Windows 8 compatibility

Basic compatibility with Windows 8 and Internet Explorer 10 has been achieved. Users can use all features of the Billing, PA Client and web site under Windows 8 operating system.

Pre-Authorizations for secondary insurances and self-pay

Before this feature, pre-authorizations could only be created for **primary insurances** and for **workers compensation** insurances. Now users will be able to add pre-authorizations for **secondary insurances** and **self-pay** as well.

The corresponding debtors are now available in the **Debtor** drop-down list on the **Pre-Auth** tab of the **Patient** screen.

The **patient** (or his/her **guarantor**) will always be present in the list of available debtors.

Secondary insurances will be present in the list of available debtors only if the patient has the corresponding insurances.

All debtors are sorted by **debtor type** and alphabetically in the following order:

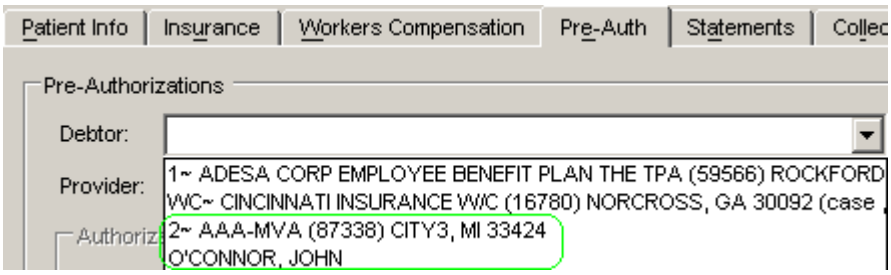
- **Primary**, **workers compensation**, **secondary**, **self-pay**.

Available pre-authorization options like **ICD9 code ranges** or **minimum visit interval** are the same for all types of debtors.

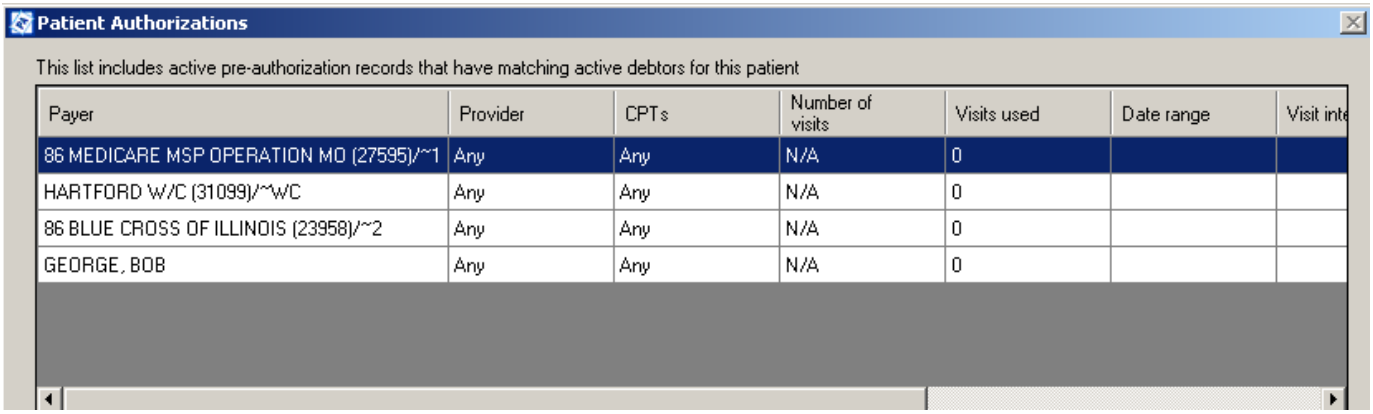
Visits will be counted for secondary insurances and for self-pay pre-authorizations the same way as they are counted for primary and workers compensation pre-authorizations.

All types of pre-authorizations are displayed in the View Authorizations window.

New pre-authorization types on the Patient screen:



New pre-authorization types in the Patient Authorizations window:

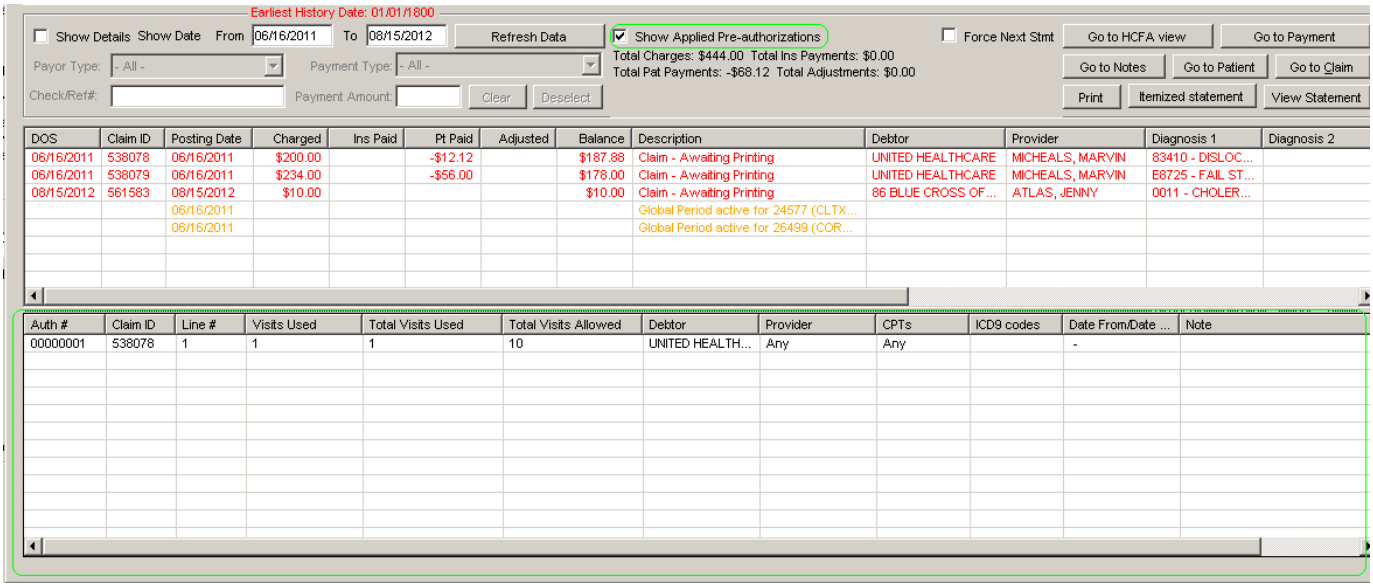


Pre-authorization information on the Patient Transaction History screen

Now all pre-authorizations used by service lines of the currently loaded patient can be reviewed from the **Patient Transaction History** screen.
There is a new table available for this purpose: **Applied Pre-authorizations**. It can be enabled by checking the **Show Applied Pre-Authorizations** checkbox next to the **Refresh Data** button.
All visits used by the patient will be displayed in this table by default (when nothing is selected). Furthermore, the list can be filtered to one claim or service line by selecting the corresponding line in the main table (for claims) or in the **Details** table (for service lines).

The **Applied Authorizations** table can be viewed independently of the **Details** table.

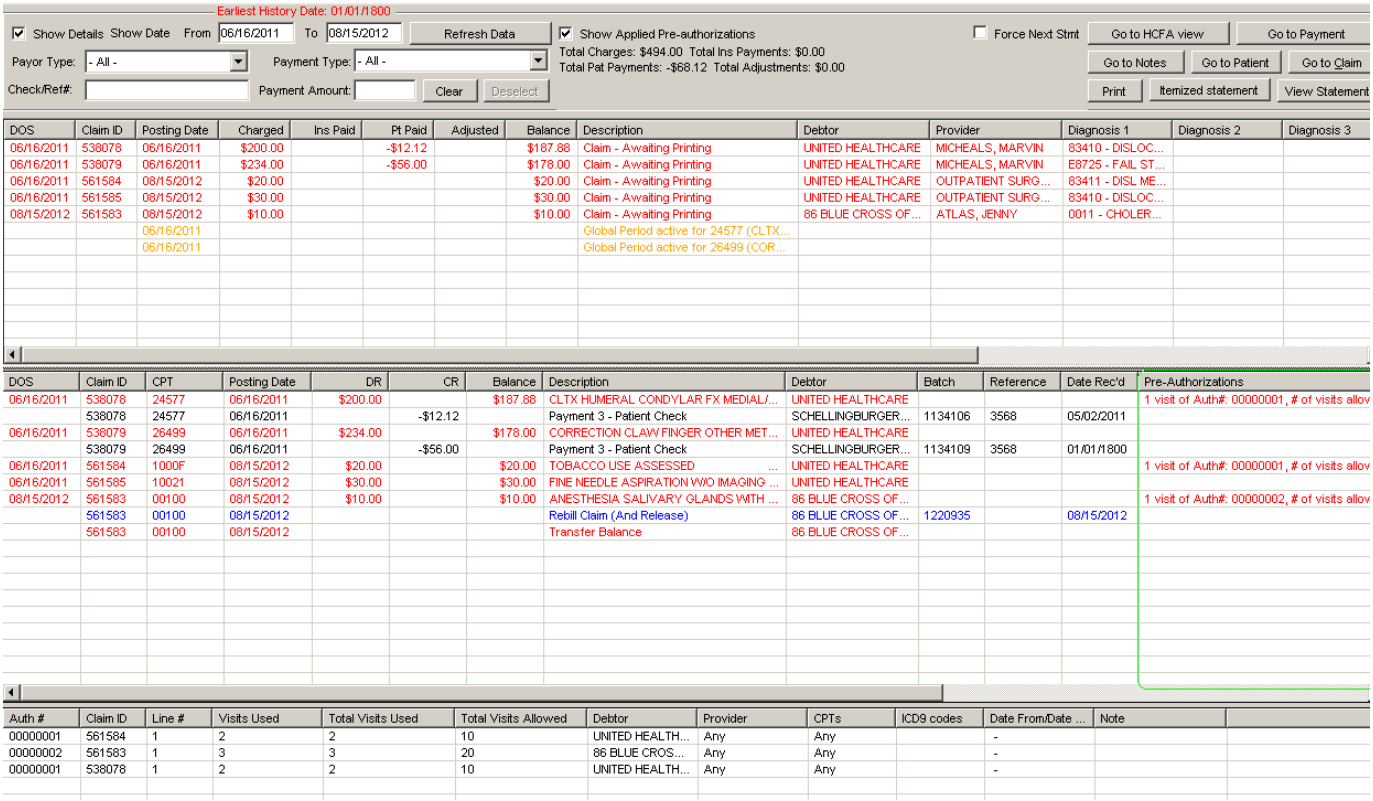
The Show Applied Pre-Authorizations checkbox:



Also, there is a new column in the **Details** table: **Pre-Authorizations**.

