviewed. It is important that you review and complete all batches before closing a financial center, because a batch cannot be changed once it is closed.

Once you close a financial center through a posting date, you cannot open any new batches for that posting date for that financial center. You also cannot open any new batches for any financial center prior to the closed-through date for the system. For example, if you have closed a financial center through November 15, 2010, then you cannot open a batch for that financial center with a posting date any earlier than November 16, 2010.

### **Unallocated Payments**

You cannot complete or close a batch that contains unallocated payments. Therefore, the application will not allow you to close a financial center if an associated batch contains a payment transaction that has not been fully allocated to either charges on superbills or to a payer credit. You must either fully allocate the payment to charges or payer credits or move the payment to a batch with a posting date later than the date you are closing through.

When a payment will be allocated to superbill charges or payer credits associated with multiple financial centers, you will not be able to close any of those financial centers through the posting date of that payment until the payment has been fully allocated.

### **Closing and Claims**

Claims may be processed for financial batches that are open, complete, or closed. Note that claims are not really in a batch; rather the charges for the superbill for which the claim is made are in a batch. Therefore, secondary and tertiary claims are associated with the same batch or batches as the primary claim, which is the batch the superbill charges are in.

## **Balancing Process**

Perform the following activities to balance your transactions before you perform the financial close by updating the closing date.

1. Balance the Batch Summary report and the Daily Charges Trial Balance report.
  - a. Generate the Batch Summary report for the posting date that you want to balance and close.
  - b. Generate the Daily Charges Trial Balance report for the posting date that you want to balance and close.
  - c. Compare the total charges on the Batch Summary report to the daily total on the Daily Charges Trial Balance.
    - If the totals are the same, then go to step 2.
    - If the totals are not the same, then identify and correct the discrepancy.
2. Balance the Deposit Slip report to the actual bank deposit.
  - a. Generate the Deposit Slip report by deposit date for the date that you want to balance and close.

- b. Compare the total deposit amount on the Deposit Slip report to the total on your actual bank deposit.
  - If the totals are the same, then go to step 3.
  - If the totals are not the same, verify the bank deposit total. Then compare the entries in the report to the entries in the actual bank deposit to identify the discrepancy, and make the needed correction.
3. Balance the Batch Summary report and the Deposit Slip report.
  - a. Compare the total deposit amount on the Batch Summary report (generated in step 1) to the total deposit amount on the Deposit Slip report (generated in step 2).
    - If the totals are the same, then go to step 3.
    - If the totals are not the same, verify the bank deposit total. Then run the Deposit Slip by posting date and/or generate the Batch Deposit Review report, and identify and correct the discrepancy.
4. If you have not already done so, complete your financial batches for the posting date you want to balance and close. (Note: You may have done this before running your balancing reports.)
  - a. Accesses the Batches window (Billing → Batches).
  - b. In the Posting Date, use the Custom Dates option to select the desired posting date.
  - c. Enter any other desired filtering criteria. For example, if you have access to another user's financial batches, you may want filter on batch Owner as well.
  - d. Select the Search button to search for the batches matching your filtering criteria.
  - e. Use the Unallocated column in the search results to verify that there are no unallocated payment amounts.

If there are unallocated payment amounts, either allocate the remaining payment amount to charges or to payer credits or move the payment into a batch for a later posting date that is not being closed.
  - f. Select the checkboxes for the batch or batches you want to complete, and then select the Complete Batch button.

## Closing Process

The closing process can be performed once all financial batches for the desired financial center and posting date have been balanced. Perform the following activities, in order, to properly close through a posting date for a financial center or centers.

1. Review all the financial batches for financial center or centers you wish to close through the posting date you want to close.
  - a. Accesses the Batches window (Billing → Batches).
  - b. In the Posting Date, use the Custom Dates option to select the desired posting date.
  - c. Select the Search button to search for the batches matching your filtering criteria.

- d. Verify that there are no unallocated payment amounts and that all the batches are completed.
  - If there are unallocated payment amounts, either allocate the remaining payment amount to charges or to payer credits or move the payment into a batch for a later posting date that is not being closed.
  - The update closing date process will allow you to close an open batch. If you are sure that the open batch is balanced and ready for closing, it is not required to complete it first. Remember, however, that a financial batch cannot be re-opened once it has been closed.
2. Update the closing date through the desired posting date for the desired financial center or centers. See the Update Closing Date section below for instructions.

## Update Closing Date

### Understanding the Update Closing Date Window

All financial centers display on the Update Closing Date window. The financial center checkboxes will be active for only those financial centers to which you have access rights.

Dates will appear in the Can Close Through column as you select the financial centers that you want to close. The Can Close Through date is the latest possible date through which you can a close a financial center. There are no batches containing unallocated payments prior to the date in the Can Close Through column. The date in the Can Close Through column is dependent on the financial centers that you have selected since financial batches may contain items associated with more than financial center.

The Update Closing Date window displays information about the financial batches, payment items, payer credits, and superbills associated with financial centers. For batches and payments, this information includes a count of all batches or payment items associated with the financial center, and a count of the batches and payment items that are blocking the financial center from closing through a later date. A batch or payment may block the financial center from closing when a payment has an unallocated amount, when a payment has an amount allocated in a financial center that is not selected to be closed, or when a batch is associated with any transaction that is marked as blocking because of the first two conditions.

For payments, the window also displays the total amount of all the payment items and the total unallocated amount. While a financial batch containing a payment with an unallocated amount cannot be closed, the total unallocated amount shown is not necessarily the total amount of the blocking payment items. This is because a payment item may be blocking because it has payment allocations in a financial center that you have not selected, not because it has an unallocated amount.

The window also displays the count of payer credits associated with a financial center, the total amount of those payer credits, and the unallocated amount (that is, the amount available to be allocated to charges). The window also displays the count of superbills associated with a financial center, the total amount of the charges on those superbills, and the amount of the charges that have not be paid (that is, the charges to which no payment allocation has been made).

## **System Closed Through Date and Items**

Along with your financial centers, the Update Closing Date also displays information for your system as a whole.

The Closed Through date for the system is the date through which all financial centers are closed. The system Closed Through date cannot be later than the latest Closed Through date for any financial center selected. Also, if there is any financial center that has never been closed, and thus has no Closed Through date, then the system will also have no Closed Through date.

Dates earlier than system closing date cannot be used as the posting date when creating a new financial batch.

The Batches All Count and Blocking Count columns for the system show the number of financial batches that contain a payment item for which an amount is not yet allocated, and so is not yet associated with any financial center. Likewise, the Payments All Count and Blocking Count are the number of payment items for which an amount is not yet allocated.

A payment item must be fully allocated to either charges on a superbill or to payer credits before the financial batches containing any allocation from that payment item can be closed.

You should update the Closed Through date for the system regularly, just as you should regularly update the Closed Through date for your financial centers.

## **Financial Balancing**

It is very important to understand that the information displayed on the Update Closing Date cannot be used for balancing. This is because the individual items in a financial batch may be associated with different financial centers or, in the case of a payment item, with no financial center. Therefore, the number of batches in the Batches All Count column for one financial center may include some of the same batches in the Batches All Count column for another financial center or for multiple financial centers. Likewise, the Payments All Count and the Payments Total and Payments Unallocated amounts for any given financial center may include payment items that are also associated with one or more other financial centers.

## **Data Display Issues When Closing for Long Periods**

If you have not closed your financial centers in a long time and have many open or completed batches, then the application may have difficulty displaying information. When you select a link (such as, All Batches, Blocking Batches, Deposits) from the Update Closing Date window, it may take several minutes for the next window to display, and the window may not display all the results. In some instances, the application may display a popup message saying that there are no items in the list, when in fact the list is too large to display.

When this happens, you should close in small amounts, starting from the oldest date and working forward until the closing date is current.

It is recommended that you close frequently. This ensures that your financial reports are accurate and makes it much easier to complete the closing process. It is not, however, necessary or recommended that you close through the current date. Closing is generally done at least one day prior to and may be several days prior to the current date.

## Updating the Closing Date for One or More Financial Centers

1. Billing → Update Closing Date
2. Select the checkboxes for the financial centers that you want to close.
3. If desired, select the checkbox for System.
4. Select the Refresh button to display the Can Close Through date, the Batches Blocking Count, and the Payments Blocking Count for the selected financial centers and the system, if selected.
5. Review the batches, payments, and superbills associated with each financial center.
  - If desired, select the Blocking Count hyperlink for batches to access the Track Batches window with a list of the batches associated with the financial center that contain unallocated payments. You may then review the batches, and allocate the payments if desired so that the financial center may be closed. (Please note that when accessing the Track Batches window from this link, the Track Batches window will not display more than 501 batches at a time.)
  - If desired, select the Blocking Count hyperlink for payments to access the Batch Payments window with a list of the payments associated with the financial center that contain unallocated payments. You may then allocate the payments if desired so that the financial center may be closed.
  - If desired, select the Count hyperlink for superbills to access the Track Superbills window with a list of the superbills associated with the financial center.

