AdvancedMD

Best Practices
Release User Guide
(Supplemental)
(Addendum to version 5.8)

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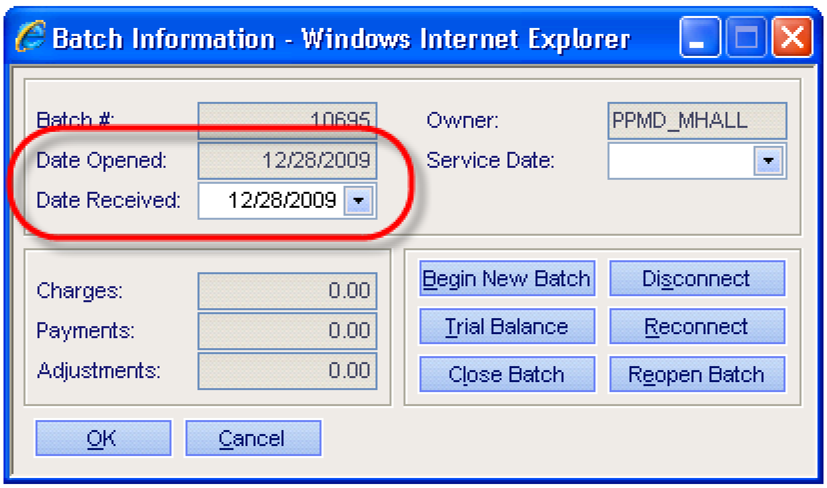
Batch Information

A new field, **Date Received**, has been added to the **Batch Information** screen for reporting purposes. This field populates with today's date by default, but you can select another date if necessary. The **Date Received** is only used in the **Elapsed Time: Date of Service to Billed** report and only used when the date received is later than the date the batch is opened. The **Date Received** field is important for reporting purposes as the date of service on the charge may not accurately reflect the date the charges were actually available to be entered. Use the **Date Received** field to indicate the date charges in the batch were available to your staff to be posted.

Note: Date received information is stored at the batch level, not the charge level. This means that all items entered using a specific batch will have the same **Date Received** value, regardless of when that value was set or modified. Because date received information is stored at the batch level, changing the value in the **Date Received** field after you have begun entering charges will affect results on the **Elapsed Time: Date of Service to Billed**.

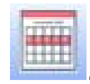
The field, **Posting Date**, has been renamed to **Date Opened**. This field is still read-only, and will still populate with the date you begin the batch.

