Optum

User Guide

Intelligent EDI 23.4

December 2023

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Getting Started

You may access the Optum Intelligent EDI Portal using the One Healthcare ID link provided via email from your Provisioning Administrator. The email instructs you to create your One Healthcare ID profile account, and send your One Healthcare ID to your Provisioning Administrator.

You will use your One Healthcare ID (aka username) to log in and access the Intelligent EDI Home page.

Currently, your One Healthcare ID can be set up with or without the use of an authenticator, however the use of an authenticator may soon be required. Certain options are available based on your particular application configuration, and the forms applicable to your situation are displayed as you move through the setup process.

When you have completed the steps to set up your One Healthcare ID account your Provisioning Administrator activates your username and applicable roles, and sends you the URL for the Optum Intelligent EDI – https://healthid.optum.com

Going forward you have the ability to manage your One Healthcare ID Profile, including self-service recovery setup, and your Cloud Profile preferences.

Note that the One Healthcare ID Profile page provides links to access Privacy Policy, Terms of Use, and Accessibility information. You may access Copyright and License information related to the Portal using that link in the page footer, and use the Optum logo to return to the Home page.

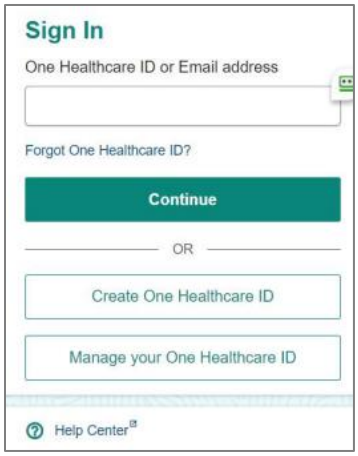
Set up One Healthcare ID Account

Setting up your One Healthcare ID Profile account includes the following steps.

- Create your One Healthcare ID – store personal information necessary for account recovery, store email address, Username, and Password where required
- Verify Email Address – validate your email address (certain users must verify phone number)
- Provide One Healthcare ID to Provisioning Administrator – via personal communication
- Sign In – respond to any questions for security and device recognition
- Setup Authenticator – this option selection may be offered after logging in

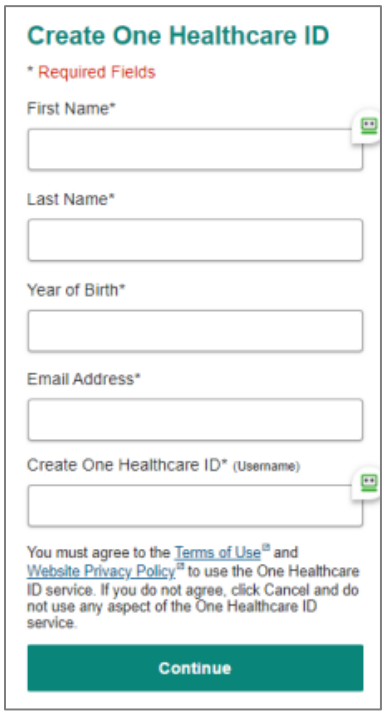
Create One Healthcare ID

Begin by using the One Healthcare ID link to open the Sign In form and select the Create One Healthcare ID button, or by using the link in your initial email message to directly access the Create One Healthcare ID form.



You must complete the required portions of the Create One Healthcare ID form, which includes personal information and may require a Password. A particular form is provided based on your application configuration, such as the sample image shown below.

It is important to note that clicking the Continue button indicates your acceptance of One Healthcare ID service Terms of Use and Website Privacy Policy.

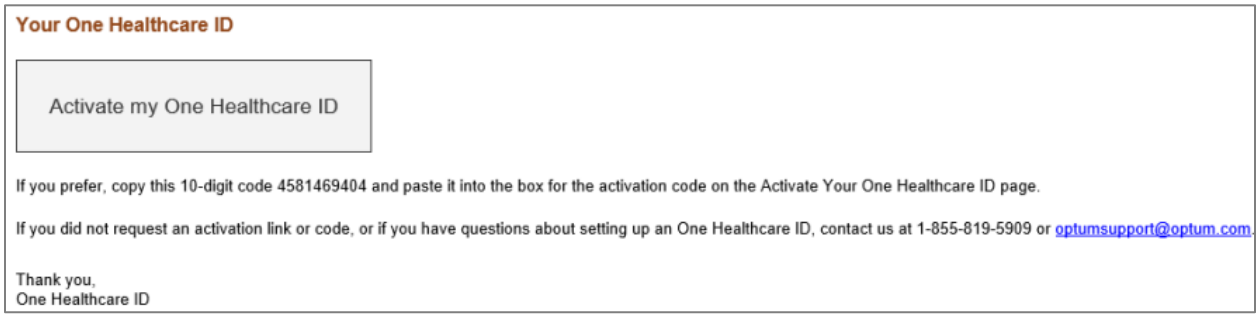


You are prompted as needed for current constraints related to One Healthcare ID (aka username) and password selection, if necessary, and any missing elements. A password must satisfy current security standards, and it is case-sensitive.

Follow the prompts to complete the form, which generates an automated email response.

Verify Email Address

Upon successful completion of the Create One Healthcare ID form you must check your email for the automated email response in order to verify your email address and activate your One Healthcare ID.



Select the Activate my One Healthcare ID button, or copy and paste the activation code onto the form displayed to verify your email address.

A success message displays when your email address is verified. You may need to select Continue to complete the action.

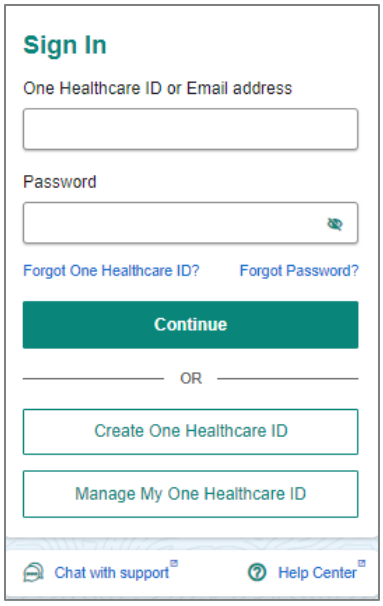
If you are using a shared email you may be instructed to provide additional information to secure access, such as a phone number or security questions and answers that you have selected. This information can be later used if you are prompted to verify your identity.

Provide One Healthcare ID to Provisioning Administrator

You must provide your One Healthcare ID to your Provisioning Administrator to gain appropriate access.

Sign In

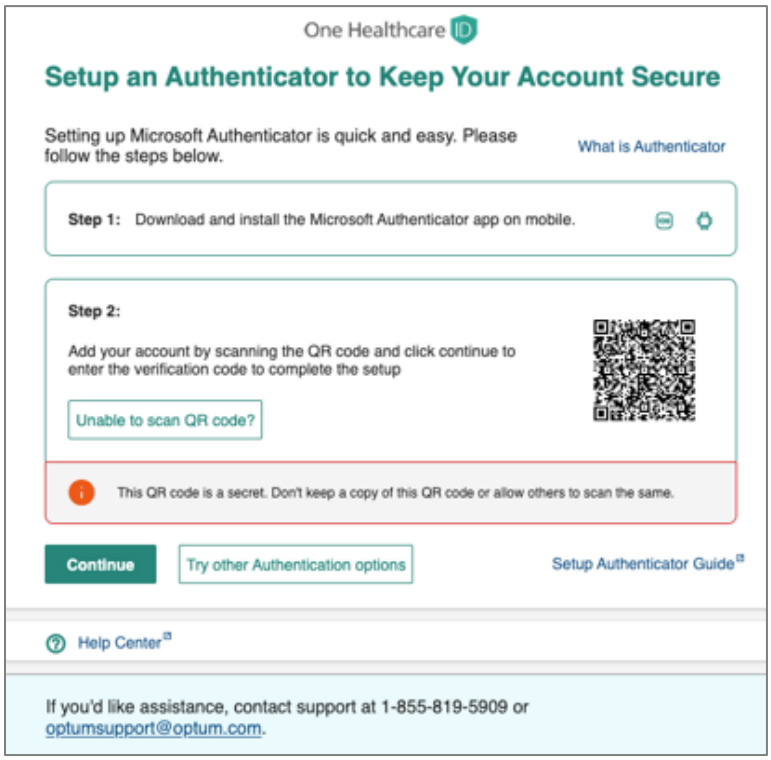
Use the One Healthcare ID link to access your applicable Sign In form. A particular Sign In form displays based on your application configuration, and may or may not require you to enter a Password.



Setup Authenticator

After logging in you may be offered the option to set up an authenticator by completing the current steps, such as described in the Setup an Authenticator to Keep Your Account Secure form as shown below.

Using an authenticator eliminates the need to maintain a password, and is more secure.



Note that you can select the Try other Authentication options button, if you wish to set a password. Complete the applicable form displayed and submit. A success message displays when your Password is set up.

Authenticator provides various avenues when you are prompted to verify your identify, such as via text message, email, a call, or via Authenticator.

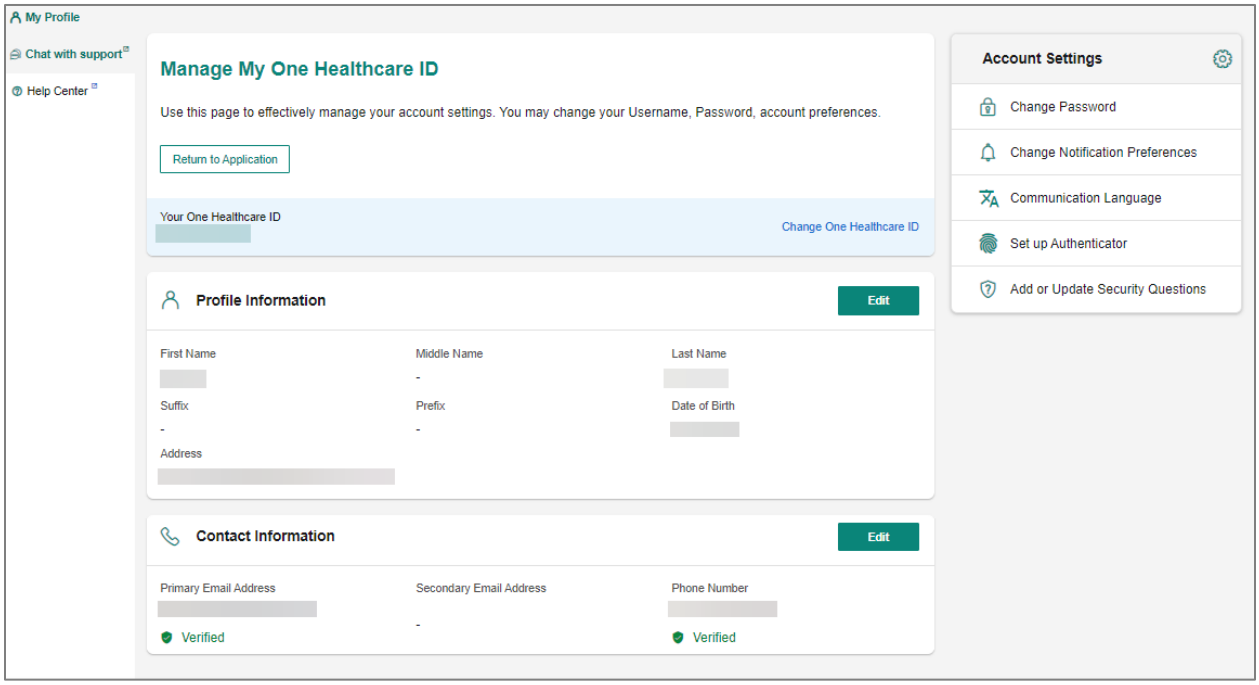
Manage One Healthcare ID Profile

You can access and manage your One Healthcare ID Profile using the Profile option in the page banner (in the drop down by your name) and selecting the One Healthcare ID Profile link.

Manage the following from your One Healthcare ID Profile:

- **Manage My One Healthcare ID** – Change One Healthcare ID
- **Profile Information** – update your personal information
- **Contact Information** – you must ensure that your current email address and phone number is stored in your One Healthcare ID Profile to receive alerts from the Portal, and to facilitate self-service recovery of your account
- **Account Settings** – Change Password (note that you are required to change your password every 90 days); Change Notification Preferences for alerts (email or text message); Add or Update Security Questions to support notifications and self-service recovery; Set up Authenticator; and select Communication Language

You may edit your One Healthcare ID Profile as needed via the One Healthcare ID Profile link. Select Save when your updates are complete, and use the Return to Application link or simply return to the Home page.



If you need guidance you can select the Help Center option, or Chat with support.

Self-Service Recovery

You must ensure that your current email address or phone information is stored in your One Healthcare ID Profile to receive alerts, and to facilitate self-service recovery of your account.

The Notification Preferences provided on the Manage Your One Healthcare ID page enable you to request an alert for the events you designate via email or text message.

You have recovery links provided at Sign In if you forgot your One Healthcare ID, Username or Password.

To verify your identify and ensure account security you may be challenged to answer your selected Security questions, to receive and enter verification code, such as via email, text, or phone call.

Note that any requested email notifications are sent to your primary address stored in your One Healthcare ID Profile. You may edit your One Healthcare ID Profile as needed.

Forgot One Healthcare ID

Use the Forgot One Healthcare ID link at login, and follow the applicable prompts, such as entering your email address, to receive your One Healthcare ID.

Forgot Password

Use the Forgot Password link at login to initiate a reset of your password, and follow the applicable prompts, such as entering your email address. You may be required to confirm your identity. Reset your password when prompted.

Account Recovery Attempt

If you lose access to your email address you can use the Forgot One Healthcare ID link at login, which provides self-service recovery using your email address.

Unlock Your Account

A Password locked form displays if your account becomes locked. Follow the applicable prompts to confirm your identity. You may be required to contact Support in order to have your account unlocked.

Cloud Profile

You can access your Cloud Profile with the Profile link in the page banner (in the drop down by your name) to access your Cloud Profile.

Your Cloud Profile enables you to store application-specific selections, such as communication options, based on your applicable role assignments.

For example, you can select to receive email notification of new enrollment forms.

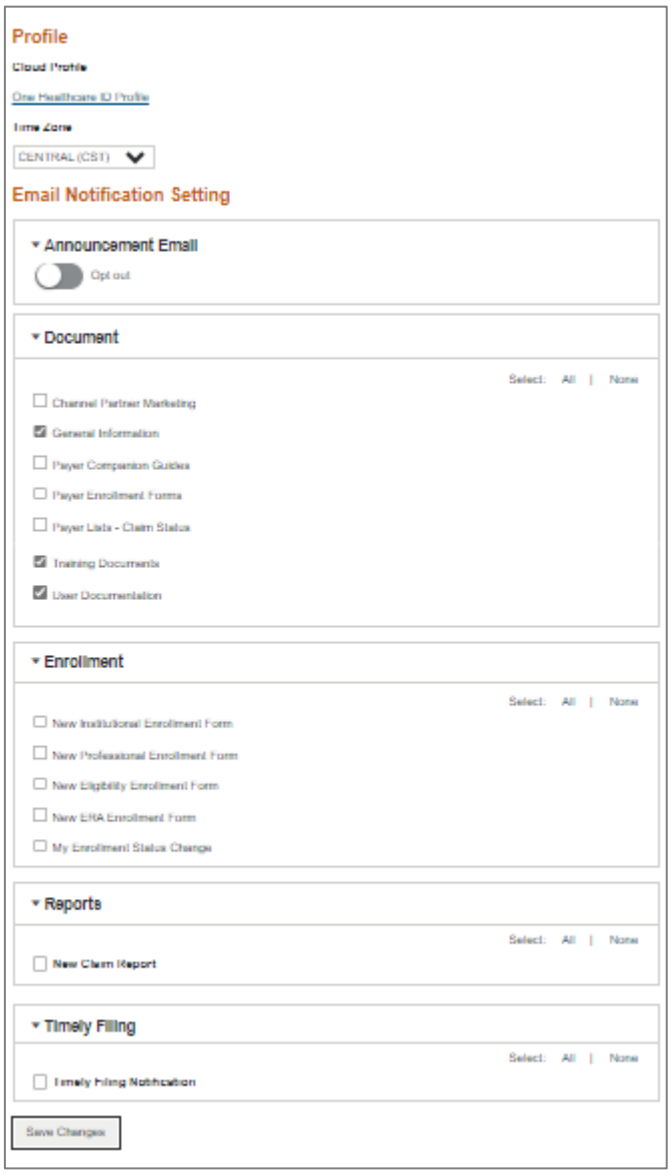
You may also reselect your default Time Zone. All times displayed in the applications are based on the Time Zone set in your Cloud Profile.

You can select your preferred election options under the Email Notification Setting, such as:

- Announcement Email – to opt out of receiving Intelligent EDI announcements
- Document – select desired categories to receive email notification of related document uploads

- Enrollment – select to receive email notification of new enrollments or My Enrollment status changes
- Reports – select to receive email notification of completed reports availability
- Timely Filing – select to receive email notification alerting that you have claims approaching timely filing thresholds

All electronic communications are sent to your primary email address stored in your One Healthcare ID Profile. Access and manage your One Healthcare ID Profile as needed using that link provided in your Cloud Profile.



Navigation and Behavior

The Optum Intelligent EDI application is designed to meet best practice standards for usability, quality and consistency. Your experience in the application benefits from the uniformity of navigation and behaviors described in the following categories.

- Navigation aids
- Forms
- Search
- Results Grid
- Messaging
- Email Notification
- Compliance

Navigation aids

Tabs – navigation is managed primarily with tabs on the Home page, and on topic pages as needed.

Links – links are provided in the page banner for related activity, e.g., to sign out.

Breadcrumbs – breadcrumbs are displayed at the top of a page to indicate where you are in the site hierarchy. Use breadcrumb links to return to a previous page, which is preferable to using the back arrow.

Icons – intuitive icons are used throughout to facilitate your activity, such as the calendar date picker, edit or delete, a magnifying glass for a closer search, expand/collapse to view more/less details, and a gears icon to access certain Utilities.

Alerts – if you do not have your cursor in a field and you click the Backspace key the response is that of the browser Back button, i.e., you will be navigated to the previous page.

Forms

Form Elements	Description
Dates	Date fields are to be completed numerically as MM/DD/YYYY. You may enter a date or select a date using the calendar icon.
Names	Names are displayed as Last, First, Middle, Suffix, Title, however, the form fields for entering names are ordered as Title, First, Middle, Last, Suffix.
Phone/Fax Numbers	Phone/fax numbers are to be formatted as (xxx) xxx-xxxx. If your activity requires you to enter a phone/fax number the following mask appears on the field: (___) ___-____
Required fields	Required fields are denoted by a red asterisk to the left of the field label. If all fields are required within a form, a message in the lower left of "All fields required." shall be used in place of asterisks
Drop Down	The default value for a drop down list is Select, which returns all items. You can limit the results by choosing a specific filter from the drop down. List options include only items that have a valid relationship to your activity.

Form Elements	Description
	Lists are generally sorted alphabetically.
Status	Status generally defaults to Active in a new form.
Cancel	The Cancel hyperlink returns you to the previous screen or screen state without saving any changes.
Calendar Picker	Once the date field is completed and saved, if the calendar picker is reopened the date will not refresh to the current date.

Search

Search features described here may refer to the submission of a search form, or to the auto-completion of a single form field.

Your search results are always determined by your login as a particular Billing Entity (default Billing Entity), or your subsequent reselection of a Billing Entity in the page banner.

Intelligent EDI is designed to ensure an effective search with valid results. Your search results will only contain potentially valid options. For example, search results are related only to the Billing Entity that you are logged in as; and drop down and auto-completions reflect only potentially valid options.

Auto-Complete Search

An Auto-Complete feature facilitates completion of certain fields, and is the most commonly used search feature. Searches generally return only those results that are in an Active status.

Enter at least the first two characters into a field to generate possible matches that begin with those two characters. The field may begin populating at once, or you may need to select from a drop down to auto-populate fields with available data.

The Auto-Complete feature may also apply stored data to related fields. For example, when you select a Provider the contact information fields may auto-populate, or when you select a Dependent the Subscriber fields may auto-populate.

Wildcard Search

For a wildcard search enter at least two characters in a field to generate possible matches that contain the exact sequence of characters you entered. Searches generally return only those results that are in an Active status.

The * asterisk character may not be substituted as an unknown in the wildcard search function. If you search using an asterisk your result is an asterisk.

All search results are based on your login as a particular Billing Entity. Your current login is shown in the page banner, but you may need to refresh if you select another Billing Entity.

Search fields require a two character minimum, unless the value is null or two characters have been entered in an alternate field within the search form (such as 'Br' in last name and 'R' in first name). Each search field is limited to the maximum number of characters that corresponds to that field.

Use the Tab key to move from one field to the next, moving left to right from top to bottom. Use the Enter key to initiate the search, or click Search.

Use the Clear Criteria link to clear any entries from the fields. For example, after a search has been executed, the Search Criteria bar displays the search values you selected. When you click Clear Criteria the Search Criteria bar no longer displays and the results grid refreshes to display the previous results.

If you are expected to make a selection from the results grid the field entries in the first column are hyperlinked for your convenience.

Results Grid

Result Grid Elements	Description
Number of Records	The Total Number of items returned is indicated above the results grid, but generally only ten records are displayed per page.
Active/Inactive Display	The results grid generally displays only Active status records, but a Show Inactive checkbox is offered if Inactive records are available. Click the Show Inactive checkbox to refresh the grid and show the inactive items within the current sort order of the grid. Inactive items have a distinctive appearance, such as grayed out or disabled. Inactive items are displayed until you uncheck the Show Inactive checkbox, perform a new search, or navigate to a different page.
Filter	Certain results grids provide additional filter options, such as accepted or rejected records.
Sort	Results are generally sorted by the contents of the first column. Exceptions are noted in specific topic descriptions. Use the double arrow icon in any column header to sort the results grid in ascending or descending order. Columns are generally sortable. (Note that grids do not scroll.)
Pagination	Pagination links are generally provided when more than 10 rows of data are returned so that you may move back and forth in the search results.
View Record	Generally, you can click a single row to view additional details, or open a related form.
Action Options	Related action options are displayed at the end of each row. Option links may be displayed as text or intuitive icons.
Checkboxes	You can generally check one or more row checkboxes to select items. You may check the header checkbox to select all of the items, but this may be limited to the items displayed.

Messaging

Messages are provided for your guidance or response. Messages are displayed in ways appropriate to the context, such as in a message or lightbox, as red text on a form, or as hover text.

Interactive messages – message boxes are used to provide information or request confirmation. After reading an informational message you may click the Close hyperlink. Confirmation boxes are requesting a response, so you may click OK to proceed on your path, or click Cancel to remain in place. (Based on the context you may see Yes and No buttons instead.)

Messages – examples of typical message include the following:

- Your changes have been saved.
- Subscriber – Birth Date: Value is required.
- There is a duplicate file entered.
- No records met the search criteria.
- This NPI is already in use for this Billing Entity. Please enter a unique NPI.
- You are not authorized to access this area. Please contact your administrator for further information.

Progress Bar – a progress bar may display while data is being retrieved.

Tool Tip – tool tips (or hover help) may be presented as an icon, orange text, or a combination of both. You may hover a tool tip to obtain additional information.

Email Notifications

Certain notifications are delivered automatically to you via email. You can opt out of receiving particular emails by clicking the 'here' link provided in the email.

Log into the Portal and go to your Cloud Profile to indicate your preferences for receiving automated emails. You may update these selections at any time.

Compliance

Features are designed to mask or avoid display of information, such as Social Security Numbers, in compliance with privacy regulations.

Login as Customer/Billing Entity

When you access Intelligent EDI you are automatically logged in with your default Customer or Billing Entity, if applicable. Your login allows you to access particular information and perform related tasks.

If you are provisioned aka set up to work under more than one Customer and/or Billing Entity you may reselect one of those as your login. The results of your activity in Intelligent EDI are always determined by your current login.

Your selected login persists as you navigate pages, and is displayed in the Intelligent EDI page banner. You may change your login at any time, from any page.

Your selection of a particular Customer or Billing Entity governs all subsequent activity and results. Your login governs all system activity, such as data security, information returned, and which records are affected by your actions.

You may wish to perform tasks by logging in at the Customer level or the Billing Entity level. Certain constraints apply to these logins, as described in the following table.

- If you select a Customer login the information and tasks for all of the associated Billing Entities are made available. The Customer login is not always an option, as shown in the table.
- If you select a Billing Entity login only the information and tasks applicable to that particular Billing Entity are made available.

Change Login

The login pane displays in each page banner and allows you to select an alternate login, and also to view additional details.

Your default Customer or Billing Entity must be changed by an administrator.

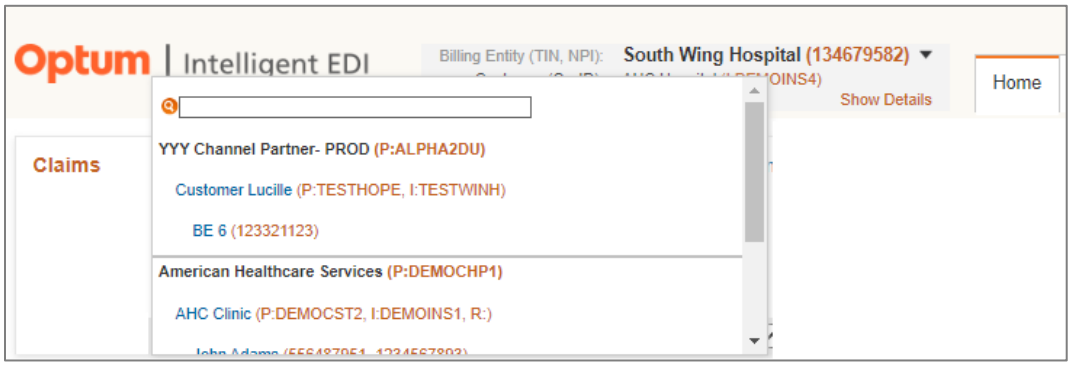
Click the Billing Entity/Customer login to open or close the drop down that contains a hierarchy of your Channel Partners, Customers, and Billing Entities. (To move through the listing use the tab key to move down, and shift+tab to move up.)

To change your login click the desired Customer or Billing Entity (or tab to your selection and use the Enter key).

Click the Show Details checkbox in the login pane to expand the pane, as shown below. Details are truncated within the banner, but you can hover to view the full information or use the drop down.

When you have selected Show Details the drop down includes the following information for your available Channel Partners:

- Customer OrgID prefixed with a letter to provide clarification as P-Professional, I-Institutional, or R-Remittance, as shown below
- Billing Entity TIN, and also NPI where applicable



You can use the search field (top of drop down) to conduct a wildcard search by name or number. For a wildcard search enter at least two characters to generate possible matches that contain that exact sequence of characters.

The search results displays the associated Channel Partner, Customer, and Billing Entity – not just the precise wildcard search results. That is, if a Billing Entity contains your search criteria but the Customer does not – the Customer aligned with that Billing Entity is also displayed to ensure clarity.

Functionalities Affected by Customer versus Billing Entity Login

Functionalities	Customer Login	Billing Entity Login
Claim File Upload	(no Customer login option)	Billing Entity login only
Claim File Reports	Provides all associated Billing Entities	Provides only for that specific Billing Entity
Claim Search	Provides all associated Billing Entities	Provides only for that specific Billing Entity
Claim Payer Reports	(no Customer login option)	Billing Entity login only
Check Claim Status	(no Customer login option)	Billing Entity login only
Check Patient Eligibility	(no Customer login option)	Billing Entity login only
Eligibility Search	Provides all associated Billing Entities	Provides only for that specific Billing Entity
Reverify Patient Eligibility	New request uses the Billing Entity used on the original request	Request shows under your current Billing Entity login
Eligibility Search - original request	Request shows under the Billing Entity used on the original request	Request shows under your current Billing Entity login
Eligibility File Upload	(no Customer login option)	Billing Entity login only
Eligibility File Upload History	Provides all associated Billing Entities	Provides only for that specific Billing Entity
Utilities - Patient Maintenance and Provider Maintenance	(no Customer login option)	Billing Entity login only

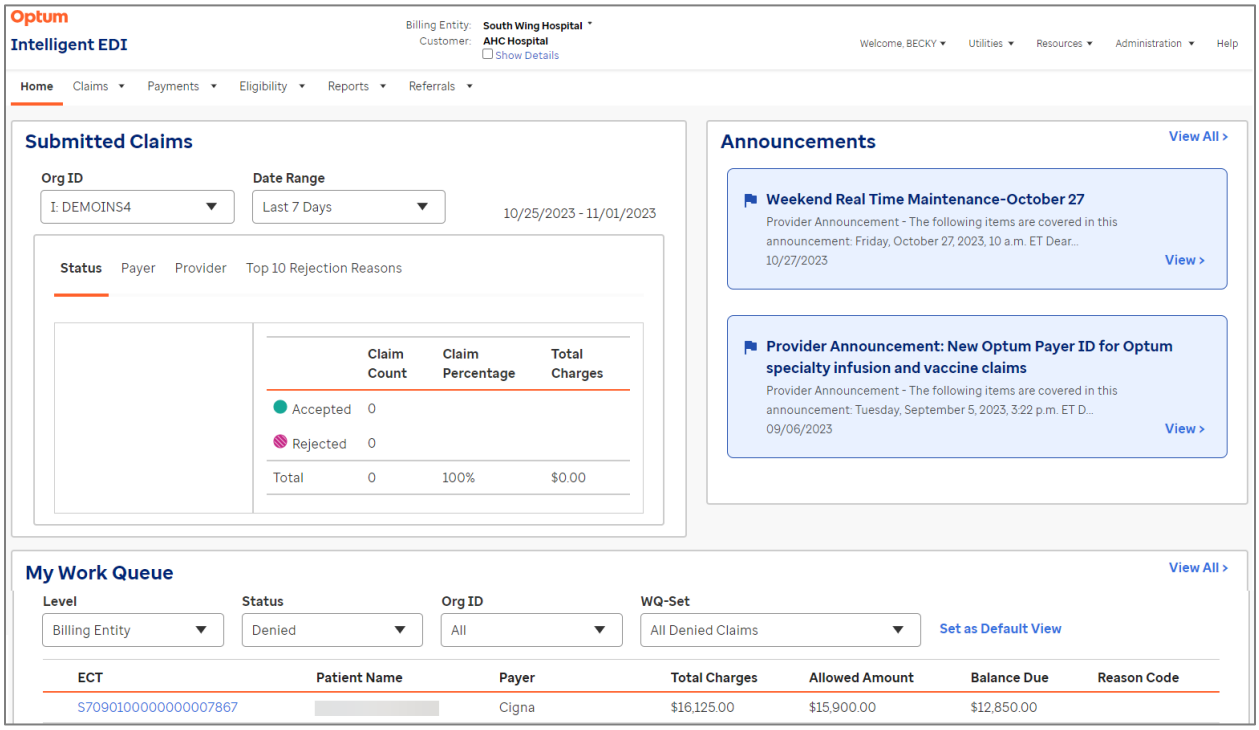
An advisory message displays if you attempt access under an invalid login. For example, if you are logged in under a Customer login and navigate from Eligibility Search to Check Patient Eligibility a message displays, such as, “You are attempting to check Patient Eligibility at a Customer level. Please select a Billing Entity in order to check Patient Eligibility.”

Home

When you access Intelligent EDI you are automatically logged in with your default Customer or Billing Entity, if applicable. Your login allows you to access particular information and perform related tasks.

The Optum Intelligent EDI Home page provides an interactive dashboard containing elements such as the following:

- Announcements -- pertinent to Intelligent EDI
- Submitted Claims – reports by Status, Payer, Provider, Date, and Top 10 Rejection Reasons
- My Work Queue -- your personal Work Queue



The Home page also contains the following:

- Your Login pane, which reflects your current Customer/Billing Entity login
- Banner links, such as Utilities, Resources, Administration, Help, and also your personal Welcome, which provides a link to your Profile, and to the Sign Out option.

It is suggested that you select Sign Out from any page banner (in the drop down by your name) when you are ready to end your session. You may select the Optum Intelligent EDI logo to return to login page.

Announcements

Task: Monitor timely alerts related to business or system issues

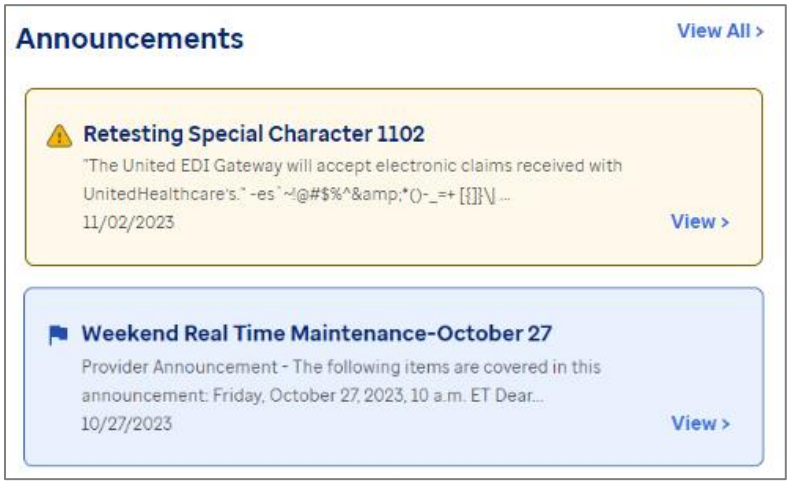
Navigation: Home/Announcements

Announcements related to Intelligent EDI activity are published on the Intelligent EDI Home page.

Certain announcements are also emailed to Intelligent EDI users. Recipients of email announcements have the option to opt in or opt out of receiving future announcement emails by navigating to their Profile and changing the Email Notification Setting for the Announcement Email.

High Priority announcement titles are flagged with an alert icon, and always remain at the top of the list.

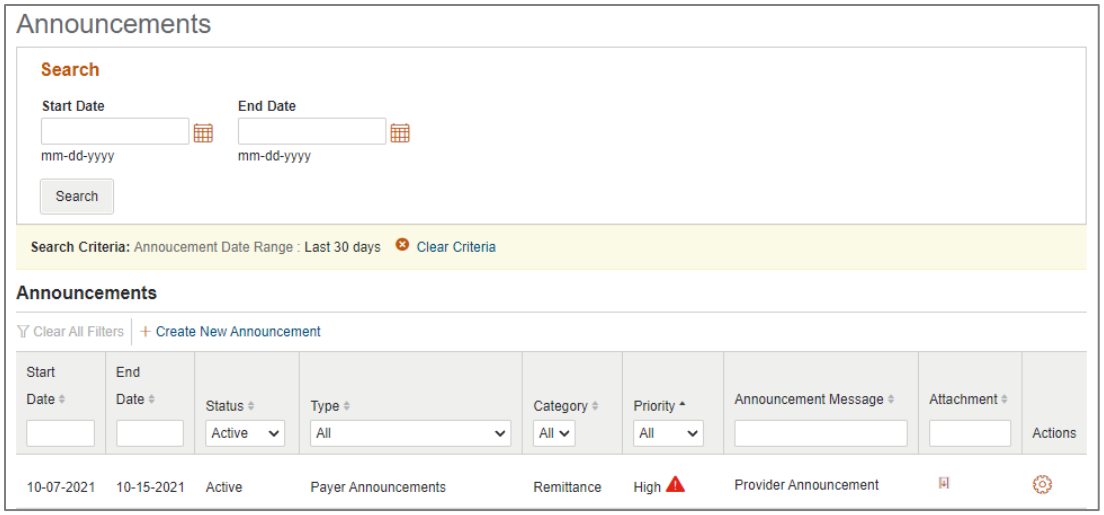
A minimal number of announcements are previewed on the Home page. To view an entire announcement use the View link in the announcement preview. The expanded Announcement provides a Print icon.



Use the View All announcements link to display all announcements for the last 30 days.

Announcements are sorted by Start Date, and High Priority announcements are displayed as a group and precede all other announcements. High Priority announcements are sorted by date within this grouping.

You have the option to Search for announcements within a preferred date range by entering both a Start Date and an End Date in those Search fields.



You can filter and sort your search results using the column header fields. Enter the desired information in the empty headers, and/or select from the drop downs for Status, Type and related Category, and also Priority.

- Use the Actions icon at the end of the row and select Print to view and/or print an announcement.
- Use the Attachment icon to view and/or download an attachment.

Note that the availability of the Create New Announcement option, as well as the Actions options to Edit and Duplicate are based on user role and permissions.

Submitted Claims Dashboard

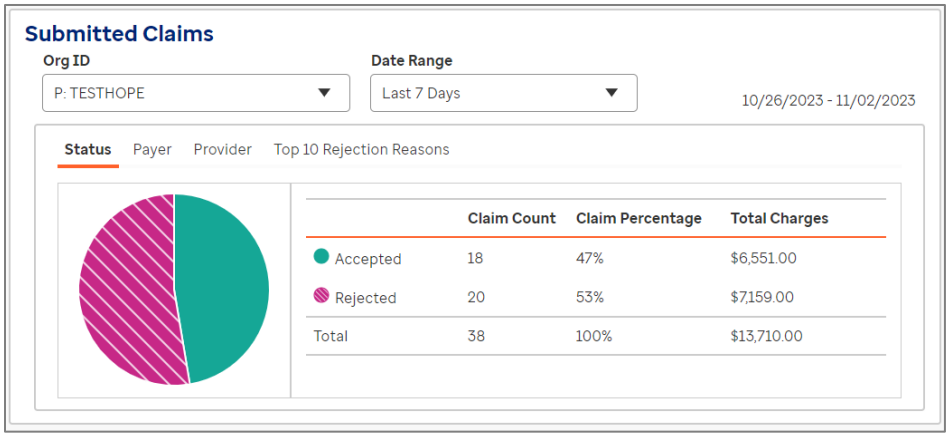
Task: See an overview of the claims accepted and rejected by category, a related rundown of claims data, and explore individual claims

Navigation: Home page/Submitted Claims

The Home page provides a Submitted Claims dashboard that reflects statistical information about claims accepted and rejected in the following categories:

- Status
- Payer
- Provider
- Top 10 Rejection Reasons

To begin a review of reported claims select an Org ID and Date Range from those drop downs. Choose a Date Range to view results for the previous 7 days, 30 days, or set a Custom range within the previous 13 months. To reset a Custom range use the Date Range drop down.



Use a link in the desired category to view the expanded Claims Data box feature, as well as a results grid listing the selected claims.

The results grid lists the claims in order by Submission Date, but the report is managed by Status Date. The claims results grid provides the following pertinent details on the Claims List page:

- Submission Date
- Status Date
- Date of Service
- ECT
- Billing Entity
- NPI
- Subscriber
- Patient Account
- Claim Amount
- Status
- Reason

You can modify the Org ID and/or Date Range, if desired, and the view refreshes to display the new results.

You may need to zoom or scroll right to see all portions of the claims grid.

You have certain options in the claims results grid:

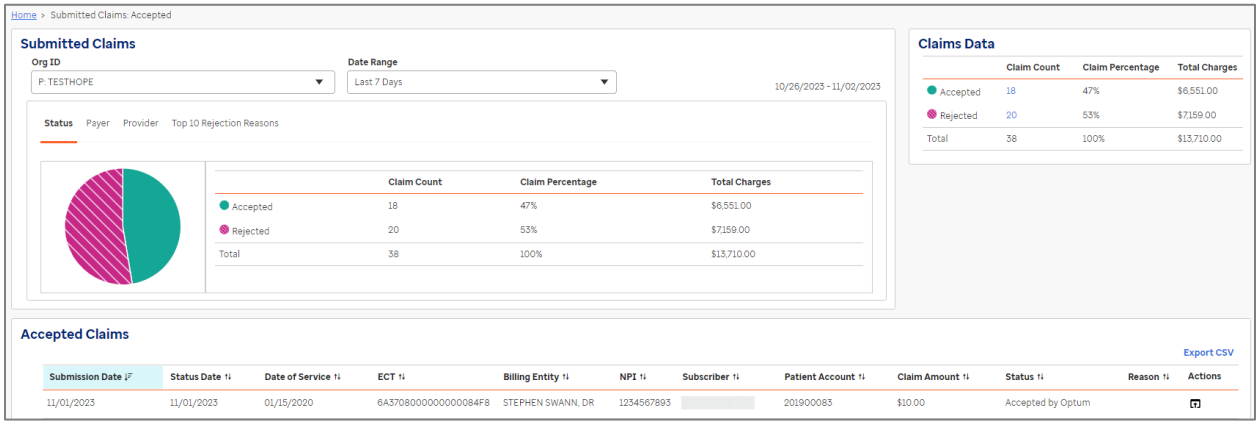
- You can hover the Reason entry to view the full length of the Reason name.
- You can click the Reason entry in order to view multiple Reasons.
- Use the View icon in the Actions column to view the claim.
- Use the Export CSV link to export the claims that are currently included in the results grid. Note that the exported file does not include any details other than what is available in the results grid.

Status

The Status report offers an interactive pie chart that contains two segments – accepted and rejected.

Select the accepted or rejected segment of the pie chart to display the Claims Data box, and the selected claims.

The Claims Data box translates the view presented in the pie chart. Select an active Claim Count link to display those claims.

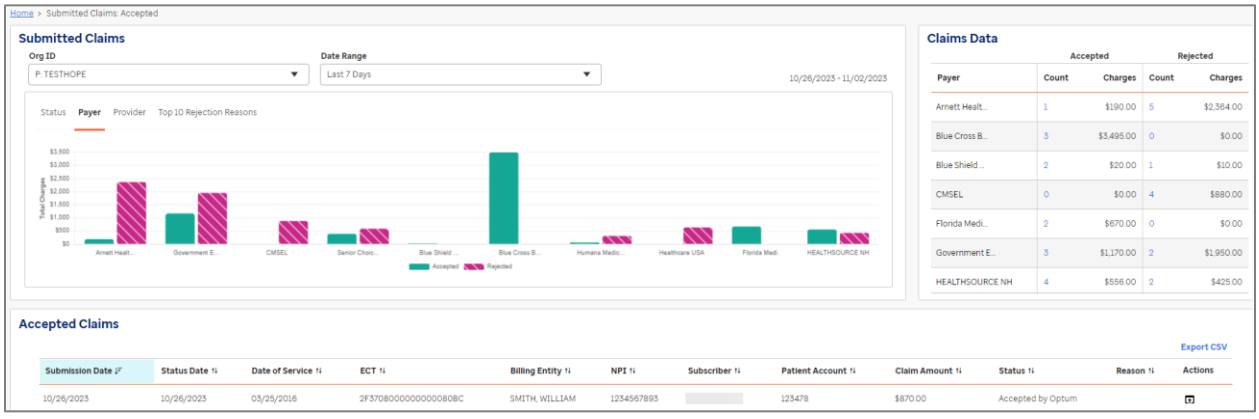


Payer

The Payer report offers an interactive bar chart that reflects the accepted and rejected ten Payers with the largest volume of claims. You may hover any bar to reveal the actual dollar value.

Select any Payer's accepted or rejected segment of the bar chart to display the Claims Data box, and the selected claims.

The Claims Data box translates the view presented in the bar chart. Select an active Count link to display those claims.

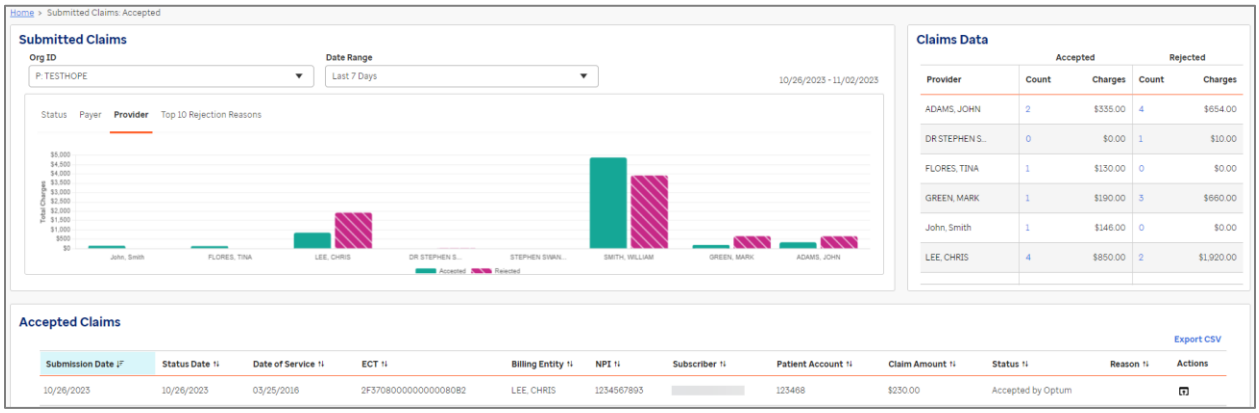


Provider

The Provider report offers an interactive bar chart that reflects the accepted and rejected ten Providers with the largest volume of claims. You may hover any bar to reveal the actual dollar value.

Select any Provider's accepted or rejected segment of the bar chart to display the Claims Data box, and the selected claims.

The Claims Data box translates the view presented in the bar chart. Select an active Count link to display those claims.



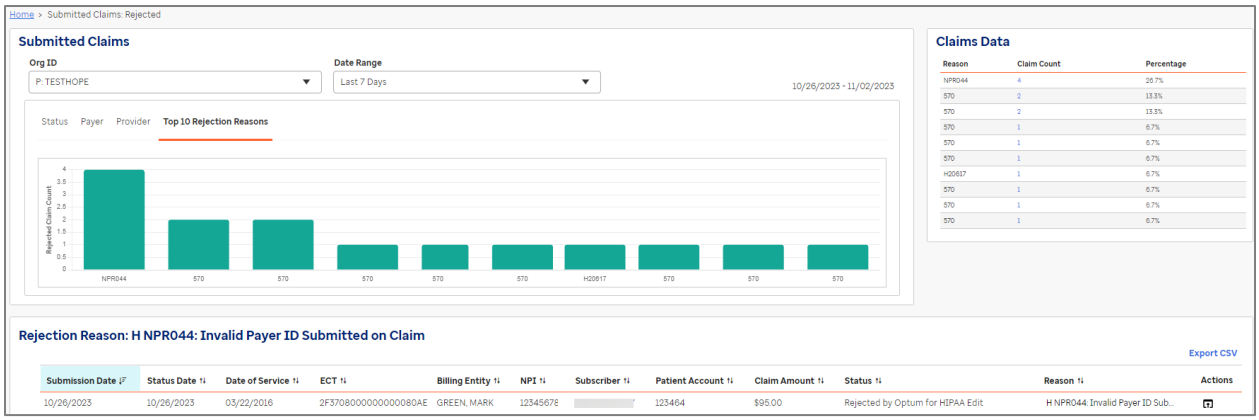
Top 10 Rejection Reasons

The Top 10 Rejection Reasons report offers an interactive bar chart that contains 10 segments that reflect the largest percentage of rejection reasons.

Select any segment of the bar chart to display the Claims Data box, and the selected claims.

The Claims Data box translates the view presented in the bar chart, and allows the following:

- You can hover the Reason entry to view the full length of the Reason name.
- You can select an active Claim Count link to display those claims.



My Work Queue

Task: Filter and view Rejected and Denied claims, self-assign claims to correct and resubmit single or bulk claims, mark resolved claims in bulk. Set a default work queue view, and customize work queue display. Based on user roles and permissions you may also assign, unassign, or reassign claims to other users.

Navigation: Home/My Work Queue

The My Work Queue feature provides a listing of all Rejected and/or Denied claims (based on Customer configuration) for the previous 13 months based on your current login, as well as Org ID, WQ-Set selections, and a WQ Claims link to facilitate your activity. A warning message and icons are provided in response to any timely filing configuration. An advisory message displays if the default Billing Entity is not affiliated with the My Work Queue service.

To begin using My Work Queue you must select from the available options, which populates the results grid:

- Level – Billing Entity Level or Customer Level
- Status – Denied or Rejected claims
- Org ID – select from the drop down
- WQ-Set – select from the drop down

Billing Entity Level or Customer Level

The viewing Level option defaults to Billing Entity. Based on your current login you may have the option to select Billing Entity Level claims only, or to select Customer Level claims, which includes all associated Billing Entities for your customer only.

The Customer Level option is available to users with specific role/permission and an error message displays if you do not have such permission, such as “You are not authorized to access this area.”

For both levels, note that an advisory message displays when a Billing Entity does not have an NPI association, which would enable rejected/denied claims to display in My Work Queue. Each Billing Entity must be edited by an administrator to add the NPI.

Denied or Rejected

For Status you must select to view either Rejected or Denied claims in the results grid. Reference to claims is clarified as follows:

Denied – received an 835 Remittance indicating the reason, due to which payer did not pay either at claim level or at service line level

Rejected – received a 277 Acknowledgement indicating a flaw in the claim, due to which the claim is not processed by payer

Org ID

The Org ID defaults to All. You can select an available Org ID from the drop down to view only those specific claims, such as Professional or Institutional.

WQ-Set

Select the desired WQ-Set from that drop down, as available based on your selection to view Denied or Rejected claims. Certain default (aka system) WQ-Sets are available to all users, such as My Assigned Claims, Unassigned Denied claims, or All Rejected Claims.

Note that at the time of this release there are two similar WQ-Sets, which are differentiated as follows:

- All Denied Claims – returns claims with Status Code 820 only
- All Denied Claims (All Statuses) – returns claims with any Status Codes applied

Your administrator may also set up customized work queue configurations (aka user defined) that allow users to filter the claim results displayed for user login.

A WQ-Set is based on customer associations, and claim results can be viewed only by users aligned with the customer designated in that particular WQ-Set.

Claims currently and specifically assigned to you by an administrator or self-assigned are available by selecting My Assigned Claims from the WQ-Set drop down

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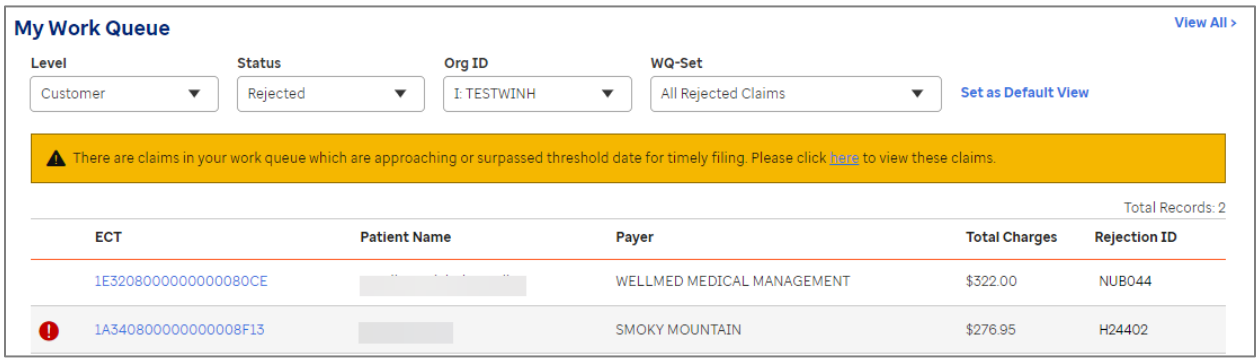
See **WQ-Set Configuration** described herein under Utilities/Work Queue Configuration.

My Work Queue results grid

My Work Queue displays up to ten records per page, sorted in descending order based on the following:

- Total Charges – in the Rejected work queue
- Balance Due – in the Denied work queue



The information listed below is provided for each individual claim in the My Work Queue results grid.

Denied Claim	Rejected Claim
ECT #	ECT #
Patient Name	Patient Name
Payer	Payer
Total Charges	Total Charges
Allowed Amount	Rejection ID
Balance Due	
Reason Code	

In the My Work Queue results grid you can hover the Reason Code or Rejection ID to display the entire message for the most recent response.

Set Default Work Queue View

You have the ability to reconfigure the default My Work Queue view by setting a single, user-specific customized view of My Work Queue. Make the desired selections in the My Work Queue fields, and select the Set as Default View link. Select Save in the displayed Set as Default View form to confirm your configuration. Your customized view will persist as the new default, but you can modify your choices at any time.

Timely Filing Email Notification

Timely Filing Email Notifications are issued for WQ-Sets configured for the timely filing threshold. You can elect to receive a weekly email notification when you have claims approaching timely filing thresholds. You must make this selection for Timely Filing Email Notification in your profile via the Profile link (in page banner by your name). These email notifications are issued in sync with any timely filing warning messages and icons displayed in My Work Queue.

WQ Claims

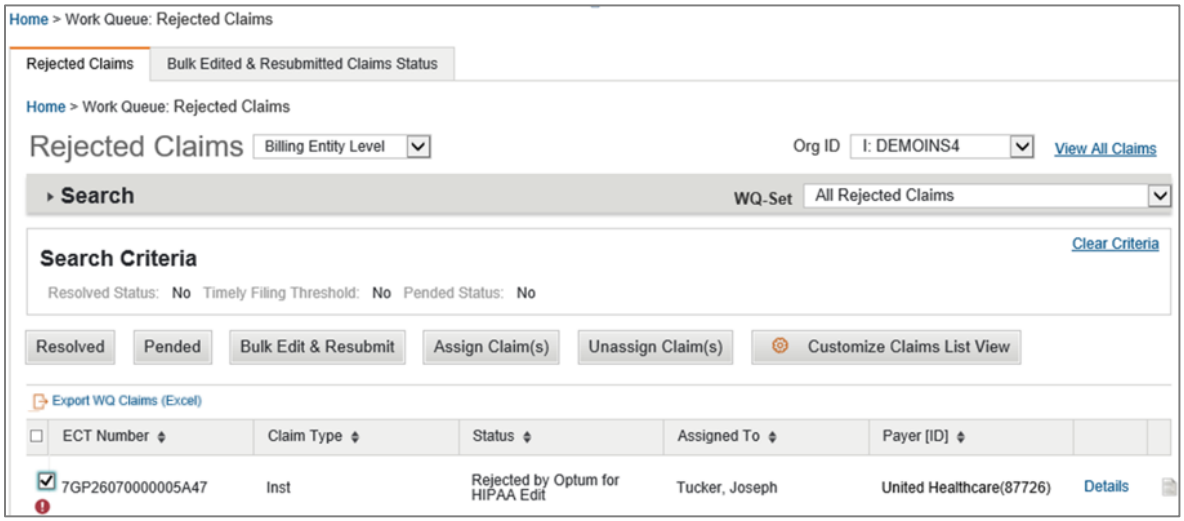
A WQ Claims link is provided at My Work Queue in the event there are no Denied or Rejected claims remaining in the selected work queue. You can use this link to access the Work Queue and search for claims based on status.

Work Queue for Denied/Rejected Claims

From My Work Queue you can select a single ECT link or the View All link to access the Work Queue for Denied or Rejected claims (for the previous 13 months) in order to begin self-assigning and resolving claims. Based on your user role you may also be able to reassign claims to other users.

If a timely filing warning is displayed in My Work Queue you may use the embedded link to access those affected claims.

The Work Queue for Denied or Rejected claim provides a View All Claims link so you have another opportunity to select to view all, if you initially selected a single row from My Work Queue.



The results grid displays a warning icon for any claim approaching or surpassing the threshold set for timely filing. The approaching timely filing gap is generally less than 5 days until the threshold date is surpassed.

By default Denied claims are sorted by Balance Due, and Rejected claims are sorted by Total Charges – both in descending order. You may use the double arrow icon in any column header to sort the results grid in ascending or descending order. (Your sort persists on subsequent pages while you perform any work queue operation.) You can revert your sort to the default sort order using the Clear Criteria or View All Claims link, or by changing the selected WQ-Set or Org ID.

Note that in the Work Queue for Denied/Rejected Claims you have tab access to view Bulk Edited & Resubmitted Claims Status.

Work Queue Search

The Search option within your Work Queue for Denied/Rejected Claims allows you to narrow the results within the WQ-Set configuration.

- If you selected a system WQ-Set this search panel is auto-populated based on the selected WQ-Set.
- If you selected a user defined WQ-Set you may use the View WQ Set Criteria link to populate the search panel based on the selected WQ-Set in order to review the work queue configuration.

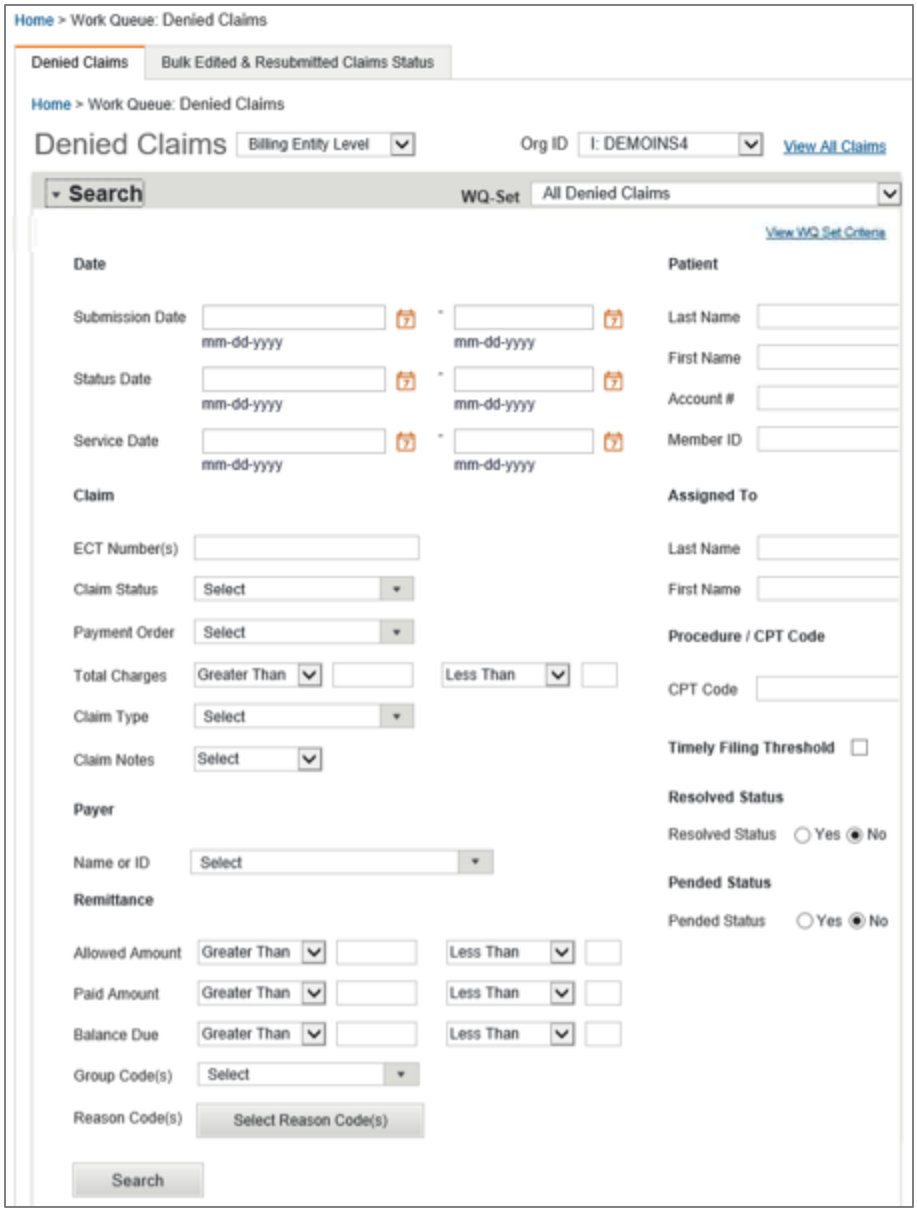
Your search may not exceed the scope of the selected WQ-Set, and you will be prompted by an error message, as needed, to refine your search to obtain accurate results. For example, the scope message displays if the Timely Filing Threshold checkbox is selected by default based on the WQ-Set configuration, and you uncheck this indicator.

To begin, select anywhere on the Search header bar to open the Search pane. To narrow your results enter any known information in the search fields, and also select desired filter options.

When you run your search the newly selected criteria is displayed in the Search Criteria pane with any initial default criteria.

- Date – Submission Date, Status Date, Service Date
- Claim – ECT Numbers, Claim Status, Payment Order, Total Charges, Claim Type, Claim Notes
- Payer – the Payer Name or ID selection is based on the Org ID selected for the WQ-Set. For a user defined WQ-Set the Payer list may be pre-populated. For a system WQ-Set use the Select Payers button to open that form. Enter the first characters to expedite this search, and use the Select Payer button to include each desired Payer for your search. Select Save to return to the Search panel where you can review your Selected Payers displayed as a list alongside the Payer field, identifying the quantity you selected. You can deselect any Payer from this filter list using the Delete icon.
- Remittance (Denied only) – Allowed Amount, Paid Amount, Balance Due, Group Codes, Reason Codes(s)
- Reason Code/Reason (Rejected only) – enter at least the first 3 characters (alpha/numeric) to filter your search results for such codes; or enter the full code to search only for that specific code
- Patient – Last Name, First Name, Account #, Member ID
- Assigned To – Last Name, First Name
- Procedure/CPT Code – enter the desired CPT Code
- Timely Filing Threshold – use the checkbox to include only those claims approaching or surpassing the threshold set for timely filing

- Resolved Status -- by default, only Unresolved claims will be included in your results grid. If you want to view Resolved claims (only) in your results grid change the Resolved Status radio button to Yes.
- Pended Status – by default, claims in a Pended status are suspended from any work queue and will not be included in your results grid. If you want to return Pended claims (only) in your results grid change the Pended Status radio button to Yes.



Claim Status

The Claim Status field allows you to search for Denied/Rejected Claims by selecting one or more Claim Status Codes.

Note that for Denied Claims (only) the Claim Status Codes are tied to claims with a remittance attached. Based on the claim status code received in an X12 claim a Status Code for the denied claim is set as shown in the table below.

CLP 02 Value	Status Code for Denied Claims	Description
1, 2, 3	810	Claim Processed Code
4	820	Claim Denied
19, 20, 21	830	Claim Processed and Forwarded to Additional Payer
22	840	Reversal of Previous Payment
23	850	Not Payers Claim, Forwarded to Additional Payers
25	860	Predetermination Pricing Only - No Payment
Any Invalid value	890	Invalid Claim Status Code received from Payer

Work Queue Results

The default Work Queue for Denied/Rejected Claims includes all available fields for each individual claim. See ***Customize Claims List View*** if you wish to reconfigure the default as a customized view.

Note the following aspects of the Work Queue for Denied or Rejected Claims.

- You can use the header row checkbox to select all records currently displayed in the results grid, in order to perform work on multiple claims.
- The Payer (ID) field provides a hover help link with that Payer phone number. You can use the link to dial that number using a soft phone (such as Jabber, Skype).
- The results grid displays only the last 3 Denial/Rejection Reasons for a claim, but you can hover that field to view any additional reasons.
- Extensive Claim Notes History (including parent/child) can be viewed using the View Notes link provided in the Claim Notes History field, and also by using the Details link.
- Note that certain information is not duplicated within individual claim results (such as Denial/Rejection Reasons, CPT Codes, Remarks Codes). For example, a particular Rejection Reason is displayed only once – it is not repeated in the results provided for that claim.

Details

You can select the Details link on the desired row for the following options.

- Status Details – view
- Claim Reports – generate, view, print and download (and view Remittance File date for Denied claims only)
- Notes – view the latest note, access Claim Notes History, and add a new note
- View 835 X12 – (for Denied claims only) view, print and download. Select the Remittance File link under Claim Reports to display the file in X12 format.
- View ERA – (for Denied claims only) view, print and save as PDF. Select the View ERA icon on the desired row to display the Viewable ERA file. Use the Convert to PDF link to print and save the file.

Export

You can use the Export WQ Claims (Excel) link to export your Work Queue for Denied/ Rejected claims list. The export applies total recall to include all of the claims in your queue. The Excel file reflects the columns that are currently displayed (such as, your customized view) with the claim record information. (The Details information is not available in the Excel file.)

Revert to Unresolved

You have the ability to revert a Resolved claim to an Unresolved status in order to rework or reassign that claim. To find Resolved claims you must indicate the Resolved Status option as Yes in your Search pane in order to display Resolved Status claims in your search results.

You can select up to 100 Resolved claims using the row checkbox, and use the Unresolved button to mark these claims as unresolved.

When you select the Unresolved button and accept any request to self-assign, a confirmation is requested. You have the option to enter Unresolved Notes related to the claim, but notes are not required. If you selected multiple claims your note will be applied to all of the claims in that batch.

You must select the Confirm as Unresolved button to restore selected claims to an Unresolved status.

Upon this action these claims are no longer visible in your current results grid. To find these Unresolved claims you must return to your Search pane and indicate the Resolved Status option as No, in order to display Unresolved Status claims.

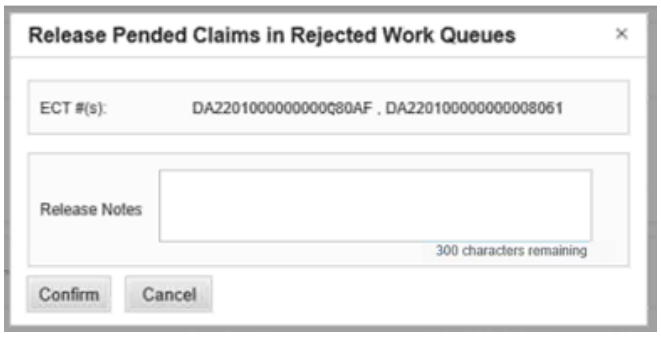
Release Pended Claims

To find Pended claims you must indicate the Pended Status option as Yes in your Search pane, and select any desired Pended Category, in order to display those Pended Status claims in your search results.

You have the ability to manage these pended claims from the results grid, or you may select up to 100 Pended claims using the row checkbox, and use the Release button to release these claims back to the work queues.

When you select the Release button and accept any request to self-assign, a confirmation is requested. You have the option to enter Release Notes related to the claim, but notes are not required. If you selected multiple claims your note will be applied to all of the claims in that batch.

You must select the Confirm button to release the selected claims from a pended status.

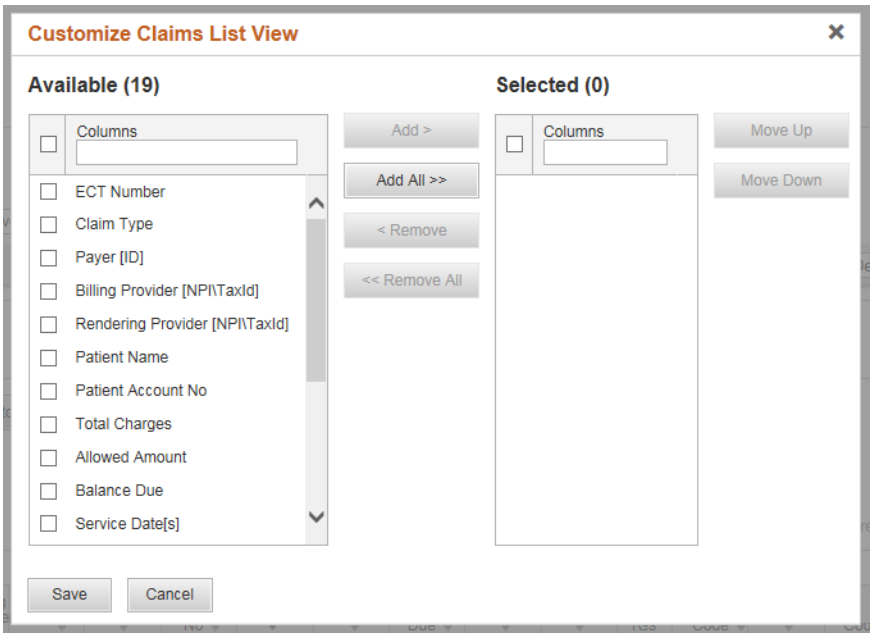


Upon this action these claims are no longer visible in your current results grid. To find these released claims you must return to your Search pane and indicate the Pended Status option as No, in order to display the claims that are no longer pended.

Customize Claims List View

You have the ability to reconfigure the default Work Queue for Denied/Rejected Claims list view by setting a single, user-specific customized view of your Work Queue for Denied/Rejected Claims. Your unique customized view will persist as the new default, but you can modify your selections at any time. This feature allows you to display only the columns that you generally want to view, and reduce the scope of the grid.

From the Work Queue for Denied/Rejected Claims begin by selecting the Customize Claims List View button to open the Customize Claims List View form, as shown in the illustration below. A tool tip displays when you first customize to advise there is an 11 column maximum capacity.



Use the Add and Remove buttons (center) to select one or more preferred fields, up to a total of 11 Columns. The Columns headers reflect the current number of fields Available and Selected.

It may be helpful to use Add All to begin your list, and use Remove until you have 11 Columns or less. You can add and remove until you are satisfied with your selections.

Use the Move Up or Move Down buttons (right) to sequence your display as you prefer. Note that you can use the checkboxes to select and move multiple fields up or down in a single action.

Note that the ECT Number and Claim Type fields are required fields. An error message alerts you if these fields are not Selected when you select the Save button.

The Available fields as of this release are listed below. Note that certain fields are available only when you use the customization option.

Available for Denied Claim	Available for Rejected Claim
ECT Number*	**ECT Number***
Claim Type*	**Claim Type***
Payer (ID)	Payer (ID)
Billing Provider (NPI/Tax ID)	Billing Provider (NPI/TaxID)
Rendering Provider (NPI/Tax ID)	Rendering Provider (NPI/Tax ID)
Patient Name	Patient Name
Patient Account #	Patient Account #
Total Charges	Total Charges
Allowed Amount	Service Date(s)
Balance Due	Rejection Date
Service Date(s)	Status
Denial Date	Rejection Reason
Denial Reason	CPT codes
CPT codes	Primary Diagnosis Code
Primary Diagnosis Code	Service Facility Name
Service Facility Name	Patient DOB
Remark Codes	Assigned To
Payer ICN	Member ID
Patient DOB	Pended Category
Assigned To	Claim Notes History
Member ID	WQ Set Name
Pended Category	
Claim Notes History	
WQ Set Name	

If you select Cancel a warning message advises that your selections will be lost, and asks if you want to navigate away without saving. You must select Yes or No to continue.

Keep in mind that new columns may be added after you have established your customized view.

You can use Customize Claims List View button at any time to review the current Available listing and make any desired updates to your customized view.

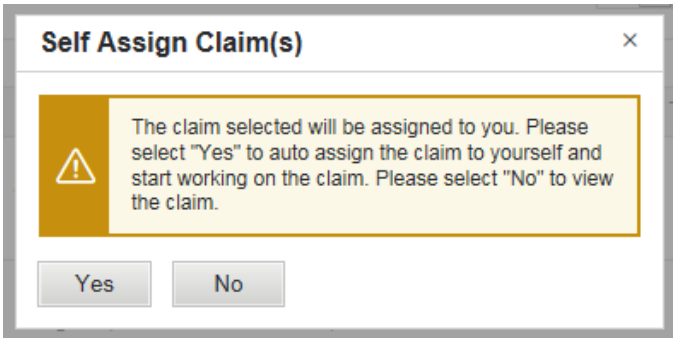
Claim Resolution

Self-Assign Claim(s)

Claims can be assigned to only one user at any time. When you self-assign claims you ensure that the claim is not editable by other users while you perform work. Likewise, when a claim is assigned to another user you may only view the claim.

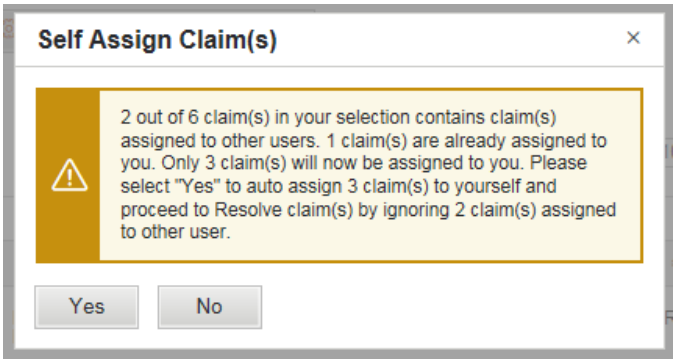
The Self-Assign Claim(s) capability applies when you perform claim resolution to correct and resubmit, bulk edit & resubmit, or mark claims as resolved or Pended.

A confirmation request displays when you select to edit a denied/rejected claim. If you wish to open and continue work on the claim you must select Yes to auto-assign the claim to make it available in your My Assigned Claims WQ-Set. Select No if you wish to open and view the claim only.



For any bulk action (bulk edit & resubmit, mark claims as resolved or revert to unresolved, pend claims or release from pend) the pertinent confirmation request identifies any number of claims assigned to other users, any number already assigned to you, and any potential number to be assigned to you by this action.

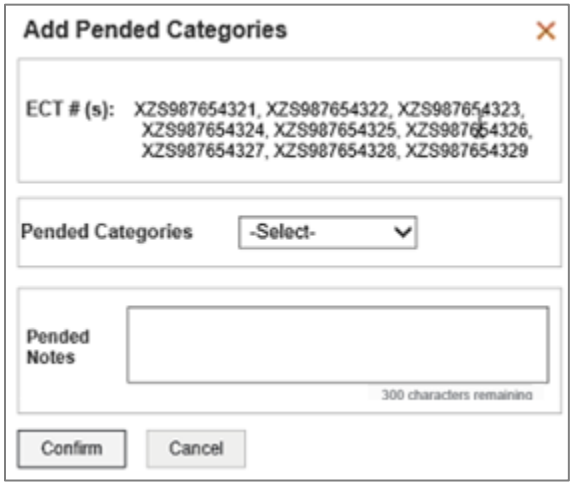
The total number of claims assigned to you can be processed if you select Yes, and those claims assigned to other users will be unaffected. If you select No you remain in the Work Queue for Denied or Rejected Claims.



Pended

From the Work Queue for Denied or Rejected Claims you may use the Pended button in order to suspend one or more claims from all work queues, in a pended status.