The column contains information on pre-authorizations currently used by service lines, displayed in the same way as on the **Claim - Details** screen. The new column will always be displayed when the **Show Details** checkbox is checked.

Pre-Authorization column on the Patient Transaction History screen:



New options for pre-authorizations

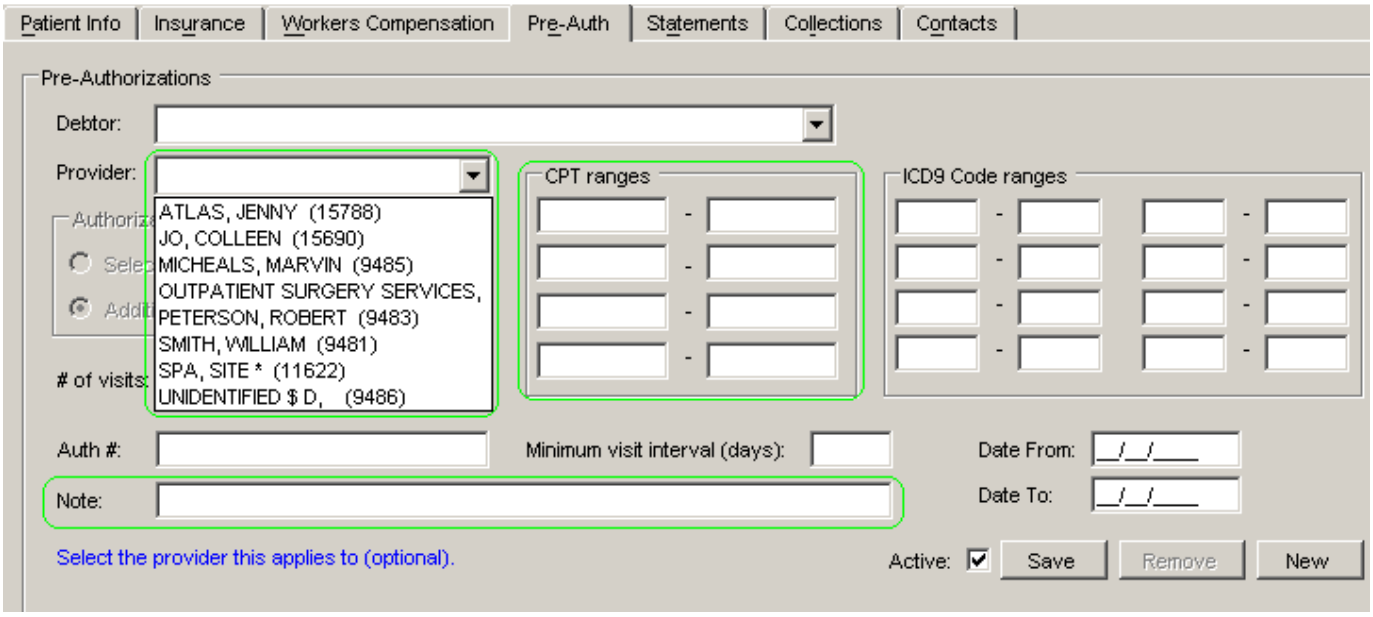
Now the users will be able to specify the following additional pre-authorizations properties:

- **Provider**
- **CPT range** (replaces the original **CPT** property)
- **Note**

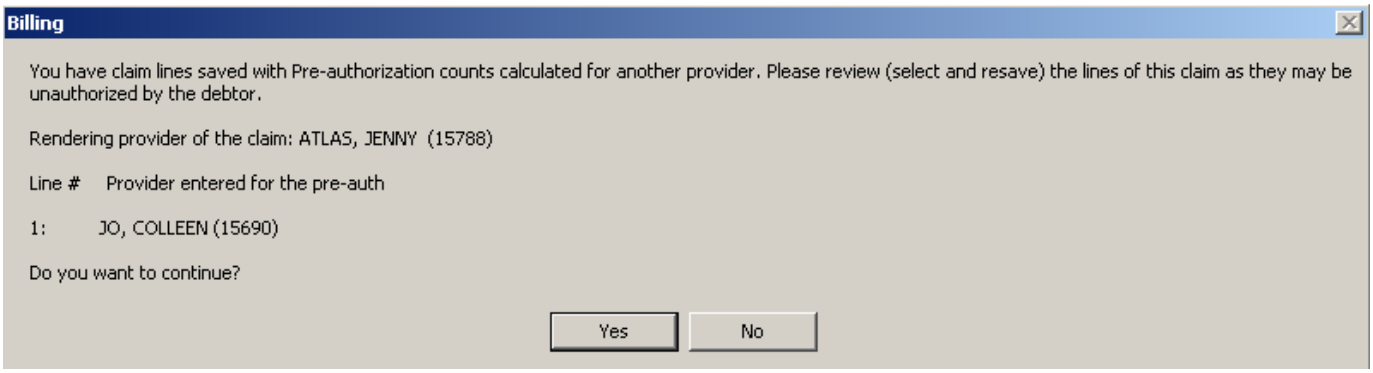
The **Provider** property will work as an additional filter in terms of applying a pre-authorization to a claim. This field is not mandatory and will allow any provider for a pre-authorization if left empty.

The list of accessible providers will be the same as for new claims in the current practice.

