
User's Guide

Thom Practice Management System ("Thom Biller")

By Thom Child and Family Services

Version 18.01d

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Contents

- Introduction** **1**
 - Welcome 1
 - Why Choose the Thom Biller 1

- Installation** **2**
 - System Requirements 2
 - Installation Steps..... 3

- Getting Started** **5**
 - The Importance of Exiting Cleanly..... 5
 - The Importance of Backing Up 5
 - The Value of your Data 5
 - The Vulnerability of Databases 5
 - Backup Requirements..... 6
 - Getting Started 6
 - User Security 6

- Basic Activities** **8**
 - Introduction 8
 - Key Windows Concepts 8
 - Key Database Concepts 9
 - Main Menu 10
 - Main Menu Configurations 11
 - Toolbar Controls..... 12
 - Editing Data..... 12
 - Toolbar Menu Options 12
 - Locating a Record: List Button 15

- Data Entry** **17**
 - Introduction 17
 - For Users 17
 - For Managers and Users 18
 - Types of Event Records..... 18
 - Preparing Your Database..... 22
 - Data Menu 23
 - Agency Data 24
 - Specialty Services Providers..... 27
 - Programs 28
 - Providers..... 29
 - EIPP Discipline 30
 - Client Assignments Tab 31

Rates	32
Introduction	32
Billing Type	33
Paper Billing Tab.....	35
Services.....	36
Entering a new rate Series based on Existing Rate Series	39
Autism Services in the Rate File.....	41
Advanced Rate Topics	44
Session Scans Associated with Rate Changes	44
HIPAA Electronic Billing Setup: HIPAA Tabs	45
270 Tab.....	47
Program-specific Billing Codes.....	49
Clients	52
Introduction	52
Basic Client Information.....	54
Closed vs. Open Clients	54
Client Information	54
Entering a New Client and Avoiding Duplicates.....	54
Other Basic Client Information	55
DPH Referrals	56
Subsequent Referrals	58
Other Client Information Fields	58
Assessment totals	61
Providers Tab	62
Waivers.....	63
Aliases	64
Client Coverages.....	65
Introduction to Coverages	65
Coverage Company Information Tab	68
Insured Information Tab.....	70
Group / Note Tab.....	70
Client Authorizations.....	76
Special cases for Medicaid RID/MMIS and PCC changes.....	78
Autism Coverage and Authorization Issues	79
Rate File Considerations.....	79
Client-level Considerations	82
Coverage Scans.....	85
Add Sessions	91
Introduction to EI Session Entry.....	91
Navigation, Editing, and Printing During Session Entry	96
Discussion and Examples	97
SSP Claim Processing	99
Introduction	99
Setting the SSP Claim Approach.....	100
Convert SSP Spreadsheet.....	101
SSP Claim Load (NO EOP Approach)	103
Prepare SSP Claims	104
SSP Session Entry.....	106
EOP Approach to SSP Claims	108
Convert SSP Spreadsheet (EOP Approach).....	108

SSP Claim Load (EOP Approach)	109
Prepare SSP Claims (EOP Approach)	111
Session Entry (EOP Approach)	114
EOP – Explanation of Payments	117

Edit Events 122

Introduction	122
Selecting Records to Edit	122
Editing Records	123
Marking Claims for SDR Resubmission	124
Marking Claims for Billing Resubmission	124
Editing Session Discipline and Other Fields	124

Add Pay, Transfer, Adjustment 126

Introduction	126
PTA Screen for Manual Entry	126
Pay	130
Cash Transfer	131
Session Transfer	132
Adjustments	133
Secondary Billing	134
PTA Batch Pay	135
PTA Batch Transfer	137
Deleting New PTA Records	140
Review, Abandon, Save PTA Run	141
Discussion and Examples	142

Other Data Forms 143

PCC Information	143
Documentation Log	143

Reports 145

Aged Receivables	145
Event Reports	147
Reports Tab	147
Event Reports Conditions Tab	150
More Conditions Tab	153
Run Report Tab	154
Event Browse	155
Special Event Reports	156
End of month troubleshooting	157
Unbilled Sessions Report	157
End of Month Reconciliation Reports	159
Service and Claim Series Reports	163
Services by service type and provider	164
Recreate Session Entry Report	165
DPH Line Status by Program	165
DPH Changed Line Status Reports	166
Single Event History Report	167
Two Stage Report	167
Special Balance Report	169
Billed Events with No Remit Information	169
Copay, Deductable Analysis	170

EIPP Planning Reports	171
Archived Events.....	172
Sorted Event Reports	173
Clients / Coverages Reports.....	175
Client Reports Tab.....	175
Client Report Run Report Tab.....	181
Special Client / Coverage Reports	182
Assessment Dates and Hours.....	183
Eligibility Reports	184
Referring Provider NPI Check	185
Coverage Addendum Reports.....	185
Client Lists Based On Sessions	186
Coverages with Blank Employer.....	186
Client Average SSP Hours Per Week.....	186
Weekly SSP Coverage Reports	188
Client Provider Assignment Reports	190
Provider Reports	191
EI Program Director Reports	191
Rates	194
Runs.....	195
Off-Site Reports.....	197
Download History.....	197
Report Manager	197
Documentation Log Reports.....	198

Bills **202**

Introduction	202
General Bills	202
General Bills.....	204
DPH Bill	212
Step 1	213
Step 2.....	214
Step 3.....	214
DPH Paper Bill / Credit Report	216
Documentation Run	218
Off Site Bill	219
Off Site Disk Recovery.....	221

SDR **222**

Introduction	222
Service Delivery Report.....	222
Discussion and Examples	225
SDR Reports	228
SDR Edit.....	229
Clear SDR Resubmissions	235

HIPAA Remits **237**

HIPAA ERA - 835 Remittance File Processing	237
Special AUTO Pay Checkboxes.....	238
HIPAA Remit Run Reports	239
HIPAA ERA File Management	246
Run 835 Remit Files In Order	247
What an 835 file looks like.....	248
HIPAA ERA Batch Pay.....	250

New Pay Records	253
New Adjustment Records	253
New Transfer Records	253
Partially paid claims with non-DPH secondary coverage.....	254
Skipped payment to avoid overpay	254
Zero Pay, No Transfer, Non-zero balance events	254
HIPAA ERA Reports.....	256

DPH Remits 258

DPH ERA Update (Remittance File Processing).....	258
Special "Force update" and "Repeat run" checkboxes.....	260
DPH Remit Reports.....	260
DPH ERA Batch Payment	263
Select PV by Pending Batch Pay	264
Select PV by ERA Run.....	265
DPH Batch Pay Reports	266
Discussion: DPH Credit handling.....	267
How to Delete a Batch Payment Run	267
DPH ERA Reports	269
Discussion	271

Admin 273

Security.....	273
Password Reset.....	274
Adding / Deleting Users	274
Errors	274
Nonrecoverable Errors.....	274
Runtime Errors	274
Creating ThomBillerErrors.zip File for Technical Support	275

Utility 276

DPH Billed To Codes	276
DPH Error Codes	276
DPH Reason Codes.....	276
Provider Activity Codes.....	277
Clear Session Holds	278
Archive	279
Restore Archive	281
Update / Repair Tables	282
Command Line	282
Miscellaneous Utilities	283

Topics 286

EI Partnership Program.....	286
EIPP Clients	287
EIPP Services	288
EIPP Bills	289
Provider Productivity Dashboard.....	289

Thom Eligibility Checks 296

Introduction	296
Mapping files	296

Eligibility Reports.....	297
Managing the Payer ID lookup table	302

Introduction

Welcome

Welcome to the Thom Practice Management System, "Thom Biller" for short – a comprehensive package for tracking and processing Early Intervention services.

This *User's Guide* is your main reference for using the software. It is available both in a printable document format and two computerized versions. The computerized versions are automatically available as “pop-up” context specific help.

Additional support is available by phone according to yearly support packages.

This is version 18.01d (Jan 2018) of the User's Guide.

Why Choose the Thom Biller

Thom Biller offers the following highly customized features for supporting Early Intervention services:

- Automated production of all Early Intervention paper and electronic bills
- A complete audit trail for all service delivery events, receipts, adjustments with full aging reports
- Complete history tracking of all billing runs
- Automated processing of DPH, Medicaid, Tufts, and Blue Cross remittance files
- Multi-user shared data across a network
- Off-site / Base setup for distributed data entry with centralized billing and accounting
- Proven training and ongoing support services

Installation

System Requirements

The following hardware and operating system components are needed for the Thom Biller. The minimum and recommended levels are indicated in the chart and discussed below:

Component	Minimum	Recommended
CPU	Single core	Dual core
Ram	2 GB	3 GB+
Hard disk free space	2 GB	5 GB +
Operating system	Win 7, Win 10	Win 7, Win 10
Windows printer	Inkjet	Laser
Dot matrix printer	optional	optional
CD-ROM drive	optional	optional
Automatic backup	required	required
Fast Internet access	required	required
Network throughput	80 Mbs	200 Mbs

The Thom Biller software uses standard Windows printing capabilities for all print jobs. You will select the printer for a print job from Window's list of installed printers. Most reports are formatted for Courier True Type fonts, which will print well on inkjet or laser printers. The dot matrix printer is used mainly for multipart billing runs. Although laser printers cost slightly more to purchase, their actual price per page is often much less than an ink jet and are therefore more cost effective over time. Printers may be local or used across a network.

Internet access is required for technical support to allow Thom support staff to look directly at any issues on your system by remote control and collaborate with you on solutions.

The free disk space numbers are approximate. Your actual needs will vary depending on the size of your program. The software can retain as many years of data as you desire, so the files can become quite large. Plenty of free space also speeds up many of the procedures.

Even if installed on a large network file server, the individual workstations will need at least 2GB and preferably 5GB of free hard disk space for temporary files created by the application. Running out of space can cause serious data corruption. Given the low price of hard drive space, these requirements should be easily met.

Thom Biller is fully multi-user, network compatible. If installed on a network, the data files are stored on the server and each workstation receives a copy of the executable software. The network must have 100Mbps speed and a suitable file server, along with reliable backup on tape or some other media that can be rotated daily, weekly, and monthly. 1 Gbit switches may be needed when more than 3 users are doing data intensive tasks simultaneously. There is a 50MB test file available on our website for testing your network throughput. It should take less than 5 seconds to copy this from a workstation to the network file server where the Thom Biller data resides (80 Mbs); a 2 second copy speed is even better (200 Mbs).

There is no additional database server software to purchase or maintain. The server functions only as a file server, so any server OS will be satisfactory. The only requirement is that the individual users have full read/write privileges to the Thom data folder on the server. This must be set in their Windows login permissions.

The actual amount of data needing to be backed up is somewhat smaller than the free disk space requirements (usually a third as much). We have found that a representative program that sees 100 clients per month will have databases totaling about 30 MB for each year of services. So if your program sees about 300 clients per month, and you are interested in how large your database files will be in 3 years, it would be $30 \text{ MB}/100 \text{ client years} * 300 \text{ clients} * 3 \text{ years} = 270\text{MB}$. This would be the amount of data you would need to be backing up after three years of operation. The data files do continue to grow over time, with archive tables being stored along side the active tables. Separate daily, weekly, and monthly backup versions must be maintained. So if a data restore is required, it should be possible to restore to any day in the previous week, or at a 1, 2, or 3 week interval, or a month ago.

Installation Steps

Single user installation

1. Run the SETUP program from the custom installation CD provided to you.
2. Accept the default home directory of C:\TPAI (or C:\TPAIOS for off-site configurations). **Do not change the default home directory.**
3. The user must have full read/write privileges to this local home folder and its subfolders.
4. Setup will copy the STPA.EXE executable program into the home directory along with a few other files. It will also install Visual FoxPro runtime modules on your system.
5. Setup will create a DATA\ subdirectory under the home directory, which will contain all the actual data files for your program.
6. Under Window's Explorer, look at the home directory (C:\TPAI or C:\TPAIOS for off-sites). Locate the shortcut named "Thom Biller Billing" and drag it to

your desktop as a way to run the Thom Biller software. (Feel free to rename it if you like).

7. Install the Generic: Text Only printer. Go to the Windows Start Button, select Settings / Printer, and use the Add Printer Wizard to do this. Locate Generic brand and choose Text Only printer. Install it. (This is used for HCFA forms.)

Multi-user installation

- Please refer to the most recent instructions for detailed network installations. In general, network installations require the program and Visual FoxPro Runtime modules to be installed on each workstation. The data is installed on your network file server, and each workstation is configured to "look" on the server for the data. The server functions simply as a file server and all the actual software runs on the workstation. Users must have full read/write privileges to both the local home folder (e.g., c:\tpai) and the network data\ and updates\ folders.
- The server also houses a program \updates folder that holds current versions of the program. Each workstation automatically checks this folder before it runs the program, and will automatically retrieve any new program updates it finds there. Updates therefore propagate automatically to all workstations, eliminating manual installation of updates across your network.
- The network must be a local area network with at least 100 Mbps speed, with higher speeds significantly improving the application speed. Visual FoxPro does not require any server software (such as SQL Server) or server configuration expertise, because it has its own database engine.

Getting Started

The Importance of Exiting Cleanly

Before entering any data in the Thom Biller, you must understand how to exit!

You must close all windows and exit the Thom Biller by the File – Exit Main Menu choice or close box on the Main window. This assures that all data is written to any open tables before it is lost.

Never turn off the computer or restart it with any forms open. This can seriously damage the tables and corrupt the data they contain.

If the computer “crashes” or freezes irrevocably during operation of the Practice Management software, **DO NOT TURN OFF THE COMPUTER**. If the screen is “frozen”, try “ending the task” by pressing the Alt+Ctrl+Del keys together. It sometimes takes a minute or two for the computer to offer you choice to “End Task”. When this comes up, choose it and the Thom Biller software should be shut down. At this point, restart the computer from the “Start” button on the task bar. Re-run the Thom Biller software and run a file integrity check immediately to test for corruption. Also check that recently entered data was actually saved to disk.

The Importance of Backing Up

The Value of your Data

You have invested a great deal of time and energy in creating the data stored in the Thom Biller System. Your agency’s billing (and capacity to meet payroll!) depends on it. Think of how long it would take to re-enter several years of data by hand. You know your data must be protected.

The Vulnerability of Databases

What you may not know is how vulnerable database tables are to corruption caused by a power failure or disk drive failure. A table is a highly ordered sequence of records, with the position of each piece of information critical to its being understood. If one character is

misplaced in the middle of a table (perhaps in a session record from a couple years ago), it can cause all the following records to be unreadable. This is unlike a word processing file in which a missing character would simply cause the specific affected word to be nonsensical; all later words, paragraphs, and pages would still be okay. So a tiny error in a database table can cause huge and disastrous results.

Backup Requirements

For all these reasons, you must have a systematic and reliable procedure for backing up the data.

We require the following backup procedures as a minimum:

- Use an automatic tape or internet backup service, or writeable CD configured for easy, “one click” activation.
- Backup all data each day on a separate disk or tape. Have a Monday, Tuesday, Wednesday, Thursday, and Friday version.
- Make a separate weekly backup of all data.
- Keep a separate monthly backup of all data with the most recent month stored in a different location from the computer to guard against fire and theft risk.
- Make sure you know how to restore from your backup and you have tested this procedure on practice data.

This backup regime may seem like “overkill” but the reason is to make sure you don’t backup corrupted data over good data. You may not know your data is corrupted for several days or weeks after the corruption occurred. If you have infrequent backups, or frequent backups on the same tape or disk, you will soon have copies of the corrupted data and no remaining good backups. If you have a separate disk for each day, then if you find on Friday, that the data was damaged on Wednesday, you can go to the Tuesday disk and restore it. If you only use one disk, your backup would have corrupted data.

If you are using Thom Biller on a network server, you probably already have a backup regime. Please make sure it includes Thom Biller files and has the same features as those recommended above, especially rotating media and off-site storage of some copies.

Getting Started

Whether you have imported data or are starting from scratch, you confirm or complete each of these steps to get your software configured and running.

User Security

You will have an initial login to run Thom Biller. You should immediately change the one user record to match your own information:

You should change the default record to make it your own, for example:

The screenshot shows a window titled "Users" with the following fields and values:

- ID: ltucker
- First: Larry
- Middle: (empty)
- Last: Tucker
- Temporary Password: temp
- Last Change: 10/08/2005
- User Security Level: B
- Currently Logged In:

A text box on the right side of the window contains the following instructions: "Enter a letter to let this user manage User Accounts and Passwords. Leave blank to prevent this user from accessing User Accounts. Enter 'B' to manage all users. Enter 'C' or".

You can use any scheme you want for creating User IDs, but just be consistent in your approach within your agency. The ID and Password fields are cap-sensitive.

The Temporary Password will be reset by the user at their first login.

Enter a User Security Level of "B" (the highest) for anyone who will be managing the Users list; enter "C" for everyone else.

Go ahead and create new User records for all Thom Biller users in your agency. For each one, enter an ID, their names, and a temporary password.

Basic Activities

Introduction

This section introduces you to the various menus and control bars used to locate information and move between different records. It also offers an overview to the entry of essential rate, provider, client, and session information. Finally, it introduces reports.

Key Windows Concepts

Forms

Most tasks are accomplished on a customized form (or “screen”) that will be presented in a window. For example, there is a Session Entry form designed specifically for that task. Similarly, there is a Client Data form that contains client, coverage, and authorization information all on a single form.

Forms are “run” by selecting them from the Main Menu. This opens a window and runs the form within it.

In most cases, more than one window can be open at once, and you are allowed to click back and forth between open windows. For example, you may be adding sessions and decide you need to look at the client’s coverage, so you open the Client screen, click on it, make necessary changes, and click back to your Add Sessions task.

In some cases, forms will not allow you to click on any other window. This restriction is intentional and is usually because the task at hand must be completed before moving to another one. Most messages that require acknowledgment are “modal” forms such as this. Another example is the receipt entry process, which requires that you complete an entry before selecting another client’s records to consider.

Navigating the Active Form

When you click on a form, it becomes “active.” The main menu and toolbar apply to the active form. If you click on another form, the toolbar navigation controls now apply to that form. So in the earlier example, if you are adding sessions, the navigation buttons will move you through the list of new sessions you have created. If you then open the client form, the same navigation buttons will now move you between client records. The main menu and toolbar sense which form is active and act on it.

Key Database Concepts

The Thom Biller is a built using “Relational Database” principles. Data is stored in files or “tables” that are custom designed for the specific data being stored. Each table has a different structure to organize and retain its specific information. For example, there is an Event table for storing all sessions, receipts, and adjustments; there is a Client table for storing client information, and so forth.

Record

Each new piece of information stored in a table is stored on a “record.” There is one record per event in the event table (one record per session, one record per receipt, etc.) There is one record per client in the client table. The tables in the Thom Biller have no significant limit to the number of records they can contain. The practical limits have more to do with the speed of processing so many records and there is an archiving process for removing some records when no longer needed.

Field

Within a record, the different pieces of information are stored on “fields.” For example, there is a field on the event record that stores the session date, one for the billed hours, one for the fee, and so forth. Similarly, on a client record, there are fields for the client last name, first name, DPHID, and so forth.

A single table can therefore be viewed as similar to a spreadsheet, with the columns representing different fields, and the rows representing different records. Each cell is therefore one column on a single row. When you add or delete a record, you are adding or deleting one row in the table. Although you cannot change the fields (add a column for instance), you can change the information in each cell or field.

Related tables

The tables are “related” as a way of further organizing the information and reducing redundancy. For example, each event record simply stores the client ID of the client for whom the service was provide, not all the client’s information (such as name, dob, etc.). These special linking fields are called “keys.” They are maintained automatically by the system and checked by the File Integrity Test process.

Indexes

A process called “indexing” also sorts tables. Various indexes are constantly maintained to present the data in useful order. For example, the client table has indexes to show the clients in order by name or DPHID. Sometimes indexes need to be rebuilt by the Reindex routine.

Corruption

Tables must be closed in an orderly fashion so that all fields, keys, and indexes are securely saved. This happens automatically when you close windows and exit the overall program from the main menu. Simply shutting off the computer, or rebooting it, is not acceptable and will damage you data. When tables are corrupted by power, network, or drive failures, the information is often shifted into incorrect fields, records may be lost, and links between files may be broken.

Data Protection

To protect your data remember to:

- Always close windows and exit using the main menu
- Never simply shut off the computer when a form the application is running
- Use a battery backup power supply (APS) in case of power failures
- Do separate daily, weekly, and monthly backups

Main Menu

The main Thom Biller screen looks like this, with a menu across the top.



The main menu is organized into the following categories:

- File: setting printer defaults, file re-indexing and integrity checks, overall exit of the application
- Edit: record specific functions such as adding, editing, reverting changes to a single record
- View: navigation within a form
- Data: specific forms for data entry and editing, including adding sessions, clients, and so forth
- Reports: reports on paper of events, clients, providers, etc. that do not alter the data in any way
- Bills: specifically formatted reports on billing forms or disk which also mark sessions as having been billed. Remit processing is also located here.
- Admin: security, error reports, system set up options

- Utility: miscellaneous utilities including backup, archiving, data conversion
- Window: select between currently active windows
- Help

Many of the navigation functions offered by the Edit and View menus are duplicated by the Main Toolbar discussed below.

Main Menu Configurations

There are three setup configurations for the Thom Biller:

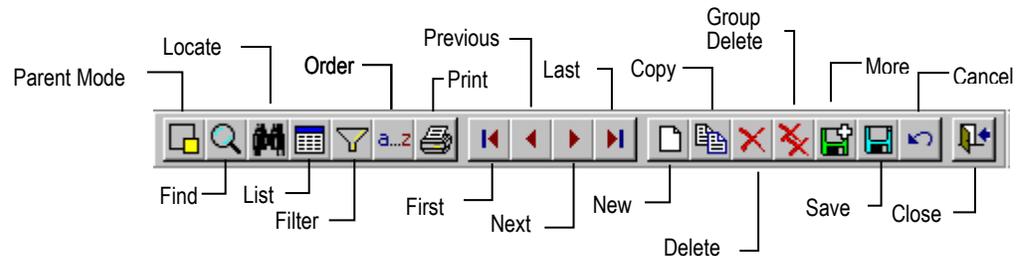
- Stand Alone
- Off-site
- Base

Each has a slightly different Main Menu to address different needs. The Stand Alone configuration is for a single EI program; the Off-site and Base setups are for EI programs with several satellite offices sending data to a single (base) office. The Base setup therefore has a Download Off-site Data option that the Stand Alone does not. The Off-site Main Menu does not offer all the billing choices of the other two and instead offers download and disk recovery options.

Toolbar Controls

The Toolbar provides controls that let you view and manage the data in the Thom Biller tables.

Toolbar controls let you navigate through the records, search for records, change the record order, add records, delete records and save changes to records. The control buttons have pictures, or icons, that represent their functions. The Form Toolbar controls are shown below.



The next two pages provide brief descriptions of each Form Toolbar control. The Find, Locate, Filter, Order, and Group Delete controls are described in more detail in following sections.

Editing Data

When a form is activated, you may enter changes directly into the fields on the form. You click the Save button on the toolbar to save your changes. If you try to leave the current record without saving your changes, the program prompts you to save your changes.

Toolbar Menu Options

The Edit and View menus contain options for each Form Toolbar control. Toolbar controls that change data are on the Edit menu. Toolbar controls that help you navigate among data are on the View menu.

The Edit and View menus display shortcut keys you can use to select a Toolbar control instead of clicking it with your mouse. The shortcut keys are listed in the *Using the Thom Biller* chapter.

Toolbar Controls

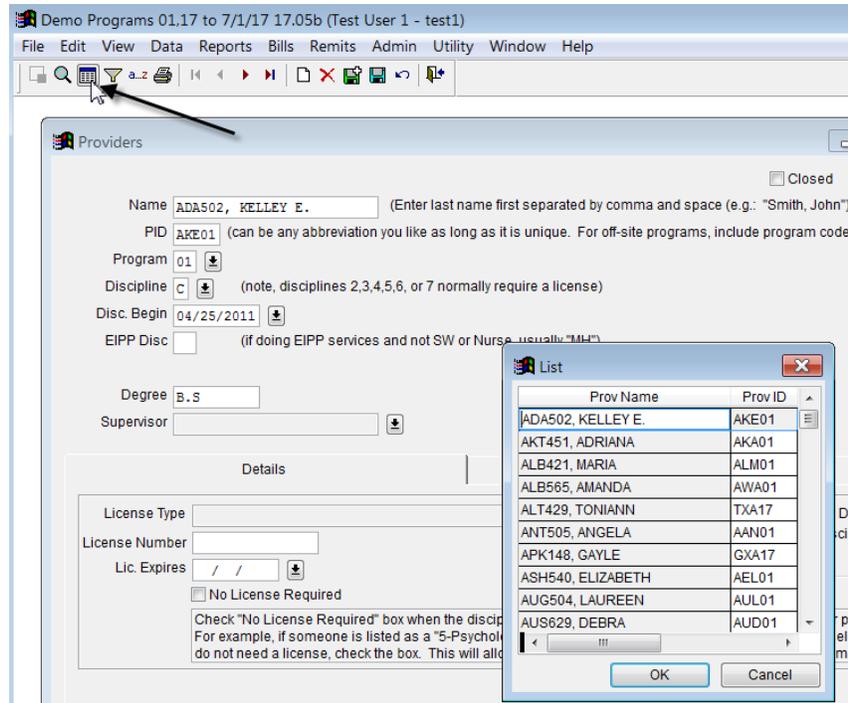
Picture	Control	Purpose
<p style="text-align: center;"><u>Record Selection Controls:</u></p>		
	Order	Lists the table's index tag descriptions for selecting the record display order.
<p style="text-align: center;"><u>Navigation Controls:</u></p>		
	Find	Brings up the Find dialog for finding a record using the table's primary key or the current Order index key. If a partial key is entered, all records matching the partial key are displayed in a Browse for user selection.
	List	Provides a pick list grid with incremental search and sortable columns for finding records quickly and easily (see example below). This is the preferred way of locating a record.
	First	Displays the first record in a table as defined by the record Order and Filter.
	Prior	Displays the previous record in a table as defined by the record Order and Filter.
	Next	Displays the next record in a table as defined by the record Order and Filter.
	Last	Displays the last record in a table as defined by the record Order and Filter.
	Print	Prints (or previews) a report appropriate to the active form.

Toolbar Controls

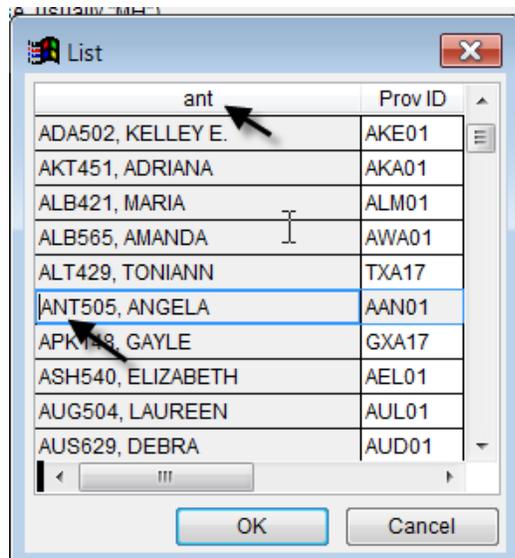
Control	Purpose
<u>Data Update Controls:</u>	You use data update controls to maintain the data in a table. As you update the data, a record of the update is entered in the Audit Trail if the Audit Trail tool is on.
	New Displays blank form fields for adding a record to a table. If the form is a child in a Related Forms group, the primary key fields in the parent record are automatically entered into the foreign key fields of the new child record.
	Delete Deletes the current record from the table. Relational Integrity is enforced, meaning a parent record cannot be deleted with existing child records.
	More After entering a new record, clicking the More control saves the record and adds a new blank record.
	Save Saves data entered while adding, Copying or editing a record and ends the add or Copy.
	Cancel Cancels data entries and changes made while Adding, Copying or editing a record and terminates the Add or Copy.
	Close Closes the form.

Locating a Record: List Button

The List Button is the preferred way to locate records and navigate within a table.



The List grid offers incremental search. Just start typing and it will jump to the first match.



In this example, we typed "ant" and it jumped to the ANT505 record.

Clicking on a column header will usually change the sort to that column.

Some list buttons will have several columns that can be searched. Click on any column and try typing to see if that is searchable. For example, the List for Clients

Data Entry

Introduction

The following sections will walk you through, in detail, how to setup and maintain all of the client, event, insurance, provider, and agency records necessary for the processes of Early Intervention billing and practice management. Most screens are reviewed on a field-by-field basis, with explanations given for all but those that are completely self-evident.

For Users

Throughout the data entry screens, some features appear repeatedly and are defined below instead of on a screen-by-screen basis. They are:

- **Note Fields:** Limitless note fields are included on most forms. Any relevant information can be recorded for future reference.
- **Quick Session Reports:** These appear on client, coverage, and session forms. They give you quick access to a report of a client's claims. If accessed from the client record or session form, they will include all claims. When accessed from a coverage record, claims will be limited to that insurer.
- **Print button (on the toolbar):** This will normally preview or print the record that you are currently looking at. Use this for a hard copy, or complete view of the record.
- **Print Setup buttons:** These allow you to redirect and/or reformat printer output. Select the correct printer, orientation, and paper.
- **Toggle between including/excluding closed clients:** Most data entry popup client lists exclude closed clients. However, there will be times when you need to post cash receipts, edit sessions, etc. for a closed client. In order to access this data, use the toggle button to include closed client names.
- **Date fields appear throughout the system.** It is only necessary to enter the last 2 digits of the year. Once you hit return, the system will fill 19 or 20. If these are not filling correctly, check the rollover settings in the Admin/Environment menu.

For Managers and Users

As users enter data in the Thom Biller, it will be helpful to keep the following in mind:

- An attempt is made to distinguish between fields that are required for billing and collections purposes, versus fields that are optional from a billing perspective but may be useful for management purposes. Program management should determine which of these optional fields they want completed.
- In the creation of the system and manual, we have tried to anticipate the most common practices, and to set defaults and offer examples accordingly. However, Early Intervention practice management is defined and deployed differently by each program. Management and administrators must establish their own procedures and policies around data collection, entry, audit documentation, etc.
- Warnings appear throughout the system to help keep users from entering data that contradicts the rules of DPH, Medicaid, or 3rd party payers. However, they are by no means exhaustive, nor do they eliminate the need for the user to actively evaluate their work and make educated decisions.
- Repeated references are made to “DPH required” fields. This means that DPH requires the data field in question to be filled, and has probably defined the acceptable responses. Failure to correctly complete DPH required fields will result in fatal errors when validating your monthly billing file on the website.
- Lastly, in documenting Early Intervention billing software, we inevitably refer to the guidelines promulgated by the Department of Public Health. While this guide sometimes offers general interpretations of data fields and expectations, it by no means provides a comprehensive explanation of these guidelines. It is each program’s responsibility to learn the rules and regulations of the DPH, and to assure that all clinical and administrative staff operate accordingly.

Types of Event Records

Before reviewing the different screens, it is important to understand the information carried on each event record and the different types of event record.

Each event record has fields for fee, pay, and balance amounts. These fields appear as columns in most event reports. Only one record per claim carries the claim balance so this field blank for all other events associated with the claim. A fee amount indicates a charge, credit, or loss. A pay amount indicates an amount actually received or an adjustment to an amount received. The sum of all fee and pay amounts for a claim equal its balance.

“Event” records are so named because there is one entry for each accounting event that affects a claim:

- A **SERV** record is entered to start a claim and describe the original service that occurred. It includes information about the billing, the hours, the fee, and it carries a running balance for the claim. It also is used to print the original bill and complete the Service Delivery Report. By definition, a SERV record must have a positive fee amount that is used as the original claim balance.
- A **PAY** record is entered when a payment comes in for a claim. It carries information about the amount of payment and it alters the claim balance. By

definition, PAY records show a positive pay amount that lowers the claim balance when entered.

- A **TRANS** record is entered when an amount is transferred from one billing type to another. TRANS records always come in pairs and they always involve a negative and positive FEE amount. The negative FEE record reduces the claim balance in original billing type and the positive FEE record pair increase the claim balance in the target billing type.
- An **ADJ-F** record is a fee adjustment. It is used to correct a claim balance by increasing or decreasing the FEE amount charged. A positive ADJ-F increases the balance by increasing the total fee; a negative FEE adjustment lowers the balance.
- An **ADJ-P** record is a pay adjustment. It is used to correct a claim balance by increasing or decreasing the PAY amount that has been received for a claim. A positive ADJ-P record lowers the claim balance by showing that more money has been received for a claim; a negative ADJ-P record increases the claim balance by showing that less money has been received for a claim.

The following example demonstrates the different event types in action:

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.0	65.00	00.00	5.00
PAY	BCB			60.00	

Here you see a 65.00 BCB session was partially paid (60.00), leaving a balance of 5.00 for the claim. You will note that the PAY record does not carry a balance itself; it altered the balance on the SERV record from 65.00 to 5.00.

Additional activity on this claim is shown below:

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.00	65.00		0.00
PAY	BCB			60.00	
TRANS	BCB	-1.00	-5.00		
TRANS	DPH	1.00	5.00		5.00

Here we have transferred the 5.00 balance from BCB to DPH. Notice that the original claim balance under BCB is now 0.00, and a DPH claim balance has been started on the TRANS event under DPH. This illustrates how claim balances are carried either on an original SERV event, or on the first TRANS event of a new billing type. It also illustrates how a single service can become more than one “claim”. In this case we would describe this as a single SERV series of records (all reflect activity on a single service) that now involves two different “claims”: one for BCB and one for DPH.

Let's continue the example and have DPH pay their amount, zeroing out the DPH claim balance:

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.00	65.00		0.00
PAY	BCB			60.00	
TRANS	BCB	-1.00	-5.00		
TRANS	DPH	1.00	5.00		0.00
PAY	DPH			5.00	

But what if BCB comes through with a late payment of the \$5.00 they had originally denied? We have to do this in two steps. First transfer the balance back to BCB.

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.00	65.00		5.00
PAY	BCB			60.00	
TRANS	BCB	-1.00	-5.00		
TRANS	DPH	1.00	5.00		-5.00
PAY	DPH			5.00	
TRANS	DPH	1.00	-5.00		
TRANS	BCB	1.00	5.00		

Note that the transfer back to DPH used to be called a "back transfer" (BTRANS) event in the old DOS system; now it is simply another TRANS. Also note that it did not carry a balance, but it restored the balance on the SERV record.

Next enter the late BCB payment, which zeros out the BCB balance:

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.00	65.00		0.00
PAY	BCB			60.00	
TRANS	BCB	-1.00	-5.00		
TRANS	DPH	1.00	5.00		-5.00
PAY	DPH			5.00	
TRANS	DPH	1.00	-5.00		
TRANS	BCB	1.00	5.00		
PAY	BCB			5.00	

The BCB process is now complete, but there is a credit (negative balance) under DPH. This will be reported on the next SDR to DPH as a credit. Assuming they accept the credit and take the money back off of their next payment voucher, then we would record the payment having been returned with a negative ADJ-P entry as follows:

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.00	65.00		0.00
PAY	BCB			60.00	
TRANS	BCB	-1.00	-5.00		
TRANS	DPH	1.00	5.00		0.00
PAY	DPH			5.00	
TRANS	DPH	1.00	-5.00		
TRANS	BCB	1.00	5.00		
PAY	BCB			5.00	
ADJ-P	DPH			-5.00	

Although this looks cumbersome, it correctly describes all the events associated with this service. Most reports will show these records sorted by billing type and therefore easier to understand from the perspective of a single claim (billing type).

Here is the same information sorted by billing type with subtotals added:

Type	Billing	Hours	Fee	Pay	Bal
SERV	BCB	1.00	65.00		0.00
PAY	BCB			60.00	
TRANS	BCB	-1.00	-5.00		
TRANS	BCB	1.00	5.00		
PAY	BCB			5.00	
Total			65.00	65.00	
TRANS	DPH	1.00	5.00		0.00
PAY	DPH			5.00	
TRANS	DPH	1.00	-5.00		
ADJ-P	DPH			-5.00	
Total			0.00	0.00	

Note that under BCB, the Fee column total 65.00 equals the Pay column total of payments received 65.00 and these add up to the claim balance shown on the original SERV record (0.00). The same is true under DPH.

The Pay column totals indicate how much money is actually in hand from each of the billing types. Under DPH, the -5.00 ADJ-P entry means “we actually returned 5.00 to DPH” and it left our DPH pocket empty. Note that this is not a “credit” record, it is actually a “refund” record: the money was truly refunded (returned) to DPH.

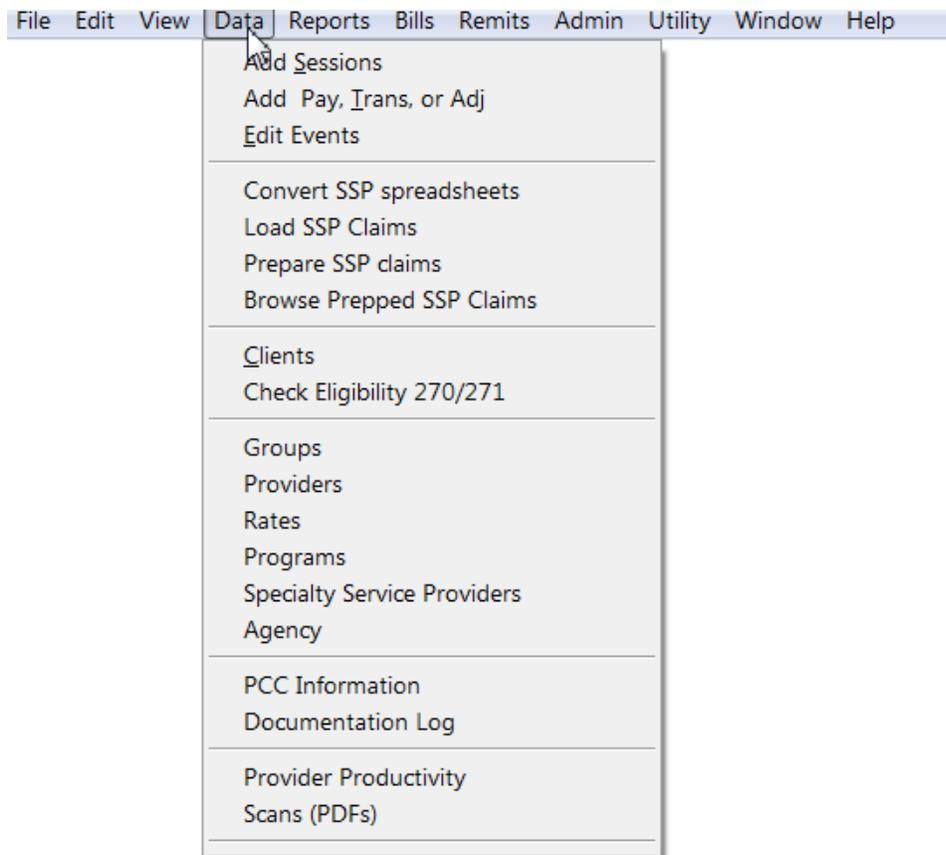
The credit record is the preceding negative FEE amount on the DPH TRANS back to BCB; this is the information actually reported to DPH as a credit on the SDR. If for some reason DPH declined to accept the credit, and did not actually take the money back on the next payment voucher, then the negative pay ADJ-P entry would not have been created and the DPH claim would continue to show a negative balance meaning money was still owed to DPH.

Preparing Your Database

You will want to work from the "top down" setting up your database: from agency level settings at the top, SSP agencies, and providers. Next enter Rate file configuration of payers and services. With these in place you can begin entering clients, coverages, and authorizations. Finally, you can enter sessions, run bills, process remits, and enter pay/transfer/adjust records. The following data entry chapters are organized in this sequence, not according to the menu options.

Data Menu

Most data (records) are managed under the Data tab on the main menu:



The following data entry discussions use forms from this menu, but the topics are addressed in the order that you would use setting up your system: more of a "top-down" approach starting with the highest level data (Agency settings) and ending up with the most detailed data (sessions and events).

Agency Data

The agency screen is shown below. It is where overall configuration and business rule settings are established. Only senior billing managers should alter these settings.

The screenshot shows the 'Agency Setup' window with the following fields and settings:

- Agency Name: [Redacted] as A. Thom Clinic
- Address: [Redacted] Central St, #22
- City / State / Zip: [Redacted] MA 01760-3758
- Phone: [Redacted] 55-5222
- Contact: [Redacted] EN REED
- Provider Signature: [Redacted] EN ROWE
- Fed Tax ID: [Redacted] 268 (prints on paper HCFA bills, not HIPAA electronic ones)
- NPI: [Redacted] 1820
- Taxonomy Code: [Redacted] QD1600X

Settings

- Exit after re-indexing
- Show Provider Hr field during session entry
- Limit session scans to # days: 90
- Business days to recover OS billing: 3
- Recovery status:
- Posting Closed: 12/10/2004
- DPH Fee Report Begin: 01/11/2012
- Offer Transition Group
- Use Alternate Session Entry Field Order
- Auto Archive (base and standalone only)
- Last Archive: 06/14/2017
- Days since last session to autoclose providers (leave 0 for no provider autoclose):

Other

SSP Settings —(base and standalone only)

- No EOPs / One CSV at a time
- Check this if you want to deal with only one SSP spreadsheet at a time and treat the spreadsheet as a single invoice. You will not be able to print EOPs and you will not be able to track SSP claims separately from the sessions you enter.
- Off Site SSP Load (base only)
- If either No EOP or Off Site Load selected, claim prep will not reject claims.
- Enforce Hard SSP Rules (30 hrs max per week)
- Enforce SSP Service Rate Rules
- SSP Filling Limit (days): 60
- Require Correct SSP Payer
- Require Correct Hr. Increment
- Lock SSP Billed Hr
- Lock SSP Service
- Lock SSP Procedure Code

Buttons: OK, Cancel. Sys_id Prefix: 90

The screenshot shows the 'Settings' and 'Other' tabs of the Agency Setup window:

Settings

- Program Category: EI
- Automatic assessment tally rollover
- Automatic eligibility check of selected payors
- Test License Expires Date
- Check Balance Integrity At Startup
- Test First IFSP Date during session entry
- Allowed Hours Before IFSP: 0

Other

Default Text for Claim Review Other and Comment Fields

- Claim Review Other: 2016 Early Intervention Emergency Rate Increase Effective 03/01/2016
- Claim Review Comment: As you may aware, there is an emergency rate increase by the State for Early Intervention services effective 03/01/2016. As a result, please find attached a corrected claim rebilled with the new rates. Please reprocess this claim and thank you for cooperation.

This screen stores some basic information about your agency all payers require that, and that will print on claim forms. Enter the **Agency Name** and **Address** where you would like all

explanations of benefit sent. Typically, this is the vendor agency to which a provider number has been issued. Enter a **Phone** number that will assist carriers in reaching the appropriate person should they have questions on your claims. **Provider Signature** is typically filled with the name of an executive officer, program director, or billing coordinator.

The Federal Tax ID field is used on HCFA paper bills.

The NPI is used on paper and electronic bills, unless overwritten at the billing type level within the rate file.

The Taxonomy code is used on HIPAA electronic bills.

Show provider hr field during session entry enables the provider hour field on that form. Tracking provider hours is optional and at the discretion of the agency.

The **Automatic assessment tally rollover** feature, if checked and activated, will update the Current year Assessment total date in each client's record at the appropriate time. Each day when you open your billing software for the 1st time, the system will review all Current year assessment dates, and automatically advance any which fall between 12 and 24 months ago. For example, if you open your software May 15, 2000 and have activated the assessment tally rollover feature, the system will find all current year assessment dates from May 15, 1998 through May 15, 1999 and advance them to May 15, 2000.

Enable **automatic EVS checking** here.

Enable **exit after re-indexing** if you want the system to close automatically when it has finished re-indexing.

Limit session scans to number days is the suggested default number of days that will be considered when you change a client's coverage.

Business days to recover OS billing is set by base systems to remind off-sites to do their disk recovery runs after a billing within the specified number of days. **Recovery status** is set to "P" when a disk recovery is pending and needs to be run.

Test License Expires Date turns this feature on during session entry to make sure provider licenses have not expired.

Check balance integrity at startup causes a quick check of balance problems within recently modified claims.

DPH Fee Report Begin date sets the first starting date for these reports.

Offer Transition Group sets whether these are offered during session entry.

Use Alternate Session Entry Field Order determines whether the SETTING and PLACE fields should follow the service type during session entry.

Posting Closed is a date that prevents entry of posting dates on or before this date. Where the Posting Plan determines the latest posting date you can enter at a given moment, Posting Closed sets the earliest boundary. It is the latest date that has been closed and therefore a day before the earliest allowable posting date.

SSP Settings

No EOP / One CSV at a time: this turns off individual adjudication of SSP claim lines (ACCEPT, REJECT) and the production of a Explanation of Payment (EOP). Instead, it allows SSP spreadsheets (CSVs) to be treated one at a time as individual invoices. This is a major system decision. See later discussion of SSP claim handling for details.

Off-site SSP Load: choose this if you are not running EOPs and you have off-site programs that will be loading SSP spreadsheets.

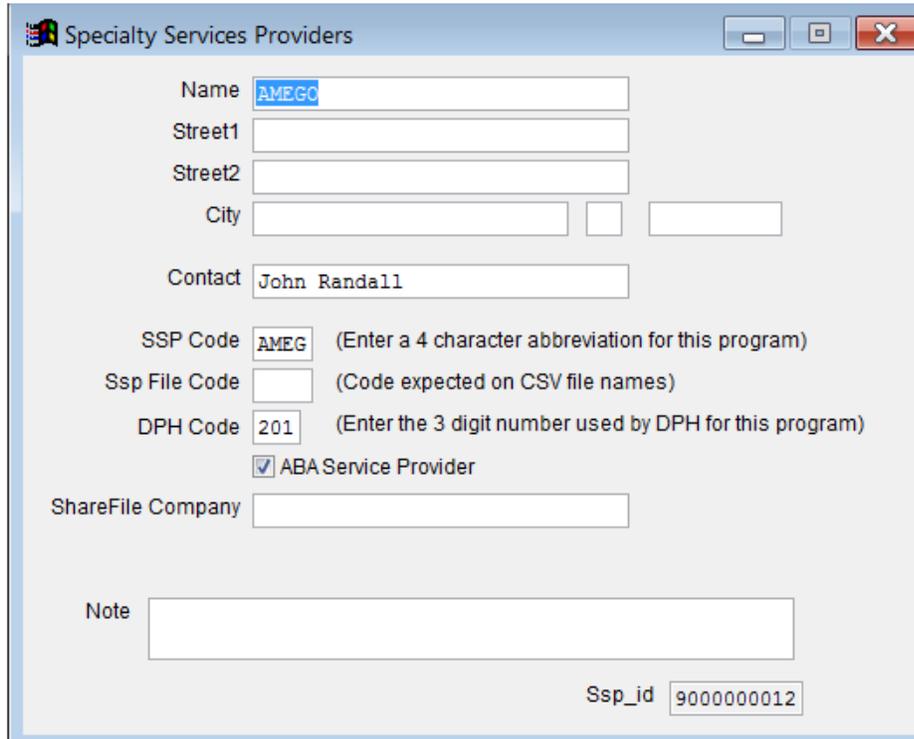
Enforce Hard SSP rules: will make it impossible to save more than 30 hours per week or 3 hours per session of autism SSP services during session entry.

SSP Filing limit: When using EOPs, this will automatically reject claims that are over X days.

The "Lock" and "Require" checkboxes under SSP settings control whether session fields must match the equivalent values on the imported SSP claim records. For the "Lock" options, these require the billed hours, service, and procedure codes to match during session entry. The "Require" correct SSP Payer means the value on the spreadsheet must be correct for the client and date of service; the same is true for requiring the correct hour increment (quarter hour, half hour, full hour) to match the way units are reported for each payer.

Specialty Services Providers

This table contains one record per Specialty Services Provider agency:



The screenshot shows a software window titled "Specialty Services Providers" with a standard Windows-style title bar (minimize, maximize, close buttons). The form contains the following fields and controls:

- Name:
- Street1:
- Street2:
- City:
- Contact:
- SSP Code: (Enter a 4 character abbreviation for this program)
- Ssp File Code: (Code expected on CSV file names)
- DPH Code: (Enter the 3 digit number used by DPH for this program)
- ABA Service Provider
- ShareFile Company:
- Note:
- Ssp_id:

You define a 4 character code to be used in Thom Biller reports for this provider, as well as the 3 digit DPH defined number for the provider (that goes on the SDR).

The ABA Service Provider indicates whether they are, or are not, ABA providers.

Programs

Base systems will open one program record for each EI program run by your agency, while standalone and off-site systems will open a single program record.

The screenshot shows a software window titled "Programs" with a standard Windows-style title bar (minimize, maximize, close buttons). The form contains the following fields and values:

- Prg ID: 01
- Full Program Name: ANNE SULLIVAN CENTER EIP
- Facility Address 1: [REDACTED] HOENIX AVE BLDG 2
- Facility Address 2: [REDACTED]
- City / State / Zip: [REDACTED] L, MA 01852-4931
- Phone: [REDACTED] 453-8331
- Contact: [REDACTED] a Wolfe
- Area Options: [REDACTED]
- NPI: [REDACTED]
- Taxonomy: [REDACTED]
- Cms32b: [REDACTED]
- Cms33b: [REDACTED]
- Sharefile Upload Folder: AnneSullivan
- Note: [REDACTED] 7837B

At the bottom of the form, there is a button labeled "Specialized Provider Numbers" and a field labeled "sys_id" with the value "11".

Enter the DPH-assigned **Program ID**, the **Program Name**, and **Address**, **Phone**, and **Contact**. The name, address, and phone will print on claim forms to indicate the facility where center-based services were rendered.

Area Options are designed to help programs categorize their clientele, if desired. For instance, programs that enroll both EI and Developmental Day clients in their program may want to set up options of EI and DD, and then assign the appropriate abbreviation to each client in the client file. This allows reports to be produced with area subsets.

Vendor agencies managing multiple programs in one database will maintain one set of rate files. For most insurers, provider numbers are assigned to the vendor, and the same number applies to all programs. If you have insurers who have issued separate provider numbers for each of your programs (such as Medicaid), you will use the Specialized Provider Numbers button. (See Rates section for details).

Providers

Every billable provider should be entered in the Provider files.

The screenshot shows a software window titled "Providers" with a "Closed" checkbox checked. The form contains the following fields and options:

- Name:** [Redacted], ADRIANA (Enter last name first separated by comma and space (e.g.: "Smith, John"))
- PID:** AKR01 (can be any abbreviation you like as long as it is unique. For off-site programs, include program code.)
- Program:** 01
- Discipline:** Nurse (note, disciplines 2,3,4,5,6, or 7 normally require a license)
- Disc. Begin:** 01/01/2009
- EIPP Disc:** (if doing EIPP services and not SW or Nurse, usually "MH")
- Group:**
- Degree:** R.N.
- Supervisor:** [Redacted] Supervises

Below the main form are two tabs: "Details" and "Client Assignments".

Details Tab:

- License Type:** [Redacted]
- License Number:** RN149204
- Lic. Expires:** 06/25/2016
- No License Required
- Check "No License Required" box when the discipline normally needs a license but not for this particular provider. For example, if someone is listed as a "5-Psychologist" but are a "License Eligible Mental Health Counselor" and do not need a license, check the box. This will allow them to have sessions entered and will exclude them from [Redacted]

Client Assignments Tab:

- License Types Displayed:** Limit by Discipline, Show all
- SSP:** [Redacted]
- Note:** HIRE AGAIN ON 12-01-14
- Quick Event Report** button
- ID:** 1100000451

Type in the **Name**, entering last name, first name (e.g., Jones, Ann E.). When a provider no longer works in your program, you will check the **Closed** box. This will remove her from all reports of active providers, and from the popup list used during session entry. Providers are never completely deleted from the system unless they have not had any activity billed to them.

Assign a unique alpha or numeric ID to the provider in the **PID** field to be used as an abbreviation on many reports. Most programs assign the staff's initials, but some choose numeric codes that combine a unique 2-digit number with the staff's discipline. For agencies with multiple programs, it helps you use the program ID as the last 2 digits of the PID. So, a provider named Ann E. Jones employed by program number 44 would likely have a PID of AEJ44.

Use the popup list to select the appropriate **Discipline**.

The Discipline Begins date is helpful when a discipline changes and you may want to do a session scan of recent sessions to update it. (This scan would be manually done in Misc Utilities).

The **Group** field is designed to help large programs with fixed assessment teams track activity. If providers do belong to established assessment groups, assign a 2-character code to each group and enter the codes in individual provider records. This will allow you to run assessment tracking reports based on each group's clients and activity. If your program does not have assigned groups, skip this field.

Degree, License, and License Expired are optional fields. Some insurers request provider degree and license information upon claims receipt, so it can be useful to store this data in the computer. Recording license expiration dates also helps management track the currency of staff credentials. It will also be tested during session entry and you will be warned if you are entering a session that is after a provider's license expiration.

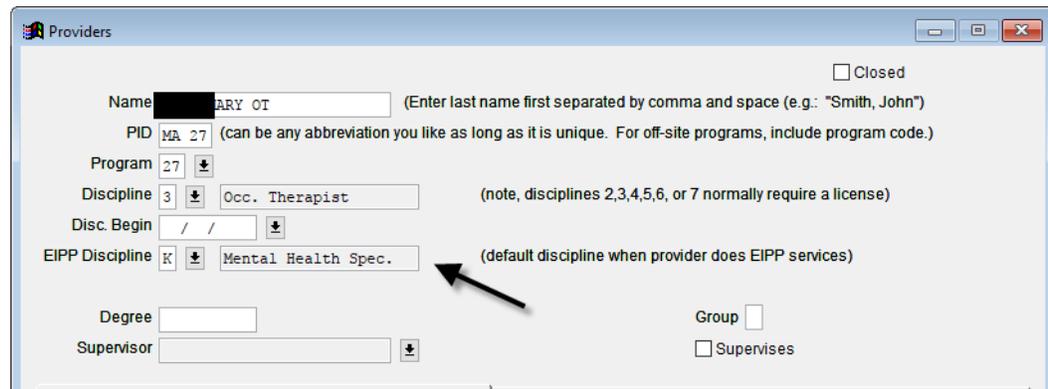
Specialty Service Provider is used to indicate the SSP for autism providers.

The Note field is just for keeping notes as needed.

EIPP Discipline

(For EIPP programs only.)

Please use the new EIPP discipline dropdown box on the provider form to indicate the alternative discipline a provider would use for EIPP services when their primary discipline does not apply.



The screenshot shows a software window titled "Providers" with a "Closed" button in the top right corner. The form contains several fields: "Name" (with a redacted value and "ARY OT" as a placeholder), "PID" (with "MA 27" as a placeholder), "Program" (with "27" as a placeholder), "Discipline" (with "3" as a placeholder and "Occ. Therapist" as a text input), "Disc. Begin" (with "/" as a placeholder), "EIPP Discipline" (with "K" as a placeholder and "Mental Health Spec." as a text input), "Degree" (empty), "Supervisor" (empty), "Group" (checkbox), and "Supervises" (checkbox). A black arrow points to the "EIPP Discipline" dropdown menu.

This will now show on the session entry screen and will be used as the default (when filled) for EIPP clients:

The discipline code stamped on the session is indicated below the two associated with the provider. As before, you can edit the session discipline if needed for an EIPP service.

Client Assignments Tab

This is one way you can assign clients to providers. The other way is within the Client form. This is optional and not required for billing.

Client (read-only)	Coordinator
SAL257, ELIJAH	<input checked="" type="checkbox"/>
TAI689, EDISON	<input checked="" type="checkbox"/>
TOL650, VINCENT	<input type="checkbox"/>

Rates

Introduction

Rate files store detailed information on insurance carriers. They govern how a claim is calculated and presented on the insurance form, and how services are reported to DPH in end of the month Service Delivery Report (SDR).

The rate file not only defines the payer and service codes used within Thom Biller, but also how these codes are mapped to two different target audiences: DPH and third-party payers.

For example, a "TA" service in Thom Biller means "Home Visit". When reported to DPH it is reported using an "A" code that they expect; when billed to a third-party payer it goes out as an H2015 (below):

The screenshot shows a software window titled "Rates" with two main sections: "Billing" and "Services".

- Billing Section:**
 - Billing Type: HPO
 - Service: TA
 - DPH Service Code: A
 - Needs Prior Authorization:
- Services Section:**
 - rat_id: 900000230
 - hea_id: 900000023

Annotations with arrows point to specific fields:

- "internal code" points to the Service field (TA).
- "DPH code" points to the DPH Service Code field (A).
- "Third party procedure code" points to the Code field (H2015).

Below the Billing section, there are fields for description and code:

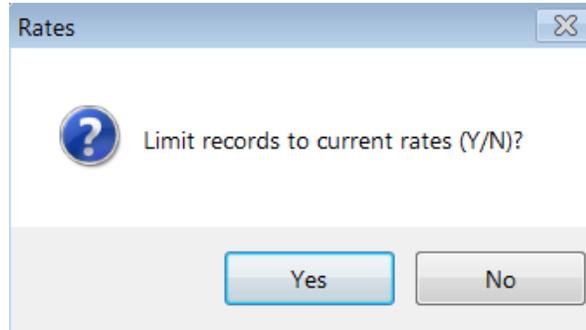
- Desc1: HOME VISIT
- Desc2: (empty)
- Code: H2015

Programs can establish as many rate files as they like. Any major insurer, with whom a significant number of clients have policies, should have one. Smaller insurers can have one, also, but it may become cumbersome for entry staff to keep track of dozens of billing types. Setting up a catchall rate type such as Other, or OTH, allows programs to group miscellaneous insurers. Individual claims address information can then be entered in client files.

It is essential that rate information be established before sessions are entered for a given payer, and that rate changes be made before new sessions are entered. The rate file is used by session entry to establish the fee and balance of a session, based on the hours of a service. Furthermore, a link to the rate file is stamped on the new session so that information can be found for procedure codes and so forth at billing.

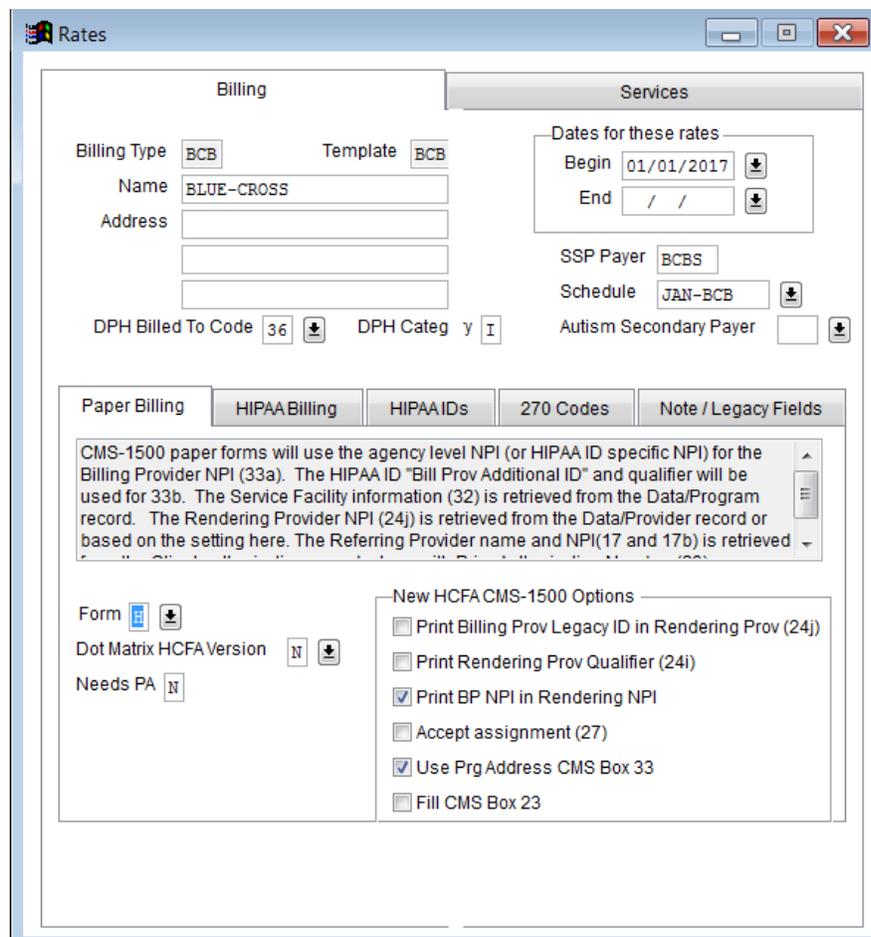
Billing Type

Payers are maintained as "Billing Types". It maintains a "rate series" of a particular payer (billing type) and all associated service codes for a given date range. When you open the Rates form, you'll be asked:



Usually you answer Yes, as this limits the display to the rate records that are current (whose date range covers today's date).

The Billing tab looks like this (below):



Billing

Billing Type: Template:
Name:
Address:

DPH Billed To Code: DPH Categ:

Services

Dates for these rates
Begin:
End:

SSP Payer:
Schedule:
Autism Secondary Payer:

Paper Billing | **HIPAA Billing** | **HIPAA IDs** | **270 Codes** | **Note / Legacy Fields**

CMS-1500 paper forms will use the agency level NPI (or HIPAA ID specific NPI) for the Billing Provider NPI (33a). The HIPAA ID "Bill Prov Additional ID" and qualifier will be used for 33b. The Service Facility information (32) is retrieved from the Data/Program record. The Rendering Provider NPI (24j) is retrieved from the Data/Provider record or based on the setting here. The Referring Provider name and NPI(17 and 17b) is retrieved

Form:
Dot Matrix HCFA Version:
Needs PA:

New HCFA CMS-1500 Options

- Print Billing Prov Legacy ID in Rendering Prov (24j)
- Print Rendering Prov Qualifier (24i)
- Print BP NPI in Rendering NPI
- Accept assignment (27)
- Use Prg Address CMS Box 33
- Fill CMS Box 23

Although you are free to make up the billing type codes you like, there are a few that are reserved and used by Thom Biller routines. These are:

DIR – Direct Annual Cost Participation (ACP) Fee

DPH – DPH

MED – Medicaid / MassHealth

OTH – Other

OTM – Other Medicaid

You will usually create new billing type codes based by using an existing rate series as a template.

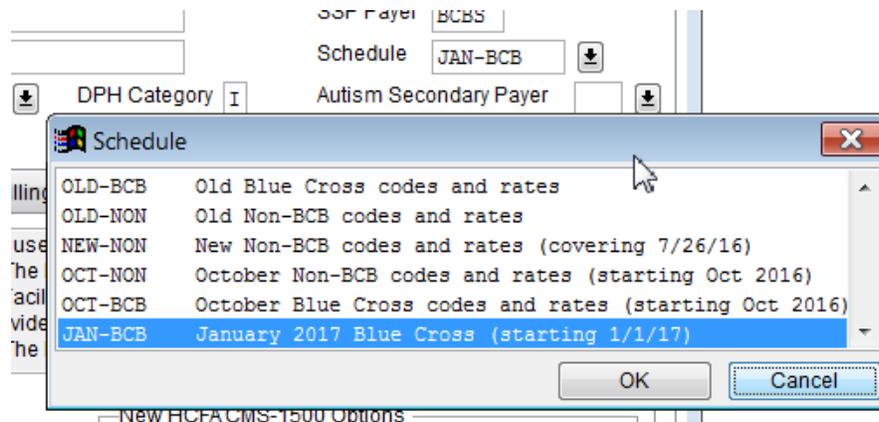
Enter the full insurance company **Name**. If you have used a template, the **Address** will fill in. Otherwise, type it in. Entering the address in the rate file will eliminate the necessity of entering it in individual client records.

Fill in a **Begin** dates for this rate record, using the date that DPH’s current set of rates was implemented. The **End** date will remain blank for now. When a rate increase is affected, it will be filled, and you will establish another set of rate records that reflect the increased rates. Around the time of the rate change, older sessions will be properly billed at the former rates, and newer ones at the revised rates.

Fill in the 2-digit **DPH Billed to Code** from the list. The Billed to Codes are DPH’s standard numeric identifiers for insurance carriers. Assign a **DPH Category**. The categories of D, M, X, H, and I have been established by DPH to help them track what types of coverage clients have, and to facilitate the application of appropriate business rules. It is critical that these 2 fields are accurately completed to insure the correct handling of your claims at DPH. DPH periodically updates these code lists. Whenever a revised list is released, programs should make any necessary edits in their rate files.

The **SSP Payer** field indicates the spelling you expect on the SSP spreadsheet for this specific billing type.

The Schedule is used to identify specific rate schedules as follows:



The Autism Secondary Payer is used to identify the billing type for autism services that the current payer uses for handling autism billing. For example, Harvard Pilgrim uses UBH to handle autism claims (below):

The screenshot shows a software window titled "Rates" with two tabs: "Billing" and "Services".

- Billing Tab:**
 - Billing Type: HPO
 - Template: HPO
 - Name: HARVARD PILGRIM HMO
 - Address: (empty field)
 - DPH Billed To Code: 20
 - DPH Category: H
- Services Tab:**
 - Dates for these rates:
 - Begin: 10/01/2016
 - End: / /
 - SSP Payer: (empty field)
 - Schedule: OCT-NON
 - Autism Secondary Payer: UBH

Paper Billing Tab

The screenshot shows the "Paper Billing" tab with the following details:

- Navigation Tabs:** Paper Billing (selected), HIPAA Billing, HIPAA IDs, 270 Codes, Note / Legacy Fields
- Text Area:** CMS-1500 paper forms will use the agency level NPI (or HIPAA ID specific NPI) for the Billing Provider NPI (33a). The HIPAA ID "Bill Prov Additional ID" and qualifier will be used for 33b. The Service Facility information (32) is retrieved from the Data/Program record. The Rendering Provider NPI (24j) is retrieved from the Data/Provider record or based on the setting here. The Referring Provider name and NPI(17 and 17b) is retrieved...
- Form:** H
- Dot Matrix HCFA Version:** N
- Needs PA:** N
- New HCFA CMS-1500 Options:**
 - Print Billing Prov Legacy ID in Rendering Prov (24j)
 - Print Rendering Prov Qualifier (24i)
 - Print BP NPI in Rendering NPI
 - Accept assignment (27)
 - Use Prg Address CMS Box 33
 - Fill CMS Box 23

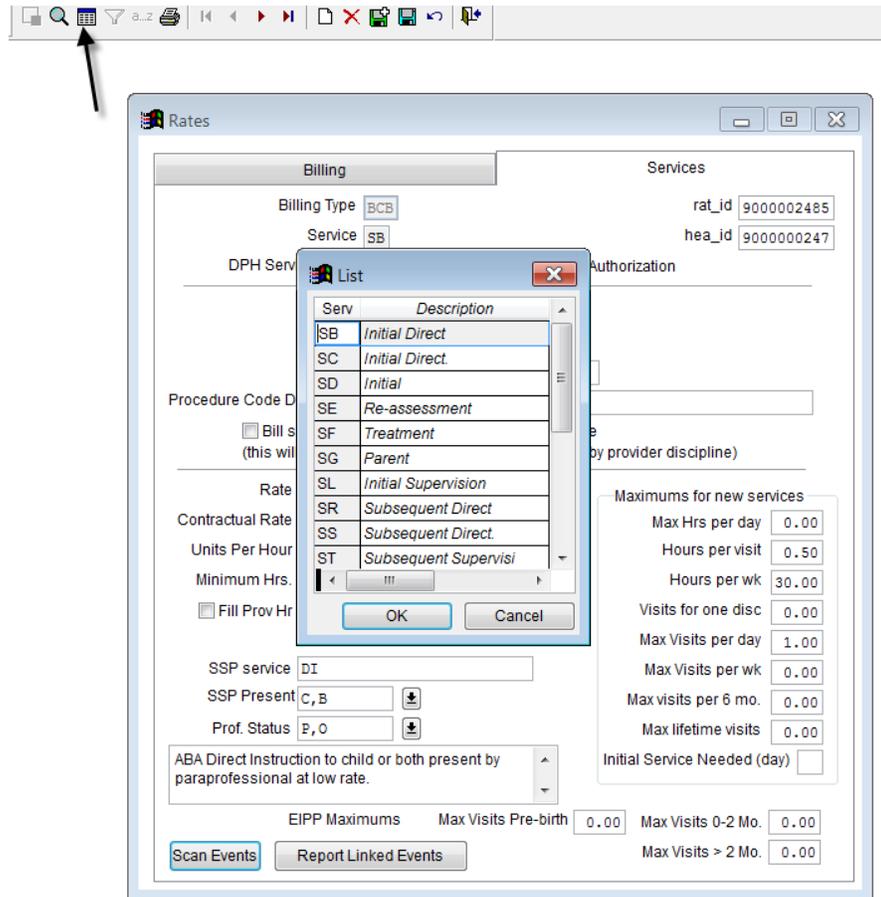
Indicate what type of claim **Form** this billing type should print on: 3rd party insurances go on the **HCFA-1500**.

The Dot Matrix HCFA version should be "N" for "New" after 5/23/07 in order to use the CMS-1500 form. (Set Laser printer choices under Misc. Utilities/Various Data Settings).

Make any other special CMS-1500 choices you need for this payer as indicated.

Services

There is one record per service per billing type. Each record under the "Services" tab is related to the currently selected billing. In this example, all Service records are "under" the BCB billing type. You can see them using the List button or by navigating with the toolbar arrows. (This form is similar to the Clients/Coverage/Authorization form in the way it handles these related records).



So this screenshot shows the information for a single SB service under the BCB billing type. The SB field is disabled because the rate record has been used in the event table and you cannot change it.

Again, the point of the rate record is to both define a service code within Thom Biller, but also to map it to other audiences. In this case, the SB service is reported to DPH as an "S" service and to BCB as 0364T.

The **Needs Prior Authorization** checkbox will be tested during session entry and used to require a prior authorization for a session before it is saved. Autism specialty services often require prior authorization when covered by third party payers.

Enter the **Description** (e.g., Home Visit) as you would like it to appear on the claim, using **Desc. Line 2** if necessary. The appropriate **Procedure Code**, as defined by the insurer or the CPT-4 codebook, is entered next.

If a **Modifier** is required, enter it here. When a specific modifier is not required for a specific service, then the modifier field on a bill may be filled during billing with a value that represents the discipline of the provider.

The **Bill services by multiple disciplines on single line** checkbox will collect services on the same date on the same claim line even when they have different provider disciplines.

The **Rate** is in dollars per hour. Sessions are entered in terms of actual hours, and this rate is used to multiply out for the fee.

Flat Rate is a check box currently only used for EIPP Home visits. It forces the fee to be whatever the rate is, no matter how many hours are provided.

The **Units Per Hour** is how many units add up to a single hour. This value is divided into the hours of a session to calculate the number of "units" as defined by a payer (usually 4 for EI).

Minimum Hrs. is not currently used.

EIPP is checked when a service should be limited to only EIPP clients. This value is tested at session entry to help prevent you from accidentally entering EI service codes for your EIPP clients, and vice versa.

Fill Prov Hr with Billed Hr in Session Entry checkbox causes the provider hour field to be filled with whatever value was entered for the billed hour amount during session entry. This only applies when you have enabled provider hour tracking on the Data/Agency screen. It makes sense for all individual services where the provider hour normally does match the billed hours. It would normally not be checked for group services, where there are usually more billed hours than provider hours.

For autism services, the following fields are used during spreadsheet load to translate the spreadsheet values into Thom Biller values:

ABA

SSP service

SSP Present

Prof. Status

ABA Direct Instruction to child or both present by paraprofessional at low rate.

Specifically, they are used to help the system locate the proper billing type and service rate record for the claim being reported by the SSP. These are the valid spreadsheet codes for the specific service. (See SSP spreadsheet discussion later for details). In this example, this means the BCB SB service code in Thom Biller is matched to a "DI" SSP Service with either the "Client or Both" people present and a professional status of "Paraprofessional or Other".

The exact matching rules have been changing over the past year so see the most recent upgrade information for current implementation.

The column of maximum hours and visits is self-explanatory. The last three **Max Visits** (pre-birth, 0-2 mo, and > 2 mo) are for EIPP services.

The "Quick Report of Linked Events" shows all current event records that are linked to this exact service. If you ever have to make retroactive changes to the rate information on a service, you should use this report to see what events will be affected by the automatic scan that will follow.

