

EMDEON OFFICE USER GUIDE - CLAIMS

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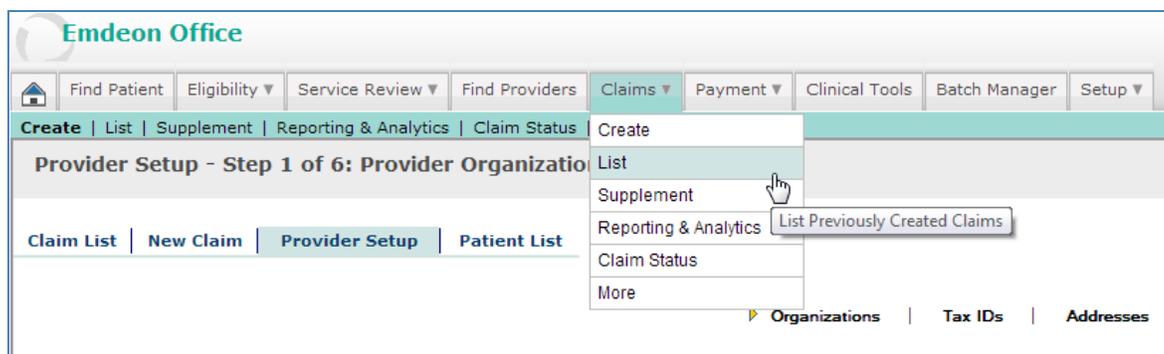
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INTRODUCTION

1 Introduction

1.1 Overview

The down arrow on the **Claims** tab indicates that there is a sub-menu below it. When the **Claims** tab is selected, the following options appear:



Note: Depending on how your account is setup, you may see *either* Claims>Create or Claims>Import in the Claims drop-down list, but not both.

1.2 Import

Import allows you to submit primary and secondary claims created in a Practice Management System (PMS) or similar application.

1.3 Create

Create allows you to enter claims in a form similar to the CMS 1500. See the **New Claim** section (page 33) for instructions. Before creating a claim for the first time, you must first complete **Provider Setup** (page 24).

1.4 List

List allows you to view, edit, and submit claims. You can sort the list of claims by clicking on any of the column headings. This list is displayed for Create users only, not users with Import.

INTRODUCTION

1.5 Supplement

Supplement allows you to add additional information to claims that were either imported or created online. The types of additional information supported include Ambulance details and Other Insurance Information.

Note: The Message Center of the Home Page displays a counter of claims that have been pending, awaiting supplement. This counter serves as a “short-cut” for accessing batches and claims that require attention.

1.6 Reporting & Analytics

Reporting & Analytics can be used to view summary and detailed status information on submitted claims. It provides users with a tool for tracking claim rejections.

Note: The Message Center of the Home Page displays a counter of un-worked claim rejections which serves as a short-cut for opening the reporting & analytics report listing all such claims.

1.6.1 Un-Worked Claim Rejections

You can access a claim rejections report from the home page. The “unworked claim rejections” link shows how many unworked claim rejections you currently have. Click the link to launch a default claim rejection report in Reporting & Analytics that includes all unworked claim rejections from the last seven days.

Home > Work Queue Search > Claim Summary

Claim Quick Search Help

Claim Received Date: 11/02/2010 Tax ID: 11/08/2010 Site ID: Optional Search Type: Rejected-Un-Worked

If no dates are entered, dates will default to last 7 days.

1 / 1 100%

Claim Summary

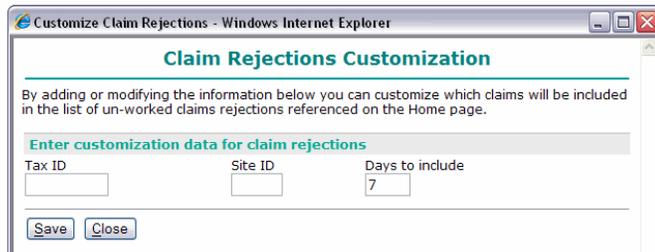
PR_1006

Search Criteria: Claim Date Range: 11/2/2010-11/8/2010 Payer ID: < Empty > Provider Tax ID: < Empty > Site ID: < Empty >
Claim Status: Rejected Worked Status: NOT_WORKED Emdeon File ID: < Empty >

Worked	Patient Name	Insured ID	Patient Control Number	Service From Date	Claim Amount	Payer ID	Payer Name	Emdeon Claim ID
Emdeon-Rejected								
	Site ID: IJKL	File ID: DK123OFFICE0001						
<input type="checkbox"/>	Greene, Julie	12345678AA24	PCN1234AA24	02/23/2010	\$2,559.00	PAY01		DK00000 OFFICE0001
<input type="checkbox"/>	Nimrod, Jeremiah	12345678AA25	PCN1234AA25	02/23/2010	\$2,240.35	PAY01		DK00000 OFFICE0001
Payer-Rejected								
	Site ID: IJKL	File ID: DK123OFFICE0001						
<input type="checkbox"/>	Banahan, Jonathon	12345678AA26	PCN1234AA26	02/23/2010	\$446.94	PAY01		DK00000 OFFICE0001
<input type="checkbox"/>	Banahamer, Patrick	12345678AA27	PCN1234AA27	02/23/2010	\$1,688.50	PAY01		DK00000 OFFICE0001

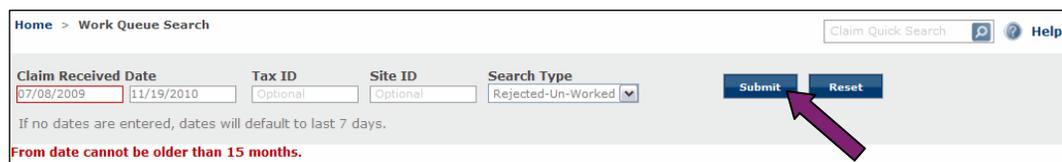
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To customize which claims will be included in the list of unworked claim rejections that appear on the report, click the pencil icon. Type a tax ID, site ID, or different number of days then click **Save**. For hints on entering values, click in each box and look at the bottom of the screen.



You will receive an error message under the following conditions:

- If the values you enter generate more than 1,000 unworked claim rejections.
- If you enter a number larger than 450 in the **Days to include** box.
- If you enter a site ID and enter a number larger than 60 in the **Days to include** box.



Modify the search criteria on the claim rejection report page and click **Submit** to relaunch the report. For help with Reporting & Analytics, please refer to the **Reporting & Analytics** section on page 88.

1.7 Claim Status

Claim Status allows you to monitor claims for status in the payer's adjudication system. For select payers, claim appeals and adjustments can be initiated from a claim status response.

1.8 More

More contains links to claims resources.

INTRODUCTION

The following table describes in detail each link on the **Claims > More** page.

Link	Description
Payer Enrollment	Takes you to the Payer Enrollment where you can access Claims Payer Enrollment forms.
Add Providers or Payers	Allows you to add providers or payers for claims submission. This feature is covered in detail in Add Providers or Payers (page 9).
Change or Remove Providers or Payers	Allows you to change or remove providers or payers you have already enrolled for claims submission. These features are covered in detail in Change or Remove Providers or Payers (page 14).
CMS NPI Enrollment	Takes you to CMS' National Plan and Provider Enumeration System, from which you can apply for a National Provider Identifier.
Complete Payer List	A complete list of available payers.
Claims Resource Center	Takes you to Claim Resource Center.
Claims User Guide	Opens the Claims User Guide.*

Note: These guides are in PDF format and require that you have the Adobe® Reader® installed on your computer. The Reader can be downloaded free of charge from www.adobe.com.

2 Send Claims

2.1 Benefits

- Submit claims to hundreds of commercial and government payers.
- Edit and submit secondary claims. Data from the primary claim is used to create the secondary claim resulting in improved efficiency and time savings.
- Upload print image and electronic claim files.
- Use your own Practice Management system to generate claim files. (Professional and Institutional claim files can be uploaded in 5010 format).

Your management system may save claims in a file as you enter them, or you may choose to save or “print” claims to a file. You’ll need to ask your Practice Management System (PMS) vendor for details on how to create the claim file and where you can find it on the PC.

2.2 Send Claims Requirements

Unlike real-time transactions, claim transactions sent through **Claim Entry** and **Send Claims** require additional setup.

Additionally, before submitting a claim file using the Send Claims service, your claim file format must be validated, otherwise, your claim file may be successfully transmitted but it will not be processed at the Claim Processing Center and you will not be notified.

If you have not validated your claim file format please create a ticket via ON24/7.

2.3 Add Providers or Payers

To add a provider for claim submission or add a payer for a provider who has already been enrolled for claim submission please follow the steps below. The enrollment team will complete the process and will notify you by email when the enrollment has been processed.

1. Select **Claims > More** from the main menu. The Claims Additional Resources window appears.
2. Click the “Add Providers or Payers” link. The Add Providers or Payers window appears.

Note: Because this page reflects information currently on file, many boxes will be pre-filled with information that will likely not need to be changed.

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Add Providers or Payers

*Required

Enter Provider Information

* Practice Name
The Office

* Provider Name

* NPI

* Tax ID Type
Tax ID

* Tax ID
123456788

Site ID

* Provider Specialty Code
--Select--

Phone
999 999 9999

Fax

* Email
@emdeon.com

A notification will be sent to this email address when your enrollment has been processed.
We will also store this email address for future communication.

Enter Payer Information

You **must** enter information for at least one payer. For each payer you add, you **must** enter a Payer ID and an Individual Provider ID.

Payer ID	Lookup	Group ID	Individual Provider ID	Payer ID	Lookup	Group ID	Individual Provider ID
*			123456788				123456788
			123456788				123456788
			123456788				123456788
			123456788				123456788
			123456788				123456788

3. In the **Enter Provider Information** section, enter the provider's identifying information. Required items are marked with a red asterisk (*).

Note: If you are adding a payer for a provider who is already enrolled, duplicate the identifying information for the provider supplied during the initial enrollment process.

Please note the following about this section:

- ✓ **Tax ID** - Select a tax ID from the list or type a new tax ID in the box. This list is made up of all the tax IDs your account is currently configured to send claims for.
- ✓ **Email** - Select an email address from the list or type a new email address in the box. We will also store this email address for future communications about your account or enrollment for additional services.

4. In the **Enter Payer Information** section, you *must* enter at least one payer. Please note the following about this section:
 - ✓ **Payer ID** - If you do not know the payer ID, click the "Lookup" link to search for the payer ID.
 - ✓ **Individual Provider ID** - Select a provider ID from the list or type a new provider ID in the box. The list includes IDs of all the providers for whom your account can send claims.
5. Click **Submit**.
6. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click on "Add or Change Another Provider" or "Return To Home Page."

2.4 Change or Remove Providers or Payers

To change or remove provider or payer information for a provider you have already enrolled or to remove a provider or payer please follow the steps in the section below. The

SEND CLAIMS

enrollment team will complete the process and will notify you by email when the enrollment has been processed.

Note: You can do any or all of the procedures listed below on the Change or Remove Providers or Payer page.

2.4.1 Change Information for Providers or Payers

1. Select **Claims** > **More** from the main menu. The Claims Additional Resources window appears.
2. Click the “Change or Remove Providers or Payers” link. The Change or Remove Providers window appears.

Note: Because this page reflects information currently on file, many boxes will be pre-filled with information that will likely not need to be changed.

Change or Remove Providers or Payers

*Required

Enter Provider Information

* Practice Name: The Office

* Provider Name:

* Email: em@emdeon.com

* Tax ID Type: Tax ID

* Tax ID: 123456788

A notification will be sent to this email address when your enrollment has been processed. We will also store this email address for future communication.

Enter Provider or Payer Changes

You **must** change or remove information for at least one provider or payer.

Provider

Change	Remove	Field	New or Removed Information
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	

Payer

Change	Remove	Payer ID	Lookup	Field	New or Removed Information
<input checked="" type="radio"/>	<input type="radio"/>			--Select--	
<input checked="" type="radio"/>	<input type="radio"/>			--Select--	
<input checked="" type="radio"/>	<input type="radio"/>			--Select--	
<input checked="" type="radio"/>	<input type="radio"/>			--Select--	
<input checked="" type="radio"/>	<input type="radio"/>			--Select--	

Submit Reset Return To Previous

3. In the **Enter Provider Information** section, enter the provider's identifying information. Required items are marked with a red asterisk (*).

Please note the following about this section:

- ✓ **Tax ID** - Select a tax ID from the list or type a new tax ID in the box. This list is made up of all the tax IDs your account is currently configured to send claims for.
- ✓ **Email** - Select an email address from the list or type a new email address in the box. We will also store this email address for future communications about your account or enrollment for additional services.

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4. In the **Enter Provider or Payer Changes** section, you *must* make changes to one provider or payer. You can make changes to both provider and payer information on this page.
 5. If you want to change *provider* information, do the following:
 - ✓ In the first row of the Provider section under Enter Provider or Payer Changes, ensure that Change is selected (it is selected by default).
 - ✓ Select an item from the Field list.
 - ✓ Type the new information in the New or Removed Information box that appears.
 6. Complete additional rows as needed. If you want to change *payer* information, do the following:
 - ✓ In the first row of the Payer section under Enter Provider or Payer Changes, ensure that Change is selected (it is selected by default).
 - ✓ In the Payer ID box, type the payer ID of the payer whose information you want to change.
- Note:** If you do not know the payer ID, click the "Lookup" link to search for the payer ID.
- ✓ Select an item from the **Field** list.
 - ✓ Type the new information in the **New or Removed Information** box that appears.
 - ✓ Complete additional rows as needed.
7. Click **Submit**.
 8. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add**, or **Change Another Provider** or **Return to Home Page**.

2.4.2 Remove Information for Providers or Payers

The following steps allow you to remove pieces of information for providers or payers. If you want to remove an entire practice/facility, provider, or payer, refer to **Remove Providers or Payers** on page 18.

1. Select **Claims** > **More** from the main menu. The Claims Additional Resources page opens.
2. Click the "Change or Remove Claims Providers" link. The Change or Remove Providers window opens.

Note: Because this page reflects information currently on file, many boxes will be pre-filled with information that will likely not need to be changed.

SEND CLAIMS

Change or Remove Providers or Payers

*Required

Enter Provider Information

* Practice Name: The Office
* Provider Name: [Text Box]
* Email: [Email Address] @emdeon.com
* Tax ID Type: Tax ID
* Tax ID: 123456788

A notification will be sent to this email address when your enrollment has been processed. We will also store this email address for future communication.

Enter Provider or Payer Changes

You **must** change or remove information for at least one provider or payer.

Provider

Change	Remove	Field	New or Removed Information
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	--Select--	

Payer

Change	Remove	Payer ID	Lookup	Field	New or Removed Information
<input checked="" type="radio"/>	<input type="radio"/>	[Text Box]		--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	[Text Box]		--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	[Text Box]		--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	[Text Box]		--Select--	
<input checked="" type="radio"/>	<input type="radio"/>	[Text Box]		--Select--	

Submit Reset Return To Previous

3. In the **Enter Provider Information** section, enter the provider's identifying information. Required items are marked with a red asterisk (*).

Please note the following about this section:

- ✓ **Tax ID** - Select a tax ID from the list or type a new tax ID in the box. This list is made up of all the tax IDs your account is currently configured to send claims for.
- ✓ **Email** - Select an email address from the list or type a new email address in the box. We will also store this email address for future communications about your account or enrollment for additional services.

4. In the **Enter Provider or Payer Changes** section, you *must* make changes to at least one provider or payer. You can remove information for both providers and payers on this page.
5. If you want to remove **provider** information, do the following:
 - ✓ In the first row of the Provider section under Enter Provider or Payer Changes, click **Remove**.
 - ✓ Select an item from the **Field** list.
 - ✓ Type the information you want to remove in the **New or Removed Information** box that appears.
 - ✓ Complete additional rows as needed.
6. If you want to remove **payer** information, do the following:
 - ✓ In the first row of the Payer section under Enter Provider or Payer Changes, click **Remove**.
 - ✓ In the Payer ID box, type the payer ID of the payer whose information you want to change.

Note: If you do not know the payer ID, click the "Lookup" link to search for the payer ID.

- ✓ Select an item from the **Field** list.

SEND CLAIMS

- ✓ Type the information you want to remove in the **New or Removed Information** box that appears.
 - ✓ Complete additional rows as needed.
7. Click **Submit**.
 8. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add** or **Change Another Provider** or **Return to Home Page**.

2.4.3 Remove Providers or Payers

Removing a practice/facility, provider, or payer means that you will no longer be able to submit claims using that entity.

To remove a practice/facility, provider, or payer, follow steps 1-3 of the previous section, and then continue as follows:

2.4.4 Remove a Practice/Facility

1. In the first row of the Provider section under Enter Provider or Payer Changes, click **Remove**.
2. Select "Practice/Facility Name" from the Field list.
3. Type the practice/facility name in the New or Removed Information box that appears.
4. Complete additional rows as needed.
5. Click **Submit**.
6. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add** or **Change Another Provider** or **Return to Home Page**.

2.4.5 Remove a Provider

1. In the first row of the Provider section under Enter Provider or Payer Changes, click **Remove**.
2. Select "Provider Name" from the Field list.
3. Type the provider name in the New or Removed Information box that appears.
4. Complete additional rows as needed.
5. Click **Submit**.
6. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add** or **Change Another Provider** or **Return to Home Page**.

SEND CLAIMS

2.4.6 Remove a Payer

1. In the first row of the **Payer** section under **Enter Provider or Payer Changes**, click **Remove**.
2. Select "Payer ID" from the **Field** list.
3. Type the payer ID in the **Payer ID** box.

Note: If you do not know the payer ID, click the "Lookup" link to search for the payer ID.

4. Type the payer ID in the **New or Removed Information** box that appears.
5. Complete additional rows as needed.
6. Click **Submit**.
7. On the page that appears, you will see "Your request has been successfully submitted for enrollment." Click **Add or Change Another Provider** or **Return to Home Page**.

2.5 Submit a Claim File for Processing

Follow these steps to upload and submit a claim file:

1. Create a claim file using your Practice Management System.
2. Select **Claims > Import** from the main menu. The Import Claims main window opens. Read the explanatory text if you are not familiar with claim file formats.
3. Click **Proceed to Next Step**. The Send Claim File form opens in a separate window.

SEND CLAIMS

Send Claim File [Help](#)

You must be registered to perform the Import Claims service. In addition, before submitting a claim file using the Import Claims service you must verify that your claim file format is valid. If you have not validated your claim file format with a technician then please contact 1-877-469-3263 for additional information. If you do not validate your claims file format then your claim file may be successfully transmitted BUT it will not be processed at the Emdeon Claim Processing Center and you will not be notified.

Hold submission for entry of additional data.

Locate claim file

Click the "Browse..." button below and you will be prompted to locate the claim file you wish to upload.

Last file uploaded: C:\Documents and Settings\jeweeks\Desktop\wrzi12345678902222.sup

Select how you wish the claim file to be processed

Normal - Upload and submit claim file to the Emdeon Business Services Claim Center for processing

Test your internet connection - Claim file will not be processed

Choose an action

You are now ready to upload your claim file. The time this takes will vary depending on the size of the claim file and the speed of your internet connection. **This window must remain open until this process is complete. Closing the window will terminate the process.**

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[Help](#) | [Glossary](#) | [Contact Customer Support](#) | [License and Business Associate Agreement](#)

Emdeon Business Services subscribes to the HONcode principles of the [Health On the Net Foundation](#)

Note: You must be registered to use the Import Claims service. In addition, before submitting a claim file using the Import Claims service you must verify that your claim file format is valid. If you have not validated your claim file format with a help desk representative, please contact customer support for additional information.

4. The "Hold submission for entry of additional data" check box should only be checked if you are planning to enter prior payment information to generate secondary claims **or** if you are adding other insurance information or ambulance data. Otherwise, leave the checkbox unchecked.

Note: For information on secondary claims, refer to **Supplement Claims** on page 47.

5. Click **Browse** to locate the claim file. Select the claim file you want to send for processing and click **Open**. The file name populates the field.
6. Select the mode in which to send the file.
7. **Normal** - Your file is encrypted, transmitted, authenticated, validated, and delivered for processing.
8. **Test your internet connection** - This option allows you to test your internet connection before actually sending the file for processing. The claim file is neither transmitted, nor presented for processing at any time.
9. Click **Submit Claim for Processing**. Once the file is submitted, a message appears indicating whether the transmission succeeded or failed.

Note: Leave the Send Claims window open during file transmission. Closing the window indicates that you want to terminate the connection and abort the transmission. You

SEND CLAIMS

can minimize the *window*, but it must not be closed or the process will end immediately.

10. When the claim file is received and processed, a claim status report is sent to your secure inbox within the application.
11. Click **Cancel** to close the Send Claim File window after your claim file is successfully transmitted.
12. Check your secure inbox within the application for messages about the status of your claims.

2.6 Send Claims Tips

The following information will help you resolve and prevent issues with claim files.

- If your claim file cannot be processed, Send Claims generates a transmission failure message and posts it in the Send Claim File window. Help identify the source of the problem by making a note of the error message before closing the message window.
- Do not close the Send Claim File window during processing. The Send Claim File window must remain open throughout your session, or your claims will not be processed. You may minimize the window, but it must not be closed, or your session will terminate and your claim submission process will end. Since transmission failure messages appear in your Send Claim File window, which is not visible once your session terminates, you will not notice your transmission has failed until much later.

2.7 Verify Claims Transmission

Once your claims are processed, a claim status report is sent to your secure inbox within the application confirming the status of the claims. Follow these steps to view this report:

1. Click the “mail messages” link on the home page.
2. To view the message, double-click the message or single click the message and then click the **Open** icon.

The following is an example of a Claim Confirmation Report:

SEND CLAIMS

EMDEON CLAIM CONFIRMATION REPORT							
REPORT GENERATION DATE: 09/18/06							
FRASIER CRANE MD							
TSO ID: #123							
CLAIMS PROCESSED ON 09/18/06 (8:00 AM CST)							
TOTAL CLAIMS PROCESSED: 5							
INPUT TYPE: HCFA							
TRANSMISSION TYPE: PRODUCTION							
BATCH ID: wk17091806075607375							
FILE CONTROL #: HCBJKU							

CLAIM SUMMARY - TAX ID: 123456789							

DOS	STATUS	PAYORID	PATIENT NAME	ACCOUNT#	\$ CHARGES	INSURANCE COMPANY	PAYOR ZIP

09/16/06	VAL	60054	DOE, J	20215	150.00	AETNA US HEALTHCARE	19244
09/16/06	VAL	60054	SMITH, B	11058	135.00	AETNA US HEALTHCARE	19244
09/16/06	VAL	60054	ALLEN, R	28602	135.00	AETNA US HEALTHCARE	19244
09/16/06	VAL	60054	WALDEN, C	10657	90.00	AETNA US HEALTHCARE	19244
09/16/06	VAL	22099	WILLIAMS, K	13045	110.00	BLUE CROSS	07101

VALID CLAIMS	:		VALID CLAIMS AMOUNT	:	\$ 620.00		
REJECTED CLAIMS	:	0	REJECTED CLAIMS AMOUNT	:	\$.00		

TOTAL CLAIMS PROCESSED ALL TAXIDS							

** TOTAL CLAIMS PROCESSED	:	5	AMOUNTING TO	:	\$ 620.00	**	
** TOTAL VALID CLAIMS	:	5	AMOUNTING TO	:	\$ 620.00		
** TOTAL REJECTED CLAIMS	:	0	AMOUNTING TO	:	\$.00		

Paper Claim Report							

3 Claim Entry

3.1 Benefits

- You can manually create Professional and Institutional claims and submit to hundreds of government and commercial payers.
- Data from patient database is integrated into the claim.
- Claims sent to payers that do not accept electronic claims are converted to paper claims and mailed to the payer.
- Allows editing and resubmitting claims.
- Claim Entry allows you to work with payers that do not accept electronic claims. Once these payers are set up, claims are automatically converted to paper and sent by mail.

3.2 System Automatically Checks if Provider and Submitter Orgs are Setup

Whenever you load the Claims setup page the system checks to confirm that provider organizations are completely setup. If they are not, you will be prompted to review and correct provider data. Whether or not the system determines that all needed provider data is available can be influenced by whether you are using the “My Favorites” or “Group Favorites” mode.

- If you are currently in Group Favorites mode



- ✓ If your group has not completed all organization setups an error message displays with instructions to complete Provider Setup.
 - ✓ If you have not completed organization setup *but the group has*, the **system will automatically** change your view to “Group Favorites” mode. The Claim Setup page will then be displayed.
- If you are currently in My Favorites mode
 - ✓ If you have completed setups, the Claim Setup page is displayed.
 - ✓ If you do not have completed setups *but the group does*, change the view to “Group Favorites” mode. The Claim Setup page is displayed.

Note: Whichever setting is selected for My Favorites or Group Favorites at the end of your session will be the setting to which your view will be set when you next login. That is, the setting selected remains resident for your account so that the application launches with that setting active for your next session.

CLAIM ENTRY

- ✓ If neither you nor the group has not completed setups, an error message displays with instructions to access Provider Setup

3.3 Provider Setup

Provider Setup must be complete before claims can be created. This feature allows you to store provider- and payer-specific information, which is used to generate new claims.

My Favorites/Group Favorites. You can toggle the view between “My Favorites” and “Group Favorites” by clicking one of the links located in the upper right of the screen. The Provider information that you entered appears as “My Favorites” while those created by your colleagues are listed in the “Group Favorites.” However, as “My Favorites” is a subset of the Group itself, if you want to display all Provider information that is maintained by your group, click “Group Favorites.”

If “Group Favorites” is Selected

- All provider and submitter organizations that belong to the group are displayed along with owner.

If “My Favorites” is Selected

- All the provider organizations that you created are displayed.
- If you haven’t setup any organizations the provider organization list is empty, even if organizations exist for other users in the group.
- However, if anyone in the group has created a Submitting Organization, it is displayed no matter who created it (in the Submitting Organization area).

The screenshot displays the 'Provider Setup - Organizations' page. At the top, there is a navigation bar with various menu items. Below this, a secondary navigation bar contains tabs for 'Claim List', 'New Claim', 'Provider Setup' (which is active), and 'Patient List'. The main heading is 'Provider Setup - Organizations', with a sub-menu for '[My Favorites | Group Favorites]'. A blue arrow points to the 'Group Favorites' link. Below the heading, there is a table with the following structure:

Provider Organization Name	Type	Action
Ap[...]	Corporation	-- Select --
ci[...]	Solo Practice	-- Select --

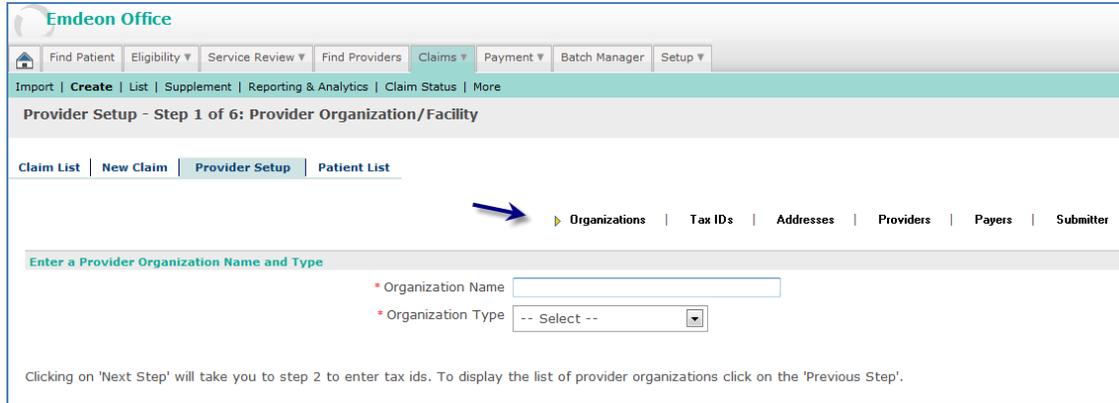
Below the table is an 'Add New Org' button. Underneath, the 'Submitter Information' section is visible, with a note: 'Current submitter information is as below. To change the submitter information click on "Edit Submitter Info".' The 'Current Submitter Information' section contains the following fields:

- Submitting Organization: Ap[...]
- Contact Name: D[...]
- Address: 12[...]
- Telephone: 6[...]

At the bottom of the submitter information section is an 'Edit Submitter Info' button.

CLAIM ENTRY

Once the provider data is stored, and you have begun the claim creation process by clicking Claims>Create, some fields in the new claim will be automatically populated. How these fields are populated depends on the provider you entered on the Claim Setup screen.



There are six steps involved in setting up a provider organization. These steps must be performed in sequence the first time you set up an organization:

Step	Provider Data	Description
1	Provider Organization/Facility	The onscreen instructions will help you complete all the required fields in this section.
2	Tax IDs	Enter at least one Tax ID for the organization.
3	Addresses	In the first field, Location Name/Description , enter either the name of the organization or the practice. If you have multiple office locations, enter the location names. Click Save Address and the next screen will allow setup of multiple addresses. If there are multiple locations, check the appropriate box to indicate where each address is, where services are performed, and if this is the address where payments are to be sent.
4	Providers	You must enter the NPI of the provider. (Required.) You can also enter either the healthcare provider's Universal Provider Identification Number (UPIN) or state license number. (Optional.) When entering multiple providers, click Save and Add New Provider . You must click Save or your information will be lost.
5	Payers	These are the insurance companies, government plans, and Health Maintenance Organizations to who claims are submitted. Use the drop-down list to individually select the payers you want to add. You can personalize your payer list by selecting the "Edit Payer List" link located next to the payer drop-down list. If your account is set up with only one payer, you will not see this link. If you leave the Payer-Assigned Provider Number field blank and click Save , the system will automatically populate the field with the provider's (rather than a payer assigned ID) "NPI".
6	Submitter	This is the person or company responsible for submitting claims for a provider. Most of this information is pre-populated.

Note: All required fields are marked with a red asterisk (*). All required fields must be completed in order to advance to the next screen.

CLAIM ENTRY

3.3.1 National Provider Identifier (NPI) and Tax ID Qualifier

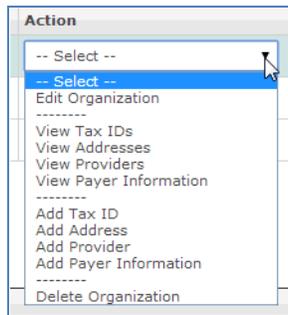
The application allows you to populate fields on a new claim by selecting provider data saved in Provider Setup.

When setting up a new provider (or editing an existing one), NPI and Tax ID Qualifier data must be saved so that the data can be automatically populated into new claims. Claims must include this information so that they can be processed.

Set Up NPI for Claim Entry

Note: For existing providers already set up for Claim Entry, skip to Step 4.

1. Select **Claims** > **Create**, and then click the "Provider Setup" link.
2. Select "Edit Organization" from the **Action** drop-down menu.

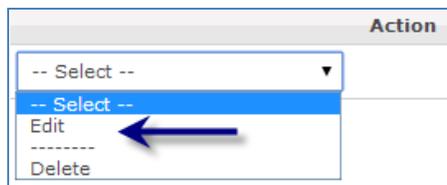


3. Select the "Providers" link.



Note: Please be sure that Provider NPI is entered through Provider Setup. Although Provider NPI is not a required field under the "Providers" link as shown above if the Provider NPI is not entered through Provider Setup the claims will be *rejected*.

4. Select "Edit" from the **Action** drop-down menu.



5. The Provider Information screen displays.

CLAIM ENTRY

Enter Provider Information

First Name

Middle Initial

* Organization/Last Name

Provider Degree/Credentials

NPI

UPIN

License # License Type

SSN

* Specialty

6. Enter the provider's ten-digit NPI number, and select **Save Provider** after NPI information is entered.

Set Up Tax ID Qualifier for Claim Entry

Note: For existing providers already set up for Claim Entry, skip to Step 4 below.

1. Select **Claims** > **Create**, then click the "Provider Setup" link.
2. Select "Edit Organization" from the **Action** drop-down menu.

Action

-- Select --

-- Select --

Edit Organization

View Tax IDs

View Addresses

View Providers

View Payer Information

Add Tax ID

Add Address

Add Provider

Add Payer Information

Delete Organization

3. Select the "Payers" link.

[Organizations](#) | [Tax IDs](#) | [Addresses](#) | [Providers](#) | [Payers](#) | [Submitter](#)

Note: **Performing Provider Tax ID Type** is not a required field under the "Payers" link, but if it is not present the claims will be rejected.

4. Select "Edit" from the **Action** drop-down menu.

CLAIM ENTRY



5. The Payer Information screen displays.

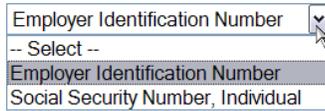
The image shows a form titled "Enter Payer Information". The form contains the following fields and options:

- Provider: Barber, Larry
- Payer: Aetna (with a link to "Edit Payer List")
- Service Address: MedClinic South
- Payer-Assigned Provider Number: 55555555 (Optional if NPI is valued in Provider)
- Provider Specialty: Emergency Medicine(093)
- Tax ID: 656565656(Federal Tax ID Number) or Use the Provider's SSN
- Performing Provider TaxID Type: Employer Identification Number (Change only if Billing and Performing Provider Tax ID TYPES are not the same.)
- Performing Provider Number: 55555555 (Optional for entity)
- Sub-Identification Number: 9999
- Submitter Code: [Empty]
- HMO/PPO Code: [Empty]
- Group NPI: [Empty]

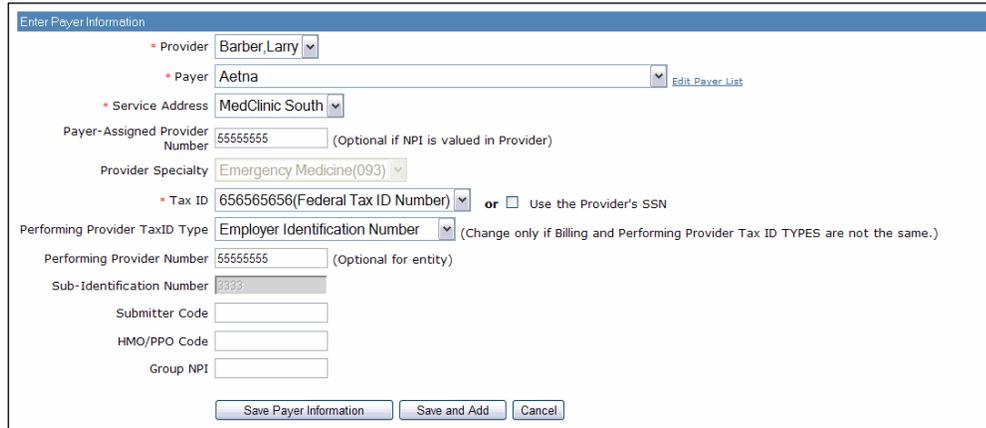
Buttons at the bottom: Save Payer Information, Save and Add, Cancel.

CLAIM ENTRY

6. Select "Employer Identification Number" or "Social Security Number" as the Performing Provider Tax ID Type from the drop-down menu.



Employer Identification Number
-- Select --
Employer Identification Number
Social Security Number, Individual



Enter Payer Information

* Provider: Barber, Larry
* Payer: Aetna
* Service Address: MedClinic South
Payer-Assigned Provider Number: 55555555 (Optional if NPI is valued in Provider)
Provider Specialty: Emergency Medicine(093)
* Tax ID: 656565656(Federal Tax ID Number) or Use the Provider's SSN
Performing Provider TaxID Type: Employer Identification Number (Change only if Billing and Performing Provider Tax ID TYPES are not the same.)
Performing Provider Number: 55555555 (Optional for entity)
Sub-Identification Number: 9999
Submitter Code:
HMO/PPO Code:
Group NPI:
Buttons: Save Payer Information, Save and Add, Cancel

7. Select **Save Payer Information** to save and exit or **Save and Add** to add the Tax ID Qualifier for other payers.

3.4 New Claim

New Claim allows you to enter claim information directly into a CMS 1500 format claim.

Note: Before using New Claim for the first time, you must complete the **Provider Setup** section on page 24.

Follow these steps to enter a new claim:

1. Select **Claims > Create**, and click the "New Claim" link.

Note: You can change the contents of the drop-down lists by selecting either "My Favorites" or "Group Favorites." Depending on how you've set up each collection of settings, the contents for each drop-down may be different for "My Favorites" and "Group Favorites."



Create | List | Supplement | Reporting & Analytics | Claim Status | More [Customize]

New Claim [My Favorites | Group Favorites]

Claim List | New Claim | Provider Setup | Patient List

1 Unsubmitted claim

Step 1 - Select organization
--Please select the organization name--

Step 2 - Select pay to address and provider
--Please select pay to address--
--Please select a provider--

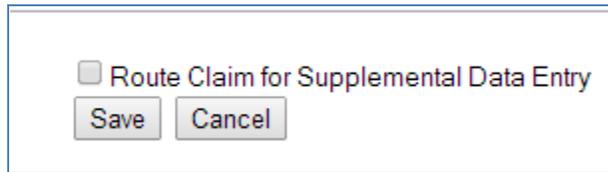
Step 3 - Select payer name
--Please select payer--

CLAIM ENTRY

2. In Step 1, select the organization for which you wish to submit the claim.
3. In Step 2, select the pay to address and the provider name for the claim.
4. In Step 3, select the payer name from the drop-down menu. Step 4 appears.
5. Select a service address by clicking the option button next to it.
6. Click **Continue to Claim Data**. The claim data entry form appears.
7. Clicking **Select Patient** at the top of the screen opens a list of patients associated with the selected payer. If you select one of the patients from the list, the patient's demographic and payer data will populate the claim entry form. This step is optional.
8. Enter the Diagnosis Code(s) and Procedure information. Additional required fields are highlighted in pink and preceded by a red asterisk (*).

Note: To progress through the required fields, use these shortcuts: Forward: CTRL + >
> Backward: CTRL + <

9. Complete the rest of the claim.
10. To use the Supplement Claims feature, place a check in the "Route Claim for Supplemental Data Entry" check box.



The image shows a rectangular dialog box with a blue border. Inside the box, there is a checkbox on the left, which is currently unchecked. To the right of the checkbox is the text "Route Claim for Supplemental Data Entry". Below the checkbox and text are two buttons: "Save" on the left and "Cancel" on the right. Both buttons have a light gray background and a thin border.