Note that there can be unexpected results in any of these windows because there are two ways that superbills and charges can be associated with a financial center. A superbill is associated directly with a financial center by the financial center identified on the patient visit note or selected on the Superbill window's Information slider. Payment items become associated with a financial center when money from the payment item is allocated to charges on a superbill. When superbills and payment allocations are put in a financial batch, those superbills and the payment items from which the allocations were made become indirectly associated with any financial centers that other superbills and payment allocations in that financial batch are directly associated with. Also remember that the Track Batches, Batch Payments, and Track Superbills windows will not display items directly associated with financial centers to which you do not have access rights, even if those items are in the financial batch with which you are working.

6. Select the Through Date. All batches for the selected financial centers will be closed through this date. If the System checkbox is selected, the system closed through date will be updated to this date.
7. Select the Update button to update the closing date for the selected financial centers and the system if selected.
8. Select the Search button to display the new Closed Through dates.

# Statements

Statements are generated for responsible parties, not for individual patients. For patients who are responsible for their own charges, the statement contains only transactions related to that patient. But, for a responsible party who is responsible for others, such as a parent responsible for more than one child, a statement may contain transactions for multiple patients.

Also, a patient may have more than one account, and those accounts may have different responsible parties. For example, a patient may be the responsible party for the main account, while the patient's employer is the responsible party for a second account related to a worker's compensation claim. Because statements are generated for responsible parties, a statement will be generated for the patient with transactions related to the patient's main account, and another statement will be generated for the employer with transactions related to the worker's compensation account. Should the employer be responsible for more than one patient, the employer's statement may contain transactions for all of the patients for which that employer is responsible.

## Statements by Practice or by Financial Center

You may generate statements for the practice as a whole or for individual financial centers. Your administrative super user will have configured the application for the method your practice chooses to use. The manner in which you generate and process statements is basically the same whether statements are generated and processed for the practice or for financial centers.

It is important to understand that you can generate statements for the whole practice or for each individual financial center, but that you cannot generate statements for some financial centers individually and generate statements for other financial centers as the practice.

When you generate statements for the practice as a whole, the statement cycle, dunning messages, and other statement generation characteristics are defined for the whole practice. When you generate statements by financial center, these characteristics are defined for each financial center.

When you generate statements by financial center, then multiple statements will be created for a responsible party if that responsible party has charges or payments associated with more than one financial center. For example, if the responsible party Jane Doe has financial transactions associated with financial center A and with financial center B, then a statement will be generated for Jane Doe when financial center A's statements are generated, and a statement will be generated for her when financial center B's statements are generated. However, the application will only generate statements for financial centers to which you have security access.

## **Statement on New Activity**

Your administrative super user will have established a statement cycle for your practice or financial centers. The statement cycle defines the frequency of statements for responsible parties. For example, if the cycle is set to 30, a statement will be generated every 30 days.

However, this statement cycle can be overridden by defining statements to generate on new activity. Then a responsible party's statement will be generated for any patient liable charge between statement cycle dates. This simply queues the responsible party for a statement in any statement batch for which the responsible party meets the filtering criteria.

If your practice generates statements by financial center and any of your financial centers is configured to generate on new activity, then that rule applies to all financial centers. So, a responsible party with new charge activity will be queued for a statement for all financial centers, not just the financial center on the new charges.

## **Changing Between Practice and Financial Center Statement Generation**

It is recommended that you consistently generate statements either by practice or by financial center. You can change methods if your needs change. There are, however, several things that must be considered before changing the method of statement generation.

### *Finalize Statements and Complete Statement Batches Before Changing Methods*

If you change between statements by practice and statements by financial center, then you will not be able to access the batch details of any batch generated for the previous method of generation. Therefore, before changing the method of generation, you must complete all statement batches by printing or sending electronically the finalized statements.

You will not be able to finalize and print or send electronically the statements in a batch after changing the statement generation method. If this happens, you will delete the incomplete batch in order to release the patient accounts, and then generate a new statement batch.

### *Notify eTactics Electronic Statements Clearinghouse Batches Before Changing Methods*

If you are using the eTactics for electronic statement clearinghouse, then you must notify eTactics before converting to statement generation by financial center, rather than by the practice as a whole. eTactics must change their setup definition for your statements before you send them a statement file that has been generated by financial center. If eTactics does not make this setup change, then their processing of your statement file will combine a responsible party's statements for different financial centers into a single statement.

### *Last Statement Date*

Generating by practice does not update the last statement date for each financial center. So, if you generate by practice, then by financial center, and then by practice again, the last statement dates for some financial centers may not be correct. As a result, statements may generate for some responsible parties that you did not expect.

## Exclusions from Statement Generation

### Excluding Superbill Statuses from Statement Generation

Your practice may select specific superbill statuses that you want to exclude when generating statements. Superbills with the excluded statuses are not included on statements and are not used when calculating statement balances. This enables you to suppress superbills based on the revenue cycle.

Superbills that are excluded from statements based on superbill status do continue to age normally. As a result, when a superbill's status changes and it is included in the statement, it may trigger a statement dunning message.

Superbill status exclusions may be set at the practice level or at the financial center level, when generating statements by financial center. This will be defined by your administrative super user.

Even though you may exclude superbill statuses, it is still important to make sure that all charges have been reviewed and all payments allocated before generating statements. For this reason, it is a good practice to review and complete financial batches just prior to generating statements. This helps you ensure that statements contain the most accurate patient account information.

### Excluding Collection Statuses from Statements

Your practice may flag collection statuses to generate or not generate statements. When a collection status is flagged to not generate statements, then the application will not generate a statement for any responsible party with that collection status.

### Excluding Responsible Parties from Statements

You may exclude responsible parties from statement generation. By default, the application will automatically exclude responsible parties if their address is marked as undeliverable or if they have a collections status that is excluded from collections. You may change the setting on a responsible party so that statements are not generated at all, or so that statements are generated regardless of whether the responsible party is in collections or whether the address is flagged undeliverable.

1. Patient Demographics → Account tab
2. Select the Responsible Party hyperlink. This opens the Responsible Party window.
3. Select the Statement tab.
4. Select the radio button for statement generation:
  - Yes: Statements will be generated whether or not the responsible party is in collections, and whether or not the address is marked as undeliverable.
  - No: Statements will not be generated whether or not the responsible party is in collections.

- System: This is the default setting. The application determines whether or not to generate a statement. The application will not generate a statement if the responsible party is in collections or if the address is marked as undeliverable.

## **Financial Center Security**

When generating statements by financial center, it is important to remember that you are only able to access data for the financial centers to which you have been assigned. This means that when you generate a statement batch, the application will only generate statements for responsible parties who have financial activity in the financial centers to which you are assigned, even if you do not specify a financial center or financial centers. This is also true when you generate an on-demand statement for a single responsible party.

However, statement batches that are generated by the Batch Statement Processing job are not restricted by financial center security. So, these statement batches will include all statements that meet the filtering criteria regardless of financial centers.

When generating statements for the practice as a whole, all statements contain all financial data for the responsible party regardless of financial center and regardless of the user's assignment to financial centers.

## **Statement Setup and Characteristics**

### **Identifying Credit Cards Accepted**

You can include up to six types of credit cards that you accept on your statements. To be included on the statement, the credit card type must be defined as a payment type within the application, and the payment type must include a credit card type code. Only six credit card types may be included on statements. If you have more than six payment types defined with credit card type codes, then only the first six such payment types listed in the Payment Type List Editor window will be included. To remove a credit card type from the statement, you must remove the credit card type code from the payment type.

By default, all credit card types that can be processed through Easy Pay include the credit card type code. You should review your payment types before printing your first batch of statements to make sure that all payment types for credit cards you do accept have the correct credit card code entered, and make sure that the payment types for any credit cards that you do not accept do not have a credit card code entered. You may also want to inactivate payment types for any credit cards that you do not accept.

## Statement Layout Options

The system-defined formatting model for statements is designed to correctly display in a #10 double-window business envelope.