The maximums for new services (below) are the hours per day, visit, and week (etc.) which are tested during session entry.

Maximums for new services

Max Hrs per day	<input type="text" value="0.00"/>
Hours per visit	<input type="text" value="0.50"/>
Hours per wk	<input type="text" value="30.00"/>
Visits for one disc	<input type="text" value="0.00"/>
Max Visits per day	<input type="text" value="1.00"/>
Max Visits per wk	<input type="text" value="0.00"/>
Max visits per 6 mo.	<input type="text" value="0.00"/>
Max lifetime visits	<input type="text" value="0.00"/>
Initial Service Needed (day)	<input type="text"/>

The EIPP Maximums are numbers of visits in different time frames. These are also changed by DPH periodically so you should check recent documentation.

EIPP Maximums	Max Visits Pre-birth	<input type="text" value="0.00"/>	Max Visits 0-2 Mo.	<input type="text" value="0.00"/>
<input type="button" value="Report Linked Events"/>			Max Visits > 2 Mo.	<input type="text" value="0.00"/>

The Report of Linked Events shows all events with this specific rate record.

The Scan Events button will scan all the linked records to see if they have the proper rate. See Rate Scan discussion below.

Entering a new rate Series based on Existing Rate Series

A) Open your Data/Rate screen and say “NO” to limiting to current records.



B) Then do the following for each billing type:

- 1) Locate the current record (with empty ending date).

Billing	Name	Begin	End
AET	AETNA	01/01/1990	06/30/2000
BCB	BLUE-CROSS	01/01/1998	06/30/2000
BCB	BLUE-CROSS	000	03/31/2002
BCB	BLUE-CROSS	002	08/31/2003
BCB	BLUE-CROSS	003	12/31/2003
BCB	BLUE-CROSS	01/01/2004	12/31/2004
BCB	BLUE-CROSS	01/01/2005	10/31/2006
BCB	BLUE-CROSS	11/01/2006	/ /
BCM	BCB MEDI	01/01/1990	06/30/2000
BLM	HMO BLU MEDICAID	01/01/1998	06/30/2000

2) Close it and press Save.

Billing

Billing Type: Template:

Name:

Address:

Services

Dates for these rates

Begin: ↓

End: ↓

3) Press “NEW” on the toolbar and create a new series of records with a consecutive starting date for the same billing type based on itself as a template. Press SAVE.

Billing

Billing Type: Template: ↓

Name:

Address:

Services

Dates for these rates

Begin: ↓

End: ↓

- 4) Edit the new services as needed. You can alter the rates. You can add or delete specific service codes as needed.
- 5) When you are finished, you may be offered session scans if some existing sessions have been affected by the changes.

Autism Services in the Rate File

In general, autism services are handled like other payers in the rate file. However, some payers do not cover autism services and have secondary payer do that. In this case, you would not enter autism service records for the payer and you would want to designate the secondary payer who covers them.

For example, Harvard Pilgrim does not currently cover autism services, so there are no autism services in its rate series but it does have UBH as secondary payer:

09/12/2017

Page: 1

Billing	Overall Template	Begin	End	SSP Payer	Schedule	DPH Code	DPH Categ.	DPH Form	Needs EA
HPO	HARVARD PILGRIM HMO	HPO	10/01/2016 / /		OCT-NON	20	H	H	N
TA	HOME VISIT	DPH Serv: A	Code: H2015			Rate: 89.40	CR: 0.00		
TB	CENTER-BASED INDIVIDUAL VISIT	DPH Serv: B	Code: T1015			Rate: 74.96	CR: 0.00		
TD	PARENT-FOCUSED GROUP SESSION	DPH Serv: D	Code: T1027			Rate: 33.52	CR: 0.00		
TC	ASSESSMENT	DPH Serv: G	Code: T1024			Rate: 119.92	CR: 0.00		
TH	ASSESSMENT	DPH Serv: H	Code: T1024			Rate: 119.92	CR: 0.00		
TI	INTAKE HOME VISIT	DPH Serv: I	Code: H2015			Rate: 89.40	CR: 0.00		
TM	Child Focused Group Community	DPH Serv: M	Code: 96153		U2	Rate: 34.32	CR: 0.00		
TN	CHILD-FOCUSED EI Only	DPH Serv: N	Code: 96153		U1	Rate: 26.12	CR: 0.00		
TQ	EIPP SCREENING	DPH Serv: E	Code: T1023			Rate: 104.48	CR: 0.00		
Count: 9									

And the UBH rate series only has autism services:

Billing	Overall Template	Begin	End	SSP Payer	Schedule	DPH Code	DPH Categ.	DPH Form	Needs EA
UBH	UNITED BEHAVIORAL / OPTUM	HPO	10/01/2016	/ /	UBH	OCT-NON	70	H	H Y
SB	Initial Direct Instruction (low)	DPH Serv: S	Code: H2019	U2	Rate: 58.92	CR: 0.00	Y		
SC	Initial Direct. Instruction (high ra	DPH Serv: S	Code: H2012	U2	Rate: 111.36	CR: 0.00	Y		
SD	Initial Assessment	DPH Serv: S	Code: H0031	U2	Rate: 111.36	CR: 0.00	Y		
SE	Re-assessment	DPH Serv: S	Code: H0031	U2	Rate: 111.36	CR: 0.00	Y		
SF	Treatment Planning	DPH Serv: S	Code: H0031	U2	Rate: 111.36	CR: 0.00	Y		
SG	Parent Training	DPH Serv: S	Code: H2012	U2	Rate: 111.36	CR: 0.00	Y		
SL	Initial Supervision (high rate)	DPH Serv: S	Code: H0032	U2	Rate: 111.36	CR: 0.00	Y		
SR	Subsequent Direct Instruction (low)	DPH Serv: S	Code: H2019	U2	Rate: 58.92	CR: 0.00	Y		
SS	Subsequent Direct. Instruction (high ra	DPH Serv: S	Code: H2012	U2	Rate: 111.36	CR: 0.00	Y		
ST	Subsequent Supervisi (high rate)	DPH Serv: S	Code: H0032	U2	Rate: 111.36	CR: 0.00	Y		

Count: 10

Also, autism services generally need prior authorization, so you should check the box for each service:

Finally, some Blue Cross autism services have to go in sequence: SB – Initial Direct Instruction 0364T must precede SR- Subsequent Direct Instruction 0365T. This is defined on the subsequent record:

Billing

Billing Type: BCB
 Service: SR
 DPH Service Code: S Needs Prior Authorization

Desc1: Subsequent Direct
 Desc2: Instruction (low)
 Code: 0365T

Procedure Code Descriptor:

Bill services by multiple disciplines on single line
 (this will also keep blank modifier from being filled by provider discipline)

Rate: 58.00 Flat Rate
 Contractual Rate: 0.00 (fill only when <standard rate)
 Units Per Hour: 2.00 EIPP
 Minimum Hrs.:

Fill Prov Hr with Billed Hr in Session Entry
 ABA

SSP service: DI
 SSP Present: C, B
 Prof. Status: P, O

Subsequent direct service low rate to child or both.
 Mainly used for BCB.

Services

rat_id: 9000002491
 hea_id: 9000000247

Maximums for new services

Max Hrs per day: 0.00
 Hours per visit: 0.00
 Hours per wk: 30.00
 Visits for one disc: 0.00
 Max Visits per day: 0.00
 Max Visits per wk: 0.00
 Max visits per 6 mo.: 0.00
 Max lifetime visits: 0.00
 Initial Service Needed (day): SB

EIPP Maximums: Max Visits Pre-birth: 0.00
 Max Visits 0-2 Mo.: 0.00
 Max Visits > 2 Mo.: 0.00

Buttons: Scan Events, Report Linked Events

Finally, autism services need an additional layer of “mapping” codes to deal with the codes uses on the current SSP spreadsheets. So in the example above, the “SR” code in Thom Biller comes in as a “DI” on the SSP service field.

And the payer code used on SSP spreadsheets for Blue Cross is set on the billing type tab:

Billing

Billing Type: BCB Template: BCB
 Name: BLUE-CROSS
 Address:

DPH Billed To Code: 36 DPH Category: I

Services

Dates for these rates

Begin: 01/01/2017
 End: / /

SSP Payer: BCBS
 Schedule: JAN-BCB
 Autism Secondary Payer:

This means that a spreadsheet might show a BCBS – DI session which would be translated by the rate file into BCB (billing type) and “SB” service.

Advanced Rate Topics

Once you have mastered the way billing types and service codes are managed by the rate table, these more advanced topics can be discussed:

Session Scans Associated with Rate Changes

Retroactive changes to rate information (that are made after sessions have already been entered) can present problems. Thom Biller will scan sessions after retroactive changes and make as many changes to sessions as is possible automatically to establish new links or new fees and balances. But if the retroactive change is made after sessions have had payments, adjustments, and transfers, it becomes increasingly difficult to automatically update a claim with new rate information. The session scans will therefore delegate any updates to such complex claims to you for manual adjustment.

These scans are similar to the coverage scans that occur when you change a client's coverage, but they apply to all events affected by changes you make in your rate information. One scan covers the retroactive addition of a new rate series and updates the link between affected events. So if you find you have to add a new rate series, perhaps because your provider ID has been changed by the payer, and this update needs to be applied retroactively, then this scan will locate all events that are currently linked to the old rate records and stamp them with links to the new rate records.

The other scan will occur when you change the fee on a rate record after some sessions have already been created using the old fee. Both of these scans will change the information they can on simple claims that have not already been paid or adjusted. Complex claims will be marked as needing "manual" attention so that you can decide what to do with them on your own. If you are paid for a \$50 session, and two months later change the rate file to \$60, the scan will mark this for "manual" handling because it is not clear to the software exactly what you might want to do. On the other hand, if the session has not yet been paid or otherwise adjusted, it will change the fee to the new value (and mark it for billing resubmission).

HIPAA Electronic Billing Setup: HIPAA Tabs

Make HIPAA 837 configuration choices here on these two tabs:

Paper Billing	HIPAA Billing	HIPAA IDs	270 Codes	Note / Legacy Fields
HIPAA Run Type <input type="text" value="BCB"/> <input type="button" value="v"/> AckReq <input type="text" value="0"/> <input type="button" value="v"/> Usage <input type="text" value="P"/> <input type="button" value="v"/> Line Terminator <input type="text"/> <input type="button" value="v"/> Payer Name <input type="text"/> ID <input type="text" value="00200"/> Payer ID Qualifier <input type="text" value="PI"/> <input type="button" value="v"/> IC Receiver Qual <input type="text" value="ZZ"/> Claim Filing Code <input type="text" value="BL"/> <input type="button" value="v"/> <input type="checkbox"/> Add Auth Info Submitter Name <input type="text"/> Ref ID Qualifier <input type="text" value="9F"/> <input type="button" value="v"/> Prov Code <input type="text"/> <input type="button" value="v"/> <input type="checkbox"/> 2010AB Prov Taxonomy Code <input type="text"/> (fill if different than agency level taxonomy code)				

Paper Billing	HIPAA Billing	HIPAA IDs	270 Codes	Note / Legacy Fields
<input type="checkbox"/> Use Program Specific Info _____ Submitter ID <input type="text" value="THC"/> <input type="button" value="v"/> Seq <input type="text" value="0"/> Bill Prov ID <input type="text" value="04210"/> <input type="button" value="v"/> Bill Prov ID Qual <input type="text" value="24"/> <input type="button" value="v"/> Bill Prov Additional ID <input type="text" value="E10"/> <input type="button" value="v"/> Bill Prov Add Qual <input type="text" value="1A"/> <input type="button" value="v"/> NPI <input type="text"/> (fill if different than agency level NPI) NPI Usage <input type="text"/> <input type="button" value="v"/> (NPI only, Legacy only, Dual use testing (both))				

Field	HIPAA Billing Tabs
HIPAA Run Type	The available certified HIPAA billing run types. These are normally linked to specific payers, but over time there may be some "Generic" options. Often this field will match your billing type, but not necessarily. For example, at Thom, BMC Healthnet uses HEA as its billing type, but the HIPAA run type is "BMC".
AckReq	Acknowledgement requested. Usually set 0 = None.
Usage	Set to "T" during testing. Remember to reset to "P" when you are approved for production runs.

Payer Name	Optional field if the payer has a specific requirement for this value, otherwise the "Name" field is used. BMC Healthnet has a specific Payer Name they want used that may not match the Name you have assigned to the billing type, so for them you should fill in the Payer Name.
ID	Payer ID provided to you by the payer. This is automatically used for the usually the HIPAA Receiver ID and IC Receiver too (1000B, ISA08, 2010BC.NM109) so these other values are not sought on this form.
Payer ID Qual	Payer ID Qualifier. Specified by the payer in their HIPAA companion guide. Usually "PI" for Payer Identification number.
IC Receiver Qual	Interchange Receiver Qualifier (ISA07). Specified by the payer in their HIPAA companion guide. Usually "ZZ".
Claim Filing Code	Specified by the payer in their HIPAA companion guide for HIPAA field 2000B.SBR09. May be payer specific or more generic.
2010AB	Check this box to use the 2010AB loop for the pay to provider ID (Bill Prov Additional ID), instead of the usual 2010AA loop. So far, only Medicaid has wanted this in the case of one EI agency (REACH) that has a different submitter number than its provider number. In this case, Medicaid wants the provider number moved down to the 2010AB loop and the submitter number repeated in the 2010AA loop, which this check box will do. Don't ask us why...
Add Auth Info	Add authorization or referral information to HIPAA file. Check this box if the payer wants these segments (2300.REF) filled in. Some do and some don't.
Submitter Name	Optional value for your submitter name if the payer wants something specific for you different than what you call yourself in the agency setup screen. For example, BMC Healthnet wants Thom Child and Family Services to refer to itself as "DTHOM".
Ref Id Qual	Reference ID Qualifier (2300.REF01). This describes the authorization or referral information you provide and will only be applied if the "Add Auth Info" checkbox is checked.
Use Program Specific Info	Check this box to use program specific information for the remaining fields (provider number, etc.) instead of using the same values for all programs in an agency. Currently, Medicaid is the only payer Thom has that has assigned a separate provider number to each of its programs, so we have this checked for Medicaid HIPAA information. When checked, the remaining fields on the screen are blanked out and you must go to the Data/Programs screen to complete the information for each program.
Prov Code	Provider Code. Defaults to "BI" Billing provider when left blank. In rare cases, you may need to choose "PT" Pay To Provider. This fills the 2000A PRV segment. The PT choice may be associated with the 2010AB choice discussed below.
Prov Taxonomy Code	Provider Taxonomy Code. If you need to overwrite the default setting, you can do it here. It may be that 282N00000X will work better for EI programs, but we will see.
Submitter ID	The Submitter ID is also used for the HIPAA Interchange Sender and Application Sender IDs too (1000A.NM109, ISA06, GS02). It is assigned by the payer during testing.
Seq	Sequence for numbering file names. Some payers want their files numbered in their names and this holds the last used value.
Bill Prov ID	Billing Provider ID (2010AA.NM109) is usually the agency federal tax ID, but depends on what the payer specifies.
Bill Prov ID Qual	Billing Provider ID Qualifier (2010AA.NM108) is a code specified by

	the payer to describe the Billing Provider ID
Bill Prov Additional ID	Billing Provider Additional Identifier (2010AA.REF02) is usually the actual billing provider number assigned by the payer.
Bill Prov Add Qual	Billing Provider Additional Identification Qualifier (2010AA.REF01) is a code specified by the payer to describe the previous field above.

270 Tab

If your agency has a single program, then you would fill in the fields for the entire agency on the rate file screens as shown below. (Note the "Use Prog-specific 270 info" checkbox has been deselected for these examples.) These 270 Codes are used for MassHealth EVS PC checks. Fill them out as indicated below. If the field is not "blacked out", fill your with the exact same value. If it is blacked out, you must fill it with the proper code for your agency.

Use the UserID and User Password you have created for one of your staff to log into the general MassHealth POSC system. It does not matter which staff person's information you use, but it is cap-sensitive. Put "00" and "ZZ" in the other fields as indicated.

Go ahead and repeat the provider number for the ISA06 field and GS02 on the next tab.

Billing | **Services**

Billing Type: **MED** | Template: **MED**

Name: **MEDICAID**

Address: []

DPH Billed To Code: **02** | DPH Category: **M** | 90000135

Dates for these rates: Begin: **01/01/2008** | End: / /

Paper Billing | HIPAA Billing | HIPAA IDs | **270 Codes** | Note / Legacy Fields

ISA | **ISA Cont.** | 2100A | 2100B | Paths

IC Receiver ID Qual (ISA07): **ZZ**

IC Receiver ID (ISA08): **DMA7384**

Acknowledgement Req (ISA14): **I**

Usage Indicator (ISA15): **P**

Sender ID (GS02): **1100278** → **Provider ID again**

Fill the other fields as indicated (“ZZ”, “DMA7384”, “I”, “P”).

Fill the 2100A fields as indicated below:

Billing | **Services**

Billing Type: **MED** | Template: **MED**

Name: **MEDICAID**

Address: []

DPH Billed To Code: **02** | DPH Category: **M** | 90000135

Dates for these rates: Begin: **01/01/2008** | End: / /

Paper Billing | HIPAA Billing | HIPAA IDs | **270 Codes** | Note / Legacy Fields

ISA | ISA Cont. | **2100A** | 2100B | Paths

Name (NM103): **MASSHEALTH**

ID Code Qualifier (NM108): **PI**

Information Source ID (NM109): **DMA7384**

Patient Level 270: []

Repeat the Provider ID one more time as above. Put “SV” in the other field.

You can leave these blank for now in the Paths tab:

Program-specific Billing Codes

If your agency has multiple programs, MassHealth probably has identifying codes specific to each of them. So on the rate file for MED, you would say

Billing

Billing Type: Template:

Name:

Address:

DPH Billed To Code: DPH Category:

Services

Dates for these rates

Begin: End:

SSP Payer:

Schedule:

Autism Secondary Payer:

Paper Billing **HIPAA Billing** **HIPAA IDs** **270 Codes** **Note / Legacy Fields**

Use Program Specific Info

Submitter ID: Seq:
 (Interchange Sender and ISA06 Submitter ID assigned by Payer)

Bill Prov ID: Bill Prov ID Qual:

(Usually agency tax ID (EIN))

Bill Prov Additional ID: Bill Prov Add Qual:

Cms32b:

Cms33b:

On the 270 tab:

The 270 information can be stored either for your agency as a whole or on a program-specific basis. If your agency has multiple programs, each with their own MassHealth identifiers, then you would check the "Use Prog-Specific 270 Info" box (as shown below) and fill in the ISA02, ISA04, ISA06 information on the Data/Programs screen (for each program).

Paper Billing **HIPAA Billing** **HIPAA IDs** **270 Codes** **Note / Legacy Fields**

ISA **ISA Cont.** **2100A** **2100B** **Paths**

Auto Check Elig Daily

Use prog-specific 270 info

(See program-specific info)

Auth Info Present (ISA01):

Authorization Info (ISA02):

Security Info Present (ISA03):

Security Info (ISA04):

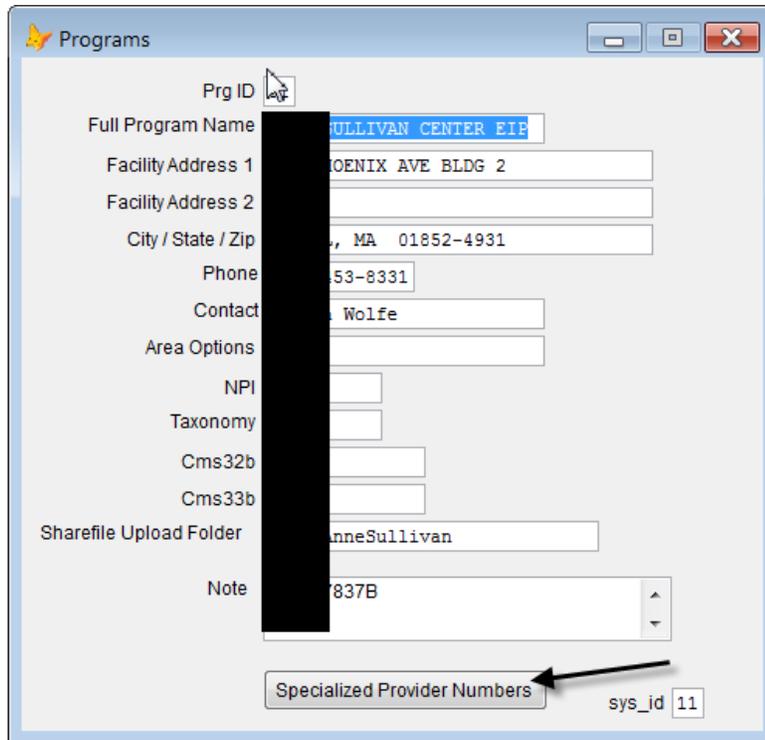
(See program-specific info)

Interchange ID Qual (ISA05):

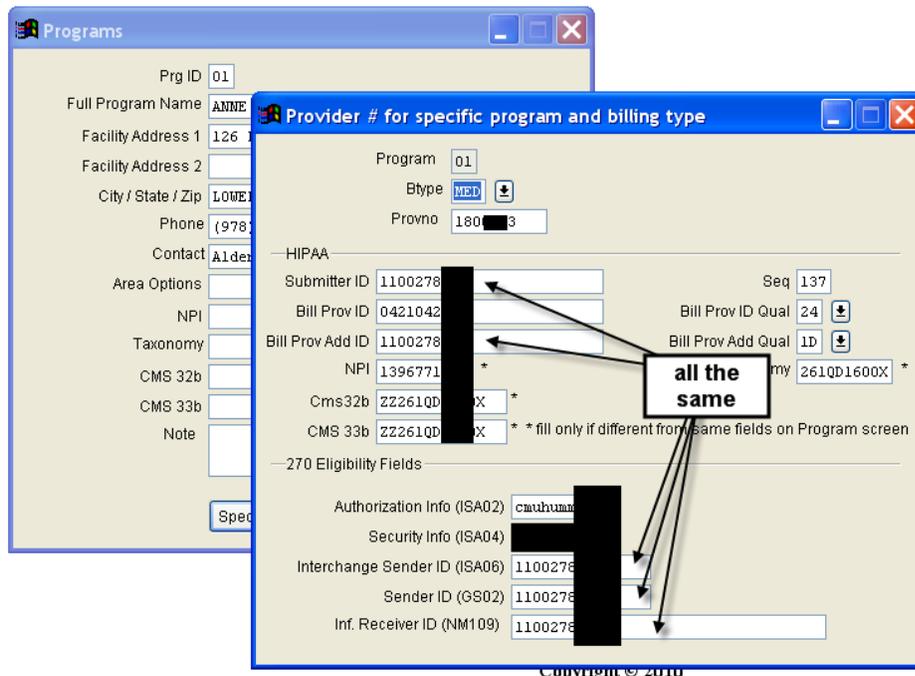
Interchange Sender ID (ISA06):

(See program-specific info)

Then under Data/Programs,



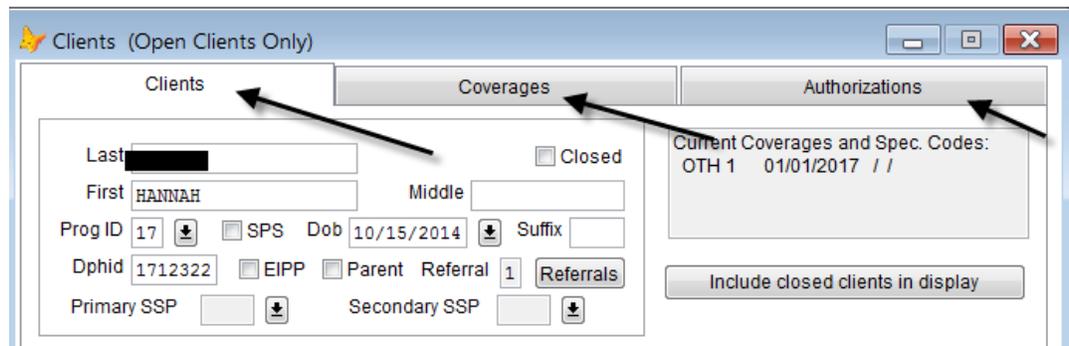
Click Specialized Provider Numbers for each program and enter the program-specific information MED requires under each:



Clients

Introduction

The Client form handles client, coverage, authorization, waiver, and referral information in one comprehensive package. The first three types of information are organized in a perfectly hierarchical fashion: for each client, there may be many coverage records, and for each coverage record, there may be many authorization records. Accordingly, a special kind of form is used that incorporates a tabbed page frame to present the information with Client, Coverage, and Authorization tabs.



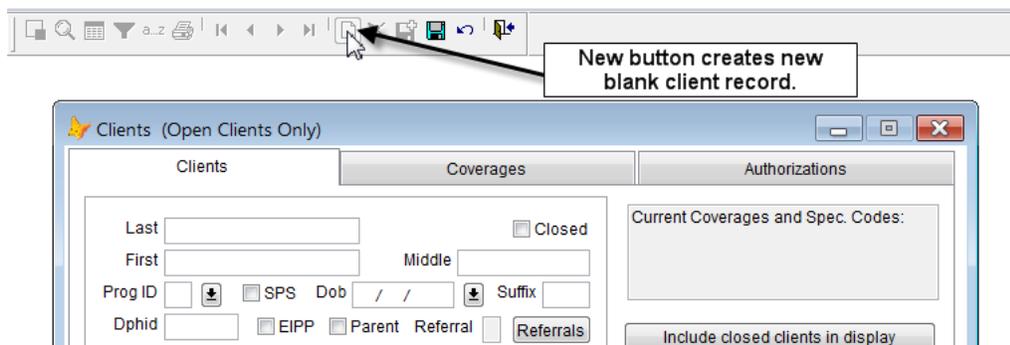
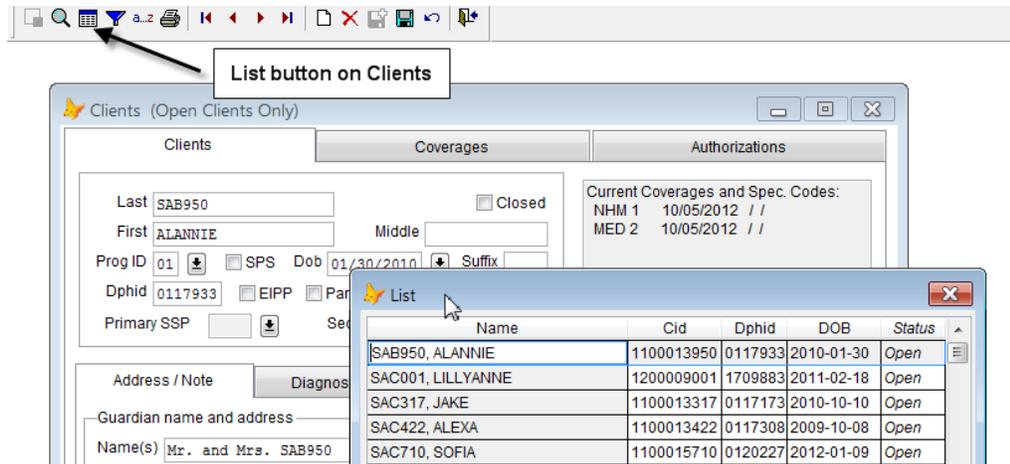
The screenshot shows a software window titled "Clients (Open Clients Only)". It features three tabs: "Clients", "Coverages", and "Authorizations". The "Clients" tab is active, displaying a form with the following fields and controls:

- Last: [Redacted]
- First: HANNAH
- Middle: [Empty]
- Prog ID: 17 (with a dropdown arrow)
- SPS: [Empty]
- Dob: 10/15/2014 (with a dropdown arrow)
- Suffix: [Empty]
- Dphid: 1712322
- EIPP: [Empty]
- Parent Referral: 1
- Referrals: [Button]
- Primary SSP: [Empty]
- Secondary SSP: [Empty]
- Closed: [Checkbox]

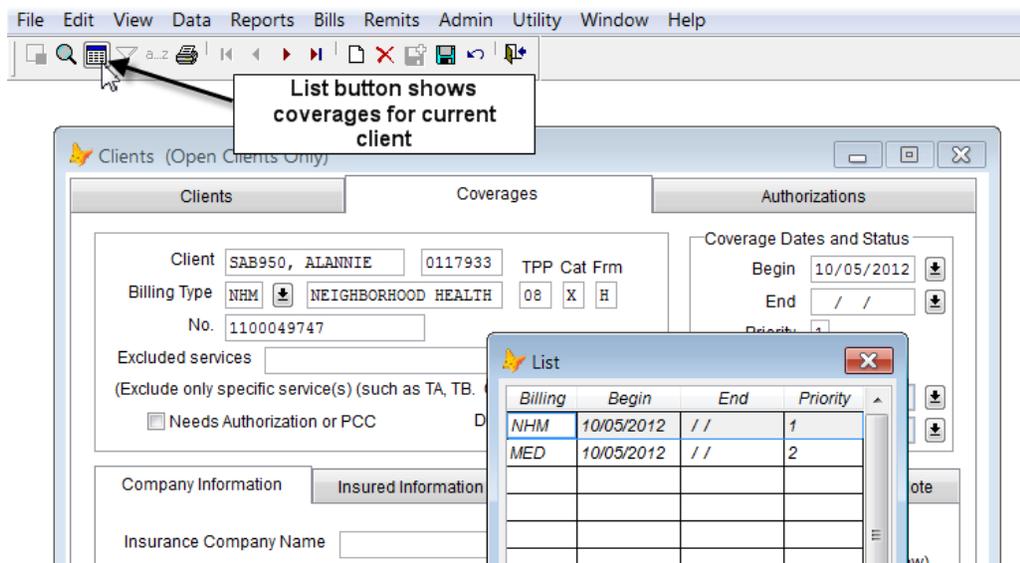
On the right side of the form, there is a section titled "Current Coverages and Spec. Codes:" containing the text "OTH 1 01/01/2017 / /". Below this is a button labeled "Include closed clients in display". Three black arrows point from the "Clients", "Coverages", and "Authorizations" tabs to their respective sections in the form.

So for each client, there may be several records "under" the Coverages tab: one for each coverage. And for each Coverage, there may be several records under the Authorizations tab.

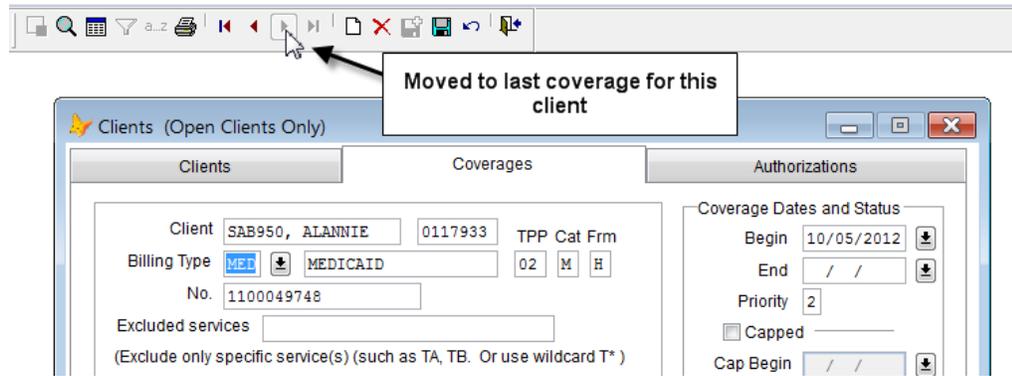
When you click on any tab, the toolbar will automatically shift to acting on that type of record. So when on the Clients tab, the toolbar List button will jump to a new client. The New or Delete button will add or delete a client record.



When you click on the Coverages Tab, the toolbar will work for coverage records for the current client:



The navigation arrows will also move through this client's coverages:



And the Add and Delete buttons will add or delete coverage records for the selected client. The same process will work for Authorization records "under" a given coverage.

Basic Client Information

All clients who receive services in your Early Intervention program should be entered in the Thom Biller. The client record contains information necessary for programs to track and bill insurance carriers, comply with DPH requirements, and track demographics.

Each client should be added to the system only one time during their Early Intervention lifespan, regardless of name changes or multiple referrals and discharges. The client record allows you to edit first and/or last names, and a referral table tracks repeated arrivals and departures from your program.

Closed vs. Open Clients

Marking a client as closed by filling the CLOSED checkbox will hide the client from most lists and dropdown boxes in Thom Biller. Indeed, when you open the Clients Form, only open (non-closed) clients will be shown by default. If you need to access the record of a closed client, click on the button labeled **"Include Closed Clients."** You will notice that the heading on the Client tab changes from Active Clients to All clients. Click on this button again to return to active clients only.

Both client additions and revisions are made from the same Clients menu item.

Client Information

Entering a New Client and Avoiding Duplicates

When you enter the Clients form, the 1st client in your list will appear. Open a new client record by clicking on the tool bar's New icon.

Type in the last name and you'll see the bottom tab jump to "Similar Clients" showing all clients with the same 1st 4 letters in their last names are displayed.

Closed	Clast	Cfirst	Dob	Cid
<input type="checkbox"/>	SMITH	ALANNIE	01/30/2010	1100013950
<input type="checkbox"/>	SMITH	BENJAMIN	05/04/2014	1200011142
<input type="checkbox"/>	SMITHY	RYAN	05/10/2011	1200009642

Review these clients to confirm that you have not already entered this client. It may be helpful to review birth dates as well as names, in case clients have been previously entered under a different version of their name. If not, proceed with your entry, completing the last and **First** names.

It is important to avoid duplicates as there is no easy way to combine two separate client records under the same client.

Other Basic Client Information

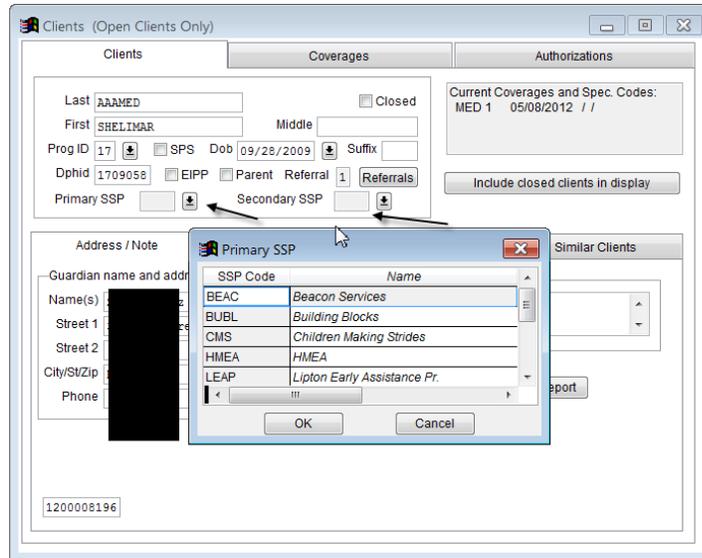
Fill in your 2-digit program ID and the client's **DPH ID.:** the 2-digit program code, and the 5-digit number unique to this client. It is critical that this number matches the I.D. the client is registered under in the DPH Client Registration system; mismatches will result in DPH suspensions for non-registration, or billing assigned to the wrong client. For clients who receive services from your program but belong to another primary EI program: enter your program ID but the DPH ID assigned by the primary program, and **SPS** (Secondary Program Services) box.

The **EIPP** checkbox is for EI Partnership program clients. The **Parent** checkbox is for EIPP parent, since mothers are the ones who receive EIPP home visits before their child is born.

Enter the **Date Of Birth** next. This is the client's date of birth, whether a child or an EIPP parent.

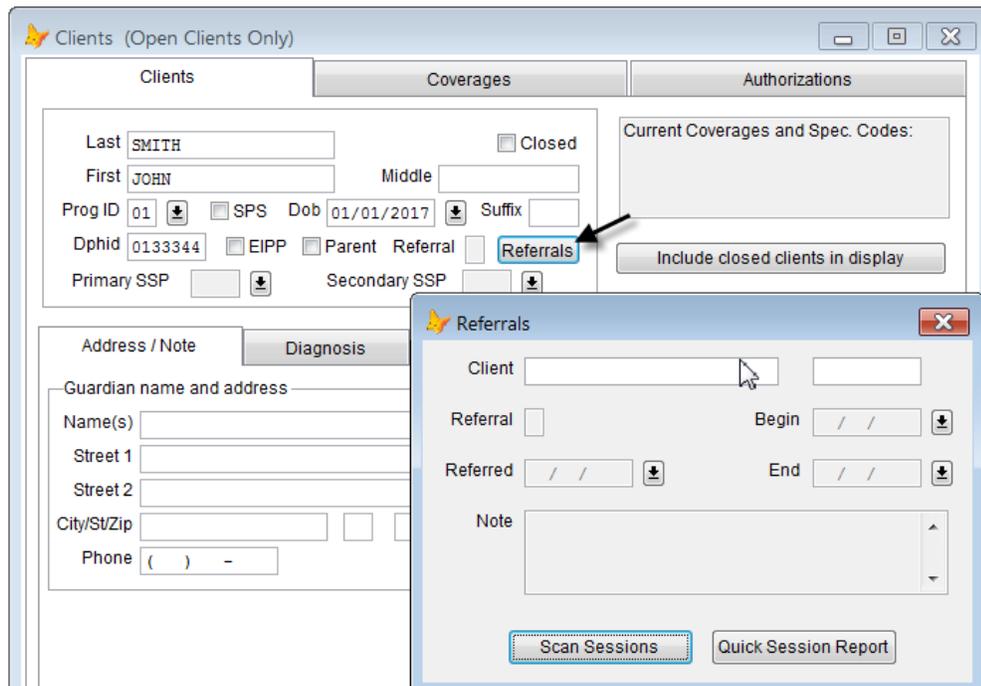
Client **Middle Name** can be filled with either a full name or initial, depending on your billing requirements. The client **Suffix** is for "Jr.", "III", and other such name suffixes.

Two fields are now provided to track the primary and secondary SSP providers for children receiving autism specialty services:

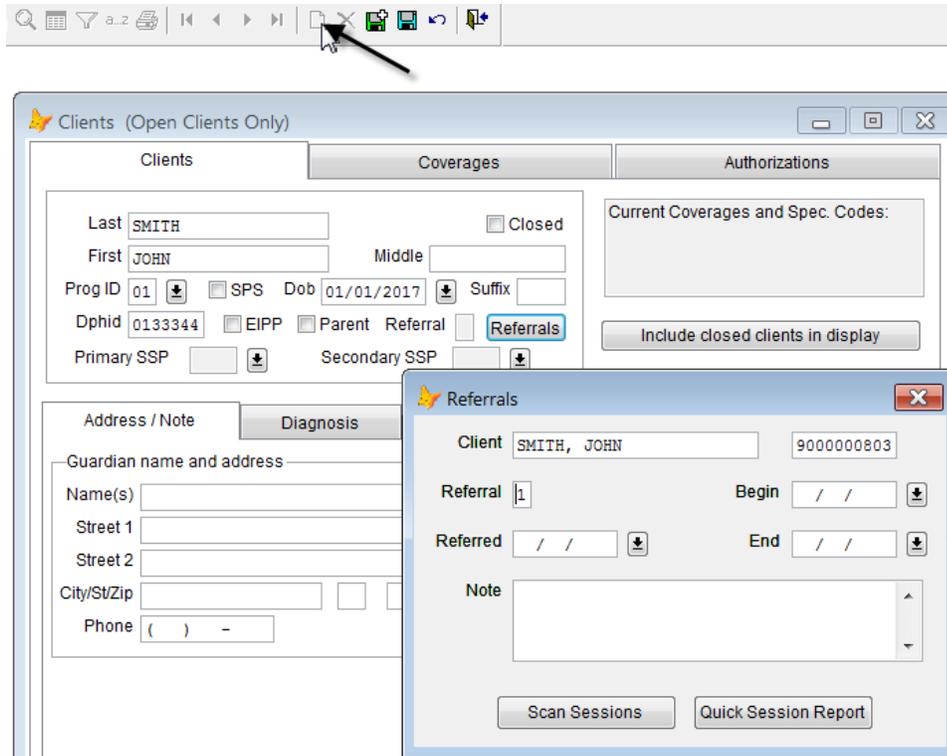


DPH Referrals

The **Referrals** section stores all of a client's DPH referrals, or times in your program, and their individual date parameters. Note, these are not the same as a "MassHealth Referral" which is treated as an authorization below.



Immediate press the New button on the toolbar to create a new Referrals record:



It will automatically fill in the Client Name and suggest a Referral number (in sequence). You can edit the Referral Number (but not the name). Enter a beginning date that will define the time period that this referral covers. The Referred date is optional, as is the Note.

If a client is referred and subsequently discharged from your program 4 times by the time they age out, then they will have 4 referral records. When entering a completely new client and opening a referral, fill in the number 1, the **Referred** date and the **Begin** date. Most programs define the referred date as the date the program received a phone referral on the client. The begin date marks the 1st day the client was seen by program staff. The end date should be filled in at the time of the client's discharge from the program, and will automatically mark the client as discharged by filling the Discharge date. For off-site programs, you should probably check the client Closed box while you are ending the referral. For base and stand-alone programs where you may have a fair amount of continuing receipt and bill processing, you should leave the client open for a while (although with a filled discharge date).

While the Referred date is an optional field, you will not be allowed to save and exit unless you complete the Begin field. The system needs this in order to correctly assign a referral number during session entry.

When you save the new Referral record, you will see the current Referral Number on the Client screen:

Subsequent Referrals

When a client returns for a second referral, you open a new referral record. The referral number will automatically be incremented from 1 to 2, or 2 to 3. Starting a new referral will clear out the Discharged date on the client record, assuming it had been filled when the client was discharged the first time. It will also clear out the Assessment year start date if the returning child is more than a year since his previous assessment start date. When you enter a new assessment session, the assessment year start date will be filled automatically.

Other Client Information Fields

Address / Note tab

The **Address/Note** tab stores the name, address, and phone number of the client's guardian. Generally, this is the person(s) with whom the client resides, and the client's place of residence.

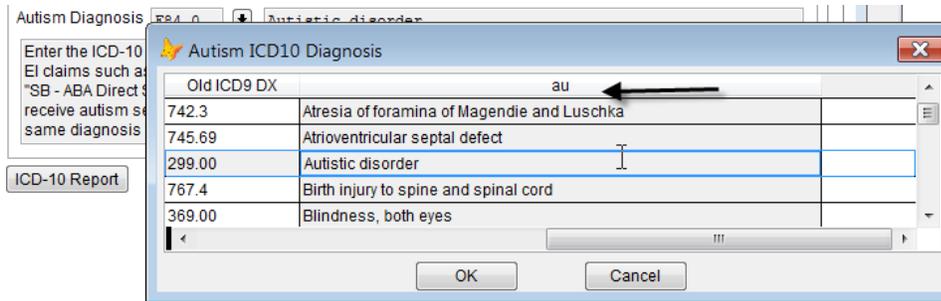
Diagnosis tab

The **Diagnosis** tab stores the diagnosis codes (and possible accident indicator values for non-EI programs). It also holds Annual Fee billing information.

Diagnoses codes should be filled in below:

There is one diagnosis for EI services received and one used for autism services.

Note both the code and name are searchable fields on the Diagnosis dropdown list:



In this example, after clicking the diagnosis name field, typing "au" jumped to the Autistic Disorder item.

IFSP dates

IFSP date information is stored in the three fields at the bottom of the tab and can be edited as IFSPs are renewed.

Initial IFSP Signed	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Current IFSP Signed	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
Current IFSP End	<input type="text" value="/"/>	<input type="text" value="/"/>	<input type="text" value="/"/>
IFSP SSP Hrs	<input type="text"/>		
(total autism hours per week in IFSP)			

Descriptive tab

The **Descriptive** tab contains fields and counters that you may use to help your program track demographic and service information, but which are not required for billing purposes.

The **Coordinator** field allows you to track a client's service coordinator. Type in the PID or choose from the pop-up list.

Gender should be filled in with M or F.

Race can be filled in with any number of abbreviations defined by your program.

Area is designed for programs that may offer EI and some other type of service, like Developmental Day, and allows programs to track and report on subgroups of clients. Define your Area options on the Agency form.

Miscellaneous allows you to track any special feature in which you may be interested. For example, some programs may want to be able to track children involved with DSS. Entering DSS in the Misc field will allow you to print a report of all DSS clients.

Referring Physician allows you to track a client's pediatrician. Unlike the DOS system, this field has no Medicaid utility and is not printed on any bills. For Medicaid bills, the PCC name is picked up from the authorization record. Similarly, the Referring Prov / PCC Name on the authorization record can be filled in for Blue Cross records to print on the UB-92 or for HCFA billing, although it is probably not necessary.

The **Discharged** date should be filled when you end a referral. This date will be checked when you enter sessions and will disallow sessions after the discharge date, except for a single transition home visit.

The **Last seen** date will continually update the client's last service date as you enter new sessions.

Assessment totals

The **Assessment Totals** block facilitates tracking each client's annual 10 hours of assessment time. Enter the beginning count date for this individual client in the **Current year**. This is the date of the client's 1st TG, or initial assessment. For new children who have not been seen by other programs, leave the assessment current year start date blank and the counts blank and they will be filled automatically when you enter assessment sessions. For children who are returning for a second referral, if this occurs within a year of the first referral's assessment year start date, then you should leave it alone. If a child comes back more than a year later, the assessment year start date should be blanked out. It will be reset by the first assessment session you enter, more than a year since the prior assessment start date. The

As you enter TGs and THs in the add session routine, they will accumulate in the **Current hr total** box. Subsequent edits or adjustments to assessment services will update this count. As you enter assessment sessions, the current count will be noted.

Reports can be run to help you track who is nearing 10 hours, and who is approaching their renewal date. (See Special Client Reports under the Reports main menu.)

If you have activated the assessment tally rollover utility on the Agency form, then your Current years will automatically rollover to the next year, and your Current hr total will move down to the **Prior year hr total** at that point. Subsequent billing will be assigned to the correct total, based upon the service date. If your Current year date is 03/28/00 and you are entering a 3/20 TH on 4/4, the system will correctly assign the hours to the Prior year hr total.

The **Quick Assessment Total** button allows you to pull up a report of all assessment hours, and offers to either limit it to current year assessments or to show the client's entire assessment history.

Providers Tab

Providers, including the Coordinator, assigned to a client are managed on the Providers Tab

Clients (Open Clients Only)

Clients
Coverages
Authorizations

Last Closed

First Middle

Prog ID SPS Dob Suffix

Dphid EIPP Parent Referral

Primary SSP Secondary SSP

Current Coverages and Spec. Codes:
OTH 1 01/01/2017 //

Address / Note
Diagnosis
Descriptive
Similar Clients
Providers

Provider	Coordinator	Discipline	SSP
THU113, THERESA	<input checked="" type="checkbox"/>	Social Worker	

(Select a single coordinator for the client)

Waivers

Use the **Waivers** pop-up button to store all waivers received from DPH. When you open a new waiver, the **Client** name will automatically fill.

The screenshot shows the 'Waivers' pop-up window. The 'Client' field is pre-filled with 'SADLER, HANNAH'. The 'Waiver no' field contains '5725'. The 'Waiver Dates' section has 'Begin' and 'End' both set to '02/01/2017'. The 'Do Count' section has 'Count' set to '0.00' and 'Units' with a dropdown arrow. The 'Limit Waiver to' section has 'Services' set to 'TA' and 'Cotonly' checked. The 'Discipline' field is empty. The 'Autofill' checkbox is checked. The 'Note' field contains 'Additional 8 hours of time for IFSP Review'. The 'Waiv_id' field contains '1200000548'. There are 'Scan Sessions' and 'Quick Session Report' buttons at the bottom. An arrow points to the 'Waivers' button in the background window.

Enter the **Waiverno** received from DPH. If they have given you **Begin** and **End** dates, enter them in the **Waiver Dates** box.

If they have specified a certain number of services for waiver coverage, check the **Do Count** box, and then enter the number they have specified. Next, complete the **Units** field. If DPH has granted you 10 extra assessment hours, enter an **H**. If they have granted you 5 extra co-treatment visits, enter **V**.

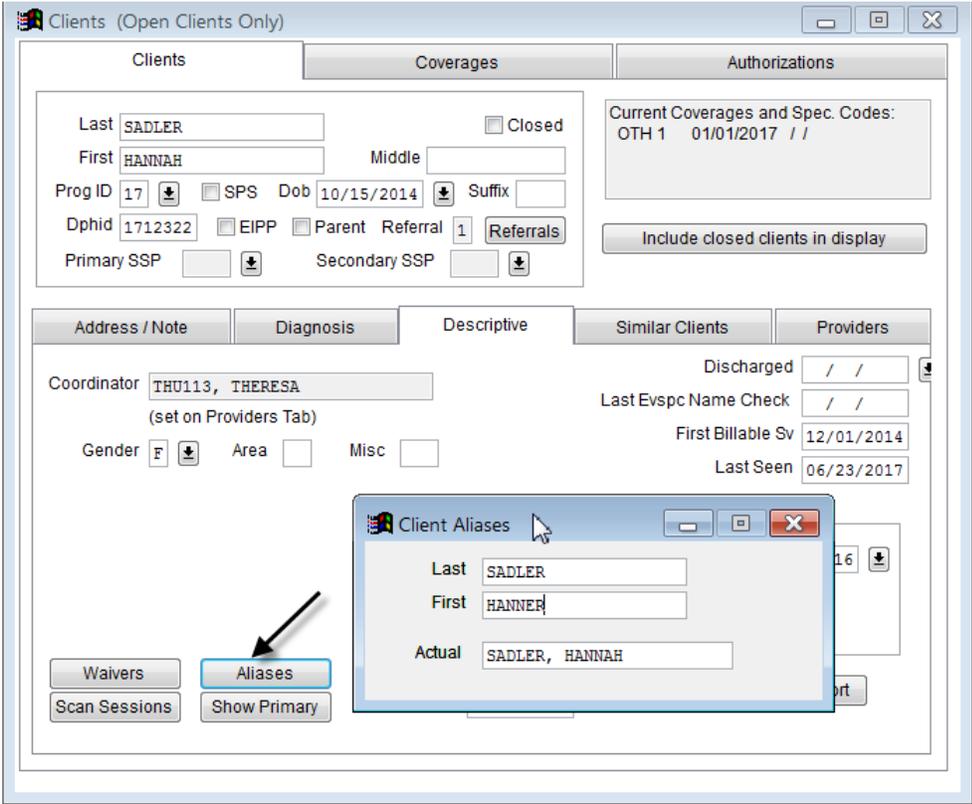
The **Limit Waiver to** box helps control what services will be stamped with the waiver number during session entry. If the waiver applies only to specified services, like home visits or assessments, then fill in these abbreviations under **Services**. Use a comma delimited list of the service codes, such as “TA, TB”. Do not fill this field or write anything else in it if the waiver applies to all service types.

Check the **CoTxOnly** box if it applies only to co-treatments. Lastly, if it applies only to providers of certain disciplines, enter them in the **Discipline** field as a comma delimited list using the standard codes such as “1” for educator.

The **Auto-fill** box should be checked if you want the computer to automatically stamp each session that meets the conditions you have entered. Check this box when the conditions are simple and you are sure they apply across all sessions. Leave it blank if you want to manually decide which sessions get stamped. So for example, if a waiver applies to all TA sessions within certain dates, go ahead and enter these conditions and check the “auto fill”

box. This will save you the trouble of manually responding to each session during the scan. If you have more vague conditions, such as stamping sessions only provided by a specific provider, then leave the “auto fill” box empty so you can manually decide which sessions to stamp during the waiver scan.

Aliases



Aliases helps you track clients who go by several different names, or who have had name changes. Add a new alias record for each of the client’s alternate names. A Client report allows you review all children with multiple names. (See Misc. Utilities for a Alias Lookup screen when you need to search the alias table; the same Alias Lookup screen is also offered when entering sessions).

The **Scan Sessions** button enables you to force a session scan at any time, and will probably be used infrequently. Typically, you will run a scan immediately after making coverage changes. The only time you might force a scan is if you think coverage changes have been made but sessions were not properly reassigned.

Client Coverages

Introduction to Coverages

As discussed earlier, the Clients form also handles an unlimited number of coverage records for each client "under" the Coverages tab. When you click on "Coverages", the toolbar navigation, add, and delete functions now operate on the the coverage records for the selected client.



In this case there is only one coverage for this client (and the navigation arrows are blanked out).

A screenshot of the 'Clients (Open Clients Only)' form, specifically the 'Coverages' tab. The form is divided into several sections: 'Clients' (Client: SABER, ELIAS, 0121991, Billing Type: MED, MEDICAID, No. 1100059036), 'Coverages' (Coverage Dates and Status: Begin 04/03/2015, End / /, Priority 1, Capped, Cap Begin / /, Cap End / /), 'Company Information' (Insurance Company Name, Address, Payer ID Qualifier, Payer ID, Last Billed, Cov_id 1100059036), 'Insured Information' (Insurance Addendum, Special TPPCODE, Special DPH Cat, No EI Coverage, No Copay Coverage), 'Group / Dollar Count', 'PA Progress', and 'Note'. A 'Quick Session Report' button is located at the bottom right. A note at the bottom right states: 'Only fill the Special Tppcode for certain MED and OTH coverages. You must also fill the insurance company name when the TPPCODE for this coverage requires it (e.g., 13, 37, 39, 88).'

To add a second coverage, use the New button and it creates a new coverage record for the same client:



Client: SABER, ELIAS 0121991 TPP Cat Frm
Billing Type: [Dropdown] [Dropdown]
No.: [Text Box]
Excluded services: [Text Box]
(Exclude only specific service(s) (such as TA, TB. Or use wildcard T*))

Coverage Dates and Status
Begin: / / [Dropdown]
End: / / [Dropdown]
Priority: [Text Box]
 Capped

When a client enters your program, insurance data is gathered from families and/or referring parties. While the majority of families carry a single policy, some will have more than one. Clients who are covered by neither a third party insurer nor Medicaid will be billed to the Department of Public Health in their role as the payer of last resort. Throughout a client's tenure in your program, their insurance coverage may remain constant or change multiple times.

All insurance information should be entered in the Coverage section of the client's record. A separate coverage record is initiated for each existing policy. If a client enters the program with both Blue Cross and United Health, then 2 coverage records are established, with defining fields to establish a billing order. If these policies terminate in the future, the terminations will be recorded on their coverage records as described below, but the coverage records will not be removed. Whenever a family reports new insurance, a new coverage record will be opened. If a client has 12 different coverages throughout their years in Early Intervention, then 12 coverage records will be attached to their client record by the time of their final discharge, allowing a complete history to be retained for each client.

When a client enters the program, begin a new coverage record for each of their insurance policies. When you open a new coverage, the client's name and DPH I.D. fill in automatically. Use the keyboard or pop-up list to enter the appropriate **Billing Type**.

Client: SABER, ELIAS 0121991 TPP Cat Frm
Billing Type: UHC [Dropdown] UNITED HEALTHCARE 26 H H
No.: 234234141
Excluded services: [Text Box]
(Exclude only specific service(s) (such as TA, TB. Or use wildcard T*))

Coverage Dates and Status
Begin: 01/01/2017 [Dropdown]
End: / / [Dropdown]
Priority: 2
 Capped
Cap Begin: / / [Dropdown]

If the client has an insurance that is not represented on your list, you will need to add it to your rate files. It is important that you choose or create a billing type that accurately reflects your client's coverage. Many of the business rules DPH currently applies to claims are based on their billing type, and the insurance category (ICAT) to which it belongs. For example, DPH rejects copays, deductibles, and capped services from Medicaid and Medicaid HMOs. If you indicate that a client has an HMO Medicaid policy, but it is actually a straight

HMO, you will not be able to transfer balances designated as copays, deductibles, and capped services to DPH.

The billing type field cannot be edited once the coverage has been applied to sessions. If you find you have entered it in error at this point, you must end the coverage and start a new one.

Enter the Policy or Subscriber ID in the **No.** field. For Medicaid clients, the 10-digit Recipient Identification (RID) is entered here. For Medicaid clients, this field can also not be edited once the coverage has been applied to sessions. Since Medicaid RID numbers change frequently, you must close the old coverage record and open a new MED coverage record for the new RID number.

If this payer has notified you of any **Excluded Services**, list them below.

Excluded services	<input type="text"/>
(Exclude only specific service(s) (such as TA, TB. Or use wildcard T*)	

For example, some smaller or out of state insurance companies do not cover group services. If you have sufficient documentation from the payer to prove that an Early Intervention service type is categorically excluded and you note that service type here, all of those services for this child will be automatically reassigned to the 2nd priority insurer during session entry. This is most common for autism services. To all EI services, use the T* wildcard; to exclude all autism services, use the S* wildcard. Otherwise enter a list of Thom Biller service codes to exclude (such as TB, TC).

Needs authorization or PCC: check this when it is true for this coverage.

In rare cases, you will create a DPH coverage record and when you do so, enter the reason in the DPH reason field.

Coverage Dates and Status box

The information in the **Coverage Dates and Status** box helps determine where the client's sessions are billed during any given time period. During session entry, client coverage files are scanned, and the highest priority coverage on the date in question is selected as the billing type. If a child enters the program with a primary Blue Cross policy and backup United Health coverage, Blue Cross will be assigned a **Priority** of 1, and United Health a priority of 2. Use the admission date for the **Coverage Begin**, unless you have a specific policy start date from the family. The **Coverage End** date will most likely remain blank at this time, indicating that the coverage is active.

When sessions are entered for this client, a scan of her coverage files will identify Blue Cross as the correct carrier to bill. If Blue Cross should terminate and a Coverage End date be entered, all sessions entered for a date of service after the Blue Cross end date would be billed to United Health as a valid coverage of the next priority.

The **Priority** field and coverage date parameters also facilitate coverage changes, helping the user to track and reassign sessions whose billing designation is impacted by a coverage termination, a retroactive start date, and similar scenarios. If you discover that your client's Blue Cross policy terminated 3 months ago, you will have sessions in your system whose assignment to Blue Cross is no longer valid. You would edit the Blue Cross coverage record and fill in the termination date. If this client also has new insurance, you would start a new coverage record. Once you have made all edits and/or additions to the coverage record files, you would return to the Client tab and click on the Scan Sessions button. At this point, all sessions designated as Blue Cross with a date of service after the Blue Cross termination date

would be reviewed, and the new active highest priority coverage would be determined. If United Health was a current coverage with a priority of 2, you would be prompted to reassign sessions there. Upon your confirmation, unbilled sessions would be edited to United Health, and sessions billed to Blue Cross with no posted payments or adjustments would be transferred to United Health.

If a coverage becomes **Capped**, check this box and fill in the beginning and ending dates of the capped period. For sessions occurring within this time period, the coverage will be considered unavailable and any other coverage or DPH billing will be recommended. Leave the coverage dates and priority alone. When sessions are entered either before or after the capped period, this coverage will again be used according to its priority.

Coverage Company Information Tab

Dealing with "OTH" Coverage

The **Company Information** tab holds the insurance name and address that will print at the top of claim forms. You may have entered an address in the billing rate file that is correct for this client's claims. If so, leave these fields blank and that address will print on the claims.

If this client's particular plan requires that claims are mailed elsewhere, or you are using a catchall billing type like "OTH," then fill in the specific company data.

The screenshot shows the 'Clients' application window with the 'Coverage' tab selected. The 'Company Information' section is active, displaying the following fields and values:

- Client: ARCSON, STEPHEN (ID: 6400311)
- Billing Type: OTH (dropdown menu)
- No.: 23423432
- Excluded services: (empty field)
- Eligible: (checkbox)
- DPH Reason: (dropdown menu)
- Dollar cnt: (empty field)
- Do Count: (checkbox)
- Insurance Company Name: London Health Admin.
- Address: (empty field)
- Payer ID Qual: (dropdown menu)
- Payer ID: (empty field)
- Special TPPCODE: 39 (dropdown menu)
- Special DPH Cat: I (dropdown menu)

Two callout boxes provide additional instructions:

- A yellow callout box points to the 'Insurance Company Name' field: "Insurance Name detail needed for '39' to fill in the TPPCODE8 field on the SDR."
- A white callout box points to the 'Special TPPCODE' field: "You must fill the insurance company name when the TPPCODE for this coverage requires it (e.g., 13, 37, 39, 88) as set in your DPH Billed To port."

So now you must make a series of decisions when you set up a client coverage record:

1. You decide the billing type (such as MED, BCB, etc.)
2. If this billing type has a specific DPH TPPCODE attached to it with no special conditions, such as BCB – 36, you are done.

3. Two of our billing types (MED, OTH) have been "broken down" by DPH into several specific TPPCODES. For example, there are several MassHealth codes (e.g., 43, 44, 45, 46, 47) for non-standard types of Medicaid coverage. If a client's billing type is MED, you need to research the subtype and enter the special TPPCODE on the client coverage record if it applies. So, if an MED child has 45- MassHealth Buy In coverage, you must put the 45 in the new "Special TPPCODE" field on that client's coverage record. The same has happened for OTH billing types. You may have been using OTH for Champus coverages. Now, you can still use OTH as the coverage but you would have to add 40- Champus to the Special TPPCODE box. So, to find a coverage's TPPCODE, the computer will always look first at the Special TPPCODE box then the code attached to the billing type.
4. After you have figured out the TPPCODE for the coverage, you may still need to type the coverage name into the Insurance Name box. Currently four TPPCODES need this sort of detail added to help DPH know specifically what the third-party payor is. Two are the same as before: 13 – Other Medicaid and 88 – Other insurance. Two new ones are 39- HCVM Health Care Value Management and 37 – Private Health Care Systems. So if the final TPPCODE is either 13, 88, 37, or 39, you must fill in this detail of the insurance name. (Note that if you have picked OTH –88 for the billing type, and a specific special TPPCODE such as 40 - Champus, you do not need to fill in the name because the 40 code does not require detail, even though the coverage screen says OTH – 88 at the top. Remember that the computer will use the 40 code if it is specified instead of the 88 for the billing type, and the 40 does not need detail.)

(Please refer to current DPH specifications for current requirements)

Special Tppcode

In September 2003, DPH asked for some new tppcodes ("Third Party Payer Codes"). These are normally picked up automatically from the billing type (via the rate file), but some of the new codes did not apply to a specific billing type. For example, there were 5 new Medicaid tppcodes for Medicaid subtypes. So we placed a "special tppcode" field on the client coverage record to allow you to override the tppcode associated with a billing type in special circumstances. Unfortunately, some Thom Biller users have filled this field far too often, and sometimes with incorrect information. To reduce errors, we add logic to the Coverage Special Tppcode field that limits what you can enter there as follows.:

- If the coverage billing type is not MED(02), OTH(88), or OTM(13), the field will be disabled and you will not be allowed to enter anything.
- If it is MED(02), then you can only enter the Medicaid subtypes 43-47.
- If it is OTM(13), you can only enter HMO Medicaid codes 35,6,8,34.
- If it is an OTH(88) coverage, then you can only enter other insurance codes that are not already in your rate file.

Insurance Addendum

DPH has asked for a descriptor for each third-party coverage, such as 1-Fully Insured. Please refer to their documentation for details.

Insured Information Tab

The **Insured Information** tab fills the insured's name and address fields on claim forms, helping the carrier to identify the policy being billed.

The screenshot shows the 'Insured Information' tab selected. It contains a checkbox for 'Patient is the Insured', a dropdown for 'Pat. Relation to Insured' set to '19', and a 'Fill' button. Below these are fields for 'Insured Name and Address' with a 'Fill from client information using guardian name and client address' button. The name fields are filled with 'JAMAL' (First), 'AHMBURG' (Last), and '123 N. South St.' (Street 1). Other fields include 'Street 2' (Apt: 679), 'City ST Zip' (TEWKSBURY MA 01876), 'Phone', 'DOB' (08/24/1963), and 'Sex' (M).

If the patient is a child, enter a '19' for the relation to the insured. The Fill button will pull the guardian's name into the insured name.

If the patient is the insured, check this box and an '18' code will indicate the relation to the insured is "Self". Now the Fill button will pull the client's name into the insured name fields.

Group / Note Tab

The screenshot shows the 'Group / Note' tab selected. It contains fields for 'MMIS', 'Lock MMIS' (checkbox), 'Dollar cnt', 'Do Count' (checkbox), 'Group/Mass Health' (group: tft1), 'Sequence', 'Plan' (plan: tft1), 'Employer' (emp: tft1), 'Note' (text area), 'Last Billed' (02/24/2010), and 'Cov_id' (5000000088).

The **Group/Note** tab stores additional plan information. Store either a plan **Group** number or the **Mass Health** card number, and the Mass Health **Sequence** number. If you have specifics on the insured's **Plan**, **Employer**, or work **Location**, enter them. The more information you are able to complete, the more likely the insurance company will be to identify the subscriber and process the claim.

For CMS-1500 paper billing forms, this information is printed in either the #11 or #5 Field sets, depending on the payer and whether it is a secondary bill or not.

On normal (non-secondary) bills the field mapping is as follows:

- Group field → Field 11
- Plan field → Field 11c
- Employer field → Field 11b

On non-MED secondary bills, the information from the current coverage goes in the same fields as above (Fields 11) and the information from the other (primary) coverage goes in fields 5. In the example below, a client has TFT for priority 1 and BCB for priority 2. The “secondary” BCB bill is illustrated:

Clients (Open Clients Only)

Client: AAAMED3, JOHN 0133399 TPP Cat Frm

Billing Type: TFT TUFTS 21 H H

No. tuftprimary111

Excluded services: []

Eligible: Y DPH Reason: []

Needs Authorization or PCC num

Coverage Dates and Status

Begin: 01/01/2010

End: / /

Priority: 1

Capped

Company Information

MMIS: [] Lock MMIS:

Group/Mass Health: group:tft1

Plan: plan:tft1

Employer: emp:tft1

Note: []

Last Billed: / /

Cov_id: 5000000088

Primary TFT

Clients (Open Clients Only)

Client: AAAMED3, JOHN 0133399 TPP Cat Frm

Billing Type: BCB BLUE-CROSS 36 I H

No. bcbsecondary111

Excluded services: []

Eligible: Y DPH Reason: []

Needs Authorization or PCC num

Coverage Dates and Status

Begin: 01/01/2010

End: / /

Priority: 2

Capped

Company Information

MMIS: [] Lock MMIS:

Group/Mass Health: group:bcb2

Plan: plan:bcb2

Employer: emp:bcb2

Note: []

Last Billed: / /

Cov_id: 5000000089

Secondary BCB

1500
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) AAAMED3, JOHN
3. PATIENT'S BIRTH DATE MM | DD | YY 01 | 03 | 10 SEX M F

4. INSURED'S I.D. NUMBER (For Program in Item 1) bcbsecondary111
5. PATIENT'S ADDRESS (No., Street) adfasdfa adfasdfa
6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S NAME (Last Name, First Name, Middle Initial) AAAMED3, JOHN
8. INSURED'S ADDRESS (No., Street) adfasdfa adfasdfa
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial) AAAMED3, JOHN
10. IS THIS INSURED'S POLICY OR GROUP NUMBER? YES NO

11. INSURED'S POLICY GROUP OR FECA NUMBER group:bcb2
12. INSURED'S DATE OF BIRTH MM | DD | YY 01 | 03 | 10 SEX M F

13. EMPLOYER'S NAME OR SCHOOL NAME emp:bcb2
14. INSURANCE PLAN NAME OR PROGRAM NAME plan:bcb2
15. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.

16. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 02 24 10

17. DATE OF CURRENT ILLNESS (First symptom) OR
18. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS
19. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

Secondary BCB has BCB coverage information here

And TFT Coverage info from priority 1 records here

MassHealth has a different approach to secondary MED claims. They want the other (primary) coverage information put in Fields 11. In the example before, the client has BCB priority 1 and MED priority 2. The secondary MED bill is shown:

Clients (Open Clients Only)

Client: AAAMED2, JIM | 0122222 | TPP Cat Frm
Billing Type: BCB | BLUE-CROSS | 36 | I | H
No.: bcbprimary1111
Excluded services:
Eligible: Y | DPH Reason:
 Needs Authorization or PCC number

Company Information: MMIS: Lock MMIS:
Group/Mass Health: group:bcb1 | Sequence:
Plan: plan:bcb1 |
Employer: emp:bcb1 |
Note:
Last Billed: / / | Cov_id: 5000000084

Coverage Dates and Status: Begin: 01/01/2010 | End: / / | Priority: 1 | Capped | Cap Begin: / /

Primary BCB

below, the client has TFT priority 1, BCB priority 2, and MED priority 3. The transfers to MED are being billed as a “secondary” run:

The screenshot shows the 'Clients (Open Clients Only)' window with the 'Clients' tab selected. The client information is as follows:

- Client: AAAMED3, JOHN (ID: 0133399)
- Billing Type: TFT (TUFTS)
- No.: tuftprimary111
- Eligible: Y
- Priority: 1
- Group/Mass Health: group:tft1
- Plan: plan:tft1
- Employer: emp:tft1
- Cov_id: 5000000088

A callout box labeled 'Primary TFT' has arrows pointing to the 'Priority 1' field and the 'group:tft1' field.

The screenshot shows the 'Clients (Open Clients Only)' window with the 'Clients' tab selected. The client information is as follows:

- Client: AAAMED3, JOHN (ID: 0133399)
- Billing Type: BCB (BLUE-CROSS)
- No.: bcbsecondary111
- Eligible: Y
- Priority: 2
- Group/Mass Health: group:bcb2
- Plan: plan:bcb2
- Employer: emp:bcb2
- Cov_id: 5000000089

A callout box labeled 'Secondary BCB' has arrows pointing to the 'Priority 2' field and the 'group:bcb2' field.

Clients (Open Clients Only)

Clients **Coverages** **Authorizations**

Client: AAAMED3, JOHN 0133399 TPP Cat Frm

Billing Type: MED MEDICAID 02 M H

No. aaamed3cov

Excluded services: _____

Eligible: DPH Reason: _____

Needs Authorization or P_____

Coverage Dates and Status

Begin: 01/01/2010

End: / /

Priority: 3

Capped

Cap Begin: / /

Cap End: / /

Company Information

MMIS: _____ Lock MMIS Dollar cnt: _____ Do Count

Group/Mass Health: group:med3 Sequence: _____

Plan: plan:med3

Employer: emp:med3

Note: _____

Last Billed: / /

Cov_id: 5000000090

Tertiary MED

1. MEDICARE MEDICAID TRICARE CHAMPUS (Sponsor's SSN) CHAMPVA (Member ID#) GROUP HEALTH PLAN (SSN or ID) FECA BLK LUNG (SSN) OTHER (ID)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
AAAMED3, JOHN

5. PATIENT'S ADDRESS (No., Street)
adfasdfa adfasdfa

CITY: adfasdfaf STATE: MA

ZIP CODE: 11111 TELEPHONE (Include Area Code): ()

8. PATIENT STATUS
Single Married Other

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)
AAAMED3, JOHN

10. OTHER INSURED'S POLICY OR GROUP NUMBER
bcbsecondary111

11. INSURED'S POLICY GROUP OR FECA NUMBER
group:tft1

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED Signature on File DATE 02 24 10

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED Signature on File

Tertiary MED (priority 3) coverage number

Priority 1 coverage information (TFT)

Priority 2 coverage information (BCB)

PATIENT AND INSURED INFORMATION

Client Authorizations

Many insurers require programs to obtain prior approval or authorization prior to service delivery. Once received, an authorization number and its specific parameters should be

entered into Thom. This helps staff track which services have a proper approval, which are missing one, and which authorizations are coming up for renewal. Most importantly, it allows authorization numbers to print out on claim forms, increasing the likelihood that bills will be paid. During session entry, client files are checked for authorizations that match the session parameters, and the appropriate authorization number is linked to the session. In addition, a scan is done when you enter the authorization in case it covers some sessions that have already been entered.

Once an authorization has been received, go to the corresponding **Coverage** tab of the client's file. Click on the **Authorization** tab and open a new one. In the **Client and Coverage** box, the **Client**, **DPH ID**, and **Billing Type** fill in automatically.

The **Dates of Coverage** box notes the **Begin** and **End** dates of this insurance. Below, fill in the **Dates of Authorization** specified by the insurer. The authorization cannot begin prior to the coverage beginning date. If it is useful to note when permission for the next approval was **Sent** and **Received**, use these optional fields.

