Veradigm Payerpath Claims Management™

Professional Claims

User Guide

www.veradigm.com

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Proprietary Notice

IMPORTANT NOTICE REGARDING GOVERNMENT USE

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Chapter 1

Basics

This chapter describes workstation requirements, logging on to Payerpath®, navigating the **Dashboard** window, and menu options in Payerpath®.

workstation requirements

Before you use , your computer system environment must meet the following requirements.

Requirement	Description
Adobe® Reader	This Internet plug-in application is used to display `.pdf` documents in the Knowledge Center and on the **Dashboard** window. To verify or update the current version of the application, do the following. 1. Click **Start > All Programs > Adobe Reader**. 2. Select **Help > About Adobe Plug-Ins**. 3. Select **Help > Check for Updates**.

Requirement	Description
JavaScript®	Many areas in the application use JavaScript® to display information on the window. The `Jscript.dll` file must be registered (which is the default setting). **Note:** JavaScript® and Java™ are two different scripting languages. JavaScript® must be enabled on the workstation although Java™ does not. Problems with JavaScript® typically manifest as display problems such as incorrect rendering of the **Dashboard** graphs, the CMS-1500 claim form, toolbox, and web page errors referencing missing objects.
Java™	Ensure that the Java™ plug-in is properly installed as follows: 1. In Google Chrome™, go to **Settings > Extensions**. 2. Ensure that both the Java™ Plug-In SSV Helper and the Java™ Plug-In two SSV Helper are enabled.
Screen Resolution	Screen resolution must be a minimum of 1024 x 768. A lower screen resolution means that many pages do not display the scroll bar that enables you to see the entire window. Some portions of the window might be cut off. To verify or change the current screen resolution, go to **Control Panel > Display > Resolution**.

Requirement	Description
Google Chrome™ ***Preferred Browser***	The application supports Google Chrome™. For specific browser requirements, refer to the *System Requirements and Troubleshooting Payerpath User Guide*. **Note:** Some contracted options do not support Chrome. Do not access Payerpath® in the Chrome browser if you have to access **KnowledgeSource Professional**.

Requirement	Description
Veradigm® Practice Management Single Sign On - SSO	On Premise clients running Veradigm® Practice Management versions 21.0 and higher already support launching Payerpath® in a designated default browser of Google Chrome™ or Microsoft® Edge. To check your current default browser **Click Settings** > **Apps**> **Default Apps**. The current default will display next to **Web Browser** in the list. To change it, **Click** on the current browser and select your new browser from the list. Hosted Veradigm® Practice Management systems are currently upgraded to Veradigm® Practice Management version 21.0 and the default browser will be set to Microsoft® Edge over the next couple of weeks. Veradigm® Practice Management users accessing Payerpath® through the SSO feature using versions prior to 21.0 will continue to launch Payerpath® in Internet Explorer®. In order to use SSO capability with Google Chrome™ or Microsoft® Edge you will need to either upgrade to at least Veradigm® Practice Management version 21.0 or you will need to log in directly by using a Google Chrome™ or Microsoft® Edge browser and navigating to **www.payerpath.com**
Unsupported Browsers	If you attempt to access Payerpath® in a version of a browser that is no longer supported (such as a very old version of Google Chrome™), you will receive an **unsupported browser banner** at the top of your screen. You can clear the message by **clicking** the **x** beside it, but it will display again the next time you log in.

Requirement	Description
Microsoft® Edge	The application supports Microsoft® Edge, including the Chromium version of Microsoft® Edge. **Note:** Some contracted options do not support Edge. Do not access Payerpath® in the Edge browser if you have to access **KnowledgeSource Professional**, **EOB Cabinet** or **Practice Performance**.
Unsupported Browser Types	If you attempt to access Payerpath® in a browser other than those listed in this table, you will be prevented from logging onto Payerpath®, and the message `Your browser is not compatible with our product` is displayed on the window.

Log on to

This section describes how to log on to Payerpath® through the website. This does not apply to users who access Payerpath through a Single Sign On option within their Practice Management System.

1. Open Google Chrome™ .
2. Navigate to www.Payerpath.com.
3. Click **Payerpath Login**.
4. Complete the following fields:
   a) **Customer Name**
   b) **User Name**
   c) **Password**

   Before you can log on to Payerpath® for the first time, your administrator or Payerpath® support must provide you with your **Customer Name** and **User Name**, which are required. Depending on your setup, they will also provide you with a temporary password or you will receive an email with an embedded link requesting you to complete the user setup and establish your password.

   Your password must meet the following conditions:

- Minimum of eight characters
- Maximum of 50 characters
- One uppercase character
- One lowercase character
- One numeric digit
- One special character (for example, ! @ # $ % ^ & *)
- You must change at least four characters
- You can only change your password once in a 24-hour period
- You cannot reuse any of the previous 10 passwords

> **Note:** The paste and insert functionality has been removed for the confirm password box. You must re-enter the password to avoid mistakes. It is strongly advised that passwords not contain dictionary words or user IDs.

5. Click **Veradigm Payerpath**.

Results of this task

You have accessed the application. Payerpath®

> **Note:** Each Payerpath® user must review and accept terms of use annually. The terms of use display when a user logs in for the first time or every 365 days. The user must scroll to the bottom (and hopefully read) before selecting the **I agree to terms of use** option, and then click **Continue** to proceed to the **Dashboard**. Users cannot proceed into the Payerpath® application unless the terms of use have been accepted.

Dashboard window is displayed.

Password maintenance

Having a valid email address on file enables you to use email-related functionality such as password maintenance. You can change your password and update an expired password as long as you know the current password.

If your email address is verified in Payerpath®, you can use **Forgot Password** if you forget your password.

> **Note:** For security purposes, your email address must be verified and accurate to reset your password if you forget it. If your email address is not verified, you must contact either Payerpath® Support or your **User Maintenance** administrator to reset your password. After you are able to

log on to Payerpath®, it is important to verify your email address in order to use this function so that you can refer to it in the future. To update and verify your email address, follow the instructions in the "Update and verify Contact Info" section.

Changing your password

You can change your password at any time after first logging on to Payerpath®, point to your user name and then select **Preferences > Change Password**. Enter your current password and a new password that conforms to the criteria stated on the window, then enter the new password again to confirm it.

Your password must meet the following conditions:

- Minimum of eight characters
- Maximum of 50 characters
- One uppercase character
- One lowercase character
- One numeric digit
- One special character (for example, ! @ # $ % ^ & *)
- You must change at least four characters
- You can only change your password once in a 24 hour period
- You cannot reuse any of the previous 10 passwords

> **Note:** The paste and insert functionality has been removed for the confirm password box. You must reentered the password to avoid mistakes. It is strongly advised that passwords not contain dictionary words or user IDs.

Click **Update** to save your changes.

Change password once per 24 hours

You are not permitted to change your password more than once within a 24-hour period. If you attempt to change your password within the 24-hour period using **Preferences > Change Password**, a message is displayed to notify you that you cannot change your password within a 24-hour period. If you click the **Forgot Password** link within the 24-hour period, you will receive an email to notify you that you cannot change your password more than once within a 24-hour period instead of receiving a temporary password.

If you must change your password again within the 24-hour period, contact your administrator to reset your password for you. Your administrator can reset your password to a temporary password as many times as necessary regardless of the 24-hour waiting period.

Account locked due to fail login attempts

If you make 10 consecutive, unsuccessful login attempts within a 24-hour period, your account will be locked for five minutes and timer is displayed to indicate the progress toward the completion of the five minutes. When five minutes has elapsed, you can log on to Payerpath® again. During the five-minute lockout period, you can unlock your account and gain access to Payerpath® by successfully changing your password using the **Forgot your Password** link or have your administrator reset your password to a temporary password.

> **Note:** The **Forgot your Password** link requires an email address to be saved and validated in that your profile. Only individual user accounts can be locked. Other users for the same Payerpath® account number are not impacted when an individual user account is locked.

Password expiration

There are three ways to reset an expired password. First, the next time that you log on after your password has expired, enter your customer name, user name, and current password as usual. The application detects that your password has expired but will not display this information explicitly. The **Change Password** window opens where you can enter and confirm a new password.

Second, depending on your user setup, you might receive an email stating that your password has expired. Click the embedded link in the email. You are taken to the Payerpath® login window. Enter your customer name, user name, and current password. You are redirected to the **Preferences > Change Password** window where you can enter a new password and confirm it.

Third, you might receive a broadcast message that your password is about to expire. Broadcast messages can be accessed through the **Quick Links** on the **Dashboard** window or by selecting **View Messages** from the **Maintenance** menu. Open the expired password broadcast message and click the embedded link. You are redirected to the **Preferences > Change Password** window where you can enter in a new password and confirm it.

Forgotten passwords

If you have forgotten your password, you can reset it yourself by clicking **Forgot Password** on the **Login** window.

You must enter your **Customer Name**, **User Name** and **Email Address**. If the application locates a matching profile but the email address in that profile has not been verified, the following message is displayed: `Forgot Password Unsuccessful: Invalid Customer Name, User Name, Email Address Combination`. This message is the same message that is displayed if any of the credentials entered are not valid. If the application locates a matching profile and the email address has been verified, an email is sent to you with a link to reset your password. Clicking the link directs you to the **Set Password** window, where you can enter your **Customer Name**, **User Name**, create a new password, and confirm it.

Concurrent sessions

Payerpath has implemented security measures to ensure that users can only operate one instance of Payerpath® at a time. This is a recommended best practice for session management to protect against potential unauthorized user access, as well as ensuring that users do not share the same credentials. When a user logs into Payerpath® with their credentials, their working session is active until they manually log out, they close the browser window, or they reach the inactivity timeout limit according to the settings in the user profile. During the time when the initial session is active, if another user logs into Payerpath® with the same credentials, the initial session is terminated and the new user will now have the active session. The original (now terminated) session displays the message: `You have been automatically signed out. Another session has been initiated for the same user.` This occurs any time credentials are used to access Payerpath and there is already an active session for those credentials. For example:

- When one or more users access Payerpath® with the same credentials from two different workstations.
- When one user accesses Payerpath® with the same credentials from two different browsers (such as Chrome and Edge) on the same workstation.

Linked user profiles

Users can easily navigate from one Payerpath® account to another using linked profiles. These profiles must be configured by Veradigm. For those users who have multiple account user profiles, one of their profiles can be identified as the Primary. Other instances of this profile belonging to the same user but associated with different Payerpath® accounts can be linked to the Primary.

When the individual logs in to Payerpath® with the Primary profile, they have the ability to seamlessly navigate to other accounts, identified by the linked profiles, with a list under their profile name on the **Dashboard**. Once configured, only the Primary profile is used to access Payerpath®. Additionally, only the Primary profile retains the ability to maintain their password. Linked profiles have that option disabled. Since a user with linked profiles can only log in with the Primary profile, there is no need to maintain the passwords for linked profiles.

Navigate the Dashboard window

The **Dashboard** window is displayed when you log in to the Payerpath® application and provides a central point for navigation and communication within the application. The Dashboard menu provides access to all of the areas of the application. Contact information for Veradigm® Support is also included in the lower portion of the window.

Dashboard window

You can access the **Dashboard** window from anywhere in the application by pointing to the Dashboard menu to expand it and then clicking **Dashboard**, or by clicking the Payerpath® name in the title bar.

> **Note:** If you access the Payerpath® web site with any unsupported operating system or browser version, you receive a message at the top of every window indicating that you are using an outdated browser. This message does not prevent you from accessing Payerpath®, but you might encounter problems using the application.

Figure 1: The Dashboard window

The menus and main sections of the Payerpath® **Dashboard** are described in the following sub topics.

The right side of the **Dashboard** window displays news items, videos, and links to access additional resources.

Menus

The Dashboard menu expands to display selection titles when you point to it. Click a menu item to display its sub structure.

- **Claims**: View your transmitted and untransmitted claims. Authorized users can access the KnowledgeSource Professional® coding tool from this menu.
- **Patients**: Perform eligibility checks. (This option is available only to clients who have purchased software.)
- **Reports**: View management reports, payer reports, and remittance reports.
- **Maintenance**: View broadcast messages and access payer enrollment forms.
- **Resources**: Access electronic reference materials for the Payerpath® application.

Two additional menus at the upper right of the **Dashboard** window provide additional choices. Point to these menus to display their options.

> **Note:** In previous Payerpath® versions, items seen in the user name menu were in the **Tools** menu.

- User name menu: Log out of Payerpath® or access ways to personalize the application.
- **Help** : Access information to assist you with using the Payerpath® application.

View payers and locations

View Payers and **View Locations** are located in the upper portion of the window. Select a payer or location from the **View Payers** list to display information for that specific payer or location. (For example, if you select **Humana** from **View Payers**, the **Claim Status** icons and graphs reflect data for only Humana® claims.) **View Locations** is displayed only if you are configured for multiple practice locations.

Quick links

Quick Links contains icons to access the following information:

- New (unread) messages
- Urgent messages
- Remit reports
- Payer filters
- Claim filters

In addition, the number of new items is displayed at the corner of each icon. You can also access links to your Claim Filters and Payer Filters. The number on each icon represents the number of filters you have created.

Claim status

Claim Status is a quick reference or shortcut to the existing reconcile-by-batch functionality. You can immediately view your untransmitted claims summarized by status:

- **Passed**
- **Failed**
- **In Process**
- **Held**

You can also view the status of your transmitted claims:

- **In transit**
- **Acknowledged**
- **Accepted**
- **Rejected**
- **Done**
- **Remit**

The number displayed on each icon represents the number of claims in that category. Click an icon to display a list of those claims.

> **Note:** Claims with `Done` status are previously rejected claims that were completed because no further action was required. The `Done` status enables you to easily distinguish between rejected claims that have been rebilled, resubmitted, or otherwise revised and the remaining rejected claims that must be addressed.

> **Note:** Only unreconciled claims are included in the **Claim Status** icons.

To refine the data that is displayed with the claim status icons, select **Professional**, **Institutional**, or **Dental** claims from the list, and then select a date (**Today**, **This Week**, **Past 30 Days**, and so on).

> **Tip:** Working on claims from this area is easier than selecting **Claims > View Claims**, and then selecting various filter criteria to work with untransmitted or failed claims. For example, after you send claims to the Payerpath® clearinghouse, you can select **Today** from **Claim Status**, and then click **Failed** to generate and work a list of your failed claims. This area also enables you to quickly verify that claims are progressing and being worked in a timely manner.

Claim upload summary

The **Claim Upload Summary** is a graphical view of the **Upload Summary Report**. The current date is displayed within the title. This graph changes throughout the day if additional claim files are received. You can point to any portion of the chart to display the percentage of total claims in the **Failed**, **Warned**, and **Passed** categories. Click a section of the chart (such as **Failed**) to display a list of claims that are specific to that claim status. To change the date range of the claims summarized in this report, click **Upload Summary Filter** and then select the date range. To view a report of claims that meet the criteria, click **View Upload Details Report List**.

Top edit errors

Top Edit Errors is a graphical view of the **Error Trend Report**. The current date is displayed within the title. Click a specific bar chart (such as **Provider Not on File**) to view a report that lists failed claims for that reason. This graph changes throughout the day if additional claim files are received.

Denial rate comparisons

The **Practice Performance Analytics** chart displays payer denial trends. Use reimbursement data from the electronic remittance/835 files that payers send through Payerpath® to gain insights that might help reduce the denial rate and increase practice revenue.

Current data is displayed in the graph as remittance files are processed.

> **Tip:** If you do not receive remittance files through Payerpath®, this chart does not display any data. Consider turning of this option in preferences.

Clicking the chart opens a window with four additional charts.

> **Note:** If you are already a Allscripts Practice Performance user, clicking the chart accesses the **Practice Performance** main window.

- **Denials Analysis vs. National and State Comparison for Last Six Months**
  - The rate of service lines denied across the last six months based on the payer check date.
  - One line of client data for the past six months.
  - Comparative Foundation (constants), which are the rendering provider taxonomy and rendering provider state (by State and National comparatives).
- **Denials Analysis by Category for Last Six Months**
  - The total billed amount for each category of denied claims with check dates during the last six months.
  - The associated reason code for each denial in the 835. The reason code categorizes the denial, which provides users with a high-level understanding of where they might be having process problems with the largest financial impact.
- Payerpath® ANSI 835 Electronic Remittance Data Overview
  - This information provides users context for the data in other charts.

- **Service Line Status Sub-Category**
  - A detailed breakdown of the **Denials Analysis by Category for Last Six Months** graph
  - **Total Denied Billed**: The total dollars billed for services lines that were denied in each category (rounded up)
  - **Denied Count**: The volume of service lines that were denied in the given category
  - **% of All Denials**: All denials (how many denials are due to a given category).

Claims menu options

The following options are available for you to select from the **Claims** menu. Some menu options are available but only in certain circumstances.

Menu Option	Description
Reconcile by Batch	(Not available to select if your site does not have all reconciliation features enabled.) Access the **Reconcile Claims Filter** page, where you can produce a list of reconciled or unreconciled claims.
Upload Claims	(Not available to select if your site key enters claims.) Access the **Upload Claim File** page, where you can upload a claims file.
View Claims	Access the **Claims List Filter** page, where you can produce a list of transmitted or untransmitted claims.
CodeCheck Defaults	(Not available to select unless your site has purchased and implemented the CodeCheck feature.) Access the **CodeCheck Defaults Filter** page, where you can change the message alert level of your **CodeCheck** edits.
EOB Cabinet	(Not available to select unless your site has purchased and implemented the EOB Cabinet product.)

> **Note:** The **Knowledge Source** menu item has moved to the **Claims** menu in the latest version of Veradigm Payerpath® software.

Patients menu options

The following options are available for you to select from the **Patients** menu. Some menu options are only available in certain circumstances.

Menu Option	Description
Eligibility Check	Not available to select unless your site has purchased and implemented or iVerify.
Patient Demographics	Access the **Patient Demographics Filter** window, where you can reduce the data entry that is required for your recurring patients. You can set default values for some boxes on claims. (This feature is intended primarily for clients who manually enter claims, as opposed to those who upload a claims file.)
eNotify	(Not Available to select unless your site has purchased and implemented eNotify.) Access and administer appointment reminders and other patient engagements.
Patient Statements	(Not available to select unless your site has purchased and implemented the Payerpath Statements™ product.) Access the **Upload Patient Statements** window, where you can upload a file containing patient statements for processing by a third-party vendor.
Patient Payment Manager	Not available unless your site has purchased and implemented Payerpath® Patient Payment Manager.

Reports menu options

The following menu options are available from the **Reports** menu. Some options are available only in certain configurations.

Menu Option	Description
Billing Summary	High-level billing data (total number of claims, dollar amounts, and so on) that is associated with transmitted or untransmitted claims during a specified time period.

Menu Option	Description
Contract Audit Recovery	Access the Contract Audit and Recovery service, that enables identification and recovery of underpayments from payers, and appeal of claims that were incorrectly denied by payers. **Note:** Available only for sites that have purchased and implemented the Contract Audit and Recovery service.
Claim Age	The total number of claims entered, according to claim status and amount of time a claim has existed.
Error Trend	The ten most frequent reasons claims fail with Payerpath®. **Note:** • Not available for sites that enter claims manually. • Includes Error Trend report claims received by Payerpath® and does not include payer rejections.
Payer Responses	A variety of reports that are associated with claim data provided to the application by payers.
Remittances	Remittance-specific summary information (check number, check amount, and check date).
ERA Optimization Report	Locates payers to enroll to receive electronic remittances. This report displays the number of claims submitted to each payer between 14 and 90 days ago for which an electronic remittance has not yet been received. It includes a link to the enrollment documents.
Payer Rejects	Claims rejected by a given payer during a given date range.
Payer Rejects Workflow	Provides access to categories of payer rejections from within an interactive version of the existing **Payer Rejects** report.

Menu Option	Description
Practice Performance	The next iteration of reimbursement and compliance insights. **Note:** Available only for sites that have purchased and implemented the Practice Performance product.
Transmitted Claim	A detailed listing of all claims that Payerpath® forwarded to a specific payer on a specific day or range of days.
Upload Detail	The status (`passed`, `failed`, `warned`, and so on) of claims contained in a file that is uploaded to Payerpath®. Use this report to troubleshoot and correct claims. **Note:** Not available for sites that manually enter claims.
Upload Reconciliation	Balances the number of claims uploaded to Payerpath® and forwarded to the payer, as compared to the number of claims regenerated from your practice management system. **Note:** Not available for sites that manually enter claims.
Upload Summary	Access the **Upload Detail Report**, which displays details about batches of claim files that uploaded to Payerpath®. **Note:** Not available for sites that manually enter claims.
Statement Reports	Reports containing processing information about electronic submissions. **Note:** Available only for clients using the MyWay™ application.

Menu Option	Description
Patient Payment Solutions	Reports containing processing information about electronic submissions. **Note:** Available only for clients using the Veradigm® Practice Management application or certain Misys practice management applications.

Maintenance menu options

The following options are available from the **Maintenance** menu. Some menu options are available only in certain circumstances.

Menu Option	Description
View Messages	View a list of broadcast messages.
Edit Claim Defaults	Edit default values that are applied to your claims.
Payer Table	Edit the name and address of a payer.
View Master Payer List	Search for payers and view all available payers.
Provider Maintenance	View data associated with the providers in your practice who use the application. You can perform actions such as editing provider data and adding a new provider to the application.
Billing Addr Override	Enter an alternate billing provider physical address if your office address is a post office (P.O.) box.

Resources menu options

The following options are available from the **Resources** menu. Some menu options are only available in certain circumstances.

Menu Option	Description
Client Portal	Access Payerpath® support, training, and product documentation.
eLearning	Access online videos to help you get the most out of Payerpath®.

Menu Option	Description
Knowledge Center	Access a collection of documentation, implementation, and training materials.
User Guide – Professional Claims	Access the *Payerpath Claims Management*™ *Professional Claims User Guide*.
User Guide – Institutional Claims	Access the *Payerpath Claims Management*™ *Institutional Claims User Guide*.

User name menu options

The following options are available for you to select from the menu that displays when you point to your name at the right side of the title bar. Some menu options are only available in certain instances.

Menu Option	Description
Logout	Use this option to exit the application.
My Filters	Use this option to create and administer filters for claims, payers, and payer rejection workflows.
Preferences	(Only available if you have the assigned permissions in the application.) Use this option to configure preferences and subscriptions for your profile.

Help menu options

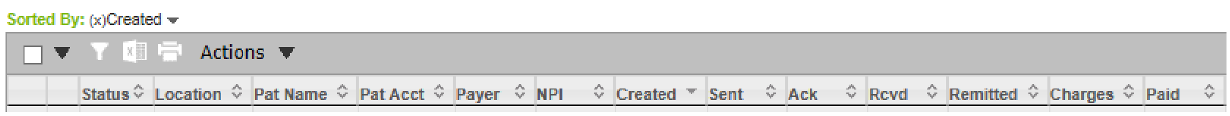
The following options are available for you to select from the help menu. Some menu options are only available in certain circumstances.

Menu Option	Description
About	View your Payerpath® version, application certifications, and Terms and Conditions.
Customer Support	Access contact information for Payerpath® online and telephone support.
Page Help	(Not available for every window.) Use this option to access the Help and quickly view information about how to use the window that you are viewing.

List pages

Many pages within the Payerpath® application display data as a list of items. Multiple features are available to help you sort and navigate through a list so you can locate the data that you want.

The transmitted and untransmitted claim lists provide additional sorting functionality. The default sort order is by the **Created** date and is displayed in the top left side of the list box.



All columns are sortable and the arrows beside the column name indicate whether the column is sorted in ascending order, descending order, or not sorted at all. You can sort by up to three different columns by clicking the up or down arrow in the column title. Your choices will be added to the **Sorted By** header in the list box heading and the items in the list will reorder accordingly. You can change the sort direction by clicking the arrow beside the column heading or by the arrow next to the column title in the **Sorted By** header. You can remove secondary or tertiary sort options by clicking the **(x)** or by clicking the column heading until both up and down arrows are displayed.

> **Tip:** Sorting by multiple columns works by ordering the list by the first column choice, then the second choice is sorted within the criteria of the first choice. For example, the default sort is the **Created** date when you first enter the claims list. If you click **Pat Name**, then the list will be sorted by **Created** date and then by **Pat Name** within each different create date. To sort only by **Pat Name** regardless of the create date then after clicking **Pat Name**, you can click **(x)** to remove the created date from the sort leaving **Pat Name** as the primary sort.

Chapter 2

File claims

This chapter describes file claim basics that are performed in Payerpath®.

Claims filing process

The claims filing process differs depending on whether your site uploads claim files or enters claims manually.

If you use the file upload method to file claims, the claims filing process typically consists of the following steps.

1. Upload your claim file.
2. Run the **Upload Detail Report** to view the results of the claim file that you uploaded.
3. View a list of claims where a payer has not been assigned, then assign the applicable payer.
4. Correct errors on claims that did not pass the claims edits.
5. Acknowledge claims that are held in a warning status.
6. Send the claims to the applicable payers.

If you use the key entry method to file claims, the claims filing process typically consists of the following high-level procedures.

1. Use the claim form replica to manually enter your claims.
2. Correct any errors on claims that did not pass the claim edits.
3. Acknowledge claims that are held in a warning status.
4. Send the claims to the applicable payers.
5. View claims from your site that are transmitted and untransmitted.

Upload a claim file

There are several ways to submit your claims to Payerpath® for processing; uploading your file from within the Payerpath® application and manually entering claims. Your Payerpath® trainer will help you choose the correct method.

Before you begin

Before you upload your claim file, compress it to decrease file size and speed the upload using the Windows compression functionality or an application such as PKZIP. For information about using PKZIP, click **PKWare Website** located in the lower portion of the window.

1. Point to the Dashboard menu to expand it and then click **Claims > Upload Claims**.
2. Click **Browse** to locate your files, and then select the correct claim file.
3. Click **Open**.
4. For **Payer Type**, select the applicable option.

   If the file contains claims for various insurance payers, select **Multi Payer UB92**. If the file contains only one insurance payer connection, select the payer as instructed by your implementation specialist.
5. If **File Type** is not set to a particular file type by default, make the applicable selection according to your implementation specialist.
6. If applicable, select the location based on the location of the claims being uploaded.
7. For **Claim Type**, select the applicable option.
8. Click **Upload**.

Results of this task

After the claims are received, a file acknowledgment is displayed.

What to do next

View the results of the file upload by running the **Upload Detail Report**.

Manually enter a claim for a new patient

Manually enter a claim for a new patient.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.

Claims List Filter is displayed.

Figure 2: My Claims Filter window

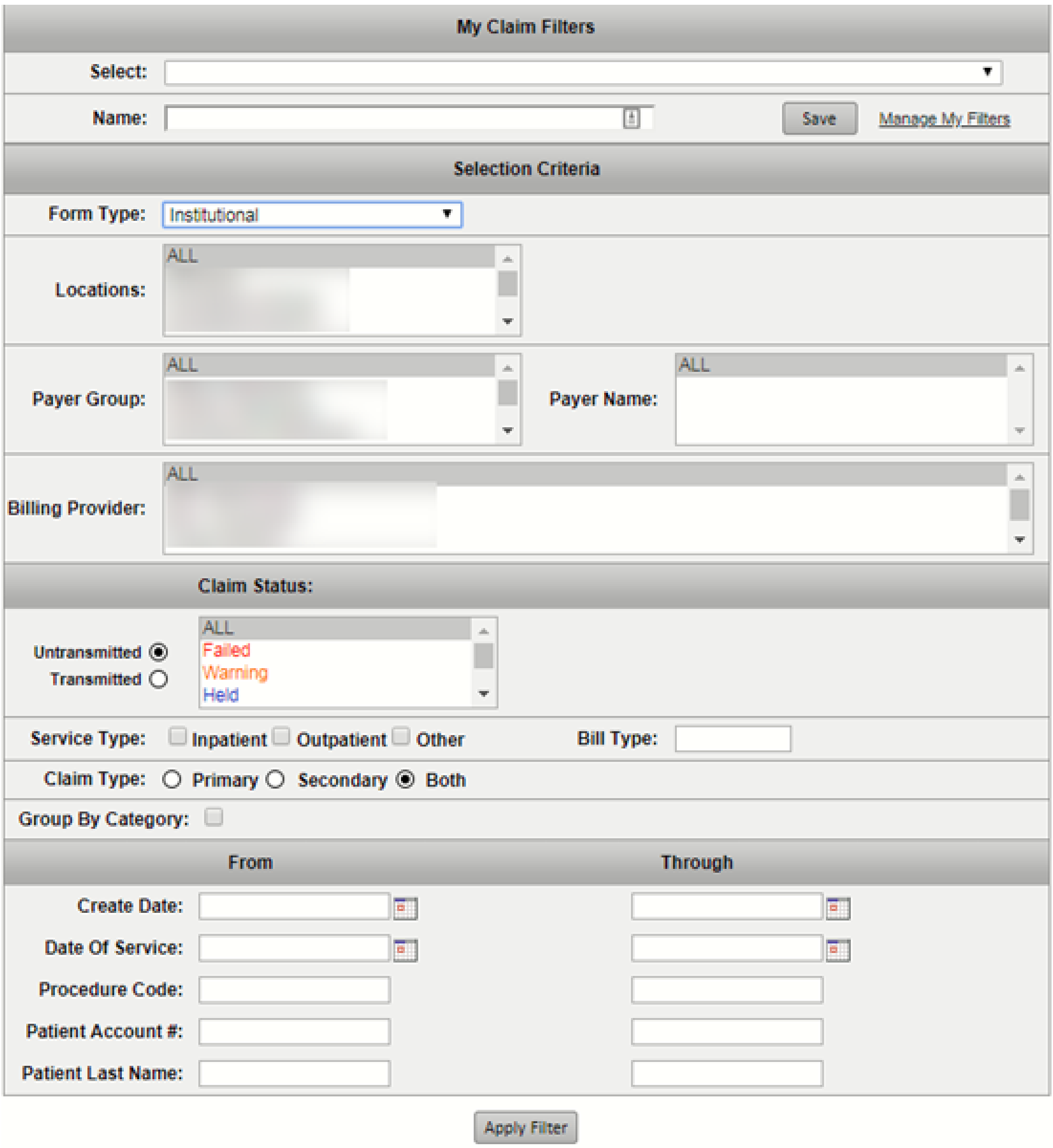
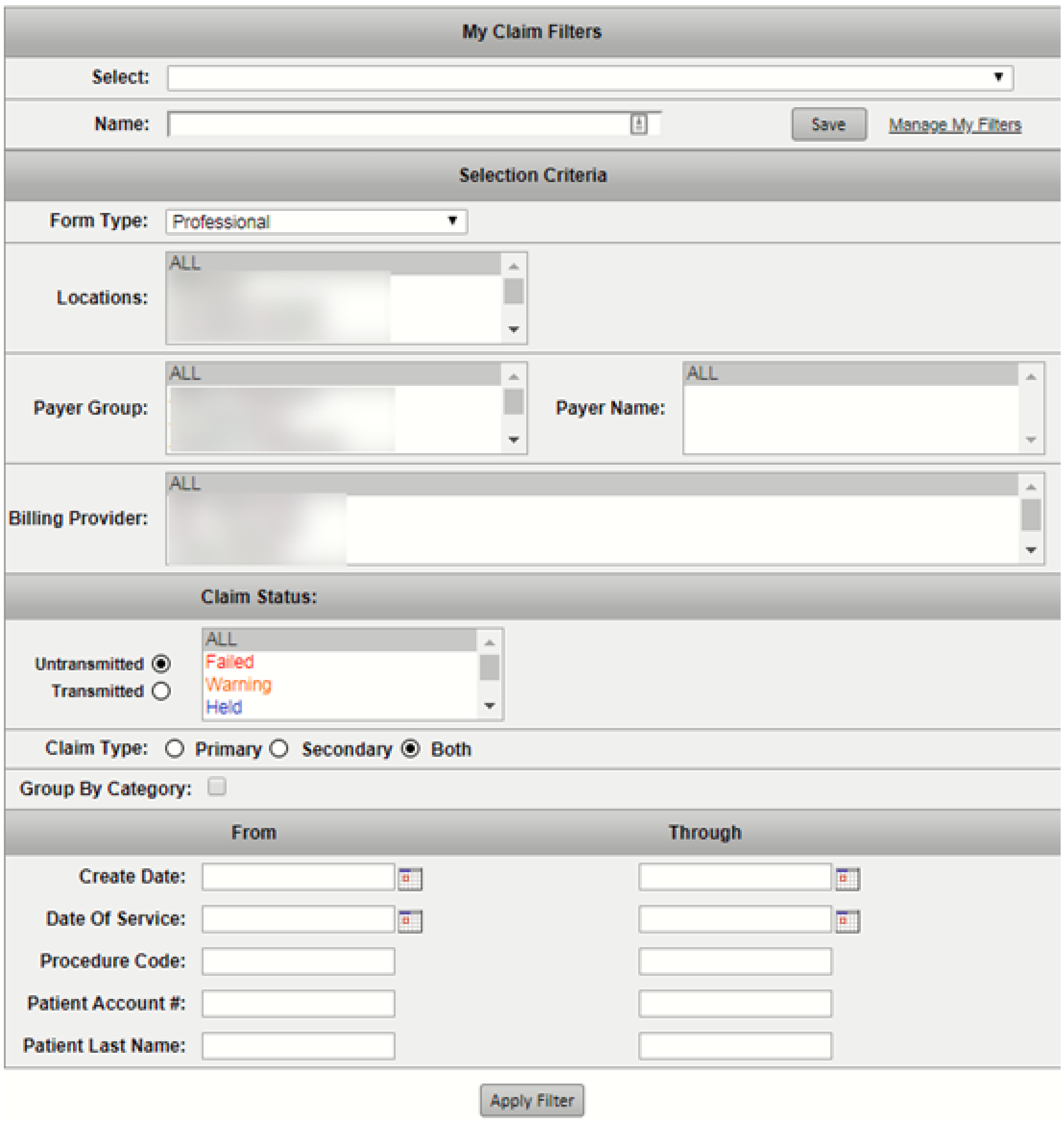


Figure 3: My Claims Filter window



2. Verify **Untransmitted** is selected for **Claim Status** and **Institutional Professional** is selected for **Form Type**, and then click **Apply Filter**.