11. To print a paper copy of the claim, press CTRL + P on your keyboard.
12. When you finish the form, select **Save** at the end of the page to save your work. A Save Confirmation screen appears with instructions for creating a new claim, adding the claim to a batch for submission, and submitting claims.
 - ✓ To submit another claim using the same provider and payer, click **New Claim** located in the upper right corner of the screen.
 - ✓ To submit a claim for a different provider or payer, click **Close** to return to the New Claim screen.
 - ✓ To create a claim batch, click **Close** and select "Claim List."

CLAIM ENTRY

3.5 Service Lines

Step 5 - Claim Line Information														
Delete	*Start Date	*End Date	*Performing Provider #	Spec	*Place Code	Type Code	*Proc	Mods	*ICD Pointers	*Unit Type	*Unit Qty	*Charges	EPSDT	Comment...
X			:iname, v 301		11					Units v		\$0.0	--Select--	Comment...
X			:iname, v 301		11					Units v		\$0.0	--Select--	Comment...
X			:iname, v 301		11					Units v		\$0.0	--Select--	Comment...
X			:iname, v 301		11					Units v		\$0.0	--Select--	Comment...
											Total	\$0.0		
											Amount Paid by Patient	\$0.0		

Note: All currency (Charges) fields allow up to 7 digits per field (e.g., \$9,999,999.99). All Total Claim Charge fields and Claim Level Adjustment fields allow up to 12 digits.

Click **Comment...** to display the "Additional Claim Line Information" window.

Additional Claim Line Information

Provider Information

Referring Provider NPI

Ordering Provider NPI Ordering Provider UPIN

Ordering Provider Last Name Ordering Provider First Name Ordering Provider Middle Initial

Supervising Provider NPI Supervising Provider UPIN Supervising Provider ID

Supervising Provider Last Name Supervising Provider First Name Supervising Provider Middle Initial

Purchase Service Provider NPI Purchased Service Provider # Purchased Service Name

CLIA ID # Mammography Cert Number

Service Information

Purchased Service Purchased Service Charge

National Drug Code NDC Quantity NDC Units of Measure

Prescription Number NDC Link Sequence #

Hemoglobin/Hematocrit Date Hemoglobin g/dl Hematocrit %

Narrative Information

Comment(Maximum allowed characters is 281)

3.5.1 Enter Attachment Information

There are many circumstances when a provider must convey to a payer that a claim includes attachment information. To convey this information to the payer please do the following:

1. Proceed to the "Attachment Information" field.

CLAIM ENTRY

Step 9 - Other Information

Date First Consulted <input type="text"/>	Initial Treatment Date <input type="text"/>	Date Last Seen <input type="text"/>	X-Ray Date <input type="text"/>
Assumed Care Date <input type="text"/>	Relinquished Care Date <input type="text"/>	Hospital Service Dates <input type="text"/> To <input type="text"/>	
Referring Provider NPI <input type="text"/>	Referring Provider # <input type="text"/>	Referring Provider TaxID Type -- Select --	
Referring Physician Last Name <input type="text"/>	First Name <input type="text"/>	M.I. <input type="text"/>	
Referring Provider State --Select--	Referral Number <input type="text"/>	Workers Condition Code -- Select --	
Delay Reason Code <input type="text"/>	Demonstration Project Identifier <input type="text"/>	Service Authorization Exception Code <input type="text"/>	
Resubmission Code <input type="text"/>	Resubmission Reference Number <input type="text"/>	Attachment Information <input type="text"/>	
Remarks <input type="text"/>			

Route Claim for Supplemental Data Entry

2. Enter applicable indicators and codes (see below).
 - ✓ a 1-Digit Documentation Indicator
 - ✓ a 1-Letter Documentation Type Code
 - ✓ a 3 to 30-Character Attachment Control Number

Referring Provider # <input type="text"/>	Referring Provider TaxID Type -- Select --
First Name <input type="text"/>	M.I. <input type="text"/>
Referral Number <input type="text"/>	Workers Condition Code -- Select --
Demonstration Project Identifier <input type="text"/>	Service Authorization Exception Code <input type="text"/>
Resubmission Reference Number <input type="text"/>	Attachment Information 1A2335678

Route Claim for Supplemental Data Entry

Note: When entering your codes and indicators do not separate the values. That is, the string must contain no spaces, symbols, commas, etc. Please see details on these codes and indicators below.

Single Digit Documentation Indicator

Code	Meaning
1	By Mail
2	FAX
3	Available on Request at Provider Site

CLAIM ENTRY

Single Letter Documentation Type Code

Code	Meaning
A	DME prescription
B	Explanation of benefits (Coordination of Benefits
C	Diagnostic report
D	Operative note
E	PEN certification
F	Ambulance certification
G	Physical therapy certification
H	Chiropractic justification
I	Prosthetics or Orthotic Certification
J	Oxygen prescription
Y	Multiple documentation items
Z	Other

3 to 30 Character Attachment Control Number

This string, usually assigned by the provider, will be recorded on the attachment. It provides a cross-reference between the attachment and the claim.

3.6 Claim List

Claim List allows you to view, edit, submit, and manage claims. Before using Claim List for the first time, you must have completed and saved one or more claims. Any claim can be edited and saved as a new claim, which helps to avoid re-keying the same information for multiple claims per patient or multiple patients with similar services.

This service provides search criteria to assist in selecting groups of claims for submission. Click **Clear** to reset all fields to their original settings.

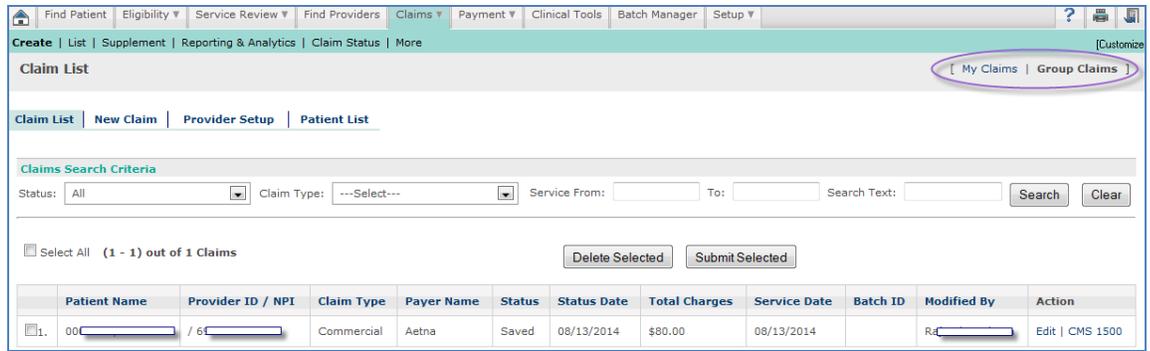
Click "Customize Page" to specify what information you want to appear on the Claim List. You can sort the list of claims by clicking on any of the column headings.

3.6.1 Use Claim List

Follow these steps to work with claims:

1. Select **Claims > Create**, and click the "Claim List" link. If any claims have been created and saved they will appear listed on the screen as shown below:

CLAIM ENTRY



To search for a claim, use the **Claims Search Criteria** fields located at the top of the screen.

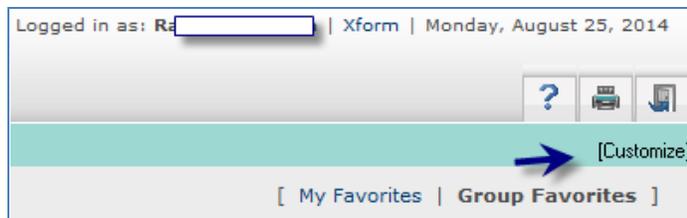
Note: Any claim that you create or edit/modify is set by the system as **My Claim**. Any claim created by someone in your organization is a **Group Claim**. You can change which claims are displayed in the Claim List by clicking either of the links located in the upper right of the screen.

When viewing the Claim List in **Group Claim** mode the name of the user who most recently made a change to a specific record is displayed in the "Modified By" column for that row.

- ✓ Click **Search** to perform a search.
 - ✓ Click **Clear** to reset all search fields to their original settings.
 - ✓ The **Search Text** box can be used to search on data contained in a claim, like "Patient Name" and "Provider ID."
 - ✓ Click **Clear** and then click **Search** to show the full claim list.
2. Check the box to the left of the claim you wish to submit or delete, or click **Edit** next to the claim you wish to edit. When you select the action you wish to take, the claim will appear in a separate window.
 3. To the right of the claim, click "CMS 1500" to view the CMS 1500 format of this claim.

3.6.2 Customize Claim List

You can make several changes to the way that the Claim List is displayed. Click the "Customize" link located in the upper right to launch the "Customizations and Settings" window.



CLAIM ENTRY

The screenshot shows a window titled "Customizations and Settings" with a tabbed interface. The "Claim List" tab is active. Under the heading "Select columns", there is a list of columns with checkboxes. The first item is "[x] Patient Name (a mandatory column)". Below it are: Provider ID, Claim Type, Payer Name, Status, Status Date, Total Charge, Service Date, and Batch ID, all with checked boxes. At the bottom of the list, there is a label "Select # of claims per page:" followed by a dropdown menu showing "20". At the very bottom of the window are two buttons: "Save" and "Close".

You can set a column to not display in the Claim List by removing its check from the Claim List tab in Customizations and Settings. You can also select the number of claims to be displayed per page (20, 100, 500, 2000). If you make any changes be sure to click **Save** to close the window.

3.7 Patient List

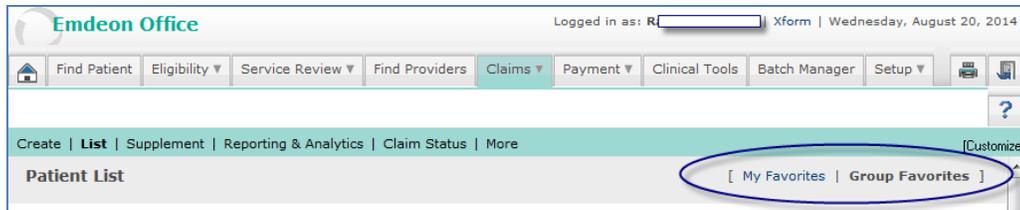
Patient List is used to store, manage, and retrieve patient demographic information. When creating a claim for a patient whose data is already stored in the database, the stored data automatically populates fields on the claim.

Before using Patient List for the first time, you must first complete the **Provider Setup** section on page 16. This is because for each patient record, you will be asked to select a payer, and this information is stored in Provider Setup.

Click "Customize" to specify what information you want to appear on the Patient List. Click **Clear** to clear the Search field.

My Favorites/Group Favorites. You can toggle the list between "My Favorites" and "Group Favorites" by clicking one of the links located in the upper right of the screen. Those patients that you created appear as "My Favorites" while those patients created by your colleagues are listed in the "Group Favorites." However, as "My Favorites" is a subset of the Group itself, if you want to display all patients maintained by your group, click "Group Favorites."

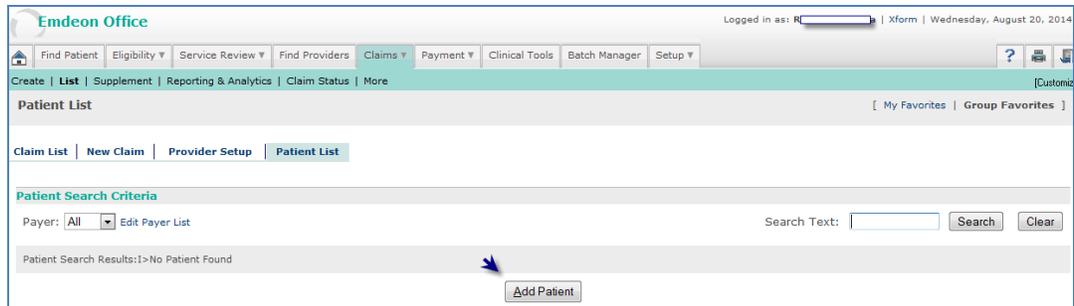
CLAIM ENTRY



3.7.1 Add a Patient

Follow these steps to add a patient record:

1. Select **Claims** > **Create** on the main menu, and then select **Patient List**. The Patient List screen appears. If there are any saved patient records, they will appear listed on the screen as shown on the illustration.



2. Select a payer from the Payer drop-down list and click **Add Patient**. The Add Patient screen appears.
3. Required fields are preceded by a red asterisk. Notice there are two tabs: Patient Details and Insurance Details. If the patient and the insured are not the same, then both sections must be completed before saving the patient record.

CLAIM ENTRY

Find Patient | Eligibility | Service Review | Find Providers | Claims | Payment | Clinical Tools | Batch Manager | Setup

Create | **List** | Supplement | Reporting & Analytics | Claim Status | More

Add Patient

* Patient Account #

Patient Details | **Insured Details**

Enter patient data * indicates required field

* Last Name * First Name Middle Initial

* Date of Birth * Gender

* Address Address2

* City * State * Zip Phone

* Member ID * Relationship To Insured

Employment Status Student Status

4. Enter the patient data and when you are finished, click **Save** to save the record. A Patient Entry Status message appears confirming the record has been saved.
5. Click **Save** to save the record and return to the Patient List (or click **Cancel** to return to the list without saving the record).
6. To return to the patient record and make changes to it or to print the record, click **Previous Screen**. Once you enter a patient record, you can print a hard copy of it by pressing CTRL + P on your keyboard.

3.7.2 Search for a Patient Record

Follow these steps to search for a patient record:

1. Use the field next to the **Search** button to enter your search criteria. You can search for a patient by using any character string found on the record, such as First and Last name, Address, City, and State.

CLAIM ENTRY

The screenshot shows the Emdeon Office web application interface. At the top, it says "Emdeon Office" and "Logged in as: R[redacted] Xform | Wednesday, August 20, 2014". Below this is a navigation menu with options: Find Patient, Eligibility, Service Review, Find Providers, Claims, Payment, Clinical Tools, Batch Manager, and Setup. A secondary menu includes Create, List, Supplement, Reporting & Analytics, Claim Status, and More. The main content area is titled "Patient List" and includes sub-links for Claim List, New Claim, Provider Setup, and Patient List. Below this is a "Patient Search Criteria" section with a "Payer" dropdown menu set to "All", an "Edit Payer List" link, a "Search Text" input field, and "Search" and "Clear" buttons. The search results area displays "Patient Search Results: I>No Patient Found" and an "Add Patient" button.

2. Press **Enter** on your keyboard or click **Search** to start the search.
3. If no patients are found or if the record you are trying to locate is not on the list, try expanding your search criteria by entering less specific data.

3.7.3 Edit a Patient Record

Follow these steps to edit a patient record:

1. If necessary, use the search procedure described above to find the patient record you wish to edit.
2. When you find the patient record, click on the hyperlinked Patient Name or the "Edit" link in the **Action** column. The Edit Patient window appears, showing the patient record.
3. Edit the data as needed and when you are finished, click **Save** to save your changes or click **Cancel** to leave the record unchanged.

3.7.4 Delete a Patient Record

Follow these steps to delete a patient record:

1. From the Patient List window, find the patient record you wish to delete and click the "Delete" link in the **Action** column. A confirmation dialog box appears asking if you want to delete the record.
2. Click **OK** to delete the record or click **Cancel** to keep the record.

4 Check Claims

4.1 Overview

The **Claim Status** service allows you to check the status of a previously submitted claim, regardless of whether the claim was submitted manually or electronically. This tool allows you to manage claim rejections, reimbursements, and online claim adjustments, which eliminates having to re-key information and generate duplicate forms.

4.2 Key Features

- Fast access to real-time claim status information for multiple payers
- Individual and batch functionality for improve productivity
- Time-saving batch management features: sort, move, copy, delete
- Ability to track claims throughout the reimbursement cycle
- Verify that claims have been received by payers
- Quickly determine the status of claims
- Expedite follow up on rejected claims
- Obtain enrollment forms by selecting **Setup > More** and clicking the “Payer Enrollment” link.

4.3 Check a Claim’s Status

1. Select **Claims > Claim Status** on the main menu.
2. Select a payer.

Note: The claim status request screen varies depending on the payer.

3. Select a search type (if applicable).
4. Enter search criteria to locate the claim.
5. Enter requesting provider and service provider information (if applicable). To find a provider ID, click **Edit**.
6. If the **Requesting Provider** is the same as the **Service Provider**, click the “Same as Requesting Provider” check box. This populates the Service Provider fields with Requesting Provider information.

CHECK CLAIMS

7. Click **Send to Payer** to process your query.

Step 1 - Select payer

Aetna

Aetna Tools

- [Aetna DocFind](#)
- [Services Requiring Precertification](#)
- [Aetna Benefit Products Booklet](#)

Step 2 - Select how you wish to search

Subscriber

Step 3 - Enter search criteria * indicates required fields

* Subscriber ID
123456789

* Subscriber Last Name WATKINS * First Name GERALD M.I.

* Subscriber DOB 02/04/1976 * Gender Male

* Service Start Date 02/16/2011 Service End Date

Total Submitted Charges Claim Number

Requesting Provider

* Provider ID Type NPI * Provider ID 1982640710 * Individual/Organization Individual

* Last/Organization Name ALAN V JONES First Name (Required for Individual) ALAN M.I.

Service Provider

Same as Requesting Provider

* Provider ID Type NPI * Provider ID 1982640710 * Individual/Organization Individual

* Last/Organization Name ALAN V JONES First Name (Required for Individual) ALAN M.I.

Step 4 - Begin search

Disclaimer: The Provider understands that receipt or use of this information does not guarantee payment of any health care claim by Aetna and such information is subject to change, even retroactively, at any time.

The following illustration shows results of this inquiry.

CHECK CLAIMS

Aetna

Claim Status Notification [\[Save Response to Batch \]](#)

Request: Insured=GERALD WATKINS MemberID=123456789 DOB=02/04/1976 ProviderID=1982640710

Emdeon Trace #: 160044503

Patient: IBA PATIENT Member ID: 222222222 DOB: 03/30/1966 Gender: Female	Service Provider: MACRAN FAMILY PHYS Federal Tax ID: 111111111
	Requesting Provider: MACRAN FAMILY PHYS Federal Tax ID: 111111111

Claim #: E8F7DZ0V01 [Financial Inquiry](#)

Status: Finalized/Payment-The claim/line has been paid.
Payment reflects usual and customary charges.
Finalized/Payment-The claim/line has been paid.
Processed according to contract/plan provisions. This change to be effective 1/1/2009: Processed according to contract provisions.
(Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).

Status Information Date: 09/30/2004
Total Claim Charge Amount: \$99,999.99
Claim Payment Amount: \$800.00
Adjudication Date: 11/19/2003
Payment Method: Check
Check or EFT Date: 11/21/2003
Check or EFT #: 00000006
Claim Service Date: 10/12/2003-10/12/2003

Line	Procedure	Svc Units	Date	As Of	Charge	Paid	Status
64400	1	10/12/2003-10/12/2003	09/30/2004	\$99,999.99	\$969.60	Finalized/Payment-The claim/line has been paid. Payment reflects usual and customary charges. Finalized/Payment-The claim/line has been paid. Processed according to contract/plan provisions. This change to be effective 1/1/2009: Processed according to contract provisions. (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).	

8. Click "Save Response to Batch" to save the response to a new or existing batch.

Note: The "Save Response to Batch" link appears only if batching is off.

The following window appears:

Default ..DH

[Refresh List](#)

-- OR --

Save Transaction to a New batch:

Do one of the following:

- ✓ To save the response to an existing batch, choose the batch from the list. Click "Refresh List" if your batch does not appear in the list.
- ✓ To save the response to a new batch, enter the batch name. Click **Save**.

9. Click **Return to Previous** to return to the Claim Status request screen. Do not click the **Back** button on your browser since this may cause unpredictable results.

4.4 Claim Status Information

- Claim status

CHECK CLAIMS

- Claim number
- Trace number
- Patient/insured data
- Provider data
- Claim amount
- Payment amount

4.5 Claim Adjustment

You can request a claim adjustment for some payers using Claim Status or Batch Manager.

Note: Claim Adjustment is only available for the payers who support the function.

4.5.1 Request a Claim Adjustment from Check Claims

1. Select **Claims** > **Claim Status** from the main menu.
2. Select a payer.
3. Enter search criteria in the remaining fields on the form.
4. Click **Send to Payer**. After a few seconds, a Claim Status Notification appears with one or more claims matching your search criteria.
5. Locate the claim you want to modify and click the "Adjustment Request" link.

CHECK CLAIMS

Blue Cross Blue Shield of Massachusetts

Claim Status Notification [\[Save Response to Batch \]](#)

BCBSMA Services
 • [Claim Coding Assistance](#)

Request: Insured=ASDFASDF ASDFASDF MemberID=34[] DOB=12[] ProviderID=4[]

Emdeon Business Services Trace #: 112166650

Patient: BE[]	Service Provider: AGAPE HOME MEDICAL
Member ID: 45[]	Federal Tax ID: 84[]
DOB: 12[]	Requesting Provider
Gender: Male	Federal Tax ID: 74[]

Claim# : 0606 [Adjustment Request](#)

Status: Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
 Claim/encounter not found.
 This is claim level status

Status Information Date : 03/28/2002
 Total Claim Charge Amount : \$22,252.11
 Claim Payment Amount : \$52.11
 Adjudication Date : 03/28/2002
 Payment Method : Check
 Check or EFT # : 003166702
 Medical Record # : 18003526
 Claim Service Date : 04/22/2002-04/22/2002

Line	Procedure	Mod	Date	As Of	Charge	Paid	Status
1	E1140	B2,D4	04/22/2002-04/22/2002	03/28/2002	\$10,052.10	\$312.43	Finalized/Payment-The claim/line has been paid. For more detailed information, see remittance advice.

CHECK CLAIMS

6. A Claim Adjustment Request data entry form appears showing the patient and claim information.

Blue Cross Blue Shield of Massachusetts

Claim Adjustment Request

Status Information

Billing Provider ID: 841266676
 Payer Claim #: 06081506010000

Status: Acknowledgement/Receipt-The claim/encounter has been received. This does not mean that the claim has been accepted for adjudication.
 Category:
 Status: Claim/encounter not found.

Validate claim information

	Correct?	Enter corrected information
Subscriber ID: 45896197600	<input type="checkbox"/> No	<input type="text"/>
Insured Name: SOTIRAKIPOULO BEN A	<input type="checkbox"/> No	<input type="text"/>
Member Name: SOTIRAKIPOULO BEN A	<input type="checkbox"/> No	<input type="text"/>
Member DOB: 19521226	<input type="checkbox"/> No	<input type="text"/>
Member Gender: M	<input type="checkbox"/> No	--Select--
Date of Service: 04/22/2002-04/22/2002	<input type="checkbox"/> No	<input type="text"/>

Enter additional claim information

If any of the following information is incorrect on the original claim, please select from choices listed or enter the correct information in the fields below

Relationship:

Primary Diagnosis:

Other Insurance Information

Other Insurer Name:

Street:

City:

State: --Select-- Zip:

Insured Name:

Policy # or Insured ID:

Comments

Describe any other information that is in error and enter the correct information below.

Contact Information *indicates required fields

* Name: * Phone: Email:

Actions

7. In the **Validate Claim Information** section, review the data elements carried over from the claim. If you want to modify the information, click **No** in the "Correct?" column and type the correct information in the box.
8. The next step varies depending on the payer:
- ✓ *Blue Cross Blue Shield of Massachusetts*: Update information in the Enter Additional Claim Information and Other Insurance Information sections if necessary.
 - ✓ *Coventry plans*: Indicate the Reason for Adjustment by selecting a value from the list. Indicate all the claim lines that need to be modified, if applicable, and include any pertinent comments for each modified item.
9. Use the **Comments** field to type any additional information that may be relevant to the claim, up to 250 characters. Be as specific as possible in making your request. If none of the data elements referenced above pertain to your inquiry, you can complete the **Comments** section only.

CHECK CLAIMS

10. In the **Contact Information** section, type the name and phone number of a contact person.
11. When you finish entering the correct claim data, click **Submit**. A Claim Adjustment Confirmation appears. Use the browser's **Print** button to print the confirmation notice for future reference.
12. Next, do one of the following:
 - ✓ To return to the previous Claim Status Notification screen, click **Return to Claims Detail**. This is the claim detail screen you created the adjustment request from.
 - ✓ To return to the Claim Status screen, click **Return to Check Claim**. This will take you to a new input screen where you can inquire on another claim.

4.5.2 Request a Claim Adjustment from Batch Manager

1. Select **Batch Manager** from the main menu.
2. Select or search for the batch that contains the transaction(s) you want to modify.
3. On the Batch Inquiry screen, click the link in the Responses column. The Claim Status Notification appears.
4. Click the "Adjustment Request" link. The Claim Adjustment Request data entry form appears.
5. Follow steps 6–10 above in the **Request a Claim Adjustment from Check Claims** section.

4.6 Claim Financial Inquiry

The Claim Financial Inquiry (CFI) transaction allows you to receive a more detailed response when checking the status of a claim. The CFI transaction occurs after a Claim Status Notification has been returned by a claim status transaction.

Note: The CFI transaction is only available for the payers who support the transaction.

4.6.1 Request a Claim Financial Inquiry

1. Select **Claims > Claim Status** from the main menu.

CHECK CLAIMS

2. Select a payer.
3. Enter search criteria in the remaining fields on the form.
4. Click **Send to Payer**. After a few seconds, a Claim Status Notification appears with one or more claims matching your search criteria.
5. Select the claim you want to receive a CFI response for.
6. If the payer supports the CFI transaction, there will be a "Financial Inquiry" link near the **Claim #** section. Click the "Financial Inquiry" link.

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Claim Status Notification [\[View Response to Batch\]](#)

Request: Insured=GERALD WATKINS MemberID=123456789 DOB=02/04/1976 ProviderID=1982640710

Emdeon Trace #: 160044503

Patient: MR PATIENT	Service Provider: MR/DR JAMAL THOMAS
Member ID: 222222222	Federal Tax ID: 111111111
DOB: 03/30/1966	Requesting Provider: MR/DR JAMAL THOMAS
Gender: Female	Federal Tax ID: 111111111

Claim #: **EBF7FDZ0V01** [Financial Inquiry](#)

Status: FinalizedPayment-The claim/line has been paid
Payment reflects usual and customary charges.
FinalizedPayment-The claim/line has been paid
Processed according to contract/plan provisions. This change to be effective 1/1/2009. Processed according to contract provisions.
(Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).

Status Information Date: 09/30/2004
Total Claim Charge Amount: \$99,999.99
Claim Payment Amount: \$800.00
Adjudication Date: 11/19/2003
Payment Method: Check
Check or EFT Date: 11/21/2003
Check or EFT #: 00000006
Claim Service Date: 10/12/2003-10/12/2003

Line	Procedure	Svc	Date	As Of	Charge	Paid	Status
64400	1	Units	10/12/2003-10/12/2003	09/30/2004	\$99,999.99	\$969.60	FinalizedPayment-The claim/line has been paid. Payment reflects usual and customary charges. FinalizedPayment-The claim/line has been paid. Processed according to contract/plan provisions. This change to be effective 1/1/2009. Processed according to contract provisions. (Contract refers to provisions that exist between the Health Plan and a Provider of Health Care Services).

7. The Claim Financial Response will be returned.
8. Click **Return to Previous** to return to the Claim Status Notification response.

5 Supplement Claims

5.1 Overview

This section describes how to supplement primary and secondary claims and how to generate and submit secondary claims through the application. For a quick review, please see the section on the **Send Claims** feature (page 13).

5.2 Secondary Claims

A secondary claim is a request for payment to a secondary payer after the primary payer has met its portion of responsibility for the claim.

A secondary claim is created by merging data from:

1. Existing data on the primary claim and
2. Supplemental data entered to the application through the Supplement Claims feature. This supplemental data is obtained from printed EOBs and electronic remittance files sent by primary payers.

5.2.1 Secondary Claims

Currently, there are two ways to create secondary claims: through Supplement Claims and through Reporting & Analytics (see **Secondary Claims** on page 176 in the Reporting & Analytics section). This section describes how to create secondary claims through Supplement Claims, but there are some fundamental differences between the two methods.

Feature	Secondary Claims: Supplement Claims	Secondary Claims: Reporting & Analytics
Create secondary claim	Upload a primary claim for the purpose of converting it to a secondary claim to submit to another payer. Make changes needed to create the secondary claim immediately after you upload the claim. The changes you make are independent of the submission of the primary claim to the primary payer.	Create a secondary claim only from a primary claim that has already been submitted through the clearinghouse to the payer. Using this method, you will upload the claim once, not twice.
Change field values	Make changes only to certain fields	Make changes to any field
Submission format	Submit claims in multiple formats	Submit claims only in ANSI X12 4010, 5010, or NSF+ format

SUPPLEMENT CLAIMS

5.2.2 Secondary Claims Workflow

The following steps describe the typical workflow for a batch file containing claims needing to be supplemented and sent to secondary payers:

1. Select Claims > Import. Click **Proceed to Next Step**.
2. On the Send Claim File screen, select the “Hold submission for entry of additional data” check box, as shown on the next illustration.

3. Using the Browse button, locate the file to be uploaded and click **Submit Claim for Processing**.
4. Return to the home page and select Claims > Supplement to open the Supplement Claims application. A list of batches appears.

Batch	Number of Claims	Status	Action
wrzi02192010141212.	1	1 Supplemented	Supplement Send Delete
wrzi02262010093717.	1	1 Supplemented	Supplement Send Delete
wrzi02262010093719.	1	0 Supplemented	Supplement Send Delete
wrzi02262010130115.	1	0 Supplemented	Supplement Send Delete
wrzi02262010141559.	1	0 Supplemented	Supplement Send Delete
wrzi02262010141577.	1	1 Supplemented	Supplement Send Delete
wrzi040710134359394	1	0 Supplemented	Supplement Send Delete
wrzi040710134413440	1	0 Supplemented	Supplement Send Delete

5. Select the batch containing the claims you would like to supplement by clicking the appropriate “Supplement” link.
6. Enter supplemental data using the various data entry screens.

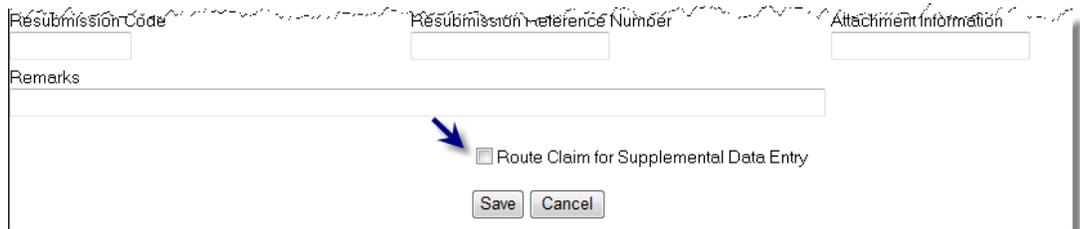
SUPPLEMENT CLAIMS

7. When you are finished working with the claims, return to the Batch List and click "Send" to submit the batch for processing.

5.2.3 Alternate Workflow using Claim Entry

When claims are entered through the Claim Entry feature:

1. Enter claims through **Claims > Create**. Place a check in the "Route Claim for Supplemental Data Entry" checkbox located directed above the **Save** button. This tells the system to hold submission of the claim to allow entry of data for secondary claims.



The screenshot shows a web form for entering claims. At the top, there are three input fields: 'Resubmission Code', 'Resubmission Reference Number', and 'Attachment Information'. Below these is a large 'Remarks' text area. At the bottom of the form, there is a checkbox labeled 'Route Claim for Supplemental Data Entry' with a blue arrow pointing to it. Below the checkbox are two buttons: 'Save' and 'Cancel'.

2. Execute batching/claims submission from Claim Entry as usual. Claims that have "Supplemental Data Entry" checkbox checked are not sent for processing.
3. Proceed to **Claims > Supplement** to supplement and submit claims using steps 4-7 listed above.

5.2.4 Email Notifications

After you upload a supplemental batch, you will receive an email notification indicating the batch is pending and that you need to supplement, send, or delete the batch. If the batch remains in a pending state for over four days, you will receive additional email notifications reminding you that action is needed.

5.2.5 Troubleshooting Guide

For a list of common issues and error messages you may encounter when working with Supplement Claims, refer to the **Troubleshooting Guide** on page 75.

5.2.6 Output Format

At the bottom left of every screen, there is a note indicating the type of output format used: NSF 2.5, NSF+, 4010, or 5010. The Claim Level and Line Level Entries screens will vary depending on which output format is used.

SUPPLEMENT CLAIMS

5.3 Batch List

When you select **Claims > Supplement**, a list of batches that have been flagged as needing to be held for the entry of supplemental data appears. The **Status** column indicates the number of claims that have already been supplemented in each batch.

Batch List	Claim List	Claim Summary	
Batch	Number of Claims	Status	Action
wrzi02192010141212.	1	1 Supplemented	Supplement Send Delete
wrzi02262010093717.	1	1 Supplemented	Supplement Send Delete
wrzi02262010093719.	1	0 Supplemented	Supplement Send Delete
wrzi02262010130115.	1	0 Supplemented	Supplement Send Delete
wrzi02262010141559.	1	0 Supplemented	Supplement Send Delete
wrzi02262010141577.	1	1 Supplemented	Supplement Send Delete
wrzi040710134359394	1	0 Supplemented	Supplement Send Delete
wrzi040710134413440	1	0 Supplemented	Supplement Send Delete

5.3.1 Action Column

In the **Action** column, you can select “Supplement,” “Send,” and “Delete.”

- The “Supplement” link opens the Claim List screen, which lists the claims in a batch that can be supplemented. When you select a batch to supplement, a file locking mechanism prevents other users from accessing the same batch. This way, only one user is allowed to work on one batch at a time. If other users select the same batch to work on, they will see an alert message as shown below.



- The “Send” link sends a batch of claims that was previously held for the entry of supplemental data. If there are no errors within the supplemented data, the file is sent to the application for processing and the batch is removed from the list. If the system detects any errors in the additional data entered, an error message will appear on the screen and the batch will not be removed from the list. Once all errors are corrected and a batch is re-sent, the batch will be removed from the list. To view some sample error messages you may encounter when sending a batch, see **Ambulance Data**
- **The 4010 and 5010 Ambulance Data** screen functions similarly to that of NSF+: you can add ambulance data to both primary and secondary claims, and available data pre-populates the appropriate fields (see **Ambulance Data** on page 71). However, with 4010 and 5010, you have the ability to add claim level ambulance data as well as line level ambulance data. Entering ambulance information at the claim level negates the need for you to include it for each service line when there are no differences to report at the line level.

SUPPLEMENT CLAIMS

Batch List | Claim List | Claim Summary | Claim Level Entries | Line Level Entries | Insurance Information | Provider Data | Patient Data | **Ambulance Data**

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrzi02262010093717	1		WILLIAMS	07/15/1990		\$600.00

Ambulance Data Claim Level

Patient Weight:
 Hospital Admit: --Select--
 *Type of Transport: --Select--
 Bed Confined Before: --Select--
 Bed Confined After: --Select--
 Moved by Stretcher: --Select--
 Unconscious/Shock: --Select--
 Emergency Situation: --Select--
 Physical Restraints: --Select--
 Visible Hemorrhaging: --Select--
 *Transported TO/FOR: --Select--
 Medically Necessary: --Select--
 *Miles:
 Purpose of Round Trip:
 Purpose of Stretcher:
 Patient Discharged: --Select--
 Patient Admitted: --Select--
 Services Available: --Select--

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Ambulance Data Applied
1	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
2	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
3	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
4	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
5	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
6	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	

Line Level Entries If different from Claim Level

Apply Adjustments to Line Number:

Ambulance Data

Patient Weight:
 Hospital Admit: --Select--
 *Type of Transport: --Select--
 Bed Confined Before: --Select--
 Bed Confined After: --Select--
 Moved by Stretcher: --Select--
 Unconscious/Shock: --Select--
 Emergency Situation: --Select--
 Physical Restraints: --Select--
 Visible Hemorrhaging: --Select--
 *Transported TO/FOR: --Select--
 Medically Necessary: --Select--
 *Miles:
 Purpose of Round Trip:
 Purpose of Stretcher:
 Patient Discharged: --Select--
 Patient Admitted: --Select--
 Services Available: --Select--

Selected Claim List: Claim 1
Output Format 4010

- Sample Error Messages on page 72.
- The “Delete” link deletes the batch. You may need to delete a batch if you realize you have already uploaded that batch and want to avoid sending duplicate claims or if you wish to print out the batch from your Practice Management System instead of sending it electronically.

5.4 Claim List

This screen opens when you click the “Supplement” link on the Batch List screen.

SUPPLEMENT CLAIMS

Batch List		Claim List	Claim Summary				
Select	Claim #	Patient Name	Gender	Date of Birth	Destination Payer	Claim Date	Claim Total
<input type="checkbox"/> <i>Secondary</i>	1	WEBB SUZIE	F	07/15/1970	PALMETTO GOVERNMENT BENEFITS ADM.	09/05/2003	\$200.00
<input type="checkbox"/>	2	DOODY HOWDY	M	07/15/1970	ALASKA MEDICARE	09/05/2003	\$126.00
<input type="checkbox"/>	3	WALKER JAY	M	11/23/1938	ALASKA MEDICARE	09/05/2003	\$388.00
<input type="checkbox"/> <i>Secondary</i>	4	WALKER JAY	M	09/10/1948	AETNA US HEALTHCARE		\$95.00

Output Format NSF2.5

Until you select one or more claims to supplement, only the tabs shown on the above illustration will appear. Some of the claims will show the label **Secondary** in the **Select** column indicating they have been previously supplemented and flagged as Secondary claims. Clicking **Supplement** opens the Claim Summary screen. This is true for all claim types: NSF 2.5, NSF+, 4010, and 5010.

If the selected claim has not been designated as Primary or Secondary, the Claim Summary screen appears, as shown on the following illustration:

Batch List		Claim List	Claim Summary					
Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707111730597	2	CROXX		DOODY, HOWDY	M	11/23/1938	09/05/2003	\$95.00
Service Line	Service Dates From - Through		Procedure Code	Procedure Modifiers	Amount	Units		
1	09/04/2003 - 09/04/2003		99213	25	\$50.00	1		
2	09/04/2003 - 09/04/2003		92020		\$45.00	1		

Secondary Claim data and Primary Claim data cannot both be entered. Please designate whether this claim should be treated as Primary or Secondary.

Selected Claim List: Claim 2

Output Format NSF+

Once a batch and an associated claim have been selected, the Claim Summary screen (shown above) allows you the option of designating the claim as either Primary, for the purpose of adding other insurance information, or as Secondary, for the purpose of adding primary payer payment information.