In the **Authorization** area, you will enter the parameters of the approval. The insurance authorization or Medicaid PCC number goes in the **PA/PCC** field, and the Medicaid **PCC Name** on the next line. The doctor's **Phone** number can be filled in for optional reference for Medicaid clients. A referring provider name and NPI may also be entered.

If the authorization is for specific service types enter each of them in the **Service** field; *if it applies to all services, leave this field blank*. If you do fill this field, which should be a rare event, you will be reminded that it is only for limiting the authorization to specific services. Leave it blank if you want the authorization to apply to all services (the usual case). Do not

write a note in this field because it will cause the authorization to not be applied to any service. Enter the correct service code, such as "TA" or several separated by commas.

The screenshot shows the 'Clients (Open Clients Only)' window. The 'Clients' tab is selected. The 'Client and Coverage' section contains fields for Client (AAABCB, ROSELY), Billing Type (BCB), and a field with the value 1709748. The 'Authorization' section includes fields for PA/Pcc # (12312313121), Ref Pro Last Name, Ref Pro First Name, Ref Pro NPI, and a field for 'Authorize Only Specific Service(s) (such as TA, TB. Or use wildcard T*)' containing 'S*'. A callout box points to the 'S*' field with the text 'wildcard for all autism services'. The 'Dates of Authorization' section has fields for Begin (07/02/2012) and End. At the bottom, there are checkboxes for 'Do Authorization Count', 'Balance', and 'Count Units', and buttons for 'Quick Session Report' and 'Authorization Scan'.

You can also use wild cards for either all EI or autism services. Use T* to limit the authorization to service codes starting with "T" (EI codes). Use S* to limit the authorization to service codes starting with "S" (autism services). A child receiving both types of services will probably need multiple authorization records tailored to the specific services.

Similarly, if the insurer has approved a specific number of services, enter it in the **Visit Balance** field and click on the **Count Visits** button. This will count down from the original amount as you enter sessions (and show on the session entry screen as you go). If the authorization applies to unlimited services within a given timeframe, skip these features. If you want to count hours, select that as the type of unit to be counted.

If you want to count up the total screenings and assessments associated with an authorization, check the "**Count screening and assessment visits**" box. This count will start at 0 and will offer you a display of the counted visits under the "Display" button.

The Quick Session Report will show all sessions stamped with this authorization.

The Authorization Scan button will apply any changes (such as new date ranges) to existing sessions. (An authorization scan will happen automatically when key changes are made, whether you press this button or not).

Special cases for Medicaid RID/MMIS and PCC changes

Medicaid RID/MMIS numbers and PCC information is stored the same way as other third-party payor and PA information: the RID is on the coverage screen and the PCC is on the authorization screen.

What is unusual for Medicaid clients is how often the RID/MMIS changes while they remain covered by MED. Most other payors leave the subscriber (coverage) number pretty much constant. Particularly unusual for MED cases is having the RID number change while the PCC number remains the same. Usually for other insurances, there may be several authorization changes without any changes to the basic coverage information.

Because we want to retain old RID/MMIS and PCC information, we have had to develop a slightly cumbersome procedure for handling new RID/MMIS numbers. The solution is to open a new MED coverage record to store the new RID/MMIS and give it new dates as appropriate. In doing this, we end the old MED coverage record with the old RID/MMIS number. This works fine but just looks and feels a bit odd: we are closing one MED coverage and opening another MED coverage right after it. As long as you remember that what is being changed is the RID/MMIS number (not the overall coverage), this works fine.

An added complication is when you open a new coverage for the new RID/MMIS, you also have to open another authorization record and refill it with the PCC information (which may not have changed). The reason is that the system was designed to limit each PA/PCC record to its “parent” coverage record.

Autism Coverage and Authorization Issues

Autism coverage and authorization presents some special challenges, but the process is the same. In general, the billing system is trying to assign the proper coverage to any given service. To do this, it uses the payer and service information in the rate file to make high level decisions, then it uses the coverage and authorization information to make client-specific decisions. For autism services, there are a few payers that don’t cover autism at all and use a secondary payer, often a “behavioral health” arm) to handle them. And even for payers that generally cover autism services, a given child’s plan may exclude them. Finally, most payers require prior authorizations. So, setting up the system to handle autism services requires correct information at the rate file, coverage, and authorization level.

Rate File Considerations

We will touch briefly on the rate file issues in this section. For payers such as Harvard Pilgrim that do not cover autism, their rate file should not have any autism services in it (below):

09/12/2017 Page: 1

Billing	Overall Template	Begin	End	SSP Payer	Schedule	DPH Code	DPH Categ.	DPH Form	Needs PA
HPO HARVARD PILGRIM HMO	HPO	10/01/2016	/ /		OCT-NOV	20	H	H	N
TA HOME VISIT				DPH Serv: A	Code: H2015	Rate: 89.40	CR: 0.00		
TB CENTER-BASED INDIVIDUAL VISIT				DPH Serv: B	Code: T1015	Rate: 74.96	CR: 0.00		
TD PARENT-FOCUSED GROUP SESSION				DPH Serv: D	Code: T1027	Rate: 33.52	CR: 0.00		
TG ASSESSMENT				DPH Serv: G	Code: T1024	Rate: 119.92	CR: 0.00		
TH ASSESSMENT				DPH Serv: H	Code: T1024	Rate: 119.92	CR: 0.00		
TI INTAKE HOME VISIT				DPH Serv: I	Code: H2015	Rate: 89.40	CR: 0.00		
TM Child Focused Group Community				DPH Serv: M	Code: 96153	U2 Rate: 34.32	CR: 0.00		
TN CHILD-FOCUSED EI Only				DPH Serv: N	Code: 96153	U1 Rate: 26.12	CR: 0.00		
TQ EIPP SCREENING				DPH Serv: E	Code: T1023	Rate: 104.48	CR: 0.00		

Count: 9

You see only EI services for this payer.

Also the HPO rate record points to the payer who is designated as the secondary autism payer, in this example, “UBH”.

If you check UBH services, you'll see they only have autism services (that start with "S"):

09/12/2017 Page: 1

Billing	Overall	Begin	End	SSP	Schedule	DPH	DPH	DPH	Needs
	Template			Payer		Code	Categ.	Form	PA
UBH	UNITED BEHAVIORAL / OPTUM HPO	10/01/2016	/ /	UBH	OCT-NON	70	H	H	Y
SB	Initial Direct Instruction (low)	DPH Serv: S	Code: H2019	U2	Rate: 58.92	CR: 0.00	Y		
SC	Initial Direct Instruction (high ra	DPH Serv: S	Code: H2012	U2	Rate: 111.36	CR: 0.00	Y		
SD	Initial Assessment	DPH Serv: S	Code: H0031	U2	Rate: 111.36	CR: 0.00	Y		
SE	Re-assessment	DPH Serv: S	Code: H0031	U2	Rate: 111.36	CR: 0.00	Y		
SF	Treatment Planning	DPH Serv: S	Code: H0031	U2	Rate: 111.36	CR: 0.00	Y		
SG	Parent Training	DPH Serv: S	Code: H2012	U2	Rate: 111.36	CR: 0.00	Y		
SL	Initial Supervision (high rate)	DPH Serv: S	Code: H0032	U2	Rate: 111.36	CR: 0.00	Y		
SR	Subsequent Direct Instruction (low)	DPH Serv: S	Code: H2019	U2	Rate: 58.92	CR: 0.00	Y		
SS	Subsequent Direct Instruction (high ra	DPH Serv: S	Code: H2012	U2	Rate: 111.36	CR: 0.00	Y		
ST	Subsequent Supervisi (high rate)	DPH Serv: S	Code: H0032	U2	Rate: 111.36	CR: 0.00	Y		

Count: 10

So the "high level" decision making for an autism service goes something like this: check if the primary payer covers autism (has autism services in it). If not, see if there is a designated Autism Secondary Payer that does.

At the coverage and authorization level, this means a child with Harvard Pilgrim primary, should have UBH added as a secondary coverage if he is receiving autism services. The billing system will automatically jump to the UBH when autism services are entered (below).

With primary coverage:

The screenshot shows the 'Clients (Open Clients Only)' window with the 'Clients' tab selected. The client information is as follows:

- Client: A-HPO-UBH, JOHNY (ID: 0190001)
- Billing Type: HPC (Selected)
- Plan: HARVARD PILGRIM HMO (TPP Cat Frm: 20 H H)
- No.: HPO1231211
- Excluded services: (Empty field)
- Needs Authorization or PCC:
- DPH Reason:

The 'Authorizations' tab is also visible, showing:

- Coverage Dates and Status:
 - Begin: 01/01/2017
 - End: / /
 - Priority: 1
 - Capped:
 - Cap Begin: / /
 - Cap End: / /

Note, there is no need to exclude autism services with an “S*” because this is handled globally by the rate file: HPO does not have any autism services.

And secondary coverage:

The screenshot shows the 'Clients (Open Clients Only)' window with the 'Clients' tab selected. The client information is as follows:

- Client: A-HPO-UBH, JOHNY (ID: 0190001)
- Billing Type: UBH (Selected)
- Plan: UNITED BEHAVIORAL / (TPP Cat Frm: 70 H H)
- No.: UBH123456
- Excluded services: (Empty field)
- Needs Authorization or PCC:
- DPH Reason:

The 'Authorizations' tab is also visible, showing:

- Coverage Dates and Status:
 - Begin: 01/01/2017
 - End: / /
 - Priority: 2
 - Capped:
 - Cap Begin: / /
 - Cap End: / /

With UBH authorization:

The screenshot shows the 'Clients (Open Clients Only)' window with the 'Coversages' tab selected. The client information is as follows:

- Client and Coverage:
 - Client: A-HPO-UBH, JOHNY (ID: 0190001)
 - Billing Type: UBH (Selected)
 - Plan: UNITED BEHAVIORAL / OPTUM
- Authorization:
 - PA/Pcc #: UBHauth123
 - Ph: (Empty field)
 - Ref Pro Last Name: (Empty field)
 - Ref Pro First Name: (Empty field)
 - Ref Pro NPI: (Empty field)
 - Authorize Only Specific Service(s) (such as TA, TB. Or use wildcard T*): (Empty field)
- Dates of coverage:
 - Begin: 01/01/2017
 - End: / /
- Dates of Authorization:
 - Begin: 01/01/2017
 - End: / /
 - Sent: / /
 - Received: / /

When you add an autism session for this child, it automatically locates the UBH coverage because of the way the rate file is configured:

The screenshot shows the 'Add Sessions' window with the following details:

- Client:** A-HPO-UBH, JOHNY
- Provider:** ASH540, ELIZABETH
- SSP:** BUBL
- Session:** 09/01/2017
- Service:** SB Initial Direct Instruction (low)
- Rate:** 58.92
- Bill:** UBH
- Bill Hr:** 1.00
- Setting:** K01
- Place:** [dropdown]
- Units Per Hour:** 4
- Proc Code:** H2019-U2
- Fee:** 58.92
- DPH Information:** Co Tx N, IFSP Meeting, Assessment Home Visit, Supervision Co-Tx HV, Waiver, DPHID 0190001
- PA Information:** PA/Pcc UBHauth123, Name, Dates 01/01/2017 to / /, Auth Visit Bal 0.00, Screen Cnt 0, Auth Svs
- Note:** [empty text area]
- Quick Session Report:** [button]
- Claim ID:** [empty], **EID:** 9010856933

Client-level Considerations

Thom Biller also allows client-level control over the how autism services are handled. Say a child has Blue Cross, which covers autism services in general (and has them in the rate file.) If a child has a Blue Cross policy that also covers autism, then you just set up the BCB coverage as expected (and get the prior authorization).

The screenshot shows the 'Clients (Open Clients Only)' window with the following details:

- Client:** A-BCB, BILLY
- DPHID:** 0190002
- Billing Type:** BCB
- Coverage:** BLUE-CROSS
- No.:** BCB12312
- Excluded services:** [empty]
- Needs Authorization or PCC:**
- DPH Reason:** [empty]
- Coverage Dates and Status:** Begin 01/02/2017, End / /, Priority 1, Capped , Cap Begin / /, Cap End / /
- Company Information:** [empty]
- Insured Information:** [empty]
- Group / Dollar Count:** [empty]
- PA Progress:** [empty]
- Note:** [empty]

Clients (Open Clients Only)

Client and Coverage
 Client: A-BCB, BILLY 0190002
 Billing Type: BCB BLUE-CROSS

Authorization
 PA/Pcc #: BCBauth0011 Ph: _____
 Ref Pro Last Name: _____
 Ref Pro First Name: _____
 Ref Pro NPI: _____
 Authorize Only Specific Service(s) (such as TA, TB. Or use wildcard T*)

Dates of coverage
 Begin: 01/02/2017
 End: / /

Dates of Authorization
 Begin: 01/02/2017
 End: / /
 Sent: / /
 Received: / /

And autism sessions would go in smoothly to BCB:

Add Sessions

Client: A-BCB, BILLY T Cov
 Provider: ASH540, ELIZABETH AEL01 Disc J
 SSP: BUBL Invoice
 Session: 09/02/2017
 Service: SB Initial Direct Instruction (low) Proc Code: 0364T
 Bill: BCB Rate: 33.00 Flat Rate Units Per Hour: 0
 Bill Hr: 1.00 Fee: 33.00
 Setting: K01 Place: _____ Forced:
 DPH Information
 Co Tx: N DOB: 01/02/2017
 IFSP Meeting DPH Rea: _____
 Assessment Home Visit
 Supervision Co-Tx HV
 Waiver: _____ DPHID: 0190002 1
 Serv_id: 9000000017 Type: SERV
 Ref: _____ Pay: _____
 Bal: _____ Posted: / /
 PA information
 PA/Pcc: BCBauth0011
 Name: _____
 Dates: 01/02/2017 to / /
 Auth Visit Bal: 0.00 Screen Cnt: 0
 Auth Svs: _____
 Note: _____
 Quick Session Report
 Claim ID: _____ EID: 9010856934

However, if Johnny's Blue Cross coverage excluded autism services, you would enter this on his coverage record (because in general, and in the rate file, Blue Cross covers autism):

Clients (Open Clients Only)

Client: A-BCB-NOAUTISM, JO 0160004 TPP Cat Frm
 Billing Type: BCB BLUE-CROSS 36 I H
 No.: BCBnoautism1231
 Excluded services: S* (indicated by an arrow)
 (Exclude only specific service(s) (such as TA, TB. Or use wildcard T*))
 Needs Authorization or PCC DPH Reason: _____

Coverage Dates and Status
 Begin: 01/01/2004
 End: / /
 Priority: 1
 Capped
 Cap Begin: / /
 Cap End: / /

Company Information Insured Information Group / Dollar Count PAProgress Note

And autism services would go to DPH during session entry:

Note, you would have to manually select the DPH reason, in this example, D25 means “autism is not a covered benefit.”

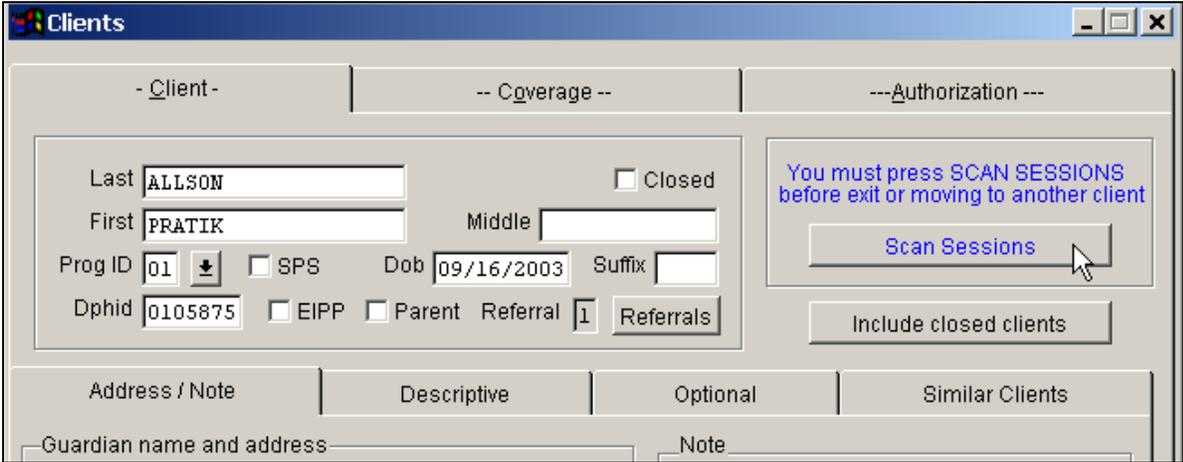
Note also that this DPH claim is using the “hidden” DPH coverage record (literally Priority 4). You would not actually create a DPH coverage record in this situation. The hidden DPH coverage is meant for these specific “payer of last resort” situations.

Finally, you may wonder what happens if you have provide an autism service before it is authorized.

You get a warning. In general, it is best practice to hold off entry of sessions until you have the authorization.

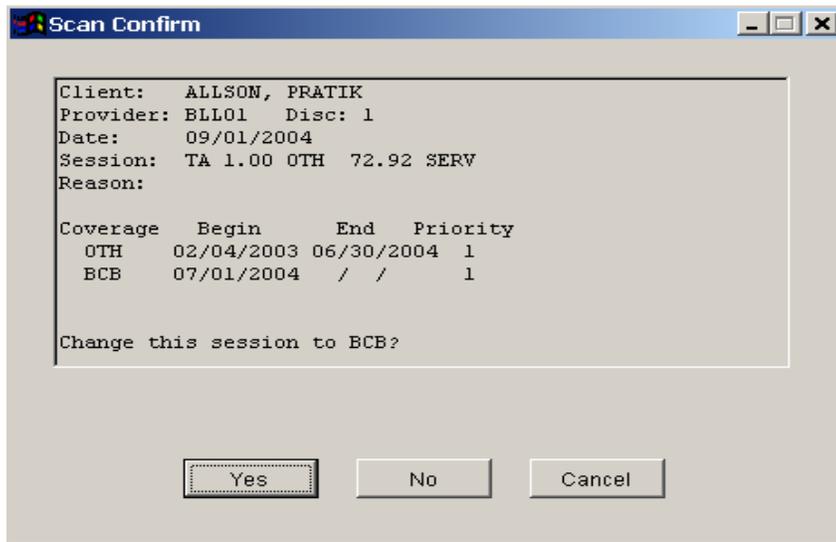
Coverage Scans

When you change the date range or priority of a coverage, the software will require you to run a coverage scan before you close the client form or move to another client (see below)

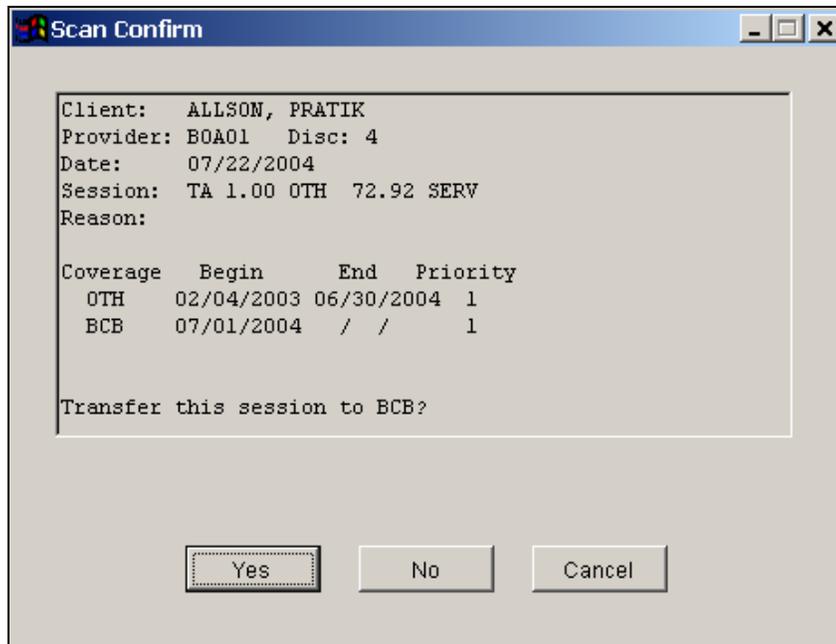


The coverage scan is normally limited to the last 120 days as it reviews each session and checks whether it has the correct coverage (given the changes you have just made). If the current recommended coverage is different, the scan will take some action to either correct it automatically, or prompt you to correct it.

The exact action taken depends on the complexity and billing status of the claim. The simplest situation is an unposted SERV session for a coverage that has been closed and replaced with a new one. In this case, the coverage scan will simply offer to edit the billing type on the session to the new value. It can be edited because it has not yet been posted (see below).



A little more complicated is a single SERV session that has already been posted and billed to the old (incorrect) billing type. The coverage scan will offer to transfer the session to the new billing type



Notice the screen is asking you to confirm a "transfer". The earlier, simpler situation asked you to confirm a "change".

A little more complicated is a claim that had been partially paid and now your coverage changes suggest it should be transferred. This would be unlikely because you have information that the coverage had closed, so why would it have been partially paid? But, if this happens, the coverage scan will take you to the Transfer screen and ask you to do something with it (below).

Transfer Only

Name: Post:

Session	Serv	Pid	Pdi	Bhour	Btype	Fee	Pay	Eve_type	Ref	Bal	Pdate
07/22/2004	TA	CAE01	3	1.00	OTH	72.92	0.00	SERV		22.92	12/07/200
07/22/2004	TA	CAE01	3		OTH		50.00	PAY	1321		12/07/200

Claim Information

Bill: Note:

Original billed hours:

Claim Bal:

MED Reason: Tcn:

MISC Reason: Resub: Rec W.O.:

Select Action

The most complicated is an old session that has been partially paid and then the balance transferred to DPH. This is also the most unlikely, because the coverage that you closed actually was paying for services. But it is logically possible, so this is how it is handled in the system. First you get a caution screen (below)

Caution

At least one paid non-DPH claim has a new recommended billing.

Current paid billing type: OTH
Recommended billing: BCB

Since the current claim was paid, no transfer will be offered. Please review the new coverage information after the scan because it may have incorrect date or priority settings.

That warns you that at least one claim for the old coverage has already been paid. This should get you thinking about why you closed the coverage in the first place! Although it does not automatically produce a transfer, the scan does take you to the Pay Transfer Adjust screen for the claim to show you what you've got.

Add Sessions

Introduction to EI Session Entry

The Add Sessions form is used for recording delivered services. Each record entered becomes the beginning of a claim that will be billed. This form draws from many tables to intelligently assign services to specific coverages, authorizations, and waivers. It is therefore important to have all this client information established before attempting to enter sessions.

When you open the Add Sessions screen, review the following entry parameters in the **Session Entry Settings** box:

Session Entry Settings

Manual Session Entry

Carry Client Forward

Carry Provider

Carry Session Date

Suggested Service

Suggested Hours

(fill any four of the 5 items above)

OR

Load SSP Claims

Limit run to single SSP (optional)

Report of Unprepped SSP Claims

Report of SSP Claims Ready for Session Entry

Show all providers in the dropdown list

Show only (EI) providers with discipline not "J"

Show only autism providers with "J" discipline

OK

If you choose to carry data forward, the client, provider, and/or session fields will come up blank for your 1st entry. Then, whatever names and/or date you enter for this 1st session will continue to fill for subsequent sessions until you change them. Once changed, these new values will continue to fill until changed. Answer these first three questions based on how your program organizes logs, or session / activity data. At most programs, clinicians fill out a sheet with their daily or weekly visits. In that case, say No to carrying clients forward, since you will not be entering session after session for the same client. Say Yes to carrying providers forward, since you will be entering an entire week of each staff's visits. And answer Yes to carrying session date forward, since you will be entering multiple visits on each date of service.

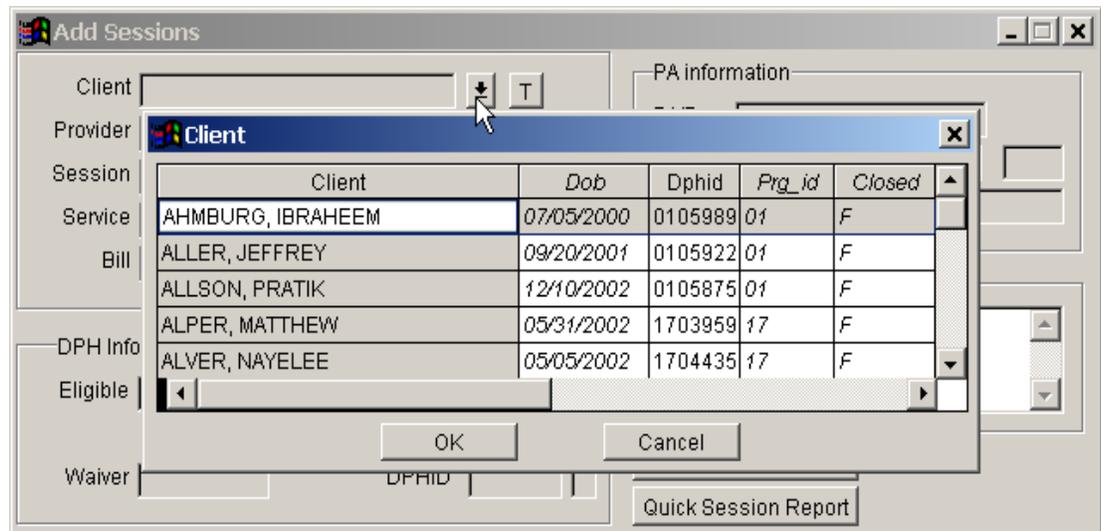
Suggesting data means that the value you choose to suggest – TA for service type, 1.00 for hours – will appear on every new session. If you are entering a different service type or hours, you will change it on that individual session, but your suggested values will reappear on the next one. If the majority of the services your program performs are 1.00 home visits,

you might choose to enter TA as the suggested service and 1.00 as the suggested hours. If your program delivers a wider array of services, then you might want to leave these blank.

The Load SSP Sessions from Spreadsheet checkbox initiates a process of loading autism specialty services from a spreadsheet and is discussed in a separate section below.

The Providers displayed can be limited to EI or Autism Only if desired.

Once your parameters are set, the **Add Sessions** form appears. Open a new session record and select a **Client** by opening the pop-up box with the mouse or F2 key.



Typing the 1st few letters of the client's last name will move you to that section of the alphabet. Use the cursor keys to select the exact client, and hit return or click on OK. If you have several clients with the same or similar names, use their DPH i.d.s and/or birth dates to help you select the correct one.

Type in the **Provider ID** or choose it from the pop-up list. Their name and **Discipline** appears to the right for confirmation purposes.

Type in the date of service in the **Session** field.

The system internally reviews the client’s coverages, and selects the highest priority active coverage for this date. You will see the abbreviation for the chosen Billing type fill in below, and ninety-nine percent of the time you will accept this choice.

Occasionally, you may have reason to direct a particular session to one of the client’s other coverages or to DPH, such as when you are billing a transition visit. In these cases, use the pop-up box next to the Bill type to view a list of all of the client’s coverages and select one. The system will warn you that you are not choosing the recommended coverage; confirm your choice if applicable. Note that you are limited to insurance carriers that already have a coverage record in this client’s file, and to DPH.

Next, enter the **Service** type or use the pop-up list to select it. Both Early Intervention and the specific insurance carrier’s regulations define the options. They will include TA (home visit), TB (center-based visit), TC (child group), TD (parent group), TE (screening), TG (initial assessment), and TH (follow-up assessment), and may also include special carrier-defined services (e.g., Medicaid’s TK, or Developmental Day visit).

In the **Bill Hour** field, indicate the duration of the session in quarter hour intervals. The Fee will automatically calculate from the rate files.

The optional **Prov Hr** field is for tracking provider hours. These would normally be the same as billed hours, except in groups. Whether this field is visible or not is determined by the setting on the Data/Agency screen. Whether it is filled in with the billed hours as a default value is determined by the setting for the particular service on the rate file.

As you enter each session, the system checks the client file for an authorization that matches the selected billing type, service date, and service type. If there is an applicable authorization, then it is linked to the session and specifics are displayed in the **PA Information** box. The **PA/PCC** number will appear, along with the **PCC Name** for Medicaid clients. Lastly, the beginning and ending **Dates** of the authorization are listed. The **NA** checkbox indicates that the coverage needs an authorization or pcc number. (This value is set on the coverage record itself and is most useful for distinguishing MassHealth coverages that do and do not need a referral authorization).

The **Auth Visit Bal** field means the current authorized visit balance. This value is enabled and maintained on the authorization record for authorizations that are limited to a certain number of visits. It counts down as visits are entered and will generate a warning when it approaches zero.

The **Screen Cnt** field counts up the number of screening or assessment visits, if enabled on the authorization record.

The **DPH Information** box contains DPH-defined fields, four of which must be completed on every session. Sessions will not be allowed to save if any of the following four fields are blank. **Eligible** asks whether or not you have confirmed that the client is eligible for coverage with this payer, and can be filled with **Yes** or **No**. The **Eligible** field is listed on each coverage record, and the session entry routine looks to this record for a suggested response. Thus, filling it on the coverage record will eliminate the need to answer it for each individual session.

The **IFSP Meeting** field indicates that the service was for an IFSP meeting.

The client's **Referral** number will be suggested based upon the referral records in their client file. The system will search for a referral that covers the date of service for which you are currently billing. If it cannot find one, you will not be allowed to save your session, and you will need to go back to the client record and enter an appropriate referral.

If the client has waivers, a **Pick Box** will pop up when you come to the **Waiver** field. It will display the first waiver, and you can scroll through the list of all the client's waivers. If you find one that applies to your current entry, click on the **Select this waiver** button.

If this session is being billed to DPH, an explanatory **DPH Reason** code is required. If the client's priority 1 insurance is DPH, the reason code that has been entered on the DPH coverage record should fill. Otherwise, use the pull-down button to select the appropriate code from the list.

Once your entry is complete, **save** the session. The system will perform a series of checks to ensure that an identical session has not been previously saved, or that the session is not exceeding any service limitations. In your rate files, there are fields to indicate the maximum hours per day or visit, maximum visits per day or week, and maximum visits per discipline. If you have filled these fields, then these checks will be implemented. For instance, if you have indicated in your rate files that only 2 child groups per week are allowed, and you are attempting to save a 3rd, you will receive a warning.

For discharged clients (those whose Discharge date has been filled on the client record), the system will only allow a single transition visit (home visit) of up to 2 hours. If the referral has an ending date already filled in (usually on the discharge date), the system will automatically extend the referral period to cover the transition visit. So for example, if client is discharged on 5/15/01, you would end the current referral on that date (under **Edit – Client**). This will automatically fill the discharge date as well. If you do a transition visit on 6/01/01, it will be allowed and the referral end date will automatically be pushed back to 6/01/01. The discharge date stays where it was. If you try to enter any more sessions after 5/15/01, they will be disallowed.

If you want to review other recent entries for this client, use the **Quick Session Report** button. Make a decision about the appropriateness of the session and save or cancel accordingly.

The **Alias Lookup** button opens a small screen that has all alternate names for clients ("aliases") linked to the current client name in the system. This small form responds to the

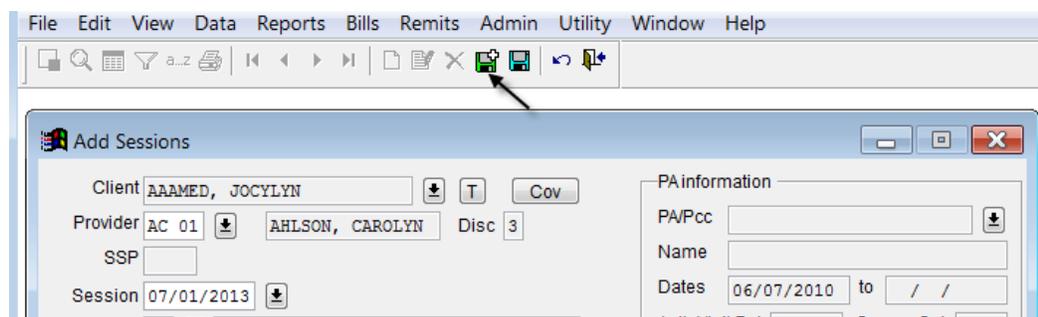
"List" button on the toolbar which offers search and sort by either the alias or client name. This is just a lookup form; it does not change anything on the session itself. If you find a client name, you must manually enter it in the session. This "Alias Lookup" form can also be run on its own from the Misc. Utilities choices.

When you finish entering a batch of sessions, you may use either the List or Print Preview options to review them. If you are reviewing by List and discover an error, highlight and click on that session to pull it up. If you are using Print Preview, close the preview to return to the session form and use the Next and Prior navigation buttons to find the session. In either case, select the Edit button to access the session once you have located it, and make the necessary changes.

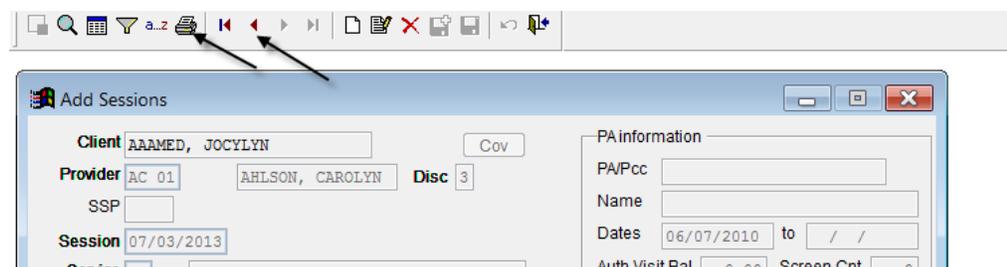
As you leave the routine, you have the option of getting a summary or detailed printout of your entries.

Navigation, Editing, and Printing During Session Entry

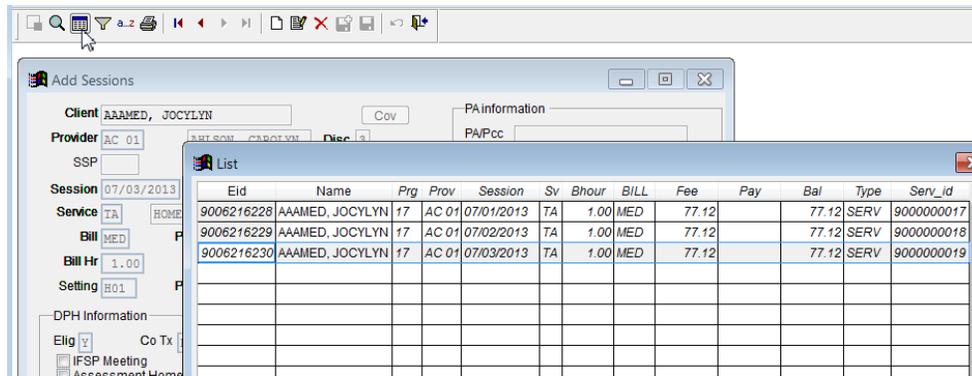
As you enter sessions, you will often use the "More" button to both save a record and add a new one (below):



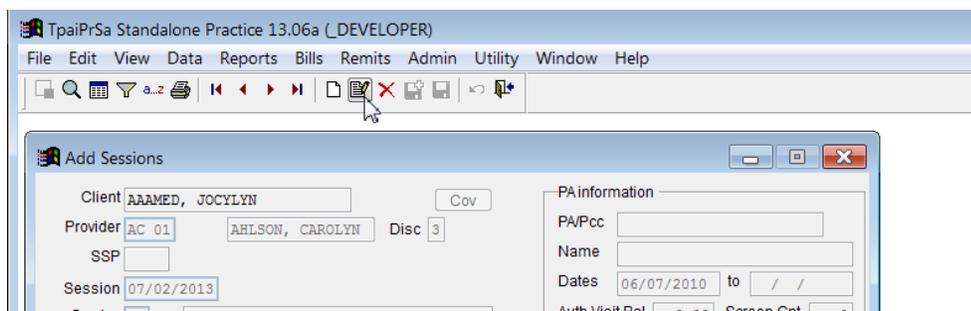
At certain points, you may want to review your work and make corrections before you exit. To do this, you must save your most recent session using the "Save" button instead of the "More" button. Once you do this, you will see that all the navigation buttons and the print button are activated (below):



So now you can use the arrows to move back to previous records. You can also use the "List" button to browse your records:



When you locate a record that needs to be edited, press the “Edit” button to enable editing of that record (below):



And if you want to review your work on paper before you exit, press the “Print” button. This brings up the same report you will see automatically as you exit the Add Sessions routine. Most people like to double check and make sure the new sessions match the provider timesheet that they are working from.

It is important to remember that you can edit during the session entry process; you do not need to use the separate “Edit Session” routine. In fact, you should not have that open on your computer at the same time as the “Add Session” screen because they can conflict with each other.

Discussion and Examples

The coverage I was expecting for a client does not show up as an option in the billing type box.

Once you have selected a client, a provider, and a session date, a number of other fields are filled automatically based on this information. The Thom Biller software will automatically create a popup list of all available coverages for this client covering this date. If the coverage you expect is not there, it means it probably has a beginning or ending date that limits it from covering the session date you have entered.

Review the session date and the coverage dates for this client. You can pull down the Clients screen while entering sessions, check the coverage information, and return to the session entry screen. (If you change something on the client's coverage, make you should cancel the session you were working on and re-enter it to make sure it has access to this new data.)

The PA I was expecting does not show for a session.

The PA is looked up after you have entered enough information about a session for the Thom Biller software to find a matching PA. An Authorization record has beginning and ending dates defining which sessions it applies to. It also can be limited to specific services. Make sure the PA you expected has correct dates that cover the session date you are working on.

The Eligible field is blank and shouldn't be.

The Thom Biller software finds the Eligible default value from the coverage record for the billing type you are entering. Check this under the Client Data screen.

The Reason code is blank and shouldn't be.

The Thom Biller software will suggest DPH billing for sessions provided by an educator, and automatically suggest a "113" reason as well. A similar conversion to DPH billing occurs for providers with an "A" discipline, meaning "Related Field Billable to DPH". However, it is up to you, the user to decide the correct reason code for these "A" providers. You can set a default value for each "A" provider in the edit provider screen and this will be suggested when you enter sessions for this provider that are sent to DPH. Often a "907" reason code makes sense for "A" providers. Go to Data / Providers and locate the default DPH reason code there for each of your "A" (related discipline) providers. If your session entry is not suggesting a reason code for your "A" providers, check the defaults on their provider record .

The service type I wanted to enter does not show up in the service code box.

The options presented for service are pulled from the rate file for the billing type you have selected. For example, if a client has BCB coverage, then the BCB rate records will be shown. However, these rate records all have beginning and ending dates, and if you have entered a session that is outside of the date range for the rates you seek, the service type box will be empty.

Check the session date you are entering, then pull down the Rates screen and look at the dates on the billing type you are seeking. Be very careful making rate date changes because these will have a broad impact.

SSP Claim Processing

Introduction

Autism billing by SSPs is handled by SSP spreadsheets that conform to the current requirement. (see below). There are two approaches available to EI programs for handling SSP Claims: one treats each spreadsheet separately as a sort of invoice of its own, the other treats each line on a spreadsheet as a claim and adjudicates each separately. The first approach requires more manual handling and discussion with SSPs as errors are corrected on each spreadsheet until it is completely correct; the second is more automated and allows some claims to be accepted and others rejected on an Explanation of Payments (EOP).

Setting the SSP Claim Approach

You set the approach in the Data/Agency screen.

The screenshot shows the 'Agency Setup' window with the 'Other' tab selected. The 'SSP Settings' section is expanded, and the 'No EOPs / One CSV at a time' checkbox is checked and highlighted with a black arrow. The 'Settings' tab is also visible, showing various configuration options like 'Exit after re-indexing', 'Limit session scans to # days', and 'Posting Closed'.

Agency Name: A. Thom Clinic
Address: Central St, #22
City / State / Zip: MA 01760-3758
Phone: (655) 655-5222
Contact: HLEEN REED
Provider Signature: ICHEN ROWE
Fed Tax ID: 68 (prints on paper HCFA bills, not HIPAA electronic ones)
NPI: 820
Taxonomy Code: 261Q...OX

Settings

- Exit after re-indexing
- Show Provider Hr field during session entry
- Limit session scans to # days: 90
- Business days to recover OS billing: 3
- Recovery status:
- Posting Closed: 12/10/2004
- DPH Fee Report Begin: 01/11/2012
- Offer Transition Group
- Use Alternate Session Entry Field Order
- Auto Archive (base and standalone only)
- Last Archive: 06/14/2017
- Days since last session to autoclose providers (leave 0 for no provider autoclose):

Other

SSP Settings —(base and standalone only)

- No EOPs / One CSV at a time
- Check this if you want to deal with only one SSP spreadsheet at a time and treat the spreadsheet as a single invoice. You will not be able to print EOPs and you will not be able to track SSP claims separately from the sessions you enter.
- Off Site SSP Load (base only)
- If either No EOP or Off Site Load selected, claim prep will not reject claims.
- Enforce Hard SSP Rules (30 hrs max per week)
- Enforce SSP Service Rate Rules
- SSP Filling Limit (days): 60
- Require Correct SSP Payer
- Require Correct Hr. Increment
- Lock SSP Billed Hr
- Lock SSP Service
- Lock SSP Procedure Code

OK Cancel Sys_id Prefix 90

This is also where rules can be set for enforcement, but when the "No EOP" choice is made, no claims are actually REJECTED at any point in the process.

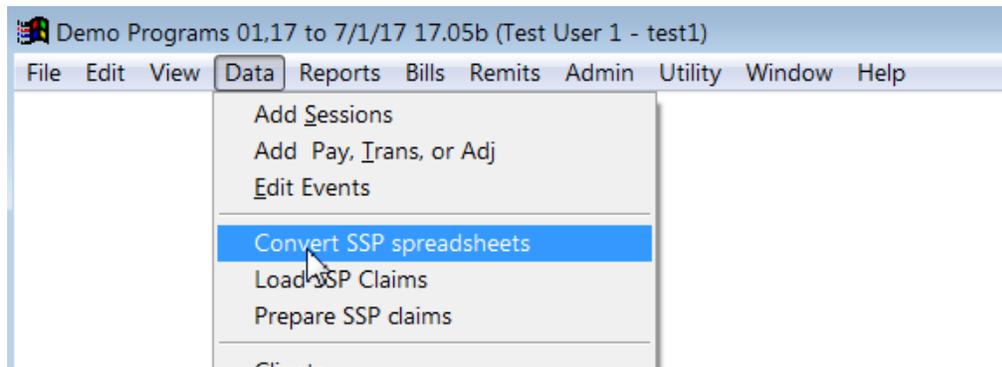
Convert SSP Spreadsheet

The SSP spreadsheet must be in the proper format based on a template provided by Thom.

Thom - SSP Activity Report (Revised 4/6/17)														
Specialty Program:		Beacon		Date Submitted:		7-Jul		SSP Internal Use						
EI Program:		1		Time Period:		7-Jul								
Service Type (ABA or Non-ABA):		ABA		Tracking Number:		(fill if desired)								
Client Name	EHS #	Date	Service Code	Location Code	Provider Name	Procedure Code	Mod	Payer	Hours	Units	SSP Unit Rate	SSP Fee (units * rate)	Session Notes	Comments if billing DPH
RSSP2, MARCOS	123299	7/1/2017	DI	K01	SSPPRO1, VANESSA	H2012	U2	MED	1.00	1	100.22	\$100.22		
RSSP2, MARCOS	123299	7/2/2017	PT	K01	SSPPRO1, VANESSA	H2012	U2	MED	1.00	1	100.22	\$100.22		
RSSP1, DAMIEN	123355	7/3/2017	DI	K01	SSPPRO1, VANESSA	0364T		BCBS	0.50	1	29.70	\$29.70		
RSSP1, DAMIEN	123355	7/3/2017	DI	K01	SSPPRO1, VANESSA	0365T		BCBS	1.00	2	29.70	\$59.40		
RSSP1, DAMIEN	123355	7/4/2017	TP	K01	SSPPRO2, ELIZABETH	G9012		BCBS	2.00	1	100.80	\$100.80		
RSSP1, DAMIEN	123355	7/5/2017	PT	K01	SSPPRO2, ELIZABETH	0370T		BCBS	1.25	1	100.80	\$100.80		
Totals:									6.75			\$491.14		

* Hours must have proper increment for payer's units per hour requirement.
** include modifier for BCBS Reassessment 0359T-52.

Convert the spreadsheet to csv as follows (or manually save as csv):



 Convert SSP Spreadsheets to CSVs

Spreadsheet file

Move spreadsheets to "Converted" subfolder when done

Target path

Completed File List

Spreadsheet: F:\ThomDemo\SSP spreadsheets\01-BEA-170707.XLS
Converted to: F:\THOMDEMO\SSP CSVS\01-BEA-170707.csv
Spreadsheet moved to: F:\ThomDemo\SSP spreadsheets\Converted\

SSP Claim Load (NO EOP Approach)

Locate the csv to load and enter needed information. Press Load.

No EOPs will be offered. SSP claim records are temporary. Only one SSP spreadsheet can be loaded at a time and all previous SSP claims must be cleared (deleted) from the SSP table before proceeding. Please make sure you have run any needed SSP claim reports on your previous SSP claims before deleting them.

Recent CSV Claim Load Runs...

07/05/2017 MAY 21 Note: MAY 6/17/17-6/23/17
File: 21-MAY-170703 W.E. 6-23-17 THOM WIT.CSV

07/05/2017 MAY 49 Note: MAY 5/22/17 RESUBMIT
File: 49-MAY-170605 W.E. 5-31 THOM SIT RESUBMIT.CSV

07/05/2017 MAY 49 Note: MAY 6/12/17-6/16/17
File: 49-MAY-170630 W.E. 6-16-17 THOM SIT.CSV

07/05/2017 MAY 49 Note: MAY 6/17/17-6/23/17
File: 49-MAY-170703 W.E. 6-23-17 THOM SIT.CSV

07/05/2017 REAC 49 Note: REAC 6/19/17-6/30/17
File: 49-REA-170705 THOM SITS 6.19 TO 6.30.CSV

07/05/2017 REAC 49 Note: REAC Supplemental - June
File: 49-REA-170705 THOM SITS SUPPLEMENTAL - JUNE.CSV

Spreadsheet file (Locate File)

Prog Run Report Add "0" to DPHIDs (if missing for ASC clients)

SSP Service Type (set by SSP selection)

Submission Date (date SSP uploaded the spreadsheet)

Move file to "Loaded" folder when done
 Print single page summary

Completed File List
(cut and paste into email if desired)

You'll get a report of the spreadsheet values directly:

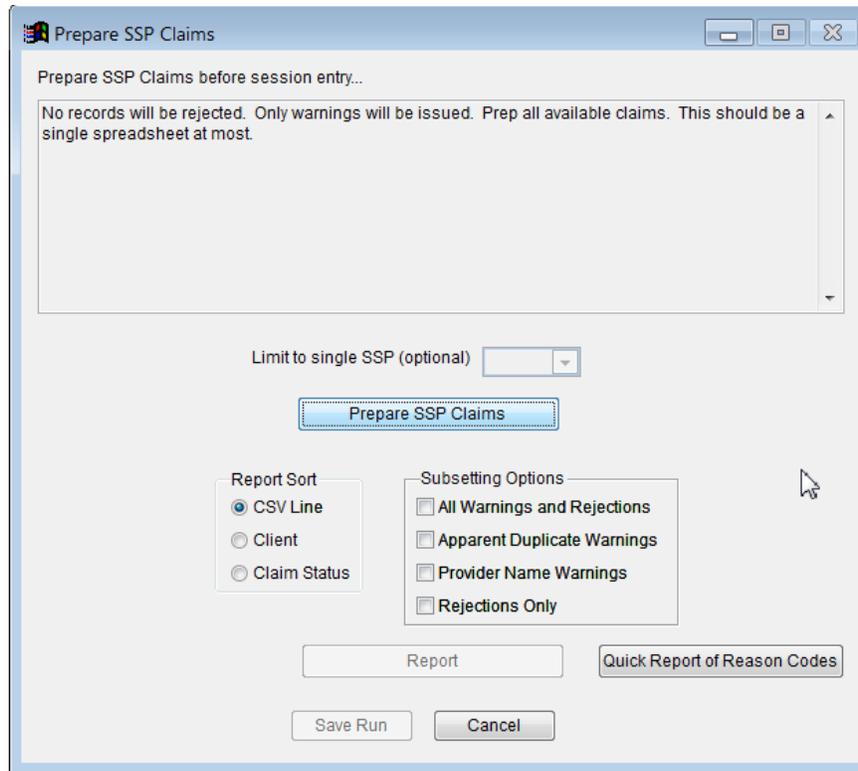
Spreadsheet Records											
Line	Client	Dphid	Date	Ser	Loc	Provider	Proc	Mod	Payer	Hours	SSP Fee
SSP Comments											
01	RSSP2, MARCOS	0123299	07/01/2017	DI	K01	SSPPRO1, VANESSA	H2012	U2	MED	1.00	\$100.22
02	RSSP2, MARCOS	0123299	07/02/2017	PT	K01	SSPPRO1, VANESSA	H2012	U2	MED	1.00	\$100.22
03	RSSP1, DAMIEN	0123355	07/03/2017	DI	K01	SSPPRO1, VANESSA	0364T		BCBS	0.50	\$29.70
04	RSSP1, DAMIEN	0123355	07/03/2017	DI	K01	SSPPRO1, VANESSA	0365T		BCBS	1.00	\$59.40
05	RSSP1, DAMIEN	0123355	07/04/2017	TP	K01	SSPPRO2, ELIZABETH	G9012		BCBS	2.00	\$100.80
06	RSSP1, DAMIEN	0123355	07/05/2017	PT	K01	SSPPRO2, ELIZABETH	0370T		BCBS	1.25	\$100.80
*** Total ***										6.75	\$491.14

Then one of how they are saved within Thom Biller:

Line	Client	Date	Proc	Mod	Payer	Hrs	SSP Fee	Claim Status	Rea	Allowed	Loaded
Provider	Dphid	Serv	Sv	Bill	Reason Description	Sent to OS					
SSP	Prg	Clm_id	ABA	Loc	Reason Note	Prepped					
EID	CSV_ID	Line	SSP note	Revised	Adjudicated	Posted					
CSV File											
1	RSSP2, MARCOS	07/01/2017	H2012	U2	MED	1.00	100.22			0.00	07/07/2017
	SSPPRO1, VANESSA	0123299	DI								/ /
	BEAC 01 9000149424	Y	K01								/ /
	9000138917	1									/ /
	01-BEA-170707.CSV										/ /
2	RSSP2, MARCOS	07/02/2017	H2012	U2	MED	1.00	100.22			0.00	07/07/2017
	SSPPRO1, VANESSA	0123299	PT								/ /
	BEAC 01 9000149425	Y	K01								/ /
	9000138917	2									/ /
	01-BEA-170707.CSV										/ /

Prepare SSP Claims

If you are dealing with just one SSP spreadsheet ("No EOP") at a time, you will be immediately taken to the SSP Prep routine.



This attempts to match the SSP's codes to those in Thom Biller. If the client, provider, or service cannot be located, warnings will be reported.

If it all goes smoothly you'll see just a final report such as this:

07/07/2017 Page 1

SSP Claim Prep Run: 9000138918

SSP Claim Prep Report In Spreadsheet Order

Client	Thom CID	Clm_id	Dphid	Date	Proc	Mod	Payer	Hours	Provider	Claim Status		
	CSV_ID	Line	ABA	Entered	Setting	Serv	Sv	Bill	PID	SSP	SSP Fee	Reason Code
	SSP Note				Reason Description	Conversion Note						
RSSP2, MARCOS	1100017912	9000149424	0123299	07/01/2017	H2012	U2	MED	1.00	SSPFR01, VANESSA			
	9000138917	1	ABA	07/07/2017	K01	DI	SC	MED	ALV01	BEAC	100.22	
RSSP2, MARCOS	1100017912	9000149425	0123299	07/02/2017	H2012	U2	MED	1.00	SSPFR01, VANESSA			
	9000138917	2	ABA	07/07/2017	K01	PT	SG	MED	ALV01	BEAC	100.22	
RSSP1, DAMIEN	1100017982	9000149426	0123355	07/03/2017	0364T		BCBS	0.50	SSPFR01, VANESSA			
	9000138917	3	ABA	07/07/2017	K01	DI	SB	BCB	ALV01	BEAC	29.70	

SSP Session Entry

Once the SSP claims have been prepped, you can do SSP session entry:

The screenshot shows a dialog box titled "Session Entry Settings" with a standard Windows window border. The dialog is divided into several sections. The top section, "Manual Session Entry", contains five options: "Carry Client Forward", "Carry Provider", "Carry Session Date", "Suggested Service" (a dropdown menu), and "Suggested Hours" (a text input field containing "0.00"). Below these is the instruction "(fill any four of the 5 items above)". A central "OR" separator is followed by a section containing a checked checkbox for "Load SSP Claims" and a dropdown menu for "Limit run to single SSP (optional)". Below this are two buttons: "Report of Unprepped SSP Claims" and "Report of SSP Claims Ready for Session Entry". The bottom section contains three radio button options: "Show all providers in the dropdown list" (which is selected), "Show only (EI) providers with discipline not 'J'", and "Show only autism providers with 'J' discipline". An "OK" button is located at the bottom center of the dialog.

Under Add Sessions, choose Load SSP Claims.

This brings up a two panel window that shows SSP claims at the bottom and resulting (accepted) billable sessions at the top:

Press Accept Claim to load it for final review and saving:

Then press Save and Next & Accept. Work your way through all claims.

EOP Approach to SSP Claims

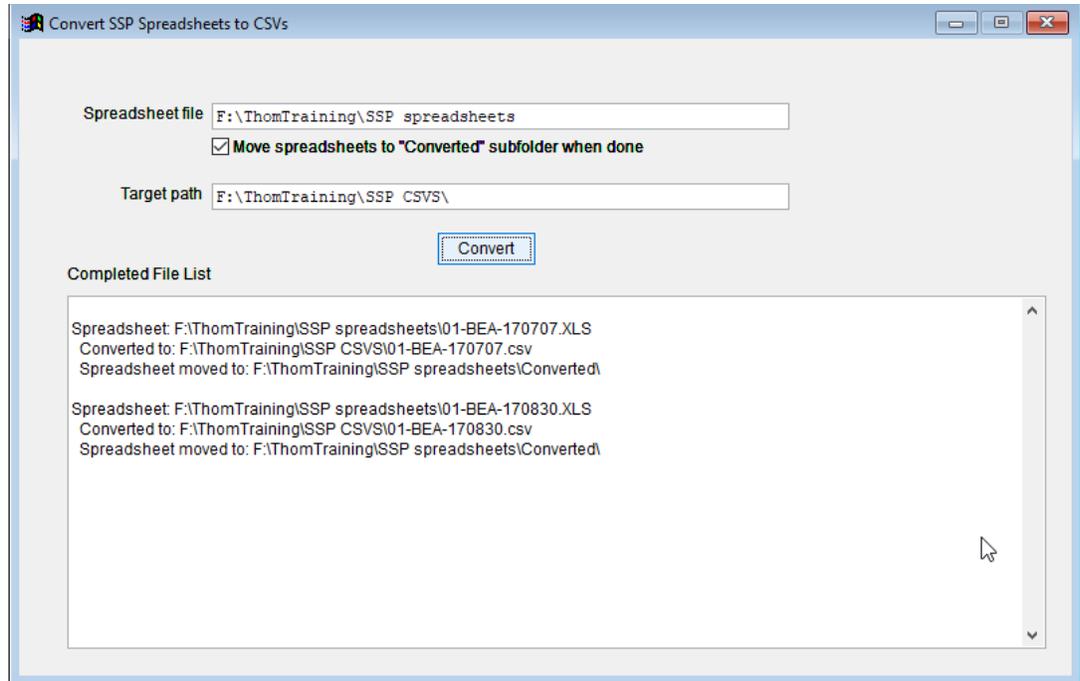
This approach, set in the Data/Agency tab as discussed above, treats every line on an SSP spreadsheet as a claim that is adjudicated and reported back to the SSP on an “Explanation of Payments” (EOP).

The screenshot shows a software dialog box with two tabs: 'Settings' and 'Other'. The 'Other' tab is active and contains a section titled 'SSP Settings – (base and standalone only)'. This section includes several checkboxes and text boxes. Two black arrows point to specific settings: one points to the 'No EOPs / One CSV at a time' checkbox, and the other points to the 'Enforce SSP Service Rate Rules' checkbox. Other visible settings include 'Enforce Hard SSP Rules (30 hrs max per week)', 'Require Correct SSP Payer', 'Require Correct Hr. Increment', 'Lock SSP Billed Hr', 'Lock SSP Service', and 'Lock SSP Procedure Code'. The 'Settings' tab on the left contains various other configuration options like 'Exit after re-indexing', 'Limit session scans to # days', and 'Posting Closed'.

We recommend turning the rules require correct SSP payer and other values and to prevent billing staff from altering the data when entered.

Convert SSP Spreadsheet (EOP Approach)

The Convert SSP spreadsheet step is the same as that noted above, simply creating a CSV file out of the spreadsheet.



SSP Claim Load (EOP Approach)

With the EOP approach, SSP claims are stored permanently in their own table (separate from billable events). This means more than one spreadsheet can be loaded at once, and they never need to be “cleared” before proceeding to the next one as is needed in the alternative approach.

Other than this, the load process is the same as that discussed above.

SSP Claim Load

This routine now expects the 4-6-2017 Thom Spreadsheet. Use this routine to load an SSP CSV file into the SSP Claims table. It will do minimal testing of the file to make sure it can be read in. If more than 10 claims match existing ones, you will be warned.

Recent CSV Claim Load Runs...

07/05/2017 MAY 21 Note: MAY 6/17/17-6/23/17
File: 21-MAY-170703 W.E. 6-23-17 THOM WIT.CSV

07/05/2017 MAY 49 Note: MAY 5/22/17 RESUBMIT
File: 49-MAY-170605 W.E. 5-31 THOM SIT RESUBMIT.CSV

07/05/2017 MAY 49 Note: MAY 6/12/17-6/16/17
File: 49-MAY-170630 W.E. 6-16-17 THOM SIT.CSV

07/05/2017 MAY 49 Note: MAY 6/17/17-6/23/17
File: 49-MAY-170703 W.E. 6-23-17 THOM SIT.CSV

07/05/2017 REAC 49 Note: REAC 6/19/17-6/30/17
File: 49-REA-170705 THOM SITS 6.19 TO 6.30.CSV

07/05/2017 REAC 49 Note: REAC Supplemental - June
File: 49-REA-170705 THOM SITS SUPPLEMENTAL - JUNE.CSV

Spreadsheet file

Prog Add "0" to DPIDs (if missing for ASC clients)

SSP Service Type (set by SSP selection)

Submission Date (date SSP uploaded the spreadsheet)

Move file to "Loaded" folder when done
 Print single page summary

Completed File List
(cut and paste into email if desired)

The "Completed File List" will show you all the files you have loaded during a single run of this form. The SSP Prep process will not run automatically.

To illustrate error trapping, there are two errors in this loaded file:

BEAC Spreadsheet submitted: 10/05/2017
 File: F:\THOMTRAINING\SSP CSVS\01-BEA-171001.CSV

Basic SSP Claims Report By Order Entered

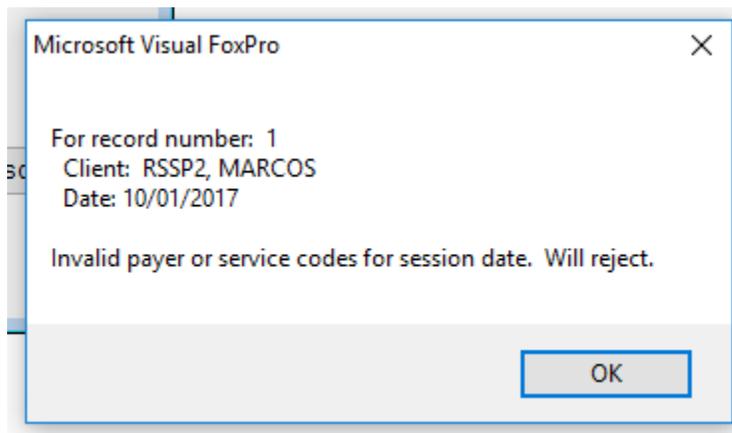
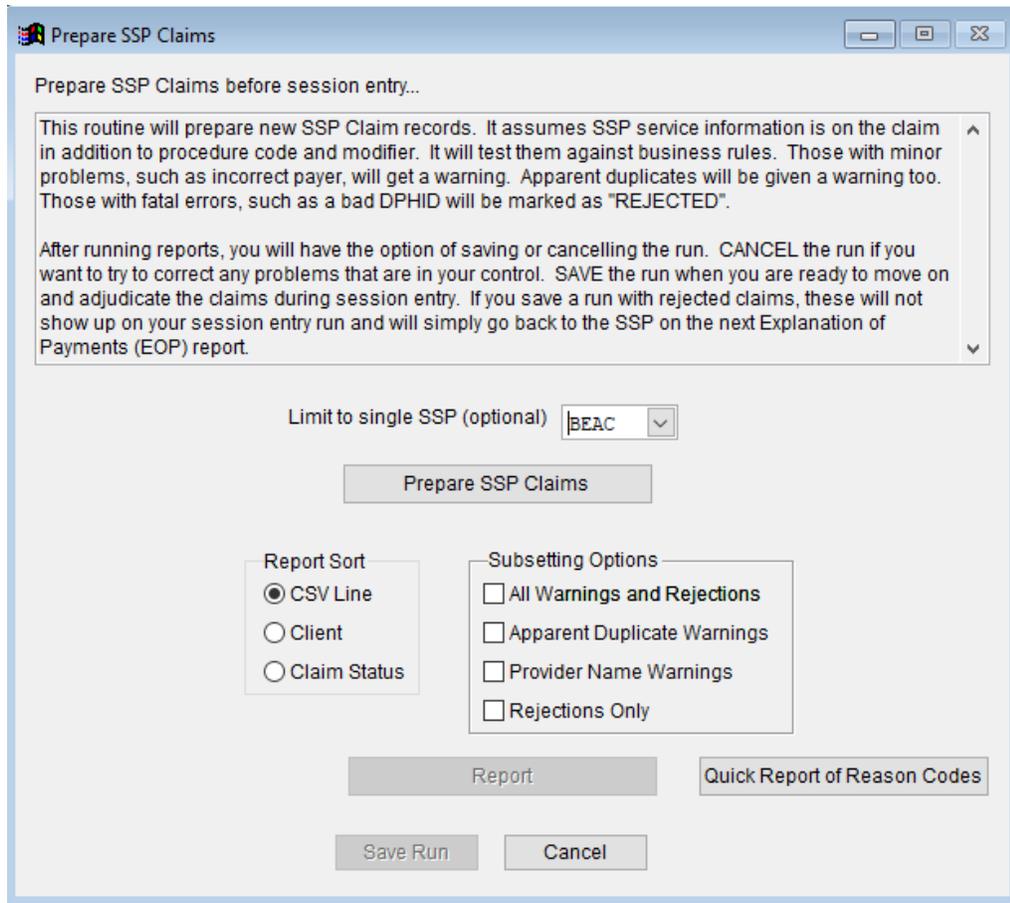
Line	Client	Date	Proc	Mod	Payer	Hrs	SSP Fee	Claim Status	Rea	Allowed	Loaded
Provider	Dphid	Serv	Sv	Bill				Reason Description			Sent to OS
SSP Prg	ABA	Loc						Reason Note			Prepped
EID	CSV_ID	Line	SSP note					Revised			Adjudicated
CSV File											Posted
1	RSSE2, MARCOS	10/01/2017	H2013	U2	MED	1.00	100.22			0.00	10/29/2017
	SSFFROL, VANESSA	0123299	DI								/ /
	BEAC 01 9000149424	Y	K01								/ /
	9000138919	1									/ /
	01-BEA-171001.CSV										/ /
2	RSSE2, MARCOS	10/02/2017	H2012	U2	MED	1.00	100.22			0.00	10/29/2017
	SSFFROL, VANESSA	0123299	PT								/ /
	BEAC 01 9000149425	Y	K01								/ /
	9000138919	2									/ /
	01-BEA-171001.CSV										/ /
3	RSSPL, DAMIEN	10/03/2017	0364T		BCBS	0.50	29.70			0.00	10/29/2017
	SSFFROL, VANESSA	0123355	DI								/ /
	BEAC 01 9000149426	Y	K01								/ /
	9000138919	3									/ /
	01-BEA-171001.CSV										/ /
4	RSSPL, DAMIEN	10/04/2017	0365T		BCBS	1.00	59.40			0.00	10/29/2017
	SSFFROL, VANESSA	0123355	DI								/ /
	BEAC 01 9000149427	Y	K01								/ /
	9000138919	4									/ /
	01-BEA-171001.CSV										/ /

incorrect

should be on same day

Prepare SSP Claims (EOP Approach)

This will REJECT any claims that violate the rules for single claims. In this example, it catches the bad procedure code on the first record. The second error will be trapped during session entry because it involves multiple records and their sequencing.



10/29/2017

Page 1

REJECTED Claims Report for SSP Claim Prep Run: 9000138920

SSP Claim Prep Report by Client

Client	Thom CID	Clm_id	Dphid	Date	Proc	Mod	Payer	Hours	Provider	Claim Status			
	CSV_ID	Line	ABA	Entered	Setting	Serv	Sv	Bill	PID	SSP	SSP Fee	Reason Code	
	SSP Note												
	Conversion Note												
Client: RSSP2, MARCOS													
RSSP2, MARCOS				0123299	10/01/2017	H2013	U2	MED	1.00	SSPPROL, VANESSA		REJECTED	
	1100017912	9000149424			K01	DI				ALV01 BEAC	100.22	CC	
	9000138919	1	ABA	10/29/2017	Service, payer, or date error								
					Invalid payer or service codes for session date. Will reject.								
* Claim Status Subtotal *								1.00			100.22		
*** Total ***								1.00			100.22		

The full report shows all records, including the one rejected claim:

10/29/2017

Page 1

SSP Claim Prep Run: 9000138920

SSP Claim Prep Report In Spreadsheet Order

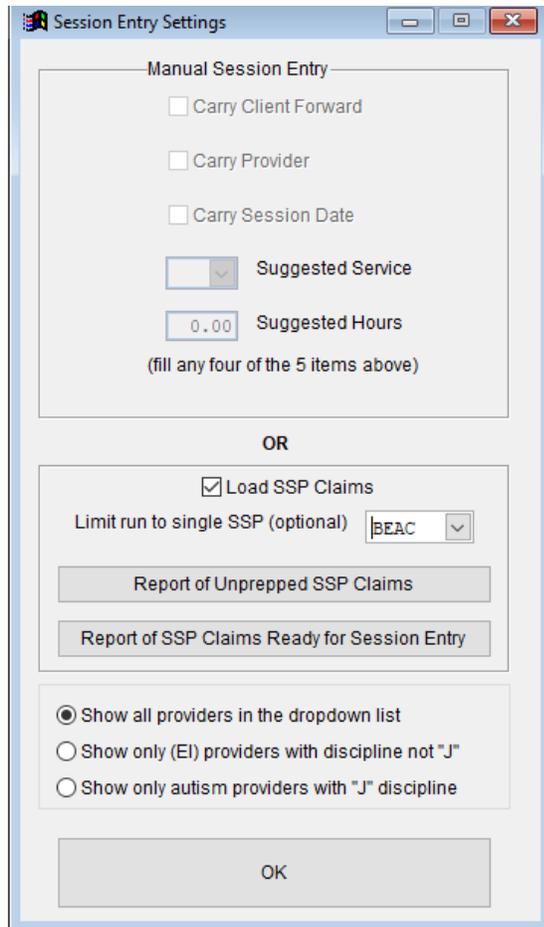
Client	Thom CID	Clm_id	Dphid	Date	Proc	Mod	Payer	Hours	Provider	Claim Status			
	CSV_ID	Line	ABA	Entered	Setting	Serv	Sv	Bill	PID	SSP	SSP Fee	Reason Code	
	Reason Description												
	Conversion Note												
RSSP2, MARCOS				0123299	10/01/2017	H2013	U2	MED	1.00	SSPPROL, VANESSA		REJECTED	
	1100017912	9000149424			K01	DI				ALV01 BEAC	100.22	CC	
	9000138919	1	ABA	10/29/2017	Service, payer, or date error								
					Invalid payer or service codes for session date. Will reject.								
RSSP2, MARCOS				0123299	10/02/2017	H2012	U2	MED	1.00	SSPPROL, VANESSA			
	1100017912	9000149425			K01	PT	SG	MED		ALV01 BEAC	100.22		
	9000138919	2	ABA	10/29/2017									
RSSP1, DAMIEN				0123355	10/03/2017	0364T		BCBS	0.50	SSPPROL, VANESSA			
	1100017982	9000149426			K01	DI	SB	BCB		ALV01 BEAC	29.70		
	9000138919	3	ABA	10/29/2017									
RSSP1, DAMIEN				0123355	10/04/2017	0365T		BCBS	1.00	SSPPROL, VANESSA			
	1100017982	9000149427			K01	DI	SR	BCB		ALV01 BEAC	59.40		
	9000138919	4	ABA	10/29/2017									
RSSP1, DAMIEN				0123355	10/05/2017	G9012		BCBS	2.00	SSPPROC, ELIZABETH			
	1100017982	9000149428			K01	TP	SF	BCB		ESAL7 BEAC	100.80		
	9000138919	5	ABA	10/29/2017									
RSSP1, DAMIEN				0123355	10/06/2017	0370T		BCBS	1.25	SSPPROC, ELIZABETH			
	1100017982	9000149429			K01	PT	SG	BCB		ESAL7 BEAC	100.80		
	9000138919	6	ABA	10/29/2017									
*** Total ***								6.75			491.14		

SSP Claim Prep Run: 9000138920

Session Entry (EOP Approach)

During session entry, all unadjudicated claims will be offered to the biller. Multiple spreadsheets could have been loaded before doing the session entry.

Any claims already rejected by the “Prep” stage will not be shown to the biller.



The screenshot shows a dialog box titled "Session Entry Settings". It is divided into two main sections by an "OR" separator. The top section, "Manual Session Entry", contains five options: "Carry Client Forward", "Carry Provider", "Carry Session Date", "Suggested Service" (a dropdown menu), and "Suggested Hours" (a text box containing "0.00"). Below these is the instruction "(fill any four of the 5 items above)". The bottom section contains a checked checkbox for "Load SSP Claims", a dropdown menu for "Limit run to single SSP (optional)" with "BEAC" selected, and two buttons: "Report of Unprepped SSP Claims" and "Report of SSP Claims Ready for Session Entry". At the bottom of the dialog are three radio buttons: "Show all providers in the dropdown list" (selected), "Show only (EI) providers with discipline not 'J'", and "Show only autism providers with 'J' discipline". An "OK" button is located at the very bottom.

So in this example, the first claim on 10/1 is not shown. The process starts with the 10/2 claim.