Additional settings for the generation of statements enable your administrative super user to define the information that is included on your statements. These settings can be defined for the practice as a whole or for individual financial centers. The settings include:

- Including or excluding the referring provider with the superbill information.
- Including or excluding your reference number with the payment information.
- Including or excluding the any procedures for which no charge was made.
- Including or excluding the CPT or HCPCS code for the procedure with the superbill information.
- Including or excluding the last date on which a claim was filed with the superbill information.

## Dunning Messages

You can include brief dunning messages on your statements if desired. A dunning message is a brief (150 character) message that appears on the statement based on the age of the oldest charge on the statement. Aging is based on when the amount became the patient's responsibility, not on the date of service.

Dunning messages can be friendly to stern reminders that a payment is due. You can define different messages for five aging categories from zero days to over 120 days. Messages are defined at the practice level when statements are produced for the practice as a whole. Messages are defined at the financial center level when statements are produced by financial center.

Enter the dunning message you wish to use for each aging category. If you do not want a dunning message for a particular category, simply leave that category blank. When you define a dunning message for an aging category, both the aging category and the dunning message appear on the statement. When no dunning message is defined for an aging category, then neither the aging category nor the dunning message appear on statements.

The aging categories are:

- 0 – 30 Days
- 31 – 60 Days
- 61 – 90 Days
- 91 – 120 Days
- 121+ Days

## Statement Batches

Statement data must be generated before you can review and process the statements. Statement data is generated in a statement batch. Statement batches may be automatically generated on a regular basis by a job or you may generate a statement batch on demand.

The Batch Statement Processing job enables you to generate statement data during off hours. Then, you can simply review and print statements during regular office hours. The job may be scheduled for each statement batch that you regularly create. Small offices may generate a single statement batch once a month, while larger offices may prefer to generate a statement batch twice a month or each week in order to reduce the processing load.

Generating a statement batch does not update the statement date for the responsible parties in the batch. It simply generates the statement data so that you can review the statements, and then process the ones that you want to complete.

When you review the statement data in a batch, you select the statements you want to process. Then, you can finalize the statement batch, which updates the statement date for the selected responsible parties. Once you finalize a batch, then no further changes can be made to it.

Once finalized, you must complete the statements. The application automatically determines how to complete each statement. The default method is printing statements for mailing. If, however, your practice has enrolled with an optional electronic claim clearinghouse, then the application creates and transmits a file of statement data to the clearinghouse. The clearinghouse then prints and mails the statements.

## Statements on the Patient Portal

If your practice is using the Patient Portal, then your administrative super user may configure the Portal to enable patients and responsible parties to access their statements. When you complete finalized statements, either by printing them or sending them to a clearinghouse, the statements are also available from the Patient Portal.

Responsible parties may choose to receive their statements only through the Portal rather than having printed statements mailed to them. To *only* send a responsible party's statement to their Portal account, you must have identified in the Responsible Party window's Statement tab that the responsible party wants to receive statements only through the Portal. Then, the application does not print the statement, or if using a clearinghouse, it does not include the statement data in the clearinghouse file. When the application sends the statement to the Portal, it also sends an email to the responsible party stating that the statement is available.

Responsible parties that do not have Patient Portal accounts may also receive their statements on the Portal if an email address is entered for them. The application sends an email to the responsible party with a link to the statement. After selecting the link, the responsible party is asked to log in using the access code in the email, their ZIP code, and either their birthdate or phone number. The link to the statement is active for 30 days, then it expires. If you are using Easy Pay for credit card processing, these responsible parties without Portal accounts may also make payments from the Portal.

If a responsible party unsubscribes from the statement notification emails, then that responsible party can no longer receive statements *only* through the Portal. The application automatically changes the setting in the Responsible Party window's Statement tab when the responsible party unsubscribes. Please note that unsubscribing affects the email address, not an individual person. If the email address is used by more than one responsible party, all responsible parties using that email address are unsubscribed and their statement options are updated.

**Note:** Responsible parties that are corporations, not individuals, cannot access the Patient Portal, and so cannot access statements on the Portal. Statements for corporations must be printed.

## Statement Generation Process

The typical process for generating statements is outlined below.

1. Statement batches are automatically generated on a regular basis by the Batch Statement Processing job.

If needed, you may generate a statement batch on demand. You may need to do this if the job fails for some reason. Or, if during your review of a statement batch (task 2), you remove statements from processing for any reason, then you may want to generate a new batch for these statements once you have dealt with the reasons they were removed.

2. Review the statements in the statement batch to determine which statements to process, and which, if any, to remove from processing. Your review of statements will depend on your business practices.

You may, for example, want to sort the statements to identify the responsible parties with payer credits. Then you can review the payer credits to determine whether they can be applied to current charges before sending statements to these responsible parties. Or, you might want to sort to identify particularly high or low statement balances, and determine whether you want to generate statements for the responsible parties or deal with the balances in a different manner. You can remove from processing any statements that you do not want to complete at this time.

Then you can review individual statements, if desired. Some practices review all statements before processing. Other practices may review some portion of the statements. If you review all or some of your statements before processing, you may identify and remove from processing any individual statement that you determine needs further review or correction.

While you are reviewing statements, you may print any statement without updating the statement date for the responsible party. A printed statement may help you or another staff member further review the responsible party's account activity.

3. Once you have removed any statements you do not want to process, then finalize the statement batch. This updates the statement date for the responsible party, and attaches the statement to the responsible party record.

Once you finalize a batch, then no further changes can be made to it. You cannot change the filtering criteria used to create the batch, and you cannot process any statements that were generated but excluded from processing before finalizing the batch. (After you complete this batch, you can generate a new batch to process those statements that you exclude from this batch.)

4. Complete the batch by printing the finalized statements or, if using a statement clearinghouse, submitting the statement files to the clearinghouse. Both printing statements and submitting statements to the clearinghouse also sends statements to your Patient Portal.

If you are using some type of postage sorting or folding software and hardware, you can print all statements to PDF files in a specified folder. Your postage software can then access those files for processing.

5. Monitor statements sent only to the Portal to ensure that responsible parties are viewing them. Then, if desired, print or send electronically statements for anyone who has not viewed the statement on the Portal.
6. Archive the statement batch once you have printed or submitted the statements in the batch. Archiving removes the statement batch from the Batch Process window so that it no longer appears when you are processing current statement batches. You can search for archived batches if for any reason you want to review it again. Remember, however, that you cannot make any changes to a completed batch.

You may also delete a statement batch once you have printed or submitted the statements in it. Deleting a batch permanently removes the batch from your database. You will not be able to access it again. Deleting a statement batch does not delete the statements in that batch that were completed. The individual statements are still attached to the responsible party record.

## **Review and Process the Statements in a Batch**

You must review and process the statements in a batch in order to print or electronically send the statements. You should review and process a statement batch promptly once the batch is generated, either by the job or on-demand. If you do not process the statements promptly, the information in the statements will become out of date. It is recommended that you completely process statements in a batch within two days. If an incomplete statement batch is older than two days, you should delete it and generate a new batch so that the financial data, the statement date, and the payment due date are accurate.

Statement batches are available in the Batch Process window. This window is used to generate and work with other types of batch processes. Therefore, some of the filtering options and columns on the window are not applicable to statement batches.

1. Billing → Statements
2. In the Batch Process window, the Batch Process Type will be defaulted to Statement.
3. Enter the desired filtering criteria, and then select the Search button to display a list of statement batches meeting your filtering criteria.
4. Review the batch information displayed.
  - Name: The name of the batch.
  - Batch Type: This will be Statement for statement batches.
  - Status: Identifies whether the data in the batch is available.
    - Detail: Detailed batch data is available.
    - Not Started: The job has not yet started creating the batch.
    - Error: The batch could not generate due to errors.

- Run Mode: Indicates whether the batch is Running or Not Running.
  - Run Start: This will be blank for statement batches.
  - Run Completed: The number of statements in the batch that are completed (either printed or sent to the statement clearinghouse).
  - Run Generated: The number of statements generated in the batch.
  - Run Errors: The number of statements with errors in the batch.
  - Run Total: The total number of statements in the batch. This is the total of the statements generated and the statements with errors.
  - Created: The date and time the statement batch was created.
5. If desired, select the Batch Type hyperlink to access the Batch Process window, where you can view and modify the filtering criteria used to create the statement batch.
    - Select the Cancel button to return to the Batch Process window without making any changes to the batch.
    - If needed, make changes to the filtering criteria and select the Auto Start Detail checkbox. Then, select the Reset button to regenerate the batch. You can only regenerate a batch if it has not been finalized (statement dates have not been updated).
  6. Select the batch Name hyperlink to access the Batch Process Summary window. This window displays summary information for the statement batch, including the status, the total number of statements in the batch, the number of completed statements in the batch, the total balance of the statements, and other information.
  7. In the Batch Process Summary window, select the View Batch Detail hyperlink. This accesses the Statement Detail window.