- If you select **Designate as Primary Claim**, the Insurance Information tab displays.
- If you select **Designate as Secondary Claim**, three more tabs display: Claim Level Entries, Line Level Entries, and Insurance Information, as the next section explains.

SUPPLEMENT CLAIMS

5.5 NSF 2.5 Claims

This section applies to NSF 2.5 claims only. If you work with another type of claim, please skip to **NSF+ Claims** on page 44 or **4010/5010 Claims** on page 69.

5.5.1 Claim Summary – Secondary Claim

When you select a secondary claim to supplement, all tabs become available. The Claim Summary screen for a secondary claim appears as shown on the next illustration:

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4110707115006985	5	HORIZON NJ PLUS		DOODY HOWDY	M	12/23/1947		\$155.00
Service Line	Service Dates From - Through		Procedure Code	Procedure Modifiers	Amount	Units		
1	04/01/2005 - 04/01/2005		99214		\$95.00	10		
2	04/01/2005 - 04/01/2005		92015		\$30.00	10		
3	04/01/2005 - 04/01/2005		82015		\$30.00	10		

Both **Adjudication Date** and **Payer Amount Paid** must be specified first to begin supplementing this claim. Then press **Save** to continue.

*Adjudication Date *Payer Amount Paid Obligated to Accept in Full Allowed Amount

Selected Claim List: Claim 5

Output Format NSF2.5

If the **Payer Amount Paid** is 0.00, you are directed to the Claim Level Entries screen to enter denial reasons. (See **Claim Level Entries – NSF 2.5** on page 54).

If the **Payer Amount Paid** is a dollar amount greater than zero, you are directed to the Line Level Entries screen to enter applied amounts. (See **Line Level Entries – NSF 2.5** on page 54).

Two new fields on this screen are described below:

Field	Description
Obligated to Accept in Full	Optional field. This is the amount the provider agreed to accept as payment in full, under contract provisions. This field should only be used if the entire claim was applied to the Obligated to Accept in Full Amount and the information will not be reported at the service line. Total Obligated to Accept Amounts may be entered at both the line and claim level but not both.
Allowed Amount	Optional field. Maximum amount a provider is allowed to charge for services under contract provisions. Allowed Amounts may be entered at the line level and if entered, will result in their claim level total being incremented.

If you select **Back Out All Changes**, the claim will revert to its original state and the previous Claim Summary screen will appear.

SUPPLEMENT CLAIMS

5.5.2 Claim Level Entries – NSF 2.5

The Claim Level Entries screen is used to enter denial reasons and denied amounts.

When the **Payer Amount Paid** on a claim equals 0.00, you must go to this screen to enter the denial reasons. This information is obtained from the EOB (Explanation of Benefits) or remittance sent by the primary payer.

Batch List	Claim List	Claim Summary	Claim Level Entries	Line Level Entries	Insurance Information	Provider Data		
Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4110707115006985	4	AETNA US HEALTHCARE		WALKER, JAY	M	09/10/1948		\$95.00
* Denial Reason 1		* Amount 1						
Non-covered benefits (02)		\$95.00						
Denial Reason 2		Amount 2						
Denial Reason 3		Amount 3						
<input type="button" value="Save"/>		<input type="button" value="Reset"/>						
Selected Claim List: Claim 4								
Output Format NSF2.5								

5.5.3 Line Level Entries – NSF 2.5

This screen allows you to enter payments and adjustment amounts for each service line on a claim. Obtain these amounts from the EOB (Explanation of Benefits) or remittance sent by the primary payer.

SUPPLEMENT CLAIMS

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
nsf4110707115006985	4	AETNA US HEALTHCARE		WALKER JAY	M	09/10/1948		\$95.00

Total Distributed

Disallowed Cost Containment	Disallowed Other	Deductible	Co-Insurance	Payment	Payer Amount Paid
\$0.00	\$0.00	\$0.00	\$35.00	\$60.00 <>	

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Applied Amount
1	04/01/2005 - 04/01/2005	99214		\$95.00	10	\$95.00
	Disallowed Cost Containment none	Disallowed Other none	Deductible \$0.00	Co-Insurance \$35.00	Payment \$60.00	
	Obligated to Accept Amount \$60.00	Allowed Amount none				
Total						\$95.00

Line Level Entries

Apply Payments/Adjustments to Line Number:

Disallowed Cost Containment Disallowed Other Deductible Co-Insurance Payment Obligated to Accept Amount Allowed Amount

At the top of the screen under **Total Distributed** there is a row of summary dollar amounts (these amounts are described in detail on the following table). Next to each service line there is also an **Applied Amount** column.

These amount fields are used to aid you in determining that you have fully accounted for the difference in the amount the payer paid on the claim versus the adjustments that occurred to the claim.

The following table contains definitions for the amounts shown on the Line Level Entries screen under Total Distributed.

Adjustment Data	Description
Disallowed Cost Containment	The portion of line charges disallowed by the payer due to the failure of either the provider or insured to meet the cost containment provisions of the insurance plan.
Disallowed Other	The portion of line charges disallowed by the payer for reasons OTHER than the failure of the provider or insured to meet the cost containment provisions of the insurance plan.
Deductible	Any applicable deductible amount. If the patient has already met their deductible for the year, this field will contain zeroes, or be empty meaning that no deductible amount was applied to the claim.
Co-Insurance	An agreement between the insured and the insurer where the insured agrees to cover a set percentage of the covered costs after the deductible has been paid. The coinsurance is typically 20% of the allowed amount. On this screen, coinsurance is the amount applied toward the coinsurance by the primary payer.
Payment	The amount paid by the insured on the claim.
Payer Amount Paid	The amount paid the payer on the claim. The Payer Paid Amount is taken from the Claim Level Entry screen where the payer amount paid was initially entered and is simply a visual aid for you to be able to compare the amounts entered at the line level against the claim level payment.
Applied Amount	This column is a total of the payments and adjustments entered for each service line.

SUPPLEMENT CLAIMS

Line Level Entries

Apply Payments/Adjustments to Line Number: Service Line 1

Disallowed Cost Containment	Disallowed Other	Deductible	Co-Insurance	Payment	Obligated to Accept Amount	Allowed Amount
		\$0.00	\$35.00	\$60.00	\$60.00	

<input type="button" value="Browse Reason"/>	Reason Code	Reason Description
--	-------------	--------------------

Selected Claim List: Claim 4

Output Format NSF2.5

The bottom portion of the screen (above) allows entering data for each service line. Two new optional fields are described below:

Adjustment Data	Description
Obligated to Accept Amount	Optional field. This is the amount the provider agreed to accept as payment in full, under contract provisions. This field should only be used if the entire claim was applied to the Obligated to Accept in Full Amount and the information will not be reported at the service line. Total Obligated to Accept Amounts may be entered at both the line and claim level but not both. Note: Obligated to Accept Amount can be valued for the service line or for the entire claim but not both.
Allowed Amount	Optional field. Maximum amount a provider is allowed to charge for services under contract provisions. Allowed Amounts may be entered at the line level and if entered, will result in their claim level total being incremented.

You can browse and search for claim adjustment reason codes and explanations by clicking **Browse Reason**. This feature is particularly helpful if you rely upon remittances that lack code descriptions to determine which adjustment field (Disallowed Cost Containment, Disallowed Other, Deductible, etc.) an amount should be attributed to.

The Disallowed Cost Containment, Disallowed Other, Deductible, Co-insurance, and Payment amounts (displayed at the top of the screen) will increase appropriately as these Line Level amounts are entered for each service line. All changes must be saved in between service lines and before leaving the screen.

5.5.4 Insurance Information – NSF 2.5

The Insurance Information screen varies based on whether the claim is primary or secondary. All fields are editable except for the **Payer Name** which populates based on the selected Payer ID. Any data present in the claim will pre-populate the screen.

SUPPLEMENT CLAIMS

Primary Claims

When a primary claim is selected, the **Insurance Information** tab allows you to add information identifying the secondary payer. This is particularly necessary for the successful submission of Medicare Crossover claims.

The screenshot shows the 'Insurance Information' tab for a primary claim. At the top, there are navigation links: 'Batch List', 'Claim List', 'Claim Summary', and 'Insurance Information' (which is highlighted). Below this is a table with the following data:

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
ns4120806143318182	2	ALASKA MEDICARE		WEBB, SUZIE	F	07/15/1970	09/05/2003	\$126.00

Below the table are several input fields and dropdown menus for insurance information:

- * Payer ID: (with a 'Payer Find' button)
- Payer Name:
- Group Number:
- * Patient Relationship to Insured:
- * Insured Last Name:
- * Insured First Name:
- Insured Middle Initial:
- * Insured ID:
- * Insured Gender:
- * Insured Date of Birth:
- Insurance Type Code:
- Payer Claim Office Number:
- Group Name:

At the bottom, there are 'Save' and 'Reset Screen' buttons, and the text 'Selected Claim List: Claim 2' and 'Output Format NSF2.5'.

Secondary Claims

For secondary claims, the **Insurance Information** tab displays insurance information for both payers. You may view, edit, and add insurance information for both prior/primary payers and secondary/destination payers.

The screenshot shows the 'Insurance Information' tab for a secondary claim. At the top, there are navigation links: 'Batch List', 'Claim List', 'Claim Summary', 'Claim Level Entries', 'Insurance Information' (which is highlighted), and 'Provider Data'. Below this is a table with the following data:

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
ns4120806143318182	4	AETNA US HEALTHCARE	Blue Crow	WALKER, JAY	M	09/10/1948		\$96.00

Below the table are several input fields and dropdown menus for insurance information:

- * Payer ID: (with a 'Payer Find' button)
- Payer Name:
- Group Number:
- * Patient Relationship to Insured:
- * Insured Last Name:
- * Insured First Name:
- Insured Middle Initial:
- * Insured ID:
- * Insured Gender:
- * Insured Date of Birth:
- Insurance Type Code:
- Payer Claim Office Number:
- Group Name:
- Prior Authorization Number:
- Insured Address 1:
- Insured Address 2:
- Insured City:
- Insured State:
- Insured Zip:

At the bottom, there is a section for 'Destination Payer Information'.

The bottom portion of the screen, shown on the next illustration, allows you to enter necessary information for the receiving payer in the event that more data is needed to successfully adjudicate the claim.

SUPPLEMENT CLAIMS

Destination Payer Information

*Payer ID 91114 <input type="button" value="Payer Find"/>	Payer Name AETNA US HEALTHCARE	
Group Number 72622001000242	*Patient Relationship to Insured [Dropdown]	
*Insured Last Name WALKER	*Insured First Name JAY	Insured Middle Initial [Text]
*Insured ID 09974470101	*Insured Gender Male [Dropdown]	
*Insured Date of Birth 09/10/1948	Insurance Type Code Individual Policy (IP) [Dropdown]	
Payer Claim Office Number [Text]	Group Name [Text]	
Prior Authorization Number [Text]	Insured Address 1 [Text]	
Insured Address 2 [Text]	Insured City [Text]	
Insured State [Text]	Insured Zip [Text]	

Selected Claim List: Claim 4

Output Format NSF2.5

Payer Search

Click **Payer Find** to open a search screen. You may search by payer name or ID. Both search fields accept partial data entries followed by a wild card character or asterisk (% , *). Neither field is case- sensitive. You may enter upper- or lowercase.

For example:

- A search on "SM*" on the Payer ID will return all payers whose Payer IDs begin with SM.
- A search on "blue*" on the Payer Name will return all BlueCross BlueShield payers.

Swap Payers

The **Swap Payers** button allows you to swap the primary and secondary payers if you notice they are reversed in the supplemental claim screens. This feature is also helpful if you wish to form a secondary claim using data from the original, primary claim.

You can determine if the payers are reversed on the supplemental claims screens by examining the Explanation of Benefits or ERA. The primary payer would be the one who created the ERA as they paid first. If the payer who created the ERA appears in the destination payer field, then it needs to be reversed since that payer has already made payments on the claim.

In this case, swapping the prior and destination payers ensures the claim is directed to the correct payer and the payment information is associated with the correct payer.

SUPPLEMENT CLAIMS

5.5.5 Provider Data – NSF 2.5

The Provider Data screen allows you to edit provider identifiers and other information at the claim level and line level. Any data present in the claim will pre-populate the screen.

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
mybatch_790	1	MEDICAL MUTUAL OF OHIO	PATIENT JANE	07/15/1970	09/05/2003	\$500.00

Claim Level Data						
Billing Provider:	*Tax ID 123456789	*Tax ID Type: --Select--	Medicare # 3636364	UPIN/USIN # 	Medicaid # 3636364	Champus # 3636364
	NPI 	State License # 	Specialty 44	Specialty Find 	BCBS # 3636364	Commerical # 3636364
Rendering Provider:	Render Prov # C44555	Tax ID 123456789	Network ID: mnb345	NPI 	Specialty 44	Specialty Find
Supervising Provider:	Supervising Id 	NPI 				
Facility/Lab:	Facility/Lab Id 	NPI 				
Referring Provider:	Referring Prov # 123456789	ID Type: Tax Id	NPI 	Network ID: 		

Save Reset Page

Line Level Data					
Showing lines 1 to 6: 1 2					
1	Rendering Prov ID mnb345	Rendering Prov Tax ID 123456789	Rendering Prov Network ID 66778899	Rendering Prov Specialty 044	Rendering Prov NPI
	Rendering Prov UPIN 	Referring Prov ID 123456789	Referring Prov NPI 123456789	Referring Prov UPIN 	Supervising Prov NPI
	Supervising Prov UPIN 	Ordering Prov NPI 1234567893	Ordering Prov UPIN 	Purchasing Prov NPI 	Copy to remaining lines
2	Rendering Prov ID 888888	Rendering Prov Tax ID 431129356	Rendering Prov Network ID 66778899	Rendering Prov Specialty 044	Rendering Prov NPI
	Rendering Prov UPIN 	Referring Prov ID 123456789	Referring Prov NPI 123456789	Referring Prov UPIN 	Supervising Prov NPI
	Supervising Prov UPIN 	Ordering Prov NPI 	Ordering Prov UPIN 	Purchasing Prov NPI 	Copy to remaining lines
3	Rendering Prov ID mnb345	Rendering Prov Tax ID 123456789	Rendering Prov Network ID 66778899	Rendering Prov Specialty 044	Rendering Prov NPI
	Rendering Prov UPIN 	Referring Prov ID 	Referring Prov NPI 	Referring Prov UPIN 	Supervising Prov NPI

Up to six line items appear in the Line Level Data area of the Provider Data screen. Scroll down to view all six line items.

The total number of pages of line items appears directly under the Line Level Data heading and also at the bottom of the page. To view another page of line items, click the number of the page you wish to view.

Note: In order to preserve your changes on a page, you must click **Save** before viewing another page.

SUPPLEMENT CLAIMS

Claim level data can be edited and saved from any Provider Data page.

Copy to Remaining Lines

The **Copy to Remaining Lines** button allows you to copy the provider data in all fields of the line item in which the button is located to all remaining line items, including those on subsequent pages. Fields in preceding line items are not affected.

Specialty Find

The **Specialty Find** button opens a search screen. You can search by specialty code or description. Both search fields accept partial data entries followed by a wild card character or asterisk (% , *). Neither field is case-sensitive. You can enter upper- or lowercase.

For example:

- A search on "3*" on the Specialty Code will return all specialty codes that begin with 3, such as "30" and "33."
- A search on "*de*" on the Specialty Description will return all specialty codes with the letters "de" in any portion of the description, such as "Dental Hygienist" and "Independently Billing Radiology Group."

Save and Reset Page

Each **Save** button on the page saves all data on the current page, including both claim level and line level data.

The **Reset Page** button clears any changes you have made on the current page since your last save, including both claim level and line level data.

5.6 NSF+ Claims

This section applies to NSF+ claims only. If you work with another type of claim, please skip to **NSF 2.5 Claims** on page 53 or **4010/5010 Claims** on page 69.

SUPPLEMENT CLAIMS

Batch List | Claim List | **Claim Summary**

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707111730597	2	CROXX		DOODY, HOWDY	M	11/23/1938	09/05/2003	\$95.00
Service Line	Service Dates From - Through		Procedure Code	Procedure Modifiers	Amount	Units		
1	09/04/2003 - 09/04/2003		99213	25	\$50.00	1		
2	09/04/2003 - 09/04/2003		92020		\$45.00	1		

Secondary Claim data and Primary Claim data cannot both be entered. Please designate whether this claim should be treated as Primary or Secondary.

Selected Claim List: Claim 2

Output Format NSF+

On this screen you can designate the claim as Secondary or Primary.

- If you select **Designate as Primary Claim** the Insurance Information tab displays.
- If you select **Designate as Secondary Claim**, three more tabs display: Claim Level Entries, Line Level Entries and Insurance Information, as shown on the next illustration.

5.7 Claim Summary

This screen shows detailed information on selected claims.

Batch List | Claim List | **Claim Summary** | Claim Level Entries | Line Level Entries | Insurance Information | Ambulance Data

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121024962	2	CROXX		DOODY, HOWDY	M	11/23/1938	09/05/2003	\$95.00
Service Line	Service Dates From - Through		Procedure Code	Procedure Modifiers	Amount	Units		
1	09/04/2003 - 09/04/2003		99213	25	\$50.00	1		
2	09/04/2003 - 09/04/2003		92020		\$45.00	1		

Both **Adjudication Date** and **Payer Amount Paid** must be specified first to begin supplementing this claim. Then press **Save** to continue.

*Adjudication Date *Payer Amount Paid

Selected Claim List: Claim 2

Output Format NSF+

Message	Action
Both Adjudication Date and Payer Amount Paid must be specified first to begin supplementing this claim.	<p>This message appears if the Adjudication Date and Payer Amount Paid fields are empty.</p> <p>Enter the missing data from the EOB and click Save. The payer paid amount comes from the EOB (Explanation of Benefits) report sent by the primary payer.</p>

If you select **Back Out All Changes**, the claim will revert to its original state and the previous Claim Summary screen will appear.

SUPPLEMENT CLAIMS

Batch List	Claim List	Claim Summary	Claim Level Entries	Line Level Entries	Insurance Information	Ambulance Data		
Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707111730597	1	MEDICAID		WEBB, SUZIE	F	07/15/1970	09/05/2003	\$285.00
Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units			
1	09/04/2003 - 09/04/2003	92004		\$110.00				
2	09/04/2003 - 09/04/2003	92015		\$15.00	1			
3	09/04/2003 - 09/04/2003	92016		\$25.00	1			
4	09/04/2003 - 09/04/2003	92017		\$35.00	1			
5	09/04/2003 - 09/04/2003	92018		\$45.00	1			
6	09/04/2003 - 09/04/2003	92019		\$55.00	1			
* Adjudication Date		* Payer Amount Paid						
<input type="text" value="11/11/2007"/>		<input type="text" value="\$120.00"/>						
<input type="button" value="Save"/>	<input type="button" value="Reset"/>	<input type="button" value="Designate as Primary Instead"/>	<input type="button" value="Back Out All Changes"/>					
Selected Claim List: Claim 1								
Output Format NSF+								

5.7.1 Claim Level Entries – NSF+

The Claim Level Entries screen is used to enter claim level adjustment reasons and amounts.

The information needed to complete the Optional Payment Information and Claim Adjustments fields is obtained from the Remittance Advice Notice sent by the primary payer.

SUPPLEMENT CLAIMS

Batch List Claim List Claim Summary Claim Level Entries Line Level Entries Insurance Information Ambulance Data					
Batch Name mybatch790	Claim # 1	Destination Payer PALMETTO GOVERNMENT BENEFITS ADM.	Patient Name PATIENT, JANE	Date of Birth 07/15/1970	Claim Date 09/05/2003
Optional Payment Information					
Patient Responsible Amount <input type="text"/>	Discount Amount <input type="text"/>	Per Day Limit Amount <input type="text"/>	Approved Amount <input type="text"/>		
Patient Paid Amount <input type="text"/>	Tax Amount <input type="text"/>	Pre-tax Claim Total Amount <input type="text"/>	Obligated to Accept Amount <input type="text"/>		
Medicare Outpatient Adjudication Reimbursement Rate <input type="text"/>	Medicare Outpatient Adjudication HCPS Payable Amount <input type="text"/>	Medicare Outpatient Adjudication ESRD Amount <input type="text"/>	MOA Non-payable Professional Component Billed Amount <input type="text"/>		
Medicare Outpatient Adjudication Remarks					
Remark Code 1 <input type="text"/>	Remark Code 2 <input type="text"/>	Remark Code 3 <input type="text"/>	Remark Code 4 <input type="text"/>	Remark Code 5 <input type="text"/>	
<input type="button" value="Search"/>	<input type="button" value="Search"/>	<input type="button" value="Search"/>	<input type="button" value="Search"/>	<input type="button" value="Search"/>	
Claim Adjustments					
CO - Contractual Obligations		<input type="button" value="Show Reasons"/>			
CR - Correction and Reversals		<input type="button" value="Show Reasons"/>			
OA - Other Adjustments		<input type="button" value="Show Reasons"/>			
PI - Payer Initiated Reductions		<input type="button" value="Show Reasons"/>			
PR - Patient Responsibility		<input type="button" value="Show Reasons"/>			
<input type="button" value="Save"/> <input type="button" value="Reset Page"/>					
Selected Claim List: Claim 1					
Output Format NSF+					

Adjustments

The **Claim Adjustments** portion of the Claim Level Entries screen, shown on the next illustration, allows you to enter up to 5 group codes per line (highlighted in blue) and up to 6 reason codes per group code.

SUPPLEMENT CLAIMS

Claim Adjustments

CO - Contractual Obligations

Amount	Reason Code		Quantity
\$1.00	1 <input type="button" value="Search Reason"/>		1
\$2.00	2 <input type="button" value="Search Reason"/>		2
\$3.00	3 <input type="button" value="Search Reason"/>		3
\$4.00	4 <input type="button" value="Search Reason"/>		4
	<input type="text"/> <input type="button" value="Search Reason"/>		
	<input type="text"/> <input type="button" value="Search Reason"/>		

CR - Correction and Reversals

OA - Other Adjustments

PI - Payer Initiated Reductions

PR - Patient Responsibility

Selected Claim List: Claim 2

If a Group Code is entered, at least one valid reason code and an amount greater than 0.00 must be entered. Otherwise, you will not be able to save entries.

Note: You have the option of entering adjustments at the claim level or at the line level. This is why the **Adjustments** section is identical on both the Claim Level and Line Level Entries screens.

The following table describes the **Adjustments** section of the screen:

Button/Field	Description
Show Reasons	These buttons expand the view to reveal 6 reason codes for each group code.
Hide Reasons	These buttons collapse the view and delete the reasons for the selected group code.
Search Reasons	Each of these buttons opens a search screen. You may enter an alpha-numeric code in the Reason Code field or you may enter a wild card (* or %) to display all the possible reason codes and their respective descriptions. The Reason Description field does not accept partial text entries so you must enter the full description in this field (for example: "Major Medical Adjustment").
Amount	The unpaid or denied dollar amount associated with a reason code.
Reason Code	The code associated with the reason for an adjustment, such as a denial or reduction in payment from the amount billed on a claim.
Quantity	The adjusted units of service if applicable.

5.7.2 Line Level Entries – NSF+

This screen allows you to enter payments and adjustment amounts for each service line on a claim. Obtain these amounts from the EOB (Explanation of Benefits) or remittance sent by the primary payer.

SUPPLEMENT CLAIMS

Batch List | Claim List | Claim Summary | Claim Level Entries | **Line Level Entries** | Insurance Information | Ambulance Data

Batch Name myach014	Claim # 1	Destination Payer PALMETTO GOVERNMENT BENEFITS ADM	Patient Name PATIENT, JANE	Date of Birth 07/15/1970	Claim Date 09/05/2003
Service Line	Service Dates From Through	Procedure Code	Procedure Modifiers	Amount	Units
1	09/04/2003 - 09/04/2003	92004		\$110.00	1.0
2	09/04/2003 - 09/04/2003	92015		\$15.00	1.0
3	09/04/2003 - 09/04/2003	92016		\$25.00	1.0
4	09/04/2003 - 09/04/2003	92017		\$35.00	1.0
5	09/04/2003 - 09/04/2003	92018		\$45.00	1.0
6	09/04/2003 - 09/04/2003	92019		\$55.00	1.0

Line Level Entries

Apply Payments/Adjustments to Line Number: Service Line 1

*Service Line Paid Amount Procedure Code Procedure Modifiers Procedure Description PD Service Unit Count Obligated to Accept Amount Allowed Amount

Line Adjustments

CO - Contractual Obligations

CR - Correction and Reversals

OA - Other Adjustments

The following table describes some of the fields on the Line Level Entries screen:

Field	Description
Procedure Code	A numeric code that describes the service.
Procedure Modifiers	Abbreviation on Remittance = MODS Procedure Modifiers are two position alpha or numeric codes appended to procedure codes that provide additional information about the billed procedure. In some cases, addition of a modifier may directly affect payment.
Amount	The dollar amount charged for the service.
Units	The quantity of service delivered. (This number can be entered as milligrams, cc, minutes etc.)
PD Service Unit Count	Paid Service Unit Count. This is the number of service units the primary payer paid for. The default value for this field is Units.
Obligated to Accept Amount	The dollar amount the provider has agreed to accept as payment in full, under contract provisions. Obligated to Accept Amounts may be entered at both the line and claim level but not both.
Allowed Amount	The maximum dollar amount a provider is allowed to charge for services under contract provisions.

Note: The **Adjustments** portion of the Line Level Entries screen is identical to the one described in **Adjustments** on page 63.

5.7.3 Insurance Information – NSF+

The Insurance Information screen varies based on whether the claim is primary or secondary. All fields are editable except for the **Payer Name**, which populates based on the selected Payer ID.

SUPPLEMENT CLAIMS

Primary Claims

When a primary claim is selected, the **Insurance Information** tab allows you to add information identifying the secondary payer. This is particularly necessary for the successful submission of Medicare Crossover claims.

Batch List | Claim List | Claim Summary | **Insurance Information** | Ambulance Data

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121134191	1	MEDICAID		WEBB, SUZIE	F	07/15/1970	09/05/2003	\$285.00

* Payer ID Payer Name

Group Number * Patient Relationship to Insured

* Insured Last Name * Insured First Name Insured Middle Initial

* Insured ID * Insured Gender

* Insured Date of Birth Insurance Type Code

Payer Claim Office Number Group Name

Selected Claim List: Claim 1

Output Format NSF+

Secondary Claims

For secondary claims, the **Insurance Information** tab displays insurance information for both payers. You may view, edit and add insurance information for both prior/primary payers and secondary/destination payers, as shown on the next illustration.

SUPPLEMENT CLAIMS

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121134191	2	CROX		DOODY, HOWDY	M	11/23/1938	09/05/2003	\$95.00

Prior Payer Information	
* Payer ID <input type="text"/>	Payer Name <input type="text"/>
<input type="button" value="Payer Find"/>	
Group Number <input type="text"/>	* Patient Relationship to Insured <input type="text"/>
* Insured Last Name <input type="text"/>	* Insured First Name <input type="text"/>
	Insured Middle Initial <input type="text"/>
* Insured ID <input type="text"/>	* Insured Gender <input type="text"/>
* Insured Date of Birth <input type="text"/>	Insurance Type Code <input type="text"/>
Payer Claim Office Number <input type="text"/>	Group Name <input type="text"/>
Prior Authorization Number <input type="text"/>	Insured Address 1 <input type="text"/>
Insured Address 2 <input type="text"/>	Insured City <input type="text"/>
Insured State <input type="text"/>	Insured Zip <input type="text"/>

The bottom portion of the screen, shown on the next illustration, allows you to enter necessary information for the receiving payer in the event that more data is needed to successfully adjudicate the claim.

Destination Payer Information	
* Payer ID 91114	Payer Name CROX
<input type="button" value="Payer Find"/>	
Group Number BLUE CROW	* Patient Relationship to Insured Self-Patient Is Insured (01)
* Insured Last Name InsLast	* Insured First Name InsFirst
	Insured Middle Initial <input type="text"/>
* Insured ID 491401342	* Insured Gender Male
* Insured Date of Birth 11/23/1938	Insurance Type Code <input type="text"/>
Payer Claim Office Number <input type="text"/>	Group Name <input type="text"/>
Prior Authorization Number <input type="text"/>	Insured Address 1 <input type="text"/>
Insured Address 2 <input type="text"/>	Insured City <input type="text"/>
Insured State <input type="text"/>	Insured Zip <input type="text"/>
<input type="button" value="Save"/>	<input type="button" value="Reset Screen"/>
<input type="button" value="Swap Payers"/>	
Selected Claim List: Claim 2	
Output Format NSF+	

SUPPLEMENT CLAIMS

Payer Search

The **Payer Find** button opens a search screen. You may search by payer name or ID. Both search fields accept partial data entries followed by a wild card character or asterisk (% , *). Neither field is case- sensitive. You may enter upper- or lowercase.

For example:

- A search on "SM*" on the Payer ID will return all payers whose Payer IDs begin with SM.
- A search on "blue*" on the Payer Name will return all Blue Cross and Blue Shield payers.

Swap Payers

The **Swap Payers** button allows you to swap the primary and secondary payers if you notice they are reversed in the supplemental claim screens. This feature is also helpful if you wish to form a secondary claim using data from the original, primary claim.

You can determine if the payers are reversed on the supplemental claims screens by examining the Explanation of Benefits or ERA. The primary payer would be the one who created the ERA as they paid first. If the payer who created the ERA appears in the destination payer field, then it needs to be reversed since that payer has already made payments on the claim.

In this case, swapping the prior and destination payers ensures the claim is directed to the correct payer and the payment information is associated with the correct payer.

5.7.4 Ambulance Data

If you submit ambulance claims using the 1500 form, the Ambulance Data screen allows you to supplement primary and secondary claims with ambulance information.

After selecting a claim and identifying the claim service lines that pertain to ambulance data, detailed information may be added using the Ambulance Data entry screen.

SUPPLEMENT CLAIMS

Batch Name	Claim #	Destination Payer	Prior Payer	Patient Name	Gender	Date of Birth	Claim Date	Claim Total
tes4110707121134191	2	CROXX		WALKER, JAY	M	11/23/1938	09/05/2003	\$95.00

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Ambulance Data Applied
1	09/04/2003 - 09/04/2003	99213	25	\$50.00	1	
2	09/04/2003 - 09/04/2003	92020		\$45.00	1	

Line Level Entries

Apply Adjustments to Line Number:

Ambulance Data

Patient Weight:

Bed Confined Before:

Unconscious/Shock:

Visible Hemorrhaging:

Medically Necessary:

Purpose of Stretcher:

Services Available:

Hospital Admit:

Bed Confined After:

Emergency Situation:

* Miles:

Patient Discharged:

* Type of Transport:

Moved by Stretcher:

Physical Restraints:

* Transported TO/FOR:

Purpose of Round Trip:

Patient Admitted:

Selected Claim List: Claim 1

Output Format NSF+

The data on this screen can be updated independently or in conjunction with primary payer data or secondary claim data. Any available data from the input file pre-populates the Ambulance Data fields.

5.8 4010 Claims*

***Note:** Instructions pertaining to 4010 also apply to 5010.

This section applies to 4010 claims only (see note). If you work with another type of claim, refer to **NSF 2.5 Claims** on page 53 or **NSF+ Claims** on page 60.

The 4010 claims output format is similar to NSF+, but it has several enhancements. Refer to the **NSF+ Claims** section beginning on page 44 for explanations of Claim Summary, Claim Level Entries, and Insurance Information. Below are details concerning the screens and features that have been enhanced or added.

Note: Extraction of the instructions for NSF+ if done needs to be done carefully so as not to delete the parts that pertain to and must be included in 4010.

5.8.1 Provider Data

The functionality of the Provider Data screen is similar to that of NSF 2.5, but with 4010/5010, there are additional controls that prevent you from entering conflicting

SUPPLEMENT CLAIMS

information or information for which sufficient supporting data does not exist in the original claim.

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrzi02262010093717.	1					\$600.00
Claim Level Data						
Billing Provider:	*Tax ID 4		*Tax ID Type: SSN	Medicare #	UPIN/USIN #	
	Medicaid #		Champus # GP-0001	BCBS #	Commerical #	
	NPI		State License #	Specialty 000	<input type="button" value="Specialty Find"/>	
Rendering Provider:	Billing is the same as Rendering Provider					
Supervising Provider:	Supervising Id		NPI			
Facility/Lab:	Facility/Lab Id SF00001		NPI			
Referring Provider:	Referring Prov #		ID Type: --Select--	NPI	Network ID:	
<input type="button" value="Save"/> <input type="button" value="Reset Page"/>						
Line Level Data						
Showing lines 1 to 6:						
1	<input type="button" value="Copy to remaining lines"/>					
2	<input type="button" value="Copy to remaining lines"/>					
3	<input type="button" value="Copy to remaining lines"/>					
4	<input type="button" value="Copy to remaining lines"/>					
5	<input type="button" value="Copy to remaining lines"/>					
6	<input type="button" value="Copy to remaining lines"/>					
Showing lines 1 to 6:						
<input type="button" value="Save"/> <input type="button" value="Reset Page"/>						
Selected Claim List: Claim 1						
Output Format 4010						

You can edit all fields except for the **Tax ID** for the Billing Provider. When the billing provider is the same as the rendering provider, the Billing Provider fields will appear, but the Rendering Provider fields will not. Instead, the following phrase will appear in the Rendering Provider section: "Billing is the same as Rendering Provider" (see above).

The Provider Data screen will only display fields for the providers or provider types that were present on the claim that was entered originally. For example, if the original claim did not contain a service facility provider/provider identifier, the fields corresponding to service facility provider will be absent from the Provider Data screen.

5.8.2 Patient Data

Patient Data is a new screen for 4010/5010. Enter identifying information about the patient here.

SUPPLEMENT CLAIMS

Batch Name	Claim #	Destination Payer	Patient Name	Date of Birth	Claim Date	Claim Total
wrcz02192010141212	1	Cigna	WILLIAMS	1991		\$100.00

* Patient Last Name WILLIAMS	* Patient First Name STACY	Patient Middle Initial H	Patient Generation
Patient ID ID12345	Patient Gender Female	* Patient Date of Birth 01/01/1991	
* Patient Address 1 123 MAIN ST			
Patient Address 2			
* Patient City ANYTOWN	* Patient State Tennessee (TN)	* Patient Zip 37996	

Selected Claim List: Claim 1

Output Format 4010

Note: The Patient Data screen is only active when the **Patient Relationship to Insured** field is a value other than **Self-Patient Is Insured (01)** for the Destination Payer on the Insurance Information screen.

Destination Payer Information	
* Payer ID [Field]	Payer Name [Field]
Group Number [Field]	* Patient Relationship to Insured Employee (08)
* Insured Last Name Williams	--Select-- Self-Patient Is Insured (01) Spouse (02) Natural child/insured has financial responsibility (03) Natural child/insured has no financial responsibility (04) Stepson or Stepdaughter (05) Foster Child (06) Ward of Court (07) Employee (08)
* Insured ID [Field]	Insured Middle Initial [Field]
* Insured Date of Birth [Field]	
Payer Claim Office Number [Field]	
Prior Authorization Number [Field]	
Insured Address 2 [Field]	
Insured State Tennessee (TN)	

Selected Claim List: Claim 1

Output Format 4010

5.8.3 Ambulance Data

The 4010 Ambulance Data screen functions similarly to that of NSF+: you can add ambulance data to both primary and secondary claims, and available data pre-populates the appropriate fields (see **Ambulance Data** on page 71). However, with 4010 (and with 5010), you have the ability to add claim level ambulance data as well as line level ambulance data. Entering ambulance information at the claim level negates the need for

SUPPLEMENT CLAIMS

you to include it for each service line when there are no differences to report at the line level.

Batch List | Claim List | Claim Summary | **Claim Level Entries** | Line Level Entries | Insurance Information | Provider Data | Patient Data | **Ambulance Data**

Batch Name wrzi02262010093717. **Claim #** 1 **Destination Payer** ██████████ **Patient Name** WILLIAMS **Date of Birth** 07/15/1990 **Claim Date** **Claim Total** \$600.00

Ambulance Data Claim Level

Patient Weight: Hospital Admit: --Select-- *Type of Transport: --Select--
 Bed Confined Before: --Select-- Bed Confined After: --Select-- Moved by Stretcher: --Select--
 Unconscious/Shock: --Select-- Emergency Situation: --Select-- Physical Restraints: --Select--
 Visible Hemorrhaging: --Select-- *Transported TO/FOR: --Select--
 Medically Necessary: --Select-- *Miles: Purpose of Round Trip:
 Purpose of Stretcher: Patient Discharged: --Select-- Patient Admitted: --Select--
 Services Available: --Select--

Service Line	Service Dates From - Through	Procedure Code	Procedure Modifiers	Amount	Units	Ambulance Data Applied
1	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
2	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
3	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
4	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
5	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	
6	01/01/2010 - 11/01/2010	9923	01 02 03 04	\$100.00	1.0	

Line Level Entries If different from Claim Level

Apply Adjustments to Line Number:

Ambulance Data

Patient Weight: Hospital Admit: --Select-- *Type of Transport: --Select--
 Bed Confined Before: --Select-- Bed Confined After: --Select-- Moved by Stretcher: --Select--
 Unconscious/Shock: --Select-- Emergency Situation: --Select-- Physical Restraints: --Select--
 Visible Hemorrhaging: --Select-- *Transported TO/FOR: --Select--
 Medically Necessary: --Select-- *Miles: Purpose of Round Trip:
 Purpose of Stretcher: Patient Discharged: --Select-- Patient Admitted: --Select--
 Services Available: --Select--

Selected Claim List: Claim 1

Output Format 4010

5.8.4 Sample Error Messages

The following are sample error messages that may appear when sending a batch of claims that have errors in any supplemental data entered.

Sample NSF2.5 Error Message:

SUPPLEMENT CLAIMS

Batch nsf10412651230rst_7 has missing information.
Please correct supplemented information before attempting send again.