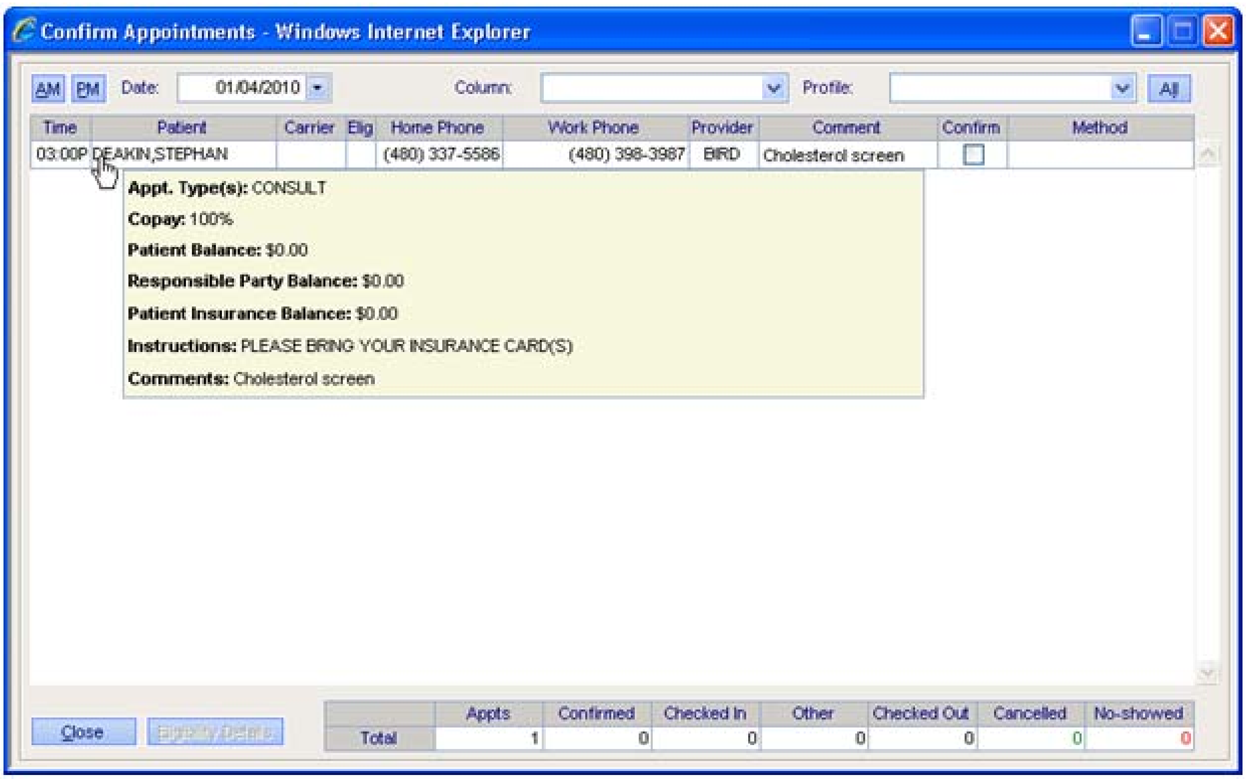


Appointment Scheduler

Confirm Appointments

A new tool tip has been added to the **Confirm Appointments** screen that displays the patient’s copay, account balance, and appointment type, comments, and instructions. The tool tip appears when you hover over the **Time**, **Patient**, **Home Phone**, **Work Phone**, **Provider**, or **Comments** columns.

1. Go to **Modules | Appointments**. Or click the **Appointments** icon .
2. Click the **Confirm** button. The **Confirm Appointments** screen will appear, defaulting to the next day's date.
3. Hover over the columns mentioned above to view the tool tip.



Master Files

Denial Categories Master File

The new **Denial Categories** master file allows you to create denial categories to group similar payment reason codes together for reporting purposes. You can assign a payment reason code to a denial category in the **Payment Reason Codes** master file. The payment reason codes will be grouped by denial category on the **Claims Submission Analysis** and **Carrier Denial Analysis** reports.

Standard Categories

Several standard categories are provided for you, and you can also add your own.

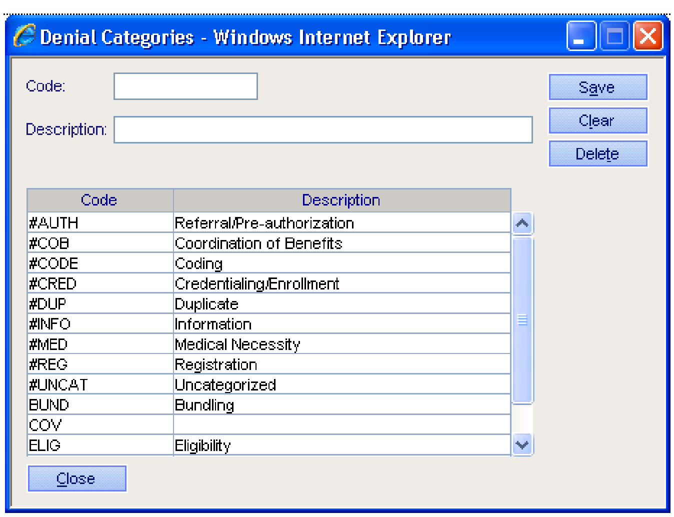
Some of the standard denial categories are noted with a "#" preceding the code. These codes cannot be changed or deleted. However, the description for these categories can be modified.

Note: Initially, all payment reason codes are assigned to the #UNCAT (uncategorized) denial category. Reassign the payment reason codes you want to track to the appropriate denial categories.

The standard denial categories are:

- #AUTH
- #COB
- #CODE
- #CRED
- #DUP
- #INFO
- #MED
- #REG
- #UNCAT
- BUND
- COV
- ELIG
- TIME

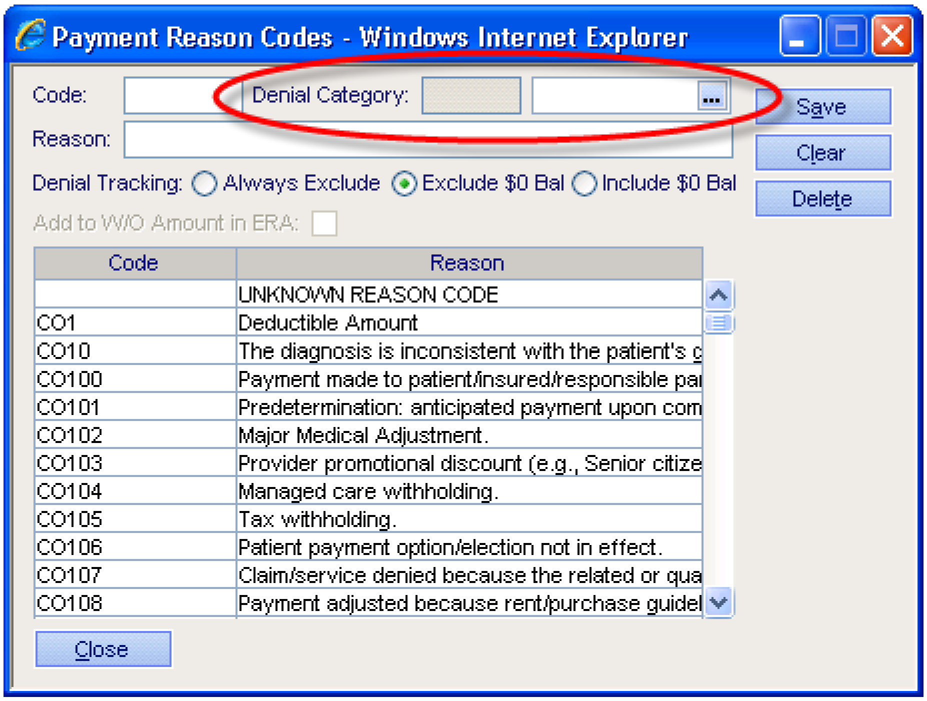
How to Create Denial Categories



1. Go to **Master Files | Transaction Codes | Denial Categories**.
2. Enter a category code.
3. Enter a description for the category.
4. Click **Save**.

Payment Reason Codes Master File

A new field, **Denial Category**, has been added to the **Payment Reason Codes** master file. This field allows you to assign a payment reason code to a denial category for reporting purposes. By grouping payment reason codes into denial categories you can track the pattern of denials that you receive. The denials are grouped by denial category on the **Claims Submission Analysis** and **Carrier Denial Analysis** reports.



1. Go to **Master Files** | **Transaction Codes** | **Payment Reason Codes**.
2. Select a Payment Reason Code.
3. Assign the code to a **Denial Category**.

   To assign a payment reason code to a denial category:

   - Clear #UNCAT and click the ellipsis.
   - Select a **Denial Category**.
   - Click **OK**.

Reports

Appointment Confirmation Detail Report

Summary

The **Appointment Confirmation Detail** report lists all appointments scheduled within the date range selected for the columns and provider profiles chosen. This detail report contains patient payment information such as copay and patient balance, and is intended to assist in following up on payment issues with the patient when confirming appointments.

Frequency

The report may be run any time the office would like to call patients with reminders. Generally offices choose to run the report one or more days in advance for reminder calls and each day to use for the current day's appointments check-in.

How to run the Appointment Confirmation Detail report

1. Go to **Reports** | **Appointments** | **Appointment Confirmation Detail**.
2. Select a **Date Range** from the drop-down, or choose a custom range using the **Low Date** and **High Date**.
3. Select the specific columns and provider profiles to include in the report.
4. Optionally, select to have the report **Group Appointments By Column**.
5. Click **Generate** or **Export to** Excel, TIFF, PDF, or CSV document.
6. Click the **Print** icon to print the report.

Note: This report only prints in landscape orientation.

Appointment Confirmation Detail

HOLDEN FAMILY CLINIC (999982)

Date range 1/1/2009 to 1/30/2009

Column Names: LARRY BIRDSON

All Providers

Appointment Date: 01/06/2009

Appt Time	Patient	Chart #	Phone #	Appointment Type	Provider Profile	Column	Comments	Copay	Patient Balance	Resp Party Balance	Pt Ins Balance
4:00 PM	KINT,STEVE	1	(801) 265-9658 (h)	FOLLOW UP	BIRDSON,LARRY	LARRY BIRDSON		0%	$150.23	$150.23	$739.10

Carrier Denial Analysis Report

The **Carrier Denial Analysis** report shows the claims denied during a selected date range. This report has a summary, detail, and landscape version. The landscape version is provided as an Excel export file with most of the report headers removed. This version of the report is intended to be used in creating graphs and doing custom data manipulation.

Note: Unapplied payments with payment reasons attached to them are not counted in this report. Denials with a payment reason amount of zero are not included.

Frequency

Run this report at least weekly to track charge rejections by carrier and to monitor trends in the types of denials.