The screenshot shows the 'Add Sessions' window with the following data entered:

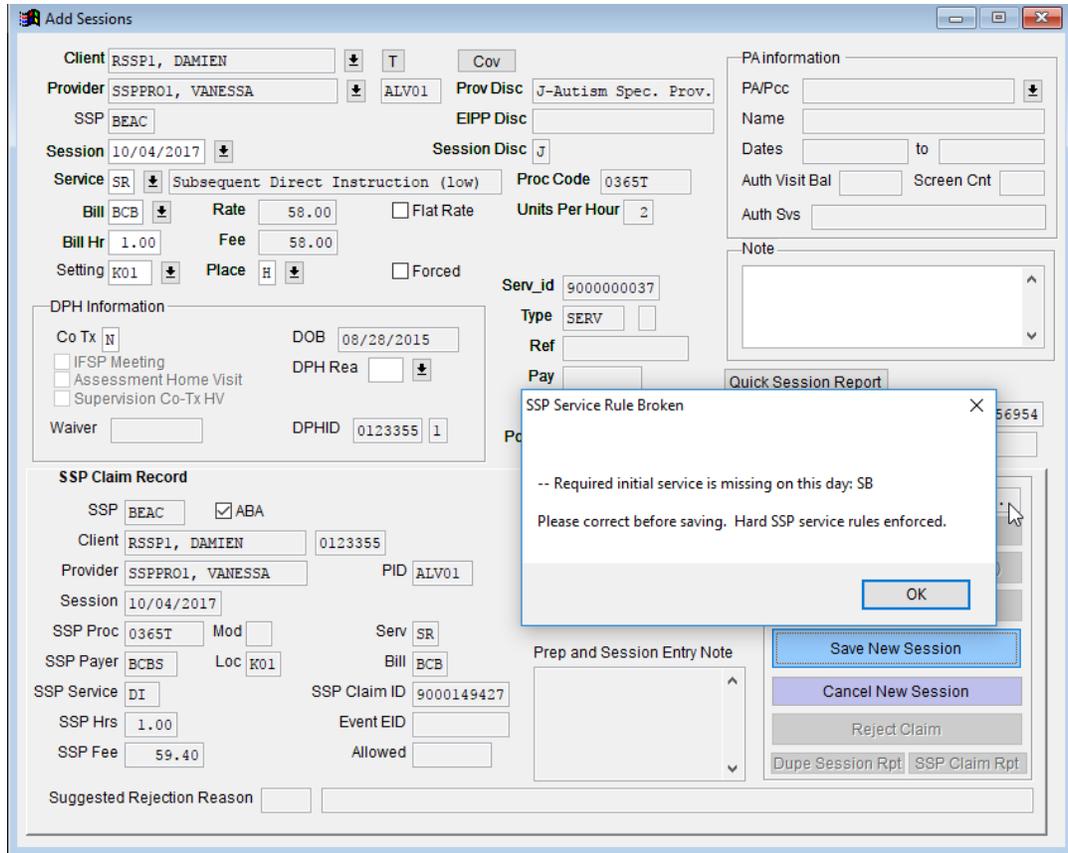
- Client:** BEAC
- Provider:** RSSP2, MARCOS
- Session:** 10/02/2017 (indicated by a black arrow)
- SSP Proc:** H2012
- SSP Payer:** MED
- SSP Service:** PT
- SSP Hrs:** 1.00
- SSP Fee:** 100.22
- SSP Claim ID:** 9000149425

The 'SSP Claim Actions' panel on the right contains the following buttons:

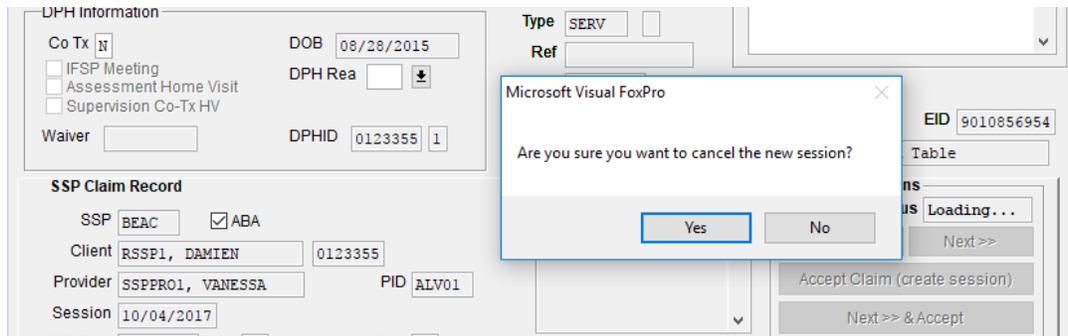
- << Previous
- Next >>
- Accept Claim (create session)
- Next >> & Accept
- Save New Session
- Cancel New Session
- Reject Claim
- Dupe Session Rpt
- SSP Claim Rpt

This claim can be accepted.

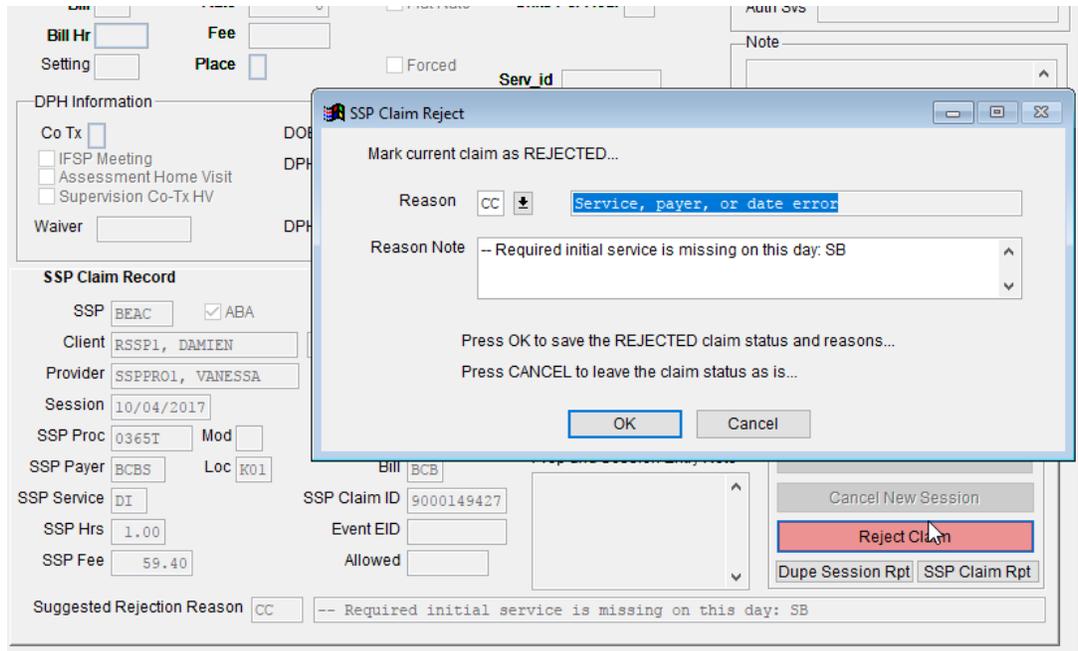
But the BCB 0365T without a preceding 0364T claim must be rejected when the SSP rules are set to be enforced:



Here the user must cancel the new billable session:



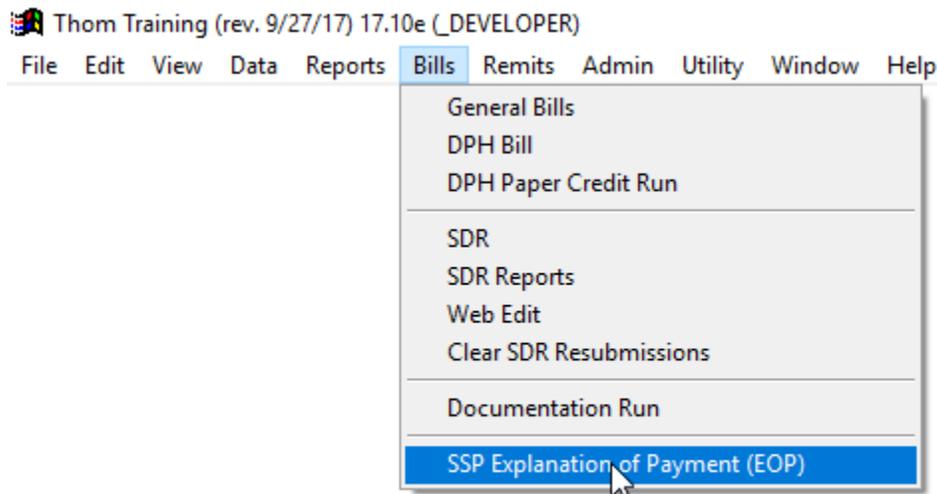
And choose REJECT:



In this example the reason for rejection is suggested.

EOP – Explanation of Payments

The Explanation of Payment is run as follows:



It is analogous to a billing run and will “post” all SSP claims with their claim status: ACCEPTED or REJECTED.

Usually pick “New Unposted Only” (like a billing run).

Usually limit the run to a single SSP.

Usually select Create CSV to send to the SSP (and accept the default file name)

SSP EOP Run

SSP Explanation of Payment (EOP) Run...

This routine will gather, report, and post SSP adjudicated claims on an EOP. The allowable fee on ACCEPTED claims will be totalled for payment to the SSP. REJECTED claims will be reported with associated reasons. Usually, an EOP will gather "new" claims that have not yet been posted. In some cases you may need to report or resubmit claims, so these options are offered as well. When a claim is resubmitted on an EOP, the billing date on the claim will be updated but the original posting date will be retained.

Adjudicated SSP Claims to Include

New Unposted Only Begin 10/29/2016

All within dates End 10/29/2017

Marked Resub / Adjustment within dates

Prior Run (within 2 mo) [dropdown]

Run information

Today's date 10/29/2017

Posting date 10/29/2017

Single SSP (optional) BEAC [dropdown]

Sort final report by program

Include second report of revised claims only

Create CSV output file

F:\SSP EOPs\EOP-BEAC-20171029

Fill Output File Name

Reason Code Report Gather sessions

Print Setup Preview Run Run EOP

Save Cancel

The Preview shows what the EOP run will do: which claims are ACCEPTED and REJECTED:

SSP EOP Preview										
Client	Dphid	Date	Proc	Mod	Payer	Claim St.	Hours	SSP Fee	Allowed	Loaded
SSP Prg Thom CID	Loc ABA	Service	Prep Sv	Bill	Reason					Prepped
Clm_id	Provider		Bill Sv	Bill	Reason Note					Adjudicated
Eid	SSP Note		Revised							Posted
Conversion Note										
* SSP: Beacon Services										
** Program: 01										
*** Claim Status: ACCEPTED										
RSSP1, DAMIEN	0123355	10/03/2017	0364T		BCBS	ACCEPTED	0.50	29.70	29.70	10/29/2017
BEAC 01 1100017982	K01 Y	DI		SB	BCB					10/29/2017
9000149426	SSPFR01, VANESSA			SB	BCB					10/29/2017
9010856953										/ /
RSSP1, DAMIEN	0123355	10/05/2017	G9012		BCBS	ACCEPTED	2.00	100.80	201.60	10/29/2017
BEAC 01 1100017982	K01 Y	TP		SF	BCB					10/29/2017
9000149428	SSPFR02, ELIZABETH			SF	BCB					10/29/2017
9010856955						Fee				/ /
Allowed SSP fee changed.										
RSSP1, DAMIEN	0123355	10/06/2017	0370T		BCBS	ACCEPTED	1.25	100.80	100.80	10/29/2017
BEAC 01 1100017982	K01 Y	PT		SG	BCB					10/29/2017
9000149429	SSPFR02, ELIZABETH			SG	BCB					10/29/2017
9010856956										/ /
RSSP2, MARCOS	0123299	10/02/2017	H2012	U2	MED	ACCEPTED	1.00	100.22	100.22	10/29/2017
BEAC 01 1100017912	K01 Y	PT		SG	MED					10/29/2017
9000149425	SSPFR01, VANESSA			SG	MED					10/29/2017
9010856952										/ /
** Claim Status Subtotal **							4.75	331.52	432.32	
*** Claim Status: REJECTED										
RSSP1, DAMIEN	0123355	10/04/2017	0365T		BCBS	REJECTED	1.00	59.40	0.00	10/29/2017
BEAC 01 1100017982	K01 Y	DI		SR	BCB	CC Service, payer, or date error				10/29/2017
9000149427	SSPFR01, VANESSA					-- Required initial service is missing on this day: SB				10/29/2017
						Fee				/ /
Manually REJECTED in session entry.										
RSSP2, MARCOS	0123299	10/01/2017	H2013	U2	MED	REJECTED	1.00	100.22	0.00	10/29/2017
BEAC 01 1100017912	K01 Y	DI				CC Service, payer, or date error				10/29/2017
9000149424	SSPFR01, VANESSA					Invalid payer or service codes for session date.				10/29/2017
						Fee				/ /
Invalid payer or service codes for session date. Will reject.										
** Claim Status Subtotal **							2.00	159.62	0.00	
** Program Subtotal **										

The actual run report is somewhat simplified for the SSP but shows essentially the same information. Note REJECTED claims have \$0.00 Allowed amounts. A check is written for the Allowed total. (Some of the SSP Fee amounts may have been revised by the adjudication process.)

SSP Claim EOP Subset by EI Program

Client	Dphid	Proc	Mod	Payer	Date	Claim Status	Hours	SSP Fee	Allowed
SSP Prg Provider		Serv	ABA	Loc	Submitted	Reason			
Clm_id	SSP Note					Reason Note			
Eid	EOP Revised Fields								
Load_id	Line Submission File								

* SSP: Beacon Services

** Prg: 01

*** Claim Status: ACCEPTED

RSSP1, DAMIEN	0123355	0364T		BCBS	10/03/2017	ACCEPTED	0.50	29.70	29.70
BEAC 01	SSPPROL, VANESSA	DI	Y	K01	10/05/2017				
9000149426									
9010856953									
9000138919	3 01-BEA-171001.CSV								
RSSP1, DAMIEN	0123355	G9012		BCBS	10/05/2017	ACCEPTED	2.00	100.80	201.60
BEAC 01	SSPPROC, ELIZABETH	TP	Y	K01	10/05/2017				
9000149428									
9010856955	Fee								
9000138919	5 01-BEA-171001.CSV								
RSSP1, DAMIEN	0123355	0370T		BCBS	10/06/2017	ACCEPTED	1.25	100.80	100.80
BEAC 01	SSPPROC, ELIZABETH	PT	Y	K01	10/05/2017				
9000149429									
9010856956									
9000138919	6 01-BEA-171001.CSV								
RSSP2, MARCOS	0123299	H2012	U2	MED	10/02/2017	ACCEPTED	1.00	100.22	100.22
BEAC 01	SSPPROL, VANESSA	PT	Y	K01	10/05/2017				
9000149425									
9010856952									
9000138919	2 01-BEA-171001.CSV								
*** Claim Status Subtotal ***							4.75	331.52	432.32

*** Claim Status: REJECTED

RSSP1, DAMIEN	0123355	0365T		BCBS	10/04/2017	REJECTED	1.00	59.40	0.00
BEAC 01	SSPPROL, VANESSA	DI	Y	K01	10/05/2017	OC Service, payer, or date error			
9000149427						-- Required initial service is missing on this day: SE			
9000138919	4 01-BEA-171001.CSV								
RSSP2, MARCOS	0123299	H2013	U2	MED	10/01/2017	REJECTED	1.00	100.22	0.00
BEAC 01	SSPPROL, VANESSA	DI	Y	K01	10/05/2017	OC Service, payer, or date error			
9000149424						Invalid payer or service codes for session date.			
9000138919	1 01-BEA-171001.CSV								
*** Claim Status Subtotal ***							2.00	159.62	0.00
** Program Subtotal **									

The CSV version looks like this:

A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
ssp_name	prg_id	clifull	dphid	sdate	service	setting	profull	proccode	modifier	payer	bhour	sspfee	sspnote	csvfile
Beacon Se	1	RSSP1, DA	123355	10/3/2017	DI	K01	SSPPROL,	0364T		BCBS	0.5	29.7		01-BEA-17
Beacon Se	1	RSSP1, DA	123355	10/5/2017	TP	K01	SSPPRO2,	G9012		BCBS	2	100.8		01-BEA-17
Beacon Se	1	RSSP1, DA	123355	10/6/2017	PT	K01	SSPPRO2,	0370T		BCBS	1.25	100.8		01-BEA-17
Beacon Se	1	RSSP2, MA	123299	10/2/2017	PT	K01	SSPPRO1,	H2012	U2	MED	1	100.22		01-BEA-17
Beacon Se	1	RSSP1, DA	123355	10/4/2017	DI	K01	SSPPRO1,	0365T		BCBS	1	59.4		01-BEA-17
Beacon Se	1	RSSP2, MA	123299	10/1/2017	DI	K01	SSPPRO1,	H2013	U2	MED	1	100.22		01-BEA-17

O	P	Q	R	S	T	U	V	W	X
csvfile	csvline	claimstatu	fee_allow	reason_cc	reason_code	reason_note_detail	submitted	eop_date	clm_id
01-BEA-17	3	ACCEPTED	29.7				10/5/2017	10/29/2017	90001494
01-BEA-17	5	ACCEPTED	201.6				10/5/2017	10/29/2017	90001494
01-BEA-17	6	ACCEPTED	100.8				10/5/2017	10/29/2017	90001494
01-BEA-17	2	ACCEPTED	100.22				10/5/2017	10/29/2017	90001494
01-BEA-17	4	REJECTED	0	CC	Service, paye	Required initial service is m	10/5/2017	10/29/2017	90001494
01-BEA-17	1	REJECTED	0	CC	Service, paye	Invalid payer or service cod	10/5/2017	10/29/2017	90001494

Edit Events

Introduction

After a session or transfer has been entered, you may need to edit it to correct erroneous information. The Edit Session or Receipt form provides access to it. The availability of fields for editing depends on whether or not the session or transfer has already been billed. If it has not, all fields are available. If billing has occurred, then only certain non-financial data fields can be accessed. Financial changes need to be made through the Add Pay, Transfer, or Adjustment form.

Selecting Records to Edit

When you pull up the form, you will go to the **Select Records** tab in order to locate your session. Enter the **Begin** and **End** date or date range. Under **Other Conditions**, enter **Program**, **Provider**, and/or **Client** to help narrow the search. The more information you enter, the fewer sessions you will have to skip through to find the one you need to edit. Click on Apply Conditions.

Editing Records

On the top part of the screen, which is set up identically to the Add Sessions form, the 1st session that meets your criteria will appear. If it is not the desired one, use the navigation buttons to skip ahead and find it. Now you are ready to edit. On an unbilled session, all fields will be white and available for editing. Although the client name field is gray, you can use the pull-down button and select a new client name off of the list. If you make service type or billed hour changes, the fee will adjust automatically. If you make a discipline change involving an educator or related field staff, any necessary billing type reassignments will be made. Save your changes and either exit or return to the Select Records tab to locate your next session.

On a previously billed session, all fields will be grayed out, or unavailable, except for DPH Information. Any change involving the actual service provision involves a financial change. If you need to correct eligibility, TPP authorization, co-treatment, reason code, or waiver information, you may do that here.

Marking Claims for SDR Resubmission

The **Other Fields** tab at the bottom of the screen allows you to both view and edit additional data. In the DPH Information box, you can mark a claim for **SDR Resubmission**. For SDR resubmission, enter an “R” in the SDR Resub field and this record will be included on your next SDR. Remember that SDR resubmission is different from billing resubmission.

Marking Claims for Billing Resubmission

In **Other Billing Information**, you can mark the claim for **Bill Resubmission**, enter a **Miscellaneous** or **Medicaid Reason** for denial, or a Medicaid **TCN** or **ICN**. You may also enter or edit this data through the Pay, Transfer, and Adjustment form. Enter “R” for Billing Resubmission and the record will be included on the next billing run, assuming you ask for resubmissions during the run.

Editing Session Discipline and Other Fields

Under Misc Labels are some other fields.

The **Discipline** field allows you to edit the discipline code stamped on the session. During session entry, this code is applied based on the default value for the provider. In rare cases, you may have had the wrong value there and therefore the wrong value stamped on the session. You can correct each session using this field. It may also be useful when a provider’s discipline changes and you don’t hear about it for a few weeks. In this case, the sessions entered with the incorrect old discipline can also be edited. You are allowed to edit posted sessions as well, in order to make sure the session can pass the DPH web site. If

changing the discipline on a posted session would affect the way a third party payor would view the record, you must make the necessary changes and communications by hand.

Rec W.O. means “Recommended Write Off.” It is a field set during receipt posting as a tag for report purposes. It can be set to “B” for Bad Debt, or “L” for Loss. Normally it is used as a way to generate a Simple Event Report for previewing before actually writing off the claims.

The **Area** and **Misc** fields are optional for subgrouping your records within a program. These were also filled based on default settings on the client record, but can be changed more easily if needed. They are used primarily to distinguish activity within a program and are used only by the report options. They do not have any role in billing or SDRs.

The **Secondary Bill** field is discussed above in the Pay, Transfer, and Adjust section. It is used on transfers to indicate that the target claim is to be billed using "Secondary Billing" logic in the General Billing run (which includes a tally of charges and payments associated with the primary payor).

The screenshot shows a software interface with three tabs: "Other Settings", "Dates / Ref / Bal / COB", and "Select Records".

- Other Settings:** Includes a checkbox for "SDR Resub" and an "Alias Lookup" button.
- Dates / Ref / Bal / COB:** Contains an "Other Billing Info" box with fields for "Bill Resub", "MISC Reason", "MED Reason", and "TCN or ICN".
- Select Records:** Contains a "Misc labels" box with fields for "Prg" (set to 01), "Misc", "Disc" (set to 3), "Rec W.O.", and a checkbox for "Secondary bill".

At the bottom of the interface is a "Bill Note (Reason for replacement)" text area.

The **Dates/IDs** tab displays the **Posted**, **Last Bill**, and **Last SDR** for the session, with the posting date reflecting the 1st time the claim was billed to this billing type, and the last bill and SDR dates reflecting the most recent activity.

The **Deposit Date** field is available for PAY or ADJ-P records if you want to manually edit the date the check was deposited. (Remember that a better way to handle deposit dates is by the batch routine in the Misc. Utilities section, which will stamp all payment records associated with a single check with the same deposit date).(10/11/01)

The **Serv_id** and **EID** are useful in confirming that you have located the correct claim. **Pay**, **Balance**, and **Reference** reflect payment activity, and Type indicates whether this is a service or a transfer event.

All edits made by off-site program staff are sent to the base system during the next disk run.

Add Pay, Transfer, Adjustment

Introduction

As discussed earlier, each new service is billed using a "SERV" event. It has a payer and balance and represents the start of a claim. Everything else that happens to the claim: payments, transfers, adjustments... are managed on the PTA screen with their own type of records (PAY, TRANS, ADJ). For electronic remittance files, there are also batch pay screens to create these types of records based on the remittance information and these are discussed later.

Note that all PAY and ADJ records are posted immediately when you save a PTA run so you should double check your work before saving. Once posted, they cannot be deleted or edited.

Transfer (TRANS) records are posted when affecting an already posted claim. Otherwise, and more frequently, the positive target of the transfer is unposted until it is billed. It can therefore be deleted in Edit events even after you have closed the PTA screen (and when you delete the target of the transfer, the system automatically deletes the paired negative source TRANS record.)

PTA Screen for Manual Entry

You use the following screen to manually enter payments, transfers, or other adjustments to existing claims.

Payment, transfer, and adjustment entries are made using a completely different form from that used for sessions. The reason is these events often depend on each other to make a coherent record of activity for a claim. For example, in order to transfer a charge from one billing to another, it is useful to be able to see all activity for associated with the session. The same is true for adjustments. Denial notations are also made on this form.

Most corrections on sessions that have already been billed (or sent to the base system) will need to be made here. Any correction changing the client identity, service type, or service hours requires this form, while changes to simple data fields (co-treatment, reason code, etc.) can be made on the edit screen.

When you open the form, enter **Check Information** if you are posting receipts (cash). Enter the **Bill** type, or insurer, who has issued the payment. Enter the **Reference** number, which will be stamped on each session posted off by this check for future tracking and audit trail purposes. Enter the check amount as the **Balance**. This figure will reduce as you apply payments to sessions, and provide an initial accuracy check. If the balance does not equal zero after you have processed all payments listed on the remittance advice, then either you have made a data entry error, or the insurer has made an error on the EOB. Further review of a detailed posting register and the remittance will be necessary.

Enter the date that you want all activity to be posted on in the **Post Run** field. We recommend that you use the today's date for all posting dates, although some users do prefer other strategies. Whatever you do, it must be done consistently. Cash that is posted in an inconsistent manner will lead to end of the month reconciliation problems.

The **Deposit** date is for recording the date the check was deposited. Some agencies may find this useful, others may not. It is totally optional and simply stamps this date on each pay or

pay adjustment record. (Note, you may stamp a deposit date on these same records at a later time using the Misc. Utility option for this purpose).

If you are not posting payments, but want to transfer, adjust, or simply view claims, then bypass the Check Information box.

Proceed to **Show Records for** to locate your session. Use the pull down box to select the client **Name**. The **Program** field is only applicable to base or standalone systems managing multiple programs. Enter your **Session date** range. If you want to limit your search to a particular billing type, fill **Show Single billing**. If you are posting cash, you will normally check the **Balances Only** box. If you are entering an adjustment and the session to be adjusted has a zero balance, leave the **Balances Only** box unchecked, and click on **Show** to pull up the session.

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub
06/02/2017	BCB	SF RAL01	J 1.00	112.00	0.00	112.00	SERV			06/30/2017		
06/12/2017	BCB	TA MM 01	7 1.25	111.75	0.00	111.75	SERV			06/30/2017		
06/13/2017	BCB	TM DEA01	C 2.00	68.64	0.00	68.64	SERV			06/30/2017		
06/15/2017	BCB	TA COC01	3 1.25	111.75	0.00	111.75	SERV			06/30/2017		

All sessions that meet your criteria will appear in the grid. Review them and select the one that needs to be acted on by clicking on it. Then, click on the **Pay, Transfer, or Adjust** button in the lower left corner.

For our example, we will show the normal one by one pay, transfer, and adjust process.

Revised Pay, Transfer, or Adjust

Name: RSSP1, DAMIEN Coverage: Service: Calendar Yr: Post: 07/07/2017

Sdate	Serv	Pid	Pdisc	Bhour	Bill	Fee	Pay	Type	TT	Ref	Bal	Pdate	Rdenial
06/02/2017	SF	RAL01	J	1.00	BCB	112.00	0.00	SERV			112.00	06/30/2017	

Claim Information

Bill: BCB Note:

Original billed hrs.: 1.00 TCN or ICN: Get TCN Browse Remits Resub:

Claim Bal: 112.00 Bill Note (Reason for replacement):

MED Reason: MISC Reason: Rec W.O.:

Select Action

Pay Cash Transfer (partial denial) Session Transfer (full denial) Adjust Done

This screen shows the claim you have selected for action. In this example, we will first pay part of its balance, then transfer a copay to DPH, then adjust off the rest.

It shows the three primary actions that are available to you when working on a claim: PAY, CASH TRANSFER, SESSION TRANSFER, or ADJUST. Not shown in this screen view is a fourth action recently added called BAL TO DPH. This button only shows up on claims that would transfer to DPH if needed for a copay. This new button will automatically transfer the balance to DPH.

Also shown on this screen are some fields for information carried on the first record of the claim. The Note field is simply that and this one shows some “rebills” have already happened on this claim. The MED and MISC Reason fields are essentially ways of tracking reason for denial information informally for these billing types; they are not the formal DPH reason for denial field that actually gets sent to DPH. The TCN field is used for MED resubmissions. The RESUB field marks the claim for billing resubmission.

A new field, “Rec W.O.” for “Recommended Write Off” was added on 8/29/01. This is intended as a tag for flagging any claims you intend to write off. Since there are actually two types of “write offs” supported by the system, “Loss” and “Bad Debt”, you should enter either an “L” or “B” into the field accordingly. You can later produce simple reports sorted by this field for review. A Misc. Utilities choice offers a way to clear the Recommended Write Off field globally.

At the top of this screen are three report options to help you understand where things stand with the given client and claim:



The **Coverage** reports shows client coverage information.

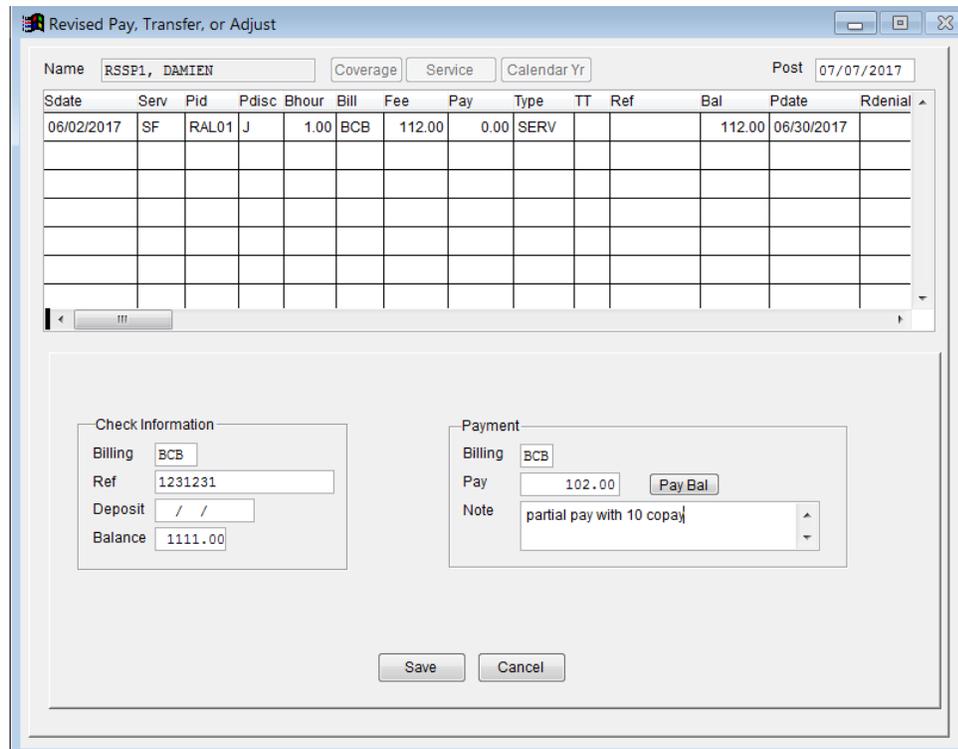
The **Service** report shows all services associated with the selected claim, including transfers and payments from other billing types.

The “**Calendar Yr.**” report shows all activity for the client for the current calendar year.

In summary, the fields shown on this screen concern the claim as a whole and they are stored on the first, balance carrying record for the claim. Some are just for internal reporting use, such as NOTE, MED Reason, MISC Reason, and Rec. W.O. Others actually cause billing actions: the RESUB will cause the claim to be resubmitted to the payor, the TCN field gets printed on MED resubmissions or adjustments.

Pay

After pressing pay, you may enter the amount of the payment.



Saving this \$102.00 payment will lower the claim balance to \$10.00.

Note the **Pay Bal** button is used to quickly fill the Pay amount with the current claim balance. Since this is a partial payment in this example, we will not use this button. The **Save** button saves the new pay entry, which shows up on the claim screen.

This screen allows you to correct or enter some of the check information that normally would have been entered at the start, such as the **billing, reference, and running balance**.

Not shown on the picture above is the new **Deposit** date field, which can also be edited here.

Cash Transfer

Next, we will transfer a copay to DPH by choosing the **Cash Transfer** action:

The screenshot shows a software window titled "Revised Pay, Transfer, or Adjust". At the top, there are input fields for "Name" (RSSP1, DAMIEN), "Coverage", "Service", "Calendar Yr", and "Post" (07/07/2017). Below this is a table with columns: Sdate, Serv, Pid, Pdisc, Bhour, Bill, Fee, Pay, Type, TT, Ref, Bal, Pdate, and Rdenial. The table contains two rows of data. Below the table is a "Cash Transfer (partial denial)" form. This form has several sections: "From" (BCB), "Fee" (-10.00), "To" (DPH), "Serv" (SF), "Fee" (10.00), "Auth" (empty), and a "Secondary bill" checkbox. There is also a "Show Closed" button. To the right of the form is a "DPH Information" section with "Reason" and "Waiver" dropdowns. Below that is a "Note" and "COB" section with a text area. At the bottom of the form are "Save" and "Cancel" buttons. A warning message is displayed: "The billing rate for the target of this transfer (DPH) is lower than the original." A button labeled "Trans Bal or Max Allowed" is also visible.

Sdate	Serv	Pid	Pdisc	Bhour	Bill	Fee	Pay	Type	TT	Ref	Bal	Pdate	Rdenial
06/02/2017	SF	RAL01	J	1.00	BCB	112.00	0.00	SERV			10.00	06/30/2017	
	SF	RAL01	J	0.00	BCB	0.00	102.00	PAY		1231231	0.00	07/07/2017	

The target of the transfer is suggested based on the client's coverage. If the client had another secondary coverage other than DPH for this session, it would be offered instead.

Since this transfer is going to DPH, we would need to fill in the reason and number of denials information before saving it.

A new field on this screen named "Secondary Bill" is shown below. Check this box when the target of the transfer will be billed using "Secondary Billing" logic within the General Billing routine. This approach will tally and report all payments from the primary payor as the bill is being printed. (See further discussion below).

Session Transfer

If the entire claim was denied, choose Session Transfer to send it fully to a secondary payer. This will recalculate the amount if the rate is different for the target payer (usually only involving BCB autism services).

The screenshot shows a software window titled "Revised Pay, Transfer, or Adjust" for patient "RSSP1, DAMIEN". The window contains a table of session data and a "Session Transfer (full denial)" form.

Sdate	Serv	Pid	Pdisc	Bhour	Bill	Fee	Pay	Type	TT	Ref	Bal	Pdate	Rdenial
06/12/2017	TA	MM 01	7	1.25	BCB	111.75	0.00	SERV			111.75	06/30/2017	

Session Transfer (full denial)

From: BCB
 Fee: -111.75
 To: DPH (dropdown)
 Serv: TA
 Fee: 111.75
 Auth:
 Secondary bill

Use the Session Transfer to transfer the entire session to another payer at the amount calculated by the payer rate. This will produce unbalanced transfers when the rate is

DPH Information
 Reason:
 Waiver:

Note:
 COB:

Buttons: Save, Cancel

Adjustments

There are several types of Fee adjustments that can be made. These subtypes are used mainly as labels for different reporting tasks. As you will see, three out of the four involve negative fee entries that have different meanings.

Revised Pay, Transfer, or Adjust

Name: RSSP1, DAMIEN Coverage: Service: Calendar Yr: Post: 07/07/2017

Sdate	Serv	Pid	Pdisc	Bhour	Bill	Fee	Pay	Type	TT	Ref	Bal	Pdate	Rdenial
06/13/2017	TM	DEA01	C	2.00	BCB	68.64	0.00	SERV			68.64	06/30/2017	

Adjustment Type: Fee Pay

Adjust either the FEE or PAY amount on a claim. Two FEE adjustments will increase the balance (Charge). A CHARGE should be used any time you want to increase a claim balance in order to rebill it. Three FEE adjustments will lower the claim balance (Credit, Loss, and Bad Debt). Use a CREDIT when you want the amount to be

Fee Adj Subtypes: Charge Credit Loss Bad Debt Rate Adj

Pay Adj Subtypes: Correction Refund

Pay: Check Ref: Deposit: / /

Bill Hr: Fee: Note:

Buttons: Save, Cancel

A Charge is an increase in the fee, which results in an increase in the claim balance. This is normally used when a session was billed for an incorrectly low number of hours, say it was initially entered as a 1.00 hour session and later you learn it should have been 2.00 hours.

A Credit will decrease the fee and lower the claim balance. A credit fee adjustment should only be used when you have inadvertently overcharged for a session, for example by billing a 2.00 hour session that should have been 1.00 hour.

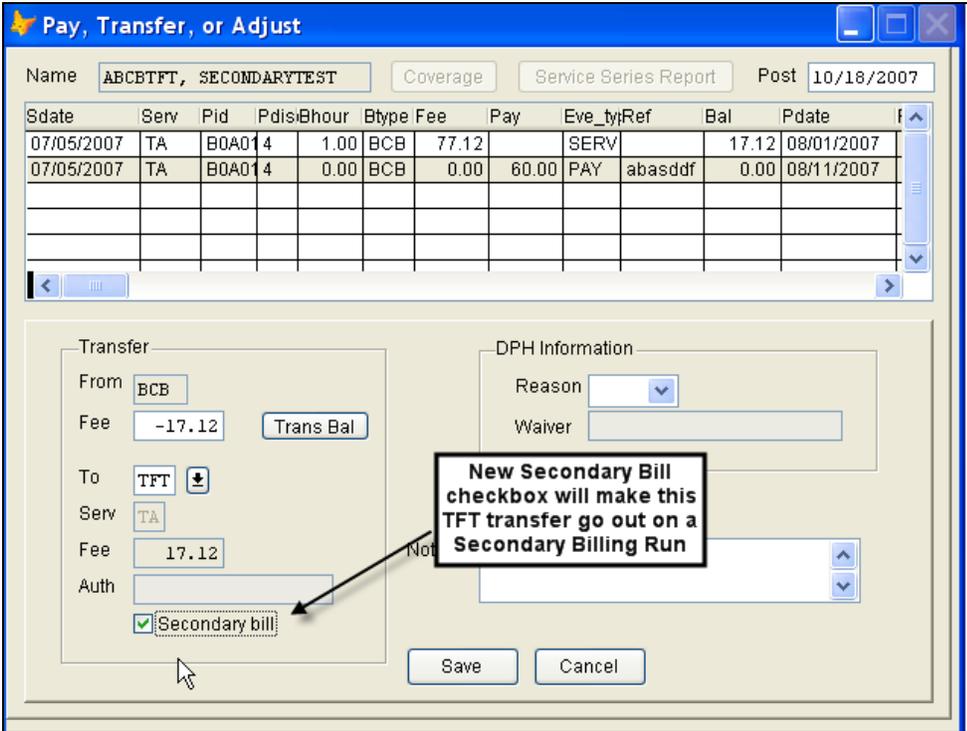
DO NOT USE ADJUSTMENTS TO TRANSFER MONEY BETWEEN BILLING TYPES. Do not use a credit fee adjustment for DPH when a late payment comes in from the original billing type: use a transfer back to the original billing type.

A Loss will decrease the fee and lower the claim balance, just like a credit. The difference is how the record is labeled: a credit is intended for reporting to a payor and a loss is not, it simply adjusts off a balance that is no longer expected to be paid. This is what is shown in the example.

A Bad Debt is similar to a loss in that it lowers the fee and should be used for zeroing out a balance that cannot be recovered. Some programs use the "Bad Debt" label to distinguish losses associated with billing or reporting practices.

Secondary Billing

When transferring an amount to a secondary payer, mark the transfer for “Secondary Billing” as shown below.



This will cause the claim to be included in a Secondary Claim Type Billing run, which will also report the primary payer information.

PTA Batch Pay

If all records selected match the amount paid, you can select "Batch Pay" to create PAY records for them all at once:

Revised Pay, Transfer, or Adjust

Check information: Bill BCB Bal 1009.00, Reference 1231231, Post run 07/07/2017, Deposit / /

Service Filter: No Filter, EI Only, Autism Only

Show records for: Client RSSP1, DAMIEN, 1100017982, Sessions dates 06/15/2017 to 06/19/2017, Show single billing BCB, Balances Only

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub
06/15/2017	BCB	TA	COC01	3	1.25	111.75	0.00	111.75	SERV			06/30/2017
06/16/2017	BCB	TA	CKE01	1	1.50	134.10	0.00	134.10	SERV			06/30/2017
06/19/2017	BCB	TA	MM 01	7	1.00	89.40	0.00	89.40	SERV			06/30/2017
06/19/2017	BCB	TA	COC01	3	1.00	89.40	0.00	89.40	SERV			06/30/2017

Single Claim: Bill BCB Bal 111.75, [Pay, Transfer, or Adjust] [Delete]

Batch Pay: Bal 424.65, [Batch Pay]

SERV Fee Total: Tot 424.65, [Pay Fee Total]

Batch Trans: To [], [Prep Batch], Amt 0, [Batch Trans], Rea [], [Secondary]

Batch Refund: Amt 0, [Batch Refund]

Run: [Review] [Print Setup], [Save Run] [Abandon Run]

In this example, all 4 were fully paid:

Revised Pay, Transfer, or Adjust

Check information: Bill **BCB** Bal 584.35
 Reference 1231231
 Post run 07/07/2017
 Deposit / /

Service Filter: No Filter
 EI Only
 Autism Only

Show records for: Client **RSSP1, DAMIEN** 1100017982
 Sessions dates 06/15/2017 to 06/19/2017
 Show single billing **BCB** Balances Only

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub 1
06/15/2017	BCB	TA	COC01 3	1.25	111.75	0.00	SERV			06/30/2017		
	BCB	TA	COC01 3	0.00	0.00	111.75	PAY	1231231		07/07/2017		
06/16/2017	BCB	TA	CKE01 1	1.50	134.10	0.00	SERV			06/30/2017		
	BCB	TA	CKE01 1	0.00	0.00	134.10	PAY	1231231		07/07/2017		
06/19/2017	BCB	TA	MM 01 7	1.00	89.40	0.00	SERV			06/30/2017		
	BCB	TA	MM 01 7	0.00	0.00	89.40	PAY	1231231		07/07/2017		
06/19/2017	BCB	TA	COC01 3	1.00	89.40	0.00	SERV			06/30/2017		
	BCB	TA	COC01 3	0.00	0.00	89.40	PAY	1231231		07/07/2017		

Single Claim: Bill **BCB** Bal 0.00
 Batch Pay: Bal 0.00
 Batch Trans: To [], Amt 0, Rea [], Secondary
 Batch Refund: Amt 424.65
 Run: Review, Print Setup, Save Run, Abandon Run

SERV Fee Total: Tot 424.65
 Pay Fee Total

TCN []

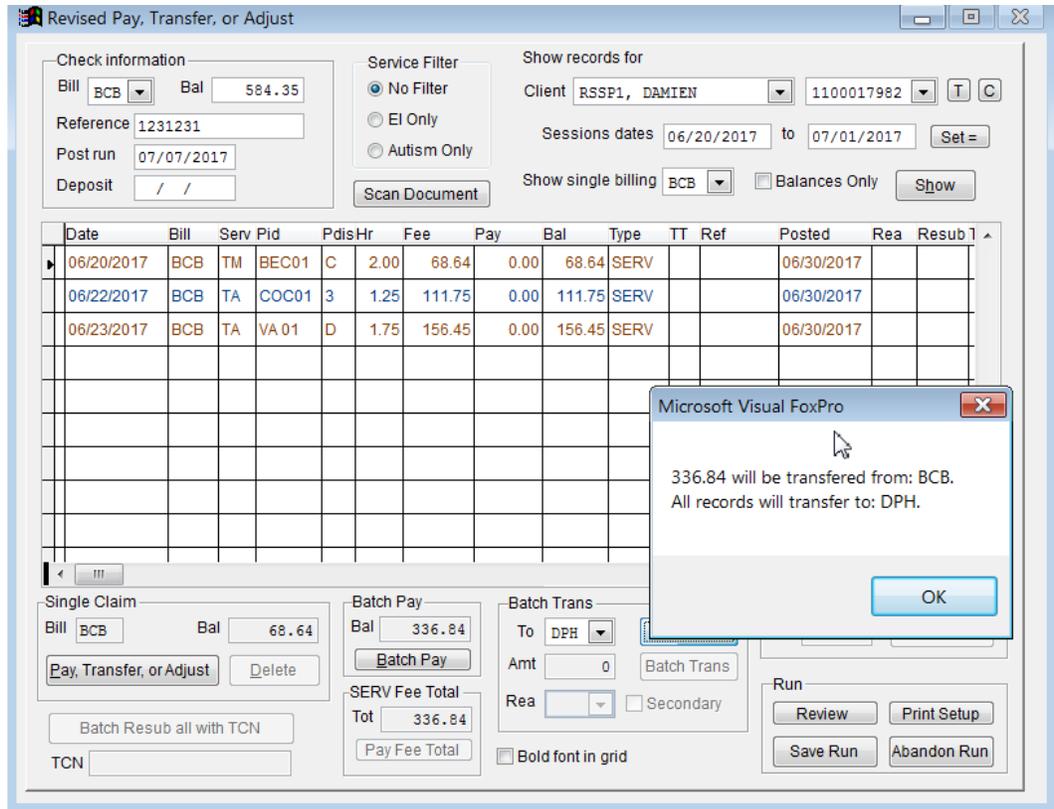
Bold font in grid

PTA Batch Transfer

Similarly, if all selected records were denied (and all have the same secondary payer), you can batch transfer them.

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub
06/20/2017	BCB	TM	BEC01	C	2.00	68.64	0.00	68.64	SERV			06/30/2017
06/22/2017	BCB	TA	COC01	3	1.25	111.75	0.00	111.75	SERV			06/30/2017
06/23/2017	BCB	TA	VA 01	D	1.75	156.45	0.00	156.45	SERV			06/30/2017

Choose the target of the Batch Transfer, then press Prep Batch.



If all will be going to the same target (according to your coverage records), you'll get an "OK" confirmation screen. Press OK.

If going to DPH, enter a reason code:

Revised Pay, Transfer, or Adjust

Check information
 Bill: BCB Bal: 584.35
 Reference: 1231231
 Post run: 07/07/2017
 Deposit: / /

Service Filter
 No Filter
 EI Only
 Autism Only

Show records for
 Client: RSSP1, DAMIEN 1100017982
 Sessions dates: 06/20/2017 to 07/01/2017
 Show single billing: BCB Balances Only

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub 1
06/20/2017	BCB	TM BEC01	C	2.00	68.64	0.00	68.64	SERV		06/30/2017		
06/22/2017	BCB	TA COC01	3	1.25	111.75	0.00	111.75	SERV		06/30/2017		
06/23/2017	BCB	TA VA 01	D	1.75	156.45	0.00	156.45	SERV		06/30/2017		

Single Claim
 Bill: BCB Bal: 68.64
 Pay, Transfer, or Adjust

Batch Pay
 Bal: 336.84
 Batch Pay

Batch Trans
 To: DPH
 Amt: 336.84
 Rea: 003
 Prep Batch
 Batch Trans

Batch Refund
 Amt: 0
 Batch Refund

Run
 Review
 Print Setup
 Save Run
 Abandon Run

TCN: _____

and press Batch Trans.

Revised Pay, Transfer, or Adjust

Check information
 Bill: BCB Bal: 584.35
 Reference: 1231231
 Post run: 07/07/2017
 Deposit: / /

Service Filter
 No Filter
 EI Only
 Autism Only

Show records for
 Client: RSSP1, DAMIEN 1100017982
 Sessions dates: 06/20/2017 to 07/01/2017
 Show single billing: BCB Balances Only

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub 1
06/20/2017	BCB	TM BEC01	C	2.00	68.64	0.00	0.00	SERV		06/30/2017		
	BCB	TM BEC01	C	-2.00	-68.64			TRANS	S TO DPH	07/07/2017		
06/22/2017	BCB	TA COC01	3	1.25	111.75	0.00	0.00	SERV		06/30/2017		
	BCB	TA COC01	3	-1.25	-111.75			TRANS	S TO DPH	07/07/2017		
06/23/2017	BCB	TA VA 01	D	1.75	156.45	0.00	0.00	SERV		06/30/2017		
	BCB	TA VA 01	D	-1.75	-156.45			TRANS	S TO DPH	07/07/2017		

Single Claim
 Bill: BCB Bal: 0.00
 Pay, Transfer, or Adjust

Batch Pay
 Bal: 0.00
 Batch Pay

Batch Trans
 To: [dropdown]
 Amt: 0
 Rea: 003
 Prep Batch
 Batch Trans

Batch Refund
 Amt: 0
 Batch Refund

Run
 Review
 Print Setup
 Save Run
 Abandon Run

TCN: _____

In this example, 3 session transfer records were created fully transferring the claims to DPH.

Deleting New PTA Records

The main screen is also where you can delete pay, transfer, or adjustment records you have just created if you find them in error. Clicking on one of these records (entered during this run) will activate the **Delete** button and allow you to delete and re-enter the erroneous information.

For example:

Revised Pay, Transfer, or Adjust

Check information: Bill Bal
 Reference
 Post run
 Deposit

Service Filter: No Filter EI Only Autism Only
 Scan Docs (appap)

Show records for: Client
 Sessions dates to
 Show single billing Balances Only

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub 1
06/22/2017	OTH	TD NYB17	6	1.50	50.28	0.00	10.28	SERV		06/30/2017		
06/22/2017	OTH	TD NYB17	6	0.00	0.00	40.00	PAY		12234234	07/08/2017		
06/22/2017	OTH	TA JYD17	1	2.00	178.80	0.00	178.80	SERV		06/30/2017		
06/23/2017	OTH	TA SAL17	D	1.00	89.40	0.00	89.40	SERV		06/30/2017		

Single Claim: Bill Bal

Batch Pay: Bal

Batch Trans: To
 Amt
 Rea Secondary

Batch Refund: Amt

SERV Fee Total: Tot

Bold font in grid

Run:

This shows that a newly created PAY record has been selected. (To see the PAY record, the "Balances Only" checkbox is unchecked.) Since it is part of the current PTA run, the Delete button is active at the bottom left. Clicking Delete will delete it and restore the \$40 to the balance for the claim:

Microsoft Visual FoxPro

? Selected record: OTH 40.00 PAY 12234234
 Are you sure you want to delete?

Revised Pay, Transfer, or Adjust

Check information: Bill: OTH, Bal: 1111.00, Reference: 12234234, Post run: 07/08/2017, Deposit: / /

Service Filter: No Filter, EI Only, Autism Only

Show records for: Client: SAB470, HANNAH, 1200011470, Sessions dates: 06/22/2017 to 07/08/2017, Show single billing: OTH, Balances Only:

Scan Docs (appap) Show

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub 1
06/22/2017	OTH	TD	NYB17	6	1.50	50.28	0.00	50.28	SERV			06/30/2017
06/22/2017	OTH	TA	JYD17	1	2.00	178.80	0.00	178.80	SERV			06/30/2017
06/23/2017	OTH	TA	SAL17	D	1.00	89.40	0.00	89.40	SERV			06/30/2017

Review, Abandon, Save PTA Run

When finished, you have the option of reviewing and either saving or abandoning all the records you have just worked on. Usually, you'll only abandon a run if the total does not match what you expect and you need to start over (rare).

Check information: Bill: BCB, Bal: 584.35, Reference: 1231231, Post run: 07/07/2017, Deposit: / /

Service Filter: No Filter, EI Only, Autism Only

Show records for: Client: RSSP1, DAMIEN, 1100017982, Sessions dates: 06/20/2017 to 07/01/2017, Show single billing: BCB, Balances Only:

Scan Document Show

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	TT	Ref	Posted	Rea	Resub 1
06/20/2017	BCB	TM	BEC01	C	2.00	68.64	0.00	0.00	SERV			06/30/2017
	BCB	TM	BEC01	C	-2.00	-68.64			TRANS S	TO DPH		07/07/2017
06/22/2017	BCB	TA	COC01	3	1.25	111.75	0.00	0.00	SERV			06/30/2017
	BCB	TA	COC01	3	-1.25	-111.75			TRANS S	TO DPH		07/07/2017
06/23/2017	BCB	TA	VA 01	D	1.75	156.45	0.00	0.00	SERV			06/30/2017
	BCB	TA	VA 01	D	-1.75	-156.45			TRANS S	TO DPH		07/07/2017

Single Claim: Bill: BCB, Bal: 0.00, Pay, Transfer, or Adjust:

Batch Pay: Bal: 0.00,

Batch Trans: To: Amt: 0, Rea: 003, Secondary

Batch Refund: Amt: 0,

SERV Fee Total: Tot: 336.84, Pay Fee Total: Bold font in grid

Run:

Again, this is important because if you save the run, all newly created PAY and ADJ records are permanently posted and cannot be edited or deleted.

Discussion and Examples

When posting cash received, make sure the total at the end of the run matches the check total. If it is way off, simply abandon the run and start over. If you can identify one or two mistakes, correct these by either deleting and re-entering the bad PAY entry or adding an appropriate PAY or ADJ-P records.

When working with late payments for charges that have already been transferred to DPH, always transfer the amount back to the original payer before entering the late payment. Do not use individual adjustment entries for this purpose.

At the end of a run, you should review it and make sure the numbers are correct. Once you save the run, all records are posted and no longer available for deletion.

I received a late BCB payment and cannot find the DPH record that is carrying the balance I need to restore.

This used to be called a “back transfer”, but in the new system it is simply a transfer. The problem is probably that you have limited the records you can see to the billing type of the check you received, in this case BCB. To see the associated DPH records for the amount earlier transferred to DPH, make sure you blank out the “Show Single Billing” box at the top of the form (just under the child’s name), and press the “SHOW” button again. Now the DPH records should be visible and you can click on the DPH record and transfer an amount back to BCB to cover the late payment.

I just transferred a balance to DPH when a late BCB payment came in and I can’t access the DPH record to restore the balance.

Assuming you can see the DPH record (see above), but the system won’t let you click on it for a transfer, it is probably because the DPH record is unposted. The transfer and adjustment process only applies to posted records. If the transfer to DPH was recent (and not yet billed to DPH), then it is unposted. You must go to Edit Events and locate the unposted DPH record. There you can press the Delete button on the toolbar and it will delete the transfer to DPH all together (both records). The deletion will also automatically restore the balance to BCB and you can go ahead and post a payment. The recent transfer to DPH will simply be gone.

Other Data Forms

PCC Information

This table is simply a convenient place to store PCC information, much like a “Rolldex”. It can be pulled down as a reference when you are working on a client’s coverage.

Documentation Log

One of the real challenges is keeping track of all the paper documentation DPH has been requesting for PENDED claims. We added a screen for you to use to track each set of documentation you send, and a way of reporting it.

Under Data, you will see "Documentation Log". Pull this down, and an initial screen comes up asking whether you are entering new information or editing existing information:



If you say, "YES", the Documentation Log screen will come up with no current records already loaded, making it easier for you to add a new batch. If you say "NO", the screen will come up with all previous records already loaded so you can locate any that need changes.

Documentation Log

Client

Date

Bill (who the documentation is going to)

Coverage (what the documentation is about)

Sessions Covered By Documentation

Begin (beginning session date is required)

End (leave end date blank if open-ended documentation)

Staff (your initials)

Pages (number of pages of documentation sent)

Hours (number of hours spent preparing documentation)

Note

Posted

Billed

doc_id

The screen itself allows you to specify the client, date of the log entry, bill (usually DPH who has requested the documentation), and coverage (what the documentation is about, usually a third party). Then you enter the date range of sessions that are covered by the documentation. Then some identifying information, including your own initials, the number of pages sent, hours it took of your time, etc.

So you should create one log entry for each set of documentation sent for a single client (concerning a single issue). A given log entry might cover many actual sessions (within the date range you specify).

Notice at the bottom that a documentation record has a posting and billing date. These are filled when you run documentation "bill" that that goes with a whole batch of documents. The "billing" process is analogous to a true bill, but in this case it simply stamps all the log entries as having been actually sent to DPH at a particular time. It also prevents you from editing log entries that have been posted.

Reports

Aged Receivables

The Aged Receivables screen lets you see outstanding balances in a number of different ways.

The **Beginning Date** of the report is entered here. If you choose today's date, the report will be based on the balances as they exist today. If you choose an earlier date, the Thom Biller software will go back and recalculate balances as they existed on that date. Any payments or transfers that were posted since that date will be excluded.

You may limit the report to a single **program** here as well.

You may select which billing types are included in the report using the **billing** choices.

Normally you will want a report of records containing **balances only**, but the option to see all events (including adjustments and transfers and pay records) is available if desired, as are negative balances.

For “Format”, you can request a single page report in landscape mode as below:

12/20/2007								Page	1
Payer	Aged Receivables							Total	
	30	60	90	120	150	180	Over 180		
BCB	0.00	3,517.54	1,475.52	810.98	701.84	632.72	-235.61	6,902.99	
BLU	0.00	1,706.90	1,928.00	327.76	154.24	0.00	-245.22	3,871.68	
DIR	0.00	180.00	0.00	240.00	0.00	200.00	0.00	620.00	
DPH	0.00	7,102.18	1,795.30	70.00	0.00	0.00	6,143.26	15,110.74	
HEA	0.00	328.52	0.00	0.00	0.00	0.00	938.42	1,266.94	
HPO	0.00	231.36	1,336.48	811.34	0.00	0.00	-72.25	2,306.93	
MED	0.00	1,377.96	173.52	534.64	838.84	269.92	772.22	3,967.10	
NHM	0.00	276.80	646.50	0.00	0.00	0.00	-102.30	821.00	
NHP	0.00	0.00	0.00	0.00	0.00	0.00	255.22	255.22	
OTH	0.00	597.68	809.76	0.00	0.00	0.00	0.00	1,407.44	
OTM	0.00	308.48	0.00	99.12	0.00	77.58	38.56	523.74	
TFT	0.00	578.40	611.24	0.00	0.00	-96.40	511.81	1,605.05	
UHC	0.00	90.12	0.00	0.00	0.00	0.00	0.00	90.12	
USH	0.00	297.00	0.00	0.00	0.00	0.00	819.89	1,116.89	
Total	0.00	16,592.94	8,776.32	2,893.84	1,694.92	1,083.82	8,824.00	39,865.84	

All billing Outstanding pos or neg balances only All Programs Posted on or before 12/20/2007
 (use landscape printing) wbagesingle.frx

Otherwise, you can request individual detailed reports for each period.

Windows and dot matrix report formats are offered, along with two levels of detail.

Five report subsetting choices are available. The **Major Category** choice aggregates billing types into categories: DPH, MED, and all other XHI categories together.

You may select a report period based on number of days from the beginning date (the usual way aging reports are constructed with 30, 60, 90, etc. time periods) or by month.

Finally, you select which reporting periods you want to see.

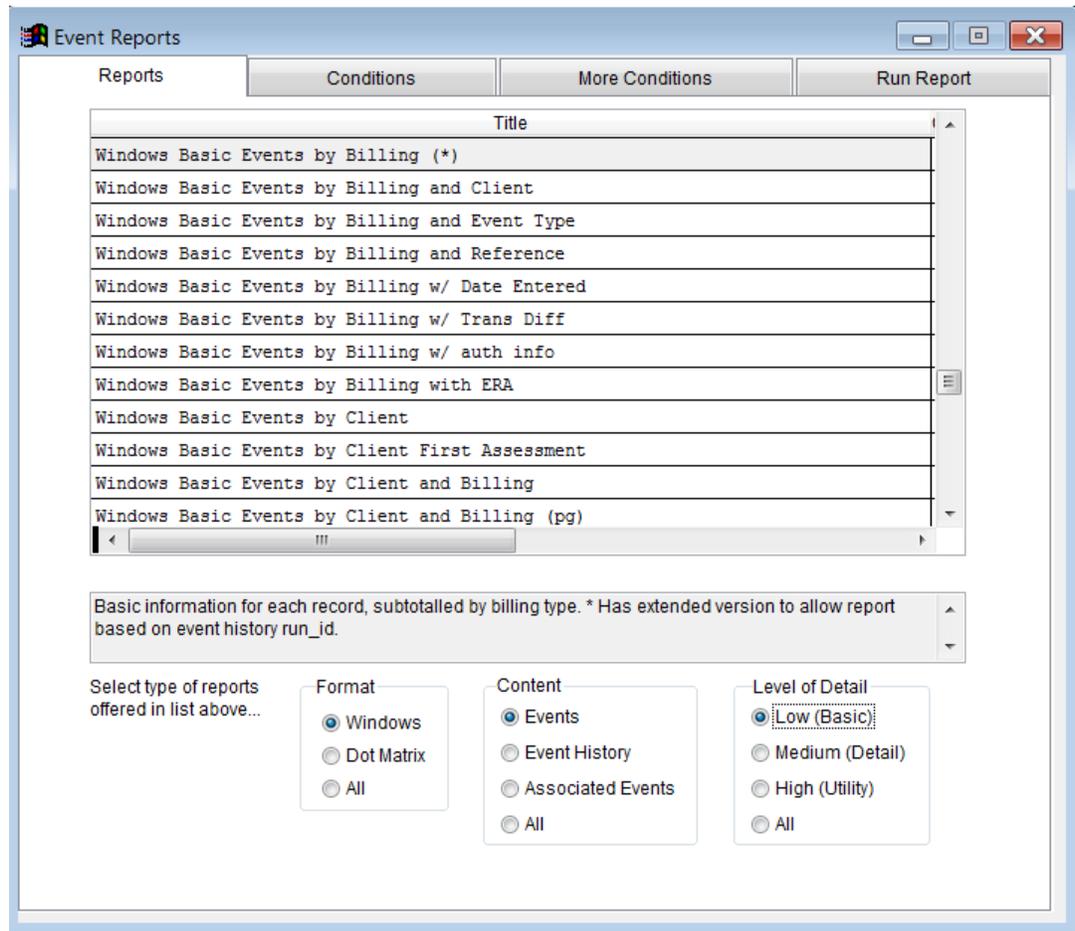
Output can also be sent to text files, tables (.dbf), or spreadsheets (.xls) for further analysis. The output files will be named AGE... and located in the OUTPUT\ folder beneath the home DATA\ folder (either on the C: drive of a stand alone computer or the server). Each period will have its own file, so the 60day period dbf table will be called AGE60.DBF.

Event Reports

Events include sessions, pay receipts, transfers, and adjustments.

Reports Tab

On the first tab, you may select the report format, the content, and level of detail of the reports displayed in the list.



The **Apply Selections** button will apply these choices. Once you have located the report you want, click on it to select it, then use the **Conditions** tab to determine which records to include in the report.

The **Content** choice determines whether anything is included in addition to the events chosen. An "Event History" report adds a listing of each billing or remit run associated with a given event. So for example, if a session was billed, then rebilled, then reported on an SDR, then updated with a ERA remit run, the single session would have 4 event history records reported by one of these reports.

An "Associated Events" report simply adds all events associated with the ones you select with your conditions. Use this, for example, to see all activity associated with a given payment check. The check reference and billing type would be the conditions, and if you had picked a normal event report, you would see only these PAY records, but if you pick an Associated Event report, all the SERV, TRANS, and ADJ records associated with these PAY records will be included as well.

Here is a simple event report for a single check reference 010131692:

Pr	Client	Session	Sv	Prov	Bl.Hr.	Bill	Fee	Pay	Type	Ref	Res
	Dphid-Ref	Serv_id	Place	Disc	Note					Eid	SDR Res
* Billing: ECB											
01		DAN	05/02/2002	TA	FUA01	0.00	BCB	0.00	86.15	PAY	010131692
			10860694		7	BATCH					90765104
01		DAN	05/03/2002	TA	MN 01	0.00	BCB	0.00	140.84	PAY	010131692
			10860874		1	BATCH					90765107
01		DAN	05/09/2002	TA	FUA01	0.00	BCB	0.00	86.15	PAY	010131692
			10861919		7	BATCH					90765110
01		DAN	05/10/2002	TA	MN 01	0.00	BCB	0.00	140.84	PAY	010131692
			10861792		1	BATCH					90765113
01		EXA	05/02/2002	TA	RS 01	0.00	BCB	0.00	81.15	PAY	010131692
			10861031		7	BATCH					90765144
01		EXA	05/09/2002	TA	RS 01	0.00	BCB	0.00	81.15	PAY	010131692
			10862109		7	BATCH					90765147
* Billing Subtotal *											
						0.00		0.00	616.28		
*** Total ***											
						0.00		0.00	616.28		

Here is part of an Associated Events report for the same check reference:

Pr	Dphid	Session	Serv	Prov	Bl.Hr.	Bill	Fee	Pay	Type	Ref	Resub	Bal
		Serv_id	Place	Disc	Note					Eid	SDR Resub	Reason
10/11/2006 Page												
Extended Report: Associated Events by Client, Claim (Serv_id) and Billing												
*** Client: ██████████												
** Serv_id: 10860694												
* Billing: ECB												
01	0104832-1	05/02/2002	TA	FUA01	1.25	BCB	91.15	0.00	SERV			0.00
		10860694		7		R06/05/2002				10473399		
01	0104832-1	05/02/2002	TA	FUA01	0.00	BCB	0.00	86.15	PAY	010131692		0.00
		10860694		7		BATCH				90765104		
01	0104832-1	05/02/2002	TA	FUA01	-1.25	BCB	-5.00	0.00	TRANS	TO DPH		0.00
		10860694		7		BATCH				90765105		
* Billing Subtotal *												
					0.00		86.15	86.15				0.00
* Billing: DPH												
01	0104832-1	05/02/2002	TA	FUA01	1.25	DPH	5.00	0.00	TRANS	FR BCB		0.00
		10860694		7		BATCH				90765106	201	
01	0104832-1	05/02/2002	TA	FUA01	0.00	DPH	0.00	5.00	PAY	THM02081302		0.00
		10860694		7		BATCH				90847044		
* Billing Subtotal *												
					1.25		5.00	5.00				0.00
** Serv_id Subtotal **												
					1.25		91.15	91.15				0.00

You can see that for one PAY record in the first report, five associated events were included in the second report.

Event Reports Conditions Tab

The conditions tab looks like this:

You may limit records based on session, posting, billing, and entry dates. “Entry date” is the actual date a session, payment, transfer, or adjustment was entered into the computer. This date may be useful when you are reconciling your monthly aged receivables.

Additional conditions are provided to limit the report. If you combine conditions, the records reported will have to meet all of the conditions. So a report of Bill = "BCB" and Serv = "TA" will show only BCB TA events, not one or the other.

Condition	Limit report to a single:
Prog	Program within an agency
Prov	Provider
Prov Disc	Provider discipline code (1,3, J, etc.)
SSP	Speciality Service Provider (BEAC, etc.)
Any SSP	Show all events that have any SSP ID stamped on them
Type	Type of event: SERV, PAY, TRANS, etc. For example, limit to SERV records to show all

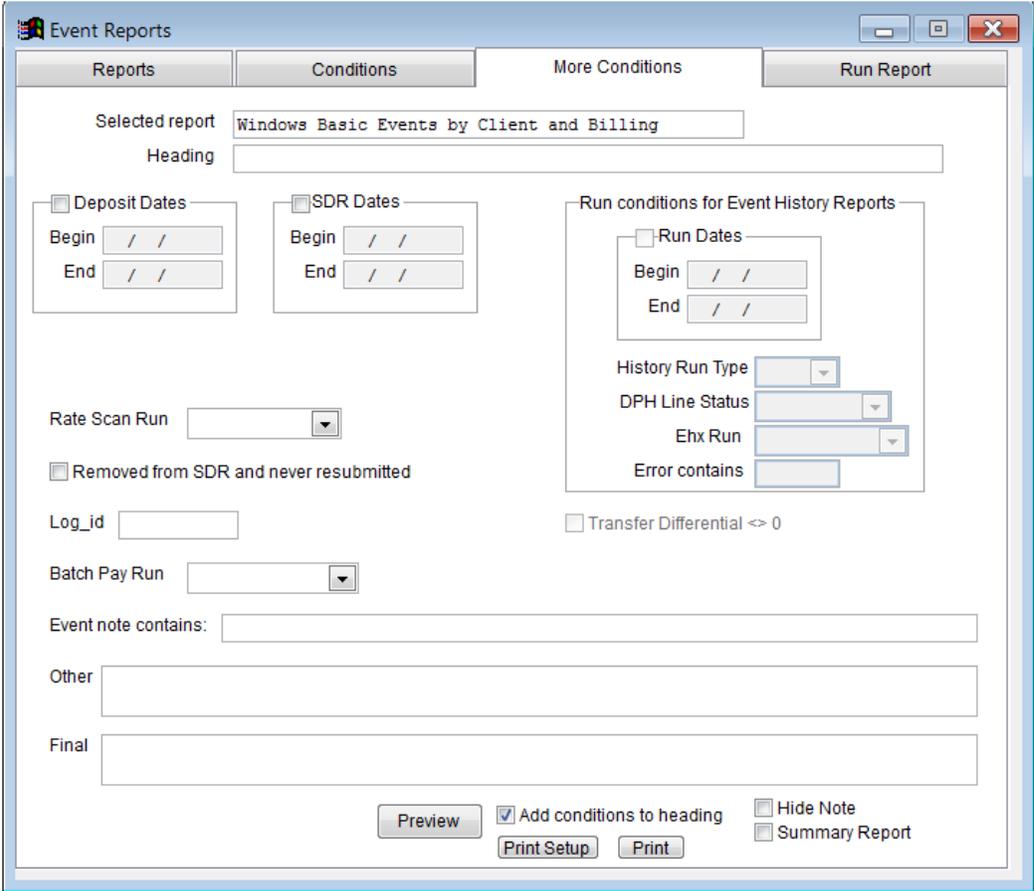
	new services.
SubType	Event subtype: Mainly for adjustments, such as LOSS, BAD DEBIT.
PAY and ADJ-P Events	Show both PAY and ADJ-P events (every record affecting pay amounts)
SERV, TRANS, and ADJ-F	Show all these types that affect Fee amounts
EID	Event EID: to see a single event. The EID is unique to every event and it is printed on most reports.
Serv_ID	Service ID: to see a single claim series. Each new SERV record receives a unique SERV_ID. All subsequent events posted to that service, such as PAY, TRANS, etc, have the same SERV_ID. This is also printed on most reports as a reference.
Bill	Billing type.
No Bill	Check box shows all events that do not have billing type. These are "lost" services in a sense: they probably were left without a billing type after a coverage scan removed a coverage from a session. Unless you correct them, they will never be billed.
No DPH	Check this box to show all billing types in the report except DPH. Leave the Bill box blank for this type of report. If you enter a Bill value, then it does not make sense to check this box.
No MED	Exclude MED events
No DIR	Exclude DIR direct annual fee events
Bill List	Enter comma delimited list of billing types to be included, such as DPH,MED,HPO
Serv	Service type, for example all "TA" home visits.
Assess	Show all service types that represent assessments; will combine TG and TH initial and subsequent assessment codes into a single report;
Group	Show all service types that represent group services, combining TC and TD groups.
No Autism Services	Exclude autism speciality services that begin with "S"
Autism Only	Include only autism services that begin with "S" (such as "SA", "SB", etc.)
Serv List	Enter comma delimited list of service codes to be included (e.g., TA,TB,TC)
Client	Single client
"T"	Toggle the client list to show either open or both open and closed clients.
Check Number	Single check reference is stamped on the event (usually PAY records and ADJ-P)
Area	Single area, an optional field for your own sorting purposes that is set on the client record
Misc	Single misc value, also an optional field for your own tracking purposes set on the client
DPH Reason	Single DPH reason code
Misc Reason	Single Misc Reason code
Pos. Bal Only	Positive balances only. This will show all receivables you have.
Neg. Bal Only	Negative balances only. This shows all claims that have been overpaid or otherwise have a negative balance.
Nonzero Bal Only	Only events with either a positive or negative balance
Unposted	Unposted events. This shows all records that have not yet been billed even once. It is the same as selecting all events with a blank posting date.

Bill Resub	Billing resubmission field is set. This shows all records currently marked for billing resubmission (RESUB field is filled). These will be include in the appropriate billing runs the next time they are run.
SDR Resub	SDR resubmission field has been set. These are marked for inclusion in the next SDR to DPH.
Rec W.O	Recommended Write off field is set. All records with something in the Recommended Write Off field. This is a flexible field for tagging claims of interest during receipt entry.
IFSP Meeting	Events marked as IFSP during session entry
Assess Home Visit	Events marked as Assessment Home Visits during session entry
Transition Group	Events marked as Transition Groups during session entry

Press the **Preview** button to see the report on the screen and have the option of actually printing it. A new **Print** button will send the report directly to the printer after offering you the chance to limit the report to specific pages or page range. You may find this useful when after previewing a long report, you decide you only want certain pages actually printed. This same small **Print** button is now available on many of the report routines.

More Conditions Tab

The "More Conditions" tab for basic events reports offers conditions based on deposit date, SDR dates, LOG_ID, and other manually entered ones. Manual conditions should only be filled after consulting with Thom tech support.

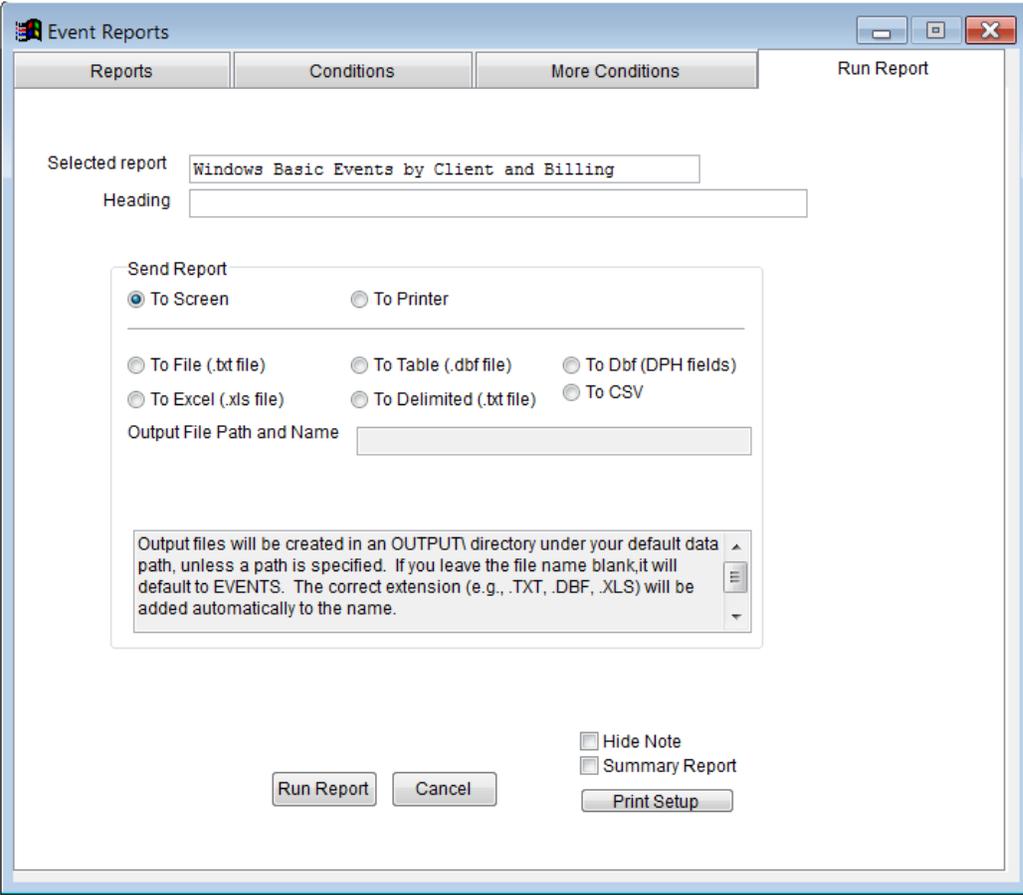


Enter Deposit or SDR date conditions here.

