EXmedic Release Notes 2005

Statements/Receipts print check box on Payment input form

To facilitate over the counter billing, a Statement/Receipt check box is available on the Payment input form. If this check box is "on", a Payment Save or Save + will launch a Printing Charges process. This is the same process that is launched when selecting Print from the File menu of a Charges selection window. If more than one Charge report design is present in the database, the selector window will be presented to allow the operator to select the most appropriate output format.

The "File preference/payments/Saving the Payment launches Statement/Receipt print job" determines how a Payment input form Statement/Receipt check box will be initially set when opened. The Statement/Receipt check box can be modified at any time. Keeping the Shift key pressed when Saving or Save plus-sing, has the same effect as having the Statement/Receipt check box on.

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Statements/Receipts & Charges

On the Charges input form a Statement and Receipt field are available. If you select the appropriate Report designs to be used, the StatementsRUN as well as the Statements/Receipts print check box modules in Charges and Payments will use the chosen Report design for output.

Statements/Receipts & Provider

The same Statement and Receipt fields are also available on the Provider input form. If Report designs are entered there, Charges in the name of the Provider will pull in that Provider's Statement and Receipt Report design selection on the Charge input form.

Statements/Receipts & StatementsRUN

When a StatementsRUN executes or Statements/Receipts print check box module is activated, the software will use the Statement and/or Receipt report designs as present on the Charge(s). If different Charges have different Statement and/or Receipt Report designs, separate Statements and Receipts will be produced.

Statements/Receipts & Payment/Charges Statement and/or Receipt Report designs

On the File preferences/charges/input 2 and File preferences/payments/input fields are available to enter Statement and or Receipt report designs choices that will be used if there is no choice made on the charge.

In a situation where neither a Statement/Receipt report is selected on the Charges nor on the File preferences Charge/Payment /input page, the regular Report design selector box will be presented.

Pro forma Claims

In a situation where the Patient pays over the counter, even while being insured, EXmedic has the option to include a Claim in the Charge "pro forma". Un-check the "Pays Provider" check box on the Claim input form in that case. While providing such a Patient with either a Statement or a Receipt, EXmedic will also automatically print the pro forma claim CMS-1500 form, so that it can be handed over to the Patient at the counter. The Patient then sends the Claim directly to the Insurance company him or herself.

Clear First Issue date, Modify First Issue Date and Modify Last Issue Date

Three new applications are available from the Applications menu of the Claims selection window: one to clear the First issue date, another one to modify it and a third to Modify the Last Issue date. First Issue Dates and Last Issue Dates are used by the Claims Issue RUN to determine which Claims need to be issued or re-submitted. Care should be exercised in modifying these dates.

Quitting EXmedic gracefully

The "Quit4D_process" method is called once when you Quit the database. The Quit4D_process method will send close instructions to all open processes. Previously EXmedic would abruptly end each running method and then quit. Any of the methods that run in a loop that might take more than a few seconds will constantly check the value of the "?Endallprocs" variable and exit gracefully if it becomes True. All of the form methods test the value variable "?Endallprocs" too.

Wide Area 4D EXmedic connections

Local are network (LAN) connections and Wide Area Network connections (WAN) between 4D Exmedic Clients and 4D Server software use the same TCP/IP protocol. The speed and latency of the network is obviously not the same. To successfully connect over a wide area network like the Internet, a minimum connection speed of 1MB with a latency lower than 20 milli seconds must be available. Now that this kind of Internet performance is becoming possible, EXmedic has been further reviewed on critical points to accommodate remote wide area client connections. Jobs are now loaded into arrays on each 4D EXmedic client, rather than being called as a record from the server data cache. A large number of other critical points have been re-designed to work better over Internet connections.

Provider reporting

Providers are now present in Posting records. This allows Postings to be searched and sorted on Providers directly in their own process. A Series of Quickreports is available to create hard copy Collection reports. The ultimate goal of a billing system is to produce concrete final results. Results that are somewhat definite and that can then be transferred into an accounting system or used for distribution to participating partners. Posting Quick reports in principle print onto paper. The operator is free to select any Quick report and any selection of Postings that makes sense. EXmedic does not put any constraints on Postings reporting.