The Batch Process Statement Detail window lists each statement in the batch by responsible party. It also gives the payer credit amount and statement balance for each statement. The bottom of the window displays the total number of statements selected in the batch and the total payer credit and statement balance amounts for the selected statements.

8. *<<Revised>>* Sort or filter the statements as needed.
  - Select any column heading to resort the statements by ascending or descending order. This enables you to review statements with payer credits or with large or small balances, for example.
  - Select the Filter () icon to enable filtering.
    - The Responsible Party, External ID, and Financial Center columns can then be filtered or searched by entering text.
    - The Payer Credits and Statement Balance columns can be filtered by minimum, maximum, or both amounts.
    - The Generated, Portal Only, and Status columns can be filtered by selecting the All button, and then selecting or deselecting the items desired.

9. To review statement errors:
  - a. Select the Error hyperlink in the Generated column. This opens the Statement Generation Error window. Depending on the error, the information in this window may indicate the problem so that you can correct it. For other errors, you may need to contact Support so that the error can be investigated and addressed.
  - b. Select the Close button to return to the Statement Detail window.
10. To review the statements:
  - a. Select any column heading to resort the statements, if desired. This enables you to review statements with payer credits or with large or small balances, for example.
  - b. Select the Preview () icon at the top of the window.
  - c. Review the statement, and then either:
    - If the statement is incorrect or has problems, you may print it by selecting the Printer () icon in the preview window. Then, select the Reject button to remove it from processing. (Printing from the preview window does not complete the statement or update the statement date.)
    - If the statement is correct, select the Keep and Continue button.
  - d. Continue until you have reviewed all the statements in the batch. (When you have reviewed all the statements, the Keep and Continue button becomes simply Keep.)
  - e. Select the Close button to close the Statement Preview window and return to the Statement Detail window.
11. In the Statement Detail window:
  - The checkbox for a statement will be unselected if you rejected the statement.
  - The checkbox for a statement will be selected if you kept (accepted) the statement.
12. To finalize the statement batch, select the Save () icon to accept your modifications to the batch.
  - The status for the selected statements changes to Incomplete. This updates the statement date for the selected responsible parties.
  - The status for the selected statements that are Portal Only changes to Portal Only, and the statements are sent to the Patient Portal accounts.
  - The status for unselected statements is changed to Excluded. The statement date is not updated for these responsible parties.
13. To complete the finalized statements and the batch, select the appropriate icon. Portal statements are completed in all of these options. Also, all options generate statement attachments on the responsible party record.
  - Select the Printer () icon to send statements to a printer.
  - Select the Submit () icon to send statements to the electronic statement clearinghouse. The Submit button is available only if your database is configured for electronic statements.

- **<<Revised>>** Select the Export to PDF () icon to generating individual PDF files in the selected file location. This is useful only if you use external postage software and hardware for sorting or folding.

When you complete the finalized statements, the application makes the following status changes:

- The status for Portal Only statements remains Portal Only.
- The status for printed statements changes to Printed.
- The status for electronically submitted statements changes to the name of your electronic statement clearinghouse.

If the statement batch is large, you may need to select the Refresh () icon to see the status changes.

14. Select the Close button to close the Statement Detail window.

### **<<New>> Export Entries from the Statement Batch**

You may export the information on the Batch Process Statement Detail window to a comma separated values (.CSV) file. This enables you to keep a record of the entries in the statement batch or to manipulate the data in Microsoft Excel.

1. In the Batch Process Statement Detail window, filter the items if needed.
2. Select the checkboxes for the entries you want to export to a .CSV file.
3. Select the Export to CSV () icon.
4. In the Save File window:
  - a. Select the desired location.
  - b. Modify the file name if desired. The file name defaults to MM-DD-YYYY HH-MM AM/PM Statement Job.csv.
  - c. Select the Save button. This saves the file, and returns to the Batch Process Statement Detail window.
5. Continue working in the Batch Process Statement Detail window or close the window.

### **Generate a Statement Batch**

In most instances statement batches will be generated automatically by the job. However, you can generate a statement batch on demand if needed.

When you enter the filtering criteria for statement batch, the application estimates the number of statements, the number of responsible parties, and the total balance of all statements that will be in the batch.

1. Billing → Statements
2. In the Batch Process window, the Batch Process Type will be defaulted to Statement. This batch process type must be selected in order to generate a statement batch.
3. Select the New button to access the New Batch Process window.

4. Enter a Name for the statement batch. The name should describe the statements that will be included in the batch. For example, 'Statements A-I'.

**Note:** The batch name may include letters, numbers, and the following special characters: &@#\$.+ -[](). The batch details will not open if the name includes any other special character.

5. In the Statement Criteria area, enter the desired filtering criteria. This may include:
  - Days from last statement: Generally, you will want this to be the same as the statement cycle defined in your Practice Settings. You may set this for a different number of days if desired.
  - Range of responsible party last name: Enter a range of letters separating the first and last letter with a hyphen. For example, "a—d" will select statements for all responsible parties who last names begin with the letters, a, b, c, and d. You may enter more than one range by separating them with a semicolon (;). For example, "a—d; x—z".
  - Balance range: Enter the lower and upper range of the balance amounts for which you want statements. These fields are disabled when generating by financial center. When generating by financial center, the application uses the minimum statement amount defined for each financial center to determine the balances for which statements are generated.
  - Financial center: This field is available only when your practice is configured to generate statements by financial center. Select the financial center for which you want to create statements.
  - Electronic Statement Partner: This read-only field will be populated with your statement clearinghouse partner, if you are using one.
  - Days Statement Due In: This read-only field will be populated with the statement configuration information from the Configure Practice Settings window or the Financial Center window. If you have selected more than one financial center, then this field will be empty since this may be different for each financial center.
  - Minimum Statement Amount: This read-only field will be populated with the statement configuration information from the Configure Practice Settings window or the Financial Center window. If you have selected more than one financial center, then this field will be empty since this may be different for each financial center.
  - Statement on New Charge Activity: This checkbox will be populated with the statement configuration information from the Configure Practice Settings window or the Financial Center window. If you have selected more than one financial center, then this field will be empty since this may be different for each financial center.
  - Excluding Superbill Statuses: This read-only field will be populated with the statement configuration information from the Configure Practice Settings window or the Financial Center window. If you have selected more than one financial center, then this field will be empty since this may be different for each financial center.
6. As you define the filtering criteria, the Estimated Batch Size area shows the estimated:
  - Number of statements,
  - Number of responsible parties, and
  - Total balance amount of all statements.
7. Select the Auto Start Detail checkbox. This must be selected in order to generate the data for the statements.

8. Select the OK button to start generating the batch. Processing is performed in the background, and it may take some time depending on the amount of data in the defined batch.

If desired, you may select the batch Name hyperlink to access the Batch Process Summary window while the batch is generating. The number of items generated or errored and the total balance will change as the statements are generated.

9. When the batch has finished generating, the Status will be Detail and the Mode will be Not Running. This information is displayed in the both the Batch Process and the Batch Process Summary windows. Once the batch has generated, follow the instructions in the 'Review and Process the Statements in a Batch' section above to complete the statements.

### **Monitor Statements Sent Only to the Patient Portal**

If you send statements only to the Portal, rather than printing and mailing them, then you may want to monitor the statements to ensure that responsible parties are viewing them in a timely manner. Then, if desired, you can print and mail the statement to any responsible who has not viewed the statement on the Portal.

1. Billing → Statements
2. In the Batch Process window, the Batch Process Type will be defaulted to Statement.
3. Enter the desired filtering criteria, and then select the Search button to display a list of statement batches meeting your filtering criteria.
4. Select the batch Name hyperlink to access the Batch Process Summary window.
5. In the Batch Process Summary window, select the View Batch Detail hyperlink. This accesses the Statement Detail window.
6. In the Statement Detail window, identify responsible parties who have not viewed their statement.
  - The Last Statement column contains the date the statement was completed and made available on the Portal.
  - The Portal Only column will contain 'Yes' for responsible parties who only receive their statements on the Portal.
  - The Portal View column contains the date the responsible party first viewed the statement. If this column is empty, the responsible party has not viewed the statement. To quickly identify all of these responsible parties, select the column heading to sort by this column.
7. If desired, print statements for responsible parties who have not viewed them.
  - a. Select the checkbox for the responsible parties for whom you want to print statements.
  - b. Either:
    - Select the Printer () icon to send statements to a printer.
    - Select the Submit () icon to send statements to the electronic statement clearinghouse. The Submit button is available only if your database is configured for electronic statements.
8. Select the Close button to close the Statement Detail window.

