What's New in NetPracticePM v7.4.2

(Final)

Version Release Date: November 8, 2012

NetPracticePM
web-based practice management

TABLE OF CONTENTS

Introduction

This document provides an overview of new features, resolutions and enhancements available in the release of NPPM v7.4.2. Each section defines the specific feature and/or enhancement associated with the new NPPM release, as well as any resolved issues.

This release has been inserted into the 2012 roadmap as it is required for and primarily includes changes needed to complete the migration of claims going from NetPracticePM to the eMedix clearinghouse in the 5010 format.

*There is a supplemental document also available for your review. The *NPPM 5010 Billing Review* document highlights the areas in NPPM that are affected in billing 5010 claims. This document and these release notes are both available on the Knowledge Tree under Release Notes/NetPracticePM/Version 7.4.2 Release.*

New Features and Enhancements

This section is not meant to be cumulative, and contains only information associated with the NetPracticePM v.7.4.2 release.

Billing

Create Insurance File and **Move/Rebuild Transmission File** *(Insurance Billing Functions)*

This note is to more clearly explain how the *Create Insurance File* and *Move/Rebuild Transmission File* work for 5010 claims.

- In the *Procedure Entry Function* when you click **Save** to post charges, the claim object is automatically created, and if the carrier is set to 5010:

  o The claim Status is set to **1-(In Process)**. *The balance stays in the Patient balance*, where it remains until you *Create Insurance File*.

  o The claim is checked for exceptions. If an exception exists, it is immediately put on the Exception Report and the claim preview tab in the Encounter view shows the red exclamation point (!) icon indicating that there is an exception on that claim. Even though an exception shows on the claim tab at this point, the claim is actually in **Status 1-(In Process)** and *the balance remains in the Patient balance* until you *Create Insurance File*. This way you can choose to correct the exceptions before you create insurance.

  o If the claim should be held (due to a set Claim Hold rule or a Claim Hold Date on the encounter), the claim is placed into a **Status 4-(On Hold)** and *the balance moves to the Insurance Balance.*

- The *Create Insurance File* checks the claim and:

  o if there are exceptions, it is placed into a **Status 3-(Exceptions)** and *the balance moves to the Insurance balance.*

  o if there are no exceptions, the claim is set to a **Status 2-(Locked)**, *the balance is moved to the Insurance balance* and the claim is moved to the transmission (or print) file.

  o If a claim should no longer be On Hold (due to a changed Claim Hold rule or a past Claim Hold date), the claim will be checked for exceptions and either moved into a **Status 3-(Exceptions)** or, if there are no exceptions, set to a **Status 2-(Locked)** and moved to the transmission (or print) file.

- If you select the **File** or **Refile Encounter Actions**, and **Save**, from the Encounter view or from *Edit an Encounter*, and the carrier is set to 5010:
  o The claim object is *rebuilt* and the claim Status is set to **2-(Locked)** and the claim *goes directly to the claim file.*

- Any time you *Create Insurance File* or *Move/Rebuild Transmission File*, the 5010 claim object is rebuilt by refreshing the data stored for the claim, including anything that changed since the claim was last created that would change the data within the claim (e.g. patient demographics, tables, integrations, etc.)

- *Create Insurance File* creates and/or rebuilds claims in Statuses 1-4 (1-In Process, 2-Locked, 3-Exceptions, 4-On Hold).

- *Move/Rebuild Transmission File* rebuilds claims in statuses 2-4 (2-Locked, 3-Exceptions, 4-On Hold) only.

- Since the *Create Insurance File* function is now also *rebuilding* the claims (the Move/Rebuild Transmission File has been built into the end of the Create Insurance File function), if there are no exceptions to correct, you can go directly from *Create Insurance File* to *Prepare/Send Transmission File* without performing the *Move/Rebuild Transmission File* function separately.

Create Insurance File *(Insurance Billing Functions)* , **Move/Rebuild Transmission File** *(Insurance Billing Functions, Electronic Claims)* and **Prepare/Send Transmission File** *(Insurance Billing Functions, Electronic Claims)*

With 5010 claims you can now create, move/rebuild and send 5010 claim files multiple times in one day *even after* you have sent 5010 claims that day.

This change does not pertain to 4010 claims. These functions remain the same for 4010 claims whereby you cannot create or move/rebuild 4010 claims if the 4010 claim file has already been sent that day.

- If you have sent 4010 claims and "create" again that day, a message, **4010 claims have already been sent today and cannot be sent again. Only new 5010 claims will be included in this Insurance Create** displays.
- If you have sent 4010 claims and "move/rebuild" again that day, a message, **4010 claims have already been sent today and cannot be sent again. Only previously unsent 5010 claims are included in this Move/Rebuild** displays.
- If you have sent 4010 claims that day and perform the *Prepare/Send Transmission File* function again that day, a message, **No 4010 files to send** displays.

Create Insurance File *(Insurance Billing Functions)*

If a patient had Medicare as the primary carrier and Medicare paid on posted procedures marked as **Take Home Supply** in the *Procedure Code Table*, a secondary claim did not generate for those procedures. This has been resolved and those procedures now generate on to the secondary claim.

Create Insurance File *(Insurance Billing Functions)*

Clients sending 5010 claims via Direct Connections Only
If an encounter had a secondary 5010 claim generated for some, but not all, of the procedures and an additional primary insurance payment was received on some of the line items (that were not paid on the first primary EOB), a new secondary claim was not generating to show the additional procedures paid. The system will now handle these claims scenarios according to the following guidelines:

If a primary insurance payment is made on an encounter where a secondary claim already exists in a status of 1-In Process, 2-Locked, 3-Exceptions, or 4-On Hold:

- The procedures from the existing claim will be combined with the new procedures that were paid to generate a new secondary claim.

- The claim may split out into more than one claim if you have splitting rules in place in the billing profile that would warrant that action to be taken.

If a primary insurance payment is made on an encounter where a secondary claim already exists in a status *other* than those listed above, (meaning the claim has already been sent or acknowledged):

- The new procedures that were paid will generate a new secondary claim that contains only those procedure codes.

Create Insurance File *(Insurance Billing Functions)*

Institutional Claims only
A change has been made so that the diagnosis codes are pulling on to the UB-04 based on what is entered on the encounter rather than the UB-04 attachment.

The fields that are now pulled from the encounter rather than from the UB-04 attachment are:
- Principal Diagnosis (Dx) code HI*BK (Outpatient and Inpatient)- Pulls the first Encounter Dx
- Admitting Dx code HI*BJ (Inpatient only) - Pulls the first Encounter Dx
- Patient reason for visit HI*PR (Outpatient only)- Pulls the first three Encounter Dx Codes that are not 'E' codes, if there
- External cause of injury E codes HI*BN (Outpatient and Inpatient) - Pulls any 'E' codes from the Encounter Dx
- Other diagnosis code HI*BF (Outpatient) - Pulls 2 thru 12 codes from the Encounter that are not 'E' codes
- Other diagnosis code HI*BF (Inpatient) - Pulls 2 thru 12 codes from the Encounter that are not 'E' codes

The fields that still pull from the UB-04 attachment are:
- HI*BH - Occurrence Codes. These are the injury codes
- HI*BQ - Other Procedure Information - (Inpatient only)
- HI*BI - Occurrence Span Information
- HI*BE - Value Information
- HI*BG - Condition Information

- HI*BR - Principal Procedure - This pulls from the **Principal Procedure** code field from the *Procedure Code Table* for the first CPT in the encounter. (Inpatient only)

Create Insurance File *(Insurance Billing Functions)*

The PDF UB-04 claim program was updated to pull the Encounter Diagnosis (Dx) codes 1-12 into Box 67. Previously it was only pulling Dx codes that were linked to the CPT codes, which was incorrect. This field should display all diagnosis codes attached to the encounter.

Create Insurance File *(Insurance Billing Functions)*

Previously, a secondary claim could be created after the primary payment even if the secondary carrier on the patient's account was marked as **Bill this Carrier**=**E** for crossover. This has been addressed and the secondary claim will no longer generate if the carrier is a crossover. The Insurance Ledger will continue to note the crossover filing as always.

Create Insurance File *(Insurance Billing Functions)*

It was possible for the primary payment to be missing from the secondary claims. The AMT*D Segment in Loop 2320 was not populating correctly in professional secondary claims. This has been resolved.

Create Insurance File *(Insurance Billing Functions)*

A change was made to the 5010 electronic Professional claims for the Referring Provider Loop 2310A. It was not taking into consideration the **Print on Insurance** check box in the *Referral Source Table*. If this check box is *not* selected, then this loop should not be sent on the electronic claim. On professional claims if the Ref Dr=0, the Ins Dr's name and NPI are sent in Loop 2310A.

This is a new Loop (2310F) for 5010 Institutional claims and the parameters differ slightly from professional claims:
- It is not sent on inpatient claims
- It is not sent if the name of the Ref Dr is the same as the name of the attending physician
- It is not sent if **Print on Insurance** is *not* selected in the *Referral Source Table*
- It is not sent if Ref Dr=0

Print Insurance Forms *(Insurance Billing Functions)*

Previously, to print PDF claims for a specific carrier you typed the carrier code in the **Begin with Insurance Carrier** field and left the **End with Insurance Carrier** field blank. Because this was inconsistent with the way the Begin/End with fields work other NetPracticePM menus, this has been changed. Now, you must type the specific carrier code in both the **Begin with Insurance Carrier** and **End with Insurance Carrier** fields.

Print Insurance Forms *(Insurance Billing Functions)*

Any claim with a procedure that contains a **PP modifier** or has **Bill to Insurance** set to **Paper** in *Maintain Procedure Codes* will originally generate from the *Procedure Entry Function* or *Create Insurance File* into a PDF paper claim regardless of what the **Enable Paper Claim Editor and Alignment Functions (PDF)** is set to in *NetPracticePM Integration Options*.

