Universal Patient Record (UPR) Guide

Enterprise Providers

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UPR

Overview

DISCLAIMER

The **UPR** features described herein are activated by HHAX System Administration. Please contact HHAX Support Team for details, setup, and guidance.

This guide covers the **Universal Patient Record (UPR)** Linked Contract functionality and how it affects the Patient record in the HHAeXchange (HHAX) system. The purpose of this functionality is to improve the Patient Management experience by resolving or removing certain limitations associated with historical HHAX Linked Payer Contract processes in the system. Historical HHAX Linked Payer Contracts were primarily governed by Payers via their own HHAX system to send Placements and Authorizations to Providers.

Key benefits of UPR Linked Contract functionality include:

- Elimination of duplicate records. The system allows one Patient record to host both Internal (Provider-controlled) and Linked (Payer-controlled) contracts.
- Greater Provider control of the Patient record. Historically, the majority of Patient details could only be updated by the Payer; Providers can edit more fields within the Patient record associated with UPR Linked Contracts.
- Standardization of functionality and workflows across all Patient records, regardless of the contract type.

The HHAX system:

- Ensures claim integrity across all contracts in the system with built-in safeguards to prevent users from sending incorrect claims or falling out of compliance.
- Maintains the core benefits and functionality associated with the historical HHAX Linked Payer Contract processes; such as Authorizations sent to Providers directly from Payers via HHAX, Communications functions for sharing information and messages with Payers, and the ability to submit claims with the proper validations in place that help increase payments and reduce denials.

Please direct any questions, thoughts, or concerns regarding the content herein to HHAeXchange Client Support.

Proprietary and Confidential

HHAX System Key Terms and Definitions

The following provides basic definition of HHAX System key terms applicable throughout the document.

Term	Definition
Patient	Refers to the Member, Consumer, or Recipient. The Patient is the person receiving services.
Caregiver	Refers to the Aide, Homecare Aide, Homecare Worker, or Worker. The Caregiver is the person providing services.
Provider	Refers to the Agency or organization coordinating services.
Payer	Refers to the Managed Care Organization (MCO), Contract, or HHS. The Payer is the organization placing Patients with Providers.
HHAX	Acronym for HHAeXchange

UPR: Patient Placement

Upon receiving a Patient Placement sent by a Payer, Providers can review and accept the placement from the Payer. In these cases, the Provider cannot schedule a Master Week at the moment of placement or prior to accepting the placement.

Once the placement is accepted, the Enterprise system creates a new *internal* Patient record (Patient Profile) populating key demographic data received from the Payer system. Allow some time for the placement to process in the system. Once a placement is accepted, it cannot be accepted by another Provider.

Note: *Refer to the Merging Patient Records section to consolidate a new placement with an existing Patient record.*

Home Page: Pending Placements

Accepted Placements

UPR: Patient Pages

Because the placement behaves similarly to an Internal Contract Patient record, Providers can edit fields and add multiple addresses, without affecting the Payer record. The same editing ability applies for phone numbers, emergency contacts, emergency preparedness, etc.

Patient Profile Page

When accepting a placement for a new Patient, the Patient Profile consists of editable fields including the ability to add multiple Patient addresses. Any changes/updates are NOT synced back to the Payer platform (self-contained within the Enterprise platform). Patients placed with multiple Providers have their own profile per Provider; no information (including addresses) is shared between Providers.

UPR Patient Profile

For billing purposes, the initial Patient Demographic details are stored at a Contract level in the Provider system and are kept up to date as changes are made by the Payer. Although Providers can change a Patient's demographic data on their system, the Payer system maintains the original details.

Payer Admission ID becomes Alt Patient ID

The **Admission ID** (the Payer's original at the time of placement) becomes the **Alt Patient ID** when the internal Patient record is created. In turn, the system creates a *new* **Admission ID** (specific to the Provider) and the **Alt Patient ID** is stored for tracking purposes.

EVV/GPS – Patient Multiple Addresses

It is recommended that the **Primary** (Billing) address coming from the Payer not be changed to prevent billing/claims issues. Providers can add and track multiple alternative addresses for EVV and operational purposes.

Merging Patient Profiles

A new placement can be merged into an existing Patient record, creating a new single Patient record. The new Patient Profile pulls information from the Payer placement. If a Patient already has an existing record, then the Merge feature is used to consolidate records.