The Other Condition is for manually entered code, as is the Final Condition. Seek technical support when using these fields.

Run Report Tab

The **Run Report** tab offers output to various file types: text, table (.dbf), Excel spreadsheet, or delimited (.txt) files. The table, spreadsheet, and delimited option send the data itself to the file in a format that can be imported into other programs and analyzed further. For example, the table output might be mail merged with a Word document, or the spreadsheet analyzed in Excel with graphing or other functions.



Event Browse

This mimics the PTA view but is much faster to use:

Event browse

Use this screen to browse events for a single client and print a report if desired. You can limit the results by session dates, billing type and balance. Press the Show button to refresh the grid. The Event Note field can be edited on the grid or in the text box below. There are additional

Service Filter
 No Filter
 EI Only
 Autism Only

Show records for
 Client SAAD, MARIM
 Sessions dates 07/10/2016 to 07/10/2017
 Show single billing Balances Only Show

Date	Bill	Serv Pid	PdisHr	Fee	Pay	Bal	Type	Ref	Posted	Resub TCN	Note (edit)	
07/12/2016	OTM	TH	MCC01	7	1.50	179.88	0.00	15.30	SERV		08/05/2016	08/28/2016
07/12/2016	OTM	TA	MCC01	7	0.50	44.70	0.00	3.80	SERV		08/05/2016	IFSP Meeti
07/12/2016	OTM	TH	MFI01	C	1.50	179.88	0.00	15.30	SERV		08/05/2016	08/28/2016
07/12/2016	OTM	TA	MFI01	C	0.50	44.70	0.00	3.80	SERV		08/05/2016	IFSP Meeti
07/12/2016	OTM	TH	BRK01	1	1.50	179.88	0.00	15.30	SERV		08/05/2016	08/28/2016
07/12/2016	OTM	TA	BRK01	1	0.50	44.70	0.00	3.80	SERV		08/05/2016	IFSP Meeti
07/14/2016	OTM	TA	MFI01	C	1.25	111.75	0.00	9.50	SERV		08/05/2016	08/28/2016
07/21/2016	OTM	TA	MFI01	C	1.25	111.75	0.00	9.50	SERV		08/05/2016	08/28/2016
08/04/2016	OTM	TA	MFI01	C	1.25	111.75	0.00	9.50	SERV		08/18/2016	08/28/2016
08/11/2016	OTM	TA	MFI01	C	1.25	111.75	0.00	9.50	SERV		08/18/2016	08/28/2016
08/19/2016	OTM	TA	MFI01	C	1.50	134.10	0.00	11.40	SERV		09/02/2016	

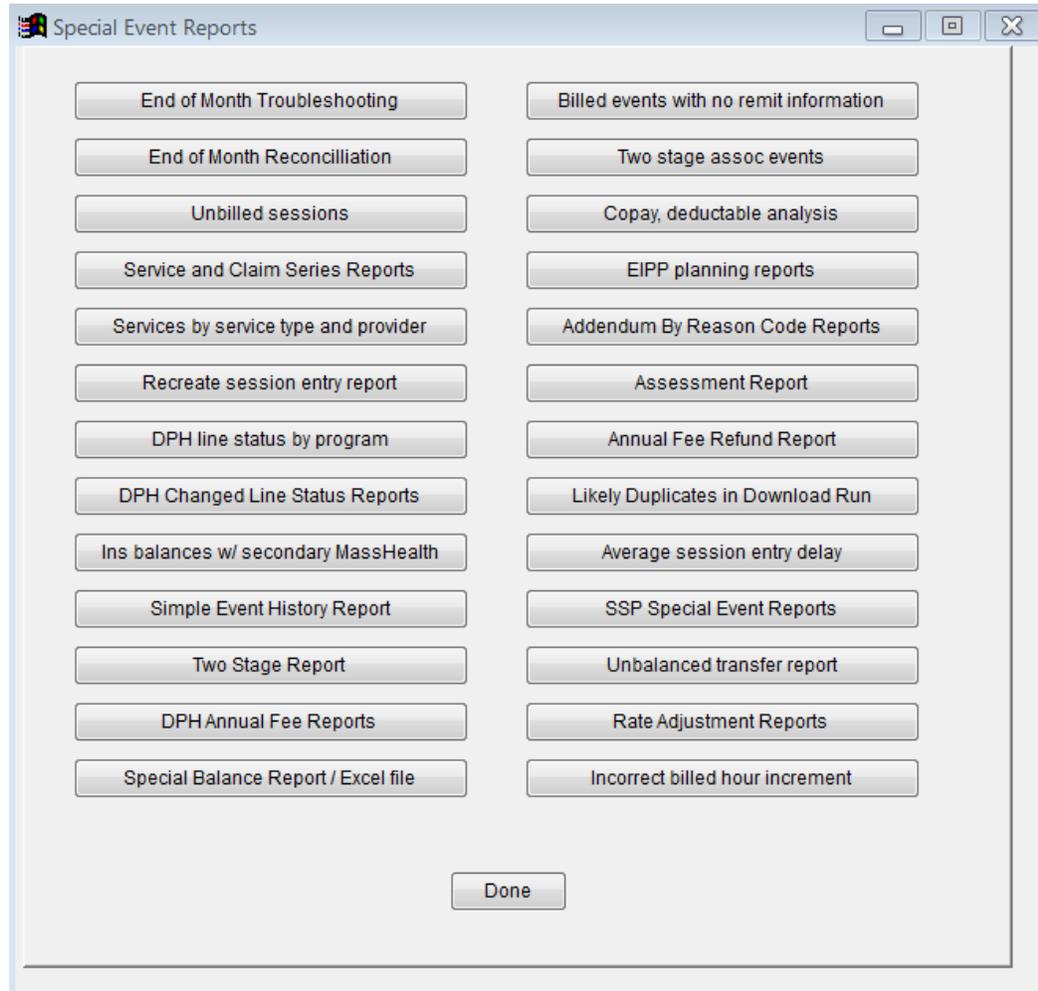
Event Note 08/28/2016: New rate record link, no rate change.

Fee 4109.63 Pay 0.00 Balance 451.65

Report Done

Special Event Reports

Special Event Reports are designed to answer specific questions.



These are each described below.

End of month troubleshooting

This is useful for SDR issues.

The screenshot shows a window titled "Special Event Reports" with the following content:

- End of month troubleshooting report series**
 - Overdue Unadjudicated SSP Claims
 - Loaded more than 3 weeks ago and not processed for session entry (adjudication). May have been overlooked somehow.
- Recently removed from SDR**
 - Removed from SDR within dates selected. Probably need attention and correction, either the reason code or perhaps incorrectly billed to DPH.
 - SDR runs beginning: 06/10/2017
 - SDR runs ending: 07/10/2017
 - DPH Only
- Blank DPH Line Status**
 - Sessions begin: 07/11/2015
 - Sessions end: 04/11/2017
 - For DPH claims that should have been adjudicated by DPH. Only DPH claims entered more than 90 days ago that have a positive balance are shown. These were probably removed from SDRs repeatedly.

Unbilled Sessions Report

Use this report to see service that have not yet been billed.

The screenshot shows the "Thom Patient Account System v9/12" interface with the "Special Event Reports" window open. The window title is "Special Event Reports" and the content is:

- Unbilled sessions report. All unbilled original SERV records will be reported.
- Format**
 - Windows
 - Dot Matrix
- Level of Detail**
 - Low
 - Medium
- Session Dates**
 - Begin: / /
 - End: 09/12/2000
- Buttons:** Run Report, Done, Summary Report, Print Setup

This is a quick way to see if any original service (SERV) records have been overlooked by billing runs. Simply enter the session date range you are concerned about (usually the last three months) and run it. This is helpful before running the SDR.

End of Month Reconciliation Reports

These reports show all new activity within a given posting date range.

Special Event Reports

Use these reports to see all activity posted within specified dates. You may load the date range from those used by your SDR reports, if desired, since these dates usually correspond to your monthly accounting period. Or you can type any posting date range you like.

The Unbilled DPH Credits report shows negative transfers from DPH that were posted, but held out from the SDR because payments had not yet come in. Usually print the Adjustment reports in detail so

Prog

Posting Dates
Begin / /
End / /

SDR Date (optional)

Billing Limits (optional)
Single Billing
 Exclude DPH
 Exclude DIR
 Exclude DPH and DIR
 Exclude Autism
 Autism Only

Level of Detail
 Low
 Low w/ FY
 Medium

Summary Report
 Show Check Ref or ADJ Subtype

Select Reports Below...

Use these reports to see all activity posted within specified dates. You may load the date range from those used by your SDR reports, if desired, since these dates usually correspond to your monthly accounting period. Or you can type any posting date range you like.

The Unbilled DPH Credits report shows negative transfers from DPH that were posted, but held out from the SDR because payments had not yet come in. Usually print the Adjustment reports in detail so you can see exactly what they were for.

The Out of Period Events report is more of a utility report to show you any events that were physically entered during the posting period, but were manually given a posting date in a prior period. These should be quite rare, but if found, would be altering your beginning balance.

The Simple Session Transfer Reports shows all Session transfers whether balanced or unbalanced. If you alter posting dates and have transfer pairs split across posting periods, this will help locate them. It will duplicate amounts shown in Unbalanced Transfer Differentials.

You set up the conditions and formats for the reports on the left side of the page, then work down the list of reports on the right side. All reports are sorted by payer (billing type).

Normally, you will define a single month for a posting date range. If you use actual posting dates for your billing and receipt runs, your posting date range for a given month will look like the example above, shifted 9 or 10 days into the month.

If you want the date range to match the SDR date range you have used, you can select the SDR Date and it will fill the posting date range automatically.

The Prior Balances report calculates the balances for each billing type up to the day before the beginning posting date range.

The Billing Limits choices are entirely optional. Some programs may want their reports to exclude DIR ("Direct Annual Fee" billing) for example. You may want to pick a single billing type if you are looking trying to troubleshoot a single payer.

Normally, you will want a Level of Detail set to "Low" or "Low with Fiscal Year". The Medium level of detail puts more information about each event in the detail band of the report.

Summary reports hide the detail band (specific events). You normally want Summary reports for most of the reports. However, it may be useful to run the two Adjustment reports with full detail (not summary).

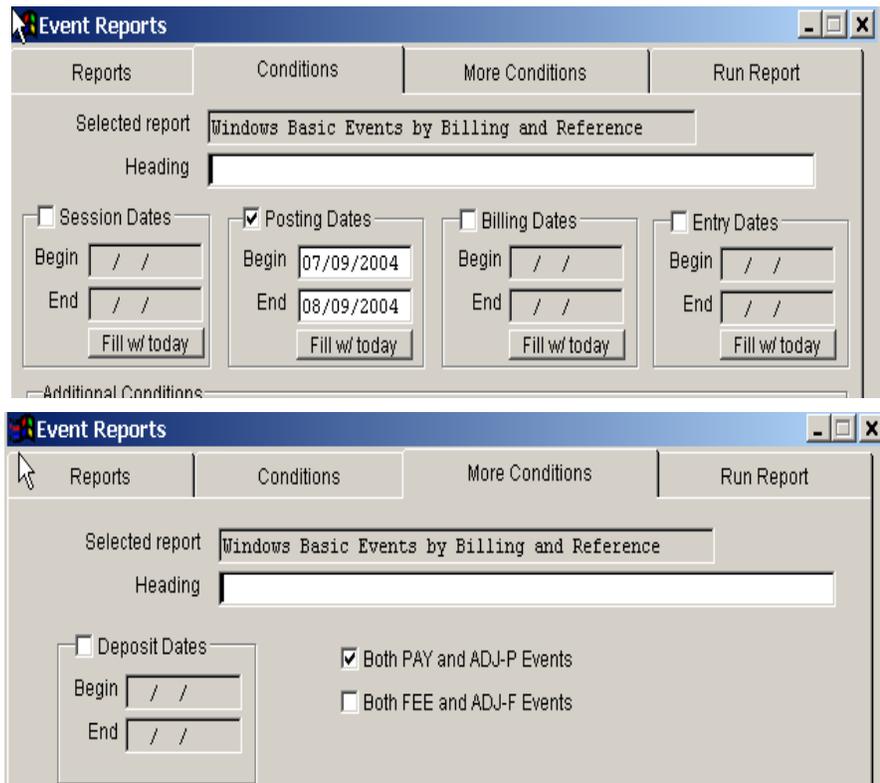
A final checkbox for showing the Check Reference or Adj Subtype is offered. This may be useful for pay and adjustment reports.

So stepping down the reports:

- **Prior Balances:** this will calculate the balance as of the day before the beginning of the posting period. It takes all events posted before that time and adds up the fee and pay amounts to calculate the balance for each billing type. It is similar to running the normal aging report "backdated" to an earlier posting date, except it runs much faster. It still may take some time and it warns you of this before you run it. The balances provided should match the ending balances of your previous month's reconciliation.
- **New Sales:** this report takes only original service (SERV) records posted within the posting date range. This is all new services that were billed within the month.
- **New Fee Adjustments:** this report takes all ADJ-F events posted within the month. You probably want a detail report (non-summary) for this run, and you may want to select the "Show Check Ref and Adj Subtype" box to sort it further.
- **Transfers:** this report takes all TRANS events posted within the month. The positive and negative transfer amounts may not add up to zero, because some positive transfers created at the end of last month may not have actually been billed and posted until this month.
- **Unbilled DPH credits:** this report shows all back transfers from DPH to a third party that were not actually reported on the SDR, even though the transfer was posted. The DPH billing run will hold these credits back from the SDR if payments from DPH have not yet come in. This report is useful if you are

comparing your DPH transfer amounts posted within the month to what actually was printed on Form D and E of the SDR.

- **New Receipts:** this report shows all PAY records posted within the month. You probably want a summary report, but may want it sorted by check reference to see the various check amounts.
- **New Pay Adjustments:** this report shows ADJ-P amounts posted within the month. Note that any money "taken back" by a third party on an EOB will be handled as a negative ADJ-P entry, with that check reference. So for example, a check reference "12345" from BCB for \$900 may have included \$1000 PAY amounts for new charges and -\$100 taken back on clients that were reviewed and deemed by BCB to have been incorrect payments on an earlier EOB. The -\$100 will come off as ADJ-P entries. The \$1000 PAY amount for check "12345" will show on the New Receipts report and the -\$100 ADJ-P amount for check "12345" will show on the Pay Adjustment report. If you want to see these amounts netted together on the same report, you can go to Basic Event Reports and choose a report sorted by billing and reference, with this posting date conditions, and a new condition "Both PAY and ADJ-P Events" (see below)



- **Ending Balances:** this report calculates the ending balance from all events posted up to and including the final day of the posting date range. It takes all fee and pay amounts and calculates the balance as of that date. It may also take a while on some systems because it goes through so many events. You definitely want a Summary report for this one.

- **Out of Period Events:** this optional report is offered to help troubleshoot changes in the prior balance amounts over a previous report. It shows any events physically entered within the posting date range but that were somehow back posted into an earlier posting date range. Normally this report will show zero such events.

Service and Claim Series Reports

One of the most powerful and useful report screens is this one, which generates reports of all claim records associated with any records that match a given condition. For example, if you wanted to see all claim records associated with a REJECTED transfer to DPH, you specify the single rejected record and this would pull out the original SERV, any payment records, adjustments and so forth.

For this report, a Service Series is all records associated with a single service (SERV) record that all share the same SERV_ID. These may be of more than one billing type if the series involved a transfer to another billing.

A Claim Series is all records of a specific billing type that go into a single claim to the third party payor.

Special Event Reports

Service and Claim Series Reports... Report detail Low High

Include Service Series Claim Series Sort Billing Client Serv_id S+B

Heading

Session Dates Begin / / End / /

Posting Dates Begin / / End / /

Billing Dates Begin / / End / /

Prog 01 Bill Client T

Eid Serv_id Check #

Type

Line Status Updated by ERA run

Error code Submitted by SDR run

PV SDR date

Other

Bill Resub Summary Report

SDR Resub Preview

Neg Bal Only

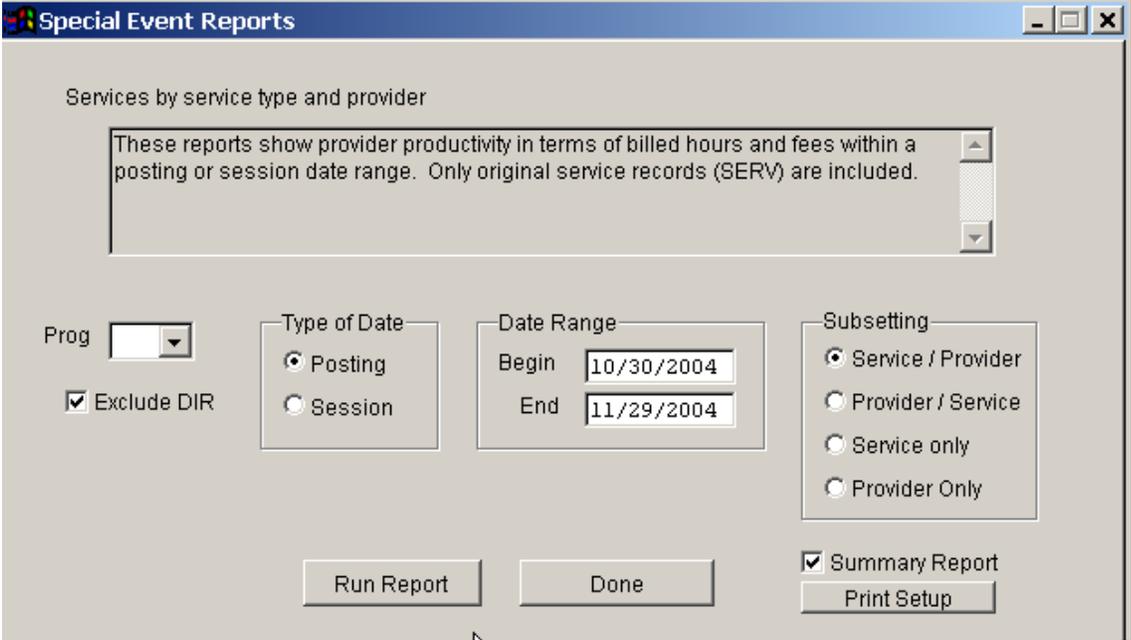
Pos Bal Only

The conditions here are similar to those in the simple event reports, but again, these conditions identify target records for whom entire service or claim series are displayed.

This screen is particularly useful troubleshooting odd or difficult claims, when you know one problematic record and want to see all its associated records.

Services by service type and provider

This report is used to assess provider productivity.



It shows all original service (SERV) records based on either posting or session dates with various sort options. (Adjustment entries are not included, so if a provider submitted a correction after a service had been billed, that correction would not show up here. Corrections made directly to the SERV record before billing runs will appear).

Recreate Session Entry Report

This will reprint the report associated with a session entry run.

Special Event Reports

Recreate session entry report..

Pick date of session entry run and level of detail for report..

Session entry date

Level of Detail

Low

Medium

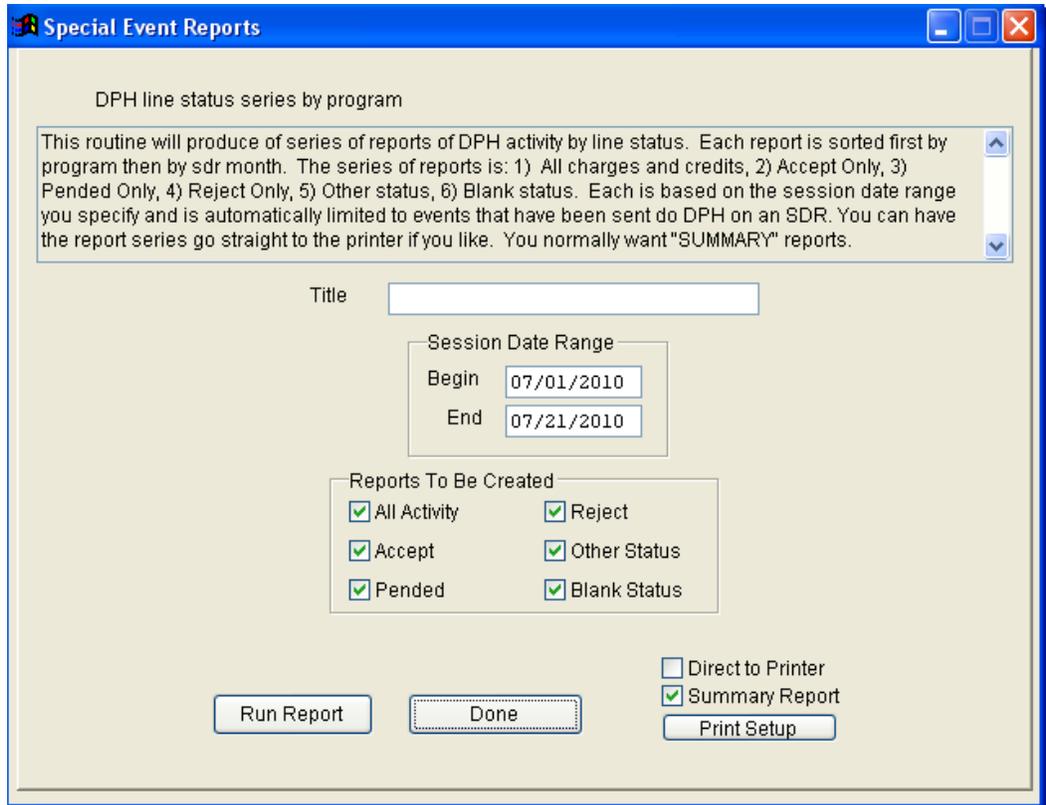
Summary Report

This report format is often used by agencies for checking clinical records and for having the provider sign off on the data entered into the computer. Normally it is printed after a batch of sessions has been entered, but this report choice allows you to recreate it.

You select the date you were entering sessions and level of detail for the report. The LOW detail report will match the original one offered during session entry. The MEDIUM detail offers more information. If you entered more than one batch of sessions on the same date, you may need to try each of the runs shown for the day to find the correct one.

DPH Line Status by Program

This routine will produce a series of reports of DPH activity by line status. Each report is sorted first by program then by SDR month. The series of reports is: 1) All charges and credits, 2) Accept Only, 3) Pended Only, 4) Reject Only, 5) Other status, 6) Blank status. Each is based on the session date range you specify and is automatically limited to events that have been sent to DPH on an SDR. You can have the report series go straight to the printer if you like. You normally want "SUMMARY" reports.



DPH Changed Line Status Reports

This report will locate all events updated by a given DPH remit (ERA) run. The line status and other remit information carried by this run will be called the "target" values. The report will then locate the prior remit values for each of these sessions so you can see what, if anything was changed by the remit run (comparing the target and prior values). Finally, since the selected remit run might itself be an old one, the report will also show the current remit values for each session. If you select the most recent remit run, then the target values and current values will be the same. You can select various sort orders, but the most likely sort will be by PV. You can also limit the report to a given target PV or line status.

Special Event Reports

Special ERA Changes report

This report will locate all events updated by a given DPH remit (ERA) run. The line status and other remit information carried by this run will be called the "target" values. The report will then locate the prior remit values for each of these sessions so you can see what, if anything was changed by the remit run (comparing the target and prior values). Finally, since the selected remit run might itself be an old one, the report will also show the current remit values for each session. If you select the most recent remit run, then the target values and current values will be the same. You can select various sort orders, but the most likely sort will be by PV. You can also limit the report to a given target PV or line status

Prog *

Updated by ERA run

DPH Only

Target Line Status

Target PV

Report Sort

by PV, Target LS, Prior LS

by Target LS, Prior LS

Other Conds.

Summary Report

Single Event History Report

Use this report to see all the event history associated with a single event. The event history includes billing, SDR, and era (electronic remit) runs. There is one event history record created for each of these runs, so you can see exactly when an event was billed and rebilled, or whether it was sent on two SDRs by accident, or how the remit status may have changed over various remit files processed.

Locate the EID you want to use from any standard event report. There is usually a column for this value. Then type it in below for the report.

Two Stage Report

This is a technical report mainly used for technical support.

10/16/2007 Basic Events by Program and Service Page
Sessions 07/01/2006-06/30/2007 Posted 07/01/2006-08/30/2007 100% SERVS (1 bhour)

Pr Client	Session	Prov	Bl.Hr.	Bill	Fee	Pay Type	Ref	Resub	Bal	Posted
Dphid-Ref	Serv_id	Place Disc	Sec	Sec			Eid	SDR Resub		Billed
* Program: 01										
** Service: A0										
** Service Subtotal **										
				378.00	0.00	0.00			0.00	
** Service: A1										
** Service Subtotal **										
				50.00	1250.00	0.00			0.00	
** Service: A2										
** Service Subtotal **										
				83.00	4150.00	0.00			50.00	
** Service: A3										
** Service Subtotal **										
				88.00	13200.00	0.00			600.00	
** Service: A4										
** Service Subtotal **										
				87.00	21750.00	0.00			250.00	
* Program Subtotal *										
				686.00	40350.00	0.00			900.00	
* Program: 17										
** Service: A0										
** Service Subtotal **										
				229.00	0.00	0.00			0.00	

Sorted by program and rate (service type)

100% of year billed (1 bhour)

10/16/2007 Page
Sessions 07/01/2006-06/30/2007 Posted 07/01/2006-08/30/2007 100% PAY (1 bhour)
Extended Report: All Activity Associated with Selected Events by Program and Serv

Pr Session	Pr.Hr.	Prov	Bl.Hr.	Bill	Fee	Pay Type	Ref	P1	Bal	Posted	Billed
Client			Sec	Sec			Serv_id				
** Prg: 01											
* Serv: A1											
* Serv Subtotal *											
	0.00		0.00	0.00	0.00	875.00			0.00		
* Serv: A2											
* Serv Subtotal *											
	0.00		0.00	0.00	0.00	3150.00			0.00		
* Serv: A3											
* Serv Subtotal *											

Second report showing payments, as opposed to charges.

Basic Events by Program and Service											
10/16/2007	Sessions 07/01/2006-06/30/2007 Posted 07/01/2006-08/30/2007 75% SERVS (.75 bhour)									Page	
Pr Client	Session	Prov	Bl.Hr.	Bill	Fee	Pay	Type	Ref	Resub	Bal	Posted
Dphid-Ref	Serv_id	Place	Disc	Sec				Eid	SDR	Resub	Billed
* Program: 01											
** Service: A0											
** Service Subtotal **											
				1.50	0.00	0.00				0.00	
** Service: A1											
** Service Subtotal **											
				5.25	131.25	0.00				0.00	
** Service: A2											
** Service Subtotal **											
				7.50	375.00	0.00				0.00	
** Service: A3											

75% of year charges

The reports continue for 75% payments, 50% charges and payments, and 25% charges and payments.

Special Balance Report

This will create a report of all events within dates that have a positive balance. You can send the report to an Excel file. If you leave the path blank, it will default to your local Thom Biller home folder. If you leave the file name blank, it will default to "EVENTS.XLS".

Billed Events with No Remit Information

Use this report to identify claims with balances that have not been reported on HIPAA 835 remittance files.

Special Event Reports

Billed events with no remit information...
Use this report to identify claims with balances that have not been reported on 835s.
(Choose other remit conditions for comparisons as needed.)

Remit condition

- Claims without remit information
- Claims with remit information
- Both claims with and without remit information

Bill

Posting Dates

Begin
End

Billing Dates

Begin
End

(Only events with positive balances will be included)

Copay, Deductable Analysis

This is a technical report for predicting the impact of changes in DPH policy on copay and deductibles.

EIPP Planning Reports

Special Event Reports

Reports for EIPP tracking of TP and TV sessions. You will normally select either the current or prior fiscal year for the date range. Then select a report sorted either by service type, month, or client. The monthly report is probably the best for checking year to date totals. The Client List with Count shows the number of clients seen within dates instead of the event hours and dollars. It is a good idea to preview the report in detail to make sure the conditions are correct, then select summary for a more condensed report.

Heading

Session Date Range

Begin

End

Prog

Report Sort

by Service code

by Month

by Client

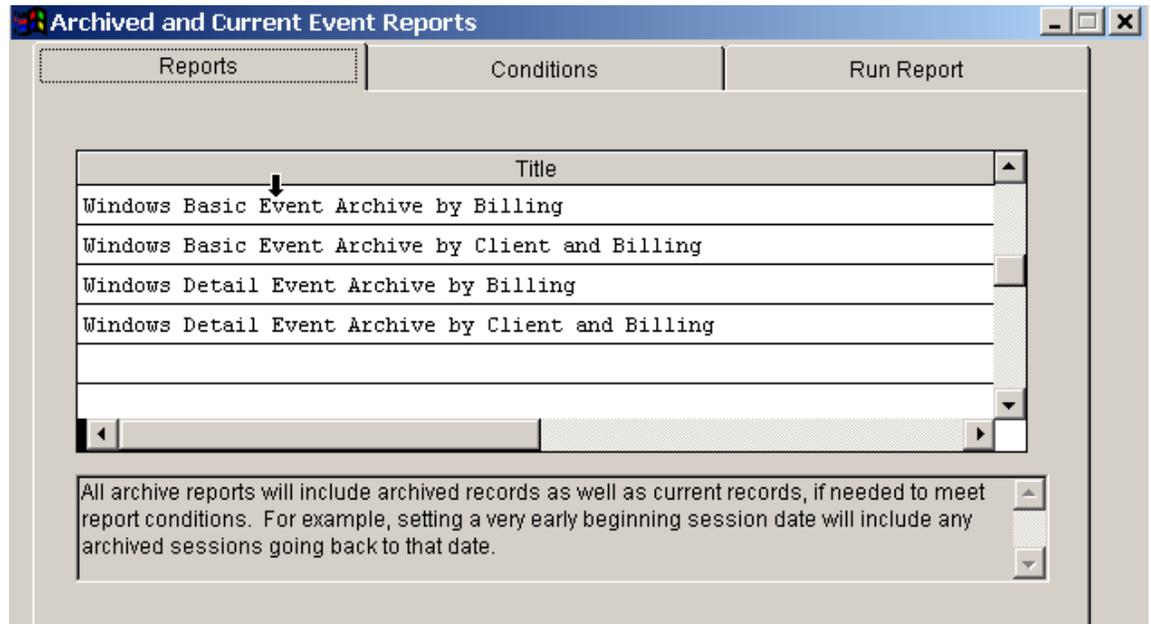
Client list w/ count

Summary Report

You will normally select either the current or prior fiscal year for the date range. Then select a report sorted either by service type, month, or client. The monthly report is probably the best for checking year to date totals. The Client List with Count shows the number of clients seen within dates instead of the event hours and dollars. It is a good idea to preview the report in detail to make sure the conditions are correct, then select summary for a more condensed report. So for example, to compare this year to last year, you would first run the report 7/1/2010 - 6/30/2011, then enter 7/1/2009 – 6/30/2010 probably using the “Month” sort.

Archived Events

These reports retrieve event archive records in addition to events from the active file and are therefore useful for covering longer time periods, or printing the complete record for a single client.



The conditions available are less sophisticated than those for active event reports.

Sorted Event Reports

This screen offers summary reports for administrative oversight of services and billing. It gives you the chance to construct your own reports with one, two, or three levels of sorting and subtotals. It can also compare a current time period with the same time period from last year.

The screenshot shows the 'Sorted Event Reports' window with the following configuration:

- First Sort:** Bill, Program, Provider, Service, Client. Start Each on New Page.
- Second Sort:** Bill, Program, Provider, Service, Client, Current vs. Last Year, None.
- Third Sort:** Bill, Program, Provider, Service, Client, Current vs. Last Year, None.
- Session Dates:** Session Dates. Begin: / /, End: / /, Fill w/ last month.
- Posting Dates:** Posting Dates. Begin: / /, End: / /, Fill w/ last month.
- Type of Records:** Original Service Hours (SERV), Original Charges (SERV), Adjusted Charges (SERV, TRANS, ADJ-F), Payments (PAY, ADJ-P).
- Additional Conditions:** Bill [dropdown], Prog [dropdown], Prov [dropdown], Serv [dropdown].
- Heading:** [text box]
- Buttons:** Preview, Print Setup, Print, Summary Report.

Using the option buttons across the top of the form, you can set up any series of sorts involving the Billing, Program, Provider, and Service fields depending on the need. The check box under the first sort option box allows you to force a new page for each primary sort. So if you want each billing type to start on a new page (as the primary sort), check this box.

The middle of the screen offers conditions for dates (session or posting) and type of record. The type of record chosen also controls what is tallied. Original Service Hours limits the report to SERV records and the tallies the number of billed hours on each. This is useful for tracking staff productivity. The other three choices tally dollars in either the fee or pay fields.

If you want to compare a current period to the same period last year, you must select either a session or posting date range. In this example, the report will be sorted by Billing and current month of October will be compared to October of last year.

The Additional Conditions allow you to limit the report further, if needed.

The default for these reports is "Summary". If you want to see the detail of the sessions being sorted, uncheck the Summary box.

Clients / Coverages Reports

This form allows you to select client, coverage, and authorization reports. They are generated from the client tables, not the event tables discussed earlier. This is where you can produce a list of client records that meet various conditions and that is generated with various sort orders.

Client Reports Tab

First define the report format and sort on the Report Tab.

The screenshot shows a window titled "Client reports" with three tabs: "Reports", "Conditions", and "Run Report". The "Reports" tab is selected and contains a list of report titles under the heading "Title". The titles are:

- Windows Basic Client
- Windows Basic Client - Alias
- Windows Basic Client - Alias by Alias
- Windows Basic Client - Assessment Info Only
- Windows Basic Client Blue Cross Fields
- Windows Basic Client Coverage / Auth
- Windows Basic Client Coverage / Auth by Prg
- Windows Basic Client Coverage / Auth w/ Cap Info
- Windows Basic Client Coverage Check Eligibility
- Windows Basic Client Coverage by Addendum
- Windows Basic Client Coverage by Employer
- Windows Basic Client Coverage w/ Employer

Below the list is a text box with the following text: "One line per client with primary billing shown, includes assessment date and total for each client. If you limit the report to a single billing type, then all clients with this coverage as any priority will be shown. For example, if you limit the report to BCB clients, all clients with BCB coverage as priority 1 2 or 3 will be shown".

Below the text box is a radio button group labeled "Select Type of Reports Offered Above" with three options: "Basic Reports" (selected), "Detail Reports", and "Labels".

Select Basic, Detailed, or Labels for different report options. Within one of these choices, you are offered a number of report formats that have different content (columns) and sort orders. Feel free to experiment with all of these report formats and see what they offer.

Client Report Conditions Tab

This tab now has most information split between a variety of sub-tabs on the screen.

Client Date Conditions Tab

Use this to set conditions on various date fields stored on the client record.

The screenshot shows a software window titled "Client reports" with three tabs: "Reports", "Conditions", and "Run Report". The "Conditions" tab is active. At the top, there are fields for "Selected report" (containing "Windows Basic Client") and "Heading". Below these are five sub-tabs: "Client Dates", "More Client Conditions", "Coverage Conditions", "Auth Conditions", and "Session Conditions". The "Client Dates" sub-tab is selected and contains nine date condition settings, each with a checkbox and two date input fields (// //):

- Last Seen Btwn
- Discharged
- Last Elig Check
- Assess Yr Btwn
- Waiver Ends Btwn
- DOB Between
- Current IFSP Btwn
- IFSP End Btwn
- Initial IFSP Btwn

At the bottom of the window, there are several controls: a checked checkbox for "Add conditions to heading", a "Preview" button, an unchecked checkbox for "Summary Report", a "Print Setup" button, and a "Print" button.

These conditions will limit the report by the date:

- Last seen
- Discharged
- Had last eligibility check
- Has an assessment year start date
- Had last annual fee bill
- Waiver ends
- Date of birth
- Current IFSP beginning date
- IFSP ending date
- Initial IFSP beginning date

More Client Conditions Tab

Additional Client Conditions can be set below:

Here you can pick a single client, program, misc value, and area. You can select clients for given coordinator, or see all whose coordinator field is blank.

All clients with a given SSP assigned to their the primary or secondary SSP field can be shown, or the Any SSP checkbox will limit the report to clients with any SSP selection in either field. Use it to see all of your SSP clients in a single list.

You can select a single annual fee service level and again those that are blank or not. EIPP conditions can be set as well as a report of those clients soon to turn 3 years of age and thus getting ready to leave EI. (The fundraising fields are for Thom programs only). Use the optional conditions with help from tech support.

The IFSP SSP Hours boxes limit the reports to those with amounts above or below the indicated values.

Coverage Conditions Tab

Client Dates	More Client Conditions	Coverage Conditions	Auth Conditions	Session Conditions
Bill <input type="text"/>	Reason <input type="text"/>	<input type="checkbox"/> Cov Ends Btwn <input type="text"/> / <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> / <input type="text"/>		
<input type="checkbox"/> Coverage No. Wrong Length	<input type="checkbox"/> Has MMIS	<input type="checkbox"/> Capped		
<input type="checkbox"/> Needs Authorization	Cov. No. <input type="text"/>	<input type="checkbox"/> No Copay Coverage		
Insurance Name <input type="text"/>	Insurance Addendum <input type="text"/>	<input type="checkbox"/> No EI Coverage		
Special Tppcode <input type="text"/>	<input type="checkbox"/> Is Blank <input type="checkbox"/> Is Not Blank	<input type="checkbox"/> Employer not blank		
	Single Employer <input type="text"/>	<input type="checkbox"/> Employer is blank		
<input type="button" value="Preview"/> <input type="checkbox"/> Summary Report <input type="button" value="Print Setup"/> <input type="button" value="Print"/>				

Here you can limit the reports based on coverage information, such as billing type, coverage date ranges, etc.

The **Reason code** limits the report to coverage records with a particular default DPH reason for denial code. For example, when a client is uninsured (reason "106"), he or she will have a primary DPH coverage record with "106" as the reason.

The **Capped** checkbox will limit the report to coverage records that have been checked as "Capped". This actually sets the coverage status field to "C", so the checkbox actually limits the report to coverage records whose STATUS = "C". If you are transferring sessions from a third party to DPH because the coverage is capped, you should mark the coverage as "Capped" to direct future sessions straight to DPH.

Auth Conditions Tab

Client Dates	More Client Conditions	Coverage Conditions	Auth Conditions	Session Conditions
--------------	------------------------	---------------------	------------------------	--------------------

Auth Visit Balance Between	<input type="text" value="0"/>	to	<input type="text" value="0"/>	<input type="checkbox"/> Auth Ends Btwn
				<input type="text" value="/ /"/>
				<input type="text" value="/ /"/>

<input type="checkbox"/> Has AReferral or PAnumber
<input type="checkbox"/> Has AReferring Provider Name
<input type="checkbox"/> Has AReferring Provider NPI

Preview Summary Report Print Setup Print

Here you can set authorization date limits, or those with an authorized visit balance in a certain range.

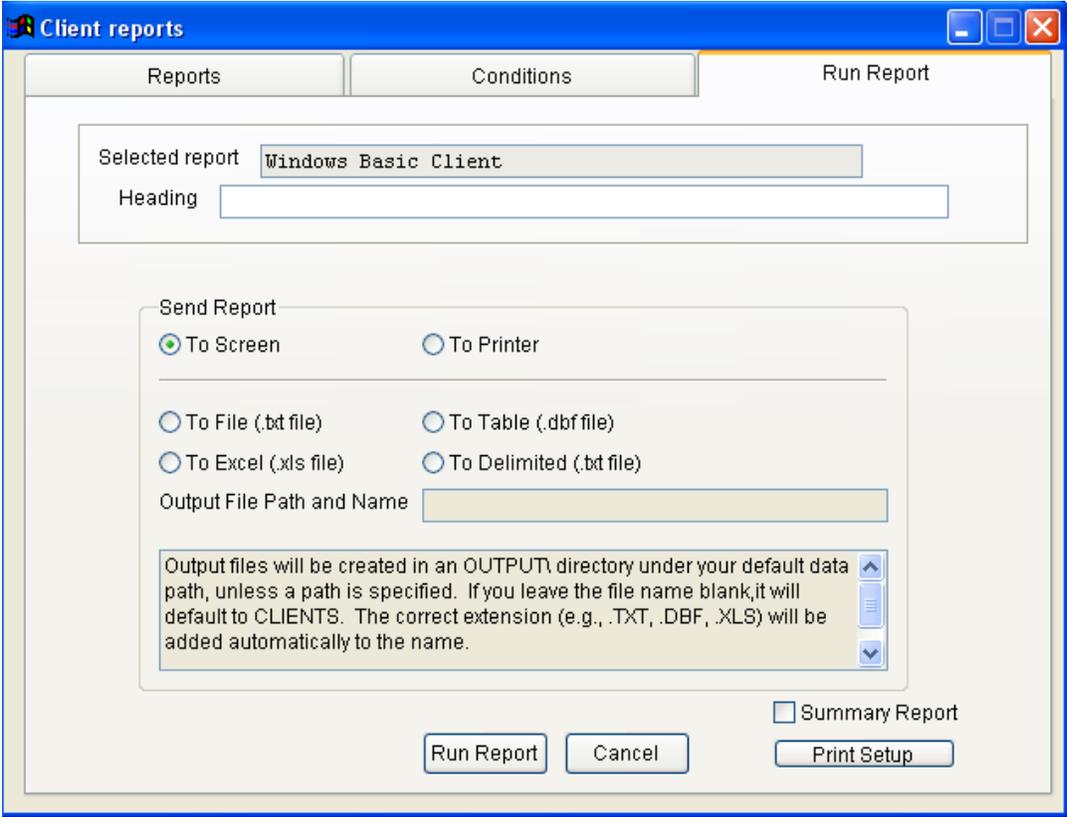
Session Conditions Tab

The screenshot shows a software window titled "Client reports" with a blue header bar. Below the header are three tabs: "Reports", "Conditions", and "Run Report". The "Conditions" tab is active. Inside this tab, there are two text input fields: "Selected report" containing "Windows Basic Client" and "Heading" containing "Any secondary claims in last six months". Below these are five sub-tab buttons: "Client Dates", "More Client Conditions", "Coverage Conditions", "Auth Conditions", and "Session Conditions" (which is highlighted with a dashed border). The "Session Conditions" section contains a checked checkbox "Any Sessions Btwn" with two date input fields below it: "01/01/2010" and "07/01/2010". To the right is an "Additional Session Conditions" section with three dropdown menus labeled "Prov", "Bill", and "Prog". Below this is another checked checkbox "Claims marked 'Secondary Billing'". At the bottom of the window are four buttons: "Preview", "Summary Report" (with an unchecked checkbox), "Print Setup", and "Print".

Finally, if you want a list of clients with sessions between certain dates, you can set that condition here. You can also generate lists based on session values for provider, billing, and program. Finally, if you want a list of clients who had any billing to their secondary coverages, you can select it here.

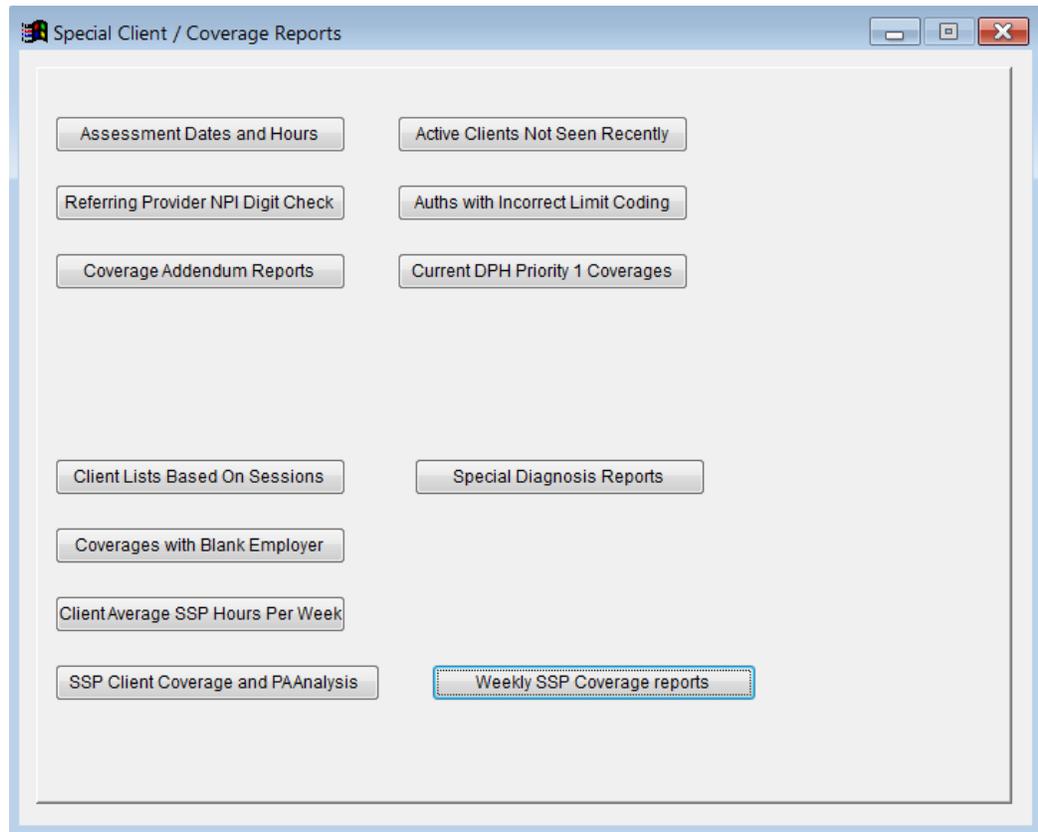
Client Report Run Report Tab

The **Run Report** tab offers different output options, just like those on the event reports.



Special Client / Coverage Reports

These are additional reports for client and coverage information.



Assessment Dates and Hours

These reports help you track assessment hours used and remaining for your clients.

Special Client / Coverage Reports

Client Assessment Hours and Dates...

Sort Order

- Client
- Assessment Year Start Date
- Assessment Hours
- Coordinator + Client

Program

Coordinator

Currently active clients (last seen for any service within 30 days)

Assessment year expiring soon (expires within 30 days)

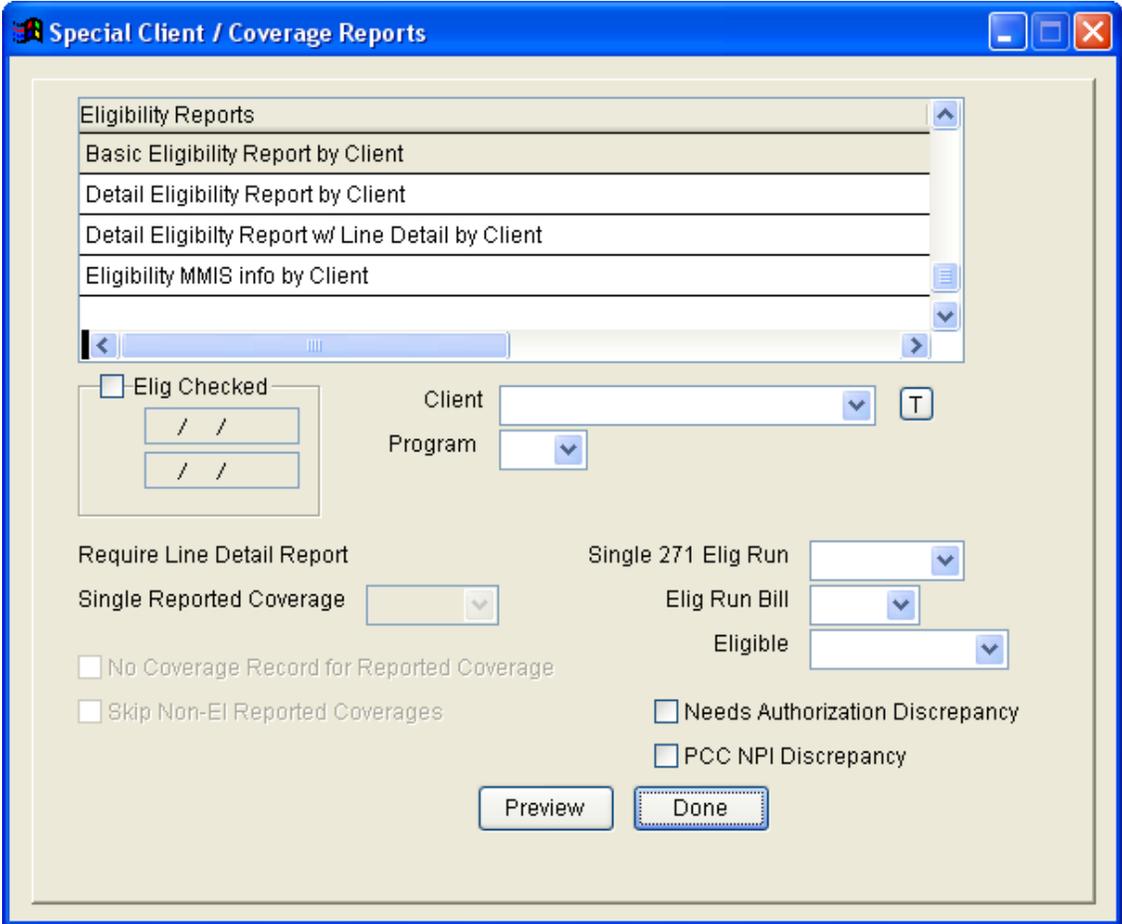
Assessment Hours Remaining in Current Assessment Year

- No assessment hours remain (all 10 hours used)
- Some assessment hours remain (9 or fewer used)
- Many assessment hours remain (6 or fewer used)

Preview Done

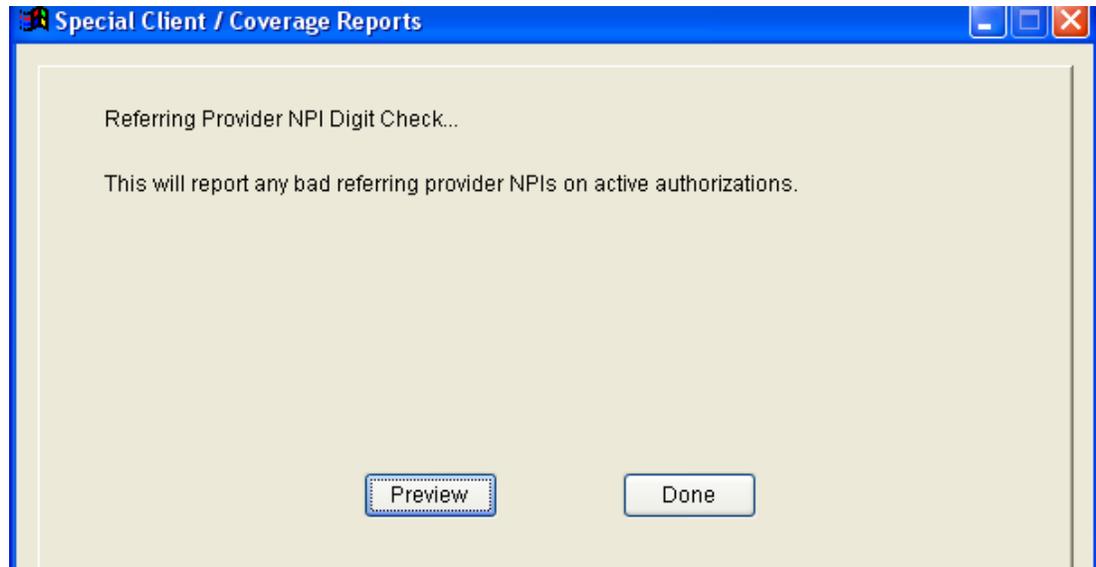
Eligibility Reports

These reports show the results of the Thom EVS checks that you may be running daily. You can see specific clients and the history of the eligibility checks.



Referring Provider NPI Check

This report shows clients with incorrect referring provider NPIs.



Coverage Addendum Reports

These show coverage addendum information.

Client Lists Based On Sessions

Use these reports to produce list of clients based on session activity.

Special Client / Coverage Reports

Report Sort
 By Client By Billing

Header

Include Event Report Too

Session Dates
Begin / /
End / /

Posting Dates
Begin / /
End / /

Billing Dates
Begin / /
End / /

Prog Bill

Type Non-Assessments

Other

Client Conditions

Preview Done Summary

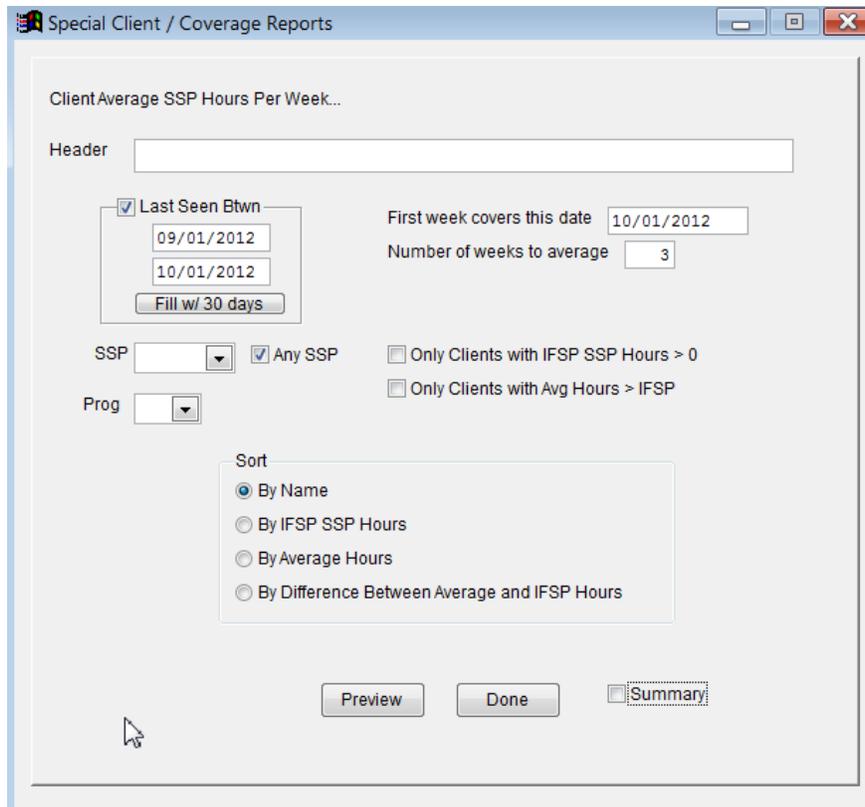
So for example, if you want a list of clients seen within a given month, or who received a specific billing type of service, you can create the client list here.

Coverages with Blank Employer

Use these reports to manage the employer field on your coverage record.

Client Average SSP Hours Per Week

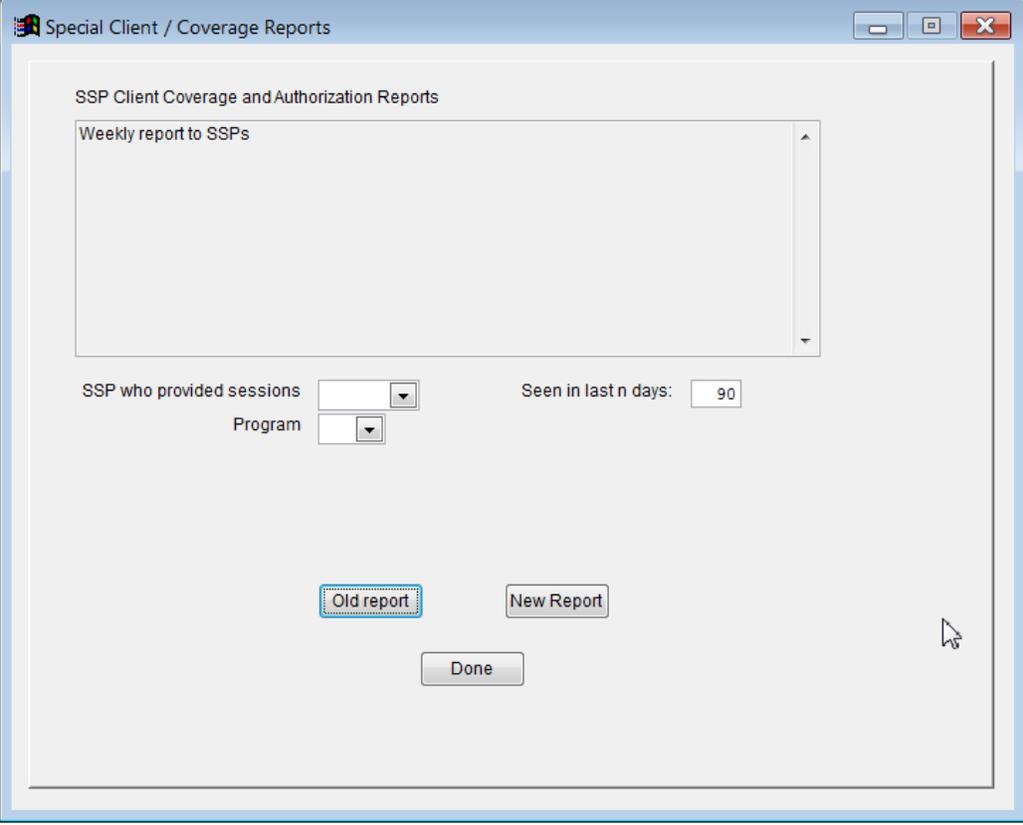
This produces reports showing the running average number of speciality services hours clients received in comparison to the amount specified in their IEPS.



The report can be sorted in various ways to help you manage clients with differences or extreme values.

Weekly SSP Coverage Reports

This is an important report to send to your SSPs so they know current client coverage information.



The screenshot shows a software window titled "Special Client / Coverage Reports". Inside the window, there is a section titled "SSP Client Coverage and Authorization Reports". Below this title is a large, empty text area with a vertical scrollbar, containing the text "Weekly report to SSPs". Below the text area are two dropdown menus: "SSP who provided sessions" and "Program". To the right of these is a text input field labeled "Seen in last n days:" with the value "90". At the bottom of the window are three buttons: "Old report" (highlighted with a blue dashed border), "New Report", and "Done".

It spells it all out as follows:

Current Client Coverages and Authorization Status for Autism Services as of Today

07/10/2017

Page: 1

Clients with autism services in past 90 days.

SSP1, DAMIEN	EIIS: 0123355	DOB: 08/28/2014	Prg: 01	
--------------	---------------	-----------------	---------	--

Priority: 1	Payer: BLUE-CROSS	BCB	Cov No: 1100065937	Begin: 05/01/2017	End: / /
	Status: All autism services covered.			Excluded:	

Authorization No: 99134CNE00	Count: 43.75	H	Begin: 05/01/2017	End: 08/28/2017
			Included: SC, SS, SL, ST, SG, SF	

Status: Authorization limited to the following services:

- Authorized: Initial Direct. Instruction (high ra 0368T
- Authorized: Parent Training 0370T
- Authorized: Initial Supervision (high rate) 0368T
- Authorized: Subsequent Direct. Instruction (high ra 0369T
- Authorized: Subsequent Supervisi (high rate) 0369T
- Authorized: Treatment Planning G9012

EI Biller Comments and Notes:

BCBA HOURS APPROVED

Authorization No: 99134CQH00	Count: 193.50	H	Begin: 05/01/2017	End: 08/28/2017
			Included: SB, SR	

Status: Authorization limited to the following services:

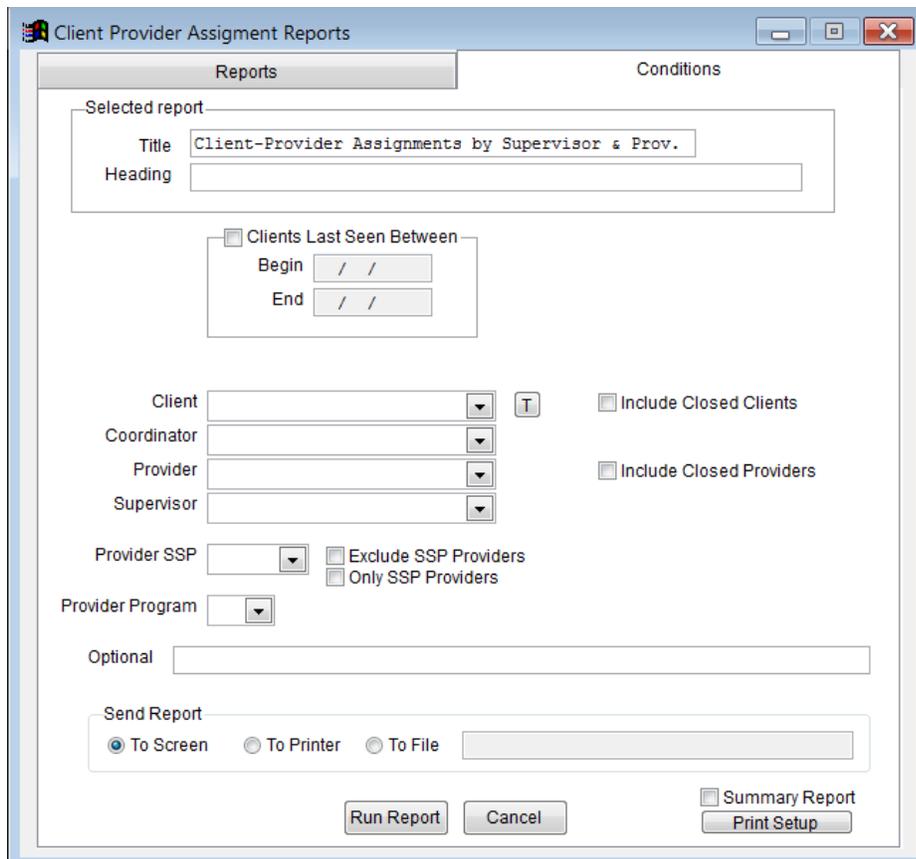
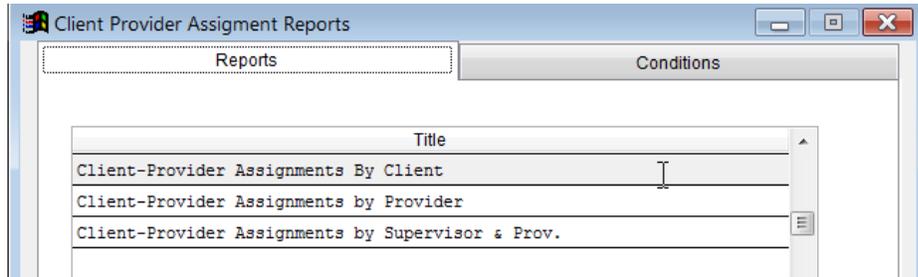
- Authorized: Initial Direct Instruction (low) 0364T
- Authorized: Subsequent Direct Instruction (low) 0365T

EI Biller Comments and Notes:

PARAPROFESSIONAL HOURS APPROVED FOR 460 UNITS

Client Provider Assignment Reports

To see assignments of client, providers, and supervisors:



Provider Reports

Simple reports of information in the provider file.

The screenshot shows a window titled "Provider reports" with two tabs: "Reports" and "Conditions".

Selected report:

- Title: *Basic Providers by Name
- Heading: (empty)

Conditions:

- License Expires Within Dates
 - Begin: / /
 - End: / /
 - Fill w/ 4 week range
- License Is Required Based on Discipline (Providers with discipline 2,3,4,5,6 or 7)
- No License Required (Providers with "No License Required" checked)
- License Has Expired (as of today)

Single License: (dropdown menu) Any License No License

Supervisor: (dropdown menu) No Supervisor Supervises

Discipline: (dropdown menu) **Program:** (dropdown menu) Include Closed

Provider: (dropdown menu)

SSP: (dropdown menu) Assigned to any SSP Not assigned to an SSP

Last session within N days (0 for all): 90 (arrow points to this field)

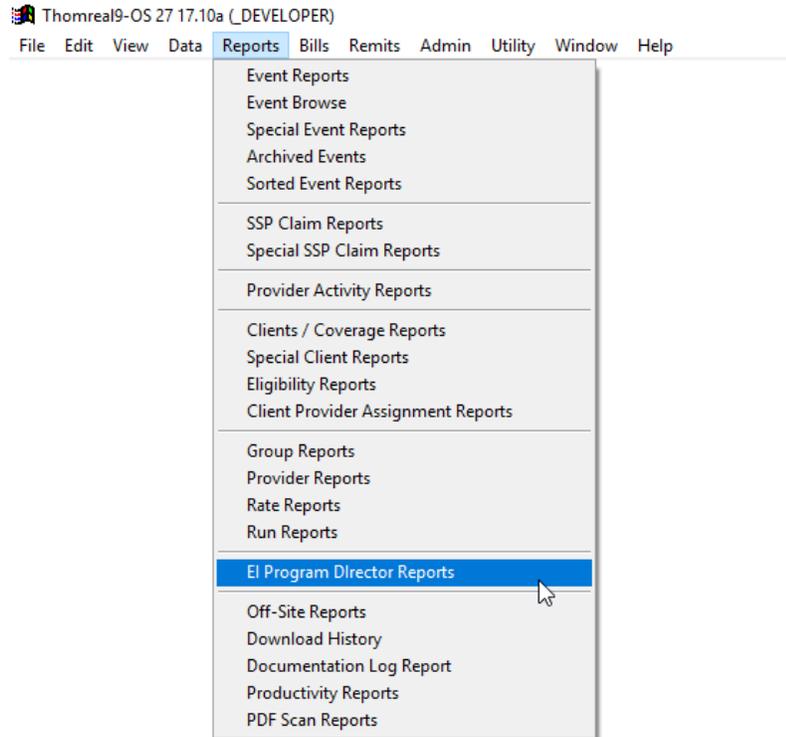
Optional: (text box)

Send Report: To Screen To Printer To File (text box)

Buttons: Run Report, Cancel, Summary Report, Print Setup

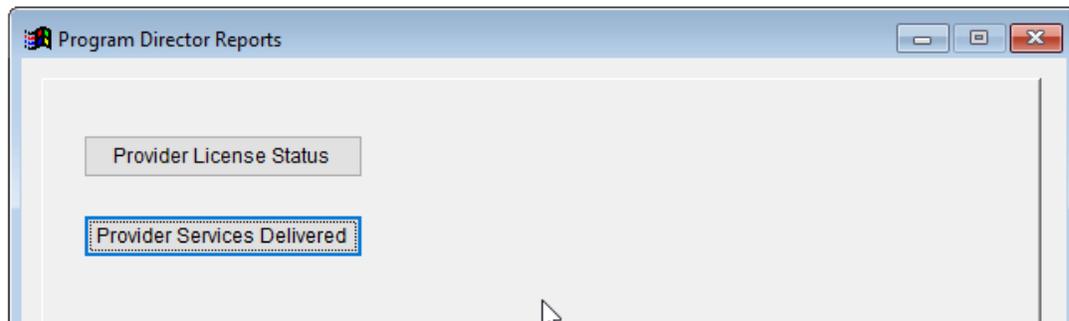
EI Program Director Reports

This new menu option will hold reports useful to program directors on a regular basis.



Right now, there are only 2 reports, but will add more as requested.

These are “canned” versions of reports available elsewhere in Thom Biller, but put here for easy access.



The first helps monitor licensure status (below):

Provider license status

Providers will be listed who have a discipline that requires a license and who have provided services in the last 90 days

Program

License Status

Already Expired

Expiring in next 4 weeks

All

Report Sort

Provider Name

Expiration Date

Preview Cancel

The second shows provider activity summary within a time period, by default the prior month, with optional sorts.

Program Director Reports

Services by service type and provider

These reports show provider activity in terms of billed hours and fees within a session date range (the date the service actually occurred). Only original service records (SERV) are included.

Program

Exclude Autism

Autism Only

Session Date Range

Begin

End

Subsetting

Service / Provider

Provider / Service

Service only

Provider Only

Summary Report

Run Report Done Print Setup

Rates

Simple reports of information in the rate file.

The screenshot shows the 'Rate Reports' window with the 'Reports' tab selected. It displays a table with the following data:

Title	Cat	Rep_oiReport Name
Basic Rate Report	RAT	WBRAT
Basic Rates (short) by Billing	RAT	WBRAT-SHOR
Basic Rates By Procedure Code	RAT	WBRATCODE
Basic Rates By Service (1 serv per page)	RAT	WBRATSV-PB
Basic Rates by Serv and Procedure Code	RAT	WBRATSVCD
Basic Rates by Service Code	RAT	WBRATSV
Detail Rate Report	RAT	WDRAT

The screenshot shows the 'Rate Reports' window with the 'Conditions' tab selected. The configuration options are as follows:

- Selected report:** Basic Rate Report
- Heading:** [Empty text box]
- Rate beginning dates:**
 - Rate beginning dates
 - Begin: / /
 - End: / /
- Additional Conditions:**
 - Autism service code (starts with "S")
 - Needs Prior Authorization
 - Bill: [Dropdown menu]
 - Rates covering: 07/10/2017
 - Include closed
 - Serv: [Dropdown menu]
 - Optional: [Empty text box]
- Send Report:**
 - To Screen
 - To Printer
 - To File [Empty text box]
 - Hide Note
 - Summary Report
- Buttons:** Run Report, Cancel, Print Setup

Runs

A “Run” in the Thom Biller is any billing, Service Delivery, or ERA run. For off-site and base configurations, the download process also counts as a run.

Each of these runs creates a single record in the Run table and these can be used to help you keep track of your activities. For example, if you want to know what Service Delivery Reports you have run in the past 4 months, the Runs Report is the place to look.

Run Reports

Use this screen to generate reports from the run table that keeps track of the various procedures you have run, such as BILLS, SDRS, ERA updates, BATCH PAYS, etc. Normally, a single run record is created each time you do one of these runs, so you can use these reports to help stay on top of tasks you have completed.

Run Dates

Begin / /

End / /

Fill w/ today

Prog

Run Type

Bill

Report Sort

Date

File name

Program

Single file name or check reference

Other Conditions

Report Done Summary Report Print Setup

It offers a simple set of conditions. The **Run Dates** box lets you limit the report to a time frame you choose. The **Prog** field limits the report to single programs, for those of you with a base configuration and multiple off-site programs. The **Run Type** field lets you limit the report to one of the following:

- Billing run;
- SDR;
- Era;
- Off-site download;

- Off-site disk recovery.

If you choose to see only Billing Runs, the **Bill** field becomes active and you can further limit the report to a single billing type. For example, you could get a quick summary of your BCB billing runs this fiscal year. Billing runs have a total hours and amount field filled in as well.