Print Insurance Forms *(Insurance Billing Functions)*

The State of California Workers' Compensation paper claim requirements have been added so that they print on the **PDF** paper claims, in the same way that they have been printing on the legacy paper claims. See the **Tables** section of these release notes for additional information on setup for these claims and a note regarding State of CA Workers' Comp *electronic* claims.

Print Insurance Forms *(Insurance Billing Functions)*

Additional changes have been added to the State of California Workers' Compensation paper claims for both legacy and PDF paper claims programs.

- **Box 10d**: The **NUBC Condition Code** field was added to the Refile dialog box for the refiling of State of CA Workers' Comp *duplicate* and *appeal claims only*. If you are refiling an appeal or duplicate claim, complete this field so that the correct value prints in Box 10d on the CMS-1500 form. A **BG** qualifier, which is added in the background, will print in front of the selected NUBC Condition Code.

- **Box 22**: In the Refile dialog box, if you enter a **7** or **8** value in the **Resubmission Code** field, that value will print in the left side of the box. If you add an **ICN** in the *Payment Entry Function* or in the Refile dialog box, that value will print in the right side of the box.

See the **Tables** section of these release notes for additional information on setup for these claims and a note regarding State of CA Workers' Comp *electronic* claims.

Print Insurance Forms *(Insurance Billing Functions)*

It was possible for the NDC code to print on a separate line item on the secondary legacy CMS-1500 claim forms instead of printing in the same line directly above the injection/medication. This has been resolved.

Print Insurance Forms *(Insurance Billing Functions)*

For the PDF Insurance Forms, the boxes on the CMS-1500 where the doctor's name prints (Boxes 17, 31 and 33) have been changed to use the doctor's **Printing Name** as stored in the *Doctor Code Table*. The HCFA Wizard and other legacy printing programs are already printing the Printing Name. The **PrintingName** property has been added to all of the **Name** Claim Data Properties in the *Paper Claim Editor.*

Print Insurance Forms *(Insurance Billing Functions)*

If **Bill this Carrier**=**C** (Courtesy) in the patient's Insurance Policy Information screen, a claim will file once to paper but there will be no notation in the patient's Insurance Ledger. This is for both 4010 and 5010 claims. If the **Enable Paper Claim Editor and Alignment Functions (PDF)** check box is selected in *NetPracticePM Integration Options,* the courtesy filing will appear as a claim preview tab in the Encounter view.

Print Insurance Forms and Reprint Insurance Forms *(Insurance Billing Functions)*

A progress bar now displays while PDF claims are generating and preparing to print.

Refile Insurance Claims and Print Insurance Form on Demand *(Insurance Billing Functions)*

Previously, when you Refiled or Demanded on a 5010 claim, the claim status was set as **1-In Process**. As a result, it would not print on the filing report until you performed the *Create Insurance File* function. With this update, the status set as **2-Locked.** This will allow the claims to print on the *Insurance Filing Report* without using the *Create Insurance File* function.

Refile Insurance Claims and Print Insurance Form on Demand *(Insurance Billing Functions)*

Previously, if an ICN had been entered in the *Payment Entry Function* and you didn't re-enter it when you refiled the claim, the original ICN would not be included on the refiled claim. This has been resolved. The **ICN** field in the Refile dialog box will now default the last refiled ICN for that claim and carrier. You can modify this field if needed.

Refile Insurance Claims *(Insurance Billing Functions)*

Previously, if you attempted to refile a 4010 claim to a secondary/tertiary carrier with **E-Secondary/E-Tertiary** selected and the claim was originally filed electronically, the message **Claim(s) have not been sent for the procedures. Unable to Refile** displayed. This has been resolved and you will now be able to refile those claims.

Insurance Filing Report *(Insurance Billing Functions)*

The claim indicator, **JP**, will print next to the form type for both legacy and PDF claims if you performed a *Transfer Journal to Current File* or a *Transfer Journal to Paper Claims*.

Insurance Filing Report (for PDF Claims Only) *(Insurance Billing Functions)*

Previously, it was possible for some claims to not print on this report even though they were available to print in the print file. This could occur when a 5010 electronic claim file was later moved to paper via *Transfer Journal to Paper Claims*. This has been resolved.

Insurance Filing Report *(Insurance Billing Functions)*

Previously, when you moved the exceptions to paper, the claims would not print on the *Insurance Filing Report* until you performed the *Create Insurance File* function. A change has been made so that these claims will immediately be available on the *Insurance Filing Report* without using the *Create Insurance* function.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

Previously, electronic claims that contained exceptions did not generate to the Exception Report until either the *Create Insurance File* or the *Move/Rebuild Transmission File* functions were performed. A change has been made so that when you click **Save** in the *Procedure Entry Function*, if there are any existing exceptions, the claim is immediately generated to the Exception Report. (This is not true for claims currently being held. Those claims do not generate until the 'hold' is removed.)

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

The following changes apply to 5010 claims only:

- If you *Transfer Journal to Current File* and if the policy on the patient's account has had the **Carrier Type** changed to a different value than what it was when the claim was originally filed, the claim will go to the exception report with a **Carrier not in effect or changed** exception. You must either change the policy information back to what it was and send the claim or move the claim to paper and refile it to the appropriate carrier.

- If the policy changed from **Primary** to **Secondary** and the carrier has the **E-Secondary** check box selected in *Maintain Insurance Carriers* and the claim was moved to the current file, one of the two following exceptions could occur: **No Payment from Primary Carrier** or **Carrier not in effect or changed**.

  - The second exception will now occur in place of the first exception if the policy information has changed and you happen to post a payment to the carrier before moving the claim to the current file.

  - If the **E-Secondary** check box is not selected, the claim will automatically generate as a paper secondary claim because there are no exception checks for paper claims.

- If the policy has changed from **Secondary** to **Primary**, the claim has been moved to the current file and it is still in the electronic file, the **Carrier not in effect or changed** exception will occur. You must either change the policy information back to what it was and send the claim or move the claim to paper and refile it to the appropriate carrier.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

Previously if a claim contained multiple charges with exceptions, only one of the exceptions would appear on the Exception Report. However, none of the charges on the claim were being submitted

due to the exception. (This is how it will continue to function for 4010 claims.) For 5010 claims, the Exception Report now displays all charges indicating the reason for the exception(s), either at the claim level or the line level:

- Exceptions occurring on the claim level will display all of the charges on the Exception Report with the claim level reason for the exception.

- Exceptions occurring on the line level will display all of the charges on the Exception Report with the reason for the exception on the claim line where the exception occurred. Claim lines without exceptions will display with the reason field blank.

REMINDER: While reviewing exceptions you could correct an exception on a claim, perform a move/rebuild, and still have the claim display on the Exception Report. This may be due to a new or additional exception occurring on the same claim. Review the details of the exception and work the new exception reason.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

Since the insurance carrier's address is now being sent on all 5010 claims, a new exception, **Carrier Missing State Code** has been added. This exception will occur if the city and state in the **City, State** field in *Maintain Insurance Carriers* is not entered correctly. The city and state must be entered as City, ST (the City followed by a comma one space and the two letter state code and no other spaces in the field).

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

Four-digit Revenue Codes are required on all institutional claims. Therefore, an exception for **Revenue Code_XXX_must be 4 digits long** has been added. This exception occurs if you have entered a Revenue Code that is less than four digits in the **Default Revenue Code** field in the *UB-04 Integration*, in the **Revenue Code** field in *Maintain Procedure Codes*, or if you have manually entered Revenue Codes in the *Paper Claim Editor*.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

The exception **No Billing Profile in effect for DOS** was appearing if a **Tax ID Number** was not entered into the *Billing Profile Rules* for the profile being used on the claim. This exception also appeared if there was not an **Entity Name** entered into the *Billing Profile Rules.* These two items have been updated to display the proper exception warnings. The edit for the Tax ID now states, **Tax Id missing from Billing Profile in effect for DOS** and the edit check for the **Entity Name** now states, **Entity Name missing from Billing Profile in effect for DOS**.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

An exception, **An Employer Name is required if the Policyholder is an Employer**, has been added to indicate that the **Policy Holder is Employer** check box is selected but the **Employer's Name** field is blank in the patient's Insurance Policy Information screen. To address this you must add the employer's name into the **Employer's Name** field or clear the **Policy Holder is Employer** check box.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

A new exception, **Invalid Carrier Electronic ID#_NOCD**, has been added. If you have **NOCD** entered in the **Electronic ID#** or **UB Electronic ID** field in *Maintain Insurance Carriers*, this exception will occur. If you have *many* carriers with this value entered in these fields you can contact customer service to run a pass-thru to remove the NOCD value from these fields. The pass-thru will only delete "NOCD" in these fields. If there is information in these fields in addition to "NOCD", that information will remain in these fields.

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

An exception, **Tricare Policy number must be 9 or 11 digits long** has been added. If the **Insurance Form** on the carrier is **Champus (H)**, and the policy number is anything but 9 or 11 digits long, this exception will occur. This refers to either the 9-digit social security number or the 11 digit DoD Benefits Number (DBN).

Print Exception Report *(Insurance Billing Functions, Electronic Claims)*

An exception, **Medicare Group Number should not exist** was added for Medicare claims where the **Insurance Form** on the carrier is **Medicare (C)**. There should never be a group number associated with these claims. Remove the value stored in the Group Number field on the patient's Insurance Policy Information screen for the Medicare carrier.