   Untransmitted Claims List is displayed.

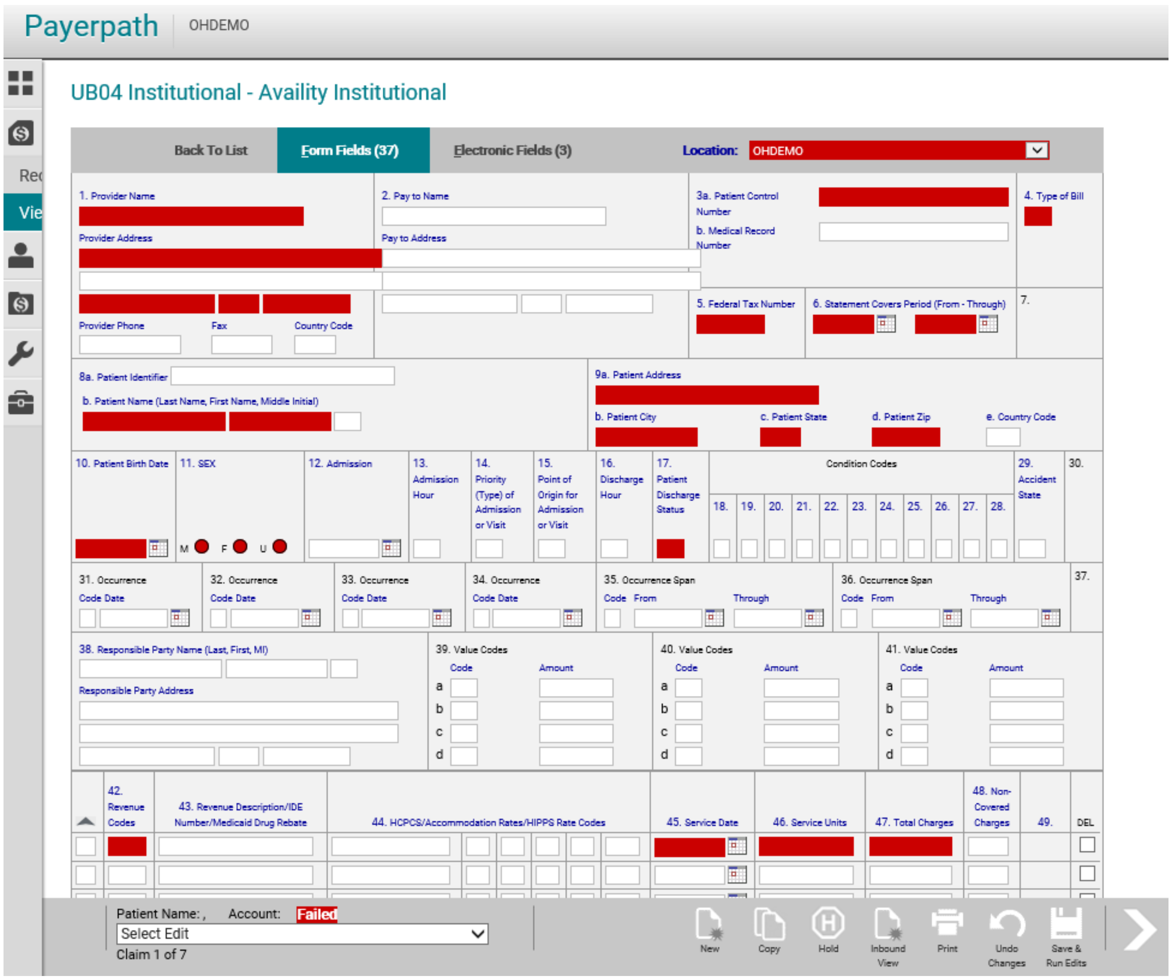
3. Select **Actions > New**.

   Select a payer for the new claim is displayed.

4. Select the applicable payer for the claim, then click **Create New Claim**.

A blank claim form is displayed. The required boxes are displayed with a red background.

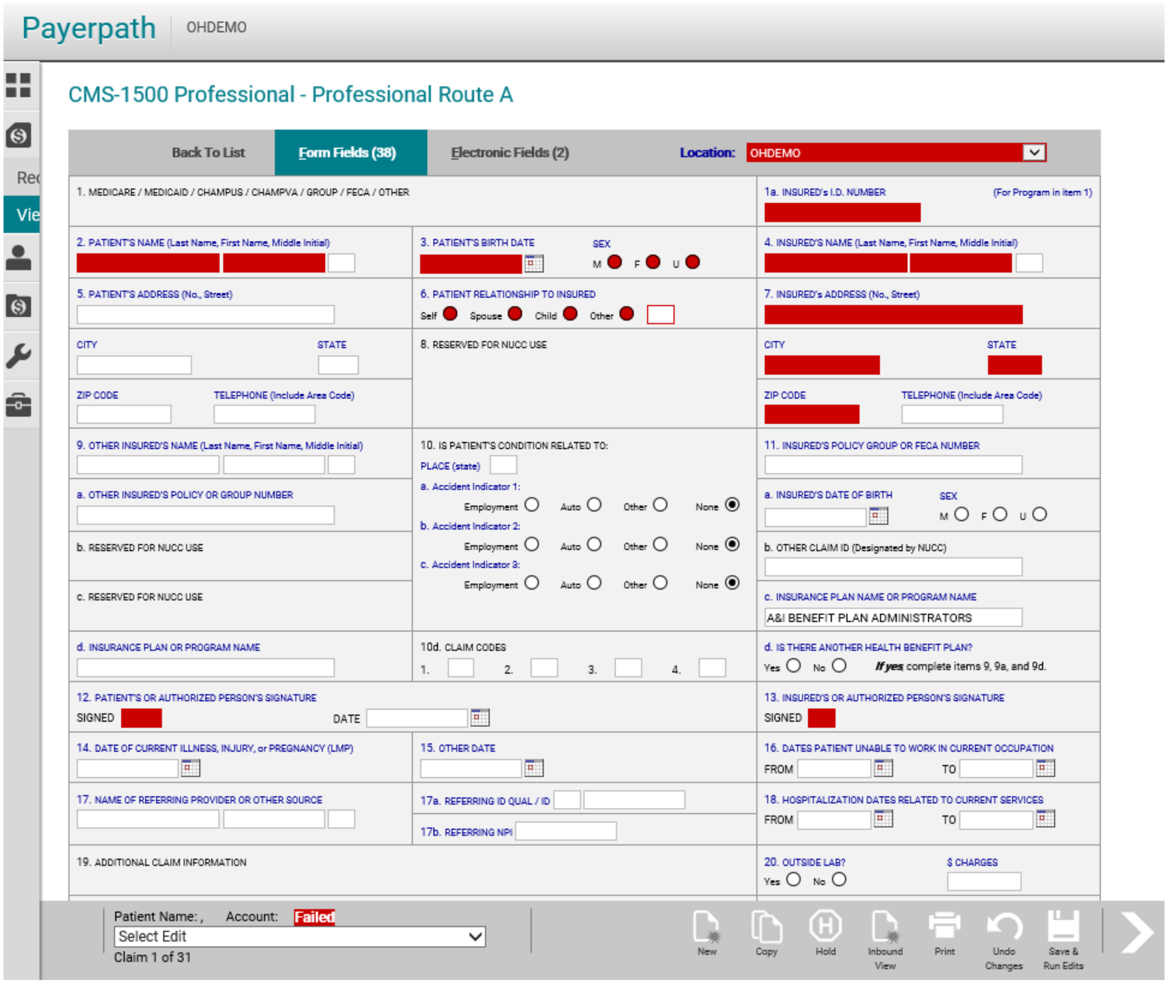
Figure 4: Sample UB-04 Institutional Claim Form



Note: In the boxes, the colors indicates the edit message in the list.

- Red - failed
- Orange or yellow - warned
- Green - informational

Figure 5: Sample CMS-1500 Professional Claim Form



5. Enter the information into all of the required boxes and any other applicable boxes.
6. Click **Save & Run Edits**.

   The applicable payer edits are applied to the claim.

   If the message `No Errors` is displayed in the lower-left side of the window, you have successfully entered the claim. You can now mark and send the claim to the payer.

   If an error occurs, details are displayed in the list in the lower-left side of the window. Make corrections to the claim, click **Save & Run Edits**, and then repeat until `No Errors` is displayed.

What to do next

Check to see if any claims are in **Warning** status, in order to acknowledge the warnings in preparation for transmission to payers.

Manually enter a claim for an existing patient

Using the **Patient Demographics** option, you can create a new claim that is partially populated with certain patient and provider data. This helps reduce the amount of data entry you have to do.

1. Point to the Dashboard menu to expand it and then click **Patients > Patient Demographics**.
2. For **Payer**, select the payer connection to which you are billing, and click **Apply Filter**.

   Patient Demographics is displayed. The window provides an alphabetical list of all patients who have previously been billed to this payer connection.

3. Create the claims.

   - To create claims for only a few patients, select the check box to the left of each patient, and select **Actions > Build New**.
   - To create claims for many patients, click **Select Page** or **Select List** from the menu in the grid, and select **Actions > Build New**.

   A blank claim is created for each selected patient, which includes the patient information and your provider information.

4. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.

My Claims Filter is displayed.

Figure 6: My Claims Filter window

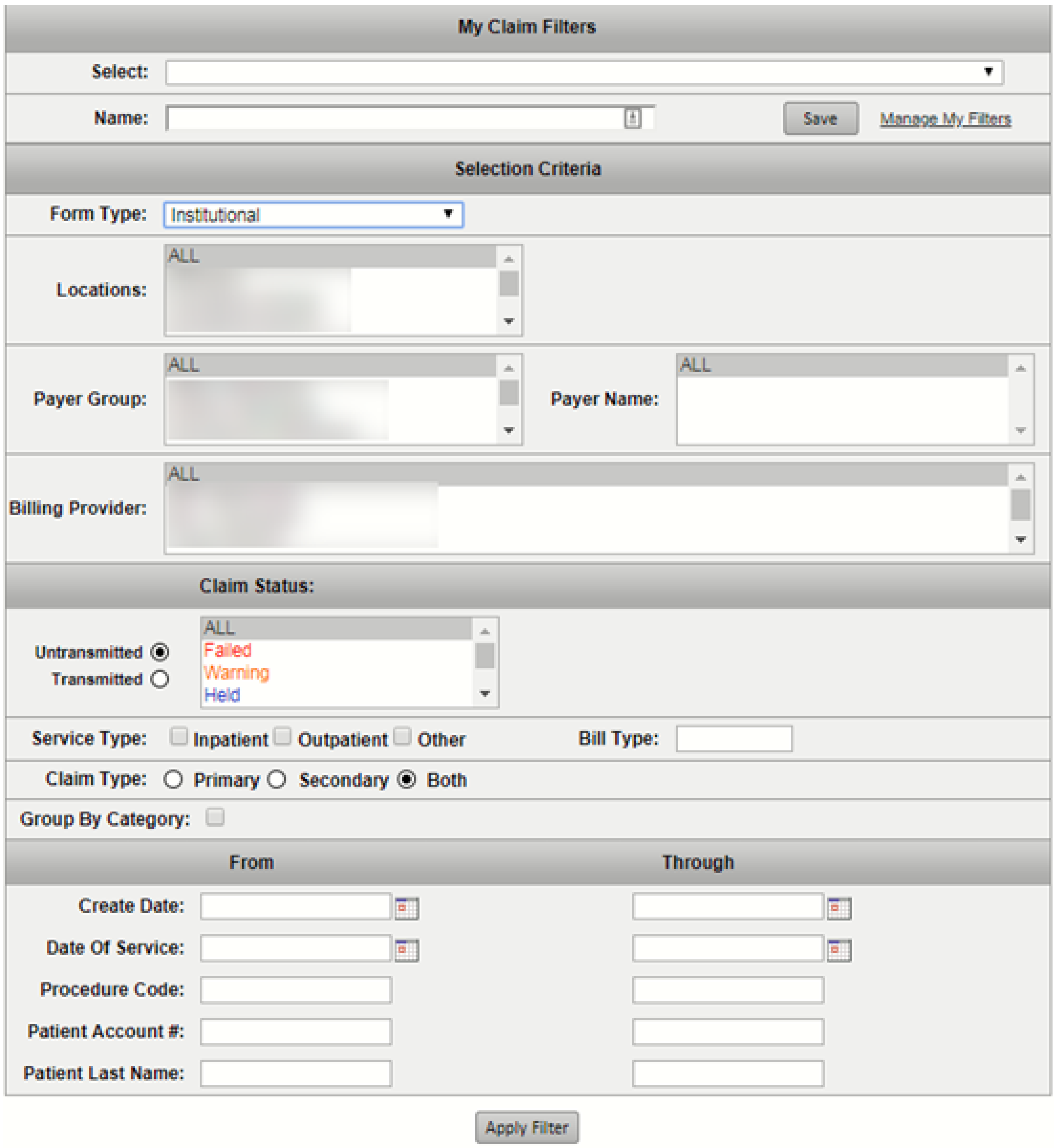
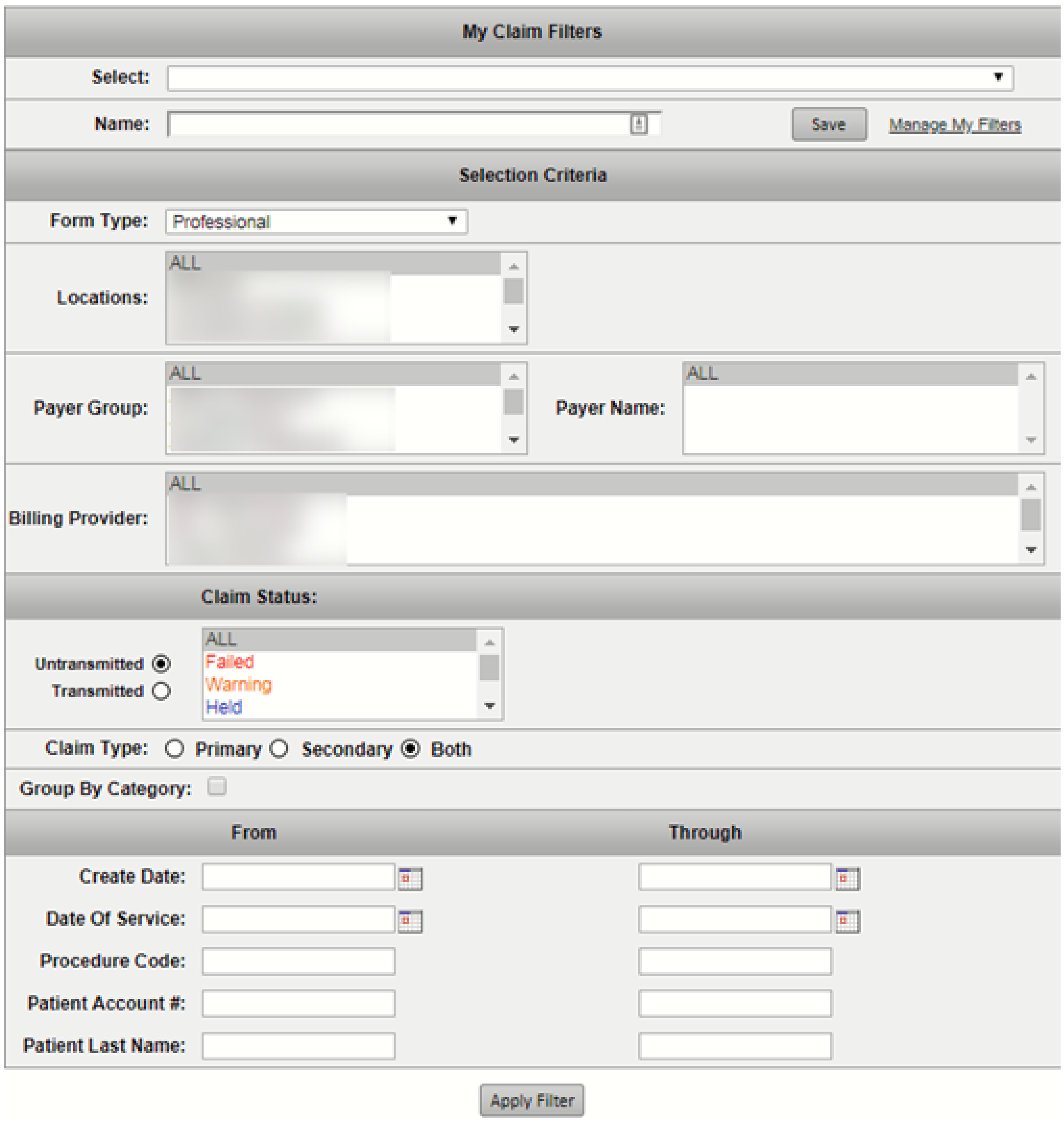


Figure 7: Claims List Filter window



5. For **Claim Status**, make sure **Untransmitted** is selected and **Professional Institutional** is selected for **Form Type**, and then click **Apply Filter**.

   If you submit claims for only one payer connection, the filter is set by default to your connection and form information. Open the filter and click **Apply Filter** at the bottom of the window.

   Untransmitted Claims List is displayed.

6. Beside the claim to complete, click **V**.

The claim form is displayed.

Figure 8: Sample UB-04 Institutional claim form

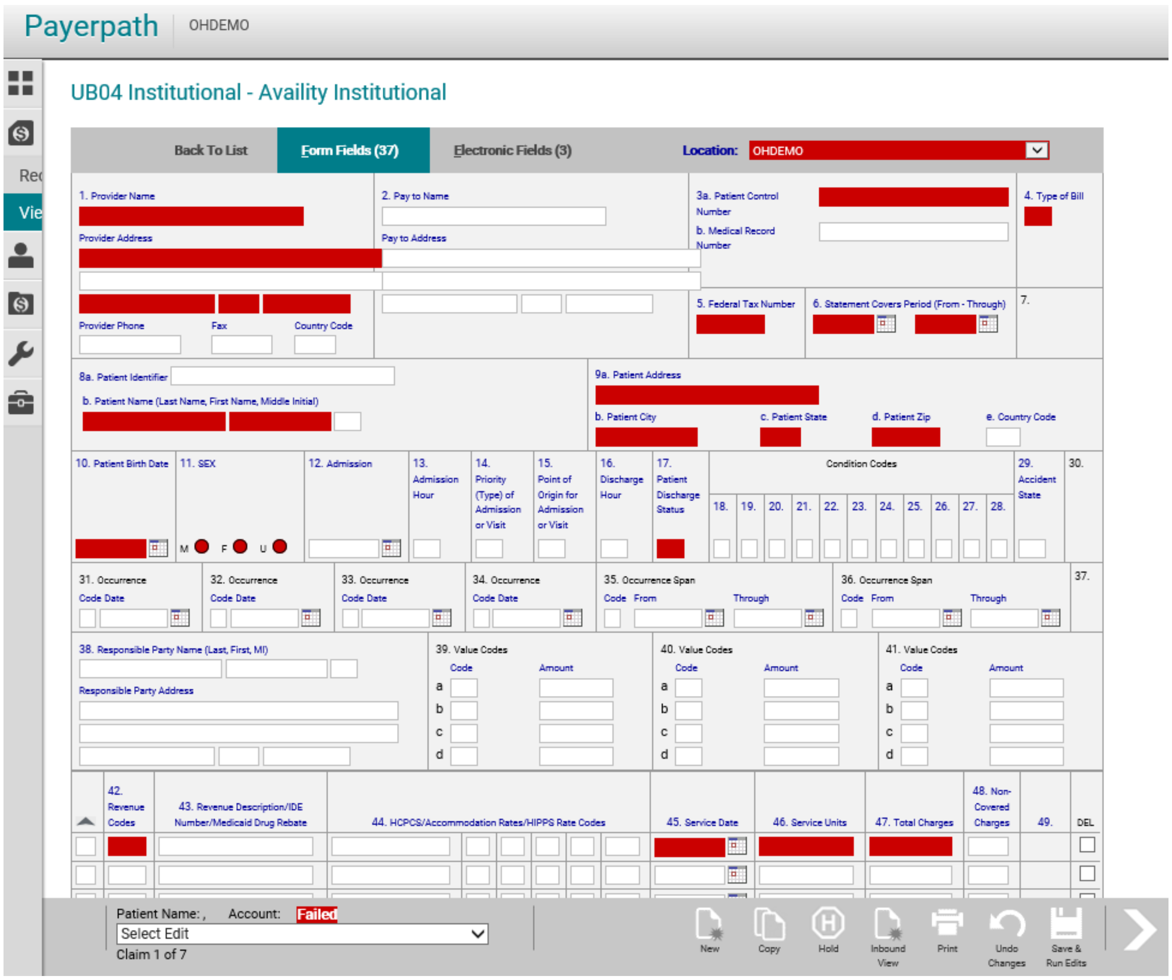
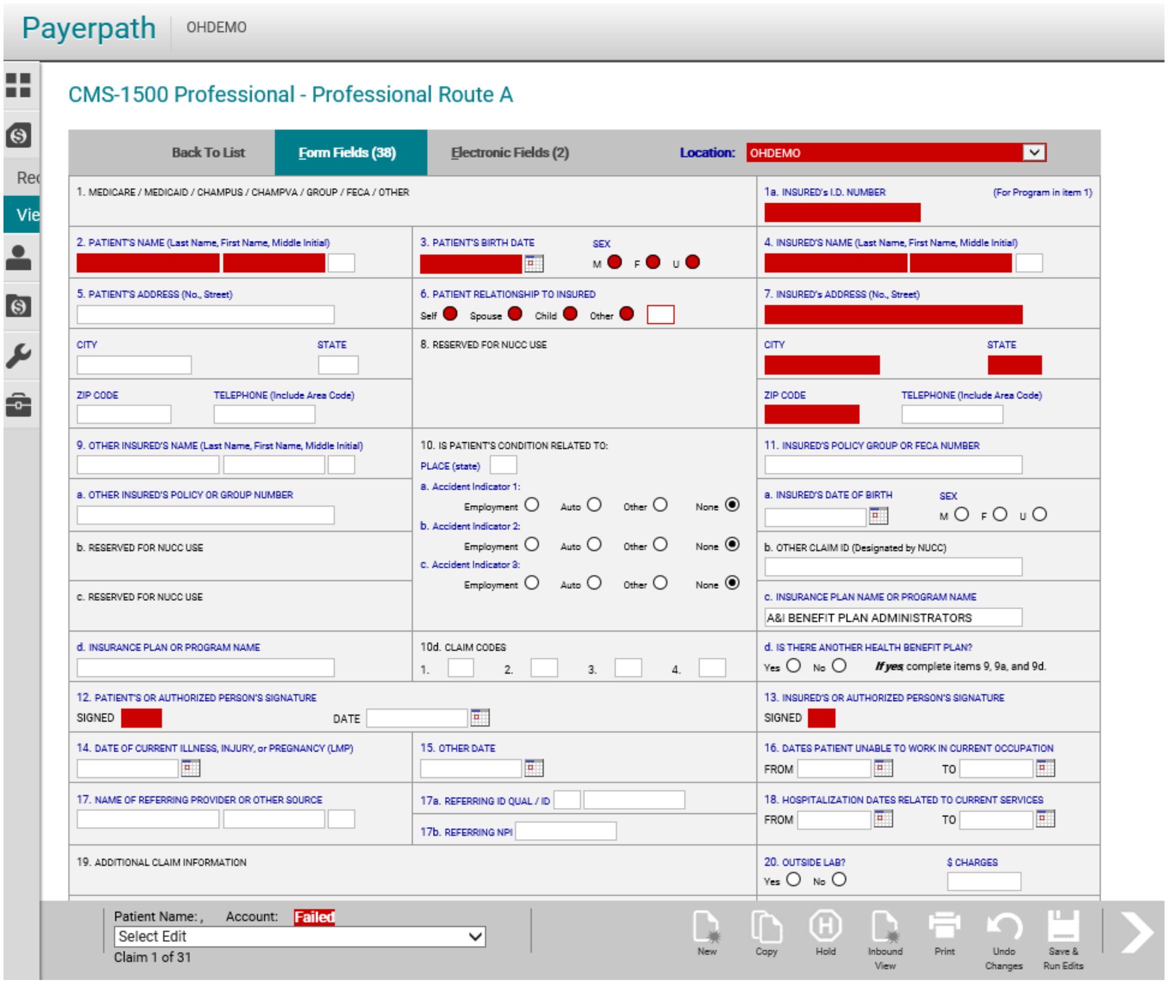


Figure 9: Sample CMS-1500 Professional Claim Form



7. Fill out the form, and then click **Save & Run Edits**.

   The applicable payer edits are applied to the claim.

   You have successfully entered the claim if the message `No Errors` is displayed in the lower-left portion of the window. You can now mark and send the claim to the payer.

   If an error occurs, details are displayed in the list in the lower-left side of the window. Make corrections to the claim, and then click **Save & Run Edits** until `No Errors` is displayed.

What to do next

Check to see if any claims are in **Warning** status. If so, acknowledge the warnings in preparation for transmission to payers.

View the Upload Detail Report

After your claim file is received, you must view the status of each claim in your batch using the **Reconcile Claims Summary** or the **Upload Detail Report** to view the results.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Detail**.
2. Click the **View** link corresponding to the report you want to view or print.

   Click the links in the toolbar of **Report Viewer** to navigate through the report, search report data, download the report, or print the report. You can also filter a report before you view it.
3. Locate claims that are in **Failed** and **Warned** status.

   For these claims, information is included about why the claim did not pass the edits.

Results of this task

You can now download, print, or export the report.

What to do next

After reviewing the **Upload Detail Report**, you must correct any errors or warnings before those claims can be forwarded to the payers.

> **Tip:** You might want to print the report to refer to as you locate a claim in the application. You can also give copies of the report to your coders for preventive actions such as documentation improvement programs.

Filter the Upload Detail Report

View passed and failed claim information in the **Upload Detail Report** by selecting applicable options on the **Upload Report Filter** window.

You can also filter to view the report as a summary of all claim information, or you can have the report organize claim information by payer connection (for example, Medicare or commercial). Totals are listed at the bottom of each **Upload Detail Report** in order to verify the number of claims uploaded, if needed.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Detail**.
2. Locate the row in the list, and then click the corresponding **Filter** link.
3. Enter your filter criteria, as follows.

Filter	Description
Claim Status	Select an item to view only claims in a specific claim status, such as failed claims.
Location	Select an item to view only claims from a specific location.
Payer	Select an item to view only claims from a specific payer.
Break by Payer	Select this option box if you want the report to group claims according to payer name.
Bill Type	(This option is only displayed when working with institutional claims.) Select an item to display claims according to inpatient or outpatient type.
Edit Message	Select an item to view only claims with a specific edit (such as **Field in Error**). You must then select the applicable error (such as **Payer Error: Insured Zip**).