Note: *In the Patient General page, the Merge Patient Record section replaces the Other Placements section to include the* ***Merge Patient*** *button.*

Complete the steps below to merge a record for a Patient with multiple records in the system.

Step	Action
1	Generate a Patient Search to locate the Patient Profile to merge records into. This is known as a *Parent* record in the system, where the merge is initiated from. Merged records into the Parent record are *Child* records; for example, a temporary record or a former Linked Contract record for the same Patient.
2	On the *Patient General* page, click the ***Merge Patient*** button to generate a list of other possible records matching the Patient record. **Merge Patient Button**
3	The system uses the following criteria to determine potential *Child* records that match the *Parent* record: • **SSN**; or • **Medicaid ID**; or • **First Name** + **Last Name** + **DOB** The image below displays the Patient's **Medicaid ID** in the Parent record (top) matching to several potential Child records (bottom). Click on the radio button to select the applicable Child record and click on ***Accept*** to initiate the merge request. **Merging Patient Records**

Step	Action
	Note: *For efficiency purposes, the system allows only one merge request per Patient at a time. One merge must be complete before initiating another.*
4	The *Confirm* window opens. The system alerts that some information may not transfer over due to potential conflicts (such as overlapping field values, visit exceptions, scheduling issues, etc.). Click **Yes** to continue. **Confirmation Window**
5	The Patient Merge request is complete. Click **OK** to continue. **Patient Merge Successful**

On the *Patient General* page, the newly merged record displays with a *Pending* **Status**, until the merge process completes.

Merge Status: Pending

When the merge status is *Pending*, additional updates can be made to both the Parent and the Child record before the merge takes place. A merge request with a *Pending* Status can also be cancelled by clicking on the Action link and selecting *Cancel*. Once the status changes to *In Progress*, the record is locked.

Once a Parent and Child record are merged, visits for both records can be seen in the Patient calendar (as illustrated in the following image). Invoices are also updated to point to the Parent record for continuity in scheduling, invoicing, billing, and remittances.

Merged Record: Patient Calendar

Confirm or Unmerge Records

Upon completion of the merge process, the Merge Patient request displays with a *Completed* **Status**. The system allows up to 5 days before permanently merging the records (and discarding the Child record completely). Within this 5-day window, users can either *Confirm* the merge permanently (before the 5 days) or *Unmerge* the records (reverting back to 2 separate records).

An Action link becomes available under the **Action** column, per row for records with a *Completed* **Status**. Click the link to open the menu to either *Confirm* the merge or *Unmerge* the merged record.

Action: Confirm or Unmerge

Select	To…
Confirm	Accept the merge permanently and the system discards the Child record via the nightly process.
Unmerge	Undo the record consolidation and revert back to 2 separate records. The Child record returns with its data set. The Status changes to **Unmerged**.

Validation to Restrict Merge of Duplicate Patient Records

A system validation stops Providers from merging duplicate Patient placements sent by a Payer; as merging such records causes billing issues. This scenario typically occurs when a Patient is discharged in the system and an additional placement for the same Patient (with the same **First Name**, **Last Name** and **DOB** or with the same **Medicaid Number**) is sent by the Payer.

When attempting to merge a new placement profile with an existing Patient Profile (with a *Discharged* status), the following factor is considered:
If the Parent and Child profile contracts do not overlap, then the system generates a validation stating that multiple placements for a specific Patient sent by the same Payer cannot be merged.

Merge Validation: Multiple Placements for Same Patient

Authorization

Providers cannot edit Authorization details for UPR Linked Contracts. Editing has been disabled for these contracts to protect Providers from changing values that may potentially cause claims rejections. If the Payer changes any details on their HHAX system, then the edit automatically reflects on the Provider's platform.

For UPR Linked Contracts, the *Patient Authorization* information is controlled by the Payer and most fields are locked including the **Billing Diagnosis Code** fields; the Diagnosis Code table is not seen for these Authorizations.

The **Diagnosis Codes** for an Authorization coming from the Payer are represented as read-only **Billing Diagnosis Code** fields on the Provider platform.