## Archive and Delete Statement Batches

Archive statement batches once you have printed or submitted the statements in the batch. If you send statements only to the Portal, rather than printing and mailing them, then you may want to wait a few days before you archive a statement batch. This will enable you to identify responsible parties who have not viewed the statement on the Portal, and print the statement for mailing, if desired.

Archiving removes the statement batch from the Batch Process window so that the batch no longer appears when you are processing current statement batches. You can search for archived batches if for any reason you want to review it again. Remember, however, that you cannot make any changes to a completed batch.

You may also delete a statement batch once you have printed or submitted the statements in it. Deleting a batch permanently removes the batch from your database. You will not be able to access it again. Deleting a statement batch does not delete the statements in that batch that were completed. The individual statements are still attached to the responsible party record.

1. Billing → Statements
2. In the Batch Process window, the Batch Process Type will be defaulted to Statement.
3. Enter the desired filtering criteria, and then select the Search button to display a list of statement batches meeting your filtering criteria.
  - To search for completed statement batches to be archived, select the Archived 'No' radio button and the Status 'Completed' radio button.
  - To search for archived statement batches to be deleted, select the Archived 'Yes' radio button and the Status 'Completed' radio button.
4. Select the checkboxes for the statement batches you want to archive or delete.
5. Either:
  - Select the Archive button to archive the selected batches.
  - Select the Delete button to delete the selected batches.

# Recomputing Financials

There are circumstances when financial information needs to be reviewed and recomputed. This may be needed, for example, when changes are made to a patient's account or when a procedure's fee or allowed amounts are corrected in a fee or amount allowed schedule. These and similar changes may affect existing superbills and charges. The recompute financials functionality can be used to identify the possible changes, and make those changes, if appropriate.

The recompute financials functionality is simply an easy, automated way of reviewing the possible effects of an account change or fee/amount allowed schedule change and applying the financial changes to superbills. To use the recompute financials functionality, users who have the authority to change financial information must be given the security rights to the recompute financials functionality. By default, these access rights are given to the system-defined Financial Administrators user group.

Remember, however, that reviewing and changing charges and payments can be done manually. Any user with security for billing and payment functionality is able to do this without using the recompute financials functionality.

When possible changes to financials are a result of changes to a patient account, the application generates an account change alert message that identifies the superbills potentially affected by the change. To use the recompute financials functionality for patient account changes, you must define the recipient or recipients for account change alert messages.

## Account Period Dates and Superbill Dates

The application uses the start and end dates of the account period and the service end date on the superbill to determine when a superbill is associated with an account period. A superbill is associated with an account period when the service end date on the superbill falls between the account period's start and end dates.

The application also uses the service end date on the superbill to determine the fee schedule and amount allowed schedule associated with the superbill. A superbill is associated with a fee schedule or amount allowed schedule when the service end date on the superbill falls between the fee schedule's or amount allowed schedule's effective period start and end dates.

The application uses the service start date on a superbill to identify the primary, secondary, and other insurance payers associated with the superbill.

## Changes to Superbills as a Result of Patient Account Changes

Changes to the insurance payer, insurance plan, or the insured party on a patient's account may affect existing superbills and charges, even those that have been completely paid. For example, if the insurance payer or plan is changed, then all superbills for the account period are updated with the new insurance information. Fee amounts, amounts allowed, and copay amounts may also need to be updated. This may mean that the insurance payer or responsible party still owes money on a superbill or that a superbill is overpaid.

Because changes to fee amounts, amounts allowed, and copay amounts affect your financials, you must review the superbills potentially affected by the account changes to determine what changes, if any, you need to make to those superbills. When the potential changes are valid, then you must make the changes and update your financials. You may also need to take further action such as submitting a claim to the new insurance payer, billing the patient, or processing a refund.

It is not always necessary to make changes to superbills affected by an account change. If the superbills are old and are completed, then you may choose not to update these amounts. Or, upon reviewing the potential changes, you may determine that the changes to the patient's account information should have been made in a new account period. Thus, the potential changes to the superbills are not valid, and should not be made.

When a user makes changes to a patient's account that may affect superbills, the application automatically creates an account change alert message that the user can send to the staff member responsible for reviewing the superbills.

The application determines the superbill that may be affected by an account change by the end service date on the superbill and the start and end dates of the account periods.

## Payment Changes

Responsible party and insurance payer payments are not automatically removed or changed when you recompute financials. Therefore, you must review any payments made for superbills affected by an account change. If the account change results in an over payment, then you will want to create a payer credit for the over payment amount. If the claim was sent to and paid by the wrong insurance payer, you will want to create a payer credit for the payment amount, and then send the claim to the correct insurance payer.

## Create the Account Change Alert Message

When you make changes to the current effective period or a prior effective period of a patient account, the application generates a message if any superbills may be affected by the account changes. The message serves as a reminder that the account changes may have affected financial information, and that the superbills need to be reviewed.

The account change alert message contains the:

- Patient name
- Account name
- Date range affected by the change
- Number of superbills potentially affected by the change
- Items changed that may result in financial changes

You must send this message in order for the changes to the patient account to be made in the database. If you cancel this message or close it without sending, then the changes to the patient account are not saved.

1. Patient Account window
2. Make the desired changes to the patient account.
3. Select the OK button to save the changes.
4. If the changes may affect superbills and their financial information, then the Message window opens with an Account Change Alert message for the patient.
5. The Assigned To field contains the default recipient defined in your user record. You may select another user desired.
6. Select a Due Date for the message. A due date is highly recommended to help ensure that account changes are reviewed and processed in a timely manner.
7. Either:
  - Select the OK button to send the message and to save the changes to the patient account. The Message window and the Account window close.
  - Select the Cancel button to cancel the message. This returns you to the Account window. The changes to the account are still shown, but they have not been saved. You may make other changes or use the Cancel to close the Account window without changes.

## Process the Account Change Alert Message

Use this process to review the superbills that may be affected by a change to a patient account. If you have the necessary security rights, you may use the recompute financials functionality to make the changes when appropriate.

It is recommended that you had the account change alert messages to your regular message filter or create a specific message filter for these messages. This will help you review the messages and process any changes needed in a timely manner.

1. Either:
  - Desktop message pane → Message date and time hyperlink
  - Desktop menu → Message Center → Created date and time hyperlink
2. In the Message window, review the account change information to understand what was changed in the patient account.

Be aware that the Message window displays the information for the time that the change was made. If additional changes have been made to the patient's account or to any of the affected superbills, then the information in the message may no longer be correct.

3. Select the Launch Track Superbills button to access the Track Superbills window for the affected superbills.
4. View the potential changes to a superbill:
  - a. Select the checkbox for the desired superbill.
  - b. Select the Recompute Financials button.

- c. The Recompute Financials window displays information about the procedures in the superbill which potentially need to be changed as result of the account change. The window displays the procedure code, the data field, the old value, and the new value based on the account change.
- d. When you have finished reviewing the potential changes, select the Close button.
- e. A popup message appears asking if you want to save the changes. Either:
  - Select the OK button to save all the changes to the superbill.
  - Select the Cancel button to cancel all the changes to the superbill.

If you want to save some, but not all of the potential changes, or if you want to make different changes, then you must select the Cancel button to cancel all the changes. Then you can open the superbill to manually make the desired changes.
5. Repeat step 4 until you have reviewed all the superbills and made the appropriate changes.
6. Once you have reviewed all the superbills, in the Message window, select the Complete button to complete the message.

## Review and Recompute a Superbill

You may review and recompute a specific superbill from within the Superbill window.

1. Either:
  - Account change alert message → Launch Track Superbills button
  - Billing menu → Track Superbills
2. Select the Superbill ID hyperlink to access the Superbill window.
3. Select the Payments slider to review the payments and adjustments.
4. Select the Recompute Financials button.
5. The Recompute Financials window displays information about the procedures in the superbill which potentially need to be changed as result of the account change. The window displays the procedure code, the data field, the old value, and the new value based on the account change.
6. When you have finished reviewing the potential changes, select the Close button.
7. A popup message appears asking if you want to save the changes. Either:
  - Select the OK button to make all the changes in the superbill.
  - Select the Cancel button to cancel all the changes to the superbill.

If you want to make some, but not all of the potential changes, or if you want to make different changes, then you must select the Cancel button to cancel all the changes. Then you can manually make the desired changes.
8. Make any manual changes to the charges, payments, or adjustments as appropriate.
9. Select the OK button to save all the changes and close the Superbill window.