Important considerations.

If EXmedic is completely free format and lets the operators report as they see fit, serious thought must be given to timing. Once Collection results are printed on paper to be distributed to parties outside of the office like accountants or are used to calculate Provider distributions, the office staff has no control over that information anymore.

Freezing charges.

For this reason Charges are frozen by Quick reports who's output is to be submitted to Accountants. This will usually mean that some delay needs to be maintained between Postings that are to be included and the actual reporting date. It is our experience that upstarting systems initially needs six weeks of tolerance to be able to iron out the last corrections. Operators with an firm hand and stabilized Fee schedules in the database may be able to reduce this to 2 weeks after a while.

Provider reporting.

Reports for Providers can be produced faster - on the first of the month covering the previous month - if it is understood and accepted that those reports have a provisional character. In order to straighten differences out it will be necessary to create a new Final Provider Collection report somewhere in February recapping the whole previous year and a year end adjustment may be necessary.

Sales Tax

More and more medical practices are confronted with Sales Tax requirements. The EXmedic sales tax is first entered on the Product or Service input form. When a Charge is created the sales Tax filed of the Product or Service record is copied into the sales Tax field of the Charge and the actual amount is calculated in the Sales Tax Amount field.

When a Payment is Posted against a Charge with a Sales Tax Amount the Sales Tax Amount collected is copied into the Posting record. Sales Tax Collection reporting is performed via a Quick report.

If the Payment posted against the Charge is not a full payment of the Charge amount, the Sales Tax copied into the Posting record is calculated pro rata.

Duplicate charges check

During creation of new Charges, EXmedic will verify if the same Service was already billed previously with the same Service date. If this is the case a Charges selection process will be opened showing the possible duplicates.

red{**Reporting Sales tax**}

Collected sales tax amounts end up in the Postings records in the Sales tax amount field. The Postings.sales tax Quick report is used to create hard copy output. The Sales Tax report is usually executed as an automatic Job on a specific day of the month. When a Sales Tax report is issued this way, the Sales Tax reported date field is written into the Posting records. This way Sales Tax amount will be included only once in the hard copy output because only Postings with a Sales Tax reported date of !00/00/00! will be included.

It is also possible to print Sales Tax reports on selections of Postings that an operator manually chooses. In such a situation the operator has full responsibility for selecting the Postings Tax Amounts to be included.

Sometimes it is necessary to re-do a Sales Tax report because the Job execution failed for instance on a printer jam. To include Postings Tax amounts again in the next automatic Sales Tax report Job, the operator may clear the Sales Tax reported dates via Application/Clear sales Tax reported date.

Maximum Diagnoses in Claims

Some Carriers & Plans limit the number of Diagnosis codes that they will accept to support a Claim. The value can be entered on the Carrier & Plans input form Type of Policy page. On paper claims there is room for only 4 Diagnoses, so if a higher number is selected, it will be truncated to 4 for paper output. The ASC X12 (hipaa) protocol allows in the "HI" segment up to 200 Diagnoses codes. At the time of this writing the relevance of this number is unclear because on the Service line level only Diagnoses 1-8 can be referenced. If Diagnoses are present on the Service line level that would yield a pointer higher than 8, this pointer will be ignored. This means that for practical purposes a maximum of 8 is to be considered (this is the default value that is implemented). If the number of Diagnoses within a series of Charges exceed the Maximum diagnoses in claim value, a Claim break will be triggered. The next Charges and Diagnoses will be part of the next Claim envelope. There is a File preference/carriers & plans/input/Maximum diagnoses in claim field to set how new Carriers & Plans Maximum Diagnoses values will be set-up when newly created (default also 8).

Use reference data only once

There is a Preference on the Charges/Input page that allows an operator to tell EXmedic that reference data must not be modified once it is selected. Examples of reference data on the Charge input form: Place of Service, Facility, Type of Service etc. If the **Use reference data only once** check box is "on", the existing reference data records will not be re-set when the Charge is recalculated by re-entering the Patient name or number of by re-calculating the fees. Patient entry or Fee re-calculation with the **Shit key** down will override the preference setting and reset the Reference data from the defaults.

Submit separately (Claims))

A **Submit separately** check box is available on the Claims input form. If checked the Claim will be submitted separately either on paper as a single service per claim form or electronically as the only service line in the Claim envelope. There are some circumstances under which this option will be very useful. For instance: a claims envelope is received by most Receivers with the first Diagnoses as the **Primary Diagnoses** and all further Diagnoses as **secondary Diagnoses**. In a situation where the Next in line service(s) in the claim envelope do/does not point to the primary Diagnoses but only to secondary diagnoses, there will be no primary Diagnoses submitted for the Next in line(s). Rarely this causes a problem since the Next in line Claims are considered supplemental services to the main service by the Receivers. But, some Receivers will not pay supplemental services if they don't point to a primary Diagnoses of their own. They will be rejected by them as being part of the main service. If you submit such a supplemental service separately, its own diagnosis will be the first diagnoses in the separate Claim envelope and as a result will always be primary. **Submit separately** Claims will appear underlined in the Carrier & Plans sub-record area on the Charge Input form.

Submit separately (Carrier fees))

If you switched the **Submit separately** check box on the Claims input form "on", this condition will be recorded in the active Carrier fee record for the combination of Service and Carrier or Plan. Next time the same combination is billed, the Claim will be automatically **Submit separately**.

Provider/Sales Tax report blocks modification

Default a Posting or Charge cannot be modified after the Posting appeared on a Provider Collection Report or Sales Tax Report. The reason for this is that Provider Collection Reports may have been the basis for pay-outs and Sales Tax may have been paid to the State. It is possible to modify the default behaviour on the File preferences/Postings/Input page. If one or both check boxes are "off", a modification will be possible.

Correction Postings

In the situation in which Provider Reports and Sales Tax Reports must **not** prevent modification of the Charge or Posting, the software will create a copy of the Posting to be deleted with all amounts and pointers set to negative, providing the Posting was previously reported. The counter Posting will act as a cancellation of the previously reported Posting. **Correction Postings** will appear italic in a Postings selection listing.

Delete applied Correction Postings

Correction Postings reside in the same Postings file as regular Postings. They can be recognized by their negative Payment number. To delete Correction Postings that were issued on Provider Reports and sales Tax Reports, there is an Application available **Delete applied Correction Postings**. This application takes the submitted selection and filters out any Postings with a negative Payment number, a Provider Report date unequal !00/00/00! (meaning the Provider reporting took place) and a sales Tax Report date unequal !00/00/00! (meaning the Sales Tax Reporting took place) and then deletes the resulting selection.

Patient's age

When entering the **Birth date** on the Patient input form, the **current age** of the Patient will be calculated and displayed behind the Birth date field. The Birth date will also appear in the Patient name field (on the right side) in a Patient's selection window.

Number of Charge Service days in future

When entering the **Service date** on the Charge input form, it is possible to make a date entry mistake. To catch very obvious mistakes, Service dates cannot be far in the future (like several years). To control how far in the future a Service date is allowed to be, there is a preference available on the File preferences/charges/input 2 page.

Number of Charge Service days in past

When entering the **Service date** on the Charge input form, it is possible to make a date entry mistake. To catch very obvious mistakes, Service dates cannot be far in the past. To control how far in the past a Service date is allowed to be, there is a preference available on the File preferences/charges/input 2 page.

Number of Payment days in future

When entering the **payment date** on the Payment input form, it is possible to make a date entry mistake. To catch very obvious mistakes, Payment dates cannot be far in the future. To control how far in the future a payment date is allowed to be, there is a preference available on the File preferences/payments/input page.

Number of Payment days in past

When entering the **Payment date** on the Payment input form, it is possible to make a date entry mistake. To catch very obvious mistakes, Payment dates cannot be far in the past. To control how far in the past a Payment date is allowed to be, there is a preference available on the File preferences/payments/input page.

E-claims submit new password

CMS orders its Medicare affiliates (and some others) to require a password change every 30-60 days. Most of our Autodialers can detect an expired password situation and submit a new password. Electronic claim documents on disk tht were not yet uploaded may still contain the old password though. In this release the Autodialer will search electronic claim documents in the E-claims to disk folder for old passwords and modifies them into the newly submitted password too.

E-claims history days

The intermediary documents on disk that are created during processing of electronic claims in the Report_designs_to_disk folder and in the E-claim reports folder are deleted after a certain number of days. The number of these 'history days' is set in the Autodialer. The File preference/claims/x12/Number of days disk document remain can be used as an overall 'cap' on the number of days that cannot be exceeded. The default value is 9.

Register this Client machine on the Server at log on

The **Register this Client machine on the Server at log on** is available on the **User preferences/network** page. Registering a Client station on the Server creates a connection for the exchange of special methods between the server and the clients. This preference does not control the normal Client/Server data flow. A Client station can work without **Register this Client machine on the Server at log on** being 'on'. This preference enables/disables some specific programming situations only.

Check my E-mail trigger

If the **Register this Client machine on the Server at log on** is 'on' and another user or a Job provokes an **E-mail upload/download** on the network, a Check my E-mail process is launched automatically. If in the mail server connection caused by an action of another operator or job downloaded E-mail for another User on the Network, that you will see the E-mail being presented, even

if he or she did no take any action.

Report design Holder & Member

In the Holder and Member input forms of Names & address and Affiliated record there is the possibility to select a Report design. Usage of this Report design is dependent on the environment.

E-claims and Provider Member Report design in Carriers & Plans.

Electronic Claims are formatted and uploaded via software modules that we call **Autodialers**. Most of the time one or two Autodialers can upload for many Insurance companies. In some cases the **Receivers** will impose such strange conditions on the uploaded format - often in violation of the hipaa protocol and other rules and regulations - that it is necessary to handle this in separate Autodialers per Provider. The Report designs field on the Member subrecord for the Provider on the Carrier & Plan's input form makes it possible to select such a customized Autodialer in much the same way as a special Provider ID can be entered in the Attachment field.

Carrier Provider Member Claim form enabled

To enable the possibility to use a Provider specific Autodialer for a certain Receiver, there is the preference "Carrier Provider Member Claim form enabled" available on the File preferences/charges/input 2 page. Default this preference is 'off'.

Force Provider or Practice claims

If you enter a value (any text) in the Title field of a Carrier or Plans Provider Member record, that Provider will be forced as a Provider claim. If you enter a value (any text) in the Function field of a Carrier or Plans Provider Member record, that Provider will be forced as a Practice claim. These settings will override the Force Provider/Practice claim check boxes on the Carrier & Plan input form.

Force Job record into process

For certain Job methods it is required to have the full job record in the process that is being called by the Job. This is for instance the case for **ClaimsPrintRUN** Jobs that have Start-up statements. Presence of Start-up statements is tested *inside* the ClaimsPrintRUN process, so the Job record must be loaded there.

Search by lay-out capability in Service default texts

In Product & Services records it is possible to enter texts that can be used as default Narratives, Notes and or Descriptions. These text values can come down into a Charge record when the Product or Service is selected there. On the Services there are now 4 fields available to enter body text search criterion. The searches are of type "contains".

Raw electronic claim data segments

On the **Product & Services record input form** there is an area in which a X12 code segment can be entered. This segment is submitted electronically "as is". The segment needs to be valid **X12 data** (hipaa protocol), otherwise the submission will be rejected by the Receiver. This raw data field makes it possible to submit segments that are not generally implemented but need to be submitted for very specific Services.

Active Policies

It often happens that Patients change Insurance company. Sometimes you may want to keep the old Policy on file. To avoid that older Policies will cause Claims creation when the Patient is billed, it is possible to declare a Policy non-active by unchecking the **Active** check box on the Policy input form.

E-claims & "AAE" and "B6" segments

Some Receivers do not process the Payer Allowable Total (AAE) and the Payer Approved Total (B6) correctly. The"AAE" & "B6" segments are not mandatory (at the time of this writing). EXmedic submits this data without problem nationwide to most Receivers, but if a Receiver has a problem with it, there is no need to insist, because a claim does not need an "AAE" or "B6". What we have done is implement a new preference on the Type of Policy page of the Carrier & Plan input form. Default the "AAE" and "B6" segments are NOT uploaded (check boxes are off) from now on. If another Carrier requires those segments, you switch the preferences on for them.

E-claims & "PRV" segment

The PRV segment (or Taxonomy code segment) is another case of confusing contradictions in the practical implementation of the Hipaa electronic claims protocol by Receivers. Some Carriers need this segment, but many others don't need it, or worse, when they see it, their system will stumble on the data. We implemented a check box to allow a per Carrier handling of this issue.

E-claims & Providers even if same as Billing Provider

The Hipaa protocol says that if the Billing Provider is the same as the Rendering, Referring or any other Provider, the latter should not be included in the Claim level segments because the information is already present in the Billing Provider Header envelope. This seems logical. Yet, many Carriers will reject claims without a Rendering or Referring Provider for each claim, even if they are the same as the Billing Provider. On the Type of Policy page of the Carrier selections can be made to cater for those requirements. During conversion from a previous database, EXmedic will "check" the Rendering Provider is mandatory option because there are so many Carriers that are non-Hipaa compliant on this point. However, there are also Carriers who are correctly Hipaa compliant. They don't require the Rendering provider to be repeated. Some even reject claims if the Rendering Provider or Referring Provider is repeated even if the same as the Billing Provider. For those Carrier the **Rendering Provider is mandatory** check box must be switch off.

E-claims & "SY" segment

Medicare does not want the Social Security segments to be submitted in REF anymore. Go to the Medicare Carrier Input form, Type of Policies Tab and uncheck "submit "SY" (social security segment). The trend to suppress Social Security Numbers from submissions is the result of a decision by the Federal Government to discourage use of the SSN identifier to prevent Identity theft. You will see more and more Carriers reject SSN's. That is why the Submit SY check is default "off". No SSN will be submitted unless the Carrier wants it and then it must be switched 'on".

Admission Dates are mandatory

Places of Servide 21,22,41,42,51,61 require Admission dates now. This rule was implemented first by Medicare and is gradually being implemented by others too. The Insurers want the Admission date because they need to match the Provider's claims with the claims they received from the Hospital or other Facility for the Place of Service codes listed above. EXmedic will test for the Admission date when new records are created only.

New Toolbar Icons

Many new Icons have been implemented to better correspond the the style of the most recent operating systems.

Negative or zero Covered sum check

To avoid claim rejections, a test has been implemented to verify, if during validation of a Charge, all Claim Covered sums have a positive value. It makes no sense to issue Claims with a negative or zero covered sum and existence of negative values usually points to other charge problems that need to be addressed.

Names & Affiliated records on load sub records limit

If there are a lot of sub records on a Names & addresses input or Affiliated record form, the On load activities may become noticeable. After all, each Sub records in fact is a real separate record, so, if you have a few Extensions and Catalogues and also have some Holders and Members you quickly may be loading tens, hundreds or sometimes thousands of sub records for each Names & addresses record. That may become heavy even on a local area network. On a wide area network (for instance a client connection over the Internet) such heavy On loaf activities may become unacceptable. For this reasons there now are 4 preferences on the Names & addresses file preferences, one for each Sub record type. You can set a limit on loading Sub records here. If the On load detects more sub records than allowed in these preference values, the load for that Sub record type will be skipped and a message will be displayed in lieu of the Sub record area to inform the operator. If the operators wants to see the Sub records anyway, a click on the Expand icon (the rightmost mini icon above the Sub record area) will display them in full page view mode.

This mechanism is particularly appropriate for sites that enter Providers and/or Referrers for each Patient in the Patient's Holders area. The Provider and/or Referrer records showing all Patients related to them as their Members, may be candidates to limit On load Member loading to avoid unnecessary Input form display delays.