Move/Rebuild Transmission File *(Insurance Billing Functions, Electronic Claims)*

If a 5010 electronic claim exists in the file and you add a **PP** modifier in *Edit an Encounter* or you change the **Bill to Insurance** option to **Paper** in *Maintain Procedure Codes*, the claim will generate into the PDF paper file instead of the legacy paper file, regardless of how the **Enable Paper Claim Editor and Alignment Functions (PDF)** check box is stored in the *NetPracticePM Integration Options*. Therefore, you must make sure that you select both the **Legacy Claims** and **PDF Claims** options when printing your paper claims or when printing the *Insurance Filing Report.*

Move/Rebuild Transmission File *(Insurance Billing Functions, Electronic Claims)*

Previously, it was possible for procedures with the **Bill to Insurance** option set to **No** in *Maintain Procedure Codes* to still be included on a claim that was filed, re-filed or demanded. This has been resolved and those procedures will not be included on any claims.

Prepare/Send Transmission File *(Insurance Billing Functions, Electronic Claims)*

The eMedix credentials are now being validated in the background *before* 5010 claim files are transmitted to eMedix. If the **eMedix User Name** and **eMedix Password**, as stored in the *eMedix eResp Integration*, cannot be validated, the following message displays: ****5010 Claims are ready, but your eMedix credentials for Database __ failed for the following reason: eMedix Credentials**

are Invalid. Those files then display in the *Transmission File Inquiry* as **Untransmitted** until the credentials are validated and the files are transmitted. You can check the credentials in the *eMedix eResp Integration*, but if they ultimately cannot be validated, you must contact customer service.

Prepare/Send Transmission File *(Insurance Billing Functions, Electronic Claims)*

A progress bar now displays while 5010 claim files are being transmitted. If a second user attempts to send claims at the same time, they will receive a message stating **Insurance files are in use, please try again later**.

Print Transmission File and Print Transmission Journal *(Insurance Billing Functions, Electronic Claims, Printing Options)*

If, in *Maintain Insurance Carriers*, **Electronic Paper Claims to CGM (6)** is selected in the **Electronic Form Number** field and there is a valid Payer ID in the **Electronic ID#**, **UB Electronic ID#** or **Additional Payer ID#** fields a message, ***This payer accepts 5010 Electronic Claims*** prints to the right of the carrier code/name on both the Transmission File and the Transmission Journal.

Print Confirmation Report *(Insurance Billing Functions, Electronic Claims, Printing Options)*

This screen has been updated to incorporate the enhanced communication and integration between NetPracticePM and eMedix for confirmation reports. The basic look and functionality still exist with the following changes and enhancements:

- Your eMedix credentials are validated in the background each time you perform this function. If the credentials cannot be validated, the **eMedix Credentials are Invalid** message displays. You can check your eMedix credentials in the *eMedix eResp Integration*, but if they ultimately cannot be validated you must contact customer service.

- The download path has been moved from the top of the screen into a new **Source** column, which displays the legacy download path for legacy reports only or **eMedix** for the reports loaded from eMedix.

- A **Report Type** column has been added which only includes information for eMedix reports.
  - The possible report types are: Payer Formatted Report, Transmission Acknowledgement, Claim Activity, Payer Status, Claim Acknowledgement, and Miscellaneous.

- The **File Date** column header has been renamed **Date** and displays the date that the file was created.

- The **File Size** column header has been renamed **Size (KB)**.

- The **Print** and **Delete** Action Column buttons are now unavailable until you select a check box next to one of the reports.

- The **Previous** and **Next** buttons at the bottom of the screen have been replaced by page navigation buttons.

Print Transmission Journal *(Insurance Billing Functions, Electronic Claims, Printing Options)*

The **No Electronic Submission (0)** form type claims will be omitted from this report. Previously, it would include form type **0** claims if you had left the **From Electronic Form Number** and **Thru Electronic Form Number** fields blank.

Transmission File Inquiry *(Insurance Billing Functions, Electronic Claims, File Maintenance)*

New Functionality A change has been made to take into account the eMedix credentials validation that is now done in the *Prepare/Send Transmission File* function. If the eMedix credentials could not be verified in that function, the file now shows on the Transmission File Inquiry screen as **Untransmitted** in the **First Trans** column. If you click to select that file, the Transmission File Inquiry detail screen displays with the following message**: File content is only available for files that have been transmitted.** The file remains as **Untransmitted** until the credentials are validated and the files are transmitted. You can check the eMedix credentials in the *eMedix eResp Integration*, but if they ultimately cannot be validated you must contact customer service.

When you click to select a 5010 claim file that has been transmitted, the Transmission File Inquiry detail screen displays the X12 ANSI electronic claim detail. A **Download** button has been added to the Action Column so you can choose to open or save a text file containing the X12 ANSI electronic claim data for that file. These files open and save in text (.txt) format only; they cannot be converted or saved in another format.

Transmission File Inquiry *(Insurance Billing Functions, Electronic Claims, File Maintenance)*

If a 5010 claim file failed to transmit to eMedix, the transmission error reason was not displaying. This has been resolved and those messages appear in red font below the file name.

Transfer Journal to Paper Claims and Transfer Journal to Current File *(Insurance Billing Functions, Electronic Claims, File Maintenance)*

Previously, if you sent 5010 claims and transferred the journal to the current file or to paper claims and then later you tried to move/rebuild or send 4010 claims, a message displayed stating that 4010 claims had already been sent that day, when they had not. Therefore, you could not move/rebuild or send 4010 claims that day. This has been resolved. The message will no longer appear, and you can now move/rebuild and send 4010 claims after 5010 claims were transmitted and transferred that day.

Move Exceptions to Paper *(Insurance Billing Functions, Electronic Claims, File Maintenance)*

This function has been updated so that 5010 claims will be moved to paper when you choose the **Select** option to move the exceptions to paper for a specific patient.

List Patients by Carrier Batch Number Menu Option Change– 4010 Claims Only *(Insurance Billing Functions, Electronic Claims, File Maintenance)*

The *List Patients by Carrier Batch Number* menu name has been changed to *List Patients by Carrier Batch Number – 4010 Claims Only***,** to indicate that this menu pertains to 4010 claim files only. It does not pertain to 5010 claims because with 5010 claims, separate files are created in the background for each Submitter ID, therefore each file will only ever have one Batch Number.

Delinquent Insurance Menu *(Insurance Billing Functions)*

Updates were made to the system, which allow the Delinquent Insurance Menu to work with your 5010 claims and PDF formatted paper claims.

Additionally, new prompts have been added to the *Delinquent Filing Report*, *Print Delinquent Insurance Forms* and *Reprint Delinquent Insurance Forms* to allow you to select **Legacy Claims**, **PDF Claims** or both.

NOTE: When printing the *Insurance Filing Report* or the *Delinquent Filing Report,* the delinquent PDF paper claims (from the last Delinquent Create date to the current date) will be included in the report.

Print Delinquent Insurance Forms and Reprint Delinquent Insurance Forms *(Insurance Billing Functions, Delinquent Insurance Menu)*

A progress bar now displays while PDF claims are generating and preparing to print.

Patient

Patient Name and Address Information *(Change Patient Data)*

A formatting change was made to accommodate the **Country Code** and **Subdivision** (Province Codes) on claims for patients with Canadian addresses and you can now send 4010 electronic claims for patients with Canadian addresses. The same formatting change has been made for the 5010 electronic claims. In addition, the Canadian addresses will now display correctly in the *Review Patient Information* and *Change Patient Data* menus.

Billing Information *(Change Patient Data)*

Any text entered into the **Internal Comment** field in the patient's Billing Information screen now displays in red font in the Billing Information section of the main Change Patient Data screen.

History – Encounter View - Ability to Perform Mass Files/Re-files and Mass Edits

New Functionality Changes have been made so that you can file or refile multiple encounters or individual charges across multiple encounters at one time. You can also perform edits to multiple encounters at one time.

On the Encounter view, check boxes have been added to the left of the **Service Date** column header and to the left of each charge line item so that you can select an individual box, multiple or all boxes. When you have selected the appropriate boxes, the new **Actions** drop-down box under the **Date of Service From** and **Thru** boxes becomes active. Click it and select to **File Selected**, **Refile Selected** or **Edit Selected**.

- If you choose **File Selected**, the standard File dialog box displays so you can select the **Insurance Carrier** that you want to file the encounter(s) or charge(s) to. A message displays indicating that the items were filed successfully. If any of the line items or encounters could not be filed, a dialog box appears listing the encounters that did not file. You must then file those separately to obtain the reason that they cannot be mass-filed.

- If you choose **Refile Selected**, the standard Refile dialog box displays so you can select the parameters for the encounter(s) or charge(s) that you want to Refile. A message displays indicating that the items were refiled successfully. If any of the line items or encounters could not be refiled, a dialog box appears listing the encounters that did not refile. You must then file those separately to obtain the reason that they cannot be refiled.

- If you choose **Edit Selected** for one encounter only, the standard Edit an Encounter screen opens.

- If you select an individual charge or multiple charges within the same encounter, the **Edit Selected** option is not available. To edit an individual charge or multiple charges within the same encounter, you still click the Encounter to access the Edit an Encounter screen to edit those individual items.

- If you select multiple charges across multiple encounters, the **Edit Selected** option is not available because it is not currently possible to edit charge line level information for charges across multiple encounters. (Note that a solution for this will be included in an upcoming future release.)

- If you want to select encounters or charges across multiple pages of the patient's transaction history, you can do that. Select the items on the current page and then paginate to the next screen to select additional items and select the **Actions** drop-down from any page.

- If you choose **Edit Selected** for multiple encounters, a new Edit Encounters dialog box opens so you can edit the encounter-level information for the selected encounters. The **Edit Reason** field is required. When you save your edits a message displays the encounters that were successfully edited. If the encounters could not be edited for some reason, a message displays indicating that.

  - If you attempt to edit encounters from within a closed billing period, a message stating the billing period is closed and statistical files should be reset displays.

    - If you attempt to edit charges, and either some or all are within a closed billing period, the **Billing Group**, **Per Dr**, **Ins Dr**, **Ins Dr Taxonomy** and **Location** fields are unavailable to be edited.