## Review and Recompute from Track Superbill Procedures

You may also review and recompute superbills from the Track Superbill Procedures window. This is useful when you need to identify superbills that may be affected by a change to a procedure's fee or allowed amounts.

You may also use the Track Superbill Procedures window to review superbills that may be affected by a change to a patient account. This is very similar to reviewing and recomputing from the account change alert message or directly from the Track Superbills window. But, the Track Superbills Procedures window displays more detailed information than the Track Superbills window. This enables you to review more information without opening each individual superbill.

1. Billing → Track Superbill Procedures
2. Enter the desired search criteria.
  - When reviewing potential changes resulting from a change to a procedure's fee or allowed amounts, the search criteria may include the procedure and the visit date or service date. You may also use the superbill status if, for example, you are not interested in possible changes to superbills that are completed.
  - When reviewing potential changes from a patient account change, the search criteria may include the patient name and the visit date or service date. You may also use the superbill status if, for example, you are not interested in possible changes to superbills that are completed.
3. Select the Search button to display a list of superbills and procedures meeting your search criteria.
4. View the potential changes to a superbill:
  - a. Select the checkbox for the desired superbill procedure.
  - b. Select the Recompute Financials button.
  - c. The Recompute Financials window displays information about the procedures in the superbill which potentially need to be changed. The window displays the procedure code, the data field, the old value, and the new value based on the account change.
  - d. When you have finished reviewing the potential changes, select the Close button.
  - e. A popup message appears asking if you want to save the changes. Either:
    - Select the OK button to save all the changes to the superbill.
    - Select the Cancel button to cancel all the changes to the superbill.

If you want to save some, but not all of the potential changes, or if you want to make different changes, then you must select the Cancel button to cancel all the changes. Then you can open the superbill to manually make the desired changes.
5. Repeat step 4 until you have reviewed all the superbills and made the appropriate changes.

# Tracking Financials

The Track Financials window enables you to view your ledger of financial activity. You can filter the ledger by payment or superbill with a variety of filtering criteria. You must, however, select at least one filtering criterion.

1. Billing → Track Financials
2. Enter the desired criteria, and then select the Search button.
3. Select an Action hyperlink to access the transaction, superbill, or payment.
4. Select the Account hyperlink to display on the Track Financials window only the financial activity for the selected superbill or payment.

# Care Management

The application's care management functionality is used for Medicare's care plan oversight (CPO) and chronic care management (CCM) programs. Both programs allow providers to bill for time they spend managing a patient's care with other physicians and health care professionals who are providing care to the patient. These payments are not for services rendered by the provider either in the provider's office or at another facility or the patient's home.

Care management payments are based on the number of minutes that the physician or other qualified health care professional spends managing a patient's care during a month. Time spent on managing care qualifies for CPO or CCM payment when the provider does not bill for services provided to the patient, either in the practice office or at an external site, on the same calendar date.

The tasks performed while coordinating care must be adequately documented. Documentation to support CPO or CCM activities must include the activities performed, the time spent on the activities, and the reason why the activities were necessary.

A patient may be eligible for both CPO and CCM at the same time. However, a provider may only bill for one program for the patient for a month. The CPO program requires more time spent during the month in order to qualify for a payment, but it also pays more for the monthly service.

The rules and qualifications for care management programs and payments are complex, and are not fully described here. Information for these programs is available from the Centers for Medicare & Medicaid Services (CMS) website (<http://www.cms.gov/>). While these are primarily Medicare programs, other insurance payers may have similar programs. Check with your insurance payers to determine their participation and rules.

The application uses the messaging, visit notes, and care management entries for patients to identify and accumulate CCM and CPO minutes. Depending on your practice's policies, you or a clinical user may review the documentation for accumulated minutes, approve or deny each item and its minutes. CCM and CPO document should be reviewed regularly throughout the month. Once the CCM or CPO requirements have been met for a patient, you should generate the superbill and submit the claim. If the patient has active entries for both CCM and CPO and has met the requirements for both, then the application determines which programs'

requirements have been met, and generates a superbill for the program with the highest charge amount for the month.

## Chronic Care Management

Medicare's chronic care management (CCM) program allows providers to bill for time they spend on non-face-to-face care coordination services. The CCM program covers Medicare patients who have two or more chronic conditions that are expected to last at least 12 months or until the patient's death and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Only one provider may receive payment for a patient's CCM service for a given calendar month.

To bill for CCM services for a patient, the provider must perform qualifying services for 20 or more minutes within a calendar month. Time cannot be rounded up.

The CCM services may be performed by the physician or non-physician provider or by a clinical staff member who is incident to the billing provider. Services performed by non-clinical staff do not qualify for CCM billing. Please refer to your Medicare and CMS documents to determine whether you qualify to bill for CCM services, who can perform the services, and whether the specific services you provide qualify for CCM billing.

In order for a patient to qualify for CCM, the patient must have two or more chronic conditions. Examples of chronic conditions include, but are not limited to, the following:

- Alzheimer's disease and related dementia
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer
- Chronic obstructive pulmonary disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoarthritis
- Osteoporosis
- Rheumatoid arthritis

## **Patient Agreement for CCM Billing**

Before billing for CCM services for an eligible patient, you must inform the patient of the program and obtain the patient's consent for the services and billing for the services. You only need to obtain informed patient consent once prior to providing CCM services. Patient consent does not have to be renewed.

Obtaining a patient's consent requires that you:

- Explain the CCM program and services to the patient, and offer the services to the patient. This should include:
  - What the CCM service is
  - How the patient may access elements of the service
  - How you will share the patient's information with other practitioners and providers who participate in the patient's care
  - How the patient's co-insurance and deductibles apply to the CCM service
  - How the patient may revoke the service
- Inform the patient that only one practitioner can furnish and be paid for the service during a calendar month.
- Document this discussion in the patient's medical record, including whether the patient accepted or declined the service.
- Obtain written agreement to have the services provided, including authorization for the electronic communication of medical information with other treating practitioners and providers.

## **Initial CCM Visit**

If the patient is new or has not been seen within a year prior to initiation of CCM, then CMS requires that you conduct an initial visit prior to billing the CCM services. This visit must be a comprehensive evaluation and management (E&M) visit, annual wellness visit, or initial preventive physical examination (IPPE) visit with the patient. You must initiate the CCM service as part of this visit.

## **Regular and Complex Services**

For a given month, you may provide a patient with regular (non-complex) or complex CCM services. The difference between regular and complex services is the complexity of the problems addressed, the extent of care planning performed, and the amount of time spent performing the services.

Complex services are paid at a higher rate than regular services, but they also require additional time spent during the month. Regular CCM service requires 20 minutes or more per month. Complex care requires 60 minutes or more per month. When performing complex care, you may bill for an additional CPT code for each additional 30 minutes of time spent.

Please note that reimbursement for complex services may be not be allowed in some circumstances, such as participation in a Federally Qualified Health Centers (FQHCs) or Rural Health Clinics (RHCs), even when all the requirements are met. In these circumstances, clinical

users should not identify their time spent as qualifying for complex care. This ensures that any superbills generated do not include the procedure codes for complex services. However, if a superbill is generated with the wrong procedure code, you may correct it before processing a claim.

## **CircleLink Health**

CircleLink Health provides chronic care management and patient engagement services. If your practice has enrolled with CircleLink, then CircleLink will provide care plans for your accepted CCM patients. CircleLink also provides remote monitoring and assessment of patients and sends them automatic alerts by phone or text messaging.

When you create CCM entry for a patient and give it a status of accepted, then the application generates a CCD file for the patient and sends it to CircleLink. CircleLink creates a care plan for the patient, and sends it back to the application.

When the application receives a care plan for a patient, it sends a message with the care plan document to the provider on the CCM entry. The provider can then review and approve the care plan attachment.

CircleLink also sends information about their interaction with the patient and the time spent on care management activities. When the application receives this information, it sends a message to the provider on the CCM entry. These system-generated messages are the same as care management messages created by users.

The application also sends CCM minutes that your clinical users enter and approve to CircleLink. The time spent by your staff on CCM activities for a patient is sent to CircleLink when the CCM minutes are approved. Therefore, it is important that CCM entries are reviewed and approved regularly throughout the month.

You review care management messages and minutes from CircleLink in the same manner as you do messages created by users.

## **Persivia**

Persivia provides chronic care management and patient engagement services. If your practice has enrolled with Persivia, then Persivia will provide care plans for your accepted CCM patients. Persivia also provides remote monitoring and assessment of patients and sends them automatic alerts by phone or text messaging.