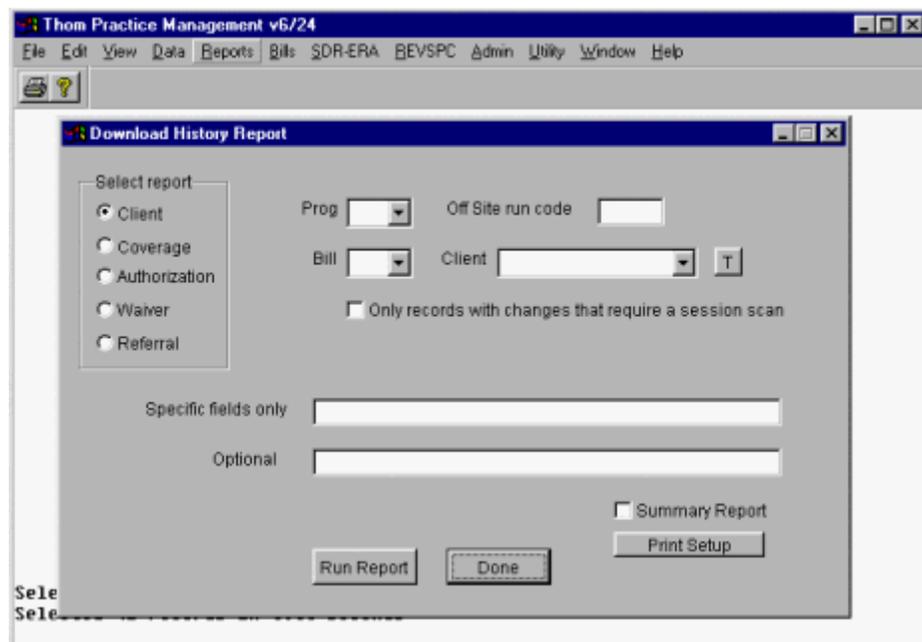
The main reason for these reports is to help you keep track of all your runs, and quickly show you what the run parameters were: the posting date, the beginning and ending dates, the output file (for SDR and ERA runs) and so forth.

Off-Site Reports

For base setups only, simple reports of the files recently received from an off-site program.

Download History

For base setups only, reports showing changed fields as a result of off-site edits.



The screenshot shows a window titled "Thom Practice Management v6/24" with a menu bar (File, Edit, View, Data, Reports, Bills, SDR-ERA, BEVSPC, Admin, Utility, Window, Help). A "Download History Report" dialog box is open, featuring a "Select report" section with radio buttons for Client (selected), Coverage, Authorization, Waiver, and Referral. Other fields include "Prog" (dropdown), "Off Site run code" (text), "Bill" (dropdown), "Client" (text with a "T" button), and a checkbox for "Only records with changes that require a session scan". There are also "Specific fields only" and "Optional" text boxes, a "Summary Report" checkbox, and "Run Report", "Done", and "Print Setup" buttons.

Select the report type for information on records changed in one of the following files: Client, Coverage, Authorization, Waiver, or Referral.

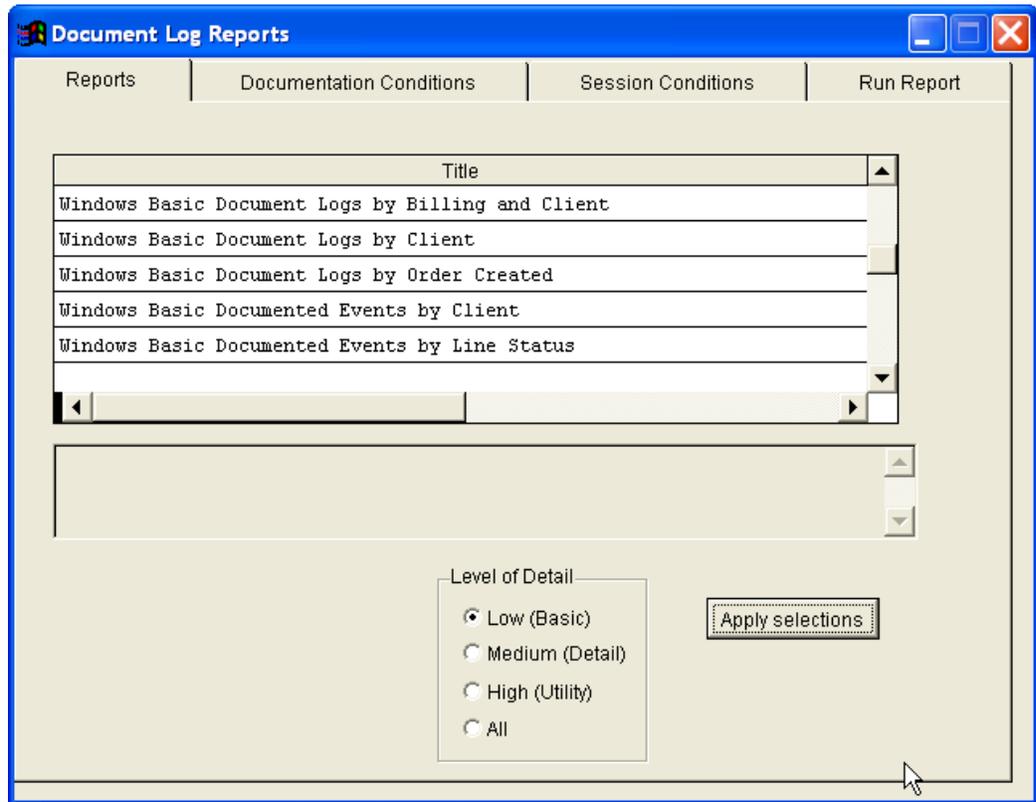
Limit the information by filling in the other fields. For example, to see changes made by a single off site run, fill that run code. To see only a single client, fill the client name. To see only records with changes requiring a session scan, check that box.

The specific fields and optional boxes probably require technical support to use.

Report Manager

This routine is currently under development.

Documentation Log Reports



Here you can select a report based on log records, or events, with various sorts.

A report of documentation log records will look like this, with one record per documentation log entry you have created with the new Documentation Log screen:

Documentation Log by Billing and Client									Page	1
Pr	DPHID-Ref	Client	Bill	Cov	Created	Begin	Posted	Staff	Pages	Hours
	Note					End	Sent	Doc_id		
* Billing: DPH										
** Client: ██████ DEVIN										
27	2703264-2	█████, DEVIN	DPH	CIG	09/26/2005	01/01/2005	/ /	KR	1	0.25
	9/26/05 Rana letter					/ /	/ /	90000122		
27	2703264-2	█████ DEVIN	DPH	CIG	09/26/2005	07/01/2004	/ /	KR	1	0.25
	9/26/05 letter from Rana					/ /	/ /	90000136		
** Client Subtotal **									2	0.50
** Client: ██████ CLARE										
44	4403332-1	█████ CLARE	DPH	BCB	09/26/2005	08/11/2004	/ /	KR	1	0.25
	9/26/05 Federal Plan					/ /	/ /	90000118		
** Client Subtotal **									1	0.25
** Client: ██████ MARIO										
49	4902169-1	█████ MARIO	DPH	USH	09/16/2005	08/10/2004	/ /	CG	5	1.50
	Multiple eobs, not payable due to plan provisions. also, form letter received back from Aetna with insurer signature, not a cov bene					/ /	/ /	90000013		
49	4902169-1	█████ MARIO	DPH	USH	09/23/2005	08/10/2004	/ /	JP	5	0.50
	various EOBs					/ /	/ /	90000073		
** Client Subtotal **									10	2.00

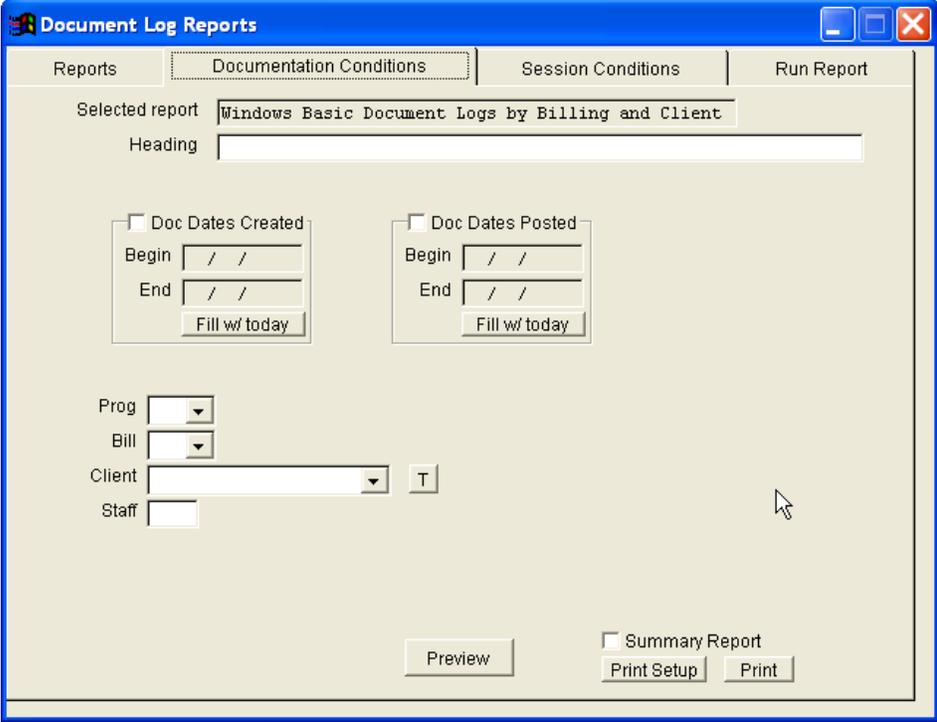
A documentation log report shows how many documents you have created, how many pages and hours you put into it, and so forth.

A documentation report based on events looks like this:

Documented Events By Client											Page	1
Dphid-Ref	Session	Sv	Bill	Type	Orig_Fee	Eid	SDR_Date	Bill_DPH	Doc_Date	Doc_Post	Staff	
	Documentation note								Line_St	Doc_Sent	Cov	
** Client: ██████, CLARE												
4403332-1	08/11/2004 TH	DPH	TRANS	FR	BLU	171.15	92110872	08/05/2005	171.15	09/26/2005	/ /	KR
	9/26/05 Federal Plan									PENDED	/ /	BCB
4403332-1	08/11/2004 TH	DPH	TRANS	FR	BLU	97.80	92110874	08/05/2005	97.80	09/26/2005	/ /	KR
	9/26/05 Federal Plan									PENDED	/ /	BCB
** Client Subtotal **					268.95			268.95				
** Client: ██████, MARIO												
4902169-1	08/10/2004 TA	DPH	TRANS	FR	USH	72.92	92013273	06/10/2005	72.92	09/16/2005	/ /	CG
	Multiple eobs, not payable due to plan provisions. also, form letter received back from Aetna with insurer signature, not a cov bene									PENDED	/ /	USH
4902169-1	08/17/2004 TA	DPH	TRANS	FR	USH	91.15	92013278	06/10/2005	91.15	09/16/2005	/ /	CG
	Multiple eobs, not payable due to plan provisions. also, form letter received back from Aetna with insurer signature, not a cov bene									PENDED	/ /	USH
4902169-1	08/24/2004 TA	DPH	TRANS	FR	USH	72.92	92013281	06/10/2005	72.92	09/16/2005	/ /	CG
	Multiple eobs, not payable due to plan provisions. also, form letter received back from Aetna with insurer signature, not a cov bene									PENDED	/ /	USH
4902169-1	09/14/2004 TA	DPH	TRANS	FR	USH	91.15	92013286	06/10/2005	91.15	09/16/2005	/ /	CG
	Multiple eobs, not payable due to plan provisions. also, form letter received back from Aetna with insurer signature, not a cov bene									PENDED	/ /	USH
4902169-1	09/14/2004 TA	DPH	TRANS	FR	USH	72.92	92013290	06/10/2005	72.92	09/16/2005	/ /	CG
	Multiple eobs, not payable due to plan provisions. also, form letter received back									PENDED	/ /	USH

The event report shows exactly which sessions and transfers have been covered by documentation. So for example, a single documentation record (one line in the first report) might actually cover 10 sessions that would show in the second (event) report. The event report also shows the line status of the sessions and when the documentation was created and sent (doc_post) as well as the initials of the staff person who created the documentation.

Then go to the Documentation Conditions tab to set conditions based on the document log record:



For example, you could see how many documents you created or posted (sent) in the last month, or narrow the report to documents created for a specific client.

On the Session Conditions tab, you can set conditions based on session details and see which sessions have had documentation.

Document Log Reports

Reports | Documentation Conditions | **Session Conditions** | Run Report

Selected report: Windows Basic Document Logs by Billing and Client

Heading: [Empty]

Session Dates

Begin: [/ /]

End: [/ /]

Fill w/ today

SDR Dates

Begin: [/ /]

End: [/ /]

Type: [Dropdown]

SERV, TRANS, and ADJ-F Events

Eid: [Text Field]

Line Status: [Dropdown]

Serv_id: [Text Field]

Preview

Summary Report

Print Setup | Print

Only sessions covered by a documentation log record's session dates will be included in this report, so if you set no session conditions, you will see all sessions that have had documentation submitted.

Bills

Introduction

The Thom Biller is designed to produce bills for 3rd party insurers, Medicaid, and the Department of Public Health. Claims can be produced as often as your program would like. While most agencies bill on a monthly or bi-weekly basis, there are no system limitations on more frequent runs. Be aware that the Department of Public Health currently accepts only one monthly submission from Early Intervention Providers.

Most programs will perform four runs per billing cycle: HCFA-1500 claims, UB-92 claims, Medicaid, and DPH. If you bill several times a month, you may omit DPH until the month's final run .

General Bills

Basic Billing Concepts and Recommendations

- Dot matrix HCFA require the use of the Generic: Text Only print driver for the font to match the form. (Add this to your Windows Printer folder if needed.)
- A general bill is created using the current balance of each claim.
- The records collected for a billing run are usually those that go on the same form: such as all billing types that go on HCFA forms.
- The billing run stamps each billed record with a posting date if it hasn't already been posted, and a billing date.
- If a session is rebilled, it gets a new billing date but the posting date remains the same for aging purposes.
- Most billing runs simply collect all unposted sessions up to a specific ending date for the run. For end of month bills, the session ending date must be set to the last day of the month being billed.

- Previously posted records can be included in one of three ways: marking them for billing resubmission, selecting them manually during the billing run, or including them based on their session dates irrespective of their posting dates.
- Most agencies like to separate billing resubmissions from original bills.
- The final billing run should be printed for all bills as a hard copy for future reference.
- The billing totals from each run should be recorded in a central billing ledger and compared later to the SDR totals.

End of month procedures for session and posting dates

You must use a consistent billing procedure at the end of each month to keep sessions from month just starting from being included in the billing runs. For example, if you are running your August bills on September 5, you must make sure no sessions dated in September are included in the run.

This is important for two reasons. First, most agency accounting practices tally “sales” activity at the end of each month. It is helpful if the actual billing run totals can be matched up to new activity reports.

More importantly, DPH requires their Service Delivery Reports to have either “current” month sessions (on Form B) or prior month activity (on Form C). The Thom Biller SDR routine controls sessions selected based on posting date. So if August sessions are your current month, you must make sure no September sessions are posted along with them because they will be “later” than the current SDR reporting month and excluded from the SDR. Furthermore, these excluded September sessions will not be picked up in the next SDR because their posting date will be too early at that point.

It is therefore essential that bills run just after the end of the month have a the ending session date set to the last day of the month.

Some agencies like to also set the posting date to the last day of the month and others allow it to be the date of the actual billing run. Whichever way you handling posting dates is okay from the point of view of the Thom Biller software and the SDR routine, but you should pick one method and stick with it. (See new Posting Plan under the Data/Agency choice from the main menu).

So for our example of a billing run occurring on 9/5/00, the session ending date must be set to 8/31/00. The posting date for the run can be either 9/5/00 or 8/31/00.

General Bills

The General Bills run is for all billing except DPH.

The screenshot shows the 'General Bills' window with the following sections:

- Run Definition:** Run Type (dropdown), Form Type (dropdown), HIPAA file name (text field), Path (text field), and a 'Fill with USB Path' button.
- Special Options:** Today's Date (07/10/2017), Posting Date (07/10/2017).
- Program:** Radio buttons for 'All' (selected) and 'Single', with a 'Sort by Prg' checkbox.
- Billing:** Radio buttons for 'All' (selected) and 'Single', with a 'No MED' checkbox.
- Claim Type:** Radio buttons for 'Primary' (selected), 'Secondary', and 'Replacement Claims'. Below are checkboxes for 'EI Only (No autism svcs)' and 'Autism Only'.
- Include:** Radio buttons for 'Bill Charges' (selected), 'Report Credits', and '837 Test Run'.
- Clients:** Radio buttons for 'All' (selected) and 'Manual'.
- Sessions:** Radio buttons for 'New Unbilled Only' (selected), 'All within dates', and 'Marked Resub / Adjustment within dates'. Includes 'Begin' (07/10/2016) and 'End' (06/30/2017) date fields. Checkboxes for 'Exclude ADJ-F records from resub run' and 'Output Claim Review Form Data (req. single billing)'. A 'Prior Run (within 2 mo)' dropdown and 'Allow Prg' checkbox are also present.
- Buttons:** 'Gather sessions', 'Preview Billing', 'Run Bill', 'Save', and 'Cancel'.
- Final Report by Client:** A checkbox and a 'Final Billing Report' button.
- Print Output:** Radio buttons for 'Dot Matrix' (selected), 'Laser', and 'Screen'. A 'Print Setup' button is also present.

Run Type:

The dropdown menu for 'Run Type' is open, showing the following options:

- Form
- Preprinted Form
- HIPAA
- HIPAA File
- Paper
- Blank Paper

Form: CMS-1500

HIPAA: Electronic 835

Paper: Seldom used blank paper dummy bill.

The HIPAA Run Type creates a HIPAA compliant 837 file for submission. The file name under this button will be filled in for you as you make other selections defining the HIPAA run. Next, you will choose a single billing type for the run. The rate header for this billing type should have a HIPAA run type established for it. Although HIPAA specifications are supposed to be the same for every payer, it turns out that different payers have slightly different specifications. This is why there are HIPAA types that you pick for different payers. Normally, picking a HIPAA run and a specific billing type will be enough to fill the

HIPAA file name with a default value. (Different payers also have different naming conventions).

The **Run Information** box states **Today's date**, and suggests it for your **Posting date**. The posting date will be stamped on each session included in a run of new claims. It indicates the 1st time a claim was ever billed to the billing type in question, and will always be that claim's posting date. The posting date determines how the claim shows up in Aged Receivable reports. It also determines inclusion on Service Delivery Reports.

Some agencies prefer to change the posting date to the last day of the month (e.g., May 31) to meet accountant or auditor expectations. We recommend that you use a consistent methodology (always use last day of month; actual date of run, etc.) Confirm it carefully, though, because it is not possible to change it once you have posted the run. See the discussion of posting plans under the Data\Agency section.

The **Program** box gives vendor agencies with multiple programs the option of running **All** of their programs' claims together, or doing **Single** program by program runs. For HCFA and UBs, running claims for all programs is probably most efficient. Report options offer sorting and subtotaling by program, allowing you to separate out activity and income. Medicaid may be the only payer you choose to run program by program, since you most likely have unique provider numbers for each.

For Medicaid, select the Single option and pick each program code off of the popup list. If you are a single EI program, leave the default button of All selected. Remember that Medicaid is one of the payer's for whom you need a "Specialized Provider Number" entered for each program. (Under the Data – Program menu, there is a button for this purpose. This is where the Medicaid Disk run will pick up the Medicaid provider number, not the Agency screen).

The **Billing** box controls whether 3rd party claims are produced by billing type, or in HCFA or UB batches. The most efficient option for HCFA paper claims is **All**. You can also bill all claims except for MED if desired. For rebilling, you may choose to isolate one particular billing type.

For HIPAA runs, you must select a single billing type.

A Primary Claim Type billing run will print only the original charges for each claim and no "other" or secondary insurer information. In contrast, a Secondary Claim Type billing run will include information about payments received from a primary insurer and will only bill claims marked "Secondary Billing" on each claim. (Secondary claims are marked when created during the Pay, Transfer, Adjust process).

So for original claims (usually "SERV" records) to be billed to the client's primary insurer, leave the Claim Type "Primary". This will exclude any claims marked "Secondary Billing" and exclude secondary payer information on the form.

For secondary claims transferred (and so marked), use a "Secondary" Claim Type run. This choice is not available for HIPAA electronic bills because secondary billing runs usually require submission of copies of the EOBs that have been returned by the primary payer.

Note that a "Secondary" claim type run should be used for paying tertiary payers as well. Here is how a secondary CMS-1500 bill would print.

ABCBTFT, SECONDARYTEST	01 01 07	X	Abcbtfu, Mr.
111 N. South St		X	111 N. South St
Boston	MA	X	Boston MA
010111	122 222-2222		010111 122 222-2222
Abcbtfu, Mr.			Tufts Group
111111		X	01 01 90 X
01 01 90	X	X	Tufts Employer
BCB Employer		X	Tufts Plan
BCB Plan			X
Signature on File	10 18 07		Signature on File
			X
315 39			
			705299
05 04 07 05 04 07 12	H2015 GP	1	77 12 4
05 05 07 05 05 07 12	H2015 GP	1	77 12 4
05 06 07 05 06 07 12	H2015 GP	1	77 12 4
05 07 07 05 07 07 11	T1015 GP	1	64 68 4
07 05 07 07 05 07 12			77 12 4
042104268	X 90000533 X		373 16 315 00 58 16
			508 655-5222
	ANNE SULLIVAN CENTER EIP		Douglas A. Thom Clinic

Primary "Other" insurance information

Total original fee for the claim, not simply the balance due

Amount paid by other (primary) payers and balance due

Secondary Billing Discussion

- Secondary billing is only available for paper forms (CMS-1500). It cannot be chosen for HIPAA runs.
- When using dot matrix CMS-1500 forms, make sure you have chosen the "New" dot matrix setting in the rate file for the billing type being printed. (You probably already have made this selection since it was needed to print NPI's on the dot matrix forms).
- All CMS-1500 laser forms have been adapted to handle secondary billing.
- If there is more than one "other payer" in a "tertiary" billing situation, you would still select the "Secondary" billing run. Since the paper forms only have room for one set of "other insurance" information, the program will select the other payer that paid the most as the one that is reported 9a-9d. However, to fully account for the amount being billed to the current (tertiary) payer, all payments are shown in box 29 no matter where they came from (primary or secondary).

Include

Leave the default of **Bill Charges** for your billing runs. Choose **Report Credits** only if you want a paper report of any existing credits in the system – over payments you may have posted, etc.

Clients

For the vast majority of runs, your **Clients** selection will remain on All. Select **Manual** only when doing very specialized runs, when you want to be able to isolate a small number of clients to run claims for probably rebilling. You may manually select the clients to be included, then pick the date range for the sessions. Normally this will involve a rebilling so you would pick “all sessions within” the date range. For example, you might rebill a couple sessions for John Smith by selecting his name from the client list, then limiting the session dates to those records only. For a single session, you must limit the run to that one date. (Manual choice of individual sessions is no longer offered).

Sessions

The **Sessions** box determines which sessions will be included in your run. When billing newly entered sessions at the end of the month, you will choose the **New Unbilled Only** option, and enter the **Begin** and **End** dates of sessions you want considered. This choice will only include sessions that have not been previously posted and billed, so you can safely use a wide date range. Setting a wide date range, usually back to the 1st day of the fiscal year for which you are still allowed to bill, insures that sessions that were submitted for billing late, or older sessions that were transferred from another billing type, will be included. If you are running bills at the end of the month, make sure you do set the ending date to the last day of the month.

The "N" button will establish "New" date ranges for most HIPAA billing runs. HIPAA runs cannot extend back before 9/1/2003 because HIPAA specifications did not exist before then.

The "O" button will establish an "Old" date range for pre-HIPAA runs that would need to go on HCFA paper bills.

Choosing **All within dates** is primarily a rebilling selection. Typically, you would specify a prior month or time period, and all sessions within those dates with outstanding balances would be included in your run. This is an efficient way of producing claim forms for previously billed yet unpaid sessions. It includes all such sessions, regardless of whether they have been marked for resubmission. This option insures that claims for which you have received no response from the insurance company will be rebilled. Any time a session is rebilled, the note field will automatically include a “RB:date” notation indicating the date of the rebill.

Choosing sessions **Marked Resub/Adj** will select all sessions within the date range you specify above that have been marked with an A or R. As you review E.O.B.s for denied claims, you may mark them with an R or A in the receipt posting routine to prepare them for resubmission. Any time a session is rebilled, the note field will automatically include a “RB:date” notation indicating the date of the rebill.

As of 4/2010, when you run a bill for resubs, the system will tally all fee and pay amounts and print them in box 28 and 29 (see below):

24. A	DATE(S) OF SERVICE						B	C	D. PROCEDURES, SERVICES, OR SUPPLIES			E	F.	G.	H.	I.	J.
	From	MM	DD	YY	To	MM			DD	YY	EMG						
1	12	03	09	12	03	09	11		96153	U2		1	75.00	10			NPI
2	12	08	09	12	08	09	12		H2015	GN		1	77.12	4			
3	12	10	09	12	10	09	11		96153	U2		1	74.00	10			
4																	
5																	
6																	
25. FEDERAL TAX ID. NUMBER		SSN EIN		26. PATIENT'S ACCOUNT NO.				27. ACCEPT ASSIGNMENT? (For gov. claims, see back)				28. TOTAL CHARGE		29. AMOUNT PAID		30. BALANCE DUE	
042 [REDACTED]		[REDACTED] X		0010 [REDACTED]				YES NO				\$ 226.12		\$ 141.24		\$ 84.88	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO & PH. #									

Total of fees, payments, and event balances shown

In the past, the amount paid box would have been blank.

Note that the total charges minus amount paid does not necessarily equal the claim balance. If, for example, you have transferred a copay to DPH and still want to resubmit a claim for a short payment to the original payer, the transfer to DPH will have lowered the claim balance but will not be reflected in either the total charge or total payment box.

A **Prior Run** will recreate a previous run. The drop down box will show you recent billing runs either for all billing types, or a single one if you have picked a single billing type earlier.

Details

The Details options for "Lump level", "Billing Discipline Type", and "Billing Place Type" are normally established by default once you have defined the run, the billing type, and the date ranges. These are needed to distinguish the billing logic for various payers during the transition to HIPAA runs. If you must edit them, you can press the Edit button next to them.

Lump Level

"Lump Level" defines how services on the same date might be combined into a single claim line. Choosing "Session Date" means all services of the same type on a given date are "lumped" together in a claim. Choosing "Discipline" means that services provided on a given date by providers of the same discipline are lumped together. Choosing "Provider" means all services provided by on a given date by a specific provider are lumped. "None" means no lumping occurs. In general, HIPAA runs lump based on "Discipline" of the providers because these all have the same procedure code and modifier for EI services.

Billing Disc Type

"Billing Disc Type" refers to the translation of discipline codes in the billing run. For HIPAA, the default is "HIPAA" translation. The other option is "HCFA" translation.

The Thom Biller uses codes such as "1" for Educator. In the past, we translated discipline codes for HCFA form lines (discipline list) in a particular way. HIPAA requires a different

mapping of codes, so when you are doing a HIPAA run, you must use HIPAA discipline codes.

	Thom	HCFA	HIPAA	DPH
Educator/ Dev Spec	1	ED	HN	AA
Nurse	2	NS	TD	NS
Occupational Therapist	3	OT	GO	OT
Physical Therapist	4	PT	GP	PT
Psychologist	5	PSY	AH	CS
Social Worker	6	SW	AJ	SW
Speech / Language	7	SP	GN	SP
Dev Specialist	C	RF	HN	BB
Specialty Provider	D	RF	HN	SS

Billing Place Type

In the past, various forms, and sometimes specific payers, had their own codes for representing where a particular service occurred. We insulated our users from having to deal with place of service codes by calculating the correct code based on the service type and the payer in question.

We are still going to do a lot of this, but again there may be a difference if you are using HIPAA codes or not (and this usually means pre vs. post 9/1/03 sessions.) In addition, MED now has three different place of code sets: one for paper before 9/1, another for paper after 9/1, and a third for true HIPAA billing runs.

New place of service codes

Name	TA	Non-TA	Other
HIPAA	12	11	11 or 99
HIPAA w/out 99	12	11	11
HCFA	04	03	11
New Form 9	02	01	01 or 99
Old Form 9	99	99	99

Note, Neighborhood Health has wanted HIPAA place of service codes on their paper bills for a long time.

Medicaid Secondary Net Billing

We added **MED Secondary Net Billing** checkbox to the General Billing run to correctly complete the Form 9 for claims when Medicaid is the secondary coverage. As you know, Medicaid wants the Form 9 filled out with the amount billed the primary coverage in the first column and the amount paid by the primary coverage in the second column. The difference or net amount is the amount being billed to Medicaid as the secondary coverage. In the past, these columns were not filled in for this situation. Now, when you want to print Form 9s for these claims, you can check this box.

A MED Secondary Net Billing run is only possible when you choose Form 9 and MED for the billing. It will select only MED TRANS records (from a primary payer).

Here are the steps.

1. It considers only transfers to MED.
2. For each TRANS event, it uses the balance on the claim as the net amount that will be reported of each line. (In other words, the Usual Fee – Other Paid Amt columns will always equal the balance on the transfer event. For lumped sessions, the same is true for the sum of the balances of the lumped TRANS records).
3. It locates the original SERV record for the claim series and uses its FEE amount as the "Usual Fee".
4. It calculates the "Other Paid Amt" as the difference between the original FEE and the current balance.

These changes have several useful consequences for billing runs:

- No claim is ever skipped or not printed because it looks "odd". (In the past, if the calculations didn't add up, the claim was skipped and you got a report of "Odd Claims" that you had to handle by hand).
- The net amount billed on the form is always exactly the balance on the MED record. In other words, you get what you asked for. The routine doesn't do any arithmetic to see if you have transferred the correct amount based on the payments received.
- It should work just as well for resubmissions as original claims. The only caution is that if you are marking a MED TRANS for rebilling, and it was originally part of a lumped line (with other services on the same date by different providers), you must mark the other records for rebilling so that they will be included. This assumes that you applied the copay evenly across lumped records and did not apply it to only one record.

Action Buttons

Once all parameters have been set, click on the **Gather Sessions** button. If you have chosen New Unbilled Sessions Only, you will be asked if you want to "Include sessions marked for resubmission?" This gives you the option of producing one run that combines new claims with those that have been hand marked for resubmission or adjustment. The system will take a minute to find all sessions that fit the selected conditions.

When this process is over, the **Preview Billing** button will become available. This gives you the option to view the selected sessions in either a summary or detailed version.

The **Output** option box offers three choices: dot matrix, laser, or file output. In the past, all billing forms have required **dot matrix** output in order to print on tractor feed forms with carbon copy material. This is still an option, but you can also use **laser** forms as well. The **"File"** option prevents forms from actually being printed and instead sends the printer output to a text file on your computer. It is intended for certain hospital programs that do not

actually submit bills on paper, but need to post bills nonetheless. Do not choose this option unless you are sure you want it.

When you are ready to produce claims or a disk, choose **Run Bill**.

If you are printing dot matrix claims, a test claim will print out and you will be asked if the printer alignment is okay. If it is, answer Yes and the entire run will proceed. If not, adjust your forms in the printer and answer No. Another test page will print out. Repeat this process until the forms are lined up correctly, and then say yes. If you decide you want to abandon the whole run, choose Cancel.

Laser forms will be printed without a test page, because there is no way to alter their alignment during a billing run. The default laser form version can be set using the Miscellaneous Utilities option for this purpose. For example, if you need to move the print down a half line on a Form 9 laser form, go to Miscellaneous Utilities and choose the WFRM9D2 options (down 2/4 of a line).

If for some reason you need to interrupt the laser print job, simply take your printer off line (or remove the paper) and Windows will offer you the ability to cancel the print job. Since each client page is a separate job, you will have to go to the windows print manager to cancel all the jobs in the queue.

Once the run is complete, you may view the **Final Billing Report** of what was actually included in the run.

Finally, choose to **Save** or **Cancel** the run. If you save the run, a history of what claims were included and the posting and billing dates will be stored, and can be accessed in the future. Saving the run posts/bills the sessions and, for new claims, makes them eligible for inclusion in the Service Delivery Report. Canceling the run means that all traces of it are wiped out of the system.

DPH Bill

The DPH Bill is run in this separate module. Although you do not produce actual claim forms for DPH sessions, it is essential to produce this billing run and pick up all sessions, either originals or transfers, that are being sent to DPH. During this process, the selected claims will be billed and posted just as insurance claims are in their billing runs. This posting date is what allows the claims to be included in the Service Delivery Report at the month's end.

The DPH bill is also the only one which you will run that routinely includes credits. This is because of DPH's role as payor of last resort. You may have thought a child had no other coverage and charged DPH as a result. If you later discover the child had insurance, you must credit DPH and transfer the charge to the insurer. This billing run will pick up these transfer credits to DPH.

DPH Billing Concepts and Recommendations:

- DPH bills are actually sent to DPH as part of a comprehensive Service Delivery Report covering all third party payor and DPH activity since the last report.
- The Thom Biller software separates these two activities (billing and reporting) into two different routines.
- The DPH billing run (called "paper bill" because it does not actually go on a specific form) must precede the SDR. It is usually run only once a month because DPH will not currently accept SDRs more frequently than that.
- The DPH billing run gathers needed records and stamps them with posting dates and billing dates in a manner analogous to the general billing run for other third party payors.
- However, the details of the DPH billing process are quite different.
- DPH bills are based on the fee amount of an event, not the claim balance. This is because DPH wants to know about each service, transfer, and adjustment on a different "form" of the SDR. This is also because DPH receives many more transfers and credits as payor of last resort.
- DPH billing runs therefore automatically include credits (general billing runs do not).
- DPH bills actually apply a billing date to transfer and adjustment records (general billing runs do not because they report the claim balance as an aggregate of all the adjusting entries that have gone into it).
- DPH bills are required to have a "current month" or "prior month" designation. Any records with session dates later than the current month will not be accepted by DPH. (End of month session date limits are not required by most third party payors, but since these records also go on SDR reports to DPH, end of month session date limits must be applied to general billing runs as well.)

- As a result, the DPH billing run is much more closely structured than the General Bill, with special attention given to session dates, posting dates, credit definitions, and report options.

Step 1

Follow the steps laid out for you, beginning with **Step 1: Define DPH run dates.**

Step 1: Define DPH run dates...

Prog (tab down through each field in order before going to the next step)

Posting Date

Current SDR Month

Current SDR Year

Current Fiscal Year (based on SDR Month and Year)

Cutoff dates for initial and subsequent claims:

Initial Charges Begin (Note, you CAN bill initial services from the prior fiscal year.)

Initial Charges End (Initial charges from the prior FY allowable until about March 11th)

Subsequent Claims Begin (Note, you can bill subsequent services from only the single prior fiscal year.)

Subsequent Claims End (Subsequent claims from two prior FYs allowable until about Sept 11th)

Two sets of cutoff dates: one for initial and one for subsequent charges

A **Posting Date** of today will be suggested. As with insurance runs, you may edit this to fit your program's practices.

A **Current SDR Month** and **Current SDR Year** will be suggested based on your posting date. The system will usually suggest last month, which is typically correct, but you should review and confirm it, editing if necessary.

The **Current Fiscal Year** and **Prior Fiscal Year** will be listed for reference.

The **Initial Charges Begin** and **Initial Charges End** dates indicate the date range in which sessions should be considered. For the beginning date, the 1st day of the fiscal year for which providers are, according to DPH, still allowed to bill will be suggested. The end date will fill with the last day of the current sdr month, or the month that you've just done all of your billing for.

Beginning and ending dates for **Subsequent Claims** are also offered. These are usually a separate, older set of dates for late credits and adjustments to claims that have already been submitted to DPH.

When these fields are complete and correct, choose to move on to the **Next Step**.

Step 2

Step 2 simply offers a review of the key choices you have made for this billing run. It shows you the posting date, the date ranges for charges to DPH, the date ranges for credits to DPH (usually wider), and the credit definition. Assuming you are ready to proceed, press **Gather Sessions** to collect records for the run.

Once sessions (and credits) have been collected, you may **preview** the billing run. This is a good time to check that the credits you are reporting are what you intend.

Press **Run Bill** to actually stamp the collected records with posting dates. No report is printed at this point, but instead you are offered a choice of billing reports on the next page.

DPH Billing

Step 2: Review choices, gather sessions, preview, and run the bill...

Posting Date

Initial Charges Begin Initial Charges End

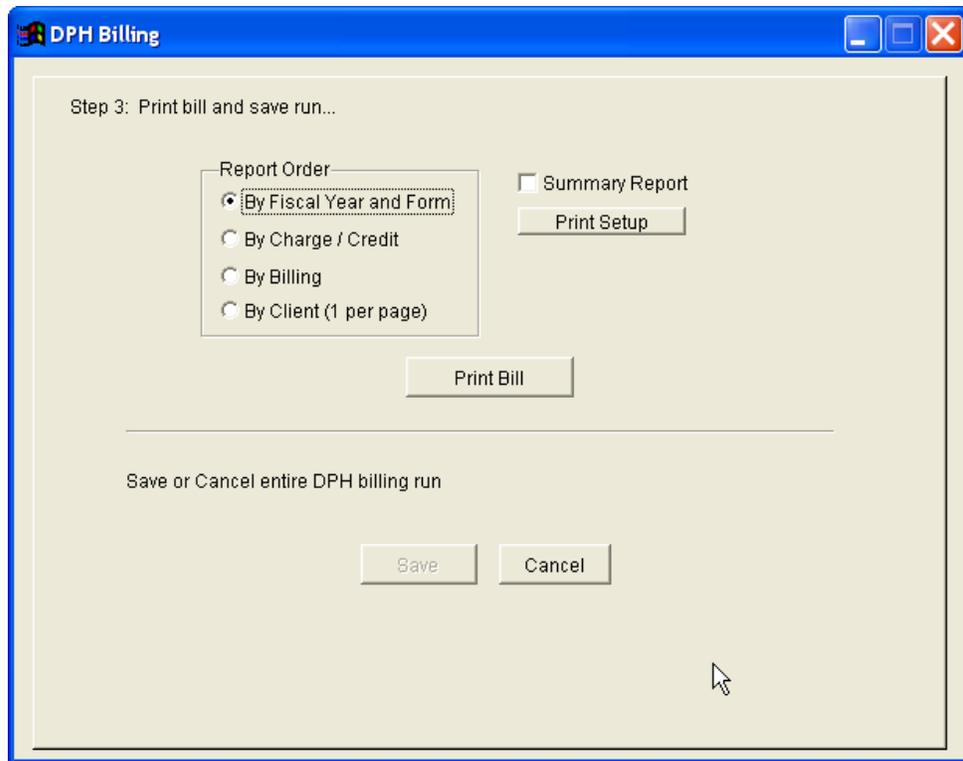
Subsequent Claims Begin Subsequent Claims End

All credits reported to DPH

Step 3

Step 3 gives you the option to print the DPH bill for your own records in one of three report orders. Most agencies will find the first choice, **by Fiscal Year and Form**, the most useful. The sort by **Charge / Credit** offers the clearest summary of credits that are being submitted to DPH. You are welcome to print all three before saving the run.

The **Save** button commits the new posting dates on the sessions and credits to disk; the **Cancel** button cancels the entire run and makes it as if it never happened.



DPH Paper Bill / Credit Report

So what if a very old late payment comes in from a third party, too old for the associated DPH credit to be reported on an electronic SDR? We created a DPH Paper Billing / Credit report to post the late transfers and print a paper report that you can send to DPH. Pull it down from the "Bills" main menu:

This routine reports and bills credits to DPH that were too late to send on an SDR. Normally, this would be for fiscal years more than 2 years earlier. You can report all credits (negative DPH balances) for a given program within session dates, or just those marked for billing resubmission (RESUB = "R"). Furthermore, you can limit the choice to a single client. You can also create Adjust Pay records to indicate that you have sent the money back and show the check reference on the adjustment (ADJ-P). The Adjust Pay records will zero out the claim balance.

Prog

Posting Date

Current FY

Sessions begin

Sessions end

Client T

Recommend paper bill from two and three prior fiscal years.

Include

All Credits within dates

Only credits marked resub (Resub = "R")

Create Pay Adjustments

Check Reference

Gather sessions Preview Billing Run Bill

Save Cancel Print Setup

Summary Report

It suggests a date range of two or three prior fiscal years and it will include only activity on subsequent claims. You can limit the run further to either all credits or just those you've manually marked to resubmit. Finally you can limit the credit report to a single client.

You have the option to use this routine to also create pay adjustments (ADJ-P) indicating that you have actually sent the money back. The negative ADJ-P records will thus zero out the negative balance of these credit claims. This is essentially a way of completing the credit process and clearing up the claims on your books. If you do this, you may want to stamp the check reference of the check you are writing on these ADJ-P records.

Our general recommendation is to first carefully preview the credit run. If you see any credits that are incorrect, stop and make needed changes in the Pay-Transfer-Adjust routine. Once you are sure the credits being reported really do need to go back to DPH, select the "Create Pay Adjustments" and enter the check reference for the check you are writing to

DPH. Go ahead and run the routine and send the check. Your claims will now be correctly zeroed out and closed.

We also recommend that you run this routine every month as part of your normal DPH billing process. This will keep old credits from being overlooked and thus accumulating in your system.

Documentation Run

It basically simulates a billing run in the submission of document log records:

The screenshot shows a software dialog box titled "Documentation 'Billing' Run". It features several input fields and buttons. The "Billing" dropdown is set to "DPH". The "Program" dropdown is empty, with "(optional)" text next to it. The "Run information" section shows "Today's date" and "Posting date" both set to "10/20/2005". The "Document Log Records" section has four radio button options: "New Unbilled Only" (selected), "All Records (whether billed or not)", "Only Records Marked Resub", and "Prior Run" (with a dropdown menu). The "Begin" date is "10/20/2004" and the "End" date is "10/20/2005". At the bottom, there are buttons for "Gather Logs", "Preview Billing", "Run Bill", "Print Bill", "Save", "Cancel", and "Print Setup".

You should run a documentation "bill" each time you send a batch of documents to DPH. This report can serve as a cover sheet for the batch.

Again, it is not really a bill, but the posting process helps you track when a specific document was sent to DPH. So for example, you will be able to see that 20 documents were sent to DPH on 10/1/05. And if DPH asks for more documentation on the same child, you'll be able to say, "We already sent it on 10/1/05...."

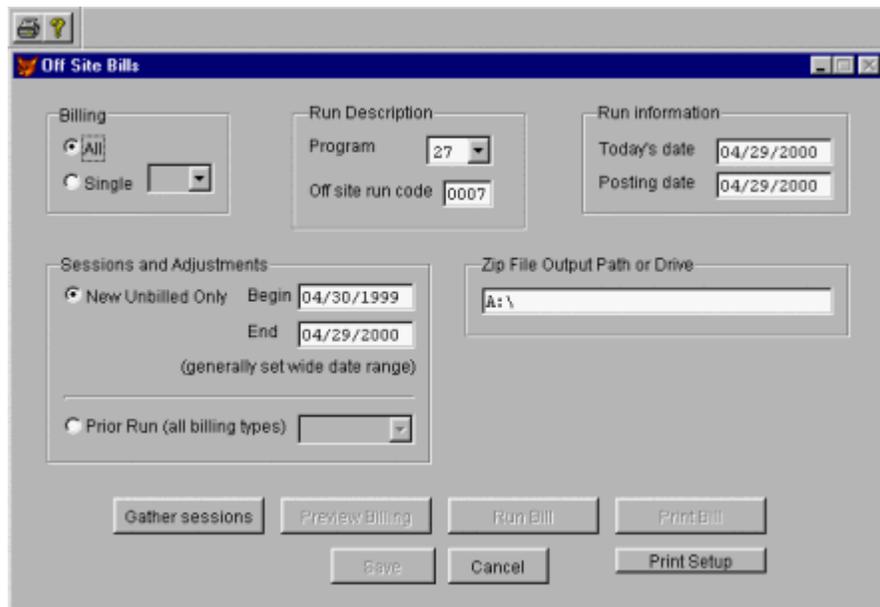
This will fill the posted and billed dates on the document log record.

Off Site Bill

This routine allows off-site programs to enter client and session data at their location and to then send a comprehensive copy to the base system, where actual billing run and collection work is done. Off-site programs can submit data to base systems as frequently as the agency would like; most setup up a monthly or bi-weekly schedule.

The Off Site Billing run produces a number of files containing information needed by the base computer: an event file containing new sessions and any adjustments, a client file with one record per client with new billing and any edited clients, a coverage file with coverage information, etc. All of these files are combined and compressed into a single submission file at the end of the run (and copied to the target path or drive you specify).

The off-site run code specified on this form is used to name the files, along with the program code. For example, the illustrated example would produce a single zip file name "Z270007.ZIP" which could be sent on disk or emailed to the base computer.



Billing

Choose the **Billing** types that you want to include in your run. With rare exception, you will choose the default of **All**. If you only want to send sessions of a particular billing type to the base system, then choose **Single** and select it from the pull down menu to the right.

Run Description

Confirm the **Run Description** data. Your 2-digit **Program** code should be correctly filled, and the **Off Site run code** should have automatically advanced since your last run. Check the **Run Information**, also. **Today's date** will be displayed, and it will also be suggested as the **Posting date**. Some agencies require that sessions be marked as billed and posted on a specific date, like the last day of the month. If necessary, edit the Posting date to meet agency specifications.

Sessions and Adjustments

In the **Sessions and Adjustments** box, set the parameters for the data you want included on this run. Most often, you will choose the default of **New Unbilled only**, meaning that only sessions and adjustments which have never been sent to the base system before will be included.

Because only unbilled sessions will be included, you can use the **Begin** and **End** parameters to set a wide date range without risk of including old sessions. You should set a wide date range to insure that old sessions that were either submitted or corrected late by providers will be included. We recommend that you use the 1st day of the fiscal year for which you are still allowed to bill. The end date should be the last day of either the month or the period that you are billing.

If you need to recreate a **Prior Run**, select this option and then choose the specific run off the pull down list to the right. You might use this if a previously prepared disk had been lost or damaged in the mail.

If you are sending corrected client coverage information immediately after sending a full monthly download, start a new run and it will include only the edited information. Do not use the Prior Run option unless the initial run actually failed to reach the base computer, either because of a disk failure or other complete loss.

Output Path

Specify the **Zip File Output Path or Drive** on which the output file will be copied. This can be either a floppy disk drive, or a location on your local hard drive or a networked drive. If you need to mail a disk to your base agency, you will probably use a floppy drive. If you are going to email it from your computer or a networked one, set up a directory where these files can be copied to and stored.

Action Buttons

Once your parameters are set, select the **Gather Sessions** button. Once appropriate sessions have been located, the **Preview Billing** button will be available. This offers you either a summary or detailed version of data selected for this run.

Choose **Run Bill** next. During this step, files will be created that will report all new clients, coverages, authorizations, sessions, etc. to your base system.

When the bill is done, choose **Print Bill** to get a report of what was included in the run.

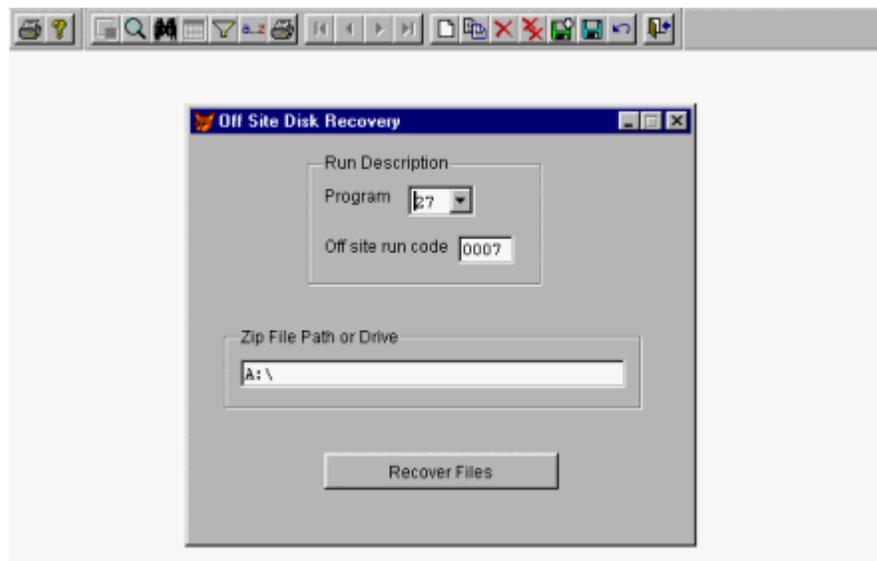
Lastly, choose **Save** to create a zip file at the location you have specified.

Prescreening for Fatal Errors

The off site billing process now includes some prescreening tests for information needed by DPH on each record, that when missing, will cause a fatal error when the base system tries to send the SDR to DPH. For now, the prescreening tests for missing information in a records Reason for Denial field, Referral field, Primary Other, and TPPCode8 fields. A report will print out directing you in how to correct any problems. You will not be able to save the run if it fails the prescreen.

Off Site Disk Recovery

Billing disks or files that are submitted to the base system must be returned to the off-site program once they have been downloaded. During the base download process, sessions which do not download correctly are marked. The recovery process on the off-site system identifies these sessions and removes the posting and billing dates, so that they will be eligible for the next billing run. A report is also produced that identifies the problematic sessions, so staff can do some troubleshooting.



Confirm your **Program** number and the **Off-Site Run Code**, which should have advanced automatically since your last recovery. Make sure the **Zip File Path or Drive** is correctly indicating where the file can be found, and then choose **Recover Files**.

SDR

Introduction

SDR means "Service Delivery Report". The Service Delivery Report (SDR) created on a monthly basis by each EI program, is a comprehensive report of all that program's service activities. Every service that has been delivered and billed to DPH, Medicaid, or any 3rd party payer is listed, along with detailed information on the duration, provider, etc. DPH uses the SDR as both an invoice from which to pay you for DPH-billed claims, and as a reporting device to gather specifics on your overall service provision.

Part of the process of submitting a SDR is sending the data through DPH's Web Site for prescreening. If fatal errors are found, the file is rejected until the errors are corrected. The Thom Biller has a custom routine called SDR Edit which allows you to make many common corrections automatically on both the SDR submission file and the original records in the Thom Biller database.

Service Delivery Report

At the end of the month, your program runs insurance and Medicaid claims, and a DPH paper billing. After these runs are completed, you are ready to create a Service Delivery Report. The Service Delivery Report informs DPH of all new billing and any adjustments or transfers that have occurred in the past month. It uses the posting date on each session, transfer, and adjustment, to decide if a given record should be included in the SDR.

Because the SDR includes claims based on posting dates, it is critical that you do not create your SDR prior to running your bills. If the claims have not been billed and posted, then they will not be included in the SDR. To make sure you have completed all your billing, a report of any unposted sessions is recommended using either the standard event report or the special billing report menu choices. If after running the SDR, you find you have forgotten to complete all your billing, you must go back and run any needed bills, then run a new SDR.

SDR Concepts and Recommendations:

- The Service Delivery Report is a comprehensive, highly structured report on disk of all DPH and third party payor activity *since the last report*.
- As such, it relies on a posting date range to determine what is new activity that has not yet been reported to DPH.

- In addition, the SDR requires all records to have session dates either in the current reporting month, or an earlier one. All billing runs at the end of the month must have had an ending session date set for the end of the month.
- The posting date range you use for each SDR depends on your agencies posting date policy. Some agencies post their end of month bills on the last day of the month; others use the actual date of the bills (early in the following month) as the posting date. Whichever posting policy you use, it must be considered when setting the posting date range of the SDR.
- From one SDR to the next, the posting date range used by each run must be continuous, with no gaps. Any gaps would mean that some activity would go unreported. Any overlap in dates will double report events posted on those dates.
- All bills for a month must be completed before running the SDR. This includes the so-called “paper” DPH bill.
- It is good practice to run a report of any unposted sessions before the SDR to make sure all billing runs have been completed.
- There will often be credits included in SDR runs. This is because late payments from a third party may come in after an amount has been transferred to DPH, and this amount must be transferred back to the third party and credited to DPH.
- Exactly how a “credit” is defined depends on whether your agency policy for handling DPH remittance advice (more on this below).

SDR - Service Delivery Report

Program: 01

The SDR run now creates a new file with a new name (.A, .B, ...C, etc.), no matter which run type you choose. Choosing a Repeat or Prior run simply sets the posting date range to the values used by the earlier run. Remember, you can set the default output path for the SDR file under Misc. Utilities/Data Settings if you want it to go somewhere other than your floppy drive.

Run Type:

- New Run
- Repeat most recent run (01/08/2010 to 02/08/2010)
- Any Prior Run (/ / to / /)

Run information:

Posting dates: 01/08/2010 to 02/08/2010 Run date: 02/25/2010

Report month: 1 Year: 2010 Note: []

Earliest Session: 07/01/2008 SDR file: []

Buttons: Run SDR, Print Form A, Save, Cancel

Program

When ready, choose the SDR option on the SDR-ERA menu. Fill in the correct **Program** code. If you are managing multiple programs, you must create a separate SDR for each one.

Run Type and Run Information

In the **Run Type** box, you will usually select **New Run**. When you do this, a suggested **Posting Date** range will fill in below under Run Information. The software suggests this date by adding one day to the ending date of your last SDR run for this particular program, and using today's date for the ending date and the **Run Date**.

The **Report Month** and **Year** are suggested as well, based on the posting date range. Usually the SDR is run a few days after the end of the month being reported. If your procedures are different, you should check that the suggested information is correct.

As you can see in the screen example, once Program 49 was selected, the dates for the new run were suggested based on the prior run that ended 6/1/2000. The new run begins on 6/2/2000 and goes to the run date of 7/5/2000. The software suggests that month 6 is being reported.

The **Repeat Most Recent Run** choice is generally used if the original run had fatal errors on the DPH Web Site and corrections were made that required a repeat of the same SDR parameters. This choice is needed only when corrections were made outside of the SDR Edit routine discussed later. The key concept is that DPH wants a report of all activity posted within the last month. If you make changes to your sessions or clients that are relevant to DPH, you must re-run the SDR to include the new information. For example, if the Referral information for a client was incorrect, and you edited it on the client record and re-scanned sessions, this new information would require a repeat SDR run.

The **Any Prior Run** choice is seldom used and is included only for rare requests by DPH to resubmit runs more than a month old

The **Note** field is for your own use to help you keep track of your SDR runs. It is stored on the Thom Biller run file and will be visible in many of the drop down boxes associated with SDR reports and ERA remittance processing. It is a good idea to make a brief statement about the particular SDR run.

The **SDR file** name is created automatically based on the run parameters. It uses the following format "S"+program code+year+month+"A.DBF". In this case, the SDR file would be named "S490006A.DBF". A second run in the same month would be tagged "B" instead of "A". This naming convention is similar to that used by DPH for their remittance files.

Action Buttons

Run SDR gathers all the sessions, transfers, and adjustments posted within the date range and converts them into records on the SDR file for DPH Form B, C, D, E, and X. In the process, it fills the field on each event indicating that it was reported on this SDR (both the SDR date, and the unique run ID as the event's SDR_ID). This is analogous to the posting and billing date being filled by a billing run. An event history record is also created for each record recording exactly what was sent to DPH.

Before running the SDR, this button will check for any unposted sessions within the SDR dates. This check will allow you to catch any missed or cancelled billing runs that should have been completed before the SDR. It will show you these and allow you to cancel the

SDR. The software will also check for any transfers with a blank billing type within the past six months. These can occur when you close a coverage without opening a new one and have sessions left “uncovered” by the coverage scan. This report is a reminder to take care of these, in case you have forgotten about them. You may run the SDR whether unbilled sessions or blank billing transfers have been found; the reports are a convenience to help you see records that probably need some attention.

Print Form A prints the Form A report that used to be required by DPH, but is still useful to many programs. For spacing purposes, it works best on a dot matrix printer and it gives you the option of selecting the printer before and after it is run.

This button will also print a report of any SDR resubmissions that might have altered the numbers on the Form A and made them different from the most recent DPH billing run.

The **Save** button commits the SDR date and SDR_ID information on each Thom Biller record to disk, as well as the event history records. The **Cancel** button cancels all changes and makes it as if the run never happened.

Discussion and Examples

The Service Delivery Report process works smoothly when all the session entry and billing steps that precede it have also been completed correctly. This section will discuss some common problems and their solution.

Example: A whole billing type is missing from the SDR

Let's say you run your SDR and notice that there are no DPH records reported, but all other billing has been. What do you do?

The problem is probably the result of having overlooked the DPH billing run (so called “DPH paper billing”) which is responsible for posting and billing DPH events. This can happen by either forgetting to do the DPH run, or by accidentally canceling it instead of saving it. Either way, current DPH events will not have a posting and billing date and will therefore be excluded by the SDR. Remember, the SDR is a report of everything that has been posted and billed within the dates you specify (usually the last month).

The solution is to go back and run the DPH bill and re-run the SDR. Let's say you run the SDR on 7/3 for the month of June with posting dates between 6/5 and 7/3. The next morning you notice the missing DPH records so you run your DPH bill and post it on 7/4. You must now re-run the SDR to pick up these newly posted sessions, but what posting date range should you use for the SDR? You must increase the date range to 6/5 – 7/4 to capture the DPH billing run. To do this, you must select a “New Run” for the SDR which allows you to enter a new posting date range. This new run will create a new output file. Do not choose the “Repeat Most Recent Run” option because that will use the same old date range ending 7/3 and missing the newly billed DPH records. Another option would have been to set the DPH billing run posting date to 7/3 even though you were running it on 7/4. With a 7/3 posting date, the DPH sessions would have been picked up by a “Repeat Most Recent Run” choice for the SDR (6/5-7/3).

If some other billing type is missing other than DPH, the solution is the same. Check your billing run records and you will probably find that the missing billing type was never actually billed within the time frame of the SDR dates.

A good strategy for making sure you haven't overlooked a billing run is to do a report of unposted sessions before your SDR. This will capture anything still sitting unposted and quickly show you if a billing run was overlooked.

What exactly is the difference between a New and Repeat SDR run?

A "New" run will suggest new dates for the SDR. It takes the ending date of your last SDR and adds 1 day to it to be used as the starting date of the new run. Then it suggests today's date for the ending date. It also will create a new output file name for the run. You can enter new values for the dates if you like.

A "Repeat" run *requires* that you use the same dates as the most recent run. It is intended for recreating an SDR following some editing required by the TVP Web Site, however it does increment the SDR file name to the next character (below).

The screenshot shows the 'SDR - Service Delivery Report' window. At the top, a text box explains: 'The SDR run now creates a new file with a new name (.A, .B, .C, etc.), no matter which run type you choose. Choosing a Repeat or Prior run simply sets the posting date range to the values used by the earlier run. Remember, you can set the default output path for the SDR file under Misc. Utilities/Data Settings if you want it to go somewhere other than your floppy drive.'

The 'Run Type' section has three options: 'New Run' (unselected), 'Repeat most recent run' (selected), and 'Any Prior Run' (unselected). The 'Repeat most recent run' option has date fields set to '01/08/2010' to '02/08/2010'. A callout box with an arrow pointing to these dates says 'Repeat run re-uses same date range'.

The 'Run information' section contains the following fields: 'Posting dates' (01/08/2010 to 02/08/2010), 'Run date' (02/25/2010), 'Report month' (1), 'Year' (2010), 'Note' (empty), 'Earliest Session' (07/01/2008), and 'SDR file' (S011001B.DBF). A callout box with an arrow pointing to the SDR file field says 'Incremented last character'.

At the bottom, there are buttons for 'Run SDR', 'Print Form A', 'Save', and 'Cancel'.

The assumption is almost every SDR will initially generate fatal errors. If some of the corrections have to be made directly to the data outside of the SDR Edit routine, such as editing referral information, then you must repeat the SDR run to bring these changes into the SDR file. The "Repeat Most Recent Run" choice is for this purpose. If you can make all your changes within the SDR Edit routine, you don't need to repeat the run.

How do I keep track of all these SDR runs?

It's easy to lose your bearings, especially if you have several off-site programs. You can see a report of your service delivery runs, when they occurred, what dates were used, what file was created, etc., in the following SDR reports section. You can also go to the Reports – Runs menu choice for this information.

What exactly is an SDR anyway?

These days, an SDR is a database file designed by DPH to carry the information they need to monitor all EI services. Since they are the payers of last resort, they want to know about all your EI billing activity.

In the old days, an SDR was actually a paper report that was literally completed on five different forms: Form A, Form B, Form C, Form D, and Form E. Form A was the summary grid still created by Thom Biller software today. Form B was all new billing for the current month and Form C was all new billing for any earlier month. DPH had their own codes for categorizing each session: D – DPH, M – Medicaid, I – Indemnity insurance, etc. Form D was for complete transfers of sessions from another payor to DPH and Form E was for partial transfers to DPH. Each form was of a different design and asked for different information.

Over the years, DPH has needed more and more detailed information about EI billing, and they moved to a computerized reporting process. There are no longer separate forms, but each record in the data file sent to DPH is still stamped with a “Form” code (B, C, D, E, X) and the record must have certain pieces of information depending on its “form.” For example, a form B, C, or D record must have the CHARGE field filled in with an amount. A form E record does not have this field filled in but has cost adjustment information in the fields INSAMT, PARTINS, and PARTDPH.

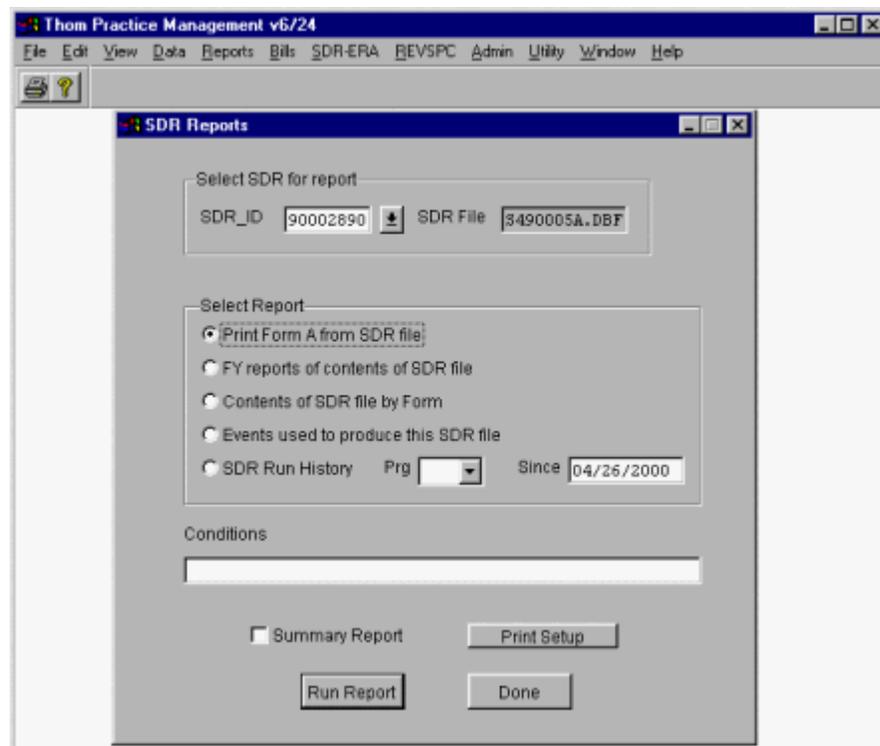
While DPH has always wanted to know about third party billing (original services on form B and C), in the past couple years DPH has also required information about transfers between third parties. Form D used to have only transfers involving DPH, now it has all transfer activity.

So these days, an SDR is a file with records and fields required by DPH. The Thom Biller creates this file by gathering up all activity posted within the specified dates, and analyzing it according to DPH requirements. If it is a new service (SERV) record and it is in the current month, it gets stamped and formatted as a Form B record. If the record is a transfer that was billed this month, it and its transfer pair record both get formatted as Form D records. If the record is a partial transfer to DPH that was billed this month, all other records for the claim are analyzed to calculate the total claim amount (INSAMT) and the amount paid by the third party (PARTINS). A single Form E record is created with this information.

Any time you want to see what is inside an SDR file, go to SDR Reports and choose ‘Contents of an SDR by Form’. Even though the process is highly automated, you should be familiar with the DPH SDR file specifications.

SDR Reports

Reports associated with Service Delivery Reports are available on the SDR Reports screen shown below.



Reports specific to a single SDR are as follows:

- **Print Form A** – for reprinting a Form A
- **FY reports of contents of SDR file** – summarizes the information on the SDR file in terms of fiscal year and whether it was a charge or credit. This is highly recommended for each SDR for use cross-referencing your numbers from earlier billing runs.
- **Contents of SDR file by Form** – shows you exactly what is being reported to DPH in terms of their fields and specifications

Another report is offered that is not specific to a single SDR. The **SDR Run History** report lists the SDR runs you have made since a given date. It is useful for keeping track of all the SDR files you have created and the posting dates used for each.

SDR Edit

After creating your SDR file, you will upload it to the DPH website and run it through a Transaction Validation Program (TVP) that will check the data against an established set of business rules. Errors will be reported to you, divided into 2 categories: fatal and non-fatal. Fatal errors must be corrected before you proceed; they prohibit the transmission of your file. After you correct them and re-validate your file, you receive your non-fatal error report. These do not have to be corrected prior to transmission, though it may make sense because they often result in pended, suspended, or rejected claims.

Once the TVP has identified fatal errors and you have determined the necessary corrections, you need to make the corrections in both your database and on your SDR file. Correcting the errors on just your SDR file, using a program like Excel, means that you are submitting a different version of data to DPH than you have in your database. This will lead to confusion down the road when you are updating your database with ERA files, etc. In order to facilitate dual correction in your database and SDR files, we created the SDR Edit.

The screenshot shows the SDR Edit application window. At the top, the title bar reads "SDR Edit". Below the title bar, there is a text field for "SDR File" containing "S871801B.DBF". The main form is divided into three sections: "Identifying", "Misc", and "Payer Codes".

Identifying Section:

- Recordno: 187918
- Form: D
- Client: 8715889 | 1
- Name: [REDACTED] LOGAN
- Service: TA | DPH
- Date: 07/01/2016
- Reason: 109
- Setting:

Misc Section:

- Thom record: TA | DPH | TRANS | FR | BCB
- Provider: [REDACTED] MAGDA (MF 87)
- Thom Discipline Code: 1
- DPH Discipline Code: AA
- Waiverno: testwia

Payer Codes Section:

- Pmlineid: 99899394
- Eid: 9011299060
- Buttons: Claim Report, Client Coverage Report

SDR Edit Actions...

- Edit reason (highlighted with a blue border)
- Edit Provider Discipline
- Edit Primary / Primary ID / Primary Addendum
- Edit Setting
- Edit Waiver
- Remove from SDR (under a "Remove" label)
- Done New reports and Exit >>

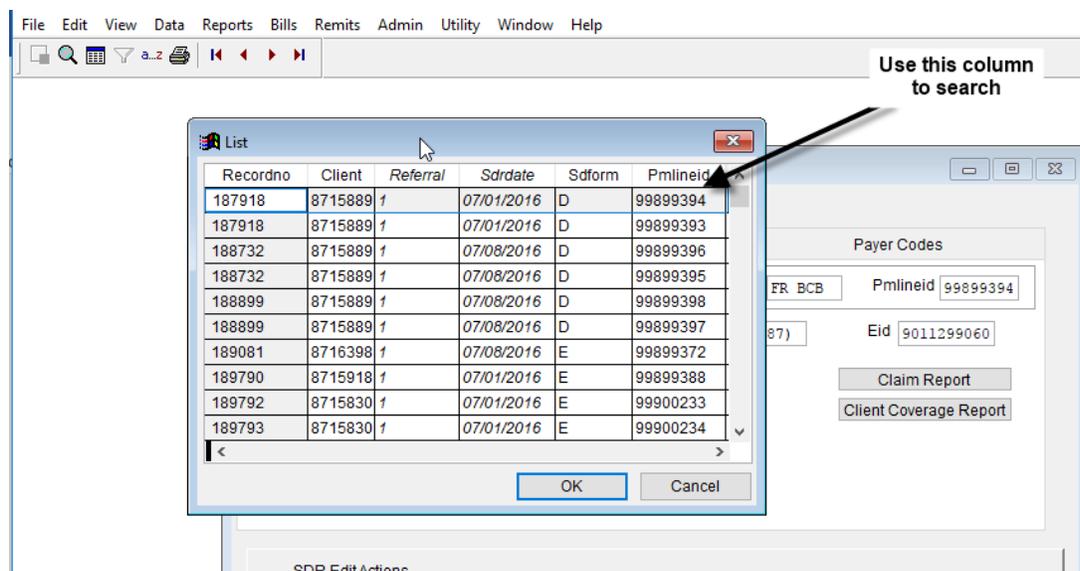
To use the form, you must first select and load the SDR file you desire to edit.

The top of the SDR Edit screen displays the SDR record you intend to edit. It also has some information brought over from the matched Thom Biller event record. It has three tabs to display all the information on the SDR record. These fields are as required by DPH and are explained in the DPH SDR specifications.

The top half now includes a **Claim Report** button that quickly shows you all events associated with the record on display. This report helps you see immediately all transfers and adjustments that have occurred for the record and solve many of the fatal errors associated with incorrect codes.

The bottom half of the screen displays the action buttons available for the specific SDR record. Some will be activated and deactivated depending on whether the action makes sense for the record, usually based on the Sdform assignment of the record. As you navigate through the SDR form, different action buttons will become enabled. You can navigate using the standard navigation buttons or the List button.

The best way to find the record with the fatal error is to search by PMLINEID (this literally means “Practice Management Line ID” and was added by DPH to match a record in your database exactly. The RECORDNO (“Record Number”) returned by DPH actually may apply to any event associated with an original service. For example, it will be the same on the original SERV record and both TRANS records that may all be reported on an SDR.



When you have completed the edits, you press the **Exit** button to both save your changes to the SDR file and produce new reports as needed. (You cannot cancel the entire editing run; each action offers you a single Save or Cancel choice that commits that action to disk).

At the minimum, the action buttons will allow you to edit a single SDR record and the same field on the source Thom Biller event record that created it. Some actions will offer a broader scope for editing changes, and let you apply the new information to all similar records on the SDR (and all their source Thom Biller event records).

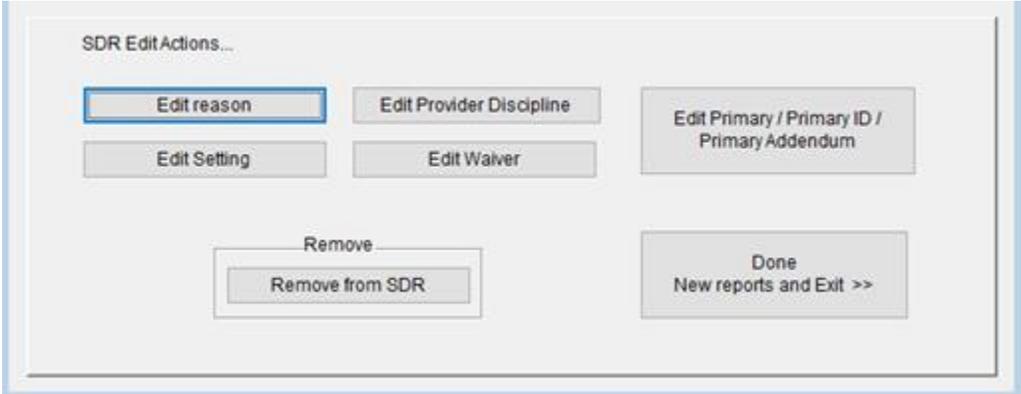
In general, there are two types of records on an SDR: those derived directly from your session records, and those either derived from other tables (such as the DPHID) or those calculated (such as the PRIMARY Coverage value). The derived and calculated fields can only be corrected by going back to the source Client or Coverage information in your

database and making the change there, scanning sessions as needed, and repeating the SDR. These are all the fatal errors that can happen other than the ones listed below that are available to SDR Edit.

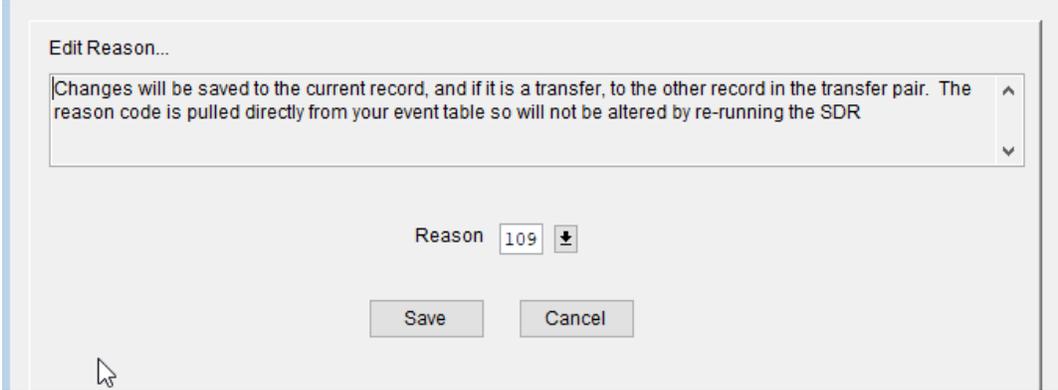
So you should make all these corrections first and repeat the SDR. Once only the following errors are left on the file, go ahead and edit them here.