- Use the row checkbox in select one or more claims to be pended. You can select up to 100 claims in a batch. (The Denied or Rejected status of pended claims does not change.)
- Select the Pended button and accept any request to self-assign.
- You must select a single Pended Category from that drop down in the Add Pended Categories form. Your selected category will be applied to all of the claims in that batch.
- You have the option to enter Pended Notes related to the claim, but notes are not required. If you selected multiple claims your note will be applied to all of the claims in that batch.
- You must select the Confirm button to change the selected claims to a Pended status.



The requested confirmation is your only alert before the claims are pended. However, you have the ability in the Work Queue to Release any claim back to the work queues.

Pended claims do not appear in any user work queue, unless you specifically perform a Search for Pended claims in order to release such claims.

Correct and Resubmit

From the Work Queue for Denied or Rejected Claims you may edit a denied/rejected claim to make necessary adjustments and resubmit the corrected claim. Note that for denied claims you can use the View ERA link on the desired row to assess the claim denial reasons.

To begin, use the Edit icon on the desired row to open the claim and accept any request to self-assign.

From the claim form you can select the links available in the ribbon to perform desired actions.

- You can select to view any available primary or secondary ERA or 835 X12, using the links provided. An advisory messages displays if the requested information is not available. While viewing, you can also download and print an ERA form as a PDF file.
- View Claim Notes History, which also includes any related parent to child, or child to parent notes that were entered for previous claims.
- View Claim History, which also includes resubmissions history. The cascading Claim History provides a view of the tracking log for each previous parent or child claim, and provides a link to view each previous parent or child claim as saved at that time.
- Based on user roles and permissions you may generate XML for download or print.
- Based on user roles and permissions you may view the 837 X12 or 277 X12.

Use the Correct and Resubmit link (lower right) to initiate an adjusted claim. If a corrected claim has already been created you alternatively have the option to use the View Corrected claim link.

Select the Correct and Resubmit button to create and edit a copy (child) of the original claim. This new child claim reflects all of the errors from the parent claim so you can work through the corrections. (Note that when copied the original (parent) claim is automatically marked as resolved.)

In the new child claim the original reference # is auto-populated with the parent/denied claim 835's Payer Claim Control Number

You have the ability to initiate a corrected claim and use the Save Progress option to keep your edits as a partially completed corrected claim.

Complete the necessary corrections, enter any notes (optional), and use Submit button to resubmit the adjusted claim. A new ECT# is applied to the copy (child) claim when it is submitted, which is linked to the original (parent) claim.

Bulk Edit & Resubmit

The Bulk Edit & Resubmit feature is available only at the Billing Entity Level. From the Work Queue for Denied/Rejected Claims you may use the row checkbox to select up to 100 claims (Professional only).

Select the Bulk Edit & Resubmit button and accept any request to self-assign. The Bulk Edit & Resubmit form displays the number of denied/rejected claims selected. An advisory error message displays if you select any (or selected only) Institutional claims.

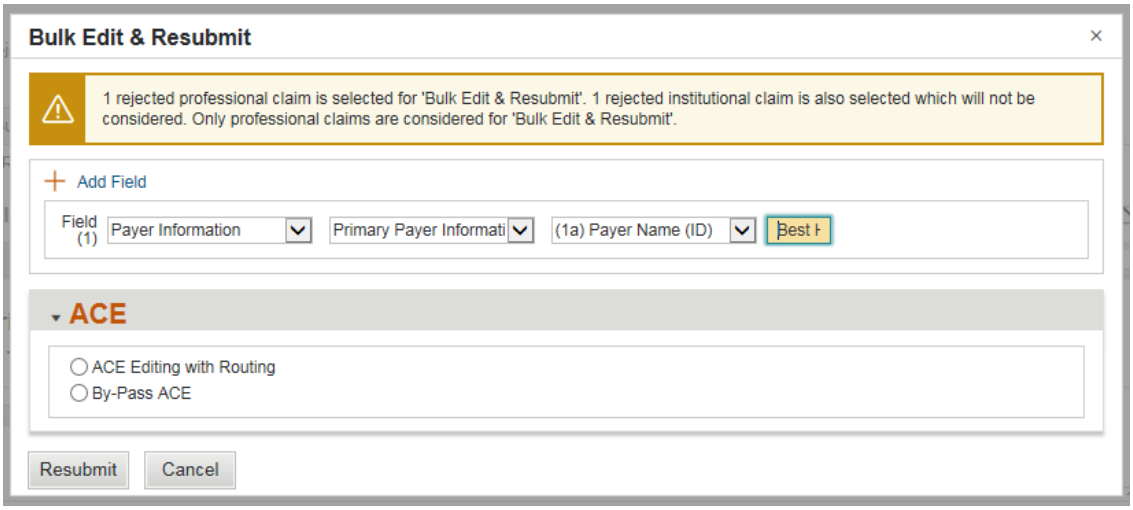
Use the Bulk Edit & Resubmit form to identify each field you wish to modify and the new value for each. Begin by selecting the desired category from the first drop down.

- Payer Information
- Patient Information
- Insured Information
- Claim Provider Information

Select any applicable subfields as those drop downs are displayed (based on your category choice).

Enter the correcting value in the open field (using the date picker where applicable).

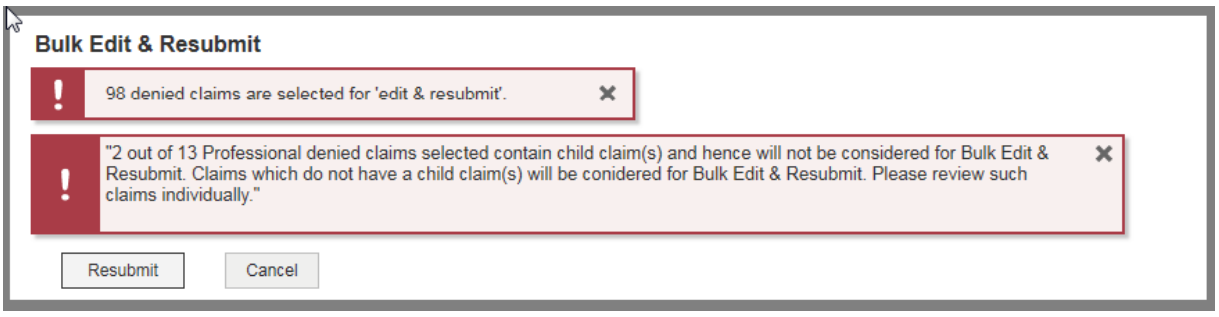
Use the Add Field link to make a new field available, which displays with a sequential number. Use the Delete icon to remove a field entirely.



An error message displays if you make duplicate field selections.

Select ACE editing options appropriately where displayed (based on login).

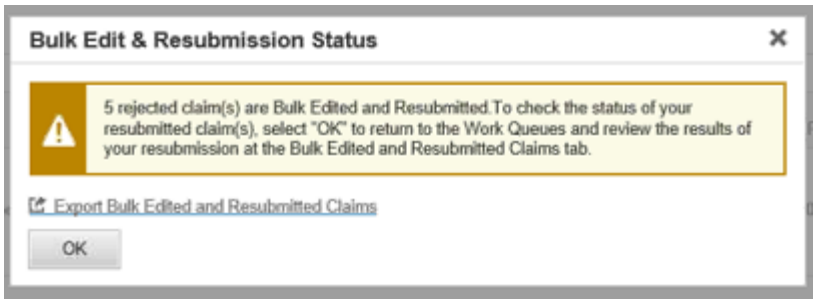
If you have selected any parent claims for which child claims have been submitted an advisory message displays when you select the Resubmit button, as shown below.



A confirmation request displays when you select the Resubmit button, and you must select the Confirm button to complete the resubmit action. (If you select Cancel a confirmation request displays and you must select to navigate away or remain in the form.)

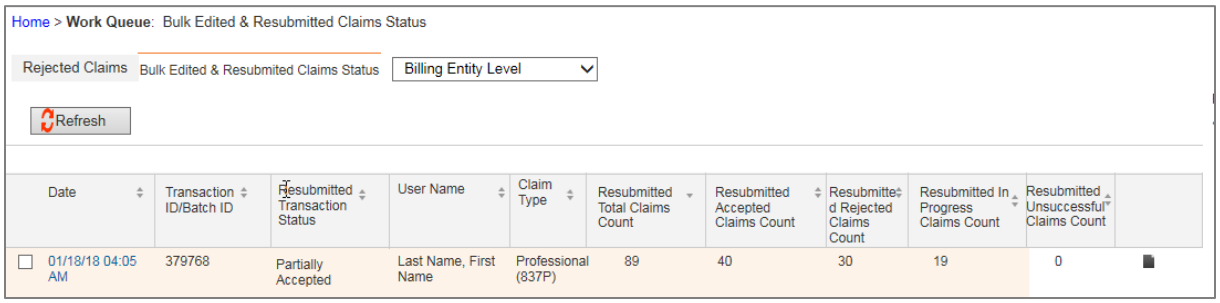
When you select the Confirm button a Bulk Edit & Resubmission Status notification displays, identifying the number of claims bulk edited and resubmitted.

The Bulk Edit & Resubmission Status notification includes a link option for Export Bulk Edited and Resubmitted Claims. This Excel file reflects Transaction ID, ECT Number, Claim Type and the resubmitted Transaction Status.



Select OK to return to the Work Queue where you can review the current status of your resubmitted claims at the Bulk Edited & Resubmitted Claims Status tab. This status check is available only at the Billing Entity Level. A Refresh button is also available.

The grid at the Bulk Edited & Resubmitted Claims Status tab provides a Report icon, which is a second opportunity to export the Bulk Edited and Resubmitted Claims listing and review status.



The status of resubmitted claims is generally Submitted, except for claims Rejected by Optum that move to a status of Unsubmitted.

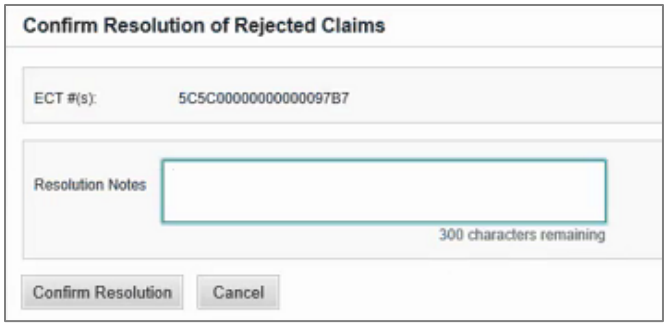
Note that the Bulk Edited & Resubmitted Claims Status tab grid provides a claims count reflecting your resubmitted claims activity, such as for total, accepted, rejected, in progress, and unsuccessful claims.

Resolved

From the Work Queue for Denied/Rejected Claims use the row checkbox in order to resolve one or more claims. You can select up to 100 claims in a batch and use the Resolved button to mark those claims as resolved. (The Denied or Rejected status of resolved claims does not change.)

When you select the Resolved button and accept any request to self-assign, a confirmation is requested. You have the option to enter Resolution Notes related to the Resolved claim, but notes are not required. If you selected multiple claims your note will be applied to all of the claims in that batch.

You must select the Confirm Resolution button to change the selected claims to a Resolved status.



The requested Confirm Resolution is your only alert before the claims are resolved. However, you have the ability in the Work Queue to return any claim to Unresolved status.

Resolved claims do not appear in any user work queue, unless you specifically perform a Search for Resolved claims, such as to rework such claims. Note that you have the option to use the WQ Claims link provided at My Work Queue to access the Work Queue and search for claims based on status.

Slated for a future release is the user's ability to remove claims from their unique work queue only.

Assigning Claims

You have the ability to self-assign claims, as described under **Claim Resolution**, and also to unassign claims from your My Assigned Claims WQ-Set (whether admin-assigned or self-assigned).

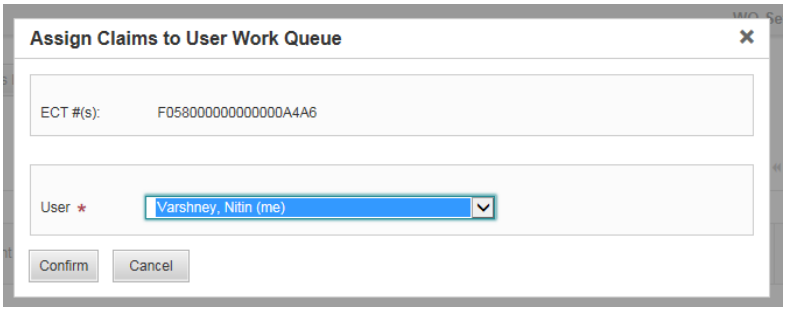
Based on user roles and permission you may have the ability to assign, unassign, and reassign claims from/to the work queue of other designated users.

Assign Claims

To assign claims begin by selecting the desired claim(s) using the row checkbox in your Work Queue. You can assign up to 100 claims in a batch to a single user.

Use the Assign Claim(s) button to open the Assign Claims to User Work Queue form. The selected ECT#s auto-populate that field.

Select the desired single User from the drop down, and select the Confirm button.



The reassigned claims are immediately updated to the selected user's My Assigned Claims WQ-Set in Work Queue, and are available to that user upon selecting My Assigned Claims.

Claims can only be assigned to one user at any time

Unassign Claims

You can unassign only those claims in your My Assigned Claims WQ-Set, unless you have the appropriate user roles and permission to unassign claims assigned to other users from any WQ-Set.

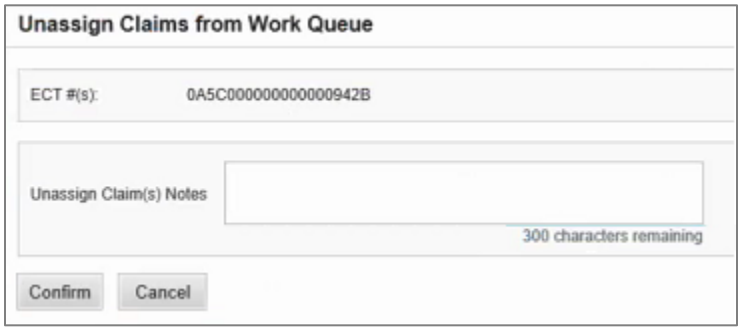
Use the row checkbox in your Work Queue to select up to 100 claim(s) that reflect an entry in the Assigned To field. That is, a claim can be unassigned only when it is currently assigned to a user.

Select the Unassign Claims(s) button. Review any advisory message displayed and select Confirm if you wish to continue. The advisory message describes the state of the claims you have selected and requests your confirmation to proceed in unassigning only those you have permission to unassign.

For example, a message may state, “10 of 17 claims in your selection are assigned to other users, 3 are assigned to you, and 4 are not assigned to any user. You may only unassign claims assigned to you. Select Confirm if you wish to proceed and unassign the 3 claims assigned to you, as shown below, ignoring the 10 claims assigned to other users, and 4 claims not assigned to any user.”

If no advisory message displays the Unassign Claims from Work Queue form opens immediately, and the selected ECT#s auto-populate that field.

It is suggested that you enter any related Unassign Claim(s) Notes to clarify why the claim has been unassigned; and why you anticipate reassigning the claim, where applicable. Select the Confirm button to complete the unassignment action.



The unassigned claims are immediately removed from the affected My Assigned Claims WQ-Set in Work Queue, and are not available to that user upon selecting My Assigned Claims.

Reassign Claims

Unassigned claims are now available to be reassigned to other users using the Assign Claim(s) option. You can reassign only those claims you initially had self-assigned, unless you have the appropriate roles and permission to assign claims to the work queue of other designated users.

Claims

The Intelligent EDI Claims function provides the following options:

- Claim File Upload
- New Institutional Claim
- New Professional Claim
- Claim Search – supports correct and resubmit, create claim status response, manage secondary claims, obtain reports
- Check Claim Status

Claim File Upload

If you select Claim File Upload and you or the default Billing Entity are not affiliated with the Claim File Upload service an advisory message displays with instructions for obtaining assistance.

Claim File Reports

Task: View, print, and download reports; submit individual claim files to be processed. Based on user roles and permissions upload Professional print images to be processed; view and download Professional print images (aka paper claims converted to electronic data)

Navigation: Claims/Claim File Upload

You can reduce the number of Claim Files displayed by applying one or more of the available filter options, which refreshes the Claim Files grid:

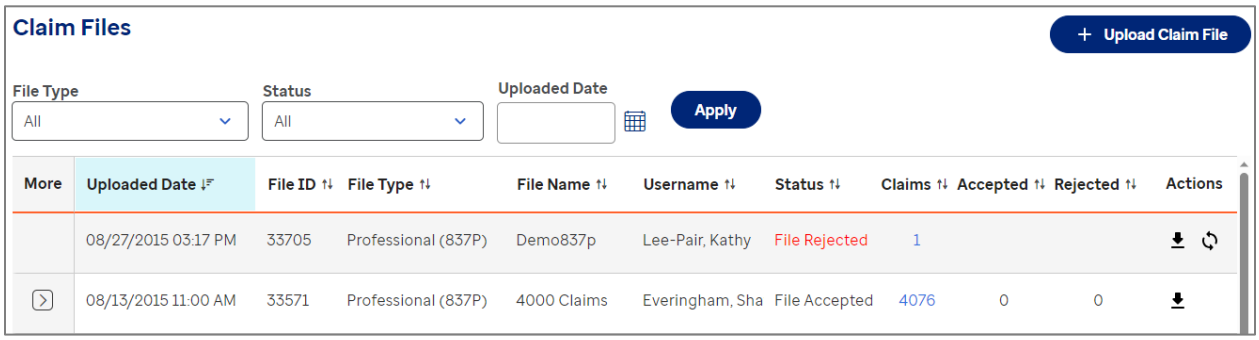
- File Type
- Status
- Uploaded Date

The Claim Files grid provides the following information about each individual claim file and Professional print image upload:

- Uploaded Date (and time)
- File ID
- File Type
- File Name
- Username
- Status
- Claims (count)
- Accepted (number)

- Rejected (number)

The Claim Files grid displays files in descending order by the date and time they were uploaded.



You have links available in the Claim Files grid related to the following capabilities.

Download

From the Actions column select the Download icon on the desired row to view, print or download that file.

Reprocess/Recheck

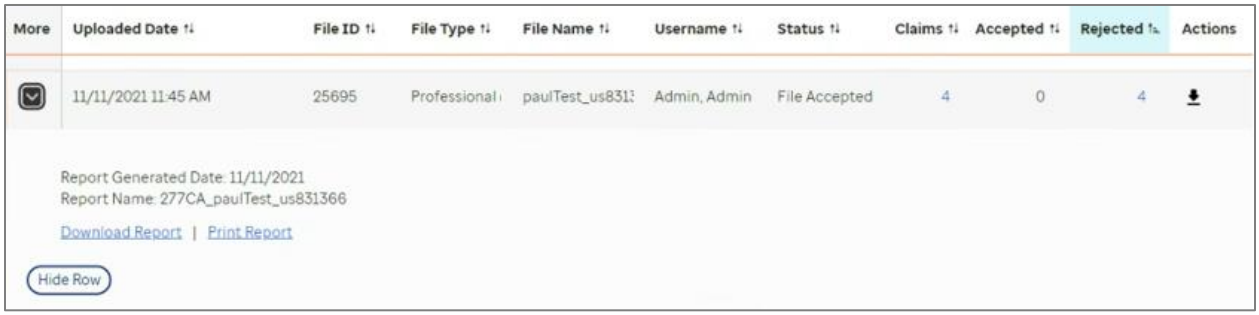
From the Actions column hover the icon (circular arrows) and select the displayed option for the desired row:

- Reprocess – select to reprocess the selected file
- Recheck – select to recheck the status of the file. Recheck icon is enabled only when the status is Unknown Response.

Reports

Use the More column arrow, if available, to open the Reports drawer, which provides the following:

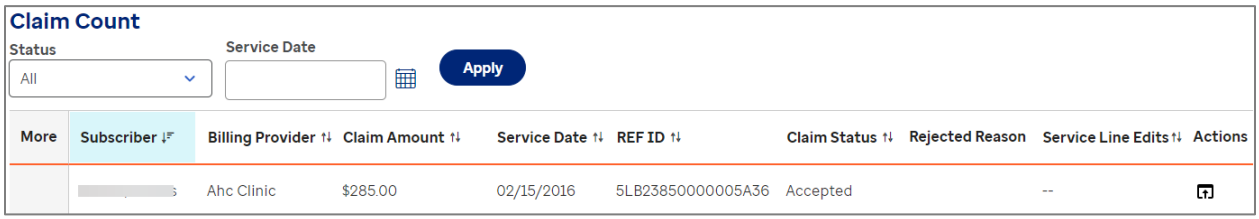
- Report Generated Date
- Report name
- Download Report link
- Print Report link
- Print image file name – if displayed (based on login) this link provides access to view and download the print image file



Claim Count

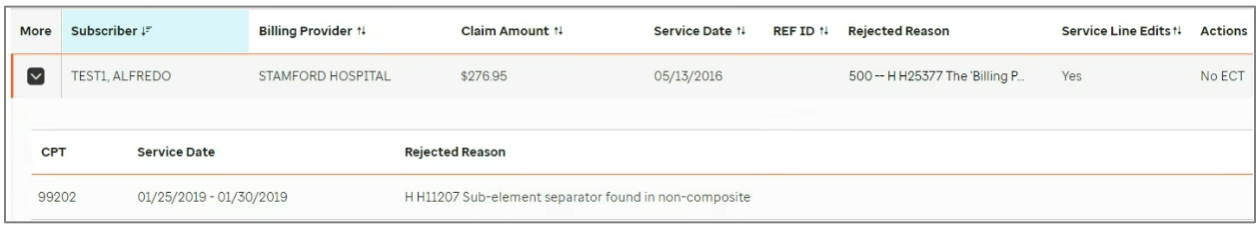
Select the Claim count number to view information about each claim. You can reduce the number of claim files displayed by applying one or both of the available filter options, which refreshes the Claim Count grid:

- Status
- Service Date



The Claim Count grid displays in alphabetical order by Subscriber, and provides the following information:

- Subscriber
- Billing Provider
- Claim Amount
- Service Date
- REF ID
- Claim Status
- Rejection Reason (if rejected) – Hover to view multiple reasons. An ACE prefix indicates ACE Editing was applied.
- Service Line Edits – if Yes, use the More column arrow to view CPT code by Service Date, and the Rejected Reason, as displayed in the Service Line Edits drawer.



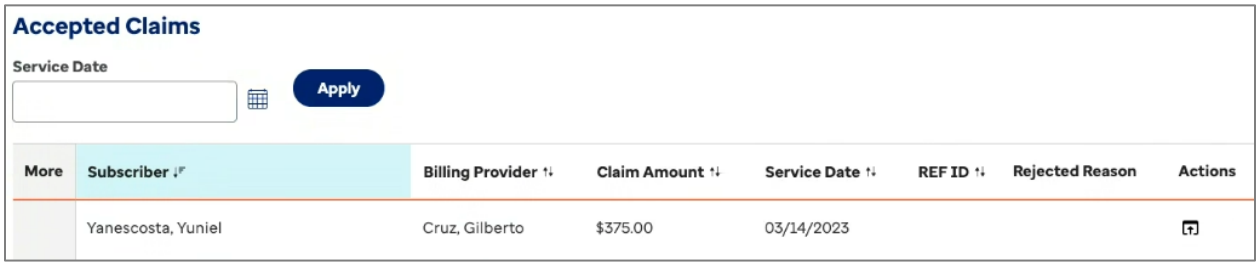
A tool tip is provided in the Actions column when you hover the View Claim icon to indicate the claim is available to be viewed. You can click the icon to View Claim.

If the claim is unavailable to be viewed a response displays when you click the view icon stating that there is No ECT, which indicates the claim cannot be viewed through this functionality.

Accepted Claims

Select the number of Accepted claims to view a list of the accepted claims, which reflects the following:

- Subscriber
- Billing Provider
- Claim Amount
- Service Date
- REF ID
- Rejected Reason

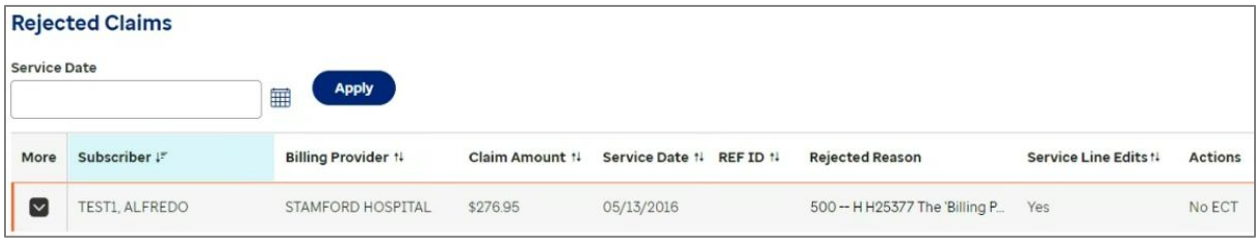


A tool tip is provided in the Actions column when you hover the View Claim icon to indicate the claim is available to be viewed. You can click the icon to View Claim.

If the claim is unavailable to be viewed a response displays when you click the view icon stating that there is No ECT, which indicates the claim cannot be viewed through this functionality.

Rejected Claims

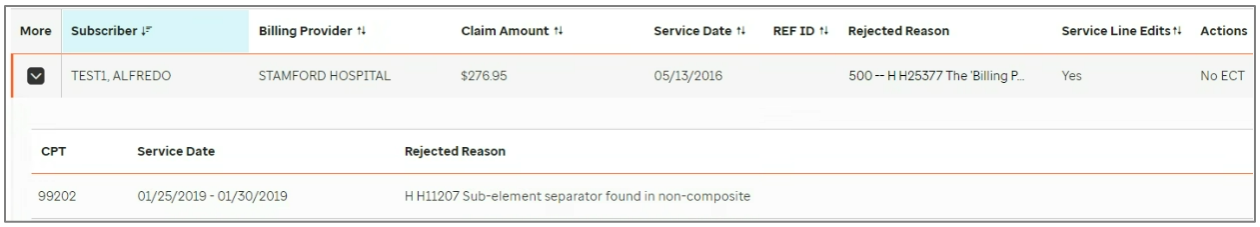
Select the number of Rejected claims to view a list of the rejected claims.



The Rejected Claims grid provides the following information:

- Subscriber
- Billing Provider
- Claim Amount

- Service Date
- REF ID
- Rejected Reason
- Service Line Edits – if Yes, use the More column arrow to view CPT code by Service Date, and the Rejected Reason, as displayed in the Service Line Edits drawer.



More	Subscriber	Billing Provider	Claim Amount	Service Date	REF ID	Rejected Reason	Service Line Edits	Actions
☑	TEST1, ALFREDO	STAMFORD HOSPITAL	$276.95	05/13/2016		500 -- H H25377 The 'Billing P...	Yes	No ECT

CPT	Service Date	Rejected Reason
99202	01/25/2019 - 01/30/2019	H H11207 Sub-element separator found in non-composite

A tool tip is provided in the Actions column when you hover the View Claim icon to indicate the claim is available to be viewed. You can click the icon to View Claim.

If the claim is unavailable to be viewed a response displays when you click the view icon stating that there is No ECT, which indicates the claim cannot be viewed through this functionality.

Upload Claim File

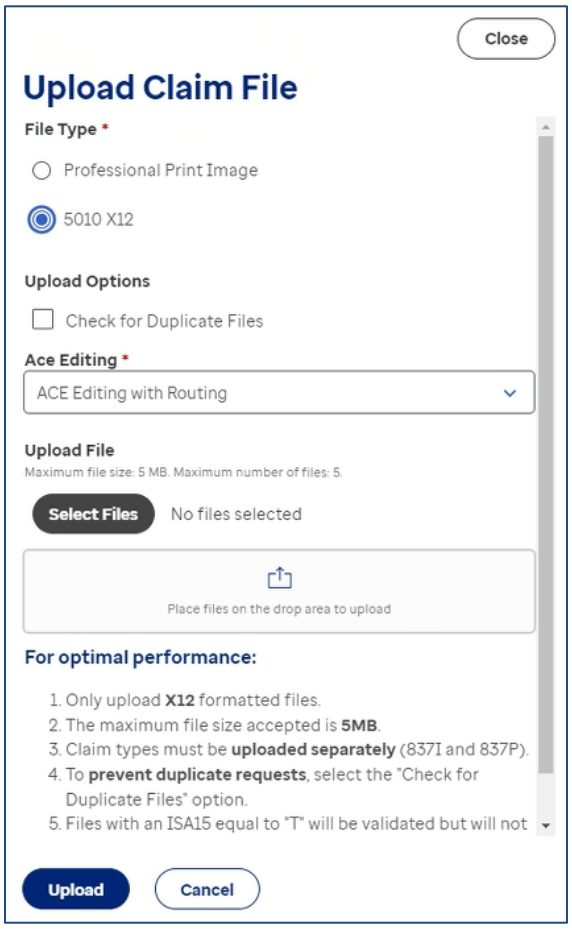
From Claim Files use the Upload Claim File button to open and complete that form, which is applicable based on your File Type selection. You must complete the required fields.

- File Type – if displayed (based on login), you must select the desired print image File Type
  - Professional Print Image – this option allows you to select the default or other associated map already available, using the Select Files button.
  - 5010 X12 – pertinent file constraints are displayed when you select this option. Note the allowable file extensions (which are not listed under file constraints), as follows: XML, TXT, 5010, 4010, 837, X12, 270, DAT, CLM, ECT, EDI, PDF, ZIP, PS, OUT, FIL, 297, PRD, ANS, 837P, 837I, ENS, PRN, X21, ME, TCH, 3026, 5497, CHK, TEXT, ELC.
- Map Name – this field is required if you selected Professional Print Image file type.
- Upload Options – to prevent uploading duplicate files you can select the Check for Duplicate Files checkbox. If a duplicate file is entered you can cancel the upload, or upload that duplicate file with a current time/date stamp.
- ACE Editing – if displayed (based on login) you must select ACE Editing with Routing (default), ACE Editing Only, or By-Pass ACE. These options are available only if the selected Billing Entity has elected ACE Validation Services. If the user does not individually have ACE permissions the default option is applied. (Keep in mind that ACE validation cannot be applied to print image files.)
- Upload File – to upload a claim file or an image file use the Select Files button to select up to 5 files. Note the pertinent optimal performance constraints displayed on the form based on your selections.
  - Only upload X12 formatted files
  - The maximum file size accepted is 5MB
  - Claim types must be uploaded separately (837I and 837P)
  - To prevent duplicate requests select the “Check for Duplicate Files” option

- Files with an ISA15 equal to “T” will be validated but will not be submitted to payer or be available in Claim Reporting, including Claim Search

To complete the action use the Upload button. If you want to select a different claim file use the Cancel button and reselect.

If the upload is successful a confirmation displays, and you are returned to the Claim Files grid where the claim displays with a Status of Processing. Use Refresh as needed to see the Status when the processing is completed.



If the upload is unsuccessful any error messages are displayed.

For a claim file to be uploaded successfully each Value shown in the table below must be included in the corresponding segment loop. If a claim file does not contain the correct values it will not be validated during file upload, and an error message will be displayed, such as “There is an invalid value in one or more loops in your file. Please refer to the **Intelligent EDI User Guide** for the correct information.”

Use the information in the Validations table below to adjust your invalid claim file and ensure a successful claim submission.

Validations

Segment	Reference Designator(s)	Value	Notes
ISA	ISA05	01, 14, 20, 27, 28, 29, 30, 33, ZZ	
	ISA06		One Healthcare ID (Submitter Id)
	ISA07	01, 14, 20, 27, 28, 29, 30, 33, ZZ	
	ISA11	^	
	ISA12	00501	
	ISA15	T or P	T= Testing P = Production
GS	GS02		One Healthcare ID (Submitter Id)
	GS08	005010X222A1	For 837P
	GS08	005010X222A2	For 837I
LOOP 1000A NM1	NM101	41	
	NM102	1 or 2	
	NM103		A value is required by Intelligent EDI clearinghouse
	NM108	46	
	NM109		One Healthcare ID (Org Id)
LOOP 2010BB NM1	NM101	PR	
	NM102	2	
	NM103		A value is required by Intelligent EDI clearinghouse
	NM108	PI	
	NM109		A value is required by Intelligent EDI clearinghouse

New Institutional Claim

Task: Complete and submit a new primary Institutional claim

Navigation: Claims/New Institutional Claim

The New Institutional Claim feature allows you to initiate a new claim and to save your entries as a partially completed claim. You can search for claims in a Saved status to return and finalize these claims for submission. Claim History tracks all changes and updates to unsubmitted as well as submitted claims.

From the Institutional claim form you can select View Claim History, which reflects Timestamp, User Name, Previous Claim Status, and Status When Saved.

Select Claims/New Institutional Claim to initiate a new primary claim, as illustrated in the partial image below.

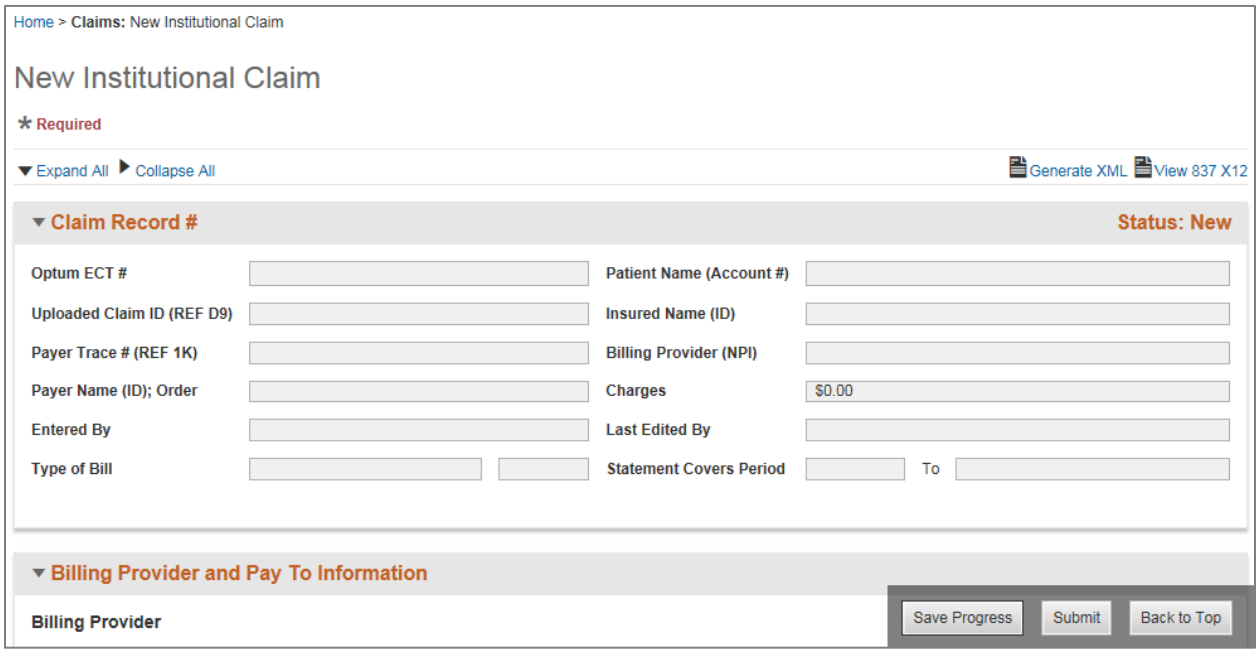
The electronic claim form is segmented into panes or boxes, which contain related fields.

The first pane is Claim Record #, which contains header information and identifies the current Status of the claim. This pane is auto-filled when you complete and save the claim form.

The form fields in the claim form are generally aligned with the familiar paper form, but certain additional information is required for electronic submission.

Name fields provide a drop down with an auto-complete search. Notice that certain fields are for an Entity only, such as the Billing Provider or Payer Name. For Patients, Insureds, and Physicians you may use the Last Name field to take advantage of the auto-complete feature.

You may use the floating Save Progress button at any time to capture your entries, as you work to complete the form.



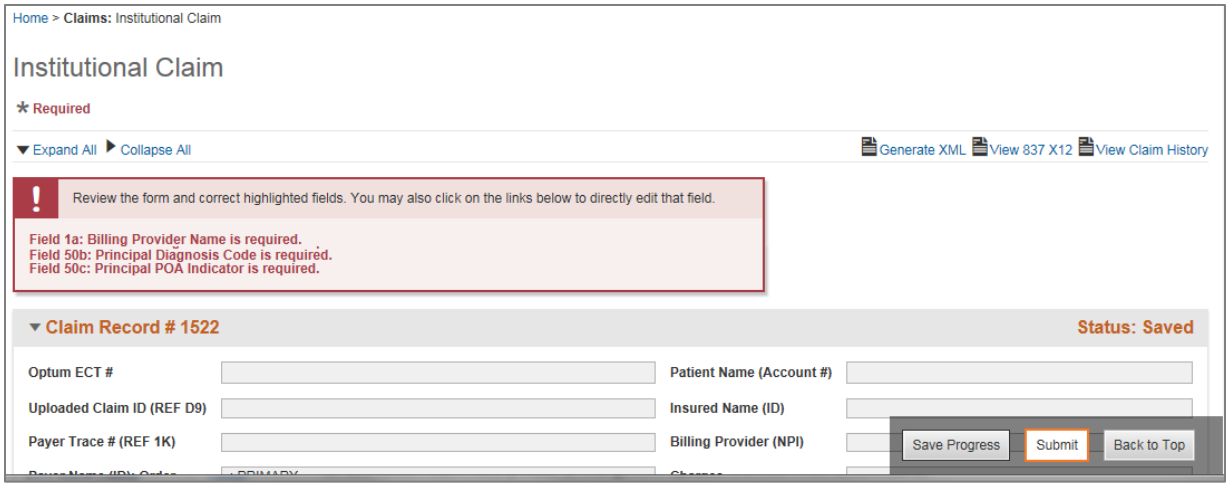
Procedure Lines can be added or removed, and the numbering sequence auto-adjusts accordingly. You can expand or collapse individual Procedures Lines, or all of the Procedure Lines.

In the Payer and Insured segments use the available Primary, Secondary, and Tertiary Insured information panes to capture appropriate information. For Payers you may need to indicate a Qualifier, ID, and Filing Indicator.

You must complete at least the required fields to build a claim that can pass both the minimal validation and the situational validation screens applied by Intelligent EDI for all claims.

- Minimal validation – required fields are marked with an asterisk and are highlighted.
- Situational validation – non-required fields become required if you populate a related non-required field (but these are not marked with an asterisk). That is, if you populate a single non-required field within a set of information, then all fields in that group become required. For example, if you enter

a last name in a non-required field the first name field is triggered to become a required field to complete the set of information related to that particular situation.



If configured Validation Rules are currently applicable to your claim the following may occur, based on the rule type.

- For a Data Manipulation Rule – field values may be changed or removed by the system
- For a Hard Stop Edit Rule – an error message displays (with message identifiers), and the claim can be submitted only after the indicated changes are made to the claim. (Note that this revised claim is again subject to any other validation rules.)
- For an Overridable Edit Rule – an error message displays (with message identifiers), but the claim can be submitted by using the Bypass Overridable Edits and Submit button (no change is required). (This action does not preclude any other validation rules.)

Use the Save Progress button at any time to check for error messages. Error alerts are highlighted in bold red, and identify the related field or box by number. You can select any such field link error message to navigate to that particular field, where the error message is displayed again, for convenience. Once selected the error message is no longer bolded. (Note that this field link is not applicable for Hard Stop and Overridable error messages, which are preceded by a code such as H rather than a field or box number.)

Note that once you have saved the claim the Delete option is enabled on the floating tool bar. You may delete an unsubmitted claim using the Delete button and selecting Yes in response to the confirmation request. If you wish to revert the deletion select the Save Progress button to return the claim to a Saved status.

Select the Submit button when you have completed the form, and no errors have been returned upon Save Progress.

Standalone Secondary Institutional Claim

Slated for a future release is the ability to create and submit standalone secondary Institutional claims.

New Professional Claim

Task: Complete and submit a new primary (or secondary) Professional claim

Navigation: Claims/New Professional Claim

The New Professional Claim feature allows you to initiate a new claim and to save your entries as a partially completed claim. You can search for claims in a Saved status to return and finalize these claims for submission. Claim History tracks all changes and updates to unsubmitted as well as submitted claims.

From the Professional claim form you can select View Claim History, which reflects Timestamp, User Name, Previous Claim Status, and Status When Saved.

Select Claims/New Professional Claim to initiate a new primary claim, as illustrated in the partial image below.

The electronic claim form is segmented into panes or boxes, which contain related fields.

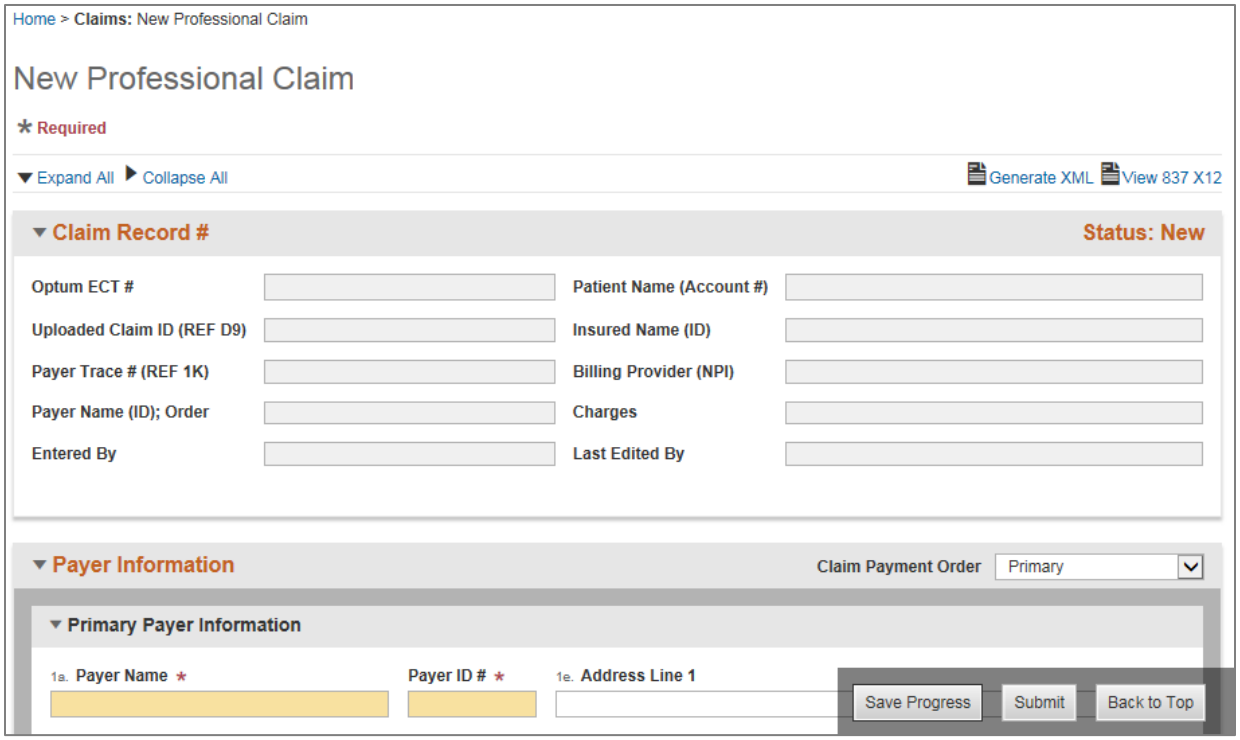
The first pane is Claim Record #, which contains header information and identifies the current Status of the claim. This pane is auto-filled when you complete and save the claim form.

Begin by selecting a Payer Name or ID in that required field of the Payer Information pane, and then complete at least the required fields in the claim form.

The form fields in the claim form are generally aligned with the familiar paper form, but certain additional information is required for electronic submission.

Name fields provide a drop down with an auto-complete search, e.g., Payer Name or ID. For Patients and Insureds use the Last Name field to take advantage of the auto-complete feature.

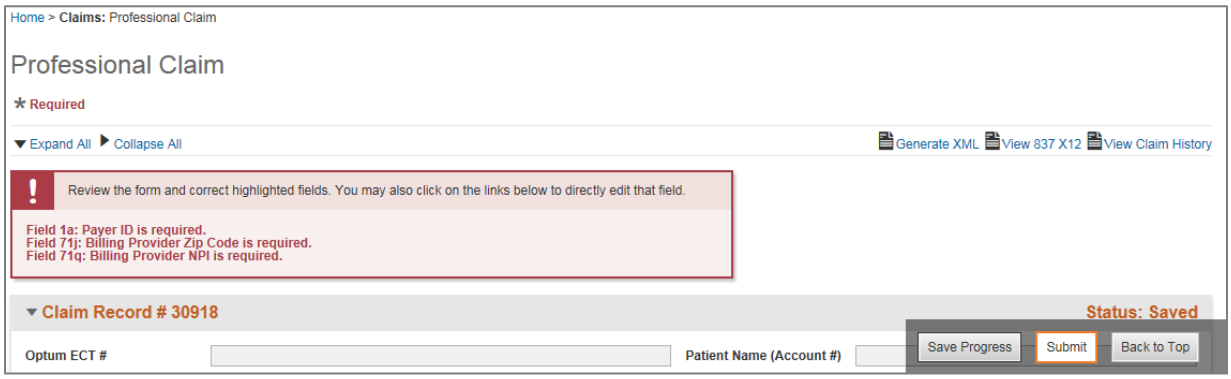
You may use the floating Save Progress button at any time to capture your progress, as you work to complete the form.



Procedure Lines can be added or removed, and the numbering sequence auto-adjusts accordingly. You can expand or collapse individual Procedures Lines, or all of the Procedure Lines.

You must complete at least the required fields to build a claim that can pass both the minimal validation and the situational validation screens applied by Intelligent EDI for all claims.

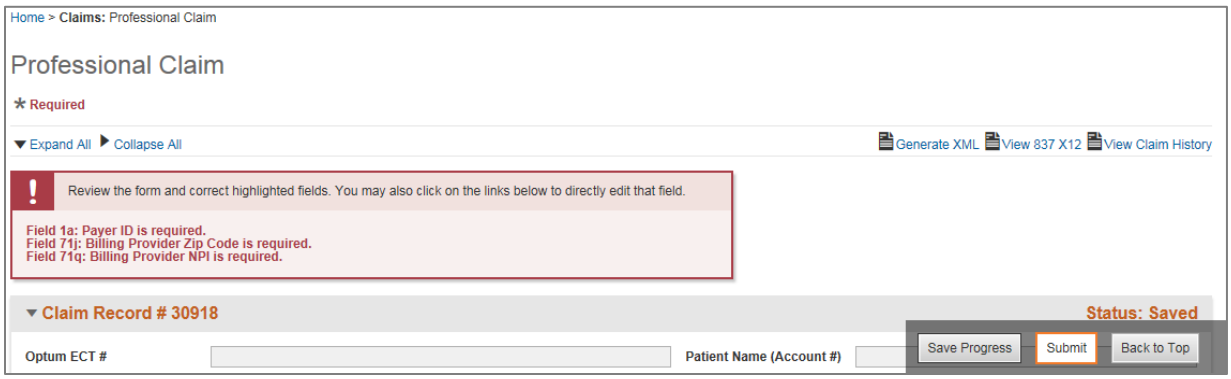
- Minimal validation – required fields are marked with an asterisk and highlighted.
- Situational validation – non-required fields become required if you populate a related non-required field (but these are not marked with an asterisk). That is, if you populate a single non-required field within a set of information, then all fields in that group become required. For example, if you enter a last name in a non-required field the first name field is triggered to become a required field to complete the set of information related to that particular situation.



If configured Validation Rules are currently applicable to your claim the following may occur, based on the rule type.

- For a Data Manipulation Rule – field values may be changed or removed by the system

- For a Hard Stop Edit Rule – an error message displays (with message identifiers), and the claim can be submitted only after the indicated changes are made to the claim. (Note that this revised claim is again subject to any other validation rules.)
- For an Overridable Edit Rule – an error message displays (with message identifiers), but the claim can be submitted by using the Bypass Overridable Edits and Submit button (no change is required). (This action does not preclude any other validation rules.)



Use the Save Progress button at any time to check for error messages. Error alerts are highlighted in bold red and identify the related field or box by number. You can select any such field link error message to navigate to that particular field, where the error message is displayed again for convenience. Once selected the error message is no longer bolded. (Note that this field link is not applicable for Hard Stop and Overridable error messages, which are preceded by a code such as H rather than a field or box number.)

The availability of the ACE Editing options is based on your current login as a particular Billing Entity.

Note that once you have saved the claim the Delete option is enabled on the floating tool bar. You may delete an unsubmitted claim using the Delete button and selecting Yes in response to the confirmation request. If you wish to revert the deletion select the Save Progress button to return the claim to a Saved status.

Select the Submit button when you have completed the form, and no errors have been returned upon Save Progress.

Standalone Secondary Professional Claim

You can complete and submit a Professional secondary (or tertiary) claim as a new standalone claim. Complete the new claim form in the same manner as described for a primary claim, except that for the Payer/Claim Payment Order you must select Secondary or Tertiary to enable the COB capabilities.

Note that the Claim Level Coordination of Benefits options are displayed in the new claim form.

You have the ability to view, edit and validate the claim before submitting, as described in **COB Adjudication**.

Claim Search

The Intelligent EDI Claim Search function provides filtered searching that enables you to effectively perform activities related to the following:

- Correct and Resubmit – edit rejected, denied or accepted claims to correct and resubmit
- Manual Secondary claims (based on user roles and permissions) – identify potential primary claims from which to generate secondary claims
- Manage COB adjudication
- Automated Secondary claims (based on user roles and permissions) – view only
- Manage unsubmitted claims – delete, or restore deleted unsubmitted claims
- Generate Volume Reports
- Generate Claim Reports

Claim Search – Results

Task: Search submitted/unsubmitted claims in order to finalize, view status details, view related claims and history, create claim status response, print claims, correct and resubmit claims, manage secondary claims and generate a report of search results.

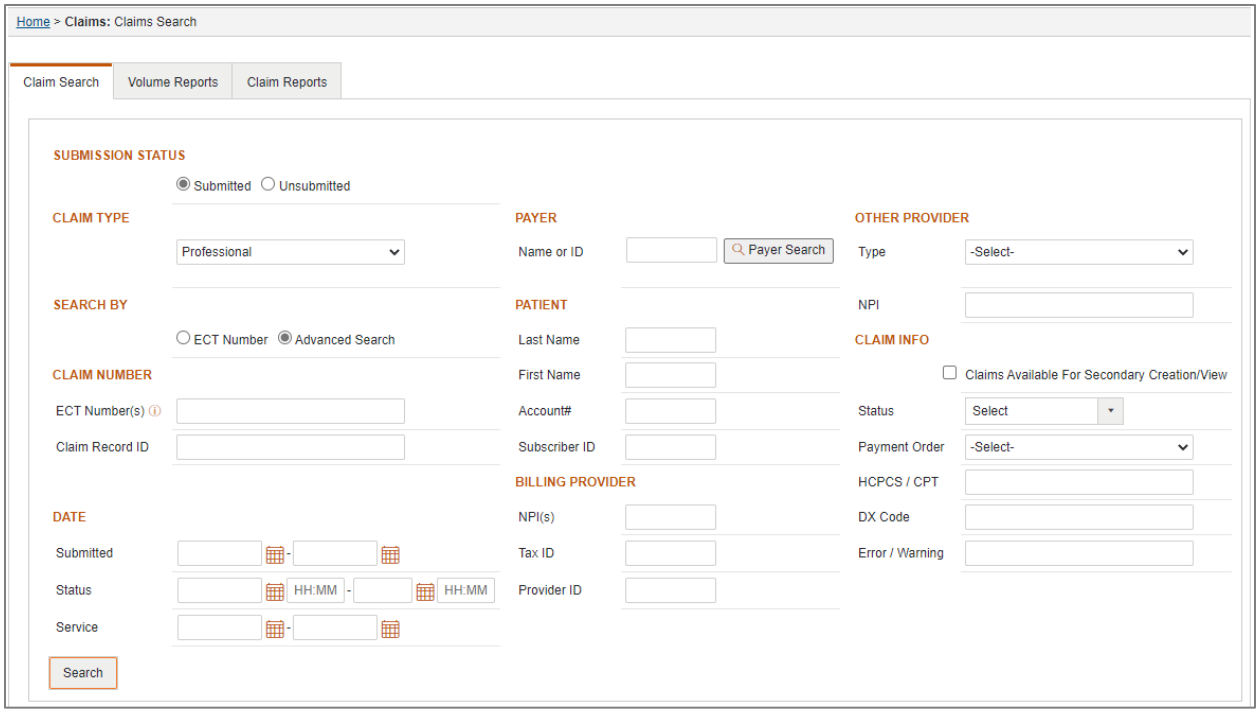
Navigation: Claims/Claim Search/Claim Search

Select Claims/Claim Search to open the Claim Search form, as shown below.

Begin by selecting a Submission Status, and Claim Type — Professional, Institutional, or Dental — and then you can search for claims using one of these three methods:

- Search By ECT Number – enter the Electronic Claims Tracking Number (the clearinghouse claim identifier)
- Search by Claim Record ID – enter the unique identifier generated by the Portal when the claim was created
- Search By Advanced Search – enter any known information into the Claim Search form. Search results correspond to the amount of information you enter on the form. You can narrow your search by entering more information in the form.
- Search without entering any information – results will reflect all claims submitted for the selected Billing Entity for the previous 7 days, which may result in an extended search time.

The search results is limited to a display of 500 records. You may adjust your search criteria to return fewer results.



Claim Search form categories and fields are described in the table below.

Claim Search Categories	Claim Search Field Descriptions
Submission Status	Select either Submitted or Unsubmitted
Claim Type	Select Professional, Institutional, or Dental. (Defaults to Professional)
Search By	Enter an ECT Number or Numbers; or select Advanced Search to enable available search fields, including potential secondary claims
Date	Enter known date ranges for Submission (defaults to 7 days if no date is selected), Status, and/or Service Lookback is limited to 13 months. The date of today is assumed if the "To" date is left blank.
Payer	Name or ID – populate using auto-complete or payer search feature
Patient	Enter known Patient information: Name, Account #, Subscriber ID
Billing Provider	Enter known information for NPI(s), Tax ID, and/or Provider ID
Other Provider	• Select a Type – the drop down is based on your selected Claim Type • Enter NPI
Uploaded File	Enter File Name/ID

Claim Search Categories	Claim Search Field Descriptions
Claim Info	• Status – choose one or more status options to filter, or choose All statuses. Note that you can choose, e.g., Denied (All) or choose only those specifically desired Denied claim statuses from the drop down. • Payment Order – choose Primary, Secondary, or Tertiary • HCPCS/CPT – enter known information • DX Code – enter known information • Error/Warning – enter the rejection code that was received • Claims Available For Secondary Creation/View – with Advanced Search you can check this box to see potential primary claims from which secondary claims can be generated manually

Select the Search button to obtain results, which is limited to a display of 500 records.

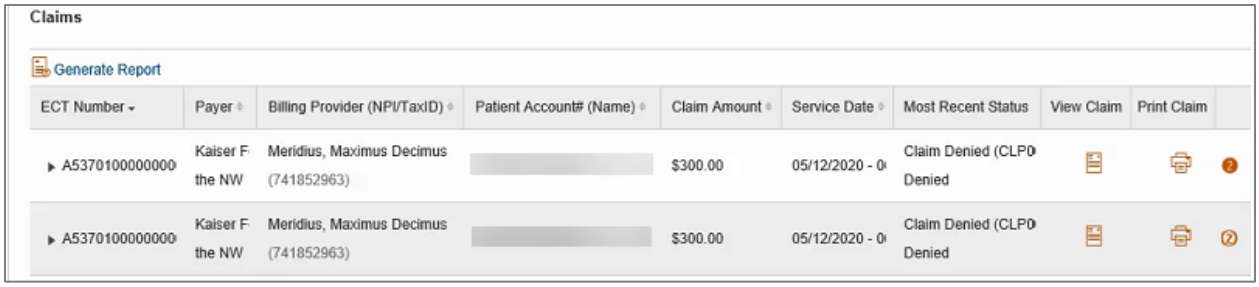
Search results contain only records for the selected Billing Entity (page banner).

Your login as a particular Billing Entity (default Billing Entity) determines the search results. If you reselect your Billing Entity in the page banner the Claim Search form clears and you may begin a new search.

The Claims grid reflects the following information about each individual claim, and provides options to view and print:

- ECT Number
- Payer
- Billing Provider (NPI/Tax ID)
- Patient Account # (Name)
- Claim Amount
- Service Date
- Most Recent Status
- View Claim
- Print Claim

The Claims grid displays files in descending order by the Claim ECT Number. You can select a number of reports to display, such as up to 100 per page, using that drop down.



The Claims grid offers the following action options:

- Use the Generate Report button to obtain a Claim Search Results report as a PDF file, which includes the first 10 records; or as a CSV file, which includes all of the currently displayed records
- Select any empty space on a row to open the details pane and view, as applicable, for Submitted or Unsubmitted claims – Status Details, Service Dates, Rejected Reason, Service Line Edits, Related Claims, and Notes, which includes the latest note and the extensive Claim Notes History (parent/child)
- Select the enabled View Claim icon to view claims in an Accepted or Pending status, or to edit and/or resubmit claims in any status. (Applicable links are provided on the claim form.)
- Select the Secondary Claim open circle ② icon to view an existing secondary claim, where icon is enabled
- Select the Secondary Claim shaded circle ② icon to generate a secondary claim, where icon is enabled
- Use the Print Claim icon to access the Print Claim option

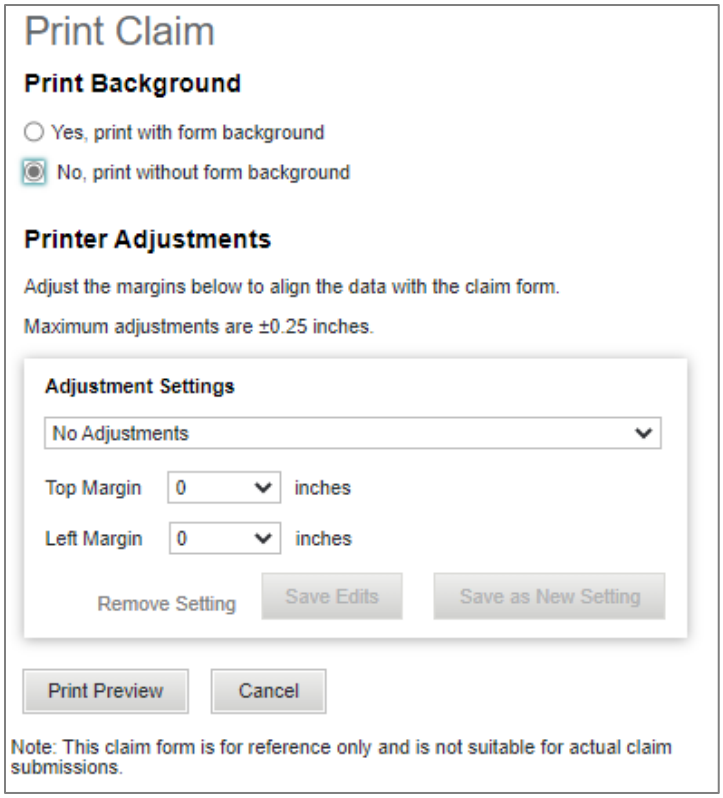
Print Claim

The Print Claim option is available for Professional and Institutional claims.

From the Claims grid use the Print icon on the desired row to open the Print Claim form, and select your preferred background option.

- Yes, print with form background – this option prints the entire claim (data, and form background) onto blank paper.
- No, print without form background – this option is used to print the claim data on a preprinted form.
  - Your printer must be loaded with a preprinted form (one form for each claim page)
  - Use Printer Adjustments to adjust margins as needed to align the claim data with your form
  - Save your adjustments as a new setting, to be available in the Adjustment Settings drop down
  - You can edit and remove each of your Adjustment Settings (note that the drop down defaults to No Adjustments, which cannot be edited or removed)

If you modify the default selection you can use the Print Preview button to review the claim prior to printing. When you are ready to print or save use those icons (top right).



The Print Claim form contains an important note advising that "This claim form is for reference only and is not suitable for actual claim submissions." (This advisory note previously appeared on the Print image form.)

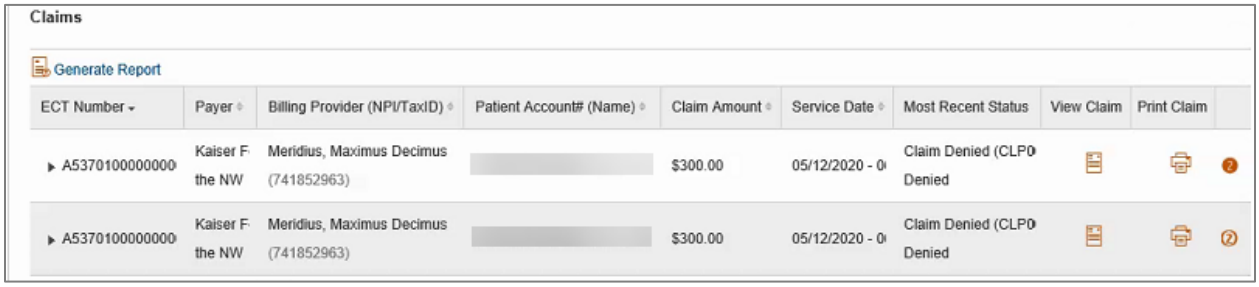
Correct and Resubmit

Task: Edit rejected, denied or accepted claims and resubmit. Based on user roles and permissions you may also generate XML, and view 837 X12 and 277 X12.

Navigation: Claims/Claim Search/Claim Search

Users may also access claims via Home/My Work Queue.

Select Claims/Claim Search to initiate a search as described in **Claim Search - Results** to obtain search results displayed in the Claims grid. Use the View Claim icon in the Claims grid to open the desired claim form.



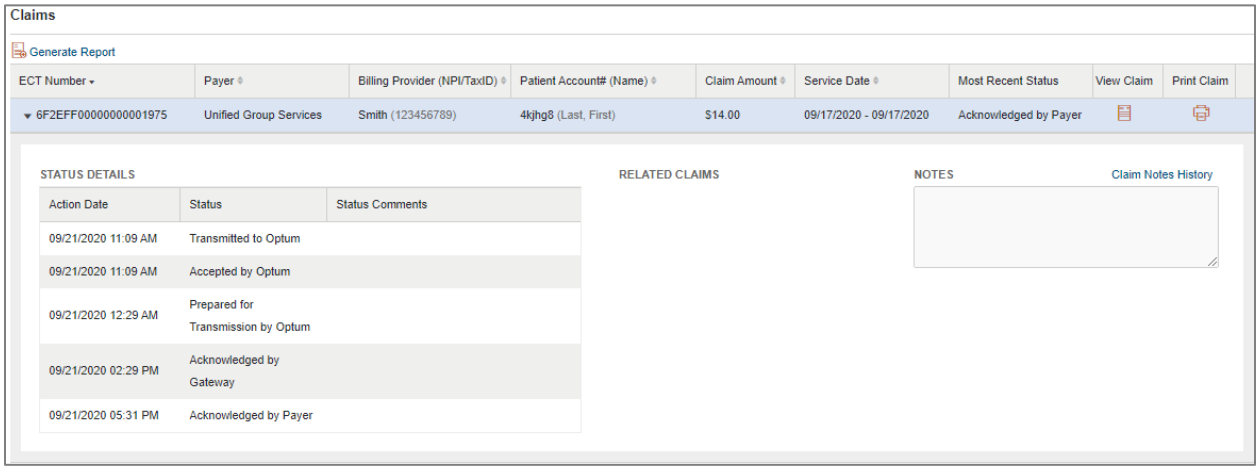
The View Claim icon and ability to edit are enabled based on your login as a particular Billing Entity, otherwise the icon is disabled and a message would alert you to select a related Billing Entity.

From the claim form you can select the links available in the ribbon to perform desired actions.

- You can select to view any available primary or secondary ERA or 835 X12, using the links provided. An advisory message displays if the requested information is not available. While viewing, you can also download and print an ERA form as a PDF file.
- View Claim Notes History, which also includes any related parent to child, or child to parent notes that were entered for previous claims.
- View Claim History, which also includes resubmissions history. The cascading Claim History provides a view of the tracking log for each previous parent or child claim, and provides a link to view each previous parent or child claim as saved at that time.
- Based on user roles and permissions you may generate XML for download or print.
- Based on user roles and permissions you may view the 837 X12 or 277 X12.

Use the Correct and Resubmit link (lower right) to initiate an adjusted claim. If a corrected claim has already been created you have the option to use the View Corrected claim link.

Using the Correct and Resubmit button creates a copy (child) of the rejected, denied or accepted claim with a new Claim Record ID, and places this child claim in a Saved status. You may select the row of any parent or child claim to open the details pane and view Related Claims information.



For a rejected or denied claim this new child claim reflects all of the errors from the parent claim so you can work through the corrections. This Claim Rejections information is displayed in red.

For an accepted claim you must determine any adjustments appropriate for resubmission.

You have the ability to initiate a corrected claim and use the Save Progress option to keep your edits as a partially completed corrected claim. When you resume work you can search for Unsubmitted claims in a Saved status (rather than a rejected, denied or accepted status) to finalize this claim for resubmission.

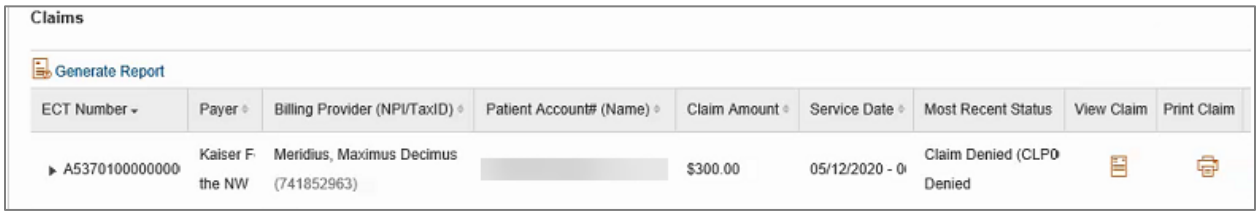
Make the necessary corrections, enter any notes (optional), and select Submit to resubmit the adjusted claim.

Create/View Claim Status Response

Task: Create and view claim status response for claims accepted by Optum that have not received an ERA, based on user roles and permissions

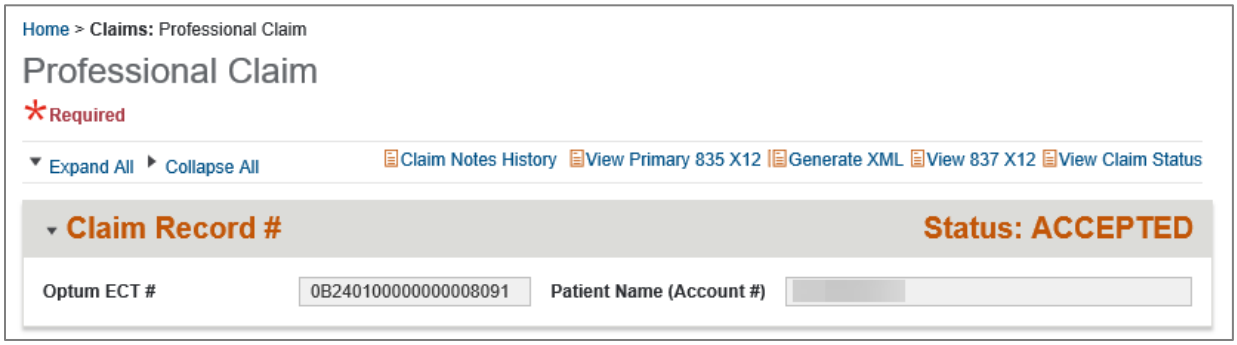
Navigation: Claims/Claim Search/Claim Search

To begin initiate a search as described in **Claim Search - Results** to obtain search results in the Claims grid. Use the View Claim icon in the Claims grid to open the desired Professional claim form.



From the claim form you can select the Create Claim Status (or View Claim Status) link to generate the Claim Status Response.

Note that once the Create Claim Status link has been used for the particular claim the link becomes View Claim Status. (The Claim Status Response pane displays for both, regardless of which link is used.)



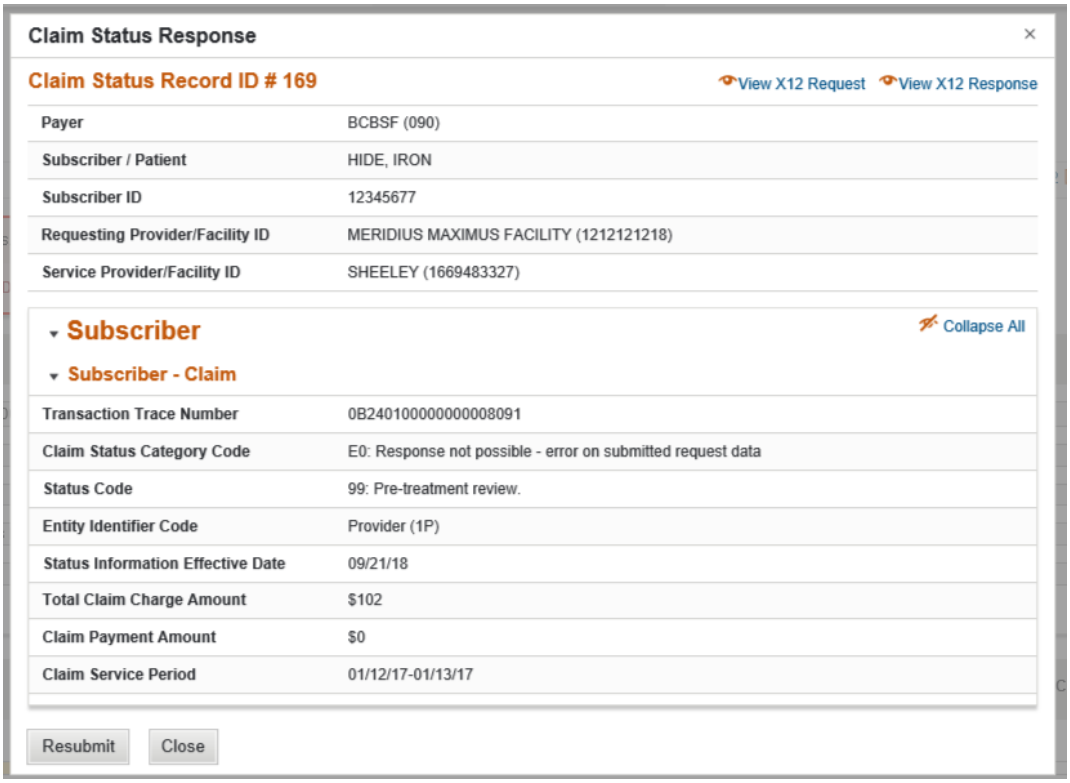
Create/View Claim Status is enabled based on your login as a particular Billing Entity, otherwise the icon is disabled.

The Claim Status Response provides the following:

- The most current response information

- Any applicable panels for viewing (such as Subscriber and Dependent; or claim line level)
- Links to View X12 Request, and View X12 Response
- Option to Resubmit or Close

You may select Resubmit to send a new inquiry on the claim as many times as you wish. However, note that the claim may generally be re-adjudicated only once a day. The Claim Status Record ID# changes each time you select Resubmit.



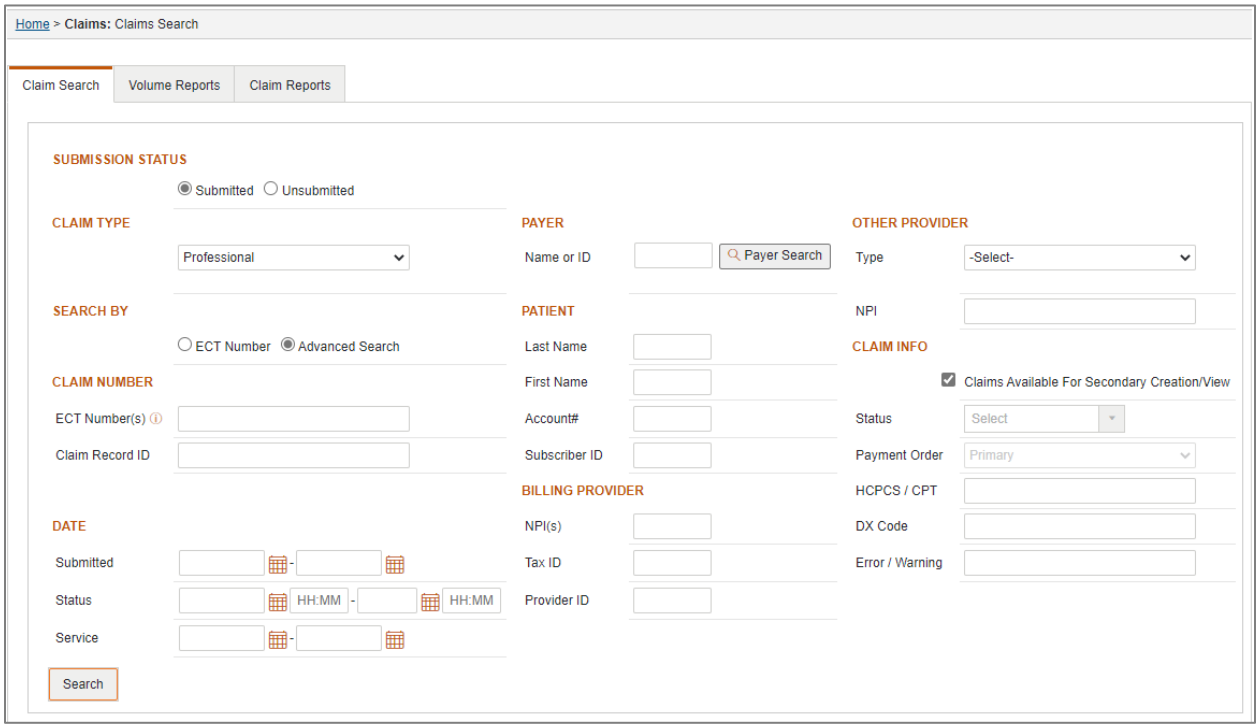
Manual Secondary Claims

Task: Identify and view potential Professional Primary claims from which you can manually generate secondary claims; view and edit secondary claims (based on user roles and permissions)

Navigation: Claims/Claim Search/Claim Search

Select Claims/Claim Search to initiate a search as described in **Claim Search - Results** to obtain results, and submit a search as follows to obtain results that automatically identify potential secondary claims based on an exact match remit constraint.