When you create a CCM entry for a patient and give it a status of Accepted, then the application generates a CCD file for the patient and sends it to Persivia. Persivia creates a care plan for the patient, and sends it back to the application.

When the application receives a care plan for a patient, it sends a message with the care plan document to the provider on the CCM entry. The provider can then review and approve the care plan attachment.

Persivia also sends information about their interaction with the patient and the time spent on care management activities. When the application receives this information, it sends a message

to the provider on the CCM entry. These system-generated messages are the same as care management messages created by users.

The application also sends CCM minutes that your clinical users enter and approve to Persivia. The time spent by your staff on CCM activities for a patient is sent to Persivia when the CCM minutes are approved. Therefore, it is important that CCM entries are reviewed and approved regularly throughout the month.

You review care management messages and minutes from Persivia in the same manner as you do messages created by users.

## Care Plan Oversight

Care plan oversight (CPO) is a Medicare program that allows a provider to bill for supervision of a patient who is receiving complex and/or multidisciplinary care provided by a participating home health agency or Medicare-approved hospice. CPO payments are for oversight and coordination of other professionals who are providing care to the patient, not for services rendered by the CPO provider either in the provider's office or at another facility or the patient's home.

Only one provider may receive payment for a patient's CPO service for a given calendar month. To bill for CPO services for a patient, the provider must be the physician who signed the patient's certified care plan. (Certification of a care plan is separate from CPO, but it is required to bill for CPO activities and services.) The provider must also have had a face-to-face encounter (not including EKG, lab services, or surgery) with the patient in the six-months prior to billing for CPO services.

To bill for services during any given month, the provider must have coordinated some aspect of the patient's care with the home health agency or hospice during that month. The provider must perform qualifying services for 30 or more minutes within the calendar month. CPO activities may be performed by a nurse practitioner, physician assistant, or clinical nurse specialist in the provider's practice, depending upon state law. Time cannot be rounded up.

Qualifying CPO services may include the following.

- Creating and revising a patient care plan
- Reviewing reports of the patient's status
- Reviewing laboratory test results and other observation items
- Communicating with other health professionals, external to your practice, who are also providing services to the patient
- Adjusting medical therapies for the patient

Some services that may be necessary in order to provide qualifying CPO services cannot be counted for CPO billing. These services include, but are not limited to, the following.

- Discussions with the patient, family members, or friends to adjust medication or treatment
- Retrieving or filing the patient's chart
- Travel

- Phoning prescriptions into the pharmacy, except when discussing pharmaceutical therapies with the pharmacist.

### **Certification and Recertification for CPO**

The CPO program requires an initial certification for a patient, and then periodic recertification for as long as CPO services are provided.

A patient's initial certification period is when the patient begins receiving home health care or hospice care after not receiving any Medicare-covered home health care for at least 60 days. You must certify a patient before they can receive home health services covered by Medicare. Once you have certified the patient, then the initial certification period is for next 60 days.

A recertification period is needed when the patient has been receiving home health care or hospice care during the past 60 days. Each recertification period is 60 days.

### **Using the Care Management Functionality**

To use the care management functionality, you must have been given the necessary security rights and the ability to document billable time for care management.

Care management tasks include:

- Identifying patients that qualify for CCM and/or CPO. This is a clinical function, and is explained in the *EHR User's Guide*.
- Creating a CCM and/or CPO entry for a patient. This is a clinical function, and is explained in the *EHR User's Guide*.
- Attaching a signed CCM consent agreement to the patient record. This is a clinical function, and is explained in the *EHR User's Guide*.
- Documenting care management time spent in messages or visit notes. This is a clinical function, and is explained in the *EHR User's Guide*.
- Reviewing the care management messages and visit notes, and approving the time spent.
- Creating a superbill for the management time spent for a patient.

### **Process Care Management Minutes**

The messages and patient visit notes that are used to document care management minutes must be reviewed regularly, and either approved for billing or denied. The review helps you ensure that minutes inadvertently recorded in messages that are unrelated to care management activities are not used for billing. It also helps you ensure that messages and visit notes contain sufficient documentation to support the number of care management minutes recorded. Depending on your practice's policies, you or a clinical user may perform this review.

If you are using a third-party vendor for chronic care management and patient engagement services, then it is important that care management minutes are reviewed and approved regularly throughout the month. Time spent by your staff is sent to the third-party when the minutes are approved.

Once the CCM or CPO requirements have been met for a patient, you should generate the superbill and submit the claim. If the patient has active entries for both CCM and CPO and has met the requirements for both, then the application determines which programs' requirements have been met, and generates a superbill for the program with the highest charge amount for the month.

### **Review and Approve Care Management Minutes**

When reviewing and approving care management minutes, you may only view entries for one month at a time. You may review minutes for the current month or for any past month.

Other filtering criteria enable you to search for a particular patient or patients, approved or unapproved minutes, and only patients with enough minutes to be billed or patients with any number of minutes recorded.

1. Desktop Menu → Care Management Review
2. Enter the desired filtering criteria, and then select the Search button.
3. To review entries for a patient, select the Patient name hyperlink.
4. The Patient Care Management Minutes Review window lists all the messages and visit notes with care management minute entries, with the approval status, and number of minutes.  
If you are using a third-party for CCM, the Integration Partner column is populated for messages received from that third-party.
5. Select the Billing Source hyperlink to access the message or visit note where the minutes are record.
6. Review the documentation to determine whether the minutes qualify. Then close the item to return to the Patient Care Management Minutes Review window.
7. To approve minutes:
  - a. Select the checkbox for each entry you want to approve.
  - b. Select the Approve button.
8. To deny minutes:
  - a. Select the checkbox for each entry you want to deny.
  - b. Select the Deny button.
9. When you have reviewed all items, select the OK button to close the window and return to the Care Management Review window.
10. Repeat steps 3 through 9 for each patient listed.

## **Create Superbills for Care Management Minutes**

At the end of the month or at the beginning of the next month, you can create superbills for the approved care management minutes for the month. Before creating superbills, review and approve the care management minutes or verify that this has been done by the appropriate staff member.

1. Desktop Menu → Care Management Review
2. Enter the following filtering criteria.
  - Recorded Month
  - Show Approved
  - Show Only Billable Patients
3. Select the Search button to display a list of patients meeting your filtering criteria.
4. Select the checkbox for each patient for whom you want to create a care management superbill.
5. Select the Create Superbill button. The application creates one superbill for each patient. If a patient qualifies for both CCM and CPO, then application creates the superbill for CPO if there are sufficient approved minutes. Otherwise, it creates a superbill for CCM.

## **Accounts Receivable Management**

There are two aspects of accounts receivable: payments due from responsible parties and payments due from insurance payers. The accounts receivable management functionally enables you to monitor and manage both aspects.

### **Accounts Receivable Management for Responsible Parties**

The application's accounts receivable management functionality provides with you an automatic process for managing your patient accounts receivable. It selects accounts with patient-liable amounts due, generates and sends payment plan and collection letters, monitors account activity, changes the collection status of accounts as a result of that account activity, and sends messages to specified users when expected payments are not received. Although the process runs automatically, you are able to view the collections activity on an account at any time, and if desired, make manual changes to alter how that account is managed by the automatic collections process or to completely remove that account from the process.

A patient account is not subject to the collections process until insurance claims have been filed, and an amount on the account becomes the liability of the patient or the patient's responsible party. Collection status is determined for responsible parties, not for individual patient accounts. So, if a responsible party is responsible for all the accounts for a family of five, the total due on all the accounts is calculated and used to determine the collection status.

If you change the responsible party for an account that is in collections, then the collections cycle restarts. The account is assigned the initial collection status level applicable to the balance due on the account. The status change will take effect the next time the Collection Nightly Processing runs. It is recommended that changes to the responsible party be documented in the Responsible Party Collections History for both the original and the new responsible parties. Any documentation supporting this change can be scanned and uploaded as an attachment to the patient record.

Collections are processed for your practice as a whole; not for individual providers, care teams, or financial centers.

If your practice is using the accounts receivable management functionality, your administrative user will have entered the settings and created the necessary statuses and status levels for your practice's accounts receivable life cycle. Your administrative user will also have defined and enabled the collection letter templates that you will use. Please see the online help or the *Administrative User's Guide* for more information and instructions if you need to review any of the accounts receivable setup.

Once the accounts receivable management functionality has been set up and the jobs have been initiated, the process will run automatically. You can then:

- Process any messages generated by the process
- Monitor the accounts receivable using the Account Responsible Party Filter window.
- Print the generated collection letters using the Print Collection Letters window.
- Enter and update any responsible party demographic, collection, and statement information using the Responsible Party window.