It turns out that almost all of these edits will probably “survive” a repeat of the SDR, but this general approach is still recommended.

SDR Edit Actions:



Edit Reason:



Edit Setting:

Edit Setting...

Select a setting for this session. Your changes will be applied to all records (SERV, TRANS, ADJ) for this session.

Setting ↓

Save Cancel

Edit Provider Discipline:

The DPH discipline for an SDR record is mapped from the Thom Discipline code on the session, which was stamped on the event when it was created. You can assign a new value here and it will also update your event record. It is most often needed for special EIPP situations. These changes will not be overwritten by re-running the SDR.

Provider (MF 87)

Thom Discipline Code

DPH Discipline Code ↓

(Edit the DPH Discipline code and the Thom code will change automatically)

Save Cancel

Edit Waiver:

Edit Waiver...

Select a waiver for this client, or delete the current waiver. Your changes will be applied to all records (SERV, TRANS, ADJ) for this session.

Waiver ↓

Save

Waiver	Begin	End	Scope	Wai Sv
testwaiver	01/01/2017	/ /		test

OK Cancel

Edit PRIMARY Fields:

Primary 36 Pri Ins Member ID LMI15010100602 Primary Addendum (tppelig) 7

MassHealth Secondary Insurer

These fields are all calculated during the SDR run based on other information in your system. You may change them if needed, but they will be overwritten if you re-run the SDR. For transfers, both records will be updated.

Primary 36 BCB If you edit the primary code, makes sure the member ID is also changed.

Primary Ins. Member ID [REDACTED]

Primary Addendum (tppelig) 7

(reminder, any changes to these fields will be overwritten if you re-run the SDR0)

Save Cancel

Remove from SDR:

This choice will remove the selected record from the SDR. This is usually done only as a last resort, when needed to clear a fatal error at the DPH web site.

Press SAVE to delete this record from the SDR submission file. This change will be shown on the associated event file by clearing its SDR date and entering a comment in its NOTE field. The event will normally be marked for SDR resubmission, so it will be picked up on your next SDR. (If you really want it never sent to DPH, check the box below to prevent SDR resubmission). For a DPH record that has no additional activity removal from this SDR will also "unbill" the record so it can be edited or deleted as an...

DPH Fatal Error []

Save Cancel

Done / Exit:

Reprint DPH billing report based on revised information...

DPH records billed between

Begin [/]

End [/]

Report Order

By Fiscal Year and Form

By Charge / Credit

By Billing

Prog [] Summary Report

Print Bill Reprint Form A

<< Backup (continue editing)

Exit Web Edit >>

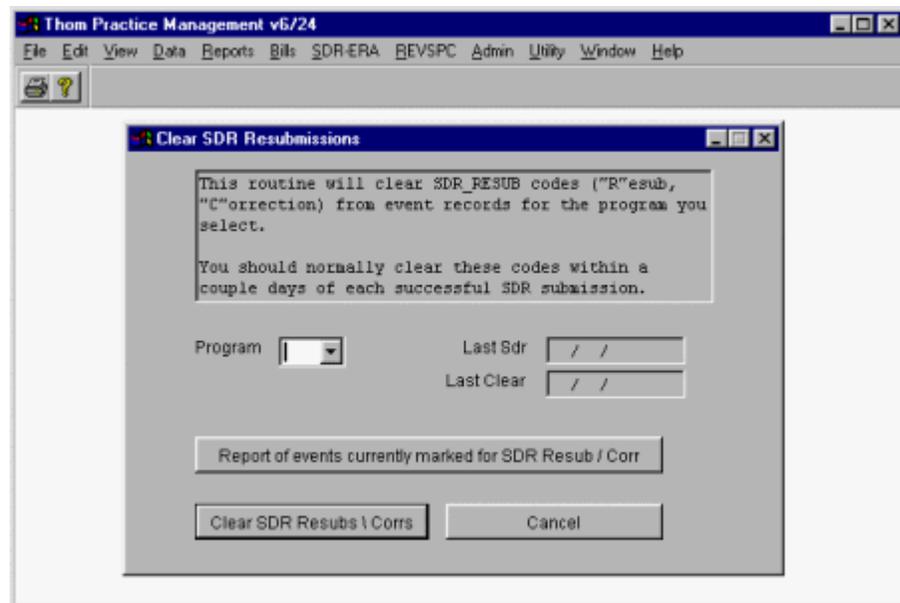
In general, if you remove and unbill a DPH claim from the SDR, this is equivalent to taking out of a billing run and never sending it to them. So if you do that, you should re-run the DPH billing report to show the new, smaller total amount billed.

If you don't remove any DPH claims, then you don't need to re-run the report. Just exit and send the revised SDR file back up to the DPH website.

Clear SDR Resubmissions

As you process DPH remittance advice you will find records that need to be corrected and resubmitted to DPH, so you mark them as SDR resubmissions (by filling the SDR_RESUB field with "R") or corrections ("C"). These records are included in your next service delivery report.

Once the SDR has been successfully submitted and passed the web sit prescreening, you will want to clear the records marked for resubmission before you start accumulating a new set of resubmissions. You do this with the Clear SDR Resubmission screen, shown below.



It works on a single program, and shows you the last time you ran an SDR for this program as well as the last time you cleared SDR resubmission tags. It will also show you the events currently marked for SDR resubmission. When ready, you press the Clear SDR RESUBS button to remove these marks.

If you have just removed a record from your last SDR and marked it for SDR resubmission next time, it will not be cleared by this run until it has gone to DPH. It will have a "P" for "pending" in its SDR_RESUB field and this routine will correctly set it to "R" after clearing all the other "R" records. In other words, it is okay, and in fact recommended, that you clear SDR resubmissions after your SDR even if you have had to remove a record. This routine will first remove the "R" settings for all the records you just resubmitted to DPH, then if any had also been removed from the SDR by SDR Edit (and marked "P"), these will be reset to "R" and correctly included in next month's SDR. This is a bit confusing, but the distinction is between current and future resubmissions. Any current resubmission that just went to DPH will be cleared; any future resubmission created by the SDR Edit "remove record" routine will be retained and ready to go the next time you run your SDR.

HIPAA Remits

HIPAA ERA - 835 Remittance File Processing

This routine processes HIPAA compliant (835) electronic remittance files.

HIPAA ERA Update

To convert a billing remittance file and update events...

This routine will process HIPAA compliant electronic remittance files (5010 835 format) and apply the information to Thom Biller events. Please read the Help section for details on how to use this routine and how to interpret the reports. Capped records (119) are now set to manual handling, not auto payment and transfer. Simple contractual adjustment late payments (045) and DPH backtransfers now handled.

Primary Billing Secondary Billing (optional)

Recent ERA Update runs for the primary billing

BCB 9000138581 06/23/2017
F:\BCB835\BCBSMA.TH01.CLAIMPAYMENT.2017061716000308178205.835
Note: 6/23/2017
BCB 9000138739 06/29/2017
F:\BCB835\BCBSMA.TH01.CLAIMPAYMENT.2017062414000220024342.835
Note: 6/29/2017
BCB 9000138740 06/29/2017
F:\BCB835\BCBSMA.TH01.CLAIMPAYMENT.2017062414000221032835.835
Note: 6/29/2017

Remittance file name and full path for selected primary billing

F:\BCB835\BCBSMA.TH01.CLAIMPAYMENT.2017062414000221032835.835

Era Run Note (Locate File)

AUTO Pay any claim where the amount paid = amount billed

AUTO Pay any contractual obligation CO*045 where amount paid = balance

(assumes 5010 format)

This routine takes an 835 HIPAA remittance file and applies the information to the matched events in Thom Biller that created each remittance claim. It does create PAY records or post anything in the system. These actions, based on remittance information, are performed later by the HIPAA Batch Pay routine. So this routine simply stamps remittance claim status, reason codes, payment amounts, etc. on Thom Biller events and reports the results to you.

To accomplish this, it must locate the event or events that were used by Thom Biller to create each original claim. In simple situations, a single SERV session event will produce a single claim line and this will result in a single 835 remittance record. But other times, several Thom Biller SERV or TRANS events might be lumped into a single claim line. In these cases a single remittance record might have to locate several "lumped" sessions in Thom Biller. Furthermore, some other activity may have already been posted to these lumped events since they were billed, further complicating the process.

Therefore, this routine tries to do the best it can to automatically handle remittance information, but it will "hand off" complicated situations to you that require extra thought and manual attention. Specifically it will do the following:

- 1) Open and read an 835 file
- 2) Try to match the 835 records to those in your billing system
- 3) Mark as "Skipped" the remittance records that it could not match to your claims. These will need your attention later.
- 4) Mark as "Updated" the remittance records that were matched to your claims and whose information was updated on the claim. For example, that a given claim was paid \$50 by check reference 12345 and had a \$10 copay.
- 5) For the successfully updated claims, decide whether they can be handled automatically or manually by you. Simple ones are marked "AUTO" and will be batch paid when you run the batch pay step. More complicated ones are marked "MANUAL" because they need manual attention in the PTA screen.

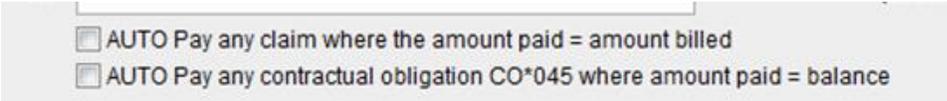
So the total of the Skipped remit records + the AUTO updated ones + MANUAL updated ones will add up to the total on the remit file.

You must print each of the reports it generates and understand what it has done and what you must do, if anything, as a result.

Special AUTO Pay Checkboxes

In general, we are conservative in Thom Biller in any batch process. For remittance processing, we normally mark for auto batch payment only claims with simple remittance reasons and amounts (such as copay or deductible).

The Auto Pay checkboxes increase the number of updated records marked for automatic batch pay:

- 
- AUTO Pay any claim where the amount paid = amount billed
 - AUTO Pay any contractual obligation CO*045 where amount paid = balance

-- Auto Pay any claim where the amount paid = amount billed;

-- Auto Pay any contractual obligation CO*045 where amount paid = balance.

The first will mark for batch payment any claim where the amount paid equals the amount billed, no matter what reason codes are involved. The second will mark for batch payment any claim that is being paid the amount of its current balance and that has CO*045 as a reason code (meaning "contractual obligation"). Both of these enhancements were added to deal with more complicate remit files after rate changes.

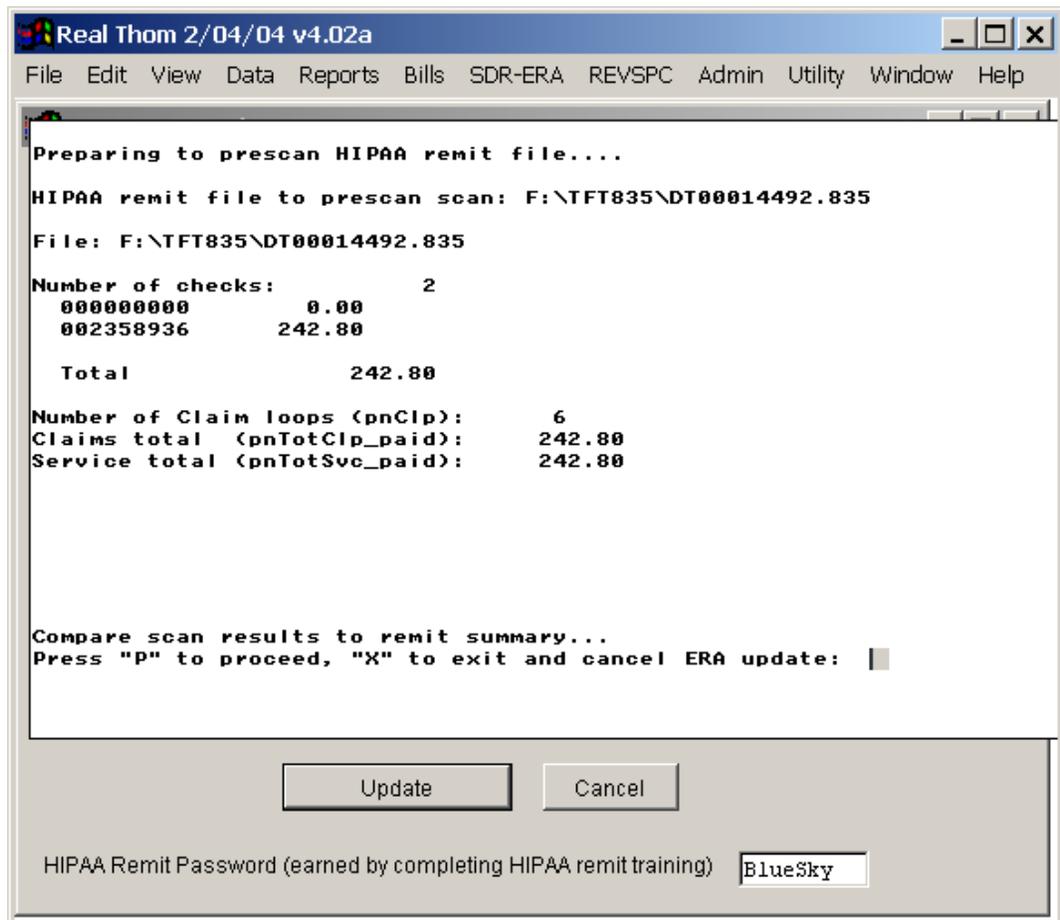
HIPAA Remit Run Reports

You should make a packet for each remittance file you run. The packet should contain the following reports:

1. Pre-scan report
2. Skipped Remittance Records (if any)
3. Summary of Updated Events by Check Reference
4. Summary of Updated Events by Batch Pay Action
5. Updated Events Needing MANUAL Attention
6. Updated Events With Claim Level Adjustments (if any)
7. Summary of AUTO PAID Events

Pre-scan Report

This report scans the 835 file and totals up the amount indicated for payment for each check. It also allocates the amounts to various programs in your agency if you have multiple programs like Thom.



If you accidentally try to process some other type of file (other than an 835 file), you will find out here. In the rare situation where the total paid for claims does not match the total for services (because of claim level adjustments), you will see that here as well. Hold this report as the first page in your remittance packet. Assuming you do not cancel, you will proceed with the remit run itself.

Skipped Remittance Records

The first report you may see after the remit run is a report of any remittance records on the 835 that the routine could not handle at all. This report of "SKIPPED" records shows remittance records for which the routine could not even locate the originating events in Thom Biller.

Report Designer - heraref.frx - Page 1

Print Preview

/23/2004 Skipped Remit Records. Handle Manually. File: F:\TFT835\DT0001B6

HIPAA ERA Information by Check Reference Number

Client	Date	Prim. Proc	Mod	Btype1	Billed	Paid	Deduct	m_St	Era_St	Prg	Cid	Btype2	Claim Number	Member ID	jNote	Pay date	Unit	RunBty	Summary Reason	Remit Fil	ra_id	BillRun_id	Line_id	ISA date	Run_id	SvcRefIdC
TSIFAS, LU	12/18/2003	H2015		TFT	18.23	0.00	0.00				80001919		4006E276	029526069		01/12/2004	1.0				00285428					
									\$																	DT0001B69
																										6R

The reason this can happen at all is that the 835 does not necessarily "pass through" enough information to exactly identify the originating sessions and it has to use various strategies to locate them. One of these strategies depends on the balance of the original events still matching the billed amount. If this is not the case, it may not be able to say for sure that it has found the original events and it will "SKIP" the particular remittance record. You must handle these remittance records completely manually and subtract any payment amounts from the later reports to come up with the actual check total.

Summary of Updated Events by Check Reference

This report shows you all Thom Biller events that were updated (e.g., not skipped) sorted by check reference. The ERA Paid amount indicates the amount that was indicated as having been paid in the remittance record. This is the amount that the Batch Pay routine will use to actually create a payment record in a later step.

02/23/2004

Updated by HIPAA ERA run: 90019552 File: F:\V

Event Bill ERA Information by ERA Check Reference

Pr	Session	Prov	Bl.Hr.	Bill	Fee	Pay	ERA
Client		Serv_id	bill_id	Note			
Bera_id	Status	ERA Chk	Ref		ERA line / TCM	ERA Misc	
Sum Adj	Reason	CS	Full Adjustment	Note			
ERA Check Reference:		000285428					
* Ref Subtotal *							
			69.50		4210.34	0.00	
ERA Check Reference:		000474162					
* Ref Subtotal *							
			29.00		2199.93	0.00	
ERA Check Reference:		002362572					

Summary of Updated Events by Batch Pay Action

This report shows you all Thom Biller events that were updated (e.g., not skipped) sorted by Batch Pay Action: whether they will need MANUAL handling or whether they will be AUTO paid by the Batch Pay routine. The next report shows you in detail the ones that you must handle manually.

Report Designer - wdherasta.frx - Page 1

Print Preview

02/23/2004

Updated by HIPAA ERA run: 90019552 File: F:\TFT935\DT0001B693.835

Event Bill ERA Information by Batch Pay Status

Pr	Session	Prov	Bl.Hr.	Bill	Fee	Pay	ERA Billed	ERA Paid
Client		Serv_id	bill_id	Note			Type	Ref
Bera_id	Status	ERA Chk	Ref	ERA	line / TCN	ERA Misc		
Sum Adj	Reason	CS	Full Adjustment	Note				
Batch Pay Status: AUTO								
* Status Subtotal *								
				597.50	38582.13	0.00	38582.13	20271.61
Batch Pay Status: MANUAL								
* Status Subtotal *								
				766.50	52310.03	0.00	52310.03	24671.24
*** Total ***								
				1366.00	90892.16	0.00	90892.16	44942.85

Updated Events Needing MANUAL Attention

This lists all Thom Biller events that had complex service level adjustments on the 835 remittance file that will need to be paid or otherwise handled by you manually.

Report Designer - wdhereref.frx - Page 1

Print Preview

12/23/2004

Updated by HIPAA ERA run: 90019552 File: F:\TFT835\DT00018693.835 MANUAL Only

Event Bill ERA Information by ERA Check Reference

Session	Prov	Bl.Hr.	Bill	Fee	Pay	ERA Billed	ERA Paid	Bal
ient	Serv_id	bill_id	Note			Type	Ref	Eid
ra_id	Status	ERA Chk Ref	ERA line / TCN	ERA Misc				
m Adj Reason	CS	Full Adjustment Note						
A Check Reference: 000285428								
12/03/2003	TA	DKJ01	3	1.00 TPT	72.92	0.00	72.92	0.00
ARADUJ, ASHVIN		10918826	90018798			SERV		10534
019552	MANUAL	000285428		4006EX10	0.00	L: 1		
8		INITIAL UPDATE PAID: 0 *SVC*CO*018*72.92						
12/10/2003	TA	DKJ01	3	1.00 TPT	72.92	0.00	72.92	0.00
ARADUJ, ASHVIN		10918831	90018798			SERV		10534
019552	MANUAL	000285428		4006EX10	0.00	L: 1		
8		INITIAL UPDATE PAID: 0 *SVC*CO*018*72.92						

Updated Events With Claim Level Adjustments

This lists events that had claim level adjustments on the HIPAA 835, not simply service line adjustments. We currently are not sure exactly how claim level adjustments will be used by payers, because 99% of all adjustments occur at a service by service level. So these are reported separately for you to handle manually.

Report Designer - wdheraref.frx - Page 1

Print Preview

2004 Updated by HIPAA ERA run: 90019552 File: F:\TFT835\DT0001B693.835 Case Level Adjustments

Event Bill ERA Information by ERA Check Reference

Session	Prov	Bl.Hr.	Bill	Fee	Pay	ERA Billed	ERA Paid	Bal	P	
id	Status	Serv_id	bill_id	Note	ERA Misc	Type	Ref	Eid	B	
Reason	CS	ERA Chk Ref	ERA line / TCN	ERA Misc						
		Full Adjustment Note								
Check Reference:		002362572								
13/2003	TA	BSK83	7	1.00 TPT	72.92	0.00	72.92	72.92	72.92	10
JMA, ANDREW		80033673	90018707			TRANS	FR 0TH		9121498812	
52	MANUAL	002362572		4002152P	72.92	L: 1	INITIAL UPDATE PAID: 72.92 *CLP*C0*023*0			
20/2003	TA	BSK83	7	1.00 TPT	72.92	0.00	72.92	72.92	72.92	10
JMA, ANDREW		80033944	90018707			TRANS	FR 0TH		9121499012	
52	MANUAL	002362572		4002152P	72.92	L: 1	INITIAL UPDATE PAID: 72.92 *CLP*C0*023*0			

Summary of AUTO PAID Events

This summary totals all other successfully updated events that will be automatically handled by the Batch Pay routine. These are events for whom there were either zero, or simple adjustments. They will be paid or transferred by the Batch Pay routine later.

02/23/2004

Auto Paid Events for HIPAA ERA Run: 90019552 File: F:\TFT835

Event Bill ERA Information by ERA Check Reference

Pr Client	Session	Prov	Bl.Hr.	Bill Fee	Pay	ERA Billed	E	
Bera_id	Status	Serv_id	bill_id	Note	ERA Misc	Type	P	
Sum Adj	Reason	CS	ERA Chk Ref	ERA line / TCN	ERA Misc			
			Full Adjustment Note					
ERA Check Reference:		000285428						
* Ref Subtotal *								
			44.75	2473.91	0.00	2473.91		
ERA Check Reference:		000474162						
* Ref Subtotal *								
			6.25	492.91	0.00	492.91		
ERA Check Reference:		002362572						
* Ref Subtotal *								
			105.50	7030.12	0.00	7030.12		

HIPAA Remit Report Reconciliation

Once these reports have printed, you must reconcile the numbers to make sure the remittance routine handled everything correctly. To do this, take the original check amounts and compare to the total ERA Paid column of the various reports. The total amount paid by Skipped remit records + the total ERA Paid MANUAL + the total ERA Paid AUTO should equal the check amount. (In the rare case of claim level adjustments, these may need to be added or subtracted depending on what they are.)

HIPAA ERA File Management

If you are not careful managing your many remittance files, you will be quickly swamped. We recommend that you set up separate folders for the different billing types that you use and store incoming remittance files in one place, and processed ones in another.

For example, you would might set up folders for current MED and TFT 835 as follows, with a \Done folder underneath each one where you immediately move each remit file after you have processed it.

\\MED835

\\Done

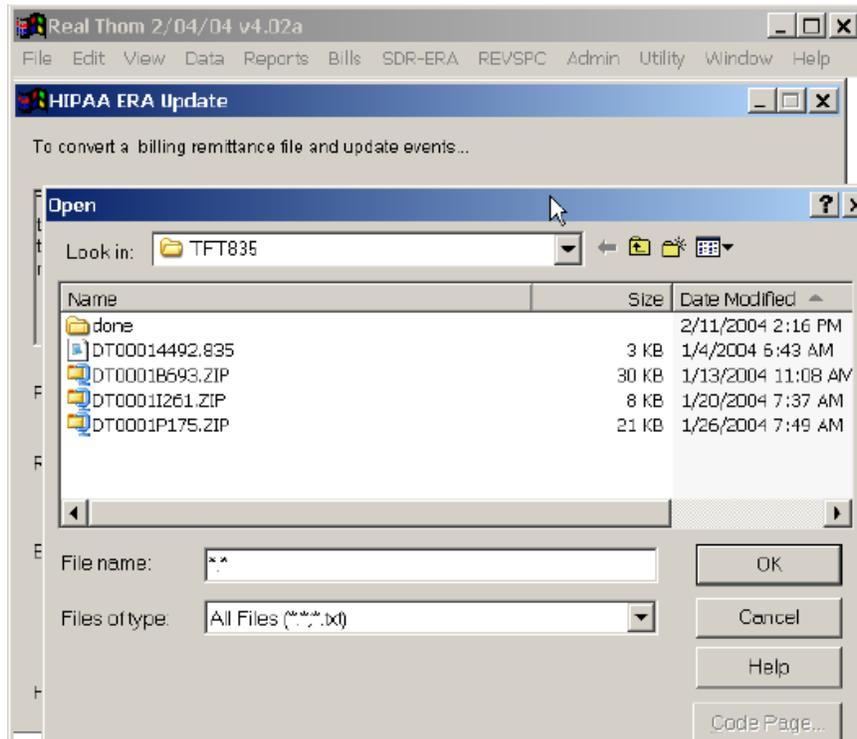
\\TFT835

\\Done

Notice that you may receive several types of remittance files from a payer: some will be actual 835 remittance files, others might be various acknowledgment or other text reports. Make sure you distinguish these and store only the 835 remittance files in your 835 folders. Only these can be processed by this routine. Also, sometimes the files will come to you in a compressed (zipped) format. You must expand them before storing them in the 835 folder and you should immediately discard the zipped version of the file (to help avoid confusion). If the unzipped file does not have an extension in its name (after the "."), you should call it a ".835" to help you remember what it is).

Run 835 Remit Files In Order

When you process 835 files, you must be careful to process them in order! To help you keep them in order, always select the "Detail" view in the Locate File Dialogue box and sort by date. This is shown below:



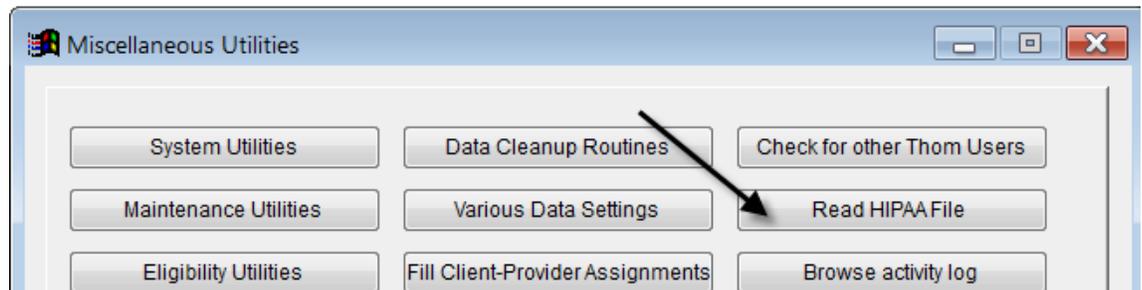
Notice how the TFT835 folder has been selected and the detail listing chosen to show the Date Modified. This has the arrow pointing up ^ indicating it is in order by date. The top file, DT00014492.835 will be chosen for the run because it is the next one. You should remember the date of the file and type it in the ERA note field to help you keep track of it.

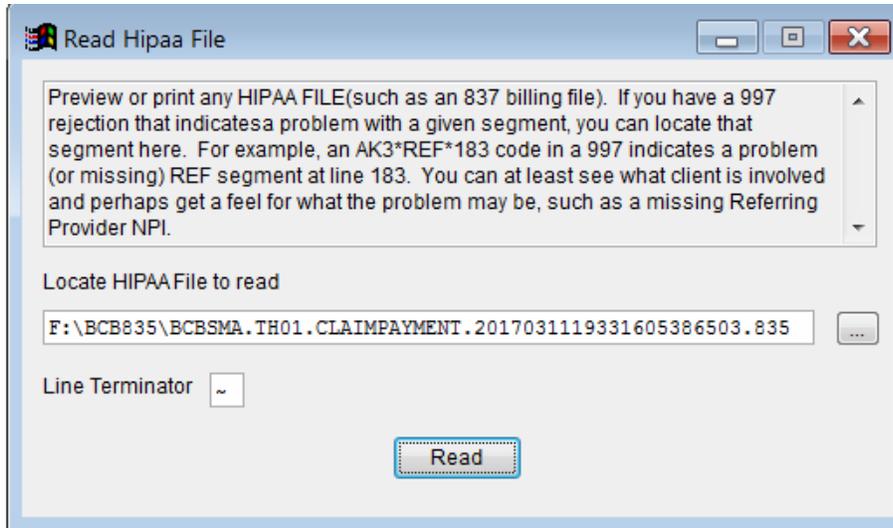
What an 835 file looks like

If you look into an 835 file, it will look something like this:

```
ISA*00*      *00*      *01*170558746  *ZZ*DT0001
*040104*0637*U*00401*000000017*0*P*~
GS*HP*170558746*DT0001*20040104*0637*17*X*004010X091A1
ST*835*170001
BPR*I*0*C*NON*****20040105
TRN*1*000000000*1042674079
REF*EV*DT0001
REF*F2*3000-001
DTM*405*20040102
N1*PR*Tufts Associated Health Maintenance Org, Inc.
N3*PO Box 9163
N4*Watertown*MA*024719163
N1*PE*DOUGLAS A THOM CLINIC, INC.*FI*042104268
REF*PQ*705299
```

Each line starts with a prefix (such as ISA, GS, ST) which defines the meaning of the values in the line. These are defined by the 835 standard. You can actually print an 835 using Misc Utilities/





This simply displays the file; it does not load it or run it or change it.

07/11/2017

Page 1

```

07/11/2017
10:30:29
HIPAA file: F:\BCB835\BCBSMA.TH01.CLAIMPAYMENT.2017031119331605386503.835
pcLineTerminator: ~
0: ISA*00*          *00*          *ZZ*00200          *ZZ*TH01          *170311*1636*
0: GS*HP*00200*TH01*20170311*1636*1*X*005010X221A1
1: ST*835*0001
2: BPR*H*0*C*NON*****20170310
3: TRN*1*NONCHECK -V811263805*1041045815
4: REF*F2*NASCO
5: DTM*405*20170310
6: N1*PR*BLUE CROSS AND BLUE SHIELD OF MASS
7: N3*401 PARK DRIVE
8: N4*BOSTON*MA*022153326
9: REF*2U*700
10: PER*CX*BLUE CROSS BLUE SHIELD OF MA*TE*8007714097
11: PER*BL*BLUE CROSS BLUE SHIELD OF MA*EM*EDISUPPORT@BCBSMA.COM
12: N1*PE*DOUGLAS A THOM CLINIC INC*XX*1396771820
13: N3*STE 22*251 WEST CENTRAL ST
14: N4*NATICK*MA*01760
15: REF*TJ*042104268
16: LX*1
17: CLP*1200013321BCB0000310*1*853.62*0*853.62*12*27170620158000700*11*1

```

HIPAA ERA Batch Pay

This routine will actually create PAY records for records updated by a recent HIPAA ERA (835 remittance) run. In special cases, it will also create transfers to DPH (TRANS). It will also create pay adjustments (ADJ-P) when money is actually being taken back by the remittance run.

As discussed above, it works on the Thom Biller claims that have already been updated by a remit run and marked as "AUTO" for "automatic batch pay." This will usually be a subset of all the claims actually in a given remittance file.

For creating PAY entries based on ERA check reference codes...(rev 6/22/16)

This routine creates a PAY entry for each HIPAA billed event that has a specific Check Reference applied by a given ERA run. It assumes that you have already run the ERA Update routine which stamps remittance information on the event records. It will create a PAY entry in the amount of the BERA_PAID value that was also filled in by the ERA Update routine.

The transfer records that will be created to DPH for simple co-pays, deductibles, and co-insurance when there is No Copay Coverage checked on the coverage record. Transfers are never created to non-DPH secondary insurers: you should do this by hand to make sure it is handled correctly for a given payer.

ERA Run Billing Type: (optional to limit Specific ERA Run ID list below)

Specific ERA Run ID:

Recent ERA Batch Pay runs for this billing type

BCB	06/22/2017	ERA ID: 9000138574	Check Ref: 715713455
BCB	06/23/2017	ERA ID: 9000138577	Check Ref: 715713454
BCB	06/23/2017	ERA ID: 9000138577	Check Ref: 715713456
BCB	06/23/2017	ERA ID: 9000138581	Check Ref: 715785602
BCB	06/29/2017	ERA ID: 9000138739	Check Ref: 715857416
BCB	06/29/2017	ERA ID: 9000138740	Check Ref: 715857414
BCB	06/29/2017	ERA ID: 9000138740	Check Ref: 715857415

Era Check Reference: Program (optional):

Posting date:

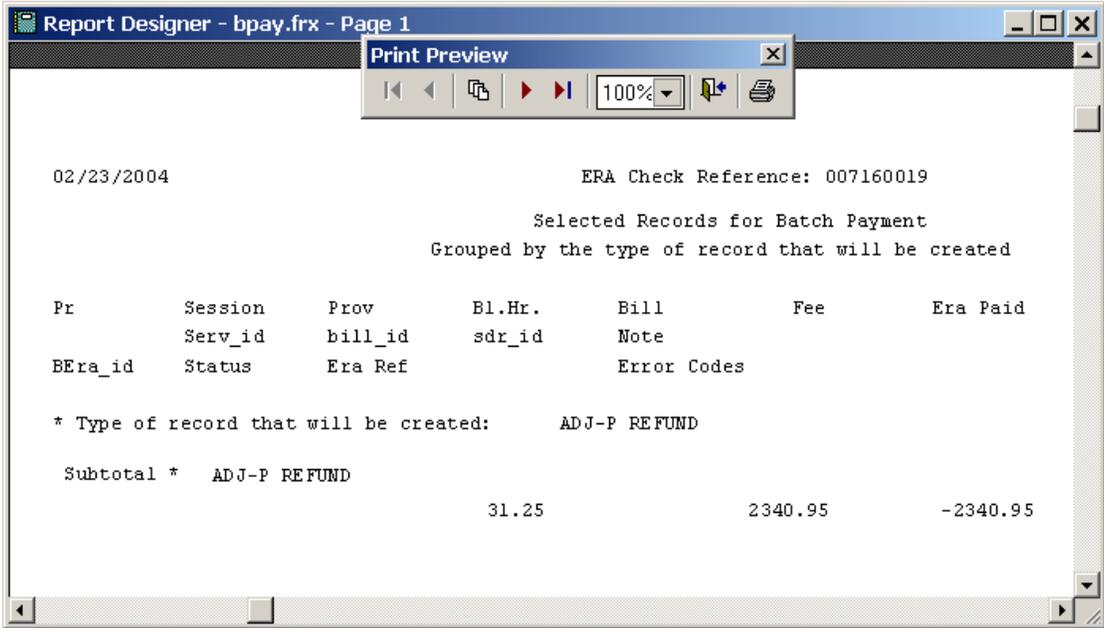
Do not create any transfer records. Limit the run to 17M entries only.

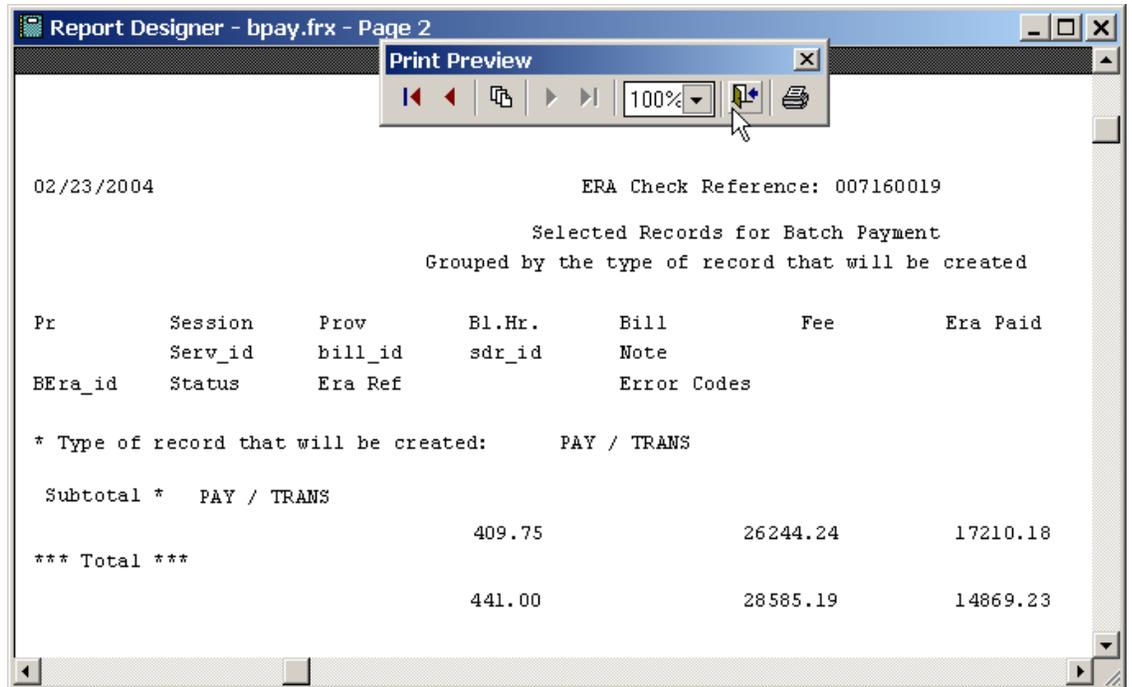
As you will recall, the HIPAA ERA Update process will mark as "AUTO" any claim with a simple reason behind the remittance advice, whether it is a full, partial, or zero payment. The Batch Pay process will create payment records for the ERA_PAID amount. If there is no secondary coverage, any partial or full balance will be transferred to DPH. If there is a secondary coverage, it will report this to you for manual handling.

It will not create a payment if the resulting claim balance will be negative, an "Overpayment" situation. This can happen if you have already transferred a claim to DPH or another payer and then a late payment comes in. These will be reported so you can manually handle them.

So to run it, you select a billing type and recent ERA run. This will cause the check reference box to be filled by the check amounts marked for AUTO handling. Select one of the checks and the run will try to create PAY (and ADJ-P) records totalling the amount indicated. In special cases it may decide not to create the payment, such as to prevent overpayment. Selected for Batch Pay Preview

As the batch pay prepares to create new payment, transfer, and adjustment records, it first gathers up all the claims it intends to work on. It is very important that you look at this report closely and make sure it is going to do what you intend it to do, because there is no way to revert the run after the fact.



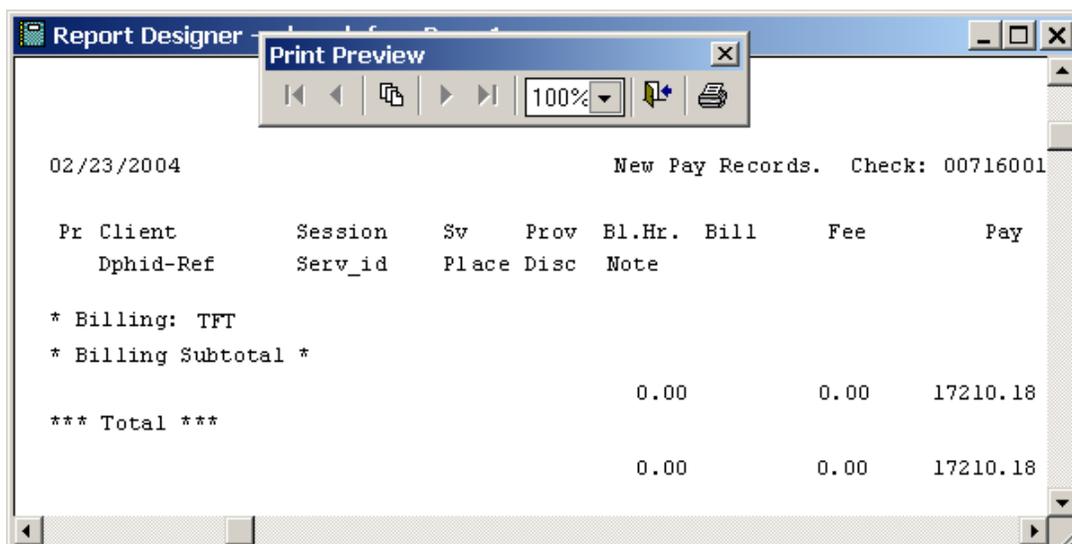


You must compare this report to the final report produced by the ERA update routine of events marked for AUTO pay. The amount shown here should match the amount in the earlier report.

Assuming the numbers match exactly, you may proceed and press the "Run Batch Pay" button. It will work through the gathered claims and actually produce new records. It reports what it has done below.

New Pay Records

The first report shows new PAY records it has created. It is recommended that you print the summary version of this report.



02/23/2004 New Pay Records. Check: 00716001

Pr Client	Session	Sv	Prov	Bl.Hr.	Bill	Fee	Pay
Dphid-Ref	Serv_id	Place	Disc	Note			
* Billing: TFT							
* Billing Subtotal *							
				0.00		0.00	17210.18
*** Total ***							
				0.00		0.00	17210.18

New Adjustment Records

The next report shows any ADJ-P adjustment records involving negative payment amounts indicative of money reclaimed by the payer. You may print either the summary or detailed version of this report, depending on how much information you want about money being taken back by the payer.

You should add up the new Pay and Adjustment report totals and see if they match the expected amount from the Batch Pay Preview. If they don't, it probably means some records were skipped to avoid overpayment (reported later). If after accounting for such claims your numbers still do not add up, please contact Thom technical support immediately.

(insert image)

New Transfer Records

This report summarizes transfers created to DPH. Only sessions with a session date before 7/1/10 will be considered for automatic transfers to DPH. After this date, "First Dollar" coverage should mean that most MA insurance companies will also not charge copays and deductibles. The batch pay routine will not transfer to other third party coverages and will report those claims later. A summary of this report is normally sufficient.

02/23/2004 New TRANS Records. Check: 007160019

Pr Client	Session	Sv	Prov	Bl.Hr.	Bill	Fee	Pay	Type	Ref	Eid	SDR
Dphid-Ref	Serv_id	Place	Disc	Note							
* Billing: DPH											
* Billing Subtotal *											
					128.50	6993.21	0.00				
* Billing: TFT											
* Billing Subtotal *											
					-128.50	-6993.21	0.00				
*** Total ***											
					0.00	0.00	0.00				

Partially paid claims with non-DPH secondary coverage

This report only prints if some claims were partially paid and which probably need manual transfer to a secondary coverage that is not DPH. (If they had had DPH secondary coverage, or no coverage at all with DPH as the payer of last resort, the balances would have been automatically transferred).

The actual PAY record for these claims will have already been reported earlier. This report shows the claim itself that you must manually transfer.

Skipped payment to avoid overpay

This report only prints if some claims were skipped during the payment process because the pay amount would have resulted in a negative balance. These probably need manual "back transfers" of a balance to this particular billing type, and then manual entry of the pay amount.

Zero Pay, No Transfer, Non-zero balance events

These are claims that have a balance, but which had neither a payment nor transfer activity during this run. You should normally print the detailed report because they may need manual attention. They may often represent capped claims and you would want to go into these client coverages and mark them as capped to prevent further billing to this payer for the rest of the year.

Report Designer - wdberac.lrx - Page 1

Print Preview

02/23/2004

Zero pay, No Transfer, Non-zero balance Events Check: 007160019

Event Bill ERA Information by Client

Pr	Session	Prov	El.Hr.	Bill	Fee	Pay	ERA Billed	ERA Paid	Bal
Dphid-ref	Serv_id	bill_id	sdrc_id	Note			Type Ref	Fl	Eid
Bera_id	Status	ERA Ck	Ref	ERA Error			ERA line / TCN		
ERA Misc									
Client: [REDACTED], KYLE									
01	11/06/2003	TA	LE 01	3	1.75	TFT	127.61	0.00	127.61
0106065-1	10915342	90018272	90018340				SERV	N	10530856
90019552	AUTO	007160019	119				33428321		
0.00 L: 1									
INITIAL UPDATE PAID: 0 *SVC*PR*119*127.61									
01	11/25/2003	TA	LE 01	3	1.50	TFT	109.38	0.00	109.38
0106065-1	10916567	90018272	90018340				SERV	N	10532194
90019552	AUTO	007160019	119				33428321		
0.00 L: 1									
INITIAL UPDATE PAID: 0 *SVC*PR*119*109.38									
01	12/05/2003	TA	CN 01	4	1.00	TFT	72.92	0.00	72.92
0106065-1	10918070	90018527	90018910				SERV	N	10533598
90019552	AUTO	007160019	119				3356K757		
0.00 L: 1									
INITIAL UPDATE PAID: 0 *SVC*PR*119*72.92									
* Client Subtotal *									
				4.25	309.91	0.00	309.91	0.00	309.91
*** Total ***									
				4.25	309.91	0.00	309.91	0.00	309.91

HIPAA ERA Reports

This screen allows you to recreate all the reports generated by the HIPAA ERA Run and others that may help you understand your remittance information.

The screenshot shows the 'HIPAA ERA Reports' application window. It is divided into several sections for configuring a report. The 'Report Content' section has two radio buttons: 'Event records with remittance information' (selected) and 'Remittance records converted from 835s'. Below this are two dropdown menus for 'Updated by ERArun'. The 'Report Sort Order' section has several radio buttons: 'by Batch Pay Status (Event content only: AUTO vs. MANUAL)' (selected), 'by Update Status (Remit content only: Updated vs. Skipped)', 'by 835 Claim Status (01 - Primary, 02 - Secondary, etc.)', 'by Summary Adjustment Reason', 'by Check Reference', 'by Session Date', 'by Client' (with checkboxes for 'w/ ERA detail' and 'w/ EVE detail'), and 'No Order'. There is also a 'Billing' section with dropdowns for 'Primary Billing' and 'Secondary Billing'. At the bottom, there are tabs for 'Status', 'Reasons', 'Check Reference', 'Pay Amounts', 'Date / Prg / Client / Other', and 'ERADetail'. Below the tabs are three dropdown menus for 'Batch Pay Status', 'Update Status', and '835 Claim Status'. At the very bottom are buttons for 'Preview', 'Done', 'Summary Report', 'Print Setup', and 'Print'.

HIPAA ERA reports can show either the original event records that have been updated by an 835, or the actual remittance records converted from an 835. Usually, you will be interested in looking at the event information, but sometimes you may want to go back to the "source" and actually look at what was in the 835. (To review "SKIPPED" remittance records, you must look at the 835 because this information was never stamped on an event record).

You must select a primary billing type and optionally a secondary one to proceed with the report. You will normally limit the report to a single ERA run.

You can select from various report sort orders.

The tabs offer additional conditions to limit the report to records with a particular status, adjustment reason, check reference, pay amount, or other date, program, and client constraints.

Reasons Tab

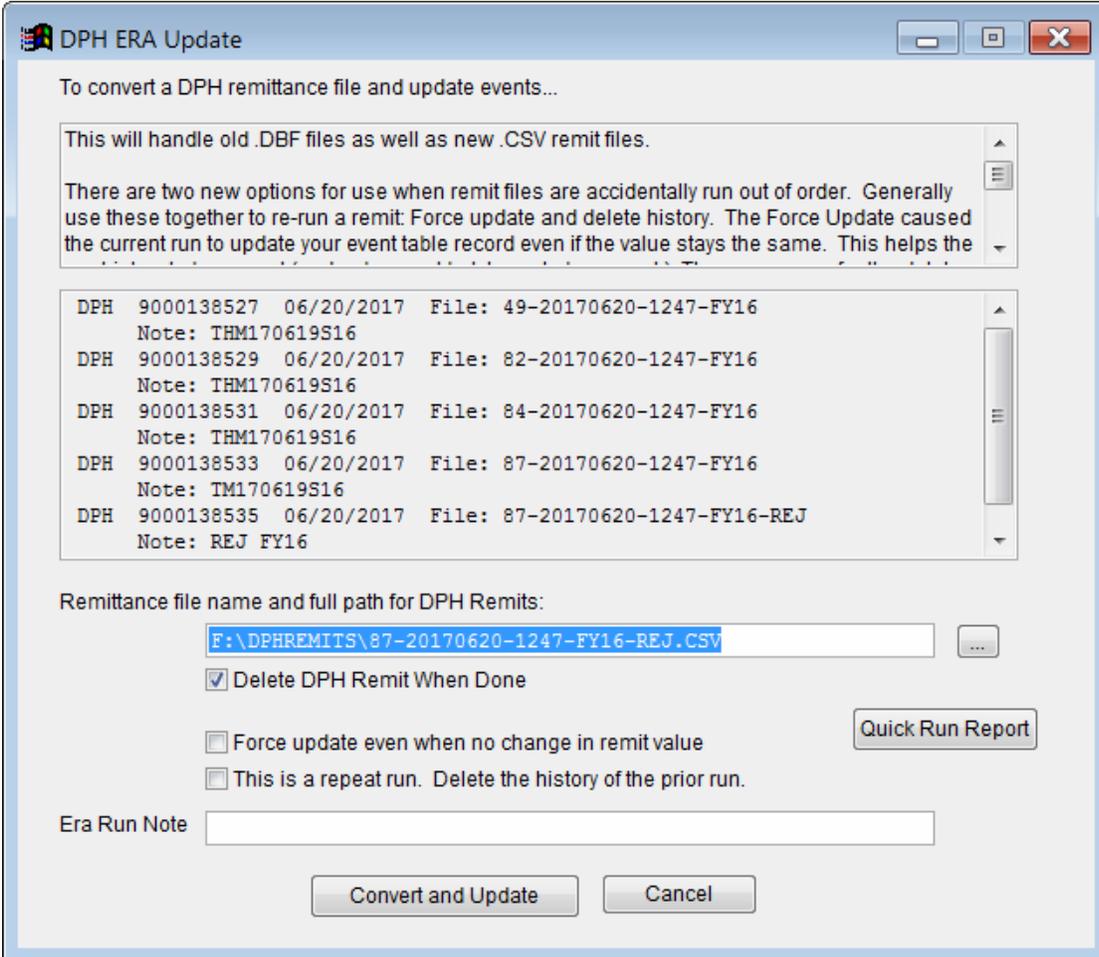
The screenshot shows a software window with a tabbed interface. The 'Reasons' tab is active. The 'Summary Reason Code' section contains four radio button options. The first option, 'Deductible (001), Co-ins (002), and/or Co-pay (003) (DCC)', is selected. To the right of this section is an 'Any Adjustment Note Value' text box and a 'MultiUpdate' checkbox. At the bottom of the window are buttons for 'Preview', 'Done', 'Summary Report', 'Print Setup', and 'Print'.

The Reasons Tab offers Summary Reason Code conditions or an exact condition if needed. The Summary Reason Code is derived from the actual reason codes on a claim. Since there can be more than one reason for adjustments, this field tries to summarize the reason in a useful way. If the reasons are either 001, 002, or 003 for Deductible, Co-insurance, or Co-pay adjustments, then these are summarized as a "DCC" and reported in the same category. Any other single reason code is reported for what it is. Any other complex multiple reason codes are summarized as "MOT", meaning "Multiple Other Reasons).

DPH Remits

DPH ERA Update (Remittance File Processing)

DPH sends Electronic Remittance Advice (ERA) information in the form of database files similar to the SDR files they received. ERA files have extra fields, such as Line Status, and Error Code, which indicate how the records fared passing DPH’s business rules. Please review your DPH information for a full explanation of these codes.



These files come to you from DPH as compressed (zipped) files in email attachments. You should create a folder named \DPHREMIT on your system and use it to hold the unzipped remit files that are waiting to be processed.

For our purposes, we want to update our event records with this information so we know which records are accepted for payment (and stamped with a payment voucher number) and which records need attention and possible resubmission or correction.

The ERA Update routine takes a DPH remittance file, converts it to a format the Thom Biller software can process, and updates our session, transfer, and adjustment record with the remittance information.

The screen remembers your most recent remit file name and the file folder. It also shows you a list of the last 5 remit runs you have completed.

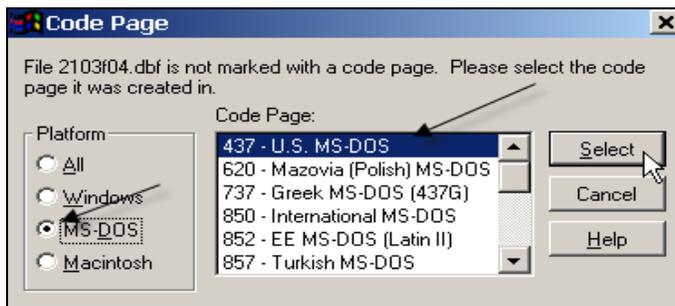
Note the "File:" name in the list of recent runs is the modified file name used by Thom Biller when it makes a backup copy of the actual remit file. In this case, the previous remit file name was 1702F04.DBF. When it was saved in the prior run, its name was changed to include the date of the run: 1702F04V050429. The "V" part of the name is in a year + month + day format (e.g.,4/29/05). This prevents the current file from overwriting one DPH would have sent last year with the same name (1702F04).

To locate the next remit file, press the "..." box next to the file name to pull up the directory.

Because Thom Biller backs up the remit file, it is safe to check the "Delete DPH Remit When Done" box . This keeps your remit folder cleaned up.

The **Convert and Update** action will convert the remittance file to backup file for storage in the data\era subdirectory. It will then loop through this file and find the original source event which created the SDR record in the first place and apply the remittance information to it.

It will locate the file and convert it into a backup file with the same name, plus the date as noted above.



If asked for a code page, which you usually will be the first time you open a remit file, choose MS-DOS and accept the 437- U.S. MS-DOS default at the top. Press SELECT.

As this routine works on a DPH remittance file, it looks at each record and tries to find the matching event record in the Thom Biller event file. The linking field is the PMLINEID on the remittance record, which matches the event file EID. Normally, there will be a perfect match and all remittance records will locate their match in the event file. With each match, the new line status and payment voucher information is brought into the event record. If a match is not found, you will receive a warning and you should contact Thom technical support to help solve the problem. A mismatch such as this means some line status and payment voucher information is not being retrieved from the remittance file, so it is important to understand why this has happened and correct it. Otherwise, your event file will no longer have the same information that DPH has reported to you.

Special "Force update" and "Repeat run" checkboxes

- Force update even when no change in remit value
- This is a repeat run. Delete the history of the prior run.

There are two new options for use when remit files are accidentally run out of order. Generally use these together to re-run a remit: Force update and delete history. The Force Update caused the current run to update your event table record even if the value stays the same. This helps the run history to be correct (and subsequent batch pay to be correct.) The same goes for the delete history. Neither of these options will cause any problem when chosen on a new remit run that is in order.

DPH Remit Reports

Report of Revised Remit Information

If the current remit file is going to change any remit information already stored within Thom Biller (from an earlier remit run), it will produce the following report. On the left half of the page is a summary of the existing DPH remit information already stamped on events with Thom Biller. The right side of the report comes from the information in the new remit file that you just loaded.

The report is sorted by the existing (old) PV and subset by the new PV that will be stamped on the event if you proceed with the run.

05/17/2005 Page 1

Events with DPH remit information that will be revised by the current DPH remit file: 2103F04
Existing and New DPH Remit Information
(RevBill_DP = bill_dp amt the existing event and pv will have after the revision)
(CS=claim,LS=line,PV=PV,ER=Error,DP=Bill_DP)

Existing DPH Remit Information on Event File						New DPH Remit Information On Current ERA File							
Prg	Date	Dphid	Sv Bill	Bal	Bill_DP	Prg	Client	Ref	Sdrdate	Sv	Pay	Bill_DP	RevBill_DP
Serv_id	Eid	Sdr_id	SDR date	Era_id		Record	PMLineID	ERA File					
Ln St.	Cl St.	PV	Errorcode			Ln St.	Cl St.	PV	Errorcode	Changed Fields			
Client Name						Era Status 0_status							
Existing PV:						New (revised) PV will be this							
** New PV: THM050415Z4													
21	09/11/2003	2101813-1	TA DPH	72.92	72.92	21	2101813	1	09/11/2003	A D		72.92	
30242693	91737778	90027204	01/10/2005	90029161		242693	91737778	2103F04V050429					
PENDEN	PENDEN		5H			ACCEPT	ACCEPT	THM050415Z4	NO ERROR	CS,LS,PV,ER,			
						R		ACCEPT/5H override - 5H approved with JS review					
21	09/19/2003	2101813-1		72.92	72.92	21	2101813	1	09/19/2003	A D		72.92	
30242763	91737780	90027204		9161		242763	91737780						
PENDEN	PENDEN					ACCEPT	ACCEPT	THM050415Z4		CS,LS,PV,ER,			
						R		ACCEPT/5H override - 5H approved with JS review					

In this example, some claims that had a blank PV because they were PENDEd are going to be changed and stamped with a new PV ("THM050415Z4") because they are now

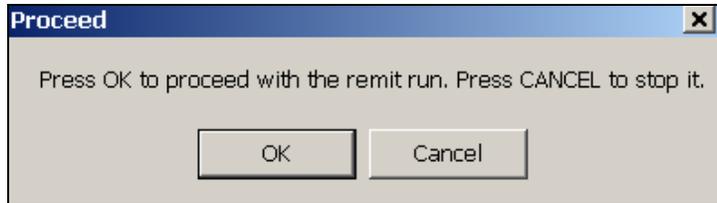
ACCEPTED by DPH. You can see a comment in the remit file O_STATUS field explaining why they were accepted.

The example shown above in which a claim is shifted from a PENDED status with blank PV to ACCEPTED with the current PV is the most common and it does not require any special attention. This is what you want to see happen after you have sent DPH additional information for pended claims. You want to see them ACCEPTED and stamped with a new PV.

More troubling and complicated are cases that go in the opposite direction: a previously ACCEPTED claim gets changed to PENDED. In these cases, DPH has changed its mind about its plan to pay a claim.

Proceed with Remit Run

Assuming you are comfortable with what the remit file is going to do to your sessions, proceed with the run.



Once you have run an ERA Update routine, this routine will offer you the basic reports needed to understand the feedback from DPH. It offers a summary report sorted by PV and a summary report sorted by Line Status.

```

05/17/2005                               Updated by era run: 90029422  Remit File: 2103F05                               Pag
                                     Event ERA Information by PV
Pr  Session      Prov      El.Hr.  Bill    Fee      Pay   Bill TPP   Bill DPH      Bal  E
Dphid-ref  Serv_id  bill_id  sdr_id  Note                                     Type Ref   Fl      Eid  E
Era_id     Line St.  Claim St. PV      Error Codes  El  Auth  Co  Rea  #den  Era Status  S
Changed Fields  (CS=claim,LS=line,PV=PV,ER=Error,DP=Bill_DP)

PV:
* PV Subtotal *
                                     91.75    6362.50    0.00    0.00    20360.33    20810.61

PV: THM05041505
* PV Subtotal *
                                     1938.50    114358.98    0.00    0.00    18573.57    112508.38

PV: THM050415D5
* PV Subtotal *
                                     6.00      387.02     0.00    0.00     387.02     387.02

*** Total ***
                                     2036.25    121108.50    0.00    0.00    39320.92    133706.01

Updated by era run: 90029422  Remit File: 2103F05

```

You always want to make sure the PV amounts match the paper PV.DOC amounts, which these do. This run has many pended claims which will be printed in summary and detail:

05/17/2005 Page

Updated by era run: 90029422 Remit File: 2103F05

Event ERA Information by Line Status and Claim Error

Pr	Session	Prov	B1.Hr.	Bill	Fee	Pay	Bill TPP	Bill DPH	Bal
Dphid-ref	Serv_id	bill_id	sdr_id	Note			Type Ref	F1	Eid
Era_id	Line St.	Claim St.	PV	Error Codes		E1	Auth Co Rea	#den	Era Status
Changed Fields (CS=claim,LS=line,PV=PV,ER=Error,DP=Bill_DP)									
Line Status: ACCEPT									
Error Code: NO ERROR									
* Subsubtotal *									
			1707.50	99808.44	0.00	0.00		18960.59	112895.40
** Subtotal **									
			1707.50	99808.44	0.00	0.00		18960.59	112895.40
Line Status: PENDED									
Error Code: 5K									
* Subsubtotal *									
			319.00	20360.33	0.00	0.00		20360.33	19957.12
** Subtotal **									
			319.00	20360.33	0.00	0.00		20360.33	19957.12
Line Status: SUSPND									
Error Code: 6A									
* Subsubtotal *									
			9.75	939.73	0.00	0.00		0.00	853.49
** Subtotal **									
			9.75	939.73	0.00	0.00		0.00	853.49
*** Total ***									
			2036.25	121108.50	0.00	0.00		39320.92	133706.01

Detail of these claims needing attention will come on next report.

Updated by era run: 90029422 Remit File: 2103F05

It then offers a detailed report with the added condition of NON-ACCEPTED records only so you can see any specific records needing action.

05/17/2005 Page 1

Updated by era run: 90029422 Remit File: 2103F05 Non-Accepted Only

Event ERA Information by Line Status and Claim Error

Pr	Session	Prov	B1.Hr.	Bill	Fee	Pay	Bill TPP	Bill DPH	Bal	Posted
Dphid-ref	Serv_id	bill_id	sdr_id	Note			Type Ref	F1	Eid	Billed
Era_id	Line St.	Claim St.	PV	Error Codes		E1	Auth Co Rea	#den	Era Status	SDR
Changed Fields (CS=claim,LS=line,PV=PV,ER=Error,DP=Bill_DP)										
Line Status: PENDED										
Error Code: 5K										
	Y, EMMA									
21	08/17/2004	TH	CG 21	7	1.00	DPH	97.80	0.00	0.00	97.80
2102018-1	30259754	90029209	90029210	Copay			TRANS FR OTH	Y	91845994	04/10/2005
90029422	PENDED	PENDED		SK		Y	096		U	04/10/2005
CS,LS,ER,DP										
	EMMA									
21	08/17/2004	TH	DB 21	4	1.00	DPH	97.80	0.00	0.00	97.80
2102018-1	30259819	90029209	90029210	Copay			TRANS FR OTH	Y	91845996	04/10/2005
90029422	PENDED	PENDED		SK		Y	096		U	04/10/2005
CS,LS,ER,DP										

Detail of Non-Accepted Claims (such as PENDED)

The summary run by PV will allow you to cross check the update process with the printed PV's you will have received from DPH. In addition, it will make it easier to take the next step: batch payment of those PVs. Make sure you print all offered reports.

DPH ERA Batch Payment

Once our event records have been updated with DPH remittance information, batch payment of accepted DPH records is possible. This routine will do that automatically, based on the PV information brought over from the remittance file.

This routine creates a PAY entry for each DPH event that has a specific PV. It assumes that you have already run the ERA Update routine which stamps PV information on the event records. It will create a PAY entry in the amount of the "BILLING_DP" value that was also filled in by the ERA Update routine. This is amount DPH has committed to pay. It will create an "ADJ-P" for negative pay amounts that have been refunded to DPH in this PV.

The total amount to be paid is likely to be close to the claim balance for all these events, but not necessarily exactly the existing balance. This routine will test whether it is fairly close and warn you if it is not.

Please be very careful not to run this routine twice for the same PV. If you do, you will have double payment entries and a lot of negative balances!

If you have any doubt, do a "claim series" report for the PV in question and examine it for any pay entries already entered.

DPH ERA Batch Payment

This routine creates a PAY entry for each DPH event that has a specific PV for a given program. First enter the program. Then choose one of the tabs for locating the PV you want to pay off. by ERA run or by Pending Batch Pay list. Select a PV. Then enter the correct

Last 10 Completed Batch Pay Runs...

DPH	06/16/2017	87	PV: THM170614D17
DPH	06/20/2017	83	PV: THM170619S16
DPH	06/20/2017	01	PV: THM170619S16
DPH	06/20/2017	17	PV: THM170619S16
DPH	06/20/2017	21	PV: THM170619S16
DPH	06/20/2017	27	PV: THM170619S16
DPH	06/20/2017	49	PV: THM170619S16
DPH	06/20/2017	82	PV: THM170619S16
DPH	06/20/2017	84	PV: THM170619S16
DPH	06/20/2017	87	PV: THM170619S16

Completed Batch Pay Report Program: 01 Pending Batch Pay Report

Select PV by ERARun **Select PV by Pending Batch Pay**

ERARun ID with desired PV: 9000138517

PV to batch pay: THM170619S16

Posting date for new PAY records: 07/11/2017

Deposit date of payment (optional): / /

Gather records Preview Run Batch Pay Cancel

If you click on the "Pending Batch Pay Report", you will see a listing of all PVs waiting to be run.

05/17/2005						
Pending Batch Pay Runs						
Expected Batch Pay Report						
(PENDING means no batch pay yet run, COMPLETED means a batch pay was run)						
Prg	Bill	Check Ref / PV	ERA Date	ERA File Source	Amt	Status
21	DPH	THM05041524	05/17/2005	2103F04V050429	783.89	PENDING
21	DPH	THM05041505	05/17/2005	2103F05V050428	18573.57	PENDING
21	DPH	THM050415D5	05/17/2005	2103F05V050428	387.02	PENDING

The Pending Batch Pay report shows the three PVs we just created by our remit runs and shows that they are pending.

There are now two ways of telling the Batch Pay screen which PV you want to pay off. You can either "Select PV by ERA Run" or "Select PV by Pending Batch Pay". The latter is probably the easiest and we'll demonstrate it first.

Select PV by Pending Batch Pay

Completed Batch Pay Report Program: 21 Pending Batch Pay Report

Select PV by ERA Run Select PV by Pending Batch Pay

(locate the PV from your Pending Batch Pay list)

PV to batch pay: [Dropdown]

Posting date for new PAY records	THM05041524	783.89	05/17/2005	21	ERA: 90029421
Deposit date of payment (optional)	THM05041505	18573.57	05/17/2005	21	ERA: 90029422
	THM050415D5	387.02	05/17/2005	21	ERA: 90029422

Pick the program you want to work on. Then click on the "Select PV by Pending Batch Pay" tab. Then select the PV from the Pending Batch Pay List. This dropdown box is offering you the same pending batch pay runs that you saw in the report earlier.

When you have found the PV you want to pay off, Press Gather Records.

Completed Batch Pay Report Program 21 Pending Batch Pay Report

Select PV by ERA Run Select PV by Pending Batch Pay

(locate the PV from your Pending Batch Pay list)

PV to batch pay THM05041524

Posting date for new PAY records 05/17/2005

Deposit date of payment (optional) / /

Gather records Preview Run Batch Pay Cancel

Select PV by ERA Run

The other approach to locating a PV uses the ERA run history to help you locate PVs created by specific remit runs.

DPH ERA Batch Payment

This routine creates a PAY entry for each DPH event that has a specific PV for a given program. First enter the program. Then choose one of the tabs for locating the PV you want to pay off: by ERA run or by Pending Batch Pay list. Select a PV. Then enter the correct

Last 10 Completed Batch Pay Runs...

DPH	05/17/2005	17	PV: THM05041554
DPH	05/17/2005	21	PV: THM05041524
DPH	05/17/2005	21	PV: THM05041505

Alternate way of selecting PV is by ERA remit run. First you locate the ERA run that created the PV you want to pay off.

Completed Batch Pay Report Program 21 Pending Batch Pay Report

Select PV by ERA Run Select PV by Pending Batch Pay

ERA Run ID with desired PV

PV to batch pay

90028934	21	03/30/2005	DPH	2102F05ERA	THM05032105	THM050321D5
90028936	21	03/30/2005	DPH	2102F05RERA	WIT 2/05 FY05 REJ	
90029029	21	04/02/2005	DPH	2111F04CERA	THM04121354 (REPROCESSED)	
90029161	21	04/08/2005	DPH	2102F04BERA	THM050321S4	
90029163	21	04/08/2005	DPH	2101F04RBERA	WITS 2/05 FY04 REJ	
90029421	21	05/17/2005	DPH	2103F04V050429	THM05041524	
90029422	21	05/17/2005	DPH	2103F05V050428	THM05041505	THM050415D5

Posting date for new PAY records

Deposit date of payment (optional)

Gather records Preview

Then choose the specific PV from the list.

Select PV by ERA Run Select PV by Pending Batch Pay

ERA Run ID with desired PV 90029422

PV to batch pay

THM05041505	18573.57
THM050415D5	387.02

Posting date for new PAY records

Deposit date of payment (optional) / /

Gather records Preview Run Batch Pay Cancel

Once you have found the PV you want to pay off, press Gather Records to proceed. Then proceed with the Gather Records.

Select PV by ERA Run	Select PV by Pending Batch Pay		
ERA Run ID with desired PV	90029422		
PV to batch pay	THM050415D5		
Posting date for new PAY records	05/17/2005		
Deposit date of payment (optional)	/ /		
Gather records	Preview	Run Batch Pay	Cancel

DPH Batch Pay Reports

Summary Report

The Batch Pay routine will create a summary report of records it is about to create. Make sure you print this report. It will show both new payments and any credits taken.

05/17/2005	PV: THM05041505	Prg: 21	Page	1				
Selected Records for Batch Payment								
Grouped by the type of record that will be created								
Pr	Session	Prov	Bl.Hr.	Bill	Fee	Bill DPH	Bal	Posted
Era_id	Serv_id	bill_id	sdr_id	Note			Eid	Billed
	Line St.	Claim St.	PV	Error Codes			Type	Ref
* Type of record that will be created: ADJ-P REFUND								
Subtotal *	ADJ-P	REFUND			-184.75	-11260.16	-11260.16	0.00

Credits accepted by DPH which will reduce the current PV and be stored as ADJ-P Refunds

05/17/2005	PV: THM05041505	Prg: 21	Page	2				
Selected Records for Batch Payment								
Grouped by the type of record that will be created								
Pr	Session	Prov	Bl.Hr.	Bill	Fee	Bill DPH	Bal	Posted
Era_id	Serv_id	bill_id	sdr_id	Note			Eid	Billed
	Line St.	Claim St.	PV	Error Codes			Type	Ref
* Type of record that will be created: PAY								
Subtotal *	PAY				756.00	29833.73	29833.73	29790.10
*** Total ***					571.25	18573.57	18573.57	29790.10

New payments coming in

Net payment should = PV total

Second and final page of the summary report

Note: normally the "Bill DPH" amount will equal the fee amount, and these totals will be close to the claim balance. The "Bill DPH" amount is the amount of the pay record that will be created by the batch run.

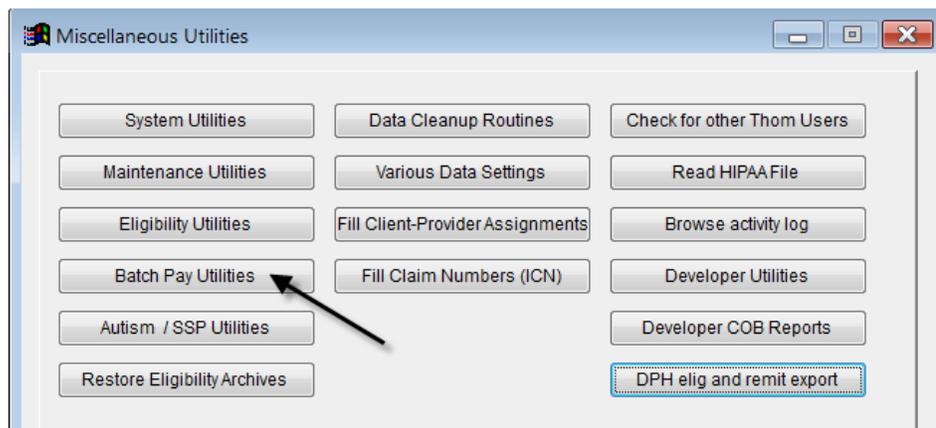
fbera.frx

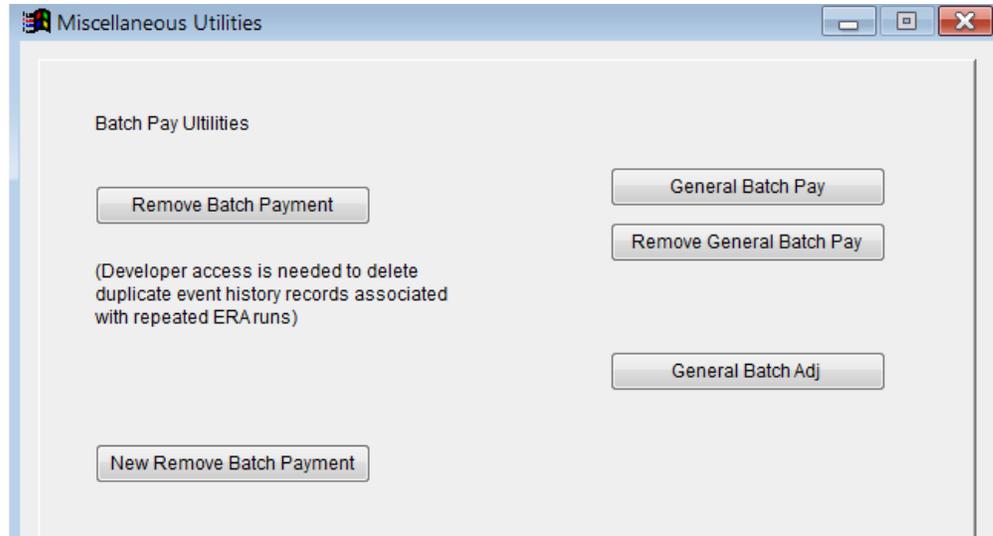
Discussion: DPH Credit handling

- A credit is reported to DPH as a negative fee amount on a transfer or adjustment record. This is our way of telling DPH to take money back. The earlier example did not include any credits, but the following discussion will describe it.
- When DPH accepts a credit, the amount is subtracted from the total of the positive fee amounts (charges) on the SDR. So if there were \$10,000 in new charges on an SDR, and -\$1,000 in accepted credits, the PV total would be \$9,000.
- When we process the remittance file that includes credits, it marks them the same as charges but with negative amounts: the matching event is marked “ACCEPT” and stamped with the PV. The Billed_DP amount is recorded (as a negative amount). The total Billed_DP will add up to the PV total (both positive and negative amounts, $10,000 + -1000 = 9000$).
- The Batch Payment routine will loop through these records and show you all the will have a normal payment (positive pay amount on the new record) and ADJ-P REFUND records created for negative pay amounts. The total of the pay amount will also equal the PV ($10000+-1000 = 9000$ payments).
- The ADJ-P records with a negative pay amount are the system’s way of confirming the an earlier payment was actually returned (refunded). These make the sum of the pay amounts equal to the net amount of money received (total received – total refunded = net received).