4. Click **Process Report**.

   The filtered **Upload Detail Report** is displayed in **Report Viewer** for you to work with. You can print or download a report, as needed.

Reassign claims in Unassigned status to the correct payer

Before you can send a claim to an electronic payer, the claim must be assigned to the correct payer connection. Claims must be reassigned if they are in a **Failed** status and listed as unassigned, (the payer specified in the claim could not be identified).

> **Tip:** Depending on your configuration, claims with payers that could not be identified might print to paper instead of failing with a condition of unassigned. Check **Print Mail** claims and reassign them to electronic paper, if possible. **Print Mail** claims are displayed in blue.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. For **Payer**, select **Print Mail** or **Unassigned**.
3. For **Claim Status**, select **Untransmitted** and **ALL**.
4. Click **Apply Filter**.

   A list of passed and failed **Print Mail** or **Unassigned** claims is displayed in the **Untransmitted Claims List** window.

5. Select each claim to assign.
6. Select the **Actions > Assign** menu.
7. Search for the desired payer in the presented list by entering the TSPID, payer ID or part of the payer name in the designated fields.
8. Select the payer, then click **Assign**.
9. Point to the Dashboard menu to expand it and then click **Claims > View Claims** to display the **Claims List Filter** window.
10. Select the payer to which you reassigned the claims, and then click **Apply Filter**.
11. View the reassigned claims and correct the errors (as indicated by the **Payer** report).

What to do next

Mark and send the claims.

Enter the explanation of benefits information for a secondary claim

Verify or edit the necessary explanation of benefits (EOB) information for a secondary claim. This feature applies only to secondary claims and cannot be used for tertiary claims. You will never have to manually key this information into Payerpath®. If you auto-post your electronic remittances, then the financial information can be imported into your practice management system so that it is included on the secondary claim when it files.

Before you begin

> **Note:** These steps assume that the secondary claim is already present in the application, but has not been transmitted to the payer. Although you can view a transmitted secondary claim, you can only edit the claim if it has not been sent to the payer.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. Enter the criteria to create a list of claims that includes the secondary claim that you want to edit or view.
3. Click **Apply Filter**.
4. Locate the claim from the list, and then click **V** to display it.
5. Click **Secondary Fields**.
6. Click a category (**Primary Payer Information**, **Secondary Payer Information**, and so on) on the left side of the window to display those boxes.

These boxes refer to the secondary payer and they are filled in with data transmitted from your practice management application. Required boxes that are missing data are displayed with an red background.

The corresponding boxes are now displayed for viewing, entry, or editing.

7. (Optional) Make any changes to the first boxes in the **Primary Payer Information** section.

   These boxes are filled in with any data that you correctly entered and transmitted from your practice management application. If you are editing the claim, complete these boxes using information found on the primary remittance.

   Claim Adjudication Date, **Payer Paid Amount** (the actual amount paid by the primary payer), and **Allowed Amount** are required by the secondary carrier to properly adjudicate the claim.

8. If applicable, enter values for the **Group Code**, **Reason**, **Amount**, and **Quantity** in the **Primary Payer Adjustments** section.

   These boxes refer to the claim level adjustments. Complete these boxes only if the secondary carrier requires adjustment information to be submitted at the claim level. (Otherwise, leave the adjustment boxes in this section blank.) This information explains to the secondary payer why the primary claim was not paid in full.

   For institutional claims, most carriers require that any adjustment information be sent at the claim level rather than service line.

   If you want to send financial information at the service line instead of at the claim level, enter adjustments information into the **Primary Payer Service Line EOB Information** section. There is a separate line for each service line that was submitted on the claim. You cannot add or delete service lines from this window; use the regular claim edit window if you want to. The most commonly required boxes are displayed. These boxes are filled in with any data that you correctly entered into and transmitted from your practice management application. If you are editing the claim, complete these boxes using information found on the primary remittance.

   As required, select the applicable **Claim Adjustment Group Prefix** and **Reason** codes along with the corresponding adjustment amounts that apply to the entire claim balance (as opposed to the individual service lines).

9. Ensure that the **Claim Level** or **Service Line Level** adjustment codes and amounts from the primary payer are present on the secondary claim, but not both.

   If you are posting claim-level adjustments, the claim adjustment amounts when added to the value for **Payer Paid Amount** must equal the total charge amount on the claim.

   If you are posting service-line-level adjustments, the service line adjustment amounts when added to the service line paid amount must equal the total to service line charge amount. If all service lines are in balance using this formula, the total charge will be in balance.

10. When you have finished entering all of the information, click **Save & Run Edits**.

    The secondary claim information is saved and checked for errors.

If there are no errors, the claim is assigned a **Passed** status. If there are errors, the boxes with incorrect information are displayed with an red background, and listed in the list in the lower-left side of the window.

Claim adjustment grouping prefix and reason codes

The claim adjustment group prefix codes and reason codes are standardized codes that are used to describe the way the primary payer responded to the charge amount on a remittance. Electronic remittances and electronic secondary claims must use only the standard ANSI-mandated codes.

Both the **Primary Payer Claim Level EOB Information** section and the **Primary Payer Service Line EOB Information** section on **Secondary Fields** include the following:

- **Group Code**: This list displays the two-character claim adjustment group prefix codes. The prefix codes are **PR** (patient responsibility), **CO** (contractual obligation), **OA** (other adjustment), **CR** (correction or reversal), or **PI** (payer initiated reduction).
- **Reason Code**: This list displays one to three alphanumeric suffix codes that explain the reason for the actual adjustment.

Many carriers already return the ANSI-mandated adjustment codes on their paper explanation of benefits (EOBs), but some do not; ANSI governs electronic transactions, not paper. If you receive an EOB that does not reflect the ANSI-mandated adjustment codes, you must contact the primary payer to determine the correct codes to use based on your contact type.

The adjustment codes that you are required to enter are based upon the actual contract type or agreement you have with the primary payer and might affect your reimbursement rate from the secondary payer.

> **Note:** Although the description for each claim adjustment group prefix code and reason code is displayed for your convenience, only the actual code is submitted to the payer.

To view a complete list of these codes, select **Help > Knowledge Center**, and then click **ANSI Group and Reason Codes**.

Correct errors on a claim form

When you submit a claim, many different edits are applied to determine whether it is correct and eligible to send to a payer. If the claim does not pass an edit, it is assigned a **F** (failed) status. You must correct these errors to send the claims to the payer. Claims can also be assigned a **W** status. For these claims, you must either correct the warning or acknowledge the warning before you will be permitted to send the claim to the payer.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.

Claims List Filter is displayed.

Figure 10: My Claims Filter window

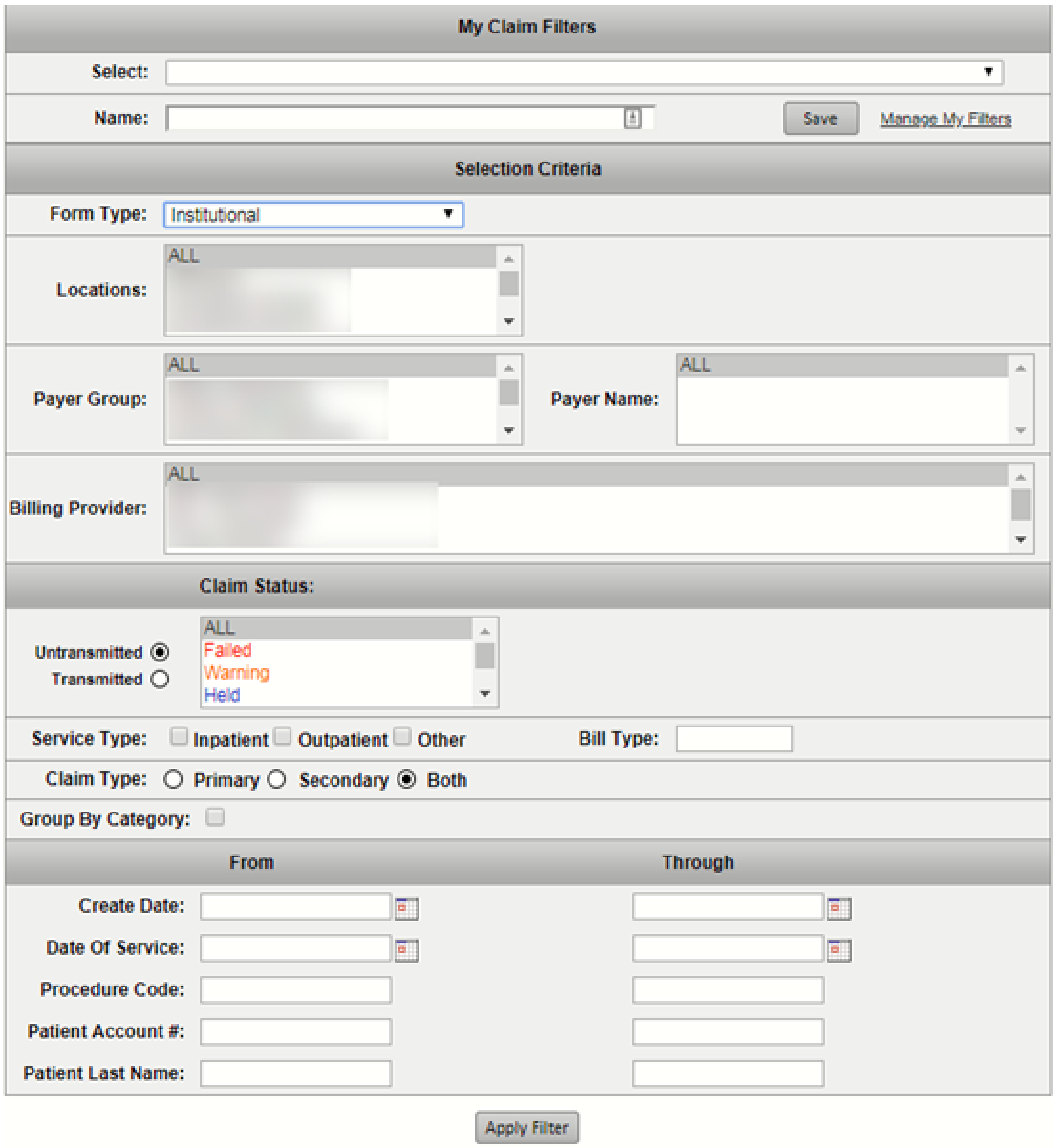
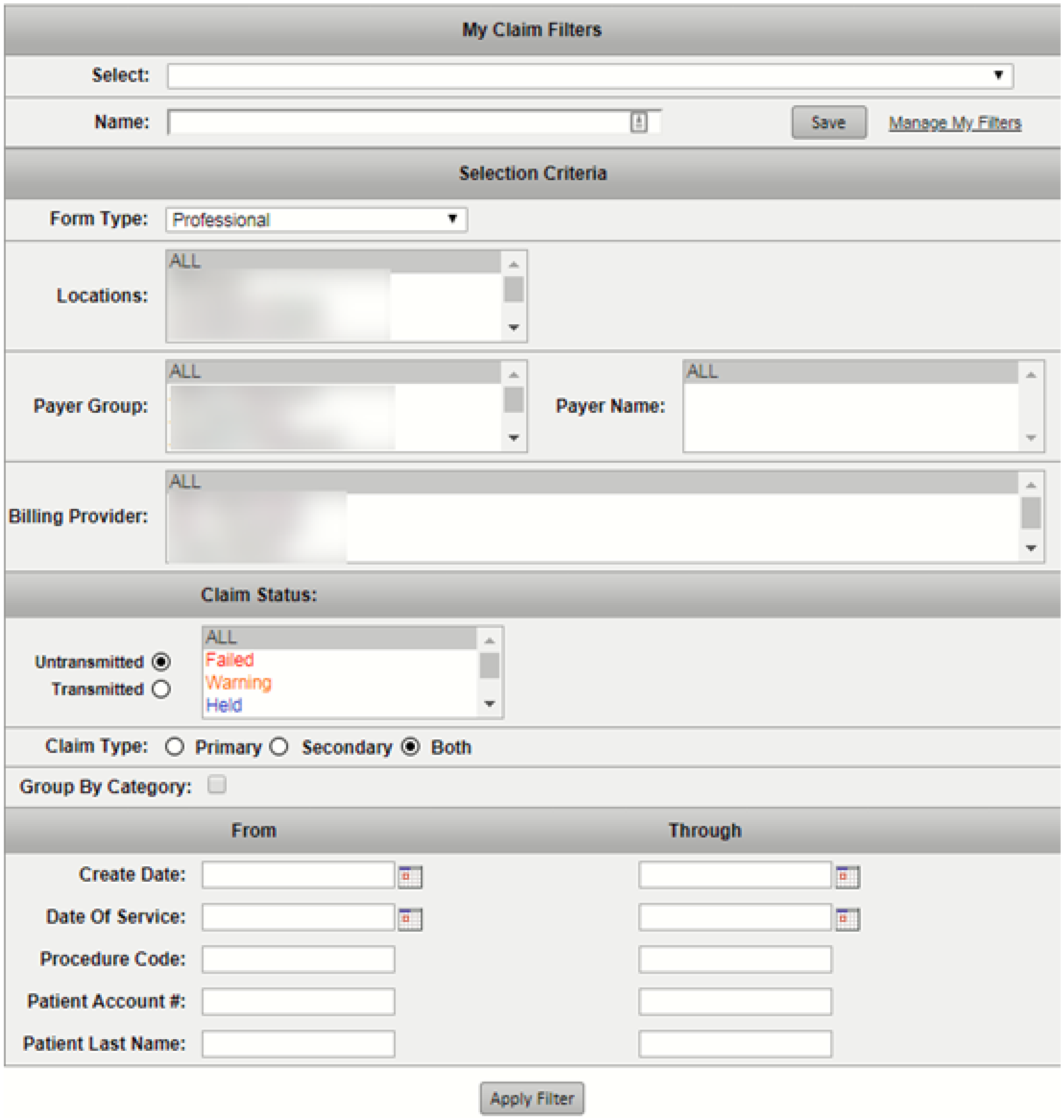


Figure 11: My Claims Filter window



2. Make sure that **Untransmitted** is selected and then select **Group by Category**.

   Edit Categories is displayed.

   The **Group Untransmitted Claims by Edit Category** enables you to access your untransmitted claims sorted into groups by failed and warned edits. This new workflow enables your practice to effectively divide the work among your staff based on area of expertise. Also, this functionality streamlines repetitive work by associating similar items together. Using the **Claims List** filter for Untransmitted claims, you can select a **Group by Category** which is located in the **Claim Status** section of the **View Claims** filter.

By default, the **Group By Category** box is not selected and results in the same claims list are not displayed in which you are accustomed to. By enabling **Group By Category** this expands additional options in **Edit Categories**, such as **All**, **Coding**, **Insurance**, **Pat Demo**, **Secondary and Other**. You can select **All** categories, one or multiple categories by pressing the **Ctrl** key and select one option at a time. When the filter is applied, the untransmitted claims list displays.

3. Select **All** to view edit messages for all categories.
4. Click **Apply Filter**.

   The claims that match your search are displayed on **Untransmitted Claims List**, as follows.

   - **Category**: A selected category or categories.
   - **Edit Message**: Various edit messages for the selected time period for each category.
   - **S**: The status of the claim (**Failed**, **Held**, **Passed**, and so on). Failed claims are displayed with a red **F** status.
   - **Location**: This field usually displays your Payerpath® account number, unless you are using the **Location** feature.
   - **Pat Name**: The patient's first and last name.
   - **Pat Acct**: The patient's voucher (claim) number.
   - **Payer**: The insurance company assigned to the voucher (claim).
   - **NPI**: The billing National Provider Identifier (NPI) on the voucher (claim).
   - **Created**: The date that the claim was received in the Payerpath® clearinghouse.
   - **Charges**: The total amount of the voucher (claim).
   - **View**: Click **View** to view a claim.
   - **History**: Click **History** to view a claim history for the patient.
   - **Report**: Click **Report** to view the report.

5. Click **+** that is beside the edit message to work on and to expand the claims associated with that message.

The claim is displayed. You can quickly identify which fields are in error because they are highlighted in a different color than the fields without errors. If you point to the field that displays the error, the edit message is displayed.

Figure 12: Example of a UB-04 Institutional claim

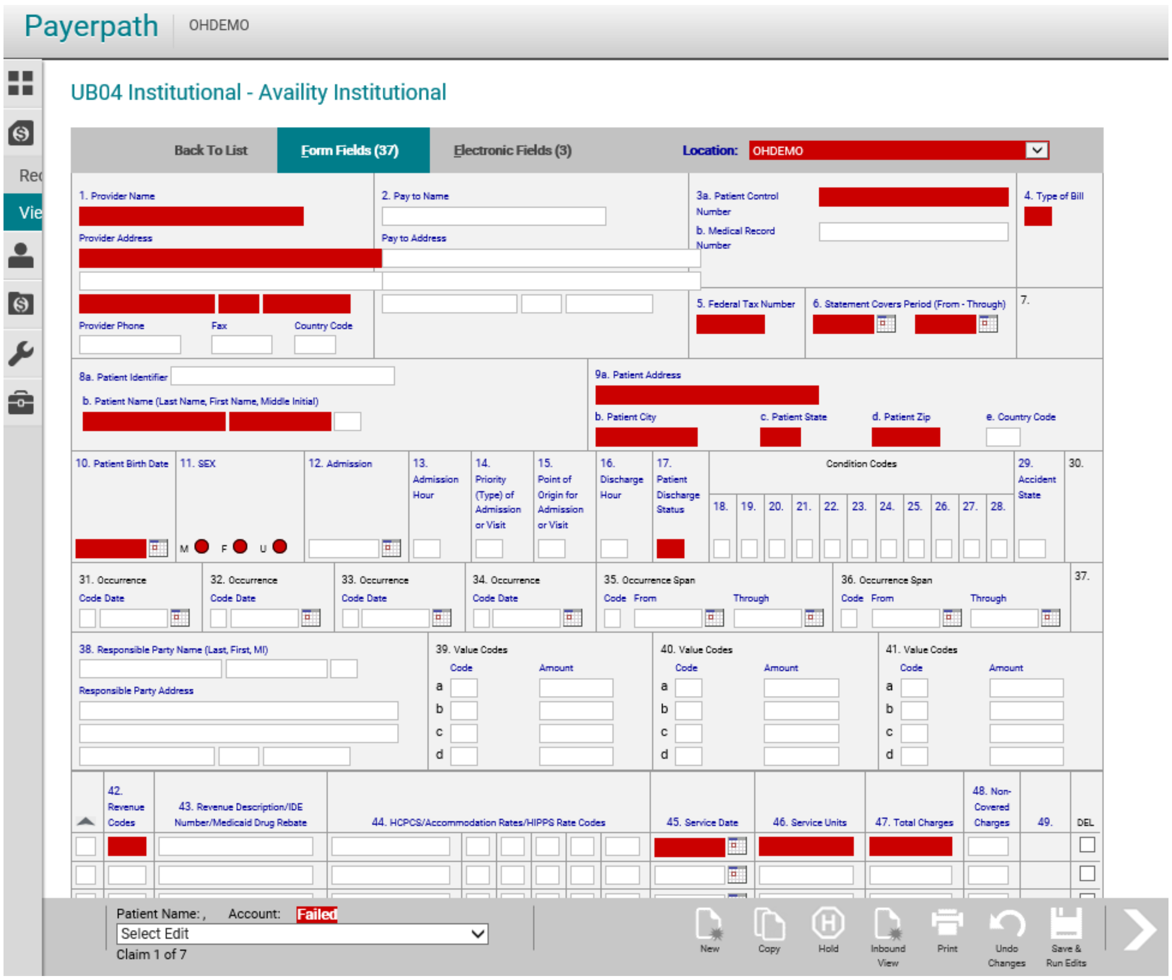
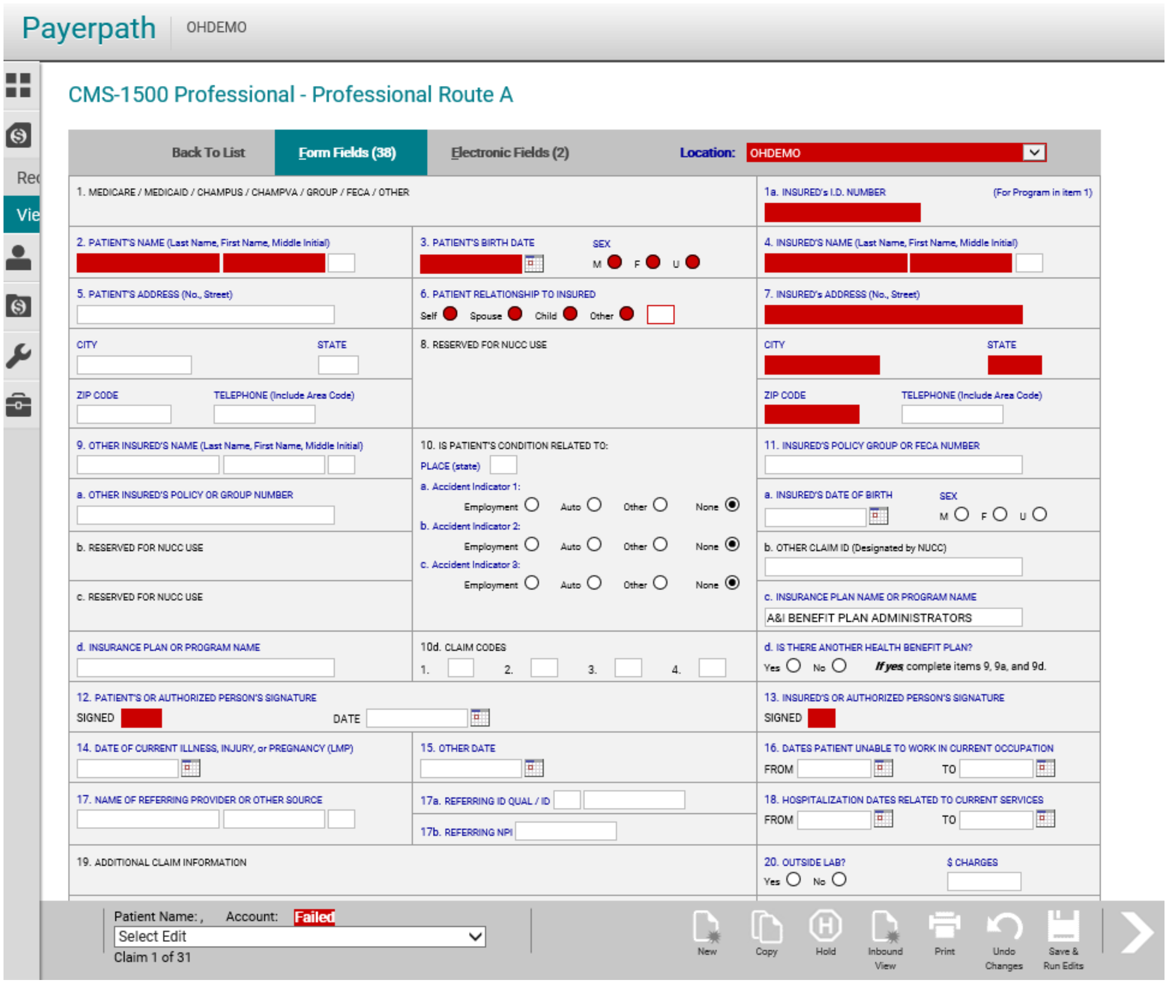


Figure 13: Example of a CMS-1500 Professional claim



6. Locate the claim to work with and click **View**.
7. Locate the claim form navigation bar that is located at the bottom of the window.

8. (Optional) To view the actual claim data, click **Inbound View**.

   The claim data is displayed in a separate window. By default, the data is displayed in a parsed format with box titles for greater readability. You can select **Raw** from **View Option** if you prefer the unformatted version.
9. Select an edit message from the list on the left of the navigation bar.

   Your pointer moves to the field in error for you to make your correction.

> **Tip:** If the edit is prefixed by an "F", the field in error will be on the main form window. If the edit is prefixed by an "E", the edit will be on one of the fields in the **Electronic Fields**. If the edit is prefixed by an "S", it will be in one of the **Secondary** fields.

10. (Optional) Point to the name of the fields containing the error.

    If the mouse cursor changes to a hand icon, you can click the field name to view a separate window that contains Help information for that field. This feature is not available for all fields.

11. (Optional) Point to the name of the fields containing the error.

    A tooltip displays the associated error message.

12. Correct the error.

    > **Best Practice:** If you are using a practice management application in conjunction with the application, only correct errors here that you can also correct in your practice management application. Changes that you make here do not carry over into your practice management application.

13. Click **Save & Run Edits**.

    Your changes are saved and edits are reapplied to validate the data.

    > **Best Practice:** Correct errors one at a time, and click **Save & Run Edits** after each correction. This method enables you to immediately see if you have fixed the error, and you also remove the error from the list to easily track what was fixed and what was not.

    > **Note:** If you have to correct errors in the **Electronic Fields** area, click the **Electronic Fields** tab or select the edit from the list and your pointer moves to the **Electronic Fields** tab and stops on the field that contains in error.

14. Repeat until a `No Errors` message is displayed in the lower-left side of the window.
15. Click the arrow icon to display the next failed claim in the claim list.
16. Repeat steps 6 through 8 to correct all the errors on the claim.
17. After you correct all the claims, click **Back to List**.

    Untransmitted Claims List is displayed, and the claims that you corrected are now assigned a **P** (passed) status.

What to do next

The claims are now ready to be sent to payers.

Acknowledge claims that are pending

If you have claims that are assigned a **Warning** status due to a custom edit or CodeCheck edit that you set up, these warning edits must be acknowledged before the claims can be sent to the payer.

You can acknowledge a single claim or multiple claims in several ways, depending on your needs.

> **Note:** Manually review these claims before sending to the payer.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. Make sure that **Untransmitted** is selected, and then select **Warning** from **Claim Status**.
3. Enter any other filter criteria that you want to use to display your list of claims to be sent.
4. Click **Apply Filter**.
5. To acknowledge a single claim, click the **V** link to display the claim, and select **Acknowledge Warning** from the navigation bar.
6. To acknowledge multiple claims, select the claims that you want to acknowledge using one of the following methods.

   - For a small number of claims, select the applicable check boxes manually.
   - For a larger number of claims, select one of the following from the menu bar.

     Select Page: Use this option to automatically select the check box for each claim displayed on the current window.

     Select List: Use this option to automatically select the check box for each claim contained in the list. (This option selects the claims that are displayed on the current window, as well as the claims on the remaining pages within the list).

   The claims in **Warning** status that you want to acknowledge are now selected.
7. Select **Acknowledge Warning > Action**.

   The warning status is now acknowledged and you can mark the claims to be sent to payers.

Send claims to payers

After a claim passes edits it is assigned a **P** (passed) status and it is ready to send to a payer. You must assign the claim an **S** (send) status, so it will be sent to payers during the next scheduled transmission time. If your site is configured for auto-send, then when you upload a file, all passed claims will automatically be marked to send so you only have to mark claims to send after fixing errors or acknowledging warnings. This manual designation tells the system that you are finished working on the claim and are ready for it to be sent to the payer.

If you are still on the claim form, you can mark it to send by selecting the Send icon on the claim form navigation bar. You can also mark claims to send in bulk using the following steps.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. Make sure that **Untransmitted** is selected, and then enter any other filter criteria that you want to use to display your list of claims to be sent.
3. Click **Apply Filter**.
4. Select the claims you want to send using one of the following methods.
    - To send one or a few claims, select the applicable check box (left side of the window), and then select **Send** from the **Actions** menu.
    - To send all claims, select **Select All** from the top left of the list box, and then select **Actions > Send**.

    The selected claims are assigned an **S** (Marked for Send) status and they will automatically be sent during the next scheduled send time for each payer connection. Exactly when claims are sent to a particular payer varies according to a number of criteria. Some payers only accept claim transmissions at certain times of day.

    > **Note:** Failed and Warning claims remain in the claims list until they are corrected and sent, deleted manually, or deleted automatically by the application after 90 days. Failed claims can also be automatically replaced by a new corrected claim if your profile is configured to automatically replace failed claims.

    After the claim has actually been transmitted to the payer, its status changes to **A** (In Process to Payer).

    > **Tip:** You might find it useful to print a list of the claims that you send to each payer.

Print a list of sent claims

Print a daily list of the claims that were sent to each payer connection. This list includes all the claims in a **Marked for Send** status. You can use this list to help reconcile your sent claims after you receive a **Response** report from the payer.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. In **Claim Status**, select **Marked for Send**.
3. Click **Apply Filter**.

Untransmitted Claims List is displayed, listing the applicable claims.

4. From the menu bar, select **Select All**.
5. Click the print icon .

   A box opens with the following options depending on whether the claims selected are professional or institutional:

   - **CMS-1500 Form - With Form**
   - **CMS-1500 Form - Without Form List**

   or

   - **UB04 Form - With Form**
   - **UB04 Form - Without Form List**
   - **UB04 Form (ICD-10) with Form**
   - **UB04 Form (ICD-10) without Form**
   - **List** (Enabled)
6. Select one of the options and click **Print**.

   Your report opens in **Print Preview**.
7. Click **Print** at the top of the window.
8. Click the print icon.

Results of this task

The resulting report is a list of claims for each payer connection along with the date sent and the total dollar amount. This total dollar amount must match the total dollar amount on the **Response** report when you receive it. Any claims that have already been sent to the payer are not included in this list.

> **Note:** If you do not print the sent claims list when you send claims, you can later retrieve a complete list and total by pointing to the Dashboard menu to expand it, clicking **Reports > Transmitted Claim**, and then entering the date the claims were sent. You can also access claims through **Claims > Reconcile by Batch**. This feature lists each batch sent along with a summary of the claims and the status of claims in the process.

Cancel Send

Cancel Send is an action available on the **Untransmitted Claims List Action** menu.

If a claim has a status of **S-Mark for Send** and the **Cancel Send** action is selected for that claim, then the claim is moved to a status of **H-Hold** with a Hold Reason of **Cancel Send**. This enables users to stop the claim from going out to the payer by deleting the claim and resubmit a corrected version or by making last-minute corrections to the virtual claim form, removing the hold, and marking it to send again.

> **Important:** After a claim is marked for send, there is only a small window of time (minutes to hours depending on the next scheduled send time for that payer) before the claim is sent to the payer. The claim is only eligible to be canceled during this window. Users will receive a message informing them that it is too late to cancel if an attempt is made to do so for a claim that has already been sent to the payer.