Provider Platform: Patient Authorization

Note: *If a Provider has access to the Patient's Clinical pages (**Patient > Clinical**), then they can enter and manage other **Diagnosis Codes**, **Surgical Codes**, as well as other Clinical information, without affecting the information received on the Authorization from the Payer.*

Limiting Entire Period Authorizations (Guardrails) for UPR Contracts

Payers can restrict **Entire Period** type authorizations to prevent Providers from over utilization (over-servicing the Member). Termed as **Guardrails** in the system, these controls govern how the authorization can be allocated by Providers, ensuring that units are available throughout the entire period (lasting to the scheduled End Date).

Refer to the Guardrails topic for full details on this feature.

Note: *This functionality only applies to **Hourly** rate types.*

Provider-Managed Guardrails for Entire Period Authorizations

Typically, when a Payer sends a Placement, all Authorization fields are locked for UPR Contracts.; however, Providers can set an Authorization Guardrail for Entire Period type Authorizations for UPR Contracts. This preserves the Payer's mandated overall Authorization limit while allowing a Provider more flexibility to subdivide the Authorization **Period** (*Monthly*, *Weekly*, or *Daily*) totals and use the **Additional Rules** functionality.

When an **Entire Period** type Authorization is sent by the Payer, the **Period** field becomes available for a Provider to edit on the *Patient Authorization* window, as seen in the following image.

Patient Authorization: Editable Period Type

If the Provider selects any other **Period** type, then the value (number of Units) originally indicated in the **Max Units per Period** field moves to the **Max Units for Entire Auth** field (and unavailable to edit), as seen in the following image. When the Period type is changed, the **Additional Rules** checkbox also becomes available to edit.

Max Units Per Period, Max Units for Entire Auth, and Additional Rules

Creating a TEMP Authorization

If a Payer does not send a timely authorization for a Patient, the Provider can create a TEMP Authorization. This enables the Provider to schedule visits and pay their Caregivers until the authorization is received from the Payer. An official Payer Authorization is required for billing; otherwise, the visits are stopped in Billing Review and cannot be billed.

To create a TEMP Authorization, navigate to ***Patient > Authorizations/Orders*** and click on the ***Add*** button to open the Patient Authorization window. Select the UPR Linked Contract from the **Contract** dropdown field. The **Authorization Number** field immediately auto-fills with *TEMP* (unavailable to edit), as seen on the image to the right.

Patient Authorization Created by Provider

Complete required fields (denoted with a red asterisk) and click ***Save*** to finalize.

In this case, once the Payer sends the official authorization, then applicable visits can be updated, and billing can take place. The TEMP Authorization can be deleted.

When the placement is sent, accept the placement from the Payer (UPR Linked Contract). Then, merge the placement with the “Temporary” Patient record and manually change the Contract on the *Schedule* tab to the UPR Linked Contract.

Solutions for TEMP Patient and/or Authorizations

The following are examples and recommended resolutions to handle missing Patient and/or Authorization scenarios.

Scenario	Recommended Steps
Brand New Placement with Authorization	Review and accept Pending Placement. A Patient Record with access to Internal and UPR Linked Contracts is created with an authorization.
Brand New Placement without Timely Authorization	1. Review the Pending Placement and accept. Once accepted, a new Patient record is created with access to both Internal and UPR Linked Contracts. 2. Create a TEMP Authorization. Refer to Creating a TEMP Authorization section. 3. Create and process visits as usual (from scheduling through payroll). ***Note:*** *Claims are held in Billing Review for TEMP Authorization.* **When the official Payer Authorization is received, two authorizations now exist for the Patient.** 1. Delete the TEMP Authorization. 2. Click on the Update link to recalculate. The recalculation process applies the Payer Authorization to the visits. Invoices are updated with the Payer Authorization number and claims can be processed.
No Timely Placement or Authorization	1. Create a new Patient record. 2. Assign an existing UPR Linked Contract to the Patient record. 3. Create a TEMP Authorization. Refer to Creating a TEMP Authorization section. 4. Create and process visits as usual (from scheduling through payroll). ***Note:*** *Claims are held in Billing Review for TEMP Authorization.* **When the official Payer Placement and Authorization are received.** • **Issue: The contract for the Payer Placement has overlapping Start of Care dates with the contract for the newly created Patient Record.** • **Resolution:** Adjust the overlapping dates, as follows: 1. Compare the dates on the contracts for the 2 Patient records. 2. Change the **Start of Care** date and **Discharge** date on both Contracts so that no overlap occurs. Contracts must have different period of care (date ranges). 3. Merge the records. 4. Click the Update link on the Authorization page. The Payer Authorization

Scenario	Recommended Steps
	is applied to all services once the nightly process completes.