How to run the Carrier Denial Analysis Detail report

1. Go to **Reports** | **Carrier** | **Carrier Denial Analysis** or open **Carrier** | **Carrier Denial Analysis** in the Report Center.
2. Select a **Denied Date Range** from the drop down, or choose a custom date range using the **Low Date** and **High Date** calendar pickers.
3. Optionally, you can choose to filter the report by carrier using the **Select by Range** or **Select by Category Range** radio buttons, then entering low and high range limits. Leaving these blank includes all carriers.
4. Select the provider profiles to include in the report.
5. Select the facilities to include in the report.
6. Choose to run the **Detail**, **Summary**, or **Landscape** version of the report.
7. Click **Generate** or **Export to** Excel, TIFF, PDF, or CSV document.
8. Click the **Print** icon to print the report.

Carrier Denial Analysis - Summary

Denial Date Range: 12/1/2009 to 12/31/2009

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All Carriers, All Provider Profiles, All Denial Category

Denial Code	Denial Category	Carrier Code	Carrier Name	Denials	Amount
#UNCAT	Uncategorized	AET5	AETNA	1	$75.00
#UNCAT	Uncategorized	MCR	MEDICARE PART B	1	$131.28
#UNCAT	Uncategorized	UHC2	UNITED HEALTHCARE	1	$0.05
Denial Category Totals:				**3**	**$206.33**

Denial Code	Denial Category	Carrier Code	Carrier Name	Denials	Amount
TIME	Timeliness	MCR	MEDICARE PART B	2	$221.78
TIME	Timeliness	UHC2	UNITED HEALTHCARE	5	$0.25
Denial Category Totals:				**7**	**$222.03**
Grand Totals:				**10**	**$428.36**

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Claim Submission Analysis Report

The **Claim Submission Analysis** report shows the total first-time billed claims for a selected date range. The report assigns each claim to one of the four groups:

- **Clean**
  - All claims that have received a non-zero dollar payment before a second claim was sent to the primary payor, and no payment reasons (other than PR1, PR2, PR3, CO42, or CO45) attached
  - All claims less than 45 days old that have not received a payment

- **No Payment in 45 Days** – claims with a date billed to primary payor more than 45 days old with no payment

- **Second Claim Sent Before Carrier Response** – claims that were submitted a second time before a payment was received

- **Denied Claims** – claims with any charges greater than five cents that are returned by the carrier with a payment reason (other than PR1, PR2, PR3, CO42, and CO45)

The types of claim rejections practices decide to follow up and rework varies widely. Also, carrier definitions of clean claims are inconsistent.

In determining what to classify as a clean claim, we considered the Medicare definition found in the Federal Register, http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr422.500.pdf

> (1) A claim that has no defect, impropriety, lack of any required substantiating documentation (consistent with § 422.310(d)) or particular circumstance requiring special treatment that prevents timely payment; and
>
> (2) A claim that otherwise conforms to the clean claim requirements for equivalent claims under original Medicare.

Denied claims are further broken down into Denial Categories. In **Denied Claims**, payment reasons are counted. Therefore a single visit may be counted in multiple Denial Categories when the visit contains multiple charges and a different payment reason is returned for each charge.

An example of this is a visit with two charges. In this case, the visit is counted once as a Denied Claim and the two payment reasons attached to the claim are counted in each of the Denial Categories that the payment reason codes have been assigned to. If one payment reason is assigned to the #ELIG (eligibility problems) Denial Category, the claim is counted in eligibility denials. If the other charge is denied for incomplete information, the claim will also be counted in the #INFO (missing or incomplete information) denial total.

Note: The example given above assumes that the payment reason codes have been attached to the denial categories described. The practice must attach payment reason codes to denial categories or all payment reasons will be grouped into #UNCAT (uncategorized).

You can use this report to find and eliminate problems and improve your clean claim rate. According to the MGMA book, The Physician Billing Process, by Keegan, Larch, and Woodcock, a well-run practice should have a clean claim rate above 93 percent.

Note: Payment information received can change the clean status of claims from day to day. Therefore, running this report on different days, even for the same billing date range, may produce different results. The report results should be considered a snapshot of where claim submissions stand when the report is run. Also, the 45-day period affects claims' status as this window moves. One of these effects is a limitation on the dates for which the report can accurately calculate data. That is, if you select a date range which includes billed dates that are less than 46 days in the past, the clean claims and claims with no payment in 45 days counts and percentages will be inaccurate. To avoid this, do not run the report for a billed date range with an end date less than 45 days in the past.