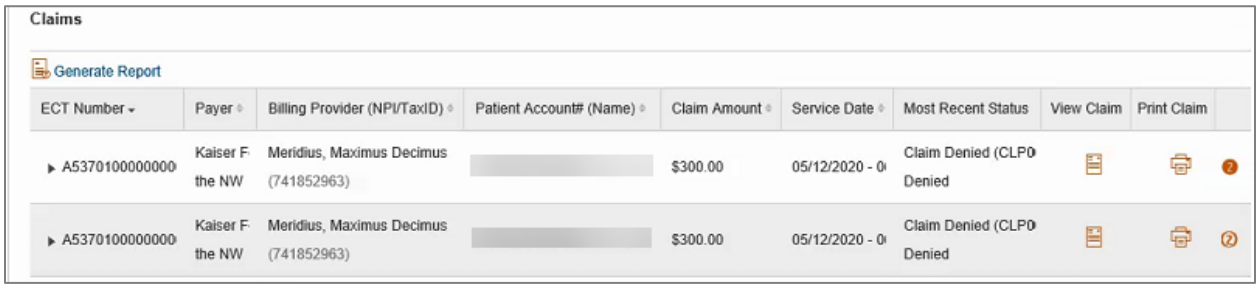
- Select Claim Type as Professional
- Use the Search By Advanced Search method – to enable the Claims Available For Secondary Creation/View checkbox
- Check the Claims Available for Secondary Creation/View checkbox under Claim Information. Note that the Status drop down defaults to All Status, and the Payment Order defaults to Primary.
- Enter any other known information and select the Search button.



In the resulting Claims grid any primary claims that have an exact match remit and therefore may be eligible for automated / Manual secondary claim generation are flagged with the secondary claim icon.

You can hover the secondary claim icon (numeral 2) on the desired row to display message text:

- View Secondary Claim – if the secondary claim has already been created you can select to view only using the open circle ② icon
- Generate Secondary Claim – you can select to generate a secondary claim from this primary claim using the shaded circle ② icon

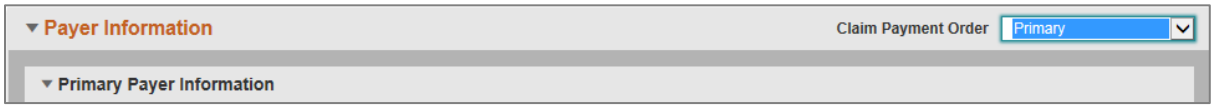


When you select to generate a secondary claim you are navigated to the Claim Submission form page where the secondary claim form is auto-populated with information from the primary claim in accordance with expected COB business rationale:

- Pertinent Primary/Secondary information is automatically interchanged (e.g., Insured/Other Insured, Primary and Destination (secondary) payer.)
- Claim Level and Line Level Coordination of Benefits information is calculated using matched remit information.

Note that you may be required to enter basic balancing sums to complete the claim.

The Payer/Claim Payment Order drop down allows you to select to view the primary claim for the claim you are completing.



You have the ability to view, edit and validate the claim before submitting, as described in **COB Adjudication**.

COB Adjudication

Task: Capture and validate coordination of benefits adjustments and contract information to complete secondary and tertiary claims

Navigation: (when working within a claim form)

The COB (Coordination of Benefit) capability supports the entry and validation of applicable information, and provides claim level adjudication, as well as line level adjudication.

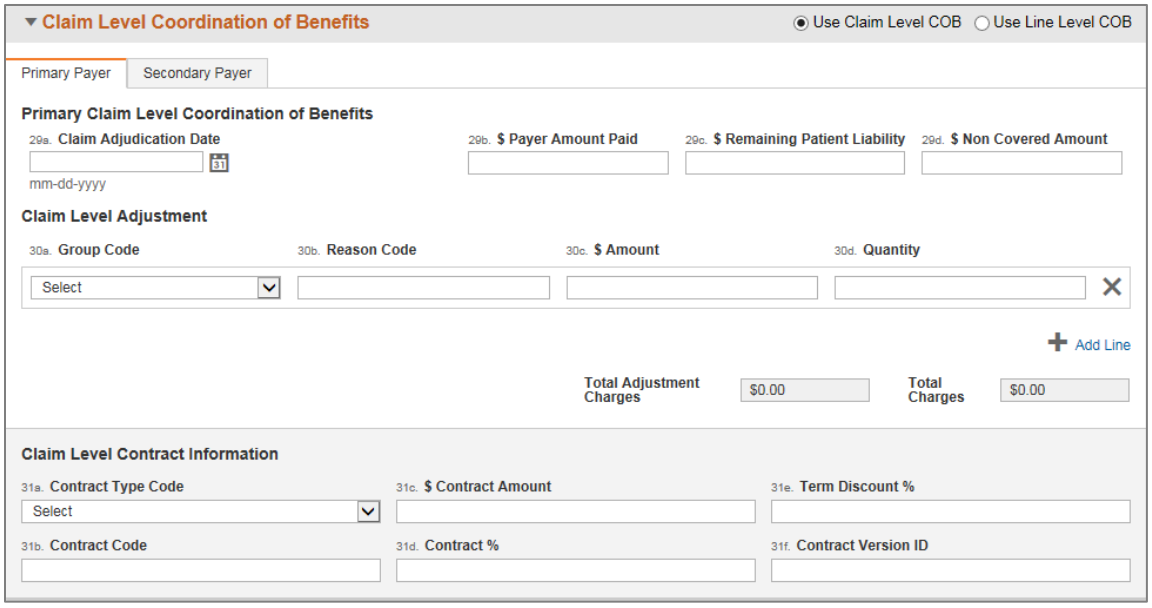
Coordination of Benefit (COB)

For secondary and tertiary claims you can manage applicable adjustments and reach adjudication using the Coordination of Benefits (COB) forms.

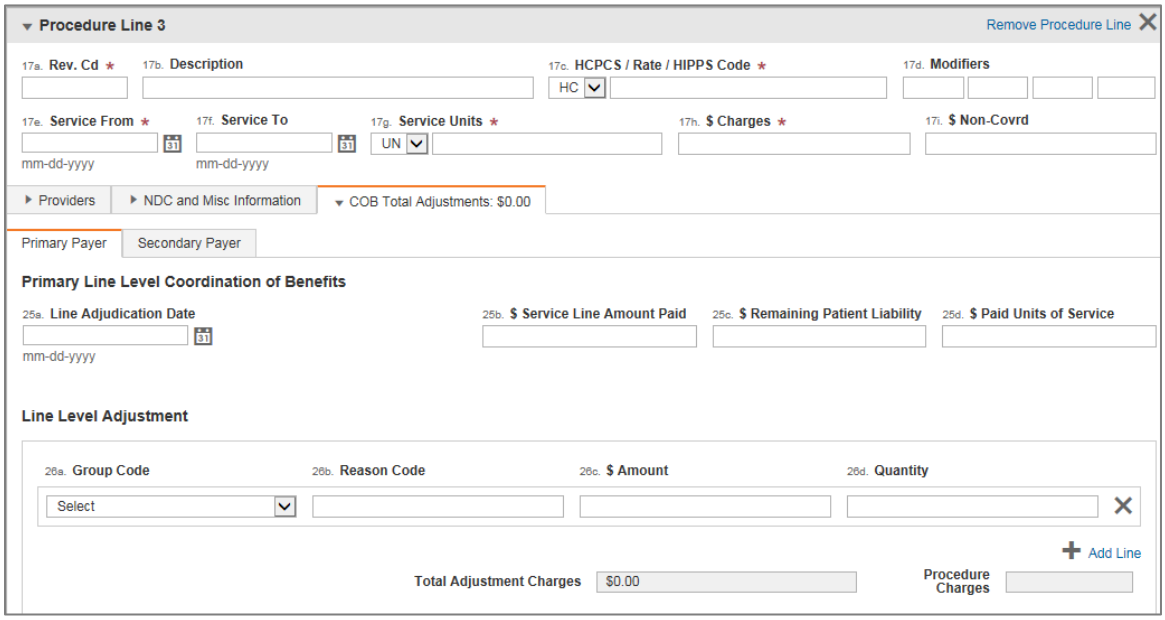
To begin, select a radio button from the Claim Level Coordination of Benefits header to indicate how you will apply adjustments.

- Use Claim Level COB
- Use Line Level COB

Use Claim Level COB provides a single form to complete for COB, as shown below.



Use Line Level COB provides a COB Total Adjustments tab for each Procedure Line, as shown below. Select the tab to open and complete a form for each Procedure Line.



The Payer/Claim Payment Order drop down allows you to select to view the primary, secondary or tertiary claim for the claim you are currently entering.

Enter your Claim Level/Line Level COB adjustments and the Claim Level/Line Level Contract Information on a Claim Level Coordination of Benefits form.

You are alerted if you select Cancel without first selecting Save Progress.

You can view adjudication at claim level and for each procedure line.

The application validates the new information and balances the claim. The adjustment amounts are displayed on the claim form at the claim level, and also each procedure adjustment amounts are provided on the Procedure Line.

COB validation is performed based on these constraints:

- Each Service Line Amount Paid plus the Line Level Adjustment Amount(s) for that line must equal the original line $ Charges
- Sum of all Service Line Amount Paid minus the sum of all Claim Level Adjustment Amount must equal the Claim Payer Amount Paid

The Payer Amount Paid plus all Claim and Line Level Adjustment Amounts must equal the original Claim Total Charge amount.

Automated Secondary Claims

Task: View automatically generated Professional secondary claims (based on user roles and permissions)

Navigation: Claims/Claim Search/Claim Search

Based on customer configuration a Secondary claim can be auto-generated from a Primary claim with an exact match remit

Based on user roles and permissions you may have the ability to view Professional secondary claims that have been generated automatically based on an exact match remit constraint.

Select the desired Payment Order as part of your search criteria to view the automatically generated secondary claims.

Manage Unsubmitted Claim

Task: Edit a single unsubmitted claim to set as deleted status, or restore from deleted status

Navigation: Claims/Claim Search/Claim Search

Select Claims/Claim Search to initiate a search as described in **Claim Search - Results** to obtain search results displayed in the Claims grid.

- Submission Status – you must select Unsubmitted status
- Claim Info /Status – filter for Saved claims and/or Deleted claims

In the Claims grid use the View icon to open and adjust the desired claim form.

You may set a Saved but unsubmitted claim to a Deleted status using the Delete button, and selecting Yes in response to the confirmation request.

If you wish to revert a deletion you can select the Save Progress button to return the claim to a Saved status. The restored claim reflects the same information it contained when it was deleted.

A success message displays when you successfully delete or restore a claim.

You may not return to the previous search results but must run a new search to adjust each additional claim.

Volume Reports

Task: Use the Claim Search feature to generate Professional and Institutional volume reports

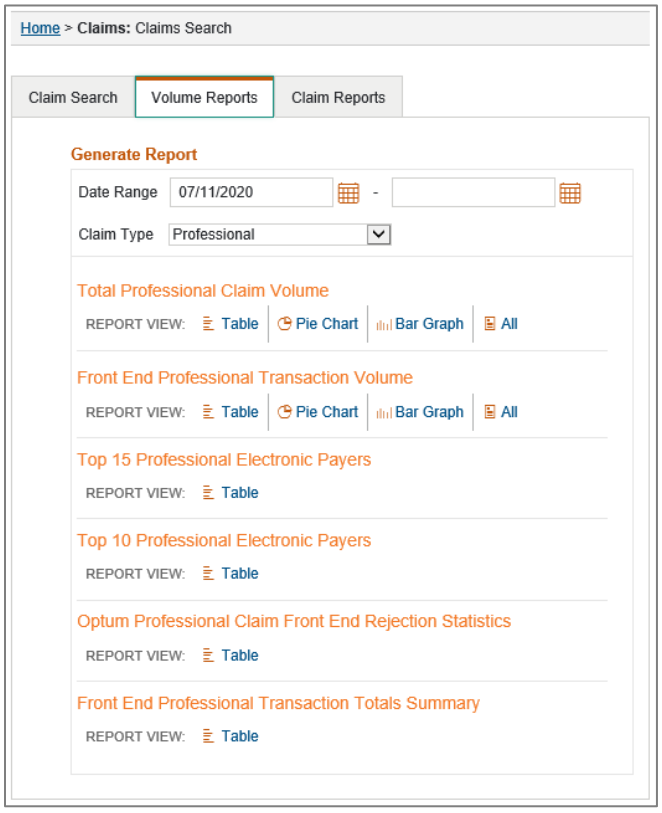
Navigation: Claims/Claim Search/Volume Reports

Select the Volume Reports tab to generate reports, as shown below.

To begin, select the desired Date Range, and Claim Type.

Use the active links to choose the preferred report type from the following options:

- Table – results for the entire date range are compiled in a single table
- Pie Chart – results are provided as one chart within the date range
- Bar Graph – results are provided as one graph within the date range
- All – results are provided within the date range (table, chart, and graph)



Volume Reports include choices such as the following for Professional and Institutional reports:

- Total Claim Volume – provides a daily breakdown
- Front End Transaction Volume – provides a daily breakdown
- Top 15 Electronic Payers – provides a monthly breakdown
- Top 10 Electronic Payers – provides a monthly breakdown

- Optum Claim Front End Rejection Statistics – provides a daily breakdown
- Front End Transaction Totals Summary – provides a daily breakdown

Claim Reports - Search

Task: Use the Claim Search feature to view and generate Claim Reports of claims received by payers for processing

Navigation: Claims/Claim Search/Claim Reports

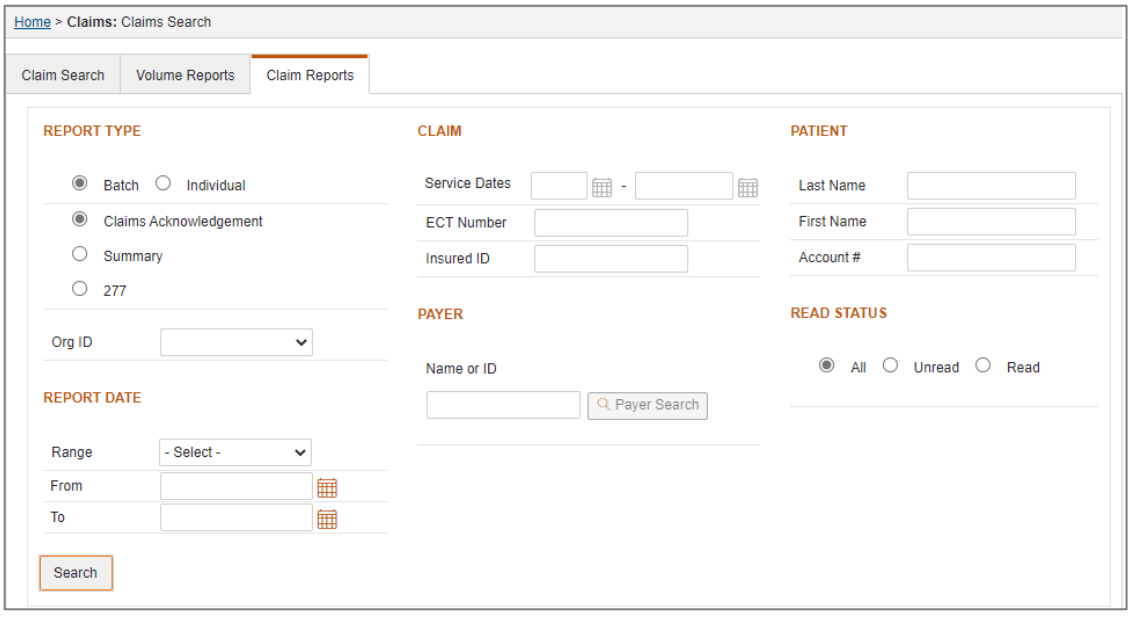
From the Claims/Claim Search page select the Claim Reports tab to generate reports for claims received by Optum and the Payer for processing. The Claim Search feature allows you to search and generate these Claim Reports:

- Claims Acknowledgement
- Summary
- 277

Search filters vary based on your selected Report Type, and may include Batch or Individual report options. Batch reports compile the data by day, i.e., for each day included in a report.

Enter any known information into the Search form to narrow your search.

A date Range, or Start and End Dates is not required, but will narrow your search when this filter is available. If you enter no date parameters the results will reflect all claims dated for the selected Billing Entity for the previous 13 months, except that the display is limited to 500 records.



Generated reports are provided as a pdf file. Multiple reports appear on separate pages of the single pdf file. Hover the footer to reveal the tool tip options, e.g., to print or save.

If no results are returned an error message displays such as, “There were errors while generating report. Please contact Service and Support to report this error. Be prepared to provide the identifiers.”

Note that in the results grid you can use the Show Per Page drop down to select a number of reports to display per page.

Claims Acknowledgement Reports

Task: Use the Claim Search feature to generate Claims Acknowledgement reports

Navigation: Claims/Claim Search/Claim Reports

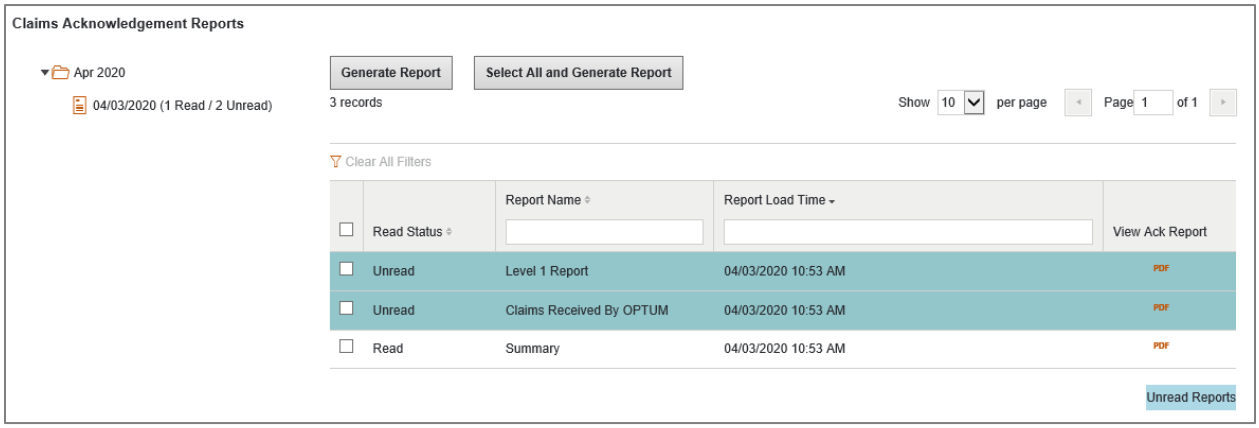
Select the Claim Reports tab to search and generate a Claims Acknowledgement report, which provides standardized Level 1 and 2 confirmation reports from Optum, and Payer acknowledgement reports. You may filter your search as follows:

- Batch Report – filter by Report Date and Read Status
- Individual Report – filter by Submission Date, Claim and Patient information

Batch Report

The Batch Claims Acknowledgement Reports grid reflects the Read Status, Report Name and Report Load Time; and provides a View Ack Report link to review a specific report.

Note that any Unread Reports are highlighted, as indicated by the legend (lower right).



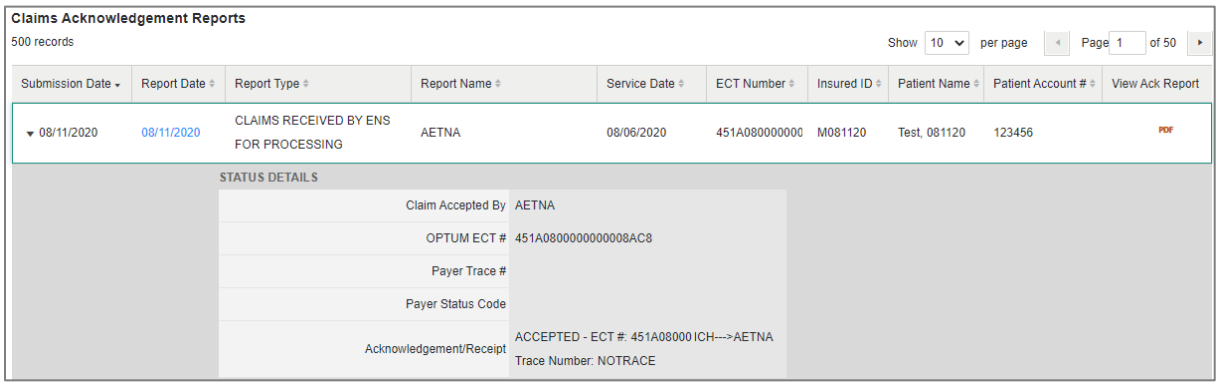
You may generate all, or only the desired Claims Acknowledgement Reports as follows:

- Select All and Generate Report – use this option to generate all of the reports displayed on the current page
- Generate Report – select one or more row checkboxes and use the Generate Report button to generate only those desired reports. (Note that you have the option to use the header checkbox to select all of the displayed reports before using the Generate Report button.)

Individual Report

The Individual Claims Acknowledgement Reports grid reflects the active fields contained in the Search form, as well as a Report Date, Report Type specifics, Report Name; and provides a View Ack Report link to review a specific report.

Select any empty space on a row to open the details pane to review specific Payer information in the Status Details pane.



To view and generate batch reports for a single date you must use the Report Date link to navigate to the Batch Claims Acknowledgement Reports grid. (You may not return to the Individual report after selecting the Report Date link.)

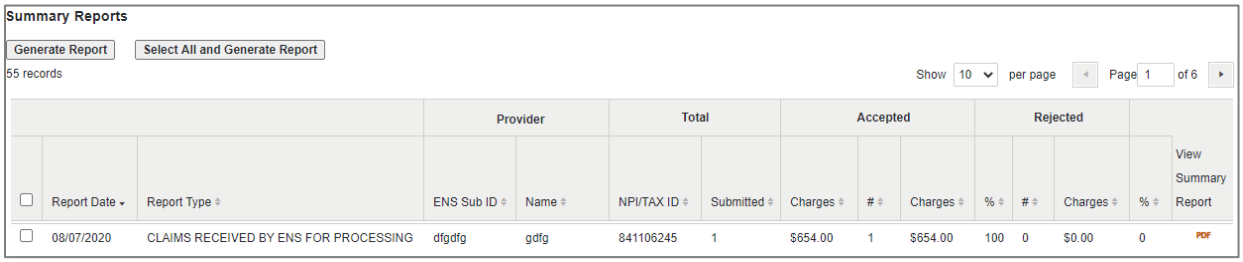
Summary Reports

Task: Use the Claim Search feature to generate Summary Reports of claims received by payers for processing.

Navigation: Claims/Claim Search/Claim Reports

Select the Claim Reports tab to search and generate Summary Reports.

The Summary Reports grid reflects the Report Date, Report Type, and contains pertinent details related to Provider, Total, Accepted and Rejected; and provides a View Summary Report link to review a specific report.



You may generate all, or only the desired Summary Reports as follows:

- Select All and Generate Report – use this option to generate all of the reports displayed on the current page
- Generate Report – select one or more row checkboxes and use the Generate Report button to generate only those desired reports. (Note that you have the option to use the header checkbox to select all of the displayed reports before using the Generate Report button.)

A sample Summary Report is shown below.

Level 2 - optum claim acknowledgement report
Claims received by optum for processing

Summary for 841106245			
Payer	ENSAK		
Tax ID	841106245		
Date	08/07/2020		
	Submitted	**Accepted**	**Rejected**
Claims	1	1	0
Charges	$654.00	$654.00	$0.00
Percentage		100%	0%

277 Response Reports

Task: Use the Claim Search feature to generate the 277 response reports (HIPAA format)

Navigation: Claims/Claim Search/Claim Reports

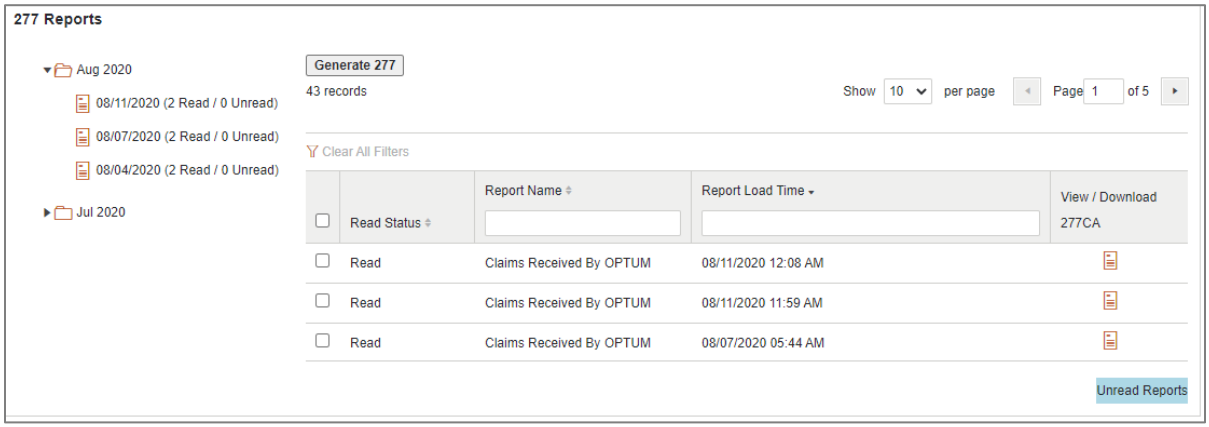
Select the Claim Reports tab to search and generate a 277 report of claims received by payers for processing. You may filter your search as follows:

- Batch Report – filter by Report Date and Read Status
- Individual Report – filter by Submission Date, Claim, and Patient, and Payer information

Batch Report

The Batch 277 Reports grid reflects the Read Status, Report Name and Report Load Time, and provides a View/Download 277CA link for each specific file.

Note that any Unread Reports are highlighted, as indicated by the legend (lower right).

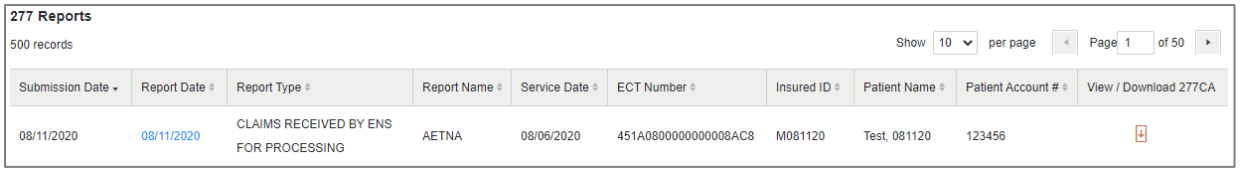


To generate the 277 Reports select one or more row checkboxes, or you may use the header checkbox to select all of the reports displayed on the current page.

Select the Generate 277 button.

Individual Report

The Individual 277 Reports grid reflects the active fields contained in the Search form, as well as a Report Date, Report Type specifics, Report Name; and provides a View/Download 277CA link for each specific file.


277 Reports

500 records

Show 10 per page Page 1 of 50

Submission Date	Report Date	Report Type	Report Name	Service Date	ECT Number	Insured ID	Patient Name	Patient Account #	View / Download 277CA
08/11/2020	08/11/2020	CLAIMS RECEIVED BY ENS FOR PROCESSING	AETNA	08/06/2020	451A0800000000008AC8	M081120	Test, 081120	123456	

To view and generate batch reports for a single date you must use the Report Date link to navigate to the Batch 277 Reports grid. (You may not return to the Individual report after selecting the Report Date link.)

Check Claim Status – Request

Task: Check the status of a claim

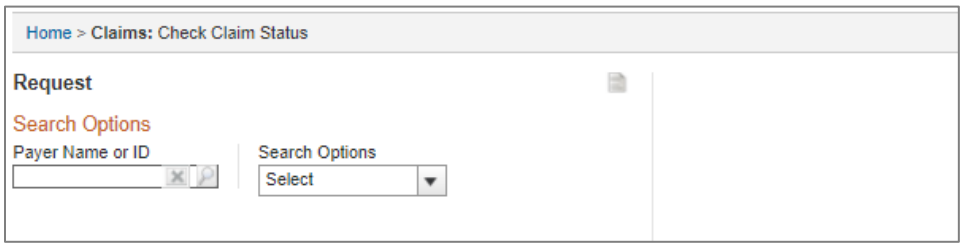
Navigation: Claims/Check Claim Status

The Check Claim Status feature allows you to manually generate a claim status request to check the status of a claim.

You may also create a Claim Status Response from the Create Claim Status link provided on the claim form (Professional), accessed via the Claim Search results.

Select Claims/Check Claim Status to open the initial view of the Request form, as shown below.

You must initiate the Request form by completing the Payer Name or ID, and Search Options fields. These fields are required and must be completed in that sequence.



The expanded Request form contains the following elements:

- Search Options – Payer Name or ID, and specific Search Options
- Search Criteria – payer requested information
- View X12 option – to view, download or print the request in X12 format

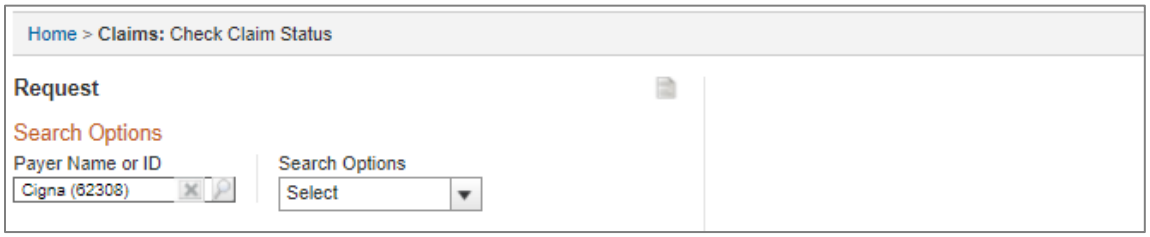
When you are using the Check Claim Status function your selected path persists on the Home line at the top of the page. You can click the active breadcrumb link to return to any previous tier.

Payer Name or ID

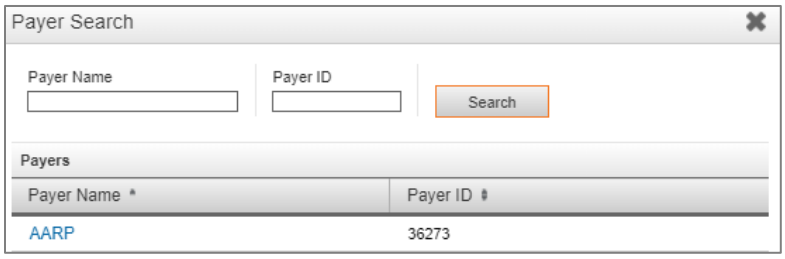
You must enter a Payer Name or ID before you can select a Search Option. You can complete the Payer Name or ID field using the auto-complete feature or the wildcard search method.

Your Payer search list is determined by the default Billing Entity (page banner).

To use the auto-complete feature enter the first two characters of a Payer Name or ID and select from the drop down results. To clear the field use the Clear feature, or click the **x** at the end of the field.



For a wildcard search click the Magnifying Glass icon to open the Payer Search form. Enter at least two sequential characters in the Payer Name field and click Search. Select the desired Payer Name link.



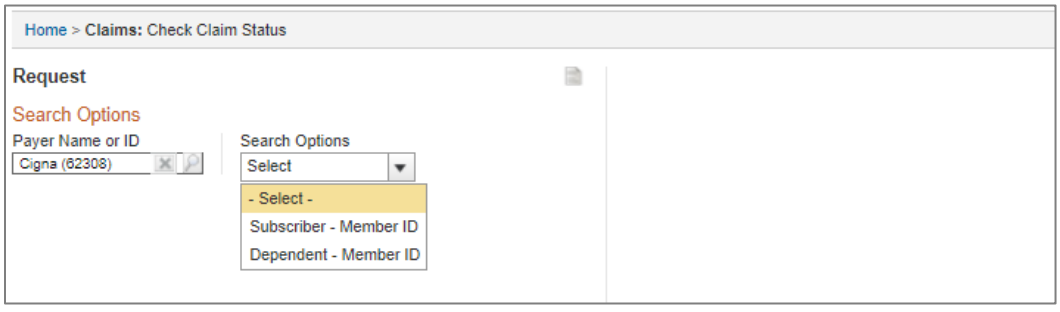
Search Options

You may select a Search Option only after you have populated the Payer Name or ID field. Only those Search Options that are applicable to the selected Payer are displayed.

Click the Search Option drop down and select from the choices provided.

Examples include options such as the following:

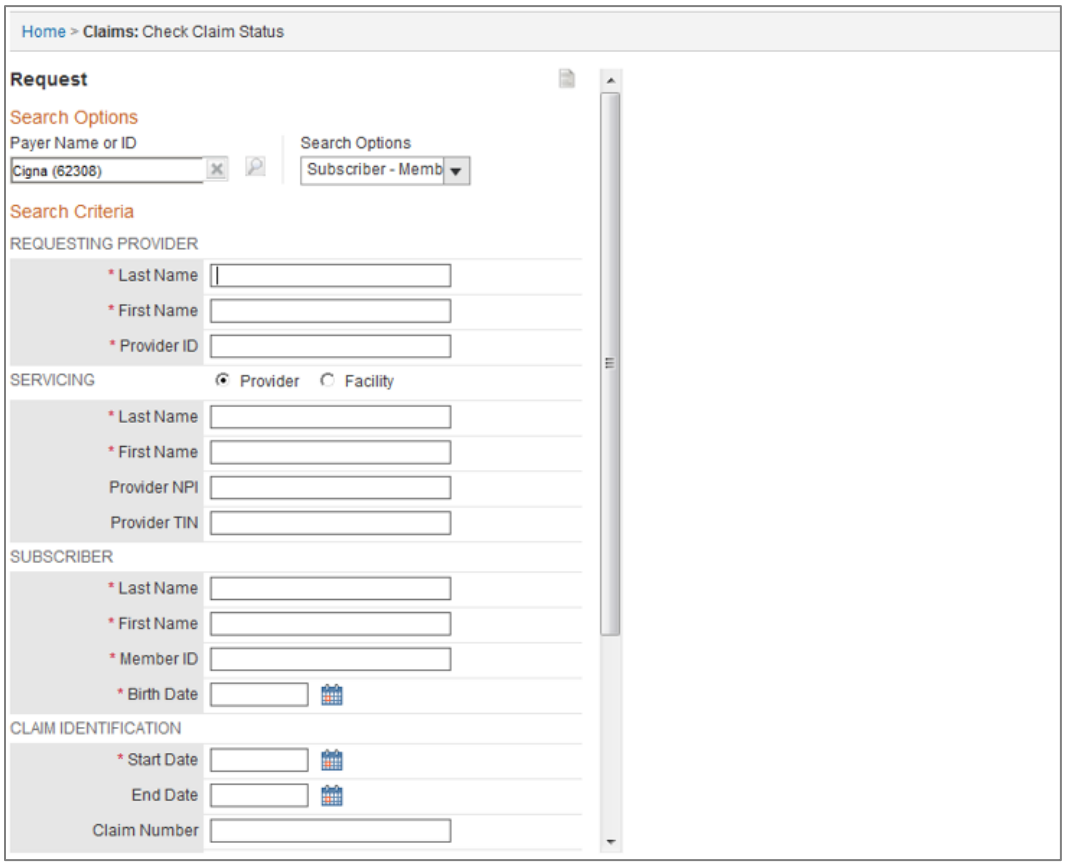
- Dependent – Member ID
- Subscriber – Member ID



Search Criteria

You may continue completion of the Request form after the Payer Name/Payer ID and the Search Options fields are populated.

The Search Criteria applicable to your Search Options are displayed on the Request form, as shown below.



The default Billing Entity (page banner) determines whether Requesting Facility or Requesting Provider fields are displayed in the Search Criteria area.

Your login as a particular Billing Entity (default Billing Entity), or your subsequent reselection of a Billing Entity in the page banner determines whether Requesting Facility or Requesting Provider fields are displayed in the Search Criteria area.

If you reselect your Billing Entity in the page banner:

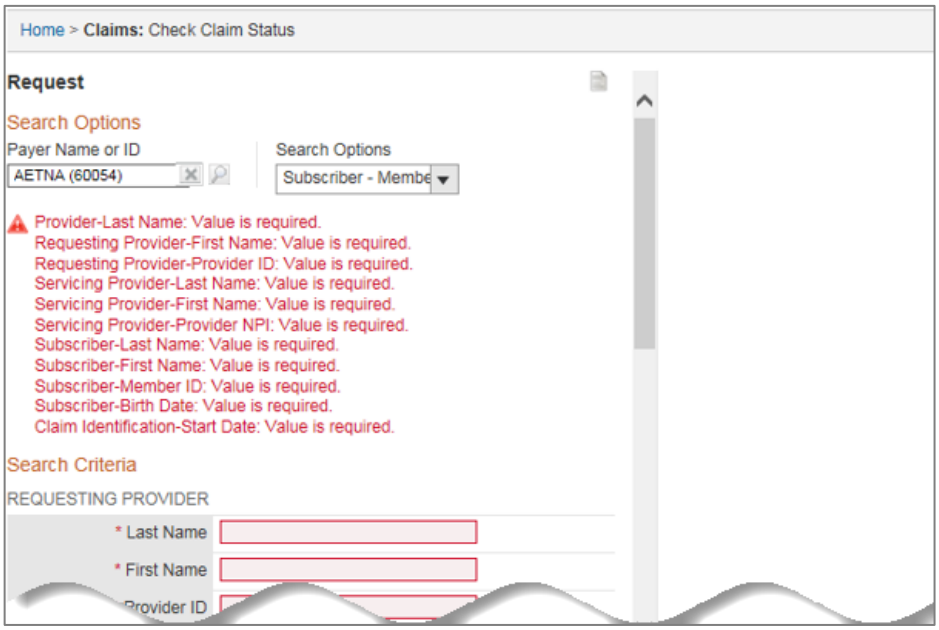
- The page refreshes to display the appropriate search fields
- Existing Payer Name or ID and Search Options entries persist
- Your Billing Entity selection persists until you change it, or log out. Note that you may need to manually refresh your page if a subsequent Billing Entity selection does not support both Provider and Facility.

Complete the Search Criteria area by selecting from the applicable options provided on the Request form, such as described in the table below.

Search Criteria Fields	Notes
Requesting Facility	Complete at least the required fields, e.g., name and ID.
Requesting Provider	Use auto-complete search by entering first two characters of Last Name. Select a Provider from the drop down to auto-populate Provider fields with data available for that Provider. If the fields remain blank you must fulfill manually.
Servicing	The radio button defaults to Provider or Facility based on your Billing Entity login. Toggling clears any entries you have made in the Servicing fields and following fields, but other data on the Request form is retained. Note: Toggling does not clear any error messages, even those that applied to the cleared fields. Only the Submit action refreshes the error message display.
Subscriber	Use calendar icon or enter date fields as MM/DD/YYYY
Dependent	Use calendar icon or enter date fields as MM/DD/YYYY
Claim Identification	May require items such as service dates, claim number, trace number, claim amount, group number, patient account number, institutional bill type, application/system identifier.

The Search Criteria function performs applicable validations on the fields. This is designed to increase the chances of an accurate claim status response.

All of the required fields (*) in the Search Criteria area must be completed with valid information for Requesting Facility or Requesting Provider, Servicing, Subscriber, Dependent, and Claim Identification. Applicable error messages are displayed and the field is highlighted if you attempt to submit incomplete or invalid information, as shown below.



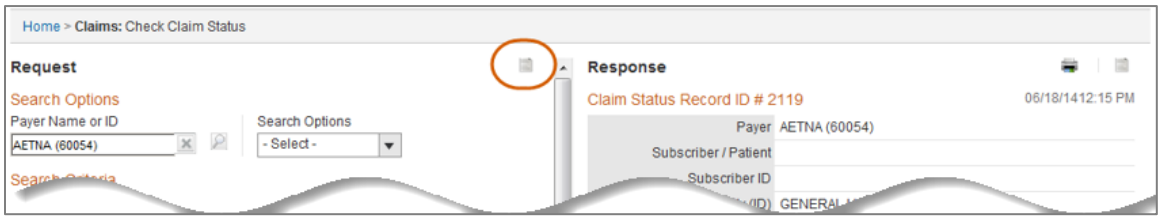
Any lower case data entered in the Check Claim Status request form is converted to upper case prior to submission to the payer, but may not display on the form as capitalized.

Click to Submit, or use the Clear Criteria option to enter new Search Criteria (the selected Search Options remain populated).

Access X12 Version of 276 Request

The View X12 icon is enabled when you successfully submit a request and the 276 Request is created.

View X12 is displayed based on user role and permissions.



- Click the View X12 icon to open and view the X12 version of the 276 Request, as shown below.
- Click the Download button (upper right) to save the X12 file to your local machine.
- Click the Print button (upper right) to print the X12 file to your printer.

Check Claim Status – Response

Task: Check the outcome of a claim

Navigation: Claims/Check Claim Status

When you have successfully submitted a Request to check claim status there are three possible outcomes or Response types:

- 277 Response
- 999 and/or TA1 Response – Errors
- Exception Errors – transmissions errors

Your Response is displayed beside your Request form for convenient reference, and you can scroll the Response pane separately to review the outcome of your Request.

The Claim Status Record ID# is an internal transaction ID for your Request and Response. Transaction details are provided, which include:

- Payer
- Subscriber/Patient
- Subscriber ID
- Requesting Facility/Provider Name (ID)
- Servicing Facility/Provider Name (ID)

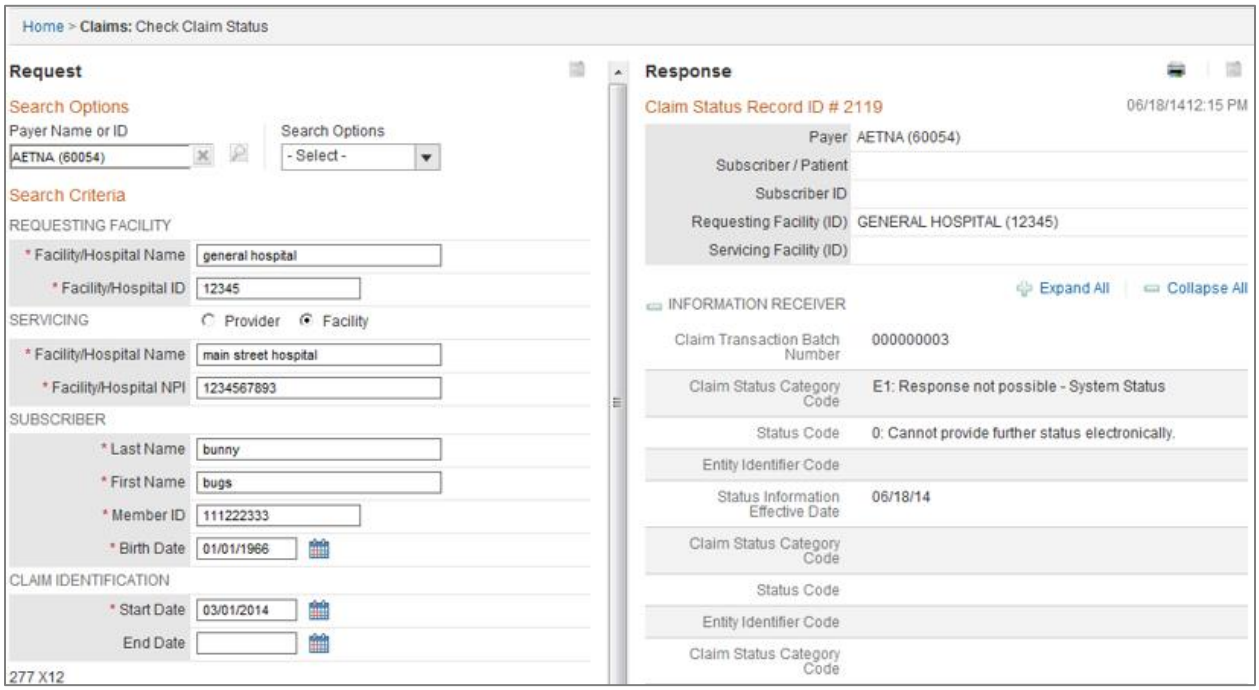
To view details provided in the Response use the Expand All / Collapse All icons. You may also expand and collapse each individual item.

Click the icons (upper right) to Print the Request and Response, and View X12.

277 Response

A 277 Response always contains the Claim Status Record ID#, as well as any other applicable categories of information.

- Claim Status Record ID# – contains the header information, as shown below.
  - Payer
  - Subscriber/Patient
  - Subscriber ID
  - Requesting Facility/Provider Name (ID)
  - Servicing Facililty/Provider Name (ID)
- Information Receiver
- Service Provider
- Subscriber - Claim
- Subscriber - Service Line – includes Line Item Control Number if returned
- Dependent - Claim
- Dependent - Service Line – includes Line Item Control Number if returned



999 and/or TA1 Response – Errors

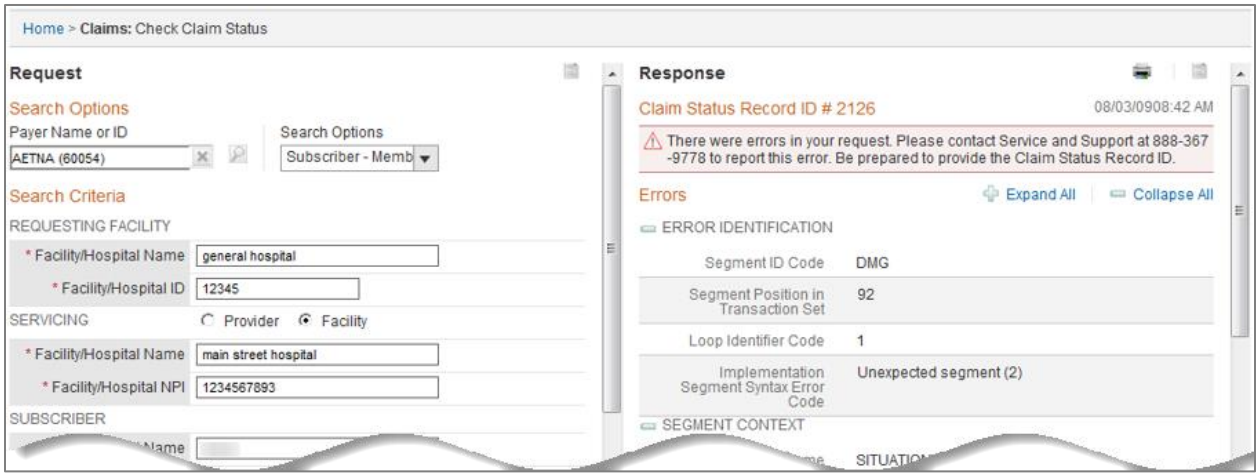
The 999/TA1 Response indicates errors in the Request, as shown below.

The 999/TA1 Response always contains the Claim Status Record ID#, as well as any other applicable categories of information.

- Claim Status Record ID# – identifier number only
- Date and Time
- Errors – can include the following:
  - Error Identification
  - Segment Context
  - Business Unit Identifier
  - Implementation Data Element Note
  - Interchange Acknowledgement

If both a 999 Response and a TA1 Response are received they are displayed together.

The default message states, e.g., “There were errors in your request. Please contact Service and Support to report the error. Be prepared to provide the Claim Status Record ID.”



Exception Errors

An Exception Errors Response is rare, but indicates a transmission error between sender and receiver, and X12 is not returned.

An Exception Errors Response contains the following information:

- Eligibility Record ID# – identifier number only
- Errors – error statement(s) only

The default message states, e.g., “There were errors in your request. Please contact Service and Support to report the error. Be prepared to provide the Claim Status Record ID.”

Payments

The Intelligent EDI Payments function provides the following options:

- Remittance Search
- Patient Statements
- Variances

Remittance Search

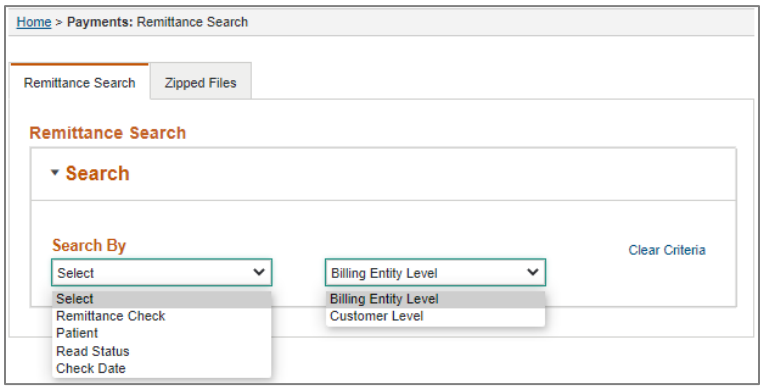
Task: Search for check received from payers for claims

Navigation: Payments/Remittance Search

The Remittance Search feature allows you to search for checks received from payers for claims. The results are displayed in the Remittance Search results grid.

Select Payments/Remittance Search to open the Remittance Search form, as shown below.

Begin by selecting from both of the two Search By drop down fields. You may search by Remittance Check#, Patient, Read Status, or Check Date; together with Billing Entity (default) or Customer Level. Your selections enable the applicable form fields.



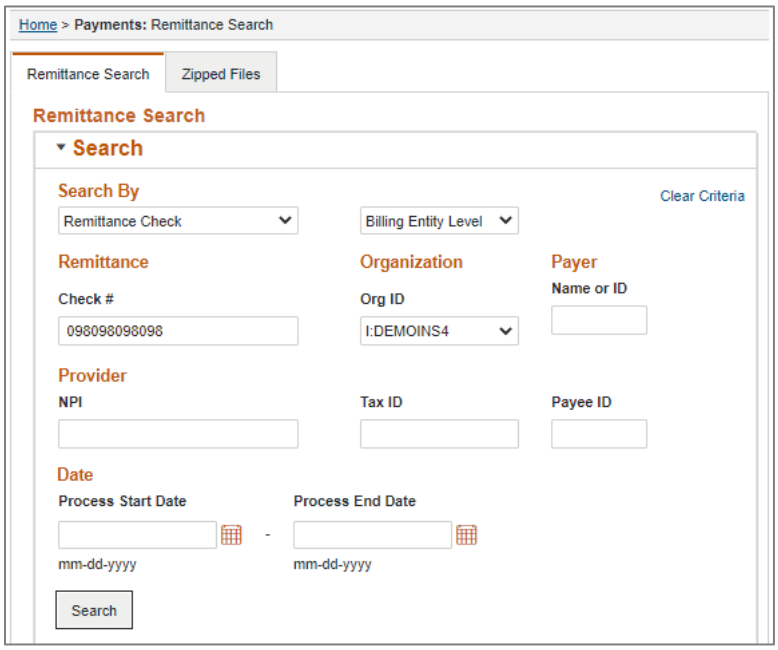
You can refine your search by entering any known information into the corresponding search fields in the Claim Search form, such as the following:

- Remittance – Check # – enter the desired check number. This search defaults to remittances dated in the previous 90 days.
- Organization ID – select Org ID from the drop down
- Date range – such as Check Date, Process Date, or Service Date
- Patient information – such as first and last name (both are required if searching by name), Account#, Subscriber ID. A search using patient name defaults to remittances dated in the previous 90 days.
- Provider identifiers – such as NPI, Tax ID, Payee ID
- Payer Name or ID
- Payment information – such as Check Amount, Total Paid, Total Allowed, CAS Code, Type of Bill, and Status Code

- Read Status – use to select files that have/have not yet been read, or to select all files. This search defaults to remittances dated in the previous 13 months.
- Check Date – you must enter a Check Date; and also a Process Date and/or a Check # must be provided to use this search option.

Search results correspond to the amount of information you enter on the form. If you enter no information the results will reflect all remittances dated for the selected Billing Entity or Customer Level option for the default timeframe. You can narrow your search by entering more information in the form.

Use the Search button for results, or use the Clear Criteria option to begin a new search.

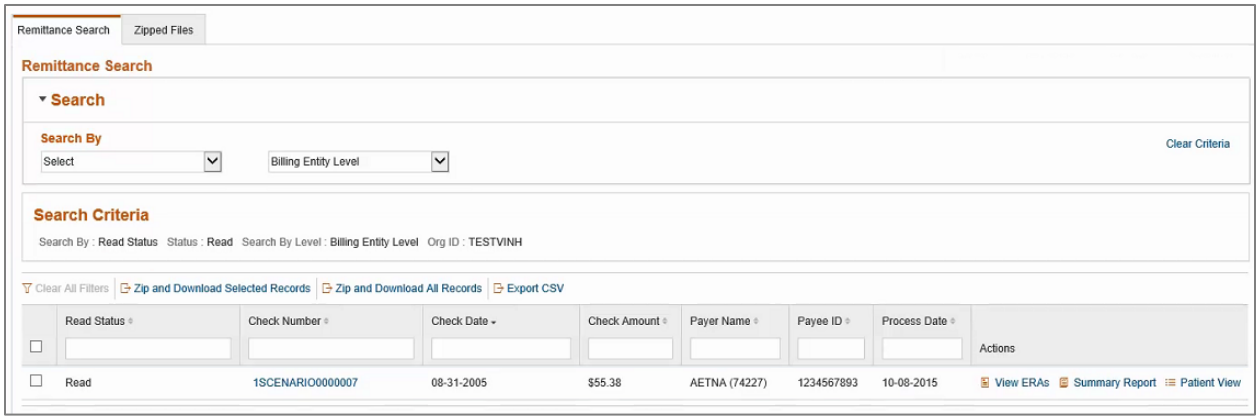


The Search feature returns possible matches in the Remittance Search results grid.

The Remittance Search results grid displays results in descending order by Check Number, and contains the following information.

- Read Status – any Unread records will be highlighted to differentiate
- Check Number
- Check Date
- Check Amount
- Payer Name (ID)
- Payee ID
- Process Date

You can filter and sort using the column headers fields.



From the Remittance Search results you have the following action options.

- View ERAs – to view ERAs at Check Level
- Summary Report – to display the readable Summary Report
- Patient View – to view remittance details at Patient Level, and access ERAs at Patient Level
- Zip and Download All Records – to download all files currently displayed. Once files are zipped the status reflected here changes from Unread to Read.
- Zip and Download Selected Records – to download one or more files. Select row checkboxes for desired files. Once files are zipped the status reflected here changes from Unread to Read.
- Export CSV – use the Export CSV link to export and save the initial results currently displayed in the Remittance Search results grid. Note that the exported file includes only the parent level information displayed on the screen, that is, the exported file does not include anything other than the level of information currently visible in the results grid.

Patient View

Task: View the details of a remittance check at the patient level

Navigation: Payments/Remittance Search/Patient View

To view the details of a remittance check at a patient level use the Patient View link in the Remittance Search results grid.

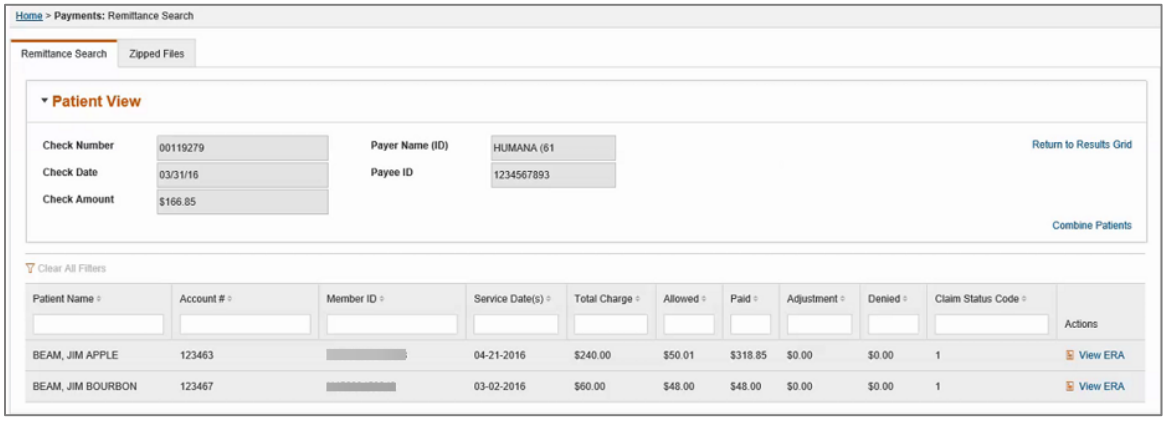
The Patient View page identifies the Check Number, Check Date, Check Amount, Payer Name (ID) and Payee ID, and provides the Patients grid.

The Patients grid is sorted by Patient Name, and contains the following details:

- Patient Name
- Account #
- Member ID
- Service Date(s)
- Total Charge
- Allowed
- Paid

- Adjustment
- Denied
- Claim Status Code – hover for a description of the claim status code

You can filter and sort using the column headers fields.



From the Patient View page you have the following action options.

- View ERAs – to view ERAs at Patient Level
- Combine Patients – use this link to pull all the patients currently displayed into one file. Use the Convert to PDF link to download and print. Each patient will display on a separate page (to facilitate individual printouts) with check information in the header.
- Return to Results Grid – use this link to navigate back to persisting Remittance Search results

View ERA at Patient Level

Task: View, download, or print a Viewable ERA at the patient level with provider level adjustments

Navigation: Payments/Remittance Search/Patient View/View ERA

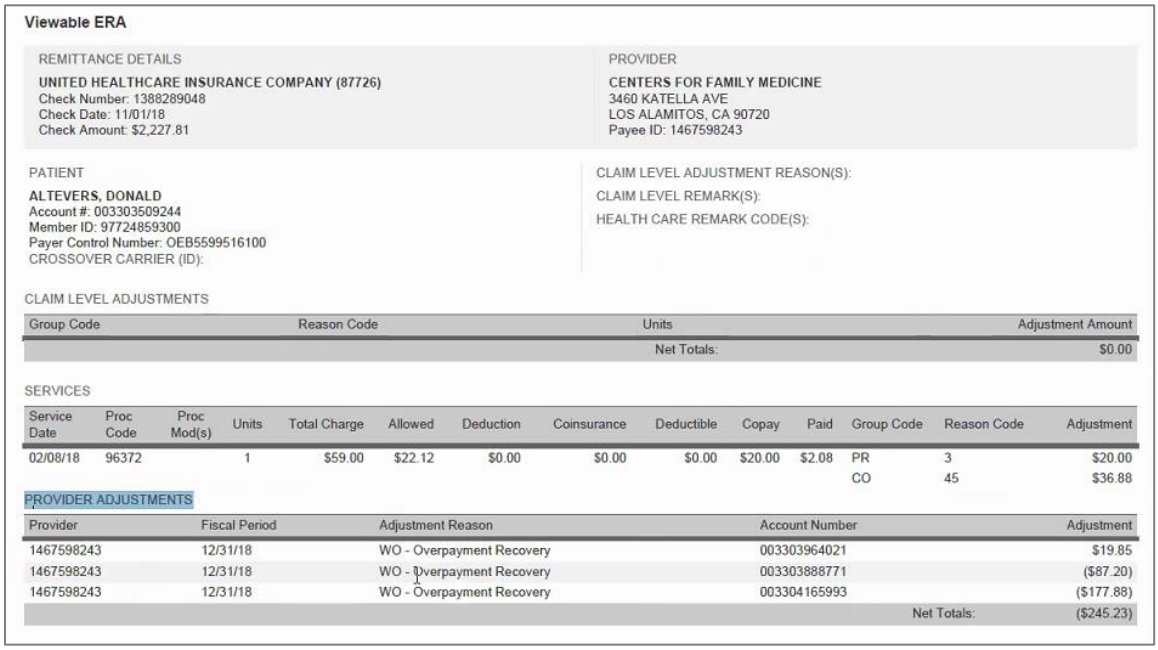
From the Patient View page use the View ERA link at the end of a row to display the Viewable ERA for that patient.

The ERA page contains pertinent information in the following categories:

- Remittance Details
- Provider
- Provider Adjustments – Fiscal Period, Adjustment Reason, Patient Account #, and Adjustment amount
- Patient
- Claim Level Adjustment Reasons, and Remarks
- Claim Level Adjustments (details)
- Services
- Service Level Group Codes
- Service Level Reason Codes

The Viewable ERA displays one or multiple patient ERAs. The Remittance Details, Provider information, and Patient Information appear as the header and are not repeated for multiple ERAs.

Use the Convert to PDF link to download and print the ERA as a pdf file.



Viewable ERA

REMITTANCE DETAILS
UNITED HEALTHCARE INSURANCE COMPANY (87726)
Check Number: 1388289048
Check Date: 11/01/18
Check Amount: $2,227.81

PROVIDER
CENTERS FOR FAMILY MEDICINE
3460 KATELLA AVE
LOS ALAMITOS, CA 90720
Payee ID: 1467598243

PATIENT
ALTEVERS, DONALD
Account #: 003303509244
Member ID: 97724859300
Payer Control Number: OEB5599516100
CROSSOVER CARRIER (ID):

CLAIM LEVEL ADJUSTMENT REASON(S):
CLAIM LEVEL REMARK(S):
HEALTH CARE REMARK CODE(S):

CLAIM LEVEL ADJUSTMENTS

Group Code	Reason Code	Units	Adjustment Amount
		Net Totals:	$0.00

SERVICES

Service Date	Proc Code	Proc Mod(s)	Units	Total Charge	Allowed	Deduction	Coinsurance	Deductible	Copay	Paid	Group Code	Reason Code	Adjustment
02/08/18	96372		1	$59.00	$22.12	$0.00	$0.00	$0.00	$20.00	$2.08	PR	3	$20.00
											CO	45	$36.88

PROVIDER ADJUSTMENTS

Provider	Fiscal Period	Adjustment Reason	Account Number	Adjustment
1467598243	12/31/18	WO - Overpayment Recovery	003303964021	$19.85
1467598243	12/31/18	WO - Overpayment Recovery	003303888771	($87.20)
1467598243	12/31/18	WO - Overpayment Recovery	003304165993	($177.88)
			Net Totals:	($245.23)

View ERA at Check Level

Task: View, download, or print a Viewable ERA at check level

Navigation: Payments/Remittance Search/View ERA

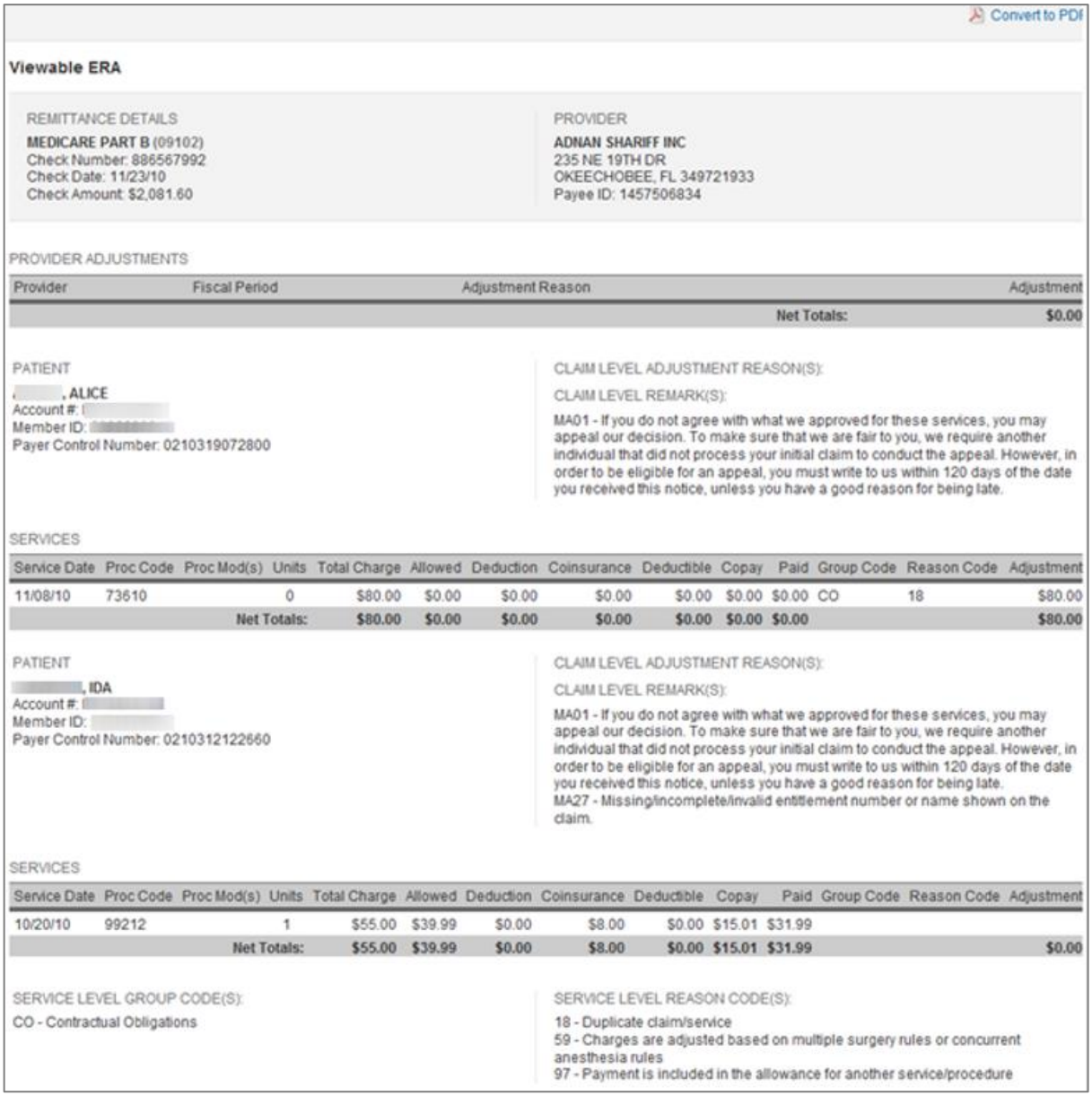
From the Remittance Search results grid use the View ERAs icon at the end of a row to display the Viewable ERA at check level, as shown below.

The ERA page contains pertinent information in the following categories:

- Remittance Details
- Provider
- Provider Adjustments – Fiscal Period, Adjustment Reason, and Adjustment amount
- Patient
- Claim Level Adjustment Reasons, and Remarks
- Claim Level Adjustments (details)
- Services
- Service Level Group Codes
- Service Level Reason Codes

The Viewable ERA displays one or multiple patient ERAs. The Remittance Details, Provider information, and Provider Adjustments appear as the header and are not repeated for multiple ERAs.

Use the Convert to PDF link to download and print the ERAs as a PDF file.



Convert to PDF

Viewable ERA

REMITTANCE DETAILS
MEDICARE PART B (09102)
Check Number: 886567992
Check Date: 11/23/10
Check Amount: $2,081.60

PROVIDER
ADNAN SHARIFF INC
235 NE 19TH DR
OKEECHOBEE, FL 349721933
Payee ID: 1457506834

PROVIDER ADJUSTMENTS

Provider	Fiscal Period	Adjustment Reason	Adjustment
		Net Totals:	**$0.00**

PATIENT
, **ALICE**
Account #:
Member ID:
Payer Control Number: 0210319072800

CLAIM LEVEL ADJUSTMENT REASON(S):
CLAIM LEVEL REMARK(S):
MA01 - If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.

SERVICES

Service Date	Proc Code	Proc Mod(s)	Units	Total Charge	Allowed	Deduction	Coinsurance	Deductible	Copay	Paid	Group Code	Reason Code	Adjustment
11/08/10	73610		0	$80.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	CO	18	$80.00
		Net Totals:		**$80.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**	**$0.00**			**$80.00**

PATIENT
, **IDA**
Account #:
Member ID:
Payer Control Number: 0210312122660

CLAIM LEVEL ADJUSTMENT REASON(S):
CLAIM LEVEL REMARK(S):
MA01 - If you do not agree with what we approved for these services, you may appeal our decision. To make sure that we are fair to you, we require another individual that did not process your initial claim to conduct the appeal. However, in order to be eligible for an appeal, you must write to us within 120 days of the date you received this notice, unless you have a good reason for being late.
MA27 - Missing/incomplete/invalid entitlement number or name shown on the claim.

SERVICES

Service Date	Proc Code	Proc Mod(s)	Units	Total Charge	Allowed	Deduction	Coinsurance	Deductible	Copay	Paid	Group Code	Reason Code	Adjustment
10/20/10	99212		1	$55.00	$39.99	$0.00	$8.00	$0.00	$15.01	$31.99			
		Net Totals:		**$55.00**	**$39.99**	**$0.00**	**$8.00**	**$0.00**	**$15.01**	**$31.99**			**$0.00**

SERVICE LEVEL GROUP CODE(S):
CO - Contractual Obligations

SERVICE LEVEL REASON CODE(S):
18 - Duplicate claim/service
59 - Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules
97 - Payment is included in the allowance for another service/procedure

Summary Report

Task: View, download, or print a Summary Report

Navigation: Payments/Remittance Search/Summary Report

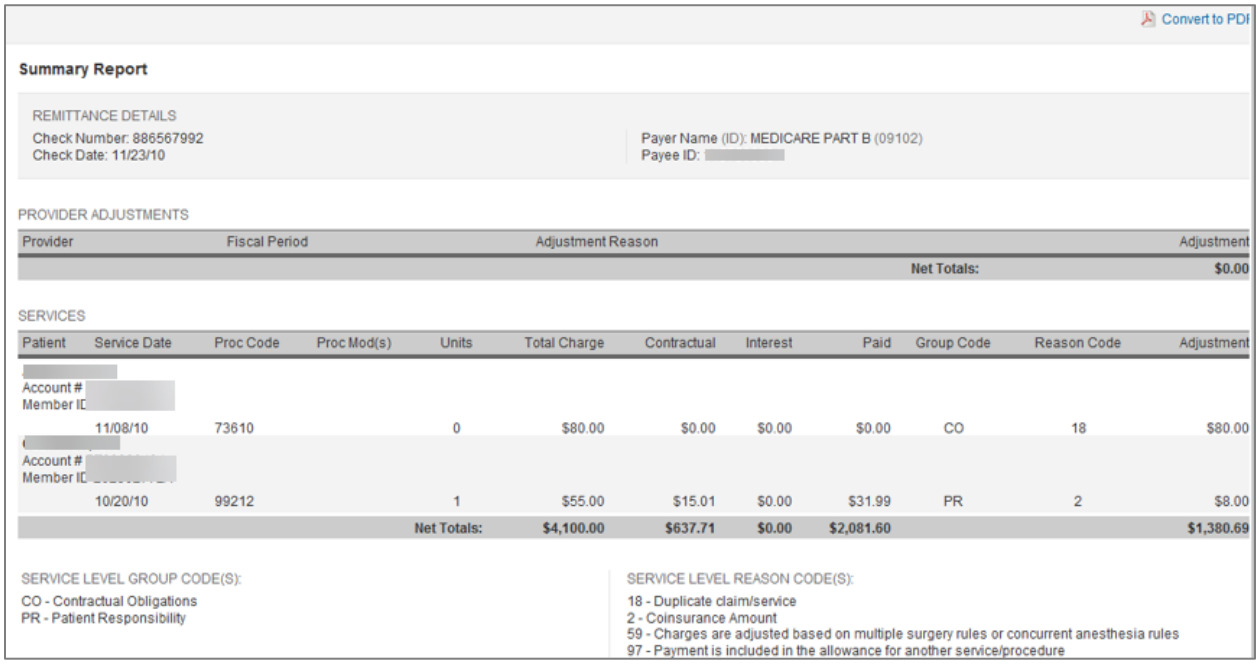
From the Remittance Search results grid select the Summary Report icon at the end of a row to display the readable Summary Report, as shown below.

The Summary Report contains pertinent information in the following categories:

- Remittance Details
- Provider Adjustments
- Services
- Service Level Group Codes
- Service Level Reason Codes

The Summary Report displays one or multiple patient reports. The Remittance Details and Provider Adjustments information appear as the header and are not repeated for multiple reports.

Use the Convert to PDF link to download and print the Summary Report as a pdf file.



Convert to PDF

Summary Report

REMITTANCE DETAILS

Check Number: 886567992
Check Date: 11/23/10

Payer Name (ID): MEDICARE PART B (09102)
Payee ID:

PROVIDER ADJUSTMENTS

Provider	Fiscal Period	Adjustment Reason	Adjustment
		Net Totals:	**$0.00**

SERVICES

Patient	Service Date	Proc Code	Proc Mod(s)	Units	Total Charge	Contractual	Interest	Paid	Group Code	Reason Code	Adjustment
Account # Member ID	11/08/10	73610		0	$80.00	$0.00	$0.00	$0.00	CO	18	$80.00
Account # Member ID	10/20/10	99212		1	$55.00	$15.01	$0.00	$31.99	PR	2	$8.00
			Net Totals:		**$4,100.00**	**$637.71**	**$0.00**	**$2,081.60**			**$1,380.69**

SERVICE LEVEL GROUP CODE(S):

CO - Contractual Obligations
PR - Patient Responsibility

SERVICE LEVEL REASON CODE(S):

18 - Duplicate claim/service
2 - Coinsurance Amount
59 - Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules
97 - Payment is included in the allowance for another service/procedure

View 835 File

Task: View a single 835 file

Navigation: Payments/Remittance Search

To view a single 835 file use the Check Number link on the desired row of the Remittance grid, and open the new browser tab.

Use the icons to download or print a single 835 file received from the payer, as shown below.

If a response is not received from the clearinghouse when you request to download the 835, an error message displays to provide guidance, such as the following, "There was a communication error in your request. Please contact Service and Support at xxx-xxx-xxxx to report this error. Be prepared to provide the Check Number. "

Zipped Files

Task: Download one or multiple 835 files

Navigation: Payments/Remittance Search/Zipped Files

Before you can download files you must first ensure that you have zipped all or selected 835 files from the Remittance Search results grid in order to make these files available for download, as described here.