Auto Placement by Service Code

The **Allow Auto Placement** field in the *Contract Service Code* window (***Admin > Reference Table Management > Contract Service Code***) allows Providers to schedule visits with the Service Code, even if the Payer has not sent a placement or an authorization. When enabled by the Payer, the field displays as auto selected and not available to edit by the Provider.

Contract Service Code: Auto Placement Field

Once the Service Code is created and synced from the Payer system, Providers can use the Auto Placement feature when creating new Contracts for a Patient by selecting the **Send Auto Placement** checkbox in the *Contracts* window, as seen in the following image.

Add a New Contract

Providers can also use the feature for an existing Contract. On the Patient *Contracts* page, right-click on the **Additional Options** link from an existing Contract and select **Send Auto Placement** from the menu, as seen in the image below.

Patient Contracts Page: Send Auto Placement Menu Option

Upon receiving the Auto Placement, the Payer reviews the Patient information (such as demographics, Medicaid ID, Patient Name, etc.) and sends the Provider a Placement Confirmation.

Discharge Date

The Payer issues and controls the Patient's **Discharge Date**, reflected on the Patient's contract. The information is synced from the Payer platform to the Provider platform, if/when modifications are applied by the Payer.

At times, the Provider may need to change a Patient's **Discharge Date** when a Patient is ready for discharge, but the Payer has not modified the information, skewing census count. In these cases, the Provider-modified **Discharge Date** only appears on the Provider platform (NOT synced to the Payer platform). This also applies if the Provider needs to extend the Discharge Date, with the understanding that those visits may not have authorization from the Payer.

Note: *The* ***Discharge Date*** *is initially set by the Payer. Any changes made by the Provider will be overwritten if a Payer makes changes.*

Patient Contract Page: Discharge Date

In addition, the system is equipped with a *Discharge Date e-billing* rule to help catch any discrepancies which may result in claim errors if the **Discharge Date** (changed by either a Provider or Payer) has elapsed for a visit's Date of Service.

Patient Visit Tabs

Tip: You can press **Ctrl-F** on your keyboard to search this topic.

Schedule Tab

All Contracts (Internal and UPR Linked) appear on the **Primary bill to** field and can be selected when scheduling a visit on the *Schedule* tab.

Selecting a Primary Bill To (Contract) on the Schedule Tab

Note: *All UPR Linked Contracts are identified by a 3-character Office suffix.*

The same applies when scheduling a Master Week. Providers can select Contracts (both Internal and UPR Linked) from the **Bill To** field interchangeably from one Patient Profile.

UPR: Master Week

Note: *All UPR Linked Contracts are identified by a 3-character Office suffix.*

Visit Info Tab

On the *Visit Info* tab, some fields (such as **TT/OT**) are unavailable if the contract selected for the visit is a UPR Linked Contract. This does not apply to internal contracts.

Sync Visit Reasons and Action Taken Fields for All Linked Contracts

The system uses the **New Reason** and **Action Taken** fields when a visit is marked as **Missed** or edits are applied to a confirmed visit, as defined by the Payer for *all* Linked Contracts. Typically, these fields are managed by Providers for Internal Contracts via the Reference Table Management function. For UPR Linked Contracts, the values for these fields depend on the contract selected in the **Primary bill to** field in the *Schedule* tab.

On the *Visit Info* tab, when a visit is marked as **Missed** or has been edited for *any* Linked Contract, the **New Reason** and **Action Taken** field values are derived from the associated Payer.

Visit Info Tab: New Reason and Action Taken Fields

Note: *If there are no* ***New Reason*** *and/or* ***Action Taken*** *values defined by the Payer for a* ***Missed Visit****, then the application pulls the values from the Provider reference tables.*

Custom Fields in Visit Info Tab

DISCLAIMER

Custom Fields are Payer and/or State required; configured by HHAX System Administration. These fields are only visible if the Payer and/or State requires capturing information. Please contact HHAX Support Team if any questions.

Custom fields may be added to the Visit Info tab for Skilled and Non-Skilled visits to capture Payer and/or State information (based on the Patient's Primary Address). If applicable to a Patient, custom fields appear in Green text to differentiate from a standard field (as seen in the following image).