Claim #	Patient Name	Claim Date	Claim Total
1	JANE DOE	09/05/2003	500.00
Adjudication Date	08/28/2006		
Payer Amount Paid	200.00		
Insured Last Name	Missing Insured Last Name		
Insured First Name	Missing Insured First Name		
Insured ID	Missing Insured ID		
Insured Gender	Missing Insured Gender		
Insured Date of Birth	Missing Insured Date of Birth		
Disallowed Cost	0.00		
Disallowed Other	0.00		
Deductible	0.00		
Coinsurance	0.00		
Payment	0.00		
Total payments (0.00) does not match payer amount paid (200.00)			
Service line 0: The charge amount (10.00) does not match the sum of supplied supplemental amounts (0.00).			
Service line 1: The charge amount (15.00) does not match the sum of supplied supplemental amounts (0.00).			
Service line 2: The charge amount (10.00) does not match the sum of supplied supplemental amounts (0.00).			
Service line 3: The charge amount (15.00) does not match the sum of supplied supplemental amounts (0.00).			
Service line 4: The charge amount (10.00) does not match the sum of supplied supplemental amounts (0.00).			
Service line 5: The charge amount (15.00) does not match the sum of supplied supplemental amounts (0.00).			

Sample NSF+ Error Message:

Batch nsf10412651230rst_7 has missing information.
Please correct supplemented information before attempting send again.

Claim #	Patient Name	Claim Date	Claim Total
1	JANE DOE	09/05/2003	500.00
Adjudication Date	08/28/2006		
Payer Amount Paid	200.00		
Insured Last Name	Missing Insured Last Name		
Insured First Name	Missing Insured First Name		
Insured ID	Missing Insured ID		
Insured Gender	Missing Insured Gender		
Insured Date of Birth	Missing Insured Date of Birth		
Disallowed Cost	0.00		
Disallowed Other	0.00		
Deductible	0.00		
Coinsurance	0.00		
Payment	0.00		

SUPPLEMENT CLAIMS

Sample 4010 Error Message:

Batch wrz02262010141577. has missing information. Please correct supplemented information before attempting send again.	
Claim #	1
Patient Name	DOE JANE
Claim Date	
Claim Total	\$100.00
Adjudication Date	04/07/2010
Payer Amount Paid	\$50.00
Total Adjustments	\$0.00
Payer amount paid plus adjustments not equal to claim total	
Prior Payer ID	Missing Payer ID
Prior Patient Relationship to Insured	Missing Patient Relationship To Insured
Prior Insured ID	Missing Insured ID
Prior Insured Gender	Missing Insured Gender
Prior Insured Date of Birth	Missing Insured Date of Birth

5.8.5 Abbreviations Used in Remittance Advice Notices

To save space, a number of abbreviations are used in a remittance advice. The following table is included as a reference.

Abbreviation	Description
PT RESP	Patient Responsibility. Includes total coinsurance, deductible, non-covered services, and psychiatric limitation.
PERF PROV	Performing Provider Number
SERV DATE	Date of Service
POS	Place of Service
NOS	Number of Services
PROC	Procedure Code
MODS	Modifiers. Modifiers are two-digit codes appended to procedure codes and/or HCPCS codes, to provide additional information about the billed procedure. In some cases, addition of a modifier may directly affect payment.
BILLED	Billed Amount
ALLOWED	Allowed Amount (prior to deductions or offsets)
DEDUCT	Deductible Due (amounts applied to patient's deductible will appear here)
COINS	Coinsurance Due (patient's 20%)
PROV PD	Amount Paid to Provider (prior to adjustments)
RC AMOUNT	Reason Code other than deductible and coinsurance. If more than one, additional adjustment codes will appear on the next line.
HIC	Medicare Health Insurance Claim number (patient's "Medicare Number")
ACNT	Patient account number assigned by the provider
ICN	Internal Control Number (also known as DCN)
ASG	Whether assignment accepted (Y = yes or N = no)
MOA	Medicare Outpatient Adjudication Remark Code. For a complete list of MOA codes click Search, and on the search screen enter a wild card in the Remark Code field (* or %) and click Search.
REM	Remark Codes
NET	The amount paid for the claim after adjustments
ADJS	Adjustments

SUPPLEMENT CLAIMS

The following abbreviations appear as adjustments:

Abbreviation	Description
PREV PD	Amounts previously paid on this claim will appear here
PD TO BENE	Amounts collected over the co-pay will appear here (This amount will be paid to the patient for this claim)
INT	Interest
MSP	Medicare Secondary Payer (Amount paid by insurer primary to Medicare)
OTHER	Other claim level adjustments that apply
FCN	Financial control number of prior claim(s) that contributed to the overpayment or that explains the reason for the offset
BF	Balance Forward (This applies to suppressed checks for less than \$1.00.)

5.9 Troubleshooting Guide

The following table lists common issues and error messages you may encounter when working with Supplement Claims.

Problem/Scenario	Possible Causes	Action Required
A batch has been indicated as needing to be held for entry of prior payment data accidentally (i.e. to send the batch without entering any supplemental data).	N/A	Proceed to the Supplement Claims function and select Send from the batch list. Note: If you entered the claim using the Claim Entry feature, remove the "Sup*" indicator in the remarks field before attempting to send.
You forgot to indicate that claims needed to be held for the entry of prior payment information.	N/A	Re-upload the batch indicating that the batch contains claims requiring supplemental information. Note: Any unaffected claims may result in rejections at the clearinghouse for duplicate claim.
You would like to use the Supplement Claims feature but receive email notification upon upload that a supplemental batch was received, and if your submission was unintentional resubmit or if the submission was intentional please contact Customer Support.	You have not been set up to take advantage of the Secondary Claims feature. You are not eligible to be set up as a Secondary Claims user (due to the input format of your data).	Contact customer service to determine if you have an eligible set up to take advantage of the Secondary Claims feature. If you have an eligible set up to take advantage of the Secondary Claims feature, Customer Support can perform the necessary activation of the feature.
You receive email notification that a batch is over 4 days old.	You have uploaded the batch indicating it as needing to be supplemented but the necessary steps to complete submission are not finished.	Proceed to the Supplement Claims function at which point you can supplement, send, or delete the batch.

SUPPLEMENT CLAIMS

Problem/Scenario	Possible Causes	Action Required
You have selected a batch under the Supplement Claims feature but are unable to select and supplement a particular claim.	The secondary payer may not be able to receive secondary claims electronically. There are multiple errors associated with the original claim data.	If the description under the Payer Name reads Non EDI Payer, the payer is unable to receive secondary claims and the user will be unable to supplement. If the description reads otherwise, please contact Customer Support for assistance with the claim errors.
You have selected a claim to supplement and the destination and prior payer are presented in reverse order.	There is a variance in your software and the order in which it provides payer information.	Use the "Swap Payers" function to properly set the destination and prior payers.
A batch of claims no longer appears under the Batch List in the Supplement Claims function.	You have either sent or deleted the batch.	If the batch was deleted and needs to be sent, re-enter the batch. If the batch was sent, confirm with other users at your site that the desired entries were made prior to sending the batch.
After sending the batch under the Supplement Claim function you receive subsequent reject notifications.	N/A	Correct the errors, re-load the batch, and re-enter any applicable supplemental information.
You receive a message that a batch is in use by another user.	Only one user can access a given batch at a time under the Supplement Claims feature.	Wait for the other user to release the batch.

6 Report

6.1 Overview

This section contains information on the text-readable reports generated from the processing system and returned to the submitter’s application email. Understanding these reports will provide a submitter the necessary knowledge to effectively manage their electronic claims. While each report displays unique and specific claims information, the following information and features are common to all reports referenced in this section:

- All reports must be requested through a representative.
- All reports are 80 characters wide and 60 lines long.
- All reports are formatted as ASCII-text and should be printed using a text-capable program. Wrapping of text may occur; therefore, it is important to establish the correct text size through your computer.

6.2 Provider Reports

The following table is a brief overview of the reports available for providers. An example of each report is included along with field description information. We recommend that you use the **Reporting & Analytics** (page 88) solution for claim status information in place of these reports. Turn on or turn off the delivery of some or all of these reports by clicking **Setup > My Account**; detailed information about changing your report delivery options can be found in the General User Guide.

Report #	Report Title	Timing*	Purpose of the Report
RPT-00	Customer Service Alert	Daily – Alerts for the business day	Provides a complete listing of all batch system Customer Service Alerts, CSAs, for the business day. The report does not contain real-time Customer Service Alerts. Depending upon the vendor’s preferences, the RPT-00 can be for vendors only or for vendors and providers. There is no preference to add or remove RPT-00, only a vendor option to indicate if the provider is to receive the CSA in addition to the Vendor.

REPORT

Report #	Report Title	Timing*	Purpose of the Report
RPT-02	File Status Report	Within 4 hours of time file submitted	Provides an initial analysis of the file, by displaying file status of accepted or rejected and a description of the status. It also indicates the total number of claims and \$ value if the file contains valid claims. The RPT-02 report is generated within a few hours after the file has been received from the clearinghouse. In order for the RPT-02 to be generated, a submitter's transmitted file must be received and opened by the clearinghouse with the file's Summary record residing in the Repository database. There is no sorting of information within the report.
RPT-03	File Summary Report	Within 48 hours of time file submitted	Provides summarized information on the quantity of accepted and rejected claims, as well as the total number of claims received for each submitted file. In order for the RPT-03 to generate, all claims contained within the submitter's file need to be processed and contain status record information. There is no sorting of information within the report.
RPT-04	File Detail Summary Report	Within 48 hours of time file submitted	Contains a detail summary of the file submitted for processing. It provides a file roll-up listing all accepted and rejected claims contained in each file submitted. It also contains payer name/id and status of claim. In order for the RPT-04 to generate, all claims contained within the submitter's file need to be processed and contain status record information. Information is sorted by user name and then by Patient (Last Name, First Initial, Middle Initial).
RPT-04A	Amended File Detail Summary Report	Daily – includes claims with an amended status within the last 24 hours	Contains a detailed listing of all claims for which the status was amended during the previous processing day. Claim statuses are amended when a pending claim is processed and/or when a claim is reprocessed at clearinghouse. It also contains payer name/id and amended status of the claim. Information is sorted by user name and then by Patient (Last Name, First Initial, Middle Initial).
RPT-05	Batch and Claim Level Rejection Report	Within 48 hours of time file submitted	Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05 report must be reviewed and worked after each file transmission. Claims that are listed as rejected are not forwarded to the payer(s) for processing. These rejected claims must be corrected and re-submitted (either electronically or on paper) for processing. In order for the RPT-05 to generate, all claims contained within the submitter's file need to be processed and contain status record information. Information is sorted by user name and then by Patient (Last Name, First Initial, Middle Initial).
RPT-05A	Amended Batch and Claim Level Rejection Report	Daily – includes claims with an amended status within the last 24 hours	Contains rejected batches and claims listed with detailed error explanations. In order to prevent "lost" claims, the RPT-05A report must be reviewed and worked after each file transmission. Claims that are listed as rejected are not forwarded to the payer(s) for processing. These rejected claims must be corrected and re-submitted (either electronically or on paper) for processing. In order for the RPT-05 to generate, all claims contained within the submitter's file need to be processed and contain status record information. Information is sorted by user name and then by Patient (Last Name, First Initial, Middle Initial).

REPORT

Report #	Report Title	Timing*	Purpose of the Report
RPT-08	Provider Monthly Summary	Monthly – by the 5 th calendar day	Displays the number and \$ value of claims accepted and forwarded by clearinghouse for the month. Monthly and Y-T-D Totals for both accepted and rejected claims are included as well as the provider's top 25 errors for the month. Information is sorted by user ID, Payer, and Error Frequency. Y-T-D totals include data for claims processed by Emdeon beginning September 1 st , 2001.
RPT-10	Provider Claim Status Report	Daily – includes payer status updates received in the last 24 hours	Contains information provided by payers who receive claims from Emdeon for adjudication. Not all payers who receive claims from clearinghouse provide information for this Claim Status Report, and the amount/frequency of information produced will vary from payer to payer. The RPT-10 does not return Unprocessed, Request for Additional Information, or Rejected statuses. This report is generated daily for each submitter for payer status updates received within the previous 24 hours. Information is sorted by user ID, Status, and then by Payer.
RPT-11	Special Handling/ Unprocessed Claims Report	Daily – includes payer status updates received in the last 24 hours	Contains information provided by payers who receive claims from clearinghouse for adjudication. Not all payers who receive claims from clearinghouse provide information for this report, and the amount/frequency of information produced will vary from payer to payer. The RPT-11 returns Unprocessed, Request for Additional Information, and Rejected Statuses only. This report is generated daily for each submitter for payer status updates received within the previous 24 hours.

Note: **Daily** reports are generated on a daily basis assuming that the submitter is part of a Submitter Report Group that receives the report and if the submitter has had claims volume with the report's specific parameters at clearinghouse in a given day. **Next Business Day** reports are generated on a next business day basis assuming that the submitter is part of a Submitter Report Group that receives the report and if the submitter has had claims volume with the report's specific parameters at clearinghouse in a given timeframe. **Monthly** reports are generated on a monthly basis assuming that the submitter is part of a Submitter Report Group that receives the report and if the submitter has had claims volume with the report's specific parameters at clearinghouse in a given month.

6.2.1 Report Details - Field Definitions

RPT-00 (Customer Service Alerts)

Report Field Name	Description
Report Date	The date the report was generated by clearinghouse.
Report #	The clearinghouse report number
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID	The identifier used by clearinghouse to identify the user.
Customer Name	The name of the customer

REPORT

Report Field Name	Description
SUBJECT: Subject Date Line of Business	The subject of the Customer Service Alert Announcement date The line of business affected
PAYER and TOPIC: Payers Topic	The payers affected by the announcement A brief text describing the announcement
RESOLUTION STATUS	The current status of the issue
ACTION REQUIRED by CUSTOMER and CLEARINGHOUSE: Required by customer Required by clearinghouse	The specific actions requested. The steps to resolve the issue.
CSA ID and PRODUCTION ISSUE NUMBER: CSA ID Production Issue Number	The ID number associated with this Customer Service Alert The associated clearinghouse production issue ticket for this Customer Service Alert

RPT-02 (File Status Report)

Report Field Name	Description
Date/Time	The date/time the claims file was processed by clearinghouse. Format is MM/DD/YY-HH:MM:SS
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
File Control #	Control number assigned to the file by the originator of the submitted transaction
Submitter Filename	The file name assigned by the submitter
Ref	The tracking number assigned by the clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
File Status	Indicates if the claims batch was ACCEPTED or REJECTED

REPORT

Report Field Name	Description
STATUS	A description of the submitter's batch file status being processed by the system. For example, a status could be a duplicate file, unknown submitter, incomplete file, accepted file but stopped during processing, etc.
File Totals: CLAIMS RCVD \$ VALUE	The number of claims received in the file. The dollar value of the claims contained in the received file.
DISCLAIMER	Text message explaining that the report is a file level acknowledgement and that it does not guarantee acceptance of the submitter's claims.

RPT-03 (File Summary Report)

Report Field Name	Description
Run Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
File Control #	Control number assigned to the file by the originator of the submitted transaction
Ref	The tracking number assigned by the clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
FILE TOTALS: CLAIMS INPUT NUMBER \$ VALUE	The total number of claims contained in the submitted claims file The total monetary value of the claims contained in the submitted claims file
TRANS TYPE: Electronic Paper Totals	Indicates that the claim was transmitted electronically Indicates that the claim was transmitted on paper Indicates the total number of claims submitted
CLAIMS ACCEPTED	The number (NUMBER) and \$ value (\$ VALUE) of the claims accepted in the file submitted
CLAIMS REJECTED	The number (NUMBER) and \$ value (\$ VALUE) of the claims rejected in the file submitted

RPT-04 (File Detail Summary Report)

Report Field Name	Description
Run Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
File Control #	Control number assigned to the file by the originator of the submitted transaction
Ref	The tracking number assigned by the clearinghouse to identify the file. This value can be used for referencing purposes.

REPORT

Report Field Name	Description
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
DISCLAIMER	Text message explaining that the report is for status information only
Customer ID/Sub	The ID and Sub ID to identify the user
Customer Name	The name of the user
FILE ROLL-UP: Patient Name Patient Control # Date of Service Total Charges Payer Name/ID Status	The name of the patient on the claim. This includes last name, first initial, and middle initial. The unique identifier assigned by the provider identifying the patient The date the services were rendered. This is the "From" date. The total \$ amount of the claim The name and ID of the payer Shows the status of the claim. For example, AE, AP, RE, RP, TE. See the Status Key Legend field description below.
Status Key Legend	Describes each status acronym AE - Accepted claim sent out electronically AP - Accepted claim sent out on paper RE - Electronic claim rejected by clearinghouse RP - Paper claim rejected by clearinghouse TE - Electronic test claim

RPT-04A (Amended File Detail Summary Report)

Report Field Name	Description
Run Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
File Control #	Control number assigned to the file by the originator of the submitted transaction
Ref	The tracking number assigned by the clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
DISCLAIMER	Text message explaining that the report is for status information only
Customer ID/Sub	The ID and Sub ID used to identify the user
Customer Name	The name of the user
FILE ROLL-UP: Patient Name Patient Control # Date of Service Total Charges	The name of the patient on the claim. This includes last name, first initial, and middle initial. The unique identifier assigned by the provider identifying the patient The date the services were rendered. This is the "From" date. The total \$ amount of the claim The name and ID of the payer

REPORT

Report Field Name	Description
Payer Name/ID Status	Shows the status of the claim. For example, AE, AP, RE, RP, TE. See the Status Key Legend field description.
Status Key Legend	Describes each status acronym. AE - Accepted claim sent out electronically AP - Accepted claim sent out on paper RE - Electronic claim rejected by clearinghouse RP - Paper claim rejected by clearinghouse TE - Electronic test claim

RPT-05 (Batch & Claim Level Rejection Report)

Report Field Name	Description
Run Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
File Control #	Control number assigned to the file by the originator of the submitted transaction
Ref	The tracking number assigned by the clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID and Sub ID used to identify user
Customer Name	The name of the user
ERROR LISTING: Patient Name Patient Ctrl # Claim ID DOS Charges Payer Name/ID ERROR MESSAGE FLD SEQ Field Name Data in Error	The name of the patient on the claim. This includes last name, first initial, and middle initial. The unique identifier assigned by the provider identifying the patient The unique claim identifier assigned by clearinghouse The date from which the services were started (rendered) for the patient. This is also known as the "From" date. The total amount of the claim The name of the payer and the identifier assigned by clearinghouse. The description of the error The field containing the data in error The sequence number of the field containing the data in error The name of the field containing the data that is in error The data causing the error in the claim. The actual data that is in error will display on the report.

REPORT

RPT-05A (Amended Batch & Claim Level Rejection Report)

Report Field Name	Description
Run Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
File Control #	Control number assigned to the file by the originator of the submitted transaction
Ref	The tracking number assigned by the clearinghouse to identify the file. This value can be used for referencing purposes.
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID and Sub ID used to identify user
Customer Name	The name of the user
ERROR LISTING: Patient Name Patient Ctrl # Claim ID DOS Charges Payer Name/ID ERROR MESSAGE FLD SEQ Field Name Data in Error	The name of the patient on the claim. This includes last name, first initial, and middle initial. The unique identifier assigned by the provider identifying the patient The unique claim identifier assigned by clearinghouse The date from which the services were started (rendered) for the patient. This is also known as the "From" date. The total amount of the claim The name of the payer and the identifier assigned by clearinghouse. The description of the error The field containing the data in error The sequence number of the field containing the data in error The name of the field containing the data that is in error The data causing the error in the claim. The actual data that is in error will display on the report.

REPORT

RPT-08 (Provider Monthly Summary)

Report Field Name	Description
Report Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
Month Ending	The month for which this summary was generated
Customer ID/Sub	The ID/Sub ID to identify the user
Customer Name	The name of the user.
CARRIER OUTPUT CLAIMS: CARRIER	The name of the payer where the claims were forwarded by clearinghouse to the payer for the month
CLAIMS	The number of claims forwarded by clearinghouse to the payer for the month
%	The percentage of total claims forwarded by clearinghouse to the payer for the month
\$ VALUE	The \$ amount forwarded by clearinghouse to the payer for claims submitted by the provider for the month
PROVIDER TOTAL INPUT CLAIMS: Totals	The monthly provider totals of the number of claims, percentage, and values categorized by CLMS INPUT, CLMS ACCEPTED, and CLMS REJECTED
Mthly	
Y-T-D*	The year-to-date provider totals of the number of claims, percentage, and values categorized by CLMS INPUT, CLMS ACCEPTED, and CLMS REJECTED
TOP 25 ERRORS:	
Field	The field containing the data in error
Field Name	The name of the field
Error	containing the data in error
Total	The description of the error
	The total number of claims that contained that error for the month

Note: Y-T-D totals include data for claims processed by clearinghouse beginning September 1st, 2001.

REPORT

RPT-10 (Provider Claim Status)

Report Field Name	Description
Report Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number
Acct ID	The submitter's login/account ID assigned by clearinghouse
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID/Sub ID to identify the user
Customer Name	The name of the user
DISCLAIMER	Text message explaining that the report is generated if information is available from the payer(s)
CLAIM STATUS: Status Provider ID Insured ID Patient Pat. Ctrl # Total Charges Amount Paid DOS Status Data Payer Name Payer ID Payer Phone Payer Ref Payer Status Date clearinghouse Process Date clearinghouse Claim ID	Indicates the status of the claim and the reason for the status. These status codes could be payer proprietary codes, ANSI defined codes, or clearinghouse-defined codes for the payer(s). The provider number assigned to the provider by the payer. It could be a unique ID or a tax ID for commercial payers. The ID of the insured The name of the patient The unique identifier assigned by the provider identifying the patient The total amount of charges for the claim The payment amount that will be made for the claim by the payer The beginning and ending date for the services rendered that the claim is covering Data referenced by status message The name of the payer providing status The electronic ID of the payer providing status The phone number the payer would like the provider to use to make inquiries The unique payer-assigned number to the claim The date the status was generated by the payer The date clearinghouse processed the claim The unique claim identifier assigned by clearinghouse

RPT-11 (Special Handling/Unprocessed Claims Report)

Report Field Name	Description
Report Date	The date the report was generated by clearinghouse
Report #	The clearinghouse report number

REPORT

Report Field Name	Description
Acct ID	The submitter's login/account ID assigned by clearinghouse
Submitter ID	The identifier used by clearinghouse to identify the submitter. A submitter is the entity submitting the file, which could be a provider, vendor, billing service, or clearinghouse.
Submitter Name	The name of the submitter
Customer ID/Sub	The ID/Sub ID to identify the user
Customer Name	The name of the user
DISCLAIMER	Text message explaining that the report is generated if information is available from the payer(s)
CLAIM STATUS: Status Provider ID Insured ID Patient Pat. Ctrl # Total Charge Amount Paid DOS Payer Name Payer ID Payer Phone Payer Ref Payer Status Date clearinghouse Process Date clearinghouse Claim ID	<p>Indicates the status of the claim and the reason for the status. These status codes could be payer proprietary codes, ANSI defined codes, or clearinghouse-defined codes for the payer(s).</p> <p>The provider number assigned to the provider by the payer. It could be a unique ID or a tax ID for commercial payers.</p> <p>The ID of the insured The name of the patient</p> <p>The unique identifier assigned by the provider identifying the patient The total amount of charges for the claim</p> <p>The payment amount that will be made for the claim by the payer</p> <p>The beginning and ending date for the services rendered that the claim is covering The name of the payer providing status</p> <p>The electronic ID of the payer providing status</p> <p>The phone number the payer would like the provider to use to make inquiries The unique payer-assigned number to the claim</p> <p>The date the status was generated by the payer</p> <p>The date clearinghouse processed the claim</p> <p>The unique claim identifier assigned by clearinghouse</p>

7 Reporting & Analytics

7.1 Introduction

When your practice or site submits claims to the clearinghouse, all claim data per regulatory guidelines are retained and archived. Through a secure, web-based portal, Reporting & Analytics gives you quick online access and detailed views of the previous 15 months of your claims data. Reporting & Analytics enables you to customize and submit several claim search options that focus on data specific to a patient, payer, or a patient claim status. These options are designed to provide you with the type of summary or detailed information you need to do the following:

- Track claims through their life cycle from first submission through payment
- Monitor progress according to claim status
- Identify claims that need rework, or that have been reworked
- Evaluate trends to make needed adjustments to claims administration
- Expedite claims payment

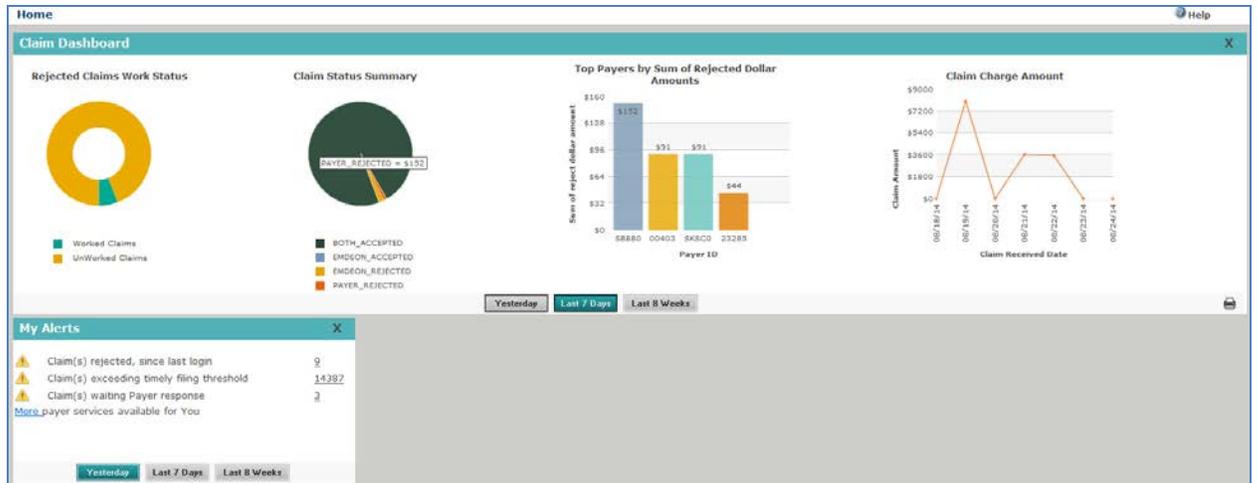
Note: All confidential data has been obscured in the following images.

7.2 Fundamentals

7.2.1 Access Reporting & Analytics

When you access Reporting & Analytics by selecting **Claims > Reporting & Analytics**, the Reporting & Analytics home page will appear. This screen provides the launching point for initiating search queries and other product functions.

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Use Search Date Ranges

To optimize system performance, use a date range of seven days or less, if possible. For selected searches, you can select either **Claim Received Date** or **Service Date**. If the date fields are left blank, Reporting & Analytics will set the date range to the previous seven days by default.

7.2.2 Limit a Search

When you perform a higher-level (summary) search, Reporting & Analytics displays the first 1,000 rows of data that match your specified search criteria.

If any search returns more than 1,000 rows of data, Reporting & Analytics displays a message to indicate that there are more items in the database that match your search criteria than can be displayed. If you see this message and have not found the data you want, return to the Search screen and re-enter your search with more restrictive criteria. (For example, consider using a more narrow date range.)

7.2.3 Filter a Search by Tax ID or Site ID

Searching against a specific Tax ID or Site ID is especially helpful for:

- Limiting search results to a specific provider or specialty area within a practice (by using the associated Tax ID as search criteria).
- Limiting search results to a specific practice site for providers using multiple site ids for claims submission.

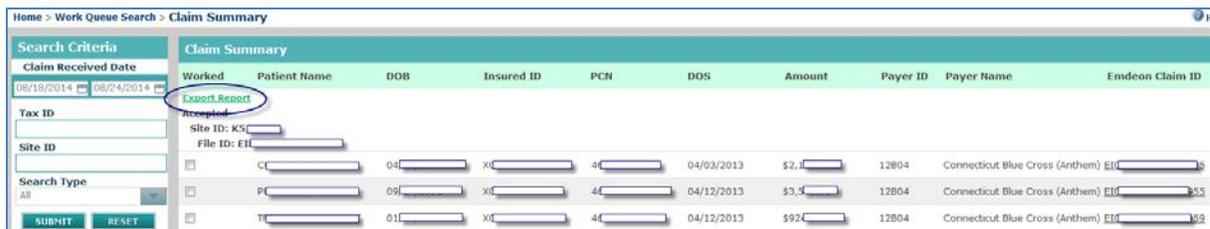
REPORTING & ANALYTICS

7.2.4 Use Claim Quick Search

There are no date range options in Quick Search. A 30-day date range is used by default. For detailed information about this search, see **Claim Quick Search** on page 107.

7.2.5 Export Entire Report

To view all rows of a report with more than 1,000 rows, you can export the report to a Microsoft Excel spreadsheet (.XLS). Click the “Export Entire Report” link located at the upper left of the report. The link is available only when a report exceeds 1,000 rows.



The screenshot shows a web application interface for a 'Claim Summary' report. On the left, there is a 'Search Criteria' panel with fields for 'Claim Received Date' (08/19/2014 to 08/24/2014), 'Tax ID', 'Site ID', and 'Search Type' (All). Below these are 'SUBMIT' and 'RESET' buttons. The main area displays a table with columns: 'Worked', 'Patient Name', 'DOB', 'Insured ID', 'PCN', 'DOS', 'Amount', 'Payer ID', 'Payer Name', and 'Emdeon Claim ID'. The 'Worked' column contains checkboxes. The 'Export Report' link is circled in the top left of the table area. The table contains three rows of data:

Worked	Patient Name	DOB	Insured ID	PCN	DOS	Amount	Payer ID	Payer Name	Emdeon Claim ID
<input type="checkbox"/>	CI	04	XI	4	04/03/2013	\$2,1	12804	Connecticut Blue Cross (Anthem) EID	58
<input type="checkbox"/>	PI	09	XI	4	04/12/2013	\$3,3	12804	Connecticut Blue Cross (Anthem) EID	55
<input type="checkbox"/>	TI	01	XI	4	04/12/2013	\$92	12804	Connecticut Blue Cross (Anthem) EID	59

This feature works for the following reports:

- Claim Summary
- File Summary Report
- Summary by Payer ID by Day
- Summary by Payer ID
- Insured Detail Report

7.2.6 Set User Preferences

User preferences allow you to set up a default search or system action (e.g., display dashboards). The default search/action runs automatically upon access to Reporting & Analytics.

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User Preferences are specific to your user ID, i.e., the selections you make are applied to your user ID only. You can choose to display a specific report or multiple “tiles” that contain clickable charts and reports.

Note: The preference selections remain in effect until cancelled.

View a Selected Report

To display a report instead of the dashboard view select a report and report criteria from the Set Preferences>Reports Preference Settings fields. Click **Save** to save your settings.

The screenshot shows the 'Preference Management' interface. At the top, there is a breadcrumb 'Home > Set Preferences' and a teal header 'Preference Management'. Below this is the 'Landing Page Tiles Preference' section, which contains four rows of settings. Each row has a 'Position' label, a dropdown menu for the tile name, and a dropdown menu for the date range. The settings are: Position 1 (My Alerts, Yesterday), Position 2 (Top 5 Claim Rejection Reas, Last 7 Days), Position 3 (Claim Dashboard, Last 8 Weeks), and Position 4 (Top 5 Payers by Unconfirme, Last 7 Days). Below these are 'SAVE' and 'RESET' buttons. The 'Reports Preference Settings' section follows, featuring a dropdown menu labeled 'Select a report instead of landing page tiles : Select' with a blue arrow pointing to it. Below this are input fields for 'Default Tax Id:', 'Default site Id:', 'Number of Rows Per Page:', and 'Default date range: YESTERDAY'. At the bottom are 'SAVE' and 'RESET' buttons.

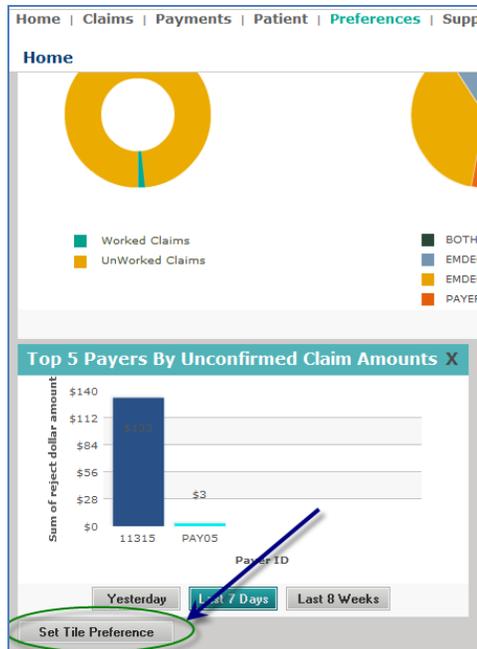
View Tiles

To display the tiles instead of a report, first confirm that no report is selected in the “Select a report instead of landing page tiles” drop-down list. When no selection is made in this list, the Tiles can be selected. Click **Save** to save your selections.

Change Tiles

If your Home Page/Landing Page view is set to “Tiles,” you can change which tiles are displayed by clicking **Set Tile Preference** located at the bottom left of the screen (when Tiles are displayed). Scroll down to access this button.

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Place a check in each checkbox to display those tiles in your Home Page/Landing Page. (See screen below.)

Note: A maximum of 4 tiles can be displayed on the Home Page/Landing Page at one time.

The 'SET TILE PREFERENCE' dialog box contains several tiles with checkboxes:

- My Alerts:** My Alerts. Summary: Claim(s) require attachments (12), Claim(s) waiting Payer response (28), Claim(s) rejected, since last login (2).
- Top 5 Claim Reject Reasons:** Top 5 Claim Rejection Reasons. Summary: Subscriber Primary Identifier: Invalid, Must not equal Subscriber Group or Policy Number (DCEEN: 2), Subscriber Primary Identifier: Invalid, Must be in a valid format for Payer (DCEEN: 1).
- Claims Dashboard:** Claims Dashboard. Summary: Report Date: 08/28/2014, Claim Date Range: 08/28/2014 - 08/28/2014, Top Payers by Total Payered Claim Amount.
- File Summary Status:** File Summary Status. Summary: Summary Date: 08/28/2014.
- Top 5 Payers By Unconfirmed Claim:** Top 5 Payers By Unconfirmed Claim. Summary: Bar chart showing reject amounts for Payer IDs Pay01 through Pay05.
- Payer Service Enrollment Matrix:** Payer Service Enrollment Matrix. Summary: Table with columns Payer Name, Payer ID, ERA, and EFT.

Buttons at the bottom: SAVE, RESET, CLOSE.

Set Up a User Preference (Default) Search

1. Click **Preferences>Set Preferences** in the navigation bar.

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2. Click on the desired search type.
3. Specify your search options (making your changes in each sub-section, as applicable).
4. Click **Save**.

Note: When you next access Reporting & Analytics, your selected search will automatically run (with your saved criteria).

Cancel a User Preference (Default) Search

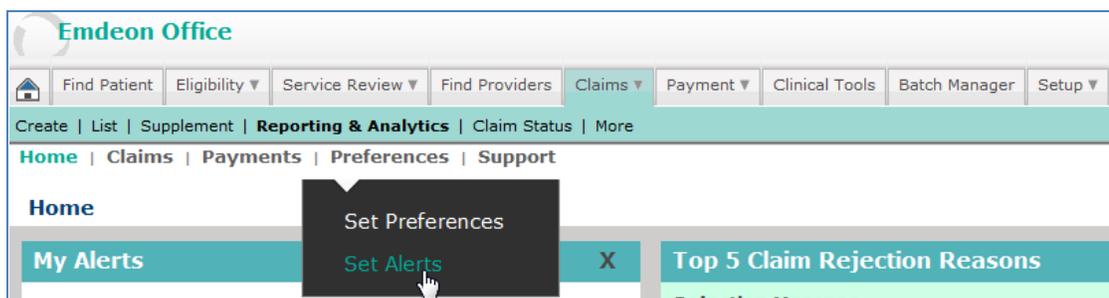
1. When you access Reporting & Analytics, your previously defined default/preferred search runs.
2. To cancel the Preferred Search, click the **Preferences > Set Preferences** tab to access the setup screen.
3. In the Preferences screen click **Reset** to cancel the user preference settings.
4. You can now define a different search preference.

7.2.7 Customizable Alerts

Use Customizable Alerts to stay informed via email when your specified claim rejection amount threshold(s) are exceeded. Alert notifications are sent to the email address on file for your account. To verify or update your existing email address, go to manage users under the Setup tab to search for and edit users. Do not reply to Reporting & Analytics email Alerts.

Note PHI is *not* included in any Alert

Click on Preferences > Set Alerts.



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Customize Your Alerts X

 Alerts should be used in addition to your normal claim management practices in Emdeon Vision. Do not rely only on Alerts to monitor claims at your facility.

Please select your options to get alerts

Alert 1: Select a threshold for individual rejected claims. You will receive an email notification when a single claim that exceeds your specified threshold is rejected.

Select Frequency of alerts

Rejected claim amount exceeds \$500

Rejected claim amount exceeds \$1000

Rejected claim amount exceeds \$2000

Alert 2: Select a threshold for multiple rejected claims. You will receive an email notification when the total amount of rejected, unworked claims exceeds your specified threshold.

Select Frequency of alerts

Total Rejected and Unworked claim amount exceeds \$5000

Total Rejected and Unworked claim amount exceeds \$10,000

Total Rejected and Unworked claim amount exceeds \$20,000

The following alerts have been set:
Rejected Claim Amount exceeds \$1,000 Frequency: Daily
No alerts set for Alert 2

Email Alert Frequency

You can receive email Alerts daily or weekly. Alerts are generated *only* if your selected threshold is reached.

Setup Alerts

1. Click on Preferences>Set Alerts. The Customize Alerts popup window displays.
2. Two types of Alerts are available, individual claim-specific (Alert 1) or combined claims totals (Alert 2).
3. Place a check in the checkbox for the Alert type you want. You can select one Alert type or both.
4. Set the frequency for each Alert by selecting Daily or Weekly for each Alert.
 - ✓ **Weekly Alert** emails are generated every Monday morning at 6am EST and include last 7 days of claims data from claims received between yesterday (Sunday) and the previous Monday.
 - ✓ **Daily Alert** emails are generated at 6am EST every day and include claims data of claims received the previous day.
5. Select monetary Alert level for each Alert type by placing a check in the applicable checkbox. You can select one Alert level per Alert type:
 - Alert 1: Threshold Alert for rejected amounts (in US dollars) for individual claims.
 - ✓ Rejected amount exceeds \$500.
 - ✓ Rejected amount exceeds \$1000.
 - ✓ Rejected amount exceeds \$2000.