From the Remittance Search results grid:

- Zip and Download All Records – use this option to zip all of the files displayed on the current page
- Zip and Download Selected Records – select one or more row checkboxes to zip only those desired files. (Note that the header checkbox can be used to select all of the displayed files, if this is helpful.)

A confirmation request displays asking if you want to zip the selected records. Use the Continue button to complete the action.

A success message displays when your request has been submitted successfully.

The zipped file name includes the file ID and date.

Note that once the files are zipped their status in the Remittance Search results grid changes from Unread to Read.

Download

The zip file is available at the Zipped Files tab.

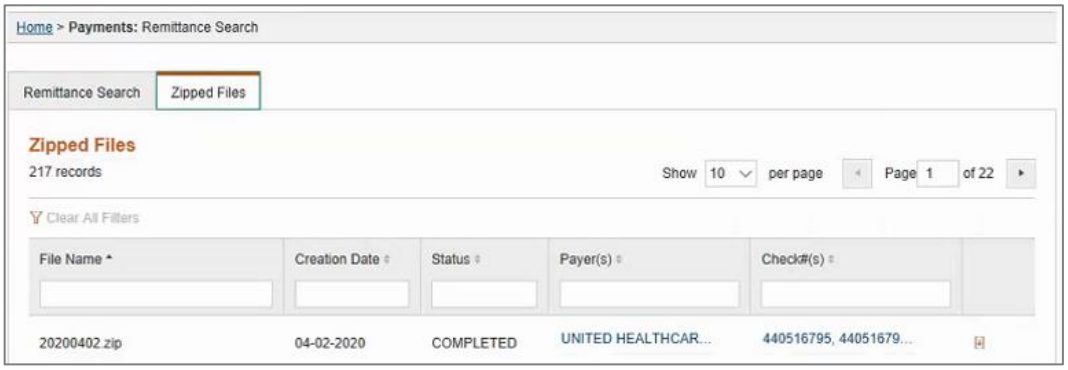
The Zipped Files grid is sorted by Creation Date in descending order, and contains the following details:

- File Name
- Creation Date
- Status – refers to the creation of the zipped file, either In Progress, Errored, or Completed. Errored indicates that a response was not received from the clearinghouse. You may hover the Errored link for more information.

- Payer(s)
- Check #(s)

You can filter and sort using the column headers fields.

Use the Download icon on the desired row to download the zipped files.



Patient Statements

File Upload

Task: Upload patient statement files for processing in order to send patient statements with outstanding balance information

Navigation: Payments/Patient Statements/File Upload

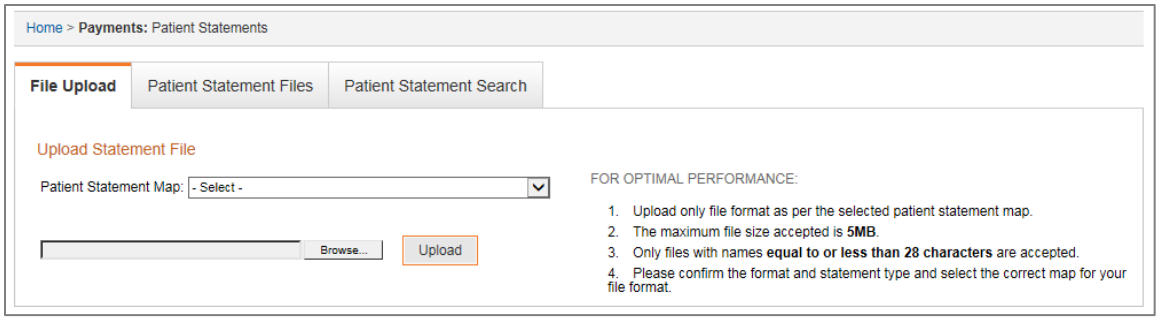
If you select File Upload and you or the Billing Entity (page banner) are not affiliated with the Patient Statements Upload service an advisory message displays with instructions for obtaining assistance.

Use the File Upload function to upload individual statement files containing data for one or more patients. When the upload is completed each separate record contained in the upload file is available and identified as a unique statement.

To begin, select the desired mapper option from the Patient Statement Map drop down:

- Standard XML (based on your login this may be your only option)
- Non-Standard XML Mapper
- Print Image Mapper
- Availity Pass-Through – these PDF files are not actually mapped but are forwarded to Availity without any validation process

Use the Browse button to select your statement file, and Upload.



File constraints include the following:

- Upload the same file type as the selected Patient Statement Map
- The maximum file size accepted is 5MB
- Only files with names less than 28 characters are accepted
- Confirm the format and statement type and select the correct map for your file format

Any error messages are displayed in a message box or under the Upload a File heading. For example, a duplicate file error message advises you that this patient statement file name has already been used for a previously uploaded file.

To complete the action use the Upload button.

If the upload is successful a confirmation displays, or a message advises that the file is being processed and reports will be available shortly.

You can use the Browse button again after each file upload. It is not necessary to clear the file name field.

For details regarding creation of the file see the **Intelligent EDI Patient Statements Companion Guide** at Resources/Downloads.

Patient Statement Files

Task: View a history of uploaded statement files, and the details for each file to confirm current status.

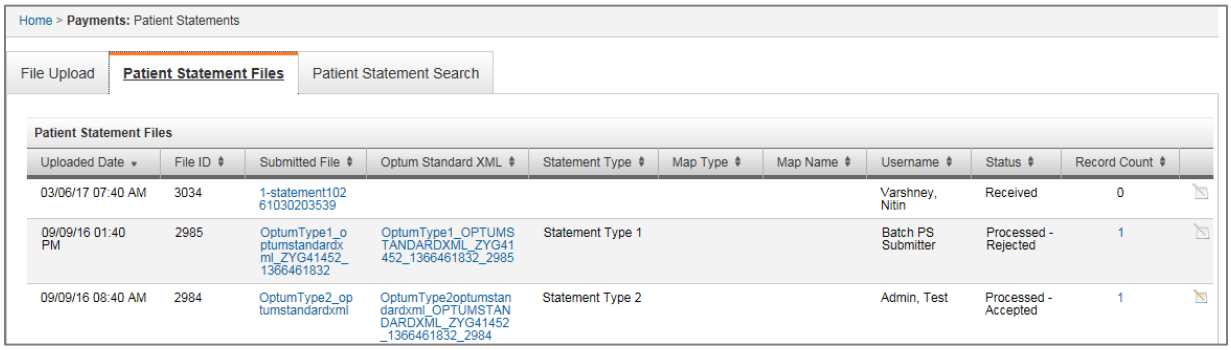
Navigation: Payments/Patient Statements/Patient Statement Files

The Patient Statement Files grid reflects the following information about each statement file upload, as shown below:

- Uploaded Date/Time
- File ID
- Submitted File
- Optum Standard XML
- Statement Type
- Map Type
- Map Name
- Username

- Status
- Record Count

The Patient Statement Files grid displays files by the Date they were uploaded.



You have links available in the Patient Statement Files grid that provide the following options:

- Select a Submitted File – to view the file that was submitted (Optum Standard XML, Non-Standard XML, Print Image, or Availity Pass-Through)
- Select an Optum Standard XML – to view the file being processed (this includes submitted Optum Standard XML, as well as any Non-Standard XML or Print Image files that are now converted to Optum Standard XML)
- Select the Record Count number – to view the separate statements in the Patient Statements grid
- Use the View Errors icon – when a file is in an Errored status this link is activated (end of row)
- Use the Reports icon – to view the responses received for a particular file in the Patient Statement Files grid. Select the Reports icon (end of row) to expand a display pane for one or more records. Reports provide the date/time the response was received, and the file names. Select a file name to open in a separate tab, and use the print and upload icons as needed.
- Use the Export CSV link – to export and save the data currently included in the results grid

Note that the Availity Pass-Through files can be viewed, but no other action is applicable.

Patient Statement Validation Errors

Task: View validation errors in patient statement file in order to correct those errors.

Navigation: Payments/Patient Statements/Patient Statement Files

Select the View Errors icon (end of row) in the Patient Statement Files grid to view error reports, which may reflect a technical failure of the file, or a list of validation errors.

Failure to Process

A failure to process message indicates that the uploaded file could not be processed for validation because it was malformed, incomplete, or corrupted.

```
PATIENT STATEMENT FILE ERROR REPORT
File ID: 271
File Name: Optum Patient Statements Test File-LTR1.xml
Uploaded Date: 09/05/2014 12:09 AM

The uploaded XML file was unable to be validated because it was malformed,
incomplete, or corrupted. Please attempt to correct and re-upload, or contact
Optum Service and Support with questions.
```

File Error Report

A Patient Statement File Error Report returned following the validation process includes file identifiers, separate statement identifiers and specific error information by field name, such as the following:

- Required data missing
- Data type must be – the data type is identified
- Invalid value – acceptable values are identified
- Field length must not exceed – maximum field length is identified

You may download or print the error report.

```
PATIENT STATEMENT FILE ERROR REPORT
File ID: 169File
Name: Angela Test XML File 3 - Errors.xml
Uploaded Date: 08/04/2014 03:08 PM

STATEMENT_IDENTIFER: 12345678901
PATIENT_ACCOUNT_NUMBER: AC422787
Errors:
STATEMENT_TYPE: Invalid value. Acceptable values:
"1","2","LTR1","LTR2","LTR3"
STATEMENT_IDENTIFIER: Field length must not exceed 10, Data type must be
number formatted
STATEMENT_DATE: Data type must be date formatted mm/dd/yyyy
ACCEPT_MC: Invalid value. Acceptable values: Y,N,null
REMIT_CITY: Field length must not exceed 20
SERVICE_DATE_FROM (Line Item1): Data type must be date formatted mm/dd/yyyy
SERVICE_DATE_FROM (Line Item2): Data type must be date formatted mm/dd/yyyy

STATEMENT_IDENTIFER: 358
PATIENT_ACCOUNT_NUMBER: AC422788
Errors:
STATEMENT_TYPE: Invalid value. Acceptable values:
"1","2","LTR1","LTR2","LTR3"

STATEMENT_IDENTIFER: 359
PATIENT_ACCOUNT_NUMBER: AC427947
Errors:
If STATEMENT_TYPE = 1, then at least one LINE ITEM must be present
```

Partially Rejected Files

Files can be deemed partially rejected when certain Patient Statements within the file could not be processed due to errors. Patient Statements that could be processed (as accepted or rejected) are not included in the File Error Report.

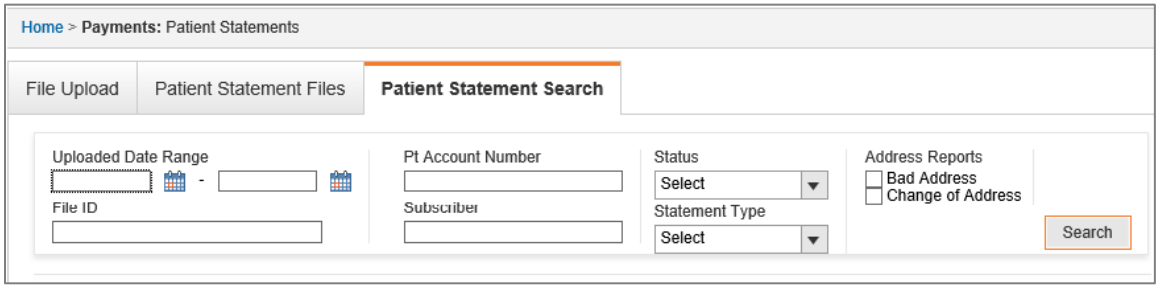
Patient Statement Search

Task: Search for individual patient statements in order to view details of the patient statement

Navigation: Payments/Patient Statements/Patient Statement Search

Note that you have the option from the Patient Statement Files grid to use the Record Count link to access the related Patient Statements grid, without the need to conduct a search.

You may use the Patient Statement Search feature to search for patient statements.



Search for patient statements using one of these three methods:

- Search By File ID – enter the File ID number
- Search with known information – enter any known information into the Patient Statement form. Search results correspond to the amount of information you enter on the form. You can narrow your search by entering more information in the form.
- Search without entering any information – results will reflect all files submitted for the selected Billing Entity, which may result in an extended search time. The display is limited to 500 records.

Patient Statement Search form categories and fields are described in the table below.

Patient Statement Search Categories	Patient Statement Search Field Descriptions
File ID	Enter a File ID number
Uploaded Date Range	• From – User date picker icon or manual entry • To (optional) – if left blank the date of today is assumed
Pt Account Number	Enter a patient account number
Subscriber	Enter a subscriber name
Status	Choose one or more to filter for only those files, or choose All to pull all files in any status. • All Statuses – apply no filter to search results • Ready for Processing • Sent for Processing • Processed - Accepted • Processed - Rejected
Statement Type	Choose one or more to filter for only those files, or choose All to pull all files with any Statement or Letter Type.
Address Reports	Use checkboxes to filter for only those files that contain a Bad Address, and/or a Change of Address report

Select the Search button to obtain results.

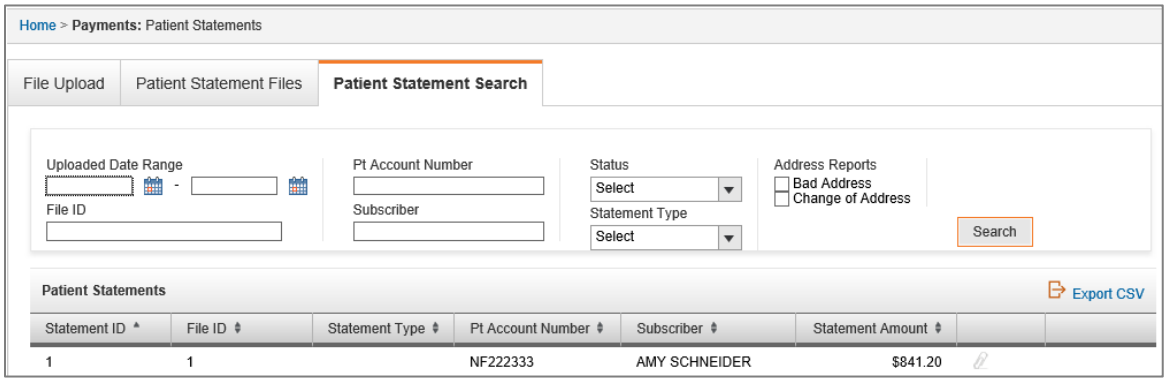
Search results contain only records for the selected Billing Entity.

Your login as a particular Billing Entity (default Billing Entity) determines the search results. If you reselect your Billing Entity in the page banner the Patient Statement form clears and you may begin a new search.

The Patient Statements grid reflects the following information about each individual record:

- Statement ID
- File ID
- Statement Type
- Patient Account Number
- Subscriber
- Statement Amount
- Attachment icon – to open the statement image
- Bad Address link – to view details
- Change of Address link – to view details

The Patient Statements grid displays statements by the Statement ID number.



The attachment icon is enabled if a final patient statement has been generated. Use the attachment icon to view an image of that statement.

The Bad Address and/or Change of Address links are enabled if you filtered for these reports. Use the applicable link to display the available details.

You can use the Export CSV link to export and save the data currently included in the results grid.

Variances

The Variances function provides the following options:

- Variance Dashboard – view significant variances

- Variance Search – search, view, and the Generate Appeal feature
- Appeals – search, view, and the Settle Appeal feature

You may change the Status of variances via any of these options.

Variance Dashboard

Task: View the most significant variances, by Payer, Provider, Status, HCPC/CPT, and change Status of variances

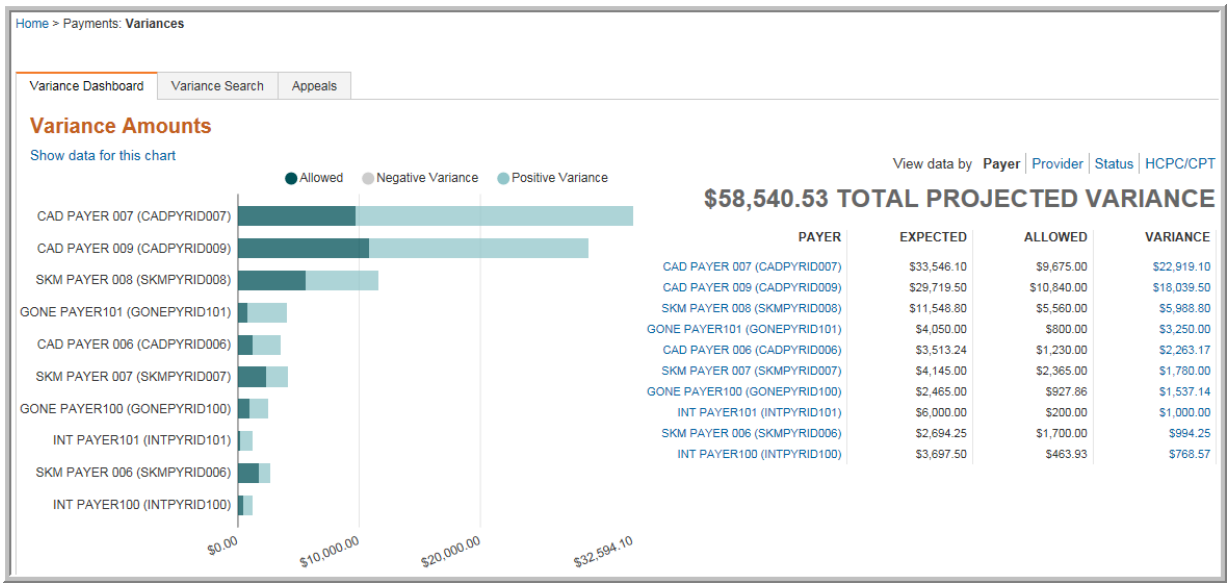
Navigation: Payments/Variances/Variance Dashboard

The Variance Dashboard provides a visual of the Variance Amounts that reflects the top ten highest variances for each of the following categories, as well as the total projected variances:

- Payer
- Provider
- Status
- HCPC/CPT

Click the desired category link to view the variances for that particular data, as shown below.

Use the radio buttons to view the Variance Amounts by total Allowed, Negative or Positive Variance. Variance amounts are displayed in the bar graph (left) and in a table (right).

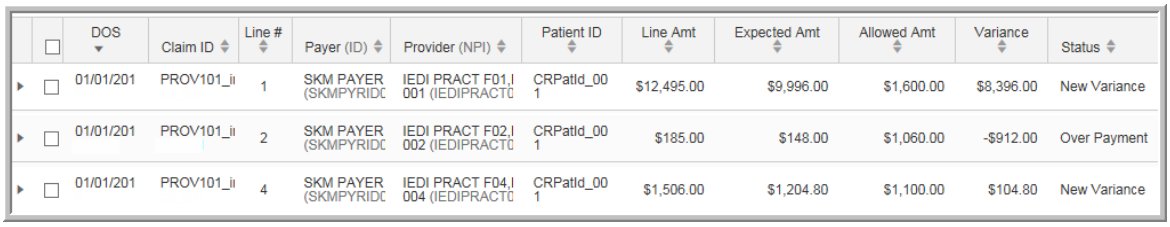


Use any active link to trigger a results grid for the selected category. You can hover and click a dollar amount in the bar graph, or click a variance amount or category item in the table.

The Variances grid can display up to 200 lines, and provides the following pertinent details:

- Date of Service

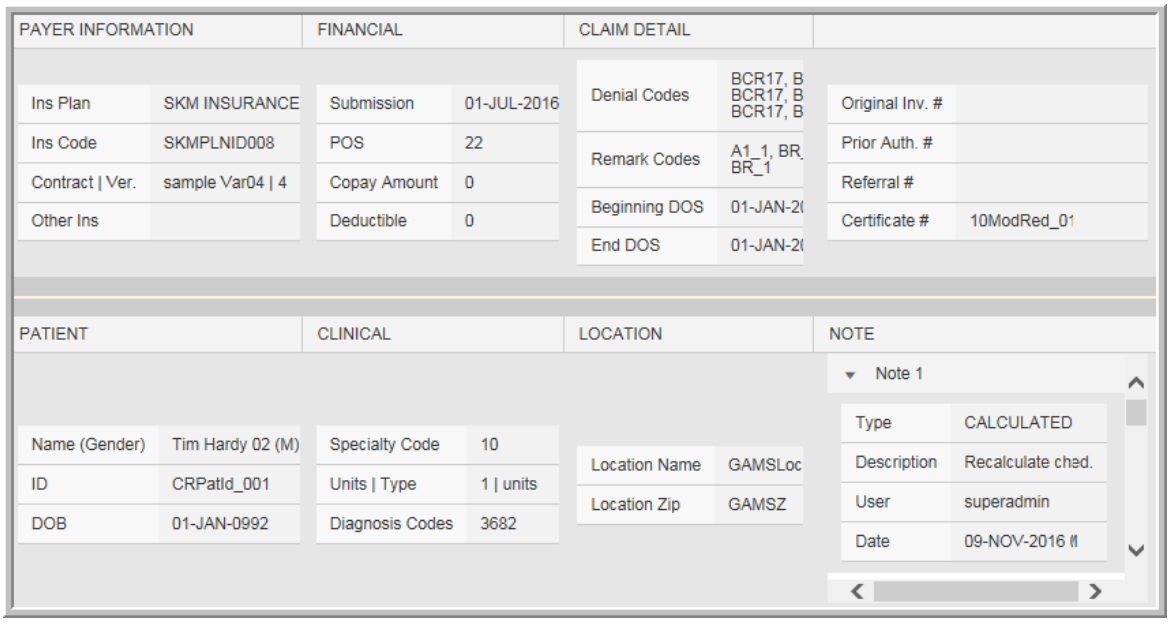
- Claim ID
- Line #
- Payer (ID)
- Provider (NPI)
- Patient ID
- Line Amount
- Expected Amt
- Allowed Amt
- Variance
- Status



DOS	Claim ID	Line #	Payer (ID)	Provider (NPI)	Patient ID	Line Amt	Expected Amt	Allowed Amt	Variance	Status
01/01/201	PROV101_	1	SKM PAYER (SKMPYRIDC	IEDI PRACT F01,I 001 (IEDIPRACTC	CRPatId_00 1	$12,495.00	$9,996.00	$1,600.00	$8,396.00	New Variance
01/01/201	PROV101_	2	SKM PAYER (SKMPYRIDC	IEDI PRACT F02,I 002 (IEDIPRACTC	CRPatId_00 1	$185.00	$148.00	$1,060.00	-$912.00	Over Payment
01/01/201	PROV101_	4	SKM PAYER (SKMPYRIDC	IEDI PRACT F04,I 004 (IEDIPRACTC	CRPatId_00 1	$1,506.00	$1,204.80	$1,100.00	$104.80	New Variance

The grid lists the claims in order by Date of Service, but the dashboard is managed by the applicable category, i.e., Payer, Provider, Status, or HCPC/CPT.

Click a row arrow or anywhere in that desired row to expand and view additional variance information, as shown below. Click again to close this display pane (drawer).



You must click each Note arrow to display the contents of that individual note. You can scroll horizontally and vertically to view the entire contents. Click the Note arrow again to close the pane.

No changes can be made to the claims data that is provided for display.

Change Status

You have the ability to use the Change Status button to change a single or multiple items, as described in **Variance Search**.

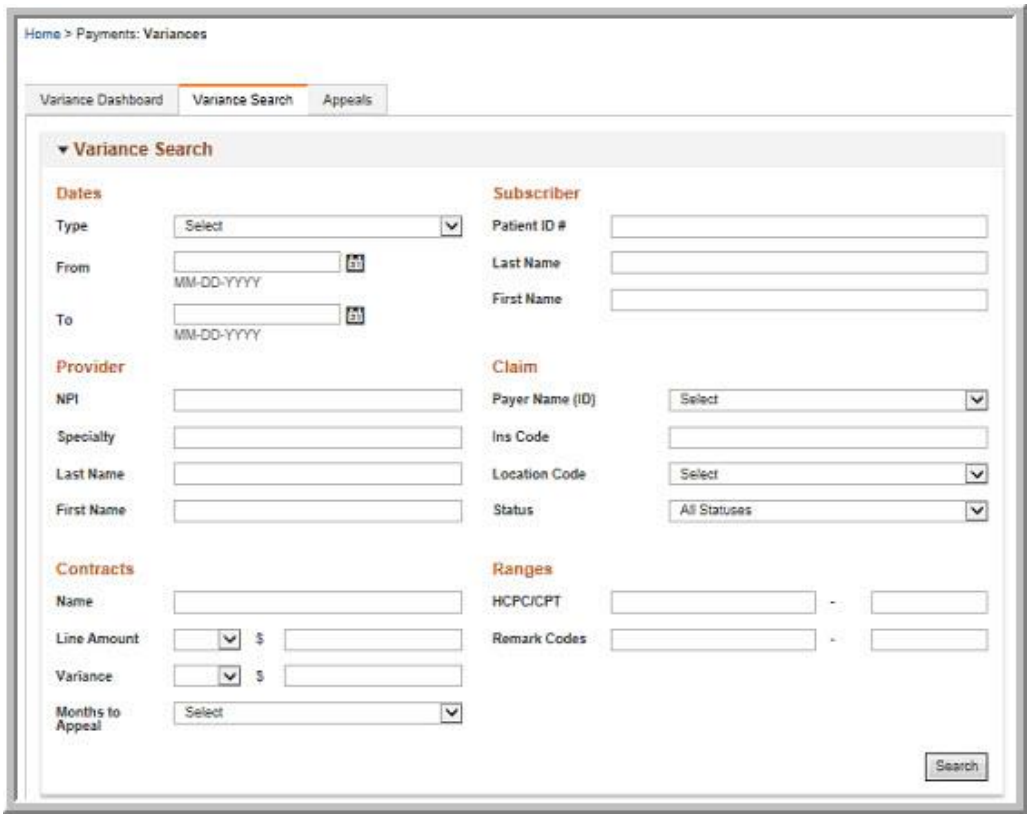
Variance Search

Task: Search and view variance details (up to 3 years prior), generate appeals, and change Status of variances

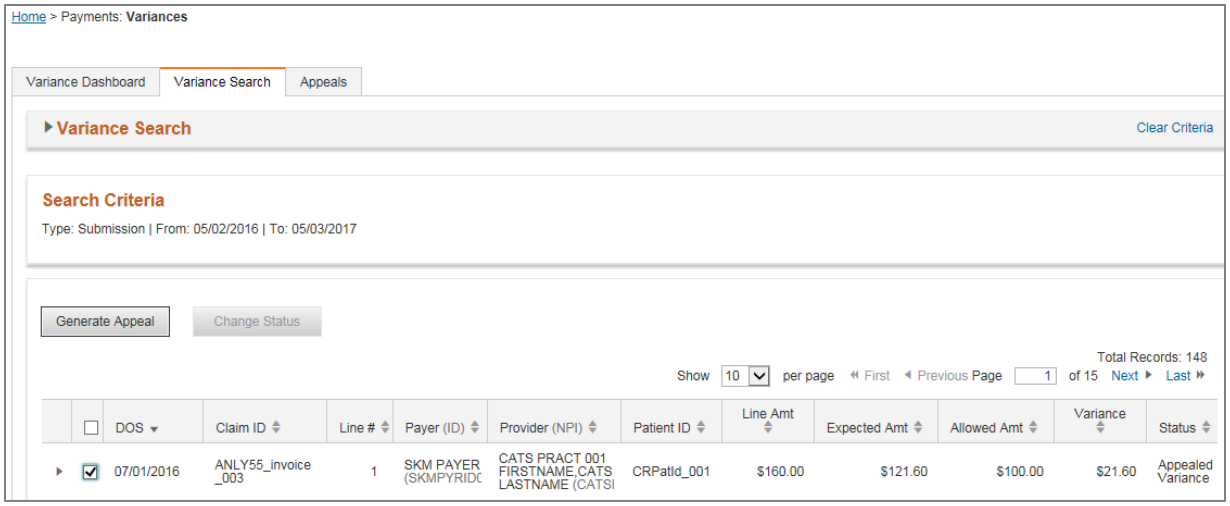
Navigation: Payments/Variances/Variance Search

The Variance Search function allows you to search based on your current login. You can limit the results by applying specific search criteria.

- Dates
- Subscriber
- Provider
- Claim
- Contracts
- Ranges



The Variance Search results grid is identical to the Variance Dashboard results grid.



In the Variance Search results grid you can select one item, as shown above, or you can select more than one item if they each have the same Payer ID, and Contract ID (displayed in the drawer).

You have the option to click the Generate Appeal button to initiate the Appeals feature, and also the option to use the Change Status button to change a single or multiple items.

Generate Appeal

In the Variance Search results grid select one or more items that have the same Payer ID, and Contract ID (displayed in the drawer), and click the Generate Appeal button to initiate the Appeal Wizard, as shown below.

Select the Appeal Type from the drop down, and enter the applicable Appeal Type Language, and Appeal Type Description.

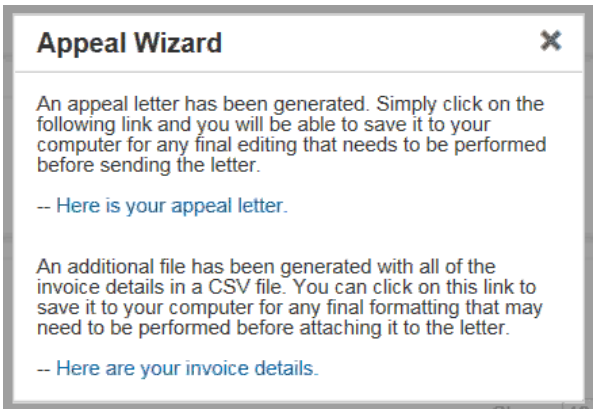
Select the preferred Appeal Letter Bundling, as available. (This option is enabled only if you bundled the variances.) Select Bulk for compiling multiple claims within one piece of correspondence, or select Individual to produce a single piece of correspondence for each claim.

You may be asked to identify certain download options.

Click the Submit button and you will see a Generating Appeal Letter message that contains a Cancel option. (This may appear only briefly.)

A success message displays and you may click the link for your appeal letter to Open or Save.

If you bundled the variances you also have the option to download your invoice details, as shown below.



Change Status

You may change the status of a single or multiple variances. To begin, select one or more items you wish to change to the same status. (Click the header checkbox to select all.)

Click the Change Status button to open the Change Status form. (Note that the current status is indicated as Multiple Statuses if you select items not in the same status.)

Select the desired new status from the drop down list.

- Minor Variance
- New Variance
- On Hold
- Registration Error
- Reviewed – No Appeal Necessary

Enter applicable notes in the free form Notes field.

Click the Submit button in the Change Status form to complete the change action.

Appeals

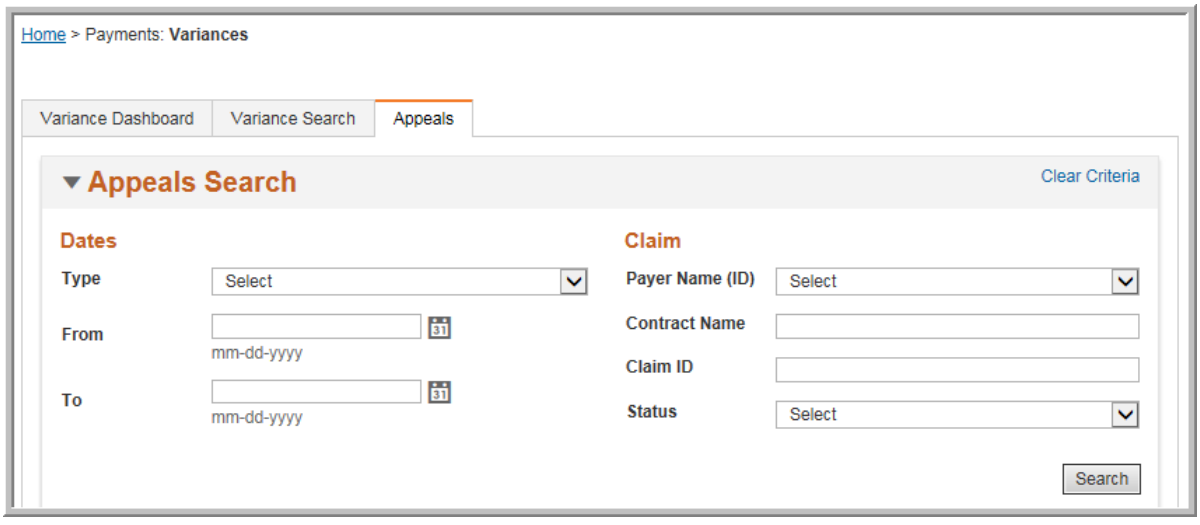
Task: Search and view appeal details (up to 3 years prior), settle appeals, and change Status of Appeals

Navigation: Payments/Variances/Appeals

The Appeals Search function allows you to search for Appeals based on your current login, and settle (or partially settle) those appeals.

You can limit your search results by applying specific criteria. If you do not limit your search using any of the following filters the results returned will include the Appeal Type, of All Statuses, for the previous thirty days.

- Dates
  - Type – select Appeal to search by appeal generation date (default), or select Submission to search by claim submission date
  - Date range
- Claim
  - Payer Name (ID) – the drop down populates based on your current login
  - Contract Name –enter the unique Contract Name
  - Claim ID – enter the Claim ID
  - Status – choose from All Statuses, Appealed, Partially Settled or Settled claims



Click the Search button.

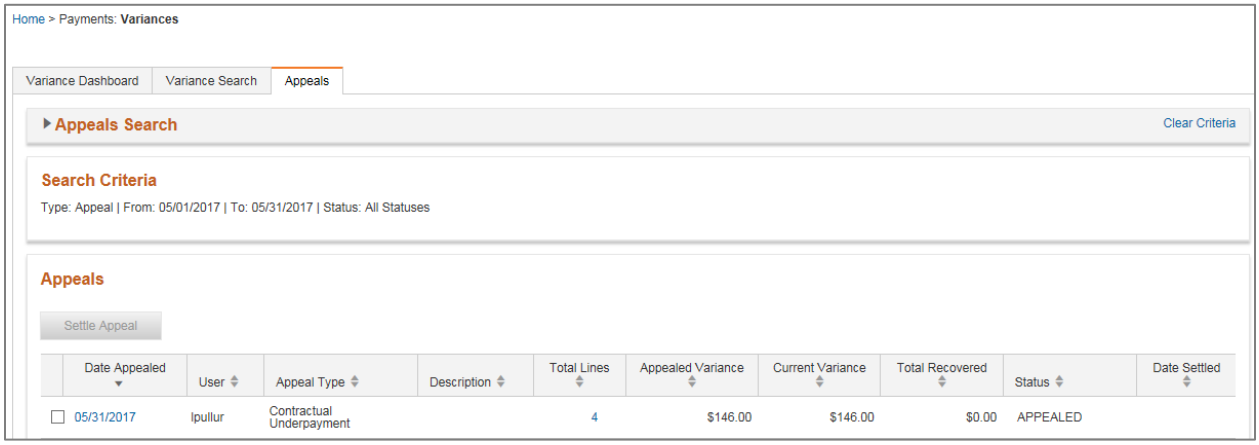
Note that when the search results are returned the Appeals Search form closes, but your Search Criteria is displayed. Click the Appeals Search header if you wish to initiate a new search.

Records

The Appeals Search grid can display up to 200 records, and provides the following pertinent details:

- Date Appealed
- User
- Appeal Type (this is not the same as the Dates Type used in your search filter)
- Description
- Total Lines
- Appealed Variance
- Current Variance
- Total Recovered
- Status
- Date Settled

The results grid lists the claims in order by the most recent Date Appealed.



Claim Lines

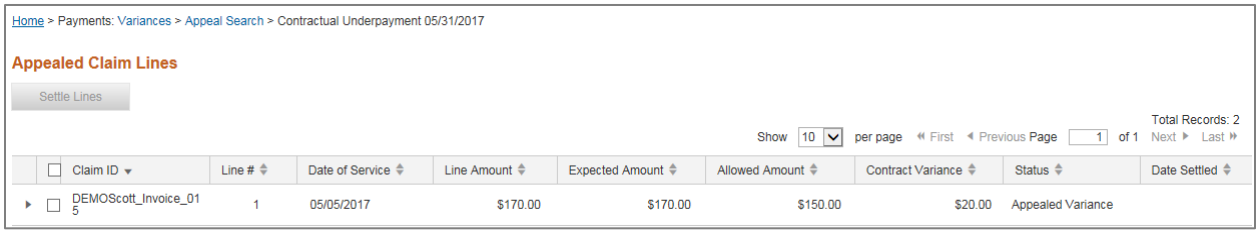
You can click the link under Date Appealed or Total Lines to view the claim line information for that record, as shown below.

Note that your Appeals Search results do not persist and you are unable to return to them when you exit the Appealed Claim Lines display pane.

The Appealed Claim Line grid can display up to 200 records, and provides the following pertinent details:

- Claim ID
- Line #
- Date of Service
- Line Amount
- Expected Amount
- Allowed Amount
- Contract Variance
- Status

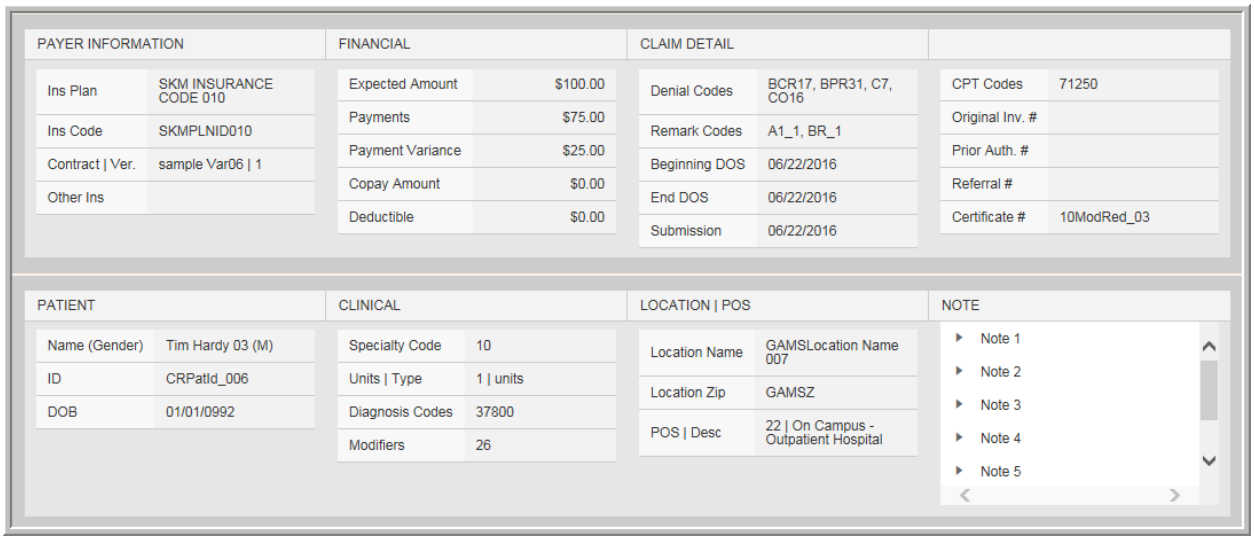
- Date Settled



No changes can be made to the claims data that is provided for display.

Claim Line details

You can click a row arrow or anywhere in that desired row to expand and view additional claim line information, as shown below. Click again in that row to close this display pane (drawer), or you may click in another row to view that information.



You must click each Note arrow to display the contents of that individual note. You can scroll horizontally and vertically to view the entire contents. Click the Note arrow again to close the pane.

No changes can be made to the claims data that is provided for display.

Settle Appeal

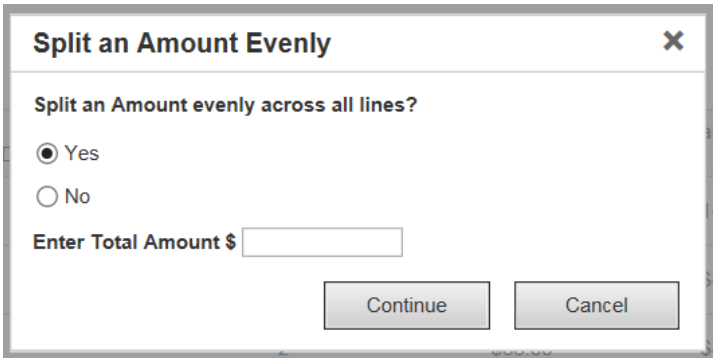
Select the desired item in the Appeals Search results grid, and click the Settle Appeal button to open the Split an Amount Evenly form, as shown below.

Note that you also have the option to use the Settle Lines button in the Appealed Claim Line grid to resolve individual claim lines. (If you select only one claim line you navigate directly to the the Settle Appealed Claim Lines form.)

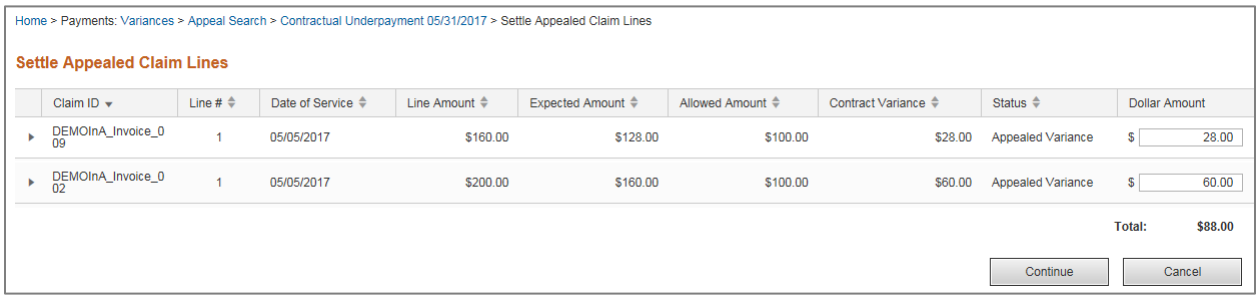
To complete the Split an Amount Evenly form you must indicate if you wish to split the total amount evenly across all lines.

- Yes (default) – indicates the amount received will be auto-applied across all claim lines. Click Continue and you will be returned to the Search Appeals results grid. A success message may be displayed.

- No – indicates you must manually apply specific amounts to specific lines, which together equal the total amount received. Click the Continue button.
- Enter Total Amount – enter the actual amount agreed upon as the settlement.



If you click No, to not split the amount, the Settle Appealed Claim Lines form displays, as shown below. You must enter the applicable Dollar Amount for each applicable claim line.



The Total field automatically updates as you enter each individual Dollar Amount, which allows you to confirm your entries are valid and complete.

Click Continue to return to the Search Appeals results grid.

An error message alerts you of a partially settled claim. You must rework any unsettled claim lines individually using the Settle Lines option. They will be displayed in a similar individual variance breakdown form that displays for this subsequent appeal settlement attempt.

Change Status

You have the ability to use the Change Status button to change one or multiple items, as described in **Variance Search**.

Eligibility

The Intelligent EDI Eligibility function provides the following options:

- Check Patient Eligibility
- Eligibility Search
- File Upload

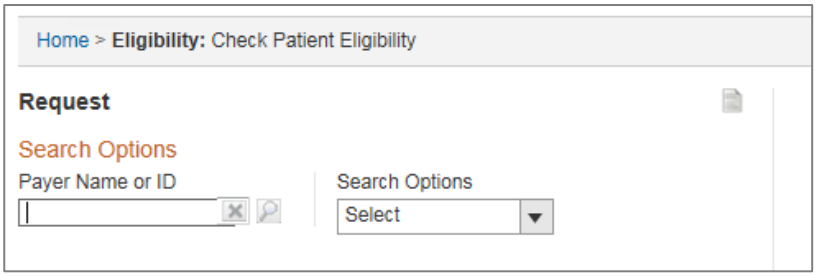
Check Patient Eligibility – Request

Task: Submit specific search criteria to confirm patient eligibility

Navigation: Eligibility/Check Patient Eligibility

Select Check Patient Eligibility to open the initial view of the Request form, as shown below.

You must initiate the Request form by completing the Payer Name or ID, and Search Options fields. These fields are required and must be completed in that sequence.



The expanded Request form contains the following elements:

- Search Options – Payer Name or ID, and specific Search Options
- Search Criteria – payer requested information
- View X12 option – to view, download or print the request in X12 format

When you are using the Eligibility function your selected path persists on the Home line at the top of the page. You can click the active breadcrumb link to return to any previous tier.

You should complete the Search Options, and Search Criteria elements of the Request form before you click the Submit button.

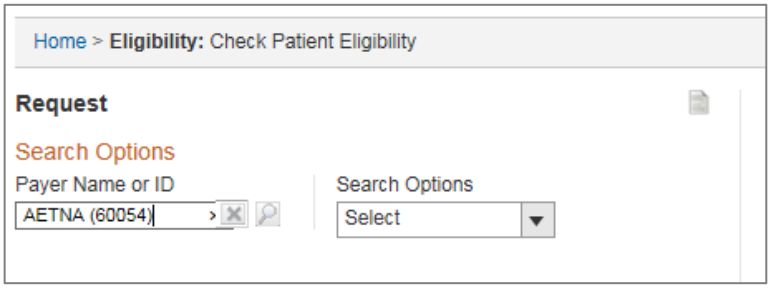
You will have the ability to make adjustments to the Request form after submitting your request, if necessary, as the field entries in the Request form remain unless you click Clear Criteria or navigate away from the page.

Payer Name or ID

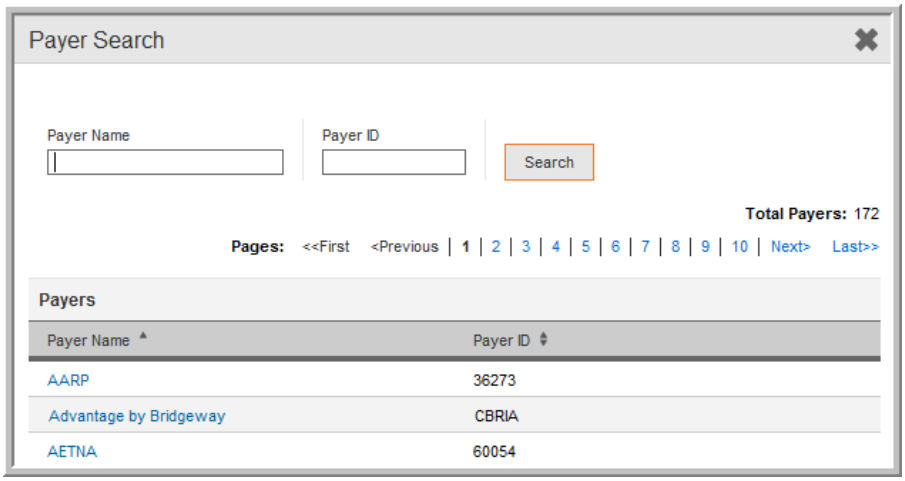
You must enter a Payer Name or ID before you can select a Search Option. You can complete the Payer Name or ID field using the auto-complete feature or the wildcard search method.

Your Payer search list is determined by the default Billing Entity (page banner).

To use the auto-complete feature enter the first two characters of a Payer Name or ID and select from the drop down results. To clear the field use the Clear feature, or click the **x** at the end of the field.



For a wildcard search click the Magnifying Glass icon to open the Payer Search form. Enter at least two sequential characters in the Payer Name field and click Search. Select the desired Payer Name link.



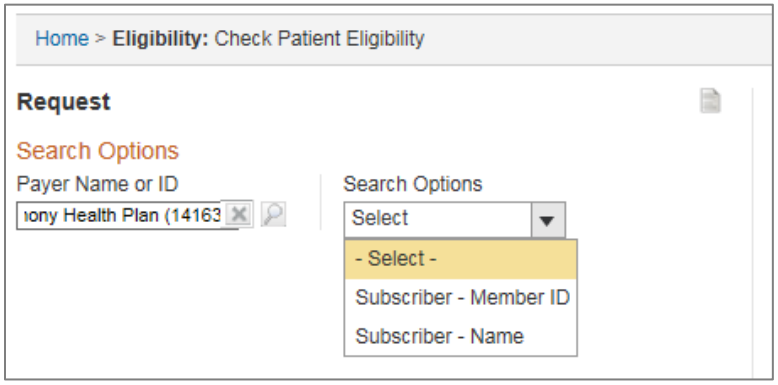
Search Options

You may select a Search Option only after you have populated the Payer Name or ID field. Only those Search Options that are applicable to the selected Payer are displayed.

Click the Search Option drop down and select from the choices provided, as shown below.

Examples include options such as the following:

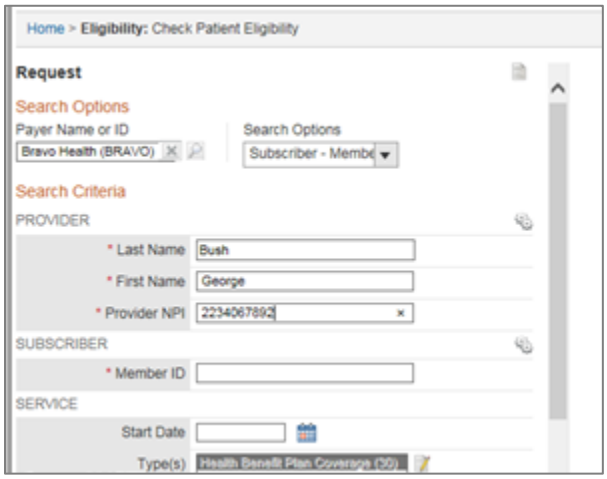
- Subscriber – HMO ID
- Subscriber – Card ID
- Subscriber – Member ID
- Subscriber – Name
- Dependent – Member ID
- Dependent – Name



Search Criteria

You may continue completion of the Request form after the Payer Name/Payer ID and the Search Options fields are populated.

The Search Criteria applicable to your Search Options are displayed on the Request form.



The Billing Entity (page banner) determines whether Facility or Provider fields are displayed in the Search Criteria area.

Your login as a particular Billing Entity (default Billing Entity), or your subsequent reselection of a Billing Entity in the page banner determines whether Facility or Provider fields are displayed in the Search Criteria area.

If you reselect your Billing Entity in the page banner:

- The page refreshes to display the appropriate search fields
- Existing Payer Name or ID and Search Options entries persist
- Your Billing Entity selection persists until you change it, or log out.

Note: You may need to manually refresh your page if a subsequent Billing Entity selection does not support both Provider and Facility.

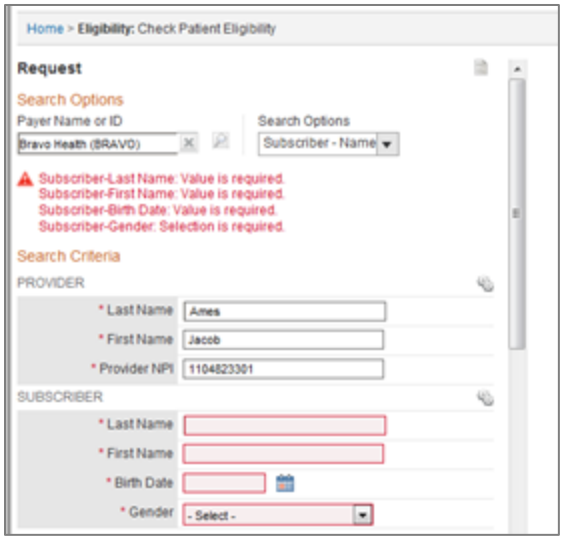
Complete the Search Criteria area by selecting from the applicable options provided on the Request form.

To manage Provider or Subscriber/Dependent information click the associated icon. (See Provider or Patient Maintenance for guidance.) Click the previous browser tab to return without losing any entries on your Request form.

- Facility or Provider – your Billing Entity login determines whether Facility or Provider fields are required as the Search Criteria. The following features support your completion of the Provider fields:
  - Auto-Complete – for a Provider enter the first two characters of the Last Name. Select a Provider from the drop down to auto-populate the Provider fields with data available for that Provider (otherwise the field remains blank).
  - Default Provider – if you have previously identified a default Provider the Provider fields are auto-populated with that Provider information. You have the ability to override the default Provider entries.
- Subscriber – for a Subscriber enter the first two characters of the Last Name. Select from the drop down to auto-populate the fields with available data.
- Dependent – for a Dependent enter the first two characters of the Last Name. Select from the drop down to auto-populate the fields with available data:
  - If a Subscriber has not been selected the Dependent search returns Active Dependents related to the Billing Entity (page banner).
  - If a Subscriber has been selected the Dependent search returns Active Dependents related to the selected Subscriber.

    Note: If you select a Subscriber via auto-complete and then a Dependent via auto-complete but later delete the selected Subscriber the Dependents for that Subscriber will persist until you either leave the page and come back or select a new Subscriber via auto-complete, in order to refresh the Dependents.
- Service – complete the fields appropriately.

All of the required fields (*) in the Search Criteria area must be completed with valid information for Facility or Provider, Subscriber, Dependent, and Service. Applicable error messages are displayed and the field is highlighted if you attempt to submit incomplete or invalid information.



Any lower case data entered in the Check Patient Eligibility request form is converted to upper case prior to submission to the payer, but may not display on the form as capitalized.

You may use the Clear Criteria option to begin a new search.

Service Types

Only those fields that are applicable are displayed on the Request form, except that the Service section is always provided to display the Service Type(s) fields.

The Service Type(s) field is populated based on the designated Default Service Types for your Billing Entity login (page banner), but limited to those supported by the selected Payer. This is designed to increase the chances of an accurate eligibility response.

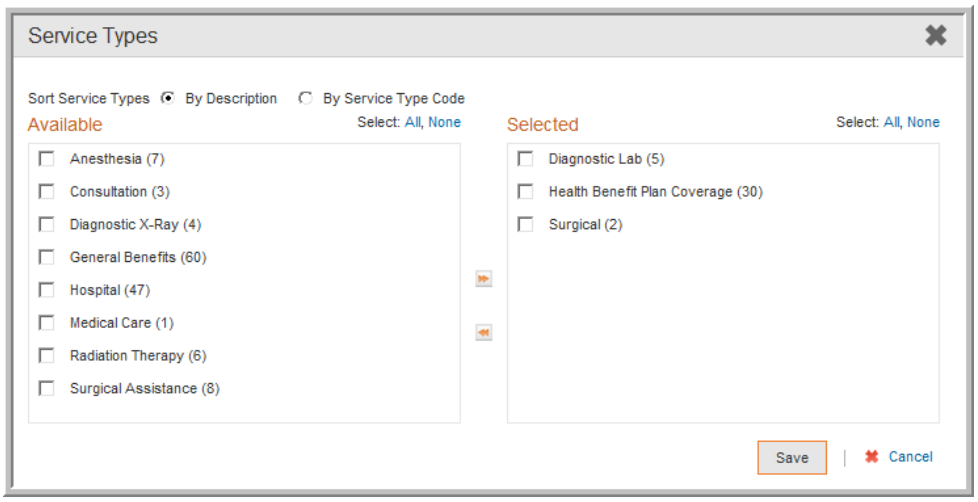
If none of the Billing Entity Default Service Types are supported by the selected Payer the Service Type is "Health Benefit Plan Coverage (30)." Note that if the Health Benefit Plan Coverage (30) service type has been removed an error message reminds you that at least one service type is required.

You may use the Edit icon provided on the Request form to modify the selected Service Types. Click the Edit icon to open the Service Types form, as shown below.

Use the radio buttons to sort the Available Service Types and Selected Service Types by Description, or by Service Type Code.

Available Service Types are those supported by the selected payer.

Selected Service Types are the Default Service Types based on Billing Entity.



To select Service Types use the checkboxes. To deselect Service Types use the checkboxes or the Select All link. You can use the Select None link to clear your selections.

Use the arrow keys to move selected Service Types into or out of the Available and Selected panes.

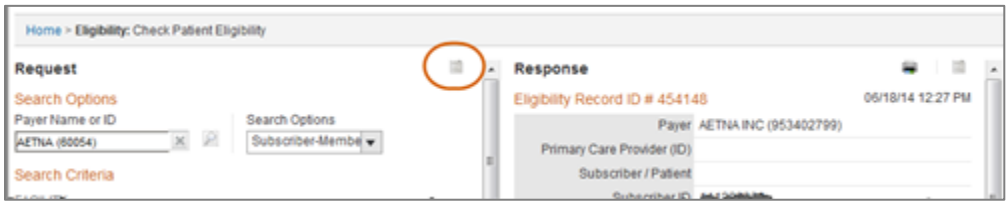
Click Save or Cancel.

You must select at least one Service Type. A reminder displays if you attempt to save with no Service Type selected.

Access X12 Version of 270 Request

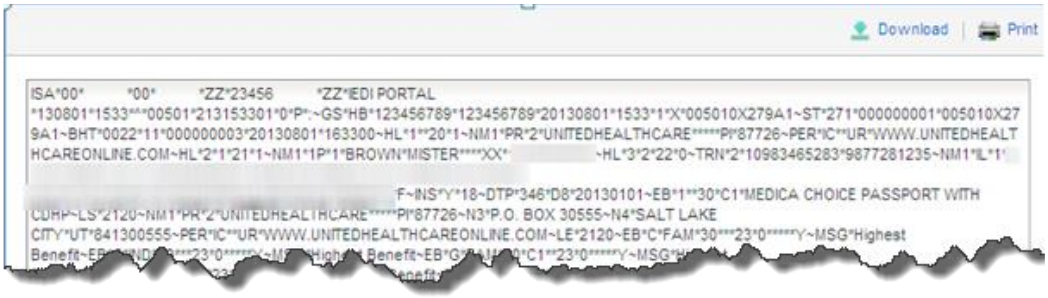
The View X12 icon is enabled when you successfully submit a request and the 270 Request is created.

View X12 is displayed based on user role and permissions.



- Click the View X12 icon to open and view the X12 version of the 270 Request, as shown below.
- Click the Download button (upper right) to save the X12 file to your local machine.
- Click the Print button (upper right) to print the X12 file to your printer.

You can adjust the Request form and resubmit, unless you click Clear Criteria or navigate away from the page.



Check Patient Eligibility – Response

Task: View the patient eligibility request results

Navigation: Eligibility/Check Patient Eligibility

When you have successfully submitted a Request to check patient eligibility there are four possible outcomes or Response types:

- 271 Response —Accepted
- 271 Response —Rejected
- 999 and/or TA1 Response —Errors
- Exception Errors —transmissions errors

Your Response is displayed beside your Request form for convenient reference, and you can scroll the Response pane separately to review the outcome of your Request.

The Eligibility Record ID# is an internal transaction ID for your Request and Response. The following information is available in the Eligibility Response header:

- Group Number
- Patient Birth Date
- Patient Gender
- Payer
- Payer Order – displays only when received from the payer, as Primary, Secondary, or Tertiary
- Primary Care Provider (ID)
- Remaining Deductible
- Subscriber/Patient
- Subscriber ID

To view details provided in the Response use the Expand All / Collapse All icons. You may also expand and collapse each individual item.

Click the icons (upper right) to Print the Request and Response, and View X12.

Set Default View

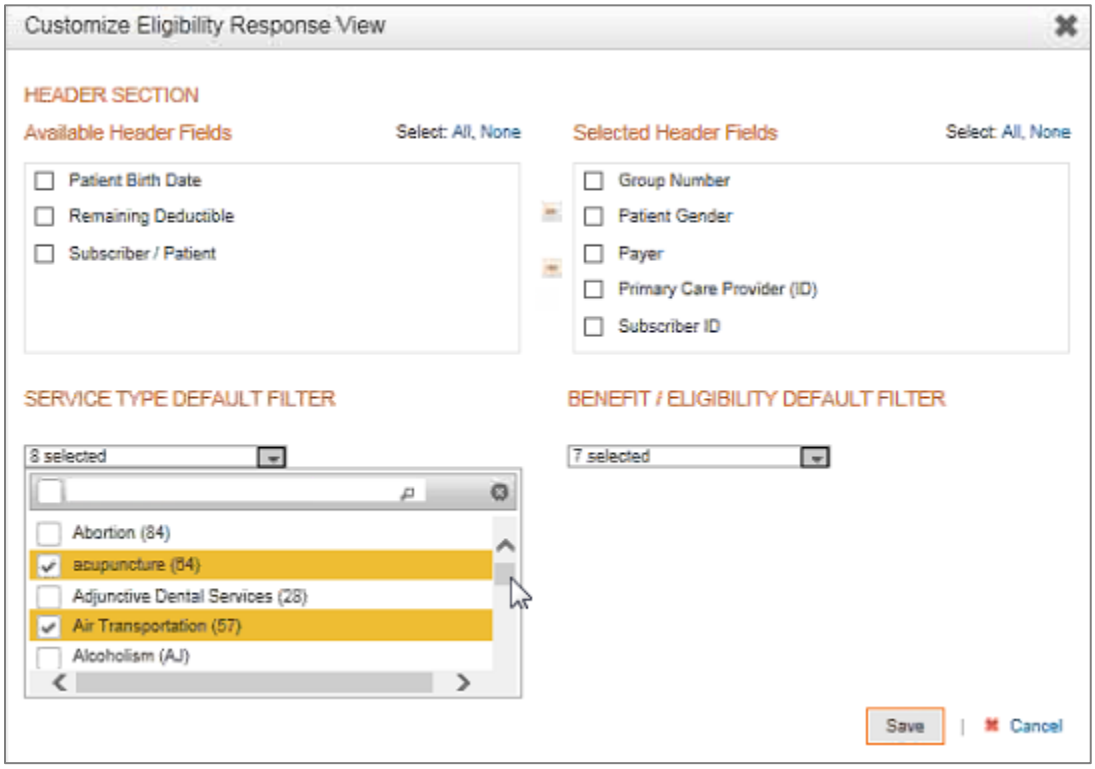
You have the ability to customize your default view of the Response pane. Your default settings are applied for any Customer/Billing Entity login.

Click the settings icon (upper right) to open the Customize Eligibility Response View form, as shown below.

- Use the checkboxes to select your core group of Header fields, and move these from the Available Header Fields pane to the Selected Header Fields pane. Once you click Save the Selected Header Fields will be displayed in the Eligibility Response header section. (Use the checkboxes to remove, as needed.)

  Note: The Payer Order field is displayed by default only when included in the payer response. That is, Payer Order is not included as an Available Header Field because it is not customizable.

- Select one or more default filters for Service Type Description, as illustrated below
- Select one or more default filters for Benefit/Eligibility Information
- Click Save when you have completed your selections



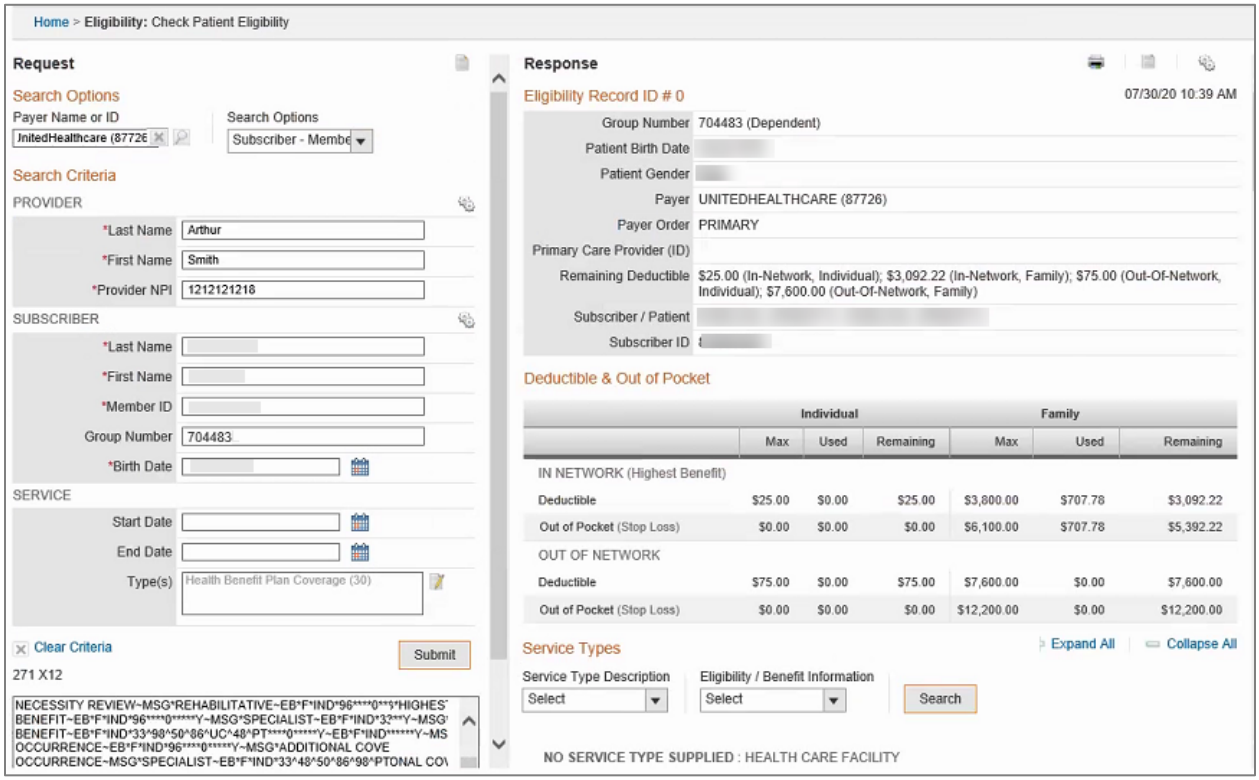
You will be able to apply additional filter choices within the Response pane.

To modify your default customization you can click the settings icon to reopen the Customize Eligibility Response View form.

271 Response – Accepted

A 271 Response contains the following categories of information, as shown below:

- Eligibility Record ID# – contains the header information.
- Deductible and Out of Pocket – displays only if included in the payer response. If the payer sends a zero value this is reflected in the grid, however, if the payer sends no value this is reflected with a dash.
- Service Types – contains every Service Type returned from the payer but those you requested are sorted to the top of the list, whether you sort the list by service type description or code. You may filter the list by either or both of the following by selecting from the drop downs:
    - Service Type Description
    - Eligibility / Benefit Information
- Subscriber and/or Dependent



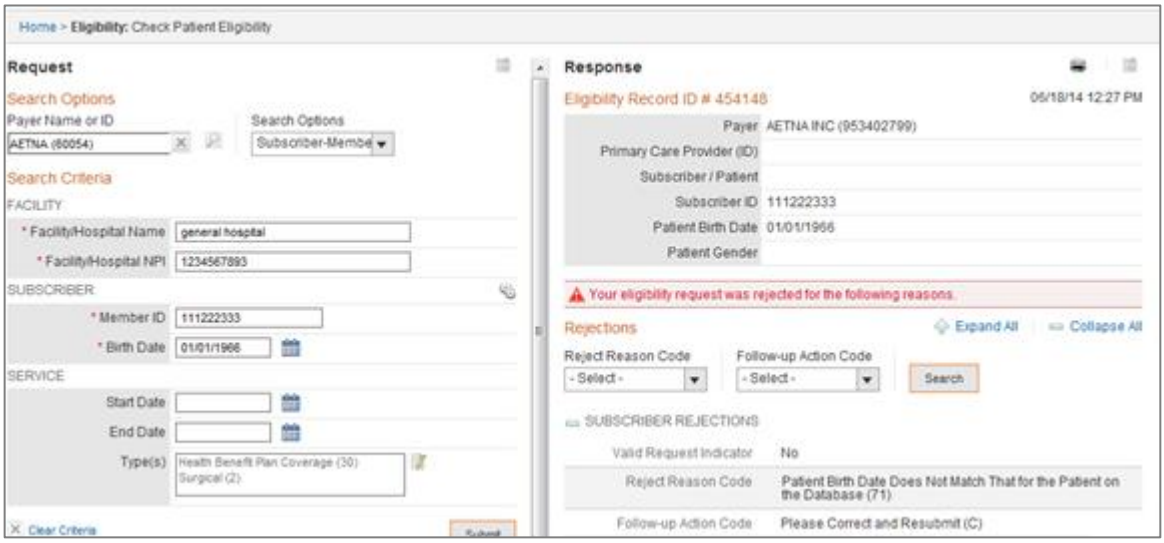
271 Response – Rejected

A 271 Response contains the following categories of information, as shown below:

- Eligibility Record ID# – contains the header information
- Rejections – can be filtered by either or both:

- Reject Reason Code
- Followup Action Code

The default message states, e.g., “Your eligibility request was rejected for the following reasons.”



999 and/or TA1 Response – Errors

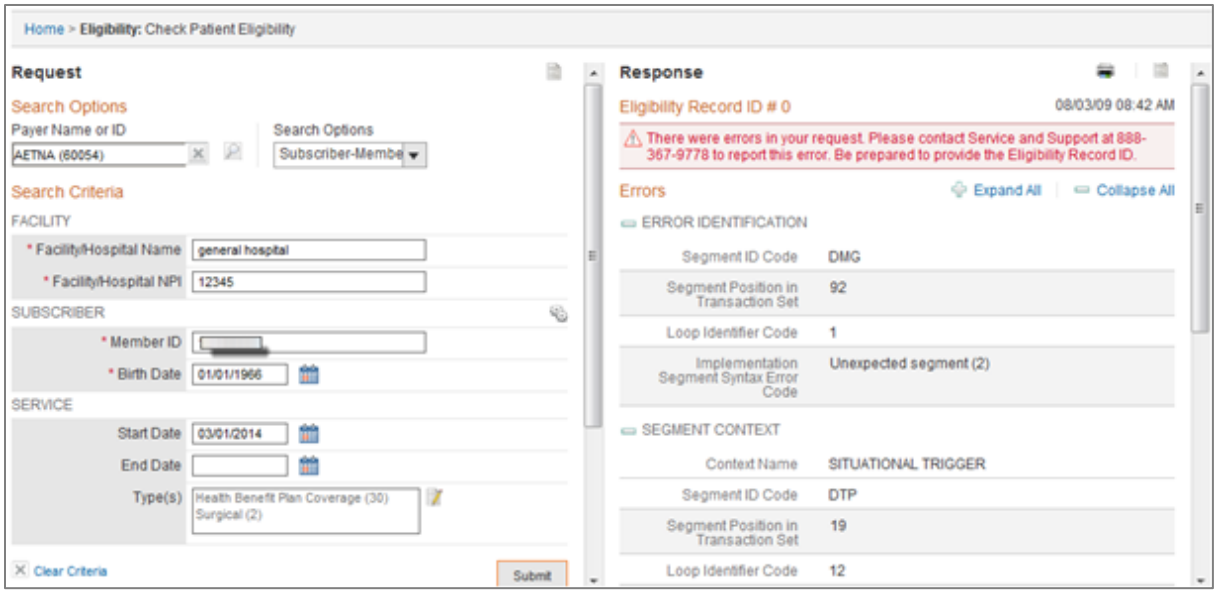
The 999/TA1 Response indicates errors in the Request, as shown below.

The 999/TA1 Response contains the following categories of information:

- Eligibility Record ID# – identifier number only
- Date and Time
- Errors – can include the following:
  - Error Identification
  - Segment Context
  - Business Unit Identifier
  - Implementation Data Element Note
  - Interchange Acknowledgement

If both a 999 Response and a TA1 Response are received they are displayed together.

The default message states, e.g., “There were errors in your request. Please contact Service and Support to report the error. Be prepared to provide the Eligibility Record ID.”



Exception Errors

An Exception Errors Response is rare, but indicates a transmission error between sender and receiver, and X12 is not returned.

An Exception Errors Response contains the following information:

- Eligibility Record ID# – identifier number only
- Errors – error statement(s) only

The default message states, e.g., “There were errors in your request. Please contact Service and Support to report the error. Be prepared to provide the Eligibility Record ID.”

Eligibility Search – Requests

Task: Perform a Search for previously entered eligibility requests

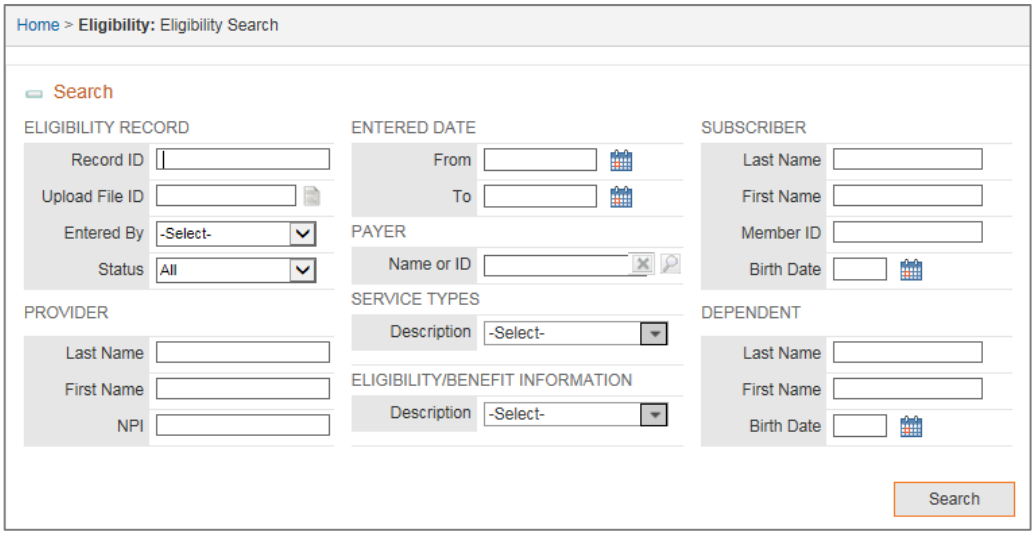
Navigation: Eligibility/Eligibility Search

Select Eligibility Search to open the Eligibility Search form, as shown below.

You can perform a broad or narrow search for previously entered eligibility requests. The search results correspond to the amount of information you enter on the Eligibility Search form.

If you enter no information the results will reflect all eligibility requests submitted for the selected Billing Entity (page banner) for the previous 13 months.