View claims

You can view lists of your site's transmitted or untransmitted claims and the claims themselves from the **Dashboard** window in Payerpath®.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.

Figure 14: My Claim Filters

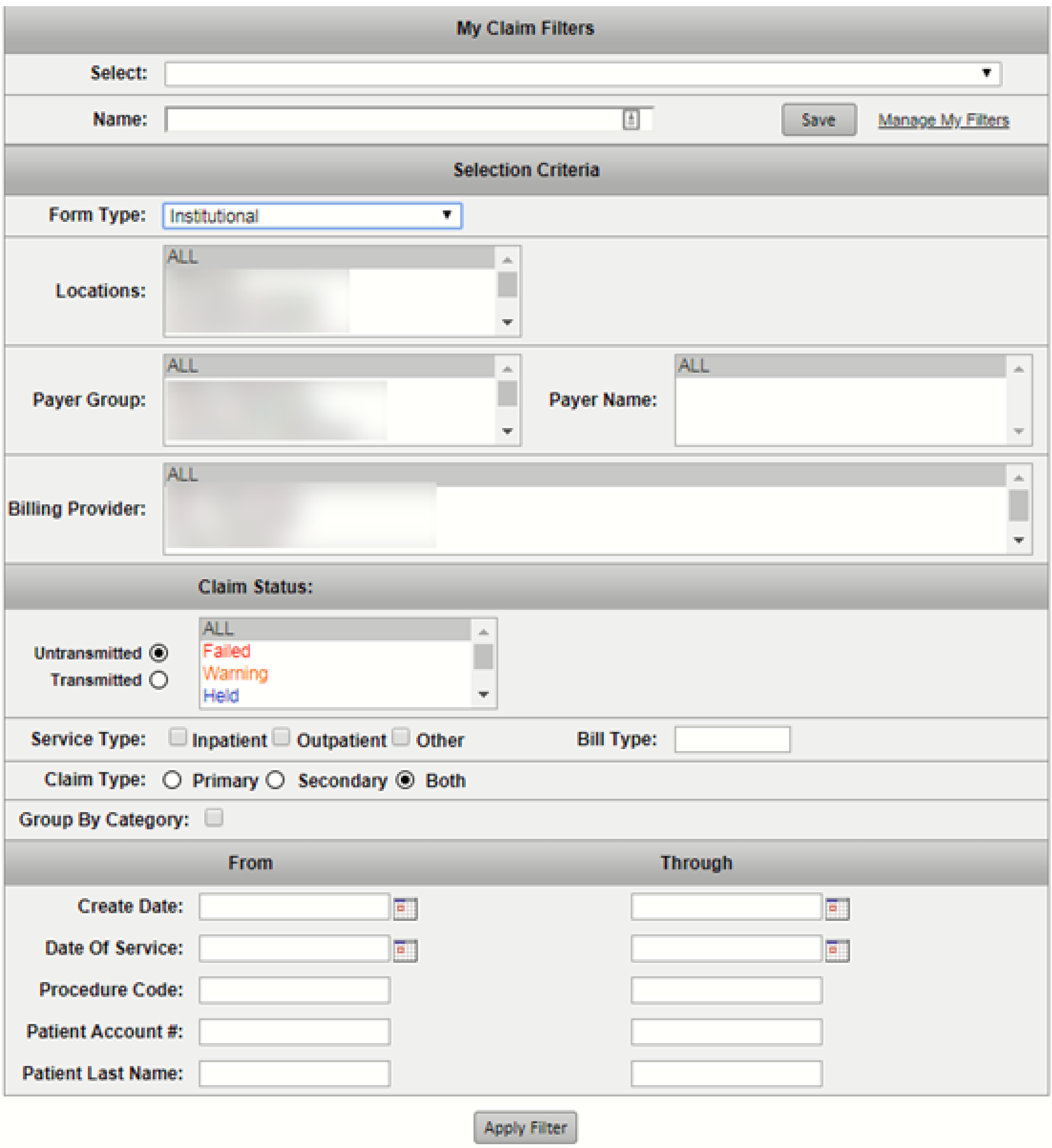
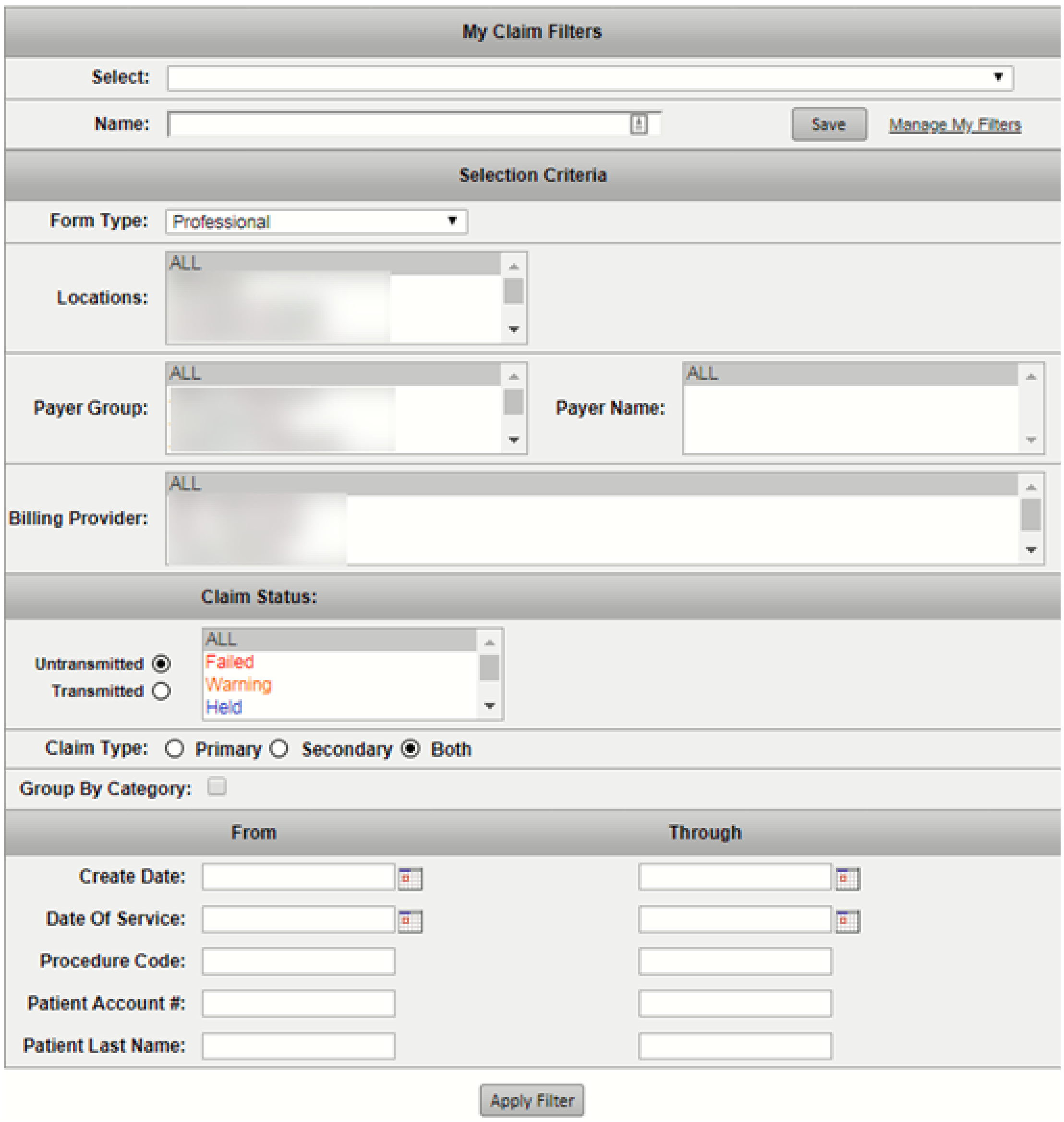


Figure 15: My Claim Filters



2. Enter your filter criteria using one of the following methods.

   - Select a custom filter from **Select** in the **My Claim Filters** section.

     > **Note:** If no items are available to select from the list, no custom filters have been created by your practice.

   - Manually enter the filter criteria to use, as follows.

Filter Name	Description
Form Type	Select **Institutional** to view institutional claims, or **Professional** to view professional claims. **Note:** If your site uses proprietary forms, those types are also available for selection.
Location	Select a specific location from the list, or leave the default **ALL** setting.
Payer Group	Select the applicable payer group to view. **Note:** The group you select determines which providers and payer names are available.
Payer Name	By default, **ALL** is selected. If you use **ALL**, every payer is searched. Select one or more payer names from the list to view claims associated with those specific payers. The payers in this list depend on the payer group that you selected. **Note:** If you send claims to a payer, that payer is added to this list automatically.
Billing Provider	Claims are selected with a matching billing provider, which is typically a group entity and not the individual rendering provider.
Claim Status	Click **Transmitted** or **Untransmitted**. You can then select specific claim statuses (such as **Acknowledged** or **Pending**) from the list.
Service Type	Select an option to include only inpatient or outpatient claims in your list. **Note:** This option is displayed when the form type is institutional claims.
Bill Type	Enter the three or four-digit type of bill for the claims to view. **Note:** This option is displayed when the form type is institutional claims.

Filter Name	Description
Claim Type	Select the type of claim to view: — **Primary** — **Secondary** — **Both**
Group By Category	**Group by Category** is available only when **Untransmitted** claims are selected and displays only claims that have failed or warrant edit messages. To view all untransmitted claims regardless of status, do not select the **Group by Category** option. If you select **Group by Category**, the **Edit Category** list is displayed. You can select one or more of the following categories: — **ALL** — **Coding Issues** — **Insurance Issues** — **Other** — **Patient Demographics** — **Secondary Claims**
Batch Status	Select these options to view reconciled or unreconciled claims. (These filters are available only if your site has enabled the full reconciliation features.)
Create Date	Click the calendar to select and enter a date in **From** to view claims according to the date they were entered or uploaded. The same date is automatically displayed when you click **Through**, which you can then modify, if necessary, to specify a range of dates. **Note:** If you select to view transmitted claims, you must specify a date range that is less than or equal to 90 days.
Sent Date	For transmitted claims, a date range is required. You can enter a create date range,a sent date range, or both. (This option applies only to transmitted claims.)
Date of Service	Click the calendar to select and enter a date in **From** to view claims according to their date of service. The same date is automatically displayed when you click **Through**, which you can then modify, if necessary, to specify a range of dates.

Filter Name	Description
Procedure Code	Enter a procedure code in **From** to view only claims that contain that code. The same code is displayed automatically when you click **Through**, which you can then modify to specify a range of codes, if necessary.
Patient Account #	Enter a patient account number in **From** to view only claims that contain that patient account number. The same patient account number is displayed automatically when you click **Through**, which you can then modify to specify a range of account numbers, if necessary.
Patient Last Name	Enter a patient last name in **From** to view only claims that contain that patient last name. The same patient last name is displayed automatically when you click **Through**, which you can then modify to specify a range of names, if necessary.

3. Click **Apply Filter**.

Manage my filters

Change filter names, delete filters, and select a default filter on **Claims Filters**.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. Click **Manage My Filters**.
3. From the list of filters, select an action:
    - To make a filter the default filter, select the option in the **Default** column.

        > **Note:** When you set a filter as the default, that filter will always be selected when you perform a new search or click the filter icon.

    - (Filter): Click this icon to generate a list of claims with criteria that apply to the customer filter for your practice.
    - (Edit): Click this icon to edit the filter name.
    - (Delete): Click this icon to delete your practice's customer filter. After you click the icon, a message is displayed to confirm that you want to delete the filter.

4. (Optional) To create additional filters, click **Create Filter**, or click **Claims > View Claims** to return to **Claims Filters**.

Results of this task

You have successfully updated, deleted, or set a filter as the default.

Create a filter

Save custom filters from **Claims Filters** for your practice.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. For **Name**, enter a unique name that identifies criteria related to the filter.
3. Manually enter the following filter criteria:

Filter Name	Description
Form Type	Select **Institutional** to view institutional claims or **Professional** to view professional claims. **Note:** If your site uses proprietary forms, those types are also available for selection.
Location	Select a specific location from the list, or leave the default **ALL** setting.
Payer Group	Select the payer group to view. **Note:** The group you select determines which providers and payer names are available to select.
Payer Name	By default, **ALL** is selected. If you use **ALL**, every payer is searched. Select one or more payer names from the list to view claims associated with those specific payers. The payers displayed in this list depend on the payer group that you selected. **Note:** If you send claims to a payer, that payer is automatically added to this list.
Billing Provider	Claims are selected with a matching billing provider, which is typically a group entity and not the individual rendering provider.

Filter Name	Description
Claim Status	Click **Transmitted** or **Untransmitted**. You can then select specific claim statuses (such as **Acknowledged** or **Pending**) from the list.
Bill Type	Enter the three or four-digit type of bill for the claims to view.
Claim Type	Select the type of claim to view: • **Primary** • **Secondary** • **Both**
Group By Category	**Group by Category** is available only when **Untransmitted** claims are selected. It displays only claims that have failed or warrant edit messages. To view all untransmitted claims regardless of status, do not select the **Group by Category** option. If you select **Group by Category**, the **Edit Category** list is displayed. Select one or more of the following categories: • **ALL** • **Coding Issues** • **Insurance Issues** • **Other** • **Patient Demographics** • **Secondary Claims**
Batch Status	Select these options to view reconciled or unreconciled claims. (These filters are available only if your site has enabled the "full reconciliation features" and" transmitted claims only.")
Claim Type	Select the type of claim to view.
Create Date	Click the calendar to select and enter a date in **From** to view claims according to the date they were entered or uploaded. The same date is displayed automatically when you click **Through**, which you can then modify to specify a range of dates, if necessary. **Note:** If you view transmitted claims, you must specify a date range that is less than or equal to 90 days.

Filter Name	Description
Sent Date	For transmitted claims, a date range is required. You can enter a create date range, a sent date range, or both. (This option only applies to transmitted claims.)
Date of Service	Click the calendar to select and enter a date in **From** to view claims according to their date of service. The same date is displayed automatically when you click **Through**, which you can then modify to specify a range of dates, if necessary.
Procedure Code	Enter a procedure code in **From** to view only claims that contain that code. The same code is displayed automatically when you click **Through**, which you can then modify to specify a range of codes, if necessary.
Patient Account #	Enter a patient account number in **From** to view only claims that contain that patient account number. The same patient account number is displayed automatically when you click **Through**, which you can then modify to specify a range of account numbers, if necessary.
Patient Last Name	Enter a patient last name in **From** to view only claims that contain that patient last name. The same patient last name is displayed automatically when you click **Through**, which you can then modify to specify a range of names, if necessary..

4. Click **Save**.

Export claims

Export a list of transmitted or transmitted claims after you complete the **Claims List Filter** search.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. Enter your filter criteria using one of the following methods.
   - Select a custom filter from **Select** in the **My Claim Filters** section.

     > **Note:** If there are no items to select from the list, no custom filters have been created by your practice yet.

   - Manually enter the filter criteria to use.

3. Click **Apply Filter**.

   The claims that match your filter criteria are displayed.

4. To export the list of claims that are displayed, click the export icon

   The file is downloaded to your local drive.

5. Navigate to the folder on your computer where your browser downloads files and open the file.

Results of this task

You have successfully exported a list of untransmitted or transmitted claims to your computer.

Claims List filter

Filter, export (`.csv` file), print, or use the **Actions** menu to show a summary of claims in each status, the total number of claims in each status and overall total, the dollar amount for each status and overall total for filtered results, and create a new claim.

> **Note:** You cannot create a new claim from the **Actions** menu for transmitted claims.

Group by Category Claims List

If you selected **Group by Category** on the **Claims Filter** window, then your search results are different than non-group-by-category claims, and the total number of claims in any category is displayed to the right of the category. The **Claims List** window enables you to filter, sort, view the claim and history in which the claim is grouped by. You can also filter columns by entering text into the box and perform actions to a claim.

Results are grouped by **Category** and **Edit/Message** on the **Claims List** window.

Each column on the **Claims List** window can be sorted and filtered:

- **Category**: Displays the type of category in groups that you selected in the **Group by Category** option on the **Claims List** window.
- **Edit/Message**: Displays the type of message in groups that is related to the failed or held claim.
- **Status**: Displays the status of the claim.
- **Customer**: Displays the customer number.
- **Location**: Displays your Payerpath® account number, unless you are using the **Location** feature.

- **Pat Name**: Displays the patient's first and last name.
- **Pat Acct**: Displays the patient's voucher (claim) number.
- **Payer**: Displays the insurance company assigned to the voucher (claim).
- **NPI**: Displays the billing National Provider Identifier (NPI) on the voucher (claim).
- **Created**: Displays the date that the claim was received in the Payerpath® clearinghouse.
- **Charges**: Displays the total amount of the voucher (claim).
- **View**: Click **View** to view the claim form to fix the error.

> **Note:** You will be taken to the **Form Fields** and **Electronic Fields** windows to fix errors and then perform **Save & Run Edits**. To return to the **Group by Category Claim List**, click **Back to List**.

- **History**:Click **History** to view the claim history.
- **Report**: Click **Report** to view a report of the claim.

Figure 16: Group by Category Claims List search results

You can search for or narrow your list of available results by entering your search criteria under each column heading. As you type, the list reflects the items that match the text you enter.

Using an asterisk (*) after the text implies that the text results are similar to the text before the asterisk, then the implication is that the text results are close to the text before the asterisk. Adding an asterisk before any text suggests that any text can prefix the search text.

You can drag columns in the order that you want to view the grouped claims list results and adjust the width of columns.

> **Tip:** If you make changes to the column order or width, they revert back to the default the next time that you log on to Payerpath®.

You can also sort multiple columns in ascending and descending order by selecting the column title.

> **Tip:** You can multi-sort columns by clicking the column that you want to sort first, then pressing **Shift** while clicking on the next column to sort. The column headings are numbered in the order you want to sort. You can expand and collapse the grouped categories by selecting **+** to the left of the **Category** column.

- **Check Box** (down arrow is used with this action): Use this option to **Select All**, **Unselect All**, **Select Restricted Claims**, or **Unselect Restricted Claims** that are grouped categories in the list.

  > **Note:** After you select the claims that you want to perform actions to, view the number of selected claims under the arrow in the menu bar.

- **Filter**: Click the filter icon to return to **Claims List Filter**.
- **Export**: Click the export icon to export your claims to a `.CSV` file.
- **Print**: Click the printer icon to print selected claims that are grouped by category.

  > **Note:** If you do not select the claims that you want to take action on, then all claims that are displayed will be printed from the active window. You must select the claims that you want to print.

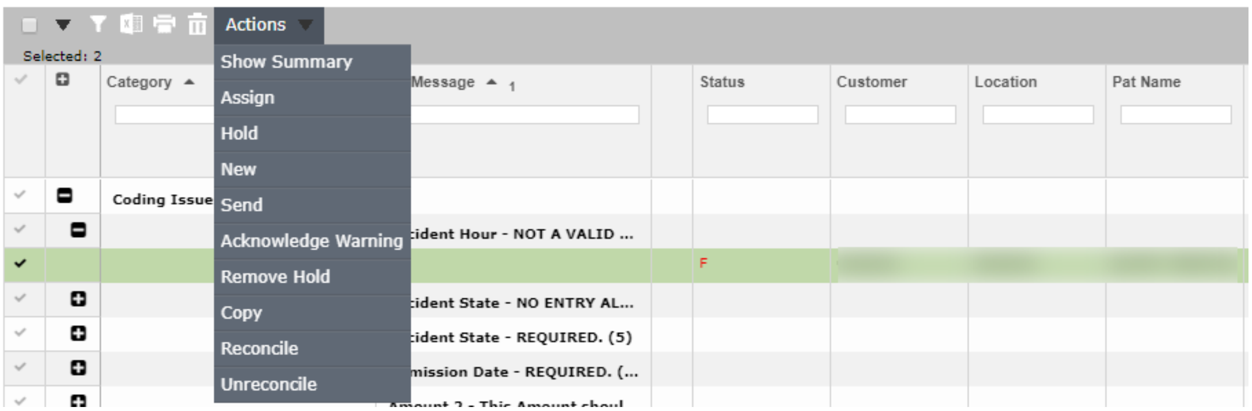
- **Delete**: Click the delete icon to delete the selected claim. Only claims with a status other than **Mark for [S]end** or **In Process[B]** can be deleted.
- **Actions**: If you do not have any claims selected, then the only action that can be performed is **Show Summary**. Otherwise, use this menu to select **Show Summary**, **Assign**, **Hold**, **New**, **Send**, **Acknowledge Warning**, **Remove Hold**, **Copy**, **Reconcile**, and **Unreconcile**. These options perform the following functions when you select one or more claims:
  - **Show Summary**: Use this option to view transmitted or untransmitted claim statuses and the number of claims and total charges in each status.
  - **Assign**: Use this option to assign a new payer to the claim.
  - **Hold**: Use this option to hold the claim for further review.
  - **New**: Use this option to create a new claim.
  - **Send**: Use this option to send the claim.
  - **Acknowledge Warning**: Use this option to acknowledge warning on the claim.
  - **Remove Hold**: Use this option to remove a hold currently on the claim.
  - **Copy**: Use this option to copy the claim.
  - **Reconcile**: Use this option to reconcile the claim.
  - **Unreconcile**: Use this option to unreconcile the claim.

To exit the claim and return to the claims list, click **Back to List**. To view the previous claim or the next claim in the list, click the applicable arrow icon. To view the **Electronic Fields** portion of the claim, click **Electronic Fields**.

Actions

Perform several actions on selected claims within the **Group by Category**. The specific actions listed might vary based on the items to which users have access and the specific claims selected.

Figure 17: Actions menu



You can take the following actions:

- **Show Summary**: View transmitted or untransmitted claim statuses along with the number of claims and total charges in each status.
- **Assign**: Assign a new payer to the claim.
- **Hold**: Hold the claim for further review.
- **New**: Create a new claim.
- **Send**: Send the claim.
- **Cancel Send**: Cancel sending the untransmitted claim to the payer. This places the claim in **Hold** status.

  > **Note:** This option is available only to power users but can be enabled upon request.

- **Acknowledge Warning**: Acknowledge warning on the claim.
- **Remove Hold**: Use this option to Remove a hold that is currently on the claim.
- **Copy**: Copy the claim.
- **Reconcile**: Reconcile the claim.
- **Unreconcile**: Unreconcile the claim (undo a reconciliation).

> **Tip:** If no claims are selected, the **Actions** menu displays only the options to **Show Summary** and create a new claim. The full list of actions is available only when one or more claims have been selected.

Claim status overview

The **Status** column on **Transmitted Claims List** or **Untransmitted Claims List** displays the most recent status of transmitted claims.

The statuses for transmitted claims or untransmitted claims are as follows.

- **TN**: In Transit
- **TA**: Transmitted Payer Acknowledged
- **TP**: Transmitted Payer Accepted
- **TR**: Transmitted Payer Rejected
- **TRD**: Transmitted Payer Rejected Done (this status indicates that the claim was marked complete)
- **TF**: Transmitted Finalized (this status indicates that the claim was remitted)

Sort the list by clicking a column header.

Click	Description
R	To view the most current payer response report (far right side of the window). **Note:** If the **R** is not displayed, then no response is available for that claim. Not all reports can be matched to a specific claim, so it is possible that a batch acceptance report was received but could not be linked to the exact claim. For that reason, you must continue to read your unmatched and partially matched payer reports.
V	To view the claim, or click **H** to view the claim history (far right side of the window).
$	To view the transaction within the remittance for the specific claim.

You can also perform the following actions for the list of claims by selecting the down arrow ▼ at the top of the table. By selecting one or more actions, the list displays the groups by one or more edit categories.

- **Select Page**
- **Unselect Page**
- **Select All**
- **Unselect all**
- **Select Restricted Claims**
- **Unselect Restricted Claims**

Chapter 3

React to payer responses

This chapter describes how to take action on recent payer responses and accessing and rebilling individual and multiple claims in Payerpath®.

View a Payer report

After a payer sends a response to the claims that you sent, that response is available as a report. When a new payer response report is available for you to review, it displays as a new payer report on the **Dashboard** window quick link and as an unread report in your **Payer Response** list.

Payer reports are designed to help you with claims reconciliation and it is a best practice that you review them timely. You can access reports that are up to two years old.

1. Point to the Dashboard menu to expand it and then click **Reports > Payer Responses**.

   Payer Responses List is displayed, with the most current report at the top of the list.
2. (Optional) To sort the list, click a column heading. You can filter this list by clicking the filter icon to limit the information that is displayed, so that you can focus on only those reports that you want to view.
3. Click the **View** link corresponding to the report that you want to review.

   The report is displayed in **Report Viewer**.
4. (Optional) To download the report to your workstation, click the diskette icon.
5. (Optional) To export the data to a spreadsheet, click **Export to CSV**.
6. Compare the total dollar amounts in the report with those in your list of sent claims to determine if the amounts are equal or if corrective action is needed.
7. As necessary, review the **Response** report in detail and identify the errors or rejected claims causing the discrepancy.

   Different information might be included in each **Payer** report. Even though the **ANSI 277CA** is a standard response report, not all payers use this format. Some payers use proprietary formats while others do not send response reports at all. As a result, the reports may not only look different from payer to payer, but the content varies as well. Check the following on each payer's report.

   - Verify the total dollar amount by viewing the totals section on the first page of the report.
   - Identify any errored or rejected claims by clicking through each page.

- If any claims are rejected in a batch, the claim information and error messages as provided by the payer are displayed on the report for you to address.

> **Tip:** The **Reconcile by Batch** feature is designed to simplify the reconciliation process by displaying the current status of each claim in each batch. You can access most payer rejections through the **Rejected Claims** column.

> **Tip:** If you work rejected claims through the **Reconcile by Batch** feature or by selecting transmitted claims in the **TR - Transmitted Rejected** column, you will find the matched column very useful. The matched flag displays in the **Matched** column beside each report. **Y** indicates all the responses on the report match back to the original claim so you do not have to review this report as long as you work claims in **TR - Transmitted Rejected** status. An **N** indicates none of the responses match to a claim, You must review this report and take actions on any errors or rejections. An asterisk (*****) means some of the responses match but some do not. Treat this the same as a **N** and review this report.

Access and rebill an individual claim

After you use a **Payer** report to identify a claim that needs to be corrected and resubmitted, you can make the corrections and resubmit the claim from your practice management system. You can also rebill the claim from Payerpath®. Rebill creates a copy of the transmitted claim that you can then edit and send to the payer.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. For **Claim Status**, select **Transmitted**.
3. Select other filter options, to refine your search. (for example, **Create Date**, **Sent Date**, or **Patient Last Name**).
4. Click **Apply Filter**.
5. Locate the claim to rebill, and click **V**.
6. Click **Rebill** on the navigation bar.

   A confirmation window is displayed.
7. Click **OK**.

   The claim is assigned a status of **F** (Failed).
8. Change the claim data, as needed, and click **Save & Run Edits**.

   If the claim contains errors, make the necessary corrections.

The claim is ready to be sent to the payer as a new claim when a `No Errors` message is displayed.

> **Note:** Claims rebilled from within Payerpath® will not be reflected in your practice management application.

9. Click **Send**.
10. Click **Back to List**.

    Rebilled Claims List is displayed with the rebilled claim.

Results of this task

The claim is rebilled to the payer.

Access and rebill multiple claims

After you use a **Payer** report to identify a claim that requires rebilling, you can rebill it to the payer. For example, a claim might have been rejected for because a patient's identification number is not valid, a provider is not valid, or incorrect date of service.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. For **Claim Status**, select **Transmitted**.
3. Select other filter options, as necessary, to refine your search. (for example, **Create Date**, **Sent Date**, or **Patient Last Name**).
4. Click **Apply Filter**.
5. Select the claims using one of the following methods.
    - Select one or more check boxes.
    - Select either **Select Page** or **Select All** from the menu bar.
6. Select **Actions > Rebill**.

    A confirmation window is displayed.
7. Click **OK**.

    The claims are assigned a status of **F** (Failed) and are now displayed in red on **Rebilled Claims List**.
8. Make the necessary corrections or updates to the claim, and then click **Save & Run Edits**.

    The claim is ready to be sent to the payer as a new claim when a `No Errors` message is displayed.
9. Click **Send**.
10. Repeat steps 8 and 9 until all rebilled claims have been corrected and marked to be sent to the payer.

Results of this task

The claims will be rebilled during the next scheduled transmission cycle.

Chapter 4

Use the reconciliation features

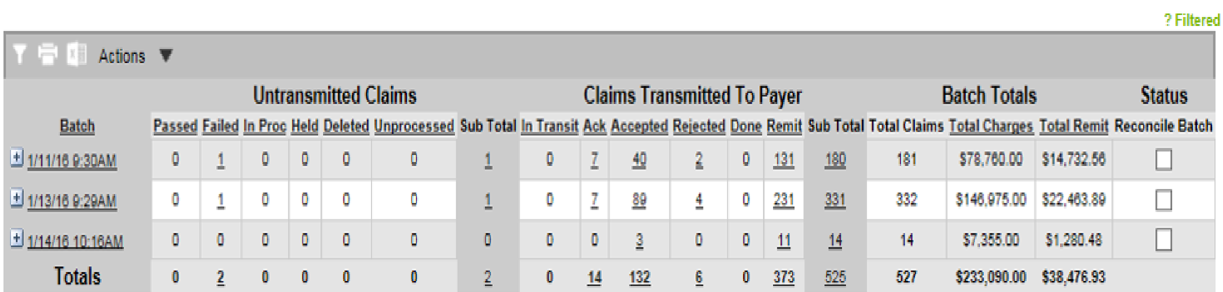
This chapter describes actions that you can take in Reconcile Claims Summary, view untransmitted claims, claims that are transmitted to a payer, and mark individual or batch claims as reconciled in Payerpath®.

For detailed instructions on reconciliation features and recommended workflows, refer to the *Veradigm Payerpath® Full Reconciliation User Guide*.

Reconcile Claims Summary

The **Reconcile Claims Summary** is a worklist. It is a central location in Payerpath® where you can monitor the current status of all your claims.

Claims are organized into batches based on when you sent the claims to Payerpath®. Claims are then grouped into columns by the current status or disposition of each claim. As each claim moves through the process and payer feedback on that claim is received, the claim's status changes. For example, a claim that was in a **Passed** status three weeks ago might be in an **Accepted** status a week later and in the **Remit** status today. The reconcile claims summary generated today reflects that claim in the remitted status because that is the last status (its current disposition) even though the claim was at one time in both the passed and accepted statuses.