Changes on the Pre-Auth tab of the Patient screen:



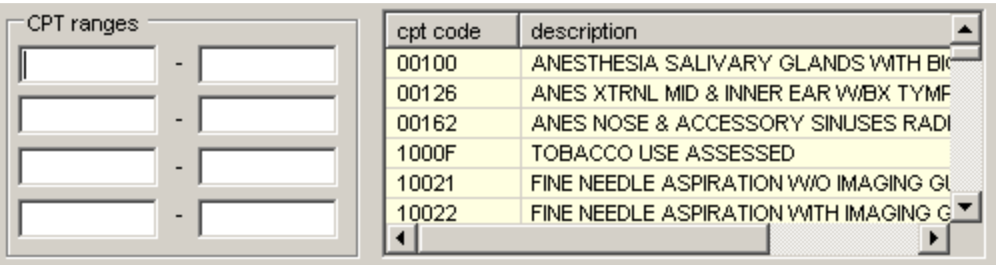
A dialog will be presented to the user during claim saving if the provider selected for the applied pre-authorization does not match the provider selected for the claim:



If the user confirms the action, the claim will be saved regardless of the mismatching provider; if the action is cancelled, the claim will not be saved.

CPT range property will behave like the original CPT field except now it will accept several CPTs or CPT ranges. To select a single CPT for the pre-authorization, simply put the same CPT in both fields of the CPT range. Up to **4 CPT ranges** can be specified for each pre-authorization; the list of available CPT codes will be the same as for the new claim within the current practice.

Please note that the users will no longer be able to specify partial CPTs.



Pre-authorization **note** field is not mandatory; it can be specified, changed or removed at any time without any specific limitations as it carries purely informational purpose. The **Note** field can hold up to **60 symbols**.

All new and modified properties are included in the informational screens both in **Client** and **Billing**, like **Patient Authorizations** window, **Pre-Authorization** column on the **Claim - Details** screen, **Active Authorizations** screen accessible from Client when looking up a patient, on the **Patient Transaction History** screen when the **Show Details** checkbox is checked, in the **Select Pre-authorization** window.

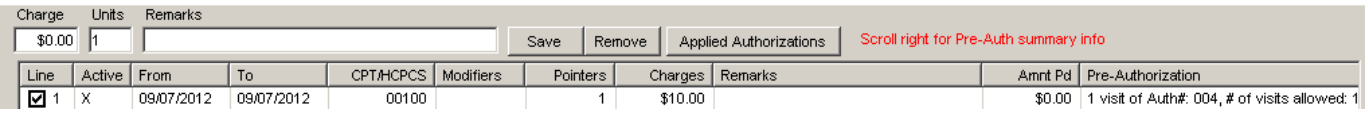
Pre-authorizations for different debtors of the same claim

Now the users will be able to preserve pre-authorizations when transferring a claim to another debtor.

A new **Applied Authorizations** dialog will be presented if the user changes the current debtor of the claim with pre-authorizations applied; the dialog will allow the users to remove the unwanted or invalid pre-authorizations currently applied to the claim regardless of the debtor. The **Applied Authorizations** dialog will replace the '***You have claim lines with pre-authorization counts calculated***' dialog displayed in such situations before.

The **Applied Authorizations** window can be accessed when changing debtors on a claim with pre-authorizations applied or from **Claim - Details** screen via the when there is at least one applied preauthorization.

The Applied Authorizations button placement on the Claim - Details screen:



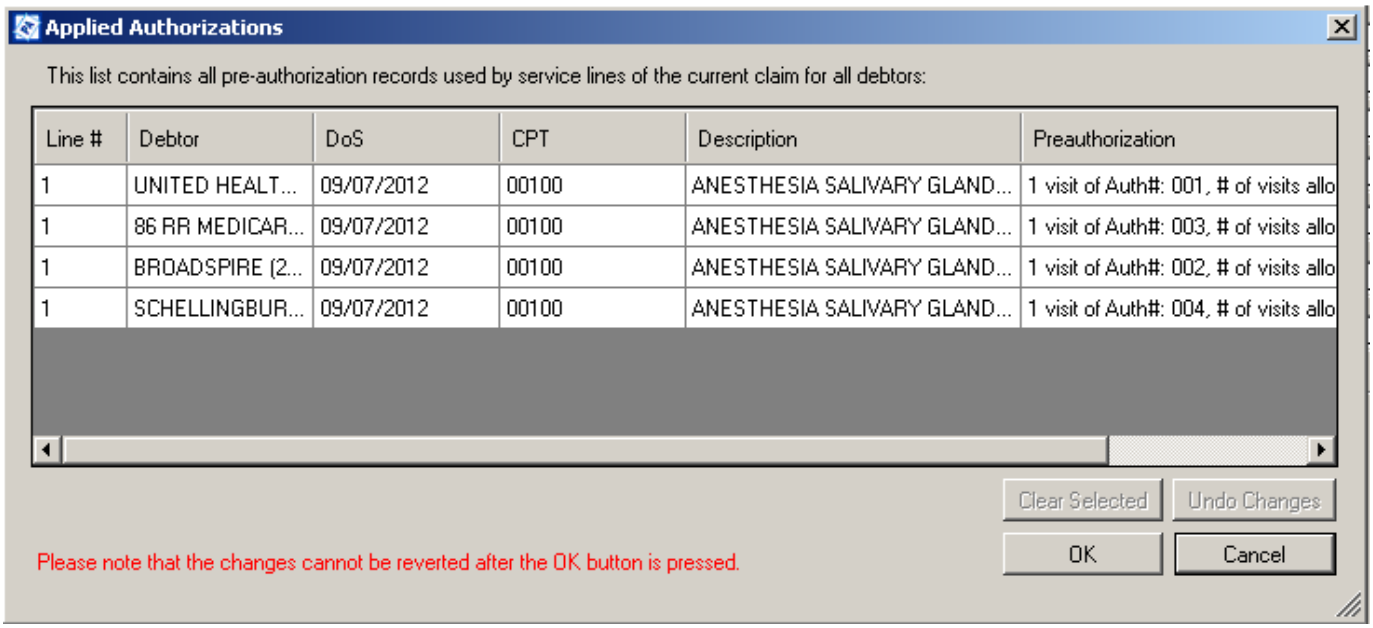
The **Applied Authorizations** window will present basic details on all the visits used for **all debtors** of the **current** claim**.**