- If the same encounter is being edited by two users simultaneously, the last record changed and saved will be the one that is retained.

A **Select All/Clear All** toggle button has been added to the Action Column. However, use extreme caution and ensure you want to edit **All** of the encounters before using this option.

You can review all of the edited transactions on the *Print Edited Transaction Journal (Reports, Transaction Journals)*. ***Reminder*** This journal prints by Accounting Date and *not* the date the edits were made.

History – Encounter View *(Change Patient Data)*

New Functionality A **Show Rev/Neg/Moved/Hide Rev/Neg/Moved** toggle button has been added to the Action Colum of the Encounter view. Click this button to show the details of all of the reversed and negated items, which are normally collapsed and grayed-out. The "Moved" option refers to functionality that will be included in a future release. The preferred view can be set in *NetPractice Default Values (System, Database Maintenance Menu).* The toggle button defaults to the view as selected in the default values. The Show/Hide view as currently selected on the screen will hold until you click **Cancel** to cancel all the way out of *Change Patient Data* or *Review Patient Information* or until you toggle back to the other view.

History – Encounter View *(Change Patient Data)*

New Functionality An **Expand All/Collapse All** toggle button has been added to the Action Column of the Encounter view. Click this button to expand all of the details of the transactions that are usually collapsed under the items next to the plus sign icon (**+**). The preferred view can be set in *NetPractice Default Values (System, Database Maintenance Menu).* The toggle button defaults to the view as selected in the default values. The Expand/Collapse view as currently selected on the screen will hold until you click **Cancel** to cancel all the way out of *Change Patient Data* or *Review Patient Information.*

History - Encounter View *(Change Patient Data)*

A **Negate Reason** field has been added to the **Negate** dialog box. This field is required and this reason prints on the ledger, on the Transaction History Detail screen and on the *Procedure Journal*.

History – Encounter View *(Change Patient Data)*

In rare instances, it is possible for the PDF claim preview to not generate. Previously, an error would result. The error has been resolved, and now if this occurs, the **Paper** tab will be unavailable and the message, **The Paper representation of this claim could not be generated because the current application settings have been changed since the claim was originally generated**, displays at the bottom of the screen. An example of this occurring is if you had the billing profile set to include $0.00 procedures and a claim was created, but then you changed that setting to not include the $0.00 procedures and tried to view that claim preview.

History – Encounter View *(Change Patient Data)*

Previously, the **Paper** claim preview of secondary electronic claims did not match the actual electronic claim or the **Electronic** claim preview. It displayed all charge line items from the original encounter even if not all of the items were sent to the secondary carrier. This was a display issue only (the correct codes were being sent) and it has been resolved.

History – Encounter View *(Change Patient Data)*

When an eMedix Claim Acknowledgment report is downloaded, it updates the patient's account in two different places to inform you that the claim has been acknowledged by the carrier:

- When you hover over the claim tab in the *Encounter* view, the hover message displays the claim **Status** as **Acknowledged** and the date of the acknowledgement report**.**

- In the patient's *Insurance Ledger*, the **Action** field displays **Primary Acknowledged**, **Secondary Acknowledged** and **Tertiary Acknowledged**.

19

CompuGroup Medical
What's New in NPPM v7.4.2| Revised: 11.7.2012

History – Encounter View *(Change Patient Data)*

Previously, an error could occur when you tried to access a patient's transaction history because the Insurance Ledger would not always update properly if you had used the **Delete** option in *Edit Transmission File* for claims to 4010 or 5010 payers. Likewise, the error could occur for the same reason after using the **Move** option in *Edit Transmission File* for claims to 5010 payers. This could also cause the claim to not move to the paper claim file for the legacy printing format. These issues have been resolved.

History – Encounter View *(Change Patient Data)*

The **I** column header in the Encounter view has been renamed **Img** to indicate the image column, and o be consistent with the **Img** (image) column in the legacy History views.

History – Encounter View *(Review Patient Information)*

If you have the Encounter view selected as your default transaction history view, the drop-down box to select the legacy transaction history views was missing. This selection box has been restored.

History *(Change Patient Data)*

The **Reversal Reason** and the **Negate Reason** now display in the ledger and on the Transaction History Detail screen in the **Alt. Desc.** field for those transactions that were reversed or negated.

History *(Change Patient Data)*

It was possible, in specific situations that when secondary payments and adjustments were posted, they would post correctly but the entry in the patient's Insurance Ledger reflected the incorrect dollar amount. This has been resolved.

History *(Change Patient Data)*

It was possible for the statement icon (**ST**) to display for statements that were printed to screen or to paper. This was resolved so that the **ST** icon shows only on those statements that were generated to a statement file.

History *(Change Patient Data)*

Enhancements have been made to the auto-generated EOB's to reflect the required changes to the ANSI-835 format (Electronic Remittance Advice) from payers.

The auto-generated EOB's are found in three places in NetPracticePM:

- In the patient's Transaction History as the **E** (EOB) icon next to the payment lines in the **Img** (Image) column

- In the **View EOB** field in the patient's Transaction History Detail screen for the payment as the **E** (EOB) icon

- In *Import and Post ERA Files* when you click the Printer icon in the **EOB** column

Slightly different modifications have been made depending on whether the payment/ERA is manually or electronically posted. The **Manually Posted** version is the EOB that is generated when you post payments manually through the *Payment Entry Function*. The **Electronically Posted** version is the EOB that is generated when you post payments automatically in *Import and Post ERA Files.*

1. The header of the auto-generated EOB reflects whether the payment was **Manually Posted** or **Electronically Posted**.

2. The payer's Web site address prints in the upper left corner of the auto-generated EOB, under the payer's address, as follows:

    a. For the **Electronically Posted** version, if the payer sends their Web site address in the ERA

    b. For the **Manually Posted** version, if you enter it in the new **Web site** field in *Maintain Insurance Carriers*

3. On the **Electronically Posted** EOB, the Remittance Delivery Method has been added. If the payer sends it in the ERA, the Remittance Code, the name of the entity to whom the payment was remitted (your bank, for example), and the phone number of that entity print in the middle section of the EOB header.

4. On the **Electronically Posted** EOB, if the payer sends it, the **Policy ID** for the Healthcare Policy Identification Segment prints in the Claim Adjustment Reason Code section at the bottom of the EOB. This prints if:

    a. the payment is adjusted in accordance with the payer's published healthcare policy code list, and

    b. a Claim Adjustment Reason Code is identified by the notation "**Refer to the 835 Healthcare Policy Identification Segment (Loop 2110 Service Payment Information REF), if present**", and

    c. the payer has a published enumerated healthcare policy code list available to healthcare providers via an un-secure public website.

5. Adjustment code and description detail have been added as follows:

    a. On the Manually Posted EOB, the co-payment amount now prints as a PR (Patient Responsibility) adjustment.

    b. On the Electronically Posted EOB, in the **GRP/RC-AMT** column, all of the adjustment reason codes and amounts are itemized.

    c. A legend for the adjustment codes has been added to the bottom of the EOB.

Insurance Policy Information *(Change Patient Data)*

Previously, if you entered a date in the **Termination Date** field and clicked **Cancel** in the Deny dialog box, the open charges would still be denied. This has been resolved.

Insurance Policy Information *(Change Patient Data)*

When accessing insurance information, if you attempt to change the **Carrier Type** (Primary, Secondary, or Tertiary) when there are existing claims for that patient and carrier that have a status of *In Process, Locked, Exception or On Hold*, you will receive the following message: **Unable to change the carrier type. Claims have already been filed for this carrier.**

If there are claims that meet these criteria, you will not be allowed to change the carrier type.

Images *(Change Patient Data)*

eDocs Clients Only Previously, it was possible for an error to occur upon uploading images in eDocs and for the images to not appear in the **Image Management** drop-down menu. This has been resolved.

Reports

List of Patients by Ins Carrier *(Patient Listings, Sorted Lists of Patients, Double Sorted Lists of Patients, List of Patients by Location)*

Previously, the **Patients with Activity Since** and the **Include Patients with No Activity** prompts overlapped one another on the parameter selection screen. This has been resolved.

Reversal Reason Voided Transactions Journal *(Transaction Journals)*

The **Reversal Reason** from the Reverse Action dialog box in the Encounter view and Edit an Encounter has been added to the *Voided Transactions Journal* to the right of the reversal detail.

Procedure Journal- Negate Reason *(Transaction Journals)*

The **Negate Reason** from the **Negate** Action dialog box in the Encounter view and Edit an Encounter will now print under the negated procedure codes.

Schedule

Enter Patient Appointments

Previously, when scheduling appointments, it was possible to receive appointment choices from databases which were inappropriate for the patient, doctor, service type or location. This has been corrected so that the Scan and Multi-scan options will only return appointment selections from the appropriate database(s).

Cancellation Report *(Scheduling Printing Menu)*

The **Begin with Doctor Code** and **End with Doctor Code** fields have been extended to accommodate four-character Doctor Codes to coincide with the **Doctor Code** field in the *Doctor Code Table*.

Credit Manager Report *(Scheduling Printing Menu)*

Family and Linking Databases Only Previously this report would show only 0.00 as the balances for patients whose accounts were not the Master account. This has been resolved and the report now prints the current balance for all patient accounts.

Print Scheduled Patient Detail to Excel *(Scheduling Printing Menu)*

New Functionality Since the *Print Appointment Schedule* report has limited parameters, this new report has been added so you can customize your schedule report with extensive detail pulled from the scheduled appointment and the patient's account. The report can only be printed to **Microsoft Excel *viaMyReports*.** The top section of the screen contains the same parameter selection fields as the existing *Print Appointment Schedule* report.

You can set up two customized headers to print on the report using the **Custom Header Line 1** and **Custom Header Line 2** fields. Using the **Excel Column…** fields you can select from the drop-down lists to include data elements from the scheduled appointment and the patient's account.