	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	Sub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Total	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	1	0	0	0	0	1	0	7	40	2	0	131	180	181	$78,760.00	$14,732.56	☐
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	☐
Totals	0	2	0	0	0	0	2	0	14	132	6	0	373	525	527	$233,090.00	$38,476.93	

Actions on the Reconcile Claims Summary

Perform actions on **Reconcile Claims Summary**. For example, you can return to the main filter window, print a list of claims, export a list of claims to Microsoft® Excel, and **Update the Reconcile** status of selected batch claims.

? Filtered

Actions

Update Reconcile Status

	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	Sub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Total	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	Update Reconcile Status				0	1	0	7	40	2	0	131	180	181	$78,760.00	$14,732.56	☐
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	☐
Totals	0	2	0	0	0	0	2	0	14	132	6	0	373	525	527	$233,090.00	$38,476.93	

In the top left corner of the **Summary** are icons which represent the actions you can take:

- The filter icon returns you to the **Reconcile Claims** filter
- The printer icon enables you to print this window
- The spreadsheet icon enables you to export the summary to Microsoft® Excel
- The **Actions** menu provides you the option to **Update the Reconcile** status of any selected batches

Point to the **? Filtered** hyperlink in the top right corner of the **Summary**, your filter selection criteria displays.

The number in each column is a hyperlink and represents the number of claims in that particular category. When you click the number, a list of claims displays.

If there is a 0 in any column, then the hyperlink is disabled because there are no claims to display.

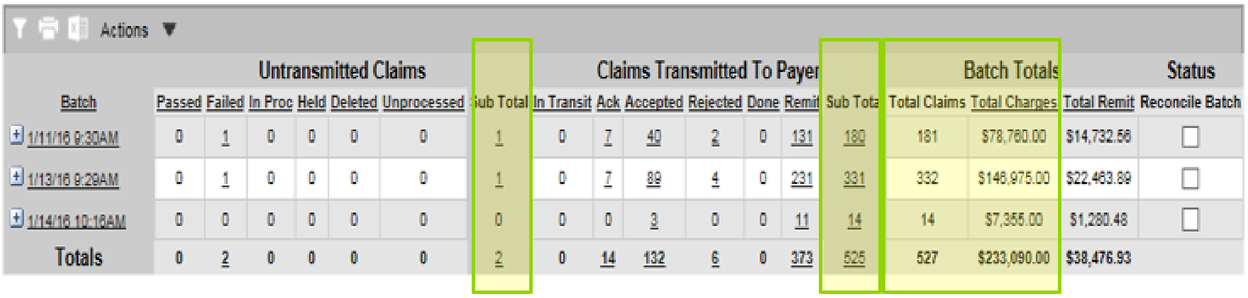
The **Totals** row displays the total number of claims in each category. These numbers are hyperlinks as well.

Batch Subtotals and Totals

The total claims and total charges in the **Batch Totals** column enable you to easily view how many claims were received by Payerpath® in each batch.

You can compare these totals with your records to ensure Payerpath® received all the claims that you intended to send. Subtotals for the **Untransmitted** and **Transmitted** claims provide a high-level breakdown of what status those claims are in. For example, you would expect claims in a batch uploaded an hour ago to be accounted for in the **Untransmitted** section. Whereas a batch that was sent last week might have plenty of time to have been sent to the payers and thus expected to be represented completely in the **Claims Transmitted to Payer** section.

Figure 18: Batch Subtotals and Totals

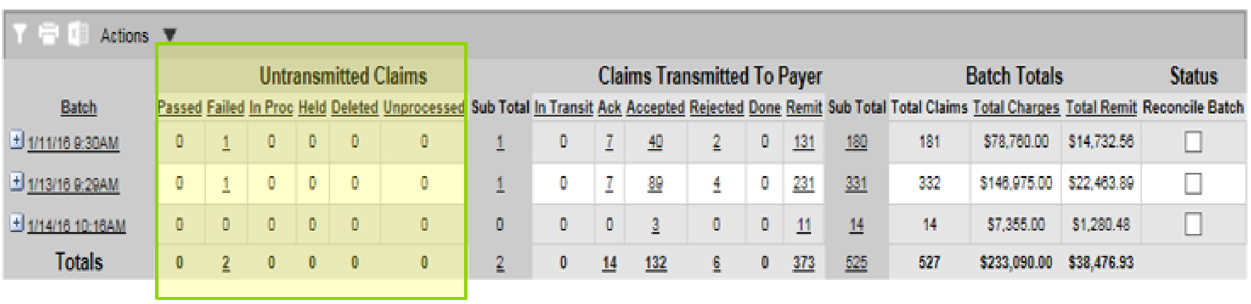


	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	ub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Tota	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	1	0	0	0	0	1	0	7	40	2	0	131	180	181	$78,760.00	$14,732.56	☐
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	☐
Totals	0	2	0	0	0	0	2	0	14	132	6	0	373	525	527	$233,090.00	$38,476.93	

Untransmitted Claims

Untransmitted Claims have not yet been sent to the payer and can be in **Passed (P)**, **Failed (F)**, **In Process (S)**, and **Held (H)** statuses.

> **Note:** The number of **Deleted** and **Unprocessed** claims in the batch are represented but the individual claims are not viewable.



	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	Sub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Total	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	1	0	0	0	0	1	0	7	40	2	0	131	180	181	$78,760.00	$14,732.56	☐
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	☐
Totals	0	2	0	0	0	0	2	0	14	132	6	0	373	525	527	$233,090.00	$38,476.93	

- **Passed**: Claims are passed through Payerpath® edits and are ready to be marked to send to the payer.
- **Failed**: Claims that have failed one or more Payerpath® edits. The claim must be corrected before they can be sent to the payer.
- **In Proc**: Claims in process have passed Payerpath® edits and have been **Marked to Send** but are waiting to be sent to the payer when Payerpath® connects to that payer.
- **Held**: An authorized user has marked these claims as **Held** for further review. The hold must be removed and all errors corrected before they go to the payer.
- **Deleted** and **Unprocessed**: Claims are accounted for in the **Reconcile Claims Summary** so that all claims in a batch are represented for tracking and balancing purposes. Since **Deleted** and **Unprocessed** claim details are not available to be displayed on the claim list,

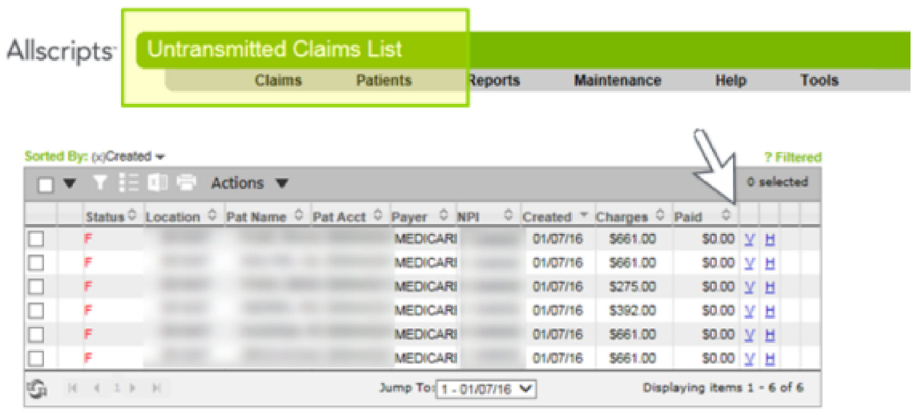
these columns (**Deleted** and **Unprocessed**) only display the number of claims, and are not hyperlinks.

> **Note:** **Unprocessed** claims are the result of unusual situations and are uncommon.

- **In Process**: Claims that have been marked to be sent to the payer and is sent the next time Payerpath® connects to that payer. Connection times vary by payer so claims can be **In Process** for up to 24 hours.

For example, click any non-zero value in the **Failed Claim** column to view the failed claims.

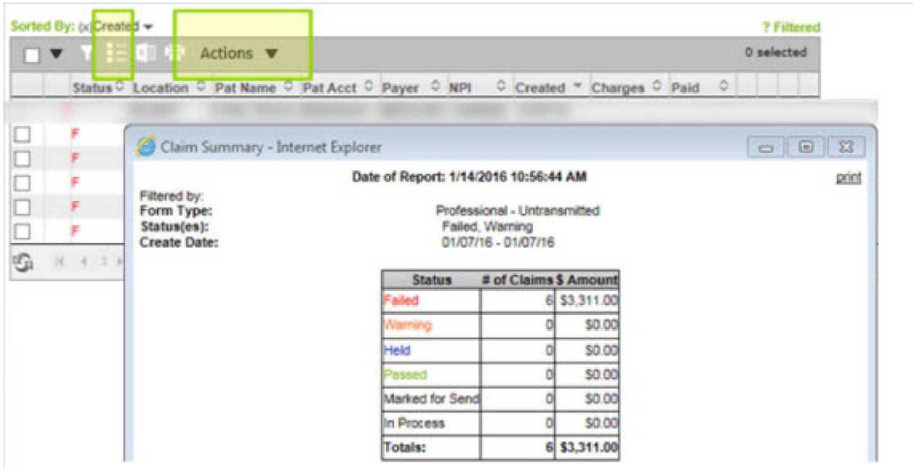
Example: Failed Claims in First Batch



The **Untransmitted Claims List** displays six failed claims. From here you can select the **V** hyperlink to display the claim form. You can immediately make corrections to the claim, save and run edits, then click the **Next** arrow on the **Form** navigation bar to advance to the next failed claim and so on until all six are done. The failed column reflects 0 and the six claims that are added to the claims in the passed column.

> **Tip:** You do not have to fix the failed claims within the Payerpath® application. You can also submit the corrected claims from your practice management system. Assuming Payerpath® is configured to do so, the new corrected claims replace the old failed claims in the Payerpath® database. The failed claim hyperlink updates to reflect 0 failed claims and the six corrected claims display in a new Reconcile Claims summary batch associated with the date and time you sent them.

Show Summary action in Untransmitted Claims List



When you select **Show Summary** from the **Actions** menu, a list of the untransmitted claim statuses along with the number of claims and total charges in each status displays.

When you click the **List** icon, you are returned back to the original **Reconcile Claims Summary** window you have been working on without having to select the claim criteria all over again.

Claims Transmitted to Payer

Transmitted claims have been sent to the payer and can be in **In Transit (TN)**, **Acknowledged (TA)**, **Accepted (TP)**, **Rejected (TR)**, **Done (TRD)**, and **Remit (TF)** statuses. Click any non-zero number in the columns for **Claims Transmitted To Payer** to display those claims in the transmitted claims list.

Actions

	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	Sub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Total	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	1	0	0	0	0	1	0	7	40	2	0	131	180	181	$78,760.00	$14,732.56	☐
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	☐
Totals	0	2	0	0	0	0	2	0	14	132	6	0	373	525	527	$233,090.00	$38,476.93	

In **Transit** claims are those claims Payerpath® has sent to the payer but the payer has not yet acknowledged they received them. Enable a claim to remain In Transit for at least 24 hours before you become concerned. How often Payerpath® connects to pick up payer acknowledgments and response reports varies greatly from payer to payer. In fact, some payers only connect one time per day, so a perceived delay can be a matter of timing.

> **Note:** It is easy to confuse In Transit with In Process. To summarize, Untransmitted claims **In Process** are in the process of being sent to the payer. Transmitted claims are **In Transit** when they have been sent to the payer and Veradigm® is waiting for the payer to confirm that they have received them.

The **Ack** or **Acknowledged** status means the payer has responded with a confirmation that they received and were able to read your file. All claims will proceed at least as far as the **Ack** column. Claims remain in that status unless or until a subsequent report is received from the payer which indicates whether the claims were accepted into their processing system, rejected or even remitted. Not all payers provide these additional reports and in a manner we can use.

The next two columns are **Accepted** and **Rejected**.

Actions

	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	Sub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Total	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	1	0	0	0	0	1	0	7	40	2	0	131	180	181	$78,760.00	$14,732.56	☐
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	☐
Totals	0	2	0	0	0	0	2	0	14	132	6	0	373	525	527	$233,090.00	$38,476.93	

An important concept is that claims only proceed from the **Acknowledged** column to the **Accepted** or **Rejected** column if the payer returns a response report and the response contains sufficient information for Payerpath® to identify which claim it belongs to. If the payer does not return a report at all or the claim referenced on the report cannot be identified in the Payerpath® application, then the claim remains in the **Acknowledged** status and you must review those reports manually to look for rejections or errors. You do not have to review every single report, just those where some or all claims on the report could not be identified. In those cases, use the matched flag on the **Payer Response** report list to help you determine which reports you still want to review.

After claims are in the **Accepted** status, the last status they move to is **Remit**. That happens if Payerpath® receives an electronic remittance that can be matched to that claim using a complicated algorithm.

> **Note:** If an accepted claim later receives a rejection, the claim moves back to the **Rejected** column.

Claims display in the **Rejected** column if they have a status of **TR** which means they were rejected by a payer on a payer response and Payerpath® was able to match that response back to the originating claim. Since claim processing has effectively been stopped by a payer for a claim that was rejected, there are no statuses after rejected, but the claim still requires user action whether it is to correct and resubmit the claim or bill the patient. This is the reason for the **Done** column.

> **Note:** While unlikely, if a rejected claim is later accepted, the claim remains in the **Rejected** column to ensure the error is taken care of.

The **Done** status indicates the number of rejected claims that have been marked by users as done, completed, or addressed. If all rejected claims for a batch were marked as **Done**, the rejected column displays a 0 (zero) and the **Done** column reflects the number of rejected done claims which enables you to easily identify when a batch is ready to be reconciled.

Click the rejected claims hyperlink to display the claims in the **Transmitted Claims List**.

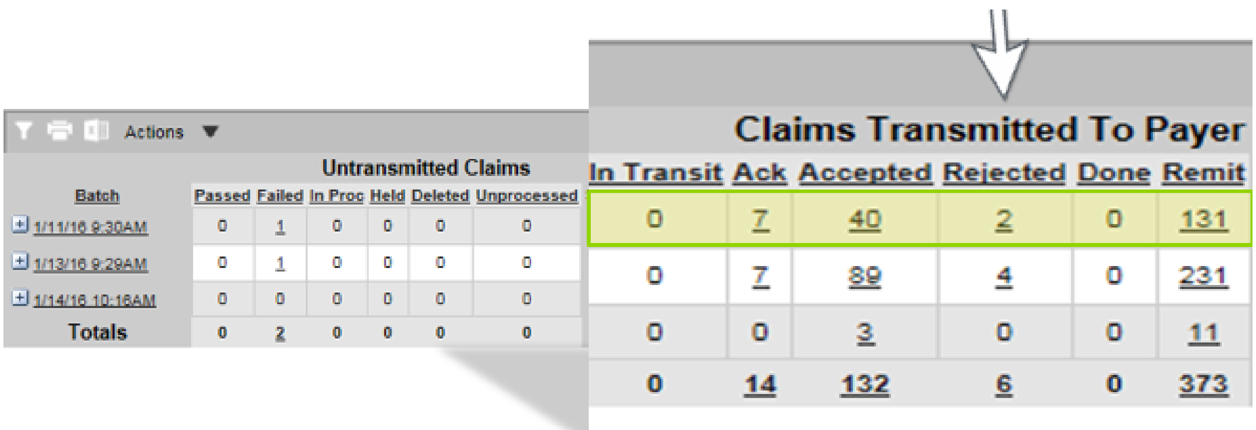
Work transmitted claims

In the **Transmitted Claims** section, the goal is for each column to contain zero claims and for all claims to display in **Remit**. The goal for payers who do not send remits through Payerpath® is to have all claims in **Accepted** or **Done**.

In Transit claims have been sent to the payer, but the payer has not acknowledged that they have received the claims and enable a claim to remain **In Transit** for at least 24 hours.

Make sure claims in **Acknowledged** are either recent enough to not have received a payer report or remittance from the payer yet, or are for payers who do not send accepted or rejected response reports or remittances that can be matched back to a claim.

You can work rejected claims by clicking **Rejected**.



Actions

Batch	Untransmitted Claims: Passed	Failed	In Proc	Held	Deleted	Unprocessed	Claims Transmitted To Payer: In Transit	Ack	Accepted	Rejected	Done	Remit
1/11/16 9:30AM	0	1	0	0	0	0	0	7	40	2	0	131
1/13/16 9:29AM	0	1	0	0	0	0	0	7	89	4	0	231
1/14/16 10:16AM	0	0	0	0	0	0	0	0	3	0	0	11
Totals	0	2	0	0	0	0	0	14	132	6	0	373

Work rejected claims

Rejected claims cannot be deleted or modified in Payerpath®, so you must make the necessary corrections in your practice management system and resubmit a corrected claim.

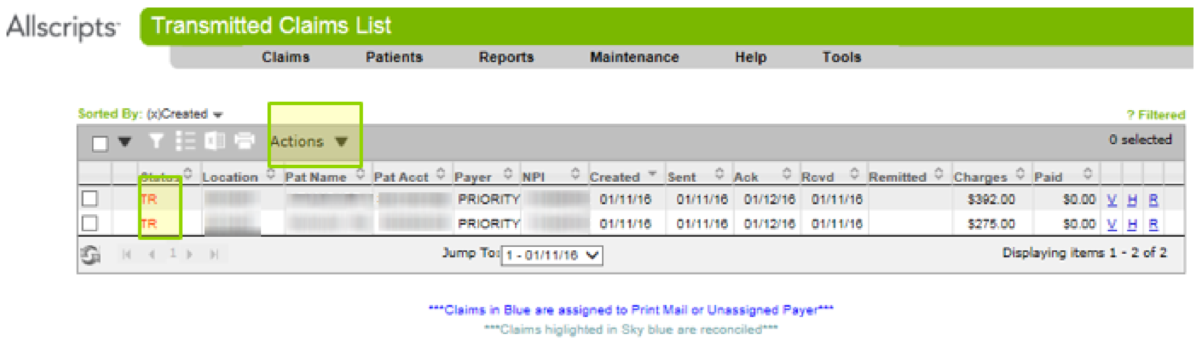
Change the claim **Done** as you address each rejected claim, so that you do not continue to revisit claims each time you run a rejected claims list or Reconcile Claims Summary. This helps you keep track of the claims you have already addressed.

Set rejected claims to done

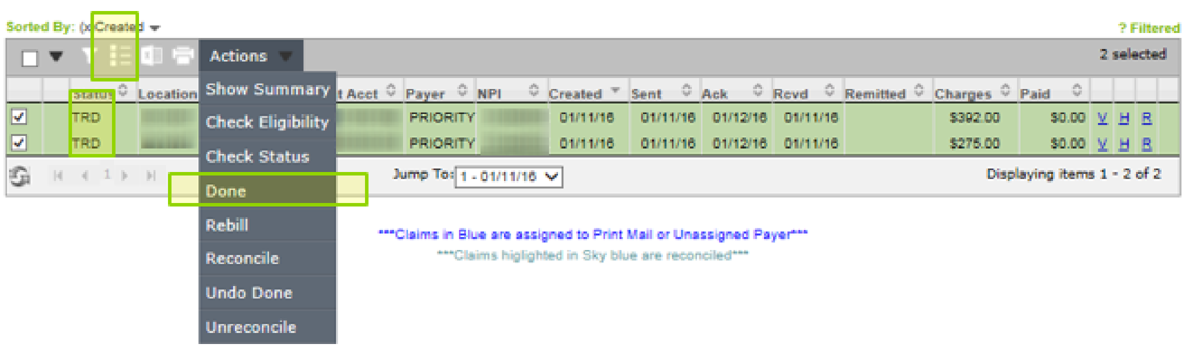
Use **Reconcile Claims Summary** to move claims from **Rejected** to **Done**.

1. From **Reconcile Claims Summary**, click a number in the **Rejected** column.

   The **Transmitted Claims List** displays all claims in **TR - Transmitted Rejected** status.



2. Click **R** or **H** to review payer responses.
3. After you are finished with a claim or a group of claims, select the check box to the left of the claim.
4. Select **Done** from the **Actions** menu.



> **Note:** Rather than submitting a new corrected claim from your practice management system, you can also rebill the claim from within Payerpath® using the **Rebill** option on the **Actions** menu. The rebill feature creates a new, untransmitted copy of the selected claims that you can edit. When a claim is rebilled this way, the claim does not link back to your practice management system. The rebill feature automatically sets the original claim status to **Done** and documents this activity in the claim history.

> **Note:** Claims highlighted in green on the claims list are currently selected. Claims highlighted in light blue on the claims list have been reconciled.

Results of this task

The claim status changes from **(TRD)** and a note is made in the claim history to this effect. The claims have moved from the **Rejected** to **Done** column when you return to the **Reconcile Claims Summary**.

What to do next

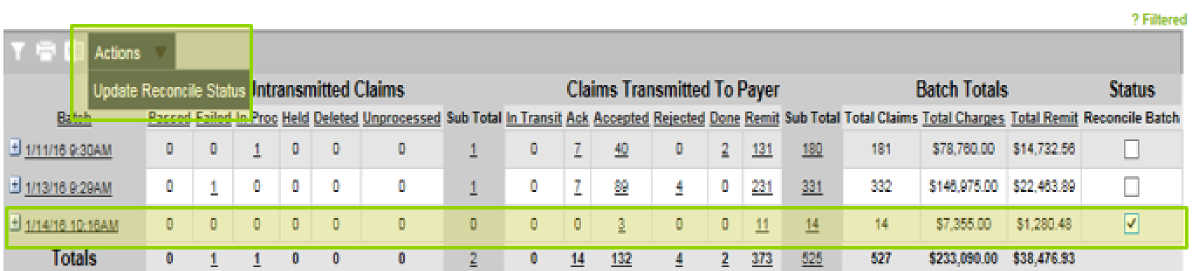
Review any payer responses that could not be linked back to their originating claims.

Mark all claims in a batch as reconciled

Reconciling a batch means you are finished with all of the claims in a batch. You can reconcile claim batches from the **Reconcile Claims Summary** window.

> **Note:** Reconciled claims do not display on the **Reconcile Claims Summary** when you filter for unreconciled batches only.

1. Point to the Dashboard menu to expand it and then click **Claims > Reconcile by Batch**.
2. Select one or more batches that you want to mark as reconciled.
3. Select **Actions > Update Reconcile Status**



An entry is made in each claim's history indicating when that claim was reconciled.

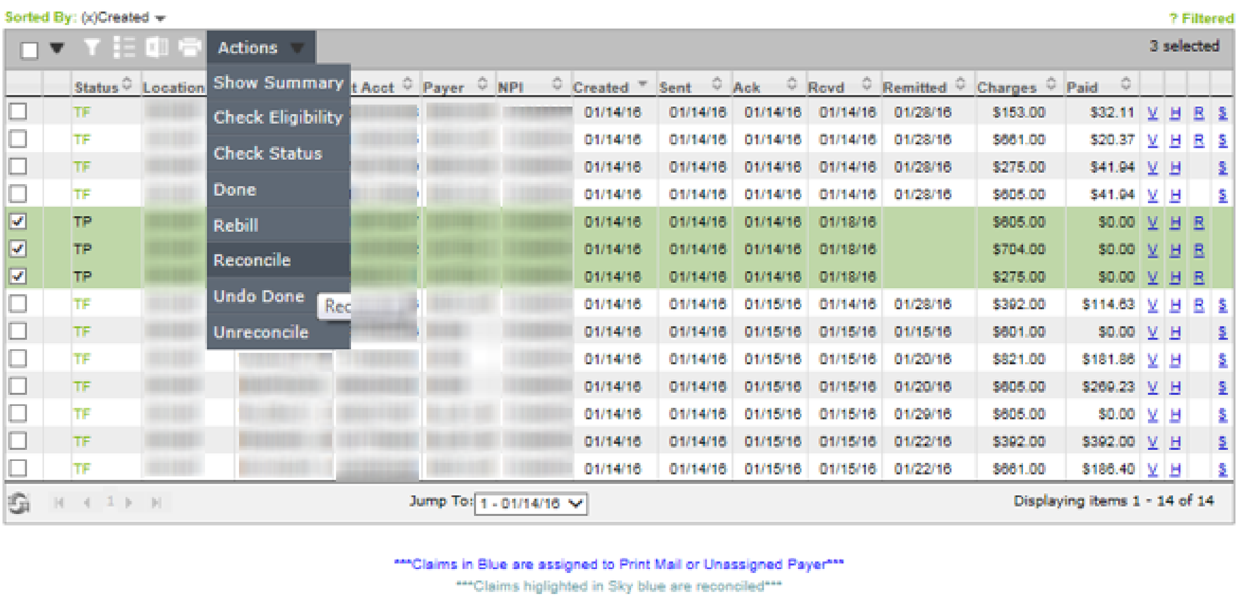
What to do next

The batches you selected are now marked as reconciled.

Reconcile individual claims

Most of the time you will reconcile all the claims in a batch at the same time. However, there might be times where want to reconcile individual claims in order to exclude those from the Reconcile Claims Summary without removing all the claims in the batch. For example, you might want to reconcile all the **Acknowledge** claims for a certain payer when you know the payer does not return reports.

To reconcile individual claims, select them from the untransmitted or transmitted claims list and then select **Reconcile** from the **Actions** menu. Reconciled claims display highlighted as light blue on the **Claims List** and an entry is made in the claim history to show this status change.



Some other common reasons for having a mix of reconciled and unreconciled claims in a single batch include the following:

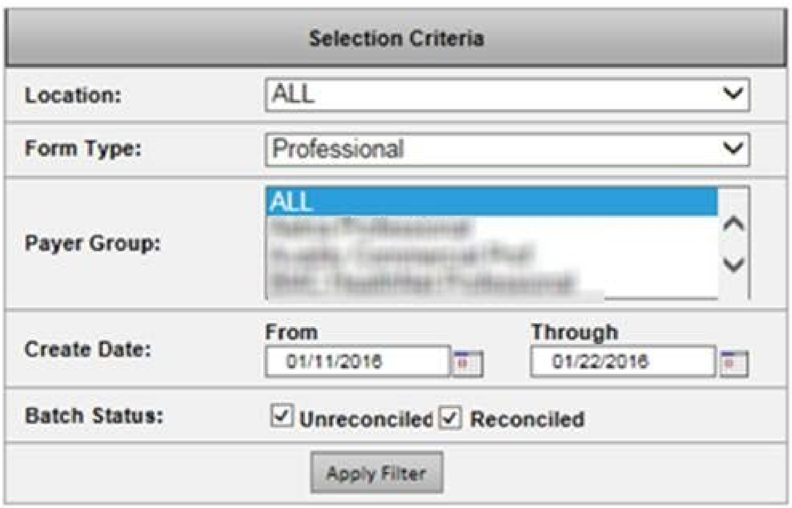
- Another user reconciles a batch that includes claims for which they do not have privileges to view. Only claims users are allowed to view can be marked as reconciled by that user.
- The Reconcile Claims Summary is run for a specific payer and only that payer's claims were reconciled.

Batches with a combination of reconciled and unreconciled claims

Since a batch can contain both reconciled and unreconciled claims and the filter enables you to select batches that are reconciled, unreconciled or a both, it is important to know how these choices impact and display in the **Reconcile Claims Summary**.

When only one batch status is selected in the filter, then only claims with that corresponding status display in the **Reconcile Claims Summary** and any other claims are excluded. For example, if you choose to view only reconciled batches, then only the unreconciled claims in each batch will display on the **Summary Page** and any reconciled claims will be excluded. In this case, you would be viewing a partial batch of claims since all claims in the batch are not being displayed.

To ensure you are viewing all claims in a batch for balancing and tracking purposes, select reconciled and unreconciled batches in the **Reconcile Claims** filter so that all claims in a batch are displayed.



When both unreconciled and reconciled batches are selected in the filter, all claims (regardless of whether they are reconciled or unreconciled) are included in the **Reconcile Claim Summary**.

	Untransmitted Claims							Claims Transmitted To Payer							Batch Totals			Status
Batch	Passed	Failed	In Proc	Held	Deleted	Unprocessed	Sub Total	In Transit	Ack	Accepted	Rejected	Done	Remit	Sub Total	Total Claims	Total Charges	Total Remit	Reconcile Batch
1/11/16 9:30AM	0	0	1	0	0	0	1	0	7	40	0	2	131	180	181	$78,760.00	$14,732.56	☑
1/13/16 9:29AM	0	1	0	0	0	0	1	0	7	89	4	0	231	331	332	$146,975.00	$22,463.89	☐
1/14/16 10:16AM	0	0	0	0	0	0	0	0	0	3	0	0	11	14	14	$7,355.00	$1,280.48	▣
Totals	0	1	1	0	0	0	2	0	14	132	4	2	373	525	527	$233,090.00	$38,476.93	

The Reconcile Batch Status indicates the status of the claims in the batch are as follows.

☑ All claims in the batch are reconciled

☐ All claims in the batch are unreconciled

▣ Some claims in the batch are unreconciled and some are reconciled

Chapter 5

Use the Daily Balancing Reports

This chapter describes different types of reporting capabilities in Payerpath®.

Daily Balancing Report

Reporting capabilities are available for you to research claims data. The following sections contain detailed descriptions for creating and using each report.

The following reports are part of the **Daily Balancing Report** group.

- **Billing Summary**
- **Remittance**
- **Transmitted Claim Detail**
- **Untransmitted Claims List**
- **Upload Summary**
- **Upload Detail**

Features of the Report Viewer

When you open a report, it is displayed in the **Report Viewer**. The **Report Viewer** provides many useful tools to help you work with your report data.

The following table describes each of the uses for the tools in the toolbar.

Control	Description
TOC	Click this icon to open the table of contents for the report. When open, you can click a link to view a specific section of the report.
Arrows	Click the innermost arrows to move from one page of the report to another. Click the outermost arrows to move to the beginning or end of the report.
Pagination	Enter a page number to display a particular page of the report.
Page Size	Select an option to change the number of pages that are displayed. 10 pages are displayed by default.
Sort By	Select an option to change how the report data is sorted.

Control	Description
Select Format Menu / Download	Select an option to change the file format to use when downloading a report, and then click **Download**.
Print	Click to open a window with a PDF version of the report to print or download.
Help	Click to open **Help**.

Figure 19: The Report Viewer toolbar

Click **TOC** (upper left portion of the window) to open the **Document Map** pane.

Within **Document Map** pane, click an item from the list to display that portion of the report.

Billing Summary Report

The **Billing Summary Report** enables you to select multiple locations. If you do so, the report displays totals for all locations first, followed by location-specific totals.