Each item in the table represents a single visit used by a service line of the current claim; the users will be able to remove any record by selecting it and pressing the **Clear Selected** button.

The changes made in the **Applied Authorizations** window can be reverted by pressing the **Undo Changes** button.

OK button commits all the changes to the database; please note that the **Undo Changes** button reverts only uncommitted changes (changes made before the **OK** button is pressed)

If the **Cancel** button is pressed, the debtor of the claim will not be changed (if the window appeared when changing debtors of a claim) and the changes made in the **Applied Authorizations** table will be discarded.



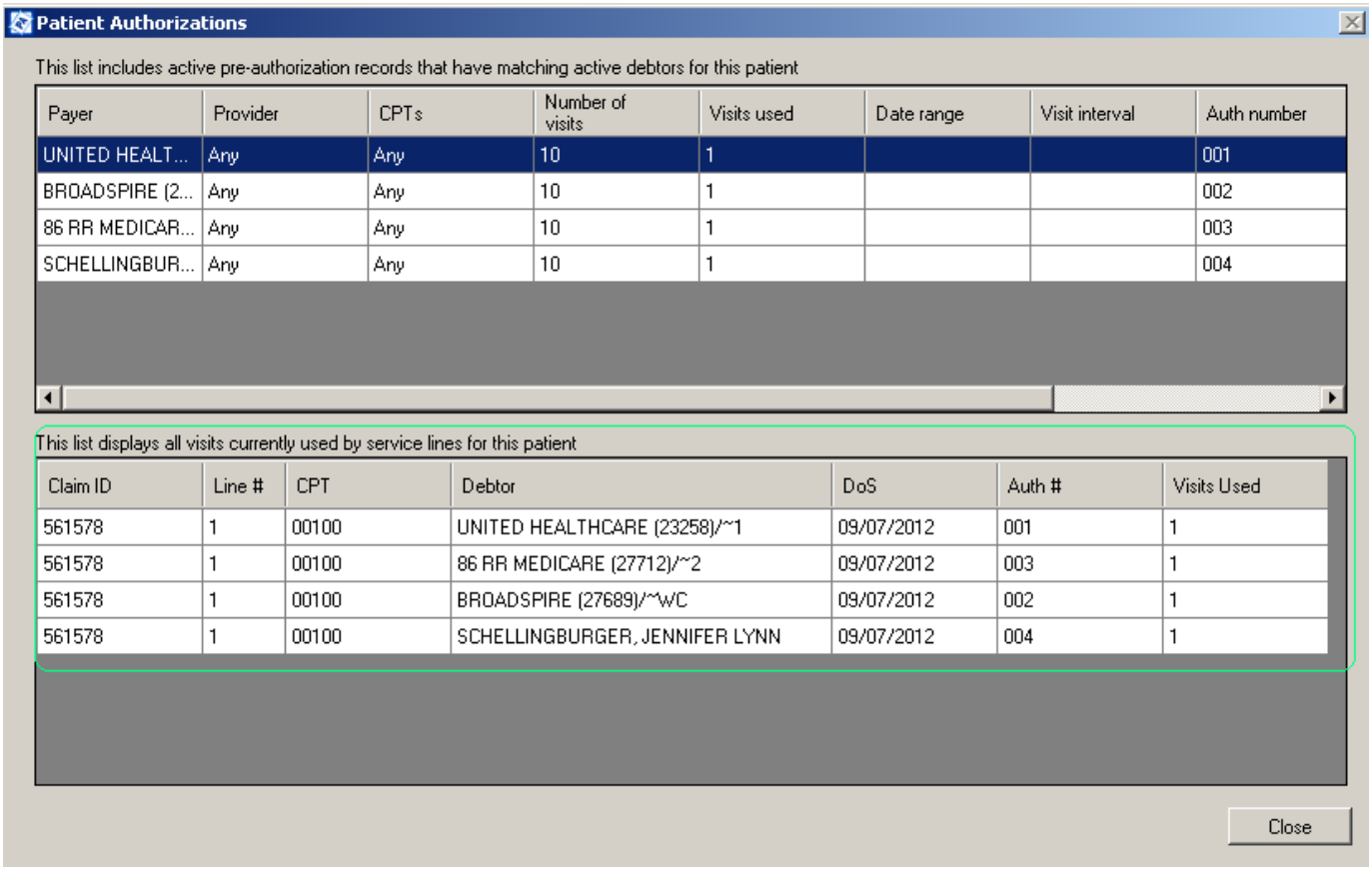
Visit counts for the cleared authorizations will be dropped; history of the corresponding pre-authorization records will reflect the changes.