You can narrow your search by entering more information in the Eligibility Search form.



Eligibility Search form categories and fields are described in the table below.

The Eligibility Search form is designed to ensure an effective search with valid results, i.e., drop down and auto-completions reflect only potentially valid options. For example, only those users who have submitted an eligibility request are listed in the Entered By drop down.

Eligibility Search Categories	Eligibility Search Field Descriptions
Eligibility Record	• Record ID • Upload File ID – use icon to open Uploaded File List. Search and/or select one or more files. • Entered By – use drop down list of valid requesters • Status - use drop down to select
Entered Date	• From – lookback is limited to 13 months. User date picker icon or manual entry. • To (optional) – if left blank the date of today is assumed
Provider	Enter at least the first two digits of the provider last name, and select a provider to auto-complete all of the Provider fields
Payer	Name or ID – populate using auto-complete or payer search feature
Subscriber	• Last Name • First Name • Member ID • Birth Date
Dependent	• Last Name • First Name • Birth Date

Eligibility Search Categories	Eligibility Search Field Descriptions
Service Types	• Sorted alphabetically by service type description, except that 'Health Benefit Plan Coverage (30)' is always listed first. • To make your selections – click to select all; enter characters for a wildcard search; or use the drop down. • To clear your selections – click to select all and click again. • A Payer selection is not required to search by service types.
Eligibility/Benefit Information	• Sorted alphabetically by the description. • To make your selections – click to select all; enter characters for a wildcard search; or use the drop down. • To clear your selections – click to select all and click again.

Complete the Eligibility Search form to your satisfaction.

Click Search, or use the Clear Criteria option to begin a new search.

Search results contain only records for the selected Billing Entity (page banner).

Your login as a particular Billing Entity (default Billing Entity) determines the search results. If you reselect your Billing Entity in the page banner the Eligibility Search form clears and you may begin a new search.

If the search returns no records a message displays, such as "No Records found."

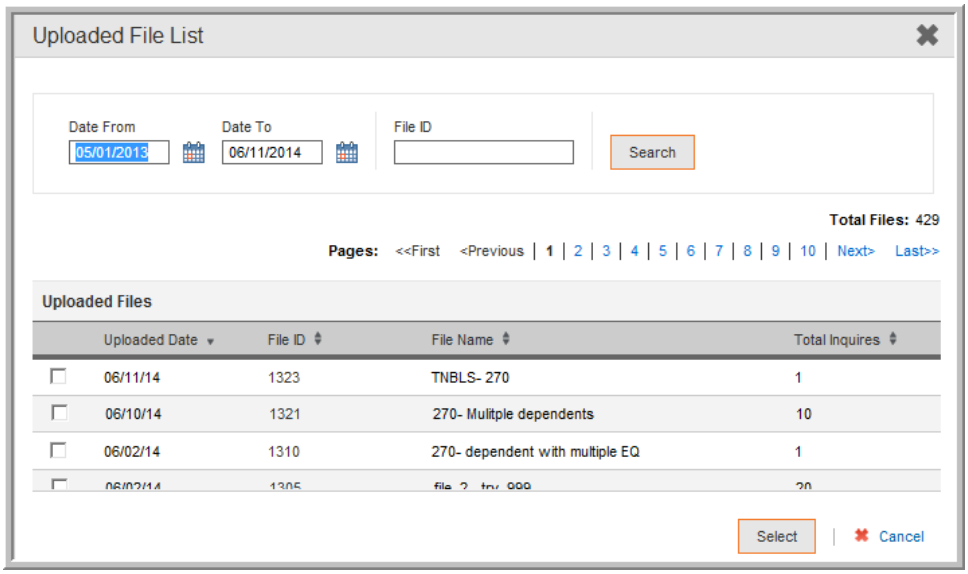
The Search pane collapses when you click Search. You may click Clear Criteria or the Search icon to expand the Search pane and begin a new Search.

Upload File ID

If you want to use the Upload File ID field click the icon (beside that field) to display the Uploaded File List, as shown below.

You can search the Uploaded File List by date range and File ID. If you entered a date range on the Eligibility Form it auto-populates the Uploaded File List date range search fields.

Click one or more row checkboxes, or click the header row checkbox to choose all File IDs.



Click Select or Cancel.

The File IDs you select are displayed in the Upload File ID field of the Eligibility Search form.

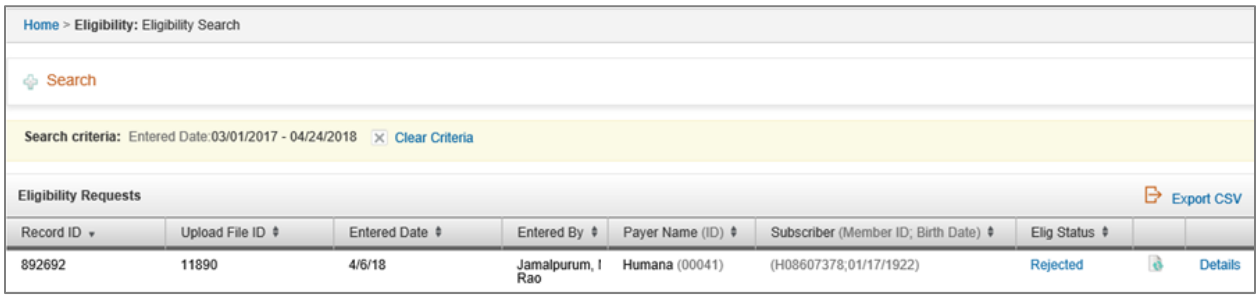
Eligibility Search – Results

Eligibility search results are displayed in the Eligibility Requests grid, as shown below. Search results are limited to the previous 13 months.

The Eligibility Requests grid duplicates the information contained in the Search Criteria, and also provides the following:

- Eligibility Status of each record
- Reverify – a refresh icon to reverify patient eligibility
- Details – a link to view additional record details
- Export CSV – a link to export and save the data currently included in the results grid. Note that the exported file does not include any details other than what is available in the grid.

The Eligibility Requests grid displays results by Record ID.



You may click Clear Criteria or the Search icon to expand the Search pane and begin a new Search .

If you reselect your Billing Entity in the page banner:

- The original results persist until you perform an action, e.g., sort the list

- Your Billing Entity selection persists until you change it, or log out.

You may click any column (other than Eligibility Status, Reverify, or Details) in the Eligibility Requests Files grid to open the individual Request/Response page to view and/or make adjustments.

From the Request/Response page you can navigate back to the Eligibility Requests Files grid using the breadcrumbs.

Eligibility Status

The Eligibility Status for each record returned is either Accepted or Rejected.

- Accepted – the Eligibility Status of Accepted indicates the submission to check patient eligibility was successful.
- Rejected – the Eligibility Status of Rejected indicates that a data element was determined to be invalid or missing by the payer or an exception (error) occurred and therefore a response was not received for the inquiry. The exception message will be displayed as 'Unable to Respond at Current Time (42)'.

If you reselect the Billing Entity in the page banner the Search Results closes and you are returned to the Eligibility Search form.

Rejection Messages

You can view rejection messages received for an individual eligibility record in the Eligibility Requests grid, which is displayed on the Search Results page.

Hover the "Rejected" Eligibility Status to open the rejection message, which includes the rejection code from the 271.

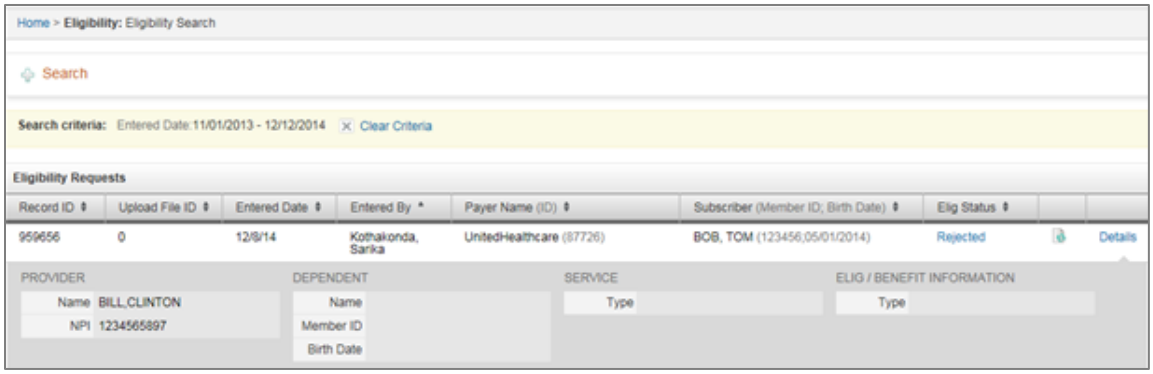
There may be multiple rejections for a single eligibility Record ID.

Record Details

Click the Details link in the Eligibility Requests grid to expand a display pane for one or more records, as shown below.

The record details provide this expanded information:

- Provider – Name, NPI
- Dependent (if applicable) – Name, Member ID, Birth Date
- Service – Service Type description and code – hover the More link to view additional codes
- Eligibility/Benefit Information – information description – hover the More link to view additional information



Click the details link to collapse the record details pane.

Reverify Patient Eligibility

Use the reverification feature in the Eligibility Requests grid to submit a reverification.

Click the refresh icon (end of row) for the desired Subscriber.

A new Record ID is created for the reverification, and the request data is an exact copy of the original request. If the reverified record was created from an uploaded request the Upload File ID is not applied to the new record. The results list is refreshed, and is sorted by Record ID in descending order.

The new record is not displayed on the refreshed list if it no longer conforms to the Search Criteria. You may adjust the search parameters to view the new record.

File Upload – Eligibility

If you select File Upload and you or the Billing Entity (page banner) are not affiliated with the Claim File Upload service an advisory message displays with instructions for obtaining assistance.

File Upload – Batch File

Task: Submit batch eligibility files

Navigation: Eligibility/File Upload

Select File Upload to open the File Upload tab, as shown below.

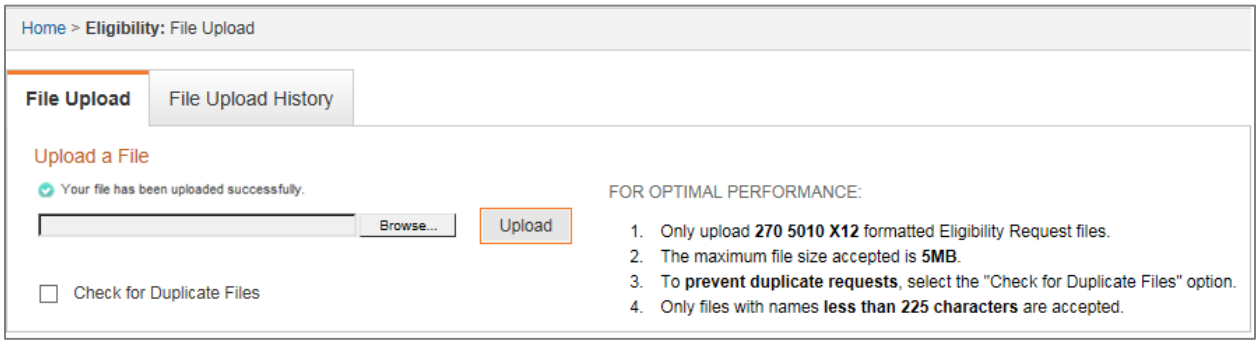
Use the File Upload function to submit batch eligibility files. When the upload is completed each individual patient eligibility request contained in the batch upload file is available as a unique eligibility record.

Click the Browse button under Upload a File to open your browser and select a single batch file. The selected file name displays in the Upload a File field.

Click the Upload button. A confirming message displays if the upload is successful.

A warning message displays if you attempt to navigate from the page without uploading or clearing the selected file. Click Yes to navigate from the page, or click No to return to the File Upload page where the selected file remains in the Upload a File field.

You can click the Browse button again after each file upload. It is not necessary to clear the file name field.



File constraints include the following:

- Only TXT files are accepted
- Only upload 270 5010 X12 formatted Eligibility Request files
- The maximum file size accepted is 5MB
- To prevent duplicate requests, select the Check for Duplicate Files option – If a duplicate file is entered you have the option to cancel the upload, or continue to upload a duplicate file with a current time/date stamp.
- Only files with names less than 225 characters are accepted

If your session times out an interactive auto-refresh option displays.

File Upload History

Task: View eligibility request files

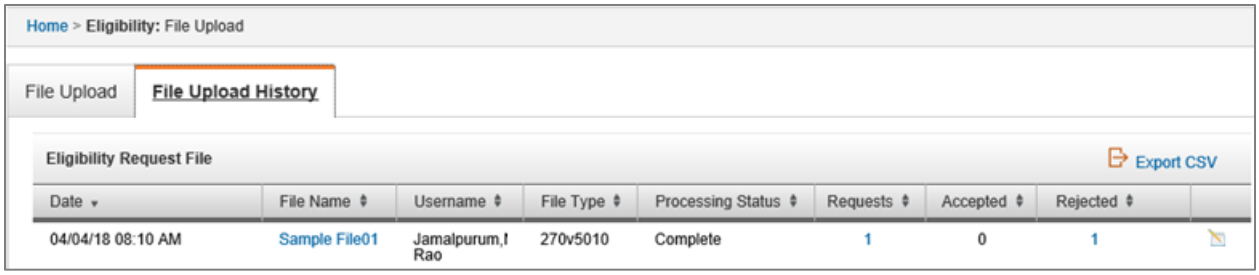
Navigation: Eligibility/File Upload/File Upload History

From File Upload select the File Upload History tab. The File Upload History page provides the Eligibility Request Files grid, as shown below.

The Eligibility Request Files grid reflects the following information about each batch eligibility file upload:

- Date/Time
- Name
- Username
- File Type
- Processing Status
- # Requests
- # Accepted
- # Rejected

The Eligibility Requests Files grid displays files in descending order by the Date they were uploaded.



You can use the Export CSV link to export and save the data currently included in the results grid. Note that the exported file does not include any details other than what is available in the grid.

You have links available in the Eligibility Requests Files grid that allow you to navigate to the Eligibility Requests grid:

- Click the number of Requests for the desired file to display the Eligibility Requests grid with all eligibility requests that have been accepted or rejected
- Click the number of Accepted claims – to view the accepted claims in the Eligibility Results grid
- Click the number of Rejected claims – to view the rejected claims in the Eligibility Results grid

In the Eligibility Requests grid click any row to view the Request/Response for that patient, which reflects the Search Options information and the Response.

An error message displays if the Request/Response cannot be mapped, e.g., if the request was submitted outside of Intelligent EDI .

The features of the Eligibility Requests grid are described under *Eligibility Search - Results*.

Processing Status

Processing Status shown in the Eligibility Requests Files grid is described in the following table.

Processing Status	Description	Options
Processing	Batch file is being split into individual eligibility requests. Files are displayed in the order they were uploaded.	• Open and download the file • Navigate away from the page
Queued	Individual eligibility requests have been split out from the batch file	Hover the Queued status to display the position of that file in the processing queue
Completed	Processing is complete for the individual eligibility requests	Click Name to view file

When the processing is complete you may click the Name link to view, download or print that particular file.

271 Response

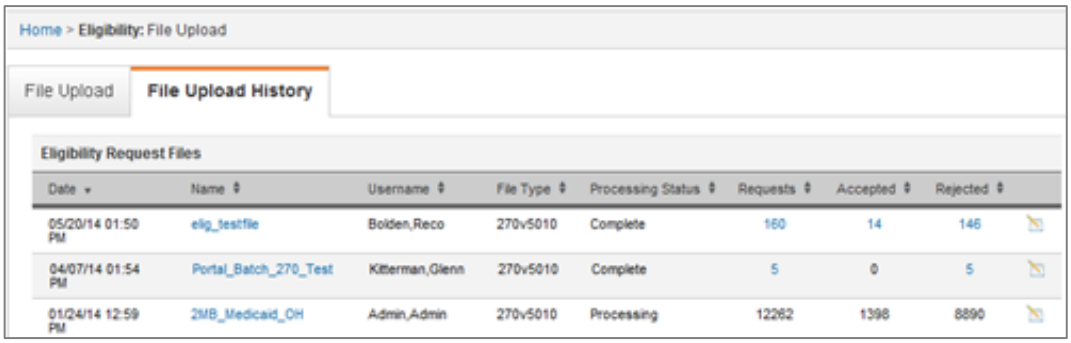
Task: Generate a 271 Response report

Navigation: Eligibility/File Upload/File Upload History

In the Eligibility Requests Files grid click the Reports icon at the end of a row to generate a 271 Response for that particular batch file.

The Reports icon is disabled if no response has been received for the requests in that particular file.

The 271 Response is provided at a new tab where you have the option to print or save the report.



Any 999 and/or TA1 rejection response is included within the 271 response, and is also reflected in the following:

- Any 999 and/or TA1 rejection response is included in the rejected count on the File Upload History page.
- Any 999 and/or TA1 rejection response is included in the rejected count on the Results page.

Any 999 and or TA1 rejection message will be displayed in the 271 Response as ‘Unable to Respond at Current Time (42)’ .

Reports

The Intelligent EDI Reports function provides the following:

- Reports
- Generated Reports

Reports

Task: Generate and save configurations for specific, customized reports of claims at any process within the claim life cycle; and generate specific, one-time (unsaved) reports

Navigation: Reports/Reports/Reports

Use the Reports/Reports feature to build custom reports based on the specific filter information you provide. For certain reports you have the option to save your user-specific Report Configuration, such as for Claim Detail and Claim Summary Report types.

Report Type

To configure a report begin by selecting a Report Type from the drop down that includes available reports, described as follows:

- Channel Partner Billing Entity – lists Billing Entities (active/inactive) for active child accounts
- Claim Detail – Comprehensive – provides a broadscope view of significant claim data
- Claim Detail – Status only
- Claim Detail – Top 20 Denials – provided by CARC codes
- Claim Detail – with Errors and Warnings
- Claim Enrollments Inventory – provides a spreadsheet export
- Claim Notes by a User – user level activity
- Claim Summary – Claim Counts by Status
- Claim Summary – Claim Counts Subtotaled by Payer
- Claim Summary – Monthly Claim Volume
- Claim Summary & Detail – Top 10 HIPAA Rejections – for H1-H2, provided by HIPAA codes
- ERA Admin Simp Export – to prepare an ERA Admin Simp Export file
- ERA Association – to view ERA Associations
- ERA Enrollment Inventory – provides a spreadsheet export
- iSCREAM – Audit – provides list of jobs run, and status
- Payer List – Payer Details
- Unmatched Remits to Claims – unmatched remittances to Claims
- User Audit Reports – offers preset Report Configuration options related to portal users
- WQ Claims Reconciliation – to view claims missing in Portal but available in Clearinghouse

Report Configuration

For Claim Detail and Claim Summary type reports you have the option to save your user-specific customized report as a named Report Configuration in order to rerun it at any time.

To rerun your custom report select the saved configuration by name from the Report Configuration drop down, and use the Generate Report button to quickly run a current report.

Certain preset configurations may be available, such as for User Audit Reports.

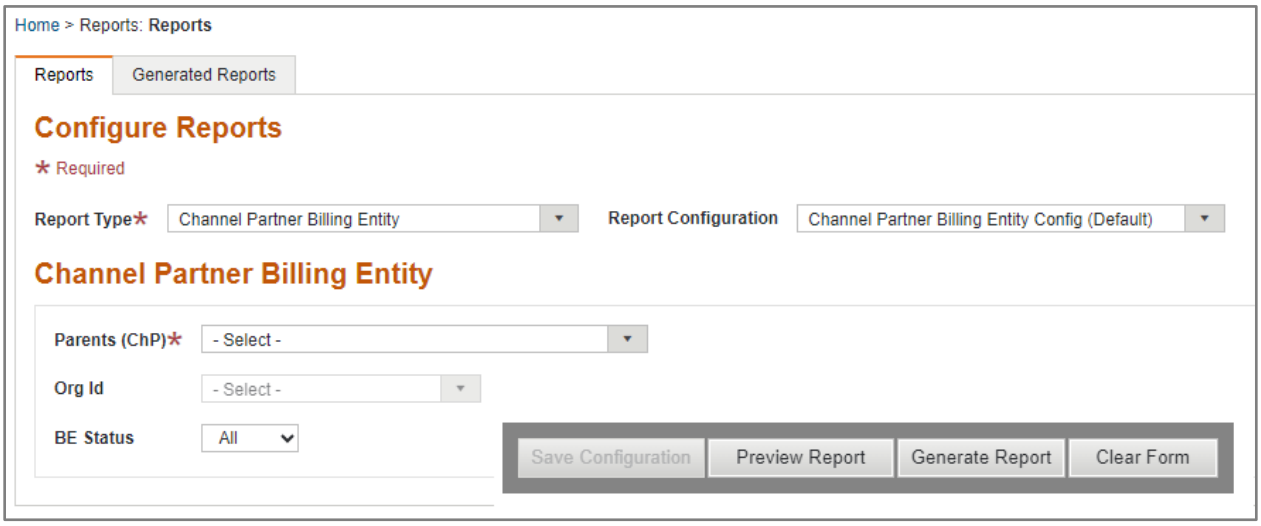
Channel Partner Billing Entity

Based on user role and permissions, you may produce a Channel Partner Billing Entity report that provides a listing of Channel Partner active and inactive Billing Entities for all active child accounts.

Begin by selecting Channel Partner Billing Entity report from the Report Type drop down.

To configure the Channel Partner Billing Entity report you must select the Parents (ChP) from that drop down. Enter any additional information to limit the scope of the report.

- Org ID – select one or more, All, or None
- BE Status – select All (default), Active, or Inactive



A Channel Partner Billing Entity report configuration cannot be saved.

You may select Preview Report to view your configuration before generating or clearing the form.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A Success message displays when the report has been generated and is available at the Generated Reports tab.

Claim Reports

Note that for Claim Reports you have the option to select Save Configuration before you generate your report, which allows you to quickly rerun this specific report at any time.

Note that for the Claim Detail, the Claim Enrollments Inventory, and the Claim Notes by a User type reports you can customize to display only the columns you want to include in a report, and for some reports you can also apply a sort preference.

When you are satisfied with your report configuration you may use the Preview Report to view your configuration before saving, or before clearing the form.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A receipt notice displays when your validated report is sent to the clearinghouse. You may continue working while the report builds.

Configuration

To configure a report begin by selecting a Report Type from that drop down.

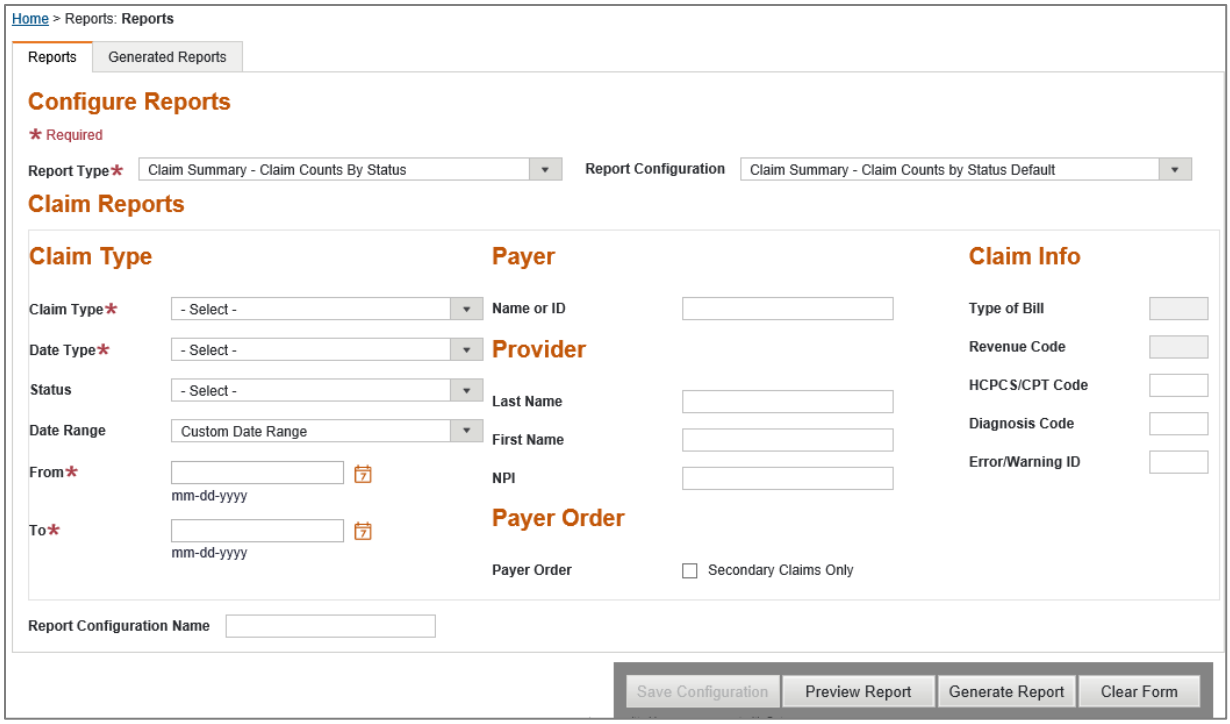
For many of the Claim type reports you must complete at least the required fields in the related Claim Reports form.

- Select the Claim Type – Professional, Institutional, or Dental
- Select the Date Type – Service or Submission
- Select the desired Date Range – if you select Custom Date Range you must complete the From and To date fields. Note that report data is generally limited to a 3-month date range within the previous 13 months.

Enter any other desired information to limit the scope of the report, such as the following:

- Status – you can select one or more, or select all statuses
- Payer – name or ID
- Provider – name, NPI
- Payer Order – you can limit to secondary claims only
- Claim Info – Type of Bill, Revenue Code, HCPCS/CPT Code, Diagnosis Code, Error/Warning ID that was received, CARC Code, Top 10 H1-H2 Rejections

Note that additional fields may display based on the Report Type selected, such as claim assignment fields for the Claim Notes by a User type report, or a Rejection Reason field for the Claim Enrollments Inventory type report.



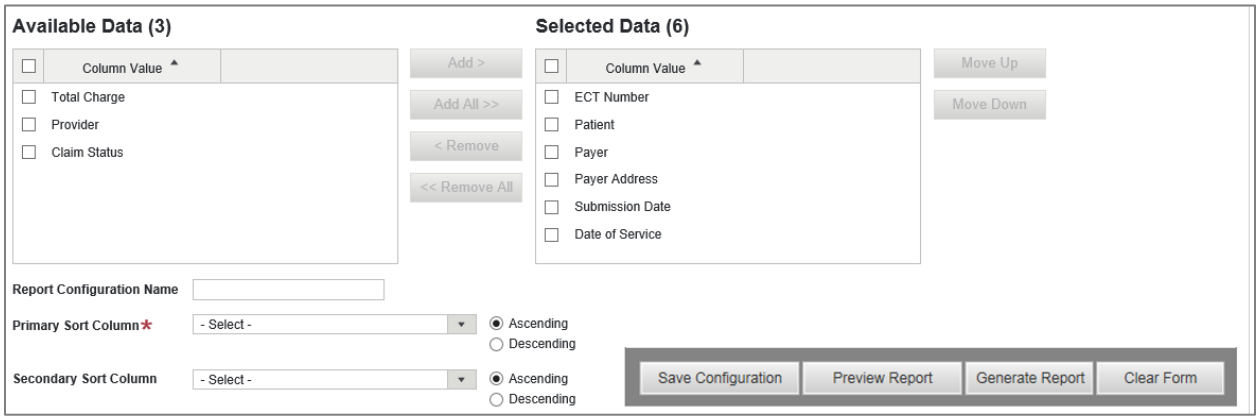
Customize – Selected Data

The Claim Detail, the Claim Enrollments Inventory, and the Claim Notes by a User type report forms expand to also capture applicable Selected Data for each report. The Available Data options are displayed based on the report type you have selected.

Selected Data defaults for each unique report type when a new form is opened, and some or all of the Available Data options are already included. Note the following in particular:

- for the Claim Notes by a User report only relevant options are included as Selected Data
- for the Claim Enrollments Inventory the Selected Data defaults to reflect the Claims Enrollments search results, and the Available Data reflects the information typically viewed via the Details link in the Claims Enrollments search results.

Note that when you open a saved configuration the Selected Data reflects that customized report.



Use the Add and Remove buttons (center) to select one or more data options until you are satisfied with your selections. The Available Data and Selected Data headers reflect your number of selections.

Use the Move Up or Move Down buttons (right) to sequence your display as you prefer.

You must enter a unique Report Configuration Name in that field if you want to save the configuration.

Where available on the form you can select your preferred Primary (required) and Secondary Sort Columns and designate each as Ascending or Descending.

Use the Clear Form button as needed to initiate a new configuration.

If you leave the form your selections will be lost.

You may use the Preview Report to view your configuration before saving, or before clearing the form.

Use the Save Configuration button when you are ready to save the Claim Report configuration. A success message displays.

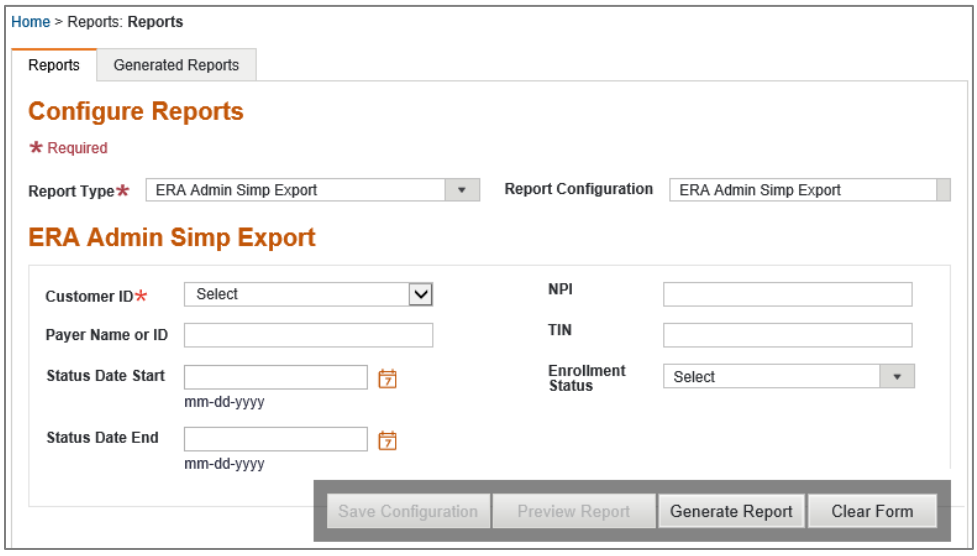
Configurations are not editable and cannot be deleted. However, you can open an existing configuration and use the populated form to capture changes, enter a new name and save as a new configuration.

ERA Admin Simp Export

To configure an ERA Admin Simp Export report begin by selecting ERA Admin Simp Export from the Report Type drop down.

To configure the ERA Admin Simp Export report you must select the Customer ID in the ERA Admin Simp Export form. Enter any additional information to limit the scope of the report.

- Customer ID – you must select the Customer ID from the drop down
- Payer Name or ID – provide either the name or ID
- Status Date – use the Start and End date fields to select the desired dates
- NPI
- TIN
- Enrollment Status – select from the drop down



An ERA Admin Simp Export report configuration cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

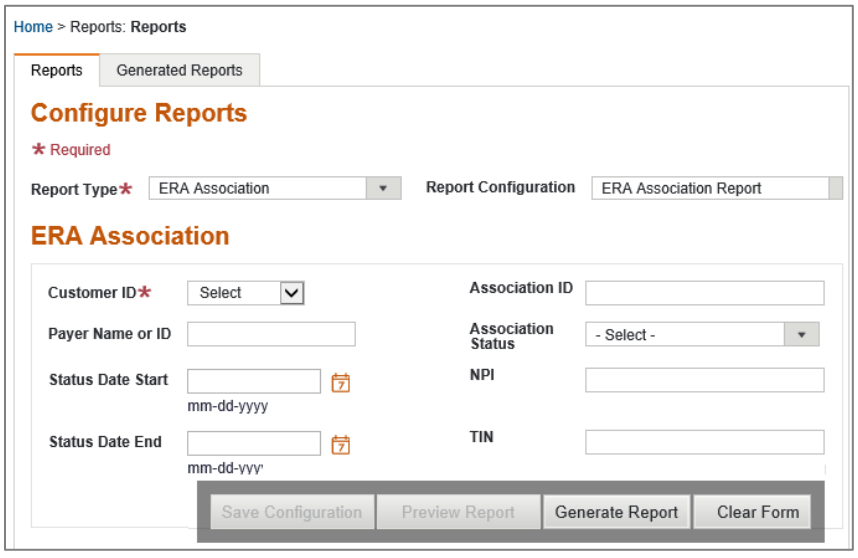
A receipt notice displays when your validated report is sent to the clearinghouse. You may continue working while the report builds.

ERA Association

To configure an ERA Association report begin by selecting ERA Association from the Report Type drop down.

To configure the ERA Association report you must select the Customer ID in the ERA Association form. Enter any additional information to limit the scope of the report.

- Customer ID – you must select the Customer ID from the drop down
- Payer Name or ID – provide either the name or ID
- Status Date – use the Start and End date fields to select the desired dates
- Association ID
- Association Status – select Active, Inactive, or All
- NPI
- TIN



An ERA Association report configuration cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A Success message displays when the report has been generated and is available at the Generated Reports tab.

ERA Enrollment Inventory

Note that for the ERA Enrollment Inventory report you have the option to select Save Configuration before you generate your report, which allows you to quickly rerun this specific report at any time.

Note that for the ERA Enrollment Inventory report you can customize to display only the columns you want to include in a report, as well as a sort preference.

When you are satisfied with your report configuration you may use the Preview Report to view your configuration before saving, or before clearing the form.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

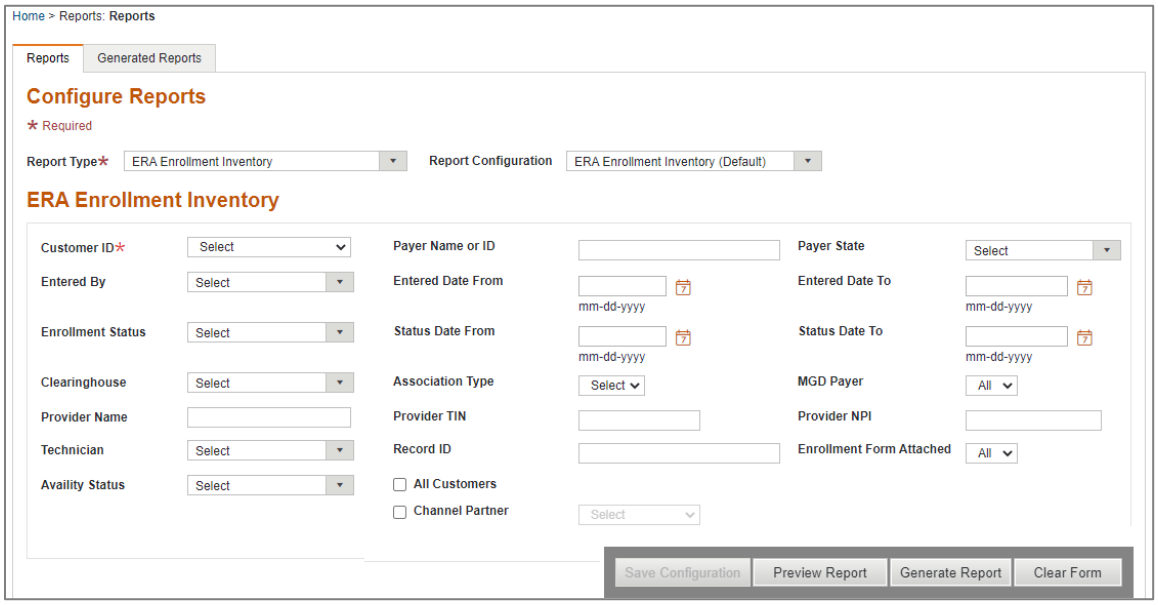
A receipt notice displays when your validated report is sent to the clearinghouse. You may continue working while the report builds.

Configuration

To configure an ERA Enrollment Inventory report begin by selecting ERA Enrollment Inventory from the Report Type drop down.

You must select a Customer ID from the ERA Enrollment Inventory form drop down.

Enter any additional information and/or apply filters to limit the scope of the report.



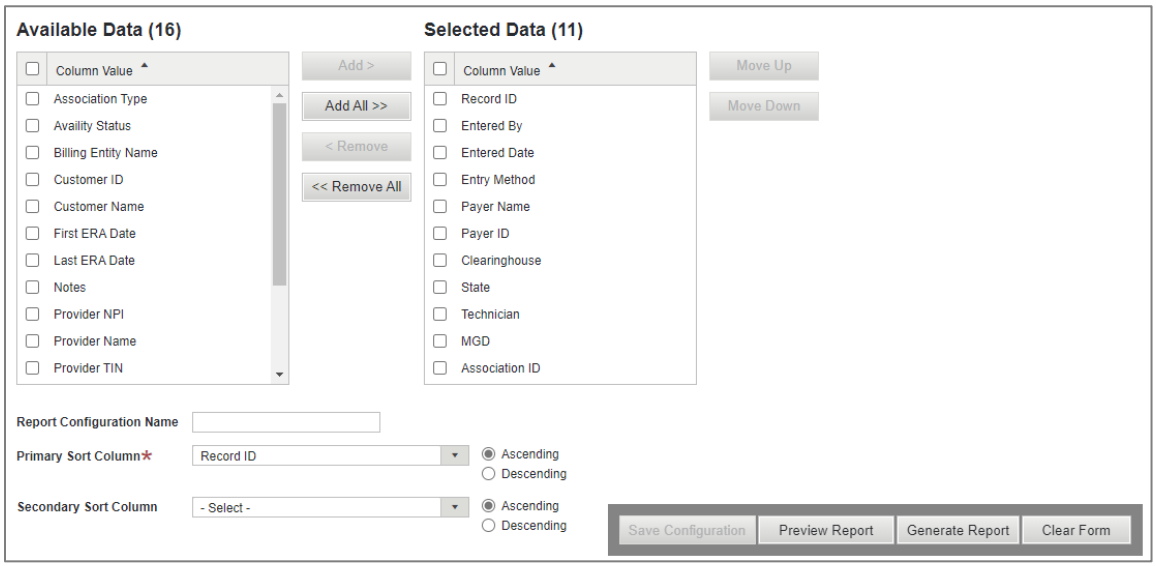
Customize – Selected Data

The ERA Enrollment Inventory type report form expands to also capture applicable Selected Data for each report. The Available Data options displayed are based on the ERA Enrollment Inventory type report.

A new ERA Enrollment Inventory type report form reflects the following:

- The Selected Data defaults to include the Available Data options that are typically displayed in a Utilities/ERA Enrollments search results grid
- The remaining Available Data options reflect the information typically viewed via the Details link in a Utilities/ERA Enrollments search results grid

However, when you open a saved configuration the Selected Data reflects that customized report.



Use the Add and Remove buttons (center) to select one or more data options until you are satisfied with your selections. The Available Data and Selected Data headers reflect your number of selections.

Use the Move Up or Move Down buttons (right) to sequence your display as you prefer.

You must enter a unique Report Configuration Name in that field if you want to save the configuration.

Select your preferred Primary (required) and Secondary Sort Columns and designate each as Ascending or Descending.

Use the Clear Form button as needed to initiate a new configuration.

If you leave the form your selections will be lost.

You may use the Preview Report to view your configuration before saving, or before clearing the form.

Use the Save Configuration button when you are ready to save the ERA Enrollment Inventory configuration. A success message displays.

Configurations are not editable and cannot be deleted. However, you can open an existing configuration and use the populated form to capture changes, enter a new name and save as a new configuration.

iSCREAM – Audit

Based on user role and permissions, you may produce an iSCREAM - Audit report that provides a list of all jobs run within a designated date range, and the resulting status of each job.

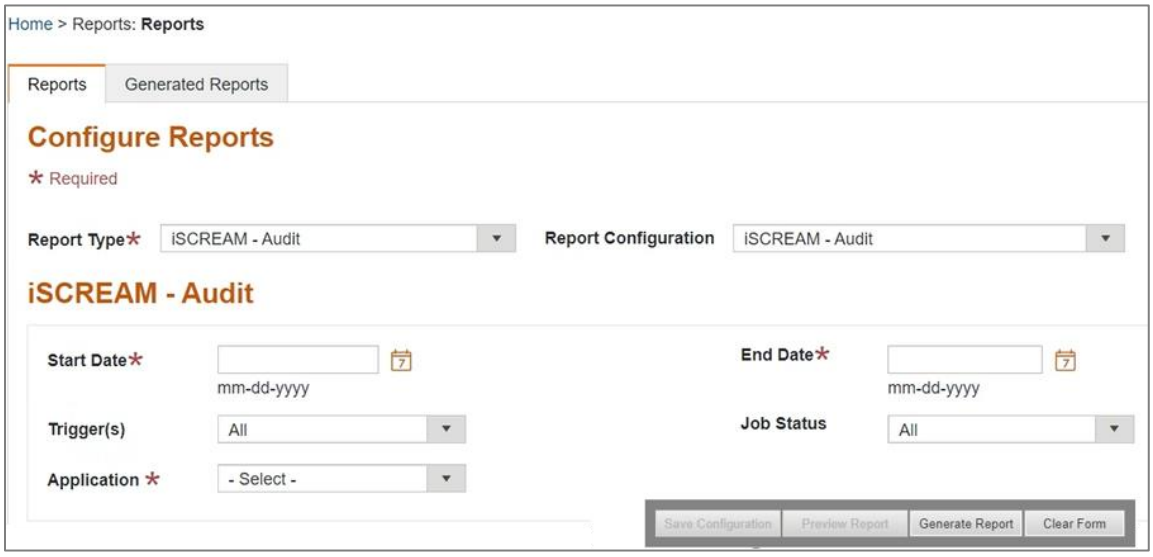
Begin by selecting iSCREAM - Audit from the Report Type drop down.

To configure the iSCREAM - Audit report you must complete at least the required fields.

- Select both a Start Date and End Date, not to exceed a 7 day range.
- Select one Application from that drop down – IEDICH or MGD.

You may enter any additional information to limit the scope of the report.

- Trigger – All (default), Systematic, Manual
- Job Status – All (default), Success, Failed



An iSCREAM - Audit report configuration cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A Success message displays when the report has been generated and is available at the Generated Reports tab.

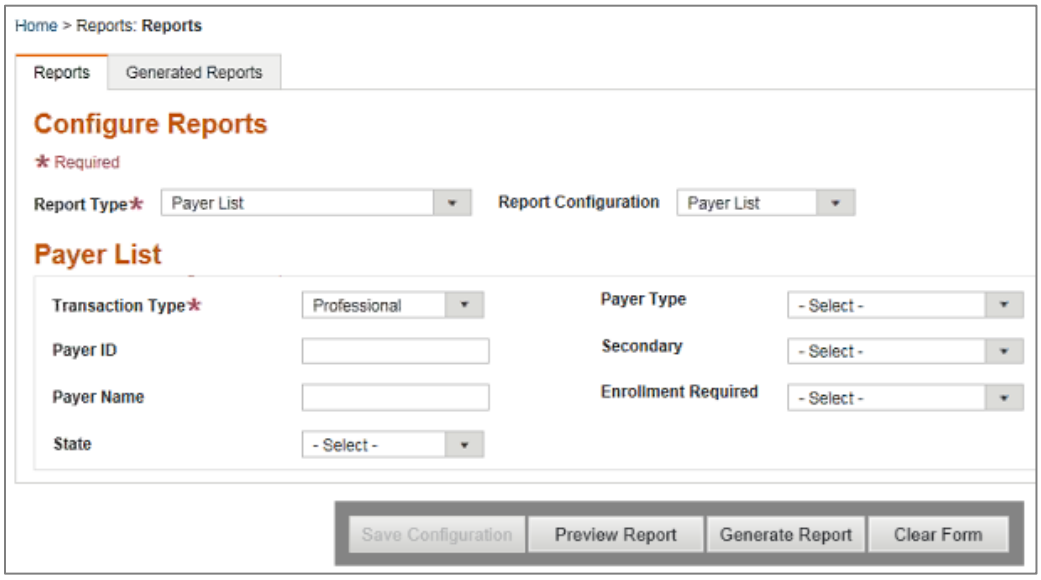
Payer List

To configure a Payer List report begin by selecting Payer List from the Report Type drop down.

To configure the Payer List report you must select the Transaction Type in the Payer List form. Enter any additional information to limit the scope of the report.

- Transaction Type – Professional, Institutional, or Dental
- Payer ID
- Payer Name
- State – select the appropriate Address State

- Payer Type – P, C, G, T, N
- Secondary – Yes or No
- Enrollment Required – Yes or No



You may select Preview Report to view your configuration before generating or clearing the form.

A Payer List report configuration cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A Success message displays when the report has been generated and is available at the Generated Reports tab.

User Audit Reports

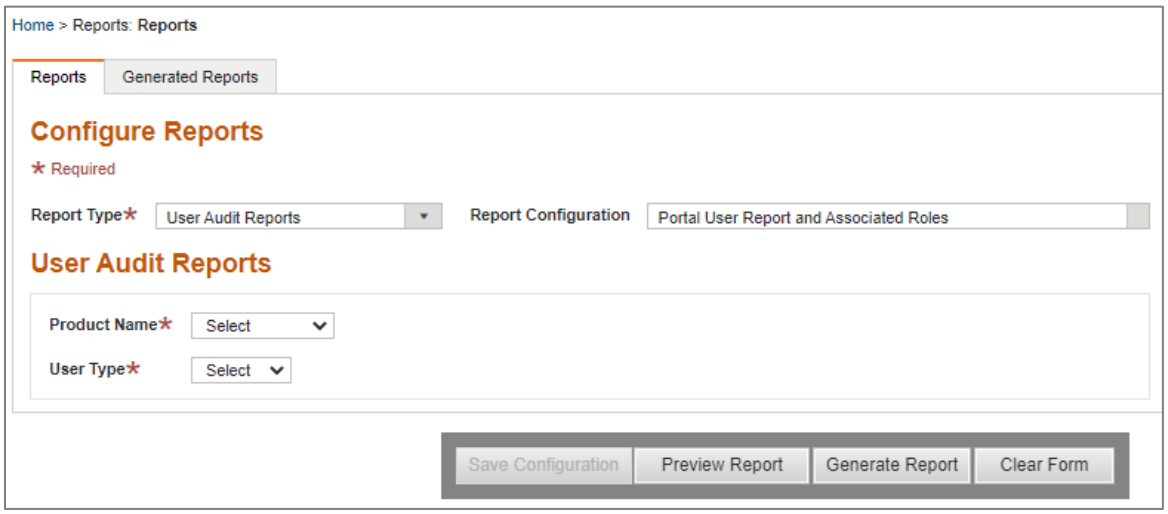
Based on user role and permissions, you may use any preset User Audit Reports/Report Configuration to configure a customized report.

Begin by selecting User Audit Reports from the Report Type drop down, and then the desired Report Configuration.

The applicable fields are displayed for the selected Report Configuration, and you must complete the required fields to configure your customized report.

- **Portal New Users and Added By** -- you must select a User Type, and also define a date range limited to 6 months by entering the event start date and end date.
- **Portal Roles Functions Permissions --** you must select a Product Name from that drop down.
- **Portal User Activity Report --** you must define a date range of 1 to 5 days by entering the event start date and end date.

- **Portal User Report and Associated Roles --** you must select a Product Name and a User Type from those drop downs.



You may select Preview Report to view your configuration before generating or clearing the form.

The User Audit Reports configurations cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A Success message displays when the report has been generated and is available at the Generated Reports tab.

Unmatched Remits to Claims

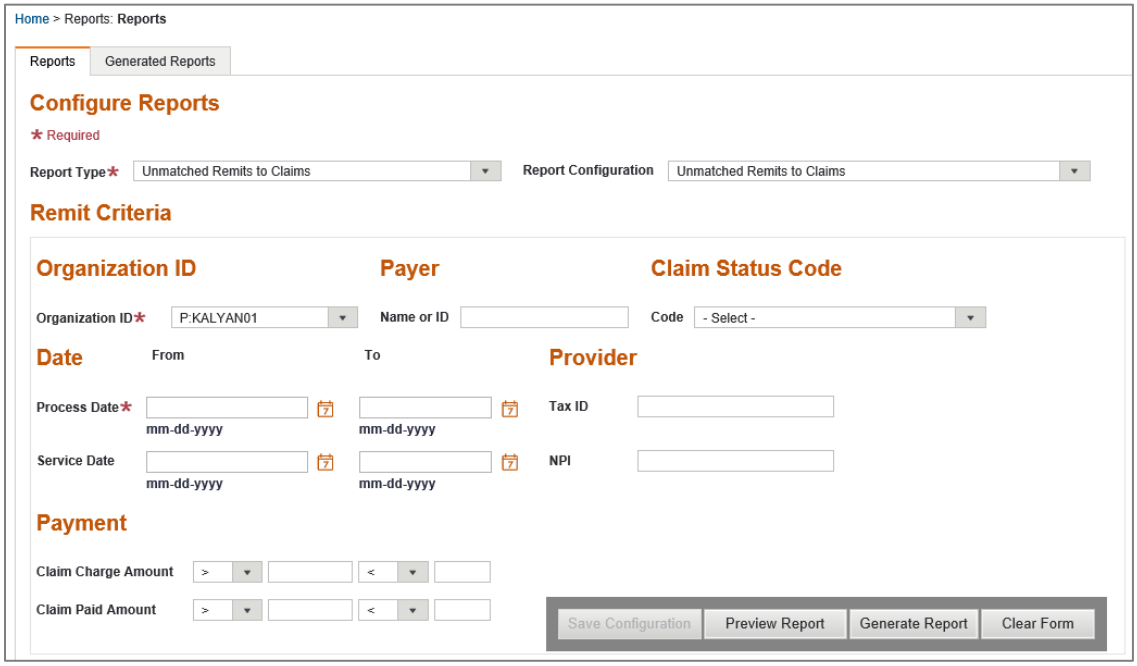
To configure an Unmatched Remits to Claims report begin by selecting Unmatched Remits to Claims from the Report Type drop down.

To configure the Unmatched Remits to Claims report you must complete these required fields in the Remit Criteria form:

- Organization ID – you must select the Organization ID from the drop down
- Process Date – you must complete the From and To date fields

Enter any additional information to limit the scope of the report.

- Payer – name or ID
- Claim Status Code – select from the drop down
- Service Date – use the From and To date fields
- Provider – enter Tax ID and/or NPI
- Payment – you can indicate a range for Claim Charge Amount, and/or Claim Paid Amount using those fields and the operators provided



You may select Preview Report to view your configuration before generating or clearing the form.

An Unmatched Remits to Claims report configuration cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

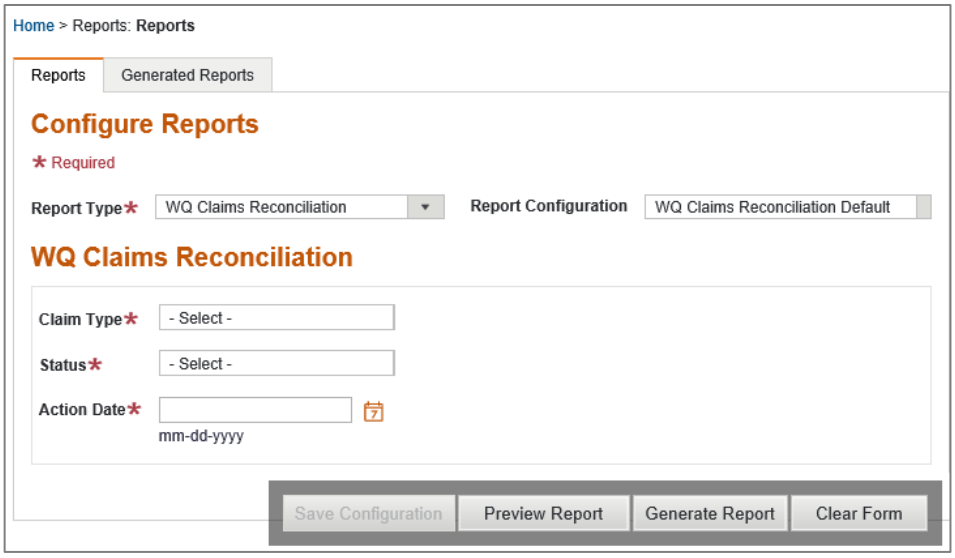
A receipt notice displays when your validated report is sent to the clearinghouse. You may continue working while the report builds.

WQ Claims Reconciliation

To configure a WQ (Work Queue) Claims Reconciliation report begin by selecting WQ Claims Reconciliation from the Report Type drop down.

To configure the WQ Claims Reconciliation report you must complete these required fields in the WQ Claims Reconciliation Report form:

- Claim Type – select from the drop down
- Status – select from the drop down
- Action Date – select the desired date



You may select Preview Report to view your configuration before generating or clearing the form.

A WQ Claims Reconciliation report configuration cannot be saved.

Use the Clear Form button to clear any completed field information to begin a new report.

Use the Generate Report button to initiate field validation, and any error messages are displayed.

A receipt notice displays when your validated report is sent to the clearinghouse. You may continue working while the report builds.

Note that if no results are returned a message displays in the generated report to confirm your report is valid and that there are no claims missing.

Generated Reports

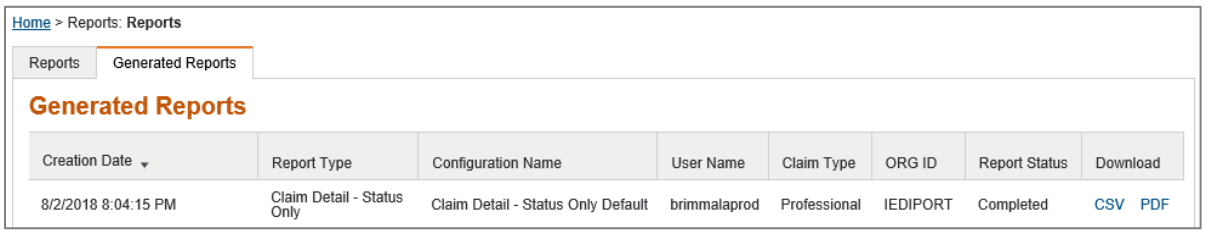
Task: View the Generated Reports results grid, download and print the report

Navigation: Reports/Reports/Generated Reports

Select the Generated Reports tab to view all of the results returned in the Generated Reports grid, sorted by the most recent.

The Generated Reports grid reflects the following:

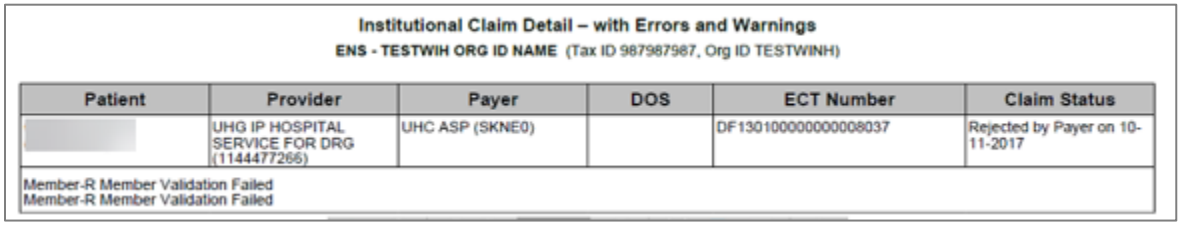
- Creation Date
- Report Type
- Configuration Name
- User Name
- Transaction Type
- ORG ID
- Report Status



The report returns any available data, and may contain blank fields.

Note that the WQ Claims Reconciliation report displays a message when no results are returned to confirm that the report is valid and that there are no claims missing from the generated report.

Use the Download icon on the desired row to open a report. Generated reports are provided as a PDF file. The CSV file cannot be opened, but you can Save As a new file.



Use the Adobe options to print or save the PDF report.

Referrals

The Intelligent EDI Referrals function provides the following options:

- Check Referrals
- Referrals File Upload

Referrals – Requests

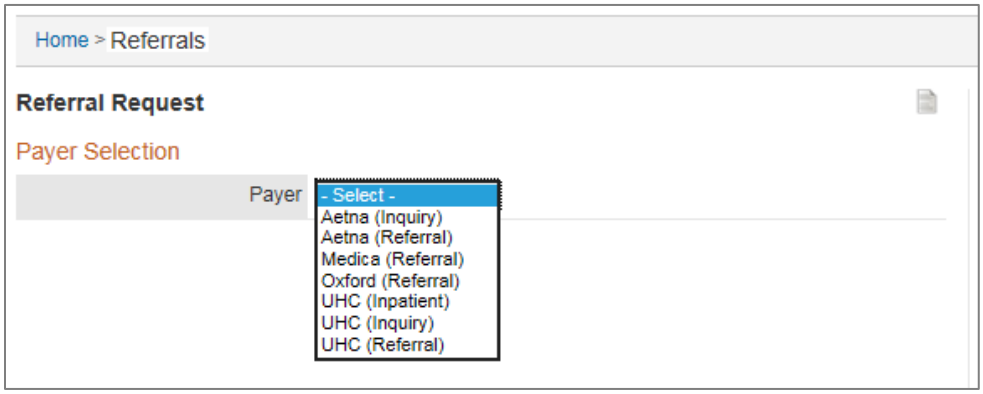
Task: Send provider and patient Referral Requests to payers, and follow up on previous requests

Navigation: Referrals/Check Referrals/Referral Request

The Referral Requests feature allows you to manage three types of requests, which are all generally referred to herein as Referrals:

- **Referral:** Provider is sending basic inquiry to payer to confirm the provider is covered and certified with that payer to perform the specified service.
- **Inquiry:** Provider is sending a follow up inquiry to payer regarding the status of a previous Referral Request. This submission includes a Certification ID from the initial request.
- **Inpatient:** Provider is submitting a request to payer to confirm that a specific individual is eligible for an inpatient admission for the specified services/or diagnosis under their healthcare plan.

To initiate a Referral Request select Referrals/Check Referrals to open a Referral Request form, and select your Payer with the desired type of request – Inquiry, Referral, or Inpatient.



The default Billing Entity (page banner) determines which Payers display in the drop down.

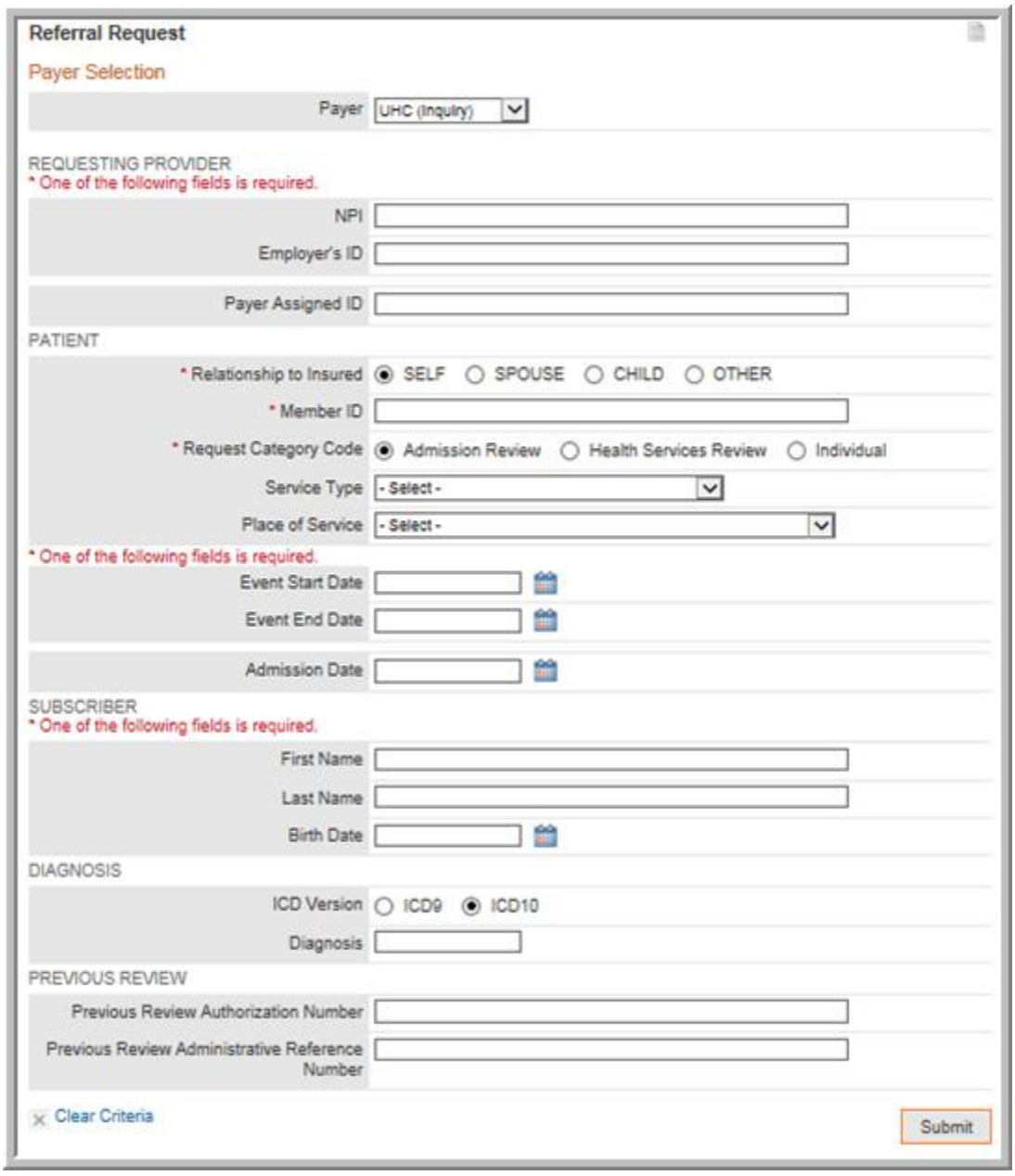
Continue completion of the Referral Request form after the Payer is selected. The expanded Request form contains various elements based on the Payer and Referral type selected. Examples include the following:

- **Referral:** Requesting Provider, Patient, Subscriber, Diagnosis, Referral Information, Services
- **Inquiry:** Requesting Provider, Patient, Certification Information

- **Inpatient:** Member, Patient, Provider Facility, Physician, Services; option to Add a Procedure Line

Complete the fields or select the applicable options provided on the Referral Request form. The fields applicable to your selected Payer and referral type are displayed on the form.

A sample Inquiry type request is shown below. Note that guidance regarding certain required fields is provided in this particular sample, such as, to select at least one field from the category.



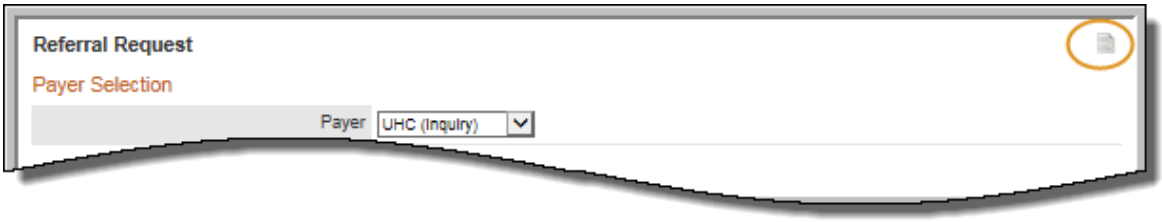
All of the required fields (*) in form the must be completed with valid information. Applicable error messages are displayed and the field is highlighted if you attempt to submit incomplete or invalid information.

Click to Submit, or use the Clear Criteria option to clear all fields other than the selected Payer.

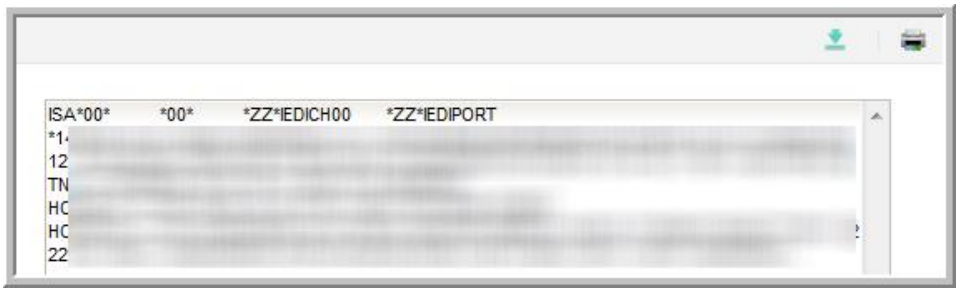
Access X12 Version of 278 Request

The View X12 icon is enabled when you successfully submit a request and the 278 Request is created.

View X12 is displayed based on user role and permissions.



- Click the View X12 icon to open and view the X12 version of the 278 Request, as shown below.
- Click the Download button (upper right) to save the X12 file to your local machine.
- Click the Print button (upper right) to print the X12 file to your printer.



Referrals – Response

Task: View the response to provider and patient Referral Requests to payers

Navigation: Referrals/Check Referrals/Referral Request

When you have successfully submitted a Referral Request there are three possible outcomes or Response types:

- 278 Response
- 999 and/or TA1 Response – Errors
- Exception Errors – transmissions errors

Your Response is displayed beside your Referral Request form for convenient reference, and you can scroll the Response pane separately to review the outcome of your request.

The Referral Record ID# is an internal transaction ID for your Request and Response. The transaction detail provides the Payer Name (ID), and indicates the real-time response.

The details of a Response, e.g., rejection reasons, are revealed at all levels as received.

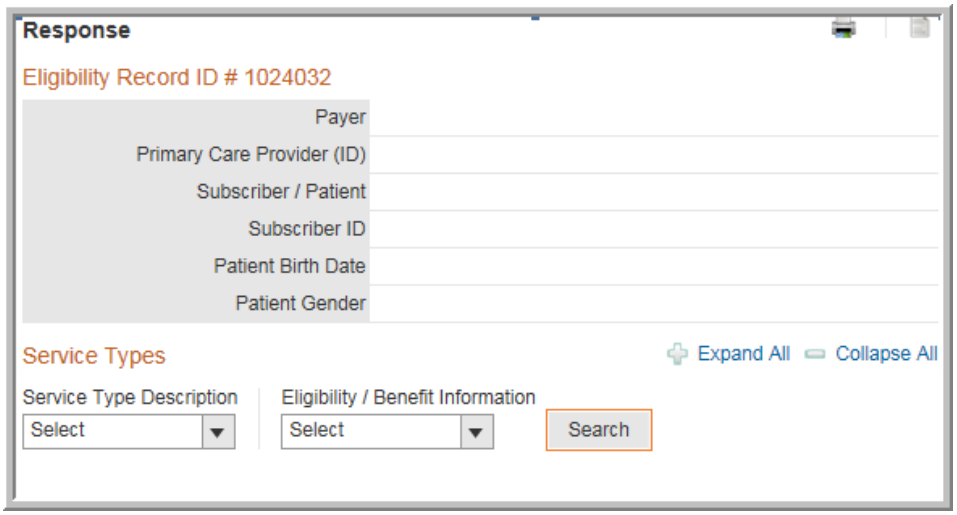
To view details provided in the Response use the Expand All / Collapse All icons. You may also expand and collapse each individual item.

Click the icons (upper right) to Print the Request and Response, and View X12.

278 Response

A 278 Response always contains the Referral Record ID#, as well as any other applicable categories of information, as shown below.

- Referral Record ID# – contains Payer Name (ID), and the response date and time
- Requestor
  - Name
  - NPI
- Patient
  - Name
  - Relationship to Insured
  - Member ID
- Referred Provider
  - Place of Service
  - Specialty Code
  - Provider Name
  - Referral Status
- Utilization Management Organization
  - Identifier
  - Name
  - Contact Information
- Accepted Information
  - Review Decision Reason Code
  - Certification Action Code
  - Patient Event Level Accepted Information
  - Service Level Accepted Information



999 and/or TA1 Response – Errors

The 999/TA1 Response indicates errors in the Referral Request, as shown below.

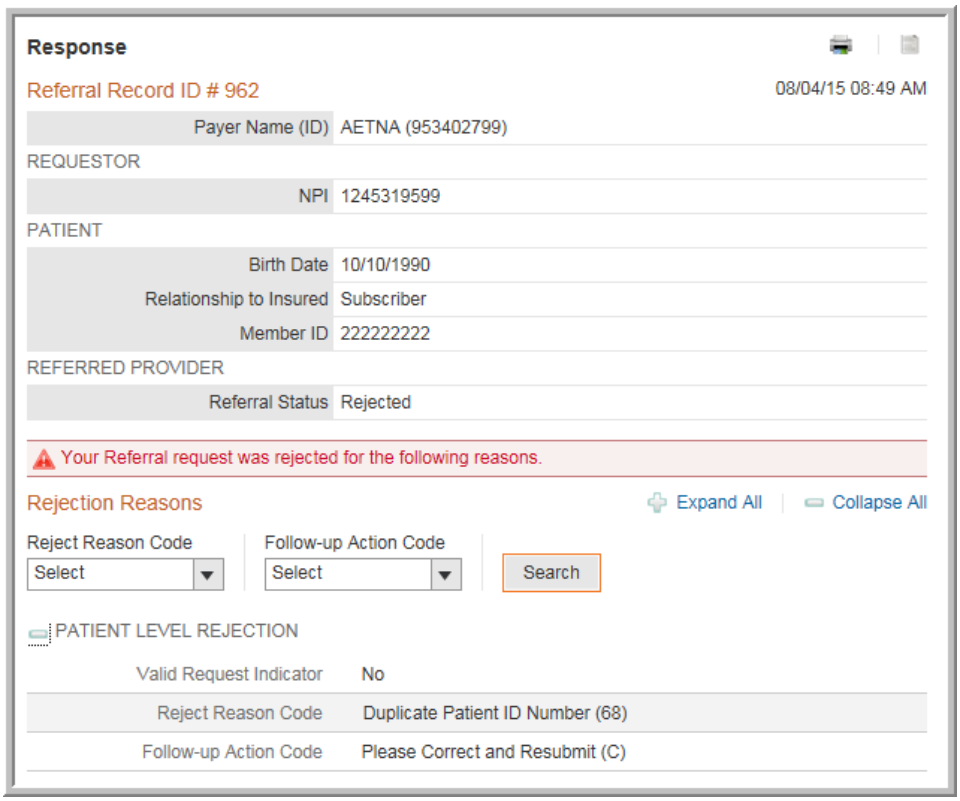
The 999/TA1 Response always contains the Referral Record ID#, as well as any other applicable categories of information.

- Referral Record ID# – contains Payer Name (ID), and the response date and time
- Requestor
- Patient
- Referred Provider
- Rejection Reasons – errors can include the following:
  - Information Source Level Rejection
  - UMO Level Rejection
  - Requestor Level Rejection
  - Patient Level Rejection
  - Patient Event Level Rejection
  - Service Level Rejection

If both a 999 Response and a TA1 Response are received they are displayed together.

The default message states, e.g., “Your Referral request was rejected for the following reasons.”

Use the Reject Reason Code, and Follow-up Action Code drop downs for specific information.



Exception Errors

An Exception Errors Response is rare, but indicates a transmission error between sender and receiver, and X12 is not returned.

An Exception Errors Response contains the following information:

- Referral Record ID# – identifier number only
- Errors – error statement(s) only

The default message states, e.g., " Your Referral request was rejected for the following reasons."

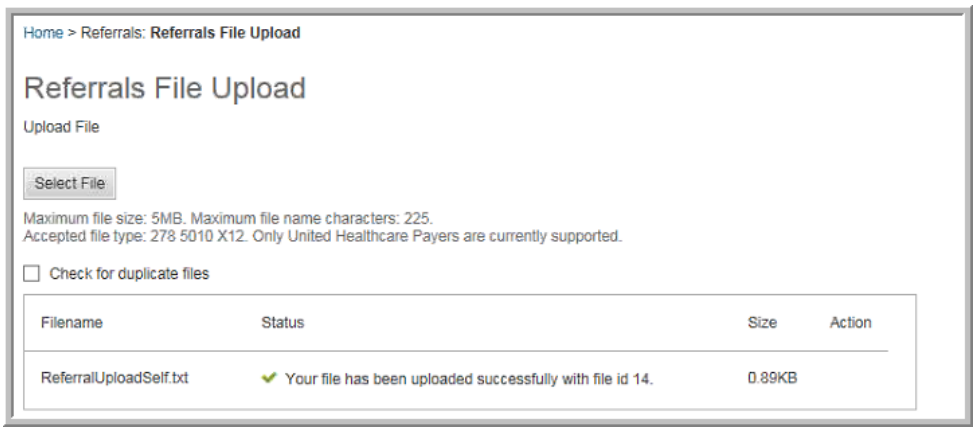
Referrals File Upload

Task: Upload provider and patient Referral Requests to process provider inquiries

Navigation: Referrals/Referrals File Upload

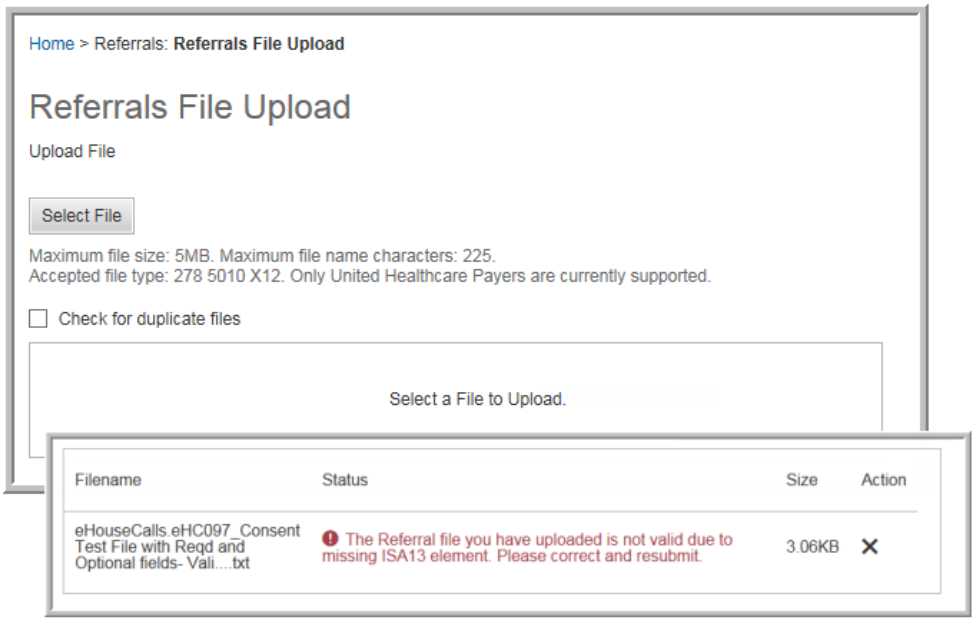
Use the Referrals File Upload function to upload provider and patient Referral Requests containing data for one or more patients. When the upload is completed each separate record contained in the upload file is available and identified as a unique statement.