### **Process Accounts Receivable Messages**

Messages are generated when an expected payment is not received within the specified time period and when a payment is received but is insufficient. The conditions for generating a message, the users or user groups to receive the message, and the urgency of the message are defined in the collection status level.

The message text includes the name of the responsible party, the payment amount expected, the payment amount received, and whether or not any previous payments were received.

Desktop → Message Time Stamp or Note icon (  )

## Monitor Accounts Receivable

The Account Responsible Party Filter window lists the accounts that must be followed up on in some way. You can use it to create a work list for the staff member who will contact the responsible parties. The window includes the responsible party, the collections balance, payment amount due, payment due date, collection status, and collections status level. It also includes any payer credit balance. This enables you to apply or investigate outstanding credits before generating collections letter.

1. Billing → Responsible Party Collections
2. Enter the selection criteria for the report. This may include:
  - Minimum number of days since last payment
  - An alpha range for responsible party last name or corporation names
  - Collection status
  - Balance range
3. Enter -1 as the Maximum Items Returned. This ensures that all accounts matching your selection criteria are included on the report. If you enter an amount, only that many accounts will be included, even if more accounts match the criteria.
4. If you want to save these criteria as a search filter, select the Save As button and give the filter a name.
5. Select the Search button to display the responsible party accounts matching your search criteria.
6. To access the Responsible Party Account report, select the External ID link for the desired account.
7. To access the Account Responsible Party window, select the Name link for the desired account.

## Print Collection Letters

The Print Collection Letters window enables you to select the letters you wish to print. Collection letters are put into the print queue as they are generated. The letters remain in the print queue until deleted.

The letters are saved as attachments to the responsible party records unless they are deleted from the print queue. If you are not going to print and mail the letter to the responsible party, you should delete it so that it is not kept as an attachment.

**Note:** If the expected collection letters have not been generated, then there may be a problem with the scheduling of the collection processing and collection letters jobs. Have your administrative super user verify that these jobs are scheduled to run on the same calendar date (both prior to midnight or both after midnight).

1. Billing → Print Collection Letters
2. Select the letters that you wish to print. Use the Select All () icon to select all the letters in the print queue.
3. Select the button for the action you wish to take.
  - Print Letters prints the selected letters.
  - Print and Remove prints the selected letters and removes them from the print queue.
  - Remove From Queue removes the selected letters from the print queue.

## Responsible Party

The Account Responsible Party windows allow you to enter Responsible Party demographic information, manually change collection information and statement information.

1. Desktop → Find Patient
2. Select patient to access the patient's demographic window.
3. Select the Account tab.
4. Select the appropriate insurance account hyperlink to access the account detail.
5. Use the Find icon next to Responsible Party to Search for the Responsible Party.

**Note:** By default, the Patient's name is included as the Responsible party.
6. To modify, select the Modify button to open the Responsible Party window.
7. Select the radio button for the appropriate type, Corporation or Person.
8. Enter the required information for the Responsible Party.
9. Select OK to close the Responsible Party window.
10. Select OK to close the search window.
11. Select OK to close the patient's Account window.

## View the Collections History

You can view a chronological list of all collections activity for a responsible party. You can also enter a note regarding collections activity.

You can follow the progress of a responsible party through your accounts receivable life cycle using the new and initial statuses. If the responsible party progresses normally through the cycle, you will see the statuses you've defined in your collection life cycle appear in order. You will also be able to identify any manual interventions in the progression of the statuses, as well as by the content of the Note and Reason fields.

1. Either:
  - Tools → List Editor → Billing → Responsible Party
  - Billing → Responsible Party Collections
2. Search for and select the desired responsible party.

**Note:** In the Responsible Party window, the application searches the entire person table. In the Responsible Party Collections window, the application searches only responsible parties who have an outstanding balance with a status in your accounts receivable life cycle.
3. Select the History button. The Collection History includes:
  - Date: The date the action occurred.
  - Note: Text entered by users. (See step 4.)
  - Reason: A description of the activity. This column contains the name of the user for user-entered notes.
  - Initial Status: The collections status of the account prior to this action.
  - Initial Level: The status level of the account prior to this action.
  - New Status: The collections status as a result of this action.
  - New Level: The status level as a result of this action.
4. To enter a new note:
  - a. Select the New Collection Note button.
  - b. Select New.
  - c. Enter a Name for the note.
  - d. Enter an ID, if desired.
  - e. Select a message type, using the Find icon. This field is optional, but will allow you to search for specific types of message (such as Claim Errors).
  - f. Enter the content of the note.

## Accounts Receivable Management for Insurance Payers

The Accounts Receivable Management functionality for insurance payers provides you an automated process for managing promises made by insurance payers in regard to the payment of specific superbills.

It is important to understand that the accounts receivable management function does not process insurance claims. You submit claims to insurance payers using the Process Claims window, and then manage them using the Filing History and Superbill History windows and the Insurance Aging report.

Accounts receivable management functionality enables you to record, track, and follow up on any promise that an insurance payer makes regarding a claim or claims that it has not processed and paid in a timely manner. When you create an insurance promise, an entry is made in the history of the superbills that you associate with the promise.

You can also create entries for insurance contacts who you work with for certain claims or types of claims.

The job for processing insurance promises is named Promise Nightly Processing. You must set up this job, and then set up a job schedule for it in order to process your insurance promises. Processing identifies whether the insurance liable portion of the balance on a superbill has been paid by the defined follow up date.

### Insurance Payer Promise

Use this window to create an insurance payer's promise to pay a specific superbill or superbills.

1. Either:
  - Billing → Insurance Promises
  - Billing → Track Superbills → select superbills → Create Insurance Promise button
  - Superbill → Create Insurance Promise button
2. Select the New button from the toolbar.
3. Enter an ID, if desired.
4. Select the Insurance Contact who made the commitment.
5. In the Contact Date field, enter the date the contact made the promise.
6. In the Follow Up Date field, enter the date the contact commits to make the payment.
7. If desired, define who will receive a message if the promise is paid or not paid by the specified date.
  - In the Paid area, select a User or user Group who will receive the message if payment is made.
  - In the Unpaid area, select a User or user Group who will receive the message if no payment is made by the follow-up date.

8. Select the Add button to associate a superbill to the promise.  
Superbills will be selected if the promise is made from the Track Superbills or Superbill windows.
  - a. Enter the search criteria, and then select Search.
  - b. Select the desired superbill.
9. Repeat step 8 to associate additional superbills with the promise to pay, if desired.
10. Enter any Notes, if desired.

### **Insurance Promise Filter**

Use this window to list the insurance payer promises.

1. Billing → Insurance Promises
2. Enter the desired search criteria. You can search by:
  - Insurance contact
  - Insurance payer and/or plan
  - The date or dates on which promises were made
  - Amounts greater than a specified amount
  - Completed promises; that is, promises that have been fully paid
  - Expired promises; that is, promises that have pasted their follow-up date and have not been fully paid
3. Select the Search button.
4. Select the Contact Name link to access information on the insurance contact.
5. Select the Promise Made date link to access information on the promise.

## Transferring Balances to the Automated Accounts Receivable Process

Practices that are transferring account balances from another practice management system can put outstanding balances into the account receivable process immediately, rather than waiting for the process to catch them. This is done by creating a custom procedure code that, when included on a superbill, causes that superbill to go directly into the accounts receivable process. Thus, it overrides the defined liability days and global sufficient percentage settings.

While the override option is intended for transferring balances into the automated accounts receivable process, you can also use it for any item that you want to move directly into the process.

To use override, you must create a custom procedure code to be used for the override, define that override code in the Collections Global Settings window, and then enter the override procedure code on any superbills you want to immediately move into the automated accounts receivable process. When the nightly collections job runs, all superbills that have the override procedure code on them will be entered into the process at the appropriate status level based on balance amount.

**Note:** The Collection Letters From Date has been removed from the Collections Global Settings window.

### Create a Custom Procedure for Accounts Receivable Override

1. List Editor () → Clinical → Procedure Code
2. Select the New button.
3. In the Add Procedure Codes from Master List window, select the Add Custom Code radio button and select the OK button.
4. In the Procedure window, enter a Code that identifies its purpose.
5. Select a Code Type.
6. Enter a Short Description and Long Description. These should clearly identify the purpose of the custom code.
7. Leave all other fields empty.

### Define an Override Procedure

1. List Editor () → Billing → Collection Global
2. Select the Global Settings entry, and then select the Modify button.
3. Select the Enable Override Procedure checkbox.
4. In the procedure field, search for and select your override procedure code.