This report is CBO-enabled. When this report is run for multiple practices, each practice is grouped and subtotaled separately.

Note: The following rules apply to whether or not claims and payments are included in this report.

- Unapplied payments are not counted in this report, even if they have payment reasons attached
- Demand claims and crossover claims are not counted in this report
- Claims with deductible or patient payment responsibility payment reasons are considered clean
- Claims with zero dollar payment reason detail are also considered clean

How to run the Claim Submission Analysis report

1. Go to **Reports** | **Carrier** | **Claim Submission Analysis**.
2. Select a **Billed Date Range** from the drop-down, or choose a custom date range using the **Low Date** and **High Date** calendar pickers.
3. Optionally, you can choose to filter the report by carrier using the **Select by Range** or **Select by Category Range** radio buttons, then entering low and high range limits. Leaving these blank includes all carriers.
4. Select the financial classes to include in the report by highlighting them.
5. Clean Claims are included by default. To remove clean claims from the report clear the **Include Clean Claims Details** checkbox.
6. Select the provider profiles to include in the report.
7. Select the facilities to include in the report.
8. Choose to run either the **Summary** or the **Detail** version of the report.
9. Click **Generate** or **Export to** Excel, TIFF, PDF, or CSV document.
10. Click the **Print** icon to print the report.

Claim Submission Analysis - Summary

Billed Date Range: 12/1/2009 to 12/31/2009

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All Carriers, All Provider Profiles
All Facilities, All Financial Classes

Delay Reason			# of Claims	Percentage
Denied Claims				
Denial Category	# of Denials	Percentage		
Uncategorized	2	40.0%		
Timeliness	3	60.0%		
Denial Category Total:	5	100.0%		
Denied Claims			4	18.2%
Second Claim Sent Before Carrier Response			1	4.5%
Clean Claims			17	77.3%
Claims Total:			22	100.0%

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Elapsed Time: Held in Unbilled Report

The **Elapsed Time: Held in Unbilled** report identifies the number of days claims remain in an unbilled state. Visits are scrubbed by the AdvancedMD application and if errors are found the charges are marked and they appear in the **Unbilled** tab of the Claims Center. The time charges are in held in unbilled begins when they are marked unbilled by the application. The held in unbilled period ends when the edits have been corrected, and the charges can be billed.

Note: Reporting of the number of days held in unbilled will not be retroactive. In other words, the number of days held in unbilled for charges that were marked unbilled prior to adding the **Elapsed Time: Held in Unbilled** report to your key will start on the day of the upgrade, not the actual date they were marked unbilled. Therefore, the total number of days held for those charges will not be accurate on the report. Accurate reporting will begin with charges marked unbilled after the addition of the report.

Frequency

Run this report often enough to know the average number of days charges remain unbilled and assign actions to decrease this number. An increase in this delay is cause for immediate action.

How to run the Elapsed Time: Held in Unbilled report

1. Go to **Reports** | **Carrier** | **Elapsed Time: Held in Unbilled**.
2. Select a **Date Range** from the drop down, or choose a custom range using the **Low Date** and **High Date**.
3. Select the minimum number of days held you want to see on the report; the default is one day. **Days Held** values less than this choice will be excluded from the results. However, all days held in unbilled will be included in the calculated average.
4. Choose to have the report results limited to a range of carrier codes or carrier categories using the radio buttons.
5. Select the provider profiles to include in the report.
6. Select the facilities to include in the report.
7. Click **Generate** or **Export to** Excel, TIFF, PDF, or CSV document.
8. Click the **Print** icon to print the report.

Elapsed Time: Held In Unbilled

Date Range: 12/1/2009 to 12/31/2009

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All Carriers, All Provider Profiles, All Facilities

Provider Profile	Facility Code	Carrier Code	Visit #	Date of Service	Unbilled Date	Billed Date	Days Held
MA, OWENS		MCD	702970	12/12/2009	12/12/2009	12/17/2009	5
						Average Days:	**5**

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Elapsed Time: Held in CI Report

The **Elapsed Time: Held in CI (Claim Inspector)** report identifies how long it takes to resolve problems identified by claim inspector.

The days in **Claim Inspector** begins when claim inspector identifies an edit associated with the charge. When all edits found by claim inspector have been resolved, the held in **Claim Inspector** period ends. The date of the last change made to the claim before **Claim Inspector** marks it clean is the end date used. If **Claim Inspector** is bypassed, or if the practice does not have this add-on, the days held in **Claim Inspector** will always be zero.