NOTE: You can click the **Defaults, Fixed and Required Fields** icon in the lower right corner of the screen to set these fields so you do not have to make the selections each time you need to print the report.

System

Electronic Direct Connect Claims Integration *(Database Maintenance Menu, Claim Management)*

The menu name and functionality of the *Electronic Claims Integration* menu have changed. The new menu is now *Electronic Direct Connect Claims Integration* and pertains *only* to those clients who have purchased separate direct connections for claim submissions to carriers and/or clearinghouses other than eMedix.

For all claims sent through eMedix, all of the settings handled previously in the former *Electronic Claims Integration* are now handled in the background between NetPracticePM and eMedix.

If you have purchased direct connections, those settings have been automatically transferred to the new menu and are available for the form types that you have been submitting. As always, these settings are maintained separately for each database and must be set up separately in each database. Going forward, the addition of any new claim form types will need to follow the **CGM** purchasing protocol so that the selection can be made available in the **Insurance Form Number** drop-down list.

Direct Connect clients only: The **Primary Identifier** field on the new *Electronic Direct Connect Claims Integration* menu has been activated for the 5010 electronic claims.

NOTE: If your practice submits claims using clearinghouses or direct connects other than eMedix, you must set up 5010 claims for direct submission according to the *Setting Up 5010 Claims for Direct Submission for NetPracticePM v7.4.2* document located on the Knowledge Tree under Release Notes/NetPracticePM/Version 7.4.2 Release.

NOTE: The functionality for the Hold Claims check box which was available on the former Electronic Claims Integration menu is now handled under the new Claim Hold Rules menu. Refer to the release note for the addition of that menu for instructions.

Electronic Direct Connect Claims Integration *(Database Maintenance Menu, Claim Management)*

The **Primary Identifier** field has now been activated for 5010 electronic claims. You can use this field to store a separate identifier for claims submissions to a specific payer or electronic form type. The number entered in this field overrides what you have entered in the **Application Receiver's Code (GS03 Loop 1000B NM109)** field on this screen.

NOTE: The new *Electronic Direct Connect Claims Integration* menu is for use by clients with direct connections to payers, or clearinghouses other than eMedix. If you are an eMedix client and need to know a stored Application Sender's Code or Primary Identifier from the previous Electronic Claims Integration screen to determine if they need to be changed in the 5010 Electronic Claims Loop and Segment Editor, contact customer service.

If a payer requires a number other than the Application Receiver's Code to be submitted in Loop 1000B Segment NM109, you must type that number in the **Primary Identifier** field on this screen and then create a profile and rule to pull that value on to the 5010 electronic claim. To accomplish this, complete the following steps:

- Go to *System, Database Maintenance Menu, Claims Management, 5010 Electronic Claim Loop and Segment Editor*
- Click **New L/S Profile** in the Action Column
- Select the appropriate **Base X12 Definition**
- Type a **Description**
- Navigate to **Loop 1000B Segment NM109**
- On the **X12 Editor** window, override the existing setting by selecting the **Override** check box next to the **Value** field
- Click the Ellipsis button to the right of the **Value** field
- In the **Claim Data Properties** window, select **ECSIntegrationDetail** and then **PrimaryIdentifier**
- Click **Save** on the **X12 Editor** window and **Save** again to get back to the rules tree screen. Either add this new Profile to an existing Rule, or create a new Rule for the specific payer that requires the different Primary Identifier

Action Required You must review the 5010 Submitter ID Rules tree to ensure that the Submitter IDs are set up to go on your claims correctly.

Electronic Direct Connect Claims Integration *(Database Maintenance Menu, Claim Management)*

If there are any valid 5010 claims in the file for the selected Insurance Form Number, all of the fields that begin with **5010** will be grayed-out and cannot be modified. If you must make changes to these fields, you must first remove the claims from the claim file using one of these three methods:

- Send the claim files that exist for that carrier
- Check the Transmission File for the current Electronic Form Number for that carrier and use the *Edit Transmission File* function to move the claims to the paper file for those patients
- Hold the claims for that Form Type or Insurance Carrier in the *5010 Claim Hold Rules* menu.

Rules Menus *(Database Maintenance Menu, Claim Management)*

When selecting to **insert** or **delete a rule** near the bottom of the screen, the drop-down menu was being cut off. This has been resolved.

5010 Claim Hold Rules *(Database Maintenance Menu, Claim Management)*

*New Functionality*The functionality of the **Hold Claims** check box in the former *Electronic Claims Integration* menu has been moved and expanded to a new *Claim Hold Rules* menu. This new menu resembles and functions similarly to the other 'rule tree' menus (*Billing Profile Rules* and the *5010 Electronic Claim Loop and Segment Editor*, for example). You can now set up rules to hold all claims by **Doctor**, **Form Type** and **Insurance Carrier.**

- When an encounter for a claim is saved or updated from the *Procedure Entry Function* or from *Edit an Encounter*, the claim will be checked against the Claim Hold rules criteria to see if it should be placed in the **Hold** status automatically.

- When claim hold rule is added, edited or deleted, upon **Save**, all claims will be rechecked and moved to the correct claim status as indicated in the rules, as follows:

  o All claims in a status of **In Process**, **Locked**, **Exceptions** or **Hold** will be checked and either moved to or remain in the **Hold** status.

  o All claim files will be checked and any claim in a status of **Ready** will be removed from the claim file and changed to **Hold** status.

  o All claim files will be checked and any claim in a claim file in a status of **Hold** will be changed to **In Process**, removed from the exception report, and placed in the appropriate claim file.

5010 Claim Exception Rules *(Database Maintenance Menu, Claim Management)*

New Functionality This menu was added so you can set up your own 5010 electronic claims exceptions if needed. This menu works like the other rules-tree menus. You can set up a rule based on **Electronic Form Number**, **Insurance Carrier**, **Insurance Doctor**, **Insurance Form Type, Location** or **Performing Doctor** and then enter your own wording for custom exceptions for 5010 claims that will apply to charges matching the parameters of the rules. Click the **History** button in the Action Column to view a complete history of your customized exceptions.

5010 Electronic Claim Loop and Segment Editor and Paper Claim Editor *(Database Maintenance Menu, Claim Management)*

In cases in which a legacy provider number still needs to be sent on claims, a new **Calculated** claim property called **Claim.Calculated.LegacyProviderNumber** has been added, and can be selected for use in the *Paper Claim Editor* to print on paper claims and in the *5010 Electronic Claim Loop and Segment Editor* electronic claims. This property pulls from the *Provider Number Table* based on the rule and profile you set up in these editors.

NOTE: Loops and Segments are features which require a higher skill set than those of the standard user. Therefore, it is strongly recommended that the profile for your designated administrator(s) of this feature have a higher system security level than standard users in your practice. Functional security levels for individual users can be maintained under *System, User Management*.

5010 Submitter ID Rules *(Database Maintenance Menu, Claim Management)*

The 5010 Submitter ID Rules have now been activated for 5010 claims. The rules that you set here will override the system default (which is the **Application Sender's Code (GS02 or Loop 1000A NM109)** field in the new *Electronic Direct Connect Claims Integration* menu).

Therefore, whatever you enter as the **Submitter ID** will be sent in Loop 1000A Segment NM109 on the 5010 claims.

5010 Submitter ID Rules *(Database Maintenance Menu, Claim Management)*

As explained above, this menu is used to ensure that the correct Submitter ID is sent on your 5010 electronic claims. Submitter IDs are generally categorized by electronic Form Type (30=Medicare, 31=Medicaid, 32=Blue Cross, etc.). But, there can also be different Submitter IDs by carrier within the same form type and even possibly different Submitter IDs by doctor and location. The Submitter ID has always been stored by form type in the **Application Sender's Code** field in the former *Electronic Claims Integration* menu. When more specificity was needed, it had to be handled through a customization. This menu gives you the control to quickly and effectively manage your Submitter IDs and any changes that may need to be made to them.

Directly under the **Start** drop-down menu on the Submitter Id Rules tree is the **Submitter Id: Use ECS Integration** selection. The **Use ECS Integration** link has been made active so you can click it to change the default **Submitter ID** if and when that is necessary. (This will be most crucial for new clients coming on to NetPracticePM after the release of 7.4.2 where they will have to set up their own Submitter ID rules.)

With this release, a pass-thru has been done to automatically set up the Submitter ID rules based on your *Electronic Claims Integration* and this is what you should review.

NOTE: If you have customizations to your Submitter IDs, CGM customer service will contact you during our 5010 migration process. Nothing will change with these customs and your claims will continue to go as they have been until CGM contacts you to assist in the necessary setup for 5010 claims.

NOTE: If you had already set up Submitter ID rules, the pass-thru will not touch your current configuration.

Paper Claim Alignment *(Database Maintenance Menu, Claim Management)*

An error could occur when scanning in the *Paper Claim Alignment* function, if the DNS security for Java needs to be updated for that workstation.

If you experience paper claim alignment issues and/or receive the following error message when scanning in the *Paper Claim Alignment* function, contact customer service for assistance and resolution.

Paper Claim Editor *(Database Maintenance Menu, Claim Management)*

Additional **When** conditions and **Equals** options have been added to the Insert Rule dialog box, as follows:

- **Carrier Type** has been added as a **When** option so you can select one of the new **Equals** options of **Primary**, **Secondary** or **Tertiary** so that you can select a profile for primary, secondary or tertiary carrier types across the board.
- **Primary Carrier**, **Secondary Carrier** and **Tertiary Carrier** have been added as **When** options so you can select a profile for carriers based on their hierarchy on the patients' accounts. For example, you can set up a profile for the rule of **When** the **Secondary Carrier** (on the patients' accounts) **Equals Medicaid**, **Use (selected profile)**.