Only pre-authorizations applied for the **current debtor** of the claim will be displayed in the **Details** table of the **Claim - Details** screen.

Please note that debtor of the claim with applied pre-authorizations can only be changed from the **Claim - General** screen; the users will not be able to change debtors from the **Claim Transaction Details** screen and from the **Payment Application** screen if there is at least one pre-authorization already applied to any of the service lines of the current claim.

All visits used by the patient can now be reviewed in the **Patient Authorizations** window on the Claim - General screen. The **View Authorizations** button will now be available when a patient has at least one visit used by one of their claims. The used visits will be listed below the original **Patient Authorizations** table.

Updated Patient Authorizations screen



Occurrence codes preserved on claim rebill

The following data related to institutional claims will now be preserved when re-billing a UB-04 claim to another debtor and can be re-used without re-entering the same data again manually for this claim and its service lines:

Claim level:

- **Bill Type**
- **Pt Status**
- **Condition Codes**

- **Occurrence Codes**

  Service line level:

- **Revenue Code**
- **ICD9 Procedure**

Hide the Patient Responsibility transaction notes when statements are created for All Balances

Now the **Patient Responsibility** notes will no longer be printed on statements when the statements are run in a practice for **All Balances** (insurance balances included).

Previously, the patients might have been confused with the notes stating a part of claim balance as '***Insurance Billed - Patient Responsible***'. To avoid confusion, these notes will be printed only for patient statements, when the '**Send statements for balance type**' setting is set to '**Patient Balances Only**'

Alphanumeric symbols allowed for NDC

The users will now be able to enter alphanumeric symbols when creating or modifying **NDC codes** on the **Claim - Details** screen. Previously, the **NDC** field would not accept any symbols except digits - this has been changed to allow any symbols.

Fixed incidents:

1. An issue when an error message about incorrectly configured printing rules would be displayed when printing CMS 1500 form for all insurance plans has been addressed.
2. An issue when service line information containing a deleted CPT code was not displayed on the Claim Transaction Detail screen is now addressed.
3. An issue when claims could not get the Paid status after an unapplied payment has been posted for the claim is now addressed.

PA Reports v6.0

Updated on 10/16/2012

New reports available

The following reports are now available in the Billing's report list:

- **Patient Count**
- **Charges Payments Adj Gross vs Net by CPT Group**
- **CPT Count by Doctor by Practice report by CPT Group**
- **Charges, Pmts, Adj by CPT Group by Provider**

- The **Patient Count** report can be set to display either all patients seen in the chosen period of time, or all new patients registered in that period of time.

- The **Charges Payments Adj Gross vs Net by CPT Group** report provides a detailed summary of charges, payments, adjustments voids and refunds for each CPT for the chosen period of time with information about CPT Groups. The report also allows filtering the results by provider and by facility. The report can be run by DOS (management report) and by accounting date.

- The **CPT Count by Doctor by Practice report by CPT Group** is an enhanced version of the original CPT Count by Doctor and Practice report. It provides additional information about provider numbers and CPT Groups. The report has the same filtering options as the original CPT Count by Doctor and Practice report.

- The **Charges, Pmts, Adj by CPT Group by Provider** report is an enhanced version of the Charges Payments Adjustments by CPT Group report. It provides a new grouping scheme - now the result grouping by provider is moved to sections - one for each provider.

Combined Report v.4 is updated

A new report is now available in the list of reports included in the **Combined report v.4**: **Provider Analysis Accounting Report.** This report provides basically the same data as the **Provider Accounting** report, but displays results by practice total.

Also, order of the sub-reports in the Combined Report v.4 has been changed to the following:

1. Charges Pmts Adj Gross vs Net by Prov (Accounting)
2. Charges Pmts Adj Gross vs Net by Location (Accounting)
3. Provider Analysis Accounting Report (Accounting, Practice Total)

4. Provider Accounting Report (Accounting, by Facility)
5. AR Analysis by DOS or Accounting Date (Accounting and DOS, YTD for All Providers and Each Provider)
6. ATB by Category (Accounting and DOS for All Providers and Each Provider)
7. CPT Count By Doctor and Practice Report (Accounting, YTD)
8. Adjustment Summary by Payer Report (Accounting)

Updated report security

Hyperlinks provided in the reports are now more secure. Now the reporting engine can determine if the request originates from outside the billing application and block the request. Hyperlinks will still work fine when opened from Billing itself.

More reports can be run by facility

The following reports can now be run by facility:

- **Claim List by CPT**
- **Claim List by Diagnosis**
- **CPT Charge dollars By Doctor Practice**
- **CPA by Payer Type with Aging**
- **Charges Pmts Adj Gross vs Net by Date**
- **Charges Pmts Adj Gross vs Net by Location**

Pre-Authorizations report is updated

New columns are available in the Pre-Authorizations report:
Pre-Auth Type
Provider
Minimum Visit Interval
Note

The **Debtor** column will now reflect insurance type (for insurance debtors):
/~1 for **primary** insurances
/~2 for **secondary** insurances

/~WC for **workers compensations**

Adjustment Detailed Report by Accounting Date report is updated

An additional column has been added to the Adjustment Detailed Report by Accounting Date: **DOS**. The column will reflect the date of service of the service lines for which an adjustment is reported.