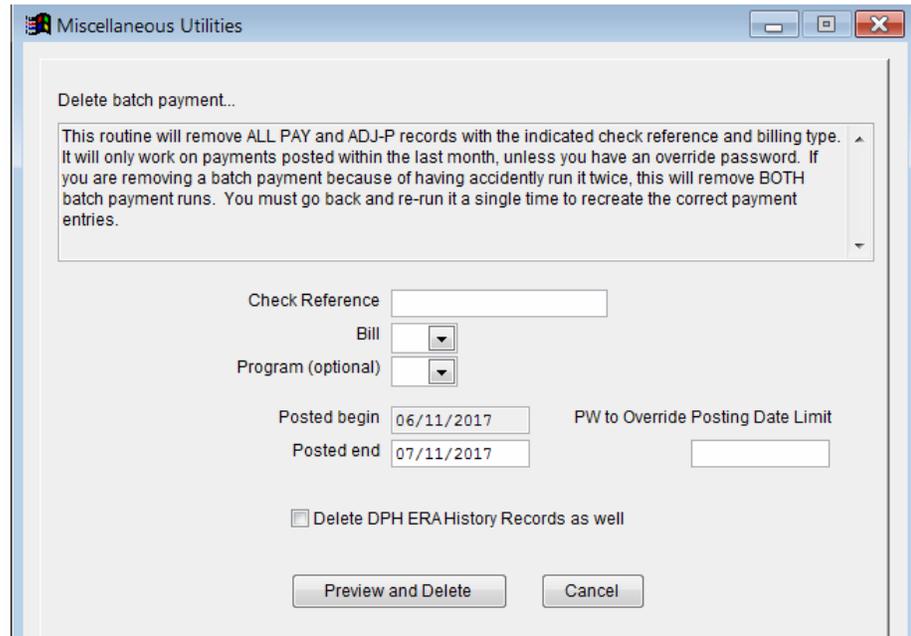
How to Delete a Batch Payment Run

- Go to the Miscellaneous Utilities and chose Remove Batch Payment option (shown below)





Choose either the old Remove Batch Payment or New Remove Batch Payment.



Enter the Program and PV information and proceed.

Most of the time you will use the remove batch payment choice because of accidental double batch payments. The old utility removes all batch payments with a given PV as the check reference, so if you want one of them to remain, you must re-run the batch payment.

The New Remove Batch Payment removes only those records for a single run. (Please check with Thom tech support for confirmation).

DPH ERA Reports

The automatic updating of Thom Biller events with DPH remittance information allows for effective problem solving of rejected sessions. The ERA Reports screen lets you select the information you need to understand and correct DPH billing problems.

DPH ERA Reports

Report Content

Sessions with remittance information

ERA file converted from DPH remittance file 17-20170615-1710-FY17

ERARun History (use Date and Prog conditions marked *)

Report Sort Order

By Line Status +Error Codes By Billing By Prg By SSP

By Payment Voucher (PV) By Client By SDR Month

Session Dates *

Begin / /

End / /

Additional Conditions

Line Status [dropdown] Cond Pay

Error code [text] Any Error

Prog * [dropdown]

Updated by ERA run [dropdown]

Use Run History

PV [text] PV Not Blank

PV Blank

Submitted by SDR run [dropdown]

PV Not Equal this value

Era Status [dropdown]

EIPP Only

EI Only (No autism svcs)

DPH records only

Reported on any SDR

Autism Only

Positive Balance Only

SSP [dropdown]

Other Conds. [text]

Preview Done Summary Report Print Setup Print

Report Content

Use this box to select the source of the information for the report. Choose **Sessions with remittance information** to create a report based on the Thom Biller event file and the remittance information the ERA update routine has brought in. For example, choose this option to see all sessions that have been rejected by DPH (by setting a condition for Line Status = "REJECT".)

If you want to see a report of the actual DPH remittance information, choose **ERA file converted from DPH remittance file**. Use this report to see all the fields DPH has sent on their remittance file for further problem solving, especially when the session report is unclear.

The final report option is based on the Thom Biller run file and it is to help you keep track of which DPH remittance files you have processed, and when: **ERA run history**. You can use the Dates and Prog box to limit the run records displayed.

Report Sort Order

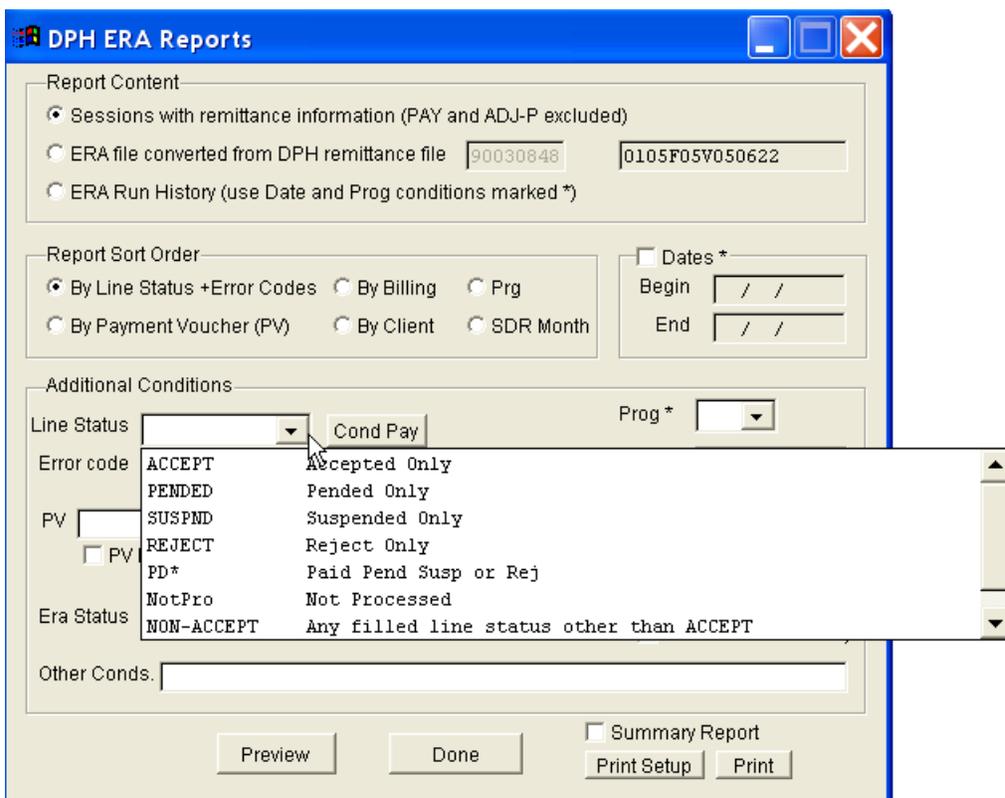
This box applies to either of the first two report content choices: either a session report or and ERA file report. These can be sorted as indicated to help you understand the remittance results.

Date

The Dates box sets the session date parameters for either main report; it limits the run dates for the ERA run report.

Additional Conditions

Aside from date parameters, you will normally limit either the session or era report with additional conditions. As shown on the screen shot below, the **line status** options can be quite useful.



The NON-ACCEPT choice perhaps best covers the records needing some sort of attention and possible correction. The other choices are generally subsets of this category.

Records can be shown that have a single **error code** or **PV**. You can check boxes to show all records **except** those with a certain PV, all records with a **blank PV**, or all records with a PV that is **not blank**.

You can further limit the records shown to those that went out originally on a specific **SDR run**, or those whose remittance information came back on a specific **ERA run**.

It often makes sense to select the **DPH Only** check box because it is usually DPH records you will be most concerned with.

Discussion

All these choices can seem a little overwhelming, but they may be useful for certain types of problems.

The most useful feature is the report of NON-ACCEPTED claims for a given ERA run, because this shows you the records that need your attention.

It is also a good idea to cross check the amount you bill DPH, the amount they report as NON-ACCEPTED (not to be paid), and the amount they indicate as paid (marked with a PV). For each month, these numbers should add up: amount billed – amount not accepted = amount paid.

Notice that we are saying, “NOT ACCEPTED” rather than “REJECTED”. There are several types of line status that will not be paid, including REJECTED, PENDED, SUSPENDED, etc.

From these reports you can find the amount billed DPH in a given month by selecting a single SDR and limiting the report to DPH only records. The FEE total of this report is the amount billed DPH that month.

The amount not accepted would be based on the remittance run for that month, so select it under the ERA run condition and choose “NOT ACCEPTED” from the line status condition. Normally you would sort this report by error to help you attend to needed corrections.

Finally, the amount likely to be paid by DPH would be, for the same ERA run, those records marked with a line status of ACCEPTED. This time, sort the report by PV and you should see the two PVs associated with the remittance run. As of this writing, DPH generally sends back two payment vouchers with each regular (not rejected) remittance file. One PV is assigned to most DPH records; the other is assigned to DPH claims that have no other insurance (these PV's end in “WD”).

If you see any ACCEPTed records with blank PV's on this run, you should contact DPH for an explanation. We have seen this every once in a while and it really throws off your numbers. The check boxes for all records except a given PV, or those with blank or nonblank PV, are designed for sorting out these odd situations, usually with another condition already set limiting the run to DPH records in a single ERA.

There are some other potential complications to making your numbers match up. The biggest is the fact that DPH can retroactively change the line status of a record. For example, the PDREJECT line status is assigned to a claim that was previously marked as ACCEPTed and means that DPH intends to take the money back.

DPH can also take money back after reviewing an earlier payment. These are indicated as ACCEPT line status, but with an error message and a negative amount.

DPH will soon (August, 2006) begin sending two remit records whenever they take money back on a re-remit claim: An ACCEPT record with an error code (such as "5H") and negative amount (just as before), and a new PEND record with a positive amount which better reflects the resulting status of the claim now that the money has been taken back. To handle these multiple remit records within a single remit file, we added DPH remit fields to

the event history table (dtpaehx.dbf) to track the remit status at the exact moment the remit file was processed, even if multiple remit records immediately change it. This history information is now used to generate batch pay records instead of the old approach which used the current remit status of a claim.

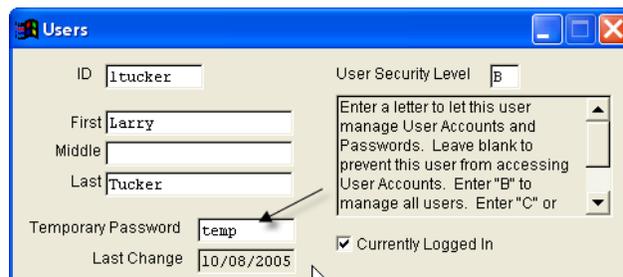
On the DPH ERA report screen, you will see a new checkbox under the ERA Run dropdown called "Use ERA Run History". This will automatically be checked when you do a report for a single ERA run and have chosen either of the usual sorts (By Line Status + Error Codes or By Payment Voucher (PV)), so that you will the remit information that was applied at the time by the remit run. This is the information that the DPH ERA Batch Pay routine will use to create pay records.

If this seems confusing, it is. It helps to have a standard procedure each month for cross checking all your numbers and catching any retroactive changes.

Admin

Security

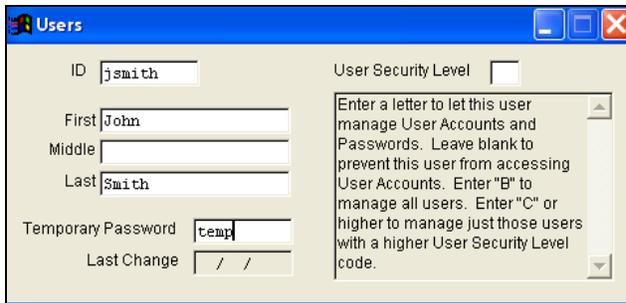
Go to Admin/Security/Users on the top main menu:



You can use any scheme you want for creating User IDs, but just be consistent in your approach within your agency. The ID and Password fields are cap-sensitive.

In this example, the User Security Level is set at "B", the highest. This allows this user to manage all other user accounts.

Go ahead and create new User records for all Thom Biller users in your agency. For each one, enter an ID, their names, and a temporary password:



For most other users, you can leave their security level blank to prevent them from accessing the user login table. Only one or two people at an agency need to be able to manage user records (and they should have "B" or "C" in their User Security field).

Password Reset

If any user forgets his or her password, just go into the Users screen and reset a new temporary password for that user. Then he or she can reset it the next time they log in. There is no way to find their old password, just give them a new one.

Adding / Deleting Users

You can add, delete, and navigate the Users records using the standard toolbar at the top of the screen. . Make sure you have at least one User record and that at least one user has a User Security setting of "B". If you delete all the users, you will not be able to login. If no users have a User Security setting, then no one will be able to add or edit user records.

Errors

The Error menu offers to selections: Nonrecoverable errors and Runtime errors.

Nonrecoverable Errors

A nonrecoverable error is the result of a problem with the program or the data which brings the software to a stop. Normally, the reasons for the problem are stored in this file and available for Thom technical support for analysis. This form is not intended to provide the average user with any useful information.

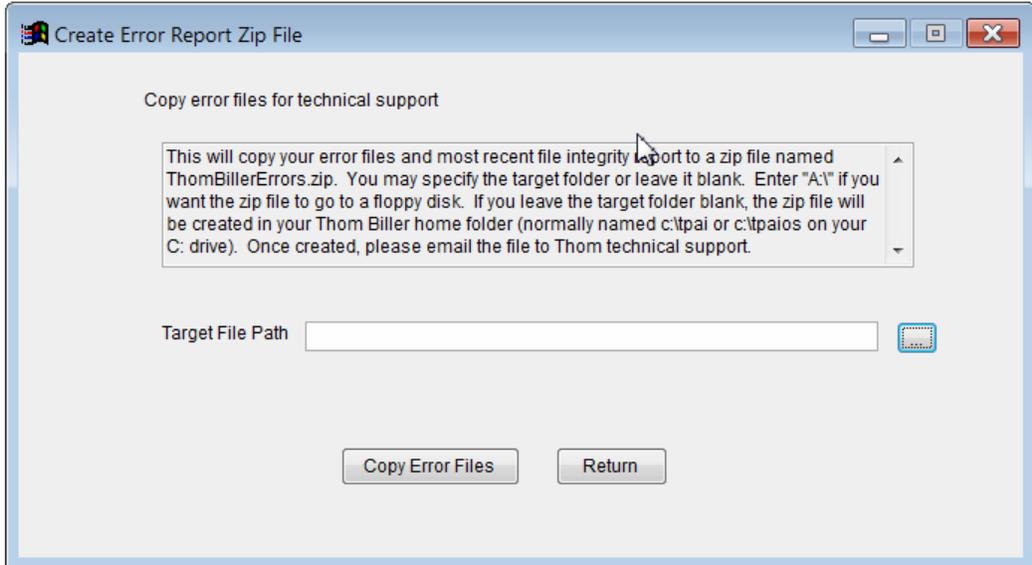
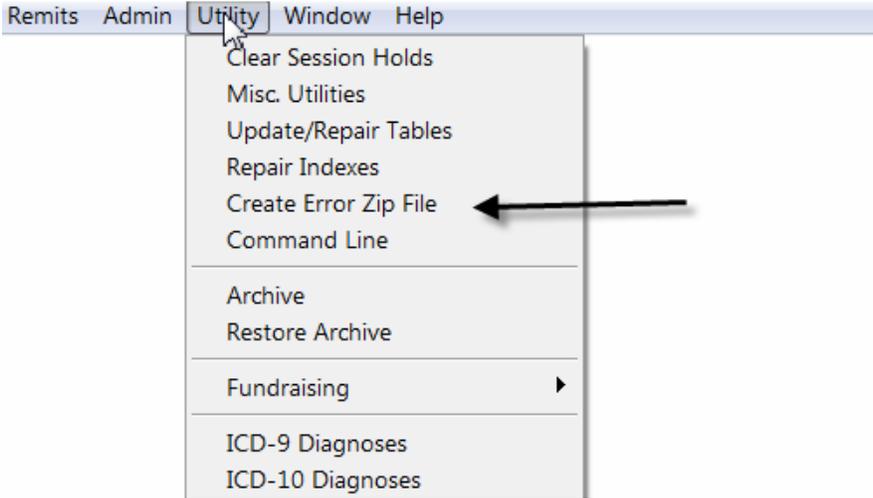
Runtime Errors

A runtime error occurs when something happens in the software that is unexpected. Runtime errors may be recoverable and you may be allowed to proceed with a task following a message. These should still be reported to Thom technical support when they occur, and this

screen is intended for troubleshooting by Thom. It is not intended to provide the average user with any useful information.

Creating ThomBillerErrors.zip File for Technical Support

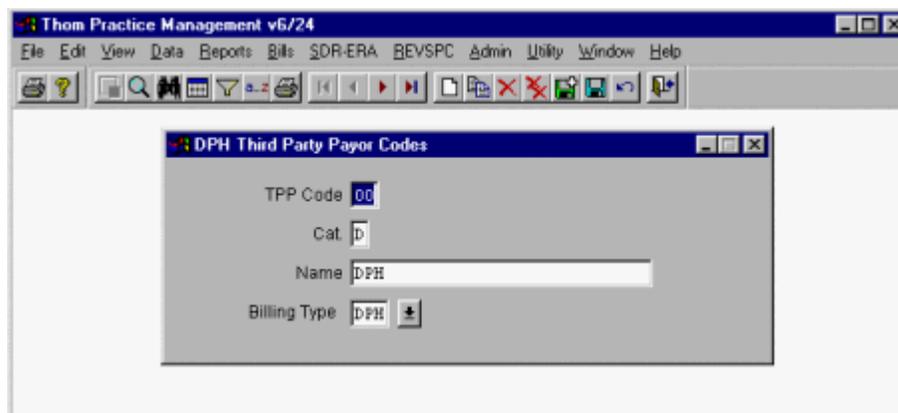
From the main Utility menu, pull down Create Error Zip File:



Utility

DPH Billed To Codes

This is a utility screen for managing DPH Billed To or Third Party Payor codes. It is used to help translate these codes between the Thom Biller billing types.



Normally these are set and left alone until a change is made by DPH. If DPH creates a new TPP code, enter it here and link it to the correct billing type in the system.

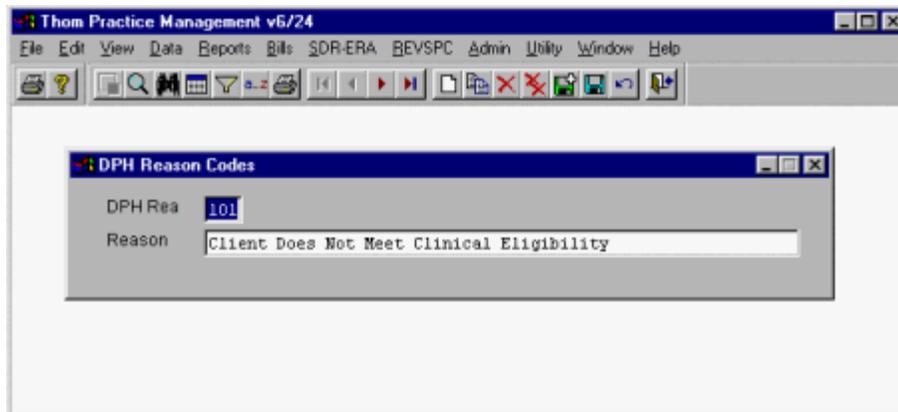
This is NOT how our billing types (such as "DPH") are translated into TPPCodes (which is the opposite direction from how this table is used). Each billing type is assigned a TPPCode in the rate file. If you find your sessions are going to DPH with an incorrect TPP Code, go to the Data / Rates screen for this problem, not this screen.

DPH Error Codes

(This routine is currently under development)

DPH Reason Codes

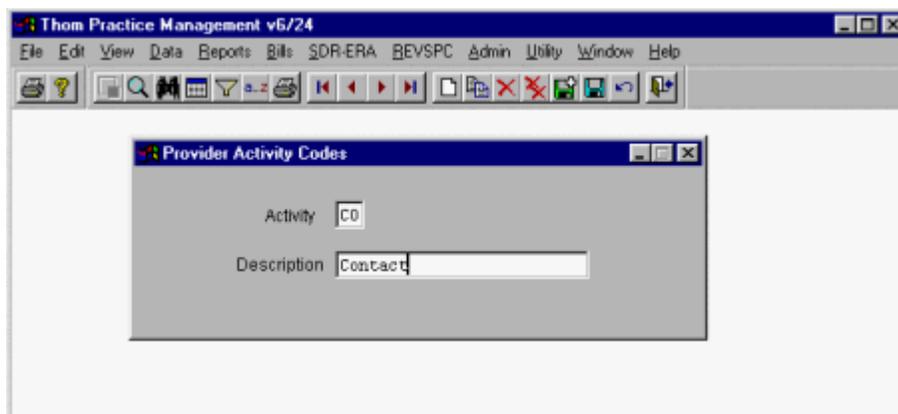
This is a utility screen for managing the lookup table of DPH reason codes.



Normally these are left alone until DPH alters their reason codes.

Provider Activity Codes

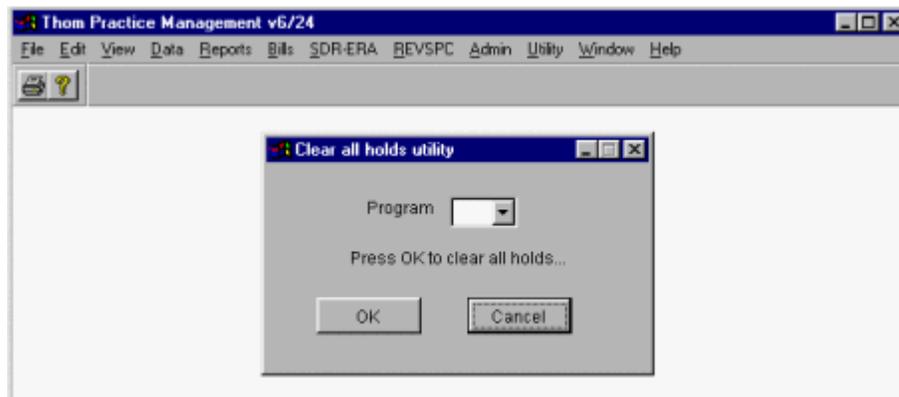
This is a utility screen for managing the lookup table of valid provider activity codes, used by the provider activity tracking module.



Clear Session Holds

This utility screen clears session holds left in place when a routine has ended incorrectly. Session holds are normally set by many of the routines, especially the session entry and billing runs, to prevent more than one routine from changing the same session at the same time. When these runs end correctly, they clear the holds. If a nonrecoverable error occurs, the holds must be cleared manually using this utility.

On multi-user systems you should make sure no one is using records for the program needing clearing.



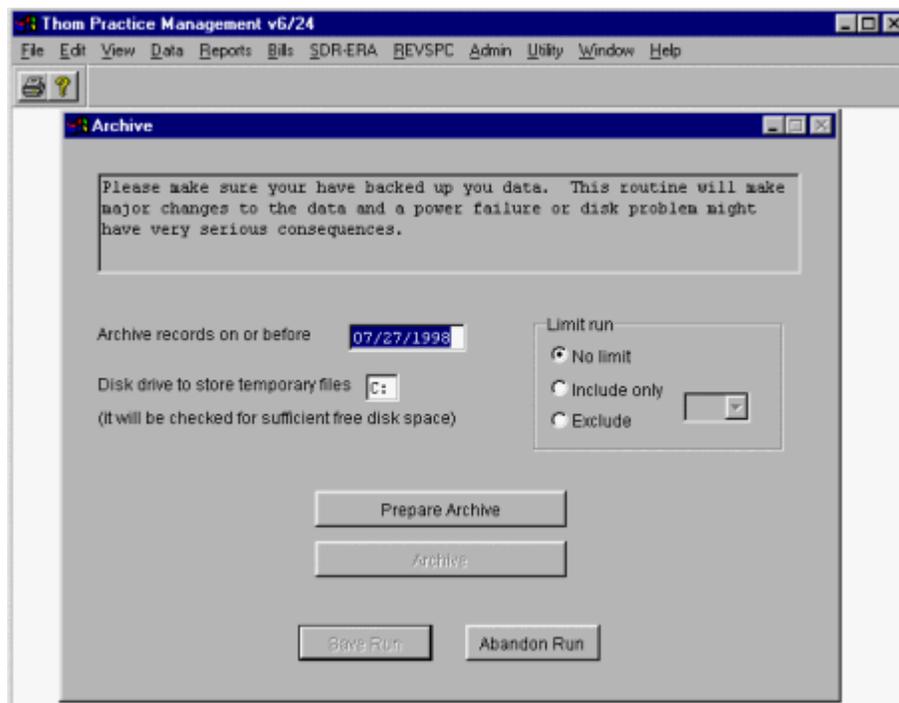
Archive

Archiving is a process of moving events from the active event file into the archived event file in order to speed up the processing of active events.

Only services with a zero balance on all billing type claims will be archived. (If a session started as BCB and was transferred to DPH, the session and all its associated events will not be archived until both the BCB and DPH claim balances are zero.)

Archived events are still available for reports and they can be restored to the active event file if needed (see Restore Archive). They cannot be edited, adjusted, billed, or included on a Service Delivery Report.

Normally, you will want to archive events that are more than two years old.



MAKE SURE YOU BACKUP YOUR DATA BEFORE ARCHIVING!

To archive, you select a session date limit, usually just before the beginning of the prior fiscal year. You can further limit the run to include only a single billing type, or exclude a single one, although you will usually need no additional limits.

Press **Prepare Archive** to analyze all records on or before the indicated date and to mark those associated with claims having a zero balance. This step may take a long time on larger, networked systems.

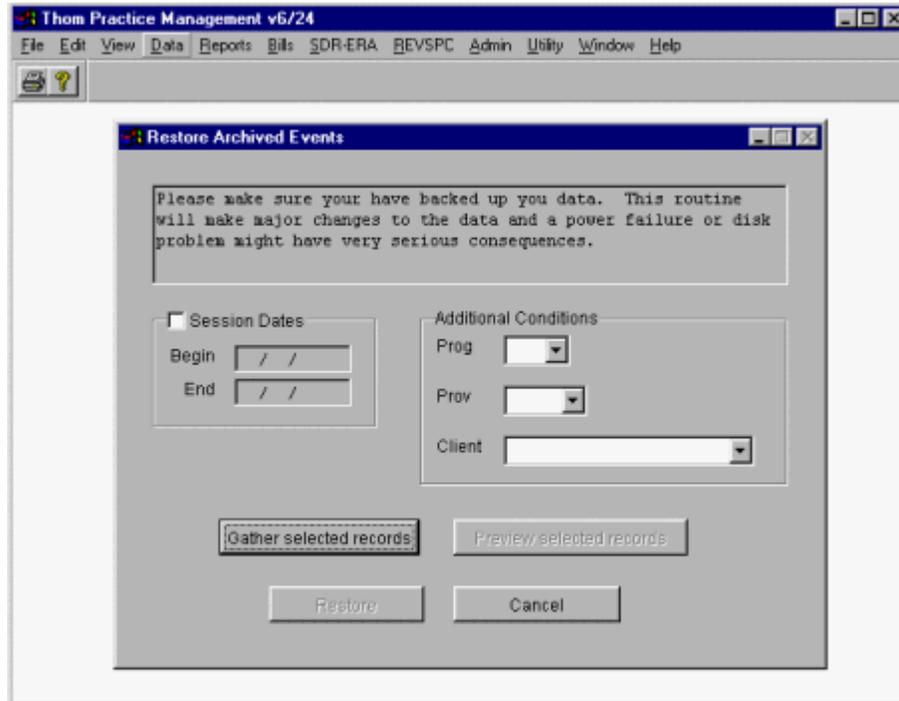
A report will be offered showing the records marked for archiving.

Press **Archive** to go ahead and move these records to the archive event file.

Press **Save Run** to save the run. **Abandon Run** will cancel all changes and make it as if it never happened.

Restore Archive

Archived records can be returned to the active event file using this routine. It should seldom be necessary because archived records can be included in many reports.



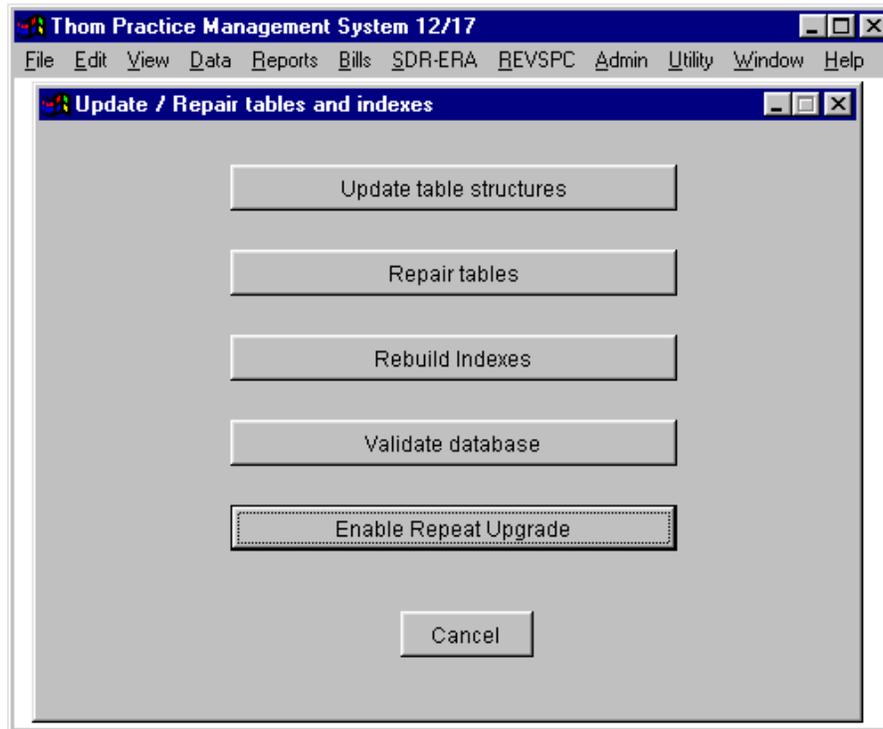
MAKE SURE YOU BACKUP YOUR DATA BEFORE RESTORING!

Set a session date range for events you want to restore. You can limit the restoration further to sessions from a single program, single provider, or single client.

When ready, press **Gather selected records** to prepare the restoration. Preview these to make sure they are what you intend, then press **Restore** to restore and save the changes.

Update / Repair Tables

This utility is usually used with the assistance of Thom technical support. It offers several update and repair utilities which can correct some types of data corruption.



The Enable Repeat Upgrade button allows a recent upgrade to be fully re-run if needed.

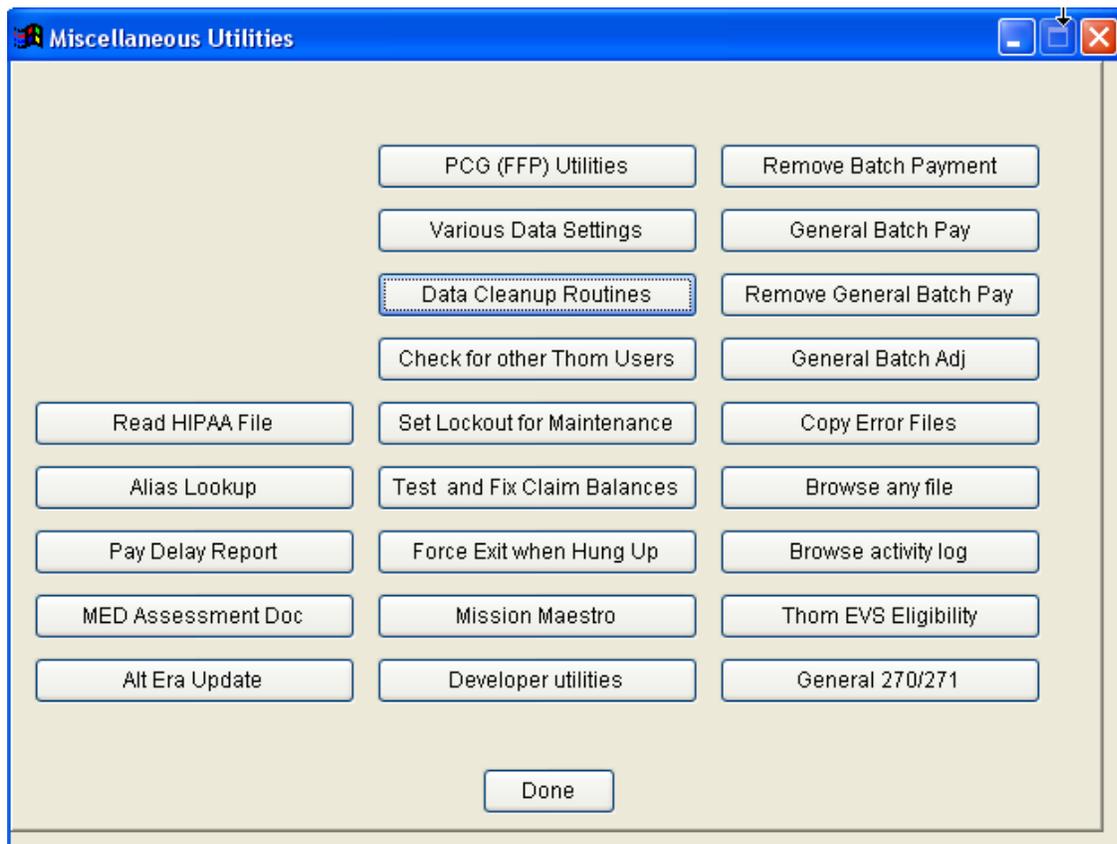
Command Line

The command line access is for use by Thom technical support only. This provides direct programming access to the system and can cause complete data loss if done in error.

DO NOT USE WITHOUT TECHNICAL SUPPORT!

Miscellaneous Utilities

These utilities do small jobs, sometimes associated with an upgrade. They may change over time.



The top set of buttons is more or less permanent. The lower half may be specifically for upgrades. Each routine should be self-explanatory.

“Recreate off site billing disk” is offered on off-site configurations to recreate the disk sent to the base program. A similar “Recreate recovery disk” is offered on base configurations to recreate the disk sent back to the off site.

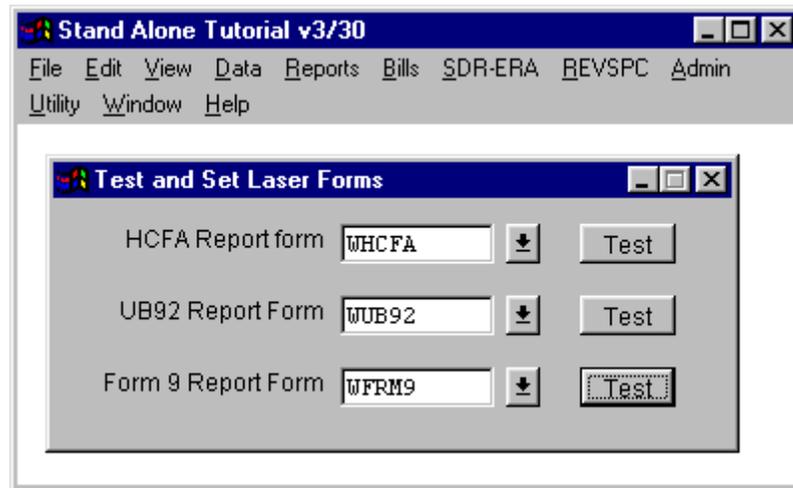
“Remove Batch Payment Run” will undo the action of the DPH batch payment routine (1/2/01).

“Browse any file” will allow you to examine the contents of any table and may be of use looking at offsite submission files or DPH remittance files when you have a question about what they contain (1/2/01).

“Browse activity log” shows you a technical file which tracks the beginning and end of each activity. The “Mprog” column shows the screen name: the most useful may be “DTPAEVE_V” which is the session entry screen. “DTPARSEL” is receipt entry and DTPABIL2” is general billing. The “Mess” column will normally show the LOG_ID

associated with the activity and this may be useful in certain reports. For example, a session entry run will stamp all sessions with the same log_id, and this value can be used in event reports to recreate the session entry report. The same is true of receipt entry, with all new records having the same log_id when created during the same receipt entry run.

The “Test and Set Laser Forms” choice sets the default alignment for HCFA, UB92, and Form 9 laser forms used by the general billing run.



You may select different versions with different spacing to match your laser printer as needed.

“Fix claim balances” will check for claims whose indicated balance does not match the total of the events associated with the claim. These balance problems occur when a nonrecoverable error interrupts the claim updating process. This is essentially a tune up for your data.

“Reset client last seen” date will also tune up a similar issue. Normally, the date of the most recent service is stored on the client record for client report purposes. Again, this may become out of synch after a nonrecoverable error, so this utility cleans it up.

“Pay delay report” will analyze all new claims within a time period and report how long it took for them to be paid or transferred. Its output reports are rather complicated and designed for use with an Excel spreadsheet for final presentation, so you should check with Thom for more information about interpreting this routine.

“General batch pay” and “Remove General Batch Pay” are designed to clear up very old balances that you assume have been paid. The “remove” routine offers a way of canceling a general batch pay. These are NOT intended for posting current receipts.

“Clear Rec. W.O” offers to clear the Recommended Write Off field on the event file. This may have been set to “L”oss or “B”ad Debt on certain claims. This utility will clear it on all records, within some conditions offered.

“Set Check Deposit Date” will stamp all PAY and ADJ-P records for a given billing type and check reference with a deposit date.

“Client Fundraising” calls a screen that can be used to create output files used for fundraising letters. Please speak to Thom support staff if you would like to use this feature.

"Change Tufts Billing Code to TFT" is need for programs that want to use the Tufts electronic billing and remittance processing. These programs assume that Tufts billing has a "TFT" code. This utility will change whatever code you currently use for Tufts to "TFT". It changes your event, event archive, and rate file automatically.

Topics

EI Partnership Program

Some EI programs will be participating in the EI Partnership Program (EIPP). You should read the DPH guidelines carefully to understand the details and procedures for billing these services. This outline is a summary meant to familiarize you with the Thom Biller procedures we have created for this purpose.

EIPP Clients

An EIPP client can be either a child or a parent. You enter them as you would normal EI clients, but check off the EIPP and EIPP Parent checkboxes as needed (next to the DPHID). The DPHID should also have an "EC" or "EM" in it for children and parents. Enter a referral as usual. If either a child or parent comes back for a new referral after a period of time as specified by DPH, you would use the same client record but create a referral #2. Enter the parent DOB for a parent client.

The screenshot shows the 'Stand Alone Tutorial v3.07e' application window. The 'Clients' window is active, displaying a form for entering client information. The form includes fields for Last, First, Middle, Prog ID, Dphid, and checkboxes for EIPP, Parent, and Referrals. A table below the form lists existing clients with columns for Closed, Last, First, Dob, and Dphid.

Client Information Form:

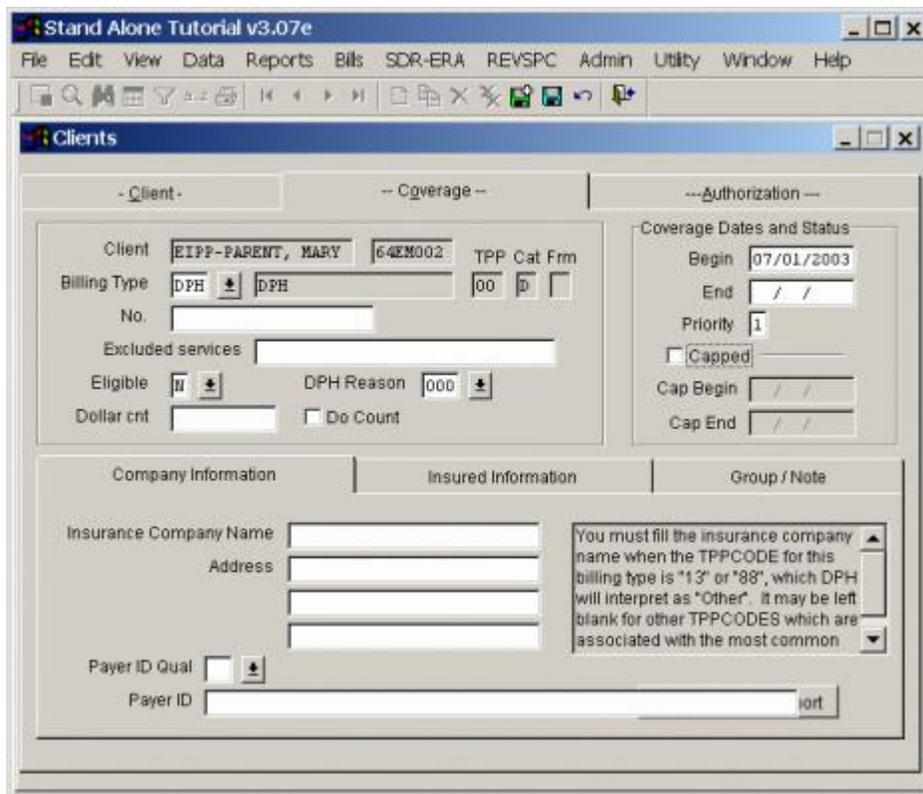
- Last: EIPP-PARENT
- First: MARY
- Middle:
- Prog ID: 64
- Dphid: 64EM002
- Referrals: 1
- Checked: EIPP, Parent

Client Table:

Closed	Last	First	Dob	Dphid
<input type="checkbox"/>	EIPP-PARENT	MARY	01/01/1977	64EM002

(Active and closed clients always shown. Use this grid for review only. Make editing changes on the main form.)

When entering an EIPP child, you enter a third party coverage if available. If none is, or when entering an EIPP parent (for home visits), you must enter "DPH" as the primary coverage. For EIPP parent DPH coverage records, enter "N" for third party eligible and "000" for the reason. For EIPP child DPH coverage records, complete the eligible and reason fields as usual.



EIPP Services

There are two new EIPP services:

TP – EIPP Home Visit (maps to "P" on DPH SDR)

TQ – EIPP Screening (maps to "E" on DPH SDR)

The appropriate Thom Biller upgrade will create TQ rate records for all of your current billing types, because you should bill EIPP screenings to available third parties before billing DPH as the last resort, just like normal screenings. EIPP screenings have the same reimbursement rate and procedure codes as normal EI screenings, but somewhat different maximum limits (1.5 hours per visit, 1 total before age 2 months, 3 after age 2 months.)

The Thom Biller upgrade will create a single TP rate record under DPH, because these EIPP Home visits are always billed to DPH. An additional twist is that they are always billed to the parent as the client, and are mainly for pre-natal services.

When entering EIPP Services, TP Home visits can only be offered to EIPP parents and then only by nurses or social workers (discipline code of 2 or 6). Thom Biller will test the maximums as currently defined before you save EIPP sessions, but you should be careful to make sure you understand the DPH guidelines. They have been revised repeatedly as this

upgrade was being prepared, so we do not know for sure that all guidelines are tested during session entry.

EIPP Bills

Off-site billings will automatically send down EIPP sessions.

Third party EIPP screenings will be picked up automatically with the procedure code needed for the given billing type.

No special steps are needed to bill EIPP services to DPH. The DPH paper billing run and SDR picks them up automatically. A "P" service column has been added to the SDR Form A report to show these sessions EIPP home visits. Remember that the dollar amount no longer matches the hours * rate. EIPP Screenings ("TQ") within Thom Biller are translated into "E" services when sent to DPH on an SDR, so they continue to show up in the "E" column of the SDR Form A report.

Provider Productivity Dashboard

Because of interest expressed at the last User Group meeting, we added an optional module for tracking provider productivity (billable hours vs. scheduled hours). Its tables are separate from those associated with the actual billing process, so it can be used or not used depending on an agency's preferences.

The basic idea of the productivity dashboard is to track the percentage of a provider's scheduled hours that are actually billable. To do this, we created a new table that has a field for billable hours and one for scheduled hours. Based on your provider activity sheets, you would enter information as needed to tally scheduled hours, any adjustments to scheduled hours (such as vacation or sick days) and then billable hours each day. At the end of a week or month or any time frame of interest, the productivity reports will should you the ratio of billable to scheduled hours.

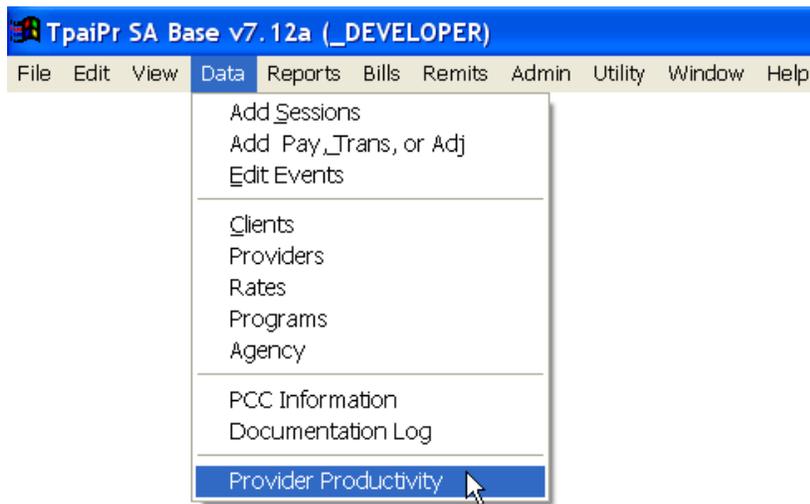
You can define the codes and types of provider hours according to your own interests. Here are the default codes we are sending along with the upgrade:

Provider Productivity Codes					
Act	Desc	Type	Sign	Note	Closed
BI	Billable	PROD	POS	billable service provided	
NB	Non-billable	PROD	POS	Non-billable activity that should count toward a provider's productive hours as if it were billable.	
OS	Other scheduled	SCHE		Enter a positive or negative amount to adjust the time a person was scheduled to work.	
PE	Personal	SCHE	NEG	Enter a negative amount that indicates the person was out of the office for personal reasons.	
SC	Scheduled	SCHE	POS	Total time provider is scheduled to work. Will be reduced by other negative adjustments for such things as vacation, sick time, etc.	
SI	Sick	SCHE	NEG	Enter a negative amount that reduces the scheduled time because the person was out sick.	
VA	Vacation	SCHE	NEG	Enter a negative amount that will reduce the scheduled total because the person was out on vacation.	

There are two “Types” of records in the productivity dashboard: “PROD” – Productive records and “SCHE” – Scheduled records. To start, we suggest at least having two PROD codes: “BI” for billable hours and “NB” for non-billable hours that you want to count as if they were actually billable. So for example, a provider might see 5 clients (for 5 BI hours) plus be given credit for a 1 hour of supervision as an NB hour.

As for SCHE hours, you should start by using “SC” for the total hours a provider is scheduled to work on a given day. This amount can be reduced by other SCHE records such as VA vacation or SI sick time. Notice that the default sign of a SC scheduled hour entry is positive and the others (such as VA or SI) negative. For example, a provider may have 8 SC scheduled hours, but go home sick after lunch (-4 SI hours). This would leave a total of $8 - 4 = 4$ SCHE hours for the day to be used as the reference for however many productive hours he completed.

To enter productivity records, pull down Data/Provider Productivity:

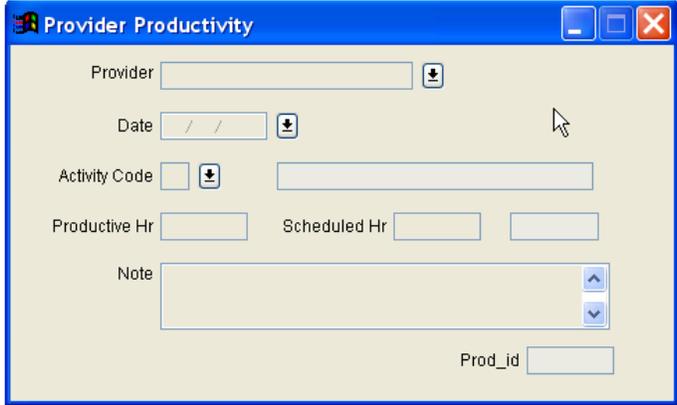


You will be given the option of entering or editing productivity records:



Normally choose the default “Add”.

This brings up a blank screen similar to session entry, but you will be entering only summary records for each provider for each day.



Press New on the toolbar for a new record and fill it out.

The screenshot shows the 'Provider Productivity' form with the following fields:

- Provider: ABEER, RAMONA
- Date: 12/26/2007
- Activity Code: SC (dropdown menu)
- Scheduled: (text field)
- Productive Hr: (text field)
- Scheduled Hr: 8.00
- POS: (text field)
- Note: (text area)
- Prod_id: 90000024

A callout box with arrows pointing to the 'Scheduled Hr' and 'POS' fields contains the text: "Based on the activity code, one of these fields will be active."

Depending on the type of activity code you enter, one of the two fields for hours will be active. In this example, we entered an “SC” for scheduled hours and the right field was active to enter 8.00 scheduled hours. Notice the recommended sign of the entry is shown on the right (POS = positive).

Let’s say the provider when home sick after lunch, so we enter a -4 hours of sick time used.

The screenshot shows the 'Provider Productivity' form with the following fields:

- Provider: ABEER, RAMONA
- Date: 12/26/2007
- Activity Code: SI (dropdown menu)
- Sick: (text field)
- Productive Hr: (text field)
- Scheduled Hr: -4.00
- NEG: (text field)
- Note: went home sick
- Prod_id: 90000025

Finally, for that day, let’s say the person saw two clients in the morning, so we’ll enter 2 billable hours.

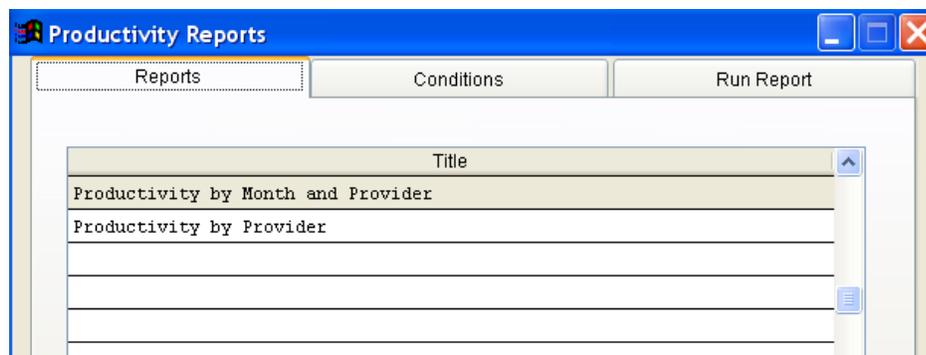
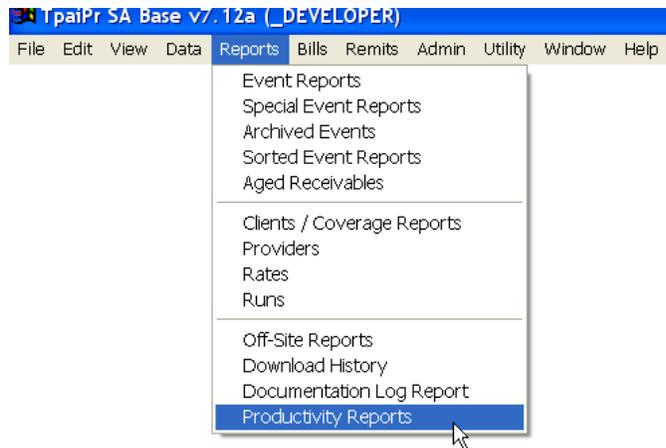
Notice these automatically go in the left “Productive Hours” field.

So if you print the report for this person, you’ll see a .50 productivity for the day:

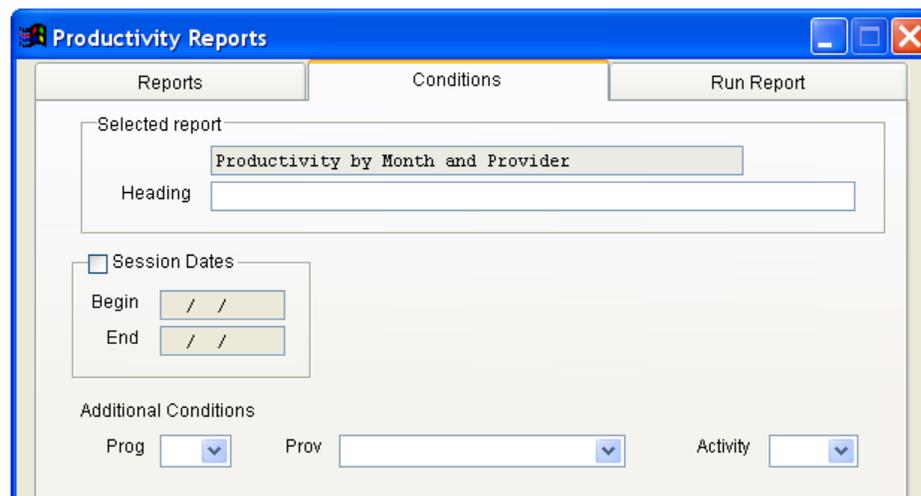
01/02/2008		Current records					Page
Productivity Activities by Provider							
Prg	PID	Date	Activity	Productive Hr	Scheduled Hr	Productivity	
* Provider: ABEER, RAMONA							
17	RXAL7	12/26/2007	SC Scheduled	0.00	8.00		
17	RXAL7	12/26/2007	SI Sick	0.00	-4.00		
17	RXAL7	12/26/2007	BI Billable	2.00	0.00		
* Provider Subtotal *				2.00	4.00	0.5000	
*** Total ***							

Repeat this process for each provider for each day in the week, assuming you want daily detail. You could also enter weekly amounts for each Friday if you only want weekly detail.

There are productivity reports available under Reports\.

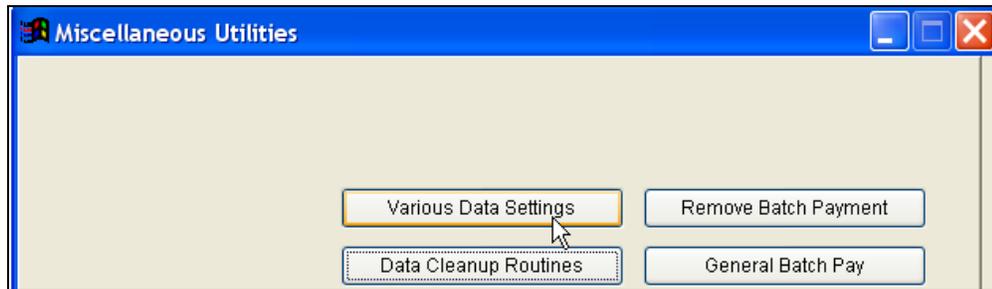


You can set conditions a variety of conditions:

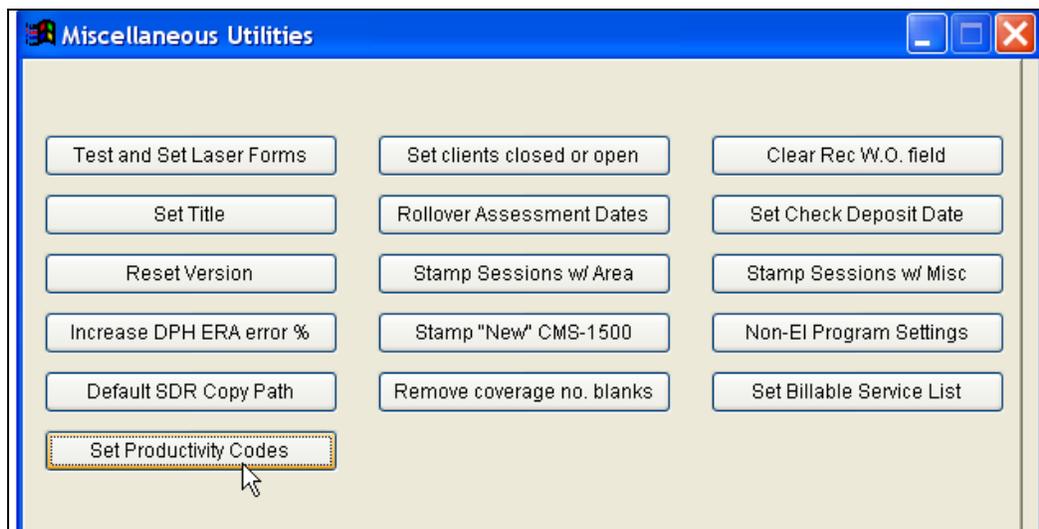


And produce reports similar to the one shown above.

If you want to use different codes to track provider time, you can edit these under Misc. Utilities\Various Data Settings:



And choose Set Productivity Codes:



Here you could add a code if needed, for something like “Long Term Illness”, or you could delete a code you don’t want to use.

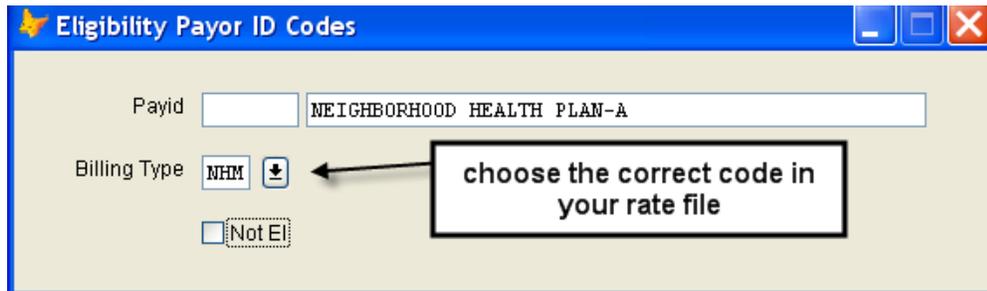
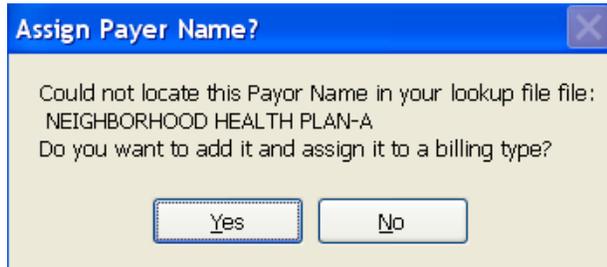
Thom Eligibility Checks

Introduction

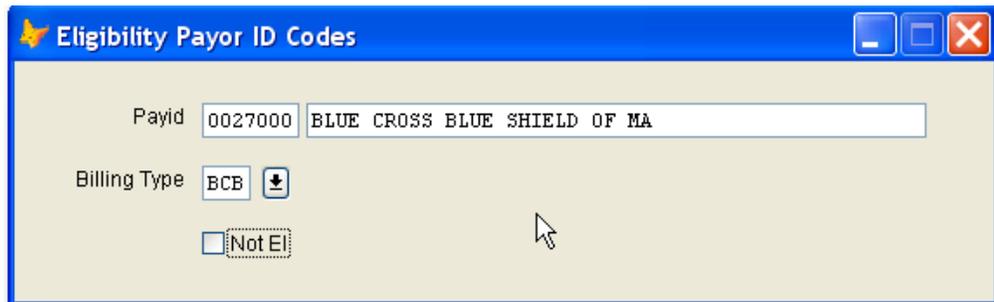
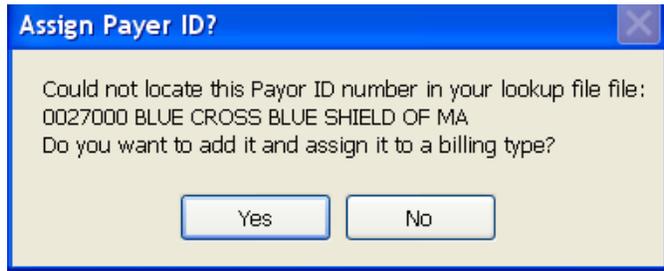
This is an introduction

Mapping files

For example,



Note, the MCOs no longer have PayID values, only names.



Other third party coverages in the EVS file do have HIPAA payer IDs that are longer than before.

Again, as before, if a coverage is for “Dental” or “Mental Health” services, you may as well save it in your Eligibility Payor ID Code file but mark it as “Not EI”.

Eligibility Reports

First report (same as before but with a couple additional fields): Clients MassHealth reports as eligible that are active in your system. No action is needed, do preview the entire report to be sure that all the clients are being checked that you think should be checked.

Eligibility Record						Located Client In Thom Database			
Client	Bill	Elig	Eli Date	PCC Name	Client	Prog	CID	DOB	Coverage
DOB	Subscriber ID		Needs Auth	PCC NPI PCC Phone					
██████████ HALEIGH 03/26/2007	MED 100047544653	E	07/08/2009 Y	NORTH SHORE 1912047788 9784064234	██████████ HALEIGH 17 20006218			03/26/2008	ACTIVE COV
██████████ IN 11/06/2007	MED 100049986605	E	07/08/2009 Y	PENTUCKET MEDICAL 1609872886 9785213210	██████████ MARTIN 17 20006405			11/06/2007	ACTIVE COV

Note the new PCC NPI and Phone information. Also the “Needs Auth” field with “Y”es or “N”o values for needs authorization.

Second report (same as before): Clients MassHealth says are ineligible but that you have as active. These need attention and you should investigate the proper coverage settings for these clients.

Eligibility Record						Located Client In Thom Database			
Client	Bill	Elig	Eli Date	PCC Name	Client	Prog	CID	DOB	Coverage
DOB	Subscriber ID		Needs Auth	PCC NPI PCC Phone					
██████████ DR 09/20/2007	MED ██████████ 5146	I	07/08/2009 N		██████████ WOR 17 20007162			09/20/2007	ACTIVE COV

Third report (same as before): Clients reported as ineligible by MassHealth that you correctly have as closed coverages. No action needed.

Eligibility Record						Located Client In Thom Database			
Client	Bill	Elig	Eli Date	PCC Name	Client	Prog	CID	DOB	Coverage
DOB	Subscriber ID		Needs Auth	PCC NPI PCC Phone					
██████████ IDEN 03/29/2007	MED 10 ██████████ 0602	I	07/08/2009 N		██████████ IDEN 17 20006523			03/29/2007	CLOSED COV
██████████ BENJAMIN 11/25/2006	MED 10 ██████████ 6172	I	07/08/2009 N		██████████ BENJAMIN 17 20006795			11/25/2006	CLOSED COV

New “Needs authorization discrepancy” report: Clients that have either a Yes or No for Needs Authorization according to MassHealth (need a PCC referral number), but you have a different setting on your MED coverage record (the new Needs Auth box

Eligibility Record					Located Client In Thom Database		
Client	Bill	Elig	Eli Date	PCC Name	Client		
DOB	Subscriber ID		Needs Auth	PCC NPI	Prog	CID	DOB
				PCC Phone			Coverage
██████████	NIKA	MED	E	07/08/2009	██████████	NIKA	
05/01/2008	██████████5378		N ←		17	20007332	05/01/2008 ACTIVE COV

PCC NPI discrepancy report (new report that shows clients whose PCC NPI is different than what you have on your Authorization record and that you should investigate):

Eligibility Record						Located Client In Thom Database			
Client	Bill	Elig	Eli Date	PCC Name		Client			
DOB	Subscriber ID		Needs Auth	PCC NPI	PCC Phone	Prog	CID	DOB	Coverage
██████████	██████████	MED	E	07/08/2009	NORTH SHORE	██████████	██████████	██████████	██████████
03/26/2007	██████████	553	Y	1912047788	9784064234	17	20006218	03/26/2008	ACTIVE COV

Error report:

Eligibility Record						Located Client In Thom Database			
Client	Bill	Elig	Eli Date	PCC Name		Client			
DOB	Subscriber ID		Needs Auth	PCC NPI	PCC Phone	Prog	CID	DOB	Coverage
██████████	██████████	MED	/ /			██████████	██████████	██████████	██████████
03/19/2007	██████████	339550	N			17	20007104	03/19/2007	CLOSED COV

Error codes: N 75 C

Error: Subscriber/Insured not found

Follow up action: Please correct and resubmit

Reported Third Party Coverage Has No Coverage Match (same as before). MassHealth is reporting a third-party coverage that you do not have in your system. This, of course, depends on you having mapped the reported coverages to your rate file the first time they came up. In the example below, we already had an Eligibility Payer record mapping “Network Health” to our “OTM” billing type. (You probably use a different code for Network Health).

07/08/2009 Eligibility Line Records by Client Page: 1

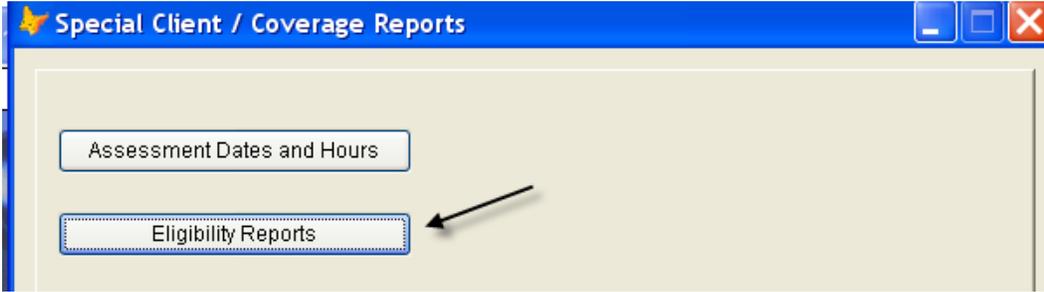
Reported Third Party Coverage Has No Coverage Match

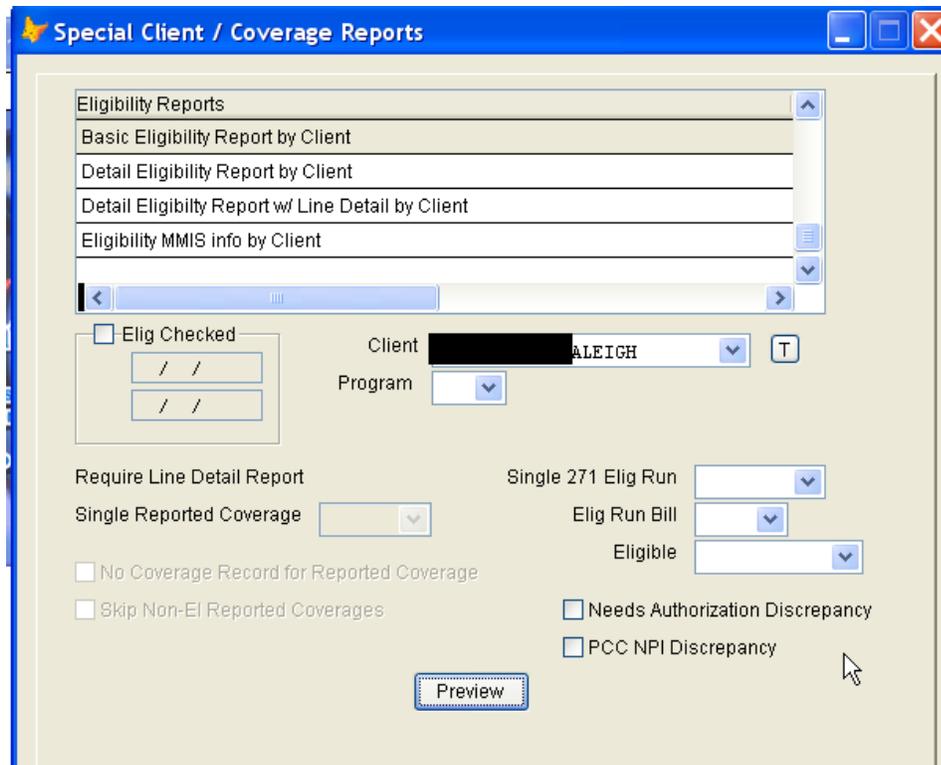
Client DOB	Eligibility Record				PCC Name			Located Client In Thom Database			
	Subscriber ID	Bill	Elig	Eli Date	PCC NPI	PCC Phone	Client Prog CID	DOB	Coverage		
05/01/2008	██████████	AJNIKA	MED	E	07/08/2009		██████████	AJNIKA	17 20007332	05/01/2008	ACTIVE COV

246 EXEMPT FROM COPAY ON PHARMACY SERVICES UNDER 130 CMR 450.130(D).
 186 EXEMPT FROM COPAY ON NON-PHARMACY SERVICES UNDER 130 CMR 450.130(D).
 056 NETWORK HEALTH MEMBER. For Medical Services call 1-888-257-1985.
 For Behavioral Health Services call 1-888-257-1986.

Bill	Result	Payer name	PayerID	Eli Date	Not EI	Policy Number	Matched cov
OTM	NO COV	NETWORK HEALTH		07/08/2009			

As before, you can go back and generate your own eligibility reports from Reports/Special Client Reports:





Here is a single client report, but you can also set a variety of other conditions.

07/08/2009 Eligibility Records by Client Page: 1

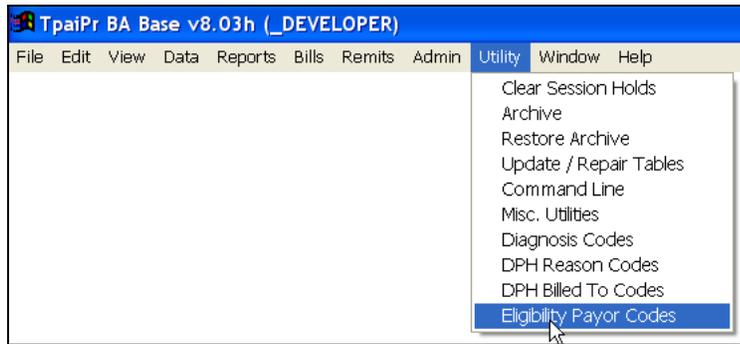
Client: ██████████ HALEIGH

Eligibility Record						Located Client In Thom Database			
Client	Bill	Elig	Eli Date	PCC Name	Client	Prog	CID	DOB	Coverage
DOB	Subscriber ID	Needs Auth		PCC MPI PCC Phone					
██████████ HALEIGH 03/26/2007	MED ██████████ 7544653	E Y	07/08/2009	NORTH SHORE 1912047788 9784064234	██████████ ED,HALEIGH	17	20006218	03/26/2008	ACTIVE COV
██████████ LEIGH 03/26/2007	MED ██████████ 44653	E Y	07/08/2009	NORTH SHORE 1912047788 9784064234	██████████ MED,HALEIGH	17	20006218	03/26/2008	ACTIVE COV

Count: 2

Managing the Payer ID lookup table

For base and standalone systems, if you make a mistake and assign a payer ID to the wrong billing type during your early Thom Revs runs, you can edit the lookup table under Utilities:



This brings up the same screen you have seen before, but you can use the normal toolbar controls to navigate, edit, or delete any record.