- **Primary Carrier Insurance Form**, **Secondary Carrier Insurance Form** and **Tertiary Carrier Insurance Form** have been added as **When** options so you can select a profile for Insurance Forms based on the hierarchy of the carriers set with that Insurance Form on the patients' accounts. For example, you can set up a profile for the rule of **When** the **Secondary Insurance Form Equals G-Blue Cross/Blue Shield** (for the secondary carrier on the patients' accounts) **Use (selected profile)**.

Paper Claim Editor *(Database Maintenance Menu, Claim Management)*

Previously, if you had set up Box 29 with a custom where you had selected **HCFABox29AllPmtsOnly** or **HCFABox29InsPmtsOnly** from the **Calculated** section, the payments would print as a credit: "-150.00", for example. This has been resolved and the numbers now print as positive numbers.

Paper Claim Editor *(Database Maintenance Menu, Claim Management)*

Changes were made to Box 32A and Box 33B for the Professional Claim map (CMS-1500):
- **Idaho Clients Only:** Box 32A - If the Billing Profile is not setup as an **Entity** or if the **State Code** in *Change Database Parameters* is **ID**, but the Insurance Doctor's Address Line 1 and Location Address Line 1 match, this box will be blank.

- Box 33B – If the **State Code** in the *Maintain Insurance Carriers* is **AZ** and the **Insurance Form**=**Medicaid (D)** or **Medicare (C)**, this box will be blank.

NetPracticePM Integration Options *(Database Maintenance Menu, Integrations)*

The **Enable Paper Claim and Alignment Functions (PDF)** prompt has changed so that when you select the check box and click **Save**, it cannot be cleared. This is to prevent claim submission and paper printing issues that could occur if this function was enabled and disabled multiple times.

NetPracticePM Integration Options *(Database Maintenance Menu, Integrations)*

If you have existing customizations to your paper claims and you select the **Enable Paper Claim**

Editor and Alignment Functions (PDF) check box, the following message appears: **There are existing customs on your paper claims that will be lost if you enable this function. If you want to keep the customs, do not select this check box. If you want to retain any of the customs and need assistance setting them up in the Paper Claim Editor contact customer service.** If you select the check box and click **Save**, your paper claim customs will be lost. If you leave the check box cleared, your paper claim customs will be retained.

Procedure Entry Integration *(Database Maintenance Menu, Integrations, Transactions Integrations)*

A **Maximum Procedure Lines** field has been added. The minimum value that can be entered is 20 and the maximum value that can be entered is 100. This setting controls how many procedure entry lines are available in the *Procedure Entry Function* to be entered on a single encounter. If you type an invalid entry into this field, the **Maximum Procedure Lines must be no less than 20, and not greater than 100** message displays.

NOTE: If you use a large number of procedure lines on one encounter and you are using a remote or slower connection, you may notice performance issues when navigating through or saving the Procedure Entry Function screen.

NetPractice Default Values *(System, Database Maintenance Menu)*

A **Show Reversed/Negated/Moved Transactions on Encounter View** check box has been added under the **Miscellaneous** section. If this is selected, all Encounter view screens for all users display all of the detail of the reversed and negated items, which are normally collapsed and grayed-out. The "Moved" option refers to functionality that will be included in a future release. See the **Patient** section of these release notes for information on these options in the Encounter view.

An **Expand All Transaction Details on Encounter View** check box has been added under the **Miscellaneous** section. If this is selected, the Encounter view screens for all users display all of the detail that is usually collapsed under the items next to the plus sign icon (**+**). See the **Patient** section of these release notes for information on these options in the Encounter view.

eDocs File Cabinet Editing **eDocs Users Only**

A message stating **The current document cannot be edited** displays when you try to edit a file that is being housed in the *eDocs File Cabinet* but that file is not available on the server. Previously, a message stating **The remote server returned an error: [404] Not Found** would display.

Tables

Maintain Doctor Codes *(Doctor Code Table)*

The system-held taxonomy code table has been updated with the 2012 taxonomy code changes from the National Uniform Claim Committee (NUCC).

Import Fee Schedules *(Fee Schedule Tables)*

The Centers for Medicare and Medicaid Services (CMS) have updated the 2012 Medicare Physician Fee Schedule effective July 1, 2012. Those updates are available for import by selecting the **Medicare – Effective 07/01/2012 (17)** option in the **Fee Schedule File** drop-down list.

Maintain Insurance Carriers *(Insurance Carrier Table)*

Action Required *Clients submitting State of California Workers' Compensation Paper Claims only* - A new **California Workman's Comp (CA)** selection has been added to the **Insurance Form** drop-down list to take into account the State of California Workers' Compensation carriers that are *not* actually located in California. State of California Workers' Compensation requires several 'customizations' to the CMS-1500 form. There are two possible ways that carriers can be set up to ensure that these custom rules print on the paper claims.

Required Action: You must confirm that your State of California Workers' Compensation carriers are configured correctly as follows:

This first configuration will work *only if the carrier's address is within the State of California*. This is how you were instructed to set up these carriers initially and it remains an accepted method.

- **Worker's Compensation (B)** is selected as the **Insurance Form**
  - *and* **CA** is the **State Code** on the carrier's address
  - *and* **No Electronic Submission (0)** is selected as the **Electronic Form Number** (or you select to **File** or **Refile** the claim as a paper claim)

The second option *must* be in place when the carrier's address is *outside* the state of California, but it will *also* work for carrier addresses within the state of California. **Therefore, going forward you should set up *all* of your State of California Workers' Compensation carriers as follows:**

- **California Workman's Comp (CA)** is selected as the **Insurance Form**
  - *and* any valid **State Code** on the carrier's address
  - *and* **No Electronic Submission (0)** is selected as the **Electronic Form Number** (or you select to **File** or **Refile** the claim as a paper claim)

NOTE: State of California Workers' Compensation required payers to accept electronic claims as of October 18, 2012. It is not required for providers to send electronic claims. Paper claims are still accepted. There are customizations to the electronic format that must still be incorporated in NetPracticePM. Those updates *are not* included in v7.4.2. Those updates will be made and released soon. **In the meantime, you must still claims to State of CA Workers' Comp carriers in *paper format only.***

Maintain Insurance Carriers *(Insurance Carrier Table)*

If you change the **Electronic Form Number** to **No Electronic Submission (0)** or try to alter the value that is stored in the **Electronic ID#** and **UB Electronic ID#** fields, checks are done in the background and if you do not have the **Enable Paper Claim Editor and Alignment Functions (PDF)** check box selected in *NetPracticePM Integration Options* **and** there are 5010 claims in **Status 2-(Locked)(In Submission File)** the following message displays: **Unprocessed claims exist in the electronic and/or paper claim file for this carrier. You must send the claims, remove them from the claim file(s) or put the claims on hold before changing the Electronic Form Number to 0**.

You must then take one of the three actions in the message to remove all claims for this carrier from a locked status before you can change the **Insurance Form Number** to **No Electronic Submission (0)**.

- Send the claim files that exist for that carrier
- Check the Transmission File for the current **Electronic Form Number** for that carrier and use the *Edit Transmission File* function to move the claims to the paper file for those patients
- Hold the claims for that **Form Type** or **Insurance Carrier** in the 5010 C*laim Hold Rules*

Maintain Insurance Carriers *(Insurance Carrier Table)*

A **Web site** field has been added to store the carrier's Web site address. This address populates into the **WEBSITE** field at the upper left corner of the auto-generated **Manually Posted** EOB.

Maintain Insurance Carriers *(Insurance Carrier Table)*

The **Force UB Claim to Paper** check box, which was added in 7.4.1, has been activated for 5010 claims. If this check box is selected and the claims generated from the encounter are institutional then the claim will be forced into a paper format regardless of what the electronic form number exists for the patient's insurance carrier for that claim.

Load the AMA ICD-9-CM® Codes *(Diagnosis Code Table, Maintain Diagnosis Codes)*

The updated ICD-9 codes, effective October 1, 2012, are available for loading for those clients who have purchased that code set. To receive the updated codes you must load the 2013 file.

Load the AMA CPT® Codes *(Procedure Code Table, Maintain Procedure Codes)*

The updated CPT codes, effective January 1, 2013, are available for loading for those clients who have purchased that code set. To receive the updated codes you must load the 2013 file.

Load the AMA HCPCS® Codes *(Procedure Code Table, Maintain Procedure Codes)*

Updates to the 2012 HCPCS data files, effective July 1, 2012 are now available for clients who have purchased that code set. To receive the updated codes you must reload the 2012 file.

Load the AMA CPT ® Codes *(Procedure Code Table)*

The American Medical Association (AMA) has released midterm CPT® code changes (release date July 1, 2012). The update includes changes to the CPT® Category I (Vaccines), Category II (Performance Measurement), and Category III (New and Emerging Technologies). Most of the codes have implementation dates of January 1, 2013 or later - meaning they won't appear in the AMA CPT® Code manuals until then. However, because they are valid, released AMA CPT® Codes, some payers may require them prior to their implementation date. Therefore, we have updated the code sets.

To accommodate the need to add CPT® Category III codes, a new check box selection, **New and Emerging Technologies (CPT® Category III)**, is available. To ensure you have the most current code information available, **you must reload the codes** to update your tables.

Maintain Procedure Codes *(Procedure Code Table)*

The following message appears if you change the **Bill to Insurance** option from **Yes** or **Paper** to **No**, and save the screen: **You have changed the 'Bill to Insurance' option on this procedure code to 'No'. If a current claim file contains this procedure code, it will still be sent on the claim(s) unless you edit the file to remove this procedure code.**

Transactions

Electronic Remittance Advice (ERA)

Several enhancements have been made to these menus to incorporate the enhanced communication and integration between NetPracticePM and eMedix for remit files.