To begin, click Select File button to select your batch file. If the file is valid it will be processed.



Any error messages are displayed in the Select a file to upload box, such as shown below.

Click the X icon to remove the unacceptable file.



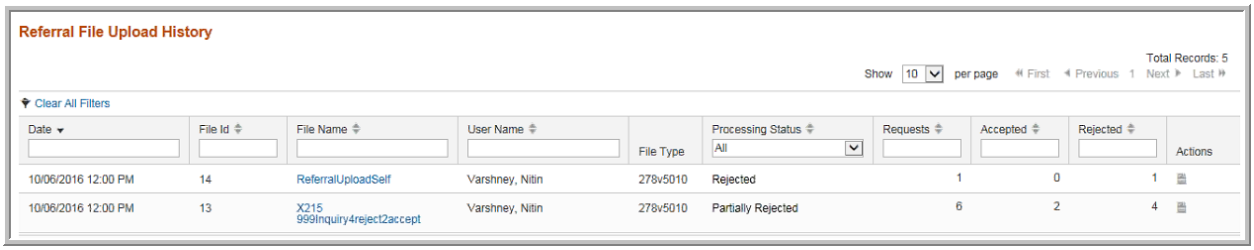
File constraints include the following:

- The maximum file size accepted is 5MB
- Only files with names less than 225 characters are accepted
- Format 278 5010 X12. Only United Healthcare Payers are currently supported.

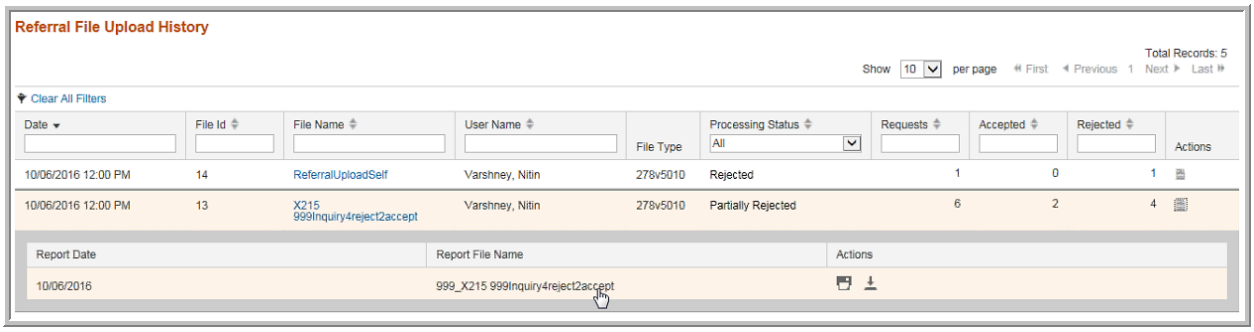
The Referral File Upload History grid (lower portion of page) reflects the following information about each file:

- Date – date entered
- File ID

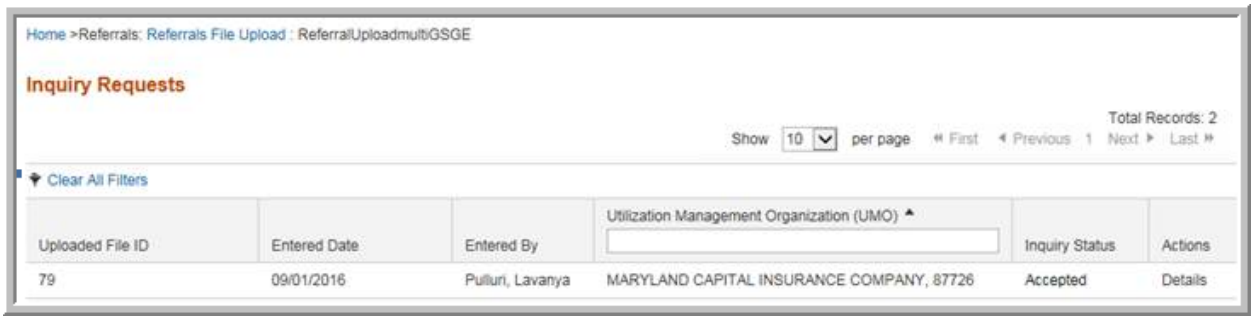
- File Name
- User Name – file entered by
- File Type
- Processing Status
- Requests – total number
- Accepted – total number
- Rejected – total number



Click the View icon in the Actions column to open an individual file, as shown below.



For any Accepted files in the Referral File Upload History grid you may click the active link number in the Accepted column to drill down into the multiple transactions of the uploaded referral file, as shown below.



Utilities

Designated external users and Optum users can access the Utilities function that supports maintenance features such as the following, which will be described herein as each feature is released:

- ACE Bypass
- Claim-Remit Matching
- Contracts
- ERA Enrollment
- Enrollments
- Patient Maintenance
- Provider Maintenance
- Real Time Payers
- Timely Filing Configuration
- WQ-Set Configuration
- X12 Mapping Service

ACE Bypass

Task: To create and manage the ACE Bypass for a specific Organization

Navigation: Utilities/ACE Bypass

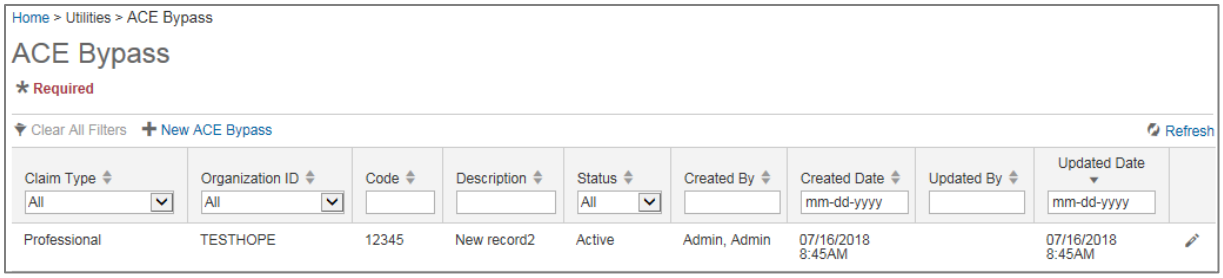
The ACE Bypass tool allows you to create and edit, as well as disable or re-enable the ACE editing claim validation service for any specific Organization and claim ACE validation code.

Search

Search for existing entries using a wildcard filter in the open column header fields. (If you have a single Organization ID that fields defaults.)

The search results include the following:

- Claim Type
- Organization ID
- Code
- Description
- Status
- Created By
- Created Date
- Updated By
- Updated Date



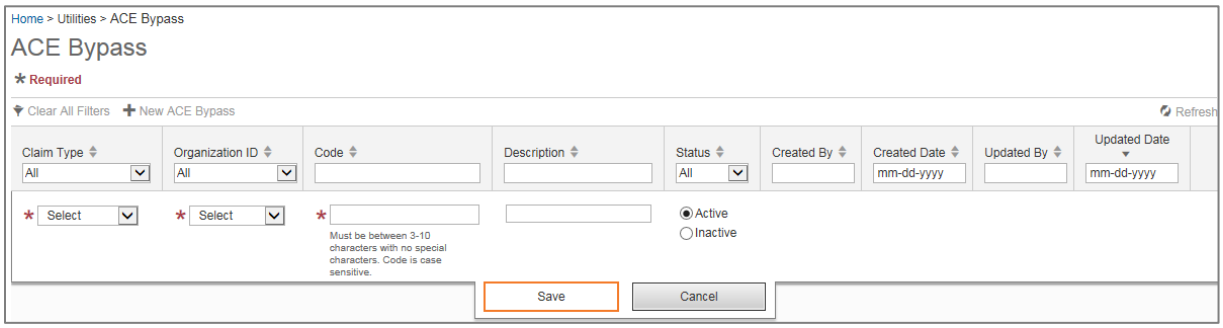
Edit

You may use the Edit icon on the desired row to change the Status or Description. (The Org ID, Claim Type, Organization ID and Code cannot be revised.)

Add New

To add a new entry select the New ACE Bypass link to open a new form, which displays as a drawer as shown below.

- Select the Claim Type, and Organization ID from those drop downs.
- Enter a Code that is between 3-10 alpha-numeric characters. Note that the Code is case sensitive.
- Use the Description field to describe what the validation is for the particular code.
- Select the desired Status of Active or Inactive before saving.



Use the Refresh link to check for updates from other users, or simply clear your filters.

Claim-Remit Matching

Task: Search claims and incoming payments and establish match

Navigation: Utilities/ Claim-Remit Matching

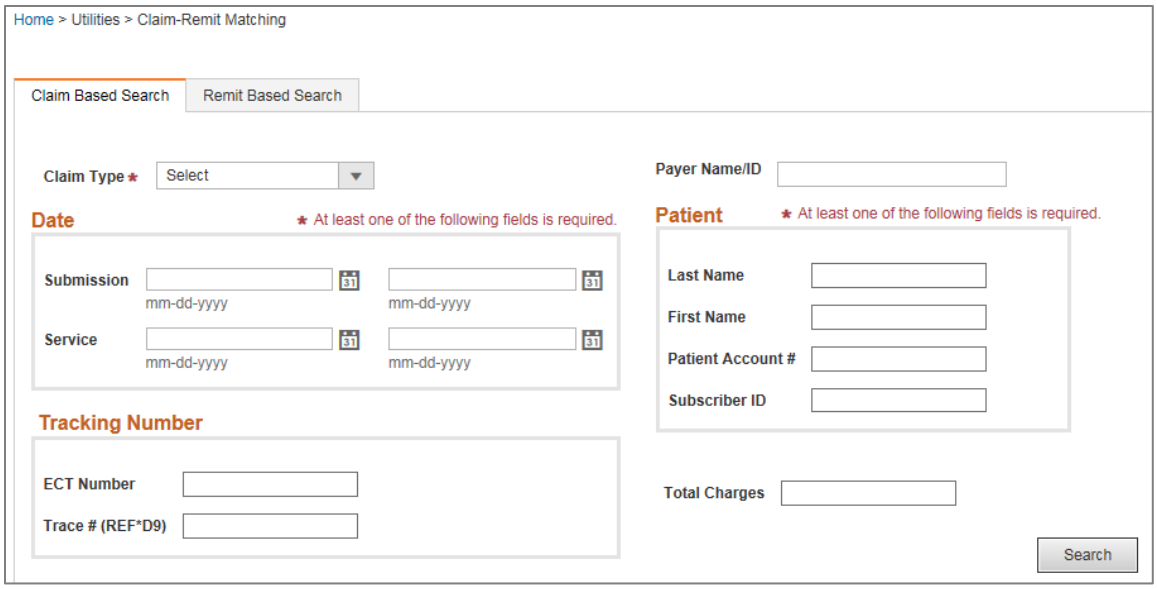
The Claim-Remit Matching utility allows you to search and link a claim with the remit received (for claims submitted within the prior 13 months).

You have the flexibility to search based on either the claim information or the remit information. Generally, if you have the claim information you will run a Claim Based Search, and if you have the remit information you will run a Remit Based Search.

Claim Based Search

For a Claim Based Search click that tab and begin by selecting the Claim Type.

Complete at least the required fields and any known information, such as related to Payer Name/ID, Date, Patient, and Tracking Number to reduce your search results.



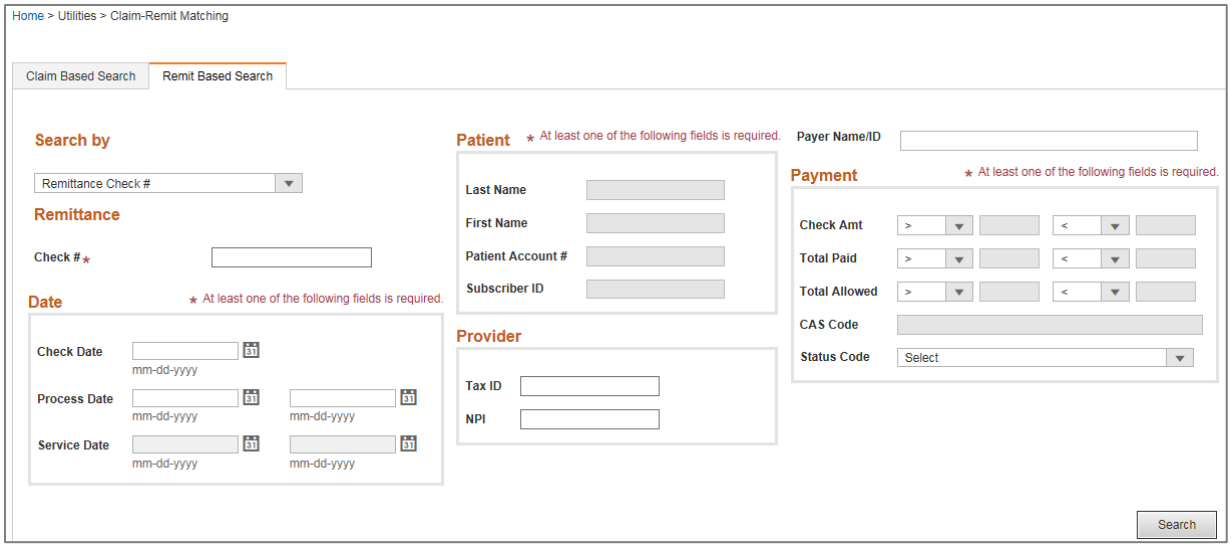
Your Search results grid may include the following information:

- Claim ID
- Payer
- Remit ID
- Provider TIN/NPI
- Patient Name
- Patient Account Number
- Claim Amount
- Total Paid
- Service Date

Remit Based Search

For a Remit Based Search click that tab and begin by selecting your Search by option – either Remittance Check# (default) or Patient. Your selection enables the applicable form fields.

Complete at least the required fields and any known information, such as related to Remittance, Date, Patient, Provider, Payer Name/ID, and Payment to reduce your search results.



Your Search results grid may include the following information:

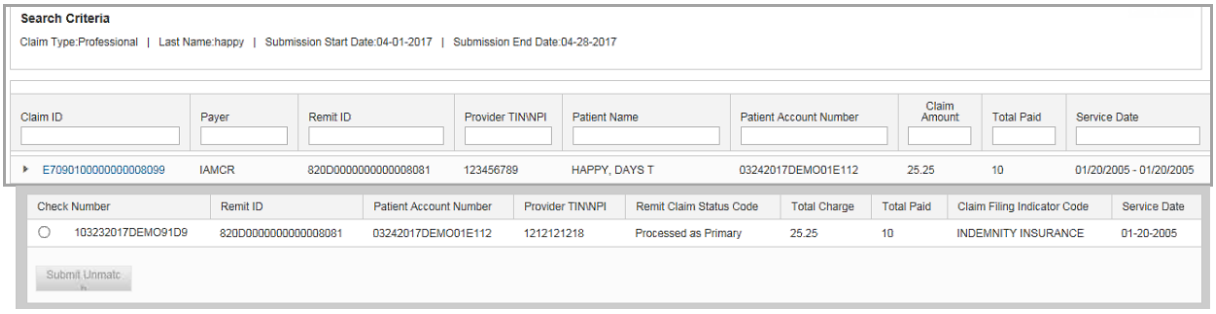
- Check Number
- Remit ID
- Patient Account Number
- Provider TIN/NPI
- Remit Claim Status Code
- Total Charge
- Total Paid
- Claim Filing Indicator Code
- Service Date

Claim-Remit Match

Your Search results can include any of the following scenarios:

- Exact Match – only one exact match is possible, and it must include a Remit ID
- Approximate Match – offers one or more potential matches based on your search criteria
- Non-Match – Claim IDs are returned but no records are found that are a potential match

Click any row in the Search results grid to display the related Claim or Remit information drawer, as shown below. That is, for Claim Based Search results you will see Remit information, and for Remit Based Search results you will see Claim information.



Exact Match – **f**or an exact match you have the Submit Unmatch option in the drawer. Click the Submit Unmatch button to remove the Exact Match tag.

Approximate Match – for an approximate match you have these options in the drawer.

- Submit Match. Select the Submit Match button in order to confirm the connection for selected items.
- Find Unlisted Match Remit. Use this option to manually conduct a Claim Based Search for Remits. You are required to enter Check Number and Remit ID to perform a search, and use the Find Remits button. Select the desired items from the results and use the Submit Match button to confirm the match.
- Find Unlisted Match Claim. Use this option to manually conduct a Remit Based Search for Claims. You are required to enter Claim ID to perform a search, and use the Find Remits button. Select the desired items from the results and use the Submit Match button to confirm the match.

Non-Match – for a Non-Match scenario the drawer displays a No Records Found entry, and you have no action options.

You must ensure that the claim and remit are an exact match before taking the Submit Match action, as you are responsible for the confirmation being entered into the database.

Contracts

The Contracts function allows you to upload business data files, and establish and maintain contracts within the application. This function is available to users with specific role/permissions.

Your current Customer/Billing Entity login governs all your contracts activity. The Business Data and Contract Maintenance tabs reflect only your current login.

Business Data

Task: Upload customer business data files so that Contracts can be set up based on this information

Navigation: Utilities/Contracts/Business Data

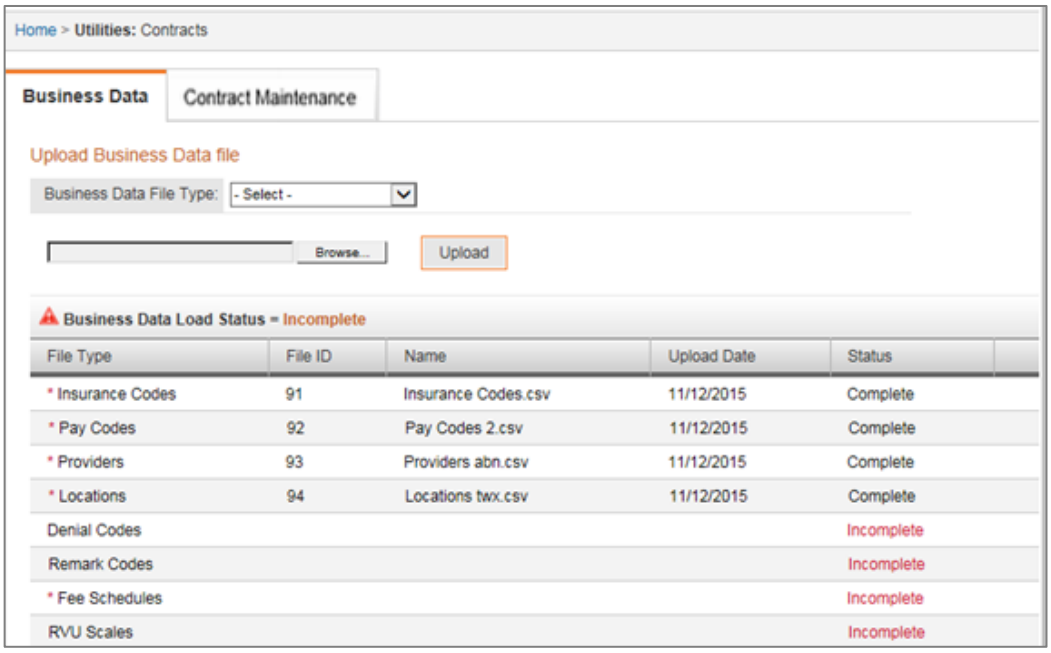
Business data files must be uploaded with insurance Codes first and then Pay Codes to ensure Contracts validation. That is, these two files are prerequisites for the remaining files. This sequencing is governed by the Business Data File Type drop down, which displays the available file types only after the prerequisite files have been uploaded.

Files **must** satisfy particular format constraints before they can be uploaded. For specific details regarding file format parameters see the **Contracts - Business Data File Formats** at Resources/Downloads.

General constraints noted for optimal performance include the following:

- Upload files in a .csv format
- Insurance Codes must be loaded first, and Pay Codes loaded secondly
- At least one Denial or Remark code file must be loaded
- The RVU Scales file is not required
- All required Business Data files must be loaded before a contract can be created

The Business Data Load Status grid displays the uploaded files by File Type, File ID, Name, Upload Date and Status.



To begin the upload process select the next sequential Business Data File Type from the drop down. Click the Browse button and select the desired file for at least each required file type.

- Insurance Codes - required
- Pay Codes - required
- Providers - required
- Locations - required
- Denial Codes and/or Remark Codes – at least one type is required, but both may be uploaded
- Fee Schedule - required
- RVU Scales - optional

Click the Upload button, and any error messages are displayed.

If the upload is successful the status is shown as Complete.

The Business Data Load Status header is indicated as Incomplete until all the required file types are uploaded and the Status for each required file type indicates Complete. The required file types are indicated in the grid by an asterisk.

There is no option to edit or inactivate a file once it is uploaded. Editing and appending the file is slated for a future release.

Contract Maintenance

Task: View current contract versions; maintain contracts by updating Contract Name and Description

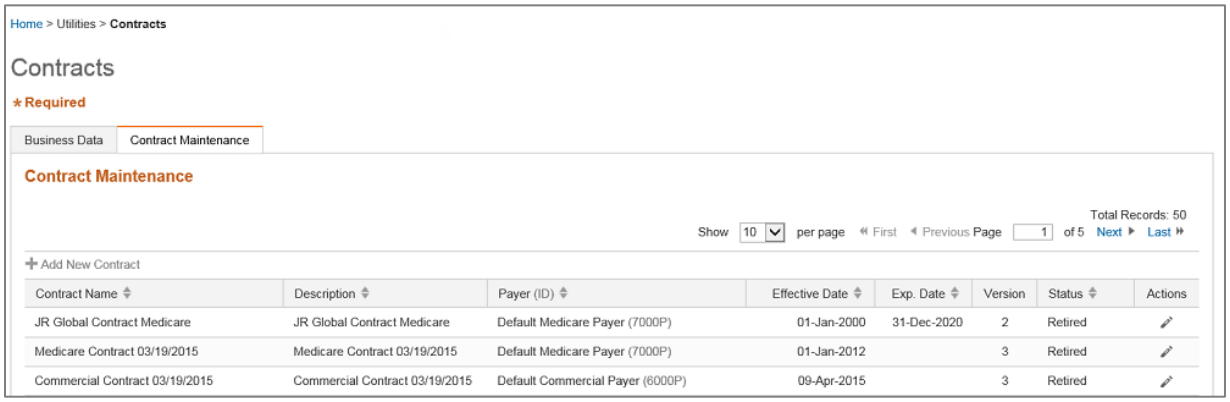
Navigation: Utilities/Contracts/Contract Maintenance

Use the Contract Maintenance tab to view a listing of existing contracts based on your current login, and to update Contract Name and Description, as needed.

Note that any new contract affects all claims going forward, but previous invoices must be manually adjusted.

Contracts are displayed in the Contract Maintenance grid, which provides the following information.

- Contract Name
- Description
- Payer (ID)
- Effective Date
- Expiration Date
- Version
- Status



With this release you have an Action option that allows you to edit the Contract Name, and Description. Click the edit icon for the desired contract to revise the Contract Name and/or Description fields, and click Save to complete the change.

Contract functionality that enables you to view versions, promote and retire contracts is slated for a future release, as well as the ability for users to add new contracts.

Enrollments

The Enrollments utility may provide any of the following features, based on user roles and permissions.

- Claims Enrollments
- Payer Enrollment Forms
- ERA Enrollments
- ERA Associations
- ERA Enrollment File Upload
- Bulk ERA Enrollment Move – for Intra-Customer, and Change of Vendor (COV)
- ERA Enrollment Payer Exports

Claims Enrollments

Task: Manage the provider Enrollment Form completion, submission, and approval process based on user roles and permissions

Navigation: Utilities/Enrollments/Claims Enrollments

Any Payer can require a Provider to submit a payer-specific enrollment form prior to sending transactions to that Payer. Optum supports this enrollment process by providing a transformation of hardcopy/paper enrollment forms to an electronic format using a mapping feature.

The Enrollments function allows you to initiate enrollments at **Payer Enrollment Forms**, and subsequently manage enrollments at **Claims Enrollments** where you can view and track progress of these efforts, upload completed hardcopy forms, and add a new provider.

Search

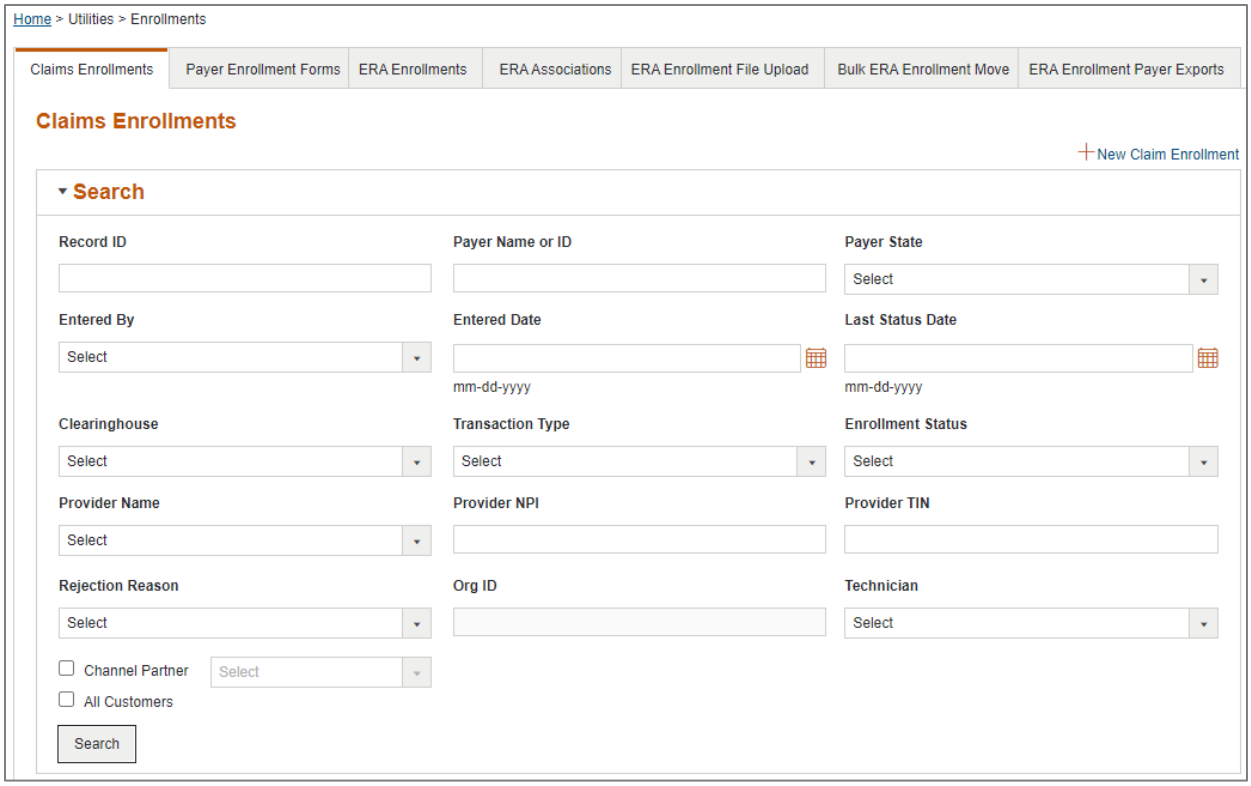
The Claims Enrollments grid displays all enrollments that have been initiated. You can use the Search feature to reduce the Claims Enrollments list using these methods:

- Search By Record ID or Payer Name or ID – enter the Record ID number or Payer Name or ID
- Search with known information – enter any known information into the Search form. Search results correspond to the amount of information you enter on the form. You can narrow your search by entering more information in the form.
- Search without entering any information – results will reflect all Enrollments submitted for the selected Billing Entity, which may result in an extended search time.

You can make multiple selections from the drop down when using certain filters, such as Clearinghouse, Transaction Type or Enrollment Status, to broaden your search.

You may also use the Channel Partner search option, which allows you to limit search results to a single Channel Partner.

Note that certain fields are available based on your roles and permissions.



Select Search, or Clear Criteria to enter new Search criteria.

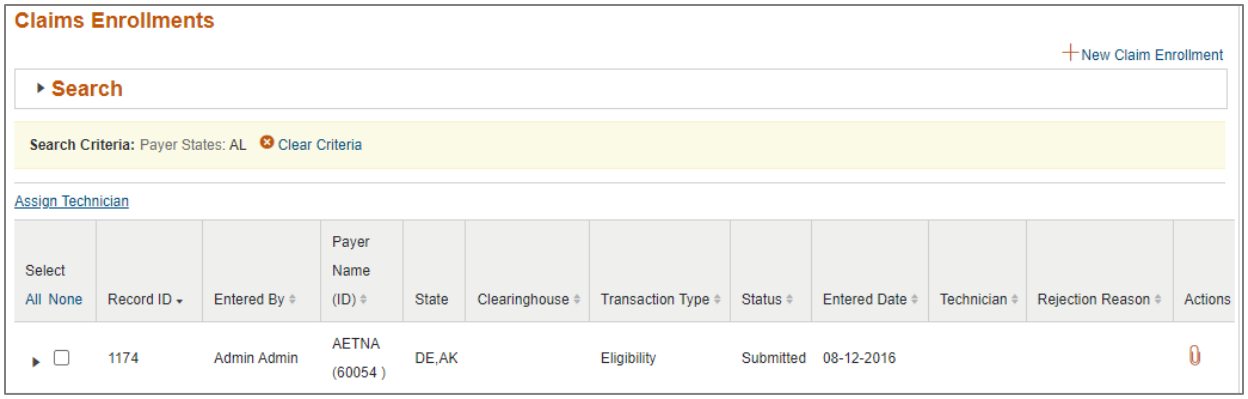
Your Enrollments search list is determined by the default Billing Entity/Customer, unless your role allows full access to all Billing Entities/Customers.

Your login as a particular Billing Entity (default Billing Entity) determines the search results. If you reselect your Billing Entity in the page banner the Claims Enrollments form clears and you may begin a new search.

The Search feature returns results in the Enrollments grid sorted by the Record ID.

The Enrollments grid may reflect the following information about each individual enrollment submission, based on your roles and permissions:

- Record ID
- Entered By
- Payer Name (ID)
- State
- Clearinghouse
- Transaction Type
- Status
- Entered Date
- Technician
- Rejection Reason



The Claims Enrollments function supports the following capabilities:

- Enrollments Search – find Enrollments that have been opened/entered in the application
- View Attached Form – (Attachment icon) view/print/download an image of the form that was submitted
- Update Enrollment Status – (select a row to open Details drawer) view progress and notes, and update the status
- New Claim Enrollment – to upload a previously completed enrollment form, and add a new provider

Liaison

Certain users serve as liaisons with payers to ensure a successful enrollment process, with added capabilities based on user roles and permissions. The Details drawer allows you to track progress and interaction with payers, make uneditable notes in support of enrollment activity, and update status.

- Access to Enrollments for all Billing Entities/Customers
- Search All Customers – this default search filter option provides full access to all enrollments, regardless of the selected Billing Entity/Customer
- Rejection Reason – search by Rejection Reasons
- Technician – search by one or more Technicians, and (based on your role) assign/reassign Technicians to Enrollments.
- Update Status, and add Rejection Notes – access Update Enrollment Status in the Details drawer
- Org ID – can be viewed in the Details drawer
- Confirmation acknowledgement is not required when updating a status

Enrollment Status

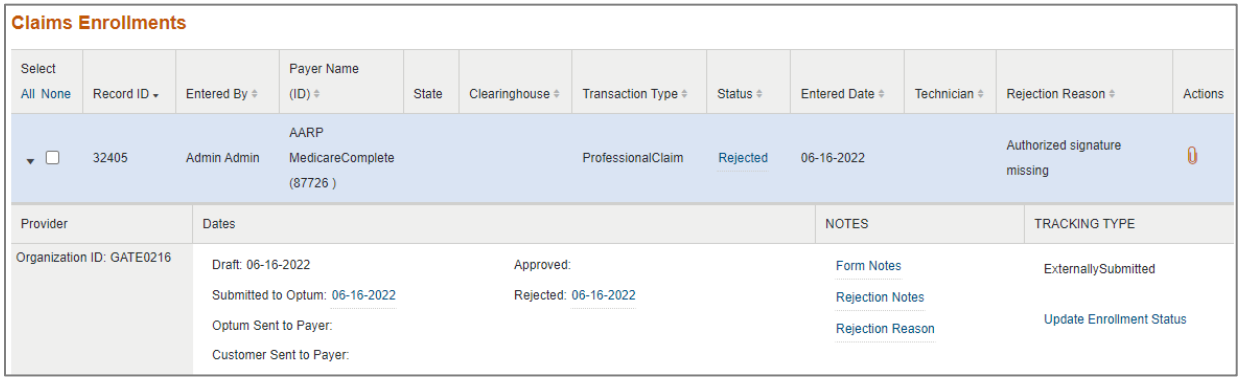
Task: View provider enrollment activity, notes, and tracking type; and update enrollment status

Navigation: Utilities/Enrollments/Claims Enrollments

To view details of the enrollment activity, and update the enrollment status select any row to open the Details drawer.

Details are displayed in an expanded pane (drawer) and provide the following, as shown below:

- Provider – Name, NPI
- Dates – Draft, Submitted to Optum, Optum Sent to Payer, Customer Sent to Payer, Approved, Rejected. Active links reveal status notes, and allow updates and new notes
- Notes – Form Notes, Rejection Notes and Rejection Reason (hover to view)
- Tracking Type – such as Optum Submitted or Externally Submitted; Update Enrollment Status link



Select the Update Enrollment Status link to view or modify the status of the enrollment activity in the Update Status form. Status options are described in the following table:

Enrollment Status	Indication
Draft	The enrollment form record has been initiated
Submitted to Optum	The record has been completed and submitted to the Optum enrollments team
Optum Sent to Payer	The enrollment form has been submitted to the payer
Customer Sent to Payer	The enrollment form has been submitted to the payer
Approved	Successful completion of enrollment process with the payer
Rejected	Unsuccessful enrollment upon submission of form to payer

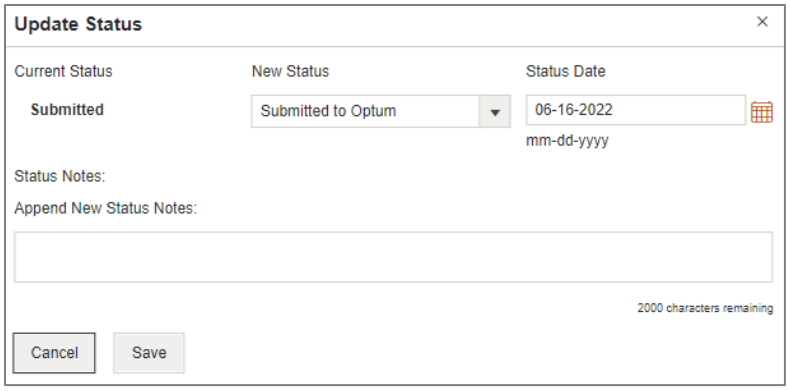
The option to use the Update Enrollment Status link provides a pre-populated Update Status form, but with different information displayed in that form, as follows:

- Update Enrollment Status link – displays the most recently entered status, which is based on the date/time entered rather than the Status Date value.
- Date link – displays the particular status that you selected.

To update an enrollment status select the Update Enrollment Status link to open the Update Status form.

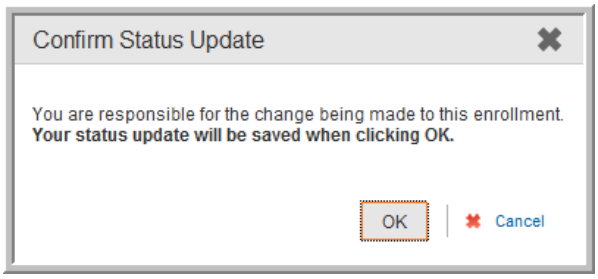
Select the new Status from the drop down and the associated Status Date. Include Status Notes in that field, if desired. Notes are uneditable, and are tagged with your name and date of entry.

Select Save or Cancel.



Status Dates are flexible to allow for adjustments during the enrollment process. However, if an enrollment form is rejected a new form should be initiated rather than modifying the initial form and the related Status Dates.

When you update a status you may be required to acknowledge a Confirmation statement indicating that you are responsible for the change being made to the enrollment. Select OK to continue.



Email Notification

An email notification is automatically issued to users when an Enrollment status change occurs. You may opt out of receiving future email notifications based on enrollment categories.

New Claim Enrollment

Task: Add previously completed provider enrollment forms – to store electronically and have a Record ID applied for tracking purposes; add new provider based on user roles and permissions

Navigation: Utilities/Enrollments/Claims Enrollments

You have the option to scan and upload up to three previously completed hardcopy enrollment forms using the New Claim Enrollment link at Claims Enrollments.

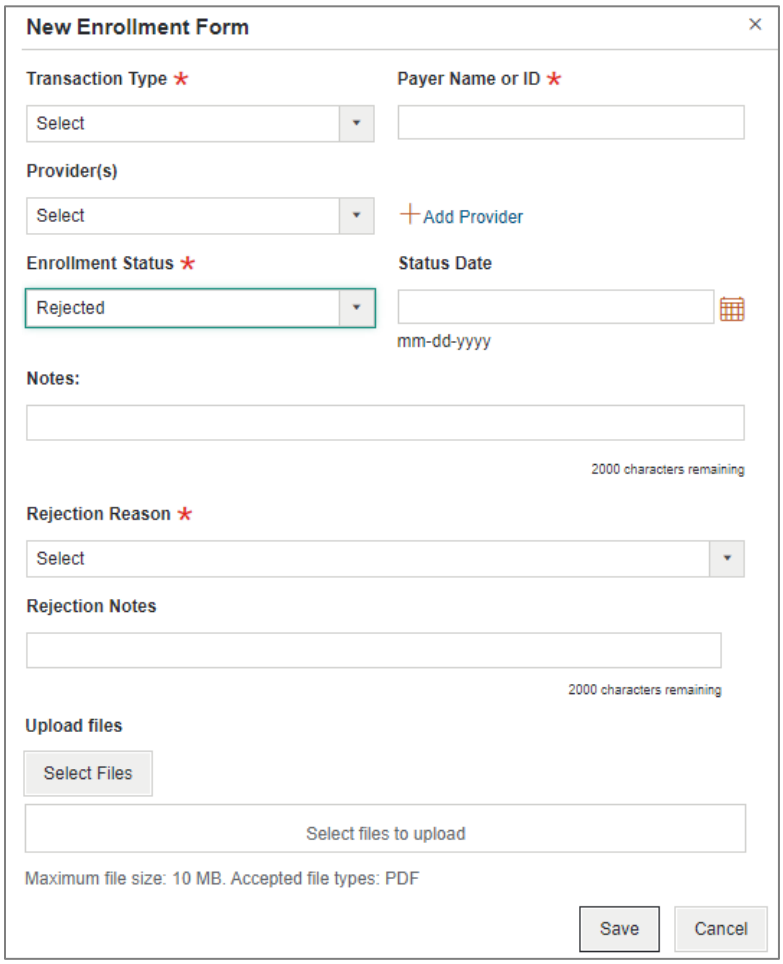
The appropriate New Enrollment Form displays based on your roles and permissions as an internal or external user, as shown below.

Complete the New Enrollment Form fields, which are described below, and select the desired pdf file to upload.

The required fields on the New Enrollment Form must be completed to successfully save the new enrollment form. Required fields are indicated by an asterisk.

Select Save or Cancel. When saved the new enrollment displays in the Claims Enrollments grid.

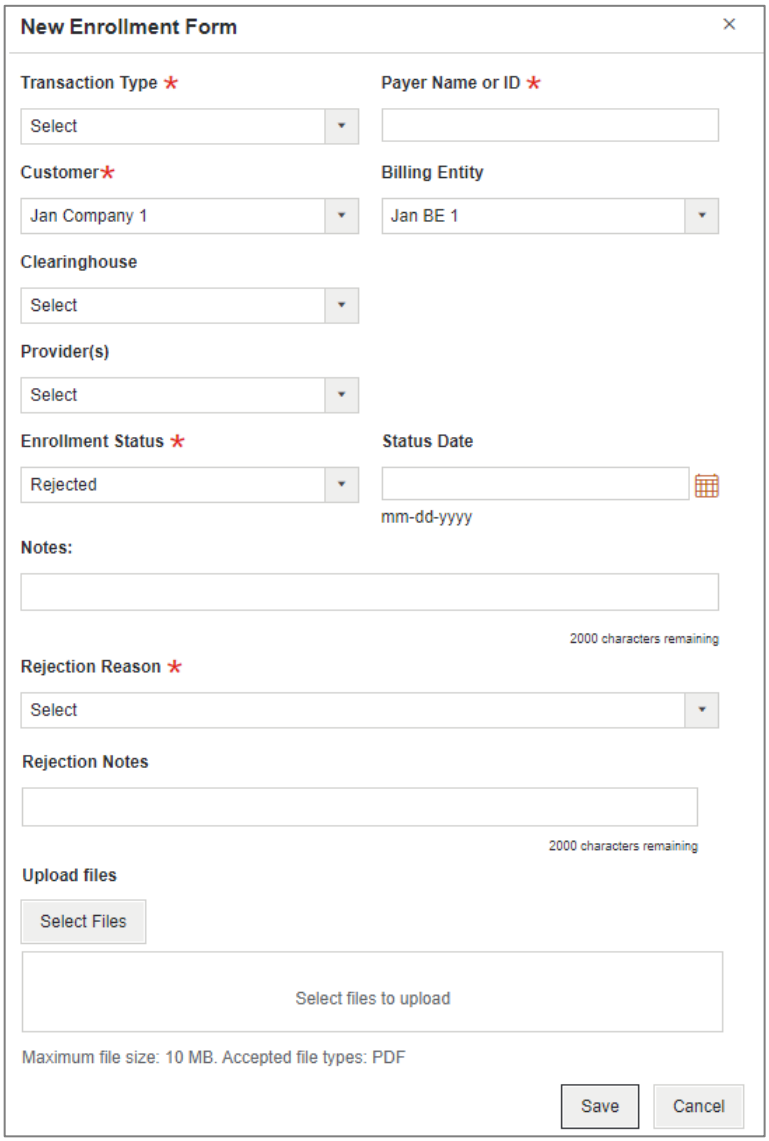
New Enrollment Form – external users



New Enrollment Form – External users	New Enrollment Form Field Descriptions
*Transaction Type	Select one from the drop down selection – Professional Claim, Institutional Claim, Eligibility
*Payer Name or ID	Auto-Complete - enter at least the first two sequential alpha or numeric characters Wildcard search – use the magnifying glass icon to conduct a Payer Search. Enter at least two characters to generate possible matches that contain the exact sequence of characters you entered.
Provider(s)	Select one or more from the drop down
Add Provider (link)	Use this link to access the Add New Provider form. See **Utilities/Provider Maintenance** for details on adding a new provider.
*Enrollment Status	Select one from the drop down selection, based on the current status
Status Date	Enter or select from the calendar

New Enrollment Form – External users	New Enrollment Form Field Descriptions
Notes	Enter only notes that are specific to the status of this enrollment. Notes are uneditable, and are tagged with your name and date of entry.
*Rejection Reason	Select one from the drop down selection
Rejection Notes	The Payer's detailed explanation that was returned after the Payer rejected the Enrollment form
Upload files	Use the Select Files button. Note the file constraints for size and type.

New Enrollment Form – internal users



New Enrollment Form – Internal users	New Enrollment Form Field Descriptions
*Transaction Type	Select one from the drop down selection – Professional Claim, Institutional Claim, Eligibility
*Payer Name or ID	Auto-Complete - enter at least the first two sequential alpha or numeric characters Wildcard search - use the magnifying glass icon to conduct a Payer Search. Enter at least two characters to generate possible matches that contain the exact sequence of characters you entered.
*Customer	Select one from the drop down selection
Billing Entity	Select one from the drop down selection
Clearinghouse	Select one from the drop down selection
Provider(s)	Select one or more from the drop down
*Enrollment Status	Select one from the drop down selection, based on the current status
Status Date	Enter or select from the calendar
Notes	Enter only notes that are specific to the status of this enrollment. Notes are uneditable, and are tagged with your name and date of entry.
*Rejection Reason	Select one from the drop down selection
Rejection Notes	The Payer's detailed explanation that was returned after the Payer rejected the Enrollment form
Upload files	Use the Select Files button. Note the file constraints for size and type.

Assign Technician

Task: Manage Technician assignments to one or more Enrollments, based on user roles and permissions

Navigation: Utilities/Enrollments/Claims Enrollments

You may have the ability to change one or more Technician assignments to a single new Technician from the Claims Enrollments grid.

To begin use the row checkboxes to choose one or more enrollments, or you can select All in the Select column header to change the assignment for all enrollments currently displayed in the results grid.

Use the Assign Technician button to open the Change Technician Assignment form, and choose the desired Technician from the drop down.

Select Save or Cancel. When saved the newly assigned Technician displays in the Claims Enrollments grid.

Rejection Reason

Task: Assign, Search by, and review Rejection Reasons and related notes, based on user roles and permissions

Navigation: Utilities/Enrollments/Claims Enrollments

Search

You may select one or more Rejection Reasons to filter your search efforts using that drop down. You can select Rejection Reasons for all Transaction types.

Rejection Reasons are applicable to Institutional claims, Professional claims, and Eligibility records.

The Rejection Reason Select field indicates how many reasons you have selected. You can choose None in the drop down to clear your selections.

Use the Search button to review your results in the Claims Enrollments grid. You may hover the Rejection Reason in the Enrollments grid to review the description.

Assign

To assign a Rejection Reason select the Update Enrollment Status link (Details drawer), to open and complete the Update Status form.

- Select Rejected from the Status drop down, as well as the new Status Date.
- Select a single Rejection Reason from the applicable drop down. Only those Rejection Reasons applicable to the record are displayed.
- Enter any notes as desired, and select Save. Notes are uneditable, and are tagged with your name and date of entry.

Payer Enrollment Forms

Task: Manage the provider Enrollment Form completion, submission, and approval process; based on user roles and permissions add and edit enrollment forms

Navigation: Utilities/Enrollments/Payer Enrollment Forms

Any Payer can require a Provider to submit a payer-specific enrollment form prior to sending transactions to that Payer. Optum supports this enrollment process by providing a transformation of hardcopy/paper enrollment forms to an electronic format using a mapping feature.

The Enrollments function allows you to initiate enrollments at **Payer Enrollment Forms**, and subsequently track enrollment progress at **Claims Enrollments**. Based on user roles and permissions you can add new enrollment forms and edit existing enrollment forms.

Search

Begin your search for existing payer Enrollment Forms by selecting Transaction Type(s), to determine the list of available Payers.

You may also choose multiple selections from the remaining drop down options, such as Payer State, Clearinghouse, and Entered Date.

You can check the Show Inactive box if you wish to see those forms.

Select the Search button, or select Clear Criteria to clear the search results and enter new Search criteria.

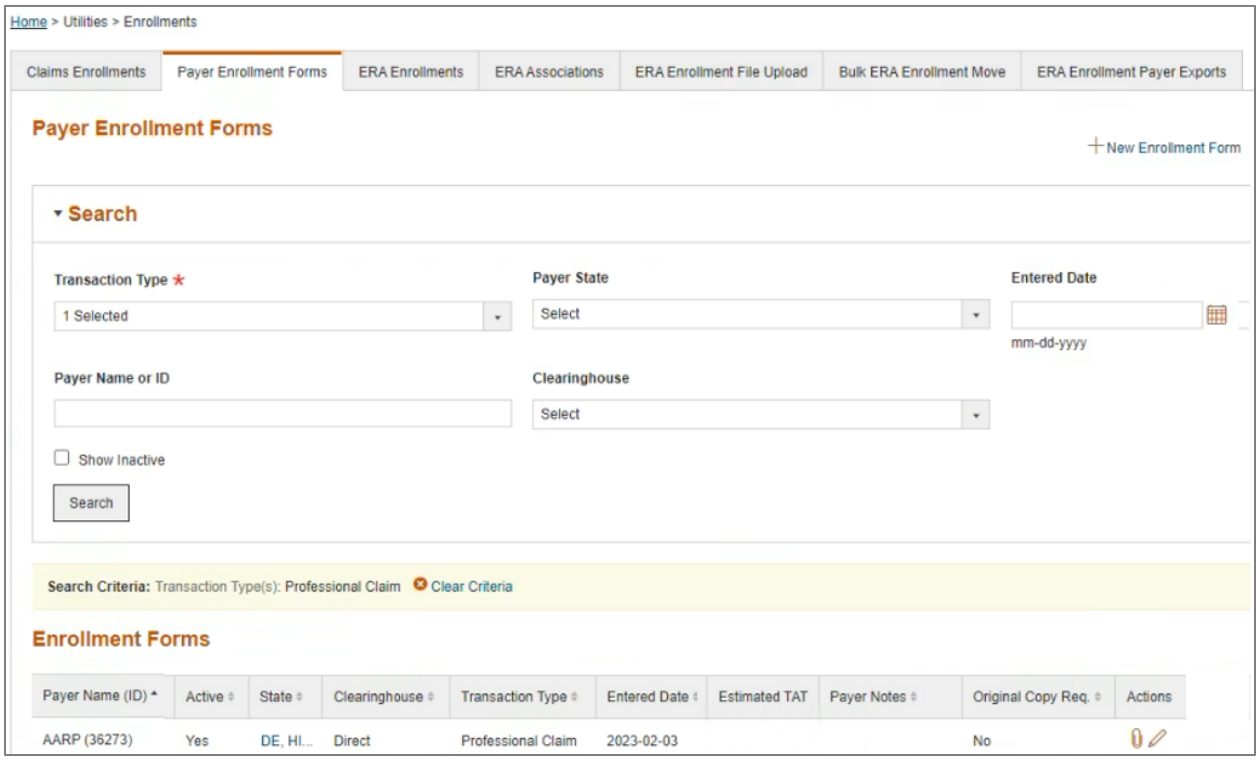
The Search feature returns results in the Enrollment Forms grid sorted by the Payer Name (ID).

Your Enrollment Forms search list is determined by the default Billing Entity/Customer, unless your role allows full access to all Billing Entities/Customers.

Your login as a particular Billing Entity (default Billing Entity) determines the search results. If you reselect your Billing Entity in the page banner the Enrollment Forms grid clears and you may begin a new search.

The Enrollment Forms search results reflects the following information about each individual payer:

- Payer Name (ID)
- Active
- Payer State – multiple states can be selected
- Clearinghouse
- Entered Date
- Transaction Type
- Estimated Turnaround Time (TAT)
- Payer Notes
- Original Copy Required (Req.)



The Payer Enrollment Forms function supports the following capabilities:

- Paper Submission – (Attachment icon) print a hardcopy of the payer's form

- ERA Association (for Remittance transactions only) – builds interconnection of TIN, NPI, Org ID, Payer ID
- Edit – use the Edit icon to open the Edit Enrollment Information form, based on user roles and permissions
- Add – use the New Enrollment Form link to add a new enrollment form, based on user roles and permissions

Paper Submissions

Task: Print a paper enrollment form when a hardcopy is required by payer

Navigation: Utilities/Enrollments/Payer Enrollment Forms

The Original Copy Req. field in the Enrollment Forms grid indicates if the payer requires a paper enrollment form.

From the Enrollment Forms grid use the Download Form attachment icon for the desired payer to download and/or print the enrollment form.

You must print the enrollment form if the payer requires paper submission, in accordance with the following:

- Print a completed enrollment form if the payer requires a hardcopy signature on the form.
- Print a blank enrollment form if the payer requires that the form be completed by hand.

Remittance Association

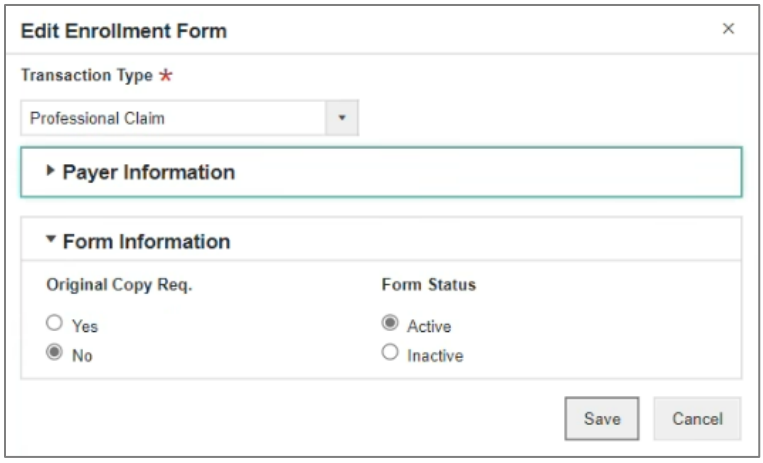
Task: Build association for Remittance type transactions

Navigation: Utilities/Enrollments/ERA Associations

When submitting enrollments for Remittance type transactions (individually or bulk) an interconnection of TIN, NPI, Org ID, Payer ID must be captured to support proper routing of these Remittance Transactions. See **ERA Associations** for details.

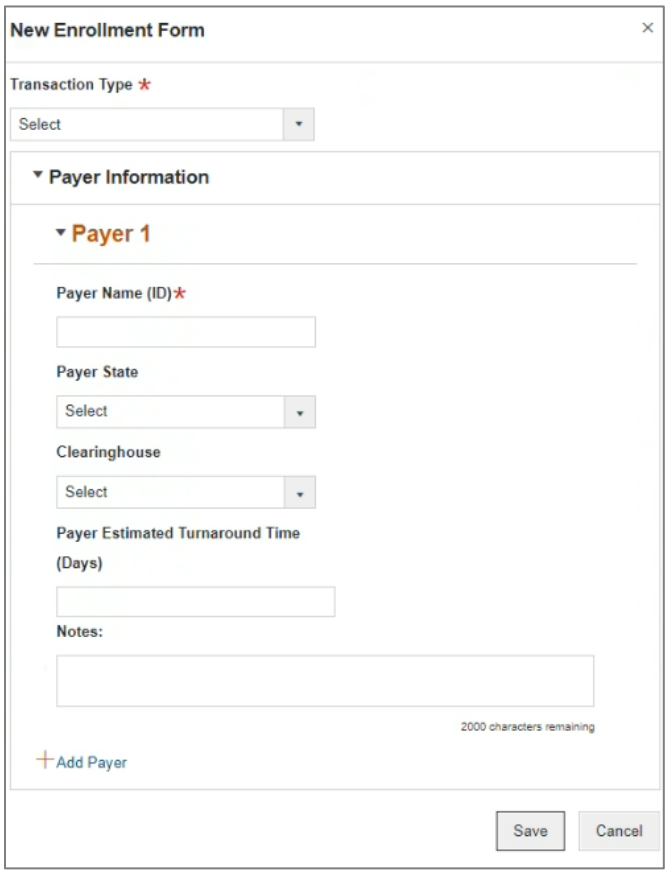
Edit

From the Enrollment Forms grid use the Edit icon to open the Edit Enrollment Form where you may select to view the Payer Information, and the Form Information panes.



The Payer Information and Form Information panes reflect the information for one or more Payers, and provides the following edit options.

- Edit Payer Information and Form Information – except that previously selected Payer States cannot be removed
- Remove Payer – use this link to remove payer
- Add Payer – use this link to add one or more payers



Add

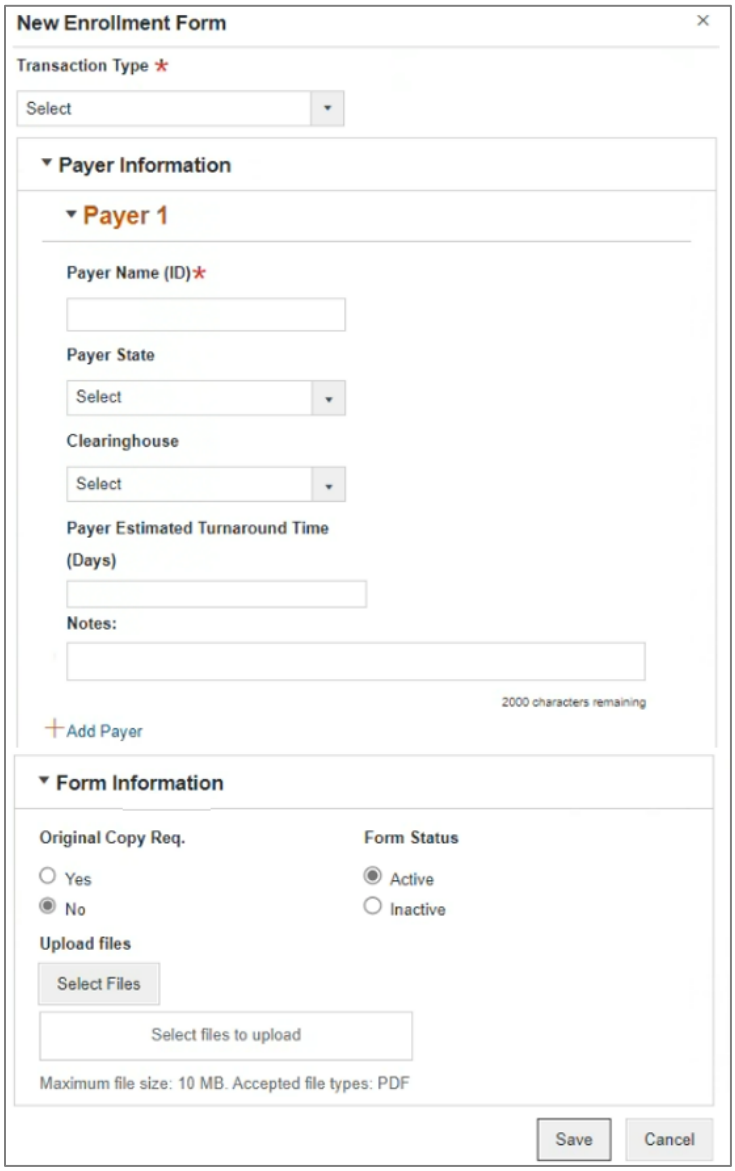
Before creating a new enrollment form you may search for an applicable, existing form.

From the Payer Enrollment Forms pane use the New Enrollment Form link to open the New Enrollment Form to create a new form by completing the Payer Information and Form Information fields, which are described in the table below.

The required fields in the New Enrollment Form form must be completed to Save the new form.

You are strongly encouraged to enter the applicable Clearinghouse connection for the Payer, as this information supports auto-population of the Clearinghouse information field when performing work.

You can add one or more payers (up to 10) using the Add Payer link. You can also remove individual payers using the Remove Payer link.



Add New Enrollment Form

Enrollment Form Fields	Enrollment Form Field Descriptions
*Transaction Type	Dropdown selection is available – must be selected first to determine the list of available payers
*Payer Name (ID)	Auto-Complete - enter at least the first two sequential alpha or numeric characters Wildcard search - use the magnifying glass icon to conduct a Payer Search. Enter at least two characters to generate possible matches that contain the exact sequence of characters you entered.
Payer State	Select one, none or multiple states (does not default based on payer selected). All selections are displayed in results grid.
Clearinghouse	Dropdown selection is available
Payer Estimated Turnaround Time	Enter the timeframe in which the payer expects to complete the enrollment process
Notes	Enter only notes that are specific to this form
Original Copy Req.	Defaults to No. Select Yes if a signed hardcopy must be sent.
Form Status	Defaults to Active.
*Upload Files	A single payer enrollment PDF file can be uploaded.

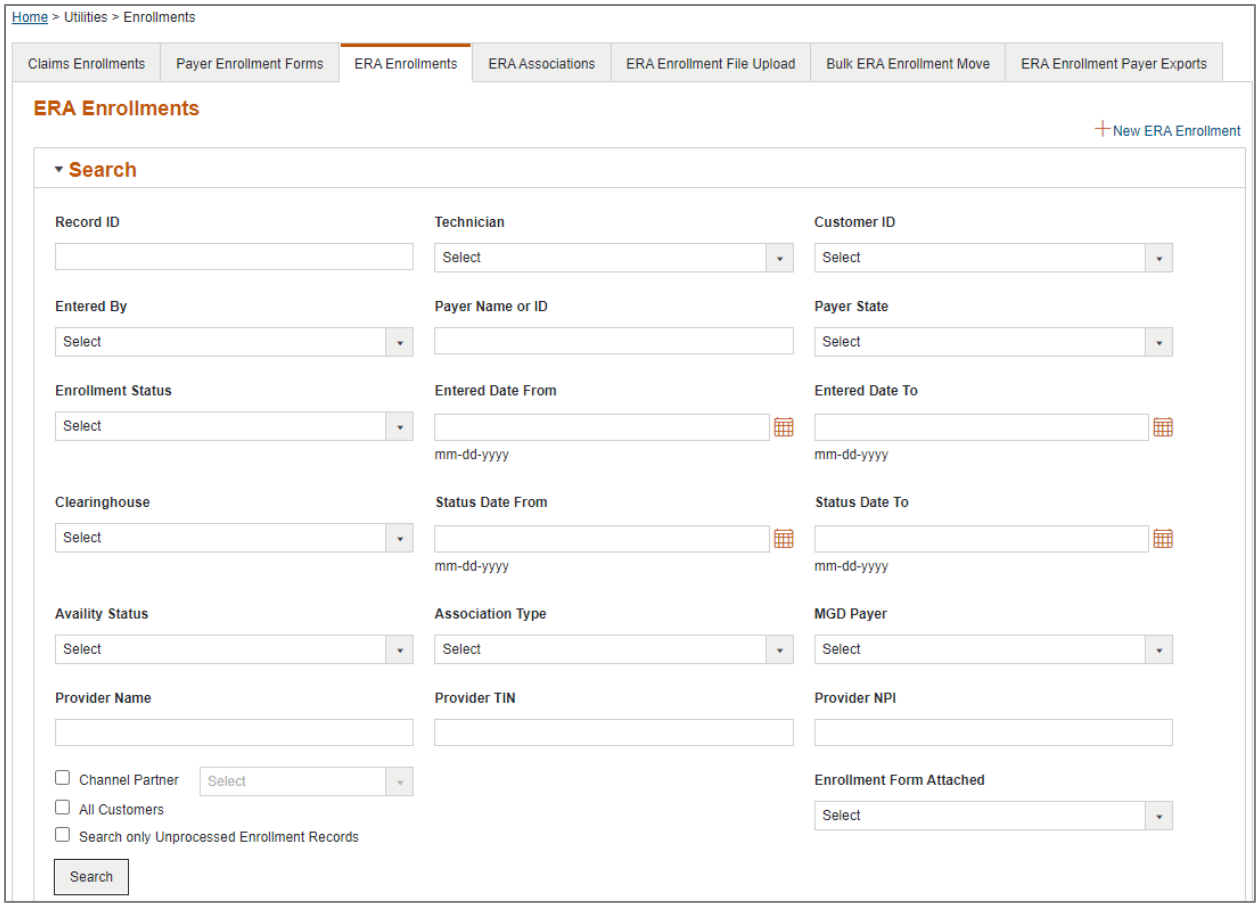
ERA Enrollments

Task: Search and view ERA Enrollments; attach Enrollment forms; and based on user roles and permissions create and manage ERA Enrollment submissions; reassign Technicians; and view record change log

Navigation: Utilities/Enrollments/ERA Enrollments

You may search using methods such as the following:

- Search By Record ID or Payer Name (ID)– enter the Record ID number or Payer Name (ID)
- Search with known information – enter any known information to narrow your search results
- Search without entering any information – results will reflect all enrollments submitted for the selected Billing Entity, which may result in an extended search time
- Search for specific Channel Partner – based on user roles and permissions you may have the ability to override your current login and search all enrollments for a particular Channel Partner with which you are aligned
- Search for All Customers – based on user roles and permissions you may have the ability to override your current login and search all enrollments for all Customers with which you are aligned
- Search only Unprocessed Enrollment Records -- based on user roles and permissions you may limit your search to only those enrollment records that have not been processed by the clearinghouse



(Note that the Customer ID drop down relates to the Org ID, rather than the Customer login.)

You can make multiple selections from the drop down when using certain filters, such as Clearinghouse, to broaden your search.

The MGD Payer default selection is All. You can select Yes to return only MGD Payers, or No to return only non-MGD payers.

You can take advantage of the date range search option using both the Entered Date From and Entered Date To fields, or you can search for a single date using only the Entered Date From field.

Use the Search button to obtain your results. After searching you can use the Clear Criteria link to initiate a new Search.

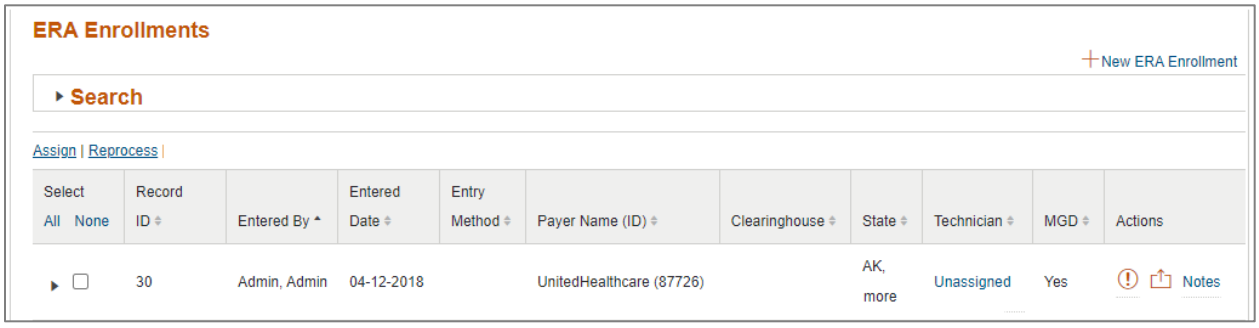
The Search feature returns results in the ERA Enrollments grid sorted by the Record ID or Payer Name (ID).

Your ERA Enrollments search list is determined by the default Billing Entity/Customer, unless your role allows full access to all Billing Entities/Customers, or Channel Partners.

Your login as a particular Billing Entity (default Billing Entity) determines the search results. If you reselect your Billing Entity in the page banner the ERA Enrollment form clears and you may begin a new search.

Your ERA Enrollments search results provides the following information.

- Record ID
- Entered By
- Entered Date
- Entry Method – File Upload, DDE, API
- Payer Name (ID)
- Clearinghouse
- State
- Technician
- MGD



You have the following options at the search results:

- Alert icon – hover to view alert that this Payer requires an enrollment form to be attached for the record to be processed
- Upload – you can attach a key ERA Enrollment form (designated by a payer) using the Upload Enrollment Form to select a PDF file. Note that once a file has been attached this Upload icon becomes an Attachment (paperclip) icon.
- Attachment icon – view any attachment (an Adobe tool bar is available, such as to print); and based on user roles and permissions you may resubmit a corrected ERA Enrollment that was previously rejected. Note that any customer may have an attachment even though an enrollment form is not required.
- Notes link – hover to view the last Update Status Note, or use the link to open the View Notes historical log (sortable by Entered Date or Entered By). Use the More link to expand lengthier notes.
- Details – select any row to open the Details drawer to display the Provider ID – both TIN and NPI – Status, Status Date, Association ID, and the First and Last ERA Dates. Use the arrow by the provider name to display any associated providers. (Note that the TIN and NPI may have different statuses.)
    - You can view the Availity Status (rejected), or the Availity Registration ID (accepted) and the interim Enrollment Status sent from Availity that identifies the precise stage of the enrollment activity.

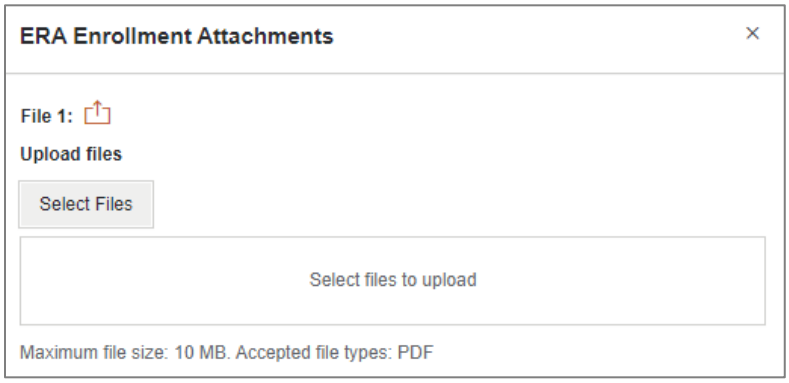
- You may hover an active Status link for Pended or Rejected to view any available tool tip, such as "An Association already exists under a different customer. To initiate a MOVE a Change of Vendor (COV) letter must be sent to enrollments@optum.com"
- You may hover an active Status link for Enrolled to view any available tool tip, such as, "An association already exists for this TIN, Customer and Payer in our system." However, note that for earlier records (prior to 2.4.2021) displaying this particular message the Status will reflect Rejected, rather than Enrolled.

- Update Enrollment Status – based on user roles and permissions the Update Enrollment Status link may be displayed by selecting any row to open the Details drawer
- ERA Enrollment Record Status History – based on user roles and permissions the ERA Enrollment Record Status History icon (clock) may be displayed by selecting any row to open the Details drawer
- Assign – based on user roles and permissions change the technician assignment
- Reprocess – based on user roles and permissions resubmit ERA Enrollment records for processing
- New ERA Enrollment – based on user roles and permissions complete a new enrollment form

Upload ERA Enrollment Attachment

You can attach a key ERA Enrollment form (designated by a payer) using the Upload icon in the ERA Enrollments grid to access the ERA Enrollment Attachments form. This option is available for Enrollment records previously created by DDE, as well as those created by the File Upload process.

Using the Upload Enrollment Form select the desired pdf file to upload. The form loads immediately and a success message displays.



Upload Corrected ERA Enrollment

Based on user roles and permissions you may have the ability to resubmit a corrected ERA Enrollment that is in a Rejected status. Note that you can take advantage of the search filter (Search for an Enrollment Status of Rejected) that allows you to pull only those records that were rejected.

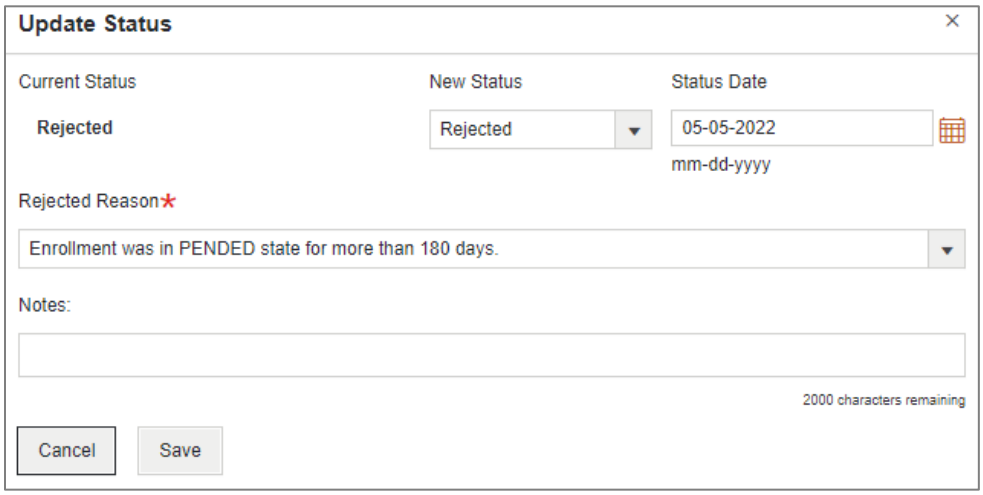
You can attach a corrected ERA Enrollment using the Attachment icon in the Enrollments grid to access the ERA Enrollment Attachments form. Using the ERA Enrollment Attachments form select the desired pdf file(s) to upload. The form is resubmitted immediately and a success message displays.

When the updated form is submitted the Enrollment Status changes from Rejected to Corrected. (This completes the work process only for payers that accept attachments electronically.)

Update Enrollment Status

Based on user roles and permissions you may have the ability from the Details drawer to use the Update Enrollment Status link to open the Update Status form.

In the Update Status form you can select a New Status for an enrollment from that drop down, and enter the new Status Date.



You must select a single Rejected Reason from that drop down. Only those Rejection Reasons applicable to the record are displayed. To expedite your search of the drop down you can enter any key word or words in an exact sequence into the drop down field to filter for Rejected Reasons that contain a match.

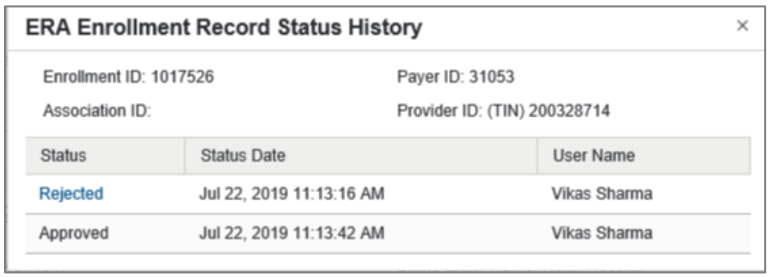
You have the option to enter Notes before submitting, limited to 2000 characters for each note. Update Status Notes may not be edited or removed, and are displayed in a View Notes historical log accessed via the Notes link for each record found in Enrollments search results. Lengthier notes can be fully expanded for view using the More link.