Some custom fields may become required (denoted by a red asterisk) depending on the Payer or State mandate. When applied, these fields are visible in both the Provider and Payer environments; read-only in the Payer environment.

Visit Info: Missed Visit Custom Fields

Bill Info Tab

For UPR Linked Contracts, Billing information is limited or unavailable to edit on the *Bill Info* tab to prevent Providers from changing any information that may result in a rejected claim. For example, the **Adj. Hours**, **Banked Hours**, **TT/OT Hours**, and **Bill Rate** fields are locked in the **Primary Bill To** section. The **Secondary Bill To** section is completely unavailable for UPR Linked Contracts (as seen in the image below).

Note: *Payers may allow a Provider to edit the billing rate, based on configuration. In these cases, the* ***Bill rate*** *field can be adjusted.*

Bill Info Tab

UPR: Patient POC

The Patient's Plan of Care (POC) functionality is standardized and streamlined for Providers to create and use one POC for a Patient, regardless of the selected Contract. The POC is fully controlled by the Provider; the Payer does not send the POC.

Patient Special Requests

The **Patient Special Request** functionality is created and managed by the Provider.

Added Rates Page for UPR Linked Contract Patients

The *Rates* page is available for UPR Linked Contracts. If the Payer allows, a Provider can:

- add rates at the Patient level,
- manage (control) rates in the ***Bill Info* tab** for a visit, and in the **Contract Setup/Billing Rates** tab.

Rates Window (Patient)

Payer-Defined Multi-Rate Feature

The Payer-defined District Rates functionality applies to Providers who service in various regions. This functionality allows Payers and Providers (with Payer permission) to set and bill for the appropriate amount (according to regional rates assigned by the Payer).

In the *Contract Setup Billing Rates* tab, any **Discipline** denoted with a **+/-** indicates multiple rates (as seen in the following image).

Payer Multi-Rates

The *District Rates* appear in the *Contract Rate* window (accessed by clicking on the Edit link). Providers can change **District Rates** based on Payer permissions. However, the system determines which rate to use based on the **Billing Address** as defined by the Payer.

District Rates

Billing Process for UPR Linked Contracts

This section covers each phase of the Billing Process for UPR Linked Contracts.

Phase 1 – Create New Invoice Batch

Step	Action
1	Navigate to ***Billing > New Invoice - (Internal)*** to generate a New Invoice Batch. Search for a specific visit using the filters or click on ***Search*** to generate all results. ***Note:*** *To search all prior visits (eligible for invoicing), HHAX recommends that the* **From Date** *field is left blank.*
2	Review the results and select the visits to invoice. **New Invoice Batch (Internal): Invoice Batch**
3	Once the visits are selected, there are various options at the bottom of the page as described in the following table. Select an action button to proceed. To invoice, click on the ***Invoice Batch*** button.

Option	Description
Save	Saves all the selected visits, but does not invoice them. From here, navigate to the next page of search results (if applicable) without losing the selection.
Save & Next	Saves all the selected visits and loads the next page of search results (if applicable).
Select All & Save	Saves all visits on the current page. From here, navigate to the next page of search results (if applicable) without losing the selection.
Unselect All	Unselect any selected/saved visits.
Invoice Batch	Invoice all selected visits and generate a new ***Invoice Batch***.

Step	Action
	Cancel Cancel entire batch
4	The system alerts that the Billing Batch is generating. Click ***OK*** to continue. **Generating Billing Batch**

Phase 2 – Create a New Claims Batch

Step	Action
1	Navigate to ***Billing > Electronic Billing > E-Submission Batches*** to generate a New Batch Claim.
2	On the *E-Submission Batches* page, click on the ***Add Original Claims*** button. **Add Original Claims**
3	On the *Add Original Claims E-Submission* page, select the **Contract**. The **Batch Number** and **Batch Date** populate. Click on the ***Add Claims*** button. **Add Claims**
4	On the *Add Claims, Claims Search* page, use the search filter fields or click on the ***Search*** button to find claims.

Step	Action
	 Claims Search
5	On the Search Results in the *Claims* section, select the claims to be added and click the ***Add*** button at the bottom of the page. **Claims Search: Select Batch(es)** ***Note:*** *Visits with a yellow warning icon (with no active checkbox) are held in Billing Review with an On Hold Status and must be resolved prior to billing. Hover over the icon for a pop-up indicating the hold reasons.*
6	The claims appear on the *Add Original Claims E-submission Batch* page. Click on the ***Save Batch & Send*** button to send the claims to the SFTP to be picked up by the Payer system via the overnight process.