1. The *Import ERA Files* and *Post ERA Files* menus have been combined into one menu and renamed *Import and Post ERA Files.* When you click the new menu:

   - Your eMedix credentials are validated in the background. If the credentials cannot be validated, the **No eMedix Credentials on File for Database __** message displays. You can check your eMedix credentials in the *eMedix eResp Integration*, but if they ultimately cannot be validated you must contact customer service.

   - A status message of **Checking for new files...** displays while all available remit files are imported. The new Import and Post ERA Files screen opens and all available remit files display.
     NOTE: This will not occur until the Web Service between NetPracticePM and eMedix is activated. This activation cannot occur until *all* clients have been upgraded to v7.4.2. All clients who have not upgraded will be informed to upgrade by a specific (and yet-to-be-determined) date. If you have not upgraded by the time the Web Service is activated, you will not have access to your 5010 remit files through NetPracticePM. Until the Web Service is activated you should continue to access your remit files via the **Download from OSC** button in the Action Column or via eMedix eResp. CGM will keep you informed about the activation date.

   - The ERAs in black font have not yet been posted. The ERAs in gray font have been posted. The font turns from black to gray after you post an ERA.

   - **Post** and **Delete** buttons have been added to the Action Column. They are both unavailable until you click one or more check boxes in the column to the left of the **Source** column.

     o You can select the check box next to any individual ERA or any multiple ERAs.
     o If you select an ERA that has not yet been posted, both the **Post** and **Delete** functions are available.
     o If you select an ERA that has previously posted, only the **Delete** function is available because that remit has already been posted and cannot be posted again.

   - The import file path has been moved from the top of the screen to the new **Source** column. This column displays the original source of the remit file.

     o If ERAs were imported prior to your system upgrade to 7.4.2 *and/or* if you send your claims directly to carriers or a clearinghouse other than eMedix, and they return an ERA file, the **Import Path**, as stored in the *ERA Integration Setup*, displays.

- o If the ERAs are imported from eMedix, **eMedix** displays.

- The **Status** column displays one of the following results:

  - o **Completed**: Indicates remits posted before the installation of version 7.4.2 on your system, therefore a date/time of when the file was posted is not available to be displayed.
  - o **Date/Time and User code**: Displays for ERAs that are posted after the installation of version 7.4.2 on your system.
  - o **In Progress**: Displays when multiple remits are selected to be posted at once and the remit is in process of being posted. When a remit shows as 'In Progress' it is unavailable so it cannot be selected again to be reposted.
  - o **File contains multiple remits, please contact CGM**: If a remit from a direct submitter contains multiple remits in one file, the remit will not post and you must contact customer service so that the remit can be split into multiple files.

- Click the printer icon in the **EOB** column next to the ERA that you want to print. You can print and reprint ERAs as many times as is necessary, even when the remit has been posted and displays in gray font. You cannot select to print multiple EOBs at one time.

- The **Exceptions** column displays a printer icon if an Electronic Remittance Exception Report exists due to payment exceptions found when the ERA was posted. You can click this printer icon to print and reprint the exceptions as many times as is necessary, even when they have been printed and resolved and the remit displays in gray font.

- You can post multiple remits at once by selecting the check boxes next to each remit and clicking **Post** in the Action Column.

  - o The **Status** column displays **In Progress** and the remit is unavailable to select.
  - o When the remit has been posted, the **Status** column updates with the date/time/user code stamp, but since this screen does not refresh automatically, you must either click **Cancel** and then re-enter the screen or select to post other remits.

2. The *Print Payment Exceptions* and *Print Archived Exceptions* menus have been removed because this functionality is now available in the new *Import and Post ERA Files* menu with the printer icon in the **Exceptions** column.

3. Updated status information has been added to the *ERA Activity Log*. Remits retrieved from the new *Import and Post ERA Files* menu can show up to three different statuses in the **Activity** column.

- **Created** – Since the import occurs automatically now *each* time you access the *Import and Post ERA Files* menu, the **Imported** status has been changed to **Created** and indicates when the remit file was *originally* received into the Import and Post ERA Files screen. Therefore, the **Date** column *always* reflects the date that the remit file was *originally* received in the *Import and Post ERA Files* menu.

- o The **Date** and **Date Time** columns display the same date, (since the creation of the file was the only activity on the ERA file at that time). Again, these columns display the <u>original</u> date the file was created. These dates do not automatically update each time you access the *Import and Post ERA Files* menu.
  - o Since the Created dates are system-generated, the **User** column populates with **CGM**.

- **Posted**

  - o The **Date** column displays the date the remit file was originally created.
  - o The **Date Time** column displays the actual date and time that the remit was **posted.**
  - o The **User** column displays the **User** code of the user who **posted** the ERA.

- **Deleted**

  - o The **Date** column displays the date the remit file was originally created.
  - o The **Date Time** column displays the actual date the remit was **deleted**.
  - o The **User** column displays the **User** code of the user who **deleted** the ERA.

NOTE: Remits received *prior* to the date that your system was upgraded to NetPracticePM version 7.4.2 display an Activity status of **Imported** or **Deleted** only.

Import and Post ERA Files *(Electronic Remittance Advice (ERA))*

Claim level adjustments are sometimes included in an Electronic Remittance Advice (ERA). These adjustments are captured on the Electronic Remittance Exception Report. However, prior to this update, only Contractual Adjustments (CO) and Patient Responsibility (PR) adjustment types were pulling into the report. The third adjustment type, Other Adjustments (OA), was not being captured. To resolve this issue, OA adjustment types have now been configured to pull into the Electronic Remittance Exception Report, allowing you to view all adjustment types and reasons.

Import and Post ERA Files *(Electronic Remittance Advice (ERA))*

This function would not capture patients with numeric characters preceding their name, therefore, the posted payments would not balance to the ERA and those patients would not appear on the auto-generated EOB's. This has been resolved.

Procedure Entry Function

*This Change Applies *Only* to FQHC Clients* When you enter both professional and institutional CPT codes on an encounter, the procedures are split into two separate encounters – one for professional and one for institutional. However, previously you could not access the UB-04 Attachment from the professional encounter. This has changed in that the UB-04 Attachment will now remain attached to the professional encounter so you can access it. It is not pulled into the professional claim at all. It is still sent only with the institutional claim.

Also, if you did not have the *UB-04 Integration* set up correctly, NetPracticePM could not identify the charges as institutional and would save them as a professional encounter and the UB-04 Attachment was deleted. This has been resolved in that the UB-04 Attachment will not be deleted, although the encounter will still be considered as professional until you correct the *UB-04 Integration*.

Therefore, regardless of the type of encounter, if a UB-04 Attachment is added, it will remain with that encounter.

Procedure Entry Function

If information in the header of the Procedure Entry Function screen matches an already existing encounter a warning message will display that states '**An Encounter already exists with this information. You can continue adding a new encounter or go to Edit an Encounter for the existing encounter and click Add Procedure to add procedures to the existing encounter**'. The message will appear after clicking **Save** on the Procedure Entry Function screen. In addition, the message will also appear when using the **Store** action button, if applicable.

Procedure Entry Function

Previously, in the **Multiplier (Mlt)** field of the NDC Code Attachment you could only enter up to three digits in this field. Now, the field has been updated to accept up to four digits and the **Data Validation Failed** message will no longer appear.

Procedure Entry Function

A change was made so that when you enter an *Encounter* level **Authorization** attachment for an Authorization with an expiration date prior to the accounting date on the encounter, but still valid for the date of service on the charge a warning message appears to inform you that the authorization is currently expired.

The same warning message appears when you enter a line item Authorization that is expired for the date of service on the line item. These are warning messages only; you are still able to save the attachments and post the charge.

Procedure Entry Function

Previously, it was possible for an **Admit/Discharge** Attachment marked as **Continuous** to be incorrectly triggered as a valid attachment on charges where a non-facility location was selected in the **Loc** field. This has been resolved and now the continuous **Admit/Discharge** Attachment will only be triggered and show as attached to charges when a facility location is entered in the **Loc** field. If you go into *Edit an Encounter* for an encounter where a continuous **Admit/Discharge** Attachment had been erroneously saved for a *non-facility* location and you change the location to any other *non-facility* location and click **Save**, the original continuous **Admit/Discharge** Attachment will automatically be deleted from the encounter.

Edit an Encounter

When the **Always Accept Assignment** check box is selected in the *Procedure Entry Integration*, the field in the *Procedure Entry Function* will always be stored as **Y** even if you change it to **N** during procedure entry. But, this **Always Accept Assignment** integration will no longer apply to *Edit an Encounter*. This means that while editing an encounter you can change the **Y** response to **N** even though the **Always Accept Assignment** integration is selected. Previously, this integration applied to both the *Procedure Entry Function* and *Edit an Encounter.*

Edit an Encounter

When editing an encounter, if you attempt to change the modifier on the procedure to **NF** (to not file to insurance) and there is an insurance balance on that charge, the following message displays: **Claims have already been created for the line item(s). You cannot use the NF modifier while the balance on the line items(s) is still in the Insurance Balance.**

Edit an Encounter

If you edit anything in the top section of the screen (*Encounter level*) the line items in the bottom section of the screen are unavailable. You must apply the Encounter level changes before you can make changes to the line items. Also, if you select a line item or multiple line items to edit, the Encounter level section is unavailable. You must apply the line level changes before you can make changes to the Encounter level.

NetTools

ScanSharp

This note is to remind you that card scanning and OCR software works best when the card is run through the scanning hardware properly. For all DocketPort and older-model scanners, that means "heads-up, face-down, straight and even". A flyer, "INUVIO-How to Correctly Scan a Card" has been added to the Knowledge Tree under Products/ScanSharp for your convenience.