Claims are also scrubbed by the application in all cases. Edits found by the system are listed in the **Unbilled** tab and the lag time for these corrections is reported in the **Elapsed Time: Held in Unbilled** report.

Note: This report is retroactive.

Note: **Claim Inspector** is an add-on to the AdvancedMD software. Contact your AdvancedMD representative for details on how to add this labor-saving, billing efficiency feature.

Frequency

Because claims with edits delay billing and revenue collection, you should run this report frequently to ensure claims with identified errors are being corrected and moved through the billing process in a timely manner.

How to run the Elapsed Time: Held in Claim Inspector report

1. Go to **Reports | Claim Inspector | Elapsed Time: Held in CI**.
2. Select a **Date Range** from the drop down, or choose a custom range using the **Low Date** and **High Date**.
3. Select the minimum number of days held you want to see on the report. **Days Held** values less than one choice will be excluded from the results.
4. Choose to have the report results limited to a range of carrier codes or carrier categories.
5. Select the provider profiles to include in the report.
6. Select the facilities to include in the report.
7. Click **Generate** or **Export to** Excel, TIFF, PDF, or CSV document.
8. Click the **Print** icon to print the report.

Elapsed Time: Held in Claim Inspector

Released date range: 12/1/2009 to 12/31/2009

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All Carriers, All Provider Profiles, All Facilities

Provider Profile	Facility Code	Carrier Code	Visit #	Date of Service	Date Inspected	Date Released	Days Held
MA, OWENS		MCR	702769	09/15/2009	12/18/2009	12/21/2009	3

Average Days: 3

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Elapsed Time: Date of Service to Billed Report

The **Elapsed Time: Date of Service to Billed** report shows the intervals between the date of service, charge entry, and billed dates. Using this data, you can eliminate or reduce billing delays in your practice and improve billing efficiency. The report is sorted in descending order by the total **Days to Billed** so that the longest delays are most visible.

Note: For visits tied to appointments, the date of the appointment is used as the date of service when calculating figures for this report.

Note: This report is retroactive.

Frequency

Run this report often enough to see changes that might occur in the interval between services and billing and the number of claims with delays. AdvancedMD recommends monitoring the billing cycle elapsed times shown in this report and acting to correct delays immediately.

How to run the Elapsed Time: Date of Service to Billed report

1. Go to **Reports | Billing | Elapsed Time: Date of Service to Billed**.
2. Select a **Date Range** from the drop down, or choose a custom range using the **Low Date** and **High Date**.
3. Choose to limit the report to show only total days between service and billed greater than a specified number of days.
4. Choose to run the report for insurance billing or patient billing. Insurance billing will display data for charges with an insurance order. Patient billing will display data for charges without an insurance order.
5. Choose to have the report include specific provider profiles and facilities.
6. Click **Generate** or **Export to** Excel, TIFF, PDF, or CSV document.
7. Click the **Print** icon to print the report.

Elapsed Time: Date of Service to Billed - Insurance

Billed Date Range: 12/14/2009 to 1/6/2010

OWENS MAR MD

All Provider Profiles, All Facilities

Provider Profile	Facility Code	Visit #	Date of Service	Days Elapsed: Service to Received	Days Elapsed: Received to Post	Days Elapsed: Post to Billed	Days Elapsed: Service to Billed
MA, OWENS		702769	09/15/2009	0	94	3	97
MA, OWENS		702970	10/15/2009	0	0	60	60
MA, OWENS		703106	12/02/2009	0	28	0	28
MA, OWENS		703107	12/03/2009	0	27	0	27
MA, OWENS		703109	12/04/2009	0	26	0	26
MA, OWENS	MHSW	703116	12/10/2009	0	21	0	21
MA, OWENS		703102	12/15/2009	0	15	0	15
MA, OWENS		703103	12/16/2009	0	14	0	14
MA, OWENS		703104	12/17/2009	0	13	0	13
MA, OWENS		703105	12/21/2009	0	9	0	9
MA, OWENS		703101	12/22/2009	0	8	0	8
MAAT,OWEN S SUGAR LAND		703117	12/31/2009	0	4	0	4
MAAT,OWEN S SUGAR LAND		703093	12/18/2009	0	0	3	3
MA, OWENS		703100	12/28/2009	0	2	0	2
MA, OWENS		703099	12/29/2009	0	1	0	1
			Average Elapsed Days:	**-0.16**	**10.64**	**2.64**	**13.12**

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