Step	Action
	 Claims E-Submission: Save Batch & Send ***Note:*** *Using the* ***Save for Later*** *button only creates the claims batch but does not send to the SFTP. Refer to Reviewing a Claims Batch for further instructions.*
7	The system alerts that the export file is generating. Click ***Close*** to continue. **Export File Generating**
8	(Optional) Navigate to ***Admin >Process Monitor*** to view the progress of the submission. Expand the **All Sections** category to view. The file can either be in *Pending* or *Completed* status. **Process Monitor: All Sections**

Phase 3 – Reviewing a Claims Batch

Follow the steps below to review claims batches. If claims are saved but not sent, follow the instructions below to Send the claims batch.

Step	Action
1	Navigate to the Batch Search window ***(Billing >Electronic Billing > E-Submission Batches***) to review the claims.
2	On the *E-Submission Batches* page, select a contract from the **Contracts** field and click on the ***Search*** button to search for batches. On the Search Results, locate the batch and click on the ellipsis (**…**) under the **Actions** column for a list of menu options to include *Batch Details*, *Export*, *Send*, *Detail Report*, and *Summary Report* (as seen in the following image). **Review a Claims Batch** ***Note:*** *If the batch has been submitted to the SFTP, then the Send option appears unavailable to select. If the Send option appears available, then the claim has not been sent.*
3	Select the ***Send*** option to manually send a claims batch to the SFTP.

Billed Status Once Exported

Providers can view up-to-date export statuses for related billing batches. On the *Batch Details* page (***Billing > Invoice Search > By Batch***), batches display the payment **Status** for exported claims to include *Pending*, *Billed*, *Partially Billed*, or *N/A*.

Batch Search: Billed/Partially Billed/Pending/NA Statuses

To view the status for a batch individually, click the **Batch Number** and view the **Status** on the top-right of the *Batch Details* page.

Batch Search: Batch Number Batch Details: Status Field

Batch Details: Status Field

Rebilling (Claims Submission)

Step	Action
1	Navigate to ***Billing > Electronic Billing > E-Submission Batches***. **Navigate to Resubmit Claims** ***Note:*** *This process is the same for UPR Linked Contracts and Internal Contracts*
2	On the *E-Submission Batches* page click on the ***Add Resubmit Claims*** button. **Add Resubmit Claims**
3	On the *Add Resubmit Claims E-submission Batch* page, select the **Contract**. The system automatically generates a **Batch Number** and the **Batch Date** for the claims resubmission. Click on the ***Add Claims*** button. **Add Claims**

Step	Action
4	On the *Add Claims, Claim Search* page, select applicable filter fields and click ***Search***. **Add Claims: Claims Search**
5	From the Search Results, select the claims to add and click on the ***Add*** button at the bottom of the page. **Add Claims** ***Note:*** *Hovering over the* ***Status*** *icon provides a high-level indication of the state of the claim and possible missing information.*
6	On the *Add Resubmit Claims E-submission Batch* page, click on the edit icon ( ) to open the *Claims Adjustment* window

Step	Action
	Select Claim to Adjust . ***Note:*** *To delete a record from the claim to be resubmitted click on the* 🗑 *icon under the* **Actions** *column.*
7	The *Claim Adjustment* window opens. Select the **Submission Type** (refer to the Rebilling Adjustment Types section for guidance). Correct any applicable fields ensuring that required fields (denoted with a red asterisk) are completed. **Note:** *The* **Billed Adjusted Hours**, **TT Hours**, *and* **3rd Party** *fields cannot be edited when resubmitting a claim.* **Claim Adjustment Window**
8	Once saved and ready to resubmit, click on the ***Save Batch & Send*** button on the *Resubmit Claims E-submission Batch* page. **Resubmit Claim**
9	The system alerts that the export file is generating. Click ***Close*** to continue.