Note that if an enrollment is automatically Pended by the system a Pended Reason is added. When an enrollment in a Pended status has not changed for 181 days that Pended enrollment will automatically change to a Rejected status, which facilitates submission of a new enrollment.

ERA Enrollment Record Status History

Based on user roles and permissions you may have the ability from the Details drawer to use the ERA Enrollment Record Status History icon (clock) to view the ERA Enrollment Record Status History change log.

In this change log you may hover an active Status link to view any available tool tip.



Change Technician Assignment

Based on user roles and permissions you may have the ability to change the technician assignment from the ERA Enrollments search results grid for one or multiple records.

- Single assignment – select the Technician link in the desired row to open the Change Technician Assignment form
- Multiple assignments – select the desired records using the row checkbox, and use the Assign button to open the Change Technician Assignment form

In the Change Technician Assignment form select the desired technician from the drop down. Use the Submit button to assign the new Technician to your single or multiple records selection.

Reprocess ERA Enrollment Records

Based on user roles and permissions you may have the ability to resubmit ERA Enrollment records that were previously submitted but not processed.

You may want to take advantage of the search filter (Search only Unprocessed Enrollment Records) that allows you to pull only those records that were not properly processed when originally submitted.

From the search results grid use one of these options:

- Select the All link in the header row to resubmit all records in the search results grid
- Select the desired records using the row checkbox

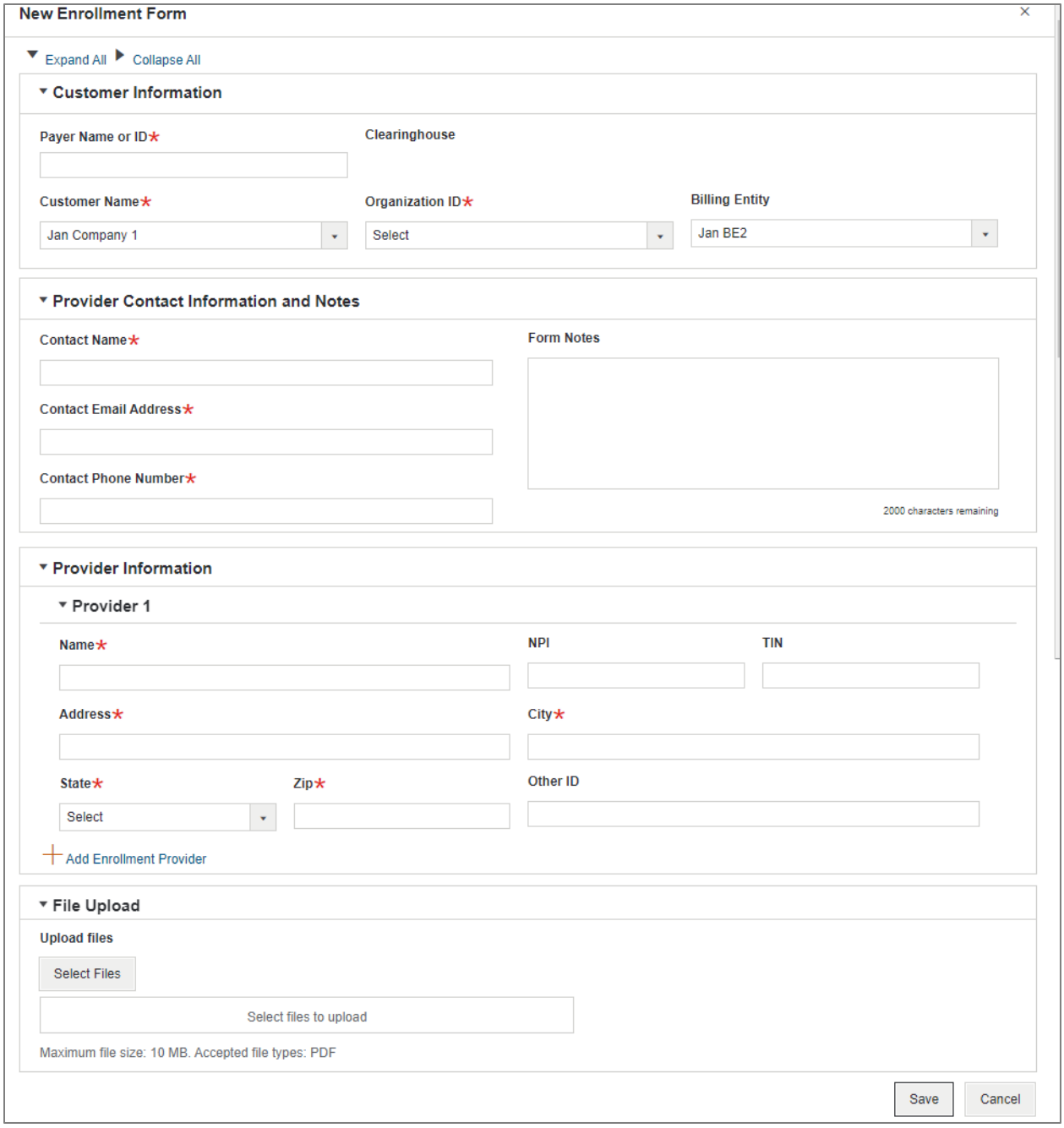
To complete this action use the Reprocess button to resubmit those records you have selected. Upon successful submission an Association ID number is assigned, otherwise the submission is returned as Pended.

New ERA Enrollment

Based on user roles and permissions you may have the ability to use the New ERA Enrollment link provided at the Enrollments tab to open and complete the New Enrollment Form to add a Provider.

Complete at least the required information for the following categories.

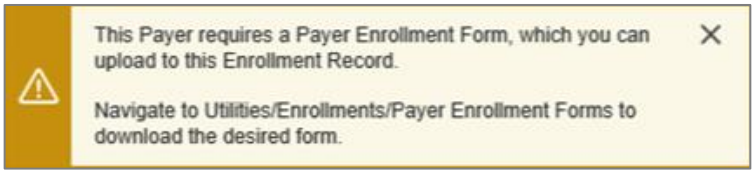
- Customer Information
- Provider Contact Information and Notes
- Provider Information – auto-populates if you search by last name and select from the drop down



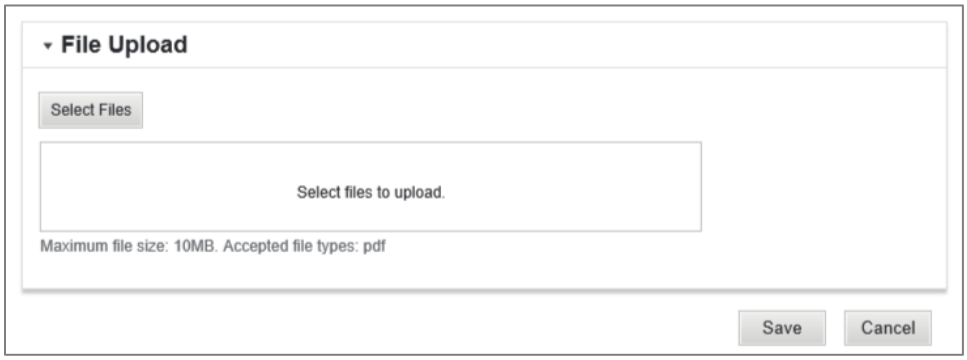
You have the option to add additional Providers using the Add Enrollment Provider link (in Provider Information pane) up to a total of 10 providers.

Any Payer can require a Provider to submit a payer-specific enrollment form prior to sending transactions to that Payer

Note that when you select your Payer Name or ID (in the Customer Information pane) a warning message displays if that payer requires a Payer Enrollment Form to be submitted.



You have the option to attach an electronic Payer Enrollment Form, prior to submitting the New Enrollment Form, using the File Upload pane. In the File Upload pane use the Select Files button to browse and upload the desired enrollment form.



Note that before you can select files to upload you must navigate to Utilities/Enrollments/Payer Enrollment Forms to download and complete the desired form.

Alternatively you may attach a completed Payer Enrollment form after the New Enrollment Form record is created, using the Upload icon found in the Actions column of the Enrollments search results grid.

Use the Save button to complete the submission of the enrollment form. Upon successful submission a Record ID number is assigned to the new enrollment record.

ERA Associations

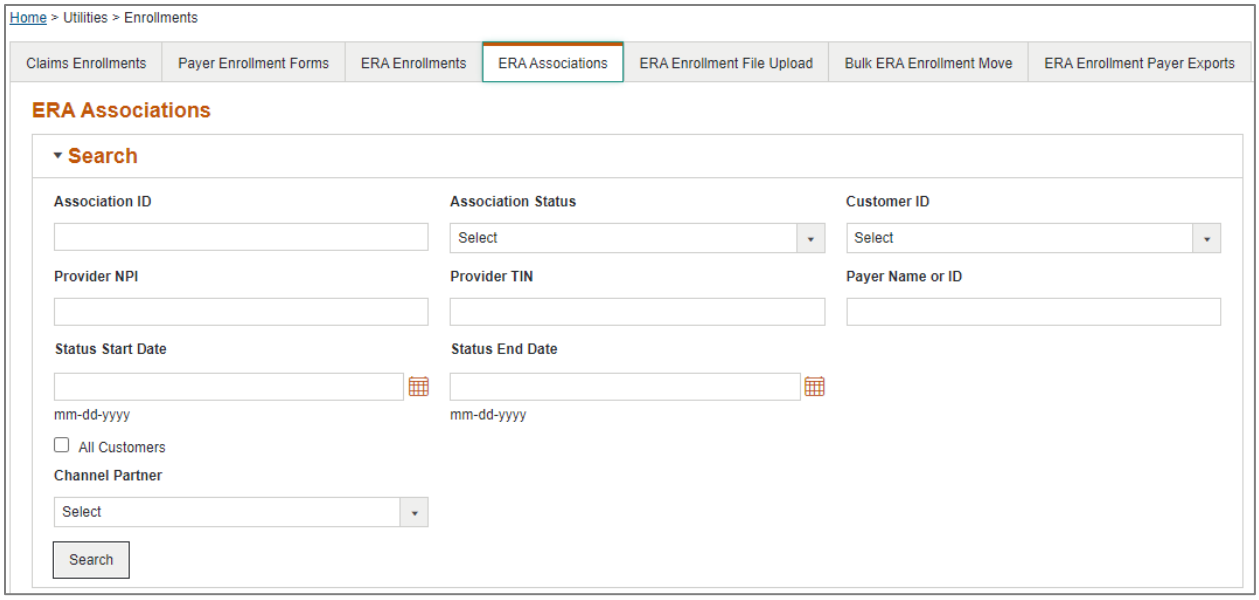
Task: Manage the provider Enrollment completion, submission, and approval process based on user roles and permissions

Navigation: Utilities/Enrollments/ERA Associations

The ERA Associations features provides a Search function to view existing associations. You can narrow your search results by entering Association ID, Association Status (active or inactive), or Customer ID, Provider NPI, Provider TIN, Payer Name or ID, and Status start and end dates.

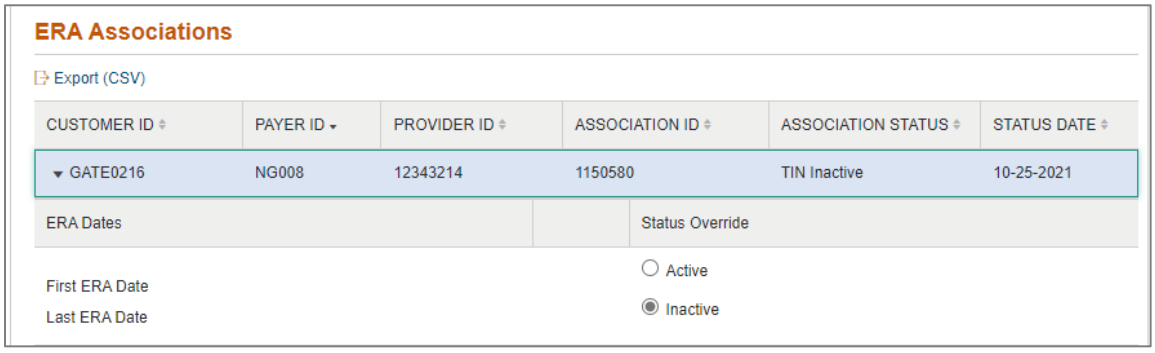
Alternatively, you can search using the All Customers checkbox, for all Customers with which you are aligned. Status Date Start and Status Date End are required for an All Customers search.

Based on user roles and permissions you may have the ability to override your current login and search all enrollments for a particular Channel Partner with which you are aligned.



The search results provides the following information.

- Customer ID
- Payer ID
- Provider ID
- Association ID
- Association Status
- Status Date



Use the row arrow in your results grid to expand the ERA Association record for the following:

- First ERA date – view to confirm the enrollment is approved by the payer
- Last ERA date
- Status Override – use the radio buttons to manually change the Status of the association as Active/Inactive

You can use the Export (CSV) link to export and save the search results displayed in the grid. Note that the exported file includes only the information currently displayed on the screen. When the prompt question displays, asking if you want to save the file, select the Save As option and store locally.

Association Status

Note that if an Association is changed to an Inactive status the ERA Enrollment record is automatically changed to a Rejected status.

When an Association is changed to an Active status the ERA Enrollment record is updated automatically to change the status of the record to Associated.

ERA Enrollment File Upload

Task: Manage the upload for Admin Simp spreadsheet based on user roles and permissions

Navigation: Utilities/Enrollments/ERA Enrollment File Upload

The ERA Enrollment File Upload feature provides the ability to upload and search Admin Simp spreadsheets.

When you select the ERA Enrollment File Upload tab the results grid is automatically refreshed to display files for the previous 7 days, based on your current login, sorted by the most recent file. You may use the Search option to search for files outside the 7 day default.

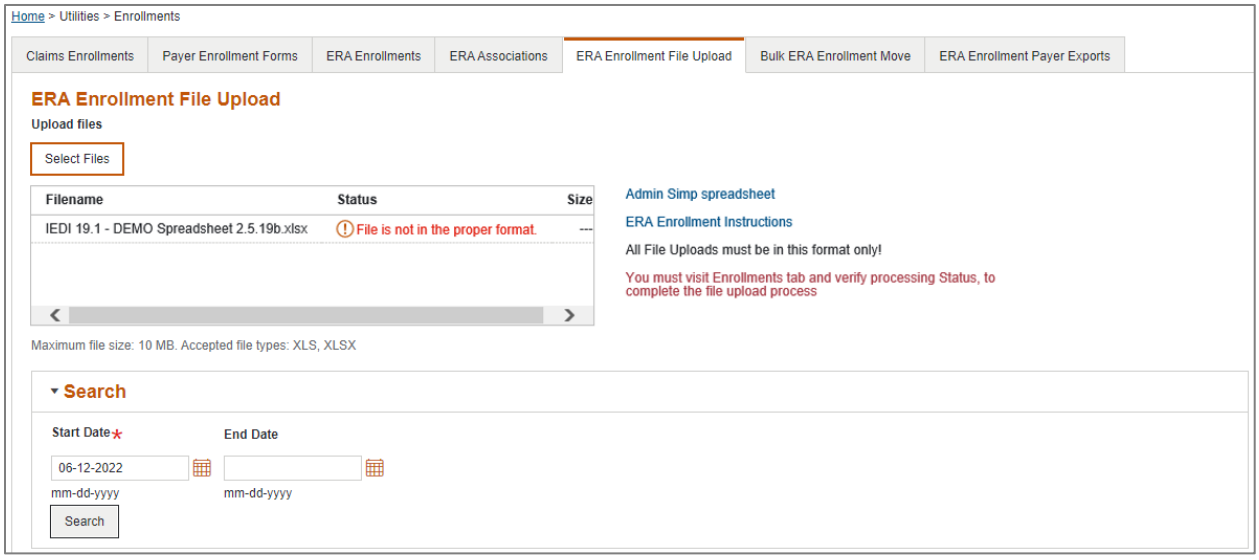
When you upload a file the results grid is refreshed immediately. Note that the Status may be reflected as Processing while the results are refreshing.

Administration Simplification (aka Admin Simp) spreadsheets are subject to the following constraints.

- Files must be in xls or xlsx format
- Files must adhere to the “ERA Enrollment Instructions” guidelines, which are accessible via the link provided on the form

The status of your file upload action is indicated in the Status column by Filename, as shown below.

It is important to note that this upload status refers only to the success of the file upload. A successfully uploaded file is then validated and you must navigate to the ERA Enrollments tab and run a search to view the processing status, which may indicate the need for further action to complete the enrollments.

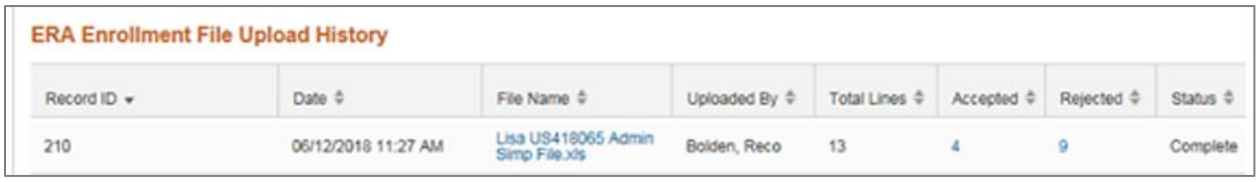


Search

You can search the ERA Enrollment file upload history by entering at least a Start Date in that Search field. Use the Search button to return results.

Search results are displayed beneath the Search pane in the ERA Enrollment File Upload History grid, which provides the following information.

- Record ID
- Date
- File Name – reflects the format such as .xlsx (via File Upload), or .json (via API)
- Uploaded By
- Total Lines
- Accepted
- Rejected
- Status



You can use the File Name link to open the file; and use the Accepted and Rejected links to view the validation results for each file.

You have links available in the ERA Enrollment File Upload History grid for the following actions:

- Use the File Name to view, print or download the file
- Use the number of Accepted files to view the validated enrollments

- Use the number of Rejected files to view enrollments that did not pass validation, including the applicable Error Messages, such as shown in the sample below:

Preference for Aggregation of Remittance Data		Other Identifiers		Clearinghouse Name	Clearinghouse Contact Name	Email Address	Reason for Submission	Authorized Signature	Error Messages
Provider Tax Identification Number (TIN)	*National Provider Identifier (NPI)*	**Assigning Authority**	**Trading Partner ID**	Clearinghouse Name	Clearinghouse Contact Name	Email Address	**Reason for Submission** **New Enrollment** **Change Enrollment** **Cancel Enrollment**	**Electronic Signature of Person Submitting Enrollment**	User Attention Required
	12345678931	Optum	TESTWINH	Optum	Ernie Sobczak	IEDIApplicationsTeam2_DL@	N	Suave, Reco	Provider Telephone number is not valid. Preference for Aggregation NPI is invalid. Preference for Aggregation NPI must match Provider NPI. Electronic Signature of Person Submitting Enrollment contains invalid characters.

For Accepted enrollments a Record ID is created automatically. You have the ability to correct any Rejected lines.

Intra-Customer Bulk Move

Task: Based on user roles and permissions find and move multiple associated or approved records from an existing Org ID to another Org ID

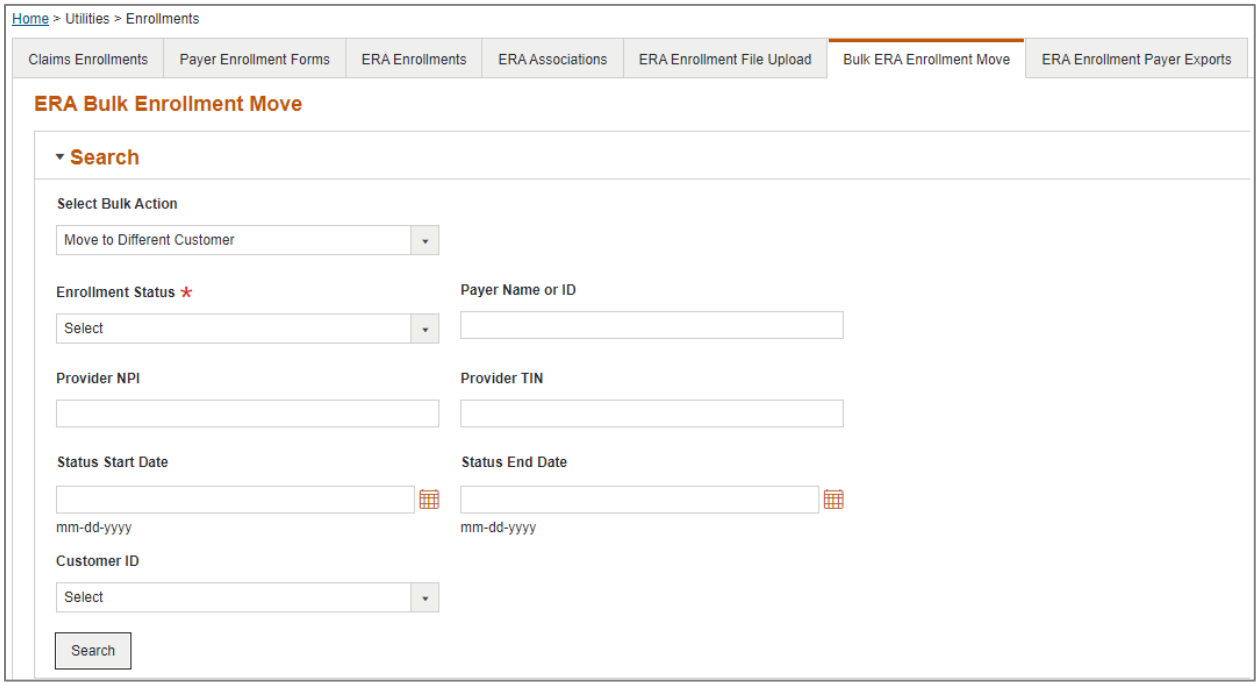
Navigation: Utilities/Enrollments/Bulk ERA Enrollment Move

Note that the Bulk ERA Enrollment Move tab is displayed only for users with specific roles and permissions for this function.

The Bulk ERA Enrollment Move feature allows you to perform a bulk move for Associated or Approved records by moving those ERA Enrollment records from the existing Org ID to a separate Org ID for customers with which you are aligned.

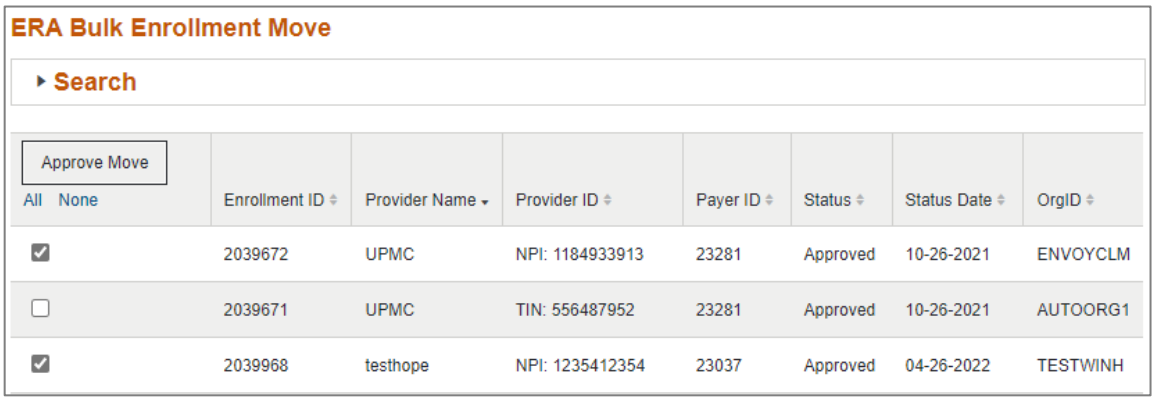
Use the Bulk ERA Enrollment Move tab to open that form, and from the Select Bulk Action drop down choose Move to Different Customer.

You must also select the Associated and/or Approved status option from the required Enrollment Status field drop down. You can narrow your search results by entering any other known information.



The search results provides the following information.

- Record ID – reflects the Enrollment Record ID
- Provider Name
- Provider ID
- Payer ID
- Status
- Status Date
- Org ID – to which the enrollment is currently associated



You must select the records you wish to be moved:

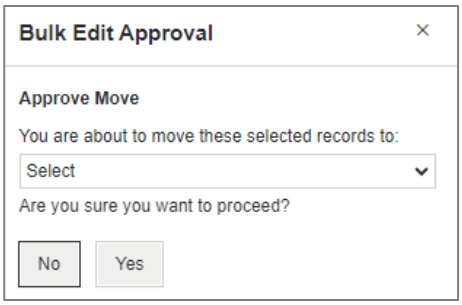
- Use the Select: All link in the header row if you wish to move all of the records in the results grid to another Org ID

- Use the individual row checkboxes to select each record you wish to move to another Org ID
- Use the Select: None link in the header row to clear your selections

Use the Approve Move button in the header row to initiate the move once you are satisfied with your selections.

A Bulk Edit Approval form opens to provide a drop down of your associated Org IDs. Select the desired new Org ID.

An attestation request is included in the Bulk Edit Approval form, and you must select the Yes option in order to approve and complete the bulk move.



A new Association ID is applied to each record when it is moved. Note that the original Association ID is updated to an Inactive status, and the original Enrollment Record is updated to a Moved status.

COV Bulk Move

Task: Based on user roles and permissions find and move multiple pended records from an existing Org ID to another Org ID, aka Change of Vendor (COV)

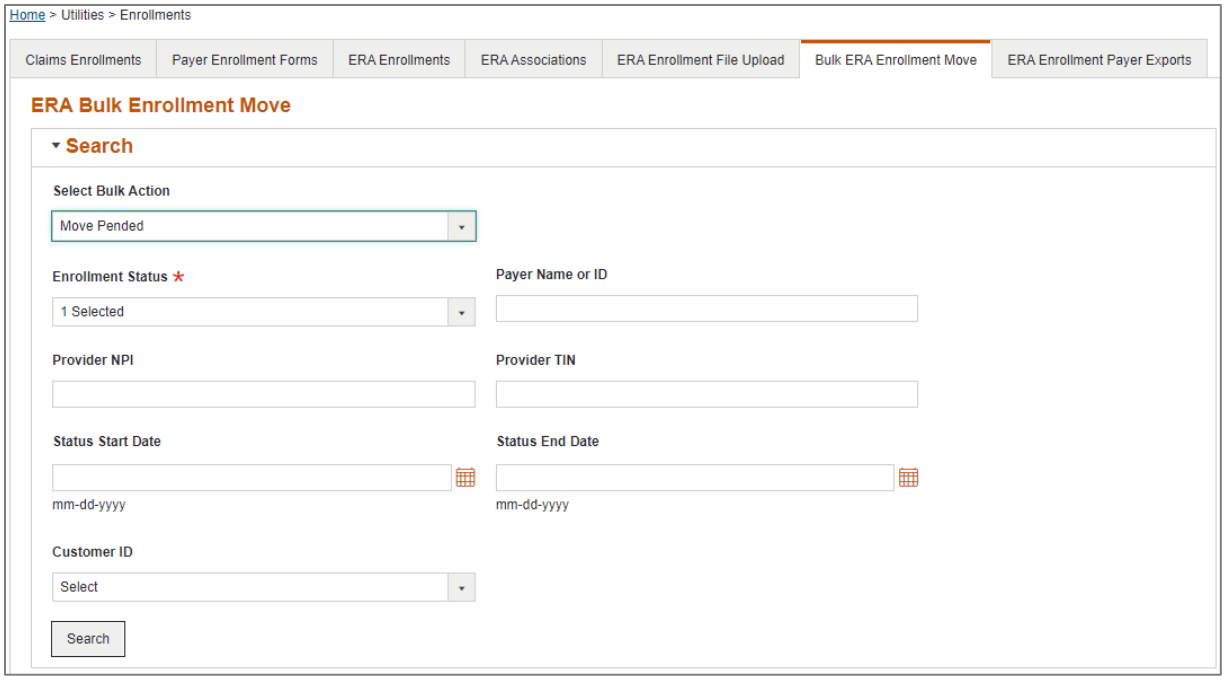
Navigation: Utilities/Enrollments/Bulk ERA Enrollment Move

Note that the Bulk ERA Enrollment Move tab is displayed only for users with specific roles and permissions for this function.

The Bulk ERA Enrollment Move feature allows you to perform a bulk Change of Vendor (COV) for Pended records by moving those ERA Enrollment records from the existing Org ID to a separate Org ID.

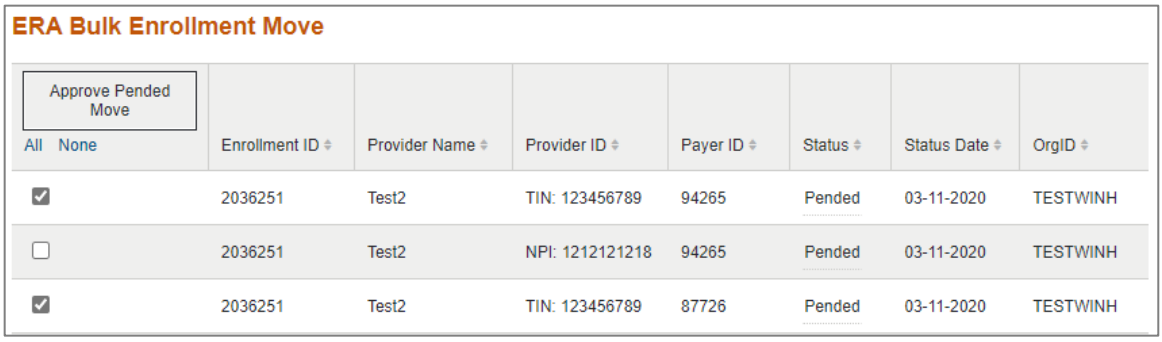
Use the Bulk ERA Enrollment Move tab to open that form, and from the Select Bulk Action drop down choose Move Pended. This selection auto-displays in the Enrollment Status field.

You can narrow your search results by entering any other known information.

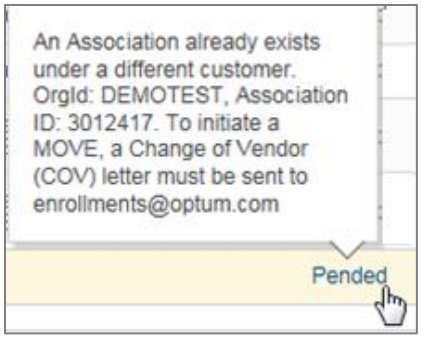


The search results provides the following information.

- Enrollment ID
- Provider Name
- Provider ID
- Payer ID
- Status Date
- Org ID



You can hover the Status Pended link in the results grid to display the original Customer Org ID and Association ID, to which that record is currently associated.

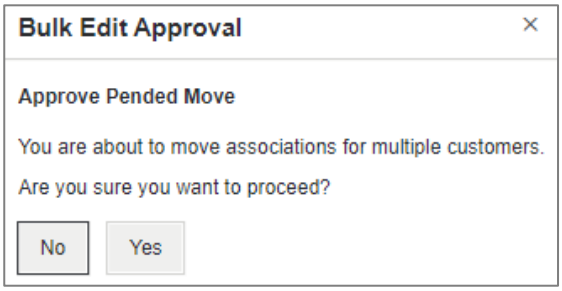


You must select the records you wish to be moved to the Org ID reflected in the results grid:

- Use the Select: All link in the header row if you wish to move all of the records in the results grid to another Org ID
- Use the individual row checkboxes to select each record you wish to move to another Org ID
- Use the Select: None link in the header row to clear your selections

Use the Approve Pended Move button in the header row to initiate the move to the Org ID reflected in the results grid, which is associated with your current Customer/Billing Entity login.

An attestation request displays when you select Approve Pended Move, and you must select the Yes option in order to approve and complete the bulk move.



A new Association ID is applied to each record when it is moved. Note that the original Association ID is updated to an Inactive status, and the original Enrollment Record is updated to a Rejected status.

ERA Enrollment Payer Exports

Task: Based on user roles and permissions search previous batch reports (Admin Simp), and export reports in batch format

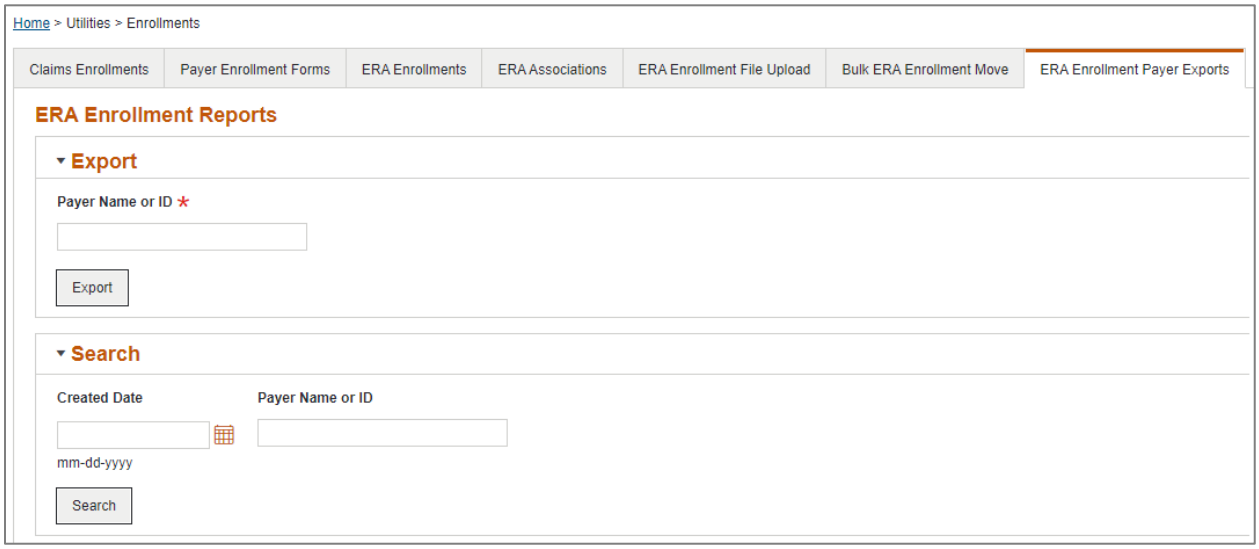
Navigation: Utilities/Enrollments/ERA Enrollment Payer Exports

The ERA Enrollment Payer Exports feature allows you to search previously created and submitted ERA enrollments that were batch exported for Remittance payers (only).

Only those enrollments in a status of Associated are included in your search results. For a provider record to be eligible for this process both the NPI and TIN must be in an Associated status.

You can obtain the desired enrollment data by either of two methods:

- Enter the Payer Name/Payer ID and select the Export button to generate the selected payer results
- Enter the Created Date and/or the Payer Name/Payer ID to return search results



The ERA Enrollment Reports Export History results grid includes the following:

- Record ID
- Creation Date (of export)
- Payer Name (ID)
- Created By (user name)
- Export Path Name – reflects the receiving folder location
- File Submitted – indicates the file has not been submitted (Mark as Submitted); or indicates who submitted the file and the date it was submitted

Export

Your search results can be downloaded in a batch format known as the Administration Simplification (aka Admin Simp). The enrollment information from each record is mapped into the Admin Simp batch format.

You can export the ERA enrollment data in the Admin Simp spreadsheet in order to submit the enrollment records to payers using the ERA Enrollment Payer Exports feature. Each enrollment record included in the export is updated to the status of To Payer.

A processing status bar displays during this export process. If you exit the process the export may not be completed successfully.

You must select the Mark as Submitted link in the ERA Enrollment Reports Export History grid under File Submitted header to indicate the record has been submitted. (The field updates automatically when you select the link.)

Patient Maintenance Utility

Task: Access and manage Patient information available in the database, and upload information files

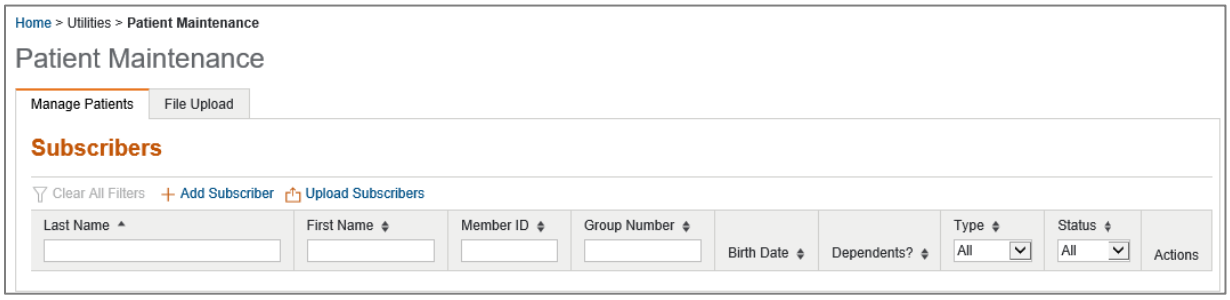
Navigation: Utilities/Patient Maintenance/Manage Patients and File Upload

Manage Patients

Use the Patient Maintenance/Manage Patients utility to manage Subscriber and Dependent data, as follows:

- Filter your Subscriber listing
- Add or Edit an individual Subscriber
- View Subscriber Details, including applicable Dependents
- Add or Edit a Dependent
- Upload Subscribers – currently you may upload only from the ENS Legacy system

Your Subscriber list is determined by the Billing Entity (page banner). The Manage Patients tab displays the list of existing Subscribers sorted by Last Name. This grid reflects Subscriber Last Name, First Name, Member ID, Group Number, Birth Date, Type, and Status, and also identifies if there are Dependents for the Subscriber.



Subscribers may be aligned with more than one Billing Entity. Billing Entities can be assigned multiple Providers, and the number of Providers is not intended to be limited.

Filter

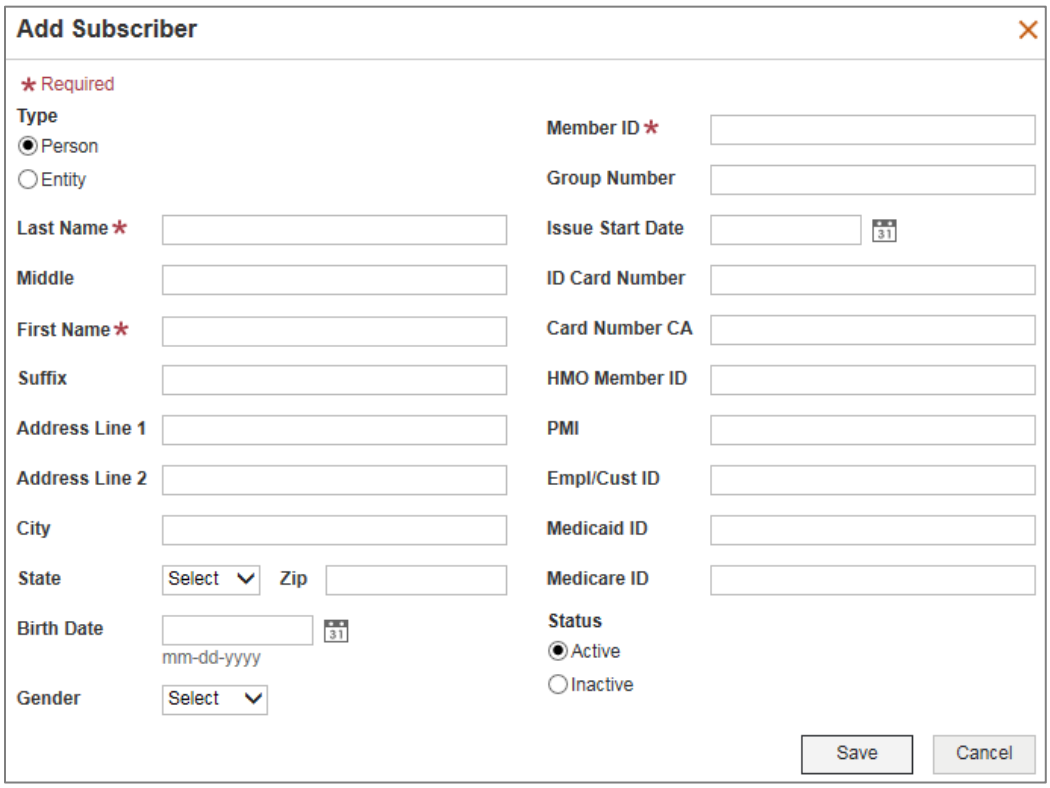
You can filter your Subscriber list by entering desired results into the available column heading fields. Use the Clear Filters link to begin a new search.

Add Subscriber

From the Subscribers grid use the Add Subscriber link to open the Add Subscriber form. Complete at least the required fields – First Name, Last Name, and Member ID. Additional fields support the auto-population of data, e.g., Intelligent EDI Eligibility forms.

You may enter the SSN when adding a new subscriber, but the SSN is not displayed on subsequent forms in compliance with privacy regulations.

Select Save or Cancel. If the new Subscriber is a duplication an advisory message displays.



Edit Subscriber

From the Subscribers grid use the Edit icon on the desired row to open the Edit Subscriber form.

You can modify any enabled field on the Edit Subscriber form. The required fields must be populated to Save your changes.

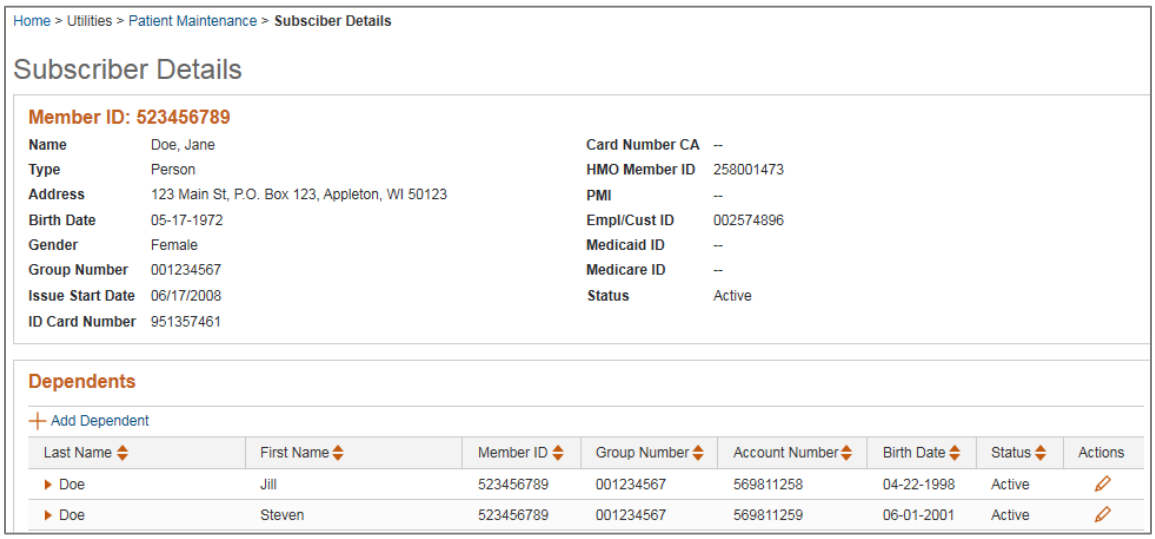
A Subscriber record may not be deleted but you may edit the Subscriber record to apply an Inactive Status, which indicates the Subscriber is currently Inactive, and by default any associated Dependents are also rendered currently Inactive.

Subscriber Details

From the Subscribers grid use the Member ID# link to display the Subscriber Details, which contains:

- Member ID – information includes additional identifiers, as well as fields that support the pre-population of data, e.g., to Intelligent EDI Eligibility forms

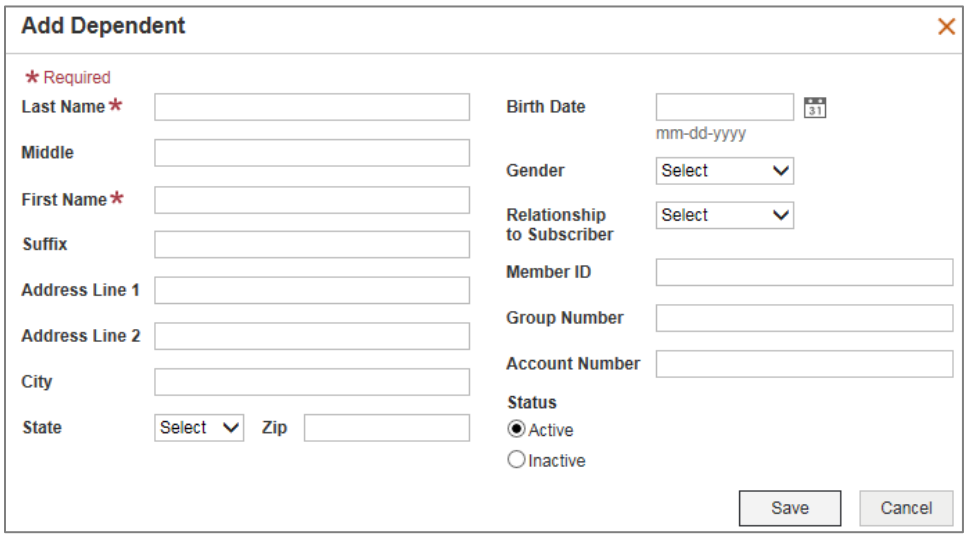
- Dependents – a listing applicable to the Subscriber (Active and Inactive status). You may use the links available here to add or edit Dependents.



Add Dependent

From the Subscriber Details use the Add Dependent link to open the Add Dependent form. Complete at least the required fields – First Name, and Last Name. Additional fields support the auto-population of data, e.g., Intelligent EDI Eligibility forms.

Select Save or Cancel. If the new Dependent is a duplication an advisory message displays.



Edit Dependent

From the Subscriber Details use the Edit icon on the desired row to open the Edit Dependent form.

You can modify any enabled field on the Edit Dependent form. The required fields must be populated to Save your changes.

A Dependent record may not be deleted but a Dependent record may be rendered Inactive, as follows:

- You may edit the Dependent record to apply an Inactive Status, which indicates the Dependent is currently Inactive.
- The Dependent record is rendered Inactive by default if the status of the associated Subscriber record is currently Inactive.

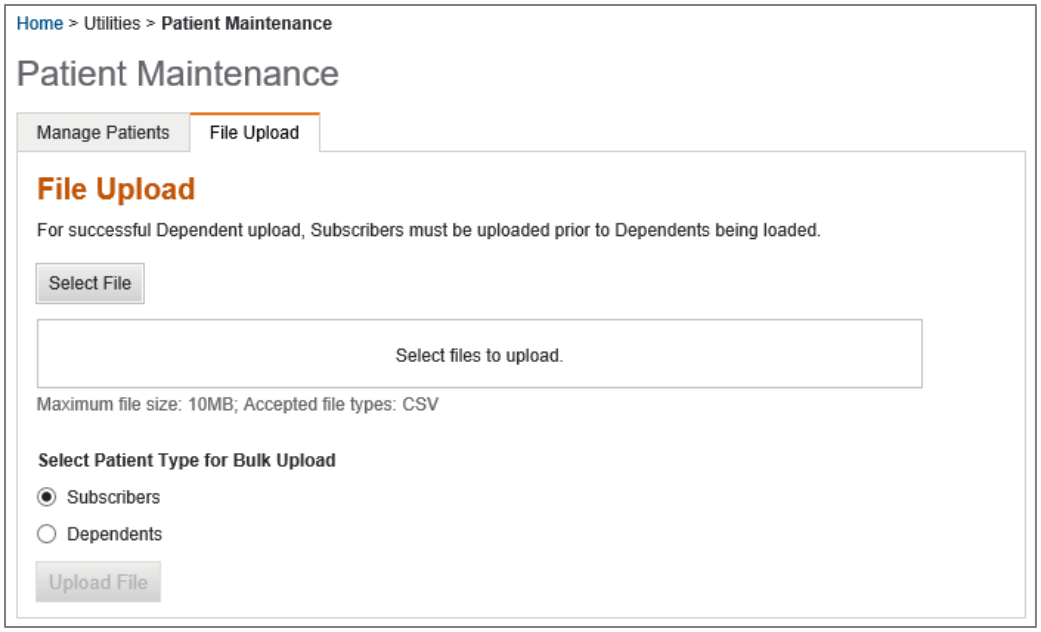
Upload Subscribers

From the Subscribers grid use the Upload Subscribers link to access the File Upload tab to upload Patient files from the ENS Legacy system containing data for one or more patients. See **File Upload** for more details.

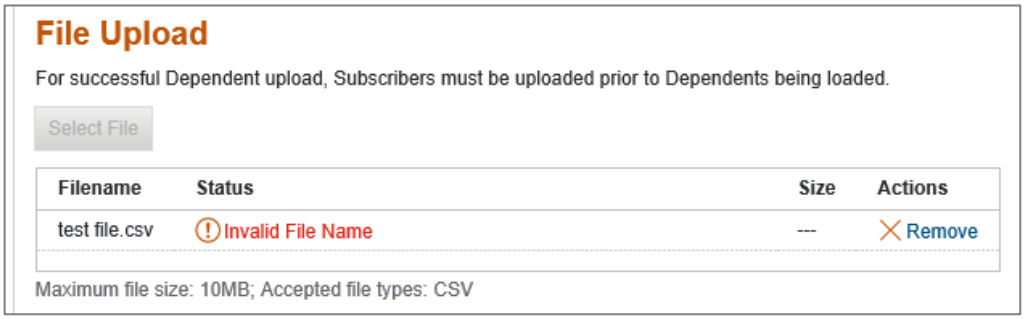
File Upload

Use the Patient Maintenance/File Upload utility to upload Patient files from the ENS Legacy system containing data for one or more patients. When the upload is completed each separate record contained in the upload file is available and identified as a unique statement.

- To begin, use the Select File button to select your batch file. If the file is valid it will be processed.
- It is important to note that only files based on the current Patient file upload template are valid and can be uploaded. This template, as designated by your administrator, contains the required fields of information.
- You must select the desired Patient Type for Bulk Upload, either Subscribers (default) or Dependents. Note that Subscribers must be uploaded prior to Dependents being loaded.
- Select the Upload File button to complete the upload.



Any error messages are displayed in the Select files to upload box, such as shown below. Use the X icon to remove the unacceptable file.



File constraints include the following:

- The maximum file size accepted is 10MB
- Only CSV files are accepted

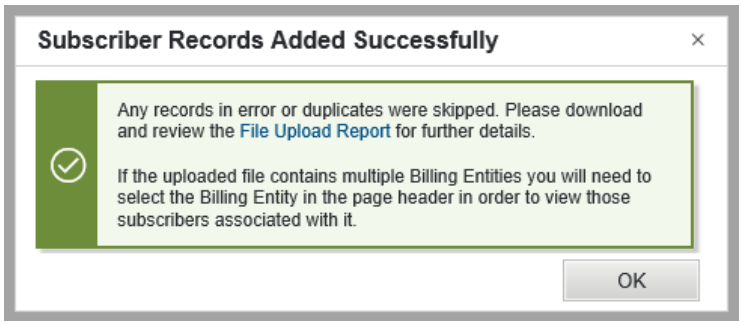
A success message displays when the file is successfully uploaded, however, it is important to note that every individual record may not be successfully included in the upload.

An active link is provided in the success message so that you can view any items not uploaded.

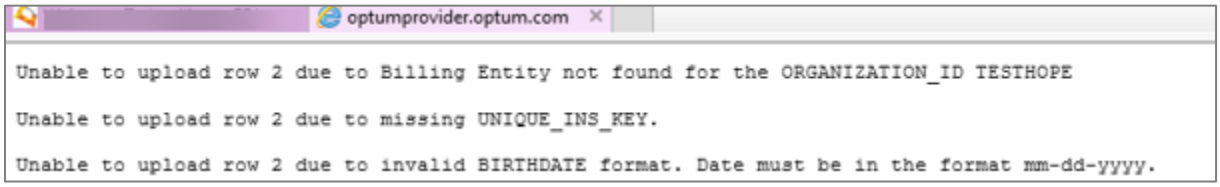
Note the guidance provided in the message:

- Any records in error, and any duplicate records are not uploaded.
- Use the File Upload Report link to open and view these details; and note that you can save the File Upload Report while it is open.
- If the uploaded file contains multiple Billing Entities you must select the Billing Entity in page header to view the associated subscribers.

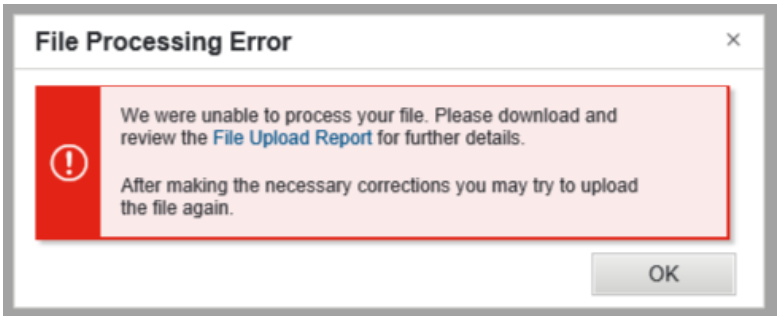
Select the OK button to close the message.



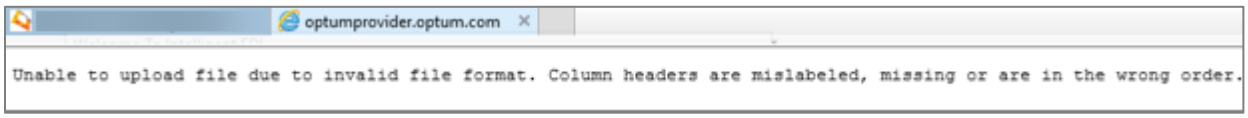
The File Upload Report for a successfully uploaded file identifies those records that were not uploaded.



A File Processing Error message displays if the file does not upload successfully.



The File Upload Report for an unprocessed file indicates why the file did not upload, as shown below.



Provider Maintenance Utility

Task: Access and manage Provider information available in the database

Navigation: Utilities/Provider Maintenance

The Provider Maintenance utility allows you to manage Provider data, as follows:

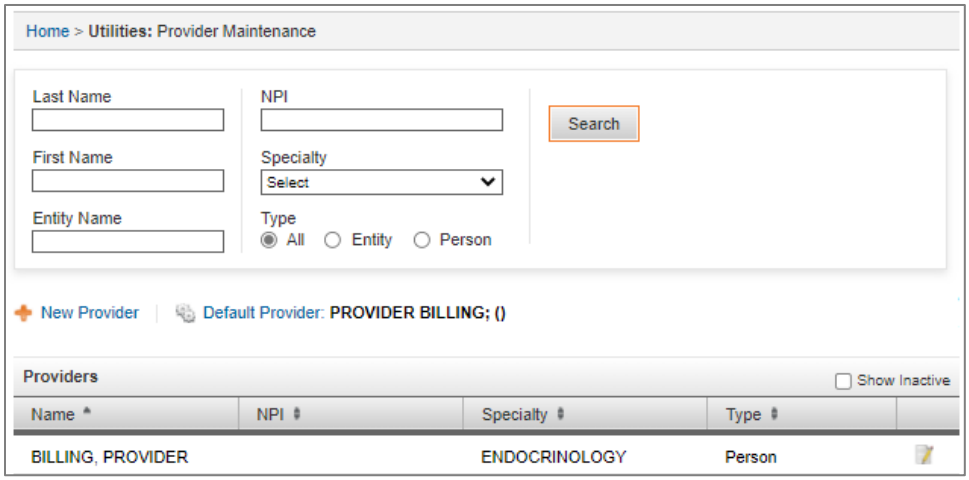
- Search for and view Provider details
- Add a new Provider
- Select a Default Provider
- Edit a Provider

Providers may be aligned with more than one Billing Entity. Billing Entities can be assigned multiple Providers, and the number of Providers is not intended to be limited.

The Provider Maintenance page displays a grid of existing Providers sorted by Name, as follows:

- Entity – sorted alphabetically by the name, as stored in the provider database)
- Person – sorted alphabetically by the individual's last name, with first name indicated

The Providers grid reflects Name, NPI, Specialty, and Type (Entity or Person).



Provider Maintenance – Search and View Provider

Task: Search for Providers, and view Provider details

Navigation: Utilities/Provider Maintenance

You can begin your search for a Provider by entering the first two characters of the known Provider information in any of the search criteria fields, such as Name or NPI.

You can narrow your search by choosing the following:

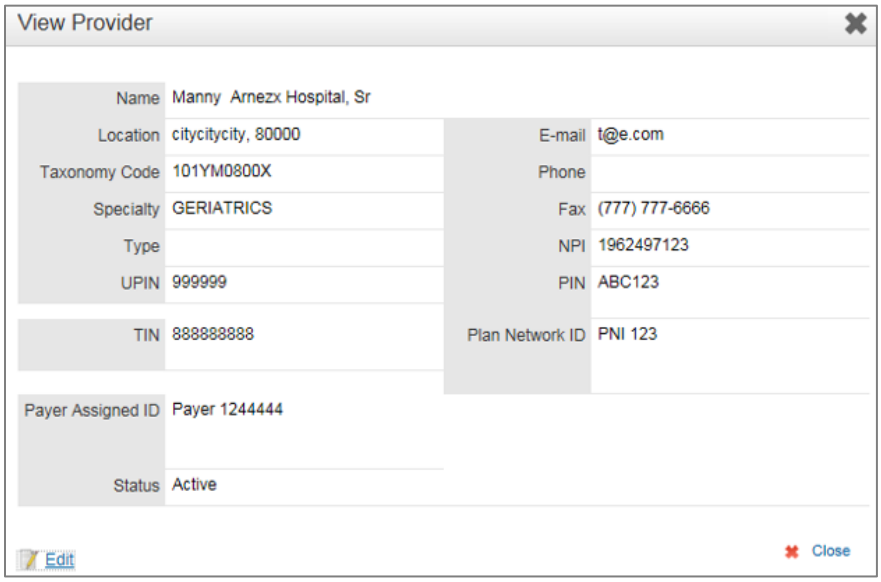
- Specialty – select from the drop down
- Type – select Entity or Person. (The Search feature defaults and reverts to All types.)

Click the Search button to continue, or use the Clear Criteria option to begin a new search.

Click a row in the Providers grid to display the View Provider form for an Entity or Person.

The View Provider form contains additional details such as Status (Active or Inactive), Contact information, UPIN, and Taxonomy Code, as well as fields that support the pre-population of data, e.g., Intelligent EDI Eligibility forms.

The View Provider form is for information only and cannot be modified. You may use the Edit icon to open the Edit Provider form, or click Close.



Provider Maintenance – Add Provider

Task: Add a Provider to the Provider database

Navigation: Utilities/Provider Maintenance

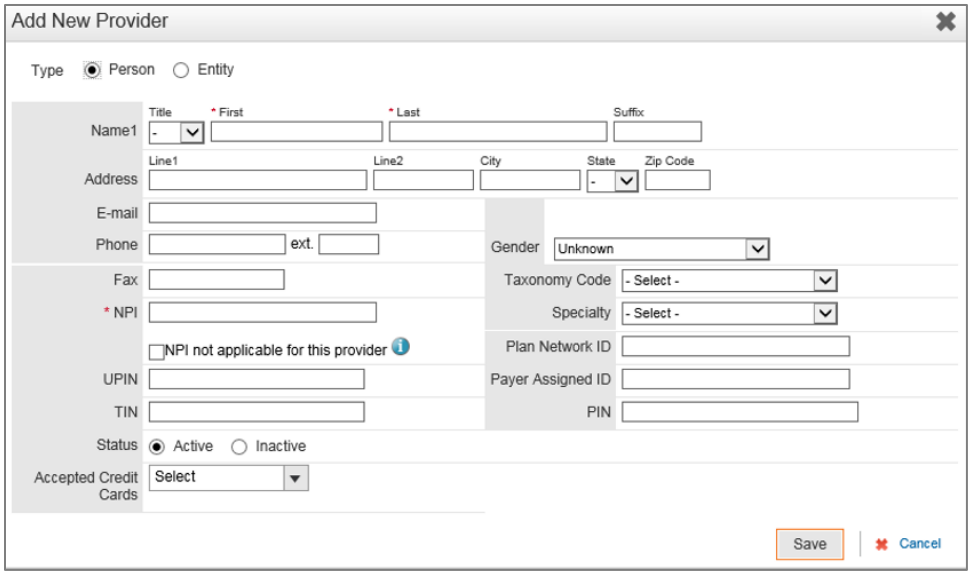
From the Providers grid click the New Provider link to open the Add New Provider form.

Click Entity as the Type, if desired, to enable those fields. (The type of Provider defaults to Person.)

Complete at least the required fields – Entity Name, or First and Last Name for a Person, and NPI. Use the information icon for clarification regarding when the NPI requirement can be waived. Additional fields support the pre-population of data, e.g., Intelligent EDI Eligibility forms.

Click to Save or Cancel.

If the new Provider NPI is a duplication an error message displays such as, “This NPI is already in use for this Billing Entity. Please enter a unique NPI. ”



Provider Maintenance – Select a Default Provider

Task: Select a default Provider

Navigation: Utilities/Provider Maintenance

From the Providers grid click the Default Provider link to open the Default Provider form.

Select the desired Provider from the list and click Select.

Certain applications support the auto-population of Provider information fields when the user has selected a default Provider.

The Default Provider link is disabled if there are no active providers available, and when the type of Billing Entity is Facility.

If a Provider's status is changed to Inactive the Default Provider automatically resets to (None).

Provider Maintenance – Edit Provider

Task: Edit the information stored for an existing Provider

Navigation: Utilities/Provider Maintenance

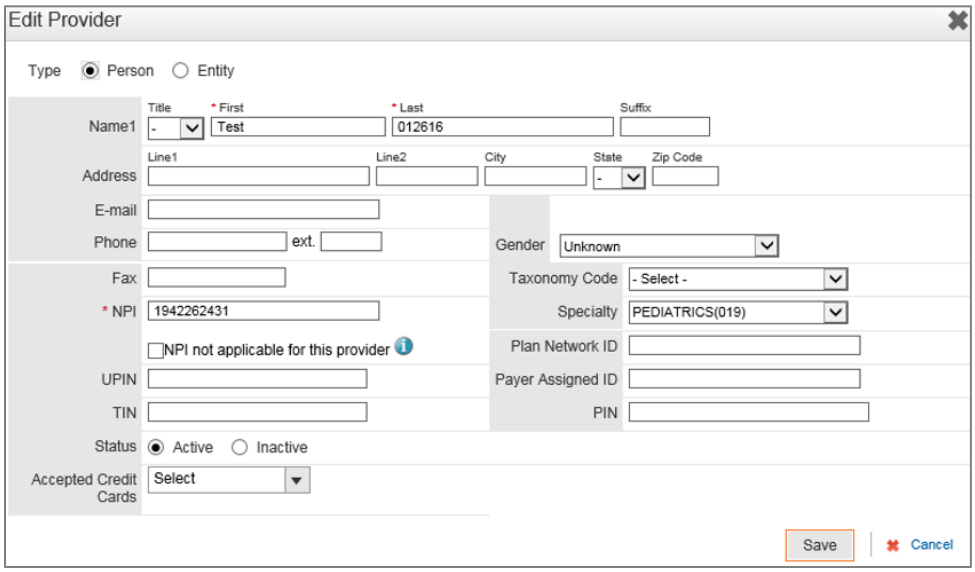
Click the Edit icon on the desired row in the Providers grid to open the Edit Provider form.

You may also access the Edit option from the View Provider form, which is opened by clicking a Provider row.

You can modify any enabled field on the Edit Provider form. The required fields must be populated to Save your changes.

You have the option to change the Type that is indicated for a Provider. If you change a Person to an Entity type the Last Name populates the Entity Name field, and likewise, if you change an Entity to a Person type the Entity Name populates the Last Name field.

A Provider record may not be deleted but you may edit the Provider record to apply an Inactive Status, which indicates the Provider is currently Inactive. If you apply an Inactive Status to your Default Provider a message displays before you can complete the inactivation, suggesting you choose another Provider as your default.



Real Time Payers

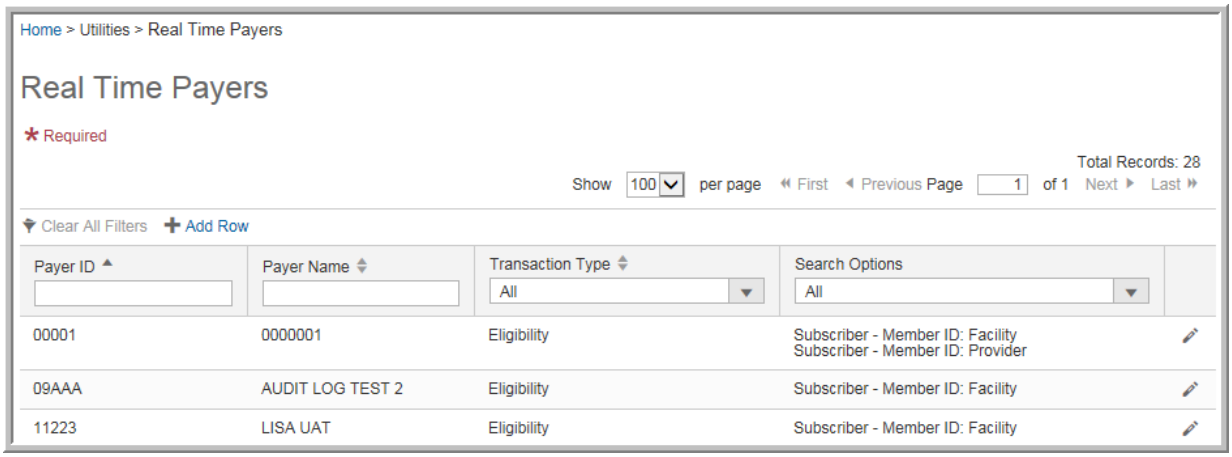
Task: Access and manage Real Time Payer information available in the database

Navigation: Utilities/Real Time Payers

The Real Time Payers function allows you to manage new Real Time Payer records, as follows:

- Search for and view Real Time Payer records
- Add a new Real Time Payer
- Edit a Real Time Payer

Real Time Payers displays the grid of existing Payers sorted by Payer ID. This grid reflects Payer ID, Payer Name, Transaction Type, and Search Options.



Your Real Time Payer list is determined by the Billing Entity (page banner).

Search and View Real Time Payers

You can search for a Real Time Payer using the auto-complete feature – enter the first two characters of the known Real Time Payer information in any of the search criteria fields, such as Payer ID, Payer Name, Transaction Type, or Search Options.

- Transaction Type – the drop down includes any types currently available for this feature, or you may select to search All types.
- Search Options – the drop down includes Subscriber or Dependent Member ID for Provider or Facility.

The filtered search results are returned as you complete the fields.

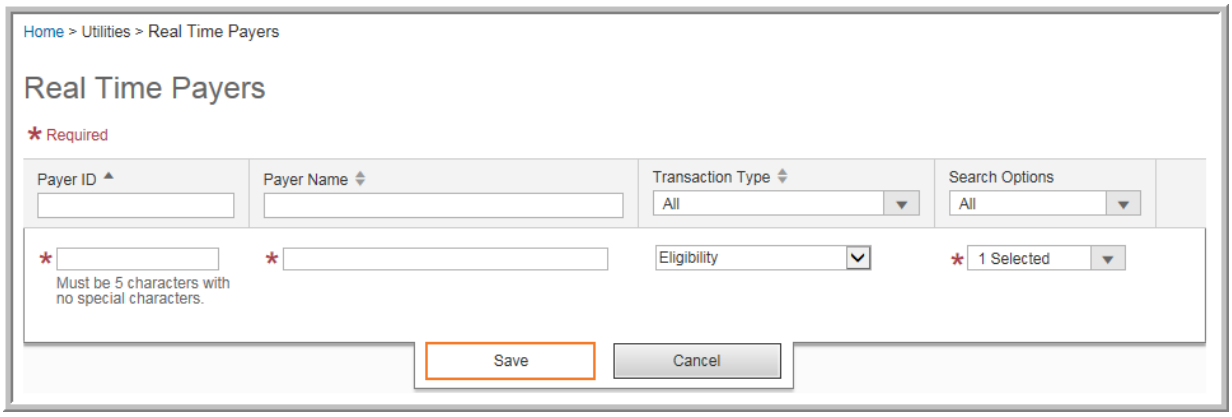
You can use the Clear All Filters option to begin a new search.

Add a Real Time Payer

From the Real Time Payers grid click the Add Row link to add a new Payer.

Complete at least the required fields – Payer ID, Payer Name, Transaction Type, and select a Search Option.

The Payer ID must be exactly 5 alpha/numeric characters to successfully save the new profile.



Click Save or Cancel. If the new Payer is a duplication of an existing payer an error message displays when you click the Save button.

Click Close when the Payer is added successfully.

Edit a Real Time Payer

Click the Edit icon on the desired row in the Real Time Payers grid to open and modify any items in the record that are editable.

A Payer record cannot be deleted or rendered inactive. However, if you no longer want the Payer to be used you may edit the record to remove the Search Options. Deselecting the Search Options renders the record currently useless.

Timely Filing Configuration

Task: Based on user roles and permission view existing configurations; configure timely filing standards for Customer and Billing Entity.

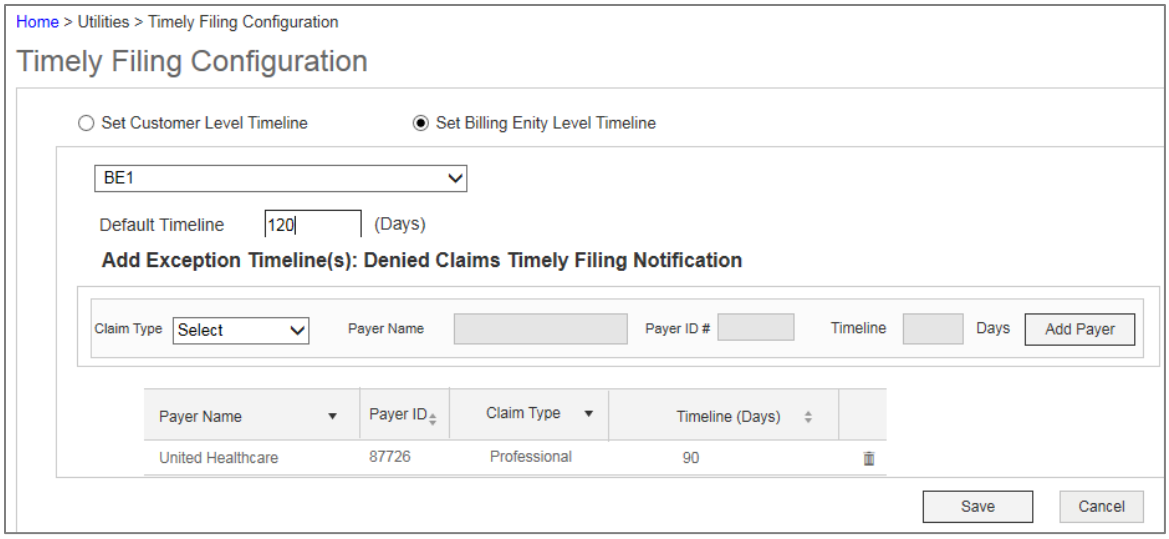
Navigation: Home/Utilities/Timely Filing Configuration

Timely Filing Configuration must be set up and managed by an administrator to establish default standards, as well as any exceptions, for timely claim completion.

Customer or Billing Entity Level

To initiate your Timely Filing Configuration you must select one of the following options. Keep in mind that the configuration is based on your current login.

- Set Customer Level Timeline – to apply the configuration to all Billing Entities of your current login Customer
- Set Billing Entity Level Timeline – to apply the configuration only to a single Billing Entity selected from the subsequent drop down



Default Timeline

Enter the desired number of days in the Default Timeline field to set this span of time as the standard or threshold allowed for completion of claim activity via My Work Queue. Note that the time span is based on business logic.

Use the Save button to finalize the default timeline.

You have the ability to override an existing Default Timeline simply by creating a new one, such as if you need to modify or delete the current standard. Make your Customer/Billing Entity selections, enter the new number of days, and Save. (To delete enter zero or clear the field before saving.)

It is important to remember that you have the ability to override the existing default when you create a new one. No warning is displayed.

Add Exception Timeline

You have the flexibility to set up exceptions to the standard/default time threshold. It is important to remember that you have the ability to override an existing exception when you create a new one.

Begin by completing these exception fields.

- Claim Type – Professional or Institutional
- Payer Name
- Payer ID#
- Timeline (Days)

Use the Add Payer button to include and view your proposed exception in the grid beneath the exception fields. You can continue to build multiple exceptions (before finalizing) using the Add Payer button. The exception(s) you build are displayed in the grid beneath the exception fields.

To finalize you must select the Save button to set up the exception(s) you have entered. If you leave the form without saving the exceptions your entries will be lost. No warning is displayed.

Note that the exceptions grid displays the entire list of exceptions built by all users and applicable to any Customers/Billing Entities as designated.

The exceptions grid provides the following information.

- Payer Name
- Payer ID
- Claim Type
- Timeline

You have the ability to override an existing Exception Timeline by creating a new one with the same configurations. Make your Customer/Billing Entity selections and enter the identical configurations for Claim Type, Payer Name, Payer ID#; enter the new number of days, select Add Payer and Save.

You can delete any exception listed in the exeptions grid using the Delete icon for that entry. Carefully select your desired Payer Name, Payer ID# and Claim Type from the exceptions list before deleting. Note that no warning is provided and the action is irreversible.

It is important to remember that you have the ability to inadvertantly affect exceptions when you override or delete entries.

Warning Message

Based on your Timely Filing Configuration warnings are provided in My Work Queue, and in the related Work Queue for Denied/Rejected Claims.

A warning message is provided in My Work Queue when a claim(s) in a related work queue is approaching or has surpassed the threshold date you established for timely filing.

- Approaching – this warning message is triggered when a claim enters the designated timely filing gap, which is less than 5 days until the threshold date is reached.
- Surpassed – this message is triggered if the user does not perform corrective action on the claim during the timely filing gap.