The **Billing Summary Report - Transmitted** provides a management level summary of the daily **Transmitted Claim Detail Report** totals. The report shows the number of claims sent and the associated dollar amount for each day in the selected range, by payer, as well as month-to-date and year-to-date totals.

The **Billing Summary Report - Untransmitted** gives managers a view of the number of claims that have been sent to the application, but not yet transmitted to the payer. These claims include passed claims that have not been sent, failed claims, warned claims, or held claims. The report shows the number of claims remaining in an untransmitted status and the associated dollar amount for each day in the selected date range, by payer, as well as month-to-date and year-to-date totals.

Run a Billing Summary Report

1. Point to the Dashboard menu to expand it and then click **Reports > Billing Summary** to display the **Billing Summary Filter** window.

> **Note:** The menus and menu options that are available on this window differ depending on whether you are working with professional or institutional claims.

2. Enter your filter criteria.

Filter Name	Description
From and **Through**	By default, the dates for the previous year are selected for you. Modify the dates using the calendars, as necessary.
Location	This filter is only available if your site uses locations. Select a single location or leave the default **ALL** option selected to include all locations.
Payers	Select a single payer or leave the default **ALL** option selected to include all payers.
Form Type	Select a claim form type.
Bill Type	Select a bill type or leave the default **ALL** option selected to include all bill types.
Status	Select a claim status.

3. Click **Process Report**.

   The report is displayed in the **Report Viewer**.

   > **Note:** By default, the report groups your results by date. To group the results by payer, click **Group by Payer** (upper-right portion of the report).

4. To view additional report details, click the **Next** arrow in the report toolbar.
5. To open the **Transmitted Claim Detail** report, click a **Payer** link.

Remittances report

The **Remittances** report provides information specific to a remittance (for example, **Check Number**, **Check Amount**, **Check Date**, **Receive Date**). This report explains how the payer adjudicated the claim.

Run the Remittances report

Create and use the **Remittances** report, download an 835 file, or view an 835 report.

1. Point to the Dashboard menu to expand it and then click **Reports > Remittances**.

Remittances Report Filter is displayed.

> **Tip:** To work with the **Remittances Report** in a spreadsheet, click **Export to CSV**.

2. (Optional) To limit the information that is displayed in order to focus on just what you want to view, apply filters.
3. (Optional) To view the remittance for the specific line of the list, click the applicable **View** link.

> **Tip:** To sort data in ascending order, descending order, or to remove a sort from being applied to a column, click the column names. A black arrow icon is displayed beside the column name when you sort a column. The direction of the arrow indicates the order that the column is currently sorted in. To remove sorting from a column, click the column name until the black arrow icon is no longer displayed. You can sort multiple columns of data at a time. You can also click and drag columns to re-size them for greater visibility.

The **Report Summary** portion of the report is displayed.

4. (Optional) Click the next arrow in the report toolbar to view additional information in the **Claim Details** portion of the report.
5. (Optional) To view a single explanation of benefits (EOB) from the list, click **Name**.

   Information from that claim is displayed in a separate window. Displaying the claim in a separate window enables you to print the details from a single claim (for example, to forward that information to a secondary payer).

> **Tip:** At the bottom of each remittance report is a glossary which provides you descriptions for all of the group and reason codes the payer used within this report.

What to do next

To download an 835 file, which might include multiple checks, click the diskette icon. Not all 835 files are available for download. To view an 835 report, which might include multiple checks, click the report icon.

Filter the Remittances List

Adjust which reports are displayed on **Remittances List**. This helps, for example, if you must locate a specific report, but you have numerous reports displayed in the list.

1. Point to the Dashboard menu to expand it and then click **Reports > Remittances**.
2. Select a date range, as follows:
    - **0-90 Days**: Select this option to view recent data. By default, this option produces a list of reports that contain data from the previous seven days through the current date. If you want to further narrow the list of reports by date, enter dates for **Report Date From** up to 90 days back and **Report Date Through**.
    - **91+ Days**: Select this option to view older data in 90-day increments. By default, this option produces a list of reports that contain data beginning 91 days from the current date, and extending back in time an additional 90 days. If you want to further narrow the list of reports by date, enter dates for **Report Date From** and **Report Date Through**.

    > **Important:** The date range cannot span the two different date ranges. For example, to search for reports 60-120 days old, you must run a search on 0-90 days and a separate search on 91-180 days.

    For example, suppose that today is August 7, 2012, and you want to view reports from January 2012. You would select **91+ Days**, and then enter `January 1, 2012` for **Report Date From**.

    The option that you selected enters default dates for **Report Date (From)** and **Report Date (Through)**. If you selected **91+ Days**, the **Display Downloadable Reports Only** option is unavailable.
3. Enter your additional filter criteria.

Filter Name	Description
Report Date (From)	This value box is filled in for you when you select **0-90 Days** or **91+ Days**. To enter a different date as the start date, click the calendar icon.
Report Date (Through)	This value box is filled in for you when you select **0-90 Days** or **91+ Days**. To enter a different date as the end date, click the calendar icon.
Payer	Select the payer that you want to include or select **ALL** to include all payers.

Filter Name	Description
NPI	Select a National Provider Identifier (NPI) number.
View	Select an option for the type of report you want to include: **Read Reports**, **Unread Reports**, **Deleted Reports**, or **All Reports**.
Display Downloadable Reports Only	Select **Display Downloadable Reports Only** if you want to include only reports that you can download. **Note:** This option is not available if you selected **91+ Days**. (Downloadable reports are only available for 90 days at this time.)
Check Amount (From and Through)	To include only a specific range of dollar amounts, enter those values.
Check Number (From and Through)	To include only a specific range of check numbers, enter those values.
Check Date (From and Through)	To include only a specific range of check dates, enter the dates or select them using the calendar icon.

4. Click **Apply Filter**.

   If an error message is displayed after you click **Apply Filter**, follow the instructions provided to make corrections. You likely attempted to enter a report date range that conflicts with **0-90 Days** or **91+ Days** that you specified.

   The reports that match your filter criteria are displayed on **Remittance List**.

Transmitted Claim Details Report

The **Transmitted Claims Detail Report** is a listing of all the claims the application has forwarded to the payer on a particular day. Its purpose is to keep as a record of claim filing, and also aid with follow-up and research. It is used to compare with the payer responses for reconciliation purposes. Because it is a record of what was actually transmitted to the payers, this report is normally available the day after the claims are set to **Marked for Send** status.

Run the Transmitted Claim Details Report

Create and run a **Transmitted Claim Details Report** in Veradigm Payerpath®.

1. Point to the Dashboard menu to expand it and then click **Reports > Transmitted Claim**.
2. Enter your filter criteria.

Filter	Description
From and **Through**	By default, the current date is entered for you. To modify the dates, use the calendar icons. You can query up to seven days at a time.
Location	This filter is available only if your site uses locations. Select a single location or leave the default **ALL** option selected to include all locations.
Type	Select a claim type, or leave the default **ALL** option selected to include all types.
Payer	Select a payer.
Provider ID	Enter a range of provider IDs.
Provider Name	Enter a range of provider names.
Patient Last Name	Enter a range of patient last names.
Patient First Name	Enter a range of patient first names.
Pat Acct #	Enter a range of patient account numbers.
Total Amount	Enter a range of values.

3. Click **Process Report**.

Untransmitted Claims List Report

The **Untransmitted Claims List Report** provides a detailed listing of all the claims that have not been sent to a payer.

Run the Untransmitted Claims List Report

Create and run an **Untransmitted Claims List Report** in Veradigm Payerpath®.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. For **Claim Status**, ensure that the **Untransmitted** option is selected.
3. (Optional) Enter additional filter criteria, if applicable.
4. Click **Apply Filter**.
5. Select the check boxes for the claims to include in your report.
6. Click the print icon .
7. Select **List**, and then click **Print**.

   Untransmitted Claims List Report is displayed. The report is organized by payer and includes claim totals, and dollar amounts.

Upload Summary Report

The **Upload Summary Report** provides a management level summary of the daily **Upload Detail Report** totals. It gives managers a daily view of their failed and warning rates and passed rates, organized by payer, on your uploaded claims. Both the number of claims and total dollar amounts are included. Subtotals by month are provided if the specified date range spans months.

If your site uses locations, you can select multiple locations and the report displays claim age details and totals for each location. Additionally, the report enables you to specify whether the report to be listed by location. If the report information is listed by location, specific error trend information is displayed for each selected location. Otherwise, the information shown is a summary for all locations.

Run the Upload Summary Report

Create and run an **Upload Summary Report** in Veradigm Payerpath®.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Summary**.

2. Enter your filter criteria.

Filter Name	Description
From	Within 90 days prior to the current date is entered by default. Modify the date using the calendar icon as necessary.
Through	The current date is entered by default. Modify the date using the calendar icon as necessary.
Location	This filter is only available if your site uses locations. Select a single location or leave the default **ALL** option selected to include all locations.
Break by Location	This filter is only available if your site uses locations. Select this option if you want to separate the upload summary data by each location.
Select Payer	Select a single payer or leave the default **All Payers** option selected to include all payers.

3. Click **Process Report**.

   The report is displayed in the **Report Viewer**.

   By default, the data is sorted by payer. Click column headings to sort the data by **Claims**, **Amt**, or **Percent**.

Upload Detail Report

After you send an electronic claims file to the Payerpath® clearinghouse, wait about two hours, and then access your **Upload Detail Report** to view the output.

> **Important:** Make sure that you generate the **Upload Detail Report** for every claim file transmitted to the Payerpath® clearinghouse. If not, contact Veradigm® Support immediately to determine if there was a problem with the transmission. Failure to do so could impact your cash flow.

The **Upload Detail Report** shows the number of passed claims and the number of failed or warned claims, organized by payer. Failed claims did not pass the payer-specific edits. Warned claims are flagged for you to review manually. Use this report to review and correct claims.

The beginning of the report shows the total number of claims in the upload file and the total dollar amount. In addition, this total is listed by number and value of passed, failed and warned, unprocessed, and discarded claims.

For each payer (one payer per window), the report then lists failed and warned claims along with the associated edit messages.

> **Note:** The data on each **Upload Detail Report** is static. It does not change after you have corrected and rebilled your claims. The data shown is representative of how the claims were received by the Payerpath® clearinghouse as of the date of the specific report.

If you ever see a 997, 999, or SBR file type displayed in red, contact Veradigm® Support immediately. The red font indicates there were problems with one or more claims in the file and it will neither be displayed on the associated **Upload Detail Report**, nor be transmitted out of the Payerpath® clearinghouse.

Run the Upload Detail Report

Create and run an **Upload Detail Report** in Veradigm Payerpath®.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Detail** to display **Upload Detail List**.

   > **Tip:** To work with the **Upload Detail List** in a spreadsheet, click **Export to CSV**.

   You have the ability to filter this list to limit the information that is displayed to focus on just what you want to view.

2. Click the applicable **View** link.

> **Tip:** To sort data in ascending order, descending order, or to remove a sort from being applied to a column, click the column names. (A black arrow icon is displayed beside the column name when you sort a column. The direction of the arrow indicates the order that the column is currently sorted in. To remove sorting from a column, click the column name until the black arrow icon is no longer displayed.) You can sort multiple columns of data at a time. You can also click and drag columns to resize them for greater visibility.

The **Report Summary** portion of the **Upload Detail Report** is displayed, sorted alphabetically by payer name. (If numerous payers are listed, and you want to resort the list by a claim status or a total dollar amount, click the arrows within the column headings.) The following information is provided for each payer in the upload file.

- The number of claims
- The dollar amount of the claims
- The status (**Passed**, **Failed** and **Warned**, **Unprocessed**, and **Discarded**) of the claims

Grand totals are displayed in the beige colored row.

3. To view details about the claims, click a payer name.

Claim Detail is displayed, and you see the following: patient name, patient account number, location (if applicable), status, service date, and the dollar amount of each claim. In addition, a description of each error and the value of the box in error are provided.

Filter the Upload Detail List

Adjust which reports that are displayed on the **Upload Detail List** window. This procedure is useful if you have numerous reports displayed in the list and you want to locate a specific report.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Detail**.
2. Click **Filter**.
3. Enter your filter criteria.

Filter	Description
Claim Status	Select a claim status or leave the default **ALL** option selected to include claims in any status.
Location	This option is available only if your site uses locations. Select a single location or leave the default **ALL** option selected to include all locations.

Filter	Description
Payer	Select a single payer or leave the default **ALL** option selected to include all payers.
Break by Payer	Select this option to separate the upload summary data by each payer.
Edit Message	Select an edit message or leave the default **ALL** option selected to include any edit message.

4. (Optional) To cancel and return to **Upload Detail List**, click **Back to List**.
5. Click **Apply Filter**.
6. Click **Download** to download the report to your workstation.
7. Click **Print** to print the report.

Results of this task

Upload Detail List is displayed, filtered according to the criteria that you specified.

Chapter 6

Use the Management Reports

This chapter describes the different types of **Management Reports** that can be accessed in Payerpath®.

Management Reports

The following reports are part of the **Management Reports** group.

- **Claim Age**
- **Claim Status Response**
- **Error Trend** (This report is only available to clients who upload their claim files.)
- **Payer Rejection**
- **Payer Reports**
- **Upload Reconciliation** (This report is only available to clients who upload their claim files.)

After you access a report, it is displayed in a separate window called the **Report Viewer**.

You can click the various icons in **Report Viewer** to navigate through different pages in the report, sort a report, print a copy of the report, or export the report data.

Claim Age Report

The **Claim Age Report** provides a list of claims that remain in the **Untransmitted Claim List** in **Passed**, **Failed**, **Held**, or **Warning** status.

> **Note:** If **NULL** is displayed under the **Provider NPI** column, the provider NPI is unavailable. Click **NULL** to view the detailed level of the report.

The **Claim Age Report** contains location names. Click a location to view additional details on the **Claim Age Detail Report**.

Run a Claim Age Report

This topic describes the tasks necessary to run a **Claim Age Report**.

1. Point to the Dashboard menu to expand it and then click **Reports > Claim Age** to view **Claim Age Filter**.

2. Select the applicable claim form type.
3. If your practice uses locations, you can also filter by all locations or specific locations.
4. Click **Process Report**.
5. Click the links in the **Claim Age Report** to view additional details on the **Claim Age Detail Report**.

   This report provides a breakdown by location. To view those claims currently in **Held** status, click **Held**. To view all claims, regardless of status, click **All**.

Error Trend Report

The **Error Trend Report** provides a management level view of the 10 most commonly occurring claim errors, organized by the boxes in error. **Carrier** report errors are not shown on this report. The report can also be run to show the error counts by the number of claims in error. Managers can use this information to determine the source of claim errors and make process improvements to increase their passed claim percentage.

The error messages are listed by payer, along with the number of times the error occurred within the selected date range.

Run the Error Trend Report

This topic describes the tasks necessary to run the **Error Trend Report**.

1. Point to the Dashboard menu to expand it and then click **Reports > Error Trend**.
2. Enter your filter criteria.

Filter	Description
From Date	Enter a start date. The start date can be up to two years prior to the current date.
Through Date	Enter an end date. The end date must be no more than 90 days from the start date.
Location	Select one or more locations. (This option is only used if your practice uses locations.)
Break by Location	Select this option to organize the data by location. (This option is only used if your practice uses locations.)
Payers	Select a payer.
Edit Message	Select an edit message.

Filter	Description
Display Counts By	Select this option to display data according to boxes in error or claims in error.

3. Click **Process Report**.
4. You can click an individual payer's name to display a list of the top nine errors, plus the other errors.

Payer Rejects report

This report is a composite of different types of response reports (such as **277-CA**, **277-B**, proprietary formats, and so on) sent from payers.

Demographic information in the report might vary depending on what the payer sends in their report. Also, not all reports are included in the **Payer Rejects** report because some non-standard reports do not have consistent formatting, do not provide sufficient detail, or includes ambiguous information for which cannot be reliably automate.

Run the Payer Rejects report

This topic describes the tasks necessary to run the **Payer Rejects** report.

1. Point to the Dashboard menu to expand it and then click **Reports > Payer Rejects**.

   Payer Rejects Filter is displayed.
2. Select a time frame using one of the following options:
   - **0-90 Days**: Choose this option to view reports that are between 0 and 90 days old.
   - **91+ Days**: Choose this option to view reports that are 91 or more days old. You can view reports dating as far back as two years from the current date, in 90-day increments.
3. For **Payer**, select the payer.
4. For **From Date** and **Through Date**, select the beginning and end dates.

   > **Important:** The date range cannot span the two different date ranges.

   For example, to search for all reports that span from two years ago to the current day, you would run two reports (one report for 0-90 days and one report for 91+ days).
5. For **Display Type**, select a view option.

   By default, both options are selected for you.

- **Claim Details**: Choose this option to include all the claim details in the report. Clear the box to exclude claim details from the report.
- **Batch Details**: Choose this option to include all the batch details in the report. Clear the box to exclude batch details from the report.

6. Click **Process Report**.

   The report is displayed in the **Report Viewer**, as follows.

   - The first page of your report is the **Report Summary**. It provides total counts of your rejected claims and batches, along with the respective dollar amounts.
   - If you included batch details, the **Batch Details** section of the report lists all your rejected batches, grouped according to payer.
   - If you included claim details, the **Claim Details** section of the report lists all your rejected claims, grouped according to payer.

   To display an alphabetical listing of all the patient names contained within the report, click **TOC**. To display the specifics for a patient, click the patient name. (The table of contents lists patient names from claim-level rejections, and is not available for batch-level.)

   The data on this report is static, which means it does not change if you run the report again for the same date after you have corrected and rebilled claims from your practice management application. The data shown is representative of how the carriers responded to claims during the date range specified.

Payer Rejects Workflow

The **Payer Rejects Workflow** enables users to work on categories of payer rejections from within an interactive version of the existing **Payer Rejects** report. The report is generated according to filter criteria that you specify.

The **Payer Rejects Workflow** information in the report might vary depending on the information payers send in their reports. Some rejections might not appear on this report due to inconsistent content and formats that are provided by payers.

Within the **Payer Rejects Workflow**, you can:

- View and work on most payer rejections in one location within the Veradigm Payerpath application.
- Work on rejections in groups based on the type of rejection. Because payer rejections are grouped by category, work can be streamlined or even divided between staff based on their areas of expertise.
- Payer rejection categories include **Coding**, **Eligibility**, **Insurance**, **Patient demographic**, and **Other**.

- Exclude payer rejections that you have finished by marking the claim **Done**.
- Filter payer rejections through additional fields, such as specific **Payers**, **Service Date Range**, **Procedure Code**, **Patient Account #**, and **Patient Last Name** within your specified report date range.
- Mark and track your progress while resolving payer rejections.
- Rebill, make corrections to, and resend corrected claims to the payer.

Run the Payer Rejects Workflow

This topic describes how to run the **Payer Rejects Workflow** filter to retrieve payer rejects according to specific criteria within Veradigm Payerpath.

Before you begin

Payer Rejects Workflow is visible to users if they have access to the **Payer Rejects Workflow**. However, if users do not have access to the **Payer Rejects** report, then access to **Payer Rejects Workflow** can be granted.

1. Point to the Dashboard menu to expand it and then click **Reports > Payer Rejects Workflow**.
2. Select the criteria to use for the filter.

Filter name	Description
Customers	This filter option is displayed and used only by practices with multiple accounts in use. Select one or more of the specific accounts.
Payers	Select one or more payers or select **ALL**.
Rejection Category	Payer rejections under a selected category are listed on the **Payer Rejects Workflow** window. Select one or more of the following options: • **ALL** • **Coding** • **Eligibility** • **Insurance** • **Pat Demo** • **Other**

Filter name	Description
	Note: The default value is **ALL**.
Rejection Status	Select one of the following options: • **Not Done**: View payer rejections that are not marked as done. • **Done**: View Payer Rejections that were previously marked as done. • **Both**: View all payer rejections both **Done** and **Not Done**. Payer rejections are included in the result. **Note:** The default value is **Not Done**.
Display Type	Select one of the following options: • **Claim Details**: View payer rejections that were received for claims. • **Batch Details**: View payer rejections that were received for batches. • **Both**: View payer rejections that were received for both claims and batches. **Note:** The default value is **Both**.
Report Date Range	Enter a **From** and **Through** date. **Note:** The range must not exceed 90 days. **Report Date Range** is required to generate a list of payer rejections.
Service Date Range	Enter a **From** and **Through** date.

Filter name	Description
Procedure Code	Enter **Procedure Code** range to view only payer rejections with certain codes.
Patient Account #	Enter **Patient Account #** range to view only payer rejections with specific patient account numbers.
Patient Last Name	Enter **Patient Last Name** range to view payer rejects for specific patients.

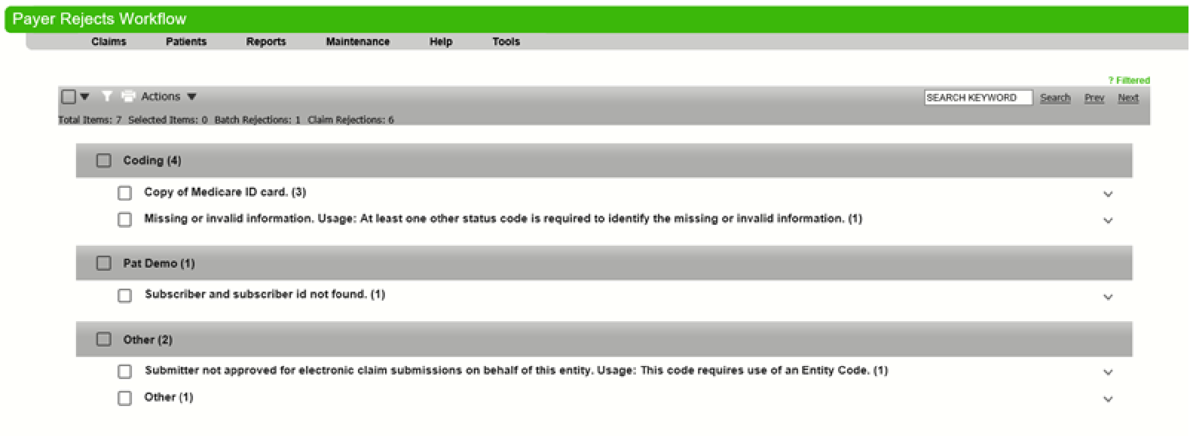
3. Click **Apply Filter**.

   The **Payer Rejections** that match your filter criteria are displayed on the **Payer Rejects Workflow** window.

   Payer Rejections are categorized first under **Rejection Category** (for example, **Coding**, **Eligibility**, **Insurance**, **Pat Demo**, and **Other**) and further categorized under **Rejection Reason**.

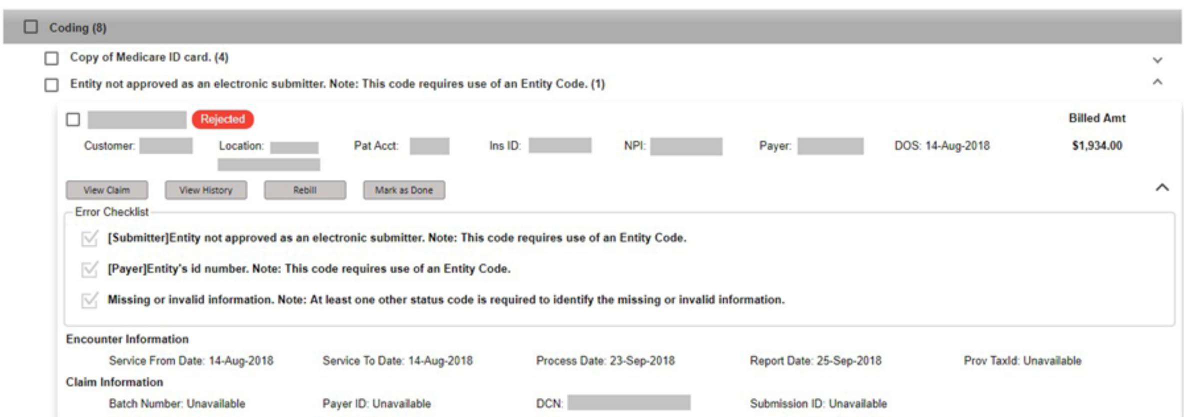
> **Note:** **Payer Rejections** can be received for individual claims or batches of claims. The application attempts to match received **Payer Rejections** to specific transmitted claims or batches of claims and enables users to perform several actions on associated claims or batches. More actions are available for rejections that can be matched to claims than for those that cannot be matched to claims.

> **Note:** The filtered criteria is applied on received payer rejections and not on the claims. As a result, rejections can be displayed on this report even when they cannot be matched back to a specific claim. Also, **Service Date Range**, **Procedure Code**, **Patient Account #**, and **Patient Last Name** filter options are claim-specific. When using filters through any of the above filters, only claim-level payer rejections are filtered. Batch-level payer rejections are not filtered.



Payer Rejections are displayed as cards beneath the category. To view **Payer Rejections**, click the rejection reason text. To view the **Error Checklist** and **Additional Payer Rejection** information, click the icon in the card to view the extended payer rejection information.

To mark progress as each error is resolved, select the box next to the error in the **Error Checklist** to indicate that you have addressed it and no further action is required. The check mark is displayed for that error message whenever the report is run. Users who work on rejections from this report can quickly identify errors that have not yet been addressed.



4. To work on a **Payer Rejection for Claim**, the following features are available:

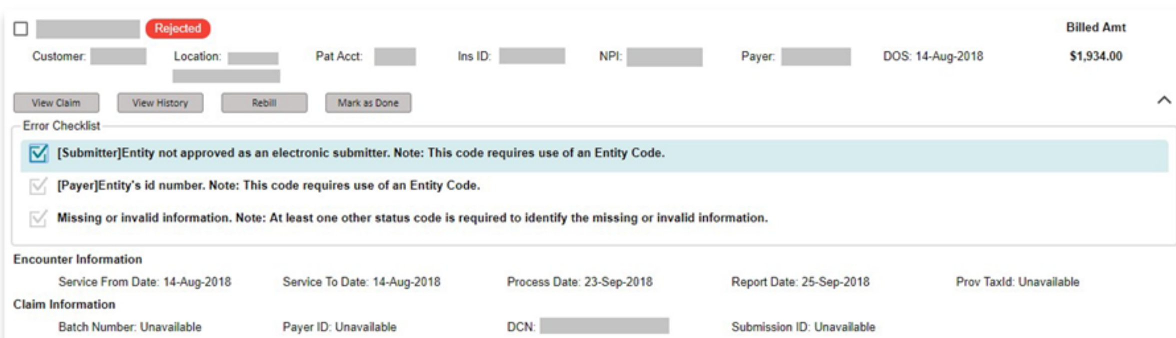
> **Note:** Payerpath® attempts to match payer rejection responses to the claim you submitted. In some cases, the response that is returned by the payer lacks the necessary information for Payerpath® to identify the associated claim by automation. In this case, the payer rejection icon is displayed. In addition, the **View Claim**, **View History** and **Rebill** options are unavailable. The **Mark as Done** option is available and selecting it marks the payer rejection as **Done**. Because the payer

> rejection cannot be matched back to a claim, the claim status cannot be updated to **TRD**.

Table 1: Claim Rejections

Action	Description
View Claim	View non-editable transmitted claims that were rejected by the payer. The virtual claim form opens. Click **Back** to return to the **Payer Rejects Workflow** list window.
View History	View the history for the transmitted claims that were rejected by the payer.
Mark as Done	Mark payer rejections as done. This option also marks transmitted rejected claims to **TRD** (Transmitted Rejected Done).
Mark as Undone	Reverse the previous action of **Mark as Done**. This also marks the transmitted rejected claims as **TR** (Transmitted Rejected).

a) To mark progress on resolving the error, select the box next to the rejection status to indicate you have taken care of it.



> **Note:** If you or another user encounter a payer rejection, the error that was taken care of displays with a check mark while the unresolved error message will remaining not selected.

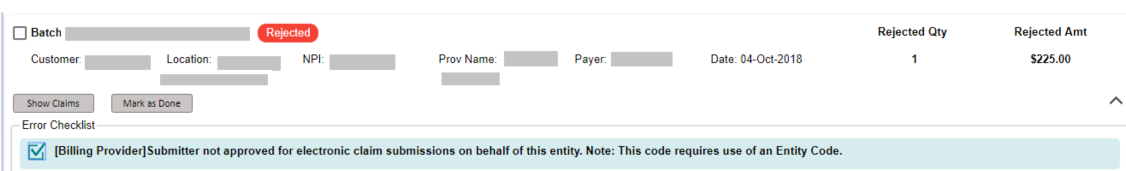
5. To work on a **Payer Rejection for Batch**, the following features are available:

> **Note:** Payerpath® attempts to match payer rejection responses to the claim you submitted. In some cases, the response that is returned by the payer lacks the necessary information for Payerpath® to identify the associated claim by automation. In this case, the payer rejection  icon is displayed. In addition, the **Show Claims** option is unavailable. The **Mark as Done** option is available and selecting it marks the payer rejection as **Done**. Because the payer rejection cannot be matched back to any claim under batch status cannot be updated to **TRD**.

Table 2: Batch Rejections

Action	Description
Show Claims	View a list of claims under a rejected batch. Users are directed to the **Transmitted Claims** list. **Note:** You can perform actions on these rejected claims on the **Transmitted Claims List** window.
Mark as Done	Mark payer rejections as done. This option also marks all transmitted rejected claims under this batch as **TRD** (Transmitted Rejected Done).
Mark as Undone	Reverse the previous action of Mark as Done. This also marks the transmitted rejected claims under this batch as **TR** (Transmitted Rejected)

a) To mark progress on resolving the error, select the box next to the rejection status to indicate that you have addressed the issue.



> **Note:** If you or another user encounters this same payer rejection, the error that was addressed displays a check mark, while the unresolved error message remains unchecked.

6. On the menu bar, select one of the following options to **Mark as Done** or **Mark as Undone**:

Menu option	Description
Mark as Done	Mark payer rejections as done. This option also marks rejected claims to **TRD** (Transmitted Rejected Done).
Mark as Undone	Reverse the previous action of **Mark as Done**. This option also marks rejected claims to **TR** (Transmitted Rejected).

7. Click the black triangle icon on the menu bar provides access to the following features:

Menu option	Description
Select All	Select all payer rejections that are included on the current list.
Unselect All	Clear all payer rejects that are included on the current list.

8. To print a payer rejection, select the box next to the **Payer Rejection** or select all in the **Actions** grid, and then select the printer icon.