Fixed incidents:

1. An issue when the **Transaction Summary by User (by Date Posted)** report would display incorrect balance for patients with partially applied payments is now addressed.
2. The Item Description column name in the Daily Activity report is now spelled correctly.
3. An issue when results of a report run overnight may be inaccessible is now addressed.
4. An issue when certain reports produced no results when ran for practice containing a facility with 48 and more symbols in its name is now addressed.

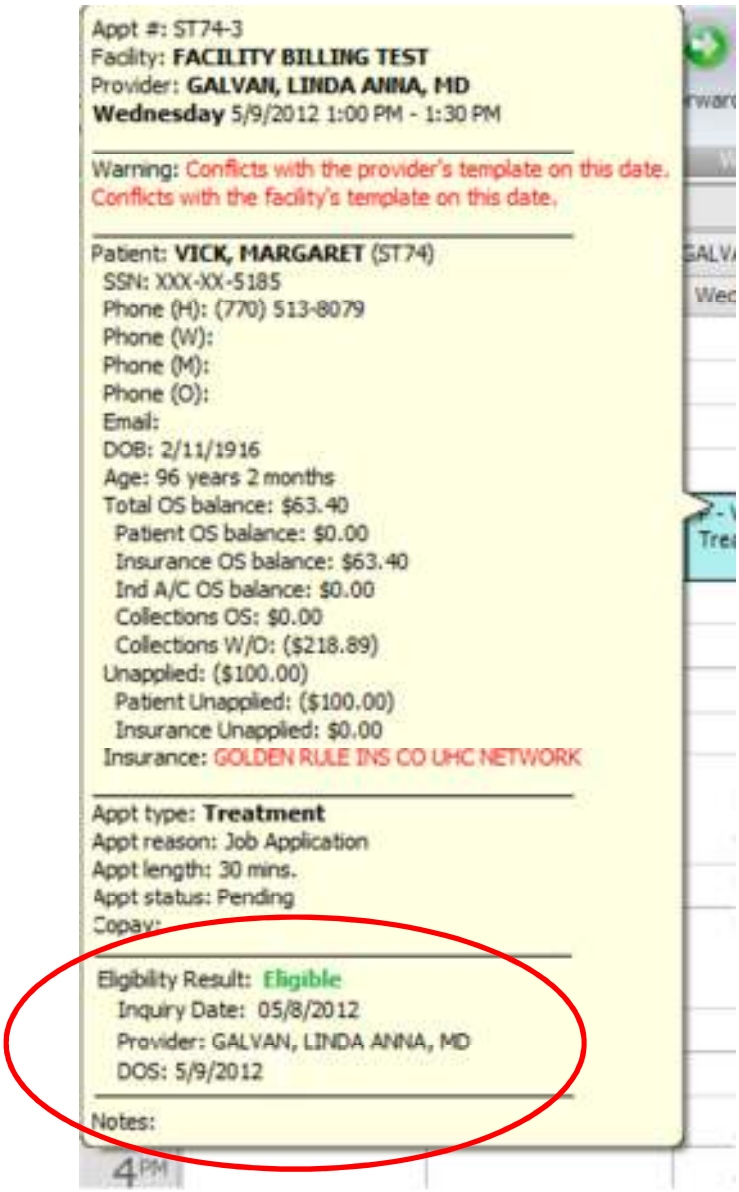
Eligibility Checks from Client

NOTE- The new 'E' icon next to the appointment is showing results from the *last* eligibility check performed on the patient. The green 'E' does not necessarily mean that the patient is eligible for the current appointment. Please hover over the appointment for date details from the last eligibility check. If a check hasn't been performed then the 'E' will be grey.**

The latest eligibility results for patients will also be reflected on the **Scheduling** screen in the top-right corner of all appointments created for this patient.

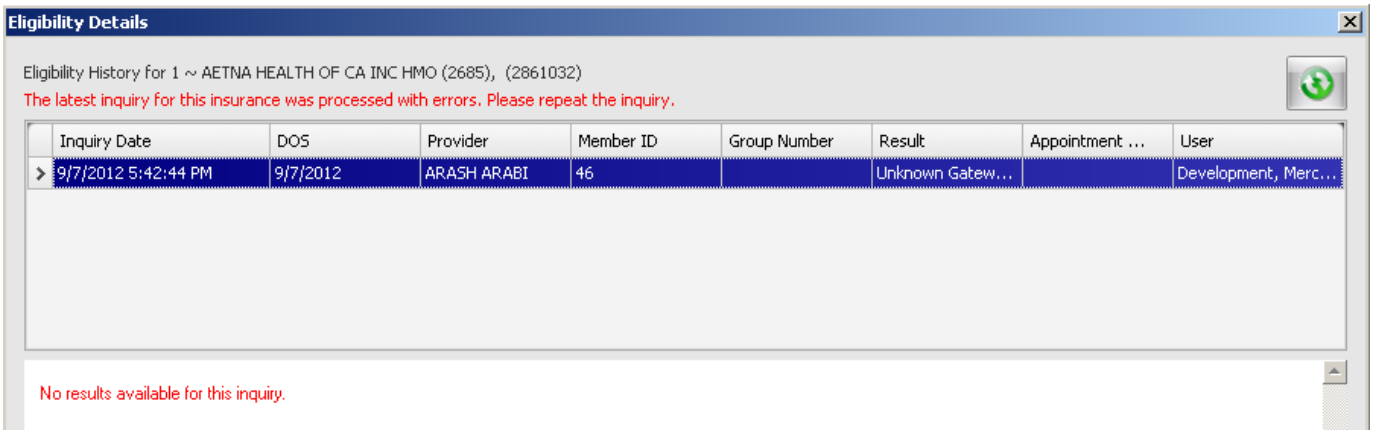
Also, detailed eligibility result can now be viewed in the tooltip for any appointment with eligibility result icon displayed.