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- Alert 2: Threshold Alert for total dollar amounts (in US dollars) for combined rejected and unworked claims.
 - ✓ Rejected amount exceeds \$5,000.
 - ✓ Rejected amount exceeds \$10,000.
 - ✓ Rejected amount exceeds \$20,000.
- 6. Click **Submit** to save your Alert settings.
- 7. After settings are saved, your saved Alerts and their frequency are displayed in a message at the bottom of the Customize Alerts window. This information is always displayed whenever the Alerts window is accessed.
 - ✓ If no Alert is set the following message is displayed: " There are no Alerts set."

7.2.8 Receiving Email Alerts from Reporting & Analytics

Do Not Reply to Alert Email

Email Alerts contain an introductory statement identifying the communication as an Alert from the application. Do not reply to the Alert email.

Alert Email Format - Alert 1

For Alert 1, the message is similar to the following:

- This is an alert regarding your claims. <Number of claims> rejected claims exceed your rejected claim amount alert threshold of <threshold value> per claim. Please login to your account and take any required actions.

Claim rejection information for individual claims (Alert 1) is organized in a table format with the following column headings:

- Claim ID
- Claim Amount
- Rejected by
 - ✓ (Either clearinghouse or payer - If by payer, payer ID is displayed.)
- Rejection Date
- Rejection Reason

The table is limited to ten claims and the sort order is by rejected claim amount.

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Alert Email Format - Alert 2

For Alert 2, the message is similar to the following:

- This is an alert regarding your claims. The total claim amount of your rejected and unworked claims is <value> which exceeds your <threshold value> setting. Please login to your account and take any required actions.

As rejected, unworked claims are “worked” in Reporting & Analytics; these changes should be reflected by this Alert. As rejected, unworked claims are corrected the number of claims causing the stated threshold to be exceeded is reduced, eventually to the point where the threshold is no longer exceeded.

Alert Email Identification

Email address of alerts is *VisionAlerts@emdeon.com*. Please be sure to add this address to your email “acceptable addresses” list so that your alerts do not arrive in your spam inbox.

Note Please do not send emails to this address, or reply to Alert emails.

7.2.9 Use the Worked Claim Feature

A claim can be marked “worked” at the Claim Detail level. This feature is used for claims that require edits or additional information prior to resubmission when the first-pass claim has been rejected by clearinghouse or the payer. The “Worked Claim” feature enables you to quickly identify those rejected claims that have been worked, and those unworked claims that require attention.

The term “Worked” may be used to signify any of the following claim conditions:

- The claim has been accessed for corrective action (edits or additional information), but has not been completely corrected for resubmission.
- Required corrective action (edits or additional required information) is complete, but the claim has not been resubmitted.
- All required corrective action (edits or additional required information) has been completed, and the claim has been resubmitted.

Note: The definition of the terms “Worked” and “Un-Worked” as they relate to your practice’s workflow should be understood by all Reporting & Analytics users within your practice/organization.

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7.2.10 View Worked vs. Unworked Claims

Work Queue search enables you to quickly identify worked and unworked claims. For more information about performing this search option, please see **Rejection Since Last Login Search**.

Access this search by selecting **Claims > Rejection Since Last Login**. This search displays a Claim Summary report of all claims that have been rejected since you last accessed Reporting & Analytics.

Note: There are no search criteria associated with this report. Click **Submit** to run the search.

7.2.11 Update Claim “Worked” Status

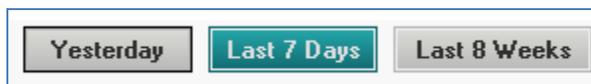
The Claim Detail Report includes a “Worked” check box that is unchecked by default. To mark a claim as “Worked” simply click once in the check box (this will place a check in the box).

The “Worked/Unworked” status can be viewed in the Claim Summary Report. In the Claim Detail Report “Worked” status of the claim is shown by a check in the “Worked/Unworked” check box, see **Descriptions and functions** of key user fields in the Claim Detail section are presented below.

7.2.12 Reporting & Analytics Home Page

Change View with Date Range

Use the date range buttons to change the displayed views. When you click on a date range, the view automatically updates.



Landing Page and Preferred Reports

If you have set a Preferred Report in User Preferences, the Preferred Report displays when you access Reporting & Analytics instead of the Home Page charts and tiles. To view the Landing Page instead of a Preferred Report on login, cancel the selected Preferred Report by clicking **Preferences**, and then **Reset**.

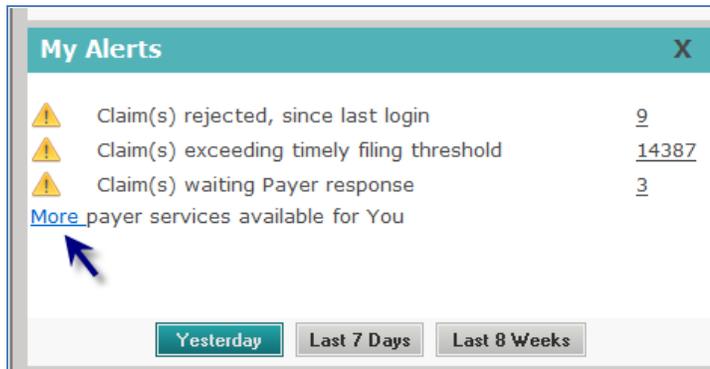
Change Display in Home Page – Preferences

Please see “Set User Preferences” on page 90.

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Access Service Enrollment Matrix

Click the "More" link in the Home/My Alerts landing page.



Which Payer Services are Available?

Reporting & Analytics includes numerous services that facilitate effective information/data exchanges between providers and payers. You can easily determine which functions a particular payer supports, and review the availability of features.

Payer Name	Payer ID	ERA	EFT
	R0200	Not Available	Not Available
Fidelis Care New York	11315	Not Available	Not Available
UnitedHealthcare	87726	Available	Not Available
MetroPlus Health Plan	13265	Available	Not Available
Healthfirst, Inc. (New York)	80141	Available	Not Available
Amerigroup RealSolutions	27514	Available	Available
Hudson Health Plan	13335	Not Available	Available
Empire Blue Cross and Blue Shield of New York	58803	Available	Not Available
HIP - Health Insurance Plan of Greater New York	55247	Available	Not Available
Affinity Health Plan	13334	Available	Available

Review Payer Offerings

The offerings of each payer are displayed in the payer row of the Service Enrollment table.

Available

If the payer offers this function but your account is not currently configured to use it, "Available" appears in the applicable box in the table. Click link to display instructions and a registration form in a separate window to setup your account for the EFT function.

Note: If you click on the *Available* link in the ERA or Claims columns an instructional message is displayed.

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Not Available

If the payer does not offer this function "Not Available" appears in the applicable box in the table.

Payer Functions

The following payer offerings/functions are displayed as column headers in the Service Enrollment matrix table. Look on the row for a specific payer to determine if a particular function is available (for your account) from that payer.

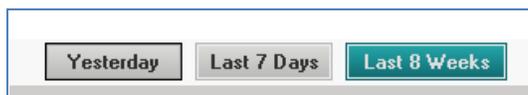
- Payer Name
- Payer ID
- ERA
 - ✓ Possible values are Available, Not Available, and Yes.
 - ✓ ERA - Electronic Remittance Advice; an electronic version of a payment explanation which provides details about providers' claim(s) payment, and if the claim(s) is denied. If claim was denied the ERA includes the required explanations. The industry standard for sending of ERA data is the HIPAA X12N 835 standard.
- EFT
 - ✓ Possible values are Available, Not Available, and Yes.
 - ✓ EFT - Electronic Funds Transfer; electronic receipt of funds from payers.

7.3 Dashboard Overview

The Reporting & Analytics Dashboard includes four views, all of which provide a clickable graphical representation of important claim data.

- Claim acceptance/rejection status percentages
- Highest dollar amounts for rejected claims by payer
- Monthly dollar sum totals for submitted claims
- Frequently occurring reasons for claim rejections

This information can be helpful in analyzing your practice's performance, and increase efficiencies by reducing rejections.



Use the **Select Date Range** drop-down list to set the date range. The optional **Provider Tax ID** field allows you to limit the displayed dashboard data to only those claim

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summaries for a specific provider or specialty area (or site) within your practice for which a Tax ID is set up. Click **Submit** to display dashboards.

Note: Tax ID must be a valid 9-digit numeric string.

7.3.1 Dashboard Views

The Reporting & Analytics Dashboard includes four views:

- Claim Status Summary (pie chart)
- Top Payers by Sum of Rejected Dollar Amounts (bar graph)
- Claim Charge Amount (line graph)
- Rejected Claims Work Status (pie chart)



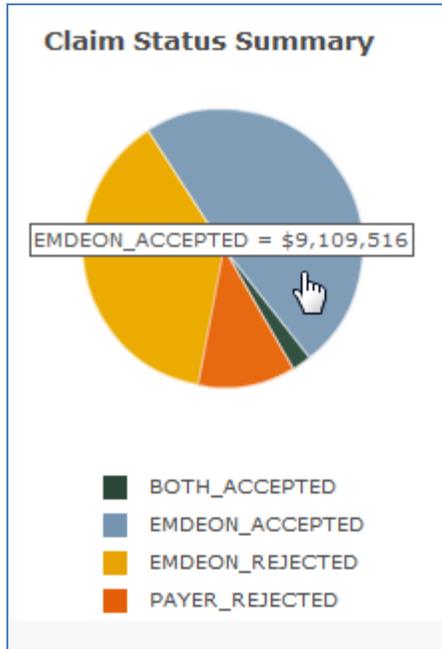
The table below describes the information that is provided in each of the four dashboard views.

Dashboard View	Information Provided for Specified Date Range	Drill-Down to Claim Summary Report
Claim Status Summary	Clickable pie chart: <ul style="list-style-type: none"> • claims accepted at clearinghouse, but no status received yet from payer • claims accepted at clearinghouse and by payer • claims rejected by clearinghouse • claims rejected by payer 	Yes – for claim status
Top Payers by Sum of Rejected Dollar Amounts	Displays a bar graph for each of 5 payers (the top 5 payers by Payer ID) with the largest rejected claim dollar amounts	Yes – for selected payer
Claim Charge Amount	Displays total charges for all claims submitted to the clearinghouse during the specified time period	Yes – for selected day, week, or month

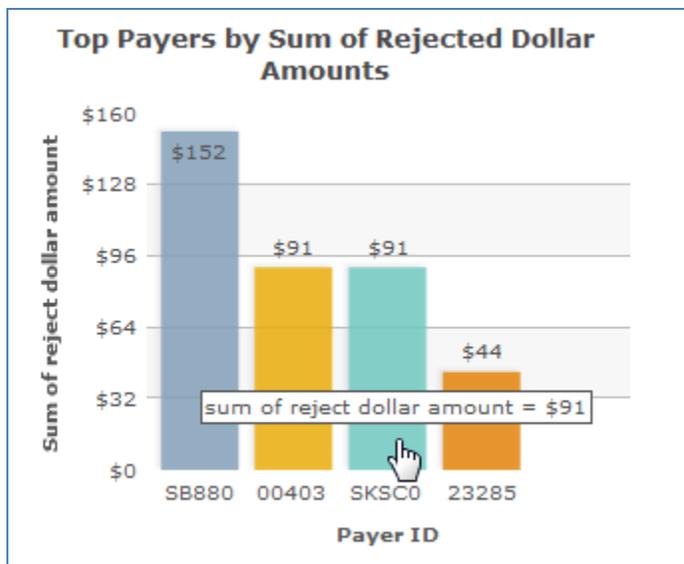
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Rejected Claims Work Status	Two kinds of information, worked and the unworked claims are displayed in the clickable "Rejected Claims Work Status" chart. Each segment of the chart is color-coded for ease of viewing. The counts for each section are displayed within the chart.	Yes – Count number is clickable and applicable Claim Summary is displayed.
-----------------------------	--	--

7.3.2 Claim Status Summary



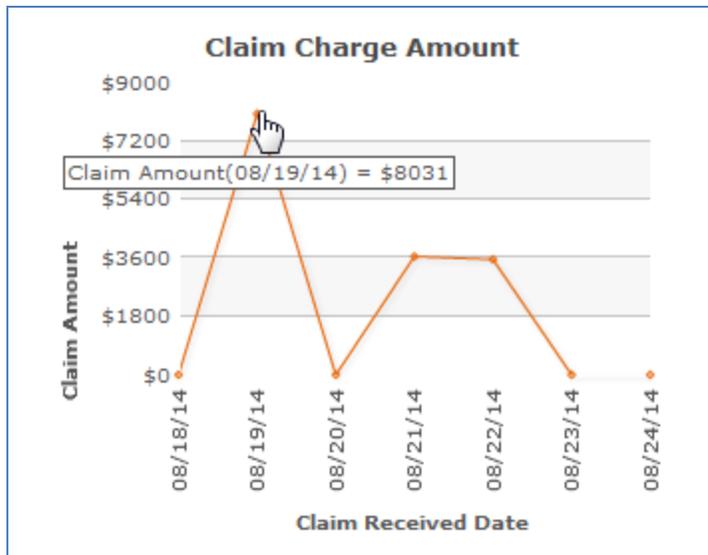
7.3.3 Top Payers by Sum of Rejected Dollar Amounts



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The dollar amount increments shown on the “y” (vertical) axis are determined according to the amounts calculated for the top five payers.

7.3.4 Claim Charge Amount



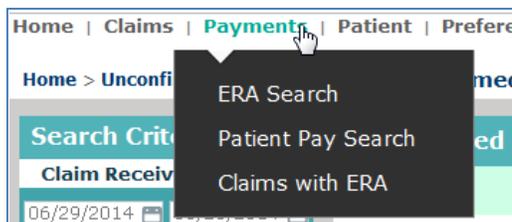
The dollar amount increments shown on the “y” (vertical) axis are determined according to the claim dollar amounts calculated for the specified day, week, or month.

7.3.5 Top 5 Claim Rejection Reasons

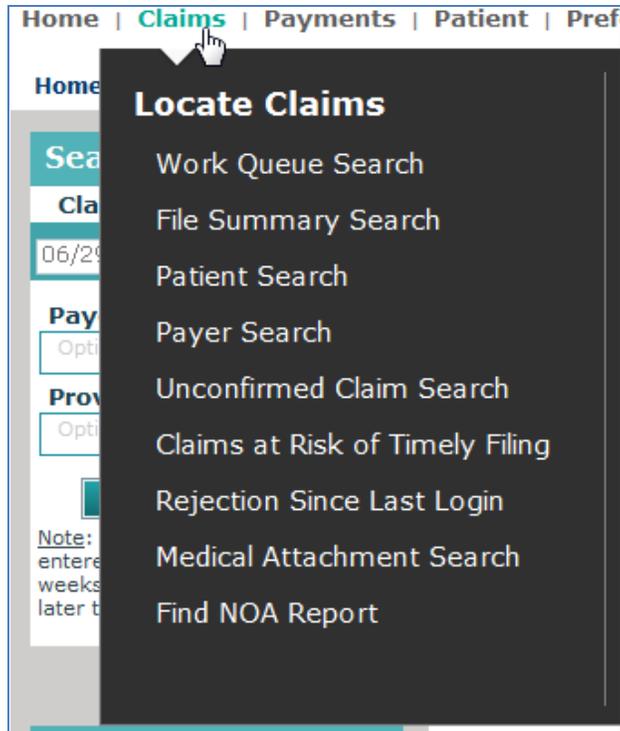
Rejection Message	Rejected By	Count
End Stage Renal Disease Payment Amount: Invalid; Must be numeric	EMDEON	15
ACK/RETURNED-Duplicate of a previously processed claim/line.	PAYER	9
Tax ID and provider number do not match provider file.	PAYER	6
MISSING OR INVALID DATA PREVENTS CARRIER FROM PROCESSING THIS CLAIM	EMDEON	5

If you click the linked Count number the applicable Claim Summary is displayed.

7.4 Claim Data Searches



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7.4.1 Options by Search Type

Search Type	Available Search Options	Search Criteria
Audit History Search	Display claims that have “worked” or “unworked” status change during the specified date range or specific date	<ul style="list-style-type: none"> • Date • clearinghouse Claim ID
Claim Quick Search	Quickly access claim information based on known search criteria	<ul style="list-style-type: none"> • clearinghouse Claim ID • Submitter Claim ID • Payer Claim ID • Insured ID • PCN (Patient Control Number) • Patient Last Name (with optional date of birth) • Patient date of birth
Claims with ERA Search	Find claims that have ERAs associated with them.	Use (optional) Tax ID or Site ID to limit search results. If your practice is part of a large organization, using your own Tax ID or Site ID will help limit search results.
File Summary Search	View all claims by claim batch that were received during a time frame (date range). Each claim batch is identified by a File ID (clearinghouse batch identifier).	<ul style="list-style-type: none"> • Received Date range and optionally , either or both of the following: <ul style="list-style-type: none"> • Tax ID • Site ID

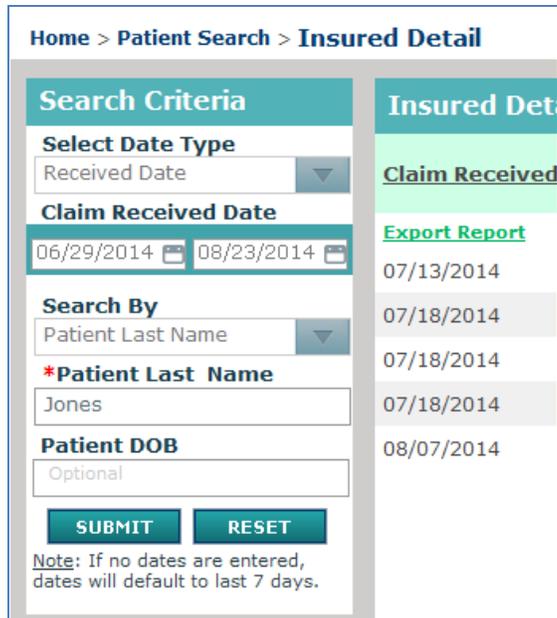
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Search Type	Available Search Options	Search Criteria
Patient Pay Search	<ol style="list-style-type: none"> 1. View all patient payments made through Patient Pay Online for a specified date range 2. View all patient payments made through Patient Pay Online for a specified date range and a specific patient name or patient account number. 	<p><i>Search by Transaction Date:</i></p> <ul style="list-style-type: none"> • Transaction Date range <p>and optionally</p> <ul style="list-style-type: none"> • Worked status <p><i>Search by Patient Name:</i></p> <ul style="list-style-type: none"> • Transaction Date range • Patient Name <p><i>Search by Patient Account Number:</i></p> <ul style="list-style-type: none"> • Transaction Date range • Patient Account Number
Patient Search	<ol style="list-style-type: none"> 1. View all claims for a specific insured party and dependents (by Insured ID) 2. Locate all claims for a specific Patient Control Number (PCN) 3. Locate all claims for a specific patient 	<ul style="list-style-type: none"> • Date range (service date OR received date) <p>and one of the following</p> <ul style="list-style-type: none"> • Insured ID • PCN • Patient Last Name (with optional date of birth)
Payer Search	<ol style="list-style-type: none"> 1. Display a summary of all claims 2. Display a summary of all claims for a specific payer 	<ul style="list-style-type: none"> • Received Date range <p>and optionally, any combination of the following:</p> <ul style="list-style-type: none"> • Tax ID • Site ID • Payer ID
Rejection Since Last Login Search	View all claims that have been rejected by all payers since your last login	None required
Work Queue Search	<ol style="list-style-type: none"> 1. Display a summary of all claims for a specific status 2. Display a summary of all claims for Rejected Claims with "Worked" or "Un-Worked" sub-status 	<ul style="list-style-type: none"> • Received Date range • Claim Status <p>and optionally</p> <ul style="list-style-type: none"> • Tax ID • Site ID • If Rejected status selected: "All," "Worked," or "Un- worked" sub-status

7.4.2 Search Fundamentals

- Required fields are indicated by a red asterisk (*).
- Enter a date range for your search. You can manually enter a date (mm/dd/yyyy format) or use the calendar tool. If no dates are selected the default date range (inclusive of the last seven days) is entered automatically.

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Home > Patient Search > Insured Detail

Search Criteria

Select Date Type
Received Date

Claim Received Date
06/29/2014 08/23/2014

Search By
Patient Last Name

*Patient Last Name
Jones

Patient DOB
Optional

SUBMIT RESET

Note: If no dates are entered, dates will default to last 7 days.

Insured Detail

[Claim Received](#)

[Export Report](#)

07/13/2014
07/18/2014
07/18/2014
07/18/2014
08/07/2014

7.4.3 Run a Search

1. Select a search type.
2. Enter all required data.
3. Enter any desired optional data.
4. Select a date range (if applicable). If dates are not selected, Reporting & Analytics will enter the default date range automatically. (Default date range is the last seven days.)
5. Click **Submit**. (Results can be searched and/or printed.)

Note: If no matches are found, change your search criteria, then rerun the search.

6. After the report displays click on any underlined hyperlink for further details.

7.4.4 Working with Dates

Date Criteria are Retained across Searches

The date or date range used in your most recent search is retained across all searches during a session. When you select a different search type, the date or date range from the previous search is automatically entered in the date fields of the new search. The purpose of this date retention functionality is to save time and keystrokes as you navigate from search to search.

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Single Date Search

If you enter a date in either the **Start Date** or **End Date** field only, when you click **Submit**, the remaining open field is filled with the same date. The resulting search will run on a single date only.

Default Date Range

If both date fields are left empty, the system will automatically enter a date range of the last 7 days (inclusive of today) when you click **Submit**.

Date Format Options

Basic syntax of manually entered dates: mm/dd/yyyy. Additional allowed date configurations:

- **Month** can be entered as either *mm* or *m*; **Day** can be entered as either *dd* or *d*; **Year** can be entered as either *yyyy* or *yy*.

Date Entry Shortcut

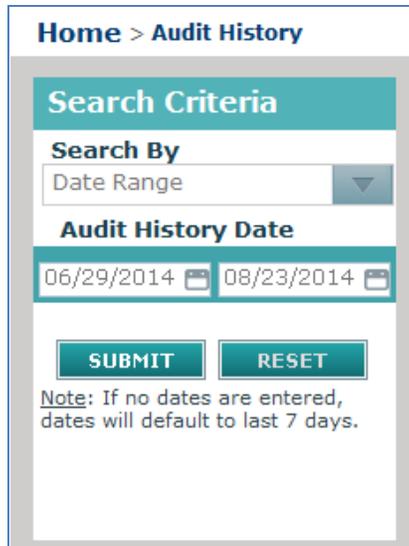
- Type the letter **t** to enter today's date in date field.
Type the letter **t** in the date field to place today's date in that field. The letter **t** is displayed until you click **Submit**, after which **t** is replaced with today's date.
- Use **t-xx** to enter a past date in the date field.
For example, type **t-3** in the date field to enter the date that occurred three days before today. The shortcut that you typed, **t-3** in this case, is displayed in the date field until you click **Submit**, after which **t-3** is replaced with a format-compliant date.

Note: Claims data for the previous 15 months can be viewed in Reporting & Analytics.

7.4.5 Audit History Search

Access this search by selecting **Support > Audit History**. Run a search to display an Audit History report of all applicable or matching claims whose "worked/unworked" status has changed. Search for updated claims by single date (or date range) or by clearinghouse Claim ID number.

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7.4.6 Claim Quick Search

This search field is located in the upper right corner of the landing page. When searching with IDs or any allowable data element in Quick Search, only those claims that exactly match your search criteria are displayed. However, when searching by a patient first or last name, you can use a name segment (three consecutive letters must be used).

Allowed Search Criteria

Only those claims that match all entered search criteria are displayed. Search criteria must match the format of at least one of the following searchable claim fields.

Searchable Claim Field	Description
PCN	Patient Control Number. An alphanumeric string that can include up to 20 characters.
Insured ID	An alphanumeric string that can include up to 20 characters.
Patient Name (Last Name and/or First Name)	Enter a patient's exact first name and/or the exact spelling of the last name. The only claims shown are those that match exactly the criteria entered. To search on the patient's full name, use quotations: "John Smith".
Patient DOB	Use the format mm/dd/yyyy (or m/d/yy) to locate claims. A forward slash (/) must be used when searching against a date. For example, to find claims for January 4, 2008, enter either 01/04/2008 or 1/4/08.
Claim ID	CORN. This ID contains 17 characters (two letters followed by 15 numbers). All 17 characters must be entered.

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Submitter Claim ID	This ID is applied to a claim by the provider's submission application vendor at the time of submission.
Payer Claim ID	This ID is assigned to a claim by the payer.

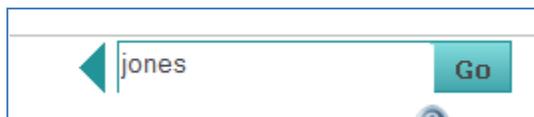
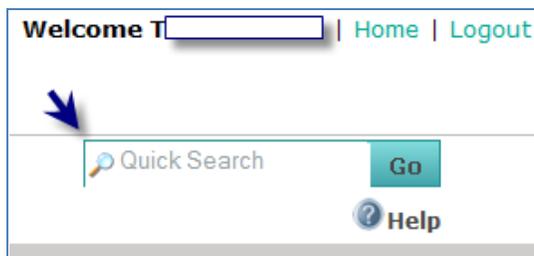
Combining Criteria

You can combine search criteria by using a separator.

Character or Word Used	Result
Space or comma (,)	All claims that include one or more keywords are shown; inclusive search.
Plus symbol (+) or the word <i>and</i>	The resulting search is exclusive. That is, only those claims are shown that match ALL the search criteria.
The word <i>or</i>	The resulting search shows all those claims that match at least one of the criteria. That is, if <i>Jones</i> and <i>Louie</i> are the keywords, claims for Jones and claims for Louie are both shown. Those claims for <i>Louie Jones</i> are also shown (see below).
Quotes (" or ")	Use single or double quotes to search for multiple keywords, as in a name. For example, to locate claims for an individual named John Adams, place quotes on both ends of the name: "John Adams". The benefit of this type of search is that the results are limited to only those claims that match <i>John Adams</i> ; claims that match only <i>John</i> or only <i>Adams</i> are not shown. (Claims for Lou Adams or John Hancock are not shown.)

Launch a Quick Search

Enter one or more criteria in the search field, then click the search icon at the right of the field. At least one search criteria must be entered to run a search. (Search criteria are not case sensitive.) There are no date range selection options in "Quick Search." A 30-day date range is used by default.

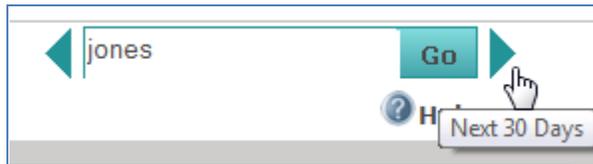
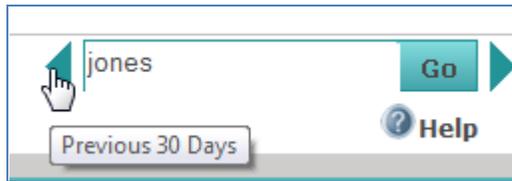


Search Results

If a search results in a single matching claim only, the Claim Detail for that claim is displayed. When more than one claim match the search criteria all matching claims for the previous 30 days are displayed in the Claim Summary report. Click "View More" to see claims older than 30 days.

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Note: Reporting & Analytics can search up to 15 months of claims data.



Note: If your search returns no results when the report is loaded, you can use the "Previous 30 days" button to search for results of your initial search for an earlier time period, and then scroll back with the "Next 30 Days" button.

Claim Quick Search Results

Quick Search results are delivered in a Claim Summary Report (see **Claim Summary Report** on page 152).

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7.4.7 Claims with ERA Search

Access this search by selecting **Payments > Claims with ERA**. Use this search to locate claims that have ERAs for a specified date or date range. Searches can also be performed on a specific tax ID or site ID, which are useful if you are part of a large organization.

Click the link in the Claim Received Date column to view the Claim Summary Report.

Home > Claims with ERA > ERA Summary by Day

Search Criteria		ERA Summary By Day	
Claim Received Date		Claim Received Date	ERA Received Quantity
08/25/2014	08/25/2014	08/25/2014	3
Tax ID Optional		Totals:	3
Site ID Optional			
<input type="button" value="Submit"/>	<input type="button" value="Reset"/>		
<small>Note: If no dates are entered, dates will default to last 7 days.</small>			
Report Criteria			
Claim Date Range : 8/25/2014 - 8/25/2014			
Provider Tax ID : < Empty >			
Site ID : < Empty >			



When viewing the Claim Detail of a claim that has ERA(s) associated to it, the Additional ID heading in the Payer Claim Status History section of the Claim Detail includes a check number link.

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Home > Claims with ERA > ERA Summary by Day > Claim Summary > Claim Detail

Search Criteria	CLAIM DETAIL	XWalk Review	Display Letter	Display Alerts						
Claim Received Date 04/01/2014 <input type="text"/> 08/25/2014 <input type="text"/> Tax ID <input type="text"/> Site ID <input type="text"/> <input type="button" value="Submit"/> <input type="button" value="Reset"/> <small>Note: If no dates are entered, dates will default to last 7 days.</small>	Patient DOB: 11 <input type="text"/> Diagnosis Code(s): 9987789, 91234 more Procedure Code(s): 91234, 99877 Claim Amount: \$33.00 Service From: 03/29/2013 Service To: 03/29/2013			Billing Provider Site ID: Patient Control Payer Name: 5010 Format: Payer Claim ID:						
Report Criteria Emdeon Claim ID : EP040913781914239	Claim Status Summary Emdeon Received: 05/21/2014 Payer Acknowledge Emdeon Accepted Date: 04/09/2013 Payer Accept Date Emdeon Reject Date: Payer Reject Date									
	Message Detail <table border="1"> <thead> <tr> <th>Standard Code</th> <th>Message</th> </tr> </thead> <tbody> <tr> <td></td> <td>Finalized. Payer has processed this claim as the primary payer.</td> </tr> <tr> <td></td> <td>Finalized. Payer has processed this claim as the primary payer.</td> </tr> </tbody> </table>				Standard Code	Message		Finalized. Payer has processed this claim as the primary payer.		Finalized. Payer has processed this claim as the primary payer.
Standard Code	Message									
	Finalized. Payer has processed this claim as the primary payer.									
	Finalized. Payer has processed this claim as the primary payer.									
	Payer Claim Status History <table border="1"> <thead> <tr> <th>Additional IDs</th> <th>Status Date</th> </tr> </thead> <tbody> <tr> <td>950 <input type="text"/> [Check Number]</td> <td>05/07/2013</td> </tr> </tbody> </table>				Additional IDs	Status Date	950 <input type="text"/> [Check Number]	05/07/2013		
Additional IDs	Status Date									
950 <input type="text"/> [Check Number]	05/07/2013									

Click the Check Number link to view the Payment Detail for the selected check.

Summary by Day > Claim Summary > Claim Detail > Payment Detail Help

Patient Control Number	Patient Name	Claim Charge	Claim Paid Amount	Difference in Payment	Service From Date	Service Thru Date	Receiver ID	Transaction ID
Z7 <input type="text"/>	ME <input type="text"/>	\$309.16	\$61.84	\$247.32	03/13/2012		UNKNOWN	293052 <input type="text"/>
Totals:		\$309.16	\$61.84	\$247.32				

7.4.8 File Summary Search

Access this search by selecting **Claims > File Summary Search**. A successful File Summary search displays a File Summary Report that provides details on all claim batches submitted to the clearinghouse during the specified (or default) date range. Each claim batch is identified by a File ID (clearinghouse batch identifier). For more information, see **ERA Linking in Claim Detail**.

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If your practice has ERA contracts with payers, ERA data is displayed in the “Payer Claim Status History” under certain conditions.

- The claim has associated ERA(s).
- Your practice has ERA contract with the payer on the claim.

If an ERA is associated to the claim a generic message is displayed in the **Status Description** field.

If the claim has been paid (and there is an ERA associated to the claim), the check number is displayed in the **Additional ID's** column. Click the check number to display the Payment Detail report.

Claim Status Summary		
Emdeon Received:	05/21/2014	Payer Ack
Emdeon Accepted Date:	04/09/2013	Payer Acc
Emdeon Reject Date:		Payer Rej
Message Detail		
Standard Code	Message	
	Finalized. Payer has processed this claim as the primary payer.	
	Finalized. Payer has processed this claim as the primary payer.	
Payer Claim Status History		
	Additional IDs	Status Date
	95 [Check Number]	05/07/2013
⏪ < 1 > ⏩ [] < >		

Payment Detail Report

If a linked check number is displayed in the Claim Detail Report you can access the Payment Detail report by clicking the check number.

The Payment Detail report provides key information on the claim (and the payment) including claim amount and the difference between paid amount and claim amount.

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Payer Claim ID in Claim Detail Report

If the payer has received the claim *and* the payer issues claim IDs to clearinghouse, then the payer's claim ID appears in the **Payer Claim ID** field. However, a blank **Payer Claim ID** field does not necessarily mean that the payer has not received the claim.

Home > Claims with ERA > ERA Summary by Day > Claim Summary > Claim Detail

Search Criteria	CLAIM DETAIL	XWalk Review	Display Letter	Display Alerts
Claim Received Date 04/01/2014 08/25/2014	View/Edit Claim	View Audit History	Get Help with this Claim	
Tax ID Optional	Emdeon Claim ID: EPO	Insured ID: 116	Provider Tax ID: 13	
Site ID Optional	Patient Name: BEV	Patient DOB: 11/	Billing Provider ID: 13	
<input type="button" value="Submit"/> <input type="button" value="Reset"/>	Diagnosis Code(s): 9987789, 91234 more	Procedure Code(s): 91234, 99877	Billing Provider NPI: 12	Site ID: D749
<small>Note: If no dates are entered, dates will default to last 7 days.</small>	Claim Amount: \$33.00	Service From: 03/29/2013	Patient Control No.: 27	Payer Name: Healthfirst, Inc. (New York)
Report Criteria	Service To: 03/29/2013		5010 Format: YES	Payer Claim ID: 95
Emdeon Claim ID : EPO	Claim Status Summary			
	Emdeon Received: 05/21/2014	Payer Acknowledge Date: 05/07/2013		
	Emdeon Accepted Date: 04/09/2013	Payer Accept Date: 05/07/2013		
	Emdeon Reject Date:	Payer Reject Date:		
	Message Detail			

In the screen shot above, no payer claim ID appears in the Claim Detail report because the claim was rejected at clearinghouse.

Note: While most payers do issue claim IDs upon receipt of a claim (which appear in the Claim Detail report) some payers do not.

View Audit History

This function, which allows you to view the audit history in a Claim Detail Report, is different from the Audit History Report which is generated by performing an Audit History search (see **Audit History Report** on p. 142).

Click the "View Audit History" link to view the audit history of a claim.

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Home > Claims with ERA > ERA Summary by Day > Claim Summary > Claim Detail

Search Criteria	CLAIM DETAIL	XWalk Review	Display Letter	Display Alerts
Claim Received Date 04/01/2014 08/25/2014 Tax ID Optional Site ID Optional Submit Reset <small>Note: If no dates are entered, dates will default to last 7 days.</small>	View/Edit Claim	View Audit History	Get Help with this Claim	
	Emdeon Claim ID: EP0			
	Insured ID: 116	Provider Tax ID: 13		
	Patient Name: BEV	Billing Provider ID: 13		
	Patient DOB: 11/	Billing Provider NPI: 12		
	Diagnosis Code(s): 9987789, 91234 more	Site ID: D749		
	Procedure Code(s): 91234, 99877	Patient Control No.: 27		
	Claim Amount: \$33.00	Payer Name: Healthfirst, Inc. (New York)		
	Service From: 03/29/2013	5010 Format: YES		
	Service To: 03/29/2013	Payer Claim ID: 95		
Report Criteria Emdeon Claim ID : EP0	Claim Status Summary			
	Emdeon Received: 05/21/2014	Payer Acknowledge Date: 05/07/2013		
	Emdeon Accepted Date: 04/09/2013	Payer Accept Date: 05/07/2013		
	Emdeon Reject Date:	Payer Reject Date:		
	Message Detail			

The following actions are tracked in Audit History:

- Click View / Edit Claim.
- Click on "Eligibility" link
- Click on "Claim Status" link
- All "Worked/Unworked" status changes for the last 15 months on the claim are shown with username and date/time stamp

Audit History		
Audit History Report For Claim: EP60		
Username	Action Performed	Date/Time stamp
du	Claim Correction View	06/24/2014 07:11:02
du	Marked claim as Worked	06/09/2014 16:30:32
du	Claim Correction View	05/25/2014 10:49:55
du	Integration PMS	08/21/2013 00:51:30
du	Claim Correction View/Edit	08/21/2013 00:49:19
du	Integration PMS	08/21/2013 00:47:26
du	Claim Correction View	08/21/2013 00:13:28
du	Claim Correction View	08/21/2013 00:11:21
du	Integration PMS	07/16/2013 04:50:11

Close

REPORTING & ANALYTICS

If the Audit History report is longer than 1,000 rows, the report can be exported in Microsoft Excel format. The export will include all rows in the report including those rows that were not displayed due to the 1,000 row display limit.

When you click the “View Audit History” link, a new window appears. The Audit History window can be moved in the same manner that the Help window can be moved (click and drag the title bar of the window).

7.4.9 Workers’ Compensation Attachments

Overview

Reporting & Analytics provides you with a convenient and powerful way to manage workers’ compensation claims.

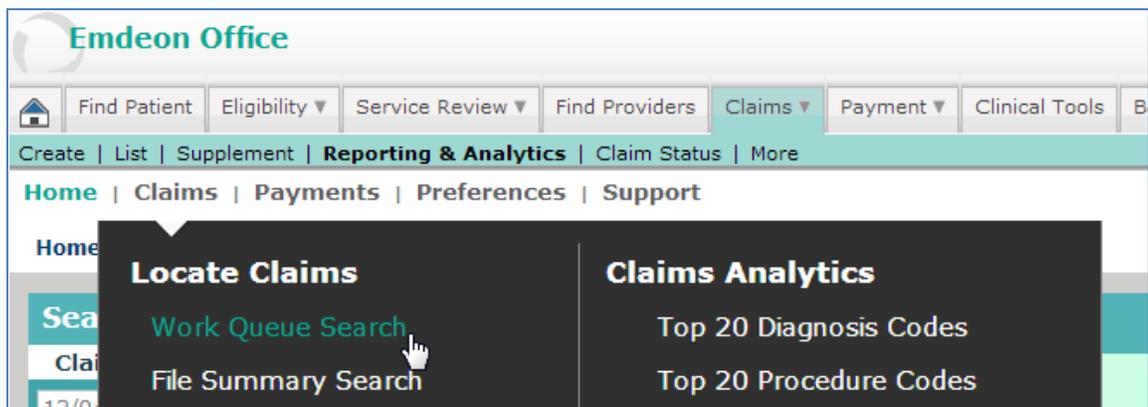
Functionality includes both claim management and the ability to respond directly to payers with requested attachments. Workers’ Compensation Attachments is available by subscription only from Reporting & Analytics.