Rebilling Adjustment Types

Select	To...
Original	Default option; used if the Provider does not edit the Submission Type.
Adjustment	The **TRN Number*** and **Update** fields are required if *Adjustment* is selected. For the **TRN Number**, indicate if this adjustment is for a *Single Claim*, *All Claims with same Invoice Number*, or *All Selected Claims*. Refer to the bullets below this table for guidance. ***TRN** refers to Transaction Reference Number, unique claim identifier number to be adjusted. The **TRN** can also be referred to as the *Form Number*, *Claim ID*, or *Claim Number*. The **TRN** can is also located on the Electronic Remittance Advice (ERA).
Void	When selecting *Void*, the **TRN Number** is required and the **Place Updated Visit on Hold** checkbox is automatically selected and un-editable. Select the applicable **Update** option (*Single Claim*, *All Claims with same Invoice Number*, or *All Selected Claims*). **Note:** *Selecting Void hides other adjustment information fields on the window.*

Upon adjusting, click ***Save*** to update the selected record(s). Based on the selected **Submission Type**, respective **TRN Number**, and **Update** option, the selected records are updated accordingly.

- If *Single Claim* is selected (from the **Update** field), then only the current record for the selected **Submission Type** and **TRN Number** is updated.
- If the *All Claims with same invoice number* is selected (from the **Update** field), then all matching records with the same Invoice Number are updated according to the chosen **Submission Type** and **TRN Number**.
- If *All Selected Claims* is selected, then all records are updated with chosen **Submission Type** and **TRN Number**.

Editable TRN on UPR Rebilling

On the *Invoiced Visit Search* page (***Billing > Invoice Search > By Search***), the **TRN** (Transaction Reference Number) can be manually edited or entered for UPR contracts to assist with electronic rebilling claim processes. Click the Y hyperlink in the **Export Status** column for a corresponding invoice to edit or enter a **TRN** number in the *Update Export Flag to "No"* window.

Invoiced Visit Search: Update Export Flag to No Window: Manual Hold Reason and TRN Fields

Additionally, the **TRN Number** is also editable at the *Billing Info* tab located at ***Patient > Search Patient > Calendar*** at the visit level.

Edit Visit Window: TRN Number Field

Rebilling Condition Code

DISCLAIMER

This feature is Payer-managed and activated by HHAX System Administration. Please contact HHAX Support Team for details, setup, and guidance.

For some contracts, Payers require a Condition Code for Providers to indicate the reason for resubmitting a claim. The **Conditional Code** field is used to provide a reason when changing the **Submission Type** of a resubmitted claim to *Adjustment* or *Void*.

When the feature is enabled for the Provider, the **Condition Code** field appears in the *Claims Adjustment* window (***Billing > Electronic Billing > E-Submission Batches > Search > Claim Batch #***). The values include the various codes assigned to the reasons listed, as seen in the following image.

Rebilling Claim Adjustment - Conditional Code

In the *Add Resubmit Claims E-Submission Batch* page, the selected *Condition Code* appears under the **Condition Code** column in the listed claims, as seen in the following image.

Add Resubmit Claims E-Submission Batch Page – Condition Code Column

EDI Billing Fields for UPR Providers

DISCLAIMER

This feature is activated by HHAX System Administration. Please contact HHAX Support Team for details, setup, and guidance.

3rd Party Providers can use their EDI Billing Interface to apply their billing rates instead of the HHAX billing rates in the application. This feature applies to Providers with UPR Contract Patients.

When this feature is enabled, three fields are available in the *Bill Info* tab: **EDI Units**, **EDI Rates**, and **EDI Total** (as seen in the following image). These fields are required (as denoted with a red asterisk). The **EDI Rate** and **EDI Total** values must be entered in whole numbers with a limit of 2 decimal placements (if applicable).

Bill Info Tab: EDI Billing Fields

Note: *HHAX billing fields display as NA to indicate that these values are EDI Billing fields. If no data is provided for the visit OR any one field value is NULL, then the EDI fields do not display.*

Validations

All 3 fields are required. If any of the fields are left blank, then the system issues a validation when attempting to save (as seen on the image to the right).

Validation(s): Required Fields

The **EDI Rate** and **EDI Total** fields are limited to 2 decimal places after a whole number. If more than 2 decimal places are entered, then the system issues a validation error as seen in the image to the right.

Validation: Field Limitations

UPR Contracts in the File Processing Page

A **Contract Type** field is available to track UPR Contracts in the File Processing feature (***Admin > File Processing***). To access file processing for UPR contracts, select *UPR Contract* in the **Contract Type** field to view what has been exported and accepted.