A warning icon is displayed on any row within the Work Queue for Denied/Rejected Claims results grid for claim(s) approaching or surpassing the threshold you set for timely filing.

Work Queue Configuration (WQ-Set)

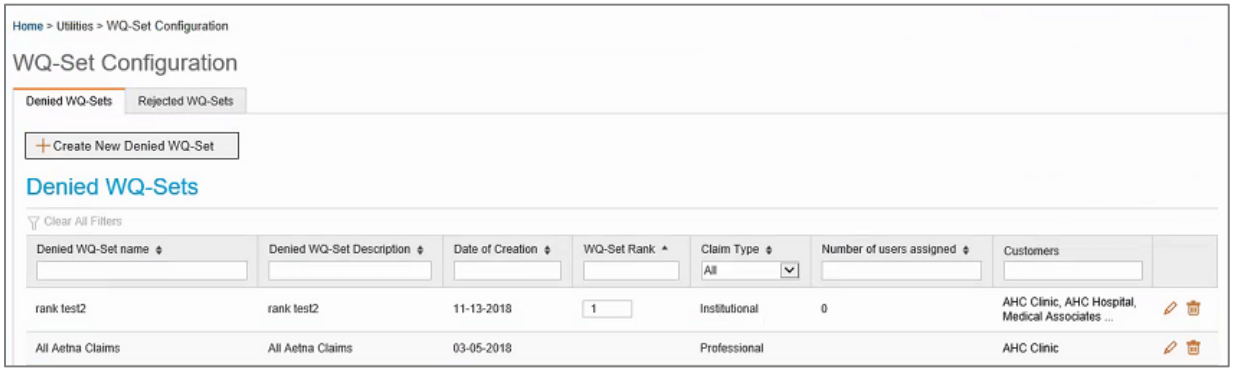
Task: View existing work queues. Based on user roles and permission configure and manage custom work queues for one or more users.

Navigation: Home/Utilities/WQ-Set Configuration

Work Queue Configuration (WQ-Set) must be set up and managed by an administrator. All users can review existing configurations.

In the WQ-Set Configuration feature select either the Denied or Rejected tab. The WQ-Sets results grid for existing configurations provides the same information for both Denied and Rejected WQ-Sets:

- Denied or Rejected WQ-Set Name
- Denied or Rejected WQ-Set Description
- Date Created
- Modified Date
- WQ-Set Rank
- Claim Type
- Number of users assigned
- Customers



WQ-Set Ranking

The working priority of custom (aka user defined) WQ-Sets is managed by applying a ranking order or position number to every WQ-Set, to provide the efficiency of a unique WQ-Set. A default rank is applied when the WQ-Set is created, but you can manage the ranking order by changing the WQ-Set Rank position number in the WQ-Set Configuration grid.

Claims can only be assigned to one user defined WQ-Set at any time. This constraint does not apply to system defined WQ-Sets, which are not ranked (such as All Claims, My Assigned Claims, Unassigned Claims).

Note that WQ-Set Rank numbers automatically adjust whenever a WQ-Set is deleted.

Create New Denied/Rejected WQ-Set

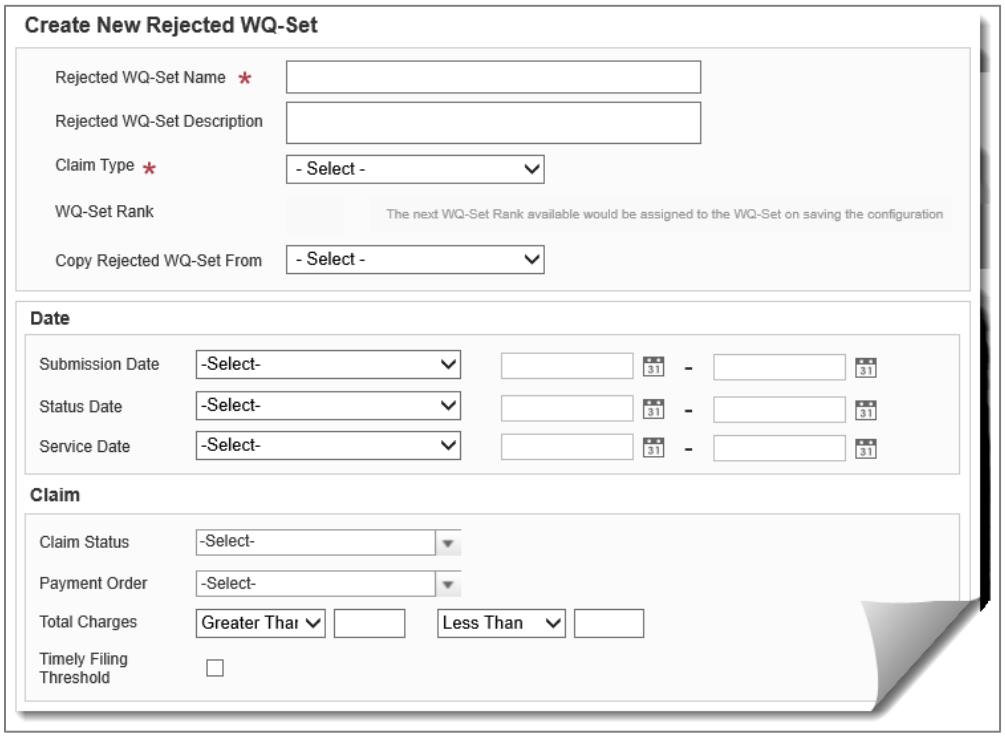
Use the WQ-Set Configuration feature to set up configurations for yourself and/or other users for either Denied or Rejected claims. Customized configurations display filtered results to facilitate your activity.

To begin select the Create New Denied/Rejected WQ-Set button. Note that you also have the option to copy an existing WQ-Set to expedite this process. See **Copy Denied/Rejected WQ-Set** for details.

Complete at least the required fields on the Create New Denied/Rejected WQ-Set form.

Many fields are completed by choosing one or more options from a drop down or selection pane, as shown in the partial image below. Drop downs and selection forms are populated based on your login.

- *Denied/Rejected WQ-Set Name
- Denied/Rejected WQ-Set Description
- *Claim Type
- WQ-Set Rank* – defaults to the next available descending position
- Date – Submission, Status, Service (select previous 7, 30, 60, or 90 days; or select custom range)
- Claim – Claim Status, Payment Order, Total Charges range, Timely Filing Threshold
- Customer – *Apply Config To, or use checkbox to select All My Customers – only associated Customers are available in the drop down
- Payer – Name or ID. A Selected Payers link allows you to see your list of selections.
- Patient – Account # (select condition, such as, ends with), Last Name alpha range
- Remittance – (Denied only) Allowed Amount, Paid Amount, Balance Due and Reason Code(s)
- Billing Entity – NPI/Tax ID(s) – the selection form contains only the NPI/Tax IDs of Billing Entities that are selected as Customer in this form. (The Add Billing Entity NPI(s)/Tax ID(s) button remains disabled until at least one Customer is selected.)
- Rendering Provider – NPI(s) – you can manually add Rendering Provider NPIs, as needed. Use the Add Rendering Provider NPI(s) button, enter the NPI # and use the Add NPI button and Save.
- Pended Categories – you can manually add Pended Categories, as needed. Use the Add Pended Categories button, enter the Pended Category name and use the Add Pended Category button and Save.
- Assign To – the selection form contains applicable Users



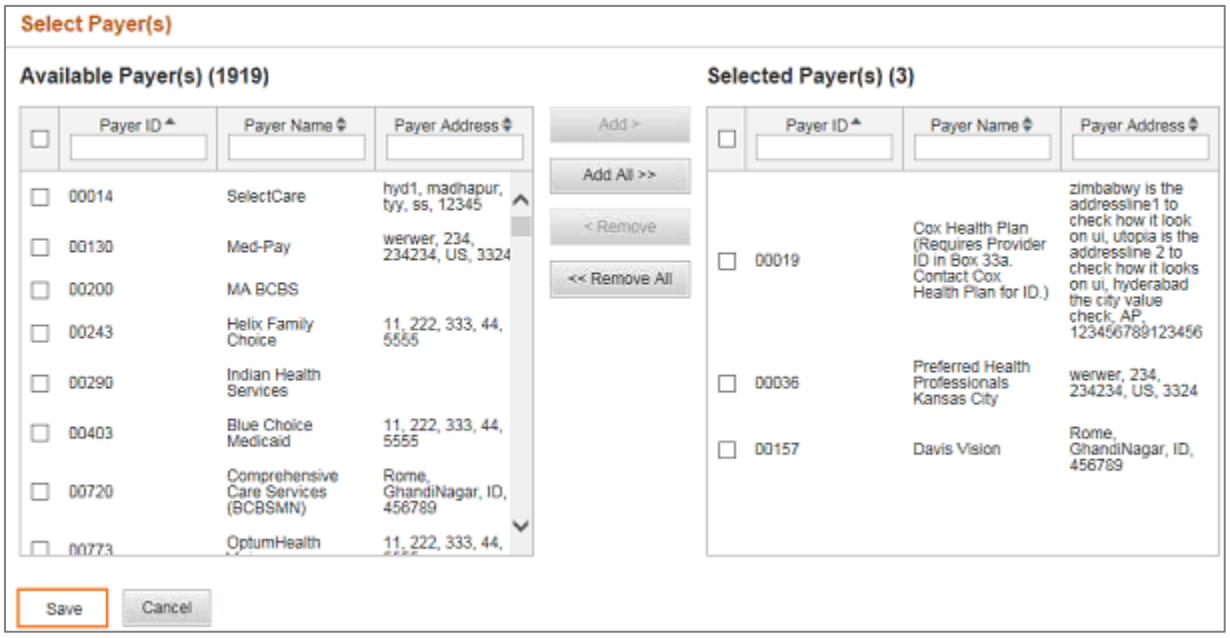
The Claim Status drop down includes all of the claim status codes beginning with the numeral 8, and you can select one or more status codes from the list. When you complete the Claim segment the fields reflect your choices, such as how many Claim Status options you selected, as shown below.

When you add or update a Payer, Billing Entity, User or Remittance Reason Code(s) the applicable selection form is displayed with available choices based on your current BE/Customer login, such as shown below in the sample Select Payer(s) form.

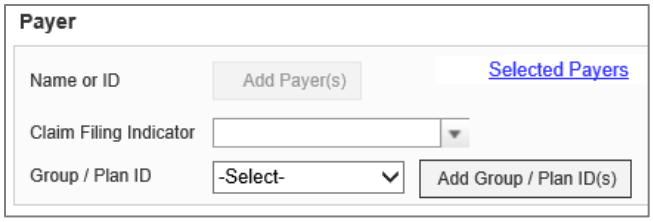
Note that once you have used the Add button it becomes an Update button.

You have search options in the header rows of the selection form to pull Available and Selected choices.

Use the buttons (center) to add and remove Available and Selected choices. Use the Save button when you have completed your selections.



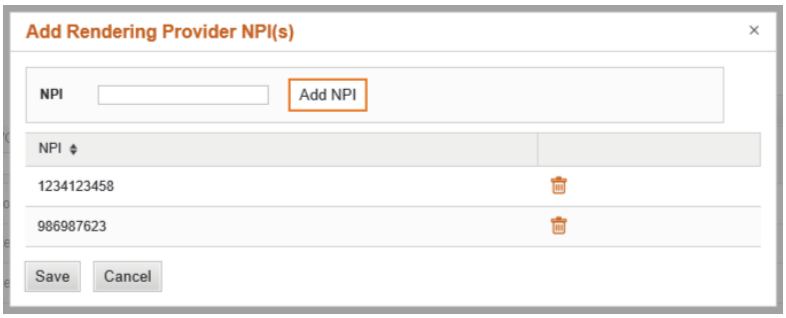
When you have saved your first Payer a Selected Payers link is enabled. The Selected Payers link displays a list of your currently selected Payers alongside the Payer pane for reference. As you Save or Update your Payer selections this list is refreshed for ongoing review.



When you add a Rendering Provider NPI, or a Pended Category you must complete the applicable Add form, such as shown below.

Enter your pertinent information and use the Add button, which displays your addition in the grid. If you are satisfied select the Save button to complete the addition.

You can update to complete more entries, and delete any entries using the delete icon. Select Save.



Copy Denied/Rejected WQ-Set

When creating a new WQ-Set you may copy an existing WQ-Set to expedite the process. Begin by selecting the Create New Denied/Rejected WQ-Set button.

You must select a Claim Type from that drop down to enable the copy option.

Select from the Copy Denied/Rejected WQ-Set From drop down, which displays your assigned WQ-Sets. This copy option expedites building an entirely new Denied/Rejected WQ-Set.

All fields are auto-populated to match the configuration of the selected WQ-Set, except for the following:

- You must enter a new WQ-Set Name in order to Save
- A new default WQ-Set Rank is applied when the WQ-Set is created
- The Assign To selection is not populated, and you can make your selections

You can make modifications to the new WQ-Set in accordance with the provisions for creating a new WQ-Set. See **Create New Denied/Rejected WQ-Set for details.**

Any required fields must be completed in order to Save.

Edit Denied/Rejected WQ-Set

You can use the Edit icon to open a Denied/Rejected WQ-Set and modify any field except the Denied/Rejected WQ-Set Name field. Select Save to complete the edit action.

Any claims subsequently added to the Work Queue reflect the updated configurations for the modified WQ-Set. However, any claims already in the WQ-Set that do not match the modified configuration will remain in the WQ-Set until it is deleted.

Administrators can view and edit only those WQ-Sets associated with customers to which they have access. Note that when a WQ-Set contains customers with which an administrator does not have an association, the WQ-Set configuration will not display those unassociated customers.

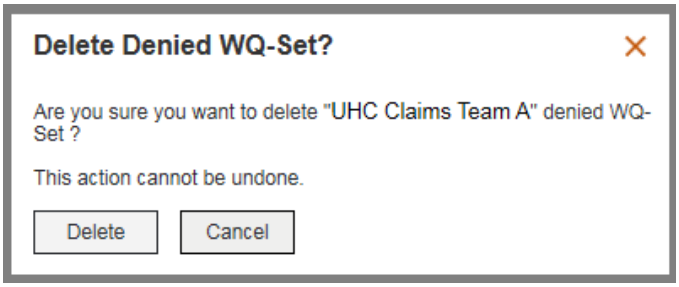
Note that the WQ-Set configuration automatically reflects any change made to the WQ-Set Rank field in the WQ-Set Configuration grid.

Delete Denied/Rejected WQ-Set

Administrators can use the Delete icon to remove those WQ-Sets associated with customers to which they have access.

Claims from a deleted WQ-Set automatically move to the next subsequently ranked matching WQ-Set. If claims do not match any existing WQ-Set configuration they are moved to the Unassigned Denied/Rejected Claims WQ-Set.

A warning displays requiring confirmation, as the WQ-Set is not retrievable. Select the Delete button to continue, or use the Cancel button.



X12 Mapping Service

The X12 Mapping Service enables a user to configure and manage customized maps for claim values, based on user roles and permissions.

- X12 Map Search – search existing maps to generate reports and manage maps
- X12 Map Configuration – open the X12 Map Configuration form to create, test and change status
- Execution Order – set the sequence in which Data Manipulation maps are applied

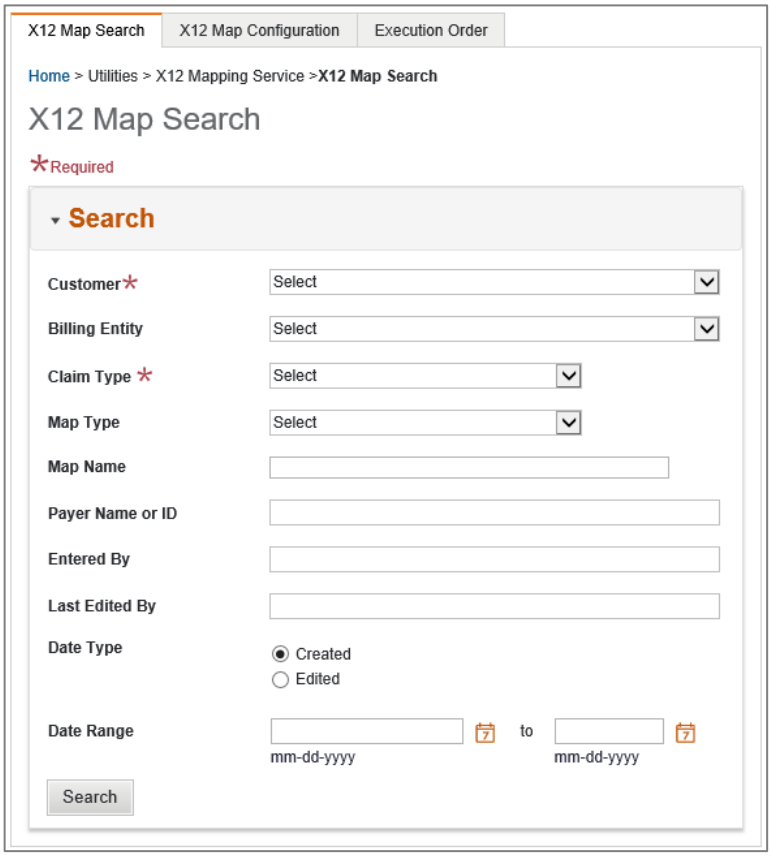
X12 Map Search

Task: Search to view, edit, copy, create map revision, change status, and generate reports of existing X12 maps

Navigation: Home/Utilities/X12 Mapping Service/X12 Map Search

The X12 Map Search feature allows you to search, review, and generate reports of existing X12 map configurations. The search results are displayed in the X12 Maps grid, from which you can edit, copy, create a map revision, or change a map status.

Select the X12 Map Search tab and complete at least the Required fields to perform a search. You can narrow your search results by entering any known information.

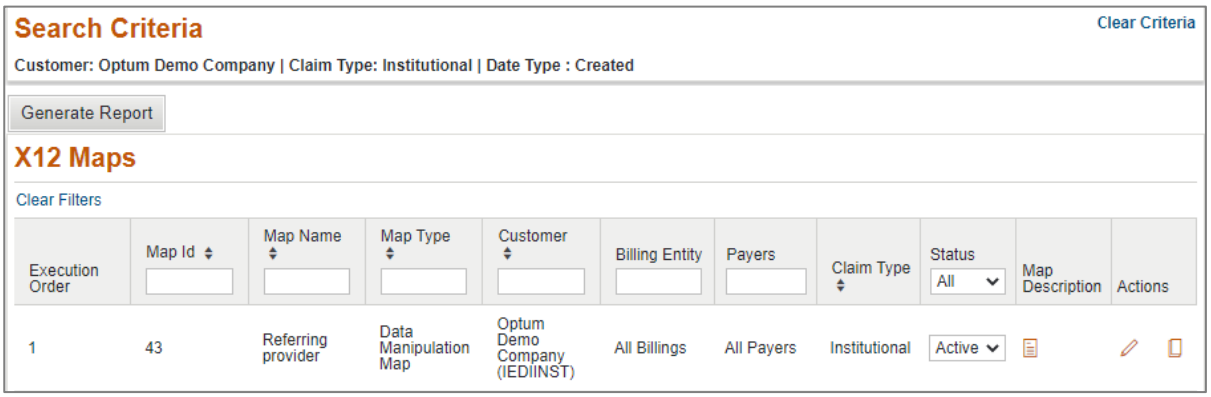


The X12 Maps grid provides the following information sorted by Active maps in ascending order followed by Inactive and Test status maps.

- Execution Order
- Map ID – a unique auto-populated number. For a map revision the Map ID consists of a leading number followed by a version number.
- Map Name
- Map Type
- Customer

- Billing Entity
- Payers
- Claim Type
- Status – note that for any Map ID there can be only one map in Active Status
- Map Description
- Actions

Use the Clear Criteria link if you wish to close the results grid and begin a new search.



In the X12 Maps results grid you have several action options:

- Use the column head fields and arrows to sort and filter your search results, as desired. Use the Clear Filters link to remove any entries you have made to the column head fields.
- Use the Generate Report button to obtain a report of all the configurations contained in your X12 Maps search results, exported in an Excel (xlsx) format.
- Use the Map Description icon to display the Map Summary. (Use the icon to open and close the drawer.)
- Action options also include capabilities described below to edit or copy, create a revision, or change status to Active or Inactive. These changes are completed in the same manner used to create a new map, see **X12 Map Configuration** for details.

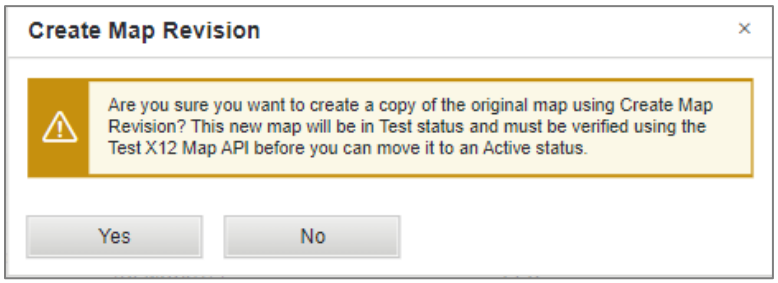
Edit or Copy

Use the Edit icon to open and either modify or copy an existing X12 map via the X12 Map Configuration form. If you choose the Copy X12 Map link a confirmation message displays and you must select Copy Map to confirm your request, or select Cancel.

A success message displays when the edits or the copied map are saved successfully.

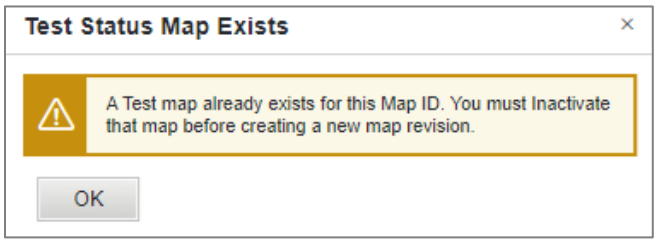
Create Map Revision

Use the Create Map Revision icon for Active or Inactive status maps to create a numbered version of the selected map. This new map revision defaults to a Test status. A confirmation message displays and you must select Yes to confirm your request, or select No.



A success message displays when the map revision and any changes you make are saved successfully.

However, a warning message displays if your particular Map ID currently has a map in Test status. If you wish to replace that current map with a new map revision you must find the current map in the X12 Map Search results, select Edit to open the X12 Map Configuration, and change the status using the Inactivate Map button in the test panel.

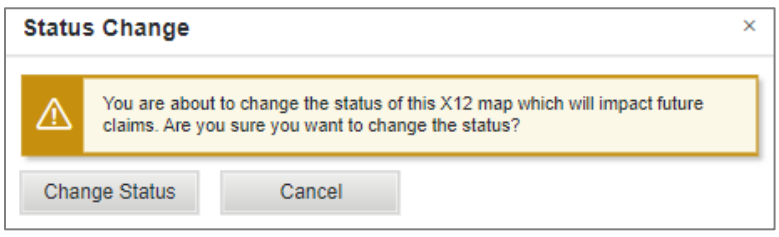


Note that Create Map Revision is not available for a map in Test status. If you wish to replace that Test map with a new map revision you must select Edit to open the X12 Map Configuration and change the status using the Inactivate Map button in the test panel.

Status Change

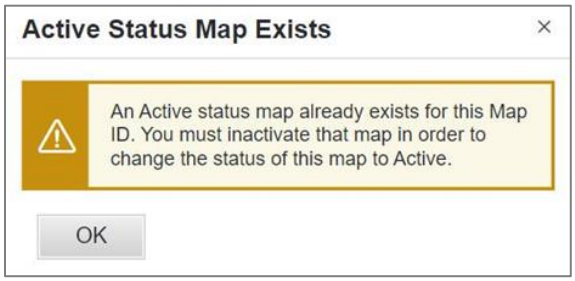
For any Map ID there can be only one map in Active status

Use the Status drop down on the desired row to change the status for any individual map from/to Active or Inactive. A confirmation message displays and you must select Change Status to confirm the change, or select Cancel.



A success message displays when the status change is saved successfully

However, a warning message displays if your particular Map ID has a map in Active status and you are attempting to move an additional map to Active status. If you wish to replace an Active map you must find that map in the X12 Map Search results, select Edit to open that X12 Map Configuration, and select Inactivate Map in the test panel.



X12 Map Configuration

Task: Create, edit or copy new map configurations, and edit or copy existing map configurations, test to verify map, change map status

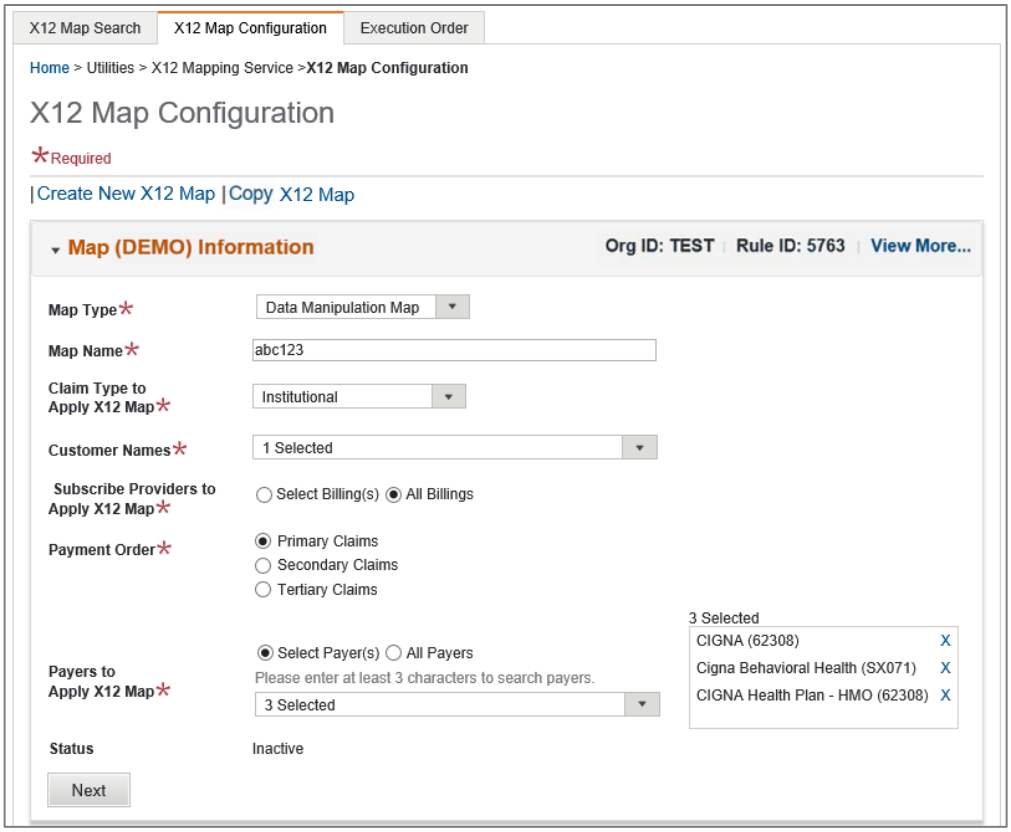
Navigation: Home/Utilities/X12 Mapping Service/X12 Map Configuration

Use the X12 Map Configuration tab to open the X12 Map Configuration form. Select the Create New X12 Map link, or to expedite this process you can select the Copy X12 Map link to copy an existing configuration that reflects your desired Map Type and Claim Type.

Note that when you choose to copy an existing map you must confirm this request, provide a new Map Name, and select Save. Your copied map can now be completed in the same manner used to create a new map. The Map Type and Claim Type fields cannot be modified, but you can modify any other element of the previous map.

The available Map Types allow you to manage those claims you designate in your X12 Map Configuration.

- Data Manipulation – causes a claim to be modified to reset or remove the value of a field.
- Overridable Edit Map – causes a claim to be rejected when your defined Conditions are met, and delivers your preset error message. However, the map can be bypassed if desired by using the Bypass Overridable Edits and Submit button to submit the claim (i.e., without change) for further processing.
- Hard Stop Edit Map – causes a claim to be rejected when your defined Conditions are met, and delivers your preset error message. The claim can be submitted only after changes are made to the rejected claim to satisfy the defined conditions.

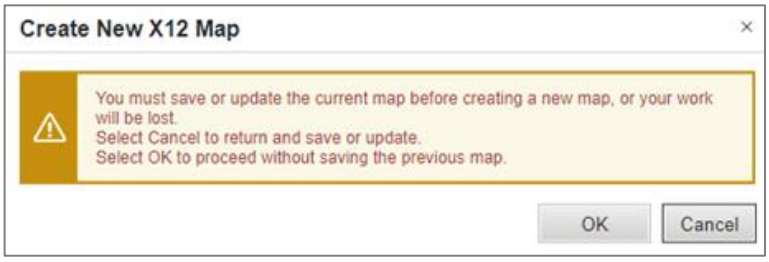


The X12 Map Configuration form contains these sections:

- Map Name and Information – establishes the basis for building customization
- Conditions and Actions – designates your customizations
- Map Summary – provides the map description, and the option to Save/Update your map
- Test X12 Map Against Claim – contains the test panel, and the option to make a status change

If you want to create more than one map use the Create New X12 Map link to open a fresh X12 Map Configuration form for each additional map you wish to create.

Note that if you have not saved your work before selecting to create an additional map a Create New X12 Map confirmation request displays advising that you must Save or Update the current map before creating a new map or your work will be lost. Select the Cancel button to return and save the previous map, or select the Ok button to proceed without saving the previous map.



Map Name and Information

You must complete at least the Required fields in the Map Name and Information pane to create a new X12 map, or edit an existing map.

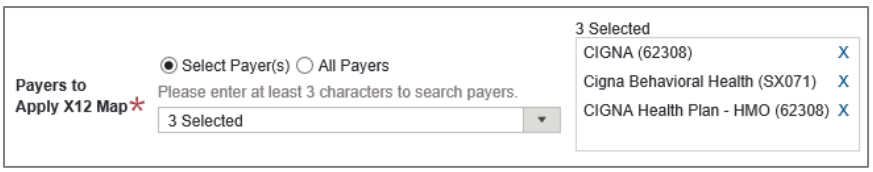
Note that you can use the View More link to review existing maps.

Several fields are completed by choosing one or more options from a drop down. Drop down options are populated based on your current login.

Certain fields reflect your number of selections if you choose more than one selection.

- Map Type – Data Manipulation, Overridable Edit Map, Hard Stop Edit Map
- Map Name – name your new map using alpha or numeric characters only, however you may use these special characters: underscore, hyphen, and period).
- Claim Type to Apply X12 Map – select Professional or Institutional, which determines the Customer Name drop down.
- Customer Names – you may select one or more Customer Names to create or edit a map
- Subscribe Providers to Apply X12 Map – use the radio buttons as follows:
  - Select Billing Entity – to select All, or one or more from the drop down of providers currently available. The drop down reflects both NPI and TIN. (Select None to clear your selections.)
  - Enter New Billing Entity – enter one or more new NPI/TIN numbers in those fields (separated by semicolons)
  - All Billing Entity – to select all possible Billing Entities, including those currently available as well as those not in our system
- Payment Order – select Primary, Secondary or Tertiary
- Payers to Apply X12 Map – use the radio buttons as follows:
  - All Payers – to select all of our active Payers
  - Select Payer(s) – to select All, or one or more from the drop down. Enter the first three characters to expedite this search. (Select None to clear your selections.) This drop down is not limited by association, but includes all of our active Payers.

    When you select one or more Payers these are displayed alongside in a separate list identifying the quantity you have selected, and providing you the ability to deselect any using the Delete icon, as shown below.



- Status – defaults to Inactive. This disabled field reflects any status change made in the test pane.

Use the Next button to continue. You will be able to modify this information if desired before saving the new map.

Conditions

The Conditions Builder segment allows you to build the configuration step by step. The Condition Description automatically compiles as you construct the configuration using the Condition Builder.

Conditions are numbered and displayed vertically in the form. The fields that define each condition are displayed horizontally.

Each subsequent and appropriate field drop down is made available as you build each condition. Drop downs are populated based on your selected Claim Type. Error messages display as necessary to clarify any constraints as you build the configuration.

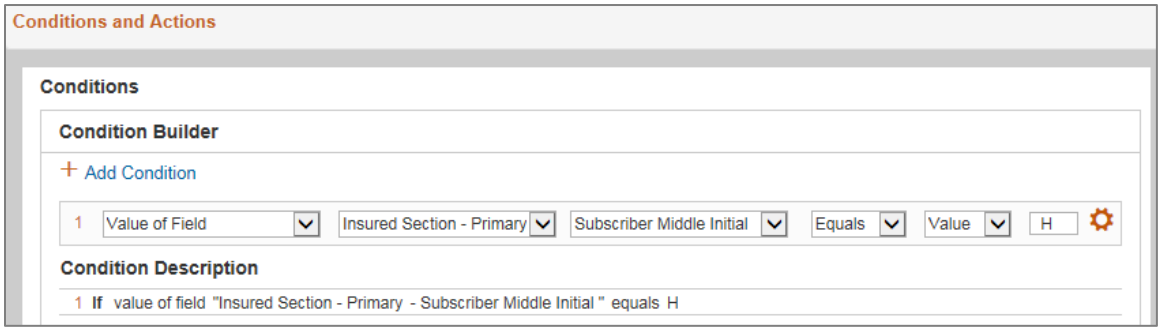
To begin, note that the initial field in each condition is limited to these options:

- Length of Field Value (default)
- Value of Field
- Date of Field
- Compare Service Lines
- Match Service Lines

The second field in each condition reflects the panes from the claim form, but these may be designated differently, such as Insured Section-Primary, or Secondary Payer Section.

The third field in each condition reflects element values that occur within the segment of the claim that you selected for the second field. For example, if you chose Insured Section-Primary, you might now select Subscriber Address1.

Additional fields capture operators (such as equals, contains, less than) and appropriate/related values. Note that for a Value of Field option using the contains/does not contain operator you can include multiple possibilities if separated by semicolons.



Use the Add Condition link to include each additional condition desired.

Select the appropriate Operators (and, or) from the drop down to indicate the relationship as you add conditions.

Use the Edit icon (gear) as needed to cut, copy, paste, or delete your information. You may want to take advantage of copying a condition rather than building a new one. To copy a condition first select Edit

(gear) Copy for that condition row, and then select the Edit (gear) Paste option on the row below which you want the copied row to appear. (Example: use the aligned Edit icon to copy row 2, but select the Edit icon on row 4 to make the copied condition become row 5.)

The Edit option can be used while creating a new map or modifying an existing map.

Actions

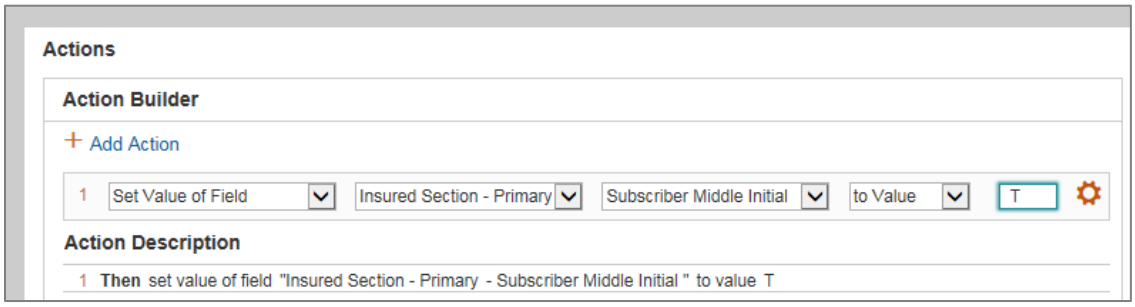
The Actions Builder segment allows you to build the response portion of the configuration step by step. The Action Description compiles as you construct the configuration using the Actions Builder.

Actions are numbered and displayed vertically in the form. The fields that define each action are displayed horizontally.

Each subsequent and appropriate field drop down is made available as you build each action. Drop downs are populated based on your selected Claim Type.

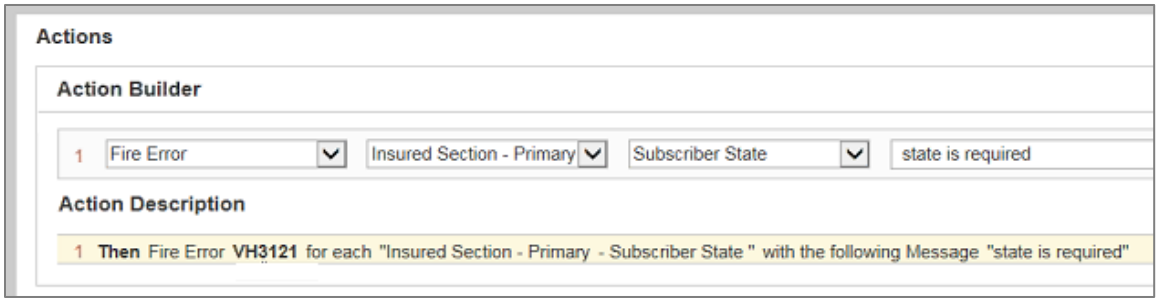
To begin, note that the actions available are based on the Map Type you selected. The initial field in each action is limited to these options, based on each Map Type:

- Remove Value of Field – Data Manipulation
- Set Value of Field – Data Manipulation
- Fire Error – Overridable Edit Map, Hard Stop Edit Map



Subsequent field options are the same as, and will generally mirror your Condition selections, except that you must enter your definitive action in the final field, based on Map Type.

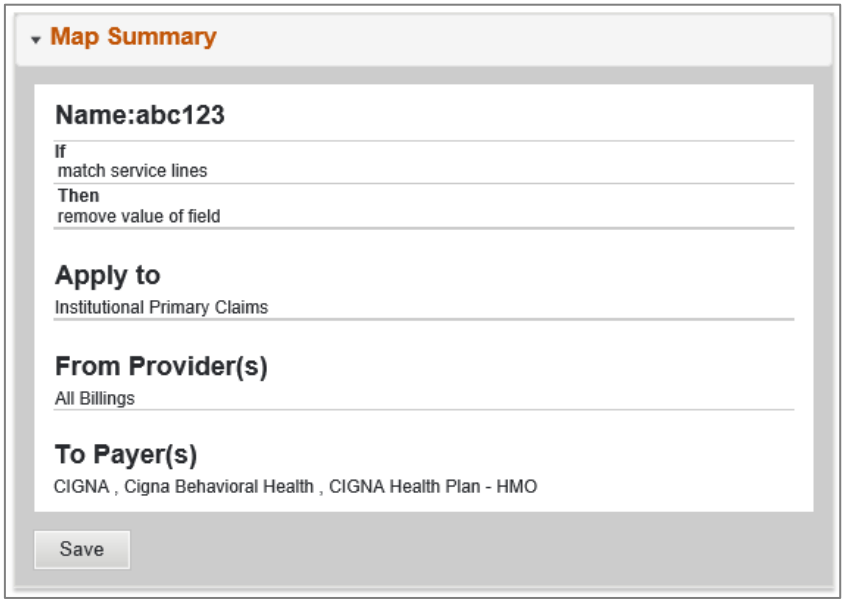
- For Data Manipulation – designate the new value, or the value to be removed
- For Overridable Edit Map and Hard Stop Edit Map – enter your preset error message (a code is auto-applied for each error message when it displays)



Map Summary

The Map Summary is automatically constructed as you complete both the Map Name and Information, and the Conditions and Actions sections of the Create New X12 Map form.

An X12 Map will be executed on a claim only when the map matches with a claim. That is, if your defined Condition is an exact match to the elements of a claim then your defined Action will be applied to that claim.



Use the Save button at any time to save your work in progress, and also to open the Test X12 Map Against Claim pane, as applicable.

Not all customers have the capability for certain maps to be applied.

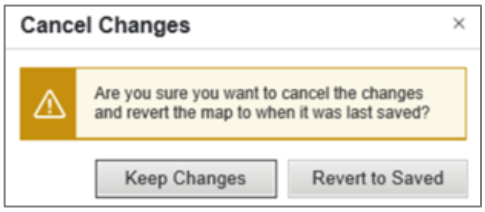
- An error message displays if the map cannot be applied to an individual customer selected; or to any of the multiple customers selected. The error message may simply indicate unable to save map.
- An alert message displays to indicate the map is successfully saved for some customers selected, and specifies other customers for which the map could not be applied.

A success message displays when the map or maps are saved successfully, such as to indicate the map saved successfully; or to list specific maps that are saved.

Note that once you have used the Save button it becomes an Update button. The Update button displays after you have saved the initial creation or modification.

Once you create (or copy) and save a map the map name will be displayed (in parenthesis) in the Map Name and Information section header, as well as in the Map Name field.

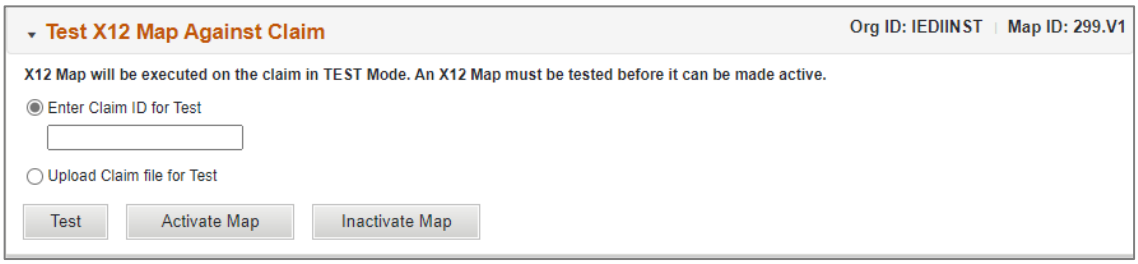
If you select the Cancel button a warning message is displayed, and you must select Keep Changes, Revert to Saved (discard changes), or use X to close the message and continue working.



Test X12 Map Against Claim

It is strongly suggested that you test your completed (or edited) X12 map before placing it in an Active status.

You can test your map at any time while creating (or editing) an X12 map. You must use the Save (or Update) button beneath Map Summary to open the Test X12 Map Against Claim form.



You must select one of the radio button options in the Test X12 Map Against Claim form.

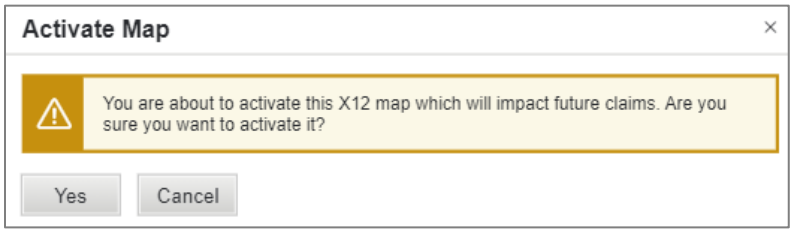
- Enter Claim ID for Test (default) – you may enter a single Claim ID in this field
- Upload Claim file for Test – use Browse to select a claim file, which must be in standard 5010 X12 format. Note that if you upload a multiple claims file the X12 maps will be applied only to the first claim.

Use the Test button to initiate the test against your claim. The X12 Map will be executed on the claim in a safe test mode, and there may be a brief moment before the test claim is displayed.

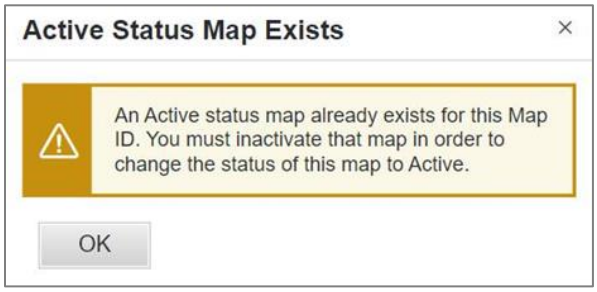
Review the changes to the test claim to confirm your conditions and actions were applied. Use the tab to close the test claim.

If you are not satisfied make the necessary modifications to your configuration, select Update, and select Test to repeat the testing process.

If you are satisfied with your changes select the Activate Map toggle button on the Test X12 Map Against Claim form. A confirmation message displays and you must select Yes to confirm your request, or select Cancel.

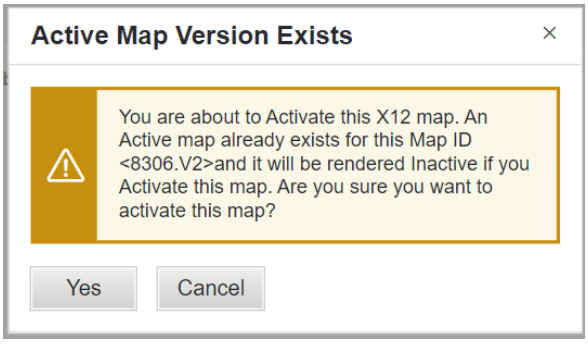


However, a warning message displays if your particular Map ID has a map in Active status and you are attempting to activate an additional map. If you wish to replace an Active map you must find that map in the X12 Map Search results, select Edit to open that X12 Map Configuration, and select Inactivate Map in the test panel.

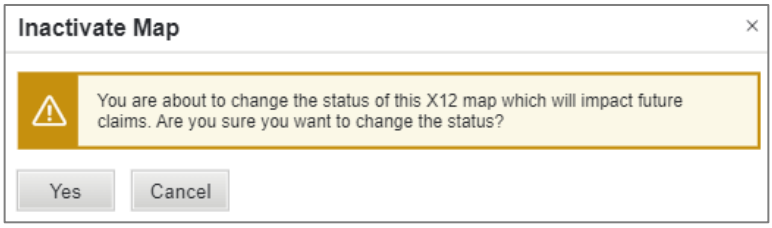


Keep in mind there can be only one map in Active status for any Map ID. For example, if Map ID: 1234.v2 is currently Active you cannot activate 1234.v3.

Note that if you are attempting to activate a Test map a warning message displays if there is currently a map in Active status for your particular Map ID. If you wish to replace that current map with your selected Test map you can select Yes to continue and the previous map will be inactivated. Select Cancel if you do not wish to have the current map rendered inactive.



To Inactivate an Active X12 map you can change the status in the test panel, or change it in the X12 Map results grid.



A success message displays when the selected status change is saved successfully.

When a map is activated it is automatically assigned the default position of being last in the order of execution.

X12 Maps Changes are tracked in Claim History for each claim, separately from changed fields

Execution Order

Task: Modify and update execution orders for Data Manipulation

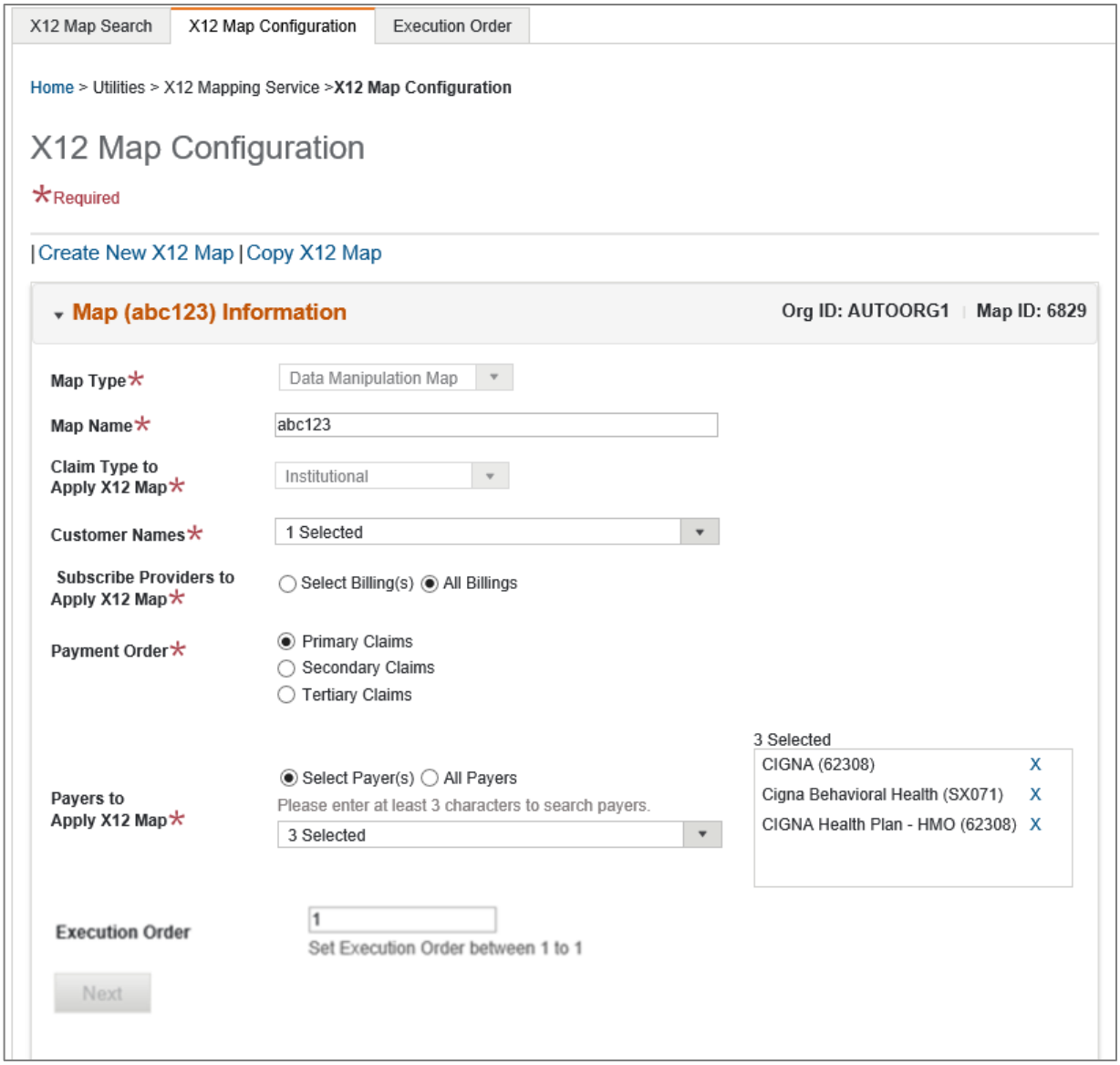
Navigation: Home/Utilities/X12 Mapping Service/X12 Map Configuration or Execution Order

The Execution Order defines the sequence in which the Data Manipulation maps are applied to the claim, including how any interdependence is managed. The Execution Order is indicated in that field within the Map Name and Information section of the X12 Map Configuration.

Note that applicable Data Manipulation maps are applied before any applicable Hard Stop Edit and Overridable Edit maps. Only Data Manipulation maps have an order of execution.

For any Data Manipulation X12 map in an Active status an Execution Order is displayed in the Map Name and Information pane based on your current login and the following constraints.

- Enabled – execution order is enabled if you have access to all of your Customer Billing Entities
- Disabled – a default execution order is displayed but disabled if you do not have access to all of your Customer Billing Entities



The X12 map search results provided in the X12 Maps grid includes the Execution Order for all Data Manipulation X12 maps in an Active status. For Inactive X12 maps the field will be blank.

Update Execution Order

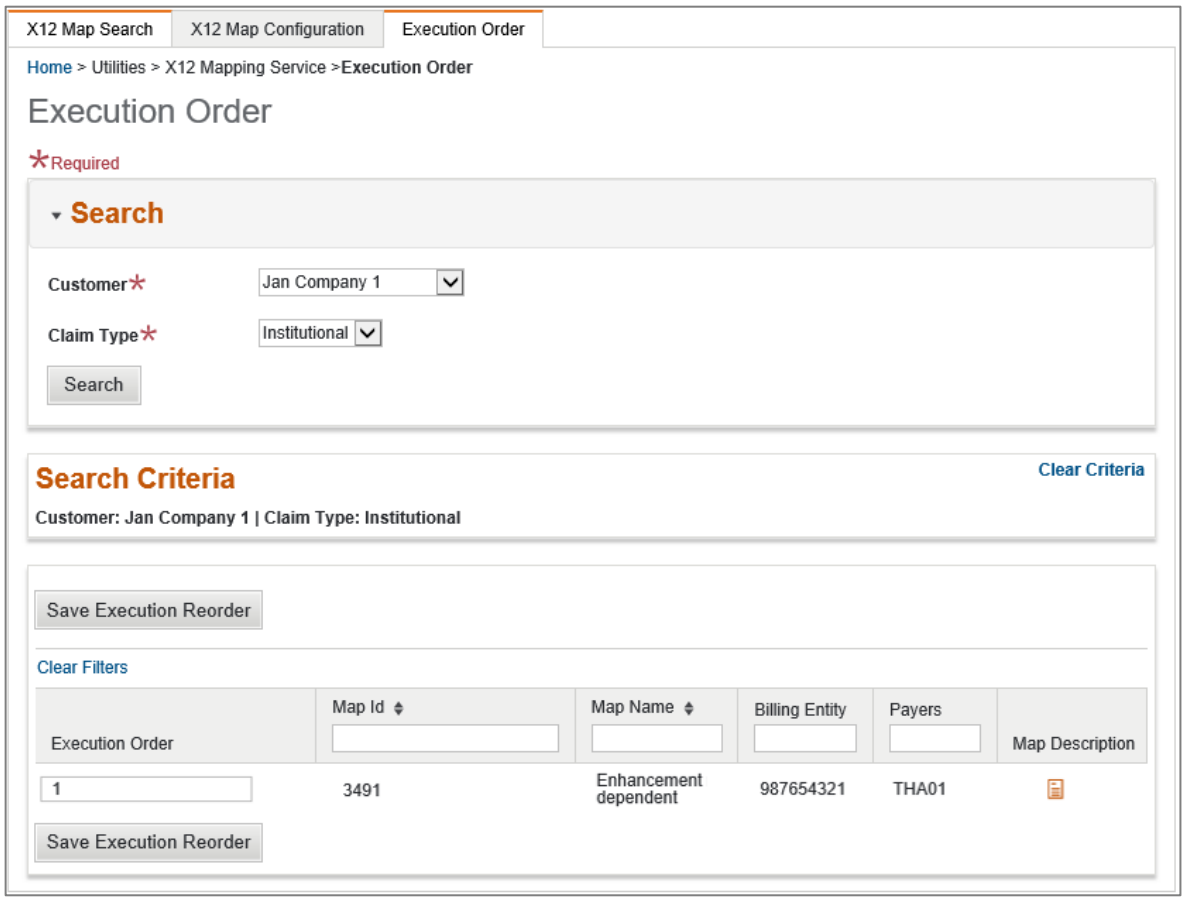
Based on user roles and permission you may be able to update execution orders. Execution Order can be modified in two ways – via the individual X12 Map Configuration or the Execution Order tab.

X12 Map Configuration

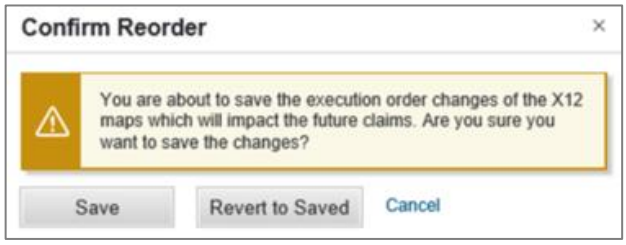
- From the X12 Map Search results use the Edit icon to open the desired X12 map
- Modify and update the execution order within the Execution Order field in the Map Name and Information pane (numeric values only)
- Select the Update button (in Map Summary pane) to apply your changes. Advisory messages display to clarify the appropriate range, or if the field is blank.

Execution Order tab

- Use the Execution Order tab and begin by selecting the required Customer, and Claim Type from the drop down (if there is no default)
- Use the Search button to generate the results grid
- In the Execution Order column enter the desired changes (numeric values only)
- You may click outside the Execution Order field to preview your changes
- Use the Save Execution Reorder button when you are satisfied with the revised order



- A confirmation message displays advising that you are about to save the execution order changes of the X12 maps, which will impact future claims, as asking for confirmation that you want to save the changes. You must select the Save button to apply your changes; or select Revert to Saved, or Cancel.



Resources

Resources includes the following features accessible from the Optum Intelligent EDI Portal page banner:

- Administration (legacy)
- Client Self Service Portal
- Documents
- ENS – Download Center
- OTI
- Payer Configuration
- Provisioning

Resources – Administration (legacy)

To access certain Intelligent EDI Administration functions select Administration (legacy) from the Resources drop down. Access is based on user roles and permissions.

Resources – Client Self Service Portal

To access Optum SalesForce select Client Self Service Portal from the Resources drop down. Access is based on user roles and permissions.

Resources – Documents

Task: Access and download documents within Intelligent EDI; and based on user roles and permissions upload documents

Navigation: Resources/Documents

To access documents available to you in the Intelligent EDI Portal select the Documents feature from the Resources drop down.

Administrators must navigate via Resources/Documents to access the document management capability

Search

Use the Search button to display all available documents. You may first narrow your search by selecting one or more filter options, such as Name, Category, Uploaded Date, and/or Status.

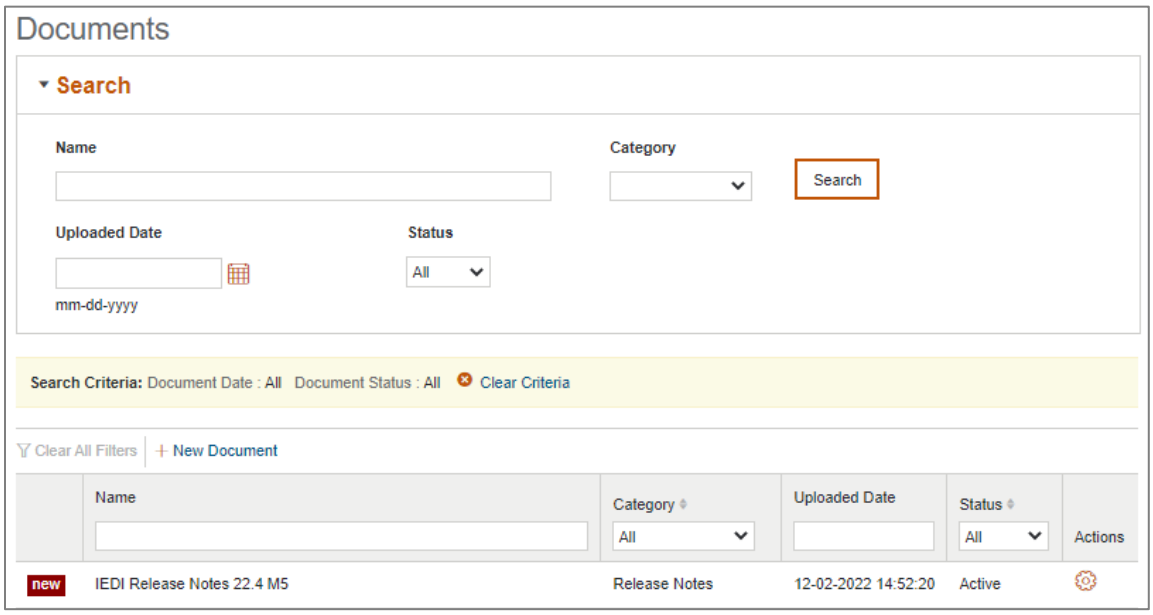
Document categories may include options such as the following:

- General Information
- Training Documents
- Payer Lists – Claims – 837P
- Payer Lists – Claims – 837I

- Payer Lists – Eligibility
- Payer Lists – Claim Status
- Payer Lists – Referral/Authorization
- Payer Enrollment Forms
- Provisioning Forms
- System Companion Guides
- Payer Companion Guides
- Channel Partner Marketing
- User Documentation
- Payer List - ERAs – 835
- Release Notes

Use the Search button to display your search results in the Documents grid.

The Documents search results grid is sorted by Uploaded Date in descending order, and also reflects the document Name, Category, and Status. Documents are designated as new for 30 calendar days following upload.



In the Documents search results grid you have the following options:

- Enter a specific Name and/or Uploaded Date in those header fields to find pertinent documents.
- Select from the Category, and/or Status drop downs to narrow your search results.
- Use the Clear All Filters link to clear any filters you have entered.
- Use the Actions gear icon at the end of the row and select Download to store a copy of the document locally.

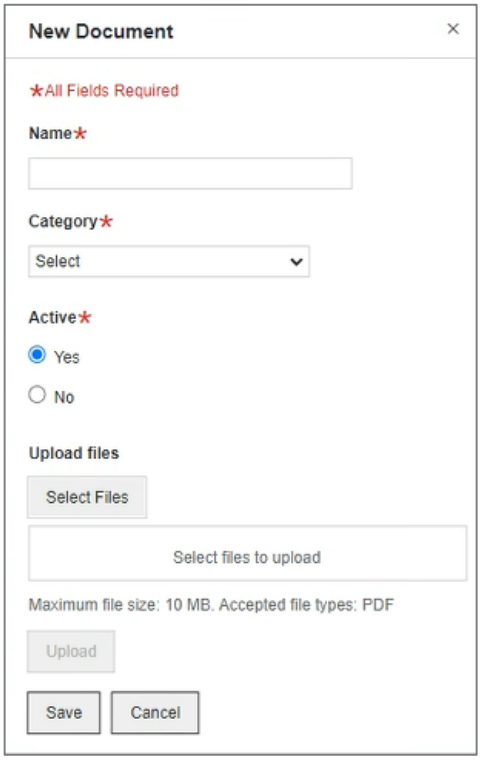
Note that the New Document link is available based on user roles and permissions.

New Document

Based on user roles and permissions Administrators have the capability to upload and manage documents within Intelligent EDI.

From the search results grid Administrators can use the New Document link to open the Add New Document form, and enter the attributes for the new document. All fields are required.

- Name – assign a file name using appropriate naming conventions
- Category – select the applicable category from the drop down
- Active – the Status defaults to Yes
- Upload File – select a single file to be uploaded. A Status is displayed, such as an error message, or an indication that the document is ready to be uploaded
- Upload – use the Upload button when the status displays as Ready to Upload
- Save or Cancel – you must use the Save button before leaving the form to complete the upload action



Edit Document

Based on user roles and permissions Administrators have the capability to access the Edit function using the Actions gear icon to open the Edit Document form.

You can modify any of the attributes of an uploaded document, such as Name, Category, Status.

View Existing Document

You may choose to view and edit a currently existing document and save it as a new file. To edit the content of a document begin by selecting the view existing document link to open the pdf and Save As a new file. Edit the new file and upload it using the New Document link.

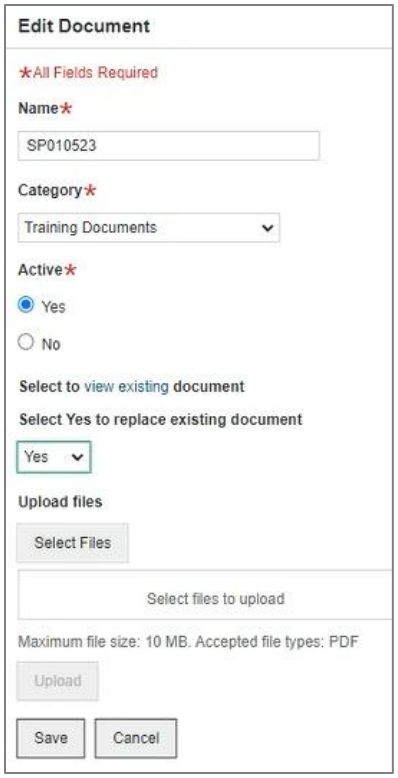
Note that you must manually edit the original document to an Inactive status.

Replace the Document

You may choose to remove the existing document completely and replace it with another file. To replace an entire document begin by selecting Yes from the Select Yes to replace existing document drop down, which opens the Upload file field.

- Select File – select a single file to be uploaded. A Status is displayed, such as an error message, or an indication that the document is ready to be uploaded
- Upload – use the Upload button when the status displays as Ready to Upload
- Save or Cancel – you must use the Save button before leaving the form to complete the upload action

Note that this action replaces the existing document, and that previous document is removed from the system.



Resources – ENS - Download Center

To access Optum Electronic Network Systems - Download Center select ENS – Download Center from the Resources drop down. Access is based on user roles and permissions.

Resources – OTI

To access Optum Transaction Integrity select OTI from the Resources drop down. Access is based on user roles and permissions.

Resources – Payer Configuration

To view Eligibility Payers and Claim Status Payers select Payer Configuration from the Resources drop down. Access is based on user roles and permissions.

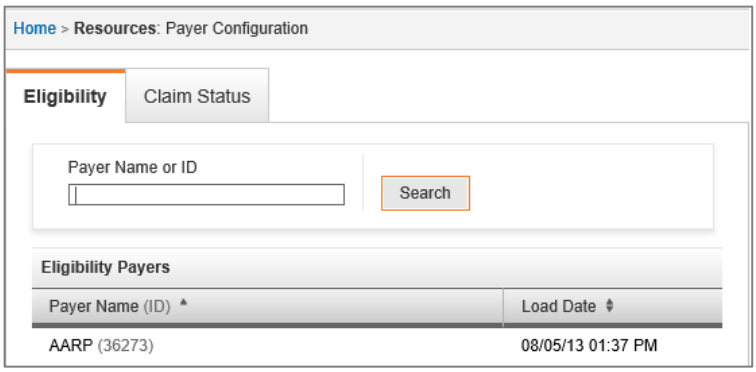
Payer Configuration – Eligibility Payers

From Resources/Payer Configuration use the Eligibility tab to view Eligibility Payers.

The Eligibility Payers grid is sorted by Payer Name (ID) , and reflects the Load Date.

You can search for an existing payer in the Eligibility Payers grid by entering the first two sequential characters in the Payer Name or ID field. Use Search to display possible matches in the Eligibility Payers grid.

Select the desired payer, or use the Clear Criteria option to begin a new search.



Select a row in the Eligibility Payers grid to view the configuration details for that specific payer. The selected payer displays in the Payer Configuration form.

The Payer Configuration form contains the Load Date, Search Options, and Service Types. You can use the active breadcrumb link to return to any previous tier.

The Search Options applicable to the selected payer are displayed in the Payer Configuration form (left pane).

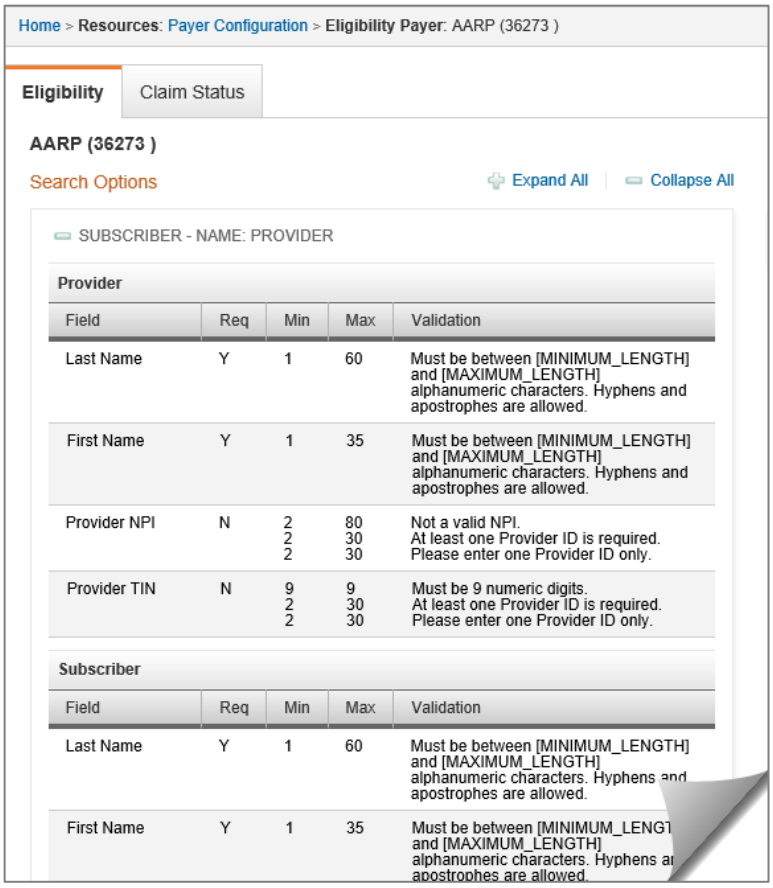
You can expand the Search Options to view search fields and validation requirements for Provider or Facility, Subscriber, Dependent, and Service.

The configuration details capture the precise validations required by the selected payer for each search field, as shown below.

The configuration details are described as follows:

- Field – the search field name
- Req – indicates if this field is a required field (Yes/No)

- Min – minimum allowable characters for the field, for each requirement if multiple
- Max – maximum allowable characters for the field, for each requirement if multiple
- Validation – specific validation requirements, which may include multiple requirements



The Service Types supported by a particular payer are displayed in the Payer Configuration form (right pane) by the service type description and code.

Use the radio buttons to sort Service Types by Description or by Service Type Code.

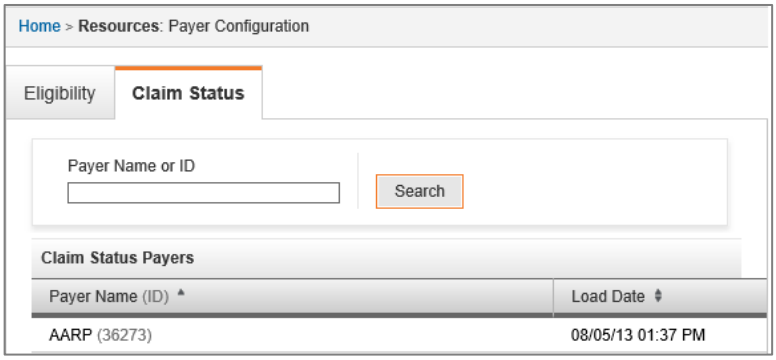
Payer Configuration – Claim Status Payers

From Resources/Payer Configuration use the Claim Status tab to view Claim Status Payers.

The Claim Status Payers grid is sorted by Payer Name (ID) in ascending order, and reflects the Load Date.

Search for an existing payer in the Claim Status Payers grid by entering the first two sequential characters in the Payer Name or ID field. Use Search to display possible matches in the Claim Status Payers grid.

Select the desired payer, or use the Clear Criteria option to begin a new search.



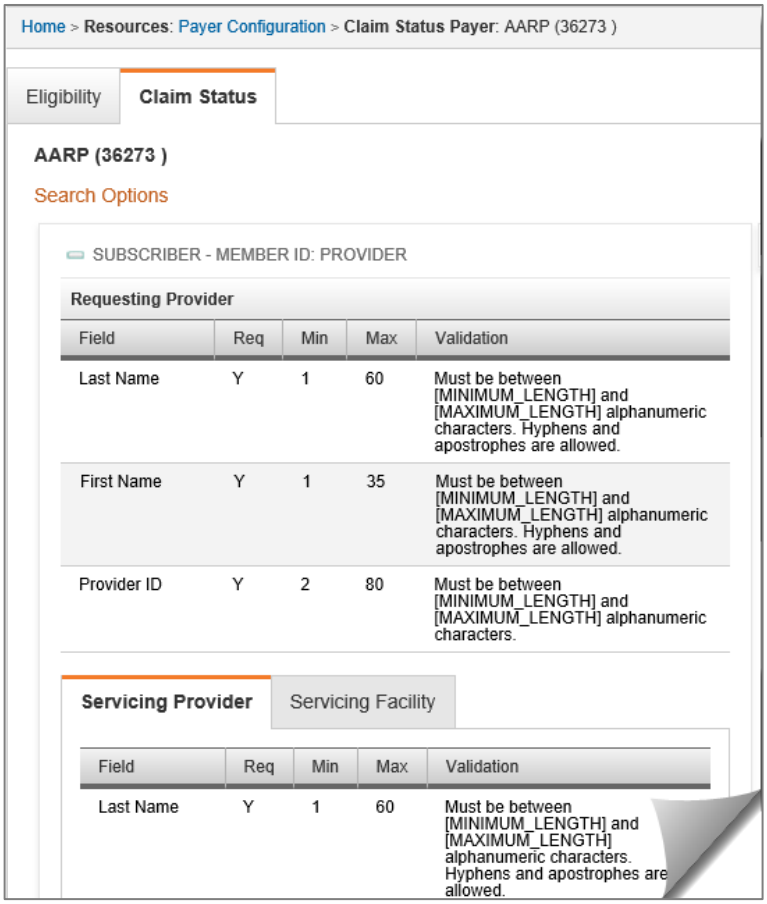
Select a row in the Claim Status Payers grid to view the configuration details for that specific payer. The selected payer displays in the Payer Configuration form.

The Payer Configuration form contains the Load Date, and Search Options. You can use the active breadcrumb link to return to any previous tier.

You can expand the Search Options to view search fields and validation requirements for Requesting Provider or Facility, and Servicing Provider or Facility, Subscriber, Dependent, and Claim Identification.

The configuration details capture the precise validations required by the selected payer for each search field, as shown below. The configuration details are described as follows:

- Field – the search field name
- Req – indicates if this field is a required field (Yes/No)
- Min – minimum allowable characters for the field, for each requirement if multiple
- Max – maximum allowable characters for the field, for each requirement if multiple
- Validation – specific validation requirements, which may include multiple requirements



Resources – Provisioning (legacy)

To access the Intelligent EDI Provisioning function select Provisioning (legacy) from the Resources drop down. Access is based on user roles and permissions.

Administration

To access certain Intelligent EDI Administration functions select from the currently available drop down in the Optum Intelligent EDI Portal page banner. Access is based on user roles and permissions.

Note that the Optum Intelligent Administrator Guide can be accessed via the Help link when you navigate to Resources/Admininstration(legacy); and also at Resources/Documents by searching the User Documentation category.

Customer Support

If you have any questions, issues, or concerns you may call 1.866.678.8646, or the assistance number currently displayed in the application.

The following information may be helpful:

- One Healthcare ID and Cloud Profiles – to access your profiles use the Profile link (in page banner by your name).
- Recommended browser is currently Microsoft Edge.
- Minimum supported Resolution 1024 x 768.
- It is suggested you open a new browser session each time you log in.
- It is recommended that you clear your browser cache as a preventive action whenever you are alerted that a new build is deployed to Production. This procedure differs based on your browser.
- If you do not have your cursor in a field and you use the Backspace key the response is that of the browser Back button, i.e., you will be navigated to the previous page.
- Your session times out after 15 minutes of inactivity.