If you have pending workers’ compensation claims, you can easily find those claims and respond to payer requests for further documentation.

Locate Claims

To locate claims in Reporting & Analytics that the payer requires additional information for, begin the search by selecting **Claims > Work Queue Search**.

In the **Search Type** drop-down list, select “Requires Attachment”. Enter your Tax ID or Site ID for a more specific search (both fields are optional).



All claims that match the selected search criteria for which the payer on workers’ compensation claim(s) has requested additional documentation are shown.

REPORTING & ANALYTICS

Payer Allowed Response Period

On workers' compensation claims that require attachments, payers provide a 15-day response period, during which time the provider can upload files and send them to the payer. If the provider does not respond within the 15-day response period, the claim is rejected and no longer appears in the **Work Queue Search** > "Requires Attachment" search results report.

Access Attachments Functionality

In the Claim Summary report, click the highlighted **Claim ID** to show the Claim Detail report for the selected claim. In the far right column of the Claim Detail report, click the "Claim Attachment" link to show the workers' compensation attachments application window.

Home > Work Queue Search > Claim Summary > Claim Detail

Search Criteria

Claim Received Date: 09/25/2014 to 09/25/2014

Tax ID: [Optional]

Site ID: [Optional]

Search Type: All

CLAIM DETAIL

Emdeon Claim ID: EP0

Insured ID: 123

Patient Name: ERL

Patient DOB: 11/

Diagnosis Code(s): Not Available

Procedure Code(s): 54hjgh5465jh4

Claim Amount: \$650.00

Service From: 03/08/2013

Service To: 03/08/2013

Provider Tax ID: 99

Billing Provider ID: 99

Billing Provider NPI: 19

Site ID: ABCD

Patient Control No.: PC

Payer Name: Test Payer - Med Attach

5010 Format: Not Available

Payer Claim ID:

Claim Received Date: 08/25/2014

Emdeon File ID: EP

Emdeon Claim ID: EP

Payer ID: PAY05

Worked Status:

Workers' compensation attachments window within Reporting & Analytics:

Print Close

cct #	Total Charges	Employer	Carrier	DOI	Service Dates	Patient Name	Status Date	Status	Attachments
260	\$630.00	RAM	TEXAS MUTUAL INSU	01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO	View Bill Commit Upload Fax

* Attachment Type: Admission Summary

Description: [Limit 80 Chars]

* Attach File: [Browse...]

*Indicates Required Field

Upload Cancel

(ACN)	Date/Time	Attachment Type	Delivery Method	Description	Detail
	01/27/2010 16:31 CST	Consultation Report	Electronically Only		View Remove
	01/27/2010 16:32 CST	Certification	Electronically Only		View Remove

Click **Upload** at the upper right to show the Upload fields. Click the **Upload** button directly beneath the **Attach File** field for each attachment to add to the bill. After all files are uploaded, click the "Commit" link to send your bill and files to the payer for review.

Workers' Compensation Attachments Interface

1. Click the "Claim Attachment" link in the Claim Detail report. The workers' compensation claim attachment window appears.

REPORTING & ANALYTICS

- To view an attachment, click the applicable “View” link. A graphic- or PDF-viewer appears (depending on what is set as the default viewer on your computer).
- Click **Print** to print a summary view. You can print uploaded files directly from the View window.
- Click **Upload** in the upper right corner to show the file upload window. Only PDF and TIFF format files can be uploaded.
 - Click **Browse** to locate the file to upload.
 - Select an attachment type from the **Attachment Type** drop-down list (required field).
 - Enter a description of the file (optional field).
 - Click the **Upload** button to upload the file. Repeat these four steps for each file to attach to the claim.
- Status conditions:

The screenshot shows a software window titled "Print" and "Close". It contains a table with columns: DOI, Service Dates, Patient Name, Status Date, Status, and Attachments. The first row shows DOI 01/05/2007, Service Dates 12/04/2009, Patient Name RAMIREZ, Status Date 01/25/2010, Status PDCO, and Attachments with links for View Bill, Commit, Upload Fax, and a printer icon. Below the table is a form with a dropdown menu for Attachment Type (currently showing "Primary"), a text field for Description, and a "Browse..." button. A "Cancel" button is also present. At the bottom, there is a table with columns: Attachment Type, Delivery Method, Description, and Detail. It lists "Primary Report" and "Primary Report" with Delivery Method "Electronically Only" and Detail links "View" and "Remove".

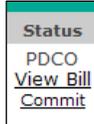
- ✓ PNDA – Pending Attachments. Attachments are pending to be sent to the payer.
- ✓ PDCO – Pending Commit. You can add files while bill is in this status. Click the “Commit” link to send the bill with attachments to the payer for review. Do not click “Commit” until all of your files are attached.
- ✓ PEND – All attachments and bill documents are ready to be sent to payer. This status occurs after “Commit” is clicked. This status is the condition prior to **SENT**. No action can be taken in the workers’ compensation claim attachment window while in this status.
- ✓ SENT – Bill and attachments sent to payer.

Note: After bill and attachments are sent, the **Upload** and **Fax** buttons are no longer available.

- Fax documents so that they are correctly received by the payer.
 - ✓ If you have paper documents that you want to scan and send to the payer, click **Fax**.
 - ✓ Print the fax cover sheet, and then fax all paper documents to the payer (at the fax number shown on the fax cover sheet) with fax cover sheet as the first document in the communication. Using the fax cover sheet ensures that your faxed documents are associated to the bill.

REPORTING & ANALYTICS

- You can view or remove uploaded files from the bill prior to clicking "Commit." Once committed, uploaded files cannot be removed.
- Review the billing image created by clicking the "View Bill" link (located in the **Status** column in the upper right of the workers' compensation attachments window).



- Click "Commit" to send uploaded files to payer for review.

Note: You must click "Commit" to complete the bill/claim submission process. If "Commit" is not clicked, attached files are not sent to the payer, and the claim will remain in **PDCO/Pending Commitment** status.

7.4.10 View and Edit Claim

View and Edit Claims

Viewing and editing claims is a feature you can access through the Claim Detail Report. For details on how to view and edit claims, see the **View and Edit Claims** section on page 159.

"Get Help with this Claim" Link

Using the "Get Help with this Claim" link enables you to access Customer Service Alerts (CSAs) and submit a support ticket for the claim you are viewing.

In a Claim Detail report, click the "Get Help with this Claim" link.

The screenshot shows a web application interface for 'Claim Detail'. At the top, there is a breadcrumb trail: 'Home > Work Queue Search > Claim Summary > Claim Detail'. Below this is a navigation bar with tabs: 'CLAIM DETAIL', 'Medical attachment', 'XWalk Review', 'Display Letter', 'Display Alerts', and 'Claim attachment'. The 'CLAIM DETAIL' tab is active. Below the navigation bar, there are several links: 'View/Edit Claim', 'View Audit History', 'Get Help with this Claim' (circled in red), and 'Link To ADS'. The main content area is a table of claim information. On the left side, there is a 'Search Criteria' panel with fields for 'Claim Received Date' (09/25/2014), 'Tax ID' (Optional), 'Site ID' (Optional), and 'Search Type' (All). There are 'SUBMIT' and 'RESET' buttons. Below the search criteria, there is a 'Report Criteria' section. The main table contains the following data:

Emdeon Claim ID:	EP0	Insured ID:	123	Provider Tax ID:	99	Claim Received Date:	08/25/2014
Patient Name:	ERL	Billing Provider ID:	99	Emdeon File ID:	EP	Emdeon Claim ID:	EP
Patient DOB:	11/	Billing Provider NPI:	19	Payer ID:	PAY05	Worked Status:	<input type="checkbox"/>
Diagnosis Code(s):	Not Available	Site ID:	ABCD				
Procedure Code(s):	54hygh5465jh4	Patient Control No.:	PC				
Claim Amount:	\$650.00	Payer Name:	Test Payer - Med Attach				
Service From:	03/08/2013	3010 Format:	Not Available				
Service To:	03/08/2013	Payer Claim ID:					

REPORTING & ANALYTICS

1. The "Claim Support" message window appears. Two links may be available:
 - ✓ Customer Alerts link – If there are recent (last 30 days) Customer Service Alerts (CSAs) on the claim from the payer, a link to the CSA will appear. Hover your cursor over the CSA to view a short description. Click the link to view the CSA.

Claim Support

- Our records indicate that your claims are being submitted through a software vendor who has selected Emdeon as the electronic clearinghouse, or some other means not directly supported by Emdeon.
- A search has been performed, and there are recent service alerts relating to the payer on this claim, which is **87726 UnitedHealthcare**. Please [click here](#) to view them.
- If the alert information does not resolve your issue, please contact your software vendor for further assistance with this claim.

- ✓ Service Request link – This link appears for all claims in Reporting & Analytics. Click the link to create a service request for the claim you are viewing.

Claim Support

- A search has been performed, and there are no recent service alerts relating to the payer on this claim, which is **PAV05**.
- Please [click here](#) to have the claim reviewed by a service representative

2. If you click the service request link, the Create Service Request form displays. The form is pre-populated with key details from the claim.

ON24/7 SEARCH emdeon

Home You are logged in as: **Rosemarie Adams (you@1047@office)** Logout

SERVICE REQUESTS
Create
View

SELF HELP TOOLS
Error Code Search
FAQ

PROJECTS
Implementations

COMMUNICATIONS
Most Recent
Detailed Search
Map Search
Preferences

REFERENCES
Payer Lists
Payer Fact Sheets

ON24/7
What's New
Coming Soon
Technical Support

Create Service Request

Claim Details From Emdeon Vision

Claim ID Number:	DK00080FF3CE0042	Claim Amount:	\$650.00
Insured ID:	123456789000	Patient Name:	0000000000000000
Service From Date:	5/31/2010	Payer Name:	EMDCON00
Service To Date:	5/31/2010	Payer ID:	PAV05
Submitter ID:	223182777	Claim Tax Id:	343434343

What type of issues are you having with this claim?

Claim Rejection

Claim Missing at Payer

Other

Workers Comp Claim Attachment

PREVIOUS **CONTINUE**

3. Click the option that describes the issue you are having with the claim, and then click **Continue**.
4. Enter identifying information on the pages that follow, clicking **Continue** at the bottom of each page. You will be able to review the information you entered before you submit the service request.
5. If you would like to change the information you entered, click **Start Over**.

REPORTING & ANALYTICS

Note: Clicking **Start Over** does not erase the claim information that was present when you created the service request.

6. Click **Submit**.
7. The Confirmation window appears, where you can choose from several options or close the window by clicking **OK**.

Confirmation

Your service request has been entered successfully.

Please reference service request number [1-565316636](#) in any communications with customer support regarding this issue.

If you need to provide additional information to Emdeon via FAX, please click on the following link to create a cover sheet and fax to 615.238.0949. [Create Cover Sheet](#)

If you wish to provide supporting attachments, please click on the following link to include supporting files.
[Upload Attachment\(s\)](#)

[Flag this case as parent](#) [Flag this case as child](#)

To manage your service requests, click the Online Support link in Emdeon Office to return to this site. Then choose View under Service Requests from the menu on the left of the screen.

[OK](#)

- ✓ **Service request reference number** – Click to access details on the service request: view the request history, add a comment, add files, flag, etc.
- ✓ **Create Cover Sheet** – If you need to fax documents to clearinghouse relating to the service request, click this link to open a fax cover sheet. The cover sheet is pre-populated with information that will associate the fax with the service request. Print the cover sheet and use it as the first page of the fax you send to clearinghouse regarding the service request.
- ✓ **Upload Attachments** – Click to upload any standard file type up to 50 MB. You can upload only one file at a time.
- ✓ **Flag this case as parent** – If you need to link cases with related issues, click to set the service request as a parent in relation to one or more service requests. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.
- ✓ **Flag this case as child** – If you need to link cases with related issues, click to set the service request as a child in relation to another service request. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.

7.4.11 Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.

REPORTING & ANALYTICS

- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.

Worked	Patient Name	DOB	Insured ID	PCN	DOS	Amount	Payer ID	Payer Name	Emdeon Claim ID
<input checked="" type="checkbox"/>	ERL [redacted]	11/19/1993	1 [redacted]	PC [redacted]	03/08/2013	\$650.00	PAY05	Test Payer - Med Attach	EP [redacted]
<input type="checkbox"/>	ERL [redacted]	11/20/1993	1 [redacted]	PC [redacted]	03/08/2013	\$60.00	PAY05	Test Payer - Med Attach	EP [redacted]
<input type="checkbox"/>	ERL [redacted]	11/21/1993	1 [redacted]	PC [redacted]	03/08/2013	\$650.00	PAY05	Test Payer - Med Attach	EP [redacted]
<input checked="" type="checkbox"/>	ERL [redacted]	11/22/1993	1 [redacted]	PC [redacted]	03/09/2013	\$60.00	PAY05	Test Payer - Med Attach	EP [redacted]
<input type="checkbox"/>	NAZ [redacted]	08/27/1998	7 [redacted]	59 [redacted]	04/15/2013	\$129.00	11315	Fidelis Care New York	EP [redacted]

Claim Summary Column Headings

Heading	Description
Worked	“Worked” progress status; determined by the “Worked” check box in the Claim Detail report
Patient Name	Name of the patient submitted on the claim
DOB	Patient’s Date of Birth
Insured ID	Insured ID submitted on the claim
Patient Control Number (PCN)	Provider’s control/tracking number for patient on claim
DOS (Date of Service)	Date on which medical treatment specified on the claim occurred.
Amount	Amount on claim; dollar amount (in US dollars) of the submitted claim.
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Claim ID	Claim ID assigned by Emdeon for the specific claim

Claim Summary Report List Order

- Clearinghouse Rejected – Claims rejected by clearinghouse.
- Payer Rejected – Claims rejected by the payer.
- Clearinghouse Accepted – Claims accepted by clearinghouse but no notification from the payer received.
- Accepted – Claims accepted by payer and the claim is pending adjudication.

Note: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and clearinghouse Batch File number, where applicable.)

REPORTING & ANALYTICS

7.4.12 ERA Summary by Day Report

This report is generated from the Claims with ERA search.

Search Criteria		ERA Summary By Day	
Claim Received Date		Claim Received Date	ERA Received Quantity
03/07/2014	08/25/2014	05/21/2014	17
Tax ID		06/01/2014	1
Optional		06/07/2014	4
Site ID		07/18/2014	1
Optional		07/27/2014	3
Submit	Reset	08/25/2014	3
<small>Note: If no dates are entered, dates will default to last 7 days.</small>		Totals:	29

Click a link in the Claim Received Date column to view the Claim Summary Report for all claims with ERAs for the date listed, and then click the clearinghouse Claim ID link to view the Claim Detail Report for that claim.

7.4.13 File Summary Report

The File Summary Report provides details on all claim batches submitted to the clearinghouse during a specific date range. Each claim batch is identified by a File ID (clearinghouse batch identifier).

Search Criteria		File Summary						
File Received Date		File Received Date	File ID	File Status	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
08/25/2014	09/25/2014	Export Report						
Tax ID		08/25/2014	EP	Accepted	1	0	0	\$26.00
Optional		08/25/2014	EP	Accepted	1	0	0	\$129.00
Site ID		08/25/2014	EP	Accepted	2	0	0	\$710.00
Optional		08/25/2014	EP	Accepted	2	0	0	\$710.00
Submit	Reset	08/25/2014	DK	Accepted	1	0	0	\$852.50
<small>Note: If no dates are entered, dates will default to last 7 days.</small>		08/25/2014	EP	Accepted	1	0	0	\$33.00
Report Criteria		08/25/2014	EN	Accepted	1	0	0	\$100.10
File Date Range	8/25/2014 - 8/25/2014	Totals:			9	0	0	\$2,560.60

File Summary Column Headings

Heading	Description
File Received Date	Date claim file was received by clearinghouse
File ID	File ID assigned by clearinghouse for the electronic file in which the claim was submitted

REPORTING & ANALYTICS

File Status	The value in this column is determined by the rejected or accepted status of the file. Accepted - If file is accepted, click the link in File ID column to view <i>Claim Summary</i> . Rejected - If file is rejected no data is displayed in clearinghouse Reject Quantity and Payer Reject Quantity columns. Click the link in File ID column to view <i>Reject File Details</i> .
Received Claim Quantity	Total number of claims received by clearinghouse
clearinghouse Reject Quantity	Number of claims rejected by clearinghouse
Payer Reject Quantity	Number of claims rejected by the payer
Claim Amount	Total dollar amount of all claims received (total dollar amount for total number of claims shown in the Received Claim Quantity column)

7.4.14 Insured Detail Report

The Insured Detail Report is displayed when you run a Patient Search.

This report provides a list of all claims for the specified patient for the date range specified in the **Claim Date Range** field.

Run a Patient Search with Insured ID

When you use Insured ID as search criteria in Patient Search the Insured Detail report displays a list of all claims for all patients (the insured party and their dependents) that are covered under the specified Insured ID (Subscriber ID) for the stated date range.

The screenshot shows the 'Insured Detail' report interface. On the left, there are search criteria fields: 'Select Date Type' (set to 'Claim Received Date'), 'Claim Received Date' (range: 04/02/2014 to 06/25/2014), 'Search By' (set to 'Patient Last Name'), 'Patient Last Name' (J...), and 'Patient DOB' (J...). There are 'SUBMIT' and 'RESET' buttons. The main table has the following columns: Claim Received Date, Patient Name, Patient Control No., Service From Date, Claim Amount, Claim Status, Payer ID, Emdeon Claim ID, and Emdeon File ID. The table contains 8 rows of data, with the first row highlighted in green.

Claim Received Date	Patient Name	Patient Control No.	Service From Date	Claim Amount	Claim Status	Payer ID	Emdeon Claim ID	Emdeon File ID
06/15/2014	JC [redacted] ISON	48 [redacted]	05/09/2014	\$49.00		23285	EPI [redacted] 101	EPI [redacted]
06/15/2014	JC [redacted] IA	369 [redacted]	04/26/2012	\$227.00		SKILO	EPI [redacted]	EPI [redacted]
06/15/2014	JC [redacted] IA	568 [redacted]	12/27/2012	\$170.30	Emdeon-Accepted	37602	EPI [redacted] 7	EPI [redacted]
06/15/2014	JC [redacted] IA	598 [redacted]	12/28/2012	\$502.00	Emdeon-Accepted	20149	EPI [redacted] 4	EPI [redacted]
06/15/2014	JC [redacted] IH	568 [redacted]	12/27/2012	\$72.00	Emdeon-Accepted	23285	EPI [redacted] 3	EPI [redacted]
06/15/2014	JC [redacted] IA	35 [redacted]	04/26/2012	\$248.00		SKILO	EPI [redacted]	EPI [redacted]
06/15/2014	JC [redacted]	600 [redacted]	12/27/2012	\$54.00	Emdeon-Accepted	57604	EPI [redacted]	EPI [redacted]

Click the highlighted "Claim ID" to view Claim Detail report for the selected claim.

Insured Detail Column Headings

Heading	Description
Claim Received Date	Date claim was received by the application or payer.
Patient Name	Name of the patient submitted on the claim.
Patient Control No.	Insured ID submitted on the claim.
Service From Date	Date of service submitted on the claim.
Claim Amount	Dollar amount of the submitted claim.
Claim Status	Current claim status within the application or at payer.
Payer ID	Payer ID submitted on the claim.

REPORTING & ANALYTICS

Claim ID	Claim ID assigned for the specific claim.
File ID	File ID assigned for the electronic file in which the claim was submitted.

7.4.15 Payment Summary Report

The Payment Summary Report displays when you perform a Patient Pay Search and search by transaction date. It shows patient payments made through Patient Pay Online for a specified date range and worked status. Click the date link in the Transaction Date column to display a Patient Payment Summary by Day Report for the date you selected.

[Home](#) > [Patient Pay Search](#) > [Payment Summary](#)

Search Criteria	Payment Summary																							
<p>Search By</p> <p>Transaction Date ▼</p> <hr/> <p>Transaction Date</p> <p>04/02/2014 🗓 08/25/2014 🗓</p> <p>Search Type</p> <p>All ▼</p> <p style="text-align: center;"> <input type="button" value="SUBMIT"/> <input type="button" value="RESET"/> </p> <p style="font-size: small;">If no dates are entered, dates will default to last 7 days.</p>	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr style="background-color: #90EE90;"> <th style="text-decoration: underline;">Transaction Date</th> <th style="text-decoration: underline;">Quantity</th> <th style="text-decoration: underline;">Amount</th> </tr> </thead> <tbody> <tr> <td>08/19/2014</td> <td style="text-align: center;">5</td> <td style="text-align: right;">\$2,418.95</td> </tr> <tr> <td>06/07/2014</td> <td style="text-align: center;">33</td> <td style="text-align: right;">\$5,761.64</td> </tr> <tr> <td>06/06/2014</td> <td style="text-align: center;">3</td> <td style="text-align: right;">\$1,892.74</td> </tr> <tr> <td>06/02/2014</td> <td style="text-align: center;">34</td> <td style="text-align: right;">\$3,259.85</td> </tr> <tr> <td>05/19/2014</td> <td style="text-align: center;">1</td> <td style="text-align: right;">\$1,683.00</td> </tr> <tr> <td>04/29/2014</td> <td style="text-align: center;">34</td> <td style="text-align: right;">\$7,431.11</td> </tr> </tbody> </table>	Transaction Date	Quantity	Amount	08/19/2014	5	\$2,418.95	06/07/2014	33	\$5,761.64	06/06/2014	3	\$1,892.74	06/02/2014	34	\$3,259.85	05/19/2014	1	\$1,683.00	04/29/2014	34	\$7,431.11		
Transaction Date	Quantity	Amount																						
08/19/2014	5	\$2,418.95																						
06/07/2014	33	\$5,761.64																						
06/06/2014	3	\$1,892.74																						
06/02/2014	34	\$3,259.85																						
05/19/2014	1	\$1,683.00																						
04/29/2014	34	\$7,431.11																						

Payment Summary Report Column Headings

Heading	Description
Transaction Date	Date that the payment was made. Click the link to view the Payment Summary by Day Report for the date you selected.
Quantity	Number of payments made on the specified transaction date.
Amount	Total amount of all payments made on the specified transaction date.

7.4.16 Patient Payment Summary by Day Report

The Patient Payment Summary by Day Report displays when you perform a Patient Pay Search and search by patient name or patient account number as well as when you click a transaction date link on the Payment Summary Report.

Search by Patient Name or Patient Account Number

When you perform a Patient Pay Search and search by patient name or patient account number, the report will show the same patient name or patient account number for the transaction date range you selected.

REPORTING & ANALYTICS

Home > Patient Pay Search > Payment Summary > Payment Summary By Day

Search Criteria

Search By
Transaction Date ▼

Transaction Date
04/02/2014 08/25/2014

Search Type
All ▼

If no dates are entered, dates will default to last 7 days.

Payment Summary By Day

Worked	Transaction Date	Service Date	Pa
<input checked="" type="checkbox"/>	08/19/2014	04/30/2014	HA
<input type="checkbox"/>	08/19/2014	05/15/2014	ME
<input checked="" type="checkbox"/>	08/19/2014	04/30/2014	CA
<input checked="" type="checkbox"/>	08/19/2014	05/15/2014	SE
<input checked="" type="checkbox"/>	08/19/2014	04/21/2014	RU

Click a Transaction Date Link

When you click a transaction date link on the Payment Summary Report, the Patient Payment Summary by Day Report shows payments for all patient names and patient account numbers for the transaction date range you selected.

Payment Summary > Payment Summary By Day Help

Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Declined	Receipt Number	Payment Method	Merchant ID
<input checked="" type="checkbox"/>	08/19/2014	04/30/2014	H[redacted] A	A[redacted]	\$2,088.56	No	32[redacted]	Visa	NWH
<input type="checkbox"/>	08/19/2014	05/15/2014	M[redacted] A	A[redacted]	\$250.00	No	32[redacted]	Visa	NWH
<input checked="" type="checkbox"/>	08/19/2014	04/30/2014	C[redacted] A	A[redacted]	\$68.00	No	32[redacted]	Visa	NWH
<input checked="" type="checkbox"/>	08/19/2014	05/15/2014	SE[redacted] A	A[redacted]	\$50.00	No	32[redacted]	Visa	NWH
<input checked="" type="checkbox"/>	08/19/2014	04/21/2014	RU[redacted] A	A[redacted]	(\$37.61)	No	32[redacted]	Visa	NWH

REPORTING & ANALYTICS

Patient Payment Summary by Day Report Column Headings

Heading	Description
Worked (check box)	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is unworked.
Transaction Date	Date that the payment was made.
Service Date	Date that medical service referenced on claim occurred.
Patient Name	Name of the patient who received the healthcare treatment on the claim.
Patient Account Number	Provider account number for the patient.
Payment Amount	Amount included in payment.
Declined	Yes - Payment from patient was declined. No - Payment from patient was not declined. NA - Decline status of specified payment is not available.
Receipt Number	Unique receipt number of the transaction. Click the link to view the Payment Detail report for the specified payment.
Payment Method	Type of card used in the payment (Visa, MasterCard, Discover, or American Express).
Merchant ID	ID of merchant on transaction.

7.4.17 Payment Detail Report

The Payment Detail Report displays when you click a date link in the **Receipt Number** column on the Patient Payment Summary by Day Report. The report shows the payment and transaction details for the transaction you selected.

Payment Summary > Payment Summary By Day > Payment Detail			
PAYMENT DETAIL			
Payment Details:		Transaction Details:	
Patient Name:	HA [REDACTED]	Transaction Date/Time:	8/19/2014 08:32:29AM
Patient Account No:	A1 [REDACTED]	Transaction ID:	VRD [REDACTED]
Service Date:	4/30/2014	Authorization Code:	02821C
Payment Amount:	\$2,088.56	Receipt No:	31 [REDACTED]
Payment Method:	Visa	Open Date:	5/19/2014 11:34:27PM
Declined:	No	Close Date:	
Worked Status:	<input checked="" type="checkbox"/>	Guarantor Name:	AL [REDACTED]
Merchant ID:	NWH		

Payment Detail Report Rows

Heading	Description
Payment Details Column	
Patient Name	Name of the patient.

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Heading	Description
Payment Details Column	
Patient Account No	Provider account number for the patient.
Service Date	Date medical services specified on claim occurred.
Payment Amount	Amount of the payment.
Payment Method	Type of card used in the payment.
Declined	Yes, No, NA
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is unworked.
Merchant ID	ID of merchant.
Transaction Details Column	
Transaction Details	
Transaction Date/Time	Date and time of the payment.
Transaction ID	Unique transaction identifier (assigned by system).
Authorization Code	Card authorization code (assigned by system).
Receipt No	Unique receipt number (assigned by system).
Open Date	Date and time the transaction started.
Close Date	Date transaction closed.
Guarantor Name	Name of the person making payment.

7.4.18 Summary by Payer Report

The Summary by Payer Report is displayed when you perform a Payer Search without specifying a Payer ID. The report includes a claim summary for each payer (sorted by Payer ID).

Search Criteria		Summary By Payer								
Claim Received Date		Payer ID	Payer Name	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
05/06/2014	08/25/2014	Export Report								
<input type="text"/>	<input type="text"/>	00403	Blue Choice Medicaid Managed Care	4	4	100%	0	0	0%	\$1,966.00
<input type="text"/>	<input type="text"/>	00802		1	0	0%	0	0	0%	\$240.00
<input type="text"/>	<input type="text"/>	01066	American Healthcare Alliance	2	2	100%	0	0	0%	\$492.00
<input type="text"/>	<input type="text"/>	02218		1	1	100%	0	0	0%	\$195.00

Summary by Payer Column Headings

Heading	Description
Payer ID	5-character alphanumeric string; ID number of payers that had claims received by clearinghouse during the specified date range. Click the highlighted date link to view the Summary by Payer by Day report for the selected Payer ID.
Payer Name	Name of payer organization.

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Heading	Description
Received Claim Quantity	Total number of claims received by clearinghouse. Number of claims received by clearinghouse during the specified date range from the payer. Click the link in the Payer ID field to view details of these claims in the Summary by Payer by Day report.
Reject Quantity	Number of claims rejected by Emdeon from the number received.
Reject %	Percentage of claims rejected by clearinghouse.
Paper Claim Quantity	Number of claims printed to paper by clearinghouse.
Payer Reject Quantity	Number of rejected claims from among those received by clearinghouse during the specified date range that were rejected by the payer specified in the Payer ID/Payer Name fields.
Payer Reject %	Percentage of those claims received by clearinghouse that were rejected by the payer.
Claim Amount	Total amount (in US dollars) of all claims received by clearinghouse for the report row. This amount includes any rejected claim amounts. The Claim Amount displayed is the totality of all clearinghouse claims received from the payer for the specified date range.

7.4.19 Summary by Payer by Day Report

The Summary by Payer by Day report can be generated in two ways:

- Perform a Payer Search with a specified Payer ID.
- Click on a Payer ID link in a Summary by Payer report.

The Summary by Payer by Day report displays a summary of claims for the specified Payer ID. Each row in the report shows the total quantity of claims received by the payer for the displayed date for that row. The amount in the **Claim Amount** column is the total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.

Summary By Payer By Day							
Claim Received Date	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
Export Report							
06/15/2014	9	0	0%	0	0	0%	\$1,102.00
Totals:	9	0		0	0		\$1,102.00

Summary by Payer by Day Column Headings

Heading	Description
Claim Received Date	This report displays a summary of all those claims received on the specific date shown per report row (per specified payer). Click the highlighted date to view details for each claim received on the claim received date. That is, if the number displayed in the Claim Received Date column is 12, then 12 claims are displayed in the resulting report.
Received Claim Quantity	Number of claims that were received on the Claim Received Date. Note: When you click the Claim Received Date link those claims that are specified in the Received Claim Quantity field are displayed.
Reject Quantity	Number of claims (from those that were received on the claim received date) that were rejected by clearinghouse.

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Heading	Description
Reject %	Percentage of claims (from those that were received on the claim received date) that were rejected by clearinghouse.
Paper Claim Quantity	Number of claims received in paper format (rather than electronically) from among those claims in the Claim Received Date number.
Payer Reject Quantity	Number of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Payer Reject %	Percentage of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Claim Amount	Total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.

File Summary Search Tips

Use the (optional) "Tax ID" filter to refine your search so that only those claim batches that contain claims for the specified Tax ID are displayed. Tax ID format is 9-character numeric string.

Use the (optional) "Site ID" filter to refine your search so that only those claim batches that contain claims relating to the specified Site ID are displayed. Site ID must be a 4-character string (alpha and/or numeric).

Note: You can also enter both optional criteria.

7.4.20 Patient Pay Search

Access this search by selecting **Payments > Patient Pay Search**. Use the Patient Pay Search to display a report that shows all patient payments made through Patient Pay Online for a specified date range.

Note: The Patient Pay Search is available to all Reporting & Analytics users, but the search will only yield results if your account is set up for the Patient Pay Online service.

7.4.21 Patient Pay Online

Patient Pay Online is a self-service, patient-facing application that provides comprehensive and secure online billing and payment management for healthcare bills. If your practice is set up for this online payment portal, when patients receive a healthcare bill from your practice, they can go to the web address displayed on the bill and make a secure payment with the type of cards your practice accepts. If you want to collect patient payments online, contact your application representative, or enter an ON24/7 request.

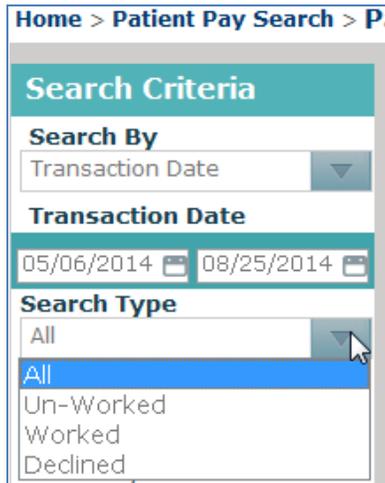
Launch a Patient Pay Search

You can search by transaction date, patient name, or patient account number.

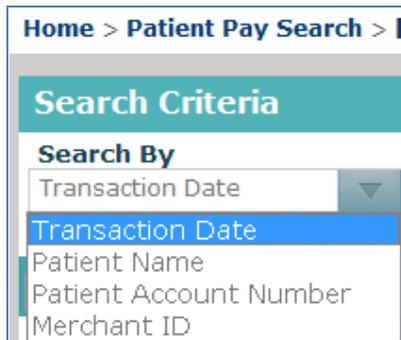
REPORTING & ANALYTICS

Search by Transaction Date

If you want to search by transaction date, select “Transaction Date” in the **Search By** list, select a date range, and then select the search type. The search type choices are All, Un-Worked, and Worked. This search generates a Payment Summary Report (see page 154) for the date range you selected.



The screenshot shows the 'Search Criteria' section of the 'Patient Pay Search' interface. The 'Search By' dropdown is set to 'Transaction Date'. Below it, the 'Transaction Date' section shows a date range from 05/06/2014 to 08/25/2014. The 'Search Type' dropdown is open, showing options: All, Un-Worked, Worked, and Declined. The 'All' option is currently selected.



The screenshot shows the 'Search Criteria' section of the 'Patient Pay Search' interface. The 'Search By' dropdown is open, showing options: Transaction Date, Patient Name, Patient Account Number, and Merchant ID. The 'Transaction Date' option is currently selected.

Search by Patient Name

To search by patient name, select “Patient Name” in the **Search By** list, select the date range, then enter part or all of the patient’s name (at least three characters). This search generates a Patient Payment Summary by Day Report (page 154) for the patient name and date range you selected.

Search by Patient Account Number

If you want to search by patient account number, select “Patient Account Number” in the Search By list, select the date range, and then enter the patient’s account number. This search generates a Patient Payment Summary by Day Report for the patient account number and date range you selected.

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7.4.22 Patient Search

Access this search by selecting **Claims > Patient Search**. Use the following search criteria to generate a report that lists all patient claims for a specified (or default) date range.

Use the Search Date Type list:

- Received Date
- Date of Service

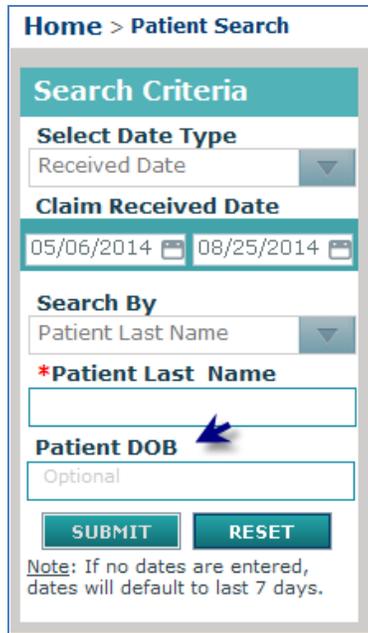
Use the **Search By** list:

- Insured ID
- Patient Control Number (PCN)
- Patient Last Name with optional Patient DOB (Date of Birth).
 - ✓ Partial last name is allowed though at least 3 consecutive characters required. For example, "Smi" will return not only those patients with the last name of "Smith", but also "Smithson", "Smithfield", etc.
 - ✓ Patient DOB is optional and must be in mm/dd/yyyy format. The Patient DOB data field displays only when "Patient Last Name" is your selection in the **Search By** drop-down list.

The screenshot shows a web form titled "Home > Patient Search". It has a teal header "Search Criteria". Below it is a "Select Date Type" dropdown menu with "Received Date" selected. Underneath is a "Claim Received Date" section with two date pickers: "05/06/2014" and "08/25/2014". Below that is a "Search By" dropdown menu with "Insured ID" selected. Underneath is a red asterisk followed by "Insured ID" and an empty text input field. At the bottom are two teal buttons: "SUBMIT" and "RESET". A note at the very bottom reads: "Note: If no dates are entered, dates will default to last 7 days."

Note that optional **Patient DOB** field is not displayed in the above screen capture. Please see screen on following page.

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Home > Patient Search

Search Criteria

Select Date Type
Received Date

Claim Received Date
05/06/2014 08/25/2014

Search By
Patient Last Name

***Patient Last Name**

Patient DOB 
Optional

SUBMIT **RESET**

Note: If no dates are entered, dates will default to last 7 days.

Note: **Patient DOB** (optional field) is displayed only when “Patient Last Name” is selected in the **Search By** drop-down list.

Search Using Last Name Results

A successful Patient Last Name search displays the Insured Detail Report and includes a list of all claims for the specified patient (PCN) or patients.

Search Using Insured ID Results

A successful Insured ID search displays the Insured Detail Report and includes a list of all claims for the primary insured party and all dependents under the Insured ID (subscriber ID) number.

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.

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Claim Summary Column Headings

Heading	Description
Worked	"Worked" progress status; determined by the "Worked" check box in the Claim Detail report
Patient Name	Name of the patient submitted on the claim.
DOB (Date of Birth)	Patient's date of birth.
Insured ID	Insured ID submitted on the claim.
Patient Control Number (PCN)	Provider's control/tracking number for patient on claim.
DOS (Date of Service)	Date of service; date that medical service specified on claim occurred.
Amount	Dollar amount (in US dollars) of the submitted claim.
Payer ID	Payer ID submitted on the claim.
Payer Name	Payer name submitted on the claim.
Claim ID	Claim ID assigned by clearinghouse for the specific claim.

Claim Summary Report List Order

1. Rejected – Claims rejected by clearinghouse.
2. Payer Rejected – Claims rejected by the payer.
3. Accepted – Claims accepted by clearinghouse but no notification from the payer received.
4. Accepted – Claims accepted by payer and the claim is pending adjudication.

Note: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID. (File ID: includes both Site ID and clearinghouse Batch File number, where applicable.)

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7.4.23 ERA Summary by Day Report

This report is generated from the Claims with ERA search.

Claim Received Date	ERA Received Quantity
12/22/2010	433
12/23/2010	170
12/24/2010	59
12/27/2010	1
Totals:	663

Click a link in the Claim Received Date column to view the Claim Summary Report for all claims with ERAs for the date listed, and then click the Claim ID link to view the Claim Detail Report for that claim.