Eligibility result details in the appointment's tooltip:



Eligibility Checks cost twenty-five cents per check. If you do more than 400 per month, contact our sales team about our Bundle Plan.

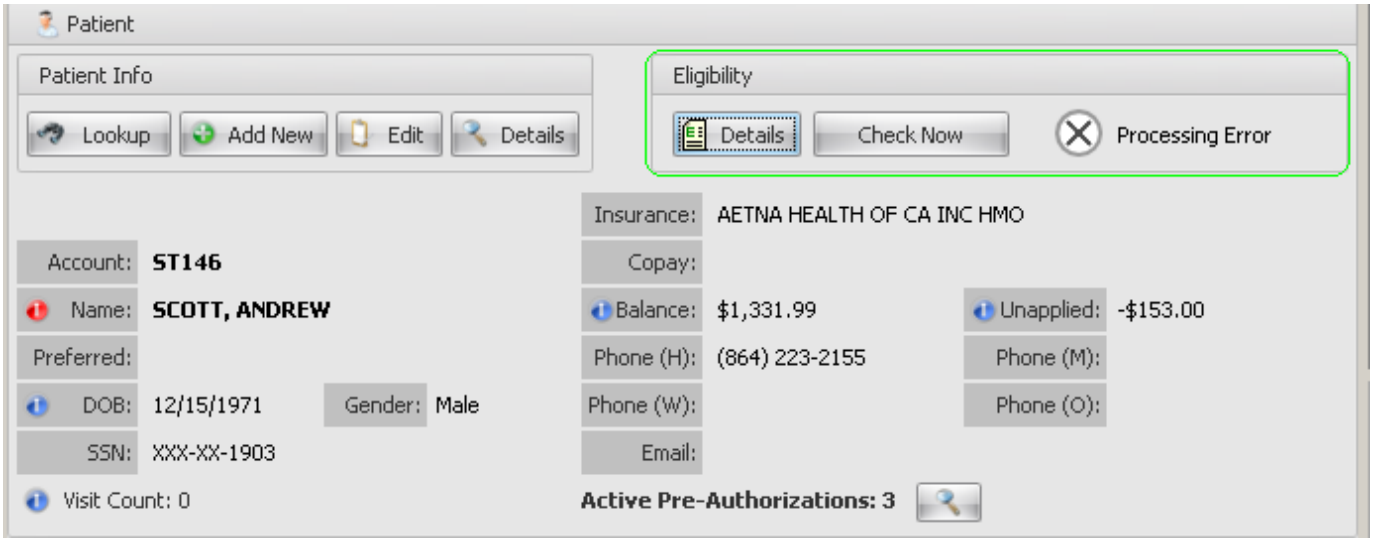
Eligibility Details



Eligibility controls will be disabled if there is no configured eligibility service available for the current practice.

If the currently selected provider does not support eligibility requests, a substitute provider can be selected to perform eligibility requests. The substitute provider can be specified on the **Setup - Providers** screen by editing the provider's scheduling options.

Eligibility controls



The users will now be able to view the eligibility history from the **Client scheduling** screen and perform eligibility requests for the currently selected patient via the **Appointment Details** window.

Eligibility requests can be controlled from the **Appointment Details** window via the controls in the **Eligibility** area.

The **Details** button allows reviewing all previously performed eligibility requests for the currently loaded patient. The **Details** screen is similar to the **Eligibility History** screen accessible in **Billing** via the **Eligibility** button on the **Patient** form.

The **Check Now** button allows performing an immediate eligibility check using the parameters currently entered on the **Appointment Details** screen: **patient**, **primary insurance**, **date of service** and **provider**.

The icon next to the **Check Now** button will reflect the **status** of the last eligibility request for the **currently loaded** patient.

Icon can be one of the following:

- **Denied**

The last eligibility inquiry was denied or required more information.

Inquiry Date:

Provider:

DOS:

- **Eligible**

The last eligibility inquiry was confirmed.
Inquiry Date:
Provider:

DOS:

- **Not available**

This insurance does not offer online eligibility inquiries.

- **No results yet**

Insurance offers eligibility inquiries but no valid results have been received yet.

- **Pending**

Eligibility inquiry is in progress.

- **Processing Error**

The last eligibility inquiry encountered an error.

New columns for the Appointment List by Patient report

The following columns can now be added via the column customization to the **Appointment List by Patient** report:

Patient First Name, Patient Middle Name, Patient Last Name, Patient Suffix, Work Phone, Home Phone Other Phone, E-mail, Address (address1+address2), City, State, Zip, Primary Ins, Prim Ins Member ID Secondary Ins, Sec Ins Member ID, Total OS Bal, Patient OS Bal, Insurance OS Bal, Ind A/C OS Bal Collections OS, Collections W/O, Copay, Provider First Name, Provider Middle Name, Provider Last Name Provider Suffix, Practice

Columns previously available in the report will remain in place. Default report layout is not modified.

Fixed incidents:

1. The issue when new appointments were not displayed in certain situations is now addressed.
2. The issue when the list of available practices could be sorted incorrectly is now addressed.
3. The issue when referring providers were displayed in the Setup - Providers list in Client is now addressed.