Appendix A – 5010 Claims Exceptions

Print Exception Report *(Billing, Insurance Billing Functions, Electronic Claims)*

Many new exceptions were added for 5010 claims. Some are the same or similar to those for 4010 claims. Some of the exceptions that were valid with 4010 claims are still valid for 5010 claims. Check back for updates to the 4010 and 5010 claims exception on the Knowledge Tree in the EDI folder.

Some of these exceptions that needed more explanation were mentioned in the Billing section of these release notes, but this is a comprehensive list as of the 7.4.2 release:

NetPracticePM Exceptions for 5010 Claims	How to Resolve the Exceptions
Database Checks:	
Missing Database Phone Number	**Phone Number** in *Change Database Parameters (System, Database Maintenance Menu)*
Submitter Checks:	
Interchange Sender ID Req	Direct Connect Clients: **Interchange Sender ID** in *Electronic Direct Connect Claims Integration (System, Database Maintenance Menu, Claim Management)* eMedix Clients: Contact customer service.
Application Sender's Code Req	Direct Connect Clients Only: **Application Sender's Code** in *Electronic Direct Connect Claims Integration (System, Database Maintenance Menu, Claim Management)* eMedix Clients: *5010 Submitter ID Rules (System, Database Maintenance Menu, Claim Management)*
Insurance Carrier Checks:	
Carrier Missing State Code	**City, State** field in *Maintain Insurance Carriers (Tables, Insurance Carrier Table)* The field must be completed as City, ST with only one space between the comma and the two-character state code and no other spaces in the field.
Carrier - Invalid State Code	**City, State** field in *Maintain Insurance Carriers (Tables, Insurance Carrier Table)* The field must be completed as City, ST with only one space between the comma and the two-character state code and no other spaces in the field.
Carrier Address1 cannot equal Carrier Address2	**Address Line One** and **Address Line Two** in *Maintain Insurance Carriers (Tables, Insurance Carrier Table)*
Insurance Doctor Checks:	
Insurance Doctor Taxonomy Code Required	**Ins Dr Taxonomy** on the Encounter, which pulls from the **Taxonomy Code** field in *Maintain Doctor Codes (Tables, Doctor Code Table)*

Patient Checks:	
Invalid or Missing Patient Sex	**Sex** field in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Invalid or Missing Birthdate	**Birth Date** field in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Patient's Address - Invalid Address (no Street Address)	**Address Line One** in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Patient's Address - Invalid City	**City** in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Patient's Address - Invalid State (If US Address)	**State Code** in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Patient's Address - Invalid or Missing Zip Code, (If US Address)	**Zip Code** in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Patient's Address - Patient Address1 cannot equal Patient Address2	**Address Line One** and **Two** in Patient Name and Address Information screen *(Patient, Change Patient Data)*
Payer- Specific Edits:	
If Claim Type=2 and Electronic ID="H00014", and no taxonomy code entered: Insurance Doctor Taxonomy Code Missing (XX) Where XX is the doctor code.	**Ins Dr Taxonomy** on the Encounter, which pulls from the **Taxonomy Code** field in *Maintain Doctor Codes (Tables, Doctor Code Table)*
If Carrier Form Type ="C", and group number is entered: Medicare Group Number should not exist	**Group Number** in Insurance Policy Information screen *(Patient, Change Patient Data)*
If Carrier Form Type ="H", and Policy number is not 9 digits long, or 11 digits long: Tricare Policy number must be 9 or 11 digits long	**Policy Number** in Insurance Policy Information screen *(Patient, Change Patient Data)*
Doctor Checks:	
Doctor Tax ID Missing (XX) where XX is the doctor code	**Tax ID Number** in *Maintain Doctor Codes (Tables, Doctor Code Table)* **Tax ID Number** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Doctor Specialty Code Missing (XX) where XX is the doctor code	**Specialty Code** in *Maintain Doctor Codes (Tables, Doctor Code Table)*
Doctor NPI Number Missing (XX) where XX is the doctor code	**NPI Number** in *Maintain Doctor Codes (Tables, Doctor Code Table)* **NPI Number** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Location Checks:	
Invalid Location Address (XX) where XX is the location code.	**Address Line One** in *Maintain Location Codes (Tables, Location Code Table)*
Invalid Location City (XX) where XX is the location code	**City** in *Maintain Location Codes (Tables, Location Code Table)*
Invalid Location State (XX) where XX is the	**State** in *Maintain Location Codes (Tables, Location Code Table)*

location code	
Invalid or Missing Location Zip Code (XX) where XX is the location code	**Zip Code** in *Maintain Location Codes (Tables, Location Code Table)*
Location Address1 cannot equal Location Address2	**Address Line One** and **Address Line Two** in *Maintain Location Codes (Tables, Location Code Table)*
Billing Address Checks:	
PO Box in Billing-Profile Address Profile Rules (PO Box not allowed in address line 1 or 2)	**Line 1** and/or **Line 2** of **Billing Address** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Invalid or Missing Billing-Profile Zip Code	**Zip** of **Billing Address** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Tax Id missing from Billing Profile in effect for DOS	**Tax ID Number** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Entity Name missing from Billing Profile in effect for DOS	**Entity Name** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Billing Profile Address1 cannot equal Billing Profile Address2	**Line 1** and **Line 2** of **Billing Address** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
Policy Checks:	
If Claim Indicator="J", Original Carrier Type does not equal the Policy Carrier type: Carrier not in effect or changed	The claim was moved in the *Transfer Journal to Current File* function and the **Carrier Type** on the patient's Insurance Policy Information screen *(Patient, Change Patient Data)* had been changed between the time the claim was first filed and the time it was transferred to current. You must either change the policy information back to what it was and send the claim or move the claim to paper and refile it to the appropriate carrier.
Insurance Carrier - Carrier set Not to Bill	**Do Not Bill to Insurance** check box is selected for the carrier in *Maintain Insurance Carriers (Tables, Insurance Carrier Table)*
Patient File - Carrier set Not to Bill	**Bill this Carrier**=**N** for this carrier in the patient's Insurance Policy Information screen *(Patient, Change Patient Data)*
No Primary Carrier on Account	**Insurance** Action Column button on patient's account *(Patient, Change Patient Data)*. Check the **Carrier Type** field for the carriers on the account.
Policy Number - Policy Number Required	**Policy Number** field in the patient's Insurance Policy Information scree *(Patient, Change Patient Data)*
Policy Number - Policy Number not Valid - (length of policy number must be greater than 2)	**Policy Number** field in the patient's Insurance Policy Information scree *(Patient, Change Patient Data)*
Other Carrier Address1 cannot equal Other Carrier Address2	**Address Line One** and **Line Two** in *Maintain Insurance Carriers (Tables, Insurance Carrier Table)* for the other carrier on the patient's account
Profile Pay To Address1 cannot equal Address2	**Line 1** and **Line 2** of **Pay To Address** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
An Employer Name is required if the Policyholder is an Employer	**Employer's Name** in the patient's Insurance Policy Information screen *(Patient, Change Patient Data)*

NPI Number Checks:	
Invalid or Missing Referring Doctor NPI Number for (XX) where XX is the Referring Doctor Code	**NPI Number** field in *Maintain Referral Source Codes (Tables, Referral Source Table)* for the Ref Dr on the claim
Invalid or Missing Insurance Doctor NPI Number (XX) where XX is the Insurance Doctor Code	**NPI Number** field in *Maintain Doctor Codes (Tables, Doctor Code Table)* for the Ins Dr on the claim
Invalid Location NPI Number (XX) where XX is the Location Code. (Not a required field)	**Location NPI Number** field in *Maintain Location Codes (Tables, Location Code Table)* for the Location on the claim
Invalid or Missing Organizational NPI Number	**NPI Number** field in *Maintain Group NPI Numbers (Tables, Doctor Code Table, Provider Number Table, Group NPI Number Table)* **NPI Number** in *Billing Profile Rules (System, Database Maintenance Menu, Claim Management)*
ERA Checks:	
If Tertiary Claim -"No Payment from Secondary Carrier"	Patient's Insurance Ledger *(Patient, Change Patient Data).* No payment entered from the secondary carrier that the claim was sent to.
If Secondary Claim - "No Payment from Primary Carrier"	Patient's Insurance Ledger (Patient, Change Patient Data). No payment entered from the primary carrier that the claim was sent to.
Encounter Level Checks:	
Diagnosis Code xx invalid where xx is an 'unlinked' diagnosis code	The Diagnosis Code on the charge is not linked to the procedure code that it is tied to in *Maintain CPT®/DX Linking (Tables, Procedure Code Table, CPT®/DX Cross Linking Table)*
Procedure Level Checks:	
Patient Address - Invalid First Visit Date	**Date of First Visit** field in the Patient Name and Address Information screen *(Patient, Change Patient Data)*
Patient Address - Service Date is Before First Visit Date	Date of Service must be the same as or later than the **Date of First Visit** field in the Patient Name and Address Information screen *(Patient, Change Patient Data)*
Revenue Code xx must be 4 digits long - where xx is the Revenue Code and the claim type is '2'.	**Default Revenue Code** field in the *UB-04 Integration (System, Database Maintenance Menu, Claim Management)* **Revenue Code** field in *Maintain Procedure Codes (Tables, Maintain Procedure Codes)*Revenue Codes in the *Paper Claim Editor (System, Database Maintenance Menu, Claim Management)*
Diagnosis Code xx invalid where xx is the DX code	**Diagnosis Code** on the encounter claim-*Edit an Encounter (Transactions)*
Invalid Modifier, Modifier not 2 characters long.	**Modifier** field on the claim-*Edit an Encounter (Transactions)*

Claim Creation Checks:	
Claim not added to claim file. Contact customer service.	This is most commonly due to the Electronic Claims Integration not being set up for the carrier on the claim. Direct Connect clients: *Electronic Direct Connect Claims Integration (System, Database Maintenance Menu, Claim Management)* eMedix clients: Contact customer service.