   Payer Rejects Workflow Report opens.

   - The first page of your report is the **Report Summary**. It provides total counts payer rejects within the category, total counts of payer rejections for claim and batch rejections along with respective dollar amounts.
   - **Report Details** section lists payer rejects that are selected in the **Payer Rejects Workflow**.

9. To return to the filter window, select icon from the menu bar.

Payer Responses reports

Payer Responses reports are a series of reports that contain claim information reported by a payer. The application provides access to any reports it receives from the payers and attempts to normalize different report formats that contain the same information. The reports indicate the status of claims, (**Passed** or **Failed** and **Warned**), according to payer. View these reports regularly to ensure that rejected claims are rebilled accurately.

> **Note:** If you do not review the **Payer Responses** reports, you could miss rejections or errors sent by the payer which can indicate the claim cannot be processed. Reviewing these reports as part of your daily insurance claim follow-up procedure is a best practice.

Payer examples of **Payer** reports include the following:

- **Responses**: Reports forwarded from the payers that acknowledge receipt of the claims and, for some payers, the results of claim adjudication.
- **Daily Clearinghouse Rejects**: Reports forwarded by the commercial clearinghouse that show any claims rejected at the clearinghouse level.
- **Daily Clearinghouse Totals**: Reports forwarded by the commercial clearinghouse that give totals of the claims processed at the clearinghouse level.
- **Payer Rejects**: Reports that show claims that were rejected by the payer after being sent by the commercial clearinghouse.

> **Note:** A number of payers do not send you any reports. For these payers, use the paper explanation of benefits (EOB) that you receive in the mail to reconcile your claims.

Some carriers return reports with no claim-level data. These are often referred to as *batch-level response reports*, and they do not have specific claim information (for example, claim numbers or patient names).

New payer responses reports are also reflected in the **Payer Responses** reports quick link on the **Dashboard** window.

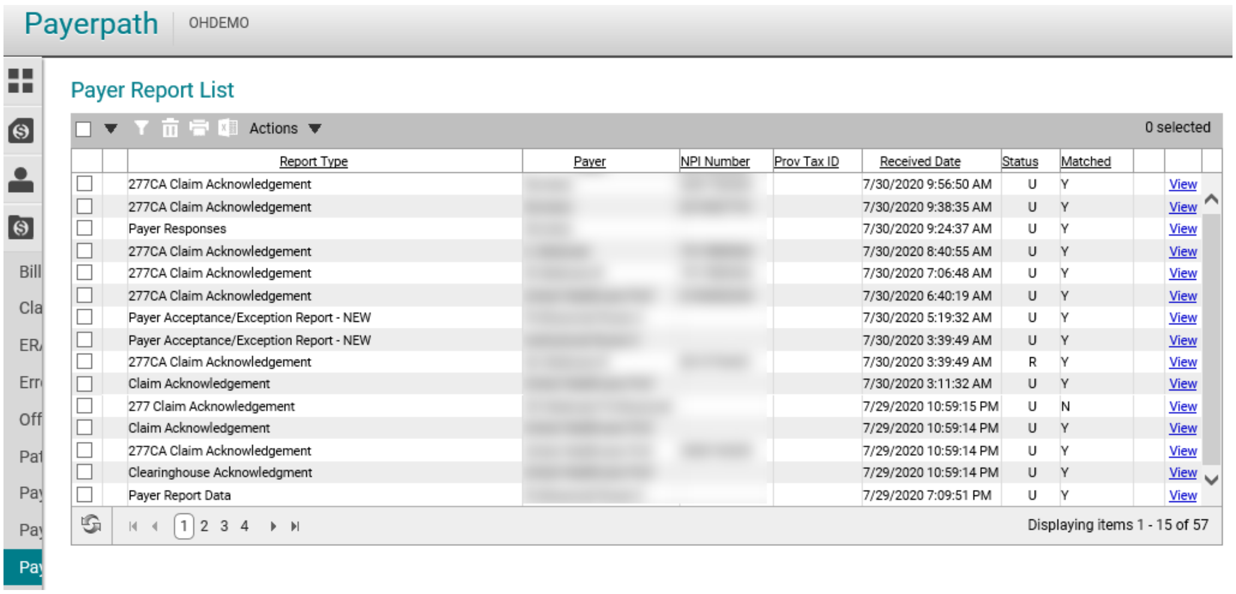
Access Payer Responses

This topic describes the tasks necessary to access **Payer Responses** on the **Payer Report List**.

1. Point to the Dashboard menu to expand it and then click **Reports > Payer Responses**.
2. Enter your filter criteria

Payer Report List is displayed.

Figure 20: Payer Report List



Payerpath® uses the **Matched** column on the **Payer Response List** to distinguish between reports that you have to manually review and those that do not require a manual review.

The **Matched** column displays a **Y** beside reports where all the responses within the report have been matched back to the originating claim. This means all responses moves claims to the **Accepted** or **Rejected** column. As a result, you are not required to manually review this report as long as you review the report response while working rejected claims (**TR** status).

A matched flag of **N** indicates that none of the responses could be matched back to a specific claim. This means the report must be manually reviewed to determine if further action is required on any or all of the claims referenced in that report.

A matched flag of an asterisk (*) indicates that there are responses where some responses within the report that could not be matched back to claims. This means the report must be manually reviewed to determine if further action is required on any or all of the claims referenced in that report.

3. Click **Apply** filter.

Upload Reconciliation Report

The **Upload Reconciliation Report** enables you to balance the number of claims that were uploaded and forwarded on to the payer, against the number of claims dropped from your practice management application.

The report provides a recap of each batch of claims as it progresses from the upload process, passes edits, and is sent to the payer. The report includes summary data on the number of claims according to status (**Uploaded**, **Unprocessed**, **Discarded**, **Deleted**, **Added**, and **Sent to the Payer**).

Run the Upload Reconciliation Report

This topic describes the tasks necessary to run the **Upload Reconciliation Report**.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Reconciliation**.
2. Locate the report in the list, and then click **View**.
3. (Optional) Click the arrow to view claim details.

> **Note:** You can also open the table of contents to quickly view the following sections of the report: **Report Summary**, **Upload Activity**, **Delete Activity**, **Sent Activity**, and **Other Activity**.

In the **Report Detail** section, a - (hyphen) is displayed if no data is available.

ERA Optimization Report

The **ERA Optimization Report** identifies which payers you send electronic claims but do not get elecronic remittances from.

Receiving electronic remittances from payers speeds reimbursement and payment posting. A best practice is to ensure your practice is receiving electronic remittances for each billing provider from as many payers as possible.

The new **ERA Optimization Report** has been added to the **Reports** menu and identifies which payers you send electronic claims to but do not get electronic remittances from. Payers who do not provide electronic remittances through Payerpath® are excluded.

The report, available to all power users, shows the number of claims submitted to each payer for each billing provider NPI where the claims are between 14 and 90 days ago and a matching remittance has not been received.

It will include a hyperlink to the Payers' enrollment documents for electronic remittance.

The results can be printed and downloaded.

This list is sorted in order of highest claim count to lowest.

Note:

The report does not display payers or NPI numbers that have received at least one ERA in the time frame defined in the report criteria because it is presumed that the existence of an ERA confirms the provider is enrolled with the payer for 835s.

Chapter 7

Use the report filters

This chapter describes how to apply filters to reports and lists in Payerpath®.

Report filters

Apply filters to certain reports in . These filters can help you to customize your report data.

You can use filters with the following reports:

- **Payer Report List**
- **Remittance List**
- **Upload Detail Reports** (Available to clients who upload claims only.)

Filter the Payer Responses List

Over time, the number of reports displayed on your **Payer Responses List** window might become extensive. You can change the criteria used to display **Payer** reports on the **Payer Responses List** window to limit which reports are displayed.

1. Point to the Dashboard menu to expand it and then click **Reports > Payer Responses**.
2. Enter your filter criteria.

Filter Name	Description
Select	Select a saved filter from the list.
Name	Enter the name of the filter if you want to save your choices.
Manage My Filters	Click **Manage My Filters** to view, edit, delete filters, or select a filter as your default filter.
0-90 Days and **91+ Days**	Select an option to run reports that are more than 90 days old or 91+ days old. By default, this option produces a list of reports that contain data from the previous seven days through the current date. **Note:** The date range cannot span the two different date ranges. For example, to search for all reports that span from two years ago to the current day, you must run two reports (one report for 0-90 days and one report for more than 91 days).

Filter Name	Description
Payer	Select the payer that you want to include or select the **ALL** option to include all payers.
Report Type	Select the report type that you want to include or select the **ALL** option to include all report types.
From and **Through** (Report Date)	To include only a specific range of report dates, enter the dates or select them using the calendar icon.
From and **Through** (Patient Last Name)	To include only a specific range of patients by last name, enter the last names. (for example: `SAARENSON-SWEENY`).
From and **Through** (Patient Account#)	To include only a specific range of patient account numbers, enter the numbers that begin and end the range.
From and **Through** (Patient ID#)	To include only a specific range of patient IDs, enter the IDs that begin and end the range.
From and **Through** (Date of Service)	To include only a specific range of dates of service, enter the dates or select them using the calendar icon.

3. Select the type of report you want to include (**Read**, **Unread**, **Deleted**, or **All** reports).

   View all unread reports (designated by a **U** in the **Status** column) until the report is viewed.
4. If you only want to include reports that you can download, select the box next to that option.
5. If you only want to include reports that were not matched back to a claim, select the **Exclude Matched Reports** option.
6. Click **Apply Filter**.
7. Locate the report in the list, and then click **View**.

   The report is displayed in the **Report Viewer**.
8. Compare the total dollar amounts in the report with those in your list of sent claims to determine if the amounts are equal or if corrective action is needed.
9. As necessary, review the report in detail and identify the errors or rejected claims causing the discrepancy.

Results of this task

You are returned to **Payer Report List**, and only the reports that match your filter criteria are displayed.

Save a Payer filter

Save various types of filter criteria that match your daily office processes, and only select that saved filter to view the **Payer** reports that meet those criteria.

1. Point to the Dashboard menu to expand it and then click **Reports > Payer Responses**.
2. For **Name**, enter a unique name for the filter.
3. Select the criteria that you want to use for the filter.

Filter Name	Description
Select	Select a saved filter from the list.
Name	Enter a payers name.
Manage My Filters	Click **Manage My Filters** to view, edit, delete filters, or select a filter as your default filter.
0-90 Days and **91+ Days**	Select an option to run reports that are more than 90 days old or 91+ days old. By default, this option produces a list of reports that contain data from the previous seven days through the current date. **Note:** The date range cannot span the two different date ranges. For example, to search for all reports that span from two years ago to the current day, you must run two reports (one report for 0-90 days and one report for more than 91 days).
Payer	Select the payer that you want to include or select the **ALL** option to include all payers.
Report Type	Select the report type that you want to include or select the **ALL** option to include all report types.

Filter Name	Description
From and **Through** (Report Date)	To include only a specific range of report dates, enter the dates or select them using the calendar icon.
From and **Through** (Patient Last Name)	To include only a specific range of patients by last name, enter the last names. (for example: `SAARENSON-SWEENY`).
From and **Through** (Patient Account#)	To include only a specific range of patient account numbers, enter the numbers that begin and end the range.
From and **Through** (Patient ID#)	To include only a specific range of patient IDs, enter the IDs that begin and end the range.
From and **Through** (Date of Service)	To include only a specific range of dates of service, enter the dates or select them using the calendar icon.

4. Click **Save**.

   The filter is now saved. You can select it from **Select** on **Payer Report Filter** or by selecting it from the **Dashboard** window.

   If you want to apply, edit, or delete a saved filter, click **Manage My Filters** (upper portion of the **Payer Report Filter**).

Filter the Remittances List

Adjust which reports are displayed on **Remittances List**. This helps, for example, if you must locate a specific report, but you have numerous reports displayed in the list.

1. Point to the Dashboard menu to expand it and then click **Reports > Remittances**.
2. Select a date range, as follows:
   - **0-90 Days**: Select this option to view recent data. By default, this option produces a list of reports that contain data from the previous seven days through the current date. If you want to further narrow the list of reports by date, enter dates for **Report Date From** up to 90 days back and **Report Date Through**.

- **91+ Days**: Select this option to view older data in 90-day increments. By default, this option produces a list of reports that contain data beginning 91 days from the current date, and extending back in time an additional 90 days. If you want to further narrow the list of reports by date, enter dates for **Report Date From** and **Report Date Through**.

> **Important:** The date range cannot span the two different date ranges. For example, to search for reports 60-120 days old, you must run a search on 0-90 days and a separate search on 91-180 days.

For example, suppose that today is August 7, 2012, and you want to view reports from January 2012. You would select **91+ Days**, and then enter `January 1, 2012` for **Report Date From**.

The option that you selected enters default dates for **Report Date (From)** and **Report Date (Through)**. If you selected **91+ Days**, the **Display Downloadable Reports Only** option is unavailable.

3. Enter your additional filter criteria.

Filter Name	Description
Report Date (From)	This value box is filled in for you when you select **0-90 Days** or **91+ Days**. To enter a different date as the start date, click the calendar icon.
Report Date (Through)	This value box is filled in for you when you select **0-90 Days** or **91+ Days**. To enter a different date as the end date, click the calendar icon.
Payer	Select the payer that you want to include or select **ALL** to include all payers.
NPI	Select a National Provider Identifier (NPI) number.
View	Select an option for the type of report you want to include: **Read Reports**, **Unread Reports**, **Deleted Reports**, or **All Reports**.
Display Downloadable Reports Only	Select **Display Downloadable Reports Only** if you want to include only reports that you can download. **Note:** This option is not available if you selected **91+ Days**. (Downloadable reports are only available for 90 days at this time.)

Filter Name	Description
Check Amount (From and Through)	To include only a specific range of dollar amounts, enter those values.
Check Number (From and Through)	To include only a specific range of check numbers, enter those values.
Check Date (From and Through)	To include only a specific range of check dates, enter the dates or select them using the calendar icon.

4. Click **Apply Filter**.

   If an error message is displayed after you click **Apply Filter**, follow the instructions provided to make corrections. You likely attempted to enter a report date range that conflicts with **0-90 Days** or **91+ Days** that you specified.

   The reports that match your filter criteria are displayed on **Remittance List**.

Filter the Upload Detail List

Adjust which reports that are displayed on the **Upload Detail List** window. This procedure is useful if you have numerous reports displayed in the list and you want to locate a specific report.

1. Point to the Dashboard menu to expand it and then click **Reports > Upload Detail**.
2. Click **Filter**.
3. Enter your filter criteria.

Filter	Description
Claim Status	Select a claim status or leave the default **ALL** option selected to include claims in any status.
Location	This option is available only if your site uses locations. Select a single location or leave the default **ALL** option selected to include all locations.
Payer	Select a single payer or leave the default **ALL** option selected to include all payers.
Break by Payer	Select this option to separate the upload summary data by each payer.
Edit Message	Select an edit message or leave the default **ALL** option selected to include any edit message.

4. (Optional) To cancel and return to **Upload Detail List**, click **Back to List**.

5. Click **Apply Filter**.
6. Click **Download** to download the report to your workstation.
7. Click **Print** to print the report.

Results of this task

Upload Detail List is displayed, filtered according to the criteria that you specified.

Chapter 8

Use the maintenance features and tools

This chapter describes how to use the maintenance features and tools in Payerpath®.

Maintenance features and tools

Access maintenance features and tools using the **Maintenance** menu.

- **View Messages:** View a list of broadcast messages that were received in the last 90 days.
- **Edit Claim Defaults:** Create default settings for your **Electronic Fields**, payer by payer.
- **Payer Table:** Update the name or address of a payer.
- **View Master Payer List:** Search for payers and view all available payers.
- **Provider Maintenance:** View or update data that is associated with the providers in your practice with access to the application.

View, print, or download messages

The **Message Center** is a centralized location where you can find time-sensitive information about new carrier releases for claims and remits, support issues (such as claims processing and remittance delays), and other news. You can view, print, and download messages.

1. Access the **Message Center** using one of the following methods.
   - Click the icons in the **Quick Links** section on the **Dashboard** window.
   - Point to the Dashboard menu to expand it and then click **Maintenance > View Messages**.
2. To download a message, click the diskette icon.
3. To view a message, click **View**.

   The message is displayed on the **Message Detail** window. In addition, the status of the message changes from **U** (Unread) to **R** (Read). You can change the status manually by selecting **Actions > Mark as Unread**. (This option is useful if someone else at your site needs to read the message.)

   > **Note:** Messages in the **Password Notification** category are displayed only in the message lists for the profile to which they belong. All messages in other categories are displayed for all users who are authorized to view messages. For example, you can see only your

> own changed password notifications that are included in the messages, and not those for other users.

To view the category of a message, move the pointer over the category value assigned to the message.

4. After you read the message:

   - Click **Next** to move to the next message
   - Click **Previous** to return to the previous message
   - Click the diskette icon to download the message
   - Click the printer icon to print the message
   - Click **Back to List** to return to the **Message Center**.

> **Note:** Messages are deleted automatically from the **Message Center** window after 90 days. To manually delete messages that you no longer want, select their accompanying check box, and then click the trash can icon.

Edit claim defaults for a payer

Set up certain information to be entered automatically on a claim form for a specific payer, which reduces the amount of data entry that is needed.

1. Point to the Dashboard menu to expand it and then click **Maintenance > Edit Claim Defaults**.
2. Select the applicable payer, and then click **Select**.

   The **Electronic Defaults** for that payer is displayed.
3. For each applicable box, enter the information that you want to display on the claim by default.
4. Click **Save Defaults**.

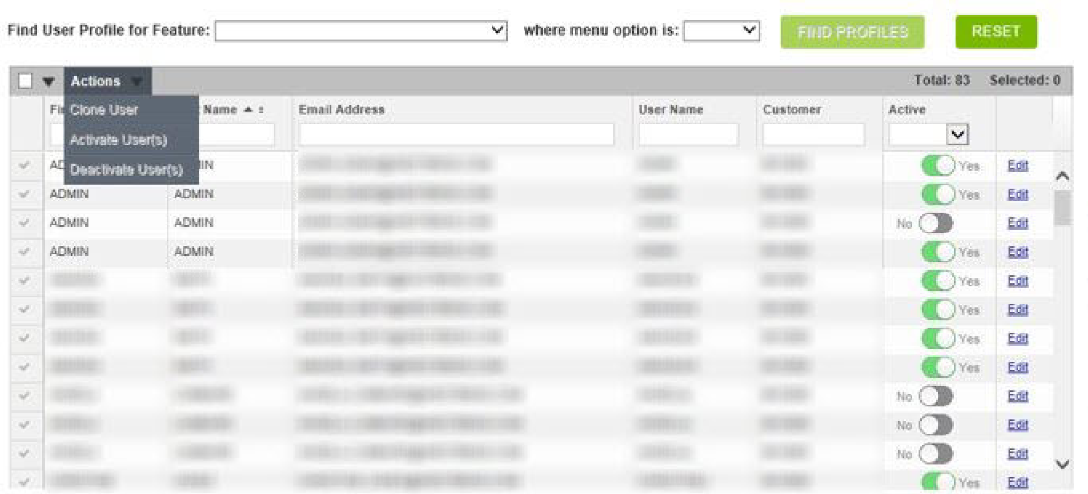
   The application displays a message that the defaults are saved.
5. Click the **Click here to go home** link to return to the **Dashboard** window.

Using the User Maintenance feature

User Maintenance enables an authorized user to manage all Payerpath® users within a practice.

You can access this window from any location within Payerpath® by selecting **Maintenance > User Maintenance**.

Figure 21: User Maintenance window



On **User Maintenance**, there are six columns that displays user information:

- **First Name**: The user's first name cannot be blank.
- **Last Name**: The user's last name cannot be blank.
- **Email Address**: The email address can be blank, but if filled in then it must be unique within the same customer account.
- **User Name**: This column must be unique within a customer account.
- **Customer**: Displays the customer name associated with each user and indicates if multiple customer names are applicable.
- **Active**: Displays **Yes** or **No**, based on whether the user is active (can log on to Payerpath®) or inactive (access to Payerpath® is prevented).

The last column enables you to edit a users profile.

All customers that you have access to are shown in the list by default.

> **Note:** If you have access to multiple associated customers (also referred to as databases or sub accounts), then a separate customer filter displays in the top left portion of the window in addition to the **Customer** column.

> You can select a specific customer from the filter, and the user list displays only users associated with that customer. This filter is helpful if you want to work with users for a specific customer only.

To view users who have access to a specified Payerpath® feature, use the **Find Profile by Feature** list. You can also filter all users who have **Active** or **Inactive** status by clicking the **where Feature Status is** list.

You can drag columns in the order that you want to view your search results and adjust the width of columns.

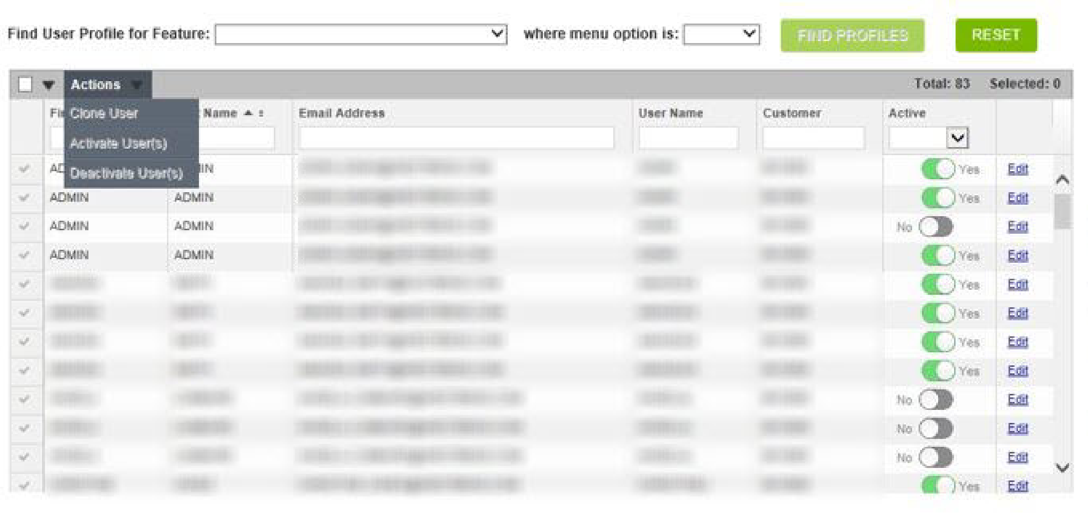
> **Tip:** If you make changes to the column order or width, they revert back to the default the next time that you log on to Payerpath®.

You can also sort multiple columns in ascending and descending order by selecting the column title.

> **Tip:** You can multi sort columns by clicking the column that you want to sort first, then pressing **SHIFT** + **click** together on the next column to sort. The column headings are numbered in order you want to sort.

- **Check Box**: Use this option to **Select All** or **Unselect All** users in the list.

Figure 22: User actions



- **Actions**: Use this menu to select **Clone User**, **Activate User**, or **Deactivate User**. These options perform the following functions:
  — **Clone User**: Use this option to create a new user profile within the same customer by copying a selected user profile and changing the user personal information. You can

select only one user at a time but the clone function enables you to create multiple new users from that selected user.

  - **Activate User(s)**: Use this option to re-activate access to Payerpath® for a deactivated user. Switch the status between active and inactive using the switch directly in the **Active** column.
  - **Deactivate User(s)**: Use this option to turn off access to Payerpath® for an active user. Switch the status between active and inactive using the switch directly in the **Active** column.

- **Total users in the list**: Displays the total number of user who access Payerpath®.
- **Total selected users**: Displays the total number of users selected from the list.

You can also edit a user's information and credentials, including resetting their password, by clicking **Edit**.

User Maintenance overview

User Maintenance enables authorized users to perform the following functions: **Clone Users**, **Activate Users**, **Deactivate Users**, **Edit** user information, and reset user passwords.

Filtering users

Any column that includes a filter box can be filtered by entering text into the box.

Search for or narrow your list of available users by entering your search criteria under each column heading. As you type, the list reflects the items that match the text you enter.

Using an asterisk (*) after the text implies that the text results are similar to the text before the asterisk, then the implication is that the text results are close to the text before the asterisk. Adding an asterisk before any text suggests that any text can prefix the search text.

Filtering user names is especially helpful if you want to locate a specific user by name or if you want to maintain a user who has multiple user accounts for different customers you administer.

> **Tip:** To locate a user named John Smith, enter `John` in the text box beneath the **First Name** box, and all users with a first name matching John are displayed in the list. You can further refine your list by entering `Smith` in the last name filter box. All users with a first name matching **John** and a last name matching **Smith** is displayed.

> **Tip:** If you select multiple users and choose to filter in the columns, users you previously selected that do not meet your new filter criteria are cleared for you.

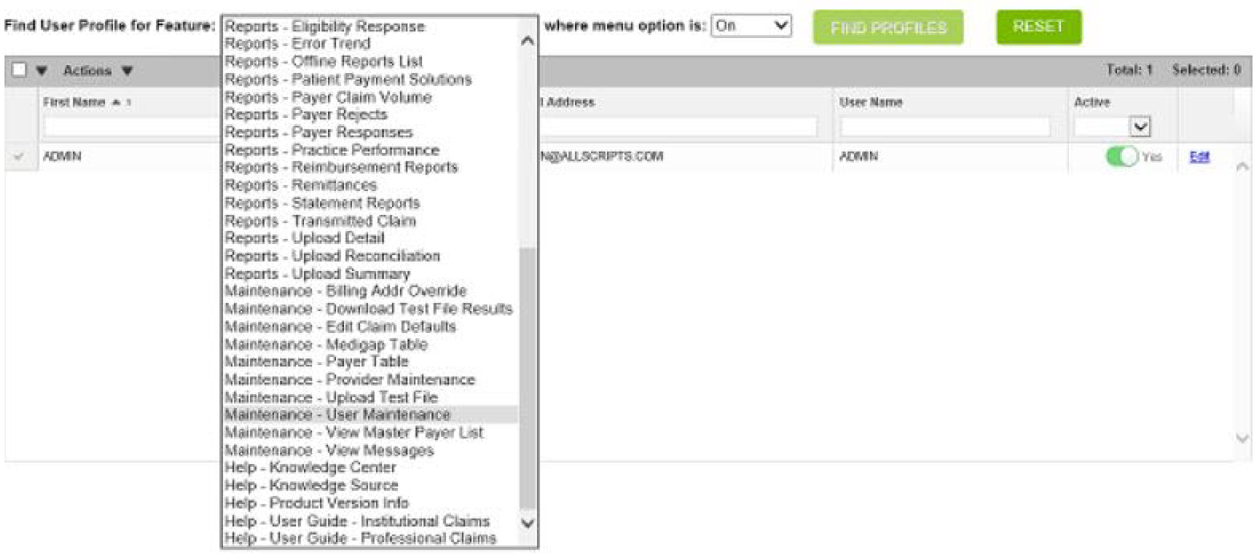
Filtering Users by Feature

You can also filter users based on their access to Veradigm Payerpath features. For example, an administrator might want to know if any other users in their Payerpath® account have access to the **User Maintenance** feature. You can perform this action from the main user list. Select the feature you want to know about from the **Find User Profile for Feature** list. In this case, **Maintenance > User Maintenance**.

On **Where the menu option is**, select **On** from the list to view which users have this feature active. (You can also select **Off** to view which users do not have this feature and **Inactive** to view which users can view the menu option as **Inactive** (or grey) but cannot selected it), then click **Find Profiles**. The user list refreshes to display only those users who meet your selection criteria. To remove the filter and see all the users again, click **Reset**.

> **Note:** Features (also known as menu options) are listed in alphabetical order based on the menu the feature is displayed in Payerpath®. For example, the **User Maintenance** option displays on the **Maintenance** menu as **Maintenance - User Maintenance**.

Figure 23: Find User Profile for Feature



Actions

Perform several actions within the **User Maintenance** menu. For example, you can clone a user, activate a user, deactivate a user, edit a user, and reset a user password.

Clone user

Use **Clone User** to duplicate a user's menu option privileges from one user to another. **Clone user** does not duplicate a user's personal information.

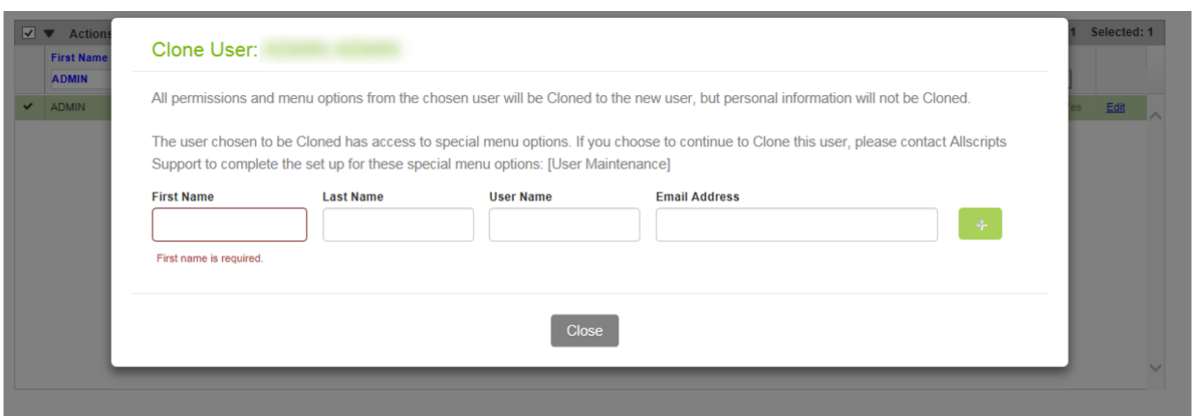
Clone User copies a user's menu option privileges in the Veradigm Payerpath application. Users cannot be cloned across customer accounts. For example, a user in customer 12345 can only be cloned within the same customer (12345) and not for a user in customer 12345B.

1. Point to the Dashboard menu to expand it and then click **Maintenance > User Maintenance**
2. From within **User Maintenance**, search for the user that you want to duplicate.
3. To the left of the user's name, click check mark icon .
   The row is highlighted and the check mark changes color.
4. Select **Actions > Clone User**.

   > **Note:** The **Clone User** action is unavailable if you do not have a user selected or you have more than one user selected.

   A window is displayed where you can enter the new user's information.

   Figure 24: Clone user



> **Note:** If the source user being cloned has access to purchased or secure features, access to those features are not replicated to the

> new user. A few examples are KnowledgeSource Professional®, EOB Cabinet, Veradigm Practice Performance™, or User Maintenance). A message is displayed on the window informing you that this is the case and after the new user is cloned you must contact Veradigm® support to have them configure the user setup for access to the features.