File Processing: Contract Type Field: UPR Contract

The **File Name** column appears blank for those Payers who have moved to a third-party EDI platform. Select *Export* from the Action link in the applicable record to submit the batch.

File Processing: Export

Once submitted the system alerts of a successful submission.

Message: Claim File Successfully Submitted

Contract Setup

Navigate to ***Admin > Contract Setup > Contract Search*** to locate the Contract. UPR Linked Contracts are created on behalf of the Payer via the linking function (not by the Provider as with Internal contracts). Specific changes to highlight for UPR Linked Contracts are in the *General*, *Billing Rates*, and *Scheduling/Confirmation* tabs.

In the *General* tab, the following fields are read-only for Providers: **Contract Name**, **Offices**, **ICD Code Requirement**, as well as the entire *Address* section.

Contract Setup: General Tab

In the Billing Rates tab, the Edit links and ***Update Rate*** buttons are enabled if the Payer allows the Provider to update rates. As stated in the Patient Rates Page section, rates can also be managed (controlled) in the ***Bill Info* tab** for a UPR Linked Contract visit, and in the **Contract Setup/Billing Rates tab**.

Contract Setup: Billing Rates Tab

In the *Scheduling/Confirmation* tab, various fields are unavailable for Providers to edit. In the *Scheduling Configuration* section, the **Authorization Required** checkbox is preselected and the **Authorization Week**

field is hard-coded for all UPR Linked Contracts as a standard. The **Auto-Confirm Visit End Time (Skilled Visits)** checkbox is unlocked allowing Providers to better manage UPR Linked Contracts.

Contract Setup: Scheduling/Confirmation Tab (Unavailable Fields)

Providers have autonomy on other areas in the Scheduling/Confirmation tab such as requiring fields on the Patients' Visit Info tab, Clinical Documentation, and Timesheets requirements.

Contract Setup: Scheduling/Confirmation Tab (Editable Fields)

Inactivate Billing Rates

Providers, with enabled permissions to manage billing rates, can inactivate billing rates for certain Linked contracts; typically, older rates that no longer apply. Because billing rates cannot be deleted, they are *inactivated* in the system. This feature helps in preventing data update conflicts between Payers and Providers.

To inactivate a billing rate, navigate to the *Contract Setup* page (***Admin > Contract Setup***) and select the applicable Contract. On the *Contract Setup* page, select the Billing Rates tab and locate the desired rate. Click on the **Edit** link for that rate to open the *Contract Rate* window.

On the *Contract Rate* window, deselect the **Active** checkbox and click ***Save*** to finalize.

Contract Rate Window

Sync Caregiver Restrictions in UPR

When a Caregiver Restriction is applied to a Caregiver by a Payer for a UPR Linked Contract, the restriction is viewed on the *Caregiver Absences/Restrictions* page (***Caregiver > Absences/Restrictions***), as illustrated in the image below. Restrictions applied by a Payer are *read-only* and identified under the **Created** column with no options to edit or delete.

Restrictions entered by a Provider have the Edit link and delete icon. Caregiver Restrictions can overlap and the Caregiver cannot be scheduled to service Patients until all restrictions are lifted.

Caregiver Absence/Restrictions Page: Payer Restrictions

Note: *Navigate to* ***Caregiver > Restricted Caregivers*** *to search for restricted Caregivers using* ***Name, DOB, SSN****, and date range.*

Automatic Creation of Schedules for UPR

The **Automatic Creation of Schedule (ACS)** feature is available for UPR Linked Contract Patients, allowing users to create visits via the *Call Maintenance > Automatic Creation of Schedules* page or the nightly process. To enable this feature, navigate to the *Contract Setup, Scheduling/Confirmation* tab (***Admin > Search Contract > Scheduling/Confirmation***) and select the **Automatic Visit Creation Based on EVV Confirmation** checkbox (as seen in the following image).

Contract Setup: Scheduling/Confirmation Tab: Automatic Creation of Schedules Checkbox

Once enabled, the system automatically creates schedules, as seen in the following image.

Edit Taxonomy and Revenue Codes in UPR

With Payer-granted permission for UPR Linked Contracts, Providers can now add/edit the **Revenue** and **Taxonomy Codes** in the *Contract Service Code* window (***Admin > Reference Table Management > Contract Service Code***).

Contract Service Code: Revenue and Taxonomy Code