7.4.24 File Summary Report

The File Summary Report provides details on all claim batches submitted to the clearinghouse during a specific date range. Each claim batch is identified by a File ID (clearinghouse batch identifier).

File Received Date	File ID	File Status	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
06/19/2014	EP1	Accepted	3	0	0	\$1,125.00
06/19/2014	EP1	Accepted	2	0	1	\$510.00
07/06/2014	EP1	Accepted	2	1	1	\$161.00
07/06/2014	EP1	Accepted	3	1	2	\$1,471.00

File Summary Column Headings

Heading	Description
File Received Date	Date claim was received by clearinghouse
File ID	File ID assigned by clearinghouse for the electronic file in which the claim was submitted
File Status	The value in this column is determined by the rejected or accepted status of the file. Accepted - If file is accepted, click the link in File ID column to view Claim Summary. Rejected - If file is rejected no data is displayed in Reject Quantity and Payer Reject Quantity columns. click the link in File ID column to view Reject File Details.

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Heading	Description
Received Claim Quantity	Total number of claims received by clearinghouse.
Reject Quantity	Number of claims rejected by clearinghouse.
Payer Reject Quantity	Number of claims rejected by the payer.
Claim Amount	Total dollar amount of all claims received (total dollar amount for total number of claims shown in the Received Claim Quantity column).

7.4.25 Payer Search

Access this search by selecting **Claims > Payer Search**. Use the Payer Search to display a report that includes all claims for a specified (or default) date range.

Note: The Payer ID must be a 5-character alphanumeric string.

The screenshot shows a web interface for 'Payer Search'. At the top, there is a breadcrumb trail: 'Home > Payer Search > Summary'. Below this is a 'Search Criteria' section with a teal header. Under the header, there is a 'Claim Received Date' section with two date pickers: '10/01/2013' and '08/27/2014'. Below the date pickers are three text input fields: 'Tax ID' (with 'Optional' text inside), 'Site ID' (with 'Optional' text inside), and 'Payer ID' (with 'Optional' text inside). At the bottom of the form are two buttons: 'SUBMIT' and 'RESET'. Below the buttons is a note: 'Note: If no dates are entered, dates will default to last 7 days.'

Search Without a Payer ID Results

A successful Payer Search without a Payer ID results in the Summary by Payer Report. For more information, see **Export and Print Reports** (page 142).

Export allows you to export a report; several file formats are available including Excel. **Print** allows you to print a report by opening the report in Adobe Viewer.

Note: Your browser must allow pop-up windows in order to use the Print or Export features.

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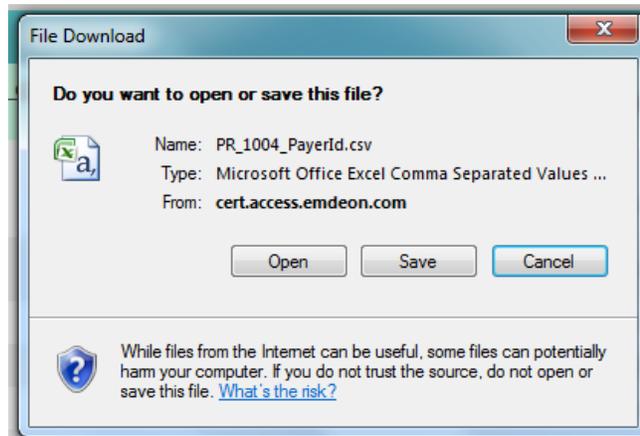
Export a Report to Excel

Export enables you to export a report from Reporting & Analytics to Excel.

1. Click the Export icon.

Payer ID*	Payer Name	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
Export Report								
E265A	P [redacted]	20	0	0%	0	3	15%	\$18,405.58
PAY01	W [redacted]	15	1	7%	0	3	21%	\$11,922.79
PAY02	TE [redacted]	18	4	22%	0	6	43%	\$10,810.04
PAY03	TC [redacted]	9	3	33%	0	1	17%	\$5,995.02
PAY04	T [redacted]	2	0	0%	0	1	50%	\$1,135.00
PAY05	T [redacted]	30	16	53%	0	3	21%	\$45,842.20
Totals:		94	24		0	17		\$94,130.63

2. Click **Save** to save the Excel export.



3. Select the target location for the file, and change the name to a more descriptive filename.
4. Click **Save**.

Print a Report

The **Print Report** function allows you to select print options prior to printing a report.

1. Click the **Print** icon located in the lower right corner of the report.



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2. The report opens in Adobe Reader (or the PDF reader that is set as the default viewer on your computer).
3. Click the Print icon from the Adobe Reader window, or select File > Print.

7.4.26 Audit History Report

Note: This report, generated by performing an Audit History search, is different from viewing the audit history in a Claim Detail Report (see **View Audit History** on page 113).

Data displayed in the Audit History report is sorted by Date/Time Stamp in descending order, with the most recent event at the top of the table.

Username

User ID of the person who made the change described in the table row.

Action Performed

One of two possible actions is displayed in this field.

- Marked claim as Worked: Specified user changed claim status to Worked.
- Marked claim as Unworked: Specified user changed claim status to Unworked.

Date/Time Stamp

Date and time of action.

Claim ID

Specific clearinghouse Claim ID (Claim Original Reference Number) of claim.

Note: This column is not displayed if a specific clearinghouse Claim ID was used in search criteria.

Search with a Payer ID Results

A successful Payer Search with a Payer ID results in the Summary by Payer by Day Report. For more information, see **Summary by Payer by Day Report** on page 158.

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7.4.27 Rejection Since Last Login Search

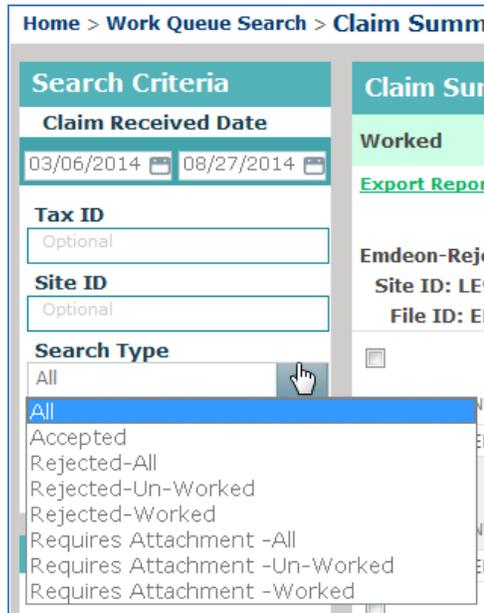
Access this search by selecting **Claims > Rejection Since Last Login**. This search displays a Claim Summary report of all claims that have been rejected since you last accessed Reporting & Analytics.

Note: There are no search criteria associated with this report. Click **Submit** to run the search.

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7.4.28 Work Queue Search

Access this search by selecting **Claims > Work Queue Search**. Use this search to locate claims based on their “Worked” status. Use the **Search Type** list to select the claim status to be searched.



The screenshot shows the 'Work Queue Search' interface. The breadcrumb trail is 'Home > Work Queue Search > Claim Summary'. The 'Search Criteria' section includes: 'Claim Received Date' with a range from 03/06/2014 to 08/27/2014; 'Tax ID' with an 'Optional' text box; 'Site ID' with an 'Optional' text box; and 'Search Type' with a dropdown menu. The dropdown menu is open, showing options: 'All', 'Accepted', 'Rejected-All', 'Rejected-Un-Worked', 'Rejected-Worked', 'Requires Attachment -All', 'Requires Attachment -Un-Worked', and 'Requires Attachment -Worked'. To the right, the 'Claim Summary' section shows a 'Worked' status indicator and an 'Export Report' button.

Search Types – Accepted, Rejected, Requires Attachment

Select one only:

- All
- Accepted
- Rejected – All
- Rejected – Un-Worked
- Rejected – Worked
- Requires Attachment – All
- Requires Attachment – Un-Worked
- Requires Attachment – Worked

Search Criteria Formats

- “Tax ID” – 9-digit numeric string

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- “Site ID” – 4-digit string (alpha and/or numeric)

“Requires Attachment” Search

All claims with status “Requires Attachment” that match all other entered search criteria for the specified date range are displayed. Claims that “require attachments” are those claims to which the payer has requested supporting documents be added.

Work Queue Search Results

- “Accepted”
Displays only claims with an “Accepted” status.
- “All”
Displays all claims regardless of accepted/rejected status.
- “Rejected” (“Worked” or “Unworked”)
Displays all claims that are currently identified with the selected status condition.

Note: For more information on how to change the status of a claim from “Un-Worked” to “Worked” please see **Descriptions and functions** of key user fields in the Claim Detail section are presented below.

7.4.29 Claim Summary Report

The Claim Summary Report can be generated from several areas within Reporting & Analytics:

- Run a Work Queue search for any claim status.
- Click a link in the **Claim Received Date** column on the Summary by Payer by Day report.
- Run a Rejection Since Last Login search.
- Click a link in the **File ID** column of the File Summary report.
- Run a Quick search.
- Click on a pie chart slice, graph bar, or graph data point in the Dashboard view.

The screenshot shows a web application interface for a Claim Summary report. At the top, there is a breadcrumb trail: Home > Work Queue Search > Claim Summary. Below this is a search criteria section with a date range from 06/29/2014 to 08/23/2014 and an Export Report button. The main table has the following column headings: Worked, Patient Name, DOB, Insured ID, PCN, DOS, Amount, Payer ID, Payer Name, and Emdeon Claim ID.

Search Criteria	Claim Summary
Claim Received Date	Worked Patient Name DOB Insured ID PCN DOS Amount Payer ID Payer Name Emdeon Claim ID
06/29/2014 - 08/23/2014	Export Report

Claim Summary Column Headings

Heading	Description
---------	-------------

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Worked	"Worked" progress status; determined by the "Worked" check box in the Detail report
Patient Name	Name of the patient submitted on the claim
DOB	Date of birth of patient.
Insured ID	Insured ID submitted on the claim
Patient Control Number (PCN)	Provider's control/tracking number for patient on claim
Date of Service (DOS)	Date of service
Amount	Dollar amount (in US dollars) of the submitted claim
Payer ID	Payer ID submitted on the claim
Payer Name	Payer name submitted on the claim
Claim ID	Claim ID assigned by clearinghouse for the specific claim

Claim Summary Report List Order

- Rejected – Claims rejected by clearinghouse
- Payer Rejected – Claims rejected by the payer
- Accepted – Claims accepted by clearinghouse but no notification from the payer received
- Accepted – Claims accepted by payer and the claim is pending adjudication

Note: File ID is the second level of sorting That is, the first level is one of the four levels listed above, the second level sort is by File ID (File ID: includes both Site ID and clearinghouse Batch File number, where applicable.)

Payment Summary Report Column Headings

Heading	Description
Transaction Date	Date that the payment was made. Click the link to view the Payment Sum Day Report for the date you selected
Quantity	Number of payments made on the specified transaction date.
Amount	Total amount of all payments made on the specified transaction date.

Patient Payment Summary by Day Report

The Patient Payment Summary by Day Report displays when you perform a Patient Pay Search and search by patient name or patient account number as well as when you click a transaction date link on the Payment Summary Report.

Search by Patient Name or Patient Account Number

When you perform a Patient Pay Search and search by patient name or patient account number, the report will show the same patient name or patient account number for the transaction date range you selected.

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7.4.30 Audit History Report

Note: This report, generated by performing an Audit History search, is different from viewing the audit history in a Claim Detail Report (see **View Audit History** on page 113).

Data displayed in the Audit History report is sorted by Date/Time Stamp in descending order, with the most recent event at the top of the table.

Username

User ID of the user who made the change described in the table row.

Action Performed

One of two possible actions is displayed in this field.

- Marked claim as Worked: Specified user changed claim status to Worked.
- Marked claim as Unworked: Specified user changed claim status to Unworked.

Date/Time Stamp

Date and time of action.

Claim ID

Specific clearinghouse Claim ID (Claim Original Reference Number) of claim.

Note: This column is not displayed if a specific clearinghouse Claim ID was used in search criteria.

7.4.31 Claim Detail Report

You can access a Claim Detail Report in two ways.

- In an Insured Detail Report, click a link in the Claim Received Date column.
- In a Claim Summary Report, click a link in the clearinghouse Claim ID column.

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Home > Work Queue Search > Claim Summary > Claim Detail

Search Criteria	CLAIM DETAIL	XWalk Review	Display Letter	Display Alerts
Claim Received Date 06/29/2014 08/23/2014	View/Edit Claim	View Audit History	Get Help with this Claim	Link To AD
Tax ID [Input Field]	Emdeon Claim ID: DK [Input Field]	Insured ID: 12 [Input Field]	Provider Tax ID:	
Site ID [Input Field]	Patient Name: TC [Input Field]	Patient DOB: 11/27/1945	Billing Provider ID:	
Search Type All	Diagnosis Code(s): Not Available		Billing Provider NPI:	
			Site ID:	

Descriptions and functions of key activity fields in the Claim Detail section are presented below.

Worked Status Indicator

Use the "Worked Status" check box to mark a claim as "worked."

When the "Worked" check box is checked the claim is shown as "worked" on the Claim Summary Report. To search for "worked" claims, use the "All" or "Rejected/All" criteria in "Work Queue" search.

Note: The definition of "worked" is practice (or site) specific. Please be sure that all Reporting & Analytics users in your organization have a clear understanding of how your practice/site uses the "worked" feature.

Timely Filing Letter

Click "Display Letter" to view the Request for Claim Review Letter. The resulting screen is a printable letter that a provider can send to a payer to support assertions of proper and timely claim filing by the provider. If you are a provider you can print this letter, enter the appropriate information, attach any pertinent supporting documentation then send the letter (with attachments) to the payer.

ERA Linking in Claim Detail

If your practice has ERA contracts with payers, ERA data is displayed in the "Payer Claim Status History" under certain conditions.

- The claim has associated ERA(s).
- Your practice has ERA contract with the payer on the claim.
- If an ERA is associated to the claim a generic message is displayed in the **Status Description** field.

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If the claim has been paid (and there is an ERA associated to the claim), the check number is displayed in the **Additional ID's** column. Click the check number to display the Payment Detail report.

Payer Claim Status History	
Additional IDs	Status Date
01190057011900571 0	05/07/2013

Payment Detail Report

If a linked check number is displayed in the Claim Detail Report you can access the Payment Detail report by clicking the check number.

The Payment Detail report provides key information on the claim (and the payment) including claim amount and the difference between paid amount and claim amount.

Payer Claim ID in Claim Detail Report

If the payer received the claim *and* the payer issues claim IDs to clearinghouse, then the payer's claim ID appears in the **Payer Claim ID** field. **However, a blank Payer Claim ID field does not necessarily mean that the payer has not received the claim.**

CLAIM DETAIL	XWalk Review	Display Letter	Display Alerts	
View/Edit Claim	View Audit History	Get Help with this Claim		
Emdeon Claim ID:	E104 <input type="text"/>			
Insured ID:	0011 <input type="text"/>	Provider Tax ID:	00 <input type="text"/>	Claim Rec
Patient Name:	WIL <input type="text"/>	Billing Provider ID:	06 <input type="text"/>	Emdeon P
Patient DOB:	04/1 <input type="text"/>	Billing Provider NPI:	15 <input type="text"/>	Emdeon C
Diagnosis Code(s):	Not Available	Site ID:	K5 <input type="text"/>	Payer ID:
Procedure Code(s):	Not Available	Patient Control No.:	465 <input type="text"/>	Worked S
Claim Amount:	\$1,510.00	Payer Name:	Conf <input type="text"/>	
Service From:	04/01/2013	5010 Format:	Not <input type="text"/>	
Service To:		Payer Claim ID:	01190 <input type="text"/>	

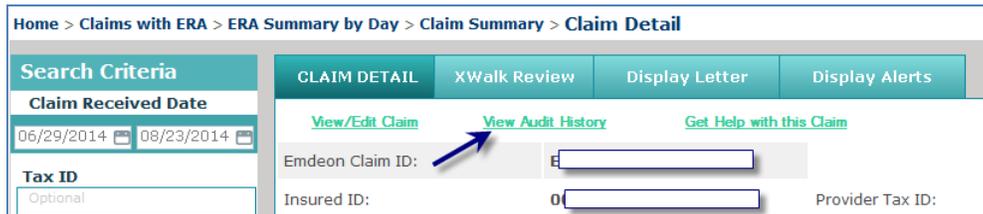
Note: While most payers do issue Claim IDs upon receipt of a claim (which appear in the Claim Detail report) some payers do not.

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View Audit History

Note: This function, which allows you to view the audit history in a Claim Detail Report, is different from the Audit History Report which is generated by performing an Audit History search.

Click the “View Audit History” link to view the audit history of a claim.



The screenshot shows the 'Claim Detail' page with a breadcrumb trail: Home > Claims with ERA > ERA Summary by Day > Claim Summary > Claim Detail. Below the breadcrumb is a search criteria section with 'Claim Received Date' (06/29/2014 to 08/23/2014) and 'Tax ID' (Optional). To the right are tabs for CLAIM DETAIL, XWalk Review, Display Letter, and Display Alerts. Under the CLAIM DETAIL tab, there are three links: View/Edit Claim, View Audit History (highlighted with a blue arrow), and Get Help with this Claim. Below the links are input fields for Emdeon Claim ID, Insured ID, and Provider Tax ID.

The following actions are tracked in Audit History:

- Click **View Claim**.
- Click on “Eligibility” link.
- Click on “Claim Status” link.
- All “Worked/Unworked” status changes for the last 15 months on the claim are shown with username and date/time stamp

If the Audit History report is longer than 1,000 rows the report can be exported in Microsoft Excel format. The export will include all rows including those rows that were not displayed due to the 1,000 row display limit.



The screenshot shows the 'Audit History' window. The window title is 'Audit History Report For Claim: E104'. The window contains a table with the following columns: Username, Action Performed, and Date/Time stamp. The table has several rows, with the first row showing 'W11' as the username and '04/01/2013' as the date. The window also has a 'Close' button at the bottom.

When you click the “View Audit History” link, a new window appears. The Audit History window can be moved in the same manner that the Help window can be moved (click and drag the title bar of the window).

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7.4.32 Workers' Compensation Attachments

Overview

Reporting & Analytics provides you with a convenient and powerful way to manage workers' compensation claims.

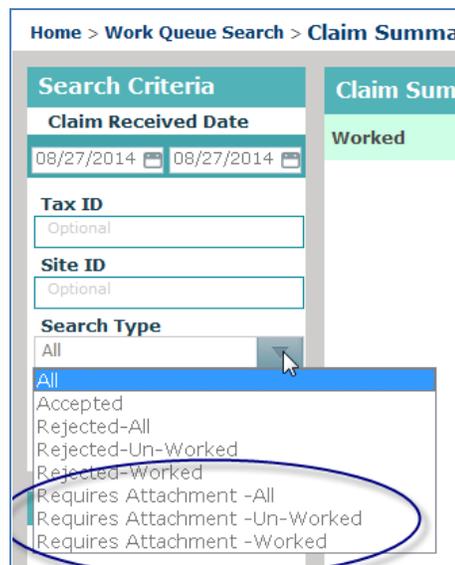
Functionality includes both claim management and the ability to respond directly to payers with requested attachments. Workers' Compensation Attachments is available by subscription only from Reporting & Analytics.

If you have pending workers' compensation claims, you can easily find those claims and respond to payer requests for further documentation.

Locate Claims

To locate claims in Reporting & Analytics that the payer requires additional information for, begin the search by selecting Claims > Work Queue Search.

In the Search Type drop-down list, select "Requires Attachment". Enter your Tax ID or Site ID for a more specific search (both fields are optional).



The screenshot shows a web interface for searching claims. The breadcrumb trail is "Home > Work Queue Search > Claim Summary". The page is divided into two main sections: "Search Criteria" and "Claim Summary".

Search Criteria	Claim Summary
Claim Received Date 08/27/2014 [calendar icon] 08/27/2014 [calendar icon]	Worked
Tax ID Optional [input field]	
Site ID Optional [input field]	
Search Type All [dropdown menu]	

The dropdown menu for "Search Type" is open, showing the following options:

- All
- Accepted
- Rejected-All
- Rejected-Un-Worked
- Rejected-Worked
- Requires Attachment -All
- Requires Attachment -Un-Worked
- Requires Attachment -Worked

The "Requires Attachment -All" option is circled in blue.

All claims that match the selected search criteria for which the payer on workers' compensation claim(s) has requested additional documentation are shown.

Payer Allowed Response Period

On workers' compensation claims that require attachments, payers provide a 15-day response period, during which time the provider can upload files and send them to the

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payer. If the provider does not respond within the 15-day response period, the claim is rejected and no longer appears in the **Work Queue Search > "Requires Attachment"** search results report.

Access Attachments Functionality

In the Claim Summary report, click the highlighted **Claim ID** to show the Claim Detail report for the selected claim. Click **Claim Attachment** link to show the workers' compensation attachments application window.

Home > Work Queue Search > Claim Summary > Claim Detail

Search Criteria

Claim Received Date: 04/01/2014 to 08/27/2014

Tax ID: Optional

Site ID: Optional

Search Type: Requires Attachment - All

SUBMIT RESET

CLAIM DETAIL XWalk Review Display Letter Display Alerts **Claim Attachment**

[View/Edit Claim](#) [View Audit History](#) [Get Help with this Claim](#)

Emdeon Claim ID: EP []

Insured ID: 10 [] Provider Tax ID: 2 []

Patient Name: ASH [] Billing Provider ID: 5 []

Patient DOB: 02 [] Billing Provider NPI: 1 []

Diagnosis Code(s): 31684965434564 [more](#) Site ID: EFGH

Procedure Code(s): 31684965434564 [more](#) Patient Control No.: P []

7.4.33 Workers' Compensation Attachments Window

Print Close

act #	Total Charges	Employer	Carrier	DOI	Service Dates	Patient Name	Status	Date	Status	Attachments
260	\$630.00	RAM	TEXAS MUTUAL INSU	01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO	View Bill Commit	Upload Fax

* Attachment Type: Admission Summary

Description: Limit 80 Chars

* Attach File: [] Browse...

* Indicates Required Field

Upload Cancel

(ACN)	Date/Time	Attachment Type	Delivery Method	Description	Detail
	01/27/2010 16:31 CST	Consultation Report	Electronically Only		View Remove
	01/27/2010 16:32 CST	Certification	Electronically Only		View Remove

Click **Upload** at the upper right to show the Upload fields. Click the **Upload** button directly beneath the **Attach File** field for each attachment to add to the bill. After all files are uploaded, click the "Commit" link to send your bill and files to the payer for review.

Use the Workers' Compensation Attachments Interface

- Click the "Claim Attachment" link in the Claim Detail report. The workers' compensation claim attachment window appears.
- To view an attachment, click the applicable "View" link. A graphic or PDF viewer appears.

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- Click **Print** to print a summary view. You can print uploaded files directly from the View window.
- Click **Upload** in the upper right corner to show the file upload window. Only PDF and TIFF format files can be uploaded.
 - ✓ Click **Browse** to locate the file to upload.
 - ✓ Select an attachment type from the **Attachment Type** drop-down list (required field).
 - ✓ Enter a description of the file (optional field).
 - ✓ Click **Upload** to upload the file. Repeat these four steps for each file to attach to the claim.
- Status conditions:

DOI	Service Dates	Patient Name	Status Date	Status	Attachments
01/05/2007	12/04/2009 12/04/2009	RAMIREZ	01/25/2010	PDCO View Bill Commit	Upload Fax

Attachment Type	Delivery Method	Description	Detail	View	Remove
Attachment Report	Electronically Only			View	Remove
Attachment	Electronically Only			View	Remove

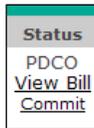
- ✓ PNDA – Pending Attachments. Attachments are pending to be sent to the payer.
- ✓ PDCO – Pending Commit. You can add files while bill is in this status. Click the “Commit” link to send the bill with attachments to the payer for review. Do not click “Commit” until all of your files are attached.
- ✓ PEND – All attachments and bill documents are ready to be sent to payer. This status occurs after “Commit” is clicked. This status is the condition prior to **SENT**. No action can be taken in the workers’ compensation claim attachment window while in this status.
- ✓ SENT – Bill and attachments sent to payer.

Note: After bill and attachments are sent, the **Upload** and **Fax** buttons are no longer available.

- Fax documents so that they are correctly received by the payer.
 - ✓ If you have paper documents that you want to scan and send to the payer, click **Fax**.
 - ✓ Print the fax cover sheet, and then fax all paper documents to the payer (at the fax number shown on the fax cover sheet) with fax cover sheet as the first document in the communication. Using the fax cover sheet ensures that your faxed documents are associated to the bill.
- You can view or remove uploaded files from the bill prior to clicking “Commit.” Once committed, uploaded files cannot be removed.

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- Review the billing image created by clicking the “View Bill” link (located in the **Status** column in the upper right of the workers’ compensation attachments window).



- Click “Commit” to send uploaded files to payer for review.

Note: You must click “Commit” to complete the bill/claim submission process. If “Commit” is not clicked, attached files are not sent to the payer, and the claim will remain in **PDCO/Pending Commitment** status.

7.4.34 View and Edit Claim

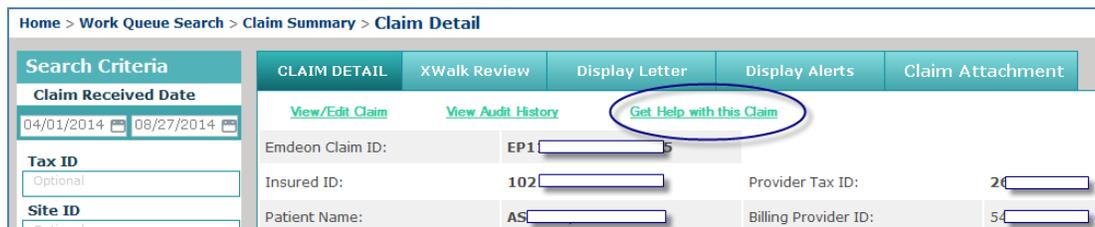
View and Edit Claims

Viewing and editing claims is a feature you can access through the Claim Detail Report. For details on how to view and edit claims, see the **View and Edit Claims** section on page 159.

“Get Help with this Claim” Link

Using the “Get Help with this Claim” link enables you to access Customer Service Alerts (CSAs) and submit a support ticket for the claim you are viewing.

- In a Claim Detail report, click the “Get Help with this Claim” link.

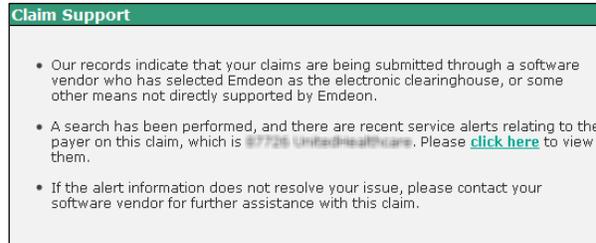


A screenshot of the 'Claim Detail' report interface. The breadcrumb trail at the top reads: Home > Work Queue Search > Claim Summary > Claim Detail. Below this is a navigation bar with tabs: CLAIM DETAIL (selected), XWalk Review, Display Letter, Display Alerts, and Claim Attachment. Under the CLAIM DETAIL tab, there are three links: View/Edit Claim, View Audit History, and Get Help with this Claim (circled in blue). The main content area displays claim information in a table format:

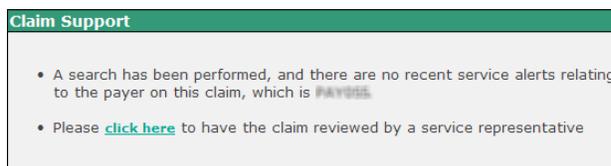
Emdeon Claim ID:	EP1		
Insured ID:	102	Provider Tax ID:	20
Patient Name:	AS	Billing Provider ID:	50

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- The "Claim Support" message window appears. Two links may be available:
 - ✓ **Customer Alerts** link – If there are recent (last 30 days) Customer Service Alerts (CSAs) on the claim from the payer, a link to the CSA will appear. Hover your cursor over the CSA to view a short description. Click the link to view the CSA.



- ✓ **Service Request** link – This link appears for all claims in Reporting & Analytics. Click the link to create a service request for the claim you are viewing.



- If you click the service request link, the Create Service Request form appears. The form is pre-populated with key details from the claim.

Claim Details From Emdeon Vision			
Claims ID Number:	0K0000QFFC0042	Claim Amount:	\$650.00
Insured ID:	123456789012	Patient Name:	[REDACTED]
Service From Date:	5/31/2010	Payer Name:	0K0000
Service To Date:	5/31/2010	Payer ID:	PAYSS
Submitter ID:	22382777	Claim Tax ID:	34343434

What type of issues are you having with this claim?

Claim Rejection

Claim Missing at Payer

Other

Workers Comp Claim Attachment

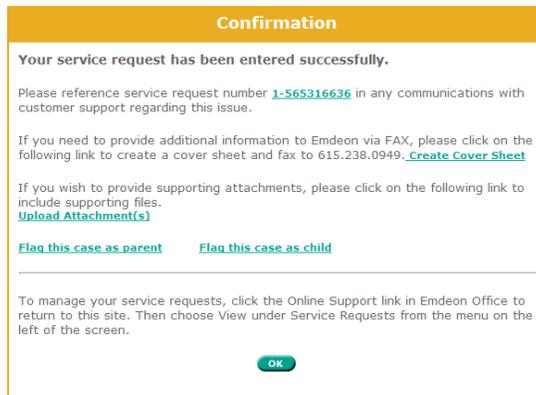
[PREVIOUS](#) [CONTINUE](#)

- Click the option that describes the issue you are having with the claim, and then click **Continue**.
- Enter identifying information on the pages that follow, clicking **Continue** at the bottom of each page. You will be able to review the information you entered before you submit the service request.
- If you would like to change the information you entered, click **Start Over**.

Note: Clicking **Start Over** does not erase the claim information that was present when you created the service request.

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7. Click **Submit**.
8. The Confirmation window displays. From this window you can choose from several options or close the window by clicking **OK**.



- **Service request reference number** – Click to access details on the service request: view the request history, add a comment, add files, flag, etc.
- **Create Cover Sheet** – If you need to fax documents to clearinghouse relating to the service request, click this link to open a fax cover sheet. The cover sheet is pre-populated with information that will associate the fax with the service request. Print the cover sheet and use it as the first page of the fax you send to clearinghouse regarding the service request.
- **Upload Attachments** – Click to upload any standard file type up to 50 MB. You can upload only one file at a time.
- **Flag this case as parent** – If you need to link cases with related issues, click to set the service request as a parent in relation to one or more service requests. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. This will create a hierarchical linkage.
- **Flag this case as child** – If you need to link cases with related issues, click to set the service request as a child in relation to another service request. Use the search function to locate a service request, select the check box next to the service request, and then click **Save**. A hierarchical linkage is created.

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7.4.35 ERA Summary by Day Report

This report is generated from the Claims with ERA search.

Home > Claims with ERA > ERA Summary by Day	
Search Criteria	ERA Summary By Day
Claim Received Date 04/01/2014 <input type="text"/> 08/27/2014 <input type="text"/>	Claim Received Date <input type="text"/> ERA Received Quantity
Tax ID Optional <input type="text"/>	05/21/2014 17
Site ID Optional <input type="text"/>	06/01/2014 1
<input type="button" value="Submit"/> <input type="button" value="Reset"/>	06/07/2014 4
<small>Note: If no dates are entered, dates will default to last 7 days.</small>	07/18/2014 1
	07/27/2014 3
	08/25/2014 3
	Totals: 29

Click a link in the Claim Received Date column to view the Claim Summary Report for all claims with ERAs for the date listed, and then click the Claim ID link to view the Claim Detail Report for that claim.

7.4.36 File Summary Report

The File Summary Report provides details on all claim batches submitted to the clearinghouse during a specific date range. Each claim batch is identified by a File ID (clearinghouse batch identifier).

Home > File Summary Search > File Summary	
Search Criteria	File Summary
File Received Date 06/10/2014 <input type="text"/> 09/01/2014 <input type="text"/>	File Received Date <input type="text"/>
Tax ID Optional <input type="text"/>	Export Report
Site ID Optional <input type="text"/>	07/13/2014
<input type="button" value="SUBMIT"/> <input type="button" value="RESET"/>	07/13/2014
<small>Note: If no dates are entered, dates will default to last 7 days.</small>	07/13/2014
Report Criteria	07/13/2014
File Date Range : 6/10/2014 - 9/1/2014	07/13/2014
Provider Tax ID : < Empty >	07/13/2014
Site ID : < Empty >	07/13/2014

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File Received Date	File ID	File Status	Received Claim Quantity	Emdeon Reject Quantity	Payer Reject Quantity	Claim Amount
07/13/2014	EP [redacted]	Accepted	4	2	1	\$2,550.00
07/13/2014	EP [redacted]	Accepted	1	0	1	\$77.00

File Summary Column Headings

Heading	Description
File Received Date	Date claim was received by clearinghouse
File ID	File ID assigned by clearinghouse for the electronic file in which the claim was submitted
File Status	The value in this column is determined by the rejected or accepted status of the file. Accepted - If file is accepted, click the link in File ID column to view Claim Summary. Rejected - If file is rejected no data is displayed in Reject Quantity and Payer Reject Quantity columns. click the link in File ID column to view Reject File Details.
Received Claim Quantity	Total number of claims received by clearinghouse.
Reject Quantity	Number of claims rejected by clearinghouse.
Payer Reject Quantity	Number of claims rejected by the payer.
Claim Amount	Total dollar amount of all claims received (total dollar amount for total number of claims shown in the Received Claim Quantity column).

7.4.37 Insured Detail Report

The Insured Detail Report is displayed when you run a Patient Search. This report provides a list of all claims for the specified patient for the date range specified in the **Claim Date Range** field.

Run a Patient Search with Insured ID

When you use Insured ID as search criteria in Patient Search the Insured Detail report displays a list of all claims for all patients (the insured party and their dependents) that are covered under the specified Insured ID (Subscriber ID) for the stated date range.

Claim Received Date	Patient Name	Patient Control No.	Service From Date	Claim Amount	Claim Status	Payer ID	Emdeon Claim ID	Emdeon File ID
06/15/2014	SN [redacted]	51 [redacted]	12/27/2012	\$49.00	Emdeon-Accepted	29076	EP [redacted]	EP [redacted] QB9
06/15/2014	SN [redacted]	51 [redacted]	12/27/2012	\$72.00		27514	EP [redacted]	EP [redacted] QB9

Click "Claim ID" (second column from the right) to view Claim Detail report for the claim.

Insured Detail Column Headings

Heading	Description
---------	-------------

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Claim Received Date	Date claim was received by clearinghouse or payer.
Patient Name	Name of the patient submitted on the claim.
Patient Control No.	Insured ID submitted on the claim.
Service From Date	Date of service submitted on the claim.
Claim Amount	Dollar amount of the submitted claim.
Claim Status	Current claim status with clearinghouse or payer.
Payer ID	Payer ID submitted on the claim.
Claim ID	Claim ID assigned by clearinghouse for the specific claim.
File ID	File ID assigned by clearinghouse for the electronic file in which the claim was submitted.

Payment Summary Report

The Payment Summary Report displays when you perform a Patient Pay Search and search by transaction date. It shows patient payments made through Patient Pay Online for a specified date range and worked status. Click the date link in the Transaction Date column to display a Patient Payment Summary by Day Report for the date you selected.

Home > Patient Pay Search > Payment Summary			
Search Criteria		Payment Summary	
Search By Transaction Date		Transaction Date	Quantity
Transaction Date 04/01/2014 - 08/27/2014		08/19/2014	5
Search Type All		06/07/2014	33
<input type="button" value="SUBMIT"/> <input type="button" value="RESET"/>		06/06/2014	3
		06/02/2014	34
		05/19/2014	1
			\$2,418.95
			\$5,761.64
			\$1,892.74
			\$3,259.85
			\$1,683.00

Payment Summary Report Column Headings

Heading	Description
Transaction Date	Date that the payment was made. Click the link to view the Payment Summary by Day Report for the date you selected.
Quantity	Number of payments made on the specified transaction date.
Amount	Total amount of all payments made on the specified transaction date.

7.4.38 Patient Payment Summary by Day Report

The Patient Payment Summary by Day Report displays when you perform a Patient Pay Search and search by patient name or patient account number as well as when you click a transaction date link on the Payment Summary Report.

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Search by Patient Name or Patient Account Number

When you perform a Patient Pay Search and search by patient name or patient account number, the report will show the same patient name or patient account number for the transaction date range you selected.

Home > Patient Pay Search > Payment Summary > Payment Summary By Day Help

Search Criteria		Payment Summary By Day									
Search By	Transaction Date	Worked	Transaction Date	Service Date	Patient Name	Patient Account Number	Payment Amount	Declined	Receipt Number	Payment Method	Merchant ID
Transaction Date	04/01/2014 - 08/27/2014	<input checked="" type="checkbox"/>	06/07/2014	04/30/2014	MA [redacted]	AI [redacted]	\$1,685.47	No	31 [redacted]	Visa	NWH
Search Type	All	<input checked="" type="checkbox"/>	06/07/2014	05/15/2014	KA [redacted]	AI [redacted]	\$743.04	No	31 [redacted]	American Express	NWH

Click a Transaction Date Link

When you click a transaction date link on the Payment Summary Report, the Patient Payment Summary by Day Report shows payments for all patient names and patient account numbers for the transaction date range you selected.

Patient Payment Summary by Day Report Column Headings

Heading	Description
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is unworked.
Transaction Date	Date that the payment was made.
Service Date	Date that medical service referenced on claim occurred.
Patient Name	Name of the patient on the claim.
Patient Account Number	Provider account number for the patient.
Payment Amount	Amount included in payment.
Receipt Number	Unique receipt number of the transaction. Click the link to view the Payment Detail report for the specified payment.
Declined	Yes - Payment from patient was declined. No - Payment from patient was not declined. NA - Decline status of specified payment is not available.
Payment Method	Type of card used in the payment (Visa, MasterCard, Discover, or American Express).
Merchant ID	Merchant ID associated with the payment described on the report row.

7.4.39 Payment Detail Report

The Payment Detail Report displays when you click a date link in the **Receipt Number** column on the Patient Payment Summary by Day Report. The report shows the payment and transaction details for the transaction you selected.

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Home > Patient Pay Search > Payment Summary > Payment Summary By Day > Payment Detail

Search Criteria	PAYMENT DETAIL	
Search By Transaction Date Transaction Date 04/01/2014 - 08/27/2014 Search Type All SUBMIT RESET If no dates are entered, dates will default to last 7 days.	Payment Details: Patient Name: KA Patient Account No: A1 Service Date: 5/15/2014 Payment Amount: \$7 Payment Method: American Express Declined: No Worked Status: <input checked="" type="checkbox"/> Merchant ID: NWH	Transaction Details: Transaction Date/Time: 6/7/2014 08:32:29AM Transaction ID: VL Authorization Code: 123 Receipt No: 31 Open Date: 9/18/2013 11:58:45AM Close Date: Guarantor Name: DEE

Payment Detail Report Rows

Heading	Description
Payment Details Column	
Patient Name	Name of the patient.
Patient Account No	Provider account number for the patient.
Service Date	Date medical service on claim occurred.
Payment Amount	Amount of the payment.
Payment Method	Type of card used in the payment.
Worked	If there is a check in the check box, the payment is worked. If there is not a check in the check box, the payment is unworked.
Merchant ID	ID of merchant in transaction.
Transaction Details Column	
Transaction Date/Time	Date and time of the payment.
Transaction ID	Unique transaction identifier (assigned by system).
Authorization Code	Card authorization code (assigned by system).
Receipt No	Unique receipt number (assigned by system).
Open Date	Date and time the transaction started.
Close Date	Date transaction closed.
Guarantor Name	Name of the person making payment.

7.4.40 Summary by Payer Report

The Summary by Payer Report is displayed when you perform a Payer Search without specifying a Payer ID. The report includes a claim summary for each payer (sorted by Payer ID).

Home > Payer Search > Summary by Payer

Search Criteria	Summary by Payer								
Claim Received Date 04/01/2014 - 08/27/2014 Tax ID Site ID	Payer ID	Payer Name	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
Export Report									
	00403	Blue Choice Medicaid Managed Care	4	4	100%	0	0	0%	\$1,966.00
	00803		1	0	0%	0	0	0%	\$240.00

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Summary by Payer Column Headings

Heading	Description
Payer ID	5-character alphanumeric string; ID number of payers that had claims received by clearinghouse during the specified date range. Click the highlighted date link to view the Summary by Payer by Day report for the selected Payer ID.
Payer Name	Name of payer organization.
Received Claim Quantity	Total number of claims received by clearinghouse. Number of claims received by clearinghouse during the specified date range from the payer. Click the link in the Payer ID field to view details of these claims in the Summary by Payer by Day report.
Reject Quantity	Number of claims rejected by clearinghouse from the number received.
Reject %	Percentage of claims rejected by clearinghouse.
Paper Claim Quantity	Number of claims printed to paper by clearinghouse.
Payer Reject Quantity	Number of rejected claims from among those received by clearinghouse during the specified date range that were rejected by the payer specified in the Payer ID/Payer Name fields.
Payer Reject %	Percentage of those claims received by clearinghouse that were rejected by the payer.
Claim Amount	Total amount (in US dollars) of all claims received by clearinghouse for the report row. This amount includes any rejected claim amounts. The Claim Amount displayed is the totality of all clearinghouse claims received from the payer for the specified date range.

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7.4.41 Summary by Payer by Day Report

The Summary by Payer by Day report can be generated in two ways:

- Perform a Payer Search with a specified Payer ID.
- Click on a Payer ID link in a Summary by Payer report.

The Summary by Payer by Day report displays a summary of claims for the specified Payer ID. Each row in the report shows the total quantity of claims received by the payer for the displayed date for that row. The amount in the **Claim Amount** column is the total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.

Search Criteria		Summary By Payer By Day							
Claim Received Date		Claim Received Date	Received Claim Quantity	Emdeon Reject Quantity	Emdeon Reject %	Paper Claim Quantity	Payer Reject Quantity	Payer Reject %	Claim Amount
04/01/2014	08/27/2014	07/13/2014	1	0	0%	0	0	0%	\$240.00
Tax ID		Totals:							
Site ID									

Summary by Payer by Day Column Headings

Heading	Description
Claim Received Date	This report displays a summary of all those claims received on the specific date shown per report row (per specified payer). Click the highlighted date to view details for each claim received on the claim received date. That is, if the number displayed in the Claim Received Date column is 12, then 12 claims are displayed in the resulting report.
Received Claim Quantity	Number of claims that were received on the Claim Received Date. Note: When you click the Claim Received Date link those claims that are specified in the Received Claim Quantity field are displayed.
Reject Quantity	Number of claims (from those that were received on the claim received date) that were rejected by clearinghouse.
Reject %	Percentage of claims (from those that were received on the claim received date) that were rejected by clearinghouse.
Paper Claim Quantity	Number of claims received in paper format (rather than electronically) from among those claims in the Claim Received Date number.
Payer Reject Quantity	Number of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Payer Reject %	Percentage of claims rejected by the specified payer from among those claims in the Claim Received Date number.
Claim Amount	Total amount in US dollars of claims (including rejected amounts) received on the specified Claim Received Date for the specified payer ID.

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7.5 View and Edit Claims

7.5.1 Overview

You can correct and refile claims from within Reporting & Analytics. You can review all the fields of a primary or secondary claim, correct errors that may have caused the claim to be rejected, and re-submit the updated claim to the payer.

You can also create secondary claims when the primary claim has been partially paid and you want to obtain payment from an additional payer for unpaid amounts. You can only create a secondary claim from a primary claim.

Information displayed in the claim editor is always specific to the claim you access in Reporting & Analytics.

Note: Claim viewing and editing may not be available to your account. If these services are not available to you please contact customer service for information about how to upgrade your account.

7.5.2 View/Edit Permissions

If you can see **View/Edit Claim**, you can view, correct, and refile claims.

The screenshot shows the 'Claim Detail' page in the Emdeon system. The breadcrumb trail is 'Home > Work Queue Search > Claim Summary > Claim Detail'. The page has a teal header with tabs for 'CLAIM DETAIL', 'XWalk Review', 'Display Letter', and 'Display Alerts'. Below the header, there are three links: 'View/Edit Claim' (circled in green), 'View Audit History', and 'Get Help with this Claim'. The main content area contains form fields for 'Emdeon Claim ID' (with value 'EP'), 'Insured ID' (with value '10'), and 'Provider Tax ID'.

Note: If you can see the **View Claim** link (but *not* the View/Edit link) this means that you can only *view* claims, and that your account is not setup for correcting or refiling claims. Please upgrade your account to be able to correct and refile claims.

7.5.3 Primary, Secondary, and Tertiary Claims

Primary Claims

You can correct and refile primary claims, and you can create a secondary claim from a primary claim.

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Secondary Claims

You can correct and refile secondary claims, and you can create a secondary claim from a primary claim. A claim is considered a secondary claim when the following conditions are true:

- The claim has Claim Adjudication and Claim Line Adjudication tabs (see the Secondary and Tertiary Claim Tabs section page 167).

and

- The Sequence field is populated with "Secondary" on the Payer/Billing Provider tab in the Payer Information section.

Tertiary Claims

Currently, you can only correct and refile tertiary claims; you cannot create tertiary claims from secondary claims. If you click **Create Secondary Claim** on a secondary claim, this message appears:

Secondary claims can only be created from primary claims. To make changes on secondary or tertiary claims, please click [View/Edit](#).

There is an additional limitation to tertiary claims: there is no indicator that shows whether the payer information in the **Other Insurance** tab and the claim adjudication information are from the primary or secondary claim. You can effectively view and edit only the current destination payer information.

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A claim is considered a tertiary claim when the following conditions are true:

- The claim has **Claim Adjudication** and **Claim Line Adjudication** tabs (see the **Secondary and Tertiary Claim Tabs** section on page 167)
and
The **Sequence** field is populated with "Tertiary" on the **Payer/Billing Provider** tab in the Payer Information section.

7.5.4 System Time Out

Non-Use Time Out

If you have Reporting & Analytics open but do not perform any actions for 15 minutes, your session will time out and you will lose your changes.

7.5.5 Access Claim Viewing and Editing

Follow these steps to access claim viewing and editing:

1. Select **Claims > Reporting & Analytics** from the main menu.
2. Search for and open the Claim Detail Report of the claim you want to use. (See the **Claim Data Searches** section on page 102 for details on search types.)
3. Click the **View/Edit Claim** link.

The screenshot shows the 'Claim Summary > Claim Detail' interface. At the top, there are four tabs: 'CLAIM DETAIL' (selected), 'Xwalk Review', 'Display Letter', and 'Display Alerts'. Below the tabs, there are three links: 'View/Edit Claim' (highlighted with a blue arrow), 'View Audit History', and 'Get Help with this Claim'. The main content area contains a form with the following fields:

Emdeon Claim ID:	EID	<input type="text"/>
Insured ID:	UID	<input type="text"/>
Patient Name:	AP	<input type="text"/>
		Provider Tax ID:
		Billing Provider ID:

4. The claim opens in a new window, with the **Errors** tab selected.

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Payer/Billing Provider Subscriber/Patient Service Line Visit Authorization Additional Providers/Facility Other Insurance Claim Adjudication Errors

Refile Close CORN ID: EP

Rejected Error Message(s) ?

No Rejected Error Messages

Validation Error(s)

[Errors that involve only one field can be clicked to jump to that field. Errors that involve multiple fields or fields that cannot be specifically identified, check the box corresponding to that error]

Payer/Billing Provider

Billing Provider Information
Billing Provider Email Address is required.
Telephone is required.
Fax is required.

Subscriber/Patient

Patient Information
Patient Account # may contain letters, numbers, dashes, periods, spaces, and asterisks.

Other Insurance Information

Please fill in the required fields in this section. If you have accidentally marked this section to be included then uncheck the box labeled *Include Other Insurance on Claim*

Other Payer Information
Warning: Payer ID matches multiple plan names. Please review and verify that the correct plan has been selected.

Service Line

Please fill in the required fields in this section and correct errors related to Diagnosis Codes, Service Start/End dates, Units and Anes Mnts

Line 1
Page: Service Line DME Information
Section: DME Information Section
Condition Indicator 1 is required.
DME Duration is required.
Certification Condition Indicator is required.
Certification Type Code is required.

7.5.6 Navigation

Main Tabs

There are eight main tabs. Each tab is a component of the claim. Tabs are organized into sections, and some tabs have sub-windows with additional tabs. You can view a new tab at any time by clicking the tab at the top of the window.

Claims Correction

Payer/Billing Provider Subscriber/Patient Service Line Visit Authorization Additional Providers/Facility Other Insurance Claim Adjudication Errors

Refile Close CORN ID: EPO

Rejected Error Message(s) ?

Before you submit a claim, you must make all of the required changes on every tab. The changes you make on one tab will be retained when you click another tab, but there is no

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way to save the claim as a work in progress if you close the claim editor window or allow your session to time out.

Note: If you close the main window without clicking **Refile** or **Submit**, all of your changes will be lost.

The following is a list of the main tabs and their sections:

Payer/Billing Provider

- Submitter Information
- Payer Information
- Billing Provider Information
- Pay-To Provider

Subscriber/Patient

- Subscriber Information
 - ✓ More Fields – Subscriber Information
- Patient Information
 - ✓ More Fields – Patient Information

Service Line

- Diagnosis Codes
- Claim Line Information
- More – see **Service Line Tab's Claim Line More** Button section on page 164.

Visit

- Occurrence Date and Details
- Ambulance Information
- Spinal Manipulation Services
- Vision Services

Authorization

- Release Information

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- Reference Information
- Claim Supplemental Information
 - ✓ Place a check in the check box to enable this section, unless already enabled.
 - ✓ The section is automatically checked if the inbound claim contains claim level attachment information.
 - ✓ "Attachment Record Type Code" and "Attachment Transmission Code" are both required fields.
 - ✓ "Attachment Control #" field is always required except when "Attachment Transmission Code" = AA – *Available on Request at Provider Site*.

Additional Providers/Facility

- Facility/Location Information
- Rendering Provider
- Referring Provider
- Supervising Provider
- Purchased Service Provider

Other Insurance

- Other Subscriber
- Other Payer Release
- Other Payer

Claim Adjudication

Note: This tab displayed for Secondary claim only.

- Claim Line Adjudication
- Claim Line Adjustment

Errors

- Rejected Error Message(s)
- Validation Errors

Service Line > More

The **Service Line** tab includes a **More** button for each claim line.

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Submit Close CORN ID: E[]

Note:
 • Fields marked * are required.
 • Mouse hover on the highlighted fields to see the error.

Diagnosis Codes ?
 * Diagnosis Codes
 1 3674 2 [] 3 [] 4 []
 5 [] 6 [] 7 [] 8 []

	Start Date	End Date	Place Code	Emergency	Proc	Modifiers	Diag Pointers	Units	Anes Mnts	Charges	EPSDT	Family Planning
X 1	06/17/2014	06/17/2014	Office	--Select--	92015	[] [] [] []	1 [] [] [] []	1.0	[]	25.00	--Select--	--Select-- More
X 2	[]	[]	--Select--	--Select--	[]	[] [] [] []	[] [] [] []	[]	[]	[]	--Select--	--Select-- More
X 3	[]	[]	--Select--	--Select--	[]	[] [] [] []	[] [] [] []	[]	[]	[]	--Select--	--Select-- More
X 4	[]	[]	--Select--	--Select--	[]	[] [] [] []	[] [] [] []	[]	[]	[]	--Select--	--Select-- More

Display 4 Lines

* Claim Total Charge Patient Paid Amount
 25.00 []

Reset Close

Click the **More** on each claim line that requires additional information. A separate sub-window with additional tabs opens.

Additional Information

Other Information Additional Providers DME Information Ambulance Information Claim Line Adjudication

Note:
 • Fields marked * are required.
 • Mouse hover on the highlighted fields to see the error.

Other Information ?
 Referral # [] CLIA # [] Prior Authorization # [] Referring CLIA # [] Hospice Employed Provider Indicator --Select--
 Mammography Certification # [] Immunization Batch # [] Line Note [] Sales Tax Amount []

Occurrence Dates ?
 Initial Treatment Date [] Last Seen Date [] Begin Therapy Date [] Last Certification Date []
 Test Performed Date [] Certification Revision Date [] Last X-Ray Date []

Prescription and Purchase Service Details ? Include Prescription and Purchase Service Details on Claim
 Line Supplemental Information ? Include Line Supplemental Information on Claim

Done Reset Close

The information entered in this sub-window refers only to the specific claim line from which the **More** button was clicked.

The following is a list of the **More** Claim Line Information sub-window tabs and sections:

Other Information (Claim Line)

- Other Information
- Occurrence Dates

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- Prescription and Purchase Service Details
- Line Supplemental Information

Additional Providers (Claim Line)

- Facility Information
- Referring Provider
- Rendering Provider
- Supervising Provider
- Ordering Provider
- Purchased Service Provider

DME Information (Claim Line)

- DME Information

Ambulance Information (Claim Line)

- Ambulance Information

Claim Line Adjudication

Note: Please check in the check box to enable data entry for these sections.

The screenshot shows a software interface titled "Additional Information". It has five tabs: "Other Information", "Additional Providers", "DME Information", "Ambulance Information", and "Claim Line Adjudication". The "Claim Line Adjudication" tab is selected. Below the tabs, there is a "Note:" section with a red bullet point: "Fields marked * are required." Below the note, there are two rows of information. The first row is "Claim Line Adjudication" with a question mark icon and a checkbox labeled "Include Claim Line Adjudication on Claim". A blue arrow points to this checkbox. The second row is "Claim Line Adjustment" with a question mark icon. At the bottom of the dialog, there are three buttons: "Done", "Reset", and "Close".

- Claim Line Adjudication
- Claim Line Adjustment

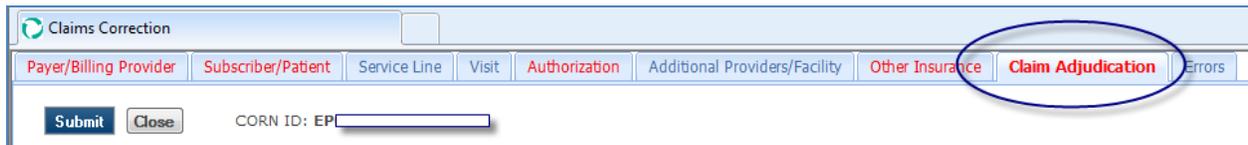
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7.5.7 Secondary and Tertiary Claim Tabs

A secondary or tertiary claim contains all the tabs (and data) from the primary claim, with the addition of two tabs:

Claim Adjudication

- Claim Adjudication
- Claim Adjustment
- Medicare Outpatient Adjudication
- Prior Payer Authorization
- Prior Payer Provider Identifiers
 - ✓ Facility
 - ✓ Rendering Provider
 - ✓ Referring Provider
 - ✓ Supervising Provider
 - ✓ Billing Provider



Claim Line Adjudication

This tab is within the **Service Line** tab. To view this tab, select the **Service Line** tab, click **More**, then select the **Claim Line Adjudication** tab.

- Claim Line Adjudication
- Claim Line Adjustment

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Reset

Click **Reset** to remove any changes that you have made in a tab or sub-window. The fields are returned to the condition they were prior to your changes. Fields that you did not change will not be affected.

Reset does not remove any data that was in the claim when you opened the claim. **Reset** affects only the edited data in the tab or sub-window in which you click **Reset**.

Refile

Click **Refile** only after you correct as many errors as possible. Once you click **Refile**, the payer will receive the claim in one business day (if the claim is not rejected at the clearinghouse). For information on how to correct errors before refiling, see the **Correct a Claim** section on page 169.

Submit

If you create a secondary claim from a primary claim, **Submit** appears instead of **Refile**. Click **Submit** only after you have supplied all the necessary information and corrected any errors that may exist. Once you click **Submit**, the payer will receive the claim in one business day (if the claim is not rejected at the clearinghouse). For information on how to correct errors before submitting, see the **Correct a Claim** section below.

Save Changes in a Sub-Window

Because changes in sub-windows are not automatically saved, click **Done** to save any changes that you make in a sub-window. If you close a sub-window without clicking **Done**, all of your changes will be lost.

7.5.9 Correct a Claim

Review and correct all errors (or as many as possible) before you refile or submit a claim. If you refile or submit a claim without correcting errors, the claim may be rejected by the payer. However, you may refile or submit a claim even if all errors have not been corrected. (Refiling or submitting a claim with errors is permitted because payers have different data requirements; some payers may disregard certain errors.)

Note: If you have the claim editor open but do not perform any actions for 15 minutes, your session will time out and you will lose your changes.

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Validation and Rejection

There are three distinct levels of validation that occur at different stages in the claim submission process:

1. In real time, claim fields are validated based on standard industry guidelines. For each error detected, an error is displayed in the Validation Error(s) section of the **Errors** tab. You can refile or submit a claim even if the claim has validation errors.
2. After you refile or submit a claim, the clearinghouse validates the claim based on known payer submission requirements. The clearinghouse can either reject the claim due to errors or pass the claim on to the payer. Errors generated by the clearinghouse are known as rejections, and they are listed in the Rejected Error Message(s) section of the **Errors** tab. You can refile or submit a claim even if the claim has rejection errors.
3. If a claim successfully passes through the clearinghouse to the payer, the payer processes the claim. Based on its criteria and business rules, the payer can pay a claim in full, pay a claim in part, or reject a claim. Errors generated by the payer are also known as rejections, and they are listed in the Rejection Error Message(s) section of the **Errors** tab. You can refile or submit a claim even if the claim has rejection errors from the payer. (See Rejected Error Messages, page 171.)

Error Indicators

These indicators help you locate errors in a claim:

- If a tab contains errors, the tab name is in red text. If a tab does not contain errors, the tab name is in blue text.
- If a field contains an error or is required but blank, a red border appears in the field, and the error appears in a tooltip when you hold your cursor over the field.
- The **Errors** tab lists errors in two categories:
 - ✓ Errors detected by clearinghouse or the payer when the claim was rejected.
 - ✓ Validation errors based on standard industry guidelines for each field included in the claim.

Use the Errors Tab

When you click **View/Edit Claim** or **Create Secondary Claim** in a Claim Detail Report, the claim opens in a new window with the **Errors** tab selected.

Note: If the claim is accepted and the claim amount paid in full, no rejection errors will appear in the **Errors** tab. In general, there will also be no validation errors in this case, but where there are validation errors for an accepted or paid claim, you can safely disregard those errors.

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There is an upper section and a lower section in the **Errors** tab, and the sections display different types of errors.

Payer/Billing Provider	Subscriber/Patient	Service Line	Visit	Authorization	Additional Providers/Facility	Other Insurance	Claim Adjudication	Errors
<input type="button" value="Submit"/>	<input type="button" value="Close"/>	CORN ID: EPO <input type="text"/>						
Rejected Error Message(s) 								
No Rejected Error Messages								
Validation Error(s)								
[Errors that involve only one field can be clicked to jump to that field. Errors that involve more than one field are not clickable]								
Payer/Billing Provider								
<u>Payer Information</u> Claim Filing Indicator is required. Payer Name is required. Payer ID is required. Sequence is required.								
Subscriber/Patient								
<u>Subscriber Information</u> First Name is required. Last Name is required. Subscriber ID is required. Patient Relationship to Insured is required.								
Authorization Information								
Not all required fields associated with the Claim Supplemental Information section have been valued. If you have accidentally marked this section of with the claim, please uncheck the box labeled Include Claim Supplemental Information. Otherwise, please be sure to correct any omissions prior to								

7.5.10 Rejected Error Message(s)

The upper section, Rejected Error Message(s), displays errors that were generated if the claim was rejected at the clearinghouse or the payer. Typically, these errors are generated regarding the payer's specific requirements.

These errors are not re-evaluated as you make changes to the claim; the application will not automatically detect that you have corrected the reason for the rejection or that you have made a change that might result in a new rejection reason that was not previously in the claim. Instead, each error message in this section has a check box beside the error code. As you correct errors in the claim, you can select the corresponding check box to track your correction of the error. The check boxes will remain selected until you refile or submit the claim or close the window.

Note: Using the check boxes in the **Errors** tab is optional. However, if you have not selected all the check boxes when you click **Refile** or **Submit**, a confirmation window will appear that advises you to make all required changes. You can click **Cancel** to return to the claim and correct the remaining errors or click **OK** to refile or submit the claim.

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7.5.11 Validation Error(s)

The lower section, Validation Error(s), displays errors generated in real time by comparing the data in every field on every tab to standard industry guidelines. These errors are warnings that a field's value is not valid or that a required field is blank. Some errors in this section may be duplicates of errors displayed in the upper section.

When you correct errors in the lower section, the error message is removed from the lower section automatically.

Linked Error Messages

Validation and Rejection error messages that are displayed in red text are linked to the field that contains the error. Click an error message in red text to go directly to the error on the tab that it appears. The field the error appears in is highlighted yellow, and the related error message appears as a tooltip when you hold your cursor over the field.

In the example below, the errors displayed are direct links to the field in which the error appears. Clicking the error opens the **Payer/Billing Provider** tab, and the cursor is automatically placed in the **NPI** field, which is highlighted yellow.

Payer/Billing Provider | Subscriber/Patient | Service Line | Visit | Authorization | Additional Providers/Facility | Other Insurance | **Errors**

Refile Close CORN ID: EPO

Rejected Error Message(s)

[Errors that involve only one field can be clicked to jump to that field. Errors that involve more than one field are not clickable]

Standard Error Code	Standard Error Message
1006	Subscriber Primary Identifier: Invalid; Must not equal Subscriber Group or Policy Number

Validation Error(s)

[Errors that involve only one field can be clicked to jump to that field. Errors that involve multiple fields or fields that cannot be specificall error, check the box corresponding to that error]

Payer/Billing Provider

Billing Provider Information
Billing Provider Email Address is required.
Telephone is required.
Fax is required

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The screenshot shows a 'Billing Provider Information' form. Fields include NPI, Tax ID Type, Tax ID, State License #, UPIN #, Currency, Taxonomy, Last/Organization Name, First Name, Middle Name, Name Suffix, Street Address, Line 2, City, State, Zip Code, Country Code, Contact Name, Email, Fax, Telephone, and Subdivision Code. A red box highlights the Telephone field, and a tooltip message reads 'Telephone is required.' A blue arrow points to the State dropdown menu, which is set to 'Connecticut'.

Unlinked Error Messages

Error messages that are displayed in black text are not linked. These errors may not correspond to a particular field, or the errors may relate to a field with multiple instances and the application is unable to determine which instance of the field contains the error. For example, a rejection error message caused by an error on a claim line is likely to be shown in black text, not linked, because the rejection errors do not identify the claim line that contained the error. You will need to use your own expertise and judgment to correct these types of errors.

Enable Sections

Some sections are grayed out by default. No changes can be made to a grayed-out section. Each grayed-out section has a check box in the section header. This may happen when the original claim contained no information relevant to that section.

To be able to edit a grayed-out section, select the check box in that section's header. Make changes to that section if necessary. Selecting the check box indicates that you are choosing to include the section's information on the claim even though it is not included by default. Once you enable the section by selecting the check box, field requirements will apply. As shown below, the Other Subscriber/Patient section is not required, but if you select the "Include Other Insurance on Claim" check box, the **Individual Relationship**, **Other Insured ID**, **Last Name**, and **First Name** fields become required.

The screenshot shows the 'Claims Correction' window with tabs for Payer/Billing Provider, Subscriber/Patient, Service Line, Visit, Authorization, Additional Providers/Facility, Other Insurance, and Errors. The 'Other Insurance' tab is active. A blue arrow points to the 'Include Other Insurance on Claim' checkbox, which is currently unchecked. A note at the top right states 'Note: Fields marked * are required.'

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Payer/Billing Provider | **Subscriber/Patient** | Service Line | Visit | Authorization | Additional Providers/Facility | **Other Insurance** | Errors

REFILE | CLOSE | CORN ID: EP090414756462880 | Note: Fields marked * are required

Other Subscriber/Patient Include Other Insurance on Claim

* Entity Type: Person | * Individual Relationship: --Select--

* Other Insured ID: [] | Policy/Group #: [] | Group Name: [] | SSN: []

* Last Name: [] | First Name: [] | Middle Name: [] | Suffix: []

Street Address: [] | Line 2: [] | * City: [] | State: --Select-- | Zip Code: [] | Country Code: [] | Subdivision Code: []

Other Payer Release

* Benefits Assignment Certification: --Select-- | * Release of Information: --Select--

Patient Signature Source: --Select--

Other Payer

* Other Payer ID: [] | * Other Payer Name: --Select--

Secondary ID Type: --Select-- | Secondary ID: [] | * Payer Responsibility Sequence: --Select-- | Claim Filing Indicator: --Select--

Exception

There is one section that does not follow the pattern described above. On the **Additional Providers/Facility** tab, the Rendering Provider section is grayed out by default, but the section header check box is selected.

To be able to edit this section, remove the check from the check box in the section header.

As shown below, clearing the check box indicates that the rendering provider is not the same as the billing provider, so the rendering provider information should be changed.

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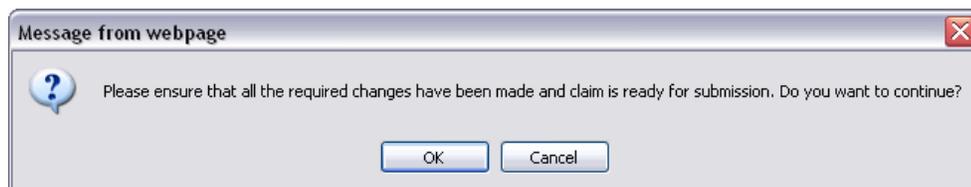
7.5.12 Refile a Claim

The application allows you to refile a claim whether or not all errors have been corrected. If you refile a claim that contains errors, the claim is still sent to the payer; however, the payer may reject the claim.

Note: It is recommended that you correct all errors if possible before you refile a claim.

Follow these steps to refile a claim:

1. Correct as many errors as possible.
2. Click **Refile**.
3. If there are one or more uncorrected errors, a confirmation window appears. Click **Cancel** to return to the claim and correct the remaining error(s), or click **OK** to submit the claim with errors.



4. If there are no errors, the claim is submitted to the clearinghouse. A confirmation window appears with the message, "The claim has been successfully refiled."

If the claim is not rejected by the clearinghouse, it is sent to the payer. The next business day, you should receive a claim confirmation report indicating whether the claim was

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rejected at the clearinghouse or sent to the payer. (You will see this report in either Reporting & Analytics or your application email depending on how your account is set up.)

Service Line Requirement

At least one Claim Line must be present with a start and end date (date of service), procedure code, diagnosis pointer and line charge in order for the claim to be refilled.

Claim Line Information													
	Start Date	End Date	Place Code	Emergency	Proc	Modifiers	Diag Pointers	Units	Anes Mnts	Charges	EPSDT	Family Planning	
X 1	08/29/2014	08/29/2014	Independent	--Select--	87206	□ □ □ □	1 □ □ □	1		15.40	--Select--	--Select--	More
X 2	08/29/2014	08/29/2014	Independent	--Select--	87102	□ □ □ □	1 □ □ □	1		24.06	--Select--	--Select--	More
X 3			--Select--	--Select--		□ □ □ □	□ □ □ □				--Select--	--Select--	More
X 4			--Select--	--Select--		□ □ □ □	□ □ □ □				--Select--	--Select--	More

7.5.13 Secondary Claims

When a claim is not paid in full by the payer, you can create a secondary claim from the primary claim. You can then send the secondary claim to another payer for payment of all or part of the remaining claim amount.

Note: The insured person on the claim must be enrolled and eligible with the payer specified on the secondary claim.

When you create the secondary claim, the application automatically populates most of the fields in the secondary claim with data from the primary claim. For example, if the primary claim included information in the **Other Insurance** tab, it will be moved to the **Payer/Billing Provider** and **Subscriber/Patient** tabs as applicable in the secondary claim. For a list of the minimum required information you need to submit a secondary claim that you created from a primary claim, see the **Minimum Required Data** section on page 181.

You can create a secondary claim from a primary claim that contains errors, but you should correct as many errors as possible before you submit the secondary claim. See the **Correct a Claim** section on page 169 for more information.

Secondary Claims

Currently, there are two ways to create secondary claims: through Reporting & Analytics and through Supplement Claims (see the **Supplement Claims** section on page 47). This section describes how to create secondary claims through Reporting & Analytics, but there are some fundamental differences between the two methods.

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Feature	Secondary Claims: Reporting & Analytics	Secondary Claims: Supplement Claims
Create secondary claim	Create a secondary claim only from a primary claim that has already been submitted through the clearinghouse to the payer. Using this method, you will upload the claim once, not twice.	Upload a primary claim for the purpose of converting it to a secondary claim to submit to another payer. Make changes needed to create the secondary claim immediately after you upload the claim. The changes you make are independent of the submission of the primary claim to the primary payer.
Change field values	Make changes to any field	Make changes only to certain fields
Submission format	Submit claims only in ANSI X12 4010, 5010 or NSF+ format	Submit claims in multiple formats

Validate Claim Charges

Because secondary claim amounts are based on the primary claim, the application validates all claim amounts at both the claim level and the service line level on secondary claims. If these amounts do not calculate correctly according to the primary claim, it will be treated as a validation error.

Claim Amount Level Validation

This level of validation ensures that the claim level payer paid amount plus all adjustment amounts entered at the claim level and line level equals the primary claim charge. If claim level payments and adjustments do not equal the primary claim charge, this error will appear on the **Errors** tab: "Claim does not balance. Adjustments and payments must equal claim total charges."

Validation logic for claim amount field validation involves the following calculation:

Payer paid amount (claim adjudication tab)
 +
 all the claim line adjustment amounts (claim line adjudication tab)
 +
 all the claim adjustment amounts (claim adjudication amount)
 =
 Total claim charge

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Service Line Amount Level Validation

This level of validation ensures that the service line level payments and adjustments equal the primary service line charge. If service line level payments and adjustments do not equal the primary line charge, this error will appear on the **Errors** tab: "Service line <#> does not balance. Service line payment amount and adjustment amounts must equal original line charge."

Service line level validation logic involves the following calculation: Service line payer paid amount

+

All claim line adjustment amounts

=

Total line charge

Create a Secondary Claim from a Primary Claim

1. Select Claims > Reporting & Analytics from the main menu.
2. Search for and open the Claim Detail Report of the primary claim on which you will be creating a secondary claim. (See the Claim Data Searches section on page 102 for details on search types.)
3. Click **Create Secondary Claim**.

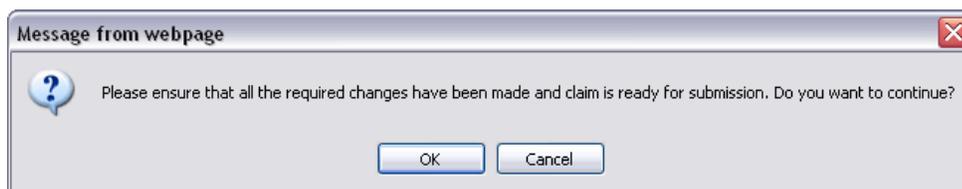
The screenshot shows the Emdeon Claims system interface. At the top, there is a navigation bar with links: Home | Claims | Payments | Preferences | Support. Below this is a breadcrumb trail: Home > Work Queue Search > Claim Summary > Claim Detail. The main content area is divided into two sections. On the left is the 'Search Criteria' section, which includes fields for 'Claim Received Date' (09/03/2014 to 09/09/2014), 'Tax ID', 'Site ID', and 'Search Type' (set to 'All'). There are 'SUBMIT' and 'RESET' buttons at the bottom of this section. On the right is the 'CLAIM DETAIL' section, which has three tabs: 'CLAIM DETAIL', 'XWalk Review', and 'Display Letter'. The 'CLAIM DETAIL' tab is active. Below the tabs are several links: 'View/Edit Claim', 'Create Secondary Claim' (circled in blue), 'View Audit History', and 'Get Help with'. Below these links is a form with the following fields: 'Emdeon Claim ID:' (EF), 'Insured ID:' (9), 'Patient Name:' (D), 'Patient DOB:' (08/), 'Diagnosis Code(s):' (6019), and 'Procedure Code(s):' (81001). There are also fields for 'Provider Tax ID:', 'Billing Provider ID:', 'Billing Provider NPI:', 'Site ID:', and 'Patient Control No.:'. A note at the bottom of the form reads: 'Note: If no dates are entered'.

4. On the **Payer/Billing Provider** tab, enter the **Payer ID** and **Name**, and for the **Sequence** field, select "Secondary".

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Note: Some fields may already be pre-populated with data from the primary claim. See the **Minimum Required Data** section on page 181 for more information.

5. On the **Subscriber/Patient** tab, enter information about the subscriber/patient.
6. On the **Authorization** tab, select the correct values in the **Release Information** section.
7. On the **Other Insurance** tab, enter required information in the **Other Payer** section.
8. On the **Claim Adjudication** tab, enter the **Adjudication/Payment Date** and **Payer Paid Amount** concerning the payment made on the primary claim.
 - ✓ If you want to include line level information on the claim, select the **Service Line** tab, click **More**, select the **Claim Line Adjudication** tab, then enter additional information relating to a specific line. (If the section you want to edit is grayed out, select the check box in the section header to enable the section for editing. See the **Enable Sections** section on page 173 for more information.)
9. On the **Errors** tab, review the information and correct as many errors as possible. (See the **Correct a Claim** section on page 169 for more information.)
10. Click **Submit**.
11. If there are one or more uncorrected errors, a confirmation window appears. Click **Cancel** to return to the claim and correct the remaining error(s), or click **OK** to submit the claim with errors.



12. If there are no errors, the claim is submitted to the clearinghouse. A confirmation window appears with the message, "The claim has been successfully submitted."

If the claim is not rejected by the clearinghouse, it is sent to the payer. The next business day, you should receive a claim confirmation report indicating whether the claim was

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rejected at the clearinghouse or sent to the payer. (You will see this report in either Reporting & Analytics or your application email depending on how your account is set up.)

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Minimum Required Data

The table below lists the minimum required data you will need to enter to submit a secondary claim. Other required data will automatically appear on the secondary claim because it will have been pre-populated from the primary claim.

Tab	Section	Field	Note
Payer/Billing Provider	Payer Information	Payer ID (which populates Name)	If the Other Payer ID and Other Payer Name fields from the Other Insurance tab on the primary claim were populated, those values will pre-populate the Payer ID and Name fields on the secondary claim. If the values did not pre-populate, complete these fields.
		Sequence	Select "Secondary"
Subscriber/Patient	Subscriber Information	Entity Type	If the Entity Type, Individual Relationship, Other Insured ID, Last Name, and First Name fields from the Other Insurance tab on the primary claim were populated, those values will pre-populate these fields on the secondary claim. If the values did not pre-populate, complete these fields.
		Patient Relationship to Insured	
		Subscriber ID	
		Last Name	
		First Name	
Authorization	Release Information	Release of Information	These fields are claim-specific and cannot be assumed or pre-populated from the primary claim. Complete these fields.
		Patient Signature Source	
		Assignment of Benefits	
Other Insurance	Other Payer	Claim Filing Indicator	These fields do not appear on the primary claim, so they will not be pre-populated. Complete these fields.
		Insurance Type	
Claim Adjudication	Claim Adjudication	Adjudication/Payment Date	If the payer amount paid differs from the claim total charges, adjustments will be required to offset the difference. These adjustments can be entered at the claim level, line level, or both. See the Claim Amount Level Validation section on page 170 for calculation specifications.
		Payer Paid Amount	
	Claim Adjustment	Claim Adjustment Group	These fields are required if you select the "Include Claim Adjustments on Claim" check box.
		Claim Adjustment Reason	
		Adjustment Amount	
Tab	Section	Field	Note

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Tab	Section	Field	Note
Claim Line Adjudication (Select Service Line tab, click More button, and select Claim Line Adjudication tab)	Claim Line Adjudication	Service Line Paid Amount	This field is required if you select the "Include Claim Line Adjudication on Claim" check box. The other relevant fields in the Claim Line Adjudication section are pre-populated from the primary claim line detail but can be changed if they are reported back differently on the ERA.
	Claim Line Adjustment	Claim Adjustment Group Code	These fields are required if you select the "Include Claim Line Adjudication on Claim" check box. See the Service Line Amount Level Validation section for calculation specifications.
		Claim Adjustment Reason Code	
		Adjustment Amount	
<p>Note: All of the other amount fields on the Claim Adjustment and Claim Line Adjustment sections are only required when they are reported on the primary claim payer's ERA.</p>			

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