5. Enter the following:

   - **First Name**: Enter the first name of the new user.
   - **Last Name**: Enter the last name of the new user.
   - **User Name**: Enter a unique user name.

     > **Note:** In order to clone a user, you must enter values for **First Name**, **Last Name**, and **User Name**. If a user name is already in use, the `User name is already in use` is displayed under the **User Name** box to let you know to enter another user name.

   - **Email Address**

     > **Note:** If email address is already in use, the `Email address is already in use` is displayed under the **Email Address** box.

6. Click  icon to add the new user.

   The completed cloned user is displayed in the cloned users section at the bottom of the window.

   If an email address was entered for the new user, then a notification email is sent to the new user along with the instructions to complete their user setup and password. If an email address was not supplied, then a system generated password is displayed. You must provide this temporary password to the new user in addition to the **Customer Name** and **User Name**.

You are presented with the boxes to enter a second cloned user.

Figure 25: Clone another user

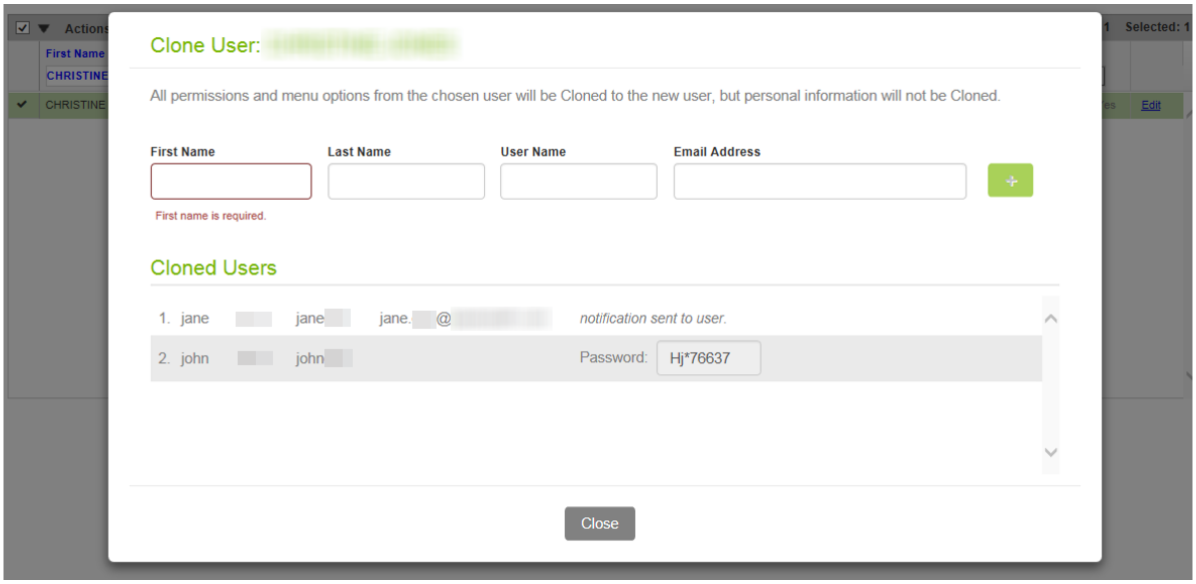
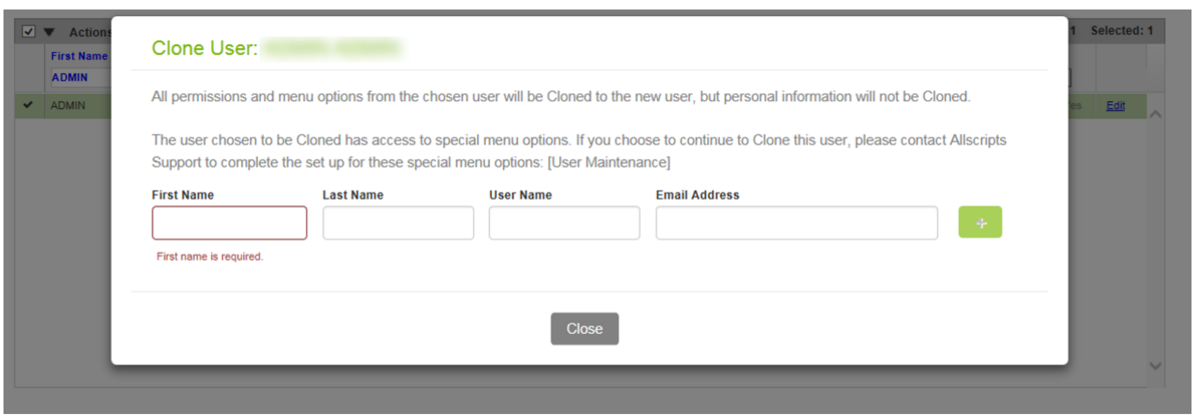


Figure 26: Clone user menu options notification



7. If no additional cloned users are required, click **Close**.

   You are returned to the search box in **User Maintenance**.

Results of this task

You have successfully cloned a user.

Activate users

Use **Activate User(s)** in **User Maintenance** to reactivate a previously deactivated user's access to Payerpath®.

Activate User(s) grants access to the Veradigm Payerpath® application.

1. In **User Maintenance**, select a user that you want to activate.

   > **Note:** To activate a single user, slide the switch from **Inactive** to **Active**.

2. To the left of the user name, click check mark icon .

   The row is highlighted and the check mark changes color.

3. Select **Actions > Activate User(s)**.

   The switch under the **Active** column changes from **No** to **Yes**.

   > **Note:** If an email address is present on the newly activated users, a notification email is sent to each user. Contact Veradigm® Support if the user's activation requires additional setup for some applications.

   If the user you are activating has access to multiple customer accounts, you are asked: `Do you want... Yes No or Cancel`

   > **Note:** If you select **Cancel**, you exit the operation without activating the user. If you select **No**, the requested changes are made to one selected user only. If you select **Yes**, the requested changes are made to that user and all users sharing the same **First Name** and **Last Name** name, which can exist for other customer accounts. Selecting **Yes** enables you to do the same for that particular user across all customers.

Figure 27: Activate a user

Results of this task

You have successfully activated Payerpath® access for a user or users.

Deactivate users

Use **Deactivate User(s)** in **User Maintenance** to make a user's access to Payerpath® unavailable.

Deactivate User(s) revokes access to the Veradigm Payerpath® application.

1. In **User Maintenance**, select a user that you want to deactivate.

   > **Note:** To deactivate a single user, slide the switch from **Active** to **Inactive**.

2. To the left of the user name, click check mark icon .
   In the **Active** column, **No** is displayed indicating the user is not active.
3. Select **Actions > Deactivate User(s)**.
   The switch under the **Active** column changes from **No** to **Yes**.

   > **Note:** If you select **Cancel**, you can exit the operation without deactivating the user. If you select **No**, the requested changes are made to the selected user only. If you select **Yes**, the requested changes are made to that user and all users sharing the same **First Name** and **Last Name**, which might exist for other customer accounts. Answering **Yes** enables you to do the same for that particular user across all customers.

Results of this task

You have successfully deactivated Payerpath® access for a user or users.

Edit user

Use the **Edit** option in **User Maintenance** to update a user's personal information or reset their password.

1. In **User Maintenance**, select a user that you want to edit.

   > **Note:** You can edit only one user at a time.

2. At the end of the row for that user, click **Edit**.
   Edit User is displayed.
   On this window, you can edit a user's **First Name**, **Last Name**, **Email Address**,**Direct Phone**, and **User Name**. The **First Name**, **Last Name**, and **User Name** are required boxes. The **Email Address** box is not required. You also have the option to reset a user's password by selecting **Reset Password**.

3. Under **Profile Information**, edit any of the following boxes:
    - **First Name**
    - **Last Name**
    - **Email Address**

        > **Note:** An email address is not required. However, it is strongly encouraged to enter an email address so that the user can reset their own password if they forget it and subscribe to receive broadcast email subscriptions. The email address must be unique and cannot be used by another user profile for your Payerpath® account.

    - **Direct Phone #**
4. (Optional) Click **Verify** to send a verification email to the user.
5. Under **Credentials**, update the **User Name**, if necessary.
6. Click **Save**.

    If the email address has been updated, a notification email is automatically sent to the user requesting them to complete the process of verifying their email address.

Results of this task

You have successfully edited a user.

Reset user password

Reset a user password within **User Maintenance** in Payerpath®.

1. In **User Maintenance**, select a user that you want to reset the password for.
2. At the end of the row for that user, click **Edit**.
3. In **Credentials**, click **Reset Password**.

    A system generated password is displayed.

    If the user's email address is blank or unverified, a system generated password displays.

    > **Note:** The system generated password cannot be edited. You must provide this new temporary password to the user. The user is prompted to change the temporary password the next time they log on to Payerpath®.

    Had this user's email address been verified, an email would have been sent to the user with an embedded link and instructions for how to reset their password.
4. Click **Save**.

Export user list

Export a list of Payerpath® users to a comma-separated value (CSV) file from the **User Maintenance** window.

The exported CSV file has one row per user, including all column values that are currently displayed in the **User Maintenance** window.

1. In the **User Maintenance** window, select each user to include in the CSV file export.

   To the left of the user name, click the check mark icon.

   > **Note:** To select all users, select the check box in the header at the top of the selection column.

2. Click the export to CSV icon in the header next to **Actions**.
   A confirmation message indicates the export-file name and size.
3. To generate and export the CSV list, click **Save** or **Cancel**.
   To change the file name or location where the file is saved, click the arrow next to **Save**.
   When the export completes, a confirmation message indicates that the CSV-file download is complete.
4. Choose an action to take with the exported CSV file:
   - To view the CSV file, click **Open**.
     Click the arrow next to **Open** for a list of file-opening options.
   - To open the folder containing the CSV file, click **Open folder**.
   - To view all downloads, click **View downloads**.
   - To close the message without taking action, click the **X** icon.

Results of this task

You have successfully exported the Payerpath® user list. This list can be opened or imported by a number of applications for analysis.

Edit the Payer Table

Edit the name, ID, or address of a payer.

1. Point to the Dashboard menu to expand it and then click **Maintenance > Payer Table**.
   Customer Payer List is displayed.

2. For **Payer**, select a payer name.

   A list of payers associated with that payer link is displayed.

3. Click the **Edit** link corresponding to the payer that you want to edit, and then update the following payer information, as necessary.

   - **Payer Name**
   - **Address**
   - **City**
   - **State**
   - **Zip Code**

4. Click **Update** to save your changes.

Use the Master Payer List

The **Master Payer List** provides real-time information about supported payers. It allows you to search for payers and view all available payers.

Use the **Master Payer List** to:

- Search, filter, and sort payers.
- Download the payer list in PDF or comma-separated value (CSV) format.
- View enrollment documents for claims and Electronic Remittance Advice (ERA).
- View payers that have been deactivated within the last six months.

> **Note:** Payers who were deactivated within six months are shown in gray text with a strike-through. Payers who were deactivated more than six months ago are not shown in the **Master Payer List**.

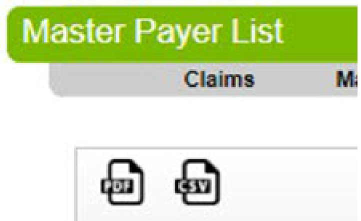
From **Master Payer List**, you can enter a variety of criteria to search for a specific payer. Content filters are displayed at the top of each column. A filter count and the total number of records is displayed in the lower-right corner of the window. Click on a column heading to sort the list based on that column.

1. Access the **Master Payer List** in one of two ways:

   - Point to the Dashboard menu to expand it and then click **Maintenance > View Master Payer List**.
   - Select **Help > Knowledge Center**, click **Payer Listings**, and then click **Payer List**.

   All payers who are supported by Payerpath® are displayed.

2. To limit the list of payers, select or enter search criteria at the top of the columns in the Master Payer List. Search criteria is applied instantly and results are displayed in the lower portion of the window.
3. To download the **Master Payer List** as a file, click the applicable `.pdf` or `.csv` file type icon.



What to do next

> **Tip:**
> If you open an exported `.csv` file directly in Microsoft® Excel®, payer identifiers with leading zeroes (**TSP ID**s or **Payer ID**s, depending on your configuration) might be trimmed automatically. To keep the leading zeros intact, complete the following steps when opening the file:
>
> 1. Prior to opening the `.csv` in Microsoft® Excel®, change file extension from `.csv` to `.txt`.
> 2. In a new Microsoft® Excel® session, click **Open**, and then click **Browse**.
> 3. In the **Open** window, change the file extension type to **Text Files**.
> 4. Locate the `.txt` file containing the **Master Payer List** and click **Open**.
> 5. In **Text Import Wizard - Step 1 of 3**, select a data description of **Delimited** and click **Next**.
> 6. In **Text Import Wizard - Step 2 of 3**, select a delimiter of **Comma** and click **Next**.
> 7. In **Text Import Wizard - Step 3 of 3**, select the individual payer identifier columns, (**TSP ID** or **Payer ID**, depending on your configuration) and **Alternate Payer ID**, and then select a **Column data format** of **Text**.
> 8. Click **Finish**.

Master Payer List columns

The Master Payer List displays all available payers. Use columns in the list to search and filter payers. The list has one row for each payer that displays supported claim transaction types (Professional, Institutional or Both), which allows users to view all transactions that were accepted by a given payer at a single location.

The following table provides information about columns of the **Master Payer List**. Minor variations might occur, based on your configuration.

Column Name	Description
Payer Name	The standard payer name.
State	The payer's state.
TSP ID / Payer ID	The unique and preferred identifier assigned to a payer. This ID is for both Professional and Institutional claims. **Note:** • You see either **TSP ID** or **Payer ID**, depending on your configuration. • If your practice does not use Veradigm® Practice Management software, this ID is also used for eligibility transactions.
Alternate Payer ID	A set of other identifiers that are used instead of the preferred payer identifier (**TSP ID** or **Payer ID**). **Note:** Use of alternate payer IDs is discouraged unless your practice already uses these IDs to submit claims or eligibility transactions.

Column Name	Description
Eligibility ID / Eligibility	If eligibility transactions are supported for a payer, an **Eligibility ID** is displayed for use with eligibility transactions. **Note:** • If your practice does not use Veradigm® Practice Management software, **Yes** is displayed and you can use the **TSP ID** or **Payer ID** for eligibility transactions. If eligibility transactions are not supported for a payer, the value is blank. **Note:** • If your practice does not use Veradigm® Practice Management software, **No** is displayed instead of a blank value.
Transaction	• **Professional**: Veradigm Payerpath supports professional claims for a payer. • **Institutional**: Veradigm Payerpath supports institutional claims for a payer **Note:** The **Payer Group**, **Secondary Claim**, **Claim Enrollment**, and **ERA** columns are specific to the transaction type.
Payer Group	The payer group name. Some names are for individual payers, others are for routes.
Secondary Claim	• **Yes**: Veradigm Payerpath can forward secondary claims electronically to this payer. • **No**: The payer does not accept electronic secondary claims.
Claim Enrollment	• **Yes**: Enrollment is required to submit electronic claims to this payer. To view the enrollment document in another window, click **Yes**. • **No**: Enrollment is not required to submit electronic claims to this payer.

Column Name	Description
ERA	• **Yes**: ERA is supported by the payer. To view the enrollment document in another window, click **Yes**. • **No**: ERA is not supported by the payer.

Payer availability on the Claims List Filter window

Select payers from the payer name box in the **Claims List Filter** to filter claims by payer within a payer group. If Veradigm Payerpath receives a claim for an individual payer within a payer group, then that payer is automatically added to the payer name list for that group.

> **Note:** When a payer name is included in the **Claims List Filter**, everyone with access to that payer group within the customer profile can select that payer. To limit the ability to select the payer to a single user, you must create a custom filter.

Maintain provider information

Use **Provider Maintenance** to view a list of your providers, add a provider, update a provider's name, edit other provider information, or change a provider's access to the application.

1. Point to the Dashboard menu to expand it and then click **Maintenance > Provider Maintenance**.
2. For **Payer**, select the applicable payers using one of the following methods.
    - Click to select a single payer.
    - Press and hold the **CTRL** key, and then click to select multiple payers.
    - Click **ALL** to view all available payers.
3. For **Provider**, select the applicable provider names using one of the following methods.
    - Click to select a single provider.
    - Press and hold the **CTRL** key, and then click to select multiple providers.
    - Click **ALL** to view all available providers.
4. For **Enrollment Status**, select one of the following.
    - **ALL**: View all enrollment statuses.
    - **Enrolled**: The provider is enrolled at the payer to send claims electronically to Payerpath®.

- **Pending**: Enrollment is required and the enrollment department is actively working to initiate and monitor enrollment until approval is received from the payer.
- **Inactive**: The provider was deactivated due to a provider number that is not valid or is no longer an active provider with this account.

5. Click **Apply Filter**.

   The providers who met the criteria that you selected are displayed.

   You can sort this list by clicking a column heading.

6. Click **Edit**.

   The boxes that contain information about the provider are now editable.

What to do next

You can perform any of the following actions:

- Change the provider's information, as needed, and then click **Save**.
- Click **History** to view previous changes that were made to that provider's information.
- Select a status from **Status**, and then select **Actions > Update Name**. Change the provider's name, as needed, and then click **Submit**.
- Select a **Status** and then select **Actions > Deactivate** or **Actions Reactivate** to deactivate or reactivate a provider's access to the application. An **I** status indicates that the provider's application access is deactivated. An **E** status indicates that the provider's application access is enabled. If the provider has a **P** (Pending) status, enrollment is required for that payer and you will be contacted with instructions.
- To add a new provider, select **Actions > New**, enter the new provider's information, and then click **Submit**.

Update and verify Contact Info

Update your first name, last name, email address, and phone number. However, you cannot update your user name.

Before you begin

Having a valid email address on file enables you to use email-related functionality such as resetting your password and **Broadcast Email Subscriptions**. Updating or verifying your email address is not required; however, only users who complete the email verification process can use **Forgot Password** and update broadcast message subscriptions.

You can update and verify your email address at any time by pointing to your user name in the title bar and clicking **Preferences > Contact Info** in the Payerpath® application. If the email address box is filled in, then an icon indicates whether your email address is in an unverified (orange triangle) or verified (green check mark) state.

> **Tip:** The update process and verify process do not have to be performed separately. When you update your email address, the email address icon changes to the unverified icon and a verification email is automatically sent to you. The only time that you need to click **Verify** is if you want to verify an existing email without updating it because you are certain that the email is already correct.

1. Point to your user name in the title bar and click **Preferences**.
2. Click **Contact Info**.
3. For **Email Address**, enter your email address.

   > **Note:** You can leave the email address blank. However, in order to reset your password and **Broadcast Email Subscriptions**, you must provide a valid email address. Email addresses must be unique and cannot be used by another user within the same Payerpath® account.

4. For **Confirm Email Address**, re-enter your email address.

   > **Note:** You must re-enter your email address into the confirm box. The cut and paste functionality is not available. This is to discourage potential cut and paste errors.

5. Click **Save**.

   The window prompts you to access your email application and complete the email verification process within 24 hours.

6. Access your email application and locate the email entitled **Email Verification Required**.
7. Click the link within the email body to complete the last step of the verification process.

   > **Tip:** For security purposes, the embedded link is active for only 24 hours. If you do not complete the process that time frame, you must send a new verification email by returning to the **Contact Info** window and clicking **Verify** which is to the right of the email address box.

   The window confirms that the email verification process is complete.

Results of this task

Your new email address is saved to your profile.

Update your broadcast message subscriptions

Subscribe to have all, none, or some types of broadcast messages sent to you by email.

Before you begin

Your email address must be verified before you can select any options. If your email address has not been verified, a message is displayed prompting you to do so.

Each broadcast message is assigned to a category that is intended to help you more easily prioritize what messages are important to you. Messages will still be displayed in your **View Messages** list and quick links in Payerpath®, but electing to have a copy sent to your email provides several benefits:

- You will receive broadcast message information immediately without having to log into Payerpath®.
- You can use the features of your email application to notify, organize, search, and forward to other users (including non-Payerpath® users).
- You can retain that information for the length of time that your email administrator has configured rather than the 90 days allotted by Payerpath®.

1. Point to your user name in the title bar and click **Preferences**.
2. Select **Subscriptions**.
3. Select the check boxes beside the category types of broadcast messages that you want to receive.

   > **Note:** You will only receive emails for broadcast messages generated after you activate that category.

4. Click **Save**.

Appendix A

Advance search and application preferences

This chapter describes how to use advance search techniques and setting your application preferences in Payerpath®.

Advanced search techniques

This chapter details how to conduct highly specific searches.

Use of operators with search values

An *operator* is a symbol, or group of symbols, that you can use along with other search values to further customize search results. The following table lists and describes the operators you can use in search expressions.

Operator	Description	Example	Sample matches
`=`	Equals	`=MR1500`	MR1500
`>`	Greater than or alphabetically after	`>100` or `>ace`	101, 115 or ace, apple
`<`	Less than or alphabetically before	`<100` or `<ace`	10, 50 or Aamco, Abel
`>=`	Greater than or equal to	`>=100` or `>=ace`	100, 200 or ace, apple
`<=`	Less than or equal to	`<=100` or `<=ace`	50, 100 or Ace, apple
`-`	Range. A hyphen separates upper and lower limits of the range.	`10-20` or `A-C`	11, 15 or art, core
`,`	Or. A comma separates two values.	`1,2` or `ace, doug`	1,2 or ace, doug
`!`	Not	`!1000` or `!MA`	998, 1001 or VA, NC

Use of wildcards with search values

A *wildcard* is a symbol that you can use to search for data that partially matches a search value. The following table lists and describes the wildcards that you can use in search expressions.

Operator	Description	Example	Sample matches
`?`	Find any one character.	`M?1680`	MR1680, MS1680
`*`	Find any number of characters.	`3M*`	3M A1000, 3M B2000
`#`	Find any ASCII numeric character (0-9).	`MS##90`	MS0490, MS3290

Use of a pattern in a search operation

You can use patterns in a search to search for characters in a range, or select only certain characters for searching. Use the [ ] (bracket) symbols to include a pattern within a search expression. The following table lists and describes the patterns that you can use in search expressions.

Pattern	Description	Example	Sample matches
[character list]	Match any character inside the brackets.	`M[PRS]16`	MP16, MR16, MS16
[a-z]	Match any lowercase character.	`m[a-f]1800`	ma1800, mc1800
[0-9]	Match any ASCII numeric character.	`MX150[1-5]`	MX1502, MX1503, MX1504
[a-z0-9]	Match any lowercase character and ASCII numeric character.	`m[a-c-1-3]`	ma1, ma3, mb2, mc3
[a-z-]	Match any character or hyphen.	`m[a-z-]`	ma, mb, m-
[^]	Match one caret.	`*[^]1650`	a^1650, b^1650

Search for special characters

The following characters have special meanings in search expressions.

- Question mark: ?
- Asterisk: *
- Pound sign: #

- Brackets: [ ]

To search for a special character itself, you can use the following options:

1. Place the special character inside [ ] (brackets).
2. Enter the \ (backslash) character before the special character, and enclose both the backslash and the special character in quotation marks.

Character	Description	Example	Sample Matches
[?] or "\?"	Match one question mark.	`M[?]1600` or `M"\?"1600`	M?1600
[#] or "\#"	Match one pound sign.	`M[#]1600` or `M"\#"1600`	M#1600
[*] or "*"	Match one asterisk.	`M[*]1600` or `M"\*"1600`	M*1600
[[] or "\["	Match one open bracket.	`M[[]A[]]6` or `M"\["A"\]"6`	M[A]6
[]] or "\]"	Match one closed bracket.	`M[[]A[]]6` or `M"\["A"\]"6`	M[A]6
["\["-"\]"]	Match any ASCII character between [and].	`M["\["-"\]"]`	M[A], M[b]

Set application preferences

Customize the appearance of your **Dashboard** window. You can also specify your session timeout preferences and update your contact information.

1. Point to your user name in the title bar and click **Preferences**.

   Preferences is displayed. The **Application Settings** options are displayed by default.
2. To change your site settings:

   a) For **Automatic Timeout**, enter the number of minutes to remain logged on to the application during periods of inactivity.

      The amount of time must be between five minutes and 60 minutes.

   b) To have the application alert you if the specified time has elapsed, select **Warn me before logging out** option.

   c) Click **Save**.

3. To set the **My Payerpath Claims** link to produce a customized list of claims:
   a) Point to your user name in the title bar and click **My Filters > Claims Filters**.
   b) Click the filter type and then select the name of the filter to use from the list.
   c) If a filter needs to be created, click **Create Filter**.

4. To change your **Dashboard** settings:
   a) Point to your user name in the title bar and click **Preferences > Dashboard**.
   b) To change the dashboard charts to display information from a single payer, select the name of the payer from **Payer (Default)**.

      > **Note:** The **Dashboard** preferences are set to show all payers by default.

   c) Select the items to display on your **Dashboard**:
      - **Quick Links: Payer Report Alerts**
      - **Quick Links: Remit Report Alerts**
      - **Claim Status Summary**

        > **Note:** By default, this option is set to **On** for every new profile.

      - **Chart: Edit Errors**
      - **Chart: Claim Upload Summary**
      - **Practice Performance Analytics**

        > **Note:** **Practice Performance Analytics** is not displayed for payer partners.

      - **My Filters**
   d) Click **Save**.

5. To update your contact email address, complete the following steps:

   > **Note:** Verify that your contact email address is accurate so that you can request your password if you forget it.

   a) Point to your user name in the title bar and click **Preferences > Contact Info**.
   b) Enter the new email address.

      An email address is not required, but is necessary to reset your password if you forget it or you subscribe to broadcast emails.
   c) Reenter the email address to confirm it.

d) Click **Save**.

6. Point to your user name in the title bar and click **Preferences > Change Password**.

   a) Enter your new password.

   Your password must meet the following criteria:

   - Minimum of eight characters
   - Maximum of 50 characters
   - One uppercase character
   - One lowercase character
   - One numeric digit
   - One special character (for example, ! @ # $ % ^ & *)
   - You must change at least four characters
   - You can change your password only once in a 24-hour period
   - You cannot reuse any of the previous 10 passwords

   > **Note:** The paste and insert functionality has been removed for the confirm password box. You must reenter the password manually to avoid mistakes. As a best practice, passwords should not contain dictionary words or user IDs.

   b) Reenter your new password to confirm it.

   > **Note:** The cut and paste functionality is not available in the **Confirm Password** box.

   c) Click **Update** to save your changes.

   An email is sent that requests you to complete the verification process.

Results of this task

Your application preferences are saved.

Create a filter

Save custom filters from **Claims Filters** for your practice.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. For **Name**, enter a unique name that identifies criteria related to the filter.
3. Manually enter the following filter criteria:

Filter Name	Description
Form Type	Select **Institutional** to view institutional claims or **Professional** to view professional claims. **Note:** If your site uses proprietary forms, those types are also available for selection.
Location	Select a specific location from the list, or leave the default **ALL** setting.
Payer Group	Select the payer group to view. **Note:** The group you select determines which providers and payer names are available to select.
Payer Name	By default, **ALL** is selected. If you use **ALL**, every payer is searched. Select one or more payer names from the list to view claims associated with those specific payers. The payers displayed in this list depend on the payer group that you selected. **Note:** If you send claims to a payer, that payer is automatically added to this list.
Billing Provider	Claims are selected with a matching billing provider, which is typically a group entity and not the individual rendering provider.
Claim Status	Click **Transmitted** or **Untransmitted**. You can then select specific claim statuses (such as **Acknowledged** or **Pending**) from the list.
Bill Type	Enter the three or four-digit type of bill for the claims to view.
Claim Type	Select the type of claim to view: • **Primary** • **Secondary** • **Both**

Filter Name	Description
Group By Category	**Group by Category** is available only when **Untransmitted** claims are selected. It displays only claims that have failed or warrant edit messages. To view all untransmitted claims regardless of status, do not select the **Group by Category** option. If you select **Group by Category**, the **Edit Category** list is displayed. Select one or more of the following categories: • **ALL** • **Coding Issues** • **Insurance Issues** • **Other** • **Patient Demographics** • **Secondary Claims**
Batch Status	Select these options to view reconciled or unreconciled claims. (These filters are available only if your site has enabled the "full reconciliation features" and" transmitted claims only.")
Claim Type	Select the type of claim to view.
Create Date	Click the calendar to select and enter a date in **From** to view claims according to the date they were entered or uploaded. The same date is displayed automatically when you click **Through**, which you can then modify to specify a range of dates, if necessary. **Note:** If you view transmitted claims, you must specify a date range that is less than or equal to 90 days.
Sent Date	For transmitted claims, a date range is required. You can enter a create date range, a sent date range, or both. (This option only applies to transmitted claims.)
Date of Service	Click the calendar to select and enter a date in **From** to view claims according to their date of service. The same date is displayed automatically when you click **Through**, which you can then modify to specify a range of dates, if necessary.

Filter Name	Description
Procedure Code	Enter a procedure code in **From** to view only claims that contain that code. The same code is displayed automatically when you click **Through**, which you can then modify to specify a range of codes, if necessary.
Patient Account #	Enter a patient account number in **From** to view only claims that contain that patient account number. The same patient account number is displayed automatically when you click **Through**, which you can then modify to specify a range of account numbers, if necessary.
Patient Last Name	Enter a patient last name in **From** to view only claims that contain that patient last name. The same patient last name is displayed automatically when you click **Through**, which you can then modify to specify a range of names, if necessary..

4. Click **Save**.

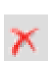
Manage my filters

Change filter names, delete filters, and select a default filter on **Claims Filters**.

1. Point to the Dashboard menu to expand it and then click **Claims > View Claims**.
2. Click **Manage My Filters**.
3. From the list of filters, select an action:

- To make a filter the default filter, select the option in the **Default** column.

> **Note:** When you set a filter as the default, that filter will always be selected when you perform a new search or click the filter icon.

-  (Filter): Click this icon to generate a list of claims with criteria that apply to the customer filter for your practice.
-  (Edit): Click this icon to edit the filter name.
-  (Delete): Click this icon to delete your practice's customer filter. After you click the icon, a message is displayed to confirm that you want to delete the filter.

4. (Optional) To create additional filters, click **Create Filter**, or click **Claims > View Claims** to return to **Claims Filters**.

Results of this task

You have successfully updated, deleted, or set a